

# Torbay and South Devon NHS Foundation Trust


## Public Board of Directors



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

02 November 2016 09:00 - 02 November 2016 11:00

# AGENDA

#	Description	Owner	Time
1	<b>PART A: Matters for Discussion/Decision</b>		
1.1	<b>Apologies for Absence - Medical Director</b> Note	Ch	
1.2	<b>Declaration of Interests</b> Note	Ch	
1.3	<b>Minutes of the Board Meeting held on the 5th October 2016 and Outstanding Actions</b> Approve  16.10.05 - Board of Directors Minutes Public.pdf 7	Ch	
1.4	<b>Report of the Chairman</b> Note	Ch	
1.5	<b>Report of the Chief Executive</b> Assurance  Report of the Chief Executive.pdf 35	CE	
1.6	<b>Report of the Medical Director</b> Information/Assurance  Report of the Medical Director.pdf 45	MD	
1.7	<b>Role of Junior Doctors and how training is delivered (N Campbell)</b> Assurance	Ch	
1.8	<b>Strategic Issues</b>		
1.8.1	<b>STP Feedback</b> Information	DSI	

#	Description	Owner	Time
1.8.2	<p><b>Into the Future: Reshaping community-based health services - response to public consultation</b></p> <p>Approve</p> <p> Reshaping community-based health services respon... 49</p>	DSI	
1.8.4	<p><b>Care Home Quality</b></p> <p>Assurance</p> <p> Care Home Quality.pdf 53</p>	CN	
1.9	<p><b>Integrated Quality, Performance and Finance Report - Month 6</b></p> <p>Assurance</p> <p> QPFW Report.pdf 65</p>	DSI	
1.9.1	<p><b>Cost Recovery Proposal - Additional Unpaid Leave</b></p> <p>Approve</p> <p> st Recovery Proposal - Additional Unpaid Leave.pdf 7</p>	DWOD	
1.10	<p><b>Governors' Questions</b></p> <p>Discuss</p>	Ch	
1.20	<p><b>Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)</b></p>		
2	<p><b>PART B: Matters for Approval/Noting Without Discussion</b></p>		
2.1	<p><b>Reports from Board Committees</b></p> <p>Assurance</p> <p> 2016.10.25_FPI_Cttee_Report_to_Board.pdf 145</p> <p> 2016 10 24_QA_Cttee_Report_to_Board FINAL.pdf 147</p>		
2.2	<p><b>Reports from Executive Directors</b></p>		
2.2.1	<p><b>Report of the Chief Nurse</b></p> <p>Information</p> <p> Six Month Chief Nurse Safer Staffing Report.pdf 149</p>	CN	

#	Description	Owner	Time
2.2.2	<p><b>Assurance from the CCG and NHS England Annual EPRR Assessment</b></p> <p>Assurance</p> <p> Assurance from the CCG and NHS England Annual... 169</p>	DECD	
2.2.3	<p><b>Key Issues and Assurance from the Capital Infrastructure and Environment Group</b></p> <p>Assurance</p> <p> y Issues and Assurance from the Captial Intrastru... 1</p>	DECD	
2.3	<b>Compliance Issues</b>		
2.4	<b>Any Other Business Notified in Advance</b>	Ch	
2.5	<b>Dates of Next Meeting - 9.00 am, Wednesday 7th December 2016</b>	Ch	
2.6	<b>Exclusion of the Public</b>	Ch	

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**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST  
BOARD OF DIRECTORS MEETING  
HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE, TORBAY  
HOSPITAL  
ON WEDNESDAY 5<sup>TH</sup> OCTOBER 2016**

**PUBLIC**

Present:	Sir Richard Ibbotson	Chairman		
	Mr D Allen	Non-Executive Director		
	Mr J Furse	Non-Executive Director		
	Mrs J Marshall	Non-Executive Director		
	Mr R Sutton	Non-Executive Director		
	Mrs S Taylor	Non-Executive Director		
	Mrs M McAlinden	Chief Executive		
	Mr P Cooper	Director of Finance		
	Ms L Davenport	Chief Operating Officer		
	Dr R Dyer	Medical Director		
	Mrs J Viner	Chief Nurse		
	Mrs A Wagner	Director of Strategy and Improvement		
	Councillor J Parrott	Torbay Council Representative		
In Attendance:	Mrs S Fox	Board Secretary		
	Mr I Currie	Deputy Medical Director		
	Mrs J Gratton	Interim Head of Communications		
	Mr R Scott	Corporate Secretary		
	Ms L Storey	Deputy Director of Workforce and Organisational Development		
Mrs C Carpenter	Governor	Mrs A Hall	Governor	
Mrs L Hookings	Governor	Mrs M Lewis	Governor	
Mr D Parsons	Governor	Mr P Welch	Governor	

**ACTION**

129/10/16 **Recipient Story**

The Recipient Story was presented by Erica Dunn, Matron and Martin Manley, Chaplain. It concerned a gentleman on Midgley Ward who was sadly receiving end of life care at Torbay Hospital prior to passing away in May of this year. His daughter was due to get married in July but because her father had wanted to give her away asked if arrangements could be made for her to get married on the ward before her father passed away. The wedding was arranged within 24 hours and involved staff from the ward, Chaplaincy team, catering and cleaning teams – with the wedding also having to be brought forward by a few hours when it became apparent the gentleman was very poorly. The wedding took place and the gentleman sadly passed away later that day.

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

### 130/10/16 **Apologies**

Apologies were received from the Director of Estates and Commercial Development, Director of Workforce and Organisational Development, Mrs J Lyttle and Mr J Welch.

### 131/10/16 **Declarations of Interest**

Nil.

### 132/10/16 **Minutes of the Board Meeting held on the 7<sup>th</sup> September 2016 and Outstanding Actions**

The minutes of the meeting held on the 7<sup>th</sup> September 2016 were approved as an accurate record.

### 133/10/16 **Report of the Chairman**

The Chairman briefed the Board on the following:

- ♦ The Board was given early sight of a video celebrating the ICO's first year with the Chief Executives from the Trust and CCG. It would be made available to all staff and also shared more widely in the peninsula. Councillor Parrott expressed disappointment that the Director of Adult Services was not involved in the video and this was acknowledged. The Chief Executive would make contact with the Director to discuss.
- ♦ The CCG had been highlighted as being one of the best performers in the country for Cancer Services – one of only 7 CCGs out of 209. The Trust's local services have played a key role in this achievement.
- ♦ Carol Gray (Strategic End of Life Lead) and Corinne Lowe (Lay Carer Facilitator) have both been awarded the title of Queen's Nurse by the Queen's Nursing Institute for Innovative Practice in Palliative and End of Life Care. The Board wished to record their congratulations for this prestigious award.
- ♦ The Chairman had reviewed the Board work schedule and noted that there were no statutory reports that needed to be considered in January, and given that it was always very difficult for Executive Directors to prepare Board reports over the Christmas holiday period, proposed that this Board meeting was cancelled. This was agreed.

CE

### 134/10/16 **Report of the Chief Executive**

The Chief Executive highlighted the following from her report:

- ♦ The Chief Executive thanked the Chairman and Executive team for taking the time at this very busy period to visit Trust sites earlier in the week to mark the ICO's first anniversary.
- ♦ ED Performance for the end of September was 92.6%, which was ahead of trajectory – the Chief Executive congratulated the Chief Operating Officer and her team on this achievement.
- ♦ As previously forecast, there had been a deterioration in RTT performance with challenges in a couple of specialities previously alerted to the Board. The Chief Operating Officer would provide more detail later in the meeting.



- ◆ The Chief Executive thanked all Board Members, Governors and Council colleagues for their support at the CCG Consultation meetings,
- ◆ NEW Devon CCG had now published their consultation papers in respect of their proposals for community hospitals. The documents had similar drivers for change, as set out in the Torbay and South Devon consultation.
- ◆ A GP workshop was held earlier in the week with over 40 GPs attending, covering the majority of practices in the community. The meeting was very positive and it was felt the turnout reflected the importance that GPs were placing on the need to work with the ICO. A further meeting would be held later in the year, and the Medical Director was leading this engagement process.
- ◆ The Board noted the changes in the services provided by Rowcroft and that the Trust was taking over delivery of the Chronic Oedema Service.
- ◆ There had been some internal disquiet over the content of the STP document that had been leaked to the BBC and the Trust has worked with the STP to agree a statement for staff in relation to maternity and paediatric services in particular.
- ◆ The Chairman asked that an article in last week's Dartmouth Chronicle be circulated to the Board which was by a Dartmouth GP and Councillor about future intent and suggested the public needed to embrace the changes and support them.
- ◆ Councillor Parrott noted from the Chief Executive's report that she had recently visited the CAMHS team and asked what her view was of the service following that visit. She explained that the meeting was very useful and informative, with the team keen for her to understand the significant improvements they had made and the innovative ways in which they were now working. The team was building closer working relationships with Child Health and Paediatrics and had a keen interest in the new management arrangements the Chief Operating Officer was putting in place, which they hoped would better integrate the different teams. The team did however, voice concerns with the ongoing increased level of demand. The Chief Executive had assured the team that the Board received regular updates on their work.
- ◆ Councillor Parrott highlighted a national report that stated GPs were prescribing anti-depressants to young people as they were not able to obtain treatment through services such as CAMHS, and he asked if this was a concern in the South Devon and Torbay area. The Chief Executive stressed the desire to focus on early intervention and said she would ask the CCG to provide the local prescribing rates for the Board.

Comms

CE

### **Strategic Issues**

#### 135/10/16 **STP Feedback**

The Director of Strategy and Improvement gave members a progress report on STP developments. She said that, following media interest in the STP submission, the next version would formally be made public. Concerns had been raised around some of the content in the draft STP including Maternity, Paediatrics and shared services. The next iteration of the STP was due for submission on 21<sup>st</sup> October and would be brought to the November Board for discussion.

The latest NHSI planning guidance references the STP, how this would affect planning at a wider Devon level and locally was still being clarified.

Mr Allen said that he felt caution needed to be taken in respect of the expectations of pace and funding released by shared services as it would take time to make change and for it to be cost effective and to ensure trust and confidence was built with staff. He said that, in his experience, if it was done too quickly it would fail.

The Director of Strategy and Improvement informed the Board that the STP Chief Executives were meeting later in the week and would be discussing revised governance arrangements for the STP to ensure it added value and work was not duplicated. Underpinning this was the place-based arrangements for South Devon and Torbay along with what would be delivered at STP level. The paper prepared by the Chief Executive setting out the approach to the Acute Services Review was also to be discussed.

The Chairman informed the Board that he had agreed with Executives that, at present, STP meetings needed to have priority in the diary – for example the Director of Estates and Commercial Development was currently at a STP meeting. In addition it was noted that the STP Collaborative Board meetings clashed with the Trust's Board of Director Meetings, so attendance at these would need to be prioritised.

Councillor Parrott asked if it was felt that the Trust was now helping to drive the STP. The Director of Strategy and Improvement said this had not been the case at the start of the process, but that the Trust was now much more involved – especially as it was further ahead with some of the changes that the STP wished to make than other organisations. The Chief Executive added that the strength this Trust brought to the STP was its defined footprint and the longstanding partnership work between the Trust, Council and CCG which has supported the care model developments.

#### 136/10/16 **Community Consultation Feedback**

The Director of Strategy and Improvement reported the following:

- ◆ 13 consultation meetings had been held, with over 15,000 people attending the meetings.
- ◆ Some meetings had been over-subscribed (Paignton and Ashburton), with further additional meetings in the process of being arranged.
- ◆ The general view from the meetings appeared to be that people understood the need for change, with a view from MPs, local stakeholders and GPs around the retention of services not buildings. People did want to understand what the alternative service would look like and to have assurance that the new model was in place before the current service was changed.
- ◆ A lot of comment had been made at the meetings around funding for the NHS and people asking what they could do to help lobby for more resources.
- ◆ Councillor Parrott provided brief feedback from the issues raised at the Paignton and Brixham meetings, supplied by Councillor Lewis.

The Board noted these points.

Strategic Context

Each year NHS England releases guidance on the processes that will be used to govern the process of developing plans and contracts for the forthcoming year. The guidance for 2017~2019 has just been released and the report briefs the Board on the guidance, key issues, and how the Trust will respond by producing a two year Operational Plan for the period 2017~2019.

In broad terms the guidance is in line with the expectations set through financial reset guidance, 'Strengthening Financial Performance and Accountability' which was issued in July, and STP briefings. The key change in these documents is for the Operational Plan to cover a two year period and be submitted three months earlier than in previous years. The planning guidance confirms this position and includes deadlines for agreement of contracts and submission of the Operational Plan by the end of December. Although these timescales will be challenging there is every sign that NHS England and NHS Improvement both believe that the timescales are achievable and clear expectations that the new timescales will be met.

Key Issues/Risks

The full detail of the guidance, and attendant annexes, is still being worked through at the time of drafting this report, however, there do not appear to be any unforeseen consequences or issues for the Trust. Key themes are:

- the Operational Plan produced by the Trust now has to be for a two year period 2017/18 to 2018/19;
- a full draft has to be submitted to NHS England by the **24<sup>th</sup> November 2016**;
- contracts with SDTCCG have to be signed by the **23<sup>rd</sup> December 2016**;
- the final version of the Operation Plan also has to be submitted by the **23<sup>rd</sup> December 2016**;
- the guidance ties together recent initiatives and publications, such as STP processes, General Practice Forward View, the nine must do's, 'financial reset' and Single Oversight Framework;
- the consequences of failure to deliver on key targets or financial control totals and failure to agree a contract with SDTCCG are spelt out very clearly in the guidance;
- in addition to the control totals which already operate at Trust level control totals will now also be introduced at STP level, with the following proviso:
  - nationally funded Trusts (e.g. ambulance services) and Local Authorities will be excluded from the STP control total at this stage;
  - all organisations with control totals will be held to account for delivery of **both** their own control total and that of the STP;
  - there is the flexibility to vary organisational control totals by agreement within the STP footprint, **but** variations cannot change the STP level control total and must be agreed prospectively with NHS England and NHS Improvement;
- the nine "must do's" from the 2016/17 planning guidance will carry through into 2017/19;

- there had been consultation on radical changes to national tariffs to incentivise reductions in follow up rates, these have been redrawn as a more moderate package of changes;
- the guidance includes reference to how the extra funding announced in the General Practice Forward View will be used to help transform services. The Executive Team are exploring how this might be applied to support the care model with colleagues from SDTCCG.

The response from NHS Providers was to welcome the move to create a more effective planning cycle for 2017/18 - 2018/19 which provides greater planning certainty and stability.

The approach the Trust will adopt to develop a two year operational plan which meets the requirements of this guidance and provides an effective business planning and delivery framework is included in the Board papers.

One practical impact of the foreshortened timescales set out in the guidance is that the current Board meeting dates in November and December do not fit well within these constraints and there may be a need to make alternative, or additional, arrangements for Board meetings to accommodate these timescales.

The Director of Strategy and Improvement reported that, at a joint meeting earlier in the week, the Trust and CCG agreed that a joint plan would be submitted to individual regulators. As part of the planning work on the joint plan, work would take place to ensure that there was no duplication in the plans to include the Council's plan, which fitted into the timescales that the Trust and CCG were required to meet.

It was noted that there might be opportunity for the CCG to access funding to support developments such as an ACO approach, and this was being taken forward.

The Director of Finance reported that the Trust's control total had been published which was a £3.1m surplus for 2017/18, based on STF of £5.8m.

The Chairman reported that, on speaking to the Executive Regional Managing Director for NHSI, it was clear that changes to control totals would not be authorised for the current year, despite the fact that the direction of travel was now for system wide approaches and RSAs. The Chairman informed her that, given the Trust's experiences in the current year, the Board might not wish to adopt the same approach and choose to move to a PbR based contract.

Mr Allen noted that the Trust was being asked to make 2% efficiency savings, when it was 5% above target with agency spend. This was acknowledged, and the Chief Nurse would provide a briefing later in the meeting.

The Board then approved the following recommendations:

- 1. Note this information and the release of this guidance.**
- 2. Note the approach to developing the Operational Plan 2017 – 2019.**
- 3. Receive further updates as appropriate.**
- 4. Consider the need to make revised or additional arrangements for meetings in November and December to accommodate the timescales for the signing of contracts and submission of the operational plan.**

**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 August (month 5) 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
- workforce framework indicators

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 (20th September) and Finance and Performance Committee 27<sup>th</sup> September. Performance of each Service Delivery Unit (SDU) is now reviewed by Executive Directors on a monthly basis through the Quality and Performance Review meetings (22<sup>nd</sup> September). This enables the corporate team to receive assurance, prioritise areas for improvement, consider support required and oversee action plan delivery.

**Key Issues / Risks:****1. Quality Framework:**

19 indicators in total of which 4 were RAG rated RED for August (5 in July) as follows:

- VTE risk assessment on admission (Acute) – 91.8% (last month 92.8%) against 95% standard.
- Fractured neck of femur time to theatre within 36 hours – 71.1% (76.3% last month) against >90% standard.
- Dementia Find – 29.2% (36.8% last month) against a standard of 90%
- Follow ups past to be seen date – 6,919 a deterioration of 318

Of the remaining 15 indicators, 14 were rated GREEN, one not rated.

**2. NHS I Compliance Framework:**

12 performance indicators in total including the quarterly governance rating of which 4 indicators are RAG rated RED for August (3 in July):

- Urgent care (ED/MIU combined) 4 hour wait – 92.8% (92.3% last month) against national standard 95%. However the Trust is overachieving against the SRG agreed STF trajectory of 90.5% for August. The standard for the Q2 NHS I assessment is forecast as being met.
- RTT incomplete pathways – 90.5% (91.4% last month) against the standard of 92%. The standard for the Q2 NHS I assessment will not be met.
- Cancer two week wait from urgent referral – 87.9% (98.1% last month) against the standard of 93%. The standard for the Q2 NHS I assessment will not be met.
- Cancer 31 day subsequent surgery – 91.4% (last month 94.6%) against the standard of 94%. The standard for the Q2 NHS I assessment can still be met

but is very high risk.

Of the remaining indicators, all 8 were rated GREEN including the forecast NHS I governance rating.

### 3. Financial Performance Summary

Key financial headlines for month 5 to draw to the Board's attention are as follows:

- **EBITDA:** for the period to 31<sup>st</sup> August 2016 EBITDA is £1.76m. Measured against the revised Risk Share Agreement (RSA) v forecast, this position represents a £0.08m favourable variance. However, against the PBR plan this represents an adverse position of £0.82m.
- **Income and Expenditure:** The year to date income and expenditure position is a £4.62m deficit, which is £0.25m better than the RSA plan and £0.65m worse than the PBR plan. The Trust has a £0.83m deficit in month after risk share income has been applied.
- **CIP Programme:** CIP delivery has improved with £4.26m delivered to date which is ahead of plan. Whilst the Trust is seeing improvement the level of savings planned increases significantly from Quarter 2 onwards. It therefore remains imperative that the Trust secures increased traction in the programme. Plans have been developed in support of the vast majority of schemes, quality assessed where appropriate and progress reported at scheme level to the Finance, Performance and Investment Committee
- **Risk Rating:** The Trust has delivered a Financial Sustainability Risk Rating of 2, which is in line with plan.
- **Cash position:** Cash balance at month 5 is £20.2m which is lower than plan – both PBR and RSA - and is mainly due to delayed settlement of debts offset by lower than planned capital spend.
- **Capital:** Capital expenditure is £3.1m behind plan at month 5.
- **Agency Spend:** For the year to date, bank, overtime and agency spend is 8.7% of total pay expenditure, 5.4% over the NHSI target cap target which has been set at 3.3%.

### 4. Contractual Framework:

15 indicators in total of which 7 are RAG rated RED in August (8 in July) as follows:

- RTT waits over 52 weeks – 8 (11 last month) against 0 standard
- On the day cancellations for elective operations – 1.0% (0.9% last month) against <0.8% standard
- Ambulance handovers > 30 minutes against trajectory - 36 delays against trajectory of 20 (last month 54)
- A&E patients (ED only) – 88.5% (88.3% last month) against 95% target Note: The locally agreed SRG trajectory for MIU / ED = 90.5% (August) was achieved
- Number of Clostridium Difficile cases (acute & community combined) – 3 (3 last month) against, <3 threshold
- Care plan summaries % completed within 24 hrs discharge weekdays 54.8% (51.2% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 24.0% (20.4% last month) against 60% target

The remaining 8 indicators, 6 were rated GREEN and two AMBER

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

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

- Number of delayed discharges – 425 bed days lost (422 last month) (annual target 2,216)
- CAMHS % of patients waiting for treatment within 18 weeks – 78.4% (87.2% last month) against a target of >92%

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

## **6. Change Framework**

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

## **7. Workforce Framework**

There are 5 indicators in total of which 2 RAG rated RED as follows:

- Staffing and vacancy factor (trust wide): The current vacancy factor of 7.71% is above our target of 5% and emphasises the recruitment challenge which is being tackled by a number of initiatives. Use of the temporary workforce and additional hours reduces the gap to 0.18% although this is not consistent for each staff group.
- Staff sickness/absence: The rolling sickness absence rate of 4.21% has increased following previous good progress towards the target which for July was 3.90%. The target for the year end is 3.80%. Management of sickness absence and specific interventions are in progress.

Of the remaining 3 indicators, 1 is rated AMBER and 2 GREEN

The Director of Strategy and Improvement highlighted the following:

- ♦ RTT incomplete pathway performance had deteriorated. Neurology performance continued to be of concern – for the Trust to be compliant by year end an additional 282 patients would need to be seen. There were also emerging workforce concerns in Cardiology and Respiratory.
- ♦ ED performance had met the locally agreed trajectory target for September. The Chief Operating Officer advised that Trusts were being asked to move to deliver 95% by the end of March 2017, and a wider Devon STP A&E Delivery Board had been established to take forward the actions to realise this. The Trust's local system was the only one in the STP that was in line with trajectory.
- ♦ The Trust was still struggling to meet the Dementia Find target, whilst using a paper and electronic system, however work was ongoing and improvements should be realised in the near future.
- ♦ Following on from a Governor query at a previous meeting, the Medical Director reported on the timeliness of Care Planning Summaries. He said that although performance was not yet where it needed to be, a new process had been put in place to improve performance but had not been taken forward due to the expected junior doctor strikes, but would now be actioned.

- ◆ The Board noted the gross contract discounts to the CCG, the difference between PbR and RSA being £5m to the end of August, which was £1.9m above planned adjustment due mainly to over performance in non-elective services.
- ◆ Financial performance was slightly ahead of the revised plan.
- ◆ An additional £4.1m had been accrued to reflect the contribution expected from the Trust's commissioning organisations under the terms of the RSA.
- ◆ There had been a reduction in pay spend of around £400,000 largely driven by a reduction in agency spend.
- ◆ CIP performance was currently on plan. The CIP forecast position had increased by £2m over the past month to £10.1m which was now £3.8m away from target.
- ◆ Councillor Parrott, in recognising the Staff Heroes Awards for frontline staff, asked what was being done to recognise staff who were taking forward the innovative work to realise efficiencies and make savings etc. The Director of Strategy and Improvement explained that each team responsible for a CIP scheme attended the Finance Committee for a deep dive of their scheme and that awards would be presented to teams for schemes delivered ahead of time and that generated efficiencies that were the reinvested into services to deliver benefits for patients.
- ◆ Mr Allen noted the improved performance in the stroke pathway.
- ◆ Mr Allen then suggested that it would be helpful for the QAC to review the performance data in the same way that Finance Committee reviewed the financial data, to provide assurance to the Board. It was agreed that both committees should receive the whole Integrated Quality, Performance, Finance and Workforce Report, in order to be able to triangulate quality vs financial performance and ensure an integrated approach.

139/10/16 **Governors' Questions**

Nil.

140/10/16 **Any Other Items Requiring Discussion/Decision**

Nil.

141/10/16 **Freedom to Speak up Guardians Network**

**Strategic Context:**

The Department of Health responded to the Sir Robert Francis report on 'Freedom to speak up', the investigation at Morecambe Bay University Hospitals NHS Foundation Trust in their report 'Learning not Blaming', which was published in July 2015.

In July 2015, the Secretary of State confirmed the steps that need to be taken to develop a culture of safety, including the appointment of a national guardian and a local guardian in every trust.

The 'National Freedom to Speak Up: raising concerns (whistleblowing) for the NHS Policy' came into force from April 2016.



A comparison of the national policy and the Trust's Raising Concerns at Work policy has been undertaken. Overall the Trust's policy exceeds the requirements of the national policy, and includes the Freedom to Speak Up Guardian role and responsibilities.

### Key Issues/Risks

There are various examples of how other Trusts have appointed to Guardian roles, including shared roles. Whilst this Trust has recruited a network of Guardians within the Trust and has an Executive-level sponsor in the Chief Executive and a designated Non-Executive Director for Whistleblowing, the guidance information indicates that there should be "one clearly identified Freedom to Speak Up Guardian (FTSU) who is highly visible and accessible across the organisation", with a network in place supporting the FTSU guardian thereby ensuring accessibility throughout the service. Within this Trust, the FTSU Guardians have decided to take a different approach (and are addressing and testing this for six months) by developing as a team and establishing key roles within the Network.

Two of the FTSU Guardians (Penny Gates and Sarah Burns) and gave the following presentation:





## The need for cultural change

- Sir Robert Francis report on 'Freedom to Speak Up'
- 'Learning not blaming'
- Culture of safety
- 'National Freedom to Speak Up: raising concerns (whistleblowing) for the NHS Policy' April 2016
- National Guardian and local guardian in every Trust (September 2016)

## Freedom to Speak Up Guardian role

- Supported through office of National Guardian
- Executive Sponsor is the Trust Chief Executive
- Raise the profile of raising concerns in the Trust
- Provide confidential advice and support to staff
- Do not get involved in investigations or complaints

## Benefits for Staff and Patients



## Our Trust

- Appointed a Network of Guardians
- Broad range of work locations and occupational groups
- Genuinely independent and impartial capacity to support staff who raise concerns
- Help signpost/facilitate where needed
- Maintain appropriate contact
- Maintain confidentiality
- Feedback on common themes

## Other Trusts

- Various examples
- Shared roles
- Recruitment
- Lead role
- Network of support – Fair Treatment Guardians



Karen Bennett



Sarah Burns



Penny Gates



Andrew Fordyce



Elaine Austin



Wayne Walker

## Freedom to Speak Up Guardian Network

- Initially 9 recruited
- 2 newly recruited (E&D Guardians)
- Meet monthly (+)
- Share and review cases
- Identify emerging themes
- Record confidentially
- Discuss escalation where necessary
- Attend National meetings and workshops

## Early Successes

- Raising of concerns has improved
- 'Thank-you's' from staff
- > 30 Presentations
- Induction
- ICON
- Total 28 concerns
- National contacts and Blog

## Analysis of Themes

- Lack of consistency in approach to policies and procedures
  - Health and Safety
  - HR
- Lack of consistency in how our managers 'manage'
  - Conflict
  - Mediation
  - Openness and transparency
  - Line management

## Priorities for Our next 6 months

- Designated time for our role
- Continue monthly meetings (quarterly with Mairead)
- Develop Standard Operating Procedures
- Develop Open Forum and regular events
- Six-monthly Board report
- Communication plan: Induction, All Managers, ICON, Blog, presentations etc
- Integrate and include in management training programmes
- Maintain support from line managers



Thank you

Any questions?

The following was noted:

- ♦ Clarity on the role of the NED with responsibility for FTSU within the review of the Raising Concerns Policy.
- ♦ The FTSU Guardians would present a bi-annual report to the Board.
- ♦ Mrs Marshall asked if the trends that had been identified by the Guardians were triangulated with other information held by the Trust for example sickness absence, disciplinary hearings etc and it was noted that the theme identified around managers not having the knowledge and skills to manage effectively was also being highlighted through the Trade Union route.

- ♦ The Director of Finance asked if the role of the Guardian was being highlighted to clinicians and it was noted that visibility was in the process of being raised with clinical staff, but it was felt it would take some time for clinical staff to feel confident in raising concerns with the Guardians.

The Board then noted the following recommendation:

## **The contents of the report, the themes identified and the proposed Action Plan.**

### 142/10/16 **The Pennine Acute Hospitals Trust CQC Inspection Report**

#### Strategic Context:

To provide the Board of Directors with a summary of the key findings from the inspection of services at Pennine Acute Hospitals NHS Trust and to set out key learning points for the Trust.

#### Key Issues/Risks:

There are a number of additional areas for discussion and agreement on further action and it is proposed the following is considered:

- Leadership capacity and capability-how does the Trust ensure that it has enough people with the right skills to lead the new delivery teams in our localities? How do we identify and develop new talent?
- Governance structures and performance management arrangements are under developed in some areas with the Executive team taking lead responsibility for managing areas of business for example the Urgent and Emergency Care Improvement and Assurance Group. Is there more to be done to strengthen the Trust's internal governance arrangement?
- Risk management arrangements are developing supported by the implementation of the new datix system. An operational risk group is being established to ensure more reliable identification, recording and management of risk in service delivery areas. Is there more the Trust should be doing?
- Incident reporting- the reports highlights that some staff had a high level of tolerance to risk which impacted on safety and quality. How does the Trust assure itself that this is not the case here? How does the Trust ensure that plans are implemented robustly?
- Implementing new structures - the report highlights the disruptive impact of organisational change. How does the Trust move to the new structure while keeping a focus on delivery?
- Temporary staff - how does the Trust assure itself that they meet required practice standards? Can we evidence this?
- Despite marked challenges in acute services community services have performed well. What can the Trust learn from this?
- How does the Trust use the new planning framework to ensure that organisational priorities are reflected in team and service objectives?

The Board noted the CQC report on the Pennine Acute Trust and any action the Trust could take to assure itself that the same failings could not take place at this Trust. Issues included leadership and support to leaders of the future in terms of



succession planning as staff took on new roles in the Trust; governance structures; delivery of new organisational structures; ensuring incident reporting took place and there were no delays in completing investigations.

## **PART B: Matters for Approval/Noting without Discussion**

### 143/10/16 **Reports from Board Committees**

The Board noted the NED report from the recent Quality Assurance Committee.

### **Reports from Executive Directors**

### 144/10/16 **Report of the Chief Nurse**

#### **Strategic Context:**

The monthly safe staffing report is a National Quality Board recommendation and informs CQC ratings.

#### **Key Issues/Risks:**

Safe staffing is reviewed at each Trust control meeting. A new process has been introduced that provides real time staffing data to the control room team. This provides a Trust overview and enables the Matron to utilise staff flexibly to ensure safe staffing.

The new Quality Improvement Group dashboard facilitates triangulation of data.

The Board noted the report. Mr Furse queried the fact that against every ward, nursing hours were above those planned and he wished to understand why this was the case. The Chief Nurse explained that the Carter Median data had only been used for a short period of time and it was not yet understood if the suggested numbers were correct for this Trust. She added that escalation wards had been open which had a knock-on effect to other wards and in addition complex patients required additional staffing resources. It was noted that agency usage had already reduced by 50% and continued to decrease. There was still work to be undertaken about how to manage specialising.

The Chief Nurse asked the Board to note that there was increasing fragility with the community out of hours nursing service due to vacancies and sickness absence and she would bring more detail to the November meeting. She would also bring a Safe Staffing six-month update to the November Board, to include work to grow the Trust's own workforce and overseas recruitment.

### 145/10/16 **Kings Funds Report – Social Care for Older People – Home Truths 2016**

#### **Strategic Context:**

The Kings Fund report examined adult social care for older people, where people were supported to live as independently as possible, protected from harm when vulnerable and helped in times of crisis. Over recent years funding nationally for local authorities had been cut and the impact of this had been that councils were struggling to meet the needs of the increasing number of older people in our communities. Very few Councils now provided care directly with most contracting with independent care providers on a means tested basis to ensure statutory duties were fulfilled. The number of people who were living longer lives with more complex care and support needs added to the national crisis – less money, more demand provides a bleak outlook. The situation was leading to pressures in the NHS as social care cuts cannot be viewed in isolation or distinct from overstretched primary care, community services and hospitals.

There was a need to understand nationally and locally the relationship between changes in public spending on social care, the quality and quantity of services and the impact on the health and wellbeing of the people who use them.

Key Issues/Risks:

The paper asks 4 questions:

1. How were local authorities dealing with current pressures, the implications of their financial sustainability and ability to meet their statutory requirements?
2. The implications for the social care market, including recruitment and retention issues, the impact of the National Living Wage and the risks of provider failure
3. The impact on the NHS, with a particular focus on primary care, community nursing and acute services. How have changes in the availability of these affected care needs and the ability of the LA to meet them?
4. The implications for older people's experience of social care and the quality of care they receive.

The CCG and Trust work with two councils; Devon County Council and Torbay Council.

Since 2010, NHS money has been transferred to local authorities via the Better Care Fund to support social care. Central government has reduced its funding to local government by 37% in real terms between 2010 and 2016.

The impact of the increased costs of the national living wage and reduction in Better Care Fund contributions has effectively meant a cut in the amount available to support adult social care. This reduction in funding has meant tough choices for the Council amongst which are the possibilities of less residential care and less day care but investment in personal budgets and more support for self- help. The Council working with NHS partners was increasing the amount spent on personal care and support for elderly and vulnerable people in their own homes.

In Torbay, the total amount available for adult social care this year (2016-17) was £39.1 million, which was a reduction of 5.8% on the available spend for 2015-16. A response to the financial constraint has been to redesign the model of social care and over the last three years commissioners and providers in Torbay have worked to align services to deliver the new model of care described in the Pioneer bid 2014. The principles of the new care model were to maximise independence and resilience, with investment in services such as Intermediate Care. The methodology and aim was to reduce cost without compromising quality. This could be achieved by engaging those with sector expertise such as My Support Broker. The Trust was also supporting the training and development of the local workforce, and continued to prioritise supporting unpaid carers – which we have a strong track record in.

However, the risk of compromised quality should not be underestimated:

- Providers were financially challenged and there was a risk that this could impact on quality of care due to poor staff retention and cuts on training or lower staffing numbers.
- The national living wage would increase costs and affect provider sustainability. The Associate Director of Adult Social Services believes that provider failure and independent sector fragility was a significant risk.

- Cuts in staffing, wages and training translate rapidly into poorer quality of care experiences. Whole home processes are increasingly focussing on these issues.

The Association of Directors of Adult Social Services has supported the Kings Fund and stated in its response:

*“We’re now at a tipping point where social care is in jeopardy, and unless the Government addresses the chronic underfunding of the sector, there will be worrying consequences for the NHS and, most importantly, older and disabled people, their families and carers. Social care providers are under unprecedented pressure and the NHS will have to pick up the pieces when they fail. (Thursday 15<sup>th</sup> September Press statement”.*

The Adult Principal Social Worker Network has released a statement welcoming the report, expressing concern that the Social Work profession are witnessing the pressure on social care providers. (Statement September 2016).

*“Adult Social Workers in particular, are the ones who are left to front the disparity between the well intentioned expectations of the Care Act 2014 and the reality on the ground of the services that can be accessed by people given the rise in demand and reduction in the services available”.*

Social Work continued to assess within the legal framework – which led them to experience the impact of low quality, sometimes scarce, care. This was reported as a key issue at a recent listening event with Torbay Social Workers.

The Chief Nurse presented this report and said that it provided a sobering view of the care provided to older people in the light of continued financial constraints in social care funding. She added that the implications of the report were very relevant to the South Devon and Torbay community.

Councillor Parrott then gave a brief overview of the work of the Council in terms of social care budget setting. It was agreed that Councillor Parrott would share the Chief Nurse’s report and Kings Fund document with Council colleagues.

JP

146/10/16 **Report of the Chief Operating Officer**

**Strategic Context:**

To provide the Board of Directors with an update on key operational issues.

**Key Issues/Risks**

- Proposed changes to the implementation of the operational delivery structure
- Baytree house closure programme has been concluded but work to redeploy staff remains in progress

The Board noted the report of the Chief Operating Officer.

147/10/16 **Report of the Director of Workforce and Organisational Development**

**Strategic Context:**

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group.

- To provide the Board with assurance on workforce and organisational development issues.

### Key Issues/Risks:

#### Issues

- Performance against the key workforce metrics for 2016/2017 is included in the report.
- A Workforce Strategy for Adult Social Work has been approved by the Workforce and OD group and a summary of its aims and recommendations are included in the report.
- Action plans to deliver the new apprenticeship reforms and apprenticeship levy and level 5 diploma for Assistant Practitioners in Healthcare were agreed by the Workforce and OD Group and support the Trusts “Growing our Own” aims.
- Plans for reducing the vacancy gap including making best use of the shift to student loans for registered staff are being developed into a proposal to manage supply and demand over the next five years and beyond.
- Roster Management Guidelines for Nursing Staff in Ward / Bed Based Areas were agreed by the Workforce and OD Group to support reductions in agency and bank usage and e-rostering.
- Reductions in agency usage and expenditure in August have been achieved following the introduction of a number of systems and initiatives.
- The Workforce and OD Group have agreed to the implementation of the ESR expenses system operated by Allocate Software.
- The Workforce and OD Group has agreed a way forward to move to electronic payslips with staff using ESR Employees self-service.

#### Risks

- A range of incentives are being implemented to attract bank workers to help mitigate agency usage which are starting to have a positive effect. This Trust continues to report weekly to monitor on the number of shifts that are not compliant with the NHS Improvement framework and price cap requirements.
- Recruitment to Band 5 nursing posts remains an issue which is consistent with other Trusts. A range of measures to support this issue are contained within this report both in the short and longer term.
- Medical recruitment remains a challenge in key areas.
- Following the rejection of the proposed new contract by Junior Doctors and the Secretary of State’s decision to introduce it in any case, industrial action is planned by Junior Doctors for days in the next 3 months. Plans to mitigate this action will be operated as previously.
- Delivery of a number of recommendations in the Workforce Strategy for Adult Social Work are reliant on additional resources and funding.
- The deteriorating position in respect of sickness absence will have an impact on productivity, efficiency and financial performance.

- Failure to deliver against targets in the apprenticeship reforms will result in at least some of the apprenticeship levy of £1.3M being withheld.
- Not achieving improvements to targets in accordance with CQC report.
- Failure to achieve workforce changes in accordance with CIP plans.

The Board noted the report of the Director of Workforce and Organisational Development.

148/10/16 **Report of the Director of Estates and Commercial Development**

Strategic Context:

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

Key Issues/Risks :

Changes have been introduced to reduce the level of some cleaning services which has been necessary due to the increasing budgetary overspend in domestic services. Assurance has been provided that all cleaning services throughout the Trust will continue to be in line with National Cleaning Standards and Trust Infection Control Policies.

The Infection control team have identified the following risks relating to the change in practice:

- A possible deviation from the Green rating for Torbay hospital bed closures (apart from Seasonal influenza) which may indicate breaches in patient safety and will score 9, on the trust's risk matrix
- A possible amber risk to patient safety by cross-infection as a result of a reduction in cleaning hours possibly leading to an increase in bay & ward closures.

There is a significant financial risk to the organisation if action is not taken to control expenditure in this area.

Mitigation of Risk

- Monitoring and reporting of cleaning standards against the national performance criteria shown on the KPI report, reported monthly to the CI&EG, IP&CC and bi-monthly to the Trust Board
- Enhanced Cleaning will continue to be available up to budget, once exceeded this will require Executive approval.
- New and close monitoring of alert organism cross infection will be undertaken and formally reported regularly to the IP&C Committee.
- Enhanced cleaning will continue to be co-ordinated and agreed via the 10.00am operation bed meeting.
- In the event that any of the key indicators turn amber an investigation will be undertaken to identify the root cause. If the root cause is directly related to cleaning standards, consideration will be given to consideration in discussion with Infection Control will be given to:

- Re-introducing enhanced cleaning in a specific area.
- Ensuring that the Cleaning Schedules match the functionality and layout, for clinical areas.
- Reviewing the existing Cleaning Services Policy, to be ratified by the IP&C Committee.

The reduced Capital programme for 2016/17 has been prioritised according to risk and there is confidence that the critical risks have been addressed through the programme. Concern has been expressed by the Capital infrastructure and Environment Group about the amount of capital investment available to address the Trust's significant backlog maintenance and the affordability and need to secure borrowing to provide the investment needed.

There is a risk of failure of critical plant that has been reflected in increasing the frequency of the risk on the corporate register to likely.

The Board discussed the Executive decision taken to make changes in cleaning standards to reduce over-expenditure, whilst ensuring that national cleaning requirements were met.

The Trust's Infection Prevention and Control (IPC) Team had raised concern in respect of the plans, and had asked the Chairman to highlight that due process needed to be followed as detailed in the Health and Social Care Act, Criterion 2 and changes in cleaning schedules should be made in consultation with Matrons and the IPC Team. The three areas of highest risk were felt to be EAUs, Paediatric in-patients/SSPAU and Orthopaedic wards.

The Chief Nurse reported that a number of conversations had been held with the lead of IPC and the IPC team. The plans were also discussed at the Joint IPC meeting where these concerns were also made.

To ensure early warning of any adverse effect of the changes to the cleaning regime were highlighted, it was agreed that the clearing credit score would be published early; matrons would give direct feedback of any concerns; cleaning standards would be reviewed; bed closures would be monitored; and if there were any CDiff outbreaks involved the same strain. The IPC Team had reported they were happy with this action and robust monitoring.

Mr Sutton queried the costings and he asked for assurance that the figure quoted for the cost of the increased hours of enhanced cleaning - £1000 per week per ward based on an additional 12 hours cleaning 7 days per week was accurate.

DECD

The Chairman asked Mr Allen to ensure that the QAC also kept an overview of the situation to provide assurance the changes did not result in any adverse outcomes.

Mrs Hall asked if the fact that staff wore uniforms outside of the Trust increased infections. The Chief Nurse said that it did not, however there was a reputational issue for the Trust and that the Trust's Uniform Policy was in the process of being updated and staff were required to cover their uniform if worn outside of the Trust.

149/10/16 **Compliance Issues**

Nil.

a) **Strike Action**

The Medical Director updated the Board that the proposed strike action had been called off, but further action could take place – but not necessary strikes. Junior Doctors have been left in a difficult situation and the Trust was working closely with them to provide support during this difficult period. It was noted that the BMA has asked Trusts to consider not implementing the contract, and though Trusts were not mandated to implement it, the Medical Director reminded the Board that any Trusts not implementing the new contract would lose funding for Junior Doctors.

Mrs Hookings raised the issue of the unhappiness of Junior Doctors following a quote that had been included in a Herald Express article. The Medical Director explained that Junior Doctors were not unhappy with the Trust, but with the national situation.

b) **Bowel Screening**

The Trust's Bowel screening service had been reviewed by the PHE National Bowel Screening QA team in late September. The team provided services for South Devon and Plymouth and were part of the new national Bowel Screening programme. The visit had been generally positive, with the only negative aspects around governance and the Trust's links with Derriford not as robust as they should be and this was in the process of being remedied. The review team also noted that the bowel screening equipment was aging rapidly, which was due to the high volume of activity - this had already been identified and was being taken through the Medical Equipment Group.

Mrs Lewis asked if there as an age limitation on screening and the Medical Director said that there was both a lower and upper age limit, but he was not sure of the exact age – he would provide this data outside of the meeting.

MD

Mr Parsons informed the Board that he had been diagnosed with bowel cancer and that if it was not for the screening programme, care and professionalism of staff he would not be here today.

Mr Welch queried the incidence of bowel cancer for patients above the upper age limit for screening and the Medical Director explained that the upper age limit was set because screening was not as effective after that age due to the cancer presenting in different ways.

151/10/16 **Date of Next Meeting – 9.00 am, Wednesday 2<sup>nd</sup> November 2016**

Noted.

**Exclusion of the Public**

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

**BOARD OF DIRECTORS**

**PUBLIC**

<b>No</b>	<b>Issue</b>	<b>Lead</b>	<b>Progress since last meeting</b>	<b>Matter Arising From</b>
1	Speak to Director of Adult Services regarding ICO one year video	CE	<b>Completed</b> – video has been reshot with all three organisational leads.	5/10/16
2	Article from Dartmouth Chronicle to be circulated to the Board.	Comms	<b>Completed</b>	5/10/16
3	CCG be asked to provide local prescribing rates for anti-depressants to young people.	CE	<b>Completed</b> - CCG contacted – they do not hold prescribing information on this issue and have previously advised this.	5/10/16
4	Kings Fund report to be shared with Council officers.	JP	<b>Completed</b>	5/10/16
5	Accuracy to be provided on the figures quoted in respect of the cost of the increased hours of enhanced cleaning - £1000 per week per ward based on an additional 12 hours cleaning 7 days per week.	DECD	<p><b>Completed</b> - Additional cleaner provided to ensure that IC protocols of all touch surfaces cleaned at least every 2 hours are adhered to. Costs of additional cleaner as follows:</p> <p>Domestic Assistant, AfC Band 2 (mid-point)  Monday to Friday @ £10.18 p/h x 12 hours per day = £610.80  Saturday @ £14.66 x 12 hours = £175.92  Sunday @ £19.14 x 12 hours = £229.68</p> <p>Weekly Total Per Ward = £1,016.40  Annual Total per Ward = £52,998</p> <p>Note: Per hour pay rates inclusive of on-costs (Tax, NI, A/L etc). Does not include costs of undertaking deep cleaning of room post-discharge of C-Diff patients.</p>	5/10/16



6	Bowel screening age limits to be clarified.	MD	<p><b>Completed</b> - There are 2 systems currently in place:</p> <p>1. Bowel Cancer Screening Programme (BCSP). Established for 10 years in this area. Bowel Cancer Screening (FOBT test kit) is automatically sent to anyone between the ages of 60-74 every two years. People younger than 60 are not eligible to participate, but from 75 you can opt in by calling the free phone number 0800 707 60 60.</p> <p>2. There is a new process just becoming established – this Trust is ahead of other Trusts in Devon. Bowel Scope Screening (one off limited flexible sigmoidoscopy) - those aged 55 who are registered with an implemented GP practice are automatically invited. There is no catch up programme, but once your GP has been included in the programme you can opt in (same Freephone number as above) up until the age of 59 (after which you would become eligible for BCSP).</p> <p>The reason these screening programmes have an upper age limit is not because the risk of bowel cancer declines but that the benefits of screening may not be as clear cut. The risks of the screening procedure increase with age and so the benefits of screening need to be balanced against the risks of the test. However, it is possible to opt in if over the age of 75.</p>	5/10/16
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<b>Report to:</b>	Trust Board
<b>Date:</b>	2 November 2016
<b>Report From:</b>	Mairead McAlinden, Chief Executive
<b>Report Title:</b>	Chief Executive's Business Report

## 1 ICO Key Issues and Developments Update

In this report the ICO updates are 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**

#### **Care Model Update**

The new delivery model has been successfully implemented in Torquay and work is progressing in Paignton and Brixham where the Health and Wellbeing team was due to relocate to Kings Ash at the end of October. In Coastal implementation continues with positive feedback being shared by members of the integrated care teams. A video featuring some of the benefits can be accessed via the following link - <https://vimeo.com/181179448>. Funding for the development of the Health and Wellbeing team has been allocated and recruitment has been successful to most posts. Good progress has also been made on the development of the enhanced intermediate care service and in South Devon a Saturday service started on 1 October, with working hours gradually expanding to a full 7-day service by March '17.

#### **Top performer for mortality after hip fracture**

According to the recently published national database for fractured neck of femur, Torbay and South Devon NHS Foundation Trust is one of the top performing hospitals. Our 30 day mortality rates following fractured neck of femur stand at 4.4% - equal 6<sup>th</sup> best out of 177 UK hospitals.

### **Improved Wellbeing through Partnership**

#### **Community Services Consultation**

Public consultation meetings have now been held across the area and most have been very well attended. Additional meetings have been arranged for Paignton on 1 and 10 November and Ashburton on 8 November as not everybody who wanted to attend the first meetings were able to gain access as the meetings were oversubscribed. As well as the formal public consultation meetings, CCG and Trust staff are also attending meetings organised by community and other groups.

All documentation, including a weekly stakeholder update is available on the CCG's website and there is a dedicated telephone number (01803 652511) for consultation enquiries. Queries and comments can be sent via email to [sdtccg.consultation@nhs.net](mailto:sdtccg.consultation@nhs.net).

The model of care being consulted on by the CCG lies at the heart of the ICO's vision for population health and care. As a key provider for the South Devon and Torbay population and key partner of the CCG it is appropriate that the Board

formally responds to the CCG's consultation including reflecting on feedback to date from the consultation meetings held so far. A proposed response is included in the papers for the Board to consider.

### **Partnership Recognition**

The following are just two of the many examples of how partnership working is supporting improvements in wellbeing:

- **National pilot site for Nursing Associate Role:** I am pleased to report that a partnership bid to Health Education England with colleagues from across Devon (NHS, social care, care homes and education partners) to become a pilot site for the new role of Nursing Associate has been successful. The bid, led by Royal Devon and Exeter FT, was one of 11 sites to be selected to deliver the first wave of training that will start in December and run over a two year period in this exciting new role which will help to transform the nursing and care workforce.
- **National Positive Practice in Mental Health Awards**  
Congratulations to the DPT Perinatal Mental Health Service who were the winners in the Community Perinatal Mental Health Services category at the National Positive Practice in Mental Health Awards on 13<sup>th</sup> October 2016. They were one of three shortlisted services, all offering targeted interventions to women in the perinatal period. The Service has grown in the last 5 years in Torbay from a fledgling team to a now well-developed team. The local team is based in Torbay Hospital antenatal clinic working with women preconceptionally, in pregnancy & postnatally. The close working relationships with Midwives has been contingent to the development of an integrated care pathway for women. To be nationally recognised is fantastic for the Service and a real credit to their partnership working with the three local Acute Trusts (T&SDHCT, RD&E, NDDH,) Midwifery & Obstetric Teams and to the women they have worked with who have with their feedback helped to shape the service.

### **Valuing our Workforce Paid and Unpaid**

#### **Reflecting on our first year of integrated care**

At last month's Board we trailed a draft version of a video for staff reflecting on our first year as an ICO. Responding to feedback from Board directors the video has been completed [here](#) and now features contributions from both of our key partner organisations, South Devon and Torbay Clinical Commissioning Group and Torbay Council.

In the video we share our reflections on the contributions staff in our organisations have made since we became an integrated care organisation last October, and the resultant improvements in health and care services we are now able to provide for our local community. These include:

- Our CQC inspection in February rated staff as 'outstanding' for caring and many services were rated 'outstanding' or 'good';
- We have accomplished nearly a complete roll-out of our seeking consultant advice service for GPs, with only a few specialties yet to provide this – helping to reduce the need for outpatient referrals;

- Our direct physiotherapy referral service offers people a wider range of orthopaedic advice and treatment, so that many are now able to avoid surgery;
- Changes proposed and agreed in the Coastal consultation last year are now progressing, with the new Minor Injuries Unit in Dawlish in place and working well; and work has started on a £200K investment to provide new clinical and office space for the expanded Health and Wellbeing Team;
- We are forging good relationships with our voluntary sector partners whom we have funded to employ 12 Wellbeing Co-ordinators spread across our five localities;
- We have been recognised as being one of the top three in the country for having a low number of delayed discharges – a direct result of more joined up working; and
- Our two 'early implementation' sites in Torquay and Coastal are progressing well, and the other three localities will follow early in 2017.

We also took the opportunity to consider the challenges ahead as we form part of a Devon-wide partnership to shape and influence the five-year Sustainability and Transformation Plan (STP).

## **Well Led**

### **New oversight ratings for every NHS trust**

As part of their new single oversight framework, NHS Improvement (NHS I) have published proposed new ratings with every NHS trust in England placed in one of four categories (segments) based on the level of support they require from NHS I. The segments determine the level of support each trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability.

Twenty-two trusts have been placed in segment four, which indicates they are in special measures due to serious concerns over their finances or the quality of services, and 74 providers are in the third segment – indicating they are receiving mandated support due to “significant concerns” over performance. The second segment contains 106 organisations requiring “potential support”, while 35 trusts in segment one will have “maximum autonomy”. The Trust has been assessed as being in segment 2 along with other local Trusts – RD&E and Northern Devon whilst Plymouth Hospitals NHS Trust is in segment 3.

The ratings are currently classed as “shadow segmentation” designed to help NHS I start their process of agreeing targeted support in advance of the first formal segmentation that will follow in November. We are in discussions with our local NHS I relationship team to agree areas where we may need support.

To be provisionally rated as ‘2’ just one year into our journey as an ICO demonstrates a fair degree of confidence in our performance and leadership.

### **2016/17 Delivery**

The Board will note the latest position for month 6 with regard to quality, performance, finance and workforce in the latest integrated performance report

included in the Board pack. With regard to key regulator performance standards Directors will note that the Trust has not achieved the NHSI Compliance Framework quarterly targets for A+E, RTT, Cancer 2ww and Cancer subsequent surgery. This equates to a score of 4 against NHS I's Risk Assessment Framework and may trigger potential governance concerns. The nature of any regulatory action is not clear but can take a range of forms. The Trust had already triggered a governance concern for breaching consecutive quarters on the 4 hour standard. This will be the first time the Trust has scored 4 in any single quarter.

### **2017-2019 Operational Planning Update**

The planning process for 2017-2019 is well underway as described and discussed with Board members at previous meetings. Initial proposals for a set of Trust Wide Improvement Programmes are being developed through a process which includes validation by the Executive team. These will be written up in the Operational Plan for 2017-19. A first draft of the Operational Plan will be presented to an extraordinary meeting of the Board, on the 22<sup>nd</sup> November; the draft Plan then has to be submitted to NHS England on the 24<sup>th</sup> of November, with a final version following by the 23<sup>rd</sup> December. Guidance issued by NHS England and NHS I is prescriptive, the content expected in each section is stipulated as is the requirement for the plan to be concise and around 15 pages in length. A copy of the Draft Plan will be circulated with papers ahead of the extraordinary Board meeting, feedback from the recent discussion of the paper with the Council of Governors will be included in the papers for consideration by the Board.

Given the ICO's strong partnership with the CCG and Torbay Council, we have agreed to align our respective operational plans so that we have in essence a single plan reflecting our shared place-based vision for the population of South Devon and Torbay.

### **System Leadership**

Directors from the Trust continue to provide 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 Delivery Board to focus on the key transformation and change programmes that will deliver the greatest system benefit. To support this the Executive teams from the Trust and CCG together with Directors of Adult Social Services from both Councils are collaborating on a number of priority work programmes to create leadership capacity and ensure delivery of 2016/17 transformation programmes
- **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 specific work programme groups to support delivery of the Wider Devon STP aspirations.

## 2 Local Health Economy Update

### **Wider Devon Sustainability and Transformation Plan (STP)**

Each of the 44 STPs, including Devon, had to submit the next draft of its five-year plan to NHS England by 21 October. While there is no timescale for this document to be made public, we hope to be able to bring to the Trust Board in the near future. The Director of Strategy and Improvement will provide a verbal update on latest STP developments at today's Board meeting.

### **Working Together Across Health and Social Care Community to Improve Outcomes for our Community**

Members of the senior leadership team of South Devon and Torbay CCG, the Trust and Torbay Council have been discussing how we can make best use of our leadership capacity, remove duplication of effort and ensure the benefits of closer working are maximised as we go forward. We have a good base to work from with a track record of joint strategic planning and close working together. Our aim is that working together we can best tackle the three gaps identified in the Five Year Forward View - health and wellbeing, care and quality, affordability and efficiency. To ensure delivery we have agreed to identify a single executive lead for a number of system-wide change programmes. This will not change any structures or line management responsibilities but is intended to share the leadership challenge and make best use of our limited resources.

### **SD&T CCG Legal Directions Update**

A financial recovery plan for 2016/17 has been approved by the CCG Governing Body and submitted to NHS England. The Trust is working with the CCG to support implementation of the improvement actions identified in it. Work is also underway as part of operational planning and the STP for 2017/18 to 2020/21 to produce a medium term financial recovery plan that returns the CCG to compliance with NHS England's business rules.

### **People Moves/Appointments**

- **SD&T and NEW Devon CCGs:** Following discussion between the two Governing Bodies and Executive Teams, it has agreed to make two joint CCG appointments at Director Level – a Director of Strategy and a Director of Corporate Affairs.
- **SD&T CCG:** Dr Derek Greatorex has confirmed he will be standing down as CCG Clinical Chair at the end of this financial year when his 5 year term of office comes to an end. The Clinical Chair is responsible for leading the Governing Body, ensuring that it and its sub-committees are able to discharge their duties effectively, and making sure the CCG has the proper constitutional and governance arrangements in place. The CCG will shortly be advertising for a replacement. The Board will want to join me in thanking Derek for his support and contribution over the years including most recently to the creation of the ICO and development of the new model of care.
- **NHS I:** With the commencement of NHS Improvement in April 2016 and the subsequent realignment of staff from both NHS TDA and Monitor, the Trust has a new relationship team for the South West with effect from 1 October 2016. Lisa Manson is the Delivery and Improvement Director, Neil Cowley is

Head of Delivery and Improvement (Cornwall & Devon); Sam Maunder is Head of Finance and Penny Smith is Head of Clinical Quality South West

### 3 Chief Executive Leadership Visibility

<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>• Newton Abbot Hospital</li> <li>• Ashburton Hospital</li> <li>• Totnes Hospital</li> <li>• Pathology Unit</li> <li>• Experts Through Experience Group</li> <li>• Careers in Healthcare Work Experience Award Ceremony</li> <li>• Integrated Physiotherapy Booking Team</li> <li>• Torbay Pharmaceuticals Half Year Staff Meeting</li> </ul>
<p><b>External</b></p> <ul style="list-style-type: none"> <li>• System Delivery Group</li> <li>• Interim Pro Vice-Chancellor and Dean, University of Exeter Medical School</li> <li>• Joint Executive Leadership Group</li> <li>• STP CEO Meeting</li> <li>• Primary Care Provider Engagement Workshop</li> <li>• Health and Wellbeing Board</li> <li>• Healthwatch Torbay</li> <li>• Kevin Foster MP</li> <li>• Anne Marie Morris MP</li> <li>• Director of Adult Services, Torbay Council</li> <li>• Lead Chief Executive, Your Future Care (Success Regime) &amp; STP</li> <li>• Strategic Director People, Business Strategy &amp; Support, Devon County Council</li> <li>• Dean, Plymouth University Peninsula Schools of Medicine &amp; Dentistry</li> <li>• Lord Carter, NED NHS Improvement (visit to Trust)</li> </ul>
<p><b>Community Consultation</b></p> <p><b>Public Meetings</b></p> <ul style="list-style-type: none"> <li>• Torquay</li> <li>• Widecombe</li> <li>• Trades Council</li> </ul> <p><b>Additional meetings on request</b></p> <ul style="list-style-type: none"> <li>• Torbay Council Liberal Democrats</li> <li>• TUC meeting</li> <li>• League of Friends Models of Care Meeting</li> <li>• Councillor Jacqui Stockman</li> </ul>



## 4 National Developments and Publications

Details of the main national developments and publications since the September 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 including undertaking “could it happen here?” reviews where appropriate.

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

### **MPs debate in Westminster Hall**

Hugo Swire, Conservative MP for East Devon secured a debate on the NHS in Devon, which took place on Wednesday 18 October in Westminster Hall. The debate was well attended by the county’s MPs, although Sarah Wollaston was unable to attend as she was Chairing a meeting of the Health Select Committee. Issues under discussion included the Success Regime and Sustainability and Transformation Plan for Devon.

MPs took the opportunity to make speeches about issues for their individual constituencies. Torbay MP, Kevin Foster, spoke of his concerns about the proposed closure of Paignton Hospital under the current consultation about the future of community services in Torbay and South Devon, and about the social care market. MP for Newton Abbot, Anne-Marie Morris voiced her worries around the pace of change and the ability to put in place the required level of community services for a rural population.

Philip Dunne, Minister of State for Health praised the work of this Trust, saying: *“Devon is a leader in many areas of the health service—perhaps to the surprise of some hon. Members who have spoken—relative to other parts of the country. Not least, the Torbay and South Devon NHS Foundation Trust was the first trust in England to join up hospital and community care with social care. A plea to do that was made by my right hon. Friend and it is already happening in South Devon. The trust operates as a single organisation, working with partners to improve the way it delivers safe, high-quality health and social care. The trust is showcasing exactly the kind of joined-up, patient-centred care that we want the NHS to provide to meet the needs of the ageing population.”*

### **Policy and guidance**

- **New pay cap for interim managers**

Under new rules set out by regulators, NHS trusts will have to obtain formal approval from NHS Improvement to employ interim managers on rates of more than £750 a day. The rules come into force on 31 October and will apply to all NHS trusts, foundation trusts in breach of their license for financial reasons, and FTs receiving bailout support from the Department of Health. The move to a new approvals process for interim “very senior managers” follows the introduction of

pay caps for nurses and doctors, as well as an approval process for management consultancy contracts and interim managers at clinical commissioning groups.

### Provider Developments

- NHS Improvement has introduced a Single Oversight Framework to replace the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'. It is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding' and will help the regulator to identify NHS providers' potential support needs across five themes: quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability
- **Clinical care at home more efficient:** A new report from an expert panel chaired by Christine Outram, chair of the Christie NHS Foundation Trust, suggests NHS providers could save £120m a year if every acute trust implemented clinical care in the home; that's a fifth of the £580m deficit predicted for 2016/17. The care was as safe and effective as in-hospital care but of shorter duration.
- **Hospitals take up social care duties:** NHS hospitals are opening their own nursing homes and employing their own home help to deal with a crisis in the elderly care system. The costs are still cheaper than seeing wards full and A&Es congested because of delays getting people out of hospital, managers say. Some hospitals have taken on full responsibility for the social care systems from councils in an attempt to join up services more effectively.
- **Third of Bupa care homes 'inadequate':** A third of Bupa's 238 UK care homes are now considered either "inadequate" or "require improvement" according to the CQC. The disclosure comes after several deaths of vulnerable residents following evidence of poor care at several homes.
- **Police threaten NHS legal action over detention of mental health patient:** Devon and Cornwall Police has threatened legal action against the NHS under the Human Rights Act ,after it was obliged to illegally detain a mental health patient for 54 hours due to a lack of beds.

### Royal College Reports

- **Leading doctors list procedures that 'give no benefit':** Leading physicians have said a number of common treatments and procedures routinely undertaken by doctors are largely pointless. The Academy of Medical Royal Colleges (AMRC) said that many treatments for conditions from minor grazes to terminal cancers often give no more benefit to the patient than simply doing nothing. The college said it wanted doctors to think carefully about whether certain procedures – such as plaster casts for some broken bones or x-rays for patients with back pain – were required, given their possible side-effects.
- **GMC warns doctors' low morale 'puts patients at risk':** The General Medical Council has warned that poor morale among doctors could put patients at risk. In its annual report into the state of medical education and practice in the UK, the doctors' regulator said there was a "state of unease within the medical profession across the UK that risks affecting patients as well as doctors". It noted that following the anger and frustration of the dispute between junior doctors in England and the Department of Health, levels of alienation "should cause everyone to pause and reflect". The report also found that 582 fewer doctors had gone on to speciality training in 2015 following their two post-graduate foundation

years, although a number take a break at this point to improve their skills either in the UK or abroad, or for personal reasons

- **Babies at risk due to failures:** A new report warns that the health of new-born babies is being put at risk because hospital staff are failing to carry out basic checks. The report by the Royal College of Paediatrics and Child Health found that 28% of babies admitted to neonatal units in 2015 were too cold and at risk of hypothermia, with it shown that one in 20 new-borns had not had their temperatures checked after the birth, despite it being a requirement under NHS guidelines. It was also found that 15% of mothers were not given steroids ahead of labour which help prevent infants suffering breathing difficulties and 7% of babies were not given an eye check before being discharged to monitor for signs of blindness. **The Trust is reviewing its practice as part of our “could it happen here” governance process.**

## 5 Media Update

### Media references to the Trust

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

- Intermediate Care – The Best Bed is Your Own Bed - Included the expansion of the service, how it supports people to be able to be at home and included two patient stories giving their positives experiences.
- The work of volunteer car drivers
- An extra £2.31million a year is being spent on services to keep people out of hospitals and care homes.
- Torbay Hospital League of Friends ball to celebrate reaching its latest £1.6million fundraising target.
- Community consultation



**REPORT SUMMARY SHEET**

<b>Meeting Date:</b>	5 <sup>th</sup> October 2016
<b>Title:</b>	Report of the Medical Director
<b>Lead Director:</b>	Rob Dyer
<b>Corporate Objective:</b>	Safe, Quality Care, Best Experience, Well-led
<b>Purpose:</b>	Information/Assurance
<b>Summary of Key Issues for Trust Board</b>	
<u>Strategic Context:</u>	
<p>Plans are in place for implementation of the new Junior doctors contract over the next 12 months. The first wave of doctors have transferred onto the new contract.</p> <p>A high-court ruling suggests that each Trust can chose whether or not to implement the contract. However funding of junior doctor posts depends upon implementation so there is in effect no option. We have appointed a Guardian of Safe Working Hours, Dr Nuala Campbell. The new contract requires quarterly reporting to the Trust Board. The new contract includes a system of fines for departments when infringements of hours worked has occurred.</p>	
<u>Key Issues/Risks</u>	
<p>Concerns remain over implementation of the contract.</p> <ul style="list-style-type: none"> <li>• Junior Doctors remain angry over the handling of the Industrial dispute.</li> <li>• The new contract is inflexible and may increase junior doctor disquiet. This may affect recruitment and retention of staff</li> <li>• The system of fines will impose additional costs on departments (estimates of cost to be established)</li> <li>• The inflexibility of the new contract will increase the risk of unfilled shifts and additional locum cost with financial and clinical risk (assessment in progress)</li> </ul>	
<u>Summary of ED Challenge/Discussion:</u>	
<p>The Board is asked to acknowledge the potential impact of the new contract and the role of the Guardian of Safe Working Hours.</p>	
<u>Internal/External Engagement including Public, Patient and Governor Involvement:</u>	
<u>Equality and Diversity Implications:</u>	
<p>The new national junior doctors' contract has been acknowledged as having greater impact on women.</p>	

<b>Report to:</b>	Trust Board
<b>Date:</b>	3rd November 2016
<b>Report From:</b>	Medical Director
<b>Report Title:</b>	Junior Doctors Contract – Report of the Guardian of Safe Working Hours

### Role of the Guardian of Safe Working Hours

This is a new role which has arisen from the negotiations between the BMA and the DoH on the new (2016) junior doctor contract. The purpose of the role is to monitor and regulate junior doctors hours and patterns of work in order to provide assurance to both the doctors and their employers that they are able to work and train within safe working hours.

The monitoring mechanism is through a system of Exception Reporting, whereby the doctor generates a report when their hours or pattern of work differs from that which they are contracted to provide. These reports are managed through both the Educational and the Guardian route to ensure that both training and safety are protected. There is a system of fines which must be levied on departments contravening the regulations. The fine covers payment to the junior doctor and a penalty to the department which is to be administered by Guardian and used for the education or welfare of the junior doctors.

The contract stipulates that the Guardian formally report to the Board at least once a quarter, including data on rota gaps and Exception Reports.

### 2016 Junior Doctor Contract: summary of changes

The major changes that the 2016 contract brings are as follows:

- 1) A reduction in the maximum average hours of work per week (from 56 to 48)
- 2) Much stricter rules around working patterns (eg 48 hours rest following a block of 4 consecutive night shifts , up from 11 hours)
- 3) Significant implications for both the doctor and the employer if these new rules are breached
- 4) Removal of pay banding system for out of hours work, replaced with pay for actual hours worked
- 5) The provision of a detailed work schedule for junior doctors which details their hours and pattern of work and their remuneration **and** the education and training opportunities that they should expect in any given post.

The rationale behind these changes is to ensure that doctors are working within safe hours and in safe patterns and that they are receiving the training and support that they need. However, as a result of all these changes there is a **reduction** in the **total hours** of the junior doctor workforce and a significant **reduction** in the **flexibility** of that workforce.

All Acute Trusts have relied on the flexibility of the junior doctor workforce to maintain the service in the event of short term sickness and gaps in the rota. The ability to swap

out of hours and weekend shifts has helped junior doctors to maintain a satisfactory work life balance. (e.g. 2 junior doctors who are partners may swop some weekend shifts so they can see each other.)

At present if junior doctors are not able to provide cover for absent colleagues, the contingency plans that are used include the use of external locums and the 'acting down' of senior colleagues (eg in Torbay hospital we have had examples of Consultants covering night time junior doctor shifts in Paediatrics, Obstetrics and Gynaecology and Anaesthetics over the past few years). These solutions have financial and service implications.

The wholesale implementation of the 2016 contract therefore brings with it significant risk to the ongoing provision of the service. It is not just the emergency and out of hours service that is at risk, as moving the medical workforce to that arena obviously denudes the provision of elective care.

There is a staggered implementation timetable (below). As of the 5<sup>th</sup> of October we have only 4 doctors on the new contract (specialty trainees in Obstetrics and Gynaecology), and no Exception Reports have yet been generated. The transition of Foundation Year 1 doctors to the contract is due in December . (These are doctors who are in their first year out of medical school and who form the basis of first line patient care on the wards).

At present, medical HR are undergoing a data gathering exercise to ascertain the extent of the risk associated with the lack of flexibility this new contract brings. ( ie how many internal and external locums, additional shifts and swaps to maintain service have taken place between August and October so far; how many gaps in rotas there are and how these have been managed) and this data should be available for the November Board meeting.

Dr Nuala Campbell, Consultant Anaesthetist and Guardian of Safe Working Hours, 20 October 2016

	<b>Local Timetable</b>
October 2016	ST3+ in Obs & Gynae
December 2016	<b>F1s (all specialties)</b>
Feb-April 2017	ST3+ in Paeds (March 2017 changeover) Dentists (March 2017 changeover) F2s in Psych (April 2017 changeover) F2s in Paeds (April 2017 changeover)
April 2017	All grades in all surgical specialties (All surgical grades which start in April will start on the new contract)
August 2017	All grades in ED All grades in Anaesthetics All remaining grades in Medicine Academic F2s Any anomalies to the above All F2s in General Practice





**REPORT SUMMARY SHEET**

<b>Meeting Date:</b>	2 <sup>nd</sup> November 2016 – Board of Directors
<b>Title:</b>	<b>Into the future: Reshaping community-based health services Response to public consultation</b>
<b>Lead Director:</b>	Ann Wagner, Director of Strategy & Improvement
<b>Corporate Objective:</b>	This proposal supports all 4 corporate objectives: <ul style="list-style-type: none"> <li>• Objective 1: Safe, Quality Care and Best Experience</li> <li>• Objective 2: Improved well-being through partnership</li> <li>• Objective 3: Valuing our workforce, paid and unpaid</li> <li>• Objective 4: Well led</li> </ul>
<b>Purpose:</b>	Approval of formal response to CCG consultation

**Summary of Key Issues for Trust Board**

**Strategic Context:**

South Devon and Torbay Clinical Commissioning Group (CCG) will shortly conclude their twelve week public consultation through which they are seeking the views of local people in relation to proposals to increase resources to fund the community based NHS services that most people use most. If approved, this will mean reducing the number of community hospital beds and establishing stronger, community based health and social care teams able to support people in or close to their homes, 24/7.

Healthwatch (Devon and Torbay) have been commissioned by the CCG to produce an independent report of the consultation and make recommendations to the CCG's Governing Body. Both Torbay Council and Devon County Council's respective Overview and Scrutiny Committees are overseeing due process. NHS England have applied the tests for public consultation including considering the case for change through their Clinical Senate review process.

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.

The proposals for change, which have been developed with the support and involvement of the Trust, and are based on extensive public and stakeholder engagement, are an important part of the ICO's 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.

As a key provider for the South Devon and Torbay population and key partner of the CCG it is appropriate that the Board formally responds to the CCG's consultation including reflecting on feedback to date from the consultation meetings held so far. A proposed response is attached for the Board to consider.

The final decision on determining the next steps post consultation lies with the CCG's Governing Body who will consider the findings and recommendations of Healthwatch and reflect on all of the responses and suggestions that they have received.

**Key Issues/Risks:**

Reconfiguring services is never easy and some difficult choices must be made if we are to ensure the sustainability of local health and social care services. We agree that current NHS and social care provision in the area is unsustainable in its current form and given funding constraints.

Unless something change we will be unable to respond to rising demand for services from our increasingly elderly population, and the number of people in our population with complex long term conditions and care needs. Change is inevitable and maintaining the status quo is neither sustainable nor clinically sound. The aim is to implement the key major developments before any changes are made to current provision.

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. This is being kept under close review with further contingency plans in place if required.

The proposal, if implemented, does impact on NHS premises owned by the Trust. Should a decision be made to close and dispose of any of these NHS premises, proceeds from any sale will be reinvested in developing community services within South Devon and Torbay

**Recommendation:**

The Board is asked to:

- **Approve** the attached formal letter of support

**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 have been present 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 has continued throughout the consultation.

Governors have been briefed and have been represented at each of the public meetings. The support of our public Governors in reflecting views from their constituents has been valuable and shared with the CCG and Healthwatch.

**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 have been given every opportunity to have their say, including suggesting alternative proposals for consideration. Quality impact assessments have been completed and are being refreshed through the consultation.

**Public**

## **Draft response to CCG**

**To: Nick Roberts Chief Clinical Officer and Derek Greatorex Chair SD&T CCG**

Dear Nick and Derek

### **Into the Future – Re-shaping community based health services: Response to public consultation**

As the public consultation on the community services proposals draws to a close, the Trust Board felt it appropriate to add our voice to the responses you are receiving and confirm our support for the changes being proposed.

As the main provider for the South Devon and Torbay population and key partner of the CCG we have been actively involved in developing the model of care which forms the basis of the CCG's proposals. This model of care – predicated on shifting resources and care from a traditional hospital based medical model to one focussed on integrating care to better meet the needs of individuals by supporting them at home and in the community – lies at the very heart of the ICO's original business case.

Attendance at the consultations and feedback from the public demonstrates the high level of support our local population has for their NHS and social care. By taking part in the consultation meetings we have had the opportunity to hear first hand the views of local people and staff which has been helpful in understanding their concerns and hearing ideas for alternative proposals.

Whilst concerns have been expressed at the potential loss of much valued community hospitals, in the main people have been more focused on potential loss of services than on buildings eg MIU and X- ray. There has been a clear theme about the resilience of the care home and domiciliary care market and the risk to the delivery of the new care model should this not be addressed. The work of the CCG and Torbay Council and Devon County Council to stimulate and support the development of the market needs to be progressed as a priority. Another concern has been workforce capacity and the reliance on the voluntary sector and whether it can cope with increasing demands. Hopefully the assurances given about our investment in additional intermediate care staff and health care coordinators in partnership with the voluntary sector will allay these concerns. Another issue frequently raised is around travel times and access to transport. We are continuing to work with our voluntary sector partners to explore how the Trust can support additional community transport for vulnerable people in local communities who need this assistance.

Reconfiguring services is never easy and some difficult choices must be made if we are to ensure the sustainability of local health and social care services. We agree that current NHS and social care provision in the area is unsustainable in its current form and given funding constraints. Unless something change we will be unable to respond to rising demand for services from our increasingly elderly population, and the number of people in our population with complex long term conditions and care needs. Change is inevitable and maintaining the status quo is neither sustainable nor clinically sound.

Change of this magnitude is not without risk – we have already seen a number of community staff move on already despite assurances regarding job security. As the CCG is aware we have taken immediate action to ensure safe staffing levels, including reducing beds temporarily where necessary. We do not underestimate the challenges we face – whilst we have ambitious plans, implementation will require all of our collective energies to ensure we deliver change in a managed way.

The Trust is committed to working with the CCG and Torbay Council as our commissioners to deliver change in a managed way. Our aim is to implement the key major service developments before changes are made to current provision.

Once the consultation is concluded and before decisions are made on the future service model, we will work with you to review the key themes from the consultation responses including any suitable alternative suggestions, so that together we can consider any reasonable adjustments to the current proposals before final decisions are made.

Your's sincerely

Mairead McAllinden  
Chief Executive

Sir Richard Ibbotson  
Chairman

Cc: Healthwatch Torbay and Devon  
Torbay Council  
Devon County Council

**REPORT SUMMARY SHEET**

<b>Meeting Date:</b>	7 September 2016
<b>Title:</b>	Report on Care Home Quality
<b>Lead Director:</b>	Chief Nurse – Jane Viner
<b>Purpose:</b>	Assurance
<b>Summary of Key Issues for Trust Board</b>	
<u>Strategic Context:</u>	
<p>This report seeks to provide the Board with an overview of the measures in place, and being developed, to assure quality in the care homes in Torbay and South Devon. It also highlights key risks in the context of local and national reports and concerns, and proposes service developments to address this key risk area for social care.</p>	
<u>Key Issues/Risks</u>	
<p>There are significant challenges in the Care Home Market locally, echoing the recent reports from both the Kings Fund ‘Social Care for Older People –September 2016’ and comments from the Care Quality Commission in its annual statement on social care in England, ‘The State of health care and adult social care in England 2015/16’ published in October 2016.</p> <p>Both reports highlight serious risks to residential and nursing care provision; which are echoed locally:</p> <p>Severe challenges in recruiting and retaining a quality workforce  Care homes finding it difficult to improve quality when required to do so by the regulator</p>	
<u>Summary of ED Challenge/Discussion:</u>	
<u>Internal/External Engagement including Public, Patient and Governor Involvement:</u>	
<u>Equality and Diversity Implications:</u>	

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## Introduction

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There is growing concern, both nationally and locally, that care providers are struggling with the challenge of providing good quality care. While, locally, there are some excellent providers – we also have an increasing number for whom we have to intervene, monitor closely and, in some cases, oversee closure.

There are 94 care homes in Torbay, with 79 of those registered with The Care Quality Commission as residential homes and 15 registered as nursing homes. Locally care homes are mainly owned by small private providers, with a few larger regional and national companies who could be expected to have a stronger infrastructure.

The commissioning of care from care homes in Torbay is the responsibility of Torbay council in Torbay and Devon County council in South Devon. The micro commissioning of purchasing services by the Trust from care homes is mainly done on a spot purchase basis, and includes people working in both social care and Continuing Healthcare.

TSDFT have statutory responsibility for adult social care and safeguarding for all residents in Torbay, and the majority of residents are funded this way. There are also people whom are self-funding in these homes, whom we must legally ensure are safeguarded as per our responsibilities under The Care Act 2014.

Other people would be placed by other councils, such as Devon County Council, and these placing authorities retain responsibility for the individuals placed under social care funding.

For note is the difference between residential and nursing homes. Residential homes would have TSDFT staff providing community nursing services to their residents when a nursing need is identified, while in the Nursing home market we have less informal oversight as they have their own registered nurses. Every resident placed by social care will have a review of their needs in the placement within 6 to 12 weeks and thereafter at least one annual review.

Torbay Council is currently appealing a Judicial Review decision, which was taken out against them by a group of Torbay Care Homes. The Judicial Review appeal is regarding the care home fees offered by Torbay Council (via TSDFT) to homes.

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## National and Local Issues

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### 1.1 Findings from SCRs and incidents

Local issues are monitored via the Datix incident reporting system, for the concerns our own staff note for anyone affected by poor quality care. These incidents along with information from CQC are shared and monitored by the Quality Improvement and Assurance Team (formally known as the Business Support and Quality Team) who carry out their own audit of care home quality. When required, concerns are escalated to Safeguarding Adults and the Local Authority Commissioning Team.

For very serious incidents, The Torbay Safeguarding Adults Board (TSAB) would consider commissioning a Safeguarding Adult Review. The TSAB published the Western Rise Serious Adult Review in October 2016, which highlighted concerns about recognising and reporting quality in residential care provision.

### 1.1.1 Western Rise

Published in October 2016, the Western Rise a Safeguarding Adult Review was commissioned by the Torbay Safeguarding Adults Board, in order to examine events that took place in the Western Rise residential care home. These events came to light in June 2014 and revealed the serious neglect of a number of residents.

The investigation identified the following key themes:

- Inadequate care planning
- Inadequate knowledge of physical care needs/activities of daily living
- Inadequate knowledge of the mental capacity act and DOLS
- Issues regarding personal allowance and personal effects
- Inadequate risk assessments
- Poor monitoring of weight and evidence of weight loss in many residents
- Poor record keeping in the home
- Poor standards of infection control
- Issues pertaining to medicines management
- Concerns about the knowledge base of the homes care staff with regard to the residents needs
- Homes overall inadequate monitoring of food and fluids
- Inadequate maintenance of the building and contents
- Inadequate housekeeping and hygiene monitoring
- Equipment not maintained or replaced where needed
- Poor management of challenging behaviour

### 1.2 National Reports

#### **Kings Fund – Social Care for Older People, Home Truths (September 2016)**

This national report was published in 2016, and presents an overarching picture of the national issues in social care for older people. Its key findings are that:

- Social care for older people is under massive pressure; increasing numbers of people are not receiving the help they need, which in turn puts a strain on carers.
- Access to care depends increasingly on what people can afford – and where they live – rather than on what they need.
- Under-investment in primary and community NHS services is undermining the policy objective of keeping people independent and out of residential care The Care Act 2014 has created new demands and expectations but funding has not kept pace. Local authorities have little room to make further savings, and most will soon be unable to meet basic statutory duties.

Based on the evidence in the report, the authors recommend that policy-makers need to address three major challenges in shaping the development of social care over the next five years, focusing on how to:

- Achieve more with fewer resources – for example, through better commissioning and integrated care – recognising that these initiatives will not be enough to close the funding gap
- Establish a more explicit policy framework, which makes it clear that primary responsibility for funding care sits with individuals and families
- Reform the long-term funding of social care because reliance on additional private funding is unlikely to be sufficient or equitable.

## **1.3 Statutory roles**

### **1.3.1 Role of the Care Quality Commission**

The Care Quality Commission (CQC) is the independent regulator for health and social care in England; they are ultimately responsible for the oversight for the quality of the care homes registered with them. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care. TSDFT uses these ratings to make judgements as to the quality of the care provided in the homes in which people are placed.

In October 2016 CQC published their annual report on social care in England, 'The State of health care and adult social care in England 2015/16' published in October 2016. In this report they describe social care provision to be 'at a tipping point'. The CQC emphasises that 71% of care provided nationally is of good quality, but for those providers who were identified as needing to improve, 25% failed to do so.

### **1.3.2 Role of TSDFT (Delegated from Local Authority) in Torbay**

The Trust's duties with regards to care home quality are separated into three duties:

- Quality and safety oversight of the responsibilities associated with being a micro commissioner of individual social care placements in Torbay; and CHC placements in Torbay and South Devon (this oversight is undertaken by the Quality Improvement and Assurance Team – details below)
- Responsibilities as a provider of Community health services in Torbay and South Devon to provide health care to vulnerable adults and monitor/support the delivery of high quality care
- The lead role in the co-ordination of the Torbay Multi-Agency Safeguarding Board and Duties, which includes oversight over the wider care market in Torbay

### **1.3.3 Role of Healthwatch Torbay**

Under the Healthwatch regulations 2012, local Healthwatch organisations have the power to enter and view residential and nursing homes in order that an authorised representative can observe provision of care relating to health and social care services.

Organisations must allow an authorised representative to enter and view and observe activities on premises controlled by the provider as long as this does not affect the provision of care or the privacy and dignity of people using services.



### **2.1 General Issues**

The oversight of day to day quality in care homes is reliant on a variety of individual mechanisms, and is a difficult and complex problem. The CQC is the legal regulator of care homes and is responsible for the monitoring and audit of quality.

The well documented challenges of reducing inspection resources leave the system vulnerable to fluctuations in the quality of care provision.

In addition, visits from social workers are usually annual, unless a person has an additional complexity such a deprivation of liberty. Community Nurses do patient specific visits to residential homes, but not nursing home. Therapy staff visit homes on a case by case basis.

### **2.2 Quality Improvement and Assurance Team and MCA DOLS/Safeguarding for Torbay Local Authority Duties**

In Torbay the Quality Improvement and Assurance Team (formerly Business Support and Quality Team) carry out annual assessments within a local quality framework to supplement the inspection regime of CQC. The team comprises three QIAT Officers who are each assigned a proportion of the 94 local care homes to monitor and review for incidents complaints and soft intelligence from partner organisations such as CQC, staff, Health Watch and the public. They also support providers in developing and meeting improvement actions plans as an outcome of CQC inspection reports, safeguarding processes and maintain relationships with home owners and managers. The monthly quality report they produce is attached as Appendix One, with provider names removed for the purposes of this report. This is presented monthly at the social care programme board.

The independent Experts by Experience group (E by E) which is facilitated by the Trust comprises trained and accredited volunteers who carry out “Mystery Shopping” in the Torbay care home area. Members of the group visit homes unannounced and record their observations in a standard set of domains. These include dignity and respect, personalised care and quality of the environment – all features of the Winterbourne View report. Feedback, both good and bad, is given to the relevant home by letter and/or in person by an E By E member and a Trust representative. The report is also shared with the QIAT who use this as part of their overall monitoring of market intelligence on quality of care and experience of residents.

The QIAT, Healthwatch and Datix manager have monthly business meetings to share their intelligence and prioritise activity to maximise their individual resources.

Processes for addressing safeguarding and quality concerns in care providers are twofold. There is an initial ‘Provider of Concern’ Process, which is a supportive framework to monitor and improve quality in partnership with providers. It involves structured meetings and improvement planning, undertaken jointly with providers, officers, CQC – it is led by Torbay Council.

Dependent on the areas of concern TSDFT staff are mobilised to support a home in such areas as medication administration, effective care planning, pressure ulcer prevention. This support is additional to the community based services that the teams provide and such demands can out strip capacity.

The Safeguarding Adults Whole Homes Procedure is the process invoked when there are serious and multiple concerns about safeguarding and the welfare of residents. It may result in the decommissioning of residential and nursing homes. Where a whole home procedure is instigated the community operational teams are required to provide significant capacity of their services to mitigating risk to individual's health and wellbeing. This can result in mobilising a wide range of professional such as Speech and language therapists, dietetics, nursing, OT, physiotherapy in a coordinated and focused intervention programme.

Ultimately a joint decision is made, with legal advice, on when to cease using a residential or nursing home. This would be as a last resort, after all attempts to improve quality and safety have failed.

### **2.3 Support from Operational Teams**

Individual clinicians have a professional responsibility to identify and deal with poor quality care, a duty which is reinforced in supervision and via mandatory training. In a broader sense, operational teams play a significant role in monitoring and supporting quality in Care homes, and early/preventative support is offered to homes from those teams.

A Community Nurse in Newton Abbot Zone has a designated role supported by a specific Job Description, which entails her leading on quality of care within the residential homes within the Newton Abbot zone. She does offer support to Nursing Home nursing colleagues. She runs a care-home forum, encouraging the sharing of best practice, learning and opportunities of an educational nature. It is proposed that the learning from this successful model – the rates of pressure ulcers have reduced; healing rates increased and nursing caseloads have reduced. These successes are due to the fact that the nurse is able to advise the care homes, and act proactively to assess and support residents and pick up issues and concerns at an early stage.

Recent months have seen the closure of 6 homes in Torbay and South Devon, in addition to 3 provider of concern process and 2 whole home processes. These processes entail intensive community staffing input to oversee the closure in Torbay and monitor safety across for homes in the whole footprint. This is a significant pressure on operational teams.

### **2.4 Governance**

The Trust Board receives assurance on safeguarding vulnerable adults from the Safeguarding / Inclusion Group chaired by The Chief Nurse.

Oversight and support of the care home market is the responsibility of Torbay and Devon Councils, who lead on the management and support of their respective care home markets. For Torbay the assurance of the quality of individual placements lies with the Trust and is overseen by the Safeguarding / Inclusion Group, alongside the Quality Assurance Committee.

Quality reports for care homes in Torbay are also received by the Social Care Program Board.

Both Devon and Torbay have statutory Safeguarding Adults Board, who have a role to lead the statutory and third sector partners in ensuring vulnerable adults are safe in all care settings.

Risks and concerns outlined in this report have highlighted the pressing need to enhance the way in which the trust monitors quality and safety in the care home market. The various mechanisms are outlined below and will be overseen by an action plan presented to the Quality Assurance Committee.

### **3.1 Implementing the Western Rise Action Plan**

An action plan is being developed with the remit of ensuring the recommendations from the Western Rise Safeguarding Adult Review are fully implemented, plus any additional actions arising from our own internal process reviews. The implementation of this plan will be overseen by a task and finish group, chaired by the Deputy Director of Nursing, and will report to the Safeguarding Inclusion Group and the Torbay Safeguarding Adults Board Executive.

### **3.2 Partnership Arrangements with Devon CC**

A Care Home Quality Framework to cover Devon CC and Torbay Council commissioning arrangements is in discussion, led by the Chief Nurse for TSDFT. This framework will provide a shared understanding of quality, and share information and systems for monitoring and improving quality.

The proposed framework will clarify team structures and terminology to make it easier for care home providers to comply with requirements. This will be reported via the Quality Improvement Group.

### **3.3 Torbay Council Commissioners and TSDFT Quality Improvement and Assurance Team Structure**

Additional clinical skills are being identified for the Quality Improvement and Assurance Team, by way of a nursing role for this team. The team will also ensure its processes and systems enhance those already in place with Torbay Council Commissioners, who are producing a memorandum of understanding in order to clarify roles and identify synergies. This will be further supported within any future Accountable Care System.

### **3.4 Education/ training for our staff**

Mandatory Training for Safeguarding Adults is currently being reviewed to be more challenging culture of acceptance through training/awareness. Care home staff in Torbay are offered access to all training that TSDFT provide at a nominal cost and with the introduction of the new learning management systems can undertake e learning programmes as well as face to face.

### **3.5 Governance**

The Western Rise Safeguarding Adult Review recommends a central point across incidents and complaints; this will be developed via the action plan in 4.1 above.

A monthly quality report has been developed for quality monitoring through Community Divisional Board, attached as Appendix One.

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## Recommendations and Next Steps

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The author recommends that the Trust board supports the proposed elements set out in section 4 that will increase the governance and assurance that we are proactively supporting and driving improvement within the care home market. This is against a backdrop of working within finite resources and a recognition that the Trust cannot compromise its own services in achieving this aim.

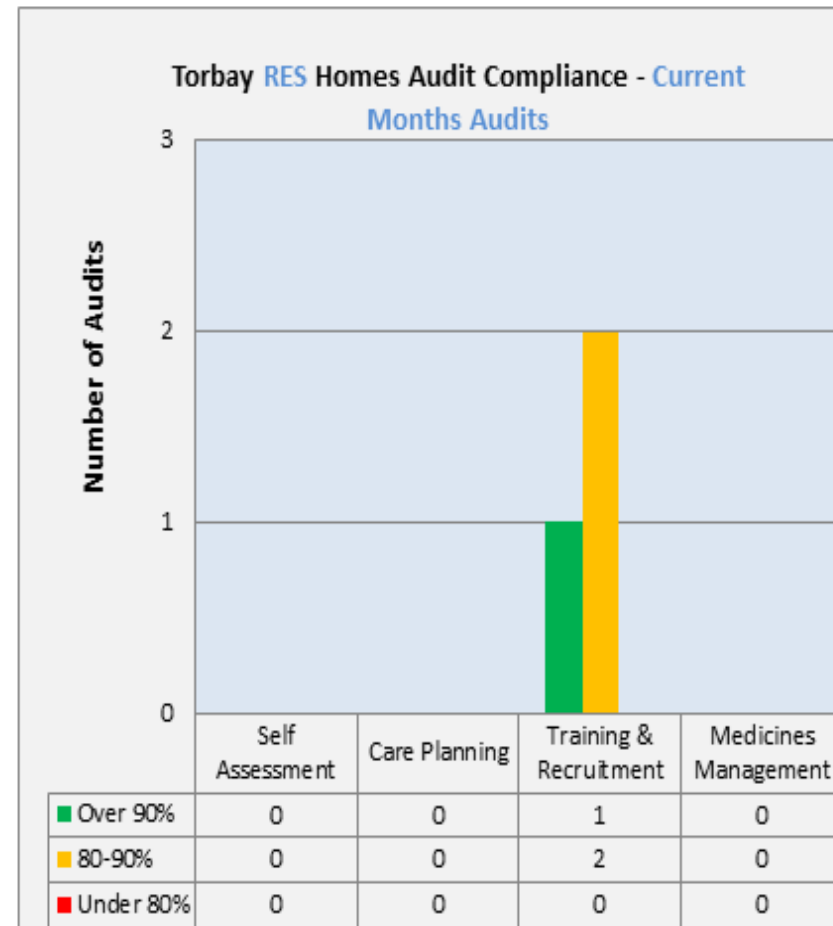
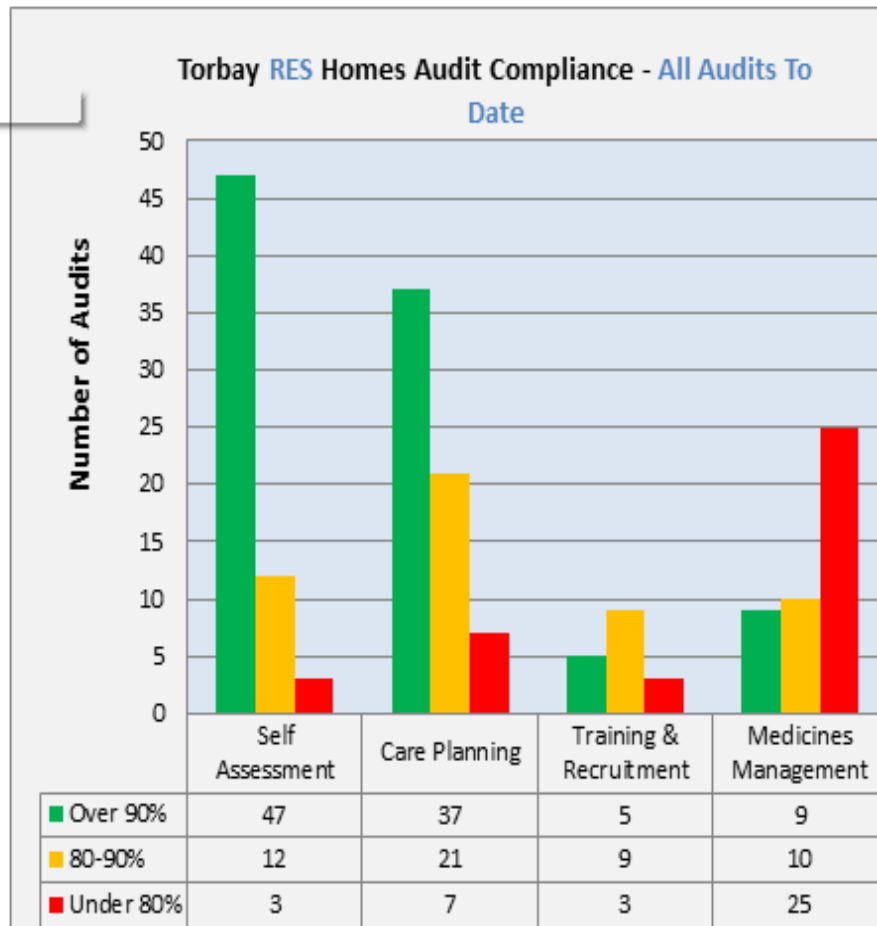
The current landscape in Torbay and South Devon is not unique to our organisational foot print but reflects and national picture of the challenges in providing and sustaining high quality, safe, effective care to vulnerable individuals in our community. To effectively address these issues requires close collaborative working with partner agencies and the voluntary sector in a sustained and structured framework. It is paramount that we optimise the support into the care home market through our operational teams which in part will require increased operational capacity. The revised governance framework will provide clarity on the roles and responsibilities of commissioners, operational teams and the Quality Improvement Assurance Team.

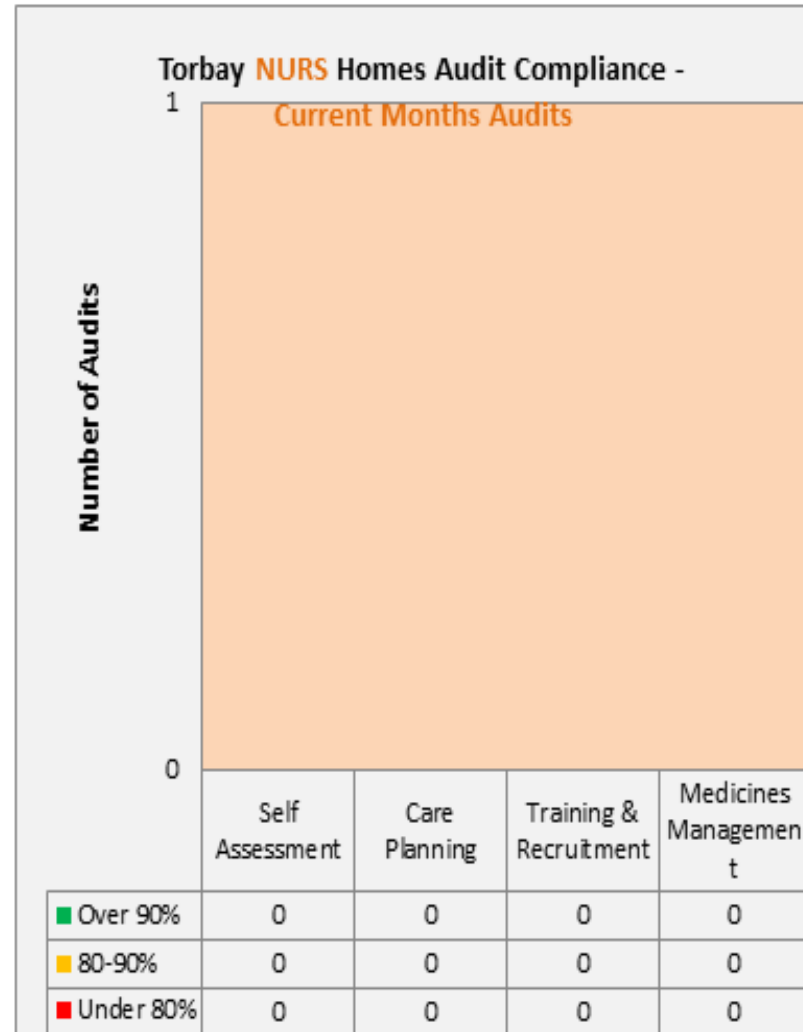
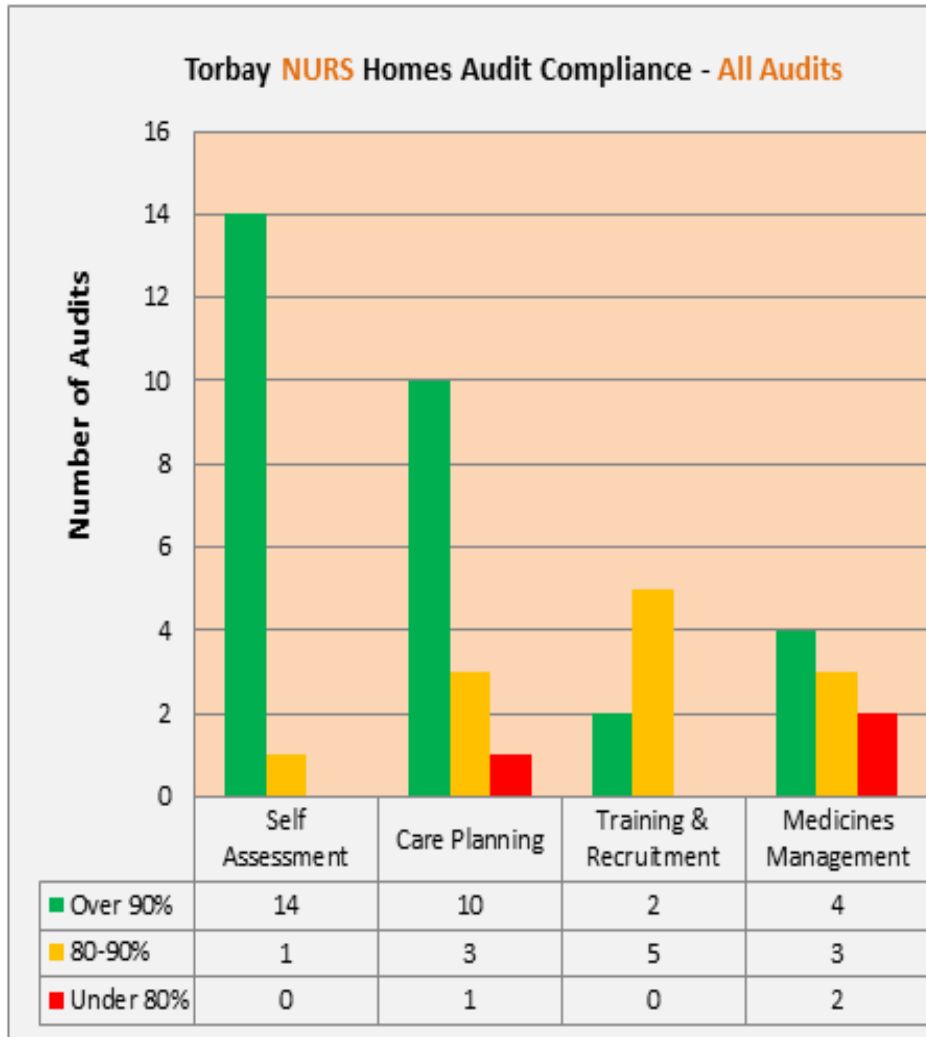
## Torbay Care Homes as at 30<sup>th</sup> September 2016

<b>Placement Suspensions</b>	
<ul style="list-style-type: none"> <li>• <b>NH 1</b> voluntary suspension for all placements. Looking to remove by beginning of November.</li> <li>• <b>NH 2</b> voluntary suspension for all placements until further notice.</li> <li>• <b>RH 1</b></li> <li>• <b>RH 2</b></li> <li>• <b>RH 3</b> voluntary suspension for all placements until further notice</li> </ul>	
<b>Placement Suspensions Removed</b>	
<ul style="list-style-type: none"> <li>• None this period</li> </ul>	
<b>Provider of Concern/ Commissioning Strategy Process</b>	
<ul style="list-style-type: none"> <li>• <b>RH 1:</b> Commissioning Strategy</li> <li>• <b>NH 2:</b> Provider of Concern</li> <li>• <b>NH 3:</b> Provider of Concern (SIRI Investigation closed June 2016 still pending closure of <u>PoC</u> process)</li> </ul>	
<b>CQC Summary Compliance/ Rating Status</b>	
<ul style="list-style-type: none"> <li>• <b>NH 3</b> – Requires Improvement in 4 areas (Caring rated Good)</li> <li>• <b>NH 1</b> – Requires Improvement overall (Effective rated Inadequate)</li> <li>• <b>RH 1</b> – Inadequate (2 Warning Notices/ Special Measures)</li> <li>• <b>RH 2</b> – Inadequate</li> <li>• <b>NH 2</b> - Inadequate (3 Warning Notices/ Special Measures)</li> </ul>	
<b>Safeguarding Adult Whole Home Investigations</b>	
<ul style="list-style-type: none"> <li>• <b>RH 2</b></li> </ul>	
<b>TSDFT Support and Improvement Plan (SIP)</b>	<b>Provider’s Internal Action Plan</b>
<ul style="list-style-type: none"> <li>• <b>RH1</b></li> <li>• <b>NH 3</b></li> <li>• <b>RH 4</b></li> <li>• <b>RH 5</b></li> <li>• <b>RH 2 (Commissioning Plan)</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>NH 1</b></li> <li>• <b>NH 2</b></li> </ul>

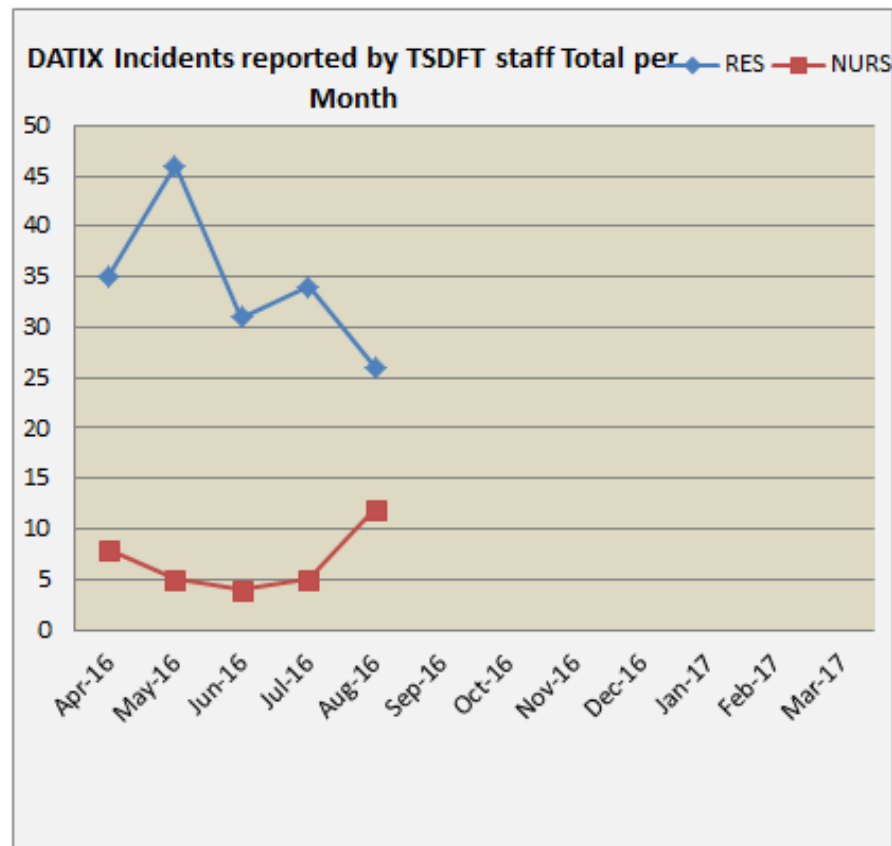
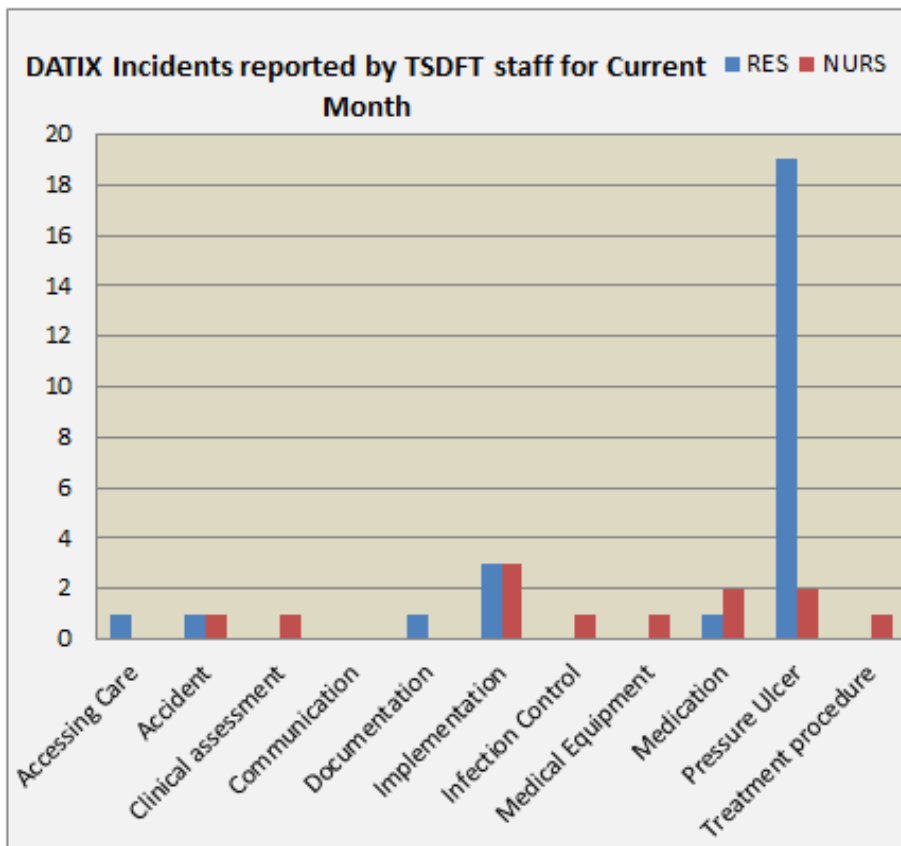


# TORBAY CARE HOME AUDIT RESULTS - AUGUST 2016





# TORBAY CARE HOME DATIX REPORTED INCIDENTS - AUGUST 2016





**REPORT SUMMARY SHEET**

<b>Meeting Date:</b>	2 <sup>nd</sup> November 2016
<b>Title:</b>	<b>Integrated Quality, Performance, Finance and Workforce Report</b>
<b>Lead Directors:</b>	Ann Wagner, Director of Strategy & Improvement and Paul Cooper, Director of Finance
<b>Corporate Objectives:</b>	Objective 1: <b>Safe, Quality Care and Best Experience</b> Objective 4: <b>Well led</b>
<b>Purpose:</b>	Assurance

**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 September (month 6) 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
- workforce framework indicators

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 (18<sup>th</sup> and 25<sup>th</sup> October) and Executive QA and challenge is reflected in this report. Performance of each Service Delivery Unit (SDU) is regularly reviewed by Executive Directors on a monthly basis through the Quality and Performance Review meetings (most recently on 20<sup>th</sup> October). This enables the corporate team to receive assurance, prioritise areas for improvement, consider support required and oversee action plan delivery.

**Key Issues / Risks:**

**1. Quality Framework:**

19 indicators in total of which 3 were RAG rated RED for September (4 in August) as follows:

- VTE risk assessment on admission (Acute) – 92.0% (last month 91.8%) against 95% standard.
- Dementia Find – 31.6% (target 90% - 29.2% last month)
- Follow ups past to be seen date – 6,533 improvement of 386 from last month

The fractured neck of femur standard; 36 hours to surgery improved to green at 94% (standard 90%) This is the first time this has been green this year.

Of the remaining 16 indicators, 14 were rated GREEN, and two AMBER.

**2. NHS I Compliance Framework:**

12 performance indicators in total including the quarterly governance rating of which 5 indicators are RAG rated RED for September (4 in August):

- Urgent care (ED/MIU combined) 4 hour wait – 92.6% (92.9% last month) against national standard 95% - note Trust is overachieving against the SRG agreed STF trajectory of 92.0% for September. The standard for the Q2 NHS I assessment is forecast as being met.

- RTT incomplete pathways – 89.3% (90.5% last month) against the standard of 92%. The standard for the Q2 NHS I assessment will not be met unless a dispensation for Neurology is secured.
- Cancer two week wait from urgent referral – 69.2% (88.7% last month) against the standard of 93%. The standard for the Q2 NHS I assessment will not be met.
- Cancer 31 day subsequent surgery – 93.2% (last month 91.2%) against the standard of 94%. The standard for the Q2 NHS I assessment will not be met.
- Standard moving to breaching compliance this month: Cancer 31 day to first treatment – 93.6% (96.7% last month) against the standard of 96%. The standard for the Q2 NHS I assessment has been met.

In summary the impact of the individual indicators above is that the Trust has not achieved the NHSI Compliance Framework quarterly targets for;

1. A+E
2. RTT
3. Cancer 2ww
4. Cancer subsequent surgery.

The Trust continues to be risk assessed against the Risk Assessment Framework and a score of 4 triggers potential governance concerns. The nature of any regulatory action is not clear but can take a range of forms. The Trust had already triggered a governance concern for breaching consecutive quarters on the 4 hour standard. This will be the first time the Trust has scored 4 in any single quarter.

Of the remaining 7 indicators, 6 were rated GREEN and as stated above the NHS I aggregate compliance framework rating is assessed as RED.

### 3. Financial Performance Summary

Key financial headlines for month 6 to draw to the Board's attention are as follows:

- EBITDA: for the period to 30th September 2016 EBITDA is £3.98m. This is showing an adverse position against the PBR plan by £0.36m. Should the plan be agreed based on the Risk Share arrangement this would result in an EBITDA position favourable position of £1.56m.
- Income and Expenditure: The year to date income and expenditure position is £3.71m deficit which is £0.04m adverse against the PBR plan, and £1.87m favourable against the RSA plan. The Trust has a £0.91m surplus in month after STF income and risk share income has been applied.
- CIP Programme: CIP delivery has marginally improved from the previous month with £4.72m delivered to date, which remains ahead of plan. Although we are seeing some improvement the level of savings planned increases significantly from Quarter 2 onwards. It therefore remains imperative that we secure increased traction in the programme. Plans have been developed in support of the vast majority of schemes, quality assessed where appropriate and progress reported at scheme level to the Finance, Performance, and Investment Committee
- Risk Rating: The Trust has delivered a Financial Sustainability Risk Rating of 2, which is on plan.
- Cash position: Cash balance at month 6 is £14.3m which is lower than PBR plan by £2.52m, and RSA plan £3.47m mainly due to debtors.
- Capital: Capital expenditure is £4.2m behind PBR plan at month 6.
- Agency Spend: At month 6, the YTD position of agency spend is at 5%, 2% over the NHSI target cap target of 3%. The projected full year spend for Agency in FY 2016/17 is £9.7m which will give the Trust a metric of '3' on Agency use under the 'Use of Resource' risk rating.

#### 4. Contractual Framework:

15 indicators in total of which 9 are RAG rated RED in September (7 in August) as follows:

Three additional indicators reported as non-compliant for September:

- Diagnostic tests – 1.7% > 6 weeks (0.7% last month) against the standard of 1.0%
- Clinic letter timeliness – 72.7% (last month 81.8%) against the standard of 80% within 4 working days.
- Trolley waits in ED > 12 hours. 2 trolley waits > 12 hours are recorded in September.

Indicators non-compliant in August and remaining non-compliant in September:

- RTT waits over 52 weeks – 10 (8 last month) against 0 standard
- On the day cancellations for elective operations – 1.0% (1.0% last month) against <0.8% standard
- Ambulance handovers > 30 minutes against trajectory - 24 delays against trajectory of 20 (last month 36)
- A&E patients (ED only) – 88.6% (88.7% last month) against 95% target Note: The locally agreed SRG trajectory for MIU / ED = 92% (September) was achieved
- Care plan summaries % completed within 24 hrs discharge weekdays 57.0% (54.8% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 22.8% (24.0% last month) against 60% target

Of the remaining 6 indicators, 4 were rated GREEN and two AMBER

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

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

- CAMHS % of patients waiting for treatment within 18 weeks – 78.9% (78.4% last month) (target >92%)
- Additional RED in September: Number of care home placements against trajectory – 635 against trajectory of 626 permanent placements.

Delayed discharges in community hospitals improved to green in September.

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

#### 6. Change Framework

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

#### 7. Workforce Framework

5 indicators in total of which 1 RAG rated RED as follows:

The data for sickness absence at the end of August 2016 indicates a rolling 12 month figure of 4.25%. This rate continues to be above the Trust target which was 3.90% at the end of August. Long term sickness makes up 66.4% of total sickness absence.

An updated action plan to reduce sickness is being drafted that includes:

- Bite size training sessions over the coming months for managers
- Asking Senior Managers the top 3 things to support them in reducing their sickness absence rates in their areas of responsibility
- Fostering a robust performance management culture that monitors progress to improve sickness absence management

Of the remaining 3 indicators, 1 rated AMBER and 2 GREEN

#### Recommendation:

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

**Summary of ED Challenge/Discussion:**

The Q2 Governance declaration has 4 indicators which have not been met. The Risk Assurance framework identifies a score of 4 or more will trigger potential governance concerns. This has been identified as a red RAG rating in the relevant section above. This will be escalated to NHSI SW Team to see if they intend to take action –2 of the cancer standards are marginal breaches relating to very low patient numbers. The Deputy CEO is following up with the NHS I SW Team.

The Chief Operating Officer is looking into any evidence that SAFER is reducing patient stays over 10 days.

The Deputy Chief Executive has been asked to escalate with NHSI / NHSE to secure approval and for a dispensation to lower the Trusts RTT trajectory in respect of the impact from Neurology. The intent is to reflect the adjustment in our Quarter 2 performance so as not to jeopardise payment of STF for this standard.

The Chief Operating Officer was asked to provide a report detailing the impact of the current position on RTT compliance and the actions required to recover the position and deliver compliance with the standard by March 2018. This is attached to the main performance report (Appendix 4).

The Director of Workforce and Organisational Development is reviewing the additional action that is being taken to manage the increased sickness absence rate.

**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

**Public**

<b>Report to:</b>	Finance Performance and Investment Committee and Trust Board
<b>Date:</b>	25 <sup>th</sup> October 2016 and 2 <sup>nd</sup> November 2016
<b>Report From:</b>	Director of Strategy and Improvement and Director of Finance
<b>Report Title:</b>	Integrated Quality, Performance, Finance and Workforce Report (Month 6: September 2016)

## 1 Introduction

This report provides commentary against performance variances and improvements at the end of September (month 6) highlighted in the performance dashboard and supported by the detailed data book which now includes finance and workforce schedules. It has been informed from the outcomes and actions from the Efficiency Delivery Group meeting (17<sup>th</sup> October), Service Delivery Unit Quality and Performance Review meetings (held on 20<sup>th</sup> October) and Executive Director 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 or sustained.

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

## 2 Quality Framework Indicators

### 2.1 VTE assessment on admission

**RAG RATING: RED**

The reported performance for acute care in September 92.0% is in line with last month and is below the national standard 95%. The VTE support team are carrying out a retrospective note audit of admissions where the VTE assessment has not been captured on the discharge summary records. This process continues to identify records where the VTE assessment has been correctly documented in the notes but not transcribed on discharge into the care planning summary.

### 2.2 Completion of Dementia 'find' assessment on admission to hospital

**RAG RATING: RED**

The standard of completing a dementia assessment for all emergency patients admitted to hospital over 75 years continues to be a challenge. In September 32% of eligible patients were recorded as having assessments completed against the standard of 90%. This is a small increase over the previous month and will not yet reflect actions within the work plan now agreed by the working group led by the Deputy Director of Nursing and Professional Practice to improve performance. It is expected that improved performance will begin to be seen from October with significant improvement in the spring with roll out of the 'nerve centre' clinical system.

## 2.3 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 clinically recommended 'see by date' remains high but have decreased in September by 386 patients from 6,919 patients in August to 6,533 at the end of September. Although this is a small reduction it comes after 6 months of increasing numbers of patients waiting six or more weeks.

**ACTION:** All teams where the number of follow ups is a significant issue have action plans in place to reduce the number of patients waiting. These plans are being monitored on a bi-weekly basis by the RTT & Diagnostics Risk and Assurance Group and monthly through the Quality and Performance Review Meetings.

To increase visibility in this area, the data book will be updated to contain the position for individual specialties and their improvement trajectories. The data book and dashboard will then show the aggregate improvement trajectory. This is outstanding at the current time.

## 3 NHS Improvement (NHS I) Performance Framework Indicators

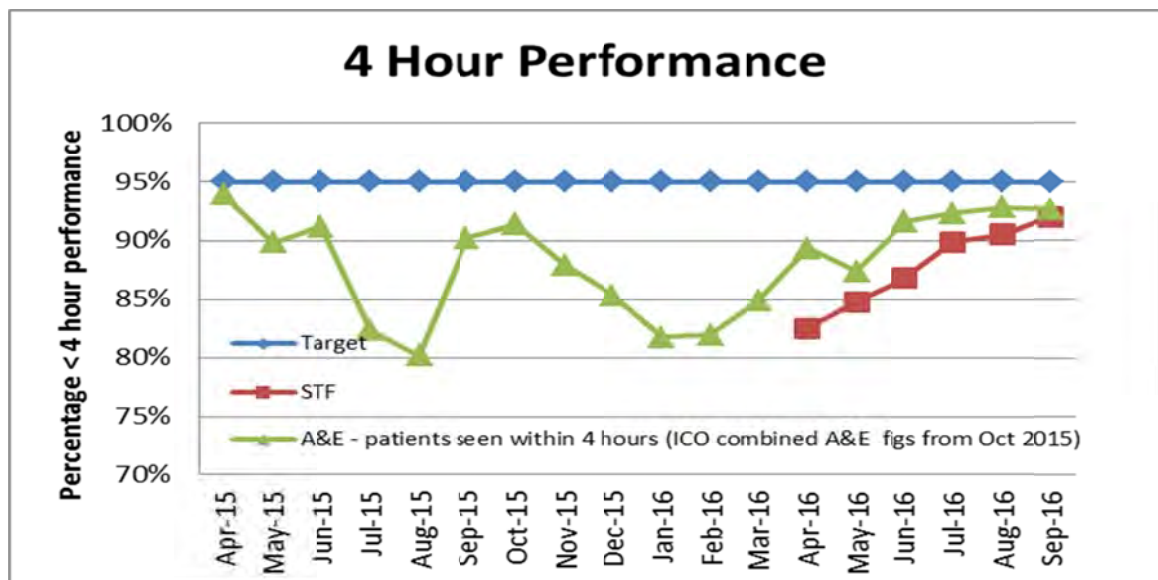
### 3.1 4 hour standard for time spent in A+E

**RAG RATING AGAINST STF 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. The Emergency Department (ED) board briefing also continues fortnightly and is shared with commissioners and governors. A summary of most recent progress and issues against the action plan monitoring is set out below:

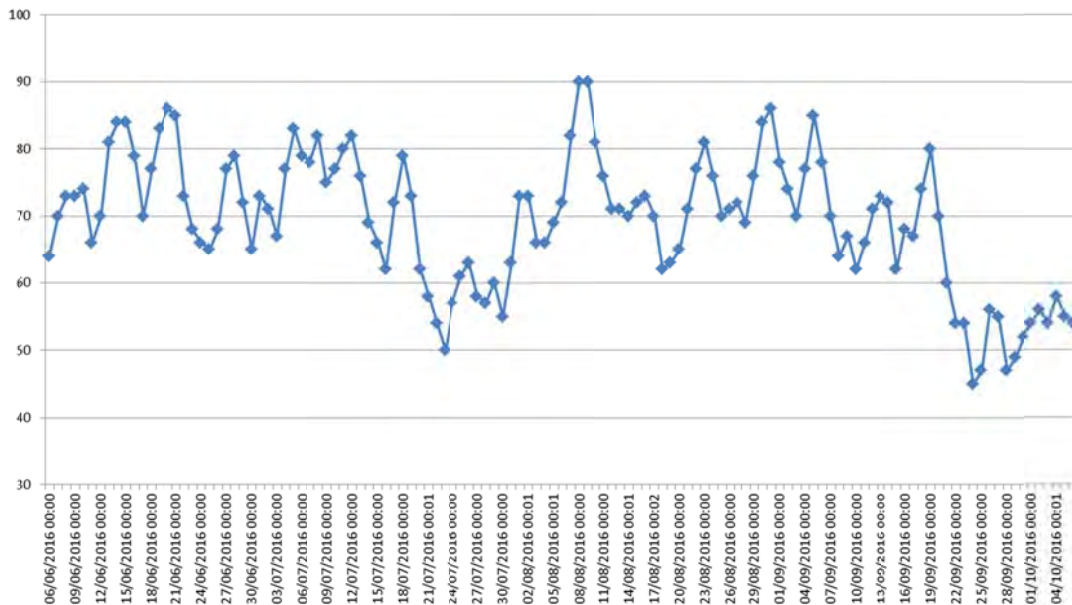
For September, the combined performance of Emergency Department (ED) and Minor Injury Units (MIUs) was 92.6%, a slight reduction to that delivered in August 92.9%. This was a significant achievement as the first half of September was extremely challenging with days of relatively low performance and delivery of the 92% STF trajectory looked to be at risk. In the second 2 weeks of September the highest level of performance this year was delivered and this is being sustained in early October.

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



- Monthly performance has been above the STP trajectory every month since April.
- During the second two weeks in September the hospital had been on GREEN escalation status for 10 of the 14 days. This is in contrast to the preceding 2 weeks where only one day was declared as GREEN escalation status. Patient flow improved and crowding<sup>1</sup> in the department reduced.
- Feedback from clinical teams indicated that increased senior medical cover on Warrington ward has been a significant factor in reducing delays in flow and increasing the number of daily discharges.
- The number of patients awaiting complex care packages has also been further reduced during this period. September data shows the lowest number of days recorded against delayed transfer of care for complex discharges from acute beds recorded this year.
- The number of patients recorded as being in acute hospital beds with a length of stay over 10 days has been around 45 – 55 patients from mid-September being a significant reduction on the previous average of 75-85 patients.

**Number of patients in hospital over 10 days - daily snapshot**



- The ‘Bed, Ready, Go’ initiative started on 19th September and this has enabled quicker transfer of patients to ward beds with the streamlined handover process.
- These factors, aligned with the on-going work on improvement across our hospital and community system have had a demonstrable impact, giving improved patient flow. This is reflected in the reduced crowding in the department and improved performance. The challenge continues to be embedding these changes as ‘business as usual’.
- The new Emergency Department (ED) consultant rotas are due to commence on Monday 24th October. This will provide further resilience and extended senior cover particularly out of hours.
- The new integrated urgent care service including 111 is provided by Devon Doctors Ltd and went live on 30<sup>th</sup> September. The CCG are reporting the initial transition has generally gone very well with staffing up to complement and only

<sup>1</sup> Measured as the number of patients in the department at one time



minimal IM&T issues. Call answering performance has been good and GP out of hours capacity appears to be sufficient to meet demand.

### 3.2. Referral to Treatment (RTT) incomplete pathways

#### RAG RATING: RED

At the end of September 89.3% of patients waiting for treatment have waited 18 weeks or less at the Trust. This is below the agreed STF trajectory and the 92% standard.

RTT delivery of the aggregate Trust position deteriorated below the 92% standard and the STF trajectory in July. Deterioration of the aggregate position was initially due to the workforce challenges and associated reduction in capacity faced by the neurology department. Further workforce challenges in cardiology, respiratory & orthopaedics are now compounding this and impacting significantly on the aggregate position. The rate of growth in the neurology backlog will decrease with additional neurology capacity coming from the appointment of a locum doctor. However in the absence of further additional capacity the neurology backlog is predicted to increase to 350/400 by March 2017.

The predicted impact on the aggregate performance position including the workforce challenges in the above named specialties is illustrated below (the red line indicates our actual position)



The cardiology position did stabilised following summer leave, but has now started to deteriorate, with a current backlog of 205. The impact of not finding a solution to the workforce shortfall in respiratory is significant and therefore is contributing to the predicted position identified in the graph above. Actions are underway to identify additional capacity for respiratory patients however successful delivery of these actions are insufficiently certain for the impact to be reflected in the forecast.

#### Assumptions in the RTT forecast chart

Between now and March 2017 some specialties have plans in place to reduce the number of patients waiting over 18 weeks, this is described below. Due to the deterioration in other specialties the aggregate position is not forecast to be delivered by March 2017. The revised trajectory (blue line on the above graph) takes into account the reduced capacity. As can be seen from the red line this new trajectory is representative of our actual performance. The main specialties contributing to the incomplete backlog other than the three mentioned above are Pain (153), Orthopaedics (303) and Orthodontics (110).

Other assumptions in this trajectory are;

- Saturday lists for Urology running Oct – Dec (up and running)
- Extended trauma Lists 4 cases per month running Nov – Mar



- Foot and ankle Saturday lists 12 cases per month running Oct-Dec (not yet started)
- Continuation of locum doctor in neurology

In order to achieve 92% of patients waiting less than 18 weeks a further 509 patients need to be seen from the longest waiters by March 2017. The Trust does not currently have plans to achieve this.

### **Existing action plans & trajectory dispensation**

CCG and Trust colleagues have worked together exploring options for resolving the capacity shortfall in Neurology. Further actions to secure capacity are being taken forward but as yet are not considered sufficiently certain for the impact to be included in the trajectory predicted above.

The Trust has sought a dispensation for a revised RTT trajectory to allow for the impact in full or in part of the deterioration in Neurology. This could reduce the Trusts STF target trajectory for RTT by between 2.5% and 0.5% during the second quarter to September 2016, depending on the terms of the agreement. Taken together with the tolerance of 1%, allowed by NHS I for RTT in the second quarter, this level of performance (with the dispensation for neurology) would be sufficient to trigger the STF payment. This dispensation has not yet been approved, and the Deputy Chief Executive has been asked to escalate with NHSI / NHSE to secure approval and for this to be reflected in our Quarter 2 performance so as not to jeopardise payment of STF for this standard.

**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

Given the deteriorating position, the Chief Operating Officer was asked to provide a report detailing the impact of the current position on RTT compliance and the actions required to recover the position and deliver compliance with the standard by March 2018. This is attached (Appendix 4).

### **3.3 Clostridium Difficile (c-diff)**

**RAG RATING: GREEN**

The 2016/17 National threshold 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 September, there were two new cases of c-diff recorded with one confirmed as "lapse in care". The cumulative number of lapses in care to the end of September for 2016/17 is 7 cases this is within the agreed trajectory.

### **3.4 Cancer standards**

**RAG RATING: GREEN**

Provisional data for September and Q2 is shown in the following table:

	July 2016				August 2016			September 2016			2nd Quarter Total		
	Target	No. Seen	Breached	%	No. Seen	Breached	%	No. Seen	Breached	%	No. Seen	Breached	%
14day 2ww ref	93.0%	951	18	98.1%	982	111	88.7%	36	36	0.0%	1969	165	91.6%
14day Br Symp	93.0%	78	2	97.4%	93	2	97.8%	0	0	100.0%	171	4	97.7%
31day 1st trt	96.0%	200	3	98.5%	180	6	96.7%	171	11	93.6%	551	20	96.4%
31day sub drug	98.0%	99	1	99.0%	93	0	100.0%	90	1	98.9%	282	2	99.3%
31day sub Rads	94.0%	49	3	93.9%	54	1	98.1%	55	3	94.5%	158	7	95.6%
31day sub Surg	94.0%	37	2	94.6%	34	3	91.2%	44	3	93.2%	115	8	93.0%
31day sub Other	-	19	0	100.0%	30	0	100.0%	28	0	100.0%	77	0	100.0%
62day 2ww ref	85.0%	103.5	12.5	87.9%	95.5	11	88.5%	106	13.5	87.3%	305	37	87.9%
62day Screening	90.0%	16	1	93.8%	11	1	90.9%	7	0	100.0%	34	2	94.1%

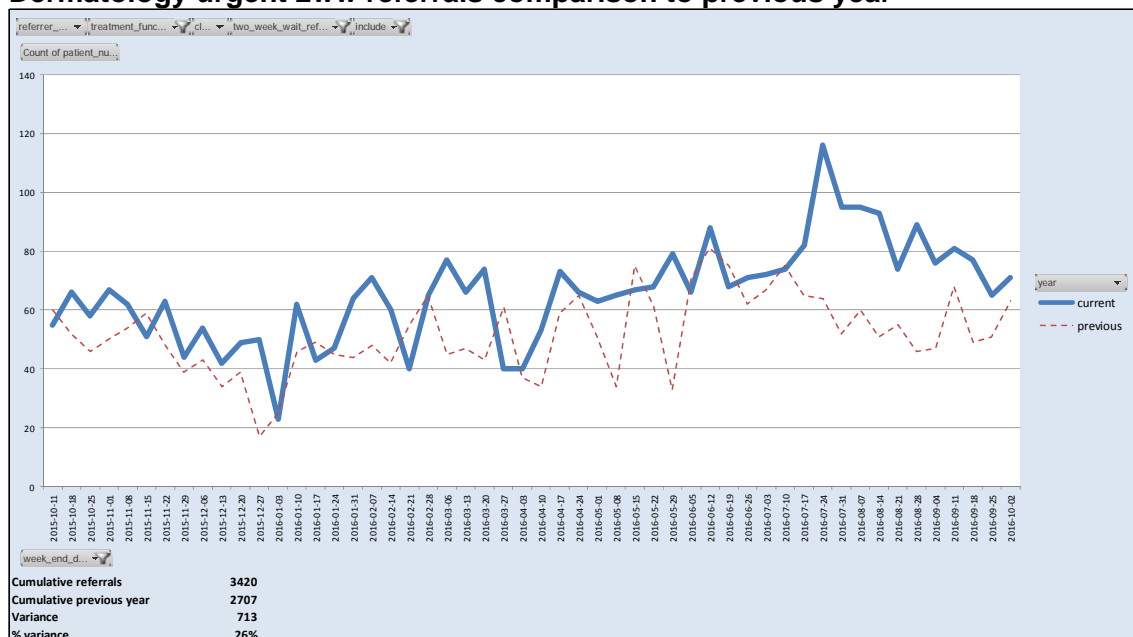
The two week wait referrals standard and the subsequent surgery treatment standard have not been achieved in September and have also not delivered to the standard for quarter 2. Breach of the two week wait standard for quarter two was reported to the Board last month. This is due to the significant pressures felt in dermatology, more information is included below. The subsequent surgery standard has breached this quarter, this and the subsequent radiotherapy standards were both reported at risk last month, both as a result of a few patients choosing to wait longer for their treatment over the summer.

### Risks and plans:

In July, August and September there was an above plan increase in urgent two week wait referrals into Dermatology (40% increase on previous year). This is illustrated in the graph below.

Appointments for routine referrals and follow up patients were therefore suspended to leave more capacity for patients referred via the 2 week wait standard. Initially it was planned that the 2 week standard would be recovered from the end of September. However the anticipated seasonal reduction in referral did not occur as quickly as predicted. The consequential higher volume of patients to be seen has resulted in a significant number of patients waiting over 2 weeks being booked into October. As a result it is now highly likely the standard in Q3 will not be delivered. In addition to the urgent referrals not meeting the 2 week wait standard, routine waiting times have increased and this is also becoming an increasing priority. The service does have plans in place with additional clinical support to recover the position but this will take further time.

### Dermatology urgent 2ww referrals comparison to previous year



## 4 Financial Performance

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 – the RSA plan in the following analyses - with the Trust picking up an £11.6m share of system risk in 2016/17. In that plan, 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 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 of the tables that follow.

The Trust has briefed NHS Improvement (NHSI) regularly on the expected impact on the Trust's plan, submitting a forecast that reflects the income loss each month since April, and is attempting to negotiate permission to submit a revised plan on the basis of final contract settlement. If successful, this would avoid the adverse FSRR scoring associated with the 'I&E margin variance' and better secure the Sustainability and Transformation Fund (STF). The Quarter 1 letter from NHS Improvement indicates this revision of the plan is looking unlikely to be granted. The Chief Executive has spoken with, and subsequently written to the Regional Managing Director of NHSI seeking to secure a targeted STF allocation to compensate for

On 7<sup>th</sup> October 2016, NHSI instituted a formal process through which Trusts 'apply' to publish a forecast at variance from their control total. This requires confirmation that a detailed checklist of expected governance has been completed prior to submission. For this Trust, consideration of that checklist has been retrospective, but confirms that all expected steps have been undertaken. Details are included in a separate report to Board and Finance Committee covering the Quarter 2 NHSI returns and Board declarations.

### 4.1 Summary of Financial Performance

	Year to Date - Month 06			Plan Changes		Previous Month YTD	
	PbR Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
<b>Income &amp; Expenditure</b>							
Income	197.45	202.66	5.21	3.12	2.09	0.36	↑
Operating expenses	(193.11)	(198.68)	(5.57)	(5.04)	(0.53)	(0.28)	↑
<b>EBITDA</b>	<b>4.34</b>	<b>3.98</b>	<b>(0.36)</b>	<b>(1.92)</b>	<b>1.56</b>	<b>0.08</b>	↑
Non-operating revenue	0.27	0.45	0.17	0.00	0.17	0.22	↓
Non-operating expenses	(8.28)	(8.14)	0.15	0.00	0.15	(0.05)	↑
<b>Surplus / (Deficit)</b>	<b>(3.67)</b>	<b>(3.71)</b>	<b>(0.04)</b>	<b>(1.92)</b>	<b>1.87</b>	<b>0.25</b>	↑

As at 30 September 2016, the Trust is reporting a £3.71m deficit. This is in line with the original PbR based plan, although at EBITDA level there is a small, £360k adverse variance. Financial performance is considerably better than the revised RSA based plan at both EBITDA, (by £1.56m) and surplus / deficit (by £1.87m) levels.

Within this position, income is ahead of plan by £5.21m based on the PbR plan, and £2.09m based on the RSA plan. Under the terms of the RSA an additional £4.51m has been accrued to reflect the contribution expected from commissioning organisations. The achievement of the financial control total and all performance standards other than RTT in months 5 and 6, has resulted in an additional £1.535m of STF funding that was not predicted in the RSA plan being included, and reflected in this position above. Total STF income received to date is £3.21m.

Operating expenses are showing an adverse position against PBR plan of £5.57m, and £0.53m against the RSA plan.

## 4.2 Income

	Year to Date - Month 06			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
<b>Income by Category</b>							
Healthcare (Acute and Community)	148.92	149.20	0.28	(1.00)	1.29	(0.33)	↑
Social Care	27.75	27.59	(0.16)	(0.61)	0.45	0.41	↑
Other Income	20.78	21.36	0.58	0.01	0.57	0.08	↓
Risk Share Agreement (RSA) Income	0.00	4.51	4.51	4.73	(0.23)	0.20	↓
<b>Total</b>	<b>197.45</b>	<b>202.66</b>	<b>5.21</b>	<b>3.12</b>	<b>2.09</b>	<b>0.36</b>	<b>↑</b>

Healthcare Income is behind the RSA plan by £0.33m (Month 5 : £0.38m). This is principally due to an adverse variance on acute income under NHS England (NHSE) contracts of £0.29m (Month 5 : £0.39m). This reflects a £0.21m (Month 5 : £0.35m) under performance in specialised services – mainly non-elective admissions, Chemotherapy, and Radiotherapy partly offset by over performance in pass-through drugs and Neonatal services. The contract for NHSE Dental services is also underperformed by £0.07m (Month 5 : £0.05m) as a result of reduced follow-up activity, although this is partly offset by over performance in day case and new out-patient activity. The local CCG contract is £0.09m behind plan as a result of penalties being applied through the RSA. The balancing variance of £0.13m is split across other Commissioners. Community Healthcare income is £0.07m higher than the RSA plan due to increased MIU income.

Schedule 7 identifies the key contract activity and finance variances. The gross discount afforded to South Devon and Torbay CCG (CCG), being the difference between PbR priced activity and the base RSA value, stands at £5.8m to 30th September 2016. This is £2m above the planned adjustment and mainly the result of over performance in non-elective services (£2.5m offset by £0.4m increase in the marginal rate adjustment). After a £3.7m contribution under the RSA, the CCG continues to receive a net benefit under the terms of the RSA, now amounting to £2.1m.

STF funding of £3.21m in total has been received and included in the year to date figures. A total of £6.7m is planned under the PbR arrangements for the full year, but was reset at £1.675m in the RSA plan after publication of the rules for receipt by NHS Improvement, with this phased into quarter one to reflect expected achievement. An additional £1.535m has been achieved for Quarter 2 as the financial control total and performance targets, other than RTT in months 5 and 6, have been met.

Social Care income is showing an adverse position against PBR plan of £0.16m, and favourable position against the RSA plan of £0.45m. This is mainly the result of additional Public Health income being received for the Drug and Alcohol Service of £0.48m. This income offsets costs being charged from Devon Partnership Trust, and is therefore neutral to the overall income and expenditure position. Client income is marginally behind plan by £0.02m.

Other income is £0.58m higher than both the PBR and Risk Share plan. This is made up mainly of a favourable variance of miscellaneous revenue (£0.37m), reflecting phasing of care model income, and smaller favourable variances in private patient income (£0.08m), R&D / education (£0.15m), site services (£0.05m). This is offset by a marginal adverse variance in revenue from non patient services £0.07m.

The graph below shows income to date at month 6 against both the PBR and RSA plan



A detailed analysis of income by Commissioner, Business Unit and Healthcare setting can be seen in Schedule 1.

### 4.3 Operating Expenditure

	Year to Date - Month 06			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
<b>Total Operating Expenses Included in EBITDA</b>							
Employee Expenses	112.75	114.32	(1.57)	1.27	(0.31)	(0.47)	↓
Non-Pay Expenses	80.10	83.92	(3.82)	3.77	(0.05)	0.33	↑
PFI / LIFT Expenses	0.27	0.44	(0.18)	0.00	(0.18)	(0.15)	↑
<b>Total</b>	<b>193.11</b>	<b>198.68</b>	<b>(5.57)</b>	<b>5.04</b>	<b>(0.53)</b>	<b>(0.28)</b>	<b>↑</b>

Total Operating Expenditure included in EBITDA is £5.57m higher than the original plan showing an adverse position. Based on the RSA plan this is reduced markedly to an adverse variance of just £0.53m at the half year.

#### Pay

Pay budgets are, in total showing an over-spend of £1.57m against the PbR plan and £0.31m against the RSA plan.

Run rates, based on a normalised position, have shown a reduction for the past three consecutive months in both agency and bank costs, with smaller increases off setting this in substantive pay costs. From the previous month agency and bank costs have reduced by £0.08m and £0.11m respectively, with a small increase in substantive costs of £0.01m. Collectively the rate of spend in September is £400k lower than in June.

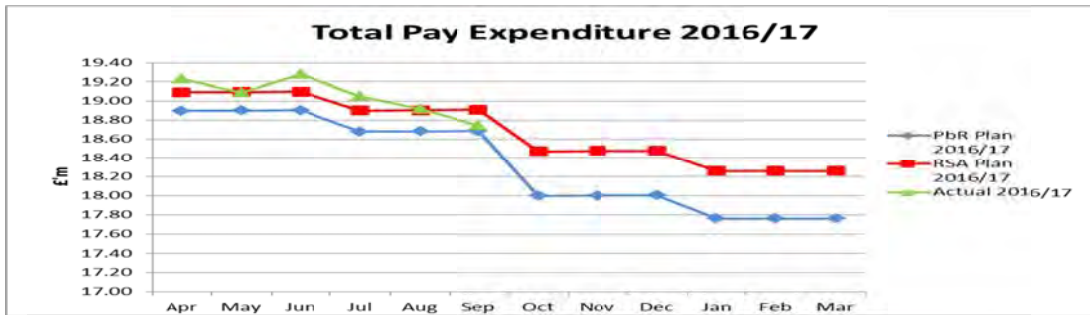
At Service Delivery Unit level we continue to see overspends, particularly in Medicine which is £2.16m overspent against the RSA plan, mainly as a result of agency costs in the Emergency Department, Care of the Elderly, Cancer Services, Heart and Lung, and General Medicine. Women and Child's Health have pay overspends of £0.47m in Obstetrics & Gynaecology and Child Health largely associated with locum, bank and agency costs. Surgical Services are showing overspends in General Surgery mainly



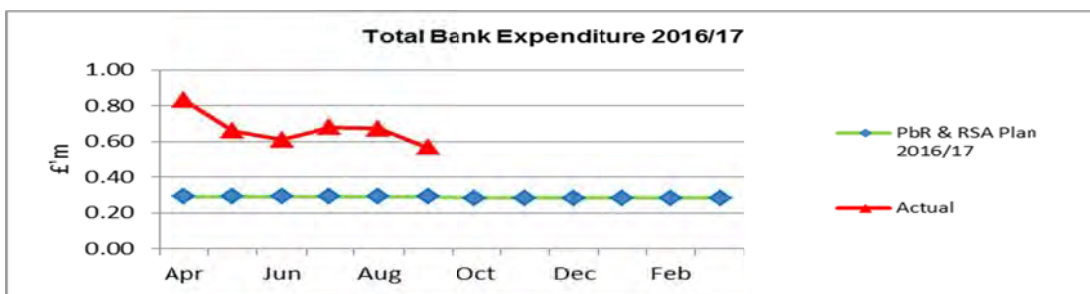
due to agency costs. Estate and Facilities management also have pay overspends of £0.19m mainly in agency and bank costs for hotel services. Adult Social Care is also showing an overspend in pay of £0.42m due to the majority of their CIP target, which was allocated to this category, being yet to be delivered.

There are off-setting pay underspends in Community Services reflecting vacancies across both Torbay and Southern Devon (£0.89), Community Hospitals (£0.11m), Torbay Pharmaceuticals (£0.01m), HQ and Corporate services of £1.93m, mainly in reserves (£1.55m), with the balance due to savings in HIS (£0.26m), Pharmacy (£0.21m) and Strategy (£0.12m).

The graph below shows pay expenditure against both the PBR and RSA plan to date. Further analysis can be seen in 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 6, the YTD position of agency spend is at 5%, 2% over the NHSI target cap target of 3%. A detailed analysis and Improvement Plan can be seen in Schedule 3.

The actual spend on medical staff agency and locums at month 6 is lower by £0.1m from the total planned medical spend.

Nursing agency run rate at M6 is £0.3m in line with M5 due to enhanced control on Agency spending, regular ward review meetings and improved rostering.

The cap set by NHSI is for Agency costs for All Staff Groups; spend to date is £5.5m.

The projected full year spend for Agency in FY 2016/17 is £9.7m which will give the Trust a metric of '3' on Agency use under the 'Use of Resource' risk rating.

Non pay

Non pay is overspending the PbR plan by £3.82m, and £0.05m against the RSA plan. The difference in the variance reflects QIPP targets processed and driving higher variances in the PbR plan.

Clinical supplies are overspent by £0.50m at month 6 against RSA plan. The run rate of spend has increased in month 6 compared to the previous two months by £0.01m mainly in Women and Children's health, and Surgical services, offset by a reduction Pharmacy manufacturing. The main areas of overspend are in Torbay Pharmaceuticals, Medicine, and Women and Children's Health.

Non pass through drugs are overspent £0.28m with the majority in Surgical Services.

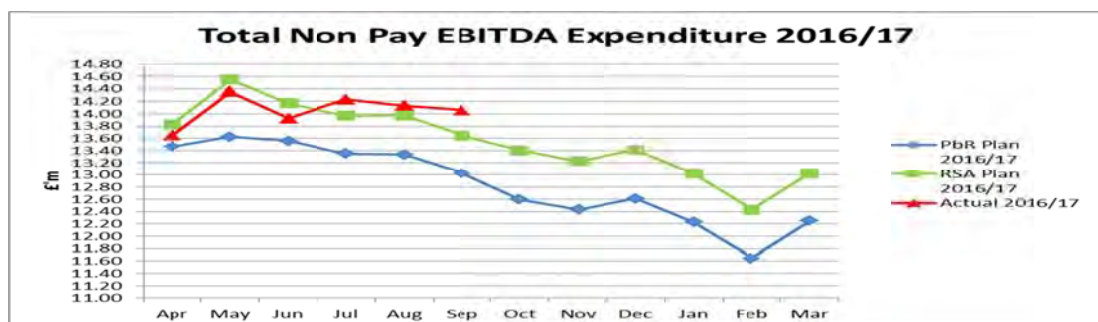
Pass through drugs, bloods and devices are £0.25m over spent against RSA plan. This is neutral to the overall income and expenditure position as additional income is received from NHSE to match these costs.

There is marginal overspend on non clinical supplies of £0.09m

Miscellaneous costs are underspent against the RSA plan by £1.07m. Within this position there are overspends in outsourcing of £1.02m; being £0.86m in Surgery and £0.16m in Women's and Child's Health, and an Adult Social Care overspend of £0.22m. This is offset by underspends in premises costs (£0.83m), Purchase of Health Care services (£0.22m) and other miscellaneous, operational and discretionary costs (£1.24m), mainly due to the release of central reserves.

PFI/LIFT expenses are showing an overspend against plan of £0.18m. This is however offset within the under spend mentioned above in premises costs due to the budget being partly held in that category.

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



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 06			Plan Changes		Previous Month YTD	
	Plan	Actual	Variance	Changes Pbr to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
<b>Non-Operating Expenses</b>							
Donations & Grants	0.19	0.14	(0.06)	0.00	(0.06)	(0.01)	↑
Depreciation & Amortisation	(5.27)	(5.03)	0.24	0.00	0.24	0.08	↑
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	0.08	0.05	(0.03)	0.00	(0.03)	(0.02)	↑
Gains / (Losses) on Asset Disposals	0.00	0.25	0.25	0.00	0.25	0.25	↔
Interest cost	(1.55)	(1.53)	0.01	0.00	0.01	0.01	↔
Public Dividend Capitals	(1.29)	(1.10)	0.19	0.00	0.19	0.16	↑
PFI Contingent Rent	(0.16)	(0.18)	(0.02)	0.00	(0.02)	(0.01)	↑
Corporation Tax expense	(0.01)	(0.01)	0.00	0.00	0.00	0.00	↔
<b>Total</b>	<b>(8.01)</b>	<b>(7.69)</b>	<b>0.32</b>	<b>0.00</b>	<b>0.32</b>	<b>0.17</b>	<b>↑</b>

Depreciation is £0.24m underspent against the RSA Plan, due to the reduction in 2016/17 capital expenditure and changes in the completion dates of capital projects.

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

Gains on Asset Disposals are £0.25m higher than the RSA Plan, primarily due to the £0.26m profit on the sale of the surgical robot.

PDC dividend payable costs are £186k less than plan reflecting the balance sheet impact of the deterioration in the Trust's financial position during 2016/17.

## 4.5 Cost Improvement Programme

### 4.5 Cost Improvement Programme

	2016-17 Position					Memo: 2017-18 Effect of 16-17 Schemes	
	Year to Date - at Month 06			Previous Month YTD		Actual £m	Variance £m
	Plan £m	Actual £m	Variance £m	Variance £m	Change		
<b>Schemes Delivered to Date M1 to M5</b>							
Delivered Schemes : Recurrent	2.45	2.95	(0.50)	(0.33)	↑		
Delivered Schemes : Non-Recurrent	0.00	1.78	(1.78)	(2.06)	↓		
<b>Delivered Schemes : Total</b>	<b>2.45</b>	<b>4.72</b>	<b>(2.27)</b>	<b>(2.39)</b>	<b>↓</b>		

<b>Full Year (Month 1 to 12) Forecast (Risk adjusted) Delivery</b>							
Forecast Schemes : Recurrent 16/17 (See note, below)	13.90	8.09	5.81	6.80	↑	8.09	5.81
Forecast Schemes : (Balance to Full Yr effect of 16/17)- See note below	0.00	-	-	-	-	3.70	(3.70)
Forecast Schemes : Non-Recurrent 16/17	0.00	2.33	(2.33)	(3.00)	↓	0.00	0.00
<b>Total Full Year End forecast Delivery</b>	<b>13.90</b>	<b>10.43</b>					
Forecast 2016-17 Yr end delivery variance			3.47	3.80	↑		
Forecast delivery variance of 2016-17 schemes in 2017-18						11.79	2.11

Note: Further Savings associated with 16-17 recurrent schemes.

Many of our recurrent schemes start part way into the financial year; the Forecast recurrent delivery shown above therefore shows 16-17 benefit. In addition a further £3.7m of recurrent savings, associated with these schemes, will be delivered in 2017-18.



CIP schemes are £2.27m ahead of target to month 6 with the majority of schemes delivering recurrently.

The forecast year end position shows a revised shortfall of £3.47m, against the £13.9m target. This represents a slight improvement compared to last month.

As part of the review of CIP governance and PMO reporting, we are better able to forecast a more accurate year end position. In addition, this report includes the forecast balance to full year effect of 2016/17 recurrent CIP schemes, reducing the recurring shortfall to £2.11m as we move forward in 2017/18.

The transfer of CIP reporting to Smartsheet Programme Management database is complete and actively used to manage project progress and financial performance / delivery. Work is ongoing to close the gap in CIP schemes with deep dives into the schemes by the Efficiency Delivery Group and Finance Committee.

The graph below shows the full year CIP target, and CIP achieved as at month 6



#### 4.6 Balance Sheet

	Year to Date - Month 06			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
<b>Non-Current Assets</b>							
Intangible Assets	9.67	7.92	(1.76)	(0.40)	(1.35)	(0.86)	↓
Property, Plant & Equipment	156.19	152.92	(3.27)	(5.12)	1.85	1.17	↑
On-Balance Sheet PFI	17.11	16.79	(0.32)	(0.20)	(0.12)	(0.10)	↓
Other	1.89	2.08	0.19	(0.24)	0.44	0.44	↔
<b>Total</b>	<b>184.87</b>	<b>179.71</b>	<b>(5.16)</b>	<b>(5.97)</b>	<b>0.81</b>	<b>0.65</b>	<b>↑</b>
<b>Current Assets</b>							
Cash & Cash Equivalents	16.85	14.34	(2.52)	0.95	(3.47)	(2.00)	↓
Other Current Assets	22.75	30.08	7.33	1.49	5.84	7.07	↓
<b>Total</b>	<b>39.60</b>	<b>44.42</b>	<b>4.82</b>	<b>2.45</b>	<b>2.37</b>	<b>5.07</b>	<b>↓</b>
<b>Total Assets</b>	<b>224.47</b>	<b>224.13</b>	<b>(0.34)</b>	<b>(3.52)</b>	<b>3.18</b>	<b>5.73</b>	<b>↓</b>
<b>Current Liabilities</b>							
Loan - DH ITFF	(6.67)	(6.26)	0.41	0.21	0.21	0.25	↓
PFI / LIFT Leases	(0.72)	(0.64)	0.08	0.09	(0.01)	(0.01)	↔
Trade and Other Payables	(29.63)	(31.42)	(1.79)	(0.46)	(1.33)	(5.38)	↑
Other Current Liabilities	(1.65)	(1.72)	(0.07)	(0.04)	(0.03)	(0.19)	↑
<b>Total</b>	<b>(38.66)</b>	<b>(40.04)</b>	<b>(1.37)</b>	<b>(0.21)</b>	<b>(1.17)</b>	<b>(5.33)</b>	<b>↑</b>
<b>Net Current assets/(liabilities)</b>	<b>0.94</b>	<b>4.38</b>	<b>3.44</b>	<b>2.24</b>	<b>1.20</b>	<b>(0.26)</b>	<b>↑</b>
<b>Non-Current Liabilities</b>							
Loan - DH ITFF	(62.29)	(63.17)	(0.88)	(0.65)	(0.23)	(0.27)	↑
PFI / LIFT Leases	(20.21)	(20.69)	(0.47)	(0.42)	(0.05)	0.00	↓
Other Non-Current Liabilities	(3.97)	(3.79)	0.18	0.03	0.15	0.13	↑
<b>Total</b>	<b>(86.47)</b>	<b>(87.65)</b>	<b>(1.18)</b>	<b>(1.04)</b>	<b>(0.14)</b>	<b>(2.41)</b>	<b>↑</b>
<b>Total Assets Employed</b>	<b>99.34</b>	<b>96.44</b>	<b>(2.89)</b>	<b>(4.77)</b>	<b>1.88</b>	<b>0.25</b>	<b>↑</b>
<b>Reserves</b>							
<b>Total</b>	<b>99.34</b>	<b>96.44</b>	<b>(2.89)</b>	<b>(4.77)</b>	<b>1.88</b>	<b>0.25</b>	<b>↑</b>

The RSA Plan has been updated to incorporate the planned reductions in capital expenditure and loan drawdown. The previous month's variances have been recalculated against the updated RSA Plan, in order to provide a meaningful comparison.

- Intangible Assets, Property, Plant & Equipment and PFI are £0.4m favourable, largely due to depreciation being lower than plan.
- Cash is £3.5m adverse to plan, largely due to other current assets being £5.8m higher than plan, partly offset by current liabilities £1.2m higher than Plan.
- Other Current Assets are £5.8m higher than plan. Significant elements include: Q2 STF income £1.5m; NHS England income paid in arrears £1.5m; NEW Devon MIU income £0.5m; increase in stock £0.4m; 2015/16 income adjustments £0.3m.
- Trade and other payables are £1.3m higher than Plan. Significant elements include: payments not collected by NHSLA £2.0m, partly offset by capital creditor lower than planned £0.9m.

#### 4.7 Capital

	Year to date - Based upon Annual Plan (April 16)			Year to date - Based upon RSA Plan (RSA Plan phasing requires review *)			Full year Annual Plan versus Revised Forecast	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m
Capital Programme	12.71	8.51	(4.20)	8.37	8.51	0.14	36.90	21.91

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 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 have been developed in the event that these loan applications are unsuccessful and these downside plans are now being Quality Impact Assessed. The outcome of this assessment will be reported to a future Board meeting .

Capital expenditure projects are approved in line with the Trust's Investment policy. The capital prioritisation process takes place at the Senior Business Management Team meetings and is overseen by the Trust's Executive Directors. Capital schemes are prioritised based upon Risk Scores and financial payback opportunities.

Variances in planned capital expenditure by scheme, and funding sources available can be seen in Schedule 6.

#### 4.8 Forecast

The Trust is currently forecasting to achieve the RSA plan at £8.6m deficit , after commissioner contributions. There do however remain a number of risks in delivering this position, most significantly the remaining gap in the CIP programme described earlier in this paper. Risks of escalating spend over the forthcoming winter and any impact, in excess of the rates currently proposed, arising from Torbay Council's consultation on care home fees are others that will need to be carefully managed throughout the remainder of the financial year.

## 4.9 Activity report

The Trust level Contract Monitoring Schedule showing activity and income across all commissioners is included in the data book as **Schedule 7** within the Financial Framework section.

The first section shows admitted patient care (APC) and key variances from plan are elective inpatients 9% under plan from 10% last month and non-electives 8% over plan from 7.8% last month. The two main specialties underperforming in inpatients continue to be are gynaecology and upper GI. The position on non-electives reflects the additional pressure the system has been under as well as the additional capacity now available on the EAU4 ward since the Acute Medical Unit (AMU) was moved to level 2.

The second section shows outpatients and here the biggest variance is on first attendances which are nearly 3.2% over plan. This over performance includes continued underperformance on neurology patients than planned being seen. The main areas of over performance are orthopaedics and dermatology. Follow ups are 1.9% over plan and again orthopaedics is one of the main contributors along with ophthalmology. Despite this additional activity the Board will be aware that there are still some significant waits for patients on the follow up lists. A&E activity is very close to plan at around 0.6% under plan.

The activities below the payment by results (PBR) section are contracted in the basis of locally agreed prices. These are all the clinical activity areas where a PBR tariff does not exist or it has been agreed with commissioners that local pathways are not appropriate for the application of a PBR tariff. Acute Medical Unit (AMU) and Clinical Decision Unit (CDU) activity is included here. Whilst AMU activity is very close to the planned levels the activity in the CDU is significantly over plan. In common with the additional activity on EAU4, in part this will be a reflection of pressures in the system. However the CDU model was under development at the point that the plan was being set and therefore the historical or baseline level of activity may have been understated in the plan.

## 5 Contract Framework

The standards set out below are the requirements agreed by 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 the relevant 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.

STF trajectories and performance												
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
<b>4 hour standard trajectory (standard 95%)</b>	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%	92.80%	92.60%						
<b>RTT - incomplete pathways trajectory (standard 92%)</b>	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%	90.50%	89.34%						
<b>Diagnostics &lt; 6 weeks wait trajectory (standard 99%)</b>	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%	99.35%	98.25%						
<b>Cancer 62 day trajectory (standard 85%)</b>	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%	90.4%	92.38%	87.92%	88.48%	87.26%						

### Notes:

- A+E / MIU (type 1 and 2) waiting times < 4 hours (Target trajectory for September 92.0% achieved 92.6%) - **Achieving trajectory**
- RTT % patients waiting under 18 weeks (Target trajectory for September 92.6%) – **Trajectory and standard not met in September (89.3%)**
- Diagnostic waiting times < 6 weeks (Standard 99.0%) - Planned delivery of 99% from July. **Standard not met in September (98.25%)**
- Cancer 62 day referral to treatment (Standard 85% some months vary due to low planning numbers) - Standard delivered from April 2016. **Achieving standard in September (87.3%)**

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

**RAG RATING: RED**

At the end of September 10 patients are recorded as waiting over 52 weeks for treatment. Last month 8 patients were waiting over 52 weeks, in July there were 11 and prior to this the numbers had increased gradually from zero at the start of the year. Of these 9 patients are waiting for inpatient admission for surgery within Upper GI surgery and one patient is waiting for a colorectal outpatient appointment as the next stage of their pathway to treatment. It is noted that 5 of these patients were also waiting and recorded in last month's report. Exception reports in the form of "root cause analysis" are being completed against all of these patients to ensure reasons for delay are understood as well as any potential harm identified. These reports are shared with the commissioner performance and clinical governance teams. The trajectory for the number of patients waiting over 52 weeks at the month end is zero all year.

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

The next quarterly report will be available for M7 Board report

### 5.4 Diagnostic tests waiting over 6 week

**RAG RATING: RED**

In September the standard for diagnostic waits has not been achieved with 1.7% (59 patients) waiting over 6 weeks at the end of the month. Of the total waiting over 6 weeks at month end 23 in MRI 15 Audiology and 10 CT.

**5.5 Ambulance handover delays > 60 minutes**

**RAG RATING: AMBER**

In September three patients are reported against this standard, the last 4 months has seen low levels or no patients reported. This is a significant improvement from the start of the calendar year when up to 35 patients were reported as waiting over 60 minutes (Feb 16). Root cause analysis for these events is being completed.

**5.6 12 hour Trolley waits**

**RAG RATING: RED**

In September there were two validated 12 hour trolley waits reported. Root cause analysis for these events is being completed.

**5.7 Cancelled operations**

**RAG RATING: RED**

Operations cancelled on the day of admission by the hospital remain above the national standard of 0.8% with 1.0% (36 patients) cancelled by hospital on the day of surgery. The number of patients cancelled each month has remained fairly static over the course of the year so far. In addition in September 4 patients were not re-admitted within 28 days of cancellation.

Reason for cancellation September 2016	
No Op time	10
Trauma / Priority patient	9
workforce	6
No bed	6
process / equipment	5
Total	36

**5.8 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 September 57.0% (target 77%) were sent to GPs within 24 hours on weekdays and 22.8% (target 60%) on the weekends.

The shortened version of the CPS template was introduced on 5<sup>th</sup> August and feedback on its functionality is good. It has been agreed that completion of CPS prior to discharge on week days will be mandatory after discussion with SDUs at the Clinical Management Group meeting on 3 November. The action plan includes a shared responsibility for timely completion between Medical, senior nursing and administrative staff in all clinical areas. The Medical Director is leading communication with ward based staff. Improved performance is expected in December 2016. Improvement will be stepwise as different methods will be required to improve weekend performance.

## 6. Community and Social Care Framework

### 6.1 Delayed discharges.

**RAG RATING: GREEN**

In September the number of community hospital days for patients delayed in their discharge was recorded as 110 days. This is the lowest number of days lost this year.

Month (2016)	Acute	Non-Acute	Total
APRIL	8	351	<b>359</b>
MAY	58	166	<b>224</b>
JUNE	52	355	<b>407</b>
JULY	70	422	<b>492</b>
AUGUST	92	425	<b>517</b>
SEPTEMBER	52	110	<b>162</b>

There are 29 fewer community hospital beds available as a result of the challenges of being able to safely staff the beds. This has increased the focus on safe patient flow through the fewer beds that are available and may have contributed to the reduction in delays. However the number of patients transferred from acute wards and the average length of stay for patients in community beds remained static over this period.

### 6.2 Child and Adolescent Mental Health Patients (CAMHS)

**RAG RATING: RED**

At the end of September 79% of CAMHS patients waiting for treatment had waited 18 weeks or less. The total number of patients waiting for treatment (38) has decreased by 14 from last month.

The service continues to prioritise cases on clinical need and priority and has robust processes in place to ensure all urgent referrals are seen within 1 week. In September 100% of urgent referrals achieved this standard.

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	Aug	Sep
Number of patients waiting longer than 18 weeks at month end*	7	6	5	6	11	8
Longest wait (in weeks)	28	26	24	21	25	28
Total Number of patients waiting for treatment at month end	61	60	53	47	51	38
RTT % incomplete (Target 92%)	89%	90%	91%	87%	78%	79%

## 7. Workforce Key Performance Indicators

Performance against a wide range of workforce key performance indicators is reported at service delivery unit and department level to all managers. These key performance indicators are subject to review at the Trusts performance review meetings and with HR Managers. Appendix 5 provides a detailed breakdown by service delivery unit and department of appraisal completions, sickness absence levels and statutory and mandatory training compliance. The following highlights progress at trust level against four workforce key performance indicators regularly included in Board reports.

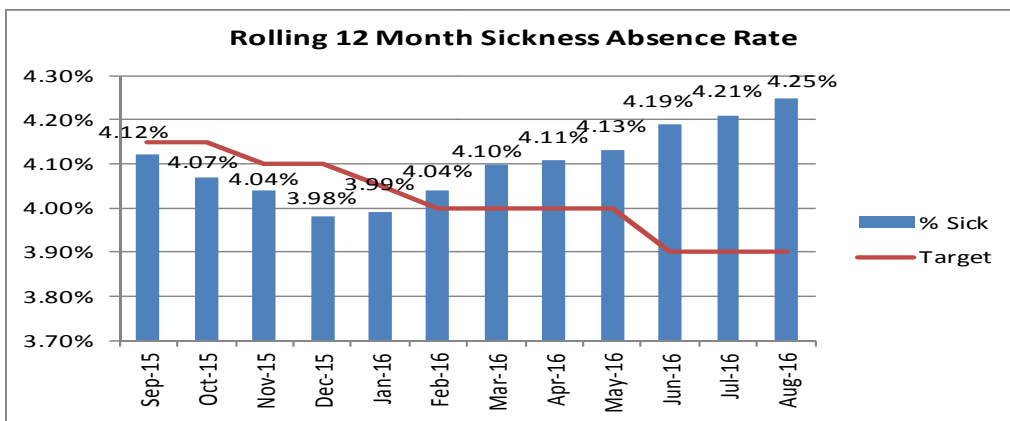


### 7.1 Staff Sickness Absence Rate

**RAG RATING: RED**

The data for sickness absence at the end of August 2016 indicates a rolling 12 month figure of 4.25%. This rate continues to be above the Trust target which was 3.90% at the end of August. Long term sickness makes up 66.4% of total sickness absence. An updated action plan to reduce sickness is being drafted that includes:

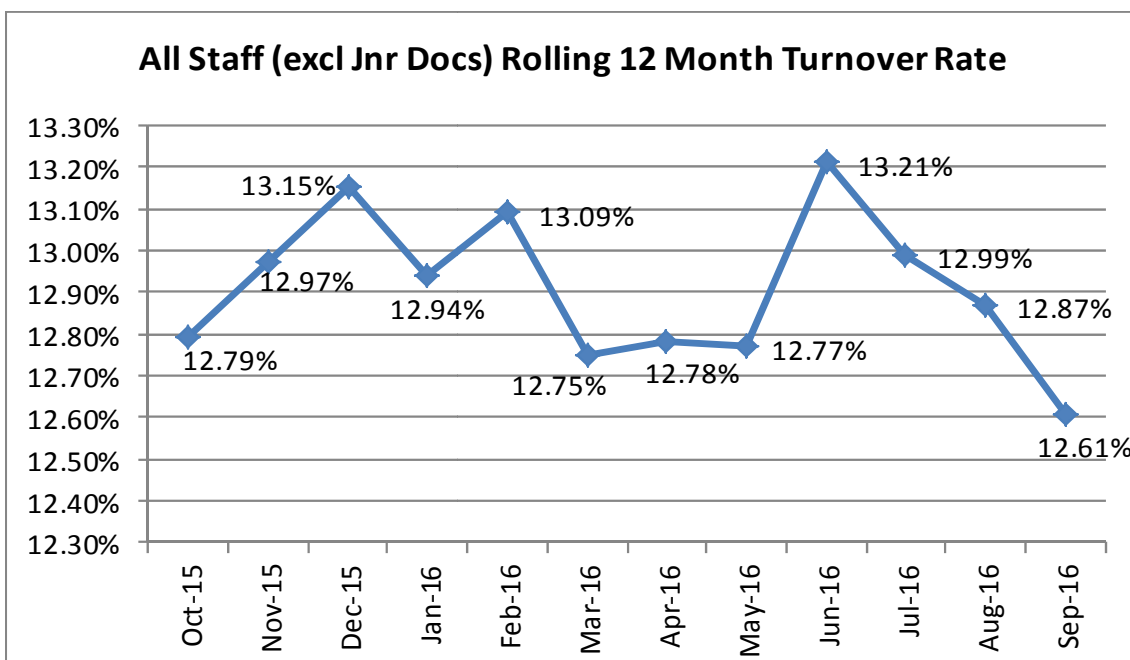
- Bite size training sessions over the coming months for managers
- Asking Senior Managers the top 3 things to support them in reducing their sickness absence rates in their areas of responsibility
- Fostering a robust performance management culture that monitors progress to improve sickness absence management



### 7.3 Turnover (excluding Junior Doctors)

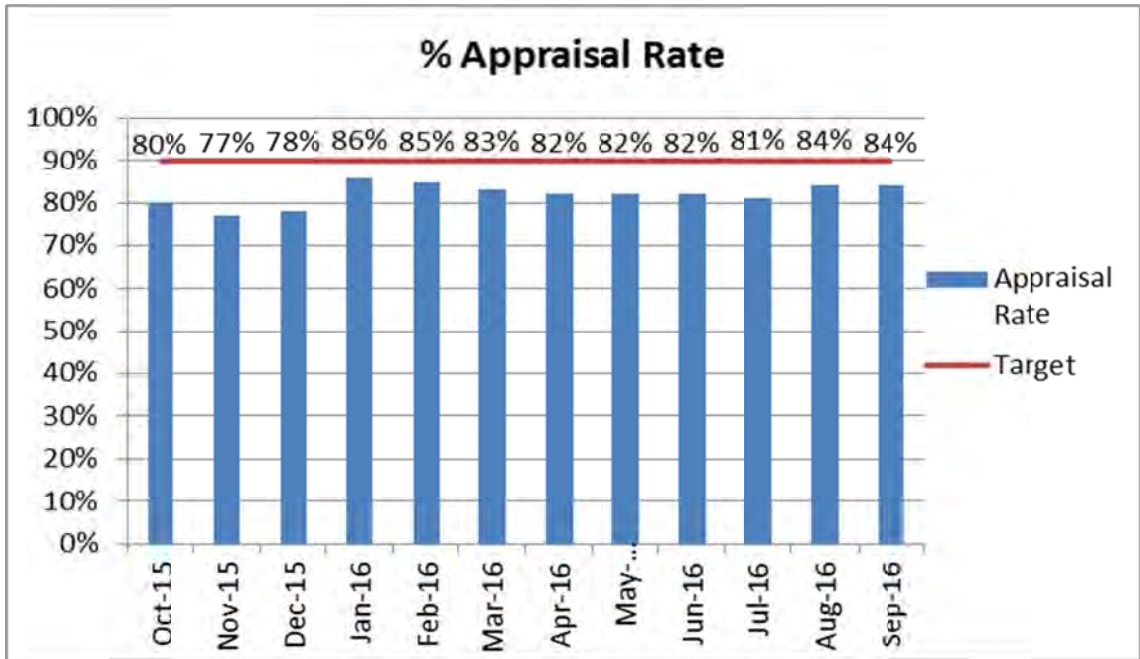
**RAG RATING: GREEN**

The graph below shows that the Trusts turnover is at its lowest since the formation of TSDFT in October 2015 and is within the target range of 10% to 14%. Never the less the recruitment challenge to replace leavers from key staff groups remains challenging. This includes Registered Nurses for whom the turnover rate was 10.95% at the end of September 2016.



**7.4 Appraisal Rate**  
**RAG RATING: AMBER**

The graph below shows that appraisal rate of 84% achieved in August 2016 has been maintained in September 2016 but remains below the target of 90%. Managers and staff are regularly reminded of the importance of an annual appraisal including by regular reports and individual emails.



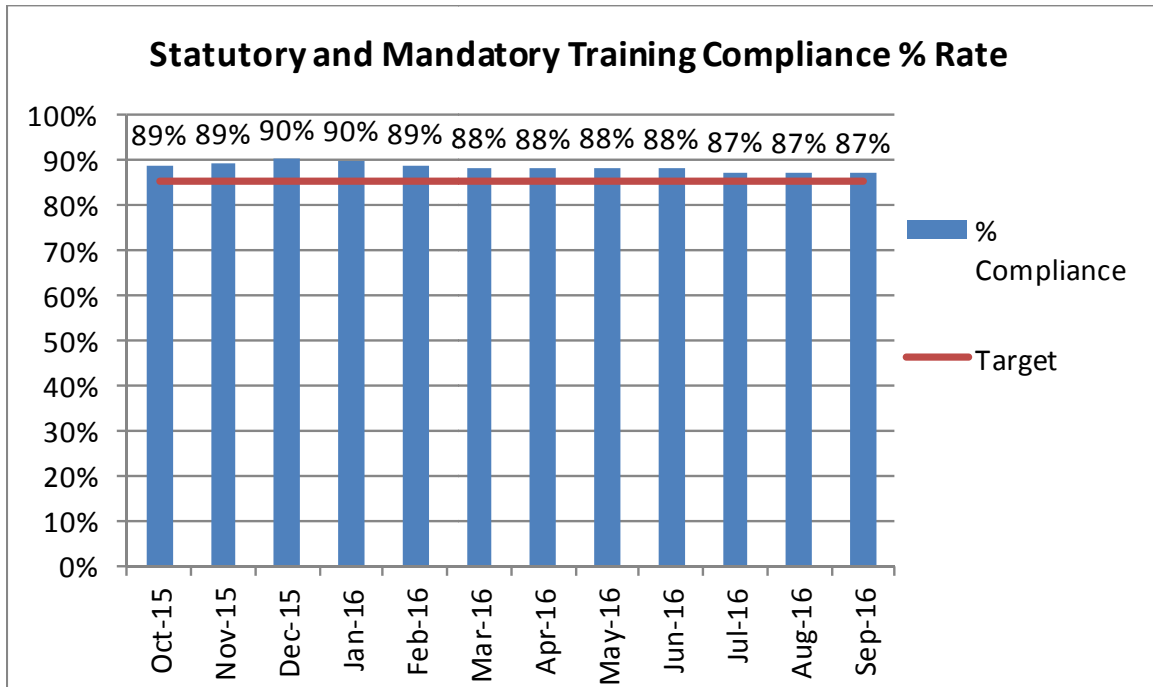
**7.5 Statutory and mandatory training Compliance**  
**RAG RATING: GREEN**

The Trust has set a target of 85% compliance as an average of 9 key statutory and mandatory training modules. The graph below shows that the current rate of 87% is above target but some individual modules remain below their target as detailed in the table below:

Module	Target	Performance
Information Governance Training	95% or above	87%
Fire Training	85% or above	84%
Infection Control	85% or above	82%

Low compliant areas continue to be contacted and support offered to increase their compliance rates.





**8. Supporting documents**

Appendix 1: Month 6 Quality, Performance and Finance Dashboard

Appendix 2: Month 6 Quality and Performance Data book including financial schedules

Appendix 3: CIP portfolio

Appendix 4: RTT report

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17
<b>QUALITY FRAMEWORK</b>																
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%	96.7%	95.9%	96.5%
1	Reported Incidents - Major + Catastrophic *	<6	4	2	2	3	2	0	1	4	5	2	4	0	1	16
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)	2	2	0	0	3	4	5	0	2	1	1	1		5
1	Never Events	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
1	SIRI - Reportable incidents	0							14	7	9	4	4	3	2	29
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		1	2	1	2	2	0	2	0	0	0	0	0	2
1	Formal Complaints - Number Received *	<60	32	31	35	27	37	43	32	29	42	40	24	37	35	207
1	VTE - Risk assessment on admission - (Acute)	>95%	94.6%	96.2%	96.1%	95.8%	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%	93.7%
1	VTE - Risk assessment on admission - (Community)	>95%	97.1%	91.7%	100.0%	100.0%	98.7%	88.8%	90.4%	92.5%	92.9%	91.2%	92.2%	97.5%	97.6%	93.9%
1	Medication errors resulting in moderate to catastrophic harm	0				0	0	0	0	2	1	0	0	0	1	4
1	Medication errors - Total reported incidents (trust at fault)	N/A				46	39	47	42	46	39	62	37	26	252	
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears (to June 16 using 14/15 benchmark. From June 16 using 15/16 benchmark)	<100%	98.7%	94.6%	84.8%	86.4%	92.8%	111.0%	98.4%	96.7%	94.5%	96.6%				96.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		101.0%	98.1%	95.6%	102.8%	101.1%	101.1%	101.2%	101.4%	102.8%	100.5%	95.6%	96.5%	99.7%
1	Safer Staffing - ICO - Nighttime (registered nurses / midwives)	90%-110%		98.8%	96.7%	98.8%	101.5%	100.8%	102.4%	97.3%	96.2%	97.5%	97.0%	94.6%	93.1%	96.0%
1	Infection Control - Bed Closures - (Acute) *	<100	18	54	92	36	12	57	38	236	56	68	28	34	6	428
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%	72.2%	85.7%	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.1%	80.0%
1	Stroke patients spending 90% of time on a stroke ward	>80%	84.0%	79.0%	85.0%	82.0%	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%	75.8%
1	Dementia - Find - monthly report	>90%	71.4%	74.4%	73.5%	65.5%	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	29.2%	31.6%	33.7%
1	Follow ups 6 weeks past to be seen date	3500	4873	4731	4542	5090	5291	4938	5732	6082	6073	6219	6601	6919	6533	6533

**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

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17
<b>NHS I COMPLIANCE GOVERNANCE</b>																
1	Overall Quarterly NHS I Compliance Framework Score	N/A	1			2			2	2	1	1	2	3	4	
1	A&E - patients seen within 4 hours [STF]	>95%	90.2%	91.4%	87.9%	85.3%	81.8%	82.0%	84.9%	89.4%	87.4%	91.6%	92.3%	92.9%	92.6%	91.1%
	A&E - trajectory [STF]	>92%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%
1	Referral to treatment - % Incomplete pathways <18 wks [STF]	>92%	92.1%	91.5%	91.2%	90.8%	91.2%	91.4%	91.8%	92.1%	92.5%	92.0%	91.4%	90.5%	89.3%	89.3%
	RTT Trajectory [STF]		90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	91.2%	91.3%	92.0%	92.6%	92.9%	92.9%
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<18 (year)	2	0	1	0	0	0	0	1	1	1	2	1	1	7
1	Cancer - Two week wait from referral to date 1st seen	>93%	97.6%	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.2%	91.2%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	97.7%	97.8%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	93.6%	96.7%
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%	99.0%	100.0%	98.9%	99.6%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%	96.6%	97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.5%	96.4%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%	97.4%	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	95.2%
1	Cancer - 62-day wait for first treatment - 2ww referral [STF]	>85%	87.8%	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.3%	89.2%
1	Cancer - 62-day wait for first treatment - screening	>90%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%	95.2%

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17
<b>NHS 1 COMPLIANCE FINANCIAL SUSTAINABILITY</b>																
4	Capital Service Cover	2	1			1			1	1	1	1	1	1	1	1
	Capital Service Cover - Plan										1	1	1	1	1	1
4	Liquidity	3	2			4			4	4	4	4	4	3	3	3
	Liquidity - Plan										4	4	3	3	3	3
4	I&E Margin	4	2			1			1	1	1	1	1	1	1	1
	I&E Margin - Plan										1	1	1	1	1	1
4	I&E Margin Variance From Plan	3	4			4			3	3	3	3	3	3	4	4
	I&E Margin Variance From Plan - Plan										3	3	3	3	4	3
4	Overall Financial Sustainability Risk Rating	3	2			2			2	2	2	2	2	2	2	2
	Overall Financial Sustainability Risk Rating - Plan										2	2	2	2	2	2
<b>FINANCE INDICATORS</b>																
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)										241	86	499	-950	-823	-361
4	Agency - Variance to NHSI cap										-1.23%	-2.06%	-2.39%	-2.00%	-1.87%	-1.56%
4	CIP - Variance from PBR plan - cumulative (£'000's)										-116	-281	1010	800	2381	1685
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)										1189	2686	3113	3699	3104	4195
4	Distance from NHSI Control total (£'000's)										329	1095	375	-354	320	14
4	Risk Share actual income to date cumulative (£'000's)										985	2180	2485	3504	4156	4505

\* For cumulative 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.

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17
<b>CONTRACTUAL FRAMEWORK</b>																
1	Diagnostic tests longer than the 6 week standard [STF]	<1%	2.7%	0.4%	0.8%	1.1%	2.8%	1.0%	1.6%	1.5%	0.9%	1.1%	0.9%	0.7%	1.7%	1.2%
	Diagnostic trajectory [STF]		1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.02%	1.04%	0.99%	0.97%	0.95%	0.95%
1	RTT 52 week wait incomplete pathway	0	1	1	1	2	3	5	4	4	6	5	11	8	10	10
1	Mixed sex accomodation breaches of standard	0	3	1	0	0	0	0	1	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%	0.8%	1.0%	1.0%	1.4%	1.3%	1.4%	0.9%	1.5%	1.4%	1.6%	0.9%	1.0%	1.0%	1.2%
1	Cancelled patients not treated within 28 days of cancellation *	0	0	0	2	3	2	9	10	4	9	6	9	3	4	35
1	Ambulance handover delays > 30 minutes	0	86	42	103	75	113	234	170	102	111	37	54	36	24	364
	Handovers > 30 minutes trajectory *		50	50	50	50	50	50	50	50	40	35	25	20	20	190
1	Ambulance handover delays > 60 minutes	0	2	2	2	5	2	35	16	26	6	0	1	2	3	38
1	A&E - patients seen within 4 hours DGH only	>95%	90.2%	87.8%	83.3%	79.7%	74.6%	74.4%	77.8%	84.5%	81.2%	87.2%	88.3%	88.7%	88.6%	86.5%
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	3	1	13	10	1	2	0	0	0	0	2	4
1	Number of Clostridium Difficile cases - (Acute) *	<3	3	1	2	1	0	1	3	1	4	2	2	3	2	14
1	Number of Clostridium Difficile cases - (Community)	0	0	0	0	1	1	0	0	0	1	2	1	0	0	4
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%	61.5%	62.4%	61.8%	55.0%	58.5%	58.5%	54.0%	63.6%	56.2%	59.4%	51.2%	54.8%	57.0%	56.9%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%	24.3%	26.7%	30.2%	23.8%	35.3%	22.0%	24.6%	25.0%	22.4%	35.0%	20.4%	24.0%	22.8%	24.7%
1	Clinic letters timeliness - % specialties within 4 working days	>80%	59.1%	59.1%	72.7%	77.3%	72.7%	77.3%	86.4%	81.8%	72.7%	81.8%	81.8%	81.8%	72.7%	78.8%

**NOTE**

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

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17	
<b>COMMUNITY &amp; SOCIAL CARE FRAMEWORK</b>																	
1	Number of Delayed Discharges *	2216 (full year)		317	211	467	327	325	415	338	359	224	407	492	517	162	2161
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		69.6%	69.9%	71.0%	67.0%	68.8%	68.8%	68.9%	85.7%	78.7%	72.1%	72.9%	73.7%	72.3%	72.3%
3	Clients receiving Self Directed Care	>90%		93.1%	92.8%	92.5%	92.7%	92.1%	92.9%	93.6%	92.5%	91.6%	91.2%	91.1%	91.7%	91.7%	91.7%
2	Carers Assessments Completed year to date	40%		27.4%	32.1%	35.9%	38.2%	41.2%	42.8%	43.3%	5.9%	11.9%	18.6%	21.9%	25.2%	28.5%	28.5%
	Carers Assessment trajectory	(Year end)		20.0%	23.3%	26.7%	30.0%	33.3%	36.7%	40.0%	3.3%	6.7%	10.0%	13.3%	16.7%	20.0%	20.0%
3	Number of Permanent Care Home Placements	<=617		639	645	630	636	637	640	635	628	624	626	614	626	635	635
	Number of Permanent Care Home Placements trajectory	(Year end)		642	640	638	636	634	632	630	634	632	631	629	628	626	626
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		199	216	216	212	174	147	139	131	137	131	117	126		140
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET		231			303			451			39				39
3	% OCU in Effective Drug Treatment (reported quarterly in arrears)	NONE SET		6.3%			6.4%			8.5%			9.2%				9.2%
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%	100.0%
1	Bed Occupancy	80% - 90%		89.9%	90.3%	92.7%	92.4%	94.8%	92.5%	91.9%	92.8%	89.8%	86.4%	92.7%	90.2%	92.6%	92.6%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%										90.0%	90.6%	87.2%	78.4%	78.9%	78.9%
<b>CHANGE FRAMEWORK</b>																	
3	Number of Emergency Admissions - (Acute)			2694	2776	2760	2708	2609	2740	2945	2797	2974	2946	3077	2935	2997	17726
3	Average Length of Stay - Emergency Admissions - (Acute)			3.2	3.2	3.4	3.5	3.5	3.3	3.4	3.7	3.3	3.2	3.0	3.4	3.3	3.3
3	Hospital Stays > 30 Days - (Acute)			28	17	18	21	21	28	29	35	34	26	21	26	24	166

Corporate Objective	Target 2016/2017	13 month trend	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Year to date 2016/17
<b>WORKFORCE MANAGEMENT FRAMEWORK</b>																
2	Staff Vacancy Rate (excl temp workforce and additional hours)	<5%		6.40%	6.60%	6.80%	7.50%	6.80%	7.00%	7.45%	7.92%	7.99%	7.97%	7.71%		
2	Staff sickness / Absence (1 month arrears)	<3.8%		4.10%	4.10%	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	4.25%
2	Appraisal Completeness	>90%		84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%
2	Mandatory Training Compliance	>85%		87.00%	89.00%	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%			12.97%	12.79%	13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.87%	12.61%

# Performance & Quality Databook

Month 6 September 2016



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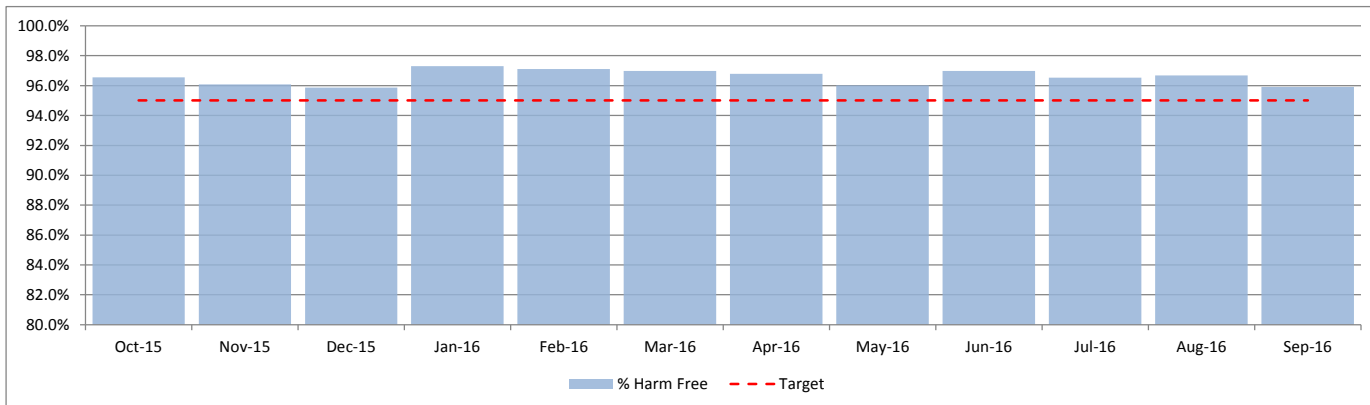
# QUALITY FRAMEWORK

Month 6 September 2016

QUALITY FRAMEWORK

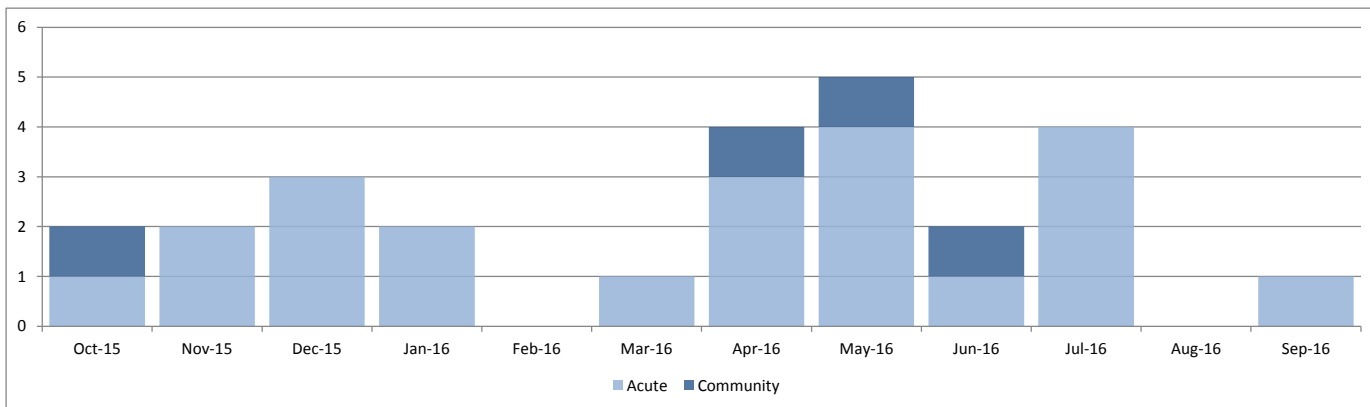
**Harm Free - Trust Total**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients		1044	994	1109	1075	1057	1027	1056	1093	1040	1083	1027
Harm Free		1003	953	1079	1044	1025	994	1014	1060	1004	1047	985
% Harm Free	96.5%	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



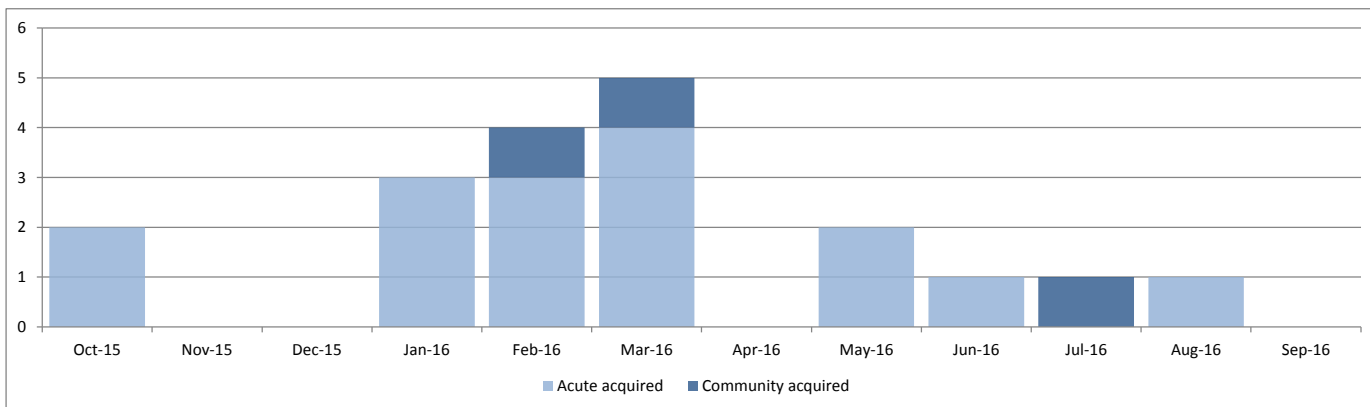
**Reported Incidents - Major and Catastrophic**

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



**New Pressure Ulcers - Categories 3 and 4 (avoidable)**

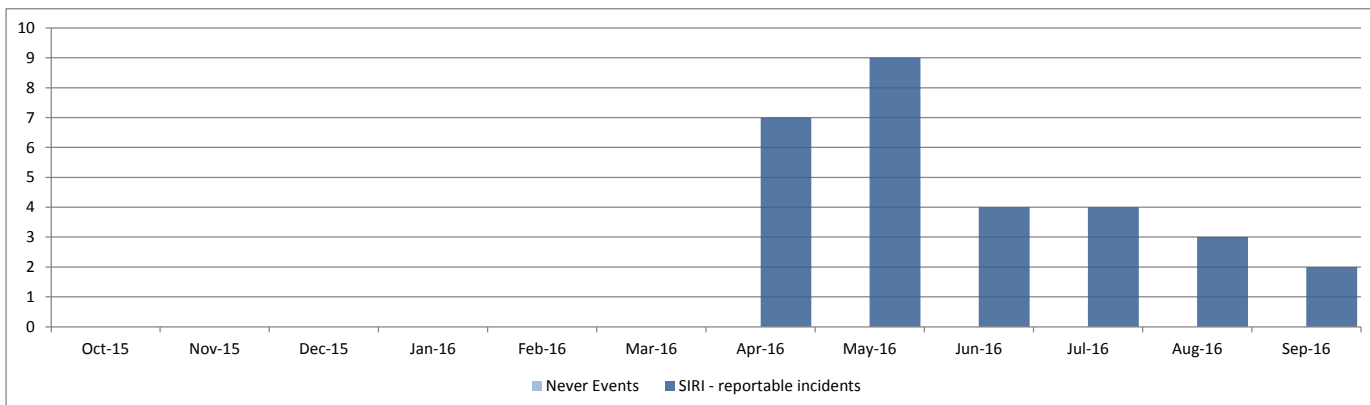
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute acquired	2	0	0	3	3	4	0	2	1	0	1	
Community acquired	0	0	0	0	1	1	0	0	0	1	0	



QUALITY FRAMEWORK

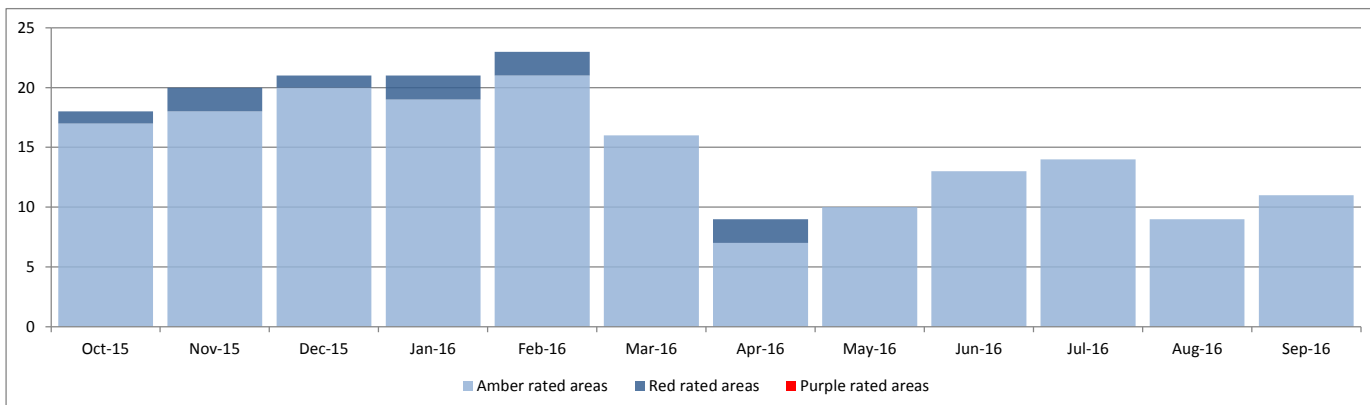
**Never events & SIRI**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Never Events	0	0	0	0	0	0	0	0	0	0	0	0
SIRI - reportable incidents							7	9	4	4	3	2



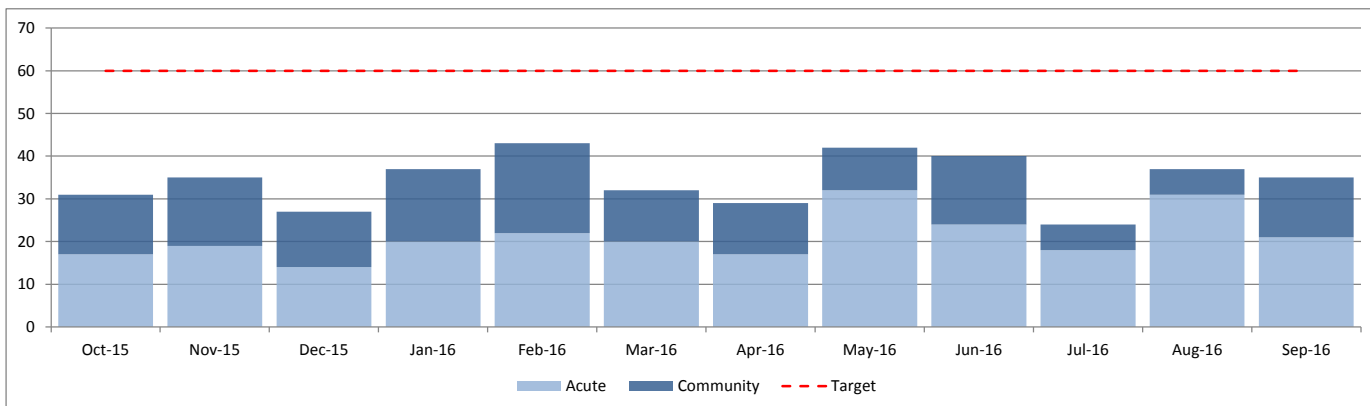
**Quality Effectiveness Safety Trigger Tool (QUEST)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Purple rated areas	0	0	0	0	0	0	0	0	0	0	0	0
Red rated areas	1	2	1	2	2	0	2	0	0	0	0	0
Amber rated areas	17	18	20	19	21	16	7	10	13	14	9	11



**Formal complaints**

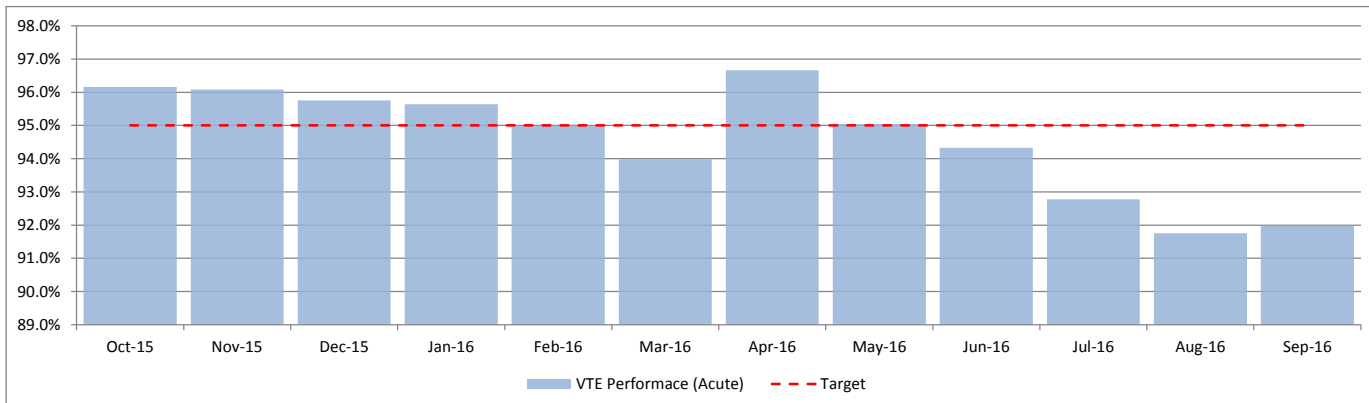
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute	17	19	14	20	22	20	17	32	24	18	31	21
Community	14	16	13	17	21	12	12	10	16	6	6	14
Total	31	35	27	37	43	32	29	42	40	24	37	35
Target	60	60	60	60	60	60	60	60	60	60	60	60



QUALITY FRAMEWORK

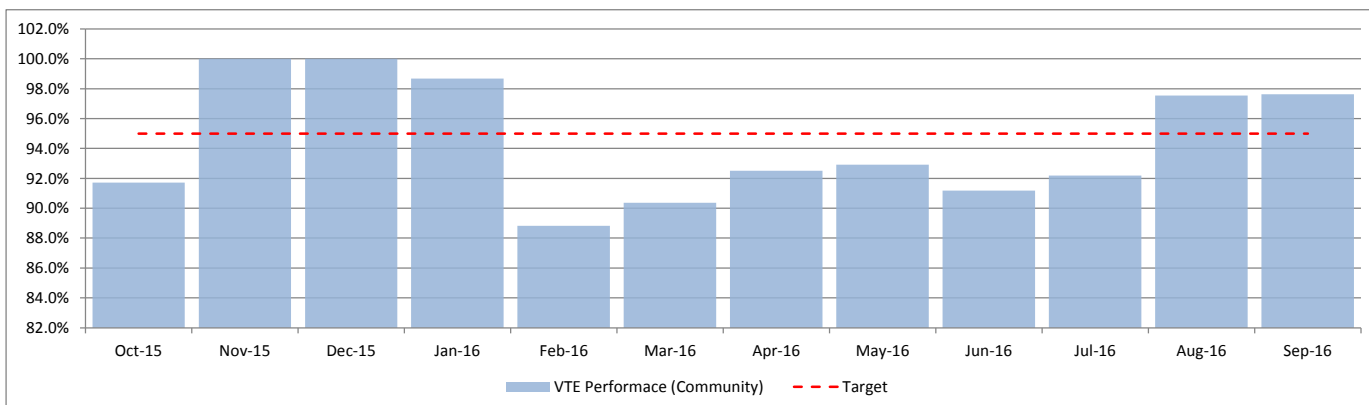
**VTE Risk assessment on admission - (Acute)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
VTE Numerator	5738	5593	5352	5653	5424	5573	5591	5883	5885	5757	5651	5737
VTE Denominator	5967	5821	5589	5911	5710	5930	5784	6190	6239	6205	6159	6237
VTE Performance (Acute)	96.2%	96.1%	95.8%	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



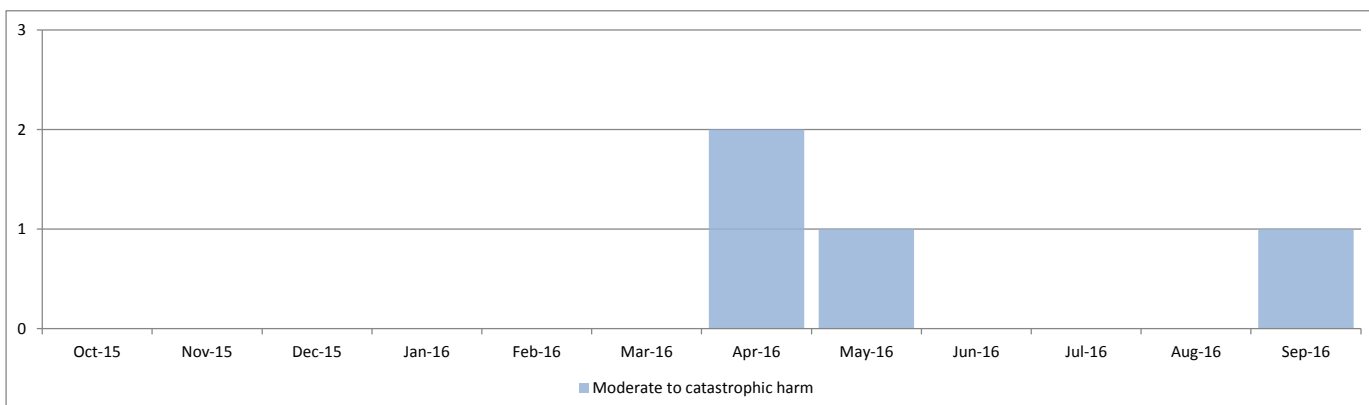
**VTE Risk assessment on admission - (Community)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
VTE Numerator	133	135	137	148	135	122	136	131	124	118	119	123
VTE Denominator	145	135	137	150	152	135	147	141	136	128	122	126
VTE Performance (Community)	91.7%	100.0%	100.0%	98.7%	88.8%	90.4%	92.5%	92.9%	91.2%	92.2%	97.5%	97.6%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



**Medication Errors Resulting in Moderate to Catastrophic Harm**

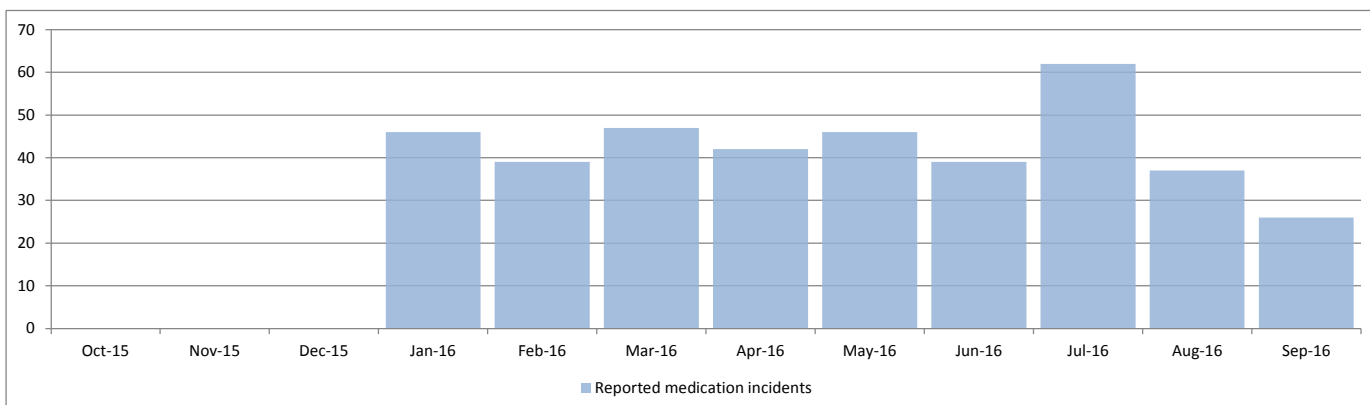
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Moderate to catastrophic harm	n/a	n/a	n/a	0	0	0	2	1	0	0	0	1



QUALITY FRAMEWORK

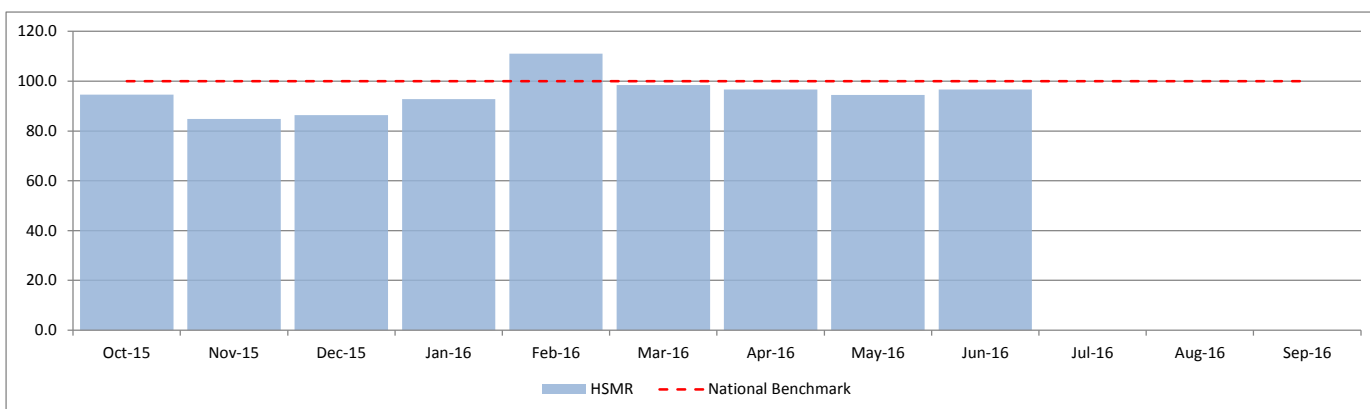
**Medication Errors - Reported incidents (trust at fault)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Reported medication incidents	n/a	n/a	n/a	46	39	47	42	46	39	62	37	26



**Hospital Standardised Mortality Rate (HSMR) national benchmark = 100**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
HSMR	94.6	84.8	86.4	92.8	111.0	98.4	96.7	94.5	96.6			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100



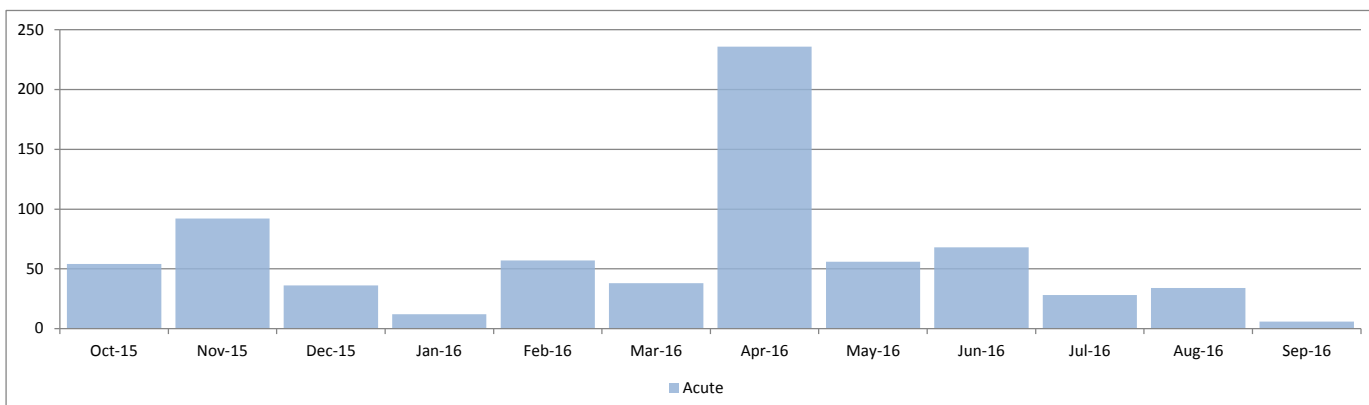
**Safer Staffing Levels**

Site	Day		Night	
	Average fill rate - registered nurses / midwives	Average fill rate - care staff	Average fill rate - registered nurses / midwives	Average fill rate - care staff
Ashburton+Buckfastleigh Hospital	100.0%	112.2%	96.7%	123.3%
Bovey Tracey Hospital	0.0%	0.0%	0.0%	0.0%
Brixham Hospital	104.4%	134.2%	103.3%	180.0%
Dartmouth Hospital	110.6%	97.3%	100.0%	98.3%
Dawlish Hospital	97.8%	103.3%	100.0%	100.0%
Newton Abbot Hospital	98.0%	100.8%	100.0%	101.4%
Paignton Hospital	103.3%	105.3%	95.0%	105.0%
Teignmouth Hospital	0.0%	0.0%	0.0%	0.0%
Torbay Hospital	95.4%	130.7%	91.8%	137.7%
Totnes Hospital	100.8%	99.5%	106.7%	100.0%
ICO	96.5%	122.4%	93.1%	130.0%

QUALITY FRAMEWORK

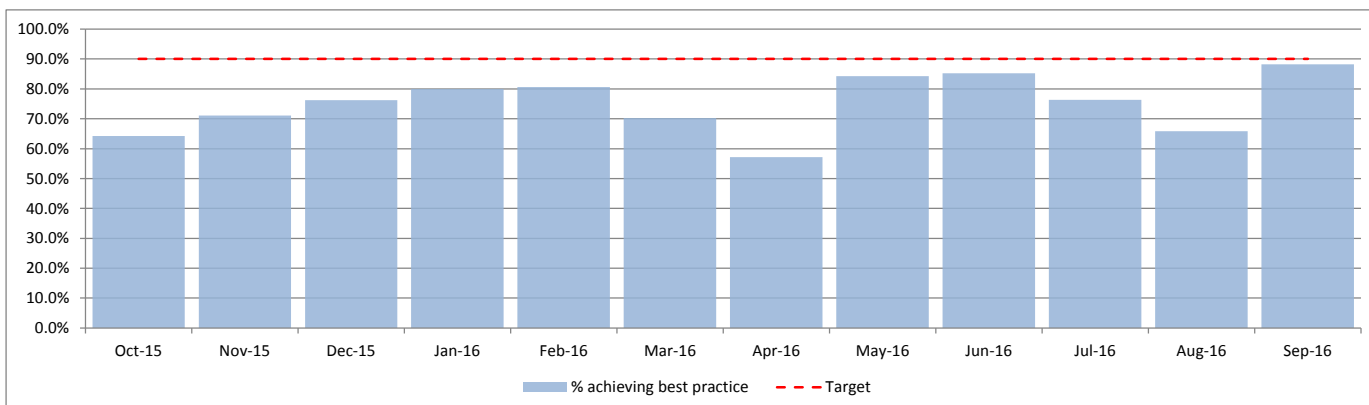
**Infection Control - Bed Closures (acute)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute	54	92	36	12	57	38	236	56	68	28	34	6



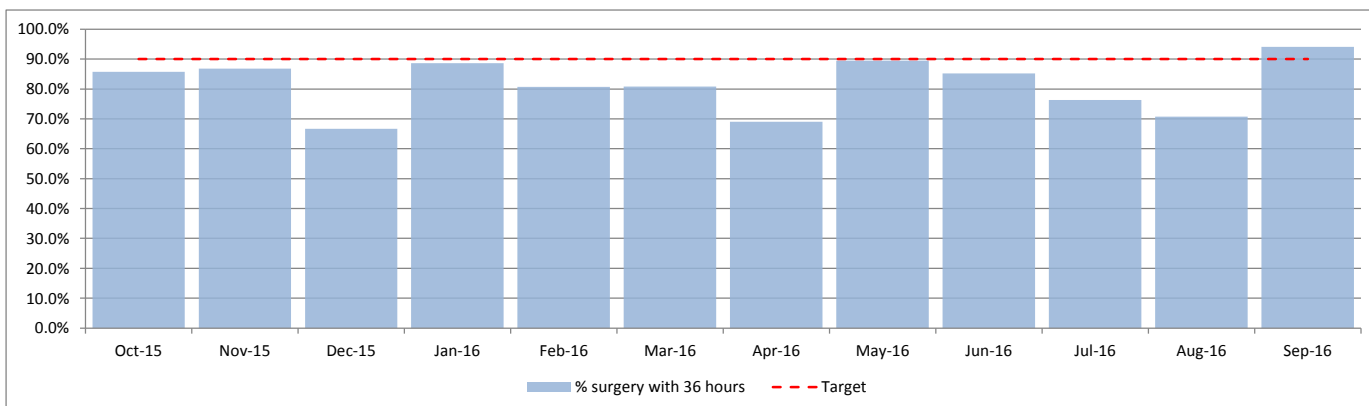
**Fracture Neck of Femur - Best tariff assessment**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients	28	38	42	35	31	47	42	38	27	38	41	34
Achieving best practice	18	27	32	28	25	33	24	32	23	29	27	30
% achieving best practice	64.3%	71.1%	76.2%	80.0%	80.6%	70.2%	57.1%	84.2%	85.2%	76.3%	65.9%	88.2%
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**

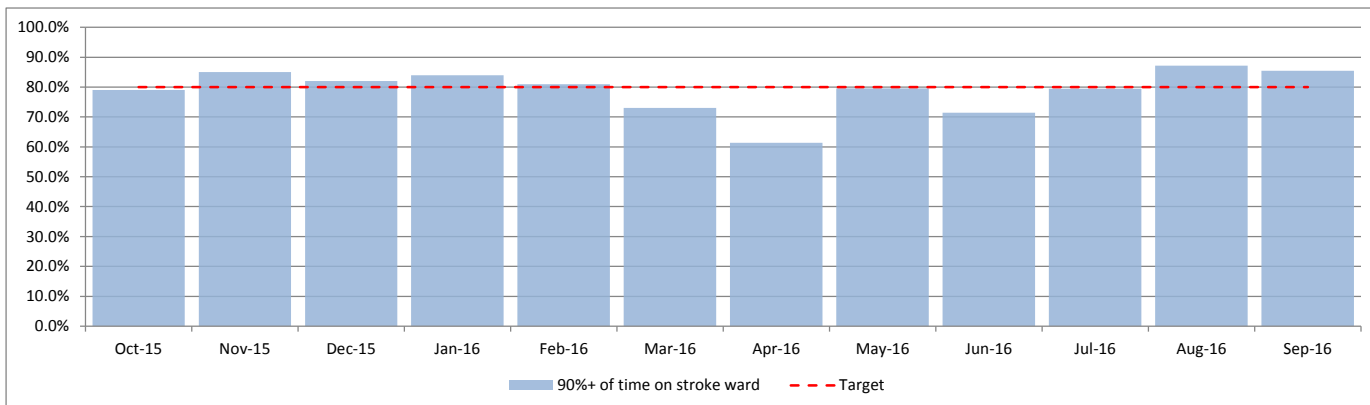
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients	28	38	42	35	31	47	42	38	27	38	41	34
Surgery with 36 hours	24	33	28	31	25	38	29	34	23	29	29	32
% surgery with 36 hours	85.7%	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.1%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



QUALITY FRAMEWORK

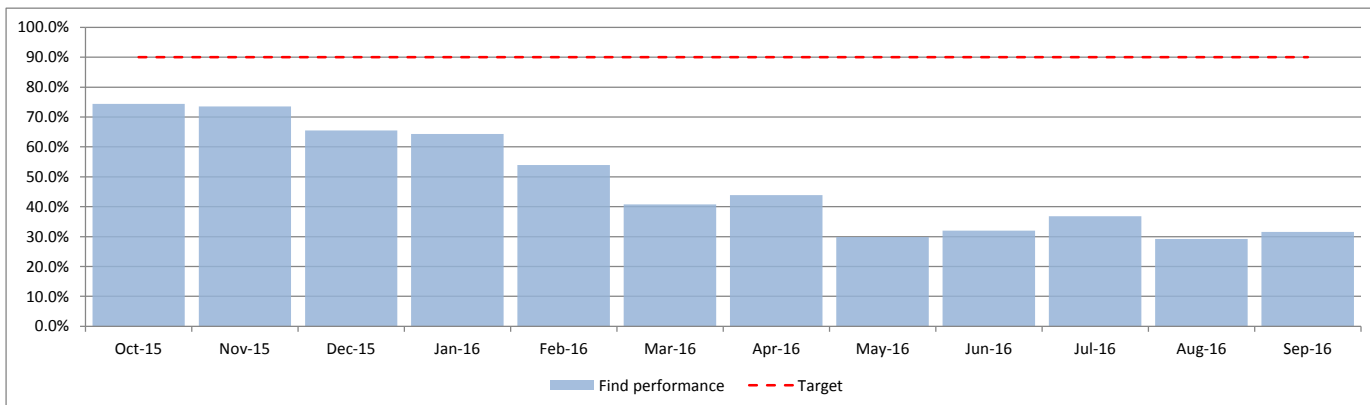
**Stroke**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
90%+ of time on stroke ward	79.0%	85.0%	82.0%	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%
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%



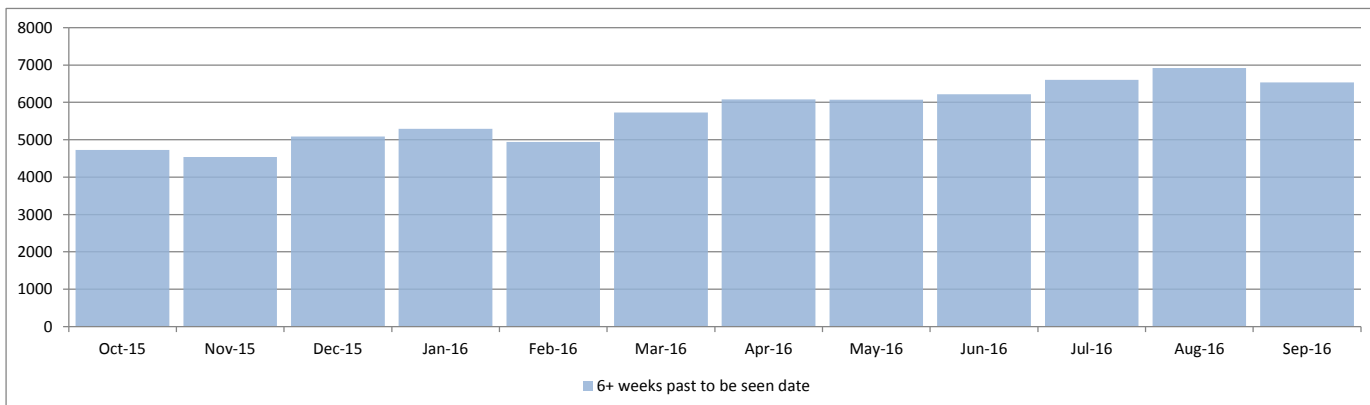
**Dementia - Find**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Numerator	472	461	484	402	360	350	366	303	250	227	264	136
Denominator	581	556	630	558	545	584	607	662	548	503	579	431
Find performance	74.4%	73.5%	65.5%	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	29.2%	31.6%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



**Follow ups 6 weeks past to be seen date**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
6+ weeks past to be seen date	4731	4542	5090	5291	4938	5732	6082	6073	6219	6601	6919	6533





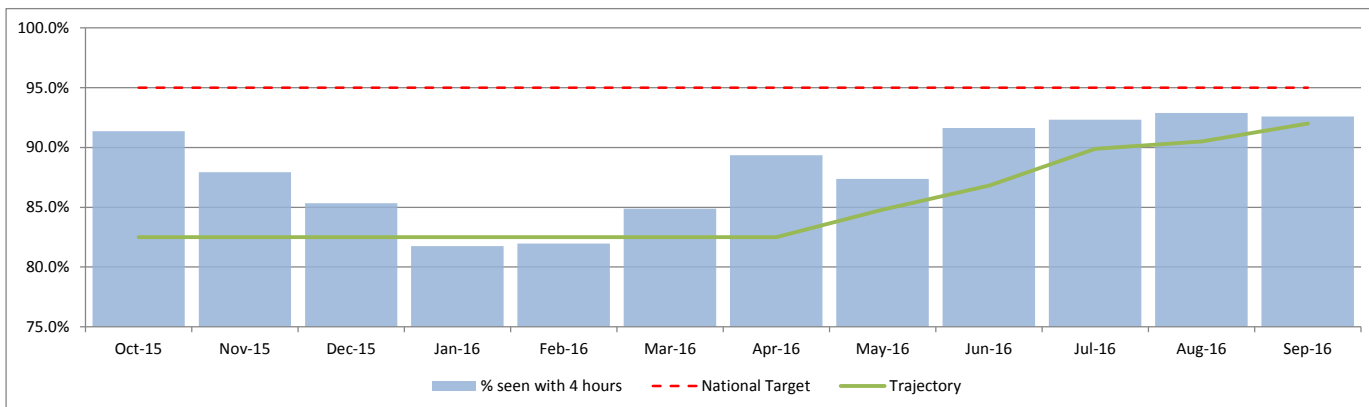
# NHS I COMPLIANCE FRAMEWORK

Month 6 September 2016

NHS I COMPLIANCE FRAMEWORK

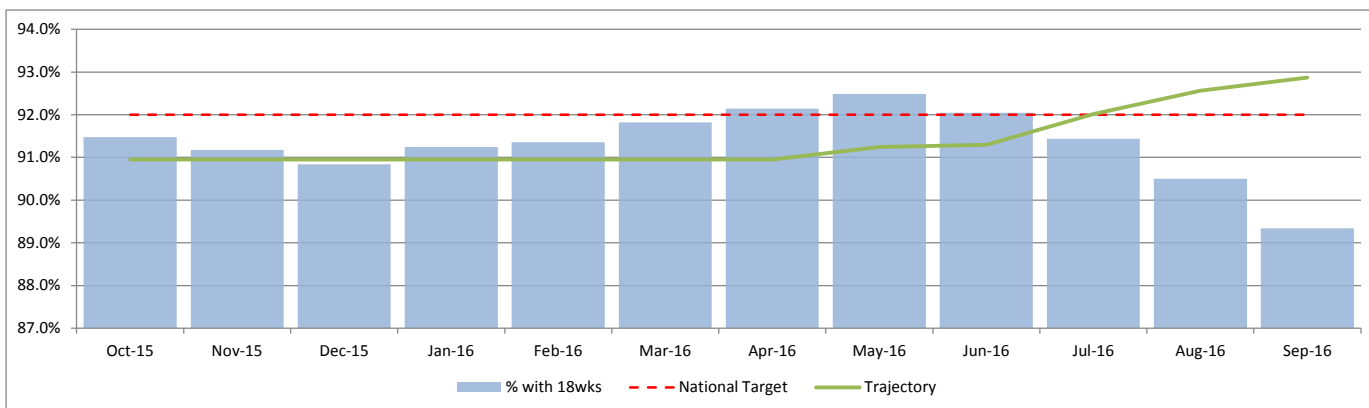
**A&E and MIU patients seen within 4 hours**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients	8712	8451	8135	8223	8084	9298	8627	9741	9672	10679	10449	9439
4 hour breaches	753	1020	1192	1500	1459	1406	918	1229	810	819	744	698
% seen with 4 hours	<b>91.4%</b>	<b>87.9%</b>	<b>85.3%</b>	<b>81.8%</b>	<b>82.0%</b>	<b>84.9%</b>	<b>89.4%</b>	<b>87.4%</b>	<b>91.6%</b>	<b>92.3%</b>	<b>92.9%</b>	<b>92.6%</b>
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%	84.8%	86.8%	89.9%	90.5%	92.0%



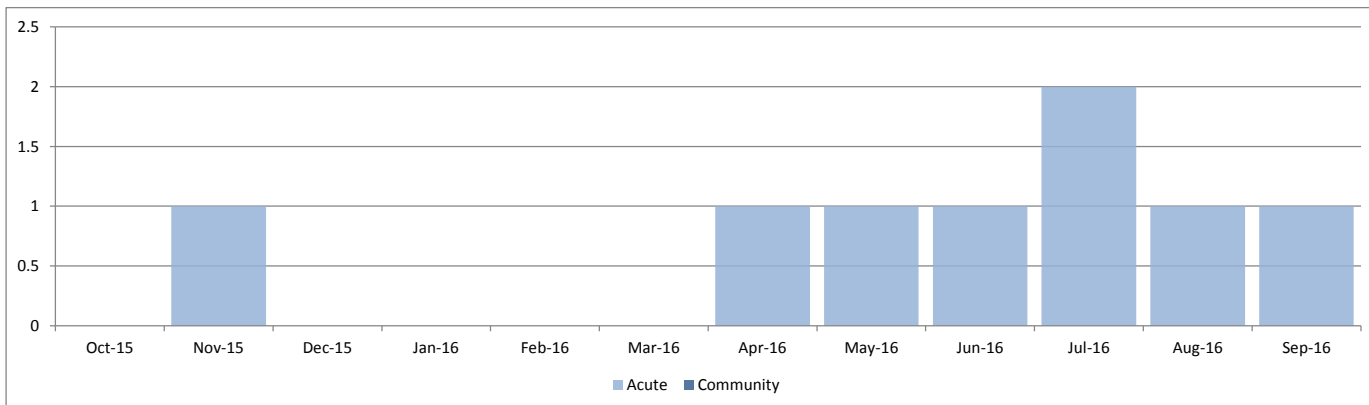
**Referral to Treatment - Incomplete pathways**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Incomplete <18wks	14140	14100	14503	14292	14566	14518	14771	15194	15119	15255	15331	15241
Incomplete >18wks	1318	1364	1462	1372	1378	1293	1260	1234	1307	1429	1609	1819
% with 18wks	<b>91.5%</b>	<b>91.2%</b>	<b>90.8%</b>	<b>91.2%</b>	<b>91.4%</b>	<b>91.8%</b>	<b>92.1%</b>	<b>92.5%</b>	<b>92.0%</b>	<b>91.4%</b>	<b>90.5%</b>	<b>89.3%</b>
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%	91.2%	91.3%	92.0%	92.6%	92.9%



**C Diff. Lapse in Care**

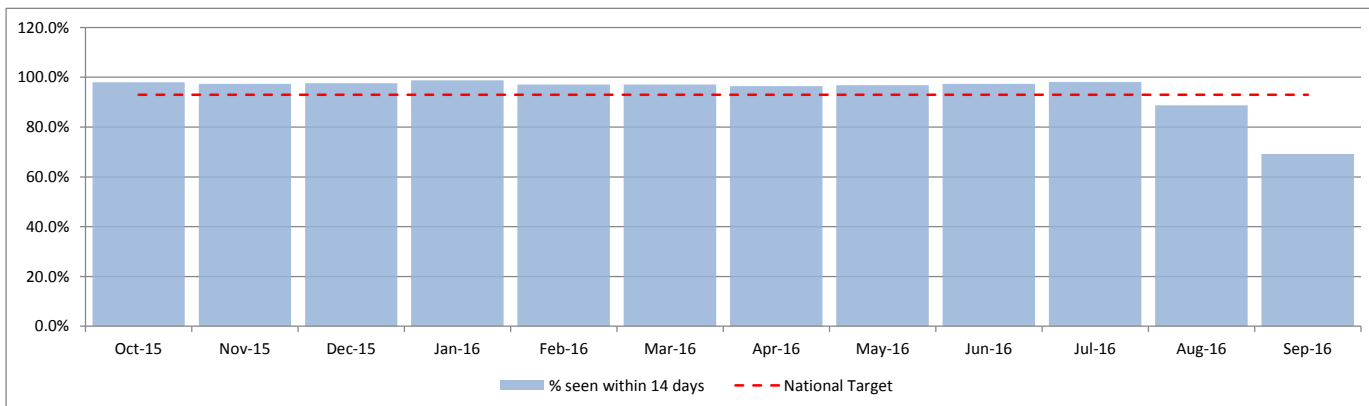
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute	0	1	0	0	0	0	1	1	1	2	1	1
Community	0	0	0	0	0	0	0	0	0	0	0	0



NHS I COMPLIANCE FRAMEWORK

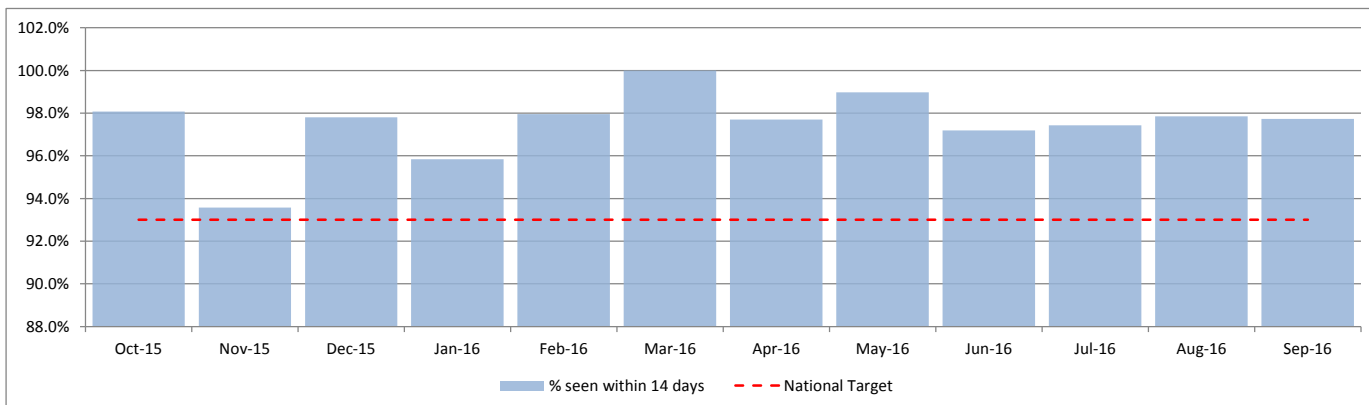
**Cancer - Two Week Wait Referrals**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
2ww Referrals	879	889	897	705	846	965	888	997	997	951	982	945
Seen within 14 days	862	865	876	696	821	937	857	965	971	933	871	654
% seen within 14 days	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.2%
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%



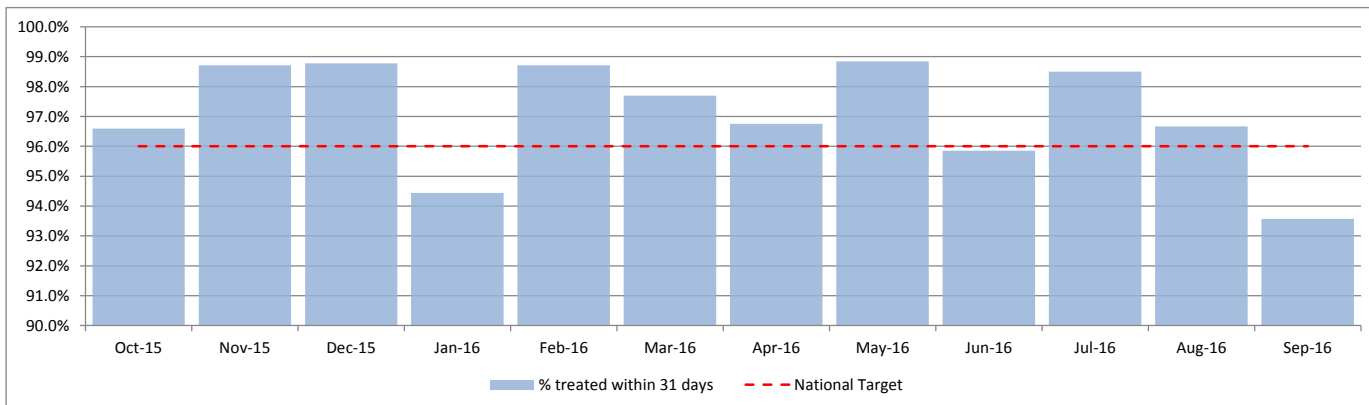
**Cancer - Breast Symptomatic Referrals**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Breast symptomatic referrals	104	109	137	96	98	130	87	97	107	78	93	88
Seen within 14 days	102	102	134	92	96	130	85	96	104	76	91	86
% seen within 14 days	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	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 - 31 day wait from decision to treat to first treatment**

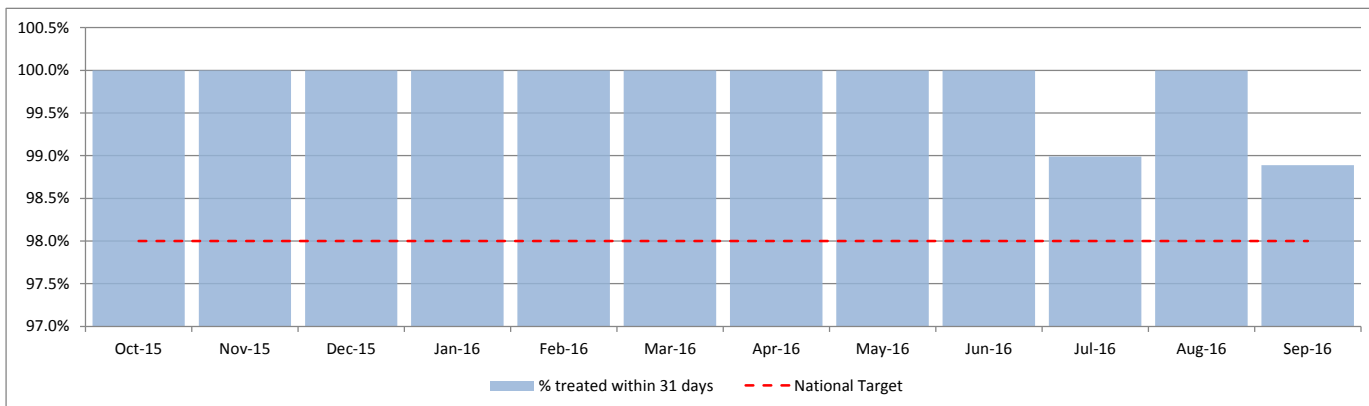
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1st treatments	176	156	163	162	155	174	185	172	193	200	180	171
Breaches of 31 day target	6	2	2	9	2	4	6	2	8	3	6	11
% treated within 31 days	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	93.6%
National 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

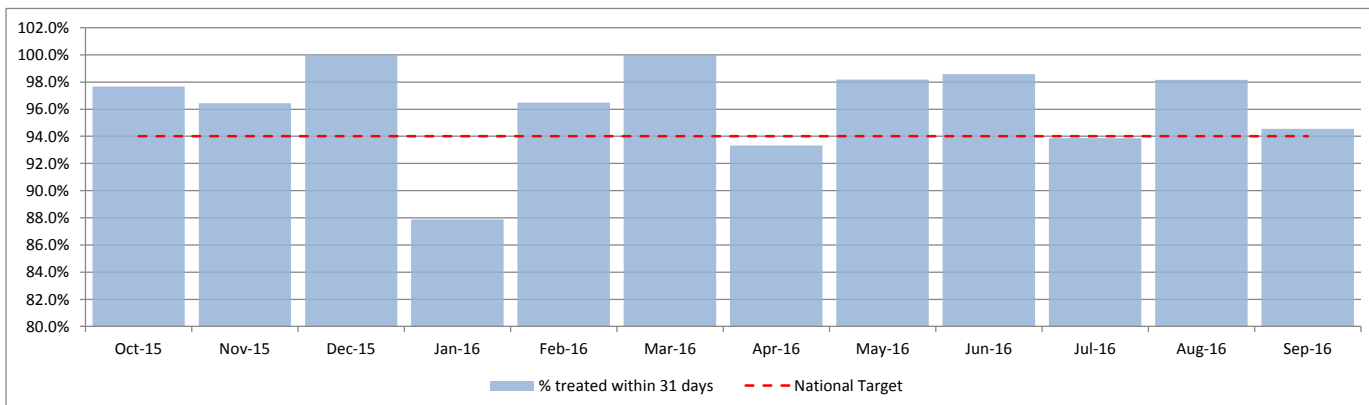
**Cancer - 31 day wait for second or subsequent treatment - Drug**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Subsequent Drug treatments	52	49	47	59	52	62	70	68	85	99	93	90
Breaches of 31 day target	0	0	0	0	0	0	0	0	0	1	0	1
% treated within 31 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	98.9%
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%



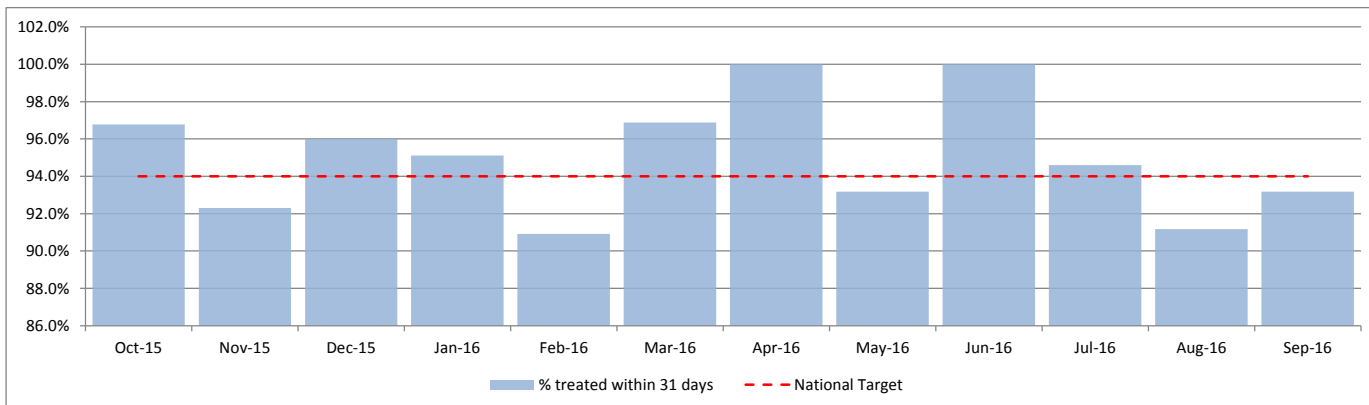
**Cancer - 31 day wait for second or subsequent treatment - Radiotherapy**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Sub radiotherapy treatments	43	56	42	66	57	64	45	55	71	49	54	55
Breaches of 31 day target	1	2	0	8	2	0	3	1	1	3	1	3
% treated within 31 days	97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.5%
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**

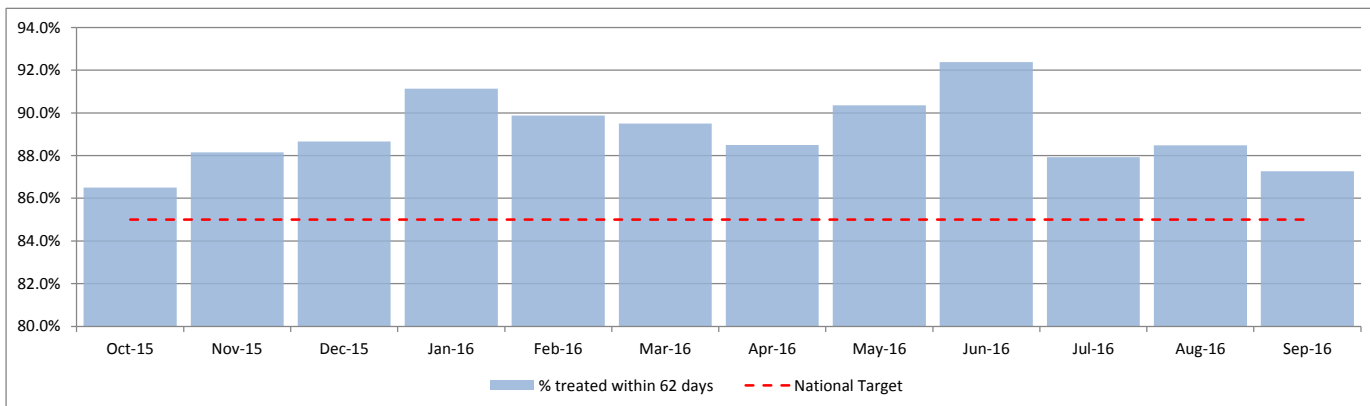
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Subsequent surgery treatments	31	39	25	41	44	32	30	44	40	37	34	44
Breaches of 31 day target	1	3	1	2	4	1	0	3	0	2	3	3
% treated within 31 days	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%
National 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

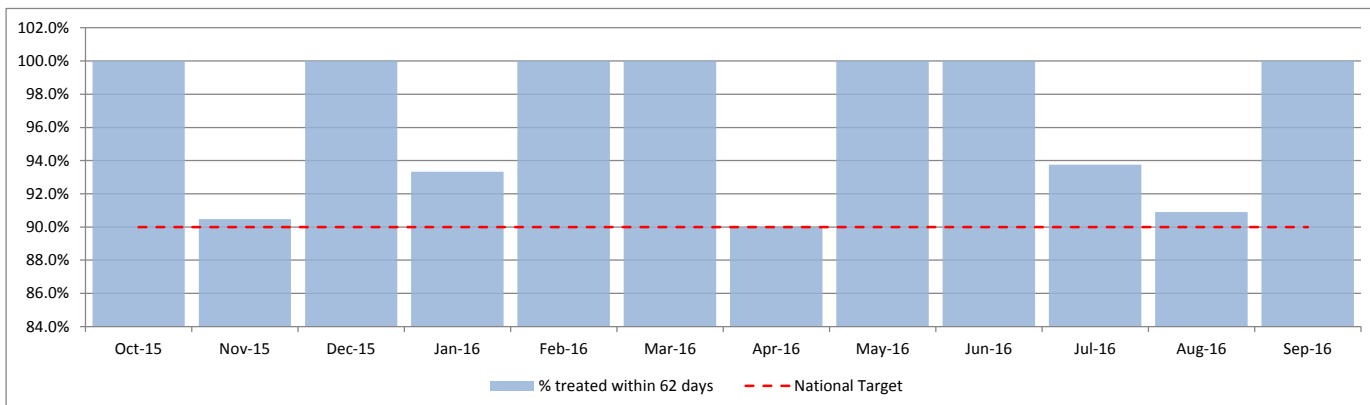
**Cancer - 62 day wait for 1st treatment from 2ww referral**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1st treatments (from 2ww)	100	76	75	79	79	90.5	100	98.5	105	103.5	95.5	106
Breaches of 62 day target	13.5	9	8.5	7	8	9.5	11.5	9.5	8	12.5	11	13.5
% treated within 62 days	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.3%
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**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1st treatments (from screening)	11	10.5	15.5	15	7	13.5	20	14	15	16	11	7
Breaches of 62 day target	0	1	0	1	0	0	2	0	0	1	1	0
% treated within 62 days	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%
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

- Schedule 1 - Income analysis
- Schedule 2 - Employee expenses
- Schedule 3 - Agency spend
- Schedule 4 - Non pay expenses
- Schedule 5 - Cash flow
- Schedule 6 - Capital
- Schedule 7 - Contract Income Analysis

Month 6 September 2016

	Year to Date - Month 06			Plan Changes		Previous Month	
	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
<b>Healthcare Income - Commissioner Analysis</b>							
	£m	£m	£m	£m	£m	£m	
South Devon & Torbay Clinical Commissioning Group	81.09	80.76	(0.33)	(0.23)	(0.10)	(0.08)	↓
North, East & West Devon Clinical Commissioning Group	2.60	2.66	0.06	0.00	0.06	0.04	↑
NHS England - Area Team	3.79	3.72	(0.07)	0.12	(0.19)	(0.15)	↓
NHS England - Specialist Commissioning	14.30	13.97	(0.33)	(0.12)	(0.22)	(0.35)	↑
Other Commissioners	4.17	4.18	0.01	(0.12)	0.13	0.17	↓
<b>Sub-Total Acute</b>	<b>105.94</b>	<b>105.28</b>	<b>(0.66)</b>	<b>(0.35)</b>	<b>(0.32)</b>	<b>(0.38)</b>	<b>↑</b>
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	38.09	39.14	1.05	1.05	(0.00)	0.00	↔
Other Commissioners	1.54	1.58	0.03	(0.04)	0.08	0.05	↔
<b>Sub Total Acute and Community</b>	<b>39.63</b>	<b>40.71</b>	<b>1.08</b>	<b>1.01</b>	<b>0.07</b>	<b>0.05</b>	<b>↑</b>
Sustainability Transformational Funding (STF) Income	3.35	3.21	(0.14)	(1.68)	1.54	0.00	↑
<b>Total Acute and Community</b>	<b>148.92</b>	<b>149.20</b>	<b>0.28</b>	<b>(1.01)</b>	<b>1.29</b>	<b>(0.33)</b>	<b>↑</b>
<b>Healthcare Income - By Business Unit</b>							
	£m	£m	£m	£m	£m	£m	
Medical Services	45.20	45.14	(0.06)	(0.24)	0.19	(0.07)	↑
Surgical Services	34.12	34.60	0.48	(0.01)	0.50	0.28	↑
Women's, Childrens & Diagnostic Services	21.91	21.08	(0.84)	(0.89)	0.05	0.69	↑
Community Services	39.63	40.71	1.08	1.01	0.07	0.05	↔
Non-Clinical Services / Central Contract Income	8.06	7.67	(0.38)	(0.87)	0.48	(1.28)	↑
<b>Total</b>	<b>148.92</b>	<b>149.21</b>	<b>0.29</b>	<b>(1.00)</b>	<b>1.29</b>	<b>(0.33)</b>	<b>↓</b>
<b>Healthcare Activity - By Setting</b>							
	Activity	Activity	Activity	Activity	Activity	Activity	
Elective In-Patient Admissions	2,162	2,201	39	246	(207)	(164)	↓
Elective Day Case Admission	16,824	17,100	276	538	(262)	(109)	↓
Urgent & Emergency Admissions	57,283	57,925	642	274	368	264	↑
Out-Patients	218,332	226,215	7,883	3,614	4,269	5,566	↓
Community Services							
<b>Total</b>	<b>294,601</b>	<b>303,441</b>	<b>8,840</b>	<b>4,672</b>	<b>4,168</b>	<b>5,557</b>	<b>↓</b>
<b>Social Care Income</b>							
	£m	£m	£m	£m	£m	£m	
Torbay Council - ASC Contract income	20.33	19.55	(0.79)	(0.78)	(0.00)	0.00	↔
Torbay Council - Public Health Income	2.48	2.96	0.48	0.00	0.48	0.40	↑
Torbay Council - Client Income	4.94	5.09	0.15	0.17	(0.02)	0.01	↓
<b>Total</b>	<b>27.75</b>	<b>27.59</b>	<b>(0.16)</b>	<b>(0.61)</b>	<b>0.45</b>	<b>0.41</b>	<b>↑</b>
<b>Other Income</b>							
	£m	£m	£m	£m	£m	£m	
Non Mandatory/Non protected clinical revenue	0.75	0.83	0.08	0.00	0.08	0.08	↔
R&D / Education & training revenue	4.36	4.50	0.15	0.00	0.15	0.12	↑
Site Services	1.08	1.13	0.05	0.00	0.05	0.02	↑
Revenue from non-patient services to other bodies	2.73	2.66	(0.07)	0.00	(0.07)	0.03	↓
Misc. other operating revenue	11.86	12.23	0.37	0.01	0.36	(0.17)	↑
<b>Total</b>	<b>20.78</b>	<b>21.36</b>	<b>0.58</b>	<b>0.01</b>	<b>0.57</b>	<b>0.08</b>	<b>↑</b>
<b>Risk Share Income</b>							
	£m	£m	£m	£m	£m	£m	
Risk Share Income	0.00	4.51	4.51	4.73	(0.23)	0.20	↓
<b>Total</b>	<b>0.00</b>	<b>4.51</b>	<b>4.51</b>	<b>4.73</b>	<b>(0.23)</b>	<b>0.20</b>	<b>↓</b>
<b>Memo</b>							
	Year to Date - Month 06			Plan Changes		Previous Month	
	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
<b>CCG Block adjustment</b>							
	£m	£m	£m	£m	£m	£m	
CCG Block adjustment	0.00	(5.83)	(5.83)	(3.78)	(2.04)	(1.93)	↑
<b>Total</b>	<b>0.00</b>	<b>(5.83)</b>	<b>(5.83)</b>	<b>(3.78)</b>	<b>(2.04)</b>	<b>(1.93)</b>	<b>↑</b>

Employee Expenses

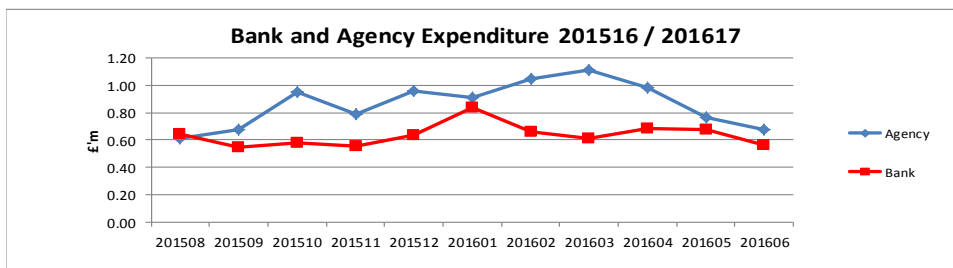
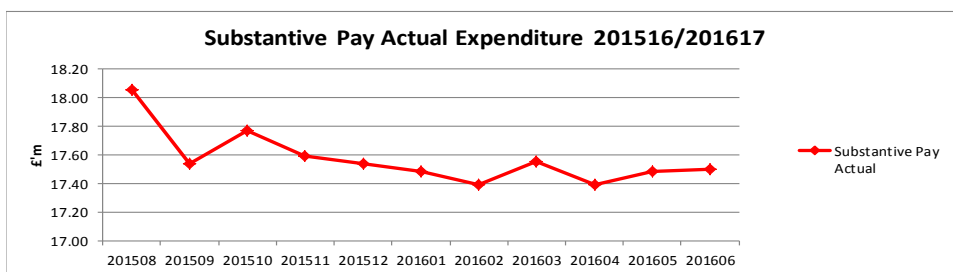
Schedule 2

	Year to Date - Month 06			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
<b>Employee Expenses - By Category</b>							
Medical and Dental staff	26.17	25.96	0.21	0.23	0.44	0.41	↑
Registered nurses, midwives and health visiting staff	28.29	29.07	(0.78)	0.36	(0.41)	(0.50)	↓
Qualified scientific, therapeutic and technical staff	22.37	21.23	1.13	0.18	1.31	0.95	↑
Support to clinical staff	9.19	10.34	(1.15)	0.00	(1.15)	(1.00)	↑
Managers and infrastructure Support	26.73	27.72	(0.99)	0.50	(0.49)	(0.34)	↑
<b>Total</b>	<b>112.75</b>	<b>114.32</b>	<b>(1.57)</b>	<b>1.26</b>	<b>(0.31)</b>	<b>(0.47)</b>	<b>↓</b>

Employee Expenses - By Type							
Substantive	106.39	104.70	1.70	1.26	2.96	2.37	↑
Bank	1.74	4.03	(2.29)	0.00	(2.29)	(2.01)	↑
Locum (including Agency)	0.87	0.84	0.02	0.00	0.02	0.04	↓
Agency (excluding Locums)	3.75	4.75	(1.01)	0.00	(1.01)	(0.87)	↑
<b>Total</b>	<b>112.75</b>	<b>114.32</b>	<b>(1.57)</b>	<b>1.26</b>	<b>(0.31)</b>	<b>(0.47)</b>	<b>↓</b>

Employee Expenses - By Service							
Medical Services	20.40	22.65	(2.25)	0.09	(2.16)	(1.84)	↑
Surgical Services	23.10	23.36	(0.26)	0.03	(0.22)	(0.16)	↑
Women's, Childrens & Diagnostic Services	18.60	19.08	(0.48)	0.01	(0.47)	(0.38)	↑
Community Hospital and Services (including ASC)	21.75	21.70	0.05	0.51	0.56	0.11	↑
Non-Clinical Services	28.90	27.53	1.37	0.62	1.99	1.80	↑
<b>Total</b>	<b>112.75</b>	<b>114.32</b>	<b>(1.57)</b>	<b>1.26</b>	<b>(0.31)</b>	<b>(0.47)</b>	<b>↓</b>

Pay run rates Oct 2015 - September 2016



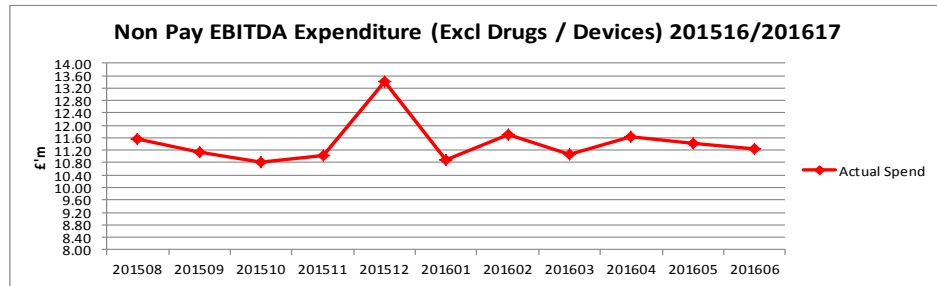


Torbay and South Devon NHS Foundation Trust							
Trust Agency Information							
Financial Year 2016/17							
<b>All Staff Group</b>	April	May	June	July	August	September	YTD 2016-17
<b>NHS Improvement - revised Ceiling (June 2016)</b>	£m	£m	£m	£m	£m	£m	£m
Total Planned Agency Cost	(0.662)	(0.643)	(0.623)	(0.590)	(0.575)	(0.556)	(3.650)
Total Planned Staff Costs	(18.898)	(18.901)	(18.904)	(18.678)	(18.681)	(18.684)	(112.745)
% of Agency Costs against Total Staff Cost	4%	3%	3%	3%	3%	3%	3%
<b>ICO Actual</b>	April	May	June	July	August	September	YTD 2016-17
Total Agency Staff Cost	£m	£m	£m	£m	£m	£m	£m
Total Actual Staff Cost	(0.911)	(1.043)	(1.112)	(0.983)	(4.224)	2.786	(5.487)
% of Agency Costs against Total Staff Cost	(19.231)	(19.090)	(19.565)	(19.053)	(18.637)	(18.742)	(114.318)
% of Agency Costs against Total Staff Cost	5%	5%	6%	5%	23%	-15%	5%
<b>Variance against Revised Ceiling</b>	April	May	June	July	August	September	YTD 2016-17
Total Agency Staff Cost	£m	£m	£m	£m	£m	£m	£m
% of Agency Costs against Total Staff Cost	(0.249)	(0.400)	(0.489)	(0.393)	(3.649)	3.342	(1.838)
% of Agency Costs against Total Staff Cost	1%	2%	2%	2%	20%	-18%	2%
<b>Nursing only</b>	April	May	June	July	August	September	YTD 2016-17
<b>NHS Improvement - revised Ceiling (June 2016)</b>	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.272)	(0.266)	(0.259)	(0.168)	(0.163)	(0.156)	(1.284)
Total Planned Staff Costs	(4.633)	(4.631)	(4.629)	(4.723)	(4.723)	(4.721)	(28.061)
% of Agency Costs against Total Staff Cost	6%	6%	6%	4%	3%	3%	5%
<b>ICO Actual</b>	April	May	June	July	August	September	YTD 2016-17
Total Agency Staff Cost	£m	£m	£m	£m	£m	£m	£m
Total Actual Staff Cost	(0.442)	(0.544)	(0.552)	(0.457)	(0.897)	0.218	(2.674)
% of Agency Costs against Total Staff Cost	(4.980)	(4.927)	(4.993)	(4.824)	(4.654)	(4.689)	(29.067)
% of Agency Costs against Total Staff Cost	9%	11%	11%	9%	19%	-5%	9%
<b>Variance against Revised Ceiling</b>	April	May	June	July	August	September	YTD 2016-17
Total Agency Staff Cost	£m	£m	£m	£m	£m	£m	£m
% of Agency Costs against Total Staff Cost	(0.170)	(0.278)	(0.293)	(0.289)	(0.734)	0.374	(1.390)
% of Agency Costs against Total Staff Cost	3%	5%	5%	6%	16%	-8%	4%
<b>Comment</b>	M1 to M6 Agency Actual is higher than revised Ceiling by £1.8m YTD, 2% more than the revised ceiling of 3%. M6 Total Agency is £5.5m across all Staff Group.						

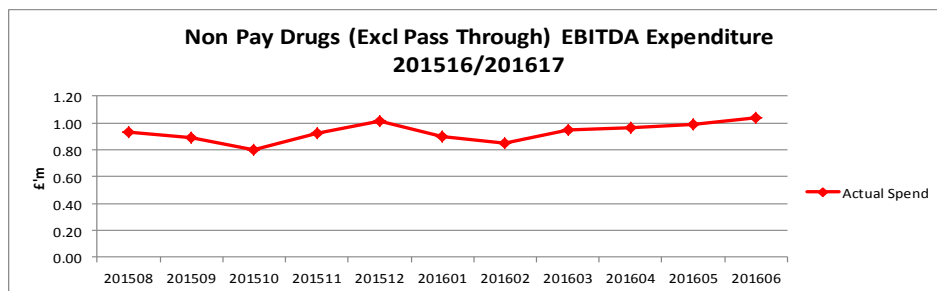
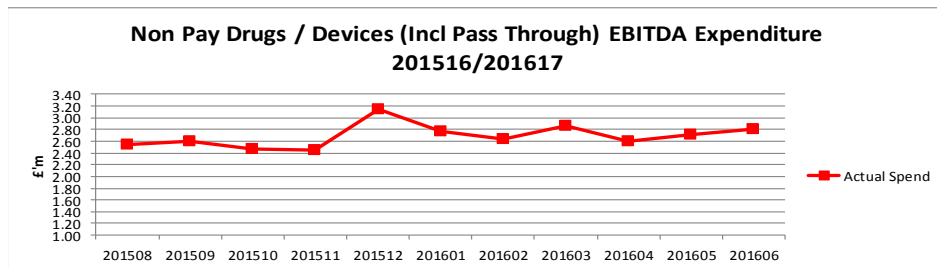
Improvement Plan			
No.	Action	Lead	Date
1	Nursing agency shifts all approved by a Director	JV	ongoing
2	Medical Agency and Locum Approved by a Director	RD	ongoing
3	Recruitment processes streamlined and regular for key clinical staff	JS	Ongoing
4	Overseas Recruitment of Nursing Staff	JS/JV	in progress
<b>Governance Arrangements</b>			
Senior Business management Team, Exec Team meetings, Finance Committee			

	Year to Date - Month 06			Plan Changes		Previous Month YTD	
	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
<b>Non Pay Expenses - By Category</b>							
Clinical Supplies	10.95	11.44	(0.50)	0.00	(0.50)	(0.36)	↑
Drugs (Excluding Pass through)	5.41	5.70	(0.28)	0.00	(0.28)	(0.14)	↑
Pass through Drugs, Blood and Devices	10.07	10.70	(0.63)	0.38	(0.25)	(0.22)	↑
Non Clinical Supplies	1.38	1.47	(0.09)	0.00	(0.09)	(0.06)	↑
Miscellaneous / Other	52.29	54.61	(2.32)	3.39	1.07	1.11	↓
<b>Total</b>	<b>80.10</b>	<b>83.92</b>	<b>(3.82)</b>	<b>3.77</b>	<b>(0.05)</b>	<b>0.34</b>	<b>↑</b>

Non pay run rates Oct 2015 - September 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.



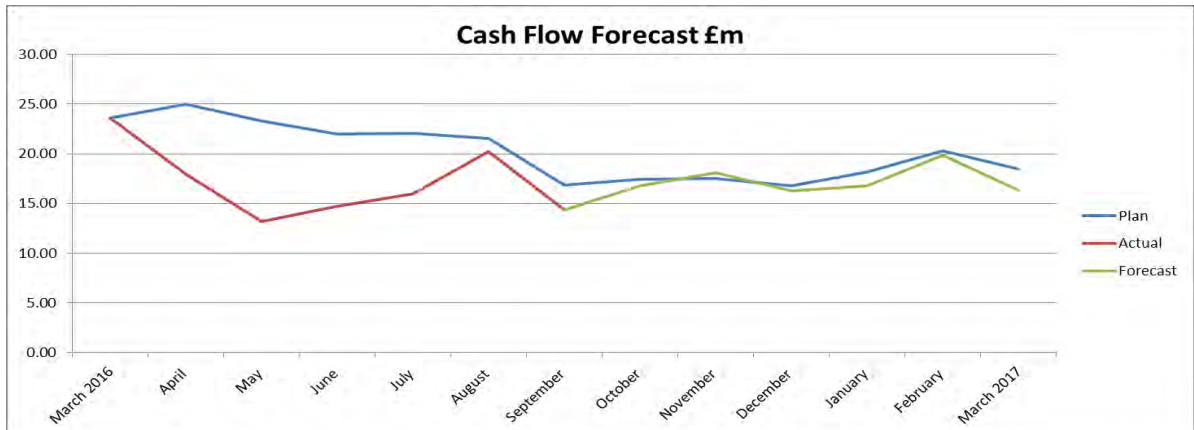
Cash Flow

Schedule 5

	Year to Date - Month 06			Plan Changes		Previous Month YTD	
	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
<b>Opening Cash Balance</b>	<b>23.57</b>	<b>23.57</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	0.00	
Cash Generated From Operations	4.85	3.79	(1.06)	(2.20)	1.14	(0.24)	↑
Debtor Movements	4.33	(3.47)	(7.80)	(2.04)	(5.76)	(7.06)	↑
Creditor Movements	(2.09)	1.59	3.68	1.38	2.31	5.90	↓
Capital Expenditure (accruals basis)	(12.71)	(8.51)	4.20	4.33	(0.14)	0.00	↓
Net Interest	(1.44)	(1.45)	(0.01)	0.00	(0.01)	0.15	↓
Loan drawdown	4.67	5.11	0.45	0.44	0.00	2.27	↑
Loan repayment	(2.84)	(2.81)	0.03	0.00	0.03	0.03	↔
PDC Dividend	(1.29)	(0.69)	0.60	0.42	0.19	0.00	↔
Other	(0.20)	(2.79)	(2.60)	(1.38)	(1.22)	(0.91)	↓
<b>Closing Cash Balance</b>	<b>16.85</b>	<b>14.34</b>	<b>(2.52)</b>	<b>0.95</b>	<b>(3.47)</b>	<b>(2.92)</b>	↓

Cash Flow Forecast

	Full Year			Plan Changes		Previous Month	
	Plan	Forecast	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance	Change
	£m	£m	£m	£m	£m	£m	
<b>Cash Flow</b>							
<b>Opening Cash Balance - 01/04/2016</b>	<b>23.57</b>	<b>23.57</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	0.00	
Cash Generated From Operations	22.36	10.52	(11.85)	(10.61)	(1.24)	(0.64)	↓
Debtor Movements	4.41	4.14	(0.27)	(0.27)	(0.00)	0.00	↔
Creditor Movements	(2.10)	(0.72)	1.38	1.38	0.00	0.00	↔
Capital Expenditure (accruals basis)	(36.90)	(21.91)	14.99	14.99	(0.00)	0.00	↔
Net Interest	(2.90)	(2.90)	0.00	0.00	0.00	0.00	↔
Loan drawdown	18.65	13.22	(5.43)	(5.43)	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	0.42	0.38	0.00	↔
Other	(0.08)	(1.80)	(1.72)	(1.38)	(0.35)	0.27	↓
<b>Forecast Cash Balance - 31/03/2017</b>	<b>18.48</b>	<b>16.37</b>	<b>(2.11)</b>	<b>(0.90)</b>	<b>(1.21)</b>	<b>(0.37)</b>	↓



	Year to date - Based upon Annual Plan (April 16)			Year to date - Based upon RSA Plan			Full year Annual Plan versus Revised Forecast	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m
<b>Capital Programme</b>	12.71	8.51	(4.20)	8.37	8.51	0.14	36.90	21.91
<b>Significant Variances in Planned Expenditure by Scheme:</b>								
HIS schemes	2.69	0.94	(1.75)	1.77	0.94	(0.83)	9.08	5.63
Estates schemes	7.53	6.27	(1.25)	4.96	6.27	1.31	16.28	10.01
Medical Equipment	0.86	0.49	(0.37)	0.57	0.49	(0.08)	7.70	4.47
Other	0.04	0.01	(0.03)	0.02	0.01	(0.02)	0.05	0.09
PMU	0.94	0.80	(0.14)	0.62	0.80	0.18	1.60	1.50
Contingency	0.66	0.00	(0.66)	0.43	0.00	(0.43)	2.19	0.21
Prior Year schemes	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
<b>Total</b>	12.71	8.51	(4.20)	8.37	8.51	0.14	36.90	21.91
<b>Funding sources</b>								
Secured loans	4.67	5.11	0.45	5.11	5.11	0.00	10.94	10.94
Unsecured loans	0.00	0.00	0.00	0.00	0.00	0.00	7.71	2.28
Charitable Funds	0.19	0.14	(0.06)	0.19	0.14	(0.06)	2.60	2.60
Internal cash resources	7.85	3.26	(4.59)	3.07	3.26	0.19	15.65	6.09
<b>Total</b>	12.71	8.51	(4.20)	8.37	8.51	0.14	36.90	21.91

Cumulative Period to:

September 2016

Schedule 7

Income Category	2016/17 Annual Plan (Activity)	2016/17 YTD Plan (Activity)	2016/17 YTD Actual (Activity)	Cumulative Variance Current Mth (Activity)	Cumulative Variance Previous Mth (Activity)	2016/17 Annual Plan (£'000)	2016/17 YTD Plan (£'000)	2016/17 YTD Actual (£'000)	Cumulative Variance Current Mth (£'000)	Cumulative Variance Previous Mth (£'000)
Inpatients	4,581	2,256	2,051	(205)	(168)	15,493	7,534	7,314	(220)	(170)
Day Cases	32,565	16,438	16,242	(196)	(70)	20,488	10,376	10,128	(248)	(174)
Non-Electives	29,681	14,707	15,905	1,198	1,036	56,391	27,742	30,253	2,511	2,267
Critical Care - Adult	0	0	0	0	0	0	0	0	0	0
Critical Care - Neonatal & Paeds	0	0	0	0	0	0	0	0	0	0
Chemotherapy Delivery	0	0	0	0	0	1,294	671	676	4	36
Chemotherapy Procurement	0	0	0	0	0	3,174	1,650	1,572	(79)	(94)
Elective Readmissions						(230)	(115)	(115)	0	0
Emergency Readmissions						(188)	(94)	(94)	0	0
Chemotherapy Core HRG Adjustment						0	0	0	0	0
Emergency Adjustment						(3,182)	(1,591)	(1,996)	(405)	(286)
Emergency adjustment add back						0	0	0	0	0
APC Variation Orders Agreed						0	0	0	0	0
<b>Total APC</b>						<b>93,241</b>	<b>46,174</b>	<b>47,737</b>	<b>1,563</b>	<b>1,580</b>
Outpatients - 1st	76,972	38,151	39,387	1,236	1,474	12,126	5,989	6,126	138	189
Outpatients - F-up	202,129	98,693	100,534	1,841	2,702	19,237	9,474	9,543	69	164
Chemotherapy Delivery	0	0	0	0	0	106	52	64	12	(35)
Chemotherapy Procurement	0	0	0	0	0	1,644	849	811	(39)	(62)
Maternity Pathway	0	0	0	0	1	4,941	2,471	2,382	(88)	(75)
Radiotherapy	12,471	6,405	6,114	(291)	(271)	2,860	1,480	1,361	(119)	(110)
OP Radiology	28,291	14,203	14,300	97	195	2,988	1,491	1,544	52	59
GP Radiology	45,398	23,253	23,499	246	381	1,838	942	973	30	31
Outpatient Variation Orders Agreed						0	0	0	0	0
<b>Total Outpatients</b>						<b>45,740</b>	<b>22,748</b>	<b>22,804</b>	<b>55</b>	<b>162</b>
A&E	75,422	38,818	38,592	(226)	(296)	8,691	4,402	4,407	5	(25)
A&E Variation Orders Agreed										
<b>Total A&amp;E</b>						<b>8,691</b>	<b>4,402</b>	<b>4,407</b>	<b>5</b>	<b>(25)</b>
<b>Total PBR</b>						<b>147,672</b>	<b>73,325</b>	<b>74,947</b>	<b>1,623</b>	<b>1,716</b>
Cost & Volume - Inpatients	325	146	150	4	7	379	160	203	42	46
Cost & Volume - Day Cases	1,659	922	858	(64)	(41)	694	390	415	24	46
Cost & Volume - Non-Electives	536	292	374	82	73	1,053	556	678	123	45
Cost & Volume - AMU	1,890	959	927	(32)	(14)	1,432	699	722	23	19
Cost & Volume - CDU	3,201	1,540	2,127	587	489	186	88	121	34	28
Cost & Volume - Outpatients 1st	27,425	13,606	14,569	963	976	2,896	1,462	1,565	103	125
Cost & Volume - Outpatients F-up	55,501	27,635	27,812	177	108	6,421	3,192	3,113	(79)	(51)
Cost & Volume - New	0	0	0	0	0	11,743	5,872	5,929	57	164
Critical Care - Adult						3,954	2,002	2,498	495	404
Critical Care - Neonatal & Paeds						1,919	956	1,037	80	79
Chemotherapy Delivery						0	0	0	0	0
Chemotherapy Procurement						0	0	0	0	0
Palliative Care						563	333	318	(11)	(38)
Other Cost & Volume - Drugs						18,457	9,227	9,653	426	378
Other Cost & Volume - Bloods						799	399	423	24	1
Other Cost & Volume - Excluded Devices						1,803	902	689	(212)	(179)
Cost & Volume - Various						1,539	770	784	15	28
Cost & Volume Variation Orders Agreed						0	0	0	0	0
<b>Total Cost &amp; Volume</b>						<b>53,838</b>	<b>27,008</b>	<b>28,147</b>	<b>1,143</b>	<b>1,095</b>
Block - Patient Related						7,560	3,780	3,780	0	0
Block - Non Patient Related						4,041	2,021	2,021	0	0
Commissioner plan adjustments to match resource envelopes						0	0	0	0	0
Block Variation Orders Agreed						0	0	0	0	0
<b>Total Block</b>						<b>11,602</b>	<b>5,801</b>	<b>5,801</b>	<b>0</b>	<b>0</b>
<b>Total Non-PBR</b>						<b>65,440</b>	<b>32,809</b>	<b>33,948</b>	<b>1,143</b>	<b>1,095</b>
CQUIN						4,634	2,317	2,317	0	0
<b>Total Contract Adjustments</b>						<b>4,634</b>	<b>2,317</b>	<b>2,317</b>	<b>0</b>	<b>0</b>
SD&T CCG plan adjustment to match resource envelope						0	0	0	0	0
<b>Total Contract</b>						<b>217,745</b>	<b>108,450</b>	<b>111,212</b>	<b>2,766</b>	<b>2,812</b>
Phasing adjustment	0	0	0	0	0	0	935	0	(935)	(1,177)
Contract Penalties						0	0	(112)	(112)	(93)
Block Adjustment						(7,567)	(3,784)	(5,826)	(2,043)	(1,926)
<b>Grand Total</b>						<b>210,178</b>	<b>105,602</b>	<b>105,274</b>	<b>(324)</b>	<b>(385)</b>
<b>Grand Total of agreed contract plan</b>						<b>210,178</b>	<b>105,602</b>	<b>105,274</b>	<b>(324)</b>	<b>(385)</b>

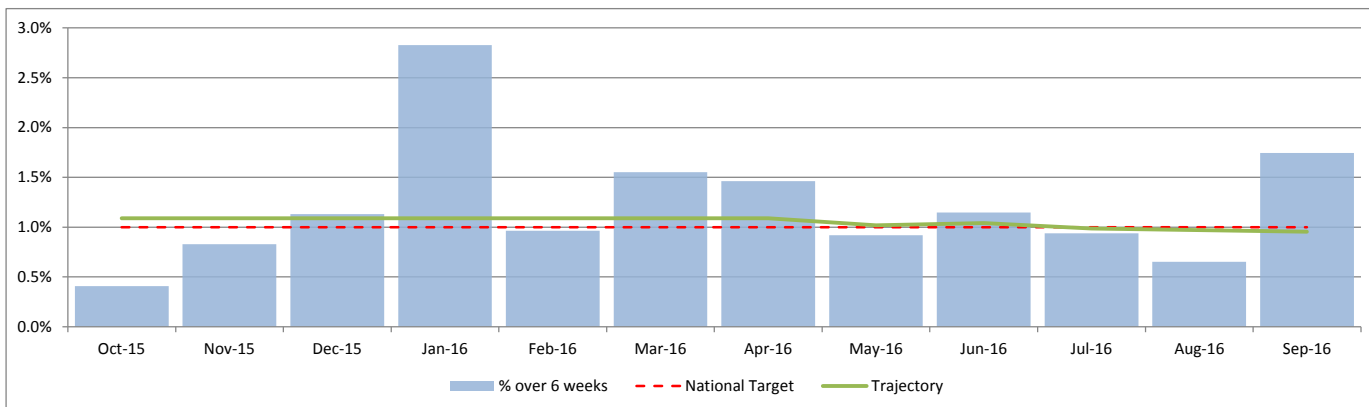
# CONTRACTUAL FRAMEWORK

Month 6 September 2016

CONTRACTUAL FRAMEWORK

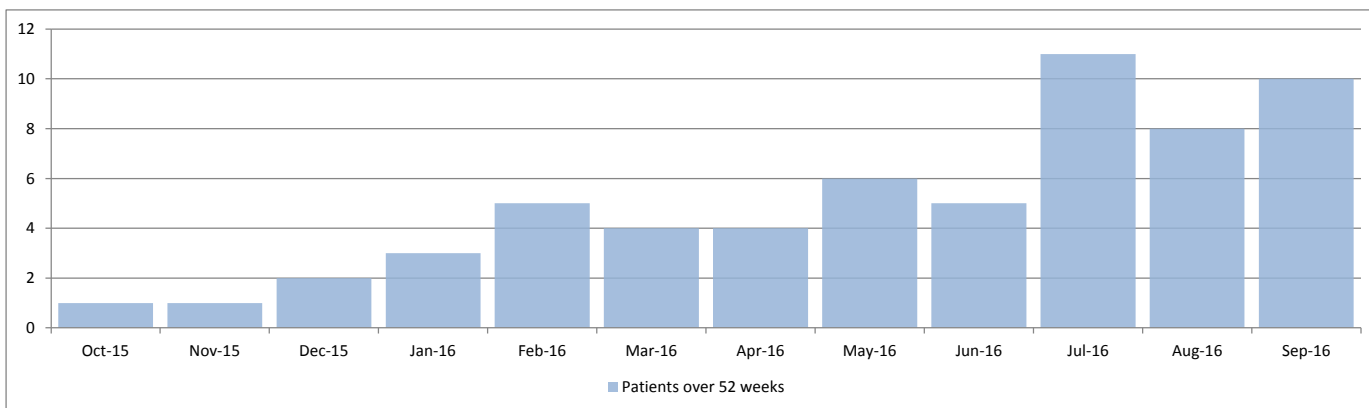
**Diagnostic Tests Longer than the 6 week standard**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients	3667	3382	3800	3750	3637	3543	3693	3377	3750	3305	3228	3381
Waiting longer than 6 weeks	15	28	43	106	35	55	54	31	43	31	21	59
% over 6 weeks	0.4%	0.8%	1.1%	2.8%	1.0%	1.6%	1.5%	0.9%	1.1%	0.9%	0.7%	1.7%
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%	1.02%	1.04%	0.99%	0.97%	0.95%



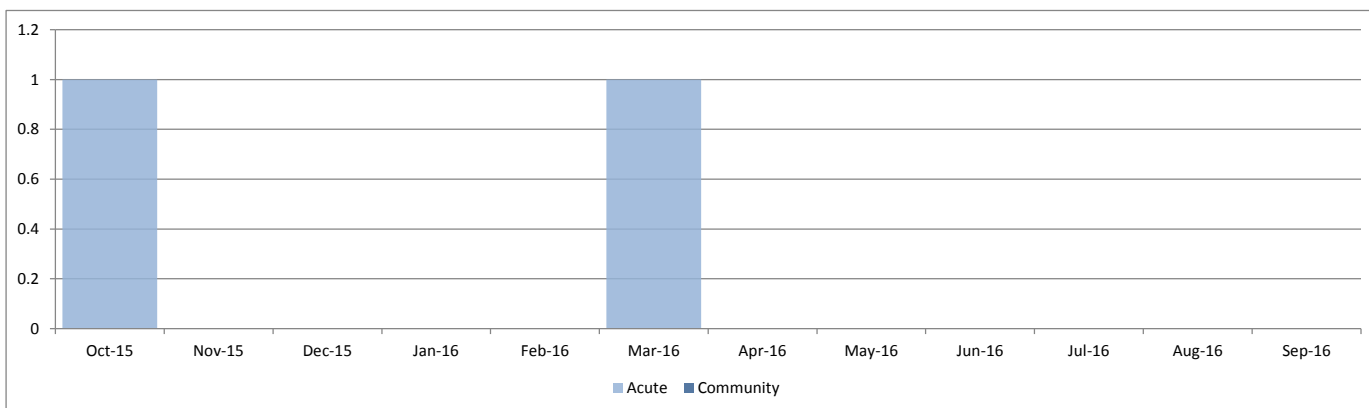
**Referral to Treatment over 52 week incomplete pathways**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients over 52 weeks	1	1	2	3	5	4	4	6	5	11	8	10



**Mixed sex accomodation breaches of Standard**

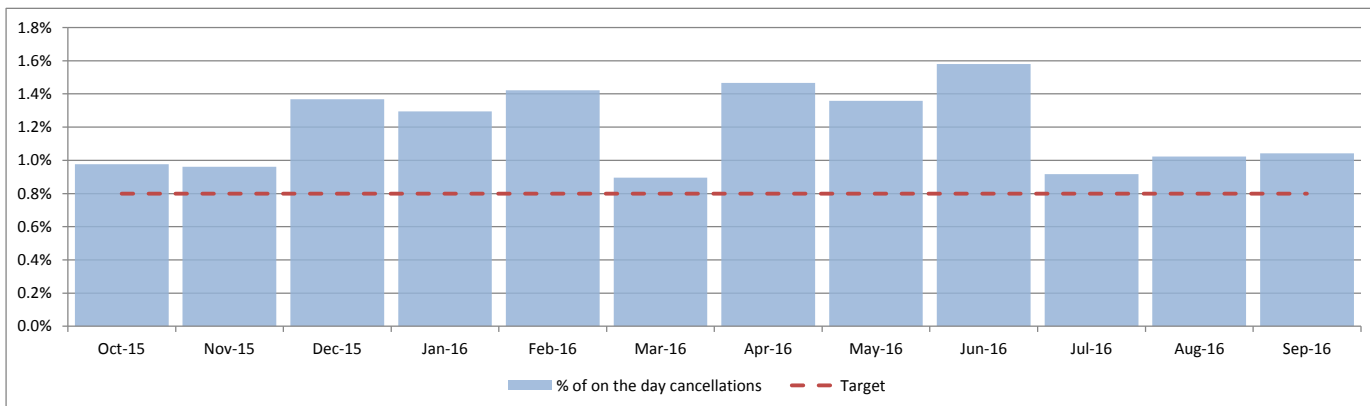
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute	1	0	0	0	0	1	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

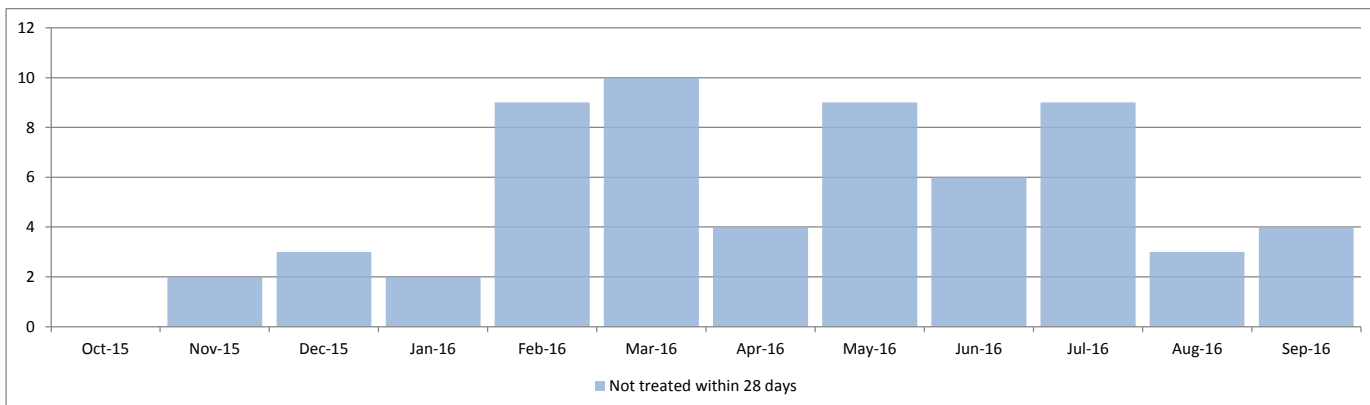
**On the day cancellations for elective operations**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Cancellations	32	30	41	40	45	29	47	46	56	30	34	36
Elective spells	3275	3123	2998	3089	3164	3236	3205	3387	3543	3271	3327	3456
% of on the day cancellations	1.0%	1.0%	1.4%	1.3%	1.4%	0.9%	1.5%	1.4%	1.6%	0.9%	1.0%	1.0%
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%



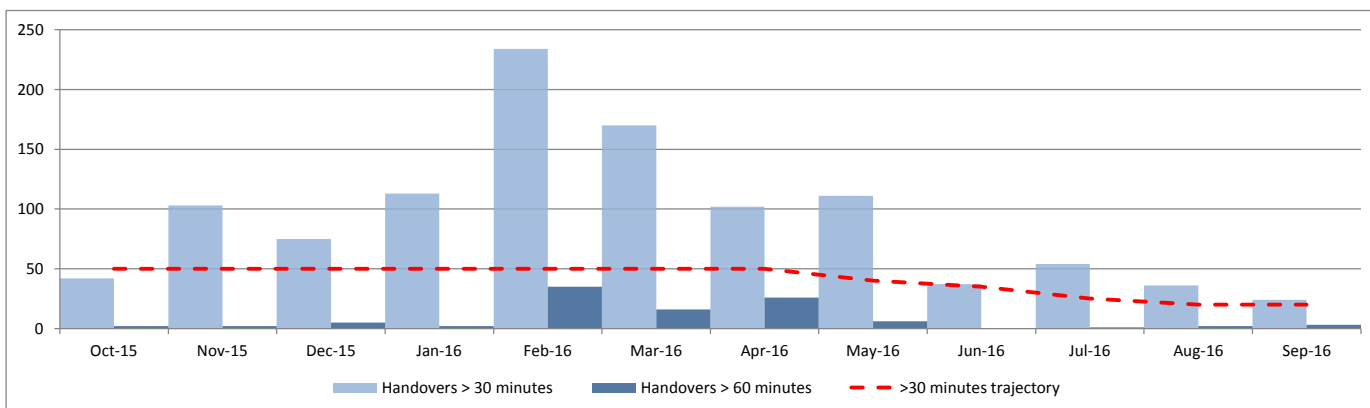
**Cancelled patients not treated within 28 days of cancellation**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Not treated within 28 days	0	2	3	2	9	10	4	9	6	9	3	4



**Ambulance handovers**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Handovers > 30 minutes	42	103	75	113	234	170	102	111	37	54	36	24
Handovers > 60 minutes	2	2	5	2	35	16	26	6	0	1	2	3
>30 minutes trajectory	50	50	50	50	50	50	50	40	35	25	20	20

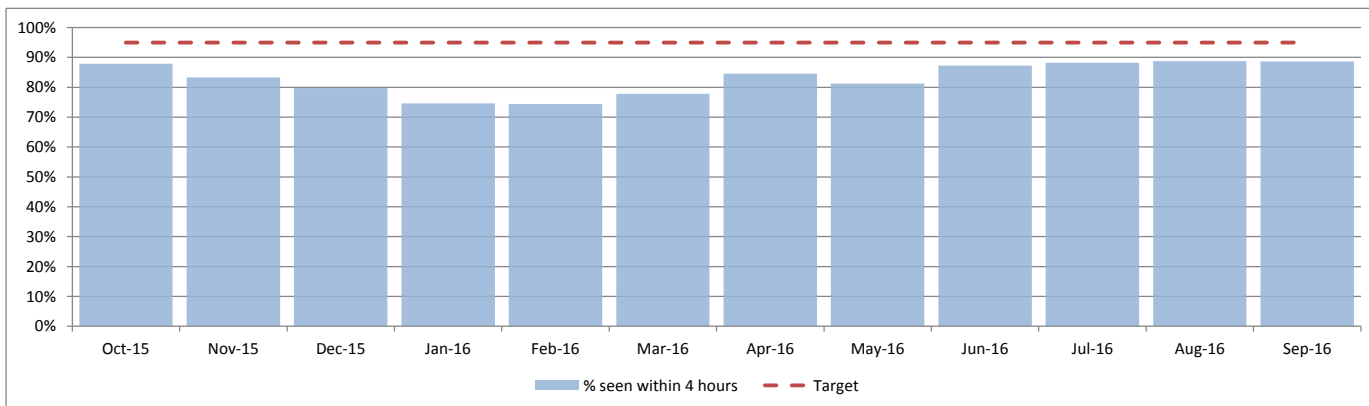




CONTRACTUAL FRAMEWORK

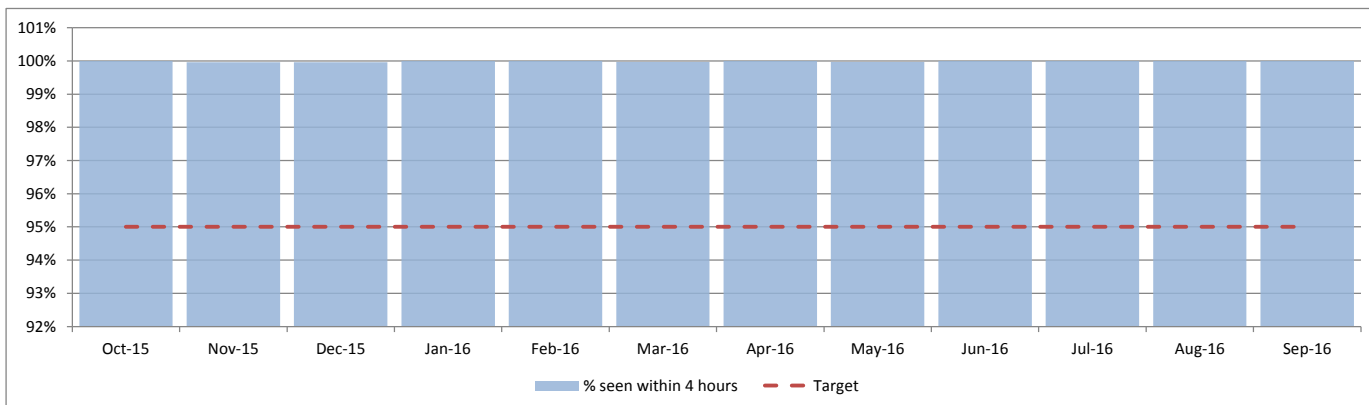
**A&E patients seen within 4 hours (DGH only)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients seen	6192	6090	5874	5896	5693	6334	5924	6534	6350	6971	6587	6142
4 hour breaches	753	1019	1191	1500	1459	1405	918	1228	810	819	744	698
% seen within 4 hours	88%	83%	80%	75%	74%	78%	85%	81%	87%	88%	89%	89%
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%



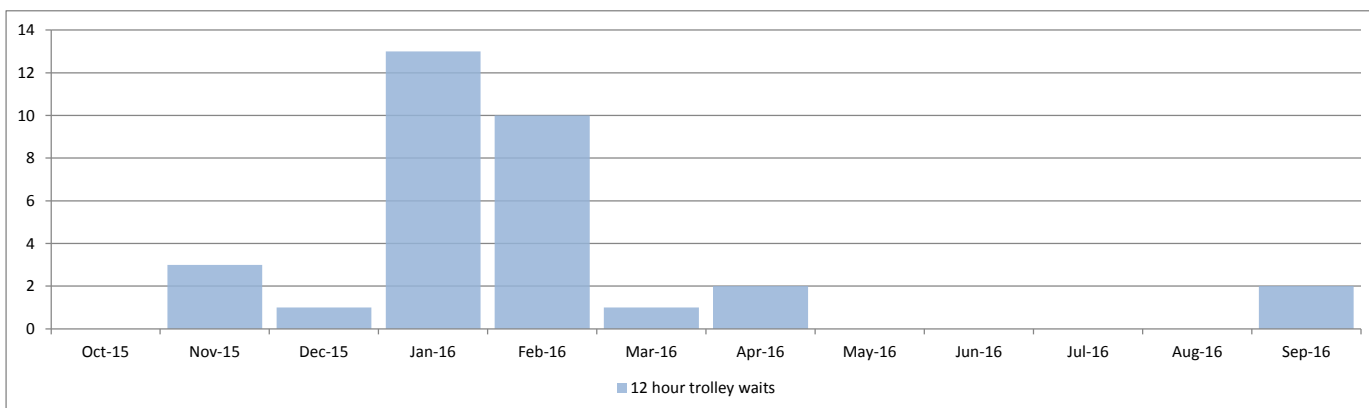
**A&E patients seen within 4 hours (community MIU)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients seen	2520	2361	2261	2327	2391	2964	2703	3207	3322	3708	3862	3297
4 hour breaches	0	1	1	0	0	1	0	1	0	0	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**

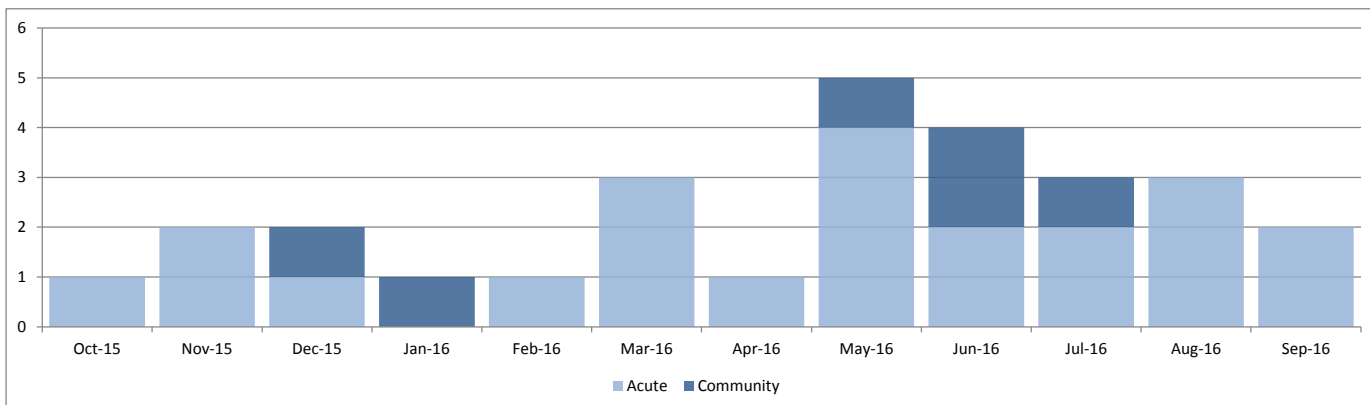
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
12 hour trolley waits	0	3	1	13	10	1	2	0	0	0	0	2



CONTRACTUAL FRAMEWORK

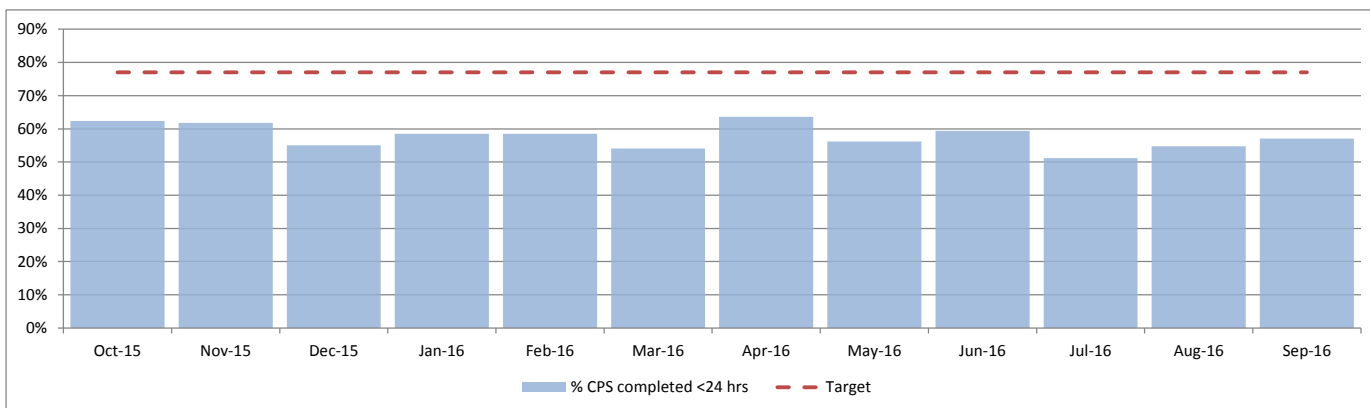
Number of Clostridium Difficile cases

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



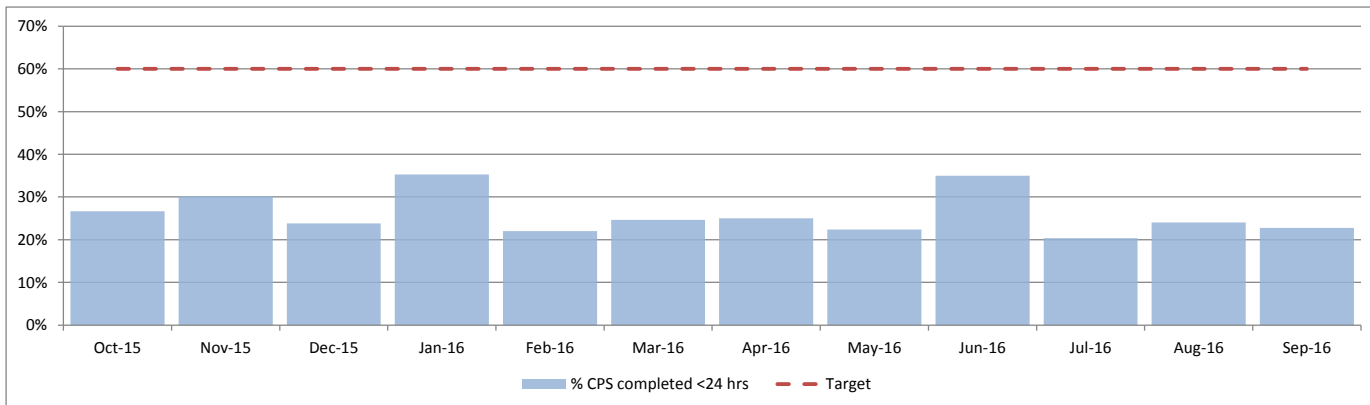
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Discharges	1148	1132	1025	997	1089	1085	1105	1109	1179	1039	1059	1187
CPS completed within 24 hours	1840	1831	1863	1705	1860	2008	1737	1975	1986	2031	1934	2081
% CPS completed <24 hrs	62%	62%	55%	58%	59%	54%	64%	56%	59%	51%	55%	57%
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

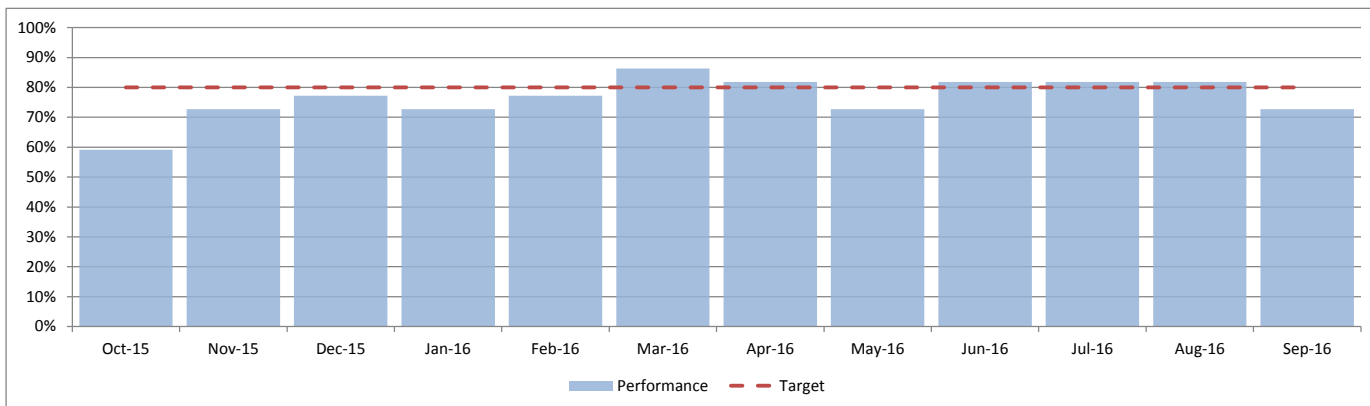
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Discharges	495	444	390	470	414	406	528	532	460	599	441	448
CPS completed within 24 hours	132	134	93	166	91	100	132	119	161	122	106	102
% CPS completed <24 hrs	27%	30%	24%	35%	22%	25%	25%	22%	35%	20%	24%	23%
Target	60.0%	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**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Specialties	22	22	22	22	22	22	22	22	22	22	22	22
Breaching 4 working days	9	6	5	6	5	3	4	6	4	4	4	6
Performance	59%	73%	77%	73%	77%	86%	82%	73%	82%	82%	82%	73%
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%



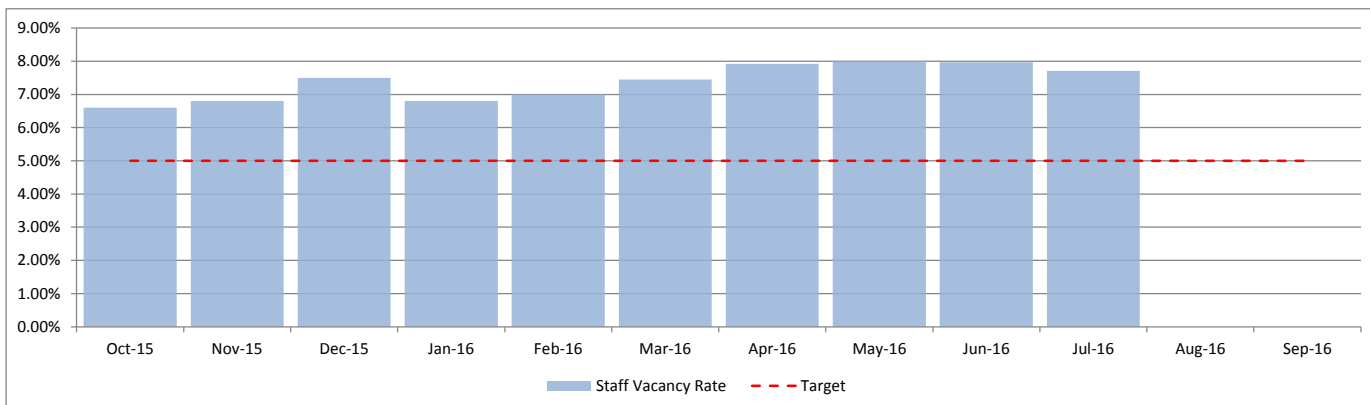
# WORKFORCE MANAGEMENT FRAMEWORK

Month 6 September 2016

WORKFORCE MANAGEMENT FRAMEWORK

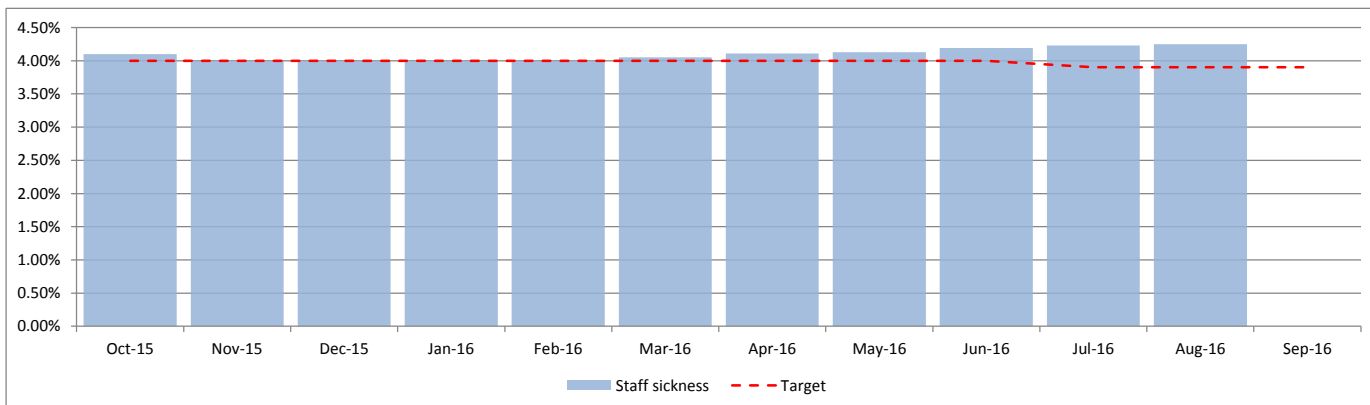
**Staff Vacancy Rate (excluding temp workforce and additional hours)**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Staff Vacancy Rate	6.60%	6.80%	7.50%	6.80%	7.00%	7.45%	7.92%	7.99%	7.97%	7.71%	n/a	n/a
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%



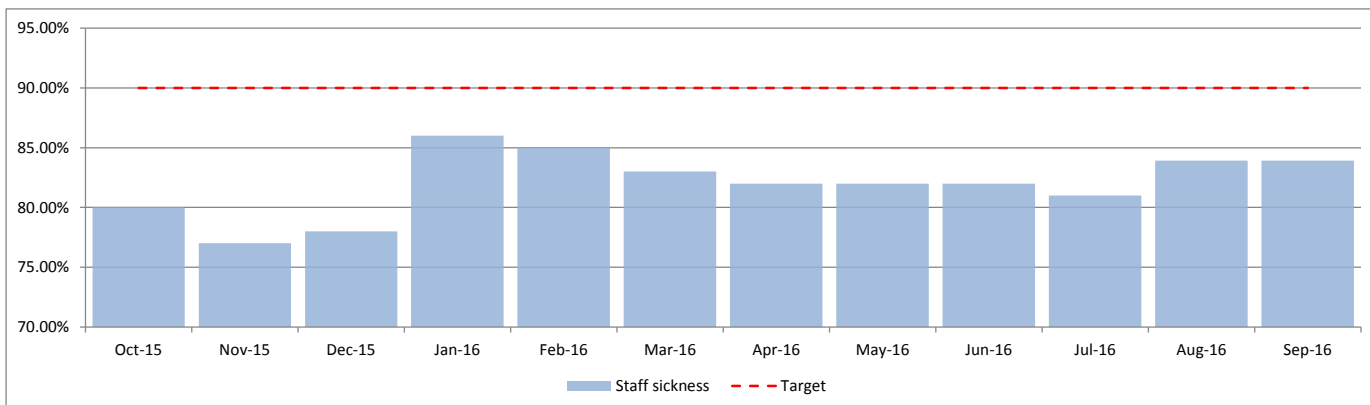
**Staff sickness**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Staff sickness	4.10%	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	n/a
Target	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%



**Appraisal Completeness**

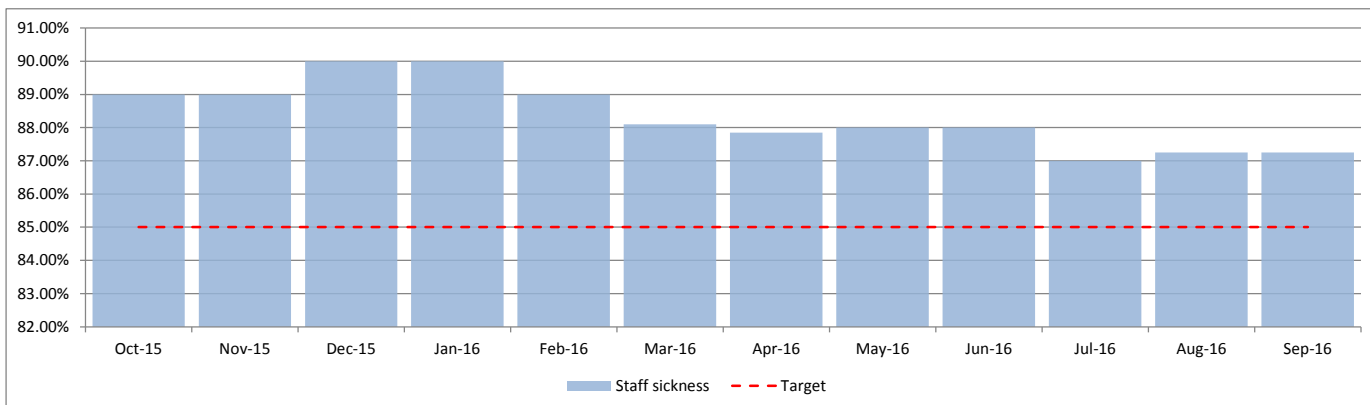
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Staff sickness	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



WORKFORCE MANAGEMENT FRAMEWORK

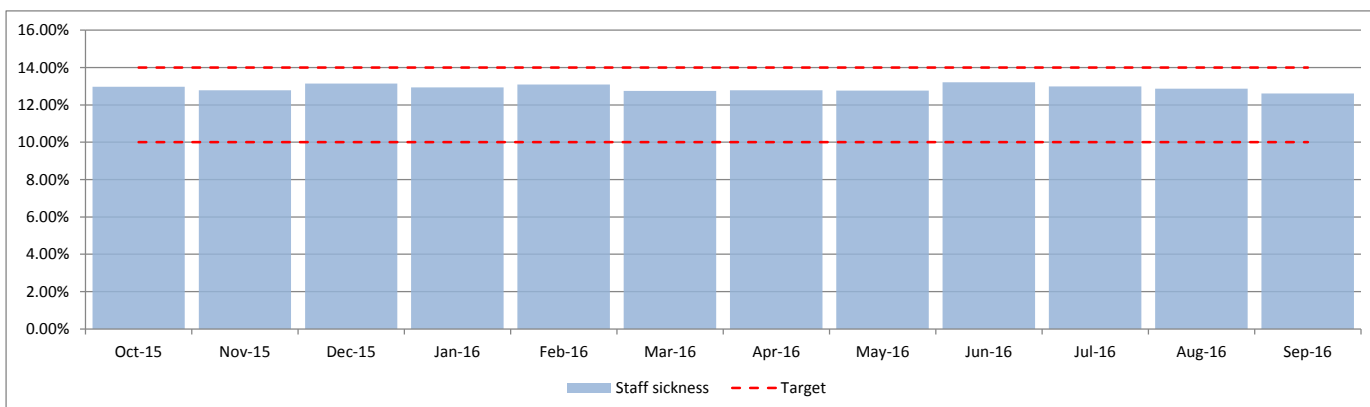
**Mandatory Training Completeness**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Staff sickness	89.00%	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%
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%



**Turnover - All Staff (Excl Jnr Docs) Rolling 12 Month Turnover Rate**

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Staff sickness	12.97%	12.79%	13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.87%	12.61%
Target	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%	10-14%



CIP year end Delivery Forecast as at Month 6 2016/17

Master Ref	Title	Confidence	Conf RAG	CIP Scheme Target 2016/17	Forecast Rec 2016/17	Forecast Non-Rec 2016/17	Delivered YTD Rec	Delivered YTD Non-rec
571	Corporate accruals review	90%	Green	£0	£335,956			£335,956
690	Income reserves not required	[0-100]	Gray	£0		£412,500	£1,650,000	
520	Improved auditing of interface between Rosterpro to ESR for Paymer	90%	Green	£0			£20,000	
468	Lost pager review	[0-100]%	Gray	£2,000			£0	
513	MR contrast for cardiac is about to be ordered in different volumes. T	100%	Green	£3,500		£3,500	£3,500	
560	Church st sale and reduction in utilities	70%	Yellow	£4,000		£0	£4,000	
417	Community Nursing Vehicle Review - Torbay and SD	100%	Green	£5,000	£0		£0	
559	Sewing room	90%	Green	£5,000		£0	£5,000	
489	Private Therapy Income	100%	Green	£5,000		£5,000	£5,000	
558	Car Parking kings ash	0%	Red	£6,000		£0	£0	
479	Outpatient Productivity	0%	Red	£6,250	£0	£0	£0	£0
557	External Non clinical Cleaning contract	50%	Red	£6,500		£0	£0	
735	Research Income	[0-100]	Gray	£9,000				
497	Increase Ultrasound scan charge Idea to work up further	100%	Green	£10,000		£0	£6,000	
551	Car Parking Introduction of New Tariff £10 for 8 hrs	70%	Yellow	£10,000		£0	£10,000	
566	Retail outlet level 4	60%	Yellow	£10,000		£0	£10,000	
565	Regents house rent review	30%	Red	£15,000		£0	£15,000	
555	Car Parking review of public charges in the community	70%	Yellow	£15,000		£0	£15,000	
737	HQ Synergies - Chief Executive	95%	Green	£17,548	£8,774			£17,548
552	FM non pay general savings	50%	Red	£20,000		£0	£0	
553	Estates non pay general savings	100%	Green	£20,000		£20,000	£20,000	
544	Income from Training	[0-100]%	Gray	£20,000			£0	
710	Strategy Directorate- MARS leaver	100%	Green	£20,089		£20,089		
695	HR - Yeovil Business Case	90%	Green	£23,333		£5,186	£23,333	
407	Joined Up TeleHealthCare Strategy	50%	Red	£25,000	£0		£13,000	
433	Cavanna House - termination of existing lease at end of current term	90%	Green	£25,000		£0	£25,000	
549	Catering review Acute	100%	Green	£25,000		£25,000	£25,000	
550	Hotel Services Community Hospitals	100%	Green	£25,000		£25,000	£25,000	
554	Management pay	100%	Green	£26,000		£26,000	£26,000	
694	CE - Corporate - pension scheme	90%	Green	£27,466		£6,867	£27,466	
693	HR - synergies - part band 8a post	90%	Green	£27,773		£13,884	£27,773	
476	Additional income via Utilisation of new Cardiac Lab	0%	Red	£30,000	£0	£0	£0	£0
487	Microbiology VAT saving	100%	Green	£30,000		£15,000	£30,000	
493	Medical Electronics Reorganisation	100%	Green	£30,000		£30,000	£30,000	
494	Clinical Psychology Staff Saving	100%	Green	£30,000		£30,000	£30,000	
469	Mobile Phone review/BYOD	20%	Red	£30,000			£0	
692	Procurement synergies - B5 post	90%	Green	£30,651		£15,243	£30,651	

413	Efficiencies from Thera Contract (ASC element) A	90%	Green	£36,000	£0	£18,000	£36,000	
434	Review of specialist LD vacancy	100%	Green	£37,000	£0	£19,000	£37,000	
466	Procurement efficiencies	100%	Green	£40,000			£0	
428	Vacant FAB team posts to be reviewed re, Care Act Funded	100%	Green	£44,000	£0	£22,000	£44,000	
739	HQ Synergies - Procurement	[0-100]	Gray	£44,200		£22,100	£44,200	
423	Robust review process for adult IPPs	90%	Green	£50,000	£0	£67,000	£146,000	
495	Reduction in spend on Blood - cell salvage	100%	Green	£50,000		£25,000	£50,000	
543	eLearning Strategy	0%	Red	£50,000			£0	
498	Reduction in discretionary spend	100%	Green	£57,000		£28,000	£57,000	
444	GPWSI	100%	Green	£58,000	£29,000	£0		£58,000
556	Car Parking community staff charges	70%	Yellow	£60,000		£0	£60,000	
446	Community funding set based on Run Rate spend last year, not now	100%	Green	£63,859	£0	£27,376	£54,753	£0
408	Independent Sector - Enhanced Brokerage	50%	Red	£75,000	£0		£38,000	
471	Printing and Electronic Communication Strategy	80%	Yellow	£75,000			£0	
713	Strategy - remaining CIP/SLIP schemes	100%	Green	£77,638				
535	PMU - increased sales on top of planned surplus	[0-100]	Gray	£78,000			£0	
424	In House Learning Disability Bay Tree (Reprovision of Respite Care)	90%	Green	£79,000	£0	£11,000	£79,000	
427	Recurrent Impact of Community Support Team savings	100%	Green	£80,000	£0	£40,000	£80,000	
421	Efficiencies from Thera Contract (PP element)	90%	Green	£81,000	£0	£41,000	£81,000	
465	Review Revenue Costs for IT Systems	[0-100]	Gray	£81,000			£0	
537	FP10 Outpatients - pharmacy scheme	90%	Green	£100,000	£0	£0	£0	£0
416	ASC Insurance Premium Reduction	100%	Green	£100,000		£50,000	£100,000	
410	Ind Sector - Additional reclaim of ASC Direct Payments	100%	Green	£100,000		£69,000	£138,000	
403	Independent Sector - Removal of Community Care Trust block and re	100%	Green	£100,000		£72,000	£144,000	
707	Clinical supplies procurement - Medicine impact	50%	Red	£109,000	£0	£0	£0	£0
705	Clinical supplies procurement - WCDT impact	50%	Red	£121,000				
464	Staff Salary Sacrifice Schemes	100%	Green	£122,000	£19,750	£32,117	£104,000	£65,000
406	Independent Sector - Supported Living	50%	Red	£125,000	£0		£63,000	
409	Ind Sector - Responsive Management of Domiciliary Care	50%	Red	£125,000	£0		£63,000	
405	Independent Sector - SPACE	70%	Yellow	£125,000			£63,000	
443	Recurrent Impact of Hotel Service re-design	0%	Red	£135,000	£0	£0	£0	
547	Gas utilities	100%	Green	£140,000		£140,000	£140,000	
709	HQ Synergies - Strategy	90%	Green	£140,400		£70,200		
488	Replacement of Existing Roche Managed Service contract	100%	Green	£147,000		£0	£147,000	
435	South Devon Operations (Community Services) CIP Saving assumption	90%	Green	£150,000	£162,000	£75,000	£150,000	£208,000
536	Drug savings - pharmacy scheme	90%	Green	£160,000	£0	£0		£0
402	Ind Sector - Reduction in Care Home Placements (Standard under £6	50%	Red	£175,000	£0		£88,000	
548	Car Parking	100%	Green	£190,000		£110,000	£190,000	
738	HQ Synergies - Education Directorate	[0-100]	Gray	£195,900				
496	Therapies recurrent vacancy factor	100%	Green	£198,000	£89,409			£198,000
425	Community Services CIP Saving assumption based on previous year	90%	Green	£200,000	£204,000	£100,000	£200,000	£262,000



538	Integrated Medicines Management - pharmacy scheme	90%	Green	£250,000	£0	£0	£0	£0
432	Co-location of Paignton & Brixham Zones	50%	Red	£250,000	£0		£125,000	
480	Clinically led procurement in surgery	100%	Green	£258,591	£18,316	£33,902	£199,730	£58,861
691	Finance restructure pay savings	70%	Yellow	£263,918		£85,167	£349,085	
706	Clinical supplies procurement - Surgery impact	50%	Red	£270,000	£0	£469	£1,126	£0
688	Synergies - EFM	50%	Red	£294,000		£0	£0	
572	Corporate non-pay savings	100%	Green	£390,870	£351,979	£0	£0	£390,870
734	CHC General Packages of Care Review	90%	Green	£417,000		£287,000	£578,000	
418	Bring review assessments up to date CHC	90%	Green	£430,000	£0	£118,000	£578,000	
481	Surgery non-pay challenge	60%	Yellow	£440,000	£0	£102,841	£246,818	£0
419	Tightening panel process (CHC)	70%	Yellow	£498,000	£0	£78,000	£443,000	
426	Torbay Operations (Community Services) CIP Saving assumption ba	90%	Green	£500,000	£556,000	£250,000	£500,000	£740,000
723	Nursing agency spend	80%	Yellow	£500,000				
697	HQ Synergies - HR	50%	Red	£552,200				
708	Medical SDU Senior agency and locum budgets	90%	Green	£600,000	£0	£300,000	£600,000	£0

1,775,184      2,947,441      8,094,435      2,334,235

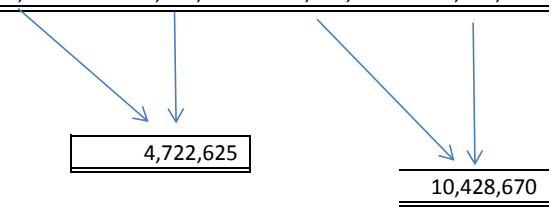
Trustwide Scheme Gap			£3,272,828
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CIP Target			13,957,514
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Yr end Forecast Total  
Delivered Year to Date

4,722,625
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10,428,670
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## Referral to Treatment Target (RTT)

The Trust has been compliant with the required performance trajectory for RTT for the first quarter of the year but there were underlying capacity issues within some specialities and neurology in particular that resulted in a predicted down turn in performance in the remaining quarters of the year.

In addition to the known capacity issues other changes have occurred that have or will impact on compliance with the target. These include:

- Re- prioritisation of medical staffing in medicine to support extended weekend working in line with the CQC improvement plan
- Further workforce issues identified in respiratory and cardiology
- A joint decision with the CCG to suspend outsourcing of hips and knees to Mount Stuart

The summary below details the impact of the current position on RTT compliance and includes a summary of the actions required to recover the position and deliver compliance with the standard by March 2018.

### **Background**

The consolidated response to performance queries at September 2016 highlighted that RTT delivery had deteriorated below the 92% standard and the STF trajectory. The deterioration of the aggregate position was reported as being driven by workforce challenges and associated reduction in capacity faced by the Neurology Department. At the time the Neurology backlog was recorded as 282 patients waiting over 18 weeks. With additional Neurology capacity coming from a recent appointment of a locum Doctor the rate of growth in the Neurology backlog will decrease from a predicted backlog of 521 to between 350/400 by March 2017.

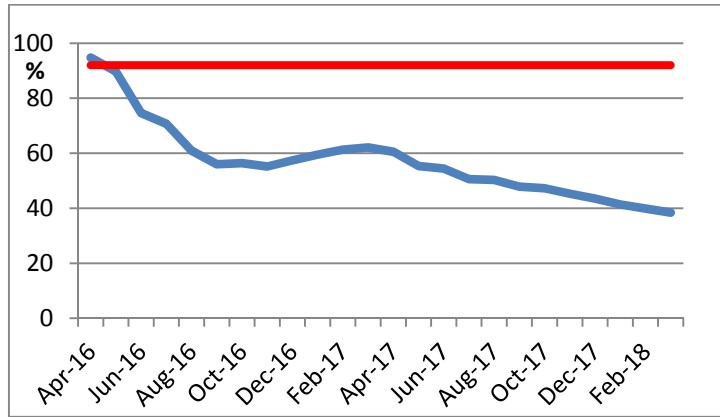
Attention was drawn to further known shortfalls in capacity in other high volume specialties, in particular cardiology and respiratory. It was reported that the cardiology position had stabilised following summer leave however, due to reduction in consultant workforce it has now started to deteriorate, with a current backlog of 205. The impact of not finding a solution to the workforce shortfall in respiratory has also had a significant impact on their backlog which currently stands at 217 and is expected to deteriorate further with the expected loss of another consultant.

The decision to suspend outsourcing of orthopaedics will bring about an increase in the backlog of 100 patients to 380 causing deterioration in the aggregate position by approximately 0.5%.

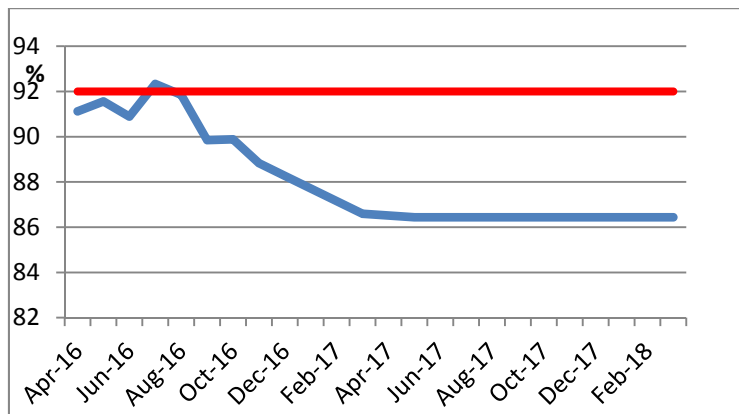
**Risks and Issues**

The following graphs illustrate the impact of current limitations of capacity on RTT by speciality

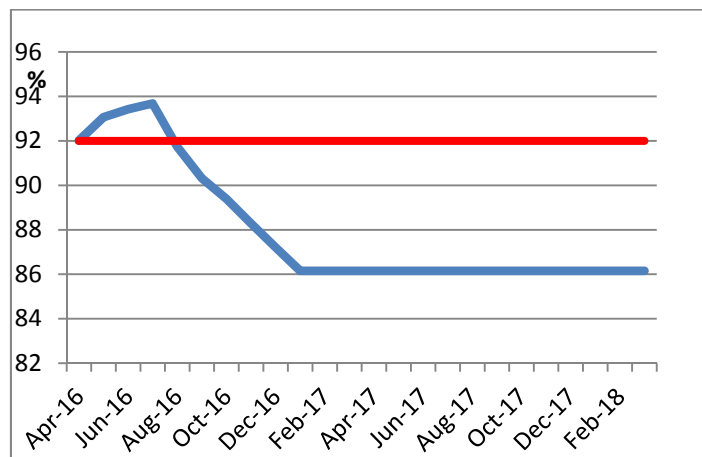
**Neurology:** Registrar doing 5 clinics per week until March 17 and no recruitment of other consultant.



**Urology:** No senior core trainee - so consultants will have to drop elective work to cover on call counter acting increase from additional consultant.

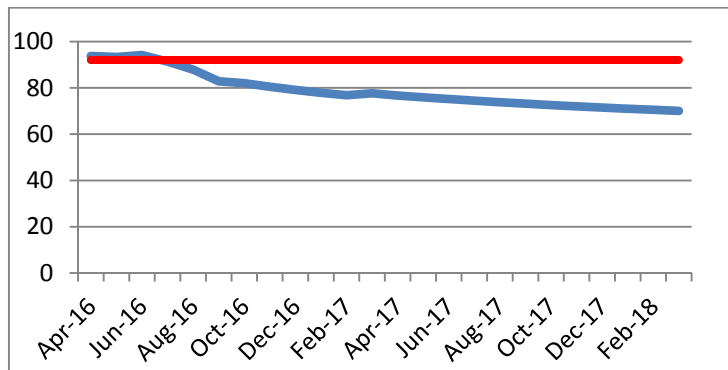


**Cardiology:** Consultant retirement and return on reduced hours with no other consultant recruited

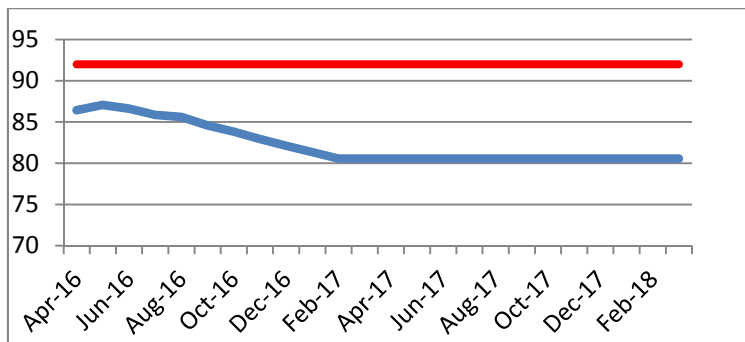


**Appendix 4 to Integrated performance report – November 2016**

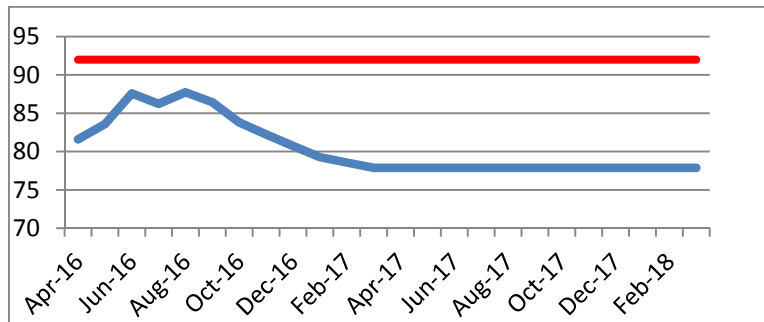
**Respiratory Medicine:** No recruitment of consultant (2 wte down)



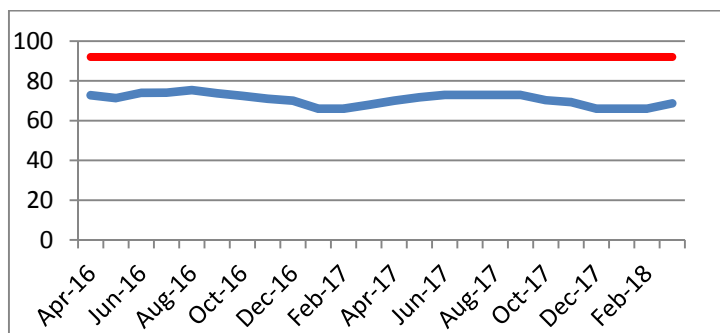
**Trauma & Orthopaedics:** No outsourcing and no recruitment of foot and ankle Fellow, no single point of access for foot and ankle.



**Colorectal Surgery:** No Saturday list (1 list /month – 6 patients on a list)



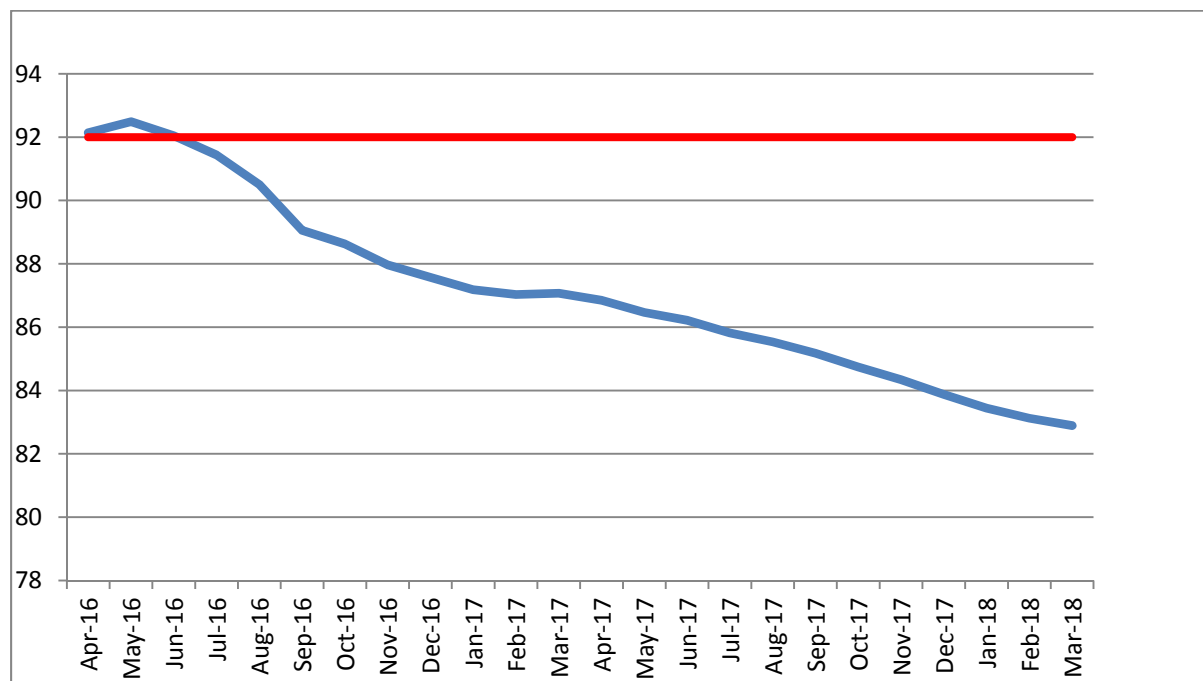
**Upper G I Surgery:** No Saturday lists (1 list /month - 5 patients on a list)



## Appendix 4 to Integrated performance report – November 2016

The combined effect on the consolidated RTT trajectory by March 2018 will result in a lowering of performance to 83%. Reversal of the decision to stop outsourcing would have minimal effect this year, 0.5%.

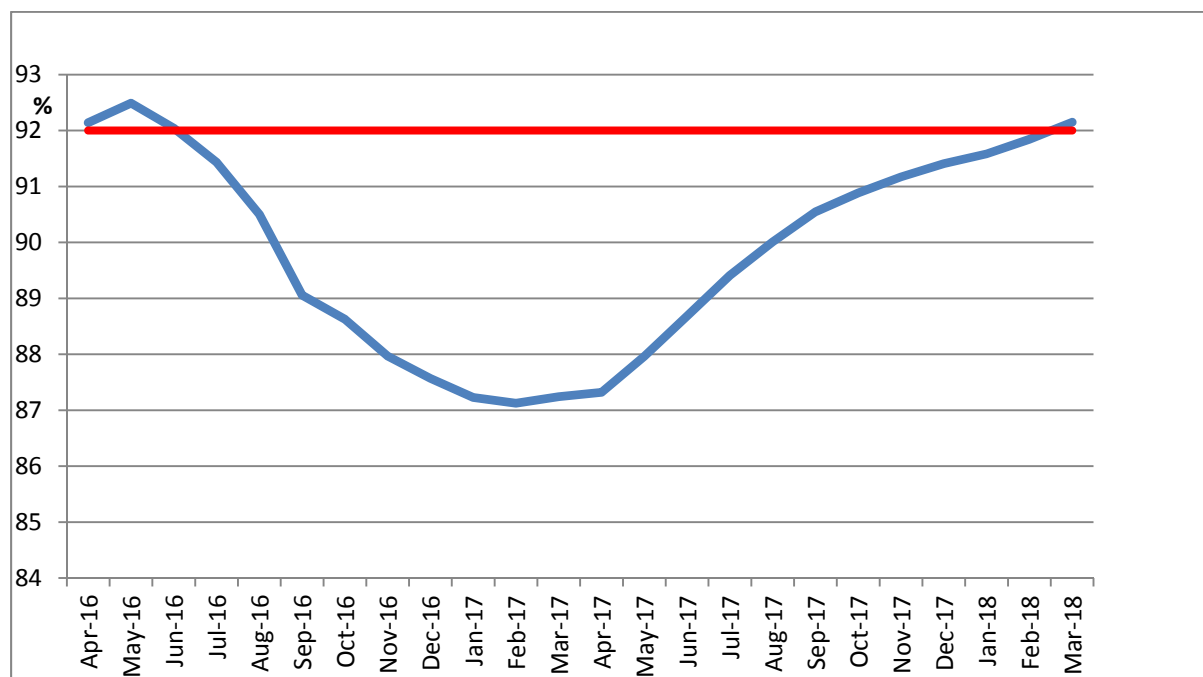
### Consolidated RTT position if current position remains.



### Recovery

The table below shows the trajectory required to return the Trust RTT performance to 92% by March 2018.

### Revised RTT consolidated trajectory to achieve 92% RTT by 31<sup>st</sup> March 2018



### Mitigation

Actions already in place between now and March 2017 are resulting in some specialties reducing their backlog of patients. Specialties contributing with backlog reductions are pain, Orthodontics and Orthopaedics. Actions include:

- Saturday lists for Urology running Oct – Dec
- Extended Trauma Lists 4 cases / month running Nov – Mar
- Foot and ankle Saturday lists 12 cases per month running Oct-Dec

To recover compliance with the RTT standard by March 2018 local solutions the following actions will be required:

#### Recruitment to vacant clinical posts

- Neurology (2 Consultants)
- Cardiology (1 Consultant)
- Respiratory (2 Consultants)
- T&O (1 Foot & Ankle Cons/Fellow)
- Urology (1 Middle Grade)
- Upper GI (1 Consultant)

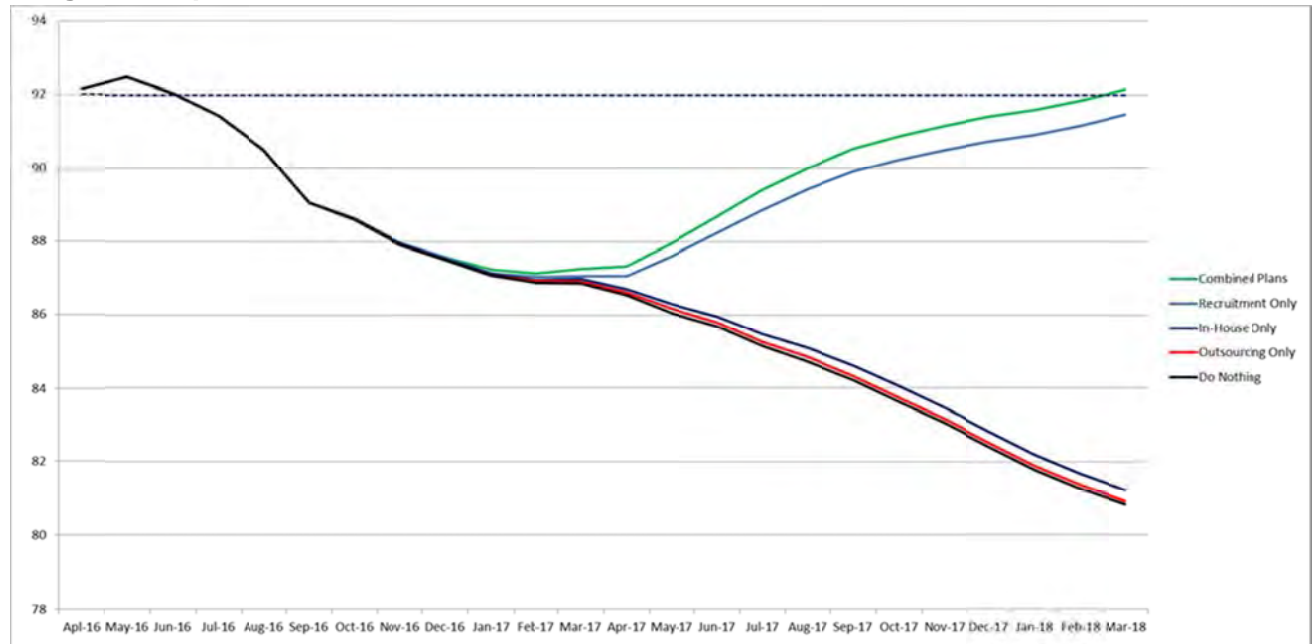
#### Outsourcing

- Continue T&O outsourcing (20 patients a month)

#### Increase in house capacity- weekend working

- Colorectal/ urology/ upper GI

### Mitigation Impact



***Conclusion***

Workforce challenges, increased demand for services and a decision to prioritise resources to key quality and safety risks will have a sustained impact on compliance with the RTT standard. Recovery relies on securing the appropriate levels of capacity through in house solutions or agreement on different working models.

**Liz Davenport**  
**Chief Operating Officer**





**REPORT SUMMARY SHEET**

<b>Meeting Date:</b>	2 November 2016
<b>Title:</b>	Additional Unpaid Annual Leave
<b>Lead Director:</b>	Judy Saunders Director Of Workforce and Organisational Development
<b>Corporate Objective:</b>	Well Led
<b>Purpose:</b>	For Approval

**Summary of Key Issues for Trust Board**

Strategic Context:

The Board has required additional CIP schemes to be brought forward under a contingency plan for under-delivery of the Trust's challenging CIP target for 16/17.

Offering staff the opportunity to take additional unpaid annual leave of up to one week in the current financial year 2016/17 would provide a means of reducing expenditure on pay.

The opportunity to take additional unpaid leave could be offered to all staff or specific groups. The leave could be optional or mandated.

Key Issues/Risks

If the scheme is offered to all staff, those working in front line roles are most likely to have applications refused as the payment for backfill would negate the objective of this scheme

A mandated approach would require a variation to existing contracts of employment or termination of contracts and re-engagement on new terms and condition of employment and could possibly lead to adverse employee relations issues.

Recommendations:

The scheme should be open to all staff groups on a voluntary basis, with clarity on the conditions of offer, and piloted for this year with the appropriate governance and authorisation processes in place. Pending assessment of the impact of the scheme, the scheme could be made permanent.

Summary of ED Challenge/Discussion:

Risk of negative employee relations in specific staff groups if not offered to all staff on a voluntary basis.

The scheme would require a guarantee that there will be no additional costs incurred through backfill or adverse impact on service delivery as a consequence of the leave.

The reduction in pay as a consequence of taking unpaid leave could be spread over the remaining months of the year in order that the effect of the reduction is evenly spread for the member of staff.

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

None

Equality and Diversity Implications:

Staff working in front line positions where backfill will be a requirement are less likely to be able to take up this offer.

PUBLIC

## ADDITIONAL UNPAID ANNUAL LEAVE

### 1. Context

Within an increasingly challenging financial environment additional unpaid annual leave provides a means for reducing expenditure on pay.

### 2. Proposal

This paper considers the principle of staff taking an additional week of annual leave on an unpaid basis in the current financial year (2016/2017). Options included are for this to be on a purely voluntary basis or by imposition. The options could apply to all staff or specified staff groups as outlined below.

### 3. Staff Groups and Estimated Cost Savings

- Band 8 and above working in non-clinical roles inclusive of Directors

Band	Total Pay	Cost of 1 week's leave
Band 8 - Range A	£5,493,431	£105,643
Band 8 - Range B	£3,433,177	£66,023
Band 8 - Range C	£2,069,946	£39,807
Band 8 - Range D	£765,480	£14,721
Band 9	£289,411	£5,566
Senior Managers	£1,063,166	£20,445
<b>Grand Total</b>	<b>£13,114,611</b>	<b>£252,204</b>

- All Non Clinical staff

Staff Group	Total Pay	Cost of 1 week's leave
Administrative and Clerical	£33,839,638	£650,762
Estates and Ancillary	£6,821,348	£131,180
<b>Grand Total</b>	<b>£40,660,986</b>	<b>£781,942</b>

- All Staff

Staff Group	Total Pay	Cost of 1 week's leave
Add Prof Scientific and Technic	£8,956,436	£172,239
Additional Clinical Services	£19,770,971	£380,211
Administrative and Clerical	£33,839,638	£650,762
Allied Health Professionals	£13,264,154	£255,080
Estates and Ancillary	£6,821,348	£131,180
Healthcare Scientists	£3,623,008	£69,673
Medical and Dental	£26,994,367	£519,122
Nursing and Midwifery Registered	£36,882,252	£709,274
Students	£93,466	£1,797
<b>Grand Total</b>	<b>£150,245,641</b>	<b>£2,889,339</b>

Staff groups included in non-clinical are A&C and Estates.

Tables are based on basic salary without on-costs.

## **4. Options for implementation of the Scheme**

### **4.1 Voluntary Approach**

#### **Band 8 and above**

Senior staff working in non-clinical roles could be positively encouraged to consider taking an additional week of unpaid annual leave in the current leave year to help with the trusts financial position. Encouraging senior staff to lead by example could be used as a trial to pave the way to open the scheme up to other staff groups, if necessary.

#### **All Non Clinical Staff**

All staff working in roles that do not require cover or incur any form of backfill costs could be offered the opportunity to take an extra week's unpaid annual leave.

#### **All Staff**

All staff could be offered the same opportunity to take an extra week of unpaid annual leave in the current financial year providing there is no cost incurred in providing any form of cover and there is no impact on clinical activity.

#### **Considerations**

Staff side representatives could be actively engaged to ensure their membership are aware of the scheme and the need to optimise uptake as a method of mitigating potentially less palatable future measures.

The detail of the scheme could include dividing the salary reduction over several months so the effect is spread. There would also need to be assurance that no additional cost would be incurred for cover or in other areas as a consequence of the additional leave.

### **4.2 Variation of Contract**

If there is a low response to a voluntary approach or the perception that this may be the case then consideration could be given to seeking agreement to a contractual change within a specified staff group e.g. Band 8a and above or for all staff groups where the savings would not be mitigated by the need for backfill. Agreement would allow for a change to terms and conditions of service for an imposition of one week's unpaid leave to be taken in one or more leave years.

Such action has taken place in a number of local government organisations over recent years. Where this has happened it has been in the context that the definitive alternative would be job losses. Acceptance has been via balloting following the presentation of a detailed proposal to staff and dialogue with the trade unions leading to a local variation outside of agenda for change or national agreements.

### **4.3 Contract Termination**

The option of imposing a contractual change unilaterally would be via the termination of contract and re-engagement on new terms of employment. A fair dismissal and appeal process would need to be followed in such circumstances. Such action would inevitably attract claims for constructive unfair dismissal and also for unlawful deduction from wages. The law around these actions provides notoriously difficult grounds for an employer to form a defence.

### **5. Further Considerations**

If the scheme is open to all staff and proves popular it is inevitable that the greatest impact will be on those staff working in front line roles where the demand for backfill is likely to be greater which will inevitably lead to a greater number of applications being refused.

### **6. Recommendations**

The scheme should be open to all staff groups and senior management teams should be asked to lead by example. Positive encouragement should also be given to those whose absence will not incur cost or any form of service detriment during the additional leave period.

Authorisation of additional annual leave should be via the Authorisation Form (Appendix 1)

This effectively requires a guarantee that there will be no additional costs incurred or adverse impact on service delivery as a consequence of the leave.

Financial savings resulting from take up of the scheme could become part of the relevant service delivery units cost improvement programme savings which should encourage promotion of the scheme.

## AUTHORISATION TO BUY ADDITIONAL ANNUAL LEAVE OCTOBER 2016 – MARCH 2017

This form should be completed by staff wishing to purchase one week of additional annual leave.

<b>PART A: For completion by the employee.</b>			
Division:			
Ward/Department:			
Full Name:			
Job Title:			
Band/Grade:		Date of Birth:	
Assignment Number/Payroll Number:			
Pay Band:		£	
Contracted Hours:			
Contact Details:	E-mail:		
	Phone:		
	Home Address:		
<b>I wish to purchase one week's annual leave to be taken prior to 31<sup>st</sup> March 2017.</b>			
Date:			
Signed:			
Name in PRINT:			

**PART B: For completion by the line manager**

1. Additional Annual Leave - Approved/Not Approved\*

If approved please complete section 2 and 3

\*(delete as appropriate)

2. Please provide details of how the post will be covered during the week of additional annual leave.

3. I can confirm that there will not be any additional costs incurred or cover required as a consequence of this additional leave.

Line Manager Signature:	Date:
Name in PRINT:	
Contact Details:	Email: Tel:

*\*If approved, please forward completed form to the Payroll Dept, Regent House, Torquay and retain one copy on the personal file*





**Report of Finance, Performance and Investment Committee Chair  
to TSDFT Board of Directors**

<b>Meeting date:</b>	25 October 2016
<b>Report by + date:</b>	Robin Sutton, 26 October 2016
<b>This report is for:</b> <i>(please select one box)</i>	Information <input checked="" type="checkbox"/> Decision <input type="checkbox"/>
<b>Link to the Trust's strategic objectives:</b> <i>(please select one or more boxes as appropriate)</i>	1: Safe, quality care and best experience <input checked="" type="checkbox"/> 2: Improved wellbeing through partnership <input checked="" type="checkbox"/> 3: Valuing our workforce <input checked="" type="checkbox"/> 4: Well led <input checked="" type="checkbox"/>
<b>Public or Private</b> <i>(please select one box)</i>	Public <input checked="" type="checkbox"/> or Private <input type="checkbox"/>

**Key issue(s) to highlight to the Board:**

- The year to date results at end August 2016 (Month 6) show: i) actual **Income** at £202.7m, a favourable variance to PBR Plan of £5.2m ii) actual **EBITDA** at £3.9m, an adverse variance to Plan of £0.4m iii) an overall **Deficit** of £3.7m, an adverse variance to Plan of £0.04m iv) actual **Cash** at £14.3m, an adverse variance to Plan of £2.5m
- The Trust has not achieved the **NHSI Compliance** Framework quarterly targets for A&E, RTT, Cancer 2ww and Cancer subsequent surgery.
- The forecast results for the full year show: i) forecast **Income** at £395.6m, a favourable variance to PBR Plan of £2.4m ii) forecast **EBITDA** at £8.8m, an adverse variance to Plan of £10.3m iii) forecast **Deficit** of £8.6m compared to a Plan surplus of £1.7m iv) forecast **Cash** at £11.8m, an adverse variance to Plan of £6.7m
- STF funding** of £1.5m has been accessed for Quarter 2.
- Year to date **CIP** (Month 6) delivery is £4.7m, a favourable variance to Plan of £2.3m. The full year forecast CIP delivery has now improved to £10.4m which is an adverse variance to Plan of £3.5m.
- Year to date (Month 6) **Capital expenditure** is £8.5m which is £4.2m below Plan, the full year forecast Capital expenditure is £21.9m against a Plan of £36.9m. In order to maintain our risk rating, it will be necessary to substantially reduce the planned level of capital expenditure.

**Key Decision(s)/Recommendations Made:**

- The **STP return** which had been prepared and submitted in conjunction with our CCG was discussed and reviewed.
- The **Adverse Change to Forecast Protocol – Board Assurance Statement** that has been submitted was reviewed and discussed.
- Ongoing deep dives into **CIP** are planned for future meetings.

Name: Robin Sutton (Committee Chair)



**Report of Quality Assurance Committee Chair  
to TSDFT Board of Directors**

<b>Meeting dates:</b>	24 October 2016
<b>Report by + date:</b>	David Allen, 25 October 2016
<b>This report is for:</b>	Information <input checked="" type="checkbox"/> Decision <input type="checkbox"/>
<b>Link to the Trust's strategic objectives:</b> <i>(please select one or more boxes as appropriate)</i>	1: Safe, quality care and best experience <input checked="" type="checkbox"/> 2: Improved wellbeing through partnership <input type="checkbox"/> 3: Valuing our workforce <input type="checkbox"/> 4: Well led <input checked="" type="checkbox"/>
<b>Public or Private</b> <i>(please select one box)</i>	Public <input checked="" type="checkbox"/> or Private <input type="checkbox"/> + Freedom of Information Act exemption [ <i>insert exemption if private box used</i> ]

**Key issue(s) to highlight to the Board:**

**1. Domiciliary Care.**

Concerns continue about the standard of service provided by Mears and the position is being closely addressed and monitored.

**2. Care Homes.**

There are approaching 100 care homes in Torbay with around 1500 residents. At any one time a small number of homes are a cause of concern. Small care homes, often owner managed, can be particularly vulnerable as the owners age themselves and more pressure is exerted on local authority budgets. The Trust is developing a more resilient and consistent system of monitoring care homes and identifying early warnings of quality challenges or market exit.

**3. Community Nursing.**

Lorraine Webber provided QAC with a report and briefing on community nursing activity, including the recording by community nurses of all their activity during a "live working week". 25% of visits are to care homes for example. The service is doing more with less through increased efficiency and better deployment of skills. Further analysis is required to ensure the right skills mix and competency framework, but the service is impressive. QAC thanked Lorraine and through her the teams for all their hard work.

**4. Deprivation of Liberty**

On reference from the Board, QAC received a report on Deprivation of Liberty (DoLs) assessments which were time consuming, required assessors with statutory qualifications and, quite rightly, a rigorous legal process. While there was a lack of capacity nationally to carry out the assessments, QAC was assured by the low numbers of urgent cases having delayed assessment and the innovative approach of the Trust to the issue.

**5. Staff recruitment and retention**

The challenges of recruiting and retaining skilled staff in certain specialties was

becoming a recurring theme in the risk register. When combined with succession planning this whole area is of the highest priority. Judy Saunders set out plans to address the shortfalls as part of a refresh of the People strategy.

**6. Board Assurance Framework.**

The Committee felt there was too much information to review the risks in detail; some risks may need reworking in the light of changing circumstances. QAC agreed that, in future, executives should identify risks of particular concern in the light of increasing impact and/or probability. Where they cannot be reviewed elsewhere e.g. at QIG, QAC would carry out a “deep dive”.

**Key Decision(s) Made** - None to report.

**Recommendation(s)** - No specific recommendations for the Board.

Name: David Allen - Committee Chair

28 October 2016

## Report Summary

<b>Meeting Date:</b>	Wednesday 2 <sup>nd</sup> November 2016
<b>Title:</b>	Six Month CNO safer staffing report – bed based
<b>Lead Director:</b>	Chief Nurse – Jane Viner
<b>Corporate Objective:</b>	Safe Quality Care Best Experience
<b>Purpose:</b>	Information/Assurance
<b>Summary of Key Issues for Trust Board</b>	
<p><u>Strategic Context:</u>            Significant streams of work continue under the Nursing Workforce Programme to ensure safety, quality and experience are delivered whilst driving forward efficiency.</p> <p>The key focus over the past 6 months has been to ensure the programme is aligned to the Trust's Corporate Objectives, Nursing Quality Board Chief Nursing Officer right staff in the right place at the right time, CQC and Lord Carter driving forward productivity and efficiency whilst maintaining safety and quality.</p> <p>The key focus areas have been:</p> <ul style="list-style-type: none"> <li>• To further review safer staffing levels</li> <li>• Recruitment, career &amp; workforce plans</li> <li>• Effective roster management</li> <li>• Reduction in agency usage and spend</li> </ul> <p>The report details the streams of work above along with key messages from each section.</p>	
<p><u>Key Issues/Risks</u></p> <p>Recruitment challenge            Increasing patient acuity and dependency:            Retirement of experienced workforce over the following 5 years            Delivering more for less            External drivers of change at pace</p> <p><u>Recommendations:</u></p> <p>For the board to note and consider the streams of work in progress and to challenge where any shortfalls in the report are noticed.</p>	
<p><u>Summary of Challenge/Discussion:</u></p> <p>Recognition that account must be taken of the changes associated with the new model of care and the move from hospital bed based care to community care. The Associate Director of Nursing (Workforce) is working with Workforce and OD colleagues to ensure the nursing</p>	

workforce strategy acknowledges these changes.

The challenge of balancing the nursing workforce efficiencies emerging from the Lord Carter productivity review, the Model Hospital and the NHSI agency cap requirement with the need to maintain CQC standards is recognised. The work underway to deliver these efficiencies and to ensure a robust quality impact assessment monitoring process is critical to maintaining safe care.

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

National Health Service Improvement (NHSI) regulation and monitoring.  
CQC  
CCG

Equality and Diversity Implications:

None

**Public**

**Six Month CNO Safer Staffing Report – Bed Based**

1. Purpose:

The purpose of this paper is to provide information and assurance regarding the Nursing and Midwifery Safer Staffing levels for the month of September 2016 and to update the board in terms of the NQB CNO recommendations in terms of safer staffing guidance.

It is the responsibility of the senior nursing and midwifery staff to be responsive to daily operational and organisational challenges by managing staff within their respective clinical areas, maintaining safe, effective, appropriate and efficient care at all times.

2. Safer Staffing Overview:

In 2013 the National Quality Board (NQB) published guidance and detailed expectations for NHS providers regarding management of Nursing and Midwifery staffing levels. One of these expectations was for Trusts to undertake establishment reviews with formal reporting at Boards level on a six monthly basis. As such a full and comprehensive establishment review, using national and professionally recognised tools, has been undertaken on a yearly basis to link into organisational business planning cycles. In addition monthly monitoring is undertaken by assessing of the acuity and dependency of the patients on the wards using both Hurst and the Shelford Group Safer Nursing Care Tool.

Along with using the recognised tools, staffing assessments have been triangulated to professional judgement which takes into account not only the variety of guidance documents which have been published by the Royal College of Nursing (RCN) to aid assessments of nurse staffing to ensure safe care provision, but also detailed knowledge of our local challenges and patients.

In July 2016 the NQB issued new guidance, which included an updated set of NQB expectations for nursing and midwifery staffing, to help NHS provider boards make local decisions that will deliver high quality care for patients. This document supports and links with other publications such as NHS England’s Framework for Nursing & Midwifery Care Staff and the Operational productivity and Performance report by Lord Carter of Coles. The expectations are summarised in the following diagram:-

<b>Safe, Effective, Caring, Responsive and Well-Led Care</b>		
<b>Measure and Improve</b>		
- patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
<b>Expectation 1</b>	<b>Expectation 2</b>	<b>Expectation 3</b>
<b>Right Staff</b> 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	<b>Right Skills</b> 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	<b>Right Place and Time</b> 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

The establishment reviews underpin Expectation 1- Right Staff, and address each of the sub points. Expectation 2 – Right Skills and Expectation 3- Right Place and Time are supported by other work streams within the developed Nursing Workforce Programme

## Ward Staffing Overview

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. However it remains unclear what data was included in this to allow accurate benchmarking for the Trust as a whole. Clarification has been requested and we are still awaiting full responses to inform future reports. In addition, national specialty specific data to allow ward based benchmarking is still not yet available.

For the month of September 2016 the organisational CHPPD is as follows:-

	TSDFT September 2016	National Median March 2016
Total CHPPD	7.84	6.77
RN/ RM CHPPD	3.73	4.07
HCA / MCA CHPPD	4.11	2.68

The analysis for September 2016 is summarised in the charts below and consists of:-

- The total Registered Nurses / Midwives (RN/RM) and Health Care Assistants / Maternity Care Assistants (HCA/MCA) combined CHPPD by ward
- The RN/RM only CHPPD by ward
- The HCA/MCA only CHPPD by ward.

A detailed monthly analysis containing planned and actual CHPPD for each of the acute wards and community hospitals is available as a table below. The analysis in the tables below show the Trust is **over** its planned total (RN + HCA) staffing levels in several areas and above the national Carter Median of 6.77. As previously stated though we are still awaiting guidance and a response from the national teams as to whether the specialist areas such as SCBU, ITU & CCU are included in the national median. There is no confirmation about areas such as Turner and CCU which also include day unit teams in their baseline establishment.

The reasons for being over planned RN hours in some areas are because of the newly qualified nurses starting plus the EAU's backfill staff needed for the AMU. The trust is still below the national CHPPD range of 4.07 for RN's.

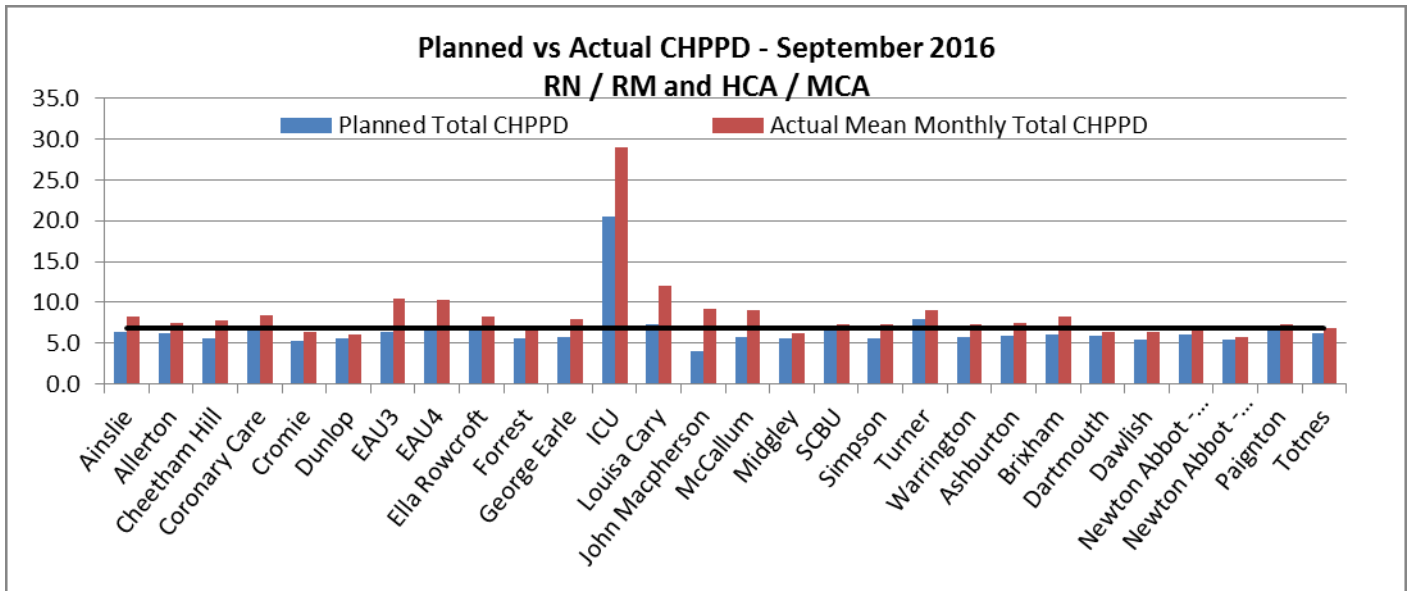
### *Key Explanatory notes*

RN = Registered Nurse / Registered Children's Nurse / RM = Registered Midwife

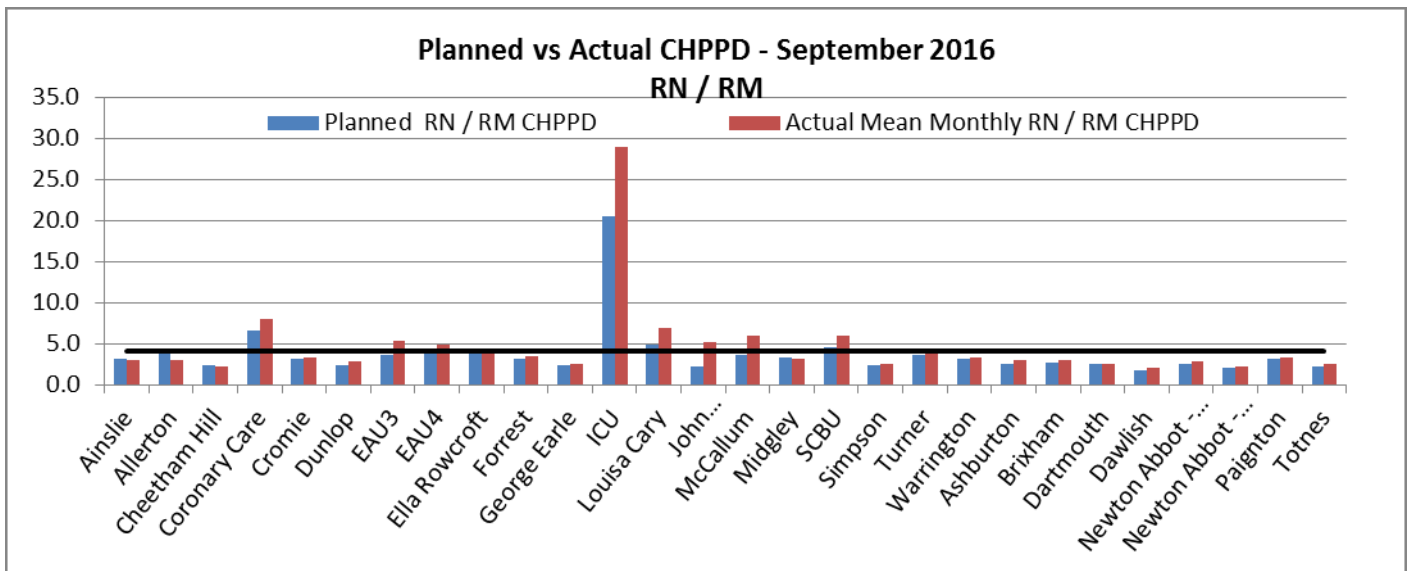
HCA = Healthcare Assistant / MCA = Maternity Care Assistant

The blue cells in the table below are the mean funded established staffing levels, the red cells are the mean actual monthly Care Hours per Patient Day (CHPPD).

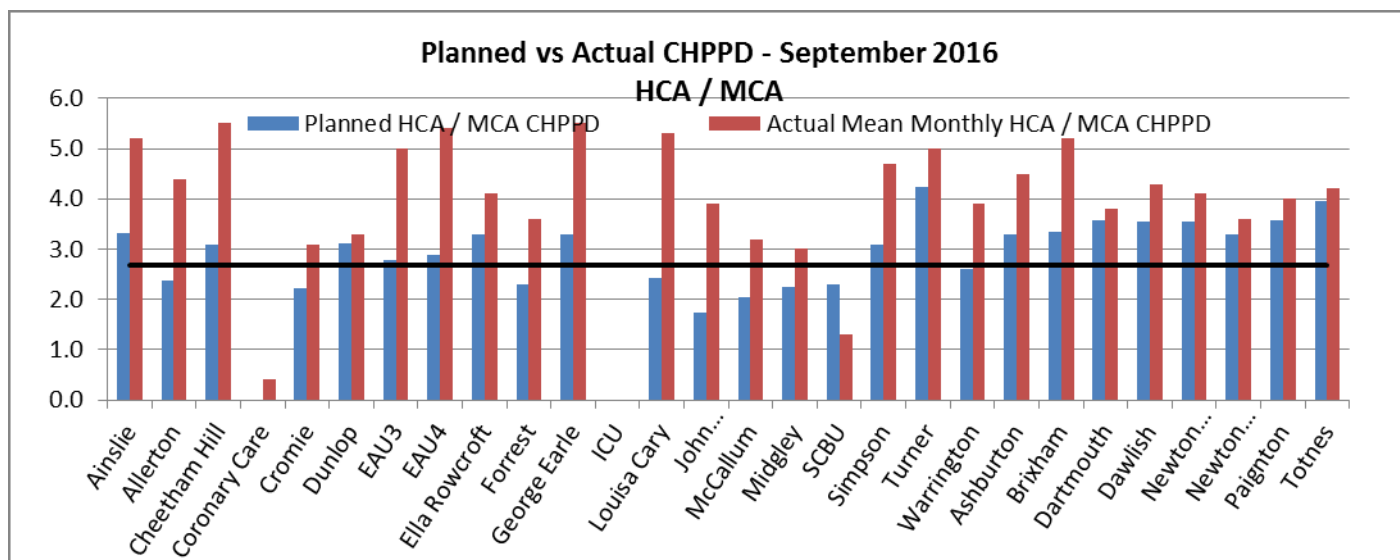




The chart above shows the combined RN and HCA staff. In some areas the actual variation is minimal and in others more significant. The variance arises predominantly from use of HCAs over establishment. The reasons are set out in Table 1 below.



The chart above shows the CHPPD for registered nurses / midwives and highlights that in most areas RN/RM are below the Carter median and planned versus actual are well matched. Note the Medical wards: CH, Dunlop, GE and Simpson which are below the Carter Mean. An establishment review has been completed which suggests the need for an increase in RN numbers in these areas. Community hospitals are also below the mean but benchmark information relating to community hospitals is less well developed.



The chart above demonstrates the widespread variance of HCAs. Table 1 below set out the reasons.

**Table 1**

Ainslee / CH	Support for 1:1 observation
Allerton	Support for High Dependency patients from ITU
CCU	This includes staff for the angiography suite in the baseline establishment. Staff also work flexibly to support Dunlop ward.
Cromie	Support increased acuity
EAU 3 / 4	Currently allocating staff to open the Acute Medical Unit & CDU
Ella	Supporting High Care area
Forrest	Support medical outliers
GE	Support 1:1 observation. Establishment under review
ITU	May not be included in Carter median data. Extra staff used for recovery
Louisa Carey	Includes RMN to support CAMHS patients & HCA support HDU / SSPAU / SCBU
JPU / McCallum	Includes staff for gynae assessment unit
Simpson	Support 1:1 observation
Turner	Higher proportion of band 4 to support acuity & flex to day unit
Warrington	Increased the HCA to support to establish a new ward
Community hospitals	Note that for all community hospitals, the RN staff is below the Carter median. HCA staff increased to support.

Care Hours Per Patient Day for Acute and Community Setting Wards

September 2016	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
<u>Ainslie</u>	6.4	3.1	3.3	8.2	3.0	5.2
<u>Allerton</u>	6.2	3.8	2.4	7.4	3.0	4.4
<u>Cheetham Hill</u>	5.5	2.5	3.1	7.8	2.3	5.5
<u>Coronary Care</u>	6.6	6.6	0.0	8.4	8.0	0.4
<u>Cromie</u>	5.3	3.1	2.2	6.4	3.3	3.1
<u>Dunlop</u>	5.5	2.4	3.1	6.1	2.8	3.3
<u>EAU3</u>	6.3	3.6	2.8	10.4	5.4	5.0
<u>EAU4</u>	6.7	3.8	2.9	10.3	4.9	5.4
<u>Ella Rowcroft</u>	7.1	3.8	3.3	8.3	4.2	4.1
<u>Forrest</u>	5.5	3.2	2.3	7.2	3.5	3.6
<u>George Earle</u>	5.8	2.5	3.3	8.0	2.5	5.5
<u>ICU</u>	20.4	20.4	0.0	29.0	29.0	0.0
<u>Louisa Cary</u>	7.3	4.8	2.4	12.1	6.9	5.3
<u>John Macpherson</u>	4.0	2.3	1.7	9.2	5.2	3.9
<u>McCallum</u>	5.8	3.7	2.1	9.1	6.0	3.2
<u>Midgley</u>	5.5	3.3	2.3	6.2	3.2	3.0
<u>SCBU</u>	6.9	4.6	2.3	7.3	6.0	1.3
<u>Simpson</u>	5.5	2.5	3.1	7.3	2.6	4.7
<u>Turner</u>	7.9	3.6	4.2	9.0	4.0	5.0
<u>Warrington</u>	5.8	3.1	2.6	7.3	3.4	3.9
<u>Ashburton</u>	5.9	2.6	3.3	7.4	3.0	4.5
<u>Brixham</u>	6.1	2.8	3.3	8.3	3.0	5.2
<u>Dartmouth</u>	5.9	2.5	3.6	6.4	2.6	3.8
<u>Dawlish</u>	5.4	1.8	3.6	6.4	2.1	4.3
<u>Newton Abbot - Teign Ward</u>	6.1	2.5	3.6	6.9	2.8	4.1
<u>Newton Abbot - Templar Ward</u>	5.4	2.1	3.3	5.8	2.2	3.6
<u>Paignton</u>	6.7	3.1	3.6	7.3	3.3	4.0
<u>Totnes</u>	6.2	2.2	3.9	6.8	2.6	4.2

Key Messages:

There are four wards that fall below the **planned RN CHPPD** for the month of September with actual ranges being from 2.3 -3.2. These are Allerton, Ainslie, Cheetham Hill & Midgley whose planned staffing levels range between 2.5 & 3.8. These wards however are over their planned levels of HCA CHPPD ranging between 3.2 & 5.5 against the planned 2.3 -3.3.

The primary reason for this is the number of RN vacancies along with sickness absence which pose a challenge when trying to ensure safer staffing levels are maintained on a shift by shift basis. When a shift is below the planned RN safer staffing levels, bank staff may be used and with Executive approval framework

agency staff may be used. Increased HCA's are used to support RN's when deemed safe and appropriate to do so by senior nursing staff. The wards have also had a number of patients requiring supportive observation.

There are workforce plans in place to address the vacancy gap detailed below in this report.

Emergency Department:

The CQC hi-lighted the need to increase the core nursing establishment in ED. The table below details the daily planned, actual and % fill rates for nurse staffing in the Emergency Department.

The total fill rate for September 2016 was 105.0% (5.0% above plan) for RN and 101.5% (1.5% above plan) for HCA. This is because the department has had a number of new starters and observational shifts where new staff join the bank.

		Total Planned shifts		Total Actual Shifts		RN Shift fill rate	HCA Shift Fill Rate
		RN	HCA	RN	HCA		
Thu	01/09/2016	17	13	18	14	105.9%	107.7%
Fri	02/09/2016	17	13	19	13	111.8%	100.0%
Sat	03/09/2016	17	13	18	12	105.9%	92.3%
Sun	04/09/2016	17	13	18	14	105.9%	107.7%
Mon	05/09/2016	17	13	17	13	100.0%	100.0%
Tue	06/09/2016	17	13	16	16	94.1%	123.1%
Wed	07/09/2016	17	13	19	13	111.8%	100.0%
Thu	08/09/2016	17	13	17	12	100.0%	92.3%
Fri	09/09/2016	17	13	17	13	100.0%	100.0%
Sat	10/09/2016	17	13	19	12	111.8%	92.3%
Sun	11/09/2016	17	13	18	12	105.9%	92.3%
Mon	12/09/2016	17	13	17	13	100.0%	100.0%
Tue	13/09/2016	17	13	17	12	100.0%	92.3%
Wed	14/09/2016	17	13	18	13	105.9%	100.0%
Thu	15/09/2016	17	13	18	13	105.9%	100.0%
Fri	16/09/2016	17	13	16	14	94.1%	107.7%
Sat	17/09/2016	17	13	16	14	94.1%	107.7%
Sun	18/09/2016	17	13	19	13	111.8%	100.0%
Mon	19/09/2016	17	13	16	13	91.2%	100.0%
Tue	20/09/2016	17	13	17	13	100.0%	100.0%
Wed	21/09/2016	17	13	17	14	100.0%	107.7%
Thu	22/09/2016	17	13	18	14	105.9%	107.7%
Fri	23/09/2016	17	13	21	13	123.5%	100.0%
Sat	24/09/2016	17	13	17	15	100.0%	115.4%
Sun	25/09/2016	17	13	20	13	117.6%	100.0%
Mon	26/09/2016	17	13	19	13	111.8%	100.0%
Tue	27/09/2016	17	13	19	13	111.8%	100.0%
Wed	28/09/2016	17	13	19	13	111.8%	100.0%
Thu	29/09/2016	17	13	18	13	105.9%	100.0%
Fri	30/09/2016	17	13	18	13	105.9%	100.0%
<b>Total</b>		<b>510</b>	<b>390</b>	<b>536</b>	<b>396</b>	<b>105.0%</b>	<b>101.5%</b>

## Medical Wards Establishment Review

Over the past few months a detailed establishment review has been undertaken across the medical wards using the Shelford & Hurst safer nursing care tool together with Professional judgement. The findings below show the medical wards are outliers in terms of the RCN safe staffing ratio of 1:8 RN to patient and below the recommended skill mix of 63 : 35 RN :HCA split and the national Carter CHPPD median of 6.7.

The following guidance and staffing ratios are used by TSDFT. All of the ratios are subject to professional judgement alterations depending on speciality and cohorts of patients

- RCN - Recommended minimum on shift RN to patient ratio (Day shifts)= 1 RN to 8 patients
- RCN – Recommended ideal budgeted WTE skill mix = RN 60% to HCA 40%
- Carter Care Hours per Patient Day (CHPPD) – Current median national data
  - Total Care hours = 6.77
  - RN Care Hours = 4.07
  - HCA Care Hours = 2.68

The proposed safer staffing levels are summarised in the table below to ensure a safer level of staffing is maintained together with supervisory ward sister status.

**Table 2:**

Ward	Current RN to Patient ratio (RCN 1:8)		Current CHPPD (National 6.7)	RCN Skill mix (RCN 63:35)	Proposed Total WTE	Proposed RN: Patient CHPPD Skill Mix
	Day	Night				
<b>Cheetham Hill</b>	1:7	1:14	Total 5.5	44.4%:55.6%	4.34 WTE	1:5.6, 1:9.3 Total CHPPD 6.2 53.8% :46.2%
<b>George Earle</b>	1:7	1:14	Total 5.8	42.9%:57.1%	9.47 WTE.	1:5.6, 1:9.3 Total CHPPD 6.2 53.8% : 46.2%
<b>Simpson</b>	1:7	1:14	Total 5.5	44.55%:55.5%	4.32 WTE	1: 5.6 , 1:9.3 Total CHPPD 6.2 53.8% : 46.2%
<b>Dunlop</b>	1:8	1:12	Total 5.5	43.5% :56.5%	0.64 WTE	1:8 , 1:12 Total CHPPD 5.5 44.2% : 55.8%

<b>Midgley</b>	1:5.6	1: 9.3	Total 5.5	59.3% : 40.7%	1.16 WTE	1:5.5, 1: 9.3 Total CHPPD 5.5 59.6% : 40.4%
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### Key Messages

Evidence suggests the three medical wards Cheetham Hill, Simpson & George Earl are adrift in their safer staffing levels as detailed above however significant work has been undertaken with the Senior Nursing team to ensure the proposed staffing levels for these areas are evidence based. Professional judgement has been applied in conjunction with the national evidence based safer nursing care tools and the proposed levels have been supported and deemed appropriate by the Chief Nurse, Associate Director of Nursing & Workforce & the SDU Associate Director of Nursing.

The proposed staffing levels for these areas include 5 day supervisory Ward Sister status to ensure there is clear, visible leadership and oversight of the clinical areas. A proposal was presented to the Senior Business Management Team in October and will progress to the Finance Committee in November.

### 3. Career Pathways & Workforce Plans

There continues to be a national shortfall in Registered Nurses and there are significant pieces of work are in progress to try and future proof the nursing workforce for the organisation. The Workforce and OD team have worked closely with senior nursing and education colleagues to develop a workforce plan that provides a robust and sustainable nursing workforce for the future.

The table below models the effect of the workforce plans and impact over the next five years. It models anticipated student numbers, return to practice nurses, associate practitioners, role redesign, general recruitment and overseas recruitment to show that if all these deliver the Trust would achieve a sustainable position. The team have considered the impact of the care model changes, the potential for changes to the number of acute and community beds and the impact of the nursing bursary. A detailed paper will be presented to Board imminently.

## Bridging the Nursing Workforce Gap

Current Nursing Workforce								Projected Nursing Workforce Gap					
					Current Registered Nurses Establishment WTE	Current Registered Nurses In-post WTE	Current Registered Nurses Vacancies WTE		2016/2017 Turnover 11.00%	2017/2018 Turnover 11.50%	2018/2019 Turnover 12.00%	2019/2020 Turnover 12.50%	2020/2021 Turnover 13.00%
Registered Nursing in Service Delivery Units					1217	1098	119	Vacancy Gap	119	144	45	7	10
								Projected Leavers	130	136	142	148	153
								Returning Filipino Nurses					80
								Leavers + Vacancies	249	280	187	155	243
Annual Recruitment													
	Newly Qualified	RTP/ Conversion	Sponsorship (AP's)	Role Redesign	General Recruitment	Overseas Recruitment Campaign	Redeployment	Total					
2016/2017	20	5	5	5	70			105	105				
2017/2018	25	5	10	5	70	80	40	235		235			
2018/2019	25	5	15	5	70	40	20	180			180		
2019/2020	25	5	15	10	70		20	145				145	
2020/2021	70	5	20	10	85		20	210					210
								Annual Gap WTE	144	45	7	10	33
								Annual Gap Vacancy Factor	11.83%	3.70%	0.58%	0.82%	2.71%

Key Messages:

The points below highlight the initiatives underway in an attempt to bridge the vacancy/turnover gap and ensure there is a sustainable nursing workforce.

- 1) The number of student nurse placements through University has increased since 2015 and therefore it is envisaged there will be an increase in the number of newly qualified nurses applying to work in the Trust from September 2018. There is no guarantee the student nurses will commit to our organisation however discussions are underway as to 'golden hello's' to encourage the nurses to come and work in Torbay. It is unknown too how the new student loan will effect applications as this comes into play from September 2017 when the bursary scheme ceases. The student loan will be £9,000 per year and will be paid back once a salary of £21,000 is reached. (I.E on qualifying).
- 2) We are continually encouraging Return to Practice Nurses which has been successful over the past few months however we recognise that these numbers will begin to decrease over time. The Trust is about to launch a campaign for nurses who are working across the health and care community that have previously qualified in this or another country and are working as unregistered nurses. The trust plans to undertake a scoping exercise and to explore the feasibility of supporting them through their IELTS, CBT & OSCE however this does need to be undertaken with caution so as not to destabilise the care homes.
- 3) The Trust will continue to support its Assistant Practitioner programme however the new nurse associate role will be piloted from January 2017 and thus posing national debate as to what the role of the assistant practitioner will be. The associate roles will also be at the band 4 level and potentially these may replace the assistant practitioner role.
- 4) The Trust is continuing to recruit locally and has held two successful open days over the past 6 months. There are plans to hold another event in February to specifically target the third year student

nurses due to qualify in September. Although nurses do apply at the time and the event days were successful, as the nurses' qualifying date nears there has been an attrition rate because of the wide choice available.

- 5) The Trust has commenced its first nurse rotation programme in September which consists of two rotations between Medicine, Surgery and the Community hospitals with a view to develop further programmes to include specialist areas such as ITU, ED & CCU/Allerton and Community, Community Nursing and GP Practice Nursing.
- 6) The first cohort of level 2 apprenticeships in healthcare have successfully completed their 12 month programme and some have substantively been recruited and will be undertaking the advanced apprenticeship level 3. Alongside this programme further work is underway to target college leavers who will be eligible to enter level 5 higher apprenticeship which will APEL 12 months form the new degree student nurse apprenticeship training. The student nurse training standards are currently under development with the NMC and colleges and will be available from September 2018. The plan is to encourage the current apprenticeship cohort to aim towards the degree apprenticeship alongside college leavers. This programme will enable student nurses to train on the job and will not incur a student loan debt which the traditional route will.
- 7) The recent recruitment trip to the Philippines remains on track with the first 12 nurses having now completed their IELTS and CBT and currently applying for their UK Visa. The plan is for this first cohort of nurses to be deployed for the UK in December/January. The remaining nurses are reviewing for their IELTS and weekly progress updates are given through our partner agencies.

The trust has recently had a visit from one of its business partner recruitment agencies in the Philippines. which was their first visit to the UK. The visit to Torbay was a resounding success which included meeting members of the executive team and senior managers along with visiting some of the ward areas. The partners are delighted with what the Trust has to offer and the strong values and beliefs of the organisation in delivering high quality compassionate care. A YouTube video clip has been filmed discussing the recent visit and will be displayed shortly on the trust Intranet.

#### 4) Safer Staffing Dashboard

A daily safer staffing dashboard is currently being piloted and underdevelopment and is accessed through the Trust intranet pages. The aim of the dashboard is to inform Matrons and Senior Nurses, the status of each ward areas and enable decision making to redeploy staff where necessary should an area be more at risk.

The ward managers are expected to publish planned & actual staffing levels each shift, together with the number of patients requiring supportive observation (specialing) and high falls risks and patients who are end of life. This builds a picture of the dependency and acuity of the wards again enabling senior nursing staff to risk assesses 'hot spot' wards and redeploy staff as necessary. This information will also inform discussions at the control meetings when assessing the status of the hospital and enable supportive or agency/temporary staff are being requested. Red Flags will also be displayed as part of the dashboard which will enable senior nursing staff to monitor action accordingly.

This is in addition to the quality performance dashboard reviewed monthly at the Quality Improvement Group. This dashboard brings together data on a range of national and local quality measures and enables the triangulation of information to correlate safe staffing variance with measures such as incidents such as pressure ulcers, falls, medication errors, complaints, mortality data to provide a comprehensive overview of clinical services. QIG members are able to check and challenge the data and ensure appropriate actions are taken as necessary. Critical issues are escalated to the Trust Quality Assurance Committee and Board.

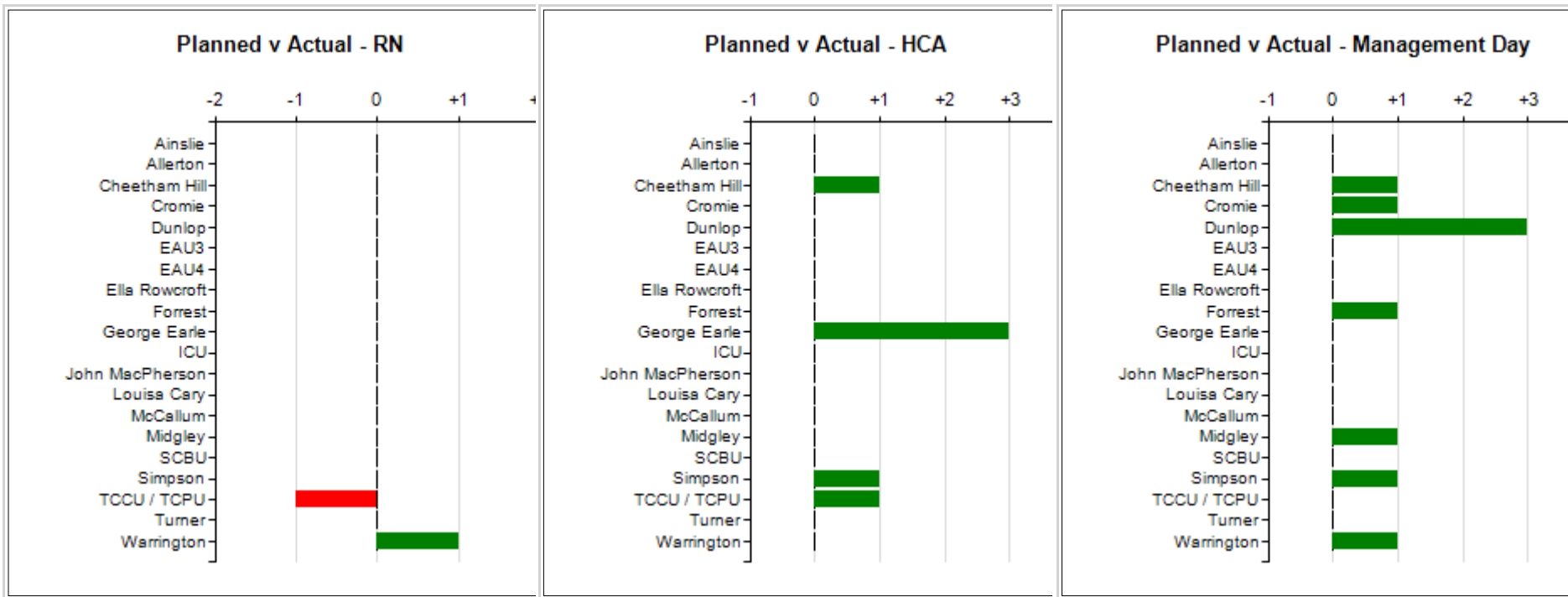
The table overleaf shows a snapshot of the daily planned & actual staffing levels:



Ward	Planned Staffing Levels			Actual Staffing Levels				B6 / B7 Present in Staffing?	Bank / Agency in Staffing	Acuity Level					1:1 Specializing	High Falls Risk	End of Life	Comments
	RN	HCA	Manage. Day	RN	HCA	Manage. Day	Other			0	1A	1B	2	3				
Ainslie																		
Allerton																		
Cheetham Hill	4	5	0	4	6 (+1)	1 (+1)	1	Yes	1					0	22	0	1 x HCA is a band 4 - awaiting PIN.	
Cromie	4	3	0	4	3	1 (+1)	2	Yes	2					0	8	0	1 RN off sick replaced with agency AoA 1 agency on placement 1 newly qualified nurse 2 patients requiring 1:1 but no HCAs available 2 student nurses first day	
Dunlop	3	4	0	3	4	3 (+3)	0	Yes	0					0	14	0	6 monthly band 6 meeting with band 7 to set new objectives.	
EAU3																		
EAU4																		
Ella Rowcroft																		
Forrest	4	3	0	4	3	1 (+1)	1	Yes	2					0	11	0	1 student nurse on first day of placement. band 7 on management day.	
George Earle	4	5	0	4	8 (+3)	0	1	Yes	3					3	22	2	1bay has 2 1:1	
ICU																		
John MacPherson																		
Louisa Cary																		
McCallum																		
Midgley	5	4	0	5	4	1 (+1)	4	Yes	4					0	11	0		
SCBU																		
Simpson	4	5	0	4	6 (+1)	1 (+1)	3	Yes	1					3	24	0	2x students and 1 supernumery RGN.	
TCCU / TCPU	4	0	0	3 (-1)	1 (+1)	0	0	Yes	0					0	0	0		

Turner																	
Warrington	3	3	0	4 (+1)	3	1 (+1)	1	Yes	1					0	13	0	

### Planned v Actual Staffing Levels



## 5) Governance & Quality Monitoring

There is a robust quality and safety monitoring process in place to ensure patient care is not compromised in any way. Patient incidents are monitored monthly by the senior nursing teams and presented through the monthly Quality Improvement Group (QIG) as a dashboard. In addition, each ward area completes the monthly Questt tool which triggers actions as highlighted in the escalation procedure. The Deputy Director of Nursing & Professional Practice & standards ensures contact is made for any area triggering an amber score and ensures appropriate action is taken place.

A weekly huddle takes place with the Chief Nurse, Associate Directors & Deputy Directors of Nursing to discuss staffing, safety & quality issues and concerns. These are closely monitored in terms of acuity of patients, safe staffing levels and any use of agency/temporary staff. In addition staffing levels and ward status is discussed three times a day at the control meetings with the Matron of the week, Senior Nurses and on call manager.

Throughout the months of August and September, the Chief Nurse and Associate Director of Nursing Workforce met weekly with the ward managers and matrons to review ward rosters and staffing levels and to discuss any concerns/issues in light of the work being undertaken to reduce agency usage. As the drive to further reduce this continues, close monitoring of incidents, complaints & Questt will continue to take place.

The Questt Dashboard is displayed in the table below for the Acute & Community Hospitals: The areas showing an amber score for September are

### **Orthopaedic Theatres** –September - score 19 (amber)

The identified risks are: vacancy rate, short and long term sickness, new manager, appraisals not performed, no formal feedback from patients in the last three months. The specific questions for orthopaedic theatres triggered including number of lists overrun in the previous month, number of lists starting late in the previous month , use of agency staff and requirements to use loan equipment.

**Actions:** The team have recruited into a band 5 and band 6 posts which have commenced in September. along with 2x HCA Band 2.

### **Simpson ward:** September score 20 (amber)

Reviewed with matron and incorrectly completed score remains green and no specific risk to raise to QIG

### **Emergency department:** September score 16 ( Amber)

The score for ED reflects the current vacancy rate which results in a reduction in capacity, planned appraisals were not performed and ED performance 80-90% against the 4 hour target.

**Action:** there is a dedicated action plan in place to support ED in performance and quality which is closely monitored at the urgent care weekly meetings

Service Rating	Level 0	Level 1	Level 2	Level 3
C. Hospital & MIU	<12	12-16	17-25	>25
Other	<16	16-24	25-35	>35

Service Type	Team	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
% Complete		52%	52%	51%	51%	50%	52%	55%	72%	77%	84%	88%	95%	95%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		2	0	0	0	1	0	0	2	0	0	0	0	0
Total Amber (L1)		7	12	11	12	10	14	16	7	10	13	14	9	11
Total Green (L0)		44	41	41	40	40	39	40	53	68	72	71	87	85
Average Score		8.8	9.3	9.4	8.8	9.3	10.8	10.9	9.4	9.2	9.1	9.0	8.9	8.8
Acute	Ainslie								11	13	10	8	12	18
	Allerton							14	8	14	17	9	12	11
	AMU										16	12	11	4
	Anaesthetics											9	12	9
	Breast Care Unit								12	8	6	7	6	4
	Cath Lab										6	2	0	2
	Cheetham Hill										17	21	7	10
	Cromie								18	13	11	10	12	7
	DSU											7	13	10
	Dunlop									5	3	4	5	6
	Early Pregnancy / Fertility Service									4	4	0	2	2
	EAU3										6	7	9	4
	EAU4										17	10	9	9
	Ella Rowcroft								7	10	10	6	10	11
	Emergency Department										12	16	16	12
	Endoscopy												7	6
	Forrest								14	18	16	16	14	14
	General Theatres											11	15	14
	George Earle										9	6	4	3
	Gynaecology Out-Patients Dept										11	7	2	13
Hutchings											2	2	5	
ICU										12	4	3	7	

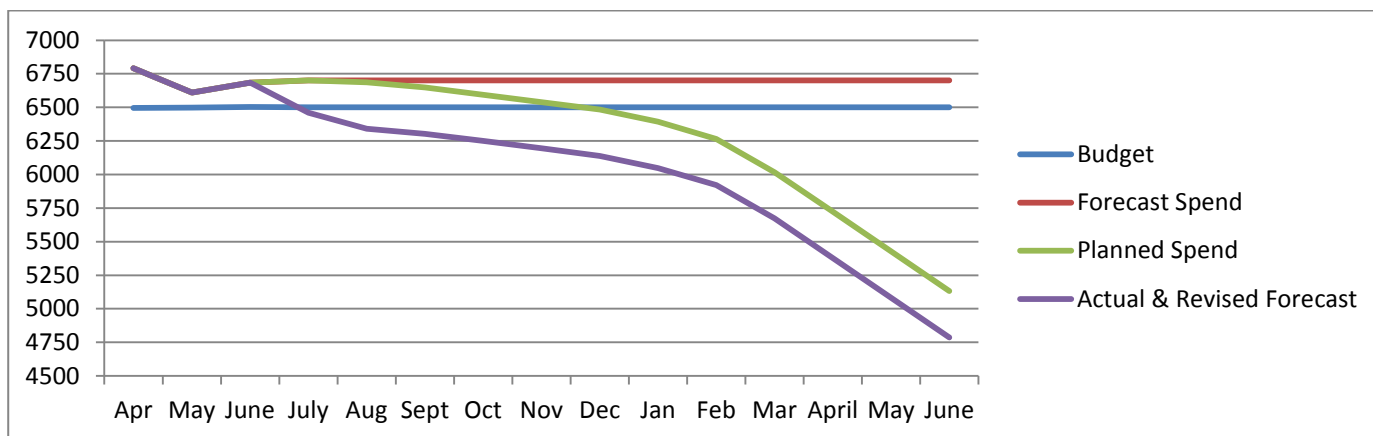
Service Type	Team	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	
Acute	Louisa Cary									4	12		7	11	
	MAT / TAIRU								10	5	4	5	4	5	
	Maternity									11	10	13	13	6	
	McCallum									8	4	8	6	6	
	Midgley									11	11	11	13	8	
	OPD								4	4	4	8	6	2	6
	Ophthalmology								11	10	10	9	10	14	13
	Ortho Theatres											17	19		
	Pre-assessment								4	3	5	4	8	6	6
	Radiology													12	
	Recovery												12		
	RGDU										11	9		3	9
	SCBU										5	0	7	3	5
	Sexual Health												16	10	10
	Simpson											14	17	20	9
	TCCU										5	5	2	4	4
	Turner									13	14	7	2	5	5
Urology										6		5	6	9	
Warrington										14	11	12	10	9	
Community Hospital	Ashburton	7	3	5	3	3	4	5	4	8	4	8	2	8	
	Bovey Tracey	8	6	6											
	Brixham	7	12	10	8	6	10	10	7	10	9	7	5	10	
	Dartmouth	6	12	6	4	2	7	5	2	4	3	7	4	10	
	Dawlish	1	1	0	0	3	1	0	1	0	1	1	4	3	
	Newton Abbot Teign	5	3	3	2	4	8	5	9	6	5	0	8		
	Newton Abbot Templar	6	8	6	3	3	10	6	9	6	7	6	9	8	
	Paignton	6	8	6	12	13	10	5	6	9	9	11	10	8	
Totnes	2	3	3	6	6	6	11	10	10		3	4	3		
MIU	Brixham	0	4	2	4	2	2	2	3	4	2	2	4	2	
	Dawlish	0	2	2	4	7	3	5	0	2	4	2	2	4	
	Newton Abbot	3	0	5	5	0	2	6	2	2	2	2	0	6	
	Paignton	0	0	7	3	3	2	3	6	2	2	2	4	2	

## 6) Agency/Temporary staffing usage.

Significant work has been undertaken over the past three months to drive down the use and cost of agency usage. Initiatives undertaken have been a review of the agency authorisation process, HCA agency ban, overtime incentive for full time staff and weekly shift reviews by the Associate Directors of nursing. This has had a significant impact in driving down the requests and as such enabled the trust to cease using the most expensive non framework agency. The agency trajectory is detailed below.

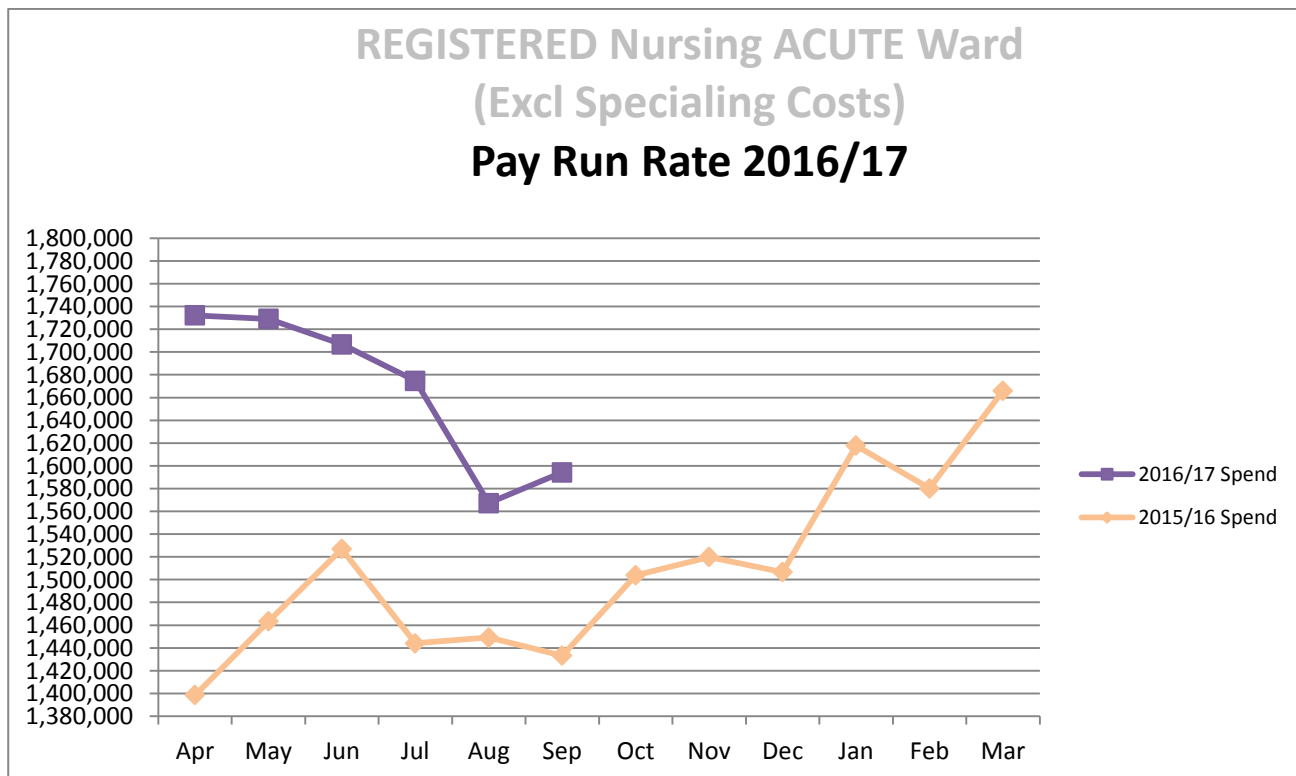
Nursing Budget - Overspend Trajectory																
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	
Budget	6496	6499	6502	6500	6500	6500	6500	6500	6500	6500	6500	6500	6500	6500	6500	6500
Forecast Spend	6792	6610	6683	6700	6700	6700	6700	6700	6700	6700	6700	6700	6700	6700	6700	6700
Planned Spend	6792	6610	6683	6700	6685.7	6648.65	6594.6	6539.55	6483.5	6392.45	6265.4	6017.35	5722.3	5427.25	5132.2	
Actual & Revised Forecast	6792	6610	6683	6459	6341	6303.95	6249.9	6194.85	6138.8	6047.75	5920.7	5672.65	5377.6	5082.55	4787.5	
Savings Projects																
Ban on HCA Agency					14.3	14.3	14.3	14.3	14.3	14.3	14.3	14.3	14.3	14.3	14.3	14.3
New Nurses - Forrest & Cromie								15	15	15	15	15	15	15	15	15
Incentivised Overtime						6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75
Improved Rostering								2	3	4	6	7	10	10	10	10
ED Substantive Recruitment											33	33	33	33	33	33
Replace Thornbury with ANOther Agency								4	4	4	4	4	4	4	4	4
Weekly Challenge meetings - Agency requests								2	2	2	2	2	2	2	2	2
Ward budget Challenges								10	10	10	10	10	10	10	10	10
Overseas Nurses												35	153	200	200	200
Project Total	0	0	0	0	14.3	37.05	54.05	55.05	56.05	91.05	127.05	248.05	295.05	295.05	295.05	

The trajectory indicates our actual and revised forecast from the actions described in the table above which clearly highlights a steeper decline in spend once the Philippine nurses start to arrive in the UK



The tables below indicate the run rate for Registered nurses at Month 6. This clearly shows the reduction in spend from July and August following the actions and initiatives in place to reduce agency usage and spend. Between the month of August and September shows an increase of £27,000 with an increase in agency spend and substantive pay. The cessation of the Non framework agency came into force following the August bank holiday period and started on the 5<sup>th</sup> September and therefore some shifts were still with this agency including RMN's. Staff overtime incentives also commenced at this time and would be indicated by the increase in substantive pay during this month along with the appointment of newly qualified nurses.

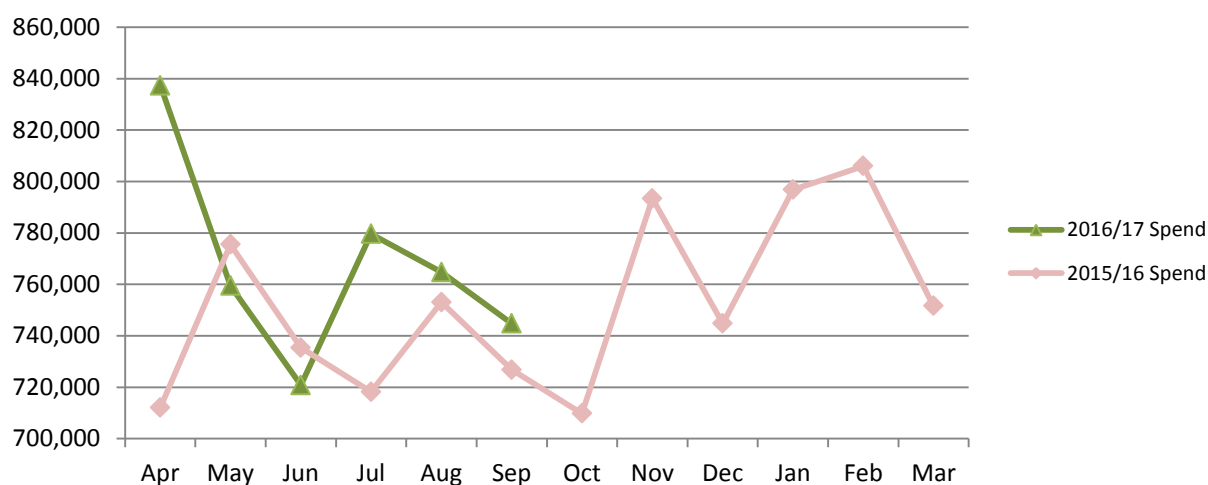
act\M3_code_description	Data					
	Sum of 2016012	Sum of 2016022	Sum of 2016032	Sum of 2016042	Sum of 2016052	Sum of 2016062
1AGENCY-Agency	301,792	421,334	401,377	364,465	263,983	290,975
1BANK-Bank	82,678	50,606	45,508	60,141	57,977	45,457
1STD-Standard	1,347,843	1,257,268	1,259,874	1,250,178	1,245,326	1,257,908
Grand Total	1,732,313	1,729,209	1,706,759	1,674,784	1,567,286	1,594,340



The tables below highlight the spend for Non-Qualified (HCA) which indicates the reduction in agency HCA use (agency HCA ban came into force August 2016) and an increase in substantive pay where HCA's have picked up additional shifts within their areas at overtime and the recruitment of HCA's.

act\M3_code_description	Data					
	Sum of 2016012	Sum of 2016022	Sum of 2016032	Sum of 2016042	Sum of 2016052	Sum of 2016062
1AGENCY-Agency	17,819	8,255	16,836	4,250	-1,682	767
1BANK-Bank	240,848	194,813	120,423	220,701	187,949	147,553
1STD-Standard	578,620	556,398	583,527	554,662	578,490	596,469
Grand Total	837,287	759,465	720,787	779,612	764,757	744,789

## UN QUALIFIED Nursing ACUTE Ward (Excl Specialing costs) Pay Run Rate 2016/17



The table below shows the agency capped rates as determined by Monitor and our actual variance for Nursing.

- The Agency cap in month is £156K, YTD £1,284K
- Usage in month is £344K, YTD £2,674K
- The M6 agency usage is similar level to M5 showing the benefit of continued work done in reducing agency usage and regular engagement with Ward Managers/Sisters and other agency control initiatives
- The YTD overspend against the cap is £1.4m, representing 4.6% more than the revised cap of 4.6%

<b>Revised Agency Ceiling - June 2016</b>		April	May	June	July	August	September	FY 2016-17
Qualified nursing, midwifery and health visiting staff (agency)		(0.272)	(0.266)	(0.259)	(0.168)	(0.163)	(0.156)	(1.284)
Qualified nursing, midwifery and health visiting staff, total		(4.633)	(4.631)	(4.629)	(4.723)	(4.723)	(4.721)	(28.061)
Qualified nursing, midwifery and health visiting staff, total		6%	6%	6%	4%	4%	4%	4.6%
<b>Actual</b>								
Qualified nursing, midwifery and health visiting staff (agency)		(0.442)	(0.544)	(0.552)	(0.457)	(0.335)	(0.344)	(2.674)
Qualified nursing, midwifery and health visiting staff, total		(4.980)	(4.927)	(4.993)	(4.824)	(4.678)	(4.690)	(29.092)
Qualified nursing, midwifery and health visiting staff, total		9%	11%	11%	9%	7%	7%	9.2%
<b>Variance</b>								
Qualified nursing, midwifery and health visiting staff (agency)		(0.170)	(0.278)	(0.293)	(0.289)	(0.172)	(0.188)	(1.390)
Qualified nursing, midwifery and health visiting staff, total								
Qualified nursing, midwifery and health visiting staff, total		3%	5%	5%	6%	3%	3%	4.6%
Comment	M1 to M6 Actual is higher than revised Ceiling by £1.4m YTD, 4.6% more than the revised ceiling of 4.6%							

Key Message:

There is substantial work in progress to continue to reduce the use of agency spend and this will continue over the coming months to further drive down usage and cost towards our capped rates as determined above. Weekly review of shifts, effective rostering management, continued use of staff initiatives will continue until the arrival of overseas nurses alongside our workforce plans to fill vacancies

Alongside this close monitoring of patient safety and quality theme's and trends and safer staffing levels will continue to ensure the quality of care continues to be delivered and not compromised in any shape or form.



## REPORT SUMMARY SHEET

<b>Meeting Date:</b>	Trust Board 2 <sup>nd</sup> November 2016
<b>Title:</b>	<b>Assurance from the CCG and NHS England annual EPRR assessment</b>
<b>Lead Director:</b>	Director of Estates and Commercial Development
<b>Corporate Objective:</b>	Objective 1: <b>Safe, Quality Care and Best Experience</b> Objective 4: <b>Well led</b>
<b>Purpose:</b>	Assurance

### Summary of Key Issues for Trust Board

**Strategic Context:**

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

**Purpose:**

The purpose of this report is to update the Trust Board on the EPRR assurance process for the year ending 2016.

**Background:**

Following the formal assessment process that was held with the CCG and NHS England on the 4<sup>th</sup> October 2016, the Trust Board are required to formally receive and sign off the ICO Trust assessment against its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004) and the accompanying improvement plan.

**Assurance report:**

From the CCG/NHS England assessment the Board can take assurance that it is compliant in the majority of the EPRR core standards and will be compliant with the one amber by November 2016. The resilient telecoms deep dive assurance indicates 2 ambers in this area; one will remain amber due to technical constraints and the second will be green on completion of a published Business Continuity Plan. An action plan for the amber rated standards is attached.

In summary:

Standards	Green	Amber	Red
37 core standards	36	1	0
14 Hazardous Material and CBRN standards	13	1	0
7 Resilient Telecoms Deep Dive	5	2*	0

\*Also linked to an outstanding amber in the December 2015 Paris attacks assurance

**Recommendations**

That the Trust Board formally acknowledge the status of EPRR performance and preparedness and endorse the signing of the assurance letter for NHS England.

**Summary of ED Challenge/Discussion:**

- Challenge to complete outstanding operational business continuity plans currently in progress.

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

Governor sits on the Capital Infrastructure and Environment Group (CIEG) – (previously workstream 5).

**Equality and Diversity Implications:**

The Disability Awareness Action Group (DAAG) considers and is involved in all EFM development proposals.

Q	Core standard		Action to be taken	Lead	Timescale
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	NHS require a list of critical service in the policy	Include a list	Head of SSEP	By November 2016
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.	No rosters planned as rely on volunteer team members.	Recruitment of up to 40 new volunteers in the Trust to be maintained to allow for enough team members to mount a response.	EPRR/ Emergency Accountable Officer	Will remain amber
Q	Telecommunications standard		Action to be taken	Lead	Timescale
LDD2	The organisation's services' business continuity plans instruct staff/ management on how to operate in the absence of operational telephone systems	No BC plan has currently been written, in progress	IT department to write a BC plan for switchboard and telecoms	Director of HIS	By end of December 2016
LDD3	All 'life and limb' services and individual sites have access to an analogue telephone line	The analogue service offered requires the use of 9 to obtain an outside line but the system is separate to the VOIP environment,	To remain Amber	Director of HIS	

## REPORT SUMMARY SHEET

<b>Meeting Date:</b>	Trust Board 2 <sup>nd</sup> November 2016
<b>Title:</b>	<b>Key Issues and Assurance from the Capital Infrastructure and Environment Group.</b>
<b>Lead Director:</b>	Director of Estates and Commercial Development
<b>Corporate Objective:</b>	Objective 1: <b>Safe, Quality Care and Best Experience</b> Objective 4: <b>Well led</b>
<b>Purpose:</b>	Assurance
<b>Summary of Key Issues for Trust Board</b>	
<p><u>Strategic Context:</u> To provide assurance to the Board on compliance with legislation, standards and regulatory requirements, and to provide information on the assessed level of risk and management of same for Board consideration.</p>	
<p><u>Key Issues/Risks</u></p> <ul style="list-style-type: none"> <li>• <b>Critical Estate Failure:</b> The fire hydrant ring main has developed a significant leak due to corroded pipework, such that the main has had to be closed off. Investigations confirm 33meters of pipework require urgent replacement in order to get the hydrant main up and running. The consequence of this is that in the event of a significant fire in the core of the Hospital there may be insufficient available water to enable the fire service to fight the fire. This risk has been placed on the Trust risk register as a 5 consequence and 2 likely hood (10 score risk). The Trust has put in place a revised evacuation plan for affected areas and the Fire service have undertaken mitigating actions siting a water bowser in Torquay and sourcing longer hoses to enable them to link with the more distant hydrant's in the area of Lowes Bridge and Cadewell Lane. Work has been instructed, it is likely to cost c£30,000 and take up to three weeks to complete.</li> <li>• <b>PLACE assessment:</b> The Trust has performed well in the 2016 PLACE assessment with five of the eight indicators above the national average, mainly cleaning and catering. The Trust scored below in the three indicators directly related to the care environment i.e. privacy dignity and well-being, dementia and disability. In six of seven indicators scores are reduced from 2015. This is an accepted risk of Board direction/decisions on capital expenditure limits and that scarce capital monies being directed at the highest priorities, risks and statutory compliance.</li> <li>• <b>National ERIC data:</b> Most of the Trust services benchmark well in comparison with peer groups. With the exception of cost of cleaning, cost of non-emergency transport and cost to eradicate backlog which are all amongst the very highest nationally, and will require further Board decisions on cost improvement priorities/risk to meet Lord Carter savings requirements. Decisions to amend cleaning schedules while balancing risks to infection control have already been made. Reductions in Estate management and EFM operational costs and to the have been made since the ERIC reporting period. The amount of the Trust backlog maintenance remains significantly high and of concern. Analysis of the Trust investment in the estate since 2012/13 shows the investment in improving existing buildings and new build has remained fairly constant at c£8m pa. The amount invested in backlog maintenance has reduced from c£10m (includes additional investment) in 2012/13 to c£1m in 2015/16.</li> </ul> <p>The risk related to the possibility of critical failure of the infrastructure of the estate due to lack of available capital is known to the Trust Board and is on the corporate risk register.</p>	
<p><u>Recommendations:</u> The Trust Board is asked to consider the risks and assurance provided within this report and to advise if further action is required.</p>	

Summary of ED Challenge/Discussion:

- Clear representation in the capital expenditure tables of the loans taken out in in 2011/12 and 2012/13 specifically to address backlog requirements.
- The need for further cost reduction proposals for cleaning and estates to come to Board for decision
- The impact on estates costs should the consultation proposals for Community Hospital be agreed.

The Environment Group will monitor progress of the PLACE action plan and escalate to QAC as appropriate.

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

Governor sits on the Capital Infrastructure and Environment Group (CIEG) – (previously workstream 5).

Equality and Diversity Implications:

The Disability Awareness Action Group (DAAG) considers and is involved in all EFM development proposals.

<b>Report to:</b>	Trust Board
<b>Date:</b>	November 2016
<b>Report From:</b>	Director of Estates & Commercial Development
<b>Report Title:</b>	Key Issues and Assurance from the Capital Infrastructure and Environment Group.

**1. Key Issues reported to the Capital Infrastructure and Environment group for the Boards attention.**

There was one critical estates failure worthy of the Trust Board attention. The Trust has a 300m fire hydrant main in a ring around the hospital to serve the tower block and the central core of the hospital. This hydrant main has corroded due to age. A patch repair was undertaken 6 weeks ago but this is not holding and further water leaks in the vicinity of the electrical ducts are representing a significant risk. The water has therefore been turned off in Fire hydrant main and is not therefore available to the fire service in the event of a fire.

A survey has clarified that a 33 metre section of pipework needs replacing. This will need to be undertaken without delay. Costs are likely to be in the region of £30,000 within the £50,000 estates contingency not yet released but identified the capital programme. £150,000 capital was identified for mains replacement for 2016/17 but when compared to other schemes was not considered a high enough priority to be funded from the reduced programme this year.

This is clearly a risk for the organisation and has been placed on the risk register as a 5 consequence and 2 likelihood (score 10) risk. A number of mitigations are in place.

- The Fire officer has developed an enhanced fire evacuation plan for theatres, ICU and the surgical block in particular which is being communicated to wards departments, operational divisions and through the management on call rota's
- The Fire Service have moved a water bowser to the Torquay fire station such that additional water provision is on hand. In addition they are putting in place a contingency to source longer hoses such that they can reach the other hydrants on site at Lowes bridge and Cadewell lane that are normally out of reach of standard hoses.
- Works will be completed at the earliest opportunity to replace the main and get the hydrant switched back on.

**2. Results of the Trust Patient Led Assessment of the Care Environment assessment 2016.**

The full PLACE report considered by the Capital Infrastructure and Environment Group can be found at Annex 1. The results are summarised in the table below:

The Trust PLACE assessment scores for 2016 show a generally good performance across the Trust. Food and catering services continue to benchmark well.

2016 scores are comparative to regional peer groups and above the national average for five of the eight indicators. Privacy dignity, dementia and disability i.e. the functional suitability of the

environment in our hospitals has fallen below the national average this year. Prioritisation of scarce capital has resulted in insufficient capital to undertake non-statutory improvements to the environment.

Of the 45 indicators across the community and acute hospital (directly comparable to last year) 62% of the scores are lower than 2015 with a 32% improvement and 6% remaining the same. The hospitals with the greatest number of lower scores including those for condition and appearance are Dartmouth, Brixham, Paignton and Torbay. For these four Hospitals 10% of the 20 indicators are improving 5% stayed the same and 85% deteriorated.

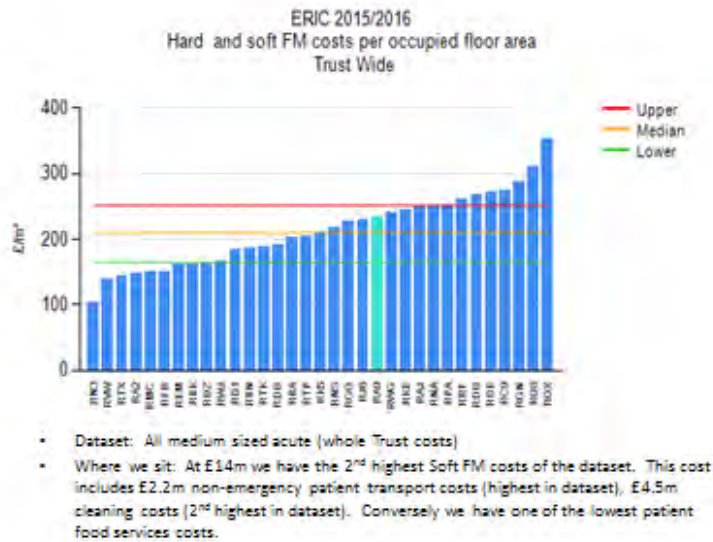
Site	Cleanliness	Food	Organisation Food	Ward Food (tasting)	Privacy, Dignity and Wellbeing	Condition Appearance & Maintenance	Dementia	Disability
<b>WHOLE TRUST SCORE 2016</b>	98.51%	90.19%	95.00%	88.12%	81.82%	93.62%	77.85%	79.74%
<b>NATIONAL AVERAGE 2016</b>	98.1%	88.2%	88.2%	88.2%	84.2%	93.4%	75.3%	78.8%
Trust position against national average 2016	↑	↑	↑	↑	↓	↑	↓	↓
<b>WHOLE TRUST SCORE 2015</b>	99.86%	94.16%	94.16%	94.16%	88.29%	92.69%	83.75%	N/A
<b>NATIONAL AVERAGE 2015</b>	97.57%	88.49%	86.03%	86.03%	86.03%	90.11%	74.51%	
Trust position against national average 2015	↑	↑	↑	↑	↑	↑	↑	
2016 Trust score against 2015 Trust score	↓	↓	↓	↓	↓	↑	↓	

A PLACE action plan has been developed, the delivery of which will be overseen by the Environment group. In the current financial position environmental improvement are unlikely to be prioritised sufficiently highly for the allocation of capital funds and therefore the environment related PLACE scores will continue to be a challenge for 2017. Consideration should be given as to whether the appropriate use of Charitable Funds to improve patient environment could be applied to address these areas of concern.

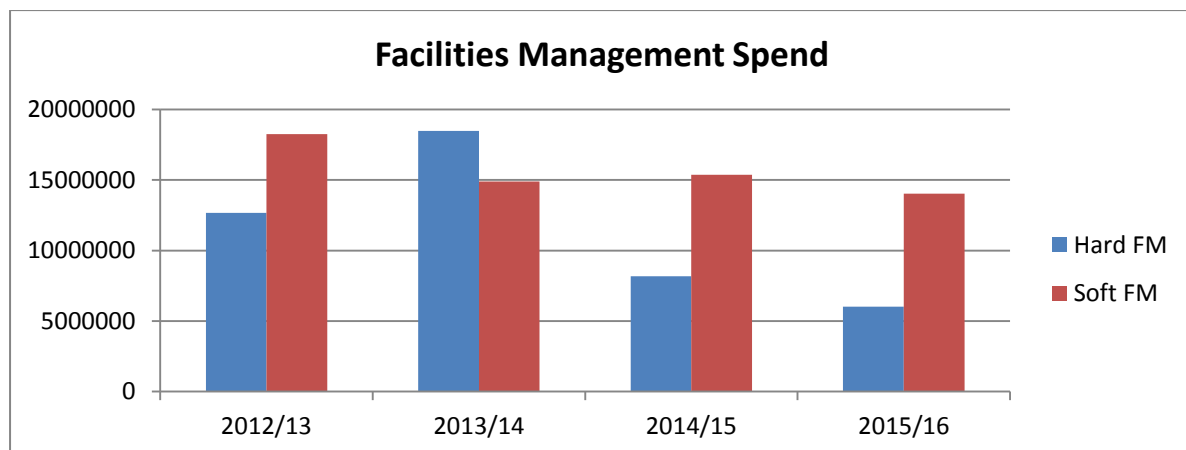
### 3. ERIC

The National ERIC (estate's return) data for 2015/16 was published in mid October 2016. It is the ERIC data that forms the basis of both the Lord Carter savings targets. The ERIC data has in previous years been unreliable (2013/14 in particular), however the accuracy of the data has been the subject of a Carter target for this year, and therefore data should be more accurate and comparable for 2015/16.

ERIC has historically used small medium and acute Trusts as groupings this makes it difficult to accurately benchmark the Trusts overall data as it includes all the community Hospitals and other acute organisations are unlikely to have this combination of buildings. Inclusion of the community services does present a challenge as FM services are more expensive to deliver where economies of scale don't exist. The table overleaf shows performance of all hard and soft fm services as just above the median. This masks a number of significant variances.



The facilities spend data graph below shows a generally decreasing cost year on year for hard (estates) and soft (cleaning catering etc) FM services. The cost of services overall in 2015/16 is c£1m less than in 2012/13.

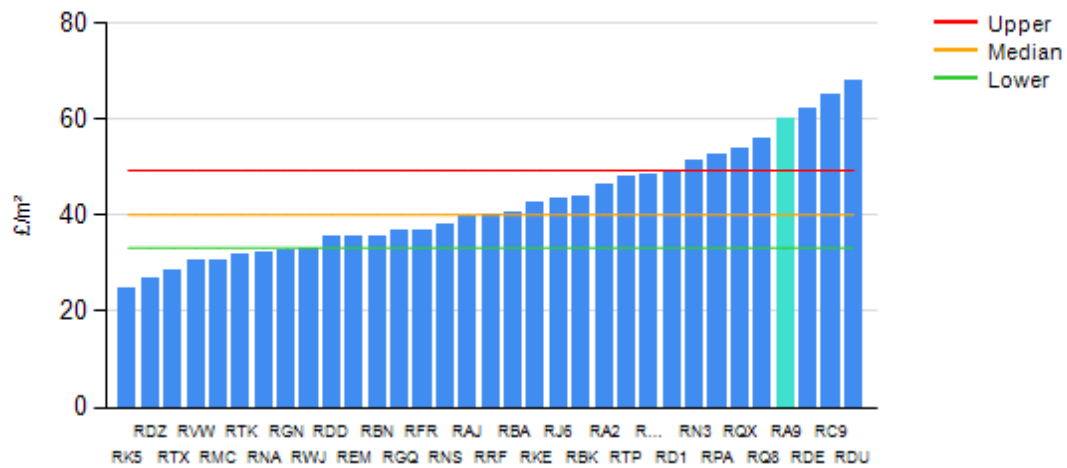


A more detailed analysis of the cost of services will be undertaken in the forthcoming month and savings identified where services are not performing well against the mean. However an initial view of the Trust data for 2015/16 shows that services and performance is generally around the median with a number of key exceptions that are referred to below.

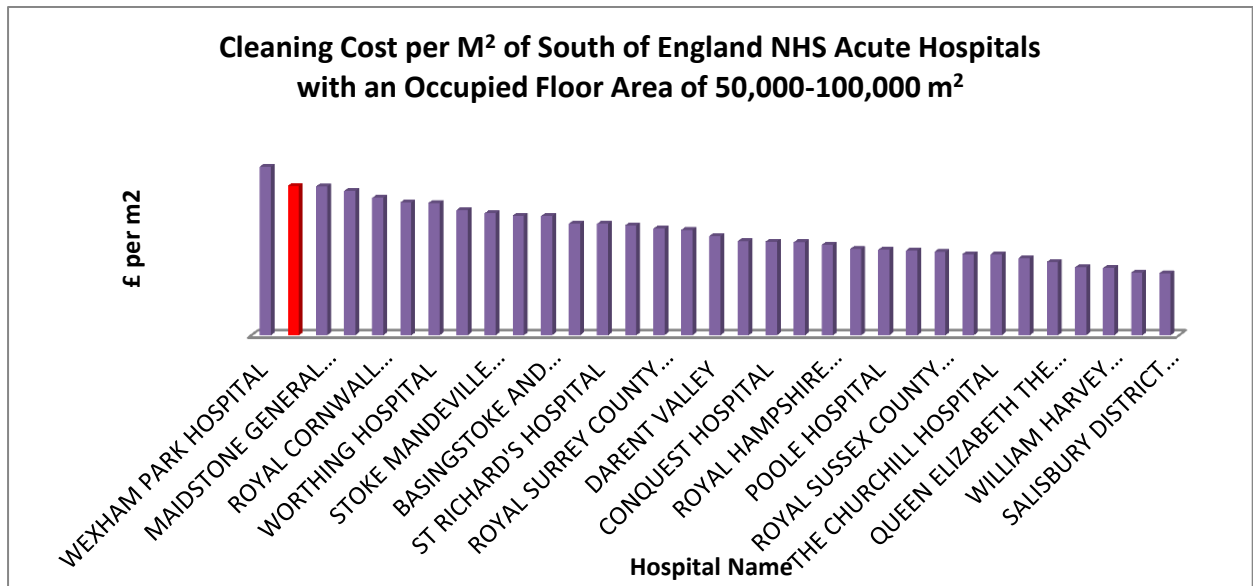
The Trust benchmarks very well for its catering costs which perform well above the National average and are the least cost in the Peninsula.

Transport services are the Highest in comparison with other medium acute trust (our comparator group) and warrant some interpretation and consideration. The Trust soft FM services are of higher cost than comparative Trusts. This is being driven by the Trust's cleaning service costs that are the third highest in our grouping.

ERIC 2015/2016  
Cleaning service cost per occupied floor area Trust Wide



And second highest in the south of England as shown in the graph below.



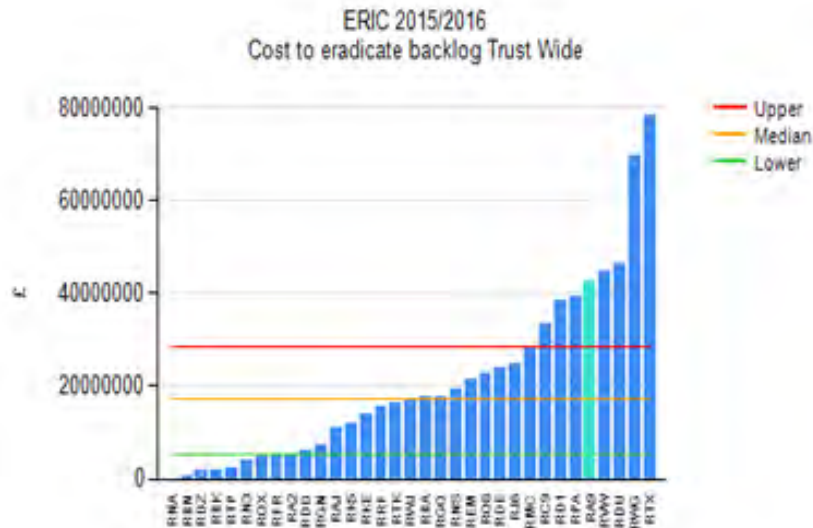
The differences by site are shown in the table below.

Site Name	Occupied floor area (m <sup>2</sup> )	Cleaning service cost (£)	Cleaning service cost per occupied floor area (£/m <sup>2</sup> )
AGGREGATE SITE	14,433	274,756	19.04
TOTNES HOSPITAL	3,590	212,002	59.05
BRIXHAM HOSPITAL	2,421	143,647	59.33
TEIGNMOUTH HOSPITAL	2,757	177,739	64.47
TORBAY HOSPITAL	70,450	4,581,033	65.03
NEWTON ABBOT HOSPITAL	7,863	517,820	65.86
PAIGNTON HOSPITAL	2,963	225,859	76.23
DAWLISH HOSPITAL	2,111	170,415	80.72
BOVEY TRACEY HOSPITAL	671	67,984	101.32
DARTMOUTH HOSPITAL	1,351	142,382	105.39
ASHBURTON HOSPITAL	866	102,697	118.59

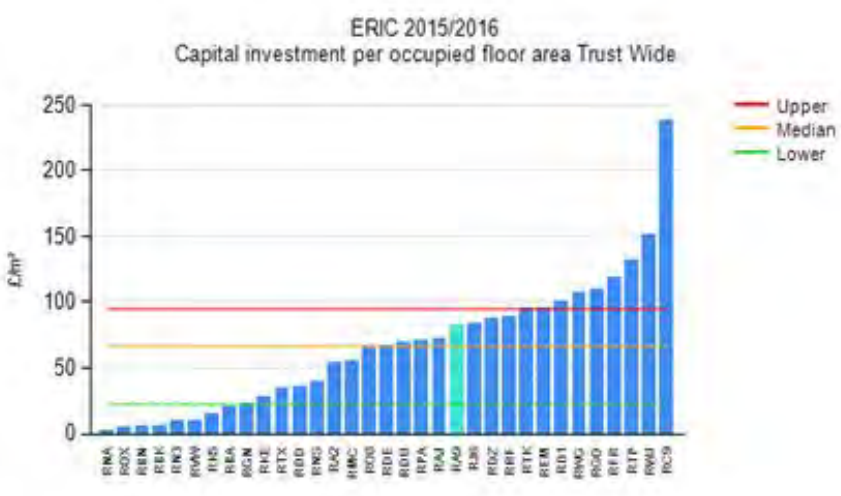


Clearly the Trust Carter challenge will need to focus on reducing the cost of cleaning services whilst maintaining performance against national standards and contributing to patient safety best practice.

The other area where the Trust is a significant outlier the cost to eradicate backlog Trust wide. The graph below shows the Trust significantly above the upper range with the 5<sup>th</sup> highest in its comparator group



This position has not improved over the last few years despite the Trust being positioned slightly above the median for capital investment per occupied floor area.



The graph below shows the investment in the Trust Estate since 12/13. In 2011/12 and 2012/13 the Trust supported investment in Backlog with additional loan investment. Whilst the investment in improving existing buildings and new build has remained fairly constant at c£8m, the amount invested in backlog maintenance has reduced from c£10m in 2012/13 to c£1m in 2015/16. Over this period ERIC data has become more accurate and the distinction between new build, existing buildings and backlog maintenance (infrastructure) is now much clearer. As part of its strategy the Trust secured additional funding to support new build in 2015/16.

