# Torbay and South Devon NHS Foundation Trust

## Public Board of Directors

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

07 September 2016 09:00 - 07 September 2016 11:30

# AGENDA

| # | Description | Owner | Time |
|---|---|---|---|
| 1 | PART A: Matters for Discussion/Decision | | |
| 1.1 | Apologies for Absence - Chief Nurse<br>Note | Ch | |
| 1.2 | Declaration of Interests<br>Note | Ch | |
| 1.3 | Minutes of the Board Meeting held on the 3rd August 2016 and Outstanding Actions<br>Approve<br>16.08.03 - Board of Directors Minutes Public.pdf 7 | Ch | |
| 1.4 | Report of the Chairman<br>Note | Ch | |
| 1.5 | Report of the Chief Executive<br>Assurance<br>Report of the Chief Executive.pdf 21 | CE | |
| 1.6 | Strategic Issues | | |
| 1.6.1 | STP Feedback<br>Information | DSI | |
| 1.6.2 | Stakeholder Engagement<br>Discuss<br>Stakeholder and Voluntary Sector Engagement.pdf 31 | DSI | |
| 1.6.3 | Community Consultation<br>Discuss<br>Reshaping Community-Based Health Services.pdf 67 | DSI | |

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| 1.7 | Integrated Quality, Performance and Finance Report - Month 4<br>Assurance<br>Integrated QPF Report.pdf 113 | DSI | |
| 1.8 | Governors' Questions<br>Discuss | Ch | |
| 1.9 | Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF) | | |
| 1.9.1 | Safety Scorecard<br>Assurance<br>Safety Scorecard.pdf 175 | MD | |
| 1.9.2 | Safeguarding Adults Annual Report<br>Assurance<br>Safeguarding Adults Annual Report.pdf 195 | CN | |
| 2 | PART B: Matters for Approval/Noting Without Discussion | | |
| 2.1 | Reports from Board Committees<br>Assurance | | |
| 2.2 | Reports from Executive Directors | | |
| 2.2.1 | Report of the Chief Nurse<br>Assurance<br>Report of the Chief Nurse.pdf 205 | CN | |
| 2.2.2 | Report of the Medical Director<br>Assurance<br>Report of the Medical Director.pdf 217 | MD | |
| 2.2.3 | Report of the Chief Operating Officer<br>Note<br>Report of the Chief Operating Officer.pdf 221 | COO | |
| 2.3 | Compliance Issues | | |

| # | Description | Owner | Time |
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| 2.4 | Any Other Business Notified in Advance | Ch | |
| 2.5 | Dates of Next Meeting - 9.00 am, Wednesday 5th October 2016 | Ch | |
| 2.6 | Exclusion of the Public | Ch | |

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Torbay and South Devon NHS
NHS Foundation Trust

**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST BOARD OF DIRECTORS MEETING HELD IN THE ARLINGTON ROOM, TOORAK HOTEL, TORQUAY ON WEDNESDAY 3RD AUGUST 2016**

**PUBLIC**

| | | |
|---|---|---|
| Present: | Sir Richard Ibbotson | Chairman |
| | Mr D Allen | Non-Executive Director |
| | Mr J Furse | Non-Executive Director |
| | Mrs J Lyttle | Non-Executive Director |
| | Mr R Sutton | Non-Executive Director |
| | Mr J Welch | Non-Executive Director |
| | Mrs M McAlinden | Chief Executive |
| | Mr P Cooper | Director of Finance |
| | Mrs L Darke | Director of Estates and Commercial Development |
| | Ms L Davenport | Chief Operating Officer |
| | Dr R Dyer | Medical Director |
| | Ms J Saunders | Director of Workforce and Organisational Development |
| | Mrs J Viner | Chief Nurse |
| | Mrs A Wagner | Director of Strategy and Improvement |
| | Councillor J Parrott | Torbay Council Representative |
| In Attendance: | Mrs S Fox | Board Secretary |
| | Mrs J Gratton | Interim Head of Communications |
| | Mr R Scott | Corporate Secretary |

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|---|---|---|---|
| Mrs C French | Lead Governor | Mrs C Carpenter | Governor |
| Mrs B Inger | Governor | Mrs M Lewis | Governor |
| Mrs W Marshfield | Governor | Mr P Welch | Governor |
| Mr D Brothwood | Member of the Public | Mr W Liddell | EMIS Account Manager |

The Chairman commenced the meeting by welcoming Ms Saunders to her first meeting as Director of Workforce and Organisational Development. He added that the Board now, for the first time in a long time, comprised substantive postholders.

**ACTION**

107/08/16 **Recipient Story**

The Recipient Story was presented by the Matron and an OT from ICU and concerned the care provided to patients who required significant rehabilitation after a lengthy period in ICU. The team outlined the importance not just of the physical but also the mental rehabilitation that was required and the multi-disciplinary team approach to provide this care. Also raised was the importance placed on the role of the carer and the need to keep them involved in the process when the patient was moved from ICU, where one to one care was provided, to a ward and then home.

Following the presentation Mr Welch stressed the need to publicise and share the work undertaken by the team so that it could be replicated in other areas of the Trust and also outside of the Trust and this was acknowledged.

**PART A: Matters for Discussion/Decision**

**Apologies**

Apologies were received from Mrs Marshall and Mrs Taylor.

**Declarations of Interest**

Nil.

**Minutes of the Board Meeting held on the 6th July 2016 and Outstanding Actions**

The minutes of the meeting held on the 6th July 2016 were approved as an accurate record.

**Report of the Chairman**

The Chairman had visited the Herald Express recently and reminded the Board that the paper was keen to publish any positive stories the Trust might have whether it was around improved services or 'people' stories. He would further discuss this with the Communications team.

The Chairman briefed the Board on the NED to NED meeting with the CCG that took place earlier in the week where the scale of the challenge for both organisations was discussed and debated.

Finally, the Chairman clarified a statement at the last Board meeting where it could have been construed that he had stated the Trust was increasing the size of its technical support team, when he was referring to the fact that the Trust had commenced an apprenticeship programme for service which was proving very successful.

**Report of the Chief Executive**

The Board noted the Chief Executive's report, and she then provided a briefing on issues that had arisen since her report was finalised:

- An Executive to Executive meeting had taken place with the CCG where the many challenges both organisations were currently facing were discussed.

- The Trust had been recognised nationally as high performing in terms of low delayed discharges and reflected the improvements the ICO, as a joined-up system, had already made. The Trust needed to build on this evidence to better explain to the community the positive changes already made since integration and she had, in the Chief Executive's Weekend Diagnosis column in the Herald Express at the weekend, set out the context and background to those changes.

- On behalf of the Chief Executive, the Chief Operating Officer had attended a meeting at Dartmouth with Sarah Wollaston MP and a number of key local stakeholders. The Chief Operating Officer reported that the meeting had been very positive and that there was a clear understanding of the need for change and also what the Care Model offered, but concern was expressed about current and future provision of services that would replace those at Dartmouth Hospital, and the workforce needed to deliver same.

**Strategic Issues**

**STP Feedback**

The Director of Strategy and Improvement informed the Board that the STP submission had been made and leaders from the Devon area met with national leaders to discuss the submission. Each submission would be categorised – Tier 1 – no further work, implement plan; Tier 2 – balanced plan but more work to do to ensure delivery; and Tier 3 – plan not balanced and a lot more work to be completed. Formal feedback on the STP submissions had not yet been received.

STP areas had then been asked to submit, at very short notice, a response on shared, vulnerable and pathology services. The wider Devon STP leadership had made it clear to the centre that progress had been made on some areas already and they would not be submitting an additional plan to the one already in place.

Final approval on the Community Consultation plans was awaited, but it was likely the local CCG would be given approval to commence in September and later for NEW Devon.

Finally, the Board noted that, as detailed in the Chief Executive's report, a 'financial reset' document had been issued relating to the STP and that a lot more communication was expected from the centre around expectations in terms of STP delivery and allocation of the STF funding.

**ICO Post Transaction Review**

The Director of Finance spoke to the paper, which was a requirement of the NHS Transaction process was to undertake a Post-Transaction Review, normally 100 days after authorisation. Its principal purpose was to provide assurance to Regulators that the transaction was executed effectively, that governance arrangements were appropriately in place and that the benefits anticipated, from a service and financial perspective, were on track to be delivered.

In a formal sense, it was also the route through which the limited number of conditions included in Monitor's Letter of Authorisation were discharged.

As well as providing assurance to Regulators and other interested stakeholders, it provides an opportunity for the Board responsible for the transaction to reflect on its delivery; to consider what went well, what could have gone better and, through that to capture 'lesson learned' for future use

Key Issues/Risks

The report highlighted the following:

- The actions required to effect a 'safe landing' of the transaction and to ensure that corporate and clinical governance systems were fit for purpose on day one of the new organisation had in very large part been delivered.

- Back office services had been effective from day one, with no interruption in service to the wider organisation.

- Good progress was being made in specifying and delivering the care model. Whilst the nature of the care model vision had developed since the transaction, this formed the core of the on-going work emerging from integration. Progress delivering the plans had been slower than anticipated, primarily due to delays in the consultation process, but there had been significant steps taken, and this remained as defining the future shape of our services. The delayed timeline was having a consequent impact on financial

plans for 2016/17.

- Despite some challenges in maintaining the Risk Share Agreement into 2016/17, contract negotiations had ultimately proven successful, and greater clarity in its operation secured going forward.

- Pressures associated with CIP delivery and the urgent and emergency care system were adding to the financial pressure in 2016/17.

The Board noted that, as stated in the report, the integration process had gone very well and that the report provided feedback to NHSI on the successful implementation of the acquisition. Councillor Parrott asked whether the report would be forwarded to Ministers for review and it was noted that the Trust was only required to submit it to NHSI. The Director of Finance said he would ascertain if there was any reason why it could not be forwarded to Ministers by this Trust, and added that as it was a public document it was already in the public domain. DoF

**The Board approved the report for publication.**

**Integrated Quality, Performance and Finance Report – Month 3 (Quarter 1)**

Strategic Context

This month's Integrated Quality, Performance and Finance Report, comprising high level summary performance dashboard, narrative with exception reports, detailed data book and financial schedules provided an assessment of the Trust's position for June (month 3) 2016/17 and the cumulative position for the first quarter of the year 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 were identified and associated action plans reported. The report identified areas where performance had improved. Based on Q1 performance the Trust would secure the Q1 element of the Sustainability and Transformation Fund.

The report also included the in-year (Q1) Governance Statement from the Board for submission to NHS Improvement declaring where the Board was confirming or not confirming compliance with the required finance and governance statements of the Risk Assessment Framework for 2016/17 Annual Plan Delivery. The declaration was reviewed by the Finance, Performance and Investment Committee and, as the Committee was not quorate, referred to the Chief Executive and Chairman for final sign off.

This report and attachments have been reviewed by the Finance, Performance and Investment Committee (26th July) and Executive Director Group (26th and 19th July). Performance of each Service Delivery Unit (SDU) was currently reviewed by Executive Directors on a bi-monthly basis through the Quality and Performance Review meetings. This enabled the corporate team to receive assurance, prioritise areas for improvement, consider support required and oversee action plan delivery. This month the Surgical SDU and Women and Children's, Diagnostics and Therapies SDU were reviewed (18th July). The Quality and Performance Reviews would move to monthly from September as part of enhanced accountability and reporting arrangements.

The new style report was presented pending a more comprehensive update being finalised for release later this year in response to Carter and the proposed Single Oversight Framework currently out to consultation by NHS I. The Performance Team had continued to work on the metrics included in the report and within the Quality Framework section there were some changes and additions which have been requested by the Chief Nurse.

**Key Issues/Risks:**

**Quality Framework:**
19 indicators in total of which 5 were RAG rated RED for June (4 in May) as follows:

- Avoidable New Pressure Ulcers – Category 3 & 4 – 2 (2 last month) against threshold max 9 in year
- VTE risk assessment on admission (community) – 91.2% (92.9% last month) against 95% standard.
- Stroke Patients Spending 90% of Time on a Stroke Ward – 71.4% (79.6% last month) against >80% standard
- Dementia Find – 31.9% (target 90% - 29.8% last month)
- Follow ups past to be seen date – 6,219 deterioration of 146

Of the remaining 14 indicators, 10 were rated GREEN, 3 AMBER and 1 rated in arrears - HSMR last rated as GREEN.

This month safer staffing measures and medication errors leading to harm have been included for the first time.

**NHS I (Monitor) Compliance Framework:**
12 performance indicators in total including the quarterly governance rating. From these, 1 is RAG rated RED for June:

- Urgent care (ED/MIU combined) 4 hour wait – 91.6% (87.4% last month) against national standard 95% - note Trust was overachieving against the SRG agreed STF trajectory of 86.8% for June.

One indicator was rated as amber, Cancer 31 day decision to first treatment.

All of the remaining indicators, 10 were rated GREEN including RTT and the forecast NHS I governance rating. The forecast governance rating includes cancer standards which are all assessed as delivering for the quarter.

At month 3 for 2016/17 the Trust is in line with the planned Financial Sustainability Risk Rating of 2. Areas under pressure included:

- CIP delivery
- Capital expenditure behind plan
- Agency spend on nursing is above the agreed cap. Further details are included in the Chief Nurse's report

Both the EBITDA and I&E positions indicated a positive position against year to date plan to M3.

**Contractual Framework:**

15 indicators in total of which 8 are RAG rated RED as follows:

- Diagnostic tests over 6 weeks – 1.1% (0.9% last month) against 1% standard
- RTT waits over 52 weeks – 5 (6 last month) against 0 standard

- On the day cancellations for elective operations – 1.6% (1.4% last month) against <0.8% standard
- Cancelled patients not treated within 28 days of cancellation – 6 (9 last month) against 0 standard
- A&E patients (ED only) – 87.2% (81.2% last month) against 95% target Note: locally agreed SRG trajectory for MIU / ED = 86.8%
- Number of Clostridium Difficile cases (acute & community combined) – 4 (5 last month) against, 3 threshold
- Care plan summaries % completed within 24 hrs discharge weekdays 59% (56% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 35% (22.4% last month) against 60% target

Of particular note was the improved (amber rated) position for ambulance handovers, there were 37 handovers greater than 30 minutes in June, compared to 111 the previous month. There were zero ambulance handovers greater than 60 minutes, this was the first time this had been achieved for 12 months.

The remaining 6 indicators were rated GREEN

**Community and Social Care Framework:**

11 indicators in total of which 2 RAG rated RED as follows:

- Number of delayed discharges – 355 bed days lost (166 last month) (annual target 2,216)
- CAMHS % of referrals seen within 18 weeks – 71.4% (80% last month) (target >92%).

The full report identified the significant improvement made during the month, reducing CAMH waiting times, only 5 patients were waiting over 18 weeks at the end of June, the longest wait was 24 weeks. This meant significant improvement was expected on the standard "% referrals seen" next month.

Of the remaining 9 indicators, 5 were rated GREEN, 1 amber and the remaining 3 awaiting data.

**Change Framework:**

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

- Board will note average length of stay reduced by 0.1 of a day and hospital stays in excess of 30 days also reduced slightly.

**Corporate Management Framework:**

4 indicators in total of which 2 RAG rated RED as follows:

- Staff vacancy rate (trust wide) – 7.97% (7.99% last month) (threshold <5%)
- Staff sickness / absence – 4.13% (4.11% previous month) (threshold <3.5%)

Of the remaining 2 indicators, 1 rated AMBER and 1 GREEN

**Performance**

The Director of Strategy and Improvement reported that this report formed the Trust's Quarter 1 report and confirmed that Trust believed it had met criteria to receive the first payment of the STF.

In terms of performance, the Trust was green for all the regulatory targets apart from the national standard on ED performance, but it had met the agreed trajectory in respect of that target. The report provided background to those targets on the Quality and Safety dashboard that were still red and the work taking place to improve

performance. There were also some reds on the CCG contract dashboard, reflecting the stretch nature of the targets. Work continued to improve performance in this area also. Finally, the Director of Strategy and Improvement reported that the Quarter 1 Governance Declaration had been signed off and submitted.

The Chairman thanked the Director of Strategy and Improvement for a much improved report in terms of information and clarity.

Given the current financial challenges facing the local system, Councillor Parrott briefed the Board on the financial issues facing Torbay Council and concern that, although it had been agreed to close Baytree and St Kilda, improvements in the Trust's finances did not appear to be taking place and the Trust did not appear to be benefitting financially from those closures, which would be difficult for him to defend with the Council. This was acknowledged and it was noted that the Trust's CIP programme would in part deliver the expected savings. The Chairman added that the closures actually illustrated the problem that the Trust was not funded properly to deliver the scale of activity currently delivered but that this was a difficult message to communicate to the population it served.

The Chief Executive stated that she felt Councillor Parrott's point was well made, and that this Board took a risk-based decision to agree a Risk Share Agreement with the CCG which had in fact made the Trust's financial position worse and in addition the Council's financial plan for the year would also negatively impact the Trust financially and she stressed the need for all parties to work closely together to manage this very challenging situation.

Mr Allen asked for some background to the current difficulties with the Neurology waiting list. The Chief Operating Officer explained that the Trust had approached the CCG some time ago around closing the list due to challenges with capacity and the CCG had agreed to make a formal request to NHSE, whilst looking for alternative pathways for the affected patients. NHSE did not approve closure of the waiting list, so the Trust continued to look at how to optimise the service provided and find alternative providers. The Trust was still unable to recruit to the vacant consultant posts and the waiting list continued to grow so negotiations were taking place with NHSI in respect of recognising this when measuring the Trust's performance against target. The Medical Director added that the shortage of Neurology consultants was a national issue and that Neurology had been identified as one of the vulnerable specialties under the STP assessment.

Mr Allen then queried the Trust's policies for managing patients with cataracts following national publicity around thresholds for operations. The Chief Operating Officer explained that the Trust's Ophthalmology team had worked hard to optimise capacity in house and to outsource where appropriate. As part of that, agreement had been made with the CCG to change the overall threshold and clinical protocol for access to cataract surgery which had resulted in a small reduction in demand, however this benefit would be lost from October onward with patients presenting with a need for second eye operations.

Mrs Lyttle recognised the work undertaken in the Emergency Department to improve performance and that the Board should not underestimate how much work had taken place. It was noted that two new consultants were commencing in post in September and October which should improve performance further.

Mr Furse queried the fact that it was proving more and more difficult to fill some consultant posts and that the Trust had some consultant posts that had been vacant since April 2015. He queried whether the Trust undertook succession planning and asked for assurance that the vacancies were being managed. The Medical Director explained that some of the turnover was expected in terms of recruitment, but added that some consultants had unexpectedly chosen to retire earlier than planned. In addition some of the other vacancies were unexpected, for example in Neurology.

He said that the Trust was looking at different ways to managing the vacancies for example using Registrars and GPs with Special Interests to cover the gaps.

Finally, the Chairman asked for a briefing on the recent decision in respect of the HIV preventative drug so that the Board could understand the implications of it and this was agreed. COO

**Finance**

The Director of Finance reported the following:

- The Trust was reporting against the original plan as summited to NHSI, as they had not agreed to the request for a revised Control Total based on the Risk Share Agreement.
- The Trust had delivered to plan at the end of Quarter 1, so should receive the first quarter payment of the STF.
- Phasing of the CIP programme was weighted towards the rest of the year.
- The cost profile was broadly stable across the organisation.
- Reasons for the overspend in pay were vacancies and agency costs.
- £1.7m of CIP was delivered against a plan of £0.7m for the quarter. The full year plan was £13.9m. There were schemes in place totalling c£8m, with confidence against around £5.8m of that total – work was taking place to move to full confidence that the plans would realise all savings. Work would then take place to look at the blocks in place that were preventing other schemes from being taken forward to see if they could be removed to take those schemes forward.
- The cash position was lower than planned, but the CCG had just agreed to pay a £2m bill for transaction support and they were also due to pay their share of the quarterly RSA bill.

Mr Allen expressed concern at the small size of some of the CIP schemes and suggested that the Trust needed some bigger broader system schemes to realise the savings required as he was not assured the current programme would meet the target. His concern was echoed by other NEDs and it was agreed that this would be discussed in some depth at the Private part of the meeting later in the day, and that further detail for scrutiny and assurance be brought to the next Board Meeting.

**Direct Debit Indemnity for NatWest**

Torbay Council has been providing a personal monitored home alarm services to approximately 500 social service clients and 1,500 vulnerable people. The former received the service free, but the latter paid quarterly by way of direct debt. The service had been transferred to the Trust, so the Trust was required to set up a direct debit service.

The direct debt scheme provided reassurance to the individual including repayment by the banks of direct debts incorrectly taken. The bank therefore required an indemnity from the Trust that should this be necessary, the Trust would reimburse the bank with the funds paid back to the individual.

**The Board approved the indemnity to the bank (NatWest (GBS)) and the setting up of a direct debit scheme.**

**Governors' Questions**

Mrs French thanked Directors for the improved information they now received which helped them to perform the role of Governor for the Trust.

Mrs French then asked whether Governors could be involved in helping with the induction of overseas nurses. The Chief Nurse said this would be welcomed and she would include this in their induction programme. CN

Mrs French said she had noted that South Devon and Torbay CCG had been rated as 'Inadequate' and queried what impact this would have on the Trust's plans for more home-based care and also its financial targets. The Chief Executive said that this was discussed at the Executive to Executive meeting with the CCG earlier in the month and that the CCG had not yet received full clarity on what 'inadequate' meant for them in terms of any measures that might be put in place. It would mean that there would be enhanced scrutiny in terms of financial performance and that both CCGs had been asked to consider difficult choices to the financial problems they faced. It was clear that this Trust's financial plan also required further efficiencies to be made and that the scale of the challenge would require planning for significant service change. As commissioners the CCGs would need to consider what services changes to make and if necessary consult with the public on them.

Finally, Mrs French queried the number of bed blocking days lost due to a lack of timely assessments. The Chief Operating Officer stated that, although from a relatively low base, there had been an increase in the number of delays over the last month and the key drivers to these were timeliness of assessment, which the Trust was seeking to rectify whilst building capacity in the community, and also availably of care placements and packages for people discharged from community hospitals. In this respect the Trust was working with the domiciliary care market to improve capacity and flexibility.

**Any Other Items Requiring Discussion/Decision**

**Safeguarding Children Annual Report**

Strategic Context:

This annual report informed the Board on issues relating to safeguarding children and young people including looked after children in Torbay and South Devon.

The Trust was a partner organisation working with Devon County Council and Torbay Council who were the lead agencies for Safeguarding Children. This duty was outlined in Section 11 of the Children's Act 2004.

The Chief Nurse was Executive Lead for Safeguarding and was supported in this role by the Associate Director of Nursing and Midwifery and the Named Professionals.

Key risks:

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

The Chief Nurse highlighted the following from the report:

- It was the first as an integrated Trust.
- Many children were using the service because of emotional and mental health issues and this would be a focus for the Trust and its stakeholders in the future.
- A Safeguarding Operational Group had been set up, chaired by the Head of Safeguarding, which brought together both the adults and children services to provide a family-oriented approach to care.
- A CQC report had recently been published on the national postilion in respect of safeguarding children, and this would help inform the Trust's future work. The report stated that children had reported that they did not feel they had a voice, however for this Trust from a 46% response rate, 80% said they felt engaged.
- Performance would move to be outcome rather than activity based.
- The report emphasised the importance of the role of schools to identify children at risk of harm.
- Finally, nationally there was a need to do more to provide access to emotional and mental health support and early intervention.

Councillor Parrott commended the quality of the report and added that the Chief Nurse had attended the last Children's Improvement Board and had provided a very positive input to the work of the Board and thanked her for her input. He said that he would recommend the Council review the report and that it be discussed at the Safeguarding Children's Board.

**Audit and Assurance Annual Report**

The Board noted the report and Mr Allen drew attention to the following:

- The Committee had met on five occasions, with a full agenda. He provided assurance that the Committee had found the assurance framework fit for purpose.
- The range of work undertaken by the Committee and the focus that the Quality Assurance Committee would give to quality and care in clinical areas in the future.
- Thanks to the Trust's internal and external auditors, Executive Directors, Company Secretary etc for the support provided to the Committee.

**The Board approved the Annual Report of the Audit and Assurance Committee.**

**PART B: Matters for Approval/Noting Without Discussion**

**Reports from Executive Directors**

**Report of the Chief Nurse**

Strategic Context

Lord Carter's report, published in February 2016, made the recommendation that the primary measure of nursing workforce become Care Hours Per Patient Day (CHPPD). We provided the initial data as requested and this had been used to

develop the first national dataset.

The NHSI agency cap was introduced in March 2016 with agency reduction targets set for each organisation. The national agency spend had been falling since Autumn 2015, there had also been a general reduction in agency prices. NHSI have identified that the area for focus in 2016 was the number of agency overrides where agency was booked outside the agency cap target and the use of non-framework agencies.

**Lord Carter review** - The data submitted each month as part of the safe staffing UNIFY return was now used to calculate the new CHPPD metric. This metric was currently summarised as a monthly mean for each ward and as a monthly mean total for the organisation. This had replaced the summary monthly care hours previously reported to the Board.

This data formed part of the newly developing Carter model hospital dashboard and would be used to benchmark the Trust against other Trusts. At present this was only available at organisation level mapped to national medians. The Carter model hospital dashboard was still in its infancy but eventually each ward / specialty would be mapped against national specialty data to provide a more accurate assessment for benchmarking and this data would be fed into our local reports.

Key Risks/Issues

- Agency cap - The Trust was currently reporting 5% against a target of 3%. Within this the nursing agency spend was 10%.
- There was a wide variation in overrides by region with the Southwest being one of the highest. NHSI were aware of the specific challenges facing Trusts in the Southwest where there were fewer agency providers.
- We have a number of queries currently with the central Carter team to gain clarity and understanding on some of the data inclusions / exclusions which would aide our understanding and confidence in our ability to benchmark like for like information.
- Impact of AHP vacancies/sickness levels on QuESTT scores and need for transformative solutions.
- Need to review role of Matron in emerging Operational structures.
- Need for overarching workforce strategy for the ICO.

**Report of the Director of Workforce and Organisational Development**

Strategic Context

The report updated the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group/Workstream 4 and provided assurance on workforce and organisational development issues.

Key Issues/Risks

- The staff appraisal rate for the Trust was 82% which benchmarked favourably with other local trusts. The target staff appraisal remained at 90%.
- The sickness absence rate was 4.13% in May 2016 which is above the target rate of 4.00% set for that month.

- The vacancy factor for the Trust at the end of June 2016 was 7.97% which is relatively unchanged since the formation of TSDFT.

- The Trust's Occupation Health service would be provided by Optima Health from August 2016.

- The Trust had appointed a Guardian of Safe Working to safeguard the working hours of doctors.

- The Equalities Freedom To Speak Up Guardian had been advertised and the interviews will be held in early August.

- A range of incentives were being implemented to attract bank workers to help mitigate agency usage. This Trust continues to report weekly to monitor on the number of shifts that were not compliant with the framework and price cap requirements.

- Recruitment to Band 5 nursing posts remained an issue which was consistent with other Trusts. A range of measures to support this issue were contained within this report.

- Medical recruitment remained a challenge.

- The BMA held a referendum of relevant BMA members on whether or not to accept the new Junior Doctors Contract. It was announced on 5th July that members had rejected the proposed new contract for junior doctors. 58% voted against the new contract compared to 42% voting to accept, with a turnout of 68% in their referendum. Subsequently the Government have announced their intention to impose the contract from 3 August 2016 with a staged transition planned.

- The consultation in respect of Community Hospitals was increasing the number of staff seeking employment elsewhere increasing the risk to the services provided.

**Report of the Director of Estates and Commercial Development**

Strategic Context

To provide assurance to the Board on compliance with legislation, standards and regulatory requirements, and to provide information on the assessed level of risk and management of same for Board consideration.

Key Issues/Risks

- Both the community Estates maintenance provider and the Trust team were still finding the urgent estates response target a challenge. An action plan was in place for both providers with a view to an improvement in performance in quarter 2 2016. The new manager of the service had commenced and a full review of work requests, resources, working hours and working practices was underway within the estates operations function.

- The Health and Safety Committee have identified concern over the peak of sharps incidents in May 2016 and lack of assurance that only risk assessed or safer sharps were in use across the organisation. There was also concern over variable practice related to the use and disposal of sharps by staff across the organisation. A new sharps group had been established under the leadership of the Director of EFM with support from the Director of Infection Prevention and Control with the aim of improving the compliance of the Trust with EU Safer Sharps Directive. A three month work plan had been

developed with specific objectives to deliver as an outcome a reduction in the number of sharps incidents and a reduction in the number of non-safe sharps in use across the Trust.

**Compliance Issues**

Nil.

**Any Other Business Notified in Advance**

Nil.

**Date of Next Meeting – 9.00 am, Wednesday 7th September 2016**

**Exclusion of the Public**

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

**BOARD OF DIRECTORS**

**PUBLIC**

| No | Issue | Lead | Progress since last meeting | Matter Arising From |
|---|---|---|---|---|
| 1 | DoF to ascertain whether the ICO Post-Transaction Review could be sent to Ministers. | DoF | | 03/08/16 |
| 2 | Briefing on the recent decision in respect of the HIV preventative drug to be provided. | COO | **Completed –** confirmation provided from CCG that NHSE will have commissioning responsibility for the prescribing costs and therefore there will be no direct impact to the local healthcare system. | 03/08/16 |
| 3 | Overseas Nurses' induction programme to include support from Governors. | CN | **Completed –** Lead Governor would be contacted when the programme was being designed. | 03/08/16 |

| | |
|---|---|
| **Report to:** | Trust Board |
| **Date:** | 7 September 2016 |
| **Report From:** | Mairead McAlinden, Chief Executive |
| **Report Title:** | Chief Executive's Business Report |

# 1 ICO Key Issues and Developments Update

In this month's report, the ICO updates have been structured under our four corporate objectives so the Board can better align developments, contributions and risks to our key priorities.

**Safe Quality Care and Best Experience**

**Junior Doctors' Strike**
Following the recent announcement of a series of planned five day strikes by Junior Doctors, the Medical Director has instigated a major planning exercise with clinical and managerial leaders. Dr Dyer will update the Board at our meeting.

**Health Select Committee A&E Inquiry**
In July, the Health Select Committee launched an inquiry on planning for how best to handle winter pressures in A&E departments. Recent history has shown that during winter although attendances decrease, admissions increase and measures of A&E performance deteriorate. We were invited to submit written evidence to the inquiry and attend a seminar to help inform the review. Our evidence outlined how our proposed new model of care will enable us to move away from reliance on bed-based care to innovative ways of providing support in peoples' own communities – including a greater focus on prevention and wellbeing in line with the NHS Five-Year Forward View.

The submission has been accepted in full and will be considered by the Health Select Committee as part of their review.

**Urgent and Emergency Care Plan**
The Board will note from the performance report in the Board pack that the monthly trend to July shows an overall improving position above trajectory reflecting the improvement actions that have been and are continuing to be undertaken to proactively manage care to meet the four hour performance standard. I am also pleased to report that for the first time the ED Department has begun to achieve its 80% target of 'time to first observations in 15 minutes'. There has been significant work to achieve this with ongoing focus required to ensure that it is sustained. However, the system is still fragile with weekly fluctuations in performance, although the level of variation overall is reducing. Increased attendances, reduced flow and staffing issues all contribute and therefore the improvements made need to be system-wide and supported by all services if they are to be sustainable.

The next major change piece is to match capacity and demand particularly in the evenings, overnight and at weekends, where most of the breaches occur. Work is on-going to change clinical working patterns within ED. There is also recognition that further work will need to be undertaken regarding working patterns with other health and care teams. We recognise that September is going to be a challenging month and we are focusing on where we can make further improvements quickly whilst continuing to increase our resilience longer term. The senior leadership team continues to support and champion the improvement work by supporting health and care teams to deliver the improvements and ensuring there is hands on support from the Directors every weekend (including bank holidays) as well as weekdays.

**MIU Cover for Dartmouth Regatta**
A number of local stakeholders approached us requesting that Dartmouth MIU re-open for the regatta period over the bank holiday weekend. The service is currently temporarily suspended as we have been unable to recruit the staff required to provide a safe service. To offer a short-term MIU service in Dartmouth would mean relocating staff from other hospitals. This would reduce the essential cover they already provide elsewhere, and create additional pressures across our whole system over a particularly busy public holiday period.

Last year, we did provide an MIU service during the regatta. However, during that time, a maximum of 7-8 people attended each day, and most of those could have been managed by pharmacies or primary care. Those who did present with injuries also needed diagnostics (eg x-ray) that were not available locally, and had to be referred elsewhere. A decision was therefore taken that it would not be viable to provide an MIU service in Dartmouth for this year's annual regatta. We worked with the CCG, 111 and SWAST to provide signposting to other services. We also put plans in place to enhance services in our MIUs over the Bank Holiday weekend, for example additional x-ray in Newton Abbot, and carried out our usual 'choose well' messaging.

## Improved Wellbeing through Partnership

**Community Services Consultation**
NHS England have authorised our Clinical Commissioning Group (CCG) to begin a twelve week public consultation on the future shape of community services across all our localities except Coastal (which was subject to a separate consultation last year and is now starting to implement changes). The proposals for change are an important part of our new model of care, with more care delivered in or close to people's homes. This will mean investing in strengthening the community-based teams and services that most people use, so there is less reliance on bed-based care. The consultation will begin on 1 September and run to 23 November. Further details are included in the Director of Strategy and Improvement's report.

**Successful Bid for Mental Health Funding**
Torbay and South Devon was one of 41 successful projects across the country to secure a share of the Department of Health's £15 million mental health fund. The fund was created in response to a lack of health and community based places of safety for people experiencing a mental health crisis. With the CCG, we submitted a proposal to create new spaces for young people who are admitted to our care in acute mental health distress. The funding will enable us to create a specially-designed private room that will provide a safe, calm and supportive environment on our children and young people's ward (Louisa Cary), as well as a separate room within our Emergency Department (A&E) for those awaiting assessment.

**100% Success for Devon Studio School**
Devon Studio School (DSS) is sponsored by the Trust and is committed to education aimed at a direct focus of promoting careers in the Social, Early Years and Health care Sectors. Following discussions at the recent Board to Council of Governors meeting regarding progress of DSS, I am delighted to report that sixth form students achieved a 100% pass rate in their recent diploma qualifications, with the majority achieving high grade classifications in the Extended Diploma in Health and Social Care.

This year, students at the school have had the choice to study a mixture of academic and vocational qualifications alongside undertaking work placement at the Trust. This has given them access to a variety of future pathways including university, apprenticeships and full-time employment. Many students have secured university places including Adult Nursing at

Plymouth University, Child Nursing at Southampton University and Primary Teaching at Plymouth University.

**Pathology – Implementing Carter**
Lord Carter has identified pathology as an area where hospital trusts can make big savings. Consolidation is one approach, but is very dependent on geography and population figures. Our own pathology department is leading the way in providing savings through collaboration, having just completed the biggest managed equipment tender ever undertaken here. This was done collaboratively with colleagues in Northern Devon Healthcare NHS Trust.

A contract was signed last month which involves a complete re-design of our laboratories to 'lean lab' principles, and a world first in the installation of cutting-edge, new haematology equipment. The project will deliver a 30% saving on overall operational costs, enabling the department to deliver on its £200k CIP target this year, and a further £50-£70k next year. The department was able to deliver £300k savings this year, and as a result is able to invest £100k on implementing a new quality management system for the pathology service.

**Valuing our Workforce Paid and Unpaid**

**Equality & Diversity Guardians**
To build upon the important work of our Freedom to Speak up Guardians, and in response to the 2015 Staff Survey and Workforce Race Equality Standard, we have now appointed two Equality and Diversity Guardians to join the existing network of Freedom to Speak Up Guardians. The Equality and Diversity Guardians will work as part of the existing network, acting in a genuinely independent and impartial capacity to support staff who raise concerns. The Equality and Diversity Guardians will have a specific remit for equalities and discrimination with a direct link to the Equality and Diversity Lead.

The Guardians will ensure that the voice of front line staff is heard at a senior level by reporting common themes to the Board on a regular basis. Our Equality and Diversity Guardians will be of key importance in helping to embed the culture this Trust aspires. We want the diverse needs of our staff and service users understood, respected, and responded to and that all staff are equally valued and supported to make their contribution to the health and wellbeing of the population we serve.

The Equality and Diversity Guardians are Julia Pinder, Transfusion Practitioner, and Julian Wright , ECSEL Tutor. They are empowered to act independently and spend time with staff, encouraging them to speak up if they feel they are experiencing unfair treatment at work.

The Freedom to Speak Up Guardians are planning a promotional week in October this year where the appointments of the Equality and Diversity Guardians will be officially launched.

**Moving On - 10 Year Anniversary for Breast Cancer Rehab Group**
Torbay and South Devon's 'Moving On' breast cancer rehabilitation group has just marked its ten year anniversary with a celebration tea party for patients and staff.
Around 190 past patients attended the event at Totnes Civic Hall with Torbay and South Devon NHS Foundation Trust staff and volunteers on Monday 15 August. The celebration included tea and cakes, a raffle, and activities to explore the benefits of the group and to share experiences. The raffle raised £371 which will be used to make improvements to the Breast Care Unit.

The Moving On group is for women who have recently finished treatment for breast cancer. It was started in 2006 by Dr Christine Ward, Macmillan Clinical and Community Psychologist at Torbay Hospital's The Lodge Cancer Centre, together with Mrs Lynette Ford, Breast Care Specialist Nurse, and Mrs Rita Stoneman, retired Breast Care Specialist Nurse.

Evaluation consistently shows a reduction in anxiety and depression over the course of the group and an increase in confidence for using skills and strategies to cope. Many of the ladies continue to meet informally on a social basis for many years after their groups have finished and the group was cited in the Department of Health document 'National Cancer Survivorship Initiative: Vision' (2010) as an example of good practice.

## Well Led

**NHS Improvement's (NHS I) Assessment of Quarter 1 (Q1) Performance**
Following our recent Q1 submission and subsequent conference call with the NHS I regional team, I have now received formal notification from the regulator confirming the Trust's ratings are in line with our plan as follows:

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

In addition to the usual reference to finances and A&E performance, the letter from NHS I also sets out the following expectations:

- provide regular updates in delivering the actions to manage the risks identified by the CQC;
- reduce agency expenditure below the agency ceiling; and
- to work with our commissioner to develop a plan to reduce the Neurology RTT backlog.

A copy of the letter is attached (**Appendix 1**).

**GP Locality Clinical Directors Appointments**
I am delighted to confirm the Trust has appointed 5 GPs to our new Locality Clinical Director posts. These leadership posts will be key to the success of our new locality structures which will be leading the delivery and development of our new model of care. Further details are included in the Medical Directors report.

**System Leadership**
Directors from the Trust are providing leadership support to a number of system wide developments including:

- **SD&T A&E Delivery Board:** The Chief Operating Officer is chairing the new A&E 4 hour delivery board which has replaced the Vanguard Urgent care Board focussing on key improvements mandated by NHS I and NHS E
- **SD&T System Transformation and Change –**Directors are working with the CCG Executive team on proposals to repurpose the existing Systems Resilience Group to create a System Transformation and Change Leadership Board to focus on the key transformation and change programmes that will deliver the greatest system benefit
- **Wider Devon STP:** A number of Directors, together with the Chairman and I are directly involved in the various leadership governance meetings, Clinical Cabinet developments and work programme groups to support delivery of the Wider Devon STP aspirations.

**Could it happen here?**
The following national report provides an opportunity for "could it happen here?" consideration and will be reviewed for learning through our clinical governance system:

- **Pennine Acute Trust CQC Inadequate Report:** the Chief Operating Officer will bring a paper to October Board following a "could it happen here?" review

## 2 Local Health Economy Update

**Wider Devon Sustainability and Transformation Plan (STP) Update**
STP sites have now received formal feedback on their end of June draft submissions. The wider Devon STP feedback is positive overall. STPs are now required to finalise their plans for submission mid-October linked to the next planning round. The Director of Strategy and Improvement will provide a verbal update on latest developments and next steps.

**Torbay Council's Efficiency Plan**
Health and wellbeing feature strongly in Torbay Council's draft Efficiency Plan, which shows how the council's Transformation Programme aims to create a prosperous and healthy Torbay, as well as meeting the challenges of reduced Government funding and the needs of communities. The council wants people's views on how it can best use its resources (to transformation@torbay.gov.uk before 7 September). The Executive team will be providing feedback on the proposals.

**New Learning Disabilities Services**
People with learning disabilities in Devon are set to benefit from a new initiative delivering high-quality, community-based services. Devon has been awarded £90,000 from the Transforming Care Programme towards the development of a service to support people with autism leaving hospital. This £90,000 will be match-funded by the Devon Transforming Care Partnership (TCP), which is made up of both Devon CCGs and the councils of Devon, Torbay and Plymouth.

**New Home Care Service Running**
Living Well at Home, the new home care service commissioned jointly by NHS NEW Devon CCG, NHS South Devon and Torbay CCG and Devon County Council, is now up and running. The Council and the NHS are increasing the amount they spend on personal care and support for elderly and vulnerable people in their own homes, in a bid to bring greater stability to the personal care market, improve quality and raise morale among the workforce. This joint approach will improve personal care services across the county by setting out higher standards of care in return for better pay and conditions, training and qualifications for the carers themselves.

**South West Success at National 2016 Patient Safety Awards**
The South West Zero Suicide Collaborative won the National Patient Safety in Mental Health Award with funding and support coming from the South West Academic Health Science Network (SW AHSN) and the Strategic Clinical Network (SCN). Bringing together people and organisations from across the South West to share knowledge, skills and information, the Zero Suicide Collaborative was established to support local network groups in developing practical suicide prevention plans. It has the ambitious aim of reducing suicide to zero across the South West by October 2018.

**People Moves and Appointments**

- **NHS NEW Devon CCG:** Rob Sainsbury, currently Executive Director of Operations at Northern Devon Healthcare NHS has been appointed as Chief Operating Office at the CCG. This post will be instrumental in ensuring that the CCG successfully delivers its strategic and operational business objectives and will be accountable for the delivery of the CCG operating plan. The role will lead and further develop integrated commissioning arrangements across Devon and will be responsible for the development of strategic commissioning plans, which are fully aligned to the wider Devon STP.
- **Exeter Medical School appointment:** Globally-renowned dementia and ageing expert Clive Ballard has been appointed as the Executive Dean and Pro Vice-Chancellor of the University of Exeter Medical School. Clive is currently Professor of Age-Related Diseases at King's College London. Professor Angela Shore, who covered the role on an interim basis will now return to her role as Vice-Dean Research for the Medical School
- **South West Leadership Academy Board:** Following the retirement of their previous Chair Edward Colgan, the Board has appointed Ann James, Chief Executive of Plymouth Hospitals NHS Trust as the Acting Chair for the South West Leadership Academy Board.
- **Devon County Council (DCC)**: DCC are consulting on a number of changes to their senior leadership structure in response to the imminent retirements of their Strategic Director Place and Head of Education and Learning. The main changes are:
  - Jennie Stephens, who is currently the Council's Strategic Director People, is taking on a more focused role working closely with health as Chief Officer for Adult Care and Health and Statutory Director for Adult Services.
  - Dr Virginia Pearson, Director of Public Health, is taking on a wider remit as Chief Officer for Community Health, Environment and Prosperity.
  - Jo Olsson will be Chief Officer for Children's Services and Statutory Director of Children's Services.
  - A fourth Chief Officer will have responsibility for Highways.
- **Royal Cornwall Hospital Trust Chairman resignation:** Dr Jon Andrewes (Chairman of legacy Torbay and Southern Devon Health and Care Trust) who led the community trust, has announced he is stepping down from his role at the Royal Cornwall Hospital Trust due to health problems. We wish him well.

# 3 Chief Executive Leadership Visibility

| **Internal** |
|---|
| • Joint meeting with Chair/Chief Executive, South Devon and Torbay CCG<br>• System Resilience Group<br>• Freedom to Speak Up Guardians' Meeting<br>• Staff Side Meeting |
| **External** |
| • Sarah Wollaston MP<br>• Dame Ruth Carnall, Carnall Farrar<br>• Lead Chief Executive, Your Future Care (Success Regime) & STP<br>• Executive Dean, Faculty of Health and Human Sciences, Plymouth University<br>• Chair, Brixham Youth Enquiry Service<br>• Strategic Director of People, Devon County Council<br>• Your Future Care Collaborative Board<br>• STP Chief Executives' Group |

# 4 National Developments and Publications

Details of the main national developments and publications since the August 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:

**New care delivery models**

- Four hospitals have been given the green light to start NHS "chains" by taking over smaller organisations.
- Coverage of the development of Sustainability and Transformation Plans across the country, with media and lobby group concerns on likely cuts to services, including anticipated closures of A&E departments, small District General Hospitals and GP surgeries.

**Quality and safety focus**

- The Care Quality Commission has set up an internal inquiry to look at the "underlying reasons" why providers are failing to improve between inspections
- The Department of Health's new online dementia atlas has begun to publish detailed information about which areas of England give people with dementia the best support, in an effort to reduce a wide variation in the quality of care provided.
- NHS England is preparing to issue new guidance on cataract treatment that will urge doctors to ensure patients are not denied the procedure on the basis of cost.

**Workforce focus**

- The British Medical Association has agreed to back junior doctors regarding their dispute against the imposition of the new junior doctor contract. A series of 5 day strikes are planned for the rest of the year which will pose a significant operational challenge to all hospital providers. The Medical Director will brief the Board on the Trust's preparedness for the first strike planned for later this month.
- A number of Trusts across the country are taking the decision to close their A&E units at night due to staffing difficulties.
- NHS Improvement has said the cap on agency rates for temporary staff in the NHS is expected to save up to £800m in its first year.
- The NHS has been accused of failing to use the talents of women and people from ethnic minorities after new research revealed they are badly under-represented in senior positions.

**Financial challenge focus**

- NHS Providers chief executive Chris Hopson has said the NHS needs to take a "reality check" about what it can provide and take national decisions about which treatments and services should be rationed.
- The Nuffield Trust has warned that NHS treatments will need to be rationed and hospitals closed unless the health service makes unprecedented efficiency savings.
- Lord Naylor's forthcoming independent review of NHS Estates and Property to support the development of a long term strategy for NHS estates use. This will build

on local estate Strategies and be informed by Lord Carter's review into NHS productivity.

- NHS England has confirmed that vanguard sites will not have transformation funding allocated directly to them after next year.
- Regulators have shelved plans for a marginal rate for specialised services under new tariff proposals covering 2017-2019.

# 5 Media Update

**National media references to the Trust**

- *The Lancet* report on deaths <30 days following chemotherapy which identified TSDFT as an outlier for deaths within 30 days of receiving chemotherapy. Investigation revealed this to be due to errors in recording treatment intent (curative vs palliative) rather than a quality and safety issue. A statement has been sent to *The Lancet* evidencing that the Trust is not an outlier.
- Article in HSJ focusing on major hospital trusts already predicting to miss control totals including the Trust
- The award of national funding including to the Trust to create a place of safety for mental health patients

**Local media**

This month the Trust has issued a number of media releases and responded to enquiries from local regional and national media including:

- Appeal to public to keep A&E for emergencies only over the bank holiday and publicising Newton Abbot's extended x-ray opening times on bank holiday Monday
- Proactive media work about Healthshare system implementation – with local and national specialist press coverage
- Issuing a joint statement with the CCG about neurology waiting lists (BBC SW coverage)
- Moving On - 10 year anniversary for Breast Cancer rehab group
- Weekend Diagnosis from Mairead McAlinden on the forthcoming public consultation about the future of health services
- Celebrating a £15k donation from Sainsbury's for the special care baby unit
- The Dermatology Service won a prestigious award from the British Dermatology Nursing Group for 'Dermatology team of the Year 2016'
- Torbay Hospital radio celebrates its 40th year
- Item filmed by ITV West country on 'natural' caesareans was broadcast on Tuesday, 2 August.

31 August 2016

Mrs Mairead McAlinden
Chief Executive
South Devon Healthcare NHS Foundation Trust
Torbay Hospital
Lawes Bridge
Torquay
Devon
TQ2 7AA

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@improvement.nhs.uk
W: improvement.nhs.uk

Dear Mairead,

**Q1 2016/17 monitoring of NHS foundation trusts**

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

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

These ratings will be published on NHS Improvement's website in September.

NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority. In this letter, "NHS Improvement" means Monitor exercising functions under chapter 3 of Part 3 of the Health and Social Care Act 2012 (licensing), unless otherwise indicated.

The trust has been allocated a financial sustainability risk rating of 2 and has failed to meet the A&E 4 hours target for the last 10 quarters.

NHS Improvement uses the measures of financial robustness and efficiency underlying the financial sustainability risk rating as indicators to assess the level of financial risk and the above target (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve a financial sustainability risk rating of 3 or above and the targets applicable to it could indicate that the trust is providing health care services in breach of its licence, which could lead to consideration of enforcement action[1].

We expect the trust to address the issues leading to the financial sustainability risk rating and the target failure and achieve financial sustainability and sustainable compliance with the target promptly, and in line with its submitted A&E performance trajectory.

[1] Under the Health and Social Care Act 2012, taking into account, as appropriate, our published guidance on the licence and enforcement action including our Enforcement Guidance (www.monitor-nhsft.gov.uk/node/2622) and the Risk Assessment Framework (www.monitor.gov.uk/raf).

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

We also note the following additional risks from our review of the trust's Q1 submissions:

- The trust received a CQC Requirement Notice on 10 March 2016 in response to significant concerns regarding management of potential risks to safe care in its Emergency Department. In response, the trust has developed an action plan and progress in delivering it is monitored weekly by commissioners, the CQC and at trust Board and sub-committee level. We expect the trust to continue to provide us with regular updates in delivering the actions to manage the risks identified by the CQC. During Q2, we intend to follow up on progress against CQC actions.
- Agency expenditure in Q1 was £3.0m, £0.2m above plan, and above the trust's agency ceiling. We expect the trust to reduce agency expenditure below the agency ceiling. We have written to you separately on this matter.
- The trust has capacity pressures affecting the delivery of Neurology RTT, which has adversely impacted on aggregate RTT performance in July 2016. We expect you to work with your commissioner to develop a plan to reduce the Neurology RTT backlog.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q1 2016/17 is available on our website (in the Resources section), which I hope you will find of interest.

For your information, we have issued a press release setting out a summary of the report's key findings.

If you have any queries relating to the above, please contact me by telephone on 02037470192 or by email (justin.collings@nhs.net).

Yours sincerely

**Justin Collings**
**Senior Regional Manager**

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

Torbay and South Devon NHS
NHS Foundation Trust

**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting Date:** | 7 September 2016 |
| **Title:** | Delivering our Shared Ambition for Local People<br>Report of Stakeholder & Voluntary Sector Engagement Events |
| **Lead Director:** | Ann Wagner, Director of Strategy and Improvement |
| **Corporate Objective:** | • Improve wellbeing through partnership<br>• Well led |
| **Purpose:** | Information |

**Summary of Key Issues for Trust Board**

Strategic Context:

Two different partnership engagements events were held on 11 March 2016 and 23 May 2016. The first small event of 40 senior leads from parties in the statutory, third and voluntary sector; the second a larger event attended by 71 people and held specifically with parties from the voluntary sector in Torbay and South Devon. Feedback received highlighted the value and importance of continued engagement.

Key Issues/Risks

Both events demonstrated the desire of the wider community across Torbay and South Devon to work together to co-design and deliver a shared vision for the population; interactive, enthusiastic, and vibrant dialogue inevitably produced a very broad range of issues and feedback.
The value and importance of engaging with all our stakeholders in this way was illustrated at both events and cannot be underestimated. Common themes emerging from the events include:

- The need for the Trust to be seen to respond and act on feedback from the event.
- The benefit of co-design and co-production in the development of services
- A range of issues around transport, particularly in more rural areas.
- The need to ensure that mental health and housing needs are taken into account in developing wellbeing services.
- Wellbeing services are needed across all age ranges, including for children and families.

Both events have acted as a catalyst to strengthen links and connections between stakeholders in the community. Examples of this are that since the event the Trust has developed the closer links with the Academic Health Science Network and CDT and CVS have begun working direct with Devon Fire and Rescue Services on home safety issues.

Such events require a considerable investment of time from partners, stakeholders and Trust staff. To maximise the return on this investment there is learning which can be taken in regard to the organisation, management, and follow up from such events.

Recommendations:

Board asked to note the contents of the report and the outcomes of these events.

| |
|---|
| Summary of ED Challenge/Discussion:<br><br>We need to broaden our engagement to innovate. A common theme from both events highlighted the need to communicate and engage better with Council, volunteers, public services. Another key theme was the need to improve transport support to local communities – the Exec team agreed this was a priority for development and is working with partners on the most appropriate options. |
| Internal/External Engagement including Public, Patient and Governor Involvement:<br><br>Representatives from a wide range of stakeholders, non-executive directors, and governors involved in both events. |
| Equality and Diversity Implications:<br><br>No negative impact. |

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

# Delivering our Shared Ambition for Local People

## Report of Stakeholder & Voluntary Sector Engagement Events

**September 2016**

## Contents

## Introduction

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

Torbay and South Devon NHS Foundation Trust (TSD) was created as an Integrated Care Organisation in October 2015 bringing together acute hospital care, community healthcare and adult social care to improve the health and wellbeing of the people of Torbay and South Devon.

We want to build on a shared vision for the delivery of health and care and further develop local partnerships and networks to deliver the best possible services for our local population. However, our journey of integration and community empowerment needs jointly held resources to manage the demands on services in a backdrop of decreasing funding and growing demand. Working in close partnership with the wider health community and the voluntary sector will provide a foundation to realise our vision for the population of Torbay and South Devon.

**The purpose of this paper is to provide a summary of the Trust's development of partnership and stakeholder engagement across Torbay and South Devon and to maintain dialogue with the wider health community as together we can maximise resources and better support the population of Torbay and South Devon.**

## Partnership Events

To date two partnership events have taken place, each with different stakeholders and objectives. Both events began with a presentation followed by round table discussions. This structure provided the opportunity to voice the aims of the event and then use the collaborative experience and expertise in the room to drive forward the requirements to develop closer working with partners across the community.

**Event One: 11 March 2016 – Toorak Hotel: 41 delegates**


**Event Two: 27 May 2016 – Newton Abbot Racecourse: 72 delegates**

## Event One: Realising our shared vision of health and care in Torbay and South Devon

### 11 March 2016 – Toorak Hotel

### Aim

The main aim for this first event was to engage with our key stakeholders and hear directly from them what they want/ need from the ICO and what they can bring to help.


### Stakeholders

We identified the key stakeholders as our local MPs, the Mayor and key councillors along with the senior leaders of partner organisations such as the police, ambulance service, voluntary services, and development agency along with senior figures from the local authorities, other health providers and commissioners.

We had an excellent response from stakeholders with representatives from a wide range of organisations agreeing to participate. In addition to the Board and our senior managers, there were 41 delegates.

We wanted them to fully understand what our purpose and vision are, and how we could work together towards shared aims. The content of the event was designed around these aims along with gaining a better understanding of what they want from the ICO and what they can bring to the discussion.

## Presentations


**Sir Richard Ibbotson** welcomed all and explained the purpose of the event.

*"… we want to build on our shared vision and agree how we can further develop local partnerships and networks to deliver the best possible outcomes for our local population…."*

He acknowledged the shared commitment of all stakeholders and thanked them for their input which would be "invaluable"

**Mairead McAlinden** gave a presentation on the ICO's progress to date, learning, and future plans including embracing the wider partnership opportunities across the Wider Devon planning footprint**.**

***"… we will embrace the partnership opportunities of the wider Devon sustainability and transformation planning footprint to address the health and well being, quality and care and efficiency gaps …"***

## Commissioners View Point

Delegates then heard from Caroline Taylor, Dr Nick Roberts and Cllr Julian Parrot who reflected on the ICO's progress to date and potential for greater integration through stronger engagement and partnerships

*'..The ICO has, for me, changed my view and proved that partnership working really can work and, though it is admittedly early days, deliver for our residents. But that is precisely because we truly succeed or fail together. Our budgets are inextricably linked to provide better services at reduced overall cost.... If we truly believe that our ICO exists to free people to live their lives despite the frailties of our minds and bodies, then there is so much work for us to do...'* **Cllr Julien Parrott**

## Table top discussions

Delegates were then asked to consider what they need/want from the ICO as well as what they can bring. Delegates discussed their thoughts and these were captured on flip charts. The main themes were:

### What do you want/need from the ICO?

- **a need for clear communications** – what is the vision, how will it be delivered and what will the outcomes be and clear accountability for who is doing what;
- **clarity on what we are trying to achieve together** - how to get everyone involved in what we are trying to achieve;
- **a commitment to meaningful partnership working across all partners** with co-design of services and must include voluntary sector, primary care, mental health and councils;
- **a health and care system that is easy for people to access that puts emphasis on preventing ill health** and where services were in local communities wherever medically appropriate.

### What do you bring to the party?

- capacity, expertise and experience;
- community networks, resources and assets;
- innovative ideas and new ways of working;
- trusted by the community to deliver

### What should we be doing together?

- joint problem solving and sharing of benefits of the model;
- consistent/coherent framework to plug in to;
- universal information sharing;
- future proofing services and understanding changes in demography;
- shared services.

## Summary

The Trust Chairman thanked everyone for their contributions and closed the event with the following remarks:

*" the ICO is complex in detail, simple in reality, doing the best we can with the available resources for the people we all serve; we must not lose sight of this. The health community needs to work with other public services for the benefit of the community and recognised the potential for a win-win for all involved. We need to ensure that our delivery and improvement processes are evidence based, learning from success as well as failure and to broaden our engagement to innovate. There was a common theme that the ICO needs to communicate and engage better with Councils, volunteers, public services…"*

## Evaluation

No formal feedback was collated, however, comments on the day and messages received following the event indicated attendees valued the opportunity to meet and discuss the future of health and care across Torbay and South Devon.

## Next steps

Continue active dialogue with stakeholders in a variety of forums to ensure momentum and engagement across Torbay and South Devon. The learning from the event will be shared with attendees to reflect on and discuss further within their areas of work and involvement in the community. Feedback from round table discussions will be taken into account in planning for the ICO for 2017/18 and beyond.

## Event Two: Working Together

### Friday 27 May 2016 – Newton Abbot Racecourse

The event held on Friday 27 May 2016 was co-ordinated and facilitated by the following organisations:

### Aim

The event signalled a new approach to partnership with the voluntary sector to co-produce services and pathways for the benefit of the population of Torbay and South Devon. The event also offered the opportunity to respond to the request for closer partnership working from the 11th March 2016 event.


### Stakeholders

Representatives from The Torbay Community Development Trust, Teignbridge Community and Voluntary Services, along with operational staff, executives, and governors of Torbay and South Devon NHS Foundation Trust joined voluntary organisations and community groups at the event.

**Presentation**

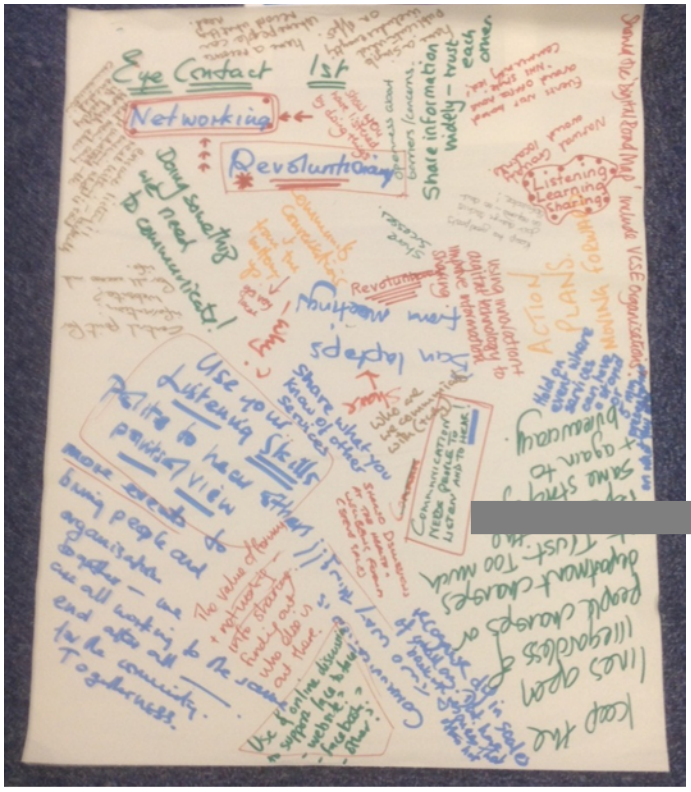

**Billy Hartstein** welcomed the group and thanked them for their time and desire to improve the services that can be provided by working together.

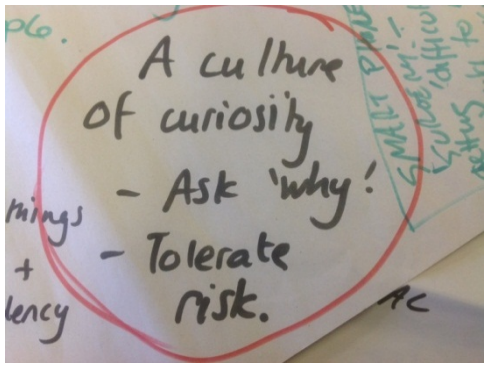
**Mairead McAlinden** acknowledged and restated the vital role of the voluntary sector and shared the commitment to invest in and develop a new partnership to co-design agreements between the Trust and voluntary organisation for services that support the new care model.

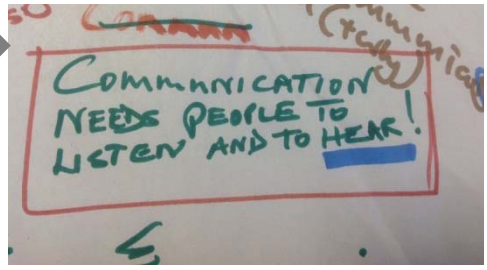

Our new model of care

**World Café discussion**

The World Café style was adopted on eight tables. Attendees were able to move between tables to contribute to themes of particular interest. Each table had a table 'host' identified to encourage participation and keep discussion flowing, inviting attendees to record their thoughts on the flip charts provided on each table.



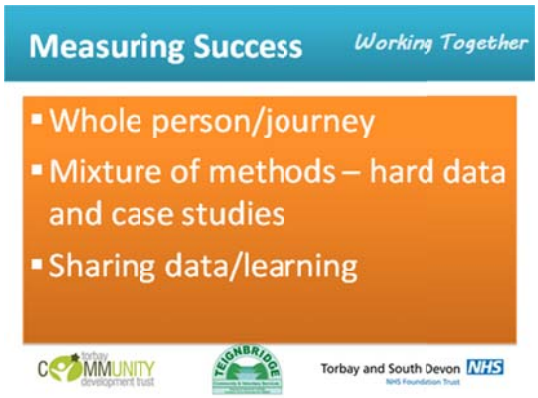




During this part of the event many people took the opportunity to introduce themselves to others they had not met before and were making links previously not established.

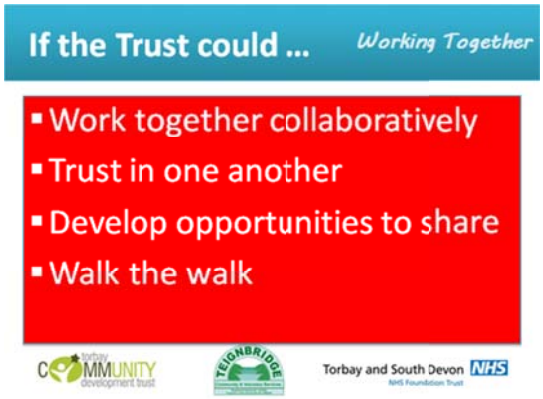
The discussions produced a multitude of flip charts and the host from each of the eight tables was asked to summarise the themes which were captured 'live' in the following slides:

**The three key themes from each table**


Services & Pathways
Working Together
Mental health
Housing
Family support/carer support
Direct pathways in both directions
Torbay and South Devon NHS

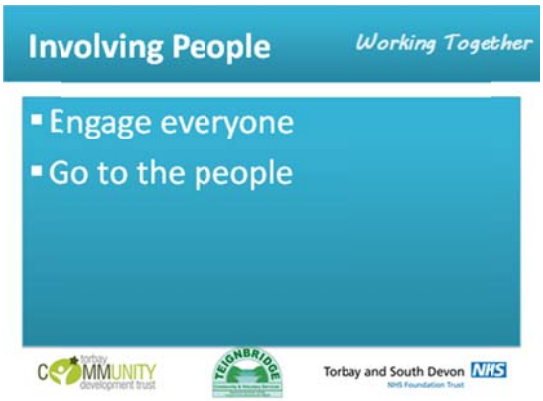

Measuring Success
Working Together
Whole person/journey
Mixture of methods – hard data and case studies
Sharing data/learning
Torbay and South Devon NHS

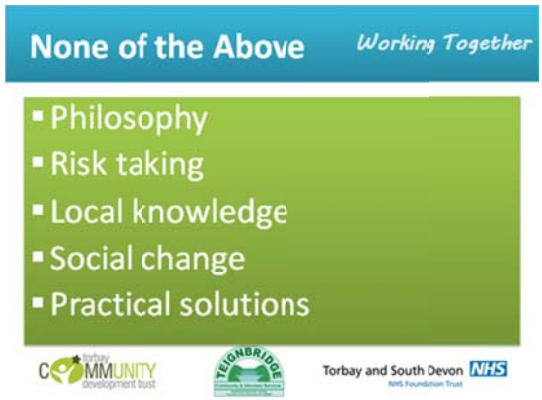

If the VCSE could ...
Working Together
Communicate what is available/signpost across sectors
Torbay/South Devon relationship
Open collaboration
Central funding across areas
Torbay and South Devon NHS


If the Trust could ...
Working Together
Work together collaboratively
Trust in one another
Develop opportunities to share
Walk the walk
Torbay and South Devon NHS


Communication
Working Together
Share new ideas/brave suggestions
Networking
Listen/hear
Digital communication
Torbay and South Devon NHS


Making a Difference
Working Together
Relationship building
Common vision and agreement
Risk enabling
Sharing resources/information
Torbay and South Devon NHS


Involving People
Working Together
Engage everyone
Go to the people
Torbay and South Devon NHS


None of the Above
Working Together
Philosophy
Risk taking
Local knowledge
Social change
Practical solutions
Torbay and South Devon NHS

**Summary**

Sir Richard Ibbotson summarised the event expressing it was a valuable and thought provoking day reflecting the strong commitment to a new model of care. The statutory sector needs to work differently and voluntary organisations are very good at making good use of limited resources There are great opportunities and yet changing direction and culture takes time; so while we need to set challenging ambitions we also need to be patient as we make the changes. Sir Richard also acknowledged this is the first opportunity for the ICO to work in a more integrated way with the voluntary sector to support local populations and could be a footprint for other parts of country.

**Evaluation/Feedback**

This was a well attended and vibrant event which highlighted the benefits and opportunities of working together more closely in the future. Feedback taken by an 'exit poll' was overwhelmingly positive.

| **Voluntary and Community Sector Feedback** | **Strongly Agree** | **Agree** | **Undecided** | **Disagree** |
|---|---|---|---|---|
| I better understand the direction of travel for service delivery of Torbay and South Devon NHS Foundation Trust | 25% | 45% | 25% | 0 |
| | | 5% | | |
| I have had the opportunity to have my voice heard by the NHS Trust today | 51% | 46% | 3% | 0 |
| I feel positive for closer working between the NHS Trust and the Voluntary Sector following today's event | 36% | 44% | 20% | 0 |
| **Statutory Sector Feedback** | **Strongly Agree** | **Agree** | **Undecided** | **Disagree** |
| I better understand the role of the voluntary sector in Torbay and South Devon following today's event | 21% | 58% | 21% | 0 |
| I feel that I have something to take away from today's event that I can discuss with colleagues and look to implement in my service planning | 27% | 68% | 5% | 0 |
| I feel positive for closer working between the NHS Trust and the Voluntary Sector following today's event | 60% | 35% | 5% | 0 |

Following the event, the group was informed that if there were issues discussed about which they felt passionate about and would like to be involved in any follow up actions to let the event organisers know, this resulted in a number of individuals with specific skills, experience, and knowledge coming forward with a desire to share their expertise. As a result of this request six people responded expressing their wish to offer additional support.

Progress to date is summarised in the following table which has been circulated to all participants.

## Next steps

| Issues | Description | Current or proposed action | Timescales |
|---|---|---|---|
| **Transport** | There is a need to work together to consider:<br>• Current patterns of demand for community transport.<br>• How this demand arises and may change.<br>• The range of transport options currently available, and how these are used and funded.<br>• Gaps in provision and how existing resources can be used more effectively. | An initial meeting is being planned to scope out these issues in more detail as the start of planning for an event to look specifically at transport issues. | Scoping work to start in July.<br>Further work to be completed during August and September.<br>Event designed to identify solutions and recommendations for change to be held in October. |
| **Mental Health and Housing Services** | There has been strong feedback about a general lack of preventative mental health and housing services which needs to be considered and scoped. | This is a complex issue, CVS, CDT and the Trust will work together with other statutory partners to assess the issues. | This work is likely to take 6 to 9 months. |
| **Two way referral routes** | Ensure colleagues from voluntary organisations who provide care and support to people in the community have access to an escalation route through which they can raise concerns with, and receive support from, statutory services if they become concerned about the wellbeing or safety of people they are working with. | This need will be taken into account as wellbeing co-ordination and (in South Devon) hospital discharge services are developed.<br>The learning from this will then be rolled out to other areas of service and support provided by voluntary organisations. | Contracts for these services are in the process of being agreed and will be updated to specifically address this issue. |
| **Collaboration and networking across Torbay and South Devon** | There would be benefits for voluntary organisations in sharing skills, expertise, and experience between Torbay and South Devon as part of breaking down the boundaries which have tended to exist between the two areas in the past. | CDT and CVS will look for opportunities to bring groups together from across the whole area as part of normal working. The Trust will work to break down barriers within its own services. | This work will be on going. |

## Conclusions and Emerging Themes

Both events demonstrated the desire of the wider community across Torbay and South Devon to work together to co-design and deliver a shared vision for the population; interactive, enthusiastic and vibrant dialogue inevitably produced a very broad range of issues and feedback.

The value and importance of engaging with all our stakeholders in this way was illustrated at both events and cannot be underestimated. Common themes emerging from the events include:

- the need for the Trust to be seen to respond and act on feedback from the event;
- the benefit of co-design and co-production in the development of services and in engagement activities;
- a range of issues around transport, particularly in more rural areas;
- the need to ensure that mental health and housing needs are taken into account in developing wellbeing services;
- wellbeing services are needed across all age ranges, including for children and families.

Both events have acted as a catalyst to strengthen links and connections between stakeholders in the community. As an example, the events have acted as a catalyst for the Trust to develop the closer links with the Academic Health Science Network and CDT and CVS have begun working direct with Devon Fire and Rescue Services on home safety issues.

Such events require a considerable investment of time from stakeholders, voluntary sector and Trust staff. To maximise the return on this investment there is learning which can be taken in regard to the organisation, management and follow up from such events.

- photos to capture the event and engagement;
- evaluation to support continuous learning;
- engagement with non-executives/governors;
- mandate and set clear objectives for event;
- consistent approach ;
- de-brief within a week;
- capture feedback at the event.

# Our Shared Vision of Health and Care in Torbay and South Devon

Friday 11 March 2016

Toorak Hotel

# What do you want/need from the ICO?

- Truly integrated IT systems across all organisation including care home sector and voluntary sector (?challenge?)
- Better articulation of new care model, where do people go for their care?
- Consideration rurality – opportunities
- Commitment to equality of outcomes and of access (needs universal IT access/transport/infrastructure)
- Genuine integrated working between primary and community services (breaking down barriers)
- Communication between ICO and primary care – more outreach
  - help/working together
  - not just clinical
  - system/process support/cultural
  - relationship of Trust and mutual respect

# What do you want/need from the ICO.....

- Clear accountability and responsibility for delivery is very confusing to public
- Shift debate from bed obsession
- Straight talking
- Smooth the money – recognise personal threat – co-funding?
- Deliver on shift from acute to community
- True partnership with the voluntary sector
- What is the added value – culture/quality/costs?
- Blurring of boundaries between primary and secondary care and voluntary sector
- Support to people with low to wider needs
- The ICO to embrace new ways of working
- Linking in with wider services e.g. transport/housing
- Minimise travel for patients
- Use facilities in a different way
- Clarity on education
- Strengthen the role of the Health and Well Being Board

# What do you want/need from the ICO.....

- Better healthcare
- Better prevention
- Collate evidence at local level
- Single point of contact – who knows all about me
- Clarity on prevention
- Clarity on education/end of life care
- Clear relation with Health and Well Being Boards
- Evidence of issues at local level
- Shared records and IT
- Clear understanding of what is the system (SPOC)
- Clear route map from vision and strategy to outcomes/impacts
- Is 5 years too short – have 15- 20 year strategy – long term vision – short term 5 year implementation
- Behaviour change – use planning process and design for health and well being
- External partners – design Council? (If Ikea ran the NHS would it look different?)
- Re-visiting design principles for prevention

# What do you want/need from the ICO.....

- Build on strengths – clean air/green area
- Build on innovative vision
- Social isolation ‘You are’
- Mental health – rural areas – new schemes
- Cultural shift to self-care
- Better ICO vision – more simple
- Support for behaviour change/shift
- Keep user at centre/future users
- Leadership behaviour – model good ‘integration’
- Better integrated adult social care – making it equal partner with acute care
- Check/track what is achieved
- Skill up the voluntary sector
- Remember rurality

# What do you want/need from the ICO.....

- Enhancing and committing to REAL partnership working
- Collaborating to ensure we put the patient at the centre
- Single point of contact/co-ordination
- Many doors to one door
- Increased level of research and development
- Patient access to the right professional quickly and appropriately
- Primary care to be included within the ICO
- Greater involvement /engagement with education
- Closer collaboration between partners to ensure that physical and mental health needs are equalised
- Delivery of the care model to ensure 'I stay in my bed'
- Taking the public on our journey as it is their journey
- Greater 100% of patients self managing
- To make sure people do not fall through the gap

# What do you want/need from the ICO.....

- Opportunities for young people/adults being clear about skills, capabilities that deliver outstanding workforce – employer of choice
- A place where people want to live and remain well
- Quicker decision making
- Freedom to make decisions in local communities (smarter governance)
- Access to the right level of support at home
- Clarity on what we are trying to achieve together - how to get everyone involved in what we are trying to achieve so they can help
- Building strong partnerships (building on what is in place)
- Sustainable support to voluntary and community organisations – contracting arrangements that enable it to happen (longer term allocation or resource)
- Define outcomes clearly that enables us to utilise social investment
- Capacity building and engagement with the voluntary and community sector. Doing this in partnership.
- Building and sharing evidence base support development or integration in other systems across Devon

# What do you want/need from the ICO.....

- Reality check on all changes – do they add value to the outcomes for people who use services
- Engage, co-design – pilot
- Value the contributions or people – strength solution focused.
- Transparency of journey – communications along the way – visibility of outcomes – successes and failures
- Healthy engaged active workforce with high productivity
- Building partnerships (wider) outside immediate area learning from each other. Shared working pooling resources and effort
- Using networks to work out better ways of working across the Peninsula – resilience of services driver
- How to get the benefits of the ICO in a system with different organisation, what can we learn?
- Understanding and benefits of the shared budgets and risk share agreement

# What do you want/need from the ICO.....

- Joint problem solving and sharing of benefits of the model
- Maintain the focus drive on prevention and low level intervention
- Do not forget Cornwall
- Consistent/coherent framework to plug in to
- Access to vulnerable groups/individuals
- Comparable journeys from reactive to proactive
- Sharing use of ‘patient-facing time’ e.g. fire officers asking if people have taken medication
- Linking in where issues identified through LMAT
- Taking learning from fire service e.g. prevention making a difference rather than re-active
- Comparing and matching scale of operations – using capacity flexibly – completely different services –
- Need good placements for students – non-traditional roles/more generalism
- Blurring the boundaries
- Embracing new models of care and ways of working

# What do you want/need from the ICO.....

- Recognition of the role that district councils can play in prevention
- Kings Fund report: The district council contribution to public health
- To learn from Collumpton GPs
- Creative thinking about where care is provided
- More concentration on prevention and child health
- Universal information sharing
- Future proofing services and understanding changes in demographic

# What to you bring to the party?

- Genuine involvement from primary care
- People resource
- Trust of the population and patient advocate and population
- Organisation
- Desire to embrace change
- Change contracts to enable integration
- Engaged leadership
- Problem solving skills
- Facilitation
- Honest broker
- Access to patient participation group
- Direct resource to achieve pace (ambition)
- Clinical and cultural expertise and experience of home care equals:
  - partnership with secondary care specialists
  - GPs are specialists
  - mentoring

# What to you bring to the party?

- Constructive challenge
- Not bunkered view
- GPs have patient list
- Innovation/learning from others
- Tried and tested IT system/paperless
- Access to wealth of information and networks (NEW Devon CCG/AHSN)
- Partnership with industry
- Support with data integration
- Work on pool budget and joint commissioning
- Research capacity (which is already funded) in masters and PHD programmes at medical schools
- Locality officers in council and CCGs to work closely together
- Housing officers understanding ICO
- Design healthier places

# What to you bring to the party?

- Bring back the milkman (rebuild caring community)
- Enable primary care to do more in localities
- Clear implementation plan so partners can see where they contribute.
- Co-ordinated  approach to preventative care at a locality level
- Knowledge of the patch
- Getting people into work
- Healthy towns
- Use what we have – hospice use of brokers etc – better community engagement
- Provide access to different networks
- Housing/transport/telehealth/Telecare
- Reflection from the users (Torbay Council)
- Non-exec directors – can have different conversations with other partners
- Healthwatch – bring the public along with ICO.
- Patient experience to forefront
- All – network of communication, co-delivery, co-production
- VCS– help behavioural shift for individuals and provide education

# What to you bring to the party?

- CVS – joining up and skilling up voluntary organisations
- Consultation
- Management shift of staff behaviour away from ‘I know best’
- To take responsibility of promoting the message and living the message
- Audit and research on the implementation of the ICO – testing out small cycles of change
- Bringing specialist mental health expertise
- Sharing experience of closure of MH inpatient units
- From voluntary sector – let us help you tap into the local knowledge
- Commitment to this being a learning organisation
- That we learn from good and no so good
- Sharing what we do, so that it is replicated
- Us using all of our networks to make the ICO a success ‘the Eddie Stobart’ model
- We need to ensure we adopt best practice
- We will continue to do what we do
- Continue to use our skills and expertise

# What to you bring to the party?

- We can articulate the story of the ICO – a common and constant message
- Untapped resource
- The wider partnership becoming an innovation network
- Council have access to everyone in the Bay, sending out information to every household (via council tax – circulation)
- Developing alternative resources (time bank as alternative to funded services
- Student population (16-18) services/future workforce
- Creating a local evidence base
- Other sectors can work quickly
- Bringing general practice to the table to engage innovation
- Can access other funds/resources to test new ways of working
- Community learning opportunities
- Involve people in developing solutions
- Critical friend/peer learning
- Can bring a different attitude to risk
- Can activate people to get involved in activities that support community vision

# What do we bring to the party?

- Support ‘culture’ change in the community – strengths based approach
- Voluntary sector – cheaper services closer to people – social model
- Willing and open partners
- Confidence and permission to challenge behaviours that do not fit
- Different ways of behaving, loosing pre-conceived/old stances and prejudices
- Willing to challenge behaviours that do not fit with the partnership model
- Wealth of information to share.  Work on sharing information across agencies, breaking down the barriers.
- LEP is a strategic forum and co-ordinated a significant amount across the area. How does the ICO link better with the LEP?
- Live Well have an integrated mental model, ICO can learn from them
- Clinical school linking ICO
- Broaden perceptions for trainees

# What do we bring to the party?

- ICO needs to let fire services know what the ICO needs – alignment – 1,200 fire fighters embedded in the community
- Make intranet available to wider partners
- Link more events together
- Formalise ‘trusted partner’ relationships
- Social return on investment – help understand value of prevention
- ICO to visit fire service
- Students to visit fire service
- Expertise
- Flexibility
- We are at the party – we do not feel particularly welcome, too much Torbay? How does Torbay feel?
- Early help hubs in Torbay to bring in children and families

# What to you bring to the party?

- Everybody owning the agenda
- Redesign basic principles around health and wellbeing
- What can we do to enable people to look after their own care
- Training and awareness around drugs and alcohol – community safety partnerships, domestic violence, immigration, slavery, exploitation
- Knowing what everybody can bring – look wider that acute, primary and community health – database
- Grow set of confident professionals able to let others help – avoid protectionism – new ways of working/new environment

Torbay and South Devon NHS
NHS Foundation Trust

**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting Date:** | 7th September 2016 – Board of Directors |
| **Title:** | **Into the future: Reshaping community-based health services**<br>**A public consultation** |
| **Lead Director:** | Ann Wagner, Director of Strategy & Improvement |
| **Corporate Objective:** | This proposal supports all 4 corporate objectives:<br>• Objective 1: Safe, Quality Care and Best Experience<br>• Objective 2: Improved well-being through partnership<br>• Objective 3: Valuing our workforce, paid and unpaid<br>• Objective 4: Well led |
| **Purpose:** | Briefing pending formal response at November Board |

**Summary of Key Issues for Trust Board**

**Strategic Context:**

NHS England have authorised the Clinical Commissioning Group (CCG) to begin a twelve week public consultation on the future shape of community services across all our localities except Coastal (which was subject to a separate consultation last year and is now starting to implement changes).

The proposals for change, which have been developed with the support of the Trust, and are based on extensive public and stakeholder engagement are an important part of our new model of care, with more care delivered in or close to people's homes. This will mean investing in strengthening the community-based teams and services that most people use, so there is less reliance on bed-based care.

The consultation proposals reflect the national Five Year Forward View policy, which has been endorsed by professional groups, the Government and the NHS as the way services should be provided in future.

**Key Issues/Risks:**

Reconfiguring services is never easy and some tough choices need to be made if we are to ensure the sustainability of local health and social care services. The current NHS provision in the area is unsustainable and will be unable to continue to cope with rising demand for services from our increasingly elderly population, increased life expectancy and the number of people with complex long term conditions. Change is inevitable and maintaining the status quo is neither sustainable nor clinically sound.

We are cognisant of the impact on staff and are ensuring those staff directly affected by the proposals are supported and briefed. Change of this magnitude is not without risk – we have seen a number of staff move on already despite assurances regarding job security. As the Board is aware we have taken immediate action to ensure safe staffing levels, including reducing beds temporarily where necessary.

**Recommendation:**

The Board is asked to:

- **receive** this report; and

- **note** a further paper with detail of initial responses will be brought to the November Board meeting where Directors will have the opportunity to agree a formal response to the proposals.

**Summary of ED Challenge/Discussion:**

Executive Directors have been very closely involved in the development of the proposals to ensure they are aligned with and support our new model of care development which lies at the very heart of our ICO aspirations for the local community. Directors and their teams will be very visible throughout the consultation to facilitate and support and to listen to the views of our local communities.

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

There has been extensive public and staff engagement throughout the pre consultation period. This will continue throughout the consultation.

Governors have been briefed and will be represented at each of the public meetings. The support of our public Governors in reflecting views from their constituents is welcomed.

Equality and Diversity Implications:

The proposals, if approved by the CCG and implemented, will impact on NHS services for years to come therefore it is essential the local community are given every opportunity to have their say, including suggesting alternative proposals for consideration. Quality impact assessments have been completed and will be refreshed through the consultation.

**Public**

| | |
|---|---|
| **Report to:** | Trust Board |
| **Date:** | 7 September 2016 |
| **Report From:** | Ann Wagner, Director of Strategy and Improvement |
| **Report Title:** | Into the future: Re-shaping community based health services CCG public consultation |

# 1 Purpose

NHS England have authorised our Clinical Commissioning Group (CCG) to begin a twelve week public consultation on the future shape of community services across all our localities except Coastal (which was subject to a separate consultation last year and is now starting to implement changes). To avoid the summer holiday recess, the CCG Governing Body agreed to commence consultation on 1 September and run to 23 November.

The proposals for change, which have been developed with the support of the Trust, are an important part of our new model of care, with more care delivered in or close to people's homes. This will mean investing in strengthening the community-based teams and services that most people use, so there is less reliance on bed-based care.

Further information is available on the CCG website, where full consultation documentation was published on 1 September (see here). We are working with staff and stakeholders in the four community hospitals where the changes are proposed to support the continued delivery of quality, safe services. A copy of the main consultation document is attached to this paper.


Throughout this consultation period the CCG, supported by the Trust, will be seeking to discuss the issues which underpin this consultation and proposed solutions with the widest possible range of people.

Whilst the proposals have been developed in partnership with the Trust, it is important that the Trust Board also considers the proposals and agrees a formal response as part of the consultation process.

**The purpose of this paper, which reflects papers being submitted to Council Overview and Scrutiny Committees, is to provide detail of the proposals and the consultation process. The intention is to keep the Board updated with feedback throughout the consultation process so that an informed view in response can be developed for consideration at the Board meeting in November to submit to the CCG Governing Body for consideration.**

## 2 Context

The consultation proposals reflect the national Five Year Forward View policy, which has been endorsed by professional groups, the Government and the NHS as the way services should be provided in future. It states that “out of hospital care needs to become a much larger part of what the NHS does” and it expects to see “far more care delivered locally, but with some services in specialist centres, organised to support people with multiple conditions, not just single illnesses”.

As indicated in previous reports and briefings, like many other places, the current NHS provision in the area is unsustainable and will be unable to continue to cope with rising demand for services from our increasingly elderly population, increased life expectancy and the number of people with complex long term conditions. As indicated in previous reports, change is inevitable and maintaining the status quo is neither sustainable nor clinically sound.

The CCG, working closely with the Trust, has engaged extensively with local people and their representatives in developing these proposals and have used their priorities to inform the proposed changes. At the heart of the consultation process is our shared wish to respond to what people told us they wanted from their health services including to provide more care in or close to people’s homes, via a more integrated joined up health and social care service. We believe these proposals will improve health services and are affordable.

## 3 Proposals

The changes being proposed have been designed to improve quality of care. The goal shared by the CCG and Trust is to ensure that our health system can meet the future needs of our population by providing the best possible health and social care we can within the geographical, staffing and financial limitations in which we operate.

In changing the way local health services are delivered, we want to ensure that in the coming years people in South Devon and Torbay are able to get responsive, quality care which meets their needs and is affordable.

The consultation document sets out the need for change and how the CCG with the support of the Trust believe we can best support our different communities. It describes a model of care where hospital beds are available when needed but where people are only admitted if they cannot be cared for safely at home or in their local community. It explains how the CCG would invest in services to keep people out of hospital unless it is medically necessary to have them in there. It also focusses on doing more to stop people getting ill, supporting them to make the best choices to be as healthy and independent as possible.

The document describes how the services in each locality might work in future if the proposals are implemented with detail of what would be different , what services could look like and where they would be. It also confirms that providing much more care to people in or near their home means that some of the buildings from which we

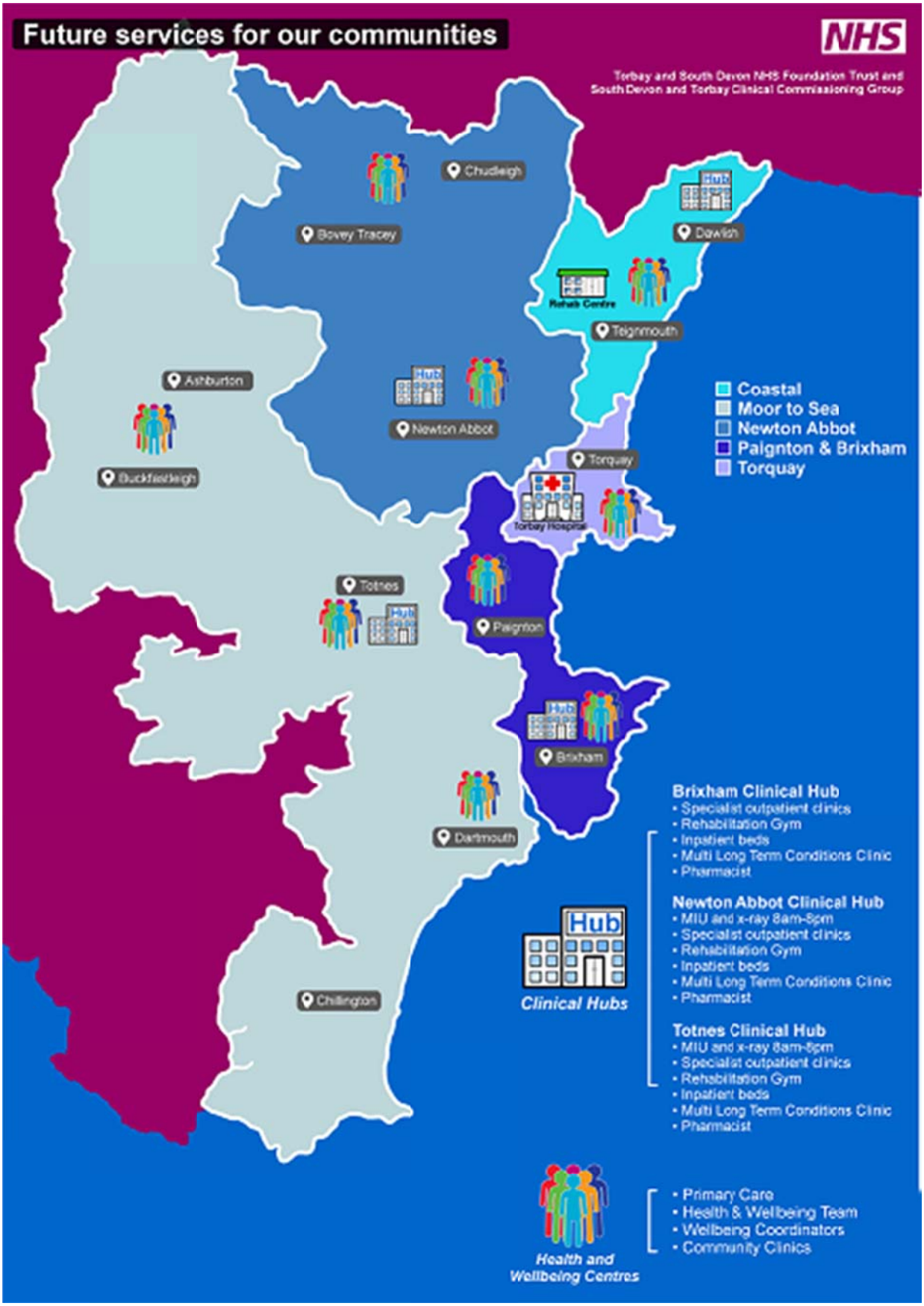
currently provide inpatient and community services would no longer be required and would close

If approved, we believe the changes described in this consultation will provide the following benefits:

- Easier access to a wider range of community-services to help people stay well and support them when they are not
- Earlier identification of those at risk of becoming more unwell through focussing on prevention and self help
- More effective response in times of crisis when people need services
- Shared information between professionals so that people only have to tell their story once
- Increased patient involvement in decisions about their care and treatment
- Closer working by different organisations which support people's well being to provide local, seamless care and to make services greater than the sum of their parts
- Reduced travel for as many people as possible for specialist services by providing services in clinical hubs – Brixham, Newton Abbot and Totnes – instead of at Torbay Hospital
- Appointments closer to home and repeat visits avoided by organising appointments where specialists can be seen during one visit
- Reduced pressure on A&E by strengthening MIUs to treat a wide range of problems keeping Torbay's A&E service free to deal with life-threatening issues
- Fewer hospital visits for treatment as a result of more effective support for people at home
- Reduced demand for services as a result of helping people live independent lives for longer
- Properly staffed and resourced community hospitals which are able to deliver quality, safe care
- Safe, high quality hospital care when needed, but keeping people out of hospital when they don't need to be there
- Reduced "bed blocking" in hospitals as a result of effective alternative community based support
- Treatment and recuperation at home, recognising that "the best bed is your own bed"
- Greater investment in local services by switching funding from hospital to community based care

The proposals will see a switch of spend from bed-based to community-based care with the number of community hospital beds being reduced to levels evidence suggests we need and more investment being made in the local services which most people use. Under the proposals, if agreed, minor injuries units (MIUs) will be concentrated in fewer locations, operating consistent hours and with x-ray diagnostics so they will provide a viable alternative to A&E.

The map on the following page shows the spread of services across South Devon and Torbay should the consultation proposals be approved and implemented.


Future services for our communities
NHS
Torbay and South Devon NHS Foundation Trust and South Devon and Torbay Clinical Commissioning Group
Chudleigh
Bovey Tracey
Dawlish
Rehab Centre
Teignmouth
Ashburton
Hub
Newton Abbot
Buckfastleigh
Torquay
Torbay Hospital
Totnes
Paignton
Brixham
Dartmouth
Chillington
Coastal
Moor to Sea
Newton Abbot
Paignton & Brixham
Torquay
Brixham Clinical Hub
• Specialist outpatient clinics
• Rehabilitation Gym
• Inpatient beds
• Multi Long Term Conditions Clinic
• Pharmacist
Newton Abbot Clinical Hub
• MIU and x-ray 8am-8pm
• Specialist outpatient clinics
• Rehabilitation Gym
• Inpatient beds
• Multi Long Term Conditions Clinic
• Pharmacist
Totnes Clinical Hub
• MIU and x-ray 8am-8pm
• Specialist outpatient clinics
• Rehabilitation Gym
• Inpatient beds
• Multi Long Term Conditions Clinic
• Pharmacist
Clinical Hubs
• Primary Care
• Health & Wellbeing Team
• Wellbeing Coordinators
• Community Clinics
Health and Wellbeing Centres

## 4 Consultation Process

The 12 week consultation started on 1 September and runs until 23 November. During this time the CCG's aim is to involve as many people as they can and to generate a debate around the consultation proposals, inviting alternative approaches which are clinically sound, affordable and sustainable.

The CCG website (www.southdevonandtorbayccg.nhs.uk/community-health-services) hosts all consultation material which can be downloaded and also enables people to request paper copies.

The main elements of the consultation material are summarised below:

- **Main consultation document:** this covers the entire CCG area; the rationale for the proposals; explains the new model of care; summarises the impact on each locality; includes details of public meetings; how to get involved and the feedback questionnaire.
- **Four locality summary documents:** these cover each of the localities which are part of this consultation and summarises the main issues; includes the same locality impact section; sets out how to get involved and includes the feedback questionnaire.
- **Feedback questionnaire:** in addition to forming part of the above documents, this is also available on line at www.communityconsultation.co.uk Although the questions are identical, the on line form provides some context to the questions for those who might not have read the consultation material or attended a meeting.
- **Support documents:** are available from the CCG website giving more details on aspects of the proposals as well as the process to date. These include:
    - The clinical case for change
    - Information about the use of local services
    - Options and rationale
    - Population case for change
    - The financial case for change
    - Travel times
    - Summary of stakeholder engagement and feedback
    - Consultation terminology.
- **Public meetings:** 17 public meetings have been arranged. Details are set out in the consultation documents and on the promotional poster which is attached for ease of reference. (Appendix 1). Each public meeting will have an independent chair. The Trust will have the Chief executive or an Executive Director at each panel to take part in the question and answer sessions. The Trust is also providing staff to facilitate the round table discussions. Trust public Governors have also agreed to attend each public meeting to provide a further link between the community and the Trust.
- **Community meetings:** community based groups are being encouraged to invite the CCG to attend one of their meetings to discuss the proposals and to answer questions. The Trust will also attend to support.

- **Staff briefings**: these took place in week one of the consultation and are likely to be repeated later in the process. The Trust is also using its internal communication and engagement channels to ensure staff are kept up to date.

**CCG Website:** (www.southdevonandtorbayccg.nhs.uk/community-health-services as well as hosting the above, the web site has a range of information including some video case studies, a Frequently Asked Question section, a presentation of the issues in each locality (based on that used in the engagement meetings); and the stakeholder updates. It also includes an interview with Chief Clinical Officer of the CCG, Dr Nick Roberts and our Chief Executive Mairead McAlinden broadcast initially by local on line health channel Hiblio TV on 2 September.

**Document request:** individuals and organisations can request paper copies, view or download consultation material via the CCG website or by:

- Emailing sdtccg.consultation@nhs.net
- Writing to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF
- Calling 01803 652511 during office hours or leaving a message outside these times

**Newspaper advertising:** public meetings are being advertised in local media and efforts are being made to encourage newspaper, radio and television coverage of the issues at the heart of the consultation.

**Social media:** the CCG's locality facebook pages and twitter feed (details on the CCG's website) will keep people in touch with the consultation and provide opportunities for discussion and for asking questions.

**Questions:** a team of CCG staff will respond to people who use the above consultation hotline number or who write/email seeking additional information. Their aim is to respond as swiftly as possible. To support this they have established the following service standards:

- telephone calls or out-of-hours messages left will be responded to by the end of the next working day; and
- written correspondence will be dealt with within five working days.

**Stakeholder update:** throughout the pre-consultation engagement phase stakeholders have been kept up to date with developments through a series of face to face meetings and a regular email briefing. The CCG plans to continue the email briefing, ensuring those who sign up to receive it are kept in touch with developments. The CCG anticipates that in the early weeks of the consultation, they will produce this weekly, covering main issues arising at the public meetings and highlighting any new information added to their website.

Material is being distributed across the area and the CCG is responding positively to suggestions for ways in which it can reach more people.

The Trust has also briefed all staff and is holding additional briefings for staff directly affected by the proposals.

## 5 Reporting on Consultation Responses

Views expressed at public meetings and others attended by the CCG will be noted by Healthwatch (Devon and Torbay) and included in their independent report on the consultation.

Correspondence, petitions and other submissions will be noted by Healthwatch but most weight will be given to the completed feedback forms, which give people an opportunity to comment on different aspects of the proposals; to say why they would choose to keep hospitals open rather than invest in community based services or vice versa; and to put forward their own ideas for sustainable, affordable change.

The feedback questionnaire goes straight to Healthwatch and responses are not seen by the CCG, other than where it is necessary to follow up alternative suggestions.

Healthwatch will independently assess the feedback received in the consultation and produce a report within 12 weeks of the closing date for consideration by the CCG governing body. Feedback from the consultation is likely to be considered by the CCG's Governing Body at a meeting in public in January/February 2017.

## 6 Recommendation

The Board is asked to:

- **receive** this report; and
- **note** a further paper with detail of initial responses will be brought to the November Board meeting where Directors will have the opportunity to agree a formal response to the proposals.

**Appendix 1**

## Public Meeting Schedule

NHS
South Devon and Torbay
Clinical Commissioning Group

# The choices facing our healthcare system

## Switching resources from hospital-based care to community care

### Have your say

- Read the proposals
- Come to a public meeting
- Invite us to a community meeting
- Join the discussion on social media
- Complete the feedback questionnaire
- Suggest alternative proposals


| | | | |
|---|---|---|---|
| **Ashburton:** | 20 Sept | 1pm, 4pm, 7pm | Ashburton Town Hall, TQ13 7QQ |
| **Bovey Tracey:** | 13 Sept | 4.30pm, 7.30pm | Phoenix Hall, TQ13 9FF |
| **Brixham:** | 29 Sept | 6.30pm | Scala Hall, TQ5 8TA |
| **Buckfastleigh:** | 22 Sept | 6.30pm | St Luke's Church, TQ11 0DA |
| **Chudleigh:** | 16 Sept | 6.30pm | Chudleigh Town Hall, TQ13 0HL |
| **Dartmouth:** | 15 Sept | 4pm, 7pm | Dartmouth Academy, TQ6 9HW |
| **Newton Abbot:** | 13 Oct | 6.30pm | Daphne Collman Hall, TQ12 2NF |
| **Paignton:** | 28 Sept | 9am, 4pm, 7pm | Sacred Heart Church, TQ3 2SH |
| **Torquay:** | 6 Oct | 6.30pm | Upton Vale Baptist Church, TQ1 3HY |
| **Totnes:** | 11 Oct | 6.30pm | Totnes Civic Hall, TQ9 5SF |
| **Widecombe:** | 12 Oct | 6.30pm | Widecome Church House, TQ13 7TA |

Latest information: **www.southdevonandtorbayccg.nhs.uk/community-health-services**

Feedback questionnaire: **www.communityconsultation.co.uk**

Want to invite us to a meeting? Got questions about the consultation? Want a paper copy of the proposals?

- email **sdtccg.consultation@nhs.net** • call **01803 652511** (Monday-Friday, 8am-5pm)
- write to **South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF**

Twitter: **twitter.com/sdtccg** Facebook: **www.facebook.com/nhs.sdtccg**

Driving quality, delivering value, improving your services

# Into the future

## Re-shaping community-based health services

A public consultation:
Thursday 1 September to Wednesday 23 November 2016

## Driving quality, delivering value, improving services

www.southdevonandtorbayccg.nhs.uk/community-health-services

**NHS**
**South Devon and Torbay Clinical Commissioning Group**




South Devon and Torbay Clinical Commissioning Group is responsible for planning and organising health services for local people. It is divided in to five localities – each led by local GPs.

Into the future: re-shaping community-based health services

## CONTENTS



# One: Welcome

Thank you for your interest in the changes being proposed for community health services across South Devon and Torbay. These changes are designed to improve quality of care. Our goal is to ensure that our health system can meet the future needs of our population by providing the best possible health and social care we can within the geographical, staffing and financial limitations in which we operate.

This document describes the reasons for change and the improvements we want to see. It includes dates and times of meetings, sets out how to contribute your views, and explains how to make alternative suggestions. We want to hear from as many people as possible. Please help us by sharing this document with your friends and family, encouraging them to participate and to tell us what they think of the proposals.

Decisions made at the end of this consultation will impact on your NHS services for years to come, so it is important that all parts of our communities get involved.

We hope you will take part.

## THE BENEFITS WE WANT TO SEE

In changing the way we deliver local health services, we want to ensure that in the coming years people in South Devon and Torbay are able to get responsive, quality care which meets their needs and is affordable.

If approved, the changes set out in this consultation would provide the following benefits:

- Easier access to a wider range of community-based services to help people stay well and to support them when they are not
- Earlier identification of those at risk of becoming more unwell through focusing on prevention and self-help
- More effective response in times of crisis when people need services
- Shared information between professionals so that patients only have to tell their story once
- Increased patient involvement in decisions about their care and treatment
- Closer working by different organisations which support people's wellbeing to provide local, seamless care and to make services greater than the sum of their parts
- Reduced travel for as many people as possible for specialist appointments by providing services in clinical hubs – Brixham, Newton Abbot and Totnes – instead of at Torbay Hospital
- Appointments closer to home and repeat visits avoided by organising appointments where specialists can be seen during one visit
- Reduced pressure on A&E by strengthening minor injuries units to treat a wide range of problems, keeping Torbay's A&E service free to deal with life-threatening issues

"We want to hear from as many people as possible. Please help us by sharing this document with friends and family, encouraging them to participate and to tell us what they think of the proposals."

- Fewer hospital visits for treatment as a result of more effective support for people at home or in their community
- Reduced demand for services as a result of helping people live independent lives for longer
- Properly staffed and resourced community hospitals which are able to deliver quality, safe care
- Safe, high-quality hospital care when needed but keeping people out of hospital when they don't need to be there
- Reduced 'bed blocking' in hospitals as a result of effective alternative community-based support
- Treatment and recuperation at home, recognising that 'the best bed is your own bed'
- Greater investment in local services by switching funding from hospital to community-based care.

## Who we are

South Devon and Torbay Clinical Commissioning Group (CCG) is the organisation which represents local GP practices and is the NHS body responsible for buying and developing services for the people of the area. We are working closely with Torbay and South Devon NHS Foundation Trust, which provides services at Torbay Hospital as well as community health and social care services in the area, including community hospitals and minor injuries units. Within South Devon and Torbay, we work in partnership with the local councils and GPs to jointly develop services.

We operate through five localities, each of which is led by local GPs: Coastal (Teignmouth and Dawlish), Moor to Sea (Ashburton, Buckfastleigh, Totnes, Dartmouth and Chillington), Newton Abbot (includes Bovey Tracey and Chudleigh), Paignton and Brixham, and Torquay. Our Coastal locality is not part of this process because we consulted there in 2015 and improvements are currently being implemented.

## Alternative formats

If you would like information about the consultation in another format such as large print, audio or in another language, please contact the CCG.

We have many Polish and Chinese people in our population, so we're including this statement below in both languages.

We are consulting people in South Devon and Torbay over possible changes to the way community-based health services are provided. If you require information in Polish/Chinese on this consultation please email: sdtccg.consultation@nhs.net or write to: South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF.

Prowadzimy konsultacje z mieszkańcami Południowego Devon i Torbay w sprawie projektu zmian, w jaki zapewniane są usługi zdrowotne w lokalnej społeczności. Osoby pragnące otrzymać informacje o konsultacjach w języku polskim proszone są o kontakt pod adresem: sdtccg.consultation@nhs.net lub o wysłanie wiadomości na adres: South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF.

**我们正在向南Devon和Torbay的居民进行征询，收集有可能改变社区健康服务提供方式的意见。如果您需要相关中文信息，请发送电子邮件至：sdtccg.consultation@nhs.net**
**或邮寄信件至：South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF。**

# Two: The need to change

## Seeking your views: Thursday 1 September to Wednesday 23 November

For these 12 weeks, we – South Devon and Torbay Clinical Commissioning Group – are asking local people from across our communities to comment on our proposals to improve healthcare.

This document sets out how we believe we can best support our different communities. It describes a model of care where hospital beds are always available when needed but where people are only admitted if they cannot be cared for safely at home or in their local community. It explains how we would invest in services to keep people out of hospital unless it is medically necessary for them to be there, make sure they don't stay a day longer than is right for them, and deliver more care in or closer to people's homes. It also focuses on doing more to stop people getting ill, supporting them to make the best choices to be as healthy as possible, and working in partnership with people with complex needs to become 'experts by experience'.

Our proposals reflect the national Five Year Forward View, which has been endorsed by professional groups, the Government and the NHS as the way services should be provided in future. It states that "out-of-hospital care needs to become a much larger part of what the NHS does" and it expects to see "far more care delivered locally but with some services in specialist centres, organised to support people with multiple conditions, not just single illnesses."

In recognising the changing needs of patients and the impact of new treatments coming on stream, the Five Year Forward View states that "there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists – all of which get in the way of care that is genuinely coordinated around what people need and want."

Our proposals reflect the ways in which we believe we can better meet the health and care needs of local communities. We have engaged extensively with local people and their representatives in developing these proposals and we have used their priorities to inform the proposed changes. We believe these would improve health services and are affordable.

However, we are open to alternative suggestions for redesigning clinically effective, sustainable services that meet local needs.

No decisions will be made until after we have heard the views of the people of South Devon and Torbay.

"To meet the scale of these challenges, change is inevitable, essential and clinically desirable."

## Why consult now?

In late 2013, South Devon and Torbay Clinical Commissioning Group (CCG) – in partnership with our acute hospital, community health providers, Devon County Council and Torbay Council – carried out extensive engagement about our community health and social care services.

People told us that the most important things to them were:

- **Accessible services** – convenient opening hours, transport and accessible buildings
- **Better communication** – between clinician and patient, and between clinicians themselves
- **Continuity of care** – to allow relationship-building with clinicians and carers
- **Coordination of care** – including joined-up information systems
- **Support to stay at home** – with a wide range of services and support.

Last year's creation of the integrated care organisation (Torbay and South Devon NHS Foundation Trust, or TSDFT) resulted in the majority of our health and care services – from district nursing, social work, community therapy, complex care and multi-agency teams, to highly specialist acute care – being delivered by the one NHS Trust. The bringing together of these and other services in one organisation created a huge opportunity to develop new ways of working which can deliver what people told us they wanted in 2013.

Since last summer, the CCG, supported by TSDFT, has engaged with groups across the area to discuss how best to deliver services which would meet the future needs of our local population. These engagement discussions involved a range of interests and expertise and looked at, for example, the predicted health needs of our population, the use of hospital beds to look after people who can no longer live on their own, ways of providing more care in the local community and the difficulties of attracting specialist staff to the area.

Out of the 2013 engagement and in parallel with these discussions, representatives of the CCG, Torbay Council, Devon County Council, TSDFT and primary care, including senior clinicians, have drawn on the feedback provided and considered how best to provide the range of services required in the future. Informed also by TSDFT staff, a new model of care (see page 9) has been developed, which these organisations believe would meet future need, can be delivered and is affordable.

We are grateful for the contributions of everyone who participated in this process and whose views have been taken into account in framing the consultation proposals. A separate paper summarising views expressed is available on our website or in hard copy by request (see back cover for contact details).

## The challenge of change

Communities across South Devon and Torbay are rightly proud of their local health and social care services and their record of meeting the expectations of people who need care, delivering improved health and wellbeing for our local population. The NHS in South Devon and Torbay provides care and treatment to a population of 286,000. Some three million episodes of NHS care are delivered in South Devon and Torbay every year, a number forecast to rise significantly over the next decade.

Year on year the NHS looks after more people, provides more specialist support and works increasingly in partnership with social care and the voluntary sector.

The NHS has kept up with growing demand by constantly responding to changing needs: redesigning how services are provided, developing new techniques and adopting new drugs and approaches.

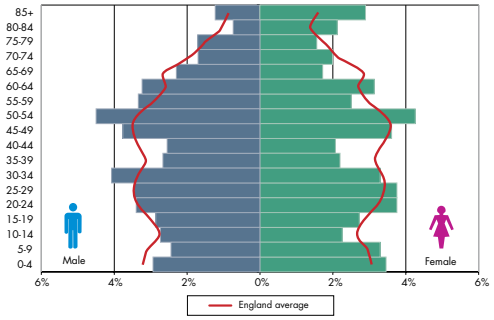
We can easily forget how much the NHS has changed over the years. It is not that long ago, for example, that lengthy hospital stays were required for treatment which now takes place routinely, in a few hours and without a hospital admission.

Delivering health services today is challenging because we have:

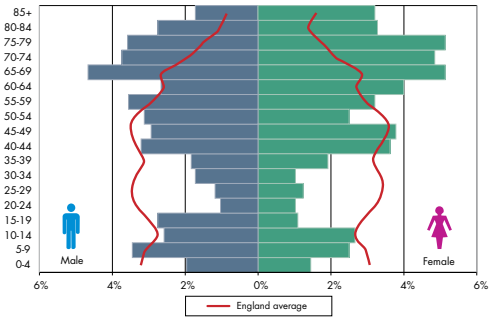
- Increasing numbers of older people, many with long-term and complex health conditions who need support to live independently

- A growing proportion of our younger people living in areas of deprivation, especially in Torbay but also in some rural areas

**Population pyramid for the most deprived area in the CCG compared to England average**




**Population pyramid for the least deprived area in the CCG compared to England average**




- Rural and urban communities with different needs

- A high use of urgent care services, especially A&E, which means increasing pressure on emergency and urgent care services

- Flat or reducing finances, especially when health and social care resources are combined

- Changes to professional NHS standards which specify minimum safe staffing levels

- Recruitment problems due to a shortage of doctors, nurses and other clinical staff in some services.

Faced with these challenges, the NHS needs to continue to work differently, creating services which are designed to support people to live well at home and in their local communities. We want to make sure that, at every stage of life, the NHS can provide the best possible care. That is why, in looking at how best to meet the future needs of local people, we want to blend the best of current practice with new, innovative and better ways of working.

Locally and nationally, the NHS must do more with the funding that it receives, responding effectively to the increasing health needs of our population, aligning physical and mental health services, promoting the most clinically effective care and support irrespective of location, and deploying resources where they can have most impact and where patient demand is greatest.

To meet the scale of these challenges, change is inevitable, essential and clinically desirable. We need to change to ensure we deliver services that support local people to live life to the full.

## Nine reasons to change

### Deliver high-quality care to an increasing number of people

Our services must meet local people's needs, both now and in the future. Our existing structures and approaches will not cope with the forecast demand for services in the coming years as illustrated in the table on page 6). If we are to provide the care to support people to live the healthiest lives possible, we need to change the way we work.

### Increase joint working between services

We have an international reputation for our pioneering 'integrated care' model in which adult social care and health services are delivered by local teams working in a joined-up way. Our new integrated care organisation, launched in October, now brings Torbay Hospital and these local community-based health and social care services into a single provider Trust (Torbay and South Devon NHS Foundation Trust). We want to extend this integration to include a more joined-up way of working with local voluntary and charitable organisations, and with our partners in other public services such as mental health and children's social care.

### Improve life expectancy

In each of our localities, there are significant differences in life expectancy between our most deprived and least deprived areas, the numbers of people in the under-16 or over-85 age groups, and the number of emergency admissions. We want to strengthen our preventative and self-care services to help tackle health inequalities and reduce the gaps in life expectancy, providing the best care we can to all sections of our communities.

**Life expectancy between most deprived and least deprived in each locality area**

## Keep more people out of hospital

People should only be admitted to hospital when it is medically necessary. If people do not need specialist nursing or medical help, they are better supported out of hospital. Successive audits have shown that almost a third of beds in community hospitals are occupied by patients who were fit to leave if more community support had been available.

We therefore want to invest more in community services so we are able to treat and support people in their own homes or in locally accessible services. This is also what people tell us they would prefer.

We know that treating people in a hospital bed is not always the best approach. For example, the longer older people remain in hospital, the harder it is for them to regain their independence and return home, the more likely they are to be readmitted, and the more vulnerable they are to hospital-acquired infections.

Evidence also suggests that some people recover much quicker if they are cared for in their own home, in a more normal environment rather than in a busy hospital setting, and we want to invest in community services to be able to support more people to recover as quickly as possible.

But where people need to be admitted to hospital, we want to make sure that they receive the best quality and experience of care, that we have enough staff to look after them, and that we meet national safety standards. This is challenging, because it is increasingly difficult to attract staff to community hospitals.

## Better support for people in the community

We need to make sure we strengthen out-of-hospital services so that they can help people to avoid the need to be admitted to hospital and respond swiftly should they experience deterioration in their health. This means investing in more community-based services so that

### Forecast demand for services, 2015 to 2025

| Number of patients with disease, known or not known to primary care | Moor to Sea | Newton Abbot | Paignton and Brixham | Torquay |
|---|---|---|---|---|
| | 2015-25 % change | 2015-25 % change | 2015-25 % change | 2015-25 % change |
| Coronary heart disease | 19.8 | 20.5 | 18.3 | 17.2 |
| Chronic kidney disease | 21.5 | 21.7 | 19.4 | 18.5 |
| People aged 65 and over predicted to have: | | | | |
| • Type1 or Type 2 diabetes | 20.0 | 20.5 | 17.1 | 16.5 |
| • A longstanding health condition caused by a stroke | 25.5 | 25.7 | 22.1 | 21.5 |
| • Dementia | 34.5 | 33.4 | 30.7 | 30.7 |
| • Depression | 20.3 | 20.7 | 17.0 | 16.5 |
| • Severe depression | 25.2 | 25.3 | 21.7 | 21.1 |
| • A longstanding health condition caused by bronchitis and emphysema | 21.5 | 21.9 | 18.5 | 17.8 |
| • A moderate or severe visual impairment | 29.2 | 28.7 | 24.9 | 24.4 |
| • A moderate or severe, or profound, hearing impairment | 31.5 | 31.0 | 26.0 | 25.0 |

This table is based on the CCG's 2015/16 locality structure in which Bovey Tracey and Chudleigh surgeries were part of Moor to Sea. They are now part of the Newton Abbot locality.

they mirror the availability and reliability of hospital-based care. We must ensure it is provided in the evenings, at weekends, 365 days a year, in urban and in rural areas.

To do this, we need to switch funding from hospital to community-based care so that we can increase the range of local services and the times that they are available.

We also want to make sure that people do not travel further than they need to for treatment and support. The more out-of-hospital services we can provide in or close to people's homes the better.

## Provide effective minor injuries units

Minor injuries units (MIUs) provide a local urgent care service in the community, filling the gap between GP services, the NHS 111 helpline service and A&E, and are intended to reduce unnecessary travel to the emergency department for non-life-threatening injuries. MIUs are an important part of urgent care services, treating people with, for example, minor burns, sprains and fractured bones.

A lack of awareness of MIUs, and inconsistencies in opening times and services provided, including x-ray diagnostic services, have limited their use by local people.

For MIUs to be a viable alternative to A&E for non-life-threatening injuries they need to:

- Be easily accessible
- Provide a treatment service led by a specialist nurse or paramedic
- Open 12 hours a day, 7 days a week
- Have x-ray diagnostic services
- Operate from an environment that can best support high-quality care.

It is estimated that MIUs need to treat 7,000 patients per annum to ensure the best use of highly skilled staff and to ensure that they are able to maintain their skills by seeing enough patients with a sufficiently wide range of minor injuries. In South Devon and Torbay, MIUs in the past have not been fully utilised, with only Newton Abbot MIU achieving at least the 7,000 criteria.

## Focus resources where they have most impact

Public finances are under considerable pressure. These are intensified within the NHS by the rising cost of some treatments, the increasing demand for specialist services and the need to look after more people with a number of long-term conditions.

NHS costs traditionally rise faster than inflation, putting further pressure on the local health community budgets.

The CCG currently receives more money than the national funding formula judges it should, and we need to manage our budgets to bring ourselves back into alignment with the formula in the coming years. Taking these factors into account, the demands on services outstrip any new funding available and the CCG needs to make significant savings over each of the coming years. For 2016/17 we currently need to save £20.5million across the services which the CCG commissions.

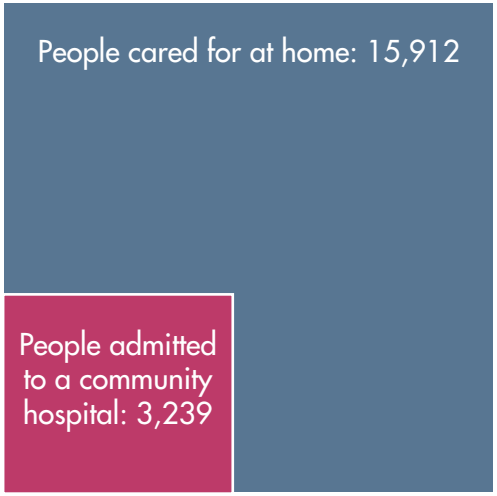
In addition to the pressures on CCG funding, Torbay and South Devon NHS Foundation Trust is required to make savings across the range of its activity. In 2016/17 this amounts to £13million.

Overall, health and social care services in South Devon and Torbay are under significant financial pressures, and services are likely to be £142million in deficit by 2020/21 if nothing changes.

In reconfiguring services, we need to not only take account of quality and safety issues but also the need to improve value for money and contribute to this funding gap by finding different and more effective ways of meeting the increasing needs of our population. The proposals which form the basis of this consultation would contribute £1.4million towards the savings requirements of the Trust.

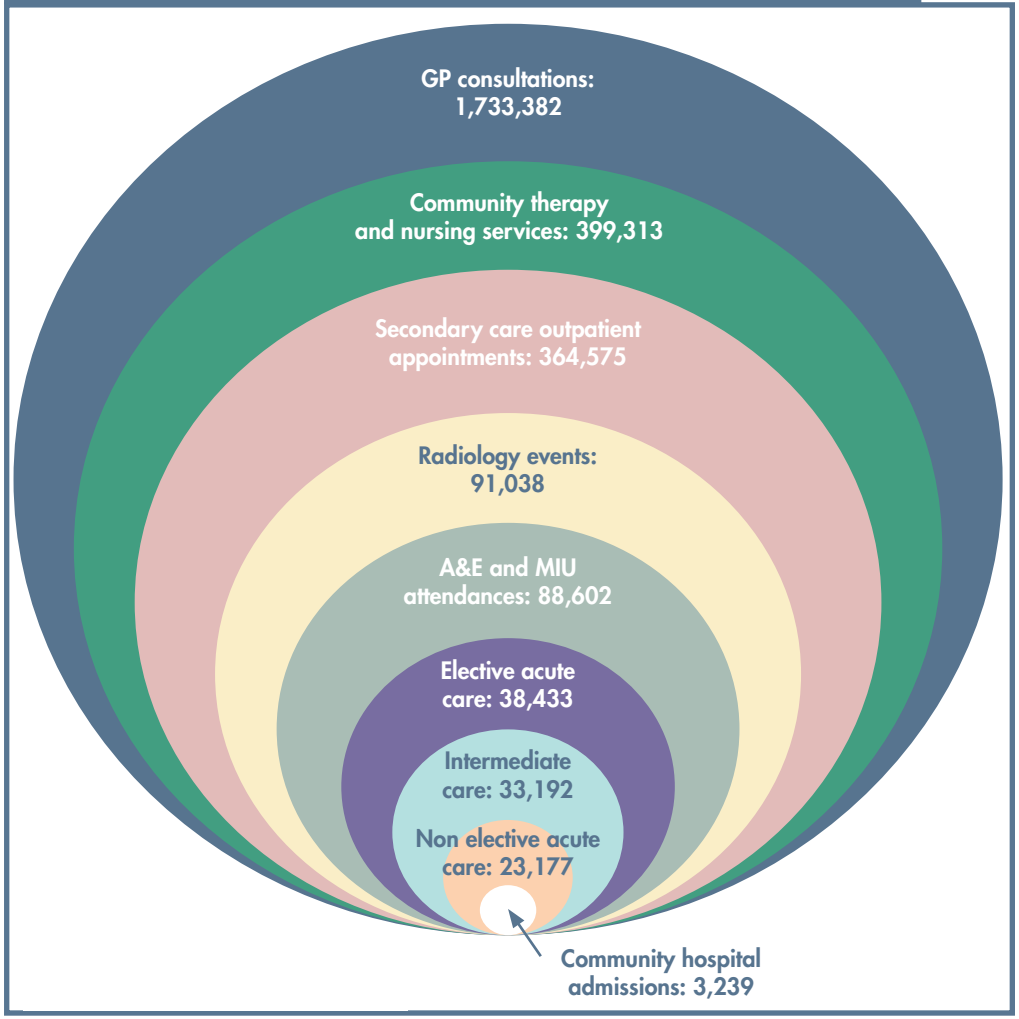
By switching funding from bed-based to community-based care, we would be investing more of our resources in the local services most used by our communities. As the diagram opposite illustrates, the largest volume of activity rests with GPs, community therapy and nursing.

As the diagram below shows, almost five times the number of people admitted to community hospitals (3,239) are cared for at home (15,912).



A separate paper setting out the financial case for change, including details of the financial cost of the different options considered as well as issues of capital funding, is available from the CCG website and in hard copy on request.

Activity across South Devon and Torbay




The figures relate to activity not people and are based on extrapolated NHS data.

## Make best use of our staff

We want to make best use of our staff, providing good career opportunities and roles which attract people to work in local health and social care services. There is a shortage of doctors, nurses and other qualified staff nationally. We already see the impact of this locally, with MIUs in Dartmouth and Ashburton temporarily closed and beds temporarily relocated to Newton Abbot from Bovey Tracey Community Hospital. The number of beds at Paignton Hospital has also been temporarily reduced due to safe staffing issues.

Many other services are under similar strain, with difficulties in recruiting to community and hospital nursing posts, some medical and therapy specialties, and to specialist social work and social care.

Our partners in residential and nursing care homes are also experiencing challenges in recruiting staff and in providing the range of specialist care needed, particularly long-term care for people with some forms of dementia. Attracting GPs to this part of the country is also difficult, with many practices struggling to recruit.

We need to design services that make the best use of the time, availability and skills of these staff. By bringing them together to work as integrated teams in partnership with the local voluntary sector, we would have the range of skills to better respond to the needs of the community they serve. Local bases would enable them to have more patient and client contact rather than use their time in travelling.

## Ensure our buildings are fit for the future

We need to rationalise many NHS and social care premises which are not fit to deliver 21st-century services and use the proceeds to invest in bases locally from which our staff can deliver our future model of care and an enhanced range of services. The major sites from which health services are currently delivered locally are owned by Torbay and South Devon NHS Foundation Trust.

# Three: Our proposals

## The proposed new model of care

The diagram below illustrates the new model of care, which has been developed in parallel with, and informed by, engagement discussions across the CCG area. It takes account of best clinical practice and is aligned with national NHS approaches such as the Five Year Forward View. It is this model which forms the basis of this consultation and the following section describes how it would operate if the consultation proposals are approved.

If supported, the model below would see GPs, community health and social care teams and the voluntary sector

The proposed new model of care

> "The proposed new model of care aims to provide the majority of care as close to home as possible, supporting people to remain independent."

working together to provide for the vast majority of people's health and wellbeing needs in each of the localities that make up the CCG and Trust population. It aims to provide the majority of care as close to home as possible, supporting people to remain independent and in their own homes, reducing reliance on bed-based services, but centralising care where that is more resilient, effective and efficient. We want to see local communities helping to support the wellbeing needs of their local population.

We recognise that one size will not fit all. From locality to locality, and from town to town, there are differences in health, demography and geography, as well as variation in the availability of services such as residential and nursing care. The proposed model of care needs to reflect these differences while being able to deliver consistent, high-quality care.

Our new model of care would reflect the needs of the community in each of the four CCG localities which are part of this consultation: Moor to Sea; Newton Abbot; Paignton and Brixham; Torquay.

Accessing services would be made simpler through a central contact point for information and signposting. By calling a single telephone number, people would be signposted to support in their local community or to local health and social care teams or services according to their needs.

There are four key elements to delivering this care model locally – locality clinical hubs, including community hospital beds and minor injuries units; local health and wellbeing centres; health and wellbeing teams; and intermediate care provision.

## Clinical hubs

In each locality there would be a clinical hub providing people with better access to medical, clinical and specialist services. These hubs would offer a broad range of services to people and, although one is proposed in each locality, they could be used by everybody irrespective of where they live.

The clinical hubs would offer services such as outpatient appointments, specialist conditions clinics and inpatient services. By bringing services together in a single location we would reduce the need for people to travel to Torbay Hospital to access services, therefore adopting the principle of 'care closer to home'. The clinical hubs would be provided in buildings that are of a high clinical standard and, where necessary, additional investment would be made to improve the quality of environment and range of services offered.

Services provided in the hubs would include:

- **Multi long-term condition clinics:** these would provide a 'one-stop shop' approach to help people manage multiple long-term conditions by accessing information and treatment in a single clinic.
- **Minor injuries unit:** Newton Abbot and Totnes clinical hubs would offer access to MIU and x-ray diagnostic services, between 8am and 8pm, seven days a week.
- **Specialist outpatient clinics:** these are attended by people from a wide geographical area. They are mainly consultant-led and usually have less than 1,000 attendances a year. Specialist services often require more bespoke facilities or equipment which would be available in clinical hubs.
- **Rehabilitation gym:** this would include equipment used to deliver early-stage rehabilitation services.
- **Inpatient care:** a minimum of 16 beds would be provided in the clinical hubs to ensure compliance with safe staffing standards. The use of inpatient services across all of the clinical hubs would be provided to everybody who requires an inpatient stay in a medical ward, irrespective of where they live.

## Local health and wellbeing centres

Linked to the locality clinical hub, local health and wellbeing centres would be delivered from Ashburton/Buckfastleigh, Bovey Tracey/Chudleigh, Brixham, Dartmouth, Newton Abbot, Paignton, Totnes and Torquay. These would see community staff based locally and working alongside GPs, pharmacists and voluntary-sector organisations to provide health and wellbeing services to the area.

Within these centres, the clinical services most frequently used by local

people would, wherever feasible, be provided by professionals based locally and who would work across community sites.

## Local health and wellbeing teams

Services from these centres would be provided in each local area by local health and wellbeing teams. These would bring together an integrated team of community health and social care staff, mental health professionals and our voluntary-sector partners to organise and deliver most of the health and social care needs of the population, working as a bridge between their GP services, the clinical hub and the highly specialist care that can only be provided in a large hospital like Torbay.

As well as face-to-face support, we would enable remote access to specialist advice using technology such as Telemedicine and support via Telehealth systems.

CASE STUDY

'Annie' lives alone with no relatives nearby. She suffers from Alzheimer's, heart arrhythmia and COPD, and is at risk from falling. Some time ago, she fell and was unable to get to her phone. She had to wait several hours for help until her care worker turned up and was able to summon assistance.

We have since provided Annie with a community alarm, pendant and key safe for emergency access. When she next fell she was able to contact the centre immediately via her pendant and we arranged for an ambulance to visit. Within 12 minutes of activating her alarm, the ambulance crew was on site and supporting Annie. Telehealth can provide support and reassurance, minimising distress as far as possible.

The local health and wellbeing team would also oversee arrangements for local intermediate care services which would cover a range of integrated services and would be provided for a limited period, to people who need extra support and care following a period of ill health. As illustrated in the case study on page 12, they are designed to help people recover more quickly following illness or injury, maximising their independence and helping them to resume normal activities as soon as possible. Intermediate care also supports more timely discharge from hospital following an inpatient stay, and helps to avoid unnecessary hospital admissions by supporting people in their local communities, either at home or in another care setting.

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CASE STUDY

'Tony' is 76 and had experienced at least four significant falls at home in four months, before finally coming in to hospital with a fractured hip. He had called an ambulance after each fall, but refused to accept any follow-up care.

After a short stay at Torbay Hospital, Tony was transferred to an intermediate care bed to recover from his surgery and regain his strength and mobility. On discharge home, he was reluctant to accept further help but agreed to short-term support with a programme of balance and mobility to reduce his risk of further falls and help him to regain his confidence. We were keen to help Tony better manage life at home so that he wouldn't keep needing 'crisis interventions'.

Our multi-disciplinary team helped him learn what to do should he have a further fall and discussed ways in which he could make his home environment safer.

Tony remains fiercely independent, but did eventually agree to a package of care that included some occupational therapy for ongoing mobility, meals, visits from the intermediate care team and support from Age UK. He has not experienced any further falls in the last six months and is planning to start going out to a local café, with the support of the volunteer from Age UK.

Providing holistic end-of-life care to people and their families would be one of the core functions of the health and wellbeing teams. This would involve coordinating support to enable a person to die in the setting of their choice, with care and support made available to provide the best possible experience for people and their families.

## Intermediate or specialist care

By switching resources to home-based care, we would be able to strengthen intermediate care teams, with seven-day cover and input from doctors, pharmacists and personal care teams. Wherever possible, a person's future needs would be assessed in their usual place of residence rather than a hospital bed. Intermediate care would be organised at locality level and delivered locally wherever possible – in the person's own home or in a local nursing or residential home. Where patients don't need to be in hospital but are unable to live alone or be supported to remain at home, they would be able to access residential care or specialist housing with care and support on site.

CASE STUDY: SPECIALIST CARE AT HOME

'Joe' has a rare condition that led to his being completely paralysed and only able to breathe on a ventilator. In previous years, his only option would have been to be cared for in an institution, either in a specialist hospital or centre. But Joe is not just a patient. He is a husband, father, grandfather and dog-owner. He wanted to make the most of life and be able to return home to live with his family.

We worked with them to put in place a package of care that meant he could continue to live at home, supported by round-the-clock carers and our community matron, as well as other professionals such as physiotherapists, occupational therapists, podiatrists and his GP. Although life is not what Joe had hoped for in retirement, he is at home with his family and much-loved dog, and is still able to get out and about, thanks to a specially-adapted car.

### Putting compassionate care at the heart of what we do every time

As our new care model develops, the importance of giving staff time to deliver compassionate care remains central at all times. One way to do this is to replace the question 'What is the matter with you?' with 'What matters to you?' A key part of giving care and support is to do the things that matter most to people and help them achieve those things for themselves wherever possible.

Library image

## Changing to the new model

Moving to the new model of care requires us to do things differently. It means switching funding from hospital to community care and making sure the new services are in place before changing the current provision.

### Investing in community services

In the current financial year, we are investing £3.9million in strengthening community services in line with the new care model. The full-year effect of this in 2017/18 would be £5.8million. The additional expenditure this year includes:

- £177,000 for wellbeing coordinators, to be employed by our voluntary-sector partners in each locality, to support and signpost local people to the most appropriate services in their local area

- £220,000 to provide clinics and services for people with multiple long-term conditions located at each of our clinical hubs – Totnes (Moor to Sea), Brixham (Paignton and Brixham), Newton Abbot and Torquay town centre – commencing with the first phase in Brixham and Teignmouth (in Coastal locality)

- £2.1million to provide additional intermediate care services in people's

own homes or close to home in local residential and nursing homes, which would support people to return to maximum independence.

## Fewer, safer community hospital beds

By introducing the new model of care throughout South Devon and Torbay, the number of community hospital beds will fall from 151 to 93. The reduction in the four localities covered by this consultation will be 44 (121 to 77).

This reduction is based on proposals to close four community hospitals (Ashburton and Buckfastleigh, Bovey Tracey, Dartmouth and Paignton) so that more can be invested in local community teams.

If these consultation proposals are agreed, there would be community hospitals in Brixham, Newton Abbot and Totnes (as well as Dawlish in our Coastal locality) serving the population of South Devon and Torbay.

By concentrating medical beds in fewer hospitals, we would be able to ensure we meet national guidance on safe staffing levels.

At present, many people admitted to hospital do not go to the one nearest to them, so concentrating medical beds in fewer locations is in line with general current usage.

## Stronger minor injuries units (MIUs)

To ensure that MIUs provide a viable, effective service, we propose to reduce the number to three and have them located in Newton Abbot and Totnes, as well as Dawlish in our Coastal locality. All MIUs would open 8am to 8pm, seven days a week, and would have x-ray diagnostic services. This means that MIUs in Ashburton, Dartmouth (both of which are currently suspended), Brixham and Paignton would close.

## Intermediate and domiciliary care

An integral part of this care model approach is to stimulate the care home/ intermediate care market in South Devon in the same way as it has been developed in Torbay. Notwithstanding the partial role that community hospitals play in this area, it is clear that provision at present does not meet current, let alone future, need.

Until there is certainty as to future demand, it is unlikely that the market would expand. An invitation to express interest will be issued to the private sector so as to facilitate discussions on how best to meet future needs and to explain the model of care and the investment strategy.

Discussions have already taken place with local authority colleagues and with some care home operators. As a result, an initiative is under way to identify the most appropriate model for the future.

The way domiciliary care in the home is purchased in Devon has recently changed. In South Devon and Torbay the primary provider is Mears, which is responsible for providing care directly or managing other providers. This change will improve the quality of patient care, as there will be a greater mix of personal care workers. People will receive packages of care more quickly, careworkers' pay and conditions will be improved, and carers will receive more training. This approach complements the proposed model of care.

In addition, the rehabilitation beds in Teignmouth Hospital will also be available to anybody who needs rehabilitation care, irrespective of the locality in which they live.

## Reduced pressure on Torbay Hospital

By improving the availability and quality of support in the community, Torbay Hospital would be able to focus attention on patients who are acutely unwell and cannot be treated near to or in their own homes or in a community hospital. Over the past year, it has had to open an additional 32 beds to cope with demand pressures, caused, in part at least, by the shortage of out-of-hospital support. Should the proposals set out in this document be approved and implemented, the additional 32 escalation beds would no longer be required. Attendances at A&E are also expected to decline as people's confidence in MIUs increases. As more resources are used to keep people well and independent for longer, then overall people would need fewer admissions to hospital for acute care.

# Four: What this might mean

## For you as a patient

For someone with a number of long-term conditions, this is how the service might work in future if proposals in this document were implemented.

'Mr Jones' lives in Buckfastleigh and has four long-term conditions, including atrial fibrillation, congestive cardiac failure, chronic kidney disease and Type2 diabetes.

| Currently | In the future |
|---|---|
| Attends three separate appointments to see his consultants at Torbay Hospital | Attends a new service in Totnes |
| Sees two specialist nurses | Has a wellbeing coordinator to put him in touch with local voluntary services |
| Sees two dieticians | Sees one team, which includes a doctor, nurse and dietician, for all his conditions |
| Has a total of 25 different hospital appointments a year | Has just six appointments a year |
| 12 appointments at his GP surgery | Through better coordination he only needs three GP visits a year |
| Admitted twice for heart failure in the last year | Given support from the heart failure team at home |
| Takes 14 different medications | Better understands his treatment and how to manage his conditions and now only takes nine medications |
| Lonely as he lives alone and doesn't know what to do for the best | Much happier as he has access to a range of support and voluntary groups which help him achieve what matters most to him |

## For your area

The likely impact of these service improvements, if approved, is set out on pages 16-20, alphabetically per locality.

Where reference is made to specialist outpatient clinics that would operate in clinical hubs, these are clinics where patients currently travel further to access them. They are mainly consultant-led and usually have less than 1,000 attendances a year. Some non-consultant-led clinics such as audiology require more specialist facilities or equipment.

Examples of specialist outpatients might include: audiology, cardiology, dermatology, ear, nose and throat, endocrinology, general medicine, general surgery, gynaecology, neurology, orthopaedics, paediatrics, rheumatology and urology.

Community clinics, which would operate in health and wellbeing centres, generally have more than 1,000 attendances a year and are mainly provided by locally-based professionals, working across community sites. Examples of community clinics include: MSK (musculoskeletal assessment and treatment), speech and language therapy and podiatry.

# MOOR TO SEA

## What would be different?

A clinical hub would be established at Totnes Community Hospital that would include community inpatient beds and a range of specialist services to reduce the need to travel as far for specialist care. These would include a new multi long-term conditions service, extended x-ray diagnostic services, specialist outpatient clinics and the existing gym-based rehabilitation services and minor injuries unit.

Totnes Community Hospital currently provides 18 beds, which would slightly reduce to 16 to meet safe staffing ratios. The MIU would open between 8am and 8pm (currently 9pm), seven days a week, reflecting the times of greatest demand and in line with the planned opening times of MIUs in Dawlish and Newton Abbot. X-ray diagnostic services would also be available during these times.

For the population of Totnes, Dartmouth and Ashburton/Buckfastleigh, local health and wellbeing teams would be co-located, where possible, with GP services. These teams would provide community nursing, physiotherapy, occupational therapy and social care support.

Community inpatient care and specialist outpatient clinics for the population of Dartmouth, Ashburton and Buckfastleigh would be provided at their nearest clinical hub in Totnes, Brixham or Newton Abbot. MIUs would be provided in Totnes and Newton Abbot.

To deliver more expert care to people in their own homes, we would invest money into more community-based staff and enhanced intermediate care services. We would work in partnership with local care home providers to provide more local intermediate care beds.

Providing much more care to people in or near their own home means that the buildings from which we currently provide inpatient and community services – including Dartmouth Community Hospital (16 beds), Dartmouth NHS Clinic and Ashburton and Buckfastleigh Community Hospital (10 beds) – would no longer be required and would close if these proposals are approved.

For those whose GP is based in Chillington, the proposals have little impact other than if adopted, the nearest MIU and community hospital run by Torbay and South Devon NHS Foundation Trust would be in Totnes.

The Trust is not the main provider of community services in this area.

## What could services look like and where would they be?

**Clinical hub in Totnes** (currently Totnes Hospital)

- MIU 8am-8pm
- X-ray diagnostic services
- New multi long-term conditions clinic
- Specialist outpatient clinics
- Community beds (16 beds)
- Rehabilitation gym
- Pharmacist

**Health and wellbeing centre in Dartmouth** (plans are being developed to co-locate with Dartmouth Medical Practice in new premises)

- Community clinics
- Rehabilitation gym
- Pharmacy
- Enhanced primary care MIU services
- Health and wellbeing team

**Health and wellbeing centre in Ashburton or Buckfastleigh** (options are being explored to co-locate with GPs in either of the local towns or in other facilities)

- Community clinics
- Health and wellbeing team

**Health and wellbeing centre in Totnes** (options are being explored to co-locate with GPs)

- Community clinics
- Health and wellbeing team

# NEWTON ABBOT

## What would be different?

A clinical hub would be established at Newton Abbot Community Hospital that would include community inpatient beds and a range of specialist services to reduce the need to travel as far for specialist care. These would include a new multi long-term conditions service, extended x-ray diagnostic services and the existing specialist outpatient clinics, gym-based rehabilitation services and the MIU.

Inpatient services at Newton Abbot Community Hospital would expand from 20 beds to 45 beds (plus 15 stroke beds). The MIU would open between 8am and 8pm (currently 10pm), seven days a week, reflecting the times of greatest demand and in line with the planned opening times of MIUs in Dawlish and Newton Abbot. X-ray diagnostic services would also be available during these times.

For the population of Newton Abbot, Bovey Tracey, Chudleigh and the surrounding areas, the local health and wellbeing teams would be co-located where possible with local GP services. These teams would provide community nursing, physiotherapy, occupational therapy and social care support.

To deliver more expert care to people in their own homes, we would invest money into more community-based staff and enhanced intermediate care services. We would work in partnership with local care home providers to provide more local intermediate care beds. Providing much more care to people in or near their own home means that the buildings such as Bovey Tracey Community Hospital (nine beds currently temporarily relocated to Newton Abbot) would no longer be required and would close if these proposals are approved.

## What could services look like and where would they be?

**Clinical hub in Newton Abbot** (currently Newton Abbot Hospital)

- MIU 8am-8pm
- X-ray diagnostic services
- New long-term conditions clinic
- Specialist outpatient clinics
- Community beds (45 beds)
- Stroke unit
- Rehabilitation gym
- Pharmacist

**Health and wellbeing centre for Newton Abbot** (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics

**Health and wellbeing centre for Bovey Tracey and Chudleigh** (developing plans to co-locate services with the Bovey Tracey and Chudleigh GP practice)

- Health and wellbeing team
- Community clinics

# PAIGNTON AND BRIXHAM

## What would be different?

A clinical hub would be established at Brixham Community Hospital that would include community inpatient beds and a range of specialist services to reduce the need to travel as far for specialist care. These would include a new multi long-term conditions service, extended specialist outpatient clinics and gym-based rehabilitation services.

The current MIU services offered at Paignton and Brixham Community Hospitals are not sustainable in their current form and, under these proposals, would close. People would have the option of visiting a designated GP practice for some MIU services provided locally or attending the MIU in Totnes or Newton Abbot, which would operate consistently seven days a week, 8am to 8pm, and provide x-ray diagnostics.

For the population of Brixham and Paignton the local health and wellbeing teams would be co-located, where possible, with local GP services. These teams would provide community nursing, physiotherapy, occupational therapy and social care support.

To deliver more expert care to people in their own homes, we would invest money into more community-based staff and enhanced intermediate care services. They would work in partnership with local care home providers to deliver more local intermediate care beds. Providing much more care to people in or near their own home means that the buildings from which we currently deliver inpatient and community services including Paignton Community Hospital (28 beds but currently 12 beds are temporarily closed due to safe staffing issues), Midvale Clinic and Church Street would no longer be required and would close if these proposals are approved.

Community inpatient care and more specialist services such as audiology, cardiology and dermatology outpatient clinics for the population of Paignton would be provided at their nearest clinical hub in Brixham, Totnes or Newton Abbot.

Staff delivering care directly to people in their own homes would have an integrated office base in the King's Ash area, providing easy access to Paignton and Brixham.

## What could services look like and where would they be?

**Clinical hub in Brixham** (currently Brixham Hospital)

- New multi long-term conditions clinic
- Specialist outpatient clinics
- Community beds (16 beds plus 4 flexible use)
- Rehabilitation gym
- Pharmacist

**Health and wellbeing centre in Brixham** (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics

**Health and wellbeing centre in Paignton** (planned to be developed in Paignton as part of providing fit-for-purpose accommodation for local GP Services)

- Community clinics
- Pharmacist
- Enhanced primary care MIU services
- Health and wellbeing team

**Health and wellbeing centre in Totnes** (options are being explored to co-locate with GPs)

# TORQUAY

## What would be different?

A health and wellbeing centre would be developed in Torquay as part of proposals to co-locate health and wellbeing services which would include community nurses, physiotherapists, occupational therapists, social care staff, coordination and support staff with local GP practices.

The community would have access to a greater range of services, including a new multi long-term conditions service, enhanced intermediate care services, and a health and wellbeing team that works in partnership with local voluntary groups and partner agencies.

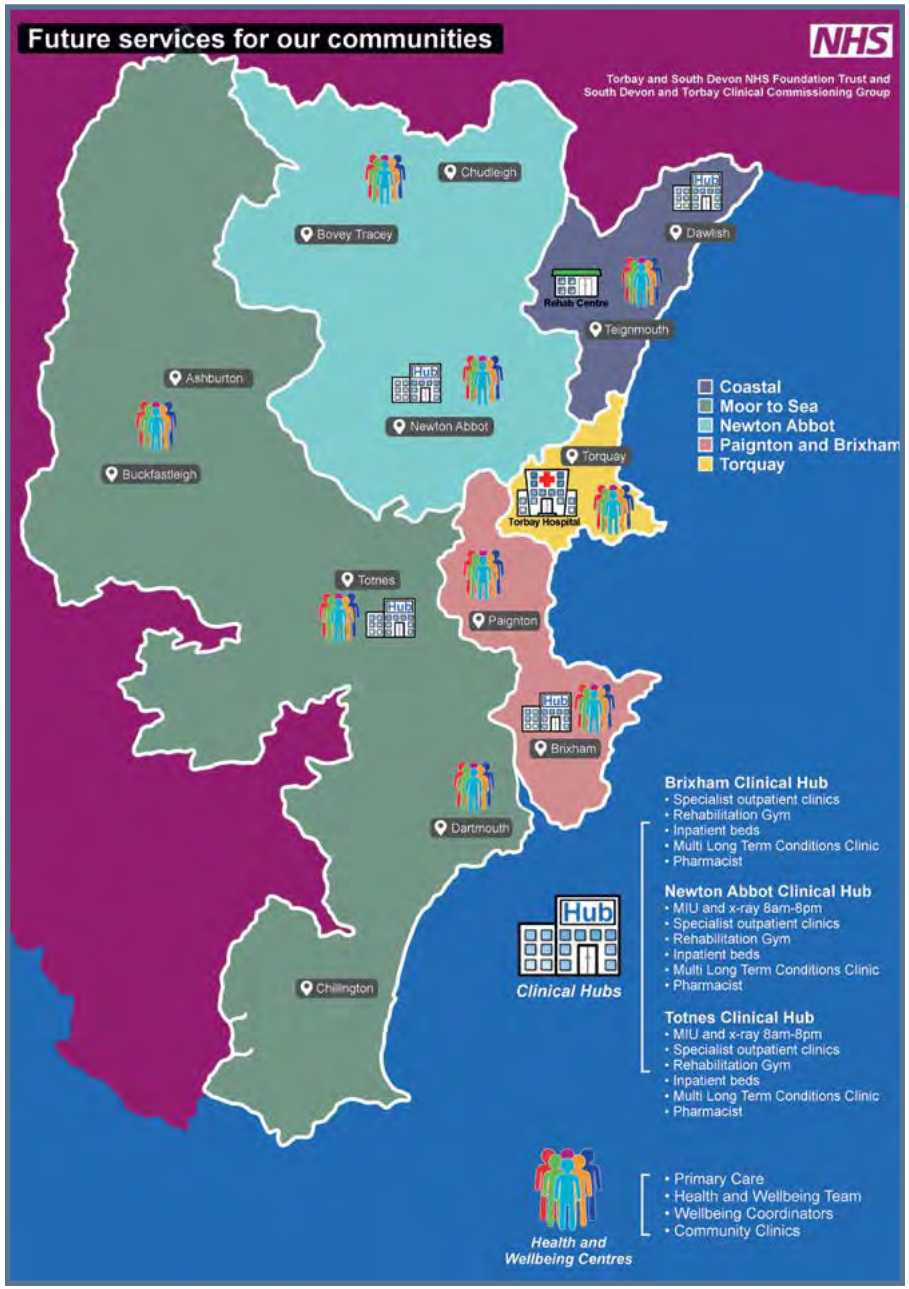
This community team has been at the forefront of piloting new enhanced services that would continue to deliver high-quality services in people's own homes.

Castle Circus Health Centre would continue to deliver community clinics and a range of health services and Torbay Hospital would continue to provide specialist services and acute care to the population of Torbay and South Devon.

## What could services look like and where would they be?

**Health and wellbeing centre for Torquay** (as part of plans to co-locate health and wellbeing services with local GP practices)

- Health and wellbeing team
- Community clinics




## For our communities

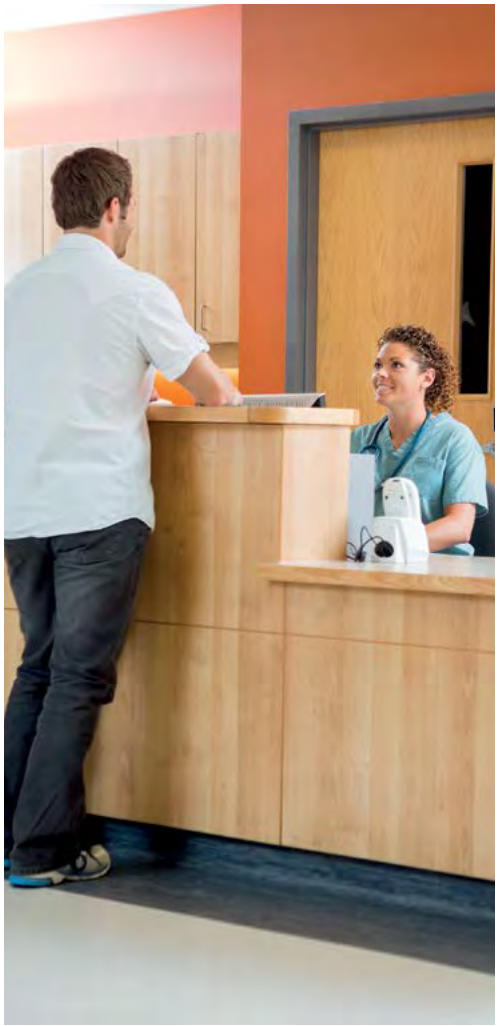
If the proposals set out in this document are approved, core services will be located as shown on this map.

## For NHS staff

Staff working across the local NHS are part of this consultation and we also want to hear their views.

We believe that more investment into community-based services would mean that local teams would be bigger, stronger and better able to support those with greatest need. They would also be able to provide staff with better career prospects and more varied work. Concentrating staff in larger teams would strengthen our ability to deliver care and make them more resilient to issues which have led to temporary suspension of services in the past.

Once a decision is made we would ensure all staff are properly supported and their skills properly utilised in the new structures. We would ensure they are fully engaged in the changes and work with them to identify any training requirements. We know that we would continue to need the skills of the staff and they have been guaranteed that there would not be any compulsory redundancies as a consequence of these proposals.



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# Five: Getting involved

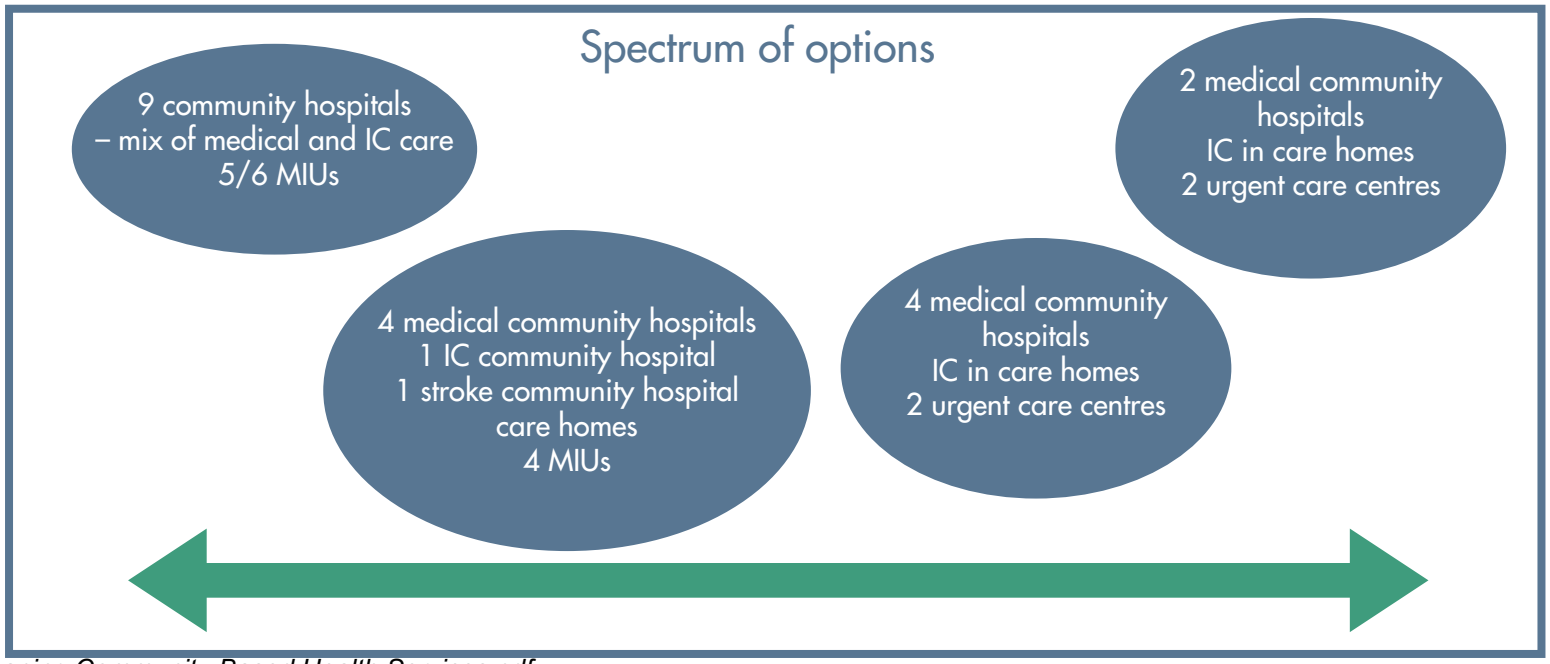
## How our proposals developed

The new model of care has been developed over the past three years, since the engagement discussions in 2013. In trying to respond to the clinical, demographic and financial pressures that face us, a range of alternative approaches has been explored with different combinations of bed-based and community-based services.

A separate paper which outlines the development and rationale of the consultation option is available on our website or in hard copy by request. Five options were considered, based on the extent to which they would enable investment in community services and deliver the new model of care. The numbers and locations of community hospitals, MIUs and local teams changed according to the option with a range of possibilities being considered.

Each option was evaluated by the multi-agency Community Services Transformation Group on the extent to which it met future patient needs, delivers safe clinical standards, was affordable and financially sustainable. Where an option did not deliver the proposed care model or was not operationally or financially sustainable, it was rejected.

The CCG and Torbay and South Devon NHS Foundation Trust believe that the approach set out in this consultation document represents the only viable option for providing what people told us they wanted, in a way that would meet future clinical needs and population pressures within the budget available.




## Alternative approaches

The CCG and the Trust would welcome alternative suggestions and approaches. Views expressed in this consultation will be independently collated by Healthwatch and reported to the governing body of the South Devon and Torbay Clinical Commissioning Group, ahead of it deciding what changes should be made. Before any decision is made, all ideas will be evaluated to asssess whether they meet the clinical, demand and financial challenges.

There is a range of ways in which local people can find out more about the proposals, discuss any alternatives and give their views as to the service improvements which we are proposing in this consultation. These are outlined on the following pages.

"The CCG and Trust would welcome alternative suggestions and approaches."

# Taking part

## Come to a public meeting

We have arranged public meetings to discuss these proposals across South Devon and Torbay and these will be held at:

| Location | Date | Time | Venue |
|---|---|---|---|
| Ashburton | 20 Sept | 1pm, 4pm and 7pm | Ashburton Town Hall, North Street, TQ13 7QQ |
| Bovey Tracey | 13 Sept | 4.30pm and 7.30pm | Phoenix Hall, St Johns Lane, TQ13 9FF |
| Brixham | 29 Sept | 6.30pm | Scala Hall, Market Street, , TQ5 8TA |
| Buckfastleigh | 22 Sept | 6.30pm | St Lukes Church, Plymouth Rd, TQ11 0DA |
| Chudleigh | 16 Sept | 6.30pm | Chudleigh Town Hall, Market Way, TQ13 0HL |
| Dartmouth | 15 Sept | 4pm and 7pm | Dartmouth Academy, Milton Lane, TQ6 9HW |
| Newton Abbot | 13 Oct | 6.30pm | Exeter Road Campus, Daphne Collman Hall, 28 Old Exeter Road, TQ12 2NF |
| Paignton | 28 Sept | 9am, 4pm and 7pm | Sacred Heart Roman Catholic Church, 24 Cecil Road, TQ3 2SH |
| Torquay | 6 Oct | 6.30pm | Upton Vale Baptist Church, St. Marychurch Road, TQ1 3HY |
| Totnes | 11 Oct | 6.30pm | Totnes Civic Hall, High Street, TQ9 5SF |
| Widecombe | 12 Oct | 6.30pm | Widecombe Church House, TQ13 7TA |

## Invite us to a local meeting

We are very happy to attend as many meetings that happen routinely in your community, as is practical.

If you would like us to present our proposals and answer questions, please email us to arrange this: sdtccg.consultation@nhs.net; or write to: South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF; or call 01803 652511.

## Read up on the detail

In addition to this document, there are more detailed papers on our website www.southdevonandtorbayccg.nhs.uk/community-health-services covering:

- The clinical case for change
- Information about the use of local services
- Options and rationale
- Population case for change
- The financial case for change
- Travel times
- Summary of stakeholder engagement and feedback
- Consultation terminology.

If you need a paper copy, please email: sdtccg.consultation@nhs.net; or write to: South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF; or call 01803 652511.

You can also visit our website to find a locality-by-locality slide presentation that brings together information used in our engagement meetings over the past year and which summarises the consultation proposals.

## Follow on Twitter or Facebook

Throughout the consultation we will be holding question-and-answer sessions on Twitter and using our social media pages for sharing information.

www.twitter.com/sdtccg

Torquay: www.facebook.com/ccgtorquay

Paignton and Brixham: www.facebook.com/ccgpaigntonandbrixham

Newton Abbot: www.facebook.com/ccgnewtonabbot

Moor to Sea: www.facebook.com/ccgmoortosea

## Ask to receive our regular briefing

During our engagement discussions we have produced a series of simple stakeholder briefings to keep those involved up to date with discussions across the area. We will continue to produce these during the consultation. They will be available on our website and emailed to stakeholders. If you would like to receive these directly, please let us have your email address by emailing sdtccg.consultation@nhs.net.

We will do our best to make paper copies available locally where it is possible to leave them – for example, in community centres or village halls, information points or GP practices.

# What happens next?

Our consultation starts on 1 September. All feedback will be gathered by Healthwatch (Devon and Torbay) and a report produced for consideration by the Governing Body of South Devon and Torbay Clinical Commissioning Group. All alternative suggestions will be fully explored ahead of any decision.

Both the feedback and details on alternative suggestions will be published.

Discussions will take place with GPs, providers, healthcare professionals and managers before a recommendation is made to the CCG's Governing Body at a meeting in public in January/February 2017. Once a decision is made, it will be communicated widely and a timetable for any changes set out.

The goal will be to put any major service changes into effect before any changes are made to current provision. As indicated earlier, NHS premises which could be affected by the proposals set out in this document are owned by Torbay and South Devon NHS Foundation Trust. Should a decision be made to close and dispose of any of these NHS premises, proceeds from any sale will be used by the Trust in support of services within South Devon and Torbay.

# Any questions?

During the consultation, if you have any questions or require more information, take a look at our website: www.southdevonandtorbayccg.nhs.uk/community-health-services.

If you can't find what you are looking for please use one of the following ways of getting in touch:

- Email sdtccg.consultation@nhs.net
- Write to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF
- Call 01803 652511.

# Make sure your views count

Views expressed at public meetings will be noted by Healthwatch, and views expressed at community meetings attended by the CCG or the Trust will also be fed back to Healthwatch to be included in its consultation report. Other correspondence and petitions will also be noted by Healthwatch.

The questionnaire seeks views on the range of issues underpinning the consultation as this will help us to evolve the model of care.

For your views to be registered as part of the consultation, please complete the questionnaire at the end of this consultation document or electronically at www.communityconsultation.co.uk. Paper copies will be available across the area and are available on request by emailing sdtccg.consultation@nhs.net, or writing to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF, or calling 01803 652511.

# Six: Other issues

## Travel

### Impact on mean (and median) travel time to closest site

| | Current model | Proposed model |
|---|---|---|
| Public transport weekend | 29 mins (19 min) | 30 mins (27 mins) |
| Public transport weekday | 20 mins (18 mins) | 26 mins (24 mins) |
| Car peak | 7 mins (7 mins) | 12 mins (13 mins) |
| Car off-peak | 5 mins (5 mins) | 8 mins (8 mins) |

### Impact on maximum travel time to closest site

| | Current model | Proposed model |
|---|---|---|
| Public transport weekend | 76 mins | 100 mins |
| Public transport weekday | 76 mins | 100 mins |
| Car peak | 38 mins | 45 mins |
| Car default speed | 27 mins | 32 mins |

- Travel times are based on a journey start point at LSOA (Lower Layer Super Output Areas) population centre. LSOAs are geographic areas used by the Office for National Statistics for census data and are areas that consist of between 1,000 and 3,000 people or 400 to 1,200 households.
- In calculating the above figures for public transport, we have taken travel times between 8am and 6pm for the weekend (average of both days) and for weekdays (average of five days).
- Travel times for car travel (road) are based on data from the Department for Transport (DfT). Off-Peak travel times use the DfT default car speeds. Peak travel times use the DfT average traffic speeds for the morning peak between 7am and 10am.
- For maximum and average travel times, we have calculated the time taken to get to the nearest clinical hub for each LSOA and taken the maximum and average of these times for all the LSOAs in the area. The assumption made in the new model calculations has been that an individual would travel to their nearest clinical hub.

In considering the impact of the proposals on communities, we have looked at the implications for travel.

A key element of these proposals is to bring care closer to people's homes, strengthening community-based services. So, for substantial numbers of people, travel times will be reduced as a result of being supported at or near to their home, in their local health and wellbeing centre or at their locality clinical hub. For many, travel to Torbay Hospital will no longer be necessary.

As the tables on the left indicate, where continued travel is necessary to access clinical hub services (such as community beds), the average time would increase by no more than nine minutes if the proposed changes are implemented, and the maximum time by no more than 32%.

We believe that as so many people will have their travel reduced, a nine-minute average increase for those who will need to travel is not unreasonable in terms of concentrating

limited budgets on securing improved, accessible care for the people of South Devon and Torbay.

For those patients who need to travel to a clinical hub but are not able to secure their own transport or voluntary transport, or are unable to access public transport, then patient transport may be available subject to eligibility criteria.

Additional information relating to travel times is contained in the additional support documentation available on our website or in hard copy on request.

## Urgent care centres

Nationally, the NHS is seeking to develop new and better ways of providing care through an initiative called Vanguard. This aims to speed up the pace of change in the NHS by developing better ways of delivering services which can be copied and implemented across the country.

South Devon and Torbay is one of eight urgent and emergency care Vanguards. Locally, a range of stakeholders, including staff and patients, has been involved in developing an improved urgent and emergency care model, covering five workstreams: self-care, NHS 111, urgent care centres (UCC), shared records and mental health.

A key Vanguard rationale is to help implement change quickly and we are running this Vanguard initiative alongside and independently of the consultation. Improvements are already being made: for example, 111 and out-of-hours services have recently been re-procured and a project team is looking at the benefits that might flow from developing MIUs into UCCs.

As part of this work, elements of UCCs are likely to be piloted at Newton Abbot over the coming months so that a judgement can be made as to the benefits they could bring in South Devon and Torbay.

The piloting of some aspects of UCCs does not pre-empt the outcome of the community consultation, although, if patient benefits are identified, it is likely that we would want to build on this in the coming year.

## National guidance

We are carrying out this consultation in line with our duties under the Health and Social Care Act 2012, section 14z2, and in line with Cabinet Office consultation principles published in January 2016.

We have also carried out equality impact assessments on our proposed model of care and our engagement and consultation process.

We have considered all characteristics protected under the Equality Act 2010 and gone further than those, to plan how we will design the consultation so that everyone can take part in it, including those who might not usually hear about such things or get around to taking part.

We are asking groups and organisations to talk about the consultation and will support them to do so. Examples of these are schools, children's centres, groups for older people, local groups that support disabled people and those with sensory loss, drug and alcohol recovery services, and organisations which provide advice.

We have also considered how we communicate changes to groups such as the travelling community, people with learning disabilities and those for whom English is not their first language. We have identified organisations which can assist in cascading information to such groups.

In terms of the proposed model of care within localities, we have considered accessibility: travel distances, access for people with disabilities or sensory loss, public transport links and parking.

## Terminology

Like every major organisation, there is a range of technical terms used in the NHS. Here are some of the terms used most frequently in this document:

**Self-care:** personal health maintenance. Any activity of an individual, family or community, which is intended to improve or restore health, treat or prevent disease or maintain existing good health.

**Urgent care services:** outpatient care services focused on treatment for injuries or illnesses requiring immediate care but that are not serious enough to require the intensive care and facilities of the acute hospital.

**Intermediate care:** a range of integrated services provided for a limited period of time to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

**Long-term condition:** a condition that lasts longer than a year, impacts on a person's life and may require ongoing care and support. Examples include diabetes, asthma, arthritis and Chronic Obstructive Pulmonary Disease (COPD). Long-term conditions become more prevalent with age and older people are more likely to have more than one long-term condition.

**Primary care:** The care given by a health provider, often a GP, who typically acts as the principle point of consultation for patients and who coordinates access to other specialists.

**Secondary care:** healthcare services provided by medical specialists and other healthcare professionals who generally do not have the first contact with the patient.

## And finally

Change is never easy, especially when it impacts on well-respected services and requires different ways of accessing services. In putting forward these proposals the CCG and Torbay and South Devon NHS Foundation Trust have sought to develop a model that takes advantage of modern, evidence-based practices, responds to what people tell us they want, and is sustainable and affordable.

This is an opportunity to build with local people a strong system that places compassionate care at its heart, and which will deliver quality care for the diverse communities of South Devon and Torbay.

Please give us your views by completing the questionnaire on the following pages.

# Seven: Complete the consultation feedback questionnaire

## To formally take part in the consultation

The questions here are presented in sections covering people's preferences for health services and the challenges we face, the proposed new model of care, and the best way we think it can be implemented. Each question provides an opportunity to comment on a number of areas and we would like you to give your views on each.

Question 13 enables you to comment more generally on the consultation proposals or to expand on the reasons for any of your answers.

The final section seeks more general information, designed to enable us to assess whether the responses received are representative of our diverse communities.

It is easier – and cheaper – to complete our feedback questionnaire electronically at www.communityconsultation.co.uk. If completing this printed version, please send it to Healthwatch Torbay, Freepost-RTCG-TRXX-ZZKJ, Paignton Library & Information Centre, Great Western Road, Paignton,TQ4 5AG.

If there is not enough room for you to provide comments, please do so on a separate piece of paper and give the number of the question to which you are responding

## Service preferences and challenges

### 1. Do you think that what people told us they wanted from health services in 2013 still applies today?

| | Yes | No | Don't know |
|---|---|---|---|
| Accessible services – convenient opening hours, transport and accessible buildings | ○ | ○ | ○ |
| Better communication – between clinician and patient, and between clinicians themselves | ○ | ○ | ○ |
| Continuity of care – to allow relationship-building with clinicians and carers | ○ | ○ | ○ |
| Coordination of care – including joined-up information systems | ○ | ○ | ○ |
| Support to stay at home – with a wide range of services and support | ○ | ○ | ○ |

### Is there anything else you would want to see? Please list:

Please continue, if necessary, on a separate sheet

### 2. Do you feel that the NHS needs to change the way it delivers services so as to:

| | Yes | No | Don't know |
|---|---|---|---|
| Establish better joint working between services? | ○ | ○ | ○ |
| Look after the rising number of elderly people, many with long-term conditions? | ○ | ○ | ○ |
| Tackle differences in life expectancy between affluent and deprived areas? | ○ | ○ | ○ |
| Provide alternatives to A&E for non-emergency care? | ○ | ○ | ○ |
| Ensure that we have enough appropriately experienced staff to look after patients safely? | ○ | ○ | ○ |
| Make best use of the money available? | ○ | ○ | ○ |

| 3. Do you think that we should develop more community health services to help keep people out of hospital and avoid unnecessary use of hospital beds? | Yes | No | Don't know |
|---|---|---|---|
| | ○ | ○ | ○ |

## New model of care

| 4. The NHS should support people to keep well and independent for as long as possible by: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Investing in health promotion activities (eg exercise classes for those with heart and lung disease) | ○ | ○ | ○ | ○ |
| Providing support nearer to where people live | ○ | ○ | ○ | ○ |
| Developing more out-of-hospital care and treatments, especially for older, frail people | ○ | ○ | ○ | ○ |
| Funding more community services by reducing the number of hospital beds | ○ | ○ | ○ | ○ |

| 5. Hospital beds are for patients requiring medical and nursing care that cannot be provided elsewhere and should not be used for people: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Who no longer need nursing or medical care | ○ | ○ | ○ | ○ |
| Who feel lonely or isolated | ○ | ○ | ○ | ○ |
| Who have medical needs that can be managed at home | ○ | ○ | ○ | ○ |
| Who have medical needs that can be met in a care home | ○ | ○ | ○ | ○ |
| Whose family feel unable to look after them | ○ | ○ | ○ | ○ |

| 6. When resources are limited, the NHS should prioritise the use of staff and funding to: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Help keep more people well for longer | ○ | ○ | ○ | ○ |
| Treat people with the most complicated health conditions | ○ | ○ | ○ | ○ |
| Care for people in their own homes or close to where they live | ○ | ○ | ○ | ○ |
| Keep open all community hospitals | ○ | ○ | ○ | ○ |

## Implementing the model of care

| 7. If you need to see a specialist (eg at an outpatient clinic), the most important aspects to you are: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| The time I have to wait for an appointment | ○ | ○ | ○ | ○ |
| The distance I have to travel | ○ | ○ | ○ | ○ |
| The expertise of the specialist that I see | ○ | ○ | ○ | ○ |

| 8. Minor injuries units, which provide treatment for non-life-threatening problems and less serious injuries (such as suspected broken bones and sprains, burns and scalds) should: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| Be open consistent hours | ○ | ○ | ○ | ○ |
| Be open seven days a week | ○ | ○ | ○ | ○ |
| Have x-ray diagnostic services | ○ | ○ | ○ | ○ |
| Be staffed by specialists experienced in dealing with minor injuries | ○ | ○ | ○ | ○ |
| Be easily reached and have good car parking | ○ | ○ | ○ | ○ |
| Operate different hours in different locations | ○ | ○ | ○ | ○ |
| Offer different services in different locations | ○ | ○ | ○ | ○ |

### 9. If the choice is between:

Using resources to keep open community hospitals which look after people from across the CCG area

**OR**

Using these resources to expand community health services by recruiting trained nurses and therapists to help keep people healthier, out of hospital and supported closer to their homes

| do you agree that it is better to do the latter? | Yes | No |
|---|---|---|
| | ○ | ○ |

If you answered 'yes', please go to question 10 (pages 30 and 31). If you answered 'no', please go to question 11 (page 32).

10. If your answer to Question 9 is 'yes', please respond to the statements below:

## Close Ashburton and Buckfastleigh Hospital

Yes ○ No ○ Don't know ○

Please give the reason for your choice:

Please continue, if necessary, on a separate sheet

## Close Bovey Tracey Hospital

Yes ○ No ○ Don't know ○

Please give the reason for your choice:

Please continue, if necessary, on a separate sheet

10 continued... If your answer to Question 9 is 'yes', please respond to the statements below:

## Close Dartmouth Hospital

Yes ○ No ○ Don't know ○

Please give the reason for your choice:

Please continue, if necessary, on a separate sheet

## Close Paignton Hospital

Yes ○ No ○ Don't know ○

Please give the reason for your choice:

Please continue, if necessary, on a separate sheet

11. If your answer to Question 9 is 'no', please say why:

Please continue, if necessary, on a separate sheet

| 12. People sometimes need nursing with extra support and care, following a period of ill health, to help them recover and regain their independence. If similar levels of care and support can be provided, this should be delivered: | Strongly agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| In a person's own home | ○ | ○ | ○ | ○ |
| In a community hospital | ○ | ○ | ○ | ○ |
| In a care home near to a person's home | ○ | ○ | ○ | ○ |

13. If you want to comment generally on the proposals set out in this document or have any alternative ideas to put forward for consideration which meet the future needs of our population and the challenges described in this document, please tell us about them below (or in an additional submission):

Please continue, if necessary, on a separate sheet

## Other information

To help put this information into context and ensure we are attracting feedback from across the South Devon and Torbay CCG area please complete the following questions:

### 14. If responding as an individual, are you a:

- ○ Member of the public?
- ○ Foundation Trust member/governor?
- ○ NHS employee?
- ○ Social care/local authority employee?
- ○ Independent/third sector employee?
- ○ Volunteer in health or social care?
- ○ Prefer not to say?

### 15. If you are responding on behalf of an organisation, please tell us what type:

- ○ NHS provider organisation
- ○ County or district council
- ○ Town council or parish council
- ○ Third sector provider
- ○ Patient representative organisation
- ○ League of Friends or equivalent
- ○ Independent healthcare provider
- ○ Other – please state in the box

### 16. Postcode (so that we will know if we are getting feedback from across the area)

- ○ Postcode (first four digits)
- ○ No fixed abode
- ○ Traveller

## 17. Age

- Under 16
- 16-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 and over

## 18. Do you consider yourself to have a disability?

- Yes
- No

## 19. Do you have one or more long-term health conditions?

- Yes
- No

## 20. Do you consider yourself to be a carer?

- Yes
- No

## 21. Gender

- Male
- Female
- Transgender
- Gender fluid
- Prefer not to say

## 22. Sexuality

- Heterosexual
- Gay
- Lesbian
- Bi-sexual
- Prefer not to say

## 23. Ethnic group – which category best describes your ethnicity? Please tick the appropriate circle to indicate

- White: British
- White: Irish
- White: European
- White: Other
- Black/Black British: Caribbean
- Black/Black British: African
- Black/Black British: European
- Black/Black British: Other
- Mixed: White & Black Caribbean
- Mixed: White & Black African
- Mixed: White & Asian
- Mixed: Other
- Chinese
- Japanese
- Asian/Asian British: Indian
- Asian/Asian British: Pakistani
- Asian/Asian British: Bangladeshi
- Asian/Asian British: Other
- Other ethnic group

Please see next page for return address

## Returning the questionnaire to Healthwatch

Thank you very much for completing this questionnaire and for formally contributing to this consultation. Please post your completed questionnaire to: Healthwatch Torbay, Freepost-RTCG-TRXX-ZZKJ, Paignton Library & Information Centre, Great Western Road, Paignton,TQ4 5AG.

There is no need to provide your name and address. If, however, you have suggested an alternative approach, providing contact details below will enable us to get in touch if necessary to clarify any aspect of your proposals.

OPTIONAL

Name: .....

Email: ..... Phone number: .....

Address: .....

No information which could identify an individual will be passed to the CCG, other than where it is necessary to follow up alternative proposals.

For the latest information on the consultation, please go to the following link: www.southdevonandtorbayccg.nhs.uk/community-health-services where all the documentation, meeting dates and frequently asked questions can be found. You can also access a link to the consultation questionnaire and watch some short videos about different aspects of the consultation.

If you have any questions about the consultation, want to receive paper copies of the documentation or invite us to attend a public meeting please contact us:

- Email sdtccg.consultation@nhs.net
- Write to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF
- Call 01803 652511 office hours (answer phone messaging at other times)

We will respond to emails and letters within five working days and to telephone messages by the end of the next working day.

You can also follow us on Facebook and Twitter (see page 23 for details).

NHS
South Devon and Torbay
Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting Date:** | 7th September 2016 |
| **Title:** | **Integrated Quality, Performance & Finance Report** |
| **Lead Director:** | Ann Wagner, Director of Strategy & Improvement and Paul Cooper, Director of Finance |
| **Corporate Objective:** | Objective 1**: Safe, Quality Care and Best Experience**<br>Objective 4: **Well led** |
| **Purpose:** | **Assuranc**e |

**Summary of Key Issues for Trust Board**

**Strategic Context**

This month's Integrated Quality, Performance and Finance Report, comprising high level summary performance dashboard, narrative with exception reports, detailed data book and financial schedules provides an assessment of the Trusts position for July (month 4) 2016/17 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 executive team (24th August) and the Finance and Performance Committee (30th August). Performance of each Service Delivery Unit (SDU) is currently 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 community SDU were reviewed (15th August). The Quality and Performance Reviews will move to monthly from September as part of enhanced accountability and reporting arrangements.

The report is presented with the finance narrative incorporated in the main body of the report. The finance schedules are now incorporated into the data book. Workforce detail will be added next month as part of the plan to produce a fully integrated report.

**Key Issues/Risks**

**1. Quality Framework**

19 indicators in total of which 5 were RAG rated RED for July (5 in June) as follows:

- VTE risk assessment on admission (Acute and community) – acute 92.8% and community 92.2% (last month 94.3% acute 91.2% community) against 95% standard.
- Fractured neck of femur time to theatre within 36 hours – 75.7% (85.2% last month - Amber) against >90% standard.
- Stroke Patients Spending 90% of Time on a Stroke Ward – 71.4% (79.6% last month) against >80% standard
- Dementia Find – 29.4% (target 90% - 31.9% last month) )
- Follow ups past to be seen date – 6,601 deterioration of 382

Of the remaining 14 indicators, 11 were rated GREEN, 3 AMBER

**2. NHS I Compliance Framework**

12 performance indicators in total including the quarterly governance rating of which 3 indicators are RAG rated RED for July (2 in June):

- Urgent care (ED/MIU combined) 4 hour wait – 92.3% (91.6% last month) against national standard 95% - note Trust is overachieving against the SRG agreed STF trajectory of 89.9% for July.
- RTT incomplete pathways – 91.4% ( 92.0% last month) against the standard of 92%.
- Cancer 31 day for subsequent treatment radiotherapy – 93.8% ( 98.6% last month) against the standard of 94%. Performance remains on track to achieve standard for the Q2 NHS I assessment.

All of the remaining indicators were rated GREEN including the forecast NHS I governance rating.

**3. Financial Performance Summary**

Key financial headlines for month 4 to draw to the Board's attention are as follows:

- **EBITDA:** for the period to 31st July 2016 EBITDA is £1.31m. This is showing an adverse position against the PBR plan by £0.95m. Should the plan be agreed based on the Risk Share arrangement this would result in an EBITDA position adverse position of £0.05m.
- **Income and Expenditure**: The year to date income and expenditure position is £3.78m deficit which is £0.80m adverse against the PBR plan, and £0.11m favourable against the RSA plan. The Trust has a £1.16m deficit in month after risk share income has been applied.
- **CIP Programme:** CIP delivery remains challenging with £2.1m delivered to date. The level of savings planned increases significantly from Quarter 2 onwards, it is therefore imperative that we secure better traction in the programme. 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 including a monthly deep dive into the larger schemes.
- **Risk Rating:** The Trust has delivered a Financial Sustainability Risk Rating of 2, which is on plan.
- **Cash position:** Cash balance at month 4 is £15.99m which is lower than PBR plan by £6.07m, and RSA plan £1.67m mainly due to debtors, offset by lower than planned capital spend.
- **Capital**: Capital expenditure is £3.7m behind plan at month 4.
- **Agency Spend:** Total trust wide agency spend to date is running at 5% in month, 5% year to date. This is therefore 2% higher against the NHSI cap of 3%.

**4. Contractual Framework**

15 indicators in total of which 9 are RAG rated RED in July as follows:

- RTT waits over 52 weeks – 11 (5 last month) against 0 standard
- On the day cancellations for elective operations – 0.9% (1.6% last month) against <0.8% standard
- Cancelled patients not treated within 28 days of cancellation – 9 (6 last month) against 0 standard
- A&E patients (ED only) – 88.2% (87.2% last month) against 95% target Note: locally agreed SRG trajectory for MIU / ED = 89.9%
- Number of Clostridium Difficile cases (acute & community combined) – 3 (4 last month) against, 3 threshold
- Care plan summaries % completed within 24 hrs discharge weekdays 51.2% (59.4% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 20.4% (35.0% last month) against 60% target
- Ambulance handover delays > 30 minutes – 54 (37 last month) against trajectory of 25
- 12 hour trolley waits from decision to admit to admission – 1 (0 last month) against 0 standard

The remaining 5 indicators were rated GREEN and one AMBER

**5. Community and Social Care Framework:**

11 indicators in total of which 2 RAG rated RED as follows:

- Number of delayed discharges – 422 bed days lost (355 last month) (annual target 2,216)
- Bed occupancy – 93.3% (86.4% last month)
- CAMHS % of patients waiting for treatment within 18 weeks – 87% (91% last month) (target >92%)

Of the remaining 9 indicators, 6 were rated GREEN, 1 amber and the remaining 2 no Rag rating.

**6. Change Framework**

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

**7. Corporate Management Framework**

4 indicators in total of which 2 RAG rated RED as follows:

- Staff vacancy rate (trust wide) – 7.71% (7.97% last month) threshold <5%
- Staff sickness / absence – 4.19% (4.13% previous month) threshold <3.5%

Of the remaining 2 indicators, 1 rated AMBER and 1 GREEN

**Recommendation:**

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

**Summary of ED Challenge/Discussion:**

Executive Directors reviewed the latest performance for July at their meeting on 24 August. Whilst performance has improved in some key areas there has also been a deterioration in others including against the locally agreed RTT trajectory due to capacity issues in neurology. The case for a trajectory dispensation for neurology submitted by the Trust following discussion with the CCG is currently being considered by NHS I and NHS E.

Work to step up CIP activity including CARTER efficiency is being taken forward through the Efficiency Delivery Group (EDG). At this month's meeting (22 August) EDG held the first of a series of deep dives into schemes designed to create the greatest value. This first deep dive focussed on nurse agency spend. Jane Viner's team will attend the Finance and Performance Committee to present the key headlines of progress to date and provide further assurance on delivery. EDG are also reviewing the process for Quality Improvement Assessments to ensure focus is on safely reducing costs and that risks are identified and mitigated.

Executive Directors are continuing their dialogue with CCG Executive Directors regarding additional cost cutting developments to address the system financial gap – this includes using Carnall Farrar to review plans to date and identify further actions.

**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

| | |
|---|---|
| **Report to:** | Finance and Performance Committee and Trust Board |
| **Date:** | 30th August 2016 and 7th September 2016 |
| **Report From:** | Director of Strategy and Improvement and Director of Finance |
| **Report Title:** | Integrated Quality, Performance and Finance Report (Month 4: July 2016) |

# 1 Introduction

This report provides commentary against performance variances and improvements at the end of July (month 4) 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 Service Delivery Unit Quality and Performance Review meetings, executive debate and challenge.

The report is structured in line with the integrated performance dashboard and draws out areas of significant variation from plan or target for review and comment. The report also highlights those indicators where improvement has been delivered.

The purpose of the report is to provide the Finance and Performance Committee and the Trust Board assurance of delivery and enable scrutiny of action plans to address any underperformance. Feedback and further action following Finance and Performance Committee scrutiny will be reflected in the Committee Chairman's report to the Board.

# 2 Quality Framework Indicators

### 2.1 Reported incidents – Major and Catastrophic

**RAG RATED AMBER**

In July there were five reported incidents categorised as "major" or "catastrophic". These were all reported in the acute setting. All these incidents are under review with findings to be reported to the Serious Adverse Events Group. In 3 of these cases there was loss of life, one being 'still birth', one an incident out of hospital soon after discharge and one a readmission with complications following discharge.

### 2.2 Fractured neck of femur time to theatre

**RAG RATING: RED**

The percentage of patients who have suffered a fracture and who receive their procedure within 36 hours of arrival in hospital was 76% in July – this compares to 85% in June. 37 patients were admitted requiring this procedure in July. The target is 90%.

**ACTION:** The approved plan is to extend trauma operating capacity to provide an additional 2 hours operating per day. This will be implemented from November 2016 with two extended lists initially per week being available until additional staffing has been recruited and in post. It is anticipated that performance will remain a challenge until the full additional capacity is available.

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

**RAG RATING: RED**

This standard is reported from the National Sentinel Stroke Audit return (SSNAP) which is available quarterly in arrears. The next report covering the period April to June is scheduled for publication on 5th September 2016. In advance of the quarterly returns being available local audit data is used to assess performance. The local reports show an improvement in performance for this indicator from 71.4% in June to 79.5% in July. The standard is for 80% of patients to spend 90% of their time on the dedicated stroke ward.

There is currently only one substantive consultant in place - the full time agency locum left the Trust on 8th July. The team are exploring temporary and substantive opportunities to replace the lost capacity. Potential capacity with a middle grade doctor via another local trust has not materialised as quickly as initially hoped. The advert for the substantive post will be re-advertised in early August. The Trust will work within the Wider Devon Sustainability and Transformation Plan (STP) footprint for stroke services and the clinical team will set out the clinical service strategy for stroke in support.

**ACTION:** Following an in-depth assessment with Executives and the operational team on the 21st June, it was agreed that in preparation for discussions as part of the STP the team would;

1) Develop a plan to achieve and sustain an improvement to a C category on the SSNAP assessment (Team level, George Earl). This would place the service in a positive position in comparison to other centres locally.

2) Explore and develop options for delivery of the hyper acute care standards. Options will include a networked delivery approach.

## 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 July 30% of eligible patients were assessed, a slight decrease from 32% in June - 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. Three pilot wards are due to commence using Nerve Centre in September 2016 (Allerton, Midgley and Louisa Cary).

In advance of the system being introduced the Deputy Director of Nursing has completed a review with the report being presented to the Quality Assurance Group on 31st August. The report sets out the current barriers to achievement and actions to improve compliance. The main issues reported are:

- Dementia FIND section of infoflex is not a mandatory field when medical practitioners complete the care plan summary. Therefore it is possible the organisation is currently under reporting performance.
- A lack of organisational standard systems and processes.
- Lack of clear leadership at a ward and senior management level.
- A lack of clarity of roles and responsibilities for completion of the dementia FIND across nursing, medical and therapy professionals.
- Paper form visually challenging to follow easily when completing the three step process.

- A lack of monitoring and reporting at ward and service delivery unit level resulting in poor line of sight from ward to Trust board.

**ACTION:** With immediate effect:

- A small task and finish group will support the Dementia Steering Group to address the key areas set out above which will include medical practitioner, nursing, performance and IT representation.
- The areas outlined above and any others identified as the baseline assessment is completed will form part of an overarching implementation plan to aid compliance of the national standard of 90%. A trajectory for improvement will be developed to track progress.
- Weekly performance reports established and shared with all relevant teams

### 2.5 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 clinical 'see by date' remain high and has increased by 382 from last month to 6601 patients waiting beyond six weeks in July. In July last year there were 4020 patients waiting 6 week or more passed their intended 'see by date' this being an overall increase of 2,581 (64%).

As reported previously all services have undertaken a clinical governance assessment of systems in place for reviewing patients exceeding the recommended "to see" period for a follow-up appointment. The reviews have been signed off by the lead clinician for each service. The review provided assurance that effective processes are in place for clinical prioritisation.

**ACTION:** Action plans to reduce the number of patients beyond their "to see" date are being monitored on a bi-weekly basis by the RTT & Diagnostics Risk and Assurance Group. Progress against improvement trajectories will be reported monthly to the Quality and Performance Review Meeting, commencing in September 2016.

## 3 NHS Improvement (NHS I) 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 risks declared against the following national standard indicators:

**3.1.1 Emergency Department (ED) and Minor Injury Unit (MIU) 4 hour 95% standard:** The submitted annual plan declaration showed risk of delivery in relation to the national 95% 4 hour standard. An improvement trajectory was agreed through the local System Resilience Group (SRG) and submitted to NHS I as part of the Sustainability and Transformation Fund (STF) requirement. The STF trajectory delivers staged improvement to 92% (combined performance ED and MIU) by September and sustains this level of performance for the remainder of the year to March 2017.

NHS England has written to all Chief Executives requiring all systems to review trajectories to deliver the 4 hour 95% standard by April 2017. This will require a review of our agreed 92% trajectory and plans to deliver the

standard. The board will be updated on the implications of this review once completed and agreed.

To support this imperative all health systems are required to set up a local A+E Delivery Board and have these in place by 1st September 2016. The Delivery Board will coordinate and oversee the delivery of 5 national initiatives and other agreed local areas of focus. The 5 national initiatives are:

1. Streaming at the front door – to ambulatory and primary care.
2. NHS 111 – Increasing the number of calls transferred for clinical advice
3. Ambulances – Decrease conveyance and increase 'hear and treat'.
4. Improved Flow – 'must do's that each trust should implement to enhance patient flow – reduce bed occupancy – reduce length of stay and implementing the SAFER bundle.
5. Discharge - mandating 'Discharge to Assess' and 'trusted assessor' type models.

**3.1.2 Referral to Treatment (RTT) 92% standard** – compliance was planned from July 2016 and supported by a detailed action plan and STF trajectory.

**3.1.3 Feedback on Annual Plan submission**

The Trust received a response from NHS I on 29th July to the annual plan submission – attached (**Appendix 1**). This highlights next steps and key areas where NHS I are requiring further assurance. The key areas are:

- achieving the Trusts control total and the impact this will have in accessing the Sustainability and Transformation (S&T) funding;
- CIP delivery plans and the number of schemes with detailed plans;
- plans to meet the A+E performance standard requiring significant investment and how this will be achieved; and
- managing within the agency cost ceiling.

## 3.2 July 2016 update against NHS I risk assessment framework performance indicators and the STF trajectory

### 3.2.1 4 hour standard for time spent in A+E

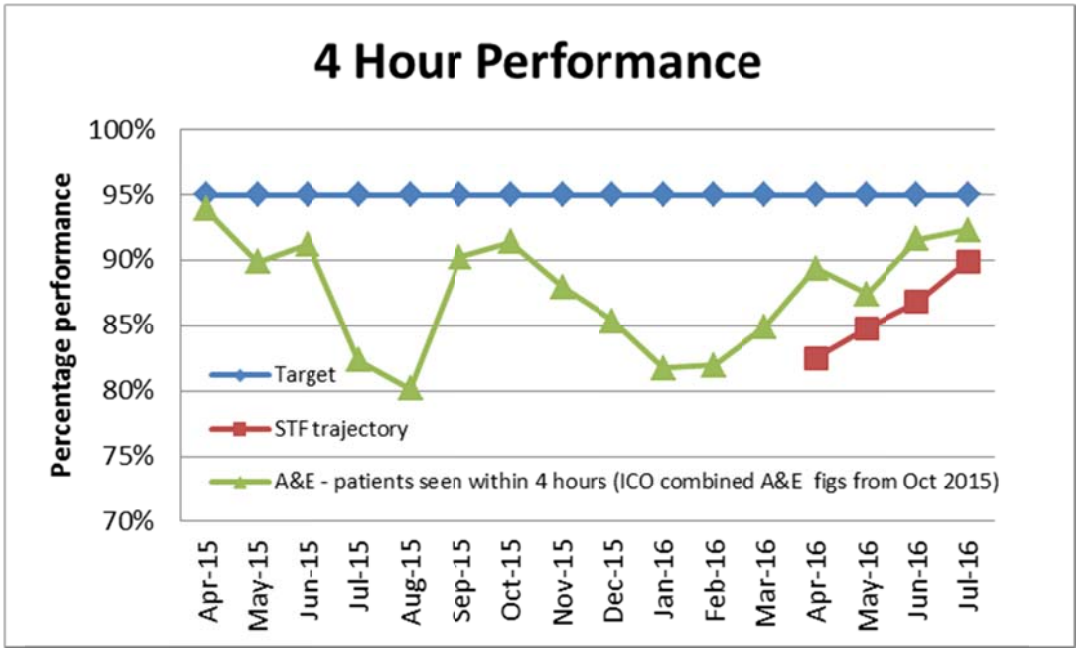
**RAG RATING AGAINST SRG TRAJECTORY: GREEN**

The 4 hour action plan continues to be reviewed bi-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 performance report provides a detailed analysis of the work to improve clinical pathways, safety indicators and system performance oversight.

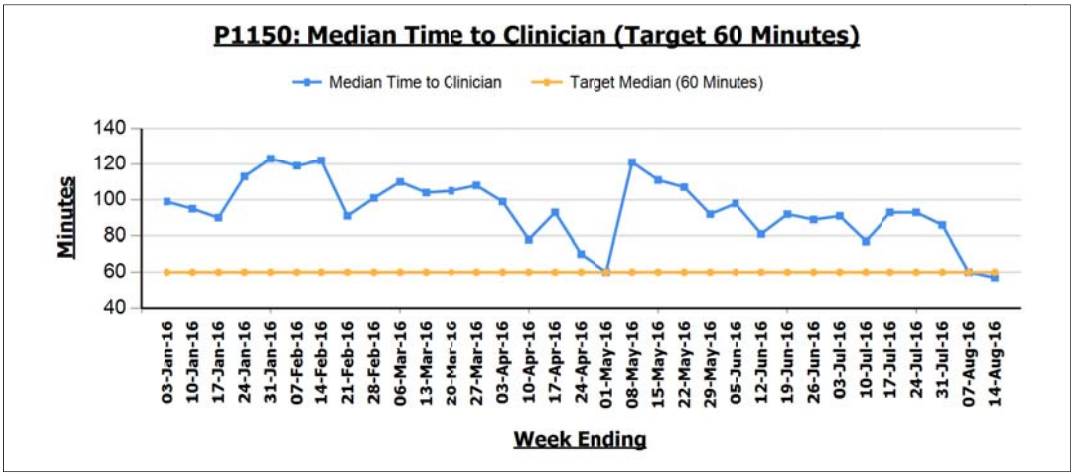
A summary of most recent progress and issues against the action plan monitoring is set out below:

- The combined performance of ED and MIUs in July was 92.3% up from 91.6% reported in June and continuing the trend of remaining ahead of the monthly improvement ahead of agreed STF trajectory, for July the trajectory is 89.9%.

  The following graph clearly illustrates the improving monthly performance towards the 95% standard and ahead of the increasing STF trajectory;




As can be seen from the graph below times for initial triage within 15 minutes have been maintained with the median time to see a clinician seeing a further improvement in early August. The improvement target of median 60 minutes has been met for the first time since monitoring began.




The improvements against these quality and safety indicators can be linked to the following changes:

- The increased availability of the RAA (Rapid Assessment Area), although standardising this at times of peak demand is dependent upon additional consultant capacity (2 new consultants recently recruited who will commence in the coming weeks) and changes to the consultant rota currently being discussed.
- Changes to ENP (Enhanced Nurse Practitioners) shift patterns with increased coverage now in place to 2am

- Embedding escalation processes within the Department with on-going focus on staff training and review using local learning from staff and teams who are performing well against these metrics.

### 3.2.2 Referral to Treatment (RTT) incomplete pathways
**RAG RATING: RED**

At the end of July 91.43% of patients waiting for treatment have waited 18 weeks or less at the Trust. This represents a 0.5% deterioration in performance from June, and is below the agreed STF trajectory of 92.0% for July.

The deterioration was predicted and the forecast is for further deterioration in coming months. This is because an increasing number of patients referred to neurology are experiencing an increased waiting time due to capacity constraints previously reported.

Should the Neurology RTT position be removed from the overall position the performance would be achieving target at 92.14%.

A case for RTT STF trajectory dispensation has been discussed with commissioners and submitted to NHS I and NHS E for consideration. This case requests a review of the agreed STF RTT trajectory taking into account the exceptional circumstances leading to the loss of capacity in Neurology and difficulties being encountered to recruit to these vacant posts.

Whilst this case has been submitted we continue to work with the CCG and NHS I for a solution to resolve the unacceptable waiting times now being experienced by newly referred patients. The earlier request to close the waiting list to new referrals has not been agreed as there are also service pressures at neighbouring trusts who would not be able to meet any sudden increase in referrals should they be directed away from TSDFT.

At individual specialty level there remain challenges to maintaining the good progress made. In ophthalmology the number of patients being added to the cataract waiting list is starting to increase and loss of foot and ankle capacity in orthopaedics are emerging risks that may require further outsourcing to manage. After Neurology, Upper GI surgery continues to be the next highest risk area with no in house option available or through outsourcing to significantly change the current position of high number of patients waiting over 18 weeks and several patients that are recorded as waiting over 52 weeks for treatment.

On current forecasts aggregate performance will continue to deteriorate and remain below 92% for the remainder of the year. Should the exceptional case for Neurology be accepted and this can be removed from the monitoring against STF trajectory it remains possible to improve back to 92% in the final quarter of 2016/17.

Specialty level risks and plans are summarised below:

**Neurology** – The backlog of patients waiting over 18 weeks has continued to rise to 171 from 141 last month 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. Discussions are also on-going with a local GP with special interest. It is unlikely that any substantive arrangements will be in place before October 2016.

**Pain Management** – The backlog has increase to 99 patients from June (68). The backlog is due to a locum consultant leaving and not being able to recruit to the vacant post which has impacted on capacity **ACTION:** A local in-house solution to change work plans is being finalised for implementation on the 5th September 2016. This will replace the lost capacity.

**Gastroenterology** – The recent 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 in this speciality. A reduction in referrals for hip and knee outpatients has been experienced recently following introduction of the new Musculoskeletal (MSK) service under the ICO 'care model'. These changes are encouraging and free up outpatient clinical capacity however the number of patients being added to the operating list has remained unchanged. The RTT backlog of patients over 18 weeks has increased to 285 in July from 260 reported in June. **ACTION:** The Trust is working with the local private provider to outsource activity 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. This in turn has resulted in some patients waiting over 52 weeks. **ACTION:** The executive team have reviewed the clinical team's plan to appoint a locum to provide additional service cover. Further information has been requested to evaluate the benefits to elective capacity to achieve RTT trajectory as well as the emergency on call prior to this being agreed for implementation.

**ENT** – The service is still experience capacity challenges from changes in the clinical timetable implemented last year to support the cancer joint MDT process with Exeter that resulted in reduced routine service capacity. Performance had been maintained until now with additional sessions however gradual deterioration from this point is anticipated. **ACTION:** The Interim Deputy Chief Operating Officer (COO) is working with the clinical team to secure a sustainable solution to the underlying imbalance in demand and capacity.

**Dermatology** – Increased levels of urgent 'Two Week Wait' referrals (2ww) continue to put pressure on the service, all routine and follow-up capacity has been converted to accommodate, although compliant against the 92% indicator in July, waits for routine appointments will now increase.

A presentation highlighting the current position and plans to address the pressures was given by the Medical Service Delivery unit manager and lead clinician at this month's e Board to Council of Governors meeting.

The presentation highlighted that Dermatology receives the fifth highest number of referrals in the Trust. However, they receive the most 2ww referrals in the Trust: 40% of referrals are 2ww as opposed the next highest ranking specialty (ENT) where 15% of their referrals are 2ww. The weekly referrals pattern is variable (between 103 -170 a week) with equal variability in the proportion of these being 2ww referrals (between 44 -75) which requires a huge amount of flexibility from within the team to meet this demand. The current wait for a routine OP appointment is 15 weeks. Actions include the training of specialty doctors, increased use of polyclinics, increasing the use of advice and guidance and telephone triage.

**Respiratory Medicine** - Increased levels of urgent referrals continue to put pressure on the service, with all routine and follow-up capacity has been converted to accommodate this demand. The specialty is currently not compliant against the 92% indicator with a backlog of 65.

**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 NHS I compliance reporting the target is also 18 cases measured as the number of cases agreed with commissioners being due to a "lapse in care".

In July, there were 3 new cases of c-diff recorded with one confirmed as “no lapse in care”. The cumulative number of lapses in care to the end of July for 2016/17 is 5 cases - this compares against the cumulative position of 7 cases to the end of July 2015.

### 3.2.4 Cancer standards

**RAG RATING: GREEN**

Provisional data for July is shown below.

| | July 2016 | | | |
|---|---|---|---|---|
| | Target | No. Seen | Breached | % |
| Urgent referrals 14day | 93.0% | 953 | 22 | 97.7% |
| Urgent referral 14day | 93.0% | 78 | 2 | 97.4% |
| 31 day diagnosis to 1st treatment | 96.0% | 205 | 3 | 98.5% |
| 31 day to subsequent drug treatment | 98.0% | 96 | 1 | 99.0% |
| 31 day subsequent Radiotherapy treatment | 94.0% | 48 | 3 | 93.8% |
| 31 day subsequent Surgery | 94.0% | 37 | 2 | 94.6% |
| 31 day subsequent Other treatment | - | 20 | 0 | 100.0% |
| 62 day from urgent 2ww ref to treatment | 85.0% | 106 | 14 | 86.8% |
| 62 day from Screening ref to treatment | 90.0% | 16.5 | 1 | 93.9% |

The subsequent radiotherapy treatment standard is just below target for July.

**Risks and plans:**

<u>Subsequent Radiotherapy and Subsequent Surgery:</u>

In addition to the issue of the subsequent radiotherapy standard in July, the subsequent surgery standard is expected to breach in August. Both of these standards have experienced a high number of patients choosing to wait for their treatment over the summer. When these patients are seen in September the number of patient choice breaches is likely to result in both standards not being achieved for the quarter. The cancer team is managing capacity with the teams very tightly to ensure no breaches other than those from patient choice occur. However because

these standards relate to very few patients the patient breaches we already know about are considered to be too high for the quarterly position to be secured. The cancer team has calculated that if we get the usual level of activity in September we are at significant risk of breaching both of these standards.

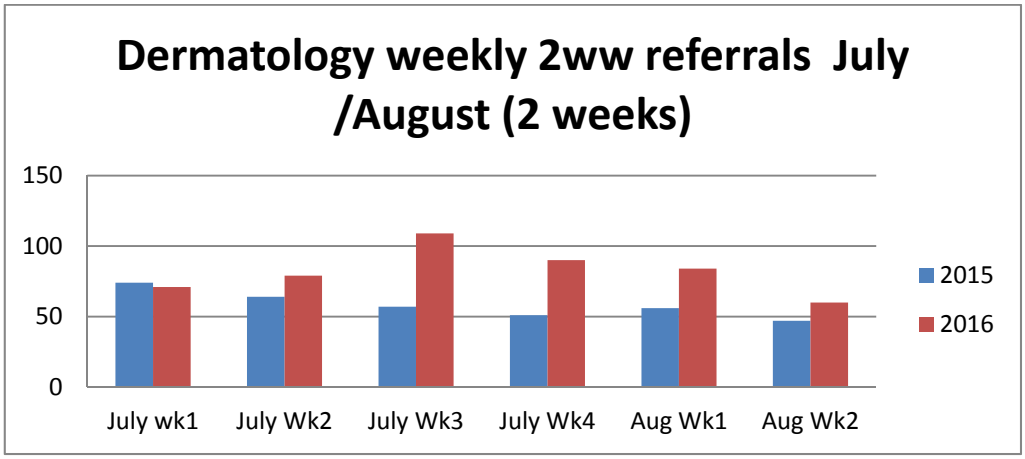
Cancer 2 Week Wait 93% standard (urgent referral 14 day):

As can be seen by the chart below, in July and August there was an above plan increase in urgent two week wait referrals into Dermatology (40% increase on previous year). Although there is a known seasonal pattern of increased demand, this year there has been significant increases over previous years and over a short period of weeks placing an unsustainable demand on the available clinical resources. All routine referral and follow up appointments have therefore been suspended to create more urgent assessment capacity.

As a result of the significant increase in dermatology referrals over the last 6 weeks the Trust is forecast not to be able to deliver the aggregate 2 week wait standard for the second quarter. July delivered at 97.7% with 22 breaches, August is predicted to be at 88.3% with 113 breaches and September already has 185 breaches booked. The dermatology team is currently booking patients chronologically at 3 weeks which means further breaches will be added.

The team has put on significant additional capacity and is forecasting that if referrals reduce in line with seasonal trends patients will again be seen within 2 weeks by the end of September. However this predicted improvement is not forecast to be sufficient to recover the position for the quarter. This means that the standard will almost certainly be reported as in breach in 4 weeks-time when August is confirmed and it is highly likely that it cannot be recovered for the quarter.

Treatment resulting from these urgent dermatology appointments will need to be completed within 62 days from referral. The operational team are seeking additional capacity to manage the immediate number of referrals to be seen and the treatments that will be required.



# 4. Financial Performance Summary

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 (PbR) contract arrangement.

The Board have been briefed on the overall financial challenge to the Health and Care System in 2016/17 and the consequent difficulties in agreeing contract arrangements. Encouraged by both Regulators - NHS England and NHS Improvement - negotiations concluded in the reinstatement of the Risk Share Agreement (RSA). This report is presented on the basis that the RSA has been maintained, with the Trust picking up an £11.6m share of system risk in 2016/17. This reduction in income is compounded by a forecast loss of £5.0m of Sustainability and Transformation (STF) funding. The combined effect is, however offset by income under the variance terms of the RSA totalling £6.56m. The Trust's revised forecast for the year is therefore EBITDA of £8.8m surplus and an overall deficit of £8.6m after estimated risk share income has been applied. In order to show a meaningful position the movement between these two plans can be seen in the "Changes to PbR and RSA plan" column in the Table below.

The Trust has briefed NHS Improvement regularly on the expected impact on the Trust's plan, submitting forecast that reflects the income loss since April, 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.

## 4.1 Summary of Financial Performance

| | Year to Date - Month 04 | | | 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 | 131.64 | 134.13 | 2.49 | 2.42 | 0.06 | 0.65 | ↑ |
| Operating expenses | (129.38) | (132.82) | (3.44) | (3.33) | (0.11) | 0.31 | ↑ |
| **EBITDA** | **2.26** | **1.31** | **(0.95)** | **(0.90)** | **(0.05)** | **0.96** | ↑ |
| Non-operating revenue | 0.16 | 0.33 | 0.17 | 0.00 | 0.17 | 0.22 | ↑ |
| Non-operating expenses | (5.40) | (5.42) | (0.02) | 0.00 | (0.02) | (0.17) | ↑ |
| **Surplus / (Deficit)** | **(2.99)** | **(3.78)** | **(0.80)** | **(0.90)** | **0.11** | **1.01** | ↑ |

Whilst now seeing an adverse variance against the original PbR based plan (EBITDA : £0.95m and deficit £0.80m), the Trust's financial performance remains in line with the revised RSA based forecast.

Within this position, income is ahead of plan by £2.49m based on PbR, and broadly on plan based on the RSA. Under the terms of the RSA an additional £3.5m has been accrued to reflect the contribution expected from commissioning organisations. This is based on the month 4 position versus the fixed target risk share position for the same period. Operating expenses are showing an adverse position against PBR plan by £3.44m, and £0.11m against the RSA plan.

A total of £1.675m of STF funding has been accrued, as the financial control total and performance targets have been met in the first quarter of the financial year. No STF has been assumed for month 4, pending conclusion of discussions with NHS Improvement on a revised control total for the Trust.

## 4.2 Income

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Income by Category** | | | | | | | |
| Healthcare (Acute and Community) | 99.43 | 102.04 | 2.61 | 2.83 | (0.22) | (0.46) | ↓ |
| Social Care | 18.50 | 18.27 | (0.23) | (0.41) | 0.18 | 0.05 | ↑ |
| Other Income | 13.71 | 13.82 | 0.11 | 0.00 | 0.11 | 1.07 | ↓ |
| Total | **131.64** | **134.13** | **2.49** | **2.42** | **0.06** | **0.65** | ↓ |

Healthcare income is ahead of PbR plan by £2.61m. This reflects £3.5m of RSA income, offset by reduced acute income of £1.05m.

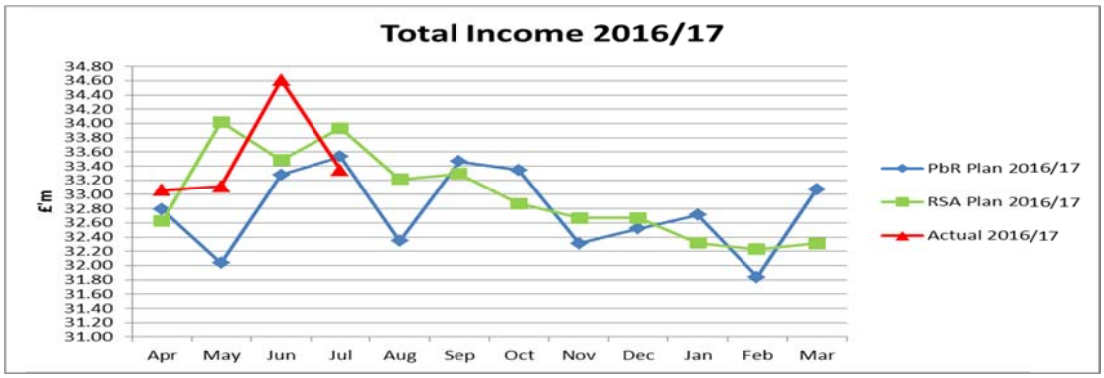
Based on the RSA plan, income is behind by just £0.22m. This is due to the adverse variance on acute income of £0.58m, of which £0.56m relates to NHS E and is mainly Non Elective and chemotherapy income. The local CCG contract is £0.07m behind plan as a result of penalties applied, and the balancing improvement of £0.05m is split across other Commissioners. There is a favourable variance of £0.32m offsetting this on the Risk Share income against plan.

STF funding of £1.65m was accrued at month 3 and is therefore included in the year to date figure at month 4. A total of £6.7m is planned under the PbR arrangements for the full year, but has been reset at £1.675m in the RSA plan, with this phased into quarter one to reflect actual income.

Social Care income is showing an adverse position against PBR plan by £0.23m, and favourable position against Risk Share plan £0.18m which is mainly due to additional Public Health income received for the Drug and Alcohol Service. This is to be used to offset costs that are being charged from DPT. There is also a small over recovery of client income of £0.06m.

Other income is £0.11m higher than both the PBR and Risk Share plan. This is made up of small favourable variances in private patient income (£0.03m), R&D / Education (£0.07m), and Site Services (£0.02m).

The graph below shows income to date against both the PBR and RSA plan.




A detailed analysis of income by Commissioner, Business Unit and Healthcare setting can be seen in Appendix 3 databook finance schedule 1

## 4.3 Operating Expenditure

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Total Operating Expenses Included in EBITDA** | | | | | | | |
| Employee Expenses | 75.38 | 76.66 | (1.27) | 0.81 | (0.46) | (0.31) | ↑ |
| Non-Pay Expenses | 53.82 | 55.87 | (2.05) | 2.51 | 0.47 | 0.70 | ↓ |
| PFI / LIFT Expenses | 0.18 | 0.30 | (0.12) | 0.00 | (0.11) | (0.09) | ↑ |
| Total | **129.38** | **132.82** | **(3.44)** | **3.33** | **(0.11)** | **0.31** | ↑ |

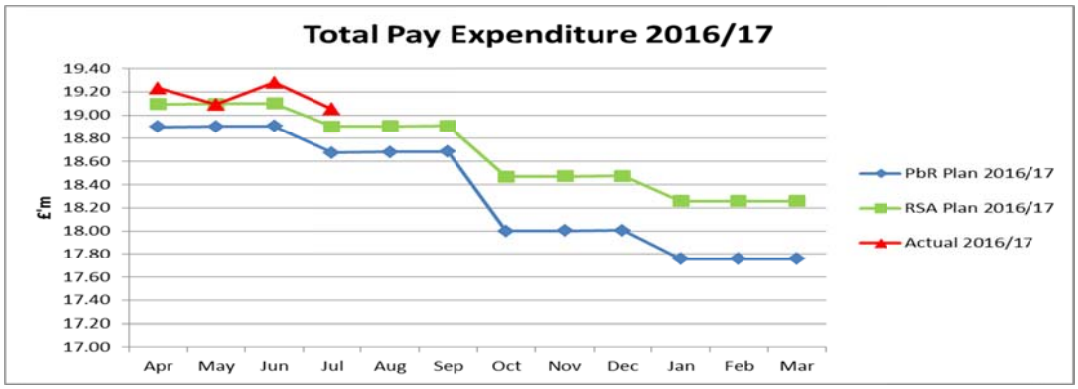
Total Operating Expenditure included in EBITDA is £3.44m above the original plan. Based on a RSA arrangement this is markedly improved, being an adverse variance of just £0.11m.

### Pay

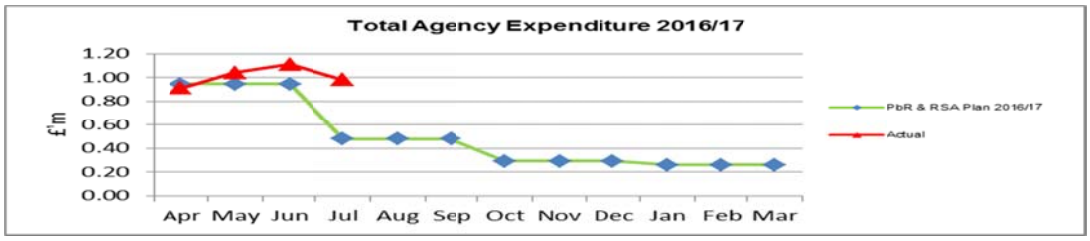
Pay is showing an overspend of £1.27m against PbR plan, and £0.46m against the Risk Share plan. Run rates based on a normalised position show a reduction in costs of £0.23m from the previous month. There has been a reduction in established pay costs (£0.17m), agency costs (£0.13m), with an increase in bank costs (£0.07m). Based on an average over the first quarter of the year, total pay costs have reduced c£0.15m this month. Service Delivery Units continue to overspend, particularly in Medicine which is £1.41m overspent against the RSA plan, mainly as a result of agency costs in the Emergency Department, Care of the Elderly, Cancer Services and General Medicine. Women and Child's Health has pay overspends of £0.03m in Obstetrics & Gynaecology and Child Health, largely associated with locum costs. Estate and Facilities management also has pay overspends due to agency and bank costs.

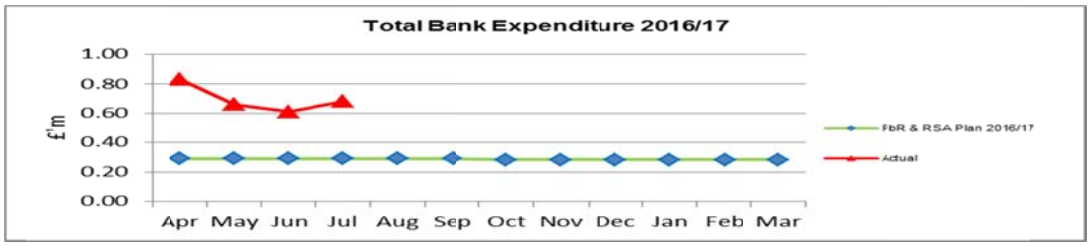
There are underspends offsetting this in Community services (£0.22m) due mainly to vacancies, and HQ and corporate services of £1.1m, mainly £0.8m in reserves and the remainder due to savings in the HIS team 0.17m, Pharmacy £0.16m, and Strategy £0.07m.

The graph below shows pay expenditure against both the PBR and RSA plan to date. Further analysis can be seen in Appendix 3 databook finance schedule 2




The graphs below show the expenditure on bank and agency staff to date. The plan for each type of spend is the same for both PBR and RSA plans including the annual phasing for 2016/17.




NHS Improvement (NHSI) have set agency spend controls and processes for all Trusts to follow. A revised profile of Agency spend for the Trust was initiated by NHSI in its letter to the Trust in June 2016. At month 4 total agency spend remains at 5%, some 2% over the NHSI target cap target. A detailed analysis and Improvement Plan can be seen in Appendix 3 databook finance schedule 3.

Nursing agency spend has been reduced by £0.1m in month. In addition to this action plan, the Senior Nursing Team has implemented tighter control on agency spending. Taking effect in mid July, this has initially delivered a significant improvement, most notably in a marked reduction in the use of Thornbury as a provider, the full impact of which is expected to continue into August.

The actual spend on medical staff agency and locums overall at month 4 is within the planned medical spend.

**Non pay**

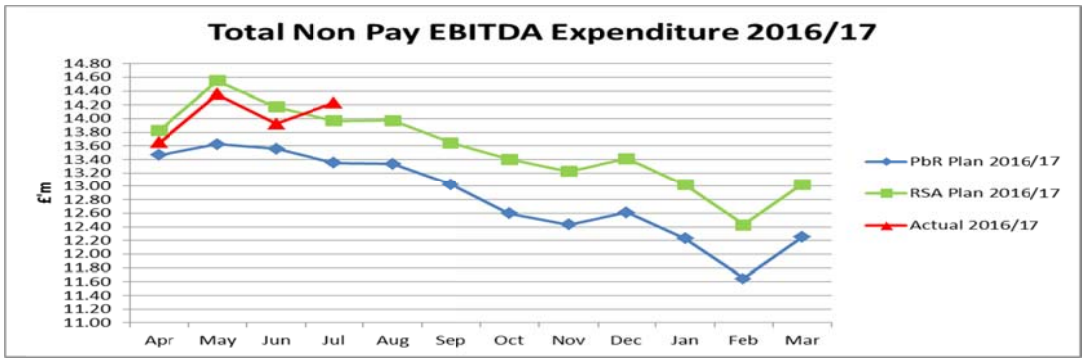
Non pay is showing an overspend against PbR plan of £2.05m, and a favourable variance of £0.47m against Risk Share plan. The difference in the variance is mainly due to the plan adjustments relating to QIPP targets causing an adverse variance against the PbR plan.

Clinical supplies are overspent £0.33m at month 4. Run rate spend is the same as the previous month with a slight reduction on prior months. The main areas of overspend are in Women and Child's Health, PMU and Medicine.

Pass through Drugs, Bloods and Devices are £0.49m over spent against RSA plan, income is received to offset against these costs.

Miscellaneous costs are underspent against the RSA plan by £1.14m. Within this position we have overspends in outsourcing (£0.65m in Surgery and £0.18n in Independent Sector), offset by underspends in premises costs (£0.7m), and other miscellaneous, operational and discretionary costs(£1.1m), mainly due to the release of central reserves . Comparing to the PbR plan these costs show as an overspend due to the QIPP target set for non pay.

The graph below shows non pay expenditure against both the PBR and RSA plan to date. Further analysis can be seen in Appendix 3 databook finance schedule 4.

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CIP targets for both pay and non pay have been profiled, with a significant increase after quarter one to the end of the financial year.

## 4.4 Non-operating Expenses

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Non-Operating Expenses** | | | | | | | |
| Donations & Grants | 0.11 | 0.00 | (0.11) | 0.00 | (0.11) | (0.06) | ↑ |
| Depreciation & Amortisation | (3.40) | (3.27) | 0.14 | 0.00 | 0.14 | 0.07 | ↑ |
| Impairments | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | ↔ |
| Restructuring Costs | 0.00 | (0.28) | (0.28) | 0.00 | (0.28) | (0.28) | ↔ |
| Finance Income | 0.05 | 0.04 | (0.01) | 0.00 | (0.01) | (0.01) | ↔ |
| Gains / (Losses) on Asset Disposals | 0.00 | 0.29 | 0.29 | 0.00 | 0.29 | 0.29 | ↔ |
| Interest cost | (1.03) | (1.02) | 0.01 | 0.00 | 0.01 | 0.02 | ↑ |
| Public Dividend Capitals | (0.86) | (0.74) | 0.13 | 0.00 | 0.13 | 0.04 | ↑ |
| PFI Contingent Rent | (0.11) | (0.12) | (0.01) | 0.00 | (0.01) | (0.01) | ↔ |
| Corporation Tax expense | (0.01) | (0.01) | 0.00 | 0.00 | 0.00 | 0.00 | ↔ |
| **Total** | **(5.25)** | **(5.10)** | **0.15** | **0.00** | **0.15** | **0.05** | ↑ |

Gains/losses on Asset Disposals are £0.28m better than the RSA Plan, primarily due to the sale of the surgical robot.

Restructuring costs are £0.28m than the RSA Plan, due to MARS costs incurred.

PDC dividend payable costs are £0.13m lower than plan due to the overall forecast deterioration in the Trust's financial position during 201617.

There are no other noteworthy variances in Non-Operating Expenses.

## 4.5 Cost Improvement Programme

| | Year to Date - at Month 04 | | | Previous Month YTD | |
|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Variance £m | Change |
| **Schemes Delivered to Date M1 to M4** | | | | | |
| Delivered Schemes : Recurrent | 1.30 | 1.40 | -0.10 | n/a | n/a |
| Delivered Schemes : Non-Recurrent | 0.00 | 0.70 | -0.70 | n/a | n/a |
| **Delivered Schemes : Total** | **1.30** | **2.10** | **-0.80** | n/a | n/a |

| | | | | | |
|---|---|---|---|---|---|
| **Full Year Forecast Delivery** | | | | | |
| Forecast Schemes : Recurrent | 13.90 | 7.20 | 6.70 | n/a | n/a |
| Forecast Schemes : Non-Recurrent | 0.00 | 0.90 | -0.90 | n/a | n/a |
| **Forecast Schemes : Total** | **13.90** | **8.10** | **5.80** | n/a | n/a |

At month 4 the Trust is cumulatively £0.8m ahead of target with the majority of schemes delivering recurrently. However the forecast year end position of £8.1m shows a shortfall of £6.7m against a recurrent plan of £13.9m, offset by £0.9m of schemes expected to be achieved non recurrently.

The transfer of CIP reporting to Smartsheet Programme Management database is complete and actively used to manage project progress and Financial performance/ delivery.

The assurance and governance processes can be seen in the table below.

| Assurance and Governance | | | |
|---|---|---|---|
| **No.** | **Action** | **Lead** | **Date** |
| 1 | CIP Scheme Delivery assurance via PMO process | Paul Cooper | Complete |
| 2 | Carter Financial aspects identified and communicated | Paul Cooper | Ongoing |
| 3 | Full Run Rate reporting in smartsheet | Paul Cooper/ Ann Wagner | Complete |
| 4 | Automation of PMO process and single point of entry for scheme tracking and perfomance management | Paul Cooper/ Ann Wagner | Complete |
| 5 | Establishment of Exec Director CIP Efficiency Group to manage | Paul Cooper | Complete |
| **Governance Arrangements** | | | |
| Quarterly Service Delivery Unit Performance reviews, monthly SBMT review, Service Delivery Units Board meetings, Bi Weekly Efficiency Delivery Group meeting | | | |

The Chief Nurse has lead a review of ward nursing that the Finance Committee have a deep dive report in this month's pack. This has led to 5 new schemes being added to Smart Sheet this month which are currently being valued. A programme of these deep dives has been created based on scheme value for future Finance committee meetings.

Further work is on going with operational teams validating the potential from the carter metrics. Carnall Farra (Management Consultants supporting the STP) have commenced their initial review of the local system plans that the Trust is expecting additional potential to be identified.

## 4.6 Balance Sheet

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Non-Current Assets** | | | | | | | |
| Intangible Assets | 8.87 | 7.70 | (1.17) | 0.00 | (1.17) | (0.86) | ↓ |
| Property, Plant & Equipment | 154.38 | 150.86 | (3.52) | 0.00 | (3.52) | (3.32) | ↓ |
| On-Balance Sheet PFI | 17.15 | 16.87 | (0.28) | 0.00 | (0.28) | (0.26) | ↓ |
| Other | 1.88 | 2.03 | 0.15 | 0.00 | 0.15 | 0.14 | ↑ |
| Total | **182.28** | **177.46** | **(4.82)** | **0.00** | **(4.82)** | (4.31) | ↓ |
| **Current Assets** | | | | | | | |
| Cash & Cash Equivalents | 22.06 | 15.99 | (6.07) | (4.40) | (1.67) | (4.39) | ↑ |
| Other Current Assets | 22.69 | 31.93 | 9.24 | 3.50 | 5.74 | 7.68 | ↑ |
| Total | **44.75** | **47.92** | 3.17 | **(0.90)** | **4.07** | 3.29 | ↑ |
| **Total Assets** | **227.03** | **225.38** | **(1.65)** | **(0.90)** | **(0.75)** | (1.02) | ↑ |
| **Current Liabilities** | | | | | | | |
| Loan - DH ITFF | (6.40) | (6.18) | 0.22 | 0.00 | 0.22 | 0.27 | ↓ |
| PFI / LIFT Leases | (0.72) | (0.64) | 0.08 | 0.00 | 0.08 | 0.08 | ↔ |
| Trade and Other Payables | (30.49) | (32.44) | (1.95) | 0.00 | (1.95) | (1.18) | ↓ |
| Other Current Liabilities | (1.76) | (1.96) | (0.20) | 0.00 | (0.20) | (0.20) | ↔ |
| Total | **(39.37)** | **(41.22)** | **(1.85)** | **0.00** | **(1.85)** | (1.03) | ↓ |
| **Net Current assets/(liabilities)** | **5.38** | **6.70** | 1.32 | **(0.90)** | **2.22** | 2.26 | ↑ |
| **Non-Current Liabilities** | | | | | | | |
| Loan - DH ITFF | (63.35) | (63.23) | 0.12 | 0.00 | 0.12 | 0.52 | ↓ |
| PFI / LIFT Leases | (20.32) | (20.74) | (0.42) | 0.00 | (0.42) | (0.42) | ↔ |
| Other Non-Current Liabilities | (3.97) | (3.83) | 0.14 | 0.00 | 0.14 | 0.11 | ↑ |
| **Total** | **(87.64)** | **(87.80)** | **(0.16)** | **0.00** | **(0.16)** | 0.21 | ↓ |
| **Total Assets Employed** | **100.02** | **96.36** | (3.66) | **(0.90)** | **(2.76)** | (1.84) | ↓ |
| Reserves | | | | | | | |
| Total | **100.02** | **96.36** | (3.66) | **(0.90)** | **(2.76)** | (1.84) | ↓ |

The 2016/17 plan had to be submitted prior to the finalisation of the 2015/16 balance sheet position. Non-current assets are lower than RSA plan by £1.6m due to changes to the 2015/16 closing position made after the plan had been submitted.

In addition, non-current assets are lower than RSA Plan by a further £3.2m, principally due to a reduced level of capital expenditure.

Cash is lower than RSA Plan by £1.7m, due to debtors being higher than RSA plan by £5.7m, partly offset by capital expenditure lower than Plan by £3.7m.

Debtors are higher than RSA Plan by £5.7m. This represents an improvement of £2m in comparison with the previous month. Extensive efforts are continuing to recover outstanding debts, with main outstanding balances being:

- Risk Share Agreement contribution £3.5m
- STF funding Q1 £1.7m;
- CCG West Devon funding £0.7m;
- CCG contribution to care model £0.7m;
- Outstanding debtors £0.4m.

The Trust is due to receive the STF funding during August 16 and a commitment has also been received from South Devon and Torbay CCG to clear the contribution to the Care Model Costs and the West Devon funding debt during August 16 and September 16 respectively. The CCG and Torbay Council have also been invoiced for their respective RSA contributions due as at 30th June 16. The Trust anticipates that these debts will also be cleared during September 16.

All NHS debtors have been agreed in the final accounts process for 2015/16. Increased balances therefore reflect a timing rather than recoverability issue.

The cash balance as at month 4 is £15.9m. A cash flow statement and forecast can be seen in Appendix 3 databook finance schedule 5.

### 4.7 Capital

| | Year to date - Based upon Annual Plan (April 16) | | | Full year Annual Plan versus Revised Forecast | |
|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Forecast £m |
| **Capital Programme** | 8.25 | 4.55 | (3.70) | 36.90 | 23.15 |

The Trust submitted an Annual Plan to Monitor in April of this year. The Annual Plan assumed that the Trust would produce a small Income and Expenditure surplus in year. That projected surplus, coupled with planned external sources of finance, i.e. Independent Trust Financing Facility loans was to fund a planned capital program totalling £36.9m during 2015/16.

Since the preparation of the April 2016 Plan, the contractual position of the Trust has become clearer and the forecast Income and Expenditure position of the Trust has deteriorated by circa £10m.This financial performance deterioration will have an adverse impact upon the Trust's cash reserves and may also be detrimental to the Trust's future borrowing capability. To protect the Trust's cash position over a forecast 5 year period of time a revised capital program is being developed. Loan applications are planned to be submitted in October 2016 to support elements of this program. In parallel with the loan application process, 'downside' plans are also being developed in the event that these loan applications are unsuccessful.

Variances in planned capital expenditure by scheme, and funding sources available can be seen in Appendix 3 databook finance schedule 6.

# 5 Contract Framework

The standards set out below are requirements placed on the Trust through the contract with the CCG and NHS England Specialised Services. They are in addition to the NHS I governance framework standards.

## 5.1 Service Transformation Fund (STF) performance trajectories

The STF trajectories are set out below and RAG rated with actual performance. The trajectories have been agreed with the CCG and submitted to NHS I in accordance with the requirement to access the STF.

The table below shows our performance against the trajectory and or standard. Where performance is meeting standard but is lower than trajectory this is shown as GREEN RAG rated. Where the performance is below Standard with the trajectory not achieved this is shown as RED RAG rated.

| | 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 trajectory - Standard 95%** | 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% | 91.6% | 92.3% | | | | | | | | |
| **RTT - incomplete pathways - Standard 92%** | 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% | 92.0% | 91.46% | | | | | | | | |
| **Diagnostics < 6 weeks wait - Standard 99%** | 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% | 98.85% | 99.03% | | | | | | | | |
| **Cancer 62 day - Standard 85%** | 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% | 90.20% | 86.50% | | | | | | | | |

Notes:

- A+E / MIU (type 1 and 2) waiting times < 4 hours (Target trajectory for July 89.9% achieved 92.3%) - Planned trajectory of improvement to achieve 92% by September 2016 to be maintained for remainder of 2016/17 – **Achieving trajectory to end of July (92.3%)**
- RTT % patients waiting under 18 weeks (Target trajectory for July 92.02%) – **Trajectory and standard to end of July not met (91.46%)**
- Diagnostic waiting times < 6 weeks (Standard 99.0% achieved 99.03) - Planned delivery of 99% from July. **Achieving standard in July (99.03%)**
- Cancer 62 day referral to treatment (Standard 85% some months vary due to low planning numbers) - Standard delivered from April 2016. **Achieving standard in July (86.5%)**

## 5.2 Referral to treatment over 52 weeks (RTT>52)

In July, 11 patients were waiting for treatment having waited over 52 weeks. The Upper GI plans referred to under 18 week RTT section above also provide capacity to support reducing the over 52 week waiters and the significant number of patients waiting over 30 weeks but less than 52.

## 5.3 Commissioning for Quality and Innovation (CQUIN) –

CQUIN schemes form part of the contract payment of 2.5% of contract value. The schemes are split between those Nationally mandated (1.5%) contract value and locally agreed schemes (1.0%) payable against the successful delivery of agreed

milestones. For 2016/17 the following schemes have been agreed and these are shown along with the initial assessment of milestone achievement for Q1.

| CQUIN 16- 17 - Quarter 1 | | | |
|---|---|---|---|
| **CQUIN** | **Indicator Name** | Exec sponsor | Quarter 1 - CCG outcome |
| 1 - National | Introduction of staff health & wellbeing initiatives | Judy Saunders | Achieved |
| 1 - National | Healthy food for NHS staff, visitors and patients | Lesely Darke | Achieved |
| 1 - National | Improving the uptake of flu vaccinations for frontline clinical staff | Judy Saunders | Achieved |
| 2 - National | Timely identification and treatment for sepsis in emergency department<br><br>(ICD 10 – antibiotic administration) | Rob Dyer | Achieved<br><br>Q1 screening 100%<br>Q1 antibiotic admin 82% |
| 2 - National | Timely identification and treatment for sepsis in inpatient settings | Rob Dyer | Achieved<br><br>Q1 baseline screening 0<br><br>Q1 antibiotic admin 60% |
| 5 - National | Reduction in antibiotic consumption per 1,000 admissions | Rob Dyer | Not achieved – evidence not submitted at review panel. Work on-going with team |
| 5 - National | Empiric review of antibiotic prescriptions | Rob Dyer | Not achieved – evidence not submitted at review panel. Work on-going with team |
| 6 - Local | Rightcare - MSK | Liz Davenport | Achieved |
| 7 - Local | Right care - Respiratory | Liz Davenport | Not achieved – evidence not submitted at review panel. CQUIN sign off 17/8/16. Work on-going with team |
| 8- Local | Right care - Cataracts | Liz Davenport | Achieved |
| 9 - Local | Right care Cancer follow up | Liz Davenport | Achieved |
| 10-Local | Enhanced intermediate care | Liz Davenport | Achieved |

The contract Risk Share Agreement (RSA) also applies to the CQUIN scheme values so in effect these schemes are de-risked however the intention is to deliver the agreed milestones as these are all areas of desired improvement.

CQUIN schemes also apply to our specialist contract with a potential value of £370k. This CQUIN value is not part of the RSA and therefore the rules for withholding payment can be applied. At the present time, no schemes have been agreed and discussions continue with specialist commissioning to identify suitable schemes that are applicable and relevant for the specialist activity we undertake.

### 5.4 Diagnostic tests waiting over 6 week
**RAG RATING: GREEN**

In July the standard for diagnostic waits has achieved with 1.00% of patients waiting at the end of month over 6 weeks.

There continue to be service pressures in particular for CT scanning and for MRI with a forecast for August that the 6 week standard will not be met. The Radiology team are reviewing the position daily and scheduling additional capacity where possible to improve the current forecast for the end of August.

### 5.5 12 hour Trolley waits
**RAG RATING: GREEN**

In July there are no 12 hour trolley waits recorded

### 5.6 Cancelled operations
**RAG RATING: RED**

Operations cancelled on the day of admission by the hospital remain above the national standard of 0.8% with 0.9% (30) patients cancelled by hospital on the day of surgery. In addition in July 9 patients were not re-admitted within 28 days of cancellation.

| Reason for cancellation July 2016 | |
|---|---|
| Trauma / priority patient | 11 |
| Theatre time | 8 |
| No ICU / HDU bed | 5 |
| Staff sickness | 5 |
| Diagnostics | 1 |
| Total | 30 |

### 5.7 Care Planning Summary (CPS) timeliness
**RAG RATING: RED**

There remain challenges with the time it takes to complete CPS conflicting with Junior Doctor clinical commitments. In July 51.2% (target 77%) were sent to GPs within 24 hours on weekdays and 20% (target 60%) on the weekends.

**ACTION**: The new CPS has been agreed and went live on 2nd August. It is too early to establish accurately the impact this has had on the timeliness and note that this change had also coincided with the junior doctor change over, which in itself presents challenges whilst the new teams get established with systems and processes.

The early indications however suggest a marginal improvement however nothing significant. Whilst there remains good compliance with the overall completion of CPS the timeliness within 24 hours of discharge is the greatest challenge and remains a

priority for further improvement work. The group led by the Medical Director will be meeting to review the performance and plans to improve the timeliness.

Weekly compliance reports are being shared with ward based and clinical teams to highlight performance against this standard and this is also a key element of focus for the SAFER ward improvement work.

One area of further improvement is to remove the delay between completion and sending of the CPS. This can be particularly prevalent later in the day when many patients are discharged and there may be no ward clerk cover to process the completed CPS. It has been agreed that the Hospital at Day team will now check each evening the list of completed CPS and ensure these are sent.

## 6. Community and Social Care Framework

### 6.1 CAMHS
**RAG RATING: RED**

The percentage of patients seen within 18 weeks in July was 87.0%. The total number waiting for treatment (47 patients) and longest waiting time (21 weeks) has continued to improve although the % of incomplete pathways under 18 weeks remains below the target of 92%.

The service continues to prioritise cases on clinical need and priority and has robust processes in place to manage risk for people waiting. The service transformation work is delivering improvements. The early indication from the investment in the Primary Mental Health Service in schools is also showing benefits.

| | Apr | May | Jun | Jul |
|---|---|---|---|---|
| Number of patients waiting longer than 18 weeks at month end* | 7 | 6 | 5 | 6 |
| Longest wait (in weeks) | 28 | 26 | 24 | 21 |
| Total Number of patients waiting for treatment at month end | 61 | 60 | 53 | 47 |
| RTT % incomplete (Target 92%) | 89% | 90% | 91% | 87% |

### 6.2 Delayed Discharges

**RAG RATING: RED (June)**

In July 422 bed days were lost involving 36 patient delays, 22 of which were in Newton Abbott, 5 in Brixham and 2 in each of Ashburton ,Dartmouth and Paignton. This is a higher number of days delayed reported in the same period last year (320 days) and an increase on the 355 days delays reported in June.

Of the 422 days lost 234 (55%) were attributable to healthcare 123 (29%) attributable to social care with the remaining 15% having shared responsibility between health and social care.

The most common reasons for delays given in July were:

- 'Patient / Family Choice' (147 days 35% - last month 18%)
- 'Completion of Assessment' (88 days; 21% - last month 24%)
- 'Care Package' (81 days; 19% - last month 17%)
- 'Residential Home Placement' (35 days; 8% - last month 20%)
- 'Nursing Home Placement (52 days; 12% - last month 20%);

This area with the greatest increase is Patient / Family Choice increasing from 65 days in June to 147 days in July.

Across all the community hospitals, 10% of Available Bed Days (4,576) were lost to delays in July, last month June, reported 7%.

## 7. Supporting documents

Appendix1: Letter from NHS I with feedback on 2016/17 Annual Plan submission

Appendix 2: Month 4 Quality, Performance and Finance Dashboard

Appendix 3: Month 4 Quality and Performance Databook including Financial schedules

Appendix 4: Smartsheet CIP Portfolio Report

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

Mairead McAlindon
Chief Executive
Torbay and South Devon NHS Foundation Trust
Torbay Hospital
Lawes Bridge
Torquay
Devon
TQ2 7AA

29 July 2016

Dear Mairead

**Operational plans 2016/17**

Thank you for submitting your final operational plan for 2016/17. I am writing to acknowledge receipt of your plan and to highlight the next steps.

'*Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21',* sets out our expectations for delivering high quality, sustainable services for the patients and communities that we serve. I would like to take this opportunity to recognise the significant work that has gone into delivering a clear plan for 2016/17 during a challenging period for the NHS.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high quality services and the agreed access standards for patients within the resources available. This will mean maintaining an effective balance between demand and capacity and continuing to develop the workforce needed for local services.

The planning guidance also set out the steps to help local organisations deliver a sustainable, transformed health service and meet the three gaps identified in the *Five Year Forward View*: health and wellbeing; care and quality; funding and efficiency. This highlights the importance of your strategic work to help create a sustainable organisation as part of a strong local health care system with agreed Sustainability and Transformation Plans.

To this end, NHS Improvement will continue to work with trusts to review progress against your plans and to support you in the delivery of the required standards in line with our new oversight model.

**Next Steps**

NHS Improvement published '*Strengthening Financial Performance and Accountability in 2016/17*' on 21 July 2016. This document provides further detail on access to the Sustainability and Transformation Fund (STF) in 2016/17, and sets out a further three areas of focus for improving provider financial positions in 2016/17: tackling excessive paybill growth; implementation of Lord Carter's recommendations on back office and pathology consolidation; and consolidation of unsustainable services. NHS Improvement will continue to work with providers and STP leads on these areas to identify where further financial savings can be made in 2016/17.

Having reviewed your plan submission, and based on our other recent engagements with the trust, we have the following specific concerns to report on your plan:

- We are aware that you have written to Jim Mackey raising concerns over the Trust's control total. NHS Improvement will write to you under separate cover on this matter.

- You have told us that following contract agreement with your commissioners you are no longer able to meet your control total. We would like to understand the impact on the trust's cash position in 2016/17 given that failure to deliver the control total will result in the Trust being ineligible for Sustainability and Transformation (S&T) funding. In particular, we would like to understand whether the Trust will require access to Distressed Funding.

- Your plan includes CIP, ICO synergy benefits and other non-recurrent benefits. Once consolidated, the efficiency challenge is significant. In your quarterly call with the relationship team, you outlined that only 30% of CIPs had detailed plans underpinning them. We will continue to monitor how the Board is getting assurance that it is making significant progress against its efficiency challenge.

- You have stated in your plan that to substantially meet the four hour A&E target and to address CQC concerns will require significant investment. Given that it is unlikely you will be able to drawdown S&T funding, we would like to understand how the Trust will ensure investments necessary to maintain quality and patient safety will be delivered. .

- Given the trust has previously exceeded its agency cost ceiling, we will continue to monitor agency spend and the actions you have in place to reduce your reliance on agency staff. You are engaging with our workforce efficiency team to help in mitigating the risks of these plans not delivering, and we will continue to monitor progress.

NHS Improvement will undertake on-going monitoring, support and escalation as necessary against the specific areas identified in this letter and the key domains and indicators outlined in the NHS Improvement oversight model.

In addition, we would request that trusts publish their finalised plan summaries on their websites by 26 August 2016 and advise their NHS Improvement regional relationship manager when this has been completed.

We will continue to work with you to ensure you are able to access the necessary development support to strengthen the trust's capability and capacity for delivery. Our central commitment to delivering a strong provider landscape can only be achieved through your success. We will ensure that wherever possible we support you to deliver your ambitions. In return, our expectation is a simple one - that the commitments you make through this planning round and through locally agreed contracts are delivered in full.
If you wish to discuss the above or any related issues further, please let me know.

Yours sincerely

**Claudia Griffith**
Regional Director
NHS Improvement

| Corporate Objective | | Target 2016/2017 | 13 month trend | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Year to date 2016/17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **QUALITY FRAMEWORK** | | | | | | | | | | | | | | | | | |
| 1 | Safety Thermometer - % New Harm Free | >95% | | | | | 96.5% | 96.1% | 95.9% | 97.3% | 97.1% | 97.0% | 96.8% | 96.0% | 97.0% | 96.5% | 96.6% |
| 1 | Reported Incidents - Major + Catastrophic * | <6 | | 0 | 2 | 4 | 2 | 2 | 3 | 2 | 0 | 1 | 4 | 5 | 3 | 5 | 17 |
| 1 | Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears) | 9 (full year) | | 0 | 1 | 2 | 2 | 0 | 0 | 3 | 4 | 5 | 0 | 2 | 1 | | 3 |
| 1 | Never Events | 0 | | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | SIRI - Reportable incidents | 0 | | | | | | | | | | 14 | 7 | 9 | 4 | 5 | 25 |
| 1 | QUEST score (Quality Effectiveness Safety Trigger Tool) | <12 | | | | | 4 | 4 | 4 | 4 | 4 | 5 | 7 | 9.5 | 9 | 7.5 | 7.5 |
| 1 | Formal Complaints - Number Received * | <60 | | 36 | 26 | 33 | 36 | 42 | 32 | 40 | 42 | 34 | 31 | 46 | 35 | 35 | 147 |
| 1 | VTE - Risk assessment on admission - (Acute) | >95% | | 95.2% | 95.3% | 94.6% | 96.2% | 96.1% | 95.8% | 95.6% | 95.0% | 94.0% | 96.7% | 95.0% | 94.3% | 92.8% | 94.7% |
| 1 | VTE - Risk assessment on admission - (Community) | >95% | | 100.0% | 93.4% | 97.1% | 91.7% | 100.0% | 100.0% | 98.7% | 88.8% | 90.4% | 92.5% | 92.9% | 91.2% | 92.2% | 92.2% |
| 1 | Medication errors resulting in moderate to catastrophic harm | 0 | | | | | | | | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 3 |
| 1 | Medication errors - Total reported incidents (trust at fault) | N/A | | | | | | | | 46 | 39 | 47 | 42 | 46 | 38 | 52 | 178 |
| 1 | Hospital standardised mortality rate (HSMR) - 3 months in arrears YTD = last 12 months cumulative | <100% | | 90.5% | 99.6% | 98.7% | 94.6% | 84.8% | 86.4% | 92.8% | 111.0% | 103.0% | 96.7% | 94.5% | | | 96.7% |
| 1 | Safer Staffing - ICO - Nursing Daytime | 90%-110% | | | | | 101.0% | 98.1% | 95.6% | 102.8% | 101.1% | 101.1% | 101.2% | 101.4% | 102.8% | 100.5% | 101.5% |
| 1 | Safer Staffing - ICO - Nursing Nightime | 90%-110% | | | | | 98.8% | 96.7% | 98.8% | 101.5% | 100.8% | 102.4% | 97.3% | 96.2% | 97.5% | 97.0% | 97.0% |
| 1 | Infection Control - Bed Closures - (Acute) * | <100 | | 40 | 68 | 18 | 54 | 92 | 36 | 12 | 57 | 38 | 236 | 56 | 68 | 28 | 388 |
| 1 | Fracture Neck Of Femur - Time to Theatre <36 hours | >90% | | 65.9% | 76.5% | 72.2% | 85.7% | 86.8% | 66.7% | 88.6% | 80.6% | 80.9% | 69.0% | 89.5% | 85.2% | 75.7% | 79.2% |
| 1 | Stroke patients spending 90% of time on a stroke ward | >80% | | 90.0% | 87.0% | 84.0% | 79.0% | 85.0% | 82.0% | 84.0% | 81.0% | 73.0% | 61.4% | 79.6% | 71.4% | 79.5% | 72.3% |
| 1 | Dementia - Find - monthly report | >90% | | 55.2% | 74.8% | 71.4% | 74.4% | 73.5% | 65.5% | 64.3% | 54.0% | 40.7% | 43.9% | 29.8% | 31.9% | 29.4% | 33.6% |
| 1 | Follow ups past to be seen date | 3500 | | 4020 | 4570 | 4873 | 4731 | 4542 | 5090 | 5291 | 4938 | 5732 | 6082 | 6073 | 6219 | 6601 | 6601 |

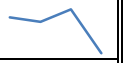
| Corporate Objective Key | |
|---|---|
| 1 | Safe, Quality Care and Best Experience |
| 2 | Improved wellbeing through partnership |
| 3 | Valuing our workforce |
| 4 | Well led |

**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 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Year to date 2016/17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NHS I COMPLIANCE GOVERNANCE** | | | | | | | | | | | | | | | | | |
| 1 | Overall Quarterly NHS I Compliance Framework Score | N/A | | | | 1 | | | 2 | | | 2 | 2 | 1 | 1 | 2 | |
| 1 | A&E - patients seen within 4 hours [STF] | >95% | | 82.4% | 80.2% | 90.2% | 91.4% | 87.9% | 85.3% | 81.8% | 82.0% | 84.9% | 89.4% | 87.4% | 91.6% | 92.3% | 90.2% |
| | 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% | 84.8% | 86.8% | 89.9% | 89.9% |
| 1 | Referral to treatment - % Incomplete pathways <18 wks [STF] | >92% | | 92.4% | 92.2% | 92.1% | 91.5% | 91.2% | 90.8% | 91.2% | 91.4% | 91.8% | 92.1% | 92.5% | 92.0% | 91.4% | 91.4% |
| | RTT Trajectory [STF] | | | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 90.9% | 91.2% | 91.3% | 92.0% | 92.0% |
| 1 | Number of Clostridium Difficile cases - Lapse of care - (ICO) * | <18 (year) | | 2 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 2 | 5 |
| 1 | Cancer - Two week wait from referral to date 1st seen | >93% | | 93.0% | 94.7% | 97.6% | 98.1% | 97.3% | 97.7% | 98.7% | 97.0% | 97.1% | 96.5% | 96.8% | 97.4% | 97.7% | 97.1% |
| 1 | Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients | >93% | | 100.0% | 97.4% | 100.0% | 98.1% | 93.6% | 97.8% | 95.8% | 98.0% | 100.0% | 97.7% | 99.0% | 97.2% | 97.4% | 97.8% |
| 1 | Cancer - 31-day wait from decision to treat to first treatment | >96% | | 100.0% | 98.7% | 98.3% | 96.6% | 98.7% | 98.8% | 94.4% | 98.7% | 97.7% | 96.8% | 98.8% | 95.9% | 98.5% | 97.5% |
| 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% | 99.0% | 99.7% |
| 1 | Cancer - 31-day wait for second or subsequent treatment - Radiotherapy | >94% | | 100.0% | 93.6% | 96.6% | 97.7% | 96.4% | 100.0% | 87.9% | 96.5% | 100.0% | 93.3% | 98.2% | 98.6% | 93.8% | 96.3% |
| 1 | Cancer - 31-day wait for second or subsequent treatment - Surgery | >94% | | 92.9% | 95.2% | 97.4% | 96.8% | 92.3% | 96.0% | 95.1% | 90.9% | 96.9% | 100.0% | 93.2% | 100.0% | 94.6% | 96.7% |
| 1 | Cancer - 62-day wait for first treatment - 2ww referral [STF] | >85% | | 93.0% | 90.3% | 87.8% | 86.5% | 88.2% | 88.7% | 91.1% | 89.9% | 89.5% | 88.5% | 90.4% | 92.4% | 86.8% | 89.5% |
| 1 | Cancer - 62-day wait for first treatment - screening | >90% | | 93.3% | 100.0% | 90.9% | 100.0% | 90.5% | 100.0% | 93.3% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 93.9% | 95.4% |

| Corporative Objective | | Target 2016/2017 | 13 month trend | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Year to date 2016/17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NHS I COMPLIANCE FINANCIAL SUSTAINABILITY** | | | | | | | | | | | | | | | | | |
| 4 | Capital Service Cover | 2 | | | | 1 | | | 1 | | | 1 | 1 | 1 | 1 | 1 | 1 |
| | Capital Service Cover - Plan | | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 |
| 4 | Liquidity | 3 | | | | 2 | | | 4 | | | 4 | 4 | 4 | 4 | 4 | 4 |
| | Liquidity - Plan | | | | | | | | | | | | 4 | 4 | 3 | 3 | 3 |
| 4 | I&E Margin | 4 | | | | 2 | | | 1 | | | 1 | 1 | 1 | 1 | 1 | 1 |
| | I&E Margin - Plan | | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 |
| 4 | I&E Margin Variance From Plan | 3 | | | | 4 | | | 4 | | | 3 | 3 | 3 | 3 | 3 | 3 |
| | I&E Margin Variance From Plan - Plan | | | | | | | | | | | | 3 | 3 | 3 | 3 | 3 |
| 4 | Overall Financial Sustainability Risk Rating | 3 | | | | 2 | | | 2 | | | 2 | 2 | 2 | 2 | 2 | 2 |
| | Overall Financial Sustainability Risk Rating - Plan | | | | | | | | | | | | 2 | 2 | 2 | 2 | 2 |
| **FINANCE INDICATORS** | | | | | | | | | | | | | | | | | |
| 4 | EBITDA - Variance from PBR Plan - cumulative (£'000's) | |  | | | | | | | | | | 241 | 86 | 499 | -950 | |
| 4 | Agency - Variance to NHSI cap | |  | | | | | | | | | | -1.23% | -2.06% | -2.39% | -2.00% | |
| 4 | CIP - Variance from PBR plan - cumulative (£'000's) | |  | | | | | | | | | | -116 | -281 | 1010 | 593 | |
| 4 | Capital spend - Variance from PBR Plan - cumulative (£'000's) | |  | | | | | | | | | | 1189 | 2686 | 3113 | 3699 | |
| 4 | Distance from NHSI Control total (£'000's) | |  | | | | | | | | | | 329 | 1095 | 375 | -354 | |
| 4 | Risk Share actual income to date cumulative (£'000's) | |  | | | | | | | | | | 985 | 2180 | 2485 | 3504 | |

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

** 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 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Year to date 2016/17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CONTRACTUAL FRAMEWORK** | | | | | | | | | | | | | | | | | |
| 1 | Diagnostic tests longer than the 6 week standard [STF] | <1% | | 1.1% | 2.6% | 2.7% | 0.4% | 0.8% | 1.1% | 2.8% | 1.0% | 1.6% | 1.5% | 0.9% | 1.1% | 1.0% | 1.1% |
| | Diagnostic trajectory [STF] | | | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.02% | 1.04% | 0.99% | 0.99% |
| 1 | RTT 52 week wait incomplete pathway | 0 | | 0 | 1 | 1 | 1 | 1 | 2 | 3 | 5 | 4 | 4 | 6 | 5 | 11 | 11 |
| 1 | Mixed sex accomodation breaches of standard | 0 | | 0 | 0 | 3 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| 1 | On the day cancellations for elective operations | <0.8% | | 0.7% | 0.8% | 0.8% | 1.0% | 1.0% | 1.4% | 1.3% | 1.4% | 0.9% | 1.5% | 1.4% | 1.6% | 0.9% | 1.3% |
| 1 | Cancelled patients not treated within 28 days of cancellation * | 0 | | 3 | 2 | 0 | 0 | 2 | 3 | 2 | 9 | 10 | 4 | 9 | 6 | 9 | 28 |
| 1 | Ambulance handover delays > 30 minutes | 0 | | 68 | 87 | 86 | 42 | 103 | 75 | 113 | 234 | 170 | 102 | 111 | 37 | 54 | 304 |
| | Handovers > 30 minutes trajectory * | | | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 40 | 35 | 25 | 150 |
| 1 | Ambulance handover delays > 60 minutes | 0 | | 1 | 3 | 2 | 2 | 2 | 5 | 2 | 35 | 16 | 26 | 6 | 0 | 1 | 33 |
| 1 | A&E - patients seen within 4 hours DGH only | >95% | | 82.4% | 80.2% | 90.2% | 87.8% | 83.3% | 79.7% | 74.6% | 74.4% | 77.8% | 84.5% | 81.2% | 87.2% | 88.2% | 85.4% |
| 1 | A&E - patients seen within 4 hours community MIU | >95% | | 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 | Trolley waits in A+E > 12 hours from decision to admit | 0 | | 0 | 0 | 0 | 0 | 3 | 1 | 13 | 10 | 1 | 2 | 0 | 0 | 0 | 2 |
| 1 | Number of Clostridium Difficile cases - (Acute) * | <3 | | 3 | 2 | 3 | 1 | 2 | 1 | 0 | 1 | 3 | 1 | 4 | 2 | 2 | 9 |
| 1 | Number of Clostridium Difficile cases - (Community) | 0 | | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 2 | 1 | 4 |
| 1 | Care Planning Summaries % completed within 24 hours of discharge - Weekday | >77% | | 61.0% | 61.7% | 61.5% | 62.4% | 61.8% | 55.0% | 58.5% | 58.5% | 54.0% | 63.6% | 56.2% | 59.4% | 51.2% | 57.3% |
| 1 | Care Planning Summaries % completed within 24 hours of discharge - Weekend | >60% | | 37.4% | 28.1% | 24.3% | 26.7% | 30.2% | 23.8% | 35.3% | 22.0% | 24.6% | 25.0% | 22.4% | 35.0% | 20.4% | 25.2% |
| 1 | Clinic letters timeliness - % specialties within 4 working days | >80% | | 77.3% | 72.7% | 59.1% | 59.1% | 72.7% | 77.3% | 72.7% | 77.3% | 86.4% | 81.8% | 72.7% | 81.8% | 81.8% | 79.5% |

**NOTE**

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

| Corporative Objective | | Target 2016/2017 | 13 month trend | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Year to date 2016/17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **COMMUNITY & SOCIAL CARE FRAMEWORK** | | | | | | | | | | | | | | | | | |
| 1 | Number of Delayed Discharges * | 2216 (full year) | | 320 | 403 | 317 | 211 | 467 | 327 | 325 | 415 | 338 | 351 | 166 | 355 | 422 | 1294 |
| 1 | Timeliness of Adult Social Care Assessment assessed within 28 days of referral | >70% | | 71.0% | 70.3% | 69.6% | 69.9% | 71.0% | 67.0% | 68.8% | 68.8% | 68.9% | 85.7% | 78.7% | 72.1% | 73.0% | 72.9% |
| 3 | Clients receiving Self Directed Care | >90% | | 93.3% | 93.4% | 93.1% | 92.8% | 92.5% | 92.7% | 92.1% | 92.9% | 93.6% | 92.5% | 91.6% | 91.2% | 91.0% | 91.2% |
| 2 | Carers Assessments Completed year to date | 40% (Year end) | | 18.4% | 24.2% | 27.4% | 32.1% | 35.9% | 38.2% | 41.2% | 42.8% | 43.3% | 5.9% | 11.9% | 18.6% | 22.0% | 22.0% |
| | Carers Assessment trajectory | | | 13.3% | 16.7% | 20.0% | 23.3% | 26.7% | 30.0% | 33.3% | 36.7% | 40.0% | 3.3% | 6.7% | 10.0% | 13.3% | 13.3% |
| 3 | Number of Permanent Care Home Placements | <=617 (Year end) | | 646 | 645 | 639 | 645 | 630 | 636 | 637 | 640 | 635 | 628 | 624 | 626 | 614 | 614 |
| | Number of Permanent Care Home Placements trajectory | | | 647 | 644 | 642 | 640 | 638 | 636 | 634 | 632 | 630 | 634 | 632 | 631 | 629 | 629 |
| 1 | Children with a Child Protection Plan (one month in arrears) | NONE SET | | 161 | 190 | 199 | 216 | 216 | 212 | 174 | 147 | 139 | 131 | 137 | 131 | | 131 |
| 3 | 4 Week Smoking Quitters (reported quarterly in arrears) | NONE SET | | | | 231 | | | 303 | | | 451 | | | | | |
| 3 | % OCU in Effective Drug Treatment (reported quarterly in arrears) | NONE SET | | | | 6.3% | | | 6.4% | | | 8.5% | | | | | |
| 1 | Safeguarding Adults - % of high risk concerns where immediate action was taken to safeguard the individual [NEW] | 100% | | | | | | | | | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| 1 | Bed Occupancy | 80% - 90% | | 90.6% | 92.3% | 89.9% | 90.3% | 92.7% | 92.4% | 94.8% | 92.5% | 91.9% | 92.8% | 89.8% | 86.4% | 93.3% | 90.6% |
| 1 | CAMHS - % of patients waiting under 18 weeks at month end | >92% | | | | | | | | | | | 89.0% | 80.0% | 91.0% | 87.0% | 90.2% |
| **CHANGE FRAMEWORK** | | | | | | | | | | | | | | | | | |
| 3 | Number of Emergency Admissions - (Acute) | | | 2732 | 2580 | 2694 | 2776 | 2760 | 2708 | 2609 | 2740 | 2945 | 2797 | 2974 | 2946 | 3078 | 11795 |
| 3 | Average Length of Stay - Emergency Admissions - (Acute) | | | 3.2 | 3.2 | 3.2 | 3.2 | 3.4 | 3.5 | 3.5 | 3.3 | 3.4 | 3.7 | 3.3 | 3.2 | 3.0 | 3.3 |
| 3 | Hospital Stays > 30 Days - (Acute) | | | 27 | 21 | 28 | 17 | 18 | 21 | 21 | 28 | 29 | 35 | 34 | 26 | 21 | 116 |
| **CORPORATE MANAGEMENT FRAMEWORK** | | | | | | | | | | | | | | | | | |
| 2 | Staff Vacancy Rate (excl temp workforce and additional hours) | <5% | | 6.50% | 4.50% | 6.40% | 6.60% | 6.80% | 7.50% | 6.80% | 7.00% | 7.45% | 7.92% | 7.99% | 7.97% | 7.71% | 7.71% |
| 2 | Staff sickness / Absence (1 month arrears) | <3.5% | | 4.20% | 4.20% | 4.10% | 4.10% | 4.00% | 4.00% | 4.00% | 4.00% | 4.05% | 4.11% | 4.13% | 4.19% | | 4.19% |
| 2 | Appraisal Completeness | >90% | | 86.00% | 86.00% | 84.00% | 80.00% | 77.00% | 78.00% | 86.00% | 85.00% | 83.00% | 82.00% | 82.00% | 82.00% | 81.00% | 81.00% |
| 2 | Mandatory Training Compliance | >85% | | 88.00% | 88.00% | 87.00% | 89.00% | 89.00% | 90.00% | 90.00% | 89.00% | 88.10% | 87.85% | 88.00% | 88.00% | 87.00% | 87.00% |

# Performance & Quality Databook

**Month 4 July 2016**

# Contents

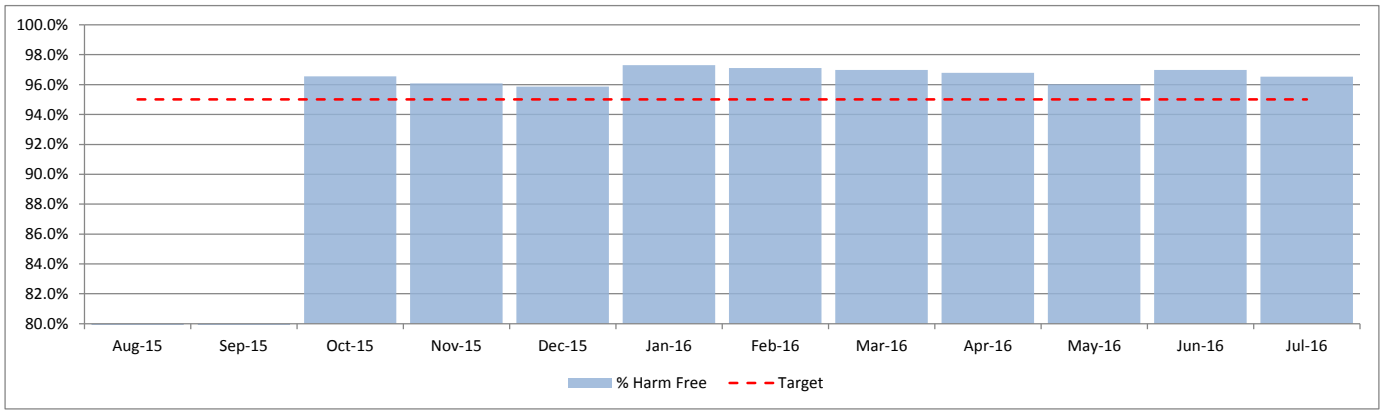
# QUALITY FRAMEWORK

**Month 4 July 2016**

QUALITY FRAMEWORK

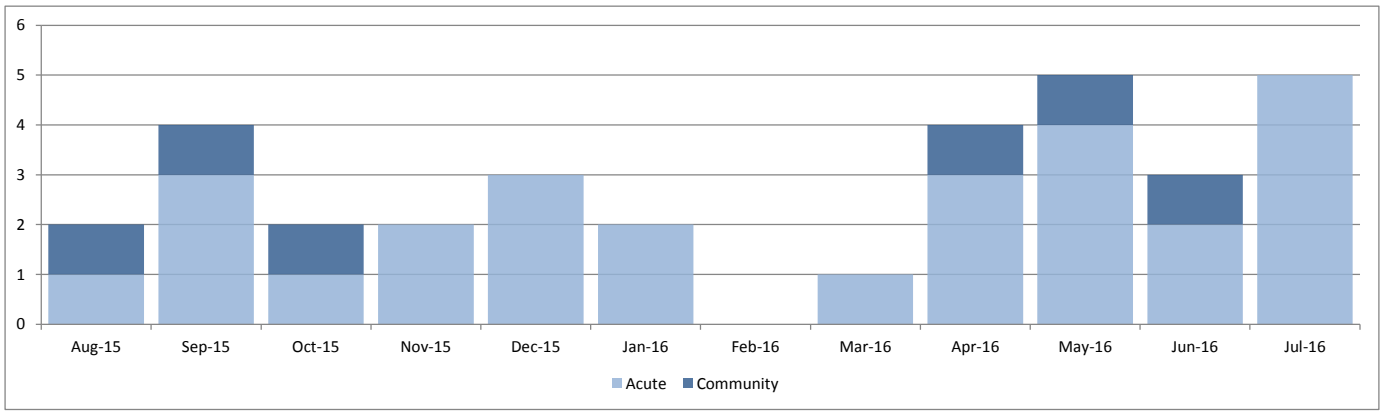
**Harm Free - Trust Total**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | | | | | 994 | 1109 | 1075 | 1057 | 1027 | 1056 | 1093 | 1040 |
| Harm Free | | | | | 953 | 1079 | 1044 | 1025 | 994 | 1014 | 1060 | 1004 |
| % Harm Free | n/a | n/a | 96.5% | 96.1% | 95.9% | 97.3% | 97.1% | 97.0% | 96.8% | 96.0% | 97.0% | 96.5% |
| 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% |



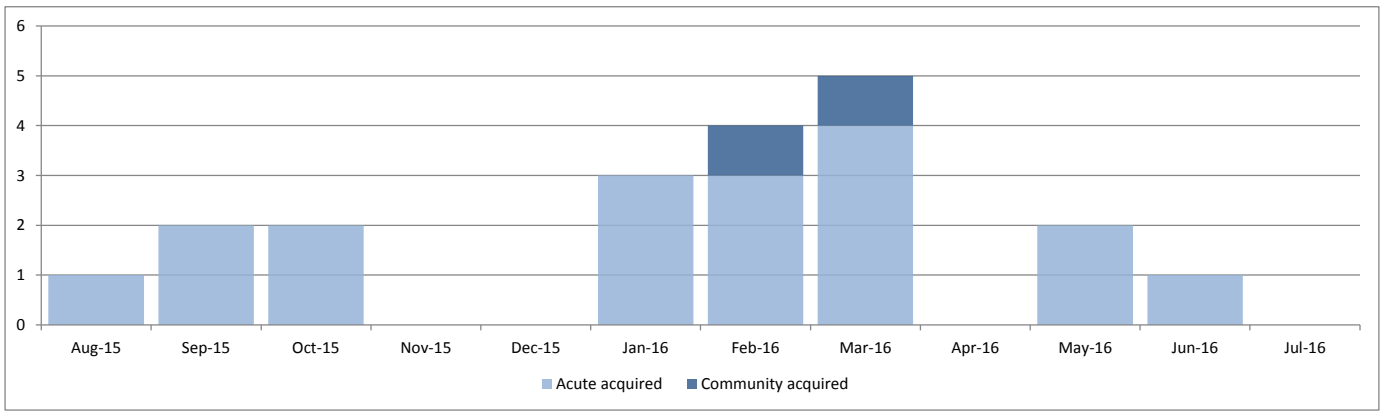

**Reported Incidents - Major and Catastrophic**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 1 | 3 | 1 | 2 | 3 | 2 | 0 | 1 | 3 | 4 | 2 | 5 |
| Community | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |




**New Pressure Ulcers - Categories 3 and 4 (avoidable)**

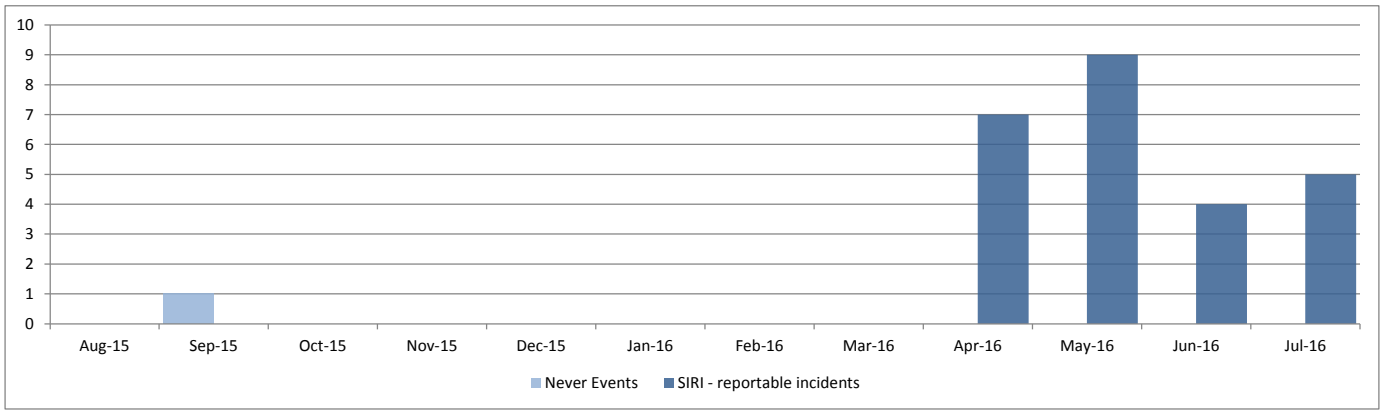
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute acquired | 1 | 2 | 2 | 0 | 0 | 3 | 3 | 4 | 0 | 2 | 1 | n/a |
| Community acquired | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |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



## QUALITY FRAMEWORK

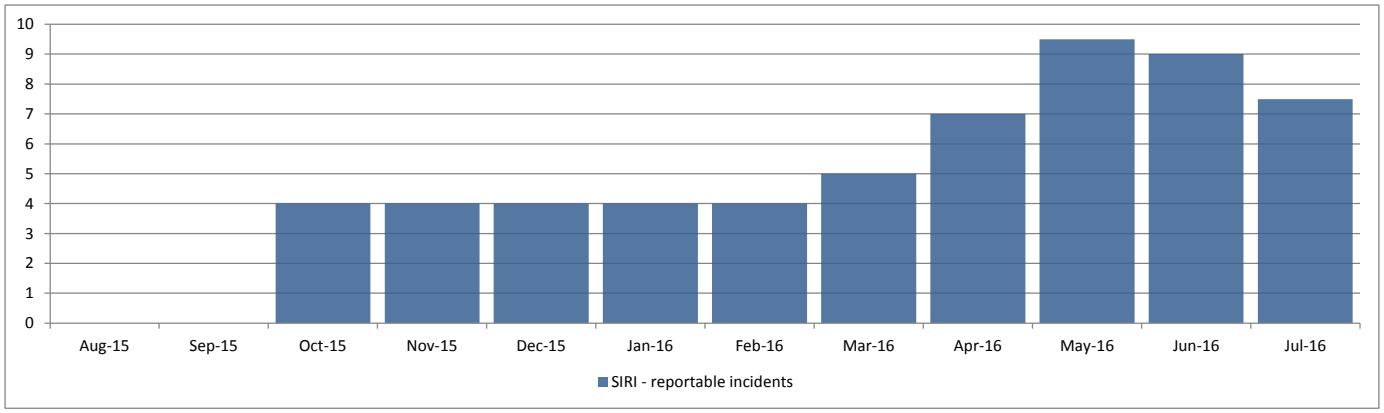
### Never events & SIRI

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Never Events | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SIRI - reportable incidents | | | | | | | | | 7 | 9 | 4 | 5 |



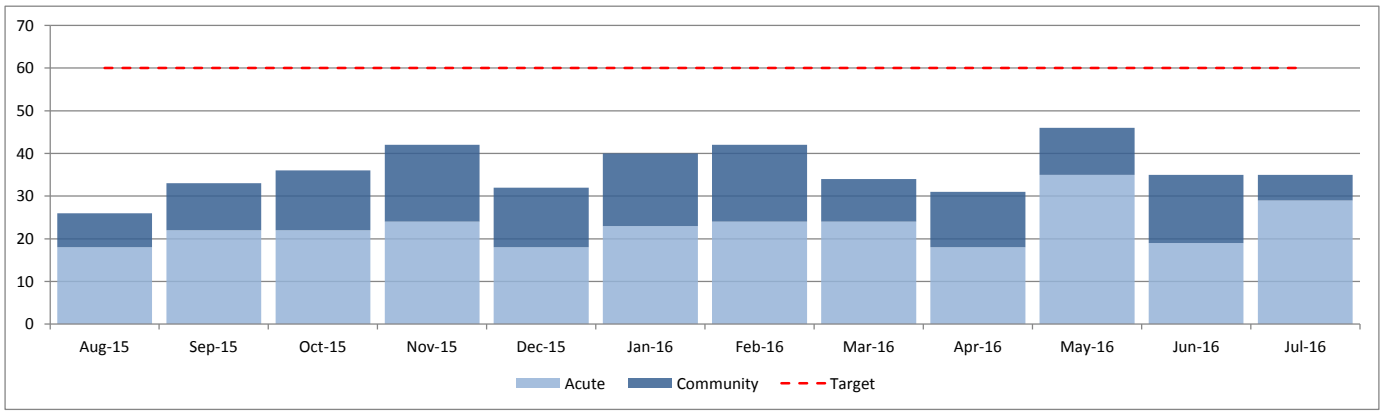

### Quality Effectiveness Safety Trigger Tool (QUEST)

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quest score | n/a | n/a | 4 | 4 | 4 | 4 | 4 | 5 | 7 | 9.5 | 9 | 7.5 |




### Formal complaints

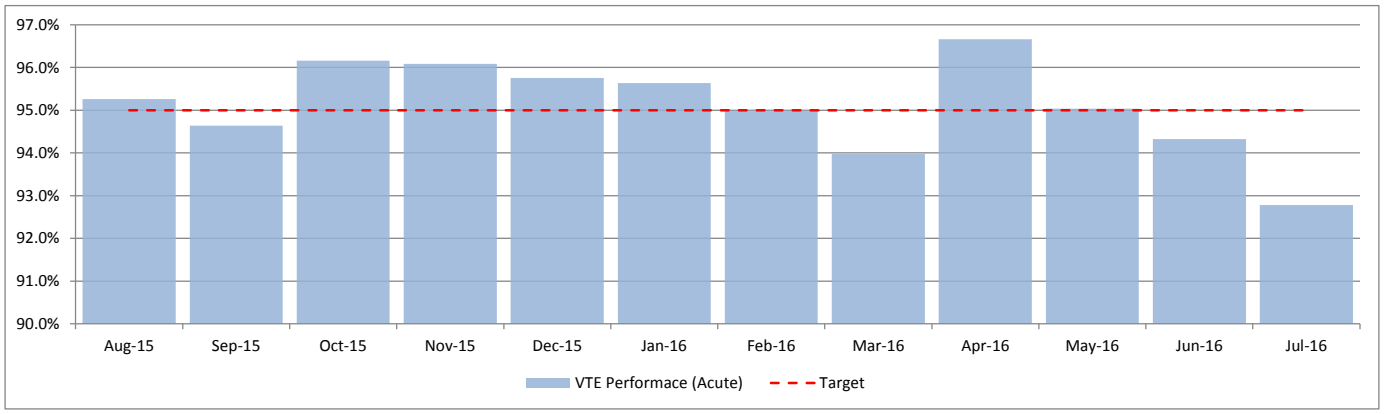
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 18 | 22 | 22 | 24 | 18 | 23 | 24 | 24 | 18 | 35 | 19 | 29 |
| Community | 8 | 11 | 14 | 18 | 14 | 17 | 18 | 10 | 13 | 11 | 16 | 6 |
| Total | 26 | 33 | 36 | 42 | 32 | 40 | 42 | 34 | 31 | 46 | 35 | 35 |
| Target | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |



QUALITY FRAMEWORK

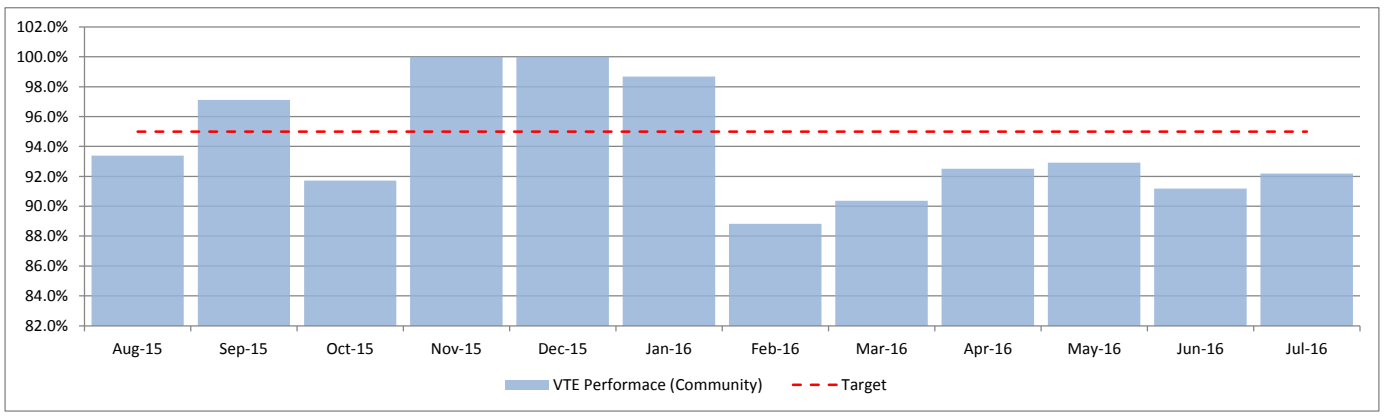
**VTE Risk assessment on admission - (Acute)**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VTE Numerator | 5528 | 5930 | 5738 | 5593 | 5352 | 5653 | 5424 | 5573 | 5591 | 5883 | 5885 | 5757 |
| VTE Denominator | 5803 | 6266 | 5967 | 5821 | 5589 | 5911 | 5710 | 5930 | 5784 | 6190 | 6239 | 6205 |
| VTE Performace (Acute) | 95.3% | 94.6% | 96.2% | 96.1% | 95.8% | 95.6% | 95.0% | 94.0% | 96.7% | 95.0% | 94.3% | 92.8% |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |



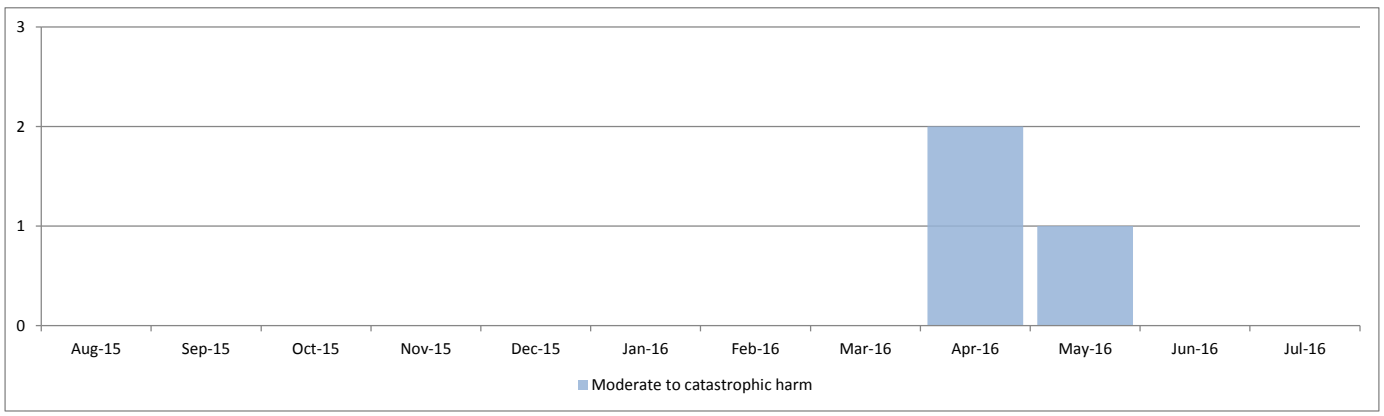

**VTE Risk assessment on admission - (Community)**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VTE Numerator | 127 | 135 | 133 | 135 | 137 | 148 | 135 | 122 | 136 | 131 | 124 | 118 |
| VTE Denominator | 136 | 139 | 145 | 135 | 137 | 150 | 152 | 135 | 147 | 141 | 136 | 128 |
| VTE Performace (Community) | 93.4% | 97.1% | 91.7% | 100.0% | 100.0% | 98.7% | 88.8% | 90.4% | 92.5% | 92.9% | 91.2% | 92.2% |
| 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% |




**Medication Errors Resulting in Moderate to Catastrophic Harm**

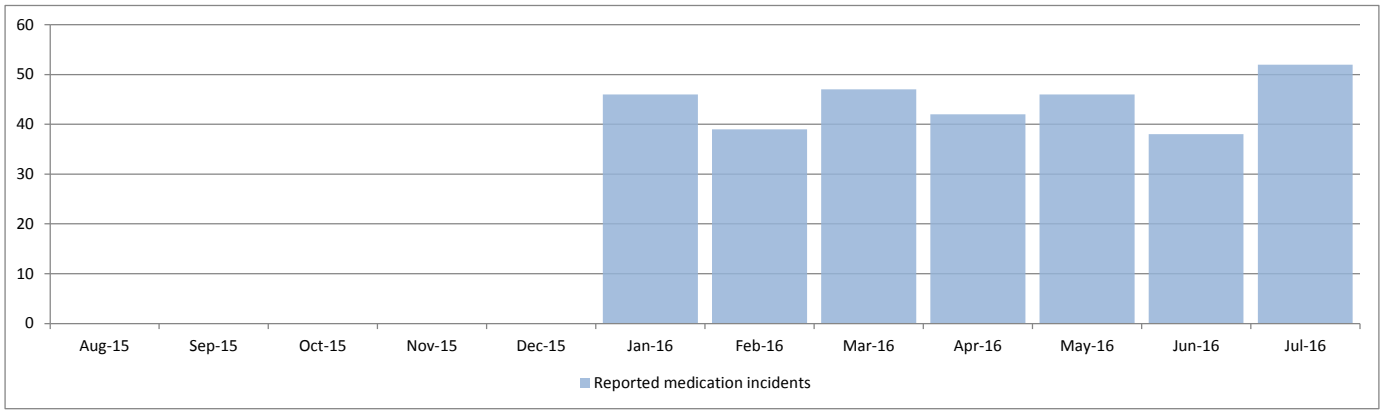
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Moderate to catastrophic harm | n/a | n/a | n/a | n/a | n/a | 0 | 0 | 0 | 2 | 1 | 0 | 0 |



QUALITY FRAMEWORK

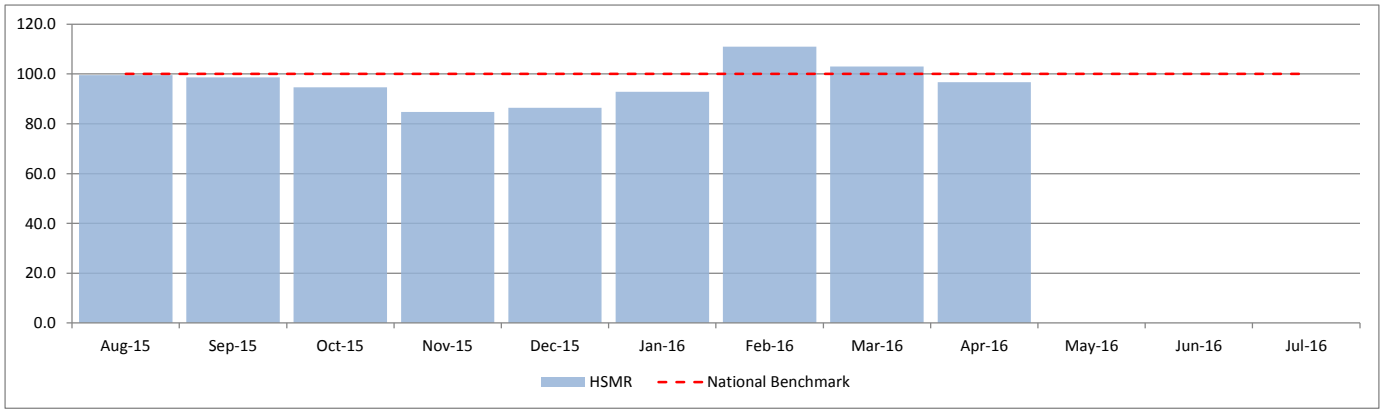
**Medication Errors - Reported incidents (trust at fault)**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reported medication incidents | n/a | n/a | n/a | n/a | n/a | 46 | 39 | 47 | 42 | 46 | 38 | 52 |




**Hospital Standardised Mortality Rate (HSMR) national benchmark = 100**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HSMR | 99.6 | 98.7 | 94.6 | 84.8 | 86.4 | 92.8 | 111.0 | 103.0 | 96.7 | | | |
| National Benchmark | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |



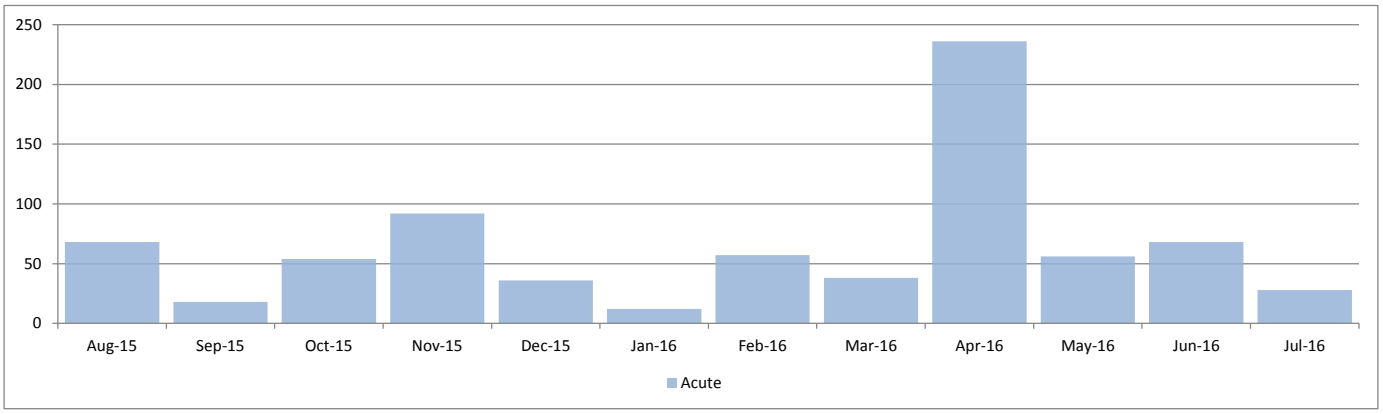

**Safer Staffing Levels**

| | Day | | Night | |
|---|---|---|---|---|
| Site | Average fill rate - registered | Average fill rate - care staff | Average fill rate - registered | Average fill rate - care staff |
| Ashburton+Buckfastleigh Hospital | 101.6% | 144.1% | 100.0% | 167.7% |
| Bovey Tracey Hospital | 0.0% | 0.0% | 0.0% | 0.0% |
| Brixham Hospital | 108.6% | 122.6% | 100.0% | 171.0% |
| Dartmouth Hospital | 97.1% | 101.9% | 100.0% | 104.8% |
| Dawlish Hosptial | 95.7% | 102.2% | 100.0% | 100.0% |
| Newton Abbot Hospital | 101.0% | 93.7% | 99.2% | 114.8% |
| Paignton Hospital | 105.8% | 98.6% | 100.0% | 100.0% |
| Teignmouth Hospital | 0.0% | 0.0% | 0.0% | 0.0% |
| Toraby Hospital | 0.0% | 0.0% | 0.0% | 0.0% |
| Totnes Hospital | 100.3% | 132.2% | 96.6% | 131.1% |
| ICO | 100.5% | 122.9% | 97.0% | 128.0% |

## QUALITY FRAMEWORK

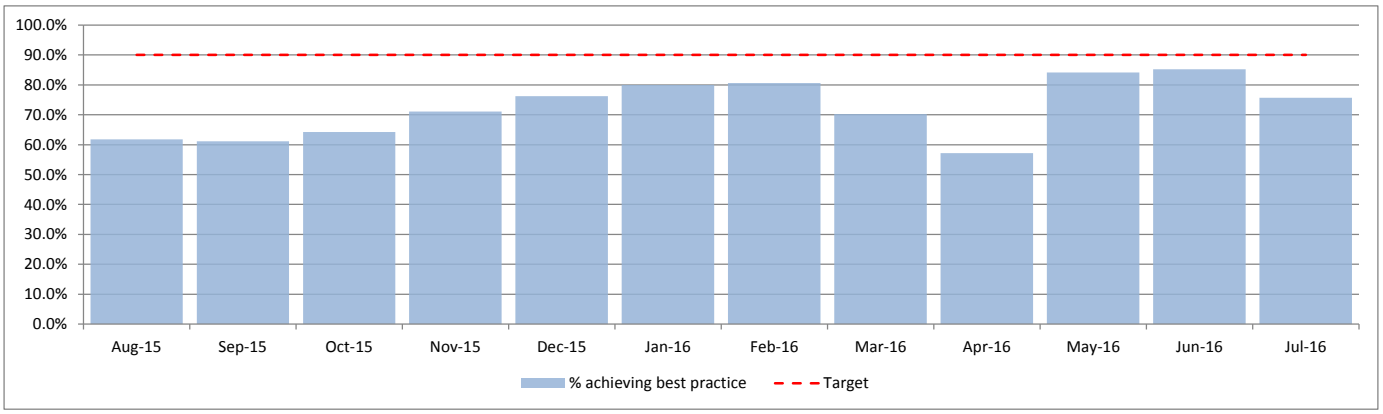
### Infection Control - Bed Closures (acute)

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 68 | 18 | 54 | 92 | 36 | 12 | 57 | 38 | 236 | 56 | 68 | 28 |



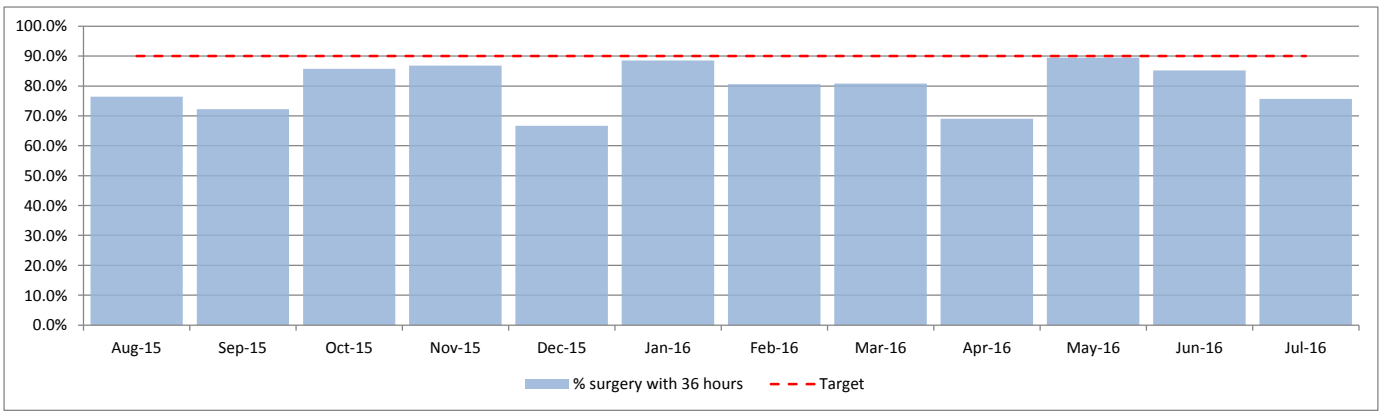

### Fracture Neck of Femur - Best tariff assessment

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | 34 | 36 | 28 | 38 | 42 | 35 | 31 | 47 | 42 | 38 | 27 | 37 |
| Achieving best practice | 21 | 22 | 18 | 27 | 32 | 28 | 25 | 33 | 24 | 32 | 23 | 28 |
| % achieving best practice | 61.8% | 61.1% | 64.3% | 71.1% | 76.2% | 80.0% | 80.6% | 70.2% | 57.1% | 84.2% | 85.2% | 75.7% |
| 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

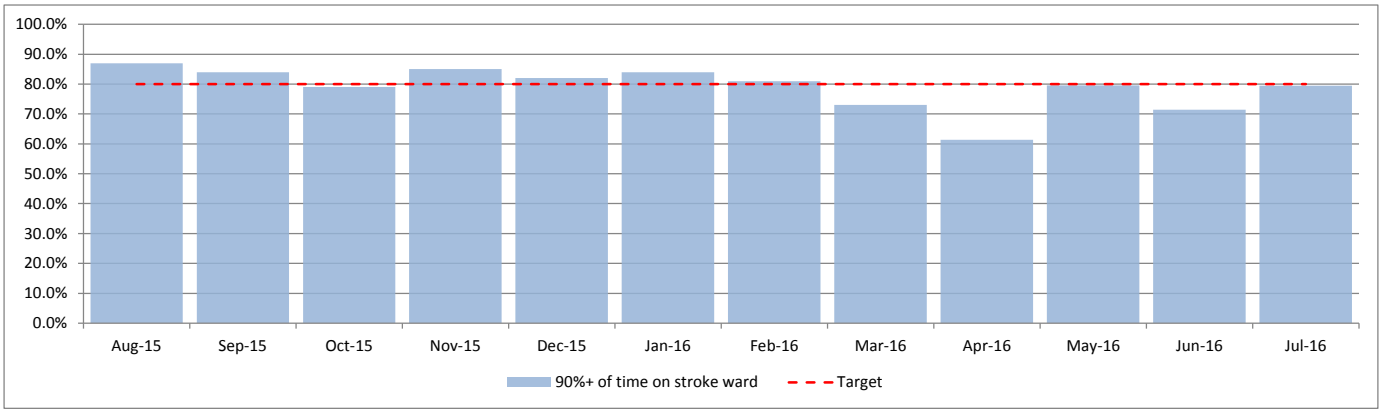
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | 34 | 36 | 28 | 38 | 42 | 35 | 31 | 47 | 42 | 38 | 27 | 37 |
| Surgery with 36 hours | 26 | 26 | 24 | 33 | 28 | 31 | 25 | 38 | 29 | 34 | 23 | 28 |
| % surgery with 36 hours | 76.5% | 72.2% | 85.7% | 86.8% | 66.7% | 88.6% | 80.6% | 80.9% | 69.0% | 89.5% | 85.2% | 75.7% |
| 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% |



QUALITY FRAMEWORK

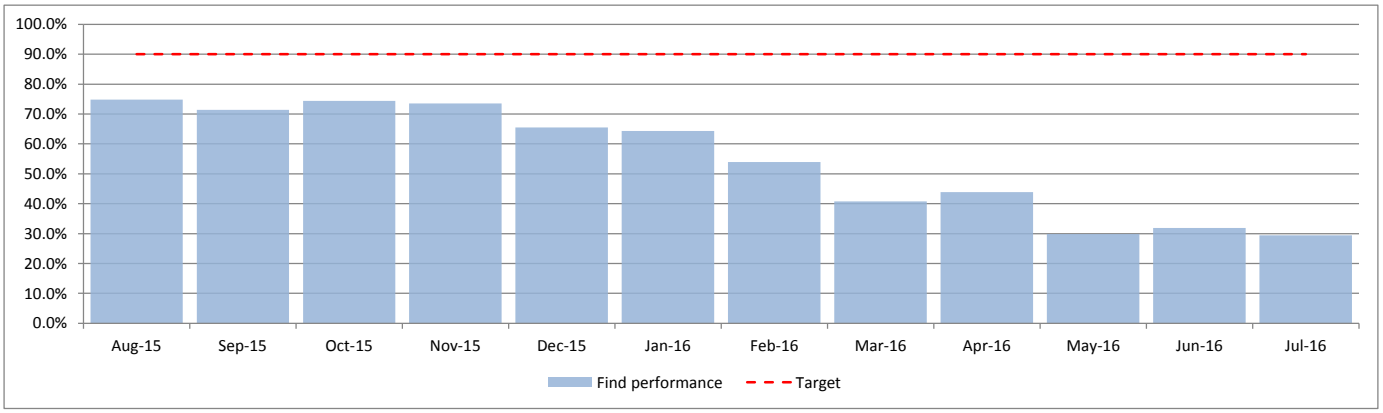
**Stroke**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 90%+ of time on stroke ward | 87.0% | 84.0% | 79.0% | 85.0% | 82.0% | 84.0% | 81.0% | 73.0% | 61.4% | 79.6% | 71.4% | 79.5% |
| 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% |



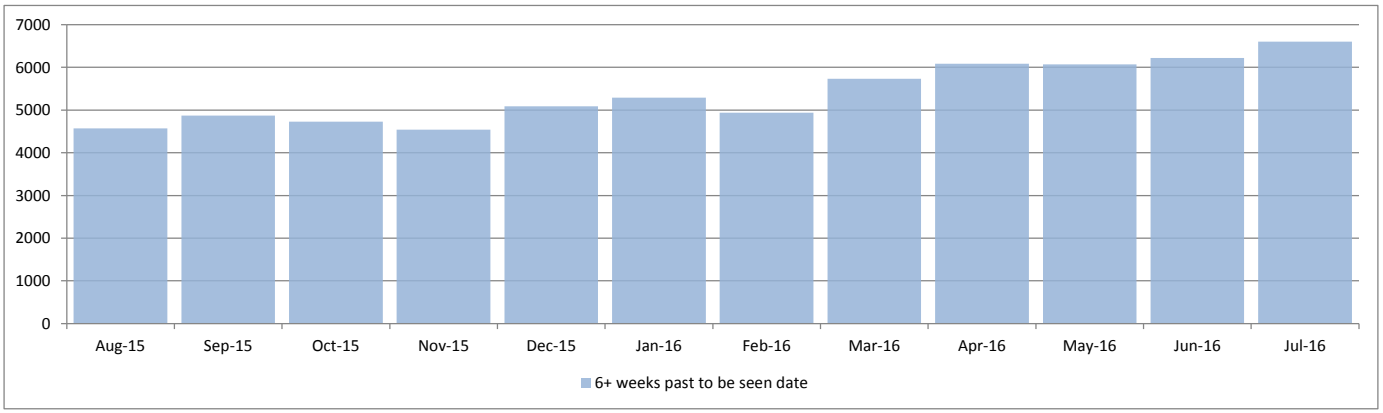

**Dementia - Find**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Numerator | 457 | 423 | 472 | 461 | 484 | 402 | 360 | 350 | 366 | 303 | 250 | 120 |
| Denominator | 543 | 532 | 581 | 556 | 630 | 558 | 545 | 584 | 607 | 662 | 548 | 408 |
| Find performance | 74.8% | 71.4% | 74.4% | 73.5% | 65.5% | 64.3% | 54.0% | 40.7% | 43.9% | 29.8% | 31.9% | 29.4% |
| 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% |




**Follow ups past to be seen date**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6+ weeks past to be seen date | 4570 | 4873 | 4731 | 4542 | 5090 | 5291 | 4938 | 5732 | 6082 | 6073 | 6219 | 6601 |



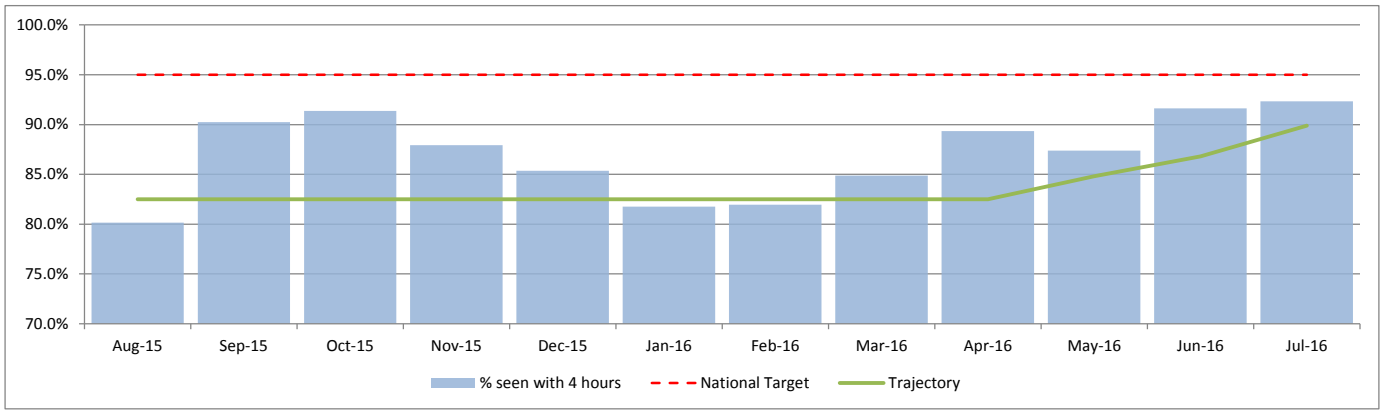
# NHS I COMPLIANCE FRAMEWORK

**Month 4 July 2016**

## NHS I COMPLIANCE FRAMEWORK

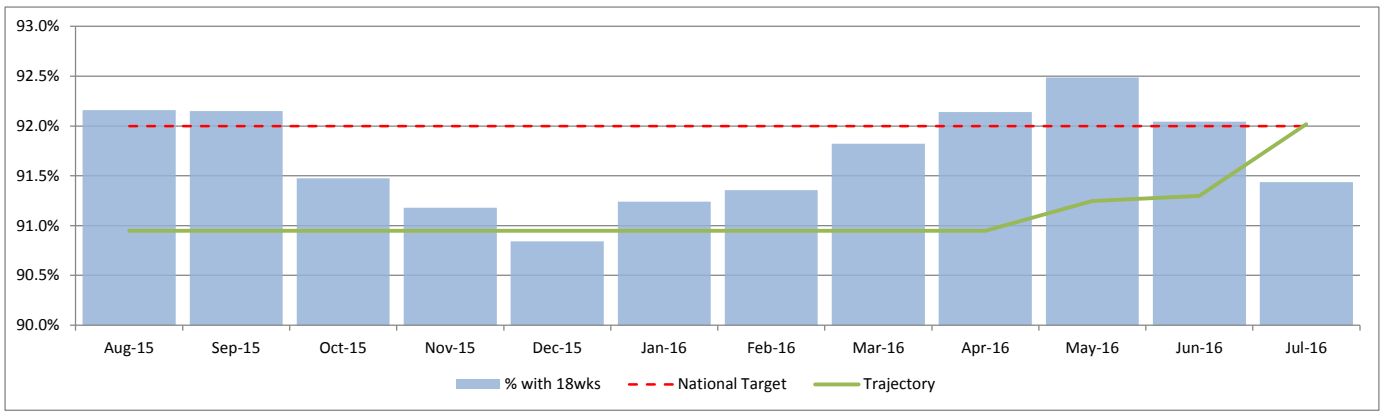
### A&E and MIU patients seen within 4 hours

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | 6209 | 6087 | 8712 | 8451 | 8135 | 8223 | 8084 | 9298 | 8627 | 9741 | 9672 | 10679 |
| 4 hour breaches | 1232 | 594 | 753 | 1020 | 1192 | 1500 | 1459 | 1406 | 918 | 1229 | 810 | 820 |
| % seen with 4 hours | **80.2%** | **90.2%** | **91.4%** | **87.9%** | **85.3%** | **81.8%** | **82.0%** | **84.9%** | **89.4%** | **87.4%** | **91.6%** | **92.3%** |
| National 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% |
| Trajectory | 82.5% | 82.5% | 82.5% | 82.5% | 82.5% | 82.5% | 82.5% | 82.5% | 82.5% | 84.8% | 86.8% | 89.9% |



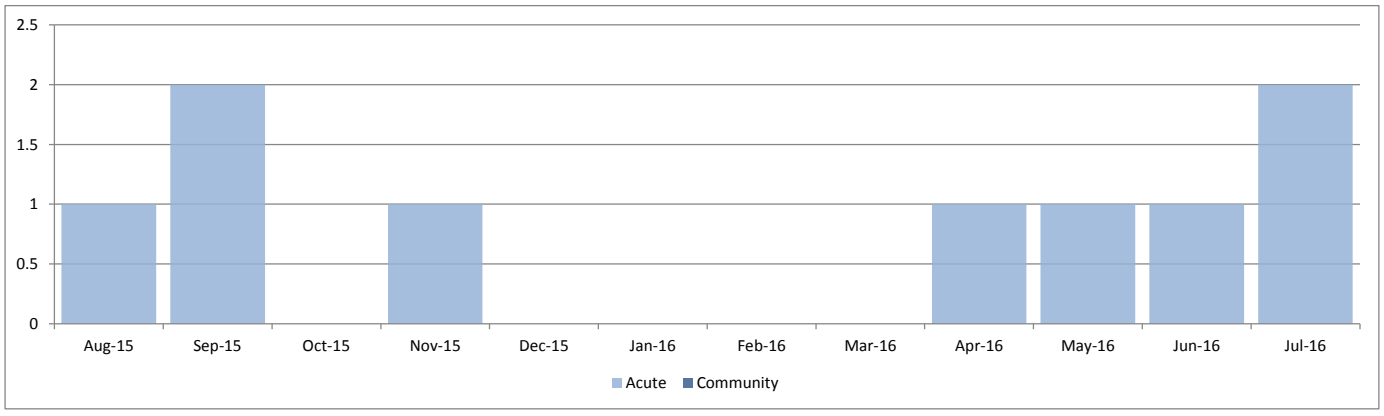

### Referral to Treatment - Incomplete pathways

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incomplete <18wks | 15763 | 14849 | 14140 | 14100 | 14503 | 14292 | 14566 | 14518 | 14771 | 15194 | 15119 | 15255 |
| Incomplete >18wks | 1341 | 1265 | 1318 | 1364 | 1462 | 1372 | 1378 | 1293 | 1260 | 1234 | 1307 | 1429 |
| % with 18wks | **92.2%** | **92.1%** | **91.5%** | **91.2%** | **90.8%** | **91.2%** | **91.4%** | **91.8%** | **92.1%** | **92.5%** | **92.0%** | **91.4%** |
| 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% | 91.2% | 91.3% | 92.0% |




### C Diff. Lapse in Care

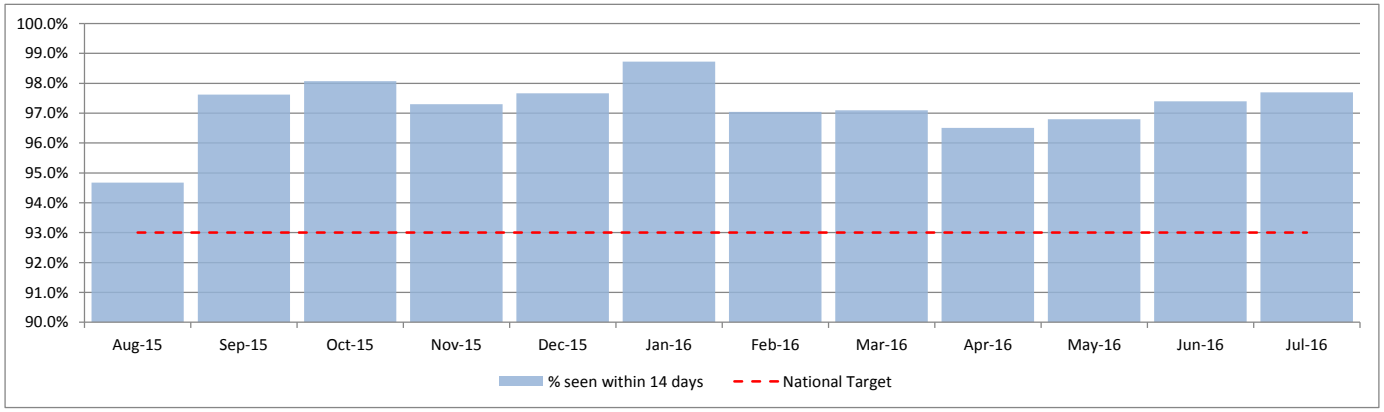
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 2 |
| Community | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |



NHS I COMPLIANCE FRAMEWORK

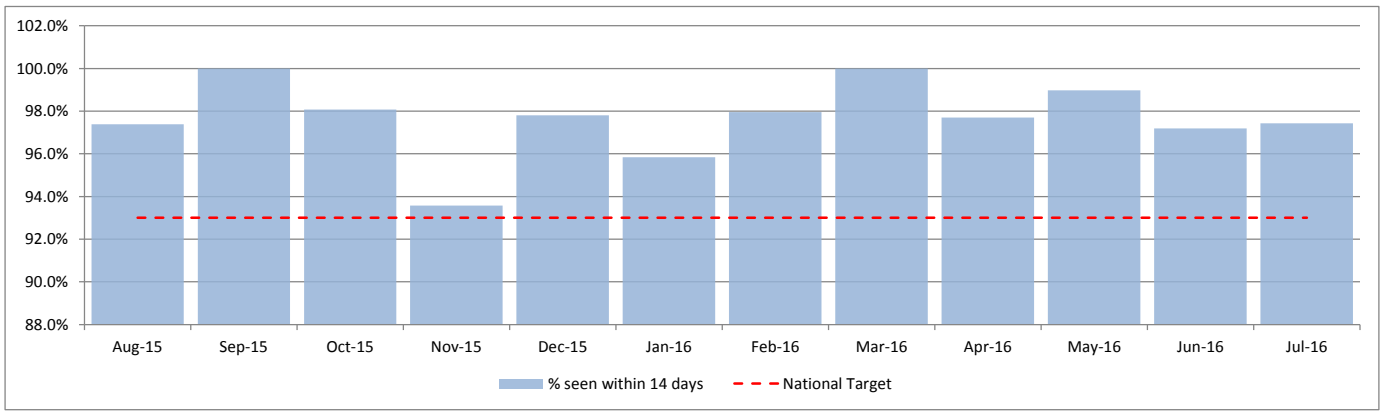
**Cancer - Two Week Wait Referrals**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2ww Referrals | 826 | 884 | 879 | 889 | 897 | 705 | 846 | 965 | 888 | 997 | 997 | 953 |
| Seen within 14 days | 782 | 863 | 862 | 865 | 876 | 696 | 821 | 937 | 857 | 965 | 971 | 931 |
| % seen within 14 days | 94.7% | 97.6% | 98.1% | 97.3% | 97.7% | 98.7% | 97.0% | 97.1% | 96.5% | 96.8% | 97.4% | 97.7% |
| 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% |



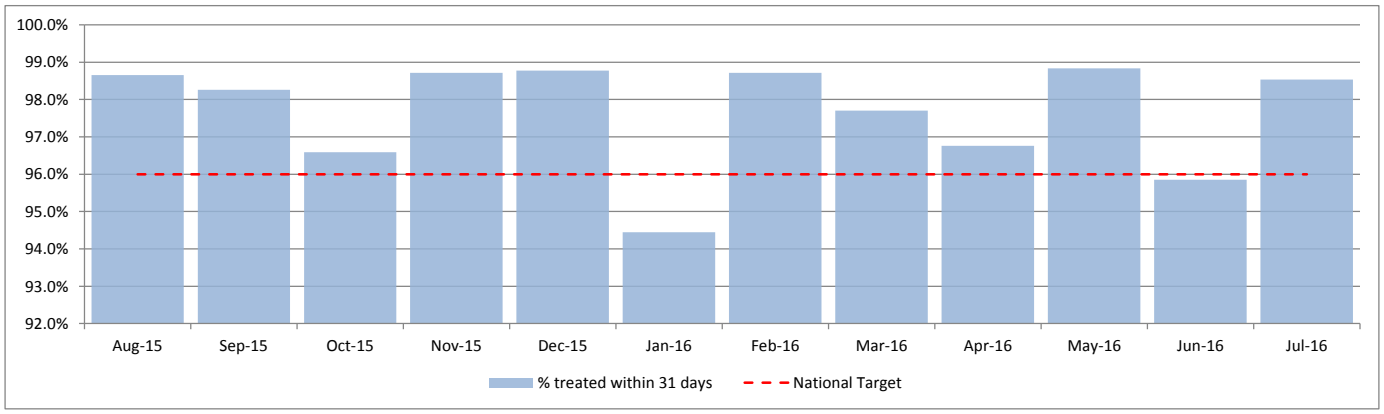

**Cancer - Breast Symptomatic Referrals**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breast symptomatic referrals | 115 | 90 | 104 | 109 | 137 | 96 | 98 | 130 | 87 | 97 | 107 | 78 |
| Seen within 14 days | 112 | 90 | 102 | 102 | 134 | 92 | 96 | 130 | 85 | 96 | 104 | 76 |
| % seen within 14 days | 97.4% | 100.0% | 98.1% | 93.6% | 97.8% | 95.8% | 98.0% | 100.0% | 97.7% | 99.0% | 97.2% | 97.4% |
| 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 - 31 day wait from decision to treat to first treatment**

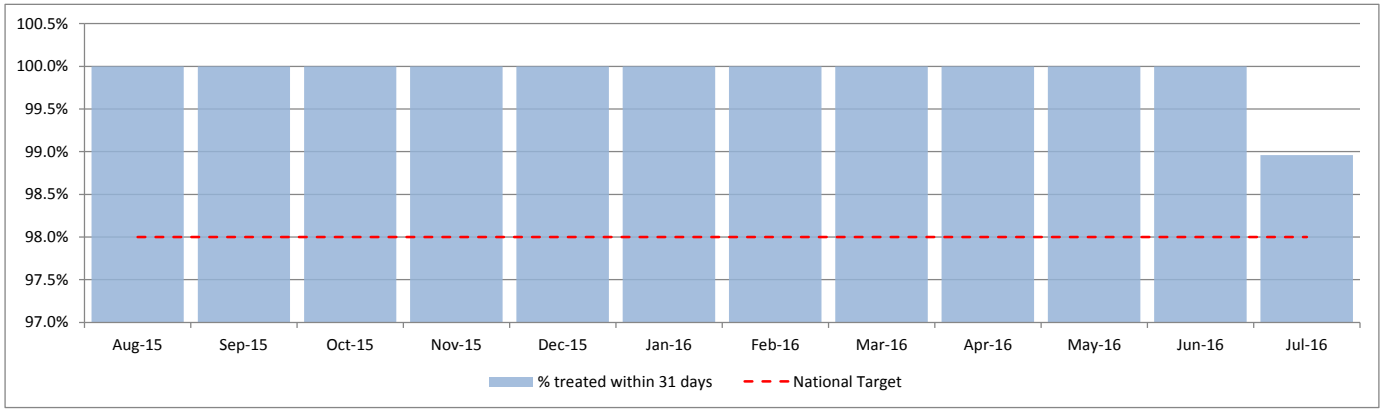
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1st treatments | 149 | 172 | 176 | 156 | 163 | 162 | 155 | 174 | 185 | 172 | 193 | 205 |
| Breaches of 31 day target | 2 | 3 | 6 | 2 | 2 | 9 | 2 | 4 | 6 | 2 | 8 | 3 |
| % treated within 31 days | 98.7% | 98.3% | 96.6% | 98.7% | 98.8% | 94.4% | 98.7% | 97.7% | 96.8% | 98.8% | 95.9% | 98.5% |
| 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% |



NHS I COMPLIANCE FRAMEWORK

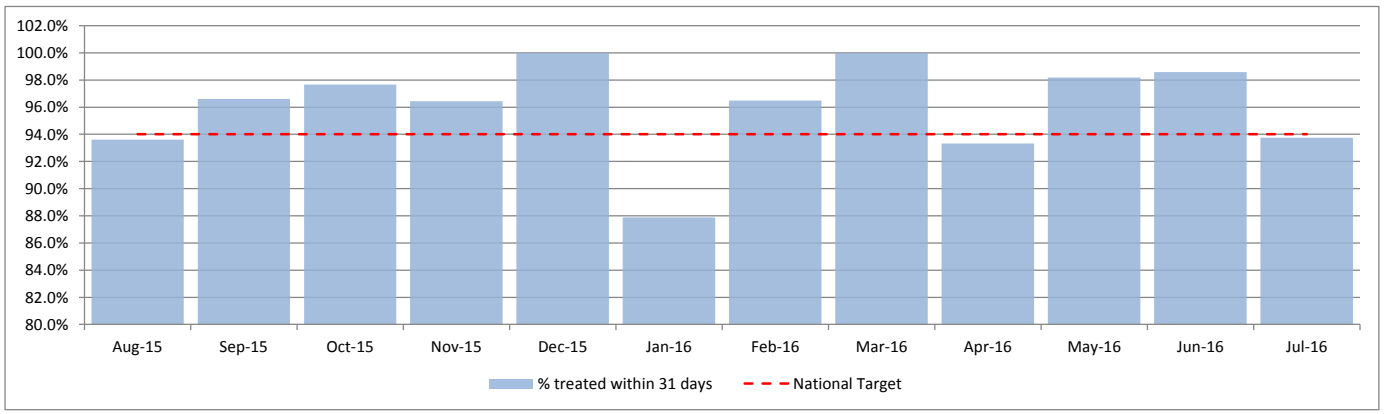
**Cancer - 31 day wait for second or subsequent treatment - Drug**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Subsequent Drug treatments | 38 | 55 | 52 | 49 | 47 | 59 | 52 | 62 | 70 | 68 | 85 | 96 |
| Breaches of 31 day target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| % 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% | 99.0% |
| 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% |



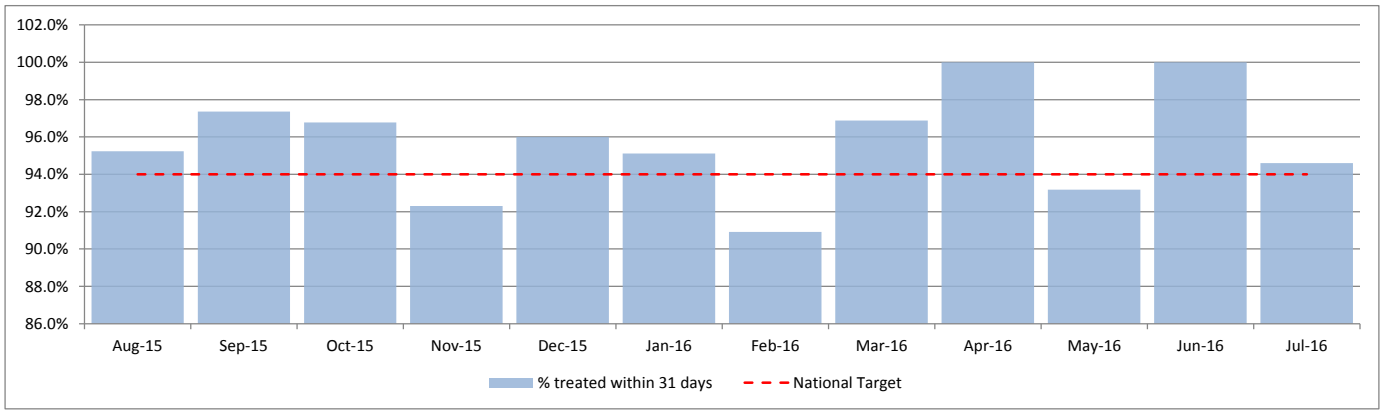

**Cancer - 31 day wait for second or subsequent treatment - Radiotherapy**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sub radiotherapy treatments | 47 | 59 | 43 | 56 | 42 | 66 | 57 | 64 | 45 | 55 | 71 | 48 |
| Breaches of 31 day target | 3 | 2 | 1 | 2 | 0 | 8 | 2 | 0 | 3 | 1 | 1 | 3 |
| % treated within 31 days | 93.6% | 96.6% | 97.7% | 96.4% | 100.0% | 87.9% | 96.5% | 100.0% | 93.3% | 98.2% | 98.6% | 93.8% |
| 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**

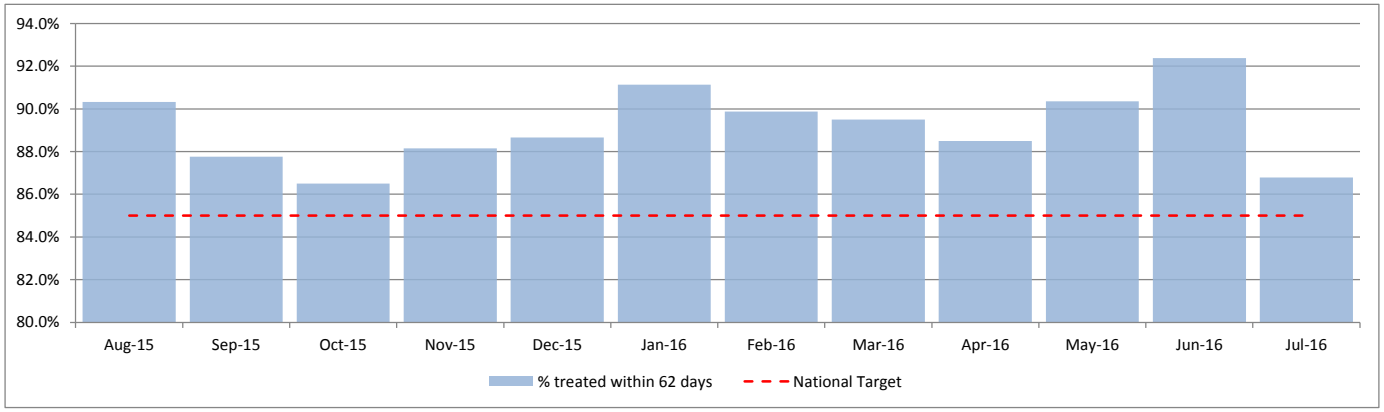
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Subsequent surgery treatments | 21 | 38 | 31 | 39 | 25 | 41 | 44 | 32 | 30 | 44 | 40 | 37 |
| Breaches of 31 day target | 1 | 1 | 1 | 3 | 1 | 2 | 4 | 1 | 0 | 3 | 0 | 2 |
| % treated within 31 days | 95.2% | 97.4% | 96.8% | 92.3% | 96.0% | 95.1% | 90.9% | 96.9% | 100.0% | 93.2% | 100.0% | 94.6% |
| 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% |



NHS I COMPLIANCE FRAMEWORK

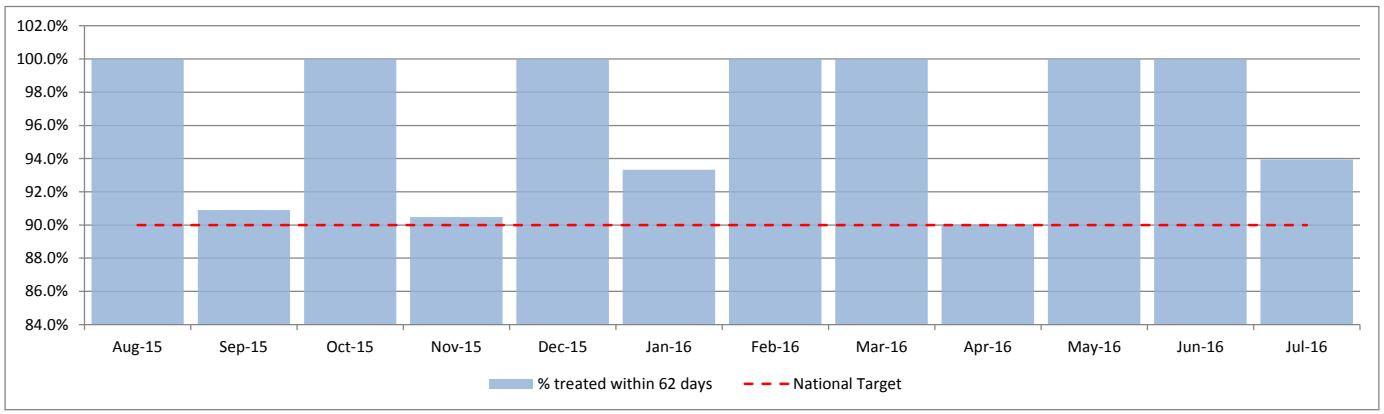
**Cancer - 62 day wait for 1st treatment from 2ww referral**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1st treatments (from 2ww) | 77.5 | 98 | 100 | 76 | 75 | 79 | 79 | 90.5 | 100 | 98.5 | 105 | 106 |
| Breaches of 62 day target | 7.5 | 12 | 13.5 | 9 | 8.5 | 7 | 8 | 9.5 | 11.5 | 9.5 | 8 | 14 |
| % treated within 62 days | 90.3% | 87.8% | 86.5% | 88.2% | 88.7% | 91.1% | 89.9% | 89.5% | 88.5% | 90.4% | 92.4% | 86.8% |
| 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**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1st treatments (from screening) | 8 | 11 | 11 | 10.5 | 15.5 | 15 | 7 | 13.5 | 20 | 14 | 15 | 16.5 |
| Breaches of 62 day target | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 |
| % treated within 62 days | 100.0% | 90.9% | 100.0% | 90.5% | 100.0% | 93.3% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 93.9% |
| 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% |



# FINANCE FRAMEWORK AND SCHEDULES



Month 4 July 2016

**Income Analysis** **Schedule 1**

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month | |
|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Changes PbR to RSA Plan | Variance to RSA Plan | Variance to RSA Plan | Change |
| **Healthcare Income - Commissioner Analysis** | | | | | | | |
| | £m | £m | £m | £m | £m | £m | |
| South Devon & Torbay Clinical Commissioning Group | 54.30 | 56.72 | 2.41 | 2.22 | 0.19 | (0.43) | ↓ |
| North, East & West Devon Clinical Commissioning Group | 1.74 | 1.79 | 0.04 | 0.00 | 0.04 | (0.01) | ↓ |
| NHS England - Area Team | 2.55 | 2.46 | (0.09) | 0.00 | (0.09) | (0.09) | ↔ |
| NHS England - Specialist Commissioning | 9.55 | 8.95 | (0.60) | (0.08) | (0.52) | (0.35) | ↑ |
| Other Commissioners | 4.86 | 5.00 | 0.13 | 0.02 | 0.12 | 0.42 | ↑ |
| **Sub-Total Acute** | **73.01** | **74.91** | **1.90** | **2.16** | **(0.26)** | **(0.46)** | ↑ |
| South Devon & Torbay Clinical Commissioning Group (Placed | 25.61 | 26.31 | 0.70 | 0.70 | 0.00 | (0.00) | ↔ |
| Other Commissioners | 0.82 | 0.79 | (0.03) | (0.03) | 0.00 | 0.00 | ↔ |
| **Total Acute and Community** | **99.43** | **102.01** | **2.57** | **2.83** | **(0.26)** | (0.46) | ↑ |

| **Healthcare Income - By Business Unit** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | |
| Medical Services | 30.33 | 29.65 | - 0.67 | (0.16) | (0.52) | (1.04) | ↓ |
| Surgical Services | 22.80 | 22.82 | 0.02 | (0.00) | 0.01 | (0.38) | ↓ |
| Women's, Childrens & Diagnostic Services | 14.52 | 14.28 | - 0.24 | (0.59) | 0.36 | (0.08) | ↓ |
| Community Services | 26.42 | 27.09 | 0.67 | 0.67 | (0.00) | 0.00 | ↔ |
| Non-Clinical Services / Central Contract Income | 5.36 | 8.16 | 2.79 | 2.92 | (0.11) | 1.04 | ↑ |
| **Total** | **99.43** | **102.01** | **2.58** | **2.83** | **(0.25)** | (0.46) | ↑ |

| **Healthcare Activity - By Setting** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Activity | Activity | Activity | Activity | Activity | Activity | |
| Elective In-Patient Admissions | 1,424 | 1,476 | 52 | 165 | (113) | (115) | ↓ |
| Elective Day Case Admission | 11,152 | 11,391 | 239 | 359 | (120) | 313 | ↑ |
| Urgent & Emergency Admissions | 38,780 | 38,723 | (57) | 183 | (240) | (100) | ↑ |
| Out-Patients | 146,448 | 152,222 | 5,774 | 2,409 | 3,365 | 4,476 | ↑ |
| Community Services | | | | | | | |
| **Total** | **197,804** | **203,812** | **6,008** | **3,116** | **2,892** | **4,574** | ↑ |

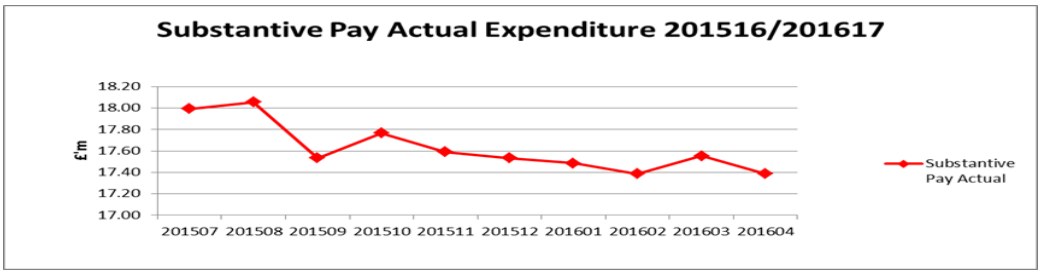
| **Social Care Income** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | |
| Torbay Council - ASC Contract income | 13.55 | 13.03 | (0.52) | (0.52) | (0.00) | (0.00) | ↔ |
| Torbay Council - Public Health Income | 1.66 | 1.77 | 0.12 | 0.00 | 0.12 | 0.00 | ↑ |
| Torbay Council - Client Income | 3.29 | 3.47 | 0.18 | 0.11 | 0.06 | 0.05 | ↑ |
| **Total** | **18.50** | **18.27** | **(0.23)** | **(0.41)** | **0.18** | **0.05** | ↑ |

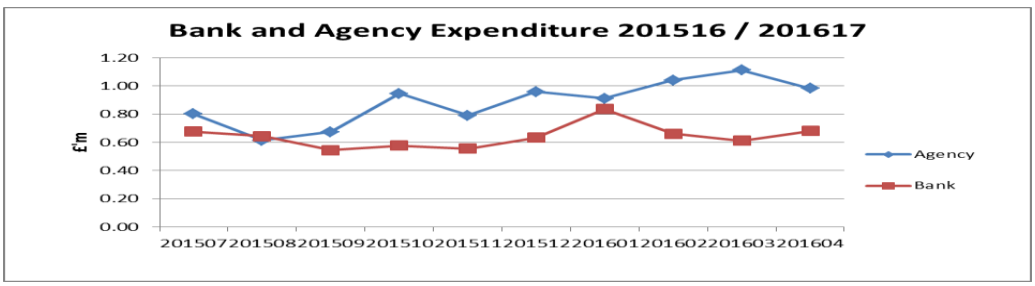
| **Other Income** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | |
| Non Mandatory/Non protected clinical revenue | 0.50 | 0.53 | 0.03 | (0.00) | 0.03 | (3.21) | ↑ |
| R&D / Education & training revenue | 2.91 | 2.97 | 0.07 | 0.00 | 0.07 | 0.09 | ↑ |
| Site Services | 0.74 | 0.76 | 0.02 | 0.00 | 0.02 | (0.00) | ↑ |
| Revenue from non-patient services to other bodies | 1.82 | 1.85 | 0.03 | 0.00 | 0.03 | 0.01 | ↑ |
| Misc. other operating revenue | 7.74 | 7.71 | (0.03) | 0.00 | (0.03) | 0.71 | ↑ |
| **Total** | **13.71** | **13.82** | **0.11** | **0.00** | **0.11** | **(2.41)** | ↑ |

**Employee Expenses** **Schedule 2**

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Employee Expenses - By Category** | | | | | | | |
| Medical and Dental staff | 17.47 | 17.18 | 0.29 | 0.15 | 0.44 | 0.44 | ↔ |
| Registered nurses, midwives and health visiting staff | 18.87 | 19.70 | (0.83) | 0.24 | (0.59) | (0.53) | ↑ |
| Qualified scientific, therapeutic and technical staff | 14.81 | 14.18 | 0.62 | 0.12 | 0.74 | 0.48 | ↑ |
| Support to clinical staff | 6.15 | 6.97 | (0.82) | 0.00 | (0.82) | (0.66) | ↑ |
| Managers and infrastructure Support | 18.09 | 18.62 | (0.53) | 0.31 | (0.23) | (0.03) | ↑ |
| **Total** | **75.38** | **76.66** | **(1.27)** | **0.82** | **(0.46)** | **(0.31)** | ↑ |
| **Employee Expenses - By Type** | | | | | | | |
| Substantive | 70.68 | 69.75 | 0.92 | 0.81 | 1.74 | 1.03 | ↑ |
| Bank | 1.16 | 2.79 | (1.63) | 0.00 | (1.63) | (1.24) | ↑ |
| Locum | 0.58 | 0.53 | 0.04 | 0.00 | 0.04 | 0.06 | ↓ |
| Agency | 2.96 | 3.58 | (0.61) | 0.00 | (0.61) | (0.17) | ↑ |
| **Total** | **75.38** | **76.66** | **(1.28)** | **0.81** | **(0.46)** | **(0.31)** | ↑ |
| **Employee Expenses - By Service** | | | | | | | |
| Medical Services | 13.78 | 15.19 | (1.40) | 0.00 | (1.40) | (0.94) | ↑ |
| Surgical Services | 15.55 | 15.59 | (0.04) | 0.00 | (0.04) | 0.12 | ↑ |
| Women's, Childrens & Diagnostic Services | 12.47 | 12.72 | (0.24) | 0.00 | (0.24) | (0.08) | ↑ |
| Community Services | 14.78 | 14.69 | 0.09 | 0.03 | 0.12 | 0.20 | ↓ |
| Non-Clinical Services + Harmonisation | 18.79 | 18.47 | 0.32 | 0.79 | 1.10 | 0.38 | ↑ |
| **Total** | **75.38** | **76.66** | **(1.28)** | **0.81** | **(0.46)** | **(0.31)** | ↑ |

**Pay run rates Oct 2015 - July 2016**



**Torbay and South Devon NHS Foundation Trust**
**Trust Agency Information**
**Financial Year 2016/17**

| **All Staff Group** | **April** | **May** | **June** | **July** | **YTD 2016-17** |
|---|---|---|---|---|---|
| **NHS Improvement - revised Ceiling (June 2016)** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.662) | (0.643) | (0.623) | (0.590) | (2.519) |
| Total Planned Staff Costs | (18.898) | (18.901) | (18.904) | (18.678) | (75.380) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 4% | 3% | 3% | 3% | 3% |
| | | | | | |
| | **April** | **May** | **June** | **July** | **YTD 2016-17** |
| **ICO Actual** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.911) | (1.043) | (1.112) | (0.983) | (4.049) |
| Total Actual Staff Cost | (19.231) | (19.090) | (19.565) | (19.053) | (76.939) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 5% | 5% | 6% | 5% | 5% |
| | | | | | |
| | **April** | **May** | **June** | **July** | **YTD 2016-17** |
| **Variance against Revised Ceiling** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.249) | (0.400) | (0.489) | (0.393) | (1.530) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 1% | 2% | 2% | 2% | 2% |
| | | | | | |
| **Nursing only** | **April** | **May** | **June** | **July** | **YTD 2016-17** |
| **NHS Improvement - revised Ceiling (June 2016)** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.272) | (0.266) | (0.259) | (0.168) | (0.965) |
| Total Planned Staff Costs | (4.633) | (4.631) | (4.629) | (4.723) | (18.617) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 6% | 6% | 6% | 4% | 5% |
| | | | | | |
| | **April** | **May** | **June** | **July** | **YTD 2016-17** |
| **ICO Actual** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.442) | (0.544) | (0.552) | (0.457) | (1.995) |
| Total Actual Staff Cost | (4.980) | (4.927) | (4.993) | (4.824) | (19.724) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 9% | 11% | 11% | 9% | 10% |
| | | | | | |
| | **April** | **May** | **June** | **July** | **YTD 2016-17** |
| **Variance against Revised Ceiling** | £m | £m | £m | £m | £m |
| Total Bank, Overtime (OT) and Agency Staff Cost | (0.170) | (0.278) | (0.293) | (0.289) | (1.030) |
| **% of Bank, OT & Agency Costs against Total Staff Cost** | 3% | 5% | 5% | 6% | 5% |
| | | | | | |
| **Comment** | M1 to M4 Actual is higher than revised Ceiling by £1.0m YTD, 5% more than the revised ceiling of 5% | | | | |

**Improvement Plan**

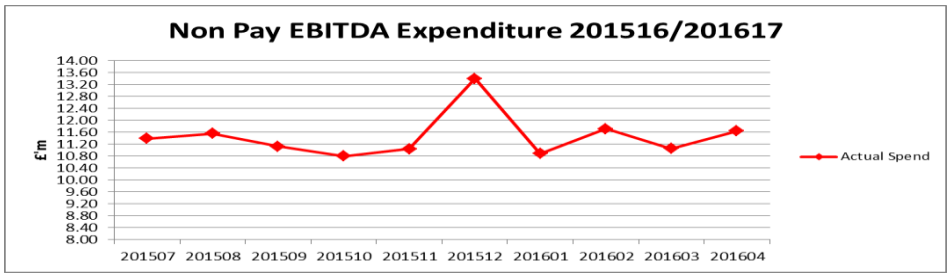
| No. | Action | Lead | Date |
|---|---|---|---|
| 1 | Nursing agency shifts all approved by a Director | JV | ongoing |
| 2 | Medical Agency and Locum Approved by a Director | RD | ongoing |
| 3 | Recruitment processes streamlined and regular for key clinical staff | MR | Ongoing |
| 4 | Overseas Recruitment of Nursing Staff | MR/JV | in progress |

| **Governance Arrangements** |
|---|
| Senior Business management Team, Exec Team meetings ,Finance Committee |

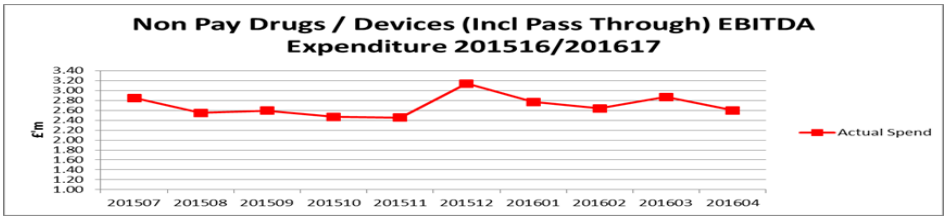
**Non Pay Expenses** **Schedule 4**

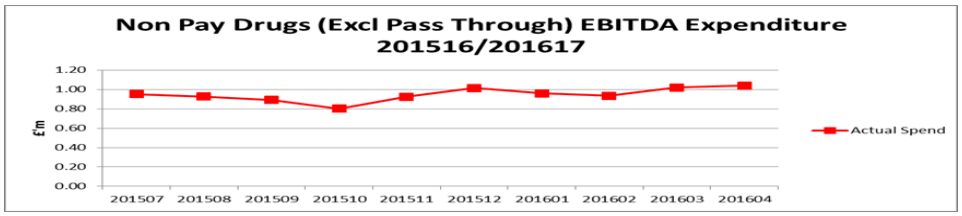
| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Non Pay Expenses - By Category** | | | | | | | |
| Clinical Supplies | 7.30 | 7.63 | (0.33) | 0.00 | (0.33) | (0.26) | ↑ |
| Drugs (Excluding Pass through) | 3.63 | 3.67 | (0.04) | 0.00 | (0.04) | 0.04 | ↑ |
| Pass through Drugs, Blood and Devices | 6.72 | 7.21 | (0.50) | 0.25 | (0.24) | (0.35) | ↓ |
| Non Clinical Supplies | 0.92 | 0.98 | (0.06) | 0.00 | (0.06) | (0.02) | ↑ |
| Miscellaneous / Other | 35.25 | 36.38 | (1.12) | 2.26 | 1.14 | 1.31 | ↓ |
| **Total** | **53.82** | **55.87** | **(2.04)** | **2.51** | **0.47** | **0.71** | ↓ |

Non pay run rates Oct 2015 - July 2016




Increase in non pay EBITDA expenditure month 12 2015/16 (201512) was due to Adult Social Care back dated Care Home fee. Income was received to offset and cover these costs.



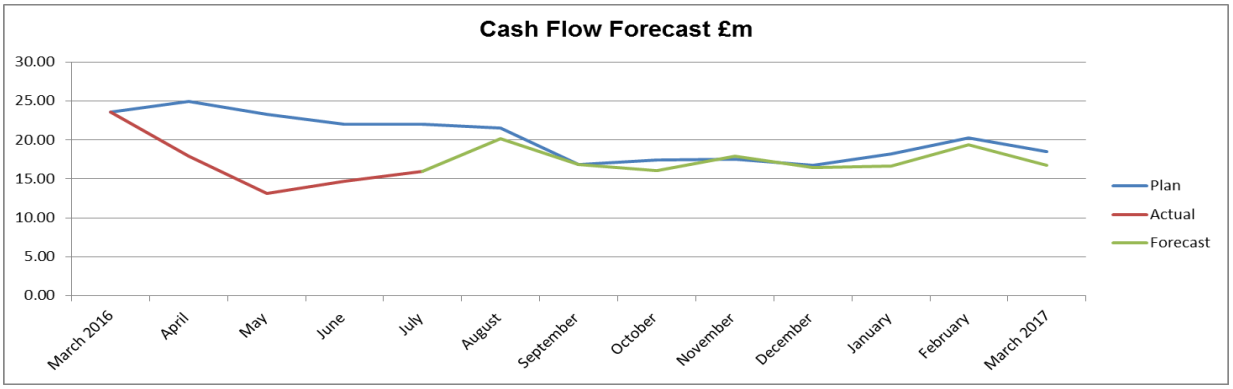



**Cash Flow** **Schedule 5**

| | Year to Date - Month 04 | | | Plan Changes | | Previous Month YTD | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance to RSA Plan £m | Change |
| **Opening Cash Balance** | **23.57** | **23.57** | **0.00** | **0.00** | **0.00** | 0.00 | ↔ |
| Cash Generated From Operations | 2.56 | 0.98 | (1.58) | (0.90) | (0.68) | 0.25 | ↓ |
| Debtor Movements | 4.51 | (5.32) | (9.83) | (3.50) | (6.33) | (8.51) | ↑ |
| Creditor Movements | (1.80) | (0.25) | 1.55 | 0.00 | 1.55 | 1.53 | ↑ |
| Capital Expenditure | (8.25) | (4.55) | 3.70 | 0.00 | 3.70 | 3.11 | ↑ |
| Net Interest | (0.82) | (0.80) | 0.02 | 0.00 | 0.02 | 0.15 | ↓ |
| Loan drawndown | 2.99 | 2.63 | (0.36) | 0.00 | (0.36) | (0.81) | ↑ |
| Loan repayment | (0.38) | (0.24) | 0.14 | 0.00 | 0.14 | 0.03 | ↑ |
| PDC Dividend | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | ↔ |
| Other | (0.32) | (0.03) | 0.29 | 0.00 | 0.29 | (0.13) | ↑ |
| **Current Cash Balance** | **22.06** | **15.99** | **(6.07)** | **(4.40)** | **(1.67)** | (4.38) | ↑ |

**Cash Flow Forecast**

| | Full Year | | | Plan Changes | | Previous Month | |
|---|---|---|---|---|---|---|---|
| | Plan £m | Forecast £m | Variance £m | Changes PbR to RSA Plan £m | Variance to RSA Plan £m | Variance £m | Change |
| **Cash Flow** | | | | | | | |
| **Opening Cash Balance - 01/04/2016** | **23.57** | **23.57** | **0.00** | **0.00** | **0.00** | | |
| Cash Generated From Operations | 22.36 | 11.36 | (11.00) | (10.32) | (0.68) | (1.12) | ↓ |
| Debtor Movements | 4.41 | 4.14 | (0.27) | (0.27) | 0.00 | (0.87) | ↑ |
| Creditor Movements | (2.10) | (1.81) | 0.29 | 0.00 | 0.29 | 0.00 | ↑ |
| Capital Expenditure | (36.90) | (23.14) | 13.76 | 13.76 | (0.00) | 0.00 | ↔ |
| Net Interest | (2.90) | (2.90) | 0.00 | 0.00 | 0.00 | 0.00 | ↔ |
| Loan drawndown | 18.65 | 13.35 | (5.30) | (5.30) | 0.00 | 0.00 | ↔ |
| Loan repayment | (5.95) | (5.95) | 0.00 | 0.00 | 0.00 | 0.00 | ↔ |
| PDC Dividend | (2.58) | (1.79) | 0.79 | 0.00 | 0.79 | 0.00 | ↑ |
| Other | (0.08) | (0.07) | 0.01 | 0.00 | 0.01 | 0.30 | ↓ |
| **Forecast Cash Balance - 31/03/2017** | **18.48** | **16.76** | **(1.72)** | **(2.13)** | **0.41** | **(1.69)** | ↑ |



**Capital** **Schedule 6**

| | Year to date - Based upon Annual Plan | | | Full year Annual Plan versus | |
|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Forecast £m |
| **Capital Programme** | 8.25 | 4.55 | (3.70) | 36.90 | 23.15 |
| **Significant Variances in Planned Expenditure by Scheme:** | | | | | |
| HIS schemes | 1.65 | 0.57 | (1.08) | 9.08 | 5.32 |
| Estates schemes | 4.92 | 3.56 | (1.36) | 16.28 | 10.84 |
| Medical Equipment | 0.47 | 0.12 | (0.35) | 7.70 | 4.79 |
| Other | 0.12 | 0.00 | (0.12) | 0.05 | 0.10 |
| PMU | 0.76 | 0.30 | (0.46) | 1.60 | 1.72 |
| Contingency | 0.33 | 0.00 | (0.33) | 2.19 | 0.38 |
| Prior Year schemes | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Total** | 8.25 | 4.55 | (3.70) | 36.90 | 23.15 |

| | | | | | |
|---|---|---|---|---|---|
| **Funding sources** | | | | | |
| Secured loans | | | | 10.94 | 10.94 |
| Unsecured loans | | | | 7.71 | 2.41 |
| Charitable Funds | | | | 2.60 | 2.60 |
| Internal cash resources | | | | 15.65 | 7.20 |
| Total | | | | **36.90** | **23.15** |

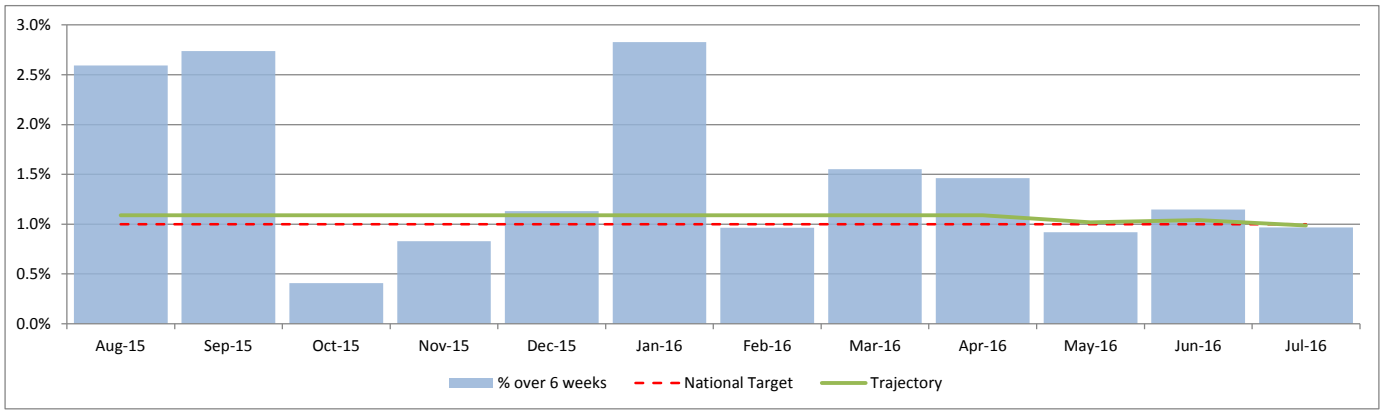
# CONTRACTUAL FRAMEWORK

**Month 4 July 2016**

CONTRACTUAL FRAMEWORK

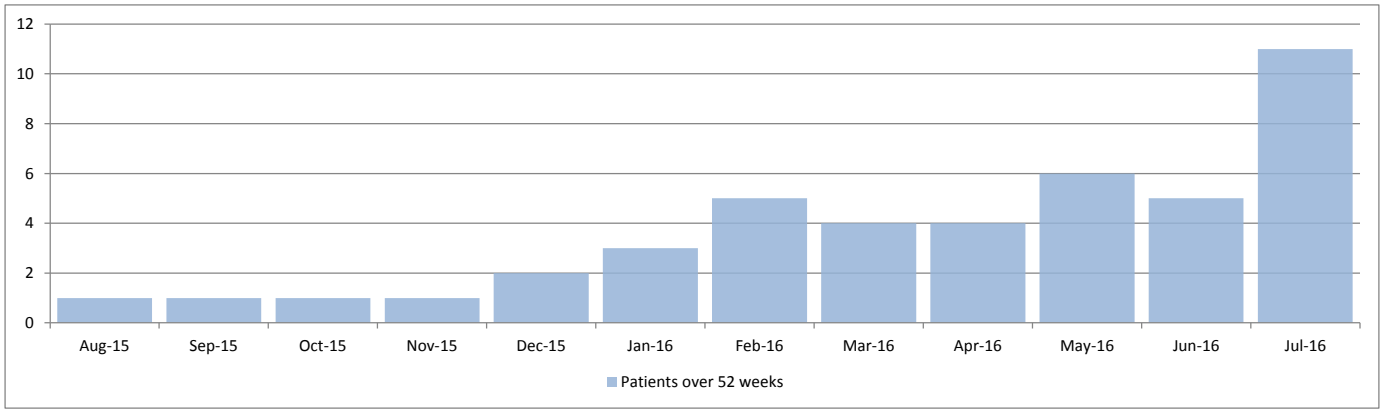
**Diagnostic Tests Longer than the 6 week standard**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | 3470 | 3688 | 3667 | 3382 | 3800 | 3750 | 3637 | 3543 | 3693 | 3377 | 3750 | 3208 |
| Waiting longer than 6 weeks | 90 | 101 | 15 | 28 | 43 | 106 | 35 | 55 | 54 | 31 | 43 | 31 |
| % over 6 weeks | **2.6%** | **2.7%** | **0.4%** | **0.8%** | **1.1%** | **2.8%** | **1.0%** | **1.6%** | **1.5%** | **0.9%** | **1.1%** | **1.0%** |
| 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 | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.09% | 1.02% | 1.04% | 0.99% |



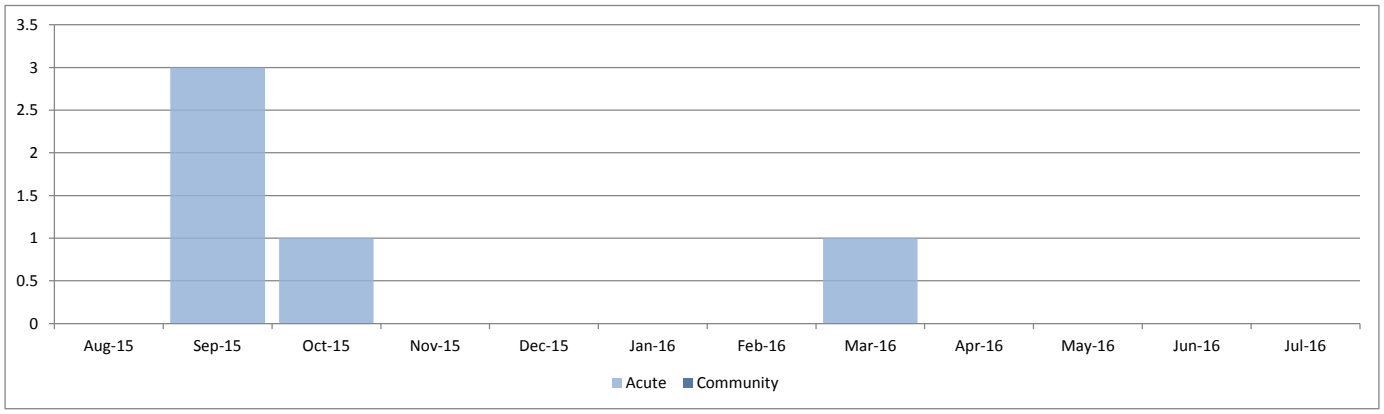

**Referral to Treatment over 52 week incomplete pathways**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients over 52 weeks | 1 | 1 | 1 | 1 | 2 | 3 | 5 | 4 | 4 | 6 | 5 | 11 |




**Mixed sex accomodation breaches of Standard**

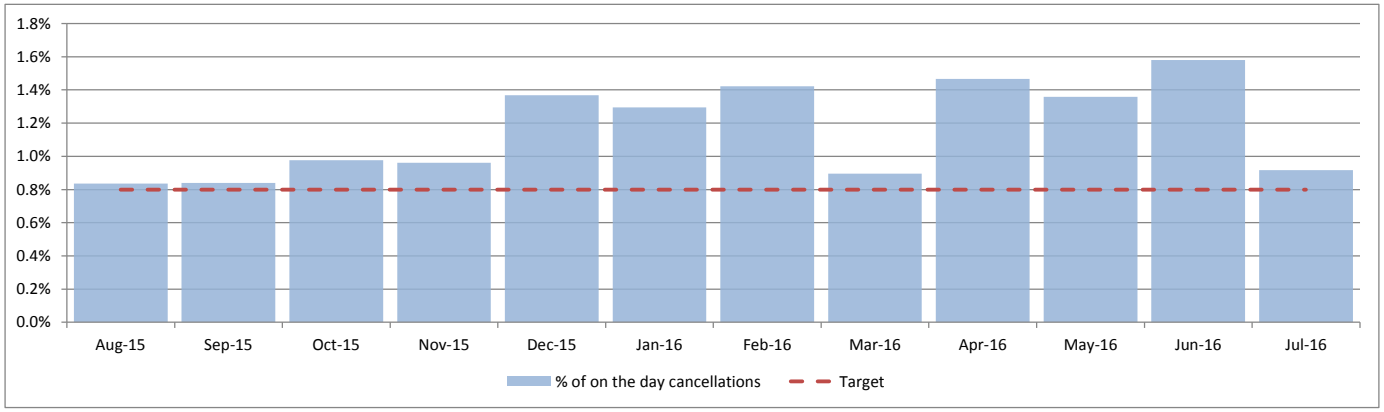
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute | 0 | 3 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Community | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |



## CONTRACTUAL FRAMEWORK

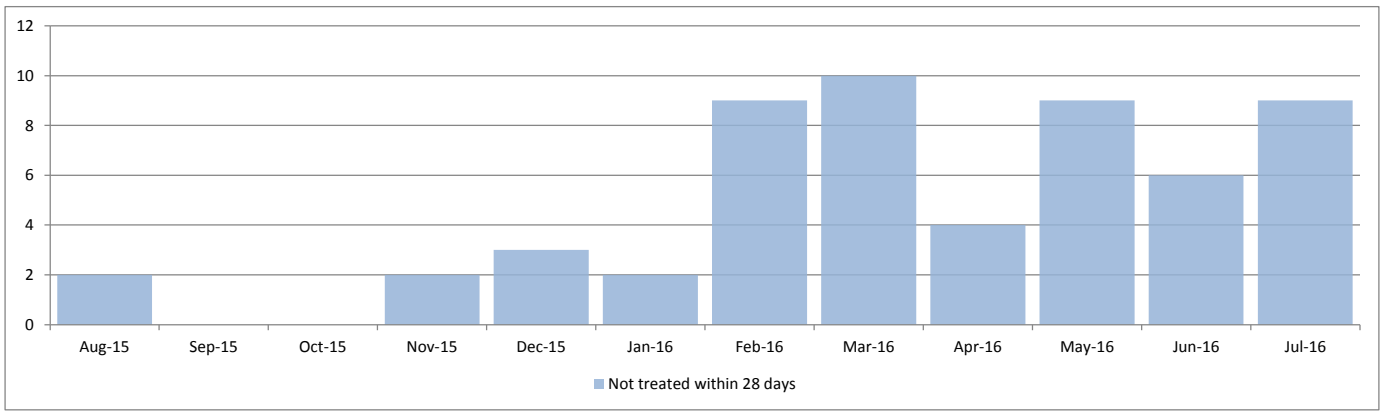
### On the day cancellations for elective operations

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancellations | 27 | 30 | 32 | 30 | 41 | 40 | 45 | 29 | 47 | 46 | 56 | 30 |
| Elective spells | 3229 | 3576 | 3275 | 3123 | 2998 | 3089 | 3164 | 3236 | 3205 | 3387 | 3543 | 3271 |
| % of on the day cancellations | 0.8% | 0.8% | 1.0% | 1.0% | 1.4% | 1.3% | 1.4% | 0.9% | 1.5% | 1.4% | 1.6% | 0.9% |
| 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% |



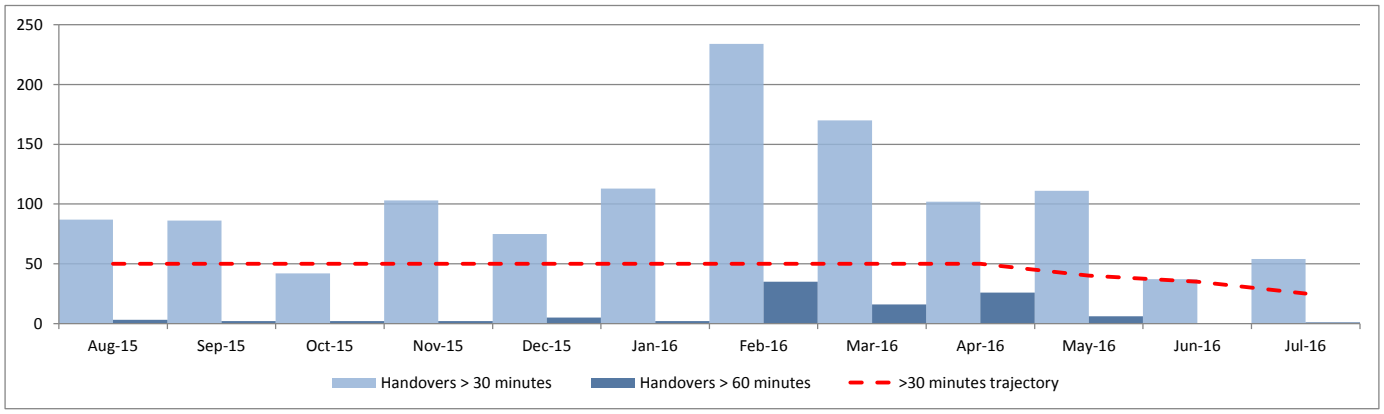

### Cancelled patients not treated within 28 days of cancellation

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Not treated within 28 days | 2 | 0 | 0 | 2 | 3 | 2 | 9 | 10 | 4 | 9 | 6 | 9 |




### Ambulance handovers

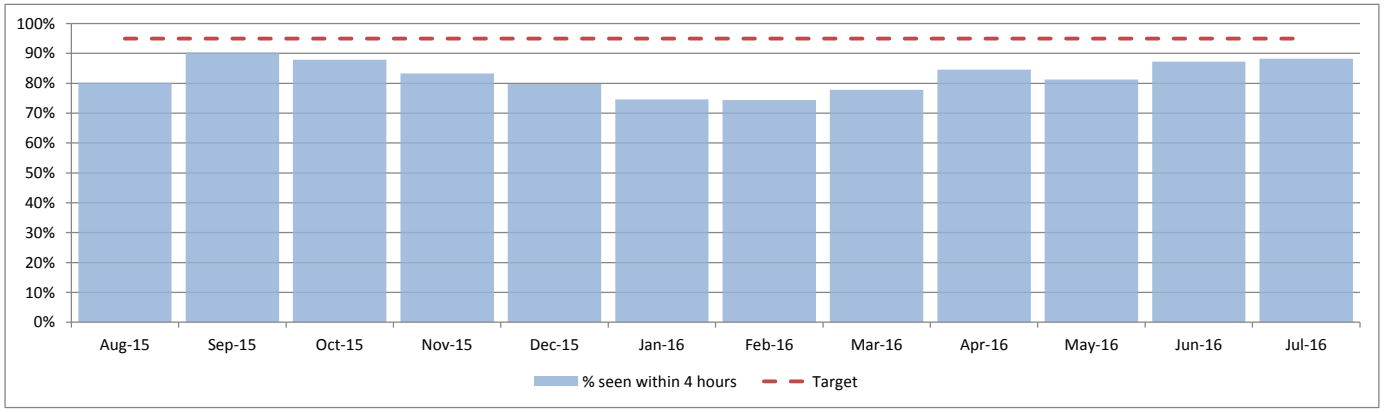
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Handovers > 30 minutes | 87 | 86 | 42 | 103 | 75 | 113 | 234 | 170 | 102 | 111 | 37 | 54 |
| Handovers > 60 minutes | 3 | 2 | 2 | 2 | 5 | 2 | 35 | 16 | 26 | 6 | 0 | 1 |
| >30 minutes trajectory | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 40 | 35 | 25 |



## CONTRACTUAL FRAMEWORK

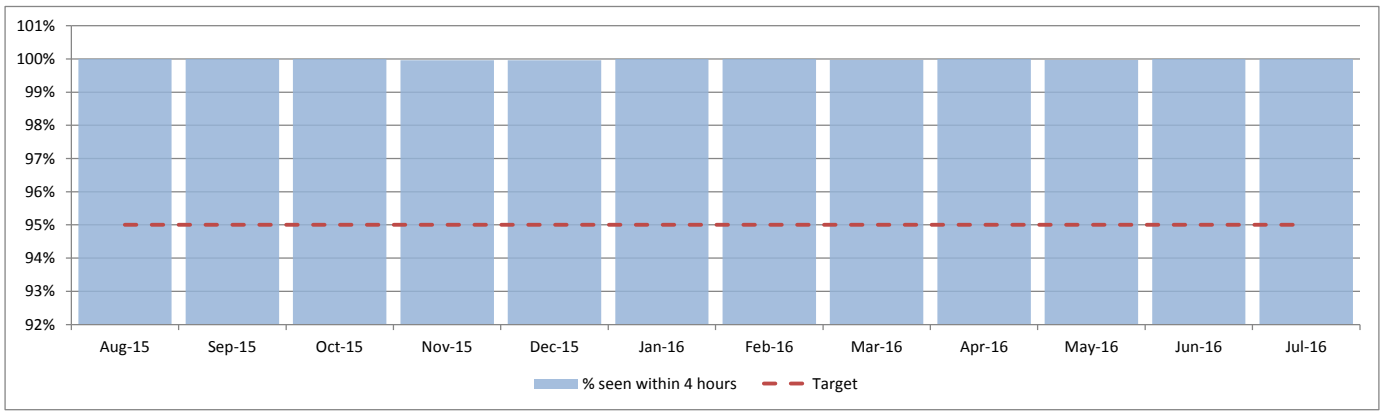
### A&E patients seen within 4 hours (DGH only)

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients seen | 6209 | 6087 | 6192 | 6090 | 5874 | 5896 | 5693 | 6334 | 5924 | 6534 | 6350 | 6971 |
| 4 hour breaches | 1232 | 594 | 753 | 1019 | 1191 | 1500 | 1459 | 1405 | 918 | 1228 | 810 | 820 |
| % seen within 4 hours | 80% | 90% | 88% | 83% | 80% | 75% | 74% | 78% | 85% | 81% | 87% | 88% |
| 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% |



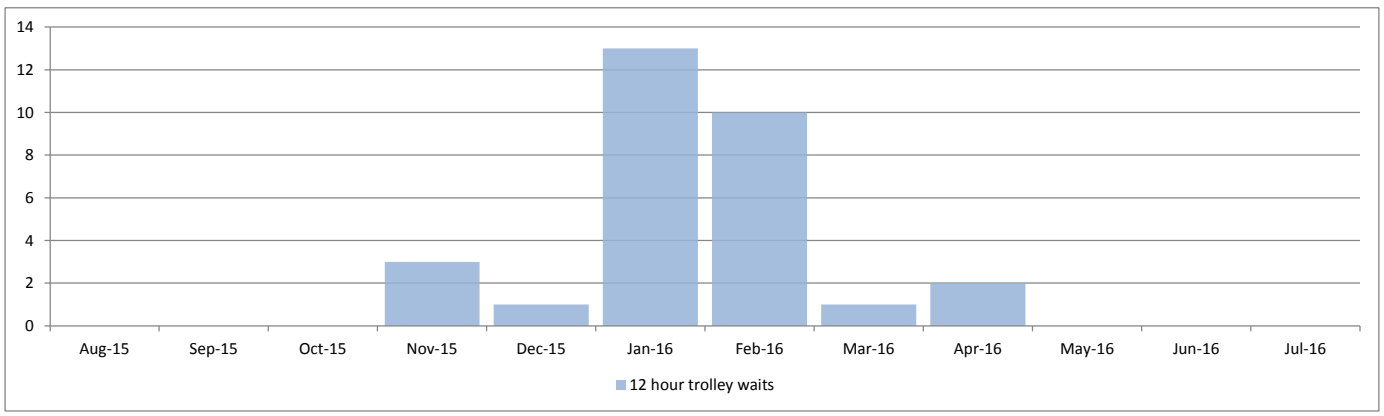

### A&E patients seen within 4 hours (community MIU)

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients seen | 3159 | 2788 | 2520 | 2361 | 2261 | 2327 | 2391 | 2964 | 2703 | 3207 | 3322 | 3708 |
| 4 hour breaches | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| % 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

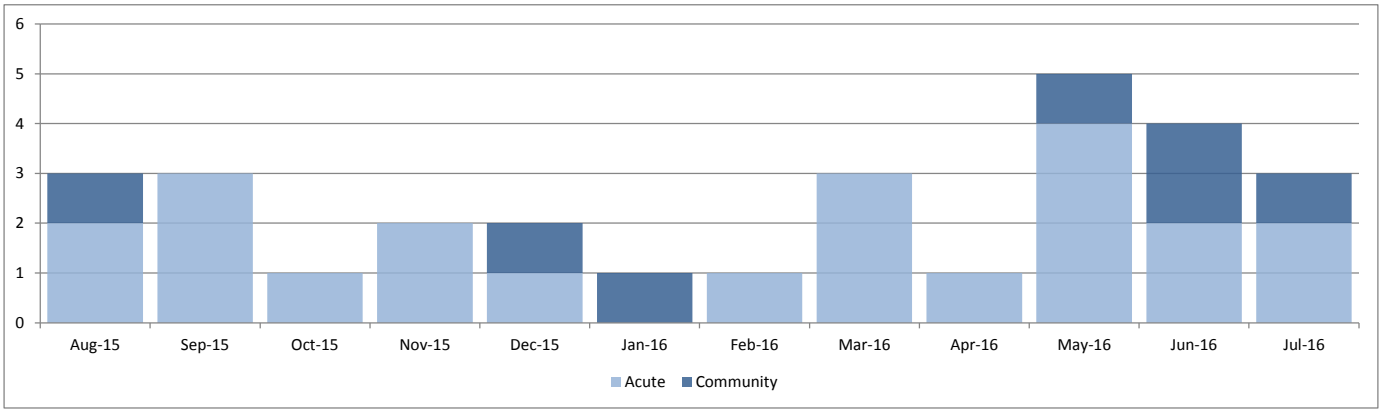
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 hour trolley waits | 0 | 0 | 0 | 3 | 1 | 13 | 10 | 1 | 2 | 0 | 0 | 0 |



CONTRACTUAL FRAMEWORK

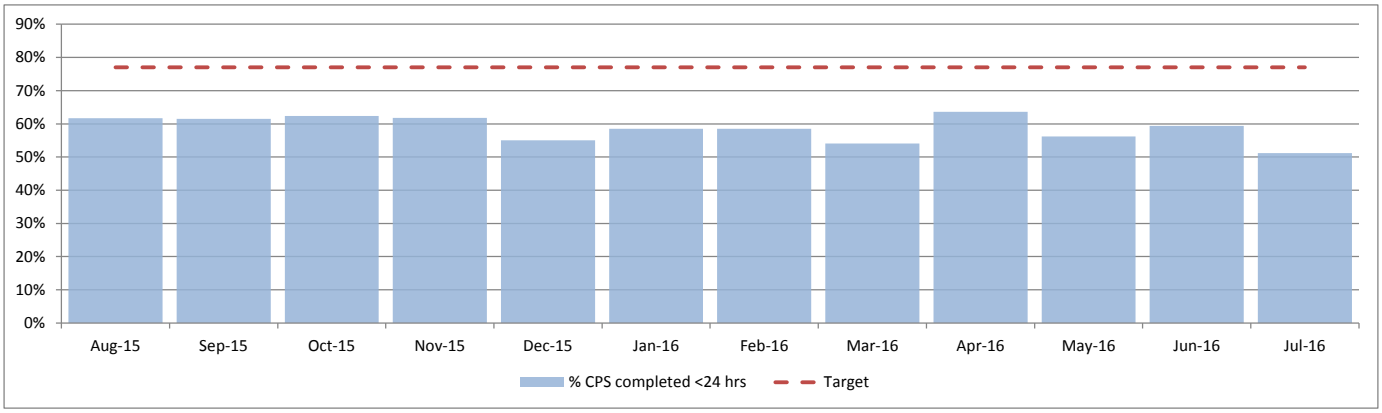
**Number of Clostridium Difficile cases**

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



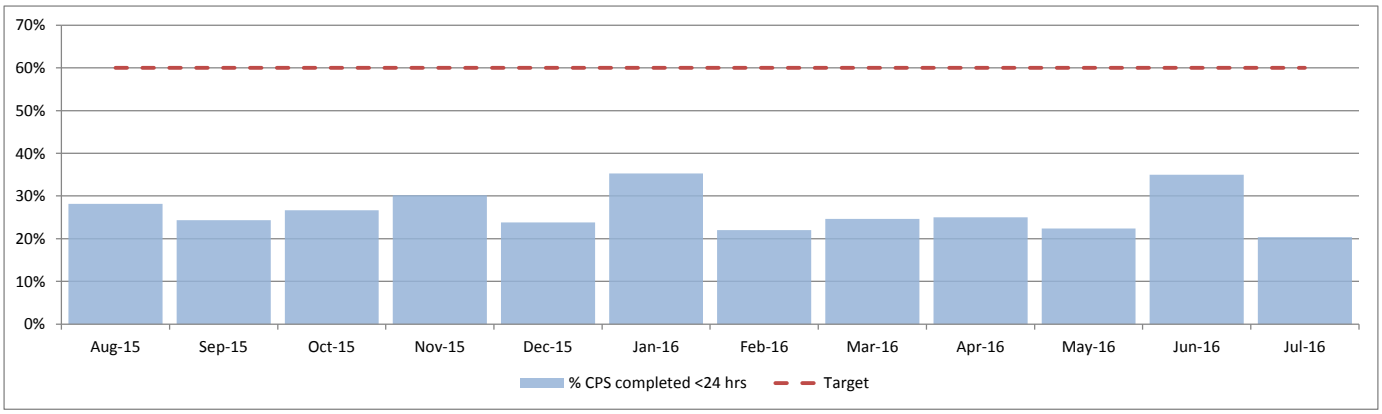

**Care Plan Summaries completed with 24 hours of discharge - Weekday**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Discharges | 1032 | 1165 | 1148 | 1132 | 1025 | 997 | 1089 | 1085 | 1105 | 1109 | 1179 | 1039 |
| CPS completed within 24 hours | 1673 | 1893 | 1840 | 1831 | 1863 | 1705 | 1860 | 2008 | 1737 | 1975 | 1986 | 2031 |
| % CPS completed <24 hrs | 62% | 62% | 62% | 62% | 55% | 58% | 59% | 54% | 64% | 56% | 59% | 51% |
| 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**

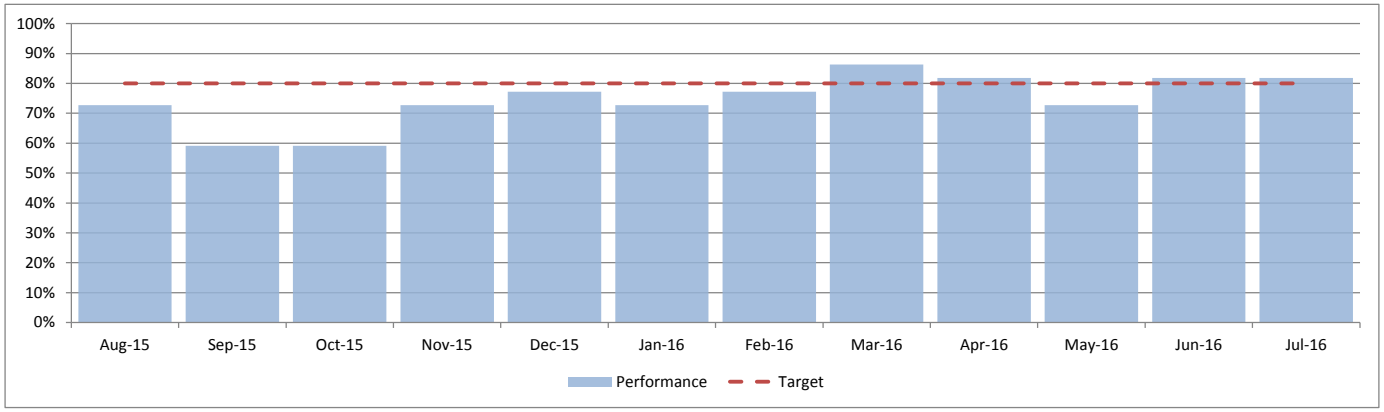
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Discharges | 565 | 444 | 495 | 444 | 390 | 470 | 414 | 406 | 528 | 532 | 460 | 599 |
| CPS completed within 24 hours | 159 | 108 | 132 | 134 | 93 | 166 | 91 | 100 | 132 | 119 | 161 | 122 |
| % CPS completed <24 hrs | 28% | 24% | 27% | 30% | 24% | 35% | 22% | 25% | 25% | 22% | 35% | 20% |
| 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% |



CONTRACTUAL FRAMEWORK

**Clinic letters - within 4 working days**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialties | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 |
| Breaching 4 working days | 6 | 9 | 9 | 6 | 5 | 6 | 5 | 3 | 4 | 6 | 4 | 4 |
| Performance | 73% | 59% | 59% | 73% | 77% | 73% | 77% | 86% | 82% | 73% | 82% | 82% |
| 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% |



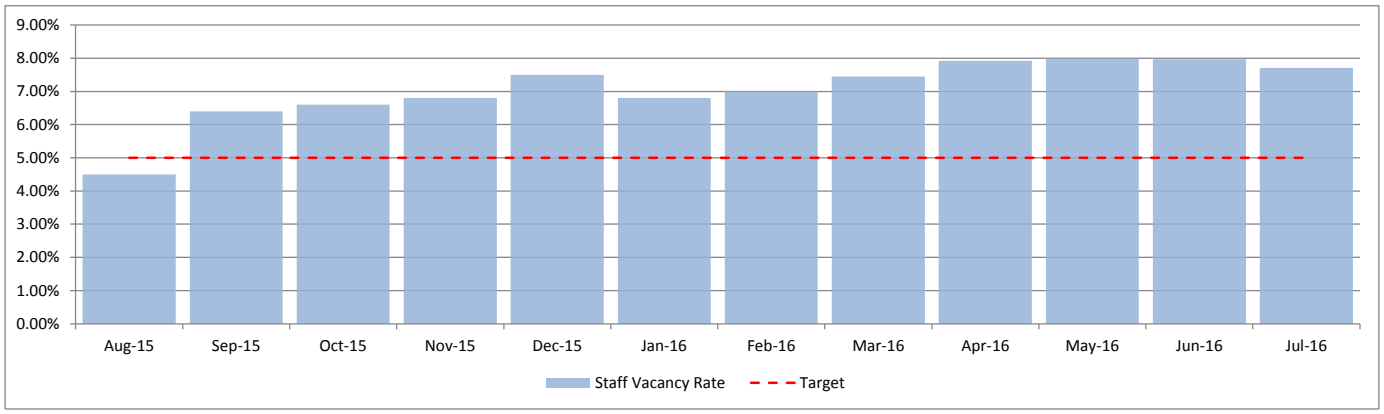
# CORPORATE MANAGEMENT FRAMEWORK

**Month 4 July 2016**

CORPORATE MANAGEMENT FRAMEWORK

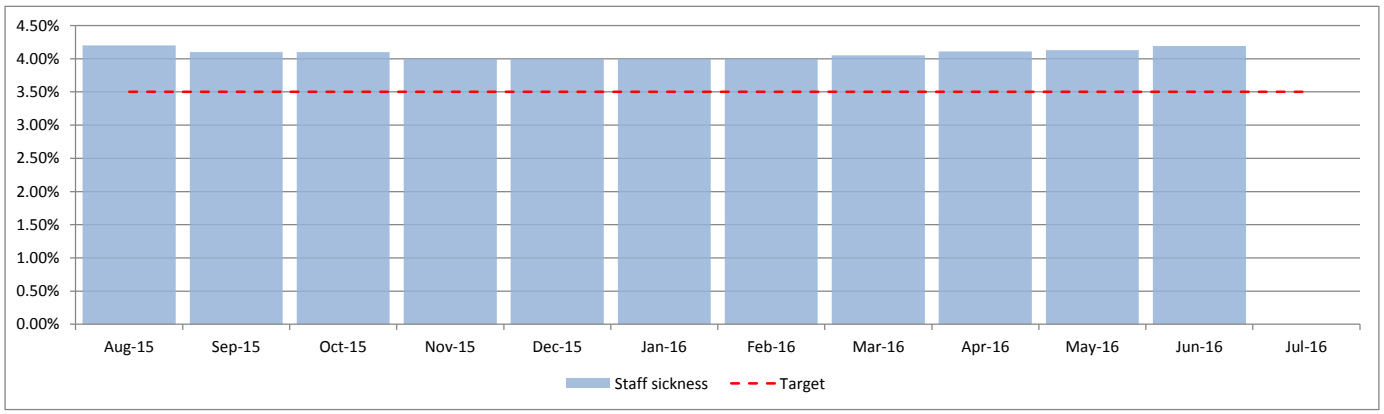
**Staff Vacancy Rate (excluding temp workforce and additional hours)**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Vacancy Rate | 4.50% | 6.40% | 6.60% | 6.80% | 7.50% | 6.80% | 7.00% | 7.45% | 7.92% | 7.99% | 7.97% | 7.71% |
| 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% |



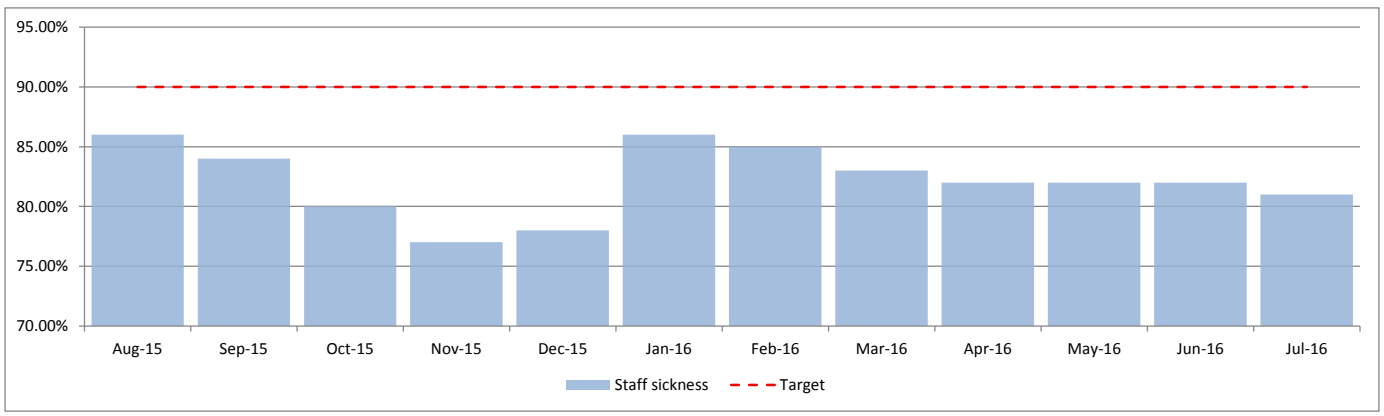

**Staff sickness**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff sickness | 4.20% | 4.10% | 4.10% | 4.00% | 4.00% | 4.00% | 4.00% | 4.05% | 4.11% | 4.13% | 4.19% | 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**

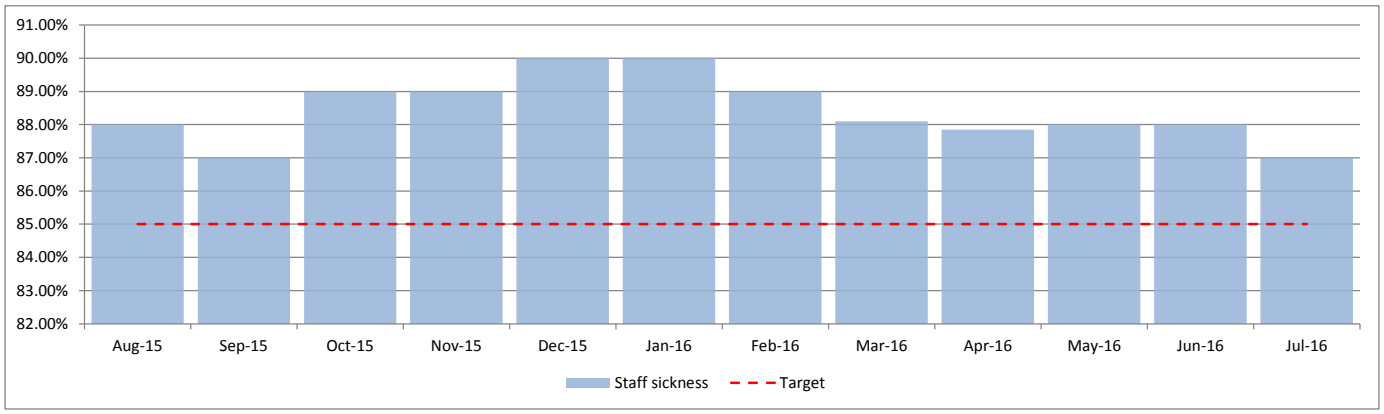
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff sickness | 86.00% | 84.00% | 80.00% | 77.00% | 78.00% | 86.00% | 85.00% | 83.00% | 82.00% | 82.00% | 82.00% | 81.00% |
| Target | 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**

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



Torbay and South Devon NHS
NHS Foundation Trust

# REPORT SUMMARY SHEET

| | |
|---|---|
| **Meeting Date:** | 7th September 2016 |
| **Title:** | Safety Scorecard |
| **Lead Director:** | Medical Director |
| **Corporate Objective:** | Safe, Quality Care and Best Experience |
| **Purpose:** | Information/Assurance |

**Summary of Key Issues for Trust Board**

Strategic Context:

The safety scorecard is collated on a quarterly basis from a variety of sources and provides internal and external assurance in relation to patient safety and experience across the Trust.

The data contained in this report is considered at Quality Improvement Group (QIG) and exceptions reported to Quality Assurance Committee.

Key Issues/Risks

- Mortality data shows a stable and favourable profile with mortality in the 'better than expected' range.
- Increased mortality in 'Low risk diagnosis groups' will be investigated. In the past this has been found to be related to coding issues.
- Handwashing compliance is lower in June 2016 than previously. This measure will be examined in detail and is reported on monthly basis.
- Clostridium Difficile data is following the expected pattern across the year.
- An increased rate of Grade 3-4 pressure ulcers was identified in January to March 2016. All cases were investigated and mitigating actions implemented. Action plans are monitored through the Pressure Ulcer Group. Ulcer rates have returned to low levels.
- DH Safety Thermometer shows percentage harm-free care above the 95% target for every month since the formation of TSDFT in October 2015.

The Board is asked to note the contents of this report.

Summary of ED Challenge/Discussion:

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

QIG includes patient and governor representation.

Equality and Diversity Implications:

Nil

Torbay and South Devon NHS
NHS Foundation Trust

# Safety Score Card No. 39

**Background & Introduction**

The indicators for this score card have been collated from a variety of data sources using defined methodology. The sources include Trust data, Dr Foster, and data collected initially as part of the NHS South West Quality and Safety Improvement programme. The data in the appendices has in the main been displayed as run charts.

**Data & Graphs – Run Charts**

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

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

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

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

Table 1: South Devon Healthcare NHS Foundation Trust

**Safety Score Card N39.**

| Safety Indicator | | Data Source | Target | RAG |
|---|---|---|---|---|
| Hospital Standardise Mortality Rate HSMR<br>Summary Hospital-level Mortality Index SHMI (Appendix 1) | Mortality | Dr Foster 2014/15 benchmark year<br>DH SHMI data | ≤90 | |
| Unadjusted Mortality rate (Appendix 2) | | Trust Data | Yearly Average ≤3% | |
| Dr Foster Patient Safety Dashboard (Appendix 3) | | Dr Foster | All 15 safety indicators positive | 1 flag |
| Trust wide hand washing compliance (Appendix 4) | Infection Control | Trust Data | 95% compliance | |
| MRSA bacteraemia Days Between (Appendix 5) | | Trust data | Zero in year | 2 MRSA |
| C Diff Number (Appendix 6) | | Trust data | DH target ≤18 lapses in care | |
| Patient Incidents (Appendix 7) | Patient Incident | Trust Safeguard system | Positive reporting | |
| Major & Catastrophic Incidents (Appendix 8) | | SPI/NHS SW Safety Programme from trust data | 10% reduction from prior year | |
| Falls Number Rate & Harm from falls (Appendix 9) | | Trust Safeguard system | Rate of ≤4 | |
| Pressure Ulcers Data (Appendix 10) | | Trust Safeguard system | 10% Reduction in pressure ulcers | |
| Medication Errors and serious harm (Appendix 11) | | Trust wide monthly audit | 95% compliance with the three measures | |
| Cardiac Arrest Calls (12) | | Trust wide monthly audit | Year on Year reduction | |
| Safety Thermometer (Appendix 13) | Assurance | DH point prevalence monthly audit tool measuring harm free care | 95% or high T&SDT Harm Free Care | |
| Never Events (Appendix 14) | | Trust Safeguard system | Zero in any financial year | 0 |

## Overview:

The Safety Score Card (SSC) is presented to the Board on a quarterly basis and will directly feed into the Quality Assurance Committee.

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

**Mortality**
The data is now being expressed for the whole organisation, including all the community hospitals since October 2015.

The HSMR position remains below the 100 line and within the expected range.

Triangulating with Dr Fosters Safety Dashboard, one area (Deaths in low-risk groups) is flagging and this will be investigated and a report sent back to the Quality Improvement Group

**Infection Control**
The data is showing a steady pattern of CDT lapses in care but within the expected trajectory. This needs to be observed via the *monthly* Performance and Quality Data book.

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

Patient falls are showing a reduction in recent months post a winter falls campaign which produced a marked reduction in harm during this period.

Grade 3 & 4 pressure ulcers have showing an increase since January, with issues identified in the assessment and recording of skin condition and a report has been sent to the Quality Improvement Group. An action plan is in place and is being monitored by the PU steering Group.

A positive culture of medication error reporting continues. Serious harm from errors are low and showing no overall trends.

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

**Assurance Data**
Safety Thermometer - All data is within the target range for each metric.

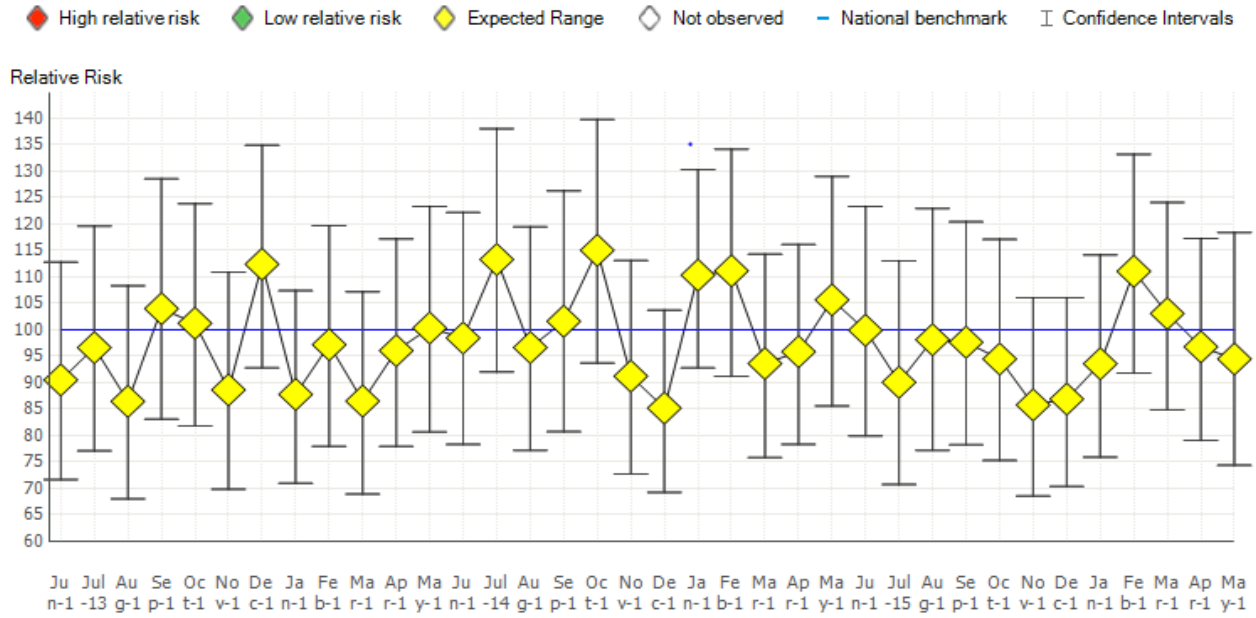
**Appendix 1**
**This metric looks at the two main standardised mortality tools:**
**(A) Hospital Standardised Mortality Rate (HSMR) and**
**(B) Summary Hospital Mortality Index (SHMI)**
(Data obtained from Dr Foster)

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

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

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

T&SDT - HSMR from Jun 13 – May 16




**Narrative**
Data from October 2015 is for Torbay and South Devon NHS Foundation Trust and includes data for acute and community.

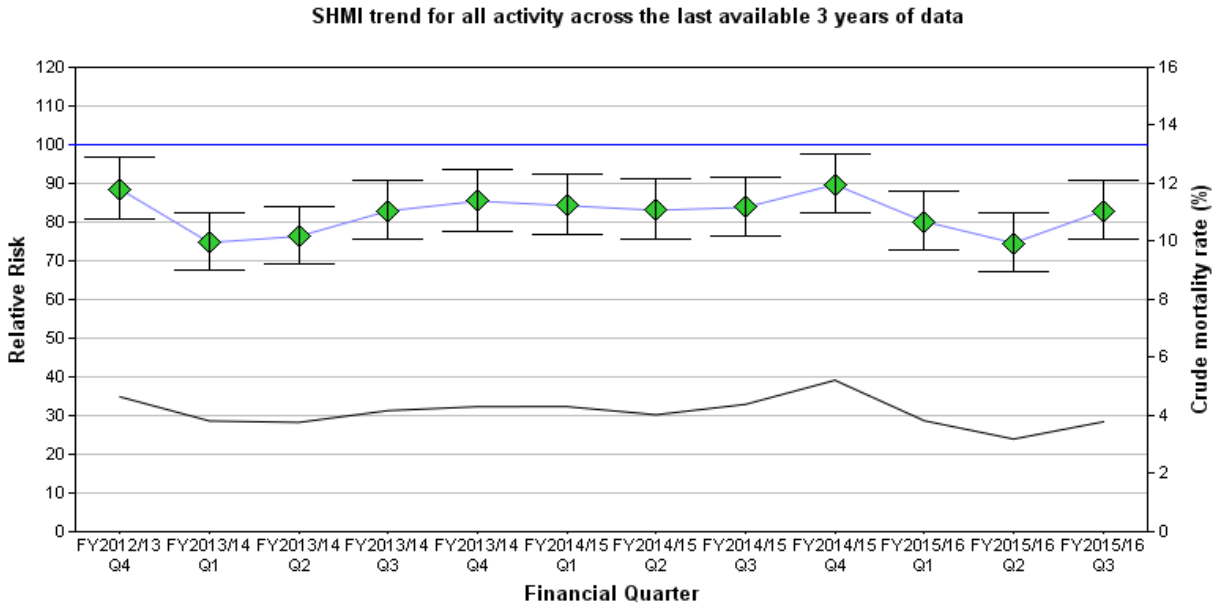
Our latest data point, May 16 is continuing to show a low relative risk of 94.80. The winter period also recorded no data points outside of the expected range. The data does show the cyclical patterns of mortality over the winter periods when mortality tends to peak.

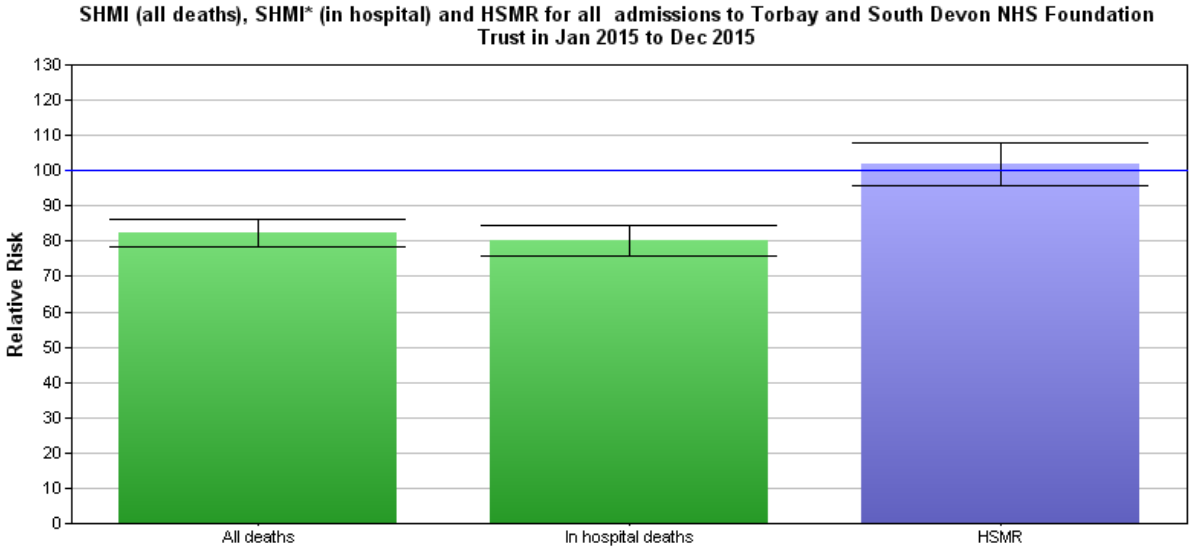
Morbidity and Mortality reviews take place in all specialist departments and in all community hospitals. In community hospitals all deaths are reviewed using software designed with the support of the South West Academic Health Sciences Network. Recurring themes are identified and changes in care pathways have been undertaken with that learning.

The Medical Director has established a Mortality Surveillance Group to provide assurance that robust investigation of avoidable deaths is undertaken and to ensure that learning is shared across the organisation when suboptimal care has been identified relating to any death.

**(B) Summary Hospital Mortality Index (SHMI)**
SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is *very* retrospective; therefore, please note *the following data is from* ***Jan 2015 - Dec 2015*** and will be very different from the dates used on Dr Foster's HSMR.

The first chart highlights SHMI by quarter, again with all data points within the expected range and trending below our 90 target

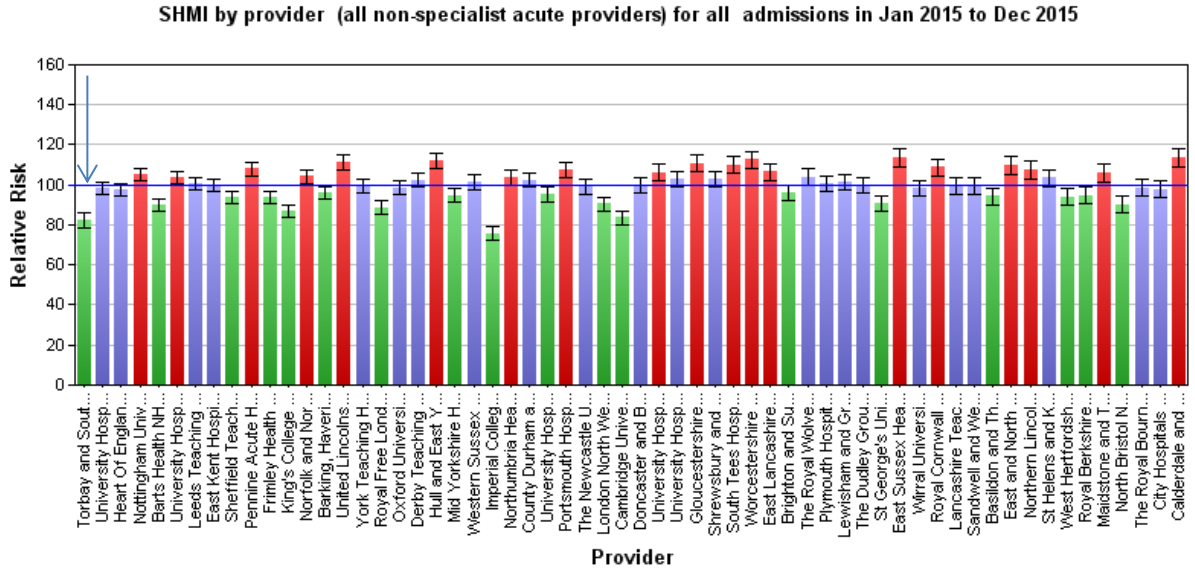


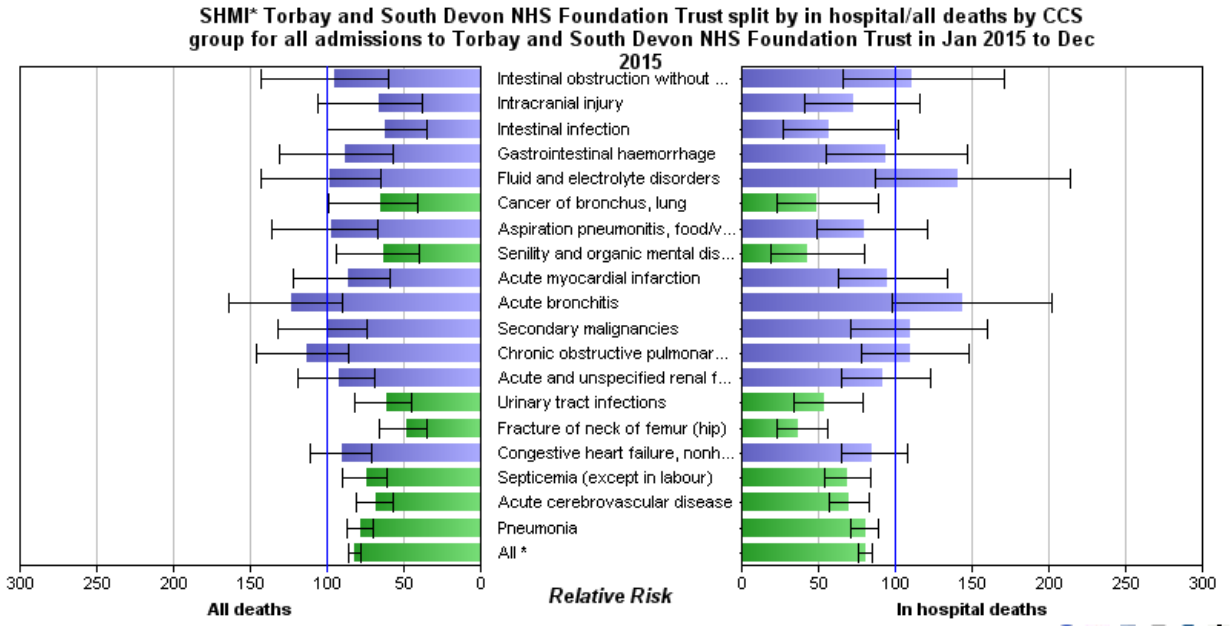

**SHMI all deaths, SHMI in hospital deaths and HSMR**

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

The next chart highlights the position of similar sized trusts within England and allows a comparison against these organisations.




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



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

# Percentage Unadjusted Mortality (UM)

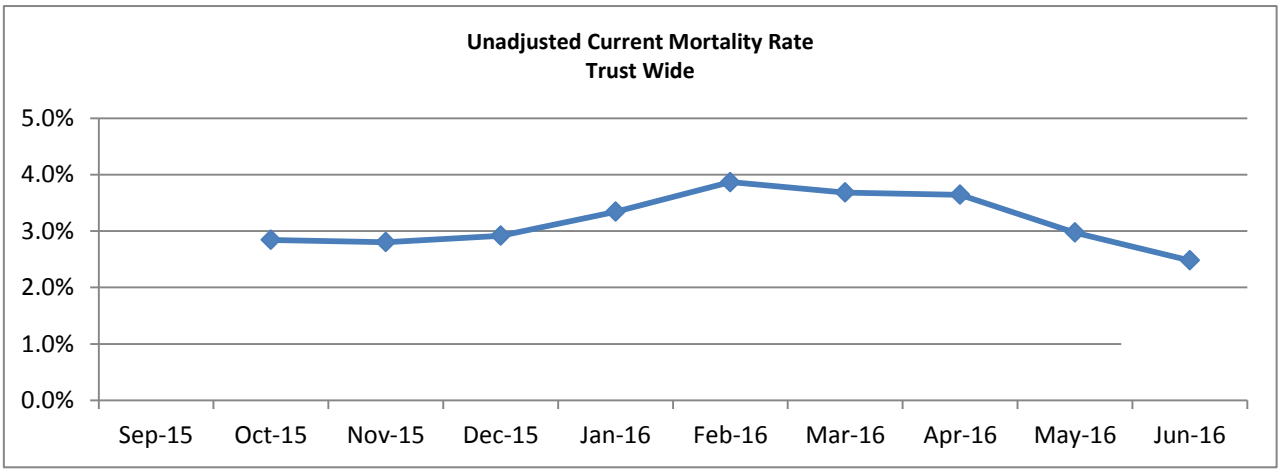
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

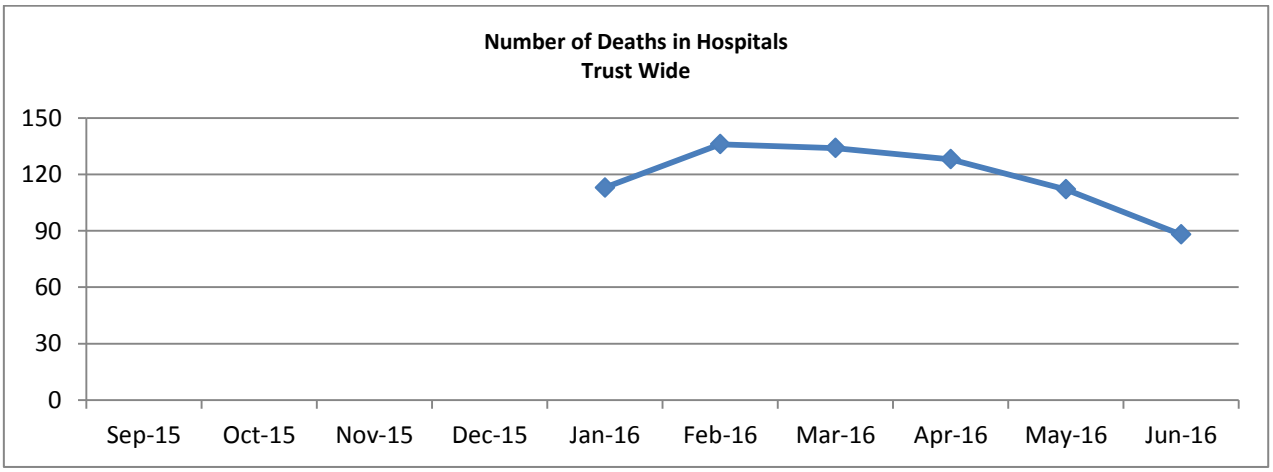
Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

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

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

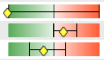
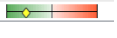
The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.



## Appendix 3
## Dr Foster Patient Safety Dashboard

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

| Indicator | Volume | Observed | Expected | Observed Rate/K | Expected Rate/K | | Relative Risk |
|---|---|---|---|---|---|---|---|
| Deaths in low-risk diagnosis groups* | 26,936 | 25 | 15.6 | 0.9 | 0.6 | 160 |  |
| Decubitus Ulcer | 7,471 | 296 | 358.2 | 39.6 | 47.9 | 83 |  |
| Deaths after Surgery | 490 | 40 | 46.1 | 81.6 | 94.1 | 87 |  |
| Infections associated with central line* | 13,721 | 1 | 0.7 | 0.1 | 0.0 | 149 |  |
| Postoperative hip fracture* | 20,285 | 1 | 1.2 | 0.0 | 0.1 | 82 |  |
| Postoperative Haemorrhage or Haematoma | 17,905 | 9 | 8.0 | 0.5 | 0.4 | 112 |  |
| Postoperative Physiologic and Metabolic Derangement* | 15,250 | 3 | 1.5 | 0.2 | 0.1 | 203 |  |
| Postoperative respiratory failure | 13,917 | 10 | 11.7 | 0.7 | 0.8 | 85 |  |
| Postoperative pulmonary embolism or deep vein thrombosis | 18,081 | 31 | 37.5 | 1.7 | 2.1 | 83 |  |
| Postoperative sepsis | 460 | 7 | 4.2 | 15.2 | 9.2 | 165 |  |
| Postoperative wound dehiscence* | 673 | 0 | 0.6 | 0.0 | 0.9 | 0 |  |
| Accidental puncture or laceration | 63,189 | 93 | 75.4 | 1.5 | 1.2 | 123 |  |
| Obstetric trauma - vaginal delivery with instrument* | 255 | 17 | 21.3 | 66.7 | 83.4 | 80 |  |
| Obstetric trauma - vaginal delivery without instrument* | 1,265 | 34 | 50.3 | 26.9 | 39.8 | 68 |  |
| Obstetric trauma - caesarean delivery* | 542 | 1 | 2.2 | 1.8 | 4.1 | 45 |  |

Of the 15 indicators above, the relative risks of 2 post-operative sepsis and Deaths in low-risk diagnosis groups are currently flagging outside of the expected norm.

**Deaths in low-risk diagnosis groups**

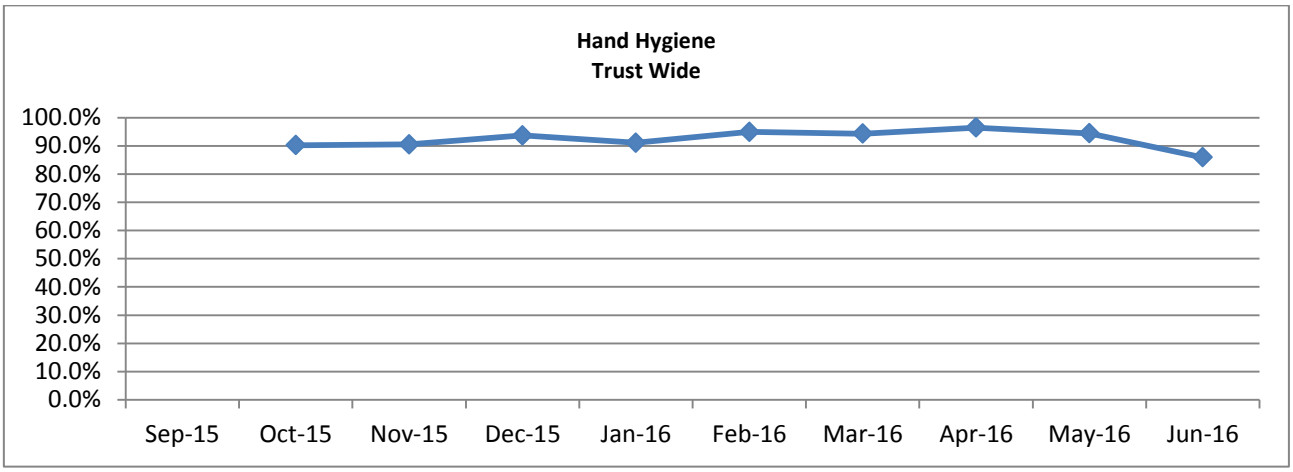
This code has being investigated a number of times and no issues have been found other than incorrect codes being issued. This latest flag will be investigated and will be presented back to the Quality Improvement Group. If further analysis is need a small team will interrogate the data from the Mortality Surveillance Group

**Appendix 4**
**Hand washing compliance**

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

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

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

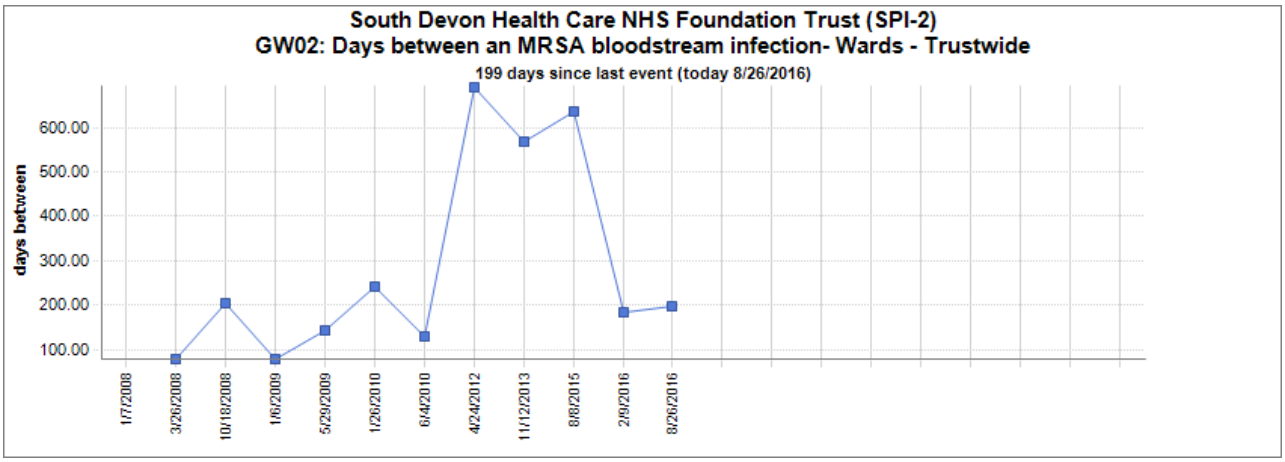



**Commentary**

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

## Appendix 5

## Days between an MRSA bacteraemia (SPI)




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

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

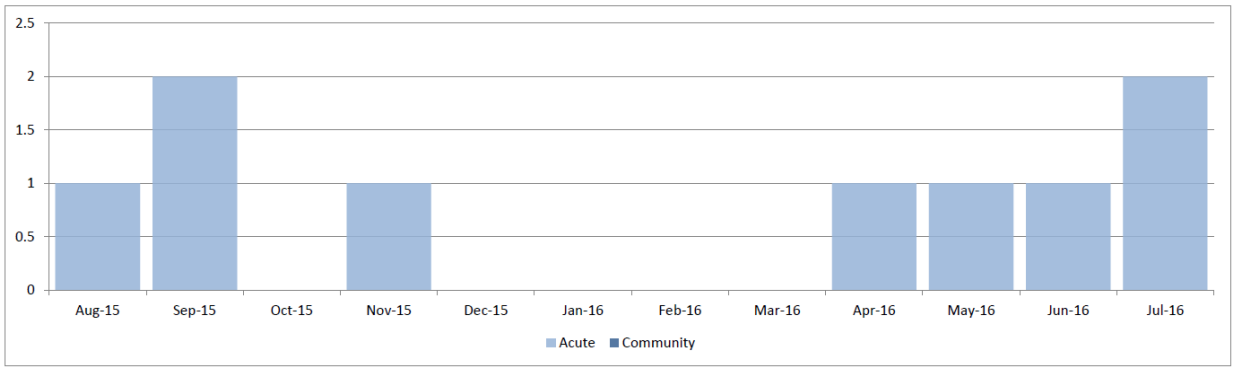
The current count stands at 199 days. The longest count has stood at 633 days and the data chart shows performance back to 2008

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

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

**C Diff. Lapse in Care**

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




### Commentary

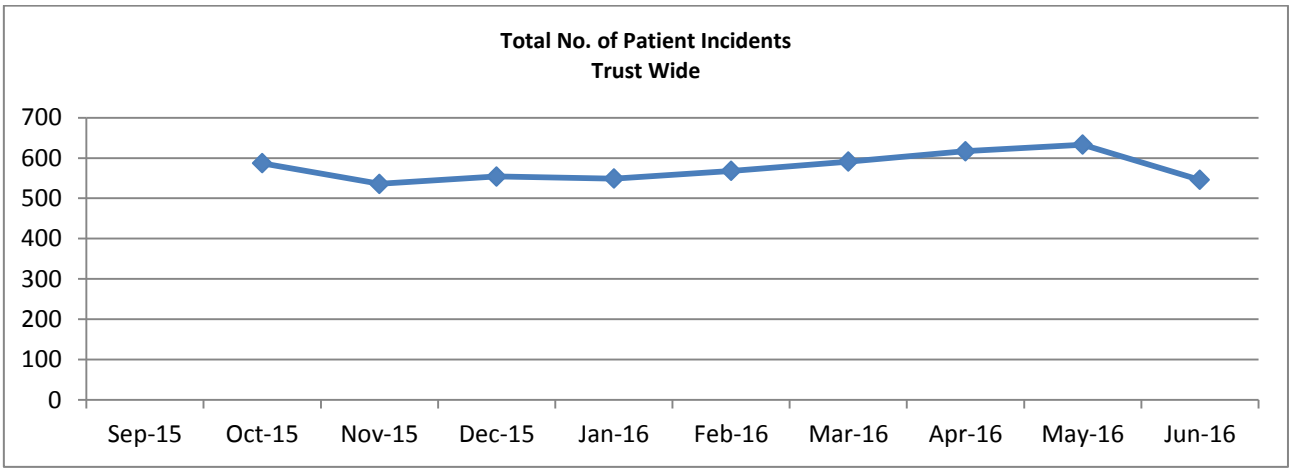
All CDiff cases are subjected to a root cause analysis and the infection control team when analysing the investigations code each case into *lapse of care* or *no lapse of care.* The above chart identifies those lapses in care.

## Appendix 7

### Total Number of Trust Wide Patient Incidents by Month

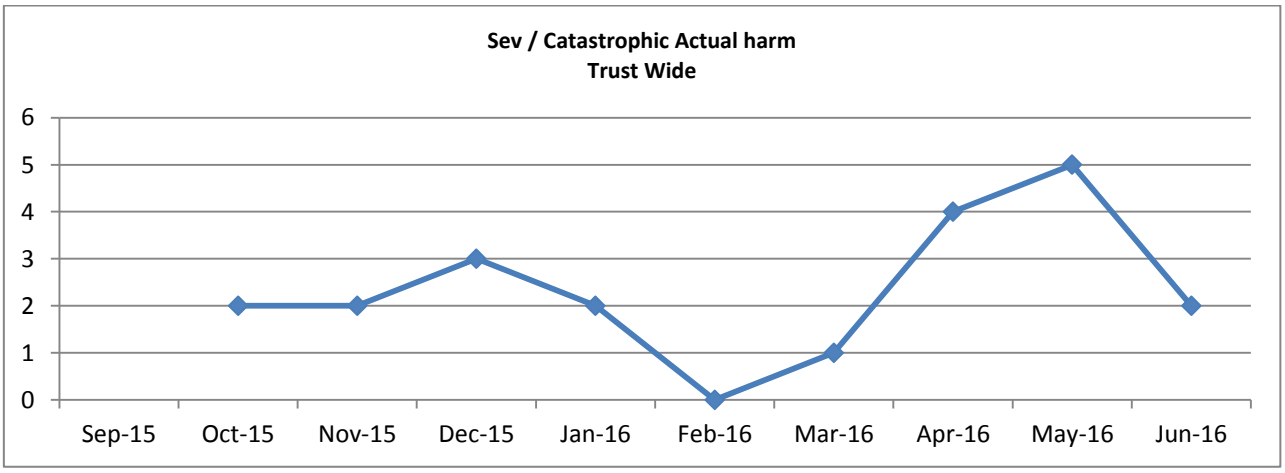
This metric is a simple count of the number of incidents reported by month.
An organisation with a healthy safety culture encourages incident reporting and uses this data to target safety improvements within its various governance structures.

SDHCFT's reporting is remaining in a healthy position.




## Appendix 8

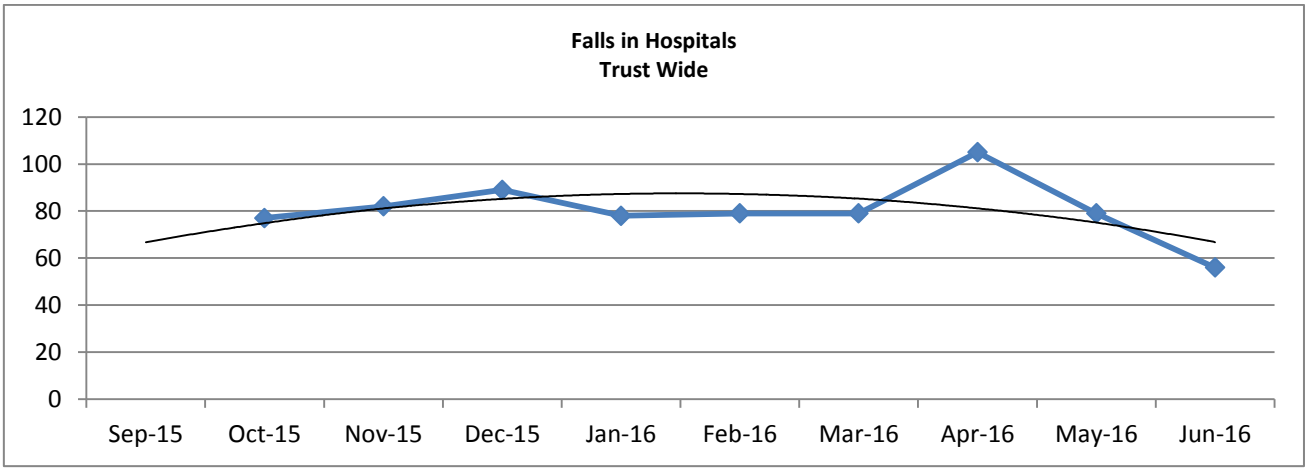
### The total number of Moderate Major and Catastrophic incidents reported by month through the Safeguard Incident reporting system

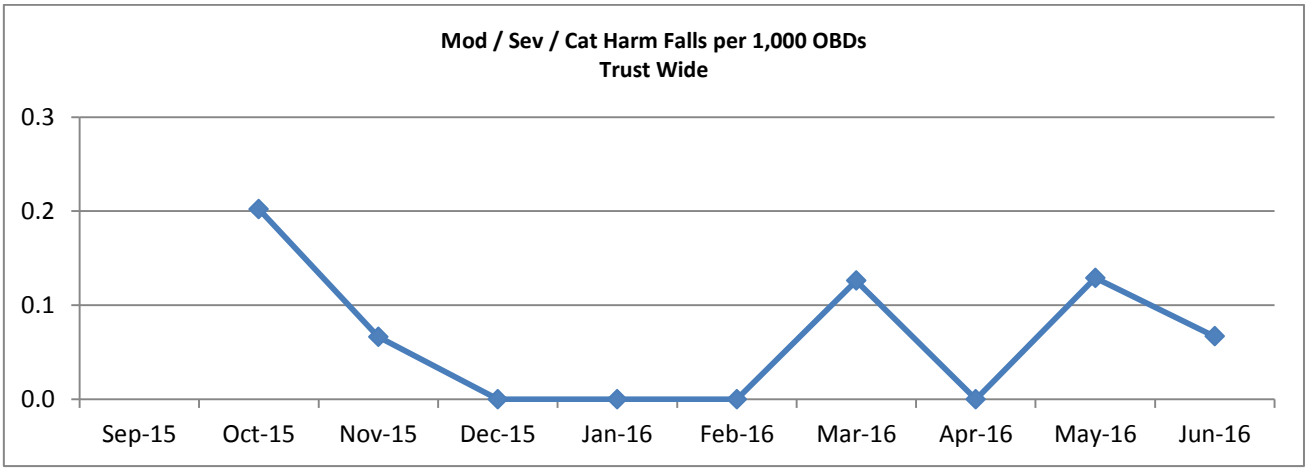



All major and catastrophic incidents are recorded on the STEIS system, presented to the Serious Adverse Events Group, complete with an investigation, root cause analysis and action plan, which is logged and monitored.

## Appendix 9
## In Hospital Falls

**The below chart records the Organisational falls number**



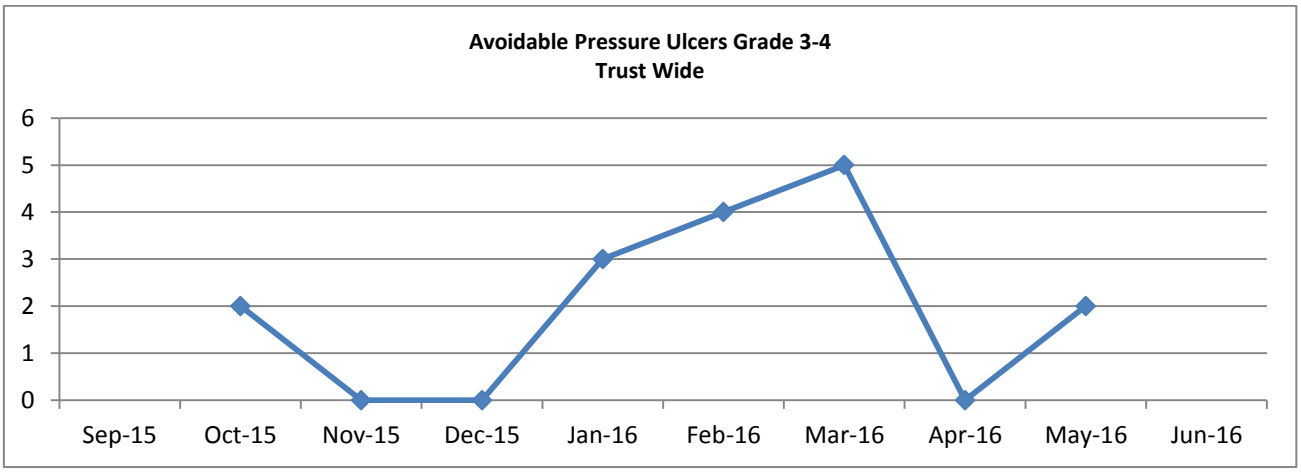

The above chart records the harm rate for the more serious incidents per 1,000 bed days within the ICO. This is showing a low harm rate. The falls data is shared with the Falls Nurse and at the Falls committee

**Appendix 10**
**Pressure Ulcers**

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

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

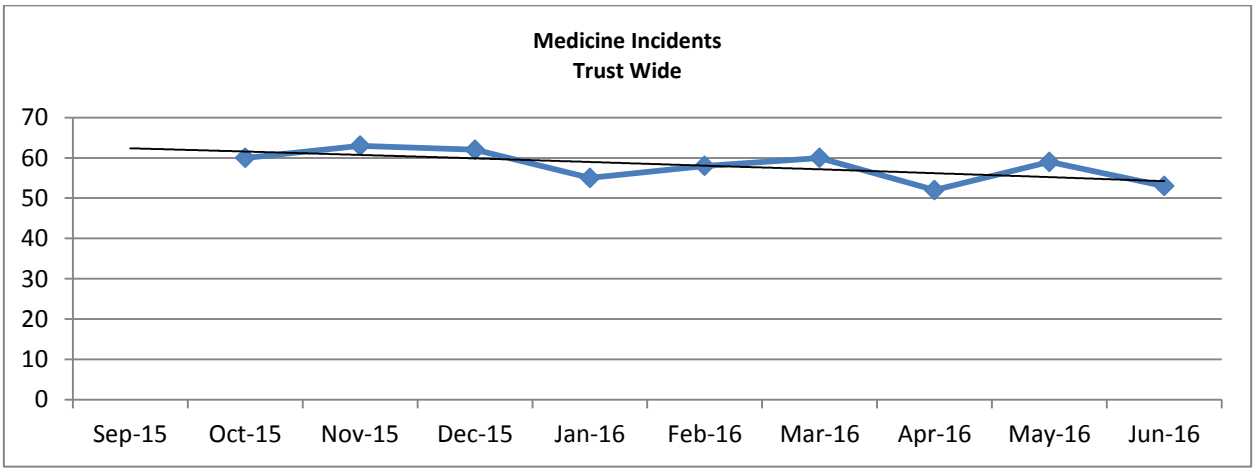
The more serious Grade 3 – 4 pressure ulcers, whilst historically low need to be observed for patterns and trends. Much work is being undertaken in the Pressure Ulcer Prevention (PUP) project which is now being rolled out to other wards under a buddy system; a ward that has been through the programme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




The rise from January has been noted and all instances have been reviewed. Much work has followed from this review particularly focusing on assessment and monitoring with a resultant action plan in evidence.

## Appendix 11
## Medication Errors

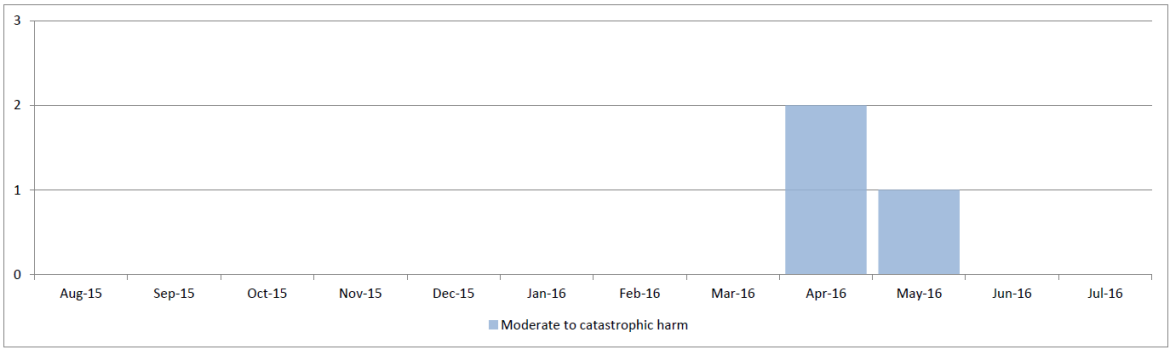
The first chart records the total number of organisational medication errors reported which is showing a slight decrease in number




The second chart below records the more serious harm from errors which is historically low

**Medication Errors Resulting in Moderate to Catastrophic Harm**

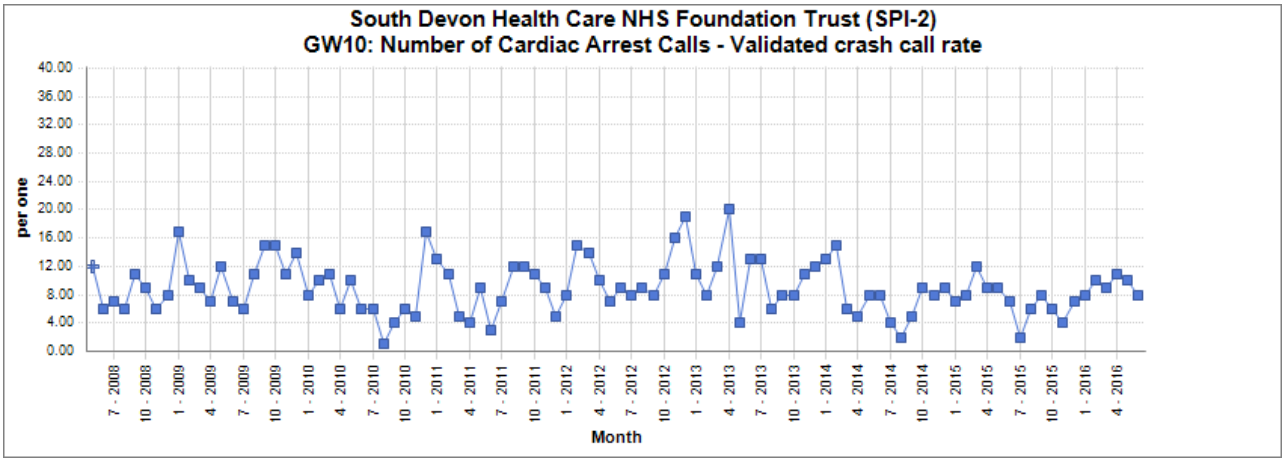
| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Moderate to catastrophic harm | n/a | n/a | n/a | n/a | n/a | 0 | 0 | 0 | 2 | 1 | 0 | 0 |



**Appendix 12**
**Cardiac Arrest Calls**

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

Cardiac Arrest Calls by Month




All cardiac arrests now have a RCA carried out post arrest for learning and the numbers of validate calls remains low. Work is still on-going by the team to try and reduce the PEA arrests from our hospital system

## Appendix 13
## Department of Health's (DH) Safety Thermometer

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

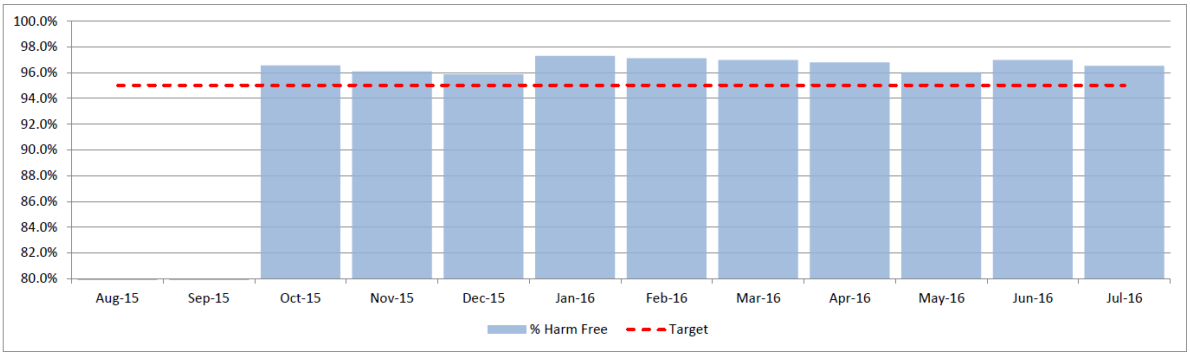
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

All patients are surveyed on *one* specific day every month and the data records if any harm, as outlined above, has occurred. The audit, therefore, provides a score for the organisation based on harm free care and new harm free care. This data is the harm caused whilst in our care and is called new harm free.

The Trust's percentage of patient new harm free care has remained constantly high and stable.

**Harm Free - Trust Total**

| | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | | | | | 994 | 1109 | 1075 | 1057 | 1027 | 1056 | 1093 | 1040 |
| Harm Free | | | | | 953 | 1079 | 1044 | 1025 | 994 | 1014 | 1060 | 1004 |
| % Harm Free | n/a | n/a | 96.5% | 96.1% | 95.9% | 97.3% | 97.1% | 97.0% | 96.8% | 96.0% | 97.0% | 96.5% |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |



**Appendix 14**
**Never Events List 2015/16**

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

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

In 2015/16 the Trust has recorded two such events, one in Obstetrics (Sept) and one in Theatre (July); in all cases the patients did not suffer any immediate physical harm and investigations and changes have been implemented.

There have been no never events in this financial year (the reporting period).

**Data 1st April 2015 – 26th August 2016 source Safeguard**

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

| | | |
|---|---|---|
| 18. | Death or severe harm as a result of inadvertent transplantation of ABO or HLA-incompatible organs | 0 |
| 19. | Death or severe harm as a result of a misplaced naso- or oro-gastric tube | 0 |
| 20. | Death or severe harm as a result of the administration of the wrong gas | 0 |
| 21. | Death or severe harm as a result of failure to monitor and respond to oxygen saturation | 0 |
| 22. | Death or severe harm as a result of intravascular air embolism | 0 |
| 23. | Death or severe harm as a result of misidentification of patient | 0 |
| 24. | Death or severe harm as a result of a patient being scalded | 0 |
| 25. | Maternal death due to post-partum haemorrhage after elective caesarean section | 0 |

Torbay and South Devon NHS
NHS Foundation Trust

**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting Date:** | 7 September 2016 |
| **Title:** | Annual Report on Safeguarding Adults and Deprivation of Liberty Safeguards |
| **Lead Director:** | Chief Nurse |
| **Purpose:** | Assurance |

**Summary of Key Issues for Trust Board**

Strategic Context:

This annual report will inform Torbay and South Devon NHS Foundation Trust board members on issues relating to safeguarding adults in Torbay and South Devon.

The Trust has delegated responsibility for Local Authority Statutory Safeguarding Duties for Adults on behalf of Torbay Council. This is governed by The Care Act 2014.

In addition the Trust is a partner organisation working with Devon County Council and Torbay Council as a provider of health and care services. Devon County Council retains the lead for Adults Safeguarding in the South Devon footprint.

The Chief Nurse is Executive Lead for Safeguarding and is supported in this role by the Associate Director of Social Care and the Named Professionals.

Key Issues/Risks

Deprivation of Liberty Safeguards remains a key risk for the organisation. Specialist assessors are very limited and the volume of assessment is very high. An action plan is in place to address risks in management of the Deprivation Liberty Safeguarding duties, with respect to the delegated duties of Supervisory Body.

Staffing challenges in qualified Social Work remain current, with the potential that this will negatively impact on the allocation of Safeguarding Cases for Social Work support.

Summary of ED Challenge/Discussion:

Executives noted the report and challenges. The safeguarding adults team are responding to recent whole service investigations and reviewing processes to ensure a timely and productive process. The need to maintain a clear separation of accountability between the delegated council function and the Trust provider function has been recognised. The management of the Trust safeguarding function will move from the Associate Director of Adult Social Care to the Trust operational team.

| |
|---|
| Internal/External Engagement including Public, Patient and Governor Involvement:<br><br>Torbay Safeguarding Adults Board and sub groups<br>Devon Safeguarding Adults Board and sub groups<br>Trust Integrated Safeguarding Committee<br>Torbay Experts by Experience Group |
| Equality and Diversity Implications:<br><br>The safeguarding function covers all protected characteristics |

| | |
|---|---|
| **Report to:** | Trust Board |
| **Date:** | 7 September 2016 |
| **Report From:** | Chief Nurse |
| **Report Title:** | Annual Safeguarding Adults Report |

**1 Purpose**

To provide the Board of Directors with the annual safeguarding adults report

1.1 **Provenance:**

The report is informed by the following:

- Trust Safeguarding Adults Group
- Trust Integrated Safeguarding Committee
- Torbay Safeguarding Adults Board
-

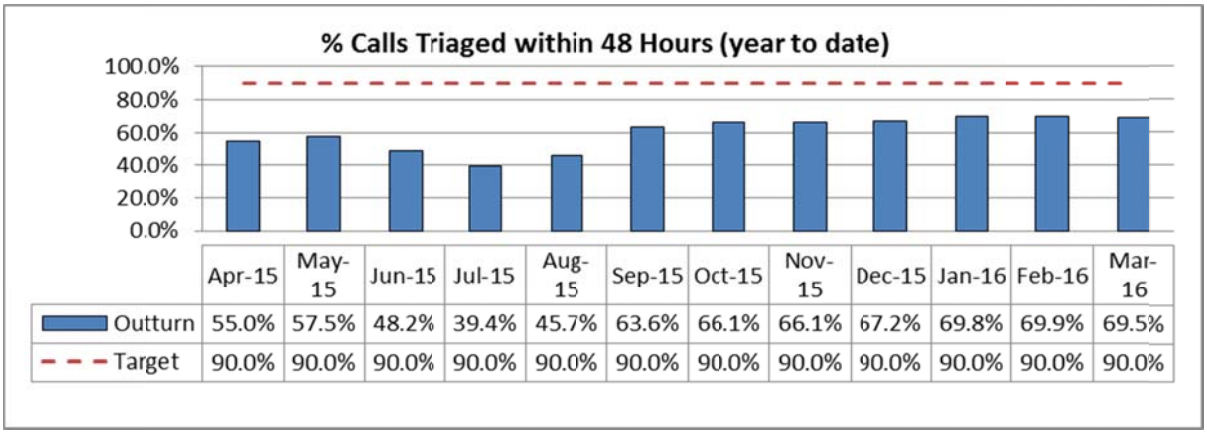
**2.0 Performance:**

2.1 Performance reporting has changed in 2016/17, reflecting the concerns that targets up to and including 2015/16 were unhelpful and not representative of the key safeguarding duties outlined in 'Making Safeguarding Personal' and The Care Act. The targets focussed on the process such as measuring time to initial strategy meeting or case conference. Performance against these are set out below.

2.2 Performance for 2015/16 with respect to key indicators in the Safeguarding Adults Process was:

**Percentage of Safeguarding Calls Triaged within 48 Hours**

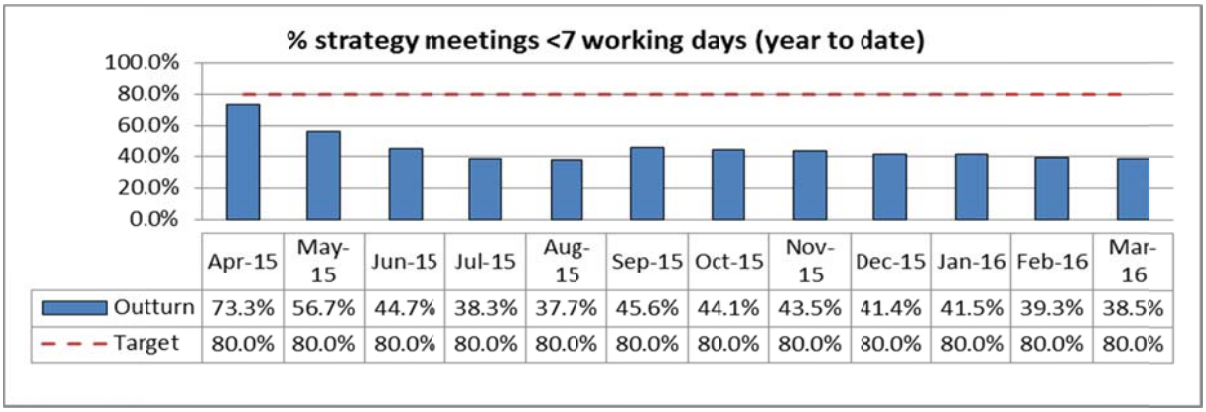
Performance to March 2016 was 69.5% against a target of 90% - rated red




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outturn | 55.0% | 57.5% | 48.2% | 39.4% | 45.7% | 63.6% | 66.1% | 66.1% | 67.2% | 69.8% | 69.9% | 69.5% |
| 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% |

**Percentage of Safeguarding Strategy Meetings held within 7 working days of alert**

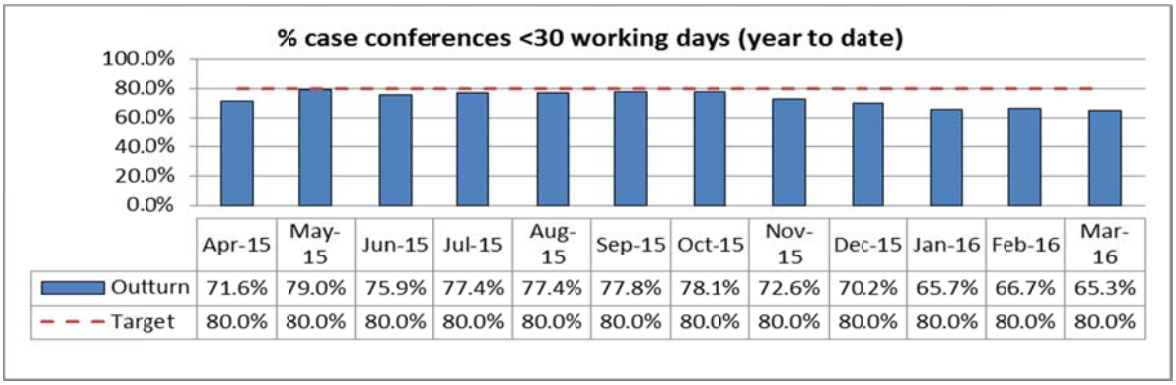
Performance to March 2016 was 38.5% against a target of 80% - rated red




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outturn | 73.3% | 56.7% | 44.7% | 38.3% | 37.7% | 45.6% | 44.1% | 43.5% | 41.4% | 41.5% | 39.3% | 38.5% |
| 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% |

**Percentage of Safeguarding Case Conferences held within 30 working days of alert**

Performance to March 2016 was 65.3% against a target of 80% - rated red




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outturn | 71.6% | 79.0% | 75.9% | 77.4% | 77.4% | 77.8% | 78.1% | 72.6% | 70.2% | 65.7% | 66.7% | 65.3% |
| 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% |

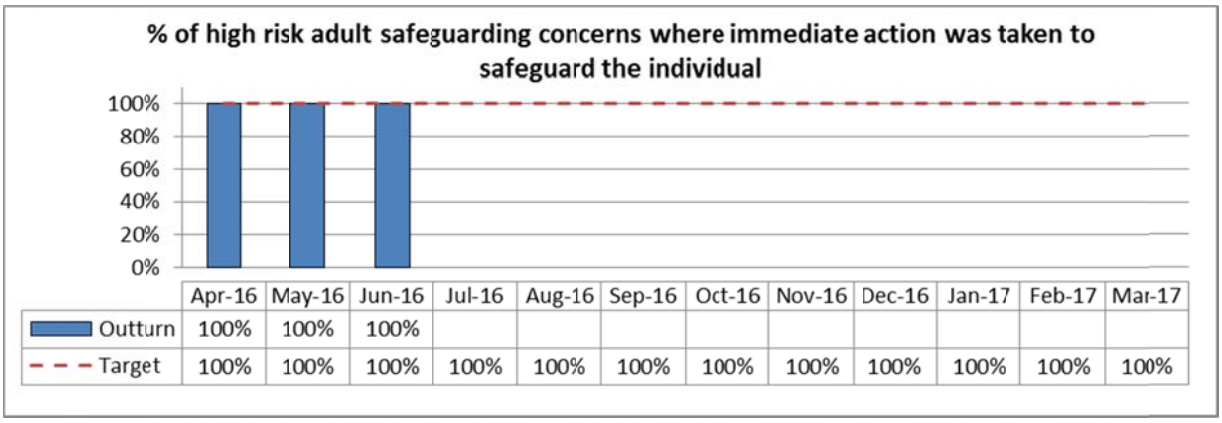
Staffing was increased to address difficulties in performance, which can be seen in the improvement trajectory in the 48hr triage target. However this 48 hour triage target was breached consistently all year. This target is not related to actions taken to ensure safety of individuals, which is always priorities and measured in the new indicator introduced in 2016/17. Monitoring of these indicators will continue through the Integrated Safeguarding Group but the focus will move to outcome measures.

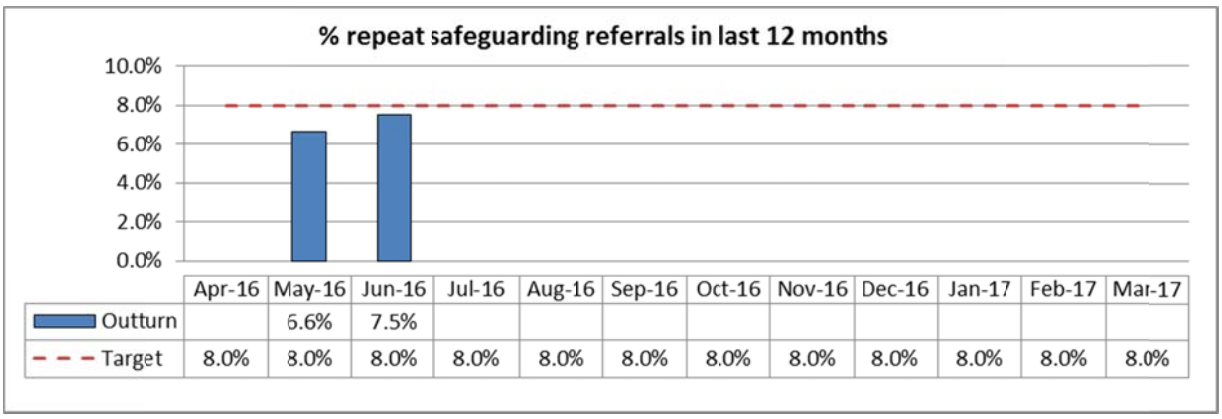
2.3 For 2016/17 reporting has been changed in agreement with Torbay Council. The new indicators reflect The Care Act's mandate to concentrate on personalisation of safeguarding.

Quarter One performance for revised key indicators for 2016/17 is:

- **Immediate Action taken to safeguard individuals who are triaged as high risk**
  Target 100%, performance for Q1 – 100%
- 
- **Repeat referrals to Safeguarding**
  Two cases were re-referred to Safeguarding in the last twelve month period.

Performance on our delegated responsibility as lead agency for Torbay Council is:




2.4 Current Training Performance: June 2016

| LEVEL | Percentage TARGET % | PERCENTAGE (meets requirement) | Staffing Figures (total staff group) | Staffing Figures (number meeting requirement) |
|---|---|---|---|---|
| One | 90% | 92.81% | 6080 | 5643 |
| Two | 90% | 75.07% | 3711 | 2786 |
| Three | 90% | 92.51% | 494 | 457 |
| Four | 90% | 94.48% | 163 | 154 |
| Five | 90% | 89.93% | 59 | 53 |
| Six | 90% | 100% | 8 | 8 |

The trust's figures on safeguarding adults training continue to improve. Lowest performance levels are in Level 2 – a targeted approach is being implemented with outlying services. This is the first year that we have reported as a whole ICO so aggregated comparator figures are not available. Senior management teams receive monthly reports on training compliance and there is a focus on providing accessible ways of accessing the level 2 training to achieve compliance.

## 3. Legislation and Guidance

*The Care Act 2014*

*The Care Act 2014* sets out provision relating to the care and support for adults and carers. Sections 42-47 of the Care Act relate specifically to Adult Safeguarding and replace the previous guidance contained in the ' No Secrets' documents.

The Act places Adult Safeguarding on a statutory footing in particular:

- **Each local authority area must set up an Adult Safeguarding Board (SAB)**
- **Each SAB must arrange for there to be Safeguarding Adult Reviews** (SAR) where a person has died and it is known or suspected that the death resulted from abuse or neglect, or where the person is still alive and has been subject to serious abuse or neglect.

*The Mental Capacity Act 2005* provides a statutory framework for:

- People who lack capacity to make decisions for themselves, or
- Who have capacity and want to make preparations for a time in the future when they may lack capacity
- Who can take decisions, in which situations, and how they should go about this.

*The Deprivation of Liberty Safeguards (DLS)* came into force in April 2009 and provides a framework for:

- Approving the deprivation of liberty for people who lack the capacity to consent to treatment or care, in either a hospital or care home and, in some circumstances, their own home.
- Requirements about when and how deprivation of liberty may be authorised.
- An assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

As a result of these and subsequent judicial reviews, a previously planned Law Commission review of DOLS has been accelerated: consultation is open currently and a revised draft Bill is to be published by the end of 2016.

In the interim, ADASS (Association of Directors of Social Services) have overseen a revision and streamlining of the standard and urgent forms which support the current DLS process; these are now being used by TSDFT staff.

## 4 Quality Assurance

### 4.1 Governance:

- Following the formation of the ICO, the Trust formed the Safeguarding Adults Operational Group to ensure clinical teams are leading the delivery of the safeguarding adults agenda. The monitoring and quality assurance of Trust wide Safeguarding Adults processes are reported to this group. This group reports to the Integrated Safeguarding & Inclusion Committee, chaired by the Chief Nurse and links to the Quality Assurance Committee internally and the Torbay Safeguarding Adults Board externally. There is an Audit programme which forms part of the standing agenda. The Trust's Integrated Safeguarding and Inclusion Committee have overseen the Operational work plan which has prioritised.

- The creation of a rapid Mental Capacity Assessment for inpatient services. This is being piloted and is designed to streamline the MCA assessments and decisions made for minor diagnostics and therapeutic inputs.
- Audit of MCA inpatient processes is in progress
- 
- Audit of Community Safeguarding processes and performance and dissemination of learning

4.2 Team Structure:

The creation of the ICO in October 2015 meant that the different functions for Safeguarding came together in the Professional Practice Directorate. The Associate Director for Social Care now manages the two discreet teams and functions, separate in order to ensure a split between the delegated Local Authority duty and our responsibilities as a provider of Health and Social Care.

There are two teams:

- The Torbay Safeguarding Adults Team consists of the Torbay Safeguarding Adults Lead and other team members. Its primary function is to deliver the Local Authority's duties, ensuring that vulnerable adults are safeguarded in Torbay. This team also oversees the Deprivation of Liberty Safeguards function.
- 
- The Safeguarding Adults Operational Team includes staff who are employed to support services to maintain and develop good practice in safeguarding adults and mental capacity. These staff currently report to the Associate Director of Social Care, in the Professional Practice Directorate but line management will transfer to the Trust operations team to ensure clear demarcation of accountability between the council and the provider.

There are challenges in the recruitment and retention of qualified, experienced Social Workers in operational teams, which has the potential to impact on the ability to allocate vulnerable adults. This is mitigated by the fact that cases involving safeguarding are always triaged as high risk and a workforce strategy is being developed to address gaps in the Social Work Workforce.

4.3 Modern Slavery:

Slavery is not an issue confined to history; A National Referral Mechanism has been established by the Home Office, of which The Trust is a statutory Partner. The process offers support to people who are identified as having been trafficked and/or are working as slaves. Our staff may very well encounter people who are trapped in slavery or have been subject to human trafficking.

In 2015/16 The Trust identified two Safeguarding Slavery Leads and formed a local partnership, led by Torbay Council. A Buzz training film has been produced. Recent activity in Torbay has identified that trafficking and slavery are real issues locally.

4.4 Prevent:

*The PREVENT strategy* was updated by the government in 2011 in response to the growing threat of terrorism and is one part of the UK Counter terrorism strategy CONTEST.

PREVENT is pertinent to adult safeguarding in that we know that vulnerable people have been targeted and radicalised. The Adult Safeguarding leads are responsible for assisting with the referral process and subsequent assessment meetings.

In 2015/16 The Trust made 2 referrals to the Prevent Channel Process, and assisted with 3 requests for information.

All staff are to be made aware of the PREVENT strategy and how it is being implemented within the Trust, via basic awareness training. This training is now included in induction training and updated via mandatory training schedules, in 3 yearly conflict training.

More detailed Health Wrap training is being undertaken for all relevant staff. 1106 staff out a cohort of 1143 has now completed this higher level training.

## 5. Whole Service Reviews (formerly whole home investigations)

Provider A
The Trust ceased an enquiry into care quality and staff misconduct on 6/5/2016. Concerns included the conduct of specific staff including the then manager. The homes ability to provide safe, well led care was of concern. The service has a new management team and has evidenced to both the Trust and Care Quality Commission (CQC) service improvement. The Trust is maintaining a level of intervention to be assured of sustainable improvement. A debrief of the enquiry is being arranged to capture learning.

Provider B
The Trust supported local commissioners in a care home closure process. The service failed to evidence to commissioners and CQC that they were able to meet their contractual and regulatory requirements. They subsequently took a unilateral decision to close the service. The home closed in June 2016 and all residents were safely moved to alternative placements.

## 6. Torbay Safeguarding Adults Board

The Trust is responsible for the delivery of this statutory board on behalf of Torbay Council. The Trust is a key partner member in both Torbay and Devon's Safeguarding Adults Boards, with respect to its provider status. The Trust's objectives in safeguarding, in both performance and training, link to both the Torbay and Devon Safeguarding Adults Boards' duty to keep people safe, as well as contributing to the key broader priority to Keep Vulnerable Adults Safe:

A new independent chair was appointed to the Torbay Safeguarding Adults Board (TSAB) in May 2016; she is currently reviewing the sub groups and membership.

The TSAB published an annual report in June 2016; this is attached as Appendix One. It is in the form of a booklet, in order to be as accessible as possible to the public. It is a statutory duty to produce this report.

One Safeguarding Adults Review (previously termed Serious Case Review) has been completed by the board, into the care and support provided by a Torbay Residential Home. This is due for publication in October 2016. A multi – agency learning event is being planned to address key recommendations, after publication.

## 7. Deprivation of Liberty Safeguards

7.1 DOLS Activity for the Supervisory Body (Delegated from Torbay Council):

Deprivation of Liberty (DOLS) assessments can only be done by Best Interest Assessors, who have undertaken a specialist qualification. The process authorises the 'deprivation of liberty' of people who cannot leave their care location and have an impairment of the mind.

DOLS statistics remain very high, and nationally there are significant problems in this field. In Torbay, staffing capacity to undertake the assessments is limited. The cases are triaged using criteria published by the Association of Directors of Social Services. An action plan is in place and is monitored by the Integrated Safeguarding and Inclusion Committee.

The team continues to prioritise high risk cases, of which there were 2 unallocated on the 18th July 2017.

The table below is for all cases, including both allocated and unallocated cases.

| Applications open by priority at snapshot | 2014/15: 31/03/15 | 2015/16: 01/04/16 | 2016/17: 23/05/16 | 01/06/16 | 01/07/16 |
|---|---|---|---|---|---|
| Awaiting Triage | 0 | 1 | 0 | 3 | 4 |
| High | 24 | 17 | 21 | 23 | 20 |
| Medium | 76 | 106 | 107 | 104 | 107 |
| Low | 409 | 447 | 458 | 446 | 447 |
| Other / Unknown | 12 | 0 | 0 | 0 | 0 |
| **Grand Total** | **521** | **571** | **586** | **576** | **578** |

7.2 Domestic DoLS:

Following the Supreme Court decision of 19 March 2014, the accommodation settings in which a person might be deemed to be deprived of their liberty was extended to include 'domestic settings' (for example Supported Housing).

This process mandates an application to the Court of Protection, and requires experienced Social Work staff, and substantial legal advice and costs. We have an estimated 150 people whom this may affect in Torbay. The process and policy are now in place and the teams are prioritising high risk cases.

**8. Priorities 2016/17:**

The Associate Director for Social Care oversees Safeguarding Adults Practice, reporting to the Chief Nurse. Priorities for the coming year with respect to Safeguarding Adults are:

- Strengthening of the arrangements for the Deprivation of Liberty Safeguards with the training additional Best Interest Assessors
- Aligning Safeguarding Training into one framework to be implemented from April 2017 onwards
- Addressing the challenges in the recruitment and retention of Band 6 Social Workers via a workforce strategy, to ensure the workforce is skilled and able to support vulnerable adults.

**9. Recommendation**:

To **note** the content of the report.

**Jane Viner - Chief Nurse**

Torbay and South Devon NHS
NHS Foundation Trust

# REPORT SUMMARY SHEET

| | |
|---|---|
| **Meeting Date:** | 7 September 2016 |
| **Title:** | Chief Nurse Report |
| **Lead Director:** | Chief Nurse |
| **Purpose:** | Noting |

**Summary of Key Issues for Trust Board**

Strategic Context:

This report will inform Torbay and South Devon NHS Foundation Trust board members on issues relating to the Chief Nurse portfolio.

Key Issues/Risks

Maintaining safe staffing required close monitoring and management. Key developments this month is the move to reporting Care Hours Per Patient Day which is in line with recommendations from Carter. Implementation of the Quality Effectiveness and Safety Trigger Tool across all care services is almost complete. It provides a clear overview of service risks and when triangulated with other clinical performance data flags area of risk but the full benefit will not be realised until a real time process is in place.

Improving our compliance with the Dementia Find measure is a key objective for Q3 and Q4. The Deputy Director of Nursing has completed a review of actions taken over the last year and identified where efforts should be focussed. Whilst the implementation of the electronic document system Nerve Centre will improve recording, this is unlikely to provide the short term solution required. For this reason the focus will be on driving the existing process with clear direction. An improvement trajectory and close monitoring.

Summary of ED Challenge/Discussion:

Achieving the dementia find target will be challenging. Staff are working to achieve a number of national and local targets with no increase in resource. Whilst the focus on Q3 and Q4 is for a rapid improvement in this measure, others such as Friends and Family may progress at a slower pace.

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

Nursing and Midwifery Council
CCG

Equality and Diversity Implications:

None

| | |
|---|---|
| **Report to:** | Trust Board |
| **Date:** | 7 September 2016 |
| **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

## 3 Safe Staffing:

### *3.1 Emergency Department*

The results from the Baseline Emergency Staffing Tool (BEST) analysis are currently being reviewed by the DGM and ADN & Matron in ED, an action plan will be decided from this over the coming weeks. The table below details the daily planned, actual and % fill rates for nurse staffing in the Emergency Department. The total fill rate for July 2016 was 107.8% (7.8% above plan) for RN and 103.5% (3.5% above plan) for HCA

| | | Total Planned shifts | | Total Actual Shifts | | RN Shift fill rate | HCA Shift Fill Rate |
|---|---|---|---|---|---|---|---|
| | | RN | HCA | RN | HCA | | |
| Fri | 01/07/2016 | 17 | 13 | 18 | 14 | 105.9% | 107.7% |
| Sat | 02/07/2016 | 17 | 13 | 18 | 12 | 105.9% | 92.3% |
| Sun | 03/07/2016 | 17 | 13 | 19 | 13 | 111.8% | 100.0% |
| Mon | 04/07/2016 | 17 | 13 | 19 | 14 | 111.8% | 107.7% |
| Tue | 05/07/2016 | 17 | 13 | 19 | 14 | 111.8% | 107.7% |
| Wed | 06/07/2016 | 17 | 13 | 17 | 12 | 100.0% | 92.3% |
| Thu | 07/07/2016 | 17 | 13 | 17 | 12 | 100.0% | 92.3% |
| Fri | 08/07/2016 | 17 | 13 | 17 | 13 | 100.0% | 100.0% |
| Sat | 09/07/2016 | 17 | 13 | 19 | 12 | 111.8% | 92.3% |
| Sun | 10/07/2016 | 17 | 13 | 18 | 14 | 105.9% | 107.7% |
| Mon | 11/07/2016 | 17 | 13 | 19 | 14 | 111.8% | 107.7% |
| Tue | 12/07/2016 | 17 | 13 | 17 | 14 | 100.0% | 107.7% |
| Wed | 13/07/2016 | 17 | 13 | 20 | 12 | 117.6% | 92.3% |
| Thu | 14/07/2016 | 17 | 13 | 17 | 14 | 100.0% | 107.7% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fri | 15/07/2016 | 17 | 13 | 17 | 14 | 100.0% | 107.7% |
| Sat | 16/07/2016 | 17 | 13 | 19 | 11 | 111.8% | 84.6% |
| Sun | 17/07/2016 | 17 | 13 | 17 | 16 | 100.0% | 123.1% |
| Mon | 18/07/2016 | 17 | 13 | 16 | 13 | 94.1% | 100.0% |
| Tue | 19/07/2016 | 17 | 13 | 19 | 13 | 111.8% | 100.0% |
| Wed | 20/07/2016 | 17 | 13 | 18 | 12 | 105.9% | 92.3% |
| Thu | 21/07/2016 | 17 | 13 | 18 | 16 | 105.9% | 123.1% |
| Fri | 22/07/2016 | 17 | 13 | 19 | 13 | 111.8% | 100.0% |
| Sat | 23/07/2016 | 17 | 13 | 19 | 14 | 111.8% | 107.7% |
| Sun | 24/07/2016 | 17 | 13 | 17 | 16 | 100.0% | 123.1% |
| Mon | 25/07/2016 | 17 | 13 | 18 | 11 | 105.9% | 84.6% |
| Tue | 26/07/2016 | 17 | 13 | 23 | 16 | 135.3% | 123.1% |
| Wed | 27/07/2016 | 17 | 13 | 19 | 13 | 111.8% | 96.2% |
| Thu | 28/07/2016 | 17 | 13 | 20 | 15 | 117.6% | 115.4% |
| Fri | 29/07/2016 | 17 | 13 | 17 | 13 | 100.0% | 100.0% |
| Sat | 30/07/2016 | 17 | 13 | 20 | 13 | 117.6% | 100.0% |
| Sun | 31/07/2016 | 17 | 13 | 18 | 15 | 105.9% | 111.5% |
| | **Total** | **527** | **403** | **568** | **417** | **107.8%** | **103.5%** |

*3.2 Care Hours Per Patient Day (CHPPD):*

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. In addition to this, in response to Lord Carter's report published in February 2016, the number of patients at midnight for the month is now also submitted. This submission supports the new primary measure of nursing workforce, Care Hours Per Patient Day (CHPPD).

The national median CHPPD, which is the metric to benchmark the organisation within the model hospital dashboard, used aggregated repurposed data for March 2016, and indicated a CHPPD of 6.77 for all care staff, with 4.07 for Registered Nurses and Midwives and 2.68 for Healthcare Assistants. For the month of July 2016 the organisational CHPPD is as follows:-

| | TSDFT July 2016 | National Median March 2016 |
|---|---|---|
| Total CHPPD | 7.99 | 6.77 |
| RN/ RM CHPPD | 3.82 | 4.07 |
| HCA / MCA CHPPD | 4.17 | 2.68 |

The table below shows the CHPPD for acute and community hospital wards.

| Ward | Planned Total CHPPD | Planned RN / RM CHPPD | Planned HCA / MCA CHPPD | Actual Mean Monthly Total CHPPD | Actual Mean Monthly RN / RM CHPPD | Actual Mean Monthly HCA / MCA CHPPD |
|---|---|---|---|---|---|---|
| Ainslie | 6.4 | 3.1 | 3.3 | 8.2 | 3.0 | 5.2 |
| Allerton | 5.9 | 3.6 | 2.4 | 8.1 | 3.6 | 4.4 |
| Cheetham Hill | 5.5 | 2.5 | 3.1 | 8.8 | 2.2 | 6.6 |
| Coronary Care | 5.8 | 5.8 | 0.0 | 9.0 | 8.6 | 0.4 |
| Cromie | 5.5 | 3.2 | 2.3 | 6.6 | 3.5 | 3.1 |
| Dunlop | 5.5 | 2.4 | 3.1 | 5.9 | 2.6 | 3.3 |
| EAU3 | 6.3 | 3.6 | 2.8 | 10.8 | 5.5 | 5.4 |
| EAU4 | 6.7 | 3.8 | 2.9 | 12.6 | 6.4 | 6.2 |
| Ella Rowcroft | 7.1 | 3.8 | 3.3 | 7.9 | 4.1 | 3.8 |
| Forrest | 5.3 | 3.1 | 2.2 | 6.7 | 3.9 | 2.8 |
| George Earle | 5.8 | 2.5 | 3.3 | 8.2 | 2.9 | 5.4 |
| ICU | 20.4 | 20.4 | 0.0 | 24.1 | 24.1 | 0.0 |
| Louisa Cary | 7.3 | 4.8 | 2.4 | 11.1 | 5.8 | 5.3 |
| John Macpherson | 4.0 | 2.3 | 1.7 | 8.3 | 4.7 | 3.7 |
| McCallum | 6.2 | 3.7 | 2.5 | 8.5 | 4.8 | 3.7 |
| Midgley | 5.5 | 3.3 | 2.3 | 6.0 | 3.1 | 3.0 |
| SCBU | 6.9 | 4.6 | 2.3 | 8.7 | 7.6 | 1.1 |
| Simpson | 5.5 | 2.5 | 3.1 | 6.7 | 2.6 | 4.2 |
| Turner | 7.9 | 3.6 | 4.2 | 8.6 | 3.6 | 4.9 |
| Warrington | 5.8 | 3.1 | 2.6 | 9.6 | 5.1 | 4.5 |
| Ashburton | 5.9 | 2.6 | 3.3 | 8.0 | 2.7 | 5.3 |
| Brixham | 6.1 | 2.8 | 3.3 | 7.9 | 3.1 | 4.8 |
| Dartmouth | 5.9 | 2.5 | 3.6 | 6.7 | 2.5 | 4.2 |
| Dawlish | 5.4 | 1.8 | 3.6 | 6.8 | 2.2 | 4.5 |
| Newton Abbot - Teign | 6.1 | 3.6 | 3.6 | 7.6 | 2.8 | 4.8 |
| Newton Abbot - Templar | 6.1 | 2.1 | 4.0 | 5.9 | 2.3 | 3.6 |
| Paignton | 5.1 | 2.0 | 3.0 | 5.9 | 2.4 | 3.4 |
| Totnes | 6.2 | 2.2 | 3.9 | 6.5 | 2.5 | 4.0 |

*Surgical Service Delivery Unit*

Ainslie vacancies awaiting newly qualified RN's, filled with agency placement and additional HCA.

*Medical Service Delivery Unit*

Cheetham Hill vacancies and absence. An agency placement has been agreed to provide continuity.

Midgley vacancies and absence. An agency placement has been agreed to provide continuity. The ward have been successful in recruiting to most vacancies and will be near establishment from October.

*Women's, Children's, Therapies and Diagnostics ServiceDelivery Unit*

SCBU continues to report a deficit in HCA hours but this being actively managed by cross cover of staff from Louisa Carey.

*Community Staffing Overview – Community Hospitals Setting*

Monthly data of staffing levels in our seven Community Hospitals with inpatient beds reflects 150 Inpatient beds open during June 2016. In early June five inpatient beds from Teignmouth transferred to Teign ward at Newton Abbot as agreed by the Trust board due to an inability to recruit registered nurses within the unit .This action was taken to maintain quality and safety of patient care. This resulted in a reduction in 7 inpatient beds across community hospitals.

Newton Abbot Teign and Templar wards show a RN staffing deficit. Staffing establishment is currently under review to ensure it reflects the move of beds from Teignmouth and Bovey Tracey.

3.4 Acute hospital escalation status:

The daily Trust alert status provides an indication of system pressure and resilience. Over the Winter months the % red escalation days has been as high as 80%, the July data shows 16%. Work is underway to ensure the escalation status accurately reflects the community services position.

| SDHFT Alert Status | No Days in Month | % days in Month |
|---|---|---|
| Red | 5 | 16% |
| Amber | 5 | 16% |
| Green | 21 | 68% |

3.5 Quality Effectiveness and Safety Trigger Tool:

The 22 quality indicators in QuESTT encompass: leadership, management, performance, Sickness , team capacity ,vacancy factor , patient feedback and a number of other domains . Eighteen questions are standardised across all settings and either 3 or 4 additional questions are service specific.

Teams scoring 12 + in community hospitals and MIU or 16+ in acute setting and other community teams are highlighted and discussed at the Quality Improvement Group. An organisational escalation procedure is in place which details the required management response based on the score and RAG rating which reflects the level of risk to quality and safety of the service.

In August 80 teams across the organisation teams completed the QuESTT and 68 teams were green and 12 teams (four acute setting and eight community teams) scored amber. No services triggered red or purple . The monthly reporting provides the organisation with an overview of the quality and safety across services and facilitates early action to be taken to mitigate risk.

In August those scoring amber in the acute settings were Cheetham Hill (21), Emergency department (16) Forrest (16) orthopaedic theatres (17). The common themes across the four acute services were nursing vacancies, sickness and appraisals not being performed in the previous month due to a lack of capacity. Cheetham Hill had an increased score (17) and this related to the dependency of

patients and short term sickness impacting on capacity , the matron has a plan in place to address the challenges. This was the first month that orthopaedic theatres had completed QuESTT and their amber score was due the common themes above plus and increase in trauma patients impacting on routine orthopaedic services. All community hospitals and Minor injury units were green.

Across the community settings the following areas were amber. Community Nursing - Brixham & Paignton – 2nd consecutive month but score reduced from 21 (amber ) to 16 (amber ). These two teams have recently been combined to improve resilience and the reduction in score is positive.

Physiotherapy in Newton Abbot has had a rising amber score for 4 consecutive months and increased from 20 in July to 22 in August: The reasons include vacancies + 1.0wte in Intermediate care team on maternity leave not backfilled and a rise in referrals being experienced. Community social work in intermediate care is also covering vacancy on the hospital ward – actions include: bank staff used, support from other localities. Recruitment is underway for the enhanced Intermediate care service.

Social Care – Brixham & Paignton – 2 months at amber and score has risen from 16 to 23. Key issue is vacancies in social work resulting in reduced capacity to manage work load. A recent recruitment drive has resulted in five social workers being recruited who will start in the coming months. The other common theme is long term sickness.

From September it is anticipated that 100 services will be reporting on the QuESTT tool monthly.

**4. Dementia Atlas**:

In England, 676,000 people live with dementia, a figure which will soar over the next forty years. In Torbay the figure is 2,722 out of a local 65+ population of 71,316 (3.82%). A dementia atlas was published online on 16 August by the Department of Health showing that standards of dementia care vary widely in different areas. The data covers the CCG population and is grouped in themes based on NHS England's dementia pathway which serves as a framework to ensure people with dementia have a better experience of health and social care support from diagnosis through to end of life.

- Preventing well
- Diagnosing well
- Supporting well
- Living well
- Dying well

Torbay and South Devon footprint data is set out below.

| **Preventing well** | | | |
|---|---|---|---|
| **Domain** | **Definition** | **Torbay** | **Trust actions** |
| Smoking – is a vascular risk factor | % over 15 recorded as smoking<br>(smaller value better) | 18.28%<br>(national avge 18.44%) | Participating in CCG and Public Health activities to reduce smoking |
| Hypertension – is a known. risk factor | % patients all ages with a recorded diagnosis of hypertension<br>(smaller value better) | 16.82%<br>(national avge 13.79%) | May be related to our local demographic. |
| **Diagnosing well** | | | |
| | % of new patients with dementia who have had a blood test recorded 6 months before or after entering the GP practice register.<br>(larger value better) | 74.01%<br>(national avge 74.71) | Action for primary care |
| | Proportion of those 65+ registered with a GP who have a formal & recorded dementia diagnosis<br>(larger value better) | 3.82%<br>(national avge 4.27%) | Action for primary care |
| | Proportion of people (all ages) registered with a GP practice in a CCG that have formal & recorded diagnosis of dementia.<br>(larger value better) | 1.14%<br>(national avge 0.74% | Action for primary care |
| **Supporting well** | | | |
| | For each CCG, how many people with a diagnosis of dementia are admitted to hospital each year as a proportion of the total number of people with a dementia diagnosis living in the area. | 50.46%<br>(national avge 54.59%) | Ensure coding accurate, sharing data |
| | Rate per 100,000 of emergency inpatient admissions for those with dementia 65+<br>(smaller value better) | 2,681 / 100,000<br>(national avge 3,306 / 100,000) | |
| **Living well** | | | |
| | Patients with dementia who have had a face to face annual review in the previous 12 months as a proportion of those on the register.<br>(larger value better) | 74.45%<br>(national avge 77.03%) | Action for primary care |
| | Number of dementia friends in the post code area | TQ9 – 171<br>TQ1 – 932<br>TQ13 - 401 | Possible area for Trust action. Trust Dementia lead to explore. |
| | Dementia friendly | Variable data | Trust participating in the |

| | | | |
|---|---|---|---|
| | communities | | Purple Angel activity coordinated by Norms McNamarra |
| **Dying well** | | | |
| | Mortality rates<br>(smaller value better) | 712,45 / 100,000 (national average 750 / 100,000) | Torbay are less than national average but this could be a result of failure to diagnose and register. |
| | Death in usual place of residence<br>(larger value better) | 81.69% (national average 67.45%) | Torbay perform well in this domain. The system EoL strategic Board have made this a priority area of action for 2016.17. |

The CCG are reviewing the information in the Atlas and the Trust will collaborate in any actions emerging from this review.

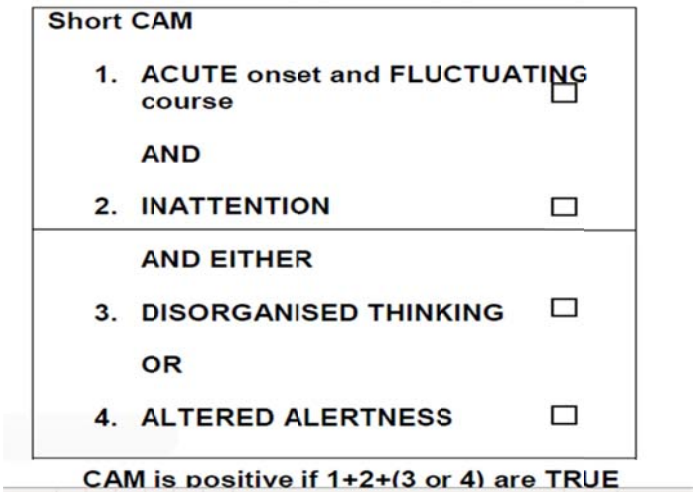
**5. Dementia Find update- Identifying inpatients 75 years and over with possible dementia :**

**Introduction:**
In 2014/15 NHS England set a Commissioning for Quality and Innovation ( CQUIN ) requirement aligned to dementia and delirium for all patients 75 years and over admitted as an emergency into acute hospital providers.

For 2016/17 the CQUIN has been retired but is retained in the standard contract as a mandatory, BAAS- approved data submission for all acute providers. It aims to maintain the identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after individuals leave hospital and to ensure that hospitals deliver high quality care to people with dementia. The data is uploaded nationally via UNIFY2 monthly and is reported quarterly to the commissioner. The indicator is divided into three parts:

- The total number of patients aged 75 and over , who are admitted as emergencies and stayed for more than 72 hours;
- Of these how many a) were asked the dementia case finding questions or b) had a clinical diagnosis of delirium using a locally developed protocol, or c ) had a known diagnosis of dementia ?
- Of there, how many should have undergone a diagnostic assessment and how many did?
- Of those who received a diagnostic assessment, how many should have been referred on to other services or back to their GP and how many were then referred in accordance with local agreed pathways.

In diagnosing delirium the Trust has adopted the Confusion Assessment Method (CAM) as set out below.




**Find , Assess, Investigate and Refer ( FIND ) process and FLOW CHART:**
There are three separate stages to the performance levels sought by the indicator:

- **FIND:**

  The case finding of at least 90% of all patients aged 75 and over following emergency admission to hospitals, using the dementia case finding question and identifying all those with delirium using the CAM assessment method and dementia with a known diagnosis of dementia. Patients with an existing diagnosis of dementia do not require further assessment but should have a diagnostic review if clinically indicated. Patients with a clinical diagnosis of delirium should receive further assessment and investigation to identify the cause and treat appropriately. Patients with neither pre-existing dementia or a presenting delirium should be asked the dementia awareness question. The question can be asked of the patient themselves, a family member of a professional care giver.*" Have you/ has the patients been more forgetful in the past 12 months to the extent that it has significantly impacted on your/their daily life?"*

- **ASSESS AND INVESTIGATE**

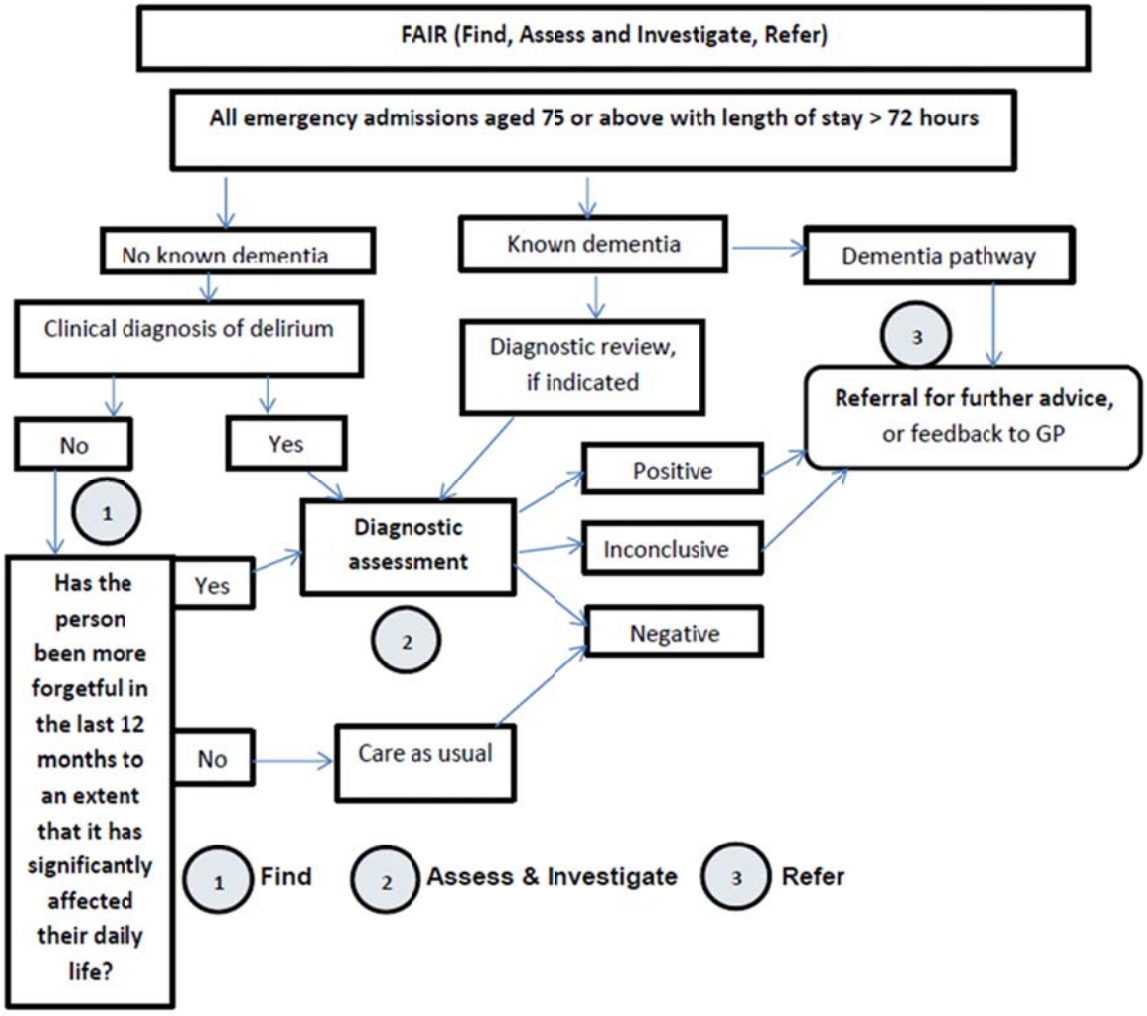
  The diagnostic assessment and investigation of at least 90% of those patients who have been assessed at risk of dementia form the dementia case finding question and / or the presence of delirium. Investigations must be undertaken to determine if the presence of dementia is possible.

- **REFER:**

  The referral of at least 90% of clinically appropriate cases for specialist diagnosis of dementia and appropriate follow up which dependent on the outcome of investigations includes :

1 Dementia suspected – forming part of the care plan summary GP to refer to memory clinic.
2 Dementia suspected – direct referral made to psychiatric services
3 Inconclusive or resolving delirium – GP to reassess in 6- 8 weeks.
4 Dementia not suspected.

**Fig 1: Dementia FAIR Flow chart**




**Current Systems and Processes**:

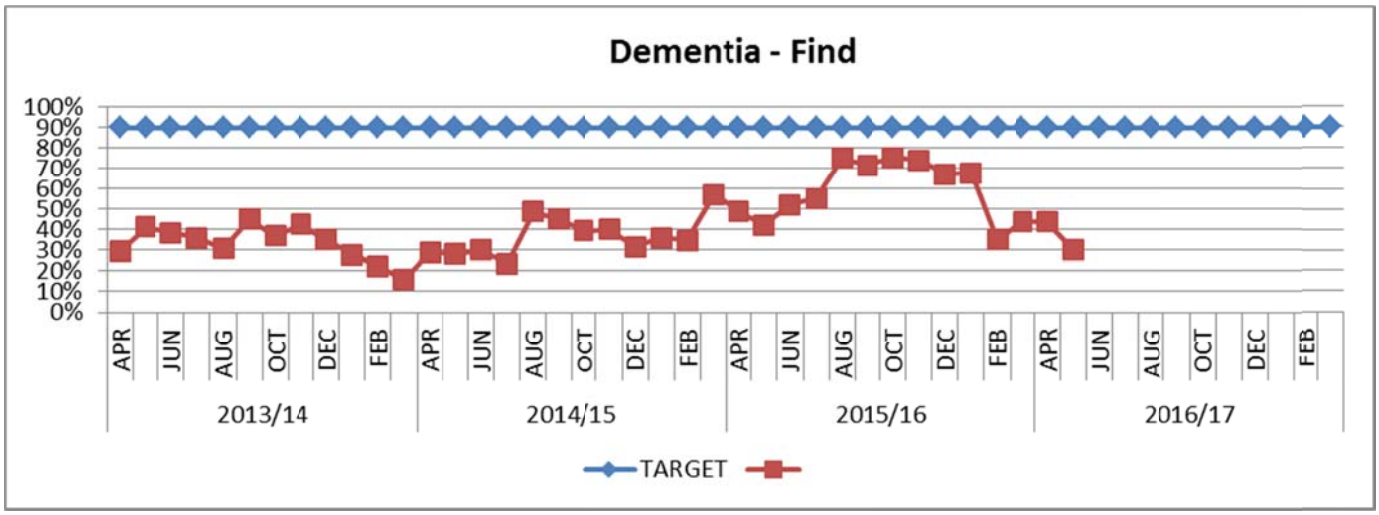
- A base line assessment exercise is currently being completed across the wards where patients 75 years and older are emergency admission inpatients to understand the current systems and processes, this includes 18 wards.
- Across the eligible wards there is a lack of a standardised process in place to support compliance.
- The responsibility for completion of the initial screen in some wards is the responsibility of the nursing workforce and in others is the remit of the medical practitioners. This is resulting in lack of clear ownership of the assessment and variable completion rates.
- In some wards the wards clerks are responsible for ensuring the form is attached to the front of the medical records on admission to alert the clinician to complete the assessment.

Some wards use the SWIFT board to identify those patients that need the assessment completed and highlight those already completed.

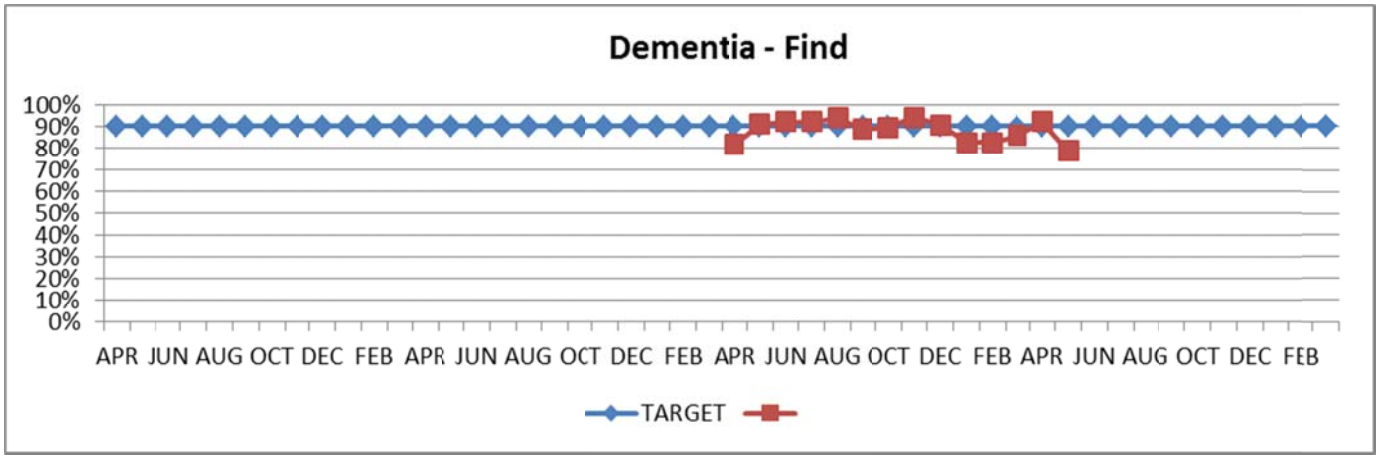
- Some have reported that the form does not currently flow well to support the clinician undertaking the assessment
- The dementia tool is a paper assessment which is transferred to an electronic system via infoflex at the point of discharge by the discharging medical practitioner.
- The infoflex data set for the dementia screening is not a mandatory field
- Infoflex provides the data source for the monthly reporting to the board.

**Current performance**:
The graphs below demonstrate the acute and community parts of the organisation performance in screening for dementia during admission since this requirement commenced in 2013.14. In the acute part of our organisation the dementia find has remained 50% or less during 2013/14 and 2014/15. In 2015.16 there was improvement achieving 75% when the dementia find was a mandatory field in infoflex. The combined organisational dementia find in May 2016 achieving 46 %

**Acute Setting**:




**Community Hospital Setting**:



**Identified issues in relation to current systems and processes:**
There are a number of deficits identified that are contributing to the organisational poor compliance with the national dementia screening standard this includes:

- A lack of organisational standard systems and processes
- The profile of the dementia screening requirements needs reinvigorating across the organisation at ward and senior level.
- A lack of clarity of roles and responsibilities for completion of the dementia FIND across nursing, medical and allied professionals.
- Paper form visually challenging to follow easily when completing the three step process.
- Dementia FIND section of infoflex is not a mandatory field when medical practitioners complete the care plan summary. Therefore it is possible the organisation is currently under reporting.
- A lack of monitoring and reporting at ward and Service delivery unit level resulting in poor line of sight from ward to Trust board.

**Nerve Centre Pilot**:
The pilot of nerve centre, which has a number of risk assessments, including the dementia find will be piloted in spetember 2016 on threre wards, Midgely , Allerton and Louisa Cary. Two of these wards will have patients meeting the crirteria for dementia screening and this work should improve compliance.

Prelimiary work undertaken by the nerve centre project team has identifed low levels of current compliance with the dementia screening on Midgely and Allerton.

The roll out to all wards will not be complete until April 2017.

**Next Steps:**
A small task and finish group to be set up to address the key areas set out above which will include medical lead, nursing lead , performance, IT and education.
The areas outlined above and any others identified as the baseline assessment is completed will form part of an overarching implementation plan to aid compliance of the national standard of 90%

**Conclusions and Recommendations:**
The Quality Assurance Committee is requested to note the content of this report and the authors request to support the proposed work programme. This is aimed at improving the number inpatients as an emergency admission that are 75 years or older to be appropriately screened for signs and symptoms of dementia and appropriate investigations and onward referral achieved.

**Recommendation**:
To note the content of the paper.

**Jane Viner - Chief Nurse**

**29 August 2016**

Torbay and South Devon NHS
NHS Foundation Trust

# REPORT SUMMARY SHEET

| | |
|---|---|
| **Meeting Date:** | 7th September 2016 |
| **Title:** | Report of the Medical Director |
| **Lead Director:** | Medical Director |
| **Corporate Objective:** | Safe, Quality Care and Best Experience |
| **Purpose:** | Information/Assurance |

**Summary of Key Issues for Trust Board**

Strategic Context:

- There is a need for strengthening of medical leadership in the Trust
- The Junior Doctors dispute relating to new contract is unresolved.

Key Issues/Risks

Medical Leadership

- Appointment of new Deputy Medical directors is completed and all will be in post by end of September
- Appointment of GP Locality Clinical directors is completed
- A review will be undertaken of medical leadership throughout the Trust with the redesign of operational structures
- A new leadership programme will be developed to strengthen leadership throughout the Trust and to improve succession.

Junior doctors new contract dispute

- The government have instructed all Trusts to implement the new junior doctors' contract commencing October 2016.
- Arrangements are in place to implement in TSDFT including appointment of the 'Guardian of Safe Working'
- The BMA Junior doctors' committee have called an all-out strike for 5 days (8am to 5pm) commencing 12 September 2016.

Summary of ED Challenge/Discussion:

The MD will give a verbal update on the planning for the junior doctors' strike.

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

Equality and Diversity Implications:

Nil

| | |
|---|---|
| **Report to:** | Trust Board |
| **Date:** | 7th September 2016 |
| **Report From:** | Medical Director |
| **Report Title:** | Medical leadership development in TSDFT |

## 1 Introduction

With the formation of the Integrated Care Organisation in October 2015 there was a plan to redesign and strengthen the medical leadership of the Trust. There was substantial loss of senior medical leadership in the first few months of the ICO through sickness, retirement and promotion outside the Trust. A programme of recruitment has been undertaken and individuals and a new structure are now in place. The individuals and their experience and skills have been chosen to match the needs of the organisation and our new care model.

The medical leadership has been redesigned at a number of levels reflecting the changing environment within which we are operating.

## 2 Corporate – Medical Director (MD) and Deputy Medical Director (DMD)

Deputy Medical Directors have been recruited to replace the previous Medical Director of Torbay and South Devon Health and Care Trust, The Deputy MD of South Devon Healthcare FT and the Director of the Horizon Institute.

The portfolio of the MD has expanded significantly since the creation of the ICO with new responsibilities for community services, voluntary sector and prevention, self-care and well-being. In addition there is a substantial commitment to the Sustainability and Transformation Plan (STP). The Deputy MDs will support the MD in all corporate areas of responsibility but will have specific additional areas of interest.

| | Commencing | Areas of responsibility |
|---|---|---|
| Mr Ian Currie<br>Vascular Surgeon in Torbay since 1999 | 1 May 2016 | Caldicott Guardian<br>Seven day Working<br>Clinical Services Review<br>Elective workstream STP |
| Miss Morven Leggott<br>Gynaecologist in Torbay since 2000 | 1 June 2016 | Review of consultant job planning<br>Divisional reconfiguration |
| Dr Andy Griffiths<br>Anaesthetist joining us from York and RAMC | 2 August 2016 | Leadership development<br>Acute Care Pathways<br>Medical Equipment |
| Dr Joanne Watson<br>Acute Medicine joining us from Taunton | 19 Sept 2016 | Quality Improvement (Horizon Institute).<br>Primary care strategy<br>Joint Prescribing |

Though there are 4 individuals sharing these responsibilities the total amount of medical leadership time and the cost is unchanged.

## 3 Locality Clinical Directors

There is agreement that there is a clear need to strengthen the voice of primary care and the community within our integrated care organisation. A new integrated operational structure is being described with 5 service delivery units (SDU) each based on one of the CCG localities. With the support of the CCG we have described a new post of Locality Clinical Director (LCD) who will join the senior leadership team in each SDU comprising other senior clinical leaders and senior managers. The key responsibilities of the post are to support the development of the Health and Well-Being Teams, to manage community medical staff and to contribute to redesign of specialist care pathways. We had an excellent response to advertisement of these posts and have been able to make high-quality appointments in all localities. All LCDs are established GPs within the locality. Appointments are not all confirmed to date.

We expect the individuals to come into post over the next 2 to 3 months and to influence the development of the new SDU structure.

## 4 Operational medical leadership

As part of the operational redesign there will be a review of operational leadership roles. At present we have Associate Medical Directors, Clinical Directors and Clinical Leads in some specialties. The aim of the review is to develop more effective clinical leadership throughout the organisation through reduction of the layers of medical leadership and improvement in clarity of role and accountability. There is a need to achieve an improved medical leadership structure without increased cost.

## 5 Medical leadership development and succession planning

Clinical leadership has been a real strength of the local health community. It has become difficult to maintain the clinical leadership voice with increasing pressure on clinical services and to ensure effective succession.

We will develop a leadership programme for medical staff, initially for newly appointed consultants and Staff Grade and Associate Specialist Doctors, designed to support the development of leadership and management skills with a strong emphasis on Quality Improvement. The development of this programme will be led by 2 of the new DMDs Dr Andy Griffiths and Dr Joanne Watson. This programme is expected to commence in the autumn of 2016.

We will also develop leadership progression for more established medical staff to build resilience and succession in leadership roles for medical staff.

Rob Dyer, Medical Director 23 August 2016

Torbay and South Devon NHS
NHS Foundation Trust

**REPORT SUMMARY SHEET**

| | |
|---|---|
| **Meeting Date:** | 7 September 2016 |
| **Title:** | Report of the Chief Operating Officer |
| **Lead Director:** | Liz Davenport |
| **Corporate Objective:** | Safe care/best care |
| **Purpose:** | Information |

**Summary of Key Issues for Trust Board**

**Strategic Context:**

To provide the Board of Directors with an update on key operational issues.

**Key Issues/Risks**

- Delivery of the care model changes and planned savings within the agreed timeframe
- Fluctuations in delivery of the 4 hour target which puts delivery against trajectory at risk
- Requirement to introduce Executive oversight and additional capacity to support delivery of the medicine CQC action plan
- Risk to delivery of cancer targets due to an increase in dermatology referrals

**Recommendations:**

To **note** the content of the report

**Summary of ED Challenge/Discussion:**

The Care model changes have been discussed at the Executive Team and agreement reached on priorities and focus in the period prior to and during consultation. The focus includes discussion on how care model changes will improve system resilience over the winter.

Weekly reviews of delivery against the Urgent Care Improvement plan are held and issues escalated for Executive attention.

Delay in progress against the medicine action plan due to capacity issues has been highlighted and mitigating actions including additional Executive level support.

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

The Care model changes will be subject to public consultation

**Equality and Diversity Implications:**

An Equality Impact assessment has been completed on the care model changes and a process is in place to complete this assessment as part of the change management process for significant service change.

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date:** | 7 September 2016 |
| **Report From:** | Chief Operating Officer |
| **Report Title:** | Report of Chief Operating Officer |

## 1 Purpose

To provide the Board of Directors with an update on 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 the Urgent Care Improvement and Assurance Group
- Minutes and action plan from the Medicine Improvement and Assurance Group
- Minutes of the Executive Team and Executive Huddle

## 3 Care Model Delivery

*Programme governance*

The Programme Management Office has taken a lead in developing a system that allows for the oversight of all projects required to deliver the care model. The Senior Responsible Owner (SRO) for each project is translating each project plan onto a project planning database. They are also responsible for ensuring that monthly updates are uploaded to the system so that the Care Model Operational Group can receive a report of progress against plan. Exceptions to delivery are highlighted and mitigating actions agreed.

A Programme Manager has been identified within the Transformation Team who has responsibility for overseeing programme delivery working closely with the Executive Sponsor and Service leads within the Service Delivery Units.

*Benefits realisation*

The SROs have been asked to complete a review of the costs of delivery of each of the projects including an updated assessment of the impact of the investment on delivery of cost savings. The work to date has identified where savings will be realised, further work is required to test the assumptions.

All the cost savings projects are being mapped and Senior Responsible Officers identified. Implementation of many of these schemes is contingent on the outcome of the Community Consultation.

In completing this work a potential gap has been identified in planned savings. It has been concluded that this is due to:

- Outpatient innovations need to be further developed in order to meet assumed savings targets. Work is underway to take forward a number of additional schemes System benefits – in some circumstances the benefit from the care model have been to the wider system and not directly to the Trust which needs further review for example the Musculoskeletal pathway changes
- Changes to bed based care within the acute sector have not been included in full as detailed plans have not been completed.

*Consultation update*

NHS England have authorised our Clinical Commissioning Group (CCG) to begin the consultation on the future of community services across all localities except Coastal (which was subject to a separate consultation last year).

The consultation will begin on 1 September and conclude on 23 November.

*Locality implementation- early adopters*

It has been agreed that 2 of the localities will be early adopters of the new model of care. In addition to taking forward the core components of the care model the teams will be reorganised to work in multi-disciplinary teams who have adopted strengths based approach to assessment and agreeing outcome statements. The intention is to introduce innovative ways of working that change how people's needs can be met. This includes the introduction of my support broker, which delivers a model of person centred care planning.

The 2 localities that have been identified are:

- Coastal
- Torquay

These areas have been working on plans for implementation on 1 October 2016.

*Delivery structures*

A revised operational delivery structure is being developed to manage delivery of services. The structure, which will be based on localities, will be finalised in September. This will be followed by period of consultation with staff affected by the changes and implementation by the early part of next year. It is anticipated that implementation will be completed in a phased way to avoid disruption to delivery of core services.

Interviews have already taken place for GP Clinical Directors who will be part of the leadership teams. There was a strong field of applicants and it is anticipated that appointments will be confirmed shortly.

*Summary of progress against projects*

The progress in the last 2 months includes:

- Vision for locality working- joint work with the 2 early adopters to describe the vision for working in localities and the measures that will be used to assess progress. Champions are also being identified to drive implementation within services.

- Recruitment to Enhanced Intermediate Care Teams across localities - good progress is being made and additional capacity has been identified in the recruitment team to support appointments by 1 October 2016

- Discharge to assess - work has been undertaken to understand current service utilisation so that we can better understand where to target delivery of discharge to assess. A steering group has been set up and implementation plans being put in place. The work programme which will be implemented on 1 October 2016 will focus on alternative to admission at the front door and 'home first' discharge plans from acute and community hospitals. The implementation will be supported by enhanced intermediate care capacity.

- Well being coordinators - training programmes have been taking place and staff are taking up their roles in localities.

- Clinical hubs and health and wellbeing bases are being described and plans being put in place to transition teams and services to new bases. Further work required to replicate this level of detail across all localities. This work will be completed with the support of the Estates Team.

- Personal commissioning - a partnership has been established with the Community Development Trust and My Support Broker. This approach will be run as a pilot Torquay and Paignton and Brixham. Appointments to brokers are taking place and training and operational plans developed. Individuals who are due a review of their current package of care will be the first to experience this way of working.

- Multi-Long term conditions management - the approach has been subject to review and an alternative approach agreed to identify people who have been identified as benefitting from support through a single team approach. Partnerships have also been established with GP practices who are keen to support a new way of working

- Seeking advice in the ICO - a review of the first 3 months data has been presented to the Clinical Management Group. The data shows that there is good take up of the function across specialities with variance across specialities on conversion from advice to referral. Further work is being

undertaken to better understand the data with a view to understanding if it is containing and/or reducing demand. This work is being done in collaboration with the CCG.

- Medical staffing - the Medical Director has been negotiating with primary care with the support of the CCG on the model of medical support to localities including Intermediate Care. Good progress has been made with the core agreement in place for each locality. The details including costs of the new model will be shared at the next Care Model Operational Group.

- Evaluation – the programme, which has been commissioned to evaluate the delivery against the agreed outcomes measures, continues with regular reports on progress to the Care Model Operational Group.

## 4 Urgent care Improvement plan (4 hours)

*A&E Delivery Boards*

NHS Improvement and NHS England have mandated the establishment of A&E Delivery Boards. Locally the function will be delivered through a group chaired by the Chief Operating Officer of the Trust. In addition a STP A&E Delivery Board has been set up which will be attended by the Chief Operating Officer of the Trust and the Director of Commissioning and Transformation from South Devon and Torbay CCG. It is understood these groups will have a defined working arrangement with the Urgent and Emergency Care Networks that have also been put in place to support improvements in Urgent and Emergency care.

The purpose of the Boards is to ensure delivery of the 4-hour target by end of 2016/17 through the application of a 5 mandated work streams. Communities will be supporting the programme through the Emergency Care Improvement Team (ECIP). The level of involvement of this team depends on a RAG rated status of the community. As a system we have ben rated amber and are in segment 2.

The 5 key areas of work are:

- Streaming at the front door to ambulatory and primary care
- NHS111- increasing the number of calls transferred for clinical advice
- Ambulances- reduce conveyance and increase ‘hear and treat’
- Improve flow – implement the SAFER bundle
- Discharge- to include discharge to assess

These work areas already feature in the Trust and wider community plan and the focus now will be delivering this at pace.

*Bid for development monies*

The Trust is waiting for a decision on a bid that was submitted for capital funding to support improvements in Urgent and Emergency Care. The bid that was submitted within a very short time frame by the Director of Estates and Business development. If it is successful it will allow significant improvements to the Emergency Department environment and development of an Urgent Care Centre. We expect to hear the outcome at the end of September.

*Current performance*

The Board of Directors has received a recent briefing on performance against the Urgent Care action plan. In summary:

- The monthly trends show an overall improvement in line with plan
- The system is fragile with weekly fluctuations in performance although this is reducing. Increased attendances, reduced flow and staffing all impact on performance
- Work is continuing to change working patterns in the emergency departments with further work required in other areas of the hospital
- In the last 2 weeks the ED has achieved its 80% target for time to first observations in 15 minutes
- Rapid assessment is becoming embedded with improved consistency to clinical review within 60 minutes
- There is a continued focus on sepsis and the target for timely screening of sepsis is reliably met.

*New areas of work*

At the last Urgent and Emergency Care Improvement Group the following areas of work were commissioned and will be taken forward by the Deputy Medical Director and clinical colleagues in the Emergency Department. These are aimed at improving flow and reducing crowding in the department. The work programme is in line with the recommendations of ECIP. The work is given the title ‘internal professional standards’ and is defined as the agreed response times to referrals made by the emergency department by specialities. The work will be addressed in 2 phases:

- Streaming (escalated referrals during busy periods)
- Routine referrals

## 5 Medicine improvement plan

It has been agreed to establish a separate Improvement and Assurance Group to oversee the delivery of the CQC action plan for medicine. The group follows a similar format to the Urgent and Emergency Care Improvement Group and is chaired by the Chief Operating Officer and members of the Executive Team will attend, along with the Senior Leadership Team from Medicine. The group will meet on a 2 weekly basis and will report to the Executive Team and the Board of Directors. Once the

programme of work has become embedded it will be managed within agreed SDU governance arrangements.

An initial work programme has been agreed that includes:

- Develop an alternative to the 'O' drive for recording, monitoring and prioritisation of patients waiting medical review
- Set standards for time to clinical review
- Medical staff working patterns - all wards to have consultant presence for part of the day
- Weekend planning standards
- Improved escalation arrangements 7 days a week
- Improve data set and information utilisation

Further details will be shared as part of the routine briefing to Board.

## 6 Internal Audit review of service delivery units' governance arrangements

A review of Governance arrangements within service delivery units was completed and the report published in June 2016. The Service Delivery Units have been updating their local arrangements to reflect the recommendations. This includes:

- Updating terms of reference and membership
- Standardising agendas and improving minute taking
- Improving access to a consistent set of information to support local decision-making.
- Formal documentation of committees and management groups being in each Service Delivery Unit
- Reporting of peer reviews and external investigations through the Service Delivery Unit Boards.

## 7 Hot issues

- **Out of Hours/111 contract-** a new contract has been agreed for 111 and out of hours services that will come into effect from 1 October. Devon Docs will provide the new service. In the transition the current service has experienced challenges in maintaining the numbers of staff required to populate shifts. Contingency plans are in place but in recent weeks the service experienced a reduction in the number of people using the service that may have an impact on the rest of the urgent and emergency care system.

- **CAMHS procurement**- the CCG has signalled their intent to tender CAMHS services in Torbay as part of the children's service re-procurement in Devon in 2017/18. If confirmed it is expected that a formal 12 notice period will be issued shortly.

- **Cancer targets**- the performance team has highlighted that there is a risk to delivery of 3 cancer standards for the quarter which is driven by an above expected levels of dermatology. The team is reviewing the detail and action plans to mitigate risks.

**Recommendation**

To **note** the contents of the report

**Liz Davenport**

**Chief Operating Officer**

**29 August 2016**