Torbay and South Devon NHS Foundation Trust

Council of Governors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

14 December 2016 15:00 - 14 December 2016 17:00

AGENDA

#	Description	Owner	Time
1	Chairman's welcome and apologies: Lesley Darke, Gary Hotine, Julien Parrott, Mark Procter, Andy Proctor For information	Chairman	
2	Declaration of interests To receive	Chairman	
3	Minutes of the last meeting held on 23 September 2016 (enc) To approve 03 - 2016.09.23_DRAFT_CoG_minutes.pdf 7	Chairman	5
4	Chairman's report (verbal) To receive	Chairman	5
5	Chief executive's report including other lead director reports (enc) -to include feedback on the CCG-led consultation To ask questions 05 - CX_Report.pdf 15	CEO/EDs	15
6	Mental Health Presentation (verbal) To receive	COO/D Somerfield	25
7	Lead governor's report including constituency reports (enc) -to include chairman's appraisal process To receive & approve 07 - Lead_Governors_Report.pdf 157	Lead Governor	5
8	Non-executive director's report (verbal) To receive	Jon Welch	15
9	Quality and Compliance Committee report (enc) To receive & approve 09 - QCC_Report.pdf 165	W Marshfield	5

#	Description	Owner	Time
10	Membership development report (enc) To receive & approve 10 - Membership_Development_Report.pdf 179	L Hookings	5
11	Secretary's report (enc) to include: To receive 11 - Secretarys_Report.pdf 185	CoSec	10
11.1	Expenses policy and review of membership recruitment To receive & approve		
11.2	Lead governor recruitment process 2017 To receive & approve		
11.3	Schedule of meetings and routine agenda items To receive & approve		
12	Urgent motions or questions To receive & action	Chairman	1
13	Motions or questions on notice (verbal) To receive & action	Chairman	1
14	Details of 2017 meetings (enc) CLOSED SESSION – please leave the meeting at this point if you are not a governor / board member 14 - Future meetings.pdf 205		
15	Private minutes of the last meeting held on the 23 September 2016 (enc) To approve - 2016.09.23_DRAFT_CoG_minutes_PRIVATE.pdf 7	Chairman	1
16	Board matters (verbal) -opportunity for the board to advise governors on any new issues; sensitive and/or confidential To receive	Chairman/CEO	5

#	Description	Owner	Time
17	Non-executive director report (enc) To receive & approve 17 - Non_Executive_Director_Report.pdf 209	Chairman	10

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Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING

HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE,

TORBAY HOSPITAL

23 SEPTEMBER 2016

Governors

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

Directors

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

(* denotes member present)

In Attendance:	Clive Brookes	Interim Deputy COO (for L Davenport)
	Richard Scott	Company/Corporate Secretary
	Monica Trist	Corporate Governance Manager and Note taker

Action

1. **Welcome and apologies**

Apologies were received from: Lesley Archer, Diane Gater, Julian Parrott, Mark Procter, Sylvia Russell, Simon Slade, John Smith, Simon Wright, Lesley Darke, Liz Davenport, Gary Hotine, Judy Saunders, James Furse, Jacqui Marshall, Robin Sutton, Sally Taylor and Jon Welch.

2. **Declaration of Interests**

There were no declarations of interests.

3. **Minutes**

The action for the Company Secretary to circulate details of NEDs' portfolio of responsibilities was completed. There was still an open action regarding governors feeding back ideas on membership engagement to Lynne Hookings, Chair of Mutual Development Group, who confirmed that no feedback had been received to date and she would welcome any suggestions from governors. The Chairman thanked the Chief Nurse and Medical Director for the comprehensive response to governors' questions raised around CQC recommendations.

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

4. **Chairman's report**

The Chairman advised the meeting of the recently received resignation from Adrian Cunningham, an elected governor from the Torbay constituency and thanked him for his contribution to the work of the governors.

This was a very important day – the first Annual Members Meeting (AMM) since the formation of the ICO, and he thanked governors for their invaluable contribution to the success of the organisation over the past 12 months.

He thanked governors for their involvement with the CCG–led consultation on transforming community services, recognising that governors had spent a large amount of time attending public meetings and providing valuable feedback.

Full details of consultation outcomes would be brought to a future Council of Governors (CoG).

5. **Ensuring an active patient and public membership – engaging young people**

Anna Pryor (AP) thanked the Chairman for inviting her to speak to the meeting and advised she would be happy to respond to any questions arising from her report included in the meeting papers, which related to work carried out in her previous role with Milton Keynes NHS Foundation Trust on engagement and involvement with young people.

Members asked for further details of methods used to contact and engage with younger people and how this work was funded. AP advised these included talks to schools and youth groups, production of leaflets and newsletters and attendance at a Trust board meeting. T Bannon felt that any such efforts could now be progressed using social media, which was not available in 2010.

L Hookings asked about resources available to carry out the work described, and AP advised no specific budget had been available and resources had been acquired from other areas. Sponsorship had also been sought for events and refreshments.

Governors felt it important to bear in mind younger users of the Trust's services; the Director of Strategy and Improvement (DSI) confirmed that a very high proportion of the public attending the current CCG consultation meetings could be described as "elderly". Torbay Council were aware of the need to make the area more "youth

friendly", and were looking at working with the local Youth Parliament and Devon Youth council.

The Chair felt it important that the governing body represented all generations and was aware of some work being undertaken to approach local schools. This was particularly important as the Trust is the biggest local employer with various opportunities available for apprenticeships and work experience.

AP was pleased to confirm that the work she started in Milton Keynes is still ongoing with the Young People's cabinet still being represented at the Trust's CoG meetings.

The CEO thanked AP for her report and the time taken to undertake this work, over and above her "day job". She said the MDG would consider how best to take forward some of the ideas described by AP to engage with younger people and how to prioritise this issue. Lead governor thanked AP for her very informative report.

The Chair asked that the Medical Director bring a report on the public health issues related to younger people to December CoG.

6. **Chief Executive's report including other lead director reports**

The CEO said that her report would cover issues rising since the 20 July CoG and a series of Board reports were provided for the information of members. The Finance, Performance and Investment Committee report related to the position as at August 2016, as the Committee meeting was not taking place until 27 September. Members' attention was drawn to the letter from NHS Improvement (NHSI) which provided details of the quarter one ratings for financial sustainability (2) and governance (green) as at 31 August 2016.

She thanked the governors for their invaluable contribution to the CCG-led public consultation on transforming community services. Nine meetings had taken place to date, with an extra meeting to be scheduled for Ashburton. Governors' support in contributing to the table discussions at each meeting was much appreciated, as was feedback provided to the Trust from various meetings, which would help inform the process.

On 1 October the first year of the Integrated Care Organisation (ICO) would be celebrated, with members of the Executive Team visiting as many sites as possible to discuss the first year with staff.

Staff had expressed some concerns following the recent Devon Sustainability and Transformation Plans (STP) report, which had been leaked to the media (Torbay and South Devon NHS Foundation Trust had now joined the STP). The NEW (North, East and West) Devon success regime had indicated a preferred two-site option for maternity services, and the Medical Director (MD), Chair and Chief Executive (CEO) were arranging to meet with service leads to discuss the implications of the report and provide assurance to staff.

NHS planning guidance had just been received on 22 September, with a focus on the STP, a quick turnaround was required and further details would be issued to governors shortly.

A Proctor felt it was difficult for the public to understand the concept of STPs, and the CEO agreed, explaining that Torbay had decided to join at this stage to be in the lead with STP planning. Communications and governance processes were still being developed, and should improve. The Chair said it was good that the Trust was already committed to the community hospital transformation process, and felt that

some unhelpful recent publicity just added to the confusion for members of the public. Governors had a critical role to play in ensuring their constituents were aware of the new model of care, which would enable improved services to be delivered to the local population. Community hospital transformation was a very emotive issue. T Bannon suggested that governors required further information in order to be able to communicate with the public effectively. MD confirmed the need to improve the services supplied by the Trust – the new model of care would be critical to this process.

W Marshfield felt that the public did not understand the new model of care, and that the consultation seemed to be focussed on community hospital closures, and gave the example of the recent Herald Express article about Paignton Hospital. All agreed the need for greater publicity about the new model of care and care pathways.

C Davidson asked about the Trust's plans for dealing with the proposed Junior Doctors strike and the MD advised that the Trust was currently awaiting the final decision from the British Medical Association (BMA), although plans were being developed to deal with the strike if it goes ahead.

7. **General feedback on the CCG-led consultation**

Further to the comments above, the DSI drew attention to the CCG's recent stakeholder briefing on the consultation on re-shaping Community Health Services in South Devon and Torbay which would run until 23 November 2016, which had been sent to governors.

This described the first four public meetings and summarised the outcome of these, and also provided details of the feedback questionnaire. The DSI felt the level of public engagement shown had been very encouraging – more than 1,000 people had attended to date, with the Trust being represented at each meeting by executives, NEDs and governors. Invaluable discussion had taken place at each table during the meetings which had all been captured in detail and would be fed back to the CCG by Healthwatch. The Chief Nurse felt that the meetings demonstrated the strength of feeling local members of the public had for their community hospitals and the CEO said one of the key issues raised at all meetings was the provision of domiciliary care. The CCG was aware they need to provide a greater level of detail around planned future services, especially in relation to social care.

Various governors asked about "Plan B" if the proposals were not taken forward, and the CEO explained the need to save money and provide services in a different way, using the new model of care, therefore there was no Plan B. The Chair confirmed that "do nothing" was not an option and the current proposals represented a lengthy period of detailed planning. The CEO had noted comments made by governors during the meeting and would feed these back to the CCG.

T Bannon felt it was important to determine future usage for the community hospitals – how best to make use of the buildings whilst at the same time providing appropriate care at home for patients. The CEO felt it important to recognise that different people had differing preferences and it may not be possible to satisfy everyone. The Chair informed governors that a recent survey had indicated the average age of the Trust's community hospital in-patients was 88.

The Chair thanked all contributors to a very informative discussion.

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

The Lead Governor thanked governors for their contribution to the consultation

process. CS confirmed that any further constituency reports would be presented to the October Board to CoG or December CoG meetings. He was aware of some issues around NHS Mail 2, and reminded governors of the training session arranged for 19 October. He asked governors to email the Foundation Trust mailbox with details of any problems they were experiencing in advance of the training and he would take forward with the HIS. | All governors

The Lead Governor thanked the CS for his efforts in this area and with regard to progress with the consultation, so that the governor only meeting prior to 19 October Board to CoG would be a good opportunity to discuss progress on the consultation.

Lead Governor, as governor for Teignbridge, reported that a very useful meeting had taken place at Dawlish Hospital.

9. **Non-executive director's report**

David Allen presented his reflections on the performance of the NHS since its formation in 1948, and the health and lifestyle of the population, and how these had changed since the NHS was formed – then and now. Longevity and co-morbidities were now placing mounting pressures on the NHS. He described the essential need to provide high quality services and the assurance provided to the Quality Assurance Committee (QAC), which he chairs. QAC is a committee of the Board, focusing on the quality of clinical and social care services provided by the Trust. He felt the information provided demonstrates the quality of the Trust's Executives, NEDs, governors and staff.

The Chair thanked Mr Allen for a very thought-provoking presentation, and for his continuing contributions to the Board and the Trust.

A Gradwell asked how the NEDs felt they received the right level of assurance and demonstrated appropriate accountability. Mr Allen felt there was a difficult balance to be struck, with an element of trust required and NEDs needing to believe the information they are presented with - how to challenge and support without being too confrontational. He felt the NEDs had a good relationship with the Executive Team, and the executives were able to raise areas of concern with the NEDs, particularly though forums such as QAC.

Public feedback was vital to enable NEDs and governors to carry out their role effectively. A discussion followed on effective risk management and the role of committees in ensuring an appropriate balance of risk and how services could continue to be provided in a safe way – involvement of the voluntary sector was key.

10. **Quality and Compliance Committee (Q&CC) report**

W Marshfield provided a report on the 24 June Q&CC. P Welch advised he had submitted a governor observation report – what would happen to regarding the points raised? A discussion followed on the role of governor observers – CS to consider outside the meeting and provide report to next Q&CC. It may be preferable to set up a task and finish group to consider the role of governor observer.

The Chair felt this was an appropriate way forward. He confirmed that the Trust ties to ensure governors are kept informed withe minimum of delay, but huge amounts of information are received every day and it is not possible to share everything. He would welcome feedback from governors regarding the amount of information they now receive – was the balance correct? | All governors

C Davidson left the meeting.

C Day felt assured by the recent visit to Dawlish Hospital, which is delivering a good level of service.

11. **Membership Development report**

L Hookings (LH) provided a report on the work of the MDG and the meeting held on 7 September 2016. LH expressed some concerns on apparent lack of progress of the MDG, which she had been a member of since 2013. She felt that many issues had been discussed on several occasions but there appeared to be little to show in the way of positive outcomes. LH was aware of the difficult financial position of the Trust but felt some investment was required to promote the work of the Trust and governors: MDG had recently been advised there was no allocated budget for this purpose.

She asked other governors to contribute their views.

The Chair and CEO thanked LH for raising this issue and they would consider how best to take this forward.

Governors suggested addressing various other groups in the community, for example Women's Institutes, to generate interest in Trust membership but C Carpenter advised this had been tried previously with little success. CS to consider how best to make progress with this issue and would report back to the governors. CS

12. **Secretary's report**

CS advised members that the Annual Report and Accounts is to be formally accepted at the Annual Members Meeting, taking place on the afternoon of 23 September, following CoG.

CS advised that a new model of care presentation had been provided for governors on 16 September, which had been very well received, but unfortunately only 8 governors had attended.

CS gave advance notice of the annual elections due to take place in the autumn and confirmed that the next Board to Council meeting would take place at 3pm on Wednesday 19 October 2016.

CS referred to minute 8 above and asked that governors provide him with details of any issues relating to NHS Mail 2, as governors were asked to access their NHS mailbox at least twice weekly to ensure they received all confidential information issued by the Trust. Personal email addresses were used for unclassified information only.

13. **Urgent motions or questions**

There were no urgent motions or questions.

14. **Motions or questions on notice**

C Carpenter raised 3 questions:- for details of questions and answers provided please see below:

1. What assurance is there that patients discharged home from hospital have adequate information about their care and support services have been arranged especially for orthopaedic patients?

Rob Dyer answered a similar question in July (July Board minutes refer). Following extract also taken from August board.

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

Following extract from September Board:

- *Care plan summaries % completed within 24 hrs discharge weekdays 51.2% (59.4% last month) against 77% target.*
- *Care plan summaries % completed within 24 hrs discharge weekend 20.4% (35.0% last month) against 60% target.*

Further update to follow especially for orthopaedic patients.

2. September Board of Directors.

   Mrs French asked, on behalf of a staff governor, what action the Trust was taking to manage waiting times for those areas not covered by RTT targets, for example there was a waiting time of 15 months to see a dietician. It was noted that a considerable amount of work was taking place in this area and a written response, outside of the meeting, would be provided.

   Monitoring and management of therapy waiting times is carried out by therapy leads and risks are identified and escalated to associate director for Therapies and the Women's, Children, Diagnostics and Therapies (WCDT) Service Delivery Unit (SDU) general manager.

   Dietetic waiting times are a particular concern currently and these have been raised at Senior Business Management Group and through the SDU's quality and performance process.

   MSK (Musculoskeletal) Physiotherapy service has clear Key Performance Indicators (KPIs) including identified waiting times and these are monitored by the South Devon and Torbay CCG.

   In order to give greater visibility of therapy waiting times there is a plan to include them as part of the Quality Improvement Group dashboard.

   Audiology is covered by an any qualified provider (AQP) contract specification with 6 week maximum waits.

3. September Board of Directors.

   Mrs French then asked, following some media coverage in respect of another Trust, what action the Trust took to ensure that equipment was recycled where possible. It was noted that this question was raised some time ago and a response made, and this would be provided again. It was also important to note that in many cases it was more costly to decontaminate equipment than purchase new items.

Update to follow.

15. **Details of next meeting:**

14 December 2016, 3pm-5pm, Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

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

1. Summary of Report

1.1 Topical areas of interest from the Chief Executive and Executive Team covering issues arising since the last Council of Governors meeting on 23 September 2016.

1.2 Please note that the next Finance, Performance and Investment Committee is not due to take place until the 20 December 2016 therefore at the time of writing, this paper highlights the latest Trust position.

1.3 The report as at attachment four shows October's performance figures; all figures that were available as at 7 December 2016. If an up-to-date dashboard is available, this will be presented on the day of the meeting.

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

2. Decisions Needed to be Taken

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

3. Attached to this Report

Attachment one	-	Chief Executive's report as presented at December's Board.
Attachment two	-	Acute Services Review as presented at December's Board.
Attachment three	-	Wider Devon Sustainability and Transformation Plan (STP) as presented at December's Board.
Attachment four	-	Integrated Quality, Performance and Finance report as presented at December's Board.
Attachment five	-	Separate report on Referral to Treatment (RTT)
Attachment six	-	Care Quality Commission Update
Attachment seven	-	Chief Operating Officer's report as presented at December's Board.
Attachment eight	-	Funding Reduction from Public Health report as presented at December's Board.

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.

Torbay and South Devon NHS
NHS Foundation Trust

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.

Torbay and South Devon NHS
NHS Foundation Trust

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

Torbay and South Devon NHS
NHS Foundation Trust

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

Torbay and South Devon NHS
NHS Foundation Trust

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.

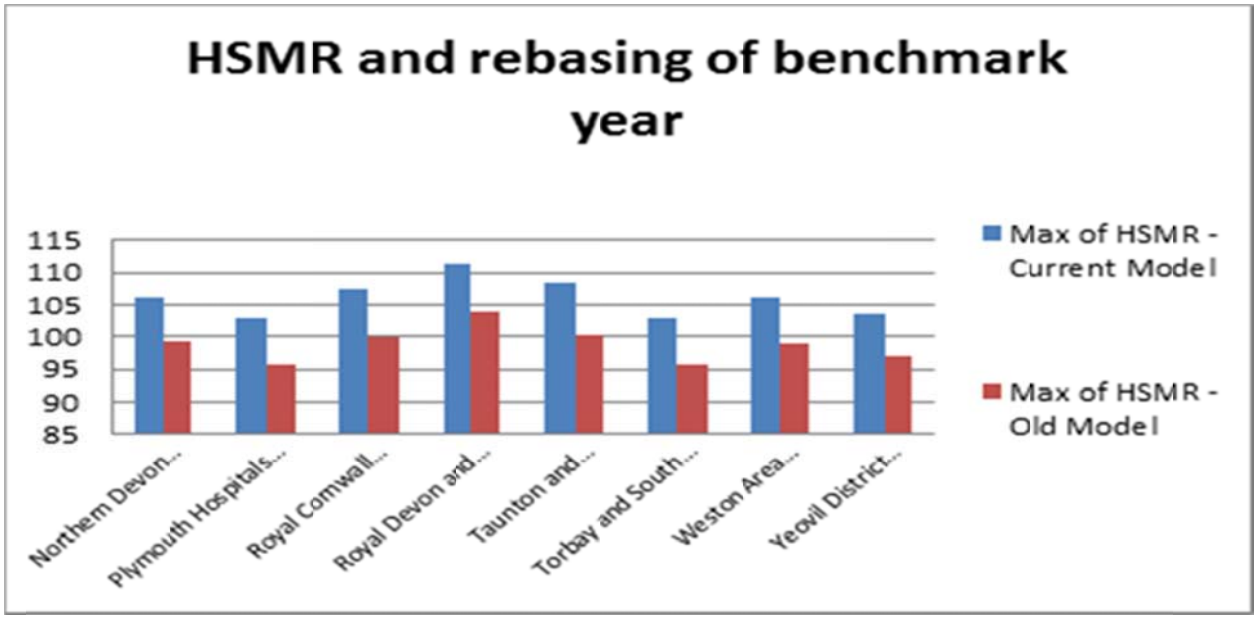
The HSMR is the measure used to show deviation against expected in hospital mortality distribution.

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

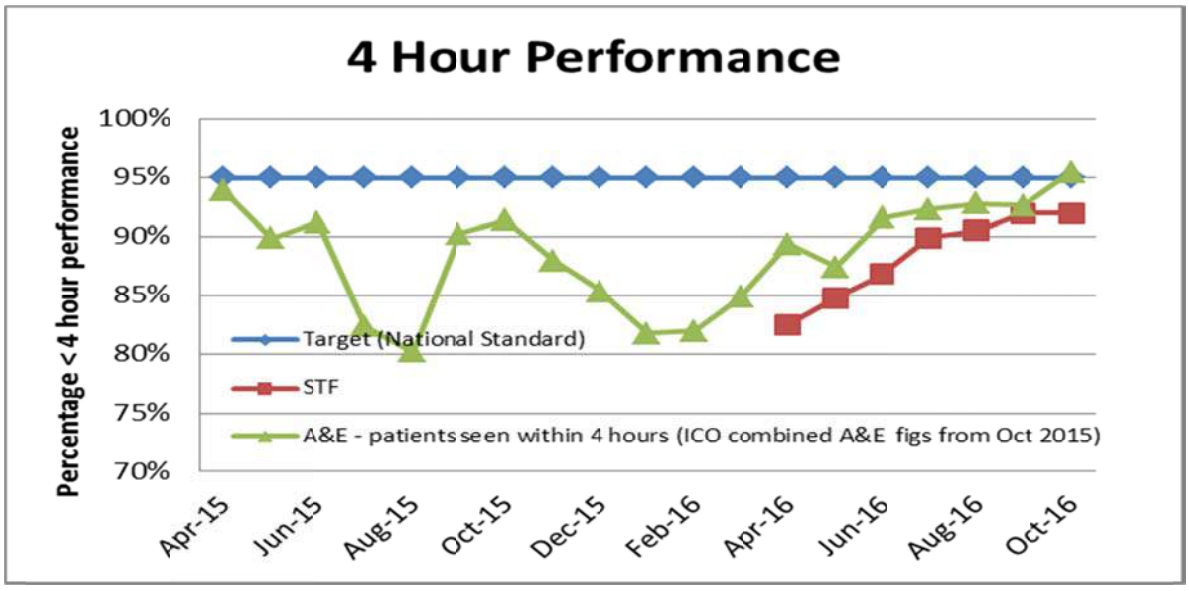
3.1 4 hour standard for time spent in A+E

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:

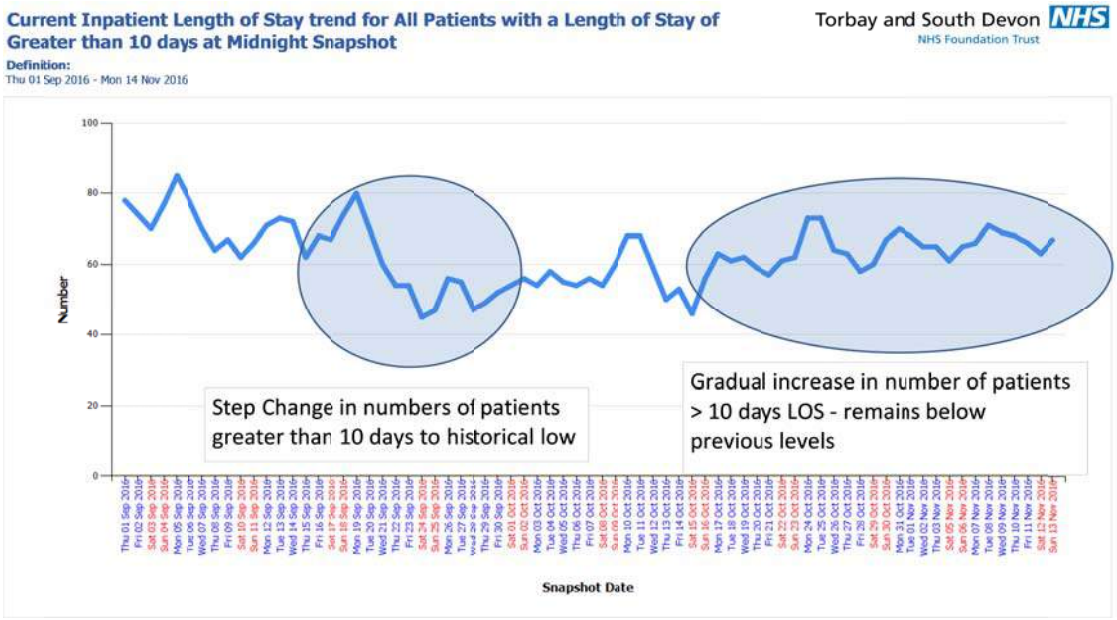
For October, the combined performance of Emergency Department (ED) and Minor Injury Units (MIUs) was 95.46%, a further improvement to that delivered in September 92.6%. This is a significant achievement and the first time that as an ICO the National standard of 95% has been received.

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.

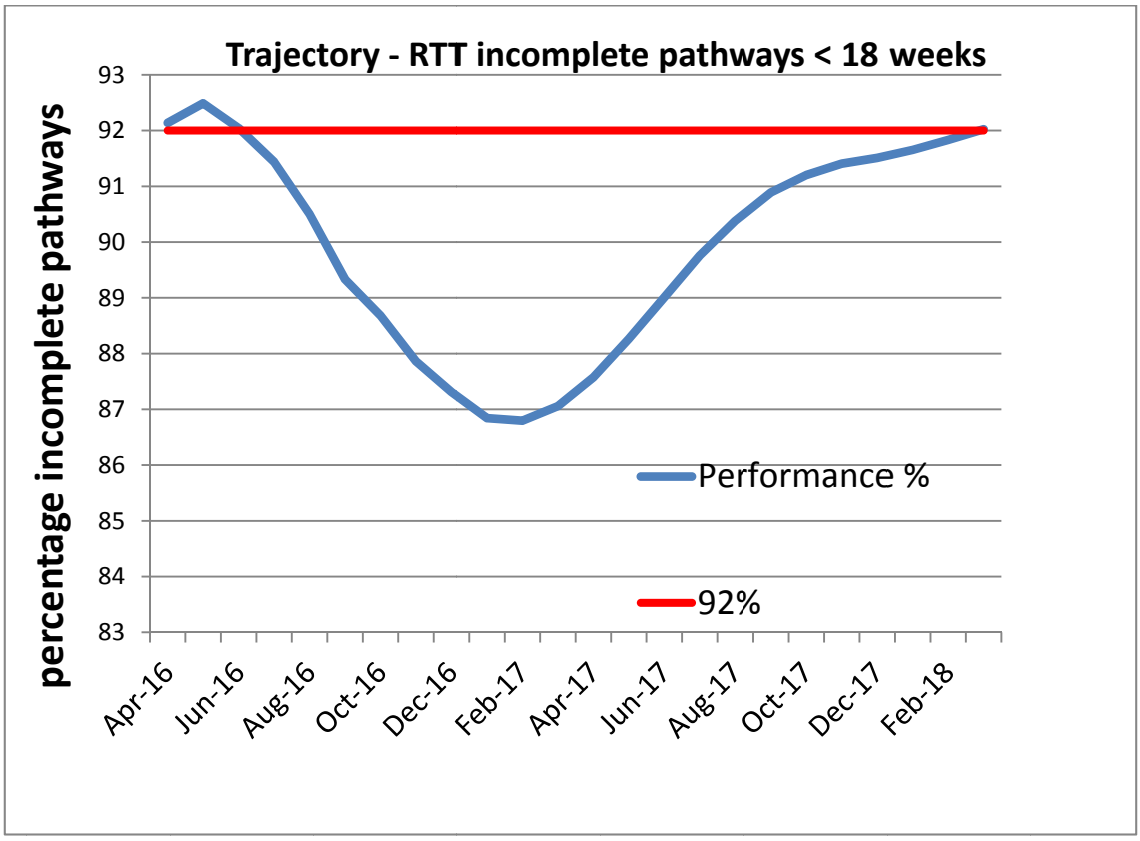
Assumptions in the current plan are;

- 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.

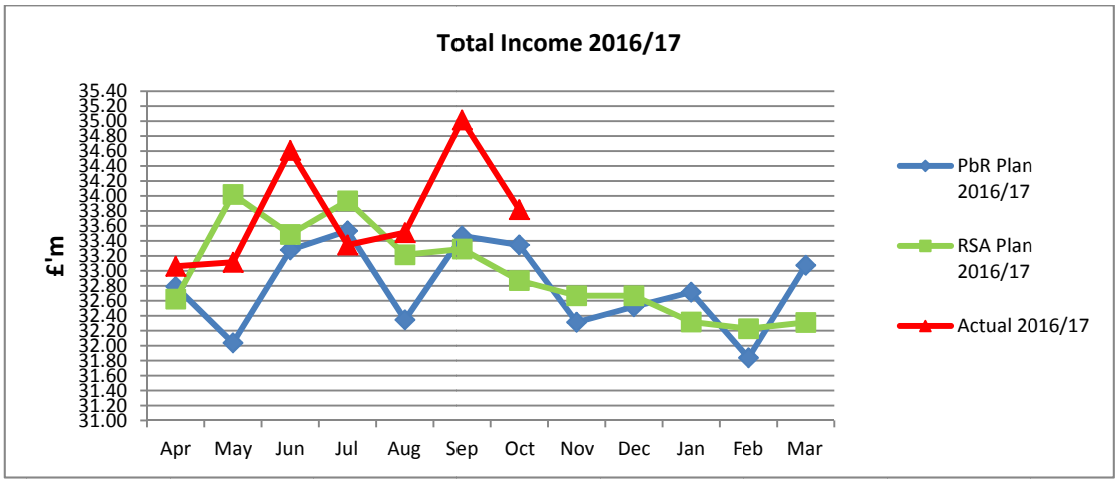
STF funding of £3.21m in total has been received and included in the year to date figures. A total of £6.7m is planned under the PbR arrangements for the full year, but was reset at £1.675m in the RSA plan after publication of the rules for receipt by NHS Improvement, with this phased into quarter one 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	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
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.

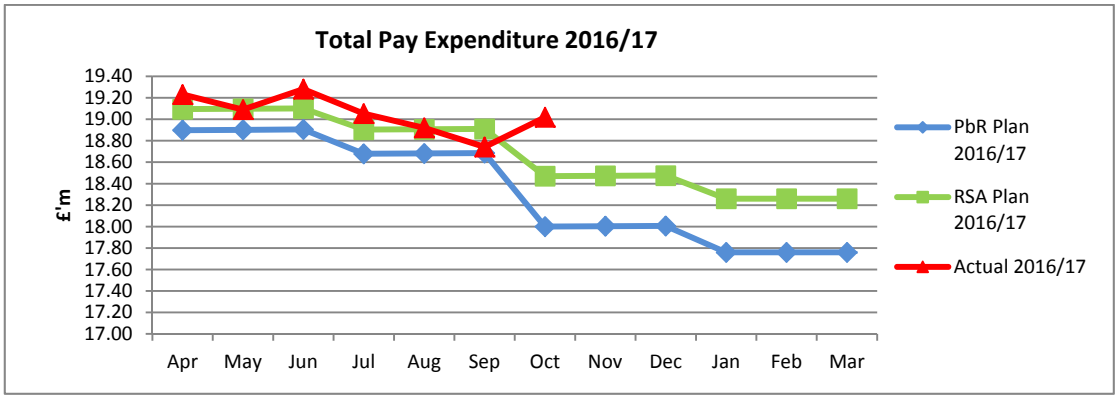
From the previous month agency and bank costs have increased by £0.01m and £0.10m respectively, with an increase in substantive costs of £0.16m. Despite run rates reducing between July and September, collectively the rate of spend in October has increased by £0.27m from the previous month, mainly in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

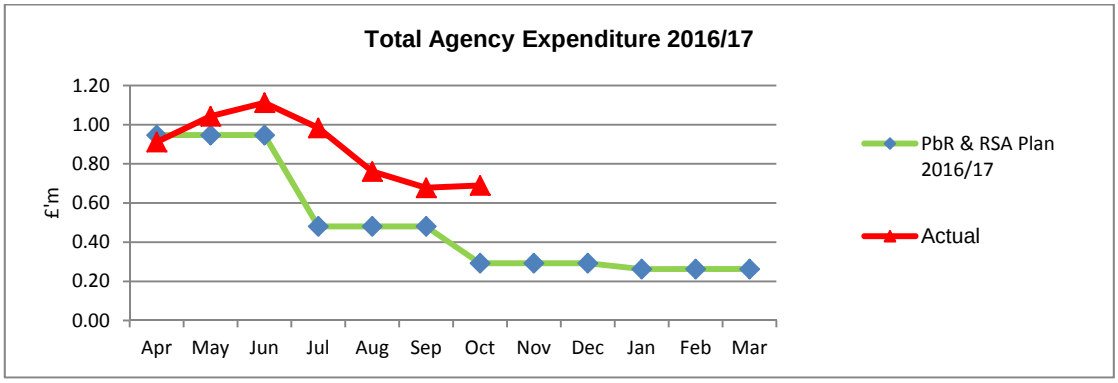
agency costs. Estate and Facilities management also have pay overspends of £0.21m mainly in agency and bank costs for hotel services. Adult Social Care is also showing an overspend in pay of £0.63m due to the majority of their CIP target, which was allocated to this category, being yet to be delivered.

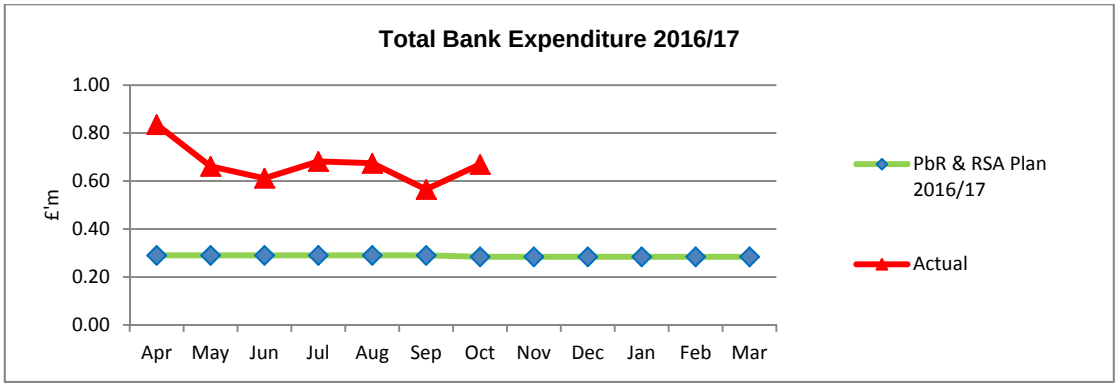
There are off-setting pay underspends in Community Services reflecting vacancies across both Torbay and Southern Devon (£1.11m),Community Hospitals (£0.15m), Torbay Pharmaceuticals (£0.13m), HQ and Corporate services of £2.36m, mainly in reserves (£1.94m), with the balance due to savings in HIS (£0.29m),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

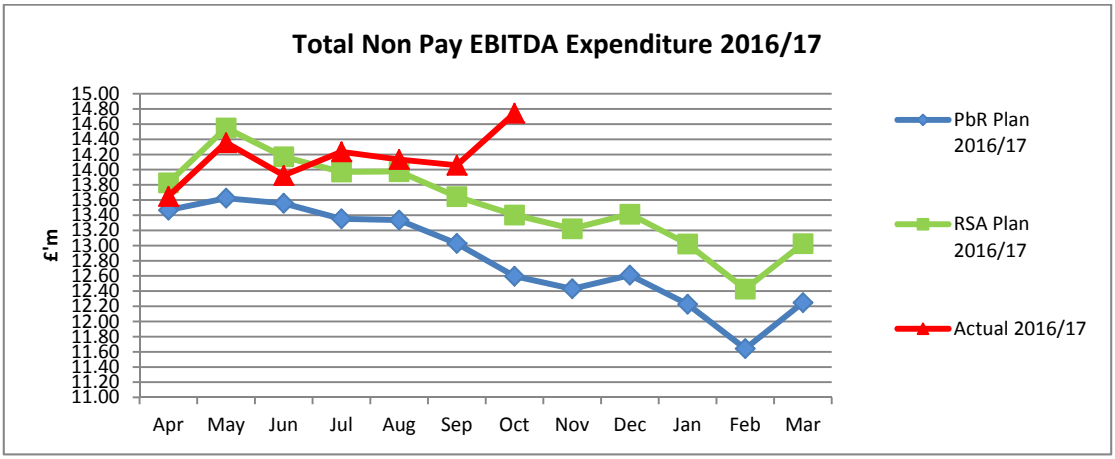
Pass through drugs, bloods and devices are £0.47m over spent against RSA plan. This is neutral to the overall income and expenditure position as additional income is received from NHSE to match these costs.

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	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
	£m	£m	£m	£m	£m	£m	
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.

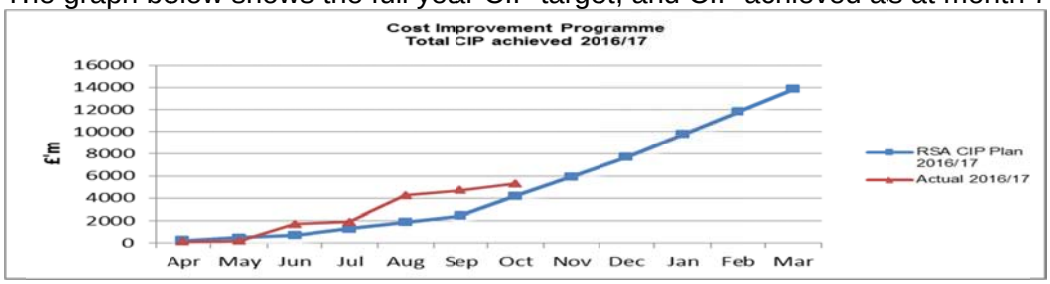
At the close of Month 7, we have cumulatively delivered £1.11m in excess of the £4.2m target. This represents a £1.16m decline in the Cumulative position, compared to last month's £2.27 cumulative surplus. This is predominantly due to a stepped increase in way the £13.9m current year CIP budget is phased 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

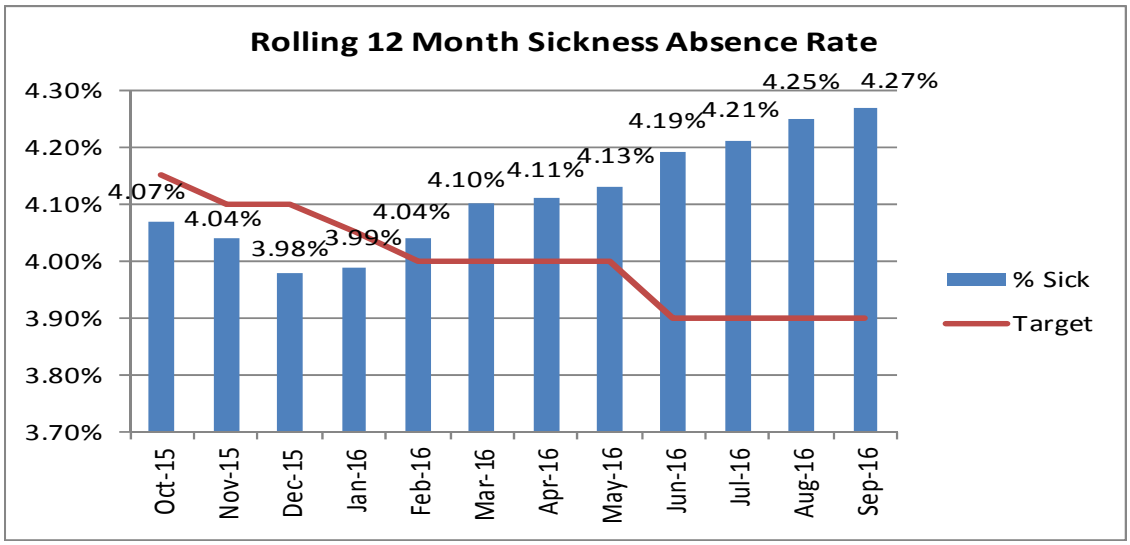
Performance against a wide range of workforce key performance indicators is reported at service delivery unit and department level to all managers. These key performance indicators are subject to review at the Trusts performance review meetings and with HR Managers. **Appendix 4** provides a detailed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

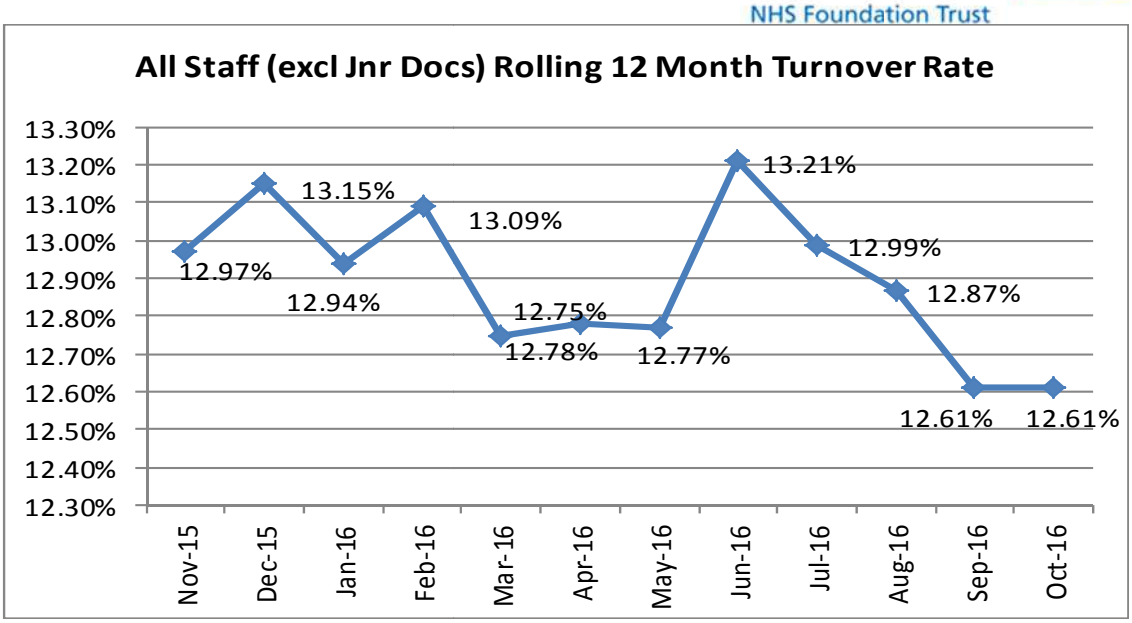
The graph below shows that the annual rolling sickness absence rate of 4.27% at the end of September 2016 represents a continuing upward trend. The target the Trust set itself was 3.90% for the end of September 2016. The rate for the month of September 2016 on its own was 4.02%, compared to 4.12% in 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

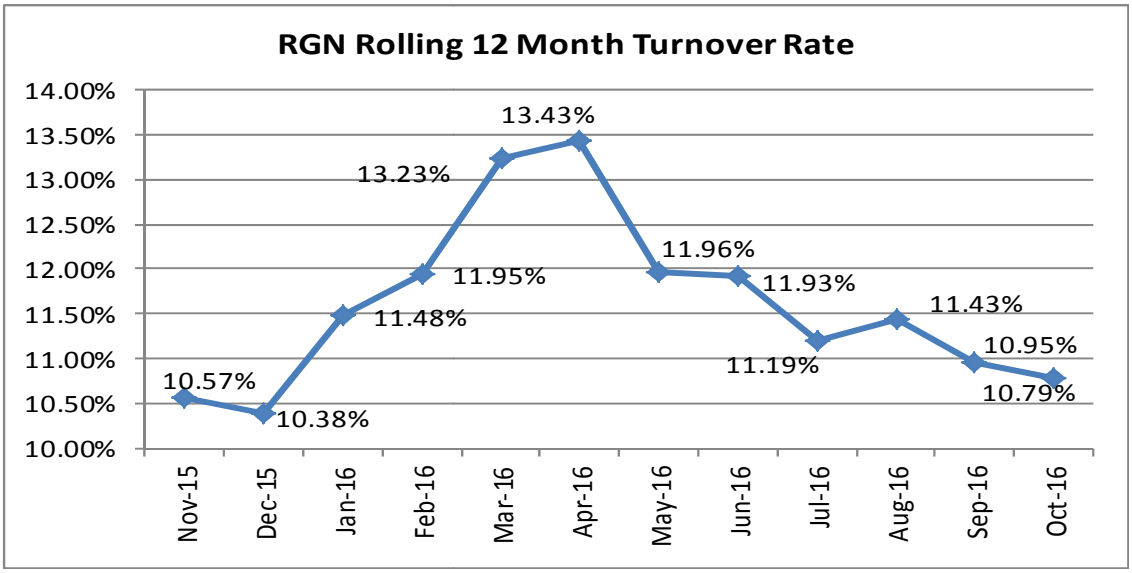


7.3 Turnover (excluding Junior Doctors)
RAG RATING: GREEN

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.

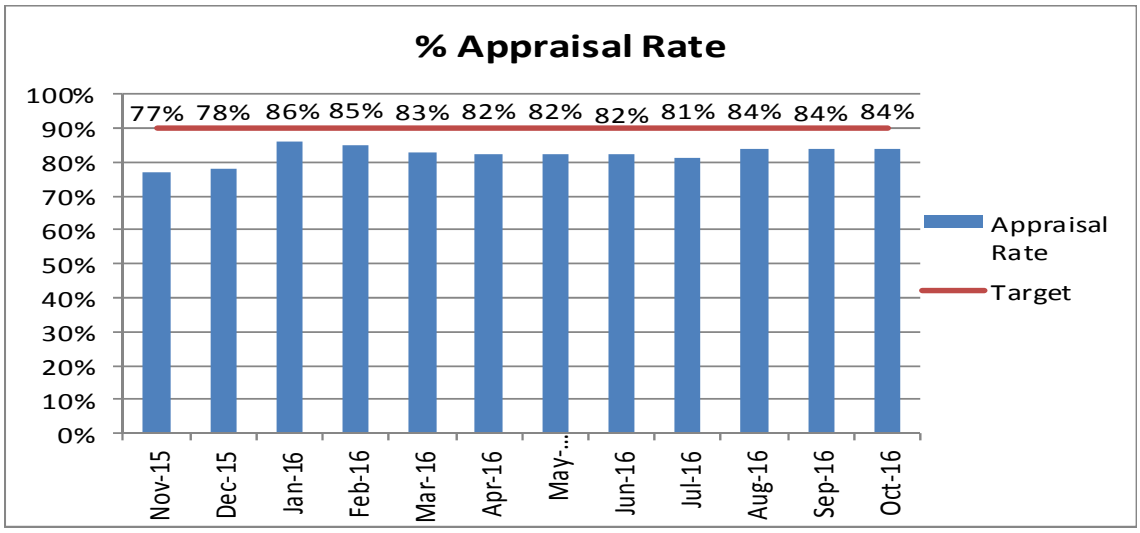


7.4 Appraisal Rate

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.



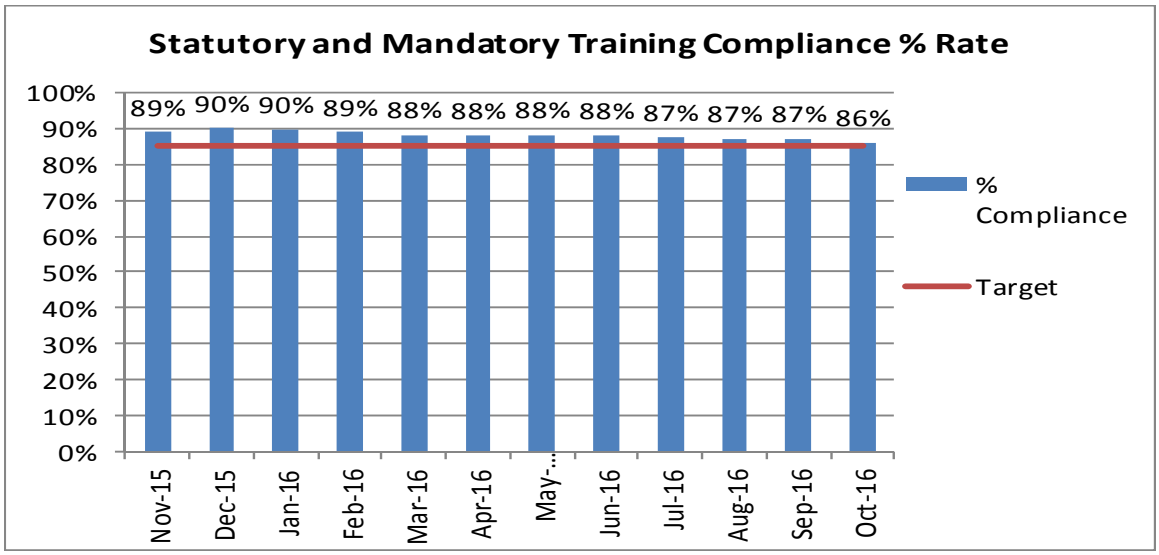
7.5 Statutory and mandatory training Compliance

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

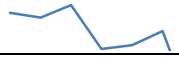
Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

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 cummulitive year to date indicators, the RAG rating is based on the monthly average

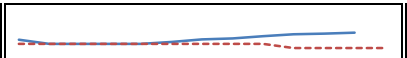
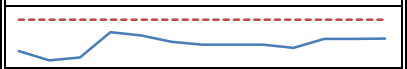
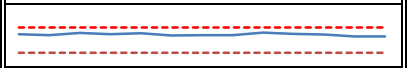
** The Governance rating score is assessed against the number of failed indicators in accordance with the Risk Assurance Framework. A score of 4 or over will trigger a RED rating. Any individual indicator failed for 3 consecutive months can trigger a status of governance concern leading to potential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

Corporative Objective		Target 2016/2017	13 month trend	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

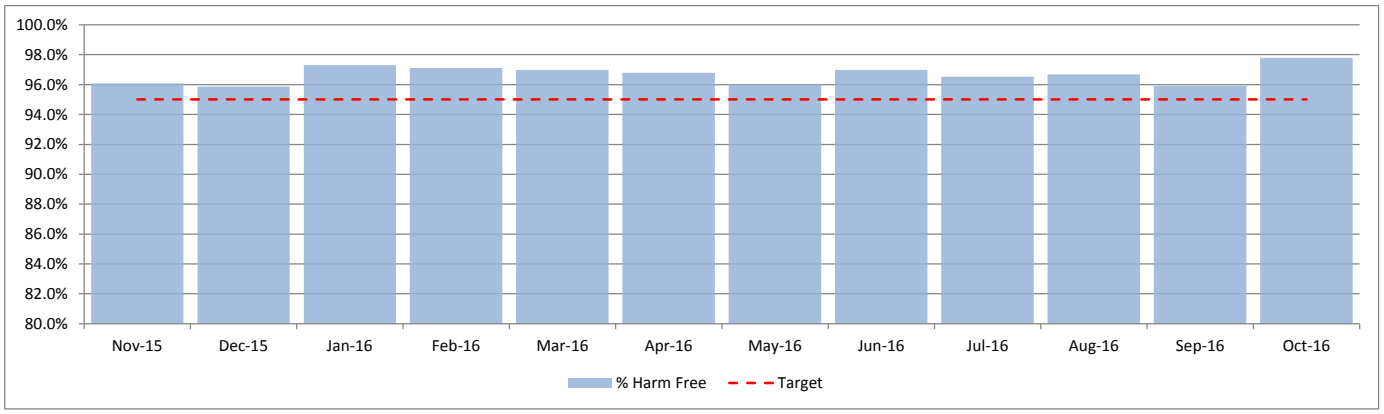
QUALITY FRAMEWORK

Month 7 October 2016

QUALITY FRAMEWORK

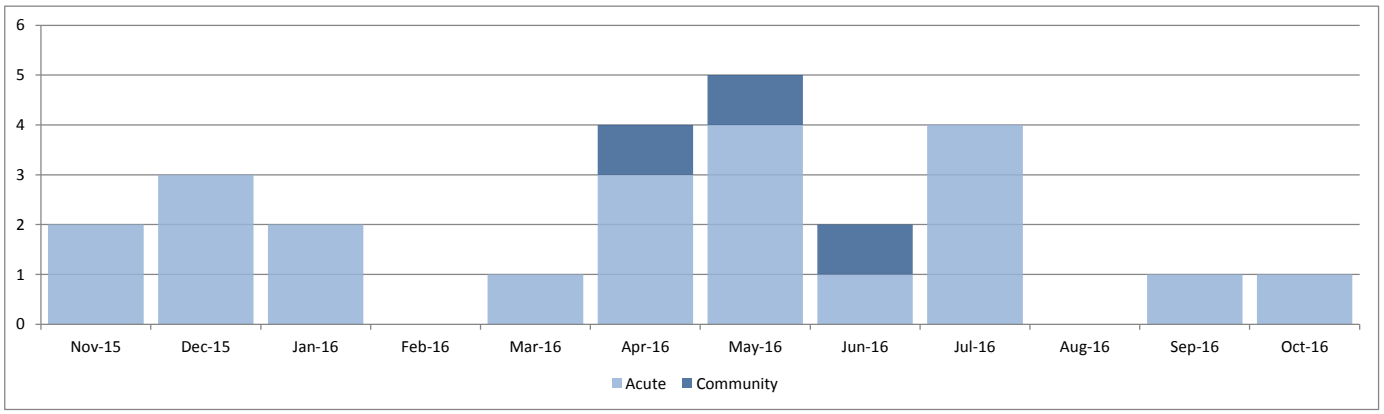
Harm Free - Trust Total

	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%



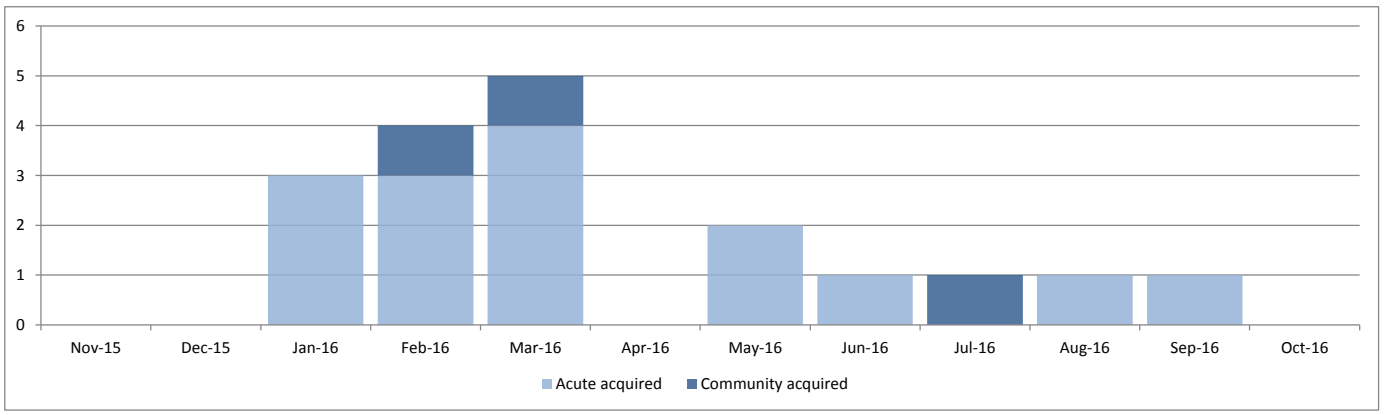
Reported Incidents - Major and Catastrophic

	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)

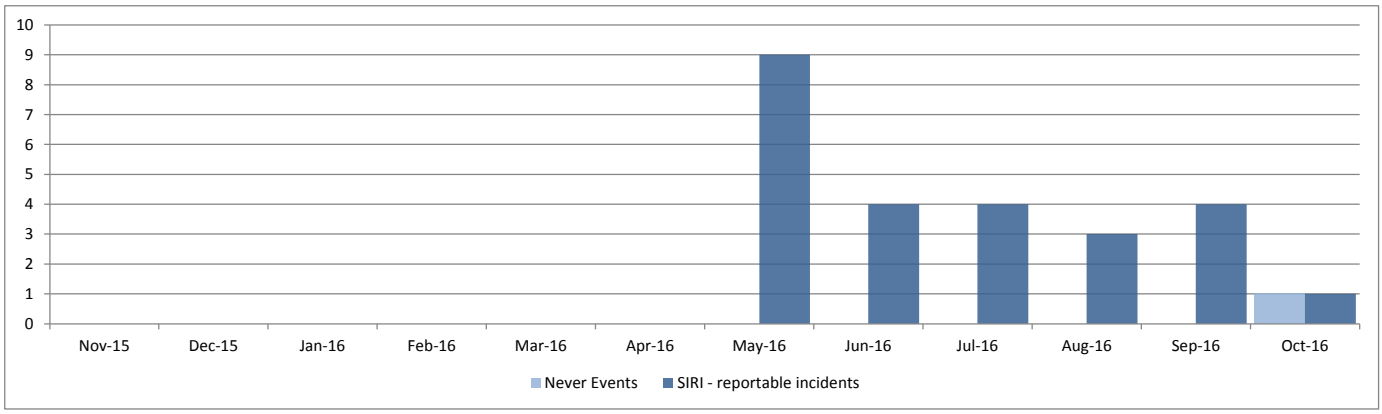
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute acquired	0	0	3	3	4	0	2	1	0	1	1	
Community acquired	0	0	0	1	1	0	0	0	1	0	0	



QUALITY FRAMEWORK

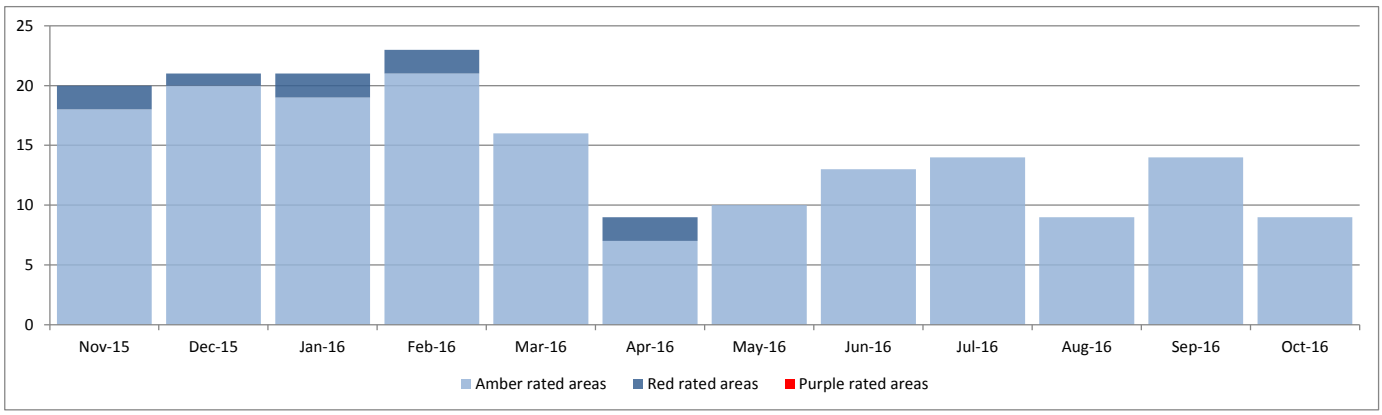
Never events & SIRI

	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



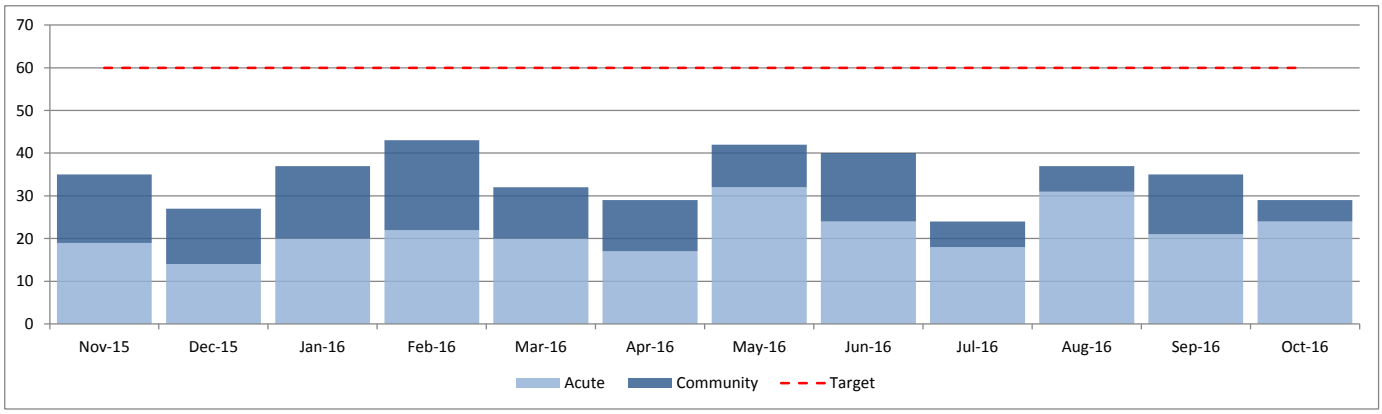
Quality Effectiveness Safety Trigger Tool (QUEST)

	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

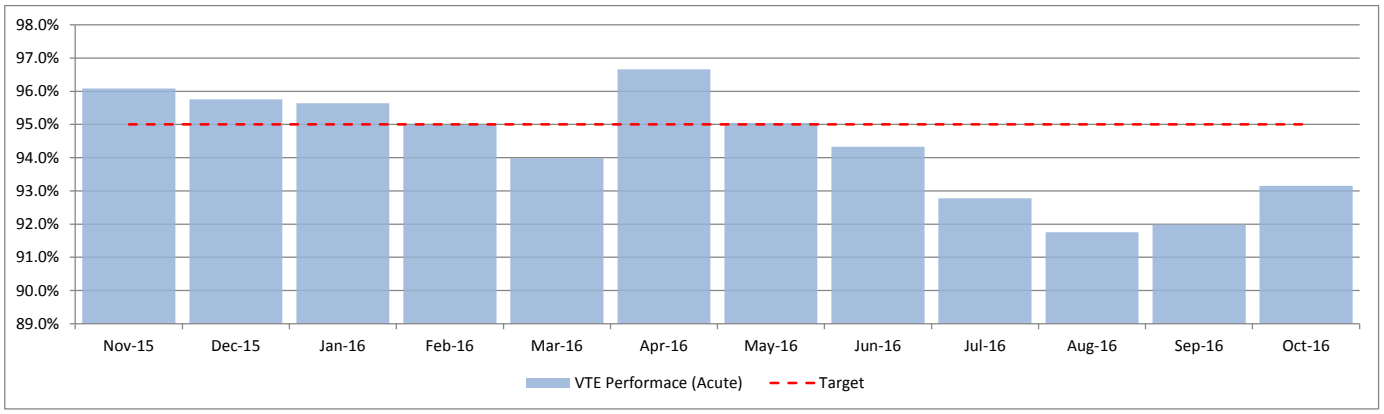
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	19	14	20	22	20	17	32	24	18	31	21	24
Community	16	13	17	21	12	12	10	16	6	6	14	5
Total	35	27	37	43	32	29	42	40	24	37	35	29
Target	60	60	60	60	60	60	60	60	60	60	60	60



QUALITY FRAMEWORK

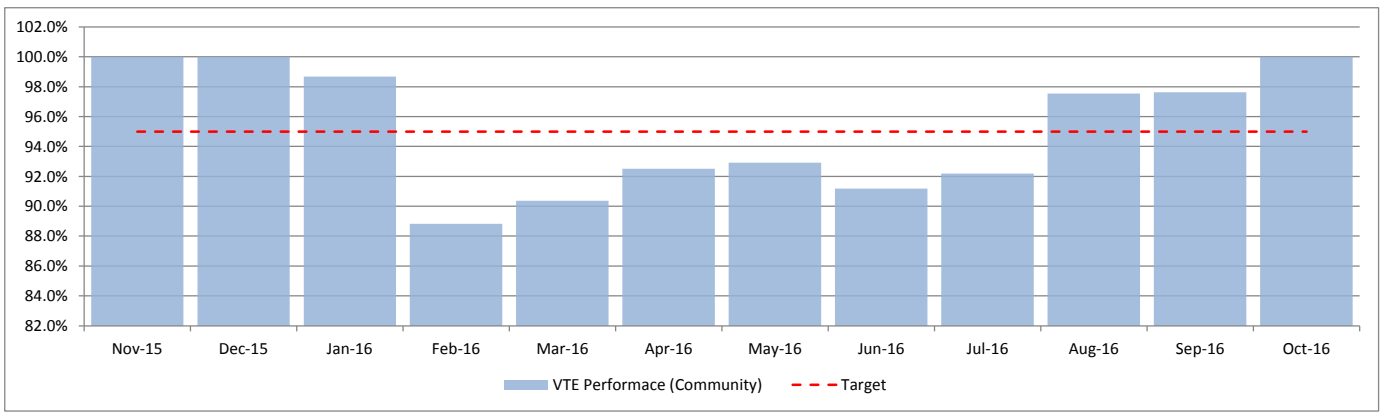
VTE Risk assessment on admission - (Acute)

	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%



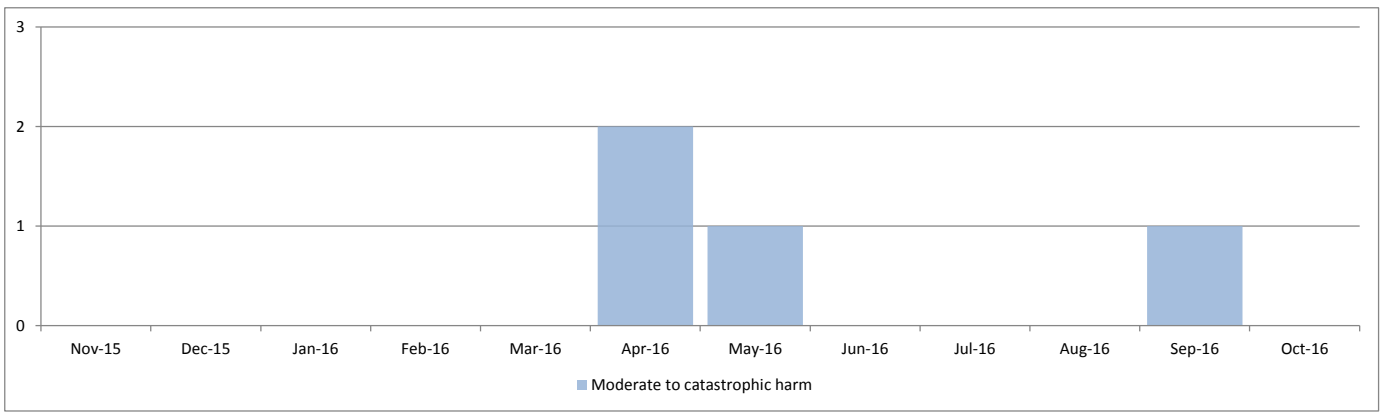
VTE Risk assessment on admission - (Community)

	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

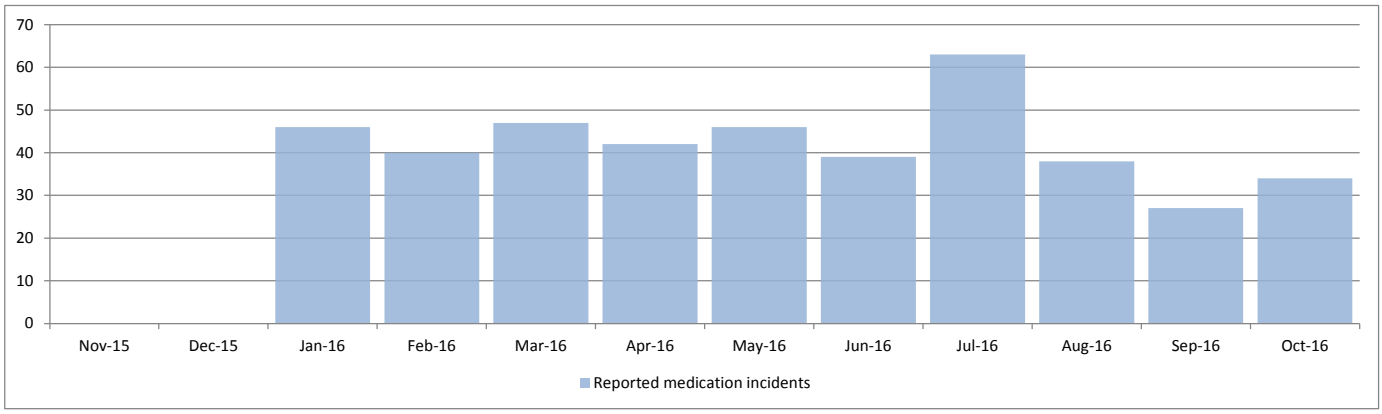
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Moderate to catastrophic harm	n/a	n/a	0	0	0	2	1	0	0	0	1	0



QUALITY FRAMEWORK

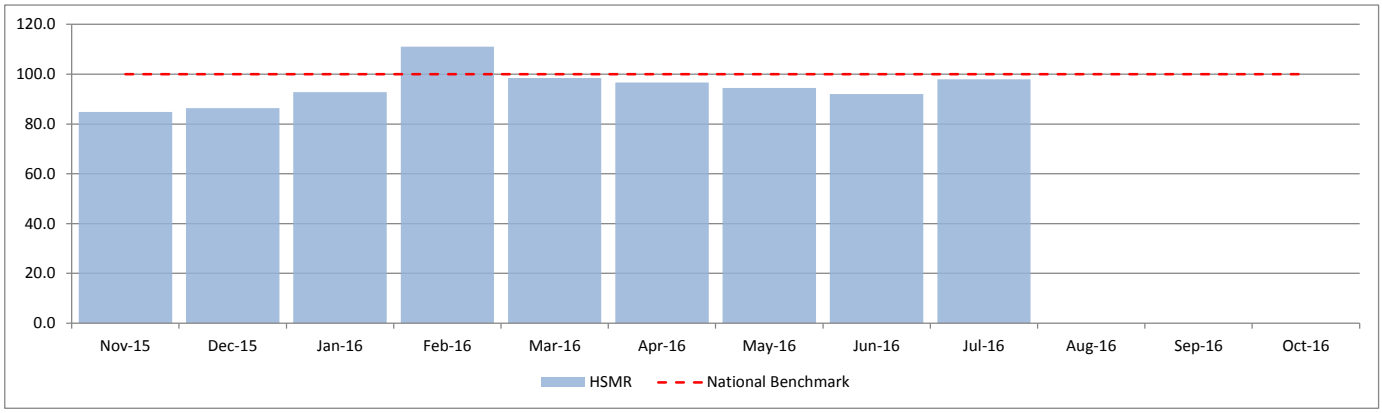
Medication Errors - Reported incidents (trust at fault)

	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



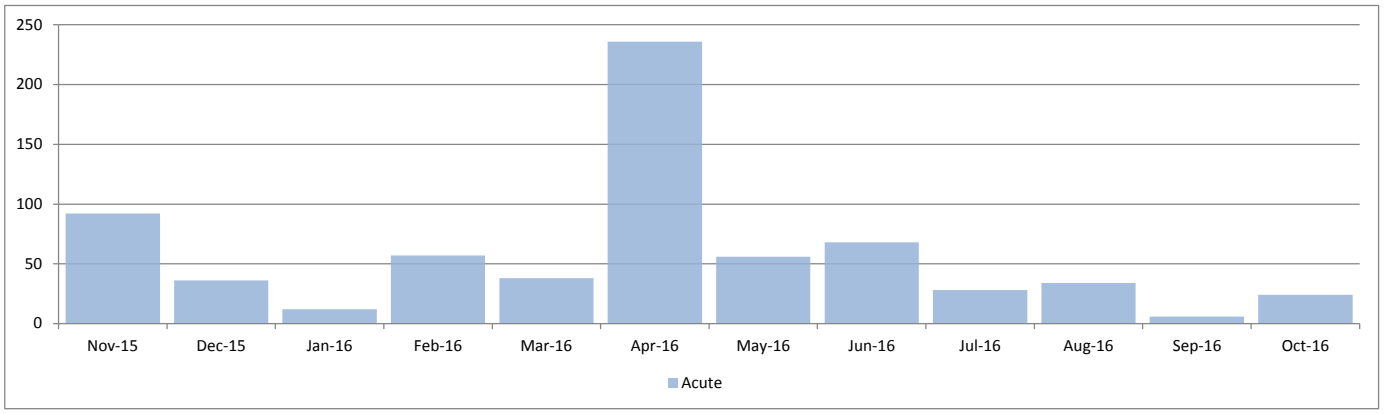
Safer Staffing Levels

	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

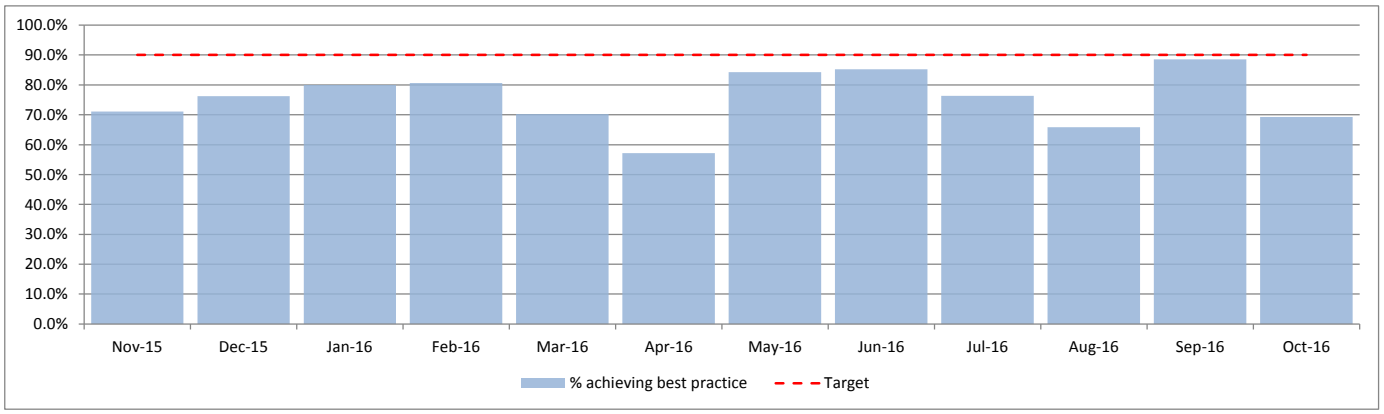
Infection Control - Bed Closures (acute)

	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



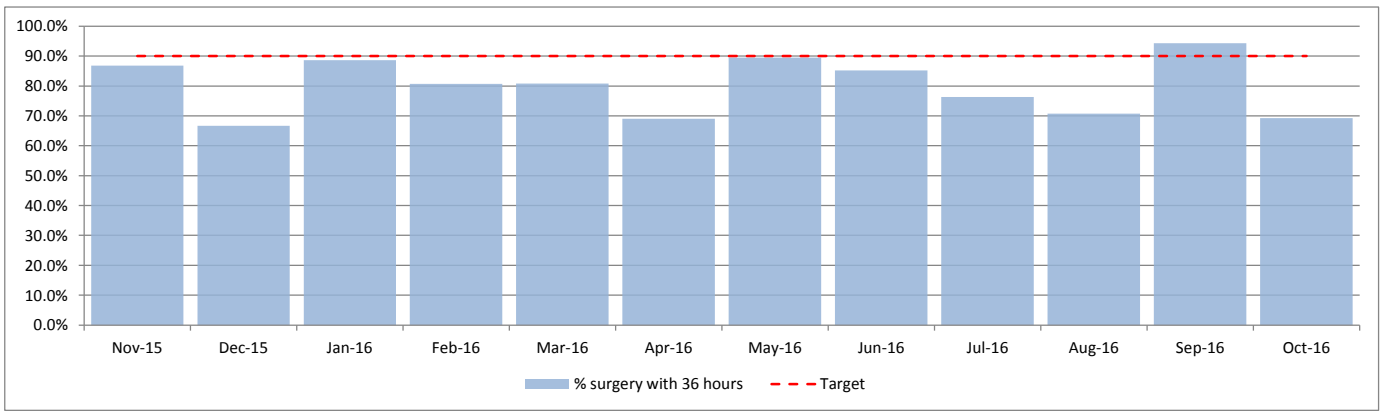
Fracture Neck of Femur - Best tariff assessment

	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

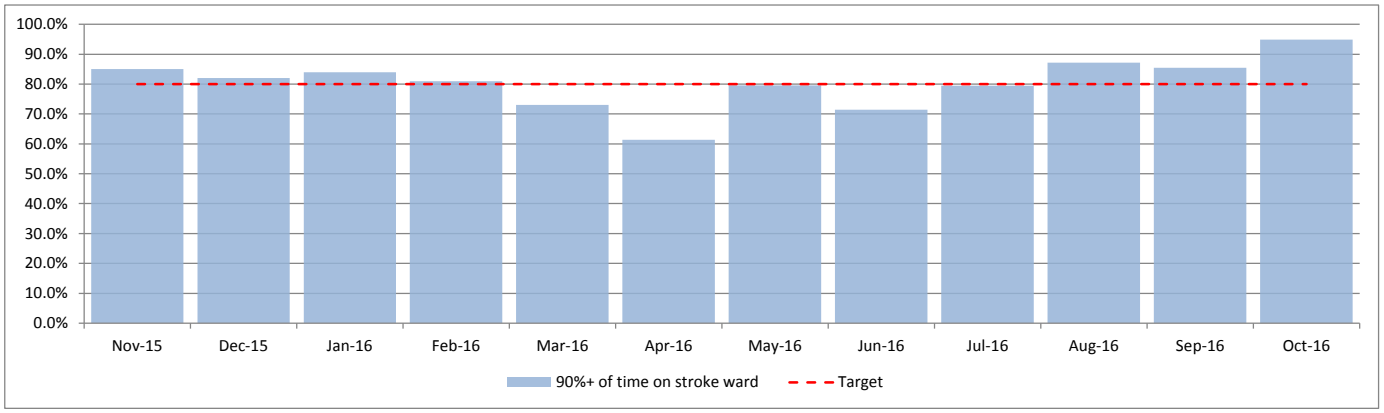
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Patients	38	42	35	31	47	42	38	27	38	41	35	26
Surgery with 36 hours	33	28	31	25	38	29	34	23	29	29	33	18
% surgery with 36 hours	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.3%	69.2%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



QUALITY FRAMEWORK

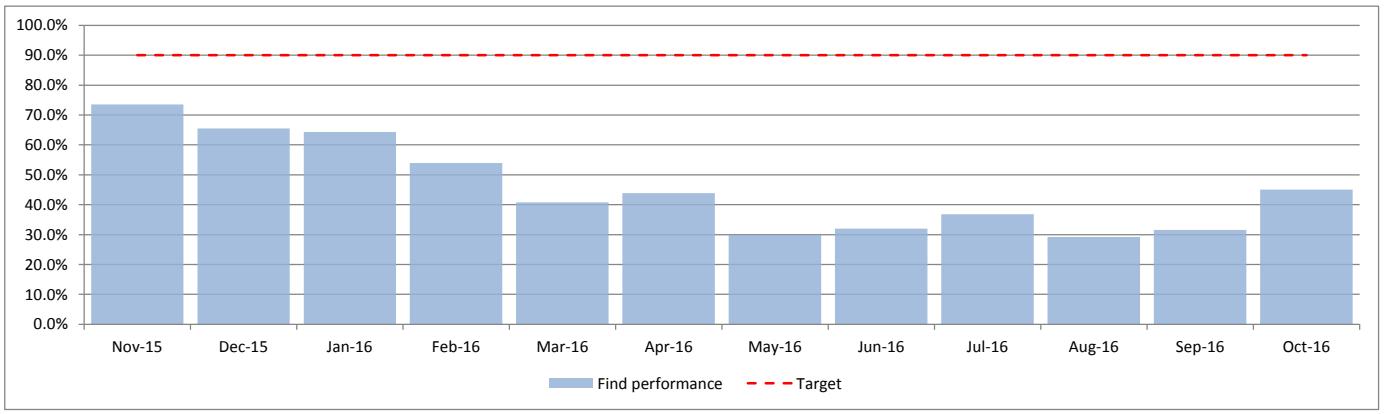
Stroke

	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%



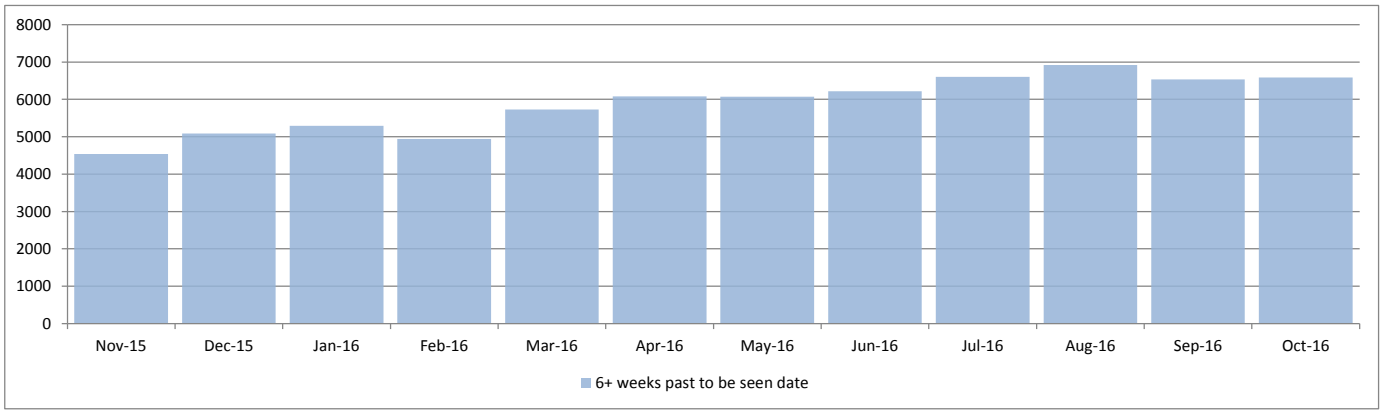
Dementia - Find

	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



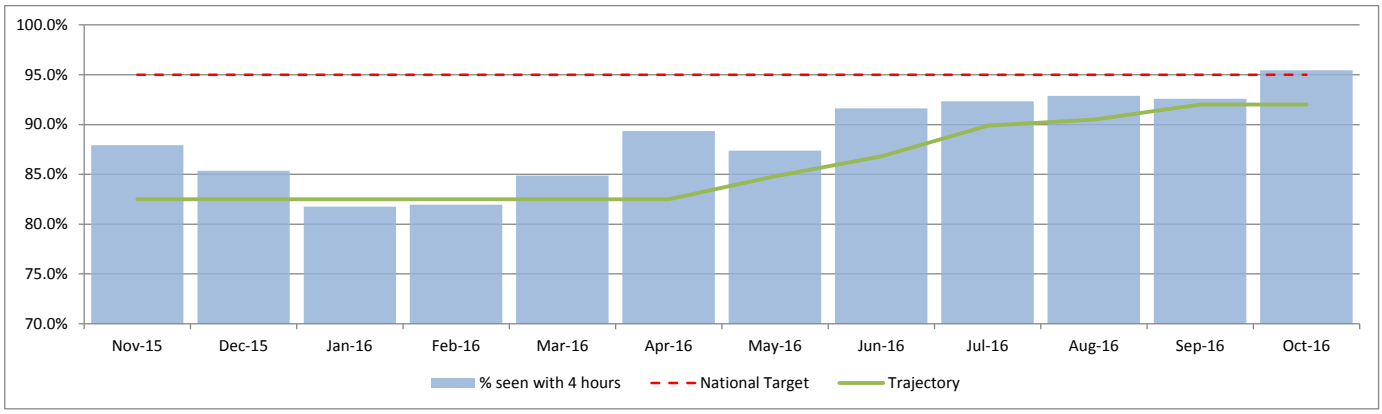
NHS I COMPLIANCE FRAMEWORK

Month 7 October 2016

NHS I COMPLIANCE FRAMEWORK

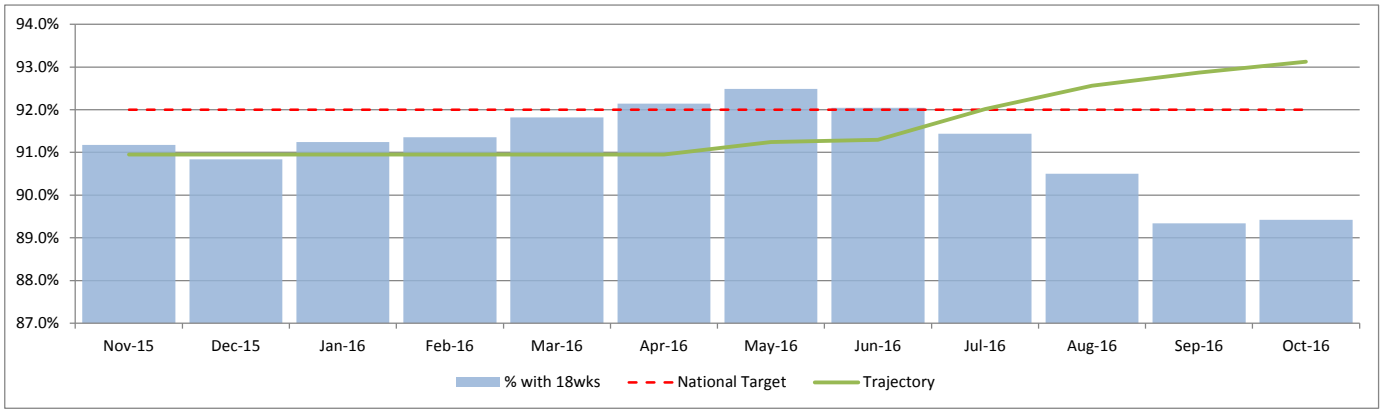
A&E and MIU patients seen within 4 hours

	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%



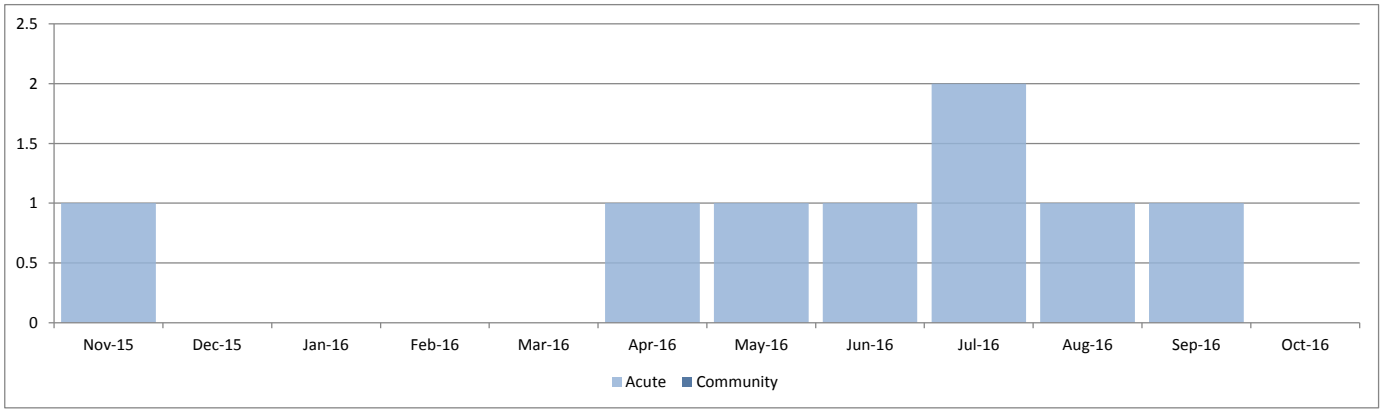
Referral to Treatment - Incomplete pathways

	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

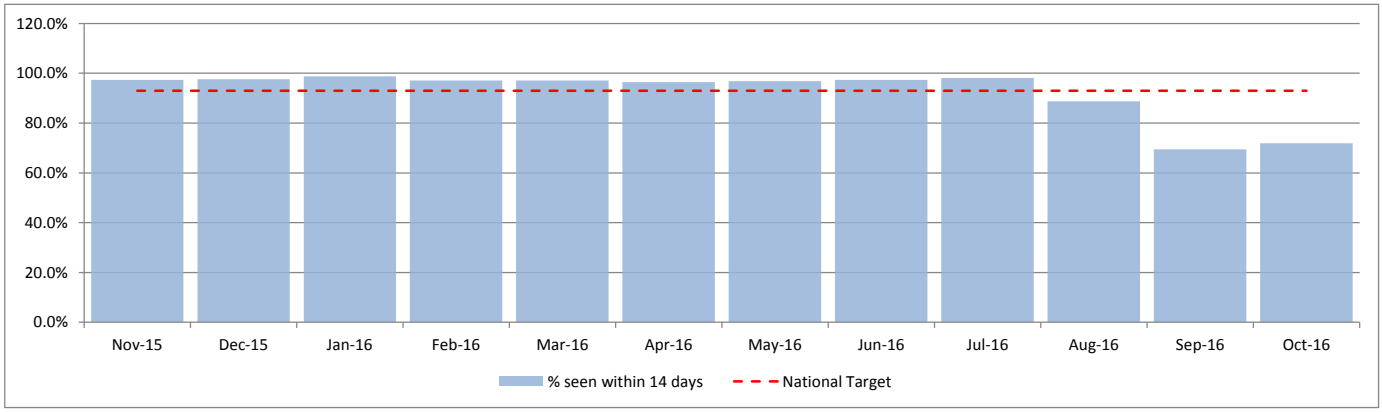
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	1	0	0	0	0	1	1	1	2	1	1	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



NHS I COMPLIANCE FRAMEWORK

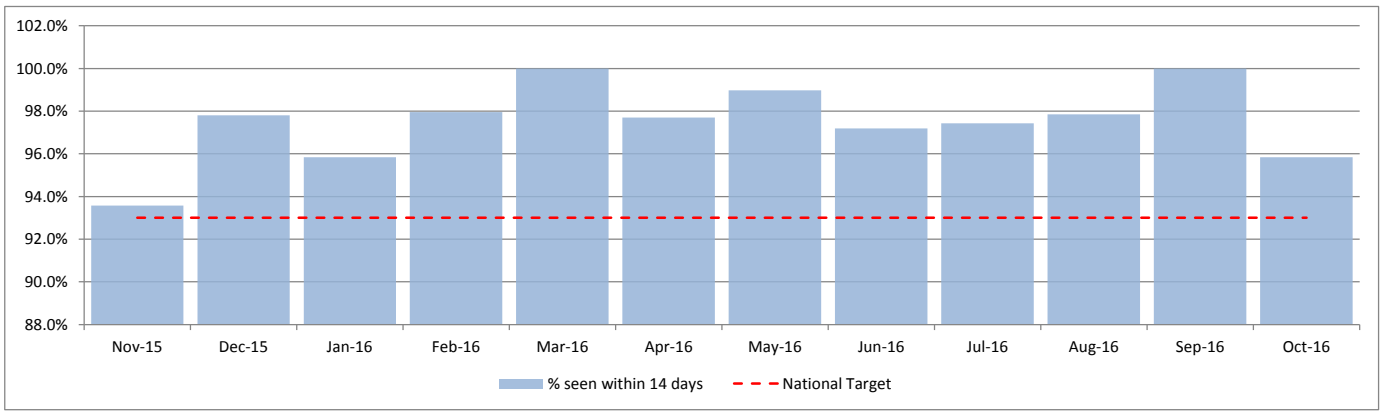
Cancer - Two Week Wait Referrals

	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%



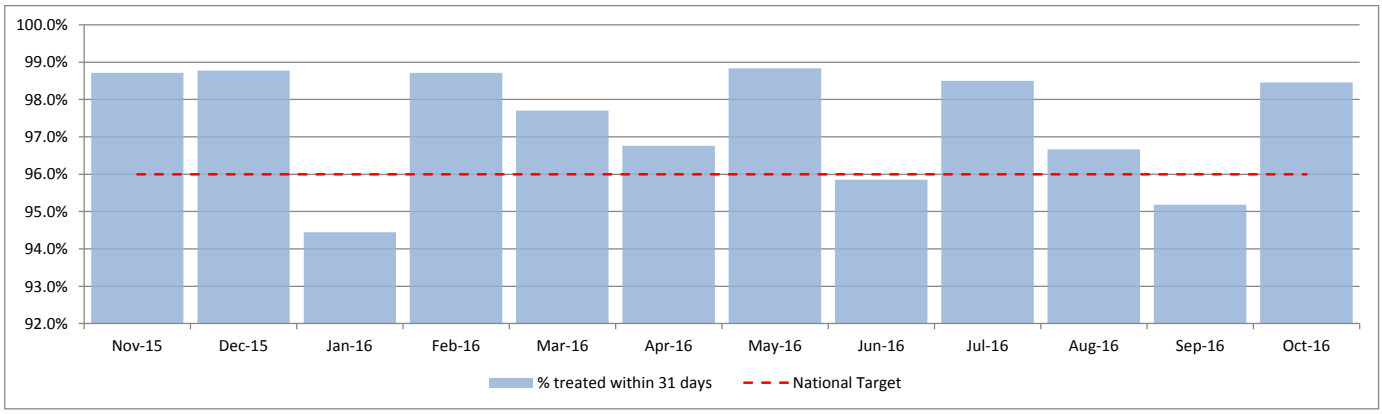
Cancer - Breast Symptomatic Referrals

	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

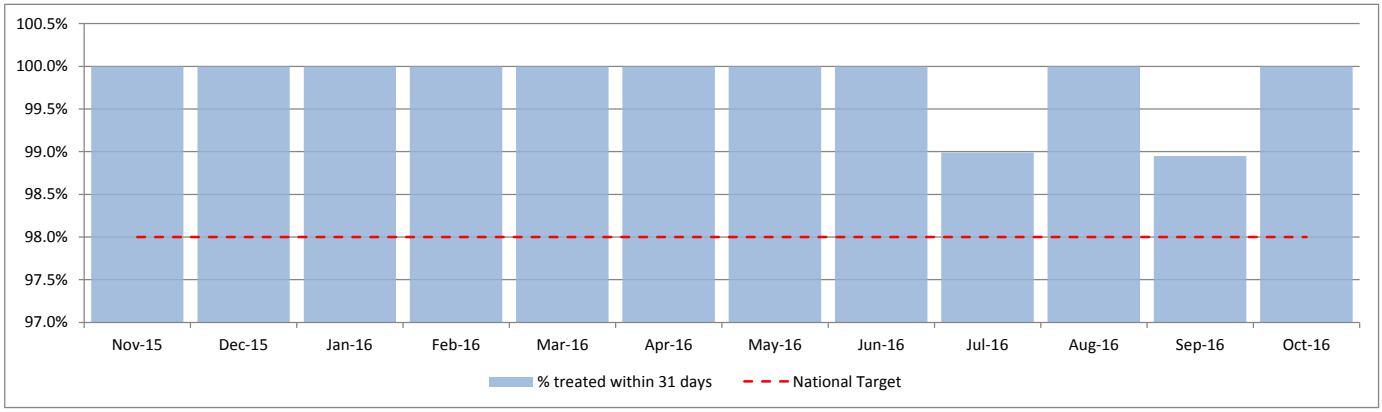
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
1st treatments	156	163	162	155	174	185	172	193	200	180	166	194
Breaches of 31 day target	2	2	9	2	4	6	2	8	3	6	8	3
% treated within 31 days	98.7%	98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	95.2%	98.5%
National 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

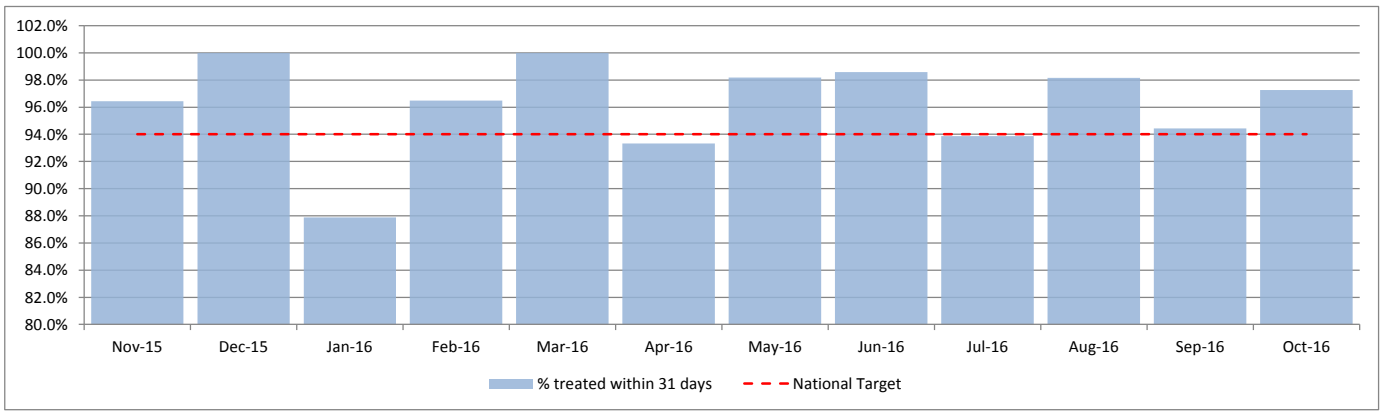
Cancer - 31 day wait for second or subsequent treatment - Drug

	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%



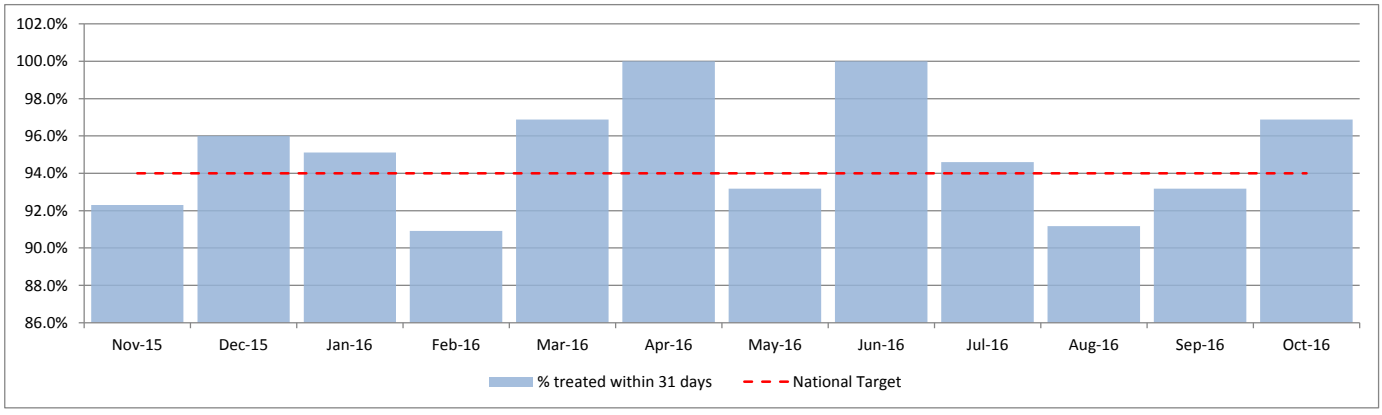
Cancer - 31 day wait for second or subsequent treatment - Radiotherapy

	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

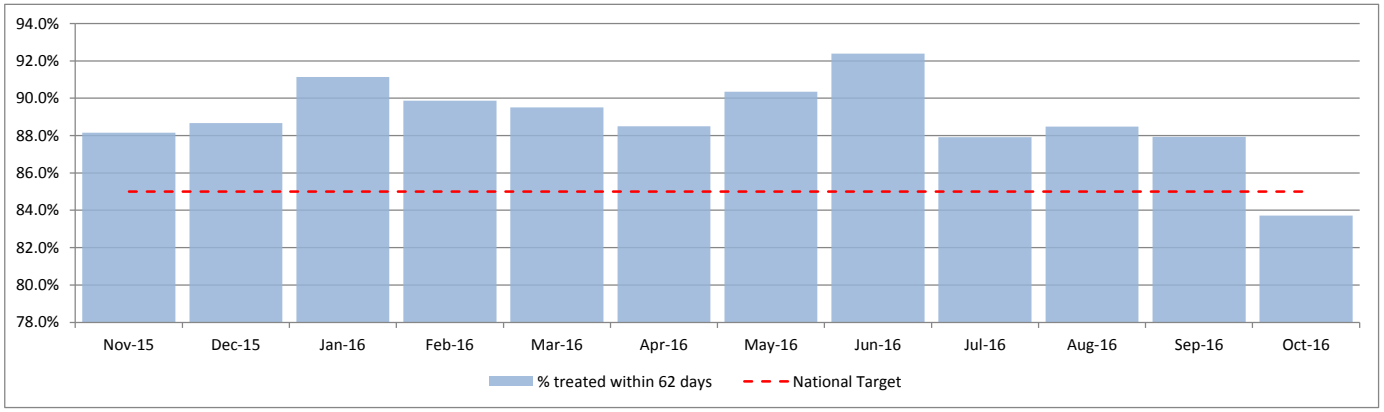
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Subsequent surgery treatments	39	25	41	44	32	30	44	40	37	34	44	32
Breaches of 31 day target	3	1	2	4	1	0	3	0	2	3	3	1
% treated within 31 days	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	96.9%
National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

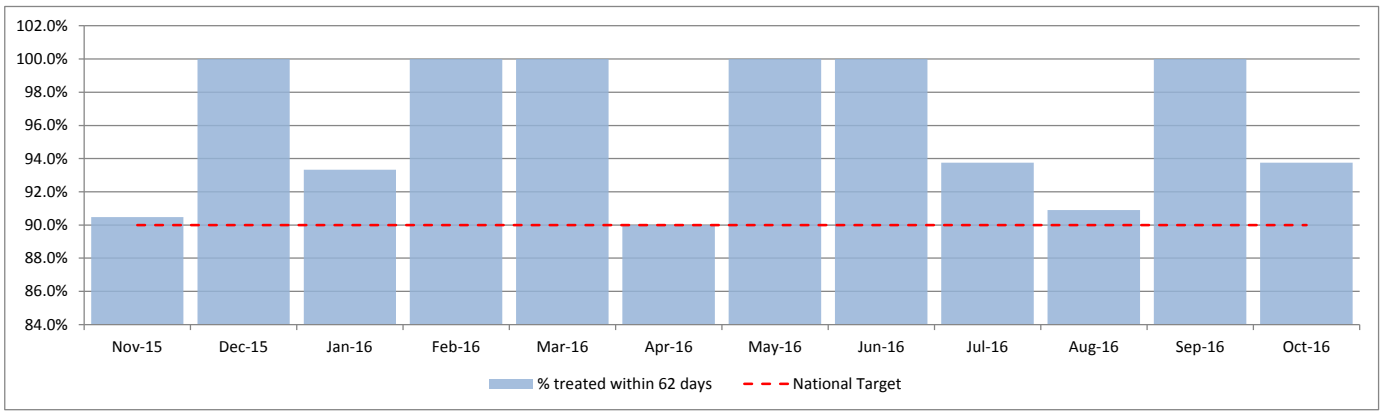
Cancer - 62 day wait for 1st treatment from 2ww referral

	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

Month 7 October 2016

Income Analysis **Schedule 1**

	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**	↑

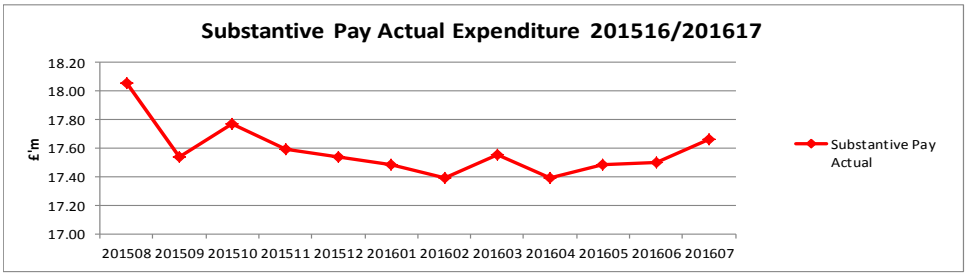
Risk Share Income							
	£m	£m	£m	£m	£m	£m	
Risk Share Income	0.00	5.84	5.84	5.05	0.78	(0.23)	↑
Total	**0.00**	**5.84**	**5.84**	**5.05**	**0.78**	**(0.23)**	↑

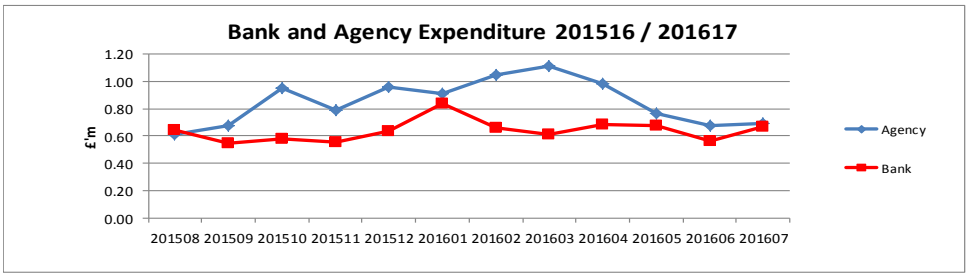
	Year to Date - Month 06			Plan Changes		Previous Month	
Memo	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
CCG Block adjustment							
	£m	£m	£m	£m	£m	£m	
CCG Block adjustment	0.00	(6.91)	(6.91)	(4.41)	(2.50)	(2.04)	↓
Total	**0.00**	**(6.91)**	**(6.91)**	**(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%**

ICO Actual	April	May	June	July	August	September	October	YTD 2016-17
	£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%**

Variance against Revised Ceiling	April	May	June	July	August	September	October	YTD 2016-17
	£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%**

ICO Actual	April	May	June	July	August	September	October	YTD 2016-17
	£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%**

Variance against Revised Ceiling	April	May	June	July	August	September	October	YTD 2016-17
	£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

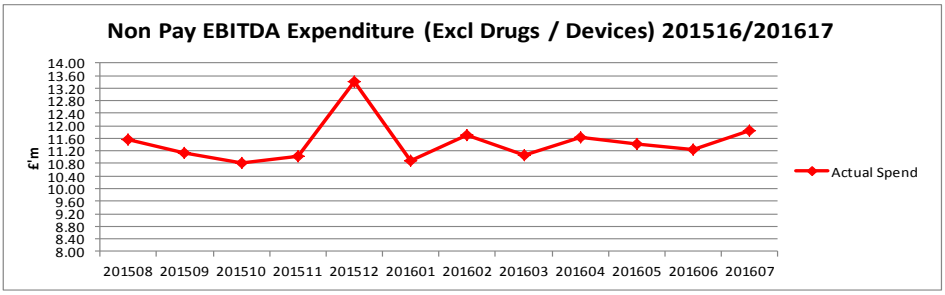
No.	Action	Lead	Date
1	Nursing agency shifts all approved by a Director	JV	ongoing
2	Medical Agency and Locum Approved by a Director	RD	ongoing
3	Recruitment processes streamlined and regular for key clinical staff	JS	Ongoing
4	Overseas Recruitment of Nursing Staff	JS/JV	in progress

Governance Arrangements
Senior Business management Team, Exec Team meetings

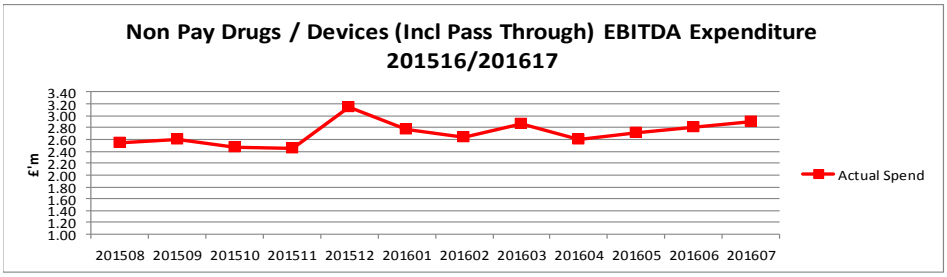
Non Pay Expenses **Schedule 4**

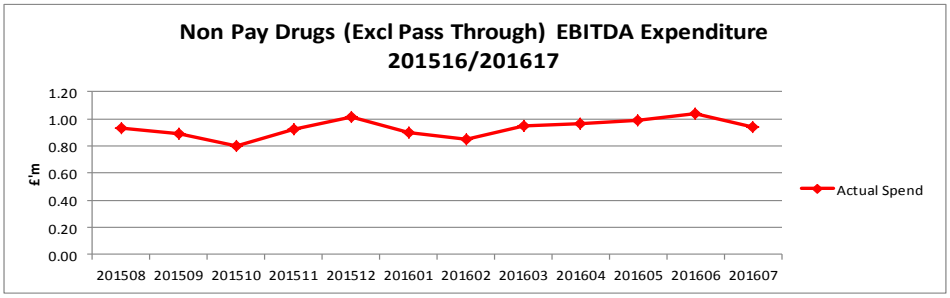
	Year to Date - Month 07			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non Pay Expenses - By Category							
Clinical Supplies	12.68	13.35	(0.67)	0.00	(0.67)	(0.50)	↑
Drugs (Excluding Pass through)	6.24	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.



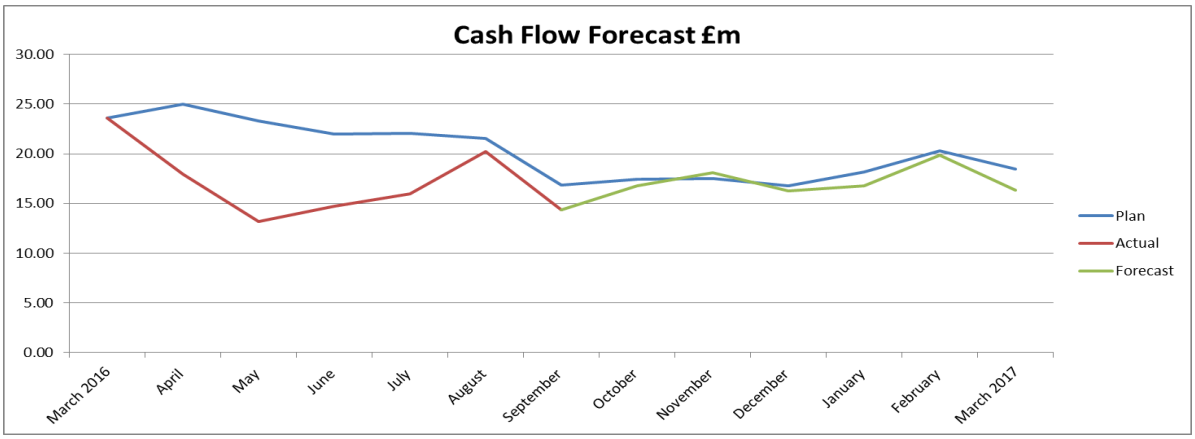


Cash Flow **Schedule 5**

	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)**

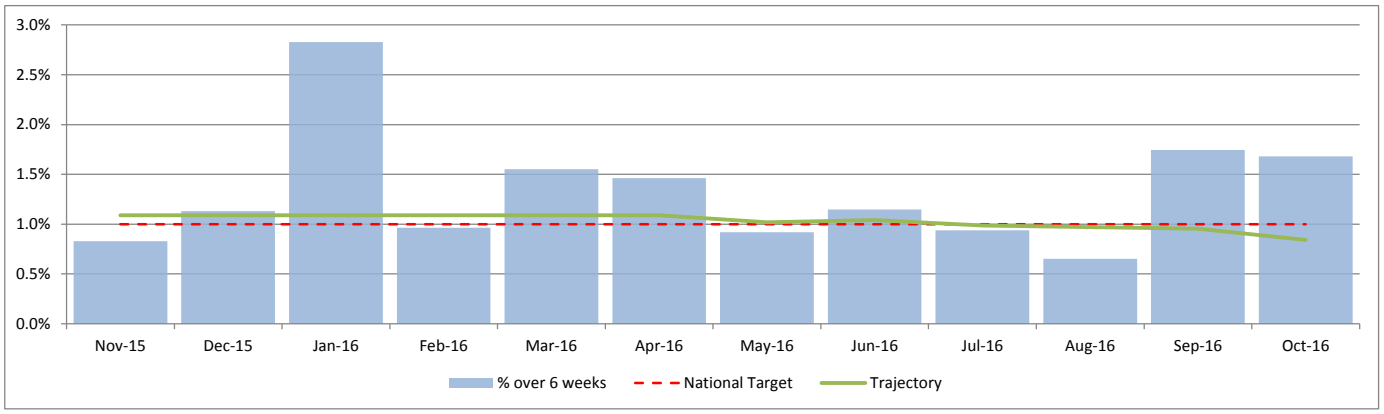
CONTRACTUAL FRAMEWORK

Month 7 October 2016

CONTRACTUAL FRAMEWORK

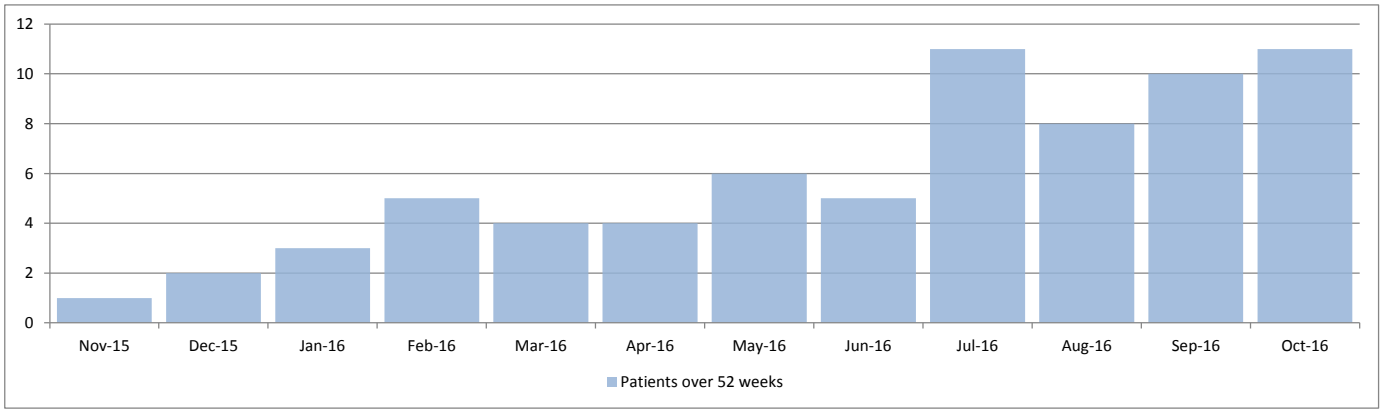
Diagnostic Tests Longer than the 6 week standard

	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%



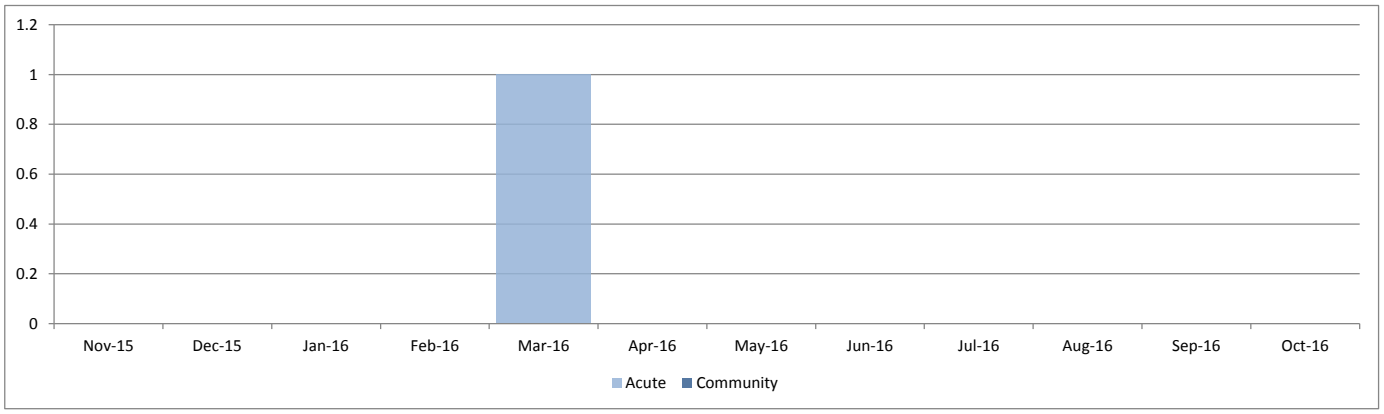
Referral to Treatment over 52 week incomplete pathways

	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

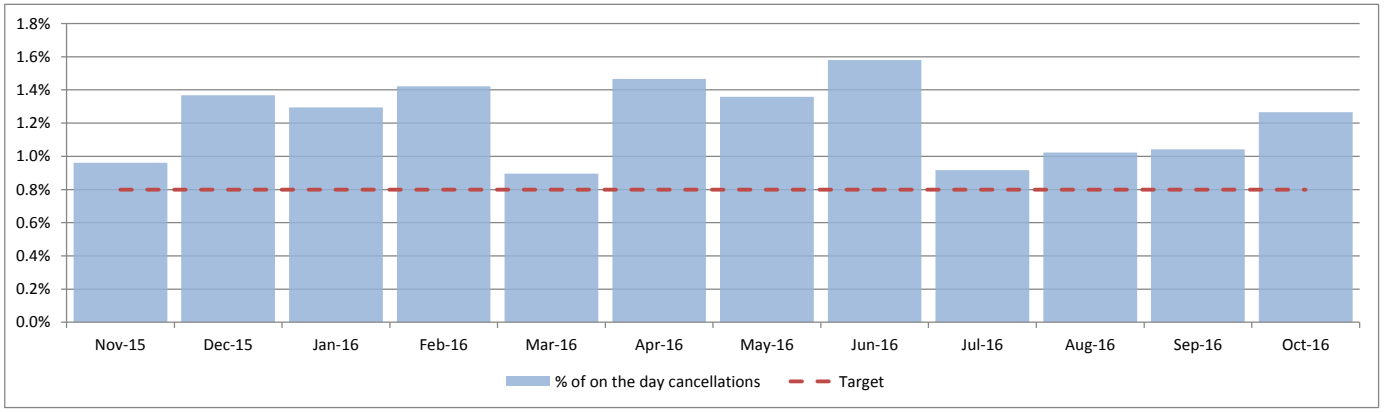
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Acute	0	0	0	0	1	0	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

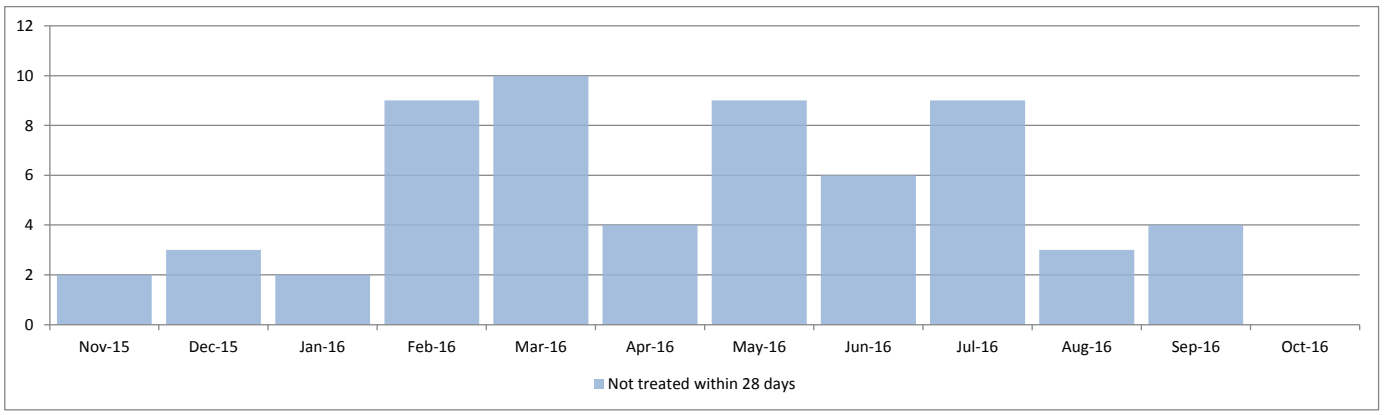
On the day cancellations for elective operations

	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%



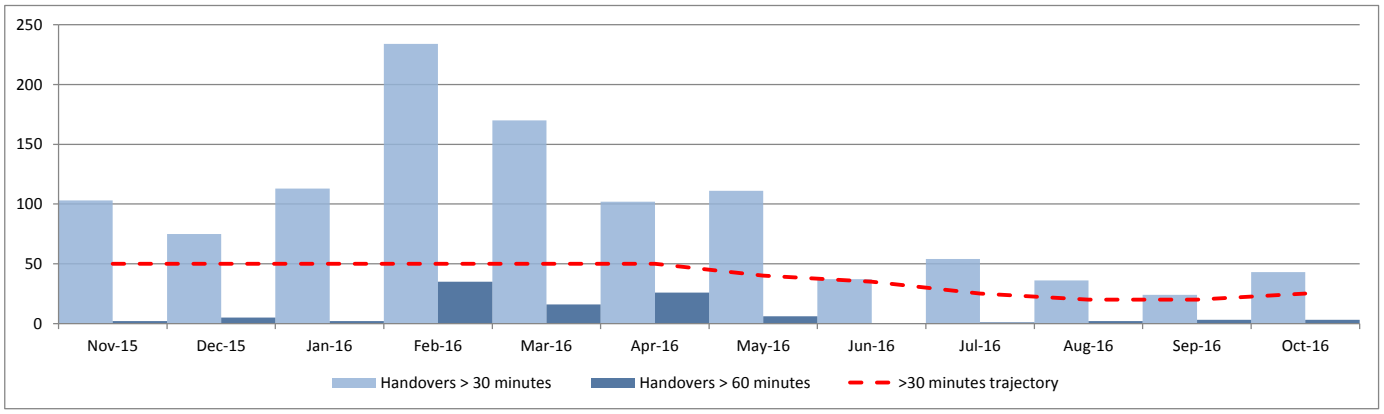
Cancelled patients not treated within 28 days of cancellation

	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

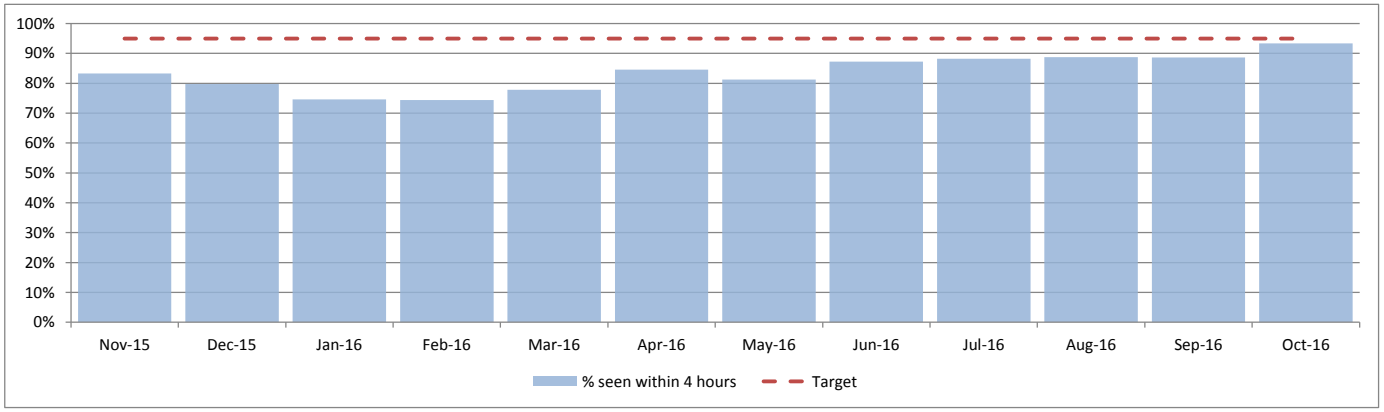
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Handovers > 30 minutes	103	75	113	234	170	102	111	37	54	36	24	43
Handovers > 60 minutes	2	5	2	35	16	26	6	0	1	2	3	3
>30 minutes trajectory	50	50	50	50	50	50	40	35	25	20	20	25



CONTRACTUAL FRAMEWORK

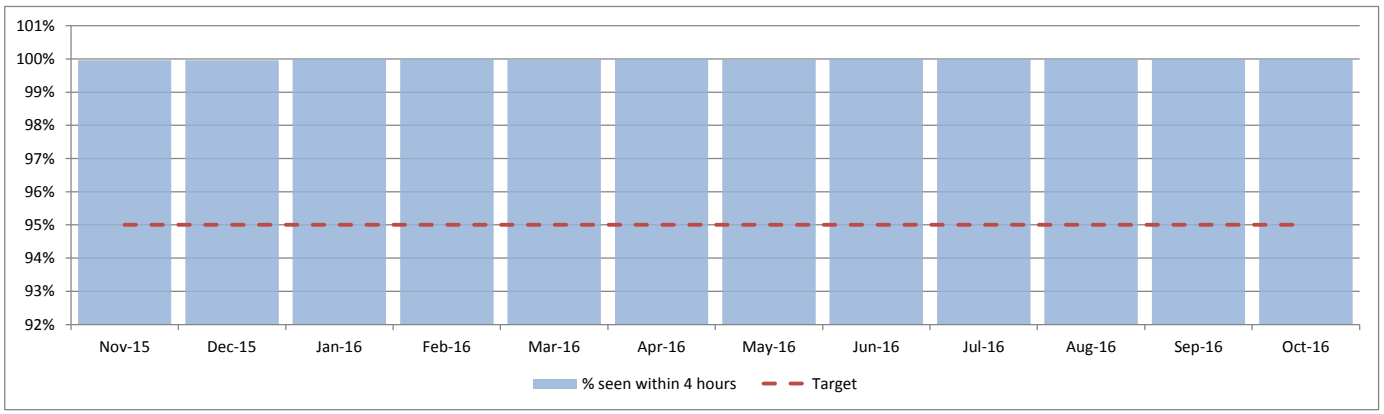
A&E patients seen within 4 hours (DGH only)

	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%



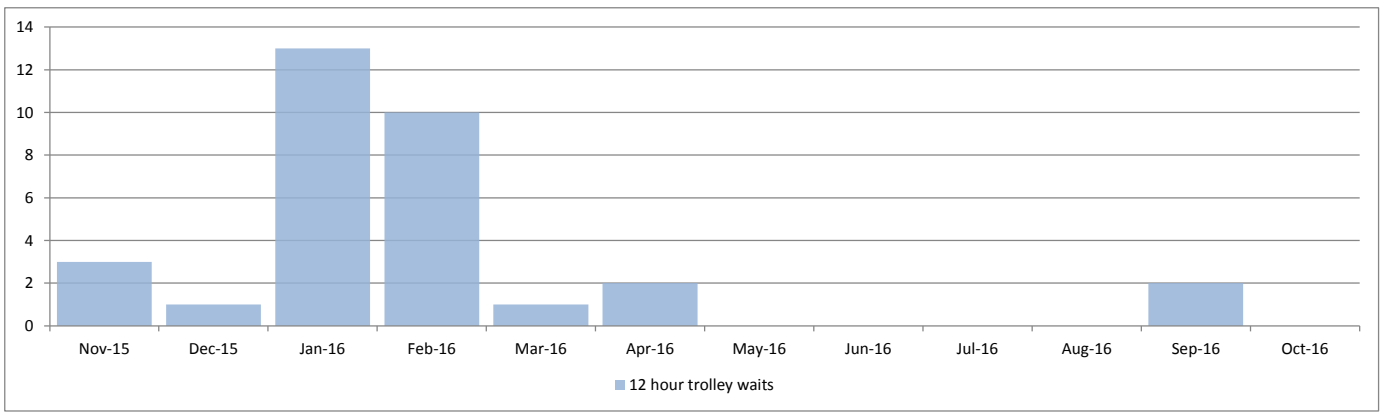
A&E patients seen within 4 hours (community MIU)

	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

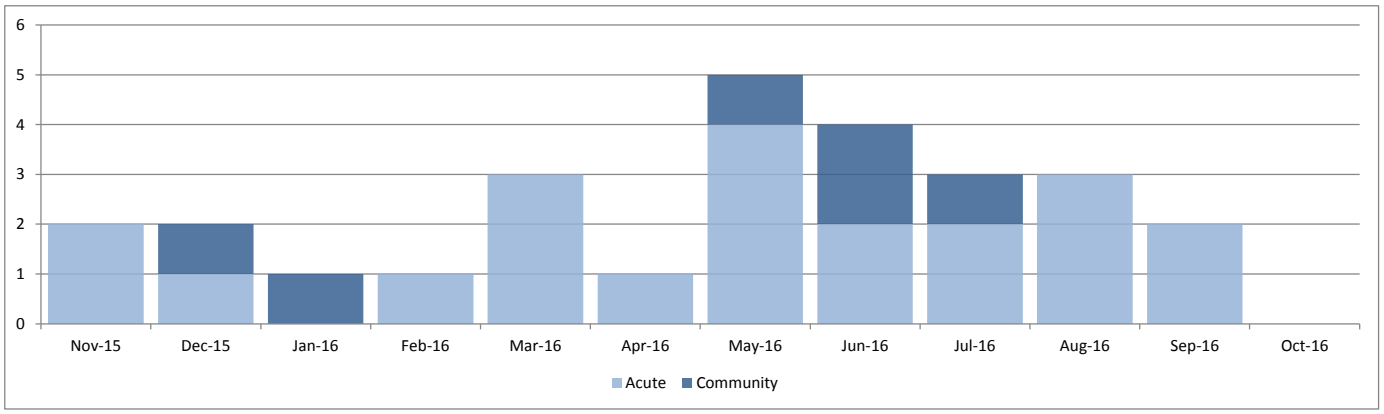
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
12 hour trolley waits	3	1	13	10	1	2	0	0	0	0	2	0



CONTRACTUAL FRAMEWORK

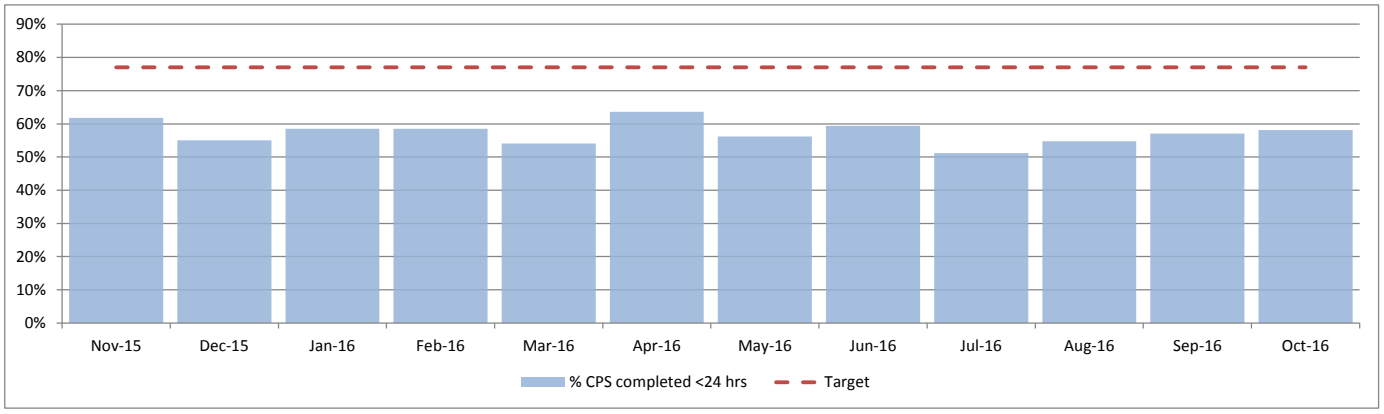
Number of Clostridium Difficile cases

	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



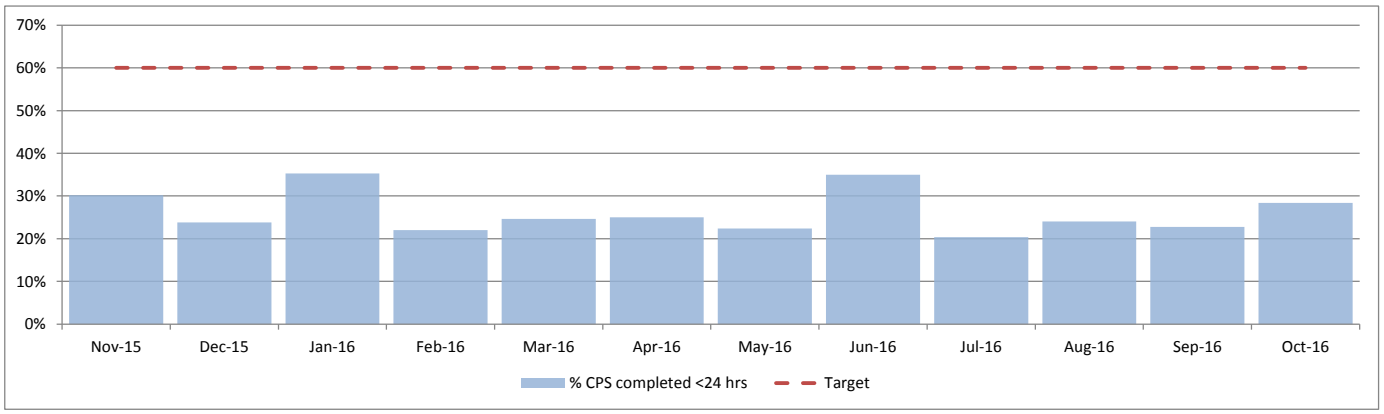
Care Plan Summaries completed with 24 hours of discharge - Weekday

	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

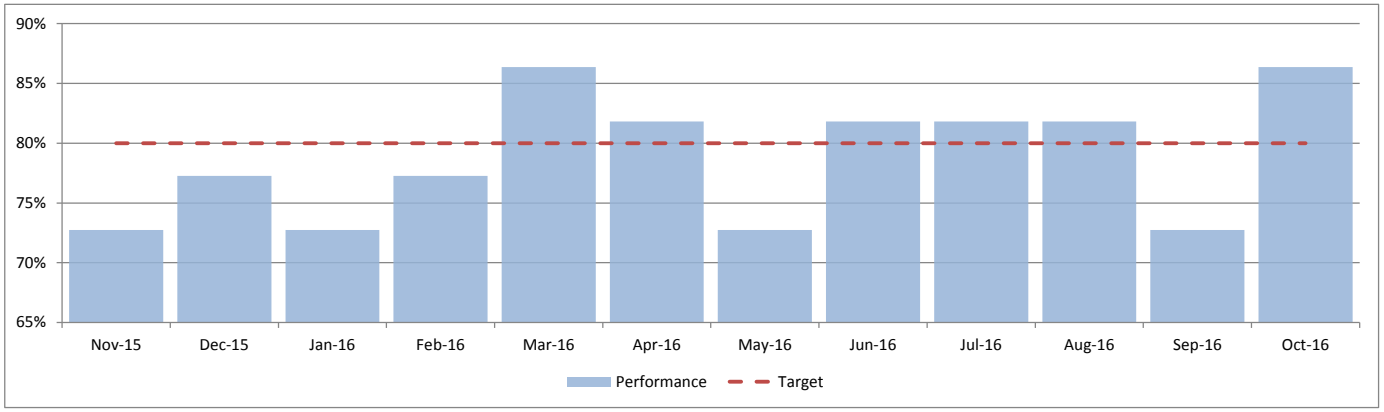
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Discharges	444	390	470	414	406	528	532	460	599	441	448	584
CPS completed within 24 hours	134	93	166	91	100	132	119	161	122	106	102	166
% CPS completed <24 hrs	30%	24%	35%	22%	25%	25%	22%	35%	20%	24%	23%	28%
Target	60.0%	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

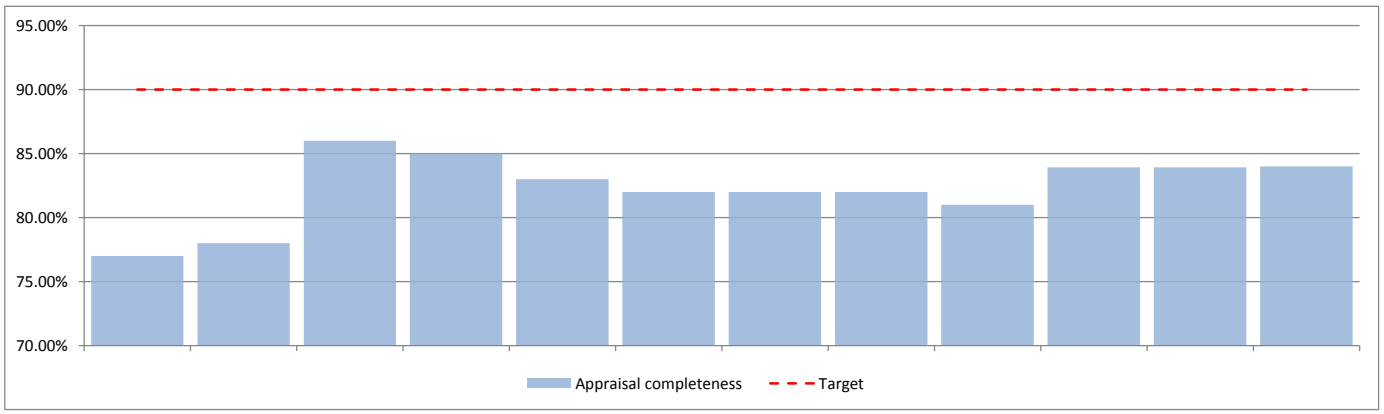
WORKFORCE MANAGEMENT FRAMEWORK

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%



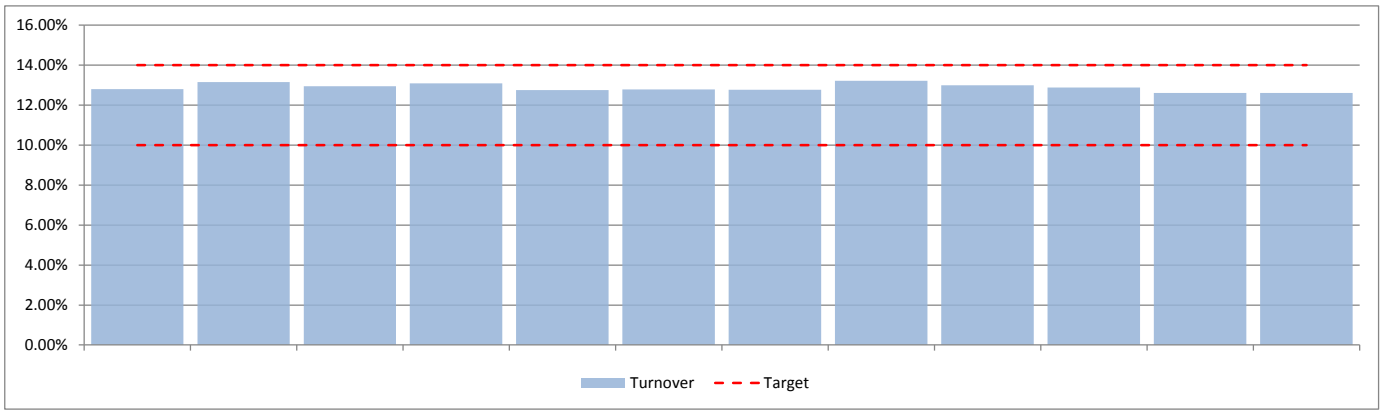
WORKFORCE MANAGEMENT FRAMEWORK

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 assumptior	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%**

Torbay and South Devon NHS
NHS Foundation Trust

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

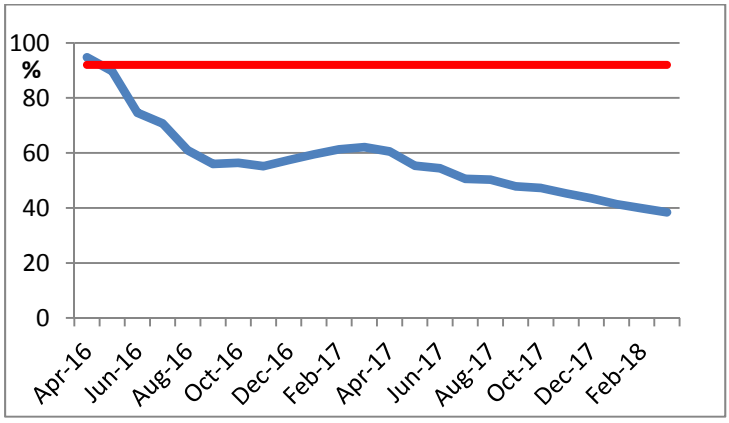
to the workforce shortfall in respiratory has also had a significant impact on their backlog which currently stands at 217 and is expected to deteriorate further with the expected loss of another consultant.

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%.

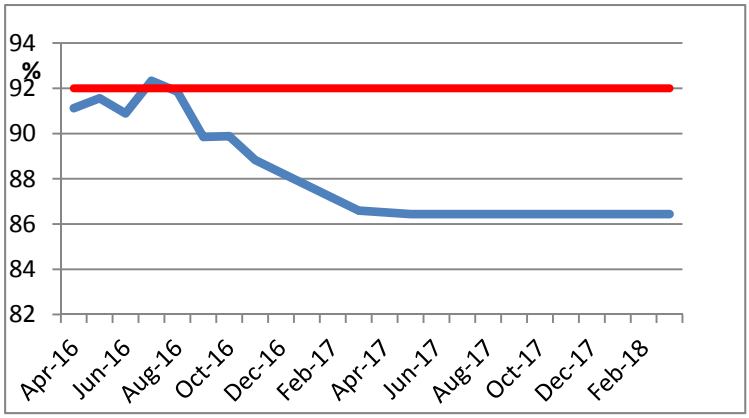
4 Risks and Issues

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

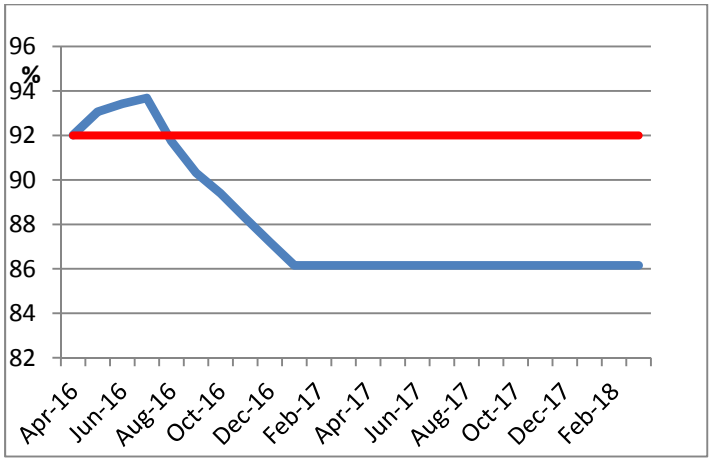
Neurology: Registrar doing 5 clinics per week until March 17 and no recruitment of other consultant.



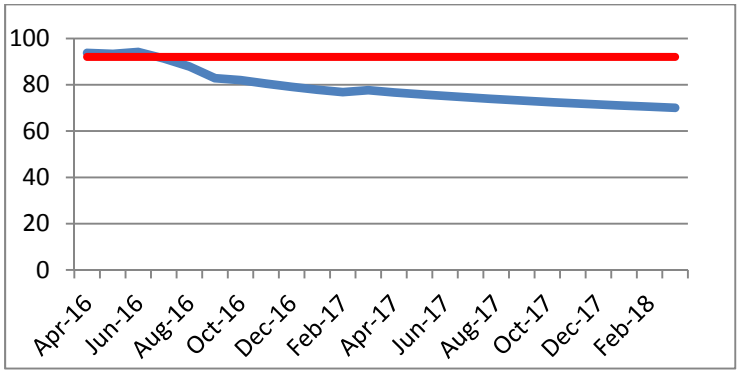
Urology: No senior core trainee - so consultants will have to drop elective work to cover on-call counter acting increase from additional consultant.



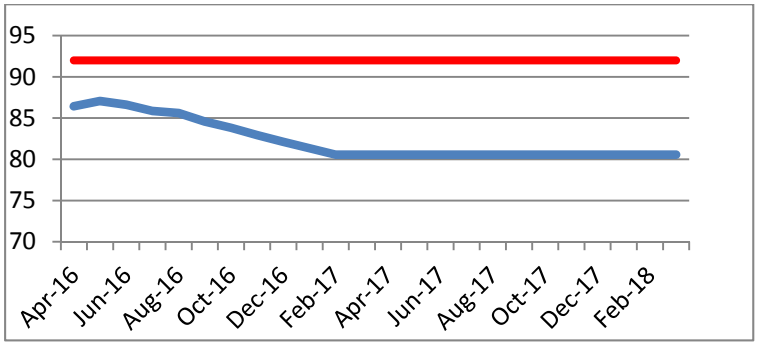
Cardiology: Consultant retirement and return on reduced hours with no other consultant recruited



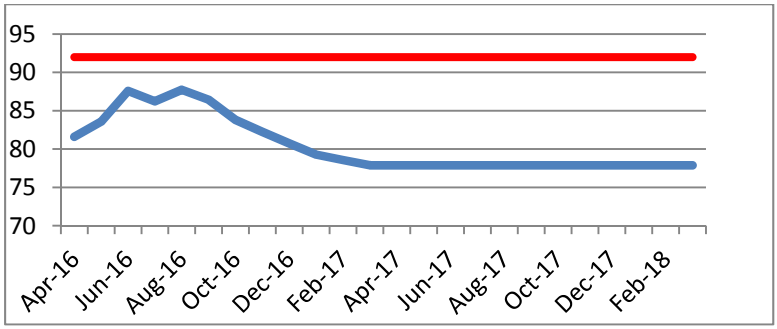
Respiratory Medicine: No recruitment of consultant (2 wte down)



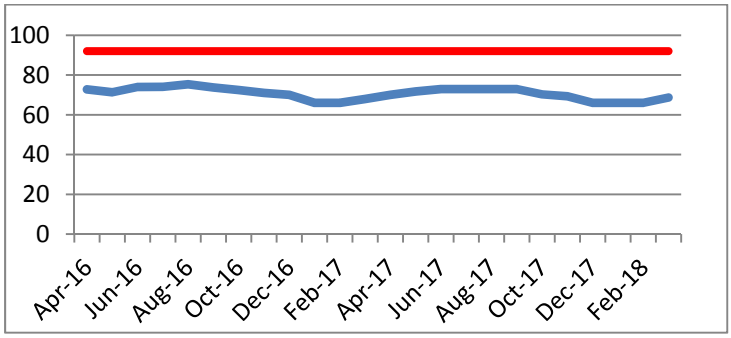
Trauma & Orthopaedics: No outsourcing and no recruitment of foot and ankle Fellow, no single point of access for foot and ankle.



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)

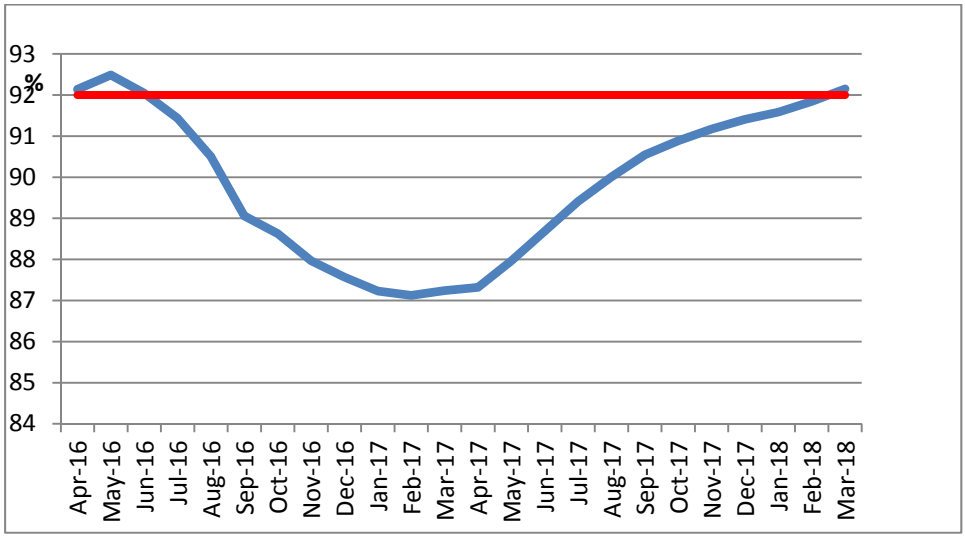


The combined effect on the consolidated RTT trajectory by March 2018 will result in a lowering of performance to 83%. Reversal of the decision to stop outsourcing would have minimal effect this year, 0.5%.

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

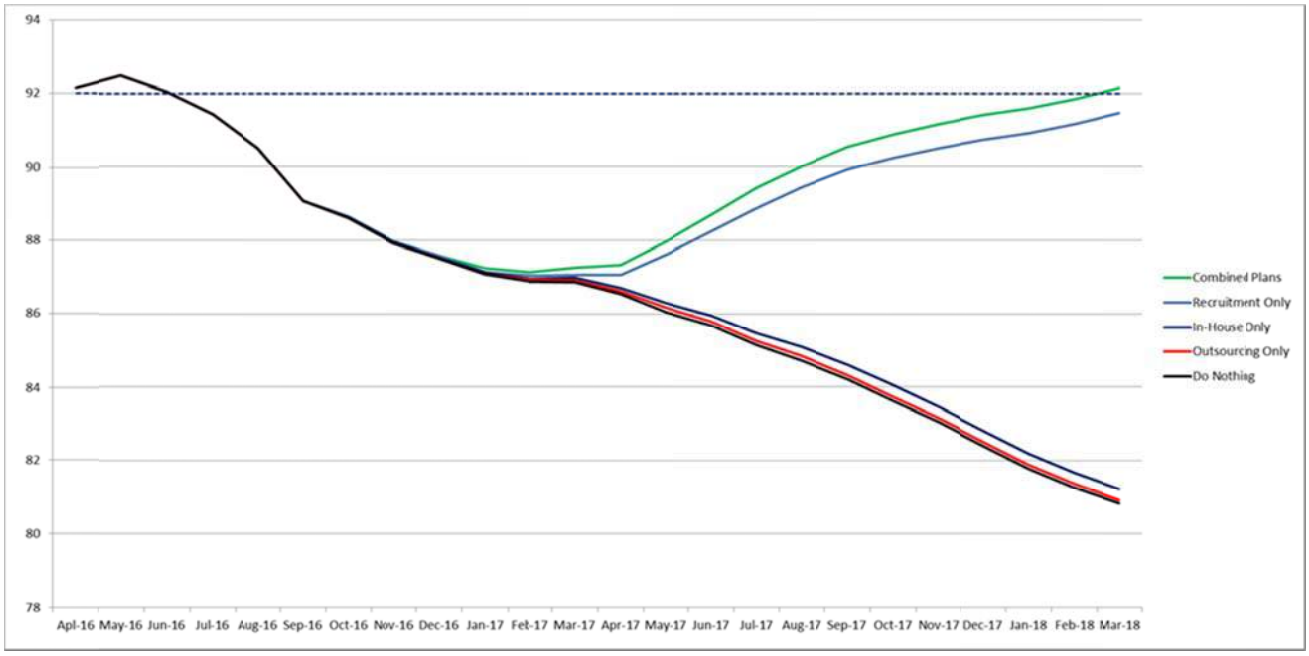
To recover compliance with the RTT standard by March 2018 in line with the trajectory submitted to NHS England and NHS Improvement the following actions will be required:
Recruitment to vacant clinical posts

- 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

Torbay and South Devon NHS
NHS Foundation Trust

Care Quality Commission (CQC) Action Plan Report – December 2016

The Trust's CQC Action Plans are reviewed monthly, with a full discussion on progress at the CQC Assurance Group. Any concerns in meeting these actions are reported to the Quality Assurance Committee. Action plans are broken down as follows:

Area:	Total Actions:	Actions Met:	Actions Outstanding:
Community Inpatients	2	2	0
Critical Care	6	3	3
Children and Young People (CYP)	15	11	4
End of Life (EOL)	7	7	0
Medical Care	8	5	3
Outpatients (Dermatology)	7	7	0
Special Care Baby Unit (SCBU)	6	6	0
Substance Misuse	1	1	0

Outstanding actions

Critical Care:

Training compliance data specifically for critical care was not available.	A Mental Capacity Act (MCA) / Deprivation of Liberties (DoLs) training schedule and attendance register is now available.	Jan-17	ongoing	An audit is being undertaken and a report of compliance with training targets will be taken to department audit meeting.
There was a lack of assurance that a patient requiring an authorisation for the deprivation of their liberty would have this appropriately applied for.	The training of senior team members to ensure there is always at least 1 person on shift who is familiar with the process. Use of MCA / DoLs prompt now in place.	Dec-16	ongoing	An audit will take place to sample of notes monthly. Report will be taken to department audit meeting.
	Critical Care Unit (CCU) staff aware of process to contact safeguarding team to seek advice. Safeguarding contact details easily accessible to all staff.	Dec-16	ongoing	Check staff knowledge of accessing safeguarding team for advice and for MCA / DoLs information on the Trust intranet site. Method to be determined.

CYP:

Initial health assessments (IHAs) for 'looked after' children were not meeting the statutory timescales.	The referrals in for IHAs are monitored weekly by the Child Health Practice Manager with support of Looked After Children (LAC) secretary. Additional capacity available for IHA's, by designated doctor during summer. From September middle grade doctors will be trained to undertake assessments, therefore facilitating greater flexibility to meet fluctuating demand.	Review Jan 17		No plans at present to train middle grades due to vacancies. This was a longer term suggestion if we had staff. Currently managing demand on weekly basis.
Records must be accessible to authorised people as necessary. Not all staff were able to access the electronic and paper records when required to access information.	New Health Visitor and School Nurses functionality will be available on Primary Access Regional Information Systems (PARIS) by the end of 2016, which will enable them to share information with other services who have access to PARIS (new users will request access through their managers).	Review Jan 17		Making good progress towards having Health Visitors (HV) and School Nurses (SN) on PARIS but there have been some delays to the project since the last one. Originally planned to go live with HV in July but due to a number of issues this has now been revised along with the SN go-live into early 2017. The impact of the delays and re-planning is still taking place so can't give a specific date but aiming to have all HV and SN live on the system by end of March 2017. The actual solution is largely built now but other infrastructure issues in the project are delaying testing. The HV and SN service is being kept informed of progress to the point where testing and training sessions were being booked.

	A review is being undertaken of who can currently access PARIS and who needs to. Managers to progress access to childrens social service PARIS (run by Torbay Council), the first meeting to discuss this is to be held in Q2 with Exec representation. Assessment to be made as to likelihood of compliance.	End Dec 16		See above update.
Shortage of middle grade doctors	Several interviews have been carried out, but unsuccessful. To mitigate, the use of locums and agencies when required to cover service will continue. Number of substantive middle grade doctors increases to 5wte from 3.9wte as of September. However, this will decrease again by December/January. Ongoing advertisements and interviews. Long term national issue being discussed within the deanery.	To review in Jan 17		Continuing to review medical model for a sustainable service. Using locums where available as middle grade doctor numbers still reducing with no immediate solution. Consultants acting down when no locum available.

Medical Care:

The Trust was not doing all practicable to mitigate risks to patients. This was because patients in the hospital at weekends did not always have appropriate or up to date risk assessments to reflect reduced medical staffing levels at weekends.	Jan-16	Audit completed from 7 day audit survey and presented at meeting (see attached). Agreed weekend plan or post take ward round sheet acceptable completed on Friday. Quality Improvement (QI) project to be set up with focus on Forrest & Warrington. Aim: 90% of medical patients on Forrest and Warrington who are planned to be in at the weekend have a weekend plan by mid-December. QI project has been set up. Forrest QI due to start 31/10/16. QI project due to start Warrington 10/11/16. Work progressing – agreed revised trajectory on 22/11/16. Aim: 90% of medical patients who are planned to be in at the weekend have a weekend plan by end of January.
Staff responsible for ward safety had not sought advice and guidance, or a review of changes imposed on them, by the Trust's Fire Safety Team in relation to shortfalls in fire safety.	Jun-16	No current safety notices outstanding for medical wards. Fire safety notices come into fire officer, sent out to relevant ward area, and are currently held on the ward in fire safety folder. Awaiting above pathway and audit of this pathway.
The Trust had not ensured there were sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients at weekends.	Nov-16	Time of senior review of acutely unwell admitted patients demonstrates compliance. Timely review (junior & senior review) of medical patients on outlying wards demonstrates compliance. Agreed to audit Forrest first as Warrington currently has consistent medical consultant cover. Cromie has developed an audit sheet to capture review information. Set up system for prospective audit for next four weeks. Findings to be shared 22nd November to the group. Sepsis audit includes time to senior review – add to evidence folder by 8/11/16.

Outpatients:

The premises used for the delivery of minor surgical procedures in dermatology general outpatients were visibly not clean, with unclear guidance on responsibility for cleaning, and no records of cleaning could be produced.	Dec-16	Standard Operating Procedure's (SOP's) now in place for cleaning schedules and being monitored daily. Records now in place for these. Both rooms 18 & 19 have now been reviewed by Infection Control, Dermatology Lead and Estates Dept. List of building works required include refurbishment of room 18 (filling of holes in walls and repainting, removal of old wall brackets, replacement of the sink, refurbishment of a dirty air vent and boxing in of an exposed and uncleanable radiator). Estates have a plan for refurbishment – start date 16 December, to ensure these rooms are now fit for purpose. The Infection Control Team have been liaising with the team about recommended standards for the two rooms in Outpatients Department (OPD) to allow us to undertake "minor skin surgery". Flaps and grafts are no longer planned for these rooms and are currently undertaken in Teignmouth.
The premises used for the delivery of minor surgical procedures in dermatology general outpatients did not have adequate ventilation or extraction.	Sep-16	Fly screens fitted, and windows now able to open when required. However, window frames internally are unclean and are not on the SOP cleaning schedule.

Torbay and South Devon NHS
NHS Foundation Trust

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 NHS
NHS Foundation Trust

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.

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:

  - 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%.

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.

Process for Winter Escalation Status Rep

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.

FINAL Risk Stratification Policy 0(

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.

Inclement Weather Policy (H7).pdf

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.

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.

Torbay and South Devon NHS
NHS Foundation Trust

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.

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.

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

Torbay and South Devon NHS
NHS Foundation Trust

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.

Torbay and South Devon NHS
NHS Foundation Trust

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.,)

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	7
Report Title:	Lead Governor's Report
Report By:	Lead Governor
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Lead Governor arising since the last Council of Governors meeting on 23 September 2016.

2. Main Report

2.1 Christina Carpenter has decided not to stand for re-election and will be missed having served six years as a publicly-elected governor for the South Hams and Plymouth Constituency. On behalf of the Council of Governors, I would like to wish Christina all the very best for the future.

2.2 I should like to recommend that governors adopt the Trust's "food strategy" as an element of interest for governors in 2017.

2.3 I should also like to recommend that governors take an especial interest in the delivery of Social Care throughout our area in order to improve the patient experience. Also that we ask for regular updates on the situation with reference to continuity of care and the assessment of fees, as well as the quality of care delivered.

2.4 Thank you to everyone for the help and support I have received during the year. I should like to thank you all for attending the consultation meetings and constituency ones and acting as observers at committees and for contributing to the debate on enhancing healthcare.

2.5 Constituency feedback forms are attached and will be discussed at the governor-only meeting on 14 December 2016.

2.6 The draft timetable for the Chairman's appraisal process is included as at attachment one for approval.

2.7 I wish you a healthy and happy Christmas and New Year.

3. Recommendations

3.1 Council of Governors accept the report.
3.2 Council of Governors approves the Chairman's appraisal process as at attachment one.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above.
4.2 Approve the recommendations as at section three.

5.

Attachment one - Constituency reports from South Hams and Plymouth, Teignbridge and Torbay.
Attachment two - Chairman's Appraisal Process.

Torbay and South Devon NHS
NHS Foundation Trust

CONSTITUENCY SUMMARY SHEET

Meeting Date:	21/11/16
Governors present:	Christine Carpenter, Mary Lewis, Craig Davidson, Simon Wright
Apologies:	James Furse
Author of the report:	Craig Davidson

Summary of key issues:

1. **Home care**

   Mears holds the contract in South Devon and acts as broker with 30+ agencies in the area.

   We heard a presentation by owner/director of The Care Agency SW, based in E Allington. Main issues common across S Devon : inadequate pay for complexity of care provided, poor quality care is common, limited/ incorrect information on clients given to agencies, many clients not unassigned to an agency at end of an intermediate care period and wasteful or inefficient use of people or resources eg excess NHS staff accompanying client home, using taxi to deliver items not provided at hospital discharge.

   Useful discussion followed. ML suggested Sarah might present to all governors.

2. **Mears**

   Recent communication from ICO noted. CQC inspection Sept 2016 followed concerns by Healthwatch. Deemed " inadequate" and service now under special measures. ICO is monitoring improvement programme. Full CQC report on web site. Concern expressed that contract should not have been awarded to Mears as it had limited experience of domiciliary care provision (primary income managing rental homes). Noted that its care division not profitable.

3. **CCG consultation.**

   Formal report by Healthwatch is awaited. Common themes at meetings were concerns about transport, bed reduction too radical, care at home less safe than in community hospitals, care agencies struggling to recruit appropriate staff.

4. **Clinical Senate.**

   CC posed the question of the remit of this organisation. The web site describes its role in approving the CCG reconfiguration plans, with caveats and warnings on risk. CD understood the Senate to be a clinical talking shop set up by NHS England to provide local governance for clinical service development and delivery, including quality. He thought it had no executive powers, unlike CCG or STP.

Risks: (if any)

Rumoured reduction in December in bed number at Dartmouth CH.
Rumours of 50% reduction in bed number in Dec because of staff shortages. CEO had stated in mid Nov no decision yet made but there is a difficulty in keeping all beds open. All agreed that a significant bed reduction at this stage would be harmful to public confidence in the ICO and CCG.

Recommendations: (if any)

Questions for COG

"How often does failure to provide agreed care needs result in a hospital admission".

"What are the admission rules of Kingsbridge community hospital with regard to some residents of Moor to Sea for whom it is closer and more convenient than Totnes? Can it be used to relieve pressure on Dartmouth".

Topics of interest/agenda items for next constituency meeting

1. Outcome of consultation and update on STP

2. Understanding social care provision locally

3. Evaluation of Care home provision in S Devon

Agenda Items for next Council of Governor (CoG)/Board to Council (B2C) Meetings:

1.

2.

3.

PUBLIC / PRIVATE (delete as appropriate – if PRIVATE, please use NHS to NHS email addresses)

Torbay and South Devon NHS
NHS Foundation Trust

TEIGNBRIDGE CONSTITUENCY SUMMARY SHEET

Meeting Date:	23.11.16
Governors present:	Annie Hall. Carol Day.John Smith.David Parsons. Cathy French
Apologies:	Barbara Inger. Sylvia Russell. Terry Bannon.
Author of the report:	Cathy French.

Summary of key issues:

1.Consultation on possible Community Hospital Closures. It was felt that the feedback form had closed questions. Are the NEDs content that only 1,500 people replied and that only 1/3rd of 1% of the population attended the meetings.
2.Format of Constituency meetings. Are they getting too formal?
3.Governor mileage @ 45p. NEDs receive 56p. (remuneration Committee) ? mechanism for Governors
4. What audit is being undertaken to ensure that the social care provided is adequate for patient's needs. Has a revolving door situation arisen?
5. There was discussion about the possibility of Governors adopting the "Food & Drink strategy" recently bought forward by the Catering Department, as the governor audit topic for 2017. It was agreed to support the idea.

Risks: (if any)
That the CCG consultation was inadequate and failed to answer people's concerns.
That Governors have received no opinion from the NEDs.
That local GPs have not been sufficiently involved in the consultation process.
That despite concerns expressed throughout the community, Mears are still providing domicillary care in Torbay.
The risk is that plans will be deferred and therefore there will be insufficient funding for the Trust to continue to give a safe quality service to the public.

Recommendations: (if any)

1. That NEDs take an active part in replying to the forthcoming Healthwatch report.
2. That agreement is reached between the constituencies on the format of meetings, and that the feed back forms are copied to the relevant lead and to the Chairman.
3. That elected Governors continue to communicate with each other as well as with staff and nominated Governors.

...

Topics of interest/agenda items for next constituency meeting

1. The Healthwatch report.
2. Governors' responsibility to members- to collect questions for the next members' survey.
3.

...etc.

Agenda Items for next Council of Governor (CoG)/Board to Council (B2C) Meetings:

e.g.

1. Presentation on risks around the proposed changes in health delivery .(B2C)
2. Information on development of community services-- physiotherapy etc. promoting healthy living. (CoG)
3. Update on NED's responsibility. (B2C)

...etc.

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Torbay and South Devon NHS
NHS Foundation Trust

CONSTITUENCY SUMMARY SHEET

Meeting Date:	30 November 2016
Governors present:	AP, WM, LH, PW
Apologies:	SG-J
Author of the report:	Andy Proctor

Summary of key issues:

1. CCG: Members concerned still over lack of detailed information (services/locations/delivery partners) about the CCG plans and lack of plan B. Also concern over assurance regarding the views of governors being taken into account in consultation process. For Torbay there is a clear message from members and the public that a clinical hub (inc MIU) is required in Paignton, but this does not seem to be acknowledged. What assurance can governors be provided in this respect?
2. Members understand that a food and hygiene strategy is being developed. In principle Torbay members support this but would need more information to make an informed judgement. (See Agenda items requested)
3. Members are seeking assurance that the Trust is being pro-active in managing the MEARS contract. For example assurance that staff & contractors that provide care in community are appropriately qualified, trained and monitored.
4. Members still have a concern over the finances of the Horizon centre. (See agenda items)
5. Members still have a concern about NED engagement. (see Agenda items)
6. Unfortunately Councillor Parrott did not attend

Risks: (if any)

1. **Torbay members believe that the CCG consultation failed to address public concerns adequately**
2. **Torbay members are concerned that there has been no opinion from the NEDS on the CCG consultation**

Recommendations: (if any)

Priority Items for Lead Governor attention and strategic input

1. Torbay recommend the provision of additional information (as noted) to provide assurance regarding governor input to CCG consultation, and to assure that public input is fed in.
2. Torbay recommend the provision of assurance that the Trust is being pro-active in managing the MEARS contract. For example, that staff & contractors that provide care in community are appropriately qualified, trained and monitored.

Secondary items

1. Need to agree a common format for constituency meeting summary sheets and agreement to distribute to relevant chairs.
2. QAC meeting minutes should be circulated and approved in a timely manner, to QAC members for verification prior to being distributed to CoG. A review of the usefulness of the governor meeting reporting form would be welcomed.
3. Torbay members to discuss with Trust Office on protocols for arrangement of formal visit Paignton hospital

Topics of interest/agenda items for next constituency meeting

1. Review of recommendations/actions from previous minutes to assess progress
2. Review/reports of committee meetings
3. Julian Parrott to present on his role
4. Constituency/Consultation feedback

Agenda Items for next Council of Governor (CoG)/Board to Council (B2C) Meetings:

1. Request to receive a presentation on the Food & Hygiene strategy being developed **(CoG) – Action RS**
2. Presentation/Discussion to clarify plans regarding formal NED→Governor meetings to allow Governors to engage to inform performance assessments. **(B2C) – Action RS**
3. Request additional information regarding the Horizon centre. Previous information supplied indicated no centralised budget, however this centre is supposed to be revenue generating, so please provide the information about revenue received, where from and against which department budget this is positive for, to assure governors on delivery to the original concept. - (**CoG) Action RS**

PUBLIC

Chairman's Annual Appraisal Review

Timetable 2016-17

Provisional Process	Dates
Draft letters for approval: Jacqui Lyttle, Senior Independent Director and Cathy French, Lead Governor	End of December 2016
Letter to Council of Governors from Cathy French Date to respond to Cathy/Sarah Fox	6 January 2017 13 January 2017
Letter to Executive Directors, Non Executives, Chief Executive, from Jacqui Lyttle Date to respond to Jacqui Lyttle/Sarah Fox	6 January 2017 13 January 2017
Sarah Fox – Anonymised comments circulated to panel members	20 January 2017
Jacqui Lyttle and Cathy French to meet to discuss feedback	w/c 6 February 2017
Letter and resume of comments sent to Chairman by e-mail	w/c 13 February 2017
Chairman to send his response and comments to Sarah Fox for appraisal meeting	w/c 27 February 2017
Appraisal meeting to comprise first half Nominations Committee and then Jacqui Lyttle and Cathy French only	**To be confirmed**
Draft Chair's objectives to be agreed 2017/2018	Via Lead Governor Send a copy to Company Secretary for Council Governors meeting in April 2017 Copy to appraisal panel Copy to Chairman

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	9
Report Title:	Quality and Compliance Committee Report
Report By:	Wendy Marshfield
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Update report of the Quality and Compliance Committee (Q&CC) following their most recent meeting on 11 November 2016.

1.2 Q&CC wish to highlight concerns raised regarding the challenges facing the organisation in respect of the capital costs to manage and maintain the infrastructure and maintenance of the Trust estate.

1.3 Members acknowledge that their remit does not extend to operational services, however, when quality and compliance concerns are raised which impact on patient care it should be recognised that governor comments should be welcomed.

2. Recommendations

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

2.2 Council of Governors approves the updated protocol as at attachment two.

2.3 Draft notes are circulated to committee members well in advance of the Council of Governor meeting in order that they can be checked for accuracy.

3. Decisions Needed to be Taken

3.1 Note and comment on the information above/attached.
3.2 Approve the recommendations as at section two.

4. Attached to this report

Attachment one - Draft notes of the November Q&CC meeting.
Attachment two - Governor Observer Protocol

Torbay and South Devon NHS
NHS Foundation Trust

NOTES OF THE QUALITY AND COMPLIANCE COMMITTEE MEETING

HELD IN THE MEMBERS ROOM, TORBAY HOSPITAL

AT 10AM ON FRIDAY 11 NOVEMBER 2016

Terry Bannon (TB)
* Lynne Hookings (LH)
David Parsons (DP)
* John Smith (JS)
* Cathy French (CF)
* Wendy Marshfield (WM)
* Andy Proctor (AP)
* Peter Welch (PW)

In attendance
* Governance Lead (GL)
Quality Lead (QL)
* Note taker (JB)
* Company Secretary (CS)
* Corporate Governance Manager (CGM)

* Denotes member present

WM welcomed PW to the meeting as a new member.

1 Apologies

Apologies received from Terry Bannon, David Parsons, Quality Lead and Ann Wagner.

2 Minutes of the last meeting

The minutes of the last meeting dated 24 June 2016 were **agreed** as accurate. It was confirmed that all actions from the meeting had been completed.

With reference to agenda item 11:
'WM would like assurance that End of Life (EOL) strategy has been completed, published and implemented'.

WM has spoken to Sally Taylor, NED with lead responsibility for EOL for the Trust, Sally informed WM that the strategy is being updated. WM raised some concerns regarding EOL care. GL stated that she will be sitting on the EOL Group.

With reference to agenda item 7:
'WM invited QL to do a presentation at the Council of Governors (CoG) meeting on 23 September'.

CS reported that Jane Viner, Chief Nurse, gave an update at July CoG. LH requested that DPT do a presentation at the next CoG. CS

With reference to agenda item 9:
'LH asked if Medicine for Members had been shelved and if the Studio School are members of the Trust and feels that we are not proactive enough. It was suggested that this be discussed at the Mutual Development Group'.

LH mentioned that Mutual Development Group (MDG) is due to meet next Friday and no-one has come forward to join the group. WM acknowledged that members of Quality and Compliance Committee (Q&CC) need assurance that other committees/groups are functioning properly. CS reminded members that MDG does not report to this committee as per the Terms of Reference (ToR) and he went on to discuss the committee structure under CoG.

3 <u>Review of observer protocol and reporting forms</u>

WM gave an outline of governor observer responsibilities.

CS informed the group that he had shared the observer protocol with the Chief Executive and Chairman and updated the protocol accordingly. CS went on to discuss this with the group.

AP feels the word 'confidential' should not be used on documents throughout the Trust if this had the same meaning as government security markings. CGM advised NHS had their own markings which might not be the same as UK government. It was **agreed** the CS would confirm NHS classifications and add these as appendix 2 CS

CS mentioned that meetings with the word 'committee' in their title, eg Infection Prevention and Control Committee, would be asked to rename the meeting if not an official committee of the Board. This will help to distinguish Groups from Board committees.

CS pointed out that Torbay Pharmaceuticals Board is not part of this group but he will ask Carol Day who is the governor observer to produce a six-monthly report to feed back to this group.

JS queried whether minutes of all meetings attended by governor observers should be included at each Q&CC meeting. CS explained that if governors have concerns on the meetings that they attend, they should feed this back to the Foundation Trust Office who will bring the relevant minutes of that committee/group to Q&CC for more in-depth discussion.

CS asked that this committee approve the protocol subject to adding the new text shown at the meeting and appendix 2 and then take to December CoG.

WM said that governor observer reports need to be received within seven days of the meeting and if the governor is not able to do this then please let the Foundation Trust Office know. It was **agreed** that information regarding the timeframe in section 1.5 be moved/copied to section 5.1. ALL CS

As per the agreed flowchart GL asked that governors contact herself if they have any immediate CQC concerns following a meeting, rather than waiting until they submit their governor observer report and CS confirmed he is always available regarding any other issues.

4. CQC update

GL will send a set of reports to members of this committee. GL reported there are action plans for the following: GL

- Emergency Department (ED)
- Medical Care
- EOL

Most requirement notices have been completed. WM asked how this is fed back to CQC. GL said that the action plans are submitted to CQC every month and they monitor our progress but CQC do not approve our action plans they are for us to set. An 8-weekly report has to be completed and to achieve this GL meets with the CQC once every 8 weeks and the Chief Nurse and Medical Director meet with CQC once every 16 weeks.

WM queried the re-inspection of ED. GL said the CQC would re-inspect in 3 months if improvement is needed but CQC did not visit. GL has spoken to the inspector regarding the visit and there are currently no plans for a visit but CQC can still come unannounced at any time.

CF queried what confidence do governors have that work is being done if there is no feedback from CQC.

GL pointed out that in terms of assurance the CQC Group holds this information and GL said she would be happy to share the minutes from this group and **agreed** to send a statement of assurance to CoG. GL

CS commented that the Board Assurance Framework is submitted to Audit and Assurance Committee with Lead Governor present as observer.

GL said that Quality Reviews have been set up and that the CCG are members of this. There is a revised ToR for the CQC Group and any requirements will go to the Quality Improvement Group (QIG). Service improvements are fed back to the Quality Assurance Committee (QAC). There has been a recent independent review and GL will be sitting on various groups to make sure the action plans are moved along. Rowcroft and Mount Stuart are registered with CQC and therefore have their own governance.

It was **agreed** to put the Board Assurance Framework on the next Q&CC agenda. CS/JB

5. Quality update

QL not in attendance. CS gave handout which included the following information:

- Quality Accounts – updates are going to the December Quality Improvement Group (QIG)

- The Commissioning for Quality and Innovation (CQUINs) – attached our self-report to QIG. This has not yet been confirmed by the Clinical Commissioning Group (CCG).

- The Quality Improvement team are supporting emergency department improvement work and CQC medicine improvement work.

WM asked that any questions be directed to AP who is governor observer on QIG.

6. <u>Feedback from governor observers</u>

WM stated that for anything of particular note, governor observers should highlight in their reports.

<u>Safeguarding/Inclusion Group</u>
WM gave a verbal report as the September meeting was cancelled and rearranged and WM was unable to attend the new date. She reported that Jane Viner, Chief Nurse, and chair of this group, was pleased with the group's progress. The next meeting is on 1 December.

<u>Quality Improvement Group (QIG)</u>
AP reported that there is both positive and negative discussion at the meetings and that the new dashboard is very good. The meetings are well attended.

<u>Workforce and Organisational Development Group (W&OD)</u>
DP is governor observer for this group and CS asked that JB send a copy of the ToR to DP. JB

<u>Capital Infrastructure and Environment Group (CIEG)</u>
PW reported that he is not assured regarding maintenance and renewals but added that the meetings are well run.

<u>Information Management and IT Group (IM&IT)</u>
TB is governor observer for this group. CF attended the last meeting as TB was unable to attend. CF reported that she felt it was an unsatisfactory meeting in that the changing systems are being led by the marketplace and there is a risk of losing funding with nothing being achieved. It was a well led meeting but no 'we need to achieve this before we can fund that'.

<u>Finance, Performance and Investment Committee (FPI)</u>
JS said he was not aware that he should be completing reports after every meeting but accepted the updated protocol earlier.

WM acknowledged that all governors are aware of the financial position of the Trust. Discussion followed regarding assurance at meetings. WM felt there were 3 key priorities for FPI, IM&IT and CIEG: What work is being

undertaken? How is this being prioritised? What is the timeline?

CS stated that he would discuss IM&IT with TB. CS

Quality Assurance Committee
WM reported that this committee is very well run. CF agreed.

Audit and Assurance Committee
The report from CF was noted.

7. Reports from non-members

A report from Sylvia Gardner-Jones (SGJ) for the Infection Prevention and Control Committee was enclosed within the meeting pack. CS felt that a quarterly summary would be sufficient. CF informed the group that SGJ will be unable to attend the next few meetings and it was **agreed** to ask Carol Day if she would cover as governor observer until SGJ returned to normal duties. JB

8. Agree annual workplan

The annual workplan was agreed.

9. Prepare/discuss report to Council of Governors on 14 December 2016

JB will send WM the CoG front sheet to complete. WM will then send to JB for circulation to members of this committee for feedback. JB/WM

CF would like to know why the Joint Equalities Cooperative meetings are not taking place. It was agreed CS/JB would enquire and report back. CS/JB

10. Decide whether to invite speaker(s) to the next meeting

Ann Wagner was unable to attend today and it was **agreed** to invite her to the next meeting in March. If Ann is unable to attend the March meeting it was **agreed** to ask Lesley Darke. JB

It was **agreed** to invite Judy Saunders to the June meeting. JB

11. Review of committee performance

As required by the constitution, the committee reviewed its performance. It concluded that it had satisfactorily fulfilled all the duties expected of it, and had made appropriate recommendations which had been approved by the Council of Governors.

Details of future meetings

All 10am – 12pm in the Boardroom:
Wednesday 29 March 2017
Friday 23 June 2017
Wednesday 6 September 2017

Protocol for Governors when attending Committee and/or Group Meetings Version 5.7 (version 6 once approved) December 2016

1. Introduction

1.1 This protocol has been drawn up to ensure that there is a common understanding of the role, responsibilities and actions of governor observers.

1.2 The document will support governors in understanding this important role in the context of the proper function of the Board of Directors and how the Board discharges its responsibilities through the committee structures, and how governor observers should inform the considerations of the Council of Governors (CoG) in assessing the performance of the Board of Directors; in particular the non-executive directors (NEDs*) who are appointed by the CoG and who chair the board committees that report to the Board of Directors.

*NEDs are expected to focus on board-level business, providing an independent view of the Trust's performance against its statutory functions, strategic and corporate plans, key corporate objectives and associated Board Assurance Framework, while avoiding operational management direction that is the domain of the executive directors. The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) places a duty on the Board of Directors and of each director individually, 'to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public'. The overall objective of the Board of Directors is therefore to secure the long-term success of the organisation in delivering high quality health and social care. This means an effective unitary board being collectively responsible for controlling the Foundation Trust, with no individual having unfettered powers of decision.

1.3 The Chairman of the Board of Directors has invited governors to attend the following board committees and the operational groups that report to these committees as observers:

- Audit and Assurance Committee
- Quality Assurance Committee
- Finance, Performance and Investment Committee
- Charitable Funds Committee
- Torbay Pharmaceuticals Board
- Safeguarding/Inclusion Group
- Quality Improvement Group
- Workforce and Organisational Development Group
- Capital Infrastructure and Environment Group
- Information Management and IT Group
- Joint Equalities Cooperative
- Disability and Awareness Action Group
- Infection Prevention and Control Group

In addition to attendance at the public Board of Directors' meetings, the Chairman has invited governors to hear the 'recipient story' if held in private session. Both public and private minutes are circulated to governors.

1.5 The committees/groups as listed above are responsible within the Trust's governance structures for monitoring some of the Key Lines of Enquiry (KLOEs) assigned to all trusts by the Care Quality Commission (CQC). Governor observers of these key Committees/groups will, ex officio, become members of the Governors' Quality and Compliance Committee (Q&CC). For each meeting, observers will be asked to report on the evidence obtained regarding the KLOEs using the proforma / template provided for which the Committees/groups are responsible. Completed proforma/templates should be sent to the Foundation Trust Office within a week of the meeting. Governor observers attending the *Charitable Funds Committee*, *Torbay Pharmaceuticals Board, Joint Equalities Cooperative, Disability and Awareness Action Group* and *Infection Prevention and Control* meeting are not required to submit a report after every meeting, but will be expected to provide a six-monthly written report to Q&CC. A different report is required for these meetings because these governor observers are not members of Q&CC.

2. Guidance on confidentiality

2.1 Apart from the public session of the Board of Directors all other meetings are held in private and some of the issues discussed may be classified as NHS CONFIDENTIAL/NHS PROTECT until reported to the public meeting of the Board of Directors. Papers for meetings of Committees/groups should therefore be treated in accordance with appendix 2. Governors should respect the confidentiality of any comments from the committee Chair or other committee members and any discussions properly not recorded in the minutes.

2.2 Governor observers must send and receive NHS CONFIDENTIAL/NHS PROTECT information via their NHS mail accounts. Governors must not forward NHS CONFIDENTIAL/NHS PROTECT from their NHS mail accounts to their personal (not secure) email accounts. General problems with NHS mail should be logged with the service desk (0300 500 7000). If calls remain unresolved, please contact the Foundation Trust Office.

2.3 Occasionally, a governor observer may be asked to leave the meeting if there are matters that require to be discussed in private session, which would include any items explicitly about an individual member of staff, a named service user, or which may be commercially sensitive. These items will be kept to the absolute minimum in the spirit of openness and transparency and will normally be grouped together at the end of the meeting, supporting papers for such agenda items will not be sent to the governor observer.

2.4 Governor observers may be asked to leave the meeting if they have declared an interest in an item to be discussed.

3. **Governor preparation**

3.1 Before their first meeting, the Chair of the meeting in consultation with the Foundation Trust Office will arrange to meet the governor observer to outline how the meeting is conducted and the Chair's expectations in relation to Governor participation, which will be in line with this protocol.

3.2 Governor observers may wish to confirm with the Chair their expectation(s) around asking questions and/or raise any particular requirements they may have / wish to highlight e.g. hearing impairment.

3.3 Before each meeting governor observers are expected to:

- read all the papers sent to them; and
- have a copy (electronic or hard copy) of the appropriate proforma/template for the meeting they are attending. Copies can be obtained from the Foundation Trust Office. A pack will be provided to each governor observer with the appropriate pro-forma and dates/times/venue of all future meetings including Q&CC. The pack will be issued after the Council of Governors' rotation meeting each April.

4. **At the meeting**

4.1 The governor will be treated as a valued member of the committee/group. The terms of reference for the meeting must be clear in clarifying the role of the governor attending e.g. attending as an observer or member. Many observers are not members and therefore do not have any operational responsibility. Governor observer contributions should reflect this and should be made through the Chair, however, Governor input is encouraged in relation to the items being discussed/presented. As the relationship and confidence between the chair and governor observer evolves, governor contributions through the chair might be more relaxed.

4.2 At the end of the agenda if appropriate, the Chair of the meeting and governor observer should advise the meeting that they can confirm or otherwise which CQC KLOEs have been addressed within the meeting. This process will assist governor observers in completing their Q&CC proforma / template.

5. **After the meeting**

5.1 The majority of governor observers are required to complete and return a proforma / template for each meeting indicating the CQC KLOEs which have fallen within the business of the meeting, and the governor observer's assessment of the manner in which they have been addressed. Completed proforma/templates should be sent to the Foundation Trust Office within a week of the meeting. Governor observers are encouraged to add any other comments that will be of value to Q&CC, to present their report at the next Q&CC meeting, and to answer other Q&CC members' questions.

5.2 The Audit and Assurance Committee governor observer will return a short written report rather than a proforma / template because this meeting does not have CQC KLOEs assigned to it. As per section one, observers attending the *Charitable Funds Committee*, *Torbay Pharmaceuticals Board, Joint Equalities Cooperative, Disability*

and Awareness Action Group and Infection Prevention and Control meeting do not have to report after every meeting, but will be expected to provide a six-monthly written report to Q&CC because these governor observers are not members of Q&CC.

5.3 The flowchart (titled '*Assurance around Care Quality Commission Process'*) as at appendix one and agreed by members of the Q&CC outlines the process to be undertaken by governor observers following a meeting where they might have urgent CQC/KLOE issues or queries to raise. A copy of this flowchart is held by the Foundation Trust Office.

5.4 Governor observers should contact the Company Secretary via the Foundation Trust Office (cc'ing the Lead Governor if using email) regarding any other urgent governance queries/issues which cannot be captured on the proforma / template and/or cannot wait until the next available Q&CC meeting.

5.5 Governor observers should return any papers they have finished with before leaving the meeting to the Chair or meeting secretary to ensure they are shredded. Any papers which are retained for reference should subsequently be disposed of by shredding or returned to the Foundation Trust Office for disposal, once they are no longer required.

6. Review

6.1 The Q&CC in consultation with the lead governor and company secretary will review governor observer involvement and their contribution on an annual basis. This will achieve the most effective contribution to the CoG. If continued observer status is not felt to be in the interests of an individual governor or in the interests of the CoG, the observer status can be ceased by the chairman in consultation with the Lead Governor, or by the CoG itself.

6.2 Feedback on the performance of Board committees will be discussed with NED committee Chairs as part of their annual performance reviews and/or ongoing review meetings between the Board Chairman, NED Committee Chair, Chief Executive and Company Secretary.

6.3 Feedback on performance of lead Directors chairing meetings of the groups that report to Board Committees or who are the designated Lead Director for Board committees will be discussed as part of their annual performance reviews and/or one-to-one meetings with the Chief Executive.

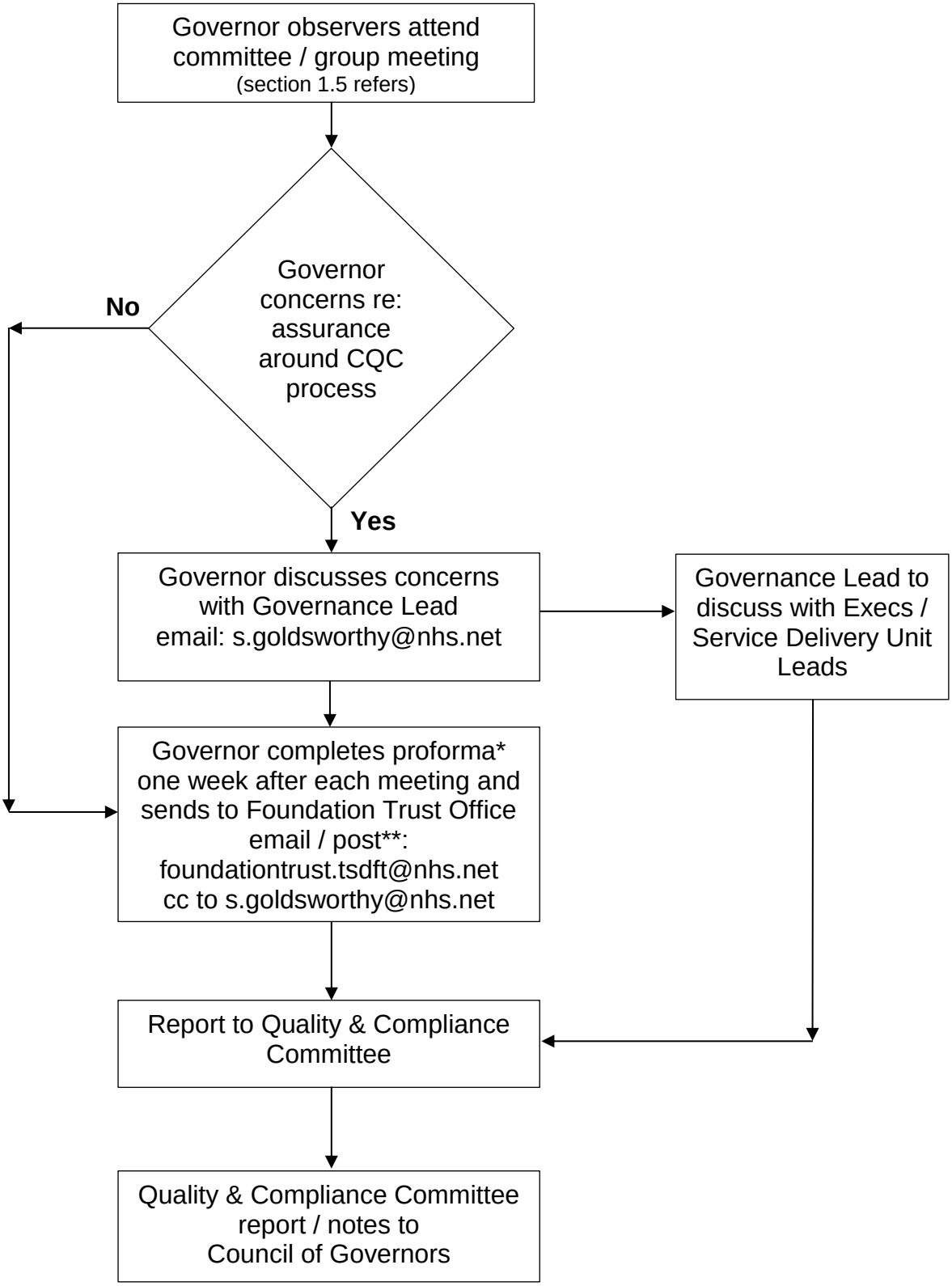
7. Rotation and substitution

7.1 When a Governor is unable, even at short notice, to be present at a meeting the Foundation Trust Office must be advised and every effort will be made to find a substitute.

7.2 Providing such substitution will enable Governors to ensure they maximise the opportunities as observers across a range of different functions.

Appendix One

Governor Observers
Assurance around Care Quality Commission (CQC) Process
February 2016



* Reminders from the Foundation Trust Office 3-4 weeks before Quality & Compliance Committee meeting

**Foundation Trust Office, Torbay Hospital, Freepost RTGS-CXYH-LZLG, TQ2 7AA

Appendix Two

Information Classification / Protective Markings

The Trust has three classifications that may be applied to information assets:

- NHS CONFIDENTIAL;
- NHS PROTECT and
- NHS UNCLASSIFIED.

Examples of information assets include databases, data files, paper records, system documentation, user manuals, training materials and operational support procedures.

NHS CONFIDENTIAL

Personal identifiable data should always be held confidentially, therefore the marking 'NHS CONFIDENTIAL' should be used for that kind of information, for example, patient/client's records, staff records.

Documents marked 'NHS CONFIDENTIAL' should be held securely at all times. They should be stored in a locked room or equivalently within secured electronic systems to which only authorised persons have access.

Documents not kept in a locked cabinet or transport (e.g. boot of car) should be kept out of sight of visitors or others not authorised to view them. Further information can be obtained from the Foundation Trust Office if needed.

NHS PROTECT

'NHS PROTECT' classification can be used for information that requires protection below that of 'NHS CONFIDENTIAL' and where care in handling is still necessary.

Documents marked 'NHS PROTECT should be held securely at all times. They should be stored in a locked room or equivalently within secured electronic systems to which only authorised persons have access.

Documents should be kept out of sight of visitors or others not authorised to view them. Further information can be obtained from the Foundation Trust Office if needed.

NHS UNCLASSIFIED

Documents that have no classification are considered 'NHS UNCLASSIFIED' and this does not have to be recorded on the document. Documents marked as 'NHS UNCLASSIFIED' require no level of protection.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	10
Report Title:	Membership Development Report
Report By:	Lynne Hookings (Chair of MDG)
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

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

2. Background Information

Mutual Development Group (MDG)

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

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

2.3 Lynne Hookings, Chair of MDG met with the Chief Executive on 22 November 2016; a follow up meeting is being arranged for January 2017.

A number of areas were covered including the following:

- Allocation of funding, £1,000 to promote the group's activities.
- Promoting awareness of membership. Rolling membership screen in the Horizon Centre with a view to rolling out Trust wide once all screens under the control of one department.
- Governors photos in community hospitals.
- Membership form – A5 booklet has been updated and available from the Foundation Trust Office.
- Member of the communications team to attend MDG on regular basis.
- Staff governors to attend MDG on regular basis.
- Membership video script prepared earlier in the year, feedback to be received from MDG members.
- Using Chief Executive Weekend Diagnosis column to promote membership.
- Governors' display board updated by Foundation Trust Office.
- Some constituency meetings and visits being held at community hospitals.
- No dedicated role/resources available at the Trust unlike the Milton Keynes position five years ago; as described by A Pryor at September's Council of Governors meeting.
- Foundation Trust Office actively engaged in contacting all academy/colleges/secondary schools in area covered by the Trust.

Opportunity to engage/visit and encourage membership in our under-represented 16-25 age group across Torbay and South Devon. Chairman fully supportive of this approach and has personally signed letters to the Heads. Latest material/offer position regarding apprenticeships will be used when visiting schools.

- Foundation Trust Office in consultation with the Carers Lead with an opportunity to engage with young carers in the Torbay area.
- Re-vitalising Medicines for Members or similar events.
- Company Secretary has raised with the new Director of Workforce and Organisational Development whether there is an opportunity to re-create an idea of running regular two-hour career sessions (with a link to apprenticeships) for young people. The only prerequisite would be for students to become members before they attended the session.

3. Recommendations

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

4. Decisions Needed to be Taken

4.1 Comment and receive the report/attached information.
4.2 Approve the recommendation outlined above.

5. Attached to this Report

Attachment one - Draft notes of the November's MDG meeting.

Torbay and South Devon NHS
NHS Foundation Trust

NOTES OF THE MUTUAL DEVELOPMENT GROUP (MDG) MEETING

HELD IN THE MEMBERS ROOM, HENGRAVE HOUSE

AT 10.30AM ON FRIDAY 25 NOVEMBER 2016

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* Christina Carpenter (CC)
  Sylvia Gardner-Jones (SGJ)
* Mary Lewis (ML)
* Cathy French (CF)
* Lynne Hookings (LH) – Chair
* Catherine Micklethwaite (CM)

In attendance
Monica Trist (MT)
Debbie Lannon (DL) – Comms Team
Jenness Barber (JB) – Note taker

* Denotes member present

ACTION

1 Apologies

Apologies were received from Sylvia Gardner-Jones.

2 Notes of the Last Meeting

The notes of the last meeting held on 7 September 2016 were confirmed as accurate.

Matters arising:

It was noted that Ann Wagner was unable to attend this meeting but will be invited to attend the next meeting of 14 March 2017. MT/JB

It was reported that there had been no response to an initial email sent to the governors from the Foundation Trust office asking for interest in joining MDG. LH had also contacted governors after this asking for interest. CF had asked at the Teignbridge Constituency meeting but no-one came forward therefore it was **agreed** that CF will attend future meetings in her capacity as Teignbridge governor as well as Lead Governor.

MT reported that the Company Secretary had spoken to the team who issue the first appointment letters regarding the paragraph which used to be included about membership, and had been informed that it was not certain how this came to be taken off the letters. It was **agreed** MT would speak with the team again to see if this can be added back in again. MT

MT spoke to CS regarding governors visiting supermarkets to promote membership and it was **agreed**, that as this could be confusing for members of the public, to wait until the CCG's community consultation period is over.

MT confirmed that the rolling TV screen advert in the HC was now up and running and looked very professional. Although none of the governors had seen this yet CM confirmed that she had noticed the screen regularly.

3 Annual Plan

MT discussed the Annual Plan.

CF reported that she attended the extra Private Board meeting held earlier this week where the Board were looking at the five year plan for the Trust. CF commented that there were several amendments proposed and that it will be revised. CF felt that governors are just observers and not participants and feels that governors are not kept in the loop.

CF concluded that the process is in hand.

4 Update from the Working with Us Panel

LH would like to thank Maureen Quartermaine for the update which was included in the meeting papers. — JB

The Capturing Patient Experience Questionnaire has been updated (included in meeting papers). CF asked whether a question could be added to this updated questionnaire: "Are you a member of the Trust, would you like to be?" CM thought wording could be "Would you like to become more involved?". It was agreed MT would agree the wording with members of this group and send to Maureen to be added to the questionnaire. — MT

5 Membership recruitment

LH reported that £1,000 has been made available to MDG to assist with membership recruitment and feels that this needs to be spent appropriately. LH went on to say that she had met with the Chief Executive earlier in the week to discuss MDG and circulated a handout to the group which MT had put together for LH '*Briefing for CEO meeting with L Hookings, Chair of MDG*'.

CF reported that she had met with the Chairman and discussed what can be done for existing Trust members eg 'Meet the Governors' the first Monday of every month in Bayview Restaurant 3pm – 4.30pm. It was **agreed** CF would take this suggestion to the December Council of Governors (CoG) meeting. — CF

CF felt that instead of displaying group photos of governors in the community hospitals, which have proven quite difficult to obtain, a membership statement could be displayed instead along with a membership leaflet dispenser. The same could also be displayed in Bayview Restaurant.

ML suggested including an item on membership recruitment on rolling TV screens at GP surgeries and pharmacies.

CM queried whether something about membership could be added to the hospital Facebook page.

DL suggested obtaining a professionally designed poster in both paper and electronic format. It was **agreed** DL, LH and CF would work on the wording for this poster and the group **agreed** to commit some money towards the cost of getting it designed and printed. All members agreed that this should be progressed as soon as possible as a starting point for all future publicity. — DL/LH/CF

LH discussed the handout ' *Briefing for CEO meeting with L Hookings, Chair of MDG'* with the group:

- MT stated that the Chairman has regular meetings with the staff governors and that at the next meeting the subject of governor attendance at MDG could be discussed.

- LH highlighted that governors need to agree the video script for Hiblio and that this could then be rolled out to GP surgeries and dentists.

- LH stated that the Chief Executive will use the weekly newspaper column to include a message about membership.

- CC informed the group that South Hams governors have had a visit to Totnes Hospital. CF added that Teignbridge governors have had visits to Ashburton, Dawlish and Teignmouth hospitals.

- It was suggested that MDG members visit Anna Pryor at Castle Circus – Anna was a dedicated membership officer at Milton Keynes Trust previously.

- MT felt that social media could be used to target younger members and DL felt that key words would need to be used when targeting this age group.

- CF reported that Yeovil Hospital spoke about membership at the South West Governor Exchange Network (SWGEN) on 22 November and CF will take this to December CoG. — CF

- LH queried what is being said to schools. MT said that she has issued letters from the Chairman and will forward an example to LH. It was suggested lowering the joining age for membership to 14 and was noted that other hospitals have a minimum age of 14. CF wondered if now would be a good time to visit South Devon College as when visited three years ago it was not appropriate at that time due to students coming from all areas of Devon and governors were only recruiting membership for Torbay Hospital whereas now it is the ICO. LH commented that the minimum age of 14 would encompass the whole of Devon Studio School. — MT

- MT stated that she will keep this group informed regarding membership for young carers. CC pointed out that there was a carers' stand at the Annual Members Meeting in September. It was **agreed** MT would contact the person who manned the stand. LH suggested giving a presentation to Devon Studio School if the age limit can be reduced to 14. — MT

- CF suggested inviting members to events that are happening at the hospital. CM queried whether we could 'piggyback' on to Horizon Centre apprenticeships. DL suggested she could inform MDG members of any events that come up in the All Staff Bulletin.

- MT said she would look into a date for another meeting with the Chief Executive. — MT

6 <u>Annual Members Survey</u>

All to consider and bring ideas to the next meeting. — ALL

7 Membership news

It was agreed to carry this item forward to the next meeting agenda. JB

8 Agree Governor Literature e.g. new membership leaflet

It was **agreed** to produce the poster first and then consider a new membership leaflet.

9 HealthWatch

Governors remain concerned that after discharge into the community it is still not safe and at a satisfactory level.

10 Any Other Business

- CC had noticed that the Friends and Family forms don't seem to be available around the hospital and would like JB to enquire. JB
- CC feels strongly that membership newsletters are sent to members in printed format.

Details of 2017 meetings

All 2pm – 3.30pm in the Executive Meeting Room:
Tuesday 14 March 2017
Tuesday 13 June 2017
Tuesday 22 August 2017
Tuesday 14 November 2017

It was **agreed** JB would look at extending 2017 MDG meetings to 2 hours. JB

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	11
Report Title:	Secretary's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Company Secretary following the last Council of Governors meeting on 23 September 2016.

2. Main Report

2.1 **Resignations:** As per the Lead Governor's report it is unfortunate to lose Christina Carpenter after six years as a publicly-elected governor for the South Hams and Plymouth Constituency. Christina's term of office ends on 28 February 2017 and the Trust would like to wish her the very best for the future wherever she may travel.

Christina is more than welcome to attend the self-assessment session in February (referred to below) if able to attend.

2.2 **Autumn elections 2016:** An election process is underway to fill the five publicly-elected seats; one seat has become available in the South Hams and Plymouth Constituency, one seat in the Teignbridge Constituency and three seats in the Torbay Constituency. Three governors have put themselves forward for re-election.

The elections timetable with key dates is as follows:

Event	Date
Notice of election. Nomination forms available	Wednesday 7 December
Deadline for receipt of nominations	Tuesday 10 January
Notice of poll published / issue of ballot packs	Wednesday 25 January
Close of poll	Friday 17 February
Declaration of result	Monday 20 February

2.3 **Joint meeting between Council of Governors and Board of Directors:** The next Board-to-Council meeting will take place on Wednesday 15 March 2017, 3pm in the Anna Dart Lecture Theatre, Horizon Centre.

2.4 **Carers session**: The Company Secretary is looking to organise a carers awareness presentation in January 2017 for governors and will seek interest for this session in due course. It is unlikely the session will be held if less than ten governors are able to attend.

2.5 **Constituency Reports**: Thank you to all the governors who submitted their feedback forms. The forms have been attached to the Lead Governor report.

2.6 **Operational Plan**: Thank you to Cathy French, Barbara Inger and Wendy Marshfield for attending the extra Board of Directors meeting to approve the draft operational plan. The additional Board meeting to approve the final version of the plan is due to take place on 20 December 2016; seven governors are due to attend.

2.7 **Board of Directors meetings:** Formal public meetings are outlined below. Governors, members and members of the public are welcome to attend these meetings as observers if they wish. The meetings are usually on a Wednesday at 9am in the Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital. Dates for 2017 are:

- 1 February;
- 1 March;
- 5 April;
- 3 May;
- 24 May (1pm to 3pm)
- 5 July;
- 2 August;
- 4 October;
- 1 November;
- 6 December.

*There is no meeting held in public in June 2017 because there is an extra private and public meeting of the Board on 24 May 2017 to approve the annual report and annual accounts in line with national submission dates.

2.8 **2017 meeting dates for governor observers:** Once the new committee and group dates have been finalised, the Foundation Trust Office will distribute electronically (unless stated otherwise) to all governors.

2.9 **Governor Expenses**: As requested at the last Council of Governors meeting the Company Secretary has written a separate paper with recommendations as at attachment one.

2.10 **Lead Governor Process**: The draft process put forward by the Company Secretary to appoint a new Lead Governor from April 2017 is at attachment two for information and approval. In April 2017, Cathy French will have served three years as Lead Governor.

2.11 **Schedule of Meetings**: The 'Schedule of Meetings and Routine Agenda Items for the Council of Governors' is at attachment three for information and approval.

2.12 **Non-executive director**: James Furse has decided to stand down as non-executive director from 31 December 2016 having served three years. The Nominations Committee met in November 2016 and a separate paper has been provided that will be discussed in private session (item 17 on the agenda).

2.13 **South West Governor Exchange Network (SWGEN):** The last SWGEN conference took place on 22 November 2016. Thank you to Carol Day for such a comprehensive report that has been be circulated to all governors via email.

2.14 **Governor self-assessment, 22 February 2017:** The Company Secretary would welcome ideas / topics of interest from all governors for the self-assessment session in the New Year**.** Governors are encouraged to contact the Foundation Trust Office as soon as possible so that the Chairman, Lead Governor and Company Secretary can start to plan the event.

The current draft agenda will include the following objectives unless advised otherwise:

- To review the effectiveness of the Council of Governors.
- To learn from the information identified through the questionnaires.
- To identify and agree opportunities for improvement and development.

Action: Governors are asked to confirm their availability with the Foundation Trust Office and pass on ideas/topics of interest.

3. Recommendations

3.1 As at section 2.9, 2.10 and 2.11, Council of Governors to work through the three attached papers and the separate recommendations.

3.2 As at section 2.14, governors are asked to confirm their availability with the Foundation Trust Office for the development session in February 2016 and pass on ideas/topics of interest.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above/attached.
4.2 Approve the above recommendations and those recommendations within the attached documents.

5. Attached to this Report

Attachment one	-	Governor expenses front sheet and policy.
Attachment two	-	Appointment of Lead Governor.
Attachment three	-	Schedule of Meetings and Routine Agenda Items

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	Attachment one Item 11
Report Title:	Reimbursement of Expenses for Governors and Members
Report By:	Company/Corporate Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 This report introduces, for discussion, the reimbursement of expenses for governors and members.

2. Background Information

2.1 It is appropriate for the Council of Governors to review and approve on a regular basis the formal guidelines under which governors and members* may be reimbursed for legitimate expenses, incurred in the course of their official duties, as governors or members of the Torbay and South Devon NHS Foundation Trust.

* Members may be entitled to claim if they have been personally requested to participate in an event by telephone call, personal letter, or personal email from a member of the Foundation Trust Office and when agreement has been made in advance for them to do so.

2.2 Following a recent request by a publicly-elected governor, reimbursement of expenses has been included on the agenda for discussion. This is a timely request as the policy should be reviewed with so many new governors commencing their terms of office in March 2016.

2.3 It is widely recognised that governors bring to foundation trusts a wealth of skills and expertise and can give up a substantial amount of their free time as unpaid statutory volunteers.

2.4 Torbay and South Devon NHS Foundation Trust has in excess of 600 volunteers (not including governors) who support the running of the hospital in a number of different ways and who are currently reimbursed at the public-transport rate of 24p per mile.

2.5 In the past, the total cost for all governor expenses (train tickets, parking at events, mileage claims for meeting/events etc.) has been less than £1,000 per annum. The total amount of expenses claimed by 14 governors during the 2015/16 financial year was £3,270.37 compared with £2800.25 claimed by 12 governors in 2014/15.

2.6 Governors who choose to make mileage claims are currently reimbursed at 45p per mile for legitimate expenses incurred in the course of their official duties. Any expenses other than vehicle mileage must be supported by valid receipts (e.g. a train ticket) and will be reimbursed in full.

2.7 The Company/Corporate Secretary has researched several foundation trusts around the country and the ones contacted currently refer to Her Majesty's Revenue and Customs (HMRC) guidance [2013] when issuing information on governor mileage rates. It is very difficult to estimate the actual cost of using a specific vehicle to travel to Trust premises and there are agreed mileage rates from the HMRC that can be paid without incurring any tax liability. Please refer to section 2.10 below.

2.8 The Non-Executive Directors at Torbay and South Devon NHS Foundation Trust are paid 56p per mile for the first 3,500 miles only as per the table below. Non-executive directors receive this rate having been issued with a 'contract for services' and receive annual remuneration as agreed by the Council of Governors.

The rate above mirrors guidance from the NHS Terms and Conditions of Service Handbook. Page 84 states the following information.

Table 7

Amended rates of reimbursement from 1 July 2014

Column 1	Column 2	Column 3	Column 4
Type of vehicle/allowance	**Annual mileage up to 3,500 miles** (standard rate)	**Annual mileage over 3,500 miles** (standard rate)	**All eligible miles travelled** (see paragraph 17.15 and Table 8)
Car (all types of fuel)	56 pence per mile	20 pence per mile	
Motor cycle			28 pence per mile
Pedal cycle			20 pence per mile
Passenger allowance			5 pence per mile
Reserve rate			28 pence per mile
Carrying heavy or bulky equipment			3 pence per mile

2.9 The Trust has a fleet of pool cars at Torbay Hospital which governors are entitled to use. The pool cars would not be suitable for all governors e.g. those living close to Exeter who would like to travel to a governor event in Taunton, but pool cars are available via the Foundation Trust Office where the cost of using your own vehicle would exceed the cost of using the pool car.

2.10 In June 2013 the HMRC released guidance titled 'Voluntary Workers' Expenses'. It is suggested that volunteers are entitled to be paid expenses and this includes travel.

The HMRC guidance continues to suggest 45p per mile or less as it is likely that tax implications may be incurred above this rate.

HMRC suggested mileage and fuel allowances from April 2011 to 2012 to present date

	First 10,000 miles	Over 10,000 miles
Cars and vans	45p per mile	25p per mile
Motorcycles	24p per mile	24p per mile
Bicycles	20p per mile	20p per mile
Passengers	5p per passenger per mile	

3. Recommendation

3.1 Council of Governors accepts the policy document as at attachment one.

4. Decisions Needed to be Taken

4.1 Decide on whether to accept the HMRC mileage rates or put forward a recommendation to the Board of Directors to increase mileage rates for governors and members (2.1 refers) and at what rate per mile.

Please note that anything above 45p per mile is likely to incur tax implications and further details would need to be sought from HMRC regarding implications for governors/members.

4.2 Approved the recommendation as at section three.

5. Attached to this Report

Attachment one - Reimbursement of Expenses for Governors and Members

Torbay and South Devon NHS
NHS Foundation Trust

Reimbursement of Expenses for Governors and Members

December 2016
Version 4.1
(version 5 once approved)

Torbay and South Devon NHS
NHS Foundation Trust

Document Information

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Date of Issue:	July 2007	**Next Review Date:**	December 2018
Version:	4.1	**Last Review Date:**	December 2016
Author:	Company / Corporate Secretary		
Director(s) Responsible	Chairman		
Approval / Consultation Route			
Approved By:		**Date Approved:**	
Governance Board		4 July 2007	
Governance Board		21 July 2010	
Council of Governors		28 September 2011	
Board of Directors		5 October 2011	
Council of Governors		14 December 2016 (once approved)	
Links or overlaps with other policies:			

Amendment History

Date	Reason for Change	Authorised
18-Dec-09	Minor changes in nomenclature e.g. 'Governor' replaced by the word 'Governor'. Section 2.1 referred to Health and Social Care Act 2003 now NHS Act 2006. Section 4.3, added some additional Groups/Committees.	Chairman
12-Jul-10	Section 2.1 (updated to reflect new Government white paper) and section 5.2 (quarterly submissions).	Chairman
5-Oct-11	Council of Governors (28 Sept) then Board of Directors approved change in mileage rate from 24p to 45p per mile. Revised section 4.3	Chairman
14-Dec-16		Chairman

DOCUMENT SUMMARY

This document lays down the guidelines under which Governors may be reimbursed for legitimate expenses, incurred in the course of their official duties, as governors or members of the Torbay and South Devon NHS Foundation Trust.

INDEX

1. Policy and Audit Identification

This policy has been drafted in accordance with the principles of significant legislation such as the European Convention on Human Rights (ECHR) 1998, Race Relations (Amendment) Act 2000 and the Disability Discrimination (Amendment) Act 2005. Under the Freedom of Information Act 2000, the document is classified as 'OPEN'.

2. Policy Statement

2.1 The Trust should provide fair and appropriate reimbursement for the governors and members who participate in events and activities arranged by the Trust (see introduction to section four).

2.2 This policy applies to all governors (and members under the conditions set out in the introduction of section four) asked to work with Torbay and South Devon NHS Foundation Trust.

3. Introduction

3.1 Torbay and South Devon NHS Foundation Trust is committed to the involvement of governors and members in all areas of its work whenever decisions are to be made which influence changes to the way the services are provided.

3.2 The post of governor of the Torbay and South Devon NHS Foundation Trust is voluntary, and it is a fundamental principle nationally that no governor shall receive any form of salary or remuneration for being a governor.

3.3 The policy of Torbay and South Devon NHS Foundation Trust requires that:

a) People contributing their views are not out of pocket for any reason as a result of participation;
b) Consideration is given for additional payments to individuals invited specifically to share their expertise or give presentations in events organised by the Trust;
c) Reimbursement practice with partner organisations for joint events is agreed, and to communicate the arrangements with participants.

4. Reimbursement

4.1 Governors participating in Foundation Trust events such as Council of Governors meetings, events, Committees or Working Groups as agreed or invited by the Trust, and whose expenses are not paid by another organisation, should be entitled to claim expenses.

4.2 Members may be entitled to claim if they have been personally requested to participate in an event by telephone call, personal letter, or personal email from a member of the Foundation Trust Office and when agreement has been made in advance for them to do so.

4.3 Expenses will only be reimbursed for the following expenditure:

i. Travel expenses by the cheapest available means to attend Council of Governors meetings, Board-to-Council meetings, regional / national governor events, members and local constituency meetings arranged by the Trust, and where applicable, meetings of the Mutual Development Group, Nominations Committee, Non-Executive Director Remuneration Committee, Quality and Compliance Committee. Travel expenses will also be reimbursed for governor observers attending committee or group meetings. Mileage rate, where authorised, will be 45p per mile or at a rate equivalent to those outlined in the 'Torbay and South Devon NHS Foundation Trust '*Guide to Expense and Allowance Rates for Employees*'.

Note: In circumstances where public transport would not be appropriate or reasonable, governors / members may claim full reimbursement (including any reasonable gratuity) for the fares incurred. Receipts must be attached to claims.

ii. Parking and toll charges incurred as a direct result of attending the above meetings;

iii. Travel by bicycle / motorcycle to be reimbursed at the staff rate for the use of a bicycle / motorcycle on official business;

iv. Public transport to be reimbursed on provision of receipt;

v. Subsistence allowance where the governor / member is away from their home either, between 5 and 10 hours (current rate £5 maximum), or over 10 hours (current rate £15 maximum), for the purpose of attending one of the above meetings, and where no refreshment is provided at the Trust's expense. Unless in exceptional circumstances, overnight expenses will not be paid. Periods away from home are calculated from the times of leaving and returning home;

vi. Where a governor / member requires alternative transport arrangements, costs will be met, by prior agreement;

vii. Expenses of a companion required to enable a governor / member to participate. If the attendance (including travel) exceeds four hours, and refreshments are not provided at the venue, expenses for refreshments of up to £5 can be claimed.

viii. Additional reimbursement or payments such as an individual or representative of a group being requested to undertake specific work like a presentation or training, payment for the individual's time, including preparation, should be agreed in advance with the Foundation Trust Company/Corporate Secretary. The suggested rates (for guidance) are £5 per hour minimum.

4.4 Due to NHS accounting rules all expenses except mileage should be submitted with receipts and expenses and should be claimed within three months. Further information should be sought from the Foundation Trust Office. The Foundation Trust Office will issue reminders to all governors who claim expenses.

4.5 Claimants should be aware that if they are in receipt of benefits these payments may impact upon their entitlements. This should be clarified with the local benefit agency prior to expense claim being made.

5. Process for Reimbursement

5.1 Governors remain wholly responsible for the completion and accuracy of their claims. Claim forms are available upon request from the Foundation Trust Office.

5.2 Completed forms should be passed to the Foundation Trust Company/Corporate Secretary for signature on a quarterly basis, who will forward them for payment. Claims will only be reimbursed direct to a nominated bank or building society account (the account number and sort code of which is stated on each claim) in accordance with the Trust's accounting timetable.

6. Audit

6.1 Completed forms will be retained for the same period as those submitted by Torbay and South Devon NHS Foundation Trust staff.

7. Contact Details

Company/Corporate Secretary	Foundation Trust Office	01803 655705

8. Review

8.1 A review of this document will be conducted every two years or following a change to associated legislation and/or expenses rates and is the responsibility of the Company/Corporate Secretary.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 14 December 2016

Agenda Item:	Attachment two Item 11
Report Title:	Appointment of the Lead Governor
Report By:	Company/Corporate Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 This report sets out the Constitutional requirement and proposed timescale for a new Lead Governor to be appointed.

1.2 The report proposes a process that will result in the election of a new Lead Governor at the Council of Governors (CoG) meeting on Wednesday 26 April 2017.

2. Background Information

2.1 Under the terms of the Constitution the Trust is required to appoint one of the publicly-elected governors to be Lead Governor.

2.2 The role of the Lead Governor, as set out in the Constitution, is to:

(a) Act ex-officio on behalf of the Chair;
(b) Chair part of the CoG meeting if the person presiding at any such meeting has a conflict of interest in relation to the business being discussed;
(c) Chair the Remuneration Committee and be a member of the Nominations Committee.
(d) To be a member of the Quality and Compliance Committee.

2.3 The Constitution does not detail the process to be followed when appointing the Lead Governor. Neither does it specify the timescale for the appointment, however, it is proposed that the appointment is for two years as discussed at the Council of Governors self-assessment session in February 2014. The local process in section 3 below is being put forward to governors by the Company Secretary.

3. Recommended Process and Timeline

3.1 The process being proposed is in five stages:

a) Company Secretary invites interested publicly-elected governors to put their name forward for the Lead Governor role.

b) Short biography put forward by each candidate including background and experience, contributions to the governor role to-date, what they perceive to be the main challenges facing the NHS and how they will meet the Lead Governor role and responsibilities (as at attachment one) including the additional time commitment required.

c) Candidate(s) submitting a response respond to the following six questions:

1) Why do you want to become the Lead Governor?

2) What experience do you have at chairing and facilitating meetings and/or working groups?

3) If you were chosen as Lead Governor, what would you like to see as an achievement for this Council of Governors, over the next year?

4) How would you challenge members of the Board and non-executive directors effectively, if the situation arises?

5) How would you maintain independence with members of the Board and non-executive directors?

6) If you could change one thing about the Trust, what would this be?

d) Five minute presentation at April's Council of Governors meeting - topic to be announced nearer the time.

e) Secret ballot at April's Council of Governors meeting.

3.2 In support of 3.1 above it is suggested that the following timeline be followed for the election of the Lead Governor.

Date	Action
6 Mar 17	Company Secretary invites interested publicly-elected governors to put their name forward for Lead Governor role. (March due to current election timetable and giving any one standing for re-election to put themselves forward)
3 Apr 17	Candidate(s) invited to provide a short biography and answer the six questions by 23 April 2017 in support of their nomination.
23 Apr 17	Prior to the CoG meeting, the biographies, candidate questions and responses are circulated to all governors as part of the CoG meeting papers.
30 Apr 17	Short presentations by the candidate(s) at the Council of Governors meeting in support of their nomination.
30 Apr 17	Ballot papers circulated immediately after the presentation(s) for immediate completion.
30 Apr 17	Announcement of election by the Company Secretary at the end of the Council of Governors meeting.

4. Recommendations

4.1 Council of Governors accepts the 'Lead Governor Role' as at attachment one.

4.2 Council of Governors agrees to the process and timeline as set out in paragraphs 3.1 and 3.2 for the election of a new Lead Governor from April 2017.

5. Decisions Needed to be Taken

5.1 Approve the recommendations outlined above.

6. Attached to this Report

Attachment one – Lead Governor Role.

The Role of Lead Governor

- To provide a focus point from within the body of governors in their engagement with the Foundation Trust.

- To facilitate direct communication between NHS Improvement and the Council of Governors in exceptional circumstances where it may not be appropriate to communicate through the normal channels, as set out in the national Code of Governance.

- To chair such parts of the meetings of the Council of Governors which cannot be chaired by the Chair or another of the non-executive directors due to a conflict of interest in relation to the business being discussed.

- To participate in the appraisal of the Chair and the non-executive directors.

- To chair the Remuneration Committee for non-executive directors.

- To be a member of the Nominations Committee and to chair it in the process of appointing a Trust Chairman.

- To be a member of the Quality and Compliance Committee.

- To act as a point of contact and liaison for the Chair and the Senior Independent Director.

Person specification (desirable)

- At least one year's experience as a publicly elected governor.

- Previous experience in relevant roles, e.g. chairing committees, conducting appraisals.

- Adequate time to devote to the additional duties.

- Good communications and diplomatic skills.

- Commitment to sustaining good working relationships between the Council of Governors and the Board of Directors, and between governors and directors generally.

Torbay and South Devon NHS
NHS Foundation Trust

Attachment three Item 11

Council of Governors: Schedule of Meetings and Routine Agenda Items

December 2016
version 11.1
(version 12 once approved)

Torbay and South Devon NHS
NHS Foundation Trust

Schedule of Routine Agenda Items

In order to assist with forward planning, the following reports are to be made by the responsible owner to the Council of Governors (CoG) at the quarterly meeting in accordance with the schedule below. Reports are to be with the Foundation Trust Office, having been cleared with the Chief Executive by the delegated Director, no later than two weeks prior to the meeting. **Note: For 2016 the reporting cycle starts at the April meeting.**

Report	Responsibility	Month			
		April	July	Sept (CoG & AMM)	Dec
Chairman's report	Chairman	X	X	X	X
Chief Executive's report	Chief Executive	X	X	X	X
Lead Governor's report including constituency reports	Lead Governor	X	X	X	X
Secretary's report	Company Sec	X	X	X	X
Non-Executive Director's report	NED	X	X	X	X
Nominated governor's report	Various	X	X	X	X
Quality & Compliance Cttee report	Chair of Q&CC	X	X	X	X
Membership development report	Chair of MDG	X	X	X	X
Board matters e.g. confidential items	Chairman / Chief Executive	X	X	X	X
Appointment of the Lead Governor	Chairman	X			
Rotation of committee / group membership	Company Sec	X			
Annual reviews of the Chairman and NEDs	Chairman / Lead Governor	X			
Review the size, composition and the effectiveness of the CoG	Chairman / Chief Executive / Lead Governor	X			
Annual plan – year-end review and year ahead	Chief Executive	X			
Attendance review	Chairman	X			
Remuneration Committee report	Lead Governor		X		
Receipt of the annual report / annual accounts	Chairman / Chief Executive			X	
Chairman's annual review	Chairman			X	
Annual clinical services overview e.g. presentation on infection control	Various			X	
Presentation from external auditors	External Auditor			X	
Appointment of the external auditor (as required)	Chair of A&A Committee			X	

AMM - Annual Members Meeting which may be held in September or October
NED - Non-Executive Director
CoG - Council of Governors
A&A - Audit and Assurance Committee

The layout for a Council of Governors paper is available from the Foundation Trust Office and the content of the report should be discussed with the Company Secretary in advance.

Torbay and South Devon NHS
NHS Foundation Trust

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Date of Issue:	March 2007	**Next Review Date:**	December 2017
Version:	11.1	**Last Review Date:**	December 2016
Author:	Company/Corporate Secretary		
Director(s) Responsible	Chairman		
Approval / Consultation Route			
Approved By:		**Date Approved:**	
Governance Board		4 April 2007 (v2)	
Governance Board		17 April 2008 (v3)	
Governance Board		10 December 2008 (v4)	
Governance Board		9 December (v5)	
Governance Board		8 December 2010 (v6)	
Council of Governors		14 December 2011 (v7)	
Council of Governors		12 December 2012 (v8)	
Council of Governors		11 December 2013 (v9)	
Council of Governors		17 December 2014 (v10)	
Council of Governors		9 December 2015 (v11)	
Council of Governors		14 December 2016 (v12) Once approved	
Links or overlaps with other policies:			
Constitution, Council of Governors Rules of Procedure, Rules of Procedure for Members Meetings, Council of Governors Code of Conduct.			

Amendment History

Date	Reason for Change	Authorised
17-Apr-08	Minor amendments following the appointment of a new Chairman.	Chairman and Chief Executive
10-Dec-08	Annual review	Chairman and Chief Executive
9-Dec-09	Minor changes following new items being reported at previous Governance Board meetings plus Annual Audit Letter minute as at 9 Dec 2009.	Chairman and Chief Executive
30-Nov-10	Minor changes.	Chairman and Chief Executive
6-Dec-11	Minor changes following the amalgamation of some items being reported e.g. Chief Executive's Report.	Chairman and Chief Executive
5-Dec-12	Minor change e.g. dates plus moved 'appointment of the external auditor' from December to September.	CoSec
3-Dec-13	Added 'Quality & Compliance Committee Report' to list	CoSec
Dec-14	Minor changes	CoSec
Dec-15	Minor changes	CoSec
Dec-16	Minor changes	CoSec

Torbay and South Devon NHS
NHS Foundation Trust

Agenda item 14

Council of Governors Meeting

Wednesday 14 December 2016 in the Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

Future meetings:

2017

1 February	9am	Public Board
22 February	**1pm**	**Self-assessment**
1 March	9am	Public Board
15 March	**3pm**	**Board to Council of Governors**
5 April	9am	Public Board
26 April	**3pm**	**Council of Governors**
3 May	9am	Public Board
24 May	9am	Public Board
5 July	9am	Public Board
19 July	**3pm**	**Council of Governors**
2 August	9am	Public Board
16 August	**3pm**	**Board to Council of Governors**
22 September	***tbc***	**CoG / AMM event**
4 October	9am	Public Board
25 October	**3pm**	**Board to Council of Governors**
1 November	9am	Public Board
6 December	9am	Public Board
13 December	**3pm**	**Council of Governors**

Highlighted **meetings/sessions** means governors are expected to attend.