Torbay and South Devon NHS Foundation Trust

Council of Governors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

23 September 2016 10:30 - 23 September 2016 12:00

AGENDA

#	Description	Owner	Time
1	Chairman's welcome and apologies: L Archer, L Darke, L Davenport, G Hotine, J Saunders, J Smith, S Russell, S Wright For information	Chairman	
2	Declaration of interests To receive	Chairman	
3	Minutes of the last meetings held on 20 July 2016 (enc) To approve 03 - 2016.07.20_DRAFT_CoG_minutes.pdf 5	Chairman	5
4	Chairman's report (verbal) To receive	Chairman	5
5	Ensuring an active patient and public membership – engaging young people (enc) To receive 05 - 2016.09.23_Anna_Pryor_Report.pdf 29	A Pyror	15
6	Chief executive's report including other lead director reports (enc) To ask questions 06 - Chief_Executive_Report.pdf 35	CEO/DoF	15
7	General feedback on the CCG-led consultation (enc) - to include feedback from governors attending the public meetings To receive 07 - Stakeholder_update8.pdf 193	DoS&I / Governors	10
8	Lead governor's report including constituency reports (enc) To receive 08 - 2016.09.23_Lead_Governors_Report.pdf 195	Lead Governor	5

#	Description	Owner	Time
9	Non-executive director's report (verbal) To receive	D Allen	15
10	Quality and Compliance Committee report (enc) To receive & approve 10 - 2016.09.23_QCC_Report.pdf 197	W Marshfield	5
11	Membership development report (enc) To receive & approve 11 - 2016.09.23_Membership_Development_Report.pdf 199	L Hookings	5
12	Secretary's report (enc) To receive 12 - 2016.09.23_Secretarys_Report.pdf 203	CoSec	5
13	Urgent motions or questions To receive & action	Chairman	1
14	Motions or questions on notice (enc) To receive & action	Chairman	1
15	Details of next meeting: 14 December 2016, 3pm-5pm, Anna Dart Lecture Theatre CLOSED SESSION – please leave the meeting at this point if you are not a governor / board member		
16	Private minutes of the last meeting held on the 20 July 2016 (enc) To approve - 2016.07.20_DRAFT_CoG_minutes_PRIVATE.pdf 5	Chairman	1
17	Board matters (verbal) -opportunity for the board to advise governors on any new issues; sensitive and/or confidential To receive	Chairman/CEO	5

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Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING

HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE,

TORBAY HOSPITAL

20 JULY 2016

Governors

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

Directors

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

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

(* denotes member present)

Action

1. **Welcome and apologies**

Apologies were received from: Carol Day, Carol Gray, Lynne Hookings, Mary Lewis, Julien Parrott, Rosemary Rowe, Simon Slade, Rob Dyer, Martin Ringrose, David Allen, James Furse.

2. **Declaration of Interests**

There were no declarations of interests.

3. **Minutes**

The minutes of the meeting held on 20 April 2016 were approved as an accurate record of the meetings.

The Chairman apologised that no NEDs had been available for the 20 April meeting, and was pleased to note increased levels of NED attendance at today's meeting. Owing to the length of today's agenda there would be no NED presentation – the next would be at the September CoG.

With regard to matters arising, the Chairman confirmed that CS had circulated details of governor observer appointments (minute 13) and the Estates Strategy (minute 14) was an item on today's agenda.

4. **Chairman's report**

The Chairman asked CoG to approve the recommendation that Jacqui Lyttle is appointed as Senior Independent Director (SID), following the retirement of Les Burnett. This proposal was unanimously approved.

Richard Ibbotson presented a verbal SWOT analysis regarding the current position of the Trust.

Strengths

- Operating profile – good improvement being seen in ED performance following implementation of improvement plan
- RTT performance also moving in right direction
- Good performance in comparison to other FTs locally and nationally
- Improved performance due to good leadership by the COO - the Chairman asked that thanks were recorded to the COO and her team for their efforts in improving performance
- Ongoing difficult financial opposition for the NHS nationally, also impacting on TSDFT, although the Trust's current financial performance is on target
- Good results from recruitment campaign for nurses in the Philippines and on-going planning for "grow your own" staffing model
- First ever technical support apprenticeships have commenced
- Good progress for the Freedom to Speak up Guardians (FTSUG) network – "See Something Say Something" initiative also well-embedded
- The Chairman expressed thanks to the staff governors – there was evidence of good engagement across the Trust
- Good level of engagement from Junior Doctors, compared to other Trusts
- WOW awards – second breakfast presentation ceremony had taken place on 19 July – pleased to note good level of attendance from Executive Directors. Staff welcomed the opportunity to come to the hospital and meet Lead Directors
- Good progress now starting to be made following Voluntary Sector event held at Newton Abbot racecourse
- The Chairman reported that the Health and Care video lab had reached the finals of the National Patient Safety awards

Weaknesses

- On-going difficult financial position for the NHS nationally, also impacting on TSDFT, although current financial performance is on target
- Delays in care model implementation
- Delays in CCG-led process for community consultation (original planned start date May 2016) and some community hospital staff starting to leave prior to outcome of consultation being known. GP engagement critical to consultation process

Opportunities

- Finance – some transformation funding to become available shortly which the Trust will bid for
- STP and Success Regime – work progressing well in Devon and some opportunities may arise regarding provision of specialist services
- Accountable Care Organisation (ACO) – various issues arising with regard to CCG and commissioner/provider split – again not down to TSDFT to lead on these

Threats

- Recent announcement regarding reduction in service provision by Rowcroft
- Reductions in domiciliary care and care home capacity – new model of care would require appropriate availability – currently this is reducing
- Need to ensure all staff involved in decision-making around the new care model

5. **Chief Executive's report**

The CEO advised the meeting that the CQC inspection report had been published, the quality summit had been held and progress was underway with implementation of the action plan. CEO advised CoG that the Lead Governor had been fully sighted on this work.

Included with the CoG papers were the CEO, Chief Nurse and COO report as presented to the July Board and the CEO would be happy to receive any questions from governors on any of those items.

CEO was pleased to report good progress on development of the new Model of Care, with significant investment in developing the community hospital strategy, also ensuring appropriate staff involvement. She reported the temporary closure of beds at Paignton hospital to ensure patient safety owing to staffing shortages.

CEO gave thanks for the work of Martin Ringrose, Interim Director of Human Resources and Organisational Development, who would be leaving the Trust at the end of July to take up a regional role with the Devon-wide Sustainability and Transformation Plan team.

The CEO also thanked COO and her team for the significant increase in performance during quarter one. There was evidence of good joined-up working between acute and community teams to improve patient flow: the CEO also commended Nicola Barker and her team for their efforts in this area. The CEO and Director of Strategy had had a tele-conference with Northumbria NHS Trust, who were facing similar challenges around joint working.

6. **Rapid Response in Torbay and South Devon and Enablement in Torbay**

The COO introduced Suzanne Skelly (SS), Lindsey Lovell and members of the Rapid Response team, explaining the extensive work being undertaken to improve community service outcomes. SS was pleased to advise CoG that the team had recently been nominated successfully for a WOW award.

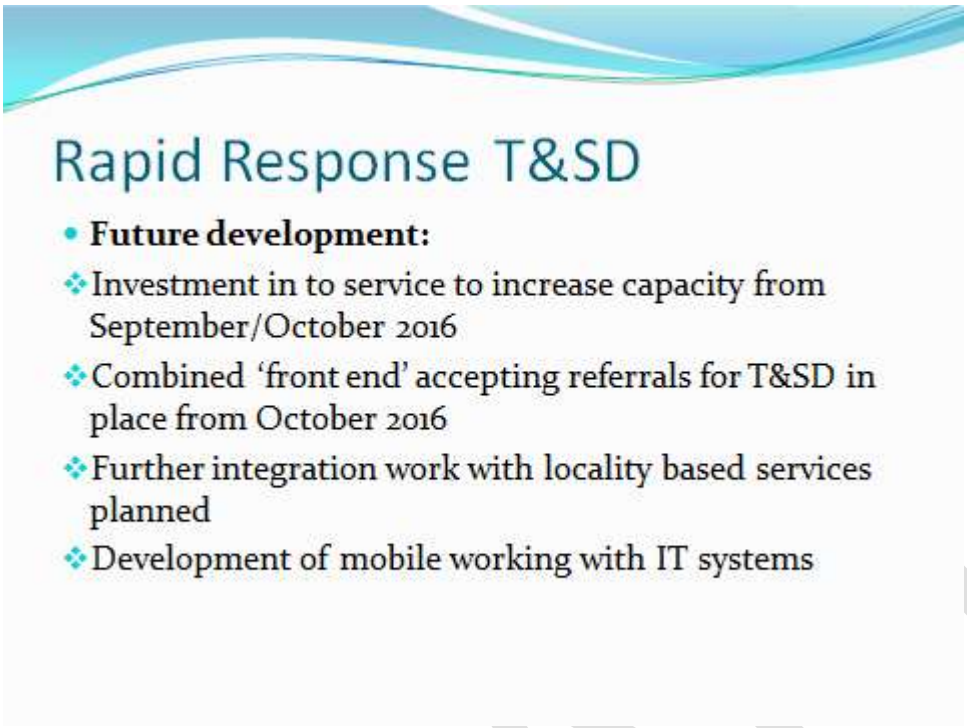
The following presentation was provided on the work of the Rapid Response team (Torbay and South Devon) and the Torbay Reablement team.

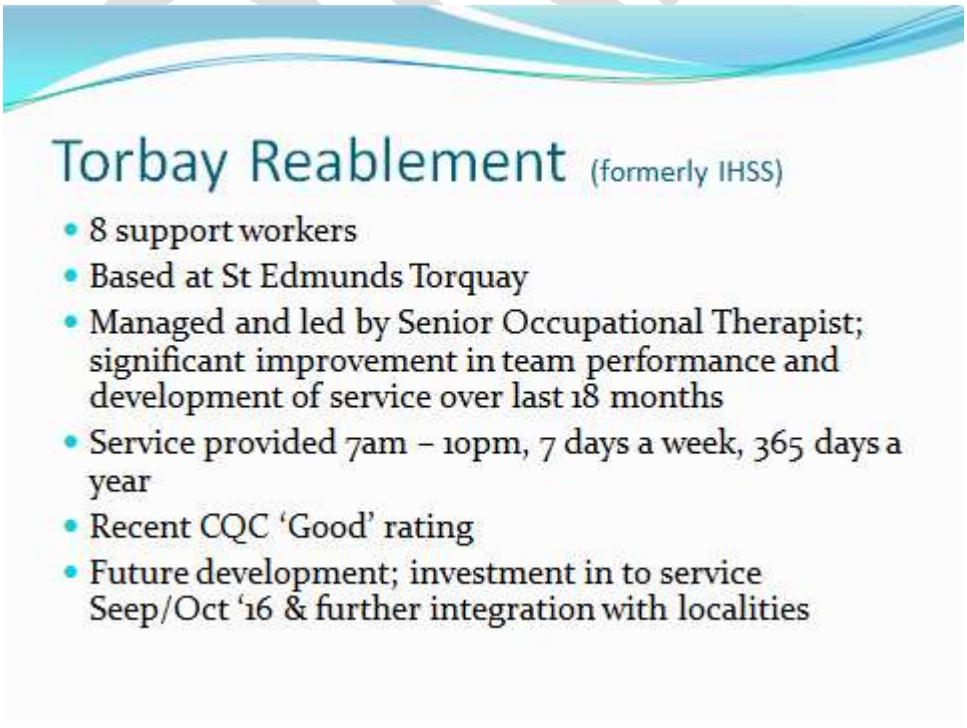
Rapid Response (Torbay) (formerly CRT)

- 10 support workers
- Based at St Edmunds in Torquay
- 24/7 365 day/year service
- Aim of service: to support people to remain at home during a health or social care crisis, including hospital discharge (limited volume)
- People are supported at home for up to 72 hours
- Recent CQC 'Good' rating

Rapid Response South Devon

- 12 support workers
- 24/7 365 day/year service
- Based at Newton Abbot Hospital
- Aim of service: to support people to remain at home during a health crisis, also supports those with carer breakdown and now includes hospital discharge (limited volume)
- People are supported at home for up to 7 days


Rapid Response T&SD
Future development:
Investment in to service to increase capacity from September/October 2016
Combined 'front end' accepting referrals for T&SD in place from October 2016
Further integration work with locality based services planned
Development of mobile working with IT systems


Torbay Reablement (formerly IHSS)
8 support workers
Based at St Edmunds Torquay
Managed and led by Senior Occupational Therapist; significant improvement in team performance and development of service over last 18 months
Service provided 7am – 10pm, 7 days a week, 365 days a year
Recent CQC 'Good' rating
Future development; investment in to service Seep/Oct '16 & further integration with localities

Following the presentation, various questions were raised by members. Lead Governor asked how referrals were made to the team and was advised that they could be made by any Health and Social Care professional. Self referrals could be made to Intermediate Care teams but not currently to Rapid Response team. Lead Governor suggested raising the profile of the team - SS to pursue with Comms Team re publicity. **Action: Su Skelly/COO** COO

COO explained the simplified Single Point of Contact system and standardised processes currently being tested which would be rolled out to all areas in due course.

Sylvia Russell asked about how the team helped to deal with the issues of social isolation experienced in rural areas of Teignbridge and South Devon and SS explained the on-going work at locality level – working with Trust teams and GP practices. Wendy Marshfield team capacity to cope with ever-increasing demand for services. Team member explained the type of care provided, ranging from personal and palliative care, ensuring that assessments are made to ensure that people are safe at home and escalating any Safeguarding issues identified. Following a question from Christina Carpenter the team explained they could deal with washing, dressing, medication and provide End of Life hospice at home cares where required. Key role of the Emergency Duty team was to ensure people were safe and that any identified issues relating to domestic violence were escalated.

SS explained the process for onward referral following engagement by the team. She confirmed there were different timescales for service provision in Torbay and South Devon owing to different commissioning arrangements with Torbay and Devon County Councils.

COO confirmed recent investment of £2.1 mil to increase team capacity and also bed-based provision where required.

Team members described their caseload, the training they received as support workers and the help and support available to them, confirming that service users welcomed their intervention as most people want to remain in their own homes. SS confirmed that opportunities for tele-health were currently being explored.

The Chair thanked SS and her team for the excellent work they do and for attending today's COG.

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

Lead Governor provided details of Governor activity since last CoG. Constituency meetings held and reports provided with meeting papers: any arrangements for inviting MPs to constituency meetings should be made through the CS/Foundation Trust office to ensure consistency. The Chairman informed governors that he and the CEO were due to meet local MPs in London in the autumn and Lead Governor said the governors would be interested to meet any available MPs - would it be possible to invite them to a COG meeting in 2017? **Action: CS**. CS

Governors had participated in PLACE inspections, and taken part in governor training. She referred to the celebrations held to mark 90th anniversary of Torbay Hospital on 23 June and the role of an 82 year old nurse, who is still working, and reflected on how best to acknowledge long service by many members of staff and volunteers. The Chairman explained the process for thanking staff on their retirement from the Trust and the planning currently underway to hold tea party for those staff. Lead Governor encouraged governors to participate in the CCG consultation programme, which is scheduled to start in September 2016.

At the pre-meeting held before today's CoG, governors had commented on the observer forms which were currently being reviewed and due for re-issue in September. **Action: CS** CS

Governors raised the issue of perceived lack of communication to staff regarding the various service changes taking place: the CEO said she understood why some staff might feel vulnerable but confirmed a range of different communications being issued on a regular basis to managers and staff at all levels. The Chairman also provided assurance to governors on this issue.

Terry Bannon felt there was a better culture of information sharing of late, which would help to break down barriers between management and staff.

The Chairman thanked the Lead Governor for her report.

8. **Estate's strategy**

The Director of Estates and Commercial Development provided the following presentation highlighting progress on the 2016 to 2021 Estates Strategy:-

Torbay and South Devon NHS
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Why is it important?

- First Impressions and fundamental to patient experience and safety
- Our service users and staff need and deserve to be safe, secure and warm and our buildings and facilities should enhance our care offering.
- Regulatory framework
- High value and high cost
- New care model and partnerships driving significant change in the estates configuration and need
- Drive to reduce cost of the estates, and drive efficiencies..

Where do we want to be?

Torbay and South Devon NHS
NHS Foundation Trust

Our Strategic aim therefore is to:

> Provide a **transformed and innovative estate portfolio** which delivers **excellent, quality, well maintained and economical buildings and facilities** which are **efficient and responsive** to the changing needs of the population and local communities of Torbay and South Devon.

The focus will be on:

- Ensuring all the Trust buildings are quality and fit for purpose,
- Delivering targeted investments and developments alongside our partners to deliver effective buildings that facilitate the delivery of the new model of care in the community.
- Targeted investments and developments to address key safety, service and quality risks.
- Investing in backlog maintenance concentrating on the areas of highest risk and greatest need across the estate.
- Improving the use of the estate, eliminating poor quality, under used and surplus assets and reducing the cost of property and facilities

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Where are we now? - Key facts

Torbay and South Devon NHS Foundation Trust	
Total occupied property floor area m^2	**123,605m^2**
Total owned property floor area m^2	110,460m^2
Total PFI floor area m^2	9,374m^2
Total owned floor area leased out m^2	7,029m^2
Total Leased property floor area m^2	10,800m^2
Total Owned Property Value (MEAV) £000	c£80 million
Total Lease cost per annum £000	£659,000
Total Lease income per annum £000	£320,000

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NHS Foundation Trust

Leases

Property	Leased / Licenced	Lease term/intention	Lessor (Owner / Leaseholder)
Formerly held by the Acute Trust:			
Broomhill Way Building	Leased	Terminate 2016	Private landlord
Regent House Building	Leased	Will remain until lease end Aug 2021	Private landlord
PMU, Unit 7 Torbay Business Park, Long Rd, Paignton	Leased	Will remain until lease end Aug 2027	Private landlord
Formerly held by the Care Trust:			
Unit 1, Cavanna House, Riviera Park	Leased	Terminate 2016	Private landlord
Unit 2, Bay House, Riviera Park	Leased	Will remain until lease end 2020	Private landlord
Unit 3, Riviera Park	Leased	Will remain until lease end 2024	Torbay Council
Union House - two floors (3rd + 4th)	Leased	Will remain until lease end 2022	Private landlord
St Edmunds Centre	Leased	On a rolling 6 month extension until 2017	Torbay Council
Walnut Lodge	Leased	Will remain until lease end Nov 2017	Chelston Hall Surgery
Brunel Dental Centre, Forde House	Leased	Being renegotiated - will continue under new terms	Teignbridge District Council
Hollacombe Community Resource Centre	Leased	On a rolling 6 month extension until 2017	Torbay Council
Paignton Library - Rooms + Offices	Leased	Will remain until lease end Dec 2017	Torbay Council
The Kings Street Rooms	Leased	Being renegotiated - will continue 12 months	Private landlord

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Condition and Suitability

- Condition assessed via comprehensive 6 facet survey every three years - building condition, statutory compliance fire DDA &H&S, functional suitability and environmental quality

Summary:

- Some poor quality estate that either needs investment to bring it up to a suitable standard or disposal.
- High level of high significant risk backlog maintenance – national outlier (but reduced since from £31m 13/14 to £19m in 15/16)

	TSDFT	Plymouth	RD&E
High	5,946,000	1,586,024	750,000
Significant	19,133,000	15,869,734	3,635,635

Condition - Hospital

Torbay and South Devon NHS
NHS Foundation Trust

Area	Condition	Strategy
Physiotherapy	D	Move the service and demolish the single storey building
TAIRU & Occupational Therapy	D	Move the service and demolish the single storey building
Critical Care Unit	D	New build Critical Care Unit and re-configure existing space
Old Hospital: Special Theatres	D	New build special theatres (x2) and re-configure existing space
Computer Suite (Annexe)	D	Short term upgrade. Long term: new build on alternative site and consider disposal of annex site.
Podium Block: Mortuary	D	Consider regional and area mortuary strategy. New build if it is to stay on the Hospital site.
Old residences	C/D	Move services and demolish
Podium Block: Fracture Clinic, ED,	C/D	New build and or major re-configuration and upgrade
Estates & Facilities	C/D	Upgrade to condition C
Podium Block X-Ray	C/D	Upgrade to condition B
Old Hospital: Medical Directorate Offices	C/D	Upgrade to condition B
Hetherington wards x4	C	Short term maximise side room capacity. Long term: New build medical wards within central hub.
Histopathology	C	Consider regional and area mortuary strategy. New build or co-location within existing pathology if it is to stay on the Hospital site.
Stores Industrial Unit, Broomhill Way (leased)	C	Dispose of the building (end lease)
Haemotology	C	Co-locate with existing pathology and re-configure vacated space.
Catering Complex	C	Upgrade to condition B
Womens Health Clinics	C	Upgrade to condition B
Generator Building	C	Upgrade to condition B
General Theatres	C	Upgrade to condition B
Hengrave House	C	Upgrade to condition B

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Condition - Community

Area	Condition	Strategy
15/16 Church Street	D	Vacate and dispose of the premises
Midvale Road Clinic	D	Vacate and dispose of the premises
Bovey Tracey Hospital	C/D	Dispose of or invest a significant amount to bring to condition B
Paignton Hospital	C/D	Dispose of or invest a significant amount to bring to condition B
Teignmouth Hospital	C	Dispose of or invest a significant amount to bring to condition B
Dartmouth Hospital	C	Dispose of or invest a significant amount to bring to condition B
Ashburton & Buckfastleigh Hospital	C	Dispose of or invest a significant amount to bring to condition B

How do we get there?

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Community facilities plan

- Provide new/upgrade buildings to deliver new model of care
  - Housing of Locality health and well being (MDT) teams
  - Capital investment in Locality clinical hubs
  - Capital investment in local towns to create health and well-being hubs likely co-located with GP's
- Rationalisation of Leases
- Partnership working with General Practice and the voluntary sectors to come up with new funding and delivery models
- Disposal of poor quality and no longer required buildings
- Neutral funding model (Investments funded by disposals)

How do we get there?

Torbay and South Devon NHS
NHS Foundation Trust

Acute facilities plan

- **Key improvement Priorities**
  - Emergency Pathway (ED and imaging – reconfigure/upgrade/new ext'n podium level 3 more single rooms and medical wards)
  - Theatres and surgical pathway (reconfigure and new theatres podium level 5)
  - Other: ANC, Mortuary (upgrade)
  - Continue site wide improvements
- **Key backlog maintenance priorities**
  - New air handling units, generators and pipes (widespread)
  - Infection control improvements (sanitary ware, sluice kitchens)
  - Building fabric - Floors, windows, doors
  - Asbestos removal (widespread)

Finances

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- The plan suggests a need for c£10m per year for the estate for five years (dev't & maintenance)
- Front loaded for the next two years £18m and £15m to deliver the priorities detailed in the plan (ED & Theatres).
- Only part of the demand on capital
- Our demand is more than our capital allocation so can only be funded via FTFF loan for developments -Subject to central approval affordability and available capital
- Affordability is dependent on delivery of CIP's.

Key Risks and mitigations

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Risks

- Current financial position across the entire NHS means capital expenditure is constrained.
- Delivery of CIP's and the control target is a challenge and therefore affordability is an issue.
- Availability of Central loan Capital may be limited.

Mitigations

- Prioritise the capital and any Trust funds we are able to use to address the essential and critical risks across all elements.
- Present coherent and well argued business cases for capital and have cases written ready in the event of further funding opportunities from the centre
- Deliver revenue savings and CIP's
- Explore new and innovative partnerships around delivery and funding options.
- Accept that some developments are unable to happen in an ideal timeframe this is likely to impact on PLACE environmental scores and CQC expectations.

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Watch this space

" Many patients arrive each day for their GP or Hospital appointment in what are – can we speak frankly?- overcrowded and clapped-out buildings in need of a makeover, if not bulldozer. Yet to help balance the books, the NHS is currently switching billions of pounds of capital investment into day-to-day running costs.

When you've got lemons, make lemonade. UK government borrowing costs are now the lowest they've been since the Napoleonic wars. Instead of inflexibly expensive PFI, how about a substantial NHS 70th Birthday Public Fund for Infrastructure? It'd create optimism across the NHS, unleash major efficiencies, turbocharge construction industry, and be welcomed in across the country."

Simon Stevens Chief Executive NHS England from an article in the telegraph 19th July (yesterday).

Scheme updates:-

Torbay and South Devon NHS
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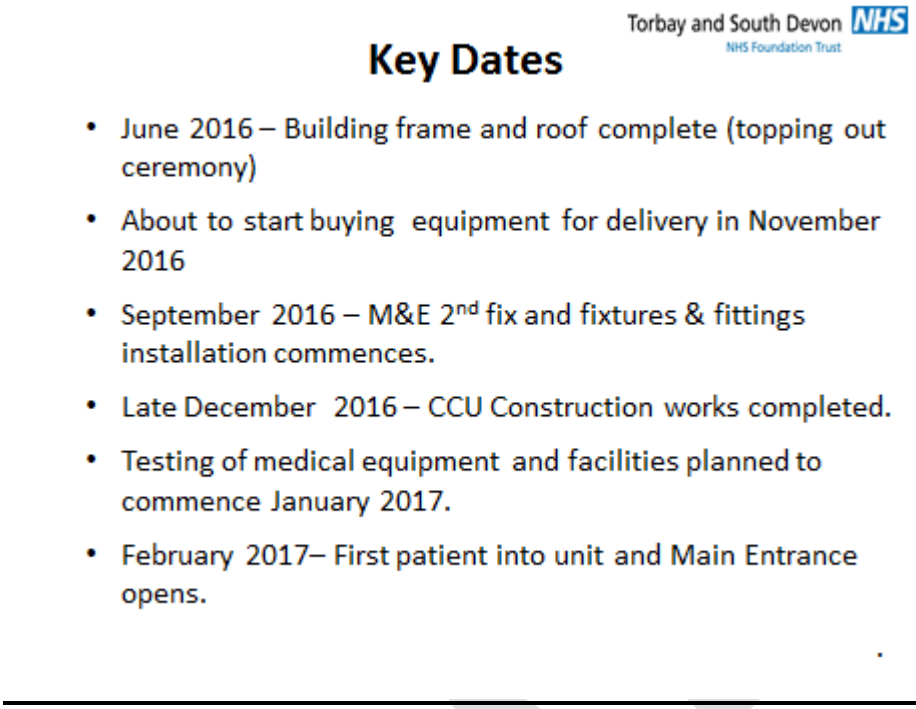
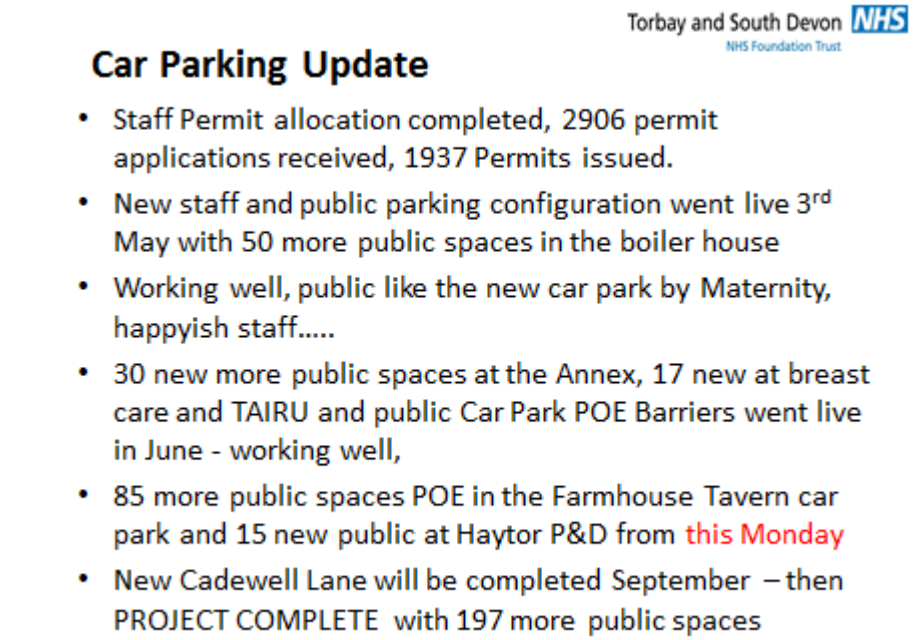
CCU Project Status

Monthly project boards reporting into the Infrastructure and the Environment Group

☺	Finances on budget
☺	Programme 2 weeks behind the target CCU handover date. On programme for completion
☺	Procurement on programme ICU information system ordered.
☺	Risk: Some residual risks remain a small concern until breakthroughs complete





The Lead Governor thanked the Director of Estates and Commercial Development for a very helpful presentation. On behalf of the governors she also thanked the DECD and her team for the improved car parking arrangements.

A question was asked about any problems arising through the removal of asbestos during on-site works and DECD confirmed that where possible asbestos is left in place to avoid disturbing it.

The CEO left the meeting at this stage.

9. **Company Secretary report**

The CS provided his report for information. There was one action outstanding – to forward to governors the updated portfolio of responsibilities for NEDs. **Action: CS** CS

10. **Sustainability and Transformation Plan**

The Director of Strategy introduced the following presentation on the sustainability and transformation plan:-

STP Requirements

Torbay and South Devon NHS
NHS Foundation Trust

All local health & care systems required to develop a 5 year sustainability & transformation plan (STP) covering period Oct 2016 to March 2021

All NHS providers required to develop & submit 1 year operational plans for 2016/17

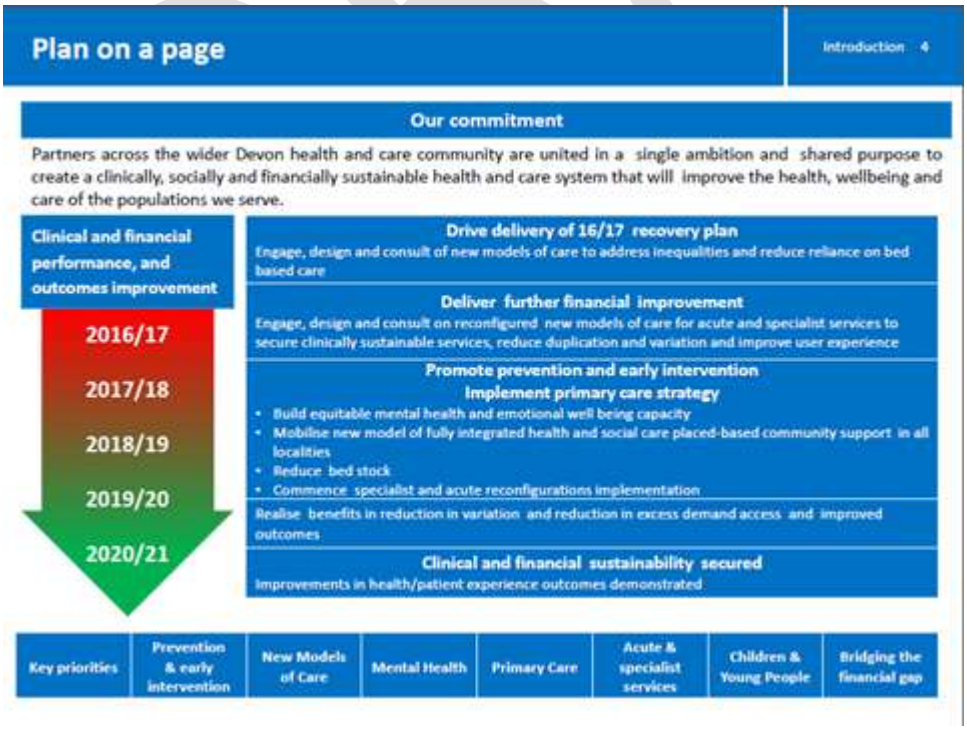
STP Investment

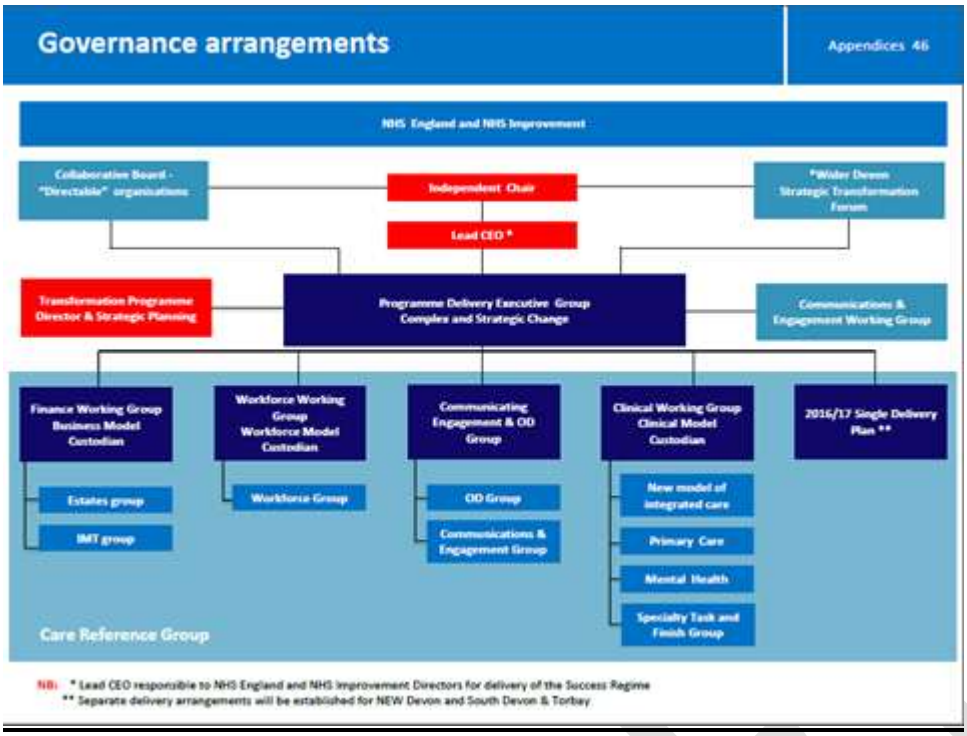
Torbay and South Devon NHS
NHS Foundation Trust

- **funding available for "strong, credible STPs"**
- **Spending Review settlement included £2.139bn investment in a Sustainability & Transformation Fund (SRF) in 2016/17. Of this £1.8bn allocated to sustainability element of the fund to bring NHS provider trust sector back to financial balance**
- **for 2016/17 quarterly release of sustainability funds to providers will depend on achieving recovery milestones for deficit reduction, access standards, and progress on transformation**
- **STF will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21**

STPs will become the single application and approval process for being accepted onto programmes with transformation funding for 2017/18 onwards, with the most credible and compelling STPs securing the earliest funding


Sustainability & Transformation Plan (STP) submission
Wider Devon 30 June 2016
Name of Footprint and number: Wider Devon (37)
Region: South
Nominated lead of the footprint: Angela Pedder,
Chief Executive, Royal Devon and Exeter NHS Trust
Contact details
angela.pedder@nhs.net
l.nicholas@nhs.net
Organisations within footprint
NEW Devon CCG, South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Living Well (formerly PCH) (CIC), Devon Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK
The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.


Plan on a page
Introduction 4
Our commitment
Partners across the wider Devon health and care community are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve.
Clinical and financial performance, and outcomes improvement
2016/17
2017/18
2018/19
2019/20
2020/21
Drive delivery of 16/17 recovery plan
Engage, design and consult of new models of care to address inequalities and reduce reliance on bed based care
Deliver further financial improvement
Engage, design and consult on reconfigured new models of care for acute and specialist services to secure clinically sustainable services, reduce duplication and variation and improve user experience
Promote prevention and early intervention
Implement primary care strategy
Build equitable mental health and emotional well being capacity
Mobilise new model of fully integrated health and social care placed-based community support in all localities
Reduce bed stock
Commence specialist and acute reconfigurations implementation
Realise benefits in reduction in variation and reduction in excess demand access and improved outcomes
Clinical and financial sustainability secured
Improvements in health/patient experience outcomes demonstrated
Key priorities
Prevention & early intervention
New Models of Care
Mental Health
Primary Care
Acute & specialist services
Children & Young People
Bridging the financial gap



STP Next Steps

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- National challenge meeting (15 July)
- Revised submission (end September)
- Plans for shared back office and pathology services by end of July
- Focus on vulnerable services
- STF allocation guidance

ICO's Role in the STP

Torbay and South Devon NHS
NHS Foundation Trust

- Being amongst the first organisations nationally to achieve structural integration via the ICO model gives us an excellent basis from which to deliver the aspirations of the Five Year Forward View in a local context
- Our purpose is completely aligned to the local place based and wider system aspirations and our operational plans reflect our commitment to the local health and care system's shared vision
- Ensure don't lose focus on local place

- Voice for SD&T population
- Maximise opportunities to make services more resilient and sustainable
- Learning opportunities and access to best practice
- Benefit from changes that drive greater quality and deliver greater efficiencies
- Strong partner - add value to help secure sustainability and transformation funding

The DFI advised members that the final document would be circulated as soon as possible.

11. **Quality and Compliance Committee report**

Wendy Marshfield introduced her report on the meeting held 24 June 2016. She asked that the CoG accept the draft notes of the meeting and the revised Terms of Reference which had been recently reviewed. The CoG approved both the above.

12. **Membership Development report**

In the absence of the Group's Chair, Lynne Hookings, Wendy Marshfield introduced the report of the meeting which had taken place on 8 July 2016. She asked that governors provide feedback directly to Lynne Hookings with any comments on proposals regarding the NHS Providers Governance Survey 2016 – "Approaches to Membership Engagement that achieved the most valuable outcomes"
Action: All members All

13. **Urgent motions or questions**

None

14. **Motions or questions on notice**

The following had been received:-

1. Please could the Trust respond to the following statement; some governors concerned that the Trust had not kept them informed of the specific emergency department red rated issues as highlighted in the Care Quality Commission's (CQC's) report i.e. aware of the four-hour target during 2015/16, but not the underlying CQC issues. ***Torbay Constituency – Lead ED Jane Viner***

2. Can you assure governors that the work required to meet the actions required following the CQC inspection are achievable and what the impact on the financial status of the Trust will be. ***Torbay Constituency – Lead ED Jane Viner***

3. The successful implementation of the care model and more efficient working within the Integrated Care Organisation (ICO) is dependent on ensuring the delivery of shared health and social records. What assurance can be given to the governors that there is clarity about the plan to deliver shared records for health and social care professionals in 2016/17 , 2017/18 onwards, that it is on target and meeting the needs of the care model as it is now being currently rolled out and CQC recommendations. ***Torbay Constituency – Lead ED Rob Dyer***

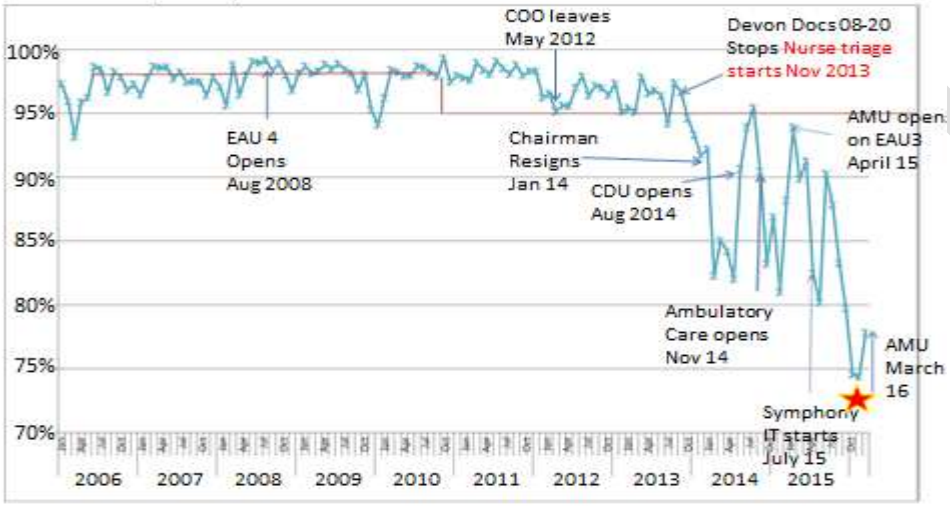
Chief Nurse provided the following presentation in response to **Question 1**

Governor Question:

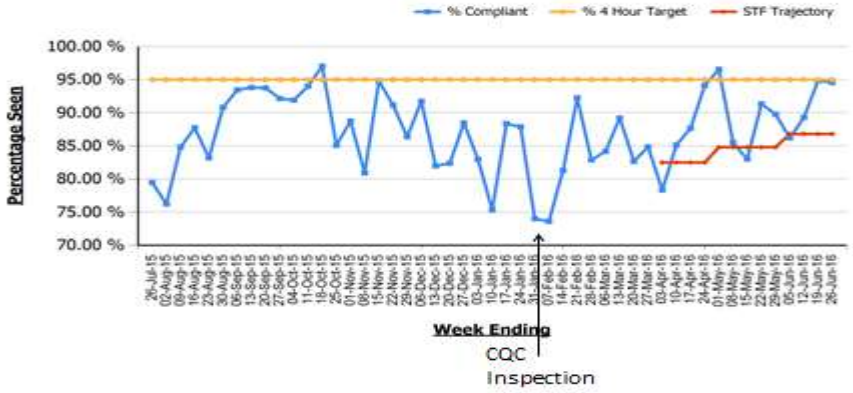
Some governors concerned that the Trust had not kept them informed of the specific emergency department red rated issues as hi-lighted in the CQC report i.e. aware of the 4 hour target but not the underlying CQC issues.

- Context
- Monitoring
- Governance
- Board awareness
- CQC requirement notice
- Current position

Look back 10 year ED performance trend of the 4 hour wait Jan 2006 - Jan2016



P1146: Weekly ED & MIU Performance - 4 Hour Target (95%)



Monitoring

Daily Monitoring:

- Exec led control room 3 x daily meeting
- Live Symphony Early Warning Score
- Senior ED team reports
- Executive on call
- Exec / Senior managers in the department
- Night report
- Incidents

Safety mitigations:

Additional staff (20 WTE)
Intentional rounding
Focus on Pressure Ulcers
Escalation wards opened
EWS monitoring
QuESTT / CQAT
Staff cultural barometer
Working with us panel

Governance

Board:

- 4 Hour performance
- 12 hour trolley waits
- Delayed ambulance handover
- OOH transfers
- Incidents & complaints
- Corporate Risk Register
- Board reports

WS1 – QIG:

4 hour performance
EWTT for ED (Amber / Red)
Risk register 'ED safety'
16 / 12
Organisational Alert Status
Jan 87% red
June 29% red

ED report to QIG December 2015

- 4 hour Performance
- Bulges in activity later in the day
- Hospital capacity / flow
- At establishment, reviewing
- Symphony IT
- Paeds positive
- Pressure ulcer prevention being implemented
- Sepsis bundle being implemented
- Domestic violence
- Safety crosses

CQC concerns - February

- Time to initial triage & assessment (vital signs)
- Monitoring and response to EWS & sepsis
- Staffing in Resus and Paeds areas
- Governance

Quality & Safety KPIs

Safe:
- Sepsis bundle
- Symphony vital signs
- Infection control
- Time to triage
- Time to Medical Assessment
- Staffing review (BEST)
- Hourly board rounds

Effective:
- QuESTT
- Review paediatric flow
- CQAT
- Extended volunteer presence
- Review shift patterns

Responsive:
- Monthly patient experience

Caring:
- Stress Busters
- Intentional Rounding
- Pressure ulcer care

Well Led:
- Exec on site
- Cultural barometer

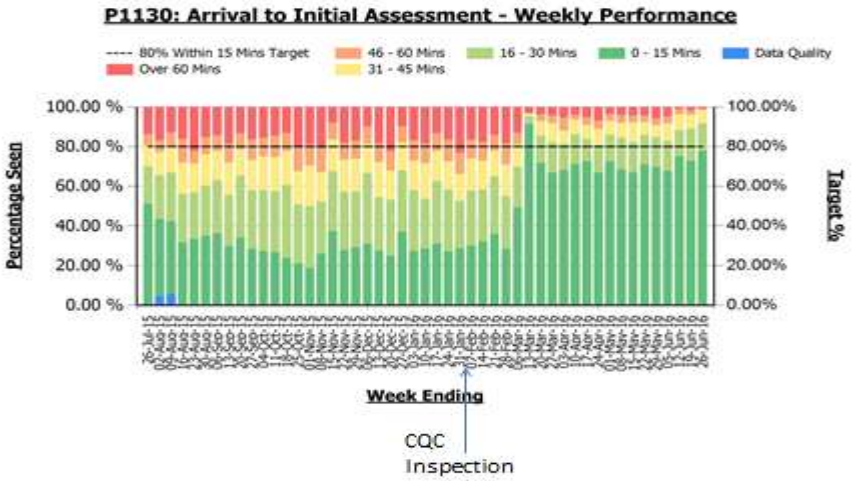
Learning

- Revised ED performance metrics
- Weekly executive monitoring
- Revised governance UCIAC / QIG / QAC
- Weekly Board briefing
- Board performance dashboard

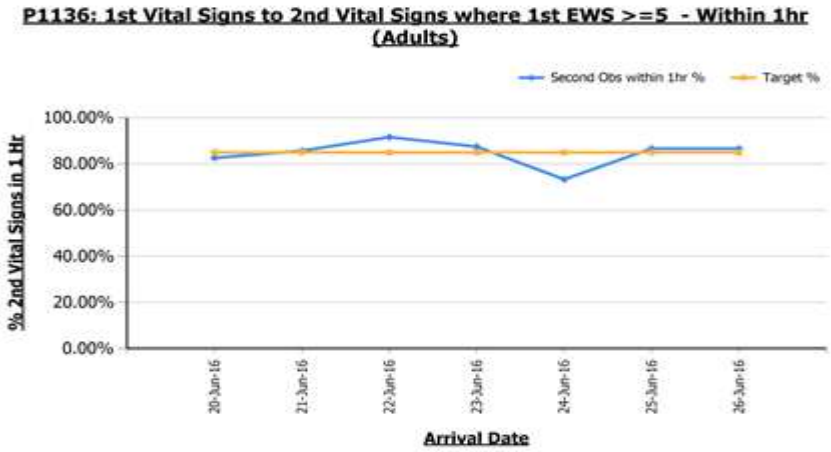
Quality and safety

Strengthening of:

- Strengthened Matron leadership
- the RCEM Crowding score
- 24 hour Triage, time to triage
- Rapid assessment area, clinical assessment
- Symphony system Vital Signs Monitoring
- CQAT / QuESTT
- Hourly safety board rounds
- Intentional rounding
- Paediatric Flow
- Safe Staffing
- Cultural Barometer



Early Warning Scores



Question 2 - Trust Response

DoF advised that investment in staffing was being planned. He was pleased to report that financial performance was currently on track in line with budget forecast, although there were some pressures relating to Agency expenditure.

A further question was asked about whether financial penalties were applied if financial targets were not achieved and the DoF advised that they were not. This issue had been discussed with the CCG as part of this year's contract negotiations but it was felt de-motivating for staff if these were applied.is had been

CN confirmed that Agency staff were only used if no permanent staff were available for overtime and no Bank staff were available, with fill rates one of the best in South West peninsula. Agency staff were then used to ensure safe staffing levels on the wards and in ED: detailed staff metrics were regularly provided to Trust Board.

Wendy Marshfield thanked the DoF and CN for this assurance on behalf of Torbay governors.

A further question was asked about whether financial penalties were applied if financial targets were not achieved.

Question 3 - Trust Response

The Trust's Information Communications Technology (ICT) Strategy is aimed at delivering clinical Information Technology (IT) solutions to meet not just current needs, but those ultimately of the new care model. Part of the Strategy is a living document (enclosed) at Appendix G which summarises the programme of work including the timescale for each constituent project. Some of these projects are fully-funded and mid implementation. Others are still dependent on funding, including external capital loan funding which is in the process of being secured by the Finance Department. Meeting the new models of care is dependent on the whole programme being delivered, so if capital funding is not available this will ultimately impact on the level of IT enablement.

15. **Date of the next meeting**

23 September 2016

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

Agenda Item:	5
Report Title:	Ensuring an active patient and public membership – engaging young people
Report By:	Anna Pryor - Torquay Health and Social Care Team
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Following a meeting with Sir Richard Ibbotson, in July, we both agreed that it would be beneficial for the Council of Governors to be made aware of the work that I had been involved in at Milton Keynes Hospital in relation to engaging and involving younger people.

2. Main Report

2.1 Before moving to Torquay in April 2011, I lived in Milton Keynes, Buckinghamshire and was very fortunate to have secured employment from October 2008 to April 2011 as Membership Officer at Milton Keynes NHS Foundation Trust. Milton Keynes Hospital became a Foundation Trust on 1 October 2007.

2.2 The main purpose of the Membership Officer role was to maintain and expand an active patient and public membership of the Milton Keynes Hospital NHS Foundation Trust and to provide a high quality service to meet the needs of members – including regular assessment of those needs. The Membership Officer was the lead contact for all aspects of FT membership recruitment, engagement and elections ensuring full compliance with the constitution of the Milton Keynes Hospital NHS Foundation Trust and the expectations of the FT Independent Regulator (MONITOR).

2.3 The role was closely allied to the Trust's communications team and the Trust's communications strategy was actively supported by preparing regular communications with members and acting as the first port of call for all queries relating to membership.

2.4 The Membership Officer's role was responsible to develop and coordinate activities for members including talks, tours and other benefits.

2.5 Some of the areas that the Membership Officer and Governors were actively involved in were:

- The Engagement Group
- Patient Panels
- Food Tasting
- Trust Tours

2.6 The Trust emphasised the quality of engagement with members and they were regularly updated with information, and informed about special and relevant events. Focus was primarily on Members' Councilors/Governors, and ensuring that they had the knowledge and understanding to communicate effectively with their constituencies and to productively help to shape the future direction of Milton Keynes Hospital and the services it provided.

2.7 One of the aims of the Membership Officer role along with the Councillors/Governors, was to increase the membership of younger people and in July 2009, the Trust was invited to attend the Annual MySayMK Youth Conference, which was held in central Milton Keynes and involved young people from local schools. These young people were happy to raise issues with the Trust staff, and following the event an excellent opportunity arose for these young people to be invited to share their experiences with the Trust board on 30 September. The young people involved made an outstanding impression on the directors, who were all looking forward to being able to work with them in the future. The young people were supported by Milton Keynes Council, Youth Service. Some of the issues that were raised at the event were developing an adolescent ward, food issues, how to communicate effectively with young people, and how we can best meet the needs of young people when they require urgent care. The Trust was very keen that the young people were encouraged to be part of a youth participation group.

2.8 Presentations to various schools and youth groups in the Milton Keynes area were pivotal to encourage young people aged 14 or over to become more involved in the Trust. Leaflets and information sheets were distributed to local schools, youth centers and colleges. Articles about membership and NHS Foundation Trust status appeared on partner organisations' websites, local papers and school newsletters. Leaflets that were produced were presented to the young people, giving them the opportunity to decide which were more appropriate and young person focused.

2.9 In February 2010, Milton Keynes Hospital NHS Foundation Trust. in partnership with the Milton Keynes Youth Cabinet, organised a 'Healthy Lifestyle' conference. The Trust wanted to give the young people an active part in shaping their hospital and raise awareness of what services were available within the hospital. More than 150 young people from secondary schools across Milton Keynes attended the conference, which was designed to feed into the personal, social, health and economic (PSHE) curriculum and offer young people the opportunity to develop their knowledge and understanding of how to stay healthy, health issues and how they can affect young people in particular. The young people were encouraged to be involved in interactive workshops, activities and information zones and covered topics such as healthy eating, how infections can be reduced, first aid, organ donation and how to keep a healthy heart and lungs.

2.10 The event was a big success and the feedback received from exhibitors, presenters, the teachers and more importantly the young people was positive and they all were very keen for another event to take place the following year.

2.11 Following the event, there was an opportunity to attend a Foundation Trust Network Conference in London and an opportunity to share the success of the event by encouraging other Trusts the benefit of involving and engaging the younger people in the community.

Resource implications

2.12 The Membership Officer post was funded primarily for Membership activities – ie. to maintain and expand membership, which included the expansion of membership of younger people, and to engage and involve the membership in Trust activities.

2.13 Facilitate accessible information to younger people by communicating with them in a meaningful manner and which included:

1. Designing and evaluating leaflets with the young people for their input into the format and content of information. This ensured that their voices were being heard and their suggestions were incorporated in Trust information. Resources to fulfil this requirement was minimal to the Trust.

2. Listening to concerns e.g., current services that they accessed such as having to use adult wards rather than one specifically for younger people – they expressed their wish to have an adolescent ward which was put to the board for consideration by Strategic Planning and Development. There was no immediate resource implication but there was resource to put forward to the next SPD.

3. Concerns raised over hospital food and ideas from the diverse group of young people who, whilst in hospital, were embarrassed to ask about culturally appropriate food, and these were put forward to the Catering Team for consideration. There was no resource implication just an awareness and training issue that was satisfactorily addressed.

4. There was a theme of external agencies (schools and support workers) not having an awareness of who to contact about any concerns or questions in relation to work experience, or information in relation to a specific subject that they were trying to resolve for the young person. Governors/Councillors were actively involved with going out to schools, working with educators to inform the young people of the services that were accessible within the Hospital environment. There was no resource implication in carrying out this task. Instead, it was a coordination of what services where available and how they were linked with each other.

5. With the Health Event, the time that was spent organizing and coordinating improved relationships with external agencies and organisations, which needed to be done owing to a gap in multi-agency approach, which reduced the expectations that the Hospital was the only source of information. By having information in school's newsletter and website, they were made aware of what advice was out there and who in fact they could contact. Local venues (local dry ski centre), with no cost to the Trust - and liquid refreshments were provided free of charge by companies, who were happy to be involved in a health event, promoting their products. In Torbay, we could use local voluntary venues which do not impact financially but have the added advantage of familiarizing the public of available resources. Alternatively, we could liaise with local Healthwatch who would be keen to work with us in organizing an event. This fulfils statutory requirements of joint working within the community.

6. In Torbay, the Healthwatch quarterly magazine would be a useful and relevant source of communication (each GP practice is sent a large number of copies of this)

Learning in Milton Keynes (MK)

2.14 The importance of having active involvement from the young people themselves, has proved invaluable in that they had ownership of the leaflets and were motivated to be engaged with future plans and events.

2.15 Bearing in mind the MK Health Event took place in 2009/2010, Social Media has subsequently had a much greater impact on people expressing their views and as a way to access information and advice. Therefore, it would be essential to factor Social Media into any future engagement and involvement. Social Media could be used as a very effective tool/method to allow members of the public to have more control over managing their health and well-being by using FAQ's, Forums and Blogs. This would be a better way of attracting younger people to become more involved with health and well-being issues rather than having to deal with face-to-face encounters with personal and private concerns. If they do need to see a doctor, they will be better informed before their appointment, which may reduce levels of stress and anxiety. This would fit with the approach, currently being approached by NHS England to promote website tools and usage.

Outcome

2.16 Since the above work was undertaken, the continued involvement and representation of the member of MK Youth Council on the Board of Governors, has demonstrated continued motivation and aspiration to actively shape current and future services. It increased younger people's awareness on how to access services and how they can be improved

2.17 Links made with other services, such as education and community support workers, have proven beneficial, promoting greater understanding of acute and primary services. Having the information available in other services, such as in the voluntary sector, schools and youth centres, should reduce the impact on GP surgeries.

2.18 The Social Care Act has reinforced the need for young people to have access to accessible advice and information. The work undertaken fits with the statutory requirements.

Learning – Applying to Torbay

2.19 Engaging with younger people directly is essential. Their understanding of how systems work, along with their valuable contributions, helps to motivate them to proactively share information with their peers. Currently, information is not easily accessible and frequently requires multiple website searches (even then, specific information may be difficult to locate).

2.20 'Wellbeing Coordinators' are currently being funded by the 'Big Lottery Fund', for people over 50. This is to identify areas of deprivation (socially and financially), and to make links to community activities. A similar process would be hugely advantageous for younger people, so could be considered as

part of the next Big Lottery Funding applications.

2.21 Torbay Council is the primary source of public health and education funding for younger people. However, that has changed to some extent, with more reliance on Lottery Funding, aimed at voluntary services developing services. The Social Care Act has introduced a 'family approach' to supporting individuals, which requires agencies across adults and children's services to work more effectively together. NHS England is in the process of updating its website, to reflect legislative changes.

2.22 Apprenticeships are also a useful tool to engage younger people. The problem lies with poor coordination of resources, to ensure that services are coordinated in a lean, but relevant manner. It would be helpful to map out which services are currently in place, evaluate and identify any duplication or gaps. This includes provision from the Local Authority and the Trust. In Torbay, apprentices and internships are already in place; this could be more effectively utilised, to incorporate some of the ideas detailed in this paper.

2.23 For example, 'Hele's Angels' would be a good place to trial some of this work. It's based in Torquay, and supports younger people, some of whom have been excluded from mainstream education. Work placements are offered, which enables individuals to develop a CV, which can be a gateway to other employment opportunities. There are also activities and events, to promote independence skills. The venue has a small bank of computers, to promote advice and information for the public. There's a rich source of advice and information, which could be usefully developed with links to other websites (eg NHS England, Torbay Council, The Orb, etc).

2.24 Paignton Library. Healthwatch and the Carers' team are co-located in the library. This would benefit from also having representation from an advisor, who would have access to a range of advice and information (for voluntary and statutory services), which would be available to visitors (including young people). This would serve to provide a full range of information, to screen those away from statutory services to community interventions that may assist. This is an excellent opportunity for people to access advice and information, without going to statutory offices or hospitals. Furthermore, the Health & Social Care teams are not accessible for the public – only by telephone. Some people find this off-putting and would prefer a face-to-face conversation, concerning their personal circumstances. The public would hugely benefit from being able to 'drop in' to a library to access that information, to assist them in planning for the future.

2.25 The MK engagement with the younger people provided a forum for public health messages to be directed to them and this is what we should be striving towards, in conjunction with Council colleagues.

2.26 Advice detailed in publications and meetings needs to fit in with the requirements of the Care Act to enable the public to make informed decisions. A national 'mystery shopper' exercise, undertaken by 'Independent Age' highlighted the difficulties in accessing the information about health and social care, in Torbay. The article can be found by clicking here.

2.27 Young people are ideally placed to inform necessary changes to websites. Furthermore, NHS England currently has a working group – looking at how to ensure information meets the 'Advice and Information' sections of the Care

Act. It would be pertinent to have a representative linked to the working group, to facilitate involvement, such as representing the needs of younger people in our community. This would also enable us to learn from what is working successfully in other geographical areas.

3. Recommendation(s)

3.1 Council of Governors accepts the report.
3.2 Mutual Development Group discusses some of the relevant issues in more detail and reports back to the Council of Governors in December 2016.
3.2 Due to the timing of the report, Lead Director for Health Promotion (Medical Director) to consider the issues raised and report back to the Council of Governors meeting in December 2016.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above.
4.2 Approve the above recommendation.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

Agenda Item:	6
Report Title:	Chief Executive's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

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

1.2 Please note that the next Finance, Performance and Investment Committee is not due to take place until the 27 September 2016 therefore at the time of writing, this paper highlights the latest Trust position.

1.3 The report as at attachment four shows July's performance figures; all figures that were available as at 16 September 2016. If an up-to-date dashboard is available, this will be presented on the day of the meeting.

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

1.5 On 31 August 2016 the Trust its quarter one feedback from NHS Improvement (previously known as Monitor pre 1 April 2016). The feedback letter is included within the Chief Executive report (attachment one).

2. Decisions Needed to be Taken

2.1 As the attached papers have been circulated as part of September's public board reports, this is an opportunity for governors to ask questions rather than receive information from board members. Board members may be asked by the chairman to provide any new/appropriate information before seeking questions from the governors/audience. Please note that governor questions put forward in advance of the meeting may be taken first.

3. Attached to this Report

Attachment one	-	Chief Executive's report as presented at September's Board.
Attachment two	-	Chief Nurse's report as presented at September's Board.
Attachment three	-	Chief Operating Officer's report as presented at September's Board.
Attachment four	-	Integrated Quality, Performance and Finance report as presented at September's Board.
Attachment five	-	Safety scorecard as presented at September's Board.
Attachment six	-	Director of Strategy and Improvement report as presented at September's Board.

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 • System Resilience Group • Freedom to Speak Up Guardians' Meeting • Staff Side Meeting
External
• Sarah Wollaston MP • Dame Ruth Carnall, Carnall Farrar • Lead Chief Executive, Your Future Care (Success Regime) & STP • Executive Dean, Faculty of Health and Human Sciences, Plymouth University • Chair, Brixham Youth Enquiry Service • Strategic Director of People, Devon County Council • Your Future Care Collaborative Board • 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
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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:	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 (smaller value better)	18.28% (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 (smaller value better)	16.82% (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. (larger value better)	74.01% (national avge 74.71)	Action for primary care
	Proportion of those 65+ registered with a GP who have a formal & recorded dementia diagnosis (larger value better)	3.82% (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. (larger value better)	1.14% (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% (national avge 54.59%)	Ensure coding accurate, sharing data
	Rate per 100,000 of emergency inpatient admissions for those with dementia 65+ (smaller value better)	2,681 / 100,000 (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. (larger value better)	74.45% (national avge 77.03%)	Action for primary care
	Number of dementia friends in the post code area	TQ9 – 171 TQ1 – 932 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 (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 (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.

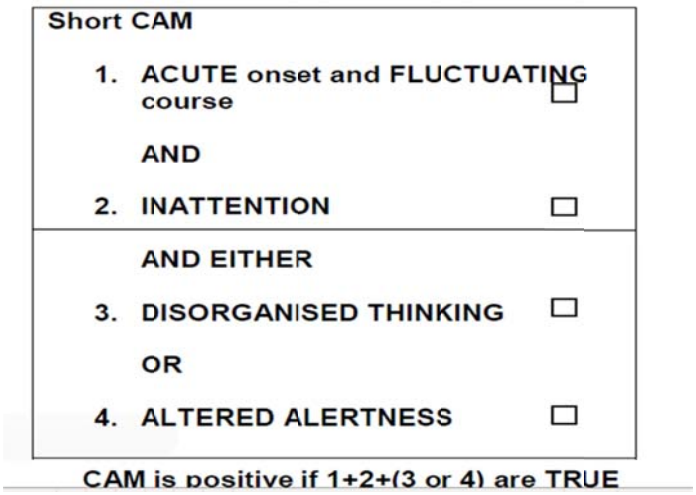
5. Dementia Find update- Identifying inpatients 75 years and over with possible dementia :

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**

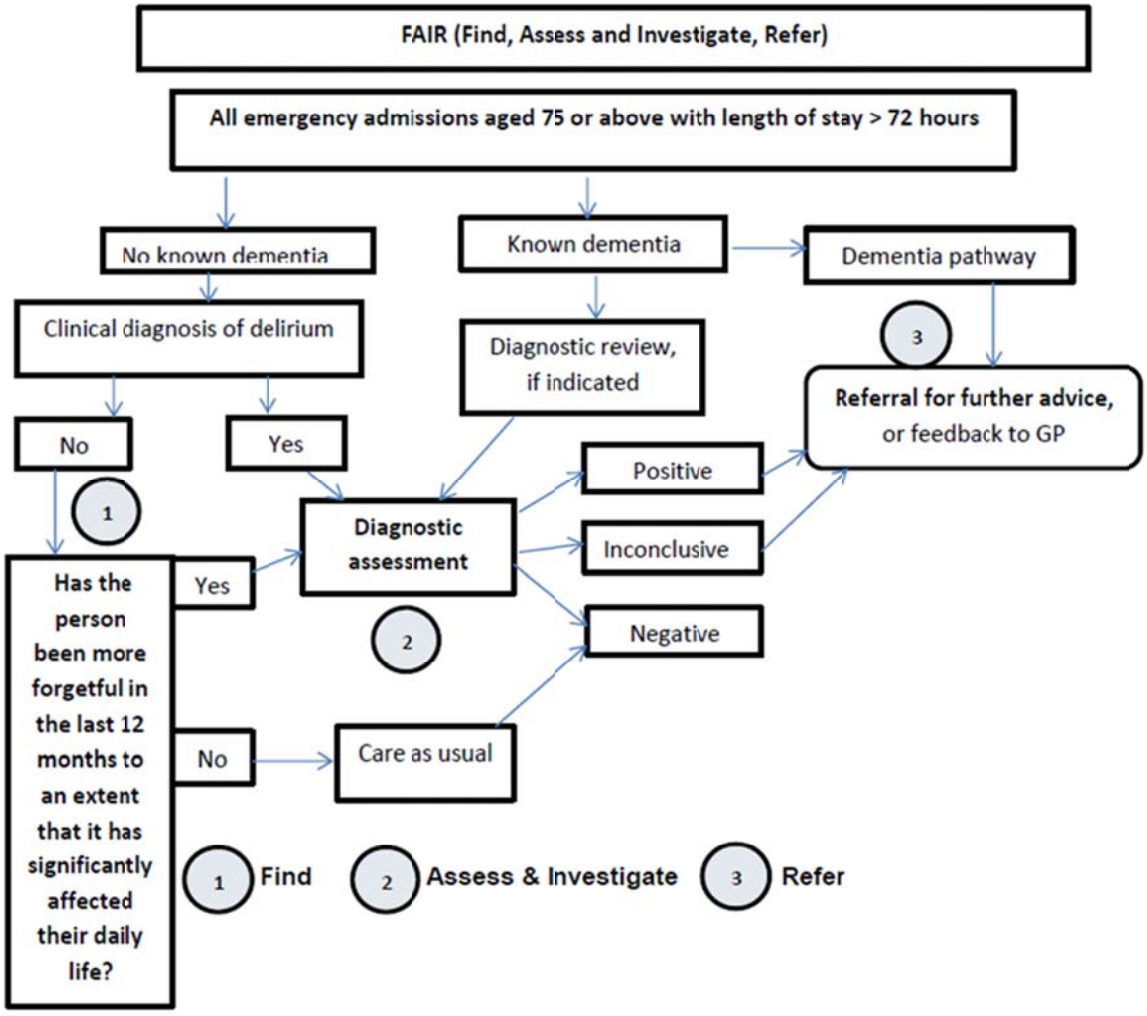
  The diagnostic assessment and investigation of at least 90% of those patients who have been assessed at risk of dementia form the dementia case finding question and / or the presence of delirium. Investigations must be undertaken to determine if the presence of dementia is possible.

- **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:

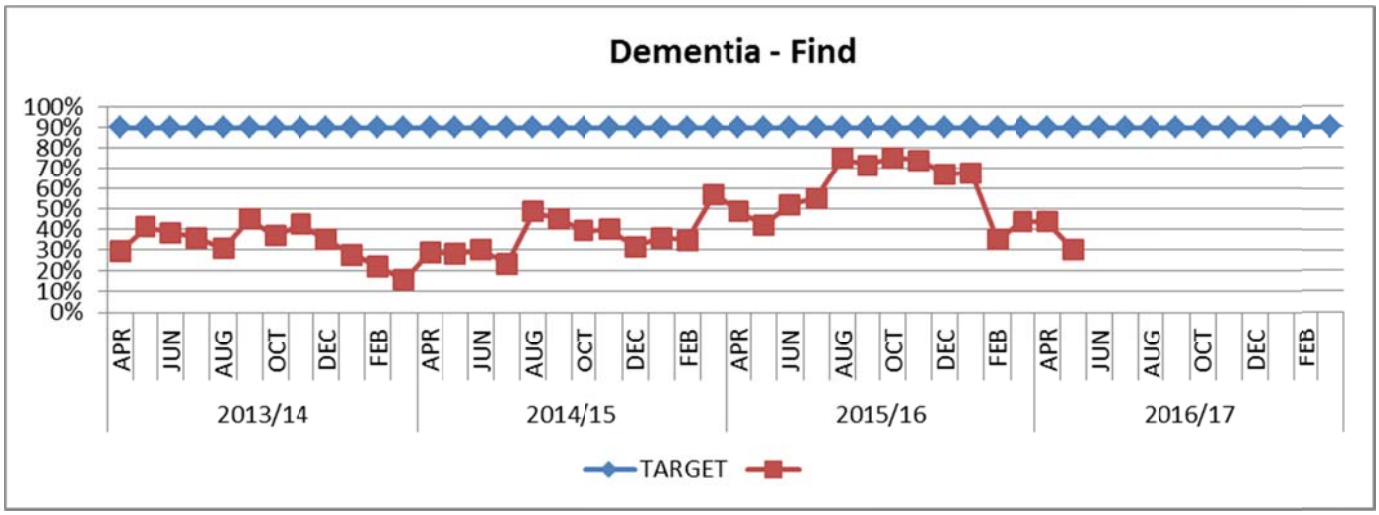
- A base line assessment exercise is currently being completed across the wards where patients 75 years and older are emergency admission inpatients to understand the current systems and processes, this includes 18 wards.
- Across the eligible wards there is a lack of a standardised process in place 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.

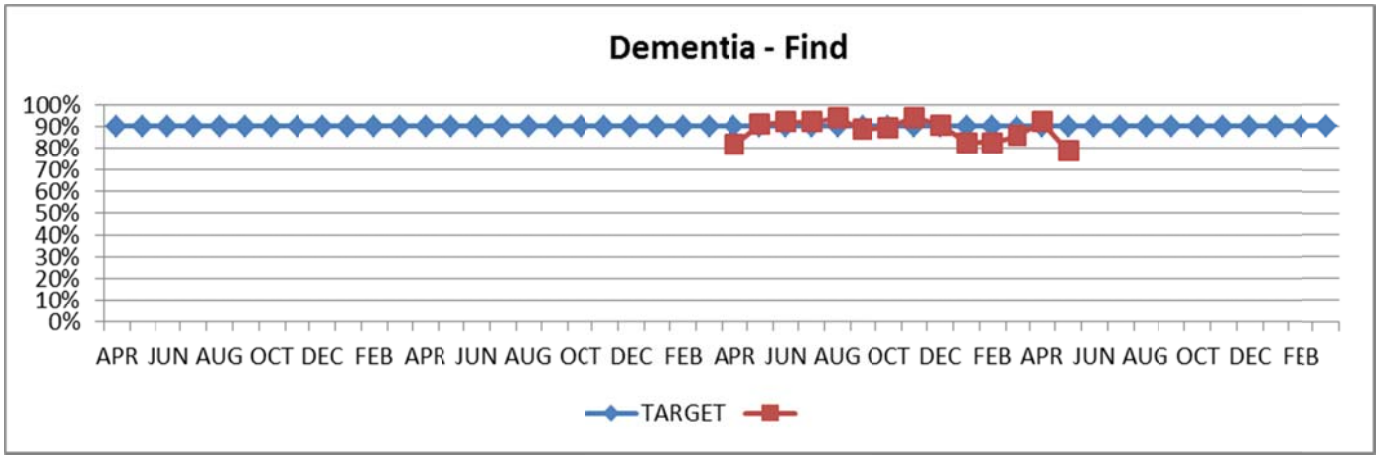
- Some have reported that the form does not currently flow well to support the clinician undertaking the assessment
- The dementia tool is a paper assessment which is transferred to an electronic system via infoflex at the point of discharge by the discharging medical practitioner.
- The infoflex data 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:	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

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** 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

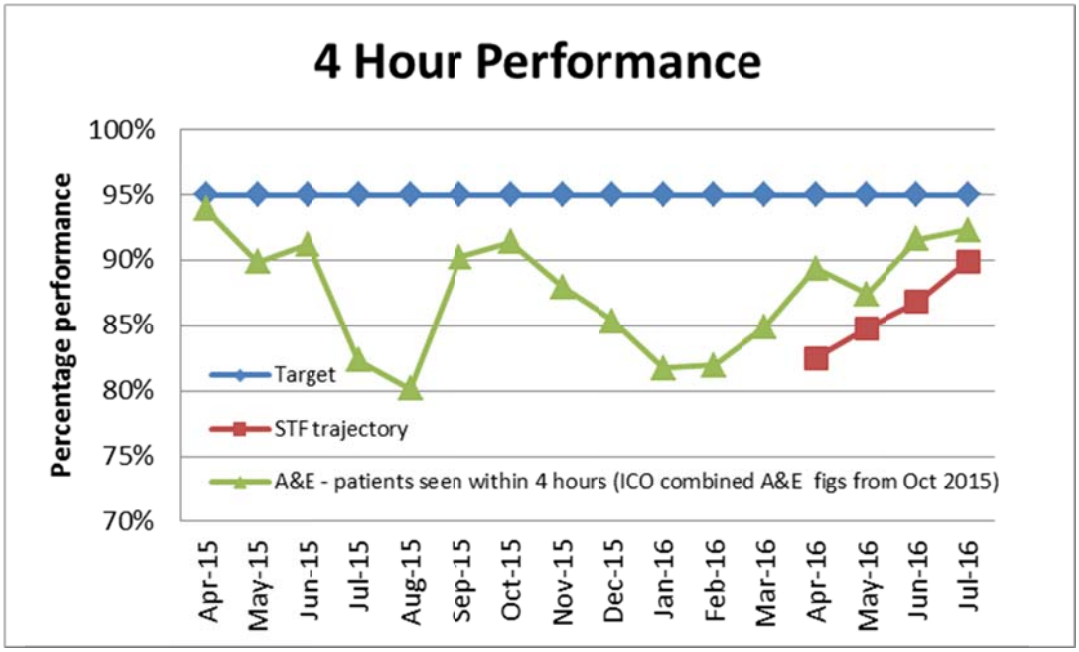
RAG RATING AGAINST SRG TRAJECTORY: GREEN

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.

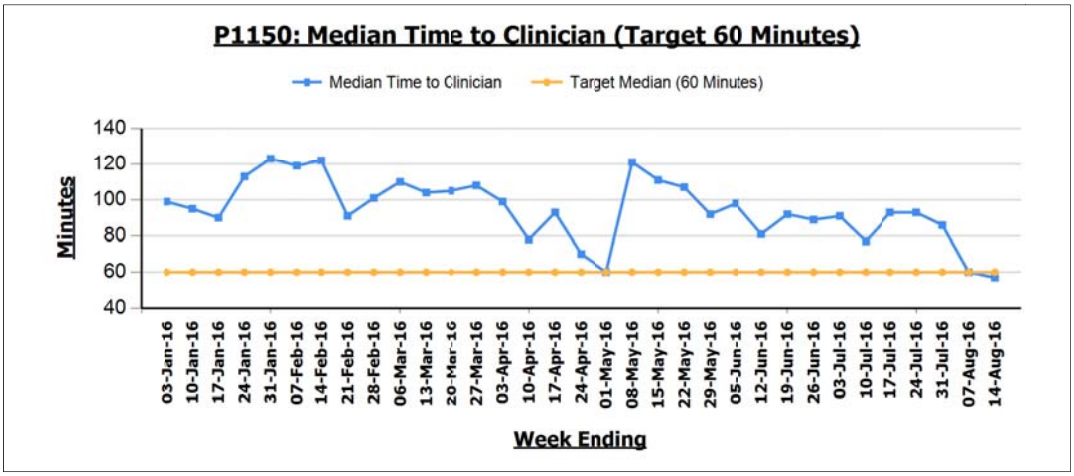
A summary of most recent progress and issues against the action plan monitoring is set out below:

- 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.

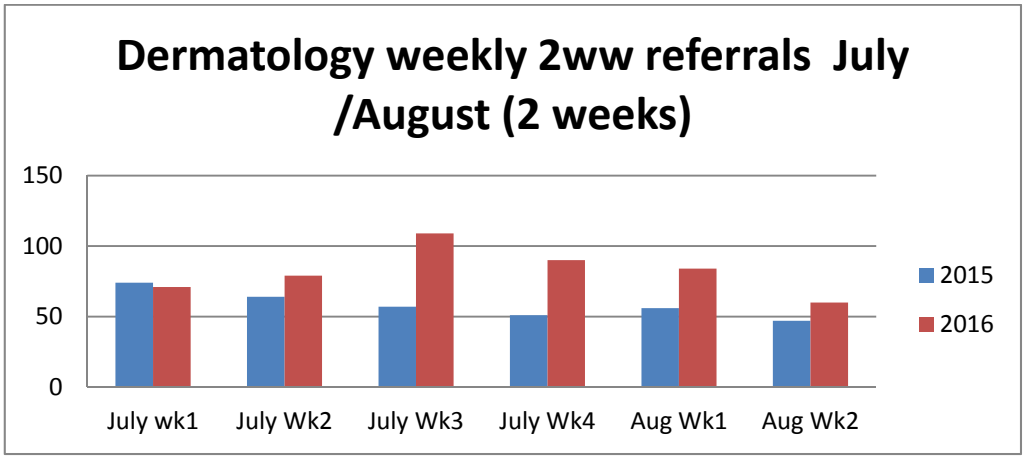
Cancer 2 Week Wait 93% standard (urgent referral 14 day):

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.

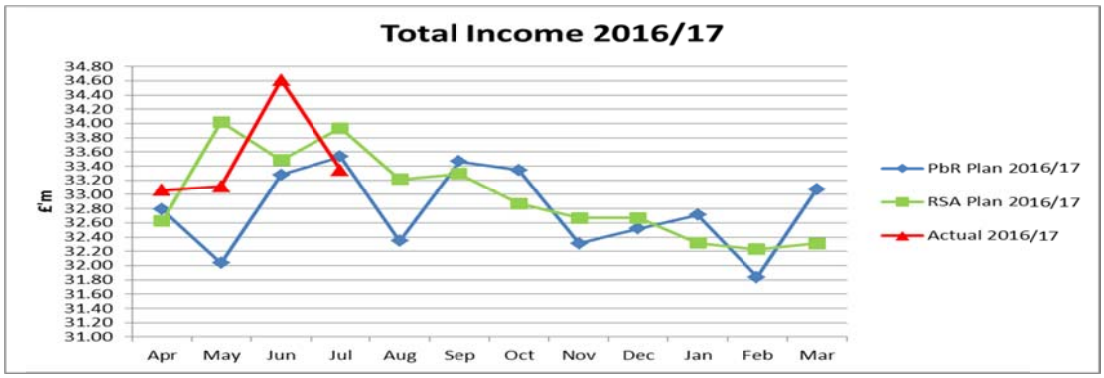
Based on the RSA plan, income is behind by just £0.22m. This is due to the adverse variance on acute income of £0.58m, of which £0.56m relates to NHS E and is mainly Non Elective and chemotherapy income. The local CCG contract is £0.07m behind plan as a result of penalties applied, and the balancing 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**	↑

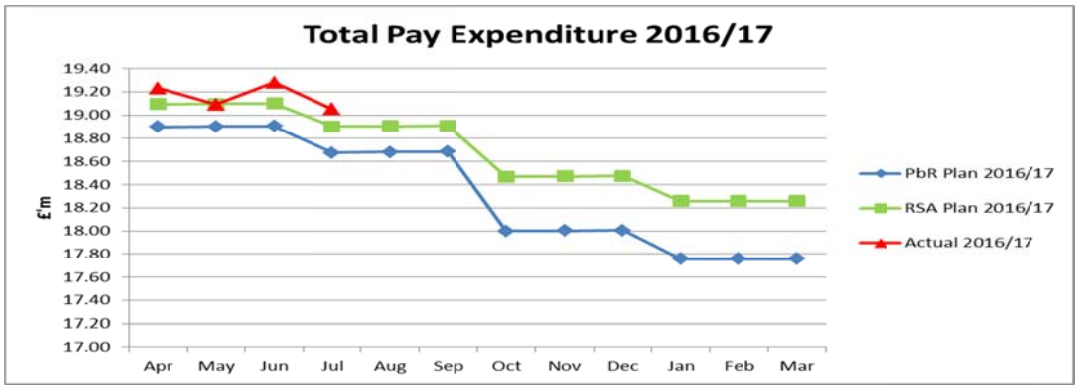
Total Operating Expenditure included in EBITDA is £3.44m above the original plan. Based on a RSA arrangement this is markedly improved, being an adverse variance of just £0.11m.

Pay

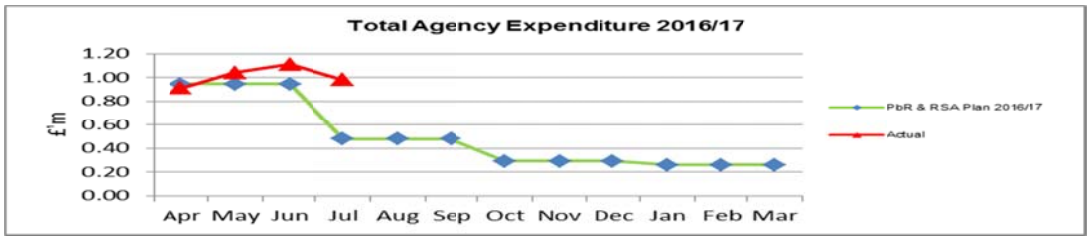
Pay is showing an overspend of £1.27m against PbR plan, and £0.46m against the Risk Share plan. Run rates based on a normalised position show a reduction in costs of £0.23m from the previous month. There has been a reduction in established pay costs (£0.17m), agency costs (£0.13m), with an increase in 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.

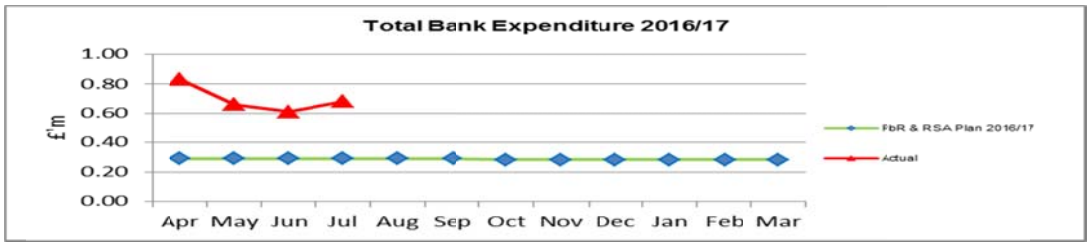
There are underspends offsetting this in Community services (£0.22m) due mainly to vacancies, and HQ and corporate services of £1.1m, mainly £0.8m in reserves and the remainder due to savings in the HIS team 0.17m, Pharmacy £0.16m, and Strategy £0.07m.

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

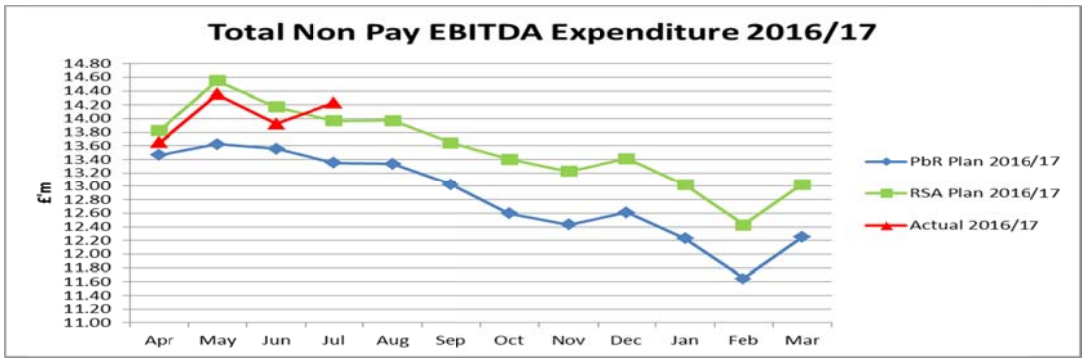
Non pay is showing an overspend against PbR plan of £2.05m, and a favourable variance of £0.47m against Risk Share plan. The difference in the variance is mainly due to the plan adjustments relating to QIPP targets causing an adverse variance against the PbR plan.

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 (ICD 10 – antibiotic administration)	Rob Dyer	Achieved Q1 screening 100% Q1 antibiotic admin 82%
2 - National	Timely identification and treatment for sepsis in inpatient settings	Rob Dyer	Achieved Q1 baseline screening 0 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

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Mairead McAlindon
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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

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
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

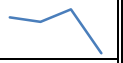
Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

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 cummulitive 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

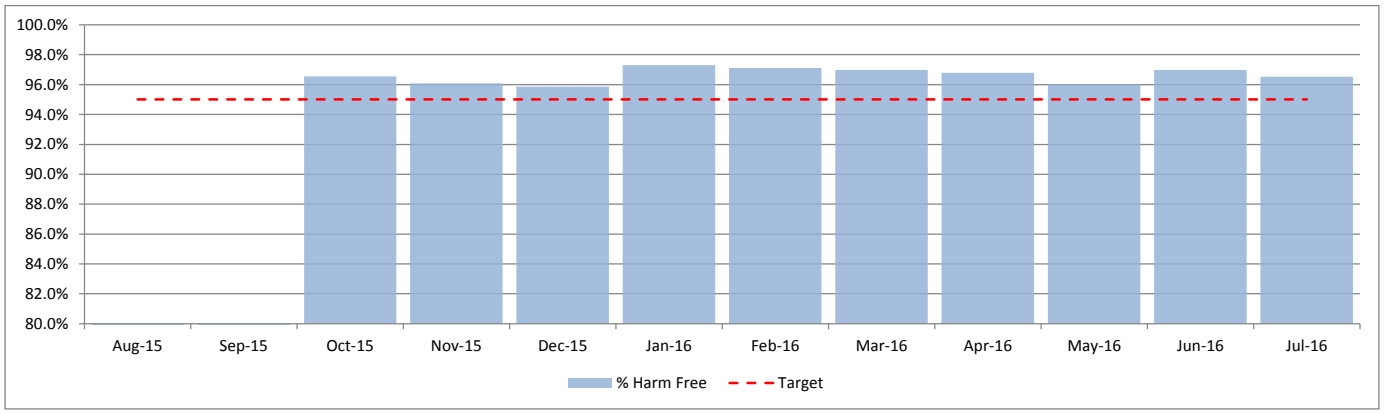
QUALITY FRAMEWORK

Month 4 July 2016

QUALITY FRAMEWORK

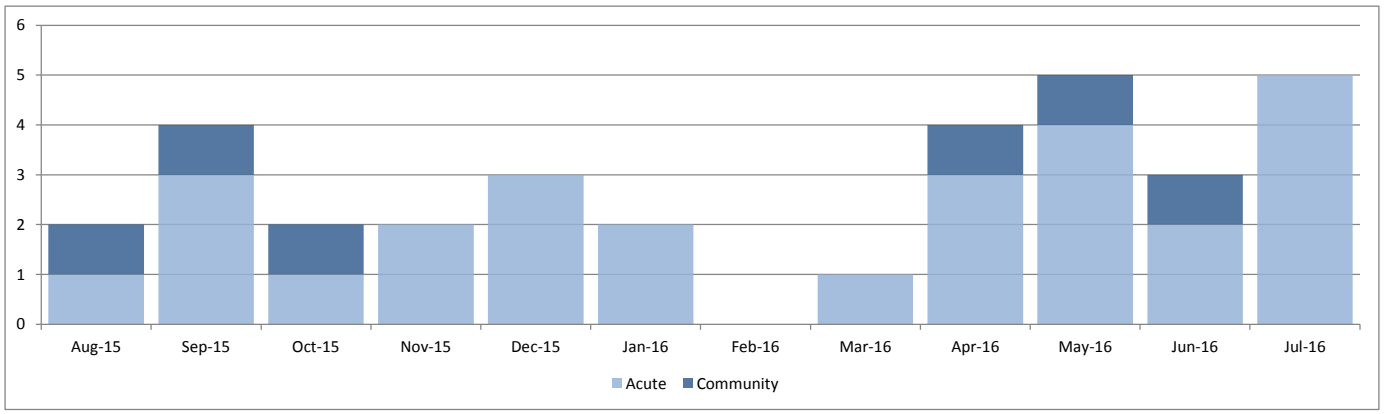
Harm Free - Trust Total

	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%



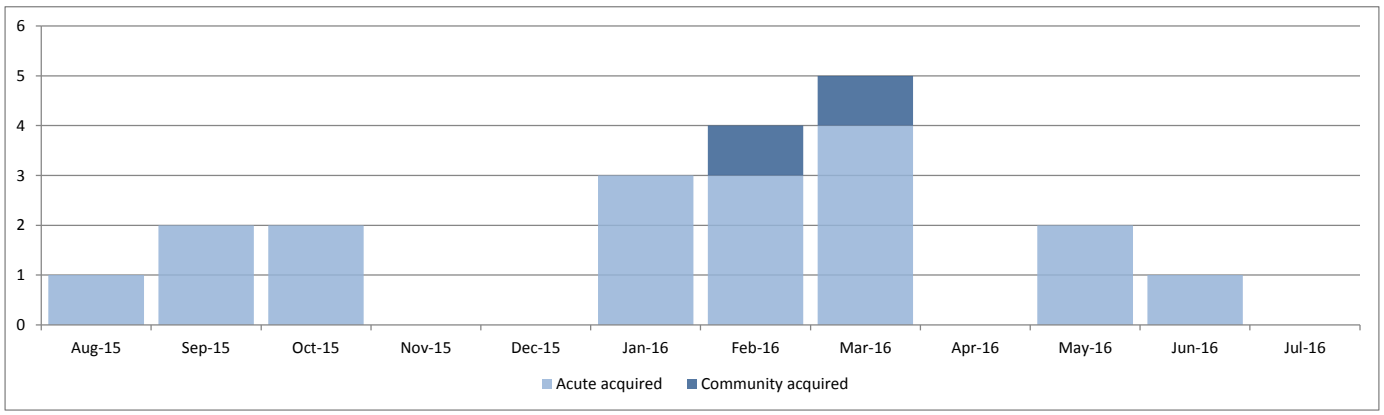
Reported Incidents - Major and Catastrophic

	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)

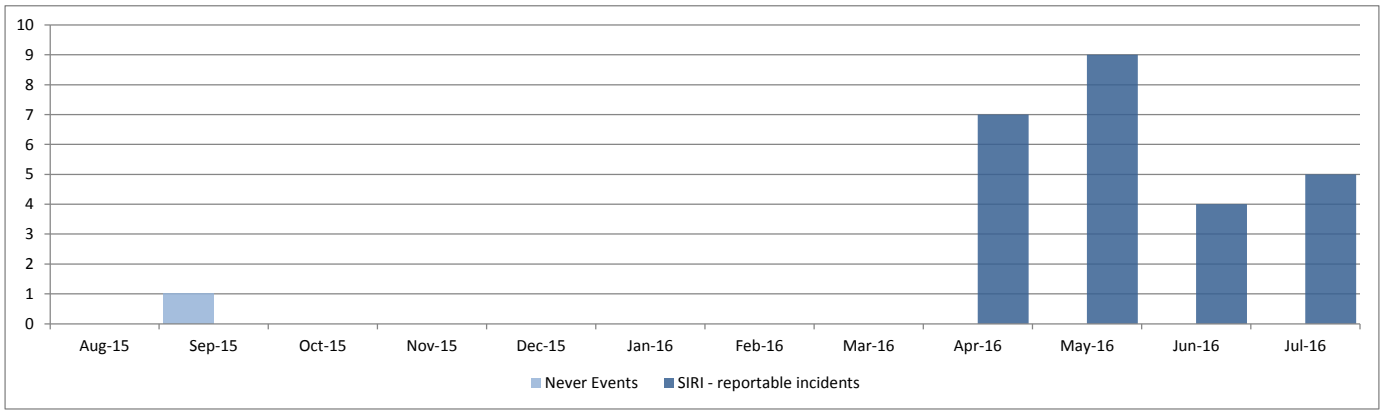
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Acute acquired	1	2	2	0	0	3	3	4	0	2	1	n/a
Community acquired	0	0	0	0	0	0	1	1	0	0	0	n/a



QUALITY FRAMEWORK

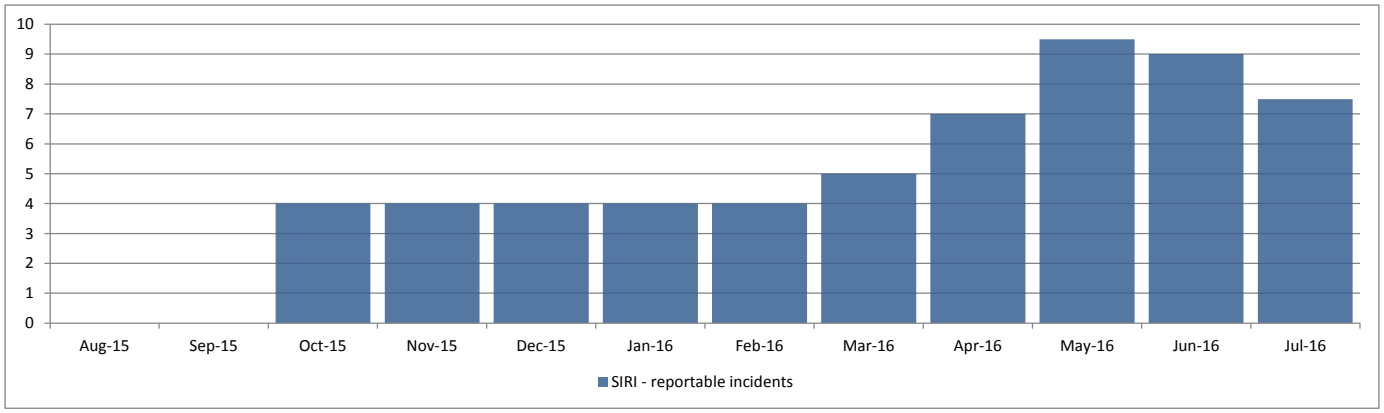
Never events & SIRI

	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



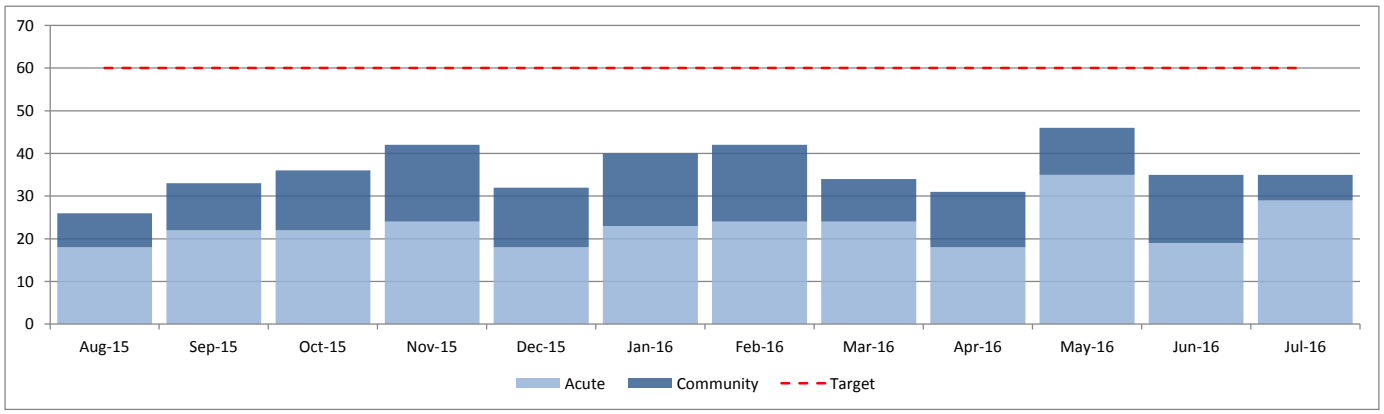
Quality Effectiveness Safety Trigger Tool (QUEST)

	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

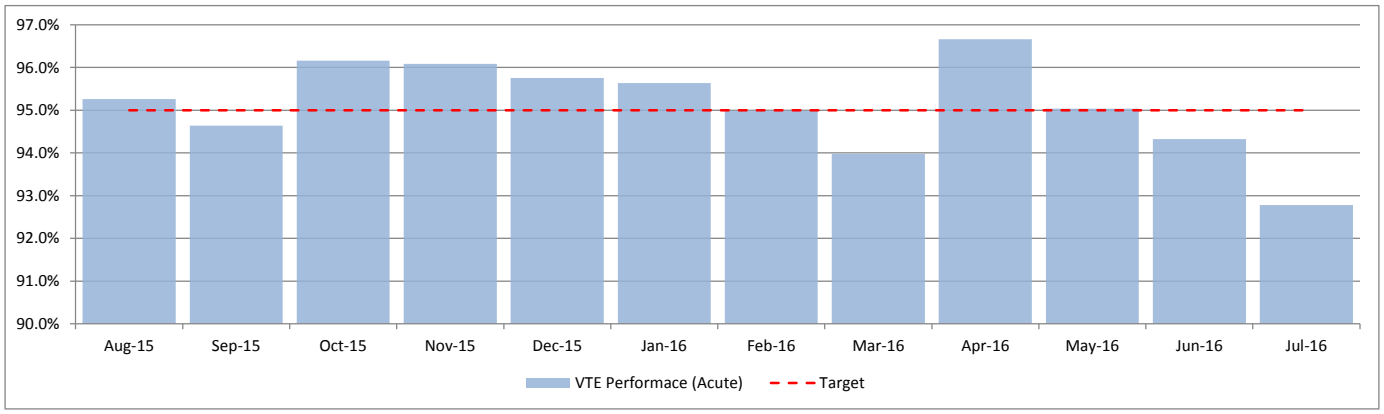
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Acute	18	22	22	24	18	23	24	24	18	35	19	29
Community	8	11	14	18	14	17	18	10	13	11	16	6
Total	26	33	36	42	32	40	42	34	31	46	35	35
Target	60	60	60	60	60	60	60	60	60	60	60	60



QUALITY FRAMEWORK

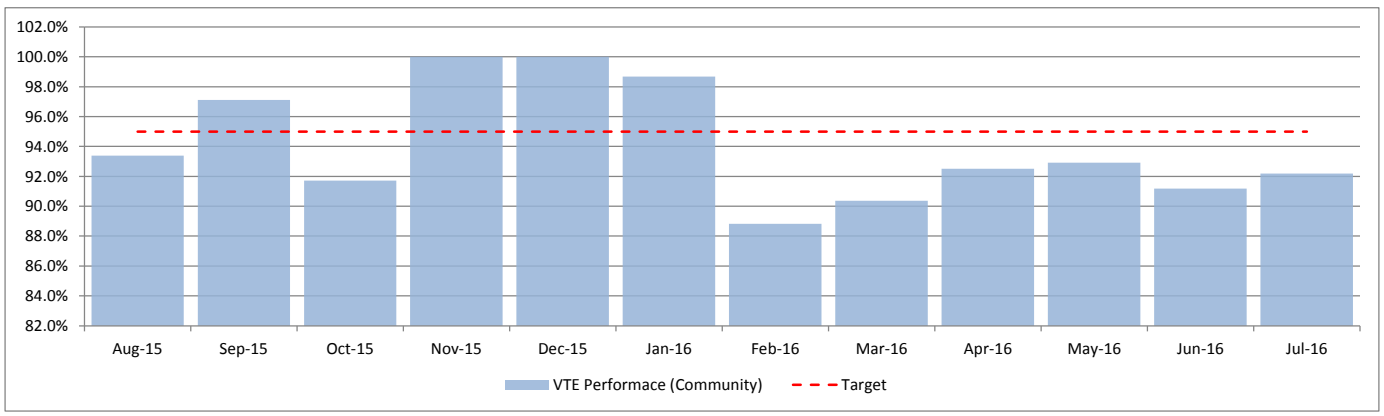
VTE Risk assessment on admission - (Acute)

	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%



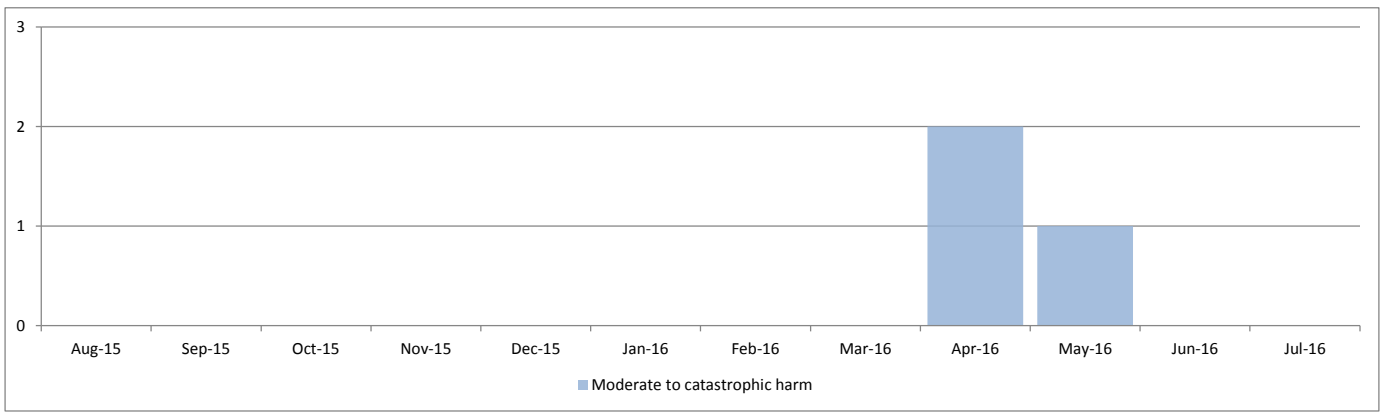
VTE Risk assessment on admission - (Community)

	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

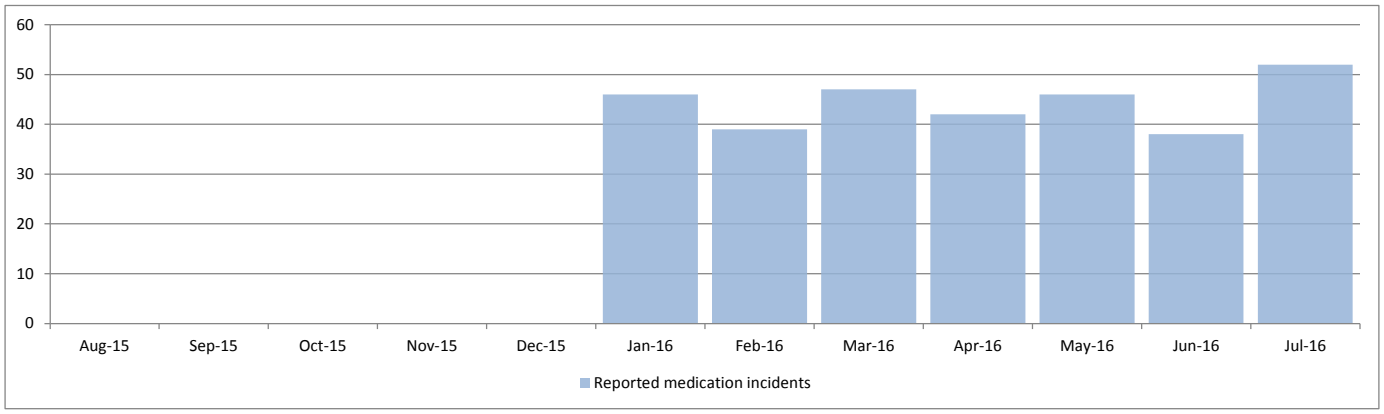
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Moderate to catastrophic harm	n/a	n/a	n/a	n/a	n/a	0	0	0	2	1	0	0



QUALITY FRAMEWORK

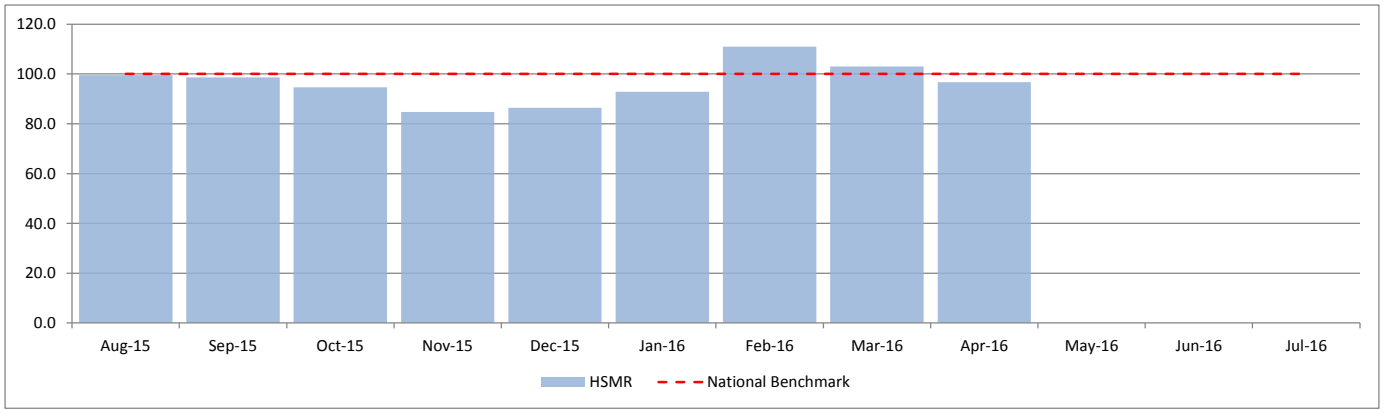
Medication Errors - Reported incidents (trust at fault)

	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



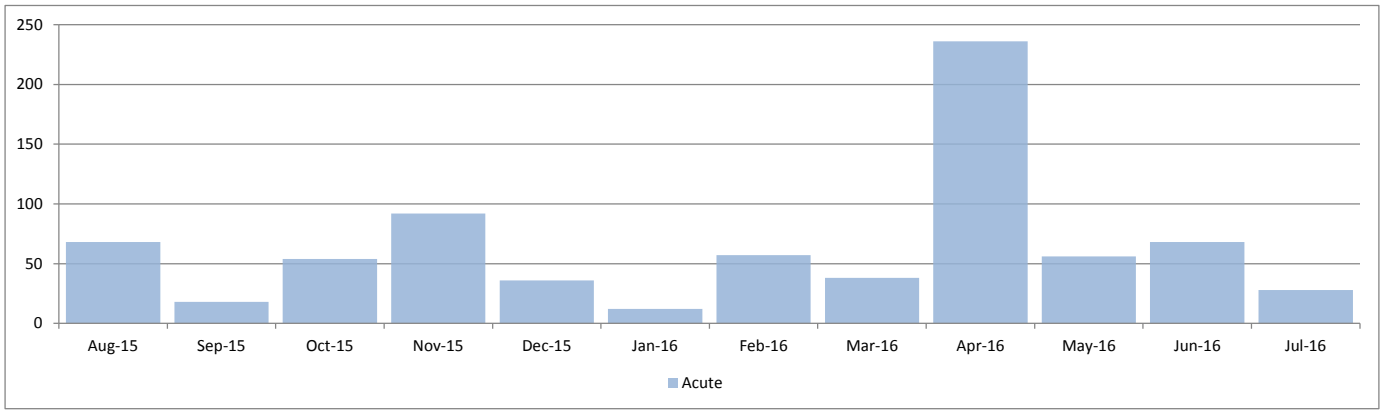
Safer Staffing Levels

	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

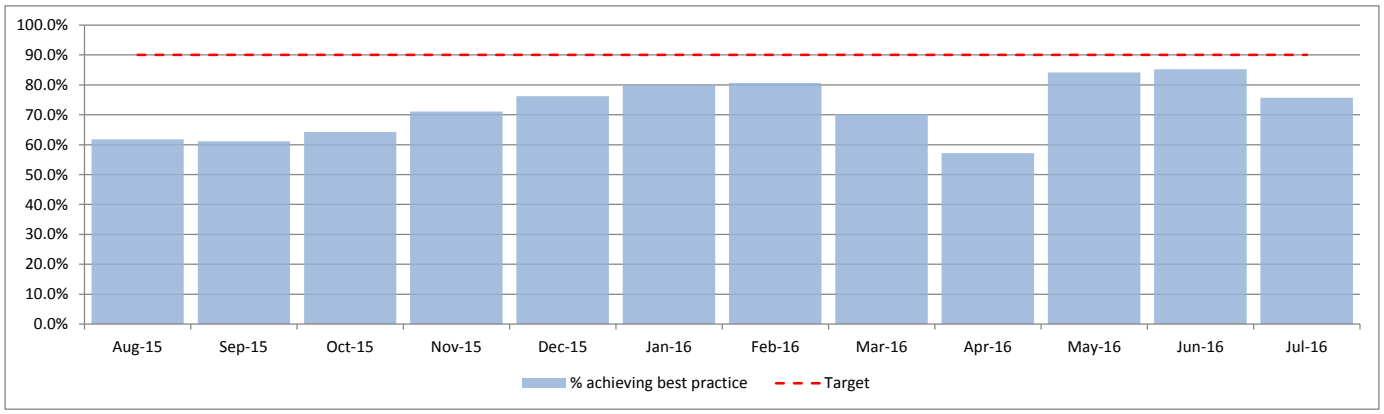
Infection Control - Bed Closures (acute)

	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



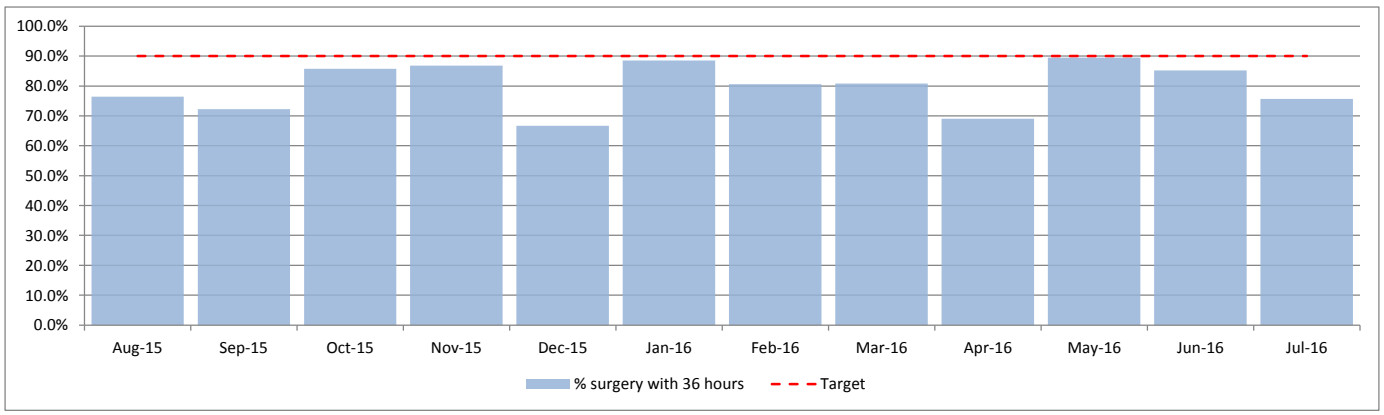
Fracture Neck of Femur - Best tariff assessment

	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

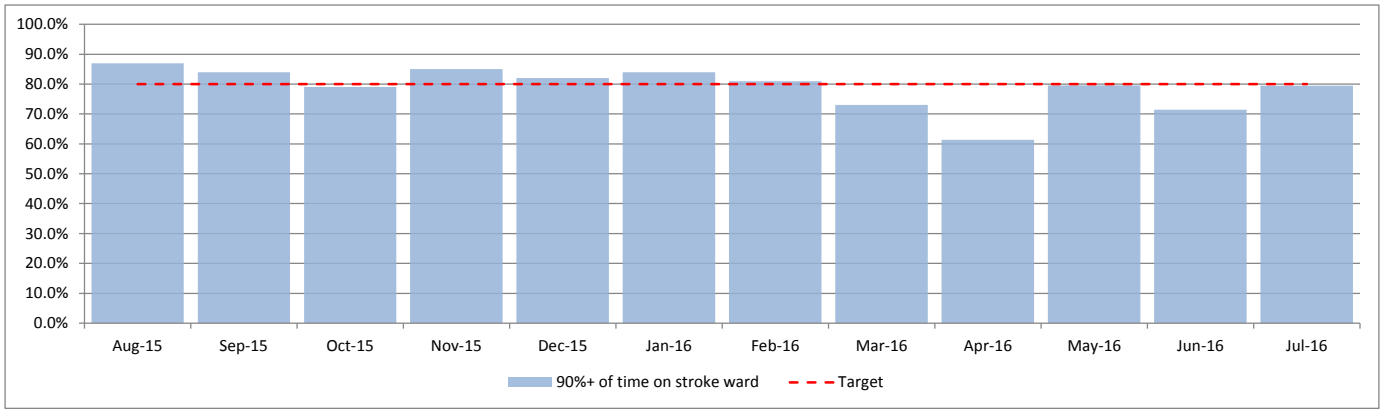
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Patients	34	36	28	38	42	35	31	47	42	38	27	37
Surgery with 36 hours	26	26	24	33	28	31	25	38	29	34	23	28
% surgery with 36 hours	76.5%	72.2%	85.7%	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	75.7%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



QUALITY FRAMEWORK

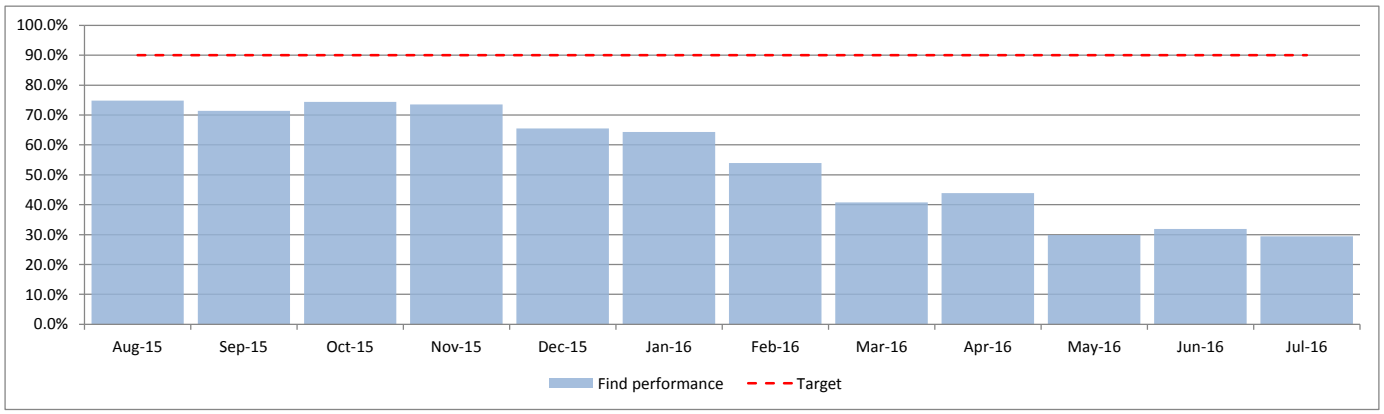
Stroke

	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%



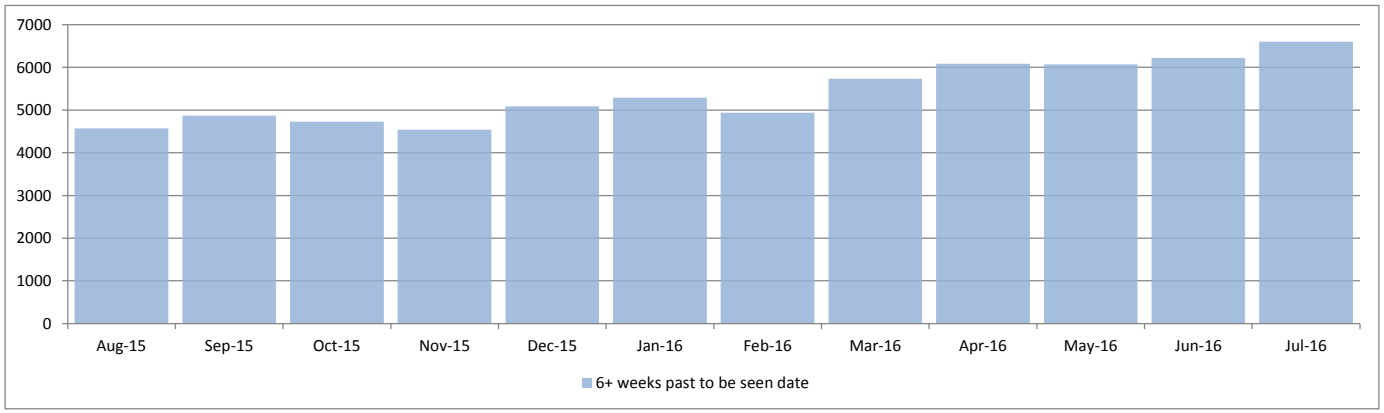
Dementia - Find

	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



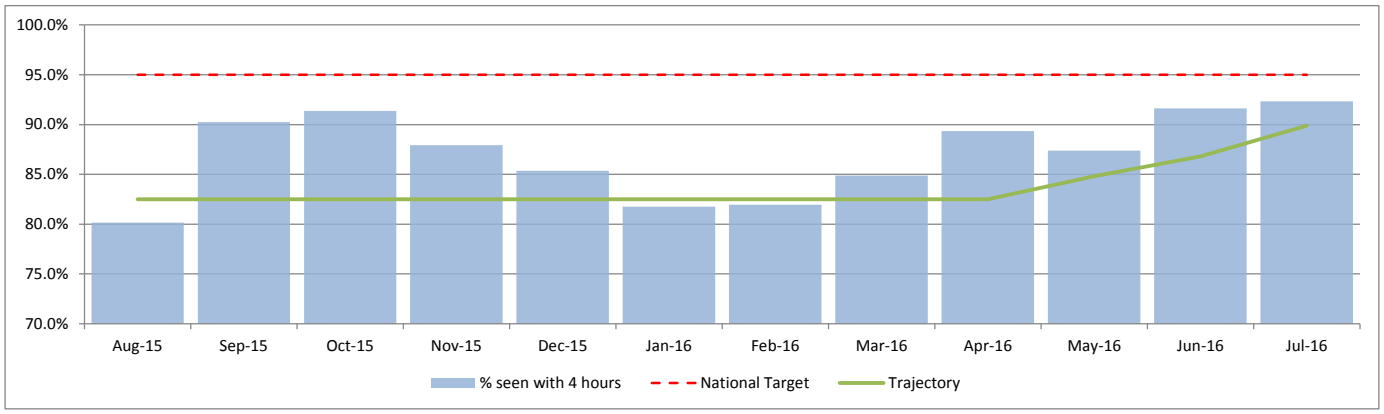
NHS I COMPLIANCE FRAMEWORK

Month 4 July 2016

NHS I COMPLIANCE FRAMEWORK

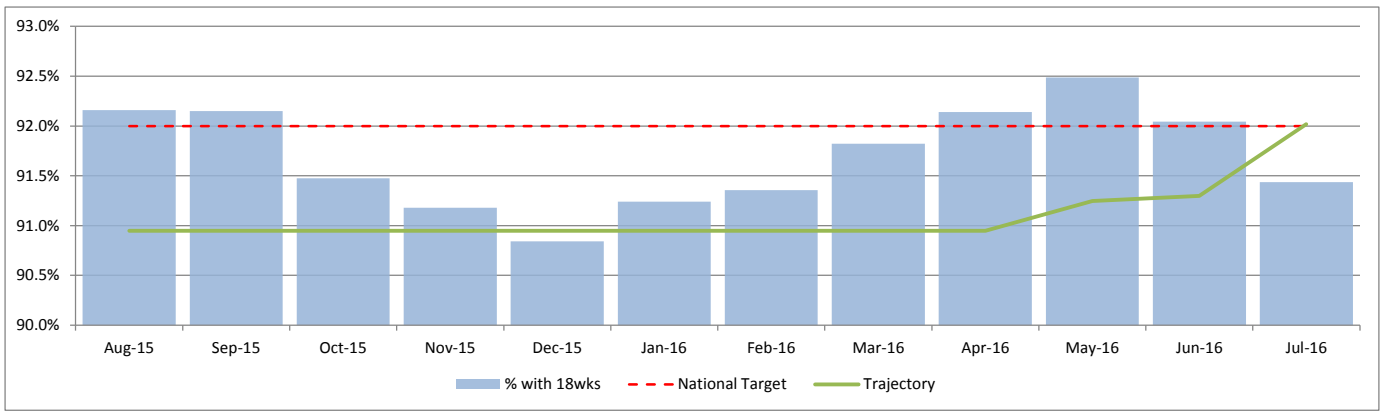
A&E and MIU patients seen within 4 hours

	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%



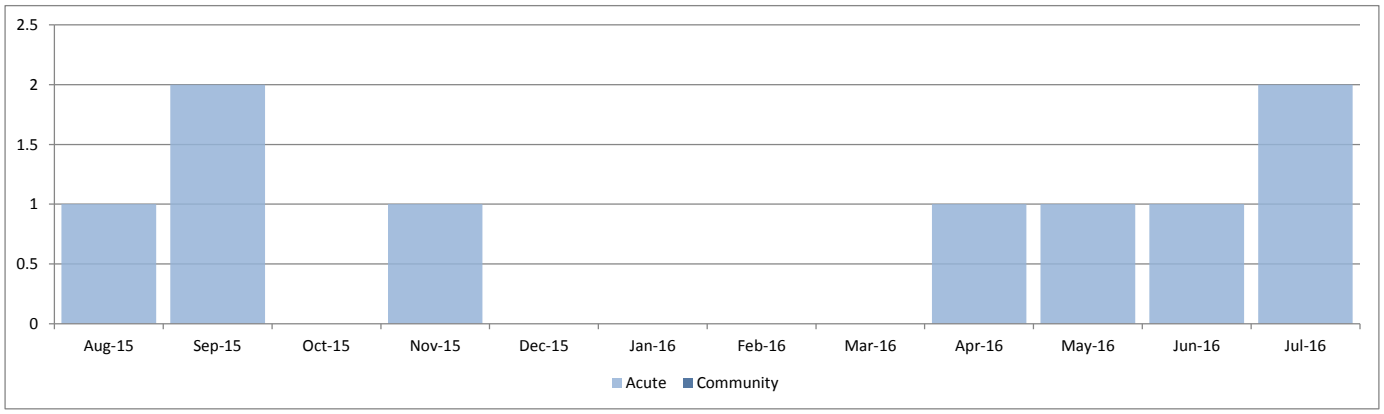
Referral to Treatment - Incomplete pathways

	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

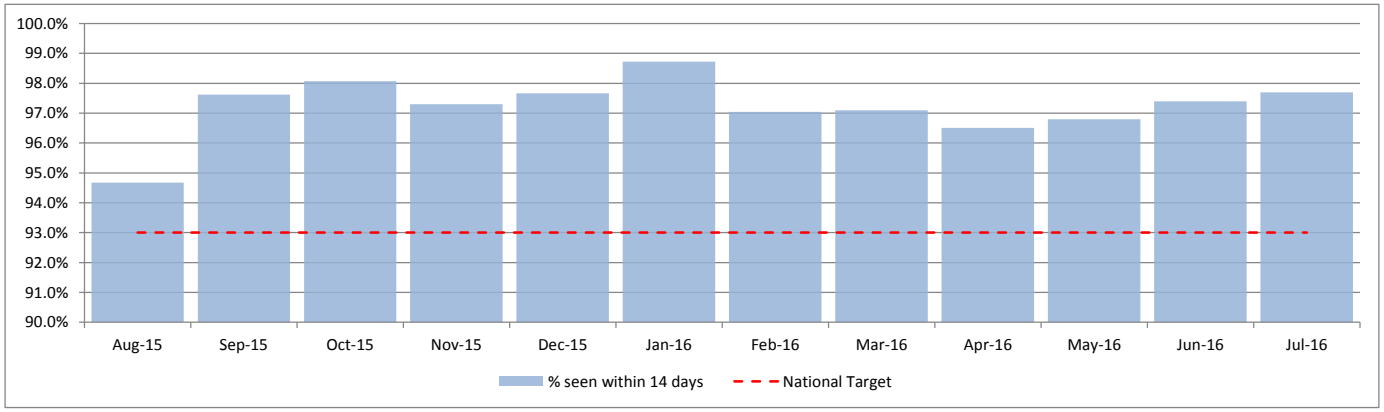
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Acute	1	2	0	1	0	0	0	0	1	1	1	2
Community	0	0	0	0	0	0	0	0	0	0	0	0



NHS I COMPLIANCE FRAMEWORK

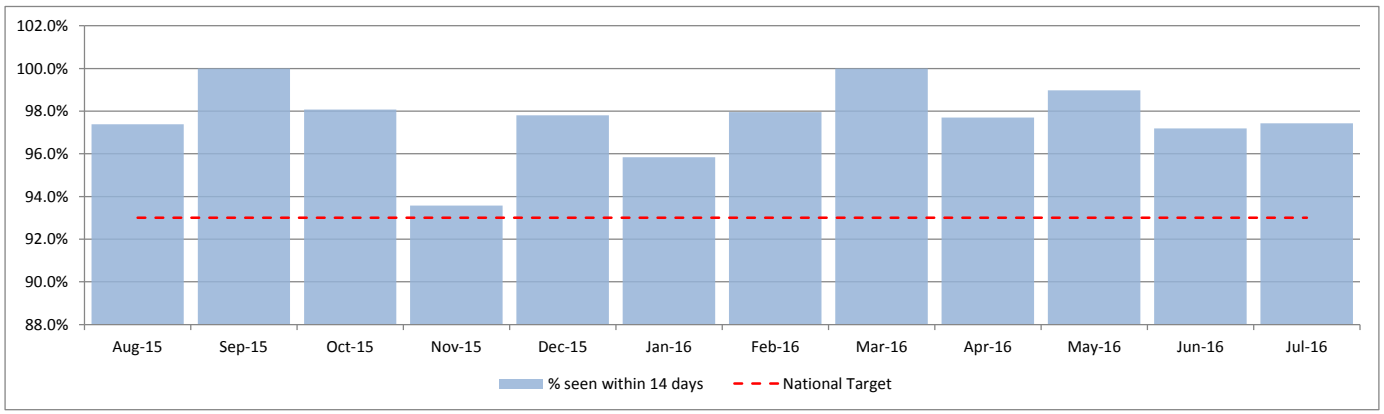
Cancer - Two Week Wait Referrals

	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%



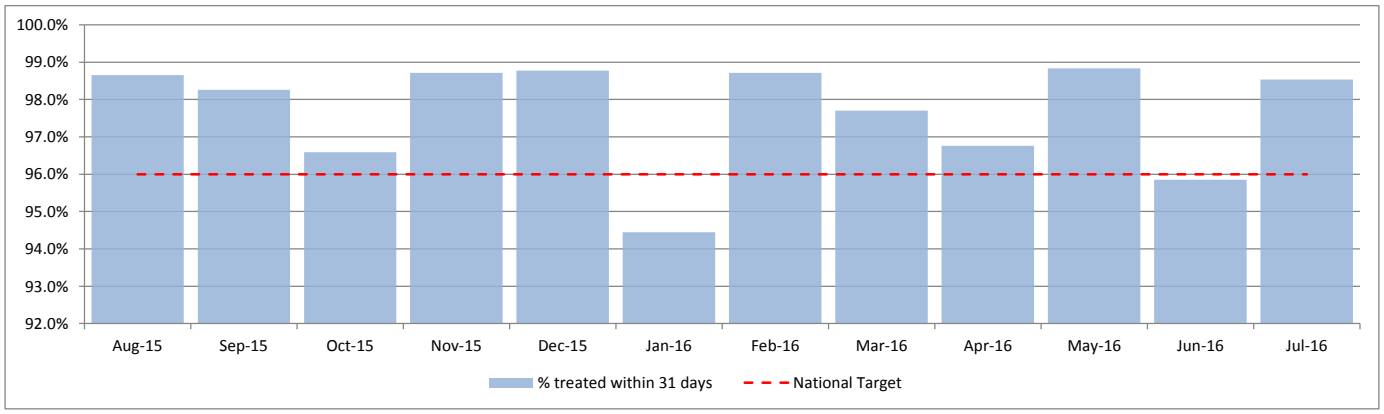
Cancer - Breast Symptomatic Referrals

	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

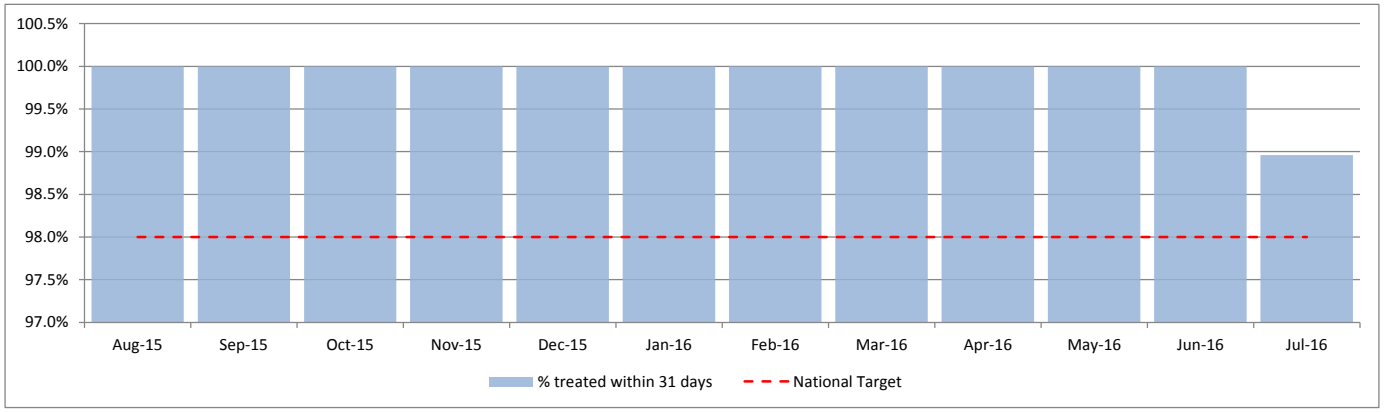
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
1st treatments	149	172	176	156	163	162	155	174	185	172	193	205
Breaches of 31 day target	2	3	6	2	2	9	2	4	6	2	8	3
% treated within 31 days	98.7%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%
National 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

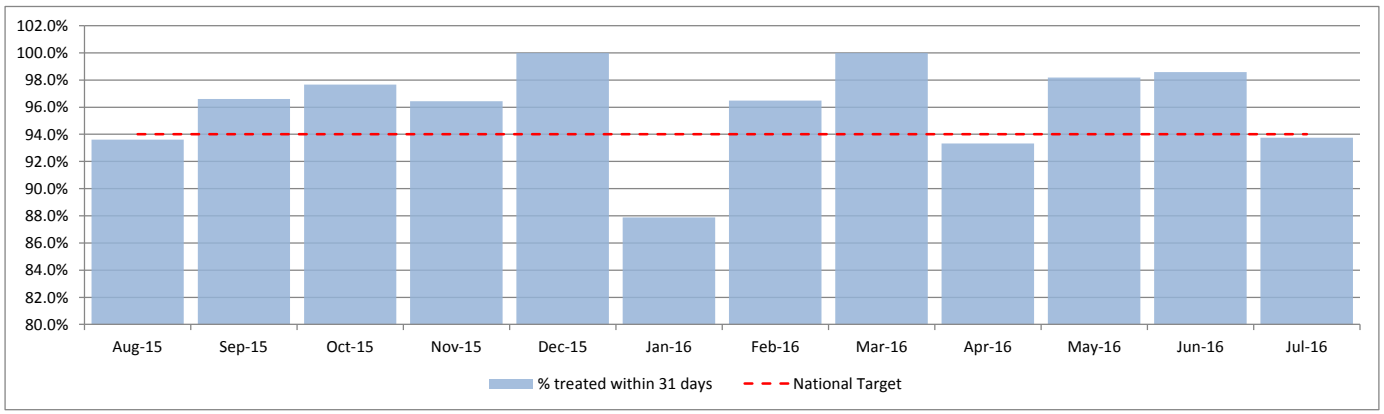
Cancer - 31 day wait for second or subsequent treatment - Drug

	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%



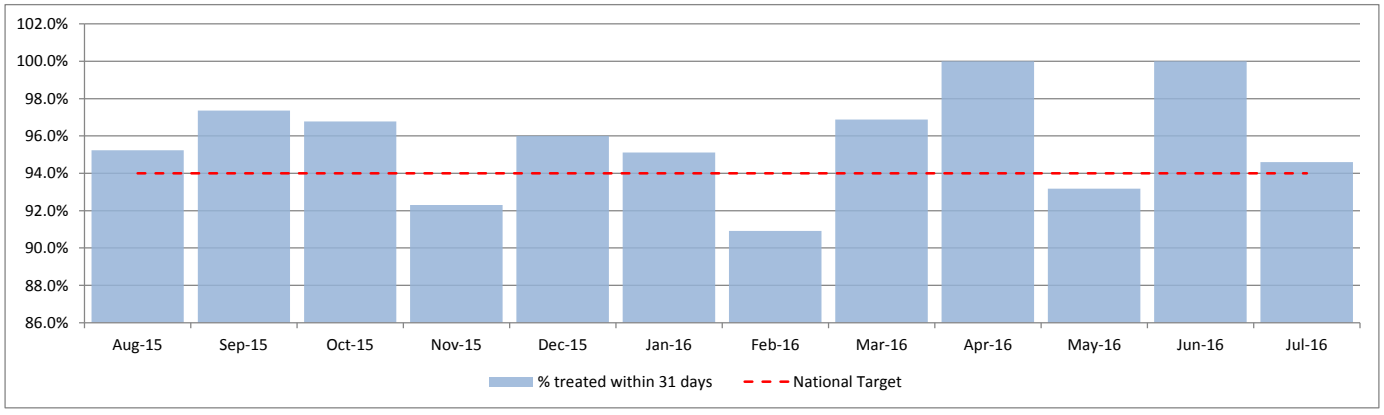
Cancer - 31 day wait for second or subsequent treatment - Radiotherapy

	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

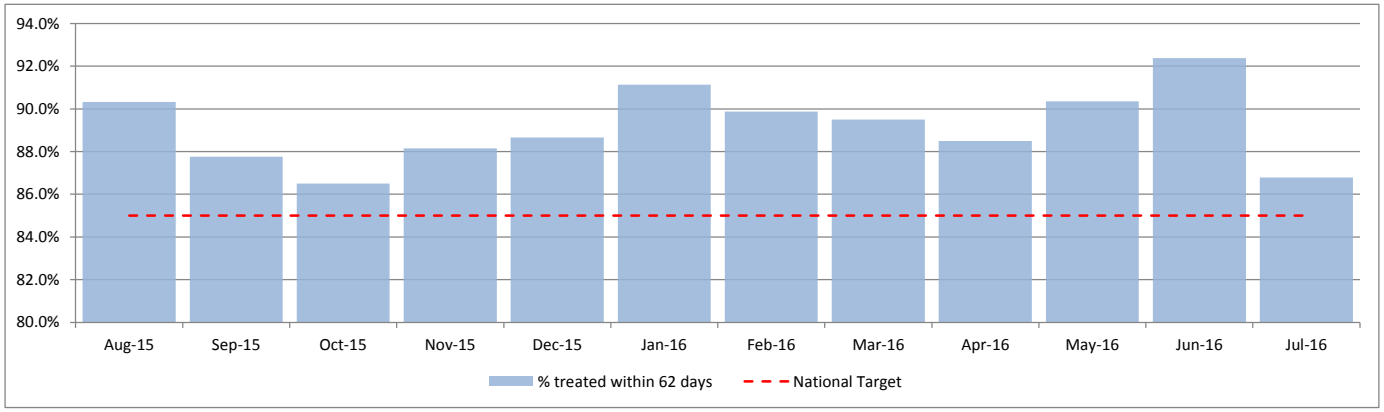
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Subsequent surgery treatments	21	38	31	39	25	41	44	32	30	44	40	37
Breaches of 31 day target	1	1	1	3	1	2	4	1	0	3	0	2
% treated within 31 days	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%
National 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

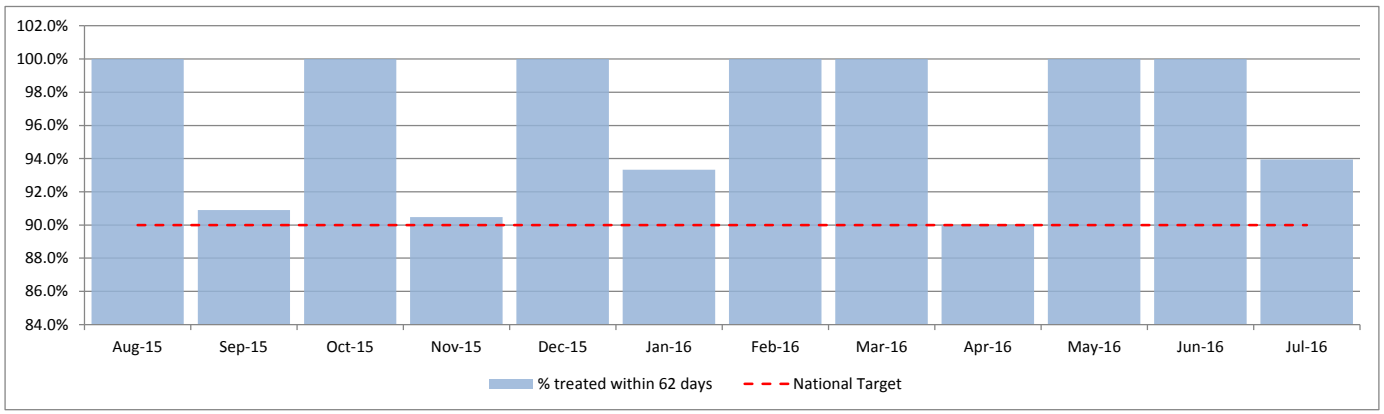
Cancer - 62 day wait for 1st treatment from 2ww referral

	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**	↑

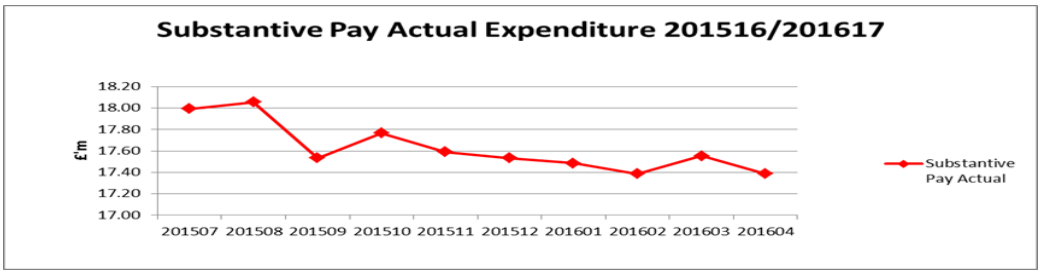
Social Care Income							
	£m	£m	£m	£m	£m	£m	
Torbay Council - ASC Contract income	13.55	13.03	(0.52)	(0.52)	(0.00)	(0.00)	↔
Torbay Council - Public Health Income	1.66	1.77	0.12	0.00	0.12	0.00	↑
Torbay Council - Client Income	3.29	3.47	0.18	0.11	0.06	0.05	↑
Total	**18.50**	**18.27**	**(0.23)**	**(0.41)**	**0.18**	**0.05**	↑

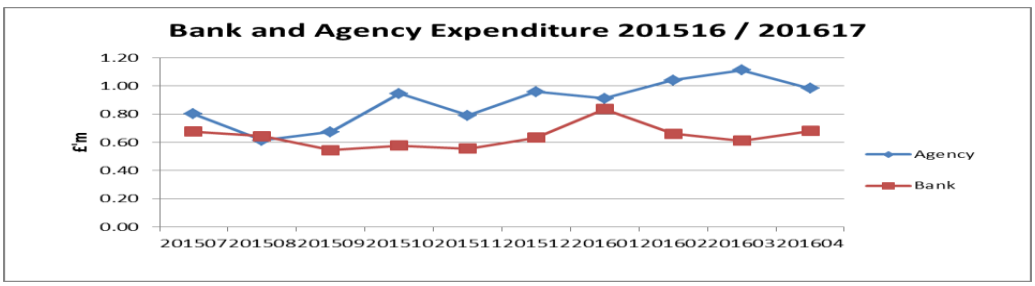
Other Income							
	£m	£m	£m	£m	£m	£m	
Non Mandatory/Non protected clinical revenue	0.50	0.53	0.03	(0.00)	0.03	(3.21)	↑
R&D / Education & training revenue	2.91	2.97	0.07	0.00	0.07	0.09	↑
Site Services	0.74	0.76	0.02	0.00	0.02	(0.00)	↑
Revenue from non-patient services to other bodies	1.82	1.85	0.03	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

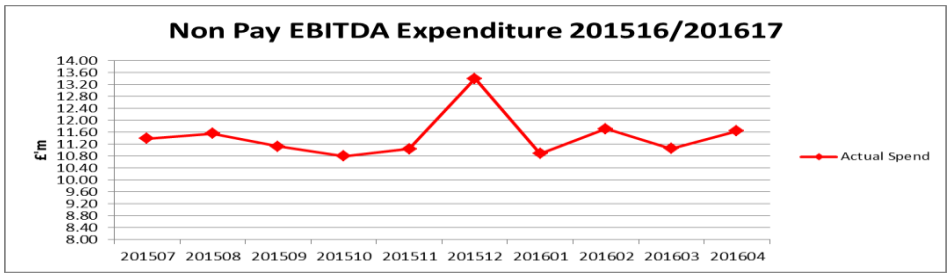
No.	Action	Lead	Date
1	Nursing agency shifts all approved by a Director	JV	ongoing
2	Medical Agency and Locum Approved by a Director	RD	ongoing
3	Recruitment processes streamlined and regular for key clinical staff	MR	Ongoing
4	Overseas Recruitment of Nursing Staff	MR/JV	in progress

Governance Arrangements
Senior Business management Team, Exec Team meetings ,Finance Committee

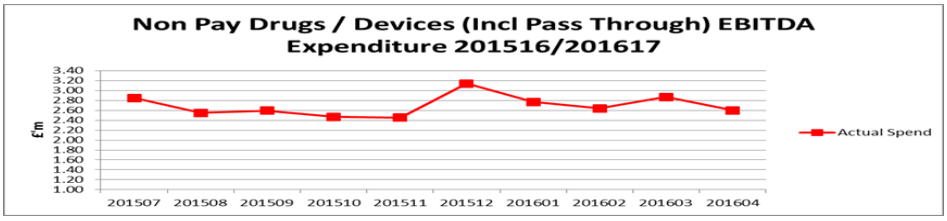
Non Pay Expenses **Schedule 4**

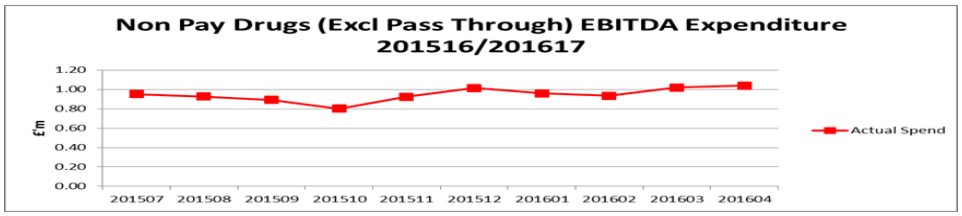
	Year to Date - Month 04			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non Pay Expenses - By Category							
Clinical Supplies	7.30	7.63	(0.33)	0.00	(0.33)	(0.26)	↑
Drugs (Excluding Pass through)	3.63	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.



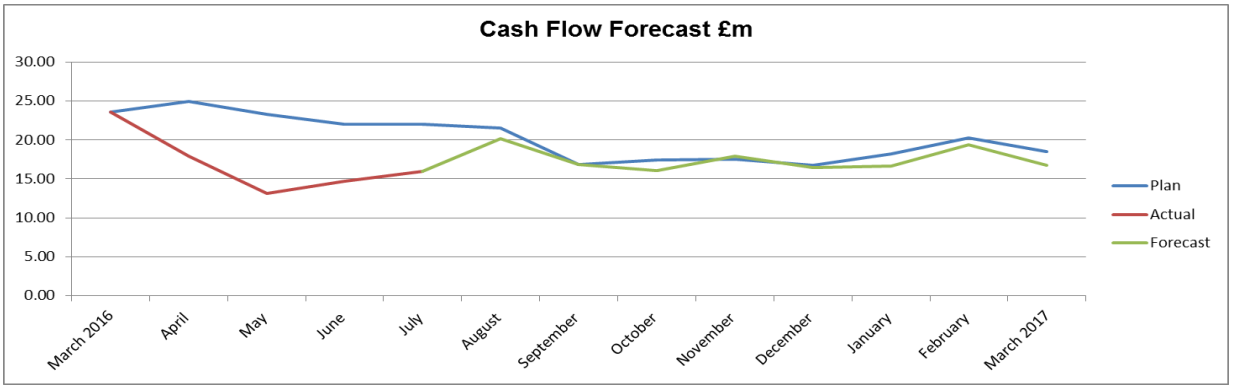


Cash Flow **Schedule 5**

	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**

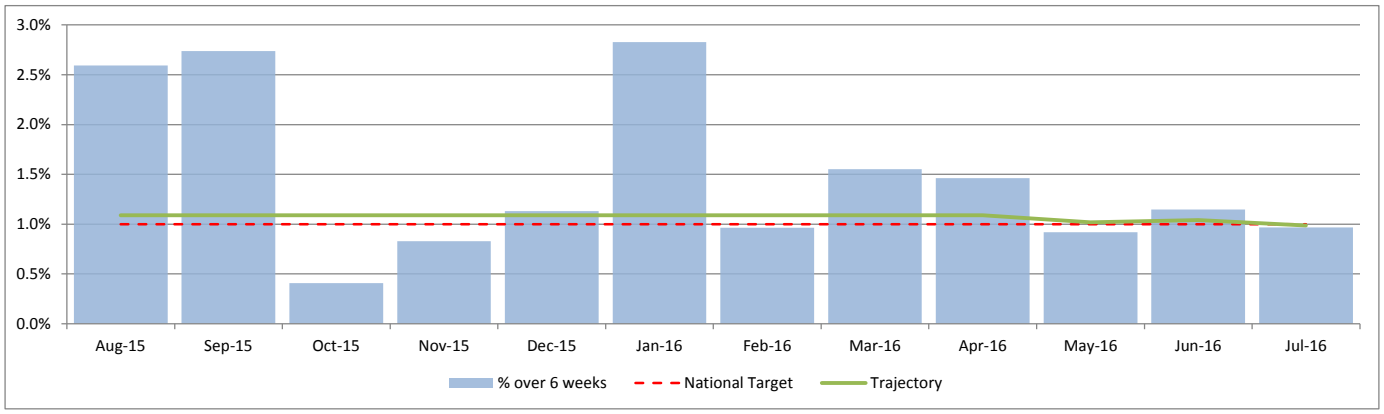
CONTRACTUAL FRAMEWORK

Month 4 July 2016

CONTRACTUAL FRAMEWORK

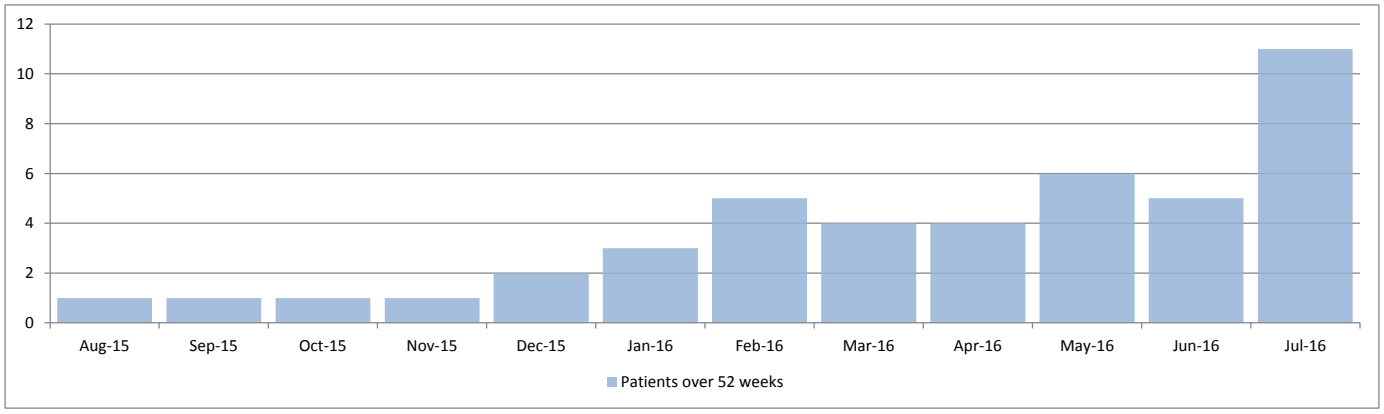
Diagnostic Tests Longer than the 6 week standard

	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%



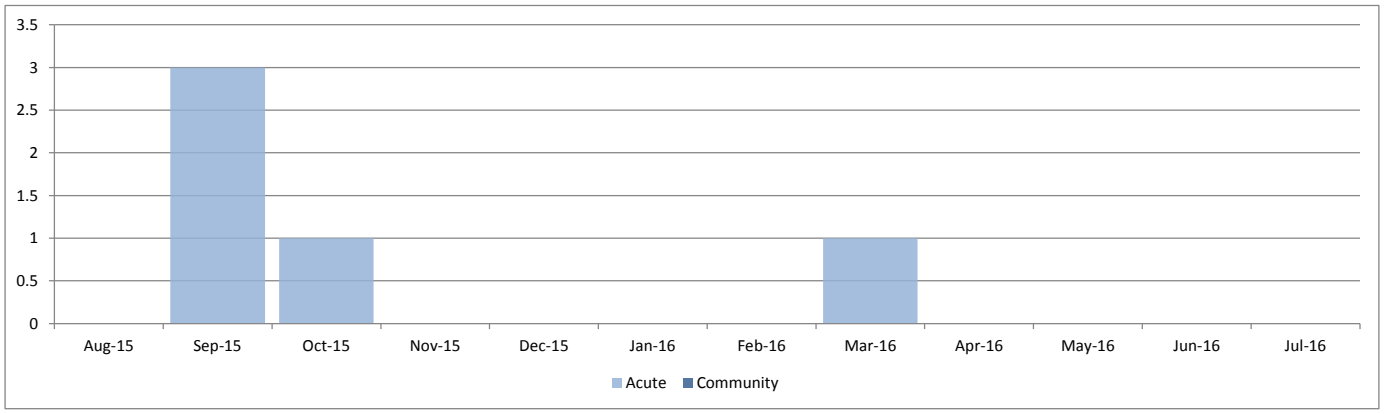
Referral to Treatment over 52 week incomplete pathways

	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

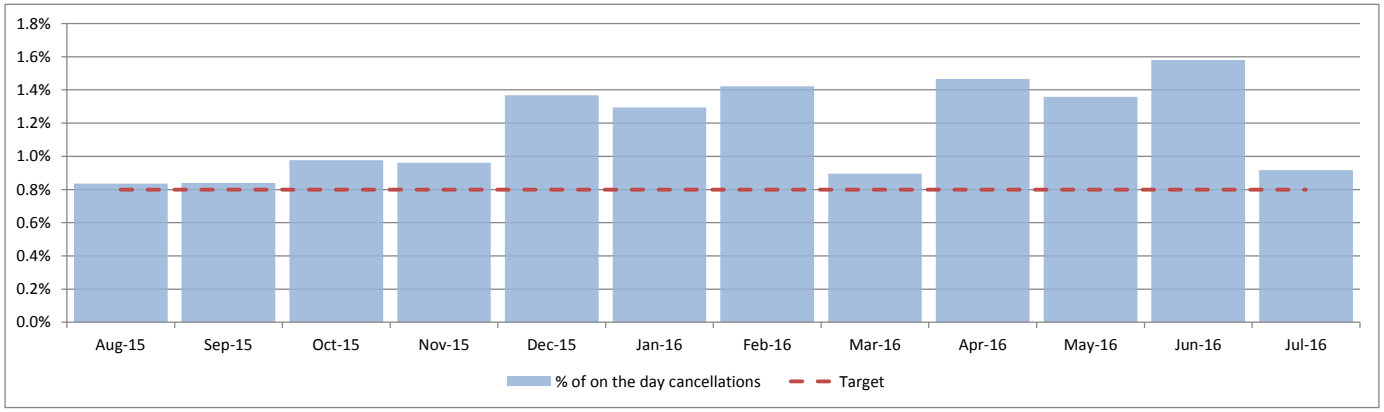
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Acute	0	3	1	0	0	0	0	1	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

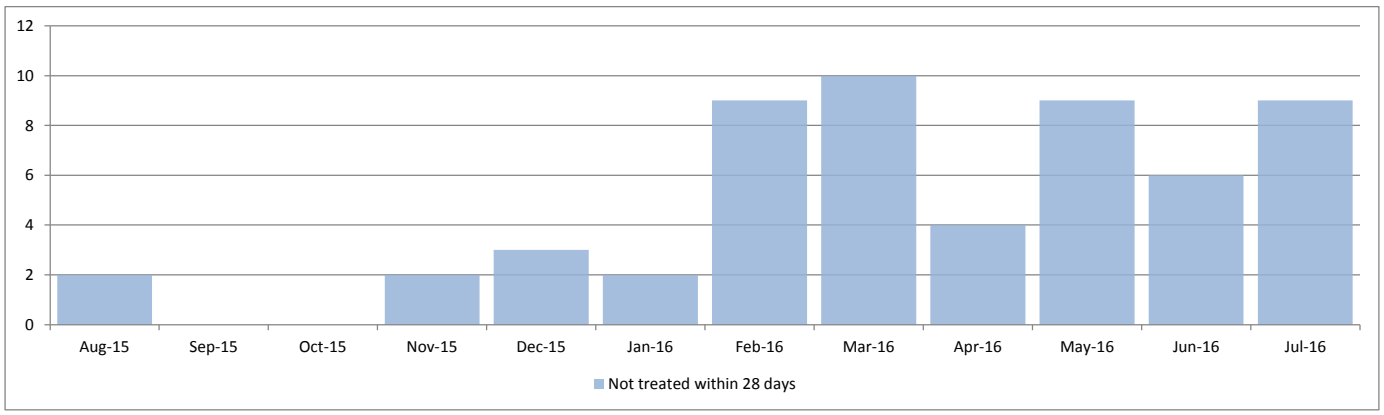
On the day cancellations for elective operations

	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%



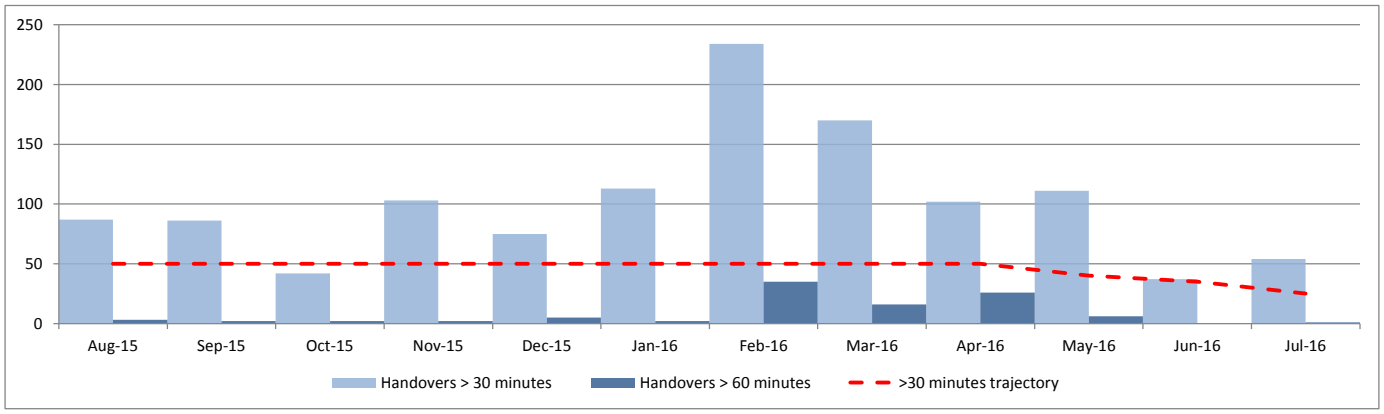
Cancelled patients not treated within 28 days of cancellation

	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

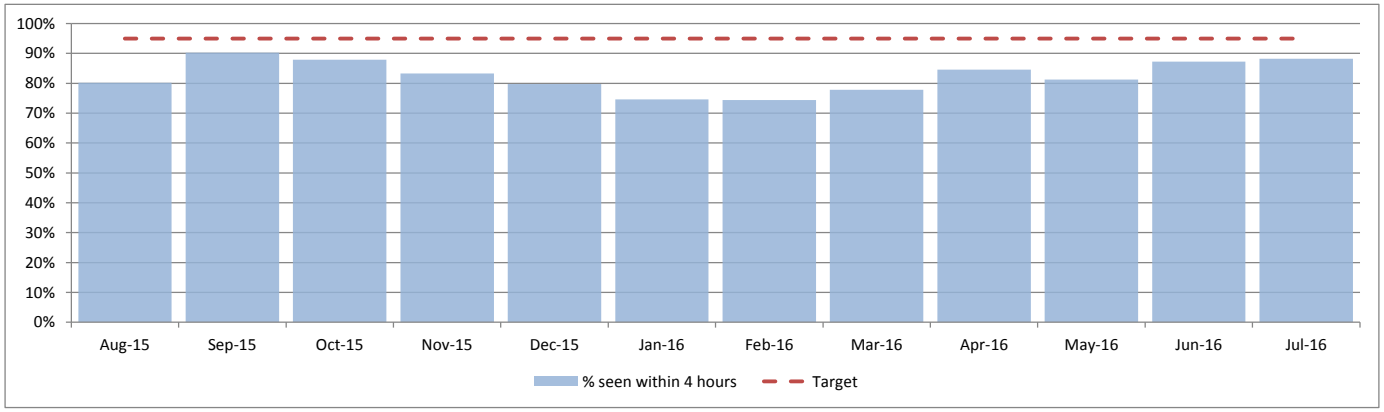
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Handovers > 30 minutes	87	86	42	103	75	113	234	170	102	111	37	54
Handovers > 60 minutes	3	2	2	2	5	2	35	16	26	6	0	1
>30 minutes trajectory	50	50	50	50	50	50	50	50	50	40	35	25



CONTRACTUAL FRAMEWORK

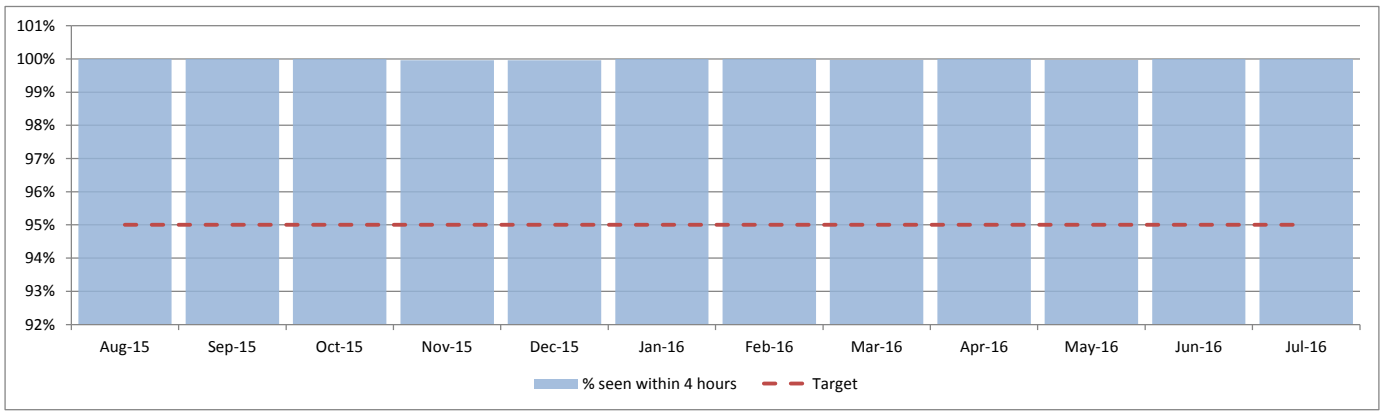
A&E patients seen within 4 hours (DGH only)

	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%



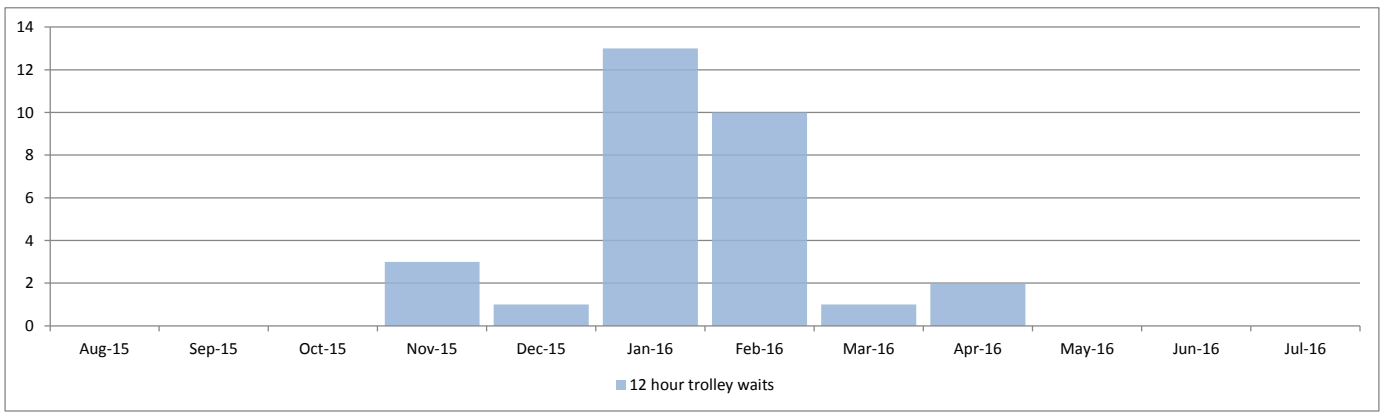
A&E patients seen within 4 hours (community MIU)

	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

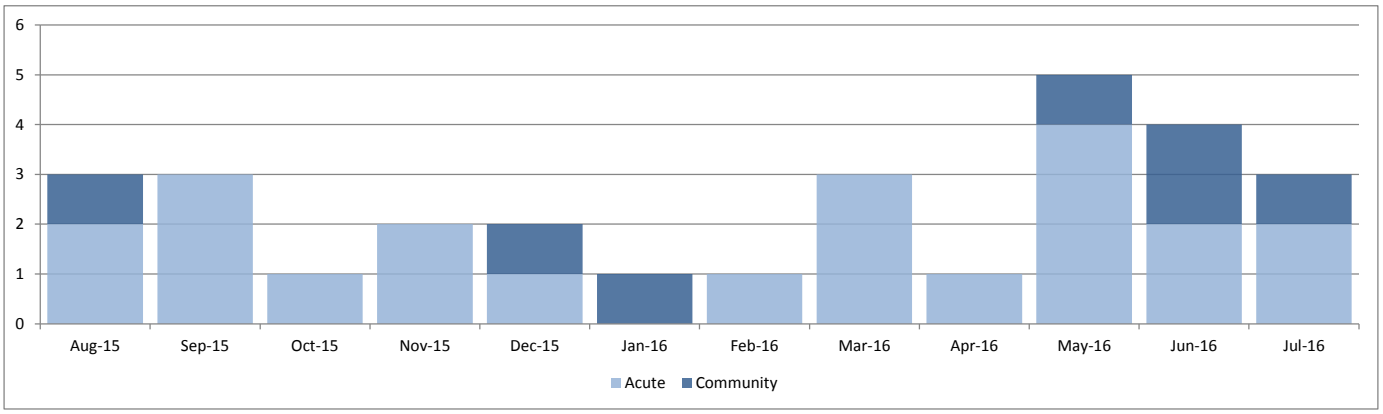
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
12 hour trolley waits	0	0	0	3	1	13	10	1	2	0	0	0



CONTRACTUAL FRAMEWORK

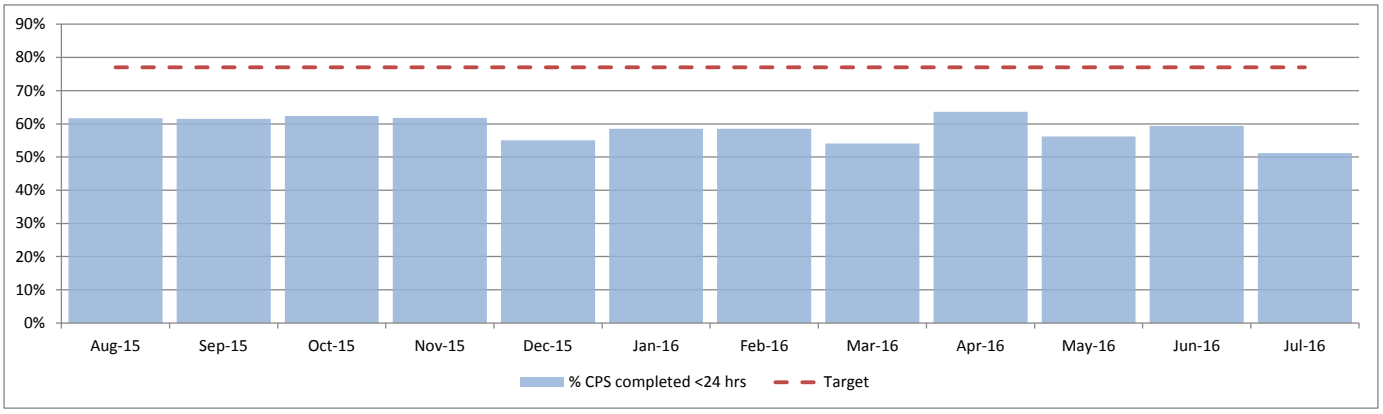
Number of Clostridium Difficile cases

	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



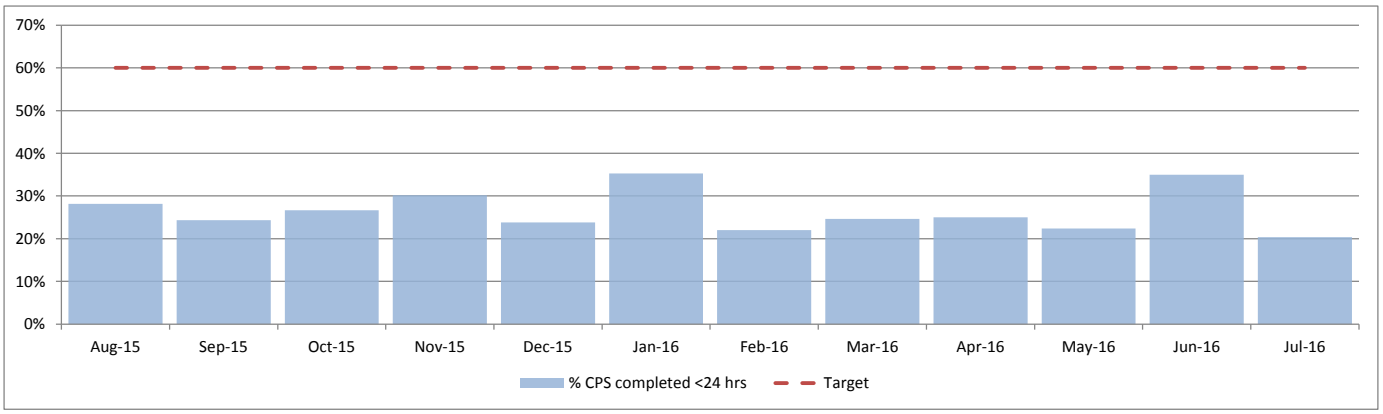
Care Plan Summaries completed with 24 hours of discharge - Weekday

	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

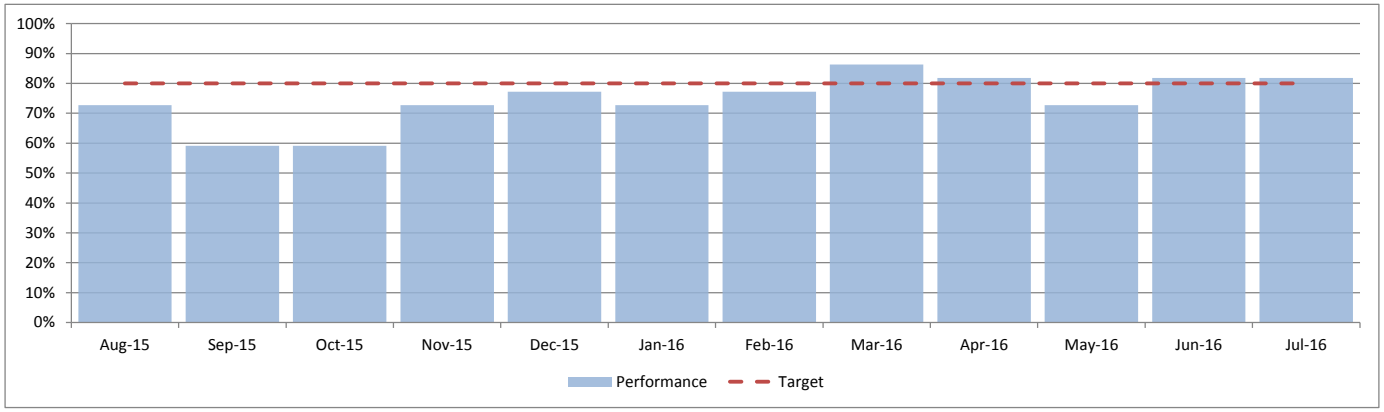
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Discharges	565	444	495	444	390	470	414	406	528	532	460	599
CPS completed within 24 hours	159	108	132	134	93	166	91	100	132	119	161	122
% CPS completed <24 hrs	28%	24%	27%	30%	24%	35%	22%	25%	25%	22%	35%	20%
Target	60.0%	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%



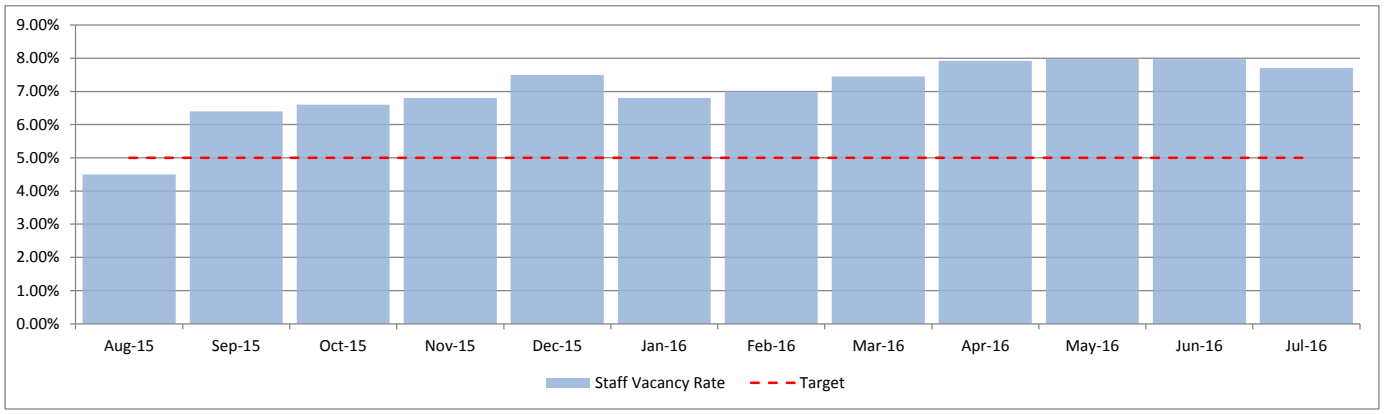
CORPORATE MANAGEMENT FRAMEWORK

Month 4 July 2016

CORPORATE MANAGEMENT FRAMEWORK

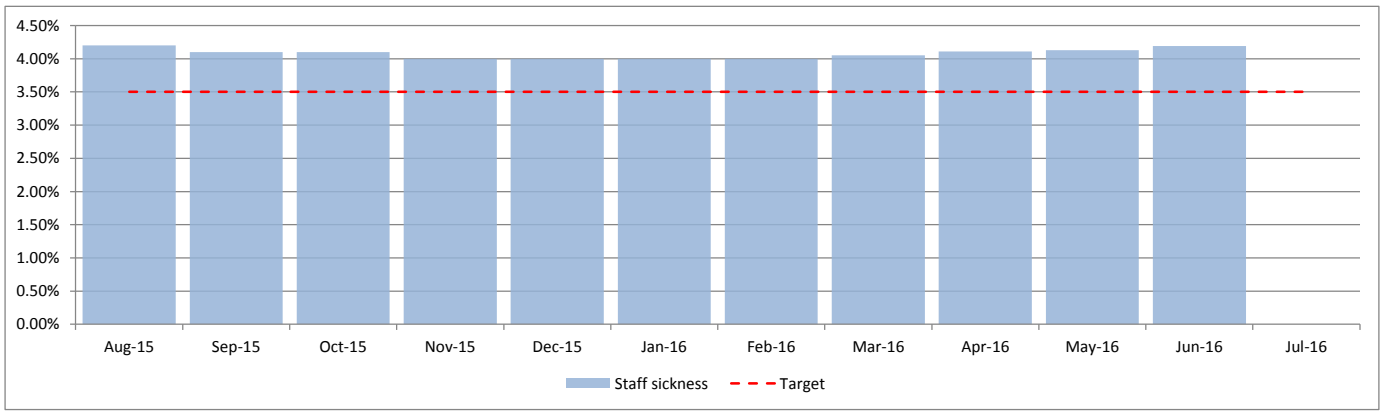
Staff Vacancy Rate (excluding temp workforce and additional hours)

	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%



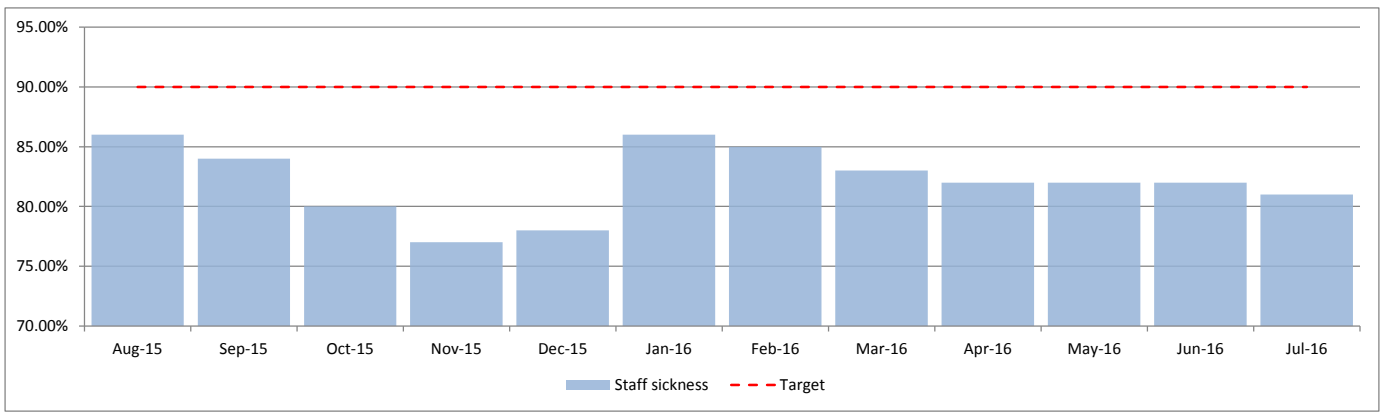
Staff sickness

	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

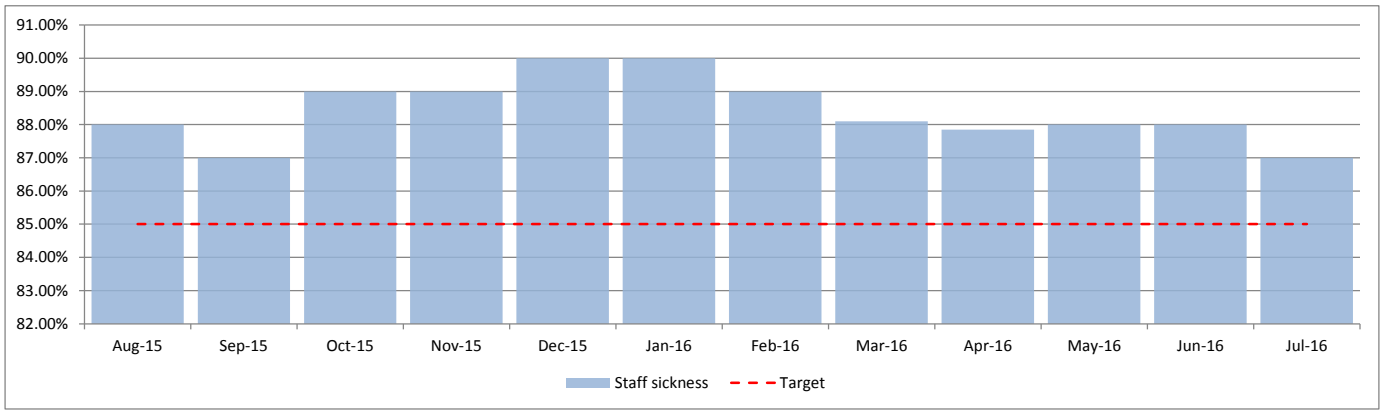
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Staff sickness	86.00%	84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



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 Summary Hospital-level Mortality Index SHMI (Appendix 1)	Mortality	Dr Foster 2014/15 benchmark year DH SHMI data	≤90	
Unadjusted Mortality rate (Appendix 2)		Trust Data	Yearly Average ≤3%	
Dr Foster Patient Safety Dashboard (Appendix 3)		Dr Foster	All 15 safety indicators positive	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.

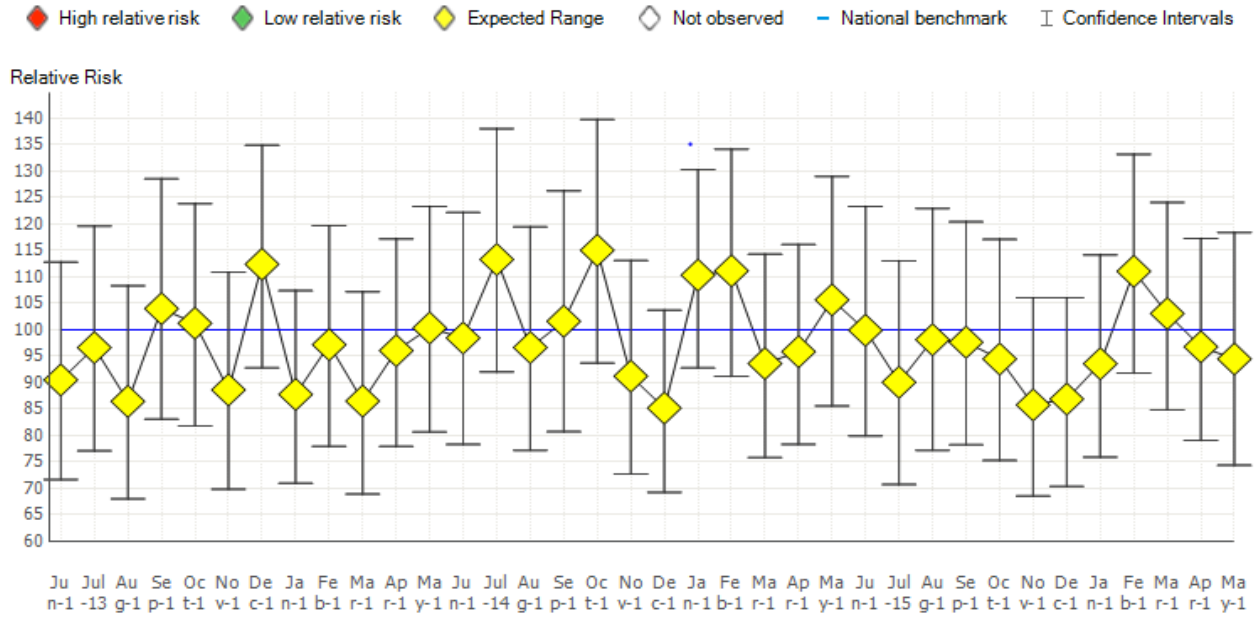
Appendix 1
This metric looks at the two main standardised mortality tools:
(A) Hospital Standardised Mortality Rate (HSMR) and
(B) Summary Hospital Mortality Index (SHMI)
(Data obtained from Dr Foster)

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.

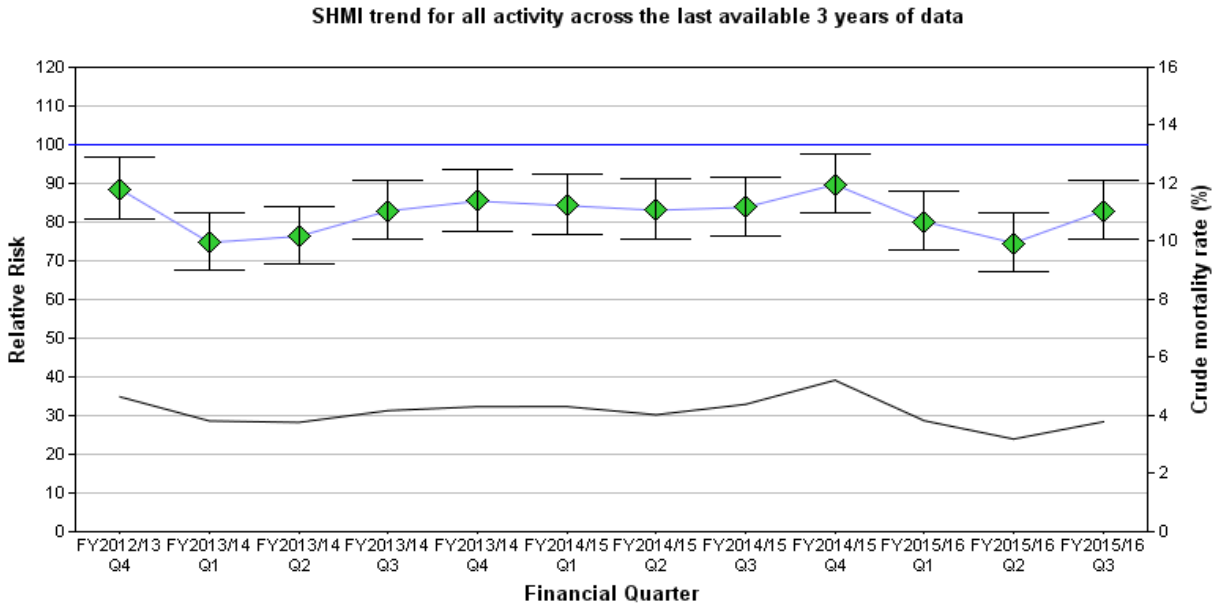
Our latest data point, May 16 is continuing to show a low relative risk of 94.80. The winter period also recorded no data points outside of the expected range. The data does show the cyclical patterns of mortality over the winter periods when mortality tends to peak.

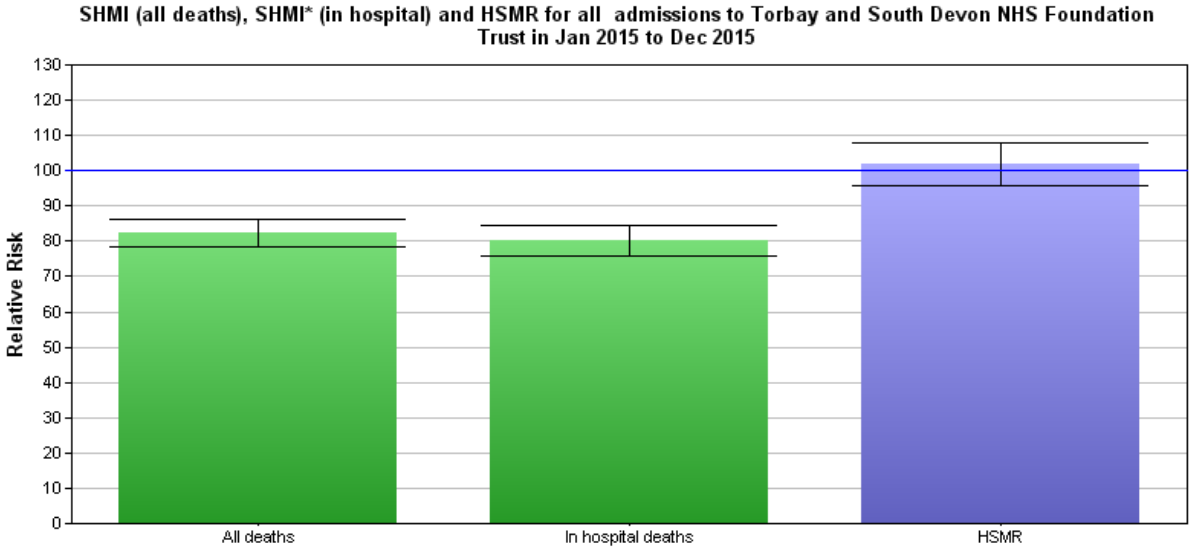
Morbidity and Mortality reviews take place in all specialist departments and in all community hospitals. In community hospitals all deaths are reviewed using software designed with the support of the South West Academic Health Sciences Network. Recurring themes are identified and changes in care pathways 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

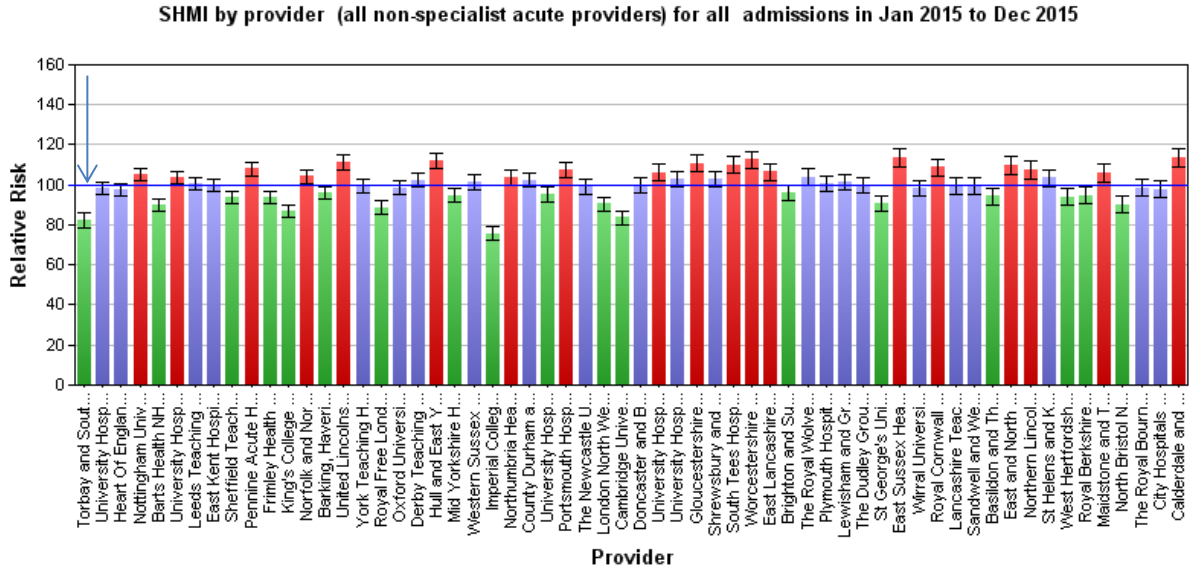




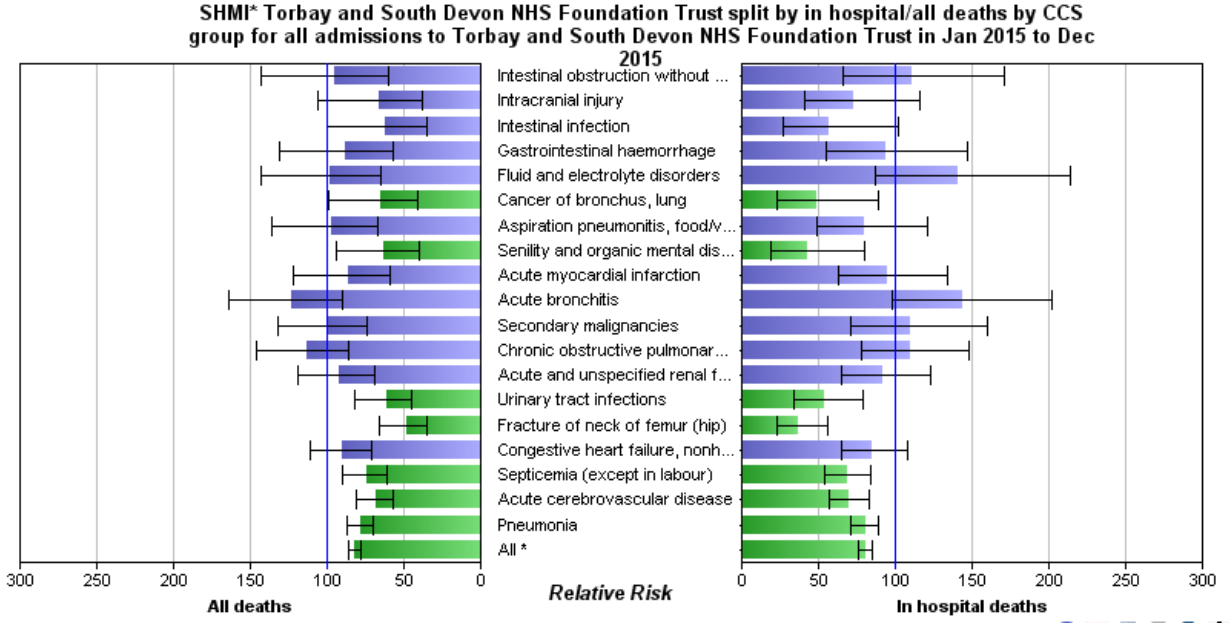
SHMI all deaths, SHMI in hospital deaths and HSMR

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)

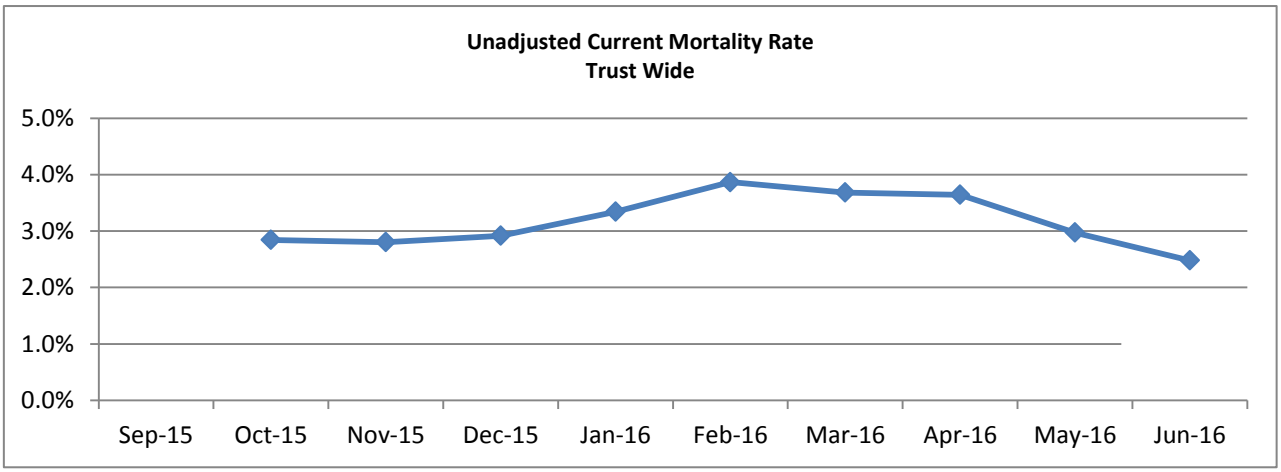
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

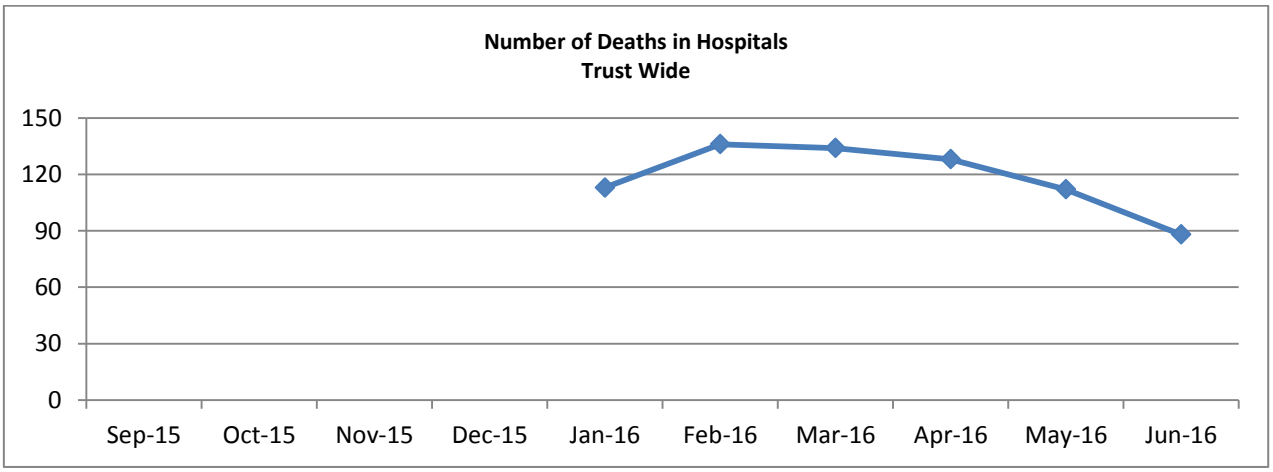
Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

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.

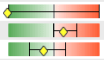
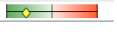
The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.





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.

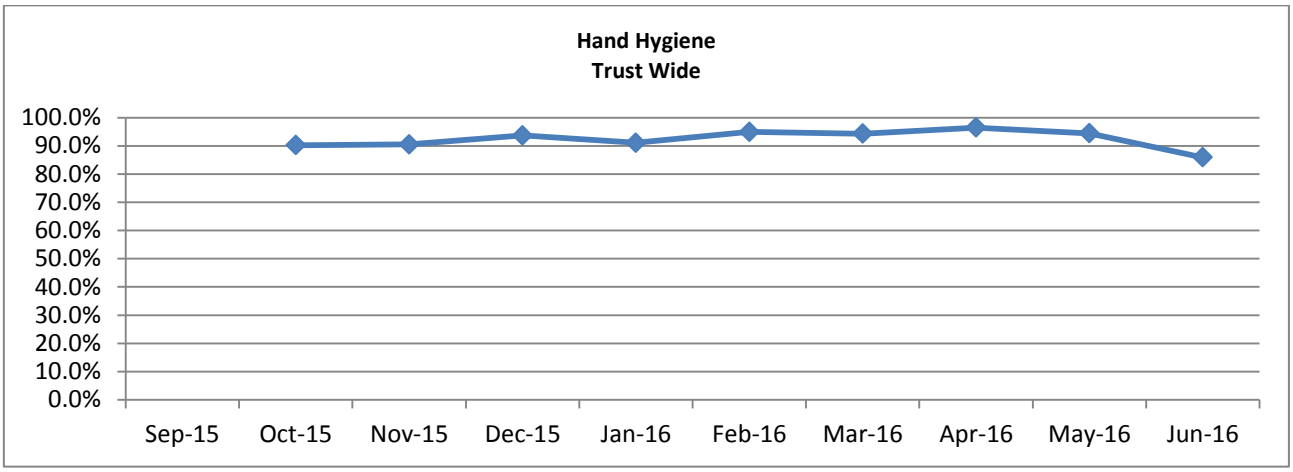
Deaths in low-risk diagnosis groups
This code has being investigated a number of times and no issues have been found other than incorrect codes being issued. This latest flag will be investigated and will be presented back to the Quality Improvement Group. If further analysis is need a small team will 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.

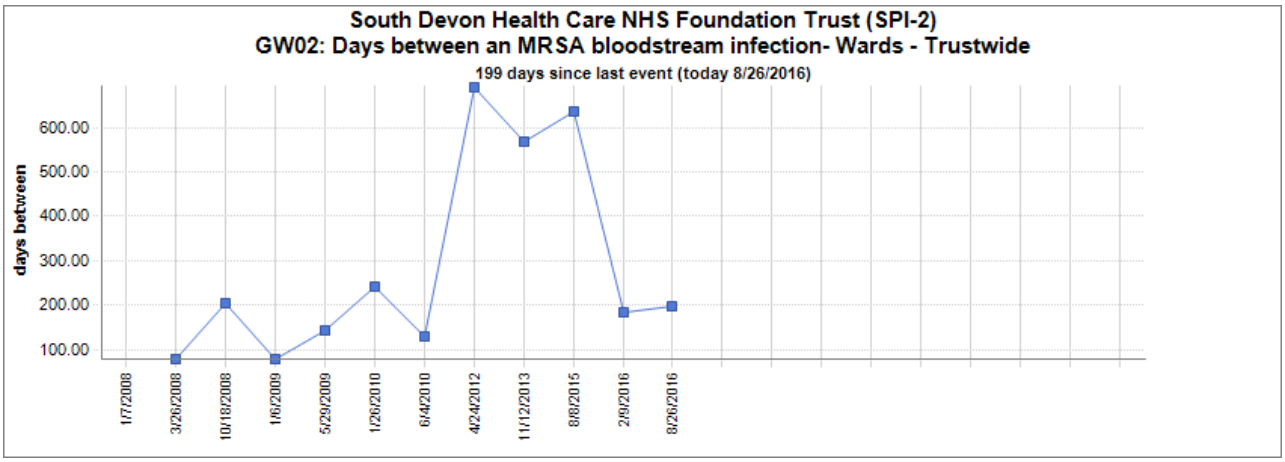


Commentary

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.

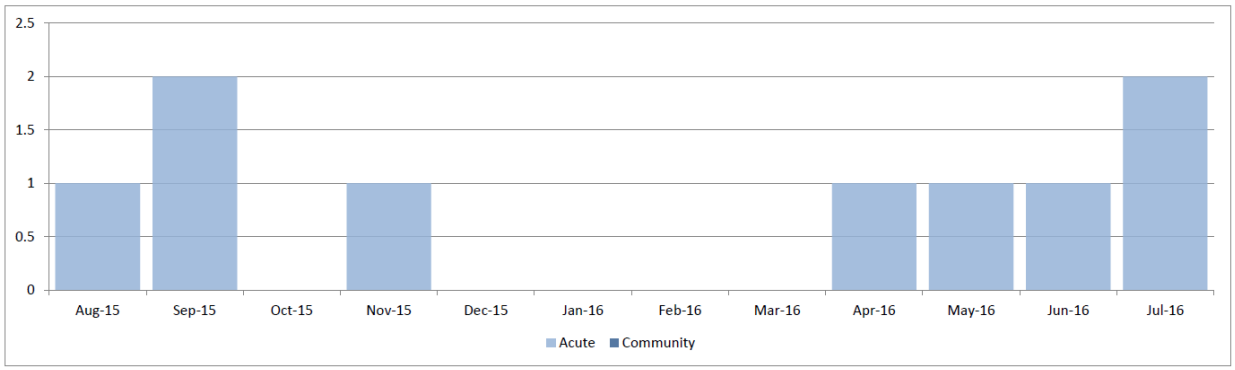
The current count stands at 199 days. The longest count has stood at 633 days and the data chart shows performance back to 2008

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

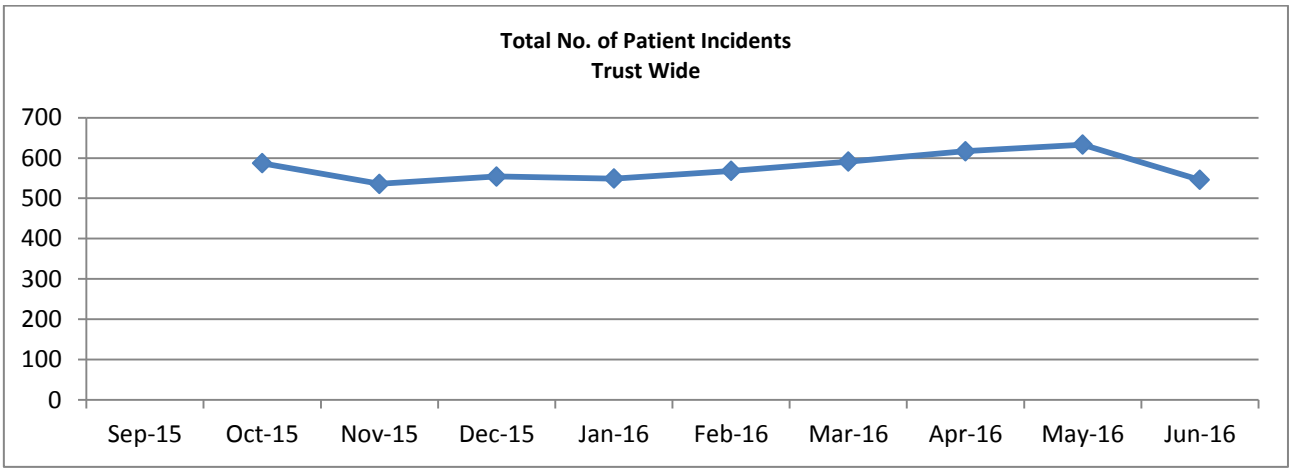
All CDiff cases are subjected to a root cause analysis and the infection control team when analysing the investigations code each case into *lapse of care* or *no lapse of care.* The above chart identifies those lapses in care.

Appendix 7

Total Number of Trust Wide Patient Incidents by Month

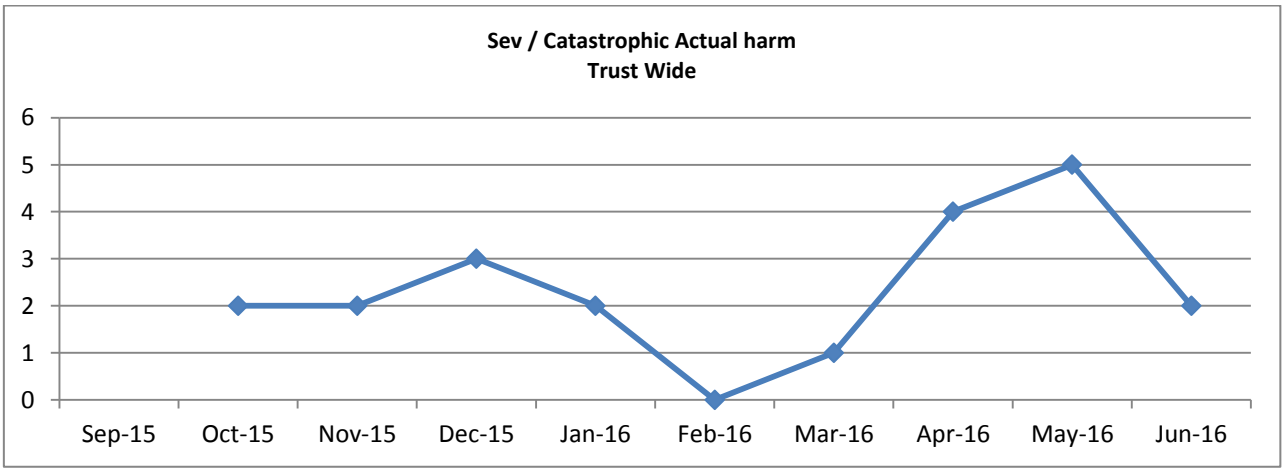
This metric is a simple count of the number of incidents reported by month.
An organisation with a healthy safety culture encourages incident reporting and uses this data to target safety improvements within its various governance structures.

SDHCFT's reporting is remaining in a healthy position.



Appendix 8

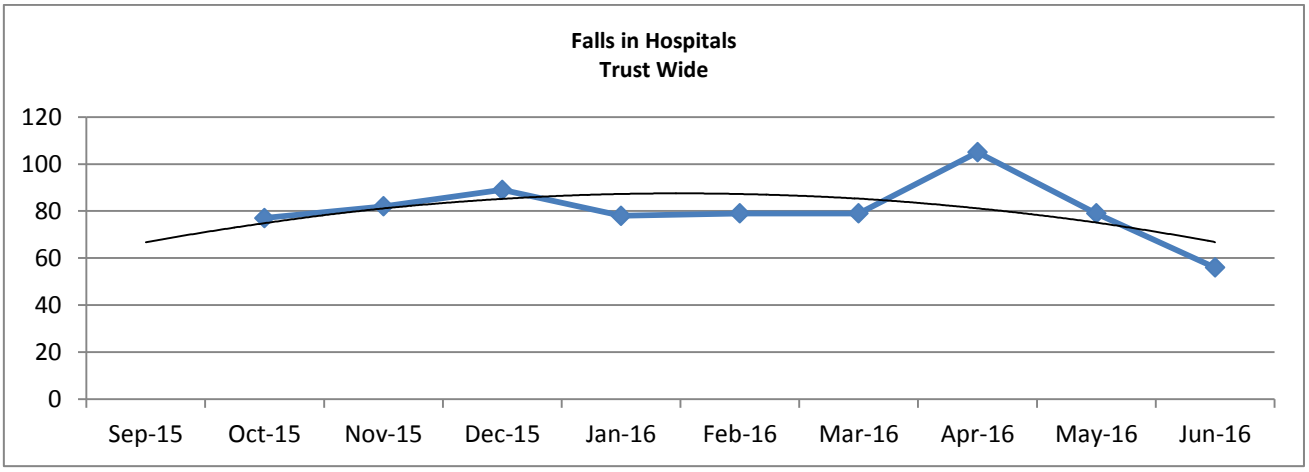
The total number of Moderate Major and Catastrophic incidents reported by month through the Safeguard Incident reporting system

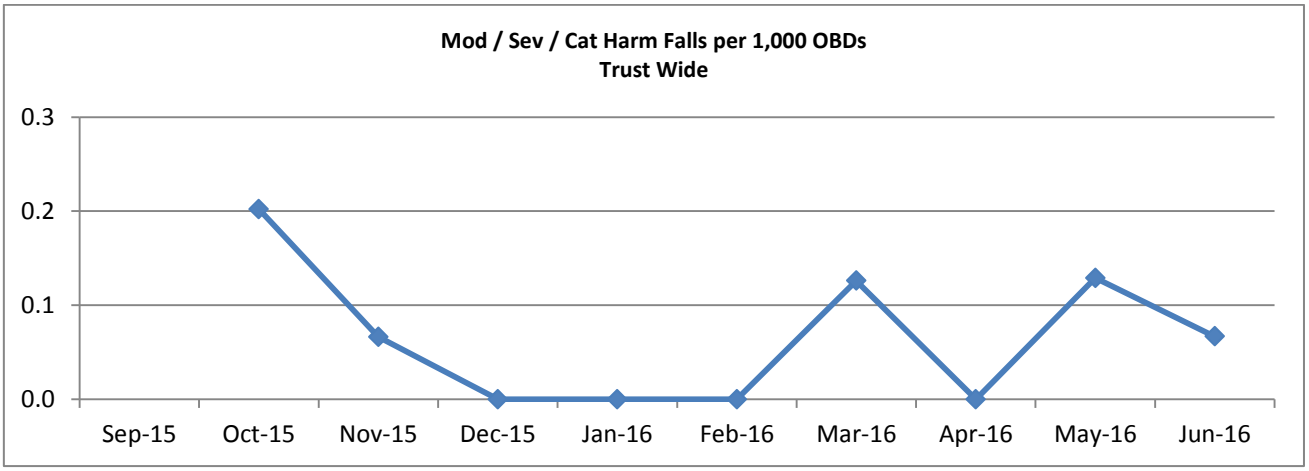


All major and catastrophic incidents are recorded on the STEIS system, presented to the Serious Adverse Events Group, complete with an investigation, root cause analysis and action plan, which is logged and monitored.

Appendix 9
In Hospital Falls

The below chart records the Organisational falls number





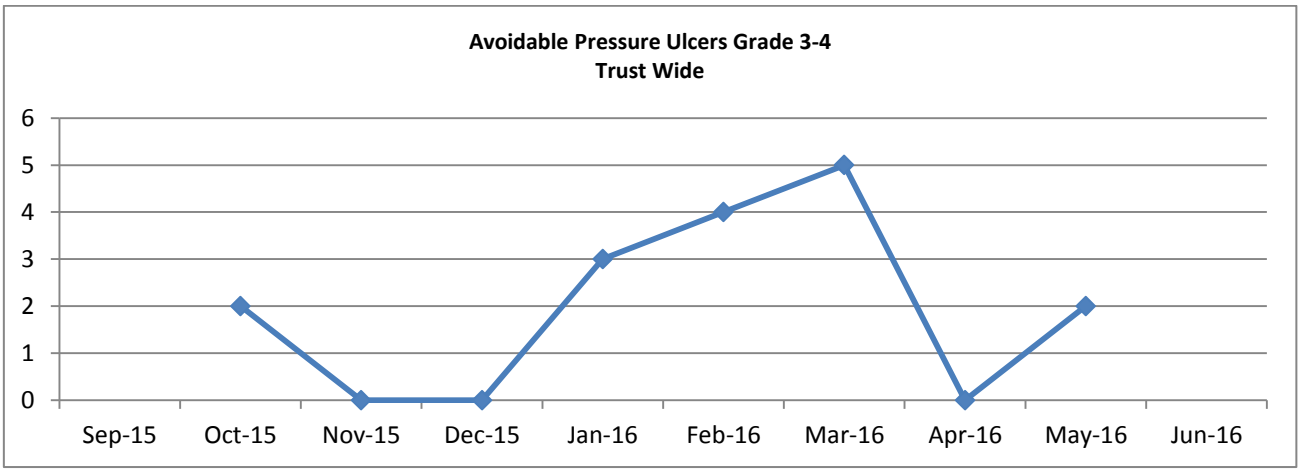
The above chart records the harm rate for the more serious incidents per 1,000 bed days within the ICO. This is showing a low harm rate. The falls data is shared with the Falls Nurse and at the Falls committee

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.

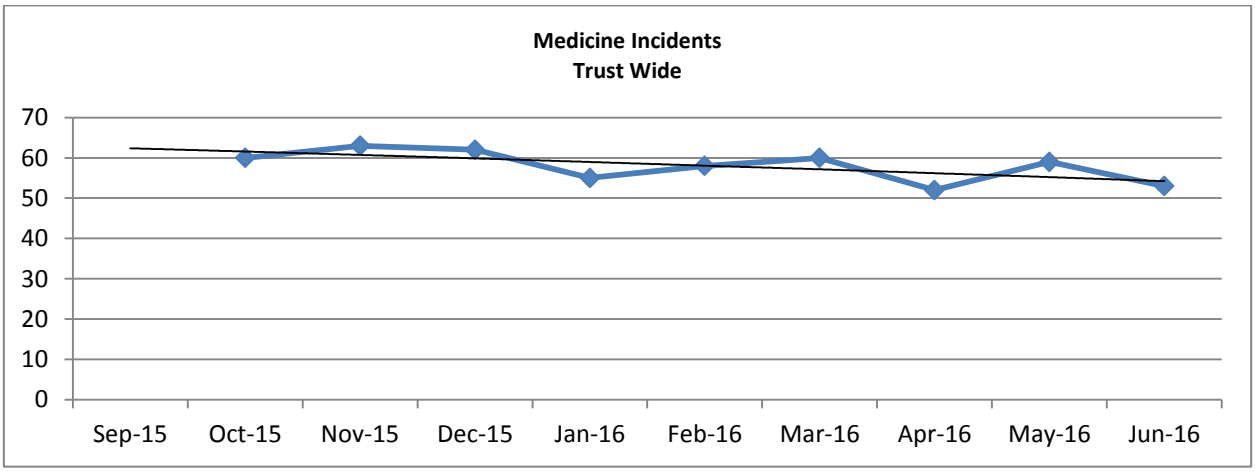
The more serious Grade 3 – 4 pressure ulcers, whilst historically low need to be observed for patterns and trends. Much work is being undertaken in the Pressure Ulcer Prevention (PUP) project which is now being rolled out to other wards under a buddy system; a ward that has been through the programme 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

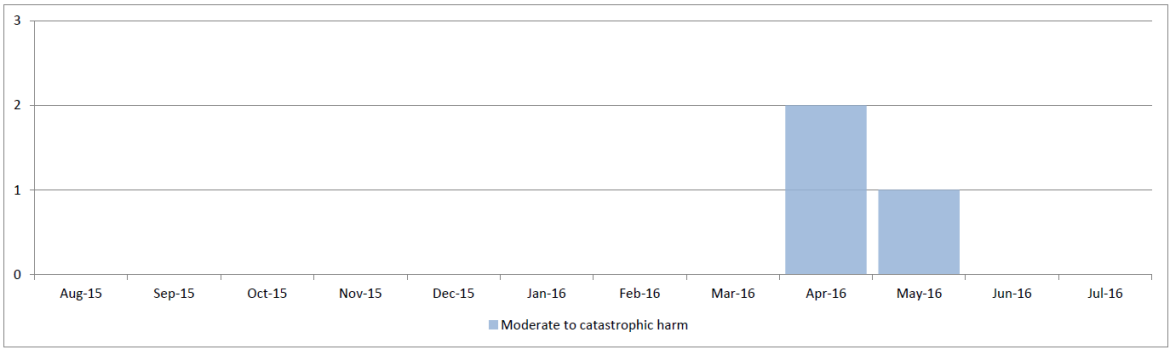
The first chart records the total number of organisational medication errors reported which is showing a slight decrease in number



The second chart below records the more serious harm from errors which is historically low

Medication Errors Resulting in Moderate to Catastrophic Harm

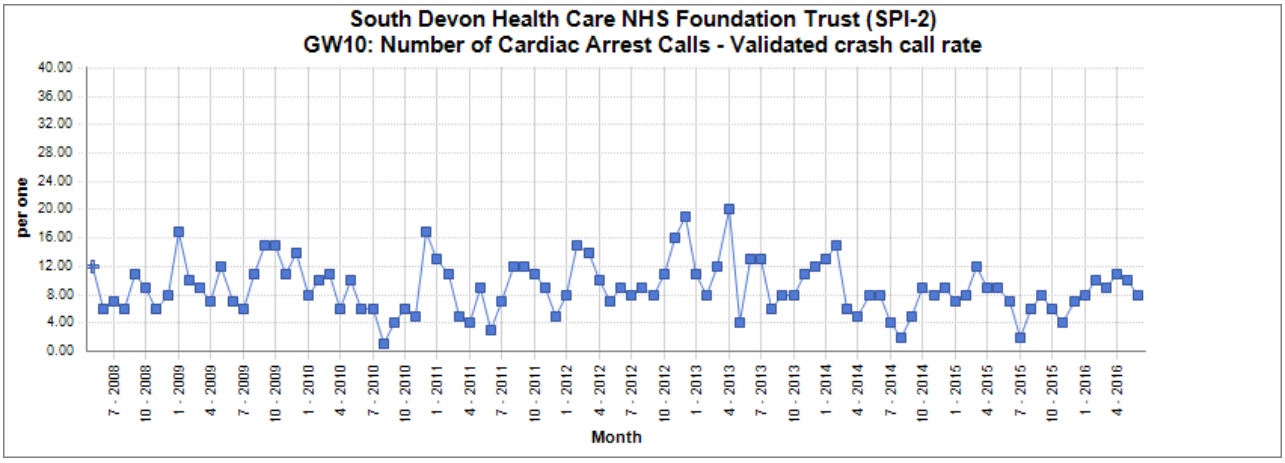
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Moderate to catastrophic harm	n/a	n/a	n/a	n/a	n/a	0	0	0	2	1	0	0



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).

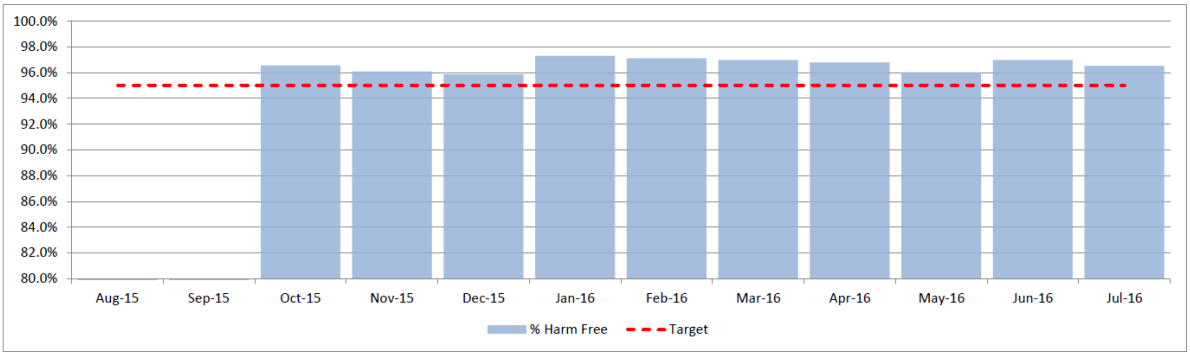
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

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

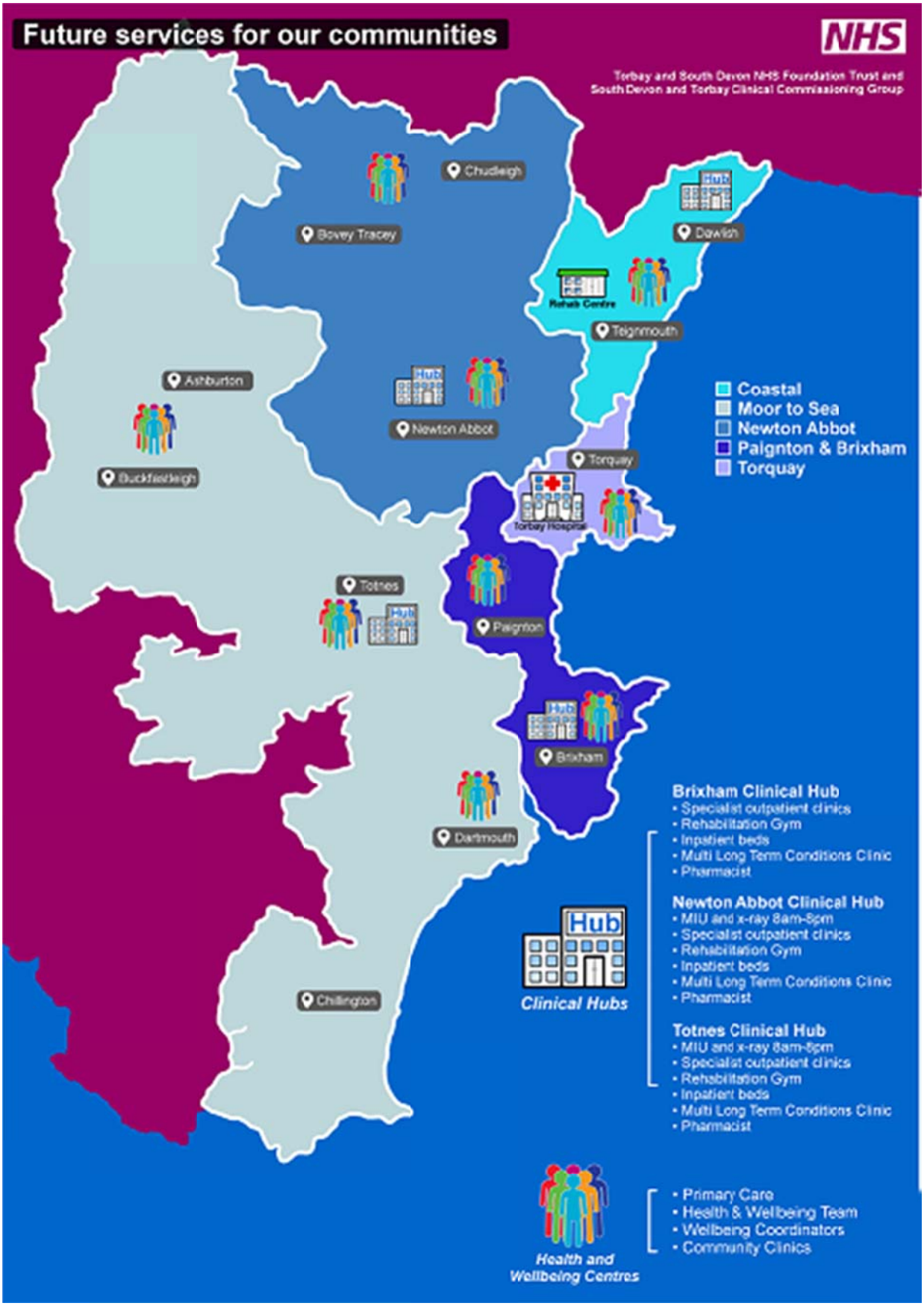
currently provide inpatient and community services would no longer be required and would close

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
Hub
Dawlish
Rehab Centre
Teignmouth
Ashburton
Hub
Newton Abbot
Buckfastleigh
Torquay
Torbay Hospital
Coastal
Moor to Sea
Newton Abbot
Paignton & Brixham
Torquay
Totnes
Hub
Paignton
Hub
Brixham
Dartmouth
Chillington
Hub
Clinical Hubs
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
Health and Wellbeing Centres
• Primary Care
• Health & Wellbeing Team
• Wellbeing Coordinators
• Community Clinics

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.

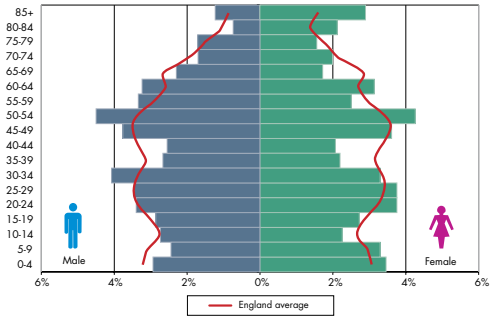
We can easily forget how much the NHS has changed over the years. It is not that long ago, for example, that lengthy hospital stays were required for treatment which now takes place routinely, in a few hours and without a hospital admission.

Delivering health services today is challenging because we have:

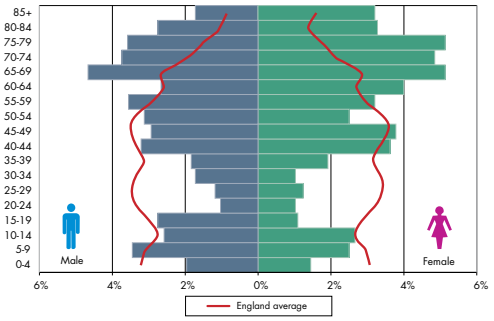
- Increasing numbers of older people, many with long-term and complex health conditions who need support to live independently

- 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.

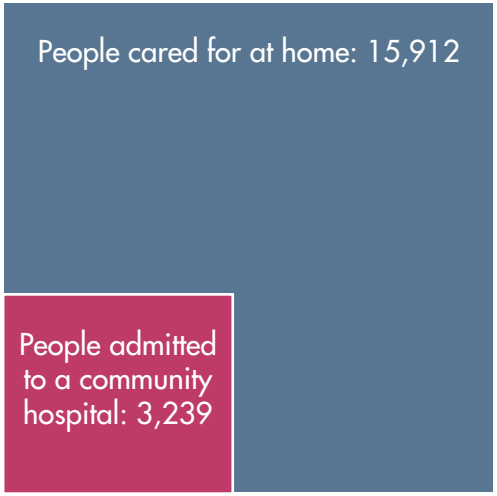
In addition to the pressures on CCG funding, Torbay and South Devon NHS Foundation Trust is required to make savings across the range of its activity. In 2016/17 this amounts to £13million.

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.

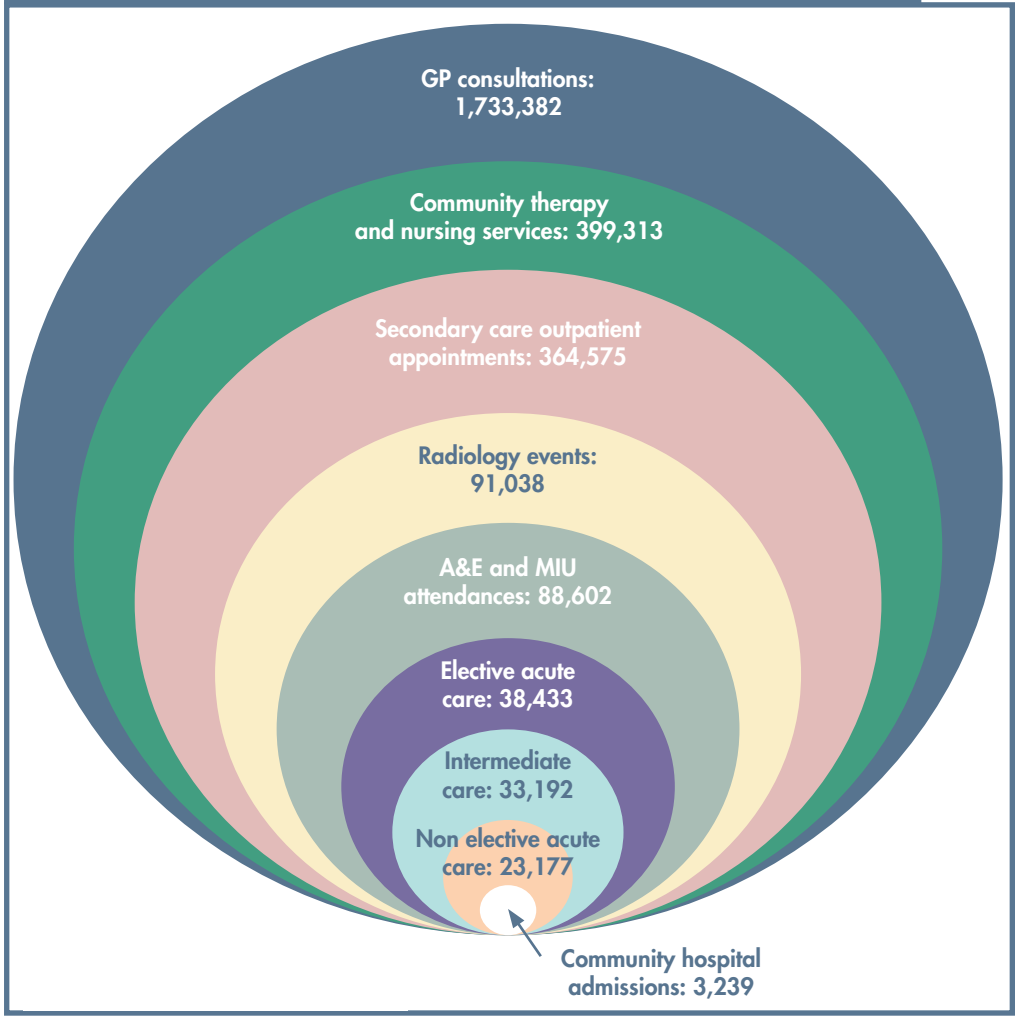
By switching funding from bed-based to community-based care, we would be investing more of our resources in the local services most used by our communities. As the diagram opposite illustrates, the largest volume of activity rests with GPs, community therapy and nursing.

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.

Library image

Library image

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.

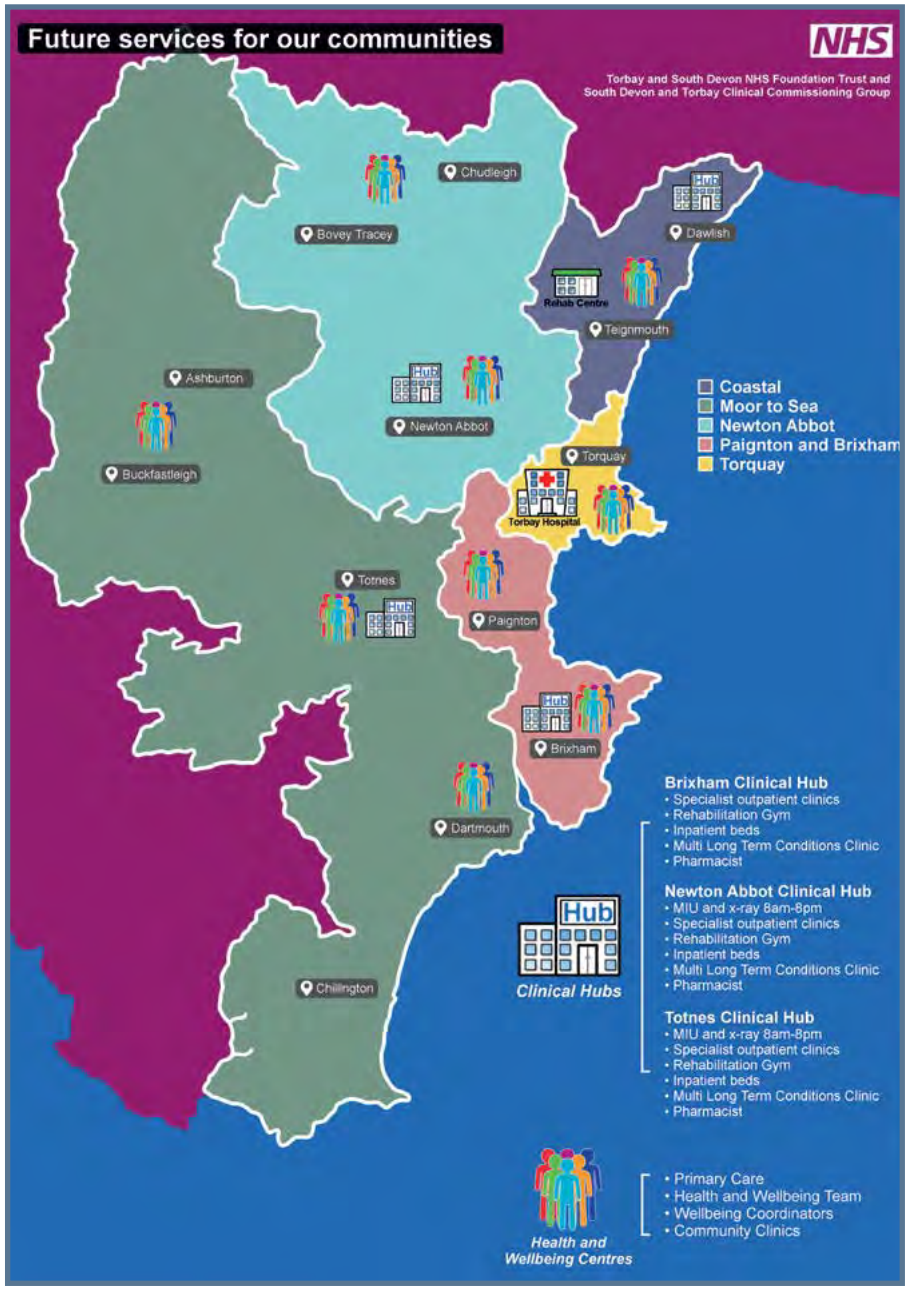
This community team has been at the forefront of piloting new enhanced services that would continue to deliver high-quality services in people's own homes.

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

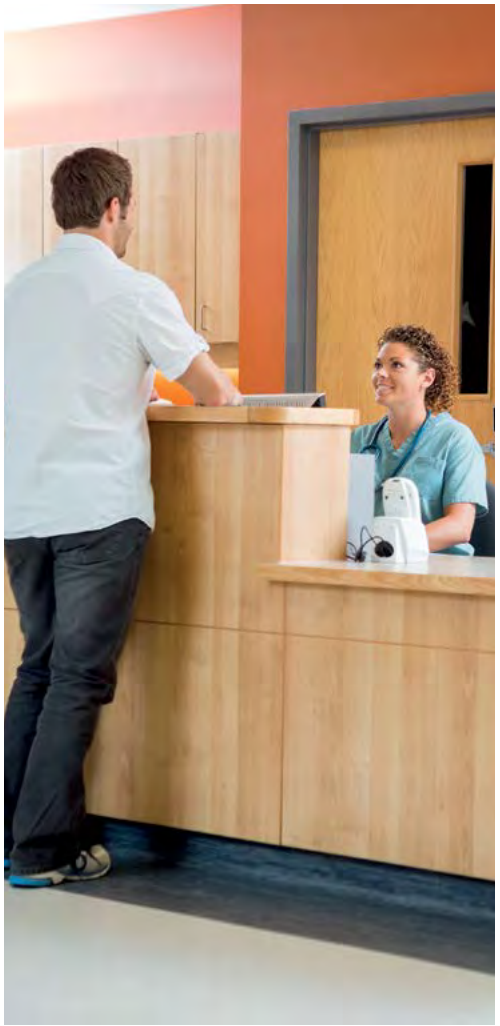
If the proposals set out in this document are approved, core services will be located as shown on this map.

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

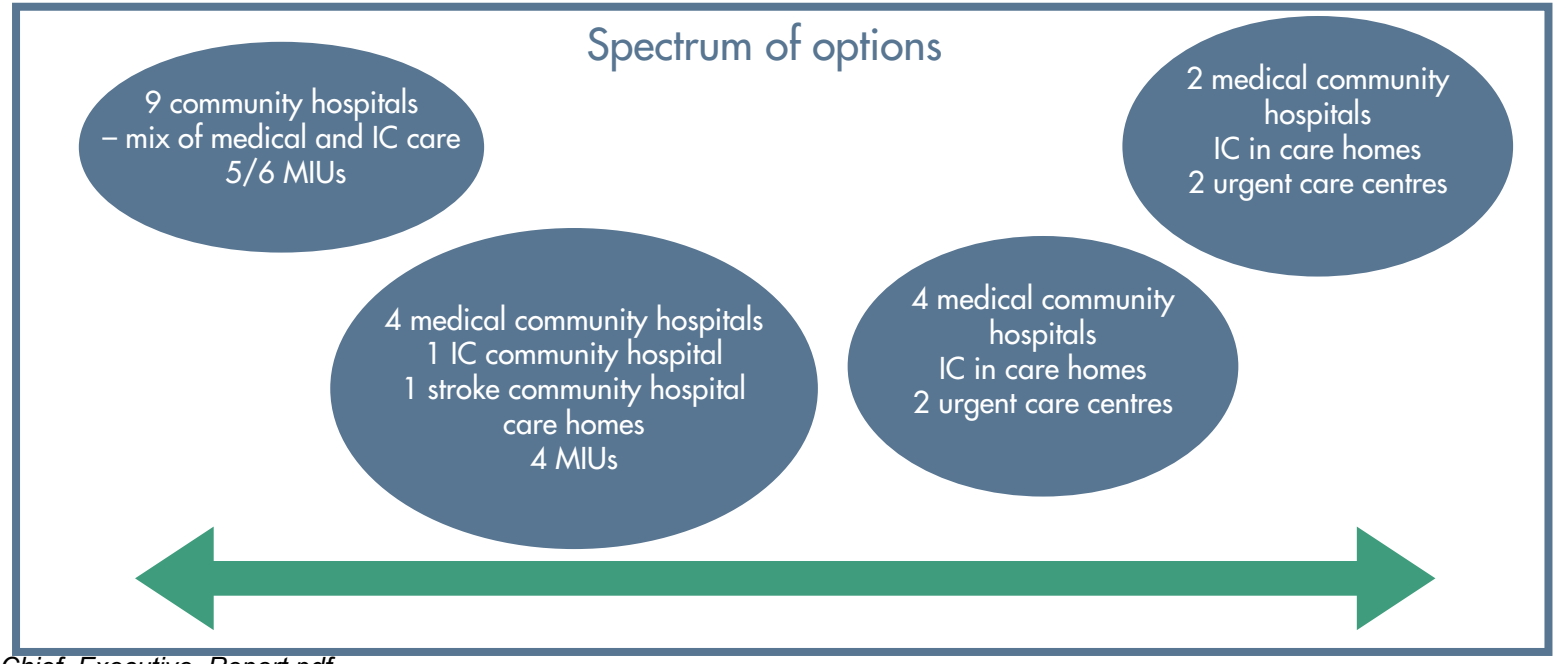
How our proposals developed

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

NHS
South Devon and Torbay
Clinical Commissioning Group

Stakeholder Briefing No 8 – 16 September 2016

Re-shaping Community Health Services in South Devon and Torbay

Consultation runs until 23 November 2016

This e-mail briefing keeps recipients up to date during consultation, highlighting and responding to issues raised. It also signposts where more information has been published which supports the consultation. People can sign up to receive it by emailing sdtccg.consultation@nhs.net

Public meetings

The first four public meetings, in Bovey Tracey and Dartmouth, attracted hundreds of people. A round table format followed by questions to a panel proved an effective way of enabling everyone at the meeting to have their say on the different aspects of the care model and to ask questions on the issues of most concern to them. Judging by the attendance and comments made, both the format of the meetings and the holding of them at different times seemed to work well.

Bovey Tracey

There were impassioned pleas to maintain the local hospital. If however it was closed following consultation, those attending wanted proceeds from any sale to be returned to the town. A commitment was made to listen to any alternative uses for the building should the hospital close. The meeting was told that it would take an estimated £1.5m investment to bring the hospital up to modern day standards for a health and care facility. Concerns were raised around the ability to recruit sufficient staff to deliver the new model of care, the need for more funding for intermediate care and the lack of local care and nursing home beds for when people needed them. The idea of a health and wellbeing centre which included local GPs was well received.

Dartmouth

Many people were concerned that Dartmouth Hospital could close. However, there was support for some initial work taking place jointly between the Trust and the GP practice to plan, subject to the consultation outcome, the possible relocation of community services and the GP practice to create a health and wellbeing centre within the existing Riverview care home. Discussions are continuing with its owners. This could include the provision of intermediate care beds; the expansion of the GP-led minor injuries service, community clinics and a base for volunteers. The meeting heard that some £2.5m would be needed to bring the hospital up to modern day standards for a health and care facility but that such investment would not resolve current access and parking issues. Some concerns were raised over access and public transport to the Riverview site, should it go ahead. Similar concerns were raised to those in Bovey Tracey relating to staffing, funding and availability of care home beds. Both meetings were attended by local MP Sarah Wollaston.

Meeting dates

Details of future public meetings are available on our website (see below) and the coming week sees three meetings in Ashburton Town Hall on 20 September (1pm, 4 pm and 7pm) and at St Luke's Church in Buckfastleigh on 22 September (6.30 pm) as well as Chudleigh tonight.

Property issues

A number of questions have been raised about the cost of maintaining hospitals, required investment and likely income from any sale. In response, the Trust and the CCG have brought together a short paper which sets out the available information and provides best estimates of some of the costs. The information is now available as a new support document on the CCG website and is available here.

The figures suggest that to bring the four hospitals proposed for closure in the consultation up to the standard to provide modern health care, meeting Disability Discrimination Act and Health & Safety requirements, would be about £6.8m. Should a decision be made to close them after consultation, proceeds from the sales would raise about £4m. The properties are owned by the Trust and proceeds would be used to fund health and social care buildings in the South Devon and Torbay area which local people use.

Feedback questionnaire

There has been some criticism of the questionnaire with allegations that it does not give people the opportunity to express their views and that it contains leading questions designed to get people to support the closure of hospitals.

The CCG has put forward for consultation a proposal which it believes will meet future health needs in a way that is affordable and sustainable. Its approach therefore in the feedback questionnaire is to give people the opportunity to comment on the different aspects of its proposals so the level of support for each can be identified. As well as the specific questions – which were developed in consultation with patients and voluntary groups - people can give their views in their own words and make alternative proposals. The CCG wants people to indicate which elements they do and do not support and in the context of the status quo not being a viable option, consider the different options that need to be taken to meet people's health needs in future.

More information

On Monday, our website (www.southdevonandtorbayccg.nhs.uk/community-health-services) will have a number of short videos on different aspects of the proposed model such as minor injuries units, integrated care, out of hospital care and integrated working. We have also expanded our Frequently Asked Questions in the light of issues which have been raised during the consultation so far and as indicated above added a property issues paper.

Paper copies of any consultation documents, which can be downloaded from our website, can be requested or questions asked by:

- Emailing sdtccg.consultation@nhs.net
- Writing to South Devon and Torbay CCG, Pomona House, Torquay, TQ2 7FF
- Calling 01803 652511office hours (voicemail messaging overnight/weekends).

If you would like to invite us to any community group meetings please get in touch and we will do our best to attend.

Submitting your views

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. Correspondence, petitions and other submissions will also be noted by Healthwatch. The feedback questionnaire can be accessed via the CCG or Trust website or via www.communityconsultation.co.uk The consultation closes on 23 November and the outcome is likely to be considered by the CCG's Governing Body at a meeting in public in January/February 2017.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

Agenda Item:	8
Report Title:	Lead Governor's Report
Report By:	Lead Governor
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Lead Governor arising since the last Council of Governors meeting on 20 July 2016.

2. Main Report

I hope that everyone has enjoyed a relaxing summer and is now taking part in the South Devon and Torbay Clinical Commissioning Group (CCG) consultations. We governors are certainly versatile. We spent two years learning about the agenda for change and now we are looking at the new agenda – less bed based care and more services at home. More emphasis on personal responsibility, less need for NHS beds.

Consultations by the CCG about the need to change the way services are delivered are at about mid-point, with a report to the Trust's Board of Directors expected in the New Year. Communication seems to be the key to success. I attended an excellent presentation at the first meeting, held at Bovey Tracey.

For ourselves, we need to be assured that adequate services are in place before changes are made.

We will have an opportunity to discuss matters fully at the governor only meeting on Wednesday 19 October 2016, prior to the next Board-to-Council of Governors meeting.

We will also have some training on the new NHS Mail 2 site, which is causing some confusion for some governors.

Thank you for your continued help and support, I know the Trust appreciates it.

3. Recommendations

3.1 Council of Governors accept the report.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

Agenda Item:	10
Report Title:	Quality and Compliance Committee Report
Report By:	Wendy Marshfield
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Update report of the Quality and Compliance Committee (Q&CC) following their most recent meeting on **24 June 2016**. The notes of this meeting were circulated at the July Council of Governors meeting.

1.2 Governor observers continue to attend their respective meetings and report back to this Committee using the agreed forms.

1.3 The next meeting is due to take place on 11 November 2016. Ann Wagner, Director of Strategy and Improvement is scheduled to attend this meeting as requested by governors.

1.4 Following recent feedback, the Company Secretary with Q&CC members will undertake a review of the 'Governor Observer Protocol'.

1.5 The draft notes from November's meeting will be taken to the Council of Governors in December.

2. Recommendations

2.1 Council of Governors receives this short report for information.

3. Decisions Needed to be Taken

3.1 Note and comment on the information above.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

Agenda Item:	11
Report Title:	Membership Development Report
Report By:	Chair of MDG/Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Current update on the work of the Mutual Development Group (MDG).

2. Background Information

Mutual Development Group (MDG)

2.1 The MDG meets on a quarterly basis (February, May, July and November) to consider and take forward the requirements placed on it by the Council of Governors. It was decided in July that an extra meeting take place in September.

2.2 Attachment one refers to the draft notes of September's meeting for your reference, information and any questions.

2.3 Any governor currently not a member is welcome to join MDG as there are seats available. Torbay / South Hams and Plymouth Constituency is represented but another governor from the Teignbridge Constituency would be welcomed. New seats can always be created if several governors come forward.

3. Recommendation

3.1 Council of Governors support the current work of the Mutual Development Group.

3.2 Any governor not currently a member contacts the Chair of MDG or Foundation Trust Office to learn more about the Mutual Development Group.

4. Decisions Needed to be Taken

4.1 Comment and receive the attached information.

4.2 Approve the recommendation outlined above.

5. Attached to this Report

Attachment one - Draft notes of the extra MDG meeting in September.

Torbay and South Devon NHS
NHS Foundation Trust

NOTES OF THE MUTUAL DEVELOPMENT GROUP (MDG) MEETING

HELD IN THE EXECUTIVE MEETING ROOM, HENGRAVE HOUSE

AT 11.30AM ON WEDNESDAY 7 SEPTEMBER 2016

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* Christina Carpenter
Sylvia Gardner-Jones (SGJ)
* Mary Lewis (ML)
* Cathy French (CF)
* Lynne Hookings (LH)
* Diane Gater

In attendance
* Monica Trist (MT)
Comms Team member
* Note taker (JB)

* Denotes member present

ACTION

1 Apologies

Sylvia Gardner-Jones, Comms Team.

2 Notes of the Last Meeting

The notes of the last meeting held on 8 July 2016 were confirmed as accurate.

Matters arising:

To note, Carol Pearson, Experience and Engagement Lead, has now left the Trust. CC sent CP a card and MT sent an email.

It was **agreed** to add 'Matters Arising' to future agendas as a standing item. JB

Ann Wagner was not available to attend MDG today and it was **agreed** to invite Ann to the next MDG meeting. MT/JB

Studio School attendance numbers are still down and only twenty achieved diplomas. Jane Viner, Chief Nurse, made a full presentation at the Board to Council of Governors meeting on 17 August on this topic.

Regarding inviting the Studio School to the Annual Members day on 23 September, JB spoke to the Studio School who provided her with email addresses for the head of the school and her pa. JB emailed but did not receive any response.

It was noted there is money set aside in the Company Secretary budget for membership engagement eg membership newsletters. Governors were advised that additional initiatives may require a separate business case.

It has been proving difficult obtaining the governors constituency group photographs which are to go on display in Torbay and community hospitals and therefore it was **agreed** to use the individual photographs from the governor page of the public website. MT/JB

It was noted that the CS has resolved the issue of microphones in TREC. There is one hand-held and two clip-on microphones available for future meetings.

Staff Governor attendance at MDG has been agreed on a rota basis. Comms Team attendance agreed although apologies received for today's meeting.

It was **agreed** a Teignbridge governor is needed on MDG as CF attends in her capacity as Lead Governor and not Teignbridge governor. MT/JB to look at the last April Committee Refresh. — MT/JB

It was **agreed** that governors would look at and discuss the Patient Services Department (Complaints and PALS) reports at constituency meetings. — All

The group felt that membership could be increased by including an invitation to become a member within the first appointment letter that a patient receives. It was noted that the wording asking for new members may have been removed from appointment letters. It was **agreed** that MT would investigate and report back at the next meeting. — MT

MT discussed with the CCG whether governors could have a recruitment stand at the CCG consultations. The CCG declined on the grounds of lack of space and not appropriate as they had received similar requests from other groups – also declined.

3 Governor presentation packs

MT will distribute to the group when completed. — MT

4 Preparation for Council of Governors/Annual Members Meeting (AMM) 23 September 2016

The rota for the governor stand was discussed and it was **agreed** all would attend. — All

It was decided not to have a questionnaire on the stand but for governors to engage with members using open questions regarding their experience. The group requested an A3 printout of the CCG consultations (dates/times/venues) for the display stand. — JB

CC and ML left the meeting at this point (12.15pm).

In addition, the group requested that the Annual Members Survey be put on MDG agendas as a standard item. — JB

It was **agreed** that MT would ask Comms to put something in the Herald Express regarding the AMM. — MT

CF would like the governors to ask members why they became members and what benefits they would like as members.

5 Patient Services Department (Complaints and PALS) report

CC suggested that the items of complaint are used in the Annual Members Survey.

6 Update from the Working with Us Panel

The group would like JB to thank Maureen Quartermaine for the update and to ask for a copy of the discharge questionnaire for JB to send to MDG members. JB

7 Membership recruitment

JB is going to look at putting the A4 membership application form into A5 booklet type form and will send to MDG members when complete. JB

Suggestions for membership recruitment:

- Having another day in Outpatients with the governor display stand.
- Governors go to supermarkets to promote membership after the CCG consultations – MT to check with CS. MT
- If the new CCU has a public opening, governors could possibly take the opportunity to meet and promote membership at this event.
- The Working with Us Panel could give membership application forms to patients.

CF felt that the Trust needs to do more for its members eg three events per year – two Medicine for Members events and the AGM.

8 Preparation for joint Board to Council of Governors meeting 19 October 2016

- The group felt that membership needs to be discussed. MT to discuss with CS re CS doing a membership report. MT

DG left the meeting at this point (1pm).

- Referral to treatment
- Disposal of medical equipment

9 HealthWatch Annual Report

The group have all read the report.

10 Any Other Business

None.

Details of next meeting

25 November 2016, 10.30am – 12pm, Members Room, Hengrave House

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Friday 23 September 2016

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

1. Summary of Report

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

2. Main Report

2.1 **Autumn Elections 2016:** The Trust would like to give advance notice of the annual elections to our Council of Governors, which take place each autumn. Anyone who is part of our membership, or who wants to join, can put themselves forward to stand in the elections. The Trust will have several seats available across all public constituencies, where the current governors (some of who are eligible for re-election) are coming to the end of their elected terms. Anyone living within our constituency boundaries or is a member of staff from both trusts are welcome to contact our Foundation Trust Office (01803 655705 / foundationtrust.tsdft@nhs.net) to find out more.

2.2 **Joint meeting between Council of Governors and Board of Directors:** The next Board-to-Council meeting will take place on Wednesday 19 October 2016, 3pm in the Anna Dart Lecture Theatre, Horizon Centre.

2.3 **NHS Mail:** The Company Secretary is aware that some governors have been experiencing some email issues following migration to the national system (NHSmail2). Governors are encouraged to ring the national helpline or email the national helpdesk in the first instance (0333 200 1133 or helpdesk@nhs.net) as this is the number/email address all staff are asked to contact with any issues. Governors are encouraged to ring the Foundation Trust Office if email issues remain unresolved.

Governors have been informed of an email training session on Wednesday 19 October 2016.

Company Secretary's preference in the past has been to use NHSmail for all governor communications, however, governors decided to use personal accounts for unclassified information and NHSmail for confidential information. Governors are encouraged to access their secure NHSmail accounts at least twice a week.

2.4 **Consultation session:** The Foundation Trust Office arranged a 'new models of care' development session on Friday 16 October 2016; eight governors were present and was very well received.

2.5	**Constituency Reports**: The Company Secretary has not received any reports since July's Council of Governors meeting. Future reports will be presented at either the Board-to-Council of Governors meeting in October or the Council of Governors meeting in December.
3.	**Decisions Needed to be Taken**
3.1	Note and comment on the information outlined above/attached.