Torbay and South Devon NHS Foundation Trust
Public Board of Directors

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

07 December 2016 09:00 - 07 December 2016 11:00

AGENDA

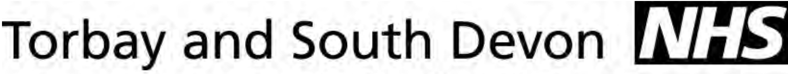
#	Description	Owner	Time
1	User Experience Story		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence - Mr J Furse Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 2nd November 2016 and Outstanding Actions Approve 16.11.02 - Board of Directors Minutes Public.pdf 7	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive Assurance Report of the Chief Executive.pdf 27	CE	
2.6	Strategic Issues		
2.6.1	Wider Devon Sustainability and Transformation Plan (STP) Information/Endorsement STP.pdf 45	DSI	
2.6.2	Wider Devon STP Acute Services Review Information/Endorsement Acute Services Review.pdf 99	CE	

#	Description	Owner	Time
2.6.3	Into the Future: Reshaping Community-based Health Services Public Consultation Update Information Community Consultationpdf.pdf 113	DSI	
2.6.4	Response to the Proposed Funding Reduction for Public Health in the Mayor of Torbay's Draft Efficiency Plan Decision) - Response to Proposed Funding Reductions fo... 3	MD	
2.6.5	Integrated Quality, Performance, Finance and Workforce Report - Month 7 Assurance QPFW Report.pdf 129	DSI/DoF/DWOD	
2.6.6	RTT Information RTT.pdf 201	COO	
2.6.7	Clinical Validation of Patients with Delayed Outpatient Reviews Assurance nical Validation of Patients with Delayed Outpatien... 9	MD	
2.6.8	Governors' Questions Discuss	Ch	
2.7	Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)		
2.7.1	Safety Scorecard Assurance Safety Scorecard.pdf 217	MD	
2.7.2	Charitable Funds Terms of Refrence Approve aritable Funds Committee - Terms of Reference.pdf 9	DoF	

#	Description	Owner	Time
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees - Charitable Funds Committee, Finance Performance and Investment Committee Assurance 2016.11.29_FPI_Cttee_Report_to_Board.pdf 247 16.11.24_Char_Funds_Cttee_Report_to_Board.pdf 9		
3.2	Reports from Executive Directors		
3.2.1	Report of the Chief Nurse Information/Assurance Report of the Chief Nurse.pdf 251	CN	
3.2.2	Report of the Chief Operating Officer Information/Assurance Report of the Chief Operating Officer.pdf 265	COO	
3.2.3	Report of the Director of Workforce and Organisational Development Information/Assurance Report of the Director of Workforce.pdf 285	DWOD	
3.2.4	Report of the Director of Estates and Commercial Development Information/Assurance Report of the Director of Estates.pdf 327	DECD	
3.3	Compliance Issues		
3.4	Any Other Business Notified in Advance	Ch	
3.5	Dates of Next Meeting - 9.00 am, Wednesday 1st February 2017	Ch	
3.6	Exclusion of the Public	Ch	

INDEX

16.11.02 - Board of Directors Minutes Public.pdf......7
Report of the Chief Executive.pdf......27
STP.pdf......45
Acute Services Review.pdf......99
Community Consultationpdf.pdf......113
RD - Response to Proposed Funding Reductions for Public Health.pdf......123
QPFW Report.pdf......129
RTT.pdf......201
Clinical Validation of Patients with Delayed Outpatient Review.pdf......209
Safety Scorecard.pdf......217
Charitable Funds Committee - Terms of Reference.pdf......239
2016.11.29_FPI_Cttee_Report_to_Board.pdf......247
2016.11.24_Char_Funds_Cttee_Report_to_Board.pdf......249
Report of the Chief Nurse.pdf......251
Report of the Chief Operating Officer.pdf......265
Report of the Director of Workforce.pdf......285
Report of the Director of Estates.pdf......327



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 2ND NOVEMBER 2016

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr J Furse	Non-Executive Director
	Mrs J Lyttle	Non-Executive Director
	Mrs J Marshall	Non-Executive Director
	Mr R Sutton	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	Mr J Welch	Non-Executive Director
	Mrs M McAlinden	Chief Executive
	Mr P Cooper	Director of Finance
	Mrs L Darke	Director of Estates and Commercial Development
	Ms L Davenport	Chief Operating Officer
	Mrs J Saunders	Director of Workforce and Organisational Development
	Mrs J Viner	Chief Nurse
	Mrs A Wagner	Director of Strategy and Improvement
In Attendance:	Mrs S Fox	Board Secretary
	Dr N Campbell	Consultant Anaesthetist
	Mr I Currie	Deputy Medical Director
	Mrs J Gratton	Interim Head of Communications
	Ms C Hoyer	Locum Consultant Anaesthetist
	Mr W Liddell	EMIS Account Manager
	Mr R Scott	Corporate Secretary

Cathy French	Lead Governor	Christina Carpenter	Governor
Carol Day	Governor	Craig Davidson	Governor
Lynne Hookings	Governor	Barbara Inger	Governor
Mary Lewis	Governor	Peter Welch	Governor

ACTION

PART A: Matters for Discussion/Decision

152/11/16b **Apologies for Absence**

Apologies for absence were noted from the Medical Director and Councillor Parrott.

153/11/16b **Declaration of Interests**

Nil.

154/11/16b Minutes of the Board Meeting held on the 5th October and Outstanding Actions

The minutes of the meeting held on the 5th October were approved as an accurate record of the meeting held apart from one amendment under item 136/10/16 where it should read that over 1,500 people had attended consultation meetings, not 15,000. — PA to CE

155/11/16b Report of the Chairman

The Chairman briefed the Board on the following:

- The Board's workplan for 2017 had been reviewed and it was agreed to stand down the September Board meeting as no statutory reports were due to go to that meeting and as the meeting date was directly after the August Bank Holiday week, it would be a challenge to deliver reports.

- The Non-Executive Directors had a joint meeting with the NEDs from the CCG Governing Body last month and it was felt to have been a very productive meeting with the group discussing system issues and future intent. A further meeting would be arranged for the New Year to allow for the community hospitals consultation to be discussed before the process concluded.

- Bishop Dame Sarah Mullally recently visited the Trust to consecrate a new altar fontal in the Chapel. Dame Sarah was an ex-Chief Nurse and was very interested and informed about the ICO. The Chairman suggested that it would be useful to build a relationship with Dame Sarah.

- Lord Carter visited the Trust last week to meet with the senior team on his forward work programme. It proved to be a very positive meeting, Lord Carter stated that he saw value in what the Trust was aspiring to achieve and that he would like to visit the Trust again.

- The Chairman and Chief Executive attended the Torbay Pharmaceuticals half yearly staff meeting last week and he reported that it had been a very positive meeting, with staff enthused and motivated for the future. The recent MHRA inspection had raised some concerns, but in the main was largely constructive and supportive.

- Judith Petts, the new Vice-Chancellor for Plymouth University recently visited the Trust for a tour of community and acute facilities. Both Plymouth and Exeter Universities were keen to provide more students to the Trust and how this might be realised would become clearer in the near to medium future.

- A meeting was held for the Chairs of the Leagues of Friends to discuss the model of care.

- Finally the Chief Executive of NHS England was visiting Exeter later today and the Chief Executive had been invited to lunch and the Chairman to dinner with him.

156/11/16b Report of the Chief Executive

Following on from her written report, the Chief Executive highlighted the following:

- CCGs ratings for mental health and maternal care standards had been recently published and South Devon and Torbay CCG had been rated as 'performing well'. The Board wished to place on record their thanks to the staff providing those services.

- The Trust's Trauma and Orthopaedic service had recently been ranked 6th out of 177 Trusts against the 30 day mortality rate for Fractured Neck of Femur. Congratulations from the Board were made to the team.

- Additional community services consultation meetings had been arranged in Paignton and Ashburton. It was noted that there had also been a ministerial debate with Devon MPs in respect of the proposals.

- The Trust is part of a Devon collaborative chosen as one of 11 national sites to pilot the Nursing Associate role. Thanks were passes to the Chief Nurse and Director of Workforce and Organisational Development and their staff for their work on this.

- The Trust had been given an oversight rating of 2 in the shadow segmentation process by NHS Improvement. This identified the Trust as requiring 'potential support', but no specific areas for support yet identified. It was felt this rating was a reflection of the level of confidence in the Trust and its performance.

- For the first time the Trust had scored 4 against the NHS Improvement risk assessment framework. The Trust had been assessed as not having achieved the ED performance target, but was in fact above the locally agreed trajectory. Also for the first time performance in October was above 95%. RTT performance was below the 92% target, and the Board was well-sighted on the reasons for this. The two week wait cancer target was affected by the issues in Dermatology and the 'subsequent treatment' performance had been affected by small numbers of patients cancelling their given dates. The Director of Finance was in discussion with NHS Improvement about any regulatory response to current performance. The Director of Finance indicated that his initial approach did not raise an imminent risk of this.

- The Board's congratulations were given to the League of Friends for reaching their target of raising £1.6m for the new Critical Care Unit and for a very successful Celebration Ball which staff very much enjoyed.

- Mr Welch suggested that it would be useful, given the STP process was a Government-driven initiative, that this be communicated more publically so that local people understood that the changes proposed were not a Trust driven initiative.

157/11/16b **Report of the Medical Director**

Strategic Context:

Plans are in place for implementation of the new Junior Doctors' contract over the next 12 months. The first wave of doctors has transferred onto the new contract. A High Court ruling suggests that each Trust can choose whether or not to implement the contract. However funding of Junior Doctor posts depends upon implementation so there is in effect no option.

The Trust has appointed a Guardian of Safe Working Hours, Dr Nuala Campbell. The new contract requires quarterly reporting to the Trust Board by the Guardian and includes a system of fines when infringements of contracted hours occur.

Key Issues/Risks

Concerns remain over implementation of the contract:

- Junior Doctors remain angry over the handling of the industrial dispute.

- The new contract is inflexible and may increase Junior doctor disquiet. This may affect recruitment and retention of staff.

- The system of fines will impose additional costs on Trusts (estimates of cost to be established).

- 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).

The Deputy Medical Director outlined the basis of the new Junior Doctor contract and rotas. He said that although Junior Doctors were very angry at the implementation of the new contract, relationships at Trust level were very good.

Junior doctors would join the new contract rotas as they commenced at the Trust and it would limit the hours they could work and reduce flexibility. This would have an impact when they were off sick or away as gaps in the rota would not be able to be filled by other junior doctors as it would take their working hours over the maximum allowed. Those gaps in the rota would either need to be filled by higher graded doctors acting down or locums.

Mr Furse raised the implications of a consultant acting down in terms of effect on elective work and this was acknowledged.

158/11/16b **Role of Junior Doctors and how training is delivered**

Dr Nuala Campbell, the Trust's Guardian of Safe Hours, gave a briefing on her role in respect of the new Junior Doctors' contract.

- The new contract would be phased in over the course of the next year until August 2017 when all junior doctors would be on the new contract.

- A new monitoring system had been put in place with junior doctors required to log the hours they have worked. It would be very responsive and highlight any exceptions to the contract.

- The Guardian role was a champion for the junior doctors, and needed to be a neutral position and independent of any groups.

- At present only four junior doctors were on the new contract, but a new cohort of junior doctors would be joining in December and would join under new contract. They were very nervous about being the first group of staff to test the contract in terms of having to, for example, inform a consultant that they had to leave as they had worked their contracted hours.

- If all junior doctors only worked their contracted hours it would have a major effect on the running of the hospital.

- It was not yet known how the junior doctors would respond, but they had been asked to ensure that if they did work over their contracted hours to make sure this was logged as part of the data monitoring requirement.

- Mr Welch stressed the need to ensure that junior doctors did log the hours they worked and this this needed to be mandatory. He also suggested that the Trust was tacitly accepting that the junior doctors would need to work over and above their contracted hours, and asked if the Board was accepting of this. Dr Campbell said that Junior Doctors had been asked to ensure they logged their working hours so that the extent of working outside of contracted hours could be understood.

- The Chief Nurse queried what contingency plans were in place if the junior doctors did only work their contracted hours. Dr Campbell said that she did not think there would be an immediate issue, however the impact would begin to be understood over the next few months and either locums would be required or consultants acting down to cover any gaps, and thereby affecting elective performance.

- Mr Davidson raised the risks of employing locums and Dr Campbell said that locums did not know the organisation and its systems and also, given that many Trusts would have the same problem, there would probably not be enough locums available in any case. At present the Trust used a lot of internal locums, for example a junior doctor from Exeter covering a shift at the Trust, but the new contract would not allow this to continue.

- Mr Allen wished to place on record the Board's support for the junior doctors, and to acknowledge the difficult position they found themselves in. He said that he felt the new contract should better reflect how the doctors should work in the best interests of patients. The Chairman endorsed Mr Allen's comments and he asked that the Executive team to consider what action would need to be taken if it became apparent that the safety of patients was at risk due to junior doctors working to the new contract. **MD**

- The Deputy Medical Director suggested that a way forward would be to identify people who could take administrative work from the junior doctors so that they primarily spent time on face to face contact with patients. Dr Campbell felt this would not be beneficial and that this type of skill mix would need to be undertaken by a clinically trained member of staff.

- Mrs Marshall queried the effect of the new contract of junior doctors in terms of coping and resilience and Dr Campbell explained that all trainees had dedicated education supervision where they could raise any concerns. Also the exception reporting would also highlight if a particular junior doctor was regularly working hours above his or her contract.

- Mrs French suggested Dr Campbell meet with Dr Sarah Wollaston MP to brief her on these issues. It was agreed that as the Chair and Chief Executive were meeting with all the Trust's local MPs in Westminster later in the month, they would raise it at that meeting. **Ch/CE**

Strategic Issues

159/11/16b **STP Feedback**

The Director of Strategy and Improvement gave an update on STP issues since the last meeting:

- STP drafts had been leaked by the press in some parts of the country. Devon STP had received approval to formally share their report and it would be publicised shortly.

- The Trust's Chief Executive was the lead for the STP Acute Services Review. Work was being undertaken to understand the scope of the project and capacity required to take it forward. Briefings for staff on the Acute Services Review would be taking place towards the end of the week.

- There were no further updates in terms of the shared services work, and the need for clear communication to staff was acknowledged.

- As well as this strategic work, the Trust needed to ensure that its local work was not affected and the Trust was working with the CCG and Council on its

placed-based plan whilst taking forward the STP work at the same time.

- The STP document would be brought to the Public Board in December for discussion and endorsement.

- Mr Furse asked if any of the Trust's plans had been affected by the STP and the Director of Strategy and Improvement said that they had not.

- Mr Welch asked whether the plans to put in place for new community services before any community hospital changes were realised, as communities had been promised that hospitals would not close unless those services were in place. The Chief Operating Officer said that around 95% of appointments to the expanded Intermediate Care Service had been made and that discussions around additional nursing and residential home capacity were taking place.

- The Chairman reminded the Board that devolution could result in changes to the Trust's commissioners, in that context the Trust might need to justify its strategy and investment plans and could have change imposed on it.

- Mrs Lyttle raised concern at the extent of the demands being placed on the Trust's Executive Team and asked for assurance that, whilst taking forward the STP strategic issues, the Trust's performance would not be affected. Mrs Marshall suggested that a plan on a page would be helpful to detail all the timelines, both local and national, and it was agreed this would be provided at the next meeting. **DSI**

- The Director of Estates and Commercial Development said that as a community the Primary Care and Estates Strategy was ahead of the rest of Devon. She added that the STP was very acute focused and savings in the acute sector could have knock-on effects in intermediate and social care and it was important the Trust did not allow this to happen or affect speed of delivery. The Chief Executive added that the capital requirements to create enhanced primary care/GP accommodation in health and wellbeing hubs were outside of the Trust's control and in this respect public perception needed to be carefully managed. Also, there needed to be clarity around the commitment to new services being put in place not new buildings.

160/11/16b **Into the Future: Reshaping community-based health services – response to the public consultation**

<u>Strategic Context</u>

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 services that 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.

HealthWatch (Devon and Torbay) has been commissioned by the CCG to produce an independent report of the consultation for the CCG's Governing Body. Both Torbay Council and Devon County Councils' respective Overview and Scrutiny Committees are overseeing due process. NHS England has 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 a 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.

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.

The Director of Strategy and Improvement informed the Board that the consultation process was over half way through, and along with the formal public meetings over 50 additional community meetings have taken place, all of which were being supported by HealthWatch who would provide a report on the responses once the consultation period had finished.

Key Issues/Risks

Reconfiguring services is never easy and some difficult choices must be made if the Trust is to ensure the sustainability of local health and social care services. The Trust agrees that current NHS and social care provision in the area is unsustainable in its current form and given funding constraints. Unless something changes the Trust will be unable to respond to rising demand for services from its increasingly elderly population, and the number of people in its 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.

The Trust is cognisant of the impact on staff and is ensuring those staff directly affected by the proposals are supported and briefed. Change of this magnitude is not without risk – the Trust has seen a number of staff move on already despite assurances regarding job security. As the Board is aware immediate action has been taken 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.

The Board discussed the draft letter to the CCG and it was agreed that the fifth paragraph be amended to reflect that the Trust believes that the proposal was the right thing to do to deliver fit for purpose services; a paragraph be added to clarify the commitment to new services, not buildings; and the final paragraph be amended to use the word 'decision' only once.

The Board approved the formal letter of support in respect of the community hospitals consultation, once the amendments detailed above were made. **DSI**

161/11/16b **Care Home Quality**

Strategic Context

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

Key Issues/Risks

There are significant challenges in the Care Home Market locally, reflecting the national picture as set out in 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.

Both reports highlight serious risks to residential and nursing care provision which are echoed locally:

- 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.

The Chief Nurse informed the Board that the report discussed how to co-ordinate all the feedback available on the performance of care homes from many different professionals and organisations, with the strengthening of the Quality and Assurance Team and stronger links with Devon County Council.

A revised performance framework had been established and would be monitored by the Safeguarding Group and Quality Improvement Group with oversight by the Quality Assurance Committee.

The Chairman thanked the Chief Nurse for the report, in particular for the 'performance on a page' data and asked that the Board's thanks be passed back to the teams who had produced this information. He also asked that, in his absence, the report be highlighted to Councillor Parrott. CN

Mr Sutton reflected that understanding the position in the local market was vital; but that the fundamental issues of pricing and capacity needed to be addressed. The Chief Nurse agreed and said that work had already commenced to consider how the market needed to be managed in the future, how it should be commissioned to better meet current needs.

Mrs Taylor raised the issue of private patients in nursing/care homes seen to be subsidising commissioned places, this was acknowledged and the Chief Nurse said that part of the market management work would be to more transparently address this issue.

162/11/16b **Integrated Quality, Performance and Finance Report – Month 6**

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 Trust's 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.

Performance of each Service Delivery Unit (SDU) is regularly reviewed by Executive Directors on a monthly basis through the Quality and Performance Review meetings and 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. Accident and Emergency
2. Referral to Treatment
3. Cancer 2 week wait
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 the Trust is 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

The following was highlighted from the report:

- As detailed above, the Trust was reporting four targets not met against the NHSI framework. All of these issues had been highlighted to the Board in previous months and were well understood. An in-depth report on RTT was included in the papers for this item.

- The Chief Executive raised the issue of patients requiring follow ups not being seen by their due date and the work being taken to ensure they were not exposed to risk. She added that she was aware that the Quality Assurance Committee was monitoring this risk.

- The Trust's performance did, however, ensure that it would receive the STF funding for Quarter 2.

- Financial performance was on plan, however the challenge would increase over Quarters 3 and 4, especially as the CIP target increased.

- A significant reduction in agency spend had been realised over the last two months, which was masked by the cumulative reporting – in year impact was detailed in the report. The Trust's performance in this respect was better than any other in the South West.

- The Chief Nurse reported that work continued to improve Dementia Find performance, which was currently at 43% and steadily improving. A full report would be included in her report to the December meeting.

- Mrs Lyttle asked if patients on all waiting lists (active and pending) were being reviewed for clinical risk if they were overdue and the Chief Operating Officer confirmed that they were. Mrs Lyttle then queried the effect of ceasing outsourcing orthopaedic work to Mount Stuart of and the Chief Operating Officer explained that it was hip and knee work and had affected RTT performance by around 0.5%. She added that it was part of the overall hip and knee pathways changed and a reduction in the overall conversation to treatment rate.

In terms of workforce reporting, the Director of Workforce and Organisational Development reported the following:

- The target to ensure staff received statutory training had been met; staff turnover had reduced; and appraisal performance had been held from the September position.

- The biggest challenge at present was the management of sickness absence which had increased between August and September. It was noted that 64% of sickness was long term, with stress and musculoskeletal injuries as the main two reasons for long term absences. Work had taken place around the Trust's Health and Wellbeing Strategy; support to staff in terms of physical activity and fast tracking physiotherapy support. Training was also being provided in conjunction with the Trade Union to managers to ensure a co-

ordinated approach to sickness management across the organisation. There wold be a cost implication to providing this additional support.

- Mr Welch stressed his view that appraisal performance should be at 100% as it was one of the basic roles of leadership. The Director of Workforce and Organisational Development acknowledged that, and said this was being addressed with managers. Mrs Marshall noted that that those staff on long term sick would not have received appraisals and so would affect performance and also that work was being undertaken to ensure that appraisal system was easy to use and provided a quality outcome.

- Mrs Lyttle raised items in the CIP programme with the heading 'HQ Synergies' which were either highlighted as red or grey with a figure of over £1m attached to them. The Director of Finance explained that they related to the ICO transaction and were grey if they had been delivered, or red if they related to building leases that would not be given up until next year.

163/11/16b **Cost Recovery Proposal – Additional Unpaid Leave**

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

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.

The Board raised the following in terms of the proposal:

- A need to ensure that the authorisation process was robust.

- The effect on team members who chose not to take leave and had to cover the work of those that did take the leave.

- It could be viewed as discriminatory as certain staff groups would not be able to take the leave due to their roles and also those that could afford to take the leave and those that could not.

- It was suggested the initiative could reduce staff sickness rates.

- Other initiatives could be considered to help those staff who were not able to take advantage of the scheme, for example annualised hours, 9 day fortnights etc.

The Board approved the proposal on a pilot basis, in the context of the Trust's current financial position. Thought to also be given to flexible working initiatives such as annualised hours and 9 day fortnights. **DWOD**

164/11/16b **Governors' Questions**

Mr Davidson queried how social care was managed in the Trust and the Chief Operating Officer explained that the Trust received a budget from Torbay Council to directly manage adult social care, whereas it did not have a funding stream from Devon Council but did host the management of the service, and so had influence over decision-making to ensure it was aligned with Torbay. The issue operationally was to be able to purchase care in a timely manner and this was why the market development strategy was so important. It was noted that in Torbay, with the Risk Share Agreement, any overspend on Adult Social Care was shared with the CCG and Council.

Mrs French asked how the Trust could reassure the public that the closure of Paignton Hospital was meaningful whilst implementing the new model of care and that it was not being done to save money. The Chief Executive stated that the current system would not cope without change, and the additional investment in intermediate care was intended to reduce hospital admissions and to allow discharges to be made more quickly. This was needed whatever the outcome of the consultation process. She understood the desire of the public to see some upfront investment made in services to build confidence that alternatives were in place if the hospital was closed. Mr Allen added that normally when significant transformational changes took place, to ensure a smooth path, upfront investment would be made in the new service before the old one ceased, however this did not normally happen in the NHS. The Chairman said that he had discussed this with Lord Carter and his view was that if he wanted the Trust to succeed as a pathfinder, then the Trust needed support in setting up the new model.

Mrs French queried the impact of the longer opening hours of MIUs at Totnes and Newton Abbot on ED attendances at the DGH. The Chief Operating Officer said that there had been around 10% movement in activity from the DGH and that she hoped this would increase once the Trust was in a position to extend x-ray service to 7 days. Mrs French felt this should be highlighted in the public arena and it was suggested it could form part of the weekly column the Herald Express. She also suggested that Governors would be willing to visit MIU waiting rooms to undertake some fact finding.

Comms

Mrs Lyttle asked if the 111 service was aware of the changes in opening hours and the Chief Operating Officer confirmed that it was. She added that the service had transferred from South West Ambulance to Devon Doctors, with a clear transfer programme in place and this was going better than planned. She said that there would be a local presence at Newton Abbot MIU from next month, and it was noted that the service worked across the whole out of hours system not just 111.

Mrs Hookings wished to formally place on record the concern raised by Paignton residents at the potential loss of the local MIU and that they had stated they would travel to Torbay for care not Brixham or Newton Abbot, so the impact of any closure would directly affect Torbay Hospital. The Chief Executive said that as part of the response to these concerns, the Trust could explore with Paignton and Brixham GPs an alternative urgent care offer.

165/11/16b **Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)**

Nil.

PART B: Matters for Approval/Noting without Discussion

166/11/16b **Reports from Board Committees**

Finance, Performance and Investment Meeting held on the 25th October 2016

Key issues to highlight to the Board:

1. 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; and
   iv) actual **Cash** at £14.3m, an adverse variance to Plan of £2.5m.

2. The Trust has not achieved the **NHSI Compliance** Framework quarterly targets for A&E, RTT, Cancer 2 week wait and Cancer subsequent surgery.

3. 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.

4. **STF funding** of £1.5m has been accessed for Quarter 2.

5. 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.

6. 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 Decisions/Recommendations Made:

1. The **STP return** which had been prepared and submitted in conjunction with our CCG was discussed and reviewed.

2. The **Adverse Change to Forecast Protocol – Board Assurance Statement** that has been submitted was reviewed and discussed.

3. Ongoing deep dives into **CIP** are planned for future meetings.

Quality Assurance Committee held on the 24th October 2016

Key issue(s) to highlight to the Board:

1. Domiciliary Care

Concerns continue about the standard of service provided by Mears' actions underway and how 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".

The Board noted the reports from the Finance and Quality Assurance Committees.

Reports from Executive Directors

167/11/16b **Report of the Chief Nurse**

<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.

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.

The key focus areas have been:

- To further review safer staffing levels
- Recruitment, career & workforce plans
- Effective roster management
- Reduction in agency usage and spend

The report details the streams of work above along with key messages from each section.

Key Issues/Risks

- 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

The Chief Nurse's report was noted.

168/11/16b **Assurance from the CCG and NHS England Annual EPRR Assessment**

Strategic Context

This report provides 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 and updated the Trust Board on the EPRR assurance process for the year ending 2016.

Following the formal assessment process that was held with the CCG and NHS England on the 4th October 2016, the Trust Board is 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.

The Board noted the report in respect of the EPRR assessment and formally acknowledged the status of EPRR performance and preparedness and endorsed the signing of the assurance letter for NHS England.

169/11/16b **Key Issues and Assurance from the Capital Infrastructure and Environment Group**

Strategic Context

This report provides 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

- **Critical Estate Failure**: 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 that 33 meters 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 hydrants 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.

The Director of Estates and Commercial Development wished the Board to be aware that without additional investment in planned maintenance, there would be more failures such as this one.

- **PLACE assessment**: 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.

- **National ERIC data**: Most of the Trust's 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 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.

- 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.

The Board noted the above report.

170/11/16b **Compliance Issues**

Nil.

171/11/16b **Any Other Business Notified in Advance**

Nil.

172/11/16b **Date of Next Meeting** – 9.00 am, Wednesday 7th December 2016.

Exclusion of the Public

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

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1.	**Minutes of the last meeting** – minutes to be amended as outlined above.	CE PA	**Completed**	02/11/16
2.	**Role of Junior Doctors and How Training is Delivered** EDs to consider what action would need to be taken if it became apparent that the safety of patients was at risk due to junior doctors working to the new contract. Chairman/Chief Executive to raise issue with Dr Sarah Wollaston MP when they meet with her later in the month.	MD Ch/CE	**Completed** - MD closely monitoring effects of new contract as stepwise implementation proceeds (first significant group transfer 1 December). Unless there is a need for more urgent action there will be a report of Guardian of Safe Working at February Board. Meeting cancelled due to Autum Statement – covered in briefing to MPs.	02/11/16
3.	**STP Feedback** – timeline 'plan on a page' to be provided detailing local and Devon-wide workstreams and timelines.	DSI	**In preparation** – will be completed for 20 Dec Board to reflect Operational Plan as well as SD&T Placed Based developments and STP programmes.	02/11/16
4.	**Community Hospitals Consultation** – response letter to be amended and submitted.	DSI	**Completed** by 23 Nov deadline. Copy in Public Board papers for information.	02/11/16
5.	**Care Home Quality** – thanks be passed back to team for producing the information in the report and the report to be highlighted to Councillor Parrott.	CN	**Completed**	02/11/16
6.	**Additional Unpaid Leave** - consideration to be given to offering staff flexible initiatives such as annualised hours and 9 day fortnights.	DWOD	**Completed** - The Trust has a Flexible Working Policy which was revised in May 2016. The policy sets out the process within which staff can request to work flexibly and takes account of the provisions of the	02/11/16

			Employment Act 1996 (as amended): It covers the following provision: • Part Time hours • Job Sharing • Term Time working • Flexi-time • Compressed Hours • Annualised hours • Temporary reduced hours	
7.	**Governors' Questions** – extended MIU operating hours to be highlighted in the Herald Express and offer of Governors to gain patients' views in MIUs to be taken forward.	Comms	**Completed**	02/11/16

Report to:	Trust Board
Date:	7 December 2016
Report From:	Mairead McAlinden, Chief Executive
Report Title:	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 that the Board can align developments, contributions and risks to the organisation's key priorities.

Safe Quality Care and Best Experience

Sam Morrish: Parliamentary Select Committee
The death of Sam Morrish from sepsis in 2010 was the focus of a parliamentary select committee inquiry last month. Sam Morris died at Torbay Hospital. Mr Morrish and Parliamentary Health Ombudsman who completed the two reports into the case, Dame Julie Mellor, were among those giving evidence. Mr Morrish said that implementing the learning following his son's death was too slow. Dame Mellor said after the hearing: "Sadly the experience of the Morrish family is not unique. We see too many local NHS investigations into avoidable deaths that are not fit for purpose. We have recommended that people at the top of the NHS consider how they can create an environment in which leaders and staff in every NHS organisation feel confident and have the competence to find out why something went wrong and to learn from it."

The Trust has implemented all agreed actions and has a robust process for monitoring compliance with sepsis best practice which is overseen by the Chief Nurse.

Reconfiguration of community services
The 12 week public consultation closed on 23 November. Since launching the consultation, the CCG, supported by the Trust, has organised some 23 formal public meetings and attended more than 50 community group meetings. The consultation has been promoted through traditional and social media, primary care, community organisations and groups, health and social care providers, both Healthwatch Torbay and Devon as well as via almost 2,000 posters, direct mail and regular briefings. Within the Board pack is an update paper from the Director of Strategy and Improvement – this includes a copy of the Board's formal response to the consultation which was amended to reflect Director's contributions following consideration at the October Board.

On 1 December I accompanied Dr Sarah Wollaston MP and Kevin Foster MP with partners from local General Practice and community representatives on a "walk through" of potential sites for a health and Wellbeing Hub in Paignton.

New Linac Radiotherapy equipment for Devon and Torbay
NHS England has announced that Torbay and South Devon NHS Foundation Trust and Royal Devon and Exeter NHS Foundation Trust have been designated as the first hospitals eligible to receive funding for new, state of the art, linear accelerators (LINACs) over the coming year, under the recently announced £130m NHS England investment to upgrade radiotherapy equipment. Recent advances in radiotherapy have helped target radiation doses at cancer cells more precisely. As a result, they enable better outcomes, with improved quality of life for patients and reduced NHS costs in the long term, through patients experiencing fewer side effects. The first LINAC for this Trust is already in operation and the second will be operational in Spring 2017.

Improved Wellbeing through Partnership

Voluntary Transport Services
Availability of transport is a key issue for local people – this has come through as a consistent theme through the community consultation. There are a range of ways that this needs to be addressed, however an immediate issue is the availability of volunteer drivers. The Trust has commissioned (contract value £4.5k) the Council for Voluntary Service (CVS) in South Devon to develop a recruitment campaign to attract more volunteer drivers to work with the local voluntary and community groups.

The recruitment campaign will include local media and video loops which can be run in the waiting areas of local GP practices. These materials will be suitable for use across Torbay and South Devon and will be in a style which does not have a shelf life so that the campaign can be re-run either across the Trust footprint or in local areas where there are specific issues.

I recently attended a 'hackathon' style workshop which was facilitated on behalf of the Trust by the South West Academic Health Science Network and Innovation Unit. The event focussed on the issues related to transport across South Devon and Torbay and was attend by 45 people drawn mainly from voluntary organisations who provide volunteer driver services and also including colleagues from our own PTS services and both Torbay and Devon County Council. The objective of the event was to ensure that solutions to current issues are generated on the basis of the views and perspectives of people using transport services with the full involvement of colleagues from the voluntary sector who coordinate and support volunteer drivers.

The AHSN are in the process of writing up the outcomes and will be working with us on implementation of the key priorities from the event.

Care Quality Commission rates Mears as "Inadequate"
On 9 November Healthwatch Torbay and the CQC published their respective reports into the domiciliary care provided by Mears. The reports are very critical and as a result the CQC rated the care as 'inadequate' and placed Mears locally in special measures. The full CQC report is available here

The Trust, Torbay Council, South Devon and Torbay CCG entered a strategic partnership with Mears in April 2015 to improve the provision of domiciliary care.

Initially it was successful in tackling backlogs in care but since May this year there has been a significant drop in performance. We are working with and supporting Mears on quickly delivering their improvement plan so that local people consistently get a good service. We had already recognised many of the issues that are included in the reports and some improvements have already been made. Carers are now attending 95% of visits within 30 minutes of the agreed time and when they are not able to, the client is informed immediately. All appointments that are time critical, such as vital medicines, are being done on time. Sustainable further improvement is still needed and Mears have voluntarily agreed to suspend taking on any new care packages to be delivered directly by their staff whilst they work on improvement actions for a period of up to four weeks. Mears are working closely with their sub-contractors to ensure new care packages are picked up in the meantime.

The Chief Operating Officer is providing Executive oversight for the delivery of the improvement plan and has deployed a team of Trust staff to support Mears.

CQC to inspect Devon Partnership Trust (DPT) services
The CQC is conducting a re-inspection of Devon Partnership NHS Trust's services in the week commencing Monday 5 December and during this visit, the inspectors will be attending our services as follows;

On **Thursday 8th December 2016**, the CQC inspection teams are planning to visit:

- Haytor Ward, Torbay Hospital
- Beech Unit, Torbay Hospital
- Devon Memory Service, Torbay Hospital
- Torbay Crisis Resolution Home Treatment Team, Torbay Hospital

We are not currently anticipating inspectors visiting the main hospital building.

Valuing our Workforce Paid and Unpaid

Staff Heroes
The first Staff Heroes awards, which has replaced the WOW awards, takes place on 13 December. These internal awards enable patients and service users to nominate staff and their teams in recognition of excellence in care provision. These Awards are to recognise the efforts of our staff, who are providing excellent services across the Trust. Nominations are open all the year round and the Heroes Awards are recognised with a certification and presentation at a celebration event hosted by the Chairman and attended by myself and the Executive Team.

Excellence in Education and Development Recognised
Staff from the ICO's Education and Development department have been in the spotlight this month for their strong partnership with South Devon College and Plymouth University:

- At the Association of Colleges National Conference, Maria Woodger (Head of Section in Health from South Devon College) and Jane Goodman (Lead for ICO Non-Medical Workforce Development) were asked to speak to a break out audience about the unique working partnership they have developed to support an increase of local people into work and then into the nursing and

AHP professions. The session evaluated extremely well with Jane and Maria referred to as “inspirational”. It was evident throughout the presentation that the tripartite working relationship with the Faculty of Health and Human Sciences (Plymouth University) South Devon College and the Trust, was making a huge quality assurance platform for now and for the future.

- As a result the team has been approached by health and education providers in Basingstoke to support them in developing a similar tripartite approach.
- A related meeting with Dr Sarah Wollaston MP focussed on progression routes via the College then into the FdSc in Healthcare for our Assistant Practitioners and then on to Nursing.

Well Led

Staff win NHS regional leadership awards

We are delighted that three of our staff were announced as finalists in the regional NHS Leadership Awards, with two of those going on to be declared the overall winners of the category. Jane Wilkinson (Named Nurse for Safeguarding Children at TSDFT) and Steve Smith (Consultant Haematologist at TSDFT) fought off stiff competition to be announced joint winners of the ‘inspirational leader’ category. The award recognises an individual or team who inspire others to achieve great things. They place quality at the heart of everything they do; they are innovative and value their partners while actively mentoring the next generation of NHS leaders. In additional to Jane and Steve’s win, Emma Baker (Community Nurse Manager, Moorland Community Nursing Team at TSDFT) was also announced as a finalist in the ‘living the values’ award. This award recognises those who demonstrate an outstanding commitment to the NHS and health and social care values in their daily role.

Children & Young People’s Services In Devon

Virgin Care currently provides the Integrated Children’s Service across Devon (excluding Plymouth and Torbay but including the South Devon area). This contract is due to end in March 2018, therefore Torbay & South Devon CCG, NEW Devon CCG, Devon County Council and Plymouth City Council are working together to plan for the next contract. For Torbay and South Devon NHS Foundation Trust the services covered include the Child and Adolescent Mental Health Services, Children’s Learning Disability Services, children with additional needs, Torbay ‘s Autistic Spectrum Disorder Assessment Service and the South Devon and Torbay Child Development Centre.

As a first step, we attended an event held on 17 November for current providers and other interested parties who deliver children’s services across Devon. The aim was to understand the service commissioners’ current thinking about the scope of a new contract, what services it might cover and how they could be tendered for in the future.

2 Local Health Economy Update

Wider Devon Sustainability and Transformation Plan (STP)
The latest draft of the Wider Devon STP was published on 4 November – one of the first draft plans in the country to be published in its complete form by the NHS. Local stakeholders were briefed and received a letter from Angela Pedder, Chief Executive of the Wider Devon STP. A copy of the full submission is included in the Board pack with a cover paper from the Director of Strategy and Improvement setting out the background, strategic context and risks and issues. All Boards within the STP are being asked to endorse this high level strategic framework.

STP - Acute Services Review
The STP includes a Wider Devon review of acute services. I am the lead Chief Executive for this programme, working alongside the clinical lead, Dr Phil Hughes, Chair of the STP Clinical Cabinet and Medical Director for Plymouth Hospitals NHS Trust.

The scope, approach and initial priorities for this review are set out in a document, *Services not Structures,* which the Board is being asked to endorse in today's meeting. It sets out a clinically led programme of work focused on achieving:

- equality of access to services
- improved outcomes and quality of care
- better staff experience
- better value.

The first services to be reviewed are stroke, maternity, paediatrics & neonatology, and urgent and emergency services.

We have confirmed the clinical leads for each of the three major phase one reviews:

- Stroke: Dr George Thompson (Northern Devon)
- Maternity and paediatrics: Dr Rob Dyer (Torbay and South Devon)
- Urgent and emergency care: Dr Adrian Harris (RD&E)

These leads are establishing their own review teams and we are putting in place a programme of reviews which enables expert staff from across wider Devon along with representative patient groups to co-design the service review.

The Board is asked to endorse the principles and criteria for the Acute Services Review.

Torbay Council budget proposals
The Mayor's draft proposals for service change, income generation and efficiencies in 2017/18 were published on 4 November by Torbay Council. The council has to make £21.5 million pounds worth of savings by 2020 – that's on top of the £62 million already made in the last six years. In total, the cumulative impact of reductions over nine years from 2011/12 to 2019/20 to achieve a balanced budget will be over £400m. In order to meet the financial challenges the council will, through its Transformation Programme, develop new ways of working and do things

differently. A six week consultation will conclude on 16 December. The consultation, which includes proposals to significantly reduce funding for public health services, are available here. This Trust is will be making a formal response to the proposals.

A draft response prepared by the Medical Director is included on the agenda for Board approval.

Estates and Technology Transformation Fund (ETTF)
South Devon and Torbay CCG has been successful in bids for ETTF funding. The Pembroke hub, Dartmouth wellbeing centre, Teignmouth integrated care scheme, remote access to clinical IT and the CCG-wide telephony scheme will all go ahead. Further details of the proposals, including timescales and the percentage of funding that has been allocated are expected soon.

Delegated Commissioning
Following the recent LMC ballot where the membership voted in favour of SDT CCG applying to NHS England to take delegated commissioning responsibility for general practice from April 2017, the CCG's Governing Body agreed this month to submit the application. The final decision to accept responsibility will be subject to the Governing Body's approval in March 2017. Further guidance about delegated commissioning can be found on the NHSE website.

People moves and appointments

- Suzanne Tracey has been announced as chief executive of Royal Devon and Exeter Foundation Trust with immediate effect. Suzanne has been Chief Financial Officer, Deputy Chief Executive and Acting Chief Executive. On behalf of the Board we have conveyed our congratulations to Suzanne.
- Dr Rosie Benneyworth, managing director of the South West Academic Health Network (SW AHSN), has announced that she will be standing down to return to healthcare delivery, with closer links to direct patient care. Director of Integrated Care at the SW AHSN, Louise Witts, has been confirmed as Interim Chief Executive Officer effective from 1 January 2017. She will remain in this role until a new CEO is appointed on a permanent basis later in 2017.
- Rebecca Harriott, Chief Operating Officer, of NEW Devon CCG is taking up a 12-month secondment to the South West Academic Health Science Network, starting on 1 December 2016. Janet Fitzgerald, who is currently CCG Corporate Affairs Director, will be taking on the role for at least the next 12 months.
- South Devon and Torbay CCG and NEW Devon CCG are recruiting two new joint directors – Director of Strategy and Director of Corporate Affairs. The interviews will be held on the 13 and 15 December respectively. A member of the Executive team will form part of the focus groups.

3 Chief Executive Leadership Visibility

Internal • Joint Consultative Negotiating Committee • Cromie Ward • Freedom to Speak Up Equality leads • Staff Side
External • STP CEO Meeting • Strategic Director People, Business Strategy & Support, Devon County Council • Simon Stevens, Chief Executive, NHS England • STP Collaborative Board • System Delivery Board • Chair, Brixham League of Friends • Programme Delivery Executive Group • Executive Leadership Group • Patient Transport Hackathon • Director of Children's Services, Torbay Council • NHS Providers Annual Conference • Anaesthetic Annual Conference • Acute Services Review
Public Meetings • PPG Consultation Meeting • Ashburton Consultation Meeting **Additional meetings on request** • Dartmouth Town Council Meeting • Dr Sarah Wollaston MP • Brixham Redesign Group • Teignmouth GP Premises Meeting

4 National Developments and Publications

Details of the main national developments and publications since the November Board meeting have been circulated to the Board each week through the weekly 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 Committee including undertaking "C*ould it happen here?*" reviews where appropriate.

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

Government

Autumn Statement

Despite significant lobbying of the Treasury by think tanks, provider representatives, MPs and others for additional investment in social care and general practice, there were no announcements specific to the Department of Health or its budget or the budgets of any of the arms length bodies in the Chancellor's Autumn Statement. A copy of NHS Providers On the Day Briefing is attached (Appendix 1).

Workforce changes

At this month's NHS Providers Annual Conference the health secretary Jeremony Hunt announced a number of workforce-related measures that are focused on flexible working, career progression, leadership and doctors in training.

Performance

- **Hospitals could lose £2m if sepsis rates continue-** Professor Sir Bruce Keogh, national medical director of NHS England, has announced that hospitals could lose up to £2m of NHS funding if they do not hit targets to reduce cases of sepsis. 0.25% of each hospital trust's turnover would be withheld each year unless they made progress. A pilot of the scheme last year has already seen huge improvements in A&E departments, with the number undergoing quick checks for sepsis rising from 52% to 78% within the space of a year. Now it will be extended, with more targets to be introduced in April, including education for GPs and hospital doctors.
- **NHS trusts record £648m deficit in first half of year** The Q2 financial performance figures from NHS Improvement which shows providers are on track to record a year-to-date deficit of £648m in the first half of the year. against the £580m planned deficit.
- **NHS England sets out steps to improve mental healthcare for pregnant women and new mums and help those attending A&E in crisis;** NHS ENGLAND has set out plans to provide more support for pregnant women and new mums suffering mental illness as well as to improve care for the many people with mental health problems attending A&E in crisis. NHS England will also reveal a new recommended standard that says anyone who walks through the front door of A&E or is on a hospital ward in a mental health crisis should be seen by a specialist mental health professional within an hour of being referred, and within four hours they should have been properly assessed in a skilled and compassionate way, with the correct next steps for their care planned in partnership with them.

Think tank reports

NHS Providers: The state of the NHS provider sector. The purpose of this new report is to provide a valuable view of how the provider sector is performing, identifying the challenges providers are facing and the successes they should be celebrating.

NAO: Two-thirds of trusts in deficit

The National Audit Office has suggested the financial problems of the NHS are now "endemic" and have worsened so significantly in the past year that the situation is no

longer sustainable. The auditors also say that two-thirds of health trusts in England are now in deficit, while their total debt has almost trebled since 2015 to £2.45bn.

The King's Fund report on STPs
Think tank the King's Fund has written a report – 'Sustainability and Transformation plans in the NHS - How are they being developed in practice?' In the report they say it is important to recognise the context in which the plans are being developed. The pressures facing local services are significant and growing, and the timescales available to develop the plans have been extremely tight. The original purpose of STPs was to support local areas to improve care quality and efficiency of services, develop new models of care, and prioritise prevention and public health. The emphasis from national NHS bodies has shifted over time to focus more heavily on how STPs can bring the NHS into financial balance (quickly).

They also mention that the work that has been put into the STPs is immense and that there has not been time so far to have meaningful engagement with staff and the public. They also say that the next phase will have to focus on implementation and they make a number of recommendations in their report. The report can be downloaded here

BMA: Junior doctors vote to end strikes
Junior doctors have voted to abandon strikes and return to talks over Government-imposed contracts, it has been claimed. A series of week-long walkouts were suspended in September following growing disquiet over the possible impact on patients.

5 Media Update

Media references to the Trust include:

- The local service one of the best cancer services in the country, according to ratings published by NHS England
- Torbay Hospital health care assistant tells others of the importance of the flu jab following her critical illness – covered nationally and being used by NHS England
- Wide local coverage of the inadequate rating of the domiciliary provider Mears
- Inquiry held into NHS investigations following avoidable death of Newton Abbot toddler – Sam Morrish

AUTUMN STATEMENT 2016

OVERVIEW

The Chancellor's key theme was shaping an economy that works for everyone. But underlying his ability to do so, and explaining in part a relatively muted Autumn Statement, was the significantly larger than expected impact of Brexit. The Office for Budget Responsibility (OBR) believes that Brexit will lessen potential growth by 2.4% over the forecast period. From this flowed his focus on building Britain's long term future, ensuring its resilience as it exits the EU, and maintaining fiscal discipline while recognising the need for investment.

Mr Hammond's focus was on capital investment in infrastructure – housing, transport, digital and economic – with few references to public services. He reiterated that the NHS would be receiving £10 bn by 2020-21, but crucially, he refrained from confirming that health was one of the public services whose budget would be protected. Instead, he stated the need to ensure 'the challenges of rising longevity and fiscal sustainability' are tackled and promised a review of 'public spending priorities and other commitments for the next Parliament in light of the evolving fiscal position at the next Spending Review'. He also confirmed that departmental spending plans set out in the Spending Review will remain in place. Although there is no explicit mention of social care in the Autumn Statement, during the debate following his speech the Chancellor highlighted that he was aware of the issue around the profile of social care investment in this Parliament and confirmed that he would de be discussing this with Secretaries of State for Health and Communities and Local Government.

The final announcement of this Autumn Statement was that this would be the last one. The Chancellor will move to delivering an autumn Budget so that changes are known in advance of the new tax year, and deliver a Spring Statement in order to respond to the required bi-annual report of the OBR. The new Spring Statement will not be a fiscal event.

This briefing sets out the economic overview based on the OBR report, and then the implications for NHS providers as well as a summary of key announcements. Our view on the Autumn Statement is also given.

ECONOMIC OVERVIEW

With new spending commitments, and a weaker outlook for the economy and tax revenues the budget is no longer expected to return to surplus in this Parliament, with a £21.7 bn deficit (0.9 per cent of GDP) remaining in 2020-21 according to the Office for Budget Responsibility (OBR).

The budget deficit has been revised up by £12.7 bn this year, thanks primarily to weakness in income tax receipts (that largely pre-date the EU referendum) and local authority spending, which was higher than expected. This means the OBR expects borrowing equal £68.2 bn this year, down from £76.0 bn in 2016.

Total managed expenditure for 2016/17 -2021 (£bn)	16/17	17/18	18/19	19/20	20/21	21/22
	778.8	797.0	814.5	823.7	855.6	886.4

The OBR notes "the government has opted neither for a large near-term fiscal stimulus nor for more austerity over the medium term. Instead the Chancellor has proposed a much looser 'fiscal mandate' that gives him scope for almost 2½ per cent of GDP (£56 bn) more structural borrowing in 2020-21 than his predecessor was aiming for in March." According to the OBR, this relaxation makes space for a "modest infrastructure spending increases over the next five years.

As a result the government has proposed new fiscal targets in a draft Charter alongside the Autumn Statement. These new targets are less limiting than the existing ones. The new fiscal targets requires a structural deficit – i.e. borrowing unrelated to temporary weakness in the economy – to be below 2 per cent of GDP in 2020-21, which would mean halving it in this Parliament. The targets also say the net debt must fall relative to GDP in 2020-21.

OBR - key forecasts

- Underlying borrowing forecast higher than predicted in March by the OBR, as can be seen in the table below

	2016-17	2017-18	2018-19	2019-20	2020-21
March 2016 forecast borrowing (£bn)	56	39.2	21.9	-4.1	16.9
November 2016 forecast borrowing (£bn)	68.2	59.0	46.5	21.9	20.7

- The OBR states that Autumn Statement policy decisions will add to the deficit in every year, highlighting Capital spending has been increased by rising amounts across the Spending Review years to 2020-21 and into 2021-22.
- The Government has also announced a small net tax increase, mainly delivered through a rise on tax on insurance premiums.
- The economy will grow more slowly than predicted by the OBR in March, with GDP growth in 2017 revised down from 2.2 to 1.4 per cent. This has been caused mainly by a weaker outlook for investment and productivity growth.
- Inflation is forecast to peak at 2.6 per cent. Unemployment to rise modestly to 5.5 per cent during 2018 up around 0.3 percentage points (or around 100,000 people) relative to our the OBR's March forecast. This is combined with "subdued" earnings growth and higher inflation meaning that real income growth is set to stall in 2017.
- Departmental resource spending plans have been increased in 2019-20 and 2020-21, but held flat in real terms in 2021-22, meaning they fall in real per capita terms and as a share of GDP.

To note in its forecasting, to take regard of Brexit, the OBR assumes:

- the UK leaves the EU in April 2019 – two years after the date by which the Prime Minister has stated that Article 50 will be invoked.
- the negotiation of new trading arrangements with the EU and others slows the pace of import and export growth for the next 10 years.

- the UK adopts a tighter migration regime than that currently in place
- sufficiently tight to reduce net inward migration to the desired 'tens of thousands'.

SPECIFIC HEALTH ANNOUNCEMENTS

There were no announcements specific to the Department of Health or its budget, or the budgets of any of the arms length bodies.

This means that the funding profile for this parliament that was outlined at the last comprehensive spending review in November 2015 (see table below). The Autumn Statement notes "with the deficit still sizeable, control of public spending and delivery of efficiencies is vital. The government is committed to the overall plans for departmental resource spending set out at Spending Review 2015.

	2016-17	2017-18	2018-19	2019-20	2020-21
DH revenue budget (£bn)	115.6	118.7	121.3	124.1	128.2
DH Capital budget (£bn)	4.8	4.8	4.8	4.8	4.8

WIDER IMPLICATIONS FOR NHS PROVIDERS

Expanding medical training places

- The Autumn Statement includes the additional student loan outlay expected following the announcement made by the Secretary of State for Health on 4 October 2016 that the government will fund up to 1,500 additional medical training places each year, from 2018-19 onwards.

Investment

- As announced at Budget 2016, the government intends to identify £3.5 bn of savings in 2019-20. The government intends to allocate £1 bn of these savings for re-investment in "priority areas." There is no introduction in the statement as to whether the NHS will be considered as a priority area and therefore be eligible for this funding.

Research, development and innovation

- The Autumn Statement announces a new NPIF which will be targeted at four areas that are critical for improving productivity: housing, transport, digital communications, and research and development (R&D). The NPIF will provide for £23 bn of spending between 2017-18 and 2021-22, with the following allocated to research and innovation funding:

	2017-18	2018-19	2019-20	2020-21
R&D funding through NPIF (£m)	425	820	1500	200

- Additional funding will be allocated to increase research capacity and business innovation. Once established, UK Research and Innovation will award funding on the basis of national excellence and "will include a substantial increase in grant funding through Innovate UK".
- To ensure the UK tax system is strongly pro-innovation, the government will review the tax environment for R&D to look at ways to build on the introduction of the 'above the line' R&D tax credit to make the UK an even more competitive place to do R&D.
- In October the government committed an additional £100 million until 2020-21 to extend and enhance the Biomedical Catalyst. These funds will be allocated to Innovate UK.
- Funding of £100 million will also be provided until 2020-21 to incentivise university collaboration in tech transfer and in working with business, with the devolved administrations receiving funding through the Barnett formula in the usual way.
- The government has selected eight areas for the second wave of Science and Innovation Audits: Bioeconomy of the North of England; East of England; Innovation South; Glasgow Economic Leadership; Leeds City Region; Liverpool City Region +; Offshore Energy Consortium; and Oxfordshire Transformative Technologies. The government is also announcing a further opportunity to apply to participate in a third wave of audits.
- The government will transfer to London, and to Greater Manchester, the budget for the Work and Health Programme, subject to the two areas meeting certain conditions, including on co-funding.

Tax

- National Insurance thresholds – as recommended by the Office of Tax Simplification (OTS), the National Insurance secondary (employer) threshold and the National Insurance primary (employee) threshold will be aligned from April 2017. This means both employees and employers will start paying National Insurance on weekly earnings above £157. This will simplify the payment of National Insurance for employers.
- The government will publish draft legislation for the Soft Drinks Industry Levy on 5 December.
- In relation to business rates, to remove the inconsistency between rural rate relief and small business rate relief the government will double rural rate relief to 100% from 1 April 2017.
- Insurance Premium Tax (IPT) – The standard rate of IPT will rise to 12% from 1 June 2017. IPT is a tax on insurers and so any impact on premiums depends on insurers' commercial decisions. This tax will affect private health insurance providers.
- Fuel duty will be frozen from April 2017, for the seventh year running.

OVERVIEW OF OTHER KEY ANNOUNCEMENTS

Pensions and savings tax

- The Individual Savings Accounts (ISA) limit will increase from £15,240 to £20,000 in April 2017.
- The band of savings income that is subject to the 0% starting rate will remain at its current level of £5,000 for 2017-18.

- The Money Purchase Annual Allowance (the annual amount individuals can contribute to defined contribution pensions after having previously accessed a pension flexibly) will be reduced to £4,000 from April 2017.
- Pensions (including advice) will be excluded from the ending of salary sacrifice schemes in April 2017.
- The tax treatment of foreign pensions will be more closely aligned with the UK's domestic pension tax regime by bringing foreign pensions and lump sums fully into tax for UK residents, to the same extent as domestic ones.

Taxation

Public sector specific

- The government will reform the off-payroll working rules in the public sector from April 2017 by moving responsibility for operating them, and paying the correct tax, to the body paying the worker's company. The 5% tax-free allowance will be removed for those working in the public sector, reflecting the fact that workers no longer bear the administrative burden of deciding whether the rules apply.

Income tax

- The personal allowance will rise to £11,500 and the higher rate income tax threshold to £45,000 next year. These thresholds will increase to £12,500 and £50,000 respectively by the end of the Parliament. From 2020, the personal allowance will rise in line with inflation.

National insurance

- National Insurance (NI), employer and employee thresholds will be aligned so that both start paying on weekly earnings above £157. NI will also be removed from the effects of the Limitation Act 1980 in order to align the time limits and recovery process for enforcing NI debts with those of other taxes.
- From April 2018 termination payments over £30,000, which are subject to income tax, will also be subject to employer NI contributions.

Business and corporate tax

- The rate of corporation tax will be cut to 17% by 2020 and business rates reduced by £6.7 bn over the next 5 years.
- The government will restrict the amount of profit that can be offset by historical losses or high interest charges.

Employee benefits

- The tax advantages of salary sacrifice arrangements will be phased out (except for arrangements relating to pensions [including advice], childcare, Cycle to Work and ultra-low emission cars). Arrangements in place before April 2017 will be protected until April 2018, and arrangements for cars, accommodation and school fees will be protected until April 2021.
- The government will consider how benefits in kind are valued for tax purposes, publishing a consultation on employer-provided living accommodation and a call for evidence on the valuation of all other benefits in kind at Budget 2017.
- The government will publish a call for evidence at Budget 2017 on the use of the income tax relief for employees' business expenses, including those that are not reimbursed by their employer.

Other tax measures

- From 6 April 2017, the amount of investment that social enterprises aged up to seven years old can raise through Social Investment Tax Relief (SITR) will increase to £1.5m.
- The government will clarify the application of the VAT zero-rating for adapted motor vehicles to stop the misuse of this legislation, while continuing to provide help for disabled wheelchair users.
- Insurance Premium Tax will rise from 10% to 12% in June 2017.
- From April 2017, all employees (as opposed to only those with allegations against them) called to give evidence in court will no longer need to pay tax on legal support from their employer.
- Reforms to the taxation of non-domiciled individuals include that, from April 2017, non-domiciled individuals will be deemed UK-domiciled for tax purposes if they have been UK resident for 15 of the past 20 years, or if they were born in the UK with a UK domicile of origin.
- The government will strengthen sanctions for and deterrents to tax avoidance and will take further action on disguised remuneration tax avoidance schemes.

Devolution

- Through the Local Growth Fund, the government will allocate £1.8 bn to Local Enterprise Partnerships, with £556 m going to the North of England, £392m to the Midlands, £151 m to the east of England, £492m to London and the south east, and £191m to the South West.
- Mayoral combined authorities will be granted powers to borrow for their new functions, subject to agreeing a borrowing cap with the Treasury.
- The government will consult on lending local authorities up to £1 bn on a new local infrastructure rate for three years, in order to support infrastructure projects that are high value for money.
- A Midlands Engine strategy will be published and investments via the Midlands Engine Investment Fund and Northern Powerhouse Investment Fund will commence from early 2017.
- The government will seek to progress a second devolution deal with the West Midlands Combined Authority and will begin talks on future transport funding with Greater Manchester.
- The Greater London Authority's we receive £3.15 bn to deliver over 90,000 housing starts by 2020-21.

Housing

- The new National Productivity Investment Fund will finance:
  - A £2.3 bn Housing Infrastructure Fund to deliver up to 100,000 new homes in areas where housing need is greatest.
  - £1.4 bn to deliver 40,000 housing starts by 2020-21, alongside relaxing restrictions on grant funding, to develop more affordable housing.
  - £1.7 bn by 2020-21 to speed up house building on public sector land in England through partnerships with private sector developers.
- Other housing announcements included:
  - A ban on letting agent's fees to tenants.
  - A large-scale regional pilot of the Right to Buy for housing association tenants.
  - Delaying the implementation of the cap on Housing Benefit and LHA rates in the social rented sector to April 2019.

- In addition, the government will publish a Housing White Paper, setting out a comprehensive package of reform to increase housing supply and halt the decline in housing affordability.

Welfare

- The Government has no plans to introduce further welfare savings measures in this Parliament beyond those already announced.
- Expenditure on welfare in 2021-22 is to be contained within a new predetermined cap and margin set by the Treasury. There will be a margin above the cap, meaning that it will only be breached if spending exceeds the cap plus the margin at the point of assessment. This assessment will be conducted by the OBR in 2020-21, at which point the welfare cap will be £123.2 bn and the margin 2.5%.
- From April 2017, the Universal Credit taper rate (the rate at which the benefit can be withdrawn from people once they find work) be reduced from 65% to 63%.

Education, training and skills

- From 2017-18, £50m a year of new capital funding to support the expansion of existing grammar schools will be made available.
- £13m will be made available to support firms' plans to improve their management skills by implementing Sir Charlie Mayfield's review of business productivity.

Transport

- The new National Productivity Investment Fund will finance:
  - £1.1 bn to tackle congestion and deliver upgrades to local roads and public transport networks.
  - £390m of investment by 2020-21 to support ultra-low emission vehicles (ULEVs), renewable fuels, and connected and autonomous vehicles (CAVs).
  - £450m for the rail network to trial digital signalling technology, expand capacity, and improve reliability.
  - Approximately £80 m to accelerate the roll out of smart ticketing on the rail network.
  - Construction of HS2 Phase 1 to start next year.

Infrastructure

- A new £400 m Infrastructure Investment Fund will be established to invest in new fibre networks, matched at least by private funding.
- A confirmed £1.8 bn of Treasury-backed infrastructure bonds and loans.
- The Chief Secretary to the Treasury will chair a new ministerial group overseeing the delivery of priority infrastructure projects.
- The government will bring forward funding to accelerate the development of the Cambridge-Milton Keynes-Oxford growth corridor.

Energy and environment

- New, lower company car tax bands will be introduced for the lowest emitting cars to incentivise the purchase of Ultra-Low Emission Vehicles.
- More than £100 bn of private investment will be made in the UK's energy sector over the next 15 years.

- The Shale Wealth Fund will provide up to £1 bn of additional resources to local communities, who will determine how the money is spent in their area.
- The government will invest £170 m in flood defences and resilience measures.

Criminal justice

- Up to £500 m will be allocated to enable the recruitment of 2,500 extra prison officers and fund wider reforms to the justice system.
- Supporting legislation for reform of whiplash claims will be brought forward, with insurers expected to pass on savings to drivers in England and Wales.

Additional areas

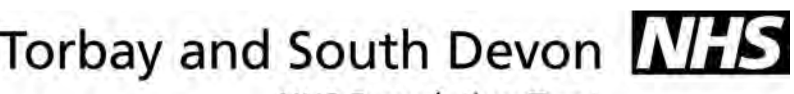
- Emergency services charities will benefit from £102 m of banking fines.
- A new NS&I 3-year savings bond with an indicative rate of 2.2% available from spring 2017.
- A gradual roll out of tax-free childcare from early 2017.
- Comic Relief to distribute £3 m from the Tampon Tax Fund to women's charities.
- Amendments to the Gift Aid Small Donations Scheme to ensure fairer treatment to all charity types.

OUR VIEW

- NHS trusts are working flat out, treating more patients than ever before, but they are experiencing record levels of demand because of the pressures in social care and general practice.
- It is on this basis that we, together with a broad range of health and social care organisations and commentators, made representations to the Treasury ahead of the Autumn Statement calling for additional funding for social care and primary care to be prioritised.
- Given the degree of consensus it is disappointing that this call has not been met.
- The NHS can deliver when it is given a reasonable task and is properly supported. However maintaining current departmental spending levels, as the Autumn Statement does, there is a clear gap between what the NHS is being asked to deliver and the funding available - something we have highlighted to consistently policy and decision makers in recent months. This means that we need a realistic, agreed, plan on how we will close this gap over the rest of this parliament

USEFUL LINKS

The full text of the Autumn Statement can be accessed here.
The full text of the Chancellor's speech is accessible here.
The Office for Budget Responsibility economic and fiscal outlook figures are available here.



REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Wider Devon Sustainability and Transformation Plan (STP)
Lead Director:	Ann Wagner Director of Strategy and Improvement
Corporate Objective:	All
Corporate Risk/ Theme	All
Purpose:	Information and Endorsement

Summary of Key Issues for Trust Board

Strategic Context:
All Provider and Commissioner Boards/Governing Bodies and Local Authority Health Overview and Scrutiny Boards within the Wider Devon STP footprint have been asked to consider and endorse the attached high level framework which was submitted to NHS England at the end of October and published on 4 November.

The STP is a strategic framework that has been developed by NHS organisations in Devon working in partnership with Devon County Council, Plymouth City Council and Torbay Council. The STP is the local plan to achieve the NHS 'Five Year Forward View' published in October 2014 and to address the challenges faced locally.

The STP is designed to provide the overarching strategic framework within which detailed proposals for how services across Devon will develop between now and 2020/21. The purpose is that people residing in wider Devon will experience safe, sustainable and integrated local support. A key theme throughout the STP is an increased focus on preventing ill health and promoting people's independence through the provision of more joined up services in or closer to people's homes. At the same time the STP is focused on closing the financial gap that exists, recognising that doing nothing is not an option and transformational change is essential to address the significant challenges faced by the local system. Analysis demonstrates unless we take action now, wider Devon faces a financial gap of £557 million by 2021.

The STP is built around an aspiration to achieve, by 2021, a fully aligned sense of place, linking the benefits of health, education, housing and employment to economic and social wellbeing for communities through joint working of statutory partners and the voluntary and charitable sectors. In this context the partner organisations involved in the STP are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations served.

The key focus of the STP will be on activities that will make the biggest difference to population health and financial recovery. Seven priorities have been identified – prevention and early intervention; care model integration; primary care; mental health and learning disabilities; acute hospital and specialised services; productivity and children and young people. These are supported and underpinned by an 8th work enabler work stream that includes workforce, estates, digital, communications and engagement and organisational development.

Key Issues/Risks
For the Trust the key issues/risks include:

- being part of a wider planning footprint may slow down the pace of locally agreed change plans
- although not yet finalised, a single financial control total for Devon may penalise impact on SD&T funding for the local population

These risks have to be balanced against the opportunities and benefits offered by being part of the STP especially in relation to creating sustainable and viable services, more resilient workforce and more efficient and productive support services.

It is important to note that the STP is designed to build on and expedite progress with current plans as well as introducing new areas of focus

Recommendations:
The Trust Board is asked to
• **endorse** the Wider Devon STP framework
• **support** Directors, clinical leads and operational teams to engage effectively
• **reques**t further regular feedback on progress

Summary of ED Challenge/Discussion:

The Trust Chief Executive and Executive Directors have contributed to the STP framework and are supporting the next steps in terms of developing detailed work stream plans. The priority areas include areas that the ICO has already been progressing – eg community services transformation and sustaining vulnerable services – which were already key programmes within the original ICO business plan which predates the STP.

Key issues considered include capacity of Directors and teams to participate in all of the work programmes and governance structures which are overlaid on our growing place–based planning requirements as well as organisational level delivery focus. The STP leadership team are reviewing governance and programme management arrangements so that they are appropriate given the scale of challenge and competing demands on organisation leadership teams.

Internal/External Engagement including Public, Patient and Governor Involvement:
In providing a framework for a programme of transformation it is essential that there is ongoing dialogue with patients, volunteers, carers, clinicians and other staff, public, local voluntary and community sector, local authorities and political representatives and an engagement plan is being developed for the whole STP, with targeted involvement and consultation on specific aspects of the STP where applicable.

Within the Trust staff and governors have been briefed and ongoing communications are planned throughout the period of the STP. Across the STP area, a communications and engagement plan will support the STP and the work streams to ensure communities, staff and other key stakeholders are involved.

Asking all Boards to endorse this strategic framework is a key step in the engagement.

Within the South Devon and Torbay Health and Care system, Torbay Council's Overview and Scrutiny Board considered the STP submission and agreed to endorse it at a meeting held on 30 November. The STP is also a standing item as part of the STP update on the Joint Executive and System Change Board agendas.

Equality and Diversity Implications:

For each work stream, where there is a significant change proposed, the STP team will engage widely with service users, clinicians, staff, unions, representative groups and the public. Where formal consultation is required, this will be planned and undertaken to meet all the statutory

requirements relating to NHS service changes.

The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.

PUBLIC

Sustainability & Transformation Plan (STP) Wider Devon

4th November 2016

Name of footprint and number: **Wider Devon (37)**
Region: **South**
Nominated lead of the footprint: **Angela Pedder, Lead Chief Executive**

Contact details
angela.pedder@nhs.net
l.nicholas@nhs.net

Organisations within Devon's STP footprint

Northern, Eastern and Western Devon Clinical Commissioning Group (CCG), South Devon and Torbay CCG, Plymouth Hospitals NHS Trust, Royal Devon and Exeter NHS Trust, Northern Devon Healthcare NHS Trust, Torbay and South Devon NHS Trust, South West Ambulance Service Trust, Devon Partnership NHS Trust, NHS England, Circa 160 GP practices, Virgin Care, Devon County Council, Plymouth City Council, Torbay Council, Livewell Southwest CIC, Devon Doctors, Healthwatch (Devon, Plymouth and Torbay) and Care UK.

The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.

Content

Section	Contents
Introduction and context	• Plan on a page • Introduction & context • Case for change • Vision
Triple Aim	• Triple aim (summary) • Our priorities (summary) • Critical decisions • Population health & wellbeing gap • Experience of care gap • Cost effectiveness gap
Governance	• Programme approach • Governance arrangements
Priorities	• Prevention & early intervention • Integrated care model • Primary care • Mental health & learning disabilities • Acute hospital & specialist services • Productivity • Children & young people
Enablers	• Workforce • Communications & engagement • Estate • Information management and technology (IM&T)

Triple aim challenge :

- Improve population health & wellbeing
- Experience of care
- Cost effectiveness per head of population

Our commitment

Partners across the wider Devon health and care community are united in a single ambition and shared purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve.

Over five years we will achieve clinical and financial performance and outcomes improvement by.....

2016/17

2017/18

2018/19

2019/20

2020/21

Phase 1 of clinical and financial recovery plan to reduce overspending 2016/17. Engage, design and consult on a new model of integrated care to ensure an equal spread of services across Devon and reduce reliance on bed-based care. Deliver early win initiatives to progress 1st phase financial recovery.

Phase 2 to start planning and implementing the longer term clinically and financially sustainable models of care

Engage, design and consult on reconfigured new models of care for mental health, acute and specialist services to secure clinically sustainable services, reduce duplication and variation and improve user experience.

Phase 3 Promote prevention and early intervention: Fully Implement the integrated care model

- Build equitable mental health and emotional well being capacity
- Mobilise new model of fully integrated health and social care, primary car and local community support in all localities and reduce bed stock
- Realign use of resources to achieve population and service equity
- Workforce redesign and capacity building to support care model delivery and to promote economic growth and resilience
- Commence specialist and acute reconfigurations implementation

Capture the benefits of Reduced variations in care and provision, reduced health inequalities, enabling people to access services that achieve better outcomes. Also enable the care providers to better manage demand for their services – right care, right place

Clinical and financial sustainability secured

Improvements in health/patient experience outcomes demonstrated

Key priorities	Prevention & early intervention	Integrated models of care	Primary care	Mental health	Children & young people	Acute hospital & specialist services	Productivity

Aspiration

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance on secondary care. We will take a place-based approach which links health, education, housing and employment to economic and social wellbeing for our communities through joint working of statutory partners and the voluntary and charitable sectors.

Framework

This Plan describes how people residing in wider Devon will experience safe, sustainable, integrated, local support by 2021. It shows how we will deliver a major programme of transformational change and improvement across wider Devon starting from 2016/17. This change will be enabled by engaging our communities, investment in technology, changes in workforce and ensuring that where estate is required, it is fit for purpose.

Challenges

The challenges we face are significant. Whilst we may all agree on the goal of achieving clinically and financially sustainable care services, there will be many views on how we get there.

We will be encouraging the community to work with us to jointly understand the challenge and develop solutions together.

Scope

The STP is a strategic plan that covers the whole of wider Devon, including its three local authorities and two clinical commissioning group areas. This plan necessarily focusses on a limited number of key transformational priorities which will deliver improvements to care services over the next 2-4 years in response to the significant financial and clinical sustainability challenges identified in the case for change.

We have identified seven high priority areas: Prevention; integrated care model; primary care; mental health; acute hospital and specialist services, children & young people and productivity. This STP does not replace the many other service plans already in development or delivery within the health and care system, but overtime will ensure all Plans align.

Growing needs

These ambitious plans will respond to the growing physical and mental health needs of people in their communities to ensure a future integrated network of support that is safe, sustainable and affordable and that enables people to live their lives well and independently.

Context and Approach

Context

Wider Devon has a resident population of around 1,160,000 within the 3 local authority areas of Devon County Council, Plymouth City Council and Torbay Council. Just over half of the populating live in urban communities, and the remainder in rural communities.

The NEW Devon CCG area has been part of a Success Regime since 2015 and, with South Devon & Torbay, both CCGs have come together to form a single strategic planning footprint with the local authorities in order to address together a common set of significant financial and service challenges around health and care.

Approach

This Plan is a work in progress that has been prioritised to provide a framework for focus on activities that will make the biggest initial difference to our population's health outcomes and financial recovery. There is a strong set of system governance arrangements in place that are enabling the 10 statutory organisations in Devon to work collaboratively to ensure the changes we make will benefit our patients and the health and social care system as a whole, not just individual organisations. At the heart of our Plan is a new model of integrated care that will reduce reliance on bed-based care and enable people to live healthy independent lives for longer, closer to where they live.

Whilst we will have one Plan for wider Devon, our approach will also ensure that local plans setting out how we deliver the common goals can be adapted to reflect local needs and existing services. We will be involving communities and our staff in doing this.

Wider Devon STP footprint

We will undertake a process of wide stakeholder engagement on the content of the STP and involve citizens and patients in its ongoing development. For this to be meaningful, it will be done both at the level of this overarching plan, and separately for the key areas of strategic change that we are proposing.

Services in Devon must change in order to become clinically and financially sustainable, and the key reasons for this are highlighted in the case for change published in February 2016:

- People are living longer and will require more support from the health and care system. In excess of 280,000 local people (23% of the population), including 13,000 children, are living with one or more long term conditions
- We need to respond better to the high levels of need and complexity in some parts of the population
- Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across Wider Devon
- There is a difference of 15 years in life expectancy across wider Devon and differences in health outcomes – or 'health inequalities' – between some areas, particularly Plymouth
- Spending per person on health and social care differs markedly between the locality areas and is 10% less in the most deprived areas
- Mental health services are not as accessible and as available as they need to be which drives people to access other forms of care which doesn't always meet their needs. People with a mental health condition have poorer health outcomes than other groups
- There is an over reliance on bed-based care - every day over 600 people in Wider Devon are medically fit to leave hospital inpatient care but can not for a variety of reasons
- The care home sector is struggling to meet increasing demand and complexity of need
- Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. Some other care services are particularly fragile due to high levels of consultant, nursing, social work or therapy vacancies
- Local health and social care services are under severe financial pressure, and health & social care services are likely to be £557million in deficit in 2020/21 if nothing changes

Our shared vision

Aim and Statement of Purpose

We will operate as an aligned health and care system, to be a major force and trustworthy partners for the continual improvement of health and care for people living in Devon, Plymouth and Torbay. We will address the NHS Five Year Forward View three key aims to improve population health & wellbeing, experience of care and cost effectiveness per head of population.

The Challenge for Wider Devon

Deliver better and more equal outcomes for more people and do it sustainably in a more joined up way harnessing the value of partners coming together to tackle problems as a collective. We will do this as efficiently as we can, within the financial resources available to us.

Mission

We will focus everything we do on improving:

- Our population's health & wellbeing
- The experience of Care
- The cost effectiveness per head of population

These mission statements underpin the NHS' Five Year Forward View and are referred to as the 'triple aims'.

Values

We will act, behave and be held to account for:

- Putting the patient/person first
- Operating without boundaries
- Working with speed and agility
- Strong teamwork
- Embracing innovation
- Relentless focus on population benefit and user experience

Strategic Objectives

We will deliver:

- Excellence in service delivery
- Improved health and well being for populations and communities
- Integrated care for people
- Improved care for people
- Empowered users who are experts in managing their care needs

Public engagement in developing our shared vision

Our plans are designed to deliver on a series of "I" statements developed by local people:

- I will take responsibility to stay well and independent as long as possible in my community
- I can plan my own care with people who work together to understand me and my family
- The team supporting me allow me control and bring services together for outcomes important to me
- I can get help at an early stage to avoid a crisis at a later time
- I tell my story once and I always know who is coordinating my care
- I have the information and help I need to use it, to make decisions about my care and support
- I know what resources are available for my care and support, and I can determine how they are used
- I receive high quality services that meet my needs, fit around my circumstances and keep me safe
- I experience joined up and seamless care – across organisational and team boundaries
- I can expect my services to be based on the best available evidence to achieve the best outcomes for me

From where we are	To where we want to be
From patients…	…to people
From care settings…	…to places and communities
From organisations…	…to networks of care and support
From what's the matter with you…	…to what matters to you
From illness management…	…to wellness support

Our aspirations against the Five Year Forward View three key aims

Improve population health & wellbeing

- Improve overall health by increasing focus on preventing or avoiding ill-health and proactively responding when required
- Improve outcomes for people with mental health problems
- Improve outcomes for people with two or more long term conditions
- Address challenges of deprivation and funding inequality across wider Devon

Experience of care

- Reduce reliance on bed-based care and the associated harm to patients of long lengths of stay in hospital through investment in community, primary care and other supporting care services
- introduce an innovative, fully integrated model of care that enables people to stay well and independent within their communities
- Deliver consistently safe and high quality acute care by introducing clinically sustainable service configurations
- Develop a well-trained, motivated and caring workforce that is empowered to deliver joined-up care and support to the communities they serve, including support to voluntary carers.
- Develop a culture of safety and continuous service improvement

Cost effectiveness per head of population

- Reduce over-reliance on use of hospital beds to release around £90m
- Invest in community, primary and social care services to support implementation of the integrated care model and improvements in care
- Improve effectiveness of spend and productivity in all service areas to release around £300m (consisting of 2% annual provider efficiency and other additional efficiency gains)
- Ensure progress towards equitable funding for the most deprived communities
- Effective care market management and efficiency of spend

STP priorities and headline solutions

Devon's objectives for the Five Year Forward View (5YFV) focus on achieving financial and clinical sustainability and addressing key health and financial inequalities by 2021. The initial proposals below will be further developed and extended over time to make sure they achieve our key objectives

1 Prevention & early intervention

- Action to tackle the top five causes of death in under 75s
- Make sure all plans and priorities have a focus on preventing ill health
- Tackle place-based socio economic health determinants
- Build community resourcefulness
- Develop workforce skills in prevention

2 Integrated care model

- Promoting health through integration
- Empower communities to take active roles in their health and wellbeing
- Locality-based care model design and implementation
- Shift resources to community from hospital
- Health & Social care integration

3 primary care

- Developing integrated GP/primary care
- Delivering the GP forward view
- Supporting general practice development to be fit for the future
- Work towards delegated commissioning

4 Mental health & learning disabilities

- Ensure our services meet local needs
- Maximise the effectiveness of mental health spending to achieve better outcomes
- Improve mental illness prevention in primary care
- Improve provision for people with severe, long term mental illness and those who also have physical health problems

5 Acute hospital & specialist services

- Ensure clinical sustainability of services across wider Devon
- Review high priority services:
  - Stroke services review
  - Urgent and Emergency Care review
  - Maternity /Paediatrics/ Neonatal service review
- Review small & vulnerable specialties

6 Productivity

- Improve the cost-effectiveness of the care delivered per head of population
- Implement Carter's recommendations in 'Reducing Variations' report
- Rationalise the 'back-office' services
- Procurement efficiencies in clinical supplies and drugs
- Review spending on continuing health care (CHC)

7 Children & young people

- Ensure seamless support and access
- Ensure high quality, effective and rapid response of services
- Enhance effective collaboration between adult and childrens' services

Enablers

- **Workforce** Stability, Workforce Redesign, Workforce Development
- **Estates** Strategy
- Information: Digital Road Map
- **Communications** & engagement
- **Organisational Development**: Towards accountable care systems
- IM&T – improving clinical decision making

Critical decisions that deliver the plan

Financial recovery and meeting of future predicted increases in demand is predicated on implementing an integrated care model that is significantly less reliant on bed-based care. The changes we are proposing will result in a significant reduction in the number of acute and community beds needed across wider Devon by 2021 where up to 600 people are being cared for inappropriately at present. As we change the model of care these beds will no longer be required and this then releases resource to invest in improved care and achieve clinical and financial sustainability.

To facilitate implementation of the care model and release funding to invest in more ambulatory care provision in community and home based settings the CCGs are currently publicly consulting:

- NEW Devon CCG is engaging on proposals for the overall strategic direction of travel and provision changes and on the components of new models of care. Public consultation on specific proposals to close a number of community hospital beds in the eastern locality commenced on 7 October 2016.
- In South Devon & Torbay implementation of the care model as set out in the Integrated Care organisation (ICO) business case is pushing ahead with consultation on community services transformation including proposals for closure of four community hospitals. This started in September 2016.

Proposals are in development for some changes to the acute care model across Devon's STP footprint to improve care and outcomes. There are a number of specialties that need to change to address future clinical sustainability issues, including: stroke, emergency services including A&E, paediatrics, maternity, neonatology and some smaller specialties. These may also require public consultation and preparations for undertaking the review will begin in October 2016.

We anticipate that we can make further progress over the five year period with developing the new care model and this may lead to further changes to how and where care is delivered. We are committed to fully engaging (and consulting as required) staff and communities on these proposals.

During the next phase of planning we will:

- Ensure that plans reflect the needs of local communities
- Engage fully with our stakeholders on future direction of travel and proposed changes to services particularly where this impacts on the number of beds available, community hospital closures, and changes to specific acute services.
- Formulate our change proposals and agree the future configuration of commissioning and provision functions to best support delivery.
- Ensure that implementation plans rapidly take shape to ensure we are ready for delivery in 2017/18

Health and wellbeing challenges we must address

There is a **real opportunity** to make significant improvements in the physical and mental health, wellbeing and care for the population and communities. This Plan is a work in progress and provides a planning framework that will evolve as we collate the evidence base and develop proposals for future improvements to the way we deliver care. We plan to **share our learning** to benefit communities beyond wider Devon.

The Public Health and Joint strategic needs assessment (JSNA)* key considerations underpinning the plan

- An ageing and growing population
- Giving every child the best start in life and ensuring children are ready for school
- Complex patterns of deprivation linked to earlier onset of health problems in more deprived areas (10-15 life year life expectancy gap)
- Balancing access to services in both urban and rural localities
- Housing issues (low incomes / high costs/ poor quality in private rental sector)
- Shifting to a prevention and early intervention focus
- Poor mental health and wellbeing, contributed to by social isolation and loneliness
- Poor health outcomes caused by modifiable behaviours
- Ensuring services are resourced to meet the needs of people particularly those with long-term conditions, multi-morbidity, mental health and frailty
- Unpaid care and the impact of caring on carers' health and wellbeing

* The Joint strategic needs assessment (JSNA) is an annual analysis of population health needs and demography undertaken by each local authority. It informs our understanding of the health of the population, disease and condition prevalence and causes of death. This helps us to plan health and care services for the future.

Health and wellbeing opportunities are based on our understanding of targeted population segments across the wider Devon

Health and Care Segmentation Devon 20/21

Devon STP	Mostly Healthy	Chronic conditions	SEMI	Dementia	Cancer	High needs	
Children 0 -15	Mostly healthy children	Children with chronic conditions	Children with SEMI		Children with cancer	Children with PD/LD	Vulnerable children
	591	1,503	4,056	-	12,733	12,127	24,914
	179.2 / 106.0	18.1 / 27.2	1.7 / 6.8	0.0 / 0.0	0.2 / 2.0	3.1 / 37.2	3.8 / 95.6
Adults 16-69	Mostly healthy adults	Adults with chronic conditions	Adults with SEMI	Adults with dementia	Adults with cancer	Adults with Phys. disabilities	Adults with Learn. disabilities
	635	1,553	7,536	6,746	3,148	13,292	30,467
	469.4 / 298.2	248.3 / 385.6	10.3 / 77.5	0.6 / 4.0	24.8 / 77.9	4.1 / 55.0	3.7 / 111.7
Elderly 70+	Mostly healthy elderly	Elderly with chronic conditions	Elderly with SEMI	Elderly with dementia	Elderly with cancer	Elderly with Phys. disabilities	Elderly with Learn. disabilities
	1,802	3,414	12,758	13,438	4,466	19,667	32,469
	29.1 / 52.4	129.9 / 443.4	1.8 / 23.2	10.5 / 140.5	37.5 / 167.5	16.3 / 319.7	0.43 / 13.8

This segmentation is based on forecast spend and population in a do nothing scenario. Opportunities have been identified based on the care segments to address the health and wellbeing gaps and public health and JSNA priorities

Sources: ONS subnational projections CCG level, Data returns from NEW Devon CCG, SDT CCG, RD&E, PHT, T&SD, NDH, Devon CC, Plymouth council, Torbay council, QOF 13/14, Carnall Farrar analysis

The care and quality challenges we must address

The case for change summary shows that care in Devon is generally high quality but is inconsistent and with variable outcomes. The principles and design features in this Plan will drive improvement in an integrated manner, delivering benefits of standardisation to reduce variation whilst ensuring our models are tailored to the clinical needs of individuals and communities. This will drive improved achievement of national performance standards, patient and staff experience, safety, service line resilience and clinical effectiveness and outcomes.

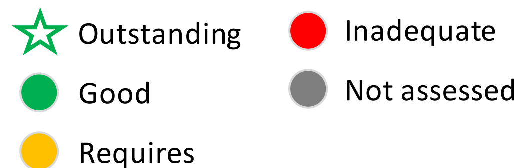
- Ensuring parity of esteem and equality of access for people with learning disability, poor mental health and looked after children
- Meeting national standards for primary, acute and specialist care with particular focus on child and adult mental health
- Achieving a minimum of good in Care Quality Commission (CQC) assessments in all services and making sure that services assessed by the CQC as inadequate or requires improvement are supported to improve rapidly and sustainably.
- Reduce harm associated with delayed discharge from bed based care
- Creating a whole system culture of continuous quality improvement and evaluation across the footprint, sharing best practice, learning and spreading the use of recognised improvement methodologies

To support a culture of high quality safe care and continuous improvement by:

- Supporting the whole system to reduce avoidable deaths, morbidity and harm
- Ensuring that people who are cared for in hospitals and residential settings are safeguarded, have personalised care plans and live in places where standards are high, and regularly monitored.
- Systematically learning from mistakes and sharing best practice
- Raising awareness and early identification of sepsis at all clinical interfaces
- Creating a positive culture of antibiotic guardianship in primary and secondary care, helping to reduce antimicrobial resistance and improve
- Safeguarding adults, young people and children through joined up safeguarding teams and processes

Key areas for care and quality improvement: comparison of CQC assessments of NHS providers

Care and quality gaps in the wider Devon heath and social care system will be addressed over the period of this plan. Current performance is variable across the system ranging from inadequate to outstanding. Our aim is to reduce variation.



CQC full inspection assessment	STP footprint	Devon Partnership NHS Trust	Northern Devon Healthcare NHS Trust	Plymouth Hospitals NHS Trust	Royal Devon & Exeter NHS FT	Torbay & South Devon NHS FT	Livewell Southwest CIC	South West Ambulance FT
Safe	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Effective	Good	Requires improvement	Good	Good	Good	Requires improvement	Good	Requires improvement
Caring	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding
Responsive	Requires improvement	Good	Requires improvement	Inadequate	Good	Requires improvement	Good	Good
Well led	Good	Good	Good	Good	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
SHMI data	Good	Not assessed	Good	Good	Good	Outstanding		
Latest CQC inspection report		18.01.2016	11.09.2014	21.07.2015	09.02.2016	07.06.2016	19.10.2016	06.10.2016
SHMI Data		03/15-04/16	03/15-04/16	03/15-04/16	03/15-04/16	03/15-04/16	-	-

NB:Virgincare Childrens Services CQC assessment not available

Key areas for care and quality improvement: comparative performance of assessments and improvement opportunities

CCG & Local Authority Assessments	NEW Devon CCG	South Devon & Torbay CCG	Devon County Council	Plymouth City Council	Torbay Council
OFSTED children's services	Not assessed	Not assessed	Requires improvement	Requires improvement	Inadequate
CCG assurance framework	Inadequate	Inadequate	Not assessed	Not assessed	Not assessed

Not assessed
Requires improvement
Inadequate

Staff and patient experience across NHS providers	RD&E	NDHT	TSDHT	PHT	DPT	England
Friends and Family Test (inpatient)	99.65%	99.95%	96.55%	99.18%	-	95%
Friends and Family Test (A&E)	95.65%	81.13%	97.1%	99.42%	-	87%
Friends and Family Test (Mental Health)	-	-	-	-	98.29%	88%
Harm free care	94%	95%	90%	96%	100%	94%
Staff survey score out of 4 Overall engagement increased in all areas	3.85	3.93	3.87	3.68	3.75	3.79 (acute) 3.75 (MH)

Source: NEW Patient Safety and Quality Scorecard in Development – Data from August 2016, England Data from August 2016
Ofsted Children's Services – Devon: Publication 03/15. Plymouth: Publication 01/2015; Torbay: Publication 01/2016
CCG Assurance Framework: 2015/2016 Data
Staff Survey: Data from 2015
Harm Free Care: August 2016 (RD&E), September 2016 (NDHT, TSDHT,DPT, England)

Drivers of the financial deficit

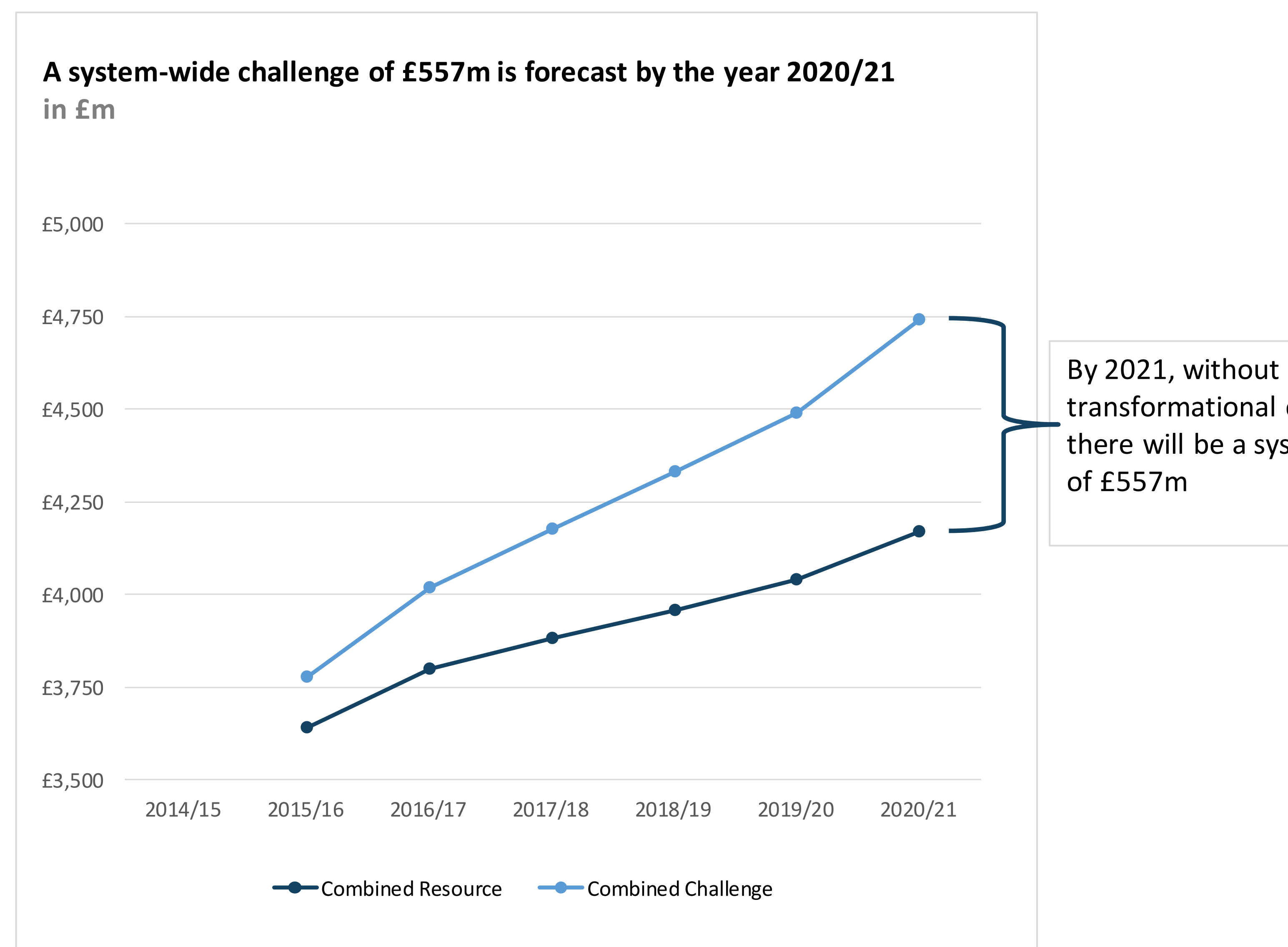
Whilst improving health, we also have to close a significant potential funding gap in health and social care funding over the next five years. If we do nothing this means the Devon STP footprint will have be £557m in debt by 2020/21 across the health and social care system. This includes the local authority adult and children's social care gap across the whole footprint

Deficit Drivers

Independent sector care including CHC	Elective care and intervention rates	Community services	Length of Stay	Productivity
Devon spends significantly more on Continuing Healthcare (CHC) than other areas of similar size/population. Unit cost of independent care sector	We treat more people than other areas with similar populations	High levels of NHS & social care community services spending compared to peers	Excess length of stay in acute hospitals and non-elective admissions where patients would benefit if we had access to ambulatory or alternative community based models of care	Trust level productivity analysis confirms opportunities across staffing, procurement and agency spend.

We will be responding to our analysis of what people need by re-allocating resources to better meet the greatest needs of the population e.g. through shifting our resources out of hospital, reducing the amount spent on unnecessary bed-based care, improving efficiency and reinvesting in more innovative, integrated care models including investing in community assets that do more to prevent ill health, keep people out of hospital, treat them effectively when needed and enable them to recover rapidly and to stay in their own homes for as long as possible.

The financial challenges we have to address



By 2021, without transformational change there will be a system deficit of £557m

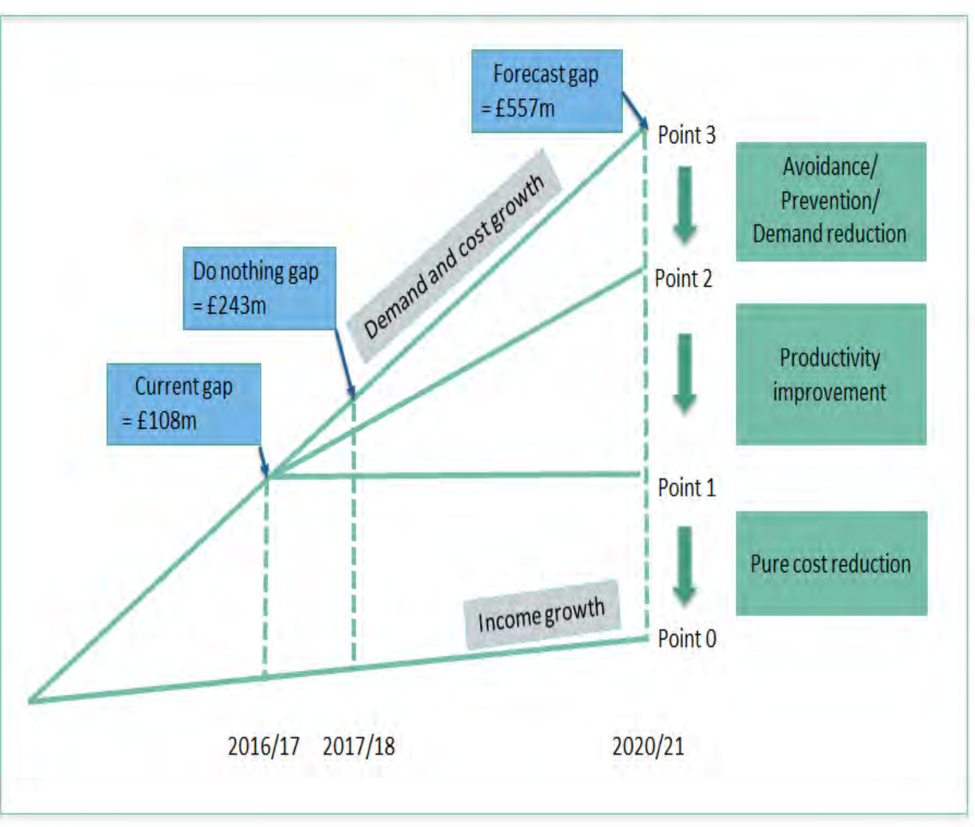
NOTE: When the RAB effect is included, the total challenge amounts to £705m.

Addressing funding inequalities

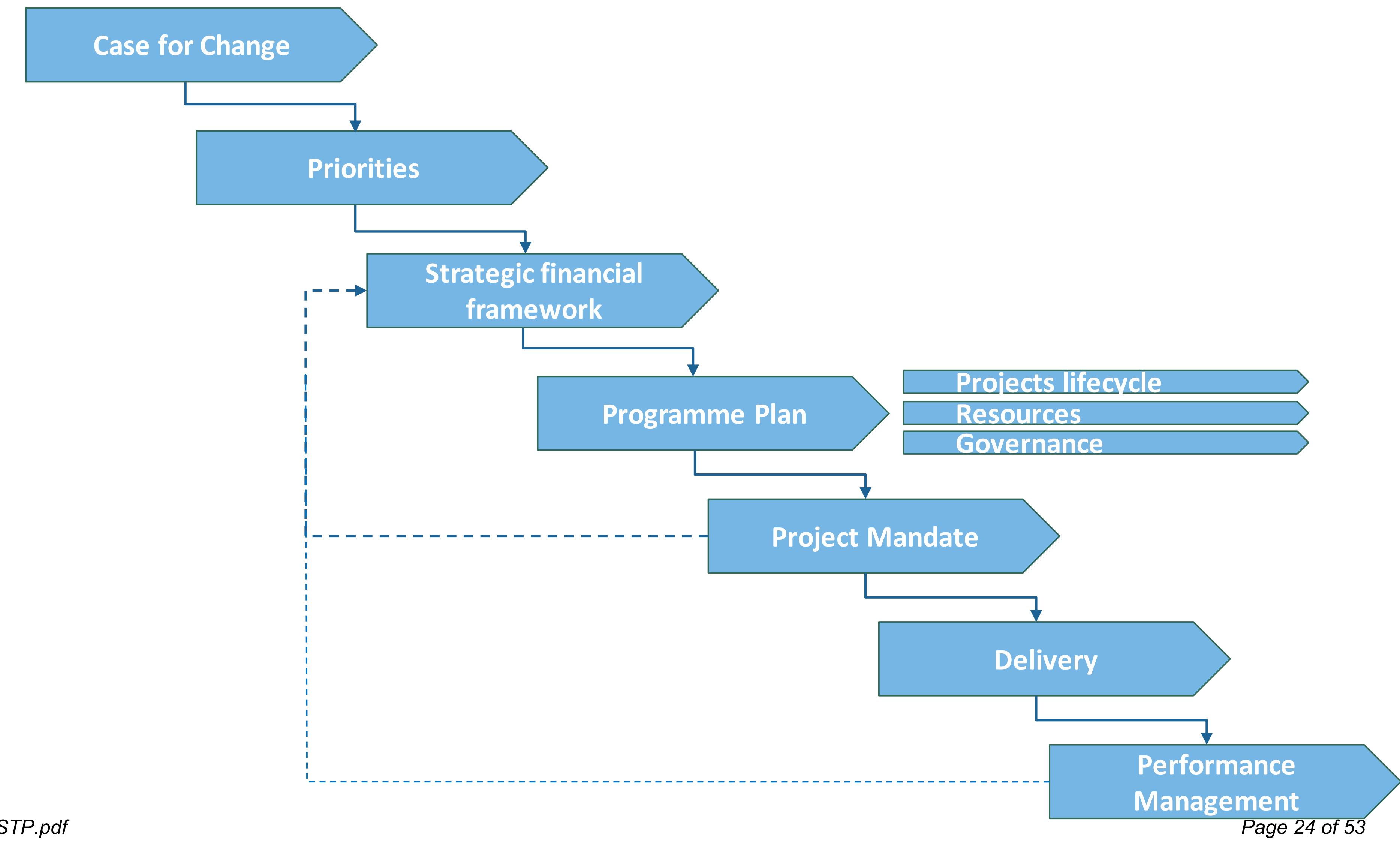
- A vital element of our return to clinical and financial sustainability is that our available resources are distributed optimally to meet population need by the end of our programme.
- Our approach to the transformation of care, which is underpinned by population need, will both determine and drive resource distribution going forward.
- Analysis of CCG spend indicates sizable inequities in resource distribution across the wider Devon system. It highlights lower levels of spend in our more deprived areas, particularly in parts of Plymouth, and on mental health care.
- A further more comprehensive analysis will be undertaken which will include sources of funding – primary care, specialised commissioning and provider deficit support - not included in the initial analysis to confirm the scale of the inequities to be addressed.
- The output will be incorporated into the financial strategy to ensure our pathway to financial sustainability includes achievement of equitable population and care group resourcing.

Closing this financial gap will rely on six things to reduce demand and cost of delivering care, improve productivity and address inequalities

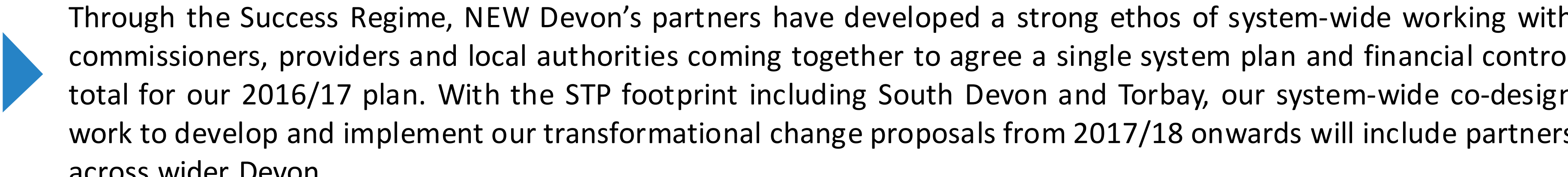
1. Delivery of the2016/17 savings opportunities and "business as usual" efficiencies in providers and commissioners is achieving savings in the region of £85m in 2016/17. These schemes form the building blocks for future years.
2. An assessment of investment in new and enhanced services and the expected impact on activity has been carried out. This will deliver the excellent care initiatives by reducing activity and shifting the setting of care closer to home.
3. Additional productivity opportunities including rationalisation of estate and back-office will contribute to provider productivity.
4. Examining the options that will ensure the clinical sustainability of acute services will help avoid forecasted cost pressures. Work on health promotion will help avoid the growth in demand for care services.
5. Delivering benefits of integrated local care, to ensure that reliance on expensive bed based care is minimised, and people retain their independence.
6. A detailed analysis of the distribution of resources, and a plan to address the current geographical and service inequities, particularly for mental health



Our STP programme management approach will ensure that there is clear line of sight from case for change through to delivery



Governance arrangements and system collaboration achievements



Through the Success Regime, NEW Devon's partners have developed a strong ethos of system-wide working with commissioners, providers and local authorities coming together to agree a single system plan and financial control total for our 2016/17 plan. With the STP footprint including South Devon and Torbay, our system-wide co-design work to develop and implement our transformational change proposals from 2017/18 onwards will include partners across wider Devon.

South Devon & Torbay have a strong track record of working collaboratively across the commissioner, providers and local authority boundaries. Torbay & South Devon Healthcare Foundation Trust is the first fully integrated care organisation in England and their local governance arrangements around this are well established.

There is already significant health and local authority integration in both commissioning and provision across Devon. Adult social care is fully integrated with health provision in Torbay; Health and social care commissioning is fully integrated in Plymouth, along with a single integrated health & social care provider. In Devon County there are numerous examples of integrated provision and ambitious plans are in development to achieve extended scope and coverage of this as part of this Plan. There is increasing collaboration across the wider local authority agenda including housing, economic development and public health. NHS organisations are supporting and contributing to local authority proposals for a new combined authority – "The heart of the south west".

These foundations provide a sound platform upon which to bring together both CCGs and three local authority areas to create strong and cohesive leadership of the STP agenda.

The new STP-wide governance infrastructure (shown in appendix 1) will allow us to work together to extend our collaborative working and decision making across the whole STP footprint, under the leadership of a lead chief executive (Angela Pedder) and an Independent chair (Dame Ruth Carnall)

Our priorities

1. Prevention & early intervention
2. Integrated care model
3. Primary care
4. Mental health
5. Acute Hospital and specialised services
6. Productivity
7. Children, young people and families

Priority 1: Prevention & early intervention

Top five causes of death in under 75s

1. Coronary heart disease (CHD)
2. Trachea, bronchus and lung cancers
3. Accidents
4. Bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD)
5. Cerebrovascular disease (stroke)

Prevention delivered through the new care model, will bring a renewed focus on prevention. To improve health and wellbeing and address health inequalities a long-term approach will be needed but we have identified some early priorities:

Smoking cessation
Alcohol misuse
Healthy eating
Moving more
Accident prevention - falls and fractures
Social connectedness and combatting loneliness
Mental health gap in access and outcomes
Addressing wider determinants of health - social, economic, environmental and cultural factors

See appendix for further information

Priority 1: Developing the prevention priorities

1

Our approach to prevention of ill health and encouraging independence and wellbeing is based on our identification of areas of significant local need and the potential to make both a health and financial impact across a large area. These priorities are better delivered together rather than in individual organisations as we will realise more cost and outcome benefits.

2

Based on key health and wellbeing challenge themes identified in our JSNAs as follows:

- Settings – place based health, care homes, workplace, housing
- Life-course – starting well, living well, ageing well
- Behaviours – smoking, eating, alcohol and physical activity and inactivity, DSVA
- Diseases and medical conditions – diabetes, hypertension, falls and fractures, sexual health
- Approach – making every contact count, complex individuals, universal proportionalism

Potential overlaps with wider work – place-based health, mental health, children and young people, planned care optimisation

3

The early priorities have been developed and further modelling and potential investment and cost savings are being scoped using the population segmentation undertaken. Early suggested priorities include:

1. Making every contact count and brief intervention training at scale
2. Test the new approach with an initial focus on the alcohol pathway from brief advice to acute alcohol liaison
3. Scale up lifestyle interventions through the new Devon Lifestyle service, Thrive Plymouth and ICO mode in T&SD
4. Focus on long-term conditions prevention and early intervention with a focus on co-morbidities in particular mental health and diabetes and hypertension
5. Develop further prevention and early intervention for pre-frail and frail to include isolation and falls prevention and the care home setting
6. Connect with the mental health and children and young people priorities to ensure a focus on emotional health & Wellbeing of children and young people

Priority 2: Promoting health through integration

In order to empower people, their carers and communities to take a more active role in their health and wellbeing we plan to:

1. Develop Integrated Personal Commissioning (IPC) to enable greater involvement in planning and choosing their care as a mainstream model of community based care for around 5% of the Devon population, including people with multiple long-term conditions, people with severe and enduring mental health problems and children and adults with complex learning disabilities and autism.

2. Expand personal health budgets and integrated personal budgets in line with the ambitions of the Five Year Forward View - including exploring the concept for maternity and end-of life. Our ambition in Devon is to use the Integrated Personal Commissioning programme to go further and faster than the national target and we aim to achieve 2,000 individual budgets by 2018. We are already well ahead of other systems in implementing IPC.

3. Achieve a step change in patient activation and self-care. The South Devon and Torbay urgent care vanguard has a framework in place which includes consideration of social segmentation, a strengths-based approach to behaviour change and the development and integration of directory of services. We also need to build on the Plymouth approach to integration, the Integrated Care in Exeter (ICE) project and One Ilfracombe.

4. Continue to work with Peninsula Urgent and Emergency Care network to develop a Peninsula-wide plan, leveraging collaborative opportunities. In parallel, we will develop detailed service models that meet local population needs. Our local delivery timeline is aligned with the emerging plan being developed for the Peninsula Urgent & Emergency Care Network.

5. Continue to develop our Better Care Funds to support our focus on prevention. They are already operating in a way that brings providers and commissioners together to determine how a single pooled fund can best be deployed to support improved flow of patients and how to keep people well and supported at home, or to return their own home as quickly as possible following a period of ill health, including support to their carers.

Priority 2: Integrated care model – promoting independence through a focus on joined up care provided locally

The best bed is my own bed

We will strengthen community health & care services so that they can both help people to avoid the need to access NHS and other provided care and respond swiftly when people become unwell. This means investing in more community-based services and associated technology so that they mirror the availability and reliability of hospital-based care. This includes enhancing our support to carers and delivering high quality end of life care, as well as building wider community support that can keeps people well.

Services closer to home

We also want to make sure that people do not travel further than they need to for care / treatment. Keeping people well and independent avoids the need to travel for care. The more community and primary care services we can provide in or close to people's homes the better.

High quality hospital care

Where people need to be admitted to hospital, we will make sure that they receive the best quality and experience of care, that we have caring and skilled staff to look after them and that we meet national quality/safety standards. New discharge to assess services will ensure people return to their normal place of residence quickly and safely and that care is coordinated around the person and their family.

What matters to me

Moving discussion from 'what's the matter with a person?' to 'what matters most to a person?' means that we will adopt a person-centred and asset-based approach to care, promoting networks of support, skills and attributes of individuals that increase people's self -confidence to manage their health and care for themselves. This approach will avoid unnecessary reliance on statutory services that can take away a person's independence and create more resilient communities. Patients will own their own digital, shared care plan.

Community-centred approach

Adopting a person-centred and community-centred approach to health and wellbeing helps to build community capacity and resilience which in turn helps provide support to reduce social isolation and loneliness and can contribute to reducing health inequalities for individuals and communities. Our voluntary and community partners are at the heart of our new care model. It is through the interaction of statutory services with local voluntary and community groups that we can improve people's health and wellbeing, reduce demand on health and care services and lead to wider social outcome improvements.

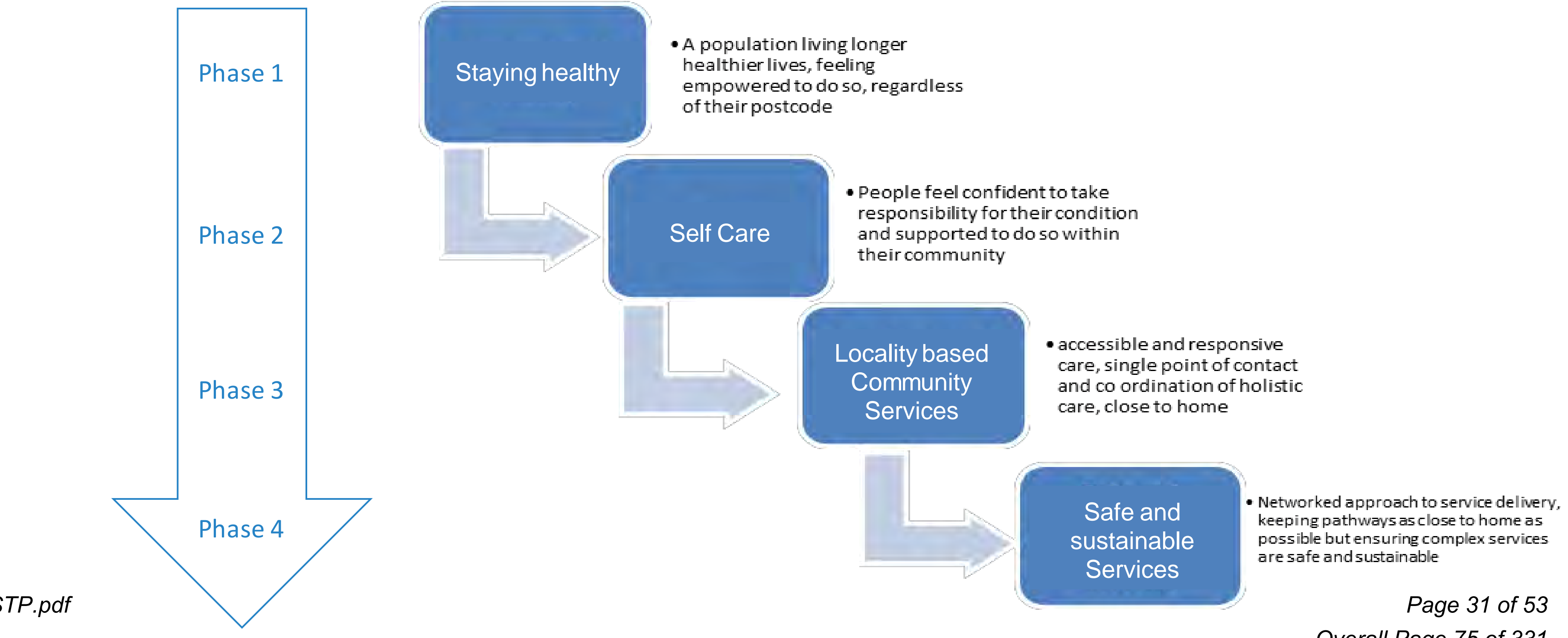
Making every contact count

Wellbeing is at the centre of our care model because it reflects the importance and necessity of focussing on prevention and early intervention. 'Making every contact count' encourages conversations based on behaviour change methodologies, ranging from brief advice and intervention, to more advanced behaviour change techniques. The aim is to empower healthier lifestyle choices and exploring the wider social determinants that influence all of our health. Patient activation measures can help us to understand where people are in terms of their level of knowledge and confidence to manage their own health. Activation measures have been linked to improved clinical outcomes and reduced costs of care.

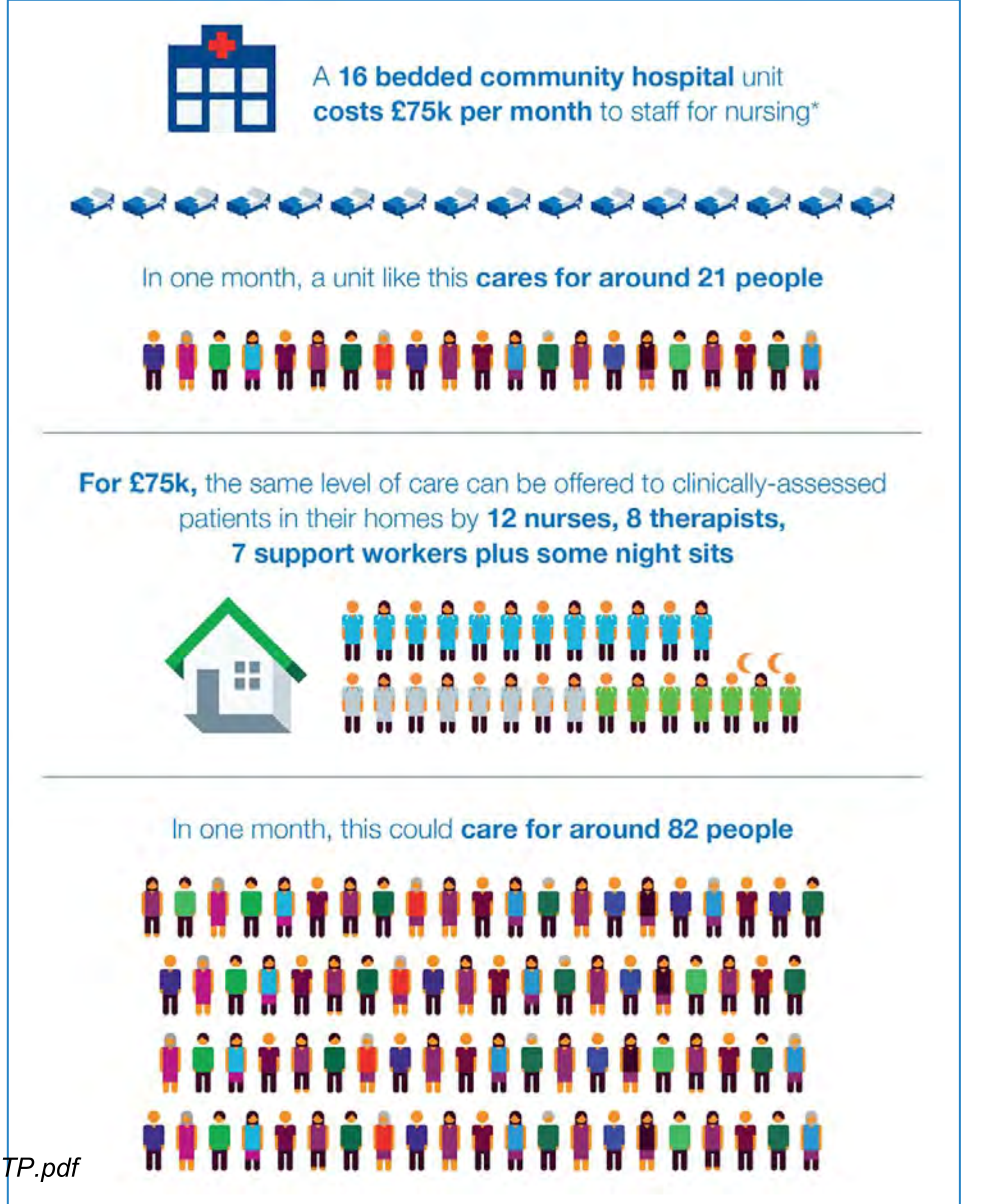
Priority 2: New models of care

The development and implementation of new models of care is fundamental in delivering the vision based on the drivers for change we have outlined earlier (on page 5). This transformation work is high profile and will realise a broad range of STP deliverables; increased focus on prevention, financial sustainability and quality of care.

Whilst the vision is consistent across the STP footprint, models of care will be tailored to meet the needs of localities. Models will maximise the use of non bed-based care and support people and carers as individuals, outcomes tailored to specific need. Development is at differing stages currently: In South Devon a full service model developed underpinned by a full engagement process and planned consultation. In the North there has been a focus on care closer to home and enhancing home-facing care services, the locality is engaging with a range of stakeholders to define the type and level of service required, location, and analysis on both financial and patient benefits. The diagram below supports us to analyse current configurations of service and work with stakeholders around which services and patient outcome should be achieved across the various phases:



Priority 2: The model allows investment to improve care capacity and delivery through reduced reliance on bed based care



Our modelling shows that the out of hospital model offers more care to people for the same cost.

Our proposals currently out to public consultation will help us enhance and increase care capacity closer to where people live.

*This is based on a daily £174/bed nursing cost in Eastern Devon (Referenced in PCBC finance appendix). This gives an annual nursing cost of £914K for a 16 bed site. Roun[illegible]nth.

Priority 2: New model of care – a local approach

Our new model of care will have a local (place / community based) approach. In developing this we have considered the work of the King's Fund "Place-based systems of care" (Ham; Alderwick 2015) recognising that systems of care exist on different place-based footprints. The wider Devon STP area has a geographical and economic coherence based on the old shire county of Devon. Within this we have recognised material variation in care & quality, health & wellbeing outcomes; productivity, and finance and delivery performance. It is at this STP population level that we want to develop strategic plans including a financial strategy to achieve financial balance. However, these variations and inequalities can only change through action and delivery at the level at which they occur.

Public and user engagement in our vision is helping shape common design principles that will enable us to prioritise and tackle specific inequalities. Currently there are 4 localities – North, East, West and South (see below). As we develop our work and define the level of place we require to best deliver our strategy our current approach may change.

Northern Devon	Eastern Devon	Western Devon (including Plymouth)	South Devon & Torbay (1ST Integrated care organisation in England)
Northern Devon Healthcare Trust Vertical integration One Ilfracombe, One North Devon Devon Cares – domiciliary care service	Royal Devon & Exeter Foundation Trust Vertical integration ICE project	Whole system commissioning fund. Integrated health & social care provider	Health and social care integrated provision. Implementing new care model through the integrated care organisation

First phase of implementation of the integrated care model is underway across the STP footprint. We are pursuing changes to service delivery in all areas that focus on promoting independence, keeping people safe and well at home / in their own communities and reducing reliance on bed-based care. We have plans to reduce both acute and community hospital bed numbers which will enable additional investment in community & primary care and other local services to help deliver more care, more effectively to more people, closer to where they live and help them to maintain the highest level of independence.

Priority 2: Integrated care - wider planning

Integrated local planning will also take account of natural cross boundary flows. Most significant is the East Cornwall population served by Plymouth Hospitals NHS Trust. We are working with Kernow CCG to ensure our plans are appropriately aligned.

There is already an established track record of achievement which we will help to accelerate change

- The first Integrated Care Organisation (ICO) in England (acute hospital, community health and adult social care) is in South Devon & Torbay
- Fully integrated health & social care commissioning in Plymouth
- Integrated community health and social care community provider in Plymouth
- A high degree of vertical integration between acute and community health and social care services already delivering benefits in Northern Devon, including an emerging place-based approach in One Ilfracombe and other towns.
- Foundations established for similar care integration between acute and community health and social care in Eastern Devon
- Northern Devon Healthcare Trust is the first NHS Trust to provide domiciliary care. Operating across Northern and Mid Devon under the name of ‘Devon Cares’ and aims to bridge gap between health and social care provision into people’s homes.
- Significant progress on integrated health & social care provision across Devon County
- A strong track record of population engagement on community services

Priority 3: Sustainable integrated primary care – the vision

Primary care will be an integral part of our new care model. We will prioritise broader integration of primary care into the wider care system in order to address some of their immediate challenges, around workforce sustainability, capacity and scale, 7 day working, IM&T and estate.

GPs will continue to be very much at the centre of patients' care, coordinating and other clinicians and healthcare providers, as well as providing care directly to patients. Partnership with patients, as well as fellow clinicians, to optimise health and wellbeing will be extended, as will pro-active identification and subsequent management of illness, and in particular long-term conditions.

We want to ensure we have high quality and sustainable primary care services which are integrated with social, voluntary, mental health, community and acute care across Devon. Primary care provision will be developed form a significant component of the integrated care model.

We recognise the need for practices to collaborate more formally than has been typical in the past, and we will provide support to make this happen, including investing in IM&T systems, workforce sustainability and premises where return on investment can satisfactorily be demonstrated. We will continue to commission integrated pathways of care that shift the focus of care from a bed-based model to one that is primary and community care focussed, and realign funding to enable this to happen.

We are developing a high level integrated primary care strategy for the STP that is capable of addressing the key challenges faced by primary care and incorporating the expectations of the GP Forward View. This will need to be translated at a local community level to agree changes that will respond to the varying needs of local communities and their different starting points. Whilst there is a significant focus on general practice we will also develop plans to better integrate other primary care providers especially pharmacy and optometry.

Engagement is key and we are working closely with both our CCG commissioning GPs and primary care provider representatives to co-design a sustainable future for the primary care sector that can make a vibrant, high quality and material contribution to our vision for fully integrated care.

Priority 3: Primary care – developing and delivering the strategy

The South Devon & Torbay Primary Care Strategy has been informed and supported by a Primary Care Stakeholder Survey. This sets out plans to proactively meet the challenges of future development including:

- Access and 7-day a week delivery
- Stakeholders and professional reputation
- Collaboration
- IM&T infrastructure
- Workforce sustainability
- Voluntary and third sector
- Education and leadership development
- Self -care
- Premises
- Patient and public participation
- Unplanned care
- Prescribing and medicines optimisation
- Funding flows
- Quality

The Northern, Eastern and Western Devon Primary Care strategy is in development. The priorities are first to support practices to work at scale, to work together and plan change together, working as part of a transformed multi-disciplinary fully integrated workforce. The CCG is working to overcome contractual and infrastructure barriers to better enable this.
In NEW Devon we need to build on the plethora of good practice but small in scale changes already in place to create a consistent and coherent set of change plans across the area.

We are working across the STP footprint to ensure that we make best use of the additional funding available to support the GP Forward View. We are aligning supported initiatives to specific local primary care challenges and our evolving integrated care model. We will support a programme of (consistent) shorter term and small scale service change and improvement at practice level to build capability and engagement and to help provide some immediate solutions to the most pressing issues.
We will work towards delegated commissioning to ensure change plans can fully align with the STP.

Priority 4: Transforming mental health & Learning disabilities

The national *Five Year Forward View for Mental Health* has set out the case for transforming mental health care across England by putting mental and physical health on an equal footing. There are benefits to this approach for people using mental health services and for the health and care system.

National priorities for all STPs are:

- High quality 7-day services for people in crisis
- Integrated approach to the delivery of physical and mental health care
- Promoting good mental health and preventing poor mental health
- Ensuring arrangements are in place for good mental health care across the NHS - wherever people need it

Our *Case for Change* highlights the fact that mental illness is relatively common in Devon and that people with serious mental illness experience poorer health outcomes than the general population. It is also identifies the need to prioritise high quality and accessible services for people with a mental illness - especially those who also have poor physical health - as well as prioritising the mental health needs of people with a physical health need. In addition more needs to be done to prevent mental illness and promote mental wellbeing. However, much less money is spent on mental health (when out-of-area placements are excluded) in Devon than in other similar areas of the country, and services are not as comprehensive as they need to be to ensure the best outcomes for people.

We believe that mental health should have equal priority with physical health and that everyone who needs mental health care should get the right support, at the right time. We have included mental health throughout our STP - in terms of prevention, integrated care and specialist services – so that mental health is an integral part of our system. We will design and deliver clear pathways of care that meet people’s mental and physical health needs. We have developed a set of local priorities to transform mental health care in Devon and these, along with the national requirements, will be addressed through our transformation programme.

Priority 4: Transforming mental health – seven priorities

1. Ensuring safe and sustainable services and addressing gaps in service provision

Clear, evidence-based pathways of care will be established for all main mental health conditions – from prevention and primary care through to secondary care, specialist care and supported recovery.

The interface between primary and secondary care will be transformed so that people can have the most appropriate care in the right setting.

Mental health will be an integral and equal part of the new model of care in order to ensure improvements in the wellbeing, support and experience of people with dementia and their carers in wider Devon.

We will strengthen plans for suicide prevention and publish our plans in accordance with national requirements.

2. Making acute and crisis care more resilient; 24 hours a day, seven days a week

We will create a more effective and robust care pathway for people experiencing a mental health crisis. We will ensure sufficient Crisis Resolution and Home Treatment Team capacity and effective step-up and step-down options to ensure that we can provide alternatives to hospital admission and ensure discharge from hospital is timely.

We will develop greater community resilience to support people with mental health needs, for example through increasing the availability of peer support programmes.

We will set out a plan of service development and improvement to achieve these aims. This will be agreed and regularly reviewed against a set of performance indicators.

3. A life course approach to care

We will develop a mental health outcomes strategy that prioritises prevention, early intervention and recovery across wider Devon that will create a framework for achieving:

- A seamless and integrated experience for everyone, regardless of their age
- Access to mental health services that are timely, proactive and effective
- Empowerment and self-help as essential principles of a remodelled mental health system
- Commissioning additional Individual Placement Support roles for those with severe and enduring mental illness
- Delivering integrated physical and mental health services

Priority 4: Transforming mental health – seven priorities

4. Achieving equity of access and national standards

We will achieve equitable access to mental health services that meets national standards for people across wider Devon, including:

- Treatment for Children and Young People
- Access to perinatal mental health support
- Early Intervention in Psychosis
- Increased access to Psychological Therapies
- Diagnosis of dementia and effective support through regular care plan reviews
- Annual physical health checks
- Access to Individual and Placement Support to find employment
- Core 24hr psychiatric liaison services where needed
- Meeting urgent care response standards
- Further reduction in out-of-area placements and care

5. Treating people with complex care needs in Devon

Enhanced expertise, services, and facilities in Devon that meet people's needs locally and reduce placements out-of-area:

- Reducing the number of people receiving specialist mental health care out-of-area; improving provision for intensive rehabilitation and specialist dementia care; improving s117 aftercare commissioning and enhancing community pathways to maximise recovery or provide onward support following hospital admission
- Extending clinically-led individual placement commissioning and considering models of provision needed to return people to Devon
- Piloting a commissioning model for specialised Secure Care and identifying opportunities to shift resources from hospital care to community pathways, aligned with Transforming Care Partnerships
- Commissioning specialist community eating disorder services and ensuring that commissioners and providers join the national quality improvement and accreditation network for community eating disorder services (QNCC ED)

6. Recruiting and retaining staff

Enabling health and care staff in the wider workforce to meet people's mental health needs with the appropriate support of mental health professionals .

Creating a balanced and flexible workforce, of the right size and with the right skills, that is well led and appropriately rewarded.

Embedding a health and social care system in which mental health and learning disability are everyone's business.

7. Increasing access to mental health support and services for children and young people

Working with our schools and Local Authorities to develop systems that support emotional wellbeing, resilience and positive mental health whilst transforming the delivery of mental health services for children and young people through our CAMHS transformation plans.

We want people in Devon with a learning disability to live well and we are developing an

Drivers behind our work in the field of learning disability include:

1. Tackling health inequalities: The Confidential Inquiry into the Premature Deaths of People who have Learning Disabilities (CIPOLD) in 2013 showed that on average “women with a learning disability were dying 20 years before women in the general population and men, on average, 13 years earlier.”

   - In order to address this we have developed nursing liaison roles across primary, acute and neurological services, however we need to ensure that as a community of health and social care providers we have a legal and moral duty to consider the needs of this population **in all our plans and pathways** and make the reasonable adjustments required to help people access the services they need.

2. There is a need across all commissioned services to maximise the independence of people who have a learning disability. Furthermore we need to support opportunities for people to develop real friendships that will reduce the number of people experiencing loneliness.

   - This can be achieved through more robust outcomes based commissioning that utilises reviews to help set new goals to help people to progress.

3. Transforming care for people who have a learning disability and/or autism who have behaviours that challenge. This aims to bring people placed in hospital back into the community, prevent admissions to hospital, and to make sure that people have every opportunity to live a good life

   - In order to address this we have developed a new Transforming Care plan that spans the whole STP area and **also includes children and young people**. In order to make sustainable change happen action needs to be undertaken in a number of areas.

Priority 4: Devon-wide transforming care partnership plan

Our vision is to create a place where children and adults with a learning disability live in the community of their choice, with the people they want, and with the right support, and are happy, healthy and safe

This plan is for people of all ages living in Devon, Torbay and Plymouth who have a learning disability and / or autism, who display behaviour that challenges, including behaviour from a mental health condition

We are succeeding when:

- All people placed out of the area are returned to their own community
- No-one remains in hospital for longer than they need to be
- People and their carers have a better quality of life and are helped to be as independent as possible
- All people on our risk register have been offered a personal budget and have an individually designed service
- There is a lifelong pathway for people
- We have a range of providers offering choice to people who have their own budgets

The current model

- Too many people in inpatient care, out of area
- People fit into services rather than services being built around them
- Over-referral to long term residential care

The new model

- Choice of local housing, care and support
- Individually designed services funded through personal budgets
- Short term inpatient care

Things to do now

- Engage service users on our vision
- Check our data and finance information
- Implement our project plan and engage key stakeholders in our working groups
- Develop our wider communication plan
- Get all the people and organisations involved working together

Things to do in the longer term

A single pathway.
Increase the choice of local housing, care and support.
Develop co-designed care and support plans with robust outcomes.
Personal budgets and direct payments.
Support for people, parents and carers.
Effective short breaks and crisis arrangements for people with complex needs.

Benefits of our new model of care

People are cared for and supported in the best place for them.
Care and support is arranged around people not where they live.
People get just the right help to be as independent as possible, without being too dependent on services.
People are able to lead active lives in the community.

Priority 4: Transforming mental health resources

We understand that transforming mental health care in Devon and addressing our priorities will require additional resources. National guidance requires an increase in baseline spending on mental health by at least the overall growth in allocations in order to deliver the Mental Health Investment Standard.

In order to make a start toward increasing resources and improving access to services, mental health services in Devon have been proactive in securing additional revenue and capital funding through national funding opportunities such as: increasing access to psychological therapies, and improving health based places of safety for people experiencing mental health crisis.

In order to secure and then sustain the priorities for improvements in mental health care in Devon we will through our STP:

- Review our spending on mental health services as a proportion of the total system
- Review how we currently use our resources to ensure they are directed toward evidence based and effective interventions, providing supporting at an early stage and ensuring safe and sustainable services.
- Realise the benefits of increasing mental health interventions that reduce activity in other parts of the system, such as reduced attendances, admissions or length of stay in hospitals, and reinvest these savings to continue to fund these enhanced mental health services in future.

Priority 5: Acute hospital and specialist services

- The NEW Devon case for change identified concerns about quality and/or sustainability of some acute hospital and specialist services. It prioritised stroke, maternity, paediatrics and neonatology and emergency and urgent care for urgent review. A similar analysis undertaken in Torbay and South Devon confirmed similar priorities for review.
- Medical leaders in Wider Devon also identified a number of clinically and financially vulnerable services where clinical sustainability was causing some concern. The causes of this vulnerability can include national staff shortages or low patient numbers, which make it difficult for clinical staff to keep their skills up to date and where action may be necessary to maintain reliable services.
- An overarching programme for the review of acute and specialist services has been established. The programme will be led by the STP Clinical Cabinet chair and a nominated Lead Chief Executive. The objectives of the review will be to optimise the quality and timeliness of acute hospital and specialist care by making services more resilient with better outcomes and improved affordability. This will allow us to meet the increased demand for hospital-based services and support services – does this need clarifying so it doesn't contradict earlier statements about not needing so much hospital inpatient capacity?
- The unique geography of Devon will not limit access to time critical services and that proposed changes are affordable within the allocated system funding

The services prioritised for review in the first phase of this programme are:

- Stroke services (including hyper-acute and stroke rehabilitation).
- Maternity (including consultant-led and midwife-led care), paediatrics and neontaology, to be reviewed together given their inter-dependency.
- Urgent and emergency services, focusing particularly on the acute hospital provision of accident and emergency and co-dependent services.

The 'vulnerable' services for review include:

- Breast services (surgery and radiology)
- Ear, Nose and Throat
- Interventional radiology
- Histopathology
- Neurology
- Interventional cardiology
- Vascular surgery

Scope and content of subsequent phases is currently being developed

Priority 5: Acute hospital & specialist services – specialised commissioning

Specialised Commissioning - services currently commissioned by NHS England

- Leaders within the wider Devon STP recognise that unifying a commissioning approach to services with Specialised Commissioning is critical to a sustainable Plan over the next five years. Both CCGs are exploring how specialised services can be commissioned differently to integrate pathways, develop local service alternatives and to crystallise opportunities for consolidation as part of reconfiguration plans
- Specialised Services within the South West Peninsula are delivered in a number of Trusts. The transformation programme for specialised services will be integrated with the Devon STP acute and specialist services review work programme
- Plymouth Hospitals NHS Trust will be the lead centre for trauma, cardiac surgery, neurosurgery and level 3 neonatology in the STP footprint
- For specialised mental health the aim is to:
  - eliminate unnecessary admissions out of the South West of England
  - establish a South West tertiary mental health care models pilot with budget circa £70m (this will be undertaken as part of the mental health work programme)

Reinvestment and collaboration

- The STP partners will seek permission to develop plans that would reinvest specialised commissioning efficiencies where our plans control demand and produce service alternatives that reduce demand for specialised interventions
- We will also work in conjunction with national and regional service networking arrangements to develop, share and implement best practice and align our plans as appropriate across neighbouring STP areas – for example, Cancer Alliance, strategic clinical networks; urgent & emergency care network.

Priority 6: Productivity – cost effectiveness of care per head of population

Objective

Each provider has had their pay and non-pay costs and spend benchmarked against similar sized and types of NHS organisations. This has enabled us to identify with a view to implementing productivity opportunities across providers in Devon.

Expected impact

- Significant reductions in pay and non-pay costs by 2020/21 across four providers in Devon (RD&E, Plymouth, NDHT, T&SD)
- Achieve operational productivity as good as top quartile performers in provider peer groups

Key workstreams

- Improving **Pay** productivity within
  - Medical staff
  - Nursing staff
  - Scientific, Therapeutic & Technical (ST&T) staff
  - Other non-clinical staff
- Improving **Non – pay** productivity within
  - Clinical supplies and drugs
  - Estates
  - Agency

Milestones

- High level productivity opportunity agreed by Finance Working Group (FWG)
- Providers to reconcile with Carter benchmarking analysis and to develop plans to target opportunities

Team

- Finance Working Group
  - consists of Directors of Finance from all providers in STP
  - chaired by Andy Robinson, STP Director of Finance

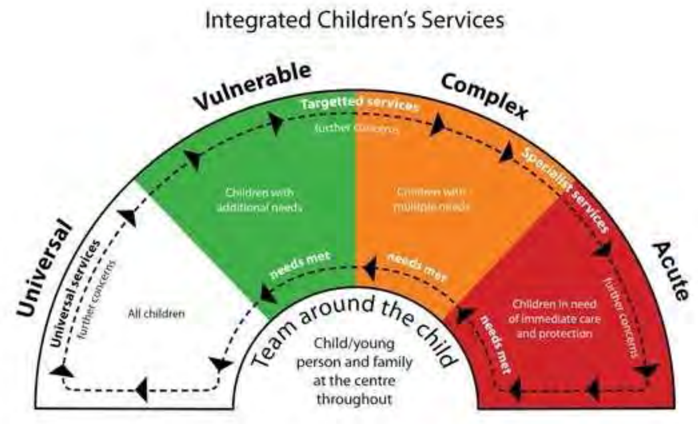
Priority 7: Children, young people and families

It is our aim to ensure we are 'doing the right thing at the right time' to support children, young people and families (CYP) across wider Devon. Support is area-based, seamless and has an integrated pathway approach that builds resilience and early support to CYP and their families. To do this we need to:

- Help families and practitioners understand and access Early Help in their community.
- Ensure that children and young people are able to access whole person support in the right place throughout their journey. This means ensuring that staff have the best skills to help them to thrive and to provide support through key transition points.
- Ensure that children and young people stay healthy, with intervention starting earlier, both in terms of access to the right people who have the skills and of expertise to their support needs.
- Commissioners and providers will co-produce a model of care across universal and specialist services that spans health, social care and education; and ensures that adult and children's services work together to prepare young people for adulthood.
- Ensure that mechanisms are in place to enable effective communication, sharing data and enabling timely access to the right pathway.
- Strengthen access to senior paediatric expertise, linked to GP practices, for urgent and non-urgent needs.
- Provide a rapid access clinic for non-emergency cases, led by paediatricians.
- Triage quickly and effectively to ensure that children and young people can access the right care appropriate to their needs and in doing so avoid unnecessary attendances and admissions whilst ensuring that their parents/carers also receive appropriate support.

We know that some CYP may need more targeted and specialist support. Therefore we need to:

- Ensure that our consistent arrangements also comply with statutory responsibilities for children with Special educational needs (SEND) their parents/carers and also young carers.
- Provide a local offer available for children under the SEND reforms, that enables them to achieve the outcomes and goals identified through their ECHP. We must support children and young people, including those with complex needs and the most vulnerable, with multi-agency co-ordinated care, as close to home as possible.
- Support children and young people with emotional well-being and mental health services in supportive communities that can build resilience and that provide access to early help that delivers prevention and early intervention. Transformation of CAMHS will ensure timely crisis responses; specific pathways for eating disorders and self-harm; specific support to cared for children.
- Evidence effective transition planning for children and young people and their families, offering more personalised care through the use of Personal Budgets.
- Facilitate access to health assessments for children in care and services which are responsive to their needs; ensuring that we are safeguarding these vulnerable CYP.



Key enabling plans

1. Workforce
2. Communications & engagement
3. Estates
4. IM&T

Enablers: Developing the workforce strategy

Opportunities

The creation of employment opportunities are key drivers of health, wellbeing, economic growth, resilient communities and the delivery of quality care. Our new models of care will create the opportunity to think and work differently, creating a flexible workforce across health and social care which is capable of responding to the changing needs of people and to address many of the problems our staff and service users currently describe.

Our workforce strategy also creates the opportunity to work with schools and colleges as well as our traditional links with universities to create new roles such as care apprentices creating more career opportunities and choice for young people locally . The STP area is one of 11 national pilot sites for the new assistant nurse roles: 76 places will be available from January 2017. This innovative scheme is the only one in the country which had included the care home sector in the pilot.

Implementation of the proposed changes in this Plan will have a major impact on the existing workforce. Our workforce will be supported to develop new skills and capability. Initial analysis indicates:

- Re-provision of up to £60m per year to deliver the new care delivery arrangement interventions could provide for between 1,000 and 1,500 redesigned roles, representing retraining of 4 - 6% of the current workforce or recruiting new staff.
- High-level estimates indicate a requirement for 900 staff to undertake different roles (these were based on traditional roles and ways of working, and require development) and many of these roles would be filled by staff relocating their work and expertise from existing services.
- Significant training and support will be needed to as staff move to new roles, working in new ways in the new models of care. An extensive OD programme is being established to underpin these changes.
- There will be challenges in recruitment in several areas such as domiciliary workers, social workers, health care assistants, primary care and senior medical staff in small specialties.
- Primary care workforce development is a key area for attention given the Devon GP age profile and the key role primary care will play in our future integrated model of care.

Workforce leads in all the partner organisations in the STP are working together to address these issues and have developed this high level shared system-wide work plan.

Enablers: Developing the workforce strategy – early actions

- Produce an agreed strategic workforce Sustainability Transformation Plan (STP) which addresses the priorities identified that spans 10 years ahead but focus on the medium to five year plan.
- Build and develop key relationships with the agreed workforce representatives from across the whole system in an ongoing way to achieve effective engagement, understanding and collaboration in delivering the workforce objectives
- Systems leaders will ensure sign-up to an implementation plan, with clearly identified achievable steps informed and agreed by the models of care and clinical cabinet, tested and assured through agreed modelling.
- Ensure workforce plans encompass the whole system for the long-term with the vision of the future integration landscape described and workforce mapped
- Agree and deliver system workforce benefits, for example, by exploring a joint values-based recruitment and retention strategy (one Devon, one workforce) that is inclusive across all statutory organisations with a focus on maximising use of the local labour force
- Explore opportunities for flexible education packages and career pathways which enable hybrid roles which can rotate within all partner organisations, working as required to support new care models (for example an Integrated Apprenticeship programme)
- Develop system wide approaches to shared flexible staff learning interventions prioritising initiatives that deliver greatest benefit to staff and patients.
- Set up and roll out pilot for assistant nurse role
- Develop the Community Education Provider Networks (CEPNs) to plan inter-professional learning (with support from Academic Health Science Network)
- Develop systems that ensure Education and continuing professional development is accessible to the whole workforce
- Consider development of shared broad based integrated training delivery opportunities (e.g. key common statutory training) across partner organisations that improve scale and efficiency of provision.
- Share best practice in care delivery practice that will support the existing workforce to implement the new care model
- Maximise the impact of the new employment deal by working collaboratively across the STP on its implementation

Enablers: Stakeholder communication and engagement (SC&E) embedded within, and integral to the STP Programme

In a change programme of this size, scope and length it is critical that staff, patients, public and stakeholders understand the context, purpose and benefits of any change as well as feeling able to influence and be involved in the decision-making process.

Current focus

Strategic

- Development of a system-wide stakeholder communications and engagement plan to support delivery of the STP
- Provision of expert SC&E advice to STP Programme Board informing strategic approach
- Representation from three Healthwatches to advise on public engagement at Programme Board
- Development of strategic narrative and key messages aligned to, and reinforcing the Devon vision
- Patient and public involvement assurance mechanism in place via NEW Devon Patient and Public Engagement Committee and SD&T Engagement Committee
- Developing approaches to co-production / planning with citizens and communities

Tactical

- Embedding SC&E within each STP Working Group (eg: the Clinical Cabinet)
- Establishing the governance structure to monitor delivery of SC&E Plan (including resourcing)
- Development of core SC&E processes, channels and protocols – ensuring consistency, evaluation and use of feedback received
- Stakeholder mapping and analysis

Operational

- Patient and public engagement working with clinicians on STP groups
- Weekly internal communication channels established
- Media protocol in place
- Daily calls between commissioner and provider comms leads

Key achievements to date

- ✓ NEW Devon case for change launched in February to more than 10,000 staff and public
- ✓ Widespread and extensive SD&T engagement in developing new model of care for community services
- ✓ A growing awareness of the need for change by the public and staff
- ✓ Key stakeholder events held in Plymouth, Torbay, Barnstaple and Exeter
- ✓ Flow of feedback from events influencing the development of STP vision and approach. SD&T survey informing IM&T and wider primary care strategy implementation
- ✓ Health and wellbeing scrutiny, Health and Wellbeing Boards and Member of Parliament briefings commenced
- ✓ Public and patient representatives influencing design of new models of care
- ✓ Clinicians and SC&E team co-designing/delivering communication and engagement activity
- ✓ Increased alignment of SC&E across New Devon and South Devon CCG footprints
- ✓ South Devon and Torbay CCG completed a nine month engagement programme which informed the "Into the Future" consultation proposals, published on 31 August
- ✓ NEW Devon CCG launched a formal consultation (7 October 2016) on proposals to achieve consistent, integrated community services.
- ✓ Stakeholder engagement forum event held on 20 October

Enablers: Developing the Estates Transformation Strategy

Strategic Aim	Provide a **transformed and innovative estate portfolio** which delivers **excellent, quality, well maintained and economical buildings and facilities** which are **efficient and responsive** to the changing needs of the new model of care population and local communities of Devon.		

Strategic Objectives	Economical and Efficient Estate	Transformed and Innovative estate portfolio	Well maintained and Responsive	Excellent and Quality Environment
	Support the on-going viability of the NHS by minimising the cost of property and waste and by maximising commercial opportunities for income generation and the use of one public estate.	In collaboration with local communities and partners, deliver changes to the estates portfolio to facilitate the delivery of the integrated service model.	Deliver a safe, statutory compliant and responsive estate by utilising new technologies, innovation and best practice to transform the way Facilities Management (FM) services are delivered.	Invest available resources wisely, delivering an environment of the highest possible quality to maintain the quality of services.

	Drivers for Change	Estates Plans/Solutions
1.	Delivery of the new model of integrated care and reduced need for bed based care. Developing mental health care services, fully integrated with primary and acute care services.	Build on the Local Estates Strategies (LES) by developing a system wide estates strategy. Disposal of poor quality buildings and re-investment in new and re-configured buildings to provide community multi-disciplinary centres and local health and well-being centres. Smaller acute Hospitals
2.	Future population increase and provision of services at the heart of the community.	Locally based affordable rural services with integrated General Practice and community care, provided through multispecialty centres. Partner working and co-ordination between NHS and Local Authorities, to forward plan effectively, and release land to create new opportunities for housing. New Care facilities and building in town centres linked with re-generation.
3.	Pockets of deprivation, levels of high-risk behaviours and multiple conditions.	Re-use of existing estate for preventative and public health services.
4.	Vanguard deliverables.	Development of urgent care centres (and, potentially, new locations).
5.	Ageing population – increased pressure on the whole care system.	Increased private sector care home provision and use of telemedicine to reduce face-to-face appointments. Co-located facilities and partnership working with voluntary services.
6.	Meeting the challenges of the General Practice Forward View (GPFV), the Five Year Forward view (5YFV) and System Transformation Plan (STP). Delivery of the Lord Carter review.	Development of health hubs with GPs operating at scale and within multi-disciplinary centres. Fewer individual GP practices and development of new estate and conversion of existing estate to deliver fit-for-purpose facilities. Partnership working to develop a system wide plan for 'One Public Estate' Reducing the cost of the estate; rationalisation of leases, disposal of buildings in poor condition. Partnership working across all sectors in the region to deliver upper quartile EFM performance, and reduction in running costs. To include new and different funding models and commercial partnership
7.	Reduced Capital resources for investment in the estate	Make use of capital received from disposal of assets for system-wide re-investment in new buildings and facilities to support the re-configured service model.

Enabling through technology – the local digital roadmap

Implementation of the proposed new care model requires new ways of working which will be enabled through technology and information sharing. Data and digital technology has the power to support people to live healthier lives and be less reliant on care services, as well as ensuring the provision of health and care is both high quality and sustainable. A local digital roadmap has been developed in collaboration with Kernow STP and sets out the shared vision, goals and plan required to deliver health and social care IT solutions across the South West Peninsula. To achieve this ambition locally there are four key areas of focus namely:

- Build the foundations: health and care organisations need to reach digital maturity
- Leverage the capability: connect all the digitally mature organisations
- Leverage existing capabilities: identify what can be achieved ahead of 2020
- Exploit the opportunities: enable citizen access.

Good progress is being made in terms of sharing the GP record in accordance with robust information sharing agreements.

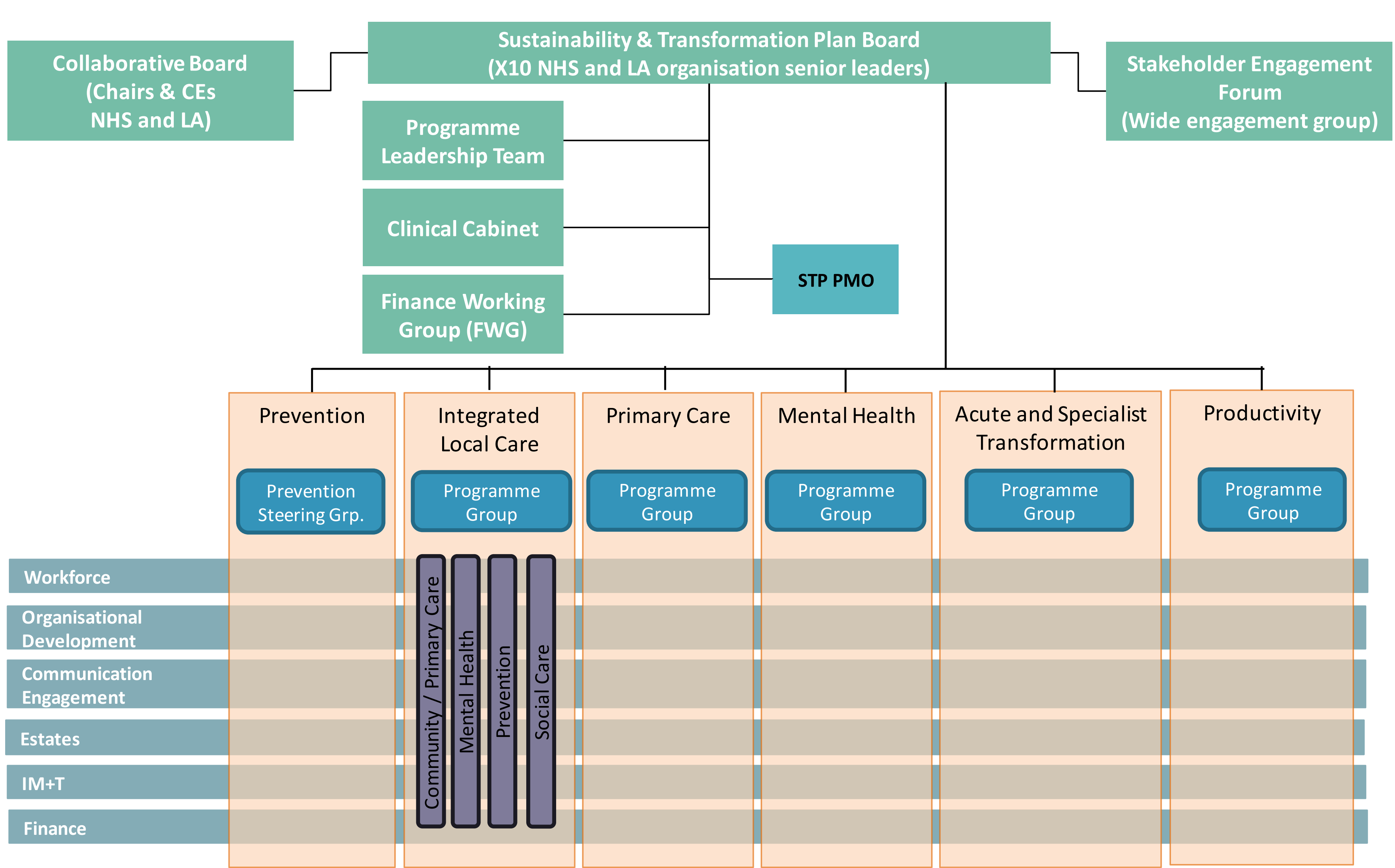
The next three areas in the local digital roadmap considered to deliver greatest alignment and impact on the seven priorities are:

1. Delivery of the integrated digital health and care record
2. Shared care plan
3. Supporting self care/prevention, including the patient held portal.

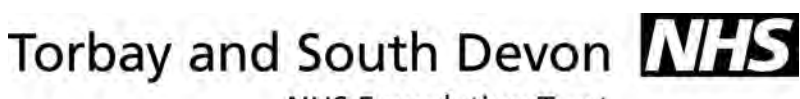
These will require significant additional resourcing over and above the current allocation.

STP priority	Digital maturity	System wide bed manage-ment	Integrated digital record	Self care	Information Sharing Framework	GP record availab-ility	Child protection information system	Secure email (care homes)	Virtual consult-ations	Secure hotspots for health and care workers	End of life wishes & shared care plan patient portal
Prevention				✓	✓			✓			
Care Model		✓	✓	✓	✓	✓		✓		✓	✓
Primary care				✓	✓	✓					✓
Mental Health			✓	✓	✓	✓			✓	✓	✓
Children & young people	✓		✓		✓	✓	✓		✓		
Acute hospital and specialist care	✓	✓	✓		✓						
Productivity	✓	✓	✓		✓						

Programme architecture to design and develop and deliver system wide plans



Place based design and delivery arrangements. Co-production with citizens & communities – NHS and LA



REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Wider Devon STP Acute Services Review
Lead Director:	Mairead McAlinden on behalf of Wider Devon STP
Corporate Objective:	All
Corporate Risk/ Theme	All
Purpose:	Information and Endorsement

Summary of Key Issues for Trust Board

Strategic Context:

All Provider and Commissioner Boards and Local Authority Health Overview and Scrutiny Committees within the Wider Devon STP footprint have been asked to consider and endorse the attached paper.

The purpose of this document is to notify Boards, Governing Bodies and Committees of the Acute Services Review (ASR) and seek endorsement of the criteria and principles contained in the attached paper.

The paper and the process has been agreed by the STP Leadership Group of Chief Executives and the Devon-wide STP Clinical Cabinet

Background:

The Acute Services Review was announced on 4 November 2016 at the same time as the Wider Devon STP published the final draft of its five year plan to transform health and care services across Devon.

The review will take a co-ordinated approach to services provided by the four hospitals (in Barnstable, Exeter, Plymouth and Torbay) and any associated 'out of hospital' services for the service area under review. The initial focus of the review is on services that are currently challenged and at risk of becoming unsustainable. The STP Clinical Cabinet, made up of representatives from all health and care organisations within Devon and including service user advocates, have prioritised the services most urgently requiring review in Phase 1 of this work. These priority services are:

- Stroke services, including hyper-acute and stroke rehabilitation;
- Maternity, Paediatrics and Neonatology, to be reviewed together given their inter-dependency; and
- Urgent and Emergency services, focussing particularly on the acute hospital provision of accident and emergency and co-dependent services

Key Issues/Risks

The Trust does have a number of what could be classed as “vulnerable services” where for example a shortage of specialist skilled workforce could render a service unviable. By reviewing services that are or at risk of being vulnerable in partnership with other providers across the Devon STP footprint, the Trust has an opportunity to work differently to make services more resilient and ensure the local population can continue to access the services they need. The Trust also has services that are more resilient that could help support other providers who are in a more vulnerable position.

Recommendations:
The Trust Board is asked to
- **endorse** the criteria and principles set out in the Acute services Review.
- **conside**r the ASR update and feedback any suggestions for improvement in the process.
- **support** clinical leads and operational teams to engage effectively
- **reques**t further regular feedback on progress

Summary of ED Challenge/Discussion:

The Trust Chief Executive is the overall sponsor for the review on behalf of the Wider Devon STP health and care community and Jane Viner and Rob Dyer are both members of the Clinical Cabinet. Executive Directors, clinical leads and staff from the services affected and senior managers are involved in the review. Key issues considered include capacity of organisation to participate in reviews balanced against risk of not participating and informing outcomes.

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

The review team will put in place robust governance arrangements, start to appoint clinical and managerial leadership for each strand of the Review and create ‘colleges of experts’ – with clinical, service user and stakeholder representatives - to develop the detailed case for change required for each service.

Within the Trust staff and governors have been briefed and ongoing communications are planned throughout the period of the review. Across the STP area, a communications and engagement plan will support the review to ensure communities, staff and other key stakeholders are involved.

Asking all Boards to receive this high level scoping documents and to endorse the principles and criteria is the first step in the engagement.

Within the South Devon and Torbay Health and care system, Torbay Council’s Overview and Scrutiny Committee have considered the paper and agreed the recommendations at a meeting held on 30 November. The review is also a standing item as part of the STP update on the Joint Executive and System Change Board agendas.

Equality and Diversity Implications:

For each service review, where there is a significant change proposed, the review team will engage widely with service users, clinicians, staff, unions, representative groups and the public. Where formal consultation is required, this will be planned and undertaken to meet all the statutory requirements relating to NHS service changes.

The NHS in Devon understands its need to meet all relevant statutory obligations when undertaking a change programme and nothing in this report should be taken to commit the NHS to a particular decision without proper consideration of those obligations.

Wider Devon STP Acute Services Review

1. Background

1.1 Since March 2016 health organisations and local authorities in North, East, South and West Devon, Plymouth and Torbay have been working together on the Wider Devon Sustainability and Transformation Plan (STP). The STP brings together two existing partnerships within Devon with individual strategic plans into a wider partnership to develop a single strategic plan. The work of the STP is to establish an overarching framework within which, health and care organisations will respond to the growing physical and mental health needs of people in the communities across Devon. Services will be delivered via integrated networks of support, as locally as possible, in a manner which is safe, sustainable and affordable.

1.2 For organisations in the NEW Devon CCG area, as part of the Success Regime work programme, a case for change was published in February 2016. It identified a number of areas where work was needed to secure clinical and financial sustainability, relating to acute and specialist care and community services. It was agreed the initial focus of the work in response to the case for change, would be developing proposals for a model of care, for integrated community services and associated changes to the number of community hospital beds. It was also agreed the work programme on acute and specialised care would follow.

1.3 In Torbay and South Devon, a 5 year plan had been developed by partners in that health and care system to introduce a new model of care that was intended to improve outcomes, reduce reliance on bed based care by an improved community offering and address the affordability gap for that population.

1.4 The NEW Devon case for change identified concerns about quality and/or sustainability of some acute and specialist services and prioritised Stroke, Maternity, Paediatrics and Neonatology, and Emergency and Urgent care for urgent review. A similar analysis undertaken in Torbay and South Devon, which confirmed similar priorities for review.

1.5 In addition, Medical Directors from all of the Trusts in Devon identified a number of other services where clinical sustainability was causing some concern and where action may be necessary to secure reliable delivery.

2.0 Acute Services Review – progress to date

2.1 As stated above, an overarching project for the Review of Acute Services has been established as a key element of the Devon STP. Draft guiding principles, approach and methodology for this review – Appendix 1 - have been endorsed by the STP Clinical Cabinet and CEO group. Mairead McAlinden, Chief Executive of Torbay and South Devon NHS Foundation Trust, and Dr Phil Hughes, Medical Director of Plymouth Hospitals NHS Trust and Chair of the STP Clinical Cabinet[1] have been nominated by the CEO Group to lead this process.

2.2 The STP Clinical Cabinet, made up of representatives from all health and care organisations within Devon and including service user advocates, have prioritised the services most urgently requiring review in Phase 1 of this work. These priority services are:

- Stroke services (including hyper-acute and stroke rehabilitation).
- Maternity (including consultant-led and midwife-led care), Paediatrics and Neonaology, to be reviewed together given their inter-dependancy.
- Urgent and Emergency services, focussing particularly on the acute hospital provision of accident and emergency and co-dependent services.

2.3 In addition, the Clinical Cabinet has identified services that need to be reviewed because clinical sustainability was causing some concern. This might be due to, for example, national staff shortages or low patient numbers making it difficult for clinical staff to keep their skills up to date. These so-called 'vulnerable' services include:

- Breast services (surgery and radiology)
- ENT
- Interventional Radiology
- Histopathology
- Neurology
- Interventional Cardiology
- Vascular Surgery

Under the 'vulnerable services' strand of the review, work is already underway in some areas, such as Neurology and ENT.

2.4 The services listed in 2.2 and 2.3 have been prioritised for Phase 1 of the

[1] Explain 'Clinical Cabinet'

Review, and other services will similarly be assessed for clinical priority in future phases of this work programme. NHS England's specialised service, which could include specialised cancer care and specialist mental health services, may also trigger the need for a Devon-wide service review in future phases of the Acute Services Review.

3 Engagement/Involvement and Timeline

3.1 The Acute Service Review Lead Chief Executive and Clinical Cabinet chair will seek clinical and managerial leadership for each of the service review strands. Expressions of interest will be sought from Medical/Nurse Directors and CCG Clinical Chairs to undertake the clinical lead role for the following service-specific reviews and all partners will be asked to nominate clinical in the 'college of experts' that will shape, debate and inform the best option for service change. Patient and public representatives will be recruited for all reviews via existing PPI networks. The opportunity to include democratic participation will also be explored.

3.2 The 'college of experts' will be charged with:

- ensuring that the review has the knowledge and experience required to deliver proposals for high quality and evidence-based change
- developing the standards and output specification for each service, drawing on national standards and guidance, interpreting these and judging those most critically important to improve the services across Devon, for approval by the Clinical Cabinet.
- Develop specific change proposals across Devon to address the challenges in the case for change, including:

  a) changes in care models
  b) the implication of these proposals on which services are delivered from which sites
  c) Identify network and site-specific options for the delivery of proposed new models.

- Evaluate options according to the approved criteria. This will require e.g. evaluation of safety, quality and access by the Clinical Cabinet and Cost Effectiveness by the Finance Working Group.
- A determination will need to be made in conjunction with the Health Overview and Scrutiny Committee if public consultation is required. In cases where consultation is required, a Pre-Consultation Business Case and then Consultation Document and Consultation plan will be developed, NHS England gateway

process followed, and consultation held before any decision is made (this process typically takes 9-12 months).

- Whether or not consultation is required, there will be a requirement to develop detailed plans for implementing proposed change, secure endorsement from the STP leadership body and to inform, involve and engage staff, service users and the public before change is implemented.

3.3 Service Review Timeline

- **Stroke Service**

The review will make use of the extensive review undertaken by the SW Clinical Senate, published in September 2016. The review will be undertaken via a programme of workshops, conducted at regular intervals from mid-November. The following matters will be addressed:

  - What is the Case for Change and what are the key standards for the service model for acute stroke and stroke rehabilitation?
  - What options exist for reconfiguration of acute stroke and stroke rehabilitation services to meet these standards?
  - What is the optimum service configuration to deliver effective and affordable stroke services for people in Devon?

The review will generate options and requirements for implementation. An initial workshop planned for November 2016 and it is anticipated the work programme should be concluded in January 2017.

- **Maternity, Paediatrics and Neonatology** and **Urgent and Emergency Services**

A similar programme will be developed for the other two priority areas for review, and a first workshop for each is planned for December 2016.

The work programme will follow a similar pattern to the programme established for stroke services. It is anticipated this work should be concluded in February 2017.

- **Review of Vulnerable Services**

Many of the services identified as having sustainability concerns due to workforce or other challenges may be able to be addressed through the brokering of local agreements between providers and/or commissioners. The programme of work for each service in this category will be developed on a 'case by case' basis with an individual 'case for change' developed for review by the STP Clinical Cabinet and timescales will be dependent upon the scale of work required to resolve the

issues of sustainability.

a) For each strand of the Review, we need to secure the expertise and capability to support an expert group from across Devon to define and design options for proposed service change, drawing on external expertise as needed and building on any previous analysis of the service challenges and improvement proposals.

b) The work programme described is significant and when complete, options that require formal consultation may emerge. The timetable for this work will be finalised when the work programme is complete; at this stage it is not anticipated any proposals for consultation will be made until mid-2017.

c) The Devon STP partners understand that all relevant statutory obligations must be met when undertaking a change programme of this scale; nothing in this paper or the work programme described should be taken to commit the NHS/STP partners to a particular decision without proper consideration of those obligations.

d) An effective Engagement and Communications strategy will be critical to this Review, and a PR lead has been identified from T&SD FT. A key task will be to secure the input of PR leads across the STP partnership to ensure effective engagement and a consistent, transparent and proactive approach to communications about the Review.

4 Conclusion and Recommendations

PEDG is asked to:

a) Approve and endorse the briefing paper for issue to all STP partner organisations to share with their Governing Board/Body and with interested staff
b) Approve the nominations for leadership of the Review
c) Approve the prioritisation of services for Phase 1 of the Review
d) Approve the action necessary to secure input from organisations involved in the reviews and to secure effective service user representation/advocacy to populate the individual service reviews.
e) Approve the timescales for Phase 1 of the Review
f) Decide whether the principles and criteria require wider engagement/testing, and what form this engagement process should take.
g) Approve engagment with local MP's to ensure they are aware of, and appropriately briefed on this Review.
h) Approve engagment with local Scrutiny Committees to ensure they are aware of and appropriately briefed on this Review.

Appendix A:

DEVON STP ACUTE HOSPITAL SERVICES REVIEW

'Services not Structures'

A Compelling Case for Change

Under the NEW Devon Success Regime, a detailed case for change has been produced and is being refreshed to reflect the transition to a Devon-wide Sustainability and Transformation Plan. The compelling case for change in Devon's current model of acute hospital care is clearly set out and includes:

- Our demographic change which is driving increased need for treatment and care, and which is outstripping the capacity of our acute hospital services to meet that need, resulting in longer waiting times for access to care, including emergency care, planned care and cancer care.
- It is challenging for the current configuration of services, designed and funded for historical levels of demand and service standards, to achieve and sustainably deliver these increasing standards of care, adoption of new technology and 'best practice' and innovative ways of working, for which it was not designed.
- The costs of striving to meet increasing need, rising standards and new technologies, including new drugs and diagnostics, through the current model of acute hospital services are higher than our current and predicted funding levels. This is partly driven by high locum and agency costs, where hospitals are unable to permanently recruit the medical and nursing workforce needed to deliver services, and duplication of specialist services. Expenditure on locum and agency was £49.7m (financial year April 2015 to March 2016) across the five Trusts in Devon.
- Provider Trusts are currently failing to deliver the key access and quality standards for access to effective assessment, treatment and care for the population of Devon. In summary for August 2016:
    - The 95% standard for patients being seen in A&E within 4 hours – the Devon system is currently achieving 91.6%
    - The 92% standard that no patient should wait more than 18 weeks from Referral to Treatment – the Devon system is currently achieving 89.7%.
    - The 85% standard for assessment and treatment for Cancer within 62 days – the Devon system is currently achieving 82.1%
    - The 99% standard for Diagnostics – the Devon system is currently achieving 96.9%
- The Devon acute hospital system is currently costing more than funded levels, with a deficit of £50m predicted for this year, increasing to £305m by 20/21 should the 'status quo' be maintained.

Scope of the Review

The Acute Services Review is not about the current system of acute hospital care staying the same but improving its efficiency - the opportunities for efficiency improvement in our acute hospital services are already being undertaken in separate projects within the STP, and we are failing to deliver timely and high quality care in a range of services right now.

This Review is a partner project to the STP project which is planning changes to the model of care in our communities and under which, both CCG's are currently consulting with the public on proposals for changes to our Community Hospitals (and in South Devon to Minor Injuries Units).

The Acute Service Review is focused on optimising the quality and timeliness of care by reforming individual acute hospital services to be more resilient, with better outcomes and improved affordability, so that they can meet the increasing demand for acute and specialist services, that can only be provided by hospital-based clinical teams and support services now and in the future.

The review is based on an 'all Devon' footprint, but some services may, because of population flows or scale of service, need to be considered on a wider geography, and for these services the Review Team will work in partnership with neighbouring STP's, Clinical Commissioning Groups and Specialist Service Commissioners.

An important step in the process will be to define and agree the set of standards that ensure services are 'good care for the people of Devon'. These are the standards against which the need for change in any given service will be assessed. Any changes proposed must consider a range of options for how they can be delivered and the level of standard that can be reached – from 'good' to 'excellent/best in class', and bring forward a preferred option.

Principles for the Review

This review will be founded on a set of principles – which will guide the work of the review. These principles are drawn from the 'triple aim' defined in the Five Year Forward View as

- Improving the health of the population
- Improving the quality of care delivery
- Achieving better value by reducing the cost of care

There is a fourth principle – improving the experience of staff working in our system of care, making their jobs challenging but satisfying and increasing the attractiveness of a career in the Devon health and social care system.

The review will:

- Address inequalities in the health of the population of Devon and improve outcomes, through the development of prevention, early intervention, expert and well informed service users, and timely and responsive treatment, care that delivers reduced variation in clinical outcomes and a good experience for the people who use our services.
- Focus on improving service quality and sustainability in the interests of an equal standard of care and not the future of buildings or individual organisational interests.

- Address the current 'post code lottery' where some people in Devon wait longer for treatment and care than others depending on where they live.
- Promote change that is evidence-based and that will result in clinical benefit and improved outcomes for patients, and ensure that the treatment offered will be of proven benefit for the individual patient.
- Recognise the unique geography of Devon and that distance from service provision should not of itself be a factor that prevents the delivery of optimum care and best outcomes for patients.
- Ensure that reconfiguration of acute and specialist hospital care will maximise the benefit of integration with primary and community health and social care, including mental health, disability and children's care, and will seek to manage population need as a system, not silos of care.
- Seek to configure acute hospital services to achieve the best outcomes for the population of Devon and for the individual service provided, while recognising the need to group certain services together because of their interdependences and critical clinical adjacencies.
- The review will not focus on the future of individual hospitals in the current system, but will seek to ensure that no single service change destabilises any hospital.
- Ensure that any proposed change will be affordable within the funding allocated for Devon, so that 'out of hospital care' can be protected and invested in.
- Draw on, and be aligned with, the work underway to deliver a new model of care for the wider health and social care system, and the intent that this model of care will provide community-based alternatives to hospital admission and will minimise delayed discharges for patients who are medically fit and ready to be discharged to a more appropriate form of care.
- Seek to promote better alternatives – more effective/efficient/better quality service model, relatively easily available – either through rationalisation of the location of services, networking across hospitals, a new integrated clinical pathway or an 'out of hospital' delivery model

Successful delivery of any change pre-supposes that the transitional funding needed to secure safe, well managed change can be secured

These general principles will inform the development of proposed changes in care models in Devon.

Criteria to Guide the Decisions of the Review

Any proposed changes to the current model of acute and specialist hospital care will rightly be subject to debate and challenge by the public, service users, local communities and their elected representatives and our staff and trade union colleagues.

We recognise that many of our citizens and staff will be concerned about any proposed change and are not confident that their voice will be heard in any consultation processes. Therefore, this review will be a transparent process that enables all stakeholders to judge whether any proposed changes will:

- be more effective in responding to current and future demand
- deliver against increasing standards for safe and high quality care
- ensure more resilient services now and in the future.

Subject to the advice of Health Oversight and Scrutiny Committees of local authorities, there may be a need for commissioners formally to consult local populations, service users and the public of

Devon about the proposed changes. In doing so, commissioners must demonstrate that options for change have been objectively assessed against these principles and criteria. Therefore, an important first step is to ensure these are accepted by our stakeholders as understandable, fair and transparent in guiding decision-making to achieve the best options for safe, effective and affordable acute hospital care services that will improve outcomes and timeliness of care for the people of Devon, and thus provide a compelling case for change.

The following criteria are proposed/will be used to guide the evaluation of any options against the current delivery of services. In making this assessment it is not expected that each option will score highly on every dimension, but that the overall assessment will deliver an option for service change, that will deliver the best overall outcome for the people of Devon. With this in mind the following criteria are proposed:

- **Safety:** delivers improved patient safety
- **Quality and Outcome:** results in clinical benefit and improved outcome for the population, and treatment offered that will be of proven benefit for the individual patient.
- **Access**: maximises the ability of patients and carers to access the service as measured by
    - reasonable travel time given the balance to be achieved with service improvement and achievement of best outcomes, and
    - access to care within the waiting time standards for that service
- **Service sustainability:** results in improved service quality and sustainability given the challenges of the availability of the permanent clinical workforce, avoids high levels of agency/locum staff usage, and addresses known and/or imminent workforce challenges to the delivery of services both during and outside traditional working hours
- **Training**: supports the effective training and development of future clinicians and care professionals.
- **Cost effectiveness:** minimises the cost of service delivery relative to the alternatives.
- **Patient Choice:** promotes patient ability to choose provider or treatment
- **User experience:** delivers an improvement to the user experience

Approach and Methodology for the Acute Hospital Service review

Clinical engagement has identified a number of services that are currently not delivering best possible outcomes for the people of Devon and are not cost effective when compared to alternative models of care. In discussions to date, a number of services have been identified which should be considered for review. These include services prioritised by the STP Clinical Cabinet from those identified by the NEW Devon Case for Change, South Devon and Torbay-specific priorities, and services identified as being potentially at risk of unplanned change because of workforce or other challenges.

The criteria above are proposed as guiding the evaluation of any specific service, and – given that capacity needs to be targeted to the most critically challenged services – for selecting and prioritising the services within the scope of the review.

It is proposed that each service, or bundle of connected services, is scored against these criteria, identifying the potential for improvement. The Clinical Cabinet, through this exercise has already identified the priorities for Phase 1 and will use the same process to identify the priorities for the next phases of the Review and to assess the degree of interdependency amongst high priority services.

The STP Clinical Cabinet, made up of representatives from all health and care organisations within Devon and including service users, have prioritised the services most urgently requiring review in Phase 1 of this work. These priority services are:

- Stroke services (including hyper-acute and stroke rehabilitation).

- Maternity (including consultant-led and midwife-led care), Paediatrics and Neonatology, to be reviewed together given their inter-dependancy.

- Urgent and Emergency services, focussing particularly on the acute hospital provision of accident and emergency and co-dependent services.

In addition, the Clinical Cabinet have identified services that need to be reviewed because clinical sustainability was causing some concern. This might be due to, for example, national staff shortages or low patient numbers making it difficult for clinical staff to keep their skills up to date. These so-called 'vulnerable' services include:

- Breast services (surgery and radiology)
- ENT
- Interventional Radiology
- Histopathology
- Neurology
- Interventional Cardiology
- Vascular Surgery

Under the 'vulnerable services' strand of the review, work is already underway in some areas, such as Neurology and ENT.

The services listed have been prioritised for Phase 1 of the Review, and other services will similarly be assessed for clinical priority in future phases of this work programme. NHS England's specialised service and primary care work programmes, which would include specialised cancer care, specialist mental health services and primary care development, may also trigger the need for a Devon-wide service review in future phases of the Acute Services Review.

Proposed methodology for undertaking specific reviews

In carrying out the reviews of specific services, it is essential that the work is undertaken in an objective and transparent way to build trust and confidence in the outcome of proposed optimum solutions for change. Fully engaging the key stakeholders and partners at every stage will be critical to the success of the process.

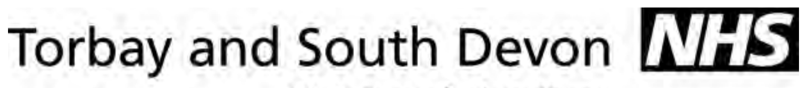
A core requirement is to set out the arrangements that will be put in place to ensure the review process is well governed and has high levels of stakeholder engagement and influence, is open and transparent, has key decisions approved in line with the STP Governance arrangements, and wider guidance and best practice on effectively managing strategic service change. An overarching project plan is required to ensure quality outcomes at each stage of the review process while delivering the review at pace. The approach proposed and the emerging detailed plan must also have the endorsement of the regulatory system within which the STP operates.

Next steps

We will put in place robust governance arrangements, start to appoint clinical and managerial leadership for each strand of the Review and create 'colleges of experts' – with clinical, service user and stakeholder representatives - to develop the detailed case for change required for each service.

For each service review, where there is a significant change proposed, we will also engage widely with service users, clinicians, staff, unions, representative groups and the public. Where formal consultation is required, this will be planned and undertaken to meet all the statutory requirements relating to NHS service changes.

This development and evaluation process is likely to take at least a year before any service change begins.



REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	*Into the future*: Reshaping community-based health services Public consultation update
Lead Director:	Ann Wagner Director of Strategy and Improvement
Corporate Objective:	All
Corporate Risk/ Theme	This paper takes account of/address the following risks from the corporate risk register 2. Failure to achieve key performance standards 3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision 4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality. 5. Failure to achieve financial plan 6. Delayed delivery of integrated care organisation (ICO) care model 8. Care Quality Commission requirement notice sets out significant concerns regarding safe quality care and best experience
Purpose:	To update the Board on the consultation process and confirm next steps

Summary of Key Issues for Trust Board

Strategic Context:

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

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

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

The purpose of this paper, which reflects papers being submitted to Council Overview and Scrutiny Committees and Health and Well Being Boards, is to provide an update on the consultation process, which has now closed, and confirm next steps.

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

Key to successful implementation of the care model is the availability of staff to form the integrated teams that lie at the heart of the proposals, together with suitable facilities to enable the co location. Success also relies on a sustainable and resilient care home sector which is currently significantly challenged.

Recommendation:
The Board is asked to **note** the report and attachment

Summary of ED Challenge/Discussion:
The Executive team has been very involved in developing the proposals which are aligned to our care model aspirations and strategy for the future. Directors will continue to work with the CCG healthwatch and other stakeholders to develop an appropriate response in light of feedback from the public consultation.

Key issues considered include workforce capacity, care home sector resilience, GP agreement to co –locate, disinvestment from old model and facilities to invest in new model and availability of fit for purpose facilities.

Internal/External Engagement including Public, Patient and Governor Involvement:
The CCG and Trust have worked hard to reach out and engage with the public and key stakeholders so that everyone has had the opportunity to understand the proposals and have an opportunity to comment, share concerns and suggest alternative proposals.

Equality and Diversity Implications:
Equality Impact Assessments have been completed and will continue to be refreshed throughout the model of care implementation

PUBLIC

Report to:	Trust Board
Date:	7 December 2017
Report From:	Ann Wagner Director of Strategy and Improvement
Report Title:	Into the future: Reshaping community-based health services Public Consultation Update

1 Purpose

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

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

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

The purpose of this paper, which reflects papers being submitted to Council Overview and Scrutiny Committees and Health and Well Being Boards, is to provide an update on the consultation process, which has now closed, and confirm next steps.

2 Context

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

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

The CCG, working closely with the Trust, has engaged extensively with local people and their representatives in developing the proposals and have used their priorities to inform the proposed changes. At the heart of the consultation process is our shared wish to respond to what people told us they wanted from their health services

including to provide more care in or close to people's homes, via a more integrated joined up health and social care service. We believe these proposals will improve health services and are affordable.

3 Proposals

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

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

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

The document described how the services in each locality might work in future if the proposals are implemented with detail of what would be different , what services could look like and where they would be. It also confirmed that providing much more care to people in or near their home would mean that some of the buildings from which we currently provide inpatient and community services would no longer be required and would close.

The main changes proposed in the consultation were:

- Closure of Ashburton and Buckfastleigh, Bovey Tracey (beds currently temporarily relocated to Newton Abbot Hospital due to safe staffing issues), Dartmouth and Paignton Hospitals.
- Totnes and Newton Abbot to be the location of enhanced MIU services and operating from 8am to 8 pm, seven days a week and with x-ray diagnostics. MIUs in Ashburton, Dartmouth (both currently suspended), Brixham and Paignton would close.
- Establishment of clinical hubs in Newton Abbot, Totnes and Brixham with medical beds and specialist out-patient clinics.
- Establishment of health and wellbeing centres in Ashburton or Buckfastleigh, Bovey Tracy or Chudleigh, Dartmouth, Newton Abbot, Totnes, Brixham, Paignton and Torquay providing a base for the delivery locally based integrated community services
- Expansion of intermediate care across the CCG area

4 Consultation Process

The 12 week consultation started on 1 September and ran until 23 November. The CCG and Trust set out to involve as many people as possible and to generate a debate around the consultation proposals and to explain why the status quo is not a sustainable option. We wanted to encourage people to use their local knowledge to come up with ways of improving the proposals and to offer alternative ideas for how we might change services for the better and to meet the growing future needs. We stressed the importance of any solution being clinically sound, affordable and sustainable.

The CCG promoted the consultation widely, using a variety of methods designed to reach different parts of our communities and to give everyone who wished to comment on the proposals the opportunity to do so. Set out below is a summary of the core activity.

- About 14,000 consultation documents were distributed, and versions were available in easy read and large print format. Some 2,000 posters promoting the consultation and public meetings were displayed.
- 23 public meetings were held and the CCG also attended more than 60 other meetings with community based groups and staff.
- Information was sent to more than 300 groups, many of whom such as Torbay Community Development Trust, shared it with their member organisations. Healthwatch Devon and Healthwatch Torbay also promoted the consultation and shared documentation via their websites and publications whilst the ICO and Devon Partnership Trust sent information to their members.
- More than 1,700 people attended the public meetings and Healthwatch was able to record views expressed in the round table discussions as well as issues raised in the question and answer sessions.
- Nine advertisements were placed in the Brixham Times, Dartmouth Chronicle, Herald Express, Mid Devon Advertiser (all six area editions), and the Totnes Times.
- Facebook advertising reached 35,000 people, more than 1,000 of whom accessed the website or online questionnaire.
- Throughout the consultation, the CCG used twitter to report on public meetings, share information and respond to questions and the number of people reached more than doubled during the consultation period, reaching more than 100,000.
- Information was also shared via the Trust's web, facebook and twitter feeds.
- The consultation pages on the CCG website received more than 8,000 hits from unique users during the consultation period.
- Presentations were made to Trust and CCG staff and to Devon, Torbay, South Hams and Teignbridge scrutiny committees.
- Some 1,400 feedback questionnaires were completed.
- More than 700 people signed up to receive the weekly stakeholder update which ran throughout the consultation.
- Throughout the consultation, and since the core proposals were published in April, different aspects have been covered by BBC Spotlight, Radio Devon and local newspapers, as well as by community based newsletters, publications and websites.

To help increase understanding, a range of support documents were also published on the CCG's website and made available at public meetings and on request. Short videos were also hosted on the website illustrating different aspects of services under the new model and a range of FAQs were published. The CCG added Browsealoud to their website to facilitate access and participation for people with Dyslexia, Low Literacy, English as a Second Language, and those with mild visual impairments by providing speech, reading, and translation

The promotional activity highlighted above targeted different groups across the area. Specifically, we directly approached a large number of groups based on our Equality Impact Assessment (EIA) to ask them to highlight the consultation to their members and to help us share consultation material. Sessions were also held specifically for young people, talked to people while they travelled on Newton Abbot community transport and attended sessions aimed at hard to reach groups.

Initial meetings in Paignton and one in Ashburton were oversubscribed and additional meetings were organised as a result. The consultation feedback questionnaire received some criticism as some people did not like the way it sought views on the CCG's specific proposals, while providing opportunities for people to respond with alternative proposals/comments in their own words.

Torbay and Devon County Council Overview and Scrutiny Boards have maintained oversight of the process throughout the consultation and have confirmed their assurance that due process has been followed and that the CCG has made every attempt to engage widely to give everyone the opportunity to listen and have their say. The Councils are now waiting to see the feedback from Healthwatch and expect the CCG to take that feedback into account in their final response.

5 Reporting on Consultation Responses

Views expressed at public meetings and others attended by the CCG were captured by Healthwatch (Devon and Torbay) ready for inclusion in their independent report of the consultation.

The main themes which we heard across the consultation were:

- Praise for NHS staff and support for the NHS and the services it provides
- Concerns relating to reliability of some current services
- Recognition of the need for change, the importance of being able to meet the rising demand for services and the financial pressures
- The prerequisite of making sure services are responsive and safe
- Support in principle for the new model of care and in particular for:
    - investment in community services to support more people in or near their own homes,
    - outpatient clinics delivered nearer to where people live
    - professionals – doctors, nurses, physiotherapists, occupational therapists and other health and social care workers – being brought together in health and wellbeing teams.
- While supporting the care model people want reassurance that:
    - expansion of community based services can be properly resourced

    - mental health services will also benefit from the changes as well as physical health
    - sufficient capacity in the voluntary sector for it to play its part in the new model
    - sufficient GPs to provide the medical cover in the community
    - quality and availability of care home beds is good enough
    - social care is resourced to play its part.
- Reducing the numbers of people admitted to hospital unnecessarily and speeding up discharges by having more out of hospital resources is also viewed positively, providing these decisions are clinically and not financially driven
- Opposition to removal of community hospital beds; a lack of acceptance that fewer hospital beds are needed or that hospitals proposed to close need substantial investment to bring them up to modern standards for bed based care or for an alternative health use
- The high regard for the role played in the past by community hospitals and the trust that people have in them
- The lack of an MIU in the Bay
- The lack of x-ray in Paignton and Brixham
- The location of a clinical hub in Brixham as opposed to Paignton
- The location of the health and wellbeing centres in Paignton and Ashburton/Buckfastleigh
- National issues outside the control of the CCG and this consultation such as NHS funding, fear of privatisation and the long term future of health and social care
- Cutting waste would enable hospitals to remain open
- Broader issues that impact on life generally such as travel, pressure on the local infrastructure caused by more house building and social isolation are also frequently raised but these are not issues the local NHS can resolve alone.
- A belief that the consultation is a ‘done deal’.

A copy of the Board’s formal response to the proposals has also been shared with Healthwatch (Attached at Appendix 1).Correspondence, petitions and other submissions will be noted by Healthwatch but most weight will be given to the completed feedback forms from the public.

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

6 What happens next?

All alternative ideas put forward in the consultation will be evaluated to see whether they would meet clinical needs and offer an affordable, sustainable solution to the challenges we face. The CCG will be inviting local stakeholders including the ICO to take part in this evaluation and more detailed criteria for evaluating alternative proposals will be published before Christmas.

The CCG governing body meeting on 26 January 2017 is likely to consider the Healthwatch report, the evaluation of alternative ideas and to make decisions on the future of community services

7 Acknowledgements

We would like to join the CCG in recording our thanks to everyone who took part in the consultation; to Healthwatch volunteers for their commitment to recording all feedback; to the independent chairs for making sure everyone at the public meetings had a voice; to the Council Overview and Scrutiny Committees for their oversight and advice; to our local MPs for their support; to the League of Friends for their unerring support; local GPs and the staff from the CCG and Trust who gave up their personal time to support the process.

8 Recommendation

The Board is asked to **receive** this report

Trust Headquarters
Torbay Hospital
Lowes Bridge
TORQUAY
TQ2 7AA

Via Email
Derek Greatorex
Nick Roberts
South Devon and Torbay CCG

Direct Line: 01803 655702
Fax Number: 01803 616334
E-Mail: chiefexecutive.tsdft@nhs.net
Website: http://www.torbayandsouthdevon.nhs.uk

Your Ref:
Our Ref: MM/SJF/158
Date: 23 November 2016

Dear Derek and Nick

Into the Future – Re-shaping community based health services: Board 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 local services, such as Minor Injuries and X Ray, than on buildings. The Trust is committed to working with the CCG and local GPs to ensure continuation of local access to services that are most frequently used by local populations. 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, Torbay Council and Devon County Council to stimulate and support the resilience and ongoing development of the independent care market needs to be progressed as a priority, and the Trust is committed to informing and supporting this work. Other concerns have included workforce capacity and the care model's reliance on the voluntary sector and whether it can cope with increasing demands. We trust that the 'up front' investment and recruitment of intermediate care staff and our partnership with the voluntary sector to embed health care co-ordinators across all locality teams will allay these concerns. Perhaps the most frequently raised barrier to the proposed changes is the difficulties of travel 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, and a Transport Workshop with the voluntary sector is being held on 24th November to progress this commitment.

The Trust Board, in considering the proposed changes, unanimously agree that maintaining the status quo is neither sustainable nor clinically sound and through the care model we must develop a more appropriate response to rising demand for support and services from our increasingly elderly population with complex long term conditions and care needs. We firmly believe that the changes to the care model being proposed are the right thing to do, and will better meet the needs of our growing, ageing population.

Change of this magnitude is not without challenge and risk, and managing the uncertainty until decisions are made is also creating risk of unplanned change. Safe staffing in our community hospitals is increasingly difficult to maintain as staff move on, 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. However we would urge the CCG to make the necessary decisions that will remove this uncertainty for staff and local populations, and allow the proposed changes to be progressed.

We do not underestimate the challenges our system faces. 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, Torbay Council and Devon County Council as our commissioners, our partners in primary care, the voluntary and private sector, and with local populations, their community leaders and elected representatives, to deliver the changes required. Our aim is to implement the key major service developments before changes are made to current service provision.

Once the consultation is concluded, the Trust is committed to work with the CCG 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.

Yours sincerely

Mairead McAlinden
Chief Executive

Sir Richard Ibbotson
Chairman

Cc:

Pat Harris/Pam Prior	Healthwatch Torbay
Miles Sibley	Healthwatch Devon
Caroline Taylor	Torbay Council
Jennie Stephens	Devon County Council
Jenny Turner	South Devon and Torbay CCG

REPORT SUMMARY SHEET

Meeting Date:	Trust Board 7th December 2016
Title:	Response to the proposals to reduce funding reduction for Public Health in the Mayor of Torbay's Draft Efficiency Plan
Lead Director:	Medical Director
Corporate Objective:	1. Safe, quality care and best experience 2. Improved wellbeing through partnership 3. Valuing our workforce
Corporate Risk/ Theme	6. Delayed delivery of integrated care organisation (ICO) care model
Purpose:	Information//Decision

Summary of Key Issues for Trust Board

Strategic Context:

The Mayor of Torbay has made proposals for reductions in commissioning of Public Health services within the Trust that amount to £1M as part of the Council's Draft Efficiency Plan (http://www.torbay.gov.uk/media/7838/efficiency-plan.pdf)

Key Issues/Risks

Torbay and South Devon Foundation Trust (the Trust) provides a range of services commissioned by Torbay Council. The services include:

- Sexual Health Services
- Health Visitors / School Nurses
- Drug & Alcohol Services
- Healthy Lifestyle Service
-

The Draft Efficiency Plan includes proposed funding reductions that would have profound effects on service delivery. The departments affected have proposed detailed Quality and Equality Impact Assessments.

The Trust needs to respond to the proposed reductions in funding as part of the formal consultation process by 16th December.

This paper includes a draft letter of response to the Mayor's proposals.

Recommendations:

The Trust Board is asked to consider the risks described within this report relating to the reduction in funding proposals and to agree a form of words to contribute to the formal consultation process.

Summary of ED Challenge/Discussion:
Executive Directors have provided support to content and style of letter to the Mayor. It has been agreed that South Devon and Torbay Clinical Commissioning Group will provide a separate response but that responses will be shared and aligned.
Internal/External Engagement including Public, Patient and Governor Involvement: Representations from patient groups and the public have been considered in the production of this report and the feedback to the consultation.
Equality and Diversity Implications: Quality and Equality Risk Assessments have suggested that the proposed changes will have an adverse effect on access to services and patient/public experience.

Response to the Mayor of Torbay's proposals for reduction in the Public Health commissioning budget for 2017/18 and 2018/19.

Dear Mayor,

We wish to express our opposition in the strongest terms to your proposals to reduce the Public Health (PH) budget for the next 2 financial years. This letter expresses the views of the Board of Torbay and South Devon NHS Foundation Trust (TSDFT).

We understand that the financial position of Torbay Council is extremely difficult and that savings must be achieved somewhere. However we believe strongly that the reductions in expenditure proposed in Public Health would result in deterioration of care for our patients, increased risk to their health and well-being and would ultimately be counterproductive, as the result would be increased costs in other sectors and for the council in the future. We believe that the proposed reductions in funding for PH services will impact adversely on the most vulnerable children, young people, families and vulnerable adults in our local communities.

Over recent years we have worked together very effectively to agree a 'joined-up' approach to the provision of health and social care in South Devon and our achievements have been recognised on the national stage and embedded with the formation of the Integrated Care Organisation (ICO). Part of the agreement is to work to ensure that decisions made in one part of our system do not have unintended adverse effects. A second cornerstone of our agreement has been to shift our investment in Health from the traditional reactive, to a proactive and preventative approach. We believe that the funding reductions you propose will damage the progress we have made on both counts.

Through the public consultation on community services over recent months, we have collectively made a commitment to the public to increase investment into prevention and community services. It is difficult for us to understand why the council, which has statutory responsibility for public health, would be proposing the opposite trajectory for funding. The proposals would lead to differential services in South Devon and Torbay, an outcome that we have been working hard to abolish. We are concerned that your proposed funding cuts will have an adverse effect on the credibility of the community service model redesign and be damaging to the reputation of both Torbay Council and the ICO.

The budget reductions described would devastate some of our services and since more than 90% of the Public Health service budget is in staff pay, would result in loss of jobs. The proposed reductions in funding to the Lifestyles team would remove more than 75% of its budget making the service unviable. The Lifestyles Team provide a range of services that are very strongly valued by service users with good outcomes. Reductions to other areas would be equally difficult to manage. We understand that the Public Health commissioning team have had no choice but to propose funding reductions to fall where they have because of the nature of the services. There would be high risk of patient harm in some services should greater budgetary restriction be applied there, e.g. in sexual health services where patients are in active treatment programmes. The Lifestyles team work with people to support them in improving their long-term health and well-being. The effect of reducing funding may be less immediate in some cases but we believe is likely to be at least as damaging in the longer term. As the ICO we have already made substantial new investments in prevention and in the voluntary sector in support of the new care model (more than £1M in the present financial year). Our own worsening financial position makes the option of further investment from TSDFT to ensure continuation of the services affected very difficult.

We would ask you to reconsider these proposals. The services described are already engaged in significant cost improvement programmes and have redesigned, or are committed to redesign, to provide services that provide better coverage of the population of Torbay with focus on the most deprived. The teams affected by these proposals have undertaken a Quality Impact Assessment and an Equality Impact Assessment, both of which are endorsed by the Trust Board. These assessments show high risk to patient care, poor experience and future increased cost to other sectors, and likely worsening of health inequalities and access for disadvantaged groups. More detail of impact is provided within the Appendix. We will, of course, make all of these QIA and EQIA assessment available to you.

While we accept that the council must find economies somewhere we believe that the funding reductions proposed will result in deterioration in service and a reversal of progress towards better Public Health. We will, of course continue, through our joined up Prevention, self-care and Well-being Board, to work with the Director of Public Health and her team towards our shared aim of making improvement in Public Health everybody's business in Health and Social Care in Torbay and South Devon.

Yours sincerely,

Sir Richard Ibbotson, Mairead McAlinden

On behalf of the Board of TSDFT

Appendix

Specific effects of proposals for reduction in Public Health funding

We believe that the proposals outlined will have the following impact on services

Sexual Health Services proposed reduction of £106K

This is an integrated service with a contract for Torbay and a contract for Devon with Torbay taking the lead commissioner role. The challenge around reductions from one commissioner is that the level of service will be different in different areas even though the Trust has a Torbay and South Devon footprint. Staff would have to be lost from the service. Areas of loss of service would include loss of outreach (which has contributed to reduction in teenage pregnancy) and effectiveness of Chlamydia screening which would result in greater costs of treatment in the future and infertility.

Health Visiting and School Nursing (Public Health Nursing) proposed reduction of £255K

We know that what happens to a child during the first 2 years of life is crucial and a key determinant of intellectual, social and emotional health and wellbeing throughout life. The Health Visiting service is the only service that comprehensively assesses the needs of every child at crucial stages of their development between pregnancy and the age of 5, often in the home environment.

The proposed reductions in funding of the HV service would require a reduction in 10 WTE Health Visitors in Torbay. Reducing the staffing capacity will impact on the number of home visits to children aged 0 to 2 years making them less visible to services. This is likely to result in increase in risk of harm to children and increase in serious case reviews. A negative impact will also be felt through failure to recognise maternal mental health concerns at an early stage with likely increased costs to mental health services, as well as great distress to the women affected. Reduction in the HV service is also likely to reduce identification of risk of domestic violence.

A reduced School Nursing service will impact on their visibility in schools and the opportunities for young people to access health services impacting on young people's mental health, emotional wellbeing and sexual health. The effect on effectiveness of schools is difficult to quantify but is likely to be significant.

Our assessment is that, in the case of Health Visiting and school Nursing, the proposed reductions in funding will have an adverse impact on partnership working with Children's Services and impair the ability of staff to meet their statutory responsibilities for Safeguarding.

Drug and Alcohol Services proposed reduction of £156

This service has a sub contractual arrangement with DPT and a board that oversees the service transformation work. The service has made plans already to reduce costs by £96K for the coming financial year. Achieving a further reduction to achieve £156K will therefore adversely affect the planned changes in service provision with significant adverse effects in the short term.

Further, due to the extent of the disinvestment, the service will no longer be able to provide an optimum / enhanced service for the criminal justice pathway into treatment provision. As a consequence, this group who are often highest risk, both in terms of offending and overdose potential, will be managed in the same manner as those accessing services voluntarily in the community, with no fast-track provision in place.

The alcohol strategy has been central to the preventative approach of the new care model within the ICO, and therefore the budgetary reduction will likely result in a negative impact on the service's ability to keep waiting times to a minimum in line with national targets, offer extended interventions to those who may

need this approach and the ability to manage referrals from primary care, the hospital and community teams with the current level of response

Broad areas of adverse impact of this scale of funding reduction will include.

- Crime
- Anti-social behaviour / drug littering
- Domestic Abuse
- Hospital admissions
- Safeguarding children
- Avoidance of drug related / accidental deaths
- Worsening of health inequalities across Torbay.

Lifestyles Services proposed reduction of £379 – decommissioning of the service

The current proposals most significantly affect our healthy lifestyle service with a proposed reduction of £379K. This will only leave £90K within the Lifestyles service making this service unviable. The additional complexity within this service is that we are commissioned by South Devon and Torbay CCG to deliver some Lifestyle services for them. The reduction on PH funding may impact on that area of service requiring an element of redesign when the PH budget is cut. The removal of some Lifestyles Team services would result in inappropriate pressure on services commissioned by the CCG (e.g. weight-management services, chronic pain).

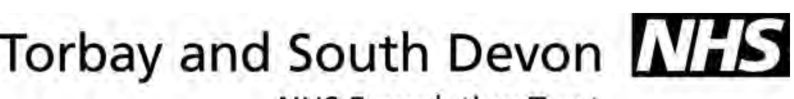
The Lifestyles team has been redesigning its services to provide support to a wider constituency. However there is a strong evidence base for one to one services in specific areas and there is evidence of effectiveness and positive feedback from service users. There is concern about potential reduction in Lifestyles service amongst allied services in the ICO such as the specialist obesity service, musculoskeletal and chronic pain services. The decommissioning of the service would result in loss of

- Information and brief advice/signposting
- Guided Self-Help/Extended Information and Brief Advice
- Health Coaching
- Specialist Intervention
- After-care, self-management

There will be risk of clinical deterioration in health status for those under specialist support programmes. Individual service users and representative groups have communicated to us their distress and concern for future service availability.

There is good evidence that present Lifestyles team services preferentially support those from disadvantaged groups. The dissolution of the Lifestyles Team as a result of this funding reduction would reverse much of that progress.

- 63.7% of referrals into weight management programmes in 2015-16 were from the top two quintiles of most deprived areas.
- 52% of stop smoking referrals in 2015-16 were either unemployed, on sickness benefit & unable to work or in routine and manual occupations.
- Audit data shows that approximately 80% of existing stop smoking clients have at least one target demographic characteristic of risk (e.g. long term condition, mental health condition, unemployed / long term sick, etc.,)



REPORT SUMMARY SHEET

Meeting Date:	7th December 2016
Title:	**Integrated Quality, Performance, Finance and Workforce Report**
Lead Director:	Ann Wagner, Director of Strategy & Improvement and Paul Cooper, Director of Finance
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Corporate Risk/ Theme	All
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

This month's Integrated Quality, Performance, Finance and Workforce report, comprising high level summary performance dashboard, narrative with exception reports, detailed data book and financial and workforce schedules provides an assessment of the Trusts position for October (month 7) 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.

Key Issues/Risks

1. Quality Framework:

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

- Never event - A wrong route administration of medication occurred in October which resulted in a patient receiving *oral* instead of intra venous sodium bicarbonate 8.4%. There was no adverse effect to the patient.
- Fractured Neck of Femur time to theatre – 69% (last month 94%) against 90% standard.
- Dementia Find – 45.1% (target 90% - 31.6% last month)
- Follow ups past to be seen date – 6,582 increase of 49 from last month

Of the remaining 15 indicators, 12 were rated GREEN, two AMBER of which one is reported a month in arrears and one is not Rag rated.

2. NHS I Compliance Framework:

The 4 hour national standard for time spent in A+E (95%) has been met in October with 95.5%. This is the first time the national standard of 95% has been met as an ICO and was previously achieved in October 2014.

Against the 12 performance indicators in total including the quarterly governance rating 3 indicators are RAG rated RED for October (5 in September):

- RTT incomplete pathways – 89.4% (89.3% last month) against the standard of 92%.
- Cancer two week wait from urgent referral – 71.9% (69.4% last month) against the standard of 93%.
- Cancer 62 day treatment from Urgent referral – 83.7% (last month 87.9%) against the standard of 85%.

Of the remaining 9 indicators, 8 were rated GREEN and the NHS I aggregate compliance framework rating is assessed as Green

3. Finance Performance Summary

Key financial headlines for month 7 to draw to the Board's attention are as follows:

- **EBITDA:** for the period to 31st October 2016 EBITDA is £4.04m. This is showing an adverse position against the PBR plan by £3.05m. Based on the Risk Share arrangement this would result in an EBITDA position favourable position of £0.61m.
- **Income and Expenditure**: The year to date income and expenditure position is £4.95m deficit which is £2.88m adverse against the PBR plan, and £0.78m favourable against the RSA plan. The Trust has a £1.2m deficit in month after STF income and risk share income has been applied.

- **CIP Programme:** CIP delivery has improved from the previous month with £5.31m delivered to date, which remains ahead of plan. Although we are seeing some improvement the level of savings planned increases significantly in the second half of the financial year. 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 Single Oversight Framework came into effect from the 1st October 2016, and the Trust has delivered a rating of 3 under the new "Use of Resource" (UOR) rating which is in line with the RSA plan (Scoring: Rating of 1 = best, Rating of 4 = poorest).

- **Cash position:** Cash balance at month 7 is £12.4m which is lower than PBR plan by £4.98m, and RSA plan £5.06m mainly due to debtors.

- **Capital**: Capital expenditure is £6.8m behind PBR plan at month 7

- **Agency Spend:** At month 7, the YTD position of agency spend is at 4.63%, 1.45% over the NHSI target cap target of 3.18%.The projected full year spend for Agency in FY 2016/17 is £9.8m 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 7 are RAG rated RED in October (7 in September) as follows:

Indicators non-compliant in October:

- Diagnostic tests – 1.7% > 6 weeks (1.7% last month) against the standard of 1.0%
- RTT waits over 52 weeks – 11 (10 last month) against 0 standard
- On the day cancellations for elective operations – 1.3% (1.0% last month) against <0.8% standard
- Ambulance handovers > 30 minutes against trajectory - 43 delays against trajectory of 25 (last month 24)
- A&E patients (ED only) – 93.4% (88.6% last month) against 95% target Note: the combined Acute and community MIU departments achieved the standard of 95%.
- Care plan summaries % completed within 24 hrs discharge weekdays 58.2% (57% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 28.4% (22.8% last month) against 60% target

Of the remaining 8 indicators, 7 were rated GREEN and one AMBER

Two indicators moving to compliant for October:

- Clinic letter timeliness – 86.4% (last month 72.7%) against the standard of 80% within 4 working days.
- Trolley waits in ED > 12 hours. Zero trolley waits > 12 hours are recorded in October.

5. Community and Social Care Framework:

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

- Number of care home placements against trajectory – 641 against trajectory of 625 permanent placements. An increase of 6 patients on last month.
- Timeliness of adult social care assessment assessed within 28 days of referral. 69.0% against a target of 70%

The CAMHS performance has not been RAG rated this month whilst a data validation exercise is completed.

Of the remaining 9 indicators, 5 were rated GREEN, 1 amber and the remaining 3 no RAG rating.

6. Change Framework

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

Finance and Investment Committee noted the increase in emergency admissions – up from 2776 to 3015 for month of October compared to previous year

7. Workforce Framework

4 indicators in total of which 1 (staff absence which is reported 1 month in arrears) is RAG rated RED as follows:

- Staff sickness / absence: The annual rolling sickness absence rate of 4.27% at the end of September 2016 represents a continuing upward trend. The target the Trust set itself was 3.90% for the end of September 2016. The rate for the month of September 2016 on its own was 4.02%, compared to 4.12% in September 2015, suggesting that over time the rolling rate will start to reduce. The Workforce and OD Group have discussed that more robust reporting and validating has contributed to the increase in the sickness absence rate. Continued activity to reduce sickness absence levels has been included in an enabling efficiency scheme in the 2017/2018 Operations Plan.

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

Recommendations:

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

Summary of ED Challenge/Discussion:

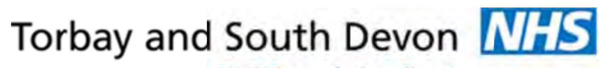
This report was reviewed by the Finance and Investment Committee (29 November), Executive Team (29th November) and Executive QA and challenge is reflected in this report.

Of particular concern is the significant overspend against budget during October, clearly indicating that the increased savings target that took effect from 1 October 2016 has not been achieved. Failure to achieve the CIP programme in full will result in the Trust not achieving its planned financial position.

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 24th November). This enables the corporate team to receive assurance, prioritise areas for improvement, consider support required and oversee action plan delivery.

Internal/External Engagement including Public, Patient and Governor Involvement: N/A
Equality and Diversity Implications: N/A

PUBLIC



Report to:	Finance Performance and Investment Committee and Trust Board
Date:	29th November 2016 and 7th December 2016
Report From:	Director of Strategy and Improvement and Director of Finance
Report Title:	Integrated Quality, Performance, Finance and Workforce Report (Month 7: October 2016)

1 Introduction

This report provides commentary against performance variances and improvements at the end of October (month 7) 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 (22nd November), Service Delivery Unit Quality and Performance Review meetings (held on 24th November) 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 Incidents Major and Catastrophic

RAG RATING: GREEN

One Major incident is reported in October (detail given below with the Never event). The migration to the single Datix Risk Management System (RMS), including incident reporting was completed on the 1st October 2016, therefore this is the first months data from the new system. Patterns of incident reporting are being observed for any noticeable trends due to the change.

2.2 Never Events

RAG RATING: RED

One Never event was reported in October. A wrong route administration of medication occurred in October which resulted in a patient receiving *oral* instead of intra venous sodium bicarbonate 8.4%. There was no adverse effect to the patient and the incident is under investigation. All correct procedure post event have been followed.

2.3 VTE assessment on admission

RAG RATING: RED

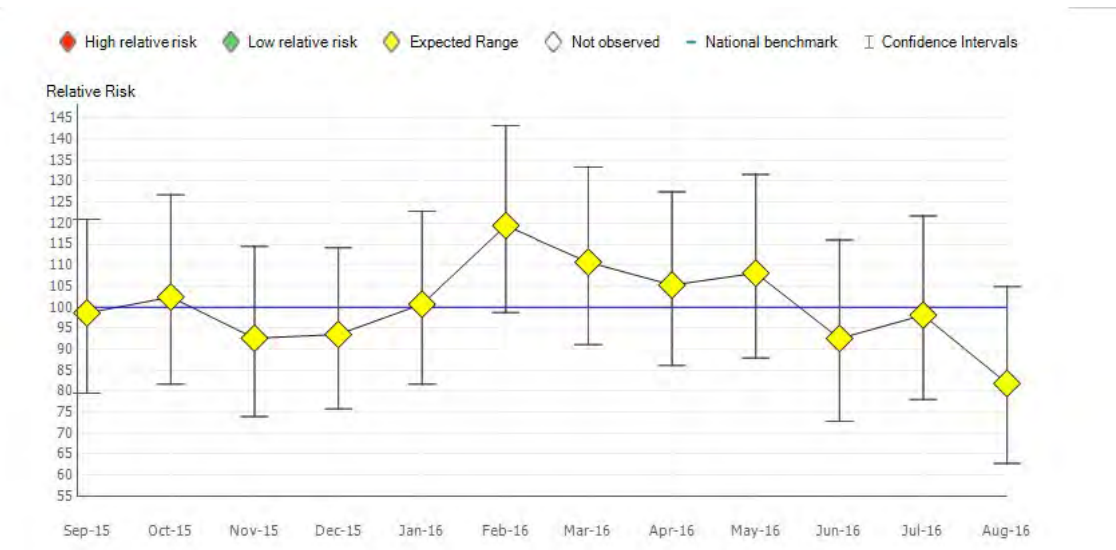
The reported performance for VTE assessment on admission for acute bed based care in October is 93.2% against the standard of 95%. The VTE support team have now ceased doing retrospective note audit of admissions where the VTE assessment has

not been captured on the discharge summary records. This will mean that the reported number of assessment will be lower than actually recorded in the notes. Improved completeness of reporting will be achieved through the roll out of the 'Nerve Centre' clinical tool. Pilot implementation on the paediatric ward is now live with two medical wards to be piloted by the New Year. Full roll out is scheduled for April 2017.

2.3 Hospital Standardised Mortality Rate (HSMR)

RAG RATING: GREEN

The Graph below shows that the benchmarked assessment of HSMR remains within the expected range.



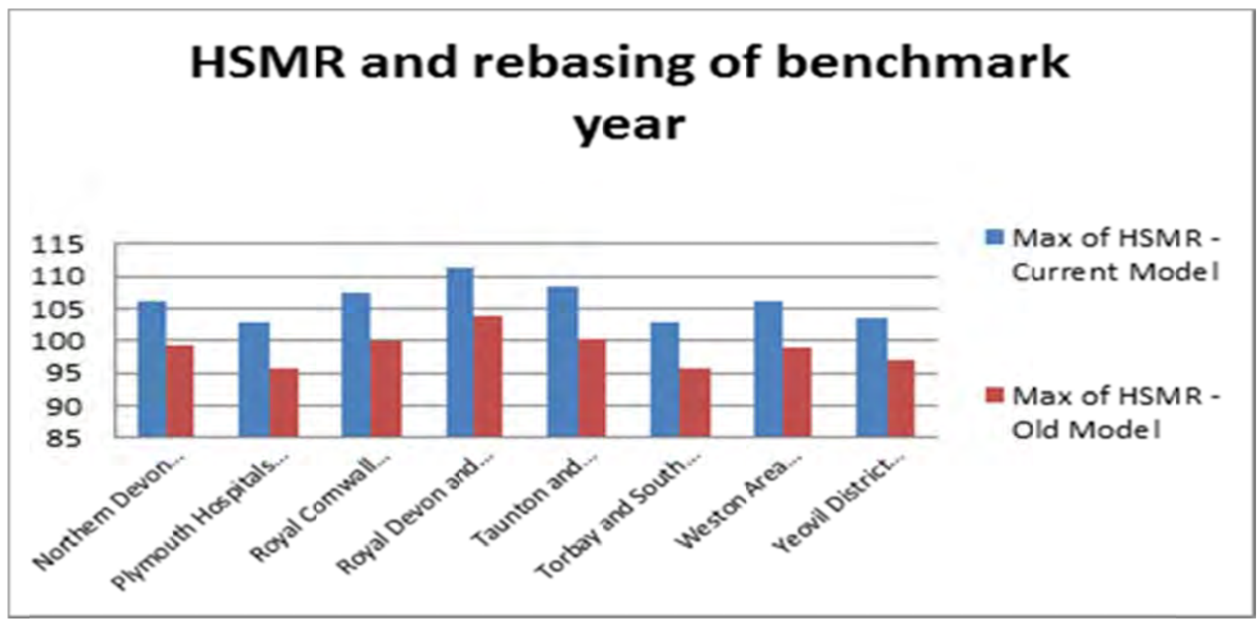
The HSMR is the measure used to show deviation against expected in hospital mortality distribution.

Once a year, Dr Foster, who we use for providing benchmarking clinical outcomes data, remodel the risks that create the benchmark figures that help project the '100' relative risk benchmark for HSMR (National average).

The reason for this is to take into account the changing patterns of in-hospital deaths and volume of admissions which alter year on year as hospitals in England improve their performance.

The remodelling is essentially resetting the national average at 100. So whilst a trust's mortality rates may be improving in absolute terms, if the improvement is significantly slower than that observed nationally, then the HSMR for the trust may not show improvement.

The chart below has been created by Dr foster to highlight how this change has impacted across the South West community. The chart looks at the SW Acute Trust peer group for the period 15/16 financial year and uses both the new benchmark year (blue or first bar) and the old 14/15 benchmark year (red or second bar) to highlight the difference.



Of the highlighted Trusts above, all have seen a rise with Plymouth Hospitals trust and ourselves rising a little over the 100 mark for the year in question. This report is to highlight the possible trend for a higher than previously seen HSMR and the explanation of why this is. The work of the Trust is to continue to ensure not just the HSMR but the SHMI remain as low as possible. This is being achieved through good clinical care, coding compliance, Mortality Surveillance Group and the specialty Mortality and Morbidity meetings.

2.4 Fracture Neck of Femur – Time to theatre < 36 hours

RAG RATING: RED

In October, 69% of patients requiring surgery reached theatre within 36 hours of admission, against the standard of 90%. The Pilot of extended trauma lists commenced in October.

2.5 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 October 45% of eligible patients were recorded as having assessments completed against the standard of 90%. This is a significant increase to the performance reported in September (32%) and is a reflection of the actions being implemented within the work plan led by the Deputy Director of Nursing and Professional Practice to improve performance. It is expected that improved performance will continue to be seen with significant improvement in the spring with roll out of the 'Nerve Centre' clinical system.

2.6 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 with 6,582 reported for October.

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. A full review of risk assessment processes and action plans has been undertaken in each of the specialties during November and is in the process of being signed off by Clinical Directors. The revised trajectories will be added into the data book when signed off by the Clinical Director.

3 NHS Improvement (NHS I) Performance Framework Indicators

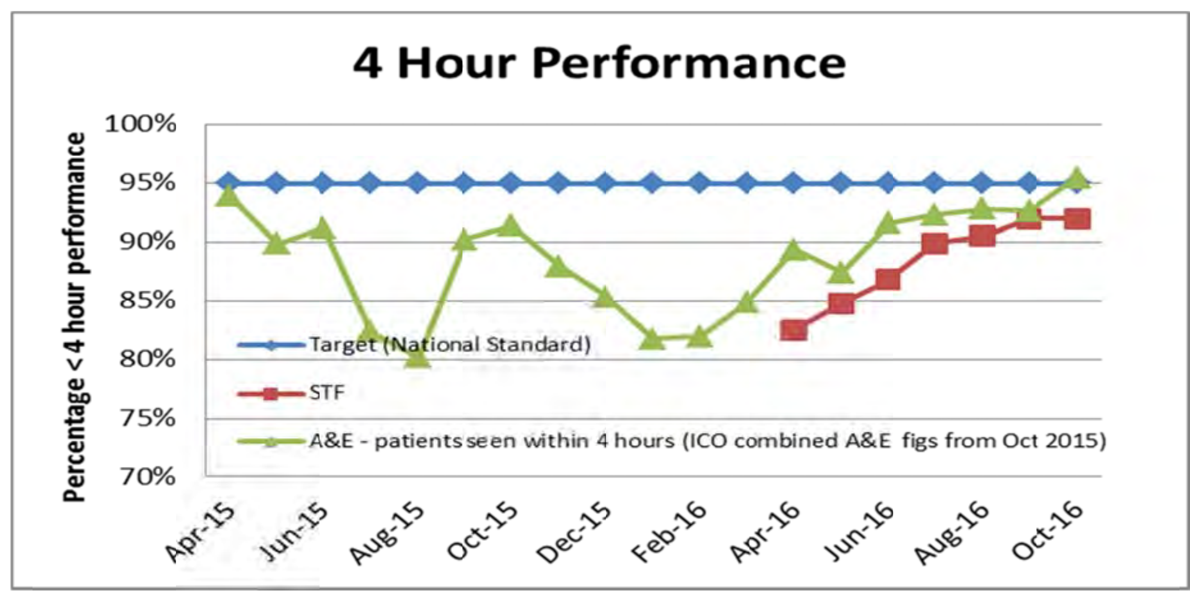
3.1 4 hour standard for time spent in A+E

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:

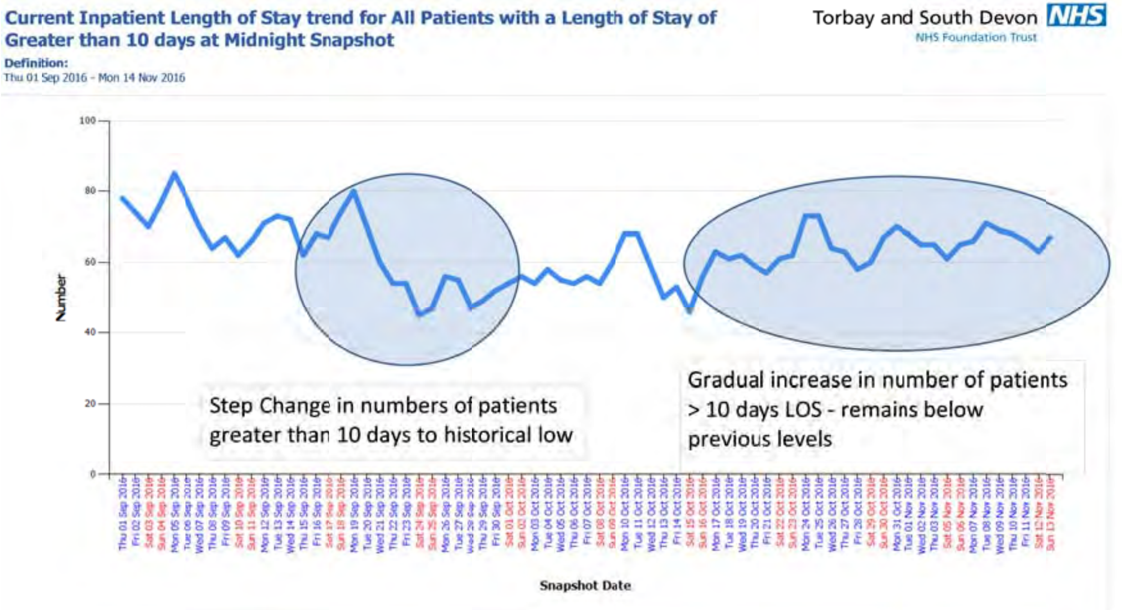
For October, the combined performance of Emergency Department (ED) and Minor Injury Units (MIUs) was 95.46%, a further improvement to that delivered in September 92.6%. This is a significant achievement and the first time that as an ICO the National standard of 95% has been received.

The following graph illustrates the delivery of improving monthly performance against the STF trajectory and the 95% National Standard;



Comments on performance and factors influencing performance against trajectory

- Monthly performance has been above the STP trajectory every month since April.
- During October the National Standard of 95% has been achieved.
- The number of patients awaiting complex care packages remains below historical levels.
- Delayed transfers of care remain at expected or lower than expected levels.
- The number of patients recorded as being in acute hospital beds with a length of stay over 10 days remains low following a step change in mid-September. Slight recent increase during October, however remains significantly below the historical level of 75-85 patients.



- The 'Bed, Ready, Go' initiative started in September is embedded and has enabled quicker transfer of patients to ward beds with the streamlined handover process.
- Discharge to assess has now been implemented across all SAFER wards.
- The new Emergency Department (ED) consultant rotas commenced on Monday 24th October. This has provided further resilience and extended senior cover particularly out of hours.

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'.

We have an increasingly clear understanding of key whole system markers that contribute to the daily delivery of the 4 hour target. When these markers are triggered escalation plans need to respond quickly and reliably to deliver the target. These markers include:

- Number of patients presenting to A+E
- Conversion rate from attendances to admission requiring hospital bed based care
- Time to triage within the department

- Time to senior medical review
- Number of discharges before 11.00am as a key marker of patient flow
- Total number of patient discharged in a day contributing to overall bed occupancy levels.
- Numbers of Delayed Transfers of Care (DTOC)
- Numbers of people in bed based care with a length of stay over 10 days

On the weekend of the 12th/13th November we recorded deteriorating performance influenced by a number of these key factors:

- Increasing numbers of patients presenting
- Increased conversion to admission
- low discharge numbers over the weekend 12th / 13th November
- a slight increase in people over 10 days length of stay in bed based care
- increased 111 activity.

Escalation plans were implemented and performance responded although it is recognised that particularly in winter months the impact of multiple deteriorating markers can present huge system challenges. It should be noted that we have continued to operate through this period with a reduced number of spaces in ED from the on-going estates improvement works that has had an impact on flow.

3.2. Referral to Treatment (RTT) incomplete pathways

RAG RATING: RED

At the end of October 89.4% 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 and recovery forecast.

Between now and March 2017 some specialties have plans in place to reduce the number of patients waiting over 18 weeks, however due to the forecast deterioration in other specialties the aggregate position is not forecast to be delivered by March 2017.

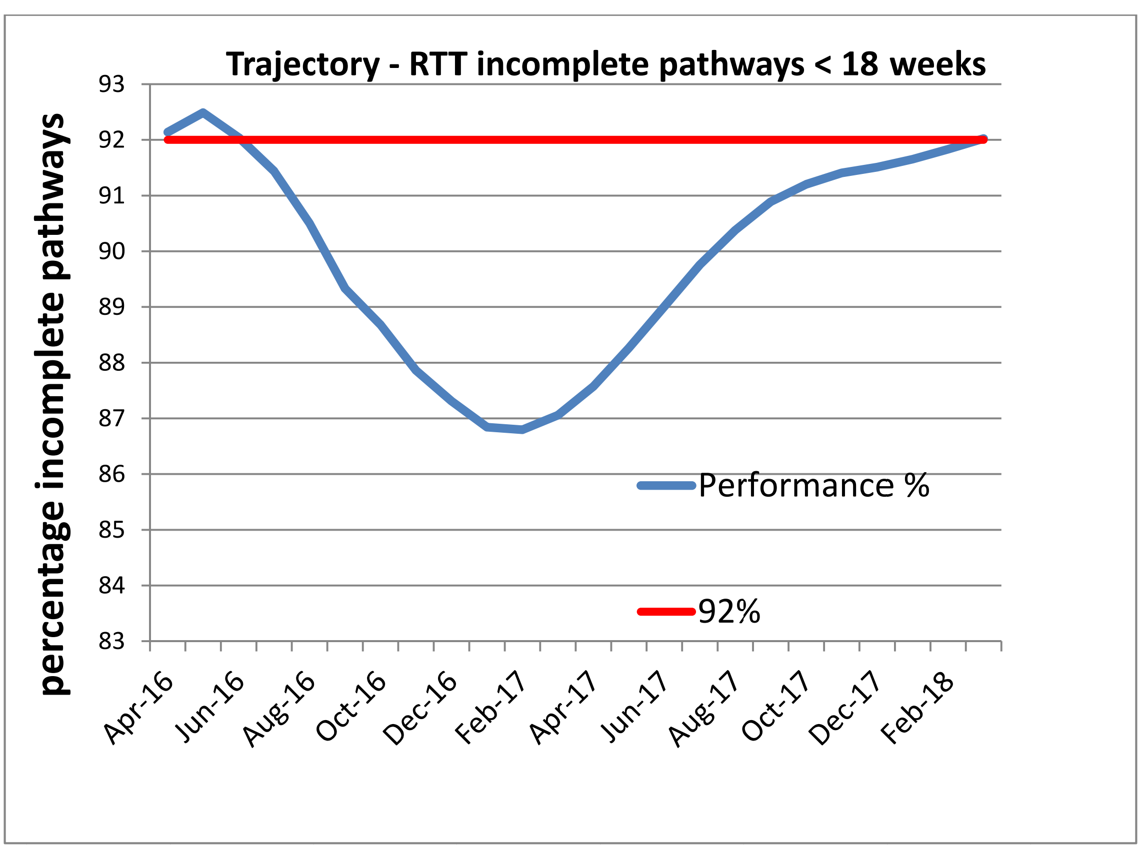
Assumptions in the current plan are;

- 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 and have therefore worked with the CCG to clarify a longer term recovery trajectory as set out below.

The recovery trajectory relies on full recruitment to vacant posts, agreed short term plans as set out above and in addition areas of service improvement and demand management that are still part on ongoing discussions with the CCG.

This trajectory for recovery to the 92% RTT standard is shown below. This shows the continued deterioration into 2017 then recovery to March 2018 once the plans to backfill lost capacity are in place.



As previous reported the Trust has an application for dispensation to adjust the 16_17 STF RTT trajectory to allow for the impact in full or in part of the deterioration in Neurology. This has not been agreed at this time and we are waiting upon information regarding the appeals process from NHSI.

Governance and monitoring: All RTT delivery plans are reviewed at the biweekly RTT and Diagnostics Assurance meeting chaired by the Chief Operating Officer (COO) with the CCG commissioning lead in attendance

3.3 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 October, there were no new cases of c-diff recorded. The cumulative number of lapses in care to the end of October for 2016/17 is 7 cases (lapse in care) and remains within the agreed trajectory.

3.4 Cancer standards

RAG RATING: AMBER

Provisional data for October is shown in the following table:

	Target	No. Seen	Breached	%
14day 2ww ref	93.0%	978	276	71.8%
14day Br Symp	93.0%	96	4	100.0%
31day 1st trt	96.0%	193	3	98.4%
31day sub drug	98.0%	82	0	100.0%
31day sub Rads	94.0%	71	2	97.2%
31day sub Surg	94.0%	31	1	96.8%
31day sub Other	-	23	0	100.0%
62day 2ww ref	85.0%	107.5	17.5	83.7%
62day Screening	90.0%	16	1	93.8%

The standards against the ‘two week wait to be seen from urgent referral’ and the ‘62 days to treatment from urgent referral’, have not been met.

The 62 day standard in October achieved 83.7% against the standard of 85% being 17.5 breaches from a total of 108 recorded treatments. (note - breaches shared with other providers count as 0.5)

This is the first time this 62 day standard from urgent referral has not been met. The breaches are spread across a number of cancer sites with two sites Urology and Lung making up the majority of the breaches. On review of the breach reasons 50% were dues to hospital capacity and process delays with the remainder due to complex pathways and patient choice. There is no single common cause to report. The latest data indicates that performance has improved in November to achieving the standard and it is forecast that the Q3 position will also be achieved.

The 2ww referrals standard achieved 71.9% against the standard of 93%. The performance has continued to be affected by the backlog in dermatology following the previously reported increase in referral over August and September; the current forecast is to achieve the standard to see urgent referrals within 2 weeks from 1st January 2017.

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 has been 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 indicated this revision of the plan is 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. The Trust is awaiting a response to this request.

On 7th 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.

4.1 Summary of Financial Performance

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	PbR Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Income & Expenditure							
Income	230.80	236.48	5.68	2.65	3.03	2.09	↑
Operating expenses	(223.71)	(232.44)	(8.73)	(6.31)	(2.42)	(0.53)	↑
EBITDA	**7.09**	**4.04**	**(3.05)**	**(3.67)**	**0.61**	**1.56**	↓
Non-operating revenue	0.63	0.45	(0.18)	0.00	(0.18)	0.17	↓
Non-operating expenses	(9.79)	(9.44)	0.35	0.00	0.35	0.15	↑
Surplus / (Deficit)	**(2.06)**	**(4.95)**	**(2.88)**	**(3.67)**	**0.78**	**1.87**	↓

As at 31 October 2016, the Trust is reporting a £4.95m deficit. This is £2.88m behind the original PbR based plan; at EBITDA level £3.05m adverse variance. Financial performance is better than the revised RSA based plan at both EBITDA, (by £0.61m) and surplus / deficit (by £0.78m) levels.

Within this position, income is ahead of plan by £5.68m based on the PbR plan, and £3.03m based on the RSA plan. Under the terms of the RSA an additional £5.84m 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, 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 At this point the commissioners have not taken the benefit of a 50% share of the Q2 STF. Total STF income received to date is £3.21m.
Operating expenses are showing an adverse position against PBR plan of £8.73m, and £2.42m against the RSA plan.

4.2 Income

	Year to Date - Month 07			Plan Changes		Previous Month	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Income by Category							
Healthcare (Acute and Community)	173.93	173.56	(0.38)	(1.70)	1.32	1.29	↑
Social Care	32.39	32.20	(0.19)	(0.72)	0.53	0.45	↑
Other Income	24.47	24.88	0.41	0.01	0.40	0.57	↓
Risk Share Agreement (RSA) Income	0.00	5.84	5.84	5.05	0.78	(0.23)	↑
Total	**230.80**	**236.48**	**5.68**	**2.65**	**3.03**	**2.09**	↑

Healthcare Income is behind the RSA plan by £0.20m (excluding STF income). This is an improvement of £0.1m in month. The adverse variance on the Acute income is £0.20m. Most of the variance relates to SD&T CCG. The local CCG contract is £0.15m behind plan as a result of penalties being applied through the RSA. The remaining adverse variance of £0.05m is split across other Commissioners.

The Trusts local CCG block adjustment stands at £6.9m (£5.8m at M6), which is £2.5m above the planned adjustment. (see the bottom of Schedule 1 tab). This is mainly as a result of over performance of Non Electives (£2.4m offset by £0.3m increase in the Emergency Adjustment). The remaining over performance is within adult critical care and pass through drugs, offset by under performance in both Elective and Day Case activity.

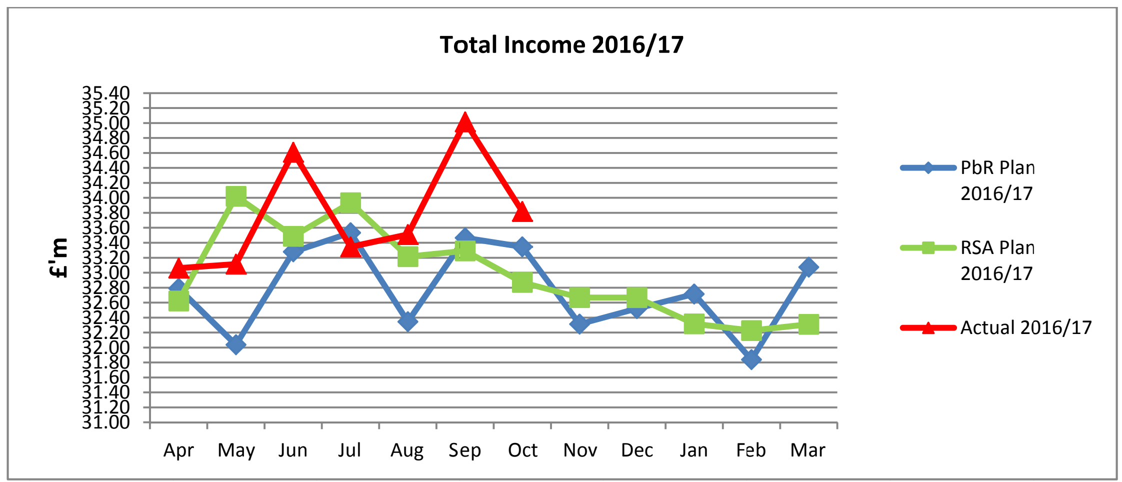
STF funding of £3.21m in total has been received and included in the year to date figures. A total of £6.7m is planned under the PbR arrangements for the full year, but was reset at £1.675m in the RSA plan after publication of the rules for receipt by NHS Improvement, with this phased into quarter one to reflect expected achievement. An additional £1.535m has been achieved at 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 £0.19m, and favourable position against the RSA plan of £0.53m. This is mainly the result of additional Public Health income being received for the Drug and Alcohol Service of £0.56m. 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 £0.03m.

Other income is £0.41m higher than the PBR Plan and £0.40m higher than the Risk Share plan. This is made up mainly of a favourable variance of miscellaneous revenue (£0.08m), reflecting phasing of care model income, and smaller favourable variances in private patient income (£0.11m), R&D / education (£0.18m), site services (£0.05m). This is offset by a marginal adverse variance in revenue from non patient services £0.03m.

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

The graph below shows income to date at month 7 against both the PBR and RSA plan.



4.3 Operating Expenditure

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Total Operating Expenses Included in EBITDA							
Employee Expenses	130.75	133.34	(2.59)	1.74	(0.86)	(0.31)	↑
Non-Pay Expenses	92.65	98.59	(5.94)	4.58	(1.36)	(0.05)	↑
PFI / LIFT Expenses	0.31	0.52	(0.20)	0.00	(0.20)	(0.18)	↑
Total	**223.71**	**232.44**	**(8.73)**	**6.31**	**(2.42)**	**(0.53)**	↑

Total Operating Expenditure included in EBITDA is £8.73m higher than the original plan showing an adverse position. Based on the RSA plan this is reduced to an adverse variance of £2.42m.

Pay

Pay budgets are, in total showing an over-spend of £1.74m against the PbR plan and £0.31m against the RSA plan.

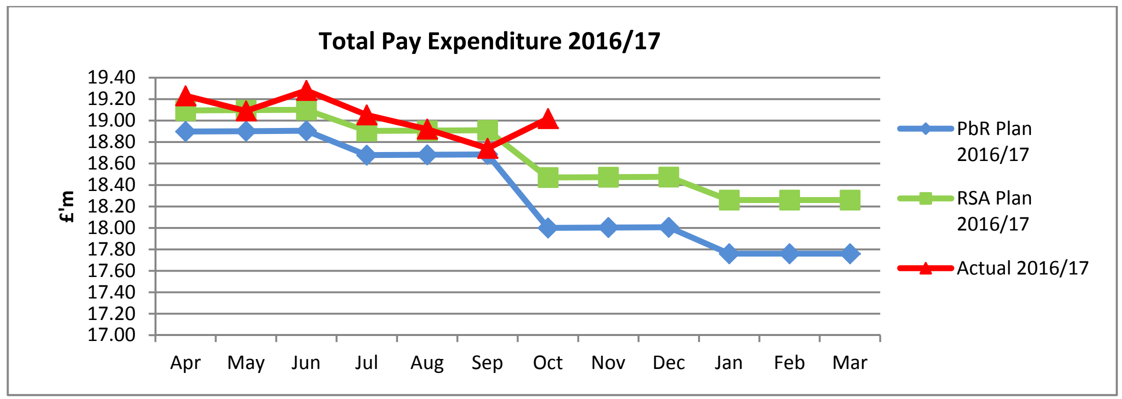
From the previous month agency and bank costs have increased by £0.01m and £0.10m respectively, with an increase in substantive costs of £0.16m. Despite run rates reducing between July and September, collectively the rate of spend in October has increased by £0.27m from the previous month, mainly in Medicine, Pharmacy Manufacturing, Women and Child's Health substantive pay costs.

At Service Delivery Unit level we continue to see overspends, particularly in Medicine which is £2.71m overspent against the RSA plan, mainly as a result of agency and bank 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 £0.70m in Obstetrics & Gynaecology, Lab Medicine and Child Health largely associated with locum, bank and agency costs. Surgical Services are showing overspends in General Surgery, Ophthalmology and Theatres £0.41m mainly due to

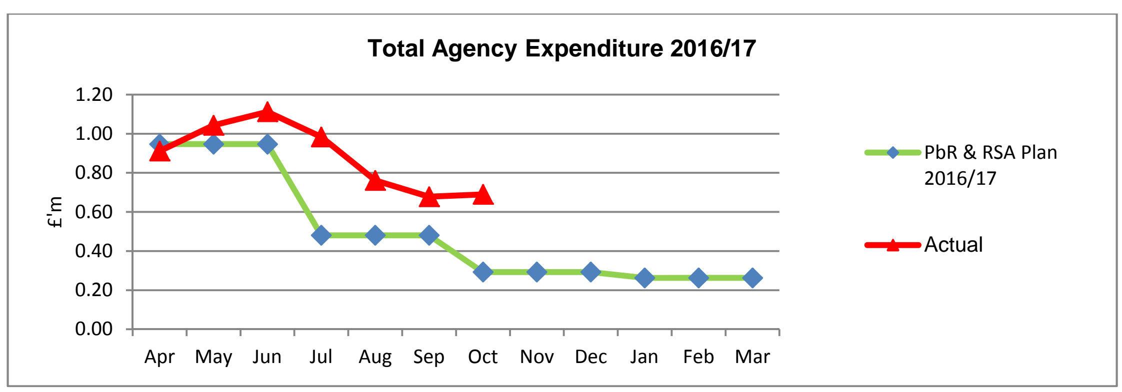
agency costs. Estate and Facilities management also have pay overspends of £0.21m mainly in agency and bank costs for hotel services. Adult Social Care is also showing an overspend in pay of £0.63m due to the majority of their CIP target, which was allocated to this category, being yet to be delivered.

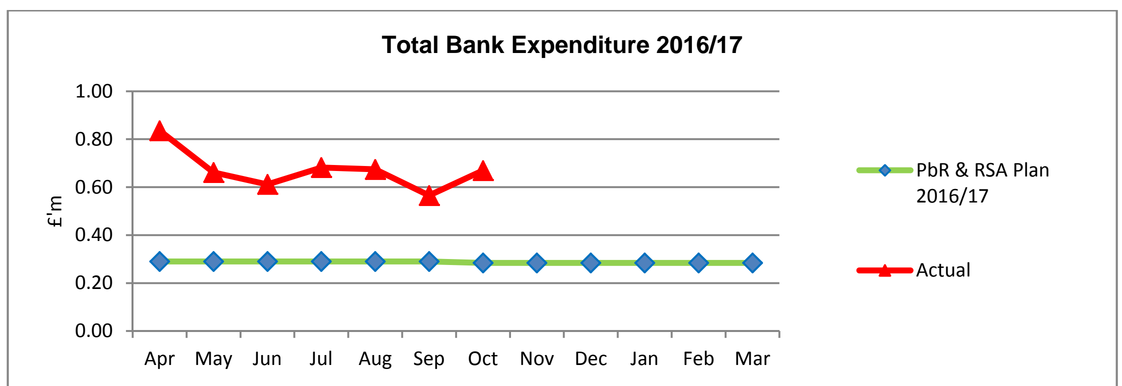
There are off-setting pay underspends in Community Services reflecting vacancies across both Torbay and Southern Devon (£1.11m),Community Hospitals (£0.15m), Torbay Pharmaceuticals (£0.13m), HQ and Corporate services of £2.36m, mainly in reserves (£1.94m), with the balance due to savings in HIS (£0.29m), Pharmacy (£0.23m) and Strategy (£0.13m).

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 7, the YTD position of agency spend is at 4.6%, 1.4% over the NHSI target cap target of 3.2%. A detailed analysis and Improvement Plan can be seen in **Schedule 3**.

Nursing agency run rate at M7 is £0.26m, lower than the last couple of months due to further 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 £6.2m.

The projected full year spend for Agency in FY 2016/17 is £9.8m 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 £5.94m, and £1.36m 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 £0.67m at month 7 against RSA plan. The run rate of spend has decreased in month 7 compared to the previous month by £0.05m mainly in Medicine, Women and Children's health, and Surgical services, offset by an increase in Pharmacy manufacturing. The main areas of overspend however are in Torbay Pharmaceuticals, Medicine, and Women and Children's Health.

Non pass through drugs are overspent £0.40m with the majority in Surgical Services (£0.19m).

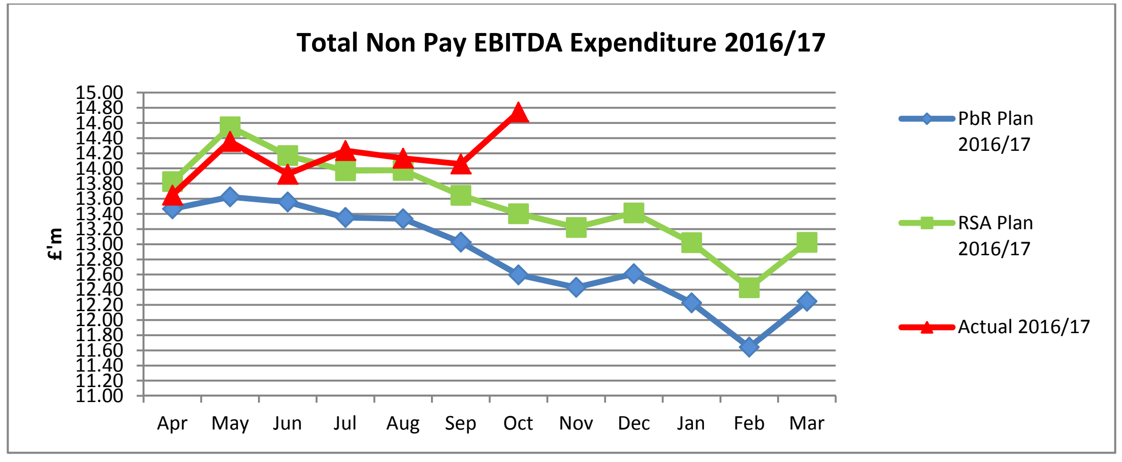
Pass through drugs, bloods and devices are £0.47m over spent against RSA plan. This is neutral to the overall income and expenditure position as additional income is received from NHSE to match these costs.

There is marginal overspend on non clinical supplies of £0.11m.

Miscellaneous costs are underspent against the RSA plan by £0.3m. Within this position there are overspends in outsourcing of £1.04m; being £0.92m in Surgery and £0.07m in Women's and Child's Health; and an Adult Social Care overspend of £0.37m. This is offset by underspends in premises costs (£0.84m), Purchase of Health Care services (£0.23m) and other miscellaneous, operational and discretionary costs (£0.32m),mainly due to the release of central reserves.

PFI/LIFT expenses are showing an overspend against plan of £0.20m. 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. **Appendix 3** gives details of schemes.

4.4 Non-operating Expenses

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non-Operating Expenses							
Donations & Grants	0.54	0.14	(0.40)	0.00	(0.40)	(0.06)	↑
Depreciation & Amortisation	(6.27)	(5.85)	0.42	0.00	0.42	0.24	↑
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	0.09	0.06	(0.04)	0.00	(0.04)	(0.03)	↑
Gains / (Losses) on Asset Disposals	0.00	0.25	0.25	0.00	0.25	0.25	↔
Interest cost	(1.81)	(1.80)	0.01	0.00	0.01	0.01	↔
Public Dividend Capitals	(1.51)	(1.29)	0.22	0.00	0.22	0.19	↑
PFI Contingent Rent	(0.19)	(0.21)	(0.02)	0.00	(0.02)	(0.02)	↔
Corporation Tax expense	(0.01)	(0.01)	0.00	0.00	0.00	0.00	↔
Total	**(9.15)**	**(8.99)**	**0.17**	**0.00**	**0.17**	**0.32**	↓

Depreciation is £0.42m 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 £0.22k 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

	2016-17 Position					Memo: 2017-18 Effect of 16-17 Schemes	
	Year to Date - at Month 07			Previous Month YTD			
	Plan £m	Actual £m	Variance £m	Variance £m	Change	Actual £m	Variance £m
Schemes Delivered to Date M1 to M7							
Delivered Schemes : Recurrent	4.20	2.92	1.28	-0.50	↓		
Delivered Schemes : Non-Recurrent	0.00	2.39	-2.39	-1.78	↑		
Delivered Schemes : Total	**4.20**	**5.31**	**-1.11**	**-2.27**	↓		
Full Year (Month 1 to 12) Forecast (Risk adjusted) Delivery							
Forecast Schemes : Recurrent 16/17 (See note, below)	13.90	6.11	7.79	5.81	↓	6.11	7.79
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	4.00	-4.00	-2.33	↑	0.00	0.00
Total Full Year End forecast Delivery	**13.90**	**10.12**					
Forecast 2016-17 Yr end delivery variance			**3.78**	**3.80**	↑		
Forecast delivery variance of 2016-17 schemes in 2017-18						**9.81**	**4.09**

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.

At the close of Month 7, we have cumulatively delivered £1.11m in excess of the £4.2m target. This represents a £1.16m decline in the Cumulative position, compared to last month's £2.27 cumulative surplus. This is predominantly due to a stepped increase in way the £13.9m current year CIP budget is phased across the financial year, to reflect that CIP delivery is usually higher towards the latter part of the year. This budgetary phasing may not necessarily reflect the timing of our actual CIP delivery but it will have an adverse effect on our overall Month 7 I&E position. Nonetheless, the Forecast year end shortfall position remains unchanged, with a £3.8m shortfall, against the £13.9 Target.

During the month, there was a reduction in recurrent year end delivery and an increase in non-recurrent delivery. This was due to the reclassification of a £1.650m CIP scheme (from recurrent to non-recurrent) associated with the reclassification of a provision CIP scheme.

Although the year end forecast remains a strong CIP position to be in, part way through the year, the outstanding gap needs to be closed and the perennial challenge

to reduce dependency on non-recurrent schemes forms the objective behind the following improvement plan

The graph below shows the full year CIP target, and CIP achieved as at month 7

4.6 Balance Sheet

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non-Current Assets							
Intangible Assets	10.47	8.18	(2.30)	(0.40)	(1.89)	(1.35)	↓
Property, Plant & Equipment	158.06	153.54	(4.53)	(7.14)	2.61	1.85	↑
On-Balance Sheet PFI	17.09	16.76	(0.34)	(0.20)	(0.14)	(0.12)	↓
Other	1.89	2.10	0.21	(0.24)	0.46	0.44	↑
Total	**187.52**	**180.57**	**(6.95)**	**(7.98)**	**1.04**	**0.81**	↑
Current Assets							
Cash & Cash Equivalents	17.43	12.45	(4.98)	0.08	(5.06)	(3.47)	↓
Other Current Assets	22.93	32.46	9.54	1.81	7.73	5.84	↑
Total	**40.35**	**44.91**	4.56	**1.90**	**2.66**	**2.37**	↑
Total Assets	**227.87**	**225.48**	**(2.39)**	**(6.09)**	**3.70**	**3.18**	↑
Current Liabilities							
Loan - DH ITFF	(6.67)	(6.28)	0.39	0.21	0.18	0.21	↓
PFI / LIFT Leases	(0.72)	(0.64)	0.08	0.09	(0.01)	(0.01)	↔
Trade and Other Payables	(29.85)	(33.24)	(3.40)	(0.46)	(2.93)	(1.33)	↓
Other Current Liabilities	(1.63)	(1.87)	(0.23)	(0.04)	(0.20)	(0.03)	↓
Total	**(38.87)**	**(42.03)**	**(3.16)**	**(0.21)**	**(2.95)**	**(1.17)**	↓
Net Current assets/(liabilities)	**1.48**	**2.88**	1.40	**1.69**	**(0.29)**	**1.20**	↓
Non-Current Liabilities							
Loan - DH ITFF	(63.94)	(63.94)	0.00	0.17	(0.16)	(0.23)	↑
PFI / LIFT Leases	(20.16)	(20.58)	(0.42)	(0.42)	0.00	(0.05)	↑
Other Non-Current Liabilities	(3.97)	(3.73)	0.24	0.03	0.20	0.15	↑
Total	**(88.07)**	**(88.25)**	**(0.18)**	**(0.22)**	**0.04**	(0.14)	↑
Total Assets Employed	**100.93**	**95.20**	(5.73)	**(6.52)**	**0.79**	1.88	↑
Reserves							
Total	**100.93**	**95.20**	(5.73)	**(6.52)**	**0.79**	1.88	↑

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 £0.6m favourable, largely due to depreciation being lower than plan.
- Cash is £5.1m adverse to plan, largely due to other current assets being £7.7m higher than plan, partly offset by current liabilities £3.0m higher than Plan.
- Other Current Assets are £7.7m higher than plan. Significant elements include: Q2 STF income £1.5m; NHS England income paid in arrears £1.9m; RSA

Debtor above plan £0.8m; NEW Devon MIU income £0.6m; increase in stock £0.4m; 2015/16 income adjustments £0.3m.

- Trade and other payables are £2.9m higher than Plan. Significant elements include: payments not collected by NHSLA £2.5m, partly offset by capital creditor lower than planned £1.1m.

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	16.96	10.17	(6.79)	10.17	10.17	0.00	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. Two loan applications for the Emergency Department and Theatres Phase 1 schemes have been submitted to the Independent Trust Financing Facility in November 2016. A third loan application for the Electronic Document Management System will be submitted in the next few weeks. These loan applications are planned to support elements of the planned 2016/17 capital program as well as future years' cash requirements. In parallel with the loan application process, 'downside' plans have been developed in the event that these loan applications are unsuccessful using a Quality Impact Assessment process.

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; along with strong management of agency and variable staffing cost 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 10% under plan, up from 9% last month and non-electives 7% over plan, down from 8% last month. The main specialties underperforming in inpatients are upper GI, gynaecology and clinical oncology. 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 1.9% over plan (3.2% last month). This over performance is despite continued underperformance in certain specialties, specifically neurology and respiratory. The main areas of over performance are ophthalmology, orthopaedics and dermatology. Follow ups are 0.5% over plan (1.9% last month) and again orthopaedics is the main contributor, along with ophthalmology and medical oncology. 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 on 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 and tariffs are more appropriate than the application of a PBR tariff, or national tariffs have not been set. 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. Three of the four monitored standards have not been achieved in October. The peer comparisons are shown in Appendix 3.

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
4 hour standard trajectory (standard 95%)	82.5%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Performance against plan / standard	89.4%	87.4%	91.6%	92.3%	92.80%	92.60%	95.46%					
RTT - incomplete pathways trajectory (standard 92%)	90.9%	91.2%	91.3%	92.02%	92.6%	92.9%	93.1%	93.2%	93.2%	93.1%	93.3%	93.3%
Performance against plan / standard	92.1%	92.5%	92.0%	91.46%	90.50%	89.34%	89.40%					
Diagnostics < 6 weeks wait trajectory (standard 99%)	98.91%	98.98%	98.96%	99.01%	99.0%	99.0%	99.2%	99.2%	99.2%	99.2%	99.2%	99.1%
Performance against plan / standard	88.50%	99.10%	98.85%	99.03%	99.35%	98.25%	98.32%					
Cancer 62 day trajectory (standard 85%)	96.0%	92.5%	85.9%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.0%	86.4%	85.2%
Performance against plan / standard	87.6%	90.4%	92.38%	87.92%	88.48%	87.26%	83.72%					

Notes:

- A+E / MIU (type 1 and 2) waiting times < 4 hours (Target trajectory for October 92.0% achieved 95.46%) - **Achieving trajectory and National standard**
- RTT % patients waiting under 18 weeks (Target trajectory for October 93.1%) – **Trajectory and standard not met in October (89.4%)**
- Diagnostic waiting times < 6 weeks (Standard 99.0%) - Planned delivery of 99% from July. **Standard not met in October (98.32%)**
- Cancer 62 day referral to treatment (Standard 85% some months vary due to low planning numbers) - **Standard not met in October (83.72%)**

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

RAG RATING: RED

At the end of October, 11 patients are recorded as waiting over 52 weeks for treatment. Last month 10 patients were waiting over 52 weeks. All of these 11 patients are waiting for inpatient admission for surgery within Upper GI surgery.

It is noted that 8 of these patients were also waiting and recorded in last month's report. Prioritisation of long waiting patients is in place in cases of needing to cancel admissions due to bed pressures, has been agreed.

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)

RAG RATING: AMBER

The Q2 CQUIN submissions have been made to commissioners. The self-assessment against the 12 schemes in the South Devon and Torbay CCG contract is that 3 are Amber and the remainder Green. Against the 'Amber' schemes it is forecast that any underachievement in Q2 can be recovered in subsequent months for achieve full

delivery. It is noted that the CCG CQUIN schemes are included as part of the overall risk share agreement.

Against the specialist commissioning contract the CQUIn schemes have been difficult to fully define and sign off. We now have 3 agreed schemes and all are on track with baseline assessments complete and monitoring against progress for Q3 and Q4 in place against agreed trajectories.
The 3 schemes are

1. Reducing delays in transfer from ITU to general wards > 4 hours and 24 hours from being fit and ready for transfer.
2. Dose banding of oral chemotherapy drugs in line with published National Dose banding tables.
3. Bluetec devices – establishment of a process for commissioner approval against specified high cost devices.

5.4 Diagnostic tests waiting over 6 week

RAG RATING: RED

In October, 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 48 were in MRI.
The MRI service has an increasing number of patients waiting (667) and this is some 200 above the level needed for a compliant 6 week wait maximum waiting time. The service is under pressure from a combination of increased demand, increasing complexity of scans being requested and staffing issues including vacancies and sickness impacting on the ability to run additional lists.
In November, additional capacity has been arranged with a mobile MRI unit visiting Torbay Hospital for 5 days, this could remove 90 patients from the list. MRI capacity seems to be a national problem and the availability of mobile units is limited and future availability is a constraint as well as the limited casemix that can be outsourced to the mobile MRI scanner.
It is forecast that the MRI waiting list will not reduce significantly and allow the 6 week standard to be achieved until February 2017.

5.5 Ambulance handover delays > 60 minutes

RAG RATING: AMBER

In October three patients are reported against this standard, the last 4 months has seen low levels or no patients reported.

5.6 Cancelled operations

RAG RATING: RED

Operations cancelled on the day of admission by the hospital remain above the national standard of 0.8% with 1.3% (42 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 October all patients requiring admission following cancellation were re-admitted within 28 days of cancellation.

Reason for cancellation October 2016	
No Op time	9
Trauma / Priority patient	12
Workforce (sickness)	13
No bed	0
process / equipment	8
Total	42

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 October 58.0% (target 77%) were sent to GPs within 24 hours on weekdays and 29% (target 60%) on the weekends.

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 Timeliness of Adult Social Care assessments within 28 days of referral
RAG RATING: RED

In October, 69% of patients referred received social care assessments within 28 days against the standard of 70%. Performance is monitored and issues escalated through the community SDU board.

6.2 Delayed discharges.
RAG RATING: GREEN

In October the number of community hospital bed days lost due to patients being delayed in their discharge was recorded as 180 days.

Month (2016)	Acute	Non-Acute	Total
APRIL	8	351	**359**
MAY	58	166	**224**
JUNE	52	355	**407**
JULY	70	422	**492**
AUGUST	92	425	**517**
SEPTEMBER	52	110	**162**
OCTOBER	61	180	**241**

7. Workforce Key Performance Indicators

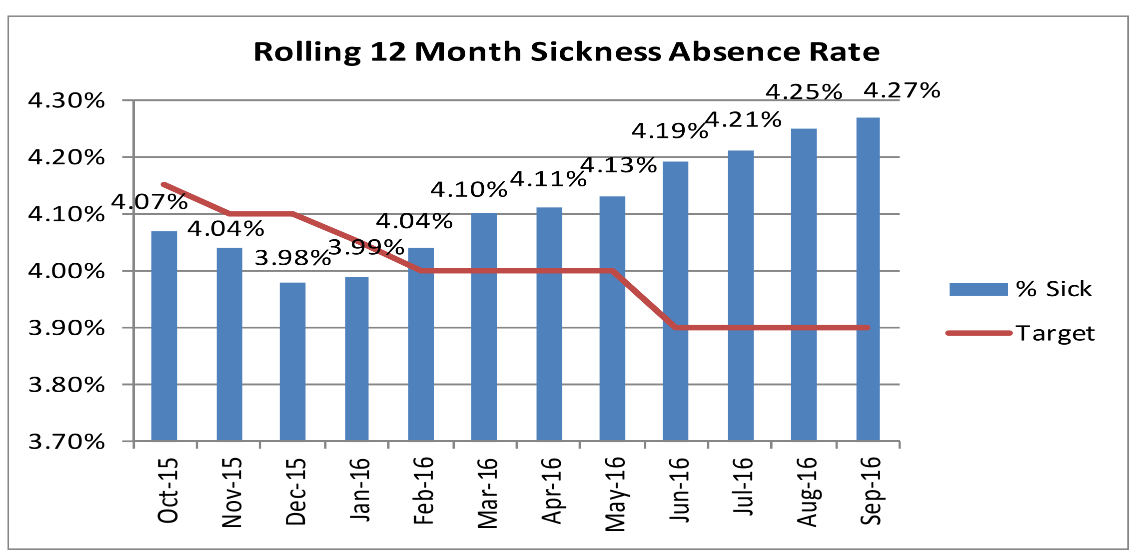
Performance against a wide range of workforce key performance indicators is reported at service delivery unit and department level to all managers. These key performance indicators are subject to review at the Trusts performance review meetings and with HR Managers. **Appendix 4** provides a detailed 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

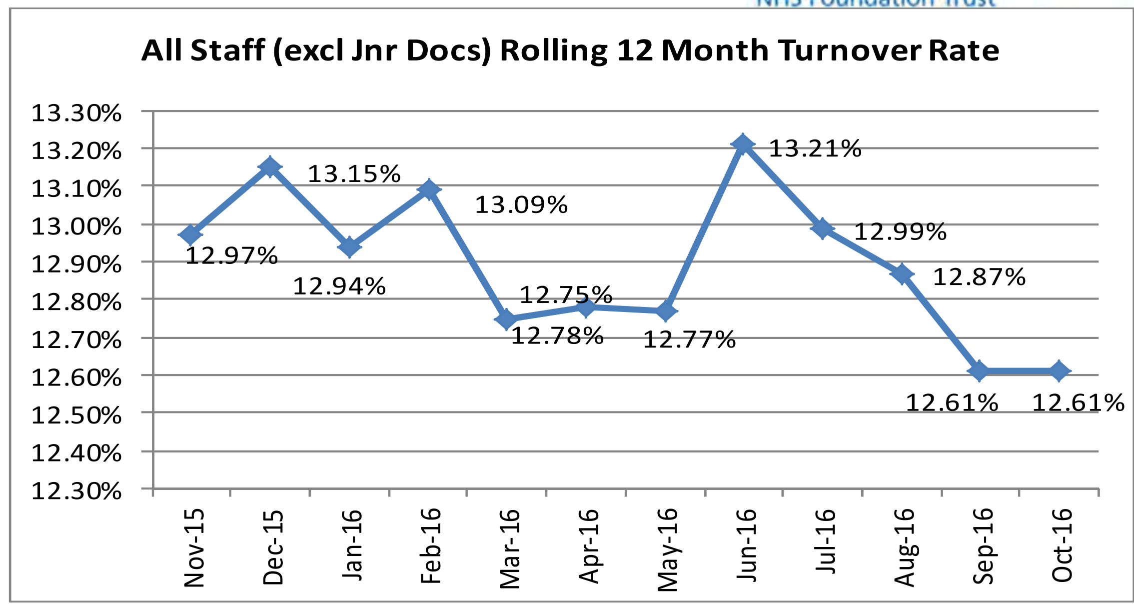
The graph below shows that the annual rolling sickness absence rate of 4.27% at the end of September 2016 represents a continuing upward trend. The target the Trust set itself was 3.90% for the end of September 2016. The rate for the month of September 2016 on its own was 4.02%, compared to 4.12% in September 2015, suggesting that over time the rolling rate will start to reduce. The Workforce and OD Group have discussed that more robust reporting and validating has contributed to the increase in the sickness absence rate. Continued activity to reduce sickness absence levels have been included in an enabling efficiency scheme in the 2017/2018 Operations Plan including:

- Revised, streamlined attendance policy
- Earlier identification/intervention in long term sickness
- Return to work initiatives
- Management refresher training
- Wellbeing initiatives

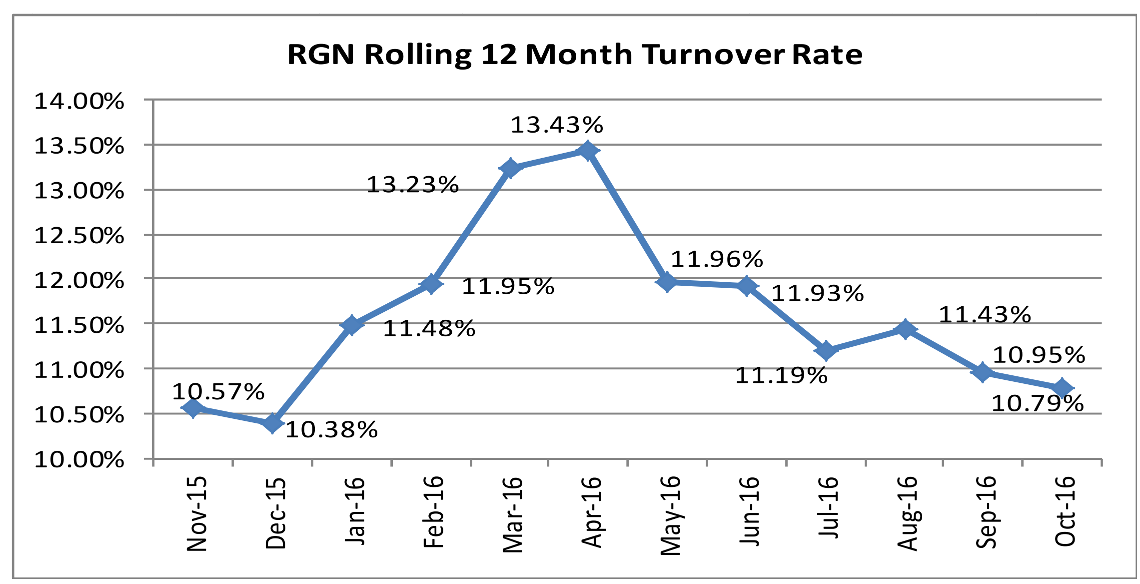


7.3 Turnover (excluding Junior Doctors)
RAG RATING: GREEN

The graph below shows that the Trusts turnover rate of 12.61% in October 2016 remains within the target range of 10% to 14%. Never the less the recruitment challenge to replace leavers from key staff groups remains significant.



This recruitment challenge includes Registered Nurses due to the supply shortage as reported elsewhere and for which the Trust has a long term capacity plan to address. The decreasing turnover rate for this staff group as shown below indicates that it is a supply issue rather than one of retention.

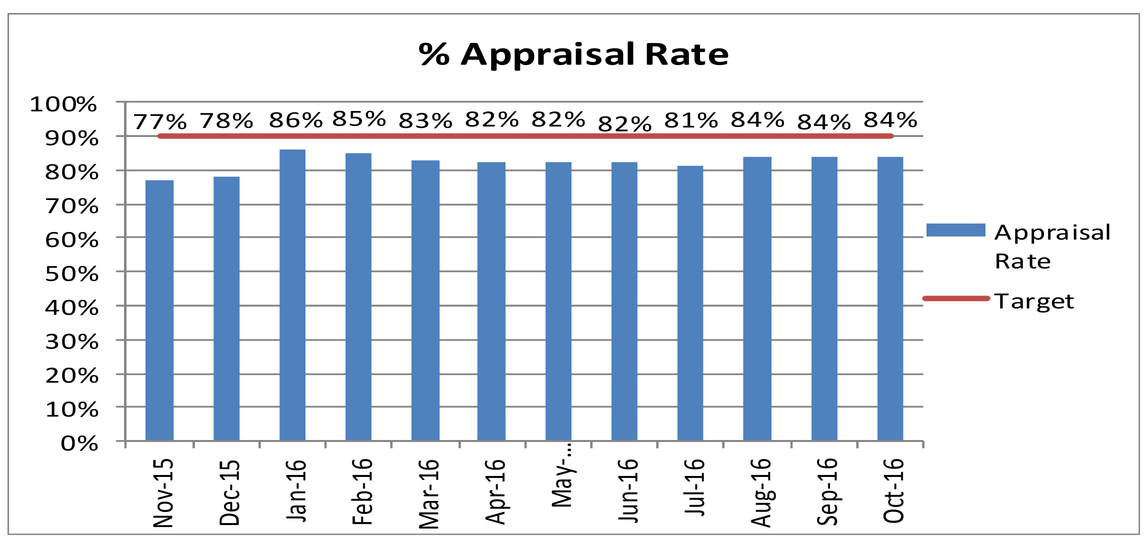


7.4 Appraisal Rate

RAG RATING: AMBER

The graph below shows that appraisal rate of 84% has remained at this level for three months and is below the target of 90%. In order to keep appraisal compliance on the agenda of managers, they currently receive monthly workforce reports detailing compliance. In addition, workforce KPIs which include appraisal rates, are a standard agenda item for discussion at senior manager meetings in the Trust and are incorporated into Divisional/Directorate reports.

A number of additional actions have now been agreed by the Workforce and OD Group including direct communication from the CEO seeking assurance plans, promoting the training and BUZZ conversation, including at All Managers meetings, targeting by occupational groups as well as Divisions.



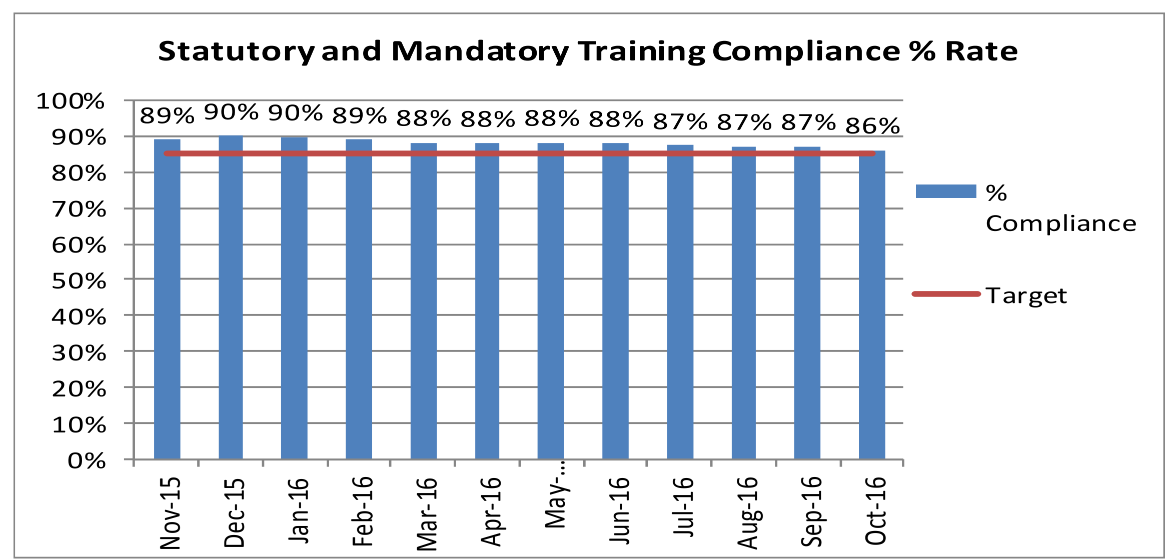
7.5 Statutory and mandatory training Compliance

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 86% is a decrease from previous months. Individual modules that remain below their target are detailed in the table below:

Module	Target	Performance
Information Governance Training	95% or above	86%
Fire Training	85% or above	82%
Infection Control	85% or above	82%
Manual Handling	85% or above	84%

In addition to continuing activity to contact low compliant areas and offer support to increase their compliance rates refresher periods for some staff groups have been changed. Non-clinical staff will only be required to refresh their infection control training every 2 years and a minimal clinical moving and handling patient course is being introduced for staff groups who only complete a small amount of moving and handling. A new Information Governance Buzz film will enable staff to complete all their yearly updates via e-learning or buzz films in 2017.



8. Supporting documents

Appendix 1: Month 7 Quality, Performance and Finance Dashboard
Appendix 2: Month 7 Quality and Performance Data book including financial schedules
Appendix 3: CIP portfolio
Appendix 4: Workforce KPI by SDU / Department

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
QUALITY FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		96.5%	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%	96.7%
1	Reported Incidents - Major + Catastrophic *	<6		2	2	3	2	0	1	4	5	2	4	0	1	1	17
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		2	0	0	3	4	5	0	2	1	1	1	1		6
1	Never Events	0		0	0	0	0	0	0	0	0	0	0	0	0	1	1
1	SIRI - Reportable incidents	0							14	7	9	4	4	3	4	1	32
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		1	2	1	2	2	0	2	0	0	0	0	0	0	2
1	Formal Complaints - Number Received *	<60		31	35	27	37	43	32	29	42	40	24	37	35	29	236
1	VTE - Risk assessment on admission - (Acute)	>95%		96.2%	96.1%	95.8%	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%	93.2%	93.6%
1	VTE - Risk assessment on admission - (Community)	>95%		91.7%	100.0%	100.0%	98.7%	88.8%	90.4%	92.5%	92.9%	91.2%	92.2%	97.5%	97.6%	100.0%	94.0%
1	Medication errors resulting in moderate to catastrophic harm	0					0	0	0	2	1	0	0	0	1	0	4
1	Medication errors - Total reported incidents (trust at fault)	N/A					46	40	47	42	46	39	63	38	27	34	289
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%		94.6%	84.8%	86.4%	92.8%	111.0%	98.4%	96.7%	94.5%	92.0%	98.0%				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%	96.5%	100.2%
1	Safer Staffing - ICO - Nightime (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%	93.1%	96.2%
1	Infection Control - Bed Closures - (Acute) *	<100		54	92	36	12	57	38	236	56	68	28	34	6	24	452
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		85.7%	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.3%	69.2%	78.9%
1	Stroke patients spending 90% of time on a stroke ward	>80%		79.0%	85.0%	82.0%	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%	94.9%	80.0%
1	Dementia - Find - monthly report	>90%		74.4%	73.5%	65.5%	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	29.2%	31.6%	45.1%	35.3%
1	Follow ups 6 weeks past to be seen date	3500		4731	4542	5090	5291	4938	5732	6082	6073	6219	6601	6919	6533	6582	6582

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

NOTES

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

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

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
NHS I COMPLIANCE GOVERNANCE																	
1	Overall Quarterly NHS I Compliance Framework Score	N/A				2			2	2	1	1	2	3	4	3	
1	A&E - patients seen within 4 hours [STF]	>95%		91.4%	87.9%	85.3%	81.8%	82.0%	84.9%	89.4%	87.4%	91.6%	92.3%	92.9%	92.6%	95.5%	91.7%
	A&E - trajectory [STF]	>92%		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%	92.0%
1	Referral to treatment - % Incomplete pathways <18 wks [STF]	>92%		91.5%	91.2%	90.8%	91.2%	91.4%	91.8%	92.1%	92.5%	92.0%	91.4%	90.5%	89.3%	89.4%	89.4%
	RTT Trajectory [STF]			90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	91.2%	91.3%	92.0%	92.6%	92.9%	93.1%	93.1%
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<18 (year)		0	1	0	0	0	0	1	1	1	2	1	1	0	7
1	Cancer - Two week wait from referral to date 1st seen	>93%		98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.4%	71.9%	88.3%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	100.0%	95.8%	97.9%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	95.2%	98.5%	97.2%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	98.9%	100.0%	99.7%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.4%	97.3%	96.5%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	96.9%	95.4%
1	Cancer - 62-day wait for first treatment - 2ww referral [STF]	>85%		86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.9%	83.7%	88.4%
1	Cancer - 62-day wait for first treatment - screening	>90%		100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%	93.8%	95.0%

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
NHS I COMPLIANCE FINANCIAL SUSTAINABILITY																	
4	Capital Service Cover	2				1			1	4	4	4	4	4	4	4	4
	Capital Service Cover - Plan									1	1	1	1	1	1	4	4
4	Liquidity	3				4			4	1	1	1	1	2	2	2	2
	Liquidity - Plan									4	4	4	4	3	3	2	3
4	I&E Margin	4				1			1	4	4	4	4	4	4	4	4
	I&E Margin - Plan									1	1	1	1	1	1	3	3
4	I&E Margin Variance From Plan	3				4			3	2	2	1	2	2	2	3	3
	I&E Margin Variance From Plan - Plan									3	3	3	3	3	3		
4	Overall Financial Sustainability Risk Rating	3				2			2	3	3	3	3	3	3	3	3
	Overall Financial Sustainability Risk Rating - Plan									2	2	2	2	2	2	2	2
4	Agency metric	3								3	3	4	4	4	4	3	3
FINANCE INDICATORS																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)									241	86	499	-950	-823	-361	-3053	
4	Agency - Variance to NHSI cap									-1.23%	-2.06%	-2.39%	-2.00%	-1.87%	-1.56%	-1.45%	
4	CIP - Variance from PBR plan - cumulative (£'000's)									-116	-281	1010	800	2381	1685	1114	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)									1189	2686	3113	3699	3104	4195	6792	
4	Distance from NHSI Control total (£'000's)									329	1095	375	-354	320	14	-1902	
4	Risk Share actual income to date cumulative (£'000's)									985	2180	2485	3504	4156	4505	5836	

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

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

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
CONTRACTUAL FRAMEWORK																	
1	Diagnostic tests longer than the 6 week standard [STF]	<1%		0.4%	0.8%	1.1%	2.8%	1.0%	1.6%	1.5%	0.9%	1.1%	0.9%	0.7%	1.7%	1.7%	1.2%
	Diagnostic trajectory [STF]			1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.02%	1.04%	0.99%	0.97%	0.95%	0.84%	0.84%
1	RTT 52 week wait incomplete pathway	0		1	1	2	3	5	4	4	6	5	11	8	10	11	11
1	Mixed sex accomodation breaches of standard	0		1	0	0	0	0	1	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<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%	1.3%	1.2%
1	Cancelled patients not treated within 28 days of cancellation *	0		0	2	3	2	9	10	4	9	6	9	3	4	0	35
1	Ambulance handover delays > 30 minutes	0		42	103	75	113	234	170	102	111	37	54	36	24	43	407
	Handovers > 30 minutes trajectory *			50	50	50	50	50	50	50	40	35	25	20	20	25	215
1	Ambulance handover delays > 60 minutes	0		2	2	5	2	35	16	26	6	0	1	2	3	3	41
1	A&E - patients seen within 4 hours DGH only	>95%		87.8%	83.3%	79.7%	74.6%	74.4%	77.8%	84.5%	81.2%	87.2%	88.3%	88.7%	88.6%	93.4%	87.4%
1	A&E - patients seen within 4 hours community MIU	>95%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	3	1	13	10	1	2	0	0	0	0	2	0	4
1	Number of Clostridium Difficile cases - (Acute) *	<3		1	2	1	0	1	3	1	4	2	2	3	2	0	14
1	Number of Clostridium Difficile cases - (Community)	0		0	0	1	1	0	0	0	1	2	1	0	0	0	4
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		62.4%	61.8%	55.0%	58.5%	58.5%	54.0%	63.6%	56.2%	59.4%	51.2%	54.8%	57.0%	58.2%	57.0%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		26.7%	30.2%	23.8%	35.3%	22.0%	24.6%	25.0%	22.4%	35.0%	20.4%	24.0%	22.8%	28.4%	25.3%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		59.1%	72.7%	77.3%	72.7%	77.3%	86.4%	81.8%	72.7%	81.8%	81.8%	81.8%	72.7%	86.4%	79.9%

NOTE

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

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges *	2216 (full year)		211	467	327	325	415	338	351	188	594	411	425	110	180	2259
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		69.9%	71.0%	67.0%	68.8%	68.8%	68.9%	85.7%	78.7%	72.1%	72.9%	73.7%	69.5%	69.0%	69.0%
3	Clients receiving Self Directed Care	>90%		92.8%	92.5%	92.7%	92.1%	92.9%	93.6%	92.5%	91.6%	91.2%	91.1%	91.7%	91.7%	92.3%	92.3%
2	Carers Assessments Completed year to date	40% (Year end)		32.1%	35.9%	38.2%	41.2%	42.8%	43.3%	5.9%	11.9%	18.6%	21.9%	25.2%	28.5%	30.0%	30.0%
	Carers Assessment trajectory			23.3%	26.7%	30.0%	33.3%	36.7%	40.0%	3.3%	6.7%	10.0%	13.3%	16.7%	20.0%	23.3%	23.3%
3	Number of Permanent Care Home Placements	<=617 (Year end)		645	630	636	637	640	635	628	624	626	614	626	635	641	641
	Number of Permanent Care Home Placements trajectory			640	638	636	634	632	630	634	632	631	629	628	626	625	625
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		216	216	212	174	147	139	131	137	131	117	126	140		156
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET				303			451			39					39
3	% OCU in Effective Drug Treatment (reported quarterly in arrears)	NONE SET				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%	100.0%	100.0%
1	Bed Occupancy	80% - 90%		90.3%	92.7%	92.4%	94.8%	92.5%	91.9%	92.8%	89.8%	86.4%	92.7%	90.2%	92.6%	92.7%	92.7%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%								89.3%	85.9%	93.7%	90.8%	80.0%	83.0%	92.8%	92.8%
CHANGE FRAMEWORK																	
3	Number of Emergency Admissions - (Acute)			2776	2760	2708	2609	2740	2945	2797	2974	2947	3078	2935	2997	3015	20743
3	Average Length of Stay - Emergency Admissions - (Acute)			3.2	3.4	3.5	3.5	3.3	3.4	3.7	3.3	3.2	3.0	3.4	3.3	2.9	3.2
3	Hospital Stays > 30 Days - (Acute)			17	18	21	21	28	29	35	34	26	21	26	24	15	181

Corporative Objective		Target 2016/2017	13 month trend	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Year to date 2016/17
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears)	<3.8%		4.10%	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%		4.27%
2	Appraisal Completeness	>90%		80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%	84.00%	84.00%
2	Mandatory Training Compliance	>85%		89.00%	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%	86.00%	86.00%
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%	12.61%	12.61%

Performance & Quality Databook

Month 7 October 2016

Contents

Quality Framework
Harm Free 4
Reported incidents - Major & Catestrophic 4
Avoidable new pressure ulcers - category 3 and 4 4
Never events and SIRI 5
Quality Effectiveness Safety Trigger Tool (QUEST) 5
Written complaints 5
VTE Risk assessment on admission 6
Medication errors 6
Hospital Standardised Mortality Rate (HSMR) 7
Safer Staffing Levels 7
Infection control - bed clossures 8
Fracture neck of femur - best practice 8
Fracture neck of femur - surgery within 36 hours 8
Stroke patients spending 90+% of time on stroke ward 9
Dementia - Find 9
Follow ups past to be seen date 9

NHS I compliance
A&E and MIU 4 hour performance 11
Referral to treatment, incomplete pathways 11
Clostridium difficile - lapse in care 11
Cancer two week wait referrals 12
Cancer breast symptomatic referrals 12
Cancer 31 day 1st treatment 12
Cancer 31 day subsequent treatment - drug 13
Cancer 31 day subsequent treatment - radiotherapy 13
Cancer 31 day subsequent treatment - surgery 13
Cancer 62 day treatment from 2ww 14
Cancer 62 day treatment from screening 14

Finance framework and schedules
Schedule 1 - Income analysis 16
Schedule 2 - Employee expenses 17
Schedule 3 - Agency spend 18
Schedule 4 - Non pay expenses 19
Schedule 5 - Cash flow 20
Schedule 6 - Capital 21
Schedule 7 - Contract Activity and Income Analysis 22

Contractual framework
Diagnostic tests waiting longer than 6 weeks 24
Referral to treatment >52 week incomplete pathways 24
Mixed sex accomodation breaches 24
Cancellations - on the day 25
Cancellations - patients not treated with 28 days of cancellation 25
Ambulance handovers 25
A&E 4 hour performance 26
MIU 4 hour performance 26
A&E trolley waits 26
Clostridium difficile cases 27
Care plan summaries 27
Clinic letters 28

Workforce Management Framework
Staff vacancy rate 30
Staff sickness 30
Staff appraisals 30
Mandatory training 31
Turnover 31

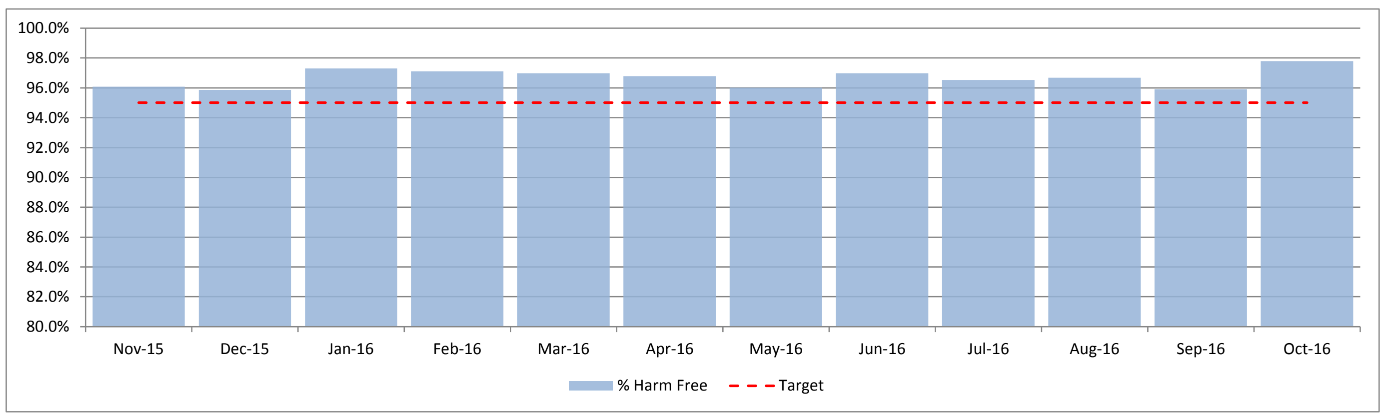
QUALITY FRAMEWORK

Month 7 October 2016

QUALITY FRAMEWORK

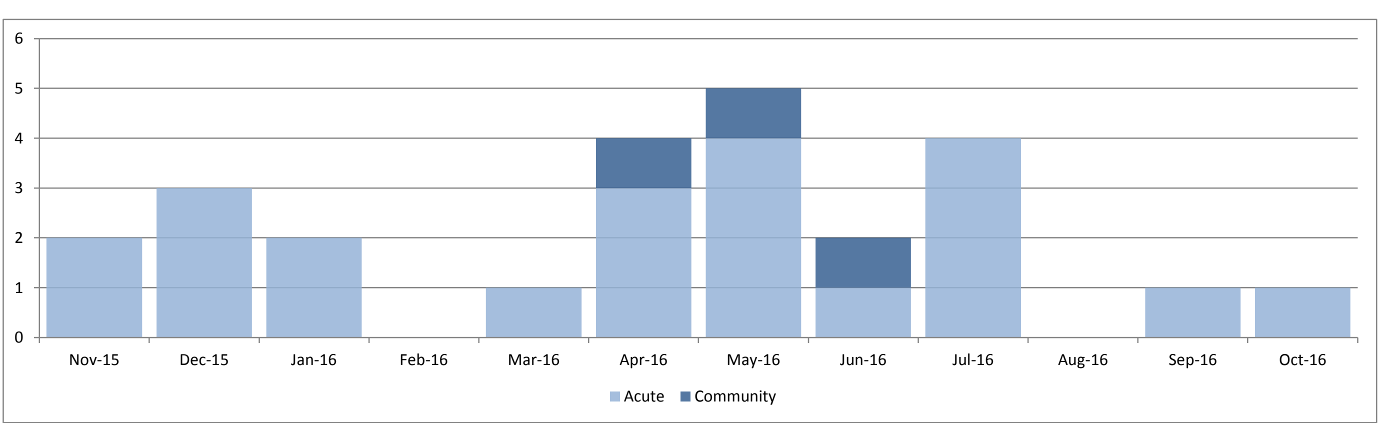
Harm Free - Trust Total

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients		994	1109	1075	1057	1027	1056	1093	1040	1083	1027	997
Harm Free		953	1079	1044	1025	994	1014	1060	1004	1047	985	975
% Harm Free	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



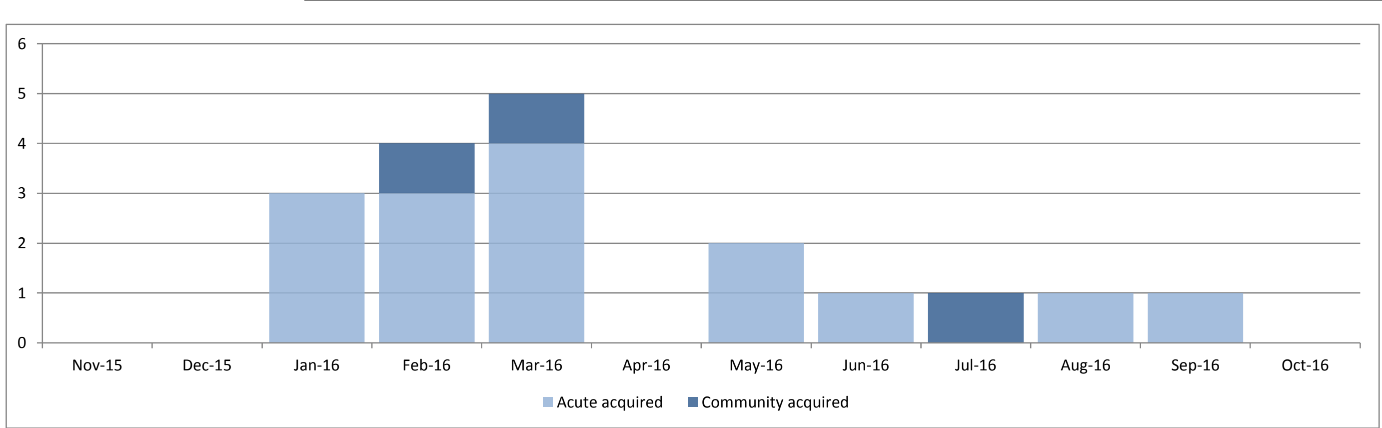
Reported Incidents - Major and Catastrophic

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



New Pressure Ulcers - Categories 3 and 4 (avoidable)

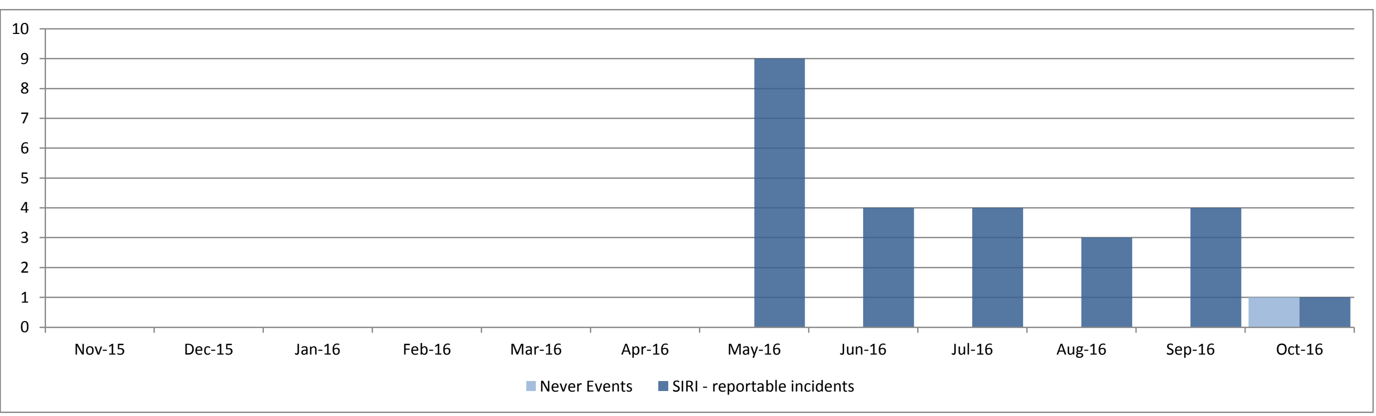
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute acquired	0	0	3	3	4	0	2	1	0	1	1	
Community acquired	0	0	0	1	1	0	0	0	1	0	0	



QUALITY FRAMEWORK

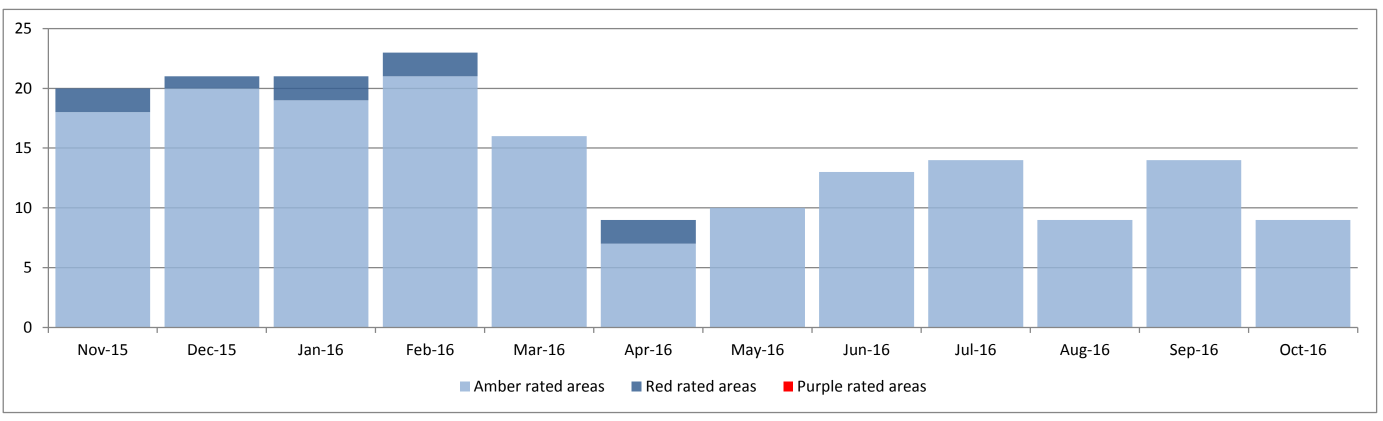
Never events & SIRI

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Never Events	0	0	0	0	0	0	0	0	0	0	0	1
SIRI - reportable incidents							9	4	4	3	4	1



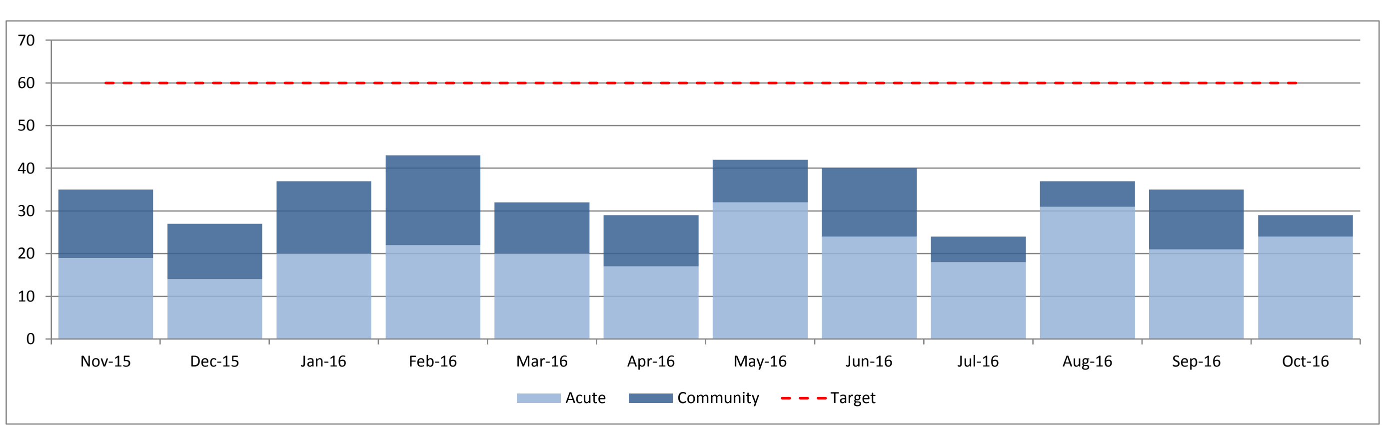
Quality Effectiveness Safety Trigger Tool (QUEST)

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



Formal complaints

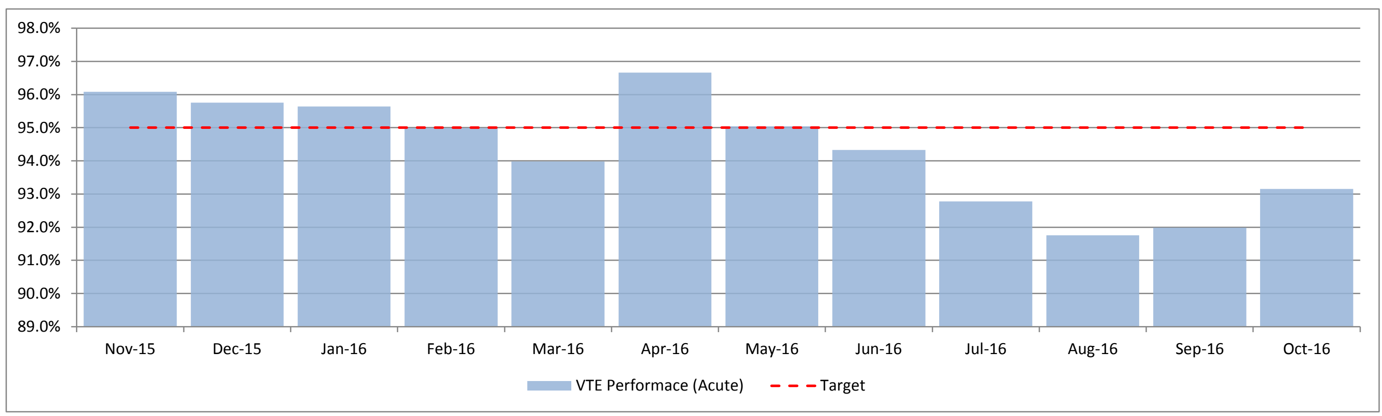
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	19	14	20	22	20	17	32	24	18	31	21	24
Community	16	13	17	21	12	12	10	16	6	6	14	5
Total	35	27	37	43	32	29	42	40	24	37	35	29
Target	60	60	60	60	60	60	60	60	60	60	60	60



QUALITY FRAMEWORK

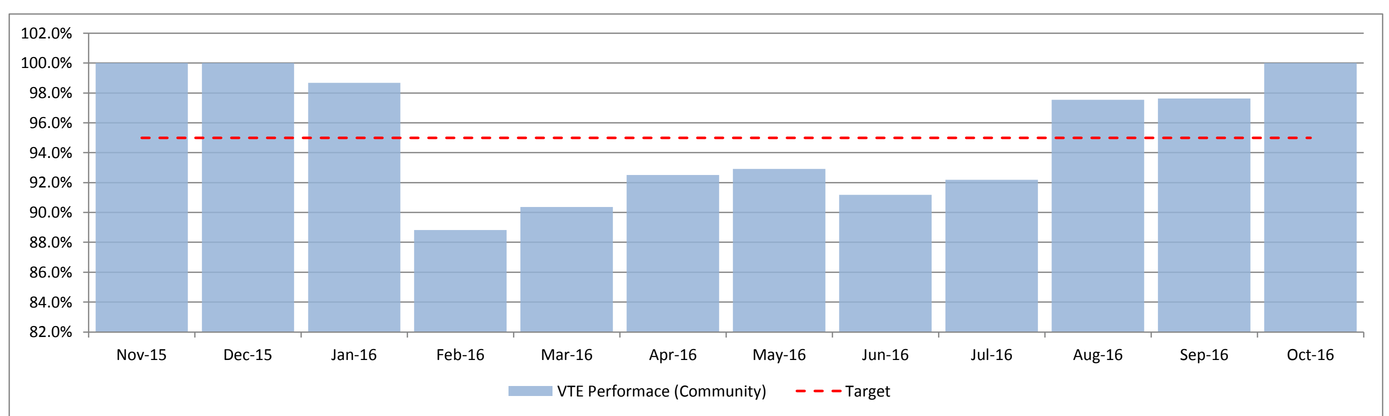
VTE Risk assessment on admission - (Acute)

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
VTE Numerator	5593	5352	5653	5424	5573	5591	5883	5885	5757	5651	5737	5798
VTE Denominator	5821	5589	5911	5710	5930	5784	6190	6239	6205	6159	6237	6224
VTE Performace (Acute)	96.1%	95.8%	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%	93.2%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



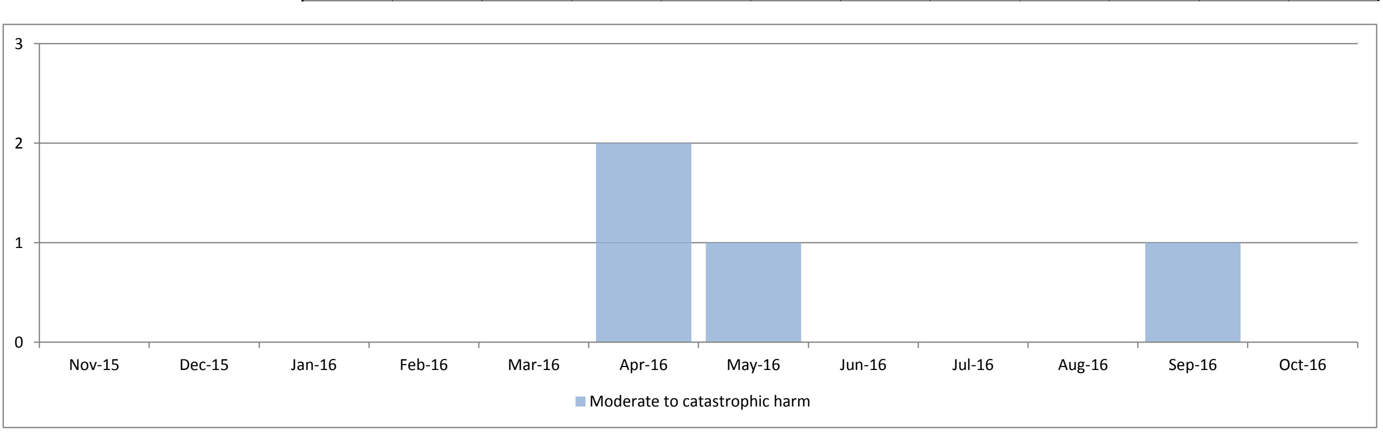
VTE Risk assessment on admission - (Community)

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



Medication Errors Resulting in Moderate to Catastrophic Harm

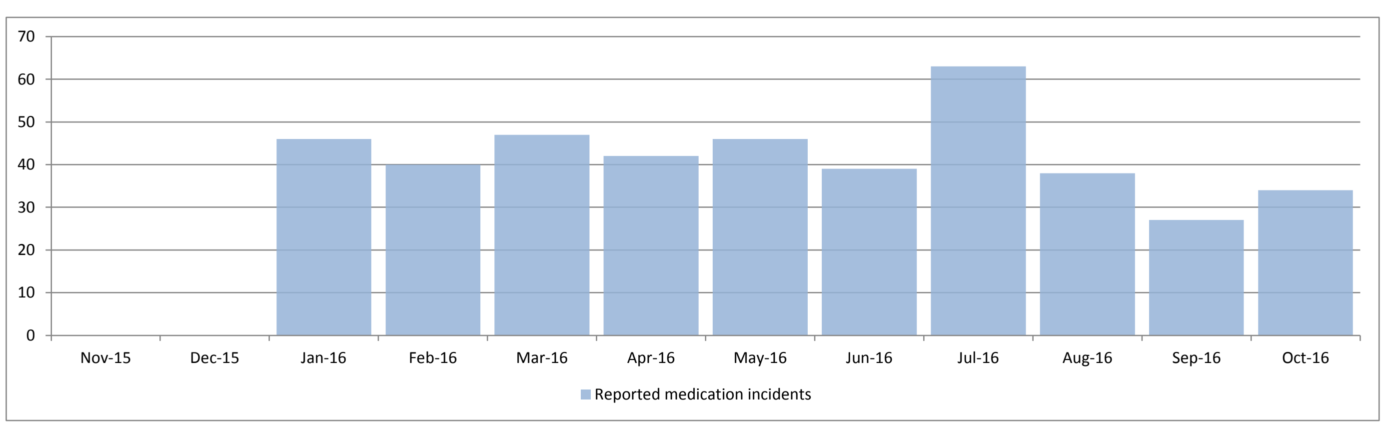
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Moderate to catastrophic harm	n/a	n/a	0	0	0	2	1	0	0	0	1	0



QUALITY FRAMEWORK

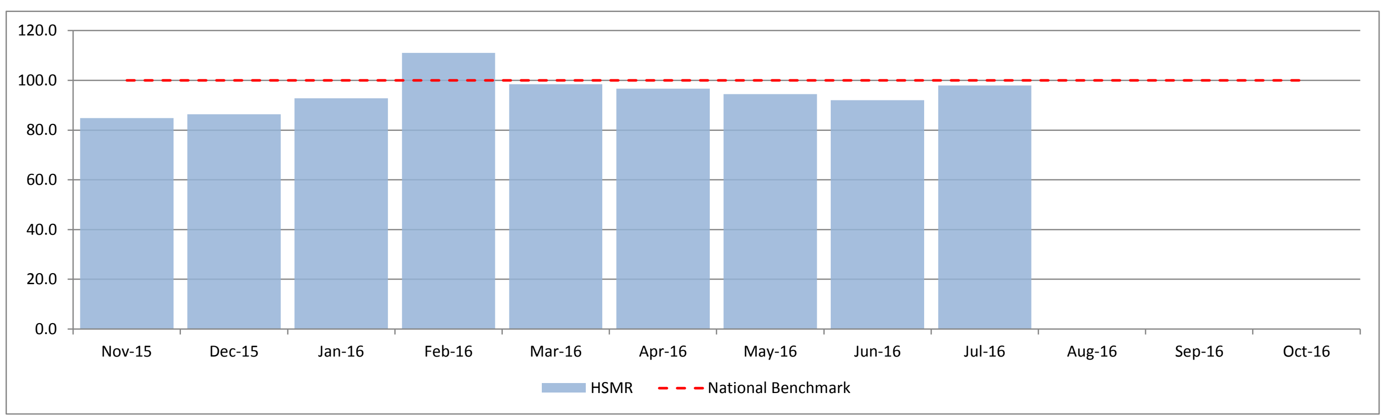
Medication Errors - Reported incidents (trust at fault)

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Reported medication incidents	n/a	n/a	46	40	47	42	46	39	63	38	27	34



Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
HSMR	84.8	86.4	92.8	111.0	98.4	96.7	94.5	92.0	98.0			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100



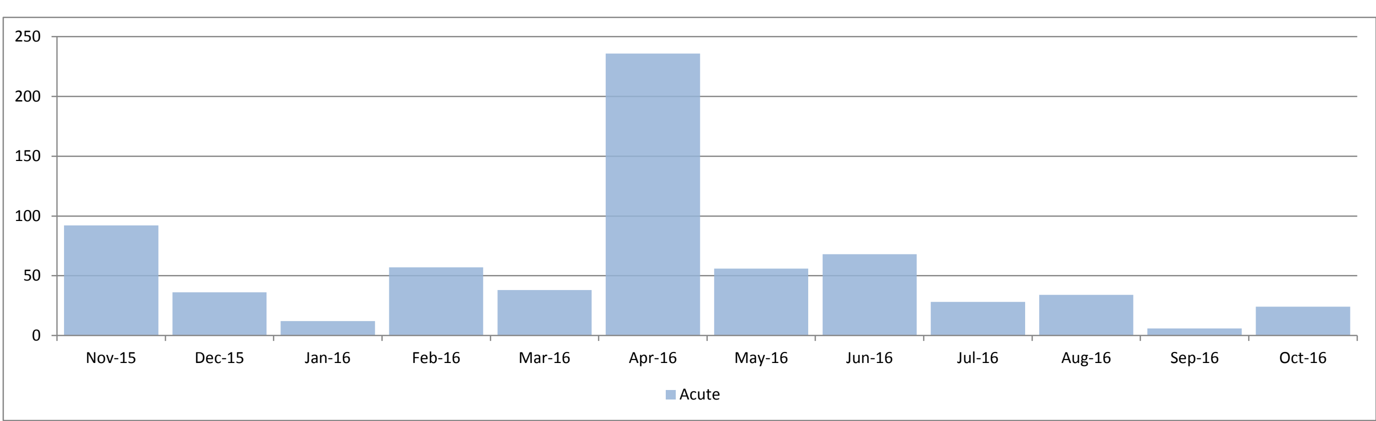
Safer Staffing Levels

	Day		Night	
Site	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	101.6%	102.2%	100.0%	103.2%
Bovey Tracey Hospital	0.0%	0.0%	0.0%	0.0%
Brixham Hospital	102.2%	135.5%	100.0%	180.6%
Dartmouth Hospital	119.2%	89.0%	100.0%	103.2%
Dawlish Hosptial	94.6%	102.7%	100.0%	100.0%
Newton Abbot Hospital	96.1%	107.1%	99.2%	116.1%
Paignton Hospital	91.9%	113.5%	79.0%	122.6%
Teignmouth Hospital	0.0%	0.0%	0.0%	0.0%
Toraby Hospital	103.6%	128.3%	96.5%	136.7%
Totnes Hospital	100.0%	97.9%	164.5%	67.7%
ICO	102.9%	121.2%	97.4%	129.9%

QUALITY FRAMEWORK

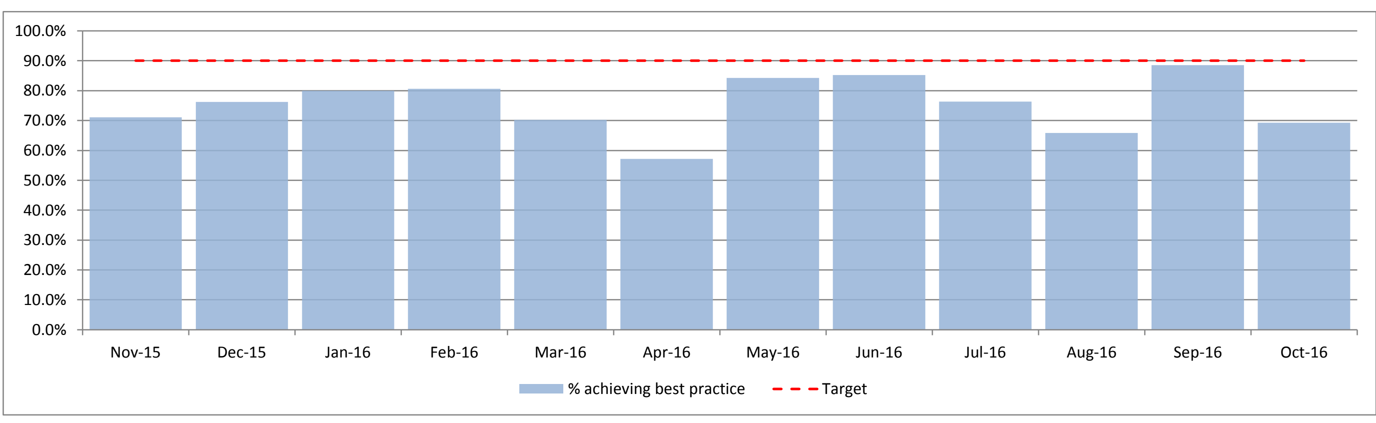
Infection Control - Bed Closures (acute)

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	92	36	12	57	38	236	56	68	28	34	6	24



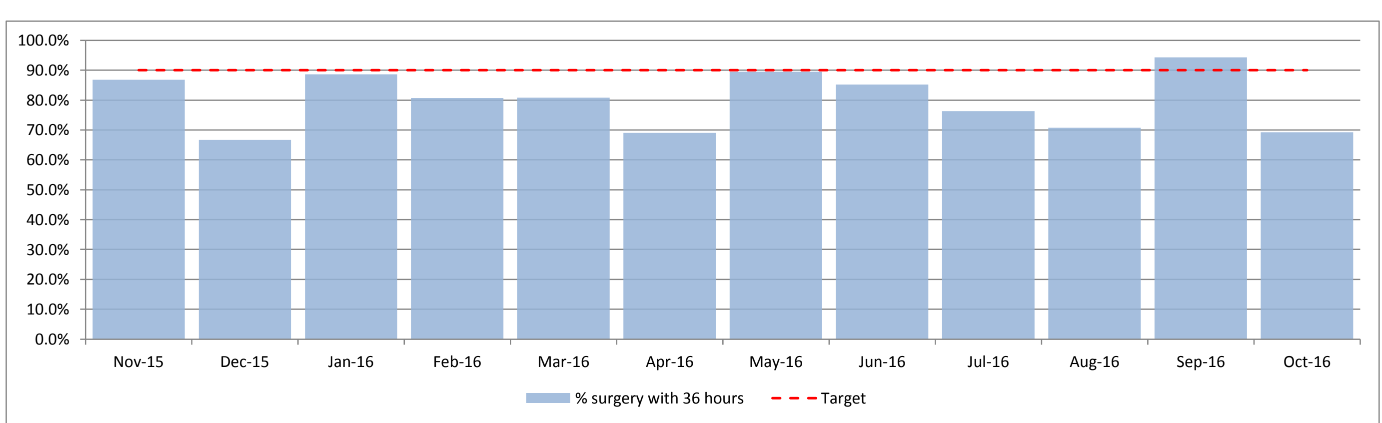
Fracture Neck of Femur - Best tariff assessment

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients	38	42	35	31	47	42	38	27	38	41	35	26
Achieving best practice	27	32	28	25	33	24	32	23	29	27	31	18
% achieving best practice	71.1%	76.2%	80.0%	80.6%	70.2%	57.1%	84.2%	85.2%	76.3%	65.9%	88.6%	69.2%
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

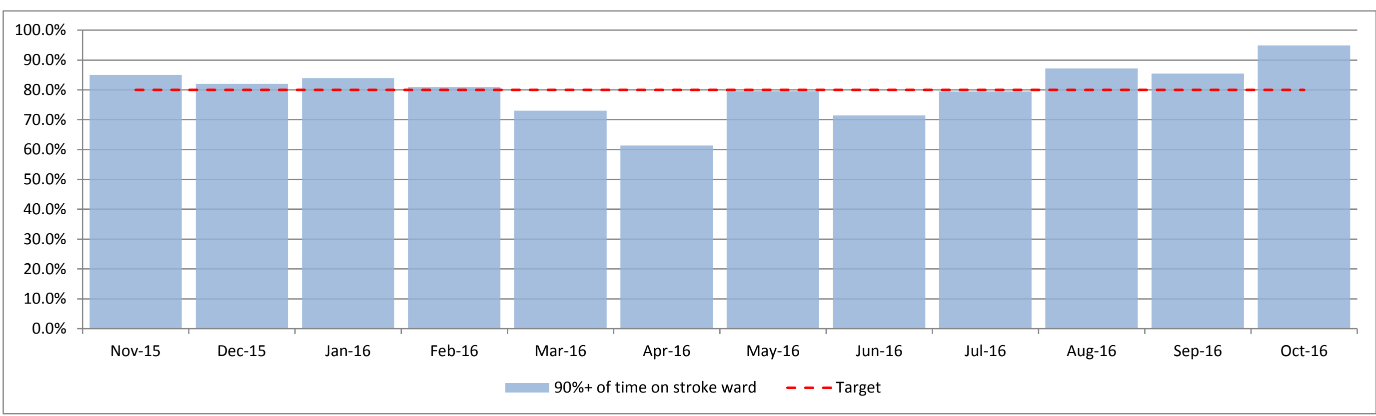
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients	38	42	35	31	47	42	38	27	38	41	35	26
Surgery with 36 hours	33	28	31	25	38	29	34	23	29	29	33	18
% surgery with 36 hours	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.3%	69.2%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



QUALITY FRAMEWORK

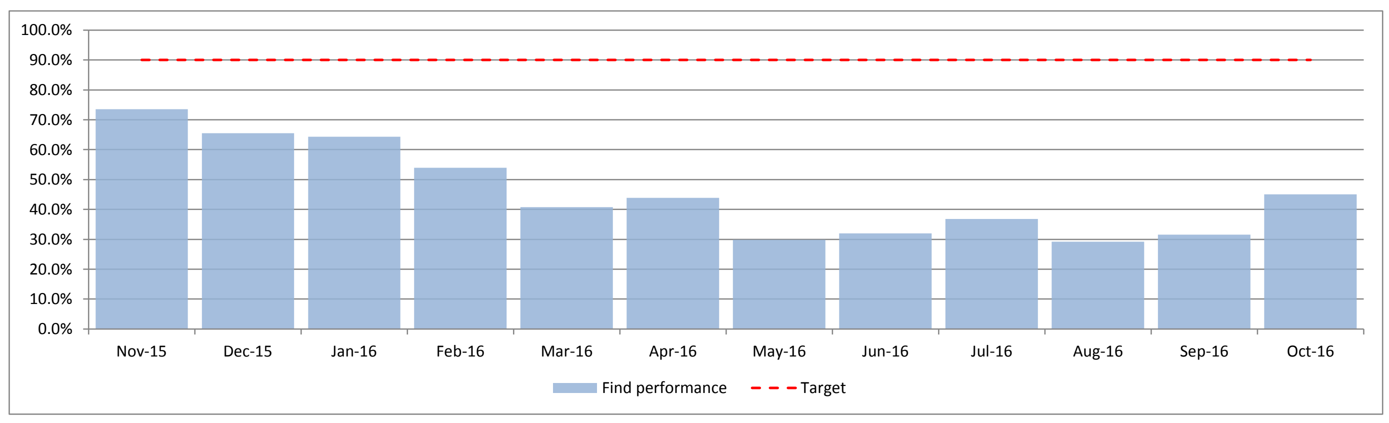
Stroke

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
90%+ of time on stroke ward	85.0%	82.0%	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%	94.9%
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%



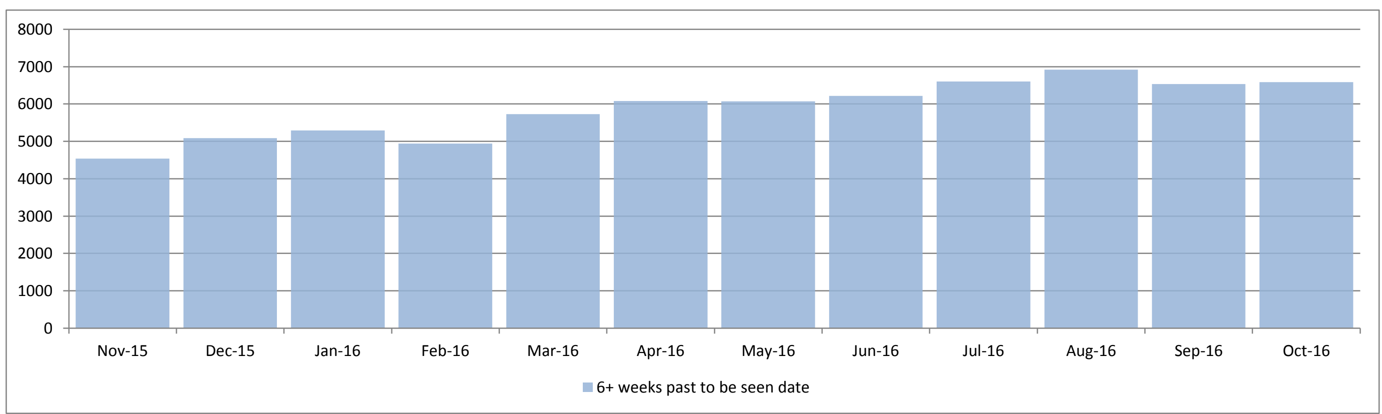
Dementia - Find

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Numerator	461	484	402	360	350	366	303	250	227	264	272	184
Denominator	556	630	558	545	584	607	662	548	503	579	574	408
Find performance	73.5%	65.5%	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	29.2%	31.6%	45.1%
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%



Follow ups 6 weeks past to be seen date

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
6+ weeks past to be seen date	4542	5090	5291	4938	5732	6082	6073	6219	6601	6919	6533	6582



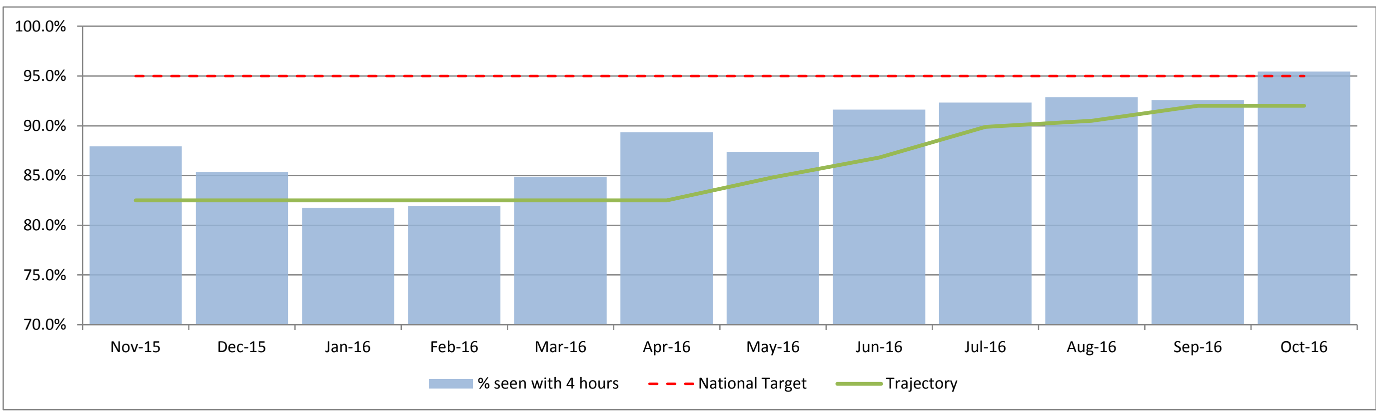
NHS I COMPLIANCE FRAMEWORK

Month 7 October 2016

NHS I COMPLIANCE FRAMEWORK

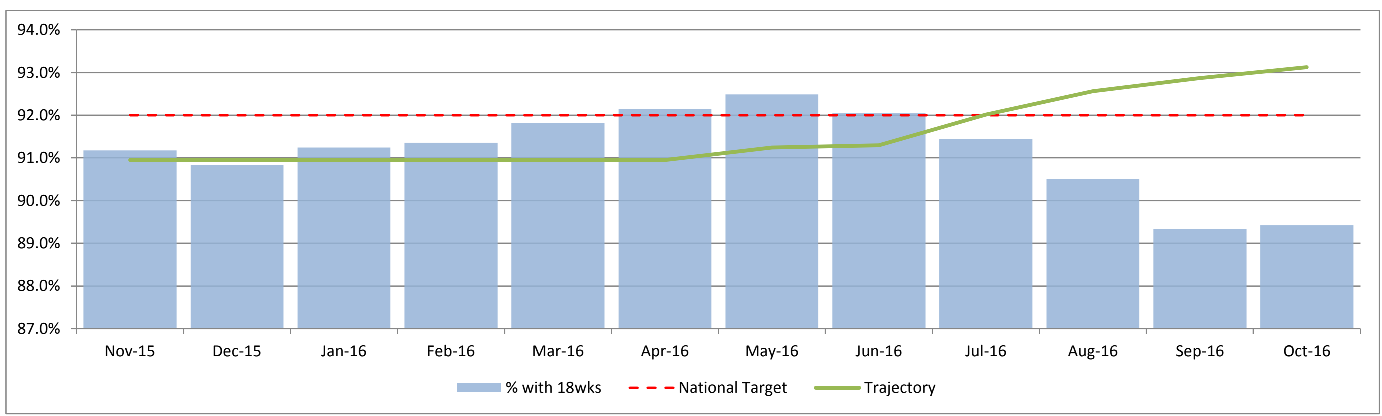
A&E and MIU patients seen within 4 hours

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients	8451	8135	8223	8084	9298	8627	9741	9672	10679	10449	9439	8989
4 hour breaches	1020	1192	1500	1459	1406	918	1229	810	819	744	698	408
% seen with 4 hours	**87.9%**	**85.3%**	**81.8%**	**82.0%**	**84.9%**	**89.4%**	**87.4%**	**91.6%**	**92.3%**	**92.9%**	**92.6%**	**95.5%**
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%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%



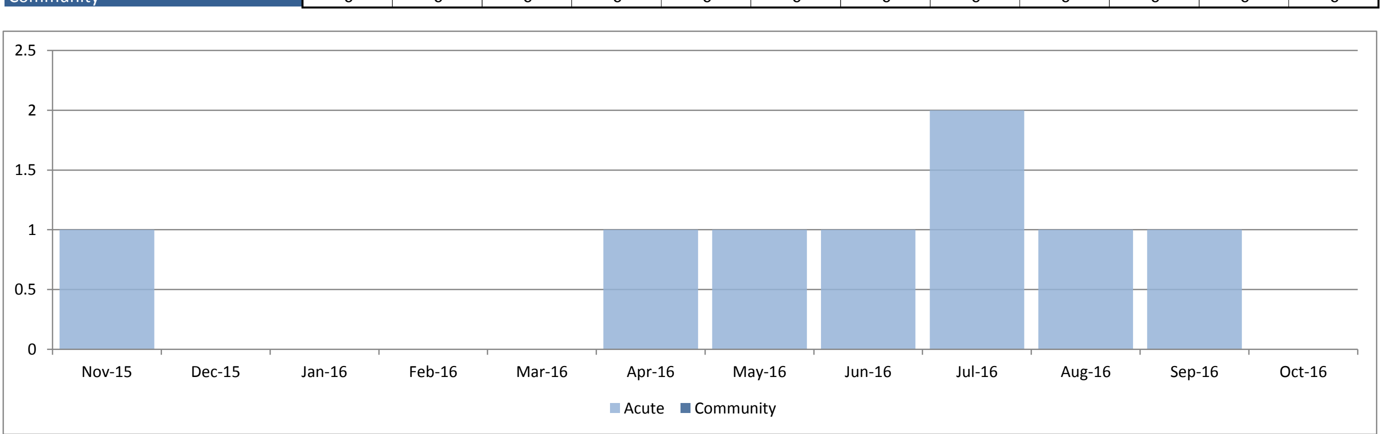
Referral to Treatment - Incomplete pathways

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Incomplete <18wks	14100	14503	14292	14566	14518	14771	15194	15119	15255	15331	15241	14940
Incomplete >18wks	1364	1462	1372	1378	1293	1260	1234	1307	1429	1609	1819	1768
% with 18wks	**91.2%**	**90.8%**	**91.2%**	**91.4%**	**91.8%**	**92.1%**	**92.5%**	**92.0%**	**91.4%**	**90.5%**	**89.3%**	**89.4%**
National Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Trajectory	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	91.2%	91.3%	92.0%	92.6%	92.9%	93.1%



C Diff. Lapse in Care

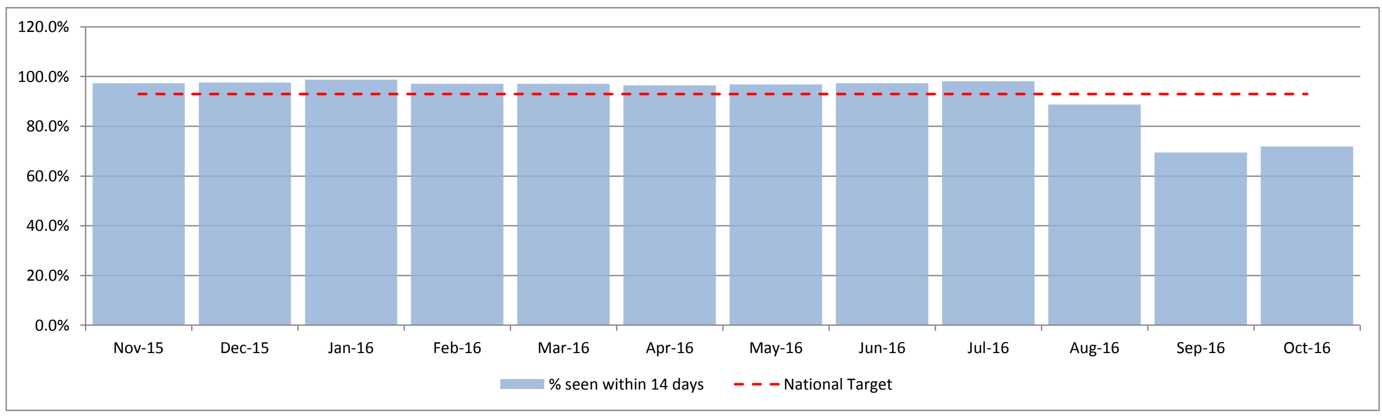
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	1	0	0	0	0	1	1	1	2	1	1	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



NHS I COMPLIANCE FRAMEWORK

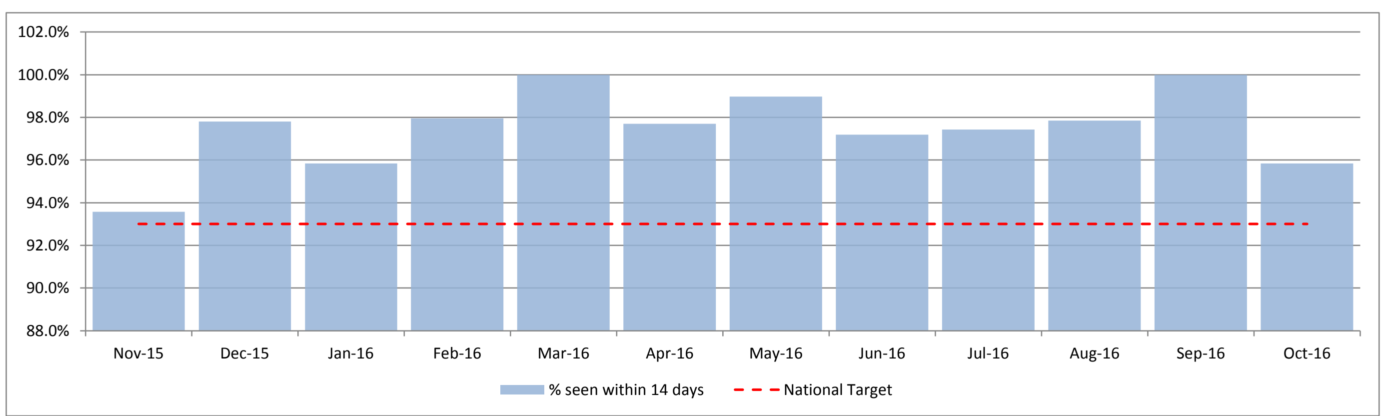
Cancer - Two Week Wait Referrals

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
2ww Referrals	889	897	705	846	965	888	997	997	951	982	994	978
Seen within 14 days	865	876	696	821	937	857	965	971	933	871	690	703
% seen within 14 days	97.3%	97.7%	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.4%	71.9%
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%



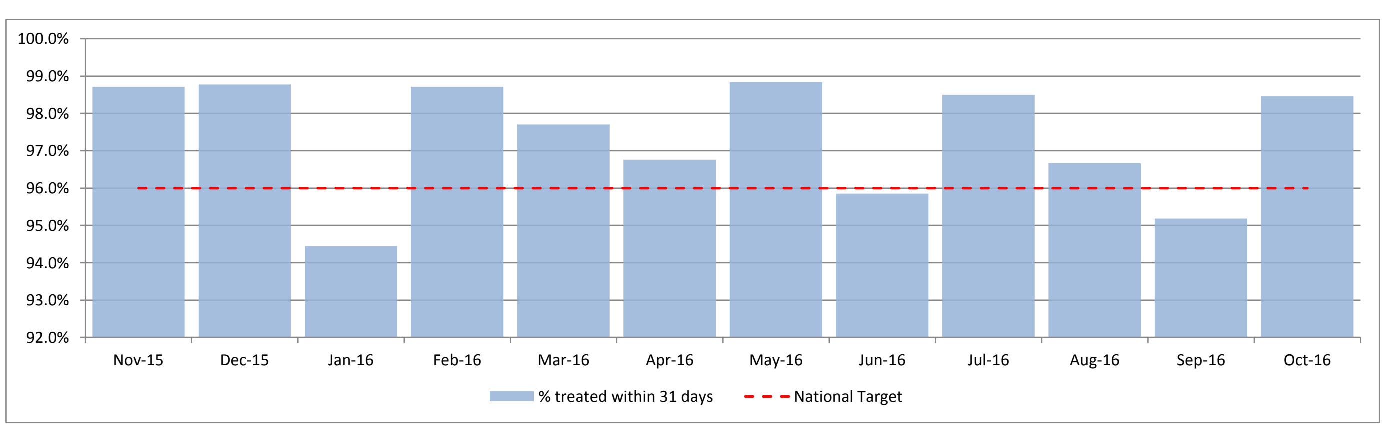
Cancer - Breast Symptomatic Referrals

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Breast symptomatic referrals	109	137	96	98	130	87	97	107	78	93	95	96
Seen within 14 days	102	134	92	96	130	85	96	104	76	91	95	92
% seen within 14 days	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	100.0%	95.8%
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

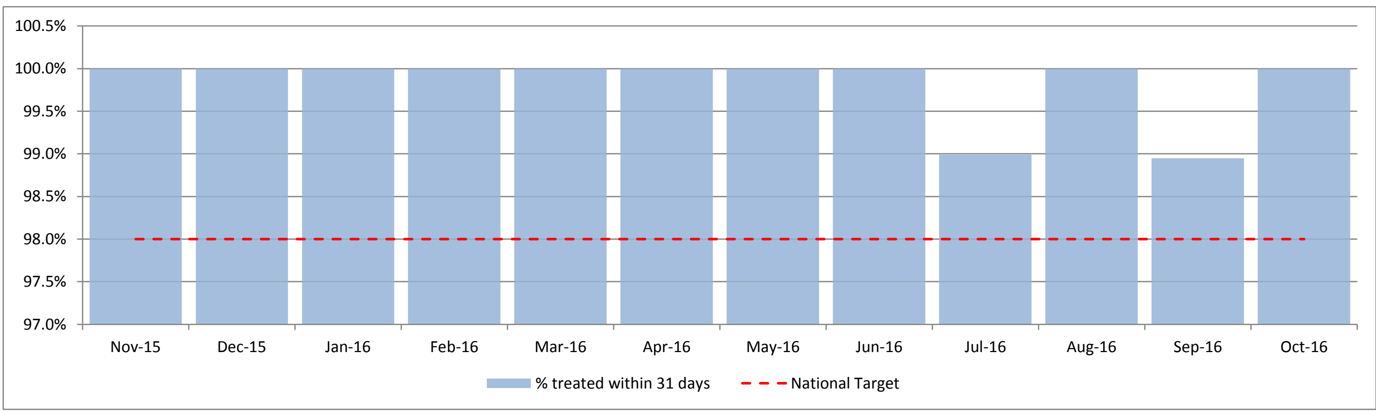
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
1st treatments	156	163	162	155	174	185	172	193	200	180	166	194
Breaches of 31 day target	2	2	9	2	4	6	2	8	3	6	8	3
% treated within 31 days	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	95.2%	98.5%
National Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%



NHS I COMPLIANCE FRAMEWORK

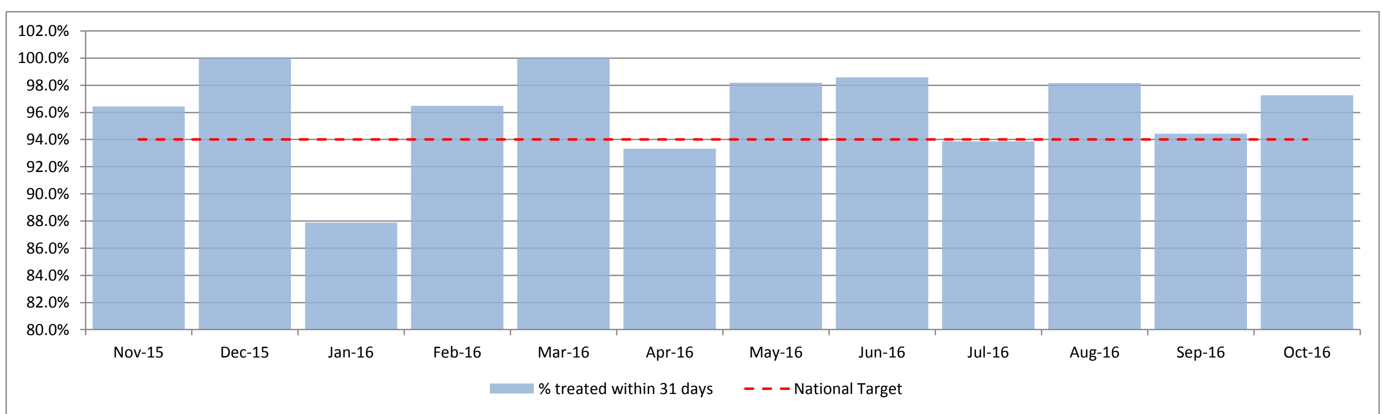
Cancer - 31 day wait for second or subsequent treatment - Drug

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Subsequent Drug treatments	49	47	59	52	62	70	68	85	99	93	95	82
Breaches of 31 day target	0	0	0	0	0	0	0	0	1	0	1	0
% treated within 31 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	98.9%	100.0%
National Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%



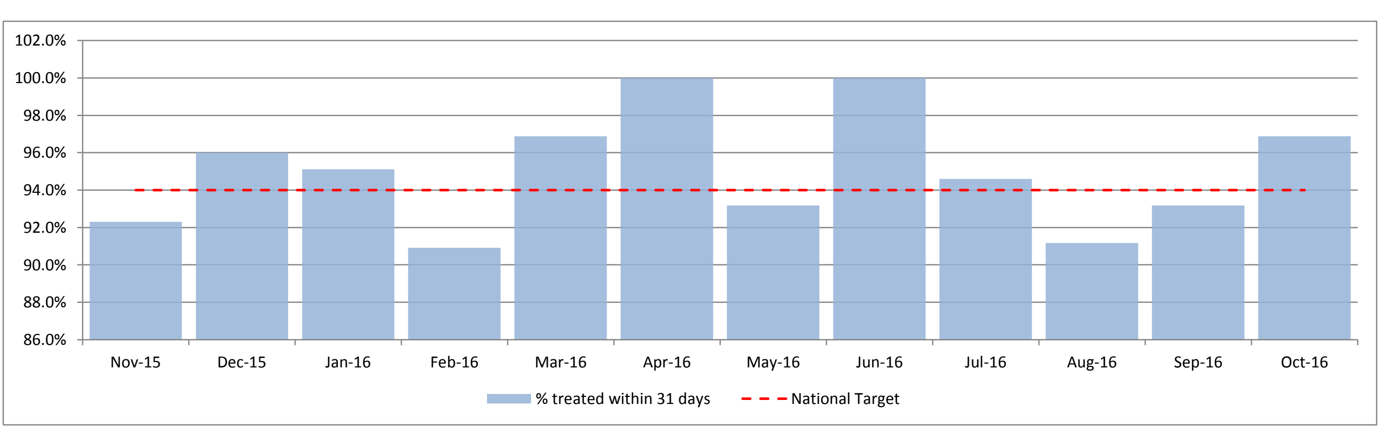
Cancer - 31 day wait for second or subsequent treatment - Radiotherapy

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Sub radiotherapy treatments	56	42	66	57	64	45	55	71	49	54	54	73
Breaches of 31 day target	2	0	8	2	0	3	1	1	3	1	3	2
% treated within 31 days	96.4%	100.0%	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.4%	97.3%
National Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%



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

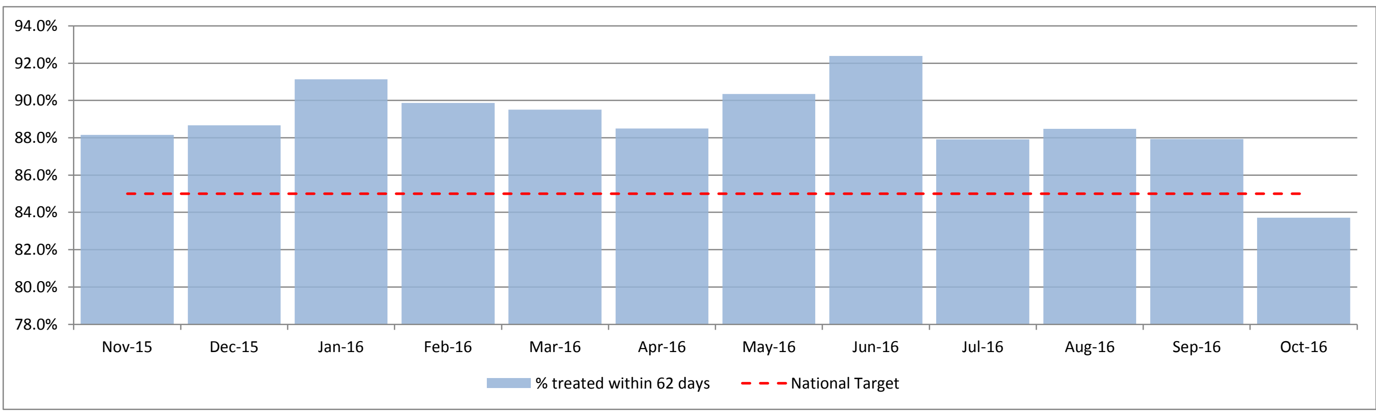
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Subsequent surgery treatments	39	25	41	44	32	30	44	40	37	34	44	32
Breaches of 31 day target	3	1	2	4	1	0	3	0	2	3	3	1
% treated within 31 days	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	96.9%
National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

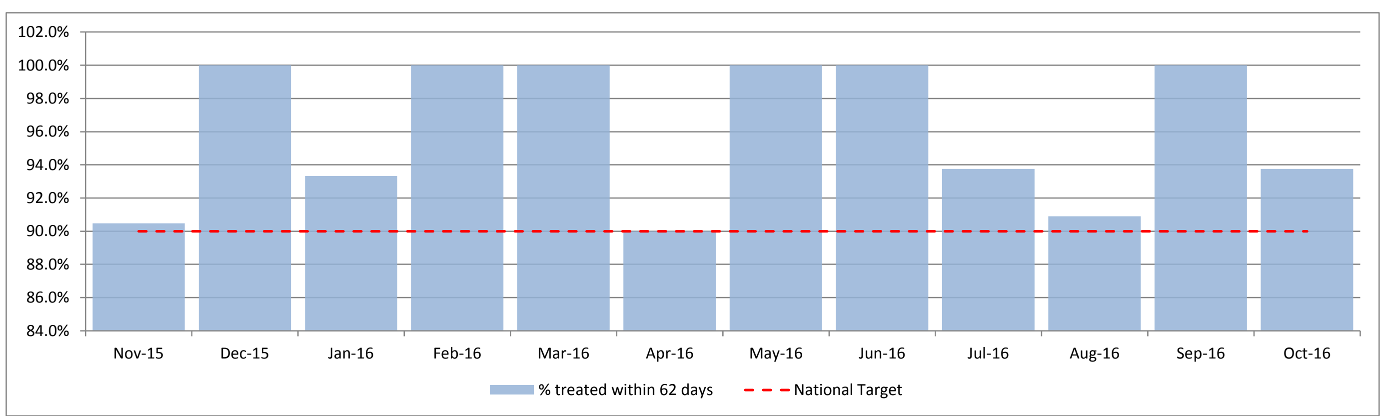
Cancer - 62 day wait for 1st treatment from 2ww referral

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
1st treatments (from 2ww)	76	75	79	79	90.5	100	98.5	105	103.5	95.5	99.5	107.5
Breaches of 62 day target	9	8.5	7	8	9.5	11.5	9.5	8	12.5	11	12	17.5
% treated within 62 days	88.2%	88.7%	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.9%	83.7%
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

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
1st treatments (from screening)	10.5	15.5	15	7	13.5	20	14	15	16	11	8	16
Breaches of 62 day target	1	0	1	0	0	2	0	0	1	1	0	1
% treated within 62 days	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%	93.8%
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 7 October 2016

<u>**Income Analysis**</u> <u>**Schedule 1**</u>

	Year to Date - Month 07			Plan Changes		Previous Month	
	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
Healthcare Income - Commissioner Analysis							
	£m	£m	£m	£m	£m	£m	
South Devon & Torbay Clinical Commissioning Group	94.85	94.19	(0.66)	(0.51)	(0.15)	(0.10)	↓
North, East & West Devon Clinical Commissioning Group	3.06	3.11	0.05	0.00	0.05	0.06	↑
NHS England - Area Team	4.45	4.35	(0.10)	(0.00)	(0.09)	(0.19)	↓
NHS England - Specialist Commissioning	16.59	16.49	(0.09)	(0.13)	0.04	(0.22)	↑
Other Commissioners	4.85	4.80	(0.05)	0.00	(0.05)	0.13	↓
Sub-Total Acute	**123.79**	**122.94**	**(0.85)**	**(0.65)**	**(0.20)**	**(0.32)**	↑
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	44.44	45.87	1.44	1.40	0.04	(0.00)	↑
Other Commissioners	1.80	1.53	(0.27)	(0.22)	(0.05)	0.08	↓
Sub Total Community	**46.24**	**47.41**	**1.17**	**1.18**	**(0.01)**	**0.07**	↓
Sustainability Transformational Funding (STF) Income	3.91	3.21	(0.70)	(2.23)	1.54	1.54	↔
Total Acute and Communuity	**173.93**	**173.56**	**(0.37)**	**(1.70)**	**1.33**	**1.29**	↑

Healthcare Income - By Business Unit							
	£m	£m	£m	£m	£m	£m	
Medical Services	52.43	52.71	0.28	0.04	0.25	0.19	↑
Surgical Services	39.98	40.34	0.36	0.17	0.19	0.50	↑
Women's, Childrens & Diagnostic Services	25.80	24.73	(1.07)	(1.03)	(0.03)	0.05	↓
Community Services	46.24	47.41	1.17	1.18	(0.01)	0.07	↑
Non-Clinical Services / Central Contract Income	9.50	8.37	(1.13)	(2.05)	0.91	0.48	↑
Total	**173.93**	**173.55**	**(0.38)**	**(1.69)**	**1.32**	1.29	↓

Healthcare Activity - By Setting							
	Activity	Activity	Activity	Activity	Activity	Activity	
Elective In-Patient Admissions	2,560	2,596	36	288	(252)	(207)	↓
Elective Day Case Admission	19,536	20,066	530	629	(99)	(262)	↓
Urgent & Emergency Admissions	66,250	67,213	963	705	258	368	↓
Out-Patients	255,032	263,437	8,405	6,625	1,780	4,269	↓
Community Services							
Total	**343,378**	**353,312**	**9,934**	**8,247**	**1,687**	**4,168**	↓

Social Care Income							
	£m	£m	£m	£m	£m	£m	
Torbay Council - ASC Contract income	23.72	22.80	(0.92)	(0.92)	(0.00)	(0.00)	↔
Torbay Council - Public Health Income	2.90	3.45	0.56	0.00	0.56	0.48	↑
Torbay Council - Client Income	5.78	5.95	0.17	0.20	(0.03)	(0.02)	↓
Total	**32.39**	**32.20**	**(0.19)**	**(0.72)**	**0.53**	**0.45**	↑

Other Income							
	£m	£m	£m	£m	£m	£m	
Non Mandatory/Non protected clinical revenue	0.87	0.99	0.11	(0.00)	0.11	0.08	↑
R&D / Education & training revenue	5.08	5.27	0.18	0.00	0.18	0.15	↑
Site Services	1.28	1.34	0.05	0.00	0.05	0.05	↔
Revenue from non-patient services to other bodies	3.19	3.16	(0.03)	0.00	(0.03)	(0.07)	↑
Misc. other operating revenue	14.04	14.13	0.09	0.01	0.08	0.36	↓
Total	**24.47**	**24.88**	**0.41**	**0.01**	**0.40**	**0.57**	↑

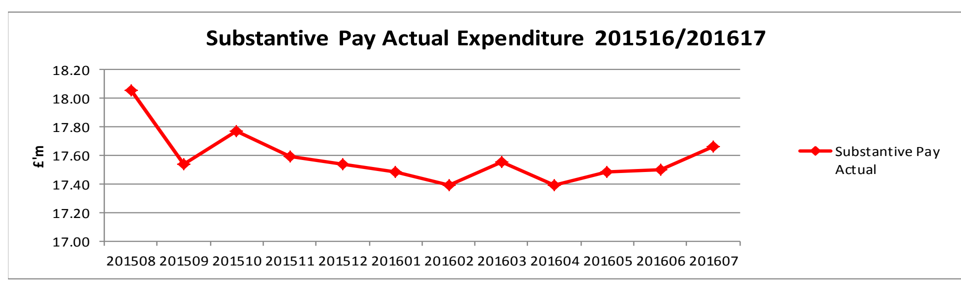
Risk Share Income							
	£m	£m	£m	£m	£m	£m	
Risk Share Income	0.00	5.84	5.84	5.05	0.78	(0.23)	↑
Total	**0.00**	**5.84**	**5.84**	**5.05**	**0.78**	**(0.23)**	↑

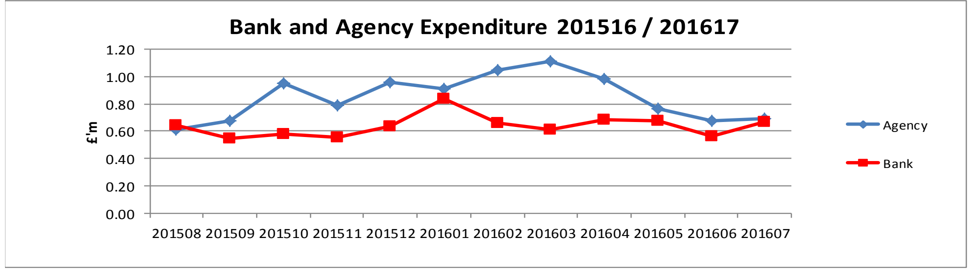
	Year to Date - Month 06			Plan Changes		Previous Month	
Memo	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
CCG Block adjustment							
	£m	£m	£m	£m	£m	£m	
CCG Block adjustment	0.00	(6.91)	(6.91)	(4.41)	(2.50)	(2.04)	↓
Total	**0.00**	**(6.91)**	**(6.91)**	**(4.41)**	**(2.50)**	**(2.04)**	↓

Employee Expenses **Schedule 2**

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Employee Expenses - By Category							
Medical and Dental staff	30.32	30.70	(0.38)	0.38	0.01	0.44	↓
Registered nurses, midwives and health visiting staff	32.78	33.75	(0.98)	0.55	(0.43)	(0.41)	↑
Qualified scientific, therapeutic and technical staff	26.16	24.60	1.56	0.20	1.76	1.31	↑
Support to clinical staff	10.61	12.09	(1.48)	0.00	(1.48)	(1.15)	↑
Managers and infrastructure Support	30.89	32.20	(1.31)	0.60	(0.71)	(0.49)	↑
Total	**130.75**	**133.34**	**(2.59)**	**1.74**	**(0.85)**	**(0.31)**	↑
Employee Expenses - By Type							
Substantive	123.76	122.35	1.41	1.74	3.14	2.96	↑
Bank	2.02	4.70	(2.67)	0.00	(2.67)	(2.29)	↑
Locum (including Agency)	1.01	1.05	(0.03)	0.00	(0.03)	0.02	↑
Agency (excluding Locums)	3.95	5.24	(1.29)	0.00	(1.29)	(1.01)	↑
Total	**130.75**	**133.34**	**(2.59)**	**1.74**	**(0.86)**	**(0.31)**	↑
Employee Expenses - By Service							
Medical Services	23.60	26.46	(2.86)	0.15	(2.71)	(2.16)	↑
Surgical Services	26.78	27.23	(0.45)	0.04	(0.41)	(0.22)	↑
Women's, Childrens & Diagnostic Services	21.61	22.32	(0.71)	0.01	(0.70)	(0.47)	↑
Community Hospital and Services (including ASC)	25.04	25.22	(0.18)	0.82	0.64	0.56	↑
Non-Clinical Services	33.73	32.11	1.61	0.70	2.32	1.99	↑
Total	**130.75**	**133.34**	**(2.59)**	**1.74**	**(0.86)**	**(0.31)**	↑

Pay run rates Oct 2015 - September 2016





Agency Spend | **Schedule 3**

Torbay and South Devon NHS Foundation Trust
Trust Agency Information
Financial Year 2016/17

All Staff Group	April	May	June	July	August	September	October	YTD 2016-17
NHS Improvement - revised Ceiling (June 2016)	£m	£m	£m	£m	£m	£m	£m	£m
Total Planned Agency Cost	(0.662)	(0.643)	(0.623)	(0.590)	(0.575)	(0.556)	(0.514)	(4.163)
Total Planned Staff Costs	(18.898)	(18.901)	(18.904)	(18.678)	(18.681)	(18.684)	(17.999)	(130.744)
% of Agency Costs against Total Staff Cost	4%	3%	3%	3%	3%	3%	3%	3.18%

	April	May	June	July	August	September	October	YTD 2016-17
ICO Actual	£m	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.911)	(1.043)	(1.112)	(0.983)	(4.224)	2.786	(0.689)	(6.176)
Total Actual Staff Cost	(19.231)	(19.090)	(19.565)	(19.053)	(18.637)	(18.742)	(19.019)	(133.337)
% of Agency Costs against Total Staff Cost	5%	5%	6%	5%	23%	-15%	4%	4.63%

	April	May	June	July	August	September	October	YTD 2016-17
Variance against Revised Ceiling	£m	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.249)	(0.400)	(0.489)	(0.393)	(3.649)	3.342	(0.175)	(2.013)
% of Agency Costs against Total Staff Cost	1%	2%	2%	2%	20%	-18%	1%	1.45%

Nursing only	April	May	June	July	August	September	October	YTD 2016-17
NHS Improvement - revised Ceiling (June 2016)	£m	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.272)	(0.266)	(0.259)	(0.168)	(0.163)	(0.156)	(0.167)	(1.451)
Total Planned Staff Costs	(4.633)	(4.631)	(4.629)	(4.723)	(4.723)	(4.721)	(4.531)	(32.592)
% of Agency Costs against Total Staff Cost	6%	6%	6%	4%	3%	3%	4%	4.45%

	April	May	June	July	August	September	October	YTD 2016-17
ICO Actual	£m	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.442)	(0.544)	(0.552)	(0.457)	(0.897)	0.218	(0.256)	(2.930)
Total Actual Staff Cost	(4.980)	(4.927)	(4.993)	(4.824)	(4.678)	(4.690)	(4.685)	(33.777)
% of Agency Costs against Total Staff Cost	9%	11%	11%	9%	19%	-5%	5%	8.67%

	April	May	June	July	August	September	October	YTD 2016-17
Variance against Revised Ceiling	£m	£m	£m	£m	£m	£m	£m	£m
Total Agency Staff Cost	(0.170)	(0.278)	(0.293)	(0.289)	(0.734)	0.374	(0.089)	(1.479)
% of Agency Costs against Total Staff Cost	3%	5%	5%	6%	16%	-8%	2%	4.22%
Comment	M1 to M7 Agency Actual is higher than revised Ceiling by £2.0m YTD, 1.45% more than the revised ceiling of 3.18%. M7 Total Agency is £6.2m across all Staff Group.							

Improvement Plan

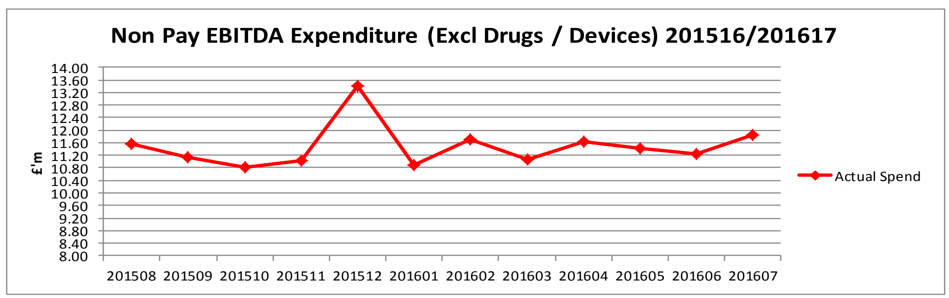
No.	Action	Lead	Date
1	Nursing agency shifts all approved by a Director	JV	ongoing
2	Medical Agency and Locum Approved by a Director	RD	ongoing
3	Recruitment processes streamlined and regular for key clinical staff	JS	Ongoing
4	Overseas Recruitment of Nursing Staff	JS/JV	in progress

Governance Arrangements
Senior Business management Team, Exec Team meetings

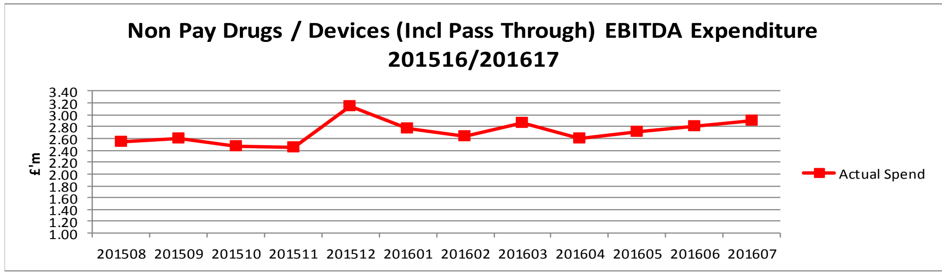
Non Pay Expenses | **Schedule 4**

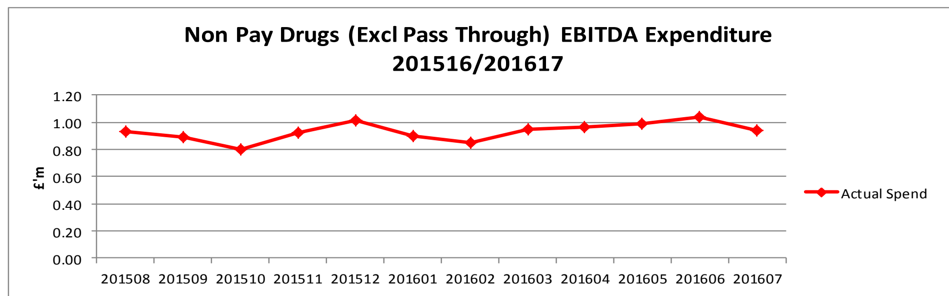
	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non Pay Expenses - By Category							
Clinical Supplies	12.68	13.35	(0.67)	0.00	(0.67)	(0.50)	↑
Drugs (Excluding Pass through)	6.24	6.64	(0.40)	0.00	(0.40)	(0.28)	↑
Pass through Drugs, Blood and Devices	11.75	12.67	(0.92)	0.44	(0.47)	(0.25)	↑
Non Clinical Supplies	1.61	1.72	(0.11)	0.00	(0.11)	(0.09)	↑
Miscellaneous / Other	60.37	64.21	(3.84)	4.14	0.30	1.07	↓
Total	**92.65**	**98.59**	**(5.94)**	**4.58**	**(1.36)**	**(0.05)**	↑

Non pay run rates November 2015 - October 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.



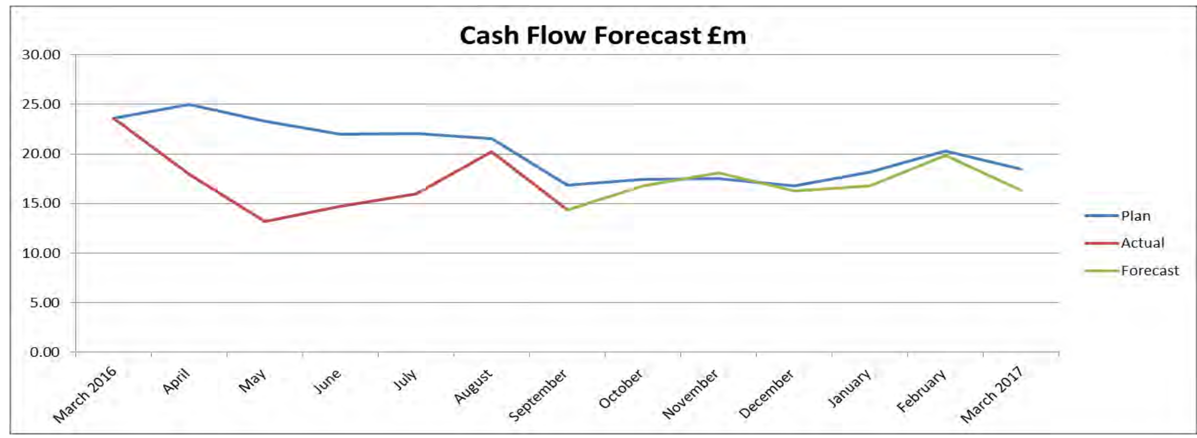


Cash Flow **Schedule 5**

	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Opening Cash Balance	**23.57**	**23.57**	**0.00**	**0.00**	**0.00**	0.00	
Cash Generated From Operations	8.00	3.85	(4.15)	(3.95)	(0.21)	1.14	↓
Debtor Movements	4.09	(5.86)	(9.95)	(2.36)	(7.59)	(5.76)	↓
Creditor Movements (excl capital creditor)	(2.09)	3.36	5.45	1.38	4.07	2.31	↑
Capital Expenditure (accruals basis)	(16.97)	(10.18)	6.79	6.35	0.44	(0.14)	↑
Net Interest	(1.70)	(1.57)	0.13	0.00	0.13	(0.01)	↑
Loan drawndown	6.32	5.90	(0.42)	(0.37)	(0.05)	0.00	↓
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	0.19	↔
Other	0.33	(3.13)	(3.45)	(1.38)	(2.08)	(1.22)	↓
Closing Cash Balance	**17.43**	**12.45**	**(4.98)**	**0.08**	**(5.06)**	(3.47)	↓

Cash Flow Forecast

	Full Year			Plan Changes		Previous Month	
	Plan £m	Forecast £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance £m	Change
Cash Flow							
Opening Cash Balance - 01/04/2016	**23.57**	**23.57**	**0.00**	**0.00**	**0.00**	0.00	
Cash Generated From Operations	22.36	10.52	(11.85)	(10.61)	(1.24)	(1.24)	↔
Debtor Movements	4.41	4.14	(0.27)	(0.27)	(0.00)	(0.00)	↔
Creditor Movements (excl capital creditor)	(2.10)	(2.10)	0.00	1.38	(1.38)	(1.38)	↔
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 drawndown	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	0.38	↔
Other	(0.08)	(0.43)	(0.35)	(1.38)	1.03	1.03	↔
Forecast Cash Balance - 31/03/2017	**18.48**	**16.37**	**(2.11)**	**(0.90)**	**(1.21)**	(1.21)	↔



Capital **Schedule 6**

	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
Capital Programme	16.96	10.17	(6.79)	10.17	10.17	0.00	36.90	21.91
Significant Variances in Planned Expenditure by Scheme:								
HIS schemes	3.86	1.78	(2.08)	1.78	1.78	0.00	9.08	5.63
Estates schemes	9.67	6.93	(2.74)	6.93	6.93	0.00	16.28	10.01
Medical Equipment	1.39	0.52	(0.87)	0.52	0.52	0.00	7.70	4.47
Other	0.04	0.01	(0.03)	0.01	0.01	0.00	0.05	0.09
PMU	1.09	0.93	(0.16)	0.93	0.93	0.00	1.60	1.50
Contingency	0.91	0.00	(0.91)	0.00	0.00	0.00	2.19	0.21
Prior Year schemes	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	16.96	10.17	(6.79)	10.17	10.17	0.00	36.90	21.91

Funding sources								
Secured loans	6.32	5.90	(0.42)	5.90	5.90	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	0.54	0.14	(0.40)	0.14	0.14	0.00	2.60	2.60
Internal cash resources	10.10	4.13	(5.97)	4.13	4.13	0.00	15.65	6.09
Total	16.96	10.17	(6.79)	10.17	10.17	0.00	**36.90**	**21.91**

Torbay & South Devon NHS Foundation Trust

Cumulative Period to: October 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	2,684	2,421	(263)	(205)	15,493	9,055	8,602	(453)	(220)
Day Cases	32,565	19,169	19,123	(46)	(196)	20,488	12,069	11,997	(72)	(248)
Non-Electives	29,681	17,301	18,468	1,167	1,198	56,391	32,559	35,085	2,526	2,511
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	780	803	23	4
Chemotherapy Procurement	0	0	0	0	0	3,174	1,899	1,840	(59)	(79)
Elective Readmissions						(230)	(134)	(134)	0	0
Emergency Readmissions						(188)	(110)	(110)	0	0
Chemotherapy Core HRG Adjustment						0	0	0	0	0
Emergency Adjustment						(3,182)	(1,856)	(2,225)	(369)	(405)
Emergency adjustment add back						0	0	0	0	0
APC Variation Orders Agreed						0	0	0	0	0
Total APC	66,827	39,154	40,012	858	797	**93,241**	**54,261**	**55,858**	**1,596**	**1,563**
Outpatients - 1st	76,972	44,936	45,810	874	1,236	12,126	7,051	7,119	68	138
Outpatients - F-up	202,129	116,633	117,255	622	1,841	19,237	11,169	11,163	(7)	69
Chemotherapy Delivery	0	0	0	0	0	106	62	73	11	12
Chemotherapy Procurement	0	0	0	0	0	1,644	1,029	943	(86)	(39)
Maternity Pathway	0	0	0	0	0	4,941	2,882	2,825	(57)	(88)
Radiotherapy	12,471	7,354	7,248	(106)	(291)	2,860	1,702	1,619	(84)	(119)
OP Radiology	28,291	16,734	16,637	(97)	97	2,988	1,762	1,796	34	52
GP Radiology	45,398	27,377	27,274	(103)	246	1,838	1,116	1,128	13	30
Outpatient Variation Orders Agreed						0	0	0	0	0
Total Outpatients	365,261	213,034	214,224	1,190	3,129	**45,740**	**26,773**	**26,665**	**(107)**	**55**
A&E	75,422	45,000	44,748	(252)	(226)	**8,691**	5,104	5,117	13	5
A&E Variation Orders Agreed										
Total A&E	75,422	45,000	44,748	-£ 252	-£ 226	**8,691**	**5,104**	**5,117**	**13**	**5**
Total PBR	507,510	297,188	298,984	1,796	3,700	**147,672**	**86,138**	**87,640**	**1,501**	**1,623**
Cost & Volume - Inpatients	325	154	175	21	4	379	170	227	56	42
Cost & Volume - Day Cases	1,659	995	943	(52)	(64)	694	438	451	13	24
Cost & Volume - Non-Electives	536	335	433	98	82	1,053	650	833	183	123
Cost & Volume - AMU	1,890	1,099	1,075	(24)	(32)	1,432	829	818	(11)	23
Cost & Volume - CDU	3,201	1,867	2,489	622	587	186	111	142	31	34
Cost & Volume - Outpatients 1st	27,425	16,066	16,648	582	963	2,896	1,732	1,807	75	103
Cost & Volume - Outpatients F-up	55,501	32,557	32,565	8	177	6,421	3,769	3,668	(101)	(79)
Cost & Volume - New	0	0	0	0	0	11,743	6,850	6,954	104	57
Critical Care - Adult						3,954	2,331	2,785	454	495
Critical Care - Neonatal & Paeds						1,919	1,104	1,189	85	80
Chemotherapy Delivery						0	0	0	0	0
Chemotherapy Procurement						0	0	0	0	0
Palliative Care						563	354	367	13	(11)
Other Cost & Volume - Drugs						18,457	10,764	11,383	618	426
Other Cost & Volume - Bloods						799	466	514	48	24
Other Cost & Volume - Excluded Devices						1,803	1,052	841	(210)	(212)
Cost & Volume - Various						1,539	898	918	20	15
Cost & Volume Variation Orders Agreed						0	0	0	0	0
Total Cost & Volume	90,537	53,073	54,328	1,255	1,717	**53,838**	**31,518**	**32,898**	**1,380**	**1,143**
Block - Patient Related						7,560	4,410	4,410	0	0
Block - Non Patient Related						4,041	2,357	2,357	0	0
Commissioner plan adjustments to match resource envelopes						0	0	0	0	0
Block Variation Orders Agreed						0	0	0	0	0
Total Block	0	0	0	0	0	**11,602**	**6,768**	**6,768**	**0**	**0**
Total Non-PBR	90,537	53,073	54,328	1,255	1,717	**65,440**	**38,286**	**39,666**	**1,380**	**1,143**
CQUIN						4,634	2,703	2,703	0	0
Total Contract Adjustments	0	0	0	0	0	**4,634**	**2,703**	**2,703**	**0**	**0**
SD&T CCG plan adjustment to match resource envelope						0	0	0	0	0
Total Contract	598,047	350,261	353,312	3,051	5,417	**217,745**	**127,127**	**130,009**	**2,881**	**2,766**
Phasing adjustment						0	434	0	(434)	(935)
Contract Penalties						0	0	(176)	(176)	(112)
Block Adjustment						(7,567)	(4,414)	(6,909)	(2,495)	(2,043)
Grand Total	598,047	350,261	353,312	3,051	5,417	**210,178**	**123,147**	**122,923**	**(224)**	**(324)**
Grand Total of agreed contract plan	598,047	350,261	353,312	3,051	5,417	**210,178**	**123,147**	**122,923**	**(224)**	**(324)**

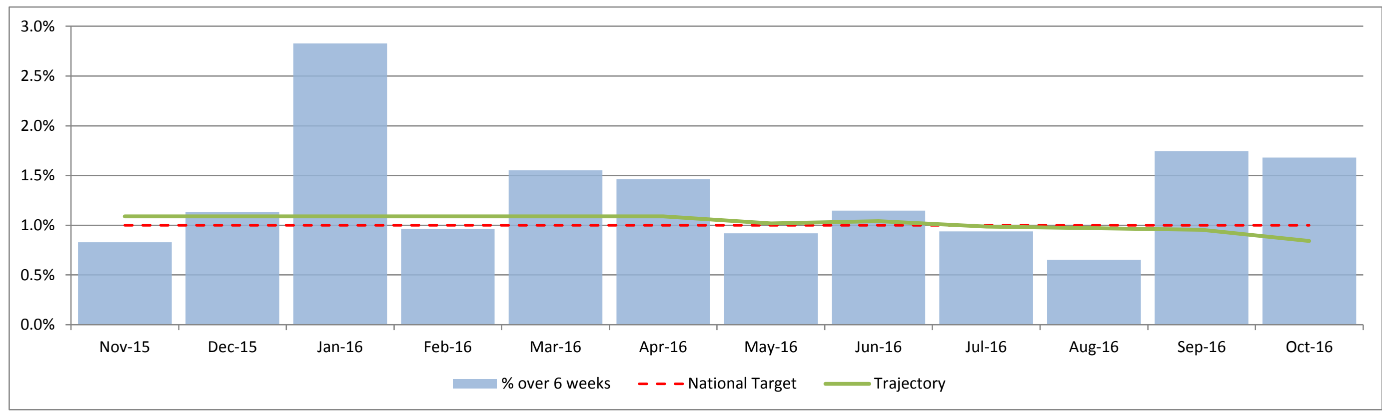
CONTRACTUAL FRAMEWORK

Month 7 October 2016

CONTRACTUAL FRAMEWORK

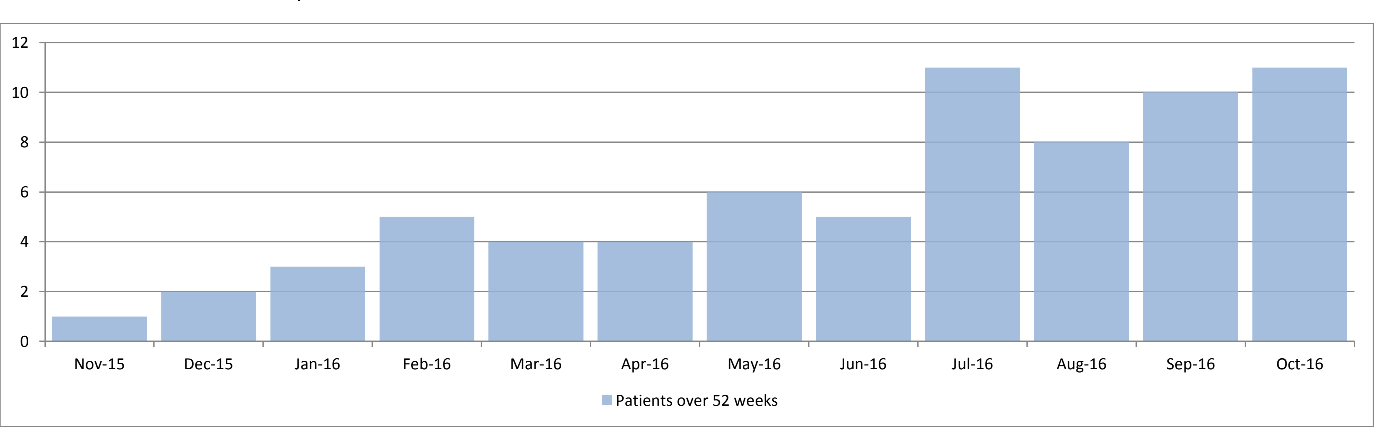
Diagnostic Tests Longer than the 6 week standard

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients	3382	3800	3750	3637	3543	3693	3377	3750	3305	3228	3381	3511
Waiting longer than 6 weeks	28	43	106	35	55	54	31	43	31	21	59	59
% over 6 weeks	**0.8%**	**1.1%**	**2.8%**	**1.0%**	**1.6%**	**1.5%**	**0.9%**	**1.1%**	**0.9%**	**0.7%**	**1.7%**	**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%	1.02%	1.04%	0.99%	0.97%	0.95%	0.84%



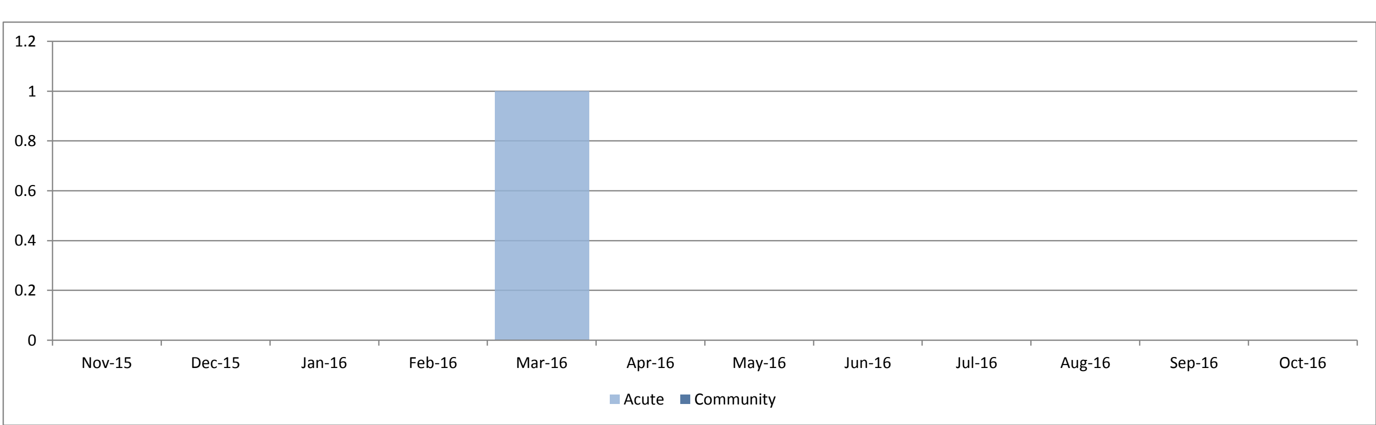
Referral to Treatment over 52 week incomplete pathways

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



Mixed sex accomodation breaches of Standard

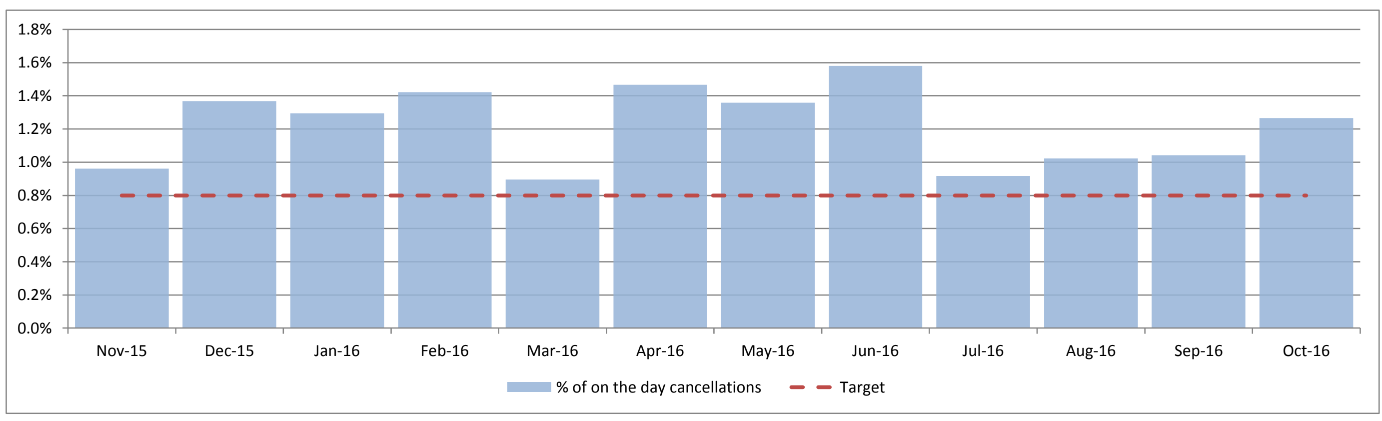
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	0	0	0	0	1	0	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

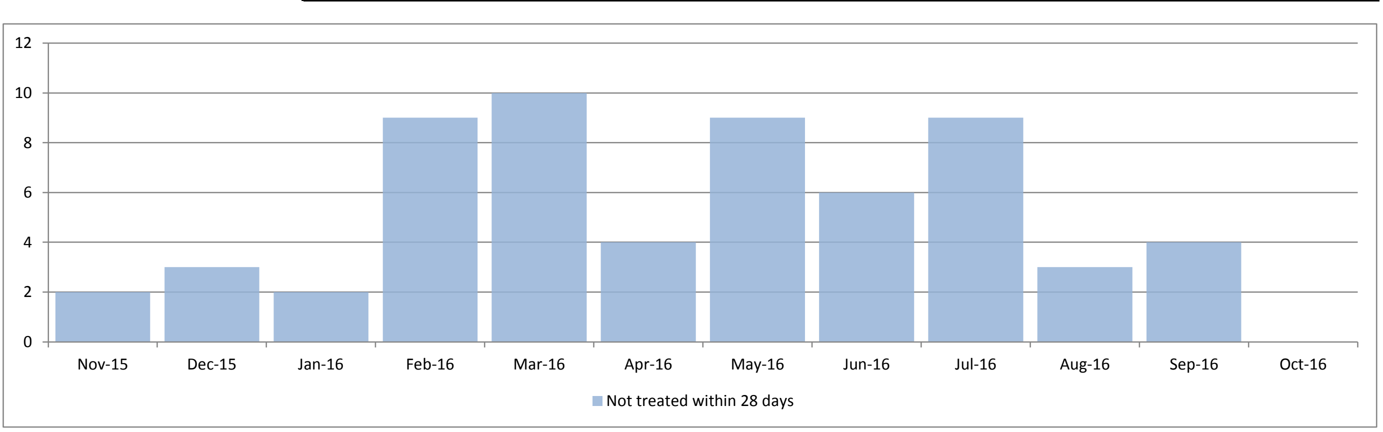
On the day cancellations for elective operations

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Cancellations	30	41	40	45	29	47	46	56	30	34	36	42
Elective spells	3123	2998	3089	3164	3236	3205	3387	3543	3271	3327	3456	3316
% of on the day cancellations	1.0%	1.4%	1.3%	1.4%	0.9%	1.5%	1.4%	1.6%	0.9%	1.0%	1.0%	1.3%
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%



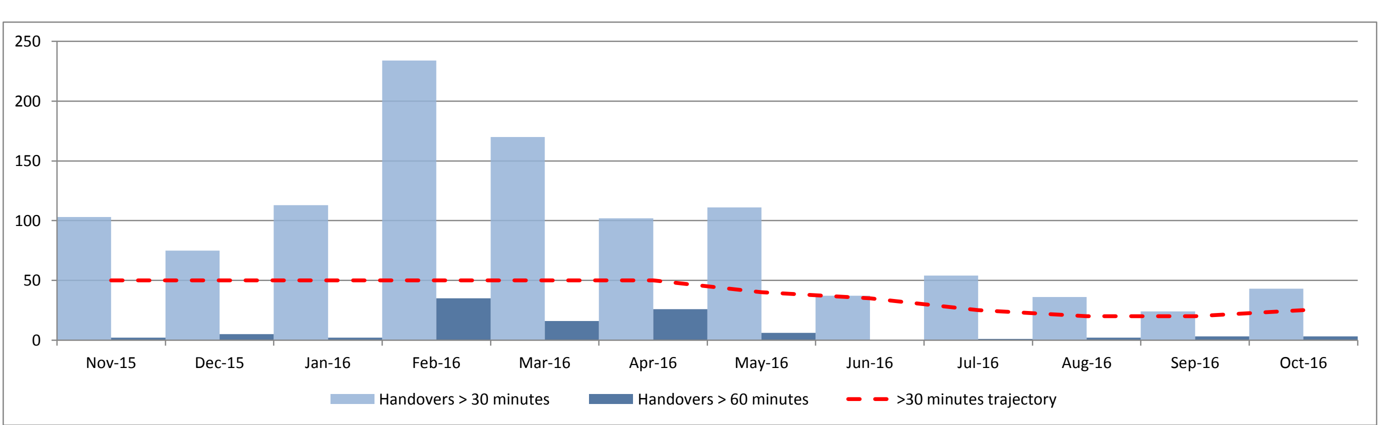
Cancelled patients not treated within 28 days of cancellation

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



Ambulance handovers

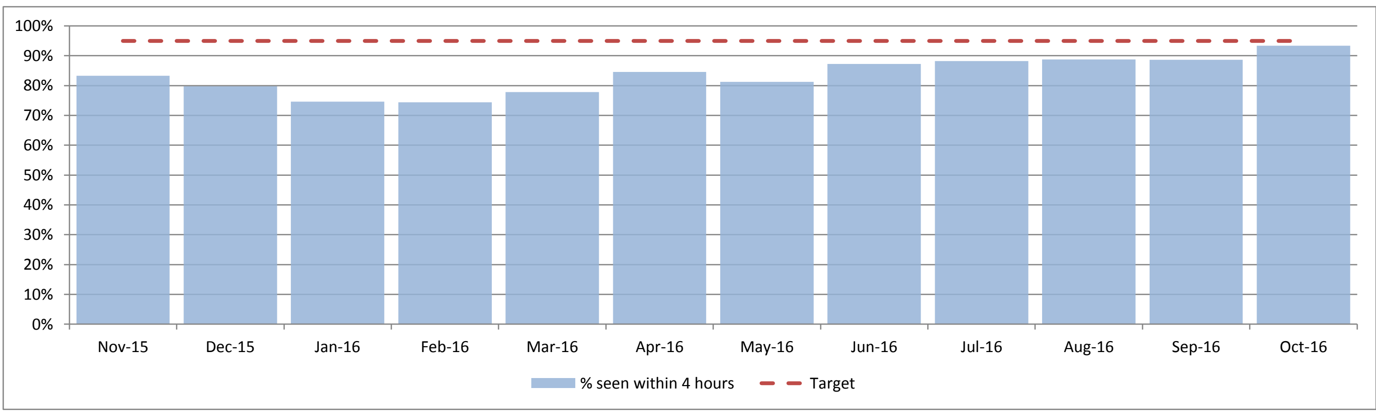
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Handovers > 30 minutes	103	75	113	234	170	102	111	37	54	36	24	43
Handovers > 60 minutes	2	5	2	35	16	26	6	0	1	2	3	3
>30 minutes trajectory	50	50	50	50	50	50	40	35	25	20	20	25



CONTRACTUAL FRAMEWORK

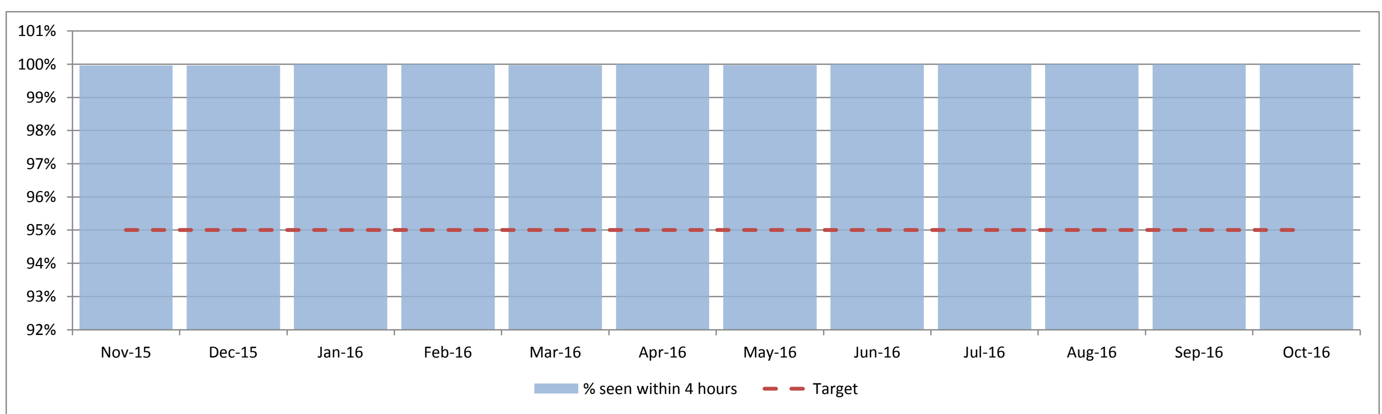
A&E patients seen within 4 hours (DGH only)

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients seen	6090	5874	5896	5693	6334	5924	6534	6350	6971	6588	6142	6153
4 hour breaches	1019	1191	1500	1459	1405	918	1228	810	819	744	698	408
% seen within 4 hours	83%	80%	75%	74%	78%	85%	81%	87%	88%	89%	89%	93%
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%



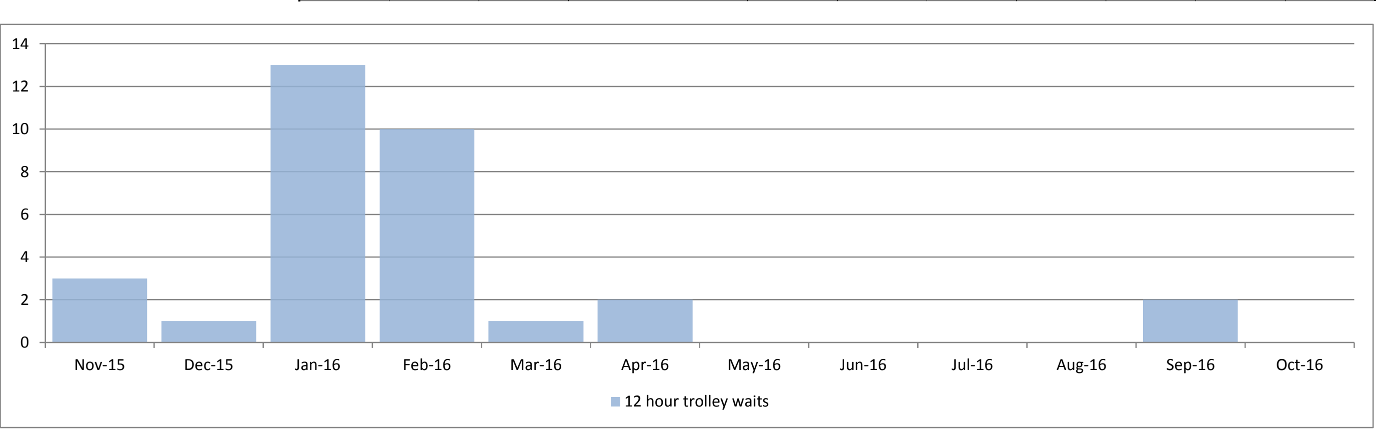
A&E patients seen within 4 hours (community MIU)

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients seen	2361	2261	2327	2391	2964	2703	3207	3322	3708	3862	3297	2836
4 hour breaches	1	1	0	0	1	0	1	0	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

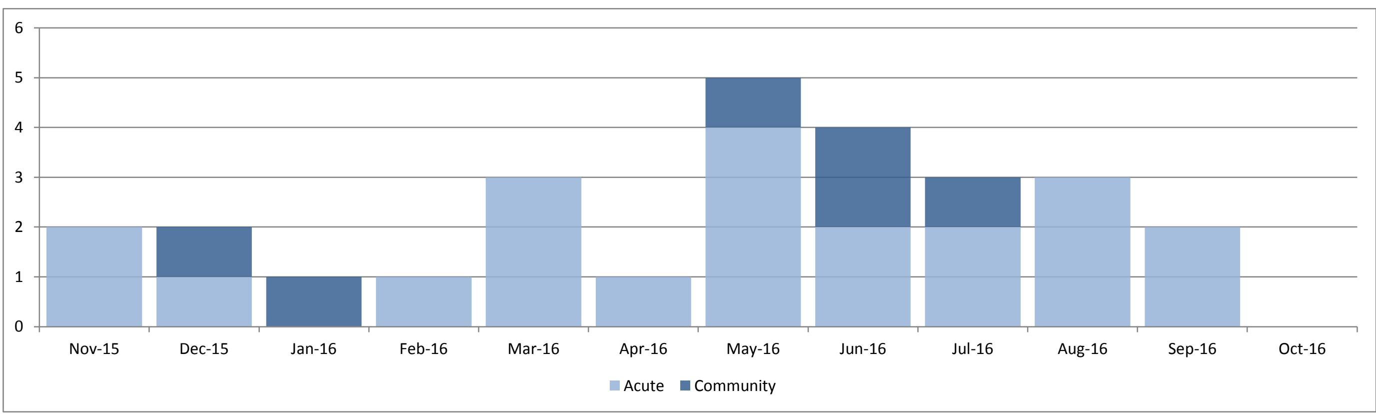
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
12 hour trolley waits	3	1	13	10	1	2	0	0	0	0	2	0



CONTRACTUAL FRAMEWORK

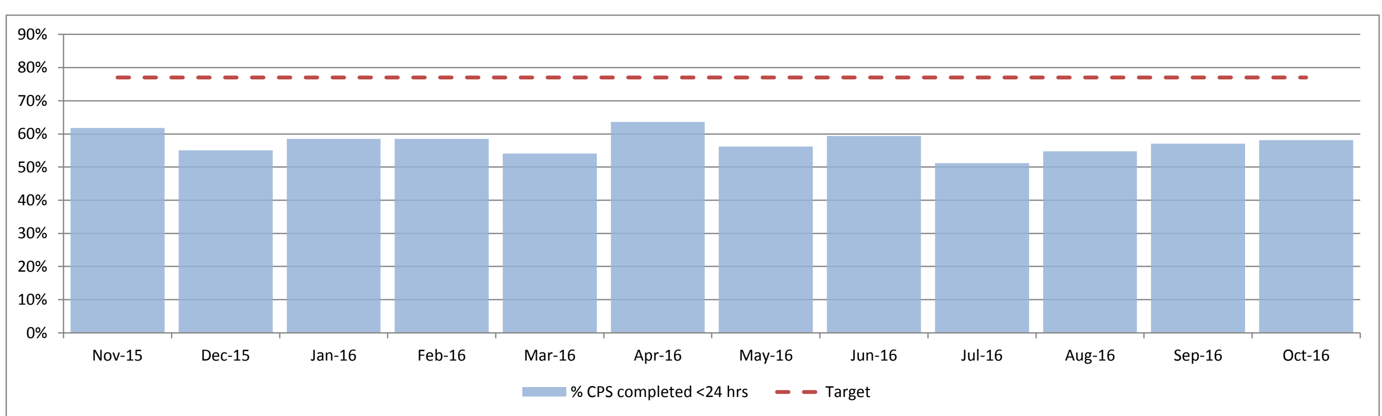
Number of Clostridium Difficile cases

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



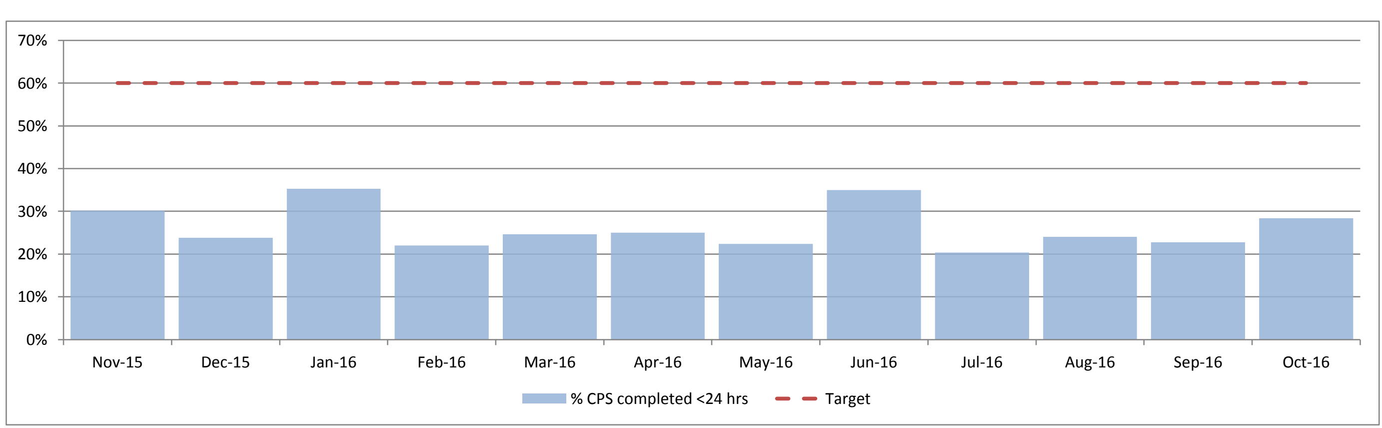
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Discharges	1132	1025	997	1089	1085	1105	1109	1179	1039	1059	1187	1070
CPS completed within 24 hours	1831	1863	1705	1860	2008	1737	1975	1986	2031	1934	2081	1840
% CPS completed <24 hrs	62%	55%	58%	59%	54%	64%	56%	59%	51%	55%	57%	58%
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

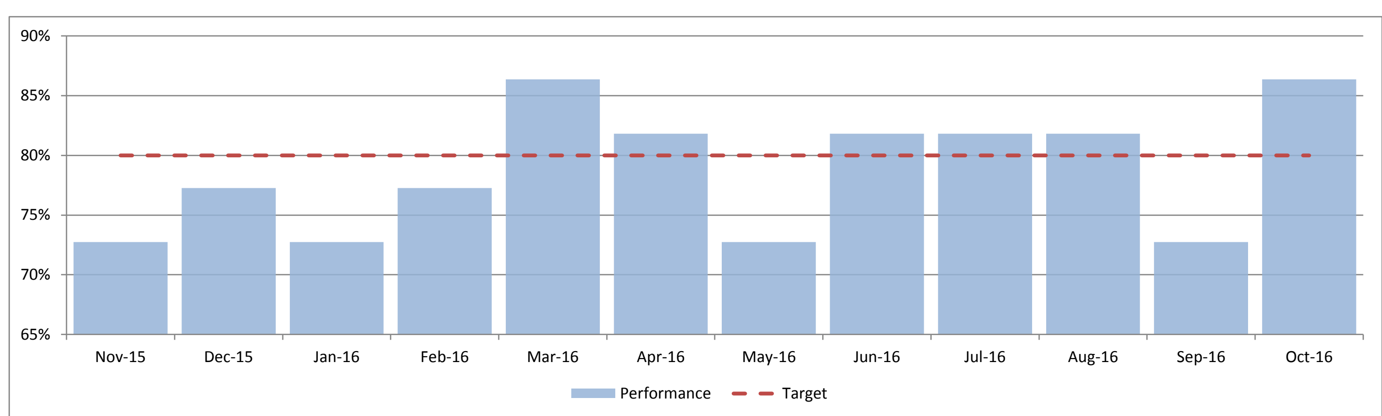
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Discharges	444	390	470	414	406	528	532	460	599	441	448	584
CPS completed within 24 hours	134	93	166	91	100	132	119	161	122	106	102	166
% CPS completed <24 hrs	30%	24%	35%	22%	25%	25%	22%	35%	20%	24%	23%	28%
Target	60.0%	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

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Specialties	22	22	22	22	22	22	22	22	22	22	22	22
Breaching 4 working days	6	5	6	5	3	4	6	4	4	4	6	3
Performance	73%	77%	73%	77%	86%	82%	73%	82%	82%	82%	73%	86%
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 7 October 2016

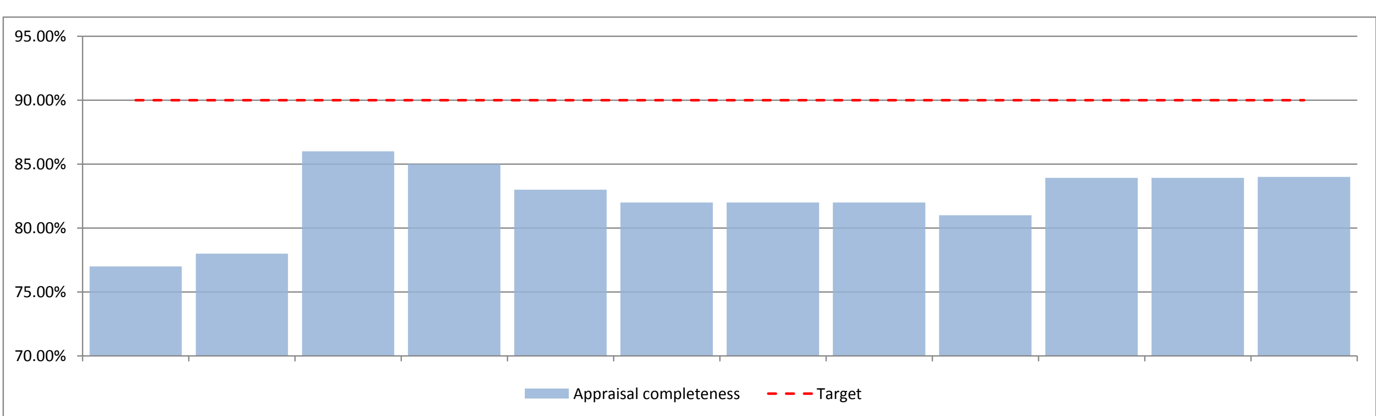
WORKFORCE MANAGEMENT FRAMEWORK

Staff sickness

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Staff sickness	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	n/a
Target	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%

Appraisal Completeness

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Appraisal completeness	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%	84.00%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



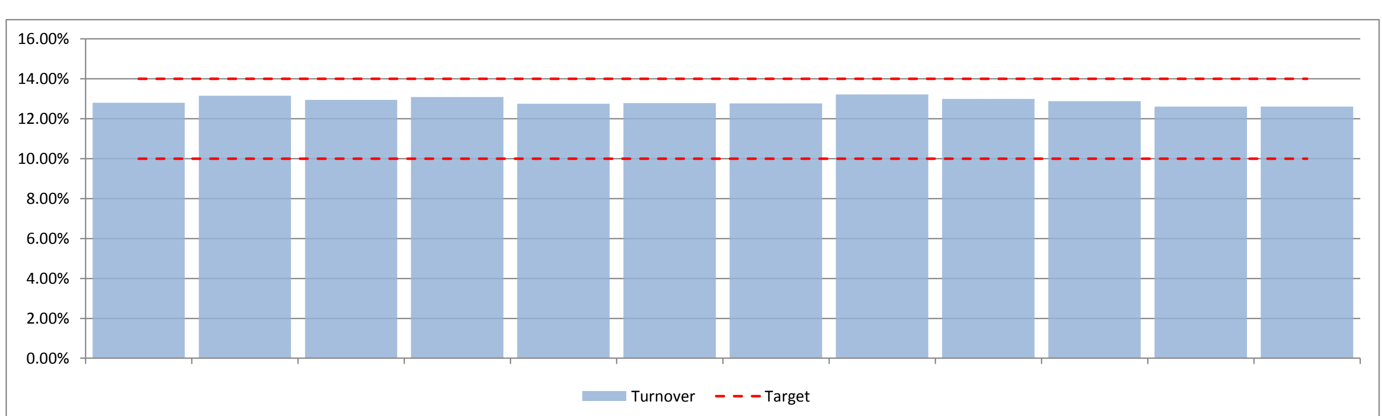
WORKFORCE MANAGEMENT FRAMEWORK

Mandatory Training Completeness

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Mandatory training	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%	86.00%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

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

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Turnover	12.79%	13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.87%	12.61%	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 7 2016/17

Master Ref	Title	Confidence	Conf RAG	Last Month Target	Target 2016/17	Forecast Rec 2016/17	Forecast Non-rec 2016/17	Delivered YTD Rec	Delivered YTD Non-rec
520	Improved auditing of interface between Rosterpro to ESR for Payment e	90%	Green	£0	£0	£20,000			
571	Corporate accruals review	90%	Green	£0	£0		£335,956		£335,956
690	Income reserves not required	[0-100]	Gray	£0	£0	£0	£1,650,000	£0	£412,500
468	Lost pager review	[0-100]%	Gray	£2,000	£2,000	£0			
513	MR contrast for cardiac is about to be ordered in different volumes. This	100%	Green	£3,500	£3,500	£3,500		£3,500	
560	Church st sale and reduction in utilities	70%	Yellow	£4,000	£4,000	£4,000		£0	
417	Community Nursing Vehicle Review - Torbay and SD	100%	Green	£5,000	£5,000	£0			£0
559	Sewing room	90%	Green	£5,000	£5,000	£5,000		£0	
489	Private Therapy Income	100%	Green	£5,000	£5,000	£5,000		£5,000	
479	Outpatient Productivity	0%	Red	£6,250	£6,250	£0	£0	£0	£0
557	External Non clinical Cleaning contract	50%	Red	£6,500	£6,500	£0		£0	
735	Research Income (Clinical Trials)	[0-100]	Gray	£9,000	£9,000				
497	Increase Ultrasound scan charge Idea to work up further	100%	Green	£10,000	£10,000	£6,000		£1,667	
566	Retail outlet level 4	60%	Yellow	£10,000	£10,000	£10,000		£0	
551	Car Parking Introduction of New Tariff £10 for 8 hrs	100%	Green	£10,000	£10,000	£10,000		£10,000	
555	Car Parking review of public charges in the community	70%	Yellow	£15,000	£15,000	£15,000		£0	
565	Regents house rent review	30%	Red	£15,000	£15,000	£15,000		£0	
737	HQ Synergies - Chief Executive	95%	Green	£17,548	£17,548		£17,548		£10,236
544	Income from Training	100%	Green	£20,000	£20,000	£0	£20,000		
552	FM non pay general savings	100%	Green	£20,000	£20,000	£20,000		£20,000	
553	Estates non pay general savings	100%	Green	£20,000	£20,000	£20,000		£20,000	
710	Strategy Directorate- MARS leaver	100%	Green	£20,089	£20,089			£20,089	
695	HR - Yeovil Business Case	90%	Green	£23,333	£23,333	£23,333		£5,186	
407	Joined Up TeleHealthCare Strategy	50%	Red	£25,000	£25,000	£10,000			£0
433	Cavanna House - termination of existing lease at end of current term	100%	Green	£25,000	£25,000	£25,000		£25,000	
549	Catering review Acute	100%	Green	£25,000	£25,000	£25,000		£25,000	
550	Hotel Services Community Hospitals	100%	Green	£25,000	£25,000	£25,000		£25,000	
554	Management pay	100%	Green	£26,000	£26,000	£26,000		£26,000	
694	CE - Corporate - pension scheme	90%	Green	£27,466	£27,466	£27,466		£16,021	
693	HR - synergies - part band 8a post	90%	Green	£27,773	£27,773	£27,773		£16,204	
469	Mobile Phone review/BYOD	20%	Red	£30,000	£30,000	£0			
487	Microbiology VAT saving	100%	Green	£30,000	£30,000	£30,000		£17,500	
493	Medical Electronics Reorganisation	100%	Green	£30,000	£30,000	£30,000		£30,000	
494	Clinical Psychology Staff Saving	100%	Green	£30,000	£30,000	£30,000		£30,000	
692	Procurement synergies - B5 post	90%	Green	£30,651	£30,651	£30,651		£17,880	
413	Efficiences from Thera Contract (ASC element) A	90%	Green	£36,000	£36,000	£36,000		£21,000	£0
434	Review of specialist LD vacancy	100%	Green	£37,000	£37,000	£37,000		£22,000	£0
466	Procurement efficiencies	100%	Green	£40,000	£40,000	£0			
428	Vacant FAB team posts to be reviewd re, Care Act Funded	100%	Green	£44,000	£44,000	£44,000		£26,000	£0
739	HQ Synergies - Procurement	90%	Green	£44,200	£44,200	£44,200		£25,783	

543	eLearning Strategy	0%	Red	£50,000	£50,000	£0			
495	Reduction in spend on Blood - cell salvage	100%	Green	£50,000	£50,000	£50,000		£29,166	
423	Robust review process for adult IPPs	90%	Green	£50,000	£50,000	£146,000		£81,000	£0
498	Reduction in discretionary spend	100%	Green	£57,000	£57,000	£57,000		£33,250	
444	GPWSI	100%	Green	£58,000	£58,000		£58,000	£0	£34,000
556	Car Parking community staff charges	70%	Yellow	£60,000	£60,000	£60,000		£0	
446	Community funding set based on Run Rate spend last year, not now re	100%	Green	£63,859	£63,859	£54,753	£0	£31,939	£0
471	Printing and Electronic Communication Strategy	80%	Yellow	£75,000	£75,000	£0			
408	Independent Sector - Enhanced Brokerage	50%	Red	£75,000	£75,000	£31,000			£0
424	In House Learning Disability Bay Tree (Reprovision of Respite Care)	90%	Green	£79,000	£79,000	£10,000		£0	£0
427	Recurrent Impact of Community Support Team savings	100%	Green	£80,000	£80,000	£80,000		£47,000	£0
465	Review Revenue Costs for IT Systems	20%	Red	£81,000	£81,000	£0			
421	Efficiences from Thera Contract (PP element)	90%	Green	£81,000	£81,000	£81,000		£47,000	£0
537	FP10 Outpatients - pharmacy scheme	90%	Green	£100,000	£100,000	£0	£0	£0	£0
416	ASC Insurance Premium Reduction	100%	Green	£100,000	£100,000	£100,000		£50,000	
403	Independent Sector - Removal of Community Care Trust block and repl	100%	Green	£100,000	£100,000	£144,000		£84,000	
410	Ind Sector - Additional reclaim of ASC Direct Payments	100%	Green	£100,000	£100,000	£243,000		£143,000	
707	Clinical supplies procurement - Medicine impact	50%	Red	£109,000	£109,000	£0	£0	£0	£0
705	Clinical supplies procurement - WCDT impact	50%	Red	£121,000	£121,000				
464	Staff Salary Sacrifice Schemes	100%	Green	£122,000	£122,000		£65,000	£32,117	£19,750
405	Independent Sector - SPACE	70%	Yellow	£125,000	£125,000	£52,000			
406	Independent Sector - Supported Living	50%	Red	£125,000	£125,000	£52,000			£0
409	Ind Sector - Responsive Management of Domicilliary Care	50%	Red	£125,000	£125,000	£52,000			£0
547	Gas utilities	100%	Green	£140,000	£140,000	£140,000		£140,000	
488	Replacement of Existing Roche Managed Service contract	100%	Green	£147,000	£147,000	£147,000		£12,250	
435	South Devon Operations (Community Services) CIP Saving assumption	90%	Green	£150,000	£150,000	£150,000	£208,000	£88,000	£212,000
536	Drug savings - pharmacy scheme	90%	Green	£160,000	£160,000		£0	£0	£0
402	Ind Sector - Reduction in Care Home Placements (Standard under £60	50%	Red	£175,000	£175,000	£73,000			£0
548	Car Parking	100%	Green	£190,000	£190,000	£190,000		£110,000	
738	HQ Synergies - Education Direcorate	0%	Red	£195,900	£195,900				
496	Therapies recurrent vacancy factor	100%	Green	£198,000	£198,000		£198,000		£135,000
425	Community Services CIP Saving assumption based on previous years	90%	Green	£200,000	£200,000	£200,000	£262,000	£117,000	£200,000
432	Co-location of Paignton & Brixham Zones	50%	Red	£250,000	£250,000	£125,000			£0
480	Clinically led procurement in surgery	100%	Green	£258,591	£258,591	£199,730	£58,861	£61,207	£27,356
691	Finance restructure pay savings	70%	Yellow	£263,918	£263,918	£349,085		£85,167	
706	Clinical supplies procurement - Surgery impact	50%	Red	£270,000	£270,000	£1,126	£0	£469	£0
572	Corporate non-pay savings	100%	Green	£390,870	£390,870	£0	£390,870	£0	£351,979
734	CHC General Packages of Care Review	90%	Green	£417,000	£417,000	£578,000		£337,000	
418	Bring review assessments up to date CHC	90%	Green	£430,000	£430,000	£578,000		£165,000	£0
481	Surgery non-pay challenge	60%	Yellow	£440,000	£440,000	£246,818	£0	£143,977	£0
419	Tightening panel process (CHC)	70%	Yellow	£498,000	£498,000	£218,000		£0	£0
723	Nursing agency spend	80%	Yellow	£500,000	£500,000				
426	Torbay Operations (Community Services) CIP Saving assumption base	90%	Green	£500,000	£500,000	£500,000	£740,000	£292,000	£647,000
708	Medical SDU Senior agency and locum budgets	90%	Green	£600,000	£600,000	£600,000	£0	£300,000	£0
709	Adjustment for scheme 709 recategorised as SLIP on 2nd run							£81,900	

	Sub totals				£9,121,448	£6,113,435	£4,004,235	£2,921,272	£2,385,777
	Trustwide Scheme Gap				£4,836,066				
	CIP (FT Plan) Target				**£ 13,957,514**				
	Yr end Forecast Total						**£ 10,117,670**		
	Delivered Year to Date								**£ 5,307,049**

Note: The Scheme delivery values have been reassessed and the value has diminished by £1.5m, this month. More schemes are needed to bridge the Forecast Delivery gap, hence a review is underway to identify which 17/18 CIP schemes / TWIPS can be started early.

\- 2,921,272

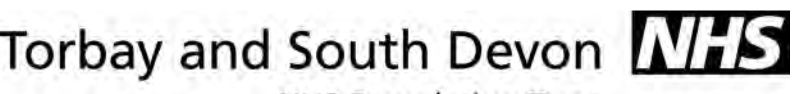
Master Ref	Title	Reason for removal	CIP Scheme Target 2016/17				
558	Car Parking kings ash	Contained within EFM Scheme	£6,000				
476	Additional income via Utilisation of new Cardiac Lab	Re-assessed, no savings this yr	£30,000				
535	PMU - increased sales on top of planned surplus	Production issues mean this won't deliver until next yr	£78,000				
443	Recurrent Impact of Hotel Service re-design	Merged with EFM	£135,000				
538	Integrated Medicines Management - pharmacy scheme	Re-assessed, no savings this yr	£250,000				
688	Synergies - EFM	Within EFM target	£294,000				
697	HQ Synergies - HR	Re-assessed, no savings this yr	£552,200				
709	HQ Synergies - Strategy	Recategorised as Slippage	£140,400				
713	Strategy - remaining CIP/SLIP schemes	Recategorised as Slippage	£77,638				
			£ 1,563,238				

Workforce analysis

Appendix 4

Division/Directorate	Sickness	Appraisals	Training (Average)	Staff	FTE	FTE Turnover
	Sep-16	Oct-16	Oct-16	Oct-16	Oct-16	Oct-16
CHARITABLE FUNDS DIVISION	3.53%	79%	71%	32	19.39	17.11%
Health Visiting & School Nursing	8.31%	95%	91%	100	78.09	15.26%
Other Public Health Provider	2.03%	92%	95%	98	81.13	13.67%
Dir - Public Health	5.13%	94%	93%	198	159.21	14.47%
SD Community Services - Coastal	3.56%	82%	85%	38	33.68	5.95%
SD Community Services - Moorland	6.12%	89%	97%	21	16.97	14.02%
SD Community Services - Newton Abbot	5.63%	90%	82%	37	29.95	13.97%
SD Community Services - Other	5.95%	81%	91%	80	65.03	17.44%
SD Community Services - Totnes and Dartmouth	3.47%	90%	93%	36	30.37	16.39%
Dir - SD Community Services	5.08%	85%	89%	212	175.99	14.26%
Operations Support	2.47%	55%	81%	36	33.34	16.44%
TCT Community Services - Adult Social Care	4.48%	62%	92%	35	31.80	10.38%
TCT Community Services - Baywide	2.48%	81%	87%	52	45.29	18.93%
TCT Community Services - BEST	10.26%	80%	97%	17	12.37	16.17%
TCT Community Services - Brixham Zone	3.17%	77%	92%	53	40.48	10.41%
TCT Community Services - Older Peoples Mental Health	2.38%	100%	83%	13	8.53	0.00%
TCT Community Services - Other Social Care	1.08%	86%	90%	16	12.21	13.43%
TCT Community Services - Paignton	8.74%	73%	89%	111	94.95	12.62%
TCT Community Services - Torquay Zone	7.12%	83%	87%	159	138.62	14.45%
Dir - Torbay Community Services	5.87%	76%	88%	492	417.60	13.67%
COMMUNITY SERVICES DIVISION	5.53%	82%	90%	902	752.80	13.98%
Dir - Chief Executive	0.00%	100%	98%	6	5.84	16.85%
Dir - Education & Development	3.16%	91%	88%	109	103.14	10.24%
Finance	3.54%	60%	81%	80	74.72	11.00%
Health Informatics Service	4.61%	81%	91%	165	143.50	10.63%
Procurement	2.50%	51%	84%	37	35.53	4.65%
Dir - Finance, HIS & Procurement	3.99%	70%	87%	282	253.76	9.90%
Dir - Medical Director	1.97%	89%	93%	29	23.57	4.60%
Dir - Nursing & Quality	1.55%	87%	87%	106	88.56	12.50%
Operations	7.21%	81%	88%	24	19.73	12.66%
Transport	5.73%	88%	90%	72	64.17	8.15%
Dir - Operations	6.06%	86%	89%	96	83.91	9.20%
Dir - Pharmacy Services	1.73%	73%	89%	98	85.42	15.04%
Dir - Strategy	0.00%	67%	82%	62	57.88	3.73%
Dir - Workforce	1.54%	93%	85%	73	64.61	28.47%
CORPORATE SERVICES DIVISION	2.96%	79%	88%	861	766.69	11.94%
Estates	6.69%	59%	100%	32	31.60	8.21%
Facilities Management	5.54%	80%	98%	27	25.28	5.28%
Dir - Estates & Facilities	6.18%	68%	99%	59	56.88	7.21%
Hotel Services - Catering	4.37%	93%	78%	51	37.09	18.46%
Hotel Services - Domestic	5.53%	97%	76%	348	248.65	14.14%
Hotel Services - Other	1.56%	94%	68%	74	68.40	14.66%
Dir - Hotel Services	4.66%	96%	75%	473	354.13	14.81%
ESTATES & FACILITIES MANAGEMENT DIVISION	4.87%	92%	78%	532	411.01	13.72%
Dir - Hospital Services - Brixham	4.06%	71%	71%	32	26.60	14.33%
Hospital Services - Dawlish Hospital	0.00%	95%	91%	27	22.90	13.16%
Hospital Services - Teignmouth Hospital	2.66%	93%	92%	18	14.83	29.48%
Dir - Hospital Services - Coastal	1.21%	94%	91%	45	37.73	21.47%
Dir - Hospital Services - Dartmouth	3.81%	96%	97%	26	20.31	20.20%
Dir - Hospital Services - MIU Services	1.70%	83%	98%	29	23.67	16.32%
Hospital Services - Ashburton Hospital	2.14%	93%	85%	18	13.80	14.91%
Hospital Services - Bovey Tracey Hospital	9.49%	100%	84%	11	8.64	57.30%
Dir - Hospital Services - Moorland	5.03%	95%	85%	29	22.44	33.32%
Dir - Hospital Services - Newton Abbot	4.66%	96%	92%	88	72.90	19.12%
Dir - Hospital Services - Other	0.00%	100%	96%	3	3.00	0.00%
Dir - Hospital Services - Paignton	4.95%	88%	93%	33	26.47	18.72%
Dir - Hospital Services - Totnes	8.08%	92%	93%	35	28.77	25.33%
HOSPITAL SERVICES DIVISION	4.11%	91%	90%	320	261.89	20.47%
Ind Sec Adult Social Care - Torbay	12.21%	70%	89%	10	9.52	0.00%
Ind Sec In House Services LD - Torbay	12.12%	83%	87%	36	28.66	8.88%
545 Dir - Independent Sector Adult Social Care - Torbay	12.14%	80%	88%	46	38.18	6.86%
546 Dir - Independent Sector Health	7.75%	73%	89%	33	29.27	28.42%
INDEPENDENT SECTOR DIVISION	10.22%	77%	88%	79	67.45	16.38%
INTERNAL AUDIT	10.95%	100%	90%	12	11.37	41.69%
Cancer Services - Medicine	5.04%	100%	89%	8	7.80	0.00%
Clinical Oncology	6.65%	80%	88%	55	48.65	13.31%
Haematology	0.00%	100%	100%	4	4.00	0.00%
Medical Oncology	0.00%	100%	89%	5	4.15	23.26%
Non Surgical Cancer Services Admin	6.11%	90%	94%	43	34.15	10.93%
Palliative Care	0.00%	100%	83%	6	4.90	0.00%

Ricky Grant Unit and Turner Ward	7.41%	87%	68%	83	68.67	16.01%
Dir - Cancer Services - Medicine	6.23%	87%	81%	204	172.32	13.25%
Care of the Elderly - Medicine	4.28%	96%	83%	102	90.26	11.54%
Stroke	3.94%	97%	87%	39	34.69	19.03%
Dir - Care of the Elderly - Medicine	4.18%	96%	84%	141	124.96	13.81%
Dermatology	0.29%	89%	90%	15	11.44	0.00%
Neurology	0.00%	100%	93%	3	3.00	50.63%
Rheumatology	2.27%	89%	87%	16	11.53	0.00%
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	1.16%	89%	89%	34	25.97	7.39%
Dir - Emergency Services	1.52%	91%	88%	268	225.09	10.32%
Diabetes and Endocrinology	4.58%	71%	90%	20	17.47	0.00%
Gastroenterology	4.43%	53%	77%	81	72.50	4.13%
Dir - Gastoenterology/Endocrinology- Medicine	4.46%	55%	80%	101	89.97	3.47%
Admin/Support- Med Div	8.89%	91%	92%	48	40.57	29.97%
General Medicine	1.49%	91%	87%	61	53.59	11.96%
Medical Division HQ	3.29%	100%	92%	4	4.05	48.45%
Dir - General Medicine	4.69%	91%	89%	113	98.21	23.58%
Cardiology	2.83%	91%	89%	127	107.84	4.40%
Respiratory	8.19%	95%	90%	68	58.26	18.96%
Dir - Heart & Lung- Medicine	4.67%	92%	89%	195	166.10	9.44%
MEDICAL SERVICES DIVISION	4.00%	88%	86%	1056	902.60	11.84%
PMU Finance	0.00%	40%	82%	5	4.64	12.15%
PMU Manufacturing	5.15%	8%	74%	53	51.23	6.40%
PMU Quality Control	0.37%	85%	86%	49	46.69	0.00%
PMU Sales & Marketing	0.52%	100%	68%	8	7.39	0.00%
PMU Senior Team	0.00%	100%	92%	4	3.70	38.29%
PMU Supply Chain	2.64%	35%	53%	19	15.68	4.04%
PHARMACY DIVISION (Manufacturing)	2.52%	50%	76%	138	129.33	4.86%
RESEARCH & DEVELOPMENT DIVISION	2.61%	86%	86%	45	34.87	8.66%
Dir - Breast Care	3.38%	100%	89%	41	32.58	12.37%
Dir - General Surgery	4.44%	80%	82%	257	217.09	10.80%
Dir - Head & Neck	1.34%	93%	87%	104	80.01	4.73%
Dir - Ophthalmology	4.97%	97%	91%	121	105.45	10.13%
Dir - Surgical Division	4.27%	81%	86%	97	84.38	11.97%
Dir - Theatres, Anaesthetics and ICU	4.28%	85%	86%	410	364.24	11.11%
Dir - Trauma and Orthopaedics	1.15%	87%	88%	163	140.56	13.42%
SURGICAL SERVICES DIVISION	3.71%	86%	86%	1193	1024.31	10.94%
Child Health Med, Mgmt and Misc Specialty	0.68%	92%	81%	61	53.71	9.94%
Paediatric	6.33%	76%	88%	96	76.54	6.03%
Dir - Child Health	4.00%	79%	86%	157	130.26	7.42%
Dir - Lab Medicine	3.75%	87%	86%	115	101.16	8.77%
Gynaecology	6.63%	97%	87%	39	29.13	1.62%
Midwifery	4.62%	84%	91%	130	102.31	4.77%
O&G Medical and Management	5.61%	87%	80%	48	43.83	19.06%
Dir - Obs & Gynae	5.21%	87%	88%	217	175.27	7.01%
Dir - Radiology & Imaging	2.20%	80%	89%	130	110.18	17.16%
Dir - Sexual Health	3.28%	79%	95%	41	31.46	13.77%
Dir - Therapies	2.03%	88%	90%	301	246.02	16.08%
Medical Electronics	1.15%	100%	98%	18	17.64	4.23%
Women's, Children's & Diagnostics	0.16%	77%	92%	15	13.25	7.38%
Dir - Women's, Children's and Diagnostics	0.74%	89%	95%	33	30.89	5.65%
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.25%	85%	89%	994	825.24	11.73%
ICO Grand Total	**4.02%**	**84%**	86%	**6164**	**5206.97**	**12.61%**



REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Referral to Treatment Target
Lead Director:	Liz Davenport, Chief Operating Officer
Corporate Objective:	Safe, Quality Care and best experience
Corporate Risk/ Theme	Theme 2- delivery of key performance targets
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

The Trust is required to ensure that 92% of people access treatment within 18 weeks of referral. In year the Trust agreed to meet this standard by end of October 2016. Delivery against this standard form part of the criteria to access the Service Transformation Fund (STF).

The Trust was compliant with the improvement trajectory for the 2 quarters of the year but has seen deterioration in performance. The paper sets out the context of the change in performance and the actions required to deliver compliance by April 2018.

Key Issues/Risks

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 through the STP Acute Services review. These solutions will need to be in place if the Trust is to recover the RTT standard by April 2018.

Recommendations:

To **consider current** performance **and risks** to delivery of the 92% RTT target

Summary of ED Challenge/Discussion:

The Executive Team have reviewed the current position and have required the following action:

- Review of risks to patient safety of waits to be seen beyond 18 weeks
- Inclusion of services that are vulnerable due to workforce issues in the STP Acute Services Review
- Prioritisation of medical capacity to support improved weekend working in line with CQC requirements
- A focus on optimisation of RTT in services where capacity is in place supported by the lead Director for Planned care

Internal/External Engagement including Public, Patient and Governor Involvement:
Discussions with South Devon and Torbay CCG
Equality and Diversity Implications:
A Quality Impact and Equality Impact Assessment will be completed.

Report to:	Board of Directors
Date:	7 December 2016
Report From:	Chief Operating Officer
Report Title:	Referral to Treatment Target

1 Purpose

To provide further detail current performance against the Referral to Treatment Target (RTT) to include plans to address performance and risks to delivery.

2 Provenance

The report has been informed by:

- Minutes of the Joint Executive
- Minutes of the Executive Team
- Minutes and action log from the RTT Risk and Assurance Group
- Performance Information
- SDU Risk Registers

3 Background

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 knee surgery 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.

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

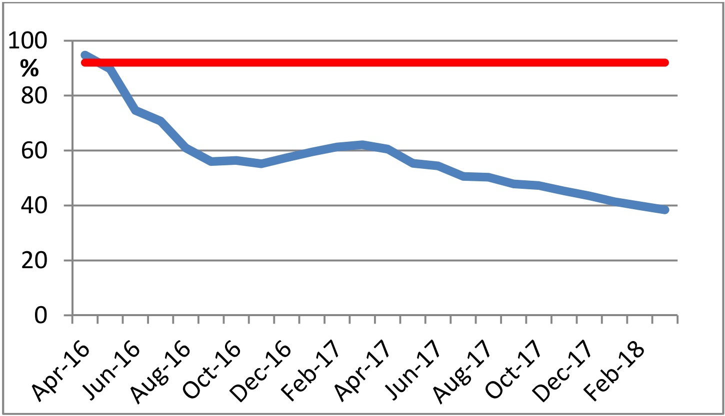
to the workforce shortfall in respiratory has also had a significant impact on their backlog which currently stands at 217 and is expected to deteriorate further with the expected loss of another consultant.

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%.

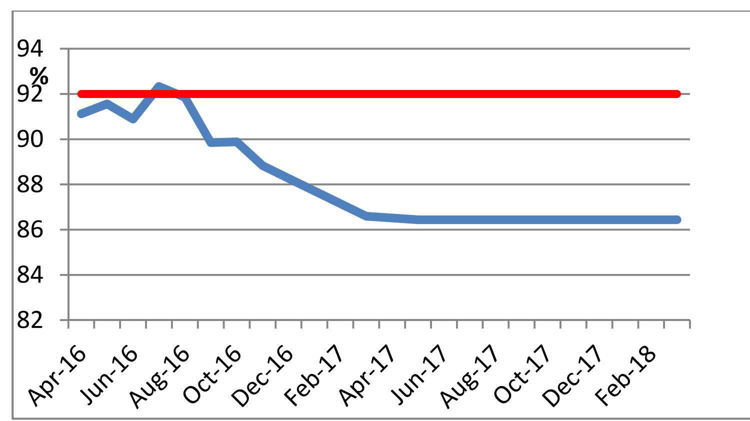
4 Risks and Issues

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

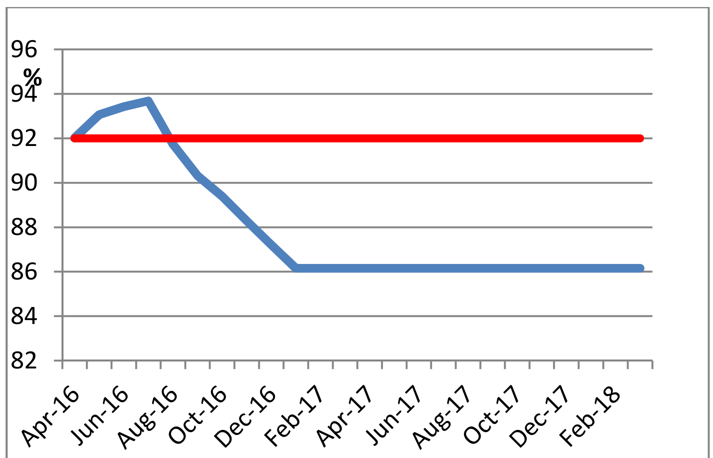
Neurology: Registrar doing 5 clinics per week until March 17 and no recruitment of other consultant.



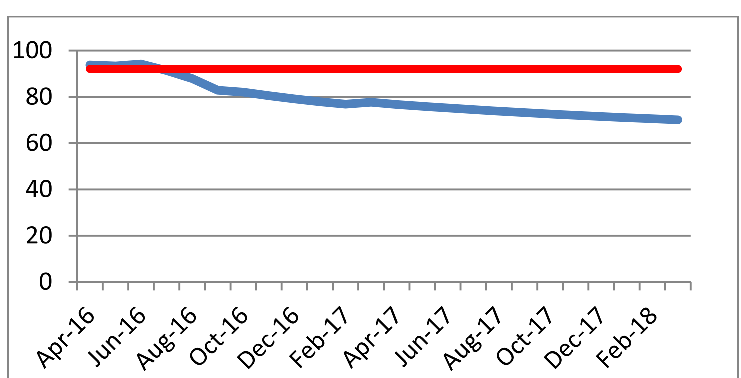
Urology: No senior core trainee - so consultants will have to drop elective work to cover on-call counter acting increase from additional consultant.



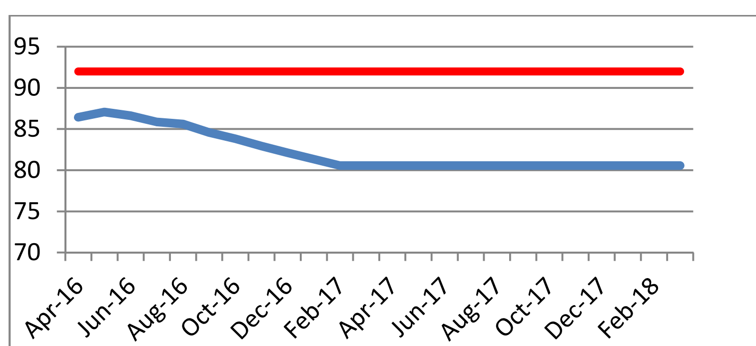
Cardiology: Consultant retirement and return on reduced hours with no other consultant recruited



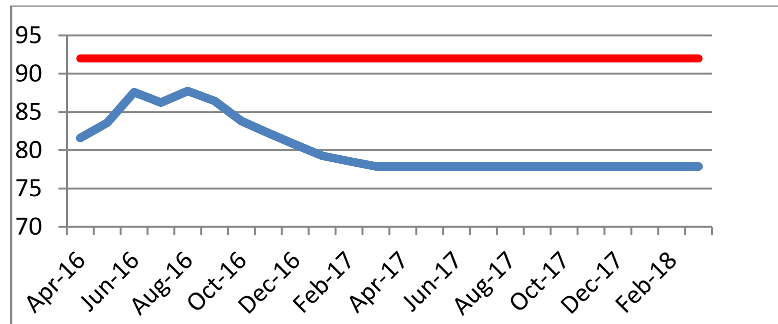
Respiratory Medicine: No recruitment of consultant (2 wte down)



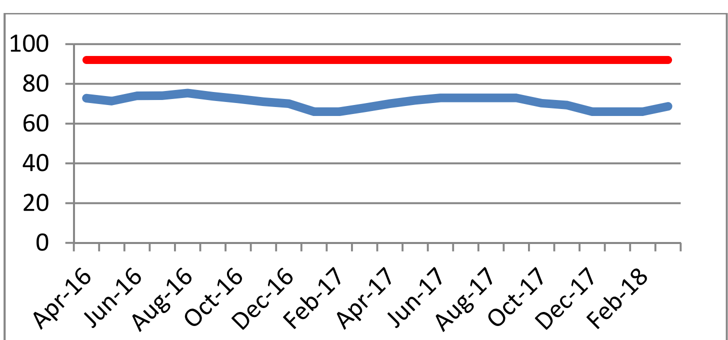
Trauma & Orthopaedics: No outsourcing and no recruitment of foot and ankle Fellow, no single point of access for foot and ankle.



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)

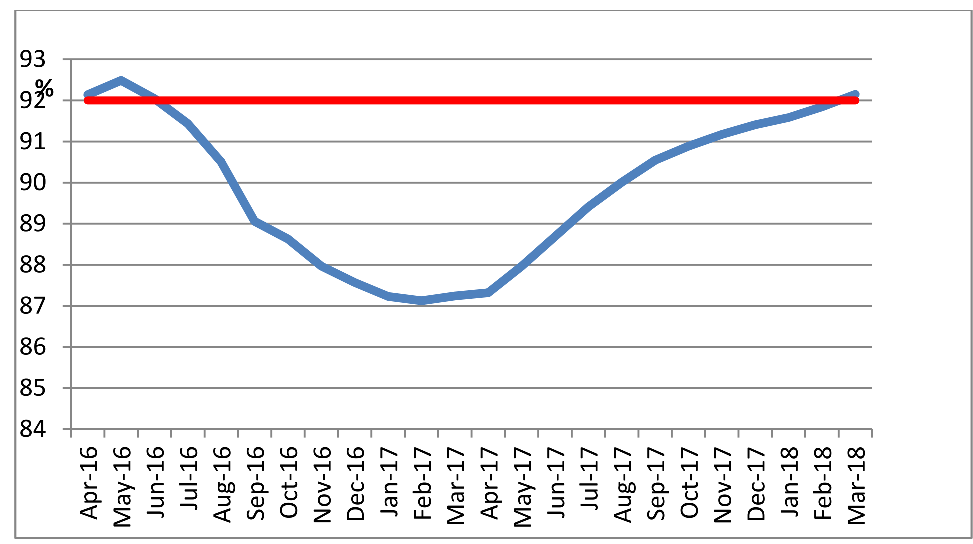


The combined effect on the consolidated RTT trajectory by March 2018 will result in a lowering of performance to 83%. Reversal of the decision to stop outsourcing would have minimal effect this year, 0.5%.

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 31st March 2018



5 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

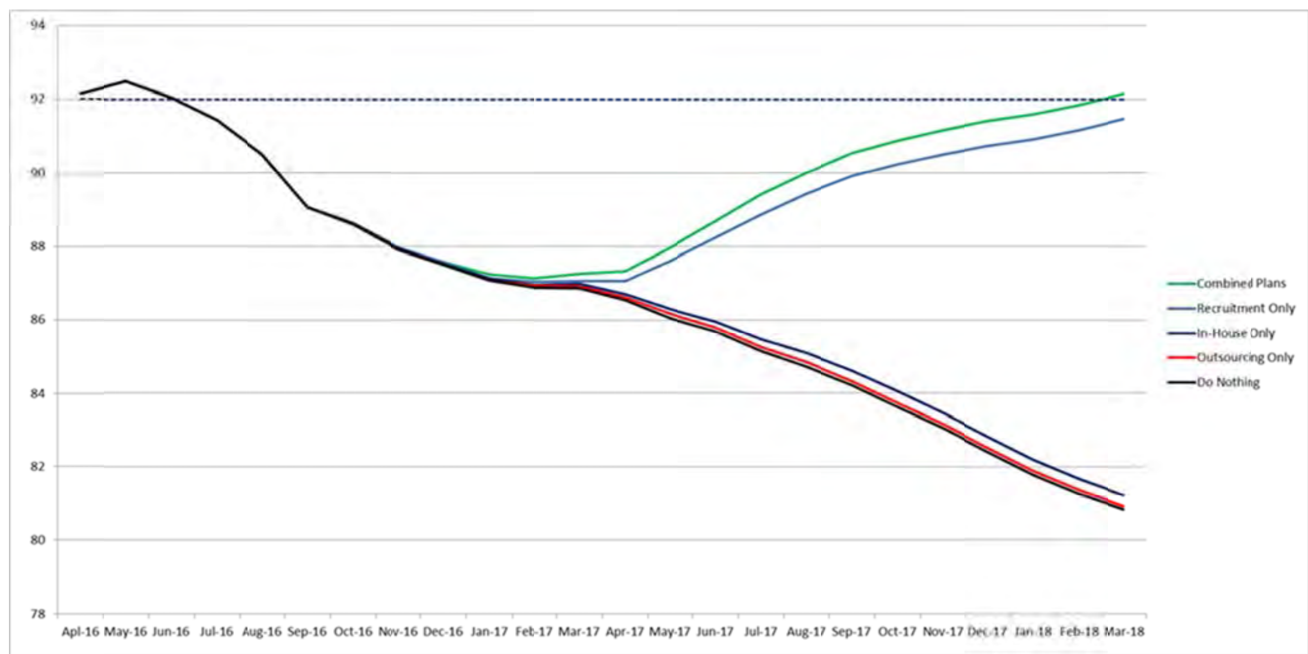
To recover compliance with the RTT standard by March 2018 in line with the trajectory submitted to NHS England and NHS Improvement the following actions will be required: Recruitment to vacant clinical posts

- 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



6 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 through the STP Acute Services review. These solutions will need to be in place if the Trust is to recover the RTT standard by April 2018.

7 Recommendation

To **consider current performance and risks** to delivery of the 92% RTT target

Liz Davenport
Chief Operating Officer

REPORT SUMMARY SHEET

Meeting Date:	7th December 2016
Title:	Clinical Validation of patients with delayed outpatient review
Lead Director:	Medical Director
Corporate Objective:	1. Safe, quality care and best experience
Corporate Risk/ Theme	2. Failure to achieve key performance standards 7. Patients lost from the follow up system may not receive required appointments resulting in critical diagnoses being missed 8. Care Quality Commission requirement notice sets out significant concerns regarding safe quality care and best experience 9. Capacity in neurology leading to lack of new patient appointments, leading to long delay to initial assessment, threat of RTT breach.
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

There is increasing delay in outpatient assessment of patients in a range of specialties, reflecting increased referrals, greater urgent care pressures and/or recruitment and retention difficulties. Action plans are in place to reduce waiting times but there is a need to ensure that the risk to patients is minimised.

Key Issues/Risks

- Risk has been identified in delays to outpatient follow up patients (6500 patients at the present time across the Trust).
- Delays to assessment of new 'first outpatient' referrals are emerging in some specialties
- Mitigating practices are in place in the majority of specialties and in all those with high risk of significant harm.
- There is residual risk after mitigation but this is low to moderate
- Concerns about Neurology have been raised by the CCG. Mitigating actions are in place to reduce risk.

Recommendations:

1. Ongoing monitoring of numbers of patients and residual risk is needed for follow-ups past their 'to be seen by' date
2. Monitoring of plans to reduce numbers of patients past their 'to be seen by ' date are needed in all affected specialties is required and will be undertaken through the DGMs' group and Quality and Performance Reviews.
3. Improved communication with the CCG is needed to ensure that referring clinicians are aware of the risk of delay when patients are referred for 'first outpatient' appointment and to include changes in status on a regular basis. A process will be agreed through CMG.
4. All specialties will be encouraged to consider alternatives to traditional follow-up through the business planning process.
5.

Summary of ED Challenge/Discussion: Executive team members have contributed to discussion of the issues and plans for mitigation of risk.
Internal/External Engagement including Public, Patient and Governor Involvement: The contents of this report will be considered at the Quality Improvement Group (QIG) the membership of which includes public, patient and Governor representation.
Equality and Diversity Implications: None identified

Report to:	Trust Board
Date:	December 2016
Report From:	Medical Director
Report Title:	Clinical Validation of patients with delayed outpatient review

1. Background

Over the last 2 years the Trust has experienced increasing pressure on achievement of Referral to Target for outpatients with particular increase in 2-week wait referrals. At the same time there has been increasing pressure on the urgent care system. Both of these shifts exerts pressure on review of outpatient activity with outpatient follow up in particular having a lower priority. It is recognised that this default operational priority may result in significant risk for patients under active treatment or with time-sensitive follow-up requirements.

1.1 Follow up patients past their 'to be seen by' date

Numbers of patients past their 'to be seen by' date have been increasing steadily and are now at a very high level. This is almost entirely a concern in the previous acute service delivery units. This is not a new problem and departments have developed a variety of approaches to mitigate risk for patients with delayed review. However, the number of patients delayed and the potential length of delay is higher than it has been in the past and the need for an assessment of risk and an agreed approach has been agreed.

Follow ups past to be seen date

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Medical	1304	1506	1710	1809	2152	2105	2166	2545	2923	3241	3332	3585
Surgical	2894	3251	3230	2768	3179	3553	3520	3259	3218	3162	2828	2650
Women and Children	344	333	351	361	401	424	387	415	460	516	373	347
Total	4542	5090	5291	4938	5732	6082	6073	6219	6601	6919	6533	6582

1.2 New outpatient referrals likely to be significantly delayed

With increasing pressure on outpatient referrals there is a greater likelihood that new referral appointments are delayed. 'Choose and Book' is designed as a national system to promote choice and allow patients to be seen and treated in an alternative centre if the local Trust cannot offer an appointment in the prescribed time. However, many patients choose to wait to be seen at TSDFT rather than travel. This delay is associated with increased risk which is difficult to quantify for TSDFT as the patients have not been seen by our staff. General Practitioners and the patients themselves carry the risk in this situation. There is a need to adopt a common approach when delays are anticipated to mitigate risk.

Significant delays to new or 'first outpatient' appointment are being experienced in a number of specialties. The reasons for this are multifactorial, including substantial increase in referral (Dermatology) and difficulties in recruitment and retention of medical staff (Respiratory Medicine, Dermatology, CAMHS, Neurology).

1.3 Neurology Service

The Neurology service at TSDFT has been the source of concern since there was a sudden unplanned reduction in consultant workforce from 4 to 1 consultant in early 2016. There have been significant delays in patients being seen as 'first outpatient'. Outpatient follow up appointments have also been affected but to a lesser degree. SDTCCG have sought assurance on the management of patients and the mitigation of risk of those who are waiting longer than is expected. The mitigating actions taken have been used as a model for managing similar difficulties in other specialties.

Capacity for new and follow up patients remains severely constrained in Neurology though we now have 2 consultants and a locum registrar in post. There is also the prospect of recruitment of a third consultant in the New Year. Capacity is likely to remain constrained for a considerable time.

2. Mitigating actions

2.1 Past to be seen by date follow ups

A risk assessment has been performed by each specialty. Table 1 describes the numbers of patients by specialty, estimated risk, mitigating actions both administrative and clinical and residual risk. Mitigating actions will vary according to specialty and risk but aare in place in all high risk areas and include

- Action plan to reduce patients past their to be seen by date, including assessment of whether follow up is needed at all, the use of non-face to face follow up, follow up by another members of staff (e.g. specialist nurse rather than consultant/medical)
- Consideration of alternative means of follow-up such as 'tracker systems'.
- Review of notes and prioritisation of higher risk patients
- Additional clinics/other activity where needed
- Communication with primary care

2.2 New outpatient referrals likely to be significantly delayed

Assessment of risk is more difficult prior to first outpatient contact and relies on information from the referrer. A standard approach to potential long-waiters will be agreed with the CCG to include

- Consultant triage of all referrals with request for further information if there is insufficient detail to assess risk.
- Standard letter informing the GP of likely length of wait so that the GP can advise the patient with regard to consideration of referral elsewhere. To include offer to reconsider priority if clinical condition changes
- Advice and Guidance through 'Seeking Advice in the ICO – SAICO' to avoid the need for face to face referral or to facilitate investigation and early treatment if appropriate prior to appointment.
- Regular updates of the length of wait for new referrals to CCG (for ongoing communication with GPs).

3. Residual Risk and further actions

The table shows the assessed risk and residual risk after mitigating actions. In most specialties the risk is low, though the prolonged waits may still represent a poor patient experience. Focus remains on the action plan for reduction in numbers of patient. Recruitment and retention difficulties will be a barrier to achievement of that objective in some specialties. There is focus on some affected specialties (including Neurology) through the vulnerable service and Acute Service Review of the Sustainability and Transformation Plan (STP).

A standard approach to communication and risk mitigation will be adopted for all specialties experiencing difficulties in meeting review targets. Clinical engagement of specialties will take place through Clinical Management Group (CMG) and the policy taken to Quality Improvement Group for consideration and ratification.

Progress against the action and compliance with the policy for new 'first outpatient' referrals will be monitored through Quality and Performance Reviews and QIG.

Table 1. Follow up patients past their 'to be seen by' date. Risk assessment and mitigating actions. November 2016.

Service Delivery Unit	Specialty	Subspecialty	No. of Patients past their to be seen by date	Risk			Mitigations in place, admin	Mitigations in place, clinical	Residual risk		
				Likelihood	Consequence	Total			Likelihood	Consequence	Total
Medicine	Nephrology		81	2	2	4	Clinicians aware of current position, all routine follow ups and escalation of appointment occurs if deemed necessary.	Additional clinics are offered on ocassion to deal with the longest waiters.	1	2	2
Medicine	Geriatric Medicine		7	1	3	3	As numbers are small for this specialty no formal process in place. Reviewed weekly by PM.	2 letter review process non repsonder alert consultant to review	1	3	3
Medicine	Cardiology	Cardiology	256	3	4	12	Each week follow up capacity and pending lists are reviewed and managed by the Cardiology management team and PAC team. Weekly numbers and dates past TBS are circulated to the Consultants. Agreed timescales past TBS have been agreed with the clinical team. Flexing of clinic templates when appropriate.	Clinic letters are reviewed at the time of clinic appointment by the Consultants of all supporting staff, eg SPR. Weekly updates of numbers past TBS and longest waiters emailed to the Consultants. Discussions at Business Meetings when appropriate.	2	4	8
Medicine	Endocrinology		174	3	4	12	Waiting list information shared with clinical team on a monthly basis so they are all aware of the current position. Most patients are routine and are co-managed with Endocrine Specialist Nurse who manages test results etc. Endocrine tracker in place to monitor all patients to ensure safety.	Additional clinics are offered on ocassion to deal with the longest waiters. Ad-hoc reviews of longest waiters.	2	3	6
Medicine	Gastro-Enterology		0	0	0	0	No Pending list for Gastro-enterology				0
Medicine	Respiratory Medicine (Chest)	General Respiratory	517	3	4	12	Communication with the Consultants on number of patients past TBS. Weekly completion of capacity sheets shared with Consultants. In the process to send letter to patients waiting for a significant period of time. Awaiting approval.	Consultants reviewing pending lists with last letters/notes. Aware of backlogs. Discussions at Business Meetings. Additional clinics for high risk patients.	2	4	8
Medicine	Rheumatology		1311	3	3	6	Waiting list information shared with clinical team on a monthly basis so they are all aware of the current position. Most patients are routine and are co-managed with GP practices re medication etc. Patients are asked to phone in to the Patient Helplineif they have a problem and the clinicians will triage. Biologics tracker in place to monitor all patients on Biologics medications to ensure safety.	Additional clinics are offered on ocassion to deal with the longest waiters.	2	3	6
Medicine	Neurology	MS	59	3	2	6	List reviewed weekly by PM. Aim is to try and clear past TBS so that those hitting the point are reviewed each week. This is not set in stone.	Last letters being passed to consultants to make decision on whether appointment needs to be expedited.	2	2	4
		Epilepsy	32	3	3	9			2	3	6
		General Neurology	5	3	4	12			2	3	6
Medicine	Dermatology	Minor Ops	154	2	3	6	Monthly review of pending lists		2	3	6
		Phototherapy	0	1	1	1			1	1	1
		Skin Cancer	0	2	2	4	Monthly review of pending lists		2	2	4
		Patch Tests	3	2	2	4			2	2	4
		Photodynamic treatment	3	1	2	2	Monthly review of pending lists		1	2	2
		Vulval	9	2	2	4	Monthly review of pending lists		2	2	4
Medicine	Diabetic		254	3	3	9	Waiting list information shared with clinical team on a monthly basis so they are all aware of the current position. Most patients are routine and are co-managed with Diabetes Specialist Nurse & Dietitians who manage queries and questions regarding treatments.	Additional clinics are offered on ocassion to deal with the longest waiters. Ad -hoc reviews of longest waiters.	2	2	4

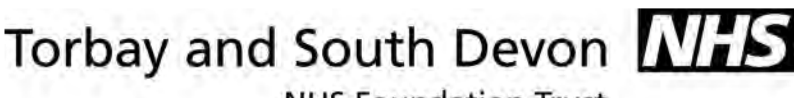
tbc…

Service Delivery Unit	Specialty	Subspecialty	No. of Patients past their to be seen by date	Risk			Mitigations in place, admin	Mitigations in place, clinical	Residual risk		
				Likelihood	Consequence	Total			Likelihood	Consequence	Total
WCDT	Dietetics: weekly	2 x general adult OP clinics	12 clinics are booked on to ICS	2	2	4	Dietitians triage all their own referrals	Priority follow up booking for high risk patients	1	2	2
	and monthly	2 x general Paed OP clinics	2 x coeliac clinics on PAC (inc monthly group session)			0	Secretary booking appointments is able to identify approximate wait for follow up	Dietitian will flag up to secretary			0
		(inc 1 x monthly Cow's Milk Allergy Group)	No way of currently measuring or monitoring accurately PTBSBD			0		Additional telephone review may be offered			0
		1 x Nutrition Support				0					0
		1 x Gastro IBD/general				0					0
		1 x Gastro IBS				0					0
		2 x Coeliac				0					0
		(inc 1 x monthly group for newly diagnosed coeliacs)				0					0
		(and inc 1 x monthly tel review clinic)				0					0
		1 x Diabetes/Obesity				0					0
	fortnightly	1 x Diabetes/Gastro				0					0
		1 x Diabetes general				0					0
		1 x Diabetes Specialist (ED/Preg)				0					0
	No service	Adult Eating Disorders	No capacity to see at present as no specialist ED Dietitian and no MDT team	4	4	16	Risk has been raised with CCG. Risk not held within the Trust.		4	4	16
	Excessive waiting list	IBS	Waiting List for first appointment >12months but follow up within expected date			0					0
	Dietitians also attend numerous MDT clinics but not booked through our dept					0					0
WCDT	Paediatrics	Community	228	4	2	8	1. PAC Book Chronologically 2. Weekly review of Oldest waiters	1. Weekly review of Oldest waiters 10 per week 2. review non	3	2	6
		General	399	4	2	8	10 per week 3. 2 letter review process non repsonder alert sent	responder letters 3. Pink Slip Review and move TBS Date if	3	2	6
WCDT	Gynaecology	Colposcopy	9	3	2	6	List reviewed weekly by Practice Manager, Escalations process in place when errors not amended. 2 letter review process non repsonder alert consultant to review, Weekly capacity meeting regarding clincis and wait times.		2	2	4
		General	64	4	2	8	List reviewed weekly by Practice Manager, Escalations process in place when errors not amended. 2 letter review process non repsonder alert consultant to review, Weekly capacity meeting regarding clincis and wait times.		2	2	4

tbc…

Surgery	Breast	Breast FU	11	3	2	6	Monthy reivew of pending lists -v- capacity.	Extra clinics where needed	2	2	4
		Delayed reconstruction	1	3	2	6			3	2	6
			52	1	1	1					0
Surgery			370	4	3	12			3	2	6
	Ophthalmology	Plastics	112	3	4	12	Monthly review of pending lists. Extra clinics organised when possible.	Named consultant for each patient. Extra clinics, redesign of clincs to increase capacity.	2	4	8
		Macular	279	4	4	16			3	4	12
		Medical Retina	654	4	3	12			3	3	9
		Retinal	141	2	3	6			1	3	3
		Surgical Retina	170	2	3	6			1	3	3
Surgery	Oral Surgery		138	4	3	12	only 13 of 138 are over 18 weeks. cancer patients are booked their appointments by use of a red dot system and post operative patients are booked so these are the routine follow ups	The longest wait is for DC, and he is reviewing his longest waiters	3	2	6
Surgery	Orthodontics		109	4	2	8	Only 22 of 109 are over 18 weeks. These are routine follow up patients. This is a small speciality that recently had a vacancy. Although extra clinics are being put in to place as patients are seen at 11:1 conversion rate this will take some time to achieve.	Consultant is currently reviewing his longest waiters	3	2	6
		Shoulder	26 (inc.10 PRP patients)	2	3	6			2	3	6
		Hands	17	2	3	6			2	3	6
Surgery	Orthopaedics	Hip	28	2	3	6	No routine process as numbers small		2	3	6
		Knees	25	2	3	6			2	3	6
		Foot & Ankle	21	2	3	6		One of the consultants reviews his overdue patients	2	3	6
		Peads - Mr Cox	2	2	3	6			2	3	6
Surgery	Orthoptist		330	3	1	3			3	1	3
Surgery	Pain Management		158	4	2	8	Most patients are routine and are co-managed with GP practices re medication etc. Patients are asked to phone in to the office if they have a problem and the clinicians will triage. The wait situation will worsen as one of the clinicians will not be undertaking pain for an indeterminate time. Currently in the process of advertising for Locum/substantive post. Practice manager reviews waiting list on a regular basis	Currently clinicians are undertaking additional clinics where possible.	2	2	4
Surgery	Plastic Surgery		130	3	3	9	Only 25 from 130 are over 18 week waits. cancer patients are booked their appointments by use of a red dot system and post operative patients are booked so these are the routine follow ups. This service is provided from RDE & Derriford	RDE currently reviewing follow up processes with their management team. Head & Neck CD has also asked plastics team to assess how they may review their Torbay past TBS patients	3	3	9
Surgery	Restorative Dentistry		1	1	2	2	Routine patients. The service will be closed from 21/12/16 as Consultant providing service has resigned, so the position will worsen in the new year unless a new Consultant is appointed and can start immediately. Current actions taken - no new referrals are being accepted and post is out to advert.	Current Consultant finishing treatment for all patients in treatment now.	1	2	2
Surgery	Upper Gastrointestinal Surg		28	1	3	3	Numbers small - no routine process		1	3	3
Surgery	Urology		179	3	3	9	Tracking of pending list size to ensure individual patients are not continuing to wait while others are treated.	Additional clinic are performed to keep the numbers as small as possible.	2	2	4
Surgery	Colorectal Surgery		52	1	4	4	No routine process		1	4	4

Public



REPORT SUMMARY SHEET

Meeting Date:	7th December 2016
Title:	Safety Scorecard
Lead Director:	Medical Director
Corporate Objective:	1. Safe, quality care and best experience
Corporate Risk/ Theme	8. Care Quality Commission requirement notice sets out significant concerns regarding safe quality care and best experience
Purpose:	Information and Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The Safety Score card views a number of different metrics from across the organisation relating to the safety of patients. The metrics are derived from internal and external sources and are there to provide top level information and assurance.

Key Issues/Risks

The paper highlights the annual rebasing exercise undertaken by Dr Foster with regard to HSMR and therefore prior data may look slightly different. The rebasing makes it harder to achieve the 100 average to take into account the improvements that are made, year on year by trusts. The latest data point for our HSMR shows that we are still performing well when benchmarked against neighbouring Trusts on an improving national trajectory.

October recorded a Never Event which does not feature in the report as it cover April 2015 to August 2016. An oral solution of sodium bicarbonate was used in error instead of an IV preparation. The patient suffered no harm and changes have been made to the ordering processes and a new label is being added to the top of the solution highlighting the solution if for oral use only. All due process post event have been followed.

Recommendations:
The Board is asked to review the content of the report.

Summary of ED Challenge/Discussion:

Internal/External Engagement including Public, Patient and Governor Involvement:
The contents of this report are considered at the Quality Improvement Group (QIG) the membership of which includes public, patient and Governor representation.

Equality and Diversity Implications:
None identified

Safety Score Card No. 40

Background & Introduction

The indicators for this score card have been collated from a variety of data sources using defined methodology. The sources include Trust data, Dr Foster, and data collected initially as part of the NHS South West Quality and Safety Improvement programme. The data in the appendices has in the main been displayed as run charts. The report is generated by the Safer Care Group, which reports through Quality Improvement Group and Quality Assurance Committee to the board.

Data & Graphs – Run Charts

A number of the run charts used are taken from data the Trust enters into the Institute for Health Improvement Extranet site, and this site does not allow for best fit trend lines to be added.

The run charts used by the IHI are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to go wrong.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to go wrong.

Table 1: South Devon Healthcare NHS Foundation Trust
Safety Score Card N40.

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

Overview:

The Safety Score Card (SSC) will directly feed into the Quality Assurance Committee via the Quality Improvement Group.

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

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

The HSMR position remains below the 100 line and within the expected range.

Triangulating with Dr Fosters Safety Dashboard, one area is flagging and this will be investigated and a report sent back to the Quality Improvement Group

Infection Control
The data is showing a steady pattern of CDT lapses in care but within the expected trajectory. This needs to be observed via the *monthly* Performance and Quality Data book.

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

Patient falls are showing a reduction in recent months post a winter falls campaign which produced a marked reduction in harm during this period.

Grade 3 & 4 pressure ulcers have showing an increase since January, with issues identified in the assessment and recording of skin condition and a report has been sent to the Quality Improvement Group. An action plan is in place and is being monitored by the PU steering Group.

Medication errors and serious harm from errors and showing no overall trends and remain stable.

Cardiac arrests have reducing over time. This is the result of sustained service improvement activity focussing on Trustwide implementation of the National Early Warning Score, early recognition and treatment of peri-arrest and implementation of Treatment Escalation plans.

Assurance Data
Safety Thermometer - All data is within the target range for each metric.

Appendix 1

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

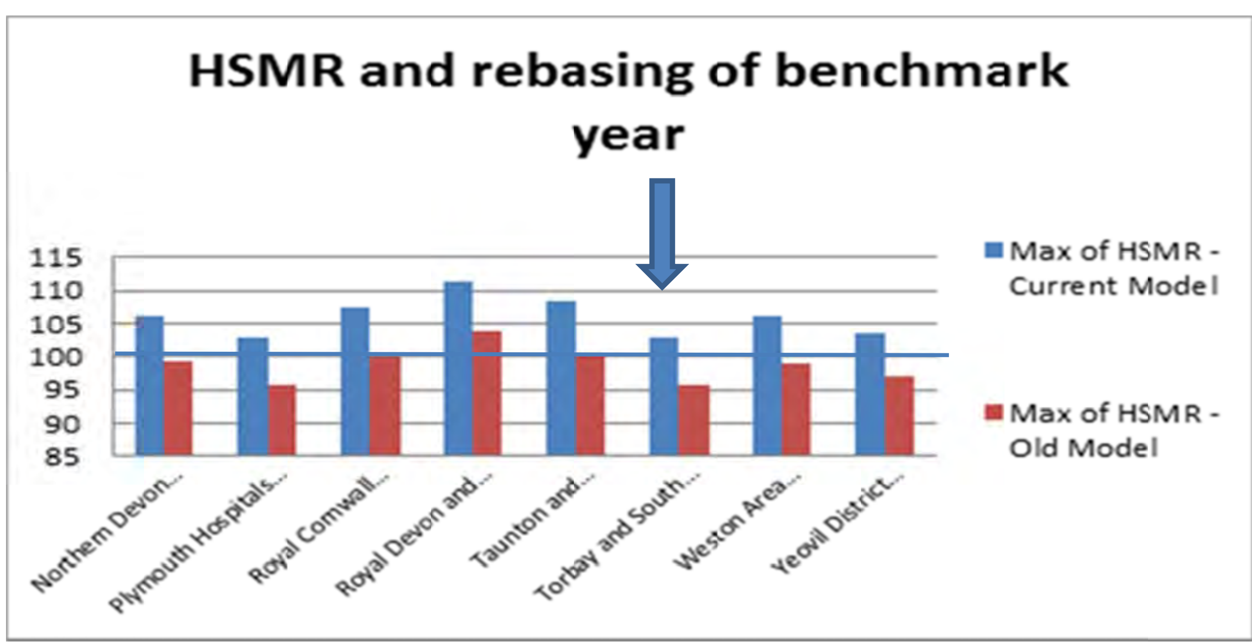
Dr Foster data rebasing prologue
Once a year, Dr Foster the tool we use for providing benchmarking clinical outcomes data, remodels the risks that create the benchmark figures that help project the 100 relative risk benchmark for HSMR (National average).

The reason for this is to take into account the changing patterns of in-hospital deaths and volume of admissions which alter year on year.

Over time, the HSMR is expected to show an improvement against the benchmark previously set, this being due to overall national mortality performance tending to improve over time. Therefore, as we see improvement nationally over time, it is important to regularly remodel against the current national benchmark to ascertain each trust's relative position.

The remodelling is essentially resetting the national average at 100. So whilst a trust's mortality rates may be improving in absolute terms, if the improvement is significantly slower than that observed nationally, then the HSMR for the trust may not show improvement.

The below chart has been created by Dr foster to highlight how this change has impacted across the South West community. The chart looks at the SW Acute Trust peer group for the time 15/16 financial year and uses both the new benchmark year (blue - left bar) and the old 14/15 benchmark year (red - right bar) to highlight the difference.

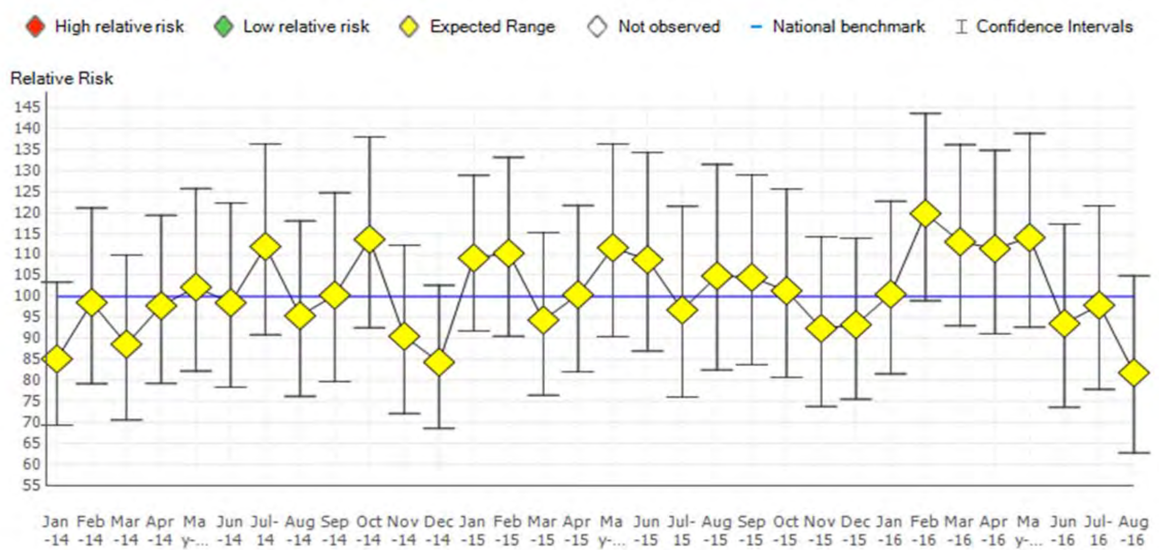


Of the highlighted Trusts above, all have seen a rise with Plymouth Hospitals trust and ourselves rising a little over the 100 mark for the year in question. This report is to highlight the possible trend for a higher than previously seen HSMR and the explanation of why this is. The work of the Trust is to continue to ensure not just the HSMR but the SHMI remain as low as possible through good clinical care and coding.

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

HSMR Measure Aim: to reduce and sustain the quarterly HSMR below a rate of ≤90

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



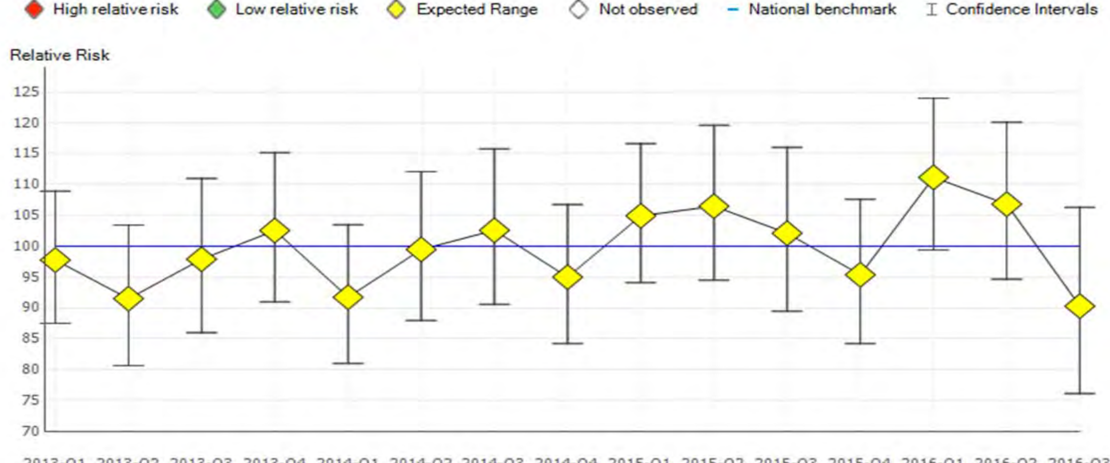
T&SDT - HSMR Trend by month from Jan 14 – Aug 16 (latest)

Narrative
This data is based on the new benchmark data

Our latest data point, August 16 is continuing to show a low relative risk of 81.83 well below the target of 90. The winter period also recorded no data points outside of the expected range. The data does show the cyclical patterns of mortality over the winter periods when mortality tends to peak.

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

The Medical Director has establishment of a Mortality Surveillance Group to provide assurance that robust investigation of avoidable deaths is undertaken and to ensure that learning is shared across the organisation when suboptimal care has been identified relating to any death.

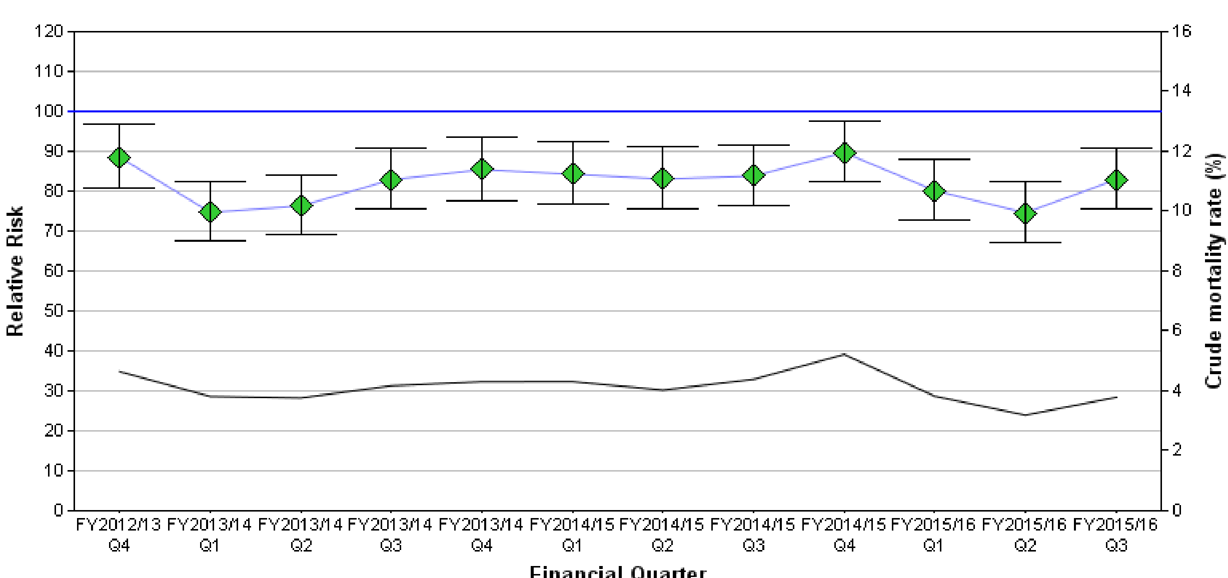


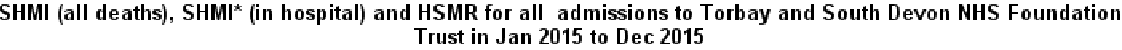
(B) Summary Hospital Mortality Index (SHMI)

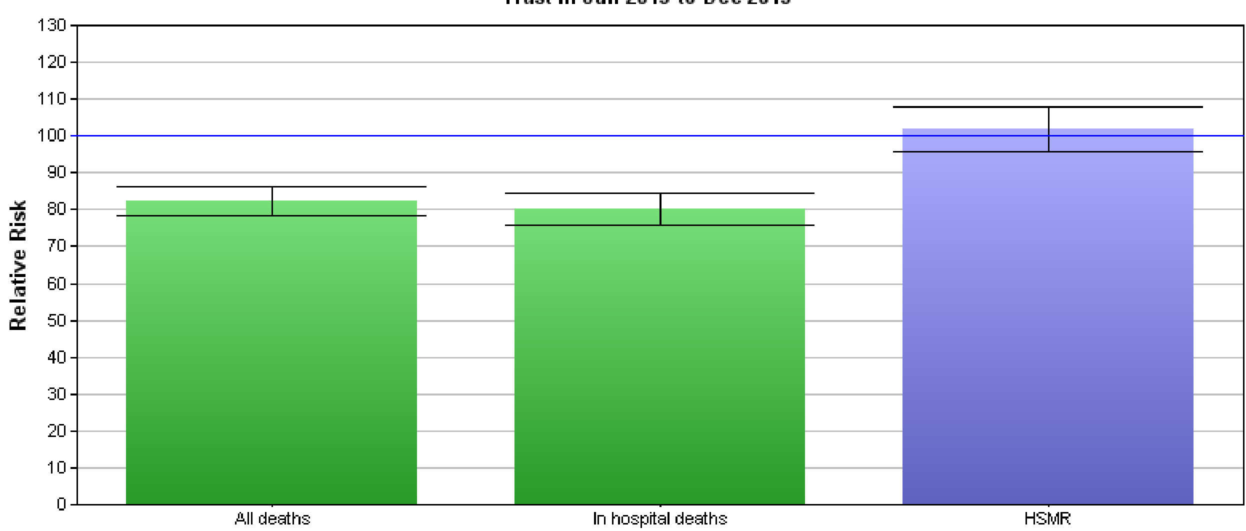
SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is *very* retrospective; therefore, please note *the following data is from **Jan 2015 - Dec 2015*** and will be very different from the dates used on Dr Foster's HSMR.

The first chart highlights SHMI by quarter, again with all data points within the expected range and trending below our 90 target

SHMI trend for all activity across the last available 3 years of data



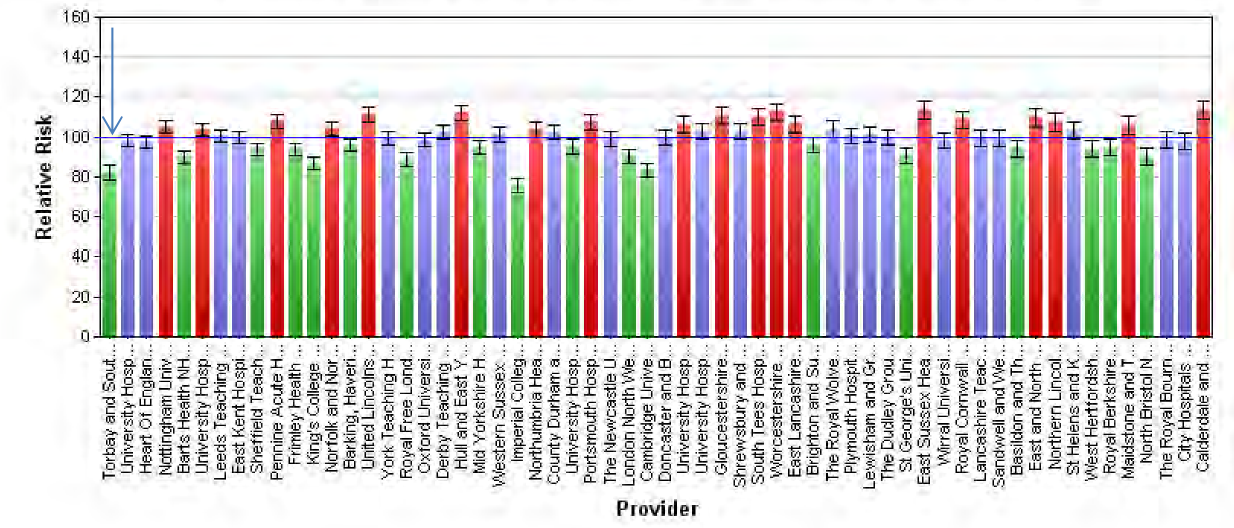




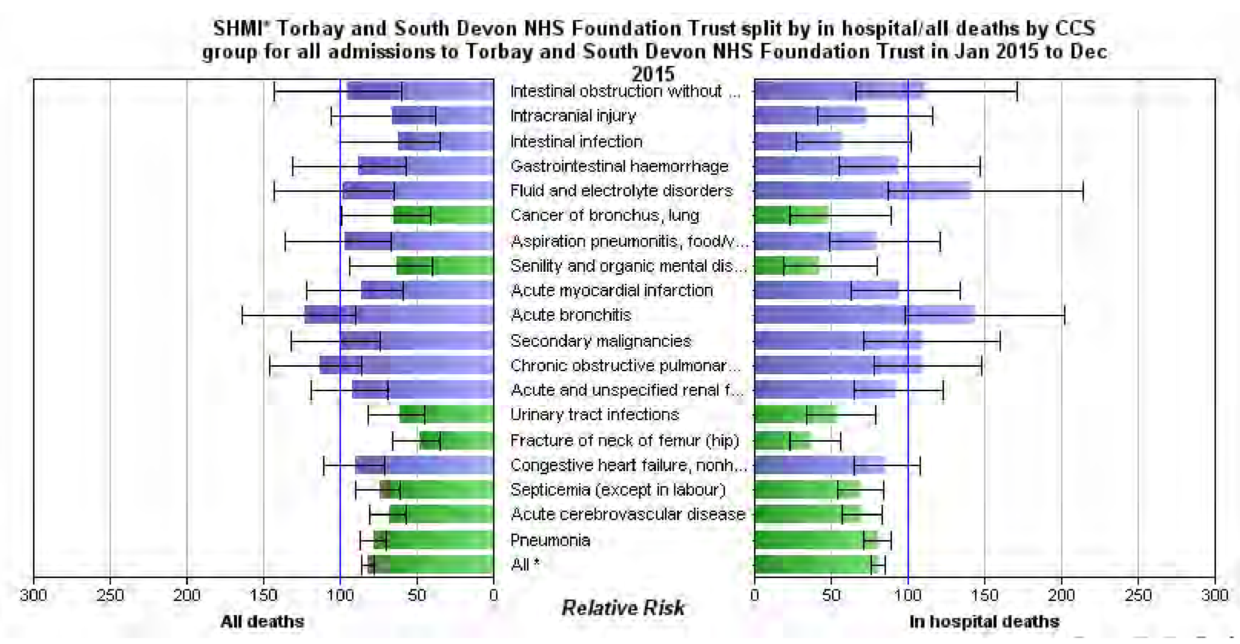
SHMI all deaths, SHMI in hospital deaths and HSMR

The above chart records all SHMI deaths, deaths in hospital as well as a comparison with HSMR for the time period Jan 2015 – Dec 2015. All are within expected range and with the in-hospital deaths at a very low relative risk.

The next chart highlights the position of similar sized trusts within England and allows a comparison against these organisations.



The final chart allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). None are flagging red and all are within normal limits or green, performing better than the norm.



Appendix 2
Unadjusted death rate (%) (SPI AH02)

Percentage Unadjusted Mortality (UM)

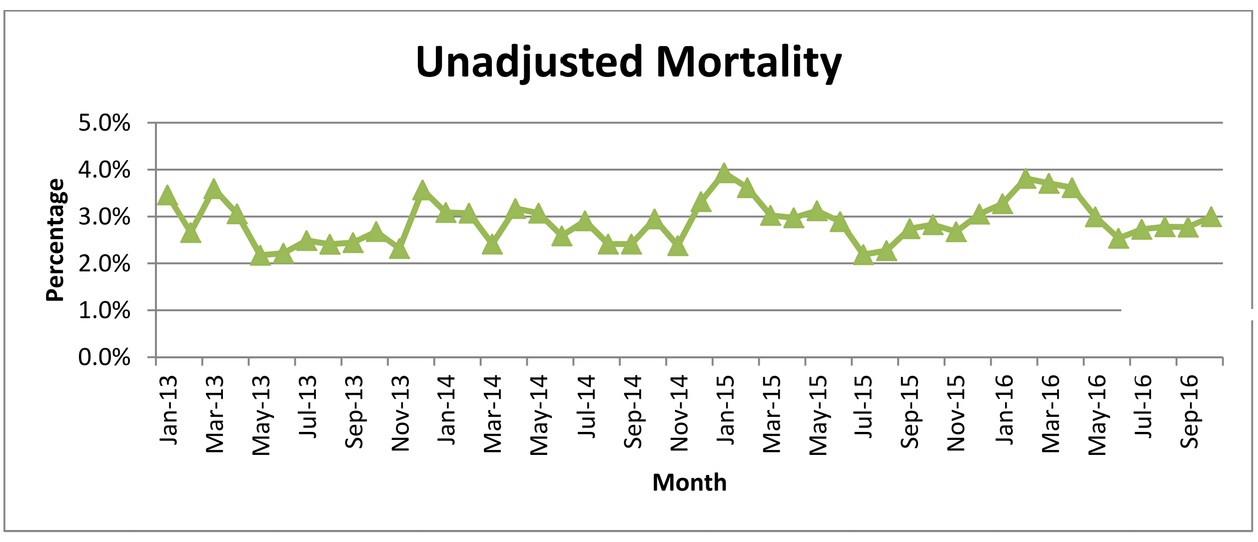
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

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

Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).

Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

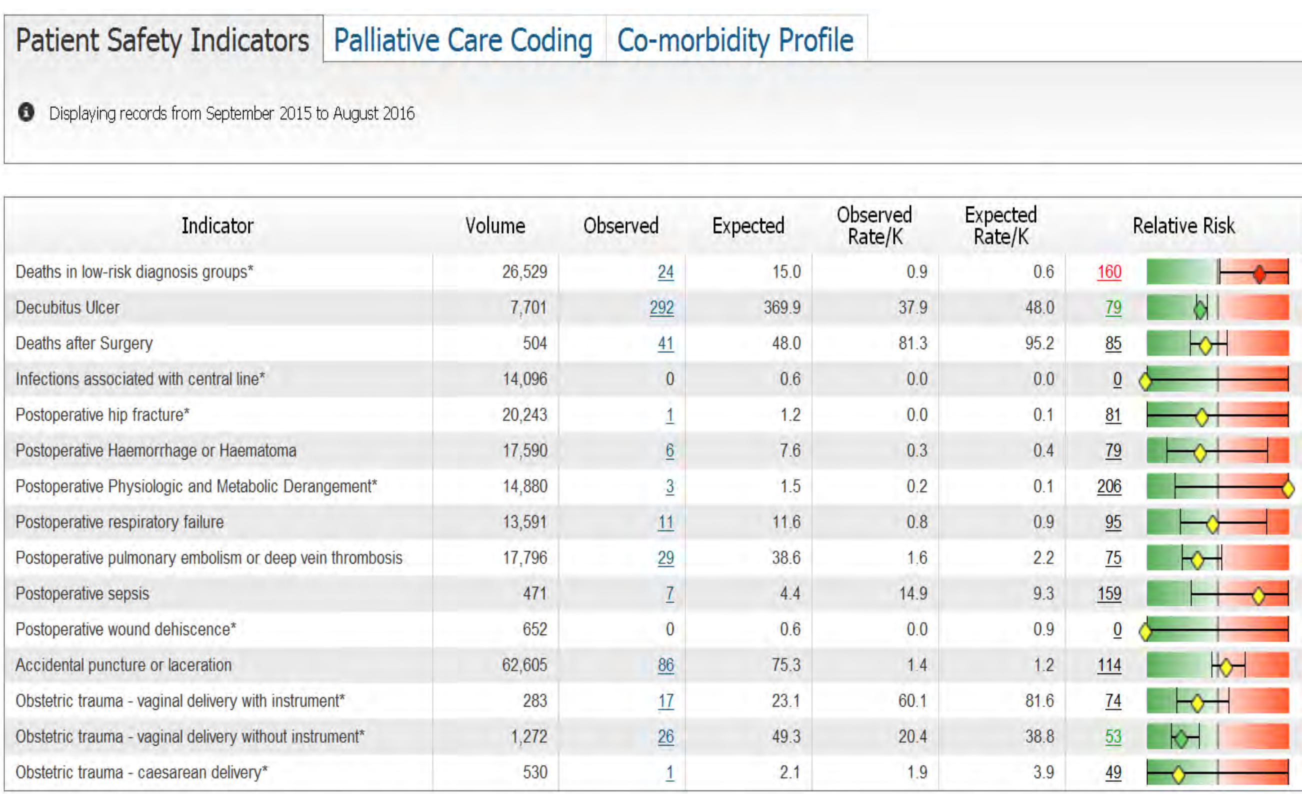
The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.



Number of deaths by month

Appendix 3
Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which is based on procedure codes used in the NHS.



Patient Safety Indicators | Palliative Care Coding | Co-morbidity Profile

Displaying records from September 2015 to August 2016

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups*	26,529	24	15.0	0.9	0.6	160
Decubitus Ulcer	7,701	292	369.9	37.9	48.0	79
Deaths after Surgery	504	41	48.0	81.3	95.2	85
Infections associated with central line*	14,096	0	0.6	0.0	0.0	0
Postoperative hip fracture*	20,243	1	1.2	0.0	0.1	81
Postoperative Haemorrhage or Haematoma	17,590	6	7.6	0.3	0.4	79
Postoperative Physiologic and Metabolic Derangement*	14,880	3	1.5	0.2	0.1	206
Postoperative respiratory failure	13,591	11	11.6	0.8	0.9	95
Postoperative pulmonary embolism or deep vein thrombosis	17,796	29	38.6	1.6	2.2	75
Postoperative sepsis	471	7	4.4	14.9	9.3	159
Postoperative wound dehiscence*	652	0	0.6	0.0	0.9	0
Accidental puncture or laceration	62,605	86	75.3	1.4	1.2	114
Obstetric trauma - vaginal delivery with instrument*	283	17	23.1	60.1	81.6	74
Obstetric trauma - vaginal delivery without instrument*	1,272	26	49.3	20.4	38.8	53
Obstetric trauma - caesarean delivery*	530	1	2.1	1.9	3.9	49

Of the 15 indicators above, the relative risks of 1 Deaths in low-risk diagnosis groups is currently flagging outside of the expected norm.

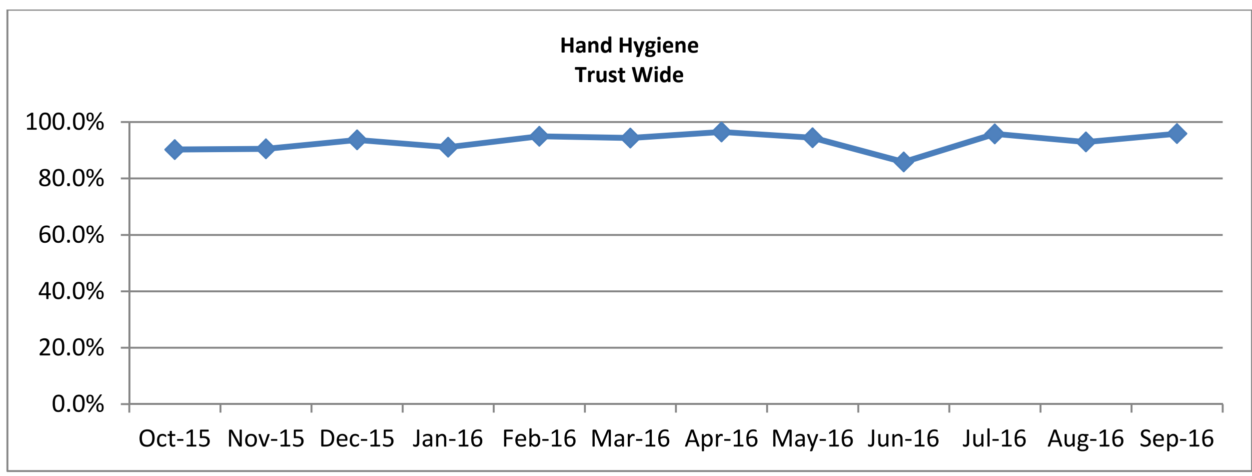
Deaths in low-risk diagnosis groups
This code has being investigated a number of times and no issues have been found other than incorrect codes being issued. This latest flag will be investigated and will be presented back to the Quality Improvement Group. If further analysis is need a small team will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

Appendix 4
Hand washing compliance

Determine the numerator: the total number of patient encounters in the sample where appropriate hand hygiene was conducted.

Determine the denominator: the total number of patients in the sample.

Calculate the percent compliance with hand hygiene by dividing the numerator by the denominator and then multiplying the resulting proportion by 100.

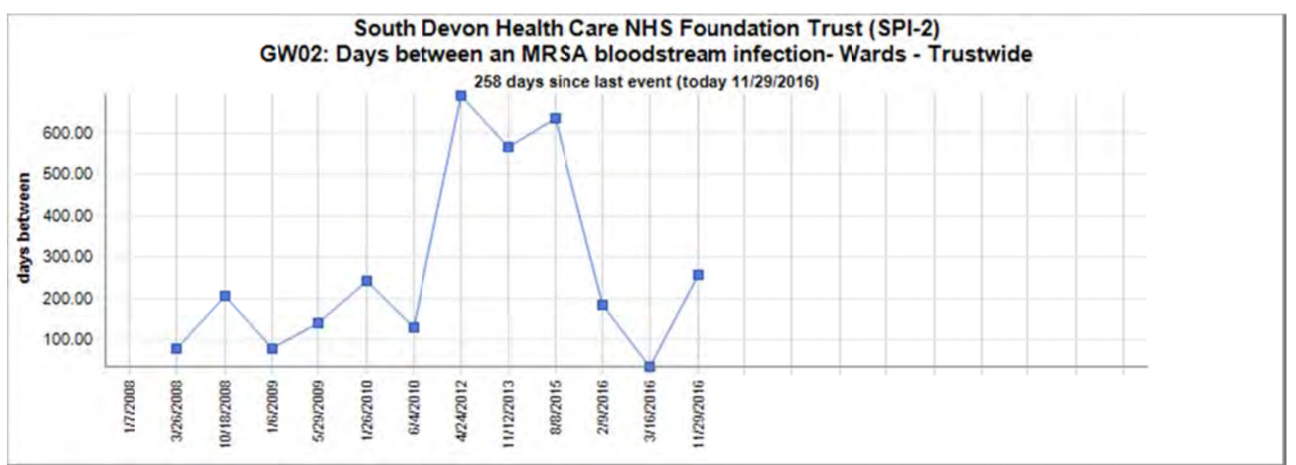


Commentary

Maintaining awareness of this important aspect of good infection control practice is crucial. Education is ongoing from Infection Control using the WHO Five Moments and posters highlighting the five moments for hygiene have been displayed around the hospital. All audit results are shared with the area at the time of the audit and any issues discussed. Any recommendations from the Peer Review on this area of practice will be actioned.

Appendix 5

Days between an MRSA bacteraemia (SPI)



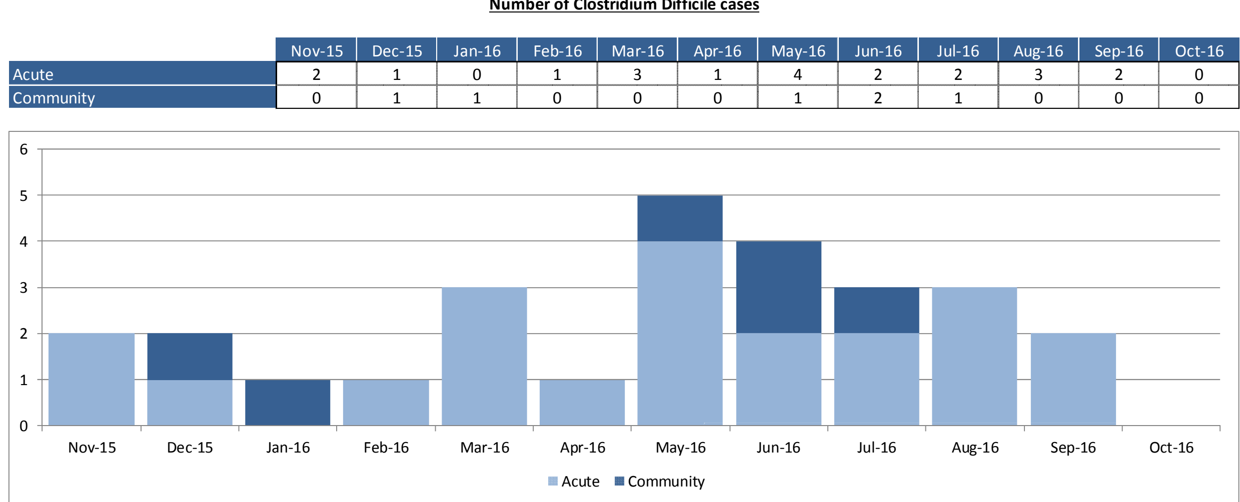
This measure is a cumulative count of the number of days that have gone by with no in hospital MRSA bacteraemia being reported.

Every time an MRSA bacteraemia occurs the count is started over again.

The current count stands at 258 days. The longest count has stood at 633 days and the data chart shows performance back to 2008

Appendix 6
Clostridium Difficile toxin detection rate
(Number of new infections -Trust data)

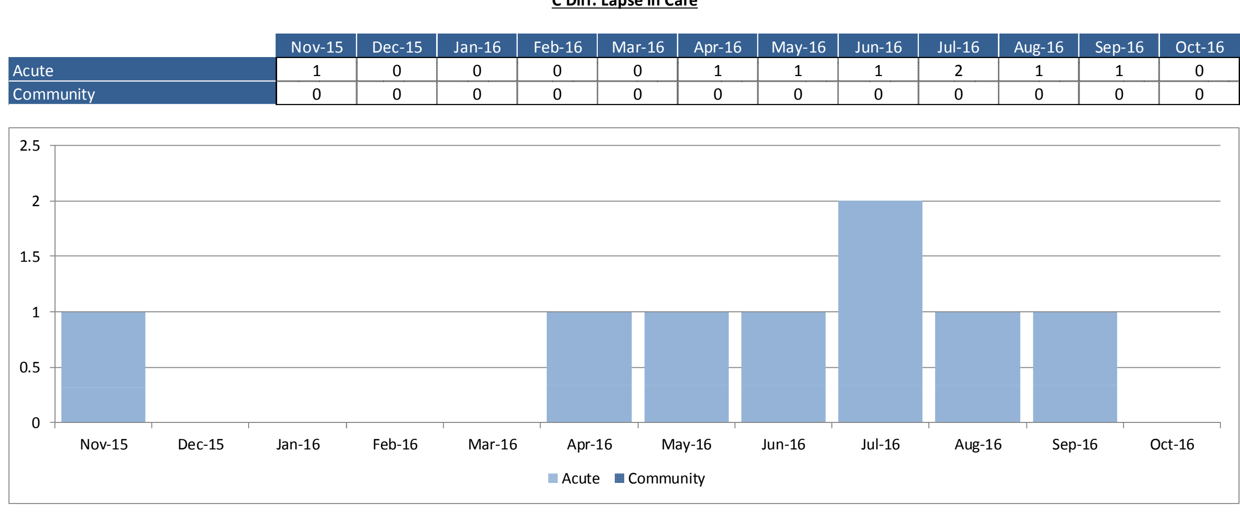
This chart highlights the number of confirmed CDT case each month and is expressed as a number in this chart. No new CDT cases have been recorded in the latest data month



Number of Clostridium Difficile cases

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

The second chart records the CDT lapses in care



C Diff. Lapse in Care

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

Commentary

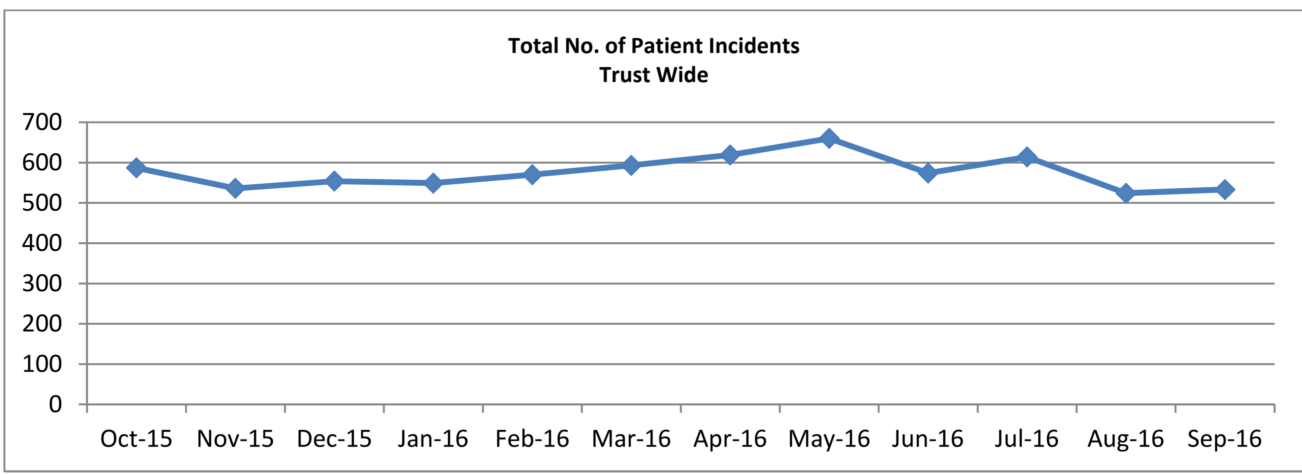
All CDT cases are subjected to a root cause analysis and the infection control team when analysing the investigations code each case into *lapse of care* or *no lapse of care.* The above chart identifies those lapses in care.

Appendix 7

Total Number of Trust Wide Patient Incidents by Month

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

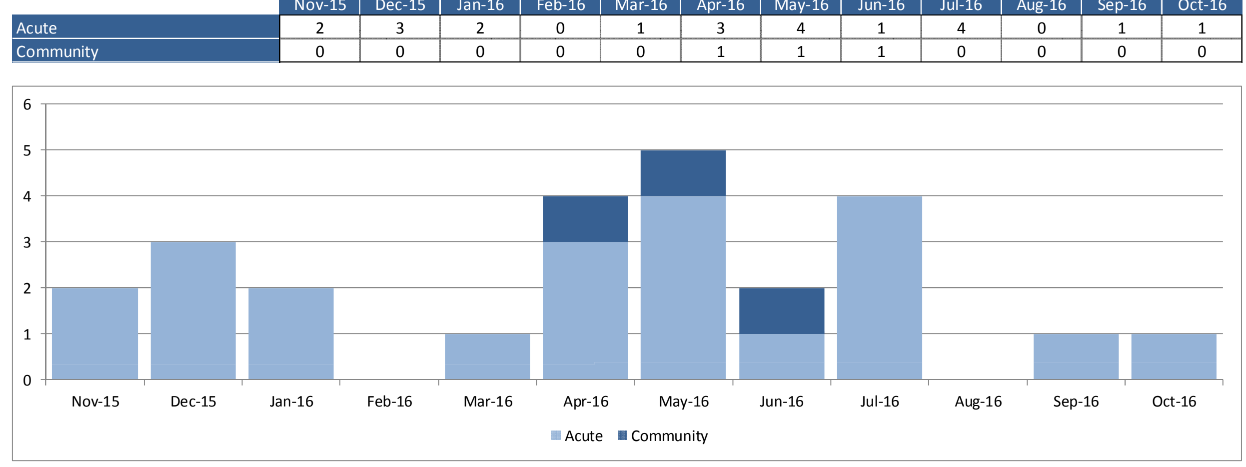
SDHCFT's reporting is remaining in a healthy position.



Appendix 8

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

Reported Incidents - Major and Catastrophic

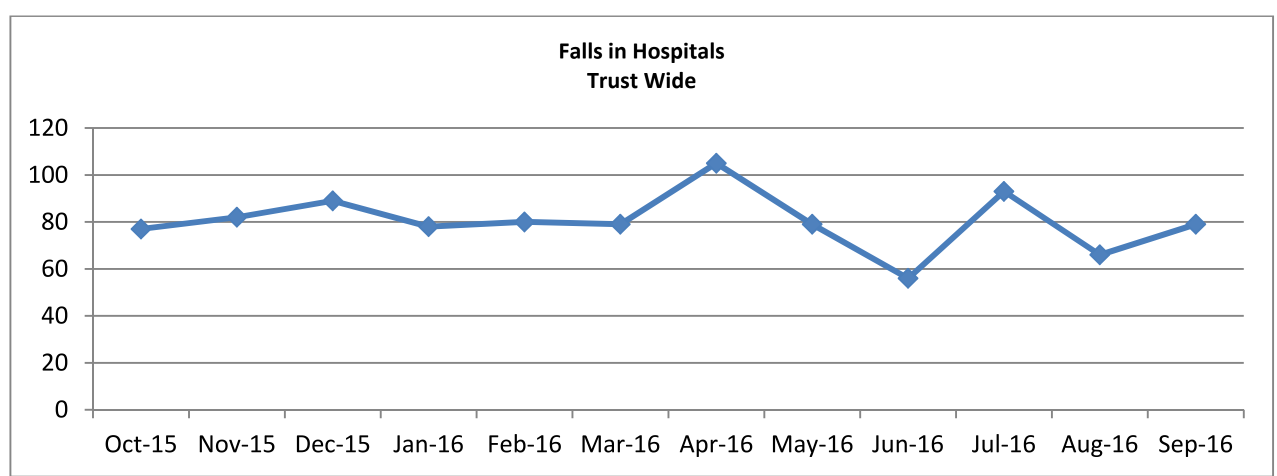


	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	2	3	2	0	1	3	4	1	4	0	1	1
Community	0	0	0	0	0	1	1	1	0	0	0	0

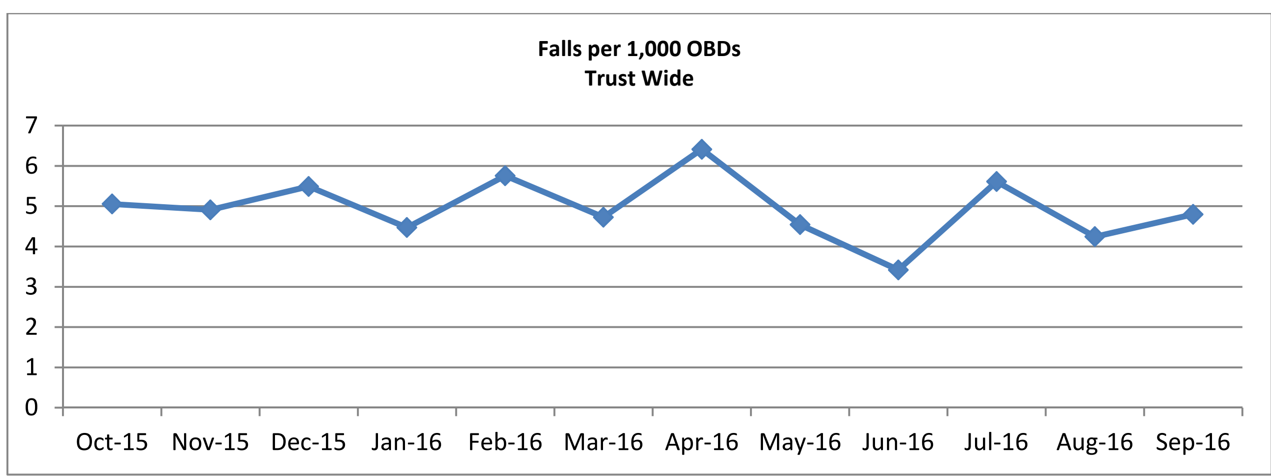
All major and catastrophic incidents are recorded on the STEIS system, presented to the Serious Adverse Events Group, complete with an investigation, root cause analysis and action plan, which is logged and monitored.

Appendix 9
In Hospital Falls

The below chart records the Organisational falls number



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

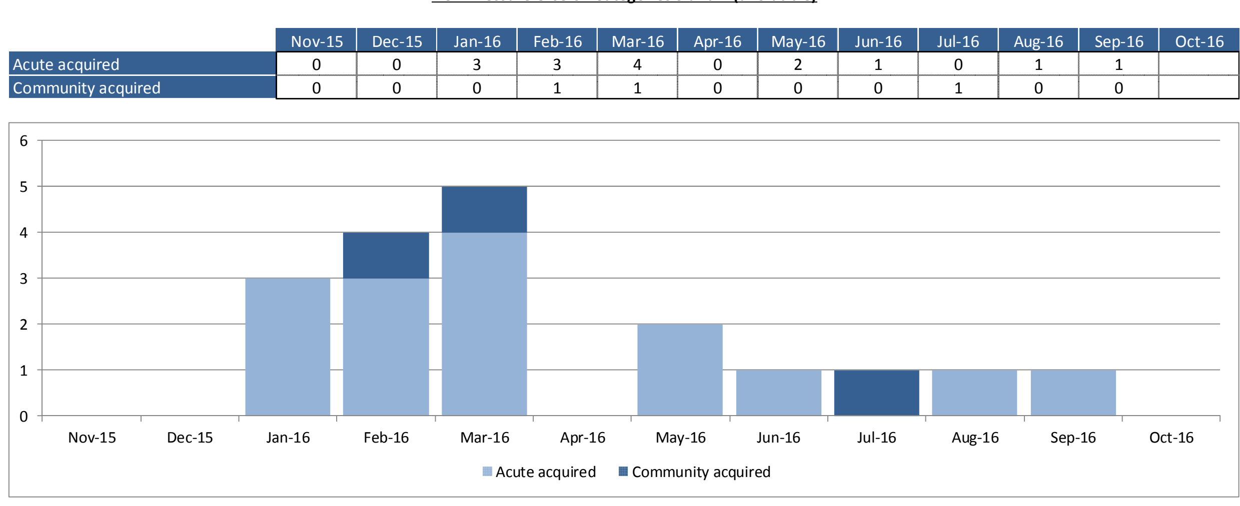


Appendix 10
Pressure Ulcers

The prevention of avoidable pressure ulcers (PU) is a key priority for the Trust and the measurement is based on the reduction in numbers of patients who develop a Grade 2, 3 or 4 PU during an inpatient stay. All pressure ulcers are graded based on the categories as outlined by the European Pressure Ulcer Scale.

The Trust has actively been encouraging the reporting of all pressure ulcers that occur. Historically Grade 1 and Grade 2 pressure ulcers may not have been accurately reported and through educational work and the use of pictorial grading guides, reporting has improved. It is essential to gain an accurate picture of PU prevalence in order to take effective action to eradicate them from our health system.

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



New Pressure Ulcers - Categories 3 and 4 (avoidable)

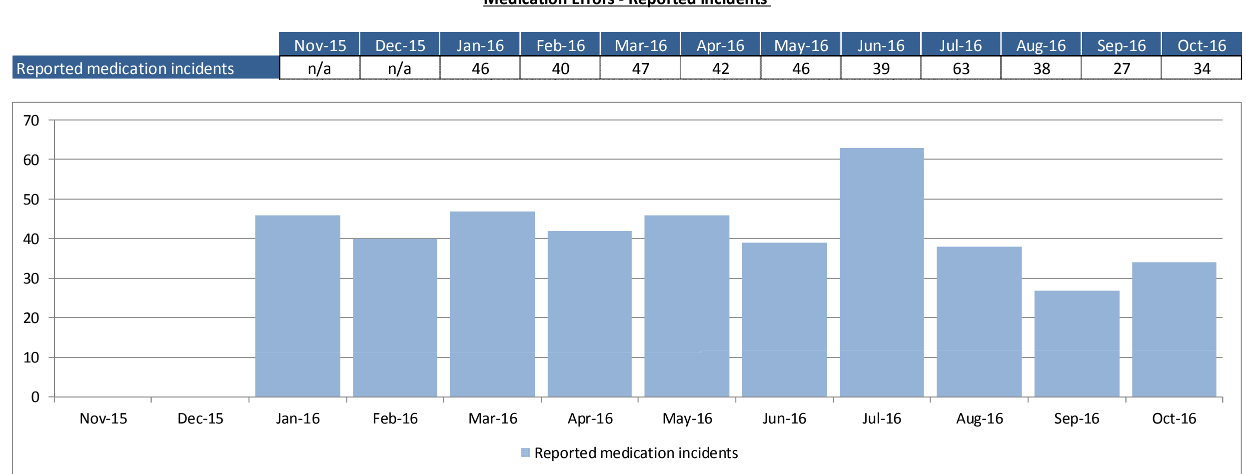
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute acquired	0	0	3	3	4	0	2	1	0	1	1	
Community acquired	0	0	0	1	1	0	0	0	1	0	0	

The rise from January has been noted and all instances have been reviewed. Much work has followed from this review particularly focusing on assessment and monitoring with a resultant action plan in evidence. This has resulted in a reduction of avoidable pressure ulcers.

Appendix 11
Medication Errors

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

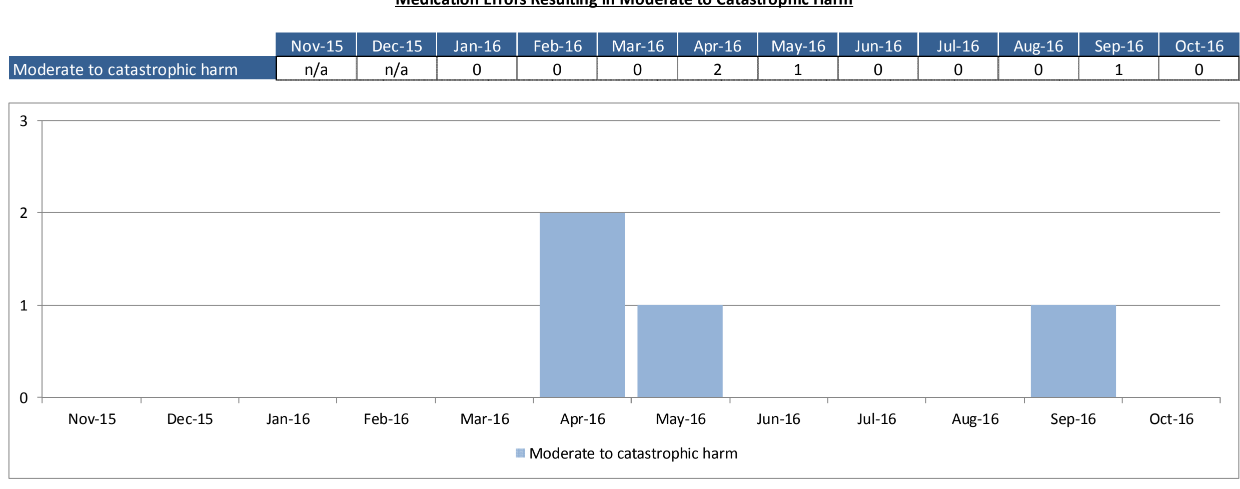
Medication Errors - Reported incidents



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Reported medication incidents	n/a	n/a	46	40	47	42	46	39	63	38	27	34

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

Medication Errors Resulting in Moderate to Catastrophic Harm



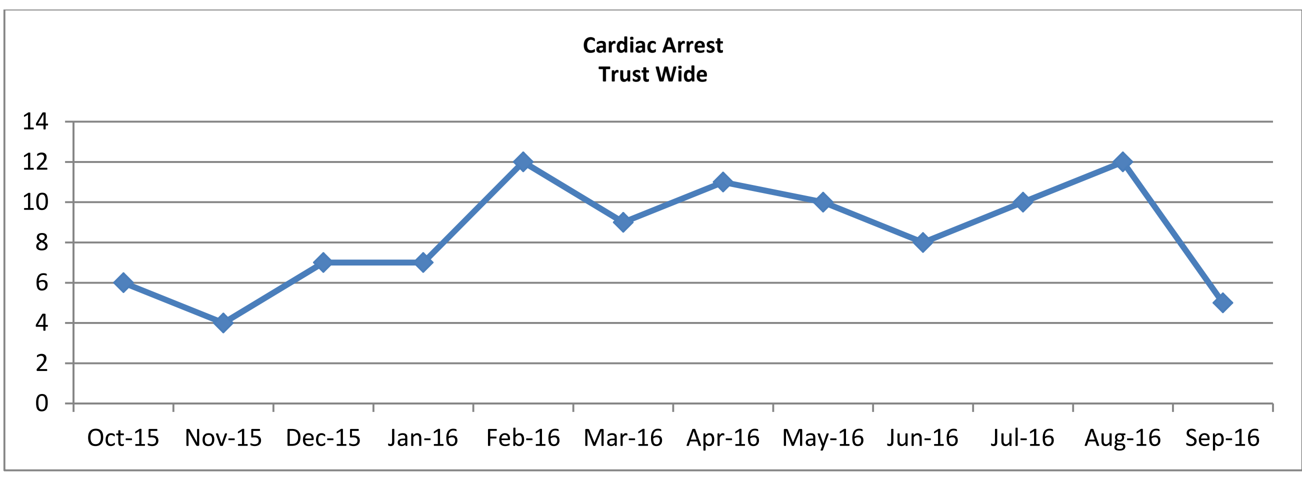
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Moderate to catastrophic harm	n/a	n/a	0	0	0	2	1	0	0	0	1	0

October did record a never event re an intravenous medication, the patient was unharmed and this is record in the never event section

Appendix 12
Cardiac Arrest Calls

The data is generated from the number of cardiac arrest calls made each month and as reliability is sustained with accurately completed patient observation charts and supported by calls to the ICU outreach team the number of cardiac arrests should fall.

Cardiac Arrest Calls by Month



All cardiac arrests now have a RCA carried out post arrest for learning and the numbers of validate calls remains low. Work is still on-going by the team to try and reduce the PEA arrests from our hospital system and the latest data point is recording a significant reduction in arrest calls. This will need to be monitored for continued improvement over the winter period.

Appendix 13
Department of Health's (DH) Safety Thermometer

The NHS Safety Thermometer (ST) is a tool used for measuring patient safety and was developed by the NHS Information Centre (NHS IC).

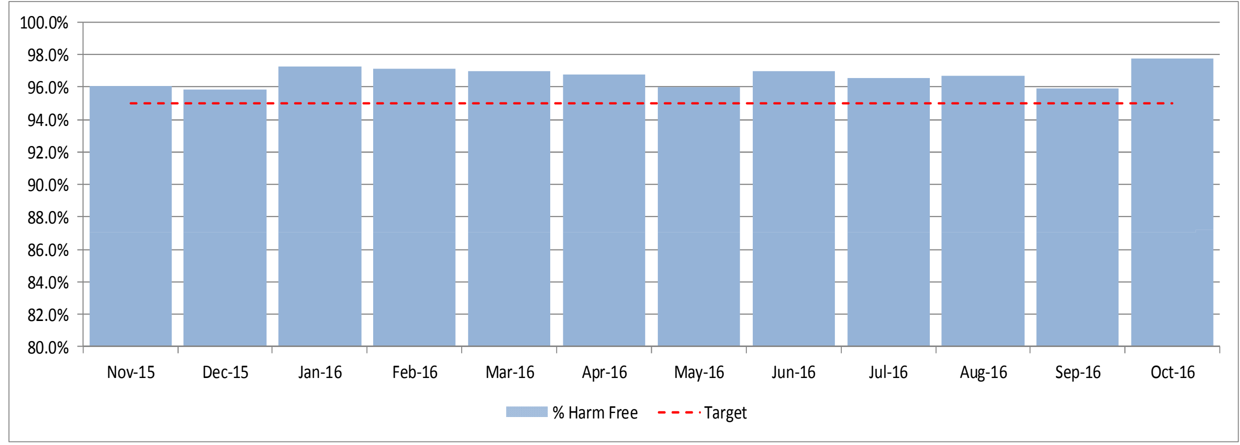
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

All patients are surveyed on *one* specific day every month and the data records if any harm, as outlined above, has occurred. The audit, therefore, provides a score for the organisation based on harm free care and new harm free care. This data is the harm caused whilst in our care and is called new harm free.

The Trust's percentage of patient **new harm free care** has remained constantly high and stable.

Harm Free - Trust Total

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients		994	1109	1075	1057	1027	1056	1093	1040	1083	1027	997
Harm Free		953	1079	1044	1025	994	1014	1060	1004	1047	985	975
% Harm Free	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



Appendix 14
Never Events List 2015/16

A Never Event (NE) as defined by the National Patient Safety Agency (NPSA 2010) as a 'serious, largely preventable patient safety incident that should not occur if the available preventable measures had been implemented by healthcare providers'.

The below are the latest Department of Health's (DH) expanded 'Never Event' list. The list has now been decreased from 25 to 14 events, one of which is only applicable to Mental Health Trusts.

In 2015/16 the Trust has recorded three such events, one in Obstetrics (Sept) and one in Theatre (July) and one in Oncology (Oct); in all cases the patients did not suffer any immediate physical harm and investigations and changes have been implemented.

Data 1st April 2015 – 26th August 2016 source Safeguard

	Description	
1.	Wrong site surgery	0
2.	Wrong implant / prosthesis	0
3.	Retained foreign object post-operation	2
4.	Death or severe harm as a result of wrongly prepared high-risk injectable medication	0
5.	Death or severe harm as a result of maladministration of potassium-containing solutions	0
6.	Wrong route administration of chemotherapy	0
7.	Death or severe harm as a result of wrong route administration of oral/enteral treatment	1
8.	Death or severe harm as a result of intravenous administration of epidural medication	0
9.	Death or severe harm as a result of maladministration of insulin	0
10.	Death or severe harm as a result of overdose of midazolam during conscious sedation	0
11.	Death or severe harm as a result of opioid overdose of an opioid-naïve patient	0
12.	Inappropriate administration of daily oral methotrexate	0
13.	Suicide using non-collapsible rails - Mental Health Trusts Only	0
14.	Escape of a transferred prisoner - Mental Health Trusts Only	0
15.	Death or severe harm as a result of a fall from an unrestricted window	0
16.	Death or severe harm as a result of entrapment in bedrails	0
17.	Death or severe harm as a result of the inadvertent transfusion of ABO-incompatible blood components	0
18.	Death or severe harm as a result of inadvertent transplantation of ABO or HLA-incompatible organs	0
19.	Death or severe harm as a result of a misplaced naso- or oro-gastric tube	0

20.	Death or severe harm as a result of the administration of the wrong gas	0
21.	Death or severe harm as a result of failure to monitor and respond to oxygen saturation	0
22.	Death or severe harm as a result of intravascular air embolism	0
23.	Death or severe harm as a result of misidentification of patient	0
24.	Death or severe harm as a result of a patient being scalded	0
25.	Maternal death due to post-partum haemorrhage after elective caesarean section	0

REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Charitable Funds Committee – Terms of Reference
Lead Director:	Paul Cooper, Director of Finance
Corporate Objective:	Safe, Quality Care, Best Experience Well Led
Corporate Risk/ Theme	Charitable Fund
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

Better targeting the resources of the Charitable Fund at patient priorities will enhance patient care and experience.

Periodically reviewing and updating the Charitable Funds Committee's Terms of Reference helps ensure that the Charitable Fund remains well led.

Key Issues/Risks

Summary of key proposed changes to Terms of Reference:

- To give the Committee a pro-active planning role, in setting spending priorities for individual Fund Managers to follow.
- To make the Committee responsible for appointing Fund Managers.
- To define the Committee's oversight role with respect to Fundraising.

Requiring individual Fund Managers to follow centrally-identified spending priorities may be contested by those Fund Managers who have been used to taking such decisions independently.

Fundraising activities require careful oversight, due to current public/media concern about inappropriate fundraising techniques used by some charities and the resulting reputational risk.

Recommendations:

That the Board approve the revised Terms of Reference of the Charitable Funds Committee (as detailed in attachment one).

Summary of ED Challenge/Discussion:

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

A Governor Observer sits on the Charitable Funds Committee.

Equality and Diversity Implications:

None identified.

Board of Directors
Report Title: Charitable Funds Committee – Terms of Reference
7 December 2016

1. Background Information

1.1 Torbay and South Devon NHS Charitable Fund (registered charity 1052232) holds charitable monies donated to the Foundation Trust for the benefit of patients.

1.2 The Foundation Trust is the Corporate Trustee of the Charitable Fund and is responsible for ensuring that the Charitable Fund acts in compliance with general law, charity law and regulatory requirements. To this end, the Board delegates powers to the Charitable Funds Committee to enable the Committee to undertake due oversight and management of the Charitable Fund.

1.3 The Committee met on 24 November 2016 and wish to recommend to the Board the following changes to the Committee's Terms of Reference.

2. Changes to Terms of Reference

A marked-up version of the Terms of Reference (to take effect on approval) is attached to this report as attachment one. The following proposed changes have been made:

2.1 Planning process (Terms of Reference section 2.6 - amended).

The existing Terms of Reference describe a passive planning role for the Committee. In line with the Charity Commission's recommendation for NHS charities, the Committee wishes to introduce a pro-active planning process, where it sets annual spending priorities for funds. This will facilitate the better targeting of charitable expenditure at patient priorities.

Given that some funds are constrained (eg by particular wishes of donors), individual funds would be given an opportunity to agree with the Committee alternative spending priorities for their fund, where these alternative priorities can be justified as being more appropriate.

This would be a significant change for existing Fund Managers, whose spending decisions have been largely independent up to now. Such a change, if approved, would therefore be communicated carefully, with the involvement of the Communications team.

2.2 Appointment of Fund Managers (Terms of Reference section 2.17 – new addition).

The existing Terms of Reference make no reference to the process for the appointment of Fund Managers of individual funds. It is proposed that the Terms of Reference specify that the Committee will approve such appointments.

The existing Terms of Reference refer to 'Fund Managers' in section 2.6 and 'Fund Holders' in section 3. It is proposed that the terminology be clarified and they be consistently referred to as 'Fund Managers'.

2.3 Fundraising (Terms of Reference section 2.18 – new addition).

The Committee is planning to start significant fundraising activities, in order to increase the level of charitable resources. The existing Terms of Reference (section 2.1) gives the Committee a power to take such decisions. However, the existing Terms of Reference do not contain specific reference to the Committee's oversight role with respect to fundraising, which is an area subject to significant Charity Commission requirements.

Such oversight is particularly important currently, due to an enhanced level of public/media concern about inappropriate fundraising techniques used by some charities (eg pressurising vulnerable individuals to donate). It is therefore proposed that the Committee's oversight role with respect to fundraising be stated in the Terms of Reference.

To facilitate effective oversight of fundraising activities, it is also proposed that the Fundraising Manager (when appointed) should be in attendance at Committee meetings (Terms of Reference section 4 – amended).

2.4 Other changes.

It is proposed that the Terms of Reference be updated to clarify that the Committee's role includes setting the strategy of the Charitable Fund (Terms of Reference section 2.16 – new addition).

3. Recommendations

3.1 That the Board approve the revised Terms of Reference of the Charitable Funds Committee (as detailed in attachment one).

Patrick Vincent
Finance Manager
November 2016

Attachment one – revised Terms of Reference (once approved)

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

ESTABLISHMENT OF A CHARITABLE FUNDS COMMITTEE

1. INTRODUCTION

This committee is responsible for controlling the management and administration of charitable funds for the following organisations:-

Torbay and South Devon NHS Foundation Trust

2. TERMS OF REFERENCE

2.1 To govern, manage and regulate the finances, accounts, investments, assets, business and all affairs whatsoever of the charity.

2.2 To establish and regularly review for the investment managers the following: -

* Investment powers;
* Investment strategy;
* Policy constraints;
* Delegated authority and monitor compliance.

2.3 To ensure that systems are in place to provide appropriate and effective financial controls and procedures in order that the funds are operated correctly, that money is used for the appropriate purpose and that funds are not overspent.

2.4 To regularly review the investment objectives of the fund and advise the funds' investment advisors.

2.5 To receive interim reports and advice regarding market condition and performance from the investment advisors.

2.6. ~~To receive, consider and approve annual expenditure plans submitted by fund managers.~~ To review and approve annual expenditure priorities for funds, to review and approve the charity's annual plan and to ensure that funds comply with these priorities (or agreed alternatives).

2.7 To consider and approve major expenditure proposals arising during the year i.e. proposals having a value in excess of £50,000 for any one item or scheme to be financed either from funds held within a charitable fund or as a rechargeable item.

2.8 To receive reports every half year in November and May/June on the actual expenditure incurred compared with plans.

2.9 To receive reports quarterly on the performance of the funds' investments.

2.10 To encourage the use of funds for the benefit of patient welfare.

2.11 To determine and approve financial strategy and to monitor performance against agreed objectives.

2.12 To consider and approve the annual accounts and report.

2.13 To review changes in legislation and approve plans for their implementation.

2.14 To appoint investment advisors and review every three years.

2.15 To oversee and monitor the performance of the advisors.

2.16 To review and approve the strategy of the charity.

2.17 To appoint Fund Managers.

2.18 To review and agree the charity's fundraising plans, to monitor fundraising performance and to ensure compliance with fundraising regulatory requirements.

3. DELEGATED POWERS

Further to sections 2.6 and 2.7 above, approval for individual purchases should be obtained from:-

Up to £5,000	Fund ~~Holder~~ Manager
£5,000 to £20,000	Director of Finance
£20,000 to £50,000	Chief Executive
Over £50,000	Charitable Funds Committee

In cases where urgent decision is required relating to the investment portfolio, the Committee have delegated the power to authorise such changes to any two of the following three members of the Committee:-

i) Committee Chair
ii) Director of Finance
iii) One non-executive member of the Board and Committee (other than Committee Chair)

4. MEMBERSHIP

Committee Chair	Non-Executive Director – Torbay and South Devon NHS Foundation Trust
Additional membership	1 Non-Executive Director – Torbay and South Devon NHS Foundation Trust
	Director of Finance - Torbay and South Devon NHS Foundation Trust
	Medical Director - Torbay and South Devon NHS Foundation Trust
In Attendance	Senior Finance Manager Corporate Services - Torbay and South Devon NHS Foundation Trust
	Governor Observer
	Investment Manager representative (if invited by the Committee)
	Fundraising Manager

5. MEETINGS

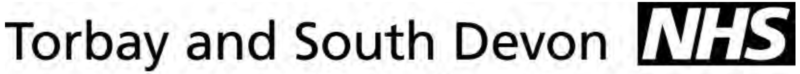
a) QUORUM

A quorum will be two Non-Executive Directors from Torbay and South Devon NHS Foundation Trust, including the Committee Chair, and one Executive Director of Torbay and South Devon NHS Foundation Trust. In the absence of the Committee Chair, one of the Non-Executives should be elected to Act as Chair in order for the Committee to remain quorate.

b) FREQUENCY

The committee will meet at least twice a year, usually May/June and November. Other meetings may be called as and when required.

Revised ~~5 August 2015~~ 7 December 2016



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

Meeting date:	29 November 2016
Report by + date:	Robin Sutton, 30 November 2016
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐+ Freedom of Information Act exemption [*S43 – commercial interests*]

Key issue(s) to highlight to the Board:

1. **EBITDA**: for the period to 31 October 2016 (Month 7) EBITDA is £4.04m. This is showing an adverse position against the PBR plan by £3.05m. Should the plan be agreed based on the Risk Share arrangement this would result in an EBITDA position favourable position of £0.61m.
2. **Income and Expenditure**: The year to date income and expenditure position is £4.95m deficit which is £2.88m adverse against the PBR plan, and £0.78m favourable against the RSA plan. The Trust has a £1.2m deficit in month after STF income and risk share income has been applied.
3. **CIP Programme**: CIP delivery has improved from the previous month with £5.31m delivered to date, which remains ahead of plan. Although we are seeing some improvement the level of savings planned increases significantly in the second half of the financial year. It therefore remains imperative that we secure increased traction in the programme. Plans have been developed in support of many of the schemes, quality assessed where appropriate and progress reported at scheme level to the Finance, Performance, and Investment Committee
4. **Risk Rating**: The Single Oversight Framework came into effect from the 1 October 2016, and the Trust has delivered a rating of 3 under the new "Use of Resource" (UOR) rating which is in line with the RSA plan (Scoring: Rating of 1 = best, Rating of 4 = poorest).
5. **Cash position**: Cash balance at month 7 is £12.4m which is lower than PBR plan by £4.98m, and RSA plan £5.06m mainly due to debtors.
6. **Capital**: Capital expenditure is £6.8m behind PBR plan at month 7
7. **Agency Spend**: At month 7, the YTD position of agency spend is at 4.63%, 1.45% over the NHSI target cap target of 3.18%. The projected full year spend for Agency in FY 2016/17 is £9.8m which will give the Trust a metric of '3' on Agency use under the 'Use of Resource' risk rating.
8. **Control totals** have been revised upwards for 17/18 and 18/19 to £4.5m and £8.4m respectively

Key Decision(s)/Recommendations Made:

1. The additional capital fit out for the second **Linac** machine was reviewed and approved, assurance was requested regarding the previous under estimate of cost.

2. A **revised Forecast** was reviewed and approved, this will be presented at Main Board.

3. Deep dives into **Trust Wide Improvement Plan/CIP** are planned for future meetings.

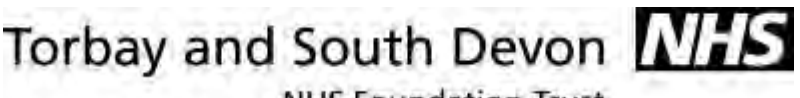
4. The **Integrated Finance and Performance Report** for month 7 was reviewed and

approved.

5. The **Loan application** for Phase 1 of our Theatre strategy based upon the outline business case was approved.

6. The **Liquidity and Capital** paper was approved.

Name: Robin Sutton (Committee Chair)



Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting dates:	24th November 2016
Report by + date:	Jacqui Lyttle, 28 November 2016
This report is for:	Information☒ and Decision ☒
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐+ Freedom of Information Act exemption [

Key issue(s) to highlight to the Board:

- In light of current volatile world-wide market conditions, the committee reviewed its risk position relating to return on investment and changed the overall risk from Low to Moderate.
- To mitigate further risk the committee agreed that it would ensure through our Investment Manager the continued diversification of our portfolio in strong and emerging markets.
- Because of our place not building based model of care and the need to ensure that donated funds are used appropriately to support the delivery of health and care services to as many people as possible, the committee agreed to move from a reactive to proactive position as a sub-committee of the board. The committee approved a new work plan and strategy, with the overall agreement of the following key enablers –
  - Agreement of forward looking plans for fund investment and send which are aligned to the corporate objectives of the trust
  - Spending down existing reserves between now and March 2018
  - More proactive direction of how funds can be spent
  - Reduction of number of small historically held funds
  - Establishment of 4 themed centrally-held funds
  - Allocation of realised gains will now be allocated to centrally held funds, and those funds subject to a legally-binding constraint imposed by a donor i.e. the Kenya project grants

Key Decision(s) Made:

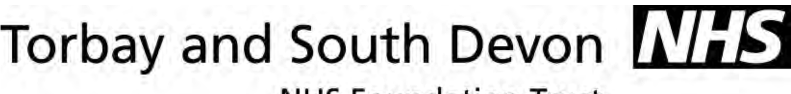
- Our risk register be amended to reflect current and forecast positions
- To ensure mitigation of future risk and aligned to our new strategy, due to the risk of capital volatility, the committee agreed an upfront sale of £980k of investments at a time recommended by the investment manager – but before 31 March 2018
- The committee reviewed and updated its investment policy to take into account a new benchmark and investment priorities

- Following discussion in June 2016, on new approaches relating to fund raising opportunities the committee agreed a new fundraising strategy, this includes:
  - Appointment of a fund-raising manager – reporting to Director of Strategy and Improvement
  - Developing a more integrated and closer working relationship with the LoF
  - Exploration of new income streams such as national bid opportunities etc.
  - Development and rollout of a new fund raising strategy with fund holders
  - The committee reviewed and approved new guidelines for fund holders.
- The committee reviewed and ratified new terms of reference for the committee which take into account guidance from the Charity Commission that the
  - committee should set annual planning priorities for individual funds and ensure that they (or agreed alternatives, where appropriate) are followed by Fund Holders
  - inclusion of fundraising as a key work programme
  - committee will become more proactive by setting strategy, agreeing forward plans and appointing fund holders

Recommendation(s):

1. That the board note the change in our risk position
2. That the board note and approve the Charitable Fund Committees new strategy
3. That the board approve the new investment policy
4. That the board approve the committee's new terms of reference (separate agenda item)
5. That the board note this update

Name: Jacqui Lyttle - Committee Chair



REPORT SUMMARY SHEET

Meeting Date:	Wednesday 7th December 2016
Title:	Chief Nurse Portfolio Report 1. Progress on improving compliance with dementia find 2. Safe staffing report 3. Update on volunteer activity
Lead Director:	Chief Nurse
Corporate Objective:	Safe Quality Care and Best Experience
Corporate Risk/ Theme	Failure to achieve key performance standards
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

- The Trust is required as part of the NHS Standard Contract (April 2016 para 39.18 technical guidance) to complete dementia case finding within 72 hours for all emergency admissions 75 years and over that are inpatients for greater than 72 hours or longer.
- Dementia case finding has been a national CQUIN since 2014/15 before forming part of the national contract in April 2016.
- Performance data is published by NHS England. On 5th October 2016 the data from July 2016 was published and the Trust was 146th in the country with a 37% achievement against a 90% target. (150 Trusts FT and non FT).
- Over 74% of Trusts achieve the 90% national target.

Key Issues/Risks

The key risk is frontline staff failing to embrace the current changes to the model with the advent of Nerve-centre. It is anticipated that Nerve-centre should be fully operational by April 2017 and includes dementia case finding.

Success will be achieved if:

The revised model is fully implemented and successfully embedded
The organisation supports the importance of dementia case finding as a priority
The performance is discussed at key meetings from ward to board.

Recommendations:

The Board supports the changes in the model of delivery to ensure those individuals accessing care in our organisation are screened appropriately.
A further progress report is provided in March 2017.

Summary of ED Challenge/Discussion:

It is recognised that despite the process redesign activity associated with the 2015/16 CQUIN, the Dementia find.

Metric has not improved over 2016. The project currently underway is delivering improvement with an increase in compliance from 25% in July to the current level of 64% in the last week of November. Whilst this improvement is encouraging it is the result of driving the existing process and not a substantive change. The implementation of the Nerve Centre electronic record system will deliver a step change in the way this data is collected and recorded that will enable sustainable improvement

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

Governors supported the Dementia CQUIN
CCG supporting the new plan and trajectory

Equality and Diversity Implications:

None

01 Dementia Progress report:

1.1 Purpose:

To provide assurance to the trust Board on the changes that have been implemented across the organisation aimed at achieving our organisational requirement to undertake dementia case finding. These changes are designed to address the underlying issues identified from the scoping work and deliver an improving trajectory on case finding patients aged 75 years and over who are admitted to the trust as an emergency who may show signs of dementia and are inpatients for 72 hours or longer.

The initial scoping of the systems and processes in place across the organisation to case find patients with possible dementia reported to the board in September 2016. This identified a number of underlying possible reasons why the Trusts current performance was not achieving the 90% national target which has been a requirement since 2014/15.

1.2 project outline:

A revised model of delivery has been developed, agreed and implemented since the report in September 2016. These system changes have been implemented over recent weeks to drive improvement including:

1. Daily patient lists of all those fitting the inclusion criteria are sent to ward managers, matrons and Associate Nurse Directors

2. Weekly progress reports on the previous week's case finding compliance is sent to medical colleagues and nurse managers and includes ward level comparative data.

3. A Presentation at the clinical management Group meeting outlining the case for change.

4. Letter to all medical and nursing colleagues clarifying the need to revise the current model and outlining the new agreed model.

5. A Flow chart of the revised model agreed and disseminated to all nursing and medical staff.

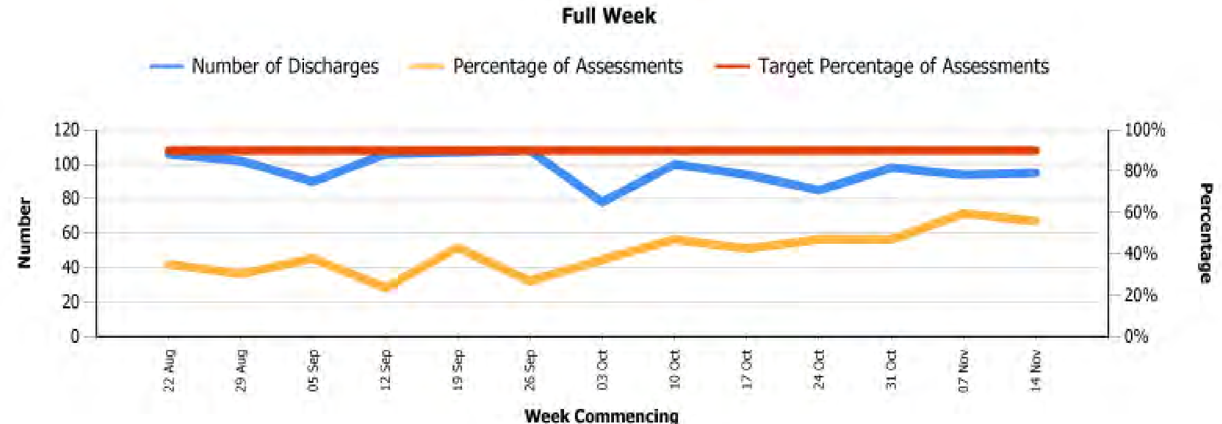
The whole system change commenced on Monday 14th November 2016 and therefore improvement in our performance remains in the early stages.

The key to successfully improving, achieving and embedding the 90% target of dementia case finding is organisational ownership at all levels in the Trust. Senior Medical and nursing colleagues are pivotal to raising the profile, recognising the importance of case finding as an integral part of providing quality and safe and driving improvement on a day to day basis. The importance of identifying individuals who may have dementia and ensure appropriate tests and investigations are undertaken and onward referral to other services will improve the lives of individuals, their families and carers.

Standardising the approach across all inpatient wards is pivotal to delivering high quality care in this respect. The revised model is led by medical colleagues and forms part of the history taking and assessment process and is the model adopted in other hospital trusts.
Nursing and administrative colleagues on the wards support the process through identify the patients for case finding and inputting the outcome and actions into info-flex.

1.3 Current performance:

The graph below demonstrates an improving trajectory from the weekly report produced on 21st November 2016. The most recent report dated 29 November shows a compliance of 64%.



The monthly reporting is also demonstrating an improving trajectory as set out below for September and October 2016:

DEMENTIA - SEP-2016 - COMBINED ACUTE AND COMMUNITY FIGURES

Measure 1

a	**Numerator**	171
b	**Denominator**	470
c	**Percentage of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services.**	36.4%

DEMENTIA - OCT-2016 - COMBINED ACUTE AND COMMUNITY FIGURES

Measure 1

a	**Numerator**	223
b	**Denominator**	451
c	**Percentage of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services.**	49.4%

1.4 Conclusion:

The recent focus on dementia case finding since September 2016 has resulted into an improving trajectory with overall performance improving by 13% in one month. The weekly reporting is also reflecting improvement and with implementation of all changes commencing on 14th November it is anticipated with continued focus that this trajectory will continue to steadily improve.

2.0 Safe Staffing:

2.1 Purpose:

The purpose of this paper is to provide information and assurance regarding the Nursing and Midwifery Staffing levels for the month of October 2016.

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.

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

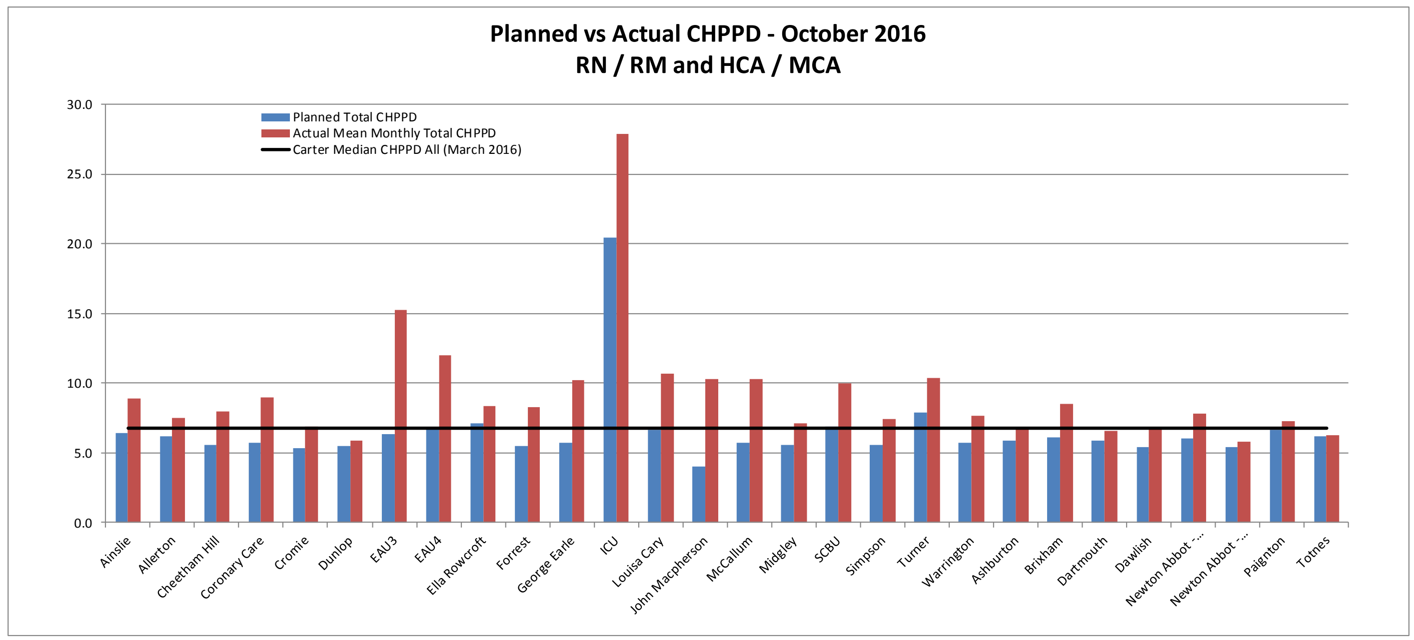
	TSDFT October 2016	National Median March 2016
Total CHPPD	8.40	6.77
RN/ RM CHPPD	4.11	4.07
HCA / MCA CHPPD	4.30	2.68

However it is 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.

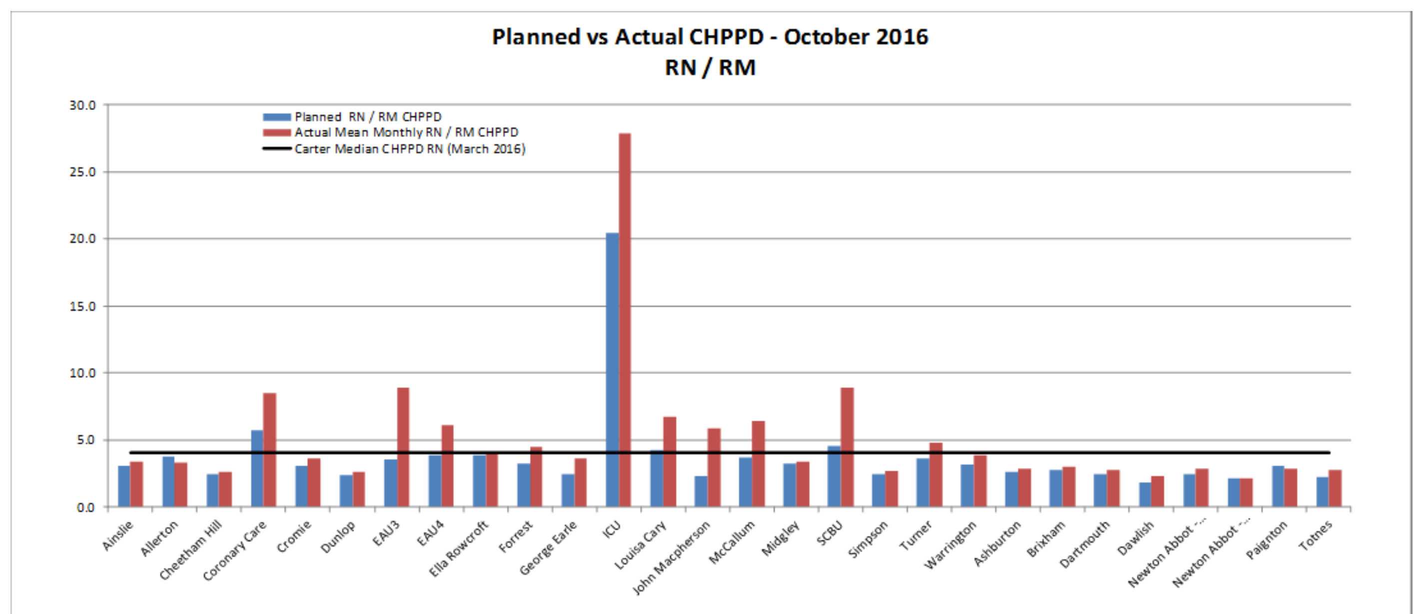
The analysis for October 2016 is summarised in the charts below and consists of:-

- 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 in Appendix 1.

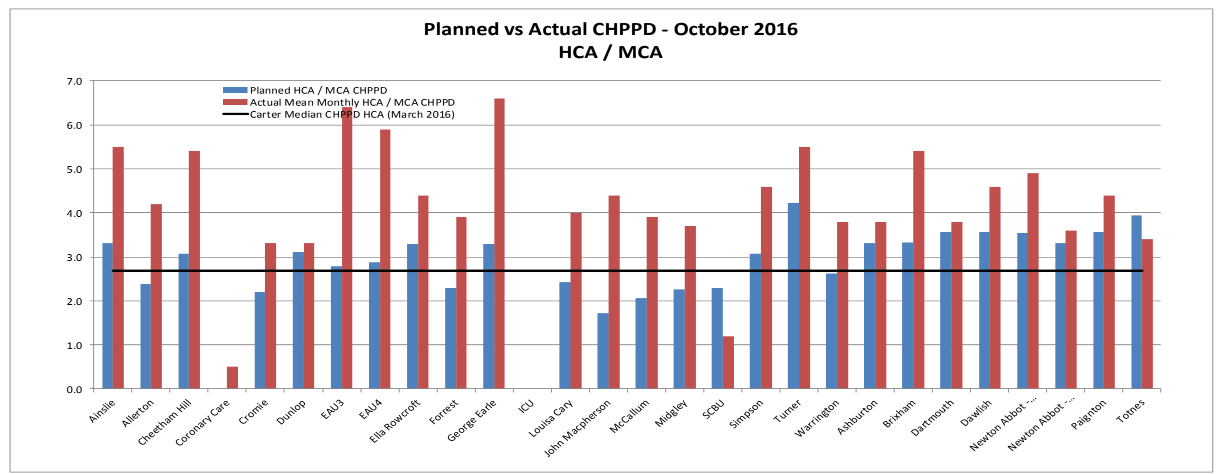


The graph above shows the combined position against the 6.77 national Carter median. The graphs below show that this is the result of increased HCA and MCA to support safe staffing.



The graph shows that in most areas the RN establishment is below the Carter median. The Carter benchmark data applies to acute ward areas and for these areas, all are at or below the Carter median. In some areas this is a planned variance but in others this is due to vacancy, absence and sickness. Variance is monitored daily and where necessary safe staffing is maintained with bank and agency.

For specialist areas such as coronary care, special care baby unit, emergency admissions units and intensive care there is no benchmark data. There is no national data set for community hospitals at present but these areas are below the Carter median.



The graph above shows that for HCA and MCA staffing is above the Carter median. This variance is associated with the need for 1:1 supervision and to provide additional support to support safe staffing.

2.3 Organisational Alert Status:

An organisational RAG status is published and shared with our partner organisations on a daily basis which provides an indicator of the operational pressures experienced within the system. This is summarized within this report, as it provides a good proxy indicator of the wider organisational pressures and climate the wards are working within, and which may impact on our staffing decisions.

The alert status for the organisation for the month of October 2016 is summarised in the table below.

SDHFT Alert Status	No Days in Month	% days in Month
Red	4	13%
Amber	7	23%
Green	20	64%

2.4 Emergency Department safe staffing:

The table below details the daily planned, actual and % fill rates for nurse staffing in the

Emergency Department.

The total fill rate for October 2016 was 107.6% (7.6% above plan) for RN and 106.2% (6.2% above plan) for HCA.

The Emergency Department staff are working flexibly to support the waiting room triage area, the Clinical Decisions Unit and the Ambulatory Care Unit. For this reason, the RN shifts are above 100%. The HCA figures reflect the movement of staff across the emergency pathway to support patient flow. Variance greater than 20% is a flag that staffing should be reviewed but variance within that reflects acceptable variation for a highly dynamic and flexible workforce.

		Total Planned shifts		Total Actual Shifts		RN Shift fill rate	HCA Shift Fill Rate
		RN	HCA	RN	HCA		
Sat	01/10/2016	17	13	17	13	100.0%	100.0%
Sun	02/10/2016	17	13	19	16	111.8%	123.1%
Mon	03/10/2016	17	13	18	16	105.9%	123.1%
Tue	04/10/2016	17	13	20	13	117.6%	100.0%
Wed	05/10/2016	17	13	18	11	105.9%	84.6%
Thu	06/10/2016	17	13	19	15	111.8%	115.4%
Fri	07/10/2016	17	13	17	13	100.0%	100.0%
Sat	08/10/2016	17	13	18	13	105.9%	100.0%
Sun	09/10/2016	17	13	19	14	111.8%	107.7%
Mon	10/10/2016	17	13	17	14	100.0%	107.7%
Tue	11/10/2016	17	13	18	13	105.9%	100.0%
Wed	12/10/2016	17	13	18	13	105.9%	100.0%
Thu	13/10/2016	17	13	19	14	111.8%	107.7%
Fri	14/10/2016	17	13	18	12	105.9%	92.3%
Sat	15/10/2016	17	13	18	15	105.9%	115.4%
Sun	16/10/2016	17	13	19	14	111.8%	107.7%
Mon	17/10/2016	17	13	17	14	100.0%	107.7%
Tue	18/10/2016	17	13	21	13	123.5%	100.0%
Wed	19/10/2016	17	13	19	13	111.8%	100.0%
Thu	20/10/2016	17	13	19	15	111.8%	115.4%
Fri	21/10/2016	17	13	21	14	123.5%	107.7%
Sat	22/10/2016	17	13	19	13	111.8%	100.0%
Sun	23/10/2016	17	13	19	14	111.8%	107.7%
Mon	24/10/2016	17	13	17	13	100.0%	100.0%
Tue	25/10/2016	17	13	18	13	105.9%	100.0%
Wed	26/10/2016	17	13	19	15	111.8%	115.4%
Thu	27/10/2016	17	13	16	15	94.1%	115.4%
Fri	28/10/2016	17	13	16	16	94.1%	123.1%
Sat	29/10/2016	17	13	18	15	105.9%	115.4%
Sun	30/10/2016	17	13	18	13	105.9%	100.0%
Mon	31/10/2016	17	13	18	13	105.9%	100.0%
	Total	**527**	**403**	**567**	**428**	**107.6%**	**106.2%**

2.5 Care Hours Per Patient Day for Acute and Community Setting Wards:

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly HCA / MCA CHPPD
Ainslie	6.4	3.1	3.3	8.9	3.4	5.5
Allerton	6.2	3.8	2.4	7.5	3.3	4.2
Cheetham Hill	5.5	2.5	3.1	8.0	2.6	5.4
Coronary Care	5.8	5.8	0.0	9.0	8.5	0.5
Cromie	5.3	3.1	2.2	6.9	3.6	3.3
Dunlop	5.5	2.4	3.1	5.9	2.6	3.3
EAU3	6.3	3.6	2.8	15.3	8.9	6.4
EAU4	6.7	3.8	2.9	12.0	6.1	5.9
Ella Rowcroft	7.1	3.8	3.3	8.4	4.0	4.4
Forrest	5.5	3.2	2.3	8.3	4.5	3.9
George Earle	5.8	2.5	3.3	10.2	3.6	6.6
ICU	20.4	20.4	0.0	27.9	27.9	0.0
Louisa Cary	6.7	4.2	2.4	10.7	6.7	4.0
John Macpherson	4.0	2.3	1.7	10.3	5.9	4.4
McCallum	5.8	3.7	2.1	10.3	6.4	3.9
Midgley	5.5	3.3	2.3	7.1	3.4	3.7
SCBU	6.9	4.6	2.3	10.0	8.9	1.2
Simpson	5.5	2.5	3.1	7.4	2.7	4.6
Turner	7.9	3.6	4.2	10.4	4.8	5.5
Warrington	5.8	3.1	2.6	7.7	3.9	3.8
Ashburton	5.9	2.6	3.3	6.7	2.9	3.8
Brixham	6.1	2.8	3.3	8.5	3.0	5.4
Dartmouth	5.9	2.5	3.6	6.6	2.8	3.8
Dawlish	5.4	1.8	3.6	6.8	2.3	4.6
Newton Abbot - Teign Ward	6.1	2.5	3.6	7.8	2.9	4.9
Newton Abbot - Templar Ward	5.4	2.1	3.3	5.8	2.2	3.6
Paignton	6.7	3.1	3.6	7.3	2.9	4.4
Totnes	6.2	2.2	3.9	6.3	2.8	3.4

Key Explanatory notes
RN = Registered Nurse / Registered Children's Nurse
RM = Registered Midwife
HCA = Healthcare Assistant
MCA = Maternity Care Assistant

Red cells indicate the mean monthly Care Hours per Patient Day (CHPPD) were below that planned and agreed as the budgeted safe staffing level for the ward. Measures to ensure safety are managed on a daily basis by the ward manager and matron.

2.6 QuESTT:

The Questt Tool is completed monthly between day 1 and day 7 and almost 100 teams across the organisation will be active by the end of the month. The monthly reporting dashboard for all teams is released on or around the 8th of each month to matrons and senior managers across the organisation. Where teams score amber or above action is required as set out in the Quality and effectiveness Trigger tool escalation procedure. Those scoring amber or above are contacted by the Deputy Director of Nursing – Professional practice and Standards to ensure appropriate interventions are in place and reflect the escalation procedure.

In October 2016 three teams in the acute setting scored amber and ten teams in the community scored amber which was an increase from six community teams in September 2016. 96 teams in total completed the QuESTT in October with an average score of 8.8.

Acute setting -amber:

Ainslie ward **–**October increased to 18 (amber) increase score from 12 (green) in September.

Identified risks: Discussion with the Matron for orthopaedics reflected a challenging month with short term sickness compounding 1.5 WTE band 5 vacancies. There were also two RCA's to investigate which are now completed and interviews for news staff took place in mid -October.

Actions**:** RCA completed , recruitment to vacancies progressing well and matron reports no additional external interventions or support required at present.

Orthopaedic theatres – October score 16 (amber) which is an improving position from September -score 19 (amber)

Risks: vacancy rate, short and long term sickness, 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 , and requirements to use loan equipment.

Actions: The band 7 is reviewing the list of orthopaedics cases each Tuesday for theatres effectiveness to improve the position for starting late or over running. Currently there are some new surgeons who have recently commenced and the theatre managers are still undertaking bench marking operating durations for various procedures times. New staff have now commenced in post but in induction period**.**

Theatre Recovery**-** October score 17 (amber) an increase from the September score of 12 (green**)**
Risks: sickness, vacancy and meeting demands. There were specific risks to theatres with patients in the previous week remaining in PACU over 5 hours and the number of HDU patients remaining in PACU overnight.

Actions: The spike in PACU has now resolved and links to ITU capacity and high care unit was closed intermittently during the month. Due to the relatively small numbers in the unit small numbers of staff will trigger and the sickness is managed appropriately. Vacancies interviews taking place 7th November 2016 2 applicants and 3 vacancies

Community teams (CSDU) - amber

Community Nursing - Brixham & Paignton – 4th consecutive month in amber and the score has decreased from 21 in September to 19 in October.

Community nursing- Dartmouth and Totnes had been green since March 2016 the QuESTT was not completed in September and in October triggered amber at 16

Risks: In the community nursing day service teams the key themes relate to vacancy and both short and long term sickness and unusual demands on the service and the number of visits requiring a registered nurse.

Community nursing OOH service- Had increased significantly from a score of 14 (green) in September to 23 a high amber in October.

Risks: The reasons for the increase relate to a wide range of triggers including short and long term sickness , vacancies within the team ,which is relatively small , this has resulted in a reduction in capacity and a need for the nurse manager to work additional clinical shifts to mitigate the risk . There has been an increase reliance on bank and demand has increased.

Actions: The service has reduced from three sites across the organisation to two sites with access to agency where required to maintain safety of the service.

Physiotherapy Newton Abbot has had a rising amber score for 4 consecutive months in September this reduced from 22 to 16:

Risks: The reasons include vacancies + 1.0wte in IC team on maternity leave not backfilled & rising referrals experienced, Community SWIC also covering vacancy on hospital ward .

Actions: bank staff used, support from other localities. Recruitment underway for enhanced IC service.

Occupational therapy – Moorlands October 19 (amber) September 17 (amber) no recording in August and prior months the team had been scoring 11 (green) . Newton Abbot October score remains unchanged in October at 18 (amber) September 18 (Amber)

Risks: The main pressure relate to long and short term sickness, capacity to meet demand. This score also relates to sickness (short term) capacity to meet referral targets.

Actions: review of case-loads and ensuring high risk patients are identified and prioritised

Podiatry - Podiatry had triggered green for two months at 15 for August and September, however in October the service has triggered 17 (amber).

Risks: Short term sickness, the number of routine patients cancelled in the previous month increase in number of requests for urgent appointments. This is linked with education of community nursing staff to risk stratify patients and refer to podiatry as appropriate. These are frequently housebound patients, which has impacted on the capacity of the domiciliary podiatry service**.** There has been an increase in RCA for amputations which have been challenging to deliver when clinical front line work is a priority.

Actions: The teams have needed to postpone routine appointments to prioritise urgent foot ulcers and meet the needs of house bound patients with high risk podiatry needs. A new model is being explored in Torquay community nursing where nurse funding has been used to employ a podiatrist to support the foot and lower limb care requirements. Additional resource has been provided from professional practice to support the RCA 's completion

HADT Torbay – October score 19 (amber) increase from 13 in September (green).

Risks: Vacancy and both short and long term sickness together with an increase number of referrals in the previous month and appraisals not performed.

Actions: sickness is being managed appropriately and recruitment into vacancies

Torquay social care: October score 16 amber an increase from September score of 8 (green)

Risks: no current line manager, appraisals not preformed, team unable to participate GP practice meetings and 28 day target not met and 6 monthly review target not met.

Actions: sickness and vacancies have recently been resolved and there is an improving picture with no specific issues that require additional support.

Non Completion (Acute setting)

In the acute setting for October three completed late but have been reviewed two are set out above as they scored amber and ITU scored 5 green .

Non Completion (Community)

One completed late in community moorlands and scored green

2.7 Surveillance:

Rotas are reviewed by Senior Sisters and Matrons. The Associate Director for Nursing – workforce, reviews the rota to ensure these are completed at least six weeks in advance and that provide a safe skill mix.

Safe Staffing is discussed at the beginning of each week by the Chief Nurse and Associate Directors of Nursing to identify risk and consider mitigating actions. Associate Directors review their areas each day. Staffing is reviewed three times daily at the control room by the duty Matron and the Executive on call. This ensures that late notice gaps are risk assessed and filled.

Safe Staffing data is presented to the Quality Improvement Group monthly and triangulated with other safety data to highlight any areas of risk. This information is provided to the Service Delivery Unity Teams for discussion at the SDU Board meetings.

3.0 Volunteers Update:

610 volunteers (334 acute, 276 community) doing 682 activities. The service is supported by 0.6 wte Volunteer Services Coordinator, full time apprentice administrator and 0.35 WTE Volunteer Lead.

There are circa 50 enquiries per month via the Trust's website plus many other direct / indirect enquiries. 52 volunteers completed their full recruitment process within the last 3 months with a further 25 in the process. This is a net increase of 30 as 22 left within the same period, giving an indication of the work involved in recruitment alone.

There has been good progress against the internal audit published August 2016 with most issues resolved. 5 low-risk DBSs still outstanding with 4 arranged for Nov 23rd. All volunteers have ID badges issued by security.

The newest roles:

Wayfinder role - led by the employability hub. Originally this provided a work experience placement but this has now widened to be a permanent volunteering opportunity.

Mealtime Companion role (MTC) - awareness sessions are being organised for nursing and domestic staff so that they are clear what MTCs can and can't do, to ensure MTC volunteers are used appropriately.

Emergency Department befrienders – new volunteers are being recruited and in the process of appointing a lead ED volunteer who can provide additional support.

Recent achievements

Rolling programme of dementia training for volunteers established
Volunteer notice board set up opposite security
Volunteer newsletter set up – and competition to name it successful
Volunteer awareness information in hospital corridor.
Mairead's official signing of Torbay's Volunteer Management Charter in partnership with CDT
Interim Volunteer Strategy produced – being consulted upon.
Mairead and Sir Richard made a video to be used for volunteer induction. This has been very well received.

Next 3 months

Hope to have Volunteer Service Manager in post
Engagement work with volunteers about Volunteering Strategy
Finalise Memorandum of Understanding with separate organisations such as Leagues of Friends
Finalise honorary contracts for non-volunteering roles

REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Report of Chief Operating Officer
Lead Director:	Liz Davenport, Chief Operating Officer
Corporate Objective:	Safe, Quality Care and best experience
Corporate Risk/ Theme	Theme 2 – Failure to achieve key performance standards Theme 4 – Home / domiciliary care capacity of the right specification and quality
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The report provides an update against key operational issues

Key Issues/Risks

- Reduction of management capacity in medicine Service Delivery Unit
- Mears who provide domiciliary care as part of the Living Well@Home contract has been rated as inadequate following a recent CQC Inspection and there is insufficient capacity to meet demand in Torbay

Recommendations:

To **note** the contents of the report

Summary of ED Challenge/Discussion:

The Executive Team have considered:

- Timeliness of delivery of the care model changes and capacity required to deliver programme
- Contingency plans to support potential risks to the delivery of domiciliary care and have supported funding of additional capacity over the winter period
- Interim support to address shortfall in management capacity in medicine
- Need to have robust escalation plan to include access to additional bed capacity in support of the winter plan.
- Action to address the significant deterioration in the ED performance over the last 2 weeks
- Reporting of risks on the risk register

Internal/External Engagement including Public, Patient and Governor Involvement:
Discussions have been held with the CCG and Council Colleagues and staff have been briefed as appropriate.
Equality and Diversity Implications:
None noted.

Report to:	Board of Directors
Date:	7 December 2016
Report From:	Chief Operating Officer
Report Title:	Report of Chief Operating Officer

1 Purpose

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

2 Provenance

The report is informed by the following:

- Minutes and action log from the Care Model Operational Group
- Minutes and action log from Senior Business Management Team
- Minutes of the Executive Team
- Minutes and programme plan from Vascular Services Group
- Minutes and action log from weekly review meeting with Mears

3 Care Model Delivery

The Care Model Implementation continues to progress overseen by the Care Model Implementation Group (CMOG). Developments include:

Enhanced Intermediate Care

The appointments have been made to the Intermediate Care Teams across Devon and Torbay in line with plan and staff have been going through a period of training and now providing additional capacity in the community. The team are working 8am – 6pm Monday to Friday and 9 am – 5 pm on Saturdays. This will increase to include Sunday's from March 2017.

The increase in capacity has allowed for the implementation of a pilot of Discharge to Assess to commence which is currently focused on the wards that have been implementing the SAFER bundle. Numbers being identified for discharge when medially fit remain small so named leads are working with wards to look at how this number can be increased. This is an important part of our plan to support people to return home as soon as possible which in turn will improve flow in the hospital.

Work has also commenced with SWAST to provide an alternative pathway for people who have fallen at home with the option of direct referral to Intermediate Care as an alternative to conveyance to ED when clinically appropriate.

My Support Broker

As part of the New Model of Care the Trust are supporting a number of initiatives to provide services differently as we move away from bed based care into a further community focus, including working with the voluntary sector. The MSB project is part of a range of new approaches including the appointment of Well Being Co-Ordinators, the development of Intermediate Care in the community and the encouragement of a "Strength Based Approach" being used by our staff to support service users and patients with self-help and resilience.

The MSB project scheme has been put in place to test the Support Planning Model with an established and well regarded provider, My Support Broker. The Trust have committed to testing the impact that person centred support planning could have within Torbay working in partnership with the Community Development Trust (CDT) and MSB.

This work and the ethos of MSB is to produce quality and innovative outcomes for clients that in turn secure sustainable savings and enhance our focus on prevention, as per the care model.

The MSB pilot approach also aligned to the Strength Based Approach.

Person centred support planning is an approach to support planning which focuses on what matters to an individual rather than what is the matter with them. There is a national evidence base building to indicate that this approach empowers and engages individuals in their care, delivers higher quality and more effective support plans at lower cost. Six support planners, working using person centred methodology, are currently hosted by CDT.

They will:

- Provide tailored support plans and services. The support brokers understand that arranging high quality, good value for money care and support is critical.

- Help people with long term health conditions produce support plans that make it possible for them to live their best life.

- To help those people allocate and manage their individual budget.

- To research and provide information about local services and opportunities, and negotiate with service providers on behalf of consumers to get the best deal and quality.

The support planning brokers in the project are hosted by Torbay Community Development Trust (CDT), and the NHS has contracted directly with MSB for their support planning product and project support through the pilot period. During 2015 and 2016 model and contractual arrangements for the MSB project were put in place. Since October this year we have moved into an operational phase at pace. An evaluation in April 2017 will assess if the model has been successful and delivered the anticipated innovation and financial benefits and reach recommendations above the way forward in this respect.

MSK pathway
The CCG has agreed to support the extension of the MSK single point of contact pathway to include foot and ankle. It is anticipated that this will reduce the overall number of people requiring surgery in line with the benefits experienced by people who have hip and knee problems.

Torquay – early implementation site
There is a co-located Health and Wellbeing team in existence in Torquay and the new model of care has built upon this. This team comprises of Nurses, Social care staff, physiotherapists, occupational therapists, Health and Social Care Co-ordinators and support workers and Intermediate Care staff.

The locality is organised into a multidisciplinary 'short term/triage' team who concentrate on completing todays work today for health and social care. This part of the system works very closely with intermediate care delivering a fast urgent response to referrals where required. This means that a client can receive a home visit in an hour with and be supported with a care package that is right for them. Equipment can be delivered within 2 hours and a care placement for intermediate care or support at home can be organised that day. The team have 5 mornings covered by a GP who supports the Intermediate care provision. Work continues in relation to understanding the best and most efficient and effective ways of working with GPs. The GPs have also supported a review of the caseloads of Community Matrons ensuring that they are focussing on the most appropriate patients and that risk is being managed well.

The other key part of the locality is the 'long term' teams who support clients with longer term need. Multidisciplinary team's work together using a risk framework to manage some of the complex issues around mental capacity, safeguarding and risk through a formal process called risk enablement.

The vast majority of the Health and wellbeing team have been trained in the strengths based approach, including the management team. This has built on the work already imbedded in teams in relation to 'personalisation' making sure that staff focus on what matters to clients and builds and recognises the strengths that people have already in their lives.

The Customer Service Centre (CSC) from the beginning of August is delivering a single point of telephony for Torbay.

Wellbeing coordinators have been recruited within Torbay and have received over 120 referrals since July 2016. 25 cases have been completed, 4 are on hold, 2 have declined to meet and 87 are ongoing cases.

As a result of service redesign and care model changes the locality has achieved:

- Today's work being done today wherever possible
- No waiting list for social care
- No waiting lists for Occupational Therapy
- Physiotherapy waiting time of 5 weeks which will be improved through direct booking into physiotherapists diaries
- Increased investment in Intermediate care;
  - 1 social care member of staff
  - 3 support staff and interviewing for a 4th on 9th of December.
- CSC calls increasing from 5000 to 7500 after the development of the single point of contact allowing us to support and signpost more clients where appropriate
- The Health and Wellbeing team are meeting national benchmarked best practice for social care:
  - 75% of people should have their needs resolved at first point of contact.

- 17% of people should have their needs resolved through short-term interventions.
- 8% of people will require longer-term services. Most of these have the capability to regain some independence.

- Majority of staff have been trained in the strength based approach

- Majority of staff attended briefing sessions led by the Associate Director and Locality manager giving information about the care model and engaging in discussion – please see attached document

- Health and wellbeing champions from the teams have been identified and 4 meetings held – these are ongoing

- Wellbeing co – ordination – progress is being made to imbed these in the Health and Wellbeing Team and GP practices (2 identified) now that the service is fully recruited. Promotion of the service is ongoing and being driven through staff engagement and locality meetings

- Prevention and screening offer in the Health and Wellbeing team has been scoped and training is being identified

- The Locality is live with the EMIS system since the start of September and information is now easily shared between all Torquay GPs and the Health and Wellbeing Team for the first time. This means that the teams have access to the right and up to date information to support the management of risk and safe and appropriate care of clients.

- Double handed care packages are being identified and reviewed at an earlier stage with equipment being provided along with training to formal and informal carers to support new ways to provide care.

- My Support Broker has received 28 referrals from the Bay – and are supporting those clients with developing innovative care plans and packages.

- 25 service users who have high attendance and admission rates to Torbay A&E have been reviewed. This has led to a further refocusing of the assertive outreach alcohol worker in the Drug and alcohol team.

- Locality Pharmacist has been recently appointed and start dates are currently being negotiated.

4 Mears update

Mears secured the contract in April 2015 to provide domiciliary care services in Torbay. The service called Living Well @home aims to provide a flexible response to people taking account of their changing needs enabling them to stay at home and remain independent. The contract is managed by the Trust on behalf of Torbay Council and is overseen on a day to day basis by our Community Management Team. There are established governance arrangements in place which include regular meetings with the Mears senior team where performance and quality and safety measures are monitored. The Trust also has a small Business and Quality Team who also have a role in monitoring quality of provider organisations including Mears.

The service had been meeting much of the contract requirements but in the spring the Trust became aware that there was increasing numbers of people waiting for packages of care. These numbers increased over the summer and community staff reported other concerns which were initially focused in areas where Mears was developing new ways of working. These concerns triggered an investigation by Healthwatch Torbay who were responding to concerns raised by members of the public.

The CQC completed and unannounced inspection in September shortly after Healthwatch had completed their review. The issues identified in this inspection were consistent with feedback received by staff and found in the Healthwatch draft report.
In response to the reports we have been working very closely with Mears to ensure that an action plan is in place to address the concerns raised and that performance and quality standards are being met. Mears have reported that the Action plan has been approved by the CQC.

The Trust has put in additional measures to support the improvement plan. These actions include:

- Executive Director oversight of the work programme
- Daily monitoring of performance standards
- Weekly meetings with the senior team
- Monitoring of complaints and incidents
- Communication with people who use services giving them information about where they can raise concerns
- Telephone contact with people who use services to secure feedback and confirm information in reports

Mears have continued to work positively with the Trust and the Council and we have seen an improvement in a number of areas and we can be confident that 95% of people who have a visit receive this within 30 minutes of the visit time. We continue to work with them to ensure all aspects of the plan are implemented.

In addition to the specific work with Mears we are also developing local contingency plans to build capacity this includes recruiting additional staff into our Rapid Response Service.

The CQC will re-inspect the service in about 6 months.

5 Winter plan

The Health Select Committee completed a review of winter planning in the NHS and the Trust submitted evidence as part of the process and attended a meeting with members of the Committee. The report was published on 3 November 2016 with a number of recommendations set out which include a number of issues highlighted in the Trust submission. These include:

- Increased social care provision
- Culture change that results in whole Hospital ownership of flow
- Improved infrastructure in type 1 Emergency Departments
- Improvements in workforce sustainability

The Trust has developed its winter plan in line with NHS England and NHS Improvement requirements and the first draft was submitted for comments. The Trust plan was reviewed along system wide plan at the A&E Delivery Board on 30 November 2016 and approved. A table top test of the plan will completed on 7 December 2016 facilitated by the Emergency Preparedness lead. The plan is attached for information.

7 Management changes

Interviews for the post of Deputy Chief Operating Officer took place on 28 November 2016 and I am pleased to confirm that John Harrison has been offered the post. John has substantial experience and has a significant amount to contribute to the delivery of the operational delivery plan. The Interim Deputy Chief Operating Officer Clive Brookes will leave the Trust on 2 December 2016.

The case for change for the new Operational delivery structure is being finalised with the expectation that consultation will start in early December. There are a number of vacancies in the operational management team currently with a particular impact on medicine and emergency care. Action is being taken to secure interim solutions to manage gaps in capacity.

8 Performance

Urgent Care Improvement and Assurance Group

The group over seeing delivery of the Urgent Care Improvement plan continues to meet on a two weekly basis. At the meeting on 29 November there was a focus on the deterioration in performance against the 4 hour target over the previous 2 weeks. The Clinical Team identified a number of factors that included:

- Utilisation of EAU 3 and CDU for beds
- Increased conversion to admission
- Reduced discharges in key medical wards including Warrington Ward
- An increase in people remaining in hospital for more than 10 days
- Inconsistent application of escalation protocols

A number of actions were agreed to address these concerns with a priority to free up assessment space on EAU3 which is essential to maintaining flow. It was noted that although there was deterioration in 4 hour performance the ED clinical team were maintaining a focus on time to triage in 15 minutes and times to first clinical review.

Medicine Improvement and Assurance Group

The group that is overseeing the delivery of the CQC action plan for medicine meets on a 2 weekly basis and is making good progress against their priority action plan. This includes:

- Introduction of weekend plans
- Increased consultant capacity at the weekends
- Redesign of the 'o' drive system for managing emergency medical admissions
-

9 Recommendation.

- To **note** the contents of the report

Liz Davenport
Chief Operating Officer

Torbay and South Devon Winter Plan 2016-17

1. Introduction

The plan has been developed in collaboration with stakeholders from the Torbay and South Devon A&E Delivery Board. The aim is to ensure operational resilience and to complement plans of partner providers, to ensure the delivery of safe and high quality services to the population of Torbay and South Devon during the winter period. Historical experience and facilitated 'lessons learnt' debrief events, alongside NHS England advice and guidance, have been used to develop this plan. CCG and ICO representatives have taken part in the South West Regional Winter Review Process.

The potential impact on the patient experience is considerable and during the winter period we will aim to ensure:

- no avoidable deaths, injury or illness
- no avoidable suffering or pain
- no unnecessary waiting or delays
- no inequality of access to our services

2. Strategic Intentions

The Torbay and South Devon Care Model clearly outlines a move towards patient independence and care closer to home. The CCG consultation reinforces those aims to ensure high quality care that is sustainable, affordable and moves away from the traditional model of bed-based care towards community provision. This is a model of prevention, re-ablement and draws upon a strength based approach to encourage independence and patient self-care.

The ICO approach to winter 2016/17 is to provide enough resilience to enable achievement of our contractual performance and quality standards. Significant focus must be maintained around:

- The 4-hour emergency standard
- RTT
- Cancer standards

Key enablers to this are:

- The Discharge to Assess (D2A) model with extended intermediate care capacity.
- Proactive management of delayed transfers of care (DToC) across all bed-bases
- Improved patient flow: SAFER principles of best practice on all wards.
- Enhanced focus on 7-day service provision.
- Early escalation processes across health and social care with clear role centred actions
- Management of the complex long stay (>10 day) patients.

DRAFT

A non-bed based focus is the objective and to ensure patients are in the right environment for their assessment, treatment, on-going care and rehabilitation.

3. Key Pressures

The key pressures generally posed by winter include:

- A tendency for a more complex/dependant case mix leading to an increase in length of stay (LOS) and a subsequent impact on capacity, especially in relation to ICU, paediatrics and respiratory patients
- Reductions in timely discharge of patients due to increased demand
- Impact of infection on patient numbers, demand for services and staff absence due to sickness
- Bed closures due to sustained infection (e.g. Norovirus) outbreaks
- Increase ambulance handover surges resulting in delays
- Adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work

The Trust has undertaken a series of debriefs and planning events which identified the following key risks:

1. Domiciliary care, especially for the complex patients
2. A vulnerable care home market
3. Community rehab beds
4. Clinical staffing, particularly safe levels of nurse staffing
5. End of life, domiciliary and hospice care

These monthly meetings will convert to winter assurance meetings with lead managers until 31st March 2017 chaired by the Head of Operations.

4. Learning from experience

The opportunity for CCG and local providers to review and learn from winter 15/16 was conducted through an NHSE facilitated winter debrief which involved representation from the ICO, peninsula acute trusts, social care, ambulance trust, primary care, out of hours services and mental health provider organisations.

The learning from the event was taken forward in a number of follow-up meetings facilitated by the ICO held between August and October and developed into an action plan. All organisations involved in this process agreed that this was an opportunity to look at breaking the cycle of the 'RED ALERT' and identify new ways of implementing actions to achieve full engagement and ownership from clinical teams.

Key outcomes from these meetings have including:

- A review and revision of the ICO Operational Pressures Escalation Action Plan to align the content with the 16/17 NHS England Operational Pressures Escalation Levels Framework:

DRAFT

  - A planned table top scenario test with key individuals (7th December 2016) to ensure that the plans for winter are clear and unambiguous in terms of the roles and actions within it
  - A larger follow up event of the ICO Escalation Plan with key clinical and managerial leads in January 2017
- Social care escalation: a review of the escalation process for delayed transfers of care to maintain patient flow and bed capacity when DToC triggers are met across bed-bases
- The identification of options for short term additional escalation bed capacity which can be safely resourced and accessed during surges in demand
- Meetings with key individuals within the local mental health provider organisation and the Emergency Department at the ICO to agree specific actions relevant to the care of mental health patients at times of system pressure.
  - A further mapping event is planned for December 2016 to outline the relevant processes and communication routes to ensure escalation is timely, effective and includes the relevant information first time.
- Development and ratification of a Reluctant Discharge Policy.
- A review of the ICO Discharge Team relating to proactive management of 'medically fit/ready for discharge' patients; focusing on roles and responsibilities as well as the funding decision-making process as part of a Complex Discharge Programme.
- Strength based approach training roll-out with a focus on independence and appropriate levels of care support within a discharge to assess culture – 24th November 2016
- Development of an Executive-led action plan relating to domiciliary care including contingency planning incorporating alternative options
- A review of nurse staffing resource to provide improved flexibility of allocation to respond to hot-spots and pressures within the system
- Development of Newton Abbot Hospital facilities to enable:
  - Focus around therapy support and team-based working with nursing and discharge team
  - Appointment of an interim therapy leader to manage the wider team during the winter period
  - If appropriate, resilience to open 10 additional beds at Newton Abbot Hospital (NAH) for stroke rehab or medical patients
- A review of the deep cleaning resource to improve responsiveness across all bed-bases to reduce infection risks and manage any potential outbreaks.
- The development of the risk stratification policy, with NEW Devon CCG, SWASFT, peninsula acute and community organisations as well as representation from primary care.

5. Reducing bed occupancy/elective scheduling

In order to manage the flow of patients, especially due to the impact of the two long festive bank holiday periods, there are plans in place to ensure that elective admissions are reduced to approximately 85%.

DRAFT

Within Torbay and South Devon, scheduling of surgical elective in-patient activity will be reduced for the period 19th December 2016 until 23rd January 2017 with a managed incremental return to normal activity levels.

This exceeds the period recommended by NHSE as local historical pressures have indicated mid-January is a critical point in the calendar. To achieve this aim and to minimise impact on RTT there will be a shift in the ratio of in-patient and day case pathways.

6. Escalation Reporting and Sitreps

A revision of the ICO Escalation Policy has been carried out to align triggers and actions with the 16/17 NHS England Operational Pressures Escalation Levels Framework. Whilst this is a national framework the Trust is responsible for defining local level triggers and actions within the framework in terms of appropriate response at each level of escalation.

The ICO will declare their escalation status no later than 10.30am each day to the CCG by either e-mailing the escalation in-box with the OPEL level in the header (escalation.sdtccg@nhs.net) or calling a member of the unplanned care team (01803 652500). If OPEL 3 or 4 is reached *for the ICO as a whole* using the national OPEL triggers an escalation status report will need to be submitted to NHS England, via the CCG, no later than 11am. Throughout the winter period, the CCG will aim to attend at least two control meetings each week in person or on the phone and, increase this during times of escalation.

In addition the Trust is introducing an electronic logging system to be used at control meetings to record escalation actions and ensure completion and de-escalation.

7. System Risk Stratification

The pressures experienced by health and social care providers across Devon continues to increase. The pattern experienced over many decades of activity peaking during winter months before returning to a lower baseline no longer occurs. Whilst activity continues to increase each winter, the baseline no longer returns to its previous level.

During periods when providers are at amber (OPEL 2) increasing to red escalation levels (OPEL 3), there is a need for the wider health and social care community to work effectively together to help manage the increased risk to patients. The timeliness of reaction to the increased escalation status is imperative to safe, quality patient care and status de-escalation to avoid OPEL 3 or a higher escalation status, the actions and responsibilities within the Risk Stratification Policy are key to facilitating this.

The escalation status will be defined by national and local policies.

DRAFT

8. Flu Vaccination Plan

All frontline health care workers are offered flu vaccination, to protect staff and their families prevent the transmission of flu to vulnerable patients and visitors. The vaccination programme at TSD is managed by the Occupational Health Service in conjunction with the Infection Control team. This year, an extensive peer vaccination programme has been established in all wards and many clinical departments. The aim is to increase the uptake of vaccine by frontline staff through local promotion of the benefits and making vaccination easily accessible in the clinical area.

[hyperlink to Infection Control Flu Policy]

9. Adverse Weather Conditions

The Trust receives warnings of severe weather from the Met Office. The Trust also receives additional information from a Met Office Adviser via the Local Resilience Forum if forecast weather has potential to cause disruption.

The Trust has plans for severe winter weather and heatwaves which can be easily accessed by all staff on the Emergency Preparedness page of the intranet. The plans are reviewed each year against national guidance which corresponds to Met Office Cold Weather Alert and Heat Health Watch Periods.

The Cold Weather Alert period operates from 1st November 2016 to 31st March 2017. During this period, the Trust receives twice weekly Met Office Weather planning advice and alerts when threshold criteria are met.

The Operations and on-call management team receive these alerts and agreed actions are managed via the Control team meetings.

10. Christmas and New Year Bank Holiday Period: 23rd December 2016 to 8th January 2017

A complete on-call rota for this period will be published week commencing 12th December.

As a general principle specialty teams will ensure that throughout the winter months, annual leave provision across wards and departments is closely monitored to ensure sufficient cover is maintained to support service continuity. This is particularly important during planned school holidays, where historically, patient flow pressures increase and access to Bank workers reduces.

Teams are also organising additional resilience during the two long Bank Holiday weekends. An example of this is demonstrated below as part of the Acute Medical teams preparedness.

Christmas Weekend/Bank Holiday

24th/25th Dec - three consultant physicians sharing on-call plus an Acute Physician ward round – including a consultant geriatrician.

26th/27th Dec - two consultant physicians sharing on-calls plus an Acute Physician ward round including a consultant geriatrician on 26th December. There is no geriatrician on the 27th December.

28th December to 30th December (inc) are normal working days plus a HoP consultant doing the post-take ward round.

New Year weekend/Bank Holiday

31st Dec/1st Jan - three physicians on-call plus an Acute Physician ward round.

Geriatrician on-call 30th into 31st December, including post-take ward round.

Rostered Geriatrician on the afternoon of New Year's Day.

2nd Jan - two physicians sharing on-call plus an Acute Physician ward round. Geriatrician doing morning post-take ward round.

4th – 6th Jan normal working days.

Post New Year Weekend 7th & 8th January

Three physicians sharing weekend on-calls plus Acute Physician ward round.

DRAFT

11. Emergency Department

The Emergency Department continues to review emergency care pathways to reduce delays and maximise the opportunity for admission avoidance. The Emergency Department team have undertaken a significant amount of work to ensure that the service is adequately resourced and that workforce capacity matches required demand.

There is now additional resource for Nurse Practitioners and the team have implemented a Rapid Assessment which puts Consultants and senior doctors at the start of the patient journey in the majors area ensuring swifter decision making.

12. AMU

To receive, assess and treat all ambulatory referred medical and surgical patients.

13. Emergency Assessment Unit

General assessment for all GP referred patients

14. Discharge Lounge Facilities

The discharge lounge facilities currently established on Elizabeth Ward are being reviewed to ensure that at times of high demand this can be flexed to receive more patients. In

addition this unit is also required to safely accommodate patients in the event of ward decant and deep cleans.

15. The Perfect Week

NHS England have requested that all providers undertake a perfect week during January 2017. The Trust has suggested conducting the "Perfect week" Wednesday 22nd February - Tuesday 28th February, with the aim of improving the 7-day focus. NHSE feedback is pending.

WINTER ACTION PLAN – 2016/17

ACTION	COMMENTS	LEAD MANAGER	TIMESCALE
ICO capacity demand Escalation Policy reviewed and updated Now titled Operational Pressures Escalation Plan (OPEL) levels of escalation	Jonathan has amended the Escalation Policy to incorporate the new NHSE Escalation Framework and OPEL levels from RAG rating. CG to review with CCG ratify at Patient Flow Board in December for A&E Delivery Board sign-off. Test and training for clinical and management leads in January 2017 New mechanism introduced for escalation reporting: Electronic incident log IT system in design for Control Team for daily escalation to communicate and monitor escalation actions.	Cathy Gardner Supported by Jonathan Edmondson	14.12.16
Strength based approach training roll-out. Focus on independence and 'appropriate' level of care support with D2A culture. Manage the limited care resource appropriately.	Training for Discharge Team, Physios etc. (50 attendees) scheduled for 24th November and a further date set for December. Continued roll out to MDT via SAFER 9am huddles.	Cathy Gardner	Completed and ongoing
Reluctant Discharge Policy	Distribute and communicate at all acute and community ward bases.	Nicola Barker	Completed to be circulated and flagged on the intranet.
Domiciliary Care – High level of risk to the organisation.	Executive-led Action Plan and resilience.	Liz Davenport Shelly Machin	Completed work continuing to support and monitor.

DRAFT

Newton Abbot additional Capacity	New Interim Head of OT and Physio will be supporting activity at NAH: able to allocate resources and to ensure adequate skill mix to cover **60 beds.** These beds can be managed as business as usual. Ongoing work with Social care team at Templar around engagement and MDT. Requirement for further work around referrals, communication to smooth these processes. Long LoS happening weekly with input from Social care. SAFER embedded. Full-time discharge co-ordinator to support team. In the event that beds are required NAH is ready.	Nell Clotworthy With Liz Stirling Lee Baxter Nicola Barker	Completed
Nurse staffing resource and assurance around flexibility to allocate across all bed bases.	Concerns around high risk areas – particularly in the community. Work progressing with ADNs to review non-clinical RNs and Options.	Jacquie Phare	Work underway.
7-day therapy support to community hospitals	Potential for intermediate care teams to provide advice at weekends	Su Skelly	Ongoing.
DTOC Escalation Processes: Reliable, clear escalation process for delayed discharges across acute/community beds	Escalation roles and responsibilities to ensure accountability to manage high numbers of patient delays across acute and community sites and free up bed capacity: Rota drawn up and agreed with Community Managers. Key individuals to lead: Associate Director Operational Lead for both Torbay and South Devon Action cards developed: - Stepdown non-essential work during the period of escalation - Expectation – what the individual will be expected to lead. - Maintain scheme delegation and funding decisions will be supported by Lee Baxter and/or Cathy Williams. - Escalation actions to be completed in hours and with a co-ordinated approach and response to the escalated demand. - Operational lead will participate in control meetings.	Lee Baxter	Completed. Action Cards.

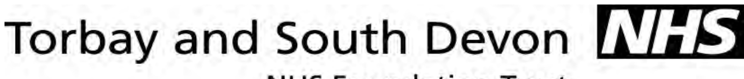
DRAFT

MFFD	Discharge Team: Roles, Responsibilites and decision-makers part of the Complex Discharge Programme. Acute – complete. Community – work underway. Information support to identify DTOC.	Helen Ireland/Nicola Barker Neil Elliott	Ongoing work around community DTOC information and robust daily management.
MH Escalation Mechanism.	Clear process to manage delays for psychiatric patients.	Cathy Gardner	Mapping meeting scheduled in December to define escalation process.
Deep Cleaning Resource	Response across acute and community sites to outbreaks/HPV cleans. Resilience for Enhanced cleaning for proactive management.	Karen Robertson	Assurance Received.
Comms Team	Choose Well and public messaging to reduce demand.	ICO Comms working with CCG team.	Assurance Received.
Additional Escalation Beds	Option appraisal with Executive Team for decision.	Jane Viner Jacquie Phare	Awaiting confirmation.
SAFER	Full roll out to all ward areas both acute and community	Cathy Gardner	Ongoing.
Complex Discharge Programme	Monitor and Measurement.	Cathy Gardner	Ongoing
Discharge to Assess	Roll out on SAFER wards. Support from I/care management to the Discharge meetings. Scale up.	Su Skelly	Ongoing
Perfect Week	Agreed to conduct system-wide perfect week from 22nd February to 28th February. Working group to be set up.	Rob Dyer – Clinical Lead Cathy Gardner – Management Lead Susan Martin – QI support.	30.11.16

DRAFT

Torbay and South Devon NHS
NHS Foundation Trust

DRAFT



REPORT SUMMARY SHEET

Meeting Date:	7 December 2016
Title:	Workforce and OD Board Report
Lead Director:	Judy Saunders, Director of Workforce & OD
Corporate Objectives:	1. Safe, Quality Care and Best Experience 2. Improved wellbeing through partnership 3. Valuing our workforce 4. Well led
Corporate Risk/Theme	Failure to achieve key performance standards Inability to recruit / retain staff in sufficient number / quality to maintain service provision Failure to achieve financial plan Delayed delivery of integrated care organisation (ICO) care model
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group.
- To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks:

Issues

- Performance against the key workforce metrics for 2016/17 are included in section 2 of this report.
- The Workforce and OD Group reviewed a capacity plan to reduce the nurse vacancy gap over the next 5 years and requested a final proposal for their next meeting in January. Section 3.2 refers.
- The Appraisal rate remains at 84% against a target of 90% a range of measures to improve the rate were agreed at the Workforce and OD Group, Section 4.2 refers.
- The Workforce and OD Group agreed at their meeting on the 17th November 2016 that given the positive effect of the existing incentives and controls to reduce agency spend the existing incentives to substantive staff and bank workers to cover shifts should be maintained. However no further incentives should be introduced pending a further update in January 2017. Section 4.6.5 refers.
- Programmed alerts to managers in respect of responsibility allowances, acting up and fixed term contracts will reduce the potential for erroneous payments. See section 6.1.1.
- The implementation of the new Learning Management System (LMS) & Nurse

Revalidation system has been delayed. Section 6.1.2 refers.

- The Senior Management Leadership Development Programme commences in December, Section 7.3.2 refers
- The Trust has been part of the successful STP bid to become one of the 11 national pilot sites for the Nursing Associate role in the UK. The Trust will employ 10 Training Nursing Associates (see section 8.4.3).

Risks

- The outcomes of the community services consultation and implementation of any changes being in close proximity making consultation challenging (see section 3.1).
- Failure to achieve workforce changes in accordance with the Trusts Operations Plan including CIP plans (see section 3.3).
- The rolling sickness absence rate has increased to 4.27% against a target of 3.90% a range of measures to mitigate the increase are contained in section 4.1. These measures are included in an enabling efficiency scheme in the Trusts 2017/2018 operations plan (see section 3.3).
- NHSi have brought in a range of additional reporting requirements for temporary staff as detailed in section 4.6.1. The Board needs to be assured that appropriate agency management action is being taken and that the self-certification checklist is completed and returned to NHSi by the end of November. Appendix D, E and F refer.
- Medical recruitment in general remains a challenge as reported in section 4.7.
- Junior doctor contract working hour's restrictions may leave the Trust at risk of covering gaps in rotas. Analysis of the data is currently being undertaken. Section 4.8 refers.
- Failure to deliver against targets in the apprenticeship reforms will result in at least some of the apprenticeship levy of £1.3M being withheld. Sections 8.1.1 refers.

Recommendations:

The Board is asked consider and discuss the assurance provided by the contents of this report.

Summary of ED Challenge/Discussion

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

Governor Observer on Workforce and Organisational Development Group (Workstream 4)

Equality and Diversity Implications:

None.

Board of Directors
Workforce and Organisational Development Directorate
7th December 2016

1. Purpose and Content of the Report

1.1 Report Purpose

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

1.2 Report Content

- A summary of progress on key performance indicators. These performance indicators are included in the Trusts monthly workforce and OD scorecards in the appendices and include key targets and monthly trends.
- Detail on actions and initiatives linked to the objectives and key performance indicators.

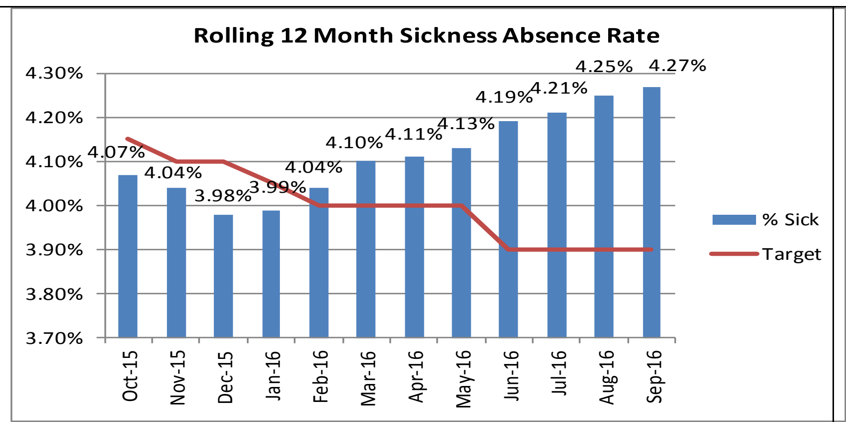
2. Progress on Key Performance Indicators

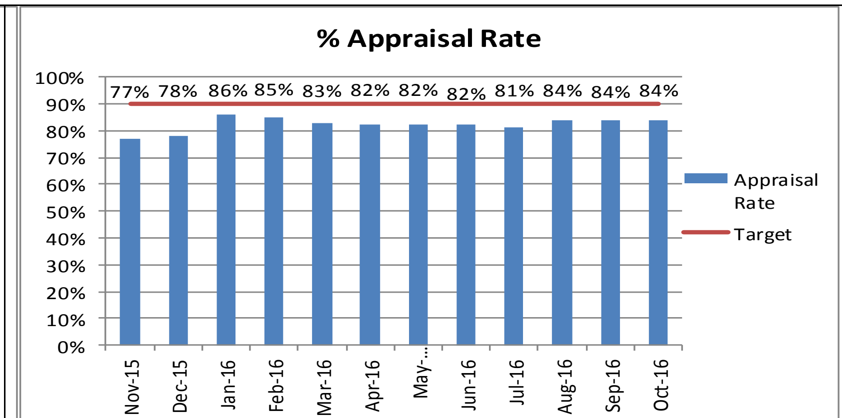
2.1 The Workforce and OD metrics included in this paper are as at the end of October 2016 and are included as detailed below.

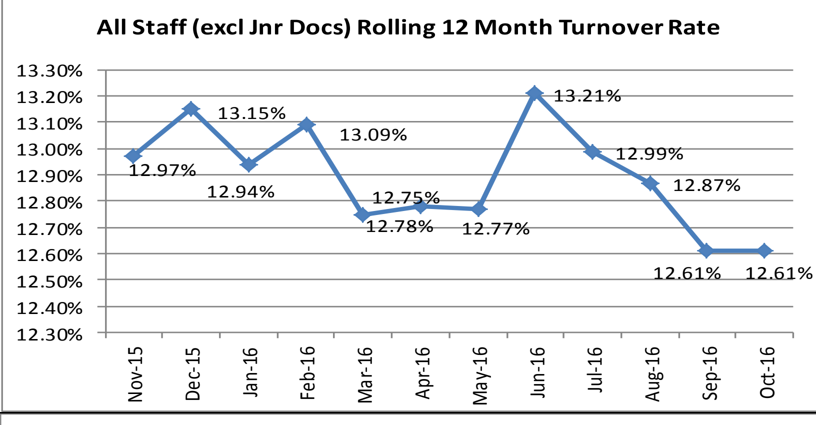
- Appendix A – Workforce and OD Scorecard – Organisational month by month metrics for the last year to show trends.
- Appendix B – Key Metrics by Business Unit – Metrics month by month for the operational Business Units for the current financial year to show trends. Metrics included are sickness absence, staff appraisal and mandatory training.
- Appendix C – Summary of key metrics by Business Unit, Division/Department. Those included are sickness absence, staff appraisal, turnover and mandatory training. In this report sickness absence rates are for the actual month rather than the rolling year.

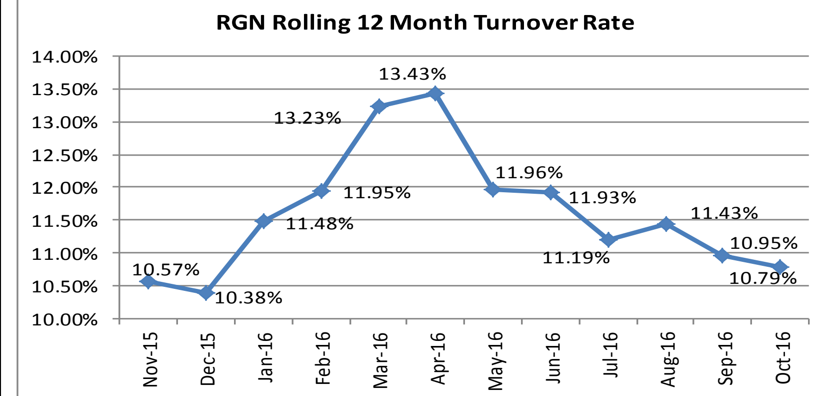
2.2 The above reports are RAG rated based on targets and thresholds agreed by this Group for 2016/2017. The targets for October 2016 are included in the Workforce and OD Scorecard (appendix A).

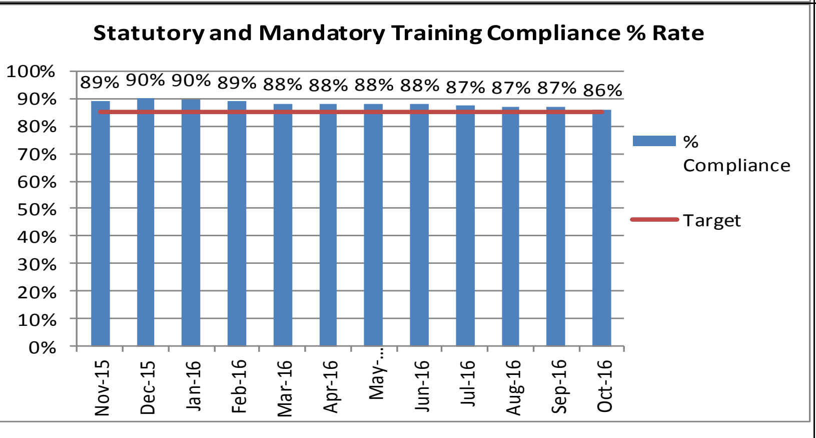
2.3 The following provides a graphical presentation of a number of the key targets and the overall trend and a brief commentary for each. In addition comparisons with neighbouring Trusts are provided.











Key Performance Indicators Comparisons

	Torbay & South Devon NHS Foundation Trust	Plymouth Hospitals NHS Trust	Royal Cornwall Hospitals NHS Trust	Royal Devon & Exeter NHS Foundation Trust	Taunton & Somerset NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Sickness Absence	4.27%	4.10%	4.41%	3.70%	3.60%	3.66%
Appraisal Rate	84%	82%	74%	81%	83%	77%
Mandatory Training	86%	88%	84%	85%	91%	88%

1. Sickness Absence

The rolling sickness absence rate has increased to 4.27% against a target of 3.90%. Activity in respect of managing sickness absence is included in 4.1 of this report.

NHS Digital produce regular reports of sickness absence levels in the NHS. The latest report they have produced that includes the annual rolling rate of sickness absence was to March 2016 and the rate for all NHS organisations was 4.15%, for Acute Trusts 3.97% and for Community Trusts 4.57%.

2. Turnover

Turnover rates have decreased in this financial year and are within the target range of 10% to 14%. Turnover rates for RGN's continue to decline but maintaining capacity due to supply shortages remains a significant challenge.

3. Appraisal

The appraisal rate of 84% in October 2016 has not changed for the last 3 months and remains below the target of 90%.Action to improve this position is included in paragraph 4.2 of this report.

4. Statutory and Mandatory Training

The Trust has a target of 85% as an average of 9 key modules. This current rate is above target but some individual modules remain below their target compliance rate.

5. KPI Comparisons

This table enables the comparison of a number of the KPI's with neighbouring NHS Trusts. See 1 above for national comparison of sickness absence.

3. Workforce Planning

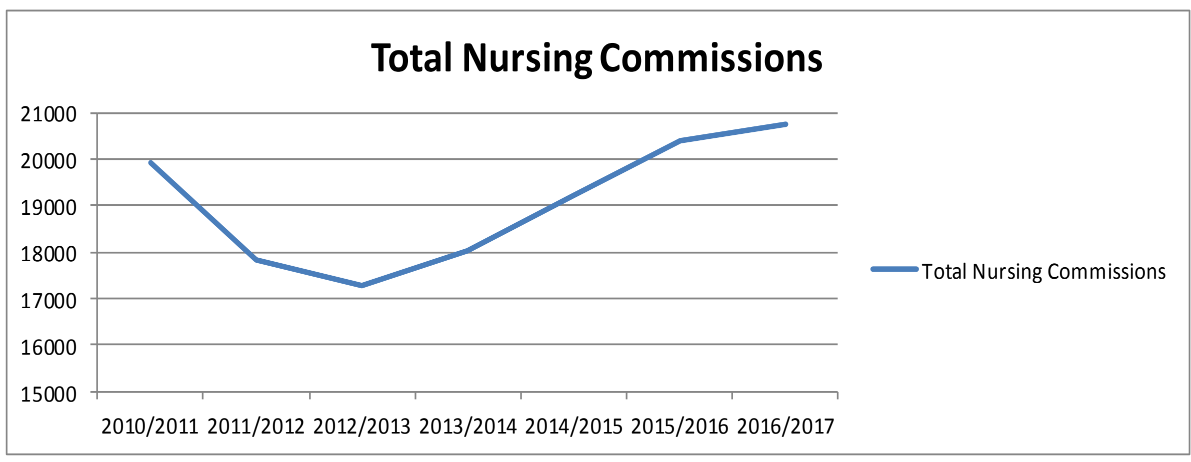
3.1 Care Model Implementation

The recruitment of staff to enhance both the Intermediate Care Teams and Trust Wide Teams has enabled those teams to enhance the service in the community as planned. The on-going consultation in respect of other services including community hospitals has caused staffing pressures in those areas and plans to deliver changes cannot be finalised until any final decisions are made. Plans to deliver the changes including reskilling the workforce where required are part of the wider care model workforce plan.

3.2 Nursing Capacity Plan

A paper setting out proposals for reducing the nurse vacancy gap was discussed in detail by the Workforce and OD Group to get views on a number of key issues. A number of policies are still to be confirmed nationally and locally before the Trust is able to finalise its proposals.

The paper set out how using a range of supply routes the Trust could reduce its Registered Nurse vacancy gap over the next 5 years. Appendix G to this report is an appendix to that paper showing the current vacancy gap and projected leavers and how the various supply routes will be used to reduce the nurse vacancy gap. The paper set out the context for the current position including that there had been significant reductions in the number of nurses had being trained nationally as shown in the graph below. The graph also shows that this position has started to be reversed.



Source: HEE commissioning and investment plan – 2016/17

The proposed supply routes the Trust will use to match demand and supply as shown in appendix G include:

- Newly Qualified – Offering a training package in return for a commitment to work in the Trust, asking the Higher Education Institutions to train more students on

our behalf, using the apprenticeship route from September 2018 and continuing to develop our recruitment strategies.
- Return to Practice/Conversion – Continuing to target nurses whose registration has lapsed or needs to be converted.
- Sponsoring Assistant Practitioners – Sponsorship for Assistant practitioners to undertake their nurse training from Health Education England is to cease although the Trust could fund sponsorship.
- Role Redesign/New Roles – Over time the introduction of new and amended roles will reduce the demand for nurses.
- General Recruitment – Recruitment from the general market has been maintained at similar levels over the last few years and improved marketing and promoting is designed to further improve that position.
- Overseas Recruitment – Overseas recruitment should enable the Trust to achieve its vacancy gap reduction in the short term whilst the other supply routes are developed.

The Workforce and OD Group agreed the approach and asked for a final proposal to be presented at the January meeting of the Group.

It was also agreed that similar capacity plans should be instigated to cover other key staff groups across the Trust.

3.3 Operations Plan

The Workforce and OD Directorate are supporting development of the 2017/2018 Operations Plan. This support includes a planned review of all efficiency schemes to identify the key workforce changes and how these will be supported and monitored for future reporting.

In addition the Directorate is the lead for two Trust wide schemes as follows:

- **Management and Administration –** This scheme identifies planned efficiencies in respect of management and administrative workforce for both back office functions and those working in service delivery units. The scheme plans to deliver the Carter Report requirements for the management and administrative workforce and the back office plans are being developed with the wider STP.

- **Sickness Absence –** This scheme is considered to be an enabler that if effective will reduce costs in other areas such as, agency usage, staff cover etc.

The plans for these schemes are included in the Trusts Efficiency Delivery Group project planning. Details of current activity in respect of sickness absence management is included in section 4.1.

4. Human Resources

4.1 Managing Sickness Absence

The annual rolling sickness absence rate has again risen and currently stands at 4.27%. However the monthly rate for September 2016 was 4.02%.

Actions to reduce levels of absence are being initiated both on a short term and medium term basis. The more immediate actions will involve the agreement and publication of a more streamlined attendance policy that incorporates a number of changes from the current approach both in terms of efficiency, focus and tenor. On the back of this will be refresher training in absence management for managers which will be run on a partnership basis with the Trade Unions.

In the medium term and as part of the revised policy there will be a greater focus on long term absence management, including earlier intervention. In addition smoother systems for the identification of interim alternative work for those staff that are able to undertake some work, but not in their substantive posts are being developed.

Finally, the initiatives to reduce absence rates will be balanced with the need to ensure that the approach to managing absence is predominantly supportive of staff and does not make staff feel that they are pressurised to attend work when they are not fit to do so.

4.2 Appraisal

PDR/Appraisal rates currently stand at 84%. The rate has been at this level for a number of months and therefore consistently remains below the Trust target of 90%. It is clearly recognised that regular and good quality appraisals are essential both for the development of staff and the delivery of the organisations business objectives. In order to keep appraisal compliance on the agenda of managers, they currently receive monthly workforce reports detailing compliance. In addition, workforce KPIs which include appraisal rates, are a standard agenda item for discussion at senior manager meetings in the Trust and are incorporated into Divisional/Directorate reports.

It has been agreed by the Workforce & OD Group that a number of additional actions should be taken to improve the compliance rates. These are as follows:

- Letter to divisional managers from the CEO highlighting hot spots and reiterating expectation around target and seeking an assurance plan within a given deadline.
- Utilise staff bulletin to advertise training dates and signpost to BUZZ conversation. In addition, managers should be reminded of the importance of informing the workforce department, as soon as an appraisal has been undertaken
- Include as an All Managers agenda item
- To confirm who is included within the appraisal statistics to enable targeting by occupational group where possible.

4.3 Staff Friends and Family Test (Staff FFT)

4.3.1 National Update

The national findings for quarter 2 (July – Sept 2016) have recently been submitted and detailed comparisons will be available once they are published on 24th November 2016.

4.3.2 Local Update

The Staff FFT is being conducted for 2016 – 2017. A programme of activity is diarised to ensure all members of staff have the opportunity to complete the survey. As in the previous two years information and findings will be fed back to the relevant senior management teams to ensure any comments/themes etc. are acted upon and shared.

4.4 Staff Survey 2016

The NHS Staff Survey has been running for 5 weeks and is on countdown to end on 2nd December 2016. As of 9th November 2016 the Trusts response rate was 41%. There are a range of activities designed to try and encourage a higher response rate.

4.5 National NHS Staff Health and Wellbeing CQUIN 2016/17

Progress continues to be made against the action plans to achieve the National NHS Staff Health and Wellbeing CQUIN for 2016/17 and are summarised below.
1a – Introduction of health and wellbeing initiatives covering physical activity schemes, mental health and improving access to physiotherapy for staff with MSK issues.

Actions include:-

- Implementation of new physical activity schemes including;
    - Corporate challenges e.g. Plymouth 10k,
    - physical evening activities e.g. Bollywood fitness programme and the identification of 'Walk for Life' trails.
- The development of a weekly wellbeing@work column providing hints and tips for increasing physical activity
- Promotion of 'Managing back pain' through hiblio videos and spotlight
- Developing the role of the Well-being at Work Champions to include mental health first aid support.

1b – Healthy food for NHS staff, visitors and patients

Actions include:-

- Removal of 'red' labelled sandwiches from pre-packaged options reducing HFSS options
- Redesign of Costa servery to comply with standards
- Till stations have been reviewed to remove all HFSS from close proximity

- New retail options have been initiated to maximise revenue from non-HFSS product lines
- Removal of HSFF promotions from League of Friends

1c- Improving the uptake of flu vaccinations to achieve 75% uptake for front line staff

Actions include:-

- Peer vaccinators have been trained and active – status as of 31st October - 47% of frontline staff have been vaccinated.
- Blogs to support the campaign have been developed including; Senior Clinician and a 'real life experience' blog by a member of staff telling her story of her fight against flu in Intensive Care
- Flu newsletter has been developed and circulated
- A heat map has been developed to identify areas of low vaccinations to help target communications.

4.6 Temporary Staffing

4.6.1 NHSI Reporting Requirements

It has been one year since NHS Improvement (NHSi) introduced the agency rules, and the sector has delivered reductions in agency spending of over £600 million. Spending on agency staffing across England is now 20% lower than the same period last year. However, agency staff still cost the NHS around £250 million a month. The South region is already £24m (10%) above the aggregate agency spending ceiling this financial year and the Trust needs to provide assurance that the appropriate controls have been implemented to meet the Trust ceiling. As the Trust has exceeded its agency ceiling in the first five months of 2016/17 further reporting requirements have been introduced to ensure that action is being taken to bring spending below the ceiling.

These requirements include:

- Measures to ensure boards have sight of prices paid and spending at cost centre level and are actively holding executives to account on reducing agency expenditure across all parts of the Trust.
- Requiring Chief Executive oversight and further reporting to NHS Improvement across areas of high concern, including off-framework use, high-price overrides and on-call rates.
- Action in respect of high on-call rates, grade inflation, high bank rates and payments for hours not worked; these are often reported to NHSi and NHSi will work with trusts to understand where this is occurring and intervene.

In order for NHSI to gain a better understanding of our agency spending and where the biggest challenges are the Trust has been asked to provide the following information:

a) Monthly agency spending broken down by cost centre/service line
b) A list of our 20 highest-earning agency staff (Appendix D)

c) A list of agency staff that have been employed for more than 6 consecutive months (Appendix E)

4.6.2 Helping boards to hold executives to account on agency spending

NHSI have produced a self-certification checklist (Appendix F) for the board to complete to be assured that the Trust is taking all appropriate actions on agency spending and to identify additional steps that can be taken. The checklist includes actions that can have an immediate impact: establishing governance, accessing accurate and timely data to inform your decisions and using appropriate tools and processes – such as rapid recruitment processes and eRostering. Trusts are expected to have tough plans to tackle unacceptable spending, including exceptional over-reliance on agency staff in services such as radiology or very high spending on on-call staff.

Where the Trust is heavily reliant on agency staff resulting in them being financially unsustainable the Trust is being asked to consider changing the way services are delivered, such as by changing roles or implementing shared service models, to achieve more sustainable staffing over the short to medium term.

4.6.3 Additional reporting on unacceptable applications of the agency rules

To ensure that chief executives have full sight of significant overrides, NHSI require in all trusts that the trust chief executive personally sign off on:

- All agency shifts by individuals costing more than £120 per hour.
- All framework overrides above price cap.

4.6.4 Senior managers

Trusts need to reduce reliance on agency staff at all levels and across all areas and this includes managerial staff. The aim should be to radically reduce and ideally eliminate reliance on agency managerial staff and use internal NHS solutions.

From 31 October 2016 trusts will be required to secure approval from NHS Improvement in advance of:

- Signing new contracts with agency senior managers where the daily rate exceeds £750, including on costs.
- Extending or varying existing contracts where the daily rate exceeds £750, including on costs or incurring additional expenditure to which they are not already committed.

Trusts will need to demonstrate that they first tried to fill the role internally, within their STP footprint or within the NHS. Guidance on this new process is awaited.

4.6.5 Nursing & HCA Bank and Agency

The Trust continues to report to Monitor on a weekly basis in respect of the number of agency shifts that are not compliant with Monitor framework, price cap and maximum wage cap requirements.

Of the weekly Monitor reports, nursing shifts remain the biggest component of the report however this has dropped over the last couple of months (averaging 130 shifts per week), followed by medical shifts (averaging 50 per week). There is minimal use of the high cost nursing agency and then only for last minute specialist roles e.g. mental health or paediatric nurse.

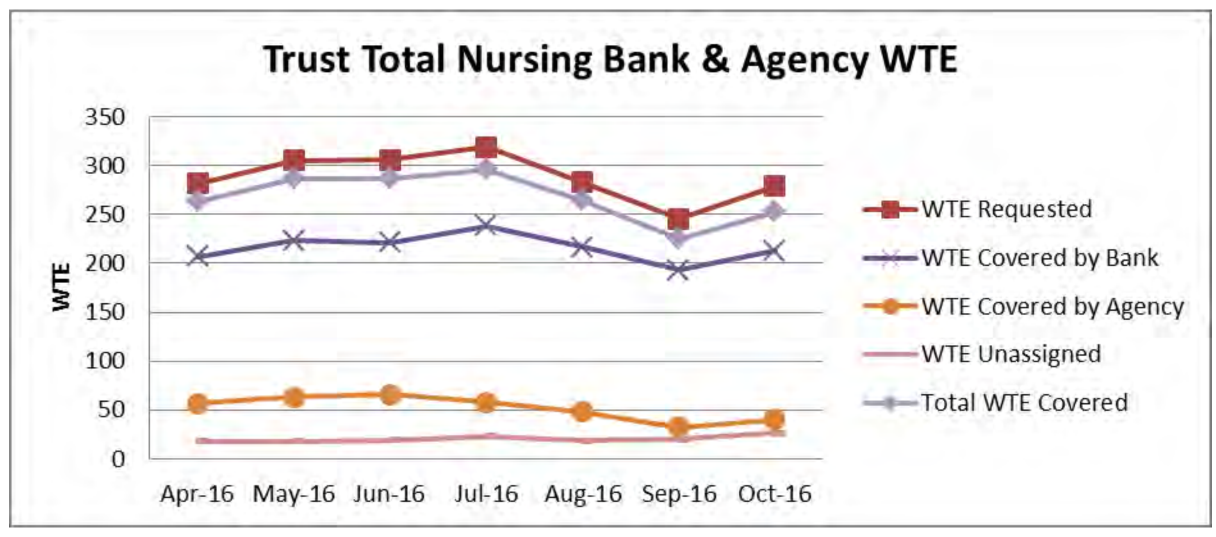
The Workforce and OD Group discussed a paper that outlined how the various incentives introduced to reduce agency costs particularly for nursing have had a positive effect and contributed to the reduction in agency usage and overall costs.

The paper included that the incentives have not been the sole reason for the reduction in temporary staffing usage and costs as some of this reduction is likely to have been as a result of improved controls and authorisation. Never the less the paper concluded that the estimated projected cost avoidance due to the incentives and more robust control are as follows.

Cost Avoidance 2016/2017	£1,731,544
Cost of Incentives 2016/2017	£424,304
Net Cost Avoidance 2016/2017	£1,307,240

The Group agreed that the existing incentives should be maintained until the end of 2016/2017 with no additional incentives implemented. These arrangements would be further reviewed and a proposal for future arrangements to be recommended to the Workforce and OD group in January 2017.

In the meantime the Temporary Staffing Team continues to strive to fill the demand for shifts across the acute and community settings. In October 2016 the Temporary Staffing Team was able to fill 91% of the shift requests through a combination of bank and agency. This equates to 253 whole time equivalents (WTE). The table below shows the bank and agency usage by WTE for the whole Trust.



Total: Nursing Bank & Agency	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
WTE Requested	281	305	306	319	283	245	279
WTE Covered by Bank	207	223	221	238	217	193	213
WTE Covered by Agency	56	63	66	58	48	32	40
WTE Unassigned	18	18	19	23	18	20	26
Total WTE Covered	263	287	287	296	265	225	253

4.6.6 AHP Agency

The Trust has recently gone live with the system called TempRE to manage and reduce our AHP temporary staffing expenditure. This system is currently used for medical agency workers. The TempRE system will deliver a number of benefits to the Trust which includes:

- Cost savings through the prevention of excessive or over contract rates and hours
- Control and transparency through strong control of vacancy authorisation and release, invoicing and timesheeting.
- Governance checks and controls
- Management information and benchmarking.

4.7 Medical Agency and Recruitment

Due to current vacancies the Trust still requires the use of medical agency locums. The Trust continues to ensure where possible that all bookings are via direct engagement to allow the Trust to make a VAT saving. The total savings year to date is £65,470 (month end September).

4.7.1 Comparative Monthly Medical Agency Spend:

Month	**2013/14**	**2014/15**	**2015/16**	**2016/17**
April	116,191	108,059	209,148	195,501
May	258,211	122,084	149,423	175,334
June	191,927	166,781	226,428	243,300
July	179,524	160,929	228,116	246,546
August	141,130	152,713	241,809	161,853
September	113,165	281,530	273,978	143,587
October	136,933	327,659	180,382	
November	50,741	330,862	124,940	
December	95,782	302,564	123,493	
January	102,846	216,263	170,802	
February	83,801	250,634	139,765	
March	57,183	150,500	198,863	
Total	**1,527,434**	**2,570,576**	**2,267,147**	**1,166,121**

4.7.2 Medical Recruitment

Following the difficulties of recruiting to a consultant post the Trust has recently been successful in appointing two SAS in AMU/Frailty. The Trust was also successful in recruiting a Consultant in Ophthalmology.

The Trust has recently had success in advertising posts via social media (Facebook and Twitter) and is about to trial this form of advertising alongside our standard advertising routes for Emergency Medicine in an effort to market to a wider field of doctors.

Current Medical Vacancies (as at 1st November 2016):

Grade	Specialty	Status
Consultant (new post)	Histopathology	Vacant since Apr 2015 and advertised on 5 occasions, including now
Consultant (replacement x2)	Stroke	Vacant since Apr 2015 and advertised on 4 occasions but now reviewing options
Consultant (New Post)	Dermatology	Vacant since July 2015 and advertised on 4 occasions but now reviewing options
Consultant (replacement x2)	Neurology	Vacant since Nov 2015 the Trust has received 2 applications, Interviews are to be confirmed with the department
Consultant (Replacement x2)	Radiology	Vacant since Feb 2015 Advertised on 5 occasions
Consultant (Replacement)	Acute Medicine	The department have an interested candidate and are hoping to interview on the 15 Nov.
Consultant x2	Emergency Medicine	The Trust is still trying to recruit to 10 consultants within the department. There have been 2 recent appointments.
Consultant (Replacement)	Cardiology	The Trust have received 4 applications and the interviews are set for 15 Nov.
Consultant (Replacement)	Respiratory	Currently out to advert, so far no suitable applications have been submitted.

4.8 Medical HR

4.8.1 Junior Doctor 2016 Contract

On 5 October the first set of trainee’s transitioned to the new contract. These were 4 ST3+ in Obstetrics and Gynaecology; there was a smooth transition with no concerns raised thus far. On the 7 December 36 Foundation year one trainees will transition to the new contract. The Trust has held two workshops on the new contract for the F1s to ensure they understand the new terms and conditions and to allow for any questions. Both workshops were well attended.

There is a concern that given the new working hours restrictions, this will leave the Trust at risk of covering gaps on trainee rotas; therefore we are currently undertaking an analysis of this and the data will be available by the end of the month.

5. Occupational Health

Optima Health' has now been providing the Occupational Health Service (OH service) for three months. Monthly KPI reporting reveals a 95% target being met on most aspects of the OH service. The target for timeliness of appointments has not been achieved but this is due to the backlog Optima Health acquired on receipt of the service. It is anticipated that in next month's reporting all targets should be met.

An Employee Assistance Programme [EAP] for all staff to access 24/7, provided by 'Workplace Wellness' is also now in place and we are awaiting the first quarterly report.

6.0 Workforce and OD Systems

6.1 Workforce and OD Systems

6.1.1 Management of Assignment Status

The Electronic Staff Record (ESR) includes the dates when certain contract types/payments are due to expire. These are known as assignment status and include:

- Responsibility Allowance
- Acting Up Allowance
- Fixed Term Contract Expiry Date

Managers are currently reminded when these assignments are due to expire but an automated alerts system will improve the management of these assignments and ensure payments are closely monitored and managed.

6.1.2 Learning Management System (LMS)/Nurse Revalidation)

The implementation of the new LMS/Nurse Revalidation system is delayed. Unforeseen work to the Active Directory (AD) continues to take place. The Health Informatics Service (HIS) anticipates that this work will now be completed in the New Year (2017). The current arrangements for learning and revalidation are robust and will continue until the picture is clearer.

6.1.3 Electronic Staff Record (ESR) National Developments

Previous reports have outlined the national developments to ESR that will support the Trusts strategy for workforce management systems. IBM (the ESR provider) have produced an ESR Roadmap for the next 12 months which will improve accessibility for managers and staff and further enable the use of employee and Managers self-service. These improvements will include internet access and reports and dashboards available to managers directly from ESR.

7.0 Organisational Development (OD)

7.1 Equality and Employability Updates

7.1.1 Workforce Disability Equality Standard (WDES)

Following the implementation of the Workforce Race Equality Standard (WRES) in 2015, the NHS Equality and Diversity Council (EDC) has recommended that a Workforce Disability Equality Standard (WDES) should be mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18. NHS England has agreed to do so.

7.1.2 Work Experience Week 2016

As part of Work Experience Week 2016, the Trust hosted a Healthcare Careers and Work Experience event on the 14th October to celebrate the achievements of learners in Torbay and South Devon and to showcase the many opportunities available.

The Trust creates opportunities for around 300 learners every year and recently achieved Gold Level Accreditation in Fair Train's national Work Experience Quality Standard. The celebration event included a business breakfast meeting for managers, an open event for local schools and members of the public, presentation of individual and team awards and presentation of the recently achieved Fair Train accreditation.

In 2016, the Employability Hub have also been nominated for an NHS Leadership Academy Award for Innovation, the Hub was shortlisted for a Community Impact Award with the Employers Network for Equality and Inclusion and has been awarded a Proud to be a Disability Confident Employer Certificate with Pluss. The Employability team are already beginning to make plans to widen participation over the upcoming year.

7.2 Senior Ward Nurse Development

The rostering guidelines which support senior ward nurse leaders in providing efficient rotas that should support safer working and reduce costs are being implemented.

Wrap-around support is being provided to the senior ward nurse leaders jointly by OD and the Senior Project Manager responsible for producing the guidelines. This support will consist of practical help of creating a roster together with practical solutions and guidance in giving clear instruction to staff regarding any leave requirements, having difficult conversations and setting out what is expected of them as managers. This will development will be provided by way of 2 hour sessions intentionally fluidly designed to ensure that as and when specific issues arise through the programme they can be discussed and explored by the members of the group. These sessions are commencing at the beginning of December with a view to roll out across the other ward areas in the acute arm of the organisation in the first instance but into the community thereafter.

7.3 Leadership Strategy

To address the leadership challenges we are faced with as an ICO in a highly complex system we are developing a leadership strategy that will provide:

- A context of the complex environment our leaders and managers find themselves in
- Clarity for all managers of the expectations of them in their role but also what they can expect by way of support and development from the organisation
- A set of standards required by all managers to ensure leadership is seen as a profession within the organisation
- Leadership programmes designed to ensure all line-managers are supported and developed to deliver
- Clarity of the style of leadership required for all disciplines of staff and support and development available at all levels
- A programme of development opportunities inside and outside of the organisation
- Options for future managers that have been identified through the talent management and succession planning programme.

During December the strategy will be shared across the organisation at different forums to ensure staff have the opportunity to contribute sharing thoughts and ideas. The strategy will be completed ready for final sign of by this group at the January Workforce Group meeting.

7.3.1 Using Meditative Approaches

A consistent theme of staff feeling bullied, harassed and under-valued has been identified through several channels within the organisation including the staff survey and feedback from the Freedom to Speak Up Guardians. It is of paramount importance that this this situation is addressed, not by way of "one intervention that fits all" but a series of interventions that provide different levels of support as required.

As such and in alignment with the Leadership Strategy a proposed plan and development will be presented for discussion and approval at the Workforce and OD Group meeting in January.

7.3.2 Senior Managers Leadership Development

In order to support senior managers and leaders going through a re-structuring process particularly in the operational arm of the organisation a development programme has been designed using an external provider. The focus of the programme will be leading self, leading others and leading the system. There will be 3 modules with the first taking place in December with the others following through in spring 2017. There are 36 places which have been prioritised with the Directors responsible for the operational delivery of the organisation. The programme will contain managers across all disciplines and staff groups.

7.4 Internal Coaching Network

A group of 19 members of staff representing different staff groups, services and at different levels in the organisation will have completed their coaching training at the end of November. They will be certified to the equivalent of and ILM level 7 and will provide coaching support that will be accessible to all members of staff by way of a systematic process.

The coaches will officially graduate on 20th December. At this point the formal launch of the new network will be publicised together with a new web-page providing visibility of the purpose of coaching, who the coaches are, the process by which the service can be accessed and information for any member of staff wishing to be part of the future network.

8.0 Education and Development

8.1 Vocational Training

8.1.1 Paying the apprenticeship levy

As previously reported with effect from April 2017, the apprenticeship levy requires all employers operating in the UK, with a pay bill over £3 million each year, to make an investment in apprenticeships. Our levy will be in the region of £1.3 million. A focus group has been set up to deliver the plan agreed by this group. The focus group will use the time between now and the implementation of the levy to work closely with our delivery partners and internal stakeholders on the practicalities of how to make best use of the £1.3 million. Funds will expire 24 months after they enter our digital account unless we spend them on apprenticeship training.

8.1.2 New Nursing Degree Apprenticeships

A new way of achieving a Registered Nursing qualification has been written based on the new standards that will combine practical training in a job with study towards a degree. Apprentices are employed for a minimum of 30 hours a week and will work towards a nationally approved apprenticeship standard. Nursing will be the first degree apprenticeship for our professions and other health professions will follow. The University of Plymouth is part of the Trailblazer group and this Trust is part of the working group that will help to shape the national nursing apprenticeship standard. The Trailblazer group will input into the curriculum to ensure a generation of Degree Apprenticeship Nurses will be workforce-ready for the Trust and to look at ways of up skilling/training our local workforce. The draft standards to Department for Education will be ready in late 2016 in the hope to provide actual delivery by 2018. All NMC competency requirements will be met.

The Registered Nurse Capacity Plan included in section 3.2 of this report includes Degree Apprenticeship Nurses as a key supply route to support reducing the Trusts vacancy gap.

The Trust's Apprenticeship Strategy is being reviewed and developed across the ICO to ensure the Trust is aligned with our stakeholders i.e. Health Education England, South Devon College, Plymouth University and others. Links have been

forged with Dartmouth Caring that aim to set out the practical considerations and to establish the strategic direction of a joined up education and training strategy. This will then be used as a template across the wider footprint of the ICO. The idea of this collaborative model is to strengthen community links offering new ways of working by utilising resources and services in an innovative way.

8.1.3 Dartmouth Academy

The Trust is hosting a careers event at Dartmouth Academy on the 24th November designed to inspire and enthuse students to consider a career in the health and social care sector. The intention is to give students the opportunity to gain a broad knowledge and understanding of, and develop skills in, the health and social care sector; support progression to a more specialised vocational or academic health and social care course or an apprenticeship; giving learners the potential opportunity, in due course, to enter employment within a wide range of job roles.

8.2 Mandatory Training

8.2.1 Compliance Rates

The small decrease in compliance has continued although the Trust is still compliant in the majority of areas. All courses have recently seen an increase in bookings which is an indicator of the trend being reversed.

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

8.3 Medical Education

8.3.1 Undergraduate Programmes (Year 1-5)

The new Medical School programmes continue to be developed, with Torbay actively involved in the curriculum development of Year 5 and contributing to the design of the new programmes. There is a meeting with both medical schools on the 16th November to negotiate how the programme will be delivered from 2018-19 within the current agreement.

The number of intercalating students returning to programme in Year 5 is now 43 for the 2017/18 programme at Torbay. An agreement is yet to be made to whether these numbers need to be topped up by PUPSMD (new school) students.

Due to the news nationally that medical student places are to be increased by 1,500, the Trust is in talks with the local medical schools in regards to the future development of the programmes here in Torbay. The medical schools are currently submitting bids to the government who will allocate the additional student places across the 33 medical schools in the country. There is the potential to significantly increase our medical education undergraduate programme delivery across the ICO and we await news from the medical schools following the outcome of the bids.

8.3.2 Postgraduate Programmes Quality Update

The GMC Regional Review update 2016 regional review of medical education in the south west has concluded with formal reports due to be published on the GMC

website and open to the public. The GMC team enjoyed their visit to the south west, finding a strong deanery team and engaged local providers. At Torbay they found that the Trust Board demonstrated accountability for educational governance, that training is taken seriously at board level and that the Trust is responsive to feedback. They warned of the impact of increasing service demands and workload on an effective learning culture.

The Deanery quality team visit the Trust on 16th November for the annual contract and quality review.

Interviews for the Director of Medical Education post are being held on Friday 25th November.

8.3.3 Physician Associate Programme

Chris Green will be starting in post as a Physician Associate from Monday 7th November. His post will part clinical with the Stroke team and part academic working with the Medical School and Trust in the development and delivery of the Physician associate training programme.

Posts for the current 5 sponsored Physician associates from next Jan/Feb 2017 have been proposed as follows:

- Cardiology
- EAU/MAU
- Respiratory
- ED
- T&O

Details are to be confirmed with the departments over the next few weeks.

8.4 Professional & Clinical Education

8.4.1 Objective Structured Clinical Examination Centre for the NMC

The Trust was unsuccessful in its bid to become a NMC OSCE Centre despite a strong performance in most areas. Oxford Brookes and Ulster Universities were offered the centres along with Northampton University, retaining their right to deliver the OSCEs.

8.4.2 Foundation Degree in Healthcare

Since the last report the Trust has been offered 10 further sponsorship places for student nursing in February 2017 from our cohort of Assistant Practitioners.

The Registered Nurse Capacity Plan included in section 3.1 and appendix G of this report includes sponsorship of Assistant Practitioners as a key supply route to support reducing the Trusts vacancy gap.

8.4.3 Nursing Associates

The Trust has been part of the successful STP bid to become one of the 11 national pilot sites for the Nursing Associate role in the UK. The Trust will employ 10 Training Nursing Associates and the intention is to place them in the community setting to support the developing care model and to embed the Nursing Associate role into the trust without destabilising the Assistant Practitioner Band 4 role. Discussions for the Nursing Associate to become a regulated role have started and the Secretary of State for Health is expected to make a statement at the end of the month.

The education programme with SD College for this new role will be a Foundation Degree Nursing Associate. The time frame for completion is very short with staff being identified and named by December for a study release date of the first week in January.

It is anticipated that the pilot funding for this programme will come from the apprenticeship levy, therefore work will need to be undertaken with this new Foundation Degree to match it to a dual award of a higher apprenticeship as with the Foundation Degree in Healthcare for the Trusts existing Assistant Practitioner role.

9.0 Staff Welfare and Wellbeing @ Work

9.1 Key Staff Welfare and Wellbeing Workstream areas

There are a range of initiatives in place to support staff and organisation ‘wellness’ including:

- Recognising and appreciating staff
- Creating a safe, happier and healthier working environment
- Encouraging and supporting employees to develop and maintain a healthy lifestyle
- Improving mental and emotional wellbeing in the workplace
- Staff disability awareness

The Staff Wellbeing@Work Forum drives and coordinates the staff welfare and wellbeing agenda. The current principle agenda item for the Forum is planning, developing and marketing the Wellbeing@Work Awarness Week. The aim of the week is to target our top two reported reasons for sickness absence, namely stress and anxiety and MSK/back pain. The week will run from 23rd to 27th January 2017 with Staff Seminars over the week being held as follows:

- 24th January ’17 - Mental Health Awareness
- 25th January ’17 - Physical Health Awareness
- 26th January ’17 - Lifestyles

9.1.1 Staff Recognition and Appreciation

- **Staff Heroes Awards -** These have now replaced the WOW awards as the monthly staff recognition scheme. The Staff Heroes Awards operate in exactly

the same way as the WOW awards with nominations being made electronically or by paper form, which is on the public website. These are judged by staff and publically elected Governors. Quarterly certificate presentations by the Chief Executive, Chairman and Executive Team now take place in Bayview Restaurant

- **Blue Shield Awards** – invitations to nominate individual staff and teams have now been distributed via the website, and using internal distribution mechanisms. The Awards Ceremony will take place on Tuesday 21st March 2017 at the English Riviera Centre. The Awards are cited on Trust values and include Awards for:

    - Individuals and Teams
    - Partnership
    - Innovation and Research
    - Volunteers
    - The Chairman's Award and Em Jefferies Award for Lifetime Achievement

- **Long NHS Service and Retirement Awards** – The table below identifies the number of staff at the end of October who have reached an age and length of service where they will become entitled to an award.

Continuous Service	Staff
25 years	306
35 years	46
Total	**352**

Retirement Age	Staff
60-64 years old	452
65 or Over	118
Total	**570**

- Continuous Service:

It is proposed that 3 certificate presentations are held in 2017 for staff who have worked for the NHS for 25 years in recognition of their contribution to the service. In addition it is proposed that a certificate presentation is held in 2017 to celebrate the achievement of staff who have worked for the NHS for more than 35 years.

Certificates will be presented by the Chairman and Chief Executive.

- Retirement Awards:

In accordance with the Retirement Policy, retirement awards are granted to all employees who have completed ten or more year's consecutive service and retire with the organisation as their last place of work. Upon retirement from the Trust, staff will receive a retirement certificate/gift in recognition of their contribution to the service. This applies equally to full or part time employees.

- Retirement and Continuous Service overlap:

Where Retirement and Continuous Service overlap there will be additional recognition at the above events.

When a Director or Senior Manager, or a manager acting under their authority, learns of the impending retirement of a member of staff in their department, they should investigate whether the individual concerned is eligible for a Continuous Service and Retirement award.

9.1.2 Workplace Champions

The Trusts various existing Workplace Champions are being brought together to make connections and to establish their different roles and similarities. Workplace Champions are voluntary and undertake the role in addition to their normal duties. The roles currently undertaken by our Workplace Champions are:

- Keeping Well at Work Champions
- ICO Champions
- Acceptable Behaviour Champions
- Freedom to Speak Up Guardians

The intention of meeting with the Workplace Champions is to define their roles and to provide training and support to extend their roles to deliver:

- Mental Health First Aid
- Coaching support
- Mentoring support

9.1.3 Lighten-up Programme

This is a practical programme designed to improve work/life balance. It is a series of five modules and is run through facilitated sessions with the use of DVD's and group and individual activities. The first Programme is being launched on the 17th November 2016.

This programme is fully subscribed with some Localities/Departments asking for a bespoke programme in the New Year

9.1.4 CQUIN - Improving the health and wellbeing of staff

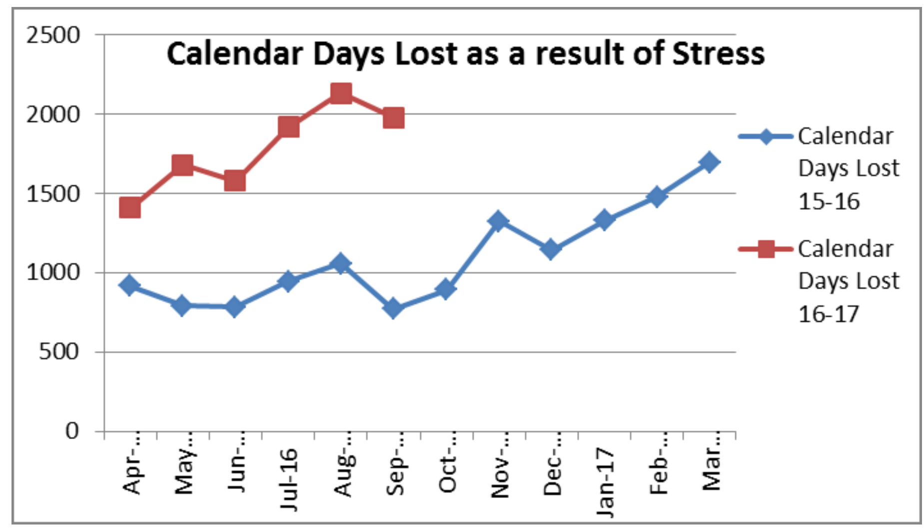
The CQUIN action plan introduces health and wellbeing initiatives covering:

- Physical activity
  - Undertaking a scoping exercise into the provision of physical activity schemes for staff
  - Promote increasing physical activity (Corporate, Team and individual challenges)
  - Identify schemes to promote active travel e.g. cycling to work, hospital walks etc.
- Mental Health
  - Introducing a range of mental health initiatives for staff
  - Supporting staff with stress with information about mental health and stress at work, management of stress/resilience training, counselling services, mental health first aid and by making reasonable flexibilities and workplace adjustments

As detailed in section 6.1 stress and anxiety and MSK/back pain are the Trusts top two reported reasons for sickness absence.

The table and graphs below show sickness absence due to stress and anxiety, comparing 2015/16 figures with current year 2016/17 figures. These tables and graphs demonstrate the need to implement the above interventions.

Month	Episodes 15-16	Episodes 16-17	Calendar Days Lost 15-16	Calendar Days Lost 16-17
Apr	34	56	914	1409
May	29	54	792	1680
Jun	32	52	784	1579
Jul	33	66	942	1918
Aug	34	68	1056	2130
Sep	35	64	769	1979
Oct	33		891	
Nov	44		1324	
Dec	40		1143	
Jan	43		1329	
Feb	50		1476	
Mar	49		1695	
Grand Total	456	360	13,115	10,695



- Improving access to physiotherapy for people with MSK issues
  - Ensuring staff have access to physiotherapy services in a timely manner and without delay

- Scoping current services available to staff e.g. moving & handling training, physiotherapy advice etc.
- Promote ‘managing back pain’ to staff

9.1.5 Staff Disability Awareness – Disability as an Asset

Research commissioned by NHS Employers and NHS England shows that disabled staff have worse experiences to other staff in key areas such as bullying, attending work when feeling ill, and mixed levels of support from managers.

Working with the Trusts Staff Disabilities Group we will be working with the Disability as an Asset approach and assessing how the Trust is doing in areas such as career progression and/or making adjustments for disabled staff. Using this assessment the trust will seek to address differences between disabled and non-disabled staff and to achieve and demonstrate improvements.

TSDFT Workforce and OD Scorecard 2016/2017 | **Appendix A**

Oct-16

Indicator and (Target)	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Bank/Agency Spend Total	£6,718,244	£7,918,436	£9,059,507	£10,494,361	£11,816,473	£13,368,816	£1,746,467	£3,450,162	£5,173,698	£6,838,622	£8,273,400	£9,516,206	£10,874,713
Bank Monthly	£522,045	£644,746	£544,710	£577,004	£554,756	£633,754	£835,496	£661,185	£611,744	£681,690	£673,890	£565,324	£669,222
Agency Monthly	£765,391	£555,446	£596,361	£857,850	£767,356	£918,589	£910,971	£1,042,510	£1,111,792	£983,234	£760,888	£677,482	£689,285
Staff Headcount Number	6089	6078	6057	6071	6069	6059	6077	6070	6056	6046	6069	6116	6164
Bank Usage (WTE)	185.09	223.51	243.61	240.63	239.78	266.85	296.85	297.19	220.12	270.87	267.77	222.61	270.39
Agency Usage (WTE)	53.87	98.78	124.20	107.26	115.45	144.27	132.66	119.55	141.95	137.71	139.60	89.18	81.47
Starters	70.0	59.9	23.9	53.4	62.5	39.4	48.1	44.9	42.6	34.4	115.5	97.2	74.5
Leavers	54.5	68.1	45.9	62.3	46.5	53.3	38.3	50.7	54.7	45.7	123.5	51.8	59.5
Staff Turnover Rate % (Between 10% - 14%)	12.79%	12.97%	13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.99%	12.61%	12.61%
Sickness Absence Rate % (4.00% or less)	4.07%	4.04%	3.98%	3.99%	4.04%	4.10%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	
Bradford Score % over 250 Points	11.62%	11.69%	10.76%	9.18%	10.68%	10.63%	10.86%	10.90%	11.07%	11.25%	11.25%	11.13%	
Sickness Cost	£6,058,810	£6,075,432	£6,042,868	£6,043,671	£6,151,402	£6,279,071	£6,292,997	£6,327,834	£6,394,148	£6,431,222	£6,457,004	£6,487,987	
Skill Mix (Registered-Band 5 & above/Non-registered-Band 4 & below)	55/45	55/45	55/45	55/45	55/45	55/45	55/45	55/45	54/46	54/46	55/45	54/46	54/46
Staff appraised in last year (90% or above)	80%	77%	78%	86%	85%	83%	82%	82%	82%	81%	84%	84%	84%
Age Profile - % of staff over 55 years of age	22.0%	22.0%	22.0%	22.0%	23.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	23.0%
* Starters and leavers in August include Junior Doctors change over													
Training and Development - Percentage of staff compliant													
Information Governance Training (95% or above)	91%	90%	90%	90%	89%	88%	88%	88%	88%	86%	87%	87%	86%
Fire Training (85% or above)	85%	84%	86%	85%	83%	83%	82%	83%	83%	83%	84%	84%	82%
Child Protection L1 (90% or above)	92%	92%	93%	93%	93%	92%	92%	92%	93%	92%	92%	92%	92%
Infection Control (85% or above)	84%	83%	85%	84%	83%	82%	81%	83%	82%	82%	82%	82%	82%
Equality & Diversity (85% or above)	91%	92%	93%	93%	93%	93%	92%	92%	91%	91%	90%	88%	88%
Conflict Resolution (85% or above)	90%	91%	92%	92%	91%	90%	89%	89%	88%	87%	87%	86%	86%
Health & Safety (85% or above)	88%	88%	89%	89%	88%	87%	86%	86%	86%	85%	85%	86%	86%
Manual Handling (85% or above)	86%	86%	88%	87%	86%	86%	86%	87%	86%	86%	86%	85%	84%
Safeguarding Adults L1 (90% or above)	93%	93%	94%	94%	94%	93%	93%	93%	93%	93%	92%	92%	92%
Average Compliance	**89%**	**89%**	**90%**	**90%**	**89%**	**88%**	**88%**	**88%**	**88%**	**87%**	**87%**	**87%**	**86%**

Appendix B

OUTTURN	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Sickness Absence - All ICO Staff	4.16%	4.15%	4.12%	4.07%	4.04%	3.98%	3.99%	4.04%	4.10%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	
Community BU Total	4.54%	4.50%	4.53%	4.38%	4.43%	4.27%	4.44%	4.29%	4.39%	4.32%	4.46%	4.62%	4.73%	4.81%	4.86%	
Medicine BU Total	3.75%	3.80%	3.85%	3.84%	3.83%	3.87%	3.94%	4.00%	4.06%	4.16%	4.16%	4.29%	4.41%	4.44%	4.45%	
Surgery BU Total	4.47%	4.40%	4.36%	4.26%	4.19%	4.08%	4.10%	4.15%	4.15%	4.12%	4.07%	4.04%	3.98%	3.97%	3.96%	
WCD BU Total	3.53%	3.46%	3.41%	3.27%	3.26%	3.19%	3.19%	3.24%	3.29%	3.18%	3.19%	3.17%	3.19%	3.22%	3.20%	
Staff Appraisals - All ICO Staff	86%	86%	84%	80%	77%	78%	86%	85%	83%	82%	82%	82%	81%	84%	84%	84%
Community BU Total	89%	86%	86%	83%	80%	85%	90%	90%	89%	88%	87%	86%	85%	88%	88%	87%
Medicine BU Total	87%	86%	86%	81%	80%	76%	83%	81%	77%	76%	78%	78%	80%	84%	87%	88%
Surgery BU Total	86%	90%	89%	88%	85%	86%	90%	89%	87%	87%	87%	85%	84%	86%	87%	86%
WCD BU Total	85%	85%	79%	81%	80%	87%	92%	89%	86%	87%	87%	88%	86%	88%	88%	85%
Mandatory Training - % Completion of 9 competencies - All ICO Staff	88%	88%	87%	89%	89%	90%	90%	89%	88%	88%	88%	88%	87%	87%	87%	86%
Community BU Total	92%	92%	91%	92%	92%	93%	92%	91%	89%	89%	91%	91%	92%	92%	90%	90%
Medicine BU Total	83%	86%	85%	85%	85%	85%	85%	86%	85%	84%	85%	86%	83%	85%	86%	86%
Surgery BU Total	86%	87%	86%	87%	87%	88%	88%	89%	88%	88%	88%	89%	87%	87%	87%	86%
WCD BU Total	90%	90%	89%	89%	89%	89%	89%	89%	89%	88%	89%	89%	89%	89%	89%	89%

					Appendix C	
Division/Directorate	**Sickness**	**Appraisals**	**Training (Average)**	**Staff**	**FTE**	**FTE Turnover**
	Sep-16	**Oct-16**	**Oct-16**	**Oct-16**	**Oct-16**	**Oct-16**
CHARITABLE FUNDS DIVISION	3.53%	79%	71%	32	19.39	17.11%
Health Visiting & School Nursing	8.31%	95%	91%	100	78.09	15.26%
Other Public Health Provider	2.03%	92%	95%	98	81.13	13.67%
Dir - Public Health	5.13%	94%	93%	198	159.21	14.47%
SD Community Services - Coastal	3.56%	82%	85%	38	33.68	5.95%
SD Community Services - Moorland	6.12%	89%	97%	21	16.97	14.02%
SD Community Services - Newton Abbot	5.63%	90%	82%	37	29.95	13.97%
SD Community Services - Other	5.95%	81%	91%	80	65.03	17.44%
SD Community Services - Totnes and Dartmouth	3.47%	90%	93%	36	30.37	16.39%
Dir - SD Community Services	5.08%	85%	89%	212	175.99	14.26%
Operations Support	2.47%	55%	81%	36	33.34	16.44%
TCT Community Services - Adult Social Care	4.48%	62%	92%	35	31.80	10.38%
TCT Community Services - Baywide	2.48%	81%	87%	52	45.29	18.93%
TCT Community Services - BEST	10.26%	80%	97%	17	12.37	16.17%
TCT Community Services - Brixham Zone	3.17%	77%	92%	53	40.48	10.41%
TCT Community Services - Older Peoples Mental Health	2.38%	100%	83%	13	8.53	0.00%
TCT Community Services - Other Social Care	1.08%	86%	90%	16	12.21	13.43%
TCT Community Services - Paignton	8.74%	73%	89%	111	94.95	12.62%
TCT Community Services - Torquay Zone	7.12%	83%	87%	159	138.62	14.45%
Dir - Torbay Community Services	5.87%	76%	88%	492	417.60	13.67%
COMMUNITY SERVICES DIVISION	5.53%	82%	90%	902	752.80	13.98%
Dir - Chief Executive	0.00%	100%	98%	6	5.84	16.85%
Dir - Education & Development	3.16%	91%	88%	109	103.14	10.24%
Finance	3.54%	60%	81%	80	74.72	11.00%
Health Informatics Service	4.61%	81%	91%	165	143.50	10.63%
Procurement	2.50%	51%	84%	37	35.53	4.65%
Dir - Finance, HIS & Procurement	3.99%	70%	87%	282	253.76	9.90%
Dir - Medical Director	1.97%	89%	93%	29	23.57	4.60%
Dir - Nursing & Quality	1.55%	87%	87%	106	88.56	12.50%
Operations	7.21%	81%	88%	24	19.73	12.66%
Transport	5.73%	88%	90%	72	64.17	8.15%
Dir - Operations	6.06%	86%	89%	96	83.91	9.20%
Dir - Pharmacy Services	1.73%	73%	89%	98	85.42	15.04%
Dir - Strategy	0.00%	67%	82%	62	57.88	3.73%
Dir - Workforce	1.54%	93%	85%	73	64.61	28.47%
CORPORATE SERVICES DIVISION	2.96%	79%	88%	861	766.69	11.94%
Estates	6.69%	59%	100%	32	31.60	8.21%
Facilities Management	5.54%	80%	98%	27	25.28	5.28%
Dir - Estates & Facilities	6.18%	68%	99%	59	56.88	7.21%
Hotel Services - Catering	4.37%	93%	78%	51	37.09	18.46%
Hotel Services - Domestic	5.53%	97%	76%	348	248.65	14.14%
Hotel Services - Other	1.56%	94%	68%	74	68.40	14.66%
Dir - Hotel Services	4.66%	96%	75%	473	354.13	14.81%
ESTATES & FACILITIES MANAGEMENT DIVISION	4.87%	92%	78%	532	411.01	13.72%
Dir - Hospital Services - Brixham	4.06%	71%	71%	32	26.60	14.33%
Hospital Services - Dawlish Hospital	0.00%	95%	91%	27	22.90	13.16%
Hospital Services - Teignmouth Hospital	2.66%	93%	92%	18	14.83	29.48%
Dir - Hospital Services - Coastal	1.21%	94%	91%	45	37.73	21.47%
Dir - Hospital Services - Dartmouth	3.81%	96%	97%	26	20.31	20.20%
Dir - Hospital Services - MIU Services	1.70%	83%	98%	29	23.67	16.32%
Hospital Services - Ashburton Hospital	2.14%	93%	85%	18	13.80	14.91%
Hospital Services - Bovey Tracey Hospital	9.49%	100%	84%	11	8.64	57.30%
Dir - Hospital Services - Moorland	5.03%	95%	85%	29	22.44	33.32%
Dir - Hospital Services - Newton Abbot	4.66%	96%	92%	88	72.90	19.12%
Dir - Hospital Services - Other	0.00%	100%	96%	3	3.00	0.00%
Dir - Hospital Services - Paignton	4.95%	88%	93%	33	26.47	18.72%
Dir - Hospital Services - Totnes	8.08%	92%	93%	35	28.77	25.33%
HOSPITAL SERVICES DIVISION	4.11%	91%	90%	320	261.89	20.47%

Ind Sec Adult Social Care - Torbay	12.21%	70%	89%	10	9.52	0.00%
Ind Sec In House Services LD - Torbay	12.12%	83%	87%	36	28.66	8.88%
545 Dir - Independent Sector Adult Social Care - Torbay	12.14%	80%	88%	46	38.18	6.86%
546 Dir - Independent Sector Health	7.75%	73%	89%	33	29.27	28.42%
INDEPENDENT SECTOR DIVISION	10.22%	77%	88%	79	67.45	16.38%
INTERNAL AUDIT	10.95%	100%	90%	12	11.37	41.69%
Cancer Services - Medicine	5.04%	100%	89%	8	7.80	0.00%
Clinical Oncology	6.65%	80%	88%	55	48.65	13.31%
Haematology	0.00%	100%	100%	4	4.00	0.00%
Medical Oncology	0.00%	100%	89%	5	4.15	23.26%
Non Surgical Cancer Services Admin	6.11%	90%	94%	43	34.15	10.93%
Palliative Care	0.00%	100%	83%	6	4.90	0.00%
Ricky Grant Unit and Turner Ward	7.41%	87%	68%	83	68.67	16.01%
Dir - Cancer Services - Medicine	6.23%	87%	81%	204	172.32	13.25%
Care of the Elderly - Medicine	4.28%	96%	83%	102	90.26	11.54%
Stroke	3.94%	97%	87%	39	34.69	19.03%
Dir - Care of the Elderly - Medicine	4.18%	96%	84%	141	124.96	13.81%
Dermatology	0.29%	89%	90%	15	11.44	0.00%
Neurology	0.00%	100%	93%	3	3.00	50.63%
Rheumatology	2.27%	89%	87%	16	11.53	0.00%
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	1.16%	89%	89%	34	25.97	7.39%
Dir - Emergency Services	1.52%	91%	88%	268	225.09	10.32%
Diabetes and Endocrinology	4.58%	71%	90%	20	17.47	0.00%
Gastroenterology	4.43%	53%	77%	81	72.50	4.13%
Dir - Gastoenterology/Endocrinology- Medicine	4.46%	55%	80%	101	89.97	3.47%
Admin/Support- Med Div	8.89%	91%	92%	48	40.57	29.97%
General Medicine	1.49%	91%	87%	61	53.59	11.96%
Medical Division HQ	3.29%	100%	92%	4	4.05	48.45%
Dir - General Medicine	4.69%	91%	89%	113	98.21	23.58%
Cardiology	2.83%	91%	89%	127	107.84	4.40%
Respiratory	8.19%	95%	90%	68	58.26	18.96%
Dir - Heart & Lung- Medicine	4.67%	92%	89%	195	166.10	9.44%
MEDICAL SERVICES DIVISION	4.00%	88%	86%	1056	902.60	11.84%
PMU Finance	0.00%	40%	82%	5	4.64	12.15%
PMU Manufacturing	5.15%	8%	74%	53	51.23	6.40%
PMU Quality Control	0.37%	85%	86%	49	46.69	0.00%
PMU Sales & Marketing	0.52%	100%	68%	8	7.39	0.00%
PMU Senior Team	0.00%	100%	92%	4	3.70	38.29%
PMU Supply Chain	2.64%	35%	53%	19	15.68	4.04%
PHARMACY DIVISION (Manufacturing)	2.52%	50%	76%	138	129.33	4.86%
RESEARCH & DEVELOPMENT DIVISION	2.61%	86%	86%	45	34.87	8.66%
Dir - Breast Care	3.38%	100%	89%	41	32.58	12.37%
Dir - General Surgery	4.44%	80%	82%	257	217.09	10.80%
Dir - Head & Neck	1.34%	93%	87%	104	80.01	4.73%
Dir - Ophthalmology	4.97%	97%	91%	121	105.45	10.13%
Dir - Surgical Division	4.27%	81%	86%	97	84.38	11.97%
Dir - Theatres, Anaesthetics and ICU	4.28%	85%	86%	410	364.24	11.11%
Dir - Trauma and Orthopaedics	1.15%	87%	88%	163	140.56	13.42%
SURGICAL SERVICES DIVISION	3.71%	86%	86%	1193	1024.31	10.94%
Child Health Med, Mgmt and Misc Specialty	0.68%	92%	81%	61	53.71	9.94%
Paediatric	6.33%	76%	88%	96	76.54	6.03%
Dir - Child Health	4.00%	79%	86%	157	130.26	7.42%
Dir - Lab Medicine	3.75%	87%	86%	115	101.16	8.77%
Gynaecology	6.63%	97%	87%	39	29.13	1.62%
Midwifery	4.62%	84%	91%	130	102.31	4.77%
O&G Medical and Management	5.61%	87%	80%	48	43.83	19.06%
Dir - Obs & Gynae	5.21%	87%	88%	217	175.27	7.01%
Dir - Radiology & Imaging	2.20%	80%	89%	130	110.18	17.16%
Dir - Sexual Health	3.28%	79%	95%	41	31.46	13.77%
Dir - Therapies	2.03%	88%	90%	301	246.02	16.08%
Medical Electronics	1.15%	100%	98%	18	17.64	4.23%
Women's, Children's & Diagnostics	0.16%	77%	92%	15	13.25	7.38%
Dir - Women's, Children's and Diagnostics	0.74%	89%	95%	33	30.89	5.65%
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.25%	85%	89%	994	825.24	11.73%
ICO Grand Total	**4.02%**	**84%**	86%	**6164**	**5206.97**	**12.61%**

Appendix D

Highest cost agency workers

	Staff group	Grade	Department	# months service	Hourly rate	Monthly cost	Reason for usage	Action taken	Risk Rating
18	Medical	Consultant	Stroke	5	£135	£14,188	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
17	Medical	Consultant	Acute Physician	2	£121	£6,970	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
15	Medical	Consultant	Stroke	5	£110	£17,775	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
16	Medical	Consultant	Stroke	2	£110	£10,610	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
14	Management	Senior Manager	Operations	6	£107	£26,400	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
13	Medical	Consultant	Dermatology	6	£105	£18,390	vacancy	Exploring alternative recruitment strategies and workforce skill mix	

12	Medical	Doctors on Call	CAMHS	4	£100	£18,980	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
11	Medical	Doctors on Call	CAMHS	6	£98	£20,393	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
10	Medical	Consultant	Emergency	3	£85	£9,272	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
9	Medical	Junior Doctor	Child Health	4	£68	£8,281	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
7	Medical	Junior Doctor	Neurology	2	£61	£6,583	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
8	Medical	Junior Doctor	Obs & Gynae	4	£60	£7,684	vacancy	Exploring alternative recruitment strategies and workforce skill mix	

1	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	£55	£4,664	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
2	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	£55	£8,723	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
3	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	£55	£2,336	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
19	AHP	Cardiology Technician	Cardiology	6	£48	£6,849	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
4	Nursing and Midwifery	6	388 General Theatres (ODPS) - 15009	6	£45	£6,653	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	

5	Nursing and Midwifery	6	388 General Theatres - 15000	6	£45	£5,712	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	
6	Nursing and Midwifery	6	388 General Theatres (ODPS) - 15009	6	£45	£6,309	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	
20	Nursing and Midwifery	6	388 Intensive Care Unit - 04300	6	£42	£3,947	vacancy	Review of shifts underway in dept	

Long term agency use - please enter all individual agency staff employed for over 6 months

	Staff group	Grade	Department	# months service	Ave Hourly rate	Ave hours worked	Monthly cost	Reason for usage	Action taken	Risk Rating
1	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	36.86	120.00	£4,423	vacancy	New ward, 6 RGNs recently recruiting, advertising remaining vacancies	
2	Nursing and Midwifery	6	388 Intensive Care Unit - 04300	6	42.15	93.64	£3,947	vacancy	Review of shifts underway in dept	
3	Nursing and Midwifery	6	388 Intensive Care Unit - 04300	6	42.15	88.30	£3,722	vacancy	Review of shifts underway in dept	
4	Nursing and Midwifery	5	545 Hospital Services Bovey Tracey Hospital H00520	6	36.86	139.29	£5,134	vacancy	Posts currently advertised. Moved booking from higher cost agency to lower cost agency.	
5	Nursing and Midwifery	6	388 General Theatres (ODPS) - 15009	6	45.18	147.25	£6,653	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	
6	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	36.86	112.54	£4,148	vacancy	New ward, 6 RGNs recently recruiting, advertising remaining vacancies	
7	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	34.04	42.82	£1,458	vacancy	Nurse supplied by our cheapest agnecy - recruting to vacancies	

8	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	42.15	92.00	£3,878	vacancy	Department is recruiting into vacancies - difficult to recruit posts. Discussions underway with agency to reduce charges	
9	Nursing and Midwifery	5	388 Forrest Ward - 04200	6	39.21	75.71	£2,969	vacancy	Recruited to the bank	
10	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	54.55	85.50	£4,664	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
11	Nursing and Midwifery	5	388 Turner/Ricky Grant - 01200	6	36.86	108.25	£3,990	vacancy	Successfully recruited, start date in December. Booking moved from higher cost agency to lower cost agency.	
12	Nursing and Midwifery	5	545 Brixham Hospital Inpatients H00103	6	36.86	80.86	£2,980	vacancy	Currently advertising vacancy	
13	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	36.86	154.43	£5,692	vacancy	New ward, 6 RGNs recently recruiting, advertising remaining vacancies	
14	Nursing and Midwifery	5	388 Cromie Ward - 04100	6	35.94	99.67	£3,582	vacancy	Interviews planned for 1st November. Negotiated agency fee reduction whilst dept are recruiting to fill vacancies	

15	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	42.15	40.29	£1,698	vacancy	Department is recruiting into vacancies - difficult to recruit posts. Discussions underway with agency to reduce charges	
16	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	36.86	185.83	£6,850	vacancy	New ward, 6 RGNs recently recruiting, advertising remaining vacancies	
17	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	54.55	159.92	£8,723	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
18	Nursing and Midwifery	6	388 General Theatres - 15000	6	45.18	126.42	£5,712	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	
19	Nursing and Midwifery	6	388 General Theatres (ODPS) - 15009	6	45.18	139.64	£6,309	vacancy	High number of vacancies within the department, currently advertising- bookings are with our main agy supplier and discussions are underway to reduce costs	

20	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	42.15	82.14	£3,462	vacancy	Department is recruiting into vacancies - difficult to recruit posts. Discussions underway with agency to reduce charges	
21	Nursing and Midwifery	5	388 Warrington Ward - 02300	6	36.86	42.82	£1,578	vacancy	New ward, 6 RGNs recently recruiting, advertising remaining vacancies	
22	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	34.02	82.07	£2,792	vacancy	Booked through our cheapest agency whilst dept is recruiting	
23	Nursing and Midwifery	6	388 Accident & Emergency - 08300	6	54.55	42.82	£2,336	vacancy	Moving booking to cheaper agency whist dept is still recruiting	
24	Nursing and Midwifery	6	388 Intensive Care Unit - 04300	6	42.15	82.07	£3,459	vacancy	Review of shifts underway in dept	
25	Nursing and Midwifery	5	545 Dart Ward Totnes Hospital H00482	6	36.86	140.93	£5,195	vacancy	Post currently advertised. Booking with our main supplier, discussions underway to reduce rates	
26	Management	Senior Manager	Operations	6	£107	37.5 pw	£26,400	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
27	Medical	Consultant	Dermatology	6	£105	40 pw	£18,390	vacancy	Exploring alternative recruitment strategies and workforce skill mix	

28	Medical	Doctors on Call	CAMHS	6	£98	40 pw	£20,393	vacancy	Exploring alternative recruitment strategies and workforce skill mix	
29	AHP	Cardiology Technician	Cardiology	6	£48	37.5 pw	£6,849	vacancy	Exploring alternative recruitment strategies and workforce skill mix	

Appendix F

	Self-Certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.		
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.		
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.		
4	We are not engaging in any workarounds to the agency rules.		
	High quality timely data		
5	We know what our biggest challenges are and receive regular (e.g. monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (e.g. vacancy, sickness) and how this differs across service lines.		
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.		
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.		
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.		

Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; e.g. exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.		
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.		
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.		
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.		
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.		
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.		
Working with your local health economy			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.		
16	The trust has regular (e.g. monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.		

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

Appendix G

Bridging the Nursing Workforce Gap

Current Nursing Workforce / Projected Nursing Workforce Gap

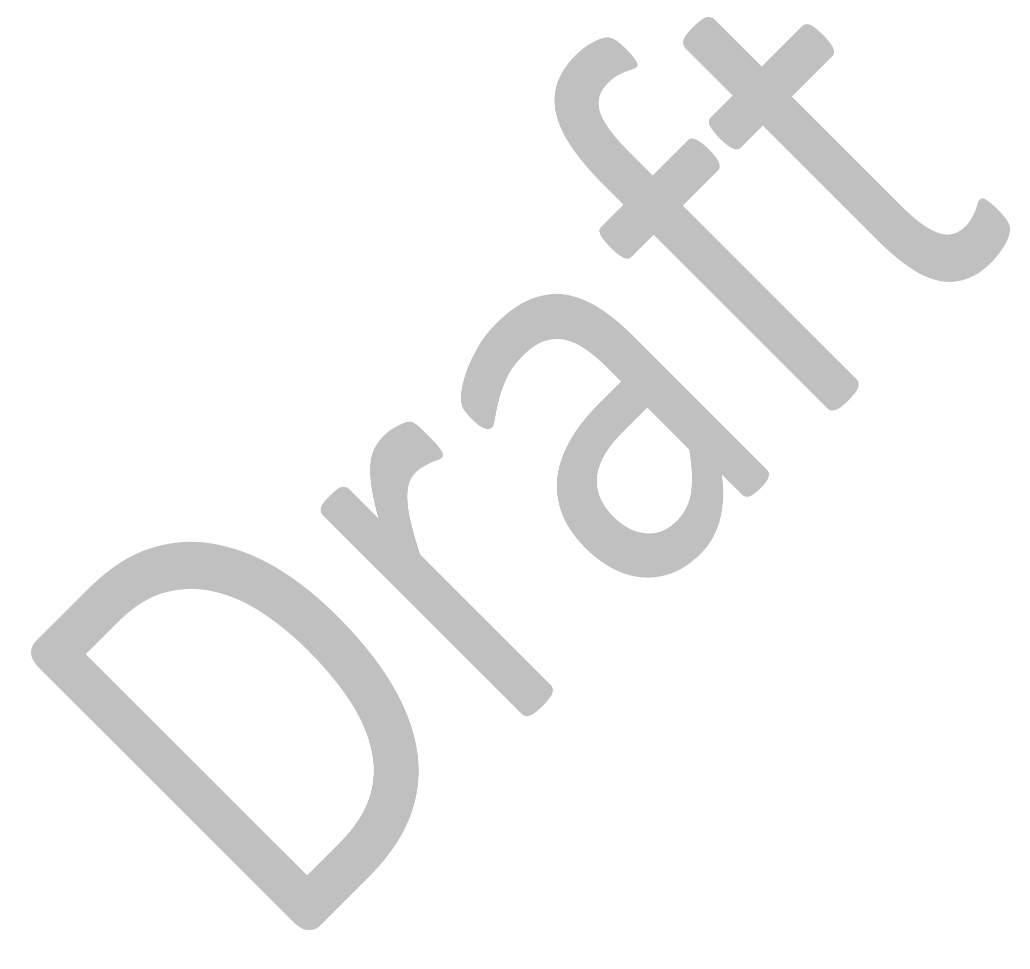
	Current Registered Nurses Establishment WTE	Current Registered Nurses In-post WTE	Current Registered Nurses Vacancies WTE		2016/2017 Turnover 11.00%	2017/2018 Turnover 11.50%	2018/2019 Turnover 12.00%	2019/2020 Turnover 12.50%	2020/2021 Turnover 13.00%
Registered Nursing in Service Delivery Units	1217	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	2017/2018	2018/2019	2019/2020	2020/2021
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

	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Annual Gap WTE	**144**	**45**	**7**	**10**	**33**
Annual Gap Vacancy Factor	**11.83%**	**3.70%**	**0.58%**	**0.82%**	**2.71%**

Draft



REPORT SUMMARY SHEET

Meeting Date:	Trust Board 7th December 2016
Title:	Estates and Facilities Management and Health and Safety: Issues and exception report
Lead Director:	Director of Estates and Commercial Development
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Corporate Risk/ Theme	Estates and Infrastructure
Purpose:	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.

Key Issues/Risks

- Critical Estate Failure: The heating to theatre 5 was lost due to age related failure of heating plant. One days operating capacity was lost. The Trust has made a temporay repair to ensure that service is not compromised futher. This plant is part of the backlog risk and requires replacement within the next year.

  There have been two further critical eaststes failures in November. The heating to the whole of the top of the site including the Breast unit was lost for a period of seven days due to the corrosion of a water pipe due to age. This has now been patched. Service was maintained through the use of additional portable electric heaters.

  One of two vaccum pumps have failed reducing the Trusts contingency to manage a possible failure of piped suction to the surgical block. Both pumps are of the same age and have been on the list of backlog for replacement. The pump has been sent away for recification (if possible) and is expected back in the Trust on the 29th November for fitting. This increased risk of failure of the Vaccum system has been placed on the Trust risk register as a 15.

  Because of the increasing number of failure's of infrastructure over the last month the risk rating of corporate risk 1083 ' lack of capital funding to spend on backlog maintenance and contingency for etstes emergency expenditure:effect failure of key plant and infrastructure score has been increased to a 20. This is as a result of the likihood moving from possible to likely.

  The Finance Committee are considering the financial position of the Trust with a view to releasing capital to spend on backlog maintenance.

Recommendations:
The Trust Board is asked to consider the risks and assurance provided within this report and to advise if further action is required.

Summary of ED Challenge/Discussion:
- Improvement in the performance of estates indicators has been noted.
- The risk of failure of the infrastructure and consequences are now so significant that a review of the Trust financial position is required to release capital for investment.paper to be prepared by the

finance team for consideration aat the Finance Committee.
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.

PUBLIC

Report to:	Trust Board
Date:	December 2016
Report From:	Director of Estates & Commercial Development
Report Title:	Estates and Facilities Management and Health and Safety: Issues and exception report

1. EFM Performance to October 2016

Table 1 below identifies performance against KIP's for September and October and changes between months for EFM. Any area of concern for the attention of the Board, with appropriate explanation and action to a resolution, is shown in Table 2.

Table 1 October 2016 Scorecard Indicator

Green ✔ Amber ! Red ✘		Sep 2016 Position	Oct 2016 Position
Setting	**Improving Indicators**		
Acute	1.2b: PPM (Estates) % success against plan	✘	!
Acute	1.1g: % of Reactive work resolved within target - Urgent – P2	✘	✔
Trust	4.1: Number of RIDDOR Incidents	!	✔
Trust	4.4: Non-patient incidents resulting in moderate harm	!	✔
Trust	5.2: Number of fire alarm activations	!	✔
	Deteriorating Indicators		
Trust	3.2: % of Total tonnage Recycled Waste	✔	!
Trust	5.5: Number of Fire audits undertaken for ' high risk' locations	✔	✘
	Red Rated Indicators with no change		
Trust	1.3: Number of Estates Internal Critical Failures	✘	✘
Trust	3.1: Total Tonnage per month all waste streams	✘	✘

	Table 2: Areas with Specific Cause for Concern		**Timeline**
Trust	1.3	Estates Critical Failure	
Explanation	There was one critical failure – loss of heating to theatre 5 resulting in theatre not being used. Service loss		

	was due to age related failure of heating plant.	
Action	Plant has now been repaired and is back in service. A review of compliance critical spares and staff understanding of impact to hospital service is underway to mitigate this type of failure again.	
Trust	3.1	Total Tonnage per month all waste streams
Explanation	The waste being created by the organisation remains more than anticipated see graph below **Total Tonnage Recycling and Landfill** Tonnage: 150.00, 100.00, 50.00, 0.00 Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar Recycling 15-16 · Recycling 16-17 · Landfill 15-16 · Landfill 16-17 · Waste to Energy 16-17	Quarter 3 2016- 17
Action	A waste awareness communication campaign is being developed and will be displayed in the Out Patients Department.	
Trust	5.5	Number of Fire audits undertaken for ' high risk' locations
Explanation	20 fire safety audits were carried out this month, a combination of 5 high risk areas and 15 medium risk areas; the reporting of audits is reported monthly although red for this month the to date performance is green.	
Action	The new indicators started in September and the target is to have all high and medium risk areas audited by the end of November 2016 this will be repeated on a 3 month rolling report. Currently all Fire Safety Risk Assessments within the Trust are in date.	

2. Health and Safety performance exception

There are no areas of health and safety concern for October.

EFM Key performance Indicators Month 7 – October 2016

	Area			Target	Monthly Performance												Current year to date (Complete Months)		Risk Threshold		
Ser	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	RAG Thresholds		
	Estates (Acute Setting)																				
1.1a	Number of PPM items planned per month			Variable	968	1181	1133	1092	1213	1029	1166							1112			
1.1b	PPM (Estates) % success against plan			95%	74%	87%	79%	74%	77%	83%	87%						95%	80%	R<85%	A85-94%	G>95%
1.1c	Planned Maintenance request access denied.			0	0	0	0	0	0	0	0						0	0	R≤5	A3-4	G≤2
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	118	137	113	122	128	114	121							122			
1.1e		Emergency – P1	<2 Hour	95%	98%	100%	98%	100%	95%	95%	98%						95%	98%	R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	269	263	272	253	249	232	203							249			
1.1g		Urgent – P2	<1- 4 Days	90%	83%	84%	85%	89%	87%	81%	94%						90%	86%	R<85%	A85-89%	G≥90%
1.1h		Routine – P3 + P4	Total Requests	Variable	298	315	281	292	291	295	294							295			
1.1i		Routine – P3 + P4	<7- 30 Days	85%	88%	90%	94%	90%	91%	91%	93%						85%	91%	R<80%	A80-84%	G≥85%
	Estates (Community Setting)																				
1.2a	Number of PPM items planned per month			Variable	244	269	232	269	243	231	279							252			
1.2b	PPM (Estates) % success against plan			95%	93%	91%	95%	97%	91%	97%	97%						95%	94%	R<85%	A85-94%	G>95%
1.2c	Planned Maintenance request access denied.			0	0	0	0	0	0	0	0%						0	0	R≤5	A3-4	G≤2
1.2d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	11	17	5	17	16	8	14							13			
1.2e		Emergency – P1	<2 Hour	95%	100%	100%	100%	100%	100%	100%	100%						95%	100%	R≤89%	A90-94%	G≥95%
1.2f		Urgent – P2	Total Requests	Variable	47	56	42	69	36	21	33							43			
1.2g		Urgent – P2	<1- 4 Days	90%	81%	91%	90%	93%	94%	90%	91%						90%	90%	R<85%	A85-89%	G≥90%
1.2h		Routine – P3 + P4	Total Requests	Variable	122	109	56	171	64	53	87							95			
1.2i		Routine – P3 + P4	<7- 30 Days	85%	93%	93%	96%	98%	94%	94%	93%						85%	94%	R<80%	A80-84%	G≥85%
	Estates (All Trust)																				
1.3	Number of Estates Internal Critical Failures			0	0	0	0	0	0	1	1						0	0	R1	-	G0
	Facilities (Acute Setting)																				
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	99%	99%	99%	99%	99%	99%						98%	99%	R<95%	A95-97%	G≥98%
2.2	Compliance High Risk Cleaning Audit			95%	97%	97%	98%	98%	97%	97%	98%						95%	97%	R≤89%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	99%	99%	98%	98%	98%						85%	99%	R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	96%	96%	96%	100%	98%	100%						75%	98%	R<70%	A70-74%	G≥75%
	Facilities (Community Setting)																				
2.5	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%	100%	100%	100%	100%						98%	100%	R<95%	A95-97%	G≥98%
2.6	Compliance High Risk Cleaning Audit			95%	99%	99%	99%	99%	99%	100%	100%						95%	99%	R≤89%	A90-94%	G≥95%
2.7	Compliance Significant Risk Cleaning Audit			85%	99%	100%	97%	99%	99%	98%	99%						85%	99%	R<80%	A80-84%	G≥85%
2.8	Compliance Low Risk Cleaning Audit			75%	100%	100%	91%	99%	95%	100%	100%						75%	98%	R<70%	A70-74%	G≥75%
	Facilities (All Trust)																				

2.9	No. of Environmental (food hygiene/Waste) Events	0	0	0	0	0	0	0	0						0	0	R1	-	G0
	Waste (All Trust)																		
3.1	Total Tonnage per month all waste streams	176	176	184	191	193	193	194	193						176	189	R≥185	A177-185	G≤176
3.2	% of Total tonnage Recycled Waste	38%	35%	40%	38%	35%	35%	45%	36%						38%	38%	R≤27%	A28-37%	G≥38%
3.3	% of Total tonnage Landfill Waste	34%	32%	28%	36%	1%	0	0	1%						34%	14%	FROM	JULY 16	See 3.7
3.4	% of Total tonnage of Clinical Non-Burn waste	12%	20%	20%	19%	19%	18%	18%	18%						12%	19%	R≥25%	A19-24%	G≤18%
3.5	% of Total tonnage of Clinical Burn waste	11%	6%	5%	5%	5%	5%	5%	5%						11%	5%	R≥16%	A12-15%	G≤11%
3.6	% of Total tonnage of Clinical Offensive waste	10%	6%	6%	6%	7%	6%	6%	6%						10%	6%	R≤2%	A3-5%	G≥6%
3.7	Waste to Energy (redirected from landfill 1100s and Compactor.	25%	FROM	JULY	2016	34%	37%	26%	34%						25%	33%	R≤15	A15-24	G≥25
3.8	% of Compliant Waste Audits	100%	100%	100%	100%	100%	100%	100%	100%						100%	100%	R<80%	A80-84%	G≥85%
3.9	% Compliance of Statutory Waste Audits	100%	100%	100%	100%	100%	100%	100%	100%						100%	100%	R≤89%	A90-94%	G≥95%
	Waste (Acute Setting)																		
3.10	Number of Waste Audits undertaken per month	10	10	10	10	10	10	10	10						10	10	R≤5	A6 - 7	G≥8
	Waste (Community Setting)																		
3.11	Number of Waste Audits undertaken per month	6	7	6	7	7	7	7	7						6	7	R≤4	A5	G≥6
	Health & Safety (All Trust)																		
4.1	Number of RIDDOR Incidents	3	10	3	3	2	1	4	0						3	4	R≤6	A4-5	G≤3
4.2	Number of days lost (due to incidents in month)	Variable	135	5	162	112	15	83	1							73			
4.3	Non-patient incidents resulting in minor harm	35	39	38	24	28	30	27	28						35	31	R>39	A36-39	G<36
4.4	Non-patient incidents resulting in moderate harm	4	4	7	8	9	2	7	3						4	6	R>7	A5-7	G≤4
4.5	% of near misses against total	20%	34%	27%	36%	36%	27%	20%	26%						20%	29%	R<15%	A15-19%	G≥20%
4.6	% of Staff receiving H & S training in month	85%	86%	86%	86%	85%	85%	86%	86%						85%	86%	R<80%	A80-84%	G≥85%
	Fire (All Trust)																		
5.1	% of Staff receiving Fire Training during month.	85%	82%	83%	83%	83%	84%	84%	82%						85%	83%	R<80%	A80-84%	**G≥85%**
5.2	Number of fire alarm activations	9	7	15	9	7	10	11	5						9	9	R≥14	A10-13	**G≤9**
5.3	Fire alarm activations attended by the Fire Service	2	1	3	3	1	2	2	0						2	2	R≥5	A3-4	**G≤2**
5.4	No. of Fires	0	0	0	0	0	0	0	0						0	0	R1	-	**G0**
5.5	Number of Fire audits undertaken for ' high risk' locations	9						11	5						9	8	R<6	A6-7	**G≥8**
5.6	Number of Fire audits Undertaken for 'medium/normal' locations	8						29	15						8	22	R<5	A5-6	**G≤7**
5.7	Completed Risk assessments for 'high risk' locations	27						27	27						27	27	R<23	A23-25	**G≤26**
5.8	Completed Risk assessments for 'medium risk' locations	45						45	45						45	45	R<40	A40-43	**G≤44**
5.9	Completed Risk assessments for 'low risk' locations	84						84	84						84	84	R<78	A78-82	**G≤83**