Torbay and South Devon NHS Foundation Trust

Public Board of Directors

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

01 February 2017 09:30 - 01 February 2017 11:30

AGENDA

#	Description	Owner	Time
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	User Experience Story Assurance		
3	PART A: Matters for Discussion/Decision		
3.1	Apologies for Absence Note	Ch	
3.2	Declaration of Interests Note	Ch	
3.3	Minutes of the Board Meeting held on the 7th December 2016 and Outstanding Actions Approve 16.12.07 - Board of Directors Minutes Public.pdf 9	Ch	
3.4	Report of the Chairman Note	Ch	
3.5	Report of the Deputy Chief Executive Assurance Report of the Deputy Chief Executive.pdf 31	DCE	
3.6	Strategic Issues		
3.6.1	Wider Devon Sustainability and Transformation Plan (STP) Update (including Acute Service Review and confirmation of STP Memorandum of Understanding) Information/Confirmation Devon STP Memorandum of Understanding for Gov... 37	DSI	

#	Description	Owner	Time
3.6.2	Into the Future: Reshaping Community-based Health Services Public Consultation Update Information/Assurance Reshaping Community Based Health Services.pdf 67	DSI	
3.6.3	Integrated Quality, Performance, Finance and Workforce Report - Month 9 Assurance QPFW Report.pdf 103	DSI/DoF/DWOD	
3.6.4	Financial Recovery Plan Assurance Financial Recovery Plan.pdf 171	DoF	
3.6.5	Governors' Questions Discuss	Ch	
3.7	Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)		
3.7.1	Reference Costs 2015/16 Assurance Reference Costs 2015-16.pdf 179	DoF	
3.7.2	User Experience Report - Incidents Assurance Clinical Incident Report.pdf 183	CN	
3.7.3	Opportunities for Increase in Undergraduate Medical Training Decision Undergraduate Medical Training.pdf 221	MD	
3.7.4	Safety Scorecard Information/Assurance Safety Scorecard.pdf 243	MD	
4	PART B: Matters for Approval/Noting Without Discussion		

#	Description	Owner	Time
4.1	Reports from Board Committees Assurance		
4.1.1	Report of the chair of Quality Assurance Committee Assurance Quality Assurance Cttee Report.pdf 257		
4.2	Reports from Executive Directors		
4.2.1	Report of the Chief Nurse (Safe Staffing 6 Month Report) Information/Assurance Report of the Chief Nurse (Safer Staffing).pdf 259	CN	
4.2.2	Report of the Chief Operating Officer Information/Assurance Report of the Chief Operating Officer.pdf 287	COO	
4.2.3	Report of the Medical Director Information/Assurance Report of the Medical Director.pdf 301	MD	
4.2.4	Report of the Director of Workforce and Organisational Development Information/Assurance Report of the Director of Workforce.pdf 329	DWOD	
4.2.5	Report of the Director of Estates and Commercial Development Information/Assurance Report of the Director of Estates.pdf 353	DECD	
4.3	Compliance Issues		
4.4	Any Other Business Notified in Advance	Ch	
4.5	Dates of Next Meeting - 9.00 am, Wednesday 1st March 2017	Ch	
4.6	Exclusion of the Public	Ch	

INDEX

Board Corporate Objectives.pdf.....7
16.12.07 - Board of Directors Minutes Public.pdf.....9
Report of the Deputy Chief Executive.pdf.....31
Devon STP Memorandum of Understanding for Governance.pdf.....37
Reshaping Community Based Health Services.pdf.....67
QPFW Report.pdf.....103
Financial Recovery Plan.pdf.....171
Reference Costs 2015-16.pdf.....179
Clinical Incident Report.pdf.....183
Undergraduate Medical Training.pdf.....221
Safety Scorecard.pdf.....243
Quality Assurance Cttee Report.pdf.....257
Report of the Chief Nurse (Safer Staffing).pdf.....259
Report of the Chief Operating Officer.pdf.....287
Report of the Medical Director.pdf.....301
Report of the Director of Workforce.pdf.....329
Report of the Director of Estates.pdf.....353

BOARD CORPORATE OBJECTIVES

Corporate Objective:

1. Safe, quality care and best experience
2. Improved wellbeing through partnership
3. Valuing our workforce
4. Well led

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems
2. Failure to achieve key performance standards
3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision
4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.
5. Failure to achieve financial plan
6. Delayed delivery of integrated care organisation (ICO) care model
7. Patients lost from the follow up system may not receive required appointments resulting in critical diagnoses being missed
8. Care Quality Commission requirement notice sets out significant concerns regarding safe quality care and best experience
9. Capacity in neurology leading to lack of new patient appointments, leading to long delay to initial assessment, threat of Referral to Treatment breach.

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST BOARD OF DIRECTORS MEETING HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE, TORBAY HOSPITAL ON WEDNESDAY 7TH DECEMBER 2016

PUBLIC

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

Mrs Cathy French	Lead Governor	Mrs Christina Carpenter	Governor
Mrs Carol Day	Governor	Dr Craig Davidson	Governor
Mrs Annie Hall	Governor	Mrs Barbara Inger	Governor
Mrs Mary Lewis	Governor	Mrs Catherine Micklethwaite	Staff Governor
Mr Simon Slade	Governor	Mr Peter Welch	Governor

ACTION

PART A: Matters for Discussion/Decision

173/12/16 **User Experience Story**

The User Experience story related to end of life care and was presented by the grandson of an elderly lady who was originally admitted for a knee replacement, with subsequent admittances to Torbay and Paignton Hospitals. The lady was hard of hearing and the family had asked that they be present whenever she was seen by a doctor, which did not happen; a transfer to Paignton Hospital was badly planned and she was readmitted back to Torbay within 36 hours; TEP forms were lost and had to be completed again; and in her final hours she was constantly interrupted by staff for vital signs and cleaning. A meal was also delivered even though the staff were informed by the family that the lady could not eat it. The family felt that there were a number of missed opportunities to accommodate the wishes of this lady for end of

life care and that her dignity was compromised in her final days on the ward, because staff were not sufficiently sensitive to her needs at the end of life.

The family were keen to stress that the Palliative Care Team worked very hard to try to get their grandmother admitted to Rowcroft and also the care of the consultant who made the decision to cease acute treatment for her.

Mrs French wished to reassure the family that the focus of Governors was always to ensure that the care received by patients was at the forefront of their work.

Mr Welch expressed concern that the care for this lady involved many separate events with evidence of poor care, involving many different people, and that it could not all be attributed to a the hospital being very busy. He also wished for assurance that the case would be used for learning throughout the Trust. The Chief Executive assured Mr Welch that learning would be taken from the case and agreed that there were a number of missed opportunities to improve this lady's care.

The Chief Nurse reported that the End of Life team were aware of this case and that they were using it as a basis for their workplan for the coming year to address each element of this lady's care and how it could be improved. Ch

The Chief Executive, on behalf of the Board and personally, apologised for the experiences of this lady and for the distress caused to the family because of this. It was agreed that the Chairman would also write to the family.

174/12/16 **Apologies for Absence**

Apologies for absence were noted from Mr Furse.

175/12/16 **Declaration of Interests**

Nil.

176/12/16 **Minutes of the Board Meeting held on the 2nd November 2016 and Outstanding Actions**

The minutes of the meeting held on the 2nd November 2016 were approved as an accurate record.

177/12/16 **Report of the Chairman**

The Chairman reported on the work of Project Search, in providing a year's internship for disabled interns and those on the autism spectrum. To date full time work has been found for many of the interns within the Trust, and work was now taking place to widen this and a meeting had recently been held with six local businesses to highlight the work of Project Search and potential employment opportunities.

The first Apprentice Awards Ceremony was being held later in the week. Over the last three years the Trust has trained over 450 apprentices of which 132 have obtained substantive posts at the Trust and many others have started training to become paramedics, nurses and AHPs. The Chairman added that earlier in the year the Trust had been awarded a National Gold Standard Accreditation Quality for its work in respect of the apprenticeship scheme.

Finally, the Chairman wished the Board to note that, following their visit in February, the CQC undertook to revisit the Trust within a year, so a visit should be expected very shortly.

178/12/16 **Report of the Chief Executive**

In addition to her report contained in the Board papers, the Chief Executive updated the Board on the following:

Dr Rose Polge

The inquest into Dr Rose's death would be taking place on the 19th December. The Medical Director confirmed that he would be attending the inquest and was ensuring that Rose's family and staff received any support they required during this difficult period.

Torbay Pharmaceuticals

The MHRA revisited the Wilkins site on the 2nd December and have now approved the use of the new site and necessary licences for operations. The thanks of the Board were extended to the leadership and staff of Torbay Pharmaceuticals for all the hard work that had been undertaken to meet the recommendations of the MHRA following their initial visit.

Community Services Consultation

A visit to some of the potential sites for the Paignton Health and Wellbeing Hub took place last week organised by Kevin Foster MP and attended by Dr Sarah Wollaston MP, local GP representatives, HealthWatch, community representatives, CCG and officials from Torbay Council and the Trust (CX and Directors of Estates). These visits were very helpful in sharing with key stakeholders the Council and Trust views on the advantages and limitations of the potential sites.

A voluntary Sector Transport 'Hackathon' recently took place in Torbay, with partners from across the South Devon and Torbay area and beyond. Exploring ways we could work together to improve access to health and care services and socialisation through an expanded transport offer is one of priority areas for more integrated work with our local voluntary sector. The Chief Executive opened this event, and specifically referenced how a more integrated and developed voluntary sector transport solution, supported by the Trust, would be a way of addressing the public concerns about access to care for vulnerable people which was consistently raised as a public concern in the recent consultation process on CCG proposals for changes to community services.

Concerns had also been raised by staff and local community leaders about the fragility of staffing levels at Dartmouth Hospital. The Chief Executive reported that a local plan to maintain safe staffing levels for the current number of beds had been put in place for December and that planning for January was underway. She also reiterated the Trust's commitment to maintain services until the CCG makes its decisions in January where that is possible given staff decisions to retire or move to other posts, which is natural and understood in this time of uncertainty. Safe staffing is also a significant challenge in some of our other Community Hospitals and the Trust will always put patient safety first in making our plans for resilience over the coming months.

ED Performance

Performance exceed 95% in October (the first time since October 2014), however this has dropped with a few challenging weeks and for November was 91.5%. December has seen a continuation of this challenge, and further actions are being taken to focus on the trigger points and escalation, and to reduce the increased number of patients with a length of stay of 10 days or more as this number has significantly increased in recent weeks.

Finance

The Trust is facing a significant challenge in delivering its financial requirements over the coming months and the Director of Finance would alert the Board to this risk as part of the Integrated Quality, Performance, Finance and Workforce Report.

Councillor Parrott wished the Board to note his disappointment that the Chancellor's Autumn Statement made no mention of Adult Social Care given the immense pressure on this service and he felt it showed that the Government did not understand current public concern. He also wished to highlight to the Board the recent concerns in respect of the Mears contract and CQC concerns around care provided in care homes. He said that the issue had been discussed at the recent Overview and Scrutiny Committee who were satisfied to date that improvements were being made. He added that Council Members have asked the Committee to devise a scheme centred around residential care with Councillors more involved in ensuring residents in care were looked after appropriately.

Councillor Parrott informed the Board that a decision had not yet been made in respect of Care Home Fees and it was likely that Judges might not be able to do this until July of next year.

Strategic Issues

179/12/16 **Wider Devon Sustainability and Transformation Plan (STP)**

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 eighth 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; and
- 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

The Director of Strategy and Improvement reminded the Board that it had been sighted on the development of the STP over recent months and this final report was now being presented to the Board in public. She wished to the Board to note that it was a high level framework and did not contain the detail of programme delivery. The programme was aiming to deliver efficiencies of £142m in South Devon over five years. Senior officers at the Trust were either directly leading or supporting the workplans to realise these efficiencies.

Councillor Parrott reported that the Director of Strategy and Improvement and team members had attended the recent Overview and Scrutiny Committee to brief the Council on the STP. He stated that he felt Council Members would be anxious about the programme until the detail of the workplans was understood.

Mr Allen stated that he would feel uncomfortable endorsing the STP without understanding the detail of the workplans and suggested that the Board could endorse the direction of travel and understood the need for change, but that it could not fully endorse it until the detail was available.

The Chief Executive said she understood these concerns and that the Executive Team had put a lot of work into the Plan to ensure it reflected the Trust's plans for its footprint and that they were specifically referred to and interwoven into the STP, however some of those plans could only be delivered on a wider-Devon basis.

The Director of Finance added that the STP included an assumption that STF funding for the system of £40m across the system would be received, however this had not yet been secured.

Mrs Marshall asked if there was any evidence that the Trust's plans had slipped due to STP and the Chief Executive stated that there had been a trade off in terms of Executive team with the necessary changes that affected the Trust but could only be achieved on a Devon-wide basis and that the Trust needed to work on a wider strategic basis to achieve all of its aims. The Chief Operating Officer added that the Board should not underestimate the benefits of sharing learning and working more

collaboratively on a wider basis. The Medical Director said that until the Trust engaged with colleagues in the rest of Devon it would not be able to address the issues being experienced in respect of vulnerable specialities.

The Board then formally endorsed the Wider Devon STP Framework, principles and direction of travel, with a caveat that it would need to understand the detail of the work before providing full endorsement.

180/12/16 **Wider Devon STP Acute Services Review**

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 Acute Services Review (ASR) criteria and principles.

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.

The Chief Executive informed the Board that if successful the review would deliver fundamental changes to the structure and service delivery of acute services across Devon. The paper had been endorsed by Torbay Council's Overview and Scrutiny Committee as one of the Trust's key partners.

Councillor Parrott stated that it was important, as this work progressed, that it was communicated in a way that the public understood it was to ensure the services affected could be delivered in a safe and effective way and that the status quo was

not an option. The Chief Executive agreed with Councillor Parrott's comments and added that as well as ensuring the wider public understood the need for the review, work had taken place with the Trust's staff to ensure they understood the reasons behind the review and to ensure there was good clinical representation for each of the services affected.

The Board formally endorsed the criteria and principles set out in the Acute services Review

181/12/16 **Into the Future: Reshaping Community-Based Health Services Public Consultation Update**

Strategic Context:

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

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

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

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

Key Issues/Risks:

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

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

The Director of Strategy and Improvement reported that the consultation had now closed. The CCG Governing Body was planning to consider recommendations in January and at that time a presentation would be made to this Board and Torbay Council's Overview and Scrutiny Committee on the outcomes from the consultation process. The paper presented to the Board also contained the final response sent to the CCG in terms of the Trust's feedback to the consultation process.

In terms of feedback on the consultation process there was some learning, but the Overview and Scrutiny Committee felt that there had been huge effort to engage with the community. The Committee would expect to see that the CCG has listened to

the feedback received.

The Chairman stated that he had attended Healthwatch's recent AGM meeting and he fed back that they felt the Trust had made a real effort to be open, transparent and engaged throughout the process. The Chief Executive wished to acknowledge Healthwatch's involvement in the process, and the quality and dedication they provided. It was agreed the Chairman would write to their Chief Executive to thank them for their involvement in the process. Ch

The Chairman also reported that he had recently attended meeting where a GP gave a presentation about the Teignmouth/Dawlish coastal changes and he said that to receive information from a local GP about the clear service benefits the changes had delivered was very compelling.

Finally, the Board's thanks were extended to all the staff who were involved in the process, form both the Trust and CCG for their support and hard work.

182/12/16 **Response to the Proposed Funding Reduction for Public Health in the Mayor of Torbay's Draft Efficiency Plan**

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.

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.

The Board discussed the draft letter and the content of the Mayor's proposals:

- The Lifestyles team would lose more than three quarters of its funding if the proposals were put in place. The team provided services across the South Devon footprint.

- Councillor Parrott wished the Board to be aware that he was not able to support the letter as he was a member of the Mayor's Cabinet and he made the following statement:

  Mr Chairman, I am concerned that the draft letter to the Mayor may lack a full appreciation of the background to the proposal to cut £345,000 from the Lifestyles budget and ask that what I am going to say be minuted.

  I should begin by saying that no one among my colleagues, including the Mayor, takes any pride or pleasure in the proposals for cuts that we are forced to make in the face of ongoing austerity. Indeed, our only source of

pride is just how hard officers have worked to identify what they have for us to consider. However, we are required by law to set a balanced and legal budget. I am sure that this is the kind of situation that is also faced by our partners here.

For Public Health, 2017-18 will see a total of £1m in reductions. £345,000 of which, it is proposed, should come from Lifestyles. The Director of Public Health assures me that, while she too is very unhappy, other options have been fully considered and that further cuts in other areas would result in clinical risk.

To be clear, a full prioritisation of services puts Lifestyle services at the bottom of the scorecard by four or more clear points. The question is, therefore, where the £345,000 might otherwise be found – remembering that all services have already been affected to some extent, and that a further £500,000 will need to be found in 2018/19? HIV? School Nurses? Drugs and Alcohol Services? Needle Exchange? Not easy questions, but serious questions.

Returning to Lifestyles in particular. Is it really an efficient and cost effective service? The Director of Public Health's office tells me that, of course, the vast majority of people who lose weight and stop smoking do so independently of our commissioned services and our model only provides support to less than 1% of the overweight and obese population. As for smoking, we are not a national outlier and our quitting rates are not statically different to the national average. Some of this, I am sure, will be down to good practice eg GPs telling patients of the serious and life-threatening implications of their behaviours in the short and longer-term.

In short, the reality is that the service has very limited reach. The proposal to digitalise, augmented with a telephone service, would undoubtedly reach a wider number of clients than one to ones.

Public Health South West have been asked for a view, and whilst they are far from happy, they agree that, in principle, public health objectives can be met by other delivery than the current Lifestyles service with close attention to specific initiatives, eg in housing.

So, Mr Chairman, colleagues, for all of these reasons, I ask you to reconsider your draft letter.

- The Medical Director acknowledged the criticism of the Lifestyles team in respect of one to one meetings vs the provision of a broader service. He added that, in theory, better reach might be realised by working digitally, but it was the view of the team that there was no evidence to support this and that they felt there was a place for both methods.

- Mrs Taylor asked whether Devon would be making similar savings as she understood Plymouth were in the process of investing in Public Health and it was noted that there was no indication that Devon was planning such cuts.

- The proposed cuts were not in line with the aspiration of the Care Model and the establishment of the Health and Wellbeing teams and the work on the prevention and early intervention agenda. As well as the Lifestyles team, the proposals would affect the public health nurse service, and the role the team played in respect of safeguarding children.

- If the letter was sent, it needed to be clear that the Trust was not in a position to financially cover the proposed cuts. The letter could also state that the

Trust had considered how to mitigate against the worst impacts of the cuts and detail those mitigating actions.

The Chairman and Chief Executive were asked to revisit the letter based on the discussions detailed above. **CE/Ch**

183/12/16 **Integrated Quality, Performance, Finance and Workforce Report – Month 7**

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

The Board noted the report and the following was discussed:

- The report content had been discussed in depth at the Finance, Performance and Investment Committee; Quality Assurance Committee; and Workforce Group.

- The ED 4 Hour target had been met in October, but performance had deteriorated since then.

- Waiting times continued to be of concern.

- CIP performance was ahead of plan at Month 7.

- It was noted that some of the stretch targets agreed with the Trust's commissioners were red, but it was important to note that they were stretch target and were also for the wider system, not just the Trust.

- The CAMHS KPI data was not available, as the data was currently in the process of being verified.

- Staff sickness was higher than target.

Councillor Parrott asked if there were any trends to the staff sickness, and the Director of Workforce and Organisational Development reported that work there were some 'hot spots' which were being addressed, and the main reasons for sickness were stress, anxiety and MSK**.** She added that networking took place to ensure any learning from other organisations was applied in the Trust. Also, there was currently a lot of sickness due to sickness bugs, colds and flu. The Chairman added that he had calculated that the increases related to 15 people out of a total of 6,000, which was not statistically relevant.

Mrs Lyttle queried the cancer wait targets and also operations cancelled on the day as these had increased and appeared to be due to process issues. The Chief Operating Officer reported that there had been an increase in operations cancelled on the day due to availability of special kit and this was being addressed. In respect of the cancer waits, the two week wait had been affected by the demand placed on Dermatology, however it was now back on target and work was taking place with Exeter to build resilience into the system. The Cancer 62 day target for urgent referrals had also been affected and this was due to a complex range of issues including the booking process (which had been resolved); and patient choice.

The Chief Nurse reported on the dementia find target and stated that a trajectory for improvement would be provided in her next report to the Board. She added that there had been some improvement but there was still some variances within individual wards. She wished to provide the Board with assurance that focus was being applied to the target.

Mr Welch raised the deterioration in ambulance handover times and asked if focus could be applied to performance. The Chief Operating Officer said that this had been identified as an issue and was being addressed through the A&E Delivery Board as part of cross-system work.

In terms of financial performance the Director of Finance reported that Month 7 performance remained close to plan, but that the position had deteriorated since Month 6 when the Trust was £1.8m better than plan. The reason for this was related to CIP under-delivery against the increase in the savings profile at this stage of the financial year. There had also been an increase in expenditure. It was noted that the Board would more fully discuss the implications of the financial position and mitigating actions in the Private Board meeting later in the day.

184/12/16 **RTT**

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 forms part of the criteria to access the Service Transformation Fund (STF).

The Trust was compliant with the improvement trajectory for the two 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.

The Chief Operating Officer stated that the Board needed to be aware of the risks and challenges facing the Trust in terms of meeting the RTT target trajectory. If no action was taken performance would be at 86% by the end of March 2017 and 83% by the end of 2018. Actions over and above those already being taken would need to be put in place to ensure the targets could be met and this would need to include outsourcing and recruitment to a significant number of Consultant vacancies. Part of the solution would also be the work taking place in the Acute Services Review to develop new delivery models for vulnerable services and how they were provided in the future.

Mrs Lyttle queried the chances of the Trust being able to fill vacant posts, given current difficulties in recruitment and this risk was assessed to be high, with potential for service change a likely outcome, again linked to the work under the Acute Service Review. Mrs Lyttle queried the additional work being undertaken by services to meet demand and the fact this this was masking the problem of not being able to fill vacant posts. The Chief Operating Officer said that any additional measures such as extra clinics were only short term and regular review points were in place and clinics were stood down if those thresholds were met.

185/12/16 **Clinical Validation of Patients with Delayed Outpatient Reviews**

Strategic Context:

There is increasing delay in outpatient assessment of patients in a range of specialties, reflecting increased referrals, greater urgent care pressures and/or recruitment and retention difficulties.

Action plans are in place to reduce waiting times but there is a need to ensure that the risk to patients is minimised.

Key Issues/Risks:

- Risk has been identified in delays to outpatient follow up patients (6,500 patients at the present time across the Trust).

- Delays to assessment of new 'first outpatient' referrals are emerging in some specialties.

- Mitigating practices are in place in the majority of specialties and in all those with high risk of significant harm.

- There is residual risk after mitigation but this is low to moderate.

- Concerns about Neurology have been raised by the CCG. Mitigating actions are in place to reduce risk.

The Medical Director stated this report gave the Board some background to the current pressures facing certain specialties resulting in delays to outpatient follow ups for around 6,500 patients. There was also a backlog of first outpatient appointments which was being managed under the RTT plan previously discussed. Measures were in place to ensure patients at high risk of harm were identified.

Also, as the Board was aware, there were significant concerns in respect of Neurology.

Recommendations on further actions to manage the risk were being discussed at the Clinical Management Group meeting later this week.

186/12/16 **Governors' Questions**

Mrs French queried the structure the Trust had in place to assess the patient experience for domiciliary care clients. The Chief Nurse said that there were quality and safety measures included in the Trust's contracts with its providers however, as previously reported, work was taking place to improve information collection from all services that had contact with clients. Mrs French asked if a report for the Board to Council could be provided on this issue. CN

Mrs French then queried the formula to calculate care home fees and it was noted that the legal judgement had not yet been in respect of Torbay Council's fees. It was agreed that a briefing on the setting of the fees would be provided at a future Board to Council once the outcome of the judicial process was understood. DoF

Mrs Carpenter queried the cost of funding per patient for a week of care home provision and it was agreed this would be provided for a future Council of Governors. JP

Mrs Hall asked, given that care homes were closing and hospital beds were being reduced, what would happen if there was flu epidemic. The Medical Director confirmed that the Trust had a Flu Pandemic Plan that would be put in place in such circumstances, with a clear escalation plan to stand down services to create capacity, and added that very few people required hospital treatment if they did suffer from the flu.

Mrs Carpenter queried the means of appealing against a package of care and the Chief Nurse explained that the Trust had a very robust process of appeal that was nationally set, and clients had this process explained to them as part of the care package process.

Finally, Mrs French noted that a pharmacy company had been fined £90m for overcharging the NHS and suggested the Trust should lobby the Government for any payback to be allocated to Trusts.

187/12/16 **Any other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)**

188/12/16 **Safety Scorecard**

Strategic Context:

The Safety Score card views a number of different metrics from across the organisation relating to the safety of patients. The metrics are derived from internal and external sources and are there to provide top level information and assurance.

Key Issues/Risks:

The paper highlights the annual rebasing exercise undertaken by Dr Foster with regard to HSMR and therefore prior data may look slightly different. The rebasing makes it harder to achieve the 100 average to take into account the improvements that are made, year on year by trusts. The latest data point for our HSMR shows the Trust is performing well when benchmarked against neighbouring Trusts on an improving national trajectory.

October recorded a Never Event which does not feature in the report as it covers April 2015 to August 2016. An oral solution of sodium bicarbonate was used in error instead of an IV preparation. The patient suffered no harm and changes have been made to the ordering processes and a new label is being added to the top of the solution highlighting the solution if for oral use only. All due processes post event have been followed.

189/12/16 **Charitable Funds Terms of Reference**

Strategic Context:

The proposed amendments to the Terms of Reference would ensure better targeting the resources of the Charitable Fund at patient priorities which will enhance patient care and experience.

Key Issues/Risks:

A summary of key proposed changes to Terms of Reference is detailed below:

- To give the Committee a pro-active planning role, in setting spending priorities for individual Fund Managers to follow.
- To make the Committee responsible for appointing Fund Managers.
- To define the Committee's oversight role with respect to Fundraising.

The revisions would require individual Fund Managers to follow centrally-identified spending priorities that may be contested by those Fund Managers who have been used to taking such decisions independently.

Fundraising activities require careful oversight, due to current public/media concern about inappropriate fundraising techniques used by some charities and the resulting reputational risk.

The Board noted the report detailing the reasons behind the need to amend the Charitable Funds Committee Terms of Reference.

The Board approved the revised Terms of Reference of the Charitable Funds Committee.

PART B: Matters for Approval/Noting without Discussion

190/12/16 **Reports from Board Committees**

The following reports were noted:

- **Charitable Funds Committee, 24th November 2016**
- **Finance, Performance and Investment Committee, 29th November 2016**

Reports from Executive Directors

191/12/16 **Report of the Chief Nurse**

Strategic Context:

- The Trust is required as part of the NHS Standard Contract to complete dementia case finding within 72 hours for all emergency admissions 75 years and over that are inpatients for greater than 72 hours or longer.
- Dementia case finding has been a national CQUIN since 2014/15 before forming part of the national contract in April 2016.
- Performance data is published by NHS England. On 5th October 2016 the data from July 2016 was published and the Trust was 146th in the country with a 37% achievement against a 90% target. (150 Trusts FT and non FT).
- Over 74% of Trusts achieve the 90% national target.

Key Issues/Risks:

The key risk is frontline staff failing to embrace the current changes to the model with the advent of Nerve-centre. It is anticipated that Nerve-centre should be fully operational by April 2017 and includes dementia case finding.

Success will be achieved if:

- The revised model is fully implemented and successfully embedded.
- The organisation supports the importance of dementia case finding as a priority.
- The performance is discussed at key meetings from ward to board.

Councillor Parrott wished to place on record his thanks to the Chief Nurse for her involvement in, and contribution to, the Children's Services Board.

Mr Welch wished to note his disappointment on the poor performance in respect of Dementia Find, while acknowledging the work that was taking place to improve performance

192/12/16 **Report of the Chief Operating Officer**

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.

193/12/16 **Report of the Director of Workforce and Organisational Development**

Strategic Context:

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group.
- To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks:

- Performance against the key workforce metrics for 2016/17 are included in the report.
- The Workforce and OD Group reviewed a capacity plan to reduce the nurse vacancy gap over the next five years and requested a final proposal for their next meeting in January.
- The Appraisal rate remains at 84% against a target of 90% a range of measures to improve the rate were agreed at the Workforce and OD Group.
- The Workforce and OD Group agreed at their meeting on the 17th November 2016 that given the positive effect of the existing incentives and controls to reduce agency spend the existing incentives to substantive staff and bank workers to cover shifts should be maintained. However no further incentives should be introduced pending a further update in January 2017.
- Programmed alerts to managers in respect of responsibility allowances, acting up and fixed term contracts will reduce the potential for erroneous payments.
- The implementation of the new Learning Management System (LMS) & Nurse Revalidation system has been delayed.
- The Senior Management Leadership Development Programme commences in December.
- The Trust has been part of the successful STP bid to become one of the 11 national pilot sites for the Nursing Associate role in the UK. The Trust will employ 10 Training Nursing Associates.

Risks

- The outcomes of the community services consultation and implementation of any changes being in close proximity making consultation challenging.
- Failure to achieve workforce changes in accordance with the Trusts Operations Plan including CIP plans.

- The rolling sickness absence rate has increased to 4.27% against a target of 3.90% a range of measures to mitigate the increase are contained in the report.

- These measures are included in an enabling efficiency scheme in the Trusts 2017/2018 operations plan.

- NHSI has brought in a range of additional reporting requirements for temporary staff. The Board needs to be assured that appropriate agency management action is being taken and that the self-certification checklist is completed and returned to NHSI by the end of November.

- Medical recruitment in general remains a challenge.

- Junior doctor contract working hour's restrictions may leave the Trust at risk of covering gaps in rotas. Analysis of the data is currently being undertaken.

- Failure to deliver against targets in the apprenticeship reforms will result in at least some of the apprenticeship levy of £1.3m being withheld.

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

194/12/16 **Report of the Director of Estates and Commercial Development**

Strategic Context:

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

Key Issues/Risks :

Critical Estate Failure: The heating to Theatre 5 was lost due to age related failure of heating plant. One day's operating capacity was lost. The Trust has made a temporary repair to ensure that service is not compromised further. This plant is part of the backlog risk and requires replacement within the next year.

There have been two further critical estates failures in November. The heating to the whole of the top of the site including the Breast unit was lost for a period of seven days due to the corrosion of a water pipe due to age. This has now been patched. Service was maintained through the use of additional portable electric heaters.

One of two vacuum pumps has failed reducing the Trust's contingency to manage a possible failure of piped suction to the surgical block. Both pumps are of the same age and have been on the list of backlog for replacement. The pump has been sent away for rectification (if possible) and is expected back in the Trust on the 29th November for fitting. This increased risk of failure of the Vacuum system has been placed on the Trust risk register as a 15.

Because of the increasing number of failures of infrastructure over the last month the risk rating of corporate risk 1083 ' lack of capital funding to spend on backlog maintenance and contingency for estates emergency expenditure: effect failure of key plant and infrastructure score' has been increased to a 20. This is as a result of the likelihood moving from possible to likely.

The Finance Committee is considering the financial position of the Trust with a view to releasing capital to spend on backlog maintenance.

The Board noted the report of the Director of Estates and Commercial Development.

195/12/16 **Compliance Issues**

Nil.

196/12/16 **Any Other Business Notified in Advance**

The Chairman reminded the Board that the trial in respect of Mrs Vasco-Knight was taking place at the end of January next year.

197/12/16 **Date of Next Meeting – 9.00 am, Wednesday 1st February 2017**

Exclusion of the Public

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

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1	Chairman to write to Mr Jon Bradley to thank him for presenting the User Experience story.	Ch	**Completed**	07/12/16
2	Chairman to write to Chief Executive of Torbay Healthwatch to thank them for their involvement in the community hospital consultation process.	Ch		07/12/16
3	Chairman/Chief Executive to finalise letter to the Mayor in respect of Public Health funding.	Ch/CE		07/12/16
4	Report to future Board to Council meeting to be provided to detail the work taking place to improve patient experience for domiciliary care clients.	CN		07/12/16
5	Briefing on social care fee setting to be provided at a future Board to Council once the outcome of the judicial process was known.	DoF		07/12/16
6	Allocation per patient for a week of care home provision to be provided.	JP		07/12/16

Report to:	Trust Board
Date:	1 February 2017
Report From:	Paul Cooper, Deputy Chief Executive
Report Title:	Chief Executive's Business Report

1 ICO Key Issues and Developments Update

Well Led

Financial Performance 2016/17

As the Board is aware, the Trust is facing a serious financial shortfall this year. We have been planning to deliver an £8.3m million planned deficit which reflected system risk under the Risk Share Agreement (RSA). However a number of new cost pressures and gaps in CIP delivery and slippage mean the Trust faces a larger deficit. A Financial Recovery Plan has been developed and is being implemented to mitigate the situation. Some £4m has been identified for delivery before the end of March which will contain the deficit growth to an additional £3m (after the RSA is applied) bringing the year end forecast to £11.3m deficit.

The Board has already approved a range of actions to help reduce the shortfall, including a vacancy freeze for all non-clinical posts; a complete stop on non-clinical agency, bank and overtime; a reduction in non-clinical temporary posts and a Mutually Agreed Resignation Scheme (MARS). Most importantly it will ensure that implementation of the new care model is expedited as quickly as possible to both improve care and enable efficiency benefits to be realised.

Further details of the Financial Recovery Plan and progress to deliver the £4m savings are set out in a separate paper on the public Board agenda. Directors propose to produce a weekly recovery plan update to track progress against KPIs to provide assurance to the Board, commissioners, community and staff that the deficit has been contained as we pursue the improvements necessary to reduce our run rate.

Risk Share Agreement (RSA)

As agreed at the December Extraordinary Board meeting to consider financial plan options for 2017/18-19, the Trust has given 12 months' notice to commissioners of our intention to exit the Risk Share Agreement. Levels of income described in the RSA are not sufficient to enable the Trust to achieve control totals now in force. The context has been fully explained, along with the need to continue to plough ahead with system-wide savings, and the intention to negotiate a more suitable arrangement before the RSA 12 month notice period expires. The Chief Executive and Deputy Chief Executive briefed local MPs, Sarah Wollaston and Kevin Foster and ensured that NHSI and NHSE had accurate information before the issue was raised in the House of Commons and at the Public Accounts Committee in January.

Safe Quality Care and Best Experience

Reconfiguration of community services

Following extensive public consultation, the CCG's Governing Body has now taken the decision, subject to the meeting of an agreed set of criteria, to approve proposals to reconfigure community hospitals, enabling the new community care model to be implemented in full. Members of the Governing Body agreed that by strengthening community-based services, more people will be looked after at home, so fewer people would need to be admitted and kept in hospital unnecessarily. As a result, hospitals in Bovey Tracey, Dartmouth and Paignton and Mid Vale and Church Street clinics will close and the buildings sold to generate capital funding to invest in local health services. While Ashburton and Buckfastleigh Hospital will also close, it could, subject to the evaluation process and discussions with local GPs, host the health and wellbeing centre with primary care co-located.

A separate paper is included in the Board packs with the detailed report presented to the Governing Body which details the key findings from the independent consultation feedback report produced by Healthwatch which informed the final set of recommendations considered by the Governing Body.

The recommendations were communicated to staff affected (and governors) when papers were published. After the decision was taken, executive directors along with operational and HR managers went to all four hospitals affected to meet with staff. The hospitals will close as soon as safety permits and all the CCG's agreed parameters are achieved.

Valuing our Staff

Staff Heroes

The second Staff Heroes awards, which has replaced the WOW awards, took place in January. These internal awards enable patients and service users to nominate staff and their teams in recognition of excellence in care provision. These Awards are for our staff, who are working day in, day out beyond the call of duty for our patients. Nominations are open all the year round and the Heroes Awards are recognised with a certificate and presentation at a celebration event with the Chairman and members of the Executive Team.

Operational Management Changes

A number of changes to the Operations management structure have taken place to reflect the organisation priorities. This includes John Harrison, Head of Planning and Performance who has been appointed to the role of Deputy Chief Operating Officer.

2 Local Health Economy Update

Upcoming consultation on Public Health nursing services
Devon County Council's cabinet has approved a six-week consultation to consider the future commissioning arrangements for Public Health nursing services in Devon. It will seek views on three options for the nationally mandated Public Health nursing service, including school nurses and health visitors. The service is currently part of an Integrated Children's Services contract, which comes to an end on 31 March 2018. The consultation will begin in the next couple of weeks. In the meantime, the CCG is still in the process of analysing data and patient experiences before planning what kind of services we will need in South Devon and Torbay. A strategy setting this out will be published in draft during February with a feedback invite. We are also continuing to work with NEW Devon and Devon County Council's children's social care department to plan services for the STP area.

Devon STP - Acute Services Review
The review of acute services across the wider Devon STP area has begun. The initial services being reviewed are Stroke, Maternity, Neonatology and Paediatrics and Urgent Care. Each review has begun holding workshops to consider the criteria and options for change.

People moves and appointments

- **South Devon & Torbay CCG: New Deputy Director of Quality Assurance**
  Lorraine Webber has been appointed as the CCG's new deputy director of quality assurance. Lorraine will join the team in the spring, taking with her a wealth of nursing and leadership experience gained from her time with us in Torbay and South Devon NHS Foundation Trust and Torbay Care Trust.
- **Devon STP: new communications lead**
  Andrew Millward has been appointed as Communications Director for the Wider Devon STP. He is well known in the region, having been Communications Director for the former Strategic Health Authority and more recently as Director of Communications and Corporate Affairs for NHS Property Services.
- **NHS E: Regional Director appointments**
  NHS E has confirmed there will be two regional directors appointed for NHS England South. Jennifer Howells has been appointed to lead the South West and will continue to lead the whole of the South region until the end of March. Work is under way to identify a regional director for the South East. The change affects the regional tier only, with Mark Cooke and his executive team continuing to lead NHS England in the existing South West patch.

3 Chief Executive Leadership Visibility

Internal: • Forrest Ward • Team at Kings Ash House • Apprentice Award Ceremony • Staff Heroes Presentation • Medical Staff Committee • Coastal Team
External: • Proposed Paignton Health and Wellbeing Hub Site Tour with Kevin Foster and Sarah Wollaston, MPs • STP Chief Executives' Meeting • STP Collaborative Board • League of Friends Monthly Meeting • Director of Adult Services, Torbay Council • Chair and Executive Director, Healthwatch Devon • South West Delivery and Improvement Director, NHSI

4 National Developments and Publications

Details of the main national developments and publications since the December 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 to highlight for the Board include:

Policy and guidance

- **Simon Stevens paves way for combining purchasing and commissioning-** A small number of the most advanced STPs will soon become "integrated organisations" combining providers and commissioners, while others will be able to take control of staff working across their region. *The Devon STP Collaborative Board has been exploring the potential benefit of accountable care communities at both local and STP level. Partners across the South Devon and Torbay system are supportive as the next step in our integration journey.*
- **National tariff payment system published for 2017/18 and 2018/19**
  Following a period of consultation, NHS Improvement and NHS England have published the National tariff payment system for 2017/18 and 2018/19.

Performance

- **Full extent of NHS winter crisis:** NHS Digital has reported that a record number of patients are facing long waits at England's A&Es. Nearly a quarter of patients waited longer than four hours in A&E last week, with just one hospital hitting its target. Since the start of December, hospitals have seen only 82.3% of patients who attended A&E within the four-hour target. Levels of bed occupancy were reported at 94.7% of beds full - above the "safe" threshold of 85%. About one in five patients – 18,000 – admitted for further treatment had to wait over four hours on trolleys and in hospital corridors. A total of 20.5m people went to emergency departments in England in 2015/16, compared with 12.3m in 2007/8, according to NHS Digital figures. Of these, 1,008,939 were aged 85 and above and more than two million children aged four and under. *Here at TSDFT in the last seven days we have seen some improvement with 4 hour waiting time performance. One of our key measures of patient flow is the number of longer stay patients, over 10 days, and encouragingly this that reduced in recent weeks from 80 patients in early December to around 45 now. Although we remain on high escalation we have been able to maintain patient flow across the wider urgent care system.*
- **Warnings about flu outbreak as hospitals feel winter pressures:** The latest winter performance data released by NHS England shows nearly half the hospitals in England declared major alerts last week. In the first week of January, 65 of 152 hospital trusts issued 'operational pressure alerts', which meant they could no longer cope and 'patient flow' was being affected. Six issued the highest alert level – 'patient safety' at risk. The paper warns that the worst may be still to come in the form of new flu outbreaks. *The Trust is feeling the impact of increased flu including within the workforce and has asked people not to visit the hospital if they are suffering from flu. Staff continue to be encouraged to have a flu jab.*
- **Hospital food fails to meet government standards:** A report by the Department of Health has found that half of hospitals are failing to meet government standards for hospital food. Only 54% of hospitals are following all ten rules covering food quality, nutrition, environmental sustainability and animal welfare. Over 90% are either fully or partially compliant. The standards also require that patients are screened for malnutrition and that meals and drinks are provided 24 hours a day. The report also found that 51% of hospitals have meals delivered while 33% cook from scratch on site. *Directors are reviewing the Trust's position against this benchmark information.*

Think tank reports

- **Nuffield Trust and the Health Foundation** have published their joint QualityWatch annual statement for 2016. *Quality at a Cost* looks at a range of care quality measures across the NHS in England. The report highlights several areas where standards have improved but warns of slowing improvement in others against a backdrop of growing waiting times and continuing financial pressures. The report argues that work by NHS staff to increase productivity and meet targets may have delayed the impact of financial pressures on the quality of healthcare, concluding that other areas of patient care may experience a similar delayed decline as the financial squeeze continues.

Representative Bodies

- **NHS Providers** calls for an urgent review of the way the health services manages winter pressures. They say trusts cannot carry on trying to manage well known winter pressures in this way and that they should have the chance to set out in a review what has worked for them and what needs to change.
- **Royal College of Surgeons**: have criticised rationing plans introduced by the NHS in the West Midlands who have introduced a scoring system designed to assess patients' illness in order to reduce hip operations by 12% and knee replacements by 19%. The system, intended to save £2.1m a year, will allow patients to be refused surgery if they are obese or unless they are in so much pain they cannot sleep.

5 Media Update

Media references to the Trust in the past month include:

- The media have covered winter pressures and our alert status
- First look at hospital's new critical care unit – *Herald Express* here
- Response to Mayor's Budget – *Herald Express* here
- Decision on community hospitals consultation - here
- Flu outbreak here
- Assaults on staff here

Paula Vasco-Knight fraud case

After one and a half days of evidence, Paula Vasco-Knight, former chief executive of South Devon Healthcare Trust, changed her plea from innocent to guilty on a charge of fraud. She and her husband, who also pleaded guilty, are due to be sentenced on 10 March. The NHS Employee accused of aiding them was found not guilty. The case attracted widespread regional and national media coverage

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017 – Board of Directors
Title:	**Devon STP Memorandum of Understanding for Governance**
Lead Director:	Ann Wagner, Director of Strategy & Improvement
Corporate Objective:	This proposal supports the following corporate objectives: • Objective 1: Safe, Quality Care and Best Experience • Objective 2: Improved well-being through partnership • Objective 4: Well led
Corporate Risk/ Theme	This proposal provides mitigation against the following corporate risks: 1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems 2. Failure to achieve key performance standards 3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision 4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality. 5. Failure to achieve financial plan 6. Delayed delivery of integrated care organisation (ICO) care model 9. Capacity in neurology leading to lack of new patient appointments, leading to long delay to initial assessment, threat of RTT breach.
Purpose:	To **update** Board on Devon STP governance development

Summary of Key Issues for Trust Board

Strategic Context:

The Devon STP is the planning footprint within which the South Devon and Torbay Health and care system is placed. Throughout 2016 the Trust has collaborated with commissioners and providers across the STP in developing the STP planning submission which identifies 7 key priority areas with underpinning work programmes to deliver the changes required to ensure a clinically and financially sustainable health and care community.

The Governance arrangements that underpin the STP, which evolved from the NEW Devon Success Regime governance arrangements, have been reviewed and a Memorandum of Understanding (MoU) for governance has been developed. This provides a mechanism for securing the agreement and commitment to sustained engagement with and delivery of the STP to realise a transformed model of care in Devon.

Key Issues/Risks:

The intent of this agreement is to bind the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. This requires the Parties to the agreement to recognise the scale of change required and that its impact may be differential on the Parties.

This MoU does not and is not intended to:

- give rise to legally binding commitments between the Parties
- affect each Party's individual accountability as an independent organisation

Recommendation:

The Board is asked to **confirm** the Trust's agreement to the Memorandum of Understanding

Summary of ED Challenge/Discussion:

Executive Directors have been closely involved in the development of the STP framework and are actively involved in the work programmes to deliver the key priorities. The development of the MoU has been reviewed in terms of obligations, benefits and risk. The MoU derives from the agreement across New Devon in lieu of a formal contract between providers and commissioners.

In the absence of any active decision to change formal contract arrangements for the South Devon System – being the Risk Share Agreement or any successor to it – will remain paramount.

The Board is well sighted on the scale of challenge – both across the STP footprint and within the South Devon & Torbay locality. Within the Board's consideration of the Trust's own operational planning submission, there was agreement to strengthen the alignment with partners in New Devon, and in particular to explore with NEW Devon Success Regime and regulators the entry criteria and benefits that would accrue to the system by a more formal alignment with the Success Regime financial plan and associated contractual arrangements with Trusts. The Trust's engagement through the MoU supports that direction.

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

Nil.

Equality and Diversity Implications:

Nil.

Public

Devon STP memorandum of understanding for governance
This memorandum of understanding is made on 16th December 2016

1. Parties

The parties to this MoU are the following NHS commissioners and providers, local authorities and regulators in the Devon STP footprint:

North East and West Devon CCG
South Devon and Torbay CCG

Devon County Council
Plymouth City Council
Torbay Council

Devon Partnership NHS Trust
Livewell Southwest
Northern Devon Healthcare NHS Trust
Plymouth Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust

NHS England
NHS Improvement

2. Background

2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create their own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV).

2.2 The Devon footprint was identified as one of the STP footprint areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations.

2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency.

2.4 The Parties have agreed and submitted their STP in the current form as set out in Schedule 1 but agree that it is a living document that may be varied and updated from time to time.

3. Objective and Intent

3.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with and delivery of the STP to realise a transformed model of care in Devon.

3.2 The intent of this agreement is to bind the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. This requires the Parties to recognise the scale of change required and that its impact may be differential on the Parties. The partnering statement is included within Schedule 4.

4. Obligations

4.1 The Parties agree to work collectively to establish the detailed plans and organisational impacts that will achieve the Objectives and Intent. These will incorporate finance, activity and workforce as a minimum, and will be set out in an annual system plan in a format to be agreed.

4.2 The Parties agree that they will comply with the annual system plans that move the system incrementally towards the Objectives and Intent according to such pace of change as agreed at Finance Working Group (FWG), and set out in the summary system plan, and contracted for periodically as required by regulators.

5. Benefits

5.1 The Parties shall realise the benefits of working collectively by receiving system and regulator support to manage in-year and longer term risks as a whole system, supported by the Parties individually and collectively to the extent that no organisation is deemed to fail individually. Regulator interventions will be aligned to this benefit in order that all parts of the system can release maximum resources to delivery of the intent.

6. Leadership

6.1 Angela Pedder has been designated the STP Leader within the Devon footprint.

6.2 The STP Leader's role and remit are set out in Schedule 2.

6.3 The designated STP Leader may change from time to time in accordance with such process as may be agreed by the Programme Delivery Executive Group (PDEG).

7. Duration of the MoU

7.1 This MoU will take effect on the date it is signed by all Parties.

7.2 The Parties expect the duration of the MoU to be for the period of 2016-2021 in line with the duration of the STP or otherwise until its termination in accordance with Clause 13.

8. Agreed principles

The Parties have agreed to work together in a constructive and open manner in accordance with the agreed principles for ways of working and culture set out in Schedule 3 to achieve the Objective and Intent.

9. Effect of the MoU

9.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.
9.2 The MoU does not and is not intended to affect each Party's individual accountability as an independent organisation.

9.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

9.3.1 have given proper consideration to the terms set out in this MoU; and

9.3.2 agree to act in good faith to meet the requirements of the MoU.

10. Governance

10.1 The Parties have agreed to establish PDEG to co-ordinate achievement of the Objective and Intent.

10.2 The Parties have agreed Terms of Reference of PDEG in the form set out in Schedule 4. Terms of Reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective and Intent.

10.3 Each Party will nominate a representative to PDEG and notify the STP Leader of his or her name and a deputy who is authorised to attend for him or her in his or her absence.

10.4 The Parties agree that PDEG will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.

10.5 PDEG will meet at least monthly or as otherwise may be required to meet the requirements of the STP.

10.6 PDEG does not have any authority to make binding decisions on behalf of the Parties. Collective decisions agreed at PDEG will require ratification by each Party's unitary Board or equivalent.

11. Subsidiarity

11.1 The Parties acknowledge and respect the importance of subsidiarity.

11.2 The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

12. Risk management and assurance

Whilst agreed system principles apply to all parties as set out in schedule 3, detailed risk management arrangements differ for the constituent parts of the system at the time of setting out this MoU. Risk management arrangements for the NEW Devon Health part of the system are set out in Schedule 7. Risk management arrangements between Plymouth City Council and the relevant part of the NEW Devon system are set out in the section 75 agreement. Risk management arrangements between Devon County Council and the relevant parts of the NEW Devon system are set out in the section 75 agreement. Risk

management arrangements for the South Devon and Torbay part of the system are set out in their contract which also incorporate the relationship with Torbay Council.

13. Resources

13.1 The Parties have agreed to commit their own resources to achieve the Objective in accordance with the arrangements set out in Schedule 5.

13.2 The Parties have further agreed the arrangements set out in Schedule 6 for engaging external resource and advice.

14. Openness and transparency

14.1 The Parties agree that they will work openly and transparently with each other and with other stakeholders including non-executive directors, governors and councillors of the Parties and other local health and care organisations.

14.2 PDEG will receive plans that demonstrate each Party's compliance with their duties of public involvement to the extent that these may impact on any other party to this agreement, or be enhanced by the involvement of one or more of the Parties. If there is any ambiguity as to whether PDEG may require these plans then this should be discussed with the STP leader.

15. Termination

Any Party may withdraw from this agreement at any time. In doing so they recognise that they will cease to benefit from any collective agreement or treatment established whilst acting under the agreement.

This agreement is intended to last for the life of the STP (currently March 2021), but this collective commitment will be reviewed at least annually to ensure that it remains fit for purpose and meets the needs of the Parties. The Parties will agree whether to extend or amend this arrangement according to prevailing circumstances.

16. Dispute resolution

16.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.

16.2 Where the Parties are unable to agree, proposals for dispute resolution will be set out by the STP lead according to the circumstances of the dispute, such that any mediation/arbitration is conducted by one or more of the Parties neutral to the dispute. This may require recourse to external expertise, and where this is the case this will be procured in accordance with Schedule 6. Some example scenarios and the suggested resolution processes are set out in schedule 8.

17. General provisions

17.1 This MoU will be governed by the laws of England and the courts of England will have exclusive jurisdiction.

17.2 The Parties agree that this MoU may be varied only with the written agreement of all the Parties.

Signed by the parties or their duly authorised representatives on the date set out above.

Signed by duly authorised for and on behalf of)
[PARTY 1])

Signed by duly authorised for and on behalf of)
[PARTY 2])

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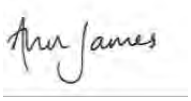
Janet Fitzgerald
Chief Officer, NEW Devon CCG

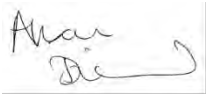
Nick Roberts
Chief Executive, South Devon & Torbay CCG

Angela Pedder
Lead Chief Executive, Your Future Care (Success Regime) & STP

Suzanne Tracey
Chief Executive, Royal Devon & Exeter Foundation Trust



Ann James
Chief Executive, Plymouth Hospitals NHS Trust



Alison Diamond
Chief Executive, Northern Devon Healthcare Trust

Mairead McAlinden
Chief Executive, Torbay & South Devon NHS Foundation Trust

Steve Waite
Chief Executive, Livewell Southwest

Melanie Walker
Chief Executive, Devon Partnership Trust

(Subject to Board ratification)

Schedule1 – Latest STP Submission

Schedule Two – Role and Remit of STP Leader

Lead Chief Executive - Plymouth and Devon
Role description and person specification

1 Introduction

The Devon Success Regime is a momentous and rare opportunity to redefine the future of health and social care. As only one of three Success Regimes to be announced nationally there is a collective responsibility to transform care and build delivery and confidence through collaborative effort. Increasingly effective performance management will only take us so far on that journey but linking the discipline and analysis with innovation, courage and a leadership model which dares to innovate together will deliver the prize for future generations - services which meet the needs of local populations which are of outstanding quality, financially and clinically sustainable.

The 5 NHS bodies that are directly accountable through the Success Regime, Devon Partnership NHS Trust, NEW Devon CCG, Northern Devon Healthcare NHS Trust, Plymouth Hospitals NHS Trust and Royal Devon & Exeter NHS Foundation Trust, and with the support of Plymouth City Council and Devon County Council have identified an essential role to support the local leadership and health social care systems - a Lead Chief Executive. The unanimous local nomination of such a role is just one example, but a fundamental signal of our collective commitment, to be greater than the sum of our parts and take this opportunity to reframe health and care services which is now so pressing for our local populations.

2 What behaviours will the Lead Chief Executive need to demonstrate?

The Lead Chief Executive and indeed all leaders across the NHS in Devon pledge to be system leaders and advocates for the population as a priority to the interests of their own organisations. In pursuit of the inclusive development and confident delivery of the transformation plans for the Success Regime, the Lead Chief Executive will need to be:

- organisationally neutral, system leadership focused
- open, frank and constructive, building good relationships with colleagues and between colleagues
- engaging of all stakeholders, partners and the public to build a momentum for constructive challenge, constructive dialogue, engagement and consultation
- committed to build on the positive experiences and services across the patch while pursuing the adoption of best practice and outcomes for all to meet the scale of the challenge faced
- act and be regarded as fair, balanced and inclusive

- be an honest broker and mandated by colleague Chief Executives to support and constructively challenge other leaders and Boards to reframe their leadership style and language if necessary to secure the agreed goals of the Success Regime

- able to unequivocally explore, through openness and transparency, areas of conflicting views or perceived vested interests of any of the parties.

- appreciate and integrate the differing requirements, governance and accountabilities involved in the Success Regime

- Coach all to secure the best of the opportunities the Success Regime affords Devon health and social care while respecting and honouring the extant statutory roles of each organisation and their respective Chair and Chief Executive's

- able to use the expertise and experience of all to provide insight in to those areas the individual may have less personal experience of for example primary care provision, specialist mental health as just 2 examples

- open to feedback - all leaders across the Success Regime commit to undergo a 360 degree appraisal every quarter – based on style, behaviours and impact to deliver the objectives agreed.

- work effectively and be accountable to an Independent Chair and through a "Collaborative Board" of CEOS/ALBs and Chairs.

- Demonstrate courage, energy and up most integrity

3 What are the requirements of the Lead Chief Executive?

This role will require an individual who has the confidence, and therefore the mandate of fellow Chair/Chief Executive colleagues with the following attributes:

- An experienced and successful executive leader
- Specifically understands the regulatory arenas and the complexity of health and social care provision
- having a national reputation and experience of working on Boards
- a wide range of experience at a national level
- an efficient, effective, person centred and future focused experienced coach of very senior individuals
- corporate track record of succeeding in a highly challenging environment where tenacity, resilience and humility have been key ingredients for success.
- Able to rapidly build confidence of the ALBs to successfully deliver the emergent case for change. *Credibly balances the local effort of best people while engaging external capacity to really drive a new way of working.*
- Visible to stakeholders to secure their engagement and offer solutions for future models of care

- Able to facilitate and resolve potential material issues of difference in terms of governance and pace of delivery
- A confident public and media spokesperson
- Fluent in the new models of care, national developments, integrated care and the potential for devolution deals across a wide and dispersed geographical patch
- Demonstrable experience of managing local delivery and change under intense national political and media interest

4 What is the role of the Lead Chief Executive

- Lead the development and delivery of one system, one plan and one control total. This would be a compelling platform from which to build at pace and scale taking forward the case for change for transformation, securing sustainability and new models of care within an ambitious timescale.
- Design, lead and drive the overall Success Regime Programme. This would include working with all stakeholders and NHS bodies to maximise our local potential for all systems to deliver excellence, improved health and well-being for populations and communities and integrated and improved care for people.
- In leading the programme exemplar engagement and consultation would be integral to the major programme of system transformation, system engagement and redesign for a sustainable future.
- The Lead CEO would develop the Case for Change into a compelling plan working with the statutory roles of organisations e.g. CCGs. Agree, with engagement from stakeholders, consultation, when appropriate, public engagement and implementation. This requires careful navigation and negotiation in relation to statutory governance, legal frameworks and forging new rules with ALBs for new models of care and organisational forms as well as with other statutory bodies. This should be primarily about reinforcing the current statutory roles of organisations whilst also filling the current gap in leading system transformation, locally effective plans for sustainability and the Success Regime.
- The lead accountability and point of contact for the Arms Length Bodies to secure the confidence and programme for delivery of the Success Regime in phases 2 and 3. This would include the line management of the current Programme Director role and central programme office functions. In addition remaining CEOs who take on a SR lead role for example Carter, Continuing Care, Dementia and Elective Care would report directly to the Lead CEO.
- The Lead CEO would work with the appointed Programme Director to develop the resource requirements for transition and transformation for submission nationally and to secure any ongoing external capacity and capability to maximise the successful delivery of the developed case for change.
- The external resource requirements would complement the establishment of our local capacity and capability ‘our best people’. This will be a fundamental focus to get the local knowledge expertise resourced and external capacity and capability.

- The One System Devon and Plymouth Board has no stand-alone statutory basis yet the commitment and confidence in its establishment and leadership needs to be sufficiently robust as to deliver the agreed collective endeavour of the Success Regime. This will require One System Board's leadership to articulate its role on which the collective support is made as being separate from the individual statutory roles and requirements of each organisation represented. As the Success Regime evolves the mechanisms for governance and organisational form will also develop.
- in collaboration with the Independent Chair and partner CEOs and Chairs design and keep under review the overall governance structures for the Success Regime.
- Executive lead for the development for the STPs as required by NHSI and NHS England (January) 2016.

Schedule 3 – Agreed Principles

Partnership Working Agreement

The Programme Delivery Executive Group (PDEG) and Collaborative Board have been established to oversee delivery of the Sustainability and Transformation Plan (STP). These groups comprise a number of organisations working in partnership and have therefore agreed the following framework to support a new way of working. Agreement to these principles is a pre-requisite for membership of PDEG and Collaborative Board.

This agreement is open to organisations with a significant local stake in the health and social care economy in Devon. In addition to committing to the principles and values set out in this agreement, members of PDEG will be either health and social care commissioners responsible for meeting the needs of the population of Devon or providers with a material stake in the health and care economy (defined as a financial relationship with one or more of the commissioners of £50m or greater). The organisations that meet these criteria and eligible for membership subject to signing up to this agreement are set out in appendix 1.

Partnership Values

The Sustainability and Transformation Plan relationship will be based on:

- First and foremost impact on people who uses services and their carers
- Collaborative Leadership & Decision Making
- An inclusive process across the NHS and Local Government
- Engaging clinicians, practitioners, and staff delivering NHS funded care
- Equality between all organisations involved
- Mutual respect and trust
- Open and transparent communications
- Co-operation and consultation
- A commitment to being positive and constructive
- A willingness to work with and learn from others
- A shared commitment to providing effective and efficient services to the population of wider Devon
- A shared commitment to deliver parity between mental and physical health care
- A desire to make the best use of resources across the NHS and local government
- Respect for each organisations statutory sovereignty
- We are committed to ensuring that we behave fairly and justly to all parties irrespective of political affiliation.

Partnership Outcomes

- Service delivery will be quality outcome focussed, prioritising people's care and experience by working towards an improvement in health and well-being and a reduction in health inequality
- All partner organisations share a common vision and values, whilst understanding the scope of their individual obligations to ensure commissioning

ambitions, service delivery and intentions of each of the organisation are accounted for

- The Model of Care within our system will be transformed to achieve a financially and clinically sustainable health and care systems within Devon and beyond
- Place Based Systems of Care (PLACE) will be the fulcrum of our work programme; we recognise the determinants of PLACE will differ for some services; more specialist services will require larger populations to ensure safe effective and financially sustainable care
- Primary Care provision will play a key role in the design and delivery of the emergent new models of care, mechanisms to secure the involvement of non-statutory body providers must be developed
- This is a five year programme; we recognise the design of the transformational new models of care will require extensive engagement and for some emergent models formal consultation will be necessary
- Our plan will deliver financial and performance improvement from year one
- The New Models of Care will determine organisational form. We expect new organisational forms will be required to embed and sustain the transformation required, consequently we expect there to be fewer statutory organisations over time both in provision and commissioning

- Within three to five years, the system will move to a position where it does not spend more resources than the resources available to it
- All parties agree that costs may be taken out of the system, which may differentially impact on organisations. This in turn may mean higher costs in short term for individual organisations and the STP Programme will oversee this to ensure unsustainable and unplanned pressures are not created.

Partnership Behaviours

- We agree to work collaboratively at pace to successfully achieve the STP
- We will identify where it is mutually beneficial to share information to advance an evidenced individual and/or system benefit, and to do so on the basis that the information requested is reasonable for the purpose only, and not excessive. Where information is shared, it is agreed that it will be used for the stated purpose only
- We will demonstrate, through our positive and proactive and inclusive manner, a willingness to make the Partnership succeed
- We will communicate openly about major concerns, issues or opportunities
- We will demonstrate transparent communications in terms of delivery of STP plans and notification of any quality or financial organisational concerns, including mitigation planning
- We will share information, experience and resource, to work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost
- We will adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information

- We will act in a timely manner and recognise the time-critical nature of judicial review processes, procurement process and any other relevant time-critical process and respond accordingly to requests for support
- We will learn from best practice of partner organisations and seek to develop as a Partnership to achieve the full potential of the relationship
- We will work collaboratively on all aspects of our work seeking to release resource to focus on the transformation and adopt an approach based on doing things once together i.e. one plan for everything we do – trusting others to act on our behalf and on behalf of the system
- We will publish operational plans and performance data including waiting times, sharing strategic plans, headline contract values and CIP plans
- We agree that challenge will be required in the system and parties will on occasion take different views. All parties agree that where possible we will aim to resolve issues of difference between organisations professionally and privately
- We will take care in content and presentations in public, including board reports and in media
- We agree not to take pre-emptive public action, which will cause a public disagreement
- We agree that the right thing to do is to take costs out of system and therefore we will not engage in activities that primarily aim to transfer deficits
- We will require programme leads to be responsible for assuring and mitigating the commercial conflict of involvement in the wider redesign programmes
- We will develop our workforce to enable people to deliver the objectives requested of them from the STP
- We will work together as partner organisations to develop plans for devolution which will support delivery of our shared objectives
- We agree to cascade within our own organisations these values, behaviours and work programmes, leading by example
- We agree to challenge openly when there is a disagreement and use peer review plans to ensure all partners keep with the pace required of the STP.

Partnership Agreement Appendix1: Programme Delivery Executive Group and Collaborative Board eligible organisations

Devon County Council
Devon Partnership Trust
Livewell Southwest
Northern, Eastern and Western Devon Clinical Commissioning Group
Northern Devon Healthcare NHS Trust
Plymouth City Council
Plymouth Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
South Devon and Torbay Clinical Commissioning Group
South Western Ambulance Service Trust
Torbay and South Devon Hospitals NHS Foundation Trust
Torbay Council

Schedule 4 – PDEG Terms of Reference

Role:

During transition from existing Success Regime/STP architecture supported by Carnall Farrar, PDEG will fulfil two roles, described here as Part One and Part Two. Over time, and as the system becomes more self-sustaining, this agenda is expected to merge to become a single agenda, supported by the system itself.

PDEG is established to act as the forum where decisions made affecting more than one and maybe all member organisations are then ratified by each unitary Board of member organisations following a recommendation agreed at PDEG.

Agenda and Order of Business to be transacted at PDEG

Part One

To provide the overall "Programme Board" function for the system
To propose the strategy for the system for approval by statutory bodies
To provide the system leadership and co-ordination for programmes requiring a system response.

Part Two

To receive assurances from its subordinate groups
To receive assurances from member organisations
To drive delivery within the system, via each attendant CEO
To monitor delivery of the system plan at the strategic level and agree corrective measure proposals from subordinate groups
To delegate tasks to subordinate groups in furtherance of STP objectives
To receive and approve recommendations and/or business cases from sub-committees or member organisations in furtherance of STP objectives

Membership:

All CEOs
System CEO
System DoF/Chair of FWG
System Medical Director/Chair of Clinical Cabinet
System Plan Delivery Group/System Performance Group Chair
Programme Director

In attendance

All Work-stream leads – as required
All other subgroup chairs – as required
Regulators (NHSE and NHSI currently)
CF support team – Part One only

Subordinate Groups:

Finance Working Group (FWG)
Clinical Cabinet
System Plan Delivery Group/System Performance Group
System executive group
System workforce and OD Group

Delegation to subordinate groups

Subordinate groups may only make such decisions without recourse to PDEG as are capable of being made within the delegated powers of the individual members. All system decisions requiring Board/Governing body approval will be referred to PDEG in the form of a recommendation made by the appropriate subordinate group with sufficient information to inform the decision making process. For the avoidance of doubt, where any conflict exists between this statement and the terms of reference of any sub-group, this statement shall prevail.

Chair:

The Group will continue to be chaired by the Independent Chair until such time as the system becomes self-sustaining and formally exits the Success Regime, at which time the chair will be appointed by such process as agreed by PDEG.

Key Agreements to be signed up to by organisations:

Declaration of commitment and accountability

In order that the system may performance manage its-self to achieve its objectives, there is a requirement for organisations to give Board/Governing body approval for their organisations to be collectively supported to deliver and to be held to account for that delivery by the system governance arrangements. Whilst their agreement cannot be legally enforced, commitment to this level of mutual accountability is essential, particularly in advance of any challenging circumstances arising.

In order to minimise external intervention, there is considerable advantage to the system of sign-up by regulators to a system-wide plan and accountability arrangements, so that they can have confidence in the system delivering its-self without their intervention. It is therefore proposed that regulators are similarly requested to sign up to a similar commitment.

The organisations therefore agree by their signature to this MoU to the following Partnership Statement:

The strategic partners in the Devon Health and Social Care Economy agree that there is considerable benefit to joint working arrangements that put our patients and service users at the heart of everything we do.

We accept that the clinical and financial sustainability challenge is of a scale that will require significant change in order for these to be addressed.

Some of the changes may require any of our organisations to enact developments that whilst demonstrably improving delivery across the system, may be suboptimal to membership organisation. We commit to making such changes where these deliver the STP overall objective of clinical and financial sustainability of the system in the knowledge that none of our organisations are likely to be considered a “going concern” in a system that remains insolvent in totality. This commitment is matched by partner

organisations agreeing to manage any detrimental consequences for individual member organisations affected such that this is agreed by all STP members including regulators.

We agree to provide the appropriate attendance to support the membership of PDEG to hold each other to account to deliver our elements of the system plan, and to support and accept support from our partner organisations to achieve our objectives. We agree that this function will be exercised collectively, and by the appointed, organisationally agnostic, officer members (System Lead CEO and DoF)

Role of Subordinate Groups

Clinical Cabinet

The role of the Clinical Cabinet is to:

- To provide clinical leadership to the programme, ensuring that the programme develops robust proposals that are safe and effective as well as clinically and financially sustainable, making recommendations to the Programme Delivery Executive Group for decision where these require a system response.

- Specifically it will:
  - Provide senior clinical leadership for Success Regime and Sustainability & Transformation Plan (STP) programme of work, making recommendations to the Programme Delivery Executive Group.
  - Establish and co-ordinate the work of the Clinical Working Groups (where required to take forward short focussed work) to develop and finalise service models and proposals for implementation or consultation where required.
  - Provide clinical leadership and advice for the development and implementation of service changes required to deliver the system objectives for 16/17 – 18/9 and beyond.
  - Ensure that clinical colleagues are kept informed about the work and are engaged in the work as appropriate.
  - Be ambassadors for the programme and ensure there are clinical and professional care advocates for proposals in each relevant service area.
  - Lead the implementation of the plans following consultation.

Finance Working Group

The role of the Finance Working Group is to:

- Provide leadership, strategic advice and guidance for the financial delivery of the Sustainability Transformational Plan (STP). This will include the provision of director level advice and support to the programme;
- Ensure that the strategy is fully costed, that its impact on the wider health and social care system is modelled and understood and that it meets the requirements to deliver a financially sustainable health system. This will be set out in a Strategic Financial Framework (StFF) that will be reviewed from time to time.

This will require close working between the Finance Directors of wider Devon in commissioners, providers, social care, NHS England, NHS Improvement and other partner organisations. It will ensure that the proposals and plans developed by the system within the proscribed governance framework meet the requirements of the Strategic Financial Framework (StFF) and support the best configuration of service, and delivery of health and care services within available resource for the population of Devon. This purpose is expected to endure for the period of the STP.

System Plan Delivery Group/System Performance Group (SPDG)

To ensure delivery of the overall agreed system plan and constitutional targets including but not limited to A&E, RTT and Cancer performance. The Group will provide leadership, strategic advice and guidance. This will include regular analysis of activity to plan, providing corrective actions, short-term improvements against quality and performance standards and mitigation where necessary.

Responsibilities:

The System Plan Delivery Group will be responsible for:

- Reviewing monthly delivery and financial validation reports from each work stream/patch
- Facilitate delivery and help individuals/teams remove blockages
- Provide a platform for teams to escalate risks and their mitigation proposals for approval
- Manage and resolve any issues where they arise, rather than making them a system problem
- Holding to account the work-stream SROs and Control Centres in supporting consistent approaches to delivery and development of new schemes.
- Ensure remedial action plans are developed and implemented when required
- Oversee the development of business cases for investment prior to submission to relevant decision making authority.
- Provide monthly report to Programme Delivery Executive Group

SPDG will be supported by locality delivery and performance groups at an operational level, and that these will subsume the current roles of IPAM/Quality review meetings. [Leadership arrangements for these are not yet finalised]

It is anticipated that SPDG will include attendance by regulators (NHSE and NHSI initially), and that the locality delivery and performance groups will facilitate any deep dive required by any of the regulators. This should then prevent the need for IDM/Quarterly review arrangements between the system and regulators on an individual organisation basis.

System Executive Group

TBA – but purpose is to manage the system performance and governance arrangements on a day to day basis, meets weekly – membership is System CEO, System FD, System Programme Director – to include South Devon equivalent, System Medical Director, PMO lead.

System workforce and OD Group

1. To provide strategic direction to the Workforce Workstream

2. To be accountable to the Programme Delivery Executive Group for the delivery of the work contained within the Workforce Workstream.

3. To be accountable to the Programme Delivery Executive Group to enable the delivery of the workforce elements identified within the Change Programmes.

4. To assure the quality and sustainability of the future workforce model options.

5. To hold to account task and finish (project) groups to deliver outcomes.

6. Through the Strategy Group membership, ensure that each members' organisation is aware of the workforce matters that may have an impact on them and organisational actions required.

7. Collaborating with the Organisational Development work stream to define the future design principles of the system way of working and then to articulate the future "employment deal" between staff and organisations – taking into account any national policy such as changes linked terms and conditions etc.

8. Engagement of educational providers (Health Education England, Universities, Colleges, Schools, Leadership Academy etc.) – regionally and nationally to influence supply of future workforce capability/skills.

9. To identify and manage risks.

Schedule 5 – Resourcing

The Devon STP represents the strategy for the system for the period 2016 – 2021. Each member organisations own strategy is expected to have significant alignment with this strategy and conflict between the two should be minimised or eliminated.

In recognition of the local circumstances set out in the Partnership Statement included in schedule 4, it is expected that delivery of the STP objectives are seen as the core business of each member organisation, and each will therefore commit their resources to delivery of the STP objectives without recourse for additional resource to the system. Each member organisations is expected to commit the equivalent of two days per week for each executive director of their organisation to the delivery of the system plan.

PDEG may from time to time agree that system objectives cannot be delivered as described above, and that some additional resourcing is required to be deployed for system benefit. In such circumstances appropriate member organisations are expected to contribute in a way that is considered fair and proportionate, recognising the respective differential roles of commissioners and providers. These will be agreed on a case by case basis as need arises.

Schedule 6 – Engaging external resources

Circumstances may arise from time to time whereby the system requires expert external advice or services that are either not available to be sourced from a partner member, or are required for purposes of independence.

Such resources will only be commissioned by agreement at PDEG, or with the agreement of PDEG by a subcommittee or individual that has been duly delegated to commission such advice or services.

Where this is the case, to provide the necessary assurances to member organisations regarding value for money and probity, proper procurement process will be followed as set out in the SFIs and SOs of the organisation most appropriate to commission the advice or services.

For the avoidance of doubt, this excludes any work commissioned for the purposes of the Success Regime – NEW Devon where existing arrangements already apply.

Schedule 7 – Risk management

MoU Schedule 7.pptx

Schedule 8 – Dispute resolution scenarios

Assuming that paragraph 16.1 has failed, the following sets out a range of possible dispute resolution scenarios. These are not exhaustive, but give a guide to the approach to local dispute resolution. Each scenario starts with the notification to the STP lead that such a dispute exists.

Parties are expected to represent themselves (no legal representations will be accommodated), and work to the time-scales indicated to bring disputes of any kind to a resolution as quickly as possible.

Scenario 1

Two organisations disagree on the location of a single-site service, and each considers it to have a material impact.

Step one: The parties in dispute complete a single agreed set of documentation that sets out an agreed back-ground statement, followed by each organisations position that clearly states what the dispute is. Each party should also set out what they believe to be reasonable as a solution to the dispute.

Timescale: Within 1 week of notification of dispute

Step two: Two or more other organisations from within the system (one or more may be regulators) are nominated to hear the dispute (The Panel). These will be selected for their expertise and neutrality. The CEOs (or regulator equivalent level) of the respective organisations will constitute the panel, but they may draw upon the relevant expertise from within the system to advise them.

Timescale: Within 3 working days of receipt of dispute documentation by the STP Lead. The STP Lead may select the panel at the point of notification if the nature of the dispute is sufficiently clear to allow this to happen.

Step three: The panel (together with any expert advisors) will convene to consider the paperwork submitted. The panel may call either or both parties for clarification. Should either or both parties be called, then the other must be present.

Timescale: Within one week of notifying the panel, or receipt of the written documentation, whichever is the later.

Step four: The panel will withdraw to consider their decision.

Step Five: The panel will present their decision to both parties, setting out their reasons as fully as is reasonably practical.
Timescale: On the day or as soon as possible thereafter, setting out clearly any reason for a delay in making a decision.

Step six: There is no appeal process. If the parties fail to agree the proposed solution then they are at liberty to terminate this arrangement.

Scenario 2

System decision leaves a single organisation in a position that its Board cannot support

Step one: The Board in dispute sets out in writing their rational for why they feel unable to support the decision. This written report should include the following headings:

Background – puts the decision in the context of the organisation

The decision not supported - A clear articulation of the decision that has been made, and reference to the document that contains the decision, or the recommendation on which the decision has been made.

Why the decision cannot be supported - The agreed system principle(s) as set out in schedule 3 that is(are) not being adhered to that gives rise to their inability to support the decision, or where they believe that one or more agreed principles are being applied that conflict.

The impact that the decision has that gives rise to their inability to support it.

Suggested remedy/alternative decision - Their suggested remedy that complies with schedule 3, or in the case of conflicting principles, complies with the spirit of schedule 3, that they believe delivers the same or better outcome.

Timescale: Within one week of notifying the STP Lead

Step three:

The STP leader will nominate an appropriately independent and skilled panel from within the parties to this agreement where possible (and where this is deemed not possible, this is sourced in accordance with schedule six) who will receive and comment on the report, drawing on such expertise as is needed in order to make a recommendation to the STP leader as to whether there is a legitimate and/or previously unconsidered reason why the decision should be reviewed.

Timescale: Within 3 working days of receipt of dispute documentation by the STP Lead. The STP Lead may select the panel at the point of notification if the nature of the dispute is sufficiently clear to allow this to happen.

Step four:

On the basis of the recommendation the STP leader, taking such advice as considered appropriate by them, will propose a solution either that the decision stands in the interest of the system, setting out the reasons why; or that the decision be revisited in the light of the reasons raised and such other information that they consider necessary and reasonable to inform the decision.

Timescale: Within one week of receipt of the written report.

Step five: There is no appeal process. If the parties fail to agree the proposed solution then they are at liberty to terminate this arrangement.

Scenario 3

One organisation cannot deliver its control total and it considers that this is as a direct result of a system decision.

Step one

The organisation will set out in writing their rational for why they believe they cannot hit their control total, and which system decision has caused this inability. The report should include the following headings:

Background – puts the decision in the context of the organisations financial position.

The decision that causes the problem - A clear articulation of the decision that has been made, and reference to the document that contains the decision, or the recommendation on which the decision has been made.

Why the decision causes the problem, including the agreed system principle(s) as set out in schedule 3 that is(are) not being adhered to that gives rise to their financial pressure, or where they believe that one or more agreed principles are being applied that conflict.

The material impact that the decision has caused that gives rise to their inability to achieve their control total.

Suggested remedy - Their suggested remedy that complies with schedule 3, or in the case of conflicting principles, complies with the spirit of schedule 3, that they believe will improve the position for their organisation and the overall system.
Timescale: Within one week of notifying the STP Lead

Step two:

The STP leader will nominate an appropriately independent and skilled panel from within the parties to this agreement where possible (and where this is deemed not possible, this is sourced in accordance with schedule six) who will receive the report.

Timescale: Within 3 working days of receipt of dispute documentation by the STP Lead. The STP Lead may select the panel at the point of notification if the nature of the dispute is sufficiently clear to allow this to happen.

Step three:

The panel will receive and comment on the report, drawing on such expertise as is needed in order to make a recommendation to the STP leader as to whether there are actions the system can take to improve the organisations and the overall system financial position.

Timescale: Within one week of receiving the report

Step four:

On the basis of the recommendation, the STP leader, taking such advice as considered appropriate by them, will propose a solution either that the decision stands in the interest of the system, setting out the reasons why; or that the decision be revisited in the light of the reasons raised and such other information that they consider necessary and reasonable to inform the decision.

Timescale: Within one week of receiving the recommendations.

Step five: There is no appeal process. If the parties fail to agree the proposed solution then they are at liberty to terminate this arrangement.

Scenario 4

One organisation changes its practice unilaterally, such that this has a negative impact on another party to this agreement or the system as a whole.

Step one: The organisation experiencing the negative impact, or becoming aware of the adverse system impact will prepare a report to include the following headings:

Background – as much as they believe relevant to the circumstances so that it is sufficient to advise the reader of the report.

The action that causes the problem – sufficient information to explain what change of practice has happened, and if possible, why the organisation changing its practice has done so, ie what risk were they mitigating?

The material impact – how the change of practice has had an impact, the scale of the impact and the other parties affected by the change of practice, and the principles under schedule 3 that have not been adhered to.

A suggested remedy – what action could the precipitating organisation or any other organisation take that could resolve the problem, including how these comply with schedule 3.

Timescale: Within one week of notifying the STP Lead

Step two

The STP leader will nominate an appropriately independent and skilled panel from within the parties to this agreement where possible (and where this is deemed not possible, this is sourced in accordance with schedule six) who will receive the report.

Timescale: Within 3 working days of receipt of dispute documentation by the STP Lead. The STP Lead may select the panel at the point of notification if the nature of the dispute is sufficiently clear to allow this to happen.

Step three:

The Panel will receive and comment on the report, drawing on such expertise as is needed in order to make a recommendation to the STP leader as to whether there are actions the system can take to resolve the issue.

Timescale: Within one week of receiving the report

Step four:

On the basis of the recommendation the STP leader, taking such advice as considered appropriate by them, will propose a solution in the interest of the system, setting out the reasons why. This solution may be that an options paper needs to be considered by PDEG.

Timescale: Within one week of receiving the recommendations

Step five: There is no appeal process. If the parties fail to agree the proposed solution then they are at liberty to terminate this arrangement.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
Title:	**Into the future: Reshaping community-based health services Governing Body response to public consultation**
Lead Director:	Ann Wagner, Director of Strategy & Improvement
Corporate Objective:	This proposal supports all 4 corporate objectives: • Objective 1: Safe, Quality Care and Best Experience • Objective 2: Improved well-being through partnership • Objective 3: Valuing our workforce, paid and unpaid • Objective 4: Well led
Corporate Risk/ Theme	All
Purpose:	To **update** Board on CCG Governing Body decision and **provide assurance** regarding next steps implementation

Summary of Key Issues for Trust Board

Strategic Context:

On 26 January the CCG Governing Body considered the attached report which details the process of consultation, responses to consultation, the Healthwatch report including alternative suggestions and an evaluation of the alternative suggestions culminating in a final set of recommendations

Following extensive public consultation, the Governing Body has now taken the decision to approve proposals to reconfigure community hospitals, enabling the new community care model to be implemented in full. Members of the Governing Body agreed that by strengthening community-based services, more people will be looked after at home, so fewer people would need to be admitted and kept in hospital unnecessarily. As a result, hospitals in Bovey Tracey, Dartmouth and Paignton and Mid Vale and Church Street clinics will close and the buildings sold to generate capital funding to invest in local health services. While Ashburton and Buckfastleigh Hospital will also close, it could, subject to the evaluation process and discussions with local GPs, host the health and wellbeing centre with primary care co-located.

The Governing Body also agreed three additional proposals in response to public feedback:

- Ashburton and Buckfastleigh Hospital will be evaluated as a base for the area's local health and wellbeing centre, which would include GPs.
- A proposal to establish an urgent care centre on the Torbay Hospital site to provide an MIU service to the Bay should be pursued.
- Specialist outpatient clinics will continue in Paignton, where the volume of patients makes this a more appropriate option to travelling to Brixham, Totnes or Torbay.

The decision means the following for each of the main towns:

- Bovey Tracey/Chudleigh: hospital will close; health and wellbeing centre to be co-located with GPs.
- Ashburton/Buckfastleigh: hospital to close but the site will be evaluated with a view to it becoming a health and wellbeing centre, co-located with GPs.
- Newton Abbot: to have medical beds, MIU, clinical hub and health and wellbeing centre.
- Totnes: to have medical beds, MIU, clinical hub and health and wellbeing centre.
- Dartmouth: the hospital to close; a health and wellbeing centre will be co-located with GPs

(likely at the Riverview site); Dartmouth clinic will close.
- Brixham: to have a clinical hub, including medical beds, and health and wellbeing centre.
- Paignton: hospital will close; a health and wellbeing centre and specialist outpatients will be created; the Midvale clinic will close.
- Torquay: to have a health and wellbeing centre, plus urgent care centre.

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

Key Issues/Risks:

The aim is for the changes to be implemented as soon as parameters are met to ensure that new services operate safely. The parameters include for example:
- the remaining community hospital inpatient services meet the requirement for safe staffing standards for sub-acute bed-based care
- Newton Abbot and Totnes MIUs to be open 8am-8pm 7 days a week, and that these MIUs to have radiology at least four hours a day, seven days a week
- intermediate care (for patients who need care but don't need a hospital) operating at least six days a week.

We are cognisant of the impact on staff and are ensuring those staff directly affected by the proposals are supported and briefed. The recommendations and parameters were communicated to staff affected when papers were published. After the decision was taken, executive directors along with operational and HR managers went to all four hospitals affected to meet with staff. The hospitals will close as soon as safety permits and all the CCG's agreed parameters are achieved

Change of this magnitude is not without risk – we have seen a number of staff move on already despite assurances regarding job security. As the Board is aware we have taken immediate action to ensure safe staffing levels, including reducing beds temporarily where necessary. This is being kept under close review with further contingency plans in place if required.

Now that the decision to implement the proposals has been made, Directors will focus on implementation and a smooth transition for service users and staff. The Chief Operating Officer, Liz Davenport, is the Executive sponsor for this work and will provide regular updates for the Board through the usual governance and reporting channels. Providing written assurance that the CCG criteria have been met prior to closure will form a key part of the governance arrangements.

Recommendation:
The Board is asked to:
- **note** the decision of CCG Governing Body;
- **recognise** the contribution staff have made in terms of excellent care provided at the community hospitals and clinics; care model development and supporting the public engagement and consultation process; and
- **note** the assurance arrangements to enable implementation.

Summary of ED Challenge/Discussion:
Executive Directors have been very closely involved in the development of the proposals to ensure they are aligned with and support our new model of care which lies at the very heart of our ICO aspirations for the local community.

Directors and their teams have been present throughout the consultation to facilitate, support and listen to the views of our local communities and staff.
Internal/External Engagement including Public, Patient and Governor Involvement: There has been extensive public and staff engagement throughout the pre consultation period. This will continue through the implementation and transition phase. Governors have been briefed and were represented at each of the public meetings. Governors attended the CCG Governing Body where the final decision to approve was reached. The support of our public Governors in reflecting views from their constituents has been valuable and shared with the CCG and Healthwatch.
Equality and Diversity Implications: The proposals will impact on NHS services for years to come therefore it was essential that the local community were given every opportunity to have their say, including suggesting alternative proposals for consideration. Quality impact assessments have been completed and will be refreshed through the implementation phase.

Public

NHS
South Devon and Torbay
Clinical Commissioning Group

GOVERNING BODY

Report title: Reconfiguring Community Services

Date: 26 January 2017

Date report produced: 19 January 2017

Author (s):

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Report approved by Director:

Name: Simon Tapley

Date:19 January

Summary of Purpose and scope of report:
(Please also indicate if the report is for consultation, approval or information)

Consultation	**Approval Yes**	**Information**

To make decisions on the reconfiguration of community services following formal consultation and evaluation of alternative suggestions and feedback

Executive Summary:

This paper summarises the engagement and consultation process followed over the past three years in relation to the development of proposals to reconfigure community services. It summarises the pressures which face our health and social care system, the rationale for change and the new model of care designed to provide a sustainable and affordable way of providing quality of care. It outlines the process followed, the way in which the CCG has met its statutory obligations and the main issues arising from the recent consultation. It also reviews the alternative proposals put forward by the public and reviews in the light of public feedback the proposals put forward by the CCG for consultation.

It also sets out the recommendations of the Community Services Transformation Group for the delivery of quality, responsive care for the communities the CCG serves and which Governing Body is asked to approve.

The main sections and page references are:

	Page
The timeline	4
The financial challenge	5
The rationale for change	6
The model of care	7
Consultation proposals	9
Adherence with engagement and consultation obligations	11
Formal consultation summary	14
South West Clinical Senate Review	15
Consultation Feedback Report	17
Evaluation process and criteria	17
Evaluation of alternative proposals	19
Consultation feedback on CCG proposals	27
Implementation	31
Recommendations	32

Strategic risk: (include risk number if on register) 141 205	**Mitigating Actions:** The Trust has managed its staffing to maintain services and clarity as to future provision will be provided by GB approving recommendations contained in this paper.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted.
Any new declarations must be fully recorded and included in the minutes of the meeting and notified to **corporate.sdtccg@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

Community Services Transformation Group
Consultation Project Board

Corporate Impact Assessment	
Quality & Safety/ Patient Engagement/ Impact on patient services	As described in paper
Finance, resources and QIPP	Implementation of the consultation proposals are estimated to save £1.4m
What, if any, are the legal implications?	Decisions by Governing Body could be challenged
Communication plan and stakeholder involvement	As described in paper
Equality Impact Assessment:	
Are there any Quality or Equalities (including inequalities) implications of this report? (Please specify)	The new model of care and related proposals are designed to deliver quality care for more people and to reduce health inequalities across our population by improving access to services
Have you carried out an initial Quality and Equality Impact Assessment (Y/N) and is it attached? (Y/N) **If not, why not?**	Equality impact assessment of the proposal Equality impact assessment of the process

Key recommendations and actions requested:

Based on the evaluation of the alternative proposals and the review of the consultation proposals in the context of feedback from the consultation:

- Governing Body reaffirms its belief that on the basis of the best available evidence the proposed model of care represents the best way of delivering quality of care in a manner that is sustainable and affordable

- Governing Body approves the proposals which formed the basis of consultation and which are summarised in section 6 above subject to the following changes:

    - The use of Ashburton Hospital as a health and wellbeing centre be fully evaluated together with the feasibility of primary care being co-located in the same building so as to ensure sustainability

- The provision of MIU and x-ray capabilities in the Bay be met by the proposed establishment of an Urgent Care Centre at Torbay Hospital

- To support patient access, high volume specialist outpatient clinics to be split between Paignton and Brixham. The number and type to be reviewed as part of the implementation plan.

- Governing Body approves the parameters set out in section 14 for the implementation of changes relating to the care model and stresses the importance of achieving full implementation as swiftly as operationally possible

- Suggestions relating to implementation of the care model put forward in the Healthwatch Consultation Report be reviewed as part of the implementation process

- Progress reports on implementation of these proposals be reported quarterly to Governing Body and be regularly communicated to the communities of South Devon and Torbay.

Accompanying paper(s):

Healthwatch Consultation Report previously circulated and available at **Healthwatch report**

Reason for reports inclusion in the confidential section of the Governing Body meeting:

N/A

***Please add N/A if any of the sections are not relevant*

Reconfiguring community services

1. Introduction

For over three years, the way in which care is delivered across our communities has been the subject of much debate as the CCG and its partners have examined how best to respond to the increasing demand, changing clinical standards and financial pressures.

This paper summarises the process followed over this period, the pressures which face our health and social care system, the rationale for change and the new model of care designed to provide a sustainable and affordable way of providing the quality of care that we all seek. It outlines the process followed, the way in which the CCG has met its statutory obligations and the main issues arising from the recent consultation. It also reviews the alternative proposals put forward by the public and looks at the recurring concerns raised in relation to the proposals put forward for consultation by the CCG.

It also sets out the recommendations of the Community Services Transformation Group for the delivery of quality, responsive care for the communities the CCG serves and which Governing Body is asked to approve.

2. The timeline – reconfiguring community services

The recommendations before Governing Body represent the conclusion of three year's development which has involved widespread engagement, discussion and most recently public consultation.

In late 2013, the CCG in partnership with our acute and community providers, Devon County Council and Torbay Council carried out extensive engagement about our community health and social care services.

People told us the most important things to them were:

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

From the latter part of 2015, engagement was undertaken with stakeholder groups in Torquay, Paignton and Brixham, Newton Abbot, Dartmouth, Bovey Tracey, Ashburton/Buckfastleigh about the significant challenges facing the health and social care community. Interested representatives with relevant knowledge or experience were invited to participate from local councils, local Leagues of Friends, voluntary groups, and the wider health and social care community, as well as those who had expressed an interest in being involved.

Separately, engagement took place with GPs and with Trust staff in the development of a new model of care. Its strategic development was informed by operational managers who have reflected the voices of practitioners and staff working in the community. Locality development groups were set up for each area and consisted of staff membership, local GPs and community representatives. Development days were organised involving staff at all levels to help inform how the principles of the care model could be implemented to best serve the needs of each locality whilst still maintaining a standardised offer to the whole area.

During engagement, the focus was on finding a sustainable way to deliver responsive, quality care; to build understanding of the underlying issues; and to draw on the expertise of participants to develop a clinically and financially viable model. Among issues discussed were:

- Future demographic profiles and their expected impact on the type and range of services required to meet the needs of the population, including the expected increase in long-term conditions
- The different health pressures across the CCG, with more deprived areas having a younger population with different health needs from people in more affluent areas, where the population tends to be older. The rural impact has also been considered
- The clinical case for change and clinical best practice
- The need to provide joined-up health and social care within an ever-tightening financial settlement.
- The costs of delivering services
- Activity levels and how to ensure any changes were sustainable.

Among most stakeholders there was general agreement that the future model of care should:

- Put greater focus on prevention and early intervention
- Ensure a seamless experience of care through partnership with statutory providers, independent and voluntary sector
- Make more flexible use of resources
- Establish a single point of access
- Manage increasing complexity in the community
- Care for people as close to home as possible
- Be sustainable in the future

In parallel with the engagement discussions, and drawing on the feedback provided, representatives of the CCG, Torbay Council, Devon County Council, Torbay and South Devon NHS Foundation Trust and primary care, including senior clinicians, considered how best to provide the range of service changes required in discussions at the CCG's Community Services Transformation Group (CSTG). A new model of care was agreed as described below which was in line with the NHS Five Year Forward View.

As Governing Body is aware, ahead of formal consultation a range of options to deliver the model of care was considered including different configurations of community hospitals, clinical hubs and the services to be provided at local health and wellbeing centres. These options ranged from radical change (very significant reduction in the number of community beds and a high level of investment in community services) to using our community hospitals in more traditional ways.

The proposal agreed for consultation by Governing Body at its meeting on 28 April 2016 reflected the option that was considered to provide the most effective and sustainable solution, switching funding from bed based to community based care. It was approved for consultation via the NHS assurance process and a report published in November by the South West Clinical Senate (see below) also supported the model.

3. The financial challenge

The consultation documentation highlighted the increasing financial pressures facing the health and social care system as a result of the rising cost of some treatments, the increasing demand for specialist services and the need to look after more people with a number of long-term conditions. It highlighted that overall, health and social care services in South Devon and Torbay are predicted to be £142million in deficit by 2020/21 if nothing changes.

Since the CCG decided in April 2016 the consultation proposals, the financial position in the South Devon and Torbay area has deteriorated. Pressures on services and delivering efficiencies within Torbay and South Devon NHS Foundation Trust will add at least £10m to this total challenge over the same period.

4. The rationale for change

Throughout engagement and the formal 12 week consultation, the CCG highlighted the increasing challenges in providing health and care services in South Devon and Torbay.

It put forward its belief that the current system was neither sustainable, affordable or delivering consistently the required quality of care. As well as the demographic and financial challenges that have to be met, the CCG was concerned that too many people were admitted to hospital and stayed there too long due to the lack of out of hospital community based alternatives and inadequate focus on prevention and self-management of recurring conditions. The CCG was concerned by the evidence which states that some people's health would deteriorate as a result of unnecessary hospital stays.

In developing the model of care and the proposals for consultation, the factors set out below were taken into account in planning how best to meet the needs of our population, both now and in the future.

- Growing demand as a result of increasing numbers of older people, many with complex long-term conditions
- Different needs of our rural and urban communities
- Significant health inequalities and differences in life expectancy between our most deprived and least deprived areas
- The desire to provide the most clinically effective care and support, irrespective of location
- The need to align physical and mental health services
- The role and sustainability of community hospitals in the context of recruitment difficulties
- National safe staffing levels for medical beds which require one nurse to eight beds and a minimum of two nurses on duty at any time, which means a minimum bed number of 16 beds
- Pressure on acute hospital beds and desire to improve community-based out of hospital services.
- Pressure on A&E and the need for more effective prevention of avoidable admissions through better utilisation of minor injuries units
- Increasing effectiveness of preventative and self-care approaches
- Desirability of closer joint working of health and social care, primary and secondary care, and a stronger partnership approach with the voluntary sector
- Inconsistent availability of private sector intermediate care beds and associated medical cover.
- Flat or reducing finances, especially when health and social care resources are combined, and the pressures of doing more with less resource
- Difficulties in recruiting doctors, nurses and other clinical staff
- Requirements of the national NHS Five Year Forward View and the NHS Mandate.

Clinically the evidence suggests that:

- Coordinated care in a person's own home, in partnership with health and social care and the voluntary sector, often delivers better outcomes than bed-based hospital care
- Patients can be admitted to hospital unnecessarily and discharge is often delayed due to a shortage of community based services appropriate to meet their needs
- About a third of people in community hospital beds at any one time are medically fit to leave if there was appropriate community support

- The longer an older person remains in a hospital bed, the harder it is for them to regain their independence and return home
- Hospitalisation and bed rest can mean enforced immobilisation and lead to reduction of plasma volume, accelerated bone loss and sensory deprivation. This can be irreversible
- Older people are more vulnerable to hospital-acquired infections
- Older people admitted to hospital stay longer and are more likely to be re-admitted
- Minor injuries unit staff should see at least 7,000 contacts per year to maintain their skills and expertise.

The above factors were fundamental to the development of the new model of care.

5. The model of care

The diagram below illustrates the model of care which was agreed. Under this model some resources would be switched from bed based to community based care, reducing the number of community hospital beds to the level evidence suggests is needed and enabling investment in prevention and in the local services which most people use.

This model of care sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs in each of the localities that make up the CCG and Trust population. It would see resources being switched from hospital and bed-based care to community-based care.

Whilst this model would ensure fair and equal access to services, one size will not fit all. From locality to locality, and from town to town, there are differences in health, demography and geography, as well as for example, variations in the availability of non-statutory services such as residential and nursing care, voluntary sector capacity and access to transport. The proposed model aims to reflect these differences so as to ensure more integrated and responsive access to safe, consistent, high-quality care which better meets the needs of local people.

The four key elements to delivering this care model are – locality clinical hubs; local health and wellbeing centres; health and wellbeing teams and intermediate care provision. They would be supported by more robust minor injuries units.

Clinical hubs: these are centres which will provide people with better access to a range of medical, clinical and specialist services. They will offer services such as outpatient appointments and specialist conditions clinics. Patients currently travel from a wide geographical footprint to access these specialist services, which are mainly consultant led and have less than 1,000 attendances a year. Specialist services often require more bespoke facilities or equipment and these are more efficiently delivered in clinical hub settings.

Health and wellbeing centres: these are the locations from where a range of health and wellbeing services, provided by a number of organisations and agencies, are brought together. This will provide easy access in one place to a number of services which support local people. Local health and wellbeing teams will use these centres as a base from which to deliver services to the community, where possible alongside local GPs. Within these centres, the clinical services most frequently used by local people will be provided by professionals who are based locally and work across community sites.

Health and wellbeing teams: these are made up of Trust staff who work most closely with GPs to provide care and support services to meet a wide range of health and wellbeing needs of local people, working closely with other organisations and agencies that contribute to the health and wellbeing of that local population.

This team will oversee arrangements for local **intermediate care** services which cover a range of integrated services, provided for a limited period of time, to people who need extra support and care following a period of ill-health. They are designed to help people recover more quickly following illness or injury, maximising their independence and helping them to resume normal activities as soon as possible. Intermediate care also supports more timely discharge from hospital following an inpatient stay, and helps to avoid unnecessary hospital admissions by supporting people in their local communities, either at home or in another care setting.

In addition, the local health and wellbeing team will coordinate access for local people to the more specialist services provided in the clinical hub, including community hospital inpatient care. Encouraging and signposting local people to appropriately use their nearest minor injury unit will also be a role for the team.

In addition, **minor injuries units** provide a local urgent care service in the community, filling a gap between GP services, the 111 service and A&E, and are intended to reduce unnecessary travel to the emergency department for non-life threatening injuries. Consistent, reliable MIU services with excellent facilities mean that patients are more likely to use them. For MIUs to be seen as an alternative to A&E for non-life threatening injuries they need to be easily accessible; provide a treatment service led by a specialist nurse; be open 12 hours a day, seven days a week; have x-ray; and be delivered in an environment that can best support high quality care.

It is estimated that MIUs need to treat 7,000 patients per annum to ensure the best use of staff and to ensure that they are able to maintain their skills by seeing enough patients with a sufficiently wide range of minor injuries. In South Devon and Torbay, MIUs have seen year-on-year reductions in attendances and only Newton Abbot MIU has achieved the 7,000 criteria.

6. Consultation proposals

In summary, the proposals which formed the basis for consultation were:

- Increased investment in community based services to provide improved out of hospital services through a clinical hub in each locality and health and wellbeing centres within the main town areas.
- Specialist outpatient services provided via the new clinical hubs, reducing the need for travel for acute hospital care, including multi-long term condition services.
- Delivery of large volume community clinics from local health and wellbeing centres
- Co-location where possible of GP practices with multi-disciplinary health and wellbeing teams
- Expansion of intermediate care services, both in a person's home and in private sector care home/intermediate care market.
- Reduced need for hospital-based inpatient care and by concentrating community hospital beds on fewer sites, compliance with national safe staffing guidance. This would be achieved by closing four community hospitals - Paignton, Dartmouth, Bovey Tracey, Ashburton and Buckfastleigh.
- MIUs concentrated on fewer sites at Totnes, Newton Abbot (and in coastal Dawlish) to provide consistent opening times (8am to 8pm) with x-ray diagnostic services, resulting in the closure of MIUs in Brixham, Paignton, Dartmouth and Ashburton (both currently suspended).

The impact of these proposed changes in each of the CCG localities is shown in the tables below, which appeared (with different headings) in the consultation documentation

Consultation proposals: Moor to Sea

Clinical hub in Totnes (currently Totnes Hospital)

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

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

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

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

- Community clinics
- Health and wellbeing team

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

- Community clinics
- Health and wellbeing team

Consultation proposals: Newton Abbot

Clinical hub in Newton Abbot (currently Newton Abbot Hospital)

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

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

- Health and wellbeing team
- Community clinics

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

- Health and wellbeing team
- Community clinics

Consultation proposals: Paignton and Brixham

Clinical hub in Brixham (currently Brixham Hospital)

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

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

- Health and wellbeing team
- Community clinics

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

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

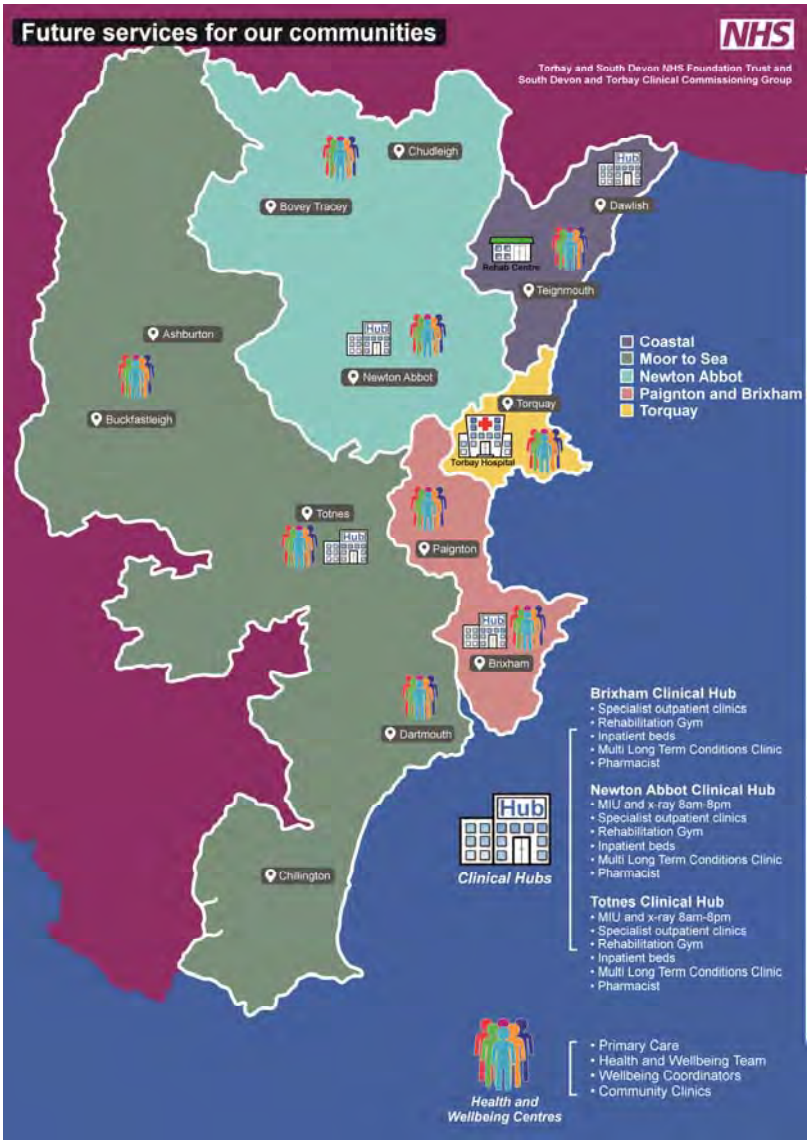
Health and wellbeing centre in Totnes (options are being explored to co-locate with GPs)

Consultation proposals: Torquay

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

- Health and wellbeing team
- Community clinics

The map below shows the distribution of services under the proposals which formed the basis of consultation.



7. Adherence with engagement and consultation obligations

NHS England published in November 2015, guidance entitled 'Planning, Assuring and Delivering Service Change for Patients' which outlines a framework for developing proposals and undertaking consultation as well as the mechanisms for the NHS England assurance processes.

Governing Body can be assured that the CCG has complied with the letter and spirit of this guidance and in relation to the engagement and consultation of the past three years with the requirements set out in the specific guidance listed below.

Section 14Z2 of the Health and Social Care Act

Section 14Z2 of the Health and Social Care Act 2012 lays down the duty to engage and involve people in decisions that affect them. The guidance states users of services should be involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the provision of those services,
b) The development and consideration of proposals for changes in the way those services are provided and
c) The decision to be made affecting the operation of those services.

This applies if implementation of the proposal would have an impact on the manner in which services are delivered and/or the range of health services available to users.

Recognising that the engagement that took place in 2013 would lead to service reconfiguration the CCG has ensured that it has met these requirements in the way the consultation proposals were developed and in the way it has regularly communicated with different groups.

Government's Four Tests of Service Reconfiguration

a) Strong public and patient engagement

As indicated in the timeline set out in section 2 above, the 2013 public discussion identified the issues that mattered to our population. The model of care was developed, working with different groups and staff. From September 2015 a series of dedicated engagement meetings were held in towns across the CCG area, covering the challenges facing the health and social care community and feedback from these meetings was considered by Governing Body when considering the consultation issues and have been published in the supporting consultation documentation.

b) Consistency with current and prospective need for patient choice

The proposals which lie at the heart of the reconfiguration services do not impact on patient choice. As a CCG, we commission a referral management service to ensure that patients are offered choice. This service provides a patient centre, centralised service for choice and booking of secondary care appointments making sure that patients are booked into the most appropriate services following clear care pathways and directory of services.

c) *Clear, clinical evidence base.*

As indicated in the rationale for change section above, the CCG produced a clinical case for change, outlining the clinical arguments for building on past service changes and the evidence from home and abroad which underpins the consultation proposals and the proposed model of care.

The clinical evidence is supported by evidence from the Joint Strategic Needs Assessment which outlines local assessment of current and future health and social care needs. A summary of this assessment is available in the consultation supporting documentation

The independent South West Clinical Senate reviewed this and, as indicated in section 9 below, supported the proposed model of care.

d) *Support for proposals from commissioners*

These proposals and model of care have been developed under the governance of the CCG's Community Services Transformation Group which has a clinical chair and includes leaders from the CCG, Torbay and South Devon NHS Foundation Trust, Devon County Council and Torbay Council. It reports to the CCG Governing Body. The role of this group is also to ensure that any proposals are consistent with local commissioning plans and fit with priorities of wider strategic partnerships such as Health and Wellbeing Boards. Input into the development of the proposals also came from our GP commissioners via our Locality Commissioning Groups, Clinical Commissioning Network and Locality Leads Group.

Assurance processes

We have presented on a number of occasions to the Health and Wellbeing scrutiny committees for Devon and Torbay and they have approved our consultation process.

The CCG has undergone a rigorous assurance process where we were required to provide to NHS England Programme Assurance Team evidence regarding the four key tests for change, the financial planning behind the proposals, clinical quality and strategic fit, workforce planning, impact on travel, communication plans, equality impact assessments and IT strategies. At the end of this process, NHS England gave us approval to proceed with the public consultation.

Gunning Principles for public consultation

These principles guide all consultations by public bodies and state that:

a) *Public bodies need to have an open mind during a consultation and not have already made the decision*

The CCG has evidenced the case for change and its proposed model of care. The CCG put forward a single option which it believed represented the only affordable, viable and clinically sound way of meeting the challenges faced while inviting the public to both comment on the option and to put forward alternative suggestions which they believe would meet the quality care, sustainability and affordability criteria. Notes from meetings and from the feedback were noted by Healthwatch which was commissioned to produce an independent consultation report entitled the People's Voice.

b) *They must give sufficient reasons for proposals to permit 'intelligent consideration'. People involved in the consultation need to have enough information to make an intelligent choice and input in the process.*

The CCG has produced clear documentation which was (and still is) available from the CCG website including:

- Full consultation document
- Summary documents for each locality
- Clinical case for change
- Information about the use of local services
- Options and rationale detailing all options considered and rationale for proposed option
- Population case for change
- Financial case for change
- Travel times
- Summary of stakeholder engagement and feedback
- Consultation terminology
- Buildings
- Equality impact assessments including details of groups that are considered hard to reach.
- Video case studies
- FAQ
- Weekly stakeholder update during the consultation.

An easy read version of the core consultation document was produced and large print documentation was available on request. Links to the documentation and the feedback questionnaire were also available from the websites of Healthwatch Torbay, Healthwatch Devon and Torbay and South Devon NHS Foundation Trust. Information was available electronically and in hard copy.

In addition to receiving questions and requests by post, the CCG established a dedicated telephone line and email address and responded to all correspondence and requests for further information within defined timescales.

We set out in section 8 summary details of core consultation activity.

c) *There must be adequate time for consideration and response*

No timescale for consultation is laid down in the guidelines. The CCG believes that 12 weeks provided adequate and proportionate time for consultation on proposals which were in the public domain since April 2016. The Health and Wellbeing Scrutiny Committees of both Torbay and Devon county councils were content with this timeframe.

d) *The feedback and responses given at consultation must be conscientiously taken into account*

The independent Healthwatch 'People's Voice' Report brought together all the feedback from the consultation and the evaluation of alternative proposals is summarised in section 12. The report is available on both the websites of Healthwatch and the CCG.

Cabinet Office consultation principles published in January 2016

These reflect the Gunning Principles and set out the requirement for consultations to be clear and concise, have a purpose, be informative, be part of an engagement process, proportionate, targeted and involve groups affected by the proposals. They require information to assist scrutiny and the outcome needs to be published in a timely fashion. They also require consultation to avoid electoral periods.

8. Formal consultation summary

Governing Body approved the basis for consultation at its meeting on 28 April, subject to NHS England assurance processes. A decision was made not to consult over the core summer school holiday period so that the formal 12 week consultation ran from 1 September to 23 November 2016.

Our goal was to get people involved from across the CCG area, to set out the reasons for our proposals, to explain why the status quo was not a sustainable option, to answer questions, respond to challenges raised and to listen to views and comments. We encouraged people to use their local knowledge to come up with ways of improving our proposals and to offer alternative ideas for how we might change services for the better and to meet the growing future needs. We stressed the importance of any solution being clinically sound, affordable and sustainable.

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

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

To help increase understanding, a range of support documents were published on our website and made available at public meetings and on request. Short videos were also hosted on the website illustrating different aspects of services under the new model and a range of FAQs (Frequently Asked Questions) were published. We added Browsealoud to our website which facilitates access and participation for people with

dyslexia, low literacy, English as a second language, and those with mild visual impairments by providing speech, reading, and translation. Large print and easy read versions of the core documentation were also produced.

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

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

Documentation continues to be available on our website at
www.southdevonandtorbayccg.nhs.uk/community-health-services

9. South West Clinical Senate review

The clinical basis for the proposals put forward by the CCG for consultation was supported by the independent South West Clinical Senate. Its report stated: "The Senate agreed that it endorses the model of care proposed by South Devon and Torbay CCG and concurs that the current historic model is not in keeping with the needs of today's population."

Following a Senate panel review of the evidence, questioning of CCG and Trust staff and consideration of the proposals it concluded that "the proposed model is in line with the policy direction set out by the Five Year Forward View" and that "the proposals are well thought through" and represent a "progressive model". The Senate report, which is available on the CCG website (here) states: "The proposals are underpinned by as much evidence as there is in this area and the direction of travel is clear with the case for change well illustrated. Overall the panel agreed that they support the proposals and believe they will deliver real benefit to patients. The panel expressed confidence in the overall model and the work already begun to invest in community services."

The Clinical Senate brings together professionals to take an overview of health and care for local populations and provide a source of strategic, independent advice and leadership on how services should be designed to provide the best overall care and outcomes for patients.

The report notes that "the model is very similar to community transformation elsewhere in the country but South Devon and Torbay CCG are much further ahead than other CCGs as their acute and community integration structure is already more advanced". The clinical review panel also outlined some recommendations around documentation, primary care engagement, and project management moving forward. In its recommendations, the panel report notes risks around recruitment and pressure on primary care and suggest that "overall confidence would be strengthened by more succinct detail outlining the model of care in terms of workforce, recruitment, time line, activity and demand for different services, interdependencies, location of services etc".

They made the following comments which have informed work already undertaken and will inform the implementation process as appropriate.

Clinical Senate comments and recommendations:

- The CCG demonstrated through panel discussion that they are significantly ahead in thinking and action of that which was described via the evidence submitted and presentations. An opportunity is being missed to describe a wider and overall better model of care than in the current system. It was clear that the CCG has made progress in delivering the new model of care and that there is robust clinical thinking behind it but this was not sufficiently evident in the submissions to the clinical panel. It is important to be able to clearly articulate the programme of work, the current status and overall timeline that is clearly already known via one or two succinct documents that go beyond communications designed for public consultation. This is recommended to support CCG planning and reporting on this model of care going forwards.

- There is a risk of either excluding or increasing pressure on the GP workforce in the new model. The concept of 'wrap around' care for long term condition management and urgent care pathways that support the delivery of primary care needs to be clarified as do the mechanisms for supporting developed roles and the portfolios of GPs.

- As the Devon wide Mental Health Partnership Trust is not part of the ICO, work programmes between the two organisations must be aligned with particular focus on elderly dementia and depression.

- The model for Health and Wellbeing Co-ordinators and evidence from Cornwall needs to be used to ensure that the 'Every Contact Counts' philosophy is a meaningful one.

- The clinical leadership model to support staff delivering place based and intermediate care across the community needs more work so that it does not rely on ad hoc relationships for quality and safety. A diagram to demonstrate the clinical leadership model of the workforce for the multidisciplinary team working is requested (to include how secondary consultants are linked in when required) and leadership and management training is recommended for clinical team leaders in the community.

- More consideration of how the model will provide the flex required in the system over the summer period should be demonstrated.

- That the Vanguard for urgent and emergency care guidance is implemented.

- More evidence on the current model in the Coastal locality and outcomes to date would be helpful to support the community transformation work and demonstrate continuous learning.

- The role of expanded primary care would merit further consideration as part of the clinical hub and Health and Wellbeing strategy by engaging relevant representative bodies (ie. LPC, LOC, GPs).

- The CCG is encouraged to seek input from the NHS England Primary Care Project Board and the Devon Project Manager to ensure consideration of primary care sustainability and links beyond the organisational arrangements of the ICO as this model of care develops.

- It is important to show that broader plans for Urgent and Emergency Care (UEC) redesign are shown to have been considered as part of the MIU closures. Clear working alongside the UEC network wasn't demonstrated.

- Pressure testing of expected population growth and increases in visitor numbers to the region would help in articulating how increases in activity will be factored into services in the community as well as into primary and urgent care

10. Consultation feedback report

Healthwatch published its independent report on the consultation on 6 January, entitled The People's Voice which has been published separately and is available on the both the CCG and Healthwatch websites. It provides an overview of common themes, comments and criticisms, as well as listing a range of suggestions made by the public.

The Report provides facts and figures on participation, details of the organisations and groups which responded and petitions submitted. It highlights the small proportion of the population which participated by attending public meetings or completing the feedback questionnaire; criticism of the process by some people; the complexity of the proposals; and the often expressed view that the consultation was not genuine.

The Report summarises the main feedback, graphically and in text, indicating the issues most important to local communities. Twenty common themes discussed in the consultation are set out in the Report, including community hospitals, minor injuries units, transport and travel, care home provision, mental health and the role of voluntary groups. The Report highlights public concerns over the closure of community hospitals, the impact on employment in local communities and the problems of travel which would be faced by people who do not have access to private transport, especially those based in more rural areas. The increased pressure on services caused by holidaymakers, the social isolation of elderly people, and the potential negative impact on Torbay Hospital are highlighted.

Responses to the consultation questionnaire are summarised, indicating that there was continued support for what people had told the CCG in 2013 they wanted from health services; that the need for the NHS to change was recognised; that services should be designed to keep people out of hospital; and that people should be supported to be independent for as long as possible. There was also support for prioritising limited resources on keeping people well and supporting people at home.

The majority of people who responded to the consultation wanted community hospitals to remain open. Many people who supported increasing community based care also wanted to retain community hospital beds.

National issues outside the control of the CCG and this consultation such as NHS funding generally, fear of privatisation and the long term future of health and social care were also raised. Broader issues that impact on life generally such as travel, pressure on the local infrastructure caused by more house building and social isolation were also frequently raised but these are not issues the local NHS can resolve alone.

There was also a significant number of people who participated in the consultation and who rejected the financial pressures facing the local health and care community and who wanted the CCG to campaign overtly for more funding.

11. The evaluation process and criteria

Over seven pages in its Report, Healthwatch summarises alternative proposals and suggestions made by the public in a verbatim manner. They fall into two broad categories – a limited number are alternative proposals which would change the proposed model of care put forward in the consultation by the CCG and a far greater number are suggestions which would need to be considered if decisions are made to implement the changes as proposed in the consultation and model of care.

The alternative proposals which would change the proposed model of care have been evaluated in three stages against a set of common criteria which is set out below:

Stage 1: to ensure transparency and to capture different perspectives, an evaluation meeting was held on 11 January and to which the CCG invited a representative from Torbay Council and Devon County Council; both Torbay and Devon scrutiny committees; the voluntary sector (Teignbridge CVS, South Hams CVS and Torbay Community Development Trust); the League of Friends from each community hospital and both Torbay and Devon Healthwatch. In addition, GP locality clinical leads, representatives from the CCG locality patient representative group, Torbay and South Devon NHS Foundation Trust Governors and representatives of its Executive and staff were also invited. Notes of their discussion in relation to each alternative proposal were taken and attendees were asked to 'score' each in terms of whether they met the criteria to be sustainable, to deliver quality care and were deliverable. Not all attendees scored all options, especially where the issues had been covered in discussion around a similar suggestion.

Stage 2: the consultation project board reviewed the feedback from the above meeting as well as the CCG's consultation proposals in the light of people's comments as reflected in the Healthwatch Report and made an initial assessment as to those which met the criteria and should be further investigated.

Stage 3: the Community Services Transformation Group (CSTG) reviewed the feedback and conclusions drawn from both the above stages, before making the recommendations contained in this document for consideration by the Governing Body of the CCG.

The criteria against which these alternative proposals were evaluated were:

Sustainable: this includes ensuring the model is able to:

- Meet the needs of the whole population across South Devon and Torbay – need to consider the whole health system and promote equitable access
- Meet the needs of increased numbers of older people – ensure that services can be delivered to a higher number of people than currently
- Support a growing number of people with co-morbidities and complex illnesses – ensure that services can be delivered to a higher number of people than currently
- Meet the needs of the population through a more proactive approach with emphasis on prevention, education and self-care and reducing demand in the future. Need to consider if this is supporting self-care and reducing dependency on the NHS
- Meet the needs of the population through increased multi-agency / joined up working – needs to be system wide and enable teams/agencies to work together
- Meet the diverse needs of local people – need to consider impact on different groups within our population and ensure equitable access
- Meet national and local policy and legal requirements e.g. Five Year Forward View, local strategies based on national good practice
- Make sure that we can continue to deliver in the future – need to consider workforce, the ability to recruit and retain staff, and ensuring the workforce is large and flexible enough to deliver a resilient service.

Providing quality/clinically sound care including

- Ensuring a safe service
  - Recruiting and retaining staff - need to be able to ensure a resilient workforce so that can provide safe service
  - Meeting minimum numbers for MIU usage – 7,000 contact per year
  - Meeting minimum standards for nurse led bed based care i.e. min 16 beds
  - Meeting building regulations/other legal requirements – ensuring buildings are fit for purpose

- Providing a good patient experience – consider travel time, number of repeat contacts required, experience of the service, staff experience
- Delivering a clinically effective service with good clinical outcomes
- Supporting care closer to home
- Improving access to health and care services – need to consider Equality Act and health inequalities.

Being financially affordable and deliverable: this includes making sure we can deliver in a timely fashion (within 12 months – definitely, within 24 months partly, over 24 months – not).

No one dissented from the CCG's proposal to cost only those alternative proposals which were sustainable and provided quality/clinically sound care.

12. Evaluation of alternative proposals

Set out below is each alternative proposal which would change the proposed model of care. For each there is a brief summary of comments from the different stages set out above and a table showing scoring at stage 1. (Not all options were scored by all attendees) The recommendation of the Community Services Transformation Group (CSTG) is set out for each, together with a brief summary explanation for their decision.

The alternative proposals are set out in two groups. Those CSTG are recommending the CCG Governing Body to consider and those they are recommending are discarded on the grounds that they do not meet the criteria set out in the previous section.

RECOMMENDED SUGGESTIONS

Use Ashburton Hospital as the health and wellbeing centre

Ashburton Hospital is in a central location with good transport links for Buckfastleigh patients. Parking is available on site. The building could be developed into a health and wellbeing Centre. Some concern on deliverability, particularly around GP support. There is a strong voluntary sector in Ashburton (DASH). Staffing the hospital has historically been difficult so may be better used as a health and wellbeing centre.

	Definitely	Partly	Not at all
Sustainable	16	0	0
Quality Care	15	1	0
Deliverable	2	11	2

Recommendation: to be explored in more detail as part of health and wellbeing centre evaluation but the site is too large for just a health and wellbeing centre and so would be contingent on co-location of primary care to make it sustainable.

Combine Brixham and Paignton MIUs to deliver 1 MIU in the Bay

The group agreed that there is a need for an MIU in the Bay. The population of Paignton and Brixham is rising rapidly, increasing the need; however, staffing of this would be difficult. There was further discussion about whether the need could be met by an urgent care centre co-located with the emergency (A&E) department at Torbay Hospital (consistent with

	Definitely	Partly	Not at all
Sustainable	4	6	0
Quality Care	4	4	0
Deliverable	3	5	2

national policy); however, this would increase parking issues at the hospital.

It was felt by the group that the advantages of having an urgent care centre co-located with A&E is that it would be easier to re-direct people from A&E. An urgent care centre located at Torbay would also be more attractive for the workforce and would allow easier management of radiography.

It was felt by the group that the advantages of having an MIU located away from the hospital could be easier access (both with parking and waiting times) and it may encourage more appropriate use of services.

There was a discussion about the possibility of a park and ride service for Torbay Hospital and it was felt that this needed to be revisited.

Recommendation: agreed that there is a demand for a MIU in the Bay and recommend that this is achieved through the intended development of an urgent care centre on the Torbay hospital site. The development of an urgent care centre would: allow for easy and safe diversion of patients from A&E as appropriate, create a critical staff mass for the delivery of safe and sustainable services, allow for support radiology and diagnostics services and give access to expert advice and support. Parking has been expanded on the Torbay site to allow for increased numbers.

Have outpatients in Paignton and beds in Brixham

	Definitely	Partly	Not at all
Sustainable	3	7	0
Quality Care	5	5	0
Deliverable	4	6	0

There was some concern that, under current proposals, there may not be enough space to accommodate all intended services so this could be an option to evaluate further but it would require a review of capital assumptions. The group feel there is no reason that the two services need to be co-located. Access would be easier for consultants travelling to Paignton and current staff would prefer to stay in the town (could outpatients be co-located with the health and wellbeing centre?). There is currently a high volume of outpatient activity in Paignton (higher than Brixham) but there are concerns over the quality of the building and the equipment that would be needed. Under this option, access to radiology would need to be considered. The group felt this option required further consideration.

Recommendation: agreed to provide some specialist outpatient clinics within Paignton that will meet the needs of the patients of Paignton where those clinics are being used in high volume. The number and type of specialist out-patient clinics to be provided in Paignton to be reviewed as part of the implementation plan.

DISCARDED SUGGESTIONS

Use Ashburton hospital to provide intermediate care (IC) beds and/or end of life care

	Definitely	Partly	Not at all
Sustainable	5	7	2
Quality Care	5	5	3
Deliverable	3	9	2

Investment required to bring the hospital up to safe standards and running costs could be significantly higher for this use. Model has worked successfully in other areas; however, there is concern about whether this could be staffed in the short/medium term. It is considered that this proposal would meet the needs of staff, patients and relatives from a quality perspective. Would offer potential for high dependency patients. This

option would reduce the number of patients who could be cared for in their home. Some IC beds are available in a local care home. The needs assessment indicates that demand for IC beds would not be high enough. Most people would prefer to receive End of Life Care in their own home. If this was provided in bed based care there would be reduced funding to support patients at home with less patient choice. Financial and staffing issues are more pronounced in Bovey Tracey than other areas.

Recommendation: discard due to lack of need (assessed as two IC beds in the area and these have been purchased on a block contract from a local care home); concern about being able staff in a sustainable way; the state of the building is assessed by band C (below standard and requires significant improvement) and would cost £707,000 to bring the hospital up to modern day standards for a health and care facility.

Expand Ashburton hospital to 16 beds

Meets the safe staffing levels of one nurse to every eight beds. Despite not being a DGH, from a quality perspective, it was considered that any less than a 1:8 ratio should not be supported. It was felt by the group that demand for medical beds for Ashburton/ Buckfastleigh does not warrant as many as 16.There would be significant investment required to expand the building and there would be an increase in running costs. It was felt that it would be difficult to staff this in the short/medium term. This proposal does not meet national direction.

	Definitely	Partly	Not at all
Sustainable	1	3	13
Quality Care	5	5	7
Deliverable	1	2	14

Recommendation: discard due to lack of need as successive audit have shown a need for less hospital beds, not more and the difficulties and cost in delivering and an extension to the current site within reasonable timescales.

Use Bovey Hospital as health and wellbeing centre

The health and wellbeing centre is likely to be located in Bovey, however, the hospital site is on the edge of town, on a hill with very little parking and there is concern over the current condition of the building. There may be better sites in the town. Other locations are currently being explored for the location of a health and wellbeing centre. GP support for the location is essential and ideally would be co-located.

	Definitely	Partly	Not at all
Sustainable	3	8	6
Quality Care	4	8	4
Deliverable	0	10	6

Recommendation: discard due to location and access and the state of the building is assessed by band C/D (poor and requires urgent action) and would cost £1.5 million to bring the hospital up to modern day standards for a health and care facility. The site is not appropriate for co-location with GP practice.

Use Bovey Hospital to provide intermediate care (IC) beds and/or End of Life Care

Options for the placement of IC beds in Bovey Tracey are very limited. There is concern over the level of medical cover that could be provided for the town and some concern about the level of support from the local GP surgery. Most people would prefer to receive End of Life Care in their own home. If this was provided in bed based care there would be reduced funding to support patients at home with less patient choice. Financial and staffing issues are more pronounced in Bovey Tracey than other areas.

	Definitely	Partly	Not at all
Sustainable	1	6	9
Quality Care	1	6	7
Deliverable	1	2	12

Recommendation: discard due to lack of need (assessed as four intermediate care beds in the area); concern about being able staff in a sustainable way; the state of the building is assessed as band C/D (poor and requires urgent action) and would cost £1.5 million to bring the hospital up to modern day standards for a health and care facility.

Build a new hospital on the ring road. Clinical HUB + health and wellbeing centre + MIU at Yalberton/White Rock. A new build that could serve all of Torbay.

GP practices are primarily based within the town at present. There is significant residential development on the Ring Road that could shift the centre of the population in the near future. There are two branch surgeries in the area that would benefit from being co-located in a new hospital. Would the clinical hub be better located here than in Brixham in the long term? This would be located near to South Devon College which could lead to opportunities to develop and attract workforce and partnership working. Land availability may be an issue. The timeframe and capital for a new build would impact on deliverability. If locating the clinical hub here, there could not be a clinical hub in Brixham as well so there would have to be another consultation process. The group agreed there is a need for this area so further discussion would be advised.

	Definitely	Partly	Not at all
Sustainable	2	4	4
Quality Care	2	5	3
Deliverable	0	0	12

Recommendation: discard due to financial implications and the ability to deliver within timescales.

Include x-ray within the Bay (Paignton or Brixham)

It would not be feasible to staff this with the issue of recruitment of radiographers alongside other MIU development. Clinicians in the room feel there is a need for a diagnostic service and that absence of radiology could conversely increase demand in secondary care if patients can't be managed by their GP.

	Definitely	Partly	Not at all
Sustainable	2	5	2
Quality Care	5	3	0
Deliverable	2	4	3

Recommendation: Discard due to the availability of radiographers and the need to deliver a sustainable service. Increasing radiographic time in the community could be achieved by moving radiographer resource from Torbay Hospital. However the work they undertake at Torbay, needs to be done at Torbay, where the

bulk of inpatients, Emergency Department (A&E) patients, theatre patients, etc attend. Until more radiographers can be recruited then the existing radiographic workforce working in the community needs to be shared between the proposed reduced number of sites so that they can provide an effective resilient service. As indicated above the proposed urgent care centre at Torbay Hospital would provide x-ray services for the population of the Bay.

Include a MIU within Brixham Hospital.

There was concern about the accessibility of Brixham Hospital for the residents of Paignton. Public transport links are poor and there was doubt over whether patients would travel to Brixham. There is a significant increase in traffic during the high season and voluntary car drivers are in short supply. Locating an MIU at Brixham Hospital would increase staffing issues.

	Definitely	Partly	Not at all
Sustainable	1	2	7
Quality Care	3	4	3
Deliverable	1	6	4

Recommendation: discard due staffing issues but consider a Baywide option as stated above in the context of the proposed urgent care centre.

Brixham surgeries to work together to provide a minor injuries service from Brixham Hospital

There is significant concern about capacity within the GP Surgeries in Brixham. This option could be feasible if demand was low enough. The practice wouldn't provide a full MIU service so increases the complexity and consistency of the offer to the public and would only be available Monday to Friday.

	Definitely	Partly	Not at all
Sustainable	0	7	5
Quality Care	3	4	4
Deliverable	0	7	5

Recommendation: discard due to lack of capacity (ability to deliver) and consistency but consider Baywide MIU as stated above in the context of the proposed urgent care centre

Use the land of St Kilda's to build a new care home/intermediate care (IC) facility

The land is owned by the Council which has no current plans for future use. There are already a number of IC beds in Brixham and it is felt that no more are required. The group agreed that this option is not feasible.

Recommendation: discard due to Council ownership and lack of need for additional IC beds.

	Definitely	Partly	Not at all
Sustainable	0	1	11
Quality Care	0	2	10
Deliverable	0	0	12

Chudleigh to have a health and wellbeing centre.

The population of Chudleigh is relatively small and has a younger population that relate to Newton Abbot Hospital for services more than Bovey Tracey. The town already receives some services from the Teignmouth Hub. It could be difficult to take existing services away from Bovey Tracey and locating a health and wellbeing centre in Chudleigh would be an added expense.

	Definitely	Partly	Not at all
Sustainable	0	1	8
Quality Care	0	1	8
Deliverable	0	1	8

Recommendation: discard due to financial implications and lack of need for an additional health and wellbeing centre. The area will be served by a health and wellbeing centre in Bovey Tracey where the need is greater.

People of Dartmouth and its surrounds, be given the opportunity to at least offer to make a contribution (financial not compulsory) towards keeping Dartmouth hospital open and re-opening the minor injuries department.

Representatives from Dartmouth indicated that the population does not wish to pursue this. It would not be sustainable, the site is not suitable and there are concerns over staffing the Hospital. The population has accepted change, as long as there are IC beds available in the town. Transport links to Totnes/Torbay cease after 7pm.

	Definitely	Partly	Not at all
Sustainable	1	0	13
Quality Care	0	1	13
Deliverable	0	0	14

Recommendation: discard due to lack of support from community representatives and need.

Use Dartmouth Hospital for intermediate care (IC) and/or End of Life Care

Transport links to Dartmouth are poor. The population has indicated that its preferred location of IC and End of Life Care beds is at Riverview.

Recommendation: discard due to lack of support from community representatives and lack of need. Also need to be able to provide for people's choice of place of care for end of life.

	Definitely	Partly	Not at all
Sustainable	0	3	10
Quality Care	1	2	8
Deliverable	0	2	10

Use Paignton Hospital as health and wellbeing centre

This option is being considered as one of the sites for the health and wellbeing centre in Paignton.

Recommendation: discard – this has been explored in more detail as part of health and wellbeing centre evaluation and is not considered a viable option due to access, parking and difficulties of redevelopment.

	Definitely	Partly	Not at all
Sustainable	0	4	1
Quality Care	0	4	1
Deliverable	0	3	2

Build a new hospital in Paignton

Query need for new hospital. Land availability may be an issue. The timeframe and capital for a new build would impact on deliverability. If locating the clinical hub here, there could not be a clinical hub in Brixham as well so there would have to be another consultation process.

Recommendation: discard due to financial implications and ability to deliver.

	Definitely	Partly	Not at all
Sustainable	2	2	6
Quality Care	1	3	6
Deliverable	0	0	12

Include a smaller MIU in chemists and supermarkets.

Concern raised over the staffing of MIUs in an increased number of locations. Concern was also raised over patient safety. This option would not meet consistency of delivery and would increase demand on pharmacists.

Recommendation: discard due to quality, ability to deliver and meeting the needs of the population.

	Definitely	Partly	Not at all
Sustainable	0	1	13
Quality Care	0	2	12
Deliverable	0	1	13

Establish the clinical hub in Paignton and not Brixham

The current Paignton Hospital site would not be viable due to the current condition of the building the condition of Brixham hospital is better. It was suggested that a location on the ring road in Paignton might better serve the populations of both Brixham and Paignton but there was concern about the financial implications and time frame of a new build for this purpose. Closure of Brixham hospital would also require another consultation which would impact further on time scale.

	Definitely	Partly	Not at all
Sustainable	2	2	1
Quality Care	2	2	1
Deliverable	2	0	3

Recommendation: discard due to state of building which is assessed as band C/D (poor and requires urgent action) and would cost £2 million to bring the hospital up to modern day standards for a health and care facility. Also discard due to cost and ability to deliver within timescales of new build.

Use Paignton Hospital as MIU and walk in centre for GPs.

Clinicians would prefer a walk in centre to be part of the practice/health and wellbeing centre which forms part of the proposed model.

Recommendation: discard but consider Baywide MIU and co-location of GPs with health and wellbeing in health and wellbeing centre evaluation.

	Definitely	Partly	Not at all
Sustainable	0	2	1
Quality Care	0	2	1
Deliverable	0	2	2

Use Paignton Hospital to provide children with care during a mental health crisis, a safe local place.

Demand isn't high enough and there is an existing facility in Plymouth. It was considered that there are better ways of managing these people rather than in a hospital based solution.

Recommendation: discard due to lack of need, impacting on the sustainability and subsequent quality of care.

	Definitely	Partly	Not at all
Sustainable	0	0	9
Quality Care	0	0	10
Deliverable	0	0	10

Close Totnes MIU and have at Paignton instead

Not supported by residents in Totnes and Dartmouth due to Totnes' central location in the rural Moor to Sea Locality. Due to Totnes' close proximity to Newton Abbot MIU, there was a suggestion to think of the bigger system and use Kingsbridge Hospitals MIU for this locality. However, the group felt that there would not be enough freedom over service design in an area managed by Live Well South West. There are also issues with recruitment of radiographers in Kingsbridge. Also noted that Paignton was close to Totnes and Torbay. Would need to re-consult.

	Definitely	Partly	Not at all
Sustainable	1	0	9
Quality Care	0	2	6
Deliverable	0	1	7

Recommendation: Discard due to need to meet needs of rural patients in the Moor to Sea locality and the increased travel times that would result.

Increase the number of beds in Totnes to 24 with three nurses

The needs assessment doesn't support 24 medical beds for this catchment. Full time medical cover and more nursing staff would also be required and parking issues would be confounded. There is an expected increase in population in Totnes with ongoing and planned housing developments.

Recommendation: discard due to lack of need, ability to deliver and additional cost

	Definitely	Partly	Not at all
Sustainable	1	1	11
Quality Care	2	3	6
Deliverable	1	1	10

Keep the community hospitals open as they are

This option was evaluated as part of the consultation process. We do not expect to receive any additional funding in the future so this is not viable.

Recommendation: discard due to sustainability, concerns of quality of care and ability to deliver. This option has already been evaluated by Governing Body as not sustainable.

	Definitely	Partly	Not at all
Sustainable	0	0	10
Quality Care	0	0	9
Deliverable	1	1	8

Do not have health and wellbeing centres but instead base health and wellbeing teams across GP all practices within the primary care teams.

Co-location where possible is part of the proposed model, however, breaking this into individual Practices would result in lack of cohesion and resilience which could impact on quality of care. Smaller practices would struggle to provide all that a health and wellbeing centre needs to offer. Where possible health and wellbeing centre will be co-located with primary care

	Definitely	Partly	Not at all
Sustainable	0	3	3
Quality Care	0	4	2
Deliverable	0	3	4

Recommendation: discard due to ability to deliver full health and wellbeing services and quality of care. Need to have all staff based together to ensure resilience.

NHS to provide services such as care homes and domiciliary care

The NHS wouldn't normally deliver direct care under this model and can only sub-contract which impacts on infrastructure costs and deliverability. So long as there is sufficient oversight on quality of care, services do not need to be NHS provided. The group acknowledged that the current state of the care home market means there may be some requirement for this in the future. The value of NHS branding in terms of recruitment was also noted and there was recognition that a central place for training and recruitment would be beneficial.

	Definitely	**Partly**	**Not at all**
Sustainable	0	3	5
Quality Care	0	3	5
Deliverable	0	2	9

Recommendation: discard due to ability to deliver within timescales. But acknowledge the importance of a sustainable care home and domiciliary care market. This could be reviewed as part of the implementation plan.

Have a mobile clinic – like a library

It was felt that this could work with certain clinics but would need to be focused on a specific need. There is some evidence that it has worked in rural areas elsewhere. The group agreed that this option is worth looking at but needs to be more specific.

	Definitely	**Partly**	**Not at all**
Sustainable	1	2	1
Quality Care	1	3	0
Deliverable	1	4	0

Recommendation: discard due to lack of specified need. This could be reviewed as part of the implementation plan.

13. Consultation feedback on the CCG proposals

In addition to the specific alternative proposals put forward in the consultation by the public and considered above, a wide range of comment was made in relation to different aspects of the core CCG proposals and the Healthwatch Report sets out a range of suggestions for improving the implementation of the proposals so as to best meet patient needs. These will need to be fully considered as part of the implementation of the new care model.

The key concerns repeatedly raised throughout the consultation are summarised below, together with Community Services Transformation Group's (CSTG) response:

Reducing community hospital beds:
As anticipated, this aspect of the proposals attracted the most concern with many people challenging the proposition that a significant number of beds could be safely taken out of the system. There was substantial support for retaining all four community hospitals with reasons ranging from a desire to maintain the 'cottage hospital' tradition in local communities; the belief that their existence positively impacts on Torbay Hospital by reducing delayed transfers of care; concern that out of hospital care would not be as good, especially where social care is also required (see below).

CSTG comment: as set out in the consultation, recurring audits show that about a third of patients do not need to be in hospital and that many would recover better in a non-hospital environment. It is not sustainable to continue to spend as much money on hospital based care where the evidence shows that supporting people in or near their own homes delivers better outcomes. Therefore not withstanding the views of many local people, CSTG believes that better care will flow from the implementation of the care model and therefore believes that the proposal to reduce the number of community hospital beds is the right option, clinically and financially.

Location of clinical hubs
The location of clinical hubs was a recurring theme and from all quarters of the CCG area, local people argued for a clinical hub to be closer to them.

The proposal to locate a clinical hub in Brixham and not in neighbouring Paignton caused particular anxiety, with local people highlighting the population differences between the two towns, the single road access to Brixham, the widespread belief that Paignton residents would travel to Torbay Hospital rather than Brixham and the impact on those who have to rely on public transport.

CSTG comment: in the context of limited resources – staffing and finance – we believe that one clinical hub per locality is sufficient and the proposed locations are those which have the most appropriate buildings. However we recognise that in Paignton there is a significant volume of specialist outpatient clinics and we believe as part of the development of the health and wellbeing centre, the location of some such clinics should be in Paignton. We therefore recognise that in some circumstances it may be appropriate and in the best interest of patients to be flexible on where specialist clinics are provided and not insist that they are always delivered in the clinical hub.

Minor Injuries Units (MIUs)
Linked to concern over location of the clinical hub many people challenged the proposal to locate the two MIUs in Newton Abbot and Totnes, and to close both MIUs in the Bay.

CSTG comment: as indicated during consultation, a proposal to establish an urgent care centre on the Torbay Hospital site is in place which will ease pressure on the hospital's A&E/Emergency Department. There is consensus that MIUs need to open consistent hours and deliver the same services so that people can become more aware of them and see them as a viable alternative to A&E for non life-threatening conditions.

A shortage (nationally) of radiographers means that we believe we can only staff two MIUs so they provide x–ray services and the locations chosen we believe reflect the best way of meeting the needs of our CCG population as a whole. Two MIUs will also ensure the estimated minimum 7,000 attendees per year required to maintain staff skills will be met.

However, we recognise the public concern relating to the absence of an MIU in the Bay but believe this is best addressed by the establishment of an urgent care centre on the Torbay Hospital site.

X-ray in the Bay
There was concern that the removal of MIUs with the loss of local x ray facilities for GP referrals would have a negative health impact locally and would result in Torbay Hospital having to cope with the vast majority of the annual 14,000 x-rays taken in the Bay.

CSTG comment: Given the staffing issues, CSTG believe it is best to provide x-ray as part of the proposed urgent care centre as this would allow for safe diversion of patients from A&E as appropriate, create a critical staff mass for the delivery of safe and sustainable services, allow for support radiology and diagnostics services and give access to expert advice and support.

X-ray capacity
There was general concern that x-ray capacity was limited and a lack of understanding as to the current use of resources.

CSTG comment: radiographers are the trained workforce who perform the majority of medical imaging in the NHS. They are registered with the Health & Care Professions Council. As is typical with all other health communities, radiographers operate a range of scanners including those relating to CT, MRI, Ultrasound, Nuclear Medicine as well as Interventional Radiology Equipment and x-ray machines. The latter imaging modality forms the bulk of an X-ray Department's workload. This equipment is found at Torbay Hospital and within the community hospitals at Dawlish, Newton Abbot, Totnes, Paignton, Brixham and Dartmouth. These community hospital x-ray departments have varying opening times. The work undertaken in these sites serves, in the main, GP referred patients. Minor injuries unit patients and outpatients are also served by these x-ray departments.

At Torbay Hospital there is a small number of 'standard' x-ray machines. These serve the emergency department (A&E), wards, theatres, outpatients (including fracture clinic, dental and cardiology). Outpatients who require an x-ray prior to their next outpatient appointment are generally booked into a community hospital x-ray department.

Increasing radiographic time in the community could be achieved by moving radiographer from Torbay Hospital. However the work they undertake at Torbay needs to be done at Torbay, at least for as long as the bulk of inpatients, emergency department (A&E) patients, theatre patients etc remain at Torbay. The Radiology service will adapt and if more outpatient services are operated in community locations then the radiographer resource and equipment will move accordingly.

The majority of radiographers at Torbay Hospital are not operating 'standard' x-ray machines. They are involved in the more specialist services such as CT, MRI and Ultrasound. Therefore this element of the radiographer workforce cannot be considered available to be reassigned to community sites. Similarly those serving Torbay Hospital associated services as outlined above need to be excluded. This, therefore, leaves the radiographic workforce already working in the community to be considered for use in a new model of provision. Until sufficient radiographer recruitment is achieved then the existing hours of community based staff could be shared across those sites based upon the outcome of a needs-based assessment.

Care at home
Notwithstanding the fact that almost five times as many people are looked after at home than are admitted to a community hospital, there was considerable concern as to whether services were of the standard required to deliver safe care.

At times, people may need personal social care (eg domiciliary care) support which is not delivered by the NHS and at other times, out of hospital support for their physical and mental health which the NHS is responsible for delivering.

In relation to social care, examples of where problems have arisen were frequently mentioned during the consultation and concerns were increased by the publication of the CQC and Healthwatch report's criticising the service provided by Mears in both South Devon and Torbay. Concerns were also raised in relation to the pressures on families and carers from looking after relatives in the community.

CSTG comment: the CCG continues to work closely with local councils and providers to secure good quality services which will meet the needs of the local population.

The impact on personal care from the closure of community beds will be minimal as if personal care is required during the intermediate care (IC) period this will be provided by in-house rapid response teams.

Where people need short term specialist health support and where it is judged to be inappropriate for this to be delivered in their homes, the specialist IC teams would support them in care homes for a short period of time (up to about 12 days) to help them regain their independence. To ensure there is capacity to do this, a number of beds are being commissioned in nursing and residential care homes to provide 24/7 care and support to people who are receiving services from the NHS intermediate care teams. The number of IC beds judged to be required to meet this need in each town is:

Torquay	16
Ashburton	2
Bovey Tracey	4
Brixham	8
Dartmouth	4
Newton Abbot	14
Paignton	14
Totnes	5

The commissioning of beds with care homes however is flexible to allow for more beds to be used to reflect demand.

Health and wellbeing centres
The concept of health and wellbeing centres as a single location for all community based services attracted positive support. But there was concern around their viability should GPs not participate, their ability to provide better mental health support, the small number of health and wellbeing co-ordinators and uncertainty as to which clinics would continue to be provided locally. Accessibility was also an issue in areas where the CCG proposal was for one centre to cover two towns.

CSTG comment: a range of suggestions in relation to these are included in the Healthwatch Consultation Report, including suggestions as to possible locations. These will need to be fully explored as part of the implementation process. The CCG and the Trust is confident that locations acceptable to local communities will be identified and that the positive experience of our Coastal locality which introduced a health and wellbeing centre last year will be replicated in the rest of South Devon and Torbay.

Mental health
Concern was raised that the new model gave inadequate focus to mental health and more needed to be done to ensure parity of support for physical and mental health.

CSTG comment: involving specialist mental health workers in the health and wellbeing teams is an important requirement of the new model of care and will ensure that people's mental and physical needs will be considered appropriately by the team. Further work is taking place across the CCG to identify how mental health services can be provided to help people, including work with Dartington Research Centre to help achieve early identification of issues in children

End of life care
Many people are concerned that there will be inadequate end of life care should community hospitals close and people are left to die alone at home.

CSTG comment: in practice very few people die in community hospitals and most people would prefer to die at home, with appropriate support. This type of palliative care needs to be tailored to individual needs and the work that we are doing around end of life strategy and care will assist this to happen.

Population growth
Concerns were raised that insufficient attention was being given to the amount of new build in the area and the increased population that would result from widespread developments, especially in and around Paignton.

CSTG comment: in the work that has been undertaken to date in developing the care model, the population growth has been a factor in planning and will need to continue to be taken into account in the coming years. We anticipate that the proposed provision will be able to meet the rising demand but should the population grow faster than is forecast, we may need to look again in the light of health needs.

Transport and travel
A recurring concern was the state of public transport and the inability of people who do not own a car to access services. Despite the sterling efforts of voluntary services, there was concern that concentrating services in different locations adversely impacted on the elderly and/or the disadvantaged

CSTG comment: the CCG recognises the difficulty of travel, whether in the more congested towns or in rural locations. In suggesting where services should be based it has taken a whole CCG area view so as to reduce the impact on most people. This though is not simply an issue for the NHS but also for public and private services.

14. Implementation

The CCG promised during consultation that any proposals for change would not be made to existing services until the new provision was in place and was operating at a level where there was confidence that demand could be met.

Community Services Transformation Group (CSTG) therefore recommends that the following parameters be met before change can take place. (CSTG would not expect that all parameters need to be occurring contemporaneously as each relate to different parts of the care model.)

In order for beds to be removed from a community hospital:

- Contracts are in place for intermediate care placements in care homes within the locality.
- Medical leadership in place in the locality.
- Medical contracts in place to support medical input to intermediate care within the locality.
- Remaining community hospital inpatient services in the locality meet the requirement for safe staffing standards for sub-acute bed based care.
- Intermediate care operating at least 6 days a week in the locality.
- Intermediate care teams are operating with a sufficient workforce that can safely deliver the service specification to the locality
- Daily multi-disciplinary team (MDT) meeting in each health and wellbeing team in the locality.
- Referral systems in place for intermediate care and wellbeing co-ordinators.
- Suitable capacity within short term intervention services.

In order for community clinics and specialist out-patient clinics to be removed from a community hospital:

- Community Clinics appropriate to need (physiotherapy, SALT, podiatry) are being delivered in alternative local venues temporarily, or until permanently provided in the local health and wellbeing centre.

In order for MIU to be removed from community hospitals:

- Newton Abbot and Totnes MIUs to be open 8am-8pm 7 days a week.
- Newton Abbot and Totnes MIUs to have radiology at least 4 hours a day, 7 days a week

Any changes to current services must be effectively communicated internally and externally to ensure that local communities understand where services are located, how to access them, what to do in the event of problems and can see the timeline for delivery of the new model.

CSTG also recognise that notwithstanding these parameters, operational decisions to ensure the safety of patients must apply at all times.

15. Recommendations

Based on the evaluation of the alternative proposals and the review of the consultation proposals in the context of feedback from the consultation:

- Governing Body reaffirms its belief that on the basis of the best available evidence the proposed model of care represents the best way of delivering quality of care in a manner that is sustainable and affordable

- Governing Body approves the proposals which formed the basis of consultation and which are summarised in section 6 above subject to the following changes:

    - The use of Ashburton Hospital as a health and wellbeing centre be fully evaluated together with the feasibility of primary care being co-located in the same building so as to ensure sustainability.

    - The provision of MIU and x-ray capabilities in the Bay be met by the proposed establishment of an Urgent Care Centre at Torbay Hospital

    - To support patient access, high volume specialist outpatient clinics to be split between Paignton and Brixham. The number and type to be reviewed as part of the implementation plan.

- Governing Body approves the parameters set out in section 14 for the implementation of changes relating to the care model and stresses the importance of achieving full implementation as swiftly as operationally possible.

- Suggestions relating to implementation of the care model put forward in the Healthwatch Consultation Report be reviewed as part of the implementation process

- Progress reports on implementation of these proposals be reported quarterly to Governing Body and be regularly communicated to the communities of South Devon and Torbay

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
Title:	**Integrated Finance, Performance, Quality and Workforce Report**
Lead Director:	Ann Wagner, Director of Strategy & Improvement Paul Cooper, Director of Finance/Deputy Chief Executive
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 report provides commentary against performance variances and improvements at the end of December (month 9) highlighted in the performance dashboard (appendix 1) and supported by the detailed data book (appendix 2) which includes finance and workforce schedules. It has been informed from the outcomes and actions from Efficiency Delivery Group meetings (12th December, 3 and 23 January), Service Delivery Unit Quality and Performance Review meetings (held on 6th and 19th January) which focussed predominantly on financial performance and recovery and Executive Director debate and challenge (24 January).

Given the seriousness of the financial position, the report, dashboard and data book have been re-ordered with financial performance brought forward as the first chapter to focus attention on financial recovery and provide context for the remaining performance domains.

The report was scrutinised by the Finance and Investment Committee on 24 February.

A separate report updating on progress from the Call to Action financial recovery programme was introduced at this month's Finance and Investment Committee and is included in this month's Board pack. The Finance and Investment committee agreed to have a regular Board briefing charting progress against key metrics to provide assurance of delivery.

Key Issues/Risks

The Board will note from the report and dashboard, the deterioration in financial and service performance against the following key NHSI Compliance Framework indicators:

Finance

- Use of resources rating – moved from 3 in November to 4 in December
- Liquidity rating – moved from 2 in November to 3 in December
- I&E Margin Variance from Plan moved from rating of 3 in November to 4 in December
- Agency cap metric – moved from rating of 3 in November to 4 in December
- CIP delivery – whilst increased to £6.4m, gap from plan at the end of Month 9 is £1.24m
- Year end forecast moved from £8.3m deficit to £11.3m deficit

Performance:

- 4 hour national standard for time spent in A+E (95%) and STF locally agreed trajectory of 92% were not met in December with performance recorded at 86.6% (last month 91.61%).

- RTT incomplete pathways – 87.4% (88.7% last month) against the standard of 92%.
- Cancer two week wait from urgent referral – 87.7% (68.7% last month) against the standard of 93%.
- Cancer 62 day treatment from screening referral – 85.7% (85.7% last month) against the standard of 90%.

Recommendation:

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

Summary of ED Challenge/Discussion:

Directors are focused on delivering improvements to 2016/17 financial and service performance as well as planning for significant challenges in 2017/18. The reasons for the financial deterioration have been reported to Board previously – CIP non delivery, slippage and cost pressures totalling £10m. A Call to Action programme has been established to focus the organisation on the changes that are required and to generate further schemes to address the financial challenge. £4m of in additional in year savings have been identified with strong confidence of delivery. NHSI have allocated an experience CEO, Mark Hackett to support the team with developing a robust financial recovery plan.

With regard to service performance, the deterioration in the ED standard was echoed across most of the Country. Directors noted the upturn in performance in January happened more rapidly than in previous years as a direct result of the care model including intermediate care and rapid response. The downturn in RTT performance is as predicted following decions not to outsource. Recovery of this target remains a risk as it requires investment and workforce capacity.

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

A Governor representative is in attendance at the Finance and Investment Committee and Governor representatives attend Board meetings.

Equality and Diversity Implications:

N/A

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Board of Directors
Date:	1 February 2017
Report From:	Director of Strategy and Improvement and Director of Finance
Report Title:	**Integrated Finance, Performance, Quality and Workforce Report (Month 9: December 2016)**

1. Introduction

This report provides commentary against performance variances and improvements at the end of December (month 9) highlighted in the performance dashboard (appendix 1) and supported by the detailed data book (appendix 2) which now includes finance and workforce schedules. It has been informed from the outcomes and actions from Efficiency Delivery Group meetings (12th December, 3 and 23 January), Service Delivery Unit Quality and Performance Review meetings (held on 6th and 19th January) which focussed predominantly on financial performance and recovery and Executive Director debate and challenge (24 January).

Given the seriousness of the financial position, the report, dashboard and data book have been re-ordered with financial performance brought forward as the first chapter to focus attention on financial recovery and provide context for the remaining performance domains.

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.

A separate report updating on progress from the Call to Action financial recovery programme is being introduced at this month's Finance and Investment Committee and will be followed by a regular Board briefing charting progress against KPIs to provide assurance of delivery.

2. Performance Summary

2.1 Financial Performance Summary

Key financial headlines for month 9 to draw to the Board's attention are as follows:

- **Risk Rating:** at month 9 the Trust has delivered a rating of 4 under the "Use of Resource" (UOR) rating which is in line with the RSA plan (Scoring: Rating of 1 = best, Rating of 4 = poorest). This has declined since the previous month's rating of 3.
- **EBITDA:** for the period to 31st December 2016 EBITDA is £3.23m.This is showing an adverse position against the PBR plan by £7.64m. Should the plan be agreed based on the Risk Share arrangement this would result in an EBITDA adverse position of £1.94m.
- **Income and Expenditure**: The year to date income and expenditure position is £8.34m deficit which is £7.12m adverse against the PBR plan, and £1.42m adverse against the RSA plan. The Trust has a £1.6m deficit in month (after STF income and risk share income has been applied).
- **CIP Programme:** CIP delivery has improved from the previous month with £6.4m delivered to date, which is behind plan by £1.29m.
- **Cash position:** Cash balance at month 9 is £12.13m which is lower than PBR plan by £4.62m, and RSA plan £7.3m mainly due to debtors.
- **Capital**: Capital expenditure is £12.0m behind PBR plan at month 9
- **Agency Spend:** At month 9, the YTD position of agency spend is at 4.42%, 1.33% over the NHSI target cap target of 3.10%.The projected full year spend for Agency in FY 2016/17 is £10.1m which will give the Trust a metric of '4' on Agency use under the 'Use of Resource' risk rating.

2.2 NHS I Compliance Framework

Against the 12 performance indicators in total including the quarterly governance rating 4 indicators are RAG rated RED for December (4 in November):

- The 4 hour national standard for time spent in A+E (95%) was not met in December with 86.6% (last month 91.61%).
- RTT incomplete pathways – 87.4% (88.7% last month) against the standard of 92%.
- Cancer two week wait from urgent referral – 87.7% (68.7% last month) against the standard of 93%.
- Cancer 62 day treatment from screening referral – 85.7% (85.7% last month) against the standard of 90%.

Of the remaining 8 indicators, 7 were rated GREEN and the NHS I aggregate compliance framework rating is assessed as Green under the original national compliance framework. Performance against the new assessment framework introduced by NHSI for Q3 is under review.

2.3 Contractual Framework

15 indicators in total of which 12 were RAG rated RED in December (8 in November) as follows:

- Diagnostic tests – 4.7% > 6 weeks (1.8% last month) against the standard of 1.0%
- RTT waits over 52 weeks – 12 (13 last month) against 0 standard
- On the day cancellations for elective operations – 1.0% (1.1% last month) against <0.8% standard
- Cancelled patients not readmitted within 28 days – 6 patients (Last month Green, 0 patients)

- Ambulance handover > 60 minutes – 10 delays against a 0 standard. (30 last month)
- Ambulance handovers > 30 minutes against trajectory - 129 delays against trajectory of 30 (last month 129)
- A&E patients (ED only) – 81.1% (87.9% last month) against 95% target.
- Trolley waits > 12 hours – 1 trolley wait (0 last month)
- Cdiff cases acute – 3 reported with one lapses in care – within target
- Cdiff cases community – 1 case reported
- Care plan summaries % completed within 24 hrs discharge weekdays 54.5% (57.5% last month) against 77% target
- Care plan summaries % completed within 24 hrs discharge weekend 26.2% (22.4% last month) against 60% target

Of the remaining 3 indicators, all were rated GREEN

2.4 Quality Framework

19 indicators in total of which 4 were RAG rated RED for December (2 in November) as follows:

- Quality Effectiveness Safety Trigger – Two areas rated RED
- Medication Errors – 2 reported moderate harms.
- Dementia Find – 49.3% (Improvement trajectory 60% against target 90% - 59.2% last month)
- Follow ups past to be seen date – 7034 increase of 833 from last month

Of the remaining 15 indicators, 10 were rated GREEN, four AMBER and one not Rag rated.

2.5 Community and Social Care Framework

12 indicators in total of which 3 RAG rated RED in December (4 November) as follows:

- Number of delayed discharges: 375 bed days lost in community hospitals from patients recorded as delayed discharge. (last month 441)
- Timeliness of adult social care assessment assessed within 28 days of referral: 69.4% against a target of 70%
- Number of care home placements against trajectory: 649 against trajectory of 623 permanent placements. No change on last month.

Of the remaining 9 indicators, 6 were rated GREEN, and the remaining 3 no RAG rating.

2.6 Change Framework

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

2.7 Workforce Framework

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

- Staff sickness / absence: The annual rolling sickness absence rate of 4.34% at the end of November 2016 represents a continuing upward trend. The target the Trust set itself was 3.90% for the end of November 2016. 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

3. Summary of Financial Performance

	Year to Date - Month 09			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	295.63	301.81	6.18	3.15	3.03	3.04	↑
Operating expenses	(284.76)	(298.58)	(13.82)	(8.85)	(4.97)	(3.91)	↑
EBITDA	**10.87**	**3.23**	**(7.64)**	**(5.70)**	**(1.94)**	**(0.87)**	↑
Non-operating revenue	0.75	0.46	(0.29)	0.00	(0.29)	(0.24)	↑
Non-operating expenses	(12.85)	(12.03)	0.82	0.00	0.82	0.58	↑
Surplus / (Deficit)	**(1.23)**	**(8.34)**	**(7.12)**	**(5.70)**	**(1.42)**	**(0.53)**	↑

As at 31st December 2016, the Trust is reporting a £8.34m deficit. This is £7.12m behind the original PbR based plan; and at EBITDA level £7.64m adverse variance. Financial performance is also behind the revised RSA based plan at EBITDA level by £1.94m, and showing a year to date deficit of £1.42m.

Within this position, income is ahead of plan by £6.18m based on the PbR plan, and £3.03m based on the RSA plan. Under the terms of the RSA an additional £7.17m 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. Total STF income received to date is £3.21m.

Operating expenses are showing an adverse position against PBR plan of £13.82m, and £4.97m against the RSA plan.

3.1 Income

	Year to Date - Month 09			Plan Changes		Previous Month	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Income by Category							
Healthcare (Acute and Community)	222.27	221.79	(0.48)	(1.63)	1.15	1.46	↓
Social Care	41.64	41.40	(0.25)	(0.92)	0.67	0.66	↑
Other Income	31.72	31.46	(0.26)	0.01	(0.27)	0.44	↑
Risk Share Agreement (RSA) Income	0.00	7.17	7.17	5.69	1.48	0.47	↑
Total	**295.63**	**301.81**	**6.18**	**3.15**	**3.03**	**3.04**	↓

Healthcare Income is behind the RSA plan by £0.4m (excluding STF income). This is an adverse movement of £0.3m in month. The adverse variance on the Acute income is £0.3m and most of the variance relates to the SCG element of the NHSE contract. This accounts for £0.23m of the adverse variance as a result of being behind plan in Non electives, chemotherapy and critical care as well as pass through items i.e. drugs and devices. The other main adverse variance is £0.07m in Public Health for screening services during the Christmas period. The other commissioners were broadly in a net balanced period overall.

The Trusts local CCG block adjustment stands at £8.8m (£8.4m at M8), which is £3.1m above the planned adjustment. (see the bottom of Appendix 1 tab). This is mainly as a result of over performance of Non Electives (£3.3m offset by £0.6m increase in the Emergency Adjustment). The remaining over performance is within adult critical care and pass through drugs, offset by under performance in Elective and A&E and excluded devices.

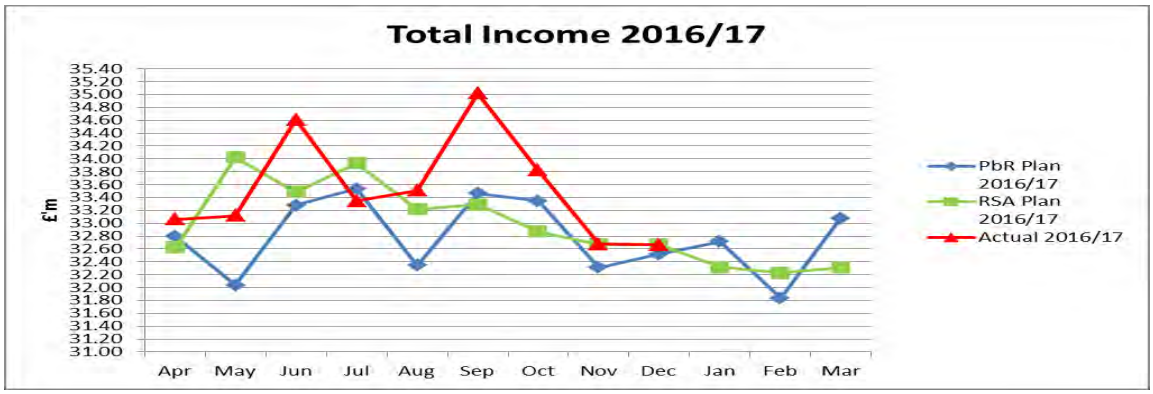
STF funding of £3.21m in total has been received and included in the year to date figures. A total of £6.7m is planned under the PbR arrangements for the full year, but was reset at £1.675m in the RSA plan after publication of the rules for receipt by NHS Improvement, with this phased into quarter one 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 £0.25m, and favourable position against the RSA plan of £0.67m. This is mainly the result of additional Public Health income being received for the Drug and Alcohol Service of £0.72m. This income offsets costs being charged from Devon Partnership Trust, and is therefore neutral to the overall income and expenditure position. Client income is slightly behind plan by £0.04m.

Other income is £0.26m behind the PBR Plan and £0.27 behind the Risk Share plan. This is made up mainly of an adverse variance of miscellaneous revenue £0.68m due to a reduction in Pharmacy Manufacturing income, and lower than planned income for e-prescribing. There are smaller favourable variances offsetting this in R&D / education (£0.30m), site services (£0.11m), and private patients (£0.08m).

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 8 against both the PBR and RSA plan.



3.2 Operating Expenditure

	Year to Date - Month 09			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Total Operating Expenses Included in EBITDA							
Employee Expenses	166.75	171.27	(4.52)	2.68	(1.84)	(1.47)	↑
Non-Pay Expenses	117.60	126.66	(9.06)	6.17	(2.89)	(2.21)	↑
PFI / LIFT Expenses	0.40	0.65	(0.25)	0.00	(0.25)	(0.22)	↑
Total	**284.76**	**298.58**	**(13.82)**	**8.85**	**(4.98)**	**(3.91)**	↑

Total Operating Expenditure included in EBITDA is £13.82m higher than the original plan showing an adverse position. Based on the RSA plan this is reduced to an adverse variance of £4.98m.

Pay

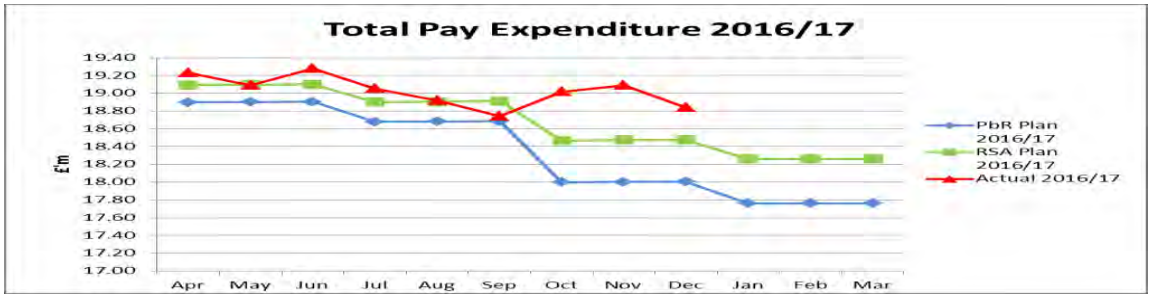
Pay budgets are, in total showing an over-spend of £4.52m against the PbR plan and £1.84m against the RSA plan.

Overall actual pay costs have decreased by £0.25m from the previous month. This is due to a reduction in substantive costs of £0.18m, and bank costs £0.06m. Agency costs have remained broadly the same as the previous month at £0.70m per month. Run rates earlier in the year had shown reductions July to September, increases in October and November, with a reduction as mentioned above in December. The main areas of pay cost reductions from the previous month are in Pharmacy Manufacturing £0.14m, Surgery £0.14m, and Medicine £0.04m, offset by an increase in Community Services of £0.06m.

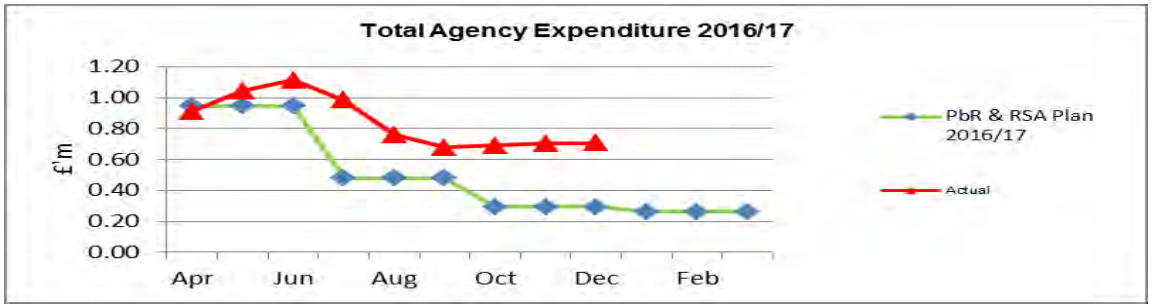
At Service Delivery Unit level we continue to see overspends, particularly in Medicine which is £3.61m overspent against the RSA plan, mainly as a result of agency and bank costs in the Emergency Department, Care of the Elderly, Cancer Services, Gastroenterology, and General Medicine. Women and Child's Health have pay overspends of £1.03m mainly in Obstetrics & Gynaecology, Child Health, Lab Medicine, and Radiology largely associated with locum, bank and agency costs. Surgical Services are showing overspends of £0.89m in General Surgery, Ophthalmology and Theatres mainly due to agency costs. Estate and Facilities management also have pay overspends of £0.26m due to agency and bank costs for Hotel Services. Adult Social Care is also showing an overspend in pay of £0.95m due to the majority of their CIP target, which was allocated to this category.

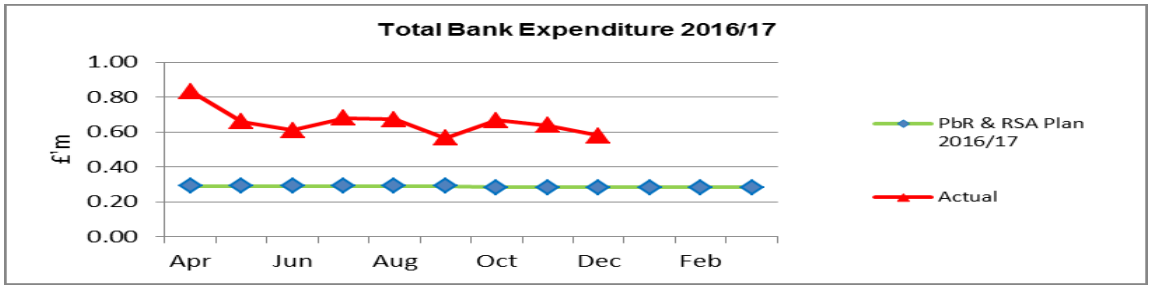
There are pay underspends in Community Services reflecting vacancies across both Torbay and Southern Devon (£1.34m),Community Hospitals (£0.25m), Torbay Pharmaceuticals (£0.31m), HQ and Corporate services (£2.92m), which is made up mainly in reserves (£2.8m), savings in HIS (£0.32m), Pharmacy (£0.30m), Strategy (£0.13m), which offsetting overspends due to CIP targets in Director of Nursing and Quality £0.2m, Operations £0.15m, and Education £0.16m

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 9, the YTD position of agency spend is at 4.42%, 1.33% over the NHSI target cap target of 3.10%. A detailed analysis and Improvement Plan can be seen in Schedule 3.

Nursing agency run rate at M is £0.30m, which is £0.06m less than last month.

The cap set by NHSI is for Agency costs for All Staff Groups; spend to date is £7.6m.

The projected full year spend for Agency in FY 2016/17 is £10.1m which will give the Trust a metric of '4' on Agency use under the 'Use of Resource' risk rating (without any further actions).

Non pay

Non pay is overspending the PbR plan by £9.06m, and £2.89m 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 £0.89m at month 9 against RSA plan. The run rate of spend has decreased over the past three months, and shows a reduction in spend of £0.13m in December from the previous month. Main areas of reduced spend are in Pharmacy Manufacturing, Surgery, and Women and Children's Health. At Service Delivery Unit we continue to see overspends mainly in Medicine £0.29m, Surgery £0.19m, Community Services £0.16m, and Women and Children's Health £0.15m.

Non pass through drugs are overspent £0.76m with main overspends in Surgery £0.24m, Medicine £0.16m, Women and Children's Health £0.11m, and Community Services £0.08m

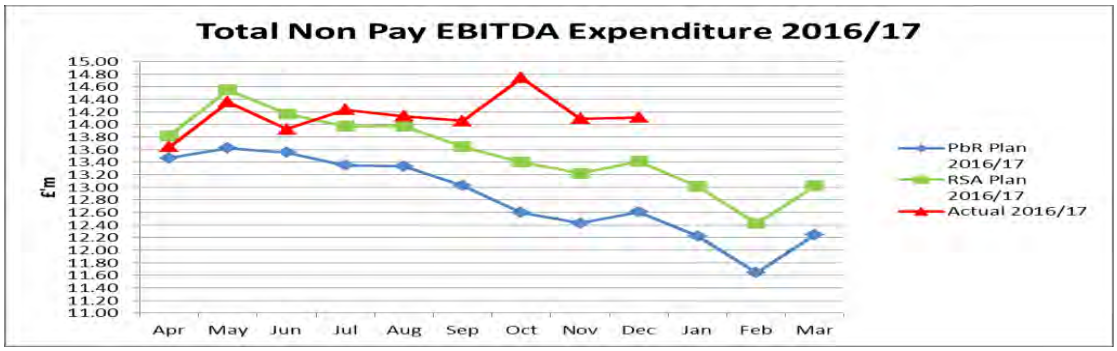
Pass through drugs, bloods and devices are £0.35m over spent against RSA plan. This is neutral to the overall income and expenditure position as additional income is received from NHSE to match these costs.

There is marginal overspend on non clinical supplies of £0.19m.

Miscellaneous costs are overspent against the RSA plan by £0.69m. Within this position there are overspends in Purchase of Healthcare from Non NHS bodies mainly due to outsourcing of £0.85m in Surgery, Adult Social Care overspend of £0.73m, and miscellaneous non pay expenses £0.6m due to challenges in delivery of the CIP target. This is offset by underspends in premises costs (£1.12m), Purchase of Other Health Care services (£0.32m)

PFI/LIFT expenses are showing an overspend against plan of £0.25m. 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.

3.3 Non-operating Expenses

	Year to Date - Month 09			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non-Operating Expenses							
Donations & Grants	0.63	0.14	(0.49)	0.00	(0.49)	(0.45)	↑
Depreciation & Amortisation	(8.32)	(7.55)	0.77	0.00	0.77	0.57	↑
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	0.12	0.07	(0.05)	0.00	(0.05)	(0.05)	↔
Gains / (Losses) on Asset Disposals	0.00	0.25	0.25	0.00	0.25	0.25	↔
Interest cost	(2.34)	(2.25)	0.09	0.00	0.09	0.08	↑
Public Dividend Capitals	(1.94)	(1.65)	0.28	0.00	0.28	0.25	↑
PFI Contingent Rent	(0.24)	(0.28)	(0.04)	0.00	(0.04)	(0.04)	↔
Corporation Tax expense	(0.02)	(0.02)	0.00	0.00	0.00	0.00	↔
Total	**(12.10)**	**(11.57)**	**0.53**	**0.00**	**0.53**	**0.34**	↑

- Donations & Grants is £0.5m adverse, primarily due to the delayed receipt of donated assets relating to the CCU.
- Depreciation is £0.8m favourable, due to the reduction in 2016/17 capital expenditure and changes in the completion dates of capital projects.
- Restructuring costs are £0.3m adverse, due to MARS costs incurred.
- Gains/losses on Asset Disposals is £0.3m favourable, primarily due to the profit on the sale of the surgical robot to Medico Systems in Poland.
- PDC dividend payable costs are £0.3m favourable to Plan, primarily due to reduced capital expenditure.

3.4 Cost Improvement Programme

	2016-17 Position					Memo: 2017-18 Effect of 16-17 Schemes	
	Year to Date - at Month 09			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	7.69	3.78	3.91	2.73	↓		
Delivered Schemes : Non-Recurrent	0.00	2.62	(2.62)	(2.32)	↑		
Delivered Schemes : Total	7.69	6.40	1.29	(1.11)	↓		
Full Year (Month 1 to 12) Forecast (Risk adjusted) Delivery							
Forecast Schemes : Recurrent 16/17 (See note, below)	13.90	5.43	**8.47**	**8.61**	↑	5.43	8.47
Forecast Schemes : (Balance to Full Yr effect of 16/17)- See note below	0.00	-	-	-	-	3.06	(3.06)
Forecast Schemes : Non-Recurrent 16/17	0.00	4.55	(4.55)	(4.13)	↑	0.00	0.00
Total Full Year End forecast Delivery	**13.90**	**9.98**					
Forecast 2016-17 Yr end delivery variance			**3.92**	**4.48**	↑		
Forecast delivery variance of 2016-17 schemes in 2017-18						**8.49**	**5.41**

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.

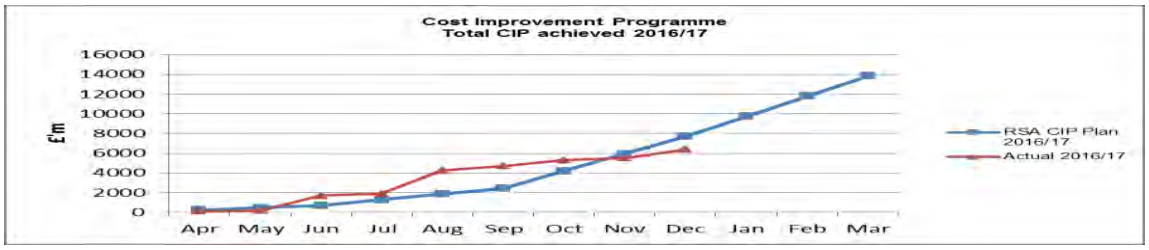
Cumulative delivery position to Month 9

At the close of Month 9, we have cumulatively delivered £6.4m of CIP savings, against a pro-rata target of £7.69m target, resulting in a £1.29m cumulative shortfall.
This represents a £1.29m adverse movement in the cumulative delivery variance in the month. The stepped increase in way the £13.9m current year CIP budget is phased across the financial year meant that the cumulative delivery target to Month 8 was a further £1.75m. This budgetary phasing may not necessarily reflect the timing of our actual CIP delivery. However, the movement is particularly pronounced this month, because only £200k (net) of additional CIP was delivered.

Year End Forecast Position

The year end forecast delivery variance improved by £600k this month. This is due to a re-assessment of likely CIP delivery made now we are closer to the end of the financial year. The cumulative year end forecast is showing as a £3.92m adverse variance.
The outstanding gap needs to be closed and further actions have been announced by the Executive board to curtail expenditure.
This includes: a new MARS scheme, further manpower controls, recruitment bans for non-clinical staff, further agency and temporary staff controls and Non-Pay discretionary controls.

The following graph shows the full year CIP target, and CIP achieved as at month 9



3.5 Balance Sheet

	Year to Date - Month 09			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	12.09	8.77	(3.32)	(0.40)	(2.92)	(2.41)	↓
Property, Plant & Equipment	162.82	154.49	(8.33)	(13.21)	4.88	2.78	↑
On-Balance Sheet PFI	17.06	16.68	(0.38)	(0.20)	(0.18)	(0.16)	↓
Other	1.89	2.14	0.25	(0.24)	0.49	0.46	↑
Total	**193.85**	**182.07**	**(11.78)**	**(14.06)**	**2.28**	**0.67**	↑
Current Assets							
Cash & Cash Equivalents	16.75	12.13	(4.62)	2.68	(7.30)	(6.41)	↓
Other Current Assets	22.98	31.43	8.45	0.13	8.32	9.91	↓
Total	**39.73**	**43.56**	3.83	**2.81**	**1.02**	**3.49**	↓
Total Assets	**233.58**	**225.63**	**(7.95)**	**(11.24)**	**3.30**	**4.16**	↓
Current Liabilities							
Loan - DH ITFF	(7.26)	(6.75)	0.51	0.21	0.30	0.22	↑
PFI / LIFT Leases	(0.72)	(0.64)	0.07	0.09	(0.01)	0.00	↓
Trade and Other Payables	(30.26)	(35.82)	(5.56)	(0.46)	(5.10)	(5.08)	↓
Other Current Liabilities	(1.65)	(1.62)	0.03	(0.04)	0.07	0.09	↓
Total	**(39.88)**	**(44.83)**	**(4.95)**	**(0.21)**	**(4.74)**	**(4.77)**	↓
Net Current assets/(liabilities)	**(0.16)**	**(1.27)**	(1.12)	**2.61**	**(3.72)**	**(1.28)**	↓
Non-Current Liabilities							
Loan - DH ITFF	(67.91)	(64.83)	3.08	3.29	(0.21)	(0.08)	↓
PFI / LIFT Leases	(20.05)	(20.46)	(0.42)	(0.42)	0.00	(0.04)	↑
Other Non-Current Liabilities	(3.97)	(3.70)	0.27	0.03	0.24	0.22	↑
Total	**(91.93)**	**(89.00)**	**2.93**	**2.90**	**0.03**	0.09	↓
Total Assets Employed	**101.77**	**91.80**	(9.96)	**(8.55)**	**(1.42)**	(0.51)	↓
Reserves							
Total	**101.77**	**91.80**	(9.96)	**(8.55)**	**(1.42)**	(0.51)	↓

The RSA Plan has been updated to incorporate the planned changes in capital expenditure and loan drawdown.

- Intangible Assets, Property, Plant & Equipment and PFI are £1.8m favourable, due to additional capex £0.4m, reduced depreciation £0.8m and the delayed sale of TP facility £0.6m.
- Cash is £7.3m adverse to Plan, largely due to other current assets £8.3m higher than Plan and the I&E position (excl non-cash items) £1.7m adverse, partly offset by current liabilities £4.7m higher than Plan.
- Other Current Assets are £8.3m higher than Plan. Significant elements include: Q3 RSA debtor £1.6m; NHS England income paid in arrears £3.1m; community debtors £1.7m; stock £0.9m.
- Trade and other payables are £4.7m higher than Plan. Significant elements include: payments not collected by NHSLA £3.8m.
- A full cash flow statement and forecast can be seen in Schedule 5

3.6 Capital

	Year to date - Based upon Annual Plan (April 16)			Year to date - Based upon new adjusted 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	25.35	13.35	(12.00)	13.35	13.35	0.00	36.90	23.81

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 2016/17.

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. In addition to this, further cost pressures have emerged during the course of this year, the net impact of which after applying additional risk share agreement income is £3m. 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 has been developed. Two loan applications for the Emergency Department and Theatres Phase 1 schemes have been submitted to the Independent Trust Financing Facility (ITFF). Initial feedback from the ITFF was positive, i.e. that the merits of the loan applications were strong but concern has been expressed over the Trust's ability to repay these loans given the Trust's current financial position. A third loan application for the Electronic Document Management System has also been discussed with the ITFF and the formal loan application to the ITFF will follow shortly. 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.

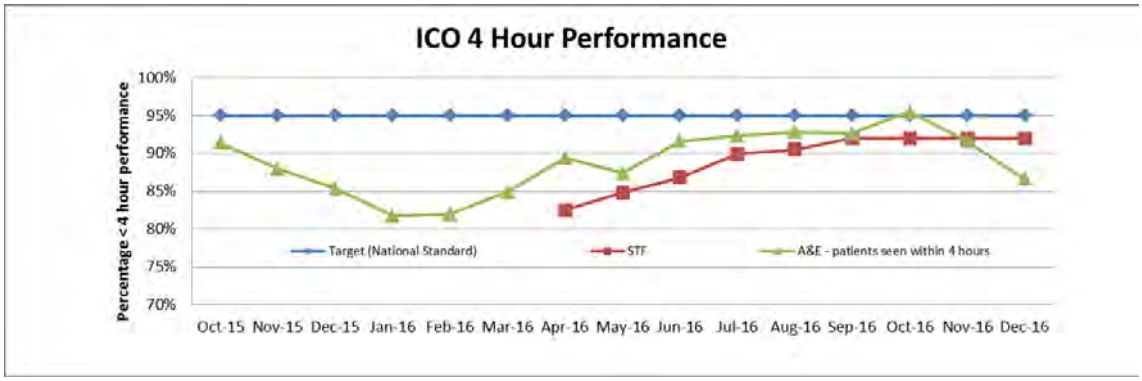
Variances in planned capital expenditure by scheme, and funding sources available can be seen in Schedule 6.

4. NHS Improvement (NHS I) Performance Framework Indicators

4.1	4 hour standard for time spent in A+E	RAG RATING: RED

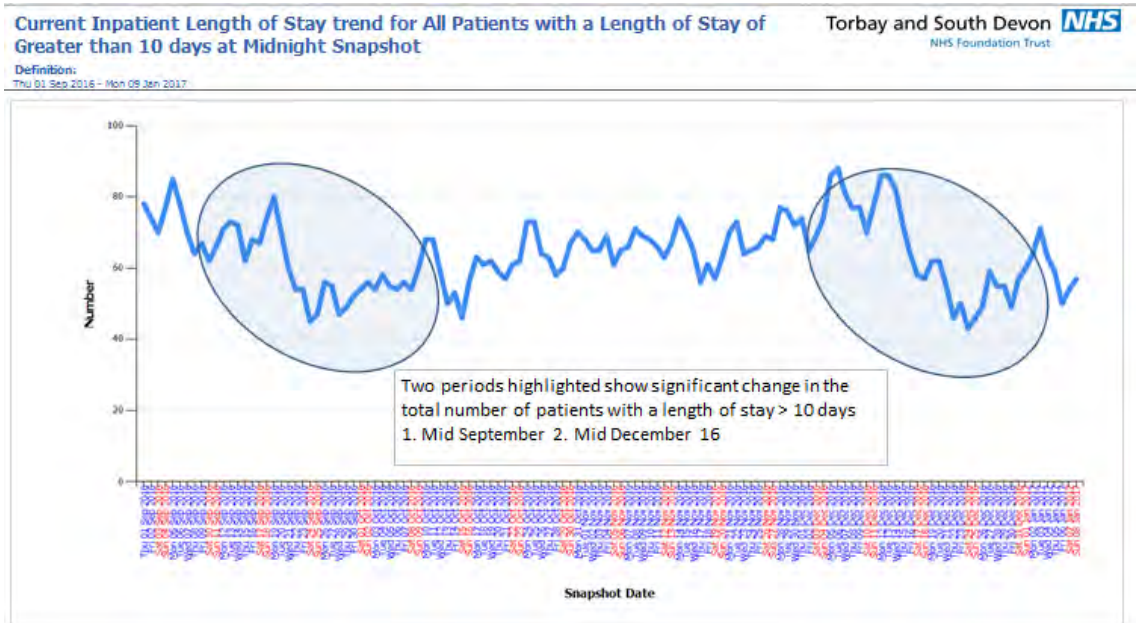
For December, the combined performance of Emergency Department (ED) and Minor Injury Units (MIUs) was 86.6% (91.61% last month) and remains below the agreed STF target agreed with the CCG and NHS I of 92%.

The following graph illustrates the monthly performance against the STF trajectory and the 95% National Standard:



4.1.1 Comment on performance and factors influencing performance against trajectory

- The number of patients recorded as being in acute hospital beds with a length of stay over 10 days during December has reduced from 85 in mid November to 45-50 being back to levels last recorded in September. This is a positive indication that length of stay is being managed and that discharge packages of care have remained available.



- Quality of care - Compliance against the key quality metrics has been maintained throughout this period. This includes time to assessment / time to see clinician and

meeting the early treatment of patients presenting with the most urgent clinical needs.

- Escalation - Due to inpatient escalation, high usage, high turnaround assessment capacity has been lost or reduced in the following areas:
    - EAU3 – converted to inpatient beds.
    - McCallum escalated to provide an additional 4 beds
    - CDU – bedded to 4 beds.
- The emergency department breach analysis shows delays being focused on delays in finding ward beds for patients requiring emergency admission. It is noted however that patient flow was maintained albeit with delays at peak times. The escalation status remained at OPEL 3 and did not escalate into OPEL 4 (the most severe) at any stage.
- The environmental improvements works continued to reduce assessment capacity within the Emergency Department in December however alternative arrangements using EAU3 for assessment space remained available, although at times particularly overnight this has been used as a bedded area during escalation. Estates works within ED were completed on schedule by Friday 16th November.

4.1.2 Escalation Plans

Escalation plans continued to support:

- Review long length of stay patients – MDT, Discharge team via daily SAFER huddles, clinical leads and matrons weekly review.
- Complex discharge team – escalate long social care waits, health funded patients for onward discharge – alternative placements.
- Hospital Inpatient Capacity (escalation beds/review and postpone elective admissions/additional medical ward rounds),
- Optimise discharge (bring forward planned discharges/ additional consultant ward rounds/ resolve funding bottlenecks/ commissioning of intermediate care beds)
- Admissions avoidance (supporting communication with primary care and wider system to seek alternatives to hospital referral - this includes telephone advice services with secondary care specialties).

4.1.3 Urgent Care Improvement and Assurance Group (UCIAG).

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.

UCIAG met on 3rd January and received operational and commissioner feedback in relation to the last two weeks operational pressures, escalation responses and the dip in performance. The following actions were agreed:

- Some of the changes in working practices and managing the floor identified as not fully embedded particularly at time of greatest pressure and required further support.
- The ED senior team attendance at 8 am Control Room meeting is working well.
- Avoidance of admission – Discussions have progressed to increase intermediate care and frailty specialist assessment at the front door.
- There has been an increase in the use of AMU (Ambulatory Medical Unit) as alternative pathway for admission from ED as well as direct from GP and support of frailty pathway.

- Concerns raised regarding levels of Ambulance delays – Operational team is working closely with SWAST to review actions over this period and to assist with joint assessment to reduce conveyance rates.

4.1.4 Summary

During December, the bank holiday period has been a challenge. Although the 4 hour improvement target trajectory has not been met in December the front door processes and escalation plans have performed well with clinical risk being kept to a minimum. The challenge for the post New Year period is known and continued escalation actions will be maintained. This will see reduced amounts of elective admissions to maximise bed availability and continued flexible use of assessment areas. Plans are focused on maintaining safe care managing the fluctuations in system demand to achieve the 4 hour standard by April 2018.

4.2	Referral to Treatment Incomplete Pathways	RAG RATING: RED

At the end of December 87.4% 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 first 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, Pain Management and Endoscopy 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.

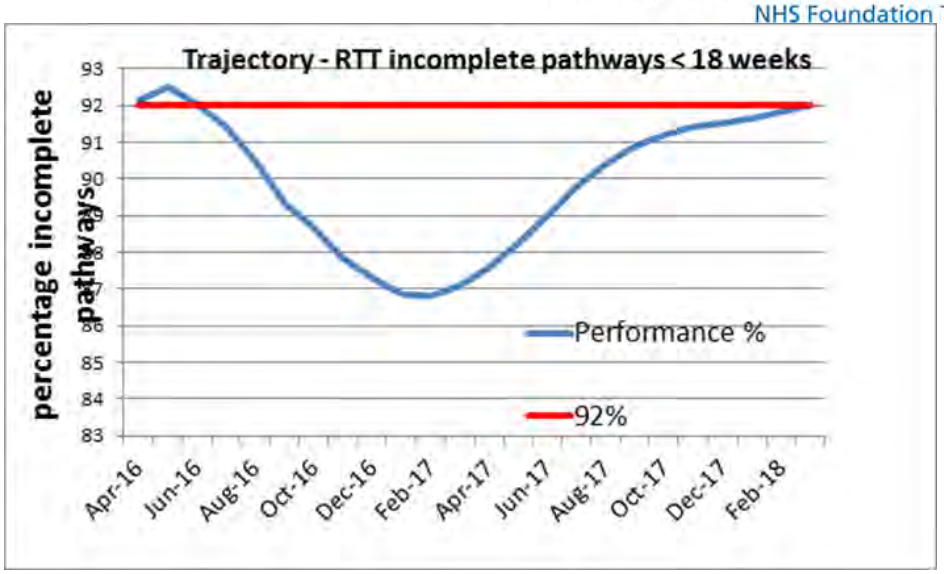
Assumptions in the plan included:

- Saturday lists for Urology running Oct – Dec (up and running) – *Now Stopped*
- Extended trauma Lists 4 cases per month running Nov – Mar – *Temporarily suspended due to bed pressures and reduced elective activity – hopefully recommencing in Feb17*
- Foot and ankle Saturday lists 12 cases per month running Oct-Dec – *Not started as unsuccessful in recruiting F&A Fellow*
- Continuation of locum doctor in Neurology – *On-going*

In order to achieve 92% of patients waiting less than 18 weeks, a further 842 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 and outsourcing of T&O and UPGI activity throughout 2017/18 with the agreed short term plans as set out above in addition areas of service improvement and demand management that are still part on on-going 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 previously reported the Trust has an application for dispensation to adjust the second quarter 2016/17 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.

Peer comparison based on published November RTT performance

- TSDFT are ranked 114 (Oct-119) against the 147 trusts who agreed and submitted STF trajectory's
- In total 75 (Oct-72) trusts failed to achieve their projected STF trajectory
- Average waiting times against the 92% access standard deteriorated further in November to 90.50% (90.4% in October)
- Compared to our local peers – Only one achieved the STF trajectory, Eleven missed their trajectory's (two still remained compliant) – Our ranking improved by one place with Gloucester dropping below us.

Local peer RTT performance comparison

	Actual Nov16 Performance	Submitted STF Trajectory
ROYAL CORNWALL HOSPITALS NHS TRUST	92.5%	92
NORTHERN DEVON HEALTHCARE NHS TRUST	92.3%	95.25
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	92.0%	93.4
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	91.6%	92
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	91.5%	92.47
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	91.4%	92
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	90.8%	93
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	**89.0%**	**93.21**
NORTH BRISTOL NHS TRUST	87.2%	?
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	87.0%	92.04
PLYMOUTH HOSPITALS NHS TRUST	85.0%	?
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	84.8%	91.3

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

4.3	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 December, there were 4 new cases (two acute and two community) with one of these confirmed as a lapse in care. The cumulative number of cases to the end of December for 2016/17 is 22 in total and 8 for a lapse in care. This remains within the target trajectory.

4.4	Cancer Standards	RAG RATING: AMBER

Provisional data for December and Q3 is shown in the following table:

	December 2016				3rd Quarter Total			
	Target	No. Seen	Breached	%	Target	No. Seen	Breached	%
14day 2ww ref	93.0%	902	111	87.7%	93.0%	2892	702	75.7%
14day Br Symp	93.0%	98	4	95.9%	93.0%	289	10	96.5%
31day 1st trt	96.0%	180	4	97.8%	96.0%	558	10	98.2%
31day sub drug	98.0%	62	0	100.0%	98.0%	231	0	100.0%
31day sub Rads	94.0%	31	0	100.0%	94.0%	170	4	97.6%
31day sub Surg	94.0%	34	2	94.1%	94.0%	115	5	95.7%
31day sub Other	-	32	0	100.0%	-	100	0	100.0%
62day 2ww ref	85.0%	114.5	11	90.4%	85.0%	310	33	89.4%
62day Screening	90.0%	7	1	85.7%	90.0%	33.5	3.5	89.6%
62day Upgrade	-	5	0	100.0%	-	21.5	1.5	93.0%

The standards against the ‘two week wait (2ww) to be seen from urgent referral’ and the ‘62 days to treatment from screening’, have not been met in December. The forecast for Quarter 3 is for all standards to be met other than the two week wait from urgent referral. The 62 day screening standard will be met once a shared breach patient with Royal Devon and Exeter NHS Foundation Trust is confirmed. This target may still be reported as failed in the National reports however due to the lag in the guidance being applied at a National level through the CWT performance metrics, NHSI have been informed.

The 2ww referrals standard achieved 87% in December against the standard of 93%. The performance has continued to improve as the backlog in Dermatology has been addressed. During December the Dermatology urgent pathway became compliant with the 2 weeks standard and is forecast to achieve in Q4.

5. Contract Framework

The standards set out below are the requirements agreed by the Trust through the contract with the CCG and NHS England Specialised Services. They are in addition to the NHSI 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 November.

The table below shows 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%	91.6%	86.6%			
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%	89.0%	87.4%			
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%	98.2%	95.3%			
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%	87.94%	83.18%	92.20%	87.60%			

Notes:

- A+E / MIU (type 1 and 2) waiting times < 4 hours (Target trajectory for December 92.0% achieved 86.6%) – **Trajectory and standard not met**
- RTT % patients waiting under 18 weeks (Target trajectory for December 92% achieved 87.4%) – **Trajectory and standard not met**
- Diagnostic waiting times < 6 weeks (Standard 99.0% achieved December 95.3%) - **Standard not met**
- Cancer 62 day referral to treatment (Standard 85% some months vary due to low planning numbers achieved December 88.7) - **Standard achieved**

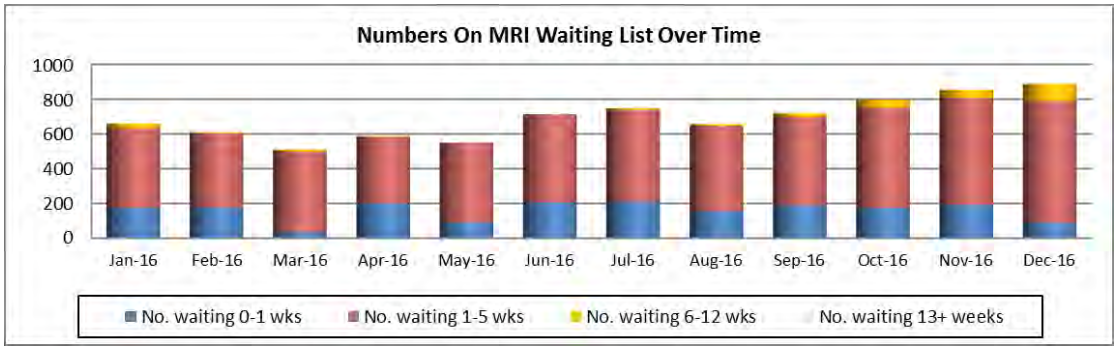
5.2 Referral to Treatment (RTT) over 52 weeks — RAG RATING: RED

At the end of December, 12 patients were recorded as waiting over 52 weeks for treatment. Last month 13 patients were waiting over 52 weeks. All 11 patients are waiting for Upper GI surgery. The operational team now agreed a set of actions that should provide increased opportunities for treatment of the upper GI patients, although this will require a reduction of outpatient clinics, and in some cases other specialties having to give up operating lists. Improvement is expected by the end of March.

5.3	Diagnostic tests waiting over 6 weeks	RAG RATING: RED

In December, the standard for diagnostic waits was not achieved with 4.7% (172 patients – 63 last month) waiting over 6 weeks at the end of the month. Of the total waiting over 6 weeks at month end, 98 were in MRI and 50 in CT.

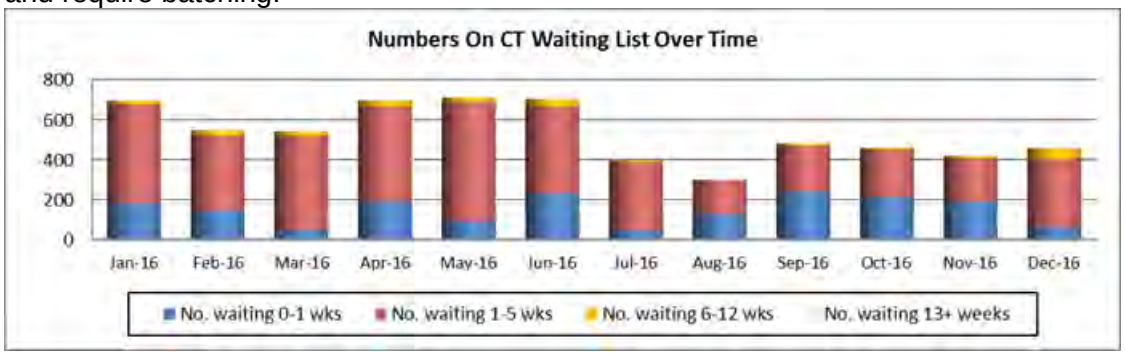
The MRI service has an increasing number of patients waiting (888) and this is some 250 above the level needed for a compliant 6 week wait maximum waiting time. The service is under pressure from a combination of increased demand, increasing complexity of scans being requested and staffing issues including vacancies and sickness impacting on the ability to run additional lists.



Actions to reduce MRI waiting times include:

- Additional capacity has been arranged through mobile MRI unit visiting Torbay Hospital with visits scheduled for January to March 2017 (21 total days, projected 480 patients). It is forecast that the MRI waiting list will not reduce significantly however due to the current imbalance between routine capacity and demand, although the 6 week standard is expected to be achieved by April 2017.
- Additional activity is being provided by the existing team though the offer of double time payment. While this offers some support there is considerable risk around workload to a depleted team. Recruitment process is on-going.
- The staffing constraint means that the current MRI service cannot fully utilise potential capacity. Recruitment is underway to allow all capacity to be used. In addition there is work being carried out to ensure more flexibility with bookings.
- In line with work to manage demand, there is work to be progressed around assuring appropriate examinations and appropriate protocol are in use and that this is supports the optimum clinical diagnosis for our patients.

In CT while there is capacity to manage overall demand (albeit with use of outsourcing), there remain capacity constraints with Cardiac CT examination. This is due to the fact that these are Consultant supervised examinations directly impacted by Consultant availability. These examinations are complex so take longer to complete and require batching.



CT in Torbay does not have the capacity to manage all demand. There is regular outsourcing of CT examination to Mount Stuart (Sat and Sun every week). This outsourcing does not substantially impact on Cardiac CT capacity as the work that remains on site is there by necessity (e.g. ED, inpatient, Colonoscopy) and thus there is little scope to increase capacity for this examination. This is in addition to the issues around requiring direct supervision.

Actions to reduce the CT long waiting times include:

- Radiologist rotas for January include additional Cardiac CT sessions. This will have an impact on the end of month position for January and February.
- Continued outsourcing.

The provision of cardiac CT is a continuing risk to achieving waiting times, particularly in the light of NICE guidance around Cardiac CT Scanning with anticipated increase in demand.

5.4	Ambulance Handover Delays	RAG RATING: RED

In December, 10 patients (Standard = 0) were delayed over 60 minutes and 129 patients (target = 30) over 30 minutes from arrival by ambulance to handover to staff within the Emergency Department. We continue to work closely with SWAST to manage daily escalations and meet weekly to review systems and responses.

5.5	Cancelled Operations	RAG RATING: RED

Operations cancelled on the day of admission by the hospital remain above the national standard of 0.8% with 1.0% (29 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 December, there are a higher number of cancellations where the consultant was sick and an increase in the number of operations cancelled as 'no bed' available.

Reason for cancellation November 2016	
No Op time	6
Trauma/Priority patient	14
Workforce (sickness)	
No bed	2
Process/equipment	7
Total	**29**

In December, six patients requiring admission following cancellation were not re-admitted within 28 days of cancellation.

5.6	A+E 12 hour Trolley waits	RAG RATING RED

In December one 12 hour Trolley wait was recorded. This has been validated and is a result of a patient presenting late in the evening requiring admission to a side room. The patient was kept in isolation on a bed within the ED department until the side room became available the following morning.

5.7	Care Planning Summary (CPS) Timeliness	RAG RATING: RED

There remain challenges with the time it takes to complete CPS conflicting with Junior Doctor clinical commitments. In December 54.5% (last month 57.5% - target 77%) were sent to GPs within 24 hours on weekdays and 26.2% (last month 22.4% - target 60%) on the weekends.

The new streamlined process is in place. It is now mandatory for patients to have a completed CPS prior to discharge Monday to Friday. The implementation of this policy was delayed until early December. Performance was not expected to improve over the Christmas and New Year period but is expected to improve with de-escalation of the urgent care system.'

6. Quality Framework Indicators

6.1	Quality Effectiveness Trigger Tool	RAG RATING: RED

In December, two teams were RAG rated as RED:

- **Community Nursing - Brixham & Paignton** – 6th consecutive month triggering which has now increased from 18 in November to 25. The key areas identified are vacancies, sickness, outstanding appraisals, and impact on work demands including intermediate care cover required.
  Action: A formal written action plan is in place which has been agreed with the SD and ADN for the community service delivery unit. This is discussed at the SDU board
- **Paignton hospital:** In November the hospital triggered amber (13) and this has escalated to 19 and red in December.
  Action: A formal written action is in place which has been agreed with the SD and ADN for the community service delivery unit. This is discussed at the SDU board

6.2	Medication Errors	RAG RATING: RED

In December there were two recorded medication errors resulting in Moderate harm. The details have been investigated.

6.3	Serious Reportable Incidents (SIRIs)	RAG RATING: AMBER

In December there were a total of 5 serious reportable incidents - 3 in the Community hospitals (1 Newton Abbott, 2 in Totnes) all falls resulting in fractures, and two in the acute Hospital (Simpson ward Patients self-discharged and tragically committed self-harm and coronary care unit fall resulting in fracture). These incidents are all under investigation and will be reported to SAE and the Falls Group

6.4	VTE Assessment on Admission	RAG RATING: AMBER

The reported performance for VTE assessment on admission has improved in November with 93.2% recorded in acute settings and 100% in community settings against the standard of 95%.

6.5	Fracture Neck of Femur – Time to Theatre	RAG RATING: AMBER

In December, 88.6% of patients requiring surgery reached theatre within 36 hours of admission, against the standard of 90%, last month 65%. The pilot of extended trauma lists commenced in October and performance has been improving from this change.

6.6	Completion of Dementia 'find' assessment	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 December 49.3% (56.7% last month) of eligible patients were recorded as having assessments completed against the standard of 90%. Performance has not improved as forecast following recent interventions to prioritise these assessment and accurate recording led by the Deputy Director of Nursing and Professional practice.

Further work will be undertaken to ensure daily ward meetings include highlighting to medical colleagues the patients that require completion of the dementia case finding assessments.

It is expected that improved performance will be seen with significant improvement in the spring with roll out of the 'Nerve Centre' clinical system.

6.7	Follow-up Appointment Waiting Time	RAG RATING: RED

The number of patients waiting for an outpatient follow up appointment and waiting six or more weeks beyond their clinically recommended 'see by date' has increased by a further 833 patients in December to 7034. This has been affected by the bank holidays and annual leave with reduced clinic capacity over this period. This follows a reduction the previous month of 381.

7. Community and Social Care Framework

7.1	Adult Social Care Assessments	RAG RATING: RED

In December, 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.

7.2	Delayed Discharges	RAG RATING: RED

In December, the number of community hospital bed days lost due to patients being delayed in their discharge was lower than the previous month with 375 days lost (last month 441 days). This remains above the monthly target of 184 days. Acute delay has also reduced from previous month.

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**
NOVEMBER	93	441	**534**
DECEMBER	59	375	**434**

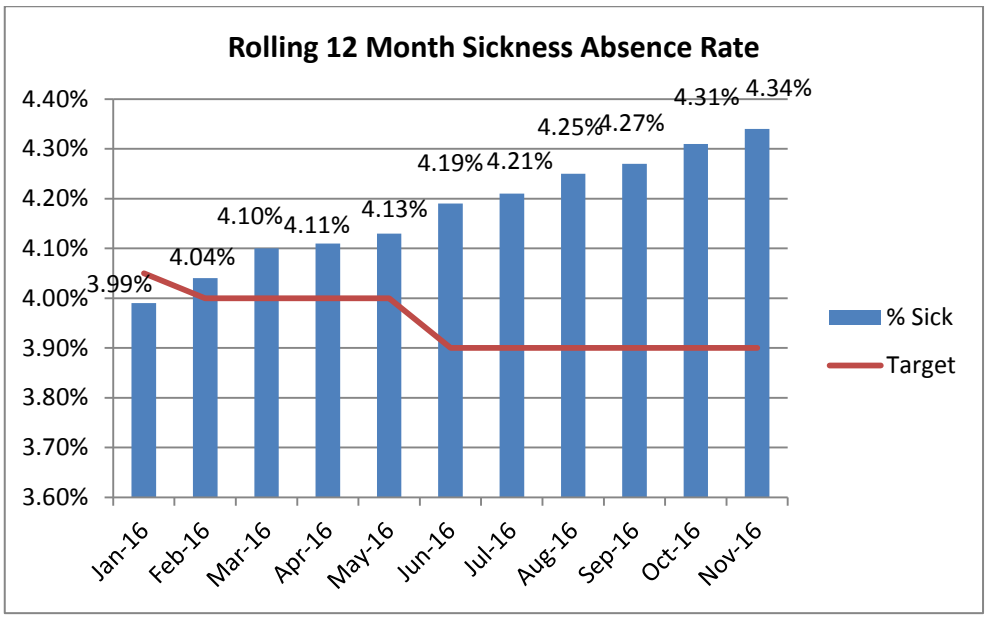
8. Workforce Key Performance Indicators

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.

8.1	Staff Sickness Absence Rate	RAG RATING: RED

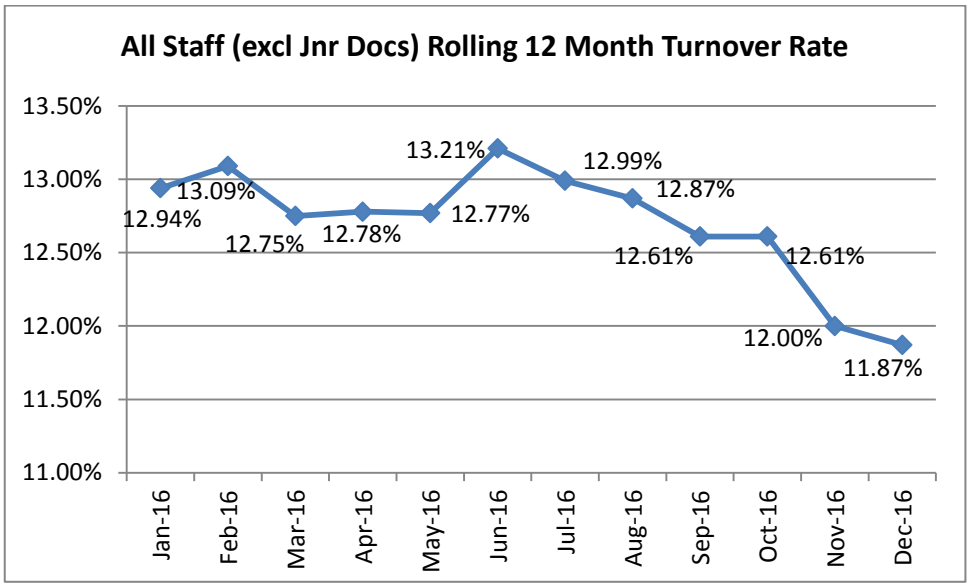
The graph below shows that the annual rolling sickness absence rate of 4.34% at the end of November 2016 represents a continuing upward trend. The target the Trust set itself was 3.90% for the end of November 2016. The Workforce and OD Group have discussed that more robust reporting and validating has 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
-

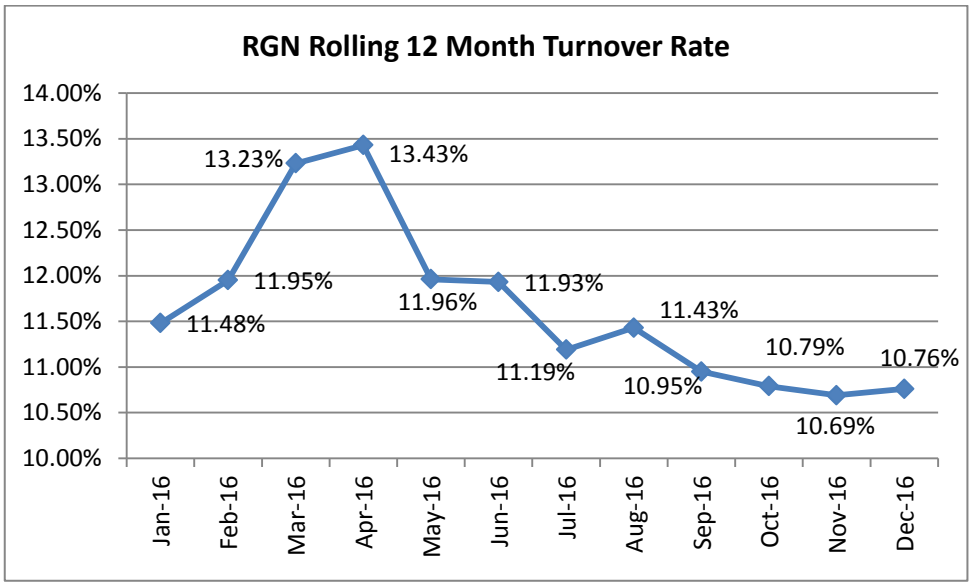


8.2	Turnover (excluding Junior Doctors)	RAG RATING: GREEN

The graph below shows that the Trusts turnover rate of 11.87% in December 2016 remains within the target range of 10% to 14%. Nevertheless the recruitment challenge to replace leavers from key staff groups remains significant.



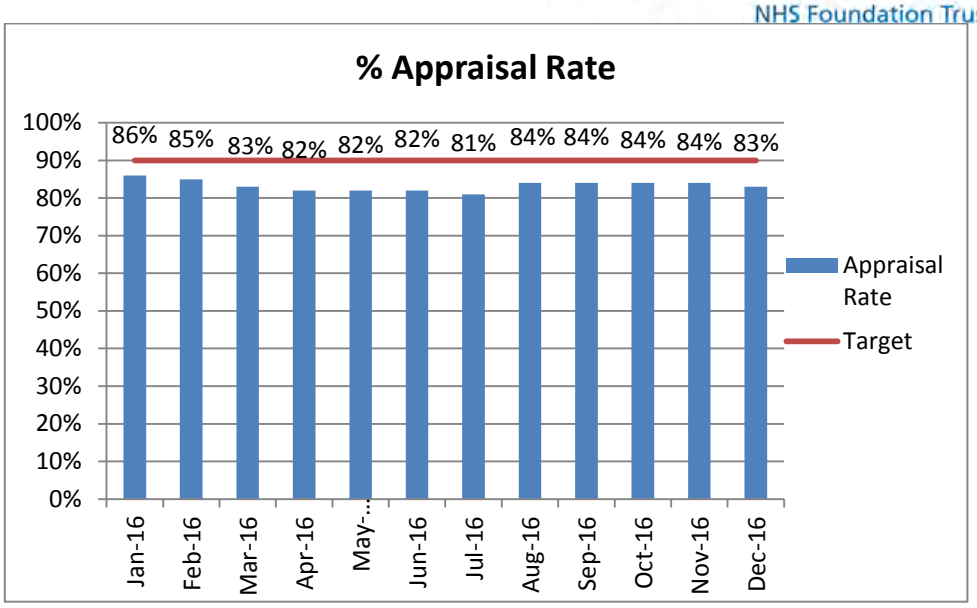
This recruitment challenge includes Registered Nurses due to the supply shortage as reported elsewhere and for which the Trust has a long term capacity plan to address. The turnover rate for this staff group as shown below indicates that it is a supply issue rather than one of retention.



8.3	Appraisal Rate	RAG RATING: AMBER

The graph below shows that the appraisal rate of 83% is a small decrease from the 84% of the previous 4 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.

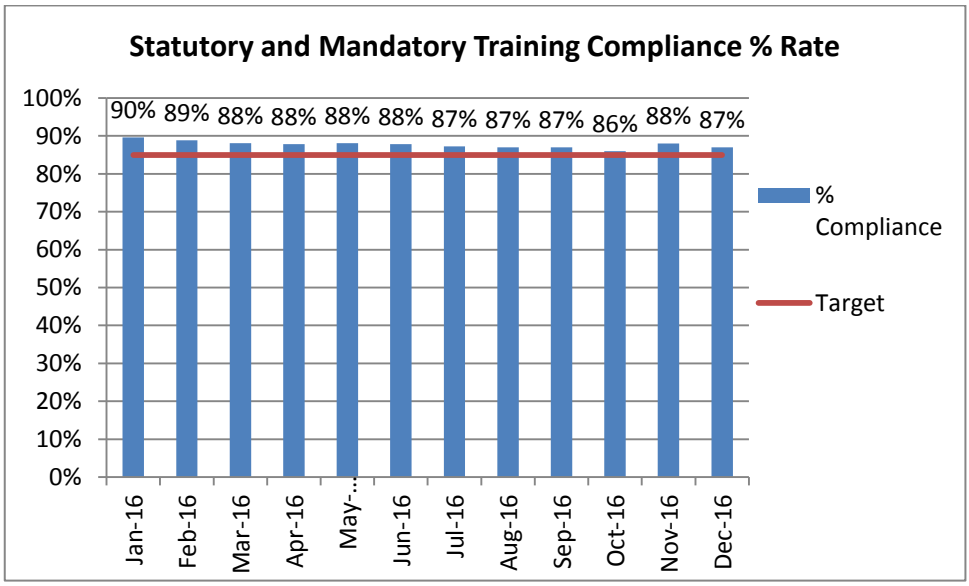


8.4	Statutory & mandatory training Compliance	RAG RATING: GREEN

The Trust has set a target of 85% compliance as an average of 9 key statutory and mandatory training modules. The graph below shows that the current rate of 87% is a decrease from the previous month. Individual modules that remain below their target are detailed in the table below:

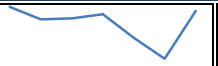
Module	Target	Performance
Information Governance Training	95% or above	82%
Fire Training	85% or above	83%
Infection Control	85% or above	83%
Manual Handling	85% or above	84%

The current rate is likely to decrease due to the Call to Action deferral of some face to face statutory and mandatory training.



9. Supporting documents

Appendix 1: Month 9 Quality, Performance, Finance and Workforce Dashboard
Appendix 2: Month 9 Quality and Performance Data book including financial schedules
Appendix 3: Workforce KPI by SDU/Department

Corporative Objective		Target 2016/2017	13 month trend	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year to date 2016/17
NHS I COMPLIANCE FINANCIAL SUSTAINABILITY																	
4	Capital Service Cover (unchanged rating)	2		1			1	4	4	4	4	4	4	4	4	4	4
	Original PbR Plan													4	4	3	3
4	Liquidity (unchanged rating)	3		4			4	1	1	1	1	2	2	2	2	3	3
	Original PbR Plan													2	2	2	2
4	I&E Margin (changed calculation)	4		1			1	4	4	4	4	4	4	4	4	4	4
	Original PbR Plan													3	3	3	3
4	I&E Margin Variance From Plan (changed calculation)	3		4			3	2	2	1	2	2	2	3	3	4	4
4	Variance from agency ceiling (new rating)	3		2			2	3	3	4	4	4	4	3	3	3	3
	Original PbR Plan													2	2	1	1
4	Overall Use of Resources Rating	3						3	3	3	3	3	3	3	3	4	4
FINANCE INDICATORS																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)									499	-950	-823	-361	-3053	-5439	-7.639	
4	Agency - Variance to NHSI cap									-2.39%	-2.00%	-1.87%	-1.56%	-1.45%	-1.38%	-1.33%	
4	CIP - Variance from PBR plan - cumulative (£'000's)									1010	800	2381	1685	1114	-403	-1287	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)									3113	3699	3104	4195	6792	9269	12002	
4	Distance from NHSI Control total (£'000's)									375	-354	320	14	-1902	-3493	-4887	
4	Risk Share actual income to date cumulative (£'000's)									2485	3504	4156	4505	5836	5844	7169	

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	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-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	3	3	
1	A&E - patients seen within 4 hours [STF]	>95%		85.3%	81.8%	82.0%	84.9%	89.4%	87.4%	91.6%	92.3%	92.9%	92.6%	95.5%	91.6%	86.6%	91.2%
	A&E - trajectory [STF]	>92%		82.5%	82.5%	82.5%	82.5%	82.5%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%	92.0%	92.0%	92.0%
1	Referral to treatment - % Incomplete pathways <18 wks [STF]	>92%		90.8%	91.2%	91.4%	91.8%	92.1%	92.5%	92.0%	91.4%	90.5%	89.3%	89.4%	88.7%	87.3%	87.3%
	RTT Trajectory [STF]			90.9%	90.9%	90.9%	90.9%	90.9%	91.2%	91.3%	92.0%	92.6%	92.9%	93.1%	93.2%	93.2%	93.2%
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<18 (year)		0	0	0	0	1	1	1	2	1	1	0	0	1	8
1	Cancer - Two week wait from referral to date 1st seen	>93%		97.7%	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.4%	72.0%	67.8%	87.7%	85.9%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	100.0%	95.8%	97.9%	95.9%	97.6%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		98.8%	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	95.2%	98.4%	98.4%	97.8%	97.4%
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%	99.0%	100.0%	98.9%	100.0%	100.0%	100.0%	99.7%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		100.0%	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.4%	97.2%	97.0%	100.0%	96.8%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		96.0%	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	97.0%	96.6%	94.1%	95.5%
1	Cancer - 62-day wait for first treatment - 2ww referral [STF]	>85%		88.7%	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.9%	83.2%	94.5%	91.6%	89.4%
1	Cancer - 62-day wait for first treatment - screening	>90%		100.0%	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%	93.8%	85.7%	85.7%	93.6%

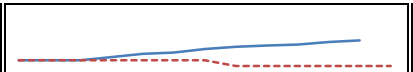
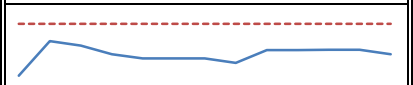
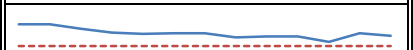
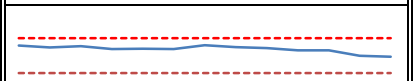
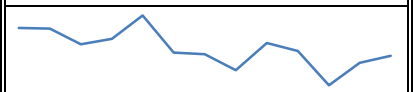
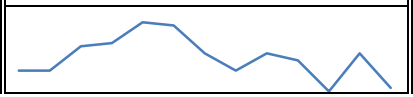
Corporative Objective		Target 2016/2017	13 month trend	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year to date 2016/17
CONTRACTUAL FRAMEWORK																	
1	Diagnostic tests longer than the 6 week standard [STF]	<1%		1.1%	2.8%	1.0%	1.6%	1.2%	1.1%	1.2%	1.1%	0.5%	1.3%	1.7%	1.8%	4.7%	1.6%
	Diagnostic trajectory [STF]			1.09%	1.09%	1.09%	1.09%	1.09%	1.02%	1.04%	0.99%	0.97%	0.95%	0.84%	0.84%	0.84%	0.84%
1	RTT 52 week wait incomplete pathway	0		2	3	5	4	4	6	5	11	8	10	11	13	12	12
1	Mixed sex accomodation breaches of standard	0		0	0	0	1	0	0	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%		1.4%	1.3%	1.4%	0.9%	1.5%	1.4%	1.6%	0.9%	1.0%	1.0%	1.3%	1.1%	1.0%	1.2%
1	Cancelled patients not treated within 28 days of cancellation *	0		3	2	9	10	4	9	6	9	3	4	0	0	6	41
1	Ambulance handover delays > 30 minutes	0		75	113	234	170	102	111	37	54	36	24	44	129	129	666
	Handovers > 30 minutes trajectory *			50	50	50	50	50	40	35	25	20	20	25	25	30	270
1	Ambulance handover delays > 60 minutes	0		5	2	35	16	26	6	0	1	2	3	2	30	10	80
1	A&E - patients seen within 4 hours DGH only	>95%		79.7%	74.6%	74.4%	77.8%	84.5%	81.2%	87.2%	88.3%	88.7%	88.6%	93.4%	87.9%	81.1%	86.8%
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		1	13	10	1	2	0	0	0	0	2	0	0	1	5
1	Number of Clostridium Difficile cases - (Acute) *	<3		1	0	1	3	1	4	2	2	3	2	0	0	3	17
1	Number of Clostridium Difficile cases - (Community)	0		1	1	0	0	0	1	2	1	0	0	0	0	1	5
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		55.0%	58.5%	58.5%	54.0%	63.6%	56.2%	59.4%	51.2%	54.8%	57.0%	58.1%	57.5%	54.5%	56.8%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		23.8%	35.3%	22.0%	24.6%	25.0%	22.4%	35.0%	20.4%	24.0%	22.8%	28.4%	22.4%	26.2%	25.1%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		77.3%	72.7%	77.3%	86.4%	81.8%	72.7%	81.8%	81.8%	81.8%	72.7%	86.4%	86.4%	81.8%	80.8%

NOTE

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

Corporative Objective		Target 2016/2017	13 month trend	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year to date 2016/17
QUALITY FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		95.9%	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%	96.9%	97.1%	96.7%
1	Reported Incidents - Major + Catastrophic *	<6		3	2	0	1	4	5	2	4	0	1	2	2	1	21
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		0	3	4	5	0	2	1	1	1	1	0	1		7
1	Never Events	0		0	0	0	0	0	0	0	0	0	0	1	0	0	1
1	SIRI - Reportable incidents	0							9	4	4	3	4	6	1	5	43
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		2	1	2	2	0	2	0	0	0	0	0	0	2	4
1	Formal Complaints - Number Received *	<60		27	37	43	32	29	42	40	24	37	36	27	38	25	298
1	VTE - Risk assessment on admission - (Acute)	>95%		95.8%	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%	93.2%	94.4%	93.5%	93.7%
1	VTE - Risk assessment on admission - (Community)	>95%		100.0%	98.7%	88.8%	90.4%	92.5%	92.9%	91.2%	92.2%	97.5%	97.6%	99.2%	95.0%	97.0%	94.9%
1	Medication errors resulting in moderate to catastrophic harm	0					0	2	1	0	0	0	1	0	0	2	6
1	Medication errors - Total reported incidents (trust at fault)	N/A					47	42	46	39	62	38	27	40	57	48	399
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%		86.4%	92.8%	111.0%	98.4%	96.7%	94.5%	92.0%	98.0%	93.0%	97.5%				96.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		95.6%	102.8%	101.1%	101.1%	101.2%	101.4%	102.8%	100.5%	95.6%	96.5%	102.9%	101.2%	101.7%	100.4%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		98.8%	101.5%	100.8%	102.4%	97.3%	96.2%	97.5%	97.0%	94.6%	93.1%	97.4%	98.2%	100.5%	96.9%
1	Infection Control - Bed Closures - (Acute) *	<100		36	12	57	38	236	56	68	28	34	6	24	98	68	618
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		66.7%	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.3%	67.9%	85.3%	88.6%	80.7%
1	Stroke patients spending 90% of time on a stroke ward	>80%		82.0%	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%	94.9%	84.6%	88.2%	81.0%
1	Dementia - Find - monthly report	>90%		65.5%	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	36.6%	36.4%	49.4%	59.2%	49.3%	41.4%
1	Follow ups 6 weeks past to be seen date	3500		5090	5291	4938	5732	6082	6073	6219	6601	6919	6533	6582	6201	7034	7034

Corporative Objective		Target 2016/2017	13 month trend	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year to date 2016/17
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges *	2216 (full year)		327	325	415	338	351	188	594	411	425	110	180	441	375	3075
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		67.0%	68.8%	68.8%	68.9%	85.7%	78.7%	72.1%	72.9%	73.7%	69.5%	69.0%	68.8%	69.4%	69.4%
3	Clients receiving Self Directed Care	>90%		92.7%	92.1%	92.9%	93.6%	92.5%	91.6%	91.2%	91.1%	91.7%	91.7%	92.3%	92.3%	92.0%	92.0%
2	Carers Assessments Completed year to date	40% (Year end)		38.2%	41.2%	42.8%	43.3%	5.9%	11.9%	18.6%	21.9%	25.2%	28.5%	30.0%	32.5%	34.9%	34.9%
	Carers Assessment trajectory			30.0%	33.3%	36.7%	40.0%	3.3%	6.7%	10.0%	13.3%	16.7%	20.0%	23.3%	26.7%	30.0%	30.0%
3	Number of Permanent Care Home Placements	<=617 (Year end)		636	637	640	635	628	624	626	614	626	635	641	649	649	649
	Number of Permanent Care Home Placements trajectory			636	634	632	630	634	632	631	629	628	626	625	623	622	622
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		212	174	147	139	131	137	131	117	126	140	156	177		177
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET		303			451			39			105				105
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET		6.4%			8.5%			9.2%			8.2%				8.2%
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%	100.0%	100.0%
1	Bed Occupancy	80% - 90%		92.4%	94.8%	92.5%	91.9%	92.8%	89.8%	86.4%	92.7%	90.2%	92.6%	92.7%	93.4%	87.9%	90.9%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		n/a	n/a	n/a		83.1%	79.4%	84.0%	85.0%	78.2%	83.4%	85.1%	91.1%	92.6%	92.6%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET						586	576	578	583	590	612	610	602	579	579

Corporative Objective		Target 2016/2017	13 month trend	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Year to date 2016/17
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears)	<3.8%		4.00%	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	4.31%	4.34%		4.34%
2	Appraisal Completeness	>90%		78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%	84.00%	84.00%	83.00%	83.00%
2	Mandatory Training Compliance	>85%		90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%	86.00%	88.00%	87.38%	87.38%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.87%	12.61%	12.61%	12.00%	11.87%	11.87%
CHANGE FRAMEWORK																	
3	Number of Emergency Admissions - (Acute)			2708	2609	2740	2945	2797	2974	2947	3078	2935	2997	3015	3012	3088	26843
3	Average Length of Stay - Emergency Admissions - (Acute)			3.5	3.5	3.3	3.4	3.7	3.3	3.2	3.0	3.4	3.3	2.9	3.1	3.2	3.2
3	Hospital Stays > 30 Days - (Acute)			21	21	28	29	35	34	26	21	26	24	15	26	16	223

Performance & Quality Databook

Month 9 December 2016

Contents

Finance framework and schedules

Schedule 1 - Income analysis	4
Schedule 2 - Employee expenses	5
Schedule 3 - Agency spend	6
Schedule 4 - Non pay expenses	7
Schedule 5 - Cash flow	8
Schedule 6 - Capital	9
Schedule 7 - Contract Activity and Income Analysis	10
Schedule 8 - CIP Analysis	11

NHS I compliance

A&E and MIU 4 hour performance	13
Referral to treatment, incomplete pathways	13
Clostridium difficile - lapse in care	13
Cancer two week wait referrals	14
Cancer breast symptomatic referrals	14
Cancer 31 day 1st treatment	14
Cancer 31 day subsequent treatment - drug	15
Cancer 31 day subsequent treatment - radiotherapy	15
Cancer 31 day subsequent treatment - surgery	15
Cancer 62 day treatment from 2ww	16
Cancer 62 day treatment from screening	16

Contractual framework

Diagnostic tests waiting longer than 6 weeks	18
Referral to treatment >52 week incomplete pathways	18
Mixed sex accomodation breaches	18
Cancellations - on the day	19
Cancellations - patients not treated with 28 days of cancellation	19
Ambulance handovers	19
A&E 4 hour performance	20
MIU 4 hour performance	20
A&E trolley waits	20
Clostridium difficile cases	21
Care plan summaries	21
Clinic letters	22

Quality Framework

Harm Free	24
Reported incidents - Major & Catestrophic	24
Avoidable new pressure ulcers - category 3 and 4	24
Never events and SIRI	25
Quality Effectiveness Safety Trigger Tool (QUEST)	25
Written complaints	25
VTE Risk assessment on admission	26
Medication errors	26
Hospital Standardised Mortality Rate (HSMR)	27
Safer Staffing Levels	27
Infection control - bed clossures	28
Fracture neck of femur - best practice	28
Fracture neck of femur - surgery within 36 hours	28
Stroke patients spending 90+% of time on stroke ward	29
Dementia - Find	29
Follow ups past to be seen date	29

Workforce Management Framework

Staff sickness	31
Staff appraisals	31
Mandatory training	32
Turnover	32

FINANCE FRAMEWORK AND SCHEDULES

Schedule 1 - Income analysis
Schedule 2 - Employee expenses
Schedule 3 - Agency spend
Schedule 4 - Non pay expenses
Schedule 5 - Cash flow
Schedule 6 - Capital
Schedule 7 - Contract Income Analysis
Schedule 8 - CIP Analysis

Month 9 December 2016

Income Analysis **Schedule 1**

	Year to Date - Month 09			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	120.92	121.07	0.14	0.37	(0.22)	(0.17)	↑
North, East & West Devon Clinical Commissioning Group	3.97	4.03	0.06	0.00	0.06	0.09	↓
NHS England - Area Team	5.65	5.51	(0.14)	0.22	(0.36)	(0.28)	↑
NHS England - Specialist Commissioning	21.34	21.06	(0.28)	(0.17)	(0.11)	0.12	↑
Other Commissioners	5.91	5.92	0.01	(0.22)	0.23	0.16	↑
Sub-Total Acute	**157.79**	**157.58**	**(0.21)**	**0.20**	**(0.41)**	**(0.07)**	↑
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	57.35	58.97	1.62	1.57	0.04	0.04	↔
Other Commissioners	2.09	2.01	(0.08)	(0.06)	(0.02)	(0.03)	↓
Sub Total Community	**59.45**	**60.98**	**1.53**	**1.51**	**0.02**	**0.01**	↑
Sustainability Transformational Funding (STF) Income	5.03	3.21	(1.82)	(3.35)	1.54	1.54	↔
Total Acute and Communuity	**222.26**	**221.77**	**(0.49)**	**(1.64)**	**1.14**	**1.47**	↓

Healthcare Income - By Business Unit							
	£m	£m	£m	£m	£m	£m	
Medical Services	66.67	67.69	1.02	0.64	0.38	0.52	↓
Surgical Services	51.04	51.44	0.40	0.24	0.16	0.22	↓
Women's, Childrens & Diagnostic Services	33.16	31.85	(1.31)	(1.32)	0.01	0.07	↓
Community Services	59.45	60.98	1.53	1.51	0.02	0.01	↑
Non-Clinical Services / Central Contract Income	11.95	9.83	(2.12)	(2.70)	0.57	7.21	↓
Total	**222.26**	**221.78**	**(0.48)**	**(1.63)**	**1.15**	**8.03**	↓

Healthcare Activity - By Setting							
	Activity	Activity	Activity	Activity	Activity	Activity	
Elective In-Patient Admissions	3,282	3,336	54	369	(315)	(271)	↑
Elective Day Case Admission	24,561	25,747	1,186	808	378	443	↓
Urgent & Emergency Admissions	84,221	85,352	1,131	1,566	(435)	(368)	↑
Out-Patients	326,054	337,101	11,047	9,256	1,791	4,090	↓
Community Services							
Total	**438,118**	**451,536**	**13,418**	**11,999**	**1,419**	**3,894**	↓

Social Care Income							
	£m	£m	£m	£m	£m	£m	
Torbay Council - ASC Contract income	30.50	29.32	(1.18)	(1.18)	(0.00)	0.00	↔
Torbay Council - Public Health Income	3.72	4.44	0.72	0.00	0.72	0.64	↑
Torbay Council - Client Income	7.42	7.64	0.21	0.26	(0.04)	0.03	↓
Total	**41.64**	**41.40**	**(0.25)**	**(0.92)**	**0.67**	**0.67**	↔

Other Income							
	£m	£m	£m	£m	£m	£m	
Non Mandatory/Non protected clinical revenue	1.12	1.21	0.08	(0.00)	0.09	0.12	↓
R&D / Education & training revenue	6.54	6.84	0.30	0.00	0.30	0.26	↑
Site Services	1.66	1.77	0.11	0.00	0.11	0.09	↑
Revenue from non-patient services to other bodies	4.10	4.02	(0.08)	0.00	(0.08)	(0.08)	↔
Misc. other operating revenue	18.30	17.62	(0.68)	0.01	(0.69)	0.05	↑
Total	**31.72**	**31.46**	**(0.26)**	**0.01**	**(0.27)**	**0.44**	↑

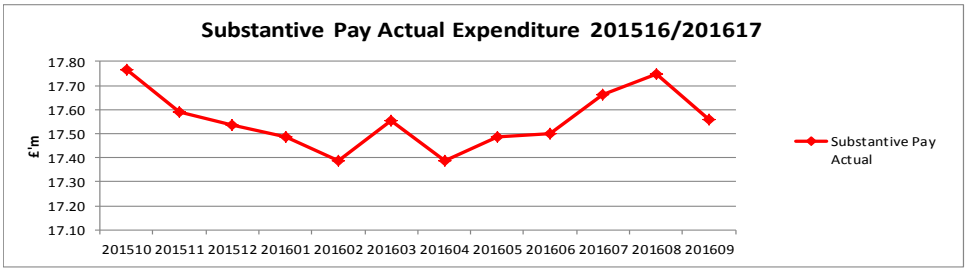
Risk Share Income							
	£m	£m	£m	£m	£m	£m	
Risk Share Income	0.00	7.17	7.17	5.69	1.48	0.47	↑
Total	**0.00**	**7.17**	**7.17**	**5.69**	**1.48**	**0.47**	↑

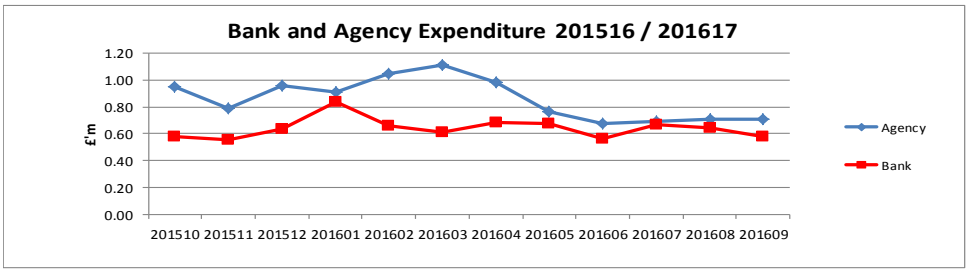
	Year to Date - Month 08			Plan Changes		Previous Month	
Memo	Plan	Actual	Variance	Changes PbR to RSA Plan	Variance to RSA Plan	Variance to RSA Plan	Change
CCG Block adjustment							
	£m	£m	£m	£m	£m	£m	
CCG Block adjustment	0.00	(8.81)	(8.81)	(5.68)	(3.13)	(3.38)	↓
Total	**0.00**	**(8.81)**	**(8.81)**	**(5.68)**	**(3.13)**	**(3.38)**	↓

Employee Expenses **Schedule 2**

	Year to Date - Month 09			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	38.61	39.53	(0.92)	0.71	(0.22)	(0.10)	↑
Registered nurses, midwives and health visiting staff	41.75	43.33	(1.58)	0.91	(0.66)	(0.61)	↑
Qualified scientific, therapeutic and technical staff	33.74	31.77	1.98	0.26	2.24	2.01	↑
Support to clinical staff	13.45	15.51	(2.06)	0.00	(2.06)	(1.79)	↑
Managers and infrastructure Support	39.20	41.13	(1.93)	0.79	(1.14)	(0.98)	↑
Total	**166.75**	**171.27**	**(4.51)**	**2.68**	**(1.84)**	**(1.47)**	↑
Employee Expenses - By Type							
Substantive	158.49	157.68	0.81	2.68	3.48	3.23	↑
Bank	2.59	5.92	(3.33)	(0.00)	(3.33)	(3.03)	↑
Locum (including Agency)	1.31	1.42	(0.11)	0.00	(0.11)	(0.05)	↑
Agency (excluding Locums)	4.36	6.25	(1.89)	0.00	(1.89)	(1.63)	↑
Total	**166.75**	**171.27**	**(4.52)**	**2.68**	**(1.84)**	**(1.48)**	↑
Employee Expenses - By Service							
Medical Services	29.99	33.88	(3.89)	0.29	(3.61)	(3.18)	↑
Surgical Services	34.14	35.09	(0.95)	0.05	(0.90)	(0.73)	↑
Women's, Childrens & Diagnostic Services	27.62	28.68	(1.06)	0.02	(1.04)	(0.87)	↑
Community Hospital and Services (including ASC)	31.62	32.41	(0.79)	1.45	0.66	0.68	↓
Non-Clinical Services	43.38	41.21	2.17	0.87	3.04	2.62	↑
Total	**166.75**	**171.27**	**(4.52)**	**2.68**	**(1.84)**	**(1.48)**	↑

Pay run rates January 2016 - December 2016





Torbay and South Devon NHS Foundation Trust
Trust Agency Information
Financial Year 2016/17

All Staff Group	April	May	June	July	August	September	October	November	December	YTD 2016-17
NHS Improvement - revised Ceiling (June 2016)	£m	£m	£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)	(0.503)	(0.497)	(5.163)
Total Planned Staff Costs	(18.898)	(18.901)	(18.904)	(18.678)	(18.681)	(18.684)	(17.999)	(18.003)	(18.007)	(166.754)
% of Agency Costs against Total Staff Cost	4%	3%	3%	3%	3%	3%	3%	3%	3%	3.10%

	April	May	June	July	August	September	October	November	December	YTD 2016-17
ICO Actual	£m	£m	£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)	(0.705)	(0.706)	(7.586)
Total Actual Staff Cost	(19.231)	(19.090)	(19.565)	(19.053)	(18.637)	(18.742)	(19.019)	(19.091)	(19.091)	(171.519)
% of Agency Costs against Total Staff Cost	5%	5%	6%	5%	23%	-15%	4%	4%	4%	4.42%

	April	May	June	July	August	September	October	November	December	YTD 2016-17
Variance against Revised Ceiling	£m	£m	£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)	(0.201)	(0.209)	(2.423)
% of Agency Costs against Total Staff Cost	1%	2%	2%	2%	20%	-18%	1%	1%	1%	1.33%

Nursing only	April	May	June	July	August	September	October	November	December	YTD 2016-17
NHS Improvement - revised Ceiling (June 2016)	£m	£m	£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)	(0.163)	(0.163)	(1.777)
Total Planned Staff Costs	(4.633)	(4.631)	(4.629)	(4.723)	(4.723)	(4.721)	(4.531)	(4.531)	(4.650)	(41.773)
% of Agency Costs against Total Staff Cost	6%	6%	6%	4%	3%	3%	4%	4%	4%	4.25%

	April	May	June	July	August	September	October	November	December	YTD 2016-17
ICO Actual	£m	£m	£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)	(0.359)	(0.299)	(3.588)
Total Actual Staff Cost	(4.980)	(4.927)	(4.993)	(4.824)	(4.678)	(4.690)	(4.685)	(4.857)	(4.699)	(43.333)
% of Agency Costs against Total Staff Cost	9%	11%	11%	9%	19%	-5%	5%	7%	6%	8.28%

	April	May	June	July	August	September	October	November	December	YTD 2016-17
Variance against Revised Ceiling	£m	£m	£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)	(0.196)	(0.136)	(1.812)
% of Agency Costs against Total Staff Cost	3%	5%	5%	6%	16%	-8%	2%	4%	3%	4.03%

Comment M1 to M9 Agency Actual is higher than revised Ceiling by £2.4m YTD, 1.33% more than the revised ceiling of 3.10%. M9 Total Agency is £7.6m across all Staff Group.

Improvement Plan

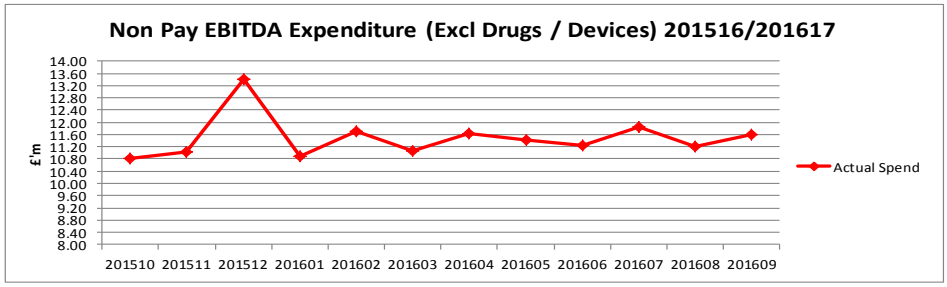
No.	Action	Lead	Date
1	Nursing agency shifts all approved by a Director	JV	ongoing
2	Medical Agency and Locum Approved by a Director	RD	ongoing
3	Recruitment processes streamlined and regular for key clinical staff	JS	Ongoing
4	Overseas Recruitment of Nursing Staff	JS/JV	in progress

Governance Arrangements
Senior Business management Team, Exec Team meetings

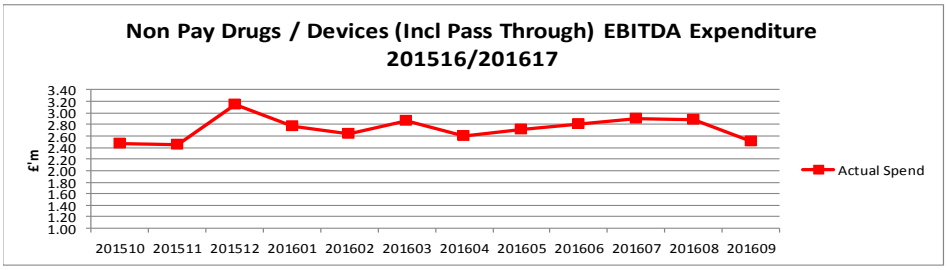
Non Pay Expenses **Schedule 4**

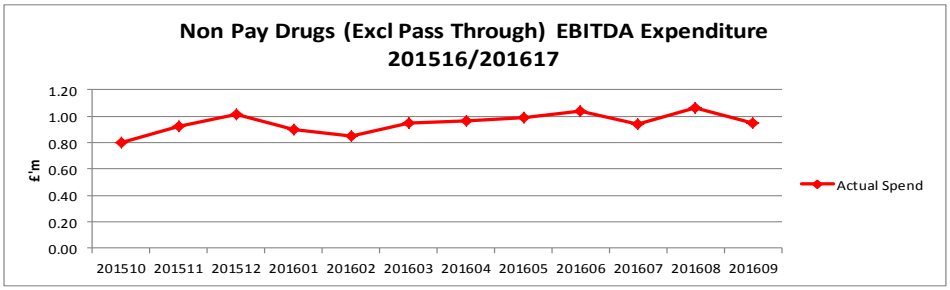
	Year to Date - Month 09			Plan Changes		Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Non Pay Expenses - By Category							
Clinical Supplies	16.12	17.00	(0.89)	0.00	(0.89)	(0.84)	↑
Drugs (Excluding Pass through)	7.89	8.65	(0.76)	0.00	(0.76)	(0.64)	↑
Pass through Drugs, Blood and Devices	15.11	16.03	(0.92)	0.57	(0.35)	(0.55)	↓
Non Clinical Supplies	2.07	2.26	(0.19)	0.00	(0.19)	(0.14)	↑
Miscellaneous / Other	76.43	82.72	(6.29)	5.60	(0.69)	(0.05)	↑
Total	**117.60**	**126.66**	**(9.06)**	**6.17**	**(2.88)**	**(2.21)**	↑

Non pay run rates January 2016 - December 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 09			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	11.99	3.07	(8.92)	(5.98)	(2.94)	(1.77)	↓
Debtor Movements	3.92	(4.86)	(8.77)	(0.68)	(8.09)	(9.73)	↑
Creditor Movements (excl capital creditor)	(2.11)	5.62	7.72	1.38	6.35	5.46	↑
Capital Expenditure (accruals basis)	(25.35)	(13.35)	12.00	12.42	(0.42)	0.96	↓
Net Interest	(2.19)	(2.04)	0.15	0.00	0.15	0.15	↔
Loan drawndown	11.26	7.76	(3.50)	(3.50)	(0.00)	(0.04)	↑
Loan repayment	(3.21)	(3.31)	(0.10)	0.00	(0.10)	(0.10)	↔
PDC Dividend	(1.29)	(0.69)	0.60	0.42	0.19	0.19	↔
Other	0.17	(3.65)	(3.81)	(1.38)	(2.44)	(1.54)	↓
Closing Cash Balance	**16.75**	**12.13**	**(4.62)**	**2.68**	**(7.30)**	(6.42)	↓

Capital **Schedule 6**

	Year to date - Based upon Annual Plan (April 16)			Year to date - Based upon new adjusted 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	25.35	13.35	(12.00)	13.35	13.35	0.00	36.90	23.81
Significant Variances in Planned Expenditure by Scheme:								
HIS schemes	6.95	2.44	(4.51)	2.44	2.44	0.00	9.98	4.23
Estates schemes	14.60	8.97	(5.63)	8.97	8.97	0.00	17.70	13.38
Medical Equipment	2.73	0.63	(2.10)	0.63	0.63	0.00	8.02	5.23
Other	0.12	0.07	(0.05)	0.07	0.07	0.00	0.12	0.11
PMU	1.40	1.24	(0.16)	1.24	1.24	0.00	1.88	1.60
Contingency	1.43	0.00	(1.43)	0.00	0.00	0.00	2.20	0.26
Anticipated slippage	(1.88)	0.00	1.88	0.00	0.00	0.00	(3.00)	(1.00)
Prior Year schemes	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	25.35	13.35	(12.00)	13.35	13.35	0.00	36.90	23.81
Funding sources								
Secured loans	7.18	7.76	0.58	7.18	7.76	0.58	10.94	9.64
Unsecured loans	4.08	0.00	(4.08)	0.00	0.00	0.00	7.71	2.28
PDC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.80
Charitable Funds	0.63	0.14	(0.49)	0.14	0.14	0.00	2.60	1.80

Torbay & South Devon NHS Foundation Trust

Cumulative Period to: **December** **2016** **Schedule 7**

DRAFT

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	3,409	3,132	(277)	(309)	15,493	11,588	10,985	(602)	(500)
Day Cases	32,565	24,111	24,657	546	521	20,488	15,156	15,570	414	408
Non-Electives	29,681	22,308	23,820	1,512	1,212	56,391	42,084	45,358	3,274	2,968
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	973	1,018	44	43
Chemotherapy Procurement	0	0	0	0	0	3,174	2,355	2,410	55	27
Elective Readmissions						(230)	(173)	(173)	0	0
Emergency Readmissions						(188)	(141)	(141)	0	0
Chemotherapy Core HRG Adjustment						0	0	0	0	0
Emergency Adjustment						(3,182)	(2,387)	(3,046)	(660)	(502)
Emergency adjustment add back						0	0	0	0	0
APC Variation Orders Agreed						0	0	0	0	0
Total APC	66,827	49,828	51,609	1,781	1,424	**93,241**	**69,456**	**71,982**	**2,525**	**2,444**
Outpatients - 1st	76,972	57,731	58,492	761	1,159	12,126	9,082	9,081	(2)	89
Outpatients - F-up	202,129	150,291	150,795	504	1,928	19,237	14,342	14,325	(17)	73
Chemotherapy Delivery	0	0	0	0	0	106	82	94	13	12
Chemotherapy Procurement	0	0	0	0	0	1,644	1,322	1,201	(121)	(83)
Maternity Pathway	0	0	0	0	0	4,941	3,706	3,637	(68)	(67)
Radiotherapy	12,471	9,327	8,681	(646)	(547)	2,860	2,151	2,084	(66)	(59)
OP Radiology	28,291	21,250	21,261	11	92	2,988	2,240	2,293	53	57
GP Radiology	45,398	34,479	34,894	415	430	1,838	1,400	1,449	50	40
Outpatient Variation Orders Agreed						0	0	0	0	0
Total Outpatients	365,261	273,078	274,123	1,045	3,062	**45,740**	**34,324**	**34,165**	**(159)**	**62**
A&E	75,422	57,536	56,473	(1,063)	(802)	**8,691**	6,579	6,495	(84)	(65)
A&E Variation Orders Agreed										
Total A&E	75,422	57,536	56,473	(1,063)	(802)	**8,691**	**6,579**	**6,495**	**(84)**	**(65)**
Total PBR						**147,672**	**110,359**	**112,642**	**2,283**	2,442
Cost & Volume - Inpatients	325	232	204	(28)	(3)	379	246	265	19	43
Cost & Volume - Day Cases	1,659	1,256	1,090	(166)	(77)	694	535	525	(10)	13
Cost & Volume - Non-Electives	536	424	548	124	101	1,053	834	1,067	233	182
Cost & Volume - AMU	1,890	1,383	1,440	57	30	1,432	1,040	1,075	34	42
Cost & Volume - CDU	3,201	2,360	3,037	677	637	186	137	173	36	32
Cost & Volume - Outpatients 1st	27,425	20,650	21,162	512	623	2,896	2,196	2,314	119	130
Cost & Volume - Outpatients F-up	55,501	41,582	41,746	164	377	6,421	4,818	4,743	(75)	(38)
Cost & Volume - New	0	0	0	0	0	11,743	8,807	8,973	165	256
Critical Care - Adult						3,954	3,019	3,482	463	387
Critical Care - Neonatal & Paeds						1,919	1,405	1,441	36	74
Chemotherapy Delivery						0	0	0	0	0
Chemotherapy Procurement						0	0	0	0	0
Palliative Care						563	444	485	41	34
Other Cost & Volume - Drugs						18,457	13,839	14,430	591	723
Other Cost & Volume - Bloods						799	599	644	45	35
Other Cost & Volume - Excluded Devices						1,803	1,352	1,045	(308)	(228)
Cost & Volume - Various						1,539	1,154	1,154	(1)	34
Cost & Volume Variation Orders Agreed						0	0	0	0	0
Total Cost & Volume	54,537	41,027	39,427	2,346	1,666	**53,838**	**40,427**	**41,815**	**1,388**	**1,718**
Block - Patient Related						7,560	5,670	5,670	0	0
Block - Non Patient Related						4,041	3,031	3,031	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**	**8,701**	**8,701**	**0**	**0**
Total Non-PBR						**65,440**	**49,129**	**50,516**	**1,388**	**1,718**
CQUIN						4,634	3,475	3,475	0	0
Total Contract Adjustments	**0**	**0**	**0**	**0**	**0**	**4,634**	**3,475**	**3,475**	**0**	**0**
SD&T CCG plan adjustment to match resource envelope						0	0	0	0	0
Total Contract						**217,745**	**162,963**	**166,633**	**3,671**	**4,160**
Phasing adjustment	0	0	0	0	0	0	709	0	(709)	(675)
Contract Penalties						0	0	(241)	(241)	(187)
Block Adjustment						(7,567)	(5,675)	(8,809)	(3,134)	(3,378)
Grand Total						**210,178**	**157,997**	**157,583**	**(414)**	**(80)**
						0	0	0	0	0

TSDFT

CIP year end Delivery Forecast as at Month 9 2016/17

Master Ref	Title	SDU	Conf RAG	Confidence	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	Corporate	Green	90%	£0	£20,000			
571	Corporate accruals review	Corporate	Green	90%	£0		£335,956	£335,956	
690	Income reserves not required	Corporate	Green	100%	£0	£0	£1,650,000	£412,500	£0
783	TAIRU Nursing Reorganisation	Medicine	Green	100%	£1,704	£1,704		£0	£1,278
468	Lost pager review	Corporate	Gray	[0-100]%	£2,000	£0			
513	MR contrast for cardiac is about to be ordered in different volumes. This	WCDT	Green	100%	£3,500	£3,500			£3,500
560	Church st sale and reduction in utilities	EFM	Yellow	70%	£4,000				
417	Community Nursing Vehicle Review - Torbay and SD	Community	Green	100%	£5,000	£0		£0	
559	Sewing room	EFM	Green	90%	£5,000				
489	Private Therapy Income	WCDT	Green	100%	£5,000	£5,000			£5,000
479	Outpatient Productivity	Surgery	Red	0%	£6,250	£0	£0	£0	£0
557	External Non clinical Cleaning contract	EFM	Red	50%	£6,500				
735	Research Income (Clinical Trials)	Corporate	Red	0%	£9,000		£154,000	£9,000	
551	Car Parking Introduction of New Tariff £10 for 8 hrs	EFM	Green	100%	£10,000				
566	Retail outlet level 4	EFM	Yellow	60%	£10,000				
497	Increase Ultrasound scan charge Idea to work up further	WCDT	Green	100%	£10,000	£6,000			£3,430
555	Car Parking review of public charges in the community	EFM	Yellow	70%	£15,000				
565	Regents house rent review	EFM	Red	30%	£15,000				
737	HQ Synergies - Chief Executive	Corporate	Green	95%	£17,548		£17,548	£13,162	
552	FM non pay general savings	EFM	Green	100%	£20,000				
544	Income from Training	Corporate	Green	100%	£20,000	£0	£20,000		
553	Estates non pay general savings	EFM	Green	100%	£20,000	£40,000			£40,000
710	Strategy Directorate- MARS leaver	Corporate	Green	100%	£20,089	£19,192			£14,394
695	HR - Yeovil Business Case	Corporate	Green	90%	£23,333	£23,333			£14,583
407	Joined Up TeleHealthCare Strategy	Community	Red	0%	£25,000	£0		£0	
549	Catering review Acute	EFM	Green	100%	£25,000				
550	Hotel Services Community Hospitals	EFM	Green	100%	£25,000				
433	Cavanna House - termination of existing lease at end of current term	Community	Green	100%	£25,000	£25,000			£8,000
554	Management pay	EFM	Green	100%	£26,000				
694	CE - Corporate - pension scheme	Corporate	Green	90%	£27,466	£27,466			£20,599
693	HR - synergies - part band 8a post	Corporate	Green	90%	£27,773	£27,773			£20,830
469	Mobile Phone review/BYOD	Corporate	Red	30%	£30,000	£0			
487	Microbiology VAT saving	WCDT	Green	100%	£30,000	£30,000			£22,500
493	Medical Electronics Reorganisation	WCDT	Green	100%	£30,000	£30,000			£30,000
494	Clinical Psychology Staff Saving	WCDT	Green	100%	£30,000	£30,000			£30,000
692	Procurement synergies - B5 post	Corporate	Green	90%	£30,651	£30,651			£22,988
413	Efficiences from Thera Contract (ASC element) A	Community	Green	90%	£36,000	£36,000		£0	£27,000
434	Review of specialist LD vacancy	Community	Green	100%	£37,000	£37,000		£0	£28,000
466	Procurement efficiencies	Corporate	Green	100%	£40,000	£0			
428	Vacant FAB team posts to be reviewd re, Care Act Funded	Community	Green	100%	£44,000	£44,000		£0	£33,000
739	HQ Synergies - Procurement	Corporate	Green	90%	£44,200	£44,200			£33,145
495	Reduction in spend on Blood - cell salvage	WCDT	Green	100%	£50,000	£0			£0
543	eLearning Strategy	Corporate	Red	0%	£50,000	£0			
423	Robust review process for adult IPPs	Community	Green	90%	£50,000	£146,000		£0	107000
498	Reduction in discretionary spend	WCDT	Green	100%	£57,000	£0			£0
444	GPWSI	Community	Green	100%	£58,000		£58,000	£44,000	£0
556	Car Parking community staff charges	EFM	Yellow	55%	£60,000				
782	Medical Physics Reorganisation	Medicine	Green	100%	£60,000	£60,000		£0	£45,000
446	Community funding set based on Run Rate spend last year, not now req	Medicine	Green	100%	£63,859	£86,074	£0	£0	£64,555
408	Independent Sector - Enhanced Brokerage	Community	Red	0%	£75,000	£0		£0	
471	Printing and Electronic Communication Strategy	Corporate	Yellow	80%	£75,000	£0			
424	In House Learning Disability Bay Tree (Reprovision of Respite Care)	Community	Green	90%	£79,000	£9,000		£0	£0
427	Recurrent Impact of Community Support Team savings	Community	Green	100%	£80,000	£80,000		£0	£60,000
465	Review Revenue Costs for IT Systems	Corporate	Red	20%	£81,000	£0			
421	Efficiences from Thera Contract (PP element)	Community	Green	90%	£81,000	£81,000		£0	61000
537	FP10 Outpatients - pharmacy scheme	Medicine	Green	90%	£100,000	£0	£0	£0	£0
416	ASC Insurance Premium Reduction	Corporate	Green	100%	£100,000	£100,000			£74,999
403	Independent Sector - Removal of Community Care Trust block and repla	Community	Green	100%	£100,000	£241,000			£181,000
410	Ind Sector - Additional reclaim of ASC Direct Payments	Community	Green	100%	£100,000	£243,000			£183,000
707	Clinical supplies procurement - Medicine impact	Medicine	Red	50%	£109,000	£0	£0	£0	£0
705	Clinical supplies procurement - WCDT impact	WCDT	Red	50%	£121,000				
464	Staff Salary Sacrifice Schemes	Trust-wide	Green	100%	£122,000		£65,000	£19,750	£32,117
405	Independent Sector - SPACE	Community	Red	0%	£125,000	£0			
406	Independent Sector - Supported Living	Community	Red	0%	£125,000	£0		£0	
409	Ind Sector - Responsive Management of Domicilliary Care	Community	Red	0%	£125,000	£0		£0	
547	Gas utilities	EFM	Green	100%	£140,000	£71,722			£71,722
709	HQ Synergies - Strategy	Corporate	Green	90%	£140,400	£140,400			£103,402
488	Replacement of Existing Roche Managed Service contract	WCDT	Green	100%	£147,000	£147,000			£73,500
435	South Devon Operations (Community Services) CIP Saving assumption	Community	Green	90%	£150,000	£112,000	£501,000	£311,000	100000
536	Drug savings - pharmacy scheme	Medicine	Green	90%	£160,000		£0	£0	£0
402	Ind Sector - Reduction in Care Home Placements (Standard under £606	Community	Red	0%	£175,000	£0		£0	
548	Car Parking	EFM	Green	100%	£190,000				
738	HQ Synergies - Education Direcorate	Corporate	Red	0%	£195,900				
496	Therapies recurrent vacancy factor	WCDT	Green	100%	£198,000		£198,000	£160,000	
425	Community Services CIP Saving assumption based on previous years	Community	Green	90%	£200,000	£192,000	£329,000	£273,000	£144,000
432	Co-location of Paignton & Brixham Zones	Community	Red	50%	£250,000	£102,000		£0	
480	Clinically led procurement in surgery	Surgery	Green	100%	£258,591	£194,961	£63,630	£65,793	£175,404
691	Finance restructure pay savings	Corporate	Yellow	70%	£263,918	£349,085			£85,167
706	Clinical supplies procurement - Surgery impact	Surgery	Red	50%	£270,000	£1,126	£0	£0	£469
572	Corporate non-pay savings	Corporate	Green	100%	£390,870	£0	£390,870	£351,979	£0
734	CHC General Packages of Care Review	Community	Green	90%	£417,000	£577,000			£438,000
418	Bring review assessments up to date CHC	Community	Green	90%	£430,000	£435,000		£0	£277,000
481	Surgery non-pay challenge	Surgery	Yellow	60%	£440,000	£246,818	£0	£0	£143,977
419	Tightening panel process (CHC)	Community	Red	10%	£498,000	£0		£0	£0
723	Nursing agency spend	Trust-wide	Red	20%	£500,000				
426	Torbay Operations (Community Services) CIP Saving assumption based	Community	Green	90%	£500,000	£736,000	£764,000	£624,000	£552,000
708	Medical SDU Senior agency and locum budgets	Medicine	Green	90%	£600,000	£600,000	£0	£0	£450,000

	Sub totals				£9,323,552	£5,432,005	£4,547,004	£2,620,140	£3,781,559
	Trustwide Scheme Gap				£4,633,962				
	CIP (FT Plan) Target				**£ 13,957,514**				
	Yr end Forecast Total						**£ 9,979,009**		
	Delivered Year to Date								**£ 6,401,699**

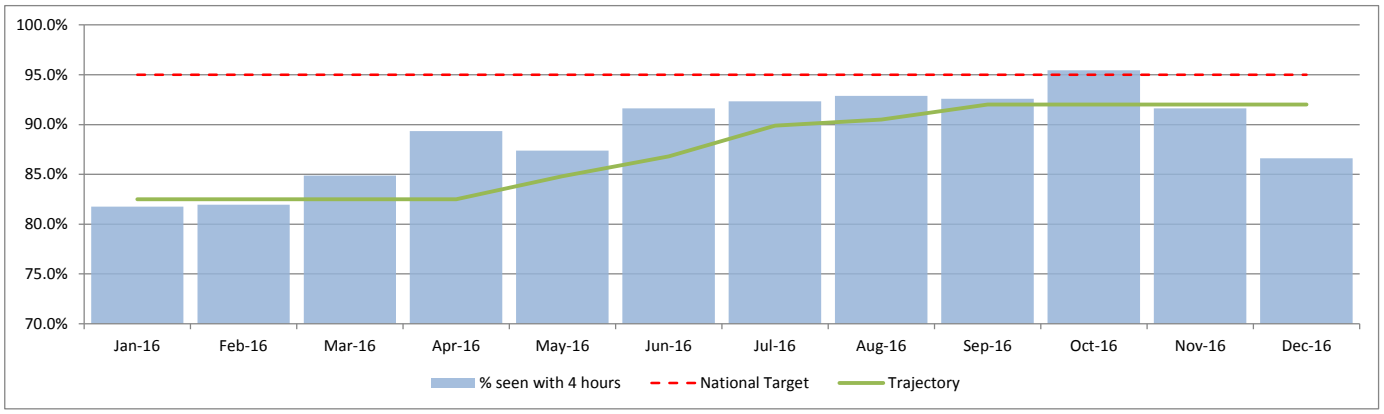
NHS I COMPLIANCE FRAMEWORK

Month 9 December 2016

NHS I COMPLIANCE FRAMEWORK

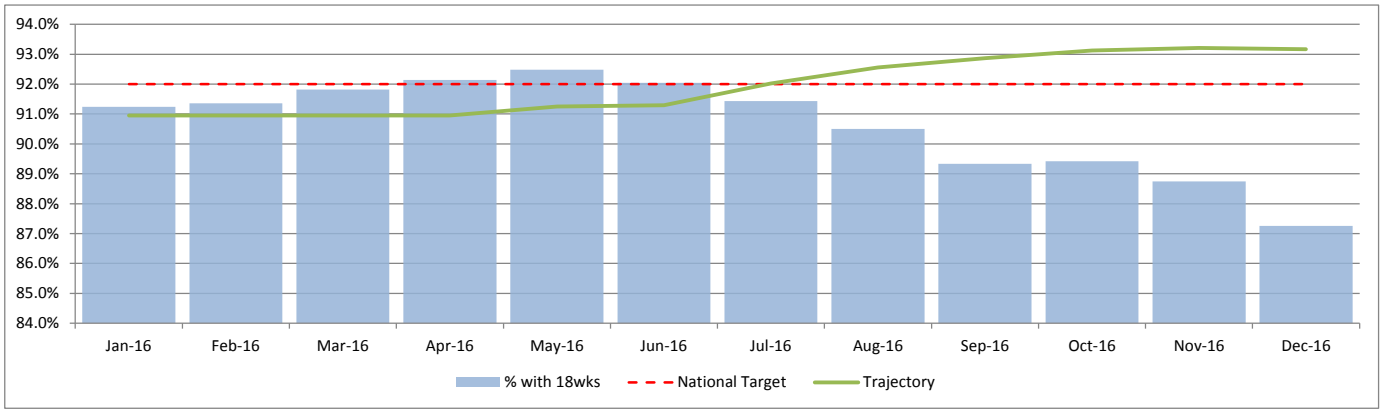
A&E and MIU patients seen within 4 hours

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients	8223	8084	9298	8627	9741	9672	10679	10449	9439	8989	8286	8419
4 hour breaches	1500	1459	1406	918	1229	810	819	744	698	408	695	1128
% seen with 4 hours	**81.8%**	**82.0%**	**84.9%**	**89.4%**	**87.4%**	**91.6%**	**92.3%**	**92.9%**	**92.6%**	**95.5%**	**91.6%**	**86.6%**
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%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%	92.0%	92.0%



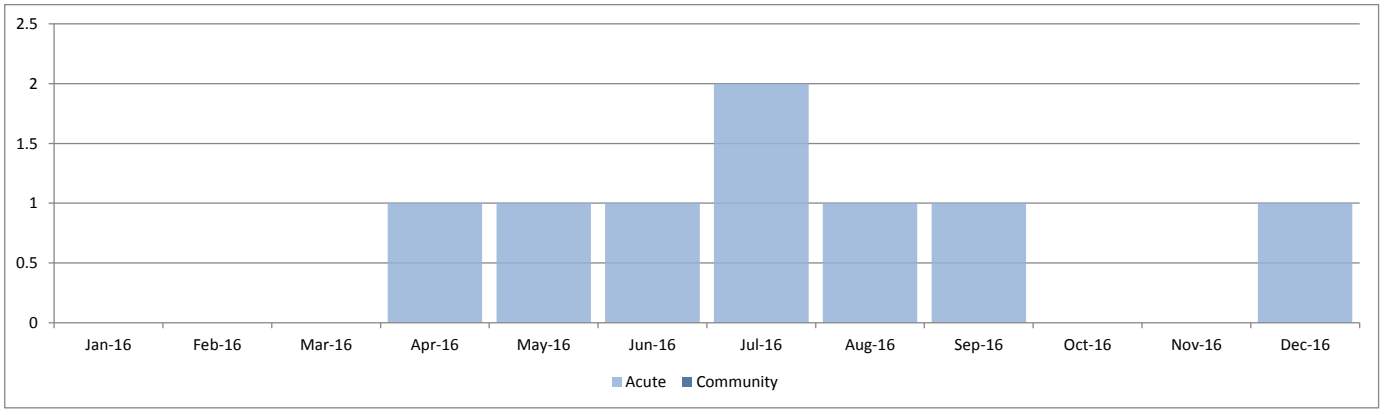
Referral to Treatment - Incomplete pathways

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Incomplete <18wks	14292	14566	14518	14771	15194	15119	15255	15331	15241	14940	14345	14273
Incomplete >18wks	1372	1378	1293	1260	1234	1307	1429	1609	1819	1768	1819	2085
% with 18wks	**91.2%**	**91.4%**	**91.8%**	**92.1%**	**92.5%**	**92.0%**	**91.4%**	**90.5%**	**89.3%**	**89.4%**	**88.7%**	**87.3%**
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%	91.2%	91.3%	92.0%	92.6%	92.9%	93.1%	93.2%	93.2%



C Diff. Lapse in Care

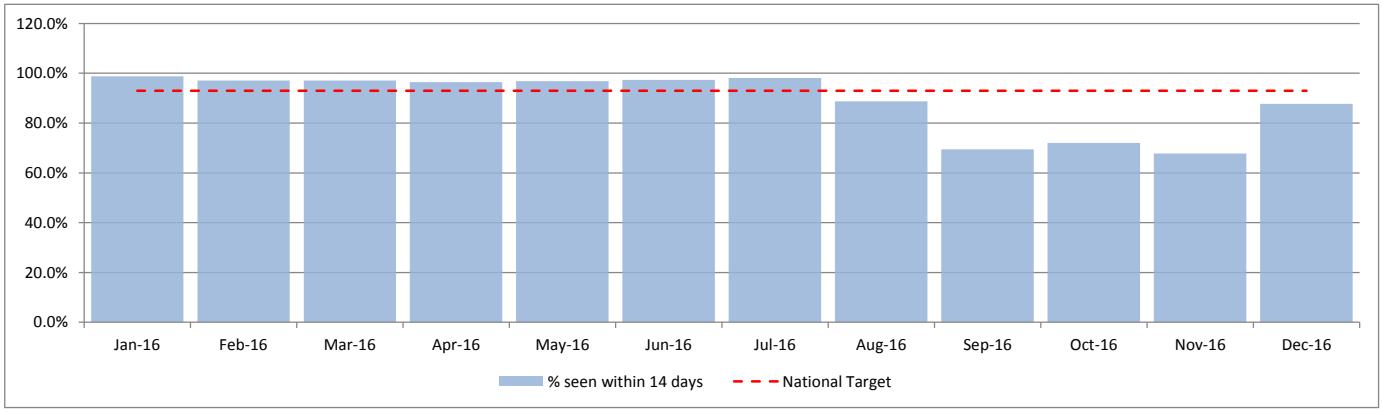
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acute	0	0	0	1	1	1	2	1	1	0	0	1
Community	0	0	0	0	0	0	0	0	0	0	0	0



NHS I COMPLIANCE FRAMEWORK

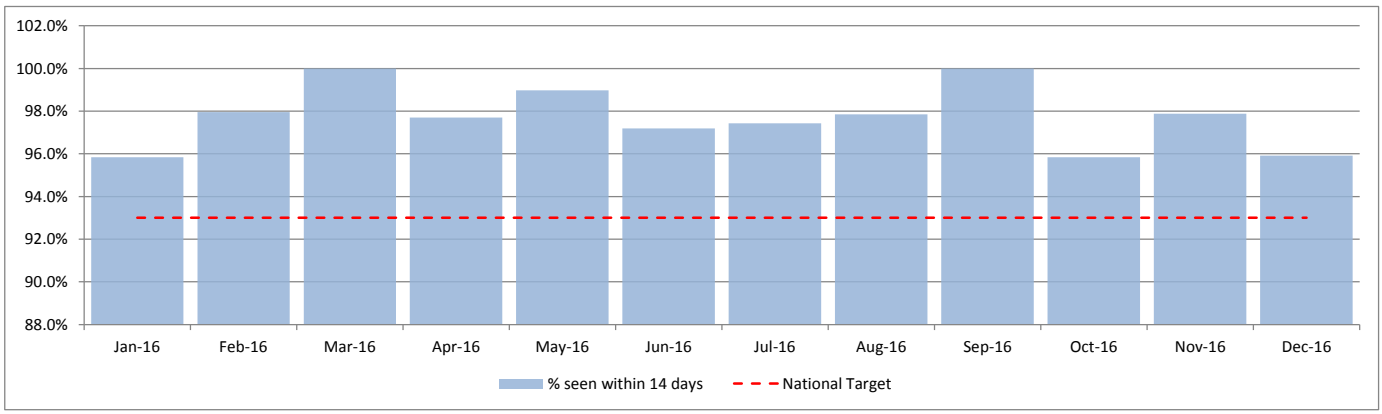
Cancer - Two Week Wait Referrals

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
2ww Referrals	705	846	965	888	997	997	951	982	994	964	994	902
Seen within 14 days	696	821	937	857	965	971	933	871	690	694	674	791
% seen within 14 days	98.7%	97.0%	97.1%	96.5%	96.8%	97.4%	98.1%	88.7%	69.4%	72.0%	67.8%	87.7%
National Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%



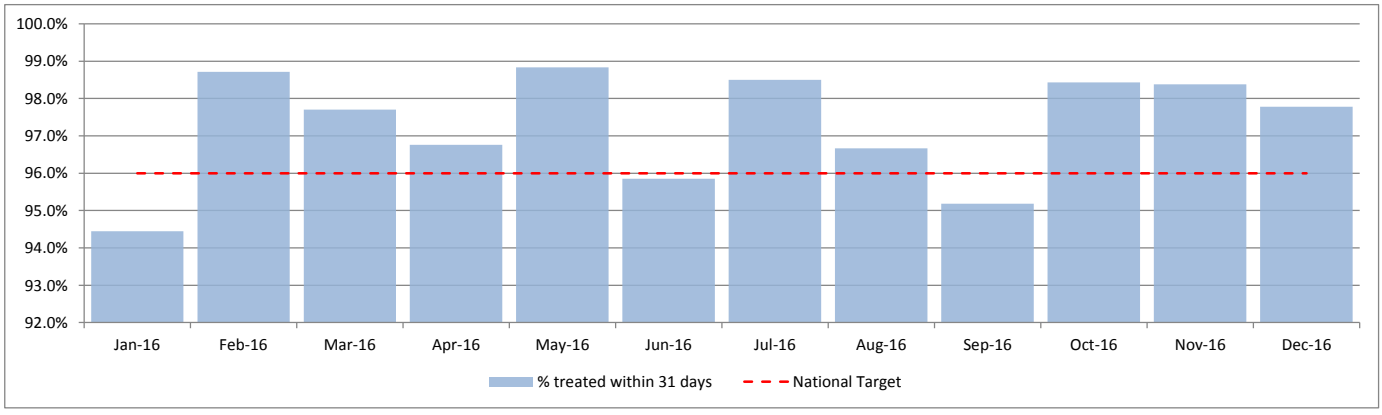
Cancer - Breast Symptomatic Referrals

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Breast symptomatic referrals	96	98	130	87	97	107	78	93	95	96	94	98
Seen within 14 days	92	96	130	85	96	104	76	91	95	92	92	94
% seen within 14 days	95.8%	98.0%	100.0%	97.7%	99.0%	97.2%	97.4%	97.8%	100.0%	95.8%	97.9%	95.9%
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 - 31 day wait from decision to treat to first treatment

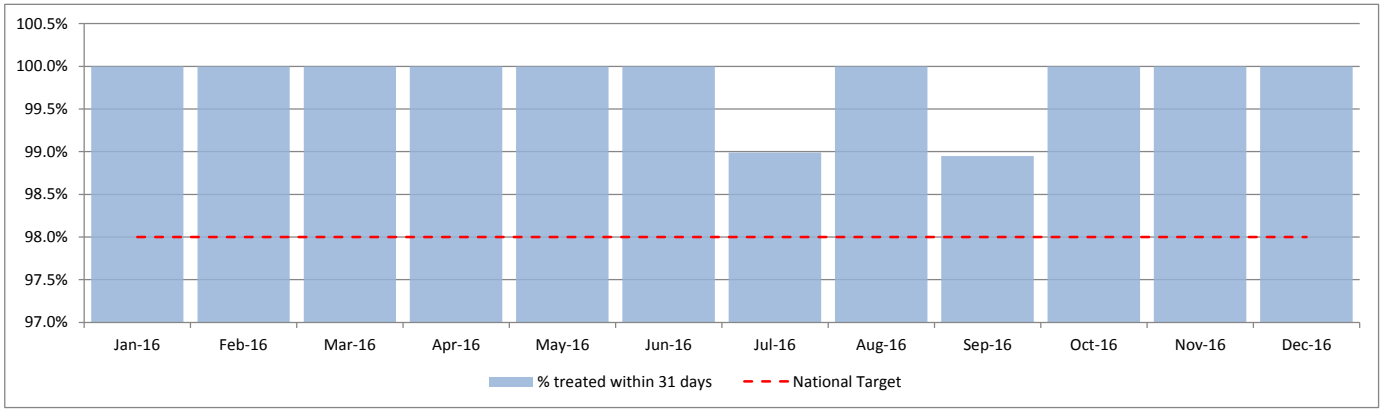
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1st treatments	162	155	174	185	172	193	200	180	166	191	185	180
Breaches of 31 day target	9	2	4	6	2	8	3	6	8	3	3	4
% treated within 31 days	94.4%	98.7%	97.7%	96.8%	98.8%	95.9%	98.5%	96.7%	95.2%	98.4%	98.4%	97.8%
National 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

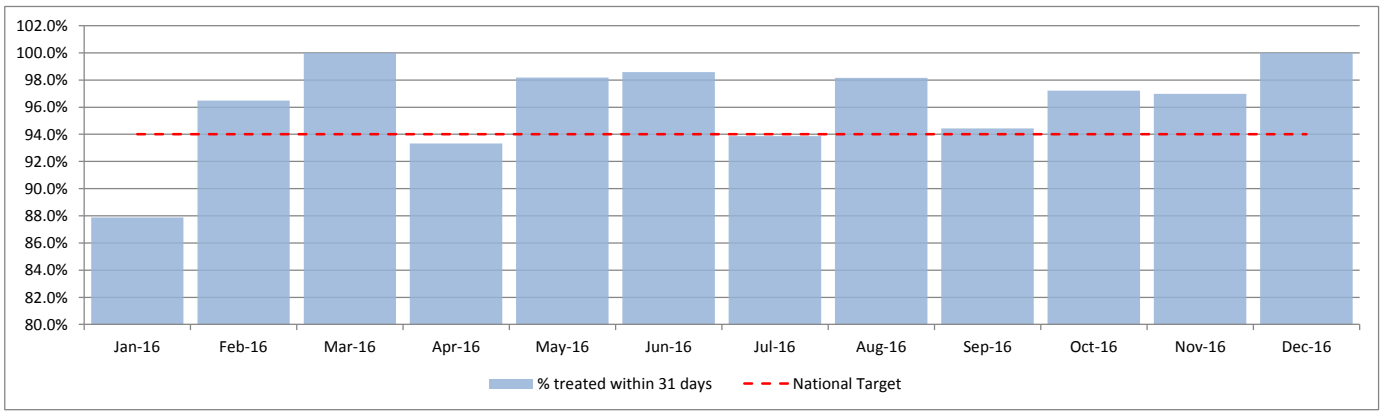
Cancer - 31 day wait for second or subsequent treatment - Drug

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Subsequent Drug treatments	59	52	62	70	68	85	99	93	95	88	85	63
Breaches of 31 day target	0	0	0	0	0	0	1	0	1	0	0	0
% treated within 31 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	98.9%	100.0%	100.0%	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%



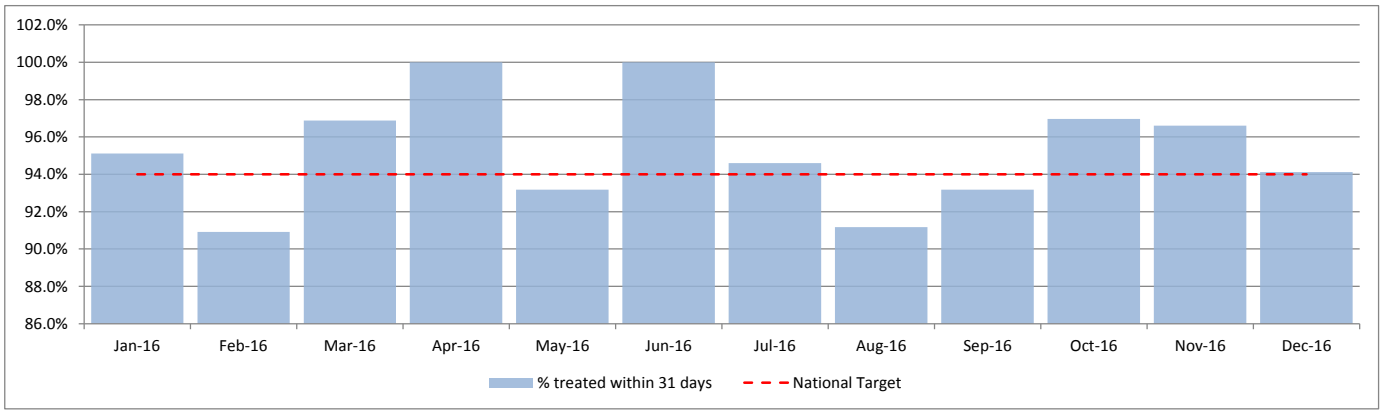
Cancer - 31 day wait for second or subsequent treatment - Radiotherapy

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sub radiotherapy treatments	66	57	64	45	55	71	49	54	54	72	66	31
Breaches of 31 day target	8	2	0	3	1	1	3	1	3	2	2	0
% treated within 31 days	87.9%	96.5%	100.0%	93.3%	98.2%	98.6%	93.9%	98.1%	94.4%	97.2%	97.0%	100.0%
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

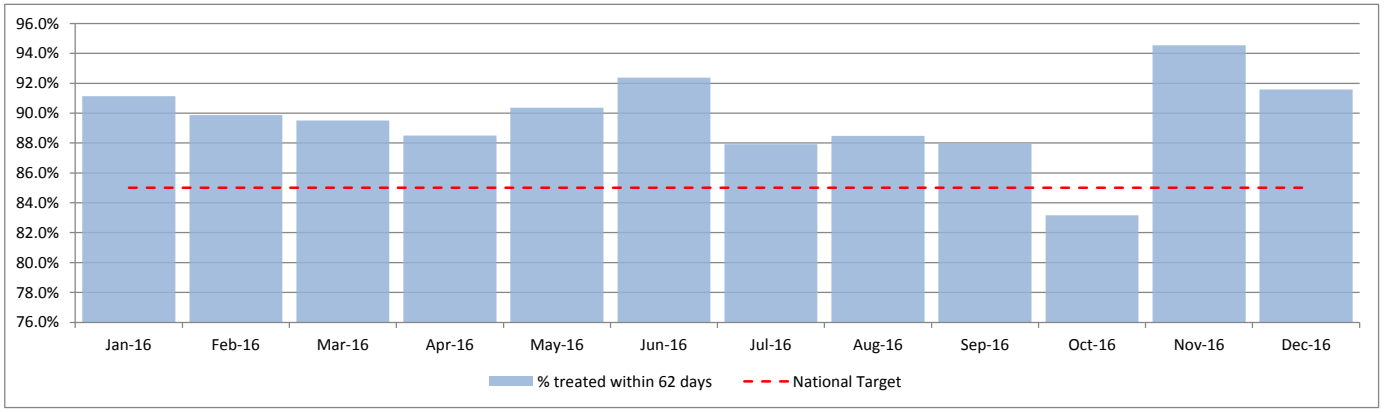
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Subsequent surgery treatments	41	44	32	30	44	40	37	34	44	33	59	34
Breaches of 31 day target	2	4	1	0	3	0	2	3	3	1	2	2
% treated within 31 days	95.1%	90.9%	96.9%	100.0%	93.2%	100.0%	94.6%	91.2%	93.2%	97.0%	96.6%	94.1%
National 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

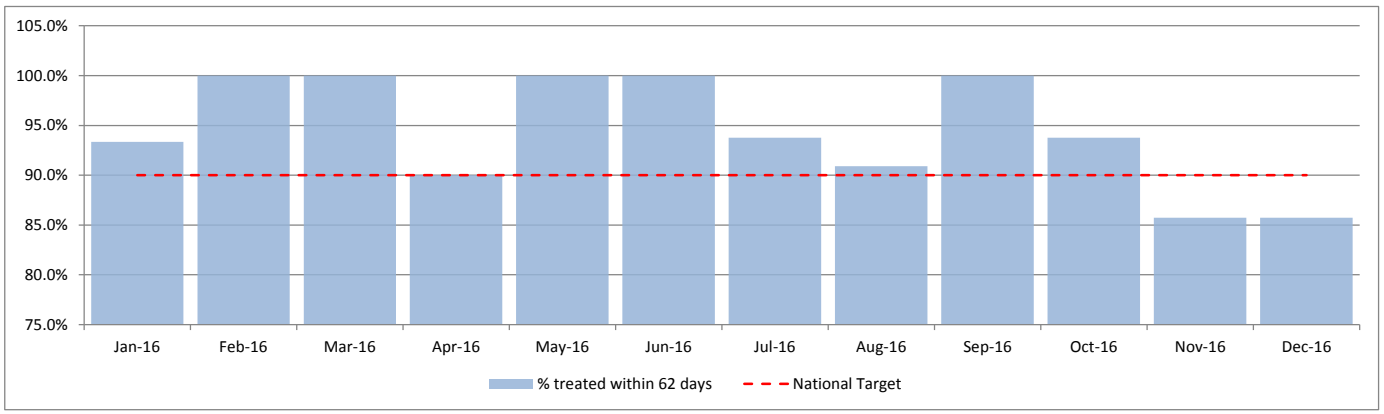
Cancer - 62 day wait for 1st treatment from 2ww referral

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1st treatments (from 2ww)	79	79	90.5	100	98.5	105	103.5	95.5	99.5	107	91.5	113
Breaches of 62 day target	7	8	9.5	11.5	9.5	8	12.5	11	12	18	5	9.5
% treated within 62 days	91.1%	89.9%	89.5%	88.5%	90.4%	92.4%	87.9%	88.5%	87.9%	83.2%	94.5%	91.6%
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

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1st treatments (from screening)	15	7	13.5	20	14	15	16	11	8	16	10.5	7
Breaches of 62 day target	1	0	0	2	0	0	1	1	0	1	1.5	1
% treated within 62 days	93.3%	100.0%	100.0%	90.0%	100.0%	100.0%	93.8%	90.9%	100.0%	93.8%	85.7%	85.7%
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%



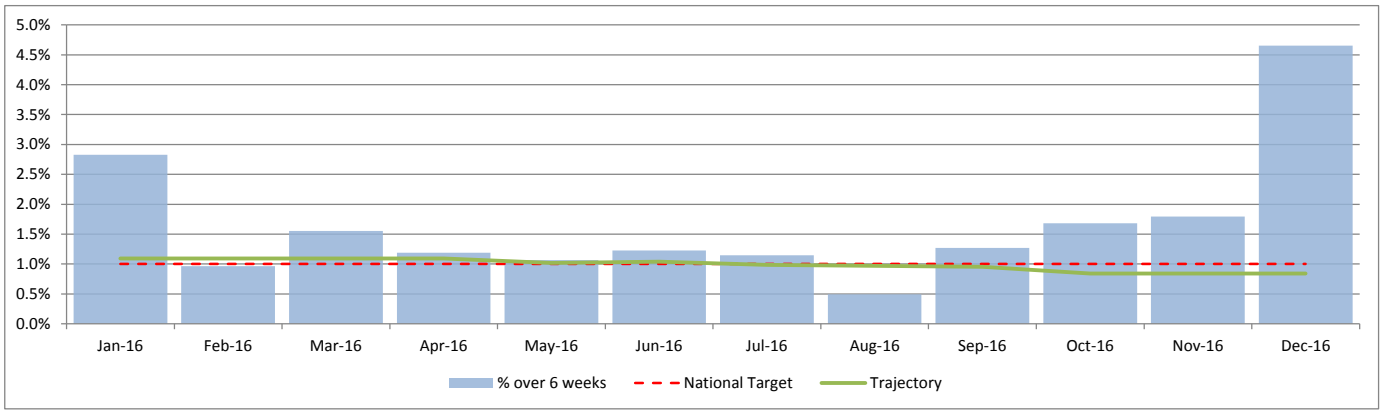
CONTRACTUAL FRAMEWORK

Month 9 December 2016

CONTRACTUAL FRAMEWORK

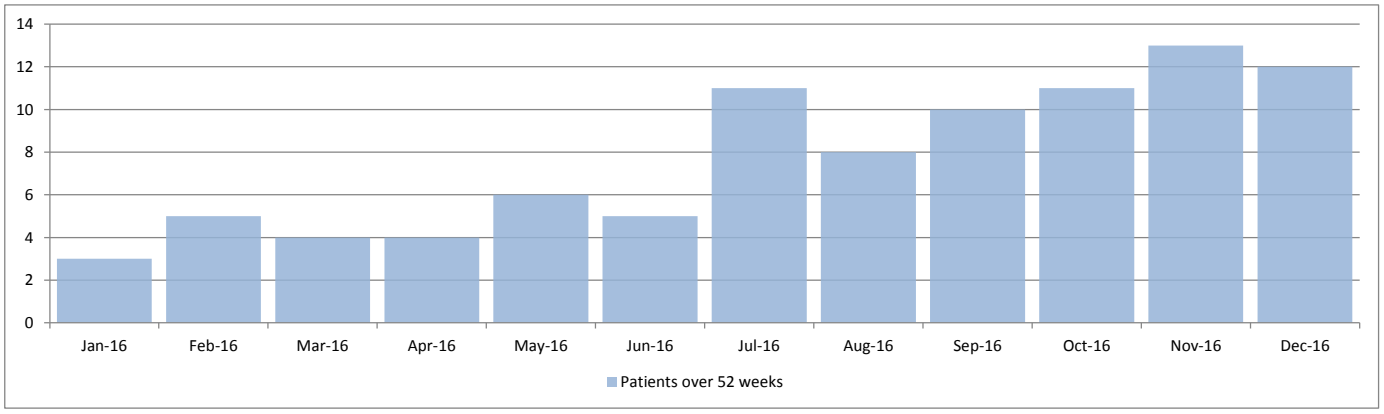
Diagnostic Tests Longer than the 6 week standard

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients	3750	3637	3543	3702	3374	3673	3231	3258	3461	3511	3523	3694
Waiting longer than 6 weeks	106	35	55	44	36	45	37	16	44	59	63	172
% over 6 weeks	**2.8%**	**1.0%**	**1.6%**	**1.2%**	**1.1%**	**1.2%**	**1.1%**	**0.5%**	**1.3%**	**1.7%**	**1.8%**	**4.7%**
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%	1.02%	1.04%	0.99%	0.97%	0.95%	0.84%	0.84%	0.84%



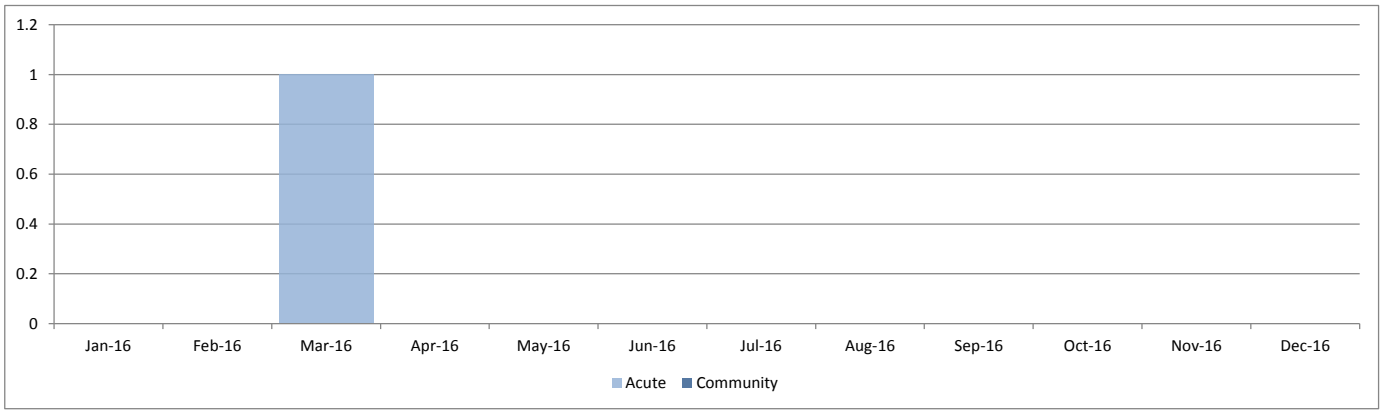
Referral to Treatment over 52 week incomplete pathways

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients over 52 weeks	3	5	4	4	6	5	11	8	10	11	13	12



Mixed sex accomodation breaches of Standard

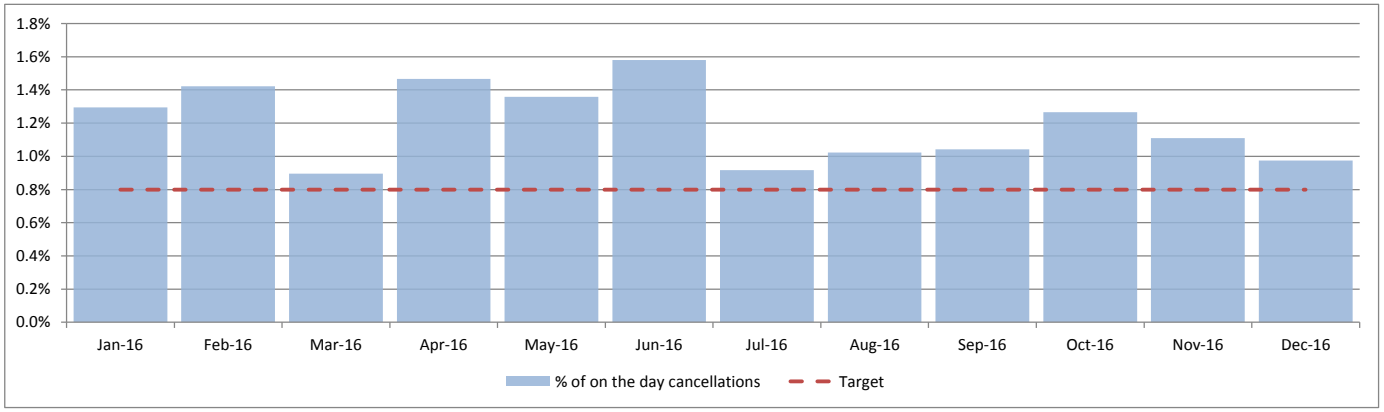
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acute	0	0	1	0	0	0	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

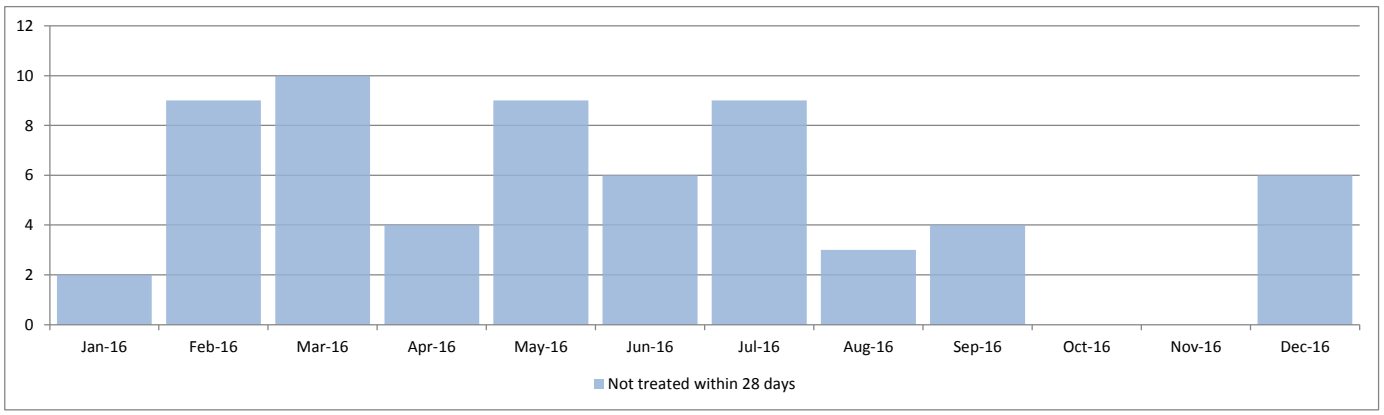
On the day cancellations for elective operations

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Cancellations	40	45	29	47	46	56	30	34	36	42	39	29
Elective spells	3089	3164	3236	3205	3387	3543	3271	3327	3456	3316	3517	2976
% of on the day cancellations	1.3%	1.4%	0.9%	1.5%	1.4%	1.6%	0.9%	1.0%	1.0%	1.3%	1.1%	1.0%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



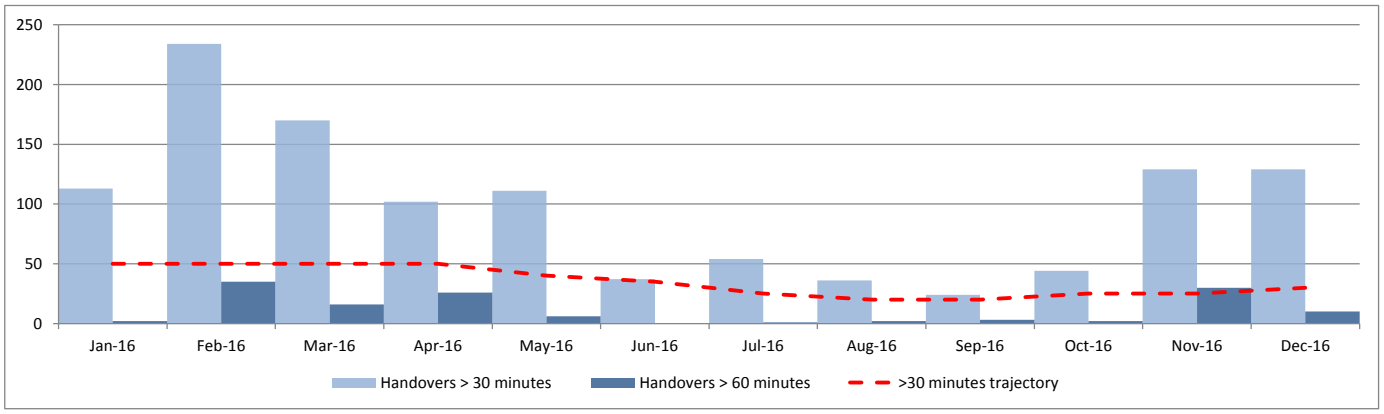
Cancelled patients not treated within 28 days of cancellation

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



Ambulance handovers

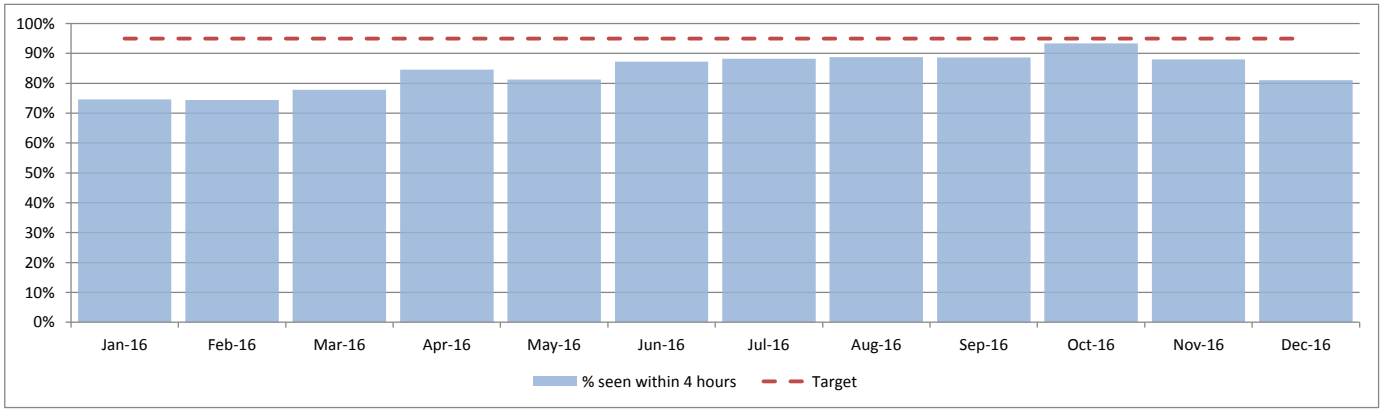
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Handovers > 30 minutes	113	234	170	102	111	37	54	36	24	44	129	129
Handovers > 60 minutes	2	35	16	26	6	0	1	2	3	2	30	10
>30 minutes trajectory	50	50	50	50	40	35	25	20	20	25	25	30



CONTRACTUAL FRAMEWORK

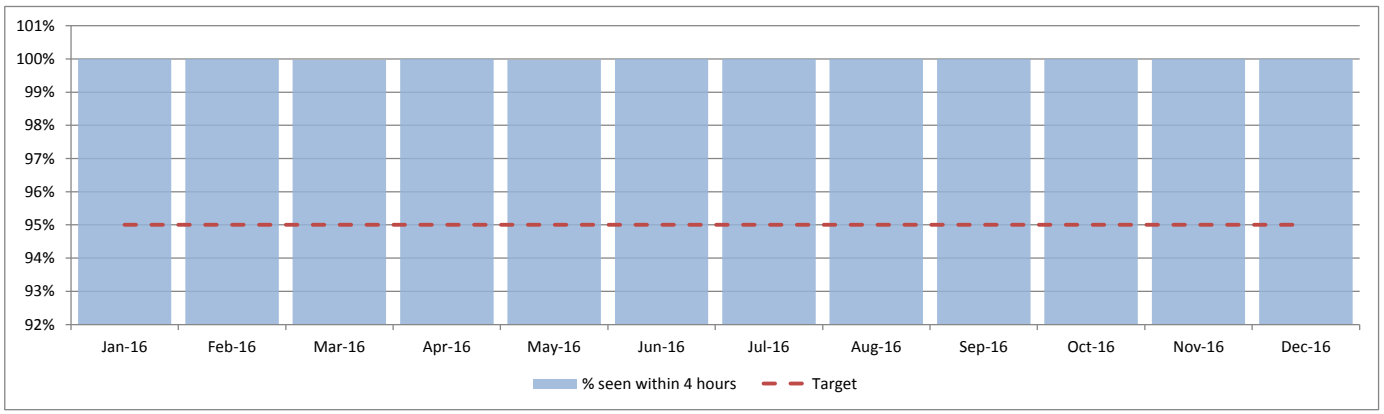
A&E patients seen within 4 hours (DGH only)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients seen	5896	5693	6334	5924	6534	6350	6971	6588	6142	6153	5764	5959
4 hour breaches	1500	1459	1405	918	1228	810	819	744	698	408	695	1128
% seen within 4 hours	75%	74%	78%	85%	81%	87%	88%	89%	89%	93%	88%	81%
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%



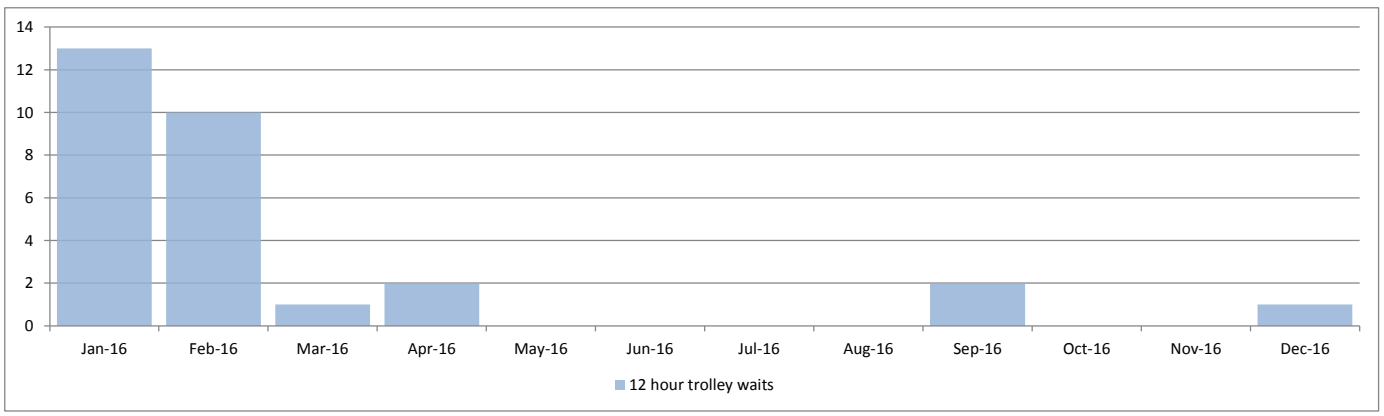
A&E patients seen within 4 hours (community MIU)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients seen	2327	2391	2964	2703	3207	3322	3708	3862	3297	2836	2522	2460
4 hour breaches	0	0	1	0	1	0	0	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

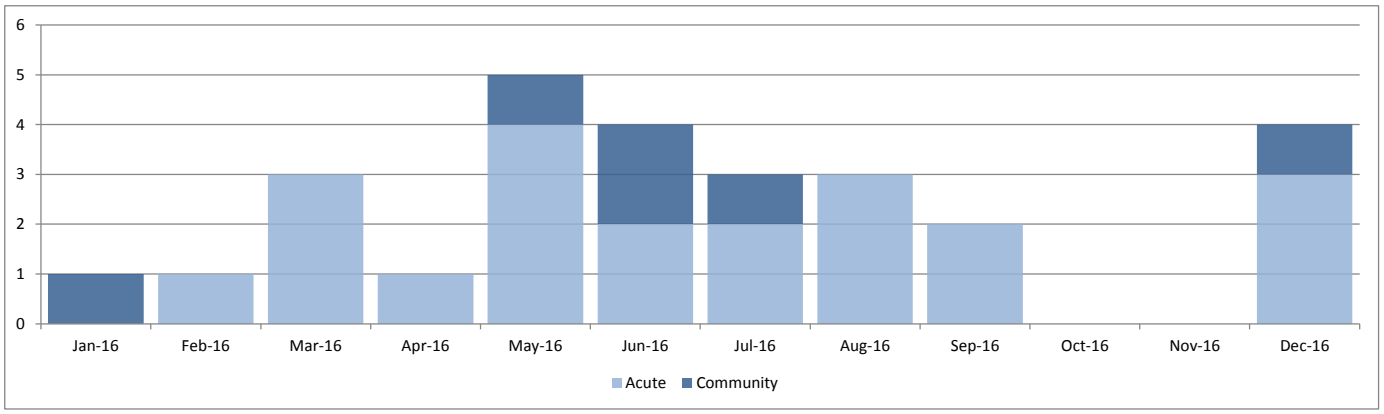
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
12 hour trolley waits	13	10	1	2	0	0	0	0	2	0	0	1



CONTRACTUAL FRAMEWORK

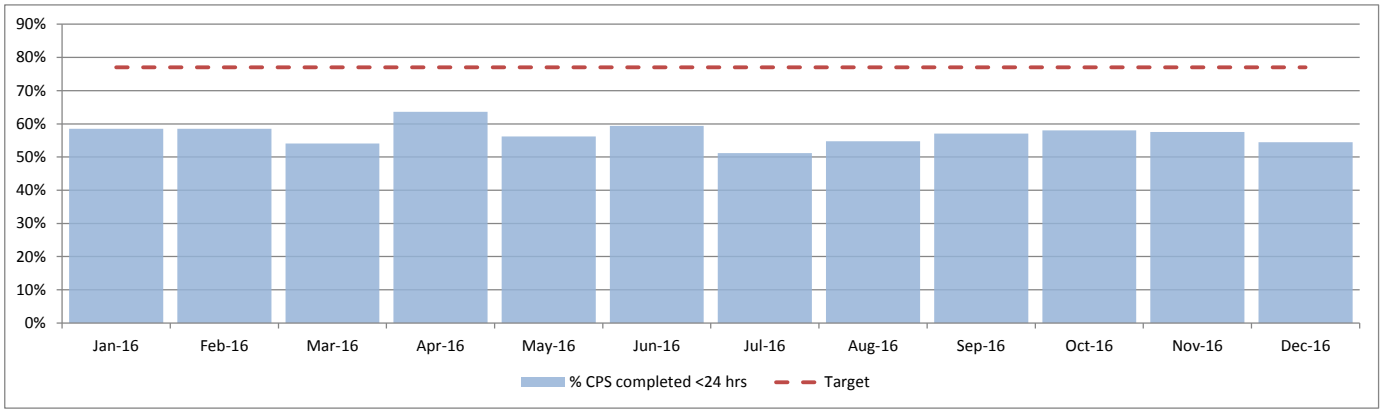
Number of Clostridium Difficile cases

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



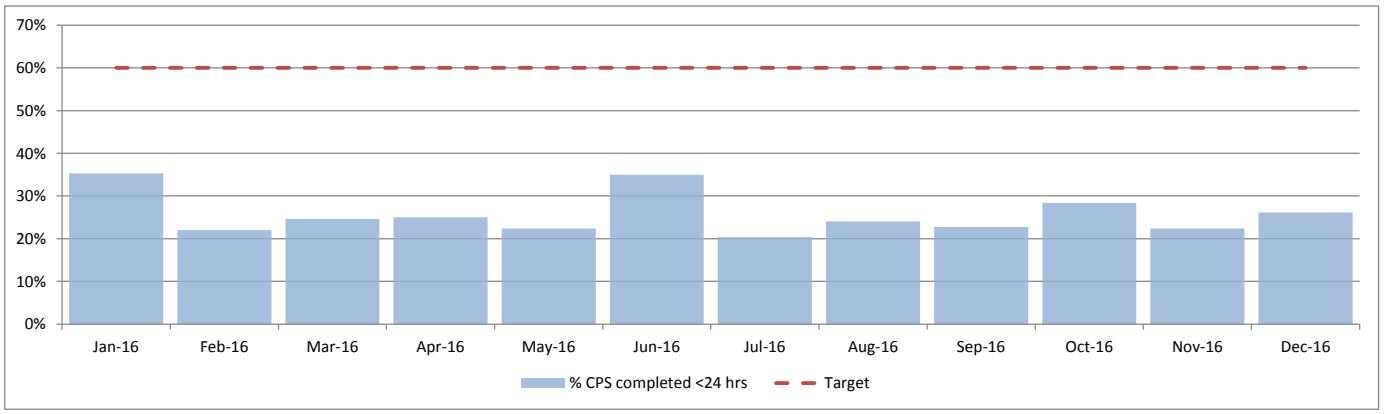
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Discharges	997	1089	1085	1105	1109	1179	1039	1059	1187	1067	1102	1079
CPS completed within 24 hours	1705	1860	2008	1737	1975	1986	2031	1934	2081	1838	1916	1981
% CPS completed <24 hrs	58%	59%	54%	64%	56%	59%	51%	55%	57%	58%	58%	54%
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

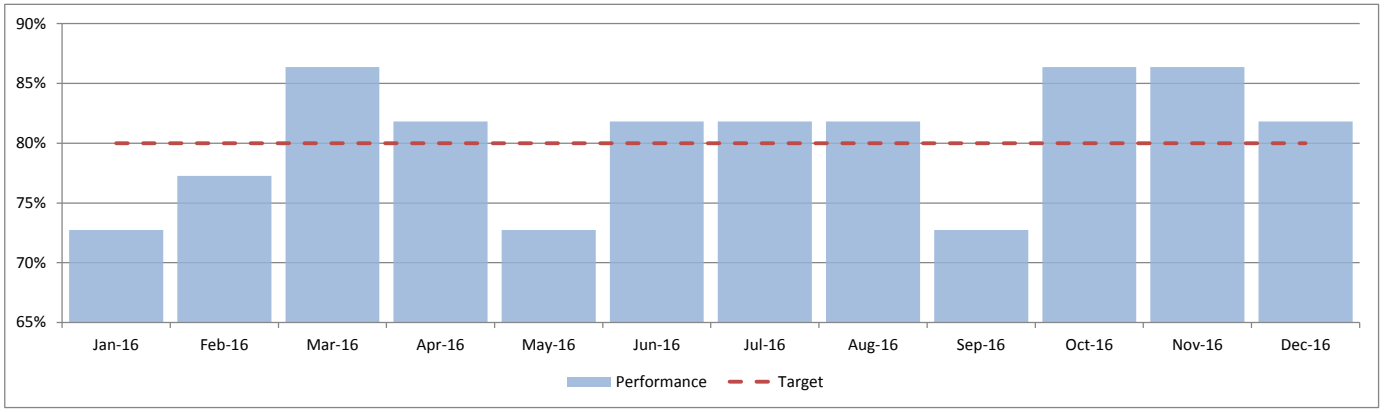
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Discharges	470	414	406	528	532	460	599	441	448	584	500	558
CPS completed within 24 hours	166	91	100	132	119	161	122	106	102	166	112	146
% CPS completed <24 hrs	35%	22%	25%	25%	22%	35%	20%	24%	23%	28%	22%	26%
Target	60.0%	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

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Specialties	22	22	22	22	22	22	22	22	22	22	22	22
Breaching 4 working days	6	5	3	4	6	4	4	4	6	3	3	4
Performance	73%	77%	86%	82%	73%	82%	82%	82%	73%	86%	86%	82%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



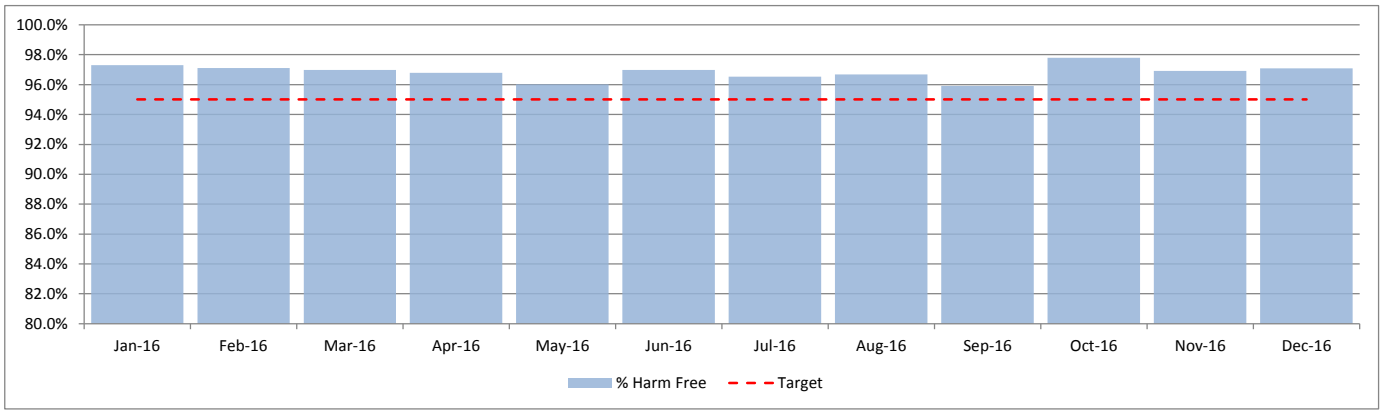
QUALITY FRAMEWORK

Month 9 December 2016

QUALITY FRAMEWORK

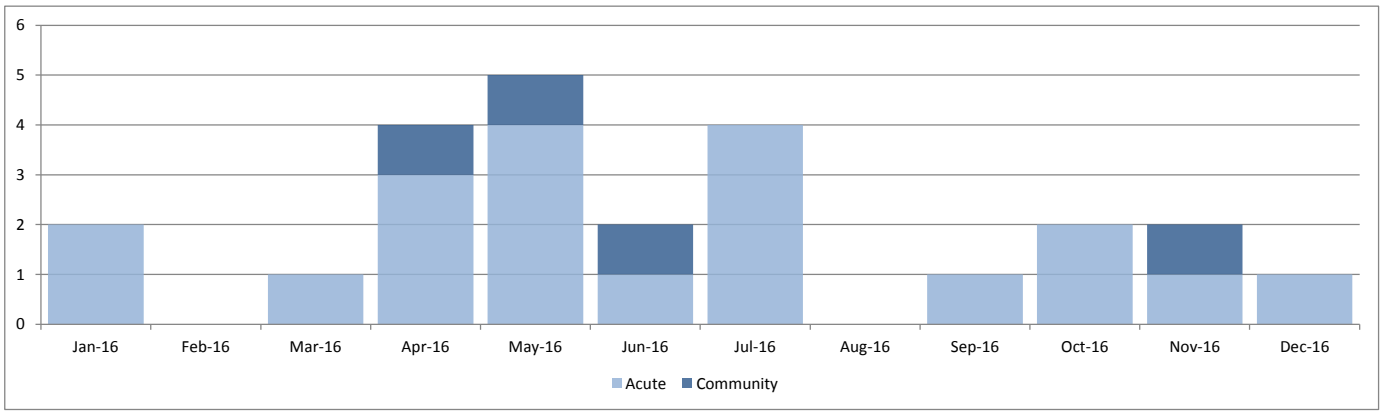
Harm Free - Trust Total

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients		1075	1057	1027	1056	1093	1040	1083	1027	997	1106	1067
Harm Free		1044	1025	994	1014	1060	1004	1047	985	975	1072	1036
% Harm Free	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%	96.9%	97.1%
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%



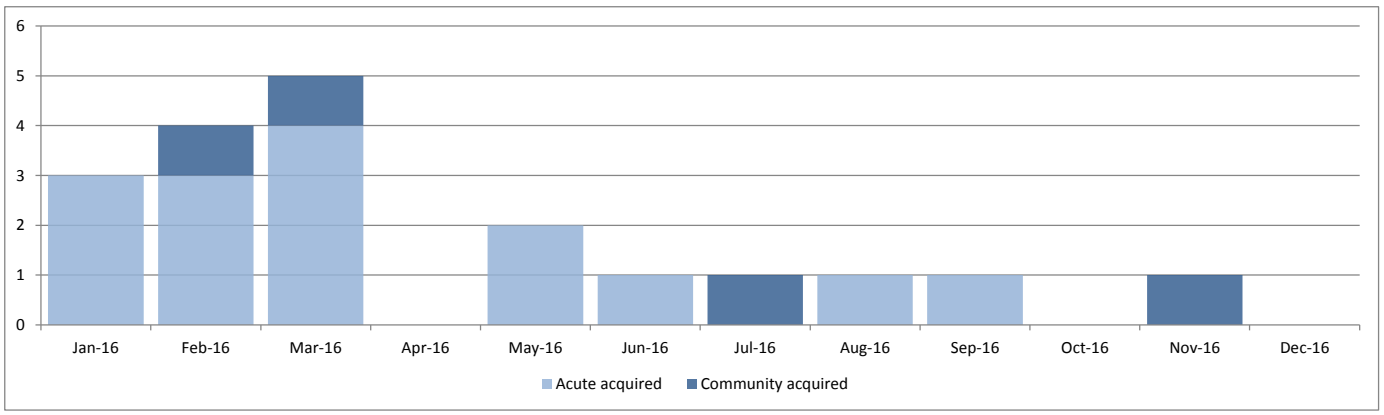
Reported Incidents - Major and Catastrophic

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



New Pressure Ulcers - Categories 3 and 4 (avoidable)

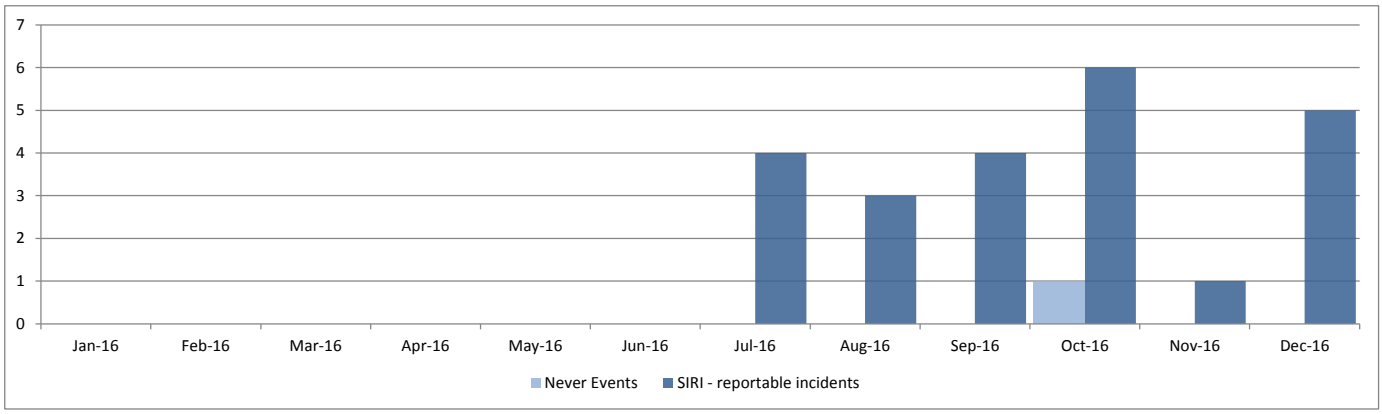
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acute acquired	3	3	4	0	2	1	0	1	1	0	0	
Community acquired	0	1	1	0	0	0	1	0	0	0	1	



QUALITY FRAMEWORK

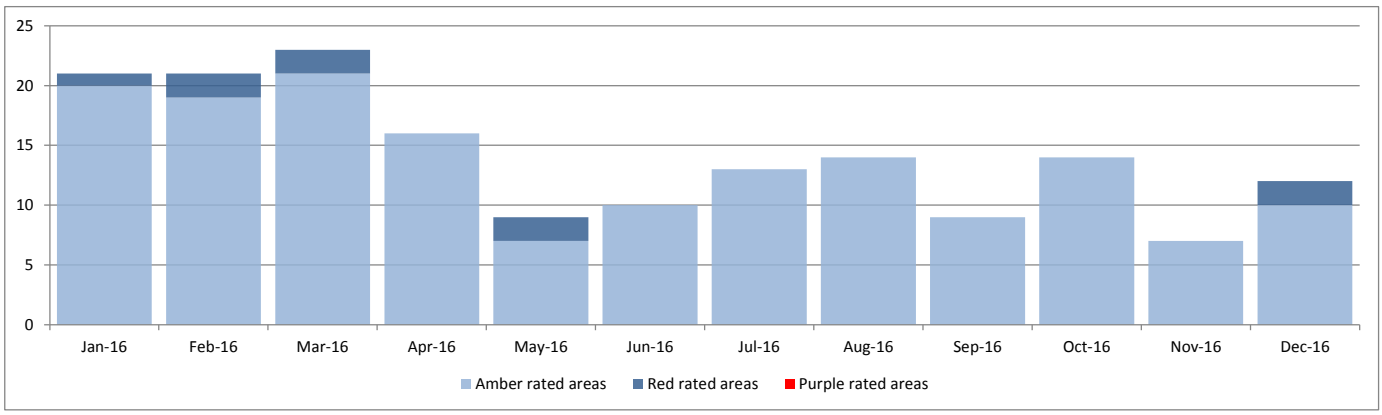
Never events & SIRI

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Never Events	0	0	0	0	0	0	0	0	0	1	0	0
SIRI - reportable incidents							4	3	4	6	1	5



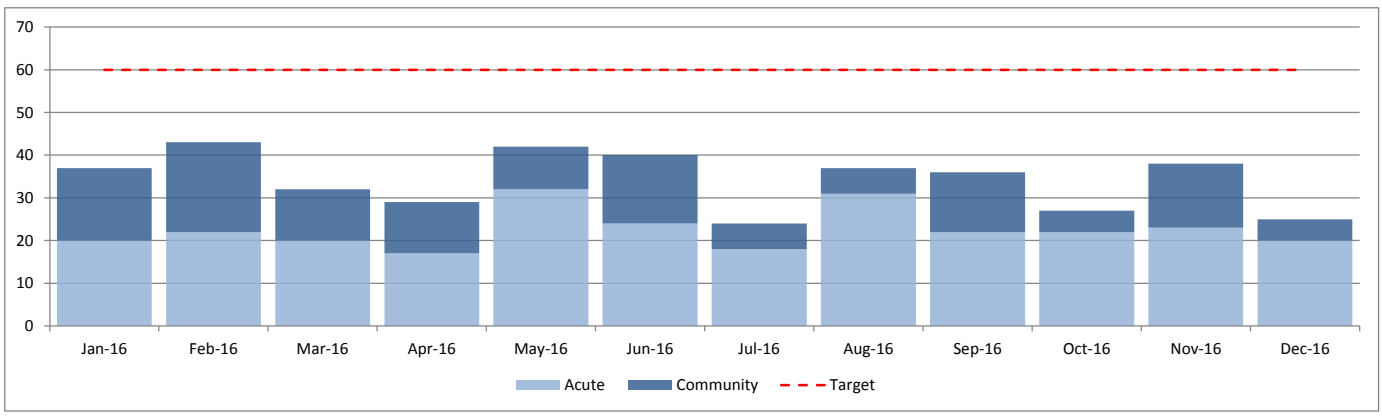
Quality Effectiveness Safety Trigger Tool (QUEST)

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



Formal complaints

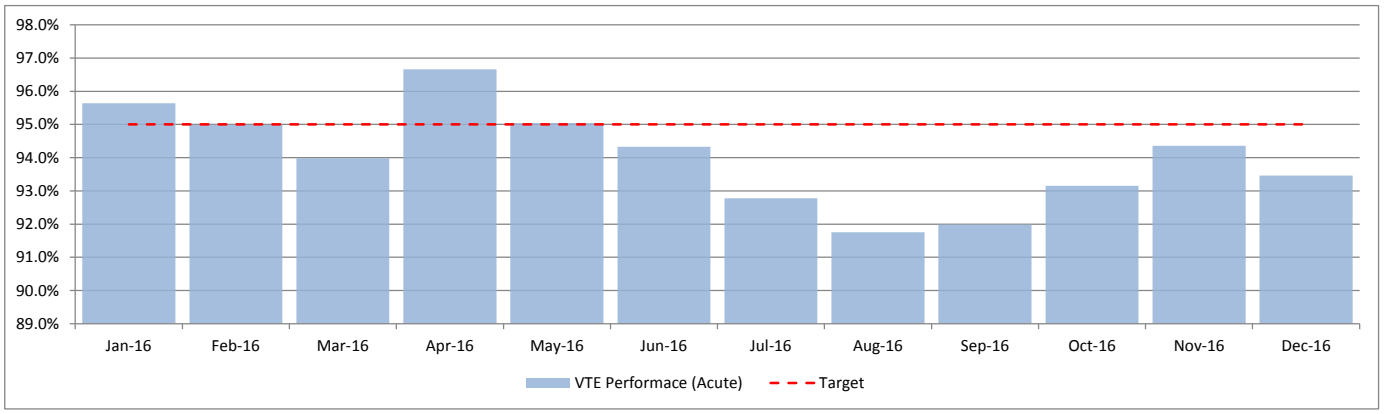
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acute	20	22	20	17	32	24	18	31	22	22	23	20
Community	17	21	12	12	10	16	6	6	14	5	15	5
Total	37	43	32	29	42	40	24	37	36	27	38	25
Target	60	60	60	60	60	60	60	60	60	60	60	60



QUALITY FRAMEWORK

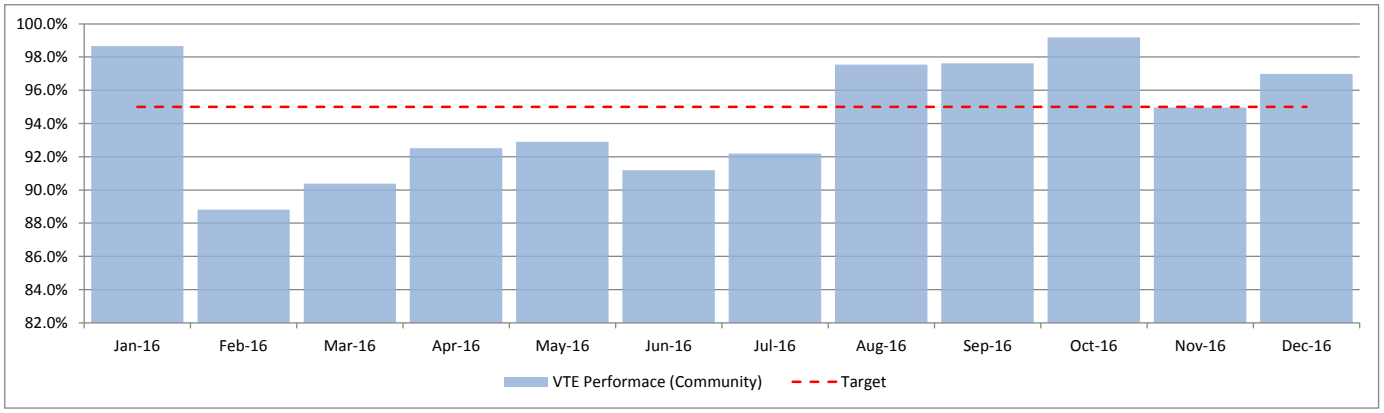
VTE Risk assessment on admission - (Acute)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
VTE Numerator	5653	5424	5573	5591	5883	5885	5757	5651	5737	5798	5955	5530
VTE Denominator	5911	5710	5930	5784	6190	6239	6205	6159	6237	6224	6311	5917
VTE Performace (Acute)	95.6%	95.0%	94.0%	96.7%	95.0%	94.3%	92.8%	91.8%	92.0%	93.2%	94.4%	93.5%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



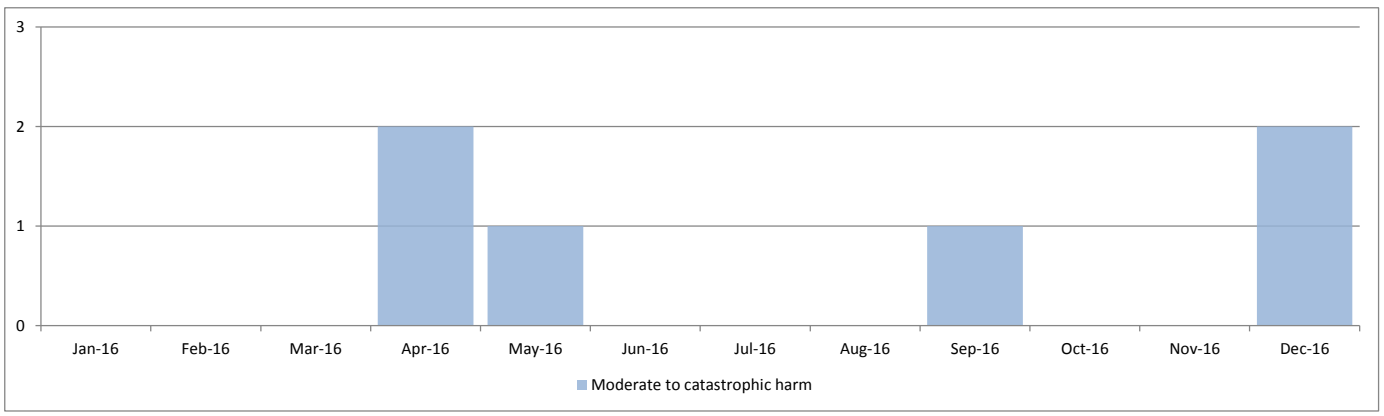
VTE Risk assessment on admission - (Community)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
VTE Numerator	148	135	122	136	131	124	118	119	123	123	113	129
VTE Denominator	150	152	135	147	141	136	128	122	126	124	119	133
VTE Performace (Community)	98.7%	88.8%	90.4%	92.5%	92.9%	91.2%	92.2%	97.5%	97.6%	99.2%	95.0%	97.0%
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

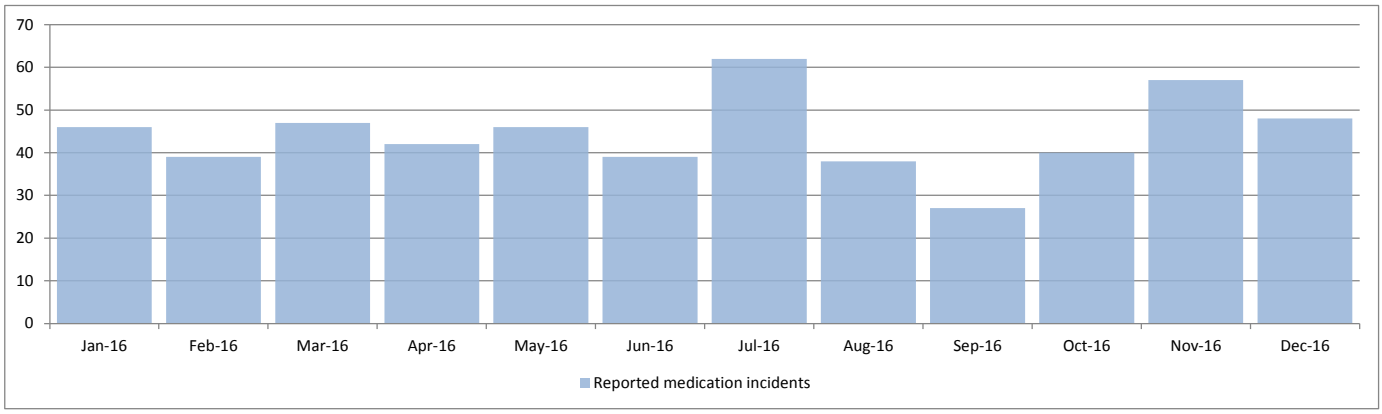
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Moderate to catastrophic harm	0	0	0	2	1	0	0	0	1	0	0	2



QUALITY FRAMEWORK

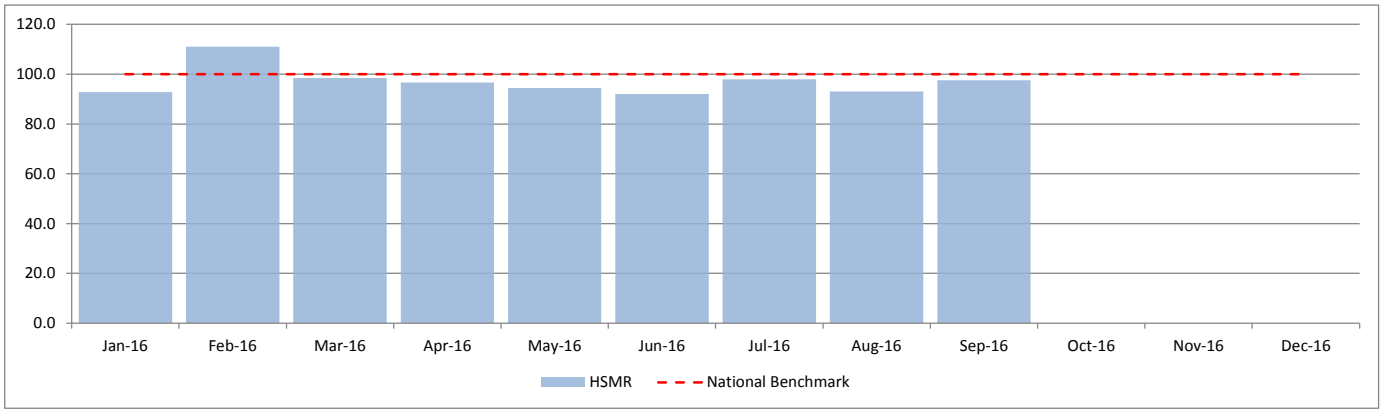
Medication Errors - Reported incidents (trust at fault)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Reported medication incidents	46	39	47	42	46	39	62	38	27	40	57	48



Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
HSMR	92.8	111.0	98.4	96.7	94.5	92.0	98.0	93.0	97.5			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100



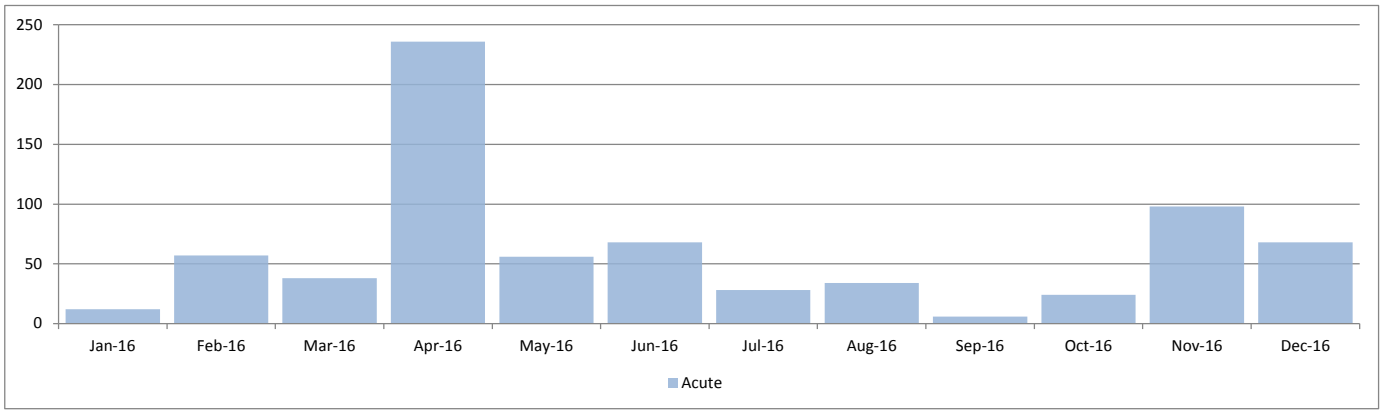
Safer Staffing Levels

	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	100.0%	135.5%	100.0%	154.8%
Bovey Tracey Hospital	0.0%	0.0%	0.0%	0.0%
Brixham Hospital	108.6%	133.9%	100.0%	190.3%
Dartmouth Hospital	106.6%	94.8%	106.5%	98.4%
Dawlish Hosptial	96.8%	100.0%	100.0%	100.0%
Newton Abbot Hospital	110.0%	119.2%	104.8%	123.9%
Paignton Hospital	102.4%	104.5%	88.7%	108.1%
Teignmouth Hospital	0.0%	0.0%	0.0%	0.0%
Toraby Hospital	101.0%	131.4%	99.3%	142.3%
Totnes Hospital	100.0%	95.9%	171.0%	64.5%
ICO	101.7%	124.9%	100.5%	134.9%

QUALITY FRAMEWORK

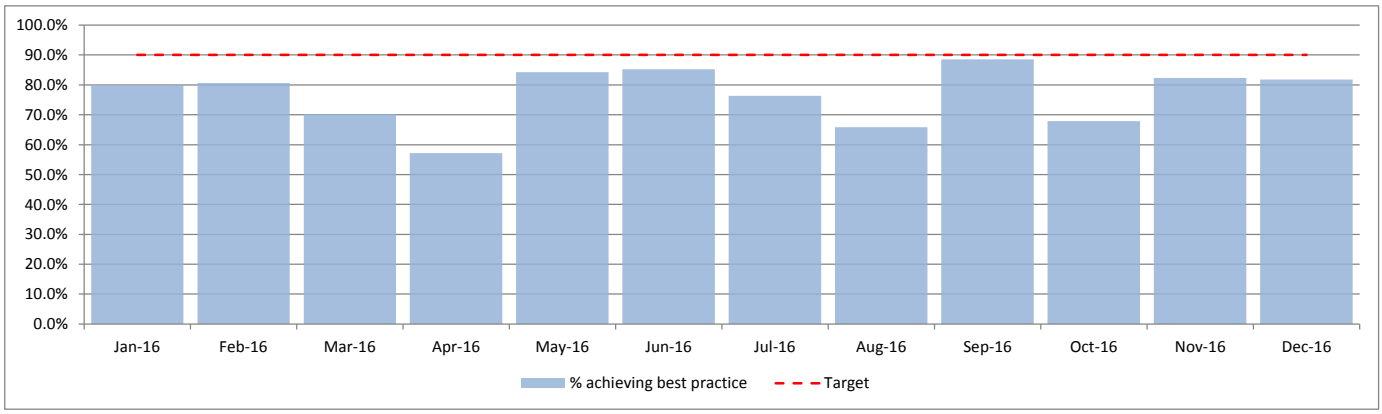
Infection Control - Bed Closures (acute)

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acute	12	57	38	236	56	68	28	34	6	24	98	68



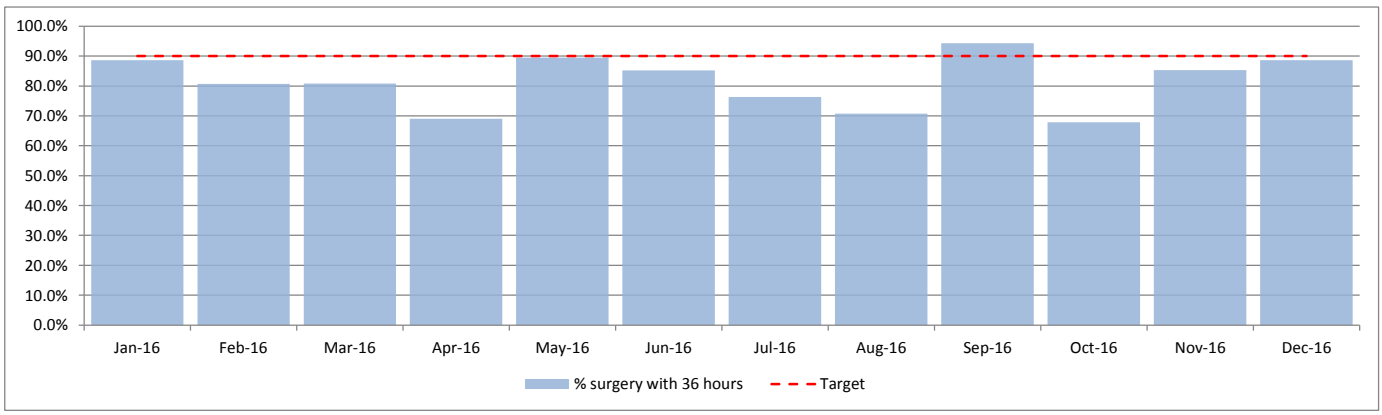
Fracture Neck of Femur - Best tariff assessment

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients	35	31	47	42	38	27	38	41	35	28	34	44
Achieving best practice	28	25	33	24	32	23	29	27	31	19	28	36
% achieving best practice	80.0%	80.6%	70.2%	57.1%	84.2%	85.2%	76.3%	65.9%	88.6%	67.9%	82.4%	81.8%
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

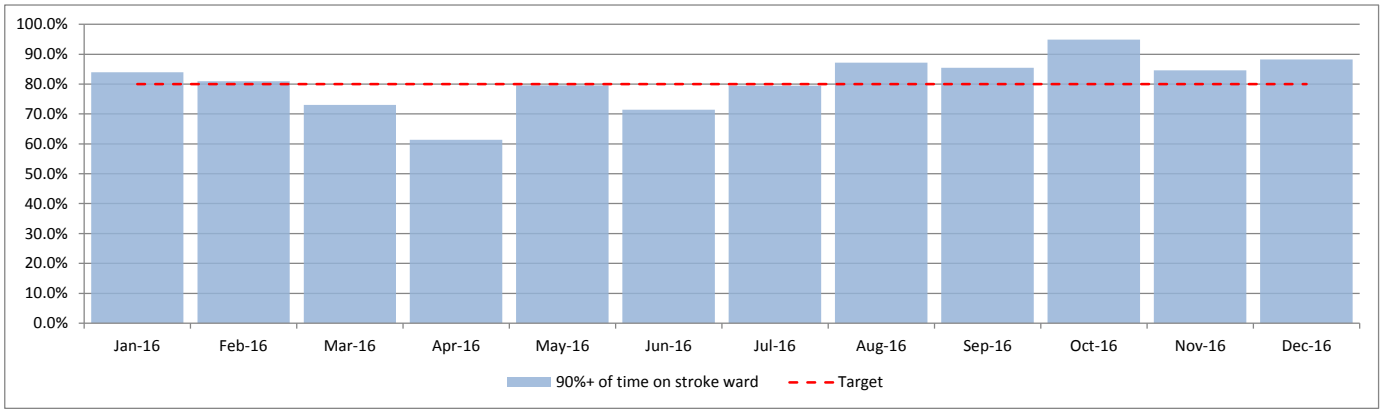
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients	35	31	47	42	38	27	38	41	35	28	34	44
Surgery with 36 hours	31	25	38	29	34	23	29	29	33	19	29	39
% surgery with 36 hours	88.6%	80.6%	80.9%	69.0%	89.5%	85.2%	76.3%	70.7%	94.3%	67.9%	85.3%	88.6%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



QUALITY FRAMEWORK

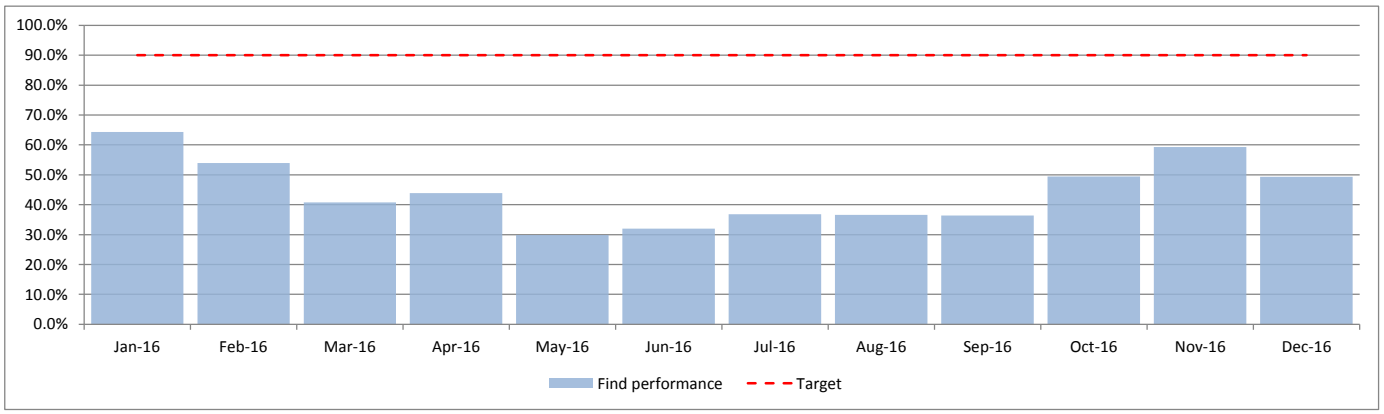
Stroke

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
90%+ of time on stroke ward	84.0%	81.0%	73.0%	61.4%	79.6%	71.4%	79.5%	87.2%	85.5%	94.9%	84.6%	88.2%
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%



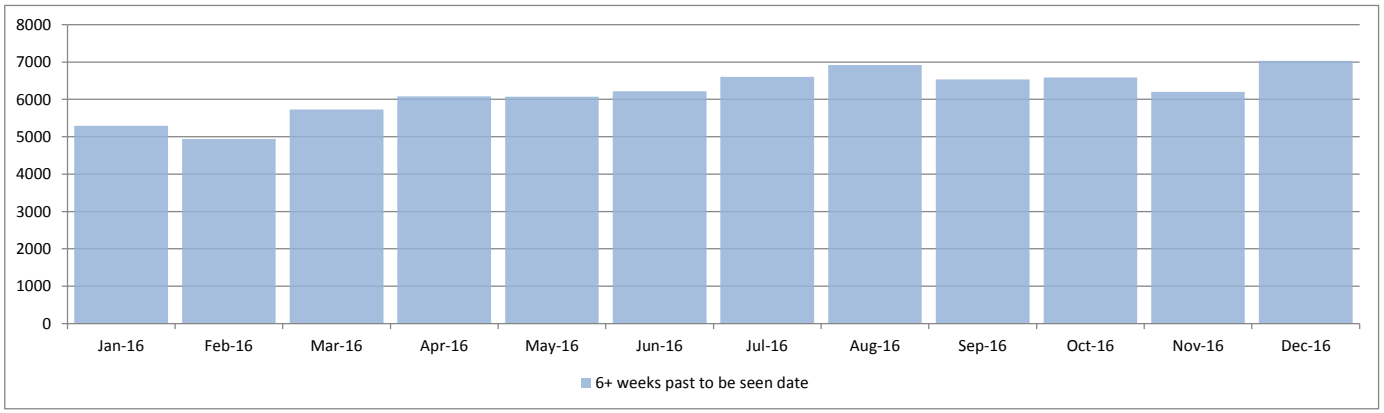
Dementia - Find

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Numerator	402	360	350	366	303	250	227	311	307	326	353	226
Denominator	558	545	584	607	662	548	503	619	613	562	533	458
Find performance	64.3%	54.0%	40.7%	43.9%	29.8%	31.9%	36.8%	36.6%	36.4%	49.4%	59.2%	49.3%
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

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
6+ weeks past to be seen date	5291	4938	5732	6082	6073	6219	6601	6919	6533	6582	6201	7034



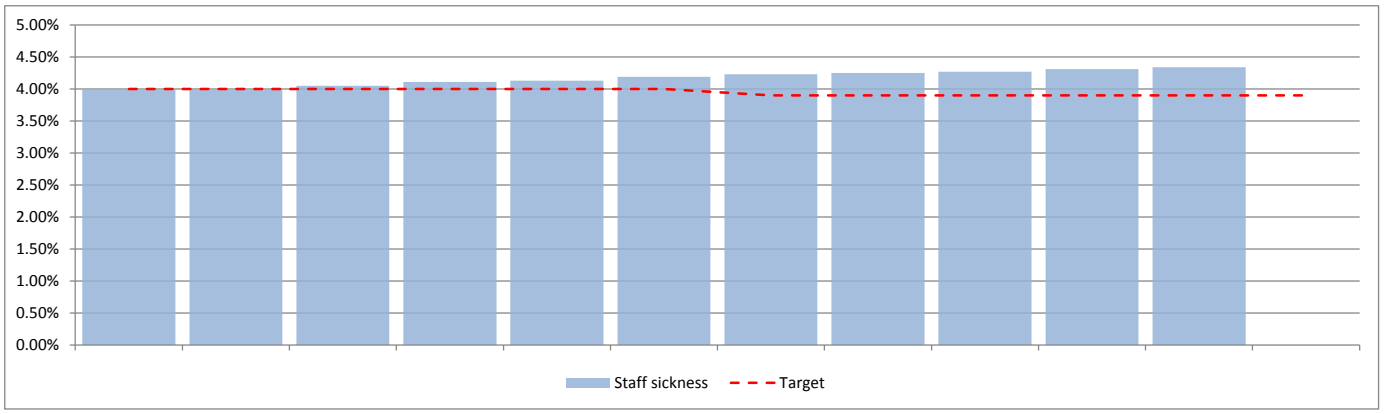
WORKFORCE MANAGEMENT FRAMEWORK

Month 9 December 2016

WORKFORCE MANAGEMENT FRAMEWORK

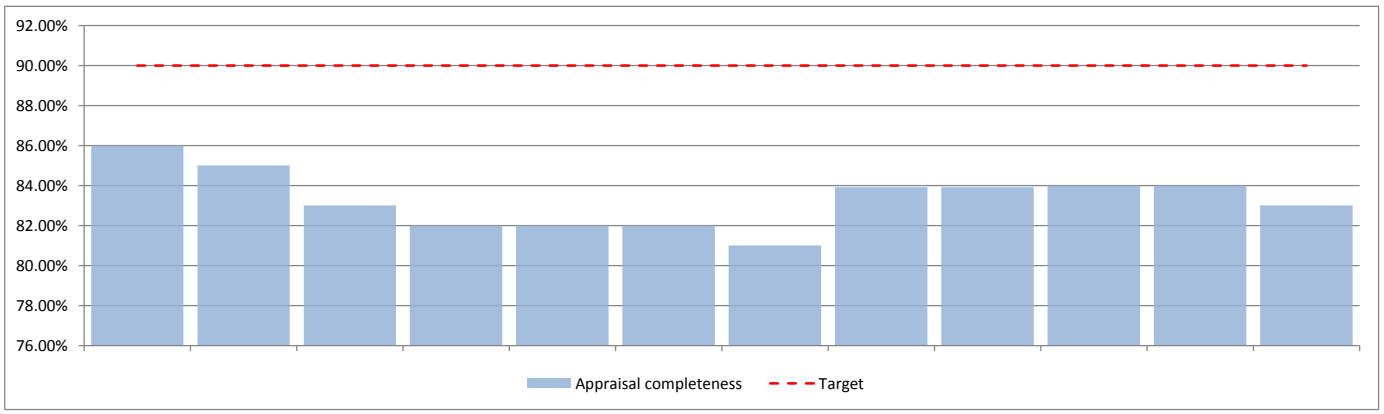
Staff sickness

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Staff sickness	4.00%	4.00%	4.05%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	4.31%	4.34%	n/a
Target	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%



Appraisal Completeness

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Appraisal completeness	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%	81.00%	83.91%	83.91%	84.00%	84.00%	83.00%
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%



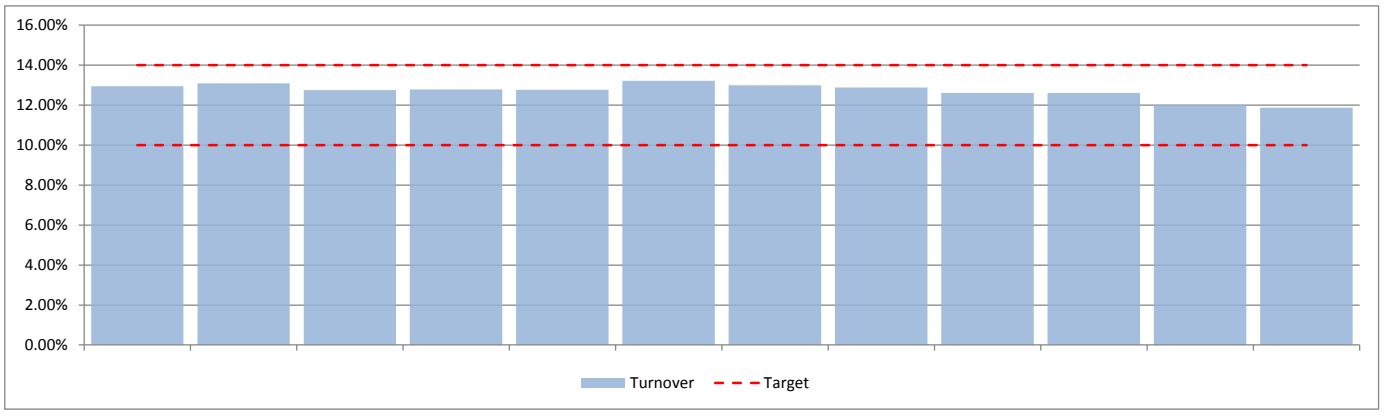
WORKFORCE MANAGEMENT FRAMEWORK

Mandatory Training Completeness

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Mandatory training	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%	87.00%	87.25%	87.25%	86.00%	88.00%	87.38%
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

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Turnover	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.87%	12.61%	12.61%	12.00%	11.87%
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%



Division/Directorate	Sickness	Appraisals	Training (Average)	Staff	FTE	FTE Turnover
	Nov-16	Dec-16	Dec-16	Dec-16	Dec-16	Dec-16
CHARITABLE FUNDS DIVISION	2.41%	68%	78%	32	19.39	17.34%
Health Visiting & School Nursing	6.32%	95%	90%	101	79.09	14.39%
Other Public Health Provider	2.82%	95%	95%	98	80.79	13.69%
Dir - Public Health	4.57%	95%	92%	199	159.88	14.05%
SD Community Services - Coastal	2.14%	75%	91%	41	36.58	5.65%
SD Community Services - Moorland	4.17%	100%	96%	20	15.78	14.05%
SD Community Services - Newton Abbot	5.65%	86%	80%	47	38.31	14.14%
SD Community Services - Other	3.66%	82%	91%	86	69.35	16.11%
SD Community Services - Totnes and Dartmouth	2.17%	85%	90%	41	35.23	13.64%
Dir - SD Community Services	3.50%	84%	89%	235	195.26	13.23%
Operations Support	6.82%	57%	76%	35	32.34	13.35%
TCT Community Services - Adult Social Care	0.79%	49%	90%	36	32.31	13.30%
TCT Community Services - Baywide	2.69%	71%	93%	57	49.69	14.71%
TCT Community Services - BEST	1.97%	100%	91%	18	12.57	13.07%
TCT Community Services - Brixham Zone	2.49%	67%	93%	45	33.43	14.22%
TCT Community Services - Older Peoples Mental Health	4.84%	100%	85%	13	8.53	0.00%
TCT Community Services - Other Social Care	0.82%	86%	92%	16	12.21	13.23%
TCT Community Services - Paignton	7.68%	80%	87%	116	98.38	15.42%
TCT Community Services - Torquay Zone	7.76%	88%	86%	159	138.24	11.04%
Dir - Torbay Community Services	5.65%	77%	88%	495	417.69	13.03%
COMMUNITY SERVICES DIVISION	3.50%	83%	89%	929	772.84	13.29%
Dir - Chief Executive	1.15%	100%	98%	7	5.95	16.85%
Dir - Education & Development	3.61%	89%	89%	105	99.33	11.13%
Finance	3.23%	60%	82%	79	73.92	10.24%
Health Informatics Service	3.97%	76%	91%	164	144.63	10.38%
Procurement	8.56%	54%	85%	37	35.53	2.78%
Dir - Finance, HIS & Procurement	4.40%	68%	87%	280	254.08	9.28%
Dir - Medical Director	1.68%	68%	76%	33	25.08	4.31%
Dir - Nursing & Quality	3.84%	90%	90%	107	89.46	13.49%
Operations	8.98%	59%	86%	25	20.73	7.65%
Transport	7.05%	97%	87%	72	64.42	2.48%
Dir - Operations	7.50%	88%	86%	97	85.15	3.70%
Dir - Pharmacy Services	3.45%	75%	88%	100	87.33	9.00%
Dir - Strategy	1.39%	72%	84%	63	58.68	1.88%
Dir - Workforce	2.36%	88%	88%	74	65.75	26.46%
CORPORATE SERVICES DIVISION	3.95%	78%	87%	866	770.81	10.33%
Estates	5.59%	59%	96%	32	31.60	8.21%
Facilities Management	5.49%	75%	97%	26	24.68	3.35%
Dir - Estates & Facilities	5.55%	66%	96%	58	56.28	6.61%
Hotel Services - Catering	3.31%	100%	72%	50	36.09	15.78%
Hotel Services - Domestic	8.43%	91%	81%	350	249.47	11.32%
Hotel Services - Other	3.95%	96%	64%	77	70.92	9.88%
Dir - Hotel Services	7.02%	93%	77%	477	356.48	11.58%
ESTATES & FACILITIES MANAGEMENT DIVISION	6.82%	89%	79%	535	412.76	10.91%
Dir - Hospital Services - Brixham	8.73%	80%	69%	31	25.20	18.47%
Hospital Services - Dawlish Hospital	1.13%	95%	97%	26	22.24	16.34%
Hospital Services - Teignmouth Hospital	4.82%	94%	96%	18	14.83	32.28%
Dir - Hospital Services - Coastal	2.60%	94%	96%	44	37.06	23.82%
Dir - Hospital Services - Dartmouth	1.59%	100%	96%	22	17.37	20.65%
Dir - Hospital Services - MIU Services	3.65%	80%	96%	29	23.67	13.21%
Hospital Services - Ashburton Hospital	1.23%	77%	94%	17	13.00	9.98%
Hospital Services - Bovey Tracey Hospital	12.13%	83%	80%	12	9.57	39.52%
Dir - Hospital Services - Moorland	5.75%	79%	88%	29	22.57	23.75%
Dir - Hospital Services - Newton Abbot	0.84%	84%	89%	89	73.65	16.05%
Dir - Hospital Services - Other	0.00%	100%	96%	3	3.00	0.00%
Dir - Hospital Services - Paignton	7.61%	72%	93%	35	27.47	14.47%
Dir - Hospital Services - Totnes	7.27%	100%	95%	34	28.04	30.93%
TORBAY HOSPITAL SERVICES DIVISION	4.04%	86%	90%	315	248.83	19.21%
Ind Sec Adult Social Care - Torbay	10.58%	60%	93%	10	9.52	0.00%
Ind Sec In House Services LD - Torbay	5.79%	72%	57%	33	26.64	9.94%
545 Dir - Independent Sector Adult Social Care - Torbay	12.23%	69%	65%	43	36.16	7.59%
546 Dir - Independent Sector Health	10.79%	65%	91%	26	23.40	28.34%
INDEPENDENT SECTOR DIVISION	10.67%	68%	75%	69	59.56	16.38%
INTERNAL AUDIT	0.00%	92%	94%	13	12.37	35.93%
Cancer Services - Medicine	1.28%	100%	83%	8	7.80	0.00%
Clinical Oncology	9.45%	71%	90%	58	51.65	13.83%
Haematology	0.00%	100%	78%	4	4.00	0.00%
Medical Oncology	0.00%	100%	89%	6	5.15	20.83%
Non Surgical Cancer Services Admin	5.87%	90%	90%	44	34.23	11.41%
Palliative Care	1.43%	100%	85%	6	4.90	0.00%
Ricky Grant Unit and Turner Ward	7.64%	71%	77%	82	66.76	16.89%
Dir - Cancer Services - Medicine	6.92%	78%	84%	208	174.49	13.83%
Care of the Elderly - Medicine	8.14%	90%	85%	105	92.94	10.98%
Stroke	9.09%	97%	90%	38	33.91	14.37%
Dir - Care of the Elderly - Medicine	8.40%	92%	86%	143	126.86	11.98%
Dermatology	2.75%	88%	90%	13	10.52	2.74%
Neurology	0.00%	0%	96%	3	3.00	57.14%
Rheumatology	2.19%	50%	81%	15	11.02	0.00%
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	2.18%	65%	86%	31	24.54	8.81%
Dir - Emergency Services	2.91%	90%	93%	267	224.91	10.39%
Diabetes and Endocrinology	4.68%	100%	84%	21	17.62	0.00%
Gastroenterology	4.60%	65%	83%	81	71.59	4.15%
Dir - Gastoenterology/Endocrinology- Medicine	4.62%	68%	83%	102	89.21	3.46%
Admin/Support- Med Div	10.39%	68%	89%	46	39.22	22.69%
General Medicine	6.55%	81%	87%	65	57.55	12.04%
Medical Division HQ	15.68%	100%	78%	4	3.80	53.57%
Dir - General Medicine	8.49%	76%	87%	115	100.57	20.07%
Cardiology	4.94%	95%	91%	128	107.77	4.83%
Respiratory	7.23%	93%	88%	64	55.05	23.96%
Dir - Heart & Lung- Medicine	5.73%	94%	90%	192	162.82	11.26%
MEDICAL SERVICES DIVISION	5.70%	84%	88%	1058	903.40	11.72%
PMU Finance	0.00%	100%	96%	5	4.64	12.15%
PMU Manufacturing	5.38%	61%	87%	59	57.57	5.99%
PMU Quality Control	2.63%	95%	94%	52	49.36	0.00%
PMU Sales & Marketing	6.95%	100%	75%	8	7.39	0.00%
PMU Senior Team	13.96%	100%	81%	4	3.70	38.29%
PMU Supply Chain	0.65%	65%	98%	20	16.68	3.91%
PHARMACY DIVISION (Manufacturing)	3.96%	89%	91%	148	136.88	4.83%
RESEARCH & DEVELOPMENT DIVISION	7.63%	61%	89%	73	33.00	15.03%
Dir - Breast Care	3.64%	94%	89%	42	33.58	12.11%
Dir - General Surgery	5.19%	79%	80%	256	216.49	13.86%
Dir - Head & Neck	2.10%	89%	87%	102	79.25	6.59%
Dir - Ophthalmology	3.77%	97%	90%	122	106.33	11.94%
Dir - Surgical Division	4.24%	80%	91%	97	83.28	11.58%
Dir - Theatres, Anaesthetics and ICU	5.40%	88%	85%	413	367.13	10.24%
Dir - Trauma and Orthopaedics	3.17%	75%	88%	161	138.45	14.20%
SURGICAL SERVICES DIVISION	4.47%	85%	86%	1193	1024.51	11.65%
Child Health Med, Mgmt and Misc Specialty	2.39%	85%	82%	62	54.51	6.27%
Paediatric	4.38%	82%	88%	100	79.85	5.94%
Dir - Child Health	3.56%	83%	86%	162	134.36	6.06%
Dir - Lab Medicine	4.27%	82%	86%	115	101.68	8.51%
Gynaecology	8.98%	86%	94%	36	27.60	7.18%
Midwifery	5.58%	83%	91%	129	102.05	5.52%
O&G Medical and Management	4.62%	100%	81%	50	45.83	12.72%
Dir - Obs & Gynae	5.90%	86%	89%	215	175.48	7.20%
Dir - Radiology & Imaging	1.90%	66%	88%	128	108.94	14.01%
Dir - Sexual Health	1.54%	76%	94%	41	32.38	11.25%
Dir - Therapies	2.20%	79%	90%	302	247.18	13.80%
Medical Electronics	6.11%	100%	99%	18	17.64	4.12%
Women's, Children's & Diagnostics	2.48%	77%	88%	15	13.25	14.76%
Dir - Women's, Children's and Diagnostics	4.49%	89%	94%	33	30.89	8.84%
WOMEN'S, CHILDREN'S & DIAG DIVISION	3.49%	80%	89%	996	860.91	10.40%
ICO Grand Total	**4.74%**	**83%**	**87%**	**6198**	**5236.90**	**11.87%**

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st February 2017
Title:	**Financial Recovery Plan**
Lead Director:	Director of Finance/Deputy Chief Executive
Corporate Objective:	Objective 4: **Well led**
Corporate Risk/ Theme	All
Purpose:	Assurance

Summary of Key Issues for Trust Board / Quality Performance Finance committee

Strategic Context:

The Trust initially submitted an Annual Plan to Monitor for financial year 2016/17 an overall surplus of £1.7m, based on a Payment By Results (PbR) contract arrangement.

Encouraged by both Regulators - NHS England and NHS Improvement - negotiations concluded in the reinstatement of the Risk Share Agreement (RSA), resulting in the Trust picking up an £11.6m share of system risk in 2016/17. In that revised plan, this reduction in income is compounded by an initial 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 initial RSA forecast for the year was an overall deficit of £8.6m.

At its meetings in November and December, the Board and Finance Committee have discussed pressures in financial performance, concluding that the forecast deficit of £8.6m is unlikely to be achieved. Resulting in a net movement of £3m. Reflecting this position, and in line with the forecast taken to Finance Committee and Board last month, a revised year end forecast position has been submitted to NHSI.

Key Issues/Risks

In response to the revised forecast, the Board communicated the 'Call to Action' across the organisation. It's purpose is to secure commitment and delivery of the £4m of recovery actions targeted in the forecast and, if possible to improve upon that position.

The communication has gone to all staff via the All Managers Meeting and has been followed up through Clinical Management Group and Divisional Boards. The responses have been reported via the Performance Review Process.

Progress is set out in the attached report, at the time of writing, the planned actions are assessed as having a potential impact of £3,815k. Whilst not yet delivering the targeted level, a total of £3,560k has been secured to date.

A further update will be provided as the Board meeting.

Recommendation:

To **note** the contents of the report and appendices and **seek further assurances** and **action** as required to improve forecast outturn position.

Summary of ED Challenge/Discussion:

The Executive Team tested confidence in delivery of the schemes as described.

There are a number of actions in train that will further improve this position:

- Capitalisation of TP development costs currently charged to revenue – potential value £200k. Confidence levels are now reasonably high.
- Benefit of releasing ward based staff training to 'rosterable' time – 1,300 hours of likely agency cost identified to date.
- Review of clinical vacancies, currently assumed to be filled in the forecast.

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

N/A

Equality and Diversity Implications:

N/A

PUBLIC

Financial Recovery Plan 2016/17

Context of the Initial Plan

The Trust initially 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 were 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), resulting in the Trust picking up an £11.6m share of system risk in 2016/17. In that revised plan, this reduction in income is compounded by an initial 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 initial RSA forecast for the year was 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 in routine financial reporting, the Trust has reported the movement between these two plans as the element of the financial variance associated with "Changes to PbR and RSA plan" in its Board papers.

The Trust has briefed NHS Improvement (NHSI) regularly on the expected impact on the Trust's plan, submitting an initial forecast at month 1 that reflects a deficit based on RSA levels of income since April 2016, and has been attempting to negotiate permission to submit a revised plan on the basis of final contract settlement. Had that revision been successful, this would have avoided 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.

Updated Context

At its meetings in November and December, the Board and Finance Committee have discussed pressures in financial performance, concluding that the forecast deficit of £8.6m is unlikely to be achieved. The movement in the forecast financial result is set out in the table below:

	£'m
CIP shortfall	3.8
Slippage shortfall	3.0
Cost pressures	3.1
Targeted recovery actions – 'Call to action'	(4.0)
Gross pressure	5.9
RSA contribution	2.9
Net movement in forecast	3.0

Financial Recovery Plan 2016/17

Reflecting this position, and in line with the forecast taken to Finance Committee and Board last month, a revised year end forecast position has been submitted to NHSI.

The forecast in line with that previously reported to the Board, with one minor amendment to reflect a movement in the donated asset income and related donated depreciation which are items not considered part of the financial performance by the Regulator. The monthly forecast and amendments are set out in the following table.

Forecast year end position (as at M7)	YTD Actual Month 06	Month 07 Forecast	Month 08 Forecast	Month 09 Forecast	Month 10 Forecast	Month 11 Forecast	Month 12 Forecast	2016/17 Total
Forecast 16/17	**(3.70)**	**(1.29)**	**(1.70)**	**(1.44)**	**0.14**	**(0.67)**	**(2.94)**	**(11.60)**
NHSI adjusted position								
Impairment	0.00	0.00	0.00	0.00	0.00	0.00	2.50	2.50
Gain/loss on disposal	(0.27)	0.00	0.00	0.00	0.00	0.00	0.00	(0.27)
Donated asset income	(0.14)	0.00	0.00	0.00	(1.46)	(0.50)	(0.20)	(2.32)
Donated depreciation	0.33	0.05	0.05	0.05	0.05	0.06	0.06	0.65
NHSI adjsuted deficit forecast	**(3.78)**	**(1.24)**	**(1.65)**	**(1.39)**	**(1.27)**	**(1.11)**	**(0.58)**	**(11.04)**

Summary Financial position	YTD Actual Month 06	Month 07 Act	Month 08 Act	Month 09 Act	Month 10 Forecast	Month 11 Forecast	Month 12 Forecast	2016/17 Total
Actual YTD to M9, forecast M10-M12	(3.70)	(1.20)	(1.81)	(1.62)	(0.36)	(0.57)	(2.86)	**(12.12)**
NHSI adjusted position								
Impairment	0.00	0.00	0.00	0.00	0.00	0.00	2.50	2.50
Gain/loss on disposal	(0.27)	0.00	0.00	0.00	0.00	0.00	0.00	(0.27)
Donated asset income	(0.14)	0.00	0.00	0.00	(0.96)	(0.50)	(0.20)	(1.80)
Donated depreciation	0.33	0.05	0.05	0.05	0.05	0.06	0.06	0.65
NHSI adjsuted deficit	**(3.78)**	**(1.15)**	**(1.76)**	**(1.57)**	**(1.27)**	**(1.01)**	**(0.50)**	**(11.04)**
Variance forecast position at M7 to SummaryNHSI adj position position	**0.00**	**0.09**	**(0.11)**	**(0.18)**	**0.00**	**0.10**	**0.08**	**(0.00)**

RSA Plan deficit movement	(8.59)
Adjustment to RSA plan	(3.00)
Revised Forecast Position	(11.59)
Adjustment to items outside Trust performance measures:-	
Donated asset income reduction	(0.80)
Profit on sale of asset	0.27
Revised Forecast	(12.12)

Performance to 31st December 2016

Performance to 31st December 2016 is in line with this forecast.

Call to Action

In response to the revised forecast, the Board communicated the 'Call to Action' across the organisation. It's purpose is to secure commitment and delivery of the £4m of recovery actions targeted in the forecast and, if possible to improve upon that position.

The communication has gone to all staff via the All Managers Meeting and has been followed up through Clinical Management Group and Divisional Boards. The responses have been reported via the Performance Review Process.

The table below sets out progress achieved against the targeted actions during December.

Financial Recovery Plan 2016/17

Action	Status
Staff related costs vacancy freeze for non-front line staff	Implemented – savings above normal turnover will improve forecast.
Over time and bank freeze for back office staff costs – (except where this is required to deliver savings or capital programme).	Implemented .
Reallocation of back office posts to support front line.	Horizon centre staff identified time and volunteered for front line duties Savings in agency was the priority for clinical staff.
Discretionary Spend controls	DGM level controls in place and communicated to all managers
Maintaining agency ban for back office services	In place.
Executive review of clinical vacancies.	Commenced January
Outcome of Consultation on Community Hospitals may have potential to deliver savings in year depending on decision.	Pending decision plans being prepared to action if decision supports plans
Review of equipment asset lives as required under accounting standards	Underway – initial discussions with auditors held, line by line review underway.
The Trust is exploring a MARS scheme.	Process commenced. Discussions with NHSI have been undertaken and recovery actions will need to cover the MARS cost in year.

During December, the Finance Team have been supporting operational managers to quantify the impact of these actions.

At the time of writing, the planned actions are assessed as having a potential impact of £3,815k. Whilst not yet delivering the targeted level, a total of £3,560k has been secured to date. A detailed analysis of both potential and current achievement is set out in the table below.

Financial Recovery Plan 2016/17

Recovery Plan		TRUST	TRUST
		Recovery plan target	Recovery Actuals/Estimates
Income and Expenditure	PAY	**230,567,926**	**230,567,926**
	NONPAY	**152,172,141**	**152,172,140**
	DRUGS	**31,804,273**	**31,804,273**
	INCOME	**(391,904,986)**	**(392,013,485)**
	IMPAIRMENT	**2,498,019**	**2,498,019**
	Grand Total	**25,137,373**	**25,028,873**
Forecast movement	*Month 8-9 forecast changes*	***0***	***94,806***
Recovery Plans:			
	Workforce Plans:		
	Vacancy Freeze Non-Clinical above mnth 8 FOT	**(459,000)**	**(163,853)**
	FTC ended (need notice periods)	**(285,000)**	**(29,533)**
	Staff redirection from non Critical areas, eg Education Dept, Agency reduction inc. 2+2.	**(325,000)**	**(114,000)**
	Non Clinical Overtime stopped	**(98,000)**	**(208,435)**
	Pension opt outs	**(33,000)**	**0**
	Buy Back Annual leave take up	**(20,000)**	**(10,729)**
	Care Model Under spend	**(728,500)**	**(1,078,000)**
	Clinical staff savings		**(261,717)**
	Healthcare Support workers premium payments	**(20,000)**	**0**
	Non-Pay:		
	Dom Care (Placed People CHC South Devon)	**0**	**(47,000)**
	ASC Residential Short Stay - volume reduction (net expend)	**0**	**(40,000)**
	Direct Payments Reclaim	**0**	**(25,000)**
	Residential Short Stay - Client Contributions	**0**	**(30,000)**
	Bad Debt Provision / Write Offs review	**0**	**(30,000)**
	Escalation Beds/site closures (staffing)	**(500,000)**	**(60,000)**
	Asset review of life - depreciation policy	**(1,000,000)**	**(1,000,000)**
	Capitalisation costs of PMU TP development	**(200,000)**	**0**
	External advertising fees stopped (only if forecast)	**(26,000)**	**0**
	Discretionary spend - conferences/travel		**(351,864)**
	Income:		
	DBS Payments New Recruits (HR directorate Income)	**(21,000)**	**(12,000)**
	Other Incomes	**0**	**(24,000)**
	Stock Take - community hospitals	**0**	**(40,000)**
TWIPS Brought Forward:			
	Estates and Facilities costs savings	**(100,000)**	**(34,000)**
Recovery Totals		**(3,815,500)**	**(3,560,131)**
	`Recovery Plan Gap		**(238,549)**
Total savings		**(3,815,500)**	**(3,703,874)**
Total excluding RSA income		**21,321,873**	**21,325,000**
	RSA (risk Share Agreement) Income Post £4m recovery Plan	**(9,200,000)**	**(9,200,000)**
Total including RSA income		**12,121,873**	**12,125,000**
NHSI adjusted position	Less:-		
	Impairment	**(2,500,000)**	**(2,500,000)**
	Gain/loss on disposal	**265,000**	**265,000**
	Donated asset income/depreciation	**1,159,000**	**1,159,000**
NHSI adjusted deficit		**11,045,873**	**11,049,000**

There are a number of actions in train that will further improve this position:

- Capitalisation of TP development costs currently charged to revenue – potential value £200k. Confidence levels are now reasonably high.
- Benefit of releasing ward based staff training to 'rosterable' time – 1,300 hours of likely agency cost identified to date.
- Review of clinical vacancies, currently assumed to be filled in the forecast.

Successful delivery of these remaining actions look set to secure the balance of the £4m currently targeted, and could potentially secure a sum in excess of that amount.

Where appropriate, schemes in the above table with recurring impact will be classified as CIP and reported as such in future reports.

Conclusion

This paper confirms that plans intended to deliver the £4m targeted response from the Call to Action have been identified and that actions to deliver them are in train.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st February 2017
Title:	Reference Costs 2015/16
Lead Director:	Director of Finance
Corporate Objective:	1. Safe, quality care and best experience
Corporate Risk/ Theme	5. Failure to achieve financial plan
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

Reference Costs are a national submission to the Department of Health completed annually that the Board and Finance Committee need to be made aware of

Key Issues/Risks

The Trust's overall Reference Cost Index (RCI) has risen from 98 for 2014.15 to 100 for 2015.16 (100 being the national average)

Recommendations:

For the Board to review Appendix 1 paying particular attention to services shown to have an RCI over 100 as a consideration in the implementation of the Trust TWIP Programme

Summary of ED Challenge/Discussion:

The Executive Team considered the deterioration in the reference cost position from 98 to 100, noting that performance had been at or around 100 for 4 consecutive years. A movement in the Market Forces Factor is noted as driving approximately half of the increase.

The breakdown by service shows that acute services are, in total performing comparatively well and it is community services that are driving the most significant adverse variances. 2015/16 is the first year that community services are included in the Trust's return. The team tested the relationship of the apparent excess cost of community services - £4.5m - against the planned care model savings £7.8m, concluding that the most significant variances are being addressed within existing programmes of work.

Concerns were noted that recording of community data - particularly the activity of community based staff - may be contributing to the higher than expected unit costs, possibly being inflated by under recording of activity. This concern needs to be addressed through the implementation of a new community information system, planned as part of the IT strategy.

The analysis of costs by specialty will be used to inform debate, both locally and at STP level, on

the viability of services and, as such will inform both the Acute Services Review and the review of vulnerable specialties.
Internal/External Engagement including Public, Patient and Governor Involvement: Reference Costs are published on the Department of Health website being available to all
Equality and Diversity Implications: None

1. Introduction

NHS providers submit reference costs to NHS Improvement on an annual basis. These costs are used to set national prices. Providers and commissioners use reference costs to agree local contracts and plan future services. Reference costs were the basis for much of the recent review of operational productivity led by Lord Carter.

In future, costing information will be used increasingly by commissioners and regulators to support the drive for greater efficiency and consistency across the sector. It is the responsibility of all trusts to improve the accuracy of the information they submit.

2. Audit of Reference Cost submission 2014-15

79 trusts were audited for their 2014-15 reference cost submissions. 51% of Trusts were rated as compliant and 49% as non-compliant with the NHS Improvement *Approved costing guidance*.

Audit Outcomes

14% Compliant – Good

37% Compliant – Improvements needed

35% Non-Compliant – Improvements needed

14% Non-Compliant – Significant Issues

This shows a marked improvement from the 2013-14 Audit, where 49% of trusts were found to have submitted materially inaccurate reference cost returns.

Areas of non-compliance

Common issues contributing to trust non-compliance included:

- Insufficient governance and assurance processes in relation to reference costs
- Costing inconsistently embedded in day-to-day financial management
- Underlying financial and activity data quality issues, often not reviewed before inputting data into the costing system
- Approaches to costing not in line with guidance

These procedural issues contributed to costing errors, such as:

- Errors in initial cost and activity data used in calculating reference costs
- Misallocation of cost pools
- Cost apportionments not accurately reflecting resource consumption

Torbay and South Devon NHS FT 2014-15 reference cost submission was not audited.

3. Reference Cost Index 2015-16

The Reference Cost Index (RCI) for 2015-16 was published in December 2016. For TSDFT the RCI has been calculated as 93.5 before adjusting by the market forces factor and 99.7 after adjusting by the market forces factor. The quoted RCI is inclusive of excess bed day costs. The Trust's reference cost index over recent years is shown in table 1 below. The summary divisional RCI is shown in table 2 below.

Table 1 – Reference Cost Index TSDFT

Year	Before MFF	After MFF
2010-11	90	96
2011-12	89	96
2012-13	95	101
2013-14	92	99
2014-15	92	98
2015-16	94	100

Table 2 – Reference Cost Index SDHC Trust – Divisional Summary

DIVISION	Actual Cost	Expected Cost	RCI	MFF	MFF adjusted RCI
Community	£43,489,120	£39,999,973	108.7	93.23	115.4
Medical	£100,424,605	£111,678,910	89.9	93.23	96.0
Other	£1,840,207	£1,445,774	127.3	93.23	135.4
Surgical	£74,182,989	£76,926,139	96.4	93.23	102.9
WCDT	£47,548,653	£56,069,855	84.8	93.23	90.5
Grand Total	£267,485,574	£286,120,651	93.5	93.23	99.7

A more detailed analysis at service line level is shown in Appendix 1.

The Market Forces Factor (MFF) applied to TSDFT for 2015-16 is 0.93227. This means that the expected costs for SDHFT should be 93.2% of the national average costs. The Trust's market forces factor over recent years is shown in table 3 below.

Table 3 – Market Forces Factor

Year	MFF
2010-11	93.41%
2011-12	93.33%
2012-13	94.58%
2013-14	95.46%
2014-15	93.30%
2015-16	93.23%

4. Costing Transformation Programme

NHS Improvement with NHS providers is working to improve the quality, consistency and availability of local and national costing information. In December 2014 the Costing Transformation Programme (CTP) was launched to lead the move from the collection of reference costs to patient-level costing (PLC) by all providers by 2021.

Standards have been set for how to cost; these have been tested for the acute, mental health and ambulance sectors. The first versions will be published in January 2017.

5. TSDFT Costing

Work is underway to adopt the Costing Transformation Programme processes and methodologies. We are intending to be an early implementer of the new costing standards participating in the patient level costing collection in September 2017. We are implementing a new costing system that is CTP compliant. We are currently reviewing our activity feeds, mapping expenditure to resource groups and working on allocation methods of support costs as detailed in the NHS Improvement Costing Standards.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2107
Title:	Clinical Incident report
Lead Director:	Chief Nurse
Corporate Objective:	Safer Care
Corporate Risk/ Theme	Safer Care
Purpose:	Information & Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The Trust has now moved, following a procurement processes, to a single incident reporting system that now allows one data set for incident management to be used. This system is also integrated with litigation, complaints, and risk to allow an aggregated overview.

Key Issues/Risks

The report highlights a dip in October in conjunction with the launch of the new integrated incident reporting system (Datix). The following data point has risen and this needs to be observed over time for any trends.

The National Reporting and Learning systems (NRLS) latest report does highlight the Trust is within the top 25% of reporting and again this needs to be observed

Following launch, the Datix system is now in phase two of implementation, which will involve refinement to ensure the system evolves and mirrors the care model

The Trust continues to use and scrutinise the Datix system in conjunction with the data provided by the QIG dashboard and external sources such as Dr Foster to help to direct patient safety activity

Recommendations:

Note the contents of the report

Summary of ED Challenge/Discussion:

- To discuss and review the dip in incident reporting in October 2016
- The implementation of the new system followed a project management plan and required significant time and resource to progress.
- In conjunction with Datix, a new Quality Improvement Group (QIG) dashboard has been created which allows Trustwide data to be held and viewed in one easy to use location

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

Torbay and South Devon NHS
NHS Foundation Trust

Clinical Incident Report

Trustwide

Dec 2015 – Nov 2016

DRAFT

Background & Introduction

The Trust operates and runs an on-line clinical incident reporting system. Incidents are reported from all areas of the Trust and are managed locally, investigated by the manager and overseen by the relevant Matron and Service Delivery Unit (SDU) Governance Co-ordinators / Medical Governance Leads.

Following a procurement process and project implementation in October 2016, the Trust started to solely use Datix as the one system for Incidents, Complaints, PALS, Risk Registers and Litigation. Prior to this point in time both Safeguard and Datix were in operation, therefore, the data in this report is aggregated from two sources. For future reports the data will be entirely from Datix.

Each SDU then generates a ward/department/SDU level monthly/quarterly incident report which is presented to the relevant governance meeting where any necessary actions can be followed and/or patient safety activity assigned. Aggregated information is presented monthly to the Quality Improvement Group (QIG) via the QIG dashboard.

The dashboard (DB) has been built on a wide range of metrics, from across the organisation and is updated monthly from a variety of data sources. This report is also designed to give a corporate level view of incident reporting and to offer assurance that the Trust's safety work is being aligned to any issues generated from the incident data and, as such, can direct future safety work as and where needed. The DB therefore, has a number of themes that have been created to allow for a deep dive into this data, namely falls, pressure ulcers and medication errors. The plan is to continue in this vein, and create more in depth areas as time and resource allow.

The DB is available on the newly created Incidents portal (accessed from the ICON home page) along with incident reporting guides, manager guides, help guides, data and statistics - including the latest monthly dashboard and summary.

Whilst the DB is not intended to replace the quality accounts or reports generated by specific groups or teams such as Infection Control, Tissue Viability, Falls, Pharmacy, etc, these will hold more information and activity pertinent to them and will help augment them.

Time period:
The report covers the time period Dec 2015 – Nov 2016.

Data & Graphical Presentation:
The report produces run charts, radar charts and bar charts taken from data the Trust enters onto Safeguard/Datix risk management reporting systems.

The run charts used are designed to look for *trends* and *shifts* in the data:
Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to go wrong.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to go wrong.

Narrative: Each aspect will include a narrative description and explanation of the data provided.

Data Sources:

- Trustwide Risk Management System = Safeguard & Datix Incident Reporting
- Dr Foster

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Table 1: Patient Centred Incident Report Card

Safety Indicator		Data Source
Trustwide Clinical Incident Report Summary	Page 4	
Appendix 1 Total Number of Clinical Incident Reports Trustwide & by Service Delivery Unit (SDU)	General Incident Reporting	Trust Risk Management System
Appendix 2 Number of Clinical Incidents by Actual Impact		Trust Risk Management System
Appendix 3 Top 10 Causes of Incidents		Trust Risk Management System
Appendix 4 Never Events		Trust Risk Management System
Appendix 5 Slips Trips & Falls – in depth review	Specific Cause Groups	Trust Risk Management System
Appendix 6 Medication Errors – In depth Review		Trust Risk Management System
Appendix 7 Venous Thromboembolic Events (VTE) - Deep Vein Thrombosis (DVT) - Pulmonary Embolism (PE)		Trust Risk Management System
Appendix 8 Mental Capacity, Learning Disability & End of Life		Trust Risk Management System
Appendix 9 Bloodhound		Trust Risk Management System
Appendix 10 Medical Devices		Trust Risk Management System
Appendix 11 Number of Grade 3 & 4 Pressure Ulcers		Trust Risk Management System
Appendix 12 Unadjusted Mortality Hospital Standardised Mortality rate (HSMR) Summary Hospital Mortality Index (SHMI)	Assurance	TSDHFT - Information Team Dr Foster Dr Foster

DRAFT

Clinical Incident Report Summary:

- **Online incident reporting**
  On the 1st October 2016 the Trust moved to one incident reporting system that covers the entire organisation and allows for incidents to be reported from every aspect of the Trust and under all relevant care situations. These include patients in their own homes, hospital (both acute and community) and intermediate care. The new system, being just a few months into operation, is still in its infancy and is being learned and adapted by the organisation during in this initial phase.

- **Medication errors**
  The Trust has been actively encouraging the reporting of medication incidents, as this type of incident has typically been under reported. All medication errors are automatically sent to the Clinical Governance Pharmacist for review and action. Pharmacy have been particularly focusing on high risk medications and missed doses with the wards and departments. Missed doses, through regular monthly audits and interventions, are showing a decrease.

    - **Pharmacy – Risk Registers**
      With the advent of the online form, Pharmacy are actively grouping incidents to aid the remedial safety work and are recording the findings on a trust wide pharmacy risk register which is used at the Medicines Management Committee.

- **VTE Reporting**
  All Deep Vein Thrombosis (DVT) and Pulmonary Embolisms (PE) that are diagnosed in patients who have had a hospital admission in the last 90 days are recorded on the incident system and are investigated. This investigation is led by a Consultant Haematologist and support nurse and the findings collated and shared with the teams involved. The investigation is primarily looking at the VTE assessment, i.e. was it done and did the patient receive the necessary VTE prophylaxis?

- **Pressure Ulcers (PU)**
  This type of injury has historically not been well reported and the Trust has been encouraging more PU incidents to be recorded. Through better reporting of the lower Grades (Grade 1-2), the more serious Grade 3-4s can be prevented.

  Through the Tissue Viability Service and Pressure Ulcer Steering Group much work has been achieved in:
    - Reviewing policy and procedure
    - Creating a rapid assessment tool for the ED department
    - Procuring pressure relieving mattresses for the A&E department that fit their trolleys
    - Creating a local equipment store for the ED department
    - Producing Hiblio training and information videos
    - Medical device equipment training on pumps and mattresses
    - Leg ulcer training continues to be run at regular intervals
    - Spreading the use of the Skin bundle
    - Roll out Trust wide post Pressure Ulcer Prevention project

- **Falls**
  The number of falls has continued to reduced. The focus for the Trust now is to reduce the harm caused by falls and this is evident within the data. The Falls Nurse and Falls Committee have introduced chair and bed alarms, revised falls assessments and bed rail assessments. They have implemented a Lying and Standing blood pressure monitoring tool and educational package. The introduction of the Fallsafe audit will greatly help as this assesses all the interventions to ensure 100% compliance of the falls prevention tools.

- **Root Cause Analysis Training**
  Circa 60 places have been offered for current staff to book onto regarding root cause analysis.

- **STEIS Reporting**
  The Trust continues to report to the STEIS system in accordance with agreed protocols.

- **Learning & Sharing from Serious Adverse Events Group (SAE)**
  All 'major/catastrophic' and 'major near miss' incidents are taken to the Trust's SAE Group for presentation, learning and acceptance of the Divisions' RCAs and action plans. The action plans are recorded on a centrally held database and updated when actions closed. The group has created a SAE alerting system to help share learning and feedback is given to the Divisions. The Falls, VTE, Infection Control and Pressure Ulcer RCAs are also tabled at the appropriate group, committee and governance meetings for wider learning and sharing.

- **End of Life / Mental Capacity / Learning Disabilities**
  With the new incident reporting system recording one data set the examination and reporting of these incidents will increase and help direct activity to the right areas.

- **Communication**
  Through the Trustwide adoption of SBARP (Situation Background Assessment Recommendation and Patient) the Trust communication incidents have continued to decline. The use of SBARP was designed to help reduce communication errors or misunderstandings, a facet present in every clinical incident. With the role out of Nerve Centre, electronic transfer of data will be possible and will help reduce communication incidents.

- **Blood matters**
  Bloodhound issues are a relatively new incident, this is a piece of work being led by the Transfusion Practitioner (TP) to ensure all blood samples and processes around the request and successful transfusion of blood products are strictly complied with.

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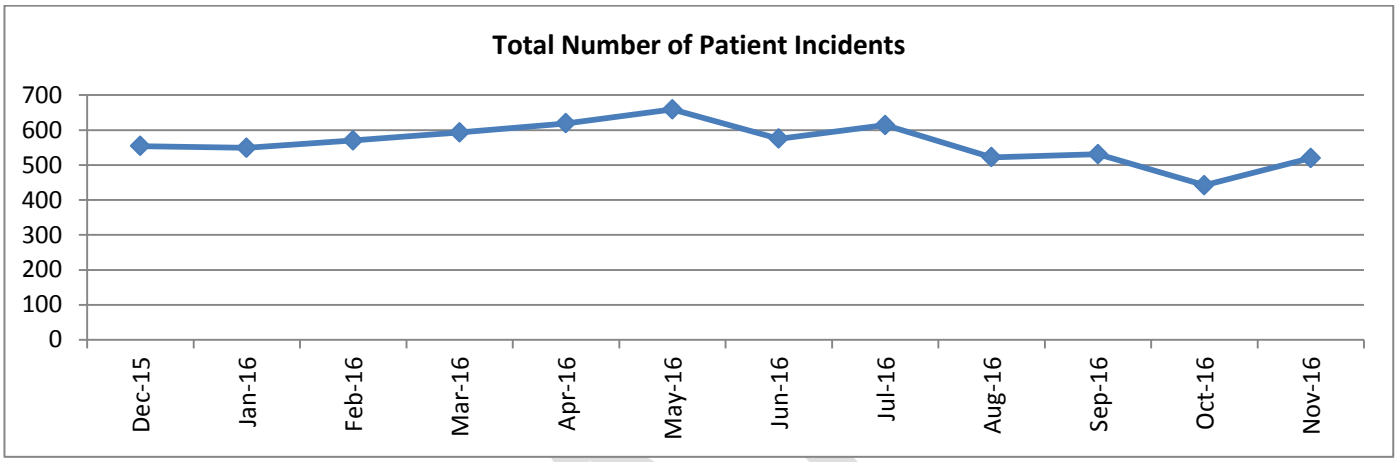
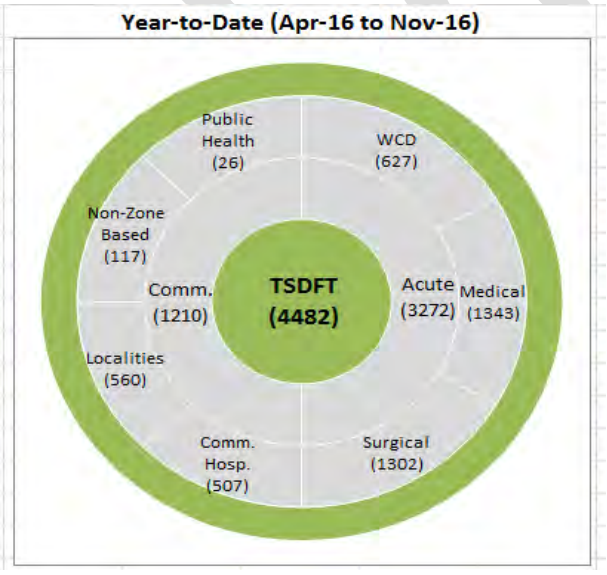
Appendix 1
Total Number of Clinical Incident Reports by Month by Year
(Data obtained from Safeguard and Datix)

Appendix 1 looks at the total number of Trustwide patient incidents reported by month, as a run chart, for Dec 2015 to Nov 2016. This format allows us to look for any trends/patterns in this top line data as outlined in data and graphical presentation.



The chart above indicates reporting over time from Dec 2015 to Nov 2016. A slight reduction is noted from August 2016 onwards until the November 2016 data point. This needs to be observed over time to see if it becomes statistically significant, otherwise reporting remains in a healthy position. The last National Reporting & Learning System (NRLS) records our position as being within the top quartile of reporters which is indicative of a positive incident reporting culture.

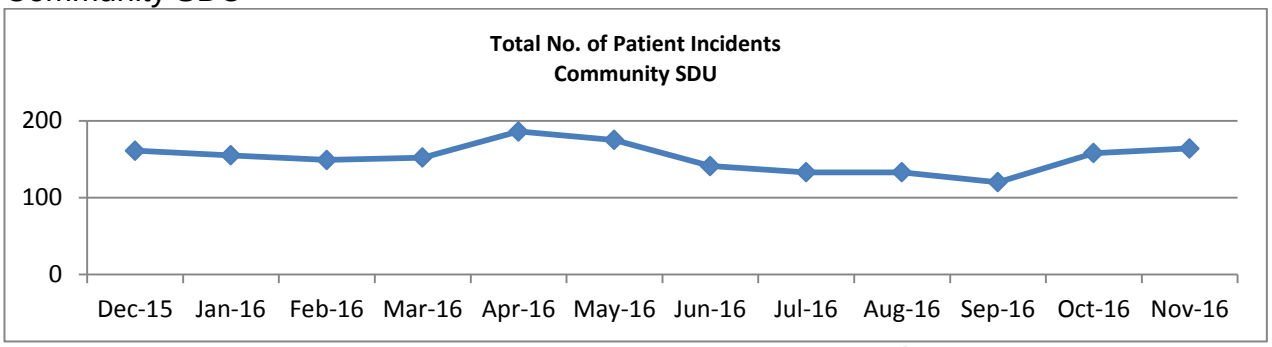
Work is ongoing with the introduction of one incident reporting system to ensure this doesn't have transient effect of reporting in the immediate phase post launch. The two initial data points we have show a dip in the launch month (which is to be expected) and then a rebound in month two. The reporting pattern is being closely monitored and more data points are needed.



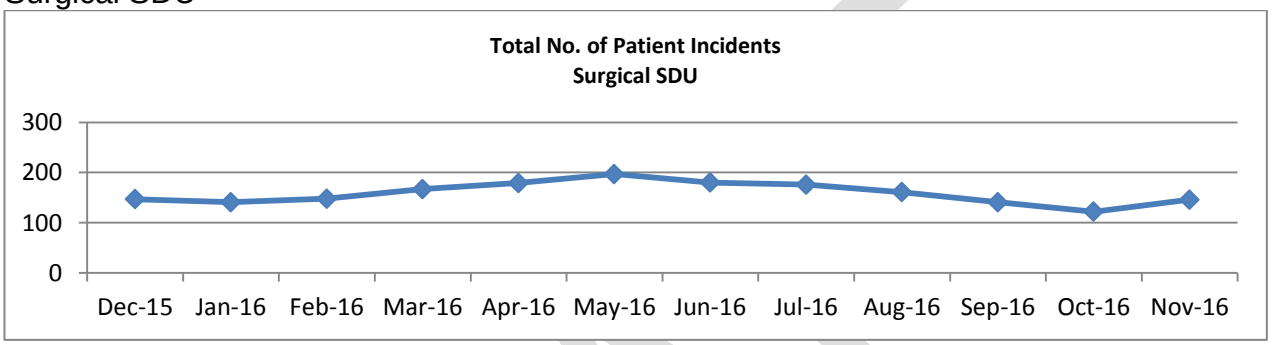
The radar chart opposite highlights the Service Delivery Units (SDUs) and their respective reporting numbers for the reported time period and again all are within the expected ranges we have set.

For an individual SDU perspective, the charts below highlight the incident reporting patterns for each delivery unit.

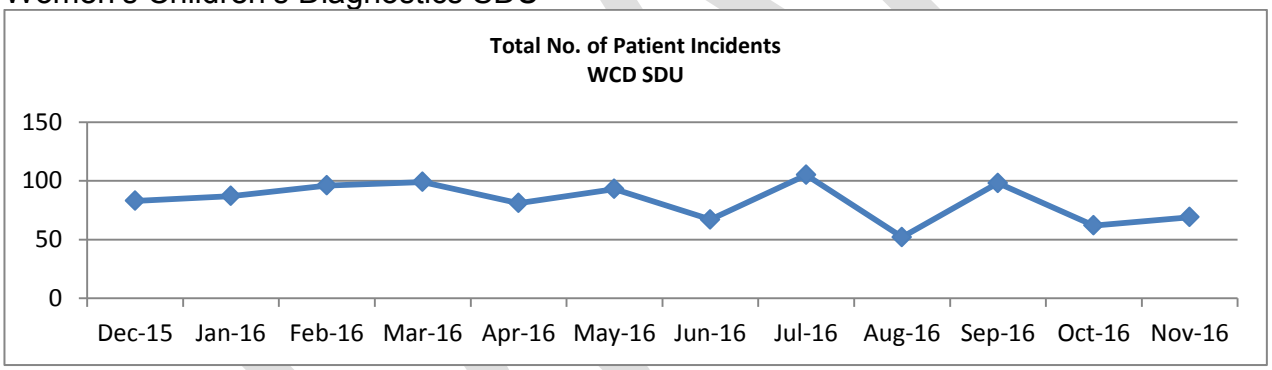
Community SDU



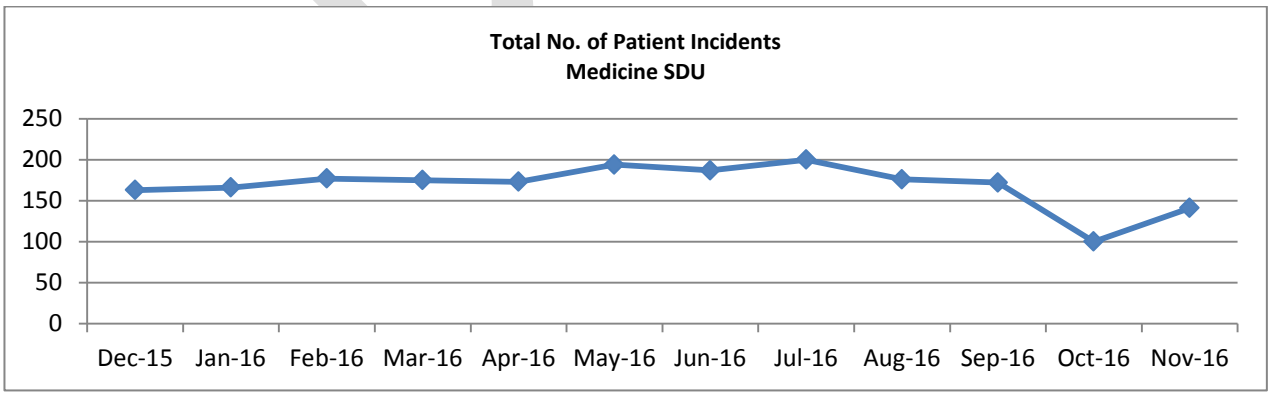
Surgical SDU



Women's Children's Diagnostics SDU

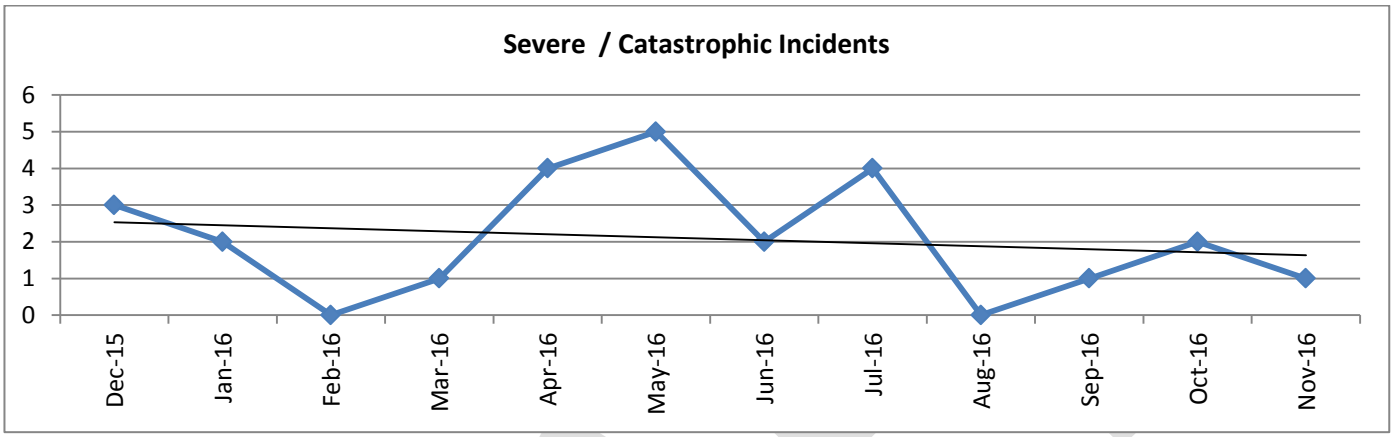


Medical SDU

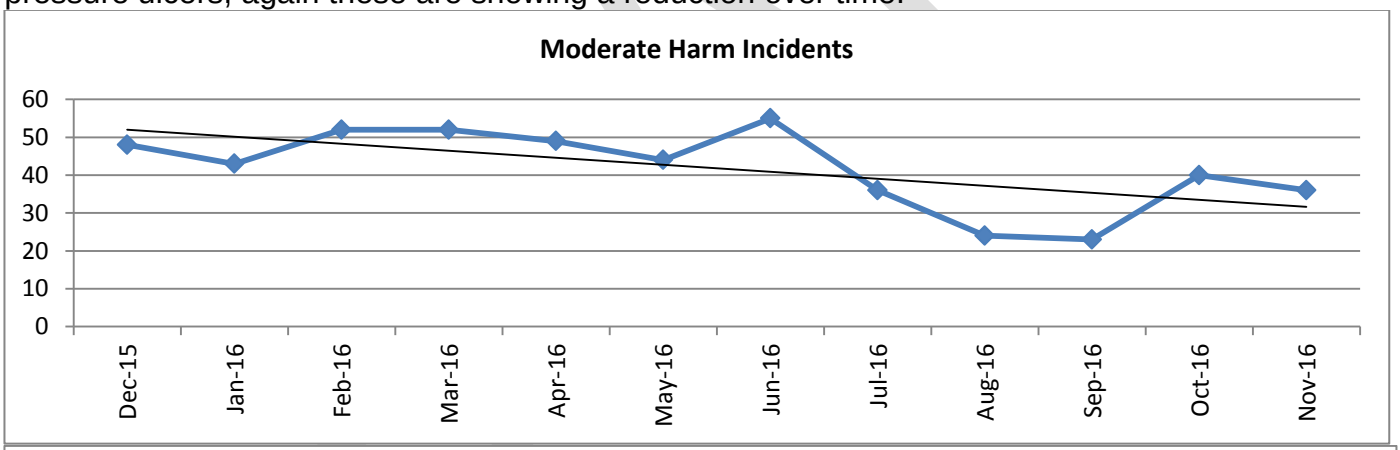


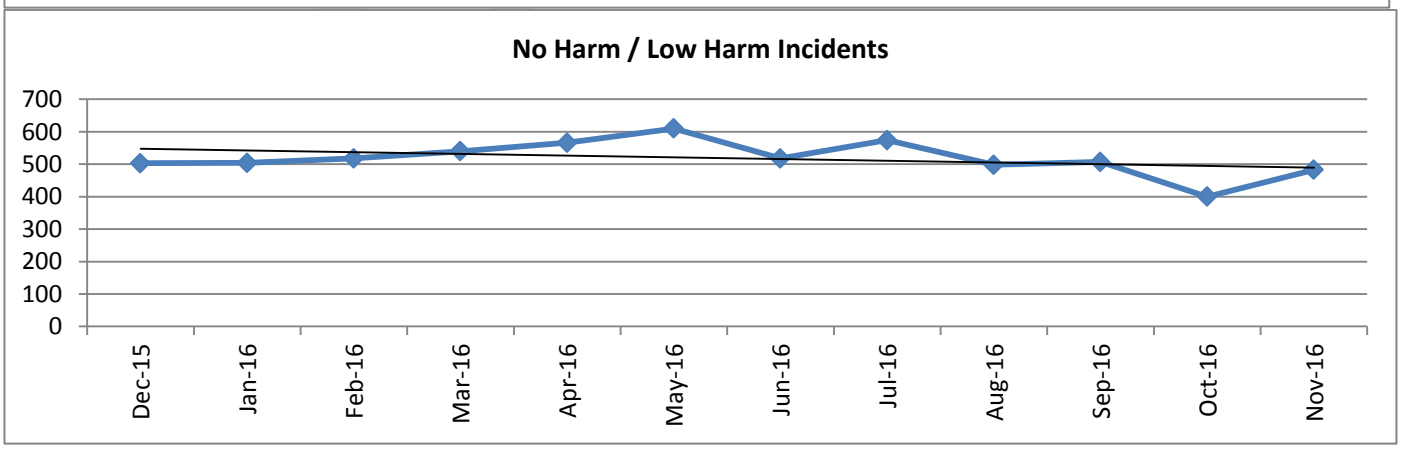
Appendix 2
Clinical Incidents by Actual Impact – Trustwide

This set of data slides records Trustwide actual harm from the incident forms entered on the risk management system. Where incidents occur that are major and catastrophic, an investigation is undertaken and the learning shared within the area and where necessary across the Trust. These types of incidents are showing a reduction over time.



Moderate incidents are again incidents that cause a level of harm that the Trust investigates and these largely include issues such as, VTE within 90 days of discharge from hospital, harmful falls, pressure ulcers; again these are showing a reduction over time.





Appendix 3
Most Frequently Occurring Cause Codes
12 Months Data Trustwide
(Data obtained from Safeguard and Datix)

The table below shows the top ten most frequently occurring cause codes, i.e. the codes that have been attributed to incidents most frequently reported.

Community Service Delivery Unit

1st Dec 2015 to 31st Nov 2016	Total
Pressure ulcer	787
Accident/Injury (Including slips, trips and falls)	542
Medication Issues	131
Implementation of care and ongoing monitoring / review	86
Access, admission, transfer, discharge (including missing patient)	51
Consent, communication, confidentiality	46
Infrastructure (e.g. staffing, facilities, environmental health)	32
Documentation (including electronic & paper records, identification and charts)	29
Medical device / equipment	20
Clinical assessment (including diagnosis, scans, tests, assessments)	19

Acute Hospital

	Total
03a Medication Error/issue - Inc. Infusion Devices	354
05i Other Non-Specific Incident	195
30h Slip/Trip/Fall - Found On Floor	152
05k Staffing Levels	142
06a Communication - Between Staff	136
03ad Blood Hound Issue	115
01h Inappropriate Admission/Transfer To Ward	113
05s Pressure Sore Grade 1/2 Not SDHCFT Hospital	110
30c Slip/Trip/Fall - Fall From Bed	95
03cc Development Of A PE	90

The two tables record the top 10 reported incidents by the Community and Acute setting. In this Incident Report, Medication, Slip Trips and Falls, Pressure Ulcers Blood Matters (Bloodhound), Medical Devices and VTE issues are recorded separately for further scrutiny and analysis. Staffing levels, whilst not formally reported in this score card are reviewed separately in the staffing report which is completed on a monthly basis and also presented to the Board.

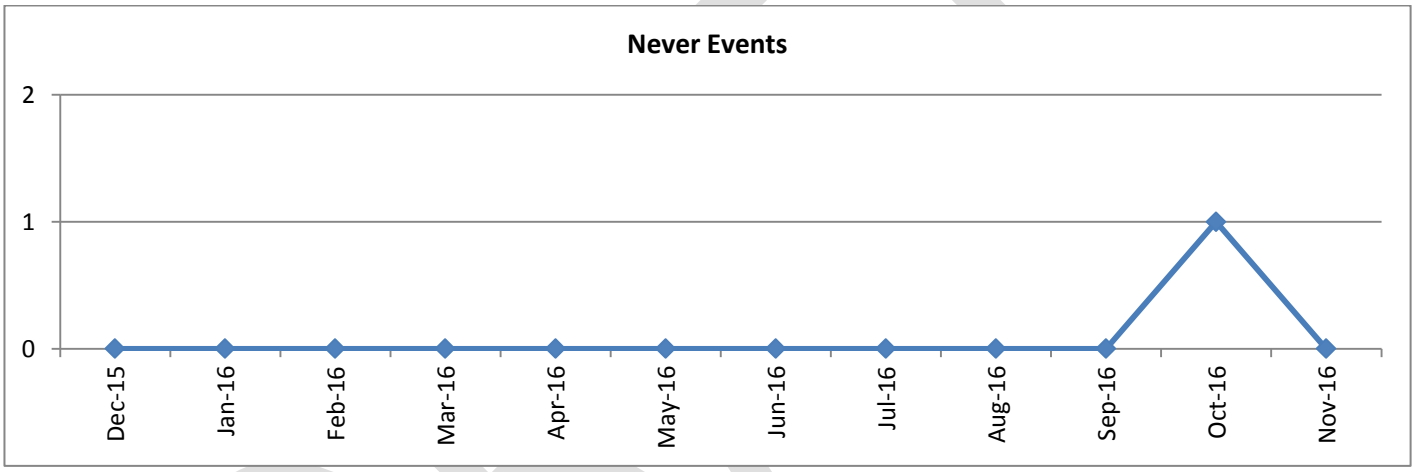
With regard to the Community SDU top 10, the number of pressure sores scores the highest due to the nature of visiting patients in their own home and/or care environment. The actual pressure damage is often not caused by the CSDU, but rather recorded by them. Any pressure sores that are caused by us are investigated and reported appropriately.

Appendix 4
Department of Health Never Event List
Dec 2015 – Nov 2016
Source Safeguard

A Never Event (NE) is defined by the National Patient Safety Agency (NPSA 2010) as a '*serious, largely preventable patient safety incident that should not occur if the available preventable measures had been implemented by healthcare providers*'.

The table below shows the Department of Health's (DH) 'Never Event' list for 2015/16.

The Trust has recorded one such event between Dec 2015 and Nov 2016. The patients received no harm and the incident has been thoroughly investigated. For more information on the event please click here to review under Medication.



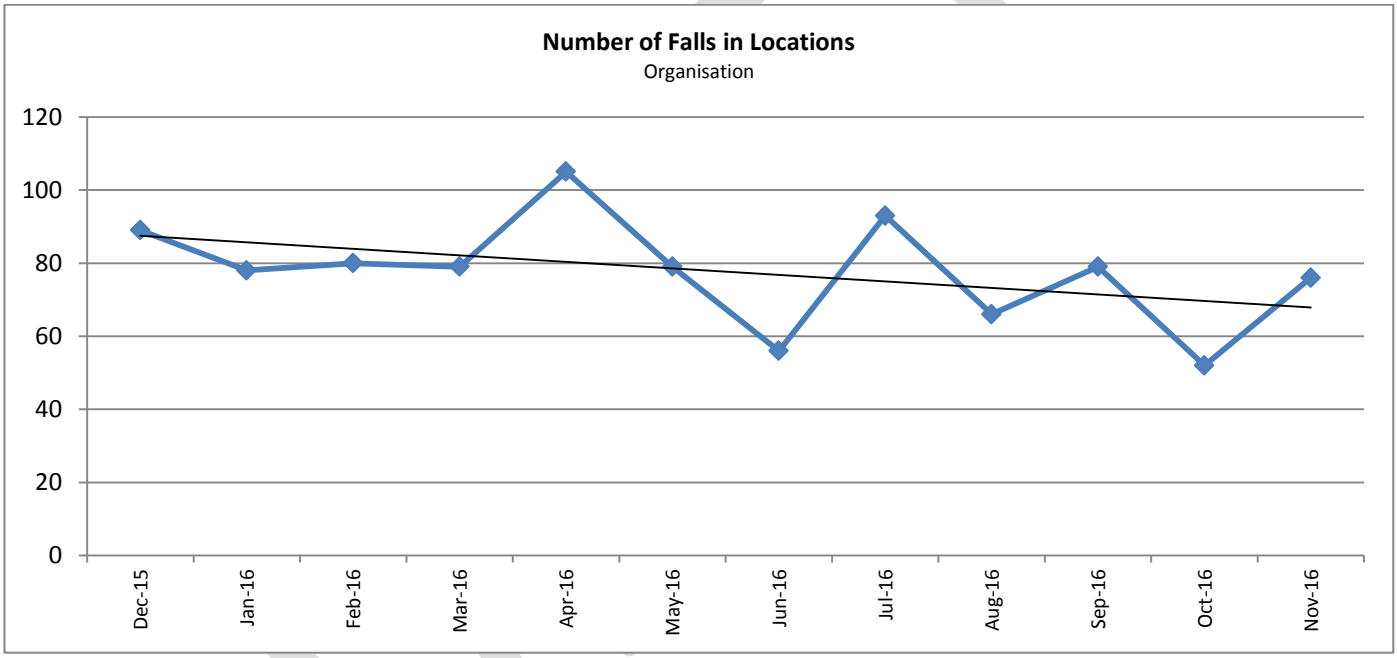
	Description	
1.	Wrong site surgery	0
2.	Wrong implant / prosthesis	0
3.	Retained foreign object post-operation	0
4.	Mis - selection of a strong potassium containing solution	0
5.	Wrong route administration of medication	**1**
6.	Overdose of insulin due to abbreviations or incorrect device	0
7.	Overdose of methotrexate for non-cancer patients	0
8.	Mis - selection of high strength midazolam during conscious sedation	0
9.	Failure to install functional collapsible shower or curtain rails - Mental Health Trusts Only	0
10.	Fall from poorly restricted window	0
11.	Chest or neck entrapment in bedrails	0
12.	Transfusion or transplantation of ABO-incompatible blood components or organs	0
13.	Misplaced naso or oro-gastric tubes	0
14.	Scalding of Patient	0

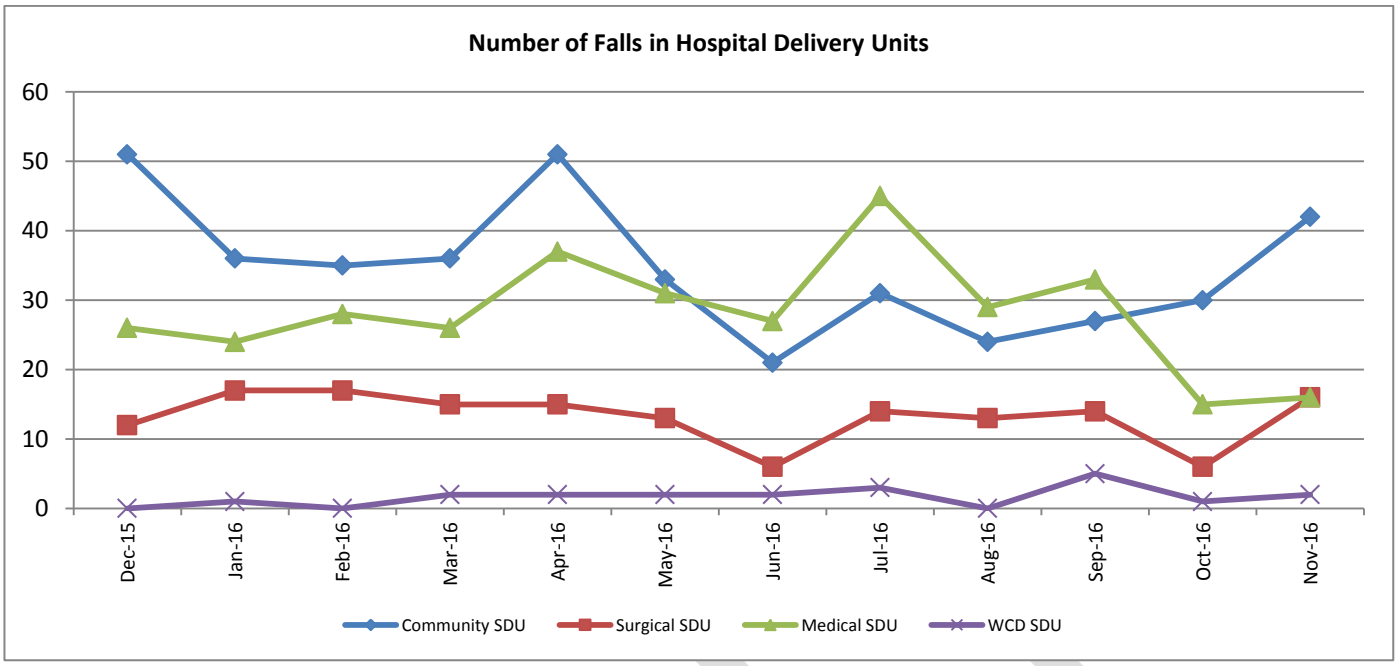
Appendix 5
Trustwide Clinical Incidents by Slips Trips & Falls

This data records Trustwide falls by number, location, actual harm, time of fall and week/weekend split. The data is shared with the Falls Steering Group to aid their work across the Trust.

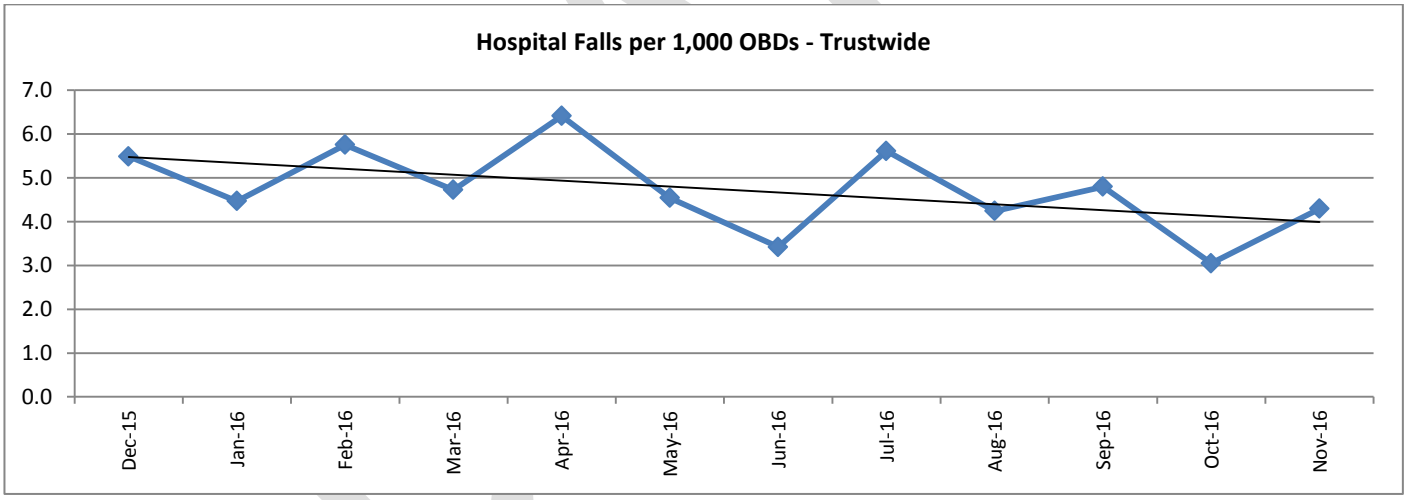
Falls are a multifactor issue within our health community due to our age demographics and morbidity profile, and as such, the prevention, intervention and reaction to these events are via a Trustwide approach. The new Integrated Care organisation is a very real example of how a contiguous approach to falls care across our community can be achieved.

The total numbers of falls experienced by our patients are decreasing over time – as per the chart below and within each Service Delivery Unit.

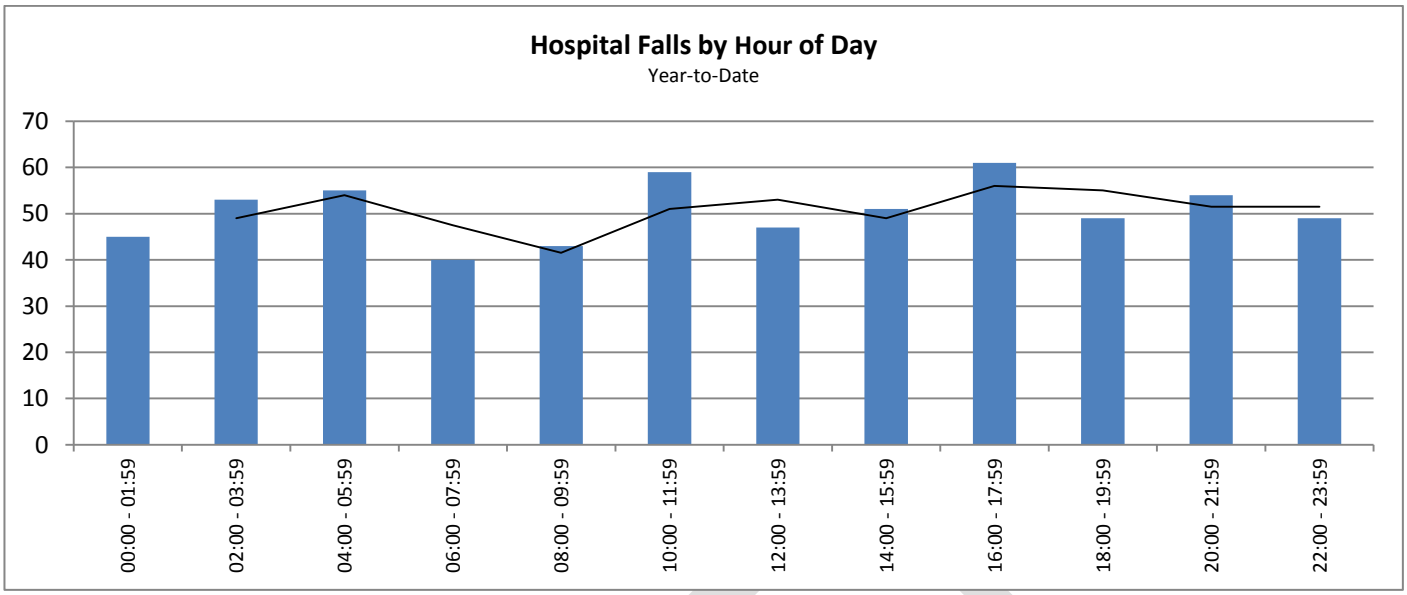




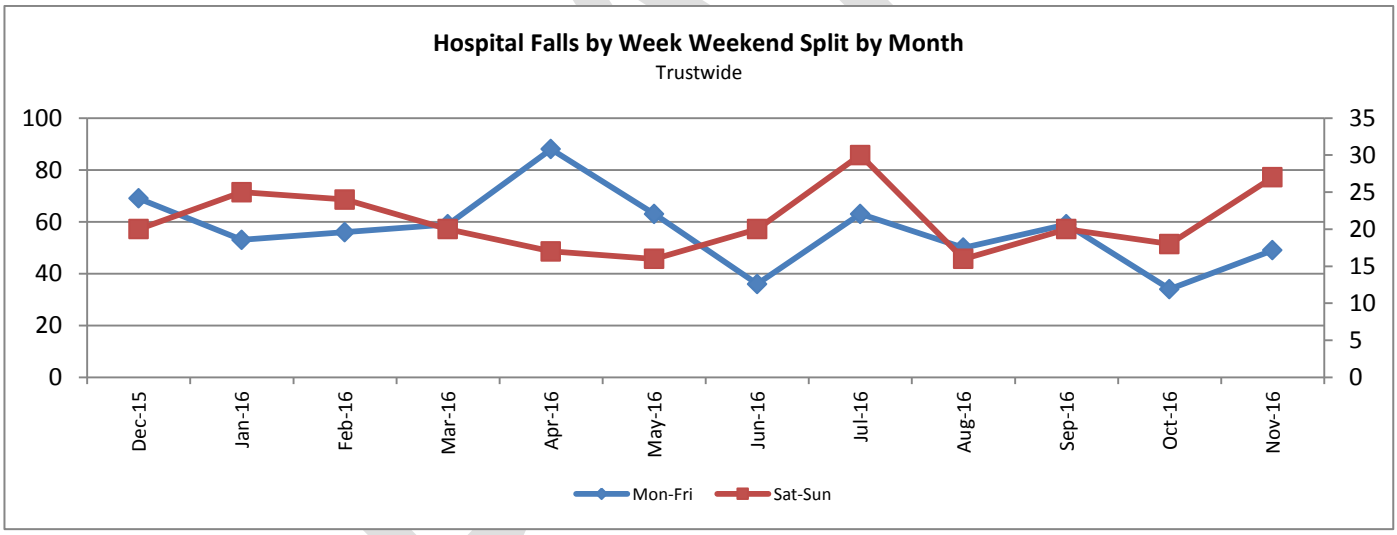
This decline is manifesting in the reduced falls rate (as below) and is to be welcomed.



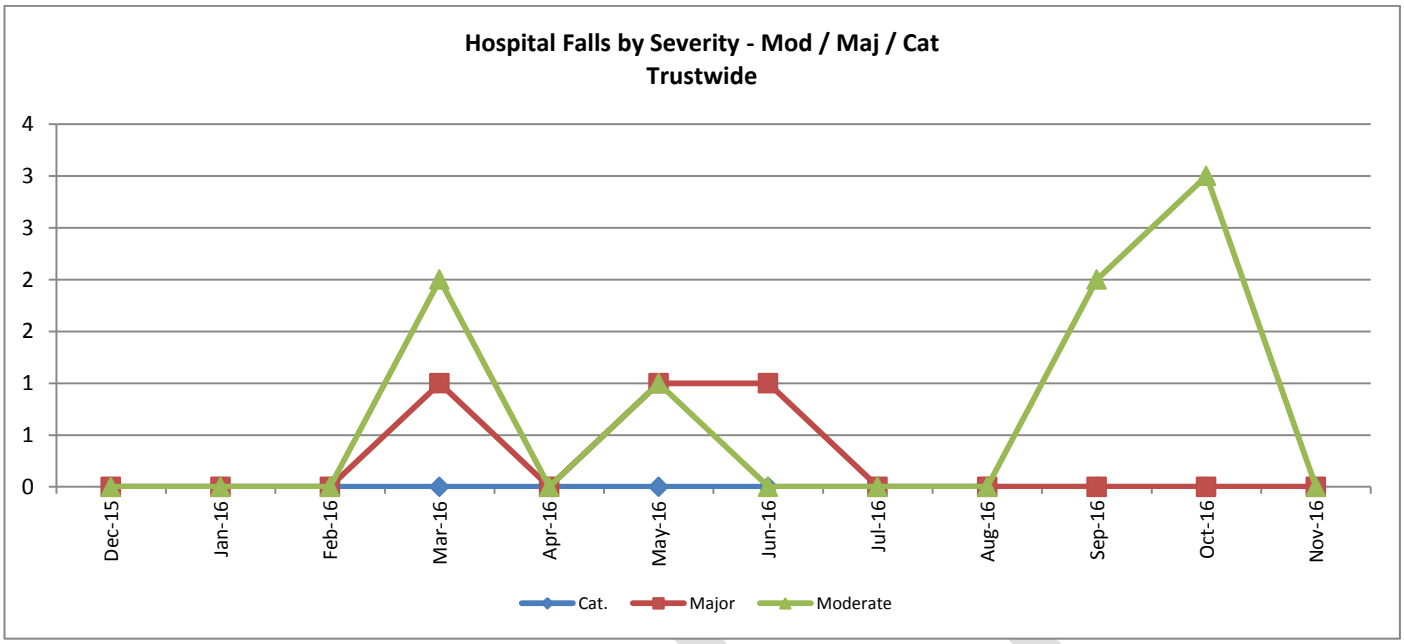
The time at which the fall occurs is granular data that is captured and used by the falls team in education sessions, specifically to make staff aware of the trends and patterns of when patients are more likely to fall. Peak times, highlighted from the below chart, are pre-lunch and pre-dinner.



When analysing the data over the weekday/weekend periods, there is a marked reduction during the weekend, which is therefore showing no adverse pattern of fall, i.e. any bias to the weekend working.

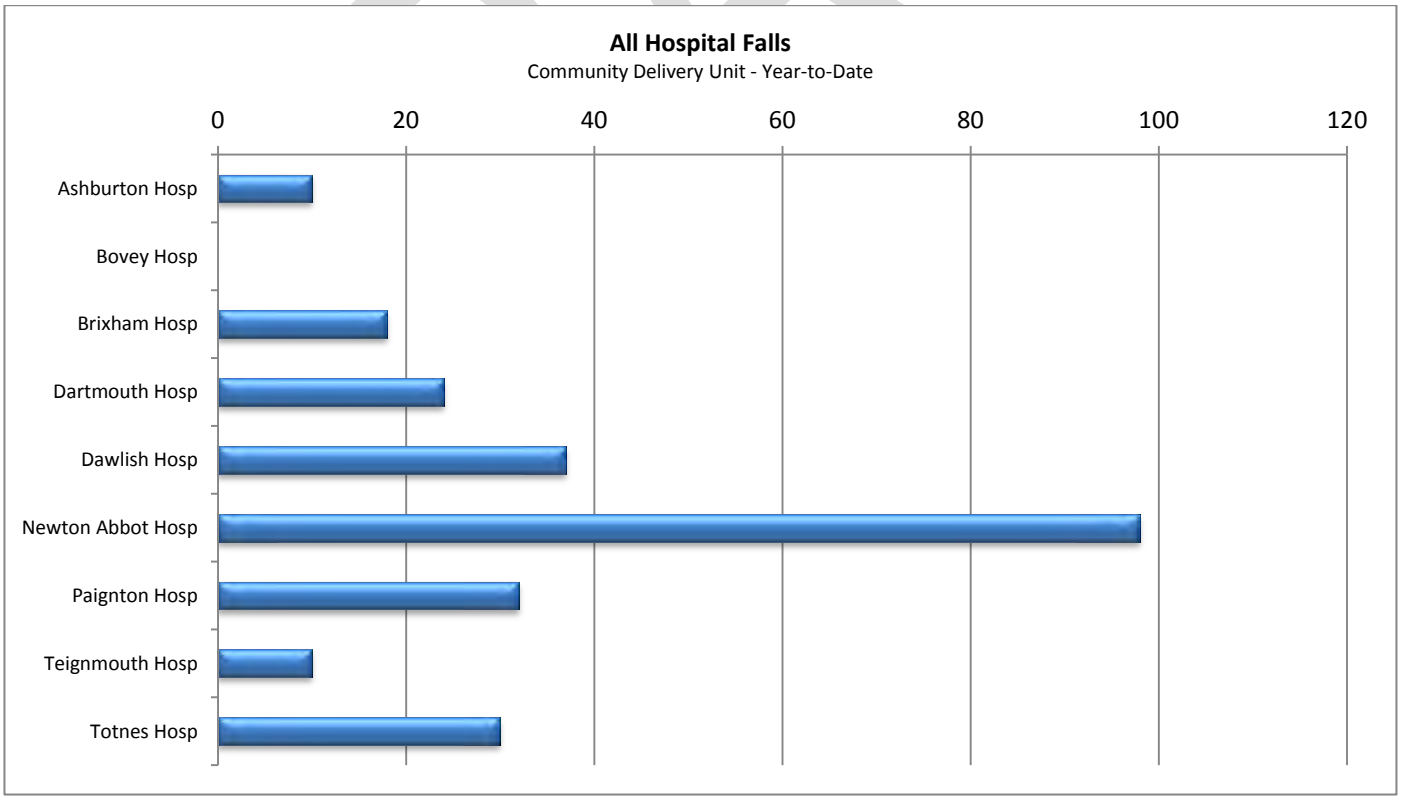


When the harm level from falls is analysed (as below) these falls have all been in the *moderate category and* the chart shows the relatively low number for the said time period. In the data, no patterns have emerged re location or time and all have been investigated. The Trust's aim is to continue to reduce the number of falls, so as to try and reduce the harm from these events, to the lowest level possible.

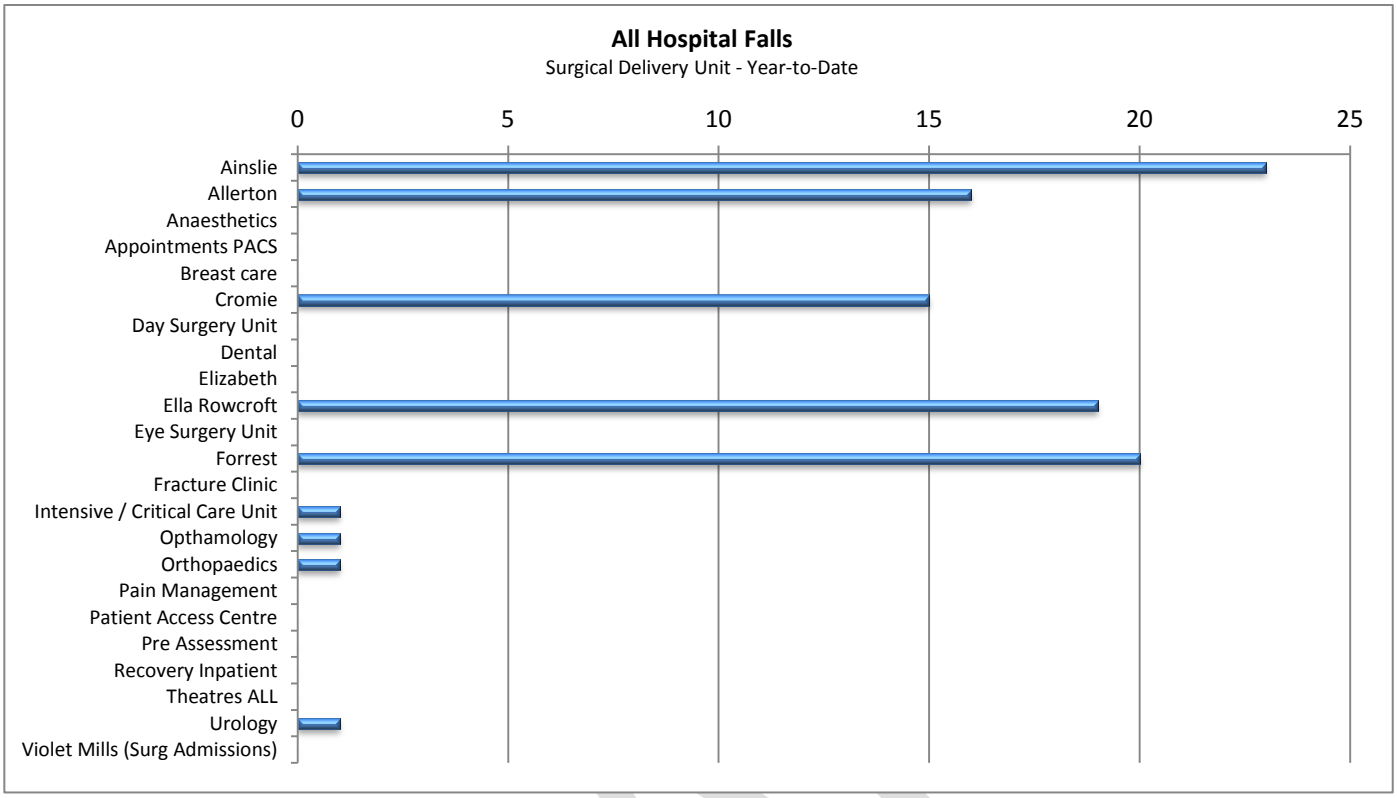


The following charts highlight falls location and falls number across the Trust and the distribution of each is within expectation in line with acuity and frailty of the patients of those areas. Examples of this are Newton Abbot Hospital which has circa three times the number of beds as the other community hospitals and is our rehabilitation ward.

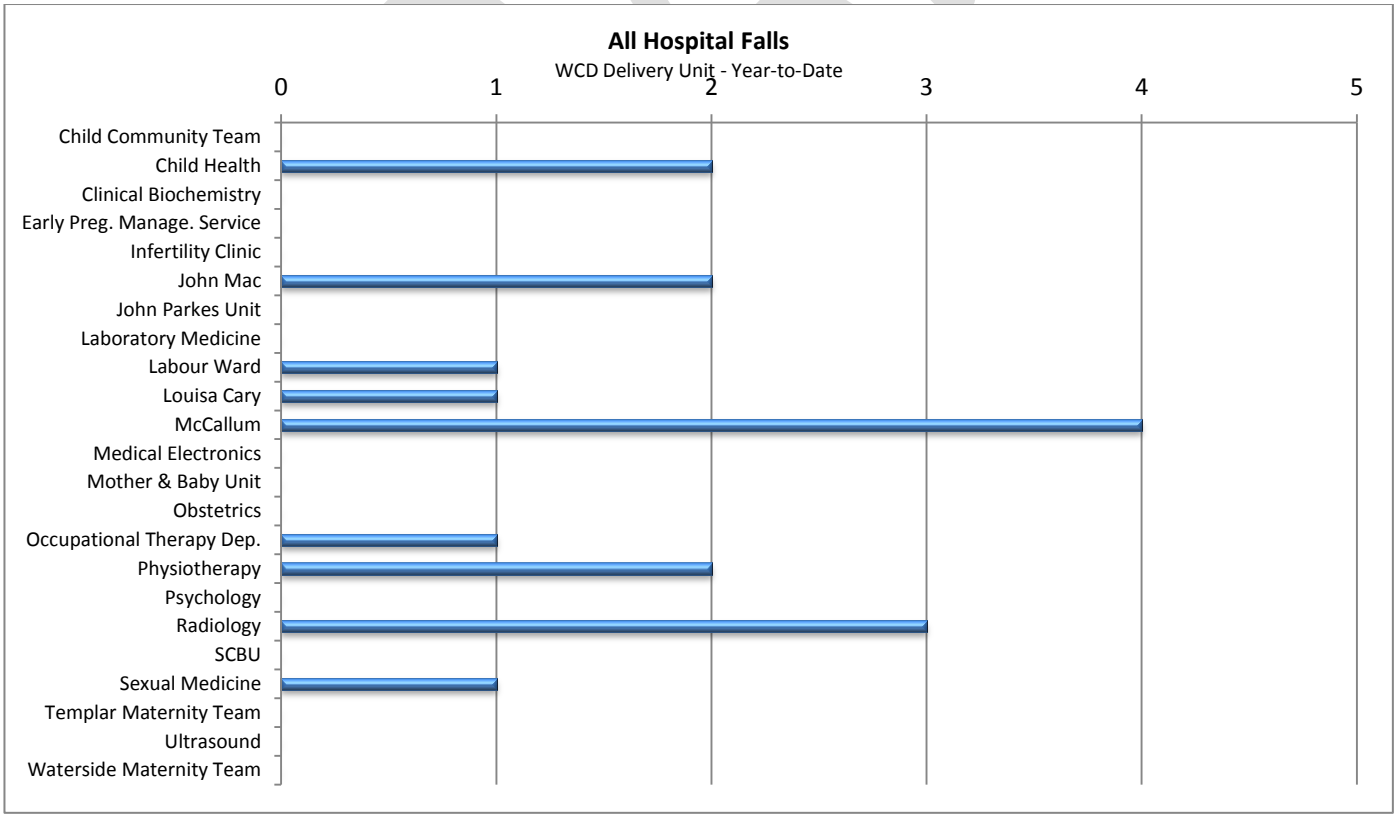
Community Service Delivery Unit



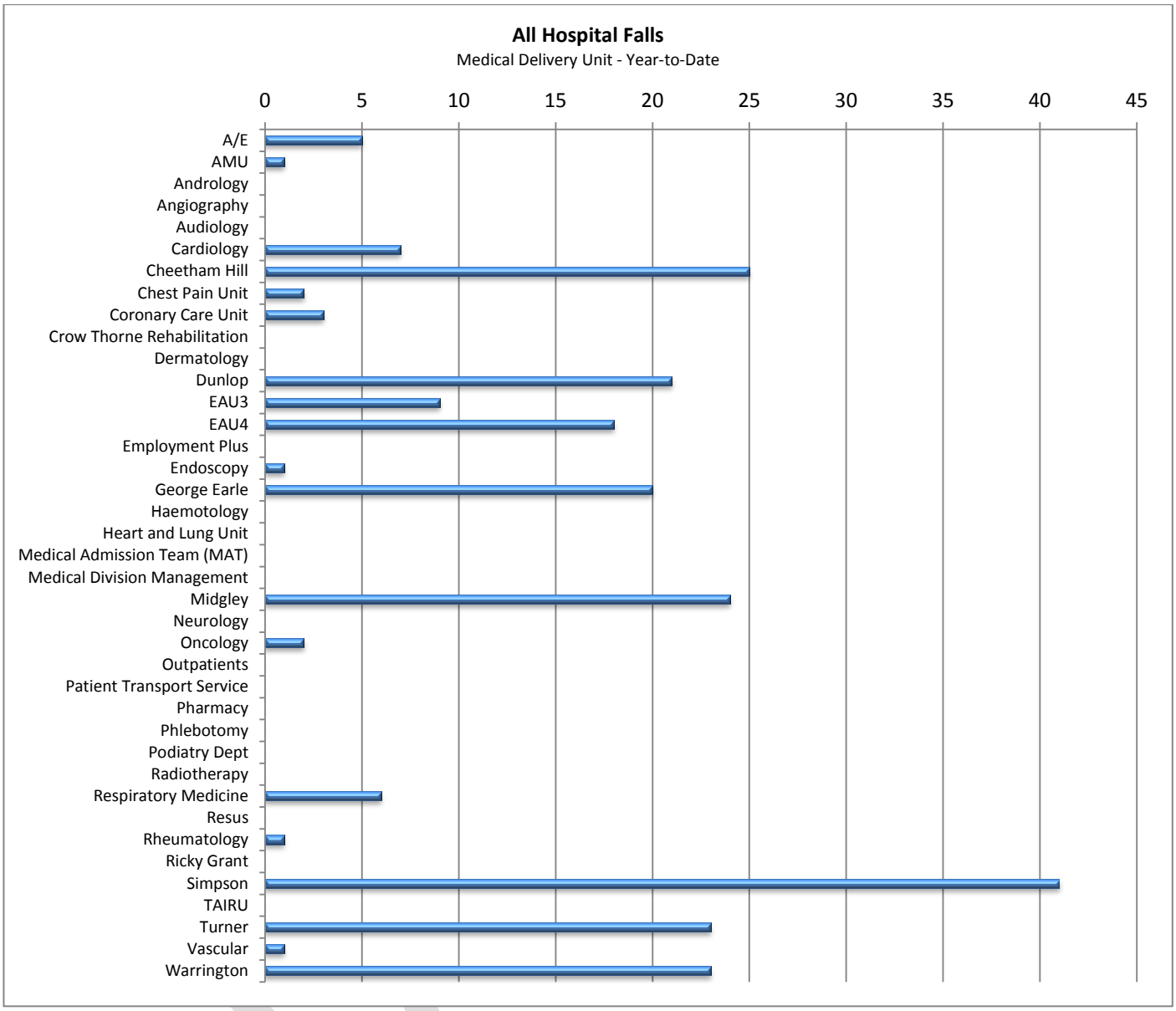
Surgical Delivery Unit



Women's and Children's Service Delivery Unit



Medical Delivery Unit



Falls Work to date

Current initiatives

1. Policy - the policies noted below have either been reviewed or re-written this year:
    - Falls policy
    - Bed rails guidance
    - Supportive Observation Guidance
    - Hi/Lo Beds
    - Falls alarms

2. Hi/Lo beds
- 32 in community
- Standard hospital bed goes very low at 16 cm from floor
- New monies for 10 new Hi/Lo beds that go 8cm from floor

3. Fallsafe audit now in operation across the community and acute, the results of which are now included on QIG Dashboard.

4. Fallsafe link nurses and study days.

5. Activity alarms in situ across the trust

6. Falls group – ICO wide
- Review all falls moderate and upwards
- Assess themes
- MDT

7. Training programme:

Advanced Falls Training
Care Home Managers
Care home Managers/GP
Carers
Corporate induction community/bank staff
Corporate induction hospital
Dementia champions
Dizziness & management
F1s
Falls & Dementia
Falls Champions
Falls Steering Group
Falls training
Falls update
Fallsafe Day 1
Fallsafe Day 2
GP training
Hiblio video hits
L/S BP training
Osteoporosis information group
OTs - Band 5
OTs & Students- Plymouth University
PUG/FSG
SIG

DRAFT

SIG/FSG
TABS training
TAPS training

Over 1,000 people trained last year and a range of Hiblio videos available too.

8. Post falls reviews – ICO wide

9. Winter Falls Campaign – November 2016 – March 2017
   - Awareness
   - Action following assessment – fallsafe bundles

10. Data

   - QIG Dashboard, comprehensive array of data – available on Incident portal and distributed at various meetings.

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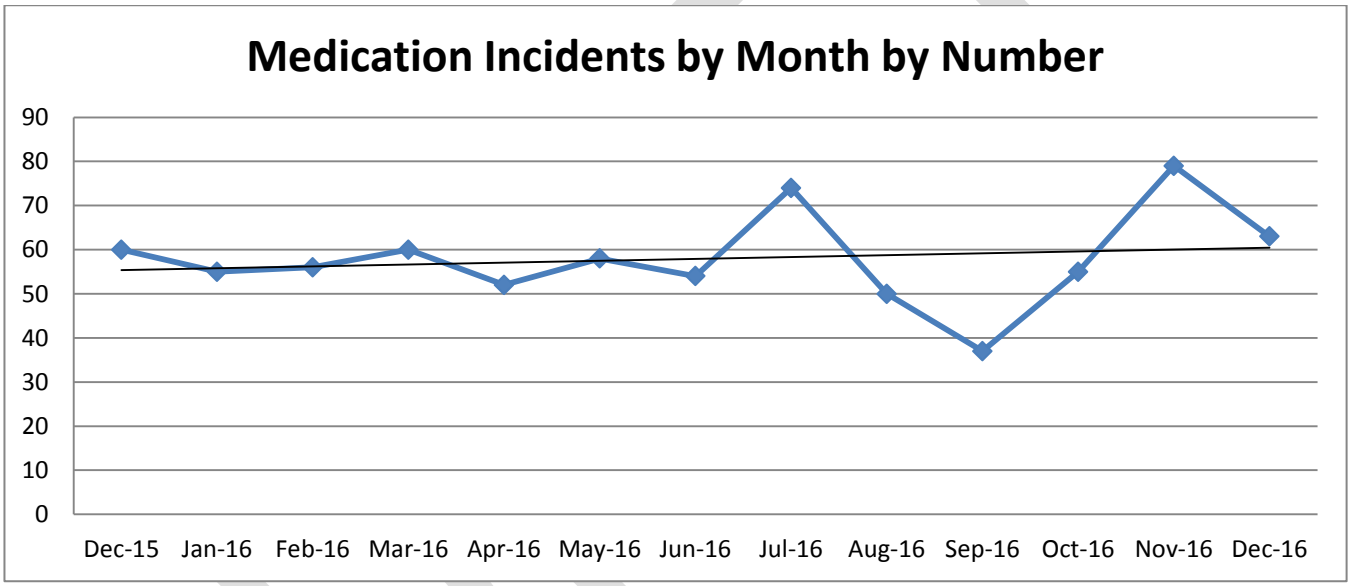
Appendix 6
Trustwide Medication Errors

This dataset looks at the Trust's patterns of medication incidents by a variety of variables.

Trust Medication Incidents

The first chart highlights the monthly distribution of reported medication incidents, the dip from August/September has rebounded back and all medication errors are reviewed by the Governance Pharmacist and are reported to the Medicines Management Committee. The reports help dictate the medicines management work that pharmacy undertakes.

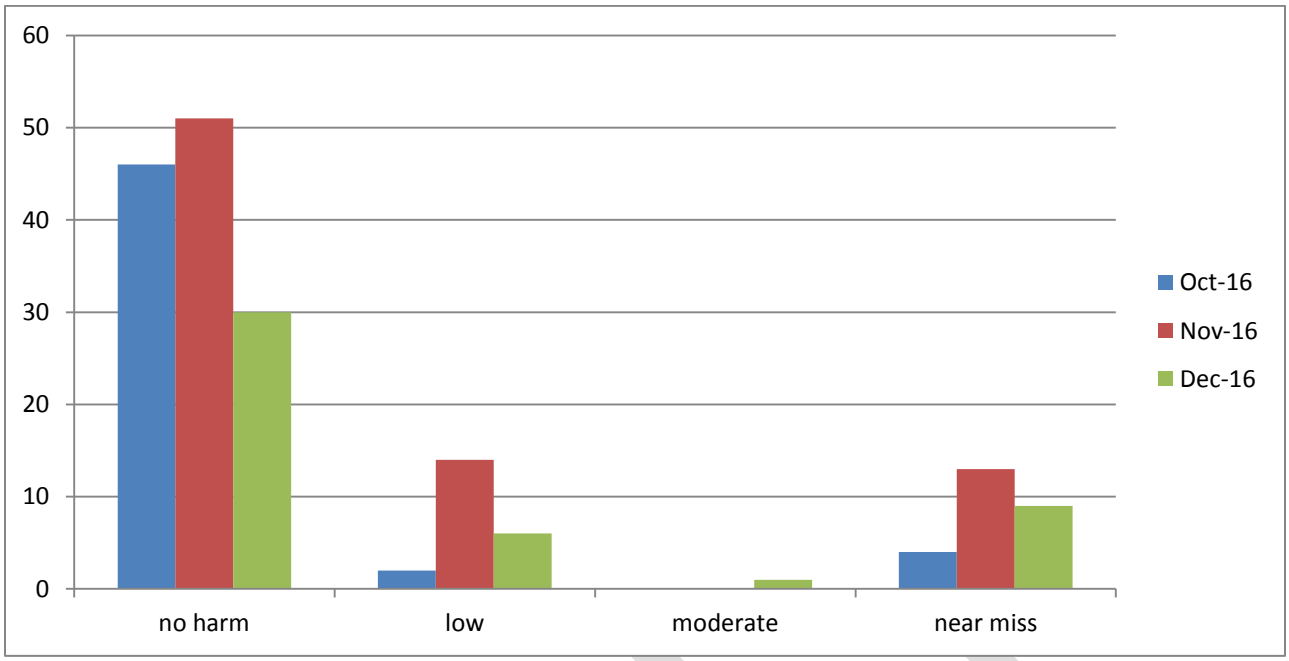
This year has also seen incidents being sent directly to the diabetic nurses for swifter responses to diabetic medication issues which has been productive.



Harm

Of the medication incidents reported to the NRLS over 90% of these are associated with no harm or low harm and our harm rate this quarter was 99.4% which is good.

Where harm is moderate or above, or the incident is of a significant nature the Governance Pharmacists will investigate along with the manager and report to the Medicines Management Committee. The following charts highlight the level of recorded harm for a three month period



Medication Never Events

There was one Never Event in October 2016, where a patient inadvertently received an oral solution of sodium bicarbonate 8.4% instead of the intended IV preparation. Immediate action was taken including a Trustwide alert and changes to storage and labelling in Pharmacy. No ill effects occurred because of the event.

Learning and remedial actions included:

- Review of pharmacy procedures & training within dispatch
- Improved labelling of shelves
- Clearer labelling of bottles for IV and oral
- New oral product purchased
- Implement spot checks on ward boxes, and second checks of picking lists against stock
- Review and further development of error reporting
- Implementation of staff feedback and engagement sessions, with a view to sharing and improving practice
- Amendment of medicine order form to include 'route'
- Review of potential parallel scenarios.

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Type of Medicines in Incidents

The following charts record the type, categories and stage of medication processes involved in an incident and help target actions and distinct pieces of Pharmacy work

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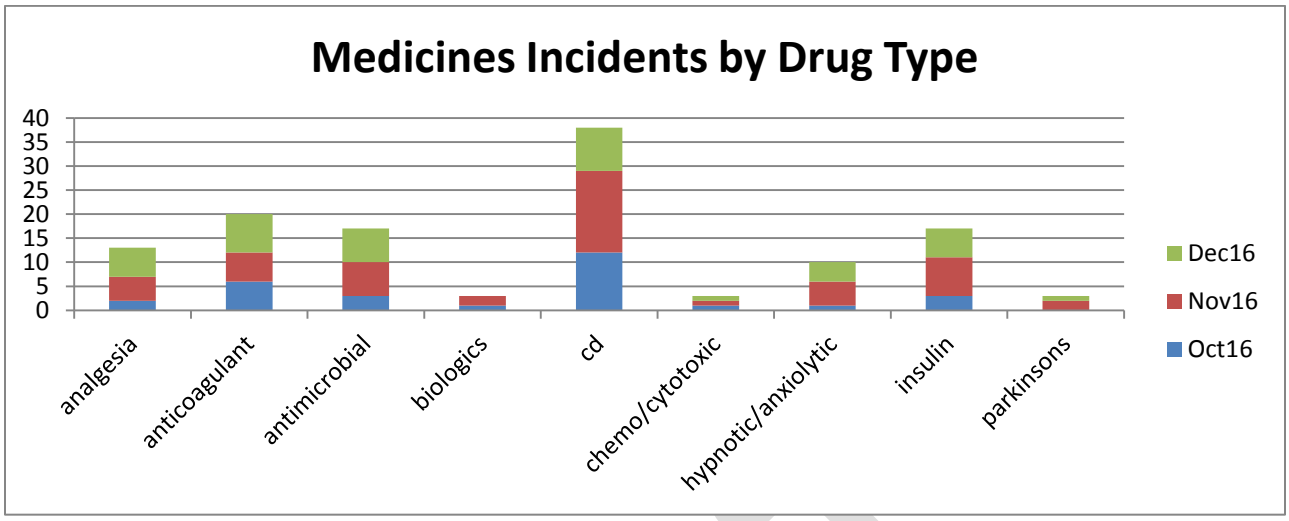
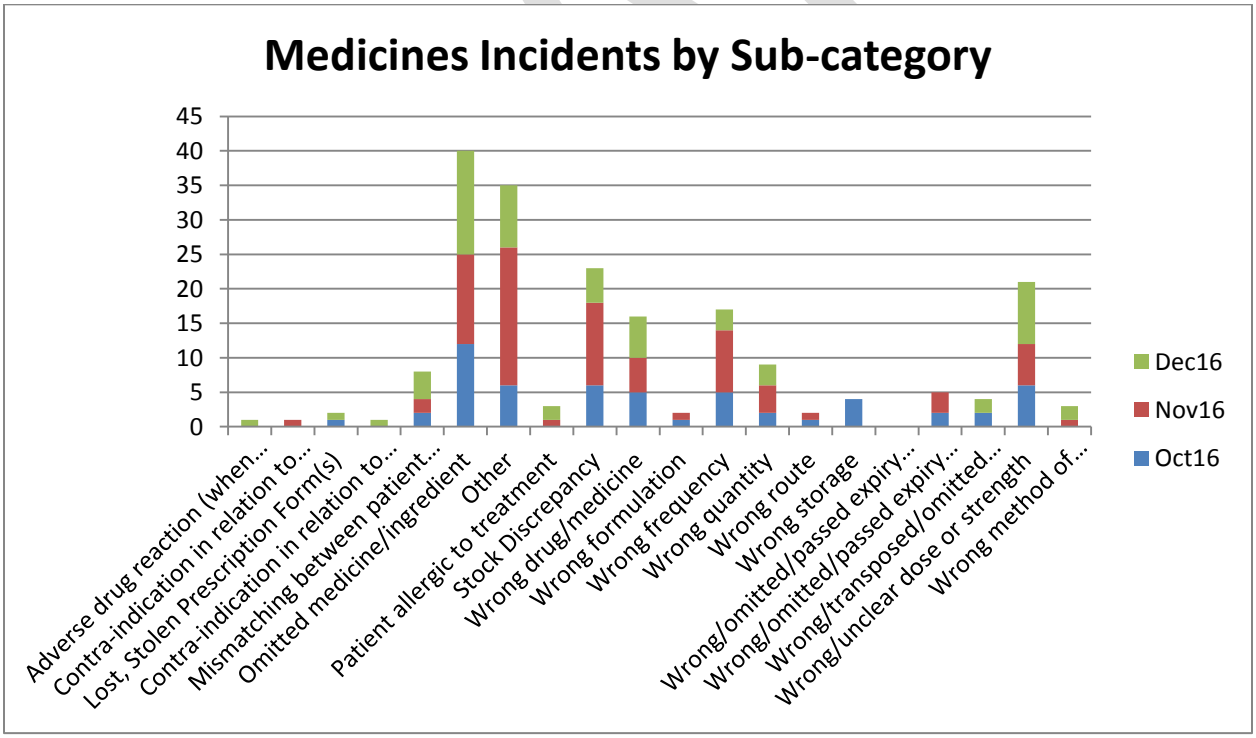


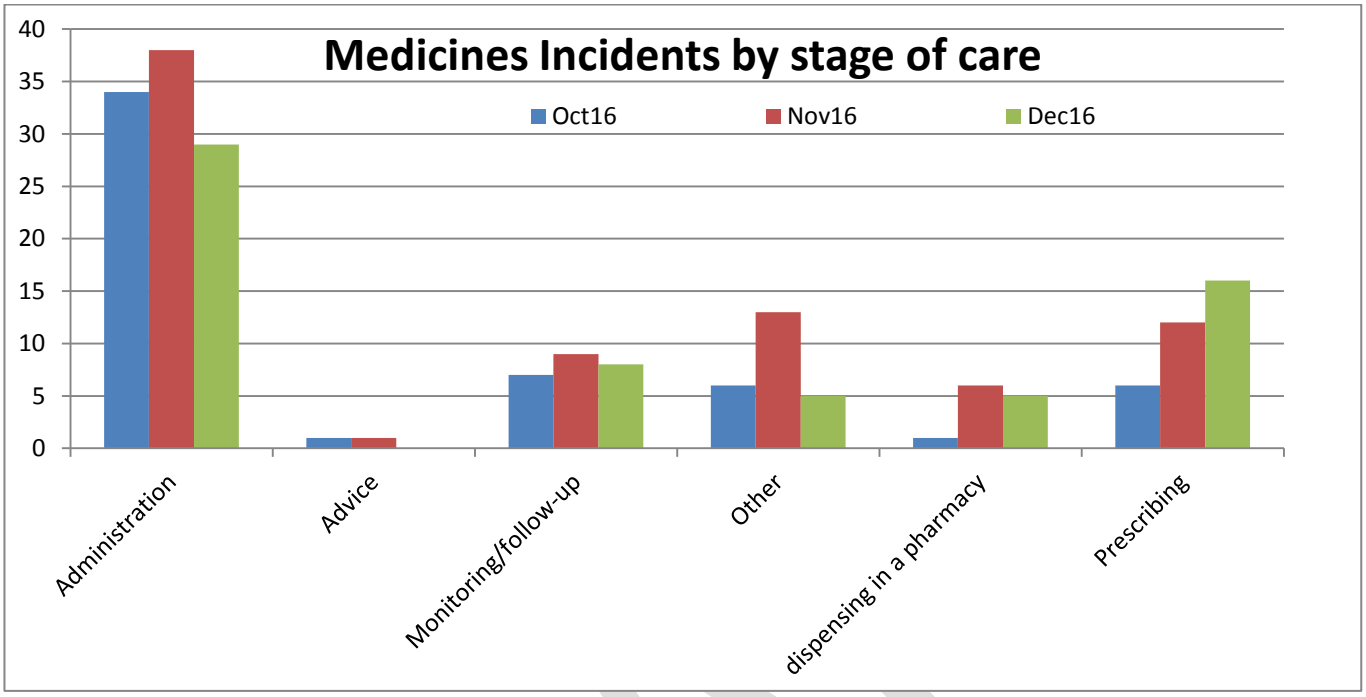
Controlled drug (CD) incidents are mainly stock discrepancies highlighted by the daily checks and documentation issues with syringe drivers. The syringe driver incidents are reviewed with Medical Electronics to ensure any training needs are met.

Categories of Medicines Incidents



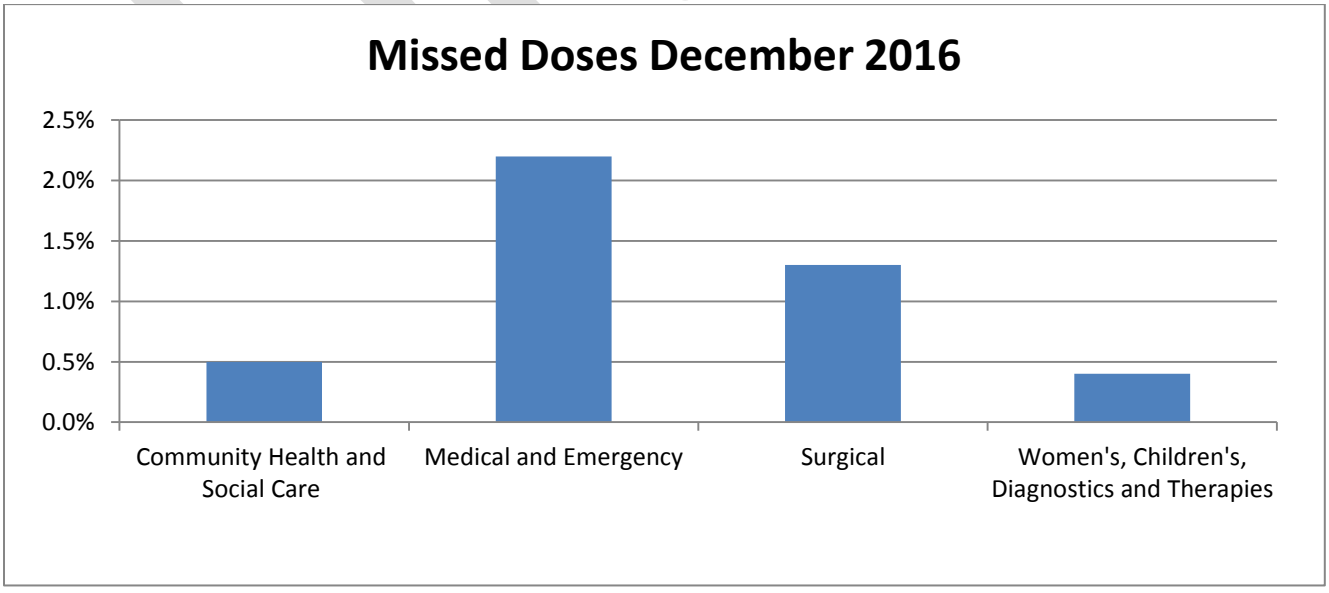
The most frequently reported types of medication incidents to the NRLS involve the wrong dose, omitted/delayed medicines or the wrong medicine. Our top three are omitted/delayed medicines, stock discrepancies and wrong/unclear dose or strength.

Looking at the incidents by stage of care shows that the majority of incidents involve administration or prescribing issues. The "other" incidents were mainly documentation errors which do not fit into the categories available.



Missed Doses

Each ward is audited weekly by sampling 10 drug charts and recording the number of potential doses and the number of missed doses. December 2016 is the first month of the new Trustwide audit system. Total compliance in all Service Delivery Units was at a very reassuring compliance rate of 98.8%. Where a missed dose does occur these are fed back to the area.



Medication: Some of the Key Action areas for 2017

Key Areas of Concern	Action	Date Due	Responsibility
High risk medicines	DOAC guidelines being drafted VTE prophylaxis in lower limb POP patients.	Feb 17 Feb 17	Haematology Haematology, A/E Orthopaedics
Administration procedures	In progress with Quality Improvement support. EPMA will impact.	On-going	Medicines Safety Group
CD incidents	ADNs & Matrons to work with their staff on daily checks.	Mar 17	ADNs
Prescribing	EPMA implementation	End 18	EPMA Team
Missed doses	Reports from new audit system to be sent out to ward managers.	Feb 17	Medicines Safety Group & Clinical Pharmacy Team
Syringe drivers	Review of syringe driver incidents with MDSO.	Mar 17	Medicines Governance Team & MDSO

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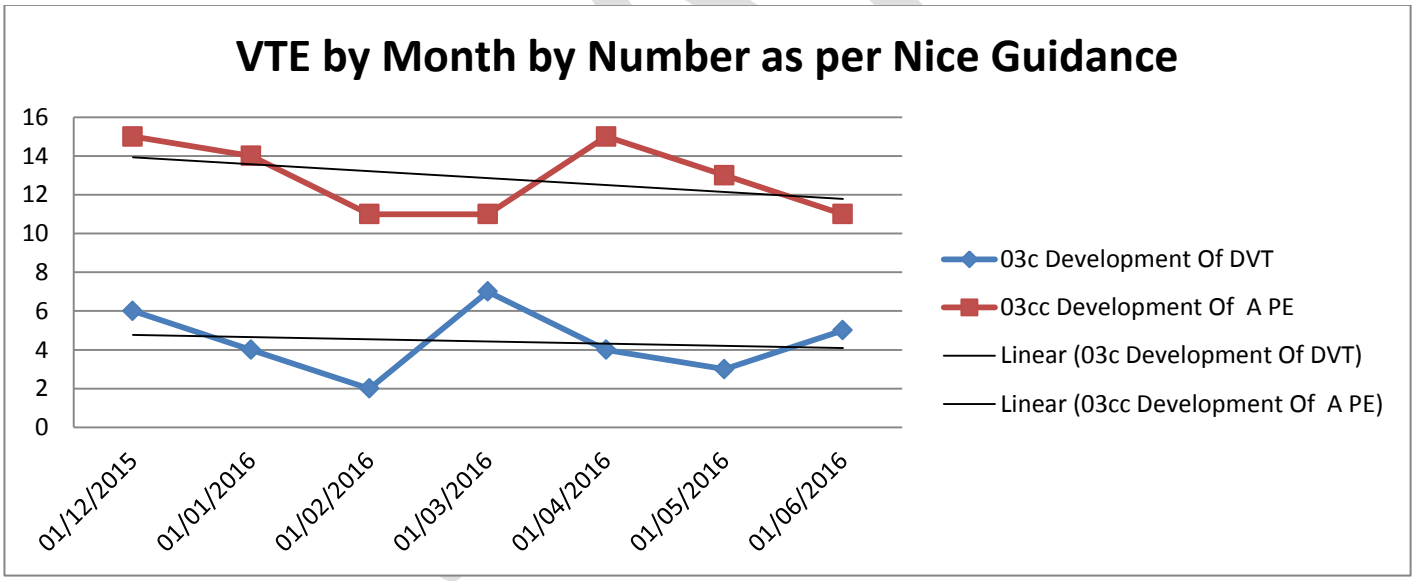
Appendix 7
Trustwide Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) Dec 2015 to June 2016

The National VTE Prevention Programme in England incorporates standardised guidance on risk assessment and thromboprophylaxis with a requirement for root cause analysis (RCA) of all episodes of hospital-associated thrombosis (HAT), defined as any VTE event occurring whilst an inpatient or within 90 days of discharge following an inpatient stay of at least 24 hours, or following a surgical procedure under general or regional anaesthesia.

The VTE team are notified of positive VTE scans through the radiology reporting system. This relies on someone manually going through the list of all VTE scans, firstly identifying the positive scans, and then manually checking IHCS for admissions in the preceding 90 days.

The VTE team has, until now, considered all admissions in the preceding 90 days including day cases that have not had a surgical procedure, i.e. patients attending the Oncology day centre for chemotherapy, blood transfusions and Endoscopy for investigations without intervention or biopsy. Therefore, the information presented today is for all patients, including these day cases and therefore the cohort is higher than the national requirement.



The number of RCAs completed between January 2016 and June 2016 was 99. This amounted to 150 admissions (if a patient attended as a day case on more than one occasion during this period, this is counted in the data as one admission). The general trend is slightly downward for the data available and where issues are identified – as below, the RCA and actions are shared with the relevant area / clinician.

Summary of underlying causes of inappropriate treatment

	Q1 Jan – Mar 2016	Q2 April - June	Total
Missed doses	**3**	**3**	**6**
Extended TP not prescribed	**1**		**1**
TOTAL	**4**	**3**	**7**

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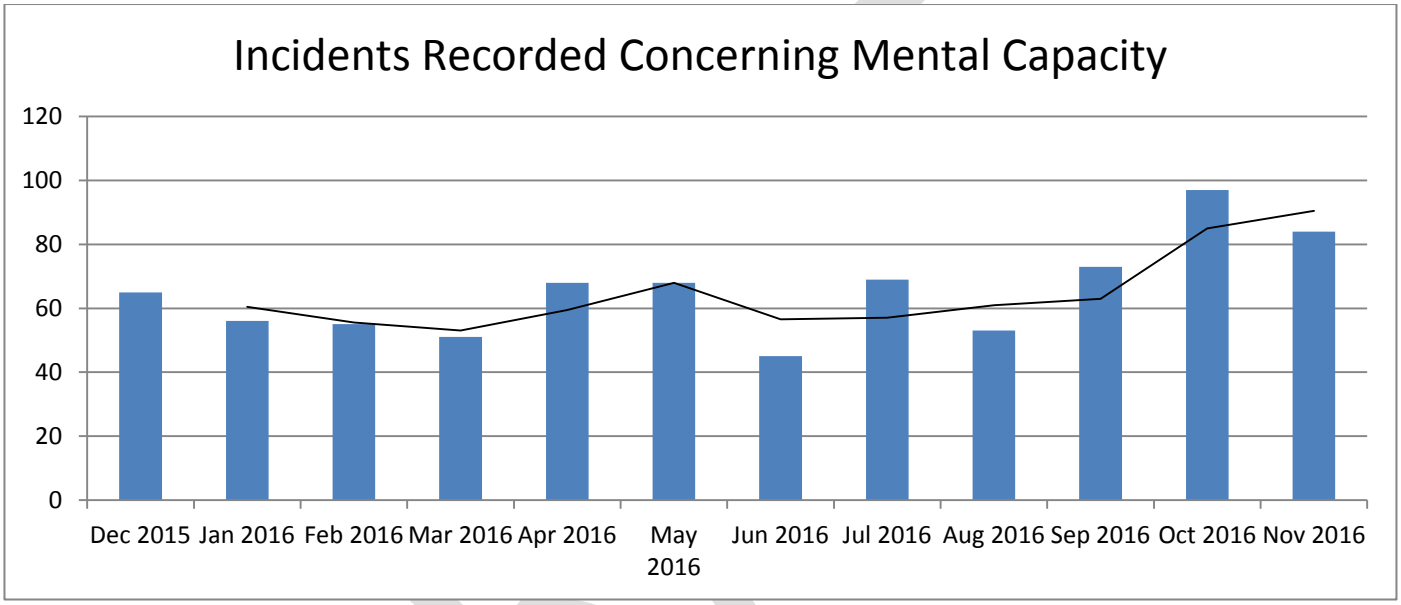
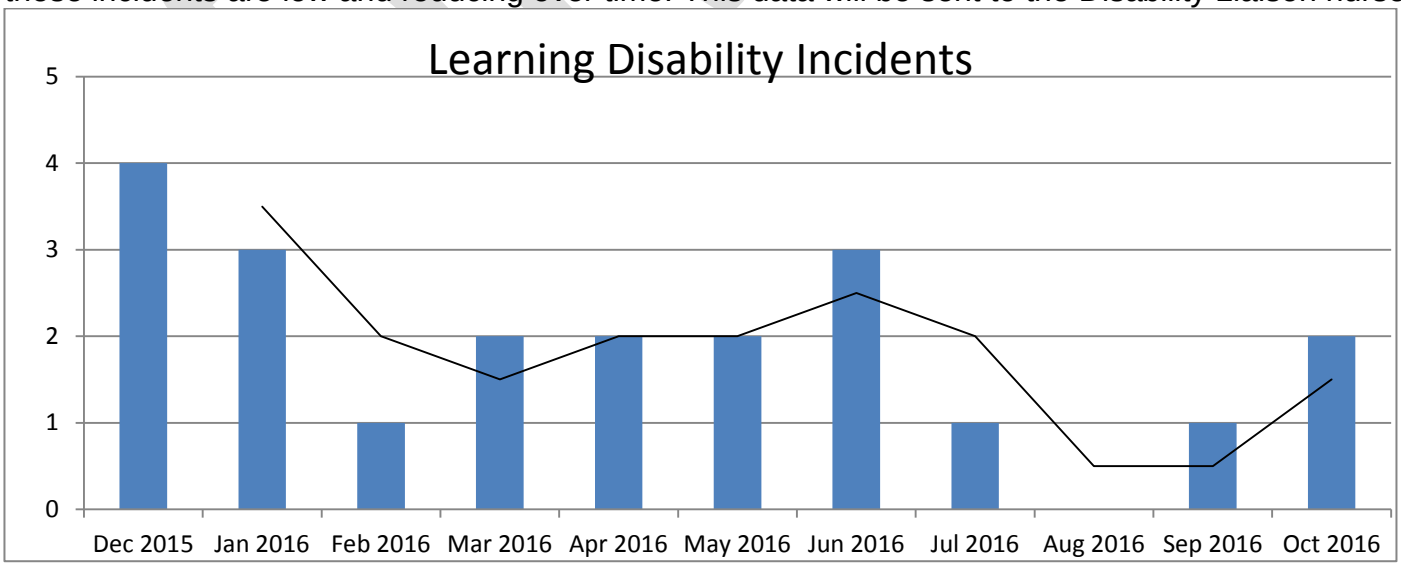
Appendix 8
Trustwide:
Mental Capacity, Learning Disability and End of Life Concerns

This data records incidents pertaining to Mental Capacity, Learning Disabilities and End of Life.

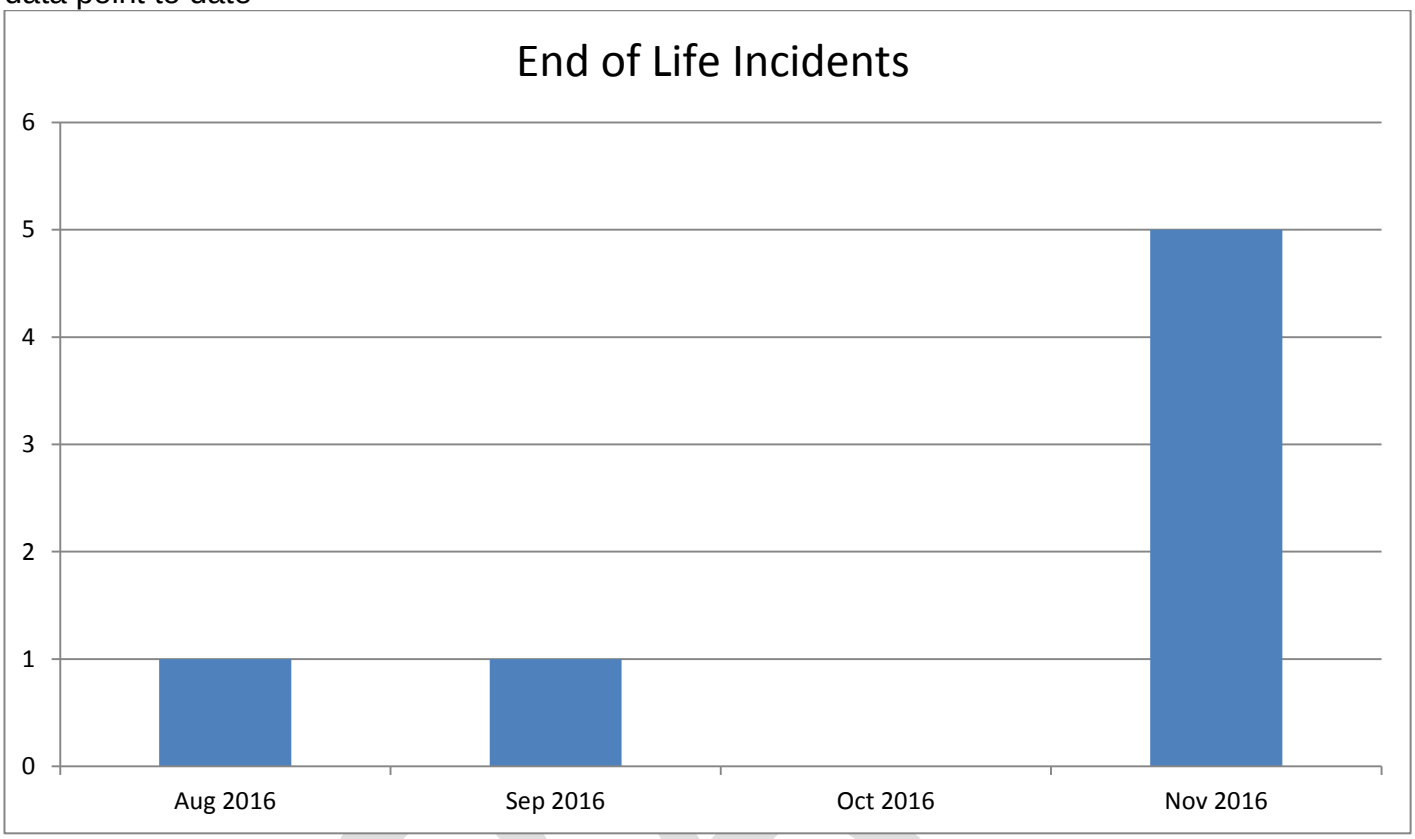
The first metric looks at all mental capacity issues, including concerns raised against patients whom we visit in all care sectors including residential and nursing home. These are largely concerns raised by us and managed by the Safeguarding team. The rise in number for the last two data points are due to the one incident system now recording all issues in one place.



The chart below records incidents concerning patients with learning disabilities. The numbers of these incidents are low and reducing over time. This data will be sent to the Disability Liaison nurse



The new Datix system has a new data set of codes for End of Life and these incidents are shared with the End of Life Group. This metric will be monitored closely over time as we only have one data point to date



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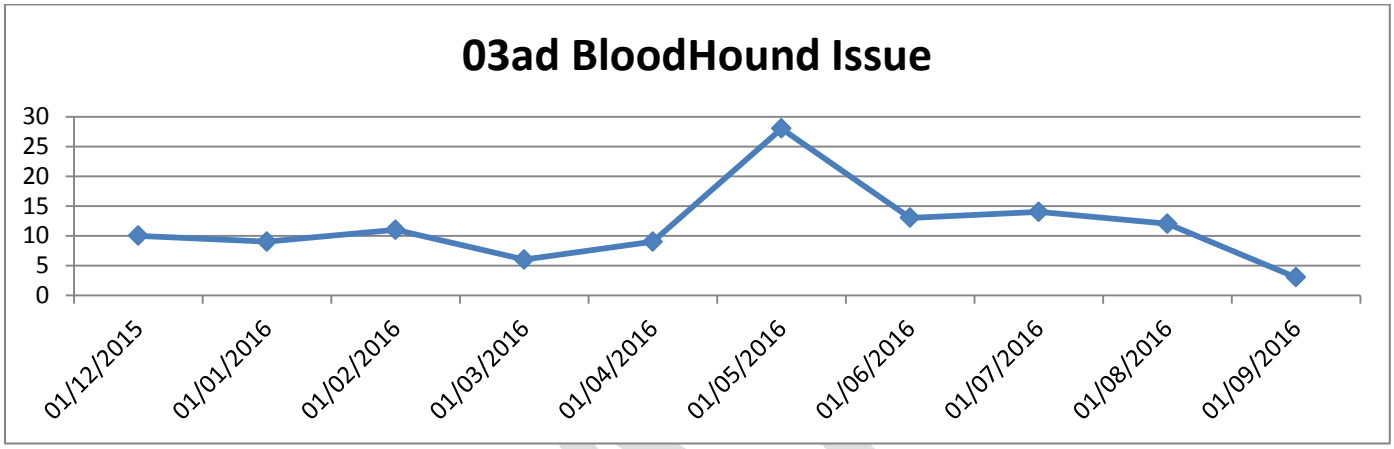
Appendix 9
Bloodhound

The electronic system for recording blood transfusions is closely monitored within the organisation and all administrative issues are stringently recorded as part the MHRA requirements.

All issues are reviewed by the Transfusion Practitioner and reported at the Blood transfusion committee.



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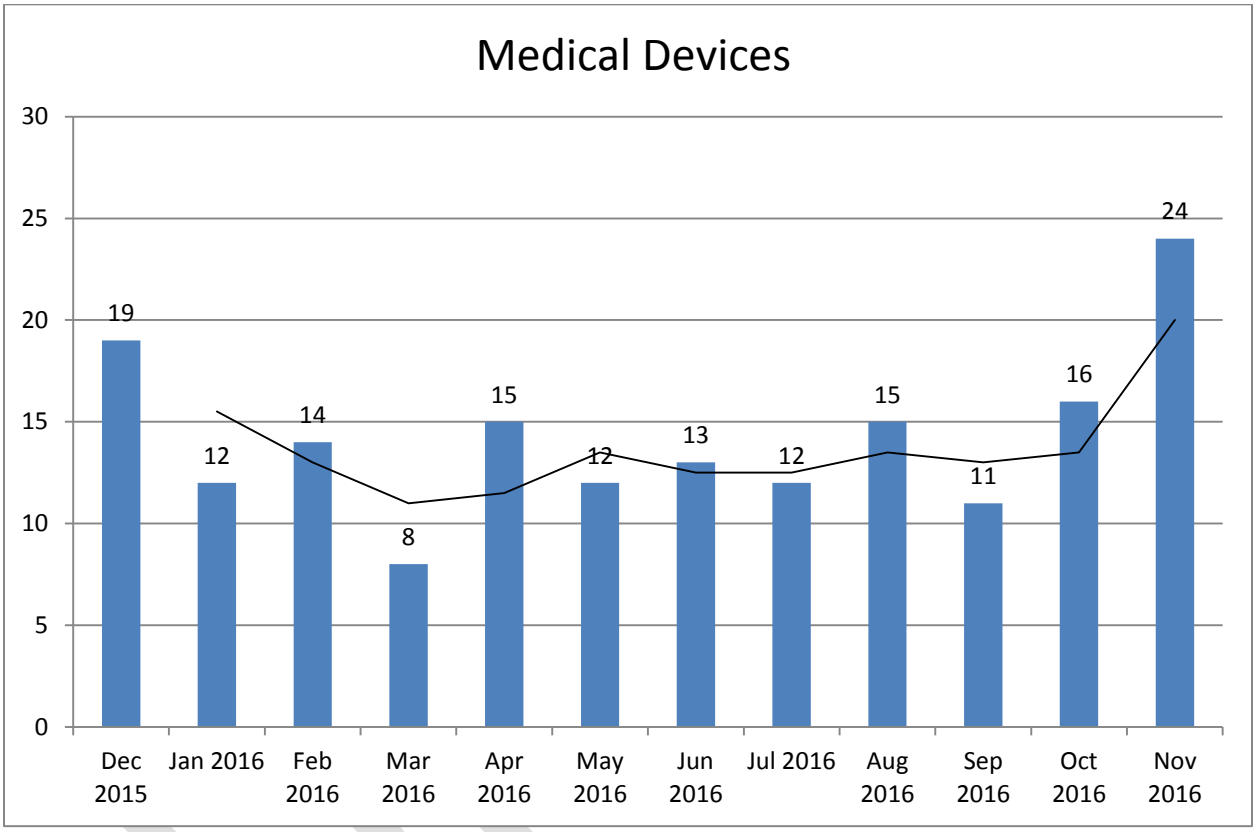
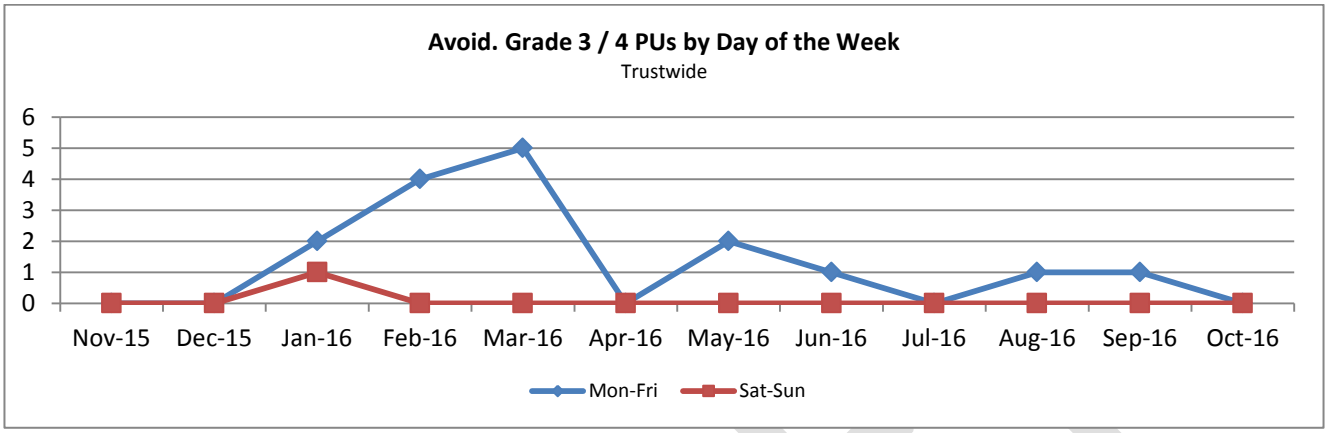
Appendix 10
Medical Devices

All incidents that involve a medical device are reported to Medical Electronics who review each incident from a medical devices perspective. The incidents are also reviewed by the Device Trainer who will look for trends, etc, and modify training accordingly. As with other metrics, November 2016 has seen an increase and this is due to the new one incident reporting system allowing for a Trustwide capture of information.



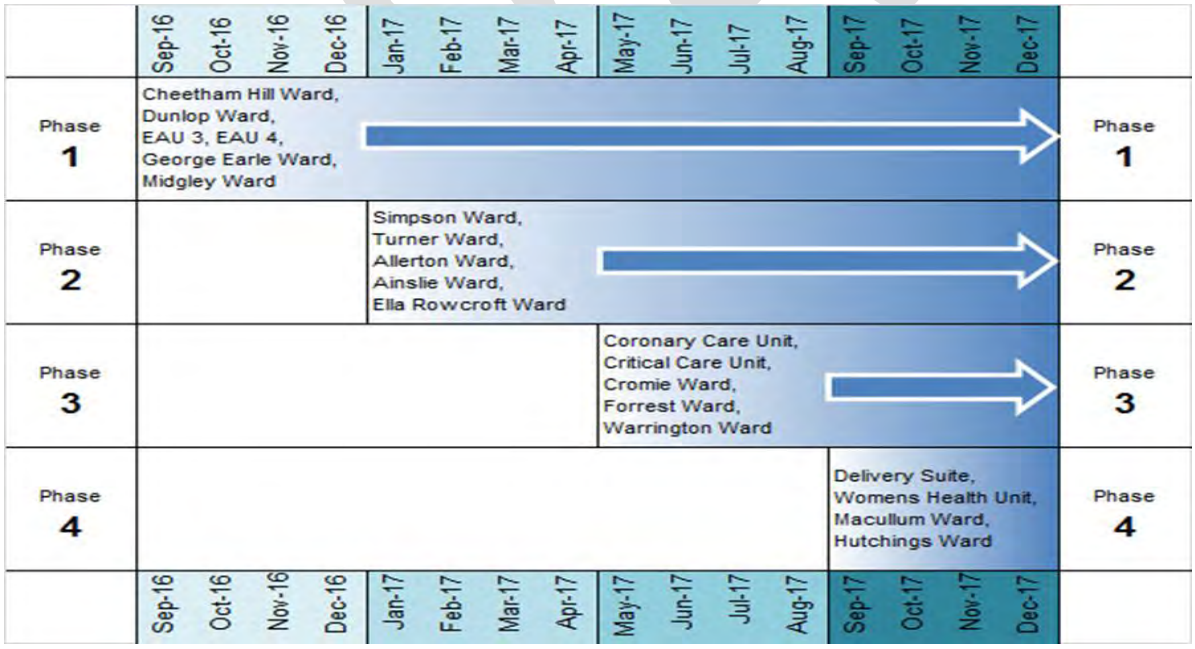
Appendix 11
Trustwide Pressure Ulcers

Pressure ulcers are an issue that affects our demographic population and is a focus of much work and many reports during the year. For this incident score this metric will look at the number reported of avoidable pressure ulcers of Grade 3 & 4 only and by a week/weekend perspective.



From the graph above the general numbers of avoidable pressure ulcers has fallen and with the exception of January 2016 none have occurred at the weekend.

Whilst many pieces of work continue with pressure damage prevention, the table below highlights the roll out of the Pressure Ulcer Prevention (PUP) work across the acute side of the organisation.



Appendix 12
Mortality

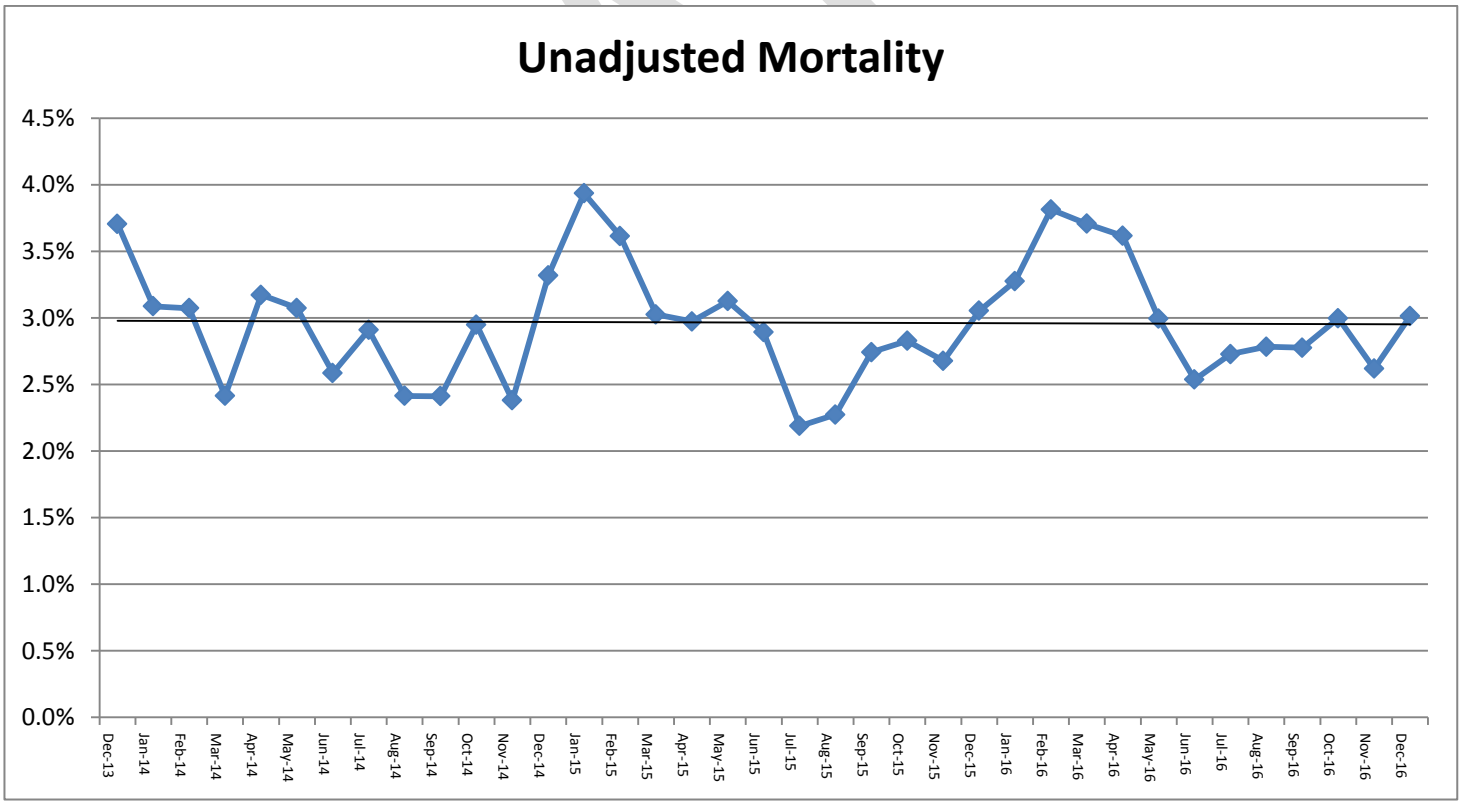
As a balancing measure this last section looks at mortality, both unadjusted (hospital data) and standardised through Dr Foster's Hospital Standardised Mortality rate (HSMR) data and the Department of Health's (DH) Summary Hospital Mortality Index (SHMI).

The hospital data is defined as the monthly unadjusted or 'raw' mortality and is computed as follows:
Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

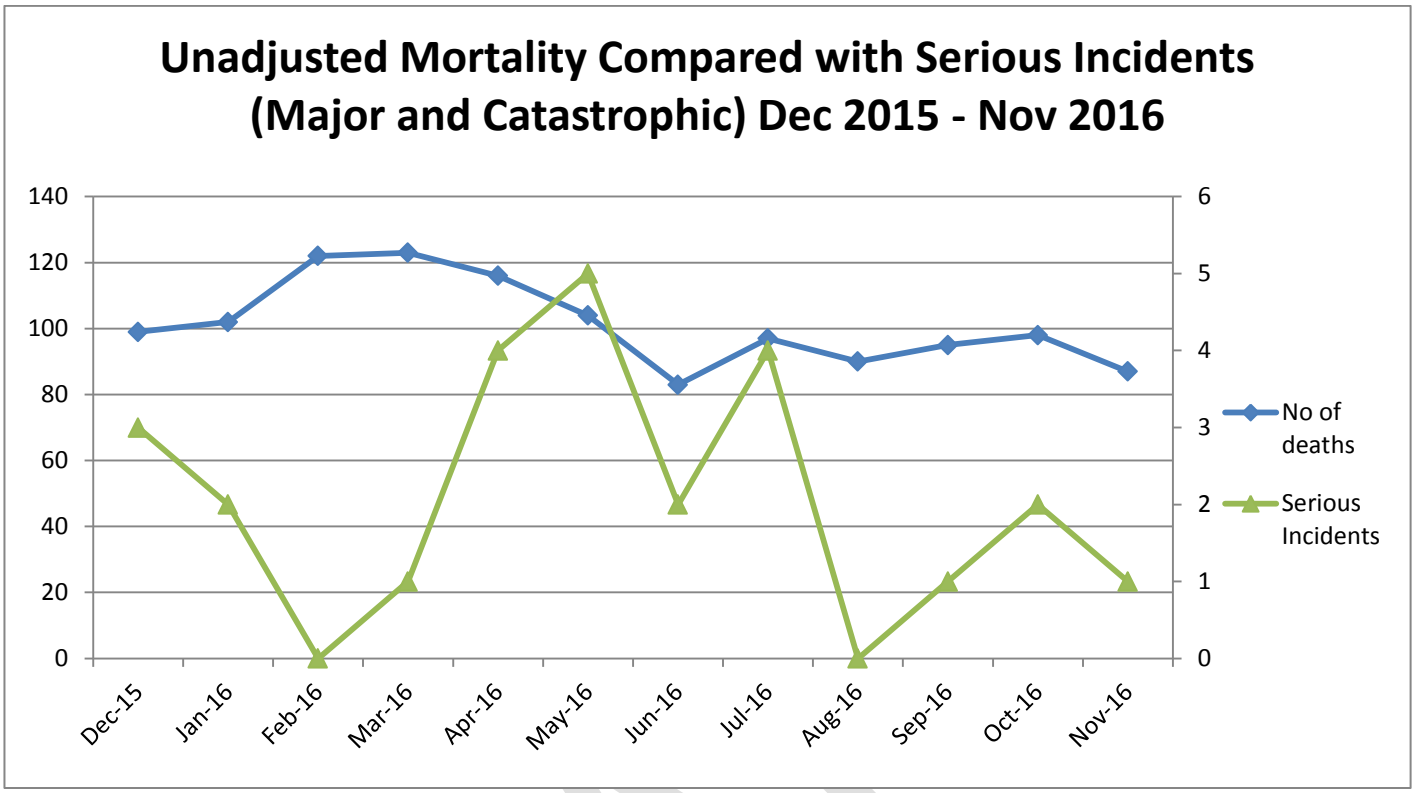
Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).

Calculate the actual percentage monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

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



Comment
Mortality is seasonal and more deaths are seen in the colder months of the year. Overall the trend is stable and slightly downward over time.

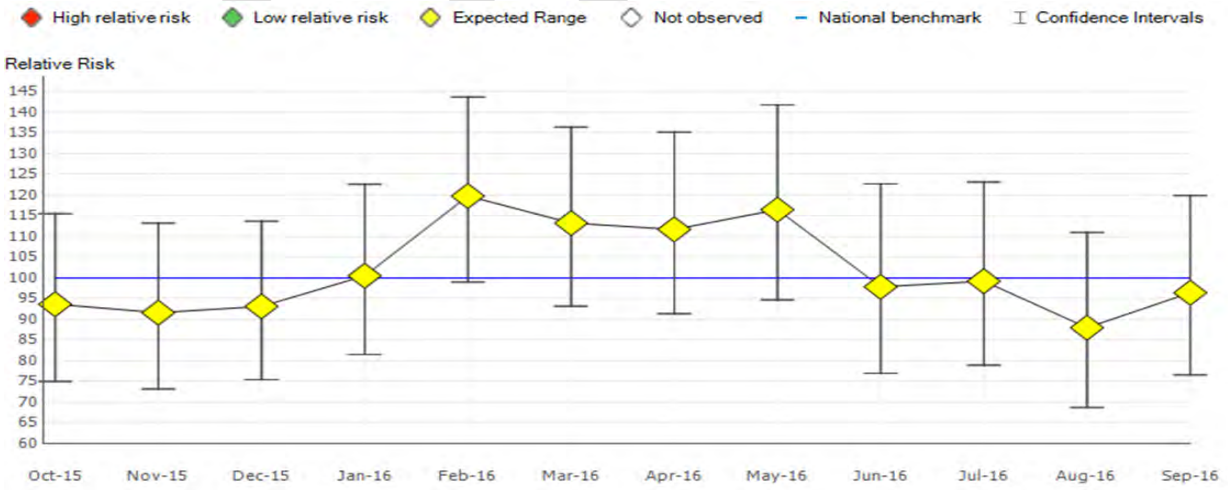


Taking our more serious incidents and comparing to hospital mortality no correlation is evident.

Hospital Standardized Mortality Rate (HSMR)

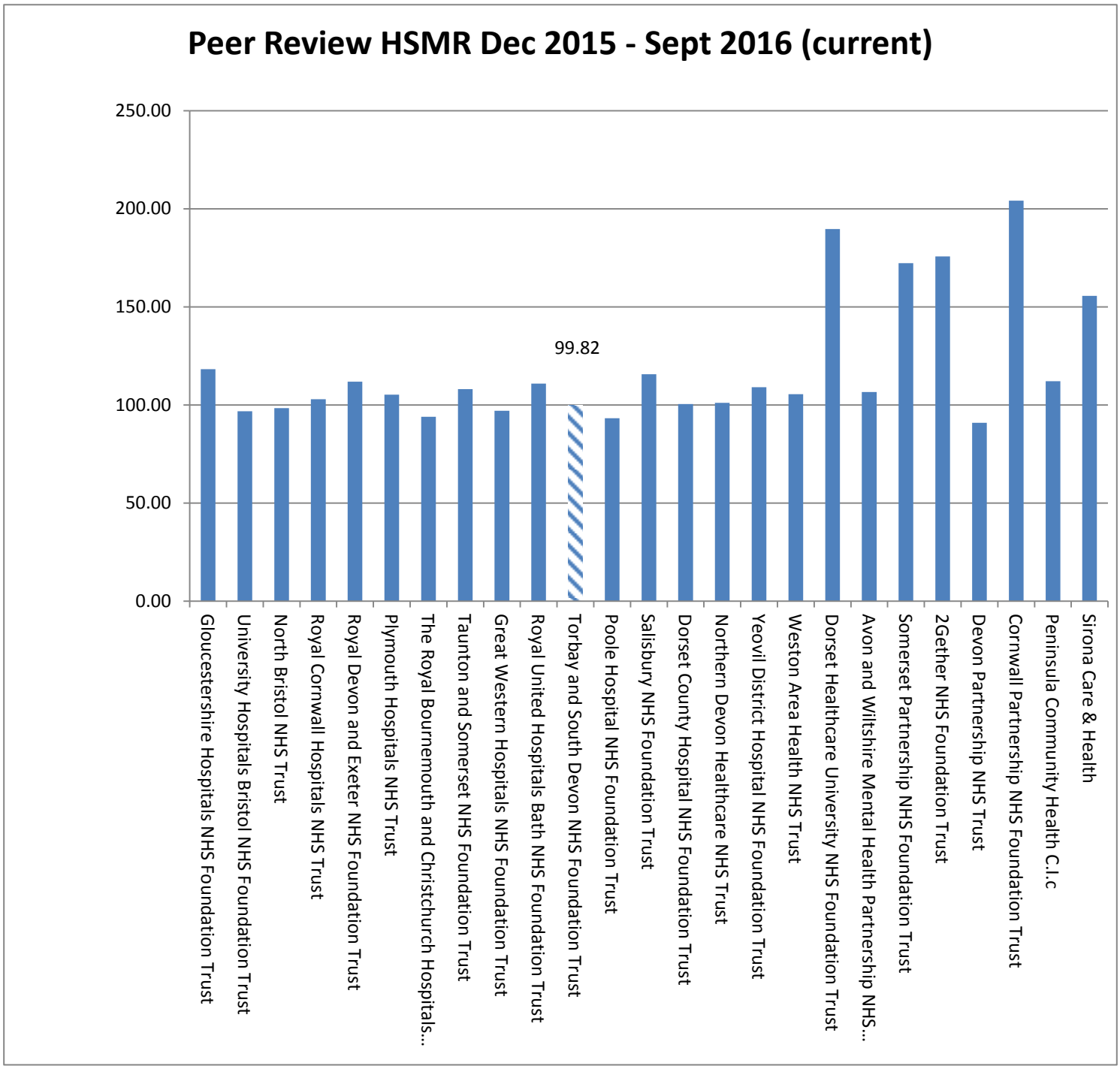
The HSMR is calculated using various methods involving deprivation scores, the Charlson index, and co-morbidity index and allows for a perspective that is comparable across the NHS in England.

The chart below shows Trend by Month over the time period Oct 2015– Sept 2016 using the benchmark data from July 2016 and HSMR basket of 56 diagnosis groups.



All the data points in this chart are within the expected range.

When looking at the peer review in Dr Foster for the data period Dec 2016 – Sept 2016 (current). Our Trust is just below the average line.

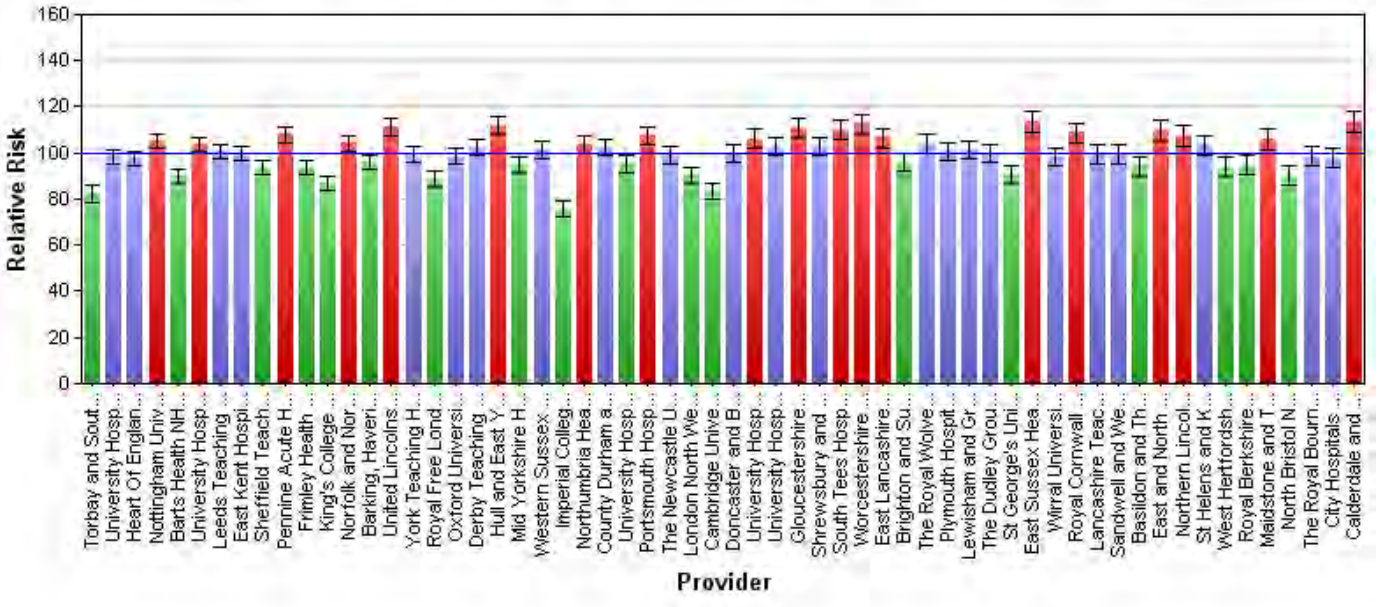


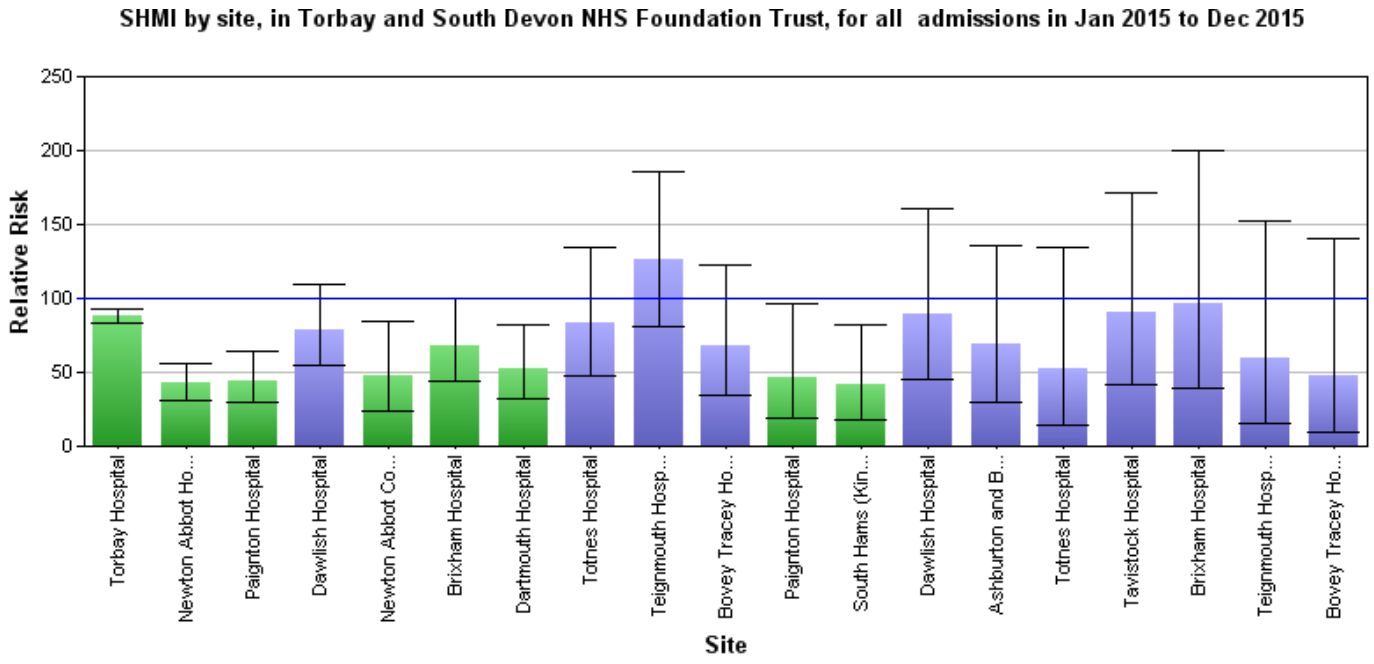
Summary Hospital Mortality Index (SHMI)

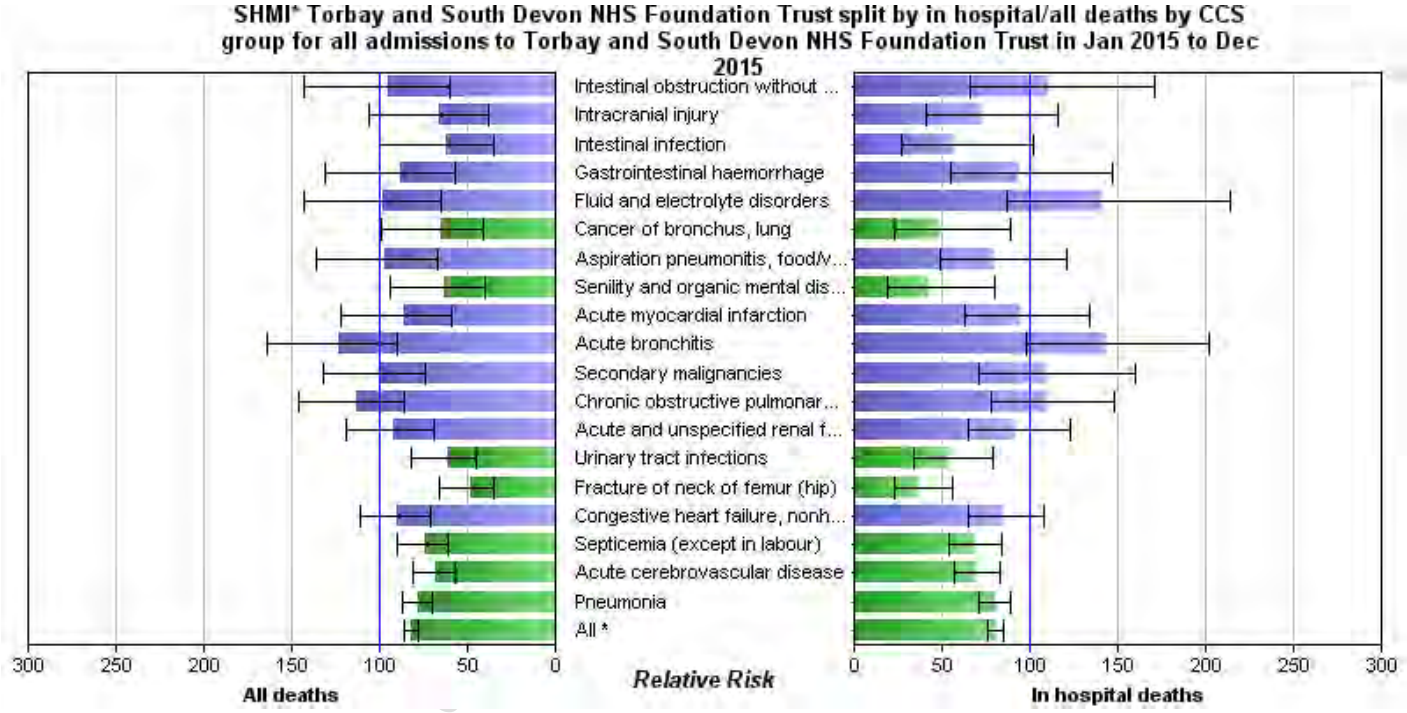
SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR.

The following data is from ***Jan 2015 - Dec 2015*** and will be very different from the dates used on Dr Foster's HSMR.

SHMI by provider (all non-specialist acute providers) for all admissions in Jan 2015 to Dec 2015







All of the SHMI data is showing the Trust well within normal limits.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
Title:	The Opportunities for Increase in Undergraduate Medical Training at Torbay and South Devon FT
Lead Director:	Medical Director
Corporate Objective:	3. Valuing our workforce 4. Well led
Corporate Risk/ Theme	3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

The Secretary of State has announced 1500 additional national training places in undergraduate medical studies in recognition of workforce shortages. The additional places will be funded from September 2018, with impact on the workforce likely in 2023 and beyond.

At present we provide Year 5 training for the last students from the Peninsula Medical School and will provide year 5 training for students from both University of Exeter and Plymouth University Medical Schools from August 2018.

Both medical schools have approached us with regard to our willingness and capacity to provide training for increased numbers of students and to increase our coverage to years 3, 4 and 5.
We have expressed willingness to support such an increase in principle. The medical schools expect to have to make firm bids for additional places in February or March 2017 and to learn whether they have been successful in the summer of 2017 (the timetable has not been announced).

Key Issues/Risks

1. This request is at a time of great demand on our clinical teachers and significant vacancies. There is the possibility of using our non-medical teachers to a greater extent, increasing development opportunities for groups in addition to medical staff.

2. At a time of financial austerity, there is some risk associated with taking on additional training but also potential for significant income.

3. Increase in medical training profile is likely to be beneficial in terms of recruitment of medical personnel, junior and senior. We are more likely to be able to benefit from academic appointments at the medical schools as a result of the expansion.

4. If we do not increase our training numbers we may lose further ground in relation to other providers. This would have adverse reputational, financial and workforce effects.

5. The present plan is to provide training for students from both medical schools. If we increase our numbers of students, maintenance of 2 training programmes is likely to become unduly onerous.

Recommendations

The Board is asked to consider the detailed paper outlining the SWOT analysis of increasing medical student numbers and to

1. Support an increase in training places at TSDFT should either or both of the medical schools be offered additional places from 2018.

2. Consider the benefits or otherwise of continuing with medical students from both medical schools versus consolidating with increased numbers with one medical school. Detailed consideration of one medical versus the other is not appropriate at this stage as no formal bid has been made by either.

Summary of ED Challenge/Discussion:

The Executive team recommends that the Board support the principle of increasing undergraduate training at TSDFT. A detailed financial analysis will be required.

A process for determining whether to proceed with students from both medical schools or one needs to be agreed. Subsequently a process allowing a decision about which medical school to support may be required depending on awarding of places.

Internal/External Engagement including Public, Patient and Governor Involvement:
None

Equality and Diversity Implications:
None

Public

Torbay and South Devon NHS
NHS Foundation Trust

Medical Education Undergraduate Programme – Current Delivery and Future options.
January 2017

1. Executive Summary

In 2016 the government announced that they were planning to increase student places by 1500 across England effecting 26 Medical Schools. The two local medical schools whom we are in joint partnership with currently are Plymouth University Peninsula School of Medicine & Dentistry (PUPSMD) and the University of Exeter Medical School (UEMS). Both medical schools have been in contact with the Trust since the government's announcement to discuss whether the organisation would have the capacity to increase student places and whether we would consider a sole partnership with one or the other medical schools to develop the future undergraduate programmes. This includes the opportunity to implement Year 3 and 4 programmes at Torbay as well as Year 5, which we currently deliver.

Both medical schools intend to bid for a significant increase in current numbers.

Current Medical School Numbers (Total Academic Year cohort):

PUPSMD – 86
UEMS – 130

There continues to be some uncertainty from the medical schools in relation to the process they will have to go through and timescales for bidding for these additional places. If normal process follows, medical schools will need to know final numbers by September 2017 for the UCAS process to start for students starting the programme in September 2018. There is some disagreement between Health Education England (HEE) and the Higher Education Funding Council (HEFCE) to whether the increase in numbers will be transitional – 500 per year over three years (HEE) or all 1500 from Year one (HEFCE). Currently the medical schools have not submitted any formal bids (as of 13thJanuary 2017) and are awaiting guidance. Both medical schools have expressed an intention to bid for more places. It is possible that both, one or neither will be awarded. Our willingness to take additional medical students is likely to factor for at least one of the medical schools in their ability to attract more students.

Postgraduate training Numbers

Another consideration is the addition of postgraduate training posts that would be required to train the additional medical graduates. This Trust may well benefit from additional training places (F1 – ST).

This paper is to:

a.) Provide information which will support the Board when considering whether the Trust is in a position and indeed wants to prioritise developing the undergraduate programme and increase student numbers.
b.) Provide the Board with an options appraisal for increasing student numbers, delivering medical student programmes for two medical schools (current plan) or one medical school (a sole partnership).

2. Background

The Trust went in to partnership with the Peninsula College of Medicine and Dentistry (PCMD) in 2006 to predominately deliver Year 5 (final year) undergraduate training for a proportion of their medical students under the Plymouth Locality as it was known at the time. PCMD was a partnership between the University of Exeter and Plymouth University to deliver undergraduate medical education training locally within the region. Delivery at the Trust increased over the years, starting with a small cohort of 8 students rotating between Plymouth and Torbay, growing to around 50 students being based at Torbay for their whole academic year. In addition to Year 5 the Trust also provides a number of shorter placements (2-3 weeks) for Year 1-4 students (approx. 30 per year).

In 2011 the Universities decided to go their separate ways and PCMD started its desegregation with the launch of the Plymouth University Peninsula School of Medicine and Dentistry (PUPSMD) and University of Exeter Medical School (UEMS). During the negotiations when the medical schools announced their split, this Trust agreed to deliver undergraduate training to both the new schools as part of the future arrangements. Within the legal document agreed between the Universities to manage the period of the desegregation, there was an agreement to send a nominated number of Year 5 students to Torbay as part of the future programme delivery – 30 from Plymouth and 20 from Exeter. This arrangement is due to be implemented from September 2018. 2017/18 will see the last cohort of Peninsula College of Medicine & Dentistry (PCMD) students in training, where there has been the agreement that this last cohort of PCMD Year 5 students will all be based at Torbay (Approx. 43 students). Following this there will be the introduction of the separate new schools programmes at the Trust from September 2018.

Regardless of any decision to enter a sole partnership or increase student numbers, there will be a period of time in the interim whereby we will need to work towards delivering Year 5 for both medical schools as any new arrangement e.g. Implementation of Year 3 and 4, will not come in to force until September 2020.

It must be noted that the Trust will require the resource to manage the transition to delivering two undergraduate programmes between 2017 and 2020 and whatever arrangement is decided for 2020 onwards

This is demonstrated below for clarity:

Academic Year	**Delivery**
2016/17	PCMD
2017/18	PCMD Last cohort

2018/19	PUPSMD & UEMS
2019/20	PUPSMD & UEMS
2020/21 onwards	To be decided Sole partnership with one school TBC Implementation of Year 3 & 4 in addition to Year 5 TBC

3. Student Numbers

Student Numbers by Year and Medical School – current plan

ACADEMIC YEAR	YEAR 5 PROGRAMME DELIVERY
2016-17	43 x PCMD
2017-18	43 x PCMD – RETURNING INTERCALATING STUDENTS – LAST PCMD COHORT
2018-19	30 x PUPSMD (NEW PLYMOUTH SCHOOL) 20 x UEMS (NEW EXETER SCHOOL) AS PER LEGAL AGREEMENT

NB. Student numbers fluctuate every academic year depending on a number of factors – the programme at the Trust is based on up to 50 students.

Factors effecting student numbers and why they fluctuate -

Overall cohort size
Number of students intercalating
Students failing or repeating
Student relocating due to personal circumstances

The major factor impacting on student numbers is students intercalating – in recent years this has increased in popularity with students and is available to the top 15-20% of top performing medical students in Year 3. Intercalation takes place between Year 4 and 5 of medical school. The last cohort of PCMD students due at Torbay in 2017/18 will be all intercalating students returning to programme for their final year.

Potential medical student numbers to consider –*Numbers shown are likely maximum. Numbers dependant on student numbers awarded to the medical schools. The flexibility in numbers accepted in Torbay would depend on which medical school was offering us additional places.*

Year	Student Numbers
3	30
4	30
5	50
Total	**110 (up from 50 currently)**

4. Funding

The Trust receives funding from HEE (Health Education England) for the delivery of undergraduate training, this income is known as SIFT (Service increment for training). Funding is tariff based per student so based on student numbers.

Current Funding breakdown

Funding Allocation	Funding
Teaching (all)	£748,948
Clinical Skills	£63,190
Library	£30,319
Clinical Sub Dean	£34,482
Management/Admin	£66,249
Overheads	£137,127
Cap Charges	£37,289
TOTAL	£1,117,604
Efficiency Saving	£26,605 (SIFT CIP contribution)
TOTAL FUNDING	**£1,091,517**

Please note the Teaching funding fluctuates year on year depending on student numbers. Funding above is based on 15/16 SIFT as we are awaiting confirmation of 16/17 SIFT funding.

The teaching money (top figure above £748,948) is funding that is allocated to divisions for teaching – see Year 5 funding model below. So far this Academic year a proportion of that funding has gone to the Trust 2016/17 CIP (approx. £600,000).

Funding is based on hours of delivery and the current rate for teaching is £108 per hour for a senior clinician.

It is worth noting that the purpose of the teaching money is to provide the relevant divisions with funding, in the recognition that some medical student teaching activity will slow down clinical activity and that some protected time is required. An annual SLA details the exact delivery each division has provided and funding associated with that delivery. Those in core roles who deliver a significant amount of training should have this recognised in Job Plans and this will be reviewed as part of the Job Planning review. This is essential to protect delivery and ensure the requirements of the contract are met (see section 5).

The SIFT income includes funding of the medical education team to support the programme and other teams – Clinical Sub Dean, Head of Medical Education, Project Support Manager, UG admin team, Clinical skills Team.

The funding for the medical school programmes is based on a tariff per student, therefore the more students the more income. Hence a lot of time and effort is spent on negotiating student numbers. There is no clarity as yet, about the payment per student for the additional places on offer.

If the Trust is in a position to increase student numbers there will be additional income per student placement (see Year 3 & 4 funding models below). If the medical schools receive a significant increase in student numbers and a large proportion of students are allocated to this Trust, the total income from undergraduate delivery has the potential to grow up to £3-4m.

Current role funding

Based on PCMD Funding Arrangements		
Role	**Funding**	
Clinical Sub Dean	£34,482	2 PA's Sub Dean + Block Lead time (approx. 2 PA)
NHS Liaison/Senior Mgr	£24,926	Band 8a (proportion of)
Admin	£41,293	
Total	**£100,701**	

Update on Role funding

University of Plymouth Peninsula Medical School (PUPSMD) will be increasing the role funding from April 2017 for 18 months as follows:

Additional 1 x PA for Clinical Sub Dean time – 3 PA's in total

Additional £20,000 for Senior Mgr time - £44,926 in total

This is based on the requirement for additional work associated with managing and implementing two programmes (e.g. increase in meeting attendance) during the 2017/18 academic year – PCMD and PUPSMD programmes.

Year 5 Funding Model (placements)

Per Placement Week	***Time (hours)***	***No.of Students***	***Price***
Placement	25.5	1	£108.00
Introduction & Learning Agreement	1	1	
Remediation	0.5	1	
Patient Based Presentation	4	5	
Practice Skills	0.9	1	
POISE	0.8	1	
Profession Judgement	1	1	
Total	**33.7**		**£3,639.60**
100% protected time	8.2		

Year 3 & 4 Funding Model (placements)

Per Placement Week	*Time (hours)*	*No. of Students*	*Price*
Placement	3.75	3	£108.00
SDL	1.5	3	
Introduction	0.5	3	
Clinical reasoning (Feedback/Assessment)	3	3	
Total	**8.75**		**£945**
100% protected time	**3.5**		

Green (DCC time) and White (protected) time

The activity highlighted 'green' represents the students time in the department hosted by a clinician or other health care professional, who is already receiving payment through their existing NHS contract to be there (e.g. operating list or clinic). This is DCC time in consultant job plans – there cannot be double payment if teaching occurs in these slots. Funding for this time is for the loss of clinical activity. This payment is in recognition that certain activities overrun or are reduced.

The activity in 'white' represents the student related activity requiring additional time over and above DCC / SPA NHS paid commitments. This represents 'protected' teaching, assessment time or specific teaching roles e.g. Academic Tutor.

5. Clinician Time to deliver Medical School activity

Year 5 Current Delivery time (based on 16/17 academic year for 43 students)

Activity	**Protected Hours**	**Unprotected hours**	**Total Hours**	***Notes***
Year 5 Placement	10578	36765	47343	Based on 30 placement weeks for 43 students (current numbers)
Year 5 SAP		693	693	Some prep time in addition
Year 5 Academic Tutoring		772	756	Relevant to specific Clinicians
Total Hours	**10578**	**38230**	**48792**	
Total PA's	**2645**	**9558**	**12198**	

Estimated Year 3 and 4 Delivery Time (based on having 60 students)

Activity	**Protected hours**	**Unprotected hours**	**Total hours**	***Notes***

Year 3 & 4 Placement	420	630	1050	Based on 3 x students for 10 weeks x 2
Year 3 & 4 Academic Tutoring	480		480	Relevant to specific Clinicians – based on 8 hours per student (10 AT's with 3 students)
Formal Teaching Programme	792		792	See below table for breakdown – this may not be all clinician time and may be delivered by other staff. Some prep time allocated in addition.
Total Hours	**1692**	**630**	**2322**	
Total PA's	**423**	**158**	**581**	

Estimated Year 3 and 4 Formal Teaching Breakdown

Activity	**Year**	**Hours**	***Notes***
Tutorial (Pathway specific)	3	74	
Tutorial (Pathway specific)	4	78	
Clinical Skills	3	48	Plus clinical skills team to support
Clinical Skills	4	48	Plus clinical skills team to support
Workshops	3	9	
Workshops	4	9	
Plenaries	3	20	
Plenaries	4	23	
Small Group	3	22	Delivered by Small Group facilitators
Small Group	4	22	Delivered by Small Group facilitators
Grand Round	3	13.5	Delivered by Bio-medical scientist
Grand Round	4	13.5	Delivered by Bio-medical scientist
SSU Core Teaching	3	8	May be delivered by core academic staff or SSU lead
SSU Core Teaching	4	8	
Total Hours		**792**	Please note this does not include prep time which will also be funded, this will vary per activity

Teaching preparation time has not been included as this is variable depending on teaching session type – this could be up to another hour per session – this will also be funded through the contract.

Clinical Teacher Leads

In addition to the above the medical school recommend the use of 'Clinical Teacher Leads' a voice on the ground for - supporting clinicians, representing the medical school, coordinating the programmes, ironing out issues and contributing to meetings/teaching. The time allocation for clinical Tutors varies depending on specialty, student numbers and activity (e.g. number of meetings) this could be up to 30 hours per year per lead but can be as little as 5 hours per year.

Approximate total 'protected' clinician time required: 3068 PA's (currently 2645)
(Based on delivering Year 3-5 for up to 110 students)
Clinical Sub Dean and clinical Teacher lead time would need to be added and teaching prep time where relevant.

6. Structure/Curriculum Requirements of the Programmes

The Trust has developed a successful Year 5 programme over the years receiving very positive feedback from the medical students who have been based here and the medical schools. Year 3 and 4 would be new ground for us, has a complete different set of requirements and will bring some challenges that will need consideration.

Year 5 Programme (Currently delivered)

The aim of year 5 is to prepare students for Foundation training (first years as a doctor). Therefore students are embedded in to the clinical team during their placements including the opportunity to 'act up' as an F1 (Foundation Year 1 doctor).

Students rotate through 5 clinical blocks of 6 weeks.

Students are split into groups of 8-10 and rotate through the clinical blocks. With anything from 1-3 students based within one clinical area at any one time.

Slot	Group A (9)	Group B (8/9)	Group C (8)	Group D (8)	Group E (8)
1	Medicine	Surgery	Immediate Care	Specialties	Community
2	Surgery	Immediate Care	Specialties	Community	Medicine
3	Immediate Care	Specialties	Community	Medicine	Surgery

4	Specialties	Community	Medicine	Surgery	Immediate Care
5	Community	Medicine	Surgery	Immediate Care	Specialties

During the clinical blocks students are required to undertake a number of workplace based assessments, the majority of which need to be signed off by a senior clinician. Students are allocated a clinical supervisor during their placements who is responsible for their activity and for completing a professional judgement at the end of placement.

All students come together for formal teaching on a Wednesday morning and this includes a combination of lectures, small group sessions and simulation training. The majority of the formal teaching is delivered by senior clinicians.

Year 3 and 4 Programmes (Not currently delivered – for consideration)

Typically students undertake 3-4 clinical pathways of 10 weeks each.

During each 10 week pathway students rotate through 10 x 1 week clinical placements.

Students rotate through each placement in groups of 3 students (30 students per Pathway).

Example Year 3 & 4 Rotation:

Pathway 1

Placements	WK 1	WK 2	WK 3	WK 4	WK 5	WK 6	WK 7	WK 8	WK 9	WK 10
Cardiology	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
Respiratory	Group 10	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9
Gastroenterology	Group 9	Group 10	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8
MAU	Group 8	Group 9	Group 10	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
EAU	Group 7	Group 8	Group 9	Group 10	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Emergency Medicine	Group 6	Group 7	Group 8	Group 9	Group 10	Group 1	Group 2	Group 3	Group 4	Group 5
T&O	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10	Group 1	Group 2	Group 3	Group 4
Stroke	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10	Group 1	Group 2	Group 3
Gynaecology	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10	Group 1	Group 2
GP	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10	Group 1

Students are based in both community and hospital placements.

Each placement week must consist of 1 x Induction session (with clinical supervisor – could be someone else in their place) 3 x scheduled clinical activities (e.g. clinic, ward, theatre – with any

health professional), 1 x SDL session (self-directed learning) and 1 x clinical reasoning session (assessment/feedback with the clinical supervisor).

Students can be timetabled together or separately for their clinical activities.

Students are in an observational capacity but are encouraged to support clinical activity if appropriate e.g. taking the history of a patient.

Formal teaching is provided every week as a whole group (similar to Year 5) and at times in a block week prior to the pathway placements (an additional week before the pathway starts).

There are some subtle differences between the PUPSMD and UEMS Year 3 and 4 programmes. For example - the PUPSMD programme is built on groups of 3 students and UEMS pairs of students. PUPSMD Pathways are designed as – Acute, Ward, Integrated Ambulatory Care and UEMS pathways are designed as Medicine, Surgery, Specialties and GP. Other differences may surface as programmes develop over time.

Both medical schools have said there is flexibility in the programmes and that they are keen to get our support for development of curricula reflecting the most unique clinical environments that our ICO affords. They have also offered support in the implementation.

Based on the potential number proposed we would be looking at running one pathway at any one time for up to 30 students in each year (Year 3 and 4) so up to 60 students in total. Therefore departments may only need to run their placement once or twice per academic year.

Academic Programme

The clinical pathways are supported by an academic programme consisting of Tutorials (pathway specific), clinical skills (Simman & communication), Workshops, Plenaries, Grand rounds, SSU teaching and Exploring professionalism.

Please see Section 5 for number of hours per teaching session for clinicians.

Tutorial – 1 hour expert led session related to the clinical pathway. Takes place in both the Foundation weeks and on academic days during the pathways.
Workshop – 1 hour session delivered on the academic days during the pathways.
3 themes – Clinical Humanities (Term 1), Medical Ethics (Term 2) and Population Health (Term 3).
Plenaries - 1 hour expert led session for the whole year cohort.
Take place during the Foundation weeks.
Small Groups – 2 hour sessions taking place on academic days – also known as exploring professionalism in Year 5.
Grand Rounds - 1.5 hour sessions on the academic days – presentation of 9 topics delivered by clinicians, students and biomedical scientists.
Clinical skills – 2 hour sessions during the Foundation weeks and academic days delivered by the clinical skills team.
SSU Core Teaching – designed to support the SSU placements e.g. Research, Management.

General requirements

Medical Education Team – current external funding via SIFT funds 1 x Clinical Sub Dean (2 x PA's), 1 x Senior Manager (Band 8a 0.5 of a post), 1 x Support Manager (Band 5 1 WTE), 1 x Programme Coordinator (Band 4 1 WTE), 1 x Admin Assistant (Band 3 0.6 WTE). The team provides multi-functions to the medical school and Trust to deliver the undergraduate contract.

Clinician time for supervision, assessment, etc. - Please see Section 5 for detail. Generally placements are supervised by senior clinicians but students can be supervised by other healthcare professionals depending on the specialty and placement. The current funding model is based on a senior clinician delivering certain activity e.g. assessments. However in some specialties it is recognised that other staff groups are more specialised to deliver particular assessments e.g. Midwives.

Horizon Centre – facilities for teaching, SDL, Medical Education Team, etc. A large proportion of the Undergraduate contract funded the initial build of the Horizon Centre and continues to fund this facility through the SIFT funding.

Academic Support - Students are each allocated an Academic Tutor to manage their educational needs – all Academic Tutors for the Torbay students are either our own hospital consultants or local GP's. Please see section 5 for detail of amount of clinician time. For 30 students approximately 10 Academic Tutors would be required based on each Tutor having 3 students each. So if we had 60 students (Year 3 & 4) and additional 20 Academic Tutors would be required.

Pastoral Support – currently we have two Pastoral Tutors (both senior clinicians) to support students whilst at Torbay. Generally responsible for signposting students to support services. This is a voluntary role and we are not funded specifically for this. The numbers of pastoral Tutors may need to increase perhaps up to 4 Tutors if we had additional students.

Year 5 Students have access to hospital counselling services who work closely with the University Student Support teams through Occupational Health and this would need expanding to Year 3 and 4 students.

Accommodation - Year 5 students live onsite in the hospital accommodation – we would need to consider future accommodation options is there was an increase in student numbers. Please see Section 7 on Accommodation.

It must be noted that both medical schools are currently redesigning their programmes including an increase in student exposure to community placements, in line with national initiatives to increase medical roles in the community. Therefore the ICO would be perfectly placed to support this.

Annual Academic Timetable (Year 3-5)
Showing how the programme run alongside each other

PUPSMD Version for 2016/17

	W/C	UoP Week #	PT	BMBS YR 3			BMBS YR 4			BMBS YR 5
	31.07.2017	1								
	07.08.2017	2								
	14.08.2017	3								ELECTIVE
	21.08.2017	4								
Summer BH	28.08.2017	5								
	04.09.2017	6		Induction / Pathway 1 Foundation Wk			SSU (MHL1)	SSU (M1)		
	11.09.2017	7		CLINICAL PATHWAY 1 10 weeks		1	Introduction / Pathway 4 Foundation Wk			
	18.09.2017	8				2	CLINICAL PATHWAY 4 10 weeks		1	
	25.09.2017	9				3			2	
	02.10.2017	10				4			3	
	09.10.2017	11		SSU (Research) 1	SSU (Drs as Educator 1)				4	INDUCTION
	16.10.2017	12	PT	CLINICAL PATHWAY 1 10 weeks		5			5	1st 5 WEEK BLOCK
HT	23.10.2017	13				6			6	
	30.10.2017	14				7	SSU (Special Environments) 2 weeks			
	06.11.2017	15				8				
	13.11.2017	16				9	CLINICAL PATHWAY 4 10 weeks		7	
	20.11.2017	17				10			8	PROF PRACTICE / STUDENT ASSISTANTSHIP
	27.11.2017	18		Pathway 2 Foundation Wk					9	2nd 5 WEEK BLOCK
	04.12.2017	19		SSU (Working Together) 2 weeks					10	
	11.12.2017	20					Pathway 5 Foundation Wk			
	18.12.2017	21		CLINICAL PATHWAY 2 10 weeks		1	CLINICAL PATHWAY 5 10 weeks		1	
	25.12.2017	22		VACATION			VACATION			VACATION
	01.01.2018	23								
	08.01.2018	24	PT	CLINICAL PATHWAY 2 10 weeks		2	CLINICAL PATHWAY 5 10 weeks		2	2nd 5 WEEK BLOCK
	15.01.2018	25		SSU (Research) 2	SSU (Drs as Educator 2)				3	PROF PRACTICE / STUDENT ASSISTANTSHIP
	22.01.2018	26		CLINICAL PATHWAY 2 10 weeks		3			4	3rd 5 WEEK BLOCK
	29.01.2018	27				4			5	
	05.02.2018	28				5			6	
HT	12.02.2018	29				6			7	
	19.02.2018	30				7			8	
	26.02.2018	31				8			9	PROF PRACTICE / STUDENT ASSISTANTSHIP
	05.03.2018	32				9			10	PREPARING FOR PRACTICE
	12.03.2018	33	PT			10	Pathway 6 Foundation Wk			4th 5 WEEK BLOCK

Formative KT Year 1	19.03.2018	34	KT	Pathway 3 Foundation Wk		SSU (MHL2)	SSU (M2)		
	26.03.2018	35		VACATION		VACATION			
	02.04.2018	36							VACATION
	09.04.2018	37		SSU (Research) 3	SSU (Drs as Educator 3)			1	4th 5 WEEK BLOCK
	16.04.2018	38		CLINICAL PATHWAY 3 10 weeks		1	CLINICAL PATHWAY 6 10 weeks	2	
	23.04.2018	39				2		3	PROF PRACTICE / STUDENT ASSISTANTSHIP
	30.04.2018	40				3		4	5th 5 WEEK BLOCK
May Day	07.05.2018	41				4		5	
	14.05.2018	42				5		6	
	21.05.2018	43	PT			6		7	
Spring BH & HT	28.05.2018	44	KT			7		8	
	04.06.2018	45				8		9	PROF PRACTICE / STUDENT ASSISTANTSHIP
	11.06.2018	46				9		10	
	18.06.2018	47				10	ISCE		
	25.06.2018	48		Panels and Boards			Panels and Boards		Panels and Boards
	02.07.2018	49							
	09.07.2018	50	KT				PHASE 2 ISCE		

7. Student Accommodation

The Medical Education department and General Services department at Torbay Hospital have an SLA agreeing the provision of a number of rooms each academic year for medical students undertaking placements at Torbay. Currently 40 rooms are reserved on site for students. This is based on the assumption that some students will choose to live at their home location. Each year the SLA is reviewed and the number of rooms provided re-negotiated. The SLA runs from 1st September to 30th June each academic year (10 month contract).

The agreement is that for the rooms to be reserved and guaranteed during the academic year, the Medical Education department fund all void periods where the rooms are not used. This is funded via the current SIFT allocation and funds transferred to the General Services Department throughout the financial year.

All students are allocated the new residences accommodation which is of a higher quality than accommodation that was previously allocated at Kitson Hall, where accommodation is no longer available.

On the occasion whereby demand exceeds the number of rooms reserved, General Services will allocate additional rooms if available but this cannot be guaranteed.

The cost of accommodation is subject to a rental review each year and usual increase in line with inflation.

Students pay themselves per night but in circumstances where they wish to keep the room to hold belongings e.g. over a weekend prior to returning to the Trust, they will be required to pay the full cost.

During the 10 month contract Medical Education covers any cost of void periods e.g. breaks in the academic timetable or placements, rooms not used, etc. so General services are not making a loss when they could be renting out the rooms to other staff groups. The cost of any void period comes from within existing SIFT funding and will need to be reviewed in line with any changes to funding.

Average void period cost (Paid by Medical Education SIFT): £4.5K per month peaking to £12K in September.

Income from medical student accommodation

This is the income General Services receive direct from medical students for accommodation. The void period payments are transferred in addition from medical education to General Services.

40 x Rooms @ £397.97 per month

32 student weeks (Year 5) x £397.97 x 40 students = **£509,401.60 per Year**
(Assuming all 40 rooms are used across all 32 student weeks).

Please note the exact income figures will be held by General Services.

We would need to consider the options for additional accommodation if we had an increase in medical students – taking in to account it is purely down to the individual choice of the student to whether they live on site at Torbay, live at home or commute from their base University.

Accommodation Options:

- Increase current on-site accommodation as per the current arrangements
- Re-development/New build of dedicated on-site accommodation
- Contract private rentals
- Leave accommodation arrangements to the student

8. Future options for Undergraduate Delivery / SWOT

- **Increasing Medical Student numbers/delivery**
- **Delivering programmes for two medical schools (current plan)**
- **Delivering programmes for a single medical school**

5.1 Increasing Medical Student Numbers/delivery

There are a number of considerations when deciding whether to increase undergraduate delivery or not. Perhaps the biggest risk of continuing as currently planned, is the fact that the medical schools may go elsewhere for a sole partnership arrangement. We have been informed that the medical schools are making enquiries with other Trusts outside the present provider group. **Any increase in delivery for this Trust would be for 2020/21 onwards assuming Year 1 of the increased student numbers starts September 2018 and get to us for Year 3 in 2020/21.**

SWOT – Increasing student numbers/delivery

STRENGTHS	**WEAKNESSES / CHALLENGES**
• Enhance teaching/Training Hospital reputation – we already have an existing excellent reputation for high quality education (UG & PG). • Attracting high calibre staff recruitment and retention perhaps with an academic interest. • Increased income (currently £1m, could be up to £3-4m) Student number dependant. • Future stability – maintain status as a training provider. • Increase input to programme design. • Strong community links through the ICO which improves our ability to place for students in the community. • Experienced clinicians already involved in teaching and education.	• Placement/teaching providers resource/capacity (Clinical). • Resource to deliver implementation (clinical and non-clinical). • Complex timetabling (specifically Year 3 and 4 programmes). • Accommodation (students). • Ability to identify education time in job plans to protect teaching and meet contract requirements. • Community capacity is a concern from both medical schools and this will need to be managed carefully with our GP partners. • Would require an increase in admin and management support – although this would be uplifted and funded via SIFT.
OPPORTUNITIES	**THREATS**
• Become an established and recognised teaching partner in the region, in our own right. • Active involvement in the future design and delivery of undergraduate training in the region • Greater student numbers = greater impact on future development, moving away from being a secondary provider linked to one of the larger sites. • Staff development opportunities e.g. academic fellowships linked to clinical posts • Attracting and developing future workforce. • Retention of high calibre staff • Increased training opportunities as	• Impact on staff (clinical and non-clinical) • Clinical services capacity (Hospital and community) • Facilities for teaching and training • Resource to deliver • Potential loss of current delivery and income if we make no change (e.g. Medical Schools making enquiries at other Trusts). • Potential impact on other partnerships e.g. research / clinical services

a result of the developing ICO. • Potential impact on other partnerships e.g. research / clinical services.	

5.2 Delivering programmes for two medical schools (current plan from 18/19)

STRENGTHS	WEAKNESSES / CHALLENGES
• Maintain partnerships with both Universities/Medical Schools • Differing academic timetables may ease capacity pressure. • Maintain income even with no increase in numbers	• Working for both medical schools for a small number of students will be complex – more resource for the same amount of students overall. • No real opportunity to expand future programme and influence UG training in the region • Working to two separate University policies and processes. • Separate academic tutors for students so manage the differing policies and processes. • Different IT systems. • Different paperwork e.g. assessment forms. • Different training requirements e.g. for clinical supervisors and Academic Tutors. • Two different sets of meetings/committees e.g. Curriculum development. • Small student cohorts – currently 20 for UEMS but could reduce further depending on student failures, intercalating, etc. • Increase in the management of exams due to different dates, processes, requirements, etc. • Managing two separate teaching programmes – team capacity, room availability (Horizon Centre). • Dealing with separate University teams. • Managing timetabling e.g. separate assessment requirements, separate deadlines, etc. • Clinicians and other staff would need to understand separate requirements, curriculum, etc.

	• Potentially could reduce our opportunity to expand.
OPPORTUNITIES • Build on opportunities from working with two Universities/medical schools	**THREATS** • Medical schools may decide to go in to sole partnership with another Trust and take our current student numbers away as part of that package • Loss of UG training status if the above happens

Potential scenario for this option

ACADEMIC YEAR	YEAR 3	YEAR 4	YEAR 5
18/19	0	0	20 UEMS / 30 PUPSMD
19/20	0	0	20 UEMS / 30 PUPSMD
20/21	30 UEMS / 30 PUPSMD*	30 UEMS / 30 PUPSMD*	20 UEMS / 30 PUPSMD

**Dependant on any increase in delivery/student numbers – if no increase dis-count Year 3 & 4 delivery.*

5.3 Delivering programmes for a single medical school (developing a sole partnership)

STRENGTHS • Single set of policy and processes. • Directed by just the one university. • Single timetable to work to. • Single set of deadlines. • Single set of assessment requirements. • Single set of documentation/paperwork. • Single set of IT systems • Become an established teaching partner. • Active involvement in design and delivery of curriculum which is more complex for two . • Make life easier for clinicians	**WEAKNESSES / CHALLENGES** • Loss of relationship with other medical school. • Impact on other academic programmes (if any) e.g. Physician Associate programme • Would require an increase in student numbers (Year 3-5) to maintain current income.

involved in teaching.	
OPPORTUNITIES • A sole partnership with one University/Medical School would give us real opportunity to be at the forefront of undergraduate development in the region. • Each University would bring its own unique academic opportunities e.g. Physician Associates, Business School, Research, etc. • Opportunities associated to clinical service development.	**THREATS** • Medical schools withdraw their students.

Potential scenario for this option

ACADEMIC YEAR	YEAR 3	YEAR 4	YEAR 5
18/19	0	0	20 UEMS / 30 PUPSMD
19/20	0	0	20 UEMS / 30 PUPSMD
20/21	30 UEMS **OR** 30 PUPSMD*	30 UEMS **OR** 30 PUPSMD*	50 UEMS **OR** 50 PUPSMD

**Dependant on any increase in delivery/student numbers – if no increase dis-count Year 3 & 4 delivery.*

9. Summary

There remains a lot of uncertainty around the process for medical schools to bid for additional student numbers and timescales. In addition the medical schools do not know what rational will be used in the allocation, for example they might reinstate the 2% of places previously reduced at the larger medical schools (mainly in London) or whether they will look to set up new schools – although this is unlikely due to the timescales. We may not know whether the local medical schools have been successful in being allocated any additional numbers until the end of the summer. If the medical schools are indeed successful in significantly increasing their student numbers more radical curriculum and programme changes may be needed to manage the numbers even if they use Torbay, as there is not much room in capacity under the current programme structure. In the meantime it is worth considering the future options as described in this paper and whether we would want to put ourselves forward as a significant partner in undergraduate delivery in the region.

Jess Piper
Raju Ramesh
Rob Dyer

January 2017

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st February 2017
Title:	Safety Scorecard
Lead Director:	Medical Director
Corporate Objective:	Safe, quality care and best experience
Corporate Risk/ Theme	Care Quality Commission requirement notice sets out significant concerns regarding safe quality care and best experience
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context

The Safety Scorecard looks at a number of metrics including mortality across the organisation assessing for trends and shifts on data

Risks and issues

The report needs to be viewed alongside this month's incident report
Nil risks identified

Recommendations

The Trust board is asked to note the contents of the Safety Scorecard.

Summary of ED Challenge/Discussion:

The scorecard provides assurance of high quality care throughout the Trust.

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

The design and content of the scorecard is considered at the Quality Improvement Group which includes patient and governor representation.

Equality and Diversity Implications:
None

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Safety Score Card No. 41

Background & Introduction

This scorecard is much reduced and needs to be viewed alongside the Trusts Clinical Incident report to avoid duplication.

The indicators for this score card have been collated from a variety of data sources using defined methodology. The sources include Trust data and Dr Foster, The data in the appendices has in the main been displayed as run charts. The report is generated for various groups and committees including the Board, Quality Improvement Group and Quality Assurance Committee as well as local governance groups.

Data & Graphs – Run Charts

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to go wrong.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to go wrong.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		Data Source	Target	RAG
• Hospital Standardise Mortality Rate (HSMR) • HSMR Peer Review • Summary Hospital Mortality Index (SHMI) (Appendix 1)	Mortality	Dr Foster 2015/16 benchmark Month June DH SHMI data	HSMR ≤93	
Unadjusted Mortality rate (Appendix 2)		Trust Data	Yearly Average ≤3%	
Dr Foster Patient Safety Dashboard (Appendix 3)		Dr Foster	All 15 safety indicators positive	
MRSA bacteraemia Days Between (Appendix 4)		Trust data	Zero in year	2 MRSA
C Diff Number and lapses in care (Appendix 5)		Trust data	DH target ≤18 lapses in care	
Safety Thermometer (Appendix 16)		DH point prevalence monthly audit tool measuring harm free care	95% or higher New Harm Free Care	

Overview:

The Safety Score Card (SSC) has taken data up to and including Dec 2016 and will directly feed into the Quality Assurance Committee via the Quality Improvement Group.

This SSC is a revised version due to the Clinical Incident report being taken to the board this month and many metrics overlap, therefore please read this SSC in conjunction with the incident report.

Mortality
The data is now being expressed for the new Integrated Care Organisation, including all the community hospitals.

The HSMR has risen above 100 line but is still within the expected range. This will need to be observed.

Triangulating with Dr Fosters Safety Dashboard, one area is flagging and this will be investigated and a report sent back to the Quality Improvement Group in February.

Infection Control
The data is showing CDT lapses in care within the expected trajectory. This needs to be observed via the *monthly* Performance and Quality Data book.

Assurance Data
Safety Thermometer - All data is within the target range for each metric.

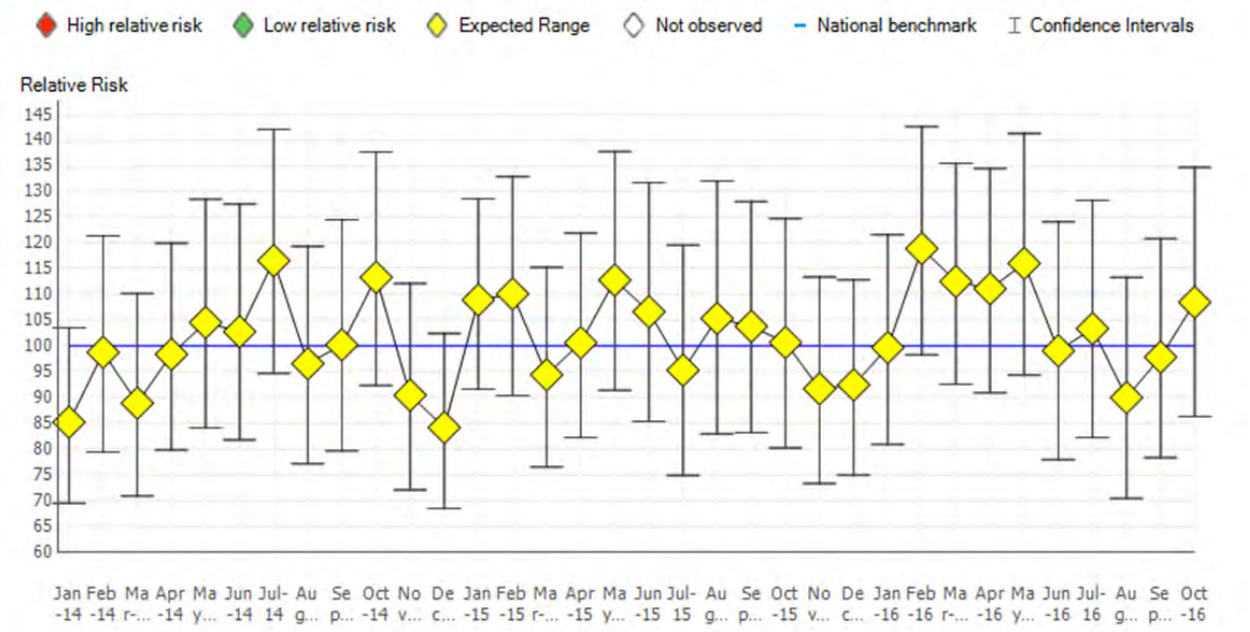
Appendix 1

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

(A)- Hospital Standardised Mortality Rate (HSMR) basket of 56 benchmark month

HSMR Measure Aim: to reduce and sustain the quarterly HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated.



HSMR Trend by month from Jan 14 – October 16 (latest)

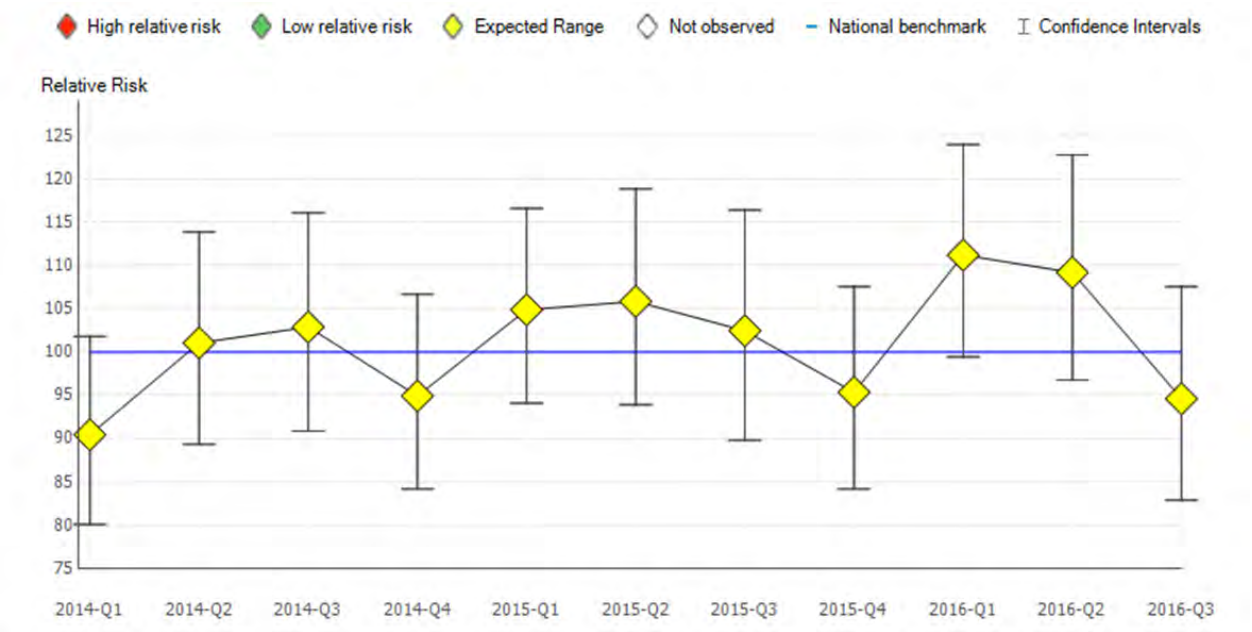
Narrative
This data is based on the new benchmark year 15/16

Our latest data point, October 16 is showing a relative risk of 108.51 but within the expected range. This data point has just been released and the trend will need to observed over the coming winter period, as historically the HSMR rises in this period.

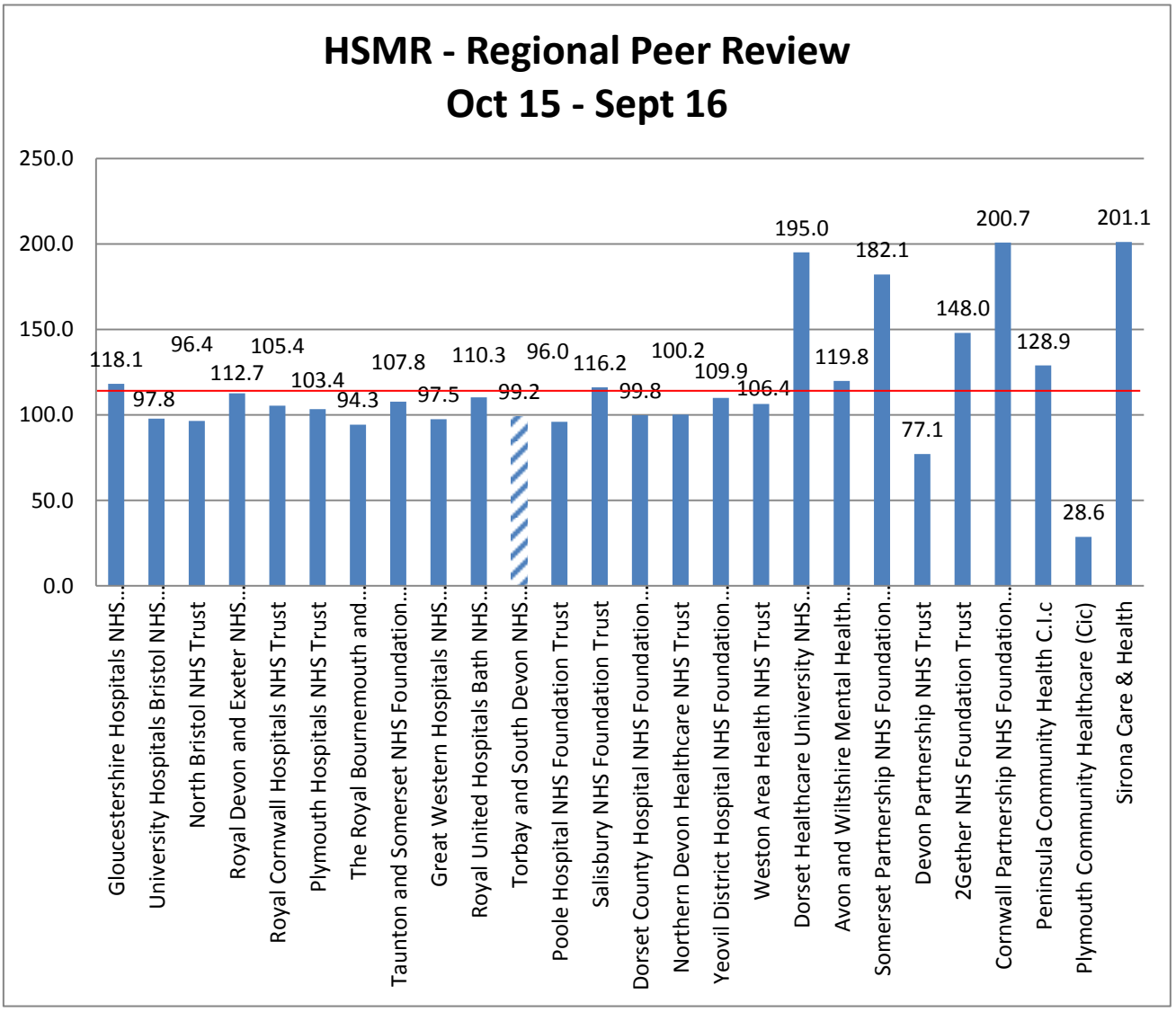
Morbidity and Mortality reviews take place in all specialist departments and in all community hospitals. In community hospitals all deaths are reviewed using software designed with the support of the South West Academic Health Sciences Network. Recurring themes are identified and changes in care pathways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

The Medical Director has establishment of a Mortality Surveillance Group to provide assurance that robust investigation of avoidable deaths is undertaken and to ensure that learning is shared across the organisation when suboptimal care has been identified relating to any death.

The following chart shows the data via quarters over time, again all are within the expected range

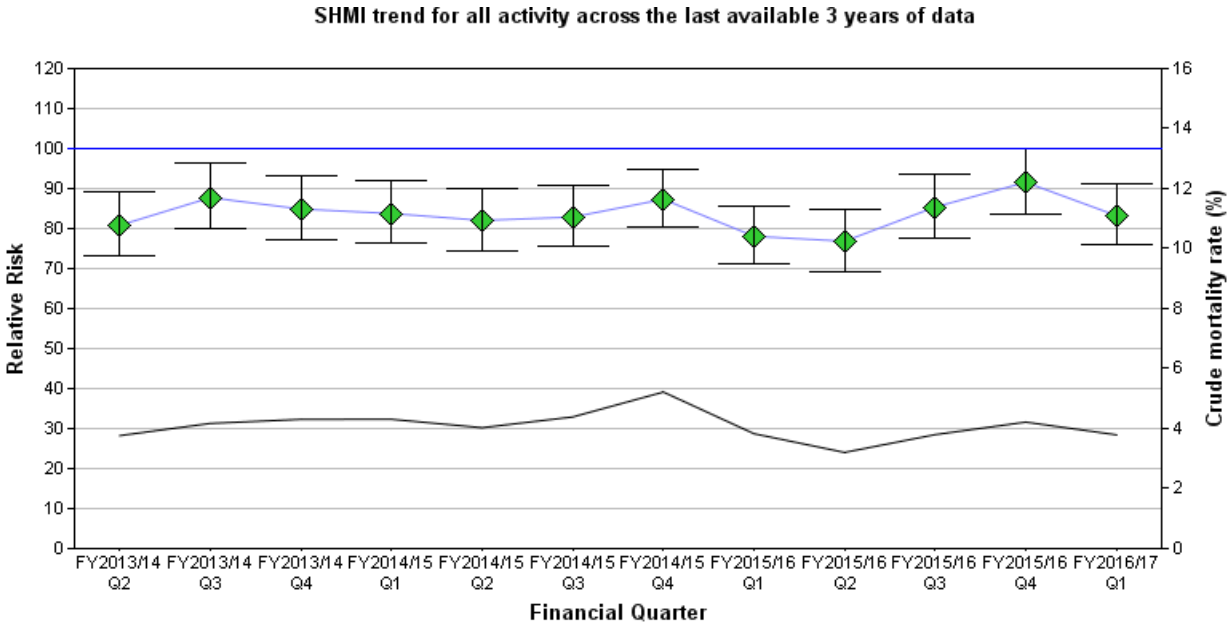


The final chart allows for a peer review of HSMR over the given time period

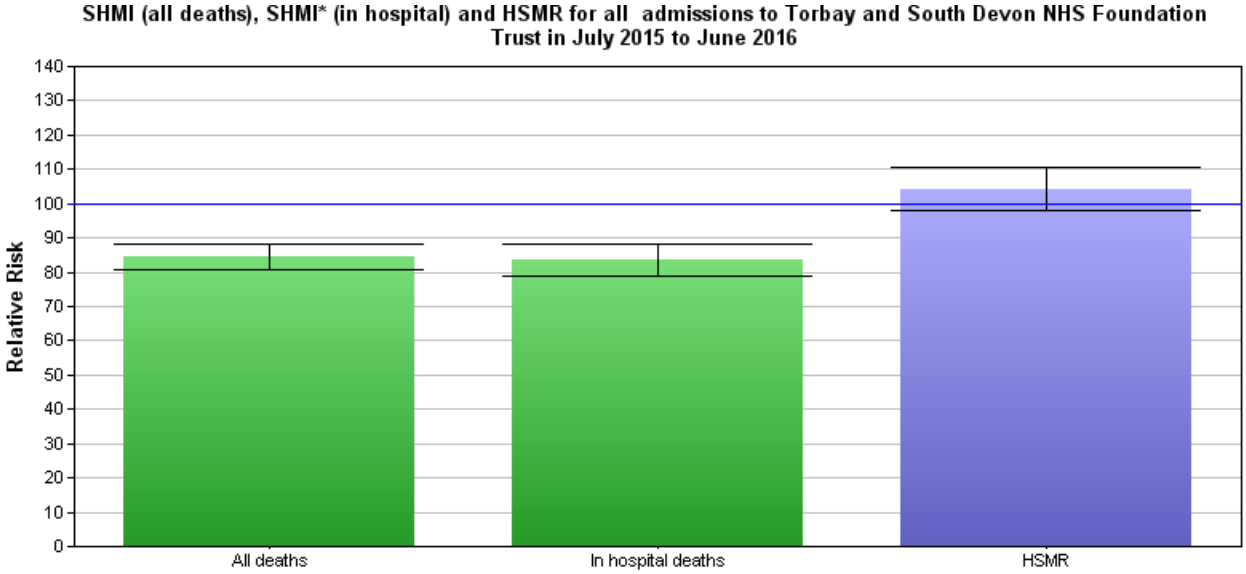


(B) Summary Hospital Mortality Index (SHMI)
SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is retrospective; therefore, please note *the following data is from* ***July 2015 – June 2016*** and will be different from the dates used on Dr Foster's HSMR.

The first chart highlights SHMI by quarter, again with all data points within the expected range and trending below our 90 target

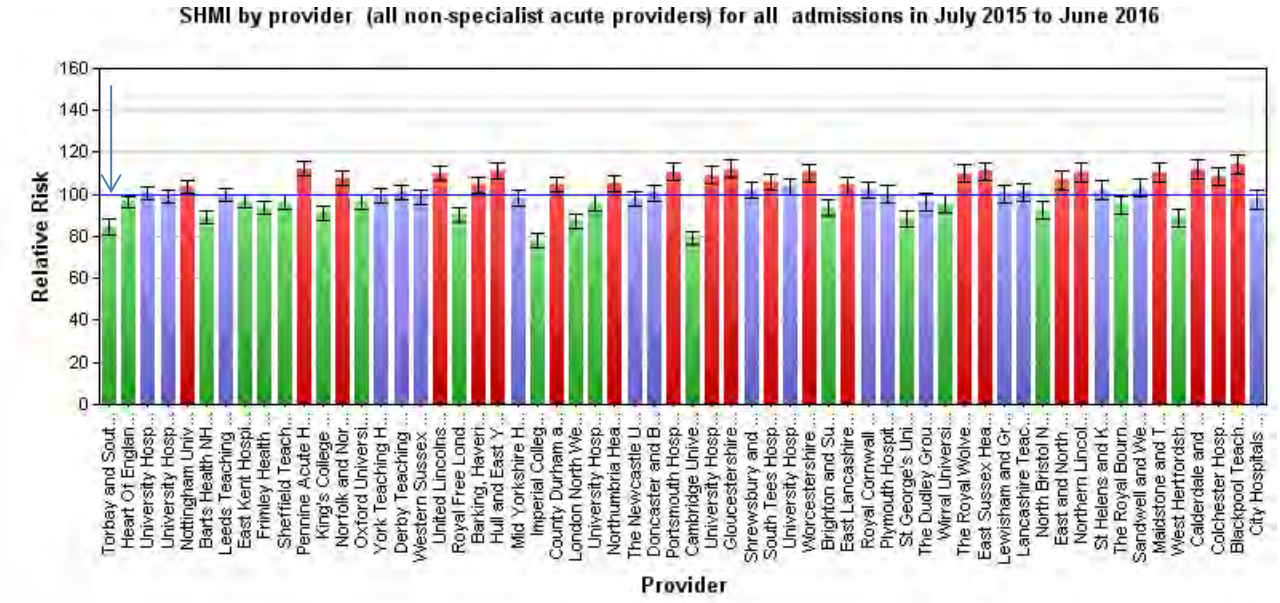


SHMI all deaths, SHMI in hospital deaths and HSMR

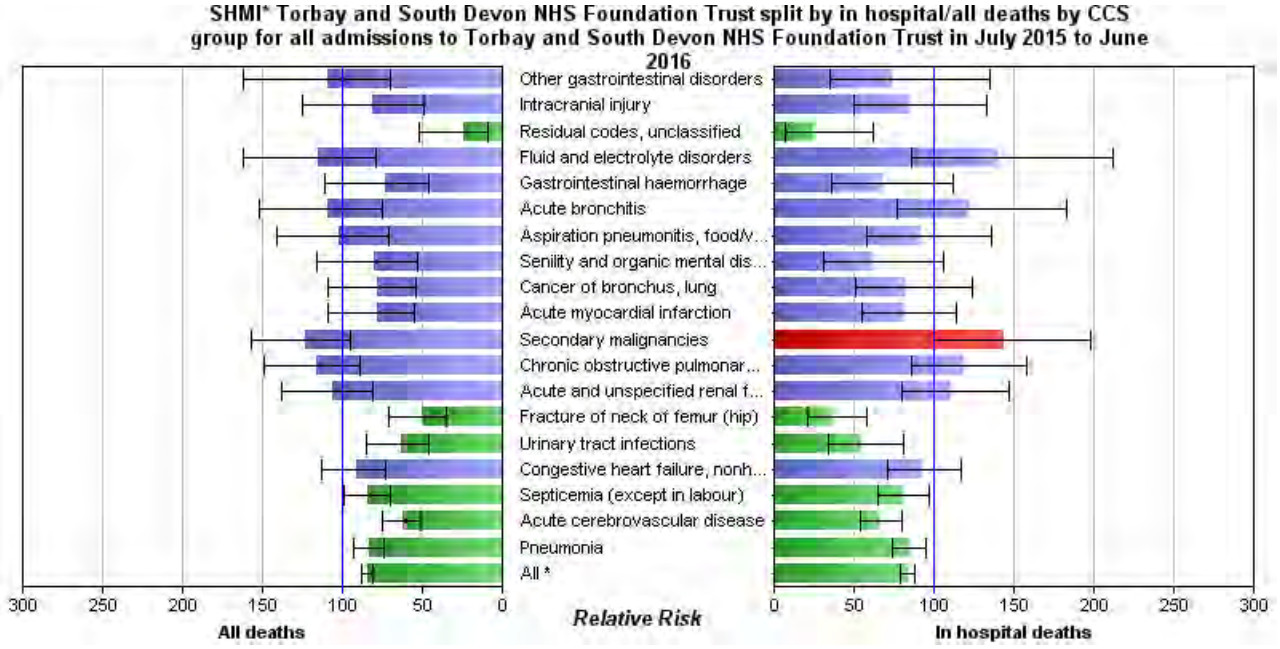


The above chart records all SHMI deaths, deaths in hospital as well as a comparison with HSMR for the time period July 2015 – June 2016. All are within expected range and with the in-hospital deaths at a very low relative risk.

The next chart highlights the position of similar sized trusts within England and allows a comparison against these organisations using SHMI.



The final chart allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). One area is flagging red with the others within normal limits or performing better than the norm.



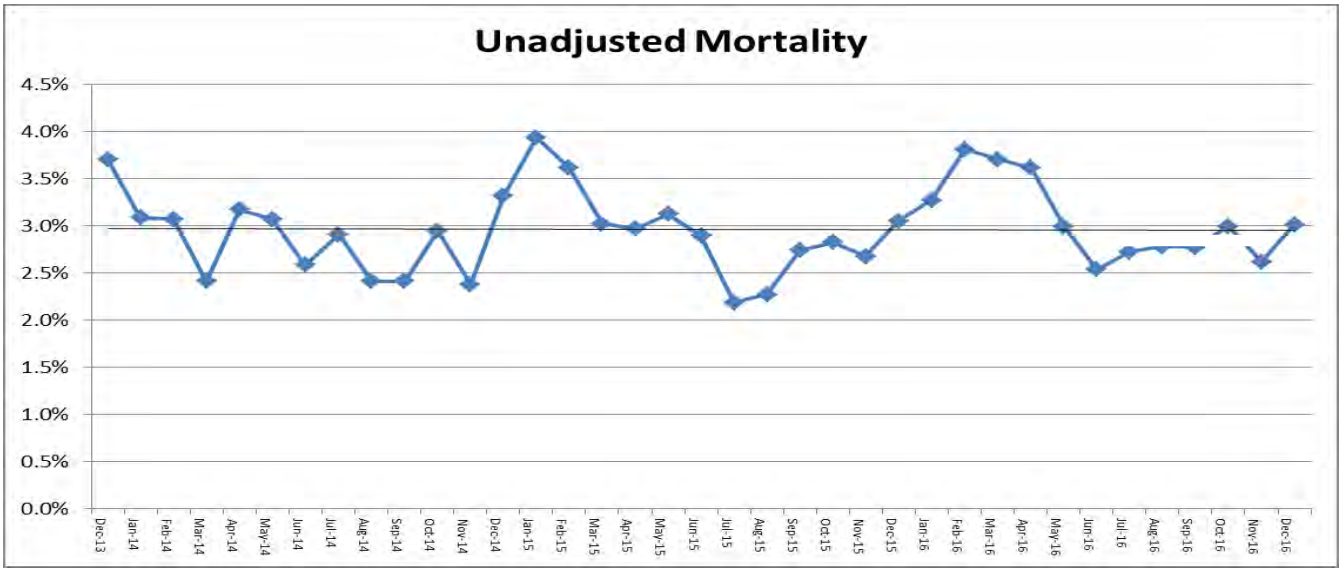
Of the one area that has flagged red, those data will be reviewed and a report sent to the Quality Improvement Group and the Mortality Group in February

Unadjusted death rate as a %
This data looks at the number of deaths in hospitals

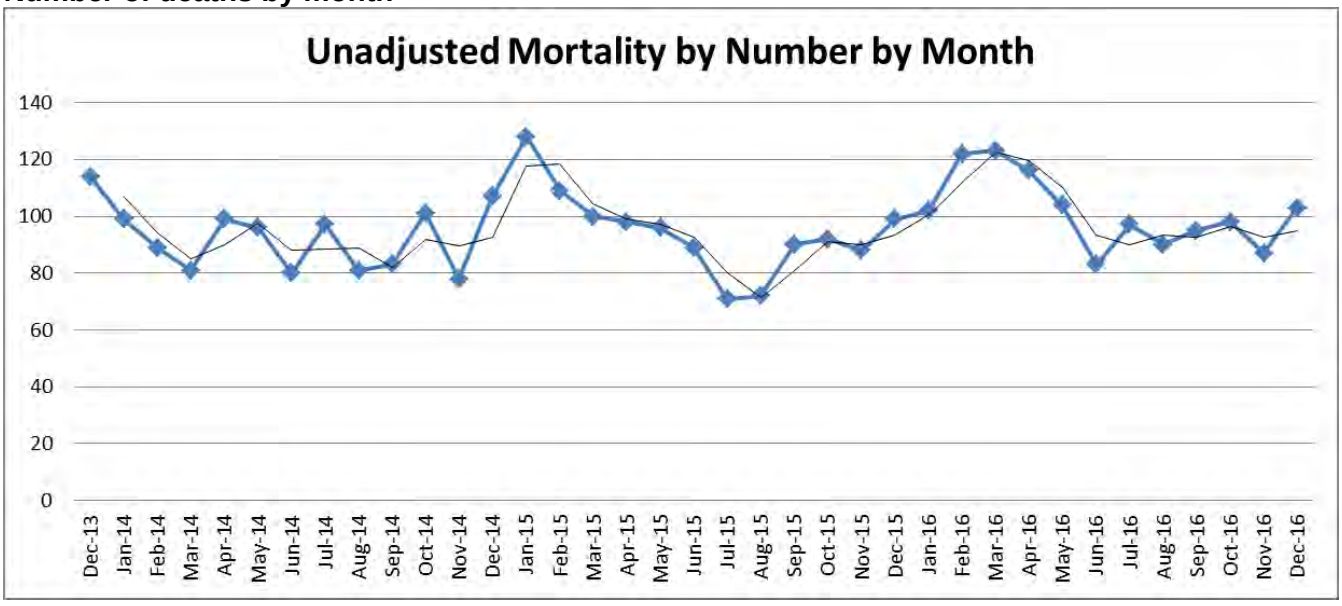
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).
Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI. The current trend is showing a similar number of deaths to Dec 2015. In that winter period unadjusted mortality rose in January/February and the data will need to be observed to see if this pattern emerges



Number of deaths by month



Appendix 3

Dr Foster Patient Safety Dashboard

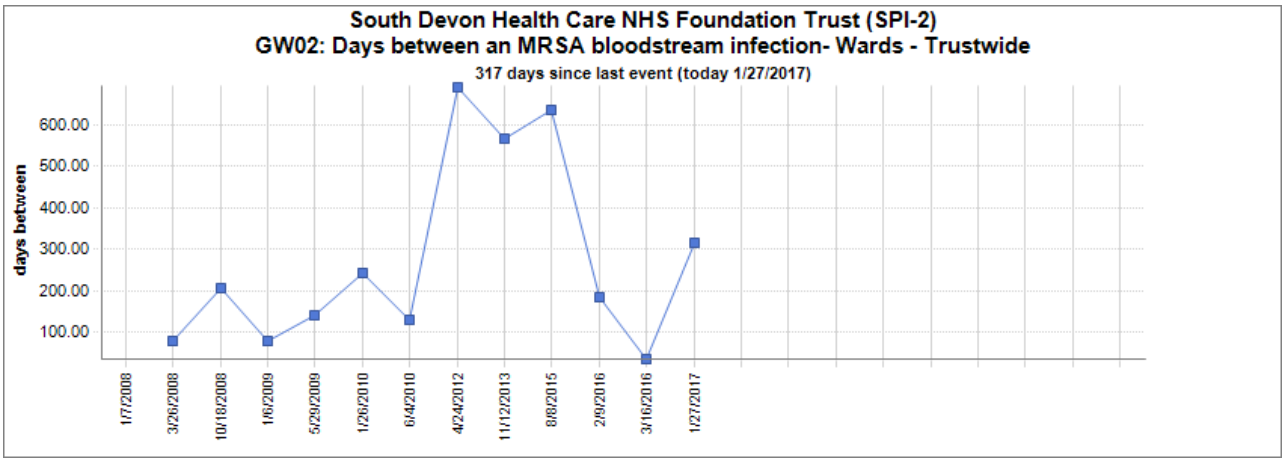
These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which is based on procedure codes used in the NHS.

The date range for this data is Nov 2015 to October 2016

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk
Deaths in low-risk diagnosis groups*	26,235	19	14.7	0.7	0.6	129
Decubitus Ulcer	7,833	297	377.0	37.9	48.1	79
Deaths after Surgery	482	39	45.0	80.9	93.4	87
Infections associated with central line*	14,155	0	0.6	0.0	0.0	0
Postoperative hip fracture*	20,097	1	1.2	0.0	0.1	83
Postoperative Haemorrhage or Haematoma	17,585	6	7.6	0.3	0.4	79
Postoperative Physiologic and Metabolic Derangement*	14,826	2	1.5	0.1	0.1	136
Postoperative respiratory failure	13,550	11	11.3	0.8	0.8	97
Postoperative pulmonary embolism or deep vein thrombosis	17,807	23	39.3	1.3	2.2	58
Postoperative sepsis	481	6	4.4	12.5	9.2	136
Postoperative wound dehiscence*	635	0	0.6	0.0	0.9	0
Accidental puncture or laceration	62,043	78	75.6	1.3	1.2	103
Obstetric trauma - vaginal delivery with instrument*	283	12	22.5	42.4	79.6	53
Obstetric trauma - vaginal delivery without instrument*	1,254	28	46.6	22.3	37.2	60
Obstetric trauma - caesarean delivery*	526	1	2.0	1.9	3.8	50

All of the 15 indicators, as above, are within the expected norm.

Days between an MRSA bacteraemia (SPI)



This measure is a cumulative count of the number of days that have gone by with no in hospital MRSA bacteraemia being reported.

Every time an MRSA bacteraemia occurs the count is started over again.

The current count stands at 317 days. The longest count has stood at 633 days and the data chart shows performance back to 2008

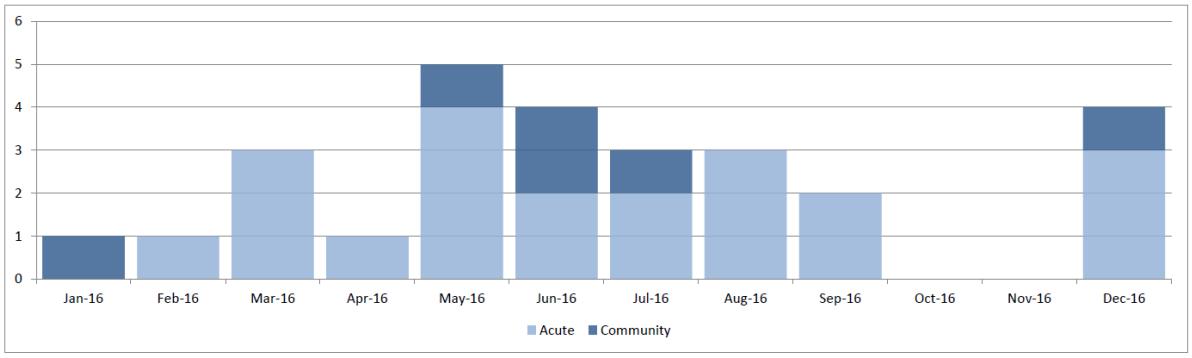
Appendix 5

Clostridium Difficile toxin detection rate
(Number of new infections -Trust data)

This chart highlights the number of confirmed CDT case each month and is expressed as a number in this chart. December record a total of four. The second chart records if the CDT was registered with a lapse in care

Number of Clostridium Difficile cases

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



Commentary

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

Appendix 6

Department of Health's (DH) Safety Thermometer

The NHS Safety Thermometer (ST) is a tool used for measuring patient safety and was developed by the NHS Information Centre (NHS IC).

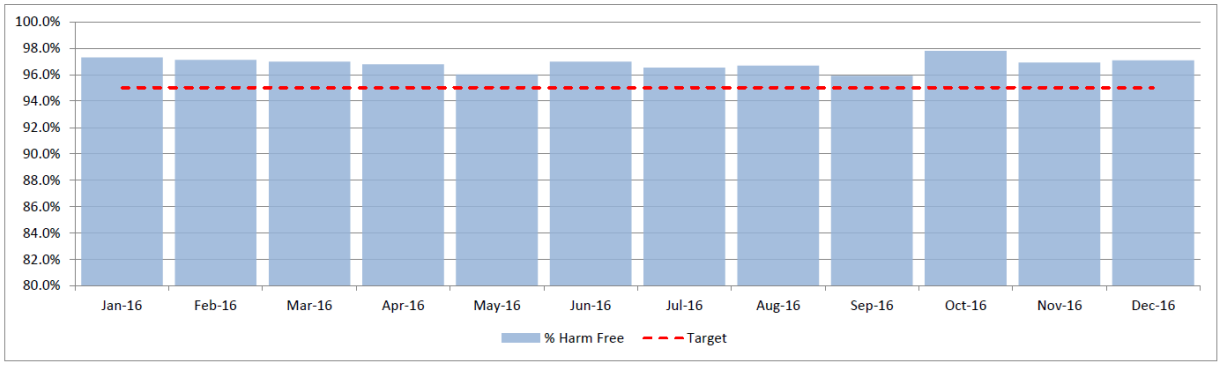
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

All patients are surveyed on *one* specific day every month and the data records if any harm, as outlined above, has occurred. The audit, therefore, provides a score for the organisation based on harm free care and new harm free care. This data is the harm caused whilst in our care and is called new harm free.

The Trust's percentage of patient **New harm free care** has remained constantly high and stable.

Harm Free - Trust Total

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Patients		1075	1057	1027	1056	1093	1040	1083	1027	997	1106	1067
Harm Free		1044	1025	994	1014	1060	1004	1047	985	975	1072	1036
% Harm Free	97.3%	97.1%	97.0%	96.8%	96.0%	97.0%	96.5%	96.7%	95.9%	97.8%	96.9%	97.1%
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%



Torbay and South Devon NHS
NHS Foundation Trust

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting dates:	22 December 2016
Report by + date:	David Allen, 23 December 2016
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐+ Freedom of Information Act exemption [*insert exemption if private box used*]

Key issue(s) to highlight to the Board:

1. Deprivation of Liberty Safeguards (DoLS). We received a very helpful update and paper from Jo Williams (AD Social Care) on the issues surrounding DoLS for adults and, in particular the impact a High Court judgment in Cheshire v West 2014 ("a gilded cage is still a cage") has had on workload and the availability of sufficient qualified and trained staff to carry out DoLS assessments, which are now required even where patients/residents are content with their care and location but, for their own safety and that of third parties, are not able to come and go as they please. We will continue to keep this matter under review, at least until such time as there may be a change in the law. In the meantime a Board level KPI has been introduced, reflecting the applications received, closed and opened each month.

2. Board Assurance Framework (BAF). QAC carried out a deep dive into two key risks from the BAF ie domiciliary care in clients' homes and care homes . Both risks were high although QAC was satisfied with the controls and mitigation in place; the risk was largely beyond the control of the Trust and related to market failure. The Committee noted the significant resources required from the Trust to support challenged providers and that, while the support helped to resolve issues for clients temporarily, it was not a sustainable solution. The Committee concluded that the process of examining a small number of key risks in detail was useful and that, in particular, the Board should be provided with a general briefing on domiciliary care/care homes, prior to a detailed options report on supporting providers and improving capacity.

3. Upper gastro-intestinal (GI) innovations and working with primary care. The COO reported on an innovative project working with primary care in relation to the identification and care of Upper GI conditions outside hospital settings as far as possible.

4. Research and Development. The MD and Dr Fiona Roberts introduced this topic accompanied by a presentation from Lead Research Nurse Chris Dixon. R and D was being squeezed by service pressures and the number of active studies was declining. However, the Trust retained significant expertise and appetite for research among its staff. A number of suggestions were made as to how to improve the position, including a leadership statement at board level of the importance of R and D, both as an end in itself and to increase income, prestige and to attract and retain staff. Greater collaboration across the Peninsula was encouraged, as well as liaison with bodies such as the Academic Health Science Network and PenCLHARC, the regional organisation for applied research into improving clinical practice.

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

Recommendation(s)

1. That the Board receive a general briefing on domiciliary and care home arrangements.

2. That the Board endorse the importance of research and development to the Trust and signal this via the Executive to staff and stakeholders.

Name: David Allen - Committee Chair

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st February 2017
Title:	Safer Staffing 6 Monthly Report
Lead Director:	Jane Viner - Chief Nurse
Corporate Objective:	Safe, Quality Care, Best Experience
Corporate Risk/ Theme	Safe Staffing
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Significant streams of work continue under the Nursing Workforce Programme to ensure safety, quality and experience are delivered whilst driving forward efficiency.

The key focus over the past 6 months has been to ensure the programme is aligned to the Trust's Corporate Objectives, National Quality Board (NQB) Chief Nursing Officer (CNO) right staff in the right place at the right time, CQC and Lord Carter driving forward productivity and efficiency whilst maintaining safety and quality.

The three key focus areas have been:

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

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

Key Issues/Risks:

- Recruitment challenges
- Increasing patient acuity and dependency
- Retirement of experienced workforce over the following 5 years
- Delivering more for less
- External drivers of change at pace
- Reduction in agency usage

Recommendations:

The Board to note the continual challenges regarding recruitment and retention of registered nurses and the drive to reduce agency usage whilst maintaining patient Safety & Quality.

Summary of ED Challenge/Discussion:

Whilst noting that CHPPD are broadly consistent with the peer group, the Executive were keen to understand the ward level data which shows, almost universally that more care hours are provided per day than is planned. Additional work has been requested to better understand this situation.

The Executive Team noted the reduction in agency spend this month, following recent months in which the rate of reduction had begun to plateau, The Team tested the extent to which further actions planned as part of the Call to Action would further reduced expenditure, bring the Trust closer in line with the NHS Improvement Agency Cap.

The Executive Team noted the inevitable challenge associated with the definition and maintenance of safe staffing levels at a time when the running costs of the organisation need to be significantly reduced. Safe staffing requirements will inform a range of activities, through which cost reduction proposals are being developed, and will be presented through appropriate Committee structures for discussion and decision over the coming weeks and months.

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

N/A

Equality and Diversity Implications:

N/A

PUBLIC

1.0 Purpose of Paper

The purpose of this paper is to provide information and assurance regarding the Nursing and Midwifery Safer Staffing levels over the previous 7 months to update the board in terms of the NQB CNO recommendations in relation to safer staffing guidance.

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

2.0 Safer Staffing Overview

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

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

In December 2016 the NQB issued a further draft Improvement Resource to support adult in patient safe staffing levels in an acute hospital which is aligned to the 9th commitment of leading change, adding value. It's based on the NQB's expectations that to ensure safe, effective, caring, responsive and well led care on a sustainable basis; trusts will employ the right staff with the right skills in the right place at the right time. It has been designed to be used as a resource to all involved in ensure collective establishment setting, approval and deployment from ward managers to Board Directors

The resource builds on the previous expectations and uses a systematic approach for identifying organisational, managerial and ward factors that support safe staffing and makes recommendations for monitoring and taking action if safe staffing levels fall below the needs of the patient. This paper will provide assurance to the board on progress against the updated NQB recommendations.

2.1 NQB Recommendations

Recommendation	Criteria	Action	Progress
Determining safe staffing levels for adult inpatient setting.	A systematic approach should be adopted using an evidence based informed decision support tool in triangulated with professional judgement and comparison with relevant peers	A full and comprehensive establishment review, using national and professionally recognised tools, has been undertaken on a yearly basis to link into organisational business planning cycles. This is a rolling annual review. Monthly monitoring is undertaken by assessing of the acuity and dependency of the patients on the wards using both Hurst and the Shelford Group Safer Nursing Care Tool. Daily monitoring of staffing levels takes place via the safer staffing dashboard which will be rolled out to the wider operational teams through the 10 am control meeting. On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. In addition to this, in response to Lord Carter's report published in February 2016, the number of patients at midnight for the month is now also submitted. This submission supports the new primary measure of nursing workforce, Care Hours Per Patient Day (CHPPD). Use of CHPPD model hospital data to benchmark against peer data in place and reported in the monthly QIG report and 6 monthly safer staffing report.	**ACHIEVED**

Recommendation	Criteria	Action	Progress
A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	Staffing decisions should be taken in the context of the wider registered Multidisciplinary team	Staffing reviews are undertaken when service changes are planned. There is further work to be undertaken in relation to inclusion of Therapists and other registered staff in the ward areas.	**ACHIEVED** **FURTHER WORK TO BE UNDERTAKEN**
Consideration of safer staffing requirements and workforce productivity should form the integral part of the operational planning process.	Action plans for recruitment & retention plans should be in place and subject to regular review	Robust R&R plans in place and 5 year workforce plan to address the vacancy gap. This includes growing our own workforce and career pathways including healthcare and nurse apprenticeships and nurse associate roles. This is presented at quarterly Workstream & OD group, monthly QIG and strategic R&R delivery group. Pilot site for the new Nursing Associate Role has commenced.	**ACHIEVED**
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Safer Staffing Dashboard is on the hospital intranet. This is completed daily by ward managers and matrons. Quality indicators such as high falls risks and number of patients requiring enhanced care. (Snapshot shown below. This dashboard is to be piloted at the 10am control meeting with the Matron of the week and temporary staffing to enable a risk assessment to be undertaken of the clinical areas and aid decision making to redeploy staff if need be. This is well established in the	**ACHIEVED & ONGOING**

Recommendation	Criteria	Action	Progress
		community hospitals and will be aligned into one dashboard. Matron of the week has a global overview of hot spot areas each shift and will risk assess accordingly. QIG & QUESTT monthly dashboards presented on a monthly basis and staffing incidents are monitored in relation to incidents such as patient falls, medication errors, and pressure ulcers, level of harm.	
Organisations should ensure they have appropriate escalation process in case staffing is not delivering the outcomes identified.	All organisations should include a process to determine an additional uplift requirements based on the needs of the patients and staff.	A 23% uplift is included in the establishment reviews however further work is in progress to address E Rostering practice to ensure compliant annual leave allocation and contracted hours. A further review of enhanced care requirements is about to commence to ensure appropriate deployment of additional staffing/cohorting of patients.	**ACHIEVED & ONGOING**
All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback.		Staffing incidents are monitored and investigated accordingly and appropriate feedback & actions are taken where applicable.	**ACHIEVED & ONGOING**

2.3 Monthly Safer Staffing Overview

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. In addition to this, in response to Lord Carter's report published in February 2016, the number of patients at midnight for the month is now also submitted. This submission supports the new primary measure of nursing workforce, Care Hours Per Patient Day (CHPPD).

The Carter model hospital data has recently been updated and now has the correct UNIFY submission for September 2016 rather than the aggregated information from March. Our CHPPD data is summarised against the national median below which includes Salford's information as they are seen as an exemplar organisation. The national total CHPPD median is 7.76 for all care staff, with 4.74 for Registered Nurses and Midwives and 2.91 for Healthcare Assistants. TSDFT is showing higher than the national median being 7.84, lower for registered at 3.73 & higher for healthcare support staff at 4.11. Our RN CHPPD is lower because our current RN vacancy levels and also a realignment required in some ward areas with Skill mix and also because of our population being primarily elderly and therefore need a higher level of HCA for specialing. There are occasions where HCA staff will backfill RN shifts when this has been deemed safe to do so and risk assessed by senior nurses.

Sep-16	**TSDFT**	**National Median**	**Salford**	**Comments**
Total CHPPD	7.84	7.76	7.86	
Total Registered CHPPD	3.73	4.74	4.31	This means we are the third lowest in the country for Registered Staff Care Hours
Total Healthcare Support CHPPD	4.11	2.91	3.55	This means we are sixth highest in the country
Cost per Care Hour (Aug 2016)	£23.28	£30.55	£28.93	
Cost per Patient Day (Aug 2016)	£166.50	£202.54	£355.79	

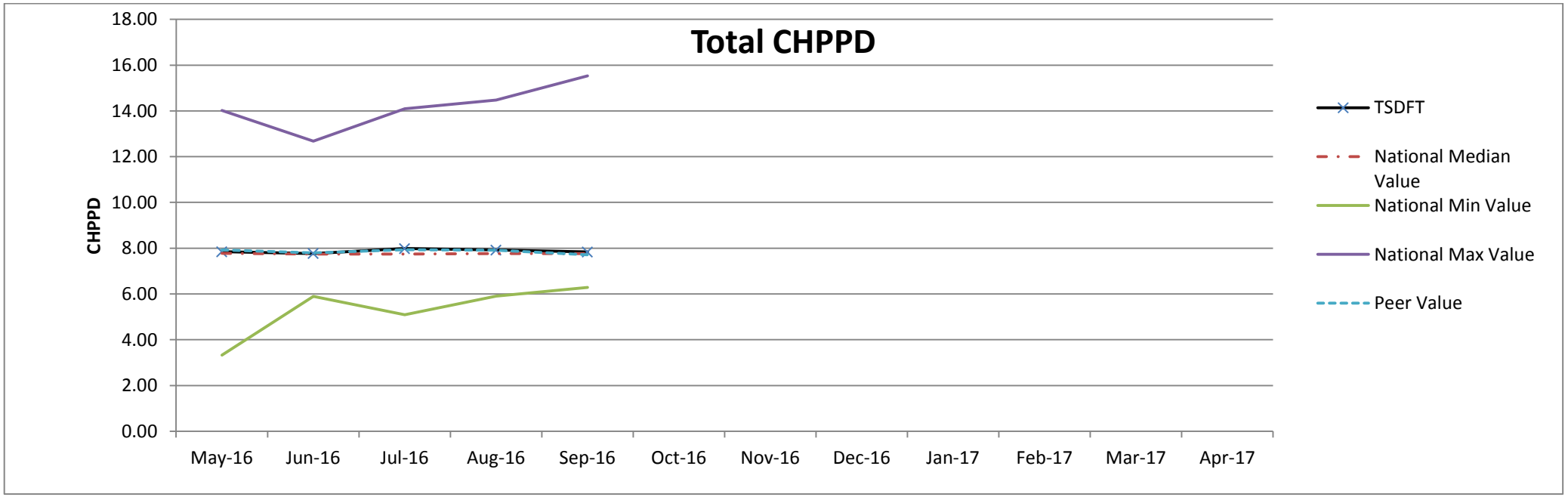
The tables below show the Total CHPPD data TSDFT and Total Registered Staff and Total healthcare support staff against the national Values. The data shows that TSDFT are slightly above the national median for total care staff and showing the Trust is consistently under for Registered staff and over for healthcare staff. The financial data too suggests TSDFT is cheaper at £23.28 per Care hour and patient

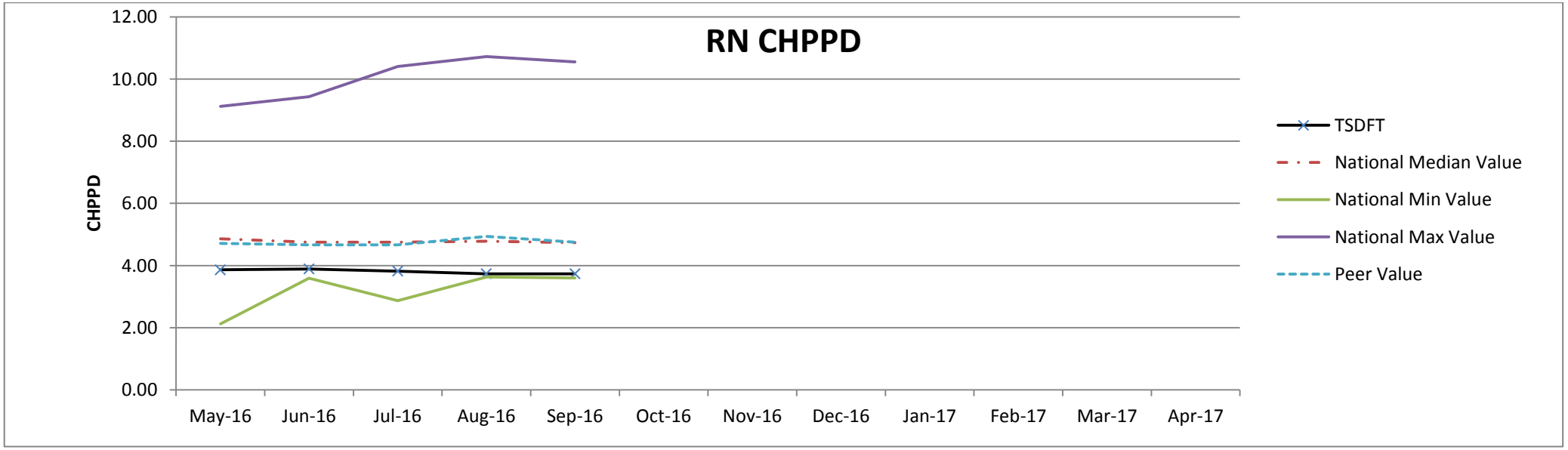
day however this needs to be used with caution due to several nuances that may determine this. These being vacancies and skill mix alignment. The tables and charts show data until September 2016 as this has been pulled from the national model hospital data set.

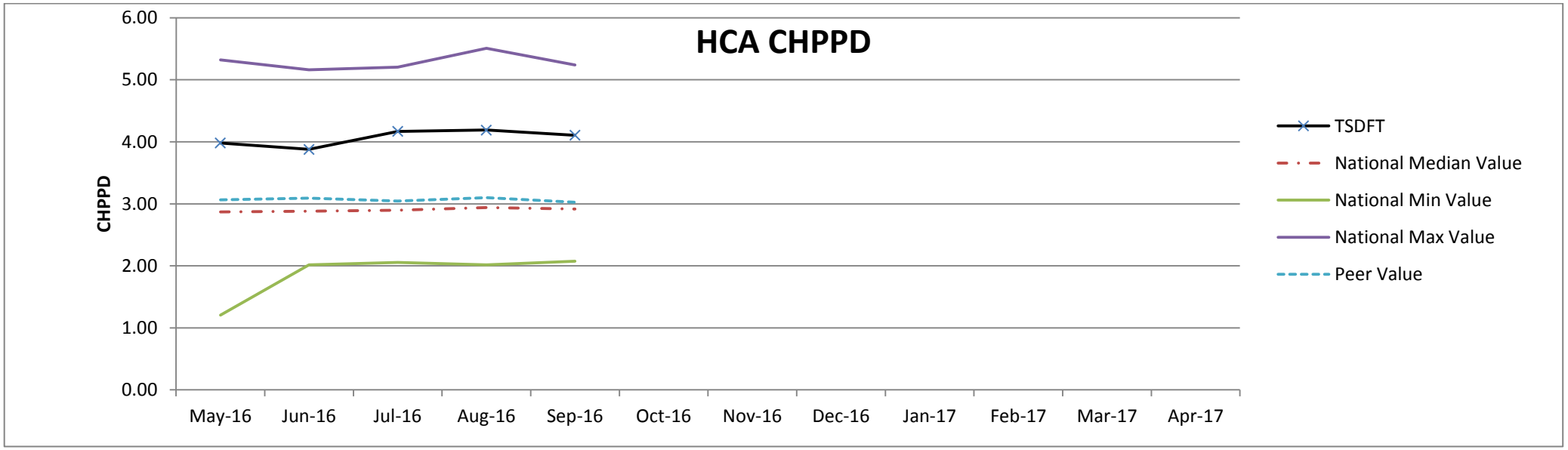
	Total CHPPD											
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
TSDFT	7.84	7.77	7.99	7.92	7.84							
National Median Value	7.78	7.74	7.75	7.76	7.76							
National Min Value	3.32	5.90	5.09	5.91	6.28							
National Max Value	14.02	12.68	14.09	14.48	15.53							
Peer Value	7.93	7.79	7.94	7.91	7.71							

	Total Registered CHPPD											
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
TSDFT	3.86	3.89	3.82	3.73	3.73							
National Median Value	4.86	4.75	4.75	4.78	4.74							
National Min Value	2.12	3.59	2.87	3.63	3.60							
National Max Value	9.12	9.44	10.40	10.72	10.55							
Peer Value	4.71	4.67	4.67	4.93	4.75							

	Total Healthcare Support CHPPD											
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
TSDFT	3.98	3.88	4.17	4.19	4.11							
National Median Value	2.87	2.88	2.90	2.94	2.91							
National Min Value	1.20	2.02	2.06	2.02	2.07							
National Max Value	5.32	5.16	5.20	5.51	5.24							
Peer Value	3.06	3.09	3.05	3.10	3.02							


Total CHPPD
CHPPD
18.00
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
TSDFT
National Median Value
National Min Value
National Max Value
Peer Value


RN CHPPD
CHPPD
12.00
10.00
8.00
6.00
4.00
2.00
0.00
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
TSDFT
National Median Value
National Min Value
National Max Value
Peer Value



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

November 2016 Safe Staffing CHPPD summary

	TSDFT October 2016	TSDFT November 2016	National Median September 2016
Total CHPPD	8.40	8.00	7.76
RN/ RM CHPPD	4.11	3.86	4.74
HCA / MCA CHPPD	4.30	4.14	2.91

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

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

- The HCA/MCA only CHPPD by ward.

A detailed monthly analysis containing planned and actual CHPPD for each of the acute wards and community hospitals is available as a table below. The analysis in the tables below show the Trust is **over** its planned total (RN + HCA) staffing levels in several areas and above the national Carter Median of 7.76 (as from September 2016). As previously stated though we are still awaiting guidance and a response from the national teams as to whether the specialist areas such as SCBU, ITU & CCU are included in the national median.

The reasons for being over planned RN hours in some areas are because of the newly qualified nurses are still within their supernumerary status plus the EAU's backfill staff needed for the AMU. There have been a number if wards also requiring RMN support during the month. The trust is still below the national CHPPD range of 4.74 for RN's.

The table also shows the Trust being over planned CHPPD for HCA's and over the national median of 2.91. The reasons for this are to backfill RN staff when deemed safe to do so plus for patients requiring enhanced observation (specialing)

Key Messages

The table below shows there are five wards that fall below the planned RN CHPPD for the month of November with actual ranges being from 2.4 -3.3. These are Allerton, Ainslie, Cheetham Hill, Warrington & Paignton whose planned staffing levels range between 2.5 to 3.8. These wards however are over their planned levels of HCA CHPPD ranging between 3.3 & 5.5 against the actual 2.4 -3.6. Totnes hospital fell below its planned HCA levels being 3.9 with actual care hours of 3.4.

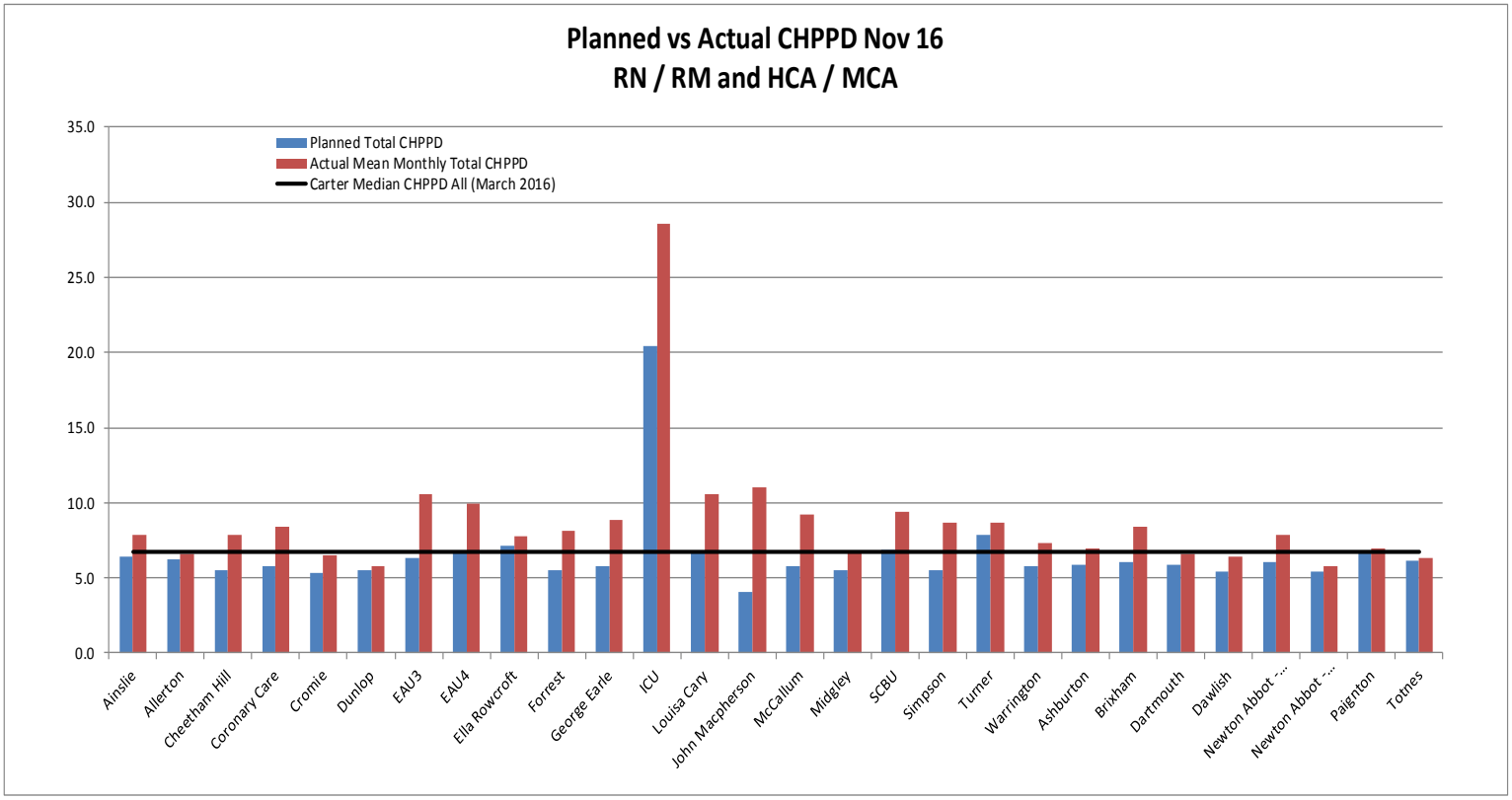
The primary reasons for the above are the number of RN vacancies along with sickness absence which pose a challenge when trying to ensure safer staffing levels are maintained on a shift by shift basis. When a shift is below the planned RN safer staffing levels, HCA's are used to backfill RN's when deemed safe and appropriate to do so by senior nursing staff. The wards have also had a number of patients too requiring supportive observation. Patient safety and quality outcomes against these wards have been reviewed to ensure there are no correlations to staffing levels. These are continually monitored by the Associate Directors of Nursing.

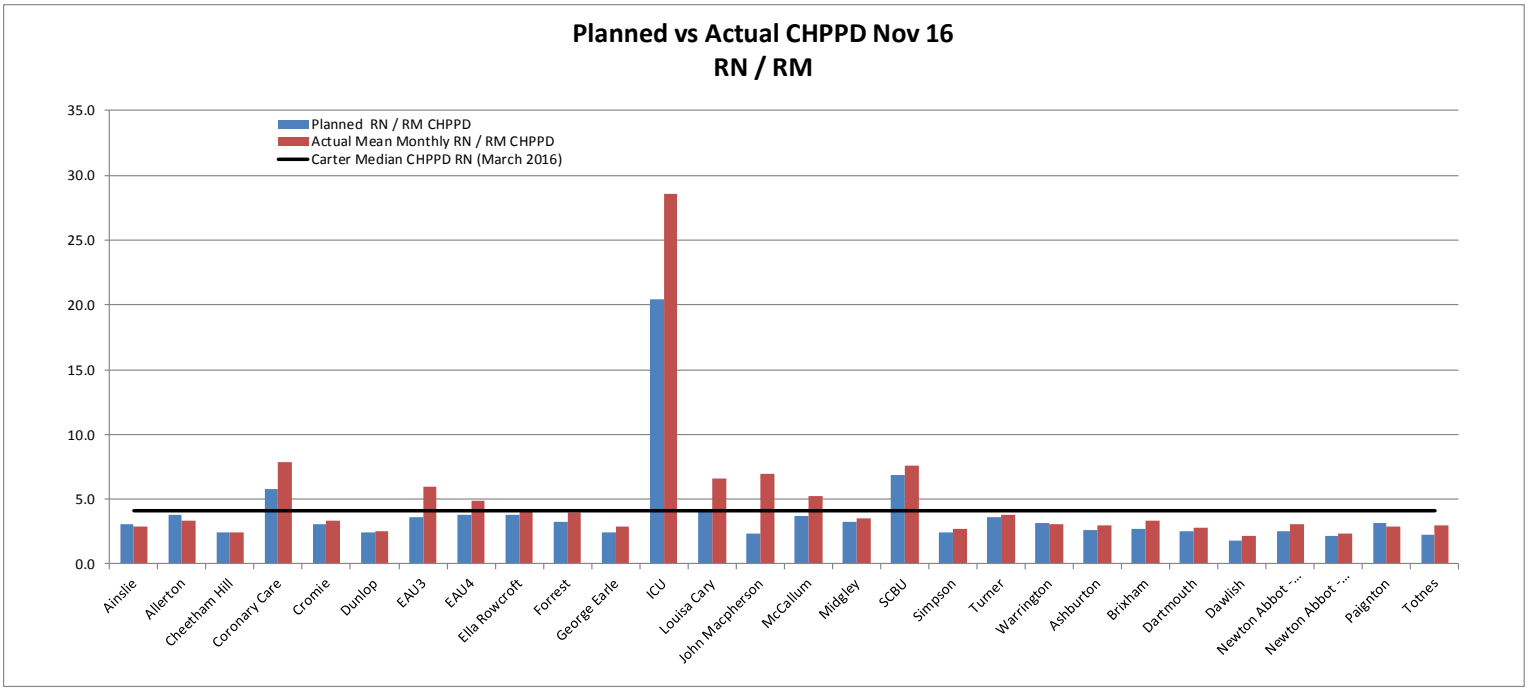
The total fill rate for November 2016 was 107.6% (7.6% above plan) for RN and 106.9% (6.9% above plan) for HCA

There are a number of shifts in ED that have required an RN for increased dependency and also new staff that join the bank undertake a supervisory observation shift.

The actual HCA shifts are also above planned and again due to increased dependency of the department and for specialing of patients. Again new staff on the bank also undertake supernumerary observation shifts.

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly HCA / MCA CHPPD
Ainslie	6.4	3.1	3.3	7.9	2.9	5.0
Allerton	6.2	3.8	2.4	6.6	3.3	3.3
Cheetham Hill	5.5	2.5	3.1	7.9	2.4	5.5
Coronary Care	5.8	5.8	0.0	8.4	7.9	0.5
Cromie	5.3	3.1	2.2	6.5	3.3	3.2
Dunlop	5.5	2.4	3.1	5.8	2.5	3.4
EAU3	6.3	3.6	2.8	10.6	6.0	4.6
EAU4	6.7	3.8	2.9	9.9	4.9	4.9
Ella Rowcroft	7.1	3.8	3.3	7.8	4.1	3.8
Forrest	5.5	3.2	2.3	8.1	4.0	4.0
George Earle	5.8	2.5	3.3	8.9	2.9	6.1
ICU	20.4	20.4	0.0	28.6	28.6	0.0
Louisa Cary	6.7	4.2	2.4	10.6	6.6	4.0
John Macpherson	4.0	2.3	1.7	11.0	7.0	4.0
McCallum	5.8	3.7	2.1	9.2	5.2	3.9
Midgley	5.5	3.3	2.3	6.8	3.5	3.4
SCBU	6.9	6.9	0.0	9.4	7.6	1.8
Simpson	5.5	2.5	3.1	8.7	2.7	6.0
Turner	7.9	3.6	4.2	8.7	3.8	4.8
Warrington	5.8	3.1	2.6	7.3	3.1	4.2
Ashburton	5.9	2.6	3.3	7.0	3.0	4.0
Brixham	6.1	2.8	3.3	8.4	3.3	5.1
Dartmouth	5.9	2.5	3.6	6.6	2.8	3.8
Dawlish	5.4	1.8	3.6	6.4	2.2	4.2
Newton Abbot - Teign Ward	6.1	2.5	3.6	7.9	3.1	4.9
Newton Abbot - Templar Ward	5.4	2.1	3.3	5.8	2.3	3.6
Paignton	6.7	3.1	3.6	7.0	2.9	4.0
Totnes	6.2	2.2	3.9	6.3	3.0	3.4


Planned vs Actual CHPPD Nov 16
RN / RM and HCA / MCA
Planned Total CHPPD
Actual Mean Monthly Total CHPPD
Carter Median CHPPD All (March 2016)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Ainslie
Allerton
Cheetham Hill
Coronary Care
Cromie
Dunlop
EAU3
EAU4
Ella Rowcroft
Forrest
George Earle
ICU
Louisa Cary
John Macpherson
McCallum
Midgley
SCBU
Simpson
Turner
Warrington
Ashburton
Brixham
Dartmouth
Dawlish
Newton Abbot -...
Newton Abbot -...
Paignton
Totnes


Planned vs Actual CHPPD Nov 16
RN / RM
Planned RN / RM CHPPD
Actual Mean Monthly RN / RM CHPPD
Carter Median CHPPD RN (March 2016)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Ainslie
Allerton
Cheetham Hill
Coronary Care
Cromie
Dunlop
EAU3
EAU4
Ella Rowcroft
Forrest
George Earle
ICU
Louisa Cary
John Macpherson
McCallum
Midgley
SCBU
Simpson
Turner
Warrington
Ashburton
Brixham
Dartmouth
Dawlish
Newton Abbot -...
Newton Abbot -...
Paignton
Totnes

The table below details the daily planned, actual and % fill rates for nurse staffing in the Emergency Department.

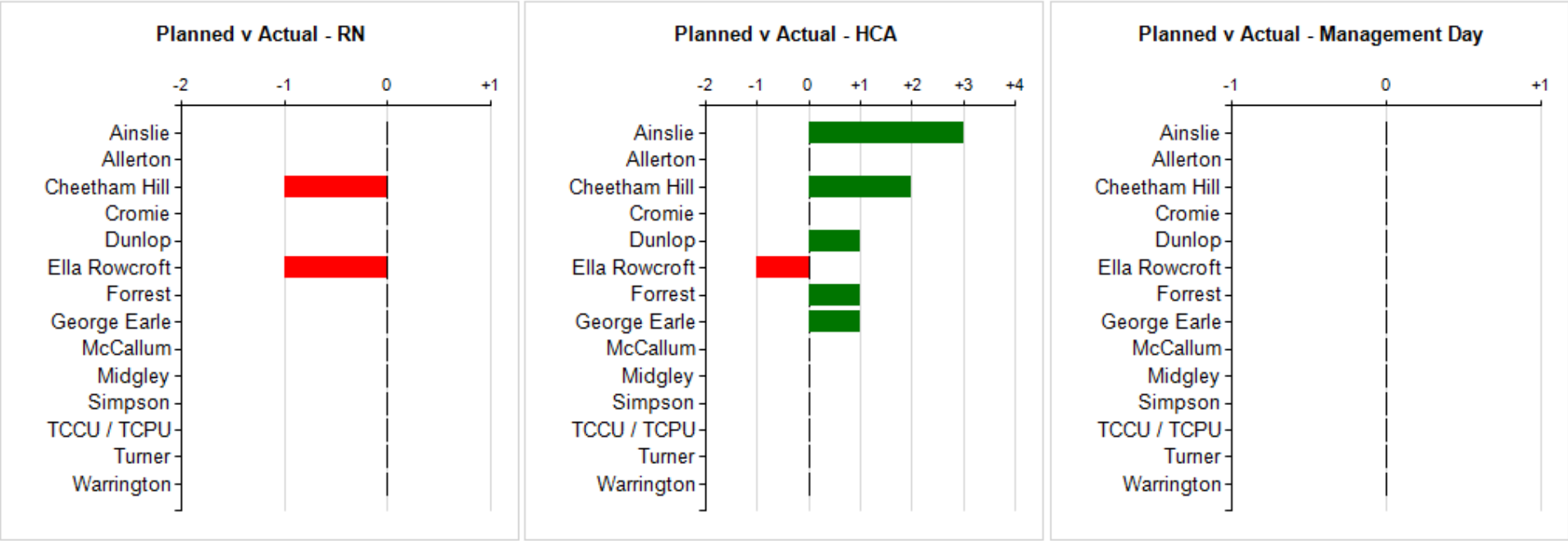
		Total Planned shifts		Total Actual Shifts		RN Shift	HCA Shift
		RN	HCA	RN	HCA	fill rate	Fill Rate
Tue	01/11/2016	17	13	17	13	100.0%	100.0%
Wed	02/11/2016	17	13	17	12	100.0%	92.3%
Thu	03/11/2016	17	13	18	13	105.9%	100.0%
Fri	04/11/2016	17	13	18	12	105.9%	92.3%
Sat	05/11/2016	17	13	19	12	111.8%	92.3%
Sun	06/11/2016	17	13	19	14	111.8%	107.7%
Mon	07/11/2016	17	13	17	14	100.0%	107.7%
Tue	08/11/2016	17	13	18	15	105.9%	115.4%
Wed	09/11/2016	17	13	19	14	111.8%	107.7%
Thu	10/11/2016	17	13	19	11	111.8%	84.6%
Fri	11/11/2016	17	13	17	14	100.0%	107.7%
Sat	12/11/2016	17	13	18	14	105.9%	107.7%
Sun	13/11/2016	17	13	20	16	117.6%	123.1%
Mon	14/11/2016	17	13	18	13	105.9%	100.0%
Tue	15/11/2016	17	13	20	14	117.6%	107.7%
Wed	16/11/2016	17	13	21	15	123.5%	115.4%
Thu	17/11/2016	17	13	22	14	129.4%	107.7%
Fri	18/11/2016	17	13	18	14	105.9%	107.7%
Sat	19/11/2016	17	13	18	13	105.9%	100.0%
Sun	20/11/2016	17	13	18	13	105.9%	100.0%
Mon	21/11/2016	17	13	16	13	94.1%	100.0%
Tue	22/11/2016	17	13	18	13	105.9%	100.0%
Wed	23/11/2016	17	13	17	15	100.0%	115.4%
Thu	24/11/2016	17	13	19	14	111.8%	107.7%
Fri	25/11/2016	17	13	19	14	111.8%	107.7%
Sat	26/11/2016	17	13	18	14	105.9%	107.7%
Sun	27/11/2016	17	13	18	15	105.9%	115.4%
Mon	28/11/2016	17	13	17	16	100.0%	123.1%
Tue	29/11/2016	17	13	18	16	105.9%	123.1%
Wed	30/11/2016	17	13	18	17	105.9%	130.8%
	Total	**510**	**390**	**549**	**417**	**107.6%**	**106.9%**

3.0 Safer Staffing Dashboard

The dashboard below has been developed to create a live overview of planned v actual staffing levels across the organisation. This is completed each shift and incorporates safety and quality indicators such as specialing patients, high falls risks and end of life patients. It is planned to use this information at the 10am control meeting by the matron of the week and senior nursing colleagues and temporary staffing. The dashboard also shows a RAG rating so hot spot areas can be seen at a glance. The snapshot below shows both Cheetham Hill and Ella Rowcroft on that day were below their planned RN levels. Cheetham Hill was over on their HCA planned numbers which also included a band 4 associate practitioner on duty and Ella was under by 1 planned HCA too however professional judgement suggested the actual staffing numbers were safe according to the acuity of the ward on that day. Below is a snapshot example :

Ward	Planned Staffing Levels			Actual Staffing Levels				B6 / B7 Present in Staffing?	Bank / Agency in Staffing	Acuity Level					1:1 Specialing	High Falls Risk	End of Life	Comments
	RN	HCA	Manage. Day	RN	HCA	Manage. Day	Other			0	1A	1B	2	3				
Ainslie	4	5	0	4	8 (+3)	0	1	Yes	3						2	20	1	1 x sectioned patient 2:1 special RMN & HCA
Allerton																		
Cheetham Hill	4	5	0	3 (-1)	7 (+2)	0	0	Yes	2						3	16	1	as early AP present in HCA numbers
Cromie																		
Dunlop	3	4	0	3	5 (+1)	0	2	Yes	1						2	12	1	lots of confused high falls risk patients.2 patients need speaciling
Ella Rowcroft	4	4	0	3 (-1)	3 (-1)	0	0	Yes	0						0	12	0	
Forrest	4	3	0	4	4 (+1)	0	3	Yes	1						0	11	1	12 medical patients. 3 x first year bnursing students. increased work load with medical outliers.
George Earle	4	5	0	4	6 (+1)	0	1	Yes	4						1	24	1	
McCallum																		
Midgley	5	4	0	5	4	0	1	Yes	2						0	9	0	
Simpson	4	5	0	4	5	0	0	Yes	3						2	23	0	2 x pts requiring 1:1
TCCU / TCPU	4	0	0	4	0	0	0	Yes	0						1	5	0	
Turner																		
Warrington																		

Planned v Actual Staffing Levels



4.0 Workforce Plans

The Trust vacancy factor continues to be at approximately 10% with 120 Registered Nurse vacancies. The Trust continues to face a recruitment challenge for registered nurses as experienced nationally. There is a continual workforce plan with an aim to close the vacancy gap over the next 5 years. In order to close this gap it is imperative that all of the recruitment supply lines continue as per plan below:

Appendix A

Bridging the Nursing Workforce Gap

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

Key Messages:

1) Student Nurse training places have increased since 2015 and therefore this will result in an increase in the number of newly qualified nurses available from 2018.

2) A further recruitment open day is scheduled for February 2017 with a further aim to attract third year student nurses due to qualify in September 2017. Interviews will take place on the day however the challenge is to ensure these numbers come to fruition through to September. Due to the number of national vacancies, nurses have the option to choose wherever they want to work. According to Plymouth University, the numbers of nurses applying for student nurse training from within our local footprint has reduced significantly however reasons for this are unknown at present. Return to practice nurses and rotation programme nurses will also form part of the open day.

3) From September 2017 the new Graduate Nurse Apprenticeship training will commence. This will enable a more practical based training with on the job learning. The new Apprenticeship standards have recently been approved by the NMC. This new programme will be marketed widely in the organisation together with the healthcare apprentice programme from level 2 through to Nurse training during March Apprenticeship week. The aim will be to target students in Devon studio school and other schools and colleges to showcase healthcare careers and focus on our local workforce.

4) International recruitment still needs to play a valuable part of the workforce plans in order to close the vacancy gap with the first 5 nurses from the Philippines due to arrive in February. They are currently awaiting the visa approval which is imminent prior to deployment to the UK.

The Trust is still currently on track as per original plan from the Philippines campaign and to date. 16 nurses have passed their IELTS and 5 have passed their CBT and certificates of sponsorship have been accepted. They are now in the process of applying for their Visa which will allow deployment to the UK. The remaining nurses are sitting their CBT exams over the coming week. The main challenge continues to be the written element of the IELTS which is reflected nationally with other Trusts.

The Associate Director of Nursing Workforce is working with other Trusts and NHSI to lobby the NMC regarding the challenges and issues faced together with the British Council. We are awaiting further negotiations and outcomes from this.

5.0 E Rostering

Over the past 6 months, a detailed piece of work has been undertaken to review current E Rostering practice. The initial focus was on 5 high agency spend wards. Rostering templates have been reviewed to ensure staff changes have been reflected and the publication of the new rostering practice guidelines was formally communicated on 28/10/2016.

Specific Key Performance Indicators (KPI's) have been identified which form part of the Lord Carter recommendations and are as follows:

Rosters are now being produced at least 8 weeks in advance by the pilot wards. In addition all ward areas have planned rosters on RosterPro ranging between 2 weeks and 6 weeks. This is a large improvement with some areas previously not having e-rosters completed until verification of actuals. Matrons sign off and approve rosters at 6 weeks.

Annual leave is being reviewed to ensure the correct amounts of staff are allocated leave and a new tool has been created as an aide memoire for Ward managers.

A lessons learnt and end stage report has commenced with input from the e-Rostering team and Matrons included in pilot. This will include a future rollout concept and on-going management processes proposal. Training from the e-rostering team has commenced together with a development plan for the B6 / B7 has been devised and due to start in February 2017.. The lessons learnt and recommendations will be finalised in the coming weeks to further agree plan of action.

6.0 Governance & Quality Monitoring

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

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

During the month of December the Associate Director of Nursing Workforce met with the ward managers to discuss rota's and any staffing concerns together with issues of clinical patient safety and quality. There were no concerns highlighted.

The Questt Dashboard is displayed in the table below for the Acute & Community Hospitals: The areas showing an amber score for December are Orthopaedic Theatres, Newton Abbot Teign Ward and Paignton Hospital.

Orthopaedic theatres: December score 16 (amber) an improving positions from 19 (Amber) in November 2016 - This team has now been amber for five consecutive months.

Identified risks: Vacancy rate, long term sickness, appraisals not performed. The specific questions for orthopaedic theatres triggered including number of lists overrun in the previous month, number of lists starting late in the previous month , and requirements to use loan equipment.

Actions: The band 7 is reviewing the list of orthopaedics cases each Tuesday for theatres effectiveness to improve the position for starting late or over running. Currently there a number of new surgeons who have recently commenced and the theatre managers are still undertaking bench marking operating time for various procedures times.

Paignton Hospital: In November the hospital triggered amber (13) and this has escalated to red 19 and Amber (14) in December. The main indicators are a new manager, vacancies, sickness, complaints and resolution to themes from complaints.

Action: A formal written action is in place which has been agreed with the SD and ADN for the Community Service Delivery Unit. This is discussed at the SDU board

Newton Abbot: In December the hospital has triggered an Amber (14) because of the escalation beds open and staffing these additional beds.

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

Service Type	Team	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
% Complete		51%	53%	56%	73%	78%	85%	89%	96%	100%	97%	99%	96%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		1	0	0	2	0	0	0	0	0	0	2	0
Total Amber (L1)		10	14	16	7	10	13	14	9	13	7	10	11
Total Green (L0)		40	39	40	53	68	72	71	87	87	90	87	85
Average Score		9.2	10.8	10.8	9.3	9.2	9.0	9.0	8.9	8.9	8.6	8.9	8.8
Acute	Ainslie				11	13	10	8	12	18	14	8	11
	Allerton			14	8	14	17	9	12	11	12	11	11
	AMU						16	12	11	4	3	11	6
	Anaesthetics							9	12	9	11	10	10
	Breast Care Unit				12	8	6	7	6	4	2	2	0
	Cath Lab						6	2	0	2	4	1	5
	Cheetham Hill						17	21	7	10	7	9	7
	Cromie				18	13	11	10	12	7	12	9	11
	DSU							7	13	10	15	9	11
	Dunlop					5	3	4	5	6	4	7	9
	Early Pregnancy / Fertility Service					4	4	0	2	2	0	4	4
	EAU3						6	7	9	4	9	12	7
	EAU4						17	10	9	9	11	9	9
	Ella Rowcroft				7	10	10	6	10	11	10	8	9
	Emergency Department						12	16	16	12	10	14	15
	Endoscopy								7	6	4	2	
	Forrest				14	18	16	16	14	14	7	9	6
	General Theatres							11	15	14	15	12	13
	George Earle						9	6	4	3	7	6	10
	Gynaecology Out-Patients Dept					11	7	2	13	2	4	7	6
	Hutchings							2	2	5	4	4	5
	ICU					12	4	3	7	5	7	8	

Quality Safety and Effectiveness Trigger Tool (QuESTT)

Torbay and

Service Type	Team	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
Acute	Louisa Cary					4	12		7	11		9	9
	MAT / TAIRU				10	5	4	5	4	5	9	5	3
	Maternity					11	10	13	13	6	6	10	6
	McCallum					8	4	8	6	6	9	12	13
	Midgley					11	11	11	13	8	9	11	11
	OPD			4	4	4	8	6	2	6	8	7	6
	Ophthalmology			11	10	10	9	10	14	13	15	8	13
	Ortho Theatres							17	19	16	19	16	16
	Pre-assessment			4	3	5	4	8	6	6	5	1	6
	Radiology									12	12	16	13
	Recovery								12	17	11	9	8
	RGDU					11	9		3	9	8	12	8
	SCBU					5	0	7	3	5		7	6
	Sexual Health							16	10	10	11	8	6
	Simpson						14	17	20	9	8	8	
	TCCU					5	5	2	4	4	2	0	0
	Turner				13	14	7	2	5	5	4	5	7
	Urology					6		5	6	9	13	8	14
	Warrington					14	11	12	10	9	5	6	6
Community Hospital	Ashburton	3	4	5	4	8	4	8	2	8	8	3	8
	Brixham	6	10	10	7	10	9	7	5	10	11	11	6
	Dartmouth	2	7	5	2	4	3	7	4	10	7	1	3
	Dawlish	3	1	0	1	0	1	1	4	3	5	2	0
	Newton Abbot Teign	4	8	8	5	9	6	5	0	8	8	10	14
	Newton Abbot Templar	3	10	6	9	6	7	6	9	8	8	8	8
	Paignton	13	10	5	6	9	9	11	10	8	13	19	14
	Totnes	6	6	11	10	10		3	4	3	10	2	10
MIU	Brixham	2	2	2	3	4	2	2	4	2	2	5	4
	Dawlish	7	3	5	0	2	4	2	2	4	2	2	0
	Newton Abbot	0	2	6	2	2	2	2	0	6	3	0	2
	Paignton	3	2	3	6	2	2	2	4	2	4	4	4
	Totnes	3	5	1	0	2	0	0	0	2	0	0	0

6.0. Agency & Temporary Staffing

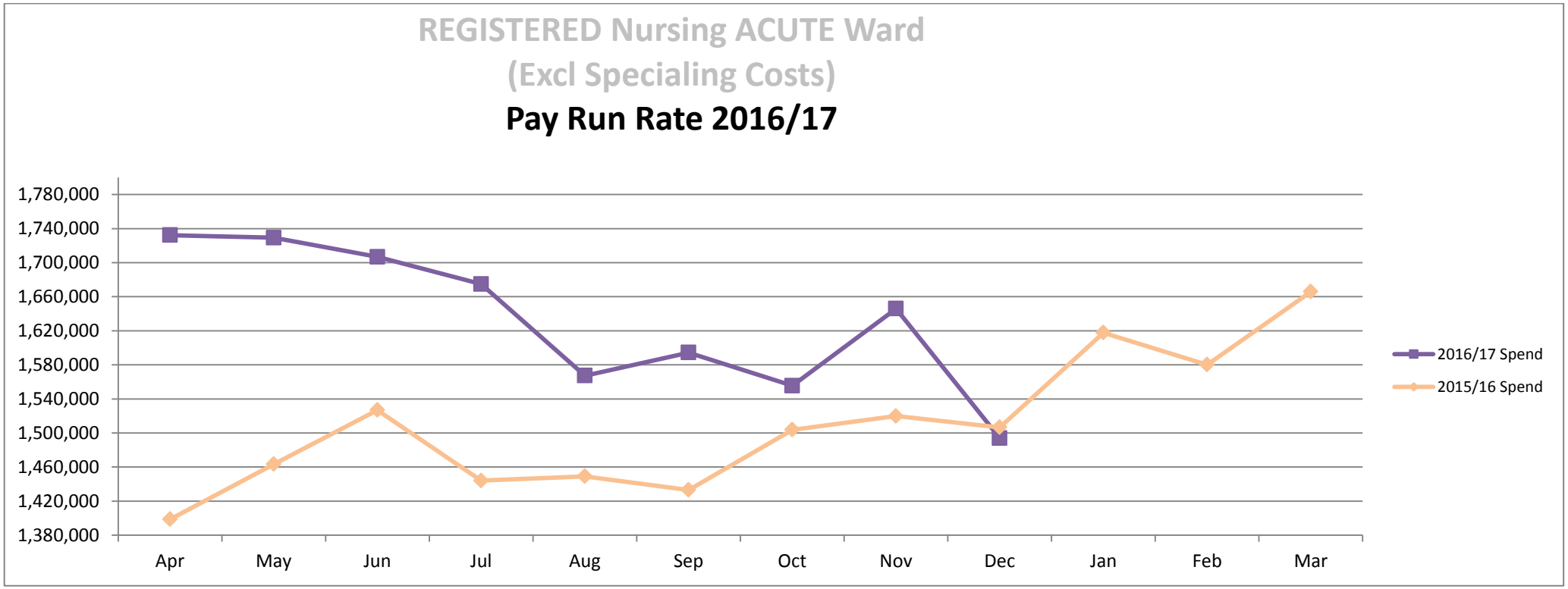
There continues to be a focus on driving down the use of agency and temporary staffing and significant progress has been made over the past months. The Associate Directors of Nursing continue to review of all agency requests weekly. The fulltime overtime incentive continues and this month the new part time overtime incentive has been introduced to help further reduce the shifts going to agency. This will enable the trust to have more bargaining power with the agencies to bring down their rates within the agency cap.

In addition the following actions have been taken to help further reduce agency. These being provide additional nursing hours to a number of wards from the education and training team and to include on the ward rota's. Postpone mandatory training which releases clinical staff back into their teams who were booked to attend training. Ward Managers to be included in the numbers and working clinically on shift. All matrons to work one ward shift per week.

The recent NHSI Agency regional performance report for November suggests TSDFT is ranked 42 out of 55 Trusts and is for all agency spend v ceiling %. Whilst there has been significant progress in Nursing for reducing spend, there is still further work to bring the spend within the capped rates.

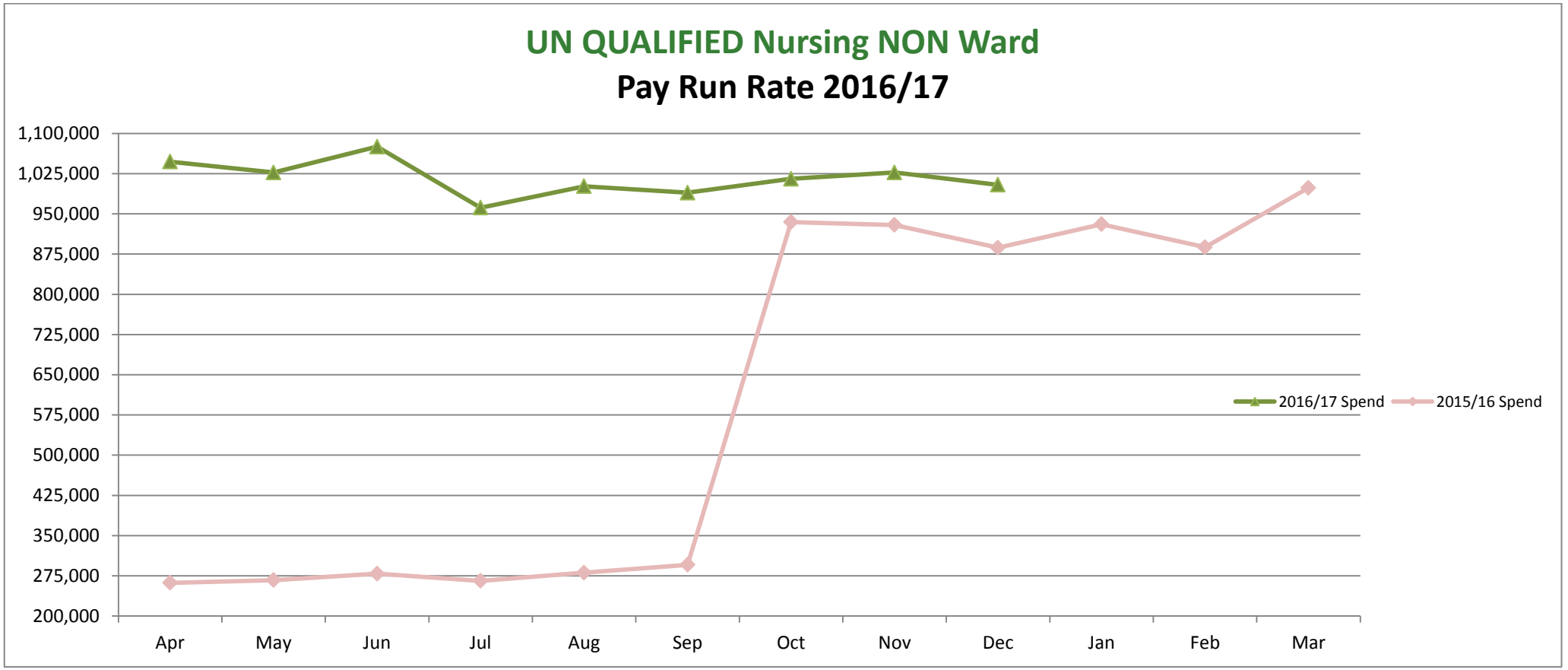
The table below shows a reduction in £152,038 total spend at month 9 with a reduction of £86,916 in agency and £67,307 in substantive pay. This would suggest that progress is being made in relation to the use of agency as the use of bank work has increased by £2,185. The reduction in substantive pay from the previous pay reflects vacancies and/or a reduction in overtime during December.

	Data								
actlvl3_code_description	Sum of 2016012	Sum of 2016022	Sum of 2016032	Sum of 2016042	Sum of 2016052	Sum of 2016062	Sum of 2016072	Sum of 2016082	Sum of 2016092
1AGENCY-Agency	301,792	421,334	401,377	364,465	263,983	290,975	209,966	244,417	157,501
1BANK-Bank	82,678	50,606	45,508	60,141	57,977	45,457	59,395	48,222	50,407
1STD-Standard	1,347,843	1,257,268	1,259,874	1,250,178	1,245,326	1,257,908	1,286,187	1,353,306	1,285,999
Grand Total	1,732,313	1,729,209	1,706,759	1,674,784	1,567,286	1,594,340	1,555,548	1,645,945	1,493,907
2016/17 Spend	1,732,313	1,729,209	1,706,759	1,674,784	1,567,286	1,594,340	1,555,548	1,645,945	1,493,907
2015/16 Spend	1,398,688	1,463,349	1,526,915	1,444,045	1,449,067	1,433,184	1,503,773	1,519,817	1,506,582



The Table below shows a reduction in spend of £22,927 for unqualified staff. Again there is a reduction substantive pay by £19,158 indicating potential vacancies or shifts that have been uncovered during December

	Data								
actlvl3_code_description	Sum of 2016012	Sum of 2016022	Sum of 2016032	Sum of 2016042	Sum of 2016052	Sum of 2016062	Sum of 2016072	Sum of 2016082	Sum of 2016092
1AGENCY-Agency	-7,465	8,709	-4,503	3,621	1,891	-3,385	785	0	0
1BANK-Bank	228,527	194,287	242,362	167,161	210,331	192,235	205,260	197,878	194,109
1STD-Standard	826,313	824,040	837,385	790,753	789,298	800,529	809,364	829,223	810,065
Grand Total	1,047,375	1,027,036	1,075,244	961,535	1,001,520	989,380	1,015,409	1,027,101	1,004,174
2016/17 Spend	1,047,375	1,027,036	1,075,244	961,535	1,001,520	989,380	1,015,409	1,027,101	1,004,174
2015/16 Spend	261,960	266,969	278,916	265,511	280,716	295,518	934,687	929,261	886,865



The table below shows the agency capped rates as determined by Monitor and our actual variance for Nursing (December 2016).

The Agency cap in month is £161K, YTD £1,775K, Usage in month is £298K, YTD £3,587K. Since M7 – the Nursing agency cap has already been exceeded. The M9 agency usage is lower by £61K from November usage and the YTD overspend against the cap is £1,811K representing 4.0% more than the revised cap of 4.3%

Foundation Trust

Trust Agency Information - Nursing/Midwifery and Health Visiting Staff

Financial Year 2016/17

	April £m	May £m	June £m	July £m	August £m	September £m	October £m	November £m	December £m	YTD 16-17 £m
Revised Agency Ceiling - June 2016	April	May	June	July	August	September	October	November	December	FY 2016-17
Qualified nursing, midwifery and health visiting staff (agency)	(0.272)	(0.266)	(0.259)	(0.168)	(0.163)	(0.156)	(0.167)	(0.163)	(0.161)	(1.775)
Qualified nursing, midwifery and health visiting staff, total	(4.633)	(4.631)	(4.629)	(4.723)	(4.723)	(4.721)	(4.531)	(4.531)	(4.532)	(41.655)
Qualified nursing, midwifery and health visiting staff, total	6%	6%	6%	4%	3%	3%	3.7%	5%	5%	4.3%
Actual	April	May	June	July	August	September	October	November	December	FY 2016-17
Qualified nursing, midwifery and health visiting staff (agency)	(0.442)	(0.544)	(0.552)	(0.457)	(0.335)	(0.344)	(0.256)	(0.359)	(0.298)	(3.587)
Qualified nursing, midwifery and health visiting staff, total	(4.980)	(4.927)	(4.969)	(4.824)	(4.678)	(4.690)	(4.685)	(4.857)	(4.724)	(43.334)
Qualified nursing, midwifery and health visiting staff, total	9%	11%	11%	9%	7%	7%	5.5%	7.4%	6.3%	8.3%
Variance	April	May	June	July	August	September	October	November	December	FY 2016-17
Qualified nursing, midwifery and health visiting staff (agency)	(0.170)	(0.278)	(0.293)	(0.289)	(0.172)	(0.188)	(0.089)	(0.196)	(0.137)	(1.811)
Qualified nursing, midwifery and health visiting staff, total										
Qualified nursing, midwifery and health visiting staff, total	3%	5%	6%	6%	4%	4%	1.8%	2%	1%	4%
Comment	M1 to M9 Actual is higher than revised Ceiling by £1.811m YTD, 4.0% more than the revised ceiling of 4.3%									

Registered WARD Nursing Gross Variances - YTD Month 01-09, 2016/17 (Excludes Specialling costs)

(Ie excludes any CIP or Slippage Targets)

		Cost Centre	YTD Net STD & Bank	YTD Agency	Overall Net Variance	
ACUTE	URGENT	08300-Accident & Emergency	-419,020	870,687	451,667	**OVER**
		02300-Warrington Ward	-312,026	470,585	158,560	**OVER**
		02405-Discharge Lounge	-3,794	587	-3,207	**Under**
		00700-EAU3 - Emergency Assessment Unit Level 3	98,465	58,787	157,252	**OVER**
		08400-EAU4 - Emergency Assessment Unit Level 4	-82,435	122,770	40,335	**OVER**
	Medicine	00900-George Earle Ward	-10,651	52,129	41,478	**OVER**
		01100-Dunlop Ward	16,468	19,861	36,329	**OVER**
		01200-Turner Ward	-42,731	20,504	-22,227	**Under**
		01300-Midgley Ward	-16,849	123,260	106,412	**OVER**
		02000-Cheetham Hill Ward	4,833	103,438	108,271	**OVER**
		02200-Simpson Ward	27,109	80,977	108,086	**OVER**
	Surgery	04000-Allerton Ward	514	3,700	4,214	**OVER**
		04100-Cromie Ward	-88,976	185,318	96,343	**OVER**
		04200-Forrest Ward	-15,486	228,461	212,975	**OVER**
		04300-Intensive Care Unit	-208,770	109,154	-99,615	**Under**
		05200-Ella Rowcroft	470	2,545	3,016	**OVER**
		05300-Ainslie Ward	-56,022	88,137	32,116	**OVER**
	Womens / Childrens	09300-McCallum Ward	14,343	4,570	18,913	**OVER**
		09800-Special Care Baby Unit	2,832	18,527	21,358	**OVER**
		42700-Louisa Cary Ward	397	61,680	62,077	**OVER**
	Acute Sub Total		**-1,091,327**	**2,625,678**	**1,534,351**	**OVER**

COMMUNITY		86521-Ashburton Hospital	-10,742	9,610	-1,132	**Under**
		86103-Brixham Inpatients	-117,576	56,003	-61,573	**Under**
		86461-Dartmouth Inpatients	-50,856	25,316	-25,540	**Under**
		86501-Dawlish Hosp Genrl	-39,070	12,724	-26,347	**Under**
		86554-Stroke Unit Teign Ward	35,114	71,637	106,751	**OVER**
		86541-Templar Ward N Abbot	-58,437	10,183	-48,253	**Under**
		86107-Coverdale-Paignton	-118,958	17,642	-101,316	**Under**
		86482-Totnes Dart Ward	-83,586	108,732	25,147	**OVER**
		86506-Kingfisher Ward	-109,720	23,030	-86,691	**Under**
	Community Sub Total		**-553,830**	**334,875**	**-218,955**	**Under**

WARDS OVERALL GRAND TOTAL (Gross, excluding CIP / Slip Targets)	**-1,645,158**	**2,960,554**	**1,315,396**	**OVER**

The above table shows the current overspend of £1.315,396 for Registered Nurses at month 9. £807,814 of this is applicable to ED and the emergency pathway and is attributed to the additional staffing costs agreed by the board post CQC. The overall overspend for registered ward based nursing at month 9 is £500,582

Key Messages:

Over the past 6 months, significant progress has been made to reduce the amount of agency and temporary staff usage. Actions implemented include a review of agency authorisation process, an immediate ban on HCA agency use, cessation of high cost non-framework agencies except for specialist areas and RMN. Robust Senior Nurse roster review with the Ward Managers and Matrons, introduction of bank HCA premium rates and overtime for full time Registered Nurses. These actions have contributed to a reduction in the number of agency shifts

There is a continual focus on driving down agency use towards our capped rates as determined above. The E rostering programme of work will continue to ensure rostering KPI's are adhered too. A further incentive for part time staff has been introduced in January and this will be reviewed each month for the next couple of months until the arrival of the overseas nurses. The weekly shift review will continue along with

the full time staff overtime incentive. This should help further reduce the number of agency shifts however close monitoring will be undertaken of staff outcomes to ensure sickness absence levels do not increase. A continual focus on the workforce plans and recruitment & retention strategies will continue to help close the vacancy gap to therefore reduce the number of agency/temporary staff requests.

Matrons and Associate Directors of Nursing will continue reviewing rosters and the risk assessing the acuity of their areas on a shift by shift basis and redeploy staff as necessary to mitigate any high risk areas. Staffing concerns and quality & safety concerns are all discussed on a weekly basis with the Associate Directors of Nursing, Deputy Directors and Chief Nurse and a monthly Nursing Workforce report is also produced each month for the Quality Improvement group.

The Associate Director of Nursing Workforce will continue to monitor patient safety outcomes including patient falls, medication errors and staffing incidents to ensure patient safety & quality are not compromised due to staffing levels & skill mix.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
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

- Meeting the required delivery timescales and benefits realisation plans in the care model implementation plan
- Capacity gaps in domiciliary care impacting management of winter pressures
- Delays in implementing the Management restructure on staff morale
- RTT compliance and potential increase in 52 week waiters
- Capacity to take forward the work on 7 day working strategy and work plan

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 the programme
- Clinical engagement in the enabling schemes that will support the hospital bed reconfiguration programme
- Action to address RTT compliance within known constraints and action to be taken to address 52 week waiters
- Ongoing capacity gaps in domiciliary care and actions being taken to mitigate the risks to patient experience and management of winter pressures
- Timeliness of progress in implementing the management restructure

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

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Board of Directors
Date:	1st February 2017
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 Delivery Group
- Minutes and action log from Senior Business Management Team
- Minutes of the Executive Team
- Minutes and action log from weekly review meeting with Mears
- Minutes and action plan from the RTT and diagnostics risk and assurance group
- Minutes and action log Urgent Care Improvement and Assurance Group
- Peer review reports – cancer services of unknown origin (CUP)

3 Care Model Delivery

Governance arrangements

The terms of reference of the Care Model Delivery Group have been refreshed to support the rapid implementation of the care model following the formal consultation on community changes. The Governing Body of South Devon and Torbay CCG will be considering a set of recommendations informed by feedback from the consultation process at its meeting on 26th January 2017 and this will inform the final shape of the community plans.

The meeting oversees the delivery of 38 individual programmes of work (appendix 1- Programme summary) and directs the enabling work streams to include; finance, workforce, IM&T and Estates.

The group is attended by the senior leaders that are accountable for delivery of work programmes including members of the Executive Team and senior clinical staff. It meets on a fortnightly basis to ensure appropriate attention is given to all aspects of the programme.

There are a number of 'task and finish' groups that are driving delivery of the work programmes, these include locality groups that are developing and taking forward implementation plans on each of the 5 localities and a disinvestment group that will be accountable for implementing the plans to reduce costs through the intended reduction in bed based care.

Finance

The Board of Directors approved an investment in the care model of £3.9 million in 2016/17 to support early implementation of community services aimed at improving the range of options that support people remaining at home and better manage a growth in demand for services.

The attached schedule (appendix 2) details spend to date and the full year effect of these investments. This confirms that the forecast spend to the end of the financial year is £3 million with a FYE of £6.7 million. At this stage no further commitment has been made pending the decision of the CCG following consultation.

Care model developments

- The enhanced intermediate care teams are building up their case load resulting in more people being supported in community settings. The teams are setting activity trajectories as a way of ensuring that capacity is being maximised in line with plans. The performance and information team are developing a performance schedule to enable routine monitoring of this activity. There is further work required to support the development of the Moor to Sea locality team where the team leader appointment has been recently made.
- Discharge to Assess (D2A) has been put in place as part of a strategy to reduce the time people need to remain in hospital. The initial focus has been on the wards that have been utilising the SAFER bundle. Although numbers of discharges to D2A have increased there is more work to do to optimise capacity. To support this it has been agreed that the Intermediate Care Teams will in-reach into the hospital supporting ward based teams to identify people who can be safely and appropriately supported in a community setting.
- SWAST pilot- The Community Teams have initiated a pilot project with SWAST with the aim of reducing the number of people conveyed to hospital. The project involves pairing a paramedic with an experienced member of the community services team who attends ambulance call outs. The initial results have been promising with a number of conveyances reduced by up to 5 a day. It has been agreed to extend the pilot with a view to meeting a 'best in class' standard of 8 avoided admissions to hospital per day.
- Single point of coordination (SPOC) - the Torbay telephony SPOC is in place and work has commenced with Devon County Council with a view to developing a single system for Devon.
- Seeking advice in the ICO- the project has been well received and has been extended to a broader range of specialities. Work is underway to assess the impact on referrals to secondary care.
- The 'My Support Broker' independent brokers have completed their training and are starting to receive referrals from community teams. Although working well for people who have accessed the service, referral numbers are low. This is likely to be a cultural issue for staff unused to delegating this function to a 3rd party organisation. To address this, referral pathways have been reviewed, staff briefing sessions are being held and targets set for delivery. The evidence from other systems is that this approach supports delivery of individualised care plans with improved service user satisfaction at a reduced cost.

Risks to delivery

The Care Model Delivery Group maintains a risk register and risks are reviewed as part of routine project governance which includes risk mitigation plans. The risks scoring over 15 on the risk register include:

- Impact of internal recruitment to care model developments impacting on delivery of existing services
- Capacity to release clinical and project management support to delivery of care model changes
- Capacity within the voluntary sector in all localities
- Slippage on delivery of schemes impacting on the delivery of care model savings
- Lack of a shared or centralised care record
- Progress in agreeing a one system IM&T strategy that will support delivery of the care model
- Medical staffing capacity to progress the full benefits of the frailty pathway.

4 Mears update

Mears is leading the living well@home contract in Torbay and was identified as a provider of concern as a result of a Healthwatch investigation and a CQC Inspection which rated the services provided by Mears in Torbay 'inadequate'. A joint agency management team led by Torbay Council has been meeting with Mears on a weekly basis to address concerns and ensure that standards are delivered. Enhanced management support has been put in place by the Trust to oversee safety and support Mears in addressing the concerns raised. To date the following has been put in place.

- An integrated management plan has been agreed that addresses the issues highlighted in both reports
- A set of key performance metrics has been identified, including client and staff experience measures, that will measure the impact of the action plan. Standards and improvement trajectories, where appropriate, have been agreed against each metric
- A dashboard has been developed and is accessed independently through a web based portal
- Daily reporting on delivery against core access standards
- Joint working arrangements have been put in place to support the brokerage function.
- Contingency arrangements have been put in place to reduce the impact of loss of capacity within Mears

Although early days the Information provided more recently is giving improved confidence that change is being implemented and the service to clients has improved. In response to this it has been agreed that the voluntary suspension will be reviewed allowing Mears to take on some new packages of care.

The routine performance and contract monitoring arrangements are being strengthened and it is anticipated when assurance is given that sustainable improvement has been achieved the Provider of Concern meetings will be stood down and performance monitored through these contract management arrangements.

The following risks and issues are highlighted:

- Lack of capacity to meet demand for domiciliary care in the Bay as sub-contractors have not been able to absorb demand
- Limited information provided from Mears on the performance of sub-contractors
- Recruitment and turnover of staff

5 Management restructure

There has been a protracted period of engagement with staff on a new operational management structure. It has been agreed that the revised proposals will now be presented to the Joint Consultation and Negotiating Committee on 30 January with a view to starting formal consultation in early February. It is anticipated that appointments to the Senior Leadership Teams will commence in April 2017.

Interim management arrangements have been put in place to enable a number of management vacancies to be held.

6 7 Day working

The Executive Team has identified as one of its priorities in 2016/17 to take forward the implementation of 7 day working in line with national guidance.

The implementation of 7 day working sits at the heart of the care model and will be essential to delivering sustainable services going forward. The investments made in the care model to date have enabled services to build capacity at weekends. For example the Intermediate Care service is available on Saturdays and plans are in place to provide this service 7 days a week from the end of March 2017. In the acute setting there has been a review of working practices that has resulted in improved numbers of consultants being available at weekends to support the review of patients. However, if the aspirations of the national plans for 7 day working are to be delivered there is a need to assess our need locally, measure current delivery and agree a local strategy and implementation plan.

A working group has been established led by Ian Currie, Deputy Medical Director and supported operationally by Liz Davenport, Chief Operating Officer. This group has been tasked to come forward with a recommendation on Trust priorities for 7 day working. The group has reviewed the guidance and has concluded that the initial priority is to ensure that the Trust is compliant with the 4 priority clinical standards for 7 day working.

These standards are:

- **Standard 2** - Emergency admissions to be seen within 14 hours by a suitable consultant
- **Standard 5** - Access to diagnostics within 1 hour for critical patients and 12 hours for urgent patients
- **Standard 6** - Access to Consultant directed interventions
- **Standard 8 -** Critical patients seen twice daily and all patients every 24 hours by a consultant

An audit of our current performance was completed in July 2016 which involved a retrospective review of emergency admissions and a survey of Consultants about access to diagnostics and interventions.

The outcome of the audit has confirmed that the Trust performs well against the South of England regional mean but has identified a number of areas where improvements can be made. In summary:

Standard 2

- 53% of patients were seen by an appropriate consultant within 14 hours of arrival
- There is no 'weekend effect'
- Illness severity does not relate to timeliness of consultant review
- Time of day for admission determines likelihood of a consultant review

Standard 5

- Access to CT and microbiology is good
- Echocardiography access at weekends could be improved
- Upper GI endoscopy could be improved
- Access to histopathology at weekends is difficult but this does not affect emergency clinical care

Standard 6

- Access to cardiac pacing, general surgery and PPCI is good
- Interventional endoscopy and radiology is available but needs an improved awareness of the service
- Renal replacement is available but needs improved awareness of the service
- Urgent radiotherapy access could be improved

Standard 8

- ICU – twice daily reviews
- 66% of ward patients seen by a Consultant at the weekend

The group has agreed that the initial focus of the work plan will be on these areas and will include a focus on:

- Review of best practice examples locally and nationally
- Workforce development
- Review of working practices and job plans
- Development of general assessment and ambulatory care services
- Developing IT strategies including using of telemedicine technologies
- Access to information on available services through centrally accessed directory of services

A detailed strategy and work plan will come to a future meeting of the Board in due course.

7 Operational delivery

Urgent Care

The improvement programme for Urgent Care has been overseen by the Urgent Care Improvement and Assurance group chaired by the Chief Operating Officer which has been meeting on a fortnightly basis. The group has made good progress in implementing the agreed action plan resulting in an overall improvement in performance. Although further work is required the team in the Emergency Department requested that they were given the opportunity to take over leadership of the on-going programme of work. The Executive agreed that the criteria for transitioning the work programme back to routine governance had been met. The team have been congratulated on the progress to date and have been offered on-going support.

Referral to Treatment standard

The Trust has seen a deteriorating level of performance as set out in the detailed briefing provided to the Board at its meeting in December 2016. NHS Improvement has approached the Trust with an offer of some external support to address current levels of delivery. In offering the support there was an acknowledgement of the current challenges to delivery and a good level of confidence in our planning processes.

It has been agreed that an initial meeting will be held with the external consultants with a view to establishing what help would be appropriate.

8. **Cancer of Unknown Primary (CUP) – peer review outcomes**

The Quality Surveillance Team completed a peer review of CUP services in July 2016 and published a report that in January 2017. The review looked at 2 areas:

- CUP Hospital services
- CUP Multi- disciplinary team arrangements

The outcome of the Hospital based services review confirmed that all standards were being met with the peer review team's findings consistent with our self-assessment.

The review of MDT services highlighted 3 issues:

- Sustainability of the MDT arrangements as a result of a CNS vacancy
- A requirement to have a stand- alone CUP MDT meeting
- Out of hours cover from RD&E and a request that the arrangement is formalised

The cancer services team developed an action plan in response to the report and I can confirm the following:

- A stand-alone MDT has been established
- Recruitment has been made to the vacant CNS and the individual is now in post
- Arrangements are in place with RD&E to support out of hours working arrangements

Recommendation

To note the content of the report

Liz Davenport
Chief Operating Officer
23 January 2017

Care Model Delivery Overview

Working with you, for you

	Task Name	Confidence	Start	Finish	Duration	Assigned To	Complete	Comments
1								
2							☐	***Guidance for Confidence Ratings***
3							*Red*	*Significant issues which are likely to impact delivery of project objectives. Requires corrective action/decision beyond the authority/remit of the project lead/team*
4							*Yellow*	*Some issues having a negative effect on project performance, project lead/team to take action to resolve or monitor the situation*
5							*Green*	*Project is performing to plan and is expected to deliver objectives*
6								
7	**Care Model Delivery Overview**							
8								
9	**Community consultation**	**60%**	**01/09/16**	**01/03/17**	**129d**		☐	
10	Formal consultation		01/09/16	23/11/16	60d		☑	
11	Review of responses		24/11/16	15/02/17	46d		☐	
12	CCG Governing body decision (date tbc)		26/01/17	01/03/17	0		☐	
13								
14	**Torquay locality**	**60%**	**01/06/16**	**31/03/17**	**189d**	**Cathy Williams**	☐	
15	Wellbeing coordination service in place	🟢	30/12/16	30/12/16	0	Des Atkins	☐	Service is in place and receiving referrals, however there is a concern about capacity/capability within the organisation to evaluate impact.
16	Non-statutory support offer fit-for-purpose	🔴	31/03/17	31/03/17	0	Bruce Bell	☐	Bruce Bell is now leading a piece of work around Asset Based Community Development which will help to deliver this objective; however it is unlikely to be achieved within the planned timeline.
17	Prevention and screening approach embedded into practice	🟡	31/03/17	31/03/17	0	Des Atkins	☐	Training underway with staff in the locality. Some concerns that this will absorb HSCC time and reduce productivity - will need to be carefully monitored in practice.
18	SW led Wellbeing Clinics in place in Torbay	🔴	30/12/16	30/12/16	0	Jo Williams	☐	Capacity and recruitment issues in Social Work impacting ability to progress
19	Telephony SPOC for Torbay complete	🟢	13/08/16	13/08/16	0	Steve Honeywill	☑	In place for Torbay and working successfully
20	New Pathway with Mears to review POC live	🔴	30/12/16	30/12/16	0	Cathy Williams	☐	The project has been suspended until further notice. Assurance re: quality and safety of the service would be essential before further development could be considered.
21	Integrated MDT practice in place	🟢	01/10/16	01/10/16	0	Des Atkins	☑	MDT working well, including IC and GPs. Locality Pharmacists will also be embedded once in place.
22	All staff employing principles of Strengths Based Approach in their practice	🟡	28/04/17	28/04/17	0	Chris Edworthy	☐	In excess of 130 staff have been through strengths-based awareness workshop/training across nursing, physio, social work, OT, administrators.
23	Locality estate configuration complete	🟢	31/03/17	31/03/17	0	Evie Langman	☐	No further changes planned for Torquay within programme scope
24	All relevant partners engaged and on-board	🟢	28/02/17	28/02/17	0	Cathy Williams	☐	Dr Sarah Rowe supporting GP engagement. Continued partner engagement at regular H&WB team meetings.
25	Workforce in place	🟢	01/10/16	01/10/16	0	Des Atkins	☑	No further changes anticipated outside BAU
26	Implement data sharing agreement within primary care	🟢	01/11/16	01/11/16	0	Steve Holman	☑	In place for EMIS
27								
28	**Coastal locality**	**90%**	**01/04/15**	**31/10/17**	**675d**	**Pat McDonagh**	☐	
29	Wellbeing coordination service in place	🟢	11/07/16	11/07/16	0	Richard Baker	☑	
30	Non-statutory support offer fit-for-purpose	🟡	31/03/17	31/03/17	0	Phil Heywood	☐	
31	Prevention and screening model in place	🔴	31/03/17	31/03/17	0	Richard Baker	☐	Requires development with DCC Public Health
32	Integrated MDT practice in place	🟢	31/03/17	31/03/17	0	Richard Baker	☐	
33	All staff employing principles of Strengths Based Approach in their practice	🟡	31/12/16	31/12/16	0	Chris Edworthy	☐	
34	Merger of Teignmouth and Dawlish MIU complete	🟢	30/06/16	30/06/16	0	Pat McDonagh	☑	
35	Locality estate configuration complete	🟢	31/12/16	31/12/16	0	Evie Langman	☑	
36	All relevant partners engaged and on-board	🟢	31/12/16	31/12/16	0	Pat McDonagh	☐	
37	Workforce in place	🟡	01/10/16	01/10/16	0	Richard Baker	☐	
38	Implement data sharing agreement within primary care	🟢	30/06/16	30/06/16	0	Richard Baker	☑	
39								
40	**Moor-to-sea locality**	**50%**	**01/04/16**	**31/10/17**	**413d**	**Lee Baxter**	☐	
41	Wellbeing coordination service in place	🟢	16/09/16	16/09/16	0	Julian Ayrton	☑	
42	Non-statutory support offer fit-for-purpose	🔴	17/09/16	17/09/16	0	Phil Heywood	☐	Operational capacity to scope and develop relationships locally is insufficient
43	Prevention and screening model in place	🔴			0	Lee Baxter	☐	Requires development with DCC Public Health
44	Integrated MDT practice in place	🟡	30/09/16	30/09/16	0	Lee Baxter	☐	
45	All staff employing principles of Strengths Based Approach in their practice	🟡	31/03/17	31/03/17	0	Chris Edworthy	☐	
46	Locality estate configuration complete	🔴	31/03/17	31/03/17	0	TBC - Lesley Darke to confirm	☐	Operational/Leadership capacity not sufficient to progress at pace
47	All relevant partners engaged and on-board	🟢	31/10/16	31/10/16	0	Lee Baxter	☐	
48	Workforce in place	🟡	31/03/17	31/03/17	0	Julian Ayrton	☐	
49	Implement data sharing agreement with primary care	🟡	31/05/17	31/05/17	0	Lee Baxter	☐	Leadership/operational capacity in locality insufficient to progress
50								
51	**Newton Abbot locality**	**70%**	**01/04/16**	**31/10/17**	**413d**	**Helen Ireland**	☐	**Helen Ireland has just started role as locality AD for Newton Abbot. There is currently no operational delivery plan in place - Helen is in the process of working this up. This work needs to be done in order to revise and update plans in Smartsheet - further evidence of progress required. Helen aims to gather this and have an outline operational plan by mid Jan**
52	Wellbeing coordination service in place	🟢	01/02/17	01/02/17	0	Sue Wroe	☑	
53	Non-statutory support offer fit-for-purpose	🟢	31/12/16	31/12/16	0	Phil Heywood	☐	
54	Prevention and screening model in place	🔴	31/03/17	31/03/17	0	Sue Wroe/Robert Bradshaw	☐	Requires development with DCC Public Health
55	Integrated MDT practice in place	🟡	31/03/17	31/03/17	0	Robert Bradshaw	☐	
56	All staff employing principles of Strengths Based Approach in their practice	🔴	31/01/17	31/01/17	0	Chris Edworthy	☐	
57	Locality estate configuration complete	🟡	31/03/17	31/03/17	0	Lesley Darke	☐	
58	All relevant partners engaged and on-board	🟢	31/12/16	31/12/16	0	Paul Johnson	☐	
59	Workforce in place	🟡	30/11/16	30/11/16	0	Robert Bradshaw	☐	
60	Implement data sharing agreement within primary care	🟡	28/02/17	28/02/17	0	Robert Bradshaw	☐	
61								
62	**Paignton & Brixham locality**	**50%**	**01/07/16**	**01/09/17**	**413d**	**Steve Honeywill**	☐	
63	Wellbeing coordination service in place	🔴	09/09/16	09/09/16	0	Helen Harman	☐	
64	Non-statutory support offer fit-for-purpose	🔴	31/01/17	31/01/17	0	Phil Heywood	☐	Limited capacity of voluntary sector in Torbay to manage volume and complexity of the demand; clear pathways required
65	Prevention and screening model in place	🔴	01/04/17	01/04/17	0	Emma Bewes	☐	Limited capacity in Lifestyles service to develop and support model long-term
66	SW led Wellbeing Clinics in place in Torbay	🔴	30/12/16	30/12/16	0	Jo Williams	☐	Capacity and recruitment issues in Social Work impacting ability to progress
67	Telephony SPOC for Torbay complete	🟢	13/08/16	13/08/16	0	Steve Honeywill	☑	
68	Integrated MDT practice in place	🟡	31/03/17	31/03/17	0	Emma Bewes	☐	

	Task Name	Confidence	Start	Finish	Duration	Assigned To	Complete	Comments
69	All staff employing principles of Strengths Based Approach in their practice		31/01/17	31/01/17	0	Chris Edworthy		
70	Make decision on support planning model for the future (following MSB pilot and evaluation)		31/05/17	31/05/17	0	Steve Honeywill		
71	Locality estate configuration complete		31/03/17	31/03/17	0	Evie Langman		Pending estates solution for Paignton Health and Wellbeing Centre
72	All relevant partners engaged and on-board		01/04/16	01/04/16	0	Steve Honeywill		
73	Workforce in place		31/03/17	31/03/17	0	Emma Bewes		
74	Implement data sharing agreement within primary care		05/08/16	05/08/16	0	Steve Honeywill	✓	
75								
76	**Locality-wide developments**	60%	**01/11/16**	**01/08/17**	**195d**	**Liz Davenport**		
77	SPOC for Torbay and South Devon complete		01/09/17	01/09/17	0	Shelly Machin		Dependent on negotiations with DCC
78	Enhanced Intermediate care service live		01/11/16	01/11/16	0	Su Skelly		
79	SWAST protocol in place and live		01/04/17	01/04/17	0	Su Skelly		
80	New integrated medical model live		01/04/17	01/04/17	0	Su Skelly		
81	Integrated medicines optimisation model live across patch		01/07/17	01/07/17	0	Paul Foster		
82	Video Conference trial commences		16/01/17	22/09/17	180d	Unallocated		
83	All Enhanced Specialist Nursing pathways live		01/08/17	01/08/17	0	Lorraine Webber		Lack of clinical capacity to progress in some areas due to vacancies
84	New mental health support pathways live		01/07/17	01/07/17	0	Rob Dyer		See Risk Register
85	IM&T support for remote/mobile working in place in all localities		01/04/17		0	Gary Hotine		See Risk Register
86								
87								
88	**Acute Frailty**	50%	**01/10/15**	**30/03/18**	**652d**	**Liz Davenport**		
89	New pathway defined		01/02/16	01/02/16	0	Lesley Wade	✓	
90	Identify base for team		01/09/16	28/02/17	129d	Lesley Wade		Dependent on acute reconfiguration
91	Refine clinical/medical model		01/04/17	01/04/17	0	Lesley Wade		See Risk Register - consultant capacity insufficient to support the model
92	Phase 1: Service launch Mon to Fri 09:00 - 17:00		01/09/16	28/02/17	129d	Lesley Wade		
93	Identify base for team		01/09/16	28/02/17	129d	Lesley Wade		An ambulatory assessment area with potential for lodging would be required in the long term; dependent on acute hospital reconfiguration. Sep 2016 - no area as yet identified, will be required for extension of the team.
94	Analysis of Phase 1		01/03/17	31/03/17	23d	Lesley Wade		
95	Link with new community service model		01/10/15	29/09/17	522d	Lesley Wade		
96	Service in place and fully utilised		30/03/18	30/03/18	0	Lesley Wade		
97								
98	**Disinvestment Programme**							
99	Define which services are in Clinical Hubs and Health and Wellbeing Centres		18/11/16	18/11/16	0	Liz Procter		
100	Clinical Validation and Impact Analysis		01/12/16	01/12/16	0	Liz Procter		
101	Baseline the current community clinic activity levels		14/12/16	31/03/17	78d	Liz Procter		
102	Develop Community Outpatient Reconfiguration Plan							
103	Identify roles which will be impacted by change and assess scope of impact		18/02/17	18/02/17	0	Mike Mogford		Achievable for community hospital inpatients staff as scope and detail is known; however further scoping and clarification is needed for outpatient and any other services affected - dependency on disinvestment projects
104	Implement staff consultation plan		01/03/17	31/05/17	66d	Mike Mogford		
105	Redeploy staff from the existing sites							
106								
107	**Other projects and innovations**		**21/12/14**	**01/02/18**	**815d**			
108	Integrated Personal Commissioning	70%	01/06/15	15/05/17	511d	Helen Davies-Cox		
109	Prevention, Wellbeing and Self-Care: System Wide	60%	25/01/16	30/12/16	245d	Paul Hurrell		Requested access to be restored by CW
110	Seeking Advice in the ICO (SAICO)	90%	15/02/16	30/12/16	230d	Beverley Parker		Some updates made but query RAG and confidence as elements of roll out put on hold - requested more ifnormation
111	Multi LTC Service	10%	31/03/15	01/02/18	743d	Suzanne Matthews		On hold as project not viable in current form - decision to be made regarding future of project - Joanne Watson will lead
112	MSK Pathway (hip and knee)	60%	31/01/15	30/12/16	501d	Frances Hunt		In process of being updated by PM
113	Diabetic Foot Amputations	90%	01/01/15	30/09/16	457d	Angie Abbot		Queries with AA whether this is part of care model, whether proceeding and any outcomes identified
114	MSK Pathway (Foot and ankle)	60%				Angie Abbott		Query whether this is in scope of care model, awaiting decisions on foot and ankle and spinal cases
115	Person centred support planning	90%	01/04/16	29/09/17	391d	Steve Honeywill		MSB
116								

Care Model 2016/17 - as at 31st December 2016

ICO Project	Div	Dir	Spec	Cost centre	Plan PYE 1617 £3.9m	YTD plan M9	YTD Actual M9	YTD Variance to Plan	Forecast Spend 1617	Care Model Plan FYE	1718 Budget	Comments
					£	£	£	£	£	£	£	
MLTC	Medicine	General Medi	General Medicine	00082	111,435	99,184	70,435	- 28,749	112,032	172,869		
Multi Long Term Conditions - Phase 1 under review						55,717		- 55,717				
Multi Long Term Conditions - Infoflex Extension						7,800		- 7,800				
Frailty	Medicine	General Medi	General Medicine	00082	230,425	- 36,164	122,240	158,404	104,752	472,508		
Frailty - Development of ED fast track ID, assess & Discharge						94,483		- 94,483				
SAICO	Medicine	General Medi	General Medicine	00082	-	-	7,328	7,328	13,848	-		Budget was not set but for ease has been deducted from Frailty
Respiratory	Medicine	General Medi	General Medicine	00082	-	-	29,064	29,064	36,548			Part of MLTC NR, Medicine absorbing
					341,859	**221,020**	**229,067**	**8,047**	**267,180**	645,377		
MSK access pathway - Hip & Knee	WCDT	Therapies	Therapies	48104	147,000	110,250	99,369	- 10,881	128,718	147,000		CCG saving - Mount Stuart
MSK access pathway - Spinal (to be approved)	WCDT	Therapies	Therapies	48108	-	-	-	-	-	-		CCG saving - RDE
MSK access pathway - Foot (to be approved)	WCDT	Therapies	Therapies		-	-	-	-	-	-		to be looked at at next CMOG
(3 pathways)					**147,000**	**110,250**	**99,369**	**- 10,881**	**128,718**	147,000		**Budget allocated was £227k but £207k set in Agresso**
HWBT (health wellbeing teams):							-	-				
LMAT Moor to Sea - IC Staffing	Community	New	IC teams		171,459	85,729	59,239	- 26,490	142,119	342,918		Forecast as at m9
LMAT Newton Abbot - IC Staffing	Community	New	IC teams		265,012	132,506	110,956	- 21,550	238,971	530,023		Forecast as at m9
LMAT Paignton & Brixham - IC Staffing	Community	New	IC teams		84,544	42,272	27,490	- 14,782	64,776	169,087		Forecast as at m9
LMAT Torquay - IC Staffing	Community	New	IC teams		63,679	31,839	18,536	- 13,303	52,000	127,358		Forecast as at m9
LMAT Coastal IC Staffing	Community	New	IC teams		188,695	94,348	71,084	- 23,264	168,591	377,390		Forecast as at m9
LMAT - Increase in community support services - Dom (	Community	New	IC teams		276,413	157,950	92,483	- 65,468	214,939	473,851		Forecast as at m9
LMAT IC Weekend Working	Community	New	IC teams		83,188	41,594	-	- 41,594	-	166,375		Forecast as at m9
LMAT Out of Hours Nursing	Community	New	IC teams		57,263	28,632	-	- 28,632	-	114,526		Forecast as at m9
Estates:							-	-				
Pgn/Brx Kings Ash House	EF	EF	ES	78140	190,000	133,000	127,518	- 5,482	170,000	228,000		late payment of original rental invoice expected costs 2016 140K 2017-18 = £190k
Moor to Sea Est. LMAT cost					30,000	-	-	-	8,000	30,000		
Newton Abbot Increased beds					400,000	50,000	30,000	- 20,000	118,261	1,200,000		to be confirmd spend on escalation and agency to date
IC Block Purchase IS Beds:							-	-				check extra therapists in here.
LMAT Moor to Sea - Beds Purchase					103,429	41,372	128,579	87,207	248,580	248,230		All IC Bed Funding for S Devon now merged into single budget
LMAT Paignton & Brixham - Beds Purchase					104,148	41,659	207,599	165,940	424,558	249,955		Increased in beds purchased since paignton temp closures/ all budget for
LMAT Torquay - Beds Purchase					58,253	23,301	-	- 23,301		139,807		
LMAT Newton Abbot - Beds Purchase					233,474	93,390		- 93,390		560,338		
LMAT Coastal - Beds Purchase					110,296	44,118		- 44,118		264,710		
Planned Reduction in Spot purchases								-	-	200,000		Total £1.263
LMAT Other							-	-				
Wellbeing Co-ordination Function net of lottery funding					235,018	170,922	110,386	- 60,536	162,250	256,383		
Additional X-ray & Diagnostics in MIU's (Dawlish, Newton Abbot & Totnes)					105,465	52,732	-	- 52,732		210,929		Staff appointed trainees to start post qulification Summer 17
LMATS Community Services:							-	-				
My support Broker				86636	146,667	106,667	114,020	7,353	161,100	160,000		
Integrated Medicines Management					40,603	20,276	-	- 20,276	37,553	81,105		Pharmacy
Hospital Discharge Voluntary Service				86636	50,000	37,500	25,000	- 12,500	50,000	50,000		Nr funded by Care Model?
UDOS	SR		MD	73404	33,999	25,500	54,986	29,486	54,986	33,999		
Medical Community Support	SR	MD	GP contracts		40,000	40,000	2,250	- 37,750	45,000	-		Additional sessions for Moor to Sea & Newton CMOG approved
ICO Evaluation - Plymouth Uni	CB	86636			50,000	37,500	37,500	-	37,500	50,000		Is this Non recurrent?
					3,121,603	**1,532,806**	**1,217,626**	**- 315,181**	**2,399,184**	5,864,985		
Other:							-	-				
Support staff				various			105,828	105,828	141,087	-		
								-		-		
MIG					12,000	12,000	-	- 12,000		12,000		
					12,000	**12,000**	**105,828**	**93,828**	**141,087**	12,000		
Total		**£3.9 less £0.3 under advised to CMDG)**			**3,622,462**	**1,876,076**	**1,651,890**	**- 224,187**	**2,936,169**	6,669,362		
Not yet Approved:												
Self Care and Prevention					*50,000*					*100,000*		
safer staffing all remaining sites					*92,473*	-				*282,927*		*Excludes Newton Abbot*
Rehab model coastal					*103,910*	-				*623,460*		
Further Medical Support					*83,333*	-				*100,000*		*Additional sessions for Moor to Sea & Newton CMOG approved*
More site costs for HWBT/LMAT					*246,000*	-				*246,000*		
Further Voluntary sector					*100,000*	-				*200,000*		
MSK pathways remaining (see above)					*240,000*	-				*321,252*		
OP innovations - ALL OTHER	*RISK - costs of delivering the £3.2m OP innovation saving not yet built in here*					-				*146,843*		*Only Alcohol/Hepatology and COPD costed in here currently*
					915,716	-	-	-	*45,000*	*2,020,482*		
												ICO Business Case:
			-	-	**4,538,179**	**1,876,076**	**1,651,890**	**- 224,187**	**2,981,169**	**8,689,844**		£6,859 Target spend
												£12,754 target saving
												For all areas of care model including IP and OP Innovation
												Net Saving £5,895

Care Model Expenditure at Month 9 2016/17

(tbc)

(-ve budgets are under spends)	2016/17						2017/18		TWIP	
	YTD plan M9	YTD Actual M9	YTD Variance to Plan	Plan PYE 1617 £3.9m	Forecast Spend 1617	Variance	Care Model Original Plan FYE of £3.9m	Updated 1718 Budget	Savings Target	Savings Versus FYE of £3.9m
Acute Pathways:										
Frailty	58,319	122,240	63,921	230,425	104,752	- 125,673	472,508			
MLTC/Respiratory	162,701	99,499	- 63,202	111,435	148,580	37,146	172,869			
	221,020	221,739	719	341,859	253,332	- 88,527	645,377	-		
Community HWBT:										
Intermediate Care and Out of ours Nursing	614,870	379,788	- 235,082	1,190,252	881,396	- 308,856	2,301,529			
Spot/Block IC beds purchased	243,840	336,178	92,338	639,600	681,138	41,538	1,293,040			
Medical IC support top up Moor to Sea temp cover	40,000	2,250	- 37,750	40,000	45,000	5,000	-			
Estates Costs for HWBT	133,000	127,518	- 5,482	190,000	170,000	- 20,000	228,000			
Wellbeing co-ordination	170,922	110,386	- 60,536	235,018	162,250	- 72,768	256,383			
Diagnostics MIU enhancements	52,732	-	- 52,732	105,465	-	- 105,465	210,929			
Newton Abbot Beds increase & safer staffing levels	50,000	30,000	- 20,000	400,000	118,261	- 281,739	1,200,000			
	1,305,364	986,120	- 319,244	2,800,334	2,058,045	- 742,289	5,489,881	-		
Other Community Services:										
My support broker	106,667	114,020	7,353	146,667	161,100	14,433	160,000			
Community pharmacists medicine management	20,276	-	- 20,276	40,603	37,553	- 3,050	81,105			
Voluntary Sector - hospital discharge	37,500	25,000	- 12,500	50,000	50,000	-	50,000			
UDOS IT system	25,500	54,986	29,486	33,999	54,986	20,987	33,999			
Care Model Evaluation	37,500	37,500	-	50,000	37,500	- 12,500	50,000			
MIG	12,000	-	- 12,000	12,000	-	- 12,000	12,000			
	239,442	231,506	- 7,936	333,269	341,139	7,870	387,104	-		
Outpatient Innovations:										
MSK pathway Hip and Knee	110,250	99,369	- 10,881	147,000	128,718	- 18,282	147,000			
MSK pathwayy F&A	-	-	-	-	-	-	-			
MSK pathway Spinal	-	-	-	-	-	-	-			
SAICO	-	7,328	7,328	-	13,848	13,848	-			
	110,250	106,697	- 3,553	147,000	142,566	- 4,434	147,000	-		
Support Services/Project Management	-	105,828	105,828	-	141,087	141,087	-			
TOTAL	**1,876,076**	**1,651,890**	**- 224,187**	**3,622,462**	**2,936,169**	**- 686,293**	**6,669,362**	**-**	**- 12,754,000**	**- 6,084,638**
Unapproved Care Model Spend:										
Self Care and Prevention	-	-	-	50,000	-	- 50,000	100,000			
safer staffing all remaining sites	-	-	-	92,473	-	- 92,473	282,927			
Rehab model coastal	-	-	-	103,910	-	- 103,910	623,460			
Further Medical Support	-	-	-	83,333	-	- 83,333	100,000			
More site costs for HWBT/LMAT	-	-	-	246,000	-	- 246,000	246,000			
Further Voluntary sector	-	-	-	100,000	-	- 100,000	200,000			
MSK pathways remaining (see above)	-	-	-	240,000	-	- 240,000	321,252			
OP innovations - Any other	RISK - costs of delivering the £3.2n		-	-	-	-	146,843			
	-	-	-	915,716	-	- 915,716	2,020,482	-	**-**	**2,020,482**
TOTAL IF APPROVED	1,876,076	1,651,890	- 224,187	4,538,179	2,936,169	- 1,602,010	8,689,844	-	- 12,754,000	**- 4,064,156**

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
Title:	Report of the Medical Director
Lead Director:	Medical Director
Corporate Objective:	• Safe, quality care and best experience • Valuing our workforce • Well led
Corporate Risk/ Theme	• Failure to achieve key performance standards • Inability to recruit / retain staff in sufficient number / quality to maintain service provision • Failure to achieve financial plan
Purpose:	Information/decision

Summary of Key Issues for Trust Board

Strategic Context:

1. The stepwise implementation of the new Junior Doctor contract continues as required. The paper from the Guardian of Safe Working describes progress and early experience of the impact.
2. Benchmarked performance for Critical Care Unit and High Care Unit
3. Service for organ donation – performance report.

Key Issues/Risks

1. **New Junior doctor Contract** – detailed paper at Appendix 1

- Monitoring of working hours demonstrates frequent contraventions of the rules of the new contract. There is evidence that the new contract will result in deterioration in work-life balance for junior doctors and is already affecting morale.
- Detailed costing of the new contract has been undertaken and demonstrates very substantial additional costs (more than £550K in the first year) which were not recognised through the national negotiation of the contract. It is likely that there will be further additional costs due to enhancements to basic pay and pay protection on transition. Additional cost due to lack of flexibility in covering rota gaps may be significant through locum or agency payments or acting down by consultants.
- The inflexibility of the new contract may have significant impact on service continuity in urgent and emergency services.

Recommendations

The Board is asked to

1. Consider the impact of full implementation of the new contract and to consider potential mechanisms for feedback to NHS England in relation to these concerns.
2. Support the development of other clinical solutions to provide cover where junior doctor cover is inadequate.

Benchmarked performance for Critical Care Unit and High Care Unit

Detail at Appendix 2

Our benchmarked data for quality and safety of patients in our Critical Care Unit and the new Orthopaedic High Care Unit is excellent. The Board is asked to accept assurance of the quality of care in these units.

Service for organ donation – performance report.

Detail at Appendix 3 includes feedback from the UK National Transplant Service. Organ donation at Torbay Hospital is an unusual event. Therefore numbers of cases are small. However, in all bar one category we scored 100% against required standards. There is marked improvement compared to the previous year in involvement of the specialist nursing service.

The Board is asked to acknowledge the performance reports.

Executive challenge

The Executive team are concerned about the financial and other potential adverse impacts of the new junior doctor contract. Similar concerns have been highlighted at neighbouring Trusts. The Board is asked to support the reporting of concerns through a network (STP) process.

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

The Trust Chair provides Governor and lay support to the Guardian of Safe Working.

Equality and Diversity Implications:

None

Public

Appendix 1

Report to:	Trust Board
Date:	1st February 2017
Report From:	Medical Director
Report Title:	Report of the Guardian of Safe Working Hours

Progress on transition to the 2016 Junior Doctor contract

From the 7th of December 2016, all Foundation year 1 doctors (F1s) transitioned to the new contract. This has given them access to the exception reporting system, whereby they may document details of any work over their timetabled hours and any missed training opportunities as a result of service pressures.

The next transition dates are in March and April 2017, when Foundation year 2 doctors in Paediatrics, some specialty trainees in Paediatrics and all Surgical trainees are due to move to the new contract.

Exception reports

(From 7/12/19 to 15/1/17)

Total number of reports	**79**		**32 doctors**
Number by specialty/rota	**Surgery**	**35**	**9 F1**
	Medicine	**44**	**23 F1**
Nature of exception	**Additional hours**	**79**	
	Missed training	**1**	
Average additional hours worked	**1 hour 15 minutes**		
Total average additional hours per week	**16.5 hours**		
Outcomes	**Time off in lieu**	**14**	
	Payment	**19**	
	Unresolved	**46**	
	Change in work schedule*	**Pending…….**	

Overview of situation

The majority of the reports from both surgery and medicine unsurprisingly relate to additional hours worked in relation to activities related to emergency admissions.

Surgery

As a result of these reports the Clinical Director in Surgery is working to review the timetables (work schedules) of the F1s , with particular reference to the surgical 'hot week' (emergency take) *. Any change in the work pattern

may manage the issue during hot week, but may have unpredictable or unintended consequences in other environments and/or on other grades of doctors. This is particularly pertinent in surgery as all grades of trainees will be transitioning to the new contract by April this year. The current limited flexibility of working hours for those training grades will no longer be available from that date, and it is likely that there will not only be a significant increase in exception reporting, both for additional hours and missed training opportunities. These will all have to be accounted for, most likely by payment of additional hours worked*. If time of in lieu is not able to be given, then this becomes a risk area with respect to safe working.*

Medicine

The exception reports from F1s in medicine were split between additional hours worked while involved in the Emergency Admissions unit (21) and on the wards (23). Most of the reports from EAU detail the large number of patients and tasks to be undertaken in managing these. Of the reports from the wards, 9 refer to increased workload consequent on rota gaps and missing doctors.

It is widely understood that the acute medical specialties have been under extreme pressure in recent weeks, so the long term resolution of the situations which gave rise to these exceptions may not be straightforward. In the first instance, however, these have been addressed by an equal split between pay for additional hours and time off in lieu.

Rota Gaps

The following table summarises the situation for those specialties/grades who are due to transition to the new contract by April this year

	Number on rotas	Number of gaps (WTE)	
Foundation Year 1 medicine	23	0	
Foundation year 1 surgery	9	0	
Specialty Trainees Obstetrics and Gynaecology	7	0.3**	** one less than full time
Specialty trainees Paediatrics	6	2.5	
F2 / core trainee/gpst paediatrics	9	1.4	
F2 surgery/core surgical trainees	8	2	
Specialty Trainees Surgery	8*	0.5	*Includes 3 Trust fellows

It is evident from this, that there are significant potential risks in Paediatrics. The Paediatric department have mitigated this by identifying the individual uncovered duties and covering these by Consultants 'acting down' (ie resident at night). This is being done in addition to their normal duties. Although this will protect the trainee doctors from unsafe working hours, this solution will take its toll on the consultant body and on their service delivery. Once the paediatric trainees move to the new contract, they will be unable to help out by providing additional internal locum cover.

Transition of surgical trainees to the new contract has been discussed above. It seems inevitable that the tighter rules on safe working hours will have an upward impact on the Consultant body in Surgery, particularly since there are already gaps at the trainee levels.

Administrative issues

The software that has been purchased for the management of the exception reports is limited in functionality resulting in a need for additional time from by the Guardian and administrator support. The company assure us they will be responding in a timely manner to requests for software development to facilitate analysis.

The Educational Supervisors' work has undoubtedly increased with this reporting system. Each report that is generated requires a meeting of the educational supervisor with their trainee. These are the very clinicians who are often stretched with busy clinical workloads. The transition of all trainees in the fullness of time will inevitably increase this work. There is no available time for this additional role either for Education Supervisors, practice managers, finance and human resources staff.

Financial Effects

Despite assurances from central government that the introduction of the new contract would be cost neutral, this is far from the case. The basic salary has increased for most of the junior doctors, and there is pay protection. The additional cost in the first 2 years of the new contract is likely to be higher than subsequent years because of pay protection. The estimated basic salary difference for junior doctors comparing pre to post contract figures is as follows:

F1/F2	£168,556.00
CT1/CT2	£98,170.00
Speciality Trainees	£163,654.00
Total	£430,380.00

There would also be additional employer's National Insurance (13.8%) on top of this of approx.£59,400.00 and additional employer pension contributions (14.3%) of approx. £61,550.00.

Total cost to the Trust = £551,330.00* (*summary provided by finance dept)

In addition to this there is an as yet unknown cost associated with the additional hours claims related to exception reporting, and the cost of additional locums as a result of the inflexibility of trainees to work outside the new strict rules on hours of work. If, as is likely in many cases, locums of an appropriate grade cannot be found, then the service will have to be delivered by more senior doctors, including consultants with additional financial cost and loss of service delivery.

Conclusion

The advantage of the exception reporting system and the Guardian overseeing role has been that we now have some data and evidence to describe the working conditions of trainee doctors more effectively . Aside from the facts and figures described above, comes a clear intimation of the professionalism and nature of the work and its stresses. (examples in box)

Needed to deal with acutely unwell patient, stayed …. to deal with patient and to call relatives as patient had deteriorated significantly.

Working as the only junior doctor (meant to have two), so double the patient caseload…. 3 patients acutely deteriorated from 5pm, so left at 19:30 (handed patients over to medical SHO but had to review patients and start initial management….. as one dropped BP to ~65systolic, one had acute chest pain, and one dropped O2 sats to 74%).

Finding solutions to ensure that all junior doctors on the new contract are able to both work and train within their prescribed work schedules is a huge challenge.

Unless there is significant modification of the new stricter working hours rules, the impact of transition of all junior doctors in all specialties is likely to be detrimental to the service provided by the Trust.

Dr Nuala Campbell, Consultant Anaesthetist and Guardian of Safe Working. January 2017

Specialised Services Quality Dashboards

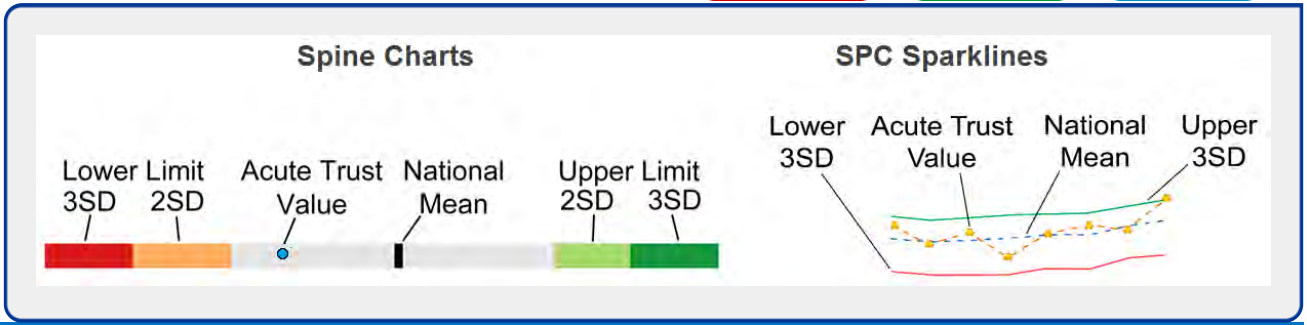
Adult Critical Care

Derek Cadle Critical Care Unit - Torbay Hospital - Torbay and South Devon NHS Foundation Trust

Dashboard

Publication Period: Q2 1617

Alerts: Negative 0 | Positive 4 | Neutral 0



Ref	Description	Data Period	Num	Denom	Value	National Average	Chart	Trend
ACC02ai	Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated).	Apr 16 - Jun 16	5.80	819.0	0.71	Mean: 2.83		
ACC02aii	Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Non-Validated).	Jul 16 - Sep 16	7.30	828.0	0.88	Mean: 2.69		

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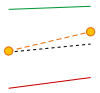
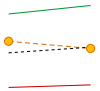
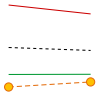
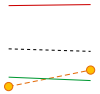
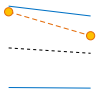
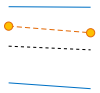
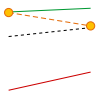
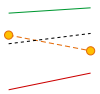
Ref	Description	Data Period	Num	Denom	Value	National Average	Chart	Trend
ACC02bi	Percentage of live discharges, discharged within 4 hours post decision to discharge (Validated).	Apr 16 - Jun 16	58.0	135.0	43.0	Mean: 38.6		
ACC02bii	Percentage of live discharges, discharged within 4 hours post decision to discharge (Non-Validated).	Jul 16 - Sep 16	47.0	116.0	40.5	Mean: 40.9		
ACC02ci	Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Validated).	Apr 16 - Jun 16	10.0	135.0	7.41	Mean: 17.9		
ACC02cii	Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Non-Validated).	Jul 16 - Sep 16	14.0	116.0	12.1	Mean: 17.4		
ACC02di	Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Validated).	Apr 16 - Jun 16	67.0	135.0	49.6	Mean: 43.4		
ACC02dii	Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Non-Validated).	Jul 16 - Sep 16	55.0	116.0	47.4	Mean: 41.7		
ACC02e	Percentage of live discharges, discharged from critical care between 07:00am and 21:59pm.	Apr 16 - Jun 16	119.0	128.0	93.0	Mean: 92.6		
ACC03a	Proportion of live discharges between 07:00am and 19:59pm.	Apr 16 - Jun 16	98.0	128.0	76.6	Mean: 82.1		

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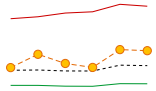
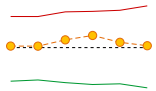
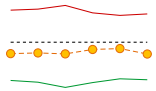
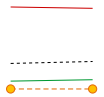
Ref	Description	Data Period	Num	Denom	Value	National Average	Chart	Trend
ACC04	Percentage of live discharges readmitted to critical care within 48 hours of discharge.	Jul 15 - Jun 16	9.00	462.0	1.95	Mean: 1.23		
ACC15	Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients.	Jul 15 - Jun 16	129.0	126.3	1.02	Mean: 1.00		
ACC15d	Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients with an expected mortality less than 15%.	Jul 15 - Jun 16	12.0	18.1	0.66	Mean: 1.00		
ACC17	Proportion of critical care bed days assigned to Zero organ HRG.	Jul 16 - Sep 16	0.00	792.0	0.00	Mean: 0.92		

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ACC02ai - Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Critical care bed days utilised for critical care unit survivors discharged more than 24 hours after the decision to discharge to a ward in the same hospital (or directly to home).

Denominator description

Total available critical care bed days.

Note

Metric renumbered, as period type changed to Quarterly (from Q1 16/17).

Rationale

Target

ACC02aii - Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Non-Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Critical care bed days utilised for critical care unit survivors discharged more than 24 hours after the decision to discharge to a ward in the same hospital (or directly to home).

Denominator description

Total available critical care bed days.

Note

Metric renumbered, as period type changed to Quarterly (from Q1 16/17).

Rationale

Target

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ACC02bi - Percentage of live discharges, discharged within 4 hours post decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) within 4 hours of the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

ACC02bii - Percentage of live discharges, discharged within 4 hours post decision to discharge (Non-Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) within 4 hours of the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

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ACC02ci - Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) greater than 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

ACC02cii - Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Non-Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) greater than 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

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ACC02di - Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) between 4 and 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

ACC02dii - Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Non-Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) between 4 and 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

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ACC02e - Percentage of live discharges, discharged from critical care between 07:00am and 21:59pm.

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital between 07:00 and 21:59.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

Note

Metric renumbered, as period type changed to Quarterly (from Q1 16/17)

Rationale

Target

ACC03a - Proportion of live discharges between 07:00am and 19:59pm.

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital between 07:00 and 19:59.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

Rationale

Target

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ACC04 - Percentage of live discharges readmitted to critical care within 48 hours of discharge.

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital readmitted (unplanned) within 48 hours.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

ACC15 - Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients.

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Observed number of deaths before ultimate discharge from acute hospital.

Denominator description

Expected number of deaths before ultimate discharge from acute hospital.

ACC15d - Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients with an expected mortality less than 15%.

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Observed number of deaths before ultimate discharge from acute hospital among patients with a predicted probability of mortality less than 15%.

Denominator description

Expected number of deaths before ultimate discharge from acute hospital among patients with a predicted probability of mortality less than 15%.

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ACC17 - Proportion of critical care bed days assigned to Zero organ HRG.

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care bed days assigned to 'No organ systems supported' HRG.

Denominator description

Total number of critical care bed days.

Rationale

Target

Comments for indicators present in this dashboard:

ACC02ai:
Data collated by ICNARC on 2nd December 2016

ACC02aii:
Data collated by ICNARC on 2nd December 2016

ACC02bi:
Data collated by ICNARC on 2nd December 2016

ACC02bii:
Data collated by ICNARC on 2nd December 2016

ACC02ci:
Data collated by ICNARC on 2nd December 2016

ACC02cii:
Data collated by ICNARC on 2nd December 2016

ACC02di:
Data collated by ICNARC on 2nd December 2016

ACC02dii:
Data collated by ICNARC on 2nd December 2016

ACC02e:
Data collated by ICNARC on 2nd December 2016

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ACC03a:

Data collated by ICNARC on 2nd December 2016

ACC04:

Data collated by ICNARC on 2nd December 2016

ACC15:

Data collated by ICNARC on 2nd December 2016

ACC15d:

Data collated by ICNARC on 2nd December 2016

ACC17:

Data collated by ICNARC on 2nd December 2016

Data collection has been been approved by the Review of Central Returns - ROCR ROCR/OR/2230/001MAND

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Specialised Services Quality Dashboards

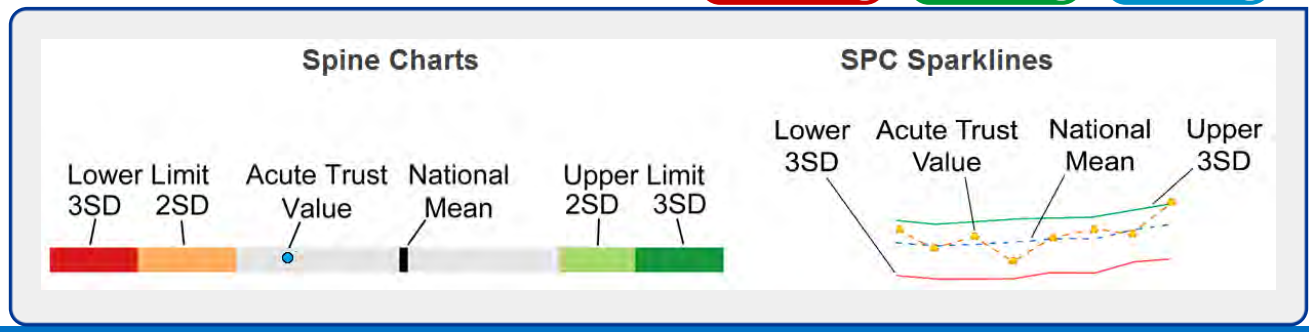
Adult Critical Care

Surgical High Care Unit - Torbay Hospital - Torbay and South Devon NHS Foundation Trust

Dashboard

Publication Period: Q2 1617

Alerts: Negative 0 | Positive 6 | Neutral 1



Ref	Description	Data Period	Num	Denom	Value	National Average	Chart	Trend
ACC02ai	Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated).	Apr 16 - Jun 16	0.00	182.0	0.00	Mean: 2.83		
ACC02bi	Percentage of live discharges, discharged within 4 hours post decision to discharge (Validated).	Apr 16 - Jun 16	60.0	70.0	85.7	Mean: 38.6		

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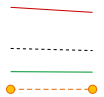
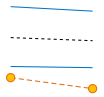
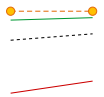
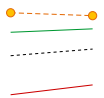
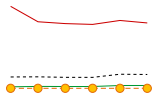
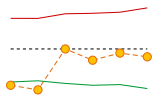
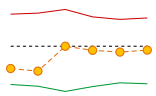
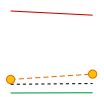
Ref	Description	Data Period	Num	Denom	Value	National Average	Chart	Trend
ACC02ci	Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Validated).	Apr 16 - Jun 16	0.00	70.0	0.00	Mean: 17.9		
ACC02di	Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Validated).	Apr 16 - Jun 16	10.0	70.0	14.3	Mean: 43.4		
ACC02e	Percentage of live discharges, discharged from critical care between 07:00am and 21:59pm.	Apr 16 - Jun 16	70.0	70.0	100.0	Mean: 92.6		
ACC03a	Proportion of live discharges between 07:00am and 19:59pm.	Apr 16 - Jun 16	69.0	70.0	98.6	Mean: 82.1		
ACC04	Percentage of live discharges readmitted to critical care within 48 hours of discharge.	Jul 15 - Jun 16	0.00	248.0	0.00	Mean: 1.23		
ACC15	Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients.	Jul 15 - Jun 16	7.00	7.70	0.91	Mean: 1.00		
ACC15d	Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients with an expected mortality less than 15%.	Jul 15 - Jun 16	< 5	< 5	0.89	Mean: 1.00		
ACC17	Proportion of critical care bed days assigned to Zero organ HRG.	Jul 16 - Sep 16	< 5	< 5	1.74	Mean: 0.92		

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ACC02ai - Percentage of total available critical care bed days utilised for patients more than 24 hours after the decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Critical care bed days utilised for critical care unit survivors discharged more than 24 hours after the decision to discharge to a ward in the same hospital (or directly to home).

Denominator description

Total available critical care bed days.

Note

Metric renumbered, as period type changed to Quarterly (from Q1 16/17).

Rationale

Target

ACC02bi - Percentage of live discharges, discharged within 4 hours post decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) within 4 hours of the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

© NHS England 2017

ACC02ci - Percentage of live discharges, discharged greater than 24hrs after decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) greater than 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

ACC02di - Percentage of live discharges, discharged in the time period 4 to 24 hours after decision to discharge (Validated).

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home) between 4 and 24 hours after the decision to discharge.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital (or directly to home).

Rationale

Target

© NHS England 2017

ACC02e - Percentage of live discharges, discharged from critical care between 07:00am and 21:59pm.

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital between 07:00 and 21:59.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

Note

Metric renumbered, as period type changed to Quarterly (from Q1 16/17)

Rationale

Target

ACC03a - Proportion of live discharges between 07:00am and 19:59pm.

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital between 07:00 and 19:59.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

Rationale

Target

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ACC04 - Percentage of live discharges readmitted to critical care within 48 hours of discharge.

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Number of critical care unit survivors discharged to a ward in the same hospital readmitted (unplanned) within 48 hours.

Denominator description

Number of critical care unit survivors discharged to a ward in the same hospital.

ACC15 - Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients.

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Observed number of deaths before ultimate discharge from acute hospital.

Denominator description

Expected number of deaths before ultimate discharge from acute hospital.

ACC15d - Standardised mortality ratio (using ICNARC risk adjustment model) for critical care patients with an expected mortality less than 15%.

Low values have been suppressed to prevent the identification of individuals

- **Domain 1:** Preventing people from dying prematurely

Numerator description

Observed number of deaths before ultimate discharge from acute hospital among patients with a predicted probability of mortality less than 15%.

Denominator description

Expected number of deaths before ultimate discharge from acute hospital among patients with a predicted probability of mortality less than 15%.

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ACC17 - Proportion of critical care bed days assigned to Zero organ HRG.

Low values have been suppressed to prevent the identification of individuals

- **Domain 4:** Ensuring that people have a positive experience of care

Numerator description

Number of critical care bed days assigned to 'No organ systems supported' HRG.

Denominator description

Total number of critical care bed days.

Rationale

Target

Comments for indicators present in this dashboard:

ACC02ai:
Data collated by ICNARC on 2nd December 2016
ACC02bi:
Data collated by ICNARC on 2nd December 2016
ACC02ci:
Data collated by ICNARC on 2nd December 2016
ACC02di:
Data collated by ICNARC on 2nd December 2016
ACC02e:
Data collated by ICNARC on 2nd December 2016
ACC03a:
Data collated by ICNARC on 2nd December 2016
ACC04:
Data collated by ICNARC on 2nd December 2016

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ACC15:

Data collated by ICNARC on 2nd December 2016

ACC15d:

Data collated by ICNARC on 2nd December 2016

ACC17:

Data collated by ICNARC on 2nd December 2016

Data collection has been been approved by the Review of Central Returns - ROCR ROCR/OR/2230/001MAND

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Appendix 3.

Executive Summary
Actual and Potential Organ Donors
1 April 2016 - 30 September 2016

NHS Blood and Transplant

South Devon Healthcare NHS Foundation Trust

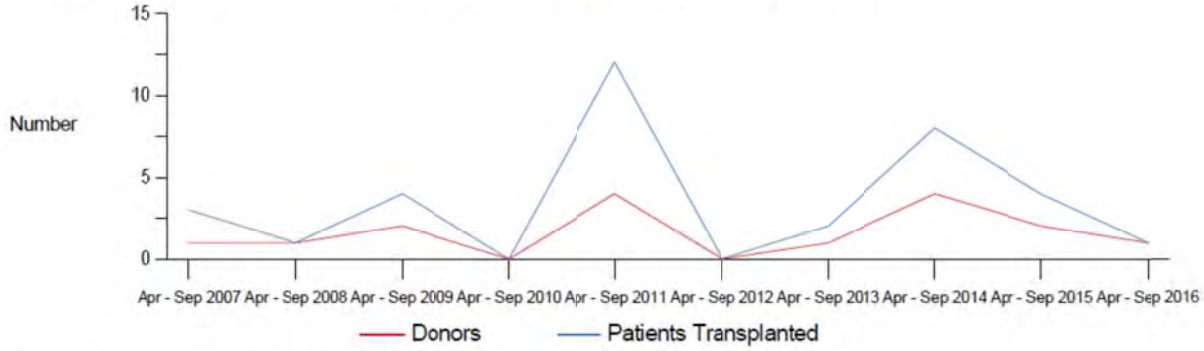
Donor outcomes

Between 1 April 2016 and 30 September 2016, your Trust had one deceased solid organ donor, resulting in one patient receiving a transplant. Further details are provided in the table and chart below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

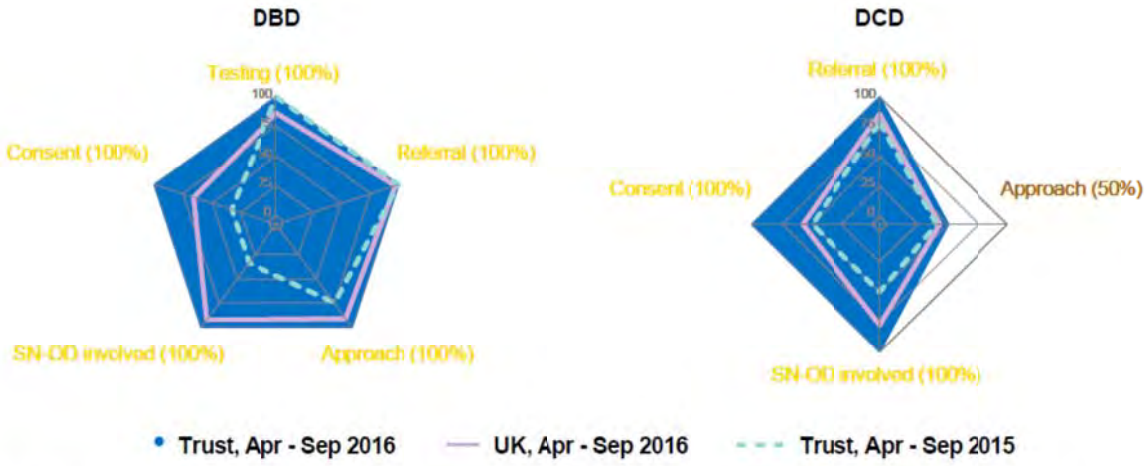
Donors, patients transplanted and organs per donor, 1 April 2016 - 30 September 2016 (1 April 2015 - 30 September 2015 for comparison)

	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
Deceased donors	1	(2)	1	(4)	2.0	(4.0)	3.4	(3.4)

Number of donors and patients transplanted between April and September each year



Radar charts of key rates, 1 April 2016 to 30 September 2016



The blue shaded area represents your Trust's rates for the first six months of 2016/17. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. The colour of the rate label on each of the radar charts indicates the Trust performance as shown in the appropriate funnel plot (included in the detailed report) using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

Key numbers and rates

There are nine measures on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. Funnel plots can be found in the detailed report. Between 1 April 2016 and 30 September 2016, your Trust met a statistically acceptable level in all of these measures. Of the 2 potential DBD donors with suspected neurological death, 1 proceeded to donation and 1 did not proceed. Neither of the eligible DCD donors proceeded to donation. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD					DCD				
	Apr - Sep 2016			Apr - Sep 2015		Apr - Sep 2016			Apr - Sep 2015	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		2	855	4	847		3	3,004	14	3,0
Referred to SN-OD		2	830	4	816		3	2,571	11	2,5
Referral rate %		G *100%*	*97%*	*100%*	*96%*		G *100%*	*86%*	*79%*	*8*
Neurological death tested		2	741	4	726					
Testing rate %		G *100%*	*87%*	*100%*	*86%*					
Eligible donors[2]		2	698	4	689		2	2,046	10	1,9
Family approached		2	636	3	639		1	873	4	9
Approach rate %		G *100%*	*91%*	*75%*	*93%*		B *50%*	*43%*	*40%*	*4*
Family approached and SN-OD involved		2	587	1	573		1	685	2	7
% of approaches where SN-OD involved		G *100%*	*92%*	*33%*	*90%*		G *100%*	*78%*	*50%*	*7*
Consent ascertained		2	418	1	438		1	506	2	5
Consent rate %	*72%*	G *100%*	*66%*	*33%*	*69%*	*68%*	G *100%*	*58%*	*50%*	*5*
Expected consents based on ethnic mix		1		2			1		2	
Expected consent rate based on ethnic mix %		*73%*		*74%*			*60%*		*57%*	
Actual donors from each pathway		1	381	1	383		0	267	1	2
% of consented donors that became actual donors		*50%*	*91%*	*100%*	*87%*		*0%*	*53%*	*50%*	*5*
Colour key - comparison with funnel plot confidence limits		G *Gold* A *Amber*		S *Silver* R *Red*			B *Bronze*			

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at
https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued November 2016 based on data reported at 7 November 2016.

REPORT SUMMARY SHEET

Meeting Date:	1 February 2017
Title:	Workforce and OD Board Report
Lead Director:	Judy Saunders, Director of Workforce & OD
Corporate Objectives:	1. Safe, Quality Care and Best Experience 2. Improved wellbeing through partnership 3. Valuing our workforce 4. Well led
Corporate Risk/Theme	Failure to achieve key performance standards Inability to recruit / retain staff in sufficient number / quality to maintain service provision Failure to achieve financial plan Delayed delivery of integrated care organisation (ICO) care model
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group.
- To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks:

Issues

- Performance against the key workforce metrics for 2016/17 are included in section 2 of this report.
- Proposed KPI's for 2017/2018, to be agreed by the Workforce and OD Group are included in paragraph 2.4 and appendix D.
- Section 3 includes forecast workforce numbers as reported to NHSi in the Trusts Operations Plan. These numbers are dependent on the Trust achieving its plans including Trust Wide Improvement Plans (TWIP's)
- Section 4 details the agreed Workforce Call to Action schemes including progress to date.
- Whilst not included in the specific Call to Action schemes the Care Model implementation is key to the Trusts recovery plans and workforce plans will be enacted when final decisions are made following the consultation (section 5 refers).
- Section 12 shows that the cost of agency has reduced since the start of the year but that it is still above Trust Plan and NHSi ceiling.

- Section 14 includes the first KPI's for the Occupational Health Service provided by Optima. It also sets out that the Workforce and OD Group will undertake an options

appraisal for an early intervention process to access physiotherapy services for staff.
- Paragraph 17.2.3 sets out that the Workforce and OD group will consider revised Apprenticeship Strategy to meet the requirements of the Apprenticeship Levy and the Trusts "Growing our Own" strategy.

Risks

- The outcomes of the community services consultation and implementation of any changes being in close proximity making consultation challenging (see section 5).
- Failure to achieve workforce changes in accordance with the Trusts Operations Plan including TWIP's plans (see section 3).
- Achieving the nursing capacity plan and matching demand and supply is reliant on a number of supply lines. Section 6 outlines risks to this plan including the challenge of increasing the number of student placements in the Trust.
- Section 7 outlines that the compliance rate for appraisals may reduce in the last quarter due to the concentration on financial recovery.
- Deferring some training as detailed in paragraph 17.1 as part of the Call to Action will result in some reduction in compliance rates for statutory and mandatory training.
- The rolling sickness absence rate has increased to 4.34% against a target of 3.90%. A sickness absence management scheme is included as a TWIP in the Trusts Operation Plan.
- Medical recruitment in general remains a challenge as reported in section 13.4.
- Failure to deliver against targets in the apprenticeship reforms will result in at least some of the apprenticeship levy of £1.3M being withheld. Paragraph 17.2 refers.

Recommendations:

The Board is asked consider and discuss the assurance provided by the contents of this report.

Summary of ED Challenge/Discussion

The Executive discussed that the sickness absence KPI is not being achieved. Director of Workforce and OD to review management of sickness absence interventions in current climate and benchmark interventions with neighbouring Trusts.

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

Governor Observer on Workforce and Organisational Development Group (Workstream 4)

Equality and Diversity Implications:

None.

PUBLIC

Board of Directors
Workforce and Organisational Development Directorate
1st February 2016

1. Purpose and Content of the Report

1.1 Report Purpose

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

1.2 Report Content

- A summary of progress on key performance indicators. These performance indicators are included in the Trusts monthly workforce and OD scorecards in the appendices and include key targets and monthly trends.
- Detail on actions and initiatives linked to the objectives and key performance indicators.

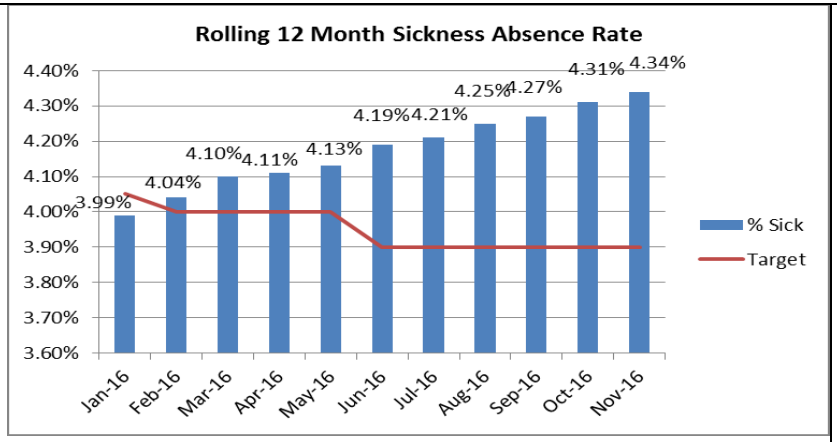
2. Progress on Key Performance Indicators

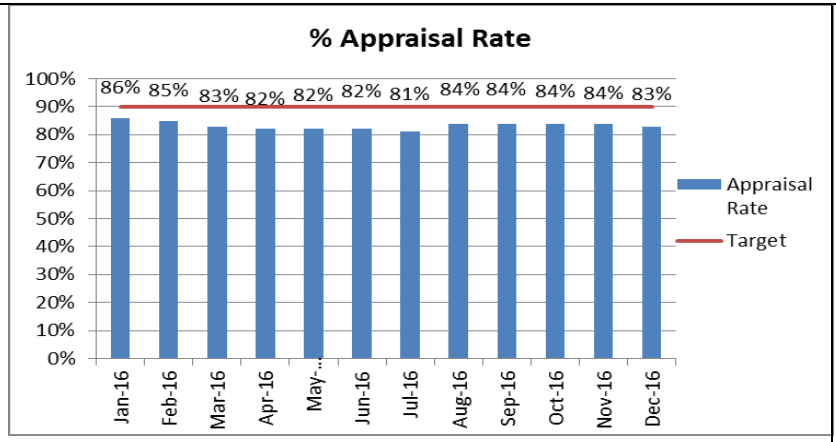
2.1 The Workforce and OD metrics included in this paper are as at the end of December 2016 and are included as detailed below.

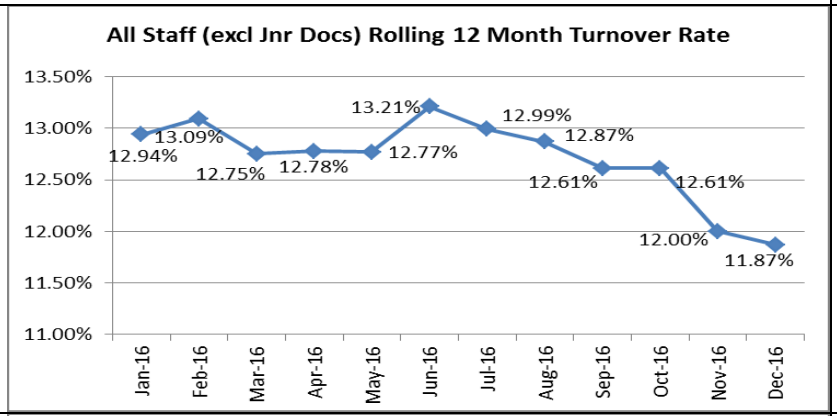
- Appendix A – Workforce and OD Scorecard – Organisational month by month metrics for the last year to show trends.
- Appendix B – Key Metrics by Business Unit – Metrics month by month for the operational Business Units for the current financial year to show trends. Metrics included are sickness absence, staff appraisal and mandatory training.
- Appendix C – Summary of key metrics by Business Unit, Division/Department. Those included are sickness absence, staff appraisal, turnover and mandatory training. In this report sickness absence rates are for the actual month rather than the rolling year.

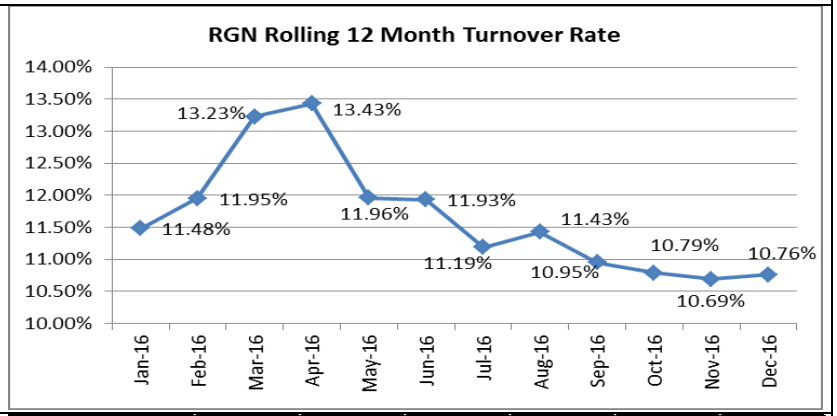
2.2 The above reports are RAG rated based on targets and thresholds agreed by the Workforce and OD Group for 2016/2017. The targets for December 2016 are included in the Workforce and OD Scorecard (appendix A).

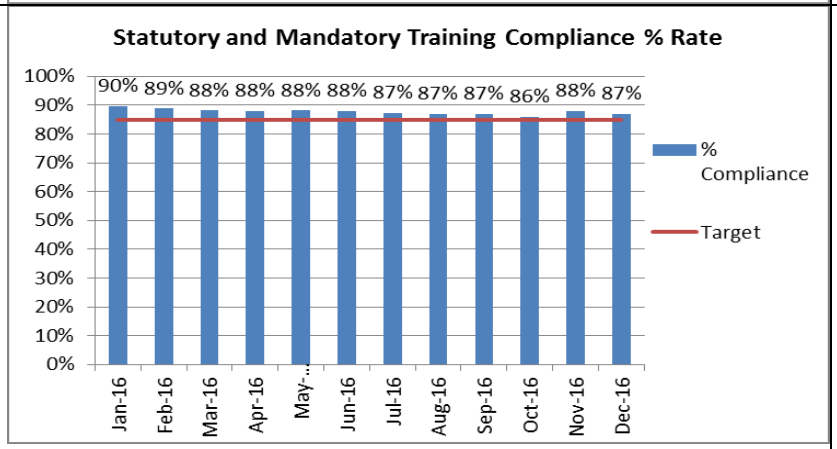
2.3 The following provides a graphical presentation of a number of the key targets and the overall trend and a brief commentary for each. In addition comparisons with neighbouring Trusts are provided.











Key Performance Indicators Comparisons

	Torbay & South Devon NHS Foundation Trust	Plymouth Hospitals NHS Trust	Royal Cornwall Hospitals NHS Trust	Royal Devon & Exeter NHS Foundation Trust	Taunton & Somerset NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Sickness Absence	4.27%	4.10%	4.41%	3.70%	3.60%	3.66%
Appraisal Rate	84%	82%	74%	81%	83%	77%
Mandatory Training	86%	88%	84%	85%	91%	88%

1. Sickness Absence
The rolling sickness absence rate has increased to 4.34% against a target of 3.90%. Activity in respect of managing sickness absence is included in section 8 of this report.

2. Turnover
Turnover rates have decreased in this financial year and are within the target range of 10% to 14%. Turnover rates for RGN's increased slightly in December and maintaining capacity due to supply shortages remains a significant challenge.

3. Appraisal
The appraisal rate of 83% in December 2016 is a slight reduction from previous months and remains below the target of 90%.Action to improve this position is included in section 7 of this report.

4. Statutory and Mandatory Training
The Trust has a target of 85% as an average of 9 key modules. The current rate of 87% is above target but some individual modules remain below their target compliance rate.

5. KPI Comparisons
This table enables the comparison of a number of the KPI's with neighbouring NHS Trusts. This table is for the previous month as the December information is not yet available from other Trusts.
NHS Digital produce regular reports of sickness absence levels in the NHS. The latest report they have produced that includes the annual rolling rate of sickness absence was to March 2016 and the rate for all NHS organisations was 4.15%, for Acute Trusts 3.97% and for Community Trusts 4.57%.
NHS Digital also produce reports by organisation type for each months sickness absence rate and a further table has been included to benchmark with this Trust on the next page.

Monthly Sickness Absence Rate Comparison with English Trusts

	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016
England	**4.49%**	**4.42%**	**4.21%**	**4.01%**	**3.84%**	**3.94%**	**4.04%**
Acute	4.29%	4.24%	4.07%	3.86%	3.69%	3.77%	3.86%
Ambulance	6.11%	5.81%	5.45%	5.14%	4.88%	4.99%	5.33%
Clinical Commissioning Group	2.98%	2.99%	2.92%	2.74%	2.57%	2.60%	2.59%
Commissioning Support Unit	3.11%	2.93%	2.62%	2.59%	2.39%	2.84%	2.68%
Community Provider Trust	5.03%	4.99%	4.67%	4.39%	4.25%	4.38%	4.50%
Mental Health and Learning Disability	5.13%	4.99%	4.67%	4.55%	4.42%	4.55%	4.65%
Special Health Authority	3.43%	3.37%	3.29%	2.92%	2.90%	3.17%	3.23%
Torbay and South Devon NHSFT	4.52%	4.25%	4.53%	4.12%	4.13%	4.13%	4.31%

Source NHS Digital

2.4 The above table shows the latest data provided by NHS Digital for sickness absence rates. It shows the actual monthly rates (as opposed to rolling year) for all English NHS Organisations. This comparison shows that as an integrated NHS Trust the Trust benchmarks favourably with Community Provider Trusts and unfavourably with Acute Trusts. This is the latest available data from NHS Digital.

2.5 The key workforce metrics targets for 2017/2018 are included in appendix D. These targets have been reported to NHSi in the Trusts Operational Plan and the Workforce and OD Group will be asked to endorse these.

3. Trust Operations Plan 2017/2018

3.1 The table below shows the planned staff in post over the next 5 years included in the Trusts Operations Plan submitted to NHSi. This plan shows forecast staff in post over the next 5 years and takes into account the effect of the care model, trust wide improvement programmes (TWIP's), reductions in the vacancy factor etc.

The staff in post WTE at the end of December 2016 was 5,236.90. The Call to Action and other remedial actions should support the reduction to the planned 5,164.27 WTE by the end of 2016/2017.

	16/17	17/18	18/19	19/20	20/21	21/22
Registered Nursing, Midwifery and Health Visiting Staff	1201.39	1191.14	1162.49	1147.31	1142.40	1142.40
Scentific, Theraputic and Technical Staff	715.30	724.90	700.84	685.46	678.46	678.46
Ambulance Staff	4.00	4.00	4.11	4.11	4.11	4.11
Healthcare Scientists	182.99	200.30	200.30	200.30	200.30	200.30
Support to Clinical Staff	1510.64	1533.34	1518.70	1505.96	1501.96	1501.96
NHS Infrastructure Support	1119.75	974.96	868.76	864.76	860.76	858.76
General Payments	6.80	6.90	6.90	6.90	6.90	6.90
Medical and Dental Staff	423.40	430.16	430.26	430.26	430.26	430.26
Total	**5164.27**	**5065.70**	**4892.36**	**4845.06**	**4825.15**	**4823.15**

The Workforce and OD Directorate has lead responsibility for the management and administration TWIP and a steering group are developing the project plan for the end of January as required. Management and administrative staff are included in NHS Infrastructure Support in the above table.

4. Call to Action

4.1 The Call to Action includes some very significant workforce actions to take effect in the last quarter of the financial year. Original plans submitted and agreed by the Board have been updated and implemented. The following shows each plan and progress to date.

Scheme	Detail
1. Vacancy Freeze	Vacancy freeze for all posts except those with direct patient/service user contact
Progress • 16.73 WTE posts held at recruitment stage • 46.00 WTE known and forecast leavers • Revised Executive Vacancy Risk Group process implemented and plans to priorotise key posts and flex the workfroce to cover.	
2. Fixed Term Contracts	Reducing fixed term contracts (FTC's) by 20%.
Progress • 14 posts, 11.04 WTE FTC's terminated and equates to 7.33% • Assessing further posts with more than 2 years service for risk and termination costs to meet and exceed target	
3. Deferred Training	Deferral of the 9 key statutory and mandatory training modules.
Progress • The Education and Development Department have reviewed all training and development and separately agreed with the Board a plan to defer some education and development but not exclusively statutory and mandatory training. • Staff from the Education and Development Department are working shifts in clinical areas reducing agency costs. This equates to 15 staff working approximately 2 WTE clinical.	
4. Individuals pay own DBS	New recruits to the Trust are required to pay for their own DBS check
Progress • Implemented and new recruits pay over 2 months.	
5. Cease overtime for non-clinical staff	Overtime above 37.5 hours to be stopped for all staff except in those areas with direct patient/service user contact where it is used as an alternative to agency usage.
Progress • Now extended to non-clinical staff working extra hours below 37.5	
6. Cease external advertising	Reduction in external advertising. Posts will only be advertised on NHS Jobs.
Progress • Implemented	
7. MARS	Implementation of a MARS at a time of significant organisational change
Progress • 55 applications were submitted of which currently 32 have been approved. • The removal of these posts at the end of February 2017 would result in the savings shown above. • The cost of making the MARS payments has not been included in the above.	

Scheme	Detail
8. NHS Pensions Opt Out	Further information to high earners who might be considering opting out of the NHS Pensions Scheme to avoid their pension exceeding their lifetime allowance
Progress • Implementing but difficult to forecast any savings	
9. Cease bank and agency for non-clinical staff	Bank and agency to be stopped for all staff except in those areas with direct patient/service user contact where it is used as an alternative to agency usage.
Progress • Not in the original Board agreed schemes but to be implemented for February 2017	
10. Buy back of annual leave	Staff have been given the opportunity to buy additional annual leave or bring forward annual leave from next year.
Progress • Implemented before the Call to Action	
11. Review of all vacancies	All vacancies to be reviewed and removed or service redesigned.
• Not in the original Board agreed schemes but to be implemented for February 2017 • Savings likely to be in next financial year and beyond.	

The current deficit between the target and current forecast as included in the Finance Report is being addressed via additional schemes including the Care Model and Medical Workforce as reported in section 12.1. The above schemes will be subject to monitoring at the end of each month including appropriate KPI's.

As part of the Call to Action members of the OD team are having a number of in depth conversations supporting managers in exploring options for the redesigning of roles and services. There are a number of themes and areas that are coming to light where system wide redesign and input is required. As part of this process there will be a number of staff workshops created to support staff and managers in moving things forward combining OD and Quality Improvement input.

5. Developing and Delivering the Care Model

5.1 Working with managers and staff plans are being developed for the continuing implementation of the Care Model. These plans include taking account of any changes as a consequence of the outcome of the consultation including community hospitals. These plans to manage any staff changes cannot be finalised until the final decision is made by the CCG Governors on the 26th January 2017.

5.2 A suite of OD products and offers are being developed that support the increased levels of prevention, self-care and wellbeing required in line with the Model of Care outcome that 'People are more empowered to manage their own health and wellbeing. Delivery of the first aspect of a new programme to staff within the health and wellbeing teams is planned for February 2017.

6. Nursing Capacity Plan

6.1 The last Workforce and OD report to the Board included details of the forecast demand for nursing staff over the next 5 years and plans to meet that demand using

a number of supply lines. The table below shows the number of recruits included in the overall plan by supply line. To meet the planned requirement for newly qualified staff in 2020/2021 the Trust needs to contribute to additional student nurses being trained. However student nurses require placements in trusts and at the annual meeting with Plymouth University this Trust was only able to offer additional C10 placements for students that will complete their training in September 2020.

This position combined with some risks to the recruitment of overseas nurses (see the recruitment section 11) will require the Trust to urgently review its placement arrangements and/or increase the contribution from other supply lines. The Workforce and OD Group will be asked to consider this position at their next meeting. It should be noted that the introduction of degree apprentices is not likely to influence the number of newly qualified staff until 2021/2022.

Supply Lines							
	Newly Qualified	RTP/ Conversion	Sponsorship (AP's)	Role Redesign	General Recruitment	Overseas Recruitment Campaign	Redeployment
2016/2017	20	5	5	5	70		
2017/2018	25	5	10	5	70	80	40
2018/2019	25	5	15	5	70	40	20
2019/2020	25	5	15	10	70		20
2020/2021	70	5	20	10	85		20

7. Appraisal

7.1 Given the concentration during the last quarter on the financial situation and consequent cost reducing measures, (including the reduction of face to face training and the focus on front line clinical duties), it was decided to defer the timing of some of the actions previously reported to the Board in respect of appraisal compliance. However, it is important to mitigate the effects and remedial action will be taken as appropriate.

8. Sickness Absence Management

8.1 A revised and streamlined 'attendance' policy will be subject to discussions/negotiations with the Trade Unions at JCNC at the end of January 2017. As previously advised, once agreed, a programme of refresher training for managers will be run on a partnership basis with the Trade Unions.

9. Staff Survey 2016

9.1 The NHS Staff Survey has now finished for 2016 and the final response rate was 45%. The national response rate was 44%. The Trusts response rate in 2015 was 46%. The results of the survey are expected in late January/early February 2017.

10. National NHS Staff Health and Wellbeing CQUIN 2016/17

10.1 Action plans to achieve the National NHS Staff Health and Wellbeing CQUIN for 2016/17 are progressing according to plan and are included in reports to the

Workforce and OD Group and reported to the CCG quarterly. The plans are delivering:

1a Introduction of health and wellbeing initiatives covering physical activity schemes, mental health and improving access to physiotherapy for staff with MSK issues.
1b Healthy food for NHS staff, visitors and patients.
1c Improving the uptake of flu vaccinations to achieve 75% uptake for front line staff. As of 8th January 2017 uptake is as follows.

- Doctors/Dentists – 62%
- Nursing/Midwifery – 51%
- AHP's/Technical and Scientific – 62%
- Support Workers – 81%
- Overall of frontline workers vaccinated – **65%**

11. Recruitment

11.1 International Recruitment

The first five nurses from the nurse candidates recruited from the Philippines should start with the Trust in February 2017. The plan is for the other nurses to follow as they achieve the necessary entry requirements and checks. The IELTS exam is the biggest hurdle for the candidates to overcome and the Trust is looking into options to provide additional support to the nurses.

11.2 Call to action

As reported in section 4 the call to action has resulted in a freeze on all non-clinical recruitment.

12. Temporary Staff

12.1 Nursing & HCA Bank and Agency

Appendix A which is the Trusts Workforce and OD Scorecard includes month by month expenditure on bank and agency. This shows that overall cost of bank and agency has decreased since the start of the financial year but is still very significantly above affordable levels.

The table below shows total agency expenditure for each month of the year and that it is above the Trusts own internal plan and NHSi's ceiling. Appendix D provides the same information by staff group.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
15/16 Outturn	526	526	526	553	611	723	821	613	674	948	792	958	8,271
16/17 Internal Plan	1,001	1,001	1,001	534	534	534	345	345	345	315	315	315	6,585
NHS Improvement Ceiling	661	644	622	590	575	555	515	503	497	484	473	467	6,586
16/17 Actual Expenditure	911	1,042	1,057	1,038	760	676	689	704	705	-	-	-	7,582

The Trust continues to report to Monitor on a weekly basis in respect of the number of agency shifts that are not compliant with the Monitor framework, price cap and maximum wage cap requirements. The reports for the last 2 weeks (see below)

show that nursing shifts remain the biggest component of the report which is primarily due to the number of registered nurse vacancies. There is minimal use of the high cost nursing agency and then only for last minute specialist roles e.g. mental health or paediatric nurse. Healthcare Assistant shifts are all filled through the internal bank, with no need for agency use.

Report Period	Shift Count	Staff Group	Control
09/01/2017	145.00	Nursing, Midwifery & Health Visiting	Both price cap & wage cap overrides
09/01/2017	6.00	Nursing, Midwifery & Health Visiting	All price cap, wage cap & framework overrides
09/01/2017	81.00	Medical & Dental	Both price cap & wage cap overrides
09/01/2017	3.00	Medical & Dental	All price cap, wage cap & framework overrides
09/01/2017	25.00	Scientific, Therapeutic & Technical (AHPs)	Both price cap & wage cap overrides
09/01/2017	20.00	Administration & estates	Both price cap & wage cap overrides
09/01/2017	44.00	Administration & estates	Framework only overrides

Report Period	Shift Count	Staff Group	Control
02/01/2017	130.00	Nursing, Midwifery & Health Visiting	Both price cap & wage cap overrides
02/01/2017	4.00	Nursing, Midwifery & Health Visiting	Both wage cap & framework overrides
02/01/2017	1.00	Nursing, Midwifery & Health Visiting	All price cap, wage cap & framework overrides
02/01/2017	58.00	Medical & Dental	Both price cap & wage cap overrides
02/01/2017	1.00	Medical & Dental	All price cap, wage cap & framework overrides
02/01/2017	34.00	Scientific, Therapeutic & Technical (AHPs)	Both price cap & wage cap overrides
02/01/2017	20.00	Other	Both price cap & wage cap overrides
02/01/2017	33.00	Administration & estates	Framework only overrides

Actions to reduce agency costs include:

- Activity to reduce the nurse vacancy gap as reported elsewhere in this report
- Continued control using existing authorisation procedure
- A medical workforce scoping exercise and action plan has been developed and will be presented along with the Medical Resilience Paper to be presented by the Medical Director. The recommended actions from the scoping exercise include:
    - Setting up the proposed Medical Workforce Group
    - Establishing clear and consistent clinical and managerial leadership
    - Developing an overarching electronic dashboard to monitor and review the medical workforce

- Review the process for agency and locum usage, ensuring adherence and authorisation
- Review Consultant/SAS local arrangements
- Consider options for the future governance and management of the medical workforce
- Carry out a targeted workforce review of some specialty areas based on cost pressure and/or clinical pressure
- Scope out how other Trusts manage medical staff and medical workforce planning
- Identify whether there are any unaccounted pieces of work/projects related to this work

13. Medical Agency and Recruitment

13.1 As detailed in section 12 above due to current vacancies the Trust still requires the use of medical agency locums. The Trust continues to ensure where possible that all bookings are via direct engagement to allow the Trust to make a VAT saving. The total savings year to date is £98,954 (month end November).

13.2 Medical Recruitment

The Trust has recently been successful in appointing an Acute Physician and a Cardiologist who are due to start shortly. The Trust has also been successful in recruiting an Orthodontist.

The Trust is continuing to try and recruit to vacant posts in respiratory, however the Trust has recently been successful in appointing a GP SAS to work 2PA's per week in respiratory.

Current Permanent Medical Vacancies (as at 20th January 2017):

Grade	Specialty	Status
Consultant x2 (Replacement/new post)	Histopathology	This post has been vacant since 2015 the Trust is offering both permanent and locum posts in order to try and attract a wider field of applicants The closing date for applicants is 12 Feb 17.
Consultant (replacement x2)	Stroke	Vacant since Apr 2015 and advertised on numerous occasions. The department have been networking and hopefully may have a candidate interested in one of the posts. An interview date has been set for 16 Mar 17.
Consultant (New Post)	Dermatology	Vacant since July 2015 and continue to advertise, whilst the department use networking to market the post
Consultant (replacement x2)	Neurology	Vacant since Nov 2015 the Trust recently received applications but were unsuccessful in recruiting

Grade	Specialty	Status
Consultant (Replacement x2)	Radiology	Vacant since Feb 2015 Recently successful in receiving applications and the interviews are set for 29 Jan 17.
Consultant x2	Emergency Medicine	The Trust is still trying to recruit to 10 consultants within the department. There have been 2 recent appointments but with further staff turnover they now have another 2 vacancies. The Trust is trialling advertising via social media in order to attract candidates.
Consultant x2 (Replacement)	Respiratory	Currently out to advert, so far no suitable applications have been received. The Trust is offering both permanent and locum posts in order to try and attract a wider field of applicants.
Consultants x3 (Replacement)	Paediatrics	Following a recent recruitment round the Trust was unsuccessful in filling the posts. The Trust is re-advertising and is offering both permanent and locum posts in order to try and attract a wider field of applicants. We have received 1 application for a locum post.
Consultant (replacement)	Haematologist	Recently advertised and closed on 19th Jan, no applications were received. The department are deciding on next steps.
Consultant x2	CAMHS	These posts are out to advert which closes on 12 Feb 17.

14. Occupational Health

14.1 Optima Health' have now been providing the Occupational Health Service (OH service) for five months. Outputs from the monthly KPI's are as follows:

- A 95% target being met on most aspects of the OH service.
- The target for timeliness of appointments has now been achieved
- A customer satisfaction survey has been conducted at the outset of the service and again after month 4 with favourable results particularly in respect of
    - ease of access
    - timeliness of appointments
    - return of management referrals reports

An Employee Assistance Programme [EAP] for all staff to access 24/7, provided by 'Workplace Wellness' is also now in place and the first quarterly report is very encouraging and the feedback from some employees that have accessed it found it extremely useful and timely.

In line with the UK National trend the most reported reasons for sickness absence in the trust are musculo-skeletal and stress. An options appraisal for an early intervention process to access physiotherapy services will be considered by the Workforce and OD Group.

The Trusts Occupational Health Lead expires in January 2017 and due to Call to Action this post will not be replaced.

15 Learning Management System (LMS/Nurse Revalidation)

15.1 The implementation of the new LMS & Nurse Revalidation was delayed due to unforeseen work to the Active Directory (AD). The Health Informatics Service (HIS) anticipates that this work will now be completed during January, with an organisation wide rollout expected in March 2017. The current arrangements for learning and revalidation are robust and will continue.

16.0 Leadership Development

16.1 Leadership Strategy

The Trusts new Leadership Strategy is awaiting feedback from key stakeholders. The strategy will include clarity of leadership development options with a view to being launched in April 2017.

16.2 Senior Manager Leadership Development

During December the first module of 3 was successfully delivered to 36 managers primarily from the Operational teams and received very positive feedback. In addition there was development day for the Exec Directors that also included feedback from the three senior manager days. The plan will now be to being both groups together in early March to move things forward and the remaining two modules to be undertaken during March and June.

17.0 Education and Development

17.1 Education Directorate Response to Call to Action

As highlighted in Section 4 of this report the Executive Call to Action has included deferring some training activity in the last quarter following a risk assessment. During Q4 compliance will be monitored and contingencies for catch up training in Q1/Q2 2017/2018 will be planned. Targeted training will be provided for any areas where significant clinical risk is identified.

All teams in the Education Directorate have identified both clinical and non-clinical resource that can be re-deployed to support the Call to Action over the next three months.

17.2 Vocational Training

17.2.1 Paying the apprenticeship levy
The agreed plan to effectively utilise the Trusts apprenticeship levy of £1.3M is progressing as proposed.

17.2.2 New Nursing Degree Apprenticeships

As previously reported the Trust is committed to "growing its own" and intends to utilise the Nursing Degree Apprenticeship. The aim is for delivery to commence in September 2017 which as reported in section 6 will enhance the supply line. The plans to deliver this are being developed in accordance with the plan.

17.2.3 Apprenticeship Strategy

The Trusts Workforce and OD Group will be asked to consider and approve a new Apprenticeship Strategy to provide direction to the Trust in the promotion, provision and most cost effective and efficient ways to develop and support the delivery of high patient care and service delivery that will increase productivity, greater staff retention and a more highly skilled and motivated sustainable workforce for the future. The strategy aims to have robust plans in place with our delivery education partners on how we are going to maximise the Trusts levy, and how we plan to increase the utilisation of apprenticeships that will incorporate career pathways and progression routes up to degree level.

17.3 Mandatory Training

As a consequence of the Call to Action as referenced in section 4 and the postponement of face to face mandatory training from Jan to March promoting digital learning where possible will be promoted.

17.4 Medical Education

17.4.1 Undergraduate Programmes (Year 1-5)

The Trust will know in the spring if it has been allocated an increase in medical student numbers. The potential opportunities to develop the undergraduate programme if numbers were increased locally are being scoped and a paper outlining these opportunities will be going to the Trust Board in February for discussion.

17.4.2 New Junior Doctors Contract

Implementation of the new Junior Doctors Contract is progressing according to plan and on a phased basis commencing in February with F2 and CT/ST in Surgery, Trauma & Orthopaedics, Paediatrics and Psychiatry. The Junior Doctor Contract Assurance Group will continue on a monthly basis to provide assurance.

17.4.3 Physician Associate Programme

Posts for the current 5 sponsored Physician Associates (PA's) have been identified across the Trust. There has been some concern that the posts are not fully integrated in to the workforce plans of the Trust. The five new PA's that commenced 12 months training in January 2017 will be ready to work in PA posts at the Trust from February 2018. Effective roles and funding for PA posts will be identified by Divisions for the next 2 years as part of integrated workforce plans.

17.5 Professional & Clinical Education

Activity to increase nurse supply as detailed in section 5 includes:

- An additional 10 sponsorship places from Health Education England for our cohort of Assistant Practitioners to undertake their Foundation Degree in Healthcare.
- The 10 Nursing Associates undertaking the education pilot Foundation Degree programme with SD College commenced in January 2017.
- A further small cohort of individuals undertaking their Return to Practice (Nursing) will commence in January 2017.
- The education programme for the nurses from the Philippines who will be arriving in cohorts commencing in February 2017 is in place and is designed to support these staff on this unfamiliar pathway.
- The Trust is scoping the potential to target a considerable number of international staff who have trained as healthcare professionals in their countries of origin and who are keen to gain nursing or other professional registrations in the UK and are currently working in non-registered roles.
- The Trust has been talent-spotting for new staff with the aptitude and transferable skills but limited healthcare experience to fast-track to the role of healthcare assistants.

18.0 Staff Welfare and Wellbeing @ Work

18.1 Each of the Staff Welfare and Wellbeing @ Work workstreams are progressing as planned.

There are a range of initiatives in place to support staff and organisation 'wellness' as follows:

- Recognising and appreciating staff
- Creating a safe, happier and healthier working environment
- Encouraging and supporting employees to develop and maintain a healthy lifestyle
- Improving mental and emotional wellbeing in the workplace
- Staff disability awareness

18.1.1 Staff Recognition and Appreciation

- **Staff Heroes Awards -** These have now successfully replaced the WOW awards as the monthly staff recognition scheme.
- **Blue Shield Awards** – Due to the Trusts financial pressures a proposal for the Awards Ceremony to take place on Tuesday 21st March 2017 in TREC rather than at the English Riviera Centre is being considered.
- **Long Service Awards –** 352 people in the organisation are coming up for Long Service of 25 years+ and awards will be presented at the above ceremony if the proposal is agreed.

18.1.2 Encouraging and supporting employees to develop and maintain a healthy lifestyle

- Following a staff survey A Staff Survey it is proposed that the Well-being Team work with Active Devon on future events i.e. Big Devon March 2017.
- Mental Health First Aid Training is already provided by the Lifestyles Team for the Trust. It is proposed to extend this training to the Workplace Champions.
- Mental Health National Awareness Day took place on Friday 10th October – this was highlighted on ICON front page and advertised the Mental Health First Aiders training for rest of 2016 and 2017.
- New Screen savers will be promoting New Year Physical Activities and will direct staff to the Well-being pages.
- Spotlight continues to direct staff to Well-being pages advertising Physical Activities.

TSDFT Workforce and OD Scorecard 2016/2017 **Appendix A**

Dec-16

Indicator and (Target)	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Bank/Agency Spend Total	£9,059,507	£10,494,361	£11,816,473	£13,368,816	£1,746,467	£3,450,162	£5,173,698	£6,838,622	£8,273,400	£9,516,206	£10,874,713	£12,219,040	£13,504,011
Bank Monthly	£544,710	£577,004	£554,756	£633,754	£835,496	£661,185	£611,744	£681,690	£673,890	£565,324	£669,222	£639,793	£579,456
Agency Monthly	£596,361	£857,850	£767,356	£918,589	£910,971	£1,042,510	£1,111,792	£983,234	£760,888	£677,482	£689,285	£704,534	£705,515
Staff Headcount Number	6057	6071	6069	6059	6077	6070	6056	6046	6069	6116	6164	6192	6198
Bank Usage (WTE)	243.61	240.63	239.78	266.85	296.85	297.19	220.12	270.87	267.77	222.61	270.39	250.81	221.67
Agency Usage (WTE)	124.20	107.26	115.45	144.27	132.66	119.55	141.95	137.71	139.60	89.18	81.47	100.88	83.16
Starters	23.9	53.4	62.5	39.4	48.1	44.9	42.6	34.4	115.5	97.2	74.5	54.6	45.6
Leavers	45.9	62.3	46.5	53.3	38.3	50.7	54.7	45.7	123.5	51.8	59.5	39.8	35.4
Staff Turnover Rate % (Between 10% - 14%)	13.15%	12.94%	13.09%	12.75%	12.78%	12.77%	13.21%	12.99%	12.99%	12.61%	12.61%	12.00%	11.87%
Sickness Absence Rate % (3.90% or less)	3.98%	3.99%	4.04%	4.10%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	4.31%	4.34%	
Bradford Score % over 250 Points	10.76%	9.18%	10.68%	10.63%	10.86%	10.90%	11.07%	11.25%	11.25%	11.13%	11.29%	11.02%	
Sickness Cost	£6,042,868	£6,043,671	£6,151,402	£6,279,071	£6,292,997	£6,327,834	£6,394,148	£6,431,222	£6,457,004	£6,487,987	£6,557,103	£6,583,344	
Skill Mix (Registered-Band 5 & above/Non-registered-Band 4 & below)	55/45	55/45	55/45	55/45	55/45	55/45	54/46	54/46	55/45	54/46	54/46	55/45	54/46
Staff appraised in last year (90% or above)	78%	86%	85%	83%	82%	82%	82%	81%	84%	84%	84%	84%	83%
Age Profile - % of staff over 55 years of age	22.0%	22.0%	23.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	23.0%	23.0%	23.0%

* Starters and leavers in August include Junior Doctors change over

Training and Development - Percentage of staff compliant

Information Governance Training (95% or above)	90%	90%	89%	88%	88%	88%	88%	86%	87%	87%	86%	87%	82%
Fire Training (85% or above)	86%	85%	83%	83%	82%	83%	83%	83%	84%	84%	82%	84%	83%
Child Protection L1 (90% or above)	93%	93%	93%	92%	92%	92%	93%	92%	92%	92%	92%	93%	93%
Infection Control (85% or above)	85%	84%	83%	82%	81%	83%	82%	82%	82%	82%	82%	84%	83%
Equality & Diversity (85% or above)	93%	93%	93%	93%	92%	92%	91%	91%	90%	88%	88%	89%	89%
Conflict Resolution (85% or above)	92%	92%	91%	90%	89%	89%	88%	87%	87%	86%	86%	87%	86%
Health & Safety (85% or above)	89%	89%	88%	87%	86%	86%	86%	85%	85%	86%	86%	89%	89%
Manual Handling (85% or above)	88%	87%	86%	86%	86%	87%	86%	86%	86%	85%	84%	84%	84%
Safeguarding Adults L1 (90% or above)	94%	94%	94%	93%	93%	93%	93%	93%	92%	92%	92%	93%	93%
Average Compliance	**90%**	**90%**	**89%**	**88%**	**88%**	**88%**	**88%**	**87%**	**87%**	**87%**	**86%**	**88%**	**87%**

Appendix B

OUTTURN	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Sickness Absence - All ICO Staff	3.98%	3.99%	4.04%	4.10%	4.11%	4.13%	4.19%	4.23%	4.25%	4.27%	4.31%	4.34%	
Community BU Total	4.27%	4.44%	4.29%	4.39%	4.32%	4.46%	4.62%	4.73%	4.81%	4.86%	4.88%	5.04%	
Medicine BU Total	3.87%	3.94%	4.00%	4.06%	4.16%	4.16%	4.29%	4.41%	4.44%	4.45%	4.52%	4.58%	
Surgery BU Total	4.08%	4.10%	4.15%	4.15%	4.12%	4.07%	4.04%	3.98%	3.97%	3.96%	4.02%	4.05%	
WCD BU Total	3.19%	3.19%	3.24%	3.29%	3.18%	3.19%	3.17%	3.19%	3.22%	3.20%	3.22%	3.24%	
Staff Appraisals - All ICO Staff	78%	86%	85%	83%	82%	82%	82%	81%	84%	84%	84%	84%	83%
Community BU Total	85%	90%	90%	89%	88%	87%	86%	85%	88%	88%	87%	85%	83%
Medicine BU Total	76%	83%	81%	77%	76%	78%	78%	80%	84%	87%	88%	85%	84%
Surgery BU Total	86%	90%	89%	87%	87%	87%	85%	84%	86%	87%	86%	86%	85%
WCD BU Total	87%	92%	89%	86%	87%	87%	88%	86%	88%	88%	85%	82%	80%
Mandatory Training - % Completion of 9 competencies - All ICO Staff	90%	90%	89%	88%	88%	88%	88%	87%	87%	87%	86%	88%	87%
Community BU Total	93%	92%	91%	89%	89%	91%	91%	92%	92%	90%	90%	90%	89%
Medicine BU Total	85%	85%	86%	85%	84%	85%	86%	83%	85%	86%	86%	88%	88%
Surgery BU Total	88%	88%	89%	88%	88%	88%	89%	87%	87%	87%	86%	87%	86%
WCD BU Total	89%	89%	89%	89%	88%	89%	89%	89%	89%	89%	89%	89%	89%

Appendix C

Division/Directorate	Sickness	Appraisals	Training (Average)	Staff	FTE	FTE Turnover
	Nov-16	Dec-16	Dec-16	Dec-16	Dec-16	Dec-16
CHARITABLE FUNDS DIVISION	2.41%	68%	78%	32	19.39	17.34%
Health Visiting & School Nursing	6.32%	95%	90%	101	79.09	14.39%
Other Public Health Provider	2.82%	95%	95%	98	80.79	13.69%
Dir - Public Health	4.57%	95%	92%	199	159.88	14.05%
SD Community Services - Coastal	2.14%	75%	91%	41	36.58	5.65%
SD Community Services - Moorland	4.17%	100%	96%	20	15.78	14.05%
SD Community Services - Newton Abbot	5.65%	86%	80%	47	38.31	14.14%
SD Community Services - Other	3.66%	82%	91%	86	69.35	16.11%
SD Community Services - Totnes and Dartmouth	2.17%	85%	90%	41	35.23	13.64%
Dir - SD Community Services	3.50%	84%	89%	235	195.26	13.23%
Operations Support	6.82%	57%	76%	35	32.34	13.35%
TCT Community Services - Adult Social Care	0.79%	49%	90%	36	32.31	13.30%
TCT Community Services - Baywide	2.69%	71%	93%	57	49.69	14.71%
TCT Community Services - BEST	1.97%	100%	91%	18	12.57	13.07%
TCT Community Services - Brixham Zone	2.49%	67%	93%	45	33.43	14.22%
TCT Community Services - Older Peoples Mental Health	4.84%	100%	85%	13	8.53	0.00%
TCT Community Services - Other Social Care	0.82%	86%	92%	16	12.21	13.23%
TCT Community Services - Paignton	7.68%	80%	87%	116	98.38	15.42%
TCT Community Services - Torquay Zone	7.76%	88%	86%	159	138.24	11.04%
Dir - Torbay Community Services	5.65%	77%	88%	495	417.69	13.03%
COMMUNITY SERVICES DIVISION	3.50%	83%	89%	929	772.84	13.29%
Dir - Chief Executive	1.15%	100%	98%	7	5.95	16.85%
Dir - Education & Development	3.61%	89%	89%	105	99.33	11.13%
Finance	3.23%	60%	82%	79	73.92	10.24%
Health Informatics Service	3.97%	76%	91%	164	144.63	10.38%
Procurement	8.56%	54%	85%	37	35.53	2.78%
Dir - Finance, HIS & Procurement	4.40%	68%	87%	280	254.08	9.28%
Dir - Medical Director	1.68%	68%	76%	33	25.08	4.31%
Dir - Nursing & Quality	3.84%	90%	90%	107	89.46	13.49%
Operations	8.98%	59%	86%	25	20.73	7.65%
Transport	7.05%	97%	87%	72	64.42	2.48%
Dir - Operations	7.50%	88%	86%	97	85.15	3.70%
Dir - Pharmacy Services	3.45%	75%	88%	100	87.33	9.00%
Dir - Strategy	1.39%	72%	84%	63	58.68	1.88%
Dir - Workforce	2.36%	88%	88%	74	65.75	26.46%
CORPORATE SERVICES DIVISION	3.95%	78%	87%	866	770.81	10.33%
Estates	5.59%	59%	96%	32	31.60	8.21%
Facilities Management	5.49%	75%	97%	26	24.68	3.35%
Dir - Estates & Facilities	5.55%	66%	96%	58	56.28	6.61%
Hotel Services - Catering	3.31%	100%	72%	50	36.09	15.78%
Hotel Services - Domestic	8.43%	91%	81%	350	249.47	11.32%
Hotel Services - Other	3.95%	96%	64%	77	70.92	9.88%
Dir - Hotel Services	7.02%	93%	77%	477	356.48	11.58%
ESTATES & FACILITIES MANAGEMENT DIVISION	6.82%	89%	79%	535	412.76	10.91%
Dir - Hospital Services - Brixham	8.73%	80%	69%	31	25.20	18.47%
Hospital Services - Dawlish Hospital	1.13%	95%	97%	26	22.24	16.34%
Hospital Services - Teignmouth Hospital	4.82%	94%	96%	18	14.83	32.28%
Dir - Hospital Services - Coastal	2.60%	94%	96%	44	37.06	23.82%
Dir - Hospital Services - Dartmouth	1.59%	100%	96%	22	17.37	20.65%
Dir - Hospital Services - MIU Services	3.65%	80%	96%	29	23.67	13.21%
Hospital Services - Ashburton Hospital	1.23%	77%	94%	17	13.00	9.98%
Hospital Services - Bovey Tracey Hospital	12.13%	83%	80%	12	9.57	39.52%
Dir - Hospital Services - Moorland	5.75%	79%	88%	29	22.57	23.75%
Dir - Hospital Services - Newton Abbot	0.84%	84%	89%	89	73.65	16.05%
Dir - Hospital Services - Other	0.00%	100%	96%	3	3.00	0.00%
Dir - Hospital Services - Paignton	7.61%	72%	93%	35	27.47	14.47%
Dir - Hospital Services - Totnes	7.27%	100%	95%	34	28.04	30.93%
HOSPITAL SERVICES DIVISION	4.04%	86%	90%	316	258.03	19.24%

Ind Sec Adult Social Care - Torbay	10.58%	60%	93%	10	9.52	0.00%
Ind Sec In House Services LD - Torbay	5.79%	72%	57%	33	26.64	9.94%
545 Dir - Independent Sector Adult Social Care - Torbay	12.23%	69%	65%	43	36.16	7.59%
546 Dir - Independent Sector Health	10.79%	65%	91%	26	23.40	28.34%
INDEPENDENT SECTOR DIVISION	10.67%	68%	75%	69	59.56	16.38%
INTERNAL AUDIT	0.00%	92%	94%	13	12.37	35.93%
Cancer Services - Medicine	1.28%	100%	83%	8	7.80	0.00%
Clinical Oncology	9.45%	71%	90%	58	51.65	13.83%
Haematology	0.00%	100%	78%	4	4.00	0.00%
Medical Oncology	0.00%	100%	89%	6	5.15	20.83%
Non Surgical Cancer Services Admin	5.87%	90%	90%	44	34.23	11.41%
Palliative Care	1.43%	100%	85%	6	4.90	0.00%
Ricky Grant Unit and Turner Ward	7.64%	71%	77%	82	66.76	16.89%
Dir - Cancer Services - Medicine	6.92%	78%	84%	208	174.49	13.83%
Care of the Elderly - Medicine	8.14%	90%	85%	105	92.94	10.98%
Stroke	9.09%	97%	90%	38	33.91	14.37%
Dir - Care of the Elderly - Medicine	8.40%	92%	86%	143	126.86	11.98%
Dermatology	2.75%	88%	90%	13	10.52	2.74%
Neurology	0.00%	0%	96%	3	3.00	57.14%
Rheumatology	2.19%	50%	81%	15	11.02	0.00%
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	2.18%	65%	86%	31	24.54	8.81%
Dir - Emergency Services	2.91%	90%	93%	267	224.91	10.39%
Diabetes and Endocrinology	4.68%	100%	84%	21	17.62	0.00%
Gastroenterology	4.60%	65%	83%	81	71.59	4.15%
Dir - Gastoenterology/Endocrinology- Medicine	4.62%	68%	83%	102	89.21	3.46%
Admin/Support- Med Div	10.39%	68%	89%	46	39.22	22.69%
General Medicine	6.55%	81%	87%	65	57.55	12.04%
Medical Division HQ	15.68%	100%	78%	4	3.80	53.57%
Dir - General Medicine	8.49%	76%	87%	115	100.57	20.07%
Cardiology	4.94%	95%	91%	128	107.77	4.83%
Respiratory	7.23%	93%	88%	64	55.05	23.96%
Dir - Heart & Lung- Medicine	5.73%	94%	90%	192	162.82	11.26%
MEDICAL SERVICES DIVISION	5.70%	84%	88%	1058	903.40	11.72%
PMU Finance	0.00%	100%	96%	5	4.64	12.15%
PMU Manufacturing	5.38%	61%	87%	59	57.57	5.99%
PMU Quality Control	2.63%	95%	94%	52	49.36	0.00%
PMU Sales & Marketing	6.95%	100%	75%	8	7.39	0.00%
PMU Senior Team	13.96%	100%	81%	4	3.70	38.29%
PMU Supply Chain	0.65%	65%	98%	20	16.68	3.91%
PHARMACY DIVISION (Manufacturing)	3.96%	80%	91%	148	139.33	4.68%
RESEARCH & DEVELOPMENT DIVISION	7.63%	81%	86%	43	33.00	15.03%
Dir - Breast Care	3.64%	94%	89%	42	33.58	12.11%
Dir - General Surgery	5.19%	79%	80%	256	216.49	13.86%
Dir - Head & Neck	2.10%	89%	87%	102	79.25	6.59%
Dir - Ophthalmology	3.77%	97%	90%	122	106.33	11.94%
Dir - Surgical Division	4.24%	80%	91%	97	83.28	11.58%
Dir - Theatres, Anaesthetics and ICU	5.40%	88%	85%	413	367.13	10.24%
Dir - Trauma and Orthopaedics	3.17%	75%	88%	161	138.45	14.20%
SURGICAL SERVICES DIVISION	4.47%	85%	86%	1193	1024.51	11.65%
Child Health Med, Mgmt and Misc Specialty	2.39%	85%	82%	62	54.51	6.27%
Paediatric	4.38%	82%	88%	100	79.85	5.94%
Dir - Child Health	3.56%	83%	86%	162	134.36	6.06%
Dir - Lab Medicine	4.27%	82%	86%	115	101.68	8.51%
Gynaecology	8.98%	86%	94%	36	27.60	7.18%
Midwifery	5.58%	83%	91%	129	102.05	5.52%
O&G Medical and Management	4.62%	100%	81%	50	45.83	12.72%
Dir - Obs & Gynae	5.90%	86%	89%	215	175.48	7.20%
Dir - Radiology & Imaging	1.90%	66%	88%	128	108.94	14.01%
Dir - Sexual Health	1.54%	76%	94%	41	32.38	11.25%
Dir - Therapies	2.20%	79%	90%	302	247.18	13.80%
Medical Electronics	6.11%	100%	99%	18	17.64	4.12%
Women's, Children's & Diagnostics	2.48%	77%	88%	15	13.25	14.76%
Dir - Women's, Children's and Diagnostics	4.49%	89%	94%	33	30.89	8.84%
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.49%	80%	89%	996	830.91	10.40%
ICO Grand Total	**4.74%**	**83%**	87%	**6198**	**5236.90**	**11.87%**

Appendix D

Workforce Metrics Targets 2017/2018

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Factor	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Staff Turnover	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%
Sickness Absence	4.05%	4.05%	4.05%	4.05%	4.05%	4.05%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Staff Appraisals	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Mandatory Training (Ave)	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**
Child Protection	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Safeguarding Adults	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Fire	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Infection Control	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Information Governance	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Health and Safety	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Conflict Resolution	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Manual Handling	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Equality and Diversity	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

Workforce Metrics RAG Thresholds 2017/2018													
		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Factor		8.0%+	8.0%+	8.0%+	8.0%+	8.0%+	8.0%+	7.0%+	7.0%+	7.0%+	7.0%+	7.0%+	7.0%+
		6%-7.9%	6%-7.9%	6%-7.9%	6%-7.9%	6%-7.9%	6%-7.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%
		0%-5.9%	0%-5.9%	0%-5.9%	0%-5.9%	0%-5.9%	0%-5.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%
Staff Turnover		16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+
		0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%
		14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%
		8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%
		10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%
Mandatory Training													
Information Governance		0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%
		85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%
		95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%
Safeguarding		0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%
		80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%
		90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%
All Others		0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%
		75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%
		85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%
Sickness Absence		4.06%+	4.06%+	4.06%+	4.06%+	4.06%+	4.06%+	4.01%+	4.01%+	4.01%+	4.01%+	4.01%+	4.01%+
		3.55%-4.05%	3.55%-4.05%	3.55%-4.05%	3.55%-4.05%	3.55%-4.05%	3.55%-4.05%	3.50%-4.00%	3.50%-4.00%	3.50%-4.00%	3.50%-4.00%	3.50%-4.00%	3.50%-4.00%
		0.00%-3.54%	0.00%-3.54%	0.00%-3.54%	0.00%-3.54%	0.00%-3.54%	0.00%-3.54%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%
Staff Appraisals		0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%
		80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%
		90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%

Torbay & South Devon NHS Foundation Trust **Appendix E**

Agency Expenditure 2016-17 - T&SD

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Medical	15/16 Outturn	250	250	249	269	309	324	236	182	205	261	165	228	2,928
	16/17 Internal Plan	518	518	518	288	288	288	138	138	138	126	126	126	3,210
	NHS Improvement Ceiling	353	344	333	316	309	299	221	215	212	209	203	200	3,214
	16/17 Actual Expenditure	234	220	273	303	202	150	536	219	281				2,418
Nursing, Midwifery & Health Visitor	15/16 Outturn	210	210	210	200	229	196	299	310	325	461	412	457	3,519
	16/17 Internal Plan	434	434	434	197	197	197	158	158	158	140	140	140	2,787
	NHS Improvement Ceiling	290	283	274	221	214	206	229	225	222	211	207	204	2,786
	16/17 Actual Expenditure	442	544	497	512	335	344	256	359	298				3,587
Healthcare Assistant & Other Support	15/16 Outturn	53	53	54	53	47	164	92	75	73	119	99	135	1,017
	16/17 Internal Plan	6	6	6	6	6	6	6	6	6	6	6	6	72
	NHS Improvement Ceiling	2	2	2	6	6	6	8	8	8	8	8	8	72
	16/17 Actual Expenditure	85	131	119	57	32	44	33	16	37				554
Scientific, Therapeutic & Technical	15/16 Outturn	13	13	13	31	26	39	194	46	71	107	116	138	807
	16/17 Internal Plan	26	26	26	26	26	26	26	26	26	26	26	26	312
	NHS Improvement Ceiling	10	9	8	29	28	27	35	34	34	34	34	34	316
	16/17 Actual Expenditure	150	147	168	166	191	138	- 136	110	89				1,023
Administrative & Estates	15/16 Outturn													-
	16/17 Internal Plan	17	17	17	17	17	17	17	17	17	17	17	17	204
	NHS Improvement Ceiling	6	6	5	18	18	17	22	21	21	22	21	21	198
	16/17 Actual Expenditure								-					-
Other	15/16 Outturn													-
	16/17 Internal Plan													-
	NHS Improvement Ceiling													-
	16/17 Actual Expenditure	-							-					-
Total	15/16 Outturn	526	526	526	553	611	723	821	613	674	948	792	958	8,271
	16/17 Internal Plan	1,001	1,001	1,001	534	534	534	345	345	345	315	315	315	6,585
	NHS Improvement Ceiling	661	644	622	590	575	555	515	503	497	484	473	467	6,586
	16/17 Actual Expenditure	911	1,042	1,057	1,038	760	676	689	704	705	-	-	-	7,582

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st February 2017
Title:	Estates and Facilities Management and Health and Safety: Issues and exception report
Lead Director:	Director of Estates and Commercial Development
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Corporate Risk/Theme	Estates and Infrastructure
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

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

Key Issues/Risks

- **Critical Estate Failure:** A further critical estate failure was reported in December. The hot water to the surgical ward block and emergency department was lost for 12 hours due to age related failure of a water pump. This plant is part of the backlog risk. A new pump was expressed delivered and fitted. Having no water circulating for 12 hours was a concern for the potential for growth of Legionella pathogens. As recommended by the Director of Infection Prevention and Control, the whole water system was heat sterilised once the water was circulating again. Subsequent widespread sampling at ward level showed no legionella in system and therefore no residual risk.

- **Planned Preventative Maintenance:** The performance of 75% of planned preventative maintenance for the period in the acute Trust is of concern. This is due to three main issues: A high level of urgent responsive maintenance requests to be actioned within 2 days; Additional theatre maintenance required over and above the maintenance scheduled; A high leave period and reduced resources due to the holding of vacancies pending an imminent re-structure of the estates workforce. Management actions are being taken to: re-profile activity, prioritise statutory maintenance for completion by the end of January and expedite the re-structure and appointment to key posts to maintain safety and compliance. The risk of planned maintenance non-compliance has been escalated to the risk register until the action plan for statutory maintenance has been completed in January and key compliance personnel are in place through the implementation of the new structure. The consultation is planned to start on the 27th of January.

- **Fire:** There was one fire in a car in the car park that was attended and put out by the fire brigade.

Recommendations:

The Trust Board is asked to consider the risks and assurance provided within this report and to advise if further action is required.

Summary of ED Challenge/Discussion:

- An understanding of the risk and potentially serious nature of the critical estates failure in relation to risk of Legionella and patient safety. The Board has made the decision, following Executive recommendation, to prioritise critical maintenance and has agreed a capital commitment of £1.2million to address critical backlog maintenance risks up to the end of March 2017.

- Improvement in the performance in the number of sharps incidents to the lowest level for 12 months is seen as a very positive improvement, and reflects the outcome of the working party on sharps. A detailed sharps report will be considered by the Quality Assurance Committee.

- Recognition that the risk of non-delivery of statutory maintenance is a compliance risk for the organisation. The Executive lead has oversight of the plan to deliver statuatory requirements by the end of January. The revised estates structure and skill mix of the Estates direct labour force, and the recruitment to key compliance posts has been agreed by the Executive, to ensure that the Trust's mandatory statutory testing and maintenance is completed, and safety maintained.

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

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

Equality and Diversity Implications:

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

PUBLIC

Report to:	Trust Board
Date:	February 2017
Report From:	Director of Estates & Commercial Development
Report Title:	Estates and Facilities Management and Health and Safety: Issues and exception report

1. EFM Performance report for December 2016

Table 1 below identifies performance for November & December 2016 and changes between months for EFM. Any area of concern for the attention of the CEIG, with appropriate explanation and action to a resolution, is shown in Table 2.

Table 1: December 2016 Scorecard Indicator

Green ✓	Amber !	Red ✘	Nov 2016 Position	Dec 2016 Position
Setting	**Improving Indicators**			
Community	1.2g: % of Reactive work resolved within target – Urgent – P2		!	✓
Trust	4.5: % of near misses against total		!	✓
Trust	5.3: Fire alarm activations attended by the Fire Service		!	✓
	Deteriorating Indicators			
Acute	1.1B: PPM (Estates) % success against plan		!	✘
Trust	3.1: Total Tonnage per month all waste streams		!	✘
Trust	4.4: Non-patient incidents resulting in moderate harm		✓	!
Trust	5.1: No of Fires		✓	✘
Trust	5.2: Number of fire alarm activations		✓	✘
	Red Rated Indicators with no change			
Trust	1.3: Number of Estates Internal Critical Failures		✘	✘

	Table 2: Areas with Specific Cause for Concern		Timeline
Acute	1.1B	PPM (Estates) % success against plan	
Explanation	Percentage completion has lowered this month. Analysis shows that significant amount of these are statutory PPMs scheduled for December.		
Action	Actions 1.PPM scheduling to be reviewed to ensure less PPMs in periods of known high leave periods ie Christmas Bank Holidays. The Christmas week is also used for essential theatre maintenance and so less time is available for other maintenance. 2. PPMs are now in process of being reviewed to ensure Statutory and Mandatory tasks can be more easily identified. 3. Weekly meeting put in place with Estate Managers to review weekly PPM schedule and ensure prioritisation of Statutory and Mandatory PPMs. 4. Plan to complete outstanding statutory and Mandatory PPMs by 18th Jan. 5. Re-structure proposal completed to change the skill mix of the direct labour force and appoint to key compliance posts where vacancies are being held up to skill mix.		January 2017
Acute	1.3	Estates Critical Failure	
Explanation	Pump failed due to age resulting in no hot water to ED and the Tower Block.		
Action	New pump fitted. Water system pasteurised and sampling carried out to check for legionella. Results from sampling show no legionella present in system.		December 2016
Trust	3.1	Total Tonnage per month all waste streams	
Explanation	Increase in recycled waste from ICU build (cardboard and wood) that we have disposed of behalf of the contractors.		
Action	Using data supplied by Viridor we are targeting key areas to decrease black bag waste e.g. Catering, Pharmacy, Pathology and Winnicot Centre and increase recycling, which has reached its highest for this financial year at over 45%.		January 2017
Trust	5.1	Number of fires	
Explanation	This was a car fire in Car park A. No patient, staff or visitor were injured, the fire service attended and extinguished the smouldering fire in the vehicle.		
Action	No further action required.		N/A
Trust	5.2	Number of fire alarm activations	
Explanation	Various reasons for the alarms including system faults, steam, aerosols, good intent		
Action	Only 1 of these was attended by the Fire Service		N/A

EFM Key performance Indicators Month 8 – December 2016																						
	Area			Target	Monthly Performance													Current year to date (Complete Months)		Risk Threshold		
Ser	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	RAG Thresholds		
	Estates (Acute Setting)																					
1.1a	Number of PPM items planned per month			Variable	968	1181	1133	1092	1213	1029	1166	1098	1157					1115			
1.1b	PPM (Estates) % success against plan			95%	74%	87%	79%	74%	77%	83%	87%	86%	75%				95%	80%	R<85%	A85-94%	G>95%
1.1c	Planned Maintenance request access denied.			0	0	0	0	0	0	0	0	0	0				0	0	R≤5	A3-4	G≤2
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	118	137	113	122	128	114	121	140	145					126			
1.1e		Emergency – P1	<2 Hour	95%	98%	100%	98%	100%	95%	95%	98%	97%	95%				95%	97%	R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	269	263	272	253	249	232	203	353	282					264			
1.1g		Urgent – P2	<1- 4 Days	90%	83%	84%	85%	89%	87%	81%	94%	86%	87%				90%	86%	R<85%	A85-89%	G≥90%
1.1h		Routine – P3 + P4	Total Requests	Variable	298	315	281	292	291	295	294	349	457					319			
1.1i		Routine – P3 + P4	<7- 30 Days	85%	88%	90%	94%	90%	91%	91%	93%	91%	93%				85%	91%	R<80%	A80-84%	G≥85%
	Estates (Community Setting)																					
1.2a	Number of PPM items planned per month			Variable	244	269	232	269	243	231	279	206	284					251			
1.2b	PPM (Estates) % success against plan			95%	93%	91%	95%	97%	91%	97%	97%	94%	94%				95%	94%	R<85%	A85-94%	G>95%
1.2c	Planned Maintenance request access denied.			0	0	0	0	0	0	0	0	0	0				0	0	R≤5	A3-4	G≤2
1.2d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	11	17	5	17	16	8	14	7	11					12			
1.2e		Emergency – P1	<2 Hour	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%				95%	100%	R≤89%	A90-94%	G≥95%
1.2f		Urgent – P2	Total Requests	Variable	47	56	42	69	36	21	33	71	40					46			
1.2g		Urgent – P2	<1- 4 Days	90%	81%	91%	90%	93%	94%	90%	91%	86%	93%				90%	90%	R<85%	A85-89%	G≥90%
1.2h		Routine – P3 + P4	Total Requests	Variable	122	109	56	171	64	53	87	80	104					94			
1.2i		Routine – P3 + P4	<7- 30 Days	85%	93%	93%	96%	98%	94%	94%	93%	89%	93%				85%	94%	R<80%	A80-84%	G≥85%
	Estates (All Trust)																					
1.3	Number of Estates Internal Critical Failures			0	0	0	0	0	0	1	1	3	1				0	1	R1	-	G0
	Facilities (Acute Setting)																					
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	99%	99%	99%	99%	99%	99%	99%	99%				98%	99%	R<95%	A95-97%	G≥98%
2.2	Compliance High Risk Cleaning Audit			95%	97%	97%	98%	98%	97%	97%	98%	98%	98%				95%	98%	R≤89%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	99%	99%	98%	98%	98%	99%	99%				85%	99%	R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	96%	96%	96%	100%	98%	100%	97%	98%				75%	98%	R<70%	A70-74%	G≥75%
	Facilities (Community Setting)																					
2.5	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%	100%	100%	100%	100%	100%	99%				98%	100%	R<95%	A95-97%	G≥98%
2.6	Compliance High Risk Cleaning Audit			95%	99%	99%	99%	99%	99%	100%	100%	98%	98%				95%	99%	R≤89%	A90-94%	G≥95%
2.7	Compliance Significant Risk Cleaning Audit			85%	99%	100%	97%	99%	99%	98%	99%	97%	97%				85%	99%	R<80%	A80-84%	G≥85%
2.8	Compliance Low Risk Cleaning Audit			75%	100%	100%	91%	99%	95%	100%	100%	96%	94%				75%	97%	R<70%	A70-74%	G≥75%
	Facilities (All Trust)																					
2.9	No. of Environmental (food hygiene/Waste) Events			0	0	0	0	0	0	0	0	0	0				0	0	R1	-	G0

	Waste (All Trust)																		
3.1	Total Tonnage per month all waste streams	176	176	184	191	193	193	194	193	182	200				176	190	R≥185	A177-185	G≤176
3.2	% of Total tonnage Recycled Waste	38%	35%	40%	38%	35%	35%	45%	36%	39%	45%				38%	39%	R≤27%	A28-37%	G≥38%
3.3	% of Total tonnage Landfill Waste	34%	32%	28%	36%	1%	0	0	1%	0	0				34%	11%	FROM	JULY 16	See 3.7
3.4	% of Total tonnage of Clinical Non-Burn waste	12%	20%	20%	19%	19%	18%	18%	18%	18%	16%				12%	18%	R≥25%	A19-24%	G≤18%
3.5	% of Total tonnage of Clinical Burn waste	11%	6%	5%	5%	5%	5%	5%	5%	5%	5%				11%	5%	R≥16%	A12-15%	G≤11%
3.6	% of Total tonnage of Clinical Offensive waste	10%	6%	6%	6%	7%	6%	6%	6%	6%	6%				10%	6%	R≤2%	A3-5%	G≥6%
3.7	Waste to Energy (redirected from landfill 1100s and Compactor.	25%	FROM	JULY	2016	34%	37%	26%	34%	32%	27%				25%	32%	R≤15	A15-24	G≥25
3.8	% of Compliant Waste Audits	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	R<80%	A80-84%	G≥85%
3.9	% Compliance of Statutory Waste Audits	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	R≤89%	A90-94%	G≥95%
	Waste (Acute Setting)																		
3.10	Number of Waste Audits undertaken per month	10	10	10	10	10	10	10	10	10	10				10	10	R≤5	A6 - 7	G≥8
	Waste (Community Setting)																		
3.11	Number of Waste Audits undertaken per month	6	7	6	7	7	7	7	7	7	7				6	7	R≤4	A5	G≥6
	Health & Safety (All Trust)																		
4.1	Number of RIDDOR Incidents	3	10	3	3	2	3	4	0	3	2				3	3	R≤6	A4-5	G≤3
4.2	Number of days lost (due to incidents in month)	Variable	136	5	198	214	15	67	6	44	27					79			
4.3	Non-patient incidents resulting in minor harm	35	39	38	24	28	30	27	32	35	25				35	31	R>39	A36-39	G<36
4.4	Non-patient incidents resulting in moderate harm	4	4	7	8	9	2	7	5	1	5				4	5	R>7	A5-7	G≤4
4.5	% of near misses against total	20%	34%	27%	36%	36%	27%	20%	23%	15%	20%				20%	26%	R<15%	A15-19%	G≥20%
4.6	% of Staff receiving H & S training in month	85%	86%	86%	86%	85%	85%	86%	86%	89%	89%				85%	86%	R<80%	A80-84%	G≥85%
	Fire (All Trust)																		
5.1	% of Staff receiving Fire Training during month.	85%	82%	83%	83%	83%	84%	84%	82%	84%	83%				85%	83%	R<80%	A80-84%	**G≥85%**
5.2	Number of fire alarm activations	9	7	15	9	7	10	11	5	6	14				9	9	R≥14	A10-13	**G≤9**
5.3	Fire alarm activations attended by the Fire Service	2	1	3	3	1	2	2	0	3	1				2	2	R≥5	A3-4	**G≤2**
5.4	No. of Fires	0	0	0	0	0	0	0	0	0	1				0	0	R1	-	**G0**
5.5	Number of Fire audits undertaken for ' high risk' locations	9						11	5	10	10				9	9	R<7	A7-9	**G>9**
5.6	Number of Fire audits Undertaken for 'medium/normal' locations	8						29	15	10	9				8	16	R<5	A5-8	**G>8**
5.7	Completed Risk assessments for 'high risk' locations	27/12						27	27	27	27				27	27	R<25	A25-27	**G>27**
5.8	Completed Risk assessments for 'medium risk' locations	45/12						45	45	45	45				45	45	R<42	A42-45	**G>45**
5.9	Completed Risk assessments for 'low risk' locations	84/24						84	84	84	84				84	84	R<80	A80-84	**G>84**