Torbay and South Devon NHS Foundation Trust
Public Board of Directors Meeting

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital, TQ2 7AA
6 December 2017 09:00 - 6 December 2017 11:00

AGENDA

#	Description	Owner	Time
	In case of fire - if the fire alarm sounds please exit the Anna Dart Lecture Theatre immediately in a calm and orderly fashion. On exiting, turn right and then left through the fire door and assemble in the car park by the Patient Transport Offices.		
1	User Experience Story Information		
2	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
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 1st November 2017 and Outstanding Actions Approve 17.11.01 - Board of Directors Minutes Public.pdf 9	Ch	
3.4	Report of the Chairman Note	Ch	
3.5	Report of the Chief Executive Assurance Report of the Chief Executive.pdf 31	CE	
3.6	Strategic Issues		

#	Description	Owner	Time
3.6.1	Shaping Future Care: Sustainability and Transformation Partnership for Devon Information/Assurance Update and Progress on Devon's STP.pdf 43	DSI	
3.6.2	Research and Development Annual Report Research and Development Annual Report.pdf 55	MD	
4	Delivery Issues		
4.1	Integrated Quality, Performance, Finance and Workforce Report - Month 7 Information/Assurance IQPFW Report.pdf 85	DSI/DoF/DWOD	
4.2	Winter Planning Assurance Winter Plan.pdf 159	COO	
4.3	Mortality Safety Scorecard Assurance Mortality Safety Scorecard.pdf 167	MD	
4.4	Education and Development End of Year Report Information/Assurance Education and Development End of Year Report.pd... 179	CN	
5	Governance Issues		
5.1	Board Assurance Framework Assurance Board Assurance Framework.pdf 195	DoF	
6	Governors' Questions Discuss	Ch	
7	PART B: Matters for Approval/Noting Without Discussion		

#	Description	Owner	Time
7.1	Reports from Board Committees Assurance		
7.1.1	Quality Assurance Committee Report - 6th November 2017 2017 11 06_QA_Cttee_Report_to_Board.pdf 207	Ch	
7.1.2	Finance, Performance and Investment Committee - 28th November 2017 Information/Assurance 2017.11.28_FPI_Cttee_Report_to_Board.pdf 209	RS	
7.2	Reports from Executive Directors		
7.2.1	Report of the Chief Operating Officer Information/Assurance Report of the Chief Operating Officer.pdf 211	COO	
7.2.2	Report of the Chief Nurse Information/Assurance Report of the Chief Nurse.pdf 219	CN	
7.2.3	Report of the Director of Estates and Commercial Development Information/Assurance EFM Board report November 2017.pdf 235	DECD	
7.2.4	Director of Workforce and Organisational Development Information/Assurance Report of the Director of Workforce.pdf 241	DWOD	
7.2.5	Report of the Director of Strategy and Improvement Report of the Director of Strategy and Improvement... 249	DSI	
7.3	Compliance Issues		
7.4	Any Other Business Notified in Advance	Ch	
7.5	Date of Next Meeting - 9.00 am, Wednesday 7th February 2018	Ch	
7.6	Exclusion of the Public	Ch	

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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 / quality 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. Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'.

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 1st NOVEMBER 2017

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
	Mr Ian Currie	Deputy Medical Director
	Ms L Davenport	Chief Operating Officer
	Mrs L Darke	Director of Estates and Commercial Development
	Mrs J Falcão	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
	Ms J Gratton	Joint Head of Communications
	Mr R Scott	Corporate Secretary
	Ms S Hayward-Wright	CQC
	Mr W Thomas	Liaison
	Mr G Jennings	Member of the Public
	Mr P Raybould	Member of the Public

Governors:	Mr R Bryant	Mrs C Day	Dr C Davidson
	Mrs C French	Mrs A Hall	Mrs L Hookings
	Mrs B Inger	Mrs W Marshfield	

ACTION

196/11/17 **Healthwatch Award – Daniel Stuart**

The Chairman commenced the meeting by presenting an award from Torbay Healthwatch, voted for by the public, to Mr Daniel Stuart from the MSK service in Brixham.

The Board wished to record their congratulations to Mr Stuart on receipt of his award.

197/11/17 **User Experience Story**

The User Experience Story was presented by the Advanced Practitioner for Perinatal and Parent/Infant Mental Health (Alan Willmott) and Torbay CAMHS Service Manager (Corinne Foy). It concerned the project for which the team were awarded the RCN

Award for Innovation in Mental Health. The project was developed in response to rising referral rates to the service and it focussed on supporting parents and young people through group work whilst waiting for individual treatment. A workshop was developed that ran over a half-term period and provided parents with support and guidance on how to manage young people with mental health issues. The project has helped to reduce referrals to the service because of the support provided to families.

Councillor Parrott queried the team's connection with the Portage Team and Mr Willmott explained that the Portage Team was a very small service that worked with a very specific age group, but that there was some limited cross over. He added that the feelings of grief after the loss of a family members were the same as those for someone with mental health issues, eg poor resilience, high anxiety, low self-esteem because the person who would provide that support was no longer there.

Councillor Parrott also asked if waiting times had reduced since the project was put in place and it was noted that the project was one of a number of initiatives that had taken place over the last two and a half years and since then the waiting list had reduced to an average of seven weeks.

Before closing the Chief Operating Officer wished to place on record her congratulations to the team for an innovative piece of work that had made a real difference at local level and which had been recognised nationally.

198/11/17 **Mental Health Presentation**

Melanie Walker, Chief Executive of Devon Partnership Trust gave a presentation on the issues affecting mental health and the opportunities for strengthening partnership arrangements with the Trust for the benefit of service users.

M Walker - SD&T board presentation.p

Following the presentation Councillor Parrott asked if the increase in sexual assaults fitted in with the spectrum for mental health and Mrs Walker explained that all mental health issues could be classed as trauma, whatever the cause, and that the service was a trauma-responsive service. She added that a lot of work had been undertaken to redesign care pathways and look at best use of resources to make care as timely as possible, and also how the service collaborated with GPs. She said that the biggest challenge is to get mental health recognised as trauma by other agencies, in the same way as physical illness was viewed, and to work with them on prevention. If there was investment in CAMHS the outcomes for young people would be better with a significant impact on society.

Mr Willmott stated that his area of work was in peri-infancy and focussed on repairing the rupture created in relationships as a result of pregnancy related mental health issues. He suggested the service needed to look ahead 20-30 years, to see the differences that could be made to people's lives if changes were made now. He added that there was a need to prepare people for becoming parents and not just those with mental health issues.

The Chief Executive, in closing, thanked Mrs Walker for taking the time to attend the Trust's Board meeting and giving such an informative presentation.

199/11/17 **Board Corporate Objectives**

Noted.

PART A: Matters for Discussion/Decision

200/11/17 **Apologies for Absence**

Apologies for absence were received from the Medical Director (Mr Ian Currie, Deputy Medical Director was in attendance).

201/11/17 **Declaration of Interests**

Nil.

202/11/17 **Minutes of the Board Meeting held on the 4th October 2017 and Outstanding Actions**

The minutes of the meeting held on the 4th October 2017 were confirmed as an accurate record.

Councillor Parrott took the opportunity to brief the Board in respect of Torbay Council's Children's Services and stated that Ofsted was currently undertaking the last of its monitoring visits and if it went well would undertake a full re-inspection of the service in January. In addition he would be meeting with Plymouth Council in the near future where he would ensure that the agreement to transfer the management of Torbay Council's Children's Social Care services took account of the Council's relationship with the ICO.

203/11/17 **Report of the Chairman**

The Chairman commenced by welcoming Carol Day to the meeting as the newly appointed Deputy Lead Governor. He also informed the Board that Mary Lewis (Governor) was making very good progress in her recovery and it was hoped she would be able to be back supporting the Trust as a Governor in the New Year.

The appointment of two new NEDs was approved at the Council of Governors meeting last week – Mr Paul Richards and Ms Vikki Matthews. In addition, the Chairman informed the Board that Mr Allen had decided to tender his notice as a NED. He wished to place on record his personal thanks for Mr Allen's support and guidance and the thanks of the Board, especially whilst acting up as Vice-Chair managing some challenging issues.

Finally, the Chairman informed the Board that he has received a very positive response to the Kite Mark Initiative from the Trust's voluntary sector partners and saw the Teignmouth Award on display in the new Coastal Information Centre recently.

204/11/17 **Report of the Chief Executive**

The Chief Executive reported on the following:

- A reminder that the Chief Executive's report is a key communication document for the Trust and was used for wider circulation amongst the Trust's staff.
- The Chief Executive wished to extend her personal thanks to Mr Allen for his personal guidance and support to her and she had benefited from his support over the past few years.
- The Board noted that the Trust had not achieved the 4 hour target trajectory at the end of September, however performance had improved and was now at 92.6% which was a significant improvement on the September performance of 89.9%.

- Following the recent 'lock-in' session with the Trust's clinical and managerial leaders to identify additional actions to manage winter pressures, seven key work programmes had been identified and were being taken forward at pace, which are described in the Chief Operating Officer's report.

- There was increased national scrutiny on winter planning and delayed transfers of care and a Joint Ministerial letter had been sent to Local Authorities outlining the consequences of not meeting targets in respect of delayed transfers of care and an implication that some of the Improved Better Care Funding could be removed.

- The Trust's flu vaccination programme continued with current uptake at 27%, with a range of actions to increase uptake.

- Month 6 performance risks were set out in the Performance report to be considered later in the meeting, and included risks in respect of the number of 52 week waiters, RTT and actions being taken to stabilise the position; and 62 day cancer performance which had returned to above the national standards after a reduced compliance in September.

- Financial performance was on track with plan, with a surplus of £830,000 being delivered in September. The Board was asked to reflect on this progress, achieved while maintaining the safety, quality and responsiveness of the Trust's services.

- The Board noted that the Trust continued to make progress in its partnerships to support the care model including with academia and the Chief Executive recently met with the Interim Dean for Health and Human Sciences from Plymouth University to this end.

- The Board will note the detailed STP update included in the Board papers, and was informed that the STP wished to put itself forward to be included in Wave 2 of the Accountable Care Systems National Programme.

- Finally, it was noted that two issues were the subject of national focus - Theatre Utilisation, where NHSI had released a press statement to be followed by a report, and an announcement about a National Review of Maternity Units.

Councillor Parrott asked if there was any evidence that the improved financial performance had impacted on service delivery. The Chief Executive reported the only significant impact was a reduction of outsourcing to improve the RTT position. This decision had been taken on a Devon-wide level to support delivery of financial targets. There was a very fine balance to reach between improving financial performance and the impact on services.

Councillor Parrott asked for assurance that the work on the seven key performance areas identified at the lock-in session was being undertaken in conjunction with colleagues from the Council, where appropriate, and the Chief Operating Officer confirmed that it was.

Mr Welch, reflecting on the presentation from Mrs Walker and the savings that could be made by investing in mental health at an early stage, suggested there should be an action plan and reporting route based on those potential savings. The Chief Executive acknowledged this suggestion and stated that she would ask for this to be a focus for the STP report next month. She agreed that invest to save and parity of investment for mental health was an issue that needed to be discussed with commissioners. CE

Mr Welch queried the process on e-prescribing and the savings that would be realised from the project and suggested the timeline to implement was too slow. Mrs Lyttle informed the Board that a presentation on e-prescribing was presented to the Quality Assurance Committee and the timeline was stress tested and assurance gained on the project. In respect of timings, the Director of Strategy reported that e-prescribing was one of five IT enabling priorities for the Trust, approved by the Clinical Management Group, and the other four projects were equally as important to the Trust as e-prescribing. There was a constant balance to manage capacity against the priority IT projects.

Strategic Issues

205/11/17 **Shaping Future Care: Sustainability and Transformation Partnership for Devon**

Strategic Context

The Devon Sustainability and Transformation Partnership (STP) provides a single framework through which the NHS, local authorities and other health and care providers work together to transform health and care services.

All leaders have been working collaboratively in Devon over the past 18 months on an ambitious STP plan.

This has resulted in significant progress in key areas. For example, a joint approach to tackling financial problems has resulted in over £100 million of savings in 2016/17, and this year Devon is on track to deliver a further £169 million in efficiency savings. There is also shared commitment to improving performance, which has seen Devon move into the top 20% in England on performance in A&E, cancer and mental health.

The purpose of this report is to ensure:

- everyone is aware of all STP developments, successes and issues in a timely way.

- consistency of message amongst STP partner organisations on what has been endorsed at the Programme Delivery Executive Group (PDEG). All Chief Executives from partner organisations in the STP are members of PDEG.

The commitment is that a monthly update will become a regular report to share with all Boards, Local Authorities, Governing Bodies, Councils of Governors and other key stakeholders.

Key Issues/Risks

Core Content
Items included in this monthly update following the PDEG meeting held on 20 October 2017 are as follows:

1. Recruitment of a system-wide Chief Executive for Devon, and independent chair.
2. Acute Services Review – phase 1 close-down, phase 2 next steps and proposals for service delivery networks.
3. Devon Accountable Care System organisational design mandate.
4. Learning from the launch of the *In Shape for Surgery* initiative.
5. A project to make best use of spend on high cost drugs.
6. Cancer services – achieving and maintaining the 62 day standard.
7. Devon STP priority workstream areas

Risk
The main risk to the Trust was having the leadership and clinical capacity to engage in and inform STP programmes and workstreams on top of Trust and local system change programmes – this was being kept under review and a "do it once" approach is being pursued

The Director of Strategy reported that the STP briefing report was now prepared by the STP so that the same message could be shared across all Trusts in the system.

Councillor Parrott queried the briefing in respect of organisational design and accountable care systems. He said that the Mayor's Policy and Development Group was meeting to discuss this issue and he expected there to be challenge around the decisions on 'place' that the local CCG could be lost, and a seeking of guarantees that the new strategic commissioners would not try to change the structure of the ICO. The Director of Strategy and Information reported that each STP was now called an accountable care system, and that the local South Devon and Torbay system was pursuing a Local Care Partnership within the Devon STP Accountable Care System. She said that a report on this issue would be brought to next month's meeting. Alongside this, clinical networks had been set up across Devon to ensure viable clinical services could be provided to support the population of Devon.

The Chairman reminded the Board that there would need to be a change to primary legislation to change the form of the Trust and that also the RSA ensured a firm arrangement was in place in terms of a contractual agreement for the local system for the next two-three years.

The Board formally noted the progress of the Devon STP.

Delivery Issues

206/11/17 **Integrated Quality, Performance, Finance and Workforce Report – Month 6**

Strategic Context

2017/18 Operational and Financial Plan and Control Total:
The Trust submitted an Operational Plan for 2017/18 to NHS Improvement (NHS I) which confirmed the commitment of the Board to ensure the Trust achieves the Control Total set by NHS I of achieving a £4.7m surplus by 31st March 2018.

Sustainability and Transformation Fund:
An allocation from the national Sustainability and Transformation Fund (STF) has been set aside for the Trust. The arrangements for allocating the STF for 2017/18 have been confirmed as follows:

- 70% is dependent on delivery of the Trust's financial plan to deliver the agreed Control Total.
- 15% is dependent on delivery of A&E performance at Trust and / or STP level
- 15% apportionment is based on the Trust's plans to deliver front door streaming by GPs by October 2017.

These thresholds have been met in Quarters 1 and 2 and £2.04m has been secured from the STF.

Regulatory Context - NHS I Single Oversight Framework:
The single oversight framework was used by NHS I to identify NHS providers' potential support needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. Against this framework, NHS I has segmented providers into

one of four segments ranging from One (maximum autonomy) to Four (special measures). The Trust has been assessed as being in Segment Two (targeted support), in response to concerns in relation to finance and use of resources. This segmentation attracted an offer of targeted support and the Trust secured the services of Mark Hackett to support delivery of our 17/18 financial improvement plan. Mark Hackett's contract ended at the end of September 2017 and the oversight his role provided has been continued through the fortnightly 'check & challenge' meetings which are now chaired by the Director of Finance.

Key Issues/Risks

The headlines for performance to the 30th September 2017, against the financial, operational, quality, change and workforce frameworks established by the Trust, are set out in the Integrated Performance Report.

The key issues and Risks to note are:

Finance:

- **Overall financial position:** The financial position against the Control Total for the 6 months to 30th September 2017 was a deficit of £2.63m against a planned deficit of £3.88m. In the month of August a surplus of £831k had been achieved, which is £450k ahead of plan.

- **Pay expenditure:** Total pay costs were underspent against plan to 30th September by £1.76m.

- **Savings Delivery:** The Trust had delivered £16.9m against our year to date savings profiled target of £15.3m (including income generation target); a £1.6m over-delivery.

- **System Savings Plan**: Against the 2017/18 £40.7m cost reduction target, and income generation target of £1.3m, required to achieve a Trust Control Total of £4.7m surplus; at the 30th September, the Trust had identified savings potential of £41.7m (£34.6m Recurrent FYE), resulting in a £0.4m shortfall (Forecast out-turn risk).

  Mitigations from further potential slippage, generated within the SDUs could support a move towards a balanced position.

  It is important to recognise that this scale of forecast delivery represented a significant improvement on the achievements of previous years. Any slippage in delivery would however put the control total and £5.7m STF funding at risk, affecting liquidity and, in turn capital investment plans.

  Focus must now turn to managing the residue of identified cost pressures and the recurrent gap in the savings programme to ensure that the Trust limit any carry forward of pressure into the 2018/19 financial year.

Summary of Performance Against Frameworks:

Framework	Number of KPIs	RAG Rating at 30th September 2017			
		Red	Amber	Green	Not Rated
National Performance Stds	4	3	0	1	0
Local Performance Framework	23	10	1	11	1
Community & Social Care Framework	15	5	0	7	3
Quality Framework	20	5	2	10	3
Workforce Framework	4	1	2	1	0

Against the national performance standards the Trust delivered the following performance to the 30th September:

- 89.9% against the 4 hour ED standard; this was below the planned trajectory of 93.5% and below the national 95% standard

- 84.0% against the RTT 18 week standard; this was below trajectory and off track to deliver the 92% standard by the end of March 2019.

  Work is underway to address this position with £1.9m already allocated to get performance back to the 86%. Work was also underway to assess what it would take to lift performance to 88% and then the 92% national target.

- The number of people waiting over 52 weeks for treatment was 16, against the national target of zero. Work to validate this position indicates that the number of people waiting over 52 weeks was likely to rise in October and November before measures to eradicate waits of 52 weeks begin to impact.

Performance against the 62 day cancer standard had been recovered in September to deliver 85.9% against the national standard of 85% or more.

The Board noted the report and the following was discussed:

Performance

- The report had been discussed in some depth at the Finance, Performance and Investment Committee and the meeting had noted that the Trust's financial plan was being met, but also acknowledged a growing set of cost pressures and the action being taken to manage these. The meeting also reviewed quality and safety performance against national and local targets.

- As at 31st October, performance was as follows:

  - RTT % incomplete pathways less than 18 weeks – 83%
  - Cancer 62 day wait for first treatment – 2 week wait - 86%

- Diagnostic tests longer than the 6 week standard – 3.90%
- RTT 52 week wait incomplete pathway – 24
- Cancer – 2 week wait from referral to date first seen – 62.77%

- There had been a significant improvement in Dementia Find performance which was now over 80% and reflected the move to using Nerve Centre.

- Mr Allen welcomed the report and how it was clear the Care Model was generating improvements, however he raised the balance between services and resources, and suggested it would be helpful to see included information showing how the Care Model has improved patient outcomes and then the Trust's financial performance. He also noted the improved performance in respect of stroke and finally suggested that there needed to be a communications plan around management of long waiters because in many cases there was a good reason for the length of wait. DSI

- The Chief Executive acknowledged Mr Allen's concerns and reported that the Trust had invested £191,000 to help control and minimise the number of 52 week waits. She added that performance in the cancer and breast symptomatic service was due to an inability to recruit specialist radiotherapy staff. The Chief Operating Officer added that 52 week waits were unacceptable for the Trust and there was a clear plan in place to reduce these to zero by the end of the financial year, with a much improved position realised by the end of the calendar year.

Finance

- In respect of financial performance, it was noted that the Trust had a deficit of £2.46m, which was £1.5m better than plan. There were no new variances to report. Agency expenditure continued to reduce which was a reflection of the controls in place.

- The Board was reminded that the savings plan was profiled with a significant amount of delivery planned in the second half of the year. £41.7m of the £42.1m target had been identified and the significant improvement in month was associated with the sign off of the revised RSA. The full year effect of recurring schemes was £34.6m, so still a gap to address.

- Work continued to manage £5m of identified cost pressures. To date £1.5m had been identified.

Quality/Safety

- The Trust's Infection Prevention and Control Lead had been invited to attend a national event in Bristol to discuss the Trust's work on infection prevention and control and it was noted the Trust had a robust flu plan in place in case of an outbreak.

- Quality and effectiveness safety metrics were reviewed on a monthly basis, along with a review of incidents, complaints etc at the Quality Improvement Group.

Workforce

- The Director of Workforce and Organisational Development outlined the work to manage staff sickness and invest in 'positive attendance' rather than 'sickness management'. Much of this work focussed on prevention, for example the provision of mindfulness sessions; flu campaign; mental health first aider training to help identify someone suffering from mental health issues;

health and wellbeing champions; and expansion to the coaching network.

- A business case was considered by the Workforce and Organisational Development Group in respect of a fast-track physio service for staff.

- In respect of performance against targets, appraisal performance had dropped slightly. A revised strength-based appraisal process had been piloted in the SDUs and positive feedback had been received with individuals seeing the value of such as approach.

- Work continued to improve mandatory training, which was lower than planned with catching up taking place after the impact of the call to action at the start of the year. An improvement plan was in place to drive an increase in performance.

- Mrs Marshall stated that she welcomed the new interventions in respect of management of sickness and suggested, as performance was reported on a rolling 12 months basis, a breakdown was provided showing how many long term sickness cases the Trust was managing and this was agreed. DWOD

The Trust Board formally considered the risks and assurance provided within the report.

Governance Issues

207/11/17 **Guardian of Safe Working Hours Update**

Strategic Context

The new Junior Doctor contract was implemented in the Trust in line with the national implementation plan between August 2016 and August 2017. Almost all junior doctors were now working on the terms and conditions of the new contract (with the exception of Trust doctors).

The Guardian of Safe Working Hours was a mandated post designed to provide support around implementation of the new contract and independent assurance in relation to the impact of the changes. A report of the Guardian was required at Trust Board on a quarterly basis.

Key Issues/Risks

The report contains information with regard to the implementation of the new contract and exception reporting by junior doctors on the new terms and conditions.

The level of reporting has fallen in recent months. It is considered that this reduction reflects a reduction in perceived usefulness and administrative burden of the reporting mechanism rather than a reduction in episodes of failures in compliance with working hours recommendations. For this reason the other forms of engagement with junior doctors are considered to be particularly important.

Detailed reporting suggests that there is a perception by some doctors in training (in some clinical areas) that exception reporting may be viewed negatively by educational supervisors.

The Deputy Medical Director reported that the financial impact of the new contact to the Trust was around £0.5m for the current year, partly due to one off payment protections that have had to be paid. Exception reports that have been received show that junior doctors, in particular in General Surgery, come to work early to complete

administration duties and this had triggered some work to try to release them for this so that they completed work that only they could do.

Mr Allen stated that that he understood that the contract was disadvantageous to women and if this was the case it should not have been introduced and he asked if the detail of the contract could be checked. The Chairman reminded the Board that this was a national issue and that it did debate whether to implement the contract or not but the implications for the Trust of not implementing were very clear. The Deputy Medical Director said that a GMC representative met regularly with junior doctors to obtain feedback on the contract and he hoped that if a group of staff felt that contract was disadvantageous to them it would be raised in that forum. It was agreed that the Chairman would meet with the GMC representative the next time he/she visited the Trust. MD

The Director of Workforce and Organisational Development suggested that there was more the Trust could do to encourage exception reporting. The Deputy Medical Director stated that preliminary data from the GMC suggested that around 22% of junior doctors felt reluctant to submit exception reports, some because they felt it could be detrimental to their career and also the time it took to actually complete a report. The Guardian of Safe Working Hours was working with the doctors to encourage them to submit reports.

The Board of Directors formally considered the risks and assurance provided within the report.

208/11/17 **Freedom to Speak up Guardians Update**

Strategic Context

As a Trust we are committed to ensuring all our staff members have a safe and supportive working environment. Every employee should feel able to raise concerns, confident in the knowledge that they will be listened to, that action will be taken and that they will be thanked and acknowledged for living the values of the NHS.

- Guardians operate in a genuinely independent capacity
- Staff can raise concerns in confidence
- Guardians have been appointed to provide an independent, confidential and accessible route to raise concerns from any member of staff
- Raising concerns can save lives, jobs and money as well as the reputation of professionals and the organisation.
- Raising concerns contributes to quality care and compassion along with staff and patient wellbeing

Key Issues/Risks

Since the last report to the Board in April 2017, 22 concerns have been raised through the Guardians.

There has been an increase in concerns being raised regarding 'culture of the organisation' with group concerns raised by departments, some of which have been raised during the Chief Executive engagement sessions which the Guardians have supported.

Sarah Burns and Julia Pinder, Freedom to Speak up Guardians attended for this item and the following was discussed:

- This Trust had taken a different approach to other Trusts in that a network of Guardians had been appointed which allowed greater flexibility in terms of support to staff. In addition two Guardians had been appointed as Diversity

and Inclusion guardians.

- The Trust had a wider staff base across a wide geographical area and the Guardians continued to work to increase their visibility across the Trust's footprint.

- Mrs Marshall asked, given the current media focus on sexual harassment, if the Guardians had received any reports of harassments. Sarah Burns stated that no reports of harassment had been received and added that over the last six months more and more staff had approached them, some informally and some on a more formal basis, and they received good feedback on how their concerns were being managed. Sarah added that the Staff Engagement sessions run by the Chief Executive and Chairman have received very good feedback and there was a lot of enthusiasm about the Back to the Floor initiative.

- The Guardians were asked how their work would link with the work of the Acceptable Behaviour Champions and it was noted that they had already started to work with the Diversity and Inclusion lead to triangulate concerns raised.

- The Guardians were asked if they would be supporting the national Employee Support Scheme, which was aimed at supporting whistle-blowers if they wanted to move organisations supported with access to training, placements etc and Sarah stated that she felt that it was an important initiative and the Guardians should be involved in this work.

- The Guardians were asked about capturing soft information and addressing issues without exposing individuals and Sarah reported that the Guardians had recently provided support to address an issue in a department without exposing the individuals who had raised the concern.

- The organisation was in a period of rapid change and it was difficult to ensure that staff received enough communication about that change and the Chairman and Chief Executive engagement sessions were seen as an important part of this process, but looking at issues on a department –wide basis with support from Human Resources was a way of focusing on hot spots on the organisation.

- It was acknowledged that the Trust had a variety of ways that staff could now raise concerns, for example the Guardians, Just Ask etc and it was felt that it would be good to bring these all into one umbrella and this was agreed.

- Mr Welch raised the concern from some staff groups that the Staff Survey was not anonymous. The Chief Executive stated that she was aware of this concern and she has communicated to staff giving her personal assurance on this on two occasions. It was agreed that the Guardians should also send out the same message given that the Staff Survey was an important source of staff feedback.

- It was acknowledged that the Guardians were not yet representative of all staff groups in the Trust, for example community, social workers and overseas nurses.

The Board thanked the Guardians for their report and endorsed the Executive Director team to take forward the report's recommendations as they did not require Board approval.

209/11/17 **Proposed Changes to Standing Financial Instructions, Standing Orders and Scheme of Delegation**

Strategic Context

The financial governance of the Trust was set out in the Trust's Standing Financial Instructions (SFI's), Standing Orders (SO's) and Scheme of Delegation (SoD).

Every two years these documents were subject to a review.

Key Issues/Risks

The Trust's SFI's, SO's and SoD set out the framework for the organisation's decision making process. The organisation needs these decision making processes to be effective to ensure appropriate governance is maintained. The changes proposed cover the following:

- Changes to the delegated authority limits of the Trust's Senior Business Management Team and Executive Directors relating to Investment Proposals.
- Changes to the decision rights of the Charitable Fund Committee.
- Changes to reflect the current working practices of the Court of Protection (CoP) Team.
- Clarification on the delegation for Independent sector placement approval limits with the structure changes since integration ie. the DGM for Community, Associate Director roles and Deputy Director of Operations.
- Delegated authority rights of the Torbay Pharmaceutical's (TP) Managing Director's when entering into new commercial contracts, and
- Access to a hospitality facility for TP.

The Director of Finance outlined the necessary changes to the documents and the reasons for those changes.

Mr Allen raised a concern in respect of Torbay Pharmaceuticals (TP) approvals and that it was possible a contract could go from TP Executive Directors to the Finance Committee and bypass the TP Board. This was acknowledged and it was agreed the Director of Finance would amend the documents to state that the TP Board must approve contracts before they were presented to the Finance Committee.

The Trust Board approved the proposed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation. The Director of Finance to amend the documents to reflect the need for the TP Board to approve any contracts before they were discussed at Finance Committee and agree wording with Mr Allen and Mr Sutton. DoF

210/11/17 **Estates and Facilities Management: National and Regional Comparison of the Trust EFM Performance from the 2016/17 published National Estates Return Information Collection (ERIC) Data**

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

All Trusts were required to submit an annual ERIC submission – a mandatory return to the Department of Health that collects information relating to the costs of providing, maintaining and servicing the NHS secondary care estate.

All the Trusts in the South West have been collaborating over the past two years to ensure that the ERIC data submitted by every organisation in Devon and Cornwall has been peer reviewed and was as accurate as possible to allow for like for like comparisons.

The ERIC data collection supported national policy development and strategic planning in the Department of Health and benchmarking and local planning in the NHS.

It was nationally recognised that there are currently no comparators for an integrated care organisation within ERIC. The Trust's comparator group was for a medium sized acute Trust and this makes direct value for money and cost comparison difficult. It was clear that operating with a large number of smaller buildings delivering health and social care services does not achieve economies of scale in EFM costs. With data from 22 sites incorporated, the Trust had the largest number of sites within our comparator group.

When compared Nationally with other medium acute Trusts the Trust performed well and in the upper quartile in 4 of the 17 outcomes: capital investment, capital investment for new builds, number of fires reported, number of disabled parking spaces and cost of portering services. Performance was average for a further 7 of the 17 outcomes, between the two quartiles and around the median mark. The Trust was benchmarked in the lower quartile across 6 areas: capital investment for improving existing buildings, cost to eradicate estate backlog, % clinical space occupied, number of RIDDOR incidents and soft FM services costs - specifically cleaning costs.

The Trust recorded 42 RIDDOR incidents throughout 2016/17, ranking the Trust third highest against this measure. However, the Trust recorded the highest number of incidents of the entire comparator group, two of whom occupy a significantly smaller footprint.

Whether this result shows a greater number of reportable incidents or a really good reporting and recording culture and systems was currently being considered by the Health & Safety Committee. It is believed that it was the latter.

Known variations around cleaning costs include a higher domestic pay banding than neighbouring Trusts, a high-cost deep clean service and associated linen usage that is significantly higher than other organisations. This variation was mainly driven by differences in infection control practices. Data on infection rates and cost savings relating to lower bed closures for infection, required comparison with the increased cleaning costs to determine the effectiveness of the additional costs and to identify future areas for savings.

Similarly, due to lack of capital the Trust had not yet substantially invested in energy efficiency schemes, explaining the utilities benchmarks and that investment in the existing physical estate and backlog has been limited due to lack of available capital. The Trust's relatively poor comparative benchmark in this area does not come as a surprise to the Trust Board.

When compared regionally there were eight areas where performance variances need to be explored (excluding rent and rates and capital charges). In four of these areas the Trust had higher costs than others (including PFI costs) specifically cleaning, portering, and energy costs. The other four areas were where the Trust has significantly lower costs than others, where it was also seen as an outlier.

The Carter model Hospital and STP work should rapidly identify where opportunities exist for savings and to improve the Trust's position. It is likely that there will be some challenging discussions for the Trust to achieve 'best in class' EFM services in the future.

The Director of Estates and Commercial Development presented the paper and reported the following:

- The report covered the 2016-17 ERIC assessment of the EFM services. It was important to triangulate the report with other assessments in place, in particularly the PLACE assessment.

- The data will form the basis of the Carter target for the model hospital and it was therefore essential to ensure it was accurate and the Director of Estates and Commercial Development was able to give this assurance.

- In terms of general performance, the Trust was performing well against national benchmarking however it was difficult to compare data as the Trust as an ICO, was compered to acute hospital data. The Trust was working with NHSI to obtain a more accurate data comparison for the ICO.

- In terms of performance there were areas rated red, but these were already known to the Board and on the risk register in terms of backlog and cost of soft EFM services, which has had the impact to reduced closures due to infection and was a deliberate strategy by the Trust. Other issues included lack of single rooms and clinical space.

- Work would be taking place across the STP to look at benchmarking and how soft FM is delivered across the region. There was a STP group set up to look at this and it was working on the model hospital framework to create a cost effective model that would delivery maximum patient benefit.

- Mr Sutton stated he was surprised to see that building maintenance was green and asked if this was because the Trust had held back on spend. The Director of Estates and Facilities Management explained that the score reflected the work that had taken place to reduce pay costs with nearly £2m of savings being taken out over the last five years.

- Mrs Marshall queried the number of reportable incidents and asked if this was because the Trust had a good reporting system in place. The Director of Estates and Commercial Development explained that it was partly due to the work that taken place in the community and the fact that more incidents took place in the community, but also because of the work over the last few years to improve reporting and embed a positive culture.

- The Chief Nurse raised cleaning and the work of the Infection Prevention and Control Team to ensure teams were confident in working together to reduce infection and she asked the Director of Estates and Commercial Development if she felt confident that whilst spending might be higher than other trusts it was for the right reasons. The Director of Estates and Commercial Development said that she was confident given the positive data available in terms of bed closures due to infection. She added that information from peer reviews at other Trusts was also reviewed to ensure the Trust was performing well.

- The Board noted that members of the Carter team would be visiting the Trust later in the year and were working on helping to develop metrics for the ICO and this would include data for estates services.

- The Director of Finance suggested that it would be helpful to provide data for RIDDOR incidents broken down by acute and community and it was agreed this would be provided through the Health and Safety Committee and Quality Assurance Committee. DECD

- Councillor Parrott recognised the national drive for estates rationalisation and that Local Authorities would be keen to retain their local estate. It was noted that the Trust was involved in the One Public Estate initiative with the Director of Estates and Development a lead in this process. In addition the STP was involved to ensure the outcome was the right solution for the systems population and patients.

- Finally the Chief Executive reminded the Board that the Trust's backlog maintenance was very high with a history of under-investment due to the Trust's financial position. This was on the Trust's corporate risk register and she wished to provide assurance to the Board that the Executive team was closely monitoring this risk. She added that the Finance Committee had released some cash for capital investment to address the highest priority areas.

The Board formally considered the analysis of the Trust's 2016/17 ERIC data submission and National and regional comparisons, noting the areas of performance in the upper and lower quartiles.

The Board formally noted the STP work that is taking place and the approach to achieving and recommending a model hospital approach for Estates and Facilities services for the region.

211/11/17 **Emergency Preparedness, Response and Resilience – Outcome of External NHSE Assessment 2017**

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

The report updates the Trust Board on the outcome of the NHS England and CCG assessment of the Trust's EPRR performance against the core National standards for the year ending 2017.

Following the formal assessment process that was held with the CCG and NHS England on the 3rd October 2017, the Trust Board was required to formally receive and sign off the outcome of the assessment against core standards in relation to its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004). The Board is also required to formally receive the accompanying improvement plan.

The Board can take assurance that the Trust is compliant and green rated in 60 of the 66 EPRR core standards and will be compliant with four of the five remaining amber rated standards, by end of October 2017.

In addition to the assessment against core standards, NHSE and the CCG undertook a deep dive into the 'governance and reporting of EPRR performance'. Performance against 6 criteria was rated as good with only one concern (red) in this area; due to the Trust not being aware and therefore not publishing the results of the EPRR assurance in its annual report. This will be undertaken for the future.

A summary of overall performance is shown in the table below:

Standards	Green	Amber	Red
46 core standards	42	4	0
14 Hazardous Material and CBRN standards	13	1*	0
6 Governance Deep Dive	5	0	1

* This will remain amber as the Trust has decided not to have rosters in place for a decontamination team; however if 40 Trust staff volunteers have decontamination training then the Trust would be compliant (currently there are 22).

Of the actions related to the four amber rated standards, three sit with the safety security and emergency planning team to deliver and one with the operational team. The operational amber rated standard is related to confidence in escalation plans particularly the mitigation of surge on the emergency system. As part of the Trust plans for this winter, the Executive have identified '7 big things' to address pressures, one of which is a Winter Leadership Team**.** One of the objectives of this team will be to ensure that full escalation plans are in place and applied consistently across the organisation.

The Director of Estates and Commercial Development reported on the outcome of the EPRR review and, as detailed above, the work to manage those standards scored amber or red.

The Chairman raised the need for a Governor to sit on the Capital Infrastructure and Environment Group and it was noted that this had been Mrs French, but she would be standing down as a Governor in the New Year so a replacement would need to be identified. In addition there was a need for a Non-Executive Director Emergency and Security Lead and this would be resolved when the portfolio of Non-Executive was reviewed in the near future. CS Ch

The Trust Board formally received the outcome of the NHS England/CCG EPPR performance and preparedness assessment for 2017 and endorsed the signing of the required assurance letter for NHS England to that effect.

212/11/17 **Governors' Questions**

There were no Governor Questions, with any issues having been discussed at the Board to Council meeting in October.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

213/11/17 **Finance, Performance and Investment Committee – 24th October 2017**

The Board noted the committee report and also Mr Sutton's reflection that the Trust was now over half way through the financial year with the savings plan profiled to deliver more in the latter part of the year.

Reports from Executive Directors

214/11/17 **Report of the Chief Operating Officer**

Strategic Context

The report provided the Board of Directors with an update on operational work programmes managed by the Chief Operating Officer.

Key Issues/Risks

The operational risks highlighted include:

- Delivery of NHSI Single Oversight Framework performance standards including 4 hour wait, RTT, 52 week waiters and diagnostics
- Winter resilience
- Reduction in Care Home and domiciliary care capacity
- Community teams' capacity reduced due to input to challenged care homes
- Clinical recruitment challenges affecting capacity in specialities including ED, Dermatology, histopathology, endoscopy and CAMHS
- Impact of extended hours for the medical take on RTT compliance in some specialities
- Increase in delays to follow up
- Emergency Duty Service resilience
- Delays in mental health pathways

The Board noted the report of the Chief Operating Officer. Mr Welch suggested that delivery of the care model has required a significant change in the Trust's culture and that not all staff would understand all aspects of the changes and this was acknowledged. The Director of Estates and Commercial Development stated that a lot of work was taking place with the Trust's Organisational Development Team around transactional change and staff development to help them as the changes took place.

Councillor Parrott queried the involvement of the Associate Director of Adult Social Care at the Council in the seven main programmes of work to address the Winter Plan and the Chief Operating Officer assured Councillor Parrott that the themes were derived from the lock-in that involved participants from across the system including the Associate Director of Adult Social Care, and that the outcome from that event was discussed at Flow Board.

To consider the content of the report and discuss if further action or assurance required.

215/11/17 **Nurse Revalidation**

Strategic Context

Every 3 years nurses and midwives need to show that they are **living by the NMC Code**'s standards of practice and behaviour. If a nurse or midwife fails to revalidate successfully, their registration is not renewed and they are no longer able to work as a registered practitioner.

Key Issues/Risks

NMC registrants are ultimately responsible for ensuring they maintain their registration by complying with the NMC's requirements. The Trust has provided and electronic system to facilitate revalidation and the NMC e-portfolio is also available for use. There was a small risk that a nurse might fail to revalidate which would mean the individual can no longer practice as a nurse. The monthly monitoring of individuals

due for revalidation mitigates this risk.

The Board discussed and noted the report of the Chief Nurse. Mrs Taylor wished to place on record her thanks to the Chief Nurse for the report and suggested it would be helpful to understand the difference between the medical and nursing appraisal process. CN

The Trust Board formally considered the risks and assurance provided within the report.

216/11/17 **Report of the Medical Director**

Strategic Context

The new junior doctor contract was introduced in 2016. The expectation that this contract would be cost-neutral but there was a failure centrally to recognise the impact of pay protection and potential additional costs due to reduced flexibility of the junior medical workforce. Most Trusts have predicted substantial increases in cost in the first 2 years of the contract.

The Medical Director has previously reported to the Trust Board an expected additional cost in the first full year of the contract of between £550K and £1M. It had been impossible to further delineate the cost until doctors were in post because of the variable impact of pay protection depending on the individual doctors appointed and because the impact of the reduction of flexibility was, to a certain extent, unpredictable and dependent on fill-rate of posts.

Almost all junior doctors have now transitioned to the new contract. Through analysis of the first 2 months of the new contract across all clinical areas, it is possible to provide a closer estimate to the likely additional cost.

Additional costs of the new contract will be felt in the Service Delivery Units (SDUs).

Key Issues/Risks

The Trust Finance Department has made a comparison of the cost of junior medical staffing, including overtime and agency staffing, between September 2016 and September 2017.

- This suggested that the additional cost is likely to be a minimum of £570K (full year effect)
- This should be considered a minimum as there was significant variation in overtime and agency costs by month and the new contract may have a greater effect on need for overtime and agency than the previous contract.
- This calculation does not include the cost of consultant 'acting down'. Whether more or less 'acting down' will be needed this year is subject to a number of factors and is difficult to predict.

The Board discussed and noted the report of the Medical Director.

The Trust Board formally considered the risks and assurance provided within this report.

217/11/17 **Compliance Issues**

Nil.

218/11/17 **Any Other Business Notified in Advance**

Nil.

219/11/17 **Date of Next Meeting – 9.00 am, Wednesday 6th December 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	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	**Completed** Judicial review not expected until June/July August Update – outcome of review still not received. October Update – outcome of review still not received. The outcome of the Judicial Review was now known and it had found in the favour of Torbay Council. The Board noted that the Council would continue to work with the Care Home market through its multi-agency forum.	07/12/16
2	Register with the Corporate Secretary relationship with NED applicant.	JM	**Completed**	04/10/17
3	Share Mark Hackett's report with SDUs.	DoF	**Completed**	04/10/17
4	Obtain from Mr Bryant further details on the closure of the 'convent' and any impact to the Trust.	CN	**Completed** – the home referred to by Mr Bryant was Margaret Clitherow and was a church-run home. The trustees made the decision to close the home around two months ago and the Trust supported them in finding alternative placements for their clients.	04/10/17
5	Arrange to discuss at STP level mental health action plan and reporting route based on potential savings that could be made if there was investment at an early stage.	CE	**Completed** – Chief Executive taking forward at STP level.	01/11/17

6	Communications plan to be put in place around numbers and reasons for long waiters.	DSI		01/11/17
7	Breakdown to be provided showing how many long term sickness cases the Trust was managing.	DWOD		01/11/17
8	Arrange for the Chairman to meet with the GMC rep to discuss the Junior Doctor contract.	MD		01/11/17
9	Amend Standing Orders, Standing Financial Instructions and Scheme of Delegation to reflect the need for the TP Board to approve any contracts before being discussed at Finance Committee.	DoF		01/11/17
10	Provide data for RIDDOR incidents broken down by community and acute to be discussed at the Health and Safety and Quality Assurance Committees.	DECD		01/11/17
11	Identify Governor to sit on the Capital Infrastructure and Environment Group.	CS	**Completed** – Cathy French.	01/11/17
12	Identify lead NED for Emergency and Security.	Ch		01/11/17
13	Information to be provided detailing the differences between medical and nursing appraisal process.	CN		01/11/17

Torbay and South Devon NHS
NHS Foundation Trust

MAIN REPORT

Report to	Trust Board
Date	6 December 2017
Lead Director	Mairead McAlinden Chief Executive
Report Title	Chief Executive's Business Update

1 Trust Key Issues and Developments Update

Key Trust issues and developments to draw to the attention of the Board since the last Board of Directors meeting held in November are as follows:

Safe Care, Best Experience

Care model shortlisted for LGC award

The Trust has been shortlisted in the health and social care category for the Local Government Chronicle awards 2018. The award entry sets out how we have developed our new model of care taking into account feedback from local people about how they want to experience health and social care services into the future. It describes how we are working with Torbay Council to create the foundations for a sustainable care system, as we respond to the challenges of an older demographic that is much higher than the national average. Judging of shortlisted entries takes place in London on Thursday 18 January 2018.

Seven Day Services

Nationally 10 clinical standards have been drawn up which will guide improvement in services for urgent and emergency patients across the seven days of the week. Standard 2 states that "All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital". A suitable consultant should be competent in dealing with emergency and acute presentations in the speciality concerned and is able to initiate a diagnostic and treatment plan. There is good evidence that the early involvement of a suitable consultant can reduce mortality and morbidity. Furthermore, early consultant involvement has been shown to reduce unnecessary admissions and benefit the wider health community.

Could it happen here?

An audit of emergency admissions to Torbay in March 2017 showed 70 per cent were seen by a suitable consultant within 14 hours, similar to the national average. There is no "weekend effect" thus the 70 per cent figure relates to the way we manage urgent admissions on any day. The most recent audit of the 14 hour target was in October 2017 and we will shortly be analysing the data of around 200 of our emergency admissions. In particular we will examine the factors which led to breeches in this target and how learning from this can inform our progress.

Current work by the 7 day services group involves increasing consultant availability for emergency care. This includes the recent introduction by general surgery of an upper and lower GI consultant to care for emergency patients between working hours Monday to Friday so doubling the commitment to emergency care during these times. Both general surgery and trauma and orthopaedics are introducing a "teatime assessment" of emergency patients admitted during the day. In medicine, we are using IT to alert the urgent medical teams to the severity of newly admitted patients and how long they have been waiting for consultant review. Further work involves looking in detail at the processes we use to manage emergency admissions to streamline administrative and IT tasks to make better use of clinicians' time.

Safely caring for our population this winter

The Trust is continuing to progress the Winter Plan as preparation for the predicted pressures of the coming months. The work programmes for the 7 priority areas programme continue to be implemented:

- Rapid Response and Domiciliary care capacity
- Develop a single point of referral and redefine roles and responsibilities for discharge including Discharge to assess pathway 3
- Optimisation of Intermediate Care Teams and integration of Community Nursing
- Ambulatory care pathway development
- Improve risk stratification, identification of ' frequent flyers' and optimisation of visi-meet to access advice and information
- Introduction of a MDT Winter Leadership Team and implementation of a site management function
- Communication/ engagement and information

As part of our plans to ensure resilient services over the winter, we have set up a dedicated winter leadership team who will oversee and monitor implementation of our winter activity plan. They are:

Winter team

Liz Davenport, Chief Operating Officer	Executive Lead
Ian Currie, Deputy Medical Director	Clinical Lead
Cathy Bessent, Deputy Director of Nursing	Nurse Lead
Cathy Gardner, Head of Operations	Management Lead

The team is setting up a 24/7 site management function, with integrated on-call cover for all our services in the community and Torbay Hospital. Liz Davenport, Chief Operating Officer, will provide weekly reports to Executive Directors on how services are coping through the winter.

In support of our winter plan we have continued to communicate to staff and the public about our plans and how they can support them. The public are being asked to ensure they are familiar with the health services available so that they can chose the right service for their needs rather than at the Emergency Department or calling 999 when their need is not life threatening.

Flu Vaccination sessions for our staff continue to be run across the Trust by our peer vaccinators. The number of staff taking up the opportunity of a flu vaccination to protect themselves and our patients continues to be good. We are continuing to communicate the importance of the vaccination widely.

The Board will take further assurance from the positive feedback the Trust has received from our regulators on the robustness of our winter plan and preparations – regulators have assessed our plan as an exemplar and asked that they can share it with other providers as good practice.

Finally the Board will have seen national media coverage of additional Government funding being made available for the NHS this winter. Further details regarding criteria and eligibility are awaited. In preparation our teams are working up bids against this funding. The Chief Operating Officer will provide a verbal update at the Board meeting.

Health & Wellbeing Centre/Riverview Care Home, Dartmouth

A key element of the plans to provide an integrated health and care centre for the people of Dartmouth and surrounding districts is the provision of a care home facility. A number of issues have been identified in the quality of provision at Riverview Care Home in Dartmouth and the home is now subject to a safeguarding review. The Trust is working with Devon County Council and South Devon and Torbay Clinical Commissioning Group (CCG) to support the registered owners of the care home, High Trees Limited, in delivering the required improvements. The owners of Riverview have decided that whilst these improvements are being made they will not take on new residents. They have also decided that, in response to concerns raised by the CQC, they are unable to continue to offer registered nursing care for a period of time. This means that while the improvements are being made there is a need to place a small number of people with nursing needs into alternative homes. The local team is working with those individuals and their families to find suitable alternative care arrangements. We understand that this is a very difficult time for these people, and we will do everything we can to minimise disruption to the support

they receive, whilst ensuring that everyone continues to receive safe care appropriate for their individual needs.

Senior Managers from Devon County Council, South Devon and Torbay Clinical Commissioning Group and the Trust are working on plans to secure nursing home beds in the Dartmouth area. The plan for the Riverview site is to create a new Health and Wellbeing Centre for the people of Dartmouth, opening in 2018, that includes new accommodation for the Dartmouth Medical Practice, Dartmouth Caring, Trust health and care staff, all the clinics currently provided in the centre of town, and Lloyds the chemist. The intention is that this facility will deliver a sustainable and high quality care home facility with intermediate care (nursing) beds. This will complement the wide range of services provided by all the partners involved in this development to support people to live independently in their own homes.

Well Led

2017/18 Month 7 service delivery and financial performance headlines

Key headlines for financial, operational, local performance, quality, and safety and workforce standards/metrics for Month 7 from the integrated performance report to draw to the Board's attention are as follows:

Service delivery headlines

- **ED 4 hour wait standard**: 92.7% of patients were discharged or admitted within 4 hours of arrival at accident and emergency departments in October. This is above the agreed Month 7 operational plan trajectory of 92% but below the 95% national standard. Delivery of the operational plan trajectory in Q3 is required to access STF monies. The aggregate target performance for achievement of STF in Q3 is 91.32% which the Trust is currently forecasting to achieve. The winter plan is being supported by 7 key work streams and progress against these is summarised in the body of the report. **In month performance to 29 November remains in line at 92.5%.**

- **RTT trajectory:** at 84.04% (84.1% last month) the Trust did not achieve the 90.7% RTT trajectory in October. The requirement is to achieve the national standard of 92% by March 2019; projections now place the Trust below this trajectory. Options for addressing this underperformance have been agreed and a revised target of 86% agreed with NHS I for March 2018 together with a commitment to have no patients waiting over 52 weeks. In October 26 people waited over 52 weeks, or more, for treatment. The Board will note from the integrated performance report this is a significant increase on last month's position (16). As previously reported there is a plan to eliminate 52 week waits by the end of March 2018.

- **Cancer 62 day standard**: at 85.7% this standard (85%) was met in October and there has been a significant improvement in most of the local cancer targets Reducing diagnostic waiting times supported by a successful bid for Cancer alliance funding has been a priority with positive impact being seen in Colonoscopy and the reducing treatment times for Upper GI diagnostic pathways. Additional MRI capacity has now been commissioned to target the lung and prostate pathways. Following a national drive and performance concerns assurances have been given to commissioners and NHS I on continued delivery of this standard.

- **Dementia Find:** Performance in October was 78.6% against the target of 90% of patients admitted to hospital over 75 years of age being screened. Improvement work continues but will only be sustained with the full implementation of "Nerve centre" – a clinical information tool which is being rolled out across the Trust.

Comment: Given the risks to patients relating to long waiting times, reducing treatment times, particularly for people on cancer pathways, is an operational priority**.** In addition to the national standards referenced above, the Board will note improvements in local targets this month including a significant improvement in most local cancer targets; achievement of 100% people treated within 18 weeks for the CAMHs service and a significant reduction in the number of people waiting for a follow up review beyond their planned 'to be seen' date. The Board should also note that, despite having one of the lowest delays for transfers of care from hospital (DToC), the percentage of these delays has begun to increase. The Chief Operating Officer will provide an update regarding her review of the cause of this increase as this is one of our key care model delivery metrics.

Jeremy Hunt praise for diagnostics improvement

On 27 November the Chairman and I received a letter from Health Secretary, Jeremy Hunt congratulating the Trust on the significant improvement in our diagnostic waiting times in September. Mr Hunt commented on the scale of improvement and hoped we would share our learning and experience with others as follows:

> *"…Moving from 7.3% to 3.9% is an achievement to be proud of. In this sense the trust is a real example to others, demonstrating how to improve performance in a short space of time and ensure that your patients get the care they deserve…*
>
> *"… From visiting organisations throughout the country I know that the immense amount of work that will have been behind this outcome cannot be underestimated.*
>
> *"… improvement such as this are impressive and testament to the hard work and dedication of the trust's staff…*
>
> *"…Please pass on my congratulations to all those who work at the trust; the service they give makes a real difference to the lives of many of the area's sickest and most vulnerable patients…"*

Financial Headlines

- **Overall financial position:** The financial position against NHSI Control Total for the 7 months to 31 October 2017 is a deficit of £1.77m against a planned deficit of £2.94m. In the month of October a surplus of £0.69m has been achieved, but this is £0.33m behind the planned £1.02m surplus for the month.

- **Pay expenditure:** Total pay costs are underspent against plan to Month 7 by £2.32m, largely due to reduced Agency spend.

- **Savings Delivery:** The Trust has delivered £22.35m against our planned savings target of £19.15m (including income generation target); a £3.2m over-delivery.

- **System Savings Plan**: Against the £40.7m cost reduction target, and income generation target of £1.3m, required to achieve a Trust Control Total of £4.7m surplus; at the end of this accounting month, the Trust has identified savings potential of £42.6m resulting in a £0.5m CYE surplus. Of this £33.8m is identified as recurrent FYE savings potential.

- The forecast CYE indicates we may marginally over-deliver against our target. At this stage the Trust continues to forecast delivery of the £4,7m control total, although this is subject to the identification of a further £5m (originally £7.2m) of savings to cover the residue of cost pressures identified at the outset of the year and the delivery of the balance of system savings plan income from the CCG of £1.5m

Comment: Based on our performance year to date, at month 7, the Trust had an actual use of resources risk rating of 3 as planned (subject to confirmation by NHS Improvement). The Agency risk rating of 1 is a material improvement to the planned rating of 3. It is important to recognise that this scale of forecast delivery represents a significant improvement on the achievements of previous years. Any slippage in delivery would however put the control total and £5.7m STF funding at risk, affecting liquidity and, in turn capital investment plans. Focus must now be on managing the residue of identified cost pressures and the recurrent gap in the savings programme to ensure that we limit any carry forward of cost pressures/non recurring savings into the 2018/19 financial year.

The development of plans to address remaining financial risk is ongoing and being monitored through the relevant Board Committees, including the Financial Improvement Scrutiny Committee (FISC) with risks escalated for Board discussion and decision.

Following the Money

A recent article within the Health Service Journal focused on the cash flow crisis at Barking, Havering and Redbridge University Hospitals Trust. The cash flow crisis was identified by suppliers taking legal action for unpaid bills, some greater than a year old. The Trust had to take out an emergency bailout loan totalling £15m to pay those invoices that were outstanding for more than three months.

Could this happen here?

The simple answer to this question is 'No'. There are safeguards to prevent such a situation arising in this Trust. These include:

- Professional accountants being employed by the Trust to manage the Trust's financial affairs.
- Robust cash planning processes being in place that are linked to saving plans and capital expenditure plans. These plans are monitored and updated on a frequent basis
- Presentation of the Trust's Statement of Financial position to the Trust's Board with disclosure and appropriate commentary for any material variances to Plan.
- A revolving working capital facility having been negotiated with the DH to enable the Trust to access cash should the need arise at short notice.

Valuing our Workforce, Paid and Unpaid

Back to the Floor

The 'Back to the Floor' is a programme where members of the executive team are shadowing frontline staff to gain a first-hand experience of their roles and work environment. It is just one of the initiatives developed to engage with and listen to staff and is a key element of the Trust's Staff Engagement and Communication strategy. The Executives accompany or work alongside front-line staff to see what it's like to be a patient or client experiencing our services, and to gain a better understanding of the challenges our staff face, discussing whether there are any improvements we could make for both our service users and staff. The programme is being initially role modelled by the Executive Team but it is intended that it will be quickly adopted across the Trust with clinical and managerial leaders at all levels regularly visiting or working alongside front line staff.

So far Executives have visited a number of front line areas including physiotherapy, community nursing and a community hospital. I went 'back to the floor' with Jennie Stephens, Chief Officer for Adult Care and Health at Devon County Council in November to spend a morning with staff teams in Albany Clinic Newton Abbot, including accompanying the Community Matron on a visit to a client with a complex long term condition. I was impressed and enthused by the commitment and skilled care that our staff provide and the progress being made to deliver integrated health and social care in this locality. I gained a valuable insight into some of the challenges we face as we push the boundaries to support more people to be able to remain independent at home.

Staff Engagement Sessions

The Chairman and I are hosting a series of joint engagement sessions with staff, most recently with staff from our Women & Children's Service Delivery Unit and a 'drop in' session at TREC. Staff were very open in sharing their concerns and questions, and a number of staff had one to one meetings with me after these sessions to raise individual concerns. The Chairman and I are grateful to our Staff Governors and Freedom to Speak Up Guardians who are attending these sessions to support staff, and to Executives who attend to provide more detailed information in response to staff questions. We hope staff are getting some value from these sessions, and we are actively seeking feedback to see if we need to change and improve this approach to staff engagement.

National Recognition for Junior Doctor

Dr Keith Pohl has won the Quality Improvement Project of the Year from the National Clinical Audit Support Group. Keith, currently an F2 doctor here at Torbay Hospital, decreased the use of cyclizine, the most expensive anti-emetic drug when given intravenously and not the most effective. It can potentially be a drug of abuse and not recommended in the USA because of this. Through repeated tests of change Keith showed that education about the problems with the drug decreased its use as did knowledge about pricing. These changes made it easy to take cyclizine off the drug charts such that it is no longer offered as a pre-printed drug on the charts. This change has saved Torbay and South Devon about £13000 per year and deservedly won Keith this national prize for his leadership of this improvement project.

Keith participated in the Trust's F1 Service Improvement Programme in his F1 year (first year as a doctor). On the course he learnt about QI principles and how to approach changing a system methodically and effectively. Well done to Keith. This was a great achievement in itself and winning a national prize an added bonus.

Emergency Department Doctor wins Carer of the Year Award

Dr John Sheppard is a doctor in the Emergency Department at Torbay Hospital, and has been recognised as a Carer of the Year at the Devon Community Honours Event. The awards are made by Devonlive, the local news website that covers many Devon newspapers including the Herald Express. The award, which will be presented on 5 December 2017, recognises Dr Shepard's caring not just for his patients but also his colleagues. Dr Shepard was nominated by the Emergency Department team who particularly cited his commitment to supporting the team and his selfless dedication to patients.

Good news stories from our Service Delivery Units

At the monthly quality and performance review meeting, as well as reviewing quality, safety, finance service delivery and workforce performance, Directors also encourage the SDUs to share developments or services of which they are particularly proud or want to highlight as good practice. I wanted to take some time in my report this month to share a flavour of their good news with the Board.

Urgent Care

"…On Sunday 12th November OPEL 3 was declared as the hospital situation was extremely challenging and by Monday 13th November this has started to become critical; Warrington had been opened to create some capacity and facilitate a clean of Ainslie Ward. As part of the Fab Week various improvement initiatives were underway and one of those was See and Treat led by a Senior Doctor in ED. This had the impact of managing the waiting patients and rapidly treating and discharging minor injury/ailment patients. It was quite labour intensive for the doctors providing the service as total emergency activity was high but an interesting statistic to come out of this was a reduction in the numbers of patients admitted to our lowest threshold – 61 patients. This served to keep ED safe and also to prioritise patients requiring an emergency admission. By Tuesday escalated actions had started to take effect and by the 15th November the Trust's OPEL status reduced to level 2 and by Wednesday 16th November returned to business as usual at OPEL 1..."

Workforce

- The Nutrition Champion's role has been fully embedded within our community both hospitals and teams. This initiative will enhance the advice ,support and education to our vulnerable clients and patients across our community.

- Community division delighted to note a considerable number of staff from community teams nominated for staff hero awards which is testament to all their efforts to deliver compassionate care.
- Recognition that the staff within Cancer, Emergency Services and Medicine continue to work additional hours/shifts to cover the service. Many of these are good will hours, showing a valued commitment to the service and Trust
- Successful bids for 2 Macmillan funded posts for The Lodge Cancer Information and Support Centre for posts to support the Living with and Beyond Cancer Strategy.
- Respiratory consultant. Dr Himali O'Regan will be joining our team of respiratory consultants from February. Himali is returning with her family to the UK from New Zealand, having trained in Leicester, and offers a wealth of experience including providing a community service across a large rural area.

Improving quality and safety

- The catheter passport is up and running successfully improving safety and quality.

Being a supportive partner to care homes

- We have had a number of care/nursing homes provide positive feedback regarding the support received to their teams and clients through both our QAIT and also our CHEST team.

Being efficient and effective

- Surgical division for exceeding its financial improvement plan

National recognition

- Cancer Services presented at a National conference in November show-casing their work to implement the Optimal Lung Cancer Pathway locally.

2 Chief Executive November Internal and External Engagement

Internal	External

• All Managers' Meetings
• Clinical Management Group
• Ambulatory Care Change Group
• JCNC
• Staff Governors
• Freedom to Speak up Guardians
• Freedom to Speak Up Champions
• Staff Side
• Staff Drop in Sessions:
  - TREC
  - Maternity Department
• Back to the Floor' with Jennie Stevens, DCC at Albany Clinic, Newton Abbot
• International Day of Medical Physics/ Radiology – staff promotion
• Presentation to Surgical Travelling Club
• Meetings with Governors
	• Sarah Wollaston MP
	• Joint Executives' Meeting with SDTCCG
	• Chief Clinical Officer, SDTCCG
	• System Delivery Board
	• Director of Adult Services, Torbay Council
	• Director of Public Health, Torbay Council
	• Strategic Director for People, Plymouth City Council
	• Launch Event – Dartmouth Health and Wellbeing Partnership
	• Health Education England Contract Meeting
	• Torbay Council Learning Disability Peer Challenge Workshop
	• Chief Officer for Adult Care and Health, DCC
	• Chief Executive, North Devon Healthcare Trust
	• STP Chief Executives' Meeting
	• STP Programme Delivery Executive Group
	• STP OD Programme Steering Board
	• STP Collaborative Board Strategy Refresh

3 Local health and Care Economy Update

Partnership Developments

Devon STP Update

A separate paper included in the Board pack sets out the latest update from Devon STP, focusing this month on the following:

- New Clinical leader for the Devon STP
- Progress in Devon – top 10 messages on successes and developments.
- Feedback from Devon STP stocktake with NHS England and NHS Improvement.
- STP Strategy into action and the Collaborative Board.
- Integrated Care Model recommendations and action on system-wide frailty tool.
- Mental health – progress update and project mandate.
- National messages from the Secretary of State and Simon Stevens, Chief Executive of NHS England.

The appointment of our Medical Director as the new Medical Lead for the STP is to be welcomed. Dr Dyer will continue in his role as Trust Medical Director while dedicating two days per week to the STP role, and has organised suitable support to backfill some of his areas of responsibility to free up his time for this commitment. My congratulations to Rob for taking on this role, and for the confidence he has secured from the Devon partners to deliver it well.

In addition our Director of Workforce and OD, Judy Falcao has been elected Management Side Chair of the STP Staff Side Partnership Forum. The Forum was set up to bring together Management and Staffside representatives from across our STP footprint in Devon. It does not replace local negotiating arrangements within individual organisations but it does provide a forum for discussion and sharing and the opportunity for joint working. An example of this is the STP Corporate Support Services Review which will impact on all NHS organisations in Devon. The development of a common approach to supporting workforce mobility and where necessary redeployment is an area where the Partnership Forum can add significant value.

Partner Updates

Leadership change at North Devon Hospitals Trust

The Chief Executive of North Devon Hospitals Trust, Alison Diamond, has confirmed her intention to retire and will leave the Trust at the end of March 2018.

Changes to SWAST call categories

NHS England's new ambulance response priorities have been were fully adopted by SWAST. Changes to call categorisation aim to improve response times to critically ill patients, making sure that the best response is sent to each patient's correct location first time with the appropriate degree of urgency. This is not about the fastest possible response, but the **best response** for each patient. SWAST have given assurances regarding the impact and stressed the following:

- This is about achieving a more clinically focussed and patient-based set of outcome standards – an improved experience for all patients.
- It means having more available resources, with less multiple allocations, to respond to life-threatening incidents.
- It means allocating the most clinically appropriate resource to patients by taking a little more time to triage the call and increasing the use of 'Hear & Treat' and 'See & Treat'.
- It will create a new process to review the evidence for the responses to the set of clinical codes that better describe the patient's problem and response/resource required.

4 National Developments and Publications

Details of the main national developments and publications since the October Board meeting have been circulated to the Board each week through the weekly developments update briefing. There have been a number of items of particular note that I wish to draw to the attention of the Board as follows:

Government

Autumn Budget Statement

The chancellor announced in the Autumn Budget Statement that the NHS would get £1.6 billion extra revenue for 2018/19; £3.5 billion extra capital funded by the treasury, £0.5bn this year and an additional £3bn over the next five years; and the government has committed to fund with new money an increase to agenda for change staff, subject to the recommendation from the pay review bodies. In addition, the government has committed extra capital and extra revenue for this year. This was set against the national context of downgraded national productivity forecasts and ongoing debt and borrowing challenges.

More detail is provided in NHS Providers' on the day briefing, which also includes NHS Providers' press statement and view of the implications for the NHS and providers.

Pay cap funding concerns

Jeremy Hunt says he has "listened carefully" to NHS trusts saying they would not be able to make further savings to fund lifting the cap on public sector workers' pay. The health secretary was asked in the Commons what he was doing to ensure NHS trusts "do not finance the lifting of the pay cap". He said: "NHS trusts are under pressure to make very ambitious efficiency savings anyway. And we have listened carefully to their case that they would not be able to make further efficiency savings to finance an increase in pay beyond the 1%."

PM makes Stevens 'personally responsible' for NHS winter performance

Theresa May has reportedly made Simon Stevens (NHS E Chief Executive) personally responsible for ensuring the health service does not suffer a winter crisis. The warning took place in a previously unreported, but tense, meeting in Downing Street. Last week, the NHS chief executive launched an attack on government underfunding at a conference and said the service should receive the extra £350m a week promised by Leave campaigners in the EU referendum.

Health Secretary outlines plan to make births safer

Jeremy Hunt has announced plans that could see the lives of more than 4,000 babies saved by 2025. The Health Secretary has announced a package of measures to improve the care of pregnant women and ensure a reduction in the number of babies born prematurely who are more likely to die or suffer lifelong complications. The drive will see women deemed to be at high risk of having a premature birth closely monitored throughout their pregnancy, with a dozen very senior doctors trained to specialise in caring for women with underlying medical conditions which make childbirth high risk. Mr Hunt will also detail plans to record data for the number of babies who suffer brain injuries during birth. New rules will also enable coroners to look into stillbirths, with Mr Hunt saying all unexplained cases of serious harm or death would now be independently investigated. Currently, coroners can only investigate deaths of babies who show signs of life after being born.

Trust's position
The Trust welcomes the package of measures which complements the work we are currently undertaking to enhance quality and safety and support team building and development in our maternity service.

NHS England Announcements

DTOCs fall but councils still miss government targets

The majority of councils have managed to reduce delayed transfers of care over the first half of 2017-18 but have still failed to meet government targets aimed at reducing pressure on hospitals, analysis of figures released in November shows. In July, the Department of Communities and Local Government and the Department of Health set "expectations" of councils for their performance on DTOCs by September, using a baseline of their performance in February. Failure to meet the targets could result in loss of better care fund cash in 2018-19. Local Government Chronicle's analysis of NHS England data for September shows almost two-thirds – 92 out of 151 – councils have reduced average daily transfers over the review period, with 27 cutting average daily rates by more than half. Nationally, DTOCs attributed solely to adult social care fell by 1 per cent in September compared to the previous month.

Could it happen here?

We have continually focussed on our DTOC performance which, although rising in recent weeks, remains one of the best in the country. The national benchmark is 3.5% - we remain consistently under this level. Our care model is designed to care for more people at home and in their communities. As an Integrated Care Organisation we have the flexibility to be able to provide onward care and therefore are able to discharge people more effectively

RTT, cancer and A&E waits - September 2017

Interactive maps with waiting times of local NHS Trusts around England in September, showing the pressures, with links to all the detail by organisation and specialty have been published. They show the local picture on 18 week RTT, cancer and A&E waits, fully updated with the latest referral to treatment waiting times data released by NHS England and interactive maps can be seen here.

Regulator developments

NHS I Chief Executive appointment confirmed

Ian Dalton, the recently appointed CEO of Imperial, has been appointed CEO for NHS I. Ian will succeed Jim Mackay who will return to his Trust in Northumberland following his 2 year secondment to NHS I. Jim has written to all NHS Provider CEOs and Chairs to thank them for their "support, guidance, challenge and encouragement".

State of Care published

October saw publication of State of Care**,** the annual CQC assessment of health and social care in England. The report looks at the trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care. This year's report shows that the quality of care has been maintained despite some very real challenges. Most of us are receiving good, safe care, and many services that were previously rated inadequate have recognised our inspection findings, made the necessary changes and improved.

Joint consultation on use of resources in NHS Hospitals

The CQC and NHS Improvement are consulting on plans to fully implement their process to report on how NHS acute trusts use their resources to provide high quality, efficient and sustainable care. NHS Improvement started its use of resources assessments at non-specialist acute trusts in October 2017. The CQC is currently piloting how it works with NHS Improvement to incorporate the findings of their assessments with its judgements on quality. Effective use of resources is fundamental to enable health and care providers to deliver and sustain safe high-quality services for patients. The responses from this consultation will be used together with feedback received from trusts during the current pilot phase to shape a final agreed approach. The consultation runs from 8 November 2017 to 10 January 2018. NHS trusts' financial efficiency will be included in their overall ratings, despite the fact it could then be "slightly easier" for providers to be rated inadequate as a result.

Under new proposals, the Care Quality Commission intends to make the use of resources rating a sixth domain alongside whether services are safe, effective, caring, responsive and well led, and then combine all six for the overall rating.

Further details on NHS I's application of the Use of Resources rating are included in the Director of Strategy and Improvements update report on the revised Single Operating Framework.

New Getting It Right First Time leads announced

Clinical leads for three areas of the Getting It Right First Time (GIRFT) programme have been announced. The £60m clinical efficiency and safety programme is run by NHS Improvement and sees clinician led teams look at service lines in every trust in England to determine whether they are operating at sufficient scale, among other factors. Some trusts change their practices or stop providing some services as a result of the subject area GIRFT reports published so far on orthopaedics and general surgery. The programme announced clinical leads for endocrinology, rheumatology and stroke medicine last week.

The endocrinology team will be led by Professor John Wass, professor of endocrinology at Oxford University. The rheumatology team is headed by Lesley Kay, consultant rheumatologist at Newcastle Upon Tyne Hospitals Foundation Trust, and chair of the British Society for Rheumatology Clinical Affairs Committee, and Peter Lanyon, consultant rheumatologist at Nottingham University Hospitals Trust and president of the BSR. Senior clinical adviser to the team is Professor Alex MacGregor, consultant rheumatologist at Norfolk and Norwich University Hospitals FT and chair of the BSR research committee.

How do we measure up? Latest GIRFT Review

Five of our specialties have been visited by the GIRFT team and a more detailed review of the outcomes will be presented at a future Board meeting.

The Obstetric and Gynaecology (O&G) team received a visit on 8th November. The outcome of the O&G review is worthy of early mention as the outcome was extremely positive. Our teams compare favourably when benchmarked against national comparator organisations. In some areas they demonstrated the highest level of performance of any service in England, with particular strength in outpatient and day-case procedures.

The visit was a very positive experience for the team. There were areas where some improvement in performance could be achieved and an action plan has been developed to ensure that, against all indicators, we have best quartile performance.

Royal College Publications

Royal College of Physicians National Falls Audit

An audit by the Royal College of Physicians reports that there were 246,425 falls on NHS wards in 2015/16, around 675 a day, and many trusts were failing to take basic measures to prevent them. The audit is based on figures from 138 hospital trusts, mental health organisations and community centres. It argues many of the falls are preventable and caused by patients not having walking frames or being unsteady from medication. More than half of respondents (52%) admitted they did not carry out medication reviews to ensure drugs were not making patients unsteady on their feet. Nice has previously estimated that falls are costing the NHS at least £2.3billion a year – and 30% are preventable. Trust boards should develop a workable policy to ensure that all patients who need walking aids have access to the most appropriate type from the time of admission

Could it happen here?

The audit is undertaken every two years. The results will go to the Trust's Falls Steering Group for review and their response will be reviewed by QIG and then be scrutinised at the Quality Assurance Committee.

Royal College of Obstetricians and Gynaecologists National Maternity and Perinatal Audit – Clinical Report 2017

The audit looked at 11 key maternal and neonatal outcome measures.

How did we do?

All of the Trust measures were within benchmark with the exception of data relating to the APGAR score. The RCOG audit shows that Torbay is an outlier with a greater number of babies having a low APGAR than the benchmark cohort. APGAR is a measure of the physical condition of a new born infant. The APGAR test is a subjective measure to assess whether a new born needs medical assistance. 1.2% of babies born at term in Britain have an APGAR score of less than 7 at five minutes of age, which is associated with short and long term morbidity. This proportion varies between maternity services, from 0.3% to 3.5%, despite adjustment for case mix. The rate in Torbay has increased from 1.9% in 2014-15 to 3.5% in 2015-16. Analysis of the 16/17 data suggests that % low APGAR will remain higher than the cohort mean. The team have reviewed 49 cases and have not identified the reason for the variation, there have been no adverse outcomes. Further work is underway to review every case where the APGAR is low, this will be monitored by the Quality Improvement Group.

5 Local Media Update

The Trust's communications and media activity in November included:

- ***Mail on Sunday*** featured research led by **Dr Richard Paisey** showing that improved foot care can save limbs in diabetes patients. (Statement provided)
- ***Herald Express***: Care system "making good progress" (following interview with Liz Davenport and Rob Dyer)
- ***Herald Express*** & ***Dawlish News – online***: A ground-breaking NHS scheme to help more than 6,000 South Devon people who have chronic breathing issues has scooped a national award.
- ***Devon Live***: Six ways you can protect yourself from the cold that's sweeping the UK – here (features Sam Morrish video as part of local campaign)
- Applications open for NHS operation course in Devon – ***The Breeze*** coverage here (*News release*)
- ***Brixham News online*** Families invited to a weekend of events in memory of babies (*News release*)
- ***Herald Express*** Newton Abbot college raise record-breaking £10.5k for SCBU
- Advice on good hygiene to avoid norovirus and to not visit the hospital if you have symptoms
- ***BBC Radio One –*** following the lead singer of Black Foxxes who is being treated for Crohn's disease. Features TSDFT consultant Catherine Edwards can be read and heard here Has been run on every news bulletin on 28 November.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Update and Progress on Devon's STP		
Lead Director	Director of Strategy and Improvement		
Corporate Objective	Safe, quality care and best experience Improved wellbeing through partnership Valuing our workforce Well led		
Corporate Risk/ Theme	Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems. Failure to achieve key performance / quality standards. Inability to recruit / retain staff in sufficient number / quality to maintain service provision. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality. Failure to achieve financial plan.		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The Devon Sustainability and Transformation Partnership (STP) provides a single framework through which the NHS, local authorities and other health and care providers work together to transform health and care services. A single board update is being produced monthly following the Programme Delivery Executive Group (PDEG) meetings. This is the second update, following the meeting of PDEG on 17 November. The purpose of this report is to: • provide a monthly update that can be shared with Governing Bodies, Board and other meetings in STP partner organisations; • ensure everyone is aware on all STP developments, successes and issues in a timely way; and • ensure consistency of message amongst STP partner organisations on what has been endorsed at the Programme Delivery Executive Group (PDEG). All partner organisations in the STP are represented at senior level at PDEG.		

Key Issues/Risks	**Core Content** Items included in this monthly update following the PDEG meeting held on 17 November 2017 are as follows: • New Clinical leader for the Devon STP (Dr Rob Dyer). • Progress in Devon – top 10 messages on successes and developments. • Feedback from Devon STP stocktake with NHS England and NHS Improvement. • STP Strategy into action and the Collaborative Board. • Integrated Care Model recommendations and action on system-wide frailty tool. • Mental health – progress update and project mandate. • National messages from the Secretary of State and Simon Stevens, Chief Executive of NHS England. **Risk** The main risk to the Trust is having the leadership and clinical capacity to engage in and inform STP programmes and workstreams on top of Trust and local system change programmes – this is being kept under review and a "do it once" approach for Devon is being pursued. The appointment of Dr Dyer as lead Medical Director will shape and influence opportunities and challenges facing the NHS in Devon and be a pivotal role in addressing them. Although this role will take him away from Trust business for two days a week, this will be managed by backfilling his responsibilities from within the existing medical leadership team.
Recommendations	The Trust Board is asked to **note** the progress of the Devon STP
Summary of ED Challenge/Discussion	STPs are increasingly being seen by NHSE as the gateway for performance and access to capital and transformation funding. It is essential that the Trust is fully engaged within the Devon STP, influencing and informing STP strategy development and implementation. The Devon STP is moving towards having a single commissioner for NHS services across the county by April 2018. Our Chief Executive is interim strategic Chief Executive lead for the STP, and our Medical Director is lead clinician from 1 December 2017. All of the Executive director team, together with many of our lead clinicians and heads of service, are involved in some way in the STP – either through direct leadership of programmes or membership of the respective programme boards/workstreams/professional working groups and enabler programmes. The aspirations and ambition of the STP regarding Accountable Care System and Integrated Care Model are absolutely aligned with and supported by the Trust's own strategy and place –based "home first" shared vision.
Internal/External Engagement inc. Public, Patient & Governor Involvement	Any requirements for internal and external engagement and consultation arising from the above projects will be led by Andrew Millward, System Lead Director of Communications & Engagement and delivered through the STP Communications and Engagement group. There will be a single, consistent and co-ordinated approach across Devon.

	Our joint heads of communication, Corinne Farrell and Jacqui Gratton are fully engaged with the work of the STP Communications and Engagement group.
Equality & Diversity Implications	A key principle of the STP is equity of access to health and care for patients across Devon. There is also a focus on achieving parity of mental and physical health considerations.

Update to	**Boards, Governing Bodies and Local Authority meetings of Devon STP partner organisations**
Date	**November 2017**
Report Author	**Mairead McAlinden, Interim Lead Chief Executive for the Devon STP (Strategic)**
Title	**Monthly Update on Devon's STP**

Introduction

In October 2017, the first **Update Report** for Boards, Governing Bodies and Local Authority meetings of Devon STP partner organisations was produced. Feedback was very positive.

The purpose of the Update Report is to:

- *Provide a **monthly update** that can be shared with Governing Bodies, Board and other meetings in STP partner organisations.*
- ***Ensure everyone is aware** on all STP developments, successes and issues in a timely way.*
- ***Ensure consistency of message** amongst STP partner organisations on what has been endorsed at the Programme Delivery Executive Group (PDEG). All partner organisations in the STP are represented at senior level at PDEG.*

This is the second Update Report, and covers developments from the PDEG meeting held on Friday, 17 November 2017.

Items included in this Update Report are as follows:

1. New Clinical leader for the Devon STP.
2. Progress in Devon – top 10 messages on successes and developments.
3. Feedback from Devon STP stocktake with NHS England and NHS Improvement.
4. STP Strategy into action and the Collaborative Board.
5. Integrated Care Model recommendations and action on system-wide frailty tool.
6. Mental health – progress update and project mandate.
7. National messages from the Secretary of State and Simon Stevens, Chief Executive of NHS England.

1. New Clinical leader for the Devon STP

Dr Rob Dyer, Medical Director at Torbay and South Devon NHS Foundation Trust, will succeed Dr Phil Hughes, Medical Director at Plymouth Hospitals NHS Trust, as Lead Medical Director for the Devon STP.

Dr Dyer's appointment was formally endorsed by the Programme Delivery Executive Group (PDEG) and commences on 1 December 2017. He will continue to hold his role as Medical Director with Torbay and South Devon NHS Foundation Trust while committing two days a week to his STP role.

The Lead Medical Director plays a key role in influencing and shaping the STP's strategic direction and in making sure that quality, safety and sustainability improvements are shaped by local clinicians and based on best practice to benefit people in all areas of Devon.

STP Interim Strategic Chief Executive, Mairead McAlinden commented: "It has been a real pleasure working so closely with Phil over the past year as we have developed our STP Plan and reviewed our first tranche of acute hospital services. He has brought experience, credibility and clinical expertise to a very challenging role and built strong relationships with his Medical Director and clinical colleagues across Devon to bring about a new approach to how hospital services are delivered in Devon.

"I am delighted that Phil is handing over to an equally skilled medical and system leader. I know Rob will continue Phil's good work in supporting the STP plans for safe, sustainable, high quality and affordable health and care services for the people of Devon."

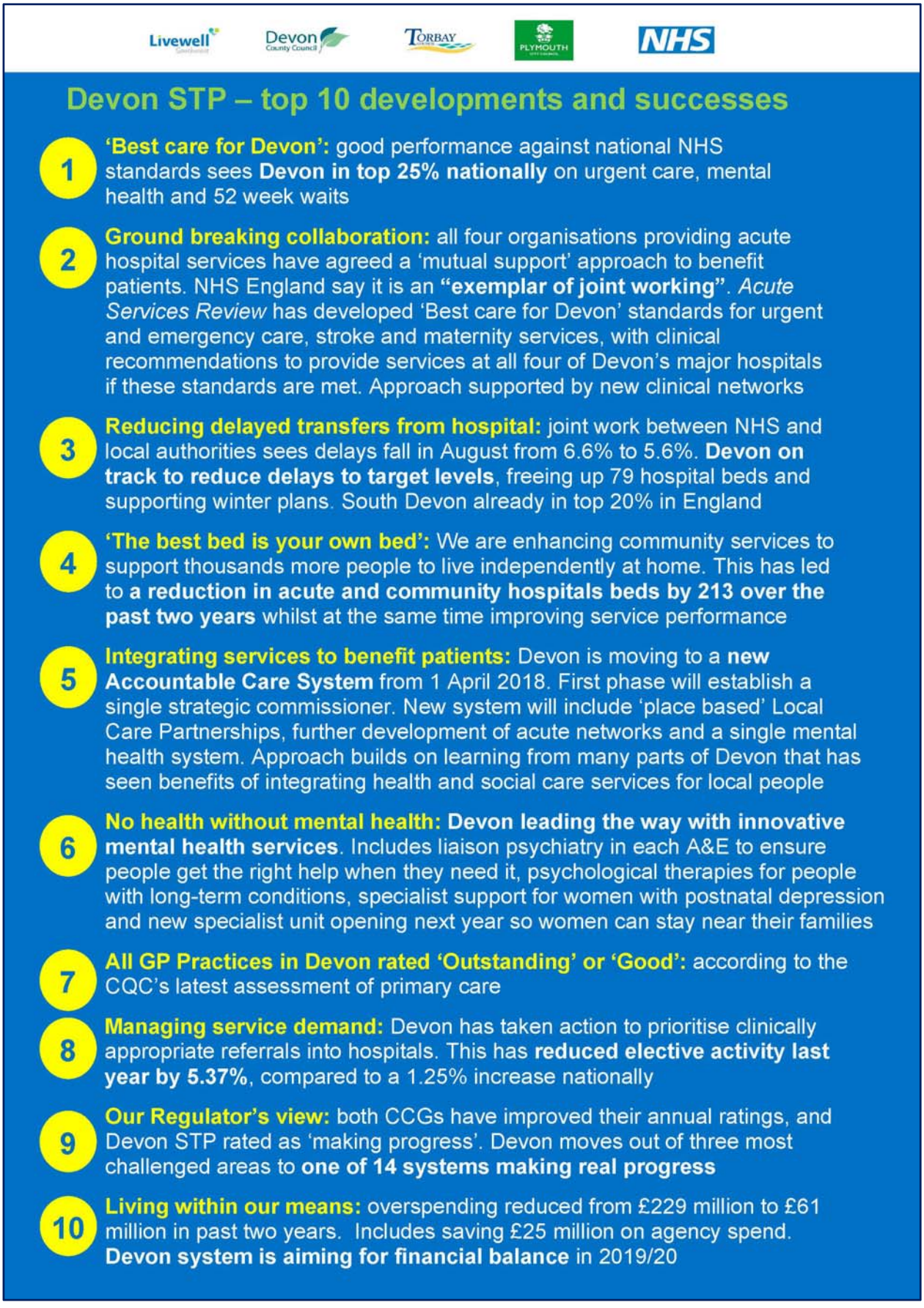
2. Progress in Devon – top 10 messages on successes and developments

To increase understanding of the positive work being undertaken across Devon, an 'at a glance' view of the top ten developments and successes has been produced.

The aim is to update these monthly so we expand the knowledge of the outcomes being achieved through the good system working across Devon.

It has been designed to be printed in A3 format, but a smaller version is enclosed overleaf.

The top 10 messages can be used in presentations and briefings with staff, as well as in meetings with key stakeholders locally.


Livewell
Devon County Council
Torbay
Plymouth
NHS
Devon STP – top 10 developments and successes
1
'Best care for Devon': good performance against national NHS standards sees Devon in top 25% nationally on urgent care, mental health and 52 week waits
2
Ground breaking collaboration: all four organisations providing acute hospital services have agreed a 'mutual support' approach to benefit patients. NHS England say it is an "exemplar of joint working". Acute Services Review has developed 'Best care for Devon' standards for urgent and emergency care, stroke and maternity services, with clinical recommendations to provide services at all four of Devon's major hospitals if these standards are met. Approach supported by new clinical networks
3
Reducing delayed transfers from hospital: joint work between NHS and local authorities sees delays fall in August from 6.6% to 5.6%. Devon on track to reduce delays to target levels, freeing up 79 hospital beds and supporting winter plans. South Devon already in top 20% in England
4
'The best bed is your own bed': We are enhancing community services to support thousands more people to live independently at home. This has led to a reduction in acute and community hospitals beds by 213 over the past two years whilst at the same time improving service performance
5
Integrating services to benefit patients: Devon is moving to a new Accountable Care System from 1 April 2018. First phase will establish a single strategic commissioner. New system will include 'place based' Local Care Partnerships, further development of acute networks and a single mental health system. Approach builds on learning from many parts of Devon that has seen benefits of integrating health and social care services for local people
6
No health without mental health: Devon leading the way with innovative mental health services. Includes liaison psychiatry in each A&E to ensure people get the right help when they need it, psychological therapies for people with long-term conditions, specialist support for women with postnatal depression and new specialist unit opening next year so women can stay near their families
7
All GP Practices in Devon rated 'Outstanding' or 'Good': according to the CQC's latest assessment of primary care
8
Managing service demand: Devon has taken action to prioritise clinically appropriate referrals into hospitals. This has reduced elective activity last year by 5.37%, compared to a 1.25% increase nationally
9
Our Regulator's view: both CCGs have improved their annual ratings, and Devon STP rated as 'making progress'. Devon moves out of three most challenged areas to one of 14 systems making real progress
10
Living within our means: overspending reduced from £229 million to £61 million in past two years. Includes saving £25 million on agency spend. Devon system is aiming for financial balance in 2019/20

3. Feedback from Devon STP stocktake with NHS England and NHS Improvement

A range of senior representatives from the Devon STP met with NHS England and NHS Improvement on 18 October 2017 as part of a formal 'stocktake'.

Following the meeting, Jennifer Howells, Regional Director South West, wrote to all participants on 8 November 2017, thanking them for the presentation and discussion.

The letter, which was shared at the Programme Delivery Executive Group (PDEG), highlighted the encouraging progress being made by the Devon STP to improve services, restore financial balance and deliver the *Five Year Forward View*, although further progress is required.

Feedback was provided in the letter on the common themes facing all STPs in the South West, which included:

- Workforce – recruitment, skills mix and turnover issues.
- Reconfiguration of services.
- Enhancing the use of digital technology.
- Knowledge management – identifying and sharing good practice and learning, locally and nationally.
- The journey to accountability.

The key issues raised that were specific to Devon included:

<u>Headline points</u>

- The STP works as a coherent system with a collaborative board and shared leadership that operates through an established governance structure.
- Recruitment underway for a lead Chief Executive for the system.
- The Devon system is signed up to the plan and committed to improving the financial position, performance and outcomes.
- The system is committed to single, strategic commissioner from April 2018.
- There has been solid engagement with Local Authorities.

<u>Next steps</u>

- Further development of the integrated Accountable Care System (ACS).
- Plan for putting 'strategy into action' to be completed in December 2017.
- Following the strategic refresh and recognition of service change options, formal engagement and public consultation in 2018, prior to reconfiguration.
- Articulation of the financial strategic plan, alignment of control totals and the use of STF as an incentive.
- Seek national support for accessing commercial market expertise to develop domiciliary services and care homes facilities.
- Support from NHS England and NHS Improvement to access capital funding.

4. STP Strategy into action and Collaborative Board

Work is progressing to highlight in detail our plans as a system for 2017/18, as part of the refresh of the STP strategy. The work will articulate the key building blocks of the strategy to deliver key financial and service plans.

The strategic refresh is to be completed by December 2017. It will highlight any proposals that may need formal 'public consultation', although this is likely to be a very small part of the overall strategy. Views on the strategy will be sought at the Collaborative Board meeting on 28 November 2017, attended by senior leaders from all NHS and Local Authority organisations across Devon.

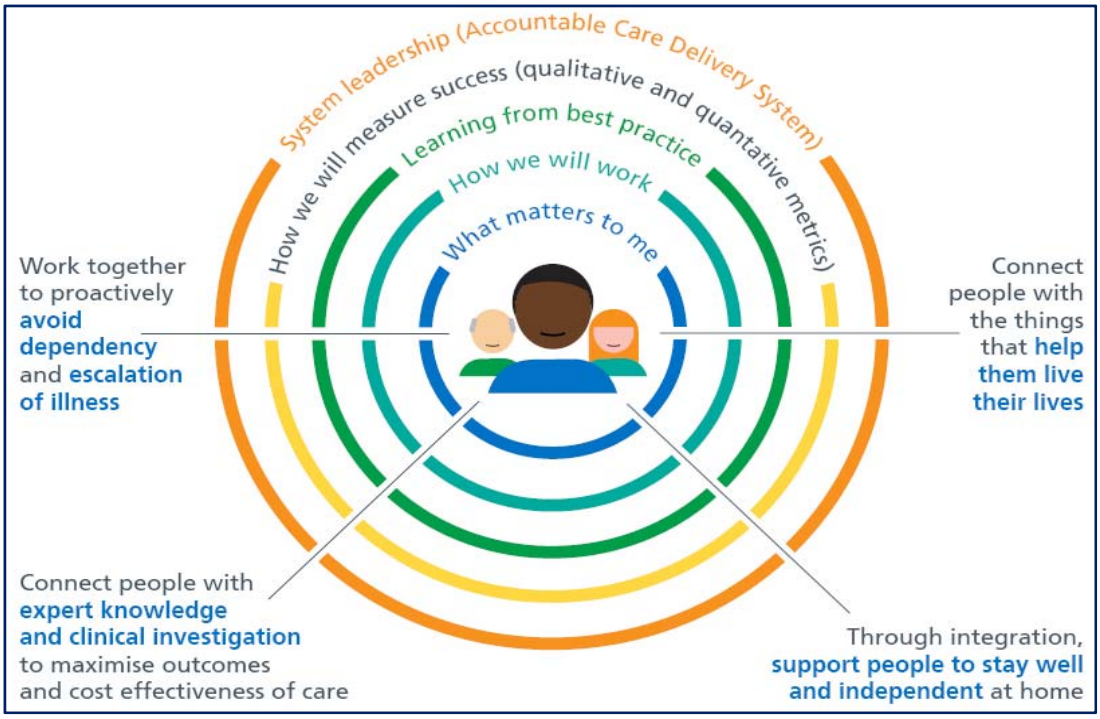
5. Integrated Care Model recommendations

The Programme Delivery Executive Group (PDEG) endorsed the work of the Integrated Care Model STP workstream, which has brought clinicians, professionals, partners from the voluntary sector and patients from across Devon together to identify and agree a Devon-wide framework for an integrated model of care.

This has involved peer reviews of community health and care service delivery across Devon to identify best practice and successful outcomes that can be drawn from. The team also drew on the latest research and successes from other health systems.

The goal was to agree how to build on the integrated working already in place in different parts of Devon to achieve consistent, effective and affordable systems of integrated care that deliver consistent outcomes for the people of Devon, irrespective of where they live and use services.

An emerging model of integrated care was presented to PDEG:



The workstream identified a number of ‘non negotiables’ for the care model, including the importance of:

- Improving health and wellbeing.
- Promoting independence.
- Delivering safe, high quality care.
- Providing cost effective and sustainable care.
- The reduction in total length of stay (taking account time spent, in acute, community or care home).
- Mental and physical health as one approach.
- Transforming our workforce.
- Less reliance on statutory services.

The importance of frailty as a key indicator of risk of declining health and wellbeing was highlighted, and it was stressed that this was not necessarily age dependant, with frailty issues being experienced by all ages in our population.

The importance of prevention and non-’health’ determinants (for example, housing) was also recognised and it was agreed that the adoption of a common ‘risk stratification’ approach would be beneficial across Devon which would support individual care plans and inform the commissioning of services.

Em Wilkinson Brice, Deputy Chief Executive at the RD&E, was thanked for her leadership of the workstream and appreciation was expressed for the commitment of all contributors from across the health and care sector in Devon in delivering this important project.

Some of the ideas in the workstream are evident in a separate project that Em has been involved in. The Integrated Care Exeter Wellbeing programme won a prestigious *Health Service Journal 2017* award for adopting best practice. Participants showing improved mental health, decreased loneliness and increased levels of social inclusion.

PDEG endorsed the recommendations below and asked that the workstream undertakes two additional pieces of work on risk stratification and social prescribing.

<u>The recommendations</u>

- Local delivery systems to implement the integrated care blueprint.
- Acknowledge locality starting points and develop from there.
- Care system must be affordable within a capitated ‘fair shares’ budget for each locality (to be developed).
- A series of assumptions are made, including better demand management across the system.
- Standardised risk stratification tool and development of roll out plan by January 2018.
- Consistent access to social prescribing is in place, taking account of local delivery systems.
- A pan-Devon approach to workforce development, which meets the needs of the new care model.

6. Mental health – progress update and project mandate

The Programme Delivery Executive Group (PDEG) was given an update on two key elements of the mental health STP workstream.

Progress on the mental health strategy

The workstream is focused on developing a strategy with four main objectives:

- To improve mental health outcomes for the population of Devon.
- To ensure that there is sufficient capacity within the system to support individuals where required, including through a sustainable workforce as well as working closely with voluntary sector organisations.
- To develop the structure for a high functioning sustainable mental health commissioning and delivery system for Devon by April 2018.
- Full engagement and ownership of all participating organisations and other stakeholders including people who use the services and primary care

The work on the strategy is now accelerating, thanks to the combination of greater support from the CCGs and a new core programme team.

The team are engaging with a wide range of service users and partners between now and January 2018 to better understand the mental health needs of our population. This is being undertaken as part of a series of events held across the county.

Finally, key elements of work to enhance mental health services are making good progress. 24/7 liaison psychiatry provision is now available in Exeter and Torbay, with investment agreed for services in Plymouth. Plans for a new £5.5 million Psychiatric Intensive Care Unit are also underway to provide specialist care for people with mental health needs closer to home.

The development of a single mental health 'Accountable Care System (ACS)'

A single mental health 'ACS' for Devon has been agreed. The team overseeing this work are liaising closely with Michael Macdonnell from NHS England, who is leading on how services, such as mental health, are integrated across the country.

It is likely that the term mental health 'ACS' will be revised in due course, given national developments.

The rationale for a mental health 'ACS' is to ensure that there is specialist knowledge at scale – and across the health and care system – to offer support for the management of highly complex patients.

The Devon STP is committed to integrating the local delivery of mental and physical health services.

The developments in Devon have attracted international interest, and discussions have now been held with Vince Barry, Chief Executive of Pegasus Health, who has transformed primary and community services in New Zealand.

7. National messages from the Secretary of State and Simon Stevens, Chief Executive of NHS England

More than 600 NHS leaders came together at the recent NHS Providers annual conference. A range of critical issues were discussed relating to quality of care, NHS finances and workforce challenges. Keynote speeches were given by the Secretary of State, Jeremy Hunt MP and Simon Stevens, Chief Executive of NHS England.

From both speeches, one of the overriding messages focused on the ***expectation that the NHS will maximise opportunities to improve efficiency.***

Examples were given on the areas the NHS should focus on, such as corporate services, the importance of benchmarking and how we should utilise approaches such as the GIRFT programme and 'model hospitals'.

All of these examples are being taken forward in a very positive way across Devon, and relevant excerpts from the two speeches are highlighted below for information.

<u>The Secretary of State, Jeremy Hunt, MP</u>

- "The NHS is efficient, but more focus is needed on corporate savings, such as e-rostering/job planning, another £0.9 billion from estates/facilities management, £1.5 billion on GIRFT, £0.8 billion from medicines management, £0.2 billion on pathology, £0.2 billion on corporate services and £0.8 billion on procurement.
- Recognise that the NHS has saved £700 million on agency spend in 2016/17.
- If the NHS can realise more efficiencies, it would help win the funding debate with the Treasury.
- NHS Trusts will be put into a new procurement league table to help them compare prices and save money.
- On pay cap, it is not fair to stick with 1%, but Treasury will consider funding pay if NHS delivers long-term productivity improvements."

<u>Simon Stevens, Chief Executive, NHS England</u>

- "All the international comparisons show that we're an incredibly efficient health service. Like every other country we've still got waste that we're going after.
- The GIRFT programme, Rightcare, model hospitals and the new care models are all now having an impact – we are driving efficiency hard.
- NHS productivity – as the Kings Fund, Health Foundation and the Nuffield Trust show – has been increasing *faster* than the rest of the UK economy.
- We have some enormous challenges that we need to square up to, and face in to, looking out over the next 5 and 10 years.
- We need to reinvent the district general hospital, the model of hospital care that has served our communities since at least 1962 and the hospital plan for England. We are doing so through: networking hospitals; through hospitals with their neighbours sharing services.
- We are also doing what most other industrialised countries are doing, which is recognising the clinical and the financial logic for integrated care, rather than fragmented competition. We are driving that through the Accountable Care Systems, and we are seeing the benefits where that is deployed."

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Research and Development Annual Report		
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 / quality standards. • Inability to recruit / retain staff in sufficient number / quality to maintain service provision. • Failure to achieve financial plan.		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The increased relevance and importance of research and development (R&D) means the Government is increasingly keen to monitor; report on and assess our performance. Each NHS organisation has a responsibility to deliver the Governments vision and strategic ambitions. This report forms part of our accountability framework within the current 5 year NIHR NHS R&D contract and supports the following primary contractual obligations: • National Institute for Health Research (NIHR) Clinical Research Network (CRN) contract • DH R&D strategy and Policy • The NHS Constitution • The Health & Social Care Act 2012 • The plan for Growth • Prime Minister Dementia Challenge • Quintiles Prime site contract • CQC domains and metrics (quality, safety, effectiveness, improvement, well led) This report provides an overview of the Trust's performance and delivery against Government metrics (KPIs) for R&D in the NHS; as part of the National Institute for Health Research (NIHR) contracts / DH Research Strategy and agendas. Details pertain to mid-year status for the current financial year (2017-18) and year end 2016/17.		
Key Issues/Risks	• In previous years there have been difficulties in achieving productivity in trial recruitment and completion. Good progress has been achieved in 2016/17 in this regard reflected in the dashboard performance figures and a very satisfactory South West CRN annual review.		

	• However there are now sustainability and viability issues due to finances, workforce & operational safety, regulatory compliance.
	
	• Finances. There are major challenges to the financial viability of the R&D portfolio related to
	
	  o Declining central government NIHR CRN funding irrespective of performance and activity
	  o Declining income generation from trials due to a decrease in the commercial trials activity despite good availability of commercial activity.
	  o The level of 'productive' R&D activity is decreasing.
	  o R&D is now unable to generate sufficient income to sustain and afford the R&D budget of £1.5M from April 2019 unless changes are made to increase income / decrease costs.
	
	• R&D becoming harder to undertake due to increasing organisational barriers and challenges:
	  o Lack of consultants willing / able to act as Principal Investigators (PIs)
	  o Increasing service and organisation pressures / demands, vacancies and staff shortages.
	  o Lack of capacity in supporting services (e.g. pharmacy, labs and MRI) – due to time and staffing issues, lack of resilience (over reliance on a few individuals).
	  o Loss of the Jubilee Research Unit (JRU); due to operational pressures & need to relocate pre – assessment:
	  o R&D remains Isolated - Lack of escalation routes / Ethos / Culture
	
	• Workload and staffing pressures have impacted on training and maintaining necessary competencies risking compliance and / or demonstrating our regulatory compliance with the UK clinical Trials regulations and other research standards. This is an organisational reputational risk and a financial risk (penalties / fines / loss of business).
	
	• Significant workforce issues - high levels of stress and increasing poor morale, has led to significant HR issues, and high staff turnover / losses. This has impacted on productivity, activity and income generation.

Recommendations	The following actions are being taken: • Detailed recovery plans are being developed with Executive support. • Short term remedial plans involve the need to downsize and consolidate the R&D portfolio; to re prioritise and re focus resources to ensure safety for participants already recruited into trials. New activity must focus on supporting areas of strength and value until recovery = less support for some clinical specialties and less non-commercial trials. • Discussions with the NIHR CRN – regarding changes to funding models and the new NIHR contracts from April 2019 and exploring regional STP options • A human resources programme is being developed under the leadership of the Director of Workforce and Organisational Development to support the improvement of working relationships within the team. • Consideration of methods of developing a more embedded model of R&D through the new delivery structure of the organisation, to achieve a feeling that R&D is everyone's business.

Summary of ED Challenge/Discussion	The Executive team recognises the value of R&D for the Trust and has reiterated the strong support of the Board for Research and Development activity. An Executive-led Steering Group has been established including the Medical Director, Director of Workforce and OD, Director of Finance and Director of Strategy and Improvement with the aim of developing a new research and development strategy taking advantage of our 'unique selling points' and developing less reliance on declining NIHR funding.
Internal/External Engagement inc. Public, Patient & Governor Involvement	
Equality & Diversity Implications	None

MAIN REPORT

Report to	Trust Board
Date	6th December 2017
Lead Director	Medical Director
Report Title	Research and Development Annual Report 2016/17

1. NIHR Clinical Research Network contract

Research is considered core NHS business (NHS Constitution) and a statutory requirement under the Health & Social Care Act; shown to significantly contribute to improving quality, safety, patient care and outcomes.

Research in England is driven by the National Institute for Health Research (NIHR) as part of the Department of Health; working through Clinical Research Networks (CRNs) to provide a unique opportunity to widen participation within research and help reshape practice with evidence. The Trust is a partner in the NIHR South West Peninsula CRN (SWP:CRN) and is commissioned to provide a clinical trials delivery service and function locally for NIHR studies; with a contribution to purchase research management & governance expertise, advice and services; in line with relevant national R&D strategies and policies and the NIHR Performance and Operating Framework contracts.

2. Annual Report 2016-17

The annual report for 2016/17 was submitted to and accepted by the NIHR South West Peninsula Clinical Research Network (SWP:CRN). The detail of the report is not included here though the majority of the content is included in this report (below). Appendix 3 contains the letter of support from SWP:CRN following our annual review meeting in July 2017.

3. NIHR - National Key Performance Indicators (KPIs) – NIHR portfolio activity only

Please see Appendix 1 – for the full dashboard. In summary the Trust:

- Significantly improved and increased our NIHR recruitment (40%)
- 10% overall improvement to our recruiting Time to Target (T2T) metric
- Our First Patient First Visit (FPFV) metric remained similar
- Lower than expected commercial activity and did not meet the target for number of new commercial studies approved
- Slight increase on overall new studies approved

4. Summary of other activity and performance

4.1 Local Grants: Torbay Medical Research fund (TMRF) – a local independent charity.

Project title	Applicant	Amount awarded
The Impact of Self-management Education on Health Outcomes in Patients with Rheumatoid Arthritis	Dr Lucie Wilk	£21,000
Is there an association between levels of plasma morphine-6-glucuronide and subjective pain scores in patients prescribed long term codeine phosphate?	Dr Andrew Gunatilleke	£4,425
Exploration into the needs and preferences of the oldest approaching end of life in the community, and if these change over time.	Mrs Carol Gray	£3,646
Can the integration of primary, secondary and community care reduce unplanned admissions, deliver cost savings, and provide better care in elderly patients?	Dr David Attwood	£131,892
Testing urease inhibitory compounds from watercress extracts against pathogenic bacteria	Dr Kyle Stewart	£49,424

4.2 Hosted research

The Trust's primary business centres around hosting (participating) in multicentre national and international commercial and non-commercial clinical trials (>90% overall business), sponsored by other organisations; many adopted by and part of the National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio. Over 150 studies were open during 2016/17 and the Trust recruited into 96 NIHR studies during the year.

5. Research Impacts, Outcomes, awards and other good news stories:

5.1 Appendix 2 summarises the impacts and outcomes from research activity and studies the Trust are or have been involved in and recently reported on. These provide a flavour of the how research has informed the evidence base and influenced quality improvements, clinical care and services.

5.2 Appendix 4 is a summary of a study of how patient insight can inform research delivery which has been highly commended.

5.3 The Trust has been part of the NIHR SWP CRN DRIVE quality Improvement programme. See below an abstract detailing the write up submitted in January 2017.

5.4 NIHR Accelerating Digital event. The Trust was one of ten selected to showcase the power of video in research demonstrating the Strength Trial video project

5.4.1 Short video series:

The Department commissioned a series of short research videos showcasing patients' experience of what it means to be invited and participate into a clinical trial; alongside the creation of a short video featuring our senior consultants about what it is like to be a Principal investigator and to offer trials to their patients. These films are shown around the organisation on 4 new screens purchased by R&D through a grant awarded by the NIHR.

5.4.2 Strength Trial pilot video project

An idea by the Trust has been taken forward to aid informed consent and recruitment to a study. Torbay is the 1st NHS organisation to pilot the use of a suite of study specific videos as a media to support current verbal and written information to patients taking part in an international cardiovascular commercial study. Using Health and Care Videos and our Prime site Collaboration with QuintilesIMS; this has been piloted in the STENGTH study at Torbay, Royal Devon & Exeter and at Barts Health in London. The study is sponsored by Astra Zeneca and run by Quintiles.

5.4.3 NIHR video business case

Following on from this project and after presenting at the National NIHR Accelerating Digital Conference to showcase our work, we were asked to further developments and collaborations to help support the NIHR Accelerating Digital Strategy and invited to submit a business case to support:

- Creation of a national library
- Integrate into future trials where e-consent is used

Progress to date:

- The concept fits within their 'Accelerating Digital' strategy and the NIHR definitely want to support it. The NIHR can facilitate the development of the national library at this stage but not willing to commission the library that we propose and wish to undertake further testing in more trials. As a result of doing more trials they want to find ways to do some more evaluation to add to this pilot to continue to build an evidence case.
- As a first step they plan to add it in to their Framework of Standard Operating Procedures for trial initiation to ask trial leads to consider using video as they believe it should be a medium that should be deployed. To complement that, In the SOP they will point their teams to Health & Care videos; by providing a case study from Strength, some more background to our approach and price list so that costs can be built in to application processes at the front end or grant applications.
- The NIHR are going to add a case study for the Strength trial into their Accelerating Digital resources to showcase what is possible and what we achieved.
- The NIHR would like to develop some videos to "show and tell" how to do other components of the Accelerating Digital programme so that it makes them easier for sites and regions to adopt and to link into other projects such use of videos to support patient engagement, education and training, staff training developments etc.
- They believe that there is more education material that they could create using video to support the sites and to enable them to be more effective in the implementation of trials.
- To explore other opportunities with partners such as Health Research Authority and their developments.

6. Patient & Public Involvement (PPI)

6.1 **NIHR CRN Patient Experience Questionnaire Survey:** This was organised by the NIHR's South West Peninsula Clinical Research Network. During November 2016 all clinical trial patients attending NHS organisations in the region were given a questionnaire as part of the survey. Overall the results were very positive, promising and encouraging with 92% saying that research should be a normal part of healthcare. The full results are as per below:

6.2 **International Clinical Trials Day (May 20th):** Each year this day is celebrated nationally on the anniversary of James Lind, who conducted the first ever recognised clinical trial in 1747 (treating scurvy with citrus fruit). The day was marked by events locally to help promote wider engagement; to help learn more about Clinical Research and learn how to get involved, who can take part, what is needed to get involved etc. Locally this included research displays in Anna Dart; where the research teams displayed examples of research activity from their specialities; alongside the launch of the new videos throughout the Trust on new screens placed around the Trust – see below

7. Workforce

In 2016/17 the total staffing compliment was 38.12 WTE with one of the highest part time workforce percentages in the Trust (>70%). All staff are externally funded through various research contracts. The Department comprises the following main teams:

- Research Management & Governance (RM&G) team
- Clinical Trials -Clinical Research Delivery Teams: Cardiology, Rheumatology, Ophthalmology, Oncology, Haematology (malignant & non-malignant), PODDS (Paediatrics, Obstetrics, Diabetes, Dementia and Stroke; MACS (Medical, Acute Care & Surgical), community and primary care.
- Technical / Service Support staff – R&D dedicated staff or purchased specialities staff time as appropriate within labs, pharmacy and radiotherapy / medical physics

7.1 Issues

- Effective from 2017/18, the CCG and NIHR SWPCRN made a strategic decision to centralise funding and create a larger central support team to manage primary care studies and community studies. As a consequence the Trust lost this funding and the fixed term contract of the primary care nurse was ended (they did not wish to transfer into the central support team service hosted by the CRN).
- Overall, the declining financial position of the department (see finance section) means that additional pressures and increasing anxieties have been placed on staff to try to increase income generation (actual and potential); improve productivity through more efficient and effective working practices, reducing variations in systems, processes etc as well as working in a more flexible and mobile manner.
- The Department has reported, in previous years, concerns over staffing and the lack of resilience and depth within our current models of work, with restricted capability or capacity to provide cover. Despite efforts to rectify this situation regrettably it has worsened instead of improved.
- There is an urgent need to rationalise the activity of the team as the number of studies is high, many of which are non-productive and not providing significant income. The emerging workforce resilience concerns is an additional factor supporting the need for rationalisation and refocus.
- A preliminary recovery plan was submitted to the executive team.
- An executive steering group has been formed and will meet on 4th December to consider a recovery strategy
- A strategy for improved team function and resilience is being led by the Director of Workforce and Organisational Development.

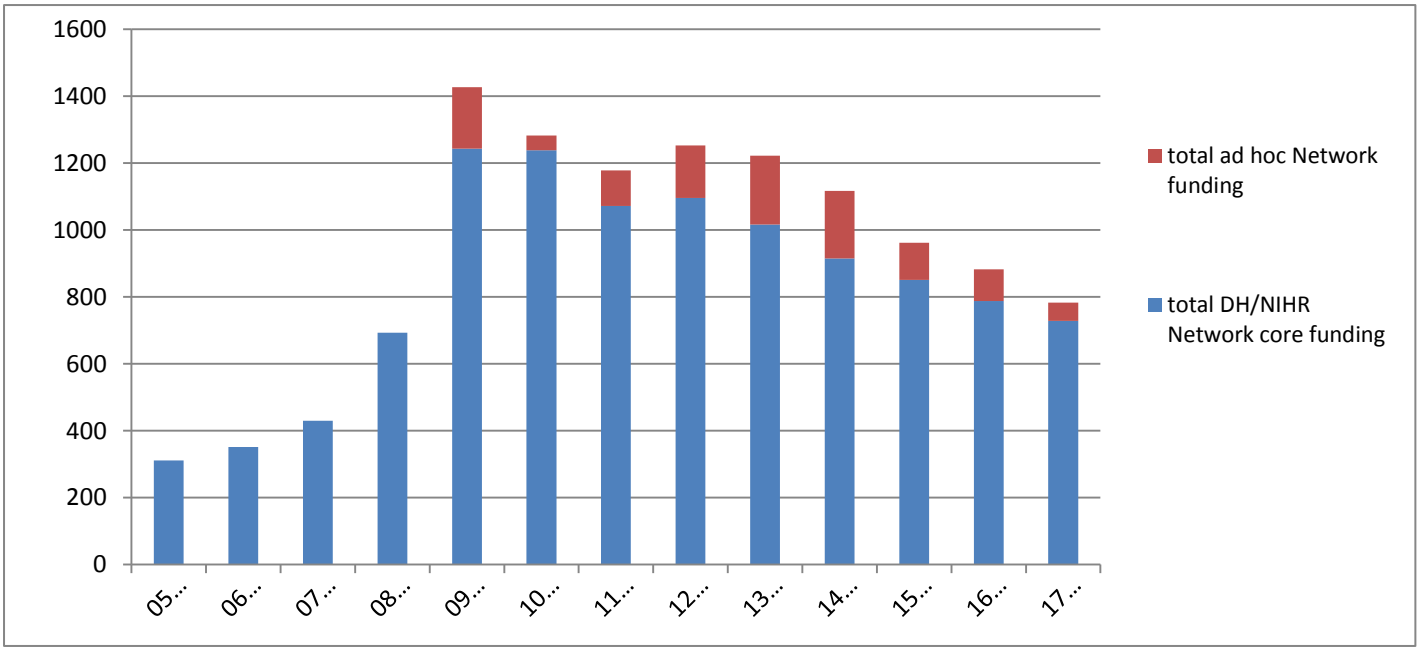
8. Clinical Trials Unit (Jubilee Research Unit - JRU)

The JRU facility remains essentially closed since March 2016 following the Trusts need to re locate surgical pre-assessment into this area. Whilst this was meant to be a temporary measure this is no longer the case. The loss of the TAIRU outpatient space during 2017 has compounded the situation. The issues and risks as reported last year remain:

- This remains a risk for R&D
- Insufficient clinic capacity to see patients
- Loss of identity and dedicated space for research
- Poor patient experience due to interruptions during consultations, treatments, leading to complaints
- Loss of marketing to potential sponsors and loss of confidence by sponsors Trust has the necessary facilities and infrastructure to delivery contracts. We are unable to remain competitive as sponsors are placing business with other Trusts and /or we have turned down contracts because we are unable to deliver.
- Created a considerable level of extra stress and pressure on staff trying to accommodate and constantly fitting in around others, fragmenting our service and staffing which is neither an effective nor efficient use of our manpower / resources.

9. Finance:

9.1 NIHR Funding: R&D's primary contract: The graph below shows the NIHR research funding awarded to the organisation over the past few years. Irrespective of Trust performance, year on year cuts have been imposed creating a significant issue now.

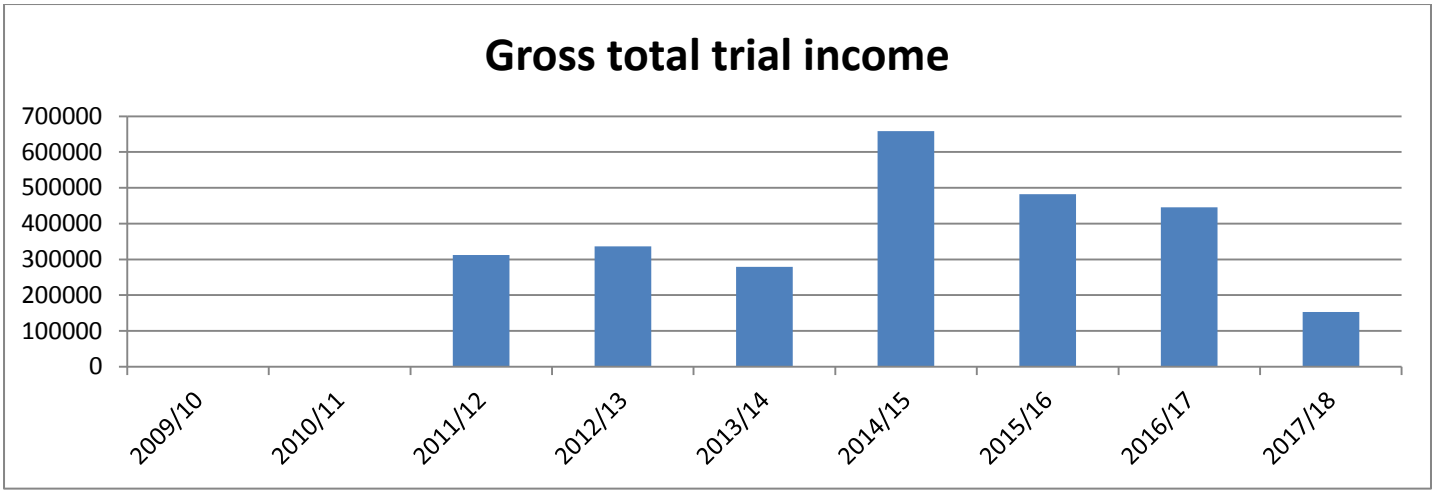


It is accepted now that the whole NIHR funding model is no longer fit for purpose as despite actual recruitment, the national funding model means that more funding is going back to the Golden Triangle, irrespective of performance of our region and Trust. Funding is based on actual recruitment under a complexity weighted model, but makes no allowances for study work up, set up or follow up of participants in non-commercial studies. This element is becoming a real issue for all NHS organisations nationally as well as locally; especially within cancer.

9.2 Gross Trials Income Summary

The other main source of funding is from income generated from the clinical trial contracts paid pro rata per study based on recruitment and performance. All commercial trials and some non-commercial trials come with payments. These payments are required to compliment and top up core NIHR funding. Trusts are not allowed to 'double count' in financial returns and the NIHR expect Trusts to demonstrate how such income is invested into the research agenda on site. Trusts are also subject to NIHR audit.

The graph below summarises the gross value over the past few years and shows it is also decreasing. This is primarily attributed to the reduction in our commercial trials activity with a portfolio balance now approx. 2% commercial as opposed to at least 15% in some years.



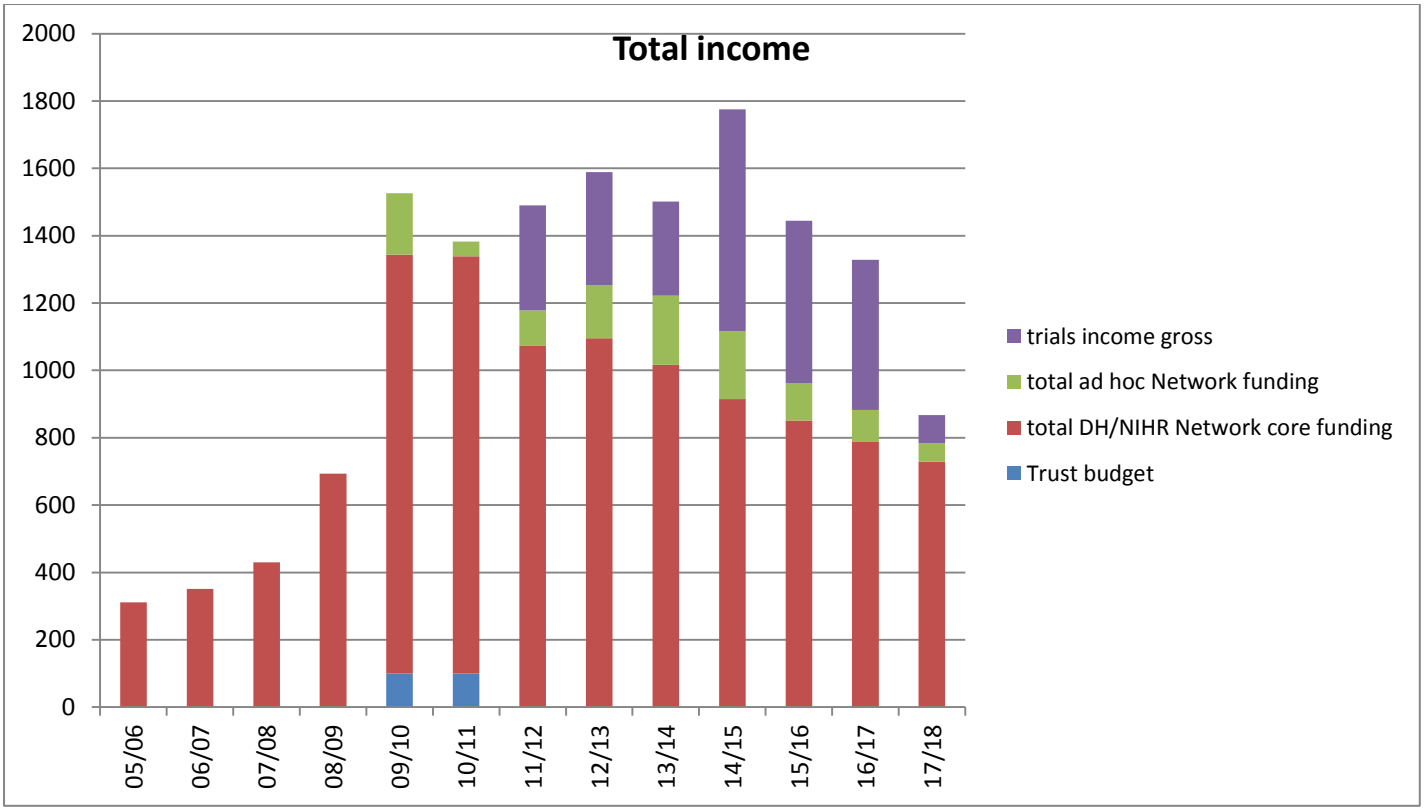
An NIHR report (Nov 2016) showed the benefits to the NHS of contract (commercial) research is valued at £192M per annum; (circa £6,658 in revenue per patient and £5,250 per patient in pharmaceutical cost savings) - see summary in Appendix 2.

Over past 3 years; out of 47 commercial studies closed, 17 were non enrollers and we only recouped 64% of contract values (see summary table below). There is scope for improvement:

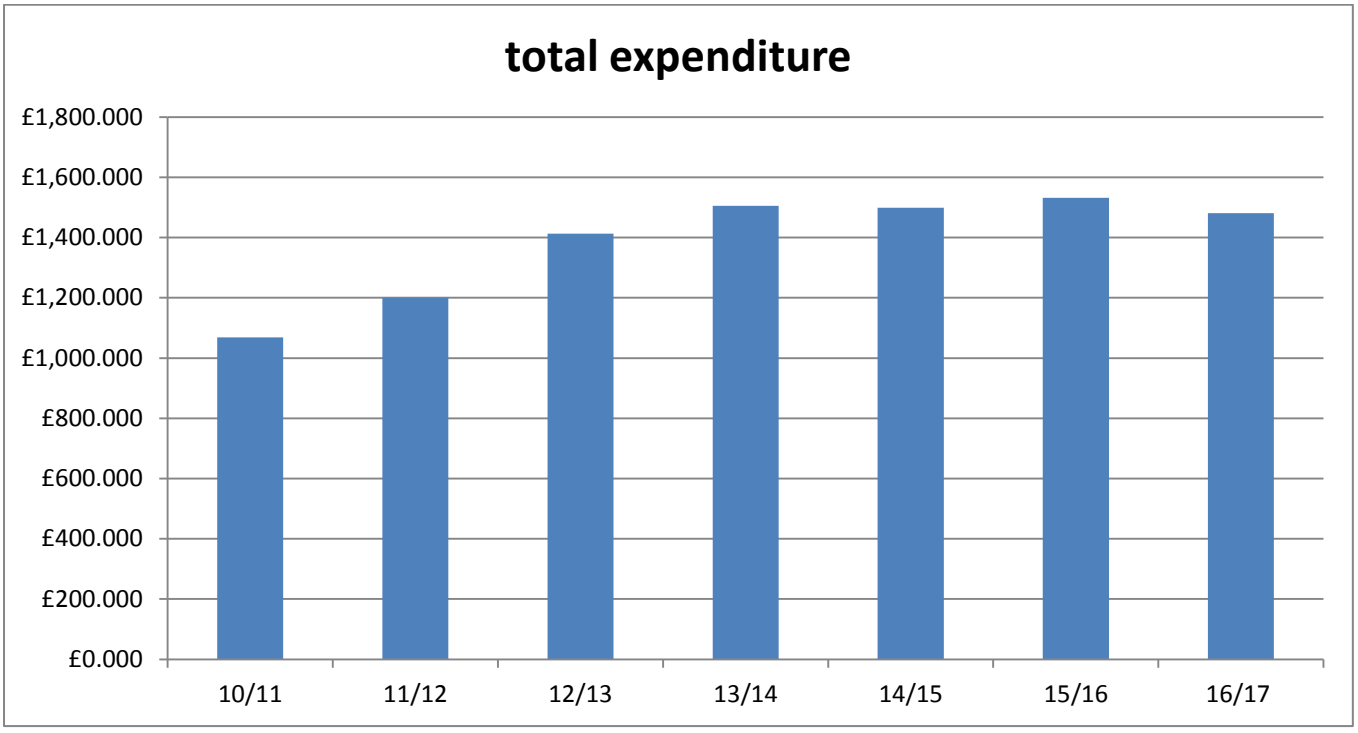
Commercial Clinical Trials - closed in past 3 years

	Speciality	No of patients agreed in contract	actual recruitment	% recruitment target met	total contract value (initial)	actual income	variance	% income rec'd
47 studies	**combined / overall**	**471**	**429**	**74%**	**£ 2,324,899**	**£1,369,376**	**-£906,959**	**64%**
	£/ per patient				**£ 4,936.09**	**£ 3,192.02**		

The graph below shows the combined income streams to give overall total income:

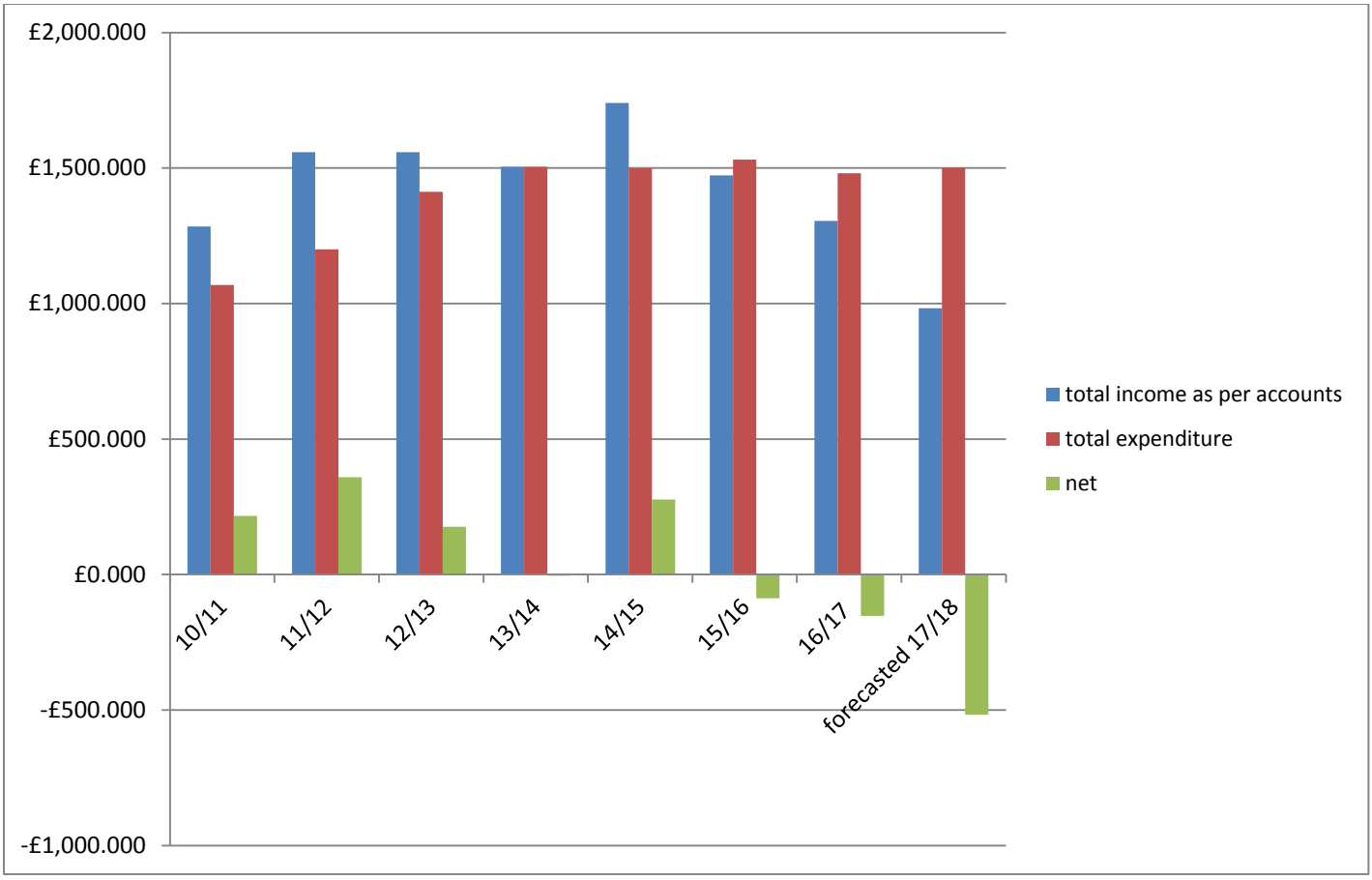


R&D's expenditure: has remained steady over the past few years which greater than 95% on staff costs. The expenditure forecasted budget for 2017/18 is similar. However staff expenditure will reduce with the level of staff leaving.



9.3 Year end position:

The graph below shows combined total income and expenditure and the forecasted budget situation for 17/18 which has triggering the need for a recovery plan and conversations currently; to try to rectify the situation to reach financial balance in 18/19



Please note: Trials payments in contracts cover several financial years and cannot be contained in separate financial years. Research has to earn income up front as well as an annual budget to meet costs both in year and costs in the subsequent years which differ to NHS business models. We generally work with a 12 month rolling 3-5 year plan / model.

9.4 Financial sustainability:

With the declining NIHR budget and potentially another 5% cut expected in 2018/19 and with our ability to generate income from trials to cover the shortfall becoming increasingly difficult with recruitment and activity falling, exacerbated by the overall pressures on clinical staff time and services (i.e. the overall system and service pressures). Increasingly there is an imbalance between what we can earn and what we need to earn and therefore poses significant risks and challenges regarding the future sustainability of the service. All Trusts regionally are experiencing similar issues.

10. Work plans and sustainability and transformational plans (future issues)

Building on the national and the local patient experience survey. Research is important to our patients and something that patients really value. This fits too with the Trusts values, – if we focus on 'what matters to you' not 'what's the matter with you'. It is still important to continue work looking at how to make clinical research appreciated, relevant and therefore important to all.

10.1 National - Future NIHR strategy

To conduct studies at appropriate sites:

- Areas of high healthcare needs
- Sites that can assure delivery (i.e. are good value, demonstrate good consistent recruitment and performance)

10.2 Incentivise more Chief Investigators (CIs) to deliver studies out of their area / own organisation and to ensure areas with high healthcare need benefits from research. The south West Peninsula stands to

gain further studies as it has a higher than average age & as a consequence healthcare needs of our population. In addition the region has a low number of CIs. However with poor current delivery (9th out of 15 CRNs), this will not provide the confidence to place further future studies.
The ongoing senior medical job plan review includes consideration of R&D activity in an attempt to incentivise the uptake of CI roles.

10.3 Accelerating Digital Programmes: **Digital acceleration is a key NIHR target for service improvement over the next three to five years.** The NIHR wishes to identify the opportunities and encourage the use of digital technology to ensure more efficient delivery of research.

10.4 Proposed NIHR Work Streams:
1. Our Workforce: creating a digitally confident and effective Workforce who uses technology and our resources to greatest impact.
2. Patients and customers: our customer facing activities are digitally enabled.
3. Unleashing data: so we know where data is and can access it.
4. Digital maturity: evidenced in thought/digital leadership in our field at any level
5. Partner collaborations: readiness to seize new opportunities in the UK research landscape

10.5 Future CRN landscape?
During 2016 the NIHR celebrated its 10 year anniversary. What might the next 10 years look like in 2026? To consider the immense steps the digital landscape has taken in the last 10 years. Some areas highlighted include:

- As patient data will be available online in cloud datasets, research will no longer need to gather data specifically for a study. It can be 'pulled' from the cloud as required.
- Research is embedded in clinical care so all nurses will be research nurses. It will then become unnecessary to have as many CRN funded research nurses.
- Patients will have direct control of who has access to their data
- The culture will be that research is part of clinical care, so all eligible NHS patients will expect to be part of research, so when and how informed consent is required will change.
- Increased tailoring of care for individuals will mean large scale RCTs are redundant – replaced by collecting data about individuals and their reaction to treatments.
- More data manager type roles will be needed.

The Trust will need to consider these emerging themes, national agendas, strategies and developments etc.

Appendix 1: NIHR CRN Key Performance Indicators (KPIs) Dashboard

Assessment Criteria - Key	>80%	60-80%	<60%

Objective		2014-15	2015-16	2016-17	Variation (%)
Proportion of NIHR CLOSED studies recruiting to Time and Target (T2T)	Commercial	30% (3/10)	50% (6/12)	64% (7/11)	+14%
	Non commercial	46% (6/13)	63% (12/19)	70% (14/20)	+7%
	Total	39% (9/23)	58% (18/31)	68% (21/31)	+10%
Proportion of NIHR studies achieving NHS permission to First Patient First Visit (FPFV) within 30 days of approval *(applies to studies recruiting >11 per annum only)*	Commercial	0% (0/3)	0% (0/1)	0% (0/1)	No change
	Non commercial	61% (8/13)	67% (4/6)	67% (4/6)	No change
	Total	50% (8/16)	57% (4/7)	60% (9/15)	+3%
Proportion of NIHR interventional studies recruiting their first patient within 70 days of a Valid Research Application (VRA) – DH metric		29% (7/24)	56% (9/16)	n/a due to national changes to approvals	n/a
Proportion of agreed NIHR recruitment goal being met		108% (1292/1200)	78% (1011/1296)	118% (1593 / 1321)	+40%
Increase in new commercial trials approved. Targets: 2016/17 = 12 to 15 2015/16 = 8 to 12 2014-15 = 10 to 12		67% (8/12)	100% (12/12)	67% 10/15	-23%

2016/17: Benchmarking with other Acute Trusts in Network (Network Report / Data)

NIHR Time to Target (closed studies)

Partner Organisation	Commercial	Non Commercial	Total
North Devon Healthcare NHS Trust	100% (2/2)	88% (7/8)	90% (9/10)
Plymouth Hospitals NHS Trust	55% (17/31)	66% (21/32)	60% (38/63)
Royal Cornwall Hospitals NHS Trust	57% (12/21)	70% (19/27)	65% (31/48)
Royal Devon & Exeter NHS Foundation Trust	65% (22/34)	78% (31/40)	72% (53/74)
Torbay and South Devon NHS Foundation Trust	64% (7/11)	70% (14/20)	68% (21/31)

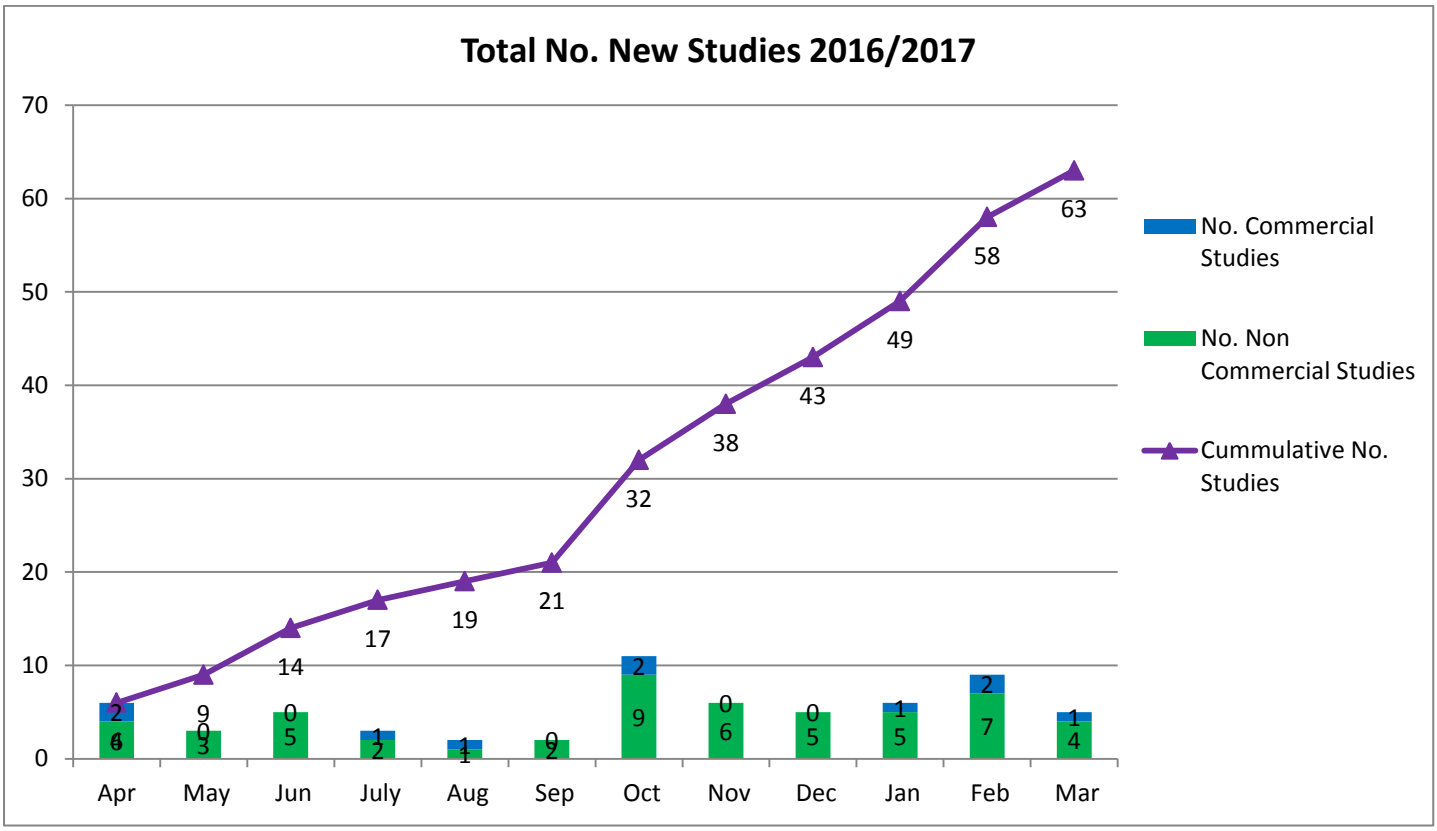
Taunton and Somerset NHS Foundation Trust	64% (7/11)	85% (23/27)	79% (31/39)
Yeovil District Hospital NHS Foundation Trust	80% (4/5)	71% (12/17)	73% (16/22)
NIHR Clinical Research Network: South West Peninsula (for all organisations, acute, partnership, CCG etc)	**59% (75/127)**	**72% (146/203)**	**67% (221/330)**

NIHR First Patient First Visit (recruit first patient within 70 days of a valid research application)

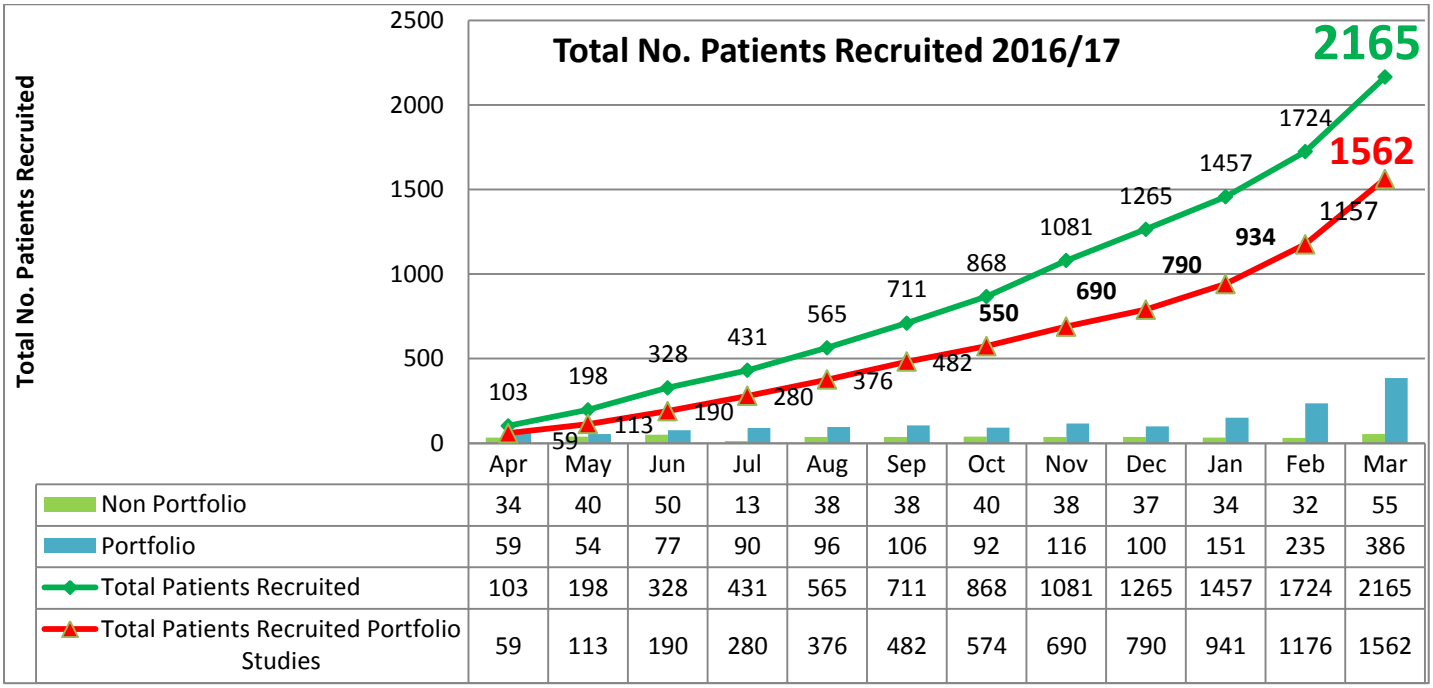
Partner Organisation	Commercial	Non Commercial	Total
North Devon Healthcare NHS Trust	0% (0/1)	67% (2/3)	50% (2/4)
Plymouth Hospitals NHS Trust	50% (3/6)	35% (7/20)	38% (10/26)
Royal Cornwall Hospitals NHS Trust	67% (2/3)	69% (11/16)	68% (13/19)
Royal Devon & Exeter NHS Foundation Trust	67% (4/6)	70% (14/20)	69% (18/26)
Torbay and South Devon NHS Foundation Trust	0% (0/1)	64% (9/14)	60% (9/15)
Taunton and Somerset NHS Foundation Trust	67% (4/6)	92% (12/13)	84% (16/19)
Yeovil District Hospital NHS Foundation Trust	75% (3/4)	100% (8/8)	92% (11/12)
NIHR Clinical Research Network: South West Peninsula (for all organisations, acute, partnership, CCG etc)	**60% (18/30)**	**67% (71/106)**	**65% (89/136)**

Total number of <u>NEW</u> studies approved (NIHR + non NIHR studies):

Overall 2016/17 showed a slight increase from 58 to 63 new studies approved.



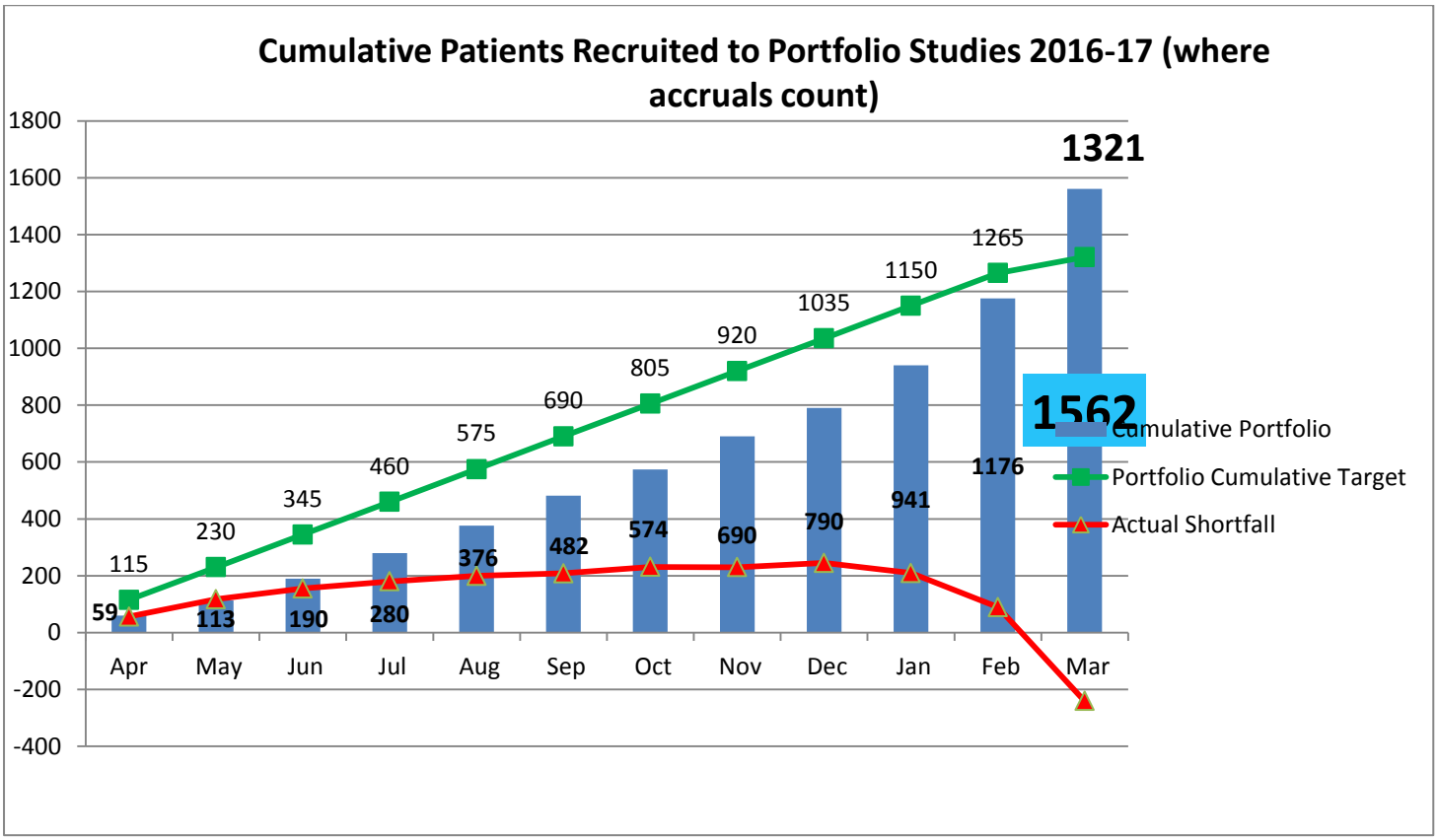
Recruitment to studies 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Non Portfolio	34	40	50	13	38	38	40	38	37	34	32	55
Portfolio	59	54	77	90	96	106	92	116	100	151	235	386
Total Patients Recruited	103	198	328	431	565	711	868	1081	1265	1457	1724	2165
Total Patients Recruited Portfolio Studies	59	113	190	280	376	482	574	690	790	941	1176	1562

A significant improvement to NIHR recruitment showed compared to the previous year (n =

The Trust hit above NIHR target set - see below:



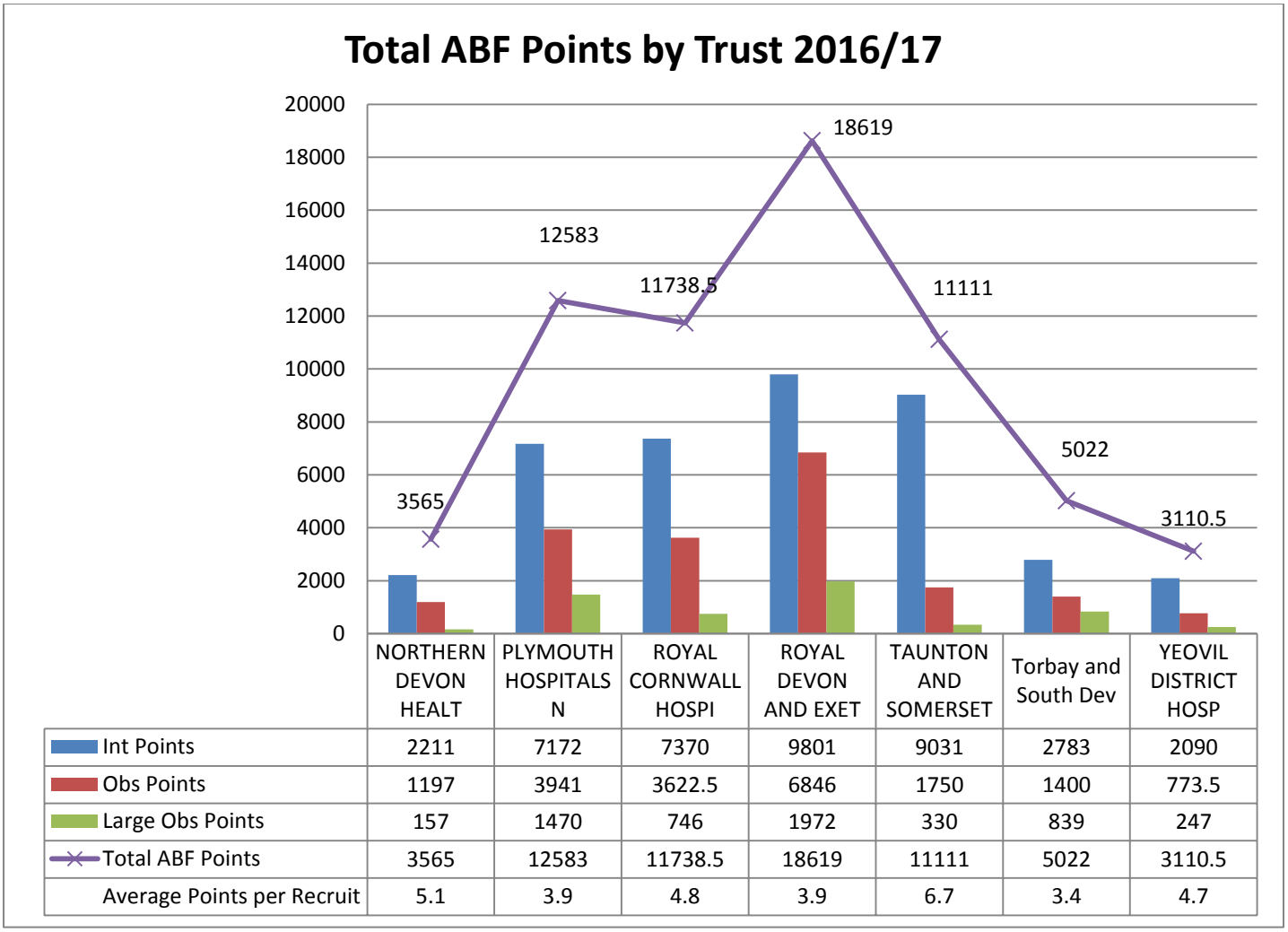
NIHR portfolio recruitment figures for 2016-17: Benchmarking against the other regional acute sites

NIHR Studies are categorised into Activity Based Funding (ABF) points as per the 3 categories below:

1. Interventional = 11 points per recruit
2. Observational (study total<10,000 recruits) = 3.5 points per recruit
3. Large Observational (study total >10, 000 recruits) = 1point per recruit

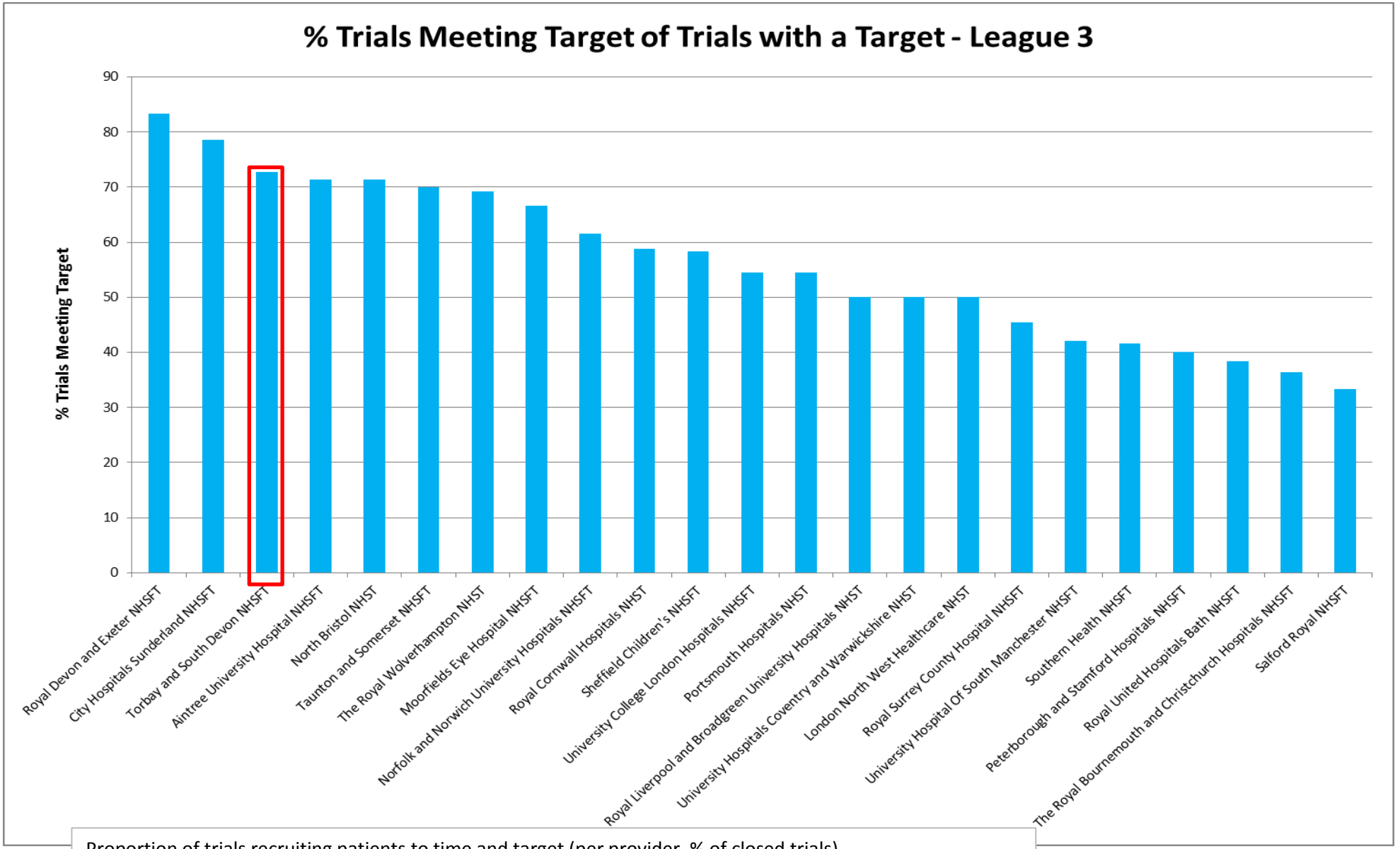
Regional performance is shown below detailing recruitment and how this converts to ABF points which is used to help benchmark activity as well as informed NIHR funding allocations per annum.

Trust	Interventional	Int Rank	Observational	Obs Rank	Large observation	Large Rank	Not Specified	Total	Total Rank
CORNWALL PARTNERSHIP	135	12	268	12	48	13-14	0	451	14
DEVON PARTNERSHIP NH	160	11	875	5	48	13-14	0	1083	8
NHS KERNOW CCG	41	16	503	8	442	6	0	986	9
NHS NORTHERN, EASTER	229	7	1058	3	667	5	0	1954	4
NHS SOMERSET CCG	52	15	504	7	134	11	0	690	12
NHS SOUTH DEVON AND	70	13	241	13	438	7	0	749	10
Non-NHS Activity in	184	10	88	16	0	-	0	272	16
NORTHERN DEVON HEALT	201	8	342	11	157	10	0	700	11
PLYMOUTH HOSPITALS N	652	5	1126	2	1470	2	0	3248	2
ROYAL CORNWALL HOSPI	670	4	1035	4	746	4	0	2451	3
ROYAL DEVON AND EXET	891	2	1956	1	1972	1	0	4819	1
SOMERSET PARTNERSHIP	59	14	211	15	50	12	0	320	15
SOUTH WESTERN AMBULA	1097	1	564	6	0	-	0	1661	5
TAUNTON AND SOMERSET	821	3	500	9	330	8	0	1651	6
TORBAY & SOUTH DEVON	253	6	400	10	839	3	0	1492	7
YEOVIL DISTRICT HOSP	190	9	221	14	247	9	0	658	13



	NORTHERN DEVON HEALT	PLYMOUTH HOSPITALS N	ROYAL CORNWALL HOSPI	ROYAL DEVON AND EXET	TAUNTON AND SOMERSET	Torbay and South Dev	YEOVIL DISTRICT HOSP
Int Points	2211	7172	7370	9801	9031	2783	2090
Obs Points	1197	3941	3622.5	6846	1750	1400	773.5
Large Obs Points	157	1470	746	1972	330	839	247
Total ABF Points	3565	12583	11738.5	18619	11111	5022	3110.5
Average Points per Recruit	5.1	3.9	4.8	3.9	6.7	3.4	4.7

2016/17 DH metric: Performance recruiting to time and target / Delivering Research (PD) metric (target = 80% studies) – assigned to leagues based on quantity of studies reported.



Proportion of trials recruiting patients to time and target (per provider, % of closed trials)
NB: Providers where the % of trials recruiting to time and target is N/A were not included in this figure.

Appendix 2: Summary of the Impacts and outcomes from studies Torbay Hospital has led or participated in.

Clinical Specialty	Study details
Anaesthetics	**Attracting trainees** As well as improving patient care, for our anaesthetics and ICU department they have demonstrated that being a research active department helps to attract trainees. Over the last few years the department has been able to attract a number of supernumerary trainees who have undertaken fellowships in peri operative medicine and day surgery. Their work in quality improvement and research has been invaluable, but in addition to this they have provided service work to the department thus limiting the amount of time that consultants have had to act down to fill holes in the emergency rota's. Within the Southwest most/all trainees are aware of the research network SWAR. The support of the SWARM network has enabled the department to recruit large numbers of patients to a number of NIHR portfolio trials. Through supporting this work and the network; trainees choose to come to our trust on rotation with the additional benefits to the service and staffing of our emergency work as an additional often unrecognised benefit to the Trust locally.
Cancer / General	**Patients more likely to survive in research-active hospitals** A study, supported by the National Institute for Health Research (NIHR) Clinical Research Network (CRN), has found that bowel cancer patients are more likely to survive in research-active hospitals. Even patients who are not involved in the trials themselves benefit from being in hospitals where a large amount of clinical research is taking place. Data collated from NIHR CRN studies over several years showed that people are more likely to survive after operations in these types of hospitals and are more likely to still be alive five years afterwards. There was nearly a four per cent increase in the five-year survival rate for those treated in highly research-active hospitals. These findings support the increasing evidence base and confirm beliefs that a research-active NHS can improve care and outcomes for all patients and therefore we must continue to support and encourage patients and frontline staff to fully embrace clinical research as an integral part of the NHS. The majority of the hospitals conducting high levels of research were district general hospitals and the effects were not limited to cancer 'centres of excellence.
Cancer – breast cancer	**The HERA study**: A randomised three arm multicentre open label global study evaluating the efficacy and safety of Herceptin single agent therapy following the completion of definitive surgery, radiotherapy (if indicated) and approved (neo) adjuvant chemotherapy in Her-2 positive women with early breast cancer. The

results of the analysis after a median of 11years of follow up were consistent with those previously reported (Herceptin given 3 weeks for either 1 or 2 years improved disease free survival and overall survival rates compared to no Herceptin after standard adjuvant therapy and that there was no statistical difference in duration indicating no additional benefit treating with Herceptin beyond 1 year). Additionally the follow up reports shows no evidence for late onset congestive heart failure events (i.e. at least 4 years after the start of Herceptin treatment).

Cancer – breast cancer

The UK FAST-Forward study: A phase 3 clinical trial testing a 1-week course of whole breast radiotherapy against the UK standard 3-week regimen after primary surgery for early breast cancer. Two acute skin toxicity sub studies were undertaken to test the safety of the test schedules with respect to early skin reactions. The results showed that acute breast skin reactions with two 1-week schedules of whole breast radiotherapy under test in FAST-Forward were mild.

Cancer - Colorectal

The SCOT study: An international phase III randomised (1:1) non-inferiority trial comparing 3 versus 6 months of oxaliplatin based adjuvant chemotherapy for colorectal cancer.

Background: Six months of oxaliplatin-based treatment has been the mainstay of adjuvant chemotherapy for colorectal cancer for the last 13 years. Neurotoxicity from oxaliplatin is cumulative, dose limiting and potentially irreversible. A shorter duration of treatment would save patients significant toxicity/time and substantially reduce the costs of the drug, its administration, and treatment of adverse effects.

Conclusions: The SCOT study has shown that 3 months adjuvant treatment is not inferior to 6 months treatment.

Local impact: Consultants have started to change practice quoting the results to patients when deciding upon treatment and starting to give 3 months chemotherapy instead of 6 months for this patient group. This reduces costs on and to NHs as well as free up capacity on our day unit.

Cancer - Malignant Haematology

Rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone (R-CHOP) in the management of primary mediastinal B-cell lymphoma: a subgroup analysis of the UK NCRI R-CHOP 14 versus 21 trial.

The main study reported showed no evidence that R-CHOP 14 is better than R-CHOP 21, they were equally effective. However a sub group analysis was undertaken to evaluate the outcomes for 50 patients with World Health Organization 2008 classified primary mediastinal B-cell lymphoma identified from

the trial database. At a median follow-up of 7·2 years the 5-year progression-free survival and overall survival was 79·8% and 83·8%, respectively. An exploratory analysis raised the possibility of a better outcome in those who received R-CHOP-14 and time intensification may still, in the rituximab era, merit testing in a randomised trial in this subgroup of patients.

Cancer - Prostate **The STAMPEDE Trial:**

Adding Celecoxib With or Without Zoledronic Acid for Hormone-Naïve Prostate Cancer: Long-Term Survival Results From an Adaptive, Multiarm, Multistage, Platform, Randomized Controlled Trial.

Men with high-risk, locally advanced or metastatic prostate cancer who were initiating long-term hormone therapy were recruited into the STAMPEDE study. A report looking at the survival data for two celecoxib (Cel)-containing comparisons, which stopped recruitment early as part of an early interim analysis shows no overall evidence of improved survival with the addition of Celecoxib.

Cancer (Prostate) **The STAMPEDE Trial:**

Previous results from this trial have already changed clinical practice – data released last year has led to docetaxel chemotherapy now being part of the standard of care for many men with prostate cancer.

In another part of the STAMPEDE trial looking at the benefits of adding abiraterone to standard hormone therapy; a drug usually given to men with advanced prostate cancer that has spread and has stopped responding to standard to hormone therapy. This study shows the added benefit to patients who are about to start long-term hormone therapy, by adding abiraterone to standard hormone therapy at the start of treatment for prostate cancer improves survival by 37% and can improve disease progression by up to 70% and demonstrates lower rates of side-effects than conventional therapies.

The results from the Cancer Research UK-funded STAMPEDE trial could change the standard of care for men with prostate cancer, making abiraterone a first-line treatment alongside hormone therapy.

Cardiology **RELAX study: A Phase III study of RLX030 (serelaxin) in patients with acute heart failure: A Novartis Global commercial study investigating the efficacy, safety and tolerability of RLX030 (serelaxin) in patients with acute heart failure (AHF).**

The study results did not meet its primary endpoints of reduction in cardiovascular death or reduced worsening heart when added to standard therapy in patients with AHF.

Diabetes

Prediction of protective sensory loss, neuropathy and foot ulceration in type 2 diabetes (funded by the Torbay Medical Research fund a local charity), led by local clinicians

In a Trust led study looking prospectively to determine the clinical and biochemical characteristics associated with the development of peripheral neuropathy, loss of protective sensation and foot ulceration in persons with type 2 diabetes over 7 years, showed that stature and worse metabolic control were associated with progression to neuropathy. Mean Hb1Ac levels were higher in those who developed foot ulcers. Graded enriched monofilament testing may enrich recruitment to clinical trials and assignation of high foot risk for foot ulceration.

Diabetes

The HEELS study: Evaluation of the effectiveness and cost-effectiveness of lightweight fibreglass heel casts in the management of ulcers of the heel in diabetes compared to usual standard care: a randomised controlled trial

The study showed that whilst there may be a small increase in healing with the use of a heel cast, the estimate was not sufficiently precise to provide strong evidence of an effect. There was no evidence of any subgroup in which the intervention appeared to be particularly effective.

The health economic analysis found only very small differences between the groups, and found no clear evidence that the heel cast device was good value for money for the NHS.

Although the provision of a lightweight heel cast may benefit some individuals, this study found no evidence to recommend that this be adopted in routine clinical practice.

Gastroenterology

Blood samples and data collected as part of a Trust led serological and genetic study, now linked into the colleagues nationally as part of the UK Irritable Bowel Disease (IBD) group has added vital knowledge about the genetics of Crohn's disease and Ulcerative Colitis, and significantly the discovery of a new gene and its role it plays in gut function helping unravel the complex caused of these conditions. Two papers published on:

Genome-wide association study implicates immune activation of multiple integrin genes in inflammatory bowel disease.

A protein-truncating R179X variant in RNF186 confers protection against ulcerative colitis.

General -

Benefits to NHS of contract research valued at £192M

25th November 2016 http://www.nihr.ac.uk/life-sciences-industry/useful-info/Key-commercial-stats.htm

Conducting commercial contract research in the NHS can help the health

service's finances to go further by an estimated £192 million, a new report shows.

The independent report, commissioned by the National Institute for Health Research (NIHR) Clinical Research Network and produced by KPMG's Economics team, provides an assessment of the economic impact of the NIHR Clinical Research Network's activities to support clinical research within the UK.

The report found that undertaking clinical studies that are funded by the life sciences industry provides an additional source of income for the NHS. On average, NHS trusts in England were estimated to receive £6,658 in revenue from life sciences companies for each patient recruited into commercial clinical research studies. This equates to an estimated total of £176 million of income over the year.

In addition, an estimated total of £16 million over 12 months in pharmaceutical cost savings are achieved when life science companies provide drugs free-of-charge to patients in clinical trials. On average, the report estimated that NHS trusts in England benefitted from a pharmaceutical cost saving of £5,250 for each patient recruited into pharmaceutical-based commercial clinical research studies, where a trial drug replaced the standard of care treatment.

The revenue and pharmaceutical cost savings combined equates to an estimated NHS financial benefit of £192 million for the NHS from all commercial research activity supported by the NIHR Clinical Research Network during the 12 month period the report looked at.

The report also looks at the wider economic impact of commercial contract research. It estimates that commercial clinical research activity conducted within the NIHR Clinical Research Network infrastructure in the period April 2014 to March 2015 helped to generate a total of £1.6 billion of Gross Value Added and 20,755 jobs.

Orthopaedics

A comparison of energy consumption between the use of a walking frame, crutches and a Stride-on rehabilitation scooter.

Following foot and ankle surgery, patients may be required to mobilise but non-weight bearing, requiring a walking aid such as crutches, walking frame or a Stride-on rehabilitation scooter, which aims to reduce the amount of work required. This study looked at the energy consumption of mobilising using a Stride-on scooter and showed that energy required for unit distance ambulation with a Stride-on device is similar to walking, and significantly lower than with a walking frame in single legged stance and three-point crutch mobilisation. This justifies its use as part of routine practice aiding early mobilisation of patients requiring restricted weight bearing or single legged weight bearing, especially in those with reduced cardio-pulmonary reserve as it is less physiologically demanding and does not rely on upper body strength.

Orthopaedics

The CARTIVA study: A Prospective, Randomized, Multi-centered Clinical Trial Assessing Safety and Efficacy of a Synthetic Cartilage Implant Versus First Metatarsophalangeal Arthrodesis in Advanced Hallux Rigidus.

Although a variety of great toe implants have been tried in an attempt to maintain toe motion, the majority have failed with loosening, malalignment/dislocation, implant fragmentation and bone loss. In these cases, salvage to arthrodesis is more complicated and results in shortening of the ray or requires structural bone graft to re-establish length. This study showed equivalent pain relief and functional outcomes. The synthetic implant was an excellent alternative to arthrodesis in patients who wished to maintain first MTP motion. The percentage of secondary surgical procedures was similar between groups. Less than 10% of the implant group required revision to arthrodesis at 2 years.

Respiratory

RESPIRE 1: A Randomized, double-blind, placebo-controlled, multicenter study comparing Ciprofloxacin DPI intermittently administered 28 days on / 28 days off or 14 days on / 14 days off) versus placebo looking at time to first pulmonary exacerbation and frequency of exacerbations in subjects with non-cystic fibrosis bronchiectasis.

The study showed that treatment with Ciprofloxacin DPI in the 14 day regimen was superior to placebo: it significantly prolonged the time to first exacerbation event and it significantly reduced the frequency of exacerbation events over 48 weeks.

Overall, Ciprofloxacin DPI given in a cyclic regimen of 14 days also increased eradication of bacterial pathogens and improved health-related quality of life when compared with placebo in non-CF bronchiectasis subjects.

The treatment with Ciprofloxacin DPI given for 48 weeks was safe and well tolerated over an observation period of up to 54 weeks.

Treatment-emergent development of resistant pathogens (mostly *P. aeruginosa*) in sputum samples at the regular end-of-study visit from pre-treatment were seen in 7.3% of subjects in the Ciprofloxacin DPI 14 group, and 2.2% of subjects in the pooled placebo group.

Rheumatology

Physical activity but not sedentary activity is reduced in primary Sjögren's syndrome.

PSS is a common autoimmune disease. People who have PSS may have symptoms including dry eyes and mouth, pain, fatigue, and experience difficulties with functional tasks. This in turn affects quality of life and employment status. Currently treatment available to these patients in the NHS is limited and is only partially effective at best.

The aim of the study was to evaluate the levels of physical activity in individuals with primary Sjögren's syndrome (PSS) and its relationship to the clinical features of PSS. The study looked at self-reported levels of physical activity, fatigue and other clinical aspects of PSS including disease status, dryness, daytime sleepiness, dysautonomia, anxiety and depression using several validated tools / Questionnaires and compared with healthy controls matched for

age, sex and body mass index. The results showed that physical activity is reduced in people with PSS and is associated with symptoms of depression and daytime sleepiness. Sedentary activity is not increased in PSS and that clinical care teams should explore the clinical utility of targeting low levels of physical activity in PSS.

Rheumatology

Subjective and Objective Measures of Dryness Symptoms in Primary Sjögren's Syndrome - Capturing the discrepancy.

There is a weak relationship between subjective symptoms and objective markers of disease activity in individuals with Primary Sjögren's Syndrome (PSS). Little is known about the reasons for this discrepancy and therefore poses a barrier to developing treatments. This study looked at developing a novel method for capturing the discrepancy between objective tests and subjective dryness symptoms (a 'Sensitivity' scale) and to explore predictors of dryness Sensitivity.

CONCLUSIONS: Ocular and oral dryness sensitivity can be classified on a continuous scale. The two symptom types are predicted by different variables. A large number of factors remain to be explored that may impact on symptom-sensitivity in PSS and the proposed method could be used to identify relatively sensitive and stoical patients for future studies.

Stroke

Does the use of Nintendo Wii SportsTM improve arm function? Trial of WiiTM in Stroke: a randomized controlled trial and economics analysis.

This home-based rehabilitation study was looking at the efficacy of using the Nintendo Wii Sports™ (Wii™) to improve affected arm function after stroke. This was a multicentre, pragmatic, parallel group, randomized controlled trial where participants were randomly assigned to exercise daily for six weeks using the Wii™ or standard arm exercises at home. The trial showed that the Wii™ was not superior to arm exercises in home-based rehabilitation for stroke survivors with arm weakness. The Wii™ was well tolerated but more expensive than arm exercises

Stroke

The SOS study: The Stroke Oxygen Study Randomized Clinical Trial: Effect of Routine Low-Dose Oxygen Supplementation on Death and Disability in Adults With Acute Stroke.

IMPORTANCE: Hypoxia is common in the first few days after acute stroke, is frequently intermittent, and is often undetected. Oxygen supplementation could prevent hypoxia and secondary neurological deterioration and thus has the potential to improve recovery.

OBJECTIVE: To assess whether routine prophylactic low-dose oxygen therapy was more effective than control oxygen administration in reducing death and disability at 90 days, and if so, whether oxygen given at night only, when hypoxia is most frequent, and oxygen

administration is least likely to interfere with rehabilitation, was more effective than continuous supplementation.

Conclusions: The study concluded that among non-hypoxic patients with acute stroke, the prophylactic use of low-dose oxygen supplementation did not reduce death or disability at 3 months. The study findings do not support low-dose oxygen in this setting.

APPENDIX 1

Summary of Annual Review assessment by SWP:CRN 2017.

National Institute for Health Research

Clinical Research Network
South West Peninsula
N8, ITTC Building
Plymouth Science Park
Research Way
Plymouth, Devon
PL6 8BX
Tel 01752 431947
Email: crn.swp@nhs.net
Web: www.crn.nihr.ac.uk/swpeninsula

17th July 2017

Dr Fiona Roberts
R&D Director
R&D Department, Horizon Centre,
Torbay District General Hospital,
Lowes Bridge, Torquay,
Devon, TQ2 7AA

Dear Chris and Fiona

NIHR CRN South West Peninsula and TRUST Performance Review Meeting 03/07/2017

Thank you all for attending the Performance Review Meeting held on Monday 3rd July 2017, where we discussed delivery of the Trusts 2016/17 Annual Plan and the plan for 2017/18 This letter provides a brief summary note of the meeting and a list of key actions.

The meeting was attended by the following colleagues:

CRN SWP attendees: Helen Quinn (HQ) - Chief Operating Officer & Lead for Nursing, Yvonne Rutter (YR) – Personal Assistant to Helen Quinn, Ray Sheridan (RW) – Clinical Research Lead, Anthony Woolf (AW) - Clinical Director, Joy Wylie (JW) – RDM.

Trust attendees: Chris Dixon (CD) – Lead Research Nurse, Megan Harris (MH) – Assistant R&D Manager, Fiona Roberts (FR) – R&D Director.

The Trust significantly improved recruitment activity in the latter part of the last financial year, it is noted the majority of this recruitment was to the DARE study which had also been used as a means to encourage cross team working and to engage the workforce. The Healthcare videos project saw a very positive influence on recruitment and the Trust video project to promote research across the organisation is very innovative and reflects the good engagement achieved across the organisation evident with the senior Executive attendance at the International Clinical Trials day.

It was very interesting to hear about the data cleansing exercise undertaken to elicit the exact follow up burden which resulted in a decrease from 7,000 participants reported in EDGE as being in active follow up to 1,500. Staff are receiving on-going training in EDGE to maintain accuracy and it was good to hear the Trust have an excellent working relationship

with the EDGE Southampton team which has supported development of the tool to further assist with trial management.

The Trust plan for 2017-18 was excellent, it was discussed that there are though challenges to delivery. HLO4 metrics are currently behind target, this has been reviewed and an improvement is expected. Recruitment to stroke studies is lower than other Trusts and the loss of two Consultants for this specialty has undoubtedly led to this. As with other regional Trusts, the sustained reduction in funding is a challenge for the organisation and it is important to maximise the potential of other funding opportunities which the Trust is doing with commercial activity, it is acknowledged this is unlikely though to bridge the gap between NIHR funding and the funds required to maintain the current team.

The CRN SWP would like to thank you formally for the continuing leadership and support for the region that you provide and we look forward to working with you again in this new financial year.

The table below summarises key actions:

Action	Lead
Forward information of the National "follow up burden" T/C to Fiona Roberts	Helen Quinn
Provide update to funding review group on follow up burden; data cleansing activity.	Fiona Roberts
Forward names of potential Principal Investigators for Cluster 4 portfolio	Ray Sheridan
Liaise with Quintiles for an update re Merck observational study contract	Joy Wylie

Kind regards

Yours sincerely

Prof Tony Woolf
Clinical Director

Helen Quinn
COO and Lead for Nursing

CC Dr Rob Dyer, Medical Director, Torbay and South Devon NHS Foundation Trust
Dr Ray Sheridan, CRL Cluster 4 & CRSL DeNDRoN
Joy Wylie CRN SWP RDM & Locality lead TSDHFT

Walking in my shoes – patient insight informs research delivery

Patients are increasing being asked to play a more active role in clinical research to improve delivery and patient experience. We discover how two initiatives in the south west are reaping the rewards of patient involvement.

Walk throughs

Research studies are reporting benefits from study 'walk throughs' by patients and non-clinical staff, as part of a pilot by NIHR Clinical Research Network South West Peninsula (CRN SWP).

A 'walk through' is a rehearsal or dry run of every step in the process of actively running a study before it starts recruiting participants.

CRN SWP Deputy Chief Operating Officer Dr Pauline McGlone, who led this initiative, said: "Overall the feedback from organisations that completed study walk throughs has been positive and allowed the trial team to consider the best way to navigate the protocol at a local level."

In some instances non-clinical staff acted as patient representatives for the study walk through exercises and some organisations chose to do a virtual walk through, rather than a physical walk through. Most of the pilot study walk throughs were completed on interventional studies in the set up phase.

It was accepted that study walk throughs are not necessary for all studies all of the time, but appropriately applied they can add value. Chief investigators will be offered study walk throughs by the CRN SWP to inform how feasible the logistics of a study are and trial set up. It was also thought to be useful when working in a new clinical area where research has not previously been conducted.

The majority of the participant NHS organisations in the pilot fed back benefits including:

- An ability to iron out problems early on and set clearer objectives for different members of the study team
- Identifying the best way to deliver the study without taking for granted prior knowledge and assumptions
- Understanding the patient pathway better
- Checking clinical and private consultation room availability and logistics
- Being very effective to support more junior research staff members
- Testing out consenting processes on complex studies
- A useful tool to use when handing over management of a study to a colleague;
- Improving understanding of study delivery and the role of everyone to achieve recruitment targets; and
- Making study teams more confident when doing the initial study recruitment.

Improving study delivery

One NHS Trust indicated that two of their studies have improved performance as a consequence of study walk throughs; and one of them recruited their first patient (also the first nationally) within four days of starting at the Trust.

Staff leading studies that were struggling to achieve objectives acknowledged that if they had conducted a walk through at the outset they would have approached the trial delivery differently. They believe this would have enhanced the delivery performance of the studies.

Involving patients/members of the public

The feedback from the south west research active trusts which involved patients or members of the public in the study walk throughs was the need for a clear explanation of what this exercise entailed to avoid confusion.

Those trusts who were not involving patients/members of the public expressed an interest in testing out how best to do this. An example of this would be to help plan appointments more effectively to factor in issues like parking on site.

As well as the walk throughs the CRN SWP pilot generated ideas on other ways patients and volunteers could be mobilised to support study setup and delivery. For example meeting and greeting, reassuring a patient in the waiting room or sharing their positive experience of research participation.

Research-active NHS organisations in Devon, Somerset, Cornwall and the Isles of Scilly are now being encouraged by the CRN SWP to complete at least two study walk throughs with patients in the next six months – one in set up and the other during the delivery phase.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	Board 6th December 2017		
Report Title	**Integrated Finance, Performance, Quality and Workforce Report: Month 7** (October Data)		
Lead Directors	Director of Strategy and Improvement Director of Finance		
Corporate Objective	Safe, quality care and best experience Improved wellbeing through partnership Valuing our workforce Well led		
Corporate Risk/ Theme	Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems. Failure to achieve key performance / quality standards. Inability to recruit / retain staff in sufficient number / quality to maintain service provision. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality. Failure to achieve financial plan. Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'.		
Purpose	**Information**	**Assurance**	**Decision**
		✓	
Summary of Key Issues for Trust Board			
Strategic Context	**2017/18 Operational and Financial Plan and Control Total:** The Trust submitted an Operational Plan for 2017/18 to NHS Improvement (NHS I) which confirmed the commitment of the Board to ensure the Trust achieves the Control Total set by NHS I of achieving a £4.7m surplus by 31st March 2018. **Sustainability and Transformation Fund:** An allocation (£5.7m) from the national Sustainability and Transformation Fund (STF) has been set aside for the Trust. The arrangements for allocating the STF for 2017/18 are: • 70% is dependent on delivery of the Trust's financial plan to deliver the agreed Control Total. • 15% is dependent on delivery of A&E performance at Trust and/or STP level. • 15% apportionment is based on the Trust's plans to deliver front door streaming by GPs by October 2017. These thresholds were met in Quarters 1 and 2 and £2.04m has been secured from the STF. The Trust is currently forecasting achievement of the Q3 thresholds **Regulatory Context - NHS I Single Oversight Framework:** The Single Oversight Framework (SOF) is used by NHS I to identify the potential support needs of NHS Providers across the five themes of quality of care,		

	finance and use of resources, operational performance, strategic change, and leadership and improvement capability. The revised SOF published by NHS I came into effect on the 1 October 2017. A briefing on the revised SOF was considered by the Finance, Performance and Investment Committee on 28th November and is contained in the Director of Strategy and Improvement Board report. In summary the underlying framework is unchanged and the performance of providers against the 'Use of Resources' metrics will continue to be made against the five themes set out above. Using this framework NHS I segment providers into one of four segments ranging from One (maximum autonomy) to Four (special measures). The Trust has previously been assessed as being in Segment Two (targeted support), in response to concerns in relation to finance and use of resources. This rating is not expected to change as a result of the revisions to the SOF. This assessment of being in segment 2 attracts the offer of targeted support; the Trust secured the services of Mark Hackett to support delivery of our 17/18 financial improvement plan. Mark Hackett's contract ended at the end of September 2017 and the oversight his role provided has been continued through the fortnightly 'check & challenge' meetings which are now chaired by the Director of Finance and the Chief Operating Officer. An additional performance metric, associated with the identification of patients who have dementia, has been added to the framework and is now included within the performance dashboard.
Key Issues/Risks	The headlines for Month 7 performance against the financial, operational, quality, change, and workforce frameworks established by the Trust are summarised in the attached Integrated Performance Report, with supporting information set out in the attached Focus Reports and the Board Dashboard. This month's report also includes, as Appendix 2, an exception report relating to delayed follow up appointments. The key issues and risks to note are: **Finance:** • **Overall financial position:** The cumulative financial position against the Control Total for the 7 months to 31st October 2017 is a deficit of £1.77m against a planned deficit of £2.94m. Against the same measure, in the month of October a surplus of £0.69m has been achieved, but this is £0.33m behind the planned £1.02m surplus for the month. • **Pay expenditure:** Total pay costs are underspent against plan to Month 7 by £2.32m. • **Savings Delivery:** At month 7 the Trust has delivered £22.35m year to date against our planned savings target of £19.15m (including income Generation target); a £3.2m over-delivery. • **System Savings Plan**: Against the £40.7m cost reduction target, and income generation target of £1.3m, required to achieve a Trust Control Total of £4.7m surplus; at the end of this accounting month, the Trust has identified savings potential of £42.6m resulting in a £0.5m surplus in the current year. (NB: £33.8m recurrent FYE savings potential). The forecast for the current year indicates we have therefore potentially over-delivered against our target. It is important to recognise that while this scale of forecast delivery represents a significant improvement on the achievements of previous years any slippage in delivery would put the control total and £5.7m STF funding at risk, affecting liquidity and, in turn capital investment plans. At this stage the Trust continues to forecast delivery of the control total, although this is subject to the identification of £5m (originally £7.2m) of savings to cover the residue of cost pressures identified at the outset of the year (but not reflected in budget setting) and the delivery of the balance of

system saving plan income from the CCG of £1.5m.

Focus must now turn to managing these residual cost pressures and the recurrent gap in the savings programme to ensure that we limit any carry forward of pressure into the 2018/19 financial year.

- **Use of Resources Risk Rating:** NHS Improvement no longer publish a planned risk rating for Trusts, due to changes they have made to the risk rating calculation. However, at Month 7, the Trust had an actual use of resources risk rating of 3 (this is no change to the M6 position and is subject to confirmation by NHS Improvement). The Agency risk rating of 1 is a material improvement to the planned rating of 3 and the I&E margin rating improved from 4 to 3 in October.

Summary of Performance Against Frameworks:

Framework	Number of KPIs	RAG Rating at the end of Month 7			
		Red	Amber	Green	Not Rated
National Performance Standards	4	3	0	1	0
Local Performance Framework	23	9	2	11	1
Community & Social Care Framework	15	4	1	7	3
Quality Framework	20	4	5	9	2
Workforce Framework	4	1	2	1	0

Single Oversight Framework Performance Standards: Against the national performance standards, for Month 7 the Trust delivered the following :

- 92.7% against the 4 hour ED standard; which is an improvement on September's 89.9% performance and above the agreed trajectory of 92% but below the national 95% standard
- 84.04% against the RTT 18 week standard; this is a marginal improvement on last month (84.01%) but remains below trajectory (90.7%) and off track to deliver the 92% standard by the end of March 2019. It is of note that the CAMHS service achieved 100% in October against this standard and currently has a YTD performance of 98.5% against the 92% target
- The number of people waiting 52 weeks, or more, is 26 this month. This is a significant increase on last month (16) and is expected to rise further in November. This is of particular concern given 'Best Practice Guidance' released by NHS I which requires a focus, and weekly reporting, on people waiting over 46 weeks and a move to zero tolerance of waits over 52 weeks. There is a plan to eliminate 52 week waits by the end of March 2018. Delivery will be monitored through the SDU Quality and Performance Review meetings
- 85.7% against the 85% cancer 62 day wait standard – this is the same performance as last month, however the Trust has delivered significant improvements against a number of the locally agreed cancer standards.
- 78.6% achieved against the 90% standard for dementia screening – this is a reduction on last month's 81.8% performance. (Note: Dementia screening is now included in the NHS I Single Oversight Framework for monitoring operational performance from October 2017).

	Performance Variances to Highlight: • Delayed Transfers of Care are an issue of national attention and are linked to securing the 'Improved Better Care Fund'. Trust performance in September and October has seen an increase in recorded delays from the acute and community hospitals. This is being investigated to understand the underlying cause. • Follow up appointments waiting beyond their planned "to be seen by" date remains high. A significant reduction has already been achieved in M7 (from 7,477 in M6 to 6,790 by the end of October); clinical teams have been asked to review the current position within each speciality to identify factors which gave rise to the current position and put in place action plans to ensure that the recent reductions are sustained and where possible accelerated. Further details are included in an exception paper appended to this report as Appendix 2.
Recommendations	The Board is asked to : • **consider** the assurances provided in the main report; • **challenge** the performance achieved; and • **agree** the further actions necessary to ensure delivery**.**
Summary of ED Challenge/Discussion	**Executive Directors**: **Finance:** Progress towards the overall financial plan remains positive, and schemes to deliver against the full £42.1m target have, all bar £400k, been identified. At month 7 savings are ahead of target, however significant activity is required in the remainder of the year if these plans are to deliver in full. Directors remain concerned that current plans, whilst more developed and granular than in previous years, may slip and have clear monitoring and performance management arrangements in place. This work also includes managing residual identified cost pressures to ensure we limit any carry forward into the 2018/19 financial year. Directors are currently holding 'Check and Challenge' meetings with SDU teams to identify further schemes to address the remaining cost pressures. Failure to address these cost pressures will mean the Trust does not hit the control total and we will need to review the forecast. **Performance:** Performance against RTT trajectories and the 52 week wait position is of concern. The additional investment approved by the Finance Performance and Investment Committee (£190k) is starting to impact on the overall RTT position which has improved slightly in M7. **SDU Quality and Performance Reviews:** Directors reviewed the Month 7 financial, service, quality and workforce performance actuals and year end forecast financial position, with SDU DGMs at the Quality and Performance Reviews held on 23rd November 2017. Directors considered cross cutting themes arising from the reviews at the Exec meeting held on 28th November 2017. In addition SDUs continue to attend fortnightly check and challenge meetings led by the Director of Finance and Chief Operating Officer to maintain momentum and ensure the groups have the capacity and capability to deliver. **New Single Oversight Framework (SOF):** Directors noted the assessment that the Trust would remain at segment 2 (targeted support) under the revised SOF. Directors are considering whether

	additional support is required to enable further financial improvement and to focus on service delivery improvement.
Internal/External Engagement inc. Public, Patient & Governor Involvement	This report is shared with Governors and contributes to a quarterly report considered by the Council of Governors.
Equality & Diversity Implications	N/A

Torbay and South Devon NHS
NHS Foundation Trust

MAIN REPORT

Integrated Finance, Performance, Quality & Workforce Report

Meeting Date: **6th December 2017**

Reporting Period: **Month 7**

Data Up To : **31st October 2017**

Version Control

Version	Meeting	Date of Circulation	Date of Meeting	Owner	This Version
Draft 1	Trust Executive	17/11/17	21/11/17	Paul Procter	☒
Draft 2	FPI Committee	22/11/17	28/11/17	Ann Wagner Paul Cooper	☒
Draft 3	Trust Executive	29/11/17	5/12/17	Ann Wagner Paul Cooper	☒
Published Report	Trust Board	30/11/17	6/12/17	Ann Wagner Paul Cooper	☒

Contents

1. Introduction and Context

Purpose

The purpose of this report is to bring together the key areas of delivery (including financial, service delivery, quality and safety, change, and workforce) into a single integrated report to enable the Board to:

- Take a view of overall delivery, against national and local standards and targets, at Trust and Service Delivery Unit (SDU) level.
- Consider risks and mitigations.
- Determine whether the Board is assured that the Trust is on track to deliver the key milestones required by the regulator and will therefore secure Sustainability and Transformation Funding (STF) and ultimately retain our license to operate.

Report Format

The main detail of the report, which follows from the ***Performance Summary*** set out below, is contained in a separate PDF file ***Performance Focus Reports.*** The Focus Reports are split into four main sections of Finance Focus; Operational Focus; Quality Focus; and Workforce Focus and are supported by the following appendices:

Appendix 1: Board Dashboard (PDF file)

Appendix 2: Exception report - Follow up patients waiting over six weeks beyond allocated date

This Performance Summary and the Focus Reports have been informed by discussions and actions at:

- EDG – Efficiency Delivery Group (17th November 2017)
- Executive Director scrutiny (21st November 2017)
- Service Delivery Unit Quality and Performance Review meetings (23rd November 2017)
- The Finance Performance and Investment Committee (28th November 2017)

Feedback and further action following scrutiny at the Finance, Performance, and Investment Committee (28th November 2017) will be reflected in the Committee Chairman's report to the Trust Board.

Financial Context: Operational and Financial Plan, Control Total and Sustainability and Transformation Fund

For 2017/18 the Trust submitted an Operational and Financial Plan to NHS Improvement (NHS I) confirming our intention to achieve the £4.7m Control Total and deliver required service performance standards to secure our designated share of the national Sustainability and Transformation Fund (STF).

Delivery of the Control Total relies on the Trust, with its system partners, delivering a Systems Savings Plan of £40.7m and an additional Income Plan of £1.3m. This leaves a system deficit of around £13m that the CCG is currently holding on behalf of the system.

In addition to financial delivery, access to a 30% of the STF funding, allocated to the Trust for 2017/18, is also dependent on delivery of service standards relating to the national ED 4 hour wait standard and new GP streaming arrangements which had to be in place by October 2017.

Regulatory Context: NHS Improvement Single Oversight Framework

The Single Oversight Framework is used by NHS I to identify NHS providers with potential support needs across the five themes of quality of care, finance

and use of resources, operational performance, strategic change, and leadership and improvement capability.

Against this framework NHS I have segmented providers into one of four categories ranging from Segment One (maximum autonomy with no support needs identified) to Segment Four (providers in special measures).

The Trust has been assessed by NHS I as being in Segment Two (providers offered targeted support). This rating was in response to concerns raised in 2016/17 in relation to finance and use of resources. As part of the targeted support, Mark Hackett was initially commissioned by NHS I to help improve the Trust's financial sustainability, efficiency, and compliance with sector controls such as agency costs. The Trust was expected to secure its own support for 2017/18 and agreed to continue using Mark Hackett for a time limited period (until end of September 2017) to provide targeted support to the delivery of our 17/18 financial plan. Mark Hackett's assignment has now completed.

Updated single oversight framework

An updated Single Oversight Framework (SOF) has been released by NHS I for implementation from M7 and this report has been updated to reflect changes in the SOF. The SOF has been updated to reflect changes in national policy and standards, other regulatory frameworks and the quality of performance data as well as feedback and lessons learned from operating the framework. There are no changes to the underlying framework and the 5 themes of quality of care; finance and use of resources; operational performance; strategic change and leadership and improvement capability. The only material change is the inclusion of the Dementia find metric into the list of indicators used to monitor operational performance.

The triggers for potential intervention remain unchanged based on failure of a national operational standard for two or more consecutive months, however where there is an agreed trajectory of improvement this will be taken into account when determining any actual underlying support need.

2. Performance Headlines: Month 7.

Key headlines for financial, operational, local performance, quality, and safety and workforce standards/metrics for Month 7 to draw to the Board's attention are as follows:

Financial Headlines

- **Overall financial position:** The financial position against NHS I Control Total for the 7 months to 31st October 2017 is a deficit of £1.77m against a planned deficit of £2.84m. Against the same measures, in the month of October a surplus of £0.69m has been achieved, which is £0.33m behind the planned £1.02m surplus for the month.
- **Pay expenditure:** Total pay costs are underspent against plan to Month 7 by £2.32m.
- **Savings Delivery:** The Trust has delivered £22.35m against our planned savings target of £19.15m (including income Generation target); a £3.2m over-delivery.
- **System Savings Plan**: Against the £40.7m cost reduction target, and income generation target of £1.3m, required to achieve a Trust Control Total of £4.7m surplus; at the end of this accounting month, the Trust has identified savings potential of £42.6m resulting in a £0.5m surplus in the current year (NB: £33.8m Recurrent FYE savings potential). The forecast for the current year therefore indicates we have potentially over-delivered against our target.

  It is important to recognise that this scale of forecast delivery represents a significant improvement on the achievements of previous years. Any slippage in delivery would however put the control total and £5.7m STF funding at risk, affecting liquidity and, in turn capital investment plans.

  At this stage the Trust continues to forecast delivery of the control total, although this is subject to the identification of £5m (originally £7.2m) of savings to cover the residue of cost pressures identified at the outset of

the year (but not reflected in budget setting) and the delivery of the balance of system saving plan income from the CCG of £1.5m.

Focus must now turn to managing the residue of identified cost pressures and the recurrent gap in the savings programme to ensure that we limit any carry forward of pressure into the 2018/19 financial year.

- **Use of Resources Risk Rating:** NHS Improvement no longer publish a planned risk rating for Trusts, due to changes they have made to the risk rating calculation. However, at Month 7, the Trust had an actual use of resources risk rating of 3 (this is no change to the M6 position and is subject to confirmation by NHS Improvement). The Agency risk rating of 1 is a material improvement to the planned rating of 3 and the I&E margin rating improved from 4 to 3 in October.

Operational Headlines: NHS Improvement Single Oversight Framework

- **ED 4 hour wait standard**: the Trust achieved 92.7% of patients discharged or admitted within 4 hours of arrival at accident and emergency departments. This is above the agreed Month 7 Operational Plan trajectory for Month 7 of 92% but below the 95% national standard. Delivery of the operational plan trajectory in Q3 is required to access STF monies. The aggregate target performance for achievement of STF in Q3 is 91.32%. The winter plan is being supported by 7 key work streams and progress against these is summarised in the body of the report.
- **RTT Trajectory:** at 84.04% (84.01% last month) the Trust recorded a slight improvement with additional capacity impacting against the 90.7% RTT trajectory in October. The requirement is to achieve the national standard of 92% by March 2019; projections now place the Trust below this trajectory. Options for addressing this declining performance have been agreed and a revised target of 86% agreed with NHS I for March 2018 together with a commitment to have no patients waiting over 52 weeks.
- **52 week waits:** The number of people waiting 52 weeks or more has risen to 26 this month. This is a significant increase on last month (16) and is expected to rise further in November. There is a plan in place to eliminate 52 week waits by the end of March 2018.
- **Cancer 62 day standard**: at 85.7% the standard (85%) was met in October. Reducing diagnostic waiting times supported by successful bid for Cancer alliance funding has been a priority with successful impact being seen in colonoscopy and the reducing treatment times for Upper GI diagnostic pathways. Additional MRI capacity has now been commissioned to target the lung and prostate pathways. Following a national drive and performance concerns assurances have been given to commissioners and NHS I on continued delivery of this standard.
- **Diagnostics:** the number of patients waiting over 6 weeks has reduced in October following the successful relocation of the Dexa scanner and additional sessions having been run. MRI have the highest number of long waits over 6 weeks.
- **Dementia:** screening of patients admitted to hospital over 75 years of age. Performance in October deteriorated to 78.6% (81.8% last month) against the target of 90% for admissions meeting the screening criteria. Improvement work continues with the introduction of "Nerve centre" clinical information tool now being rolled out.

Operational Headlines: Local Performance Indicators

In addition to the national operational standards there are a further 23 indicators agreed locally with the CCG, of which 9 were RAG rated RED in October (10 RAG rated in September). The indicators RAG rated RED are summarised in Table 1:

Table 1: Local Performance Indicators RAG Rated RED

Standard	Standard/ target	This month Month 7	Last month Month 6
Cancer 2ww urgent GP referral	93%	63.7%	61.1%

This report is currently in a draft format which is still under development, if you have any comments or feedback on the format please contact
tsdft.businessplanning@nhs.net

Standard	Standard/ target	This month Month 7	Last month Month 6
Cancer - 31-day wait from decision to treat to first treatment	96%	95.95%	98.9%
RTT waits over 52 weeks:	0	26	16
% On the day cancellations of surgery	0.8%	1.1%	1.0%
Ambulance handovers > 30 minutes:	30	110	150
Ambulance delays > 60 minutes	0	6	10
A&E patients (ED only):	95%	89.6%	85.5%
Care plan summaries % completed within 24 hrs of discharge weekdays:	77%	69.5%	71%
Care plan summaries % completed within 24 hrs discharge weekend:	60%	25.1%	38.5%

Of the remaining indicators, 11 were rated GREEN and 1 AMBER. One indicator does not yet have an agreed target.

Operational Headlines: Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 4 were RAG rated RED in October 2017 (5 in September 2017) as follows:

Table 2: Community and Social Care Framework RAG Rated RED

Standard	Target	This month Month 7	Last month Month 6
Delayed transfers of care bed days (Community)	315 days per month	490	445
Delayed transfers of Care bed days (acute)	64 days per month	205	184
Number of permanent care home placements	627	632	638
Community hospital admissions *Note: target lower admissions due to community hospital bed reductions and alternative provision in place*	Not set	238	240

Quality Headlines

There are 20 Local Quality Framework indicators in total of which 4 are RAG rated RED for October (compared to 5 for September) as follows:

Table 3: Local Quality Indicators RAG Rated RED

Standard	Target	This month Month 7	Last month Month 6
VTE assessment on admission (acute)	>95%	n/a	88%
Medication errors - Total reported incidents (trust at fault)	0	2	0
Fractured neck of femur time to theatre	>90%	75.0%	70.6%
Follow ups past to be seen date:	3,500	6790	7477

Of the remaining 17 indicators, 9 were rated GREEN, 5 AMBER and 2 not RAG rated.

This report is currently in a draft format which is still under development, if you have any comments or feedback on the format please contact ***tsdft.businessplanning@nhs.net***

Workforce Headlines

There are four workforce KPIs on the current dashboard one is RAG rated Green, two RAG rated Amber and one RAG rated Red as follows:

- **Staff sickness/absence: RED -** The rolling annual average sickness absence rate of 4.11% to the end of September 2017 represents a further small improvement. Although this cumulative rate still remains above target the in-month performance is 3.57% which is the fourth time in 6 months that the monthly sickness rate has been below the target of 3.80%.
- **Appraisal rate**: **AMBER -** At the end of October 2017 the appraisal rate was 82% the same as last month. Appraisal rates remain below the overall target of 90%, consequently further support is being offered to departments and delivery units to help achieve improvements. The accountability and oversight framework will be utilised to support and drive improvements.
- **Mandatory Training rate: AMBER** – At the end of October the overall mandatory training rate was 83% against the target of >85%. Performance has been static at this level for the last four months and support is being offered to enable staff to access on line training resources more easily.

In addition to the workforce KPIs there are 2 further workforce indicators that are being tracked to provide assurance to the Board

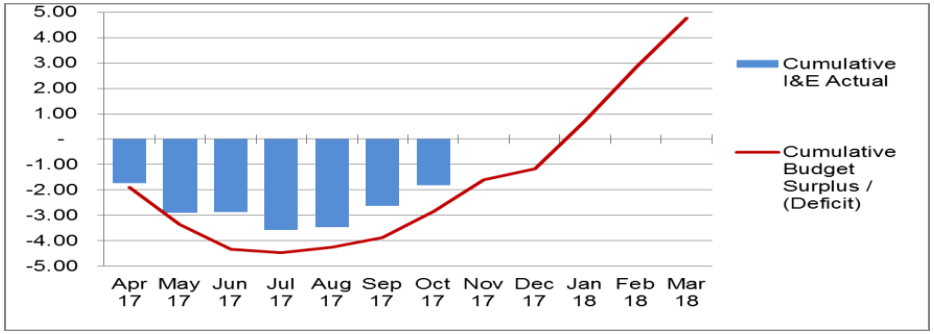
- **Workforce Plan -** The workforce plan aims to have 5001.3 staff in post at the end of the financial year. At the end of October an overachievement of 15.94 staff less in post are reported against plan.
- **Agency Expenditure -** Agency expenditure at Month 7 is overachieving against plan by £1.658m and is on target to achieve the NHS I cap by the end of the year.

This report is currently in a draft format which is still under development, if you have any comments or feedback on the format please contact ***tsdft.businessplanning@nhs.net***

Finance Focus

Summary of Financial Performance

Current Performance



	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Income	239.25	2.30	241.55	239.63	(1.91)	410.62	417.10
Pay	(129.64)	(1.77)	(131.42)	(129.09)	2.32	(217.32)	(223.00)
Non Pay	(101.23)	(2.66)	(103.89)	(103.29)	0.61	(169.30)	(173.80)
EBITDA	**8.37**	**(2.14)**	**6.23**	**7.25**	**1.02**	**24.00**	**20.30**
Financing Costs	(11.22)	2.15	(9.08)	(9.07)	0.01	(19.24)	(15.54)
SURPLUS / (DEFICIT)	**(2.85)**	**0.01**	**(2.84)**	**(1.82)**	**1.03**	**4.76**	**4.76**
NHSI Exclusions	(0.10)	0.00	0.00	0.05	0.15	(0.17)	(0.17)
NHSI Adjusted Surplus / (Deficit)	**(2.95)**	**0.01**	**(2.84)**	**(1.77)**	**1.18**	**4.58**	**4.58**
Cash Balance	0.83			4.71	**3.88**	**6.17**	
Capital Expenditure	16.42	(10.30)	6.12	2.65	**(3.47)**	**29.58**	

KPIs (Risk Rating)	YTD Plan	YTD Actual
Indicator	**Rating**	**Rating**
Capital Service cover rating	4	4
Liquidity rating	4	4
I&E Margin rating	4	3
I&E Margin variance rating	N/A	1
Agency rating	3	1
Finance Risk Rating	**N/A**	**3**

Key Points

- To enable robust monitoring all budget adjustments will be reflected in the "Re Categorisation of plan" column and referred to as "budget" in this report, with variances analysed accordingly. This provides an updated view of the trustwide budgeted position. The Trust's control total remains the same.
- At a £1.82m deficit for the period to 31st October 2017, the Trust's overall income and expenditure deficit is £1.03m better than budget. Excluding expenditure not used by NHS Improvement in their assessment framework, performance against the published 'Control Total', a deficit of £1.77m is recorded; £1.18m better than budget for the period.
- The Trust has recorded a surplus of £0.81m in the month; below the budgeted level by £230k. The position is supported by additional income due from Torbay Council following final agreement of the revised Risk Share Agreement. There has been no increase in underlying expenditure, and run rates have remained broadly consistent except for the Purchase of Social Care, where an increase has been experienced.
- The CIP target for the seven months to 31 October 2017 is £19.15m, against which a total of £22.35m has been delivered; a favourable variance of £3.2m.
- The burden of savings requirements increases later in the year, reducing the run rate of expenditure, decreasing the deficit and ultimately result in a surplus position as per the control total. Run rates will need to reduce at a more significant rate than that seen in the first half of this financial year in order to achieve this.
- The current forecast of CIP delivery for the full year is £42.6m against a target of £42.1m, indicating that plans are in place to deliver against the balance. It is critical that these plans are executed to full effect for the Control Total to be achieved.
- The Trust continues, at this stage to forecast delivery of control total, though this is subject to the identification of £5m (originally £7.2m) of savings to cover the residue of cost pressures identified at the outset of the year, but not reflected in budget setting, and the delivery of additional £1.5m income.
- The Trust has a year to date Finance Risk Rating of 3, including an improved I&E Margin rating scoring a '3' against a planned '4'.

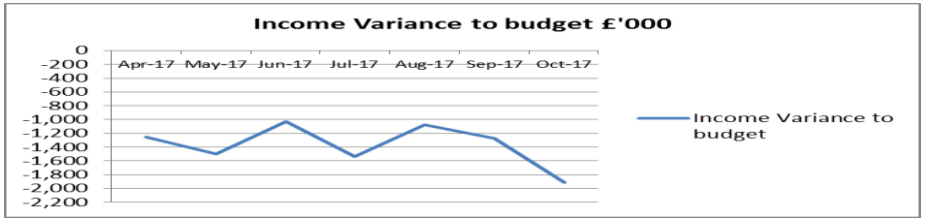
Summary of Financial Performance

	Month 7					Year to date								
	Current Month Plan	Re-Categorisation of Plan	Current Month Budget	Current Month Actual	Current Month Variance to Budget	Plan for Period YTD	Re-Categorisation of Plan	Budget for Period YTD	Actual for Period YTD	Variance to Budget YTD	Prior Month Variance YTD	Change	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M
Operating income from patient care activities	29.90	1.20	31.10	30.33	(0.78)	208.24	3.76	212.01	211.03	(0.98)	(0.20)	(0.78)	356.04	361.30
Other Operating income	4.78	(0.10)	4.68	4.82	0.14	31.01	(1.47)	29.54	28.61	(0.93)	(1.07)	0.14	54.59	55.79
Total Income	**34.68**	**1.10**	**35.78**	**35.14**	**(0.64)**	**239.25**	**2.30**	**241.55**	**239.63**	**(1.91)**	**(1.27)**	**(0.64)**	**410.62**	**417.10**
Employee Benefits - Substantive	(17.52)	(0.92)	(18.44)	(17.91)	0.53	(124.92)	(2.15)	(127.08)	(126.03)	1.05	0.52	0.53	(210.73)	(216.88)
Employee Benefits - Agency	(0.42)	0.02	(0.40)	(0.37)	0.03	(4.72)	0.38	(4.34)	(3.07)	1.28	1.25	0.03	(6.60)	(6.12)
Drugs (including Pass Through)	(2.97)	0.15	(2.82)	(2.67)	0.15	(20.80)	0.10	(20.71)	(18.43)	2.28	2.13	0.15	(35.62)	(35.45)
Clinical Supplies	(1.98)	(0.07)	(2.04)	(2.05)	(0.01)	(13.88)	(0.46)	(14.34)	(13.91)	0.43	0.43	(0.00)	(23.36)	(24.22)
Non Clinical Supplies	(0.41)	(0.00)	(0.41)	(0.36)	0.05	(2.84)	0.03	(2.81)	(2.42)	0.38	0.33	0.05	(4.86)	(4.84)
Other Operating Expenditure	(8.76)	(0.59)	(9.35)	(9.74)	(0.39)	(63.71)	(2.33)	(66.04)	(68.52)	(2.48)	(2.09)	(0.39)	(105.46)	(109.29)
Total Expense	**(32.04)**	**(1.41)**	**(33.45)**	**(33.08)**	**0.37**	**(230.87)**	**(4.44)**	**(235.31)**	**(232.38)**	**2.93**	**2.57**	**0.36**	**(386.62)**	**(396.80)**
EBITDA	**2.64**	**(0.31)**	**2.33**	**2.06**	**(0.27)**	**8.37**	**(2.14)**	**6.23**	**7.25**	**1.02**	**1.30**	**(0.28)**	**24.00**	**20.30**
Depreciation - Owned	(1.14)	0.30	(0.84)	(0.93)	(0.08)	(7.99)	2.08	(5.90)	(5.82)	0.08	0.17	(0.09)	(13.69)	(10.12)
Depreciation - donated/granted	(0.07)	0.00	(0.07)	(0.06)	0.01	(0.48)	0.00	(0.48)	(0.40)	0.09	0.08	0.01	(0.83)	(0.83)
Interest Expense, PDC Dividend	(0.48)	0.01	(0.46)	(0.44)	0.02	(3.34)	0.06	(3.28)	(3.25)	0.02	0.00	0.02	(5.72)	(5.59)
Donated Asset Income	0.08	0.00	0.08	0.18	0.09	0.58	0.00	0.58	0.35	(0.24)	(0.33)	0.09	1.00	1.00
Gain / Loss on Asset Disposal	0.00	0.00	0.00	(0.00)	(0.00)	0.00	0.00	0.00	0.05	0.05	0.05	0.00	0.00	0.00
Impairment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
SURPLUS / (DEFICIT)	**1.03**	**0.00**	**1.04**	**0.81**	**(0.23)**	**(2.85)**	**0.01**	**(2.84)**	**(1.82)**	**1.03**	**1.27**	**(0.24)**	**4.76**	**4.76**
NHSI Adjusted Position (Control Total)														
Donated Asset Income	(0.08)	0.00	(0.08)	(0.18)	(0.09)	(0.58)	0.00	(0.58)	(0.35)	0.24	0.33	(0.09)	(1.00)	(1.00)
Depreciation - Donated / Granted	0.07	0.00	0.07	0.06	(0.01)	0.48	0.00	0.48	0.40	(0.09)	(0.08)	(0.01)	0.83	0.83
Impairment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHSI Adjusted Surplus / (Deficit)	**1.02**	**0.00**	**1.02**	**0.69**	**(0.33)**	**(2.95)**	**0.01**	**(2.94)**	**(1.77)**	**1.18**	**1.52**	**(0.34)**	**4.58**	**4.58**

- The position for Month 7 is a surplus of £810k, which is £230k behind the budgeted position (£1,038k surplus) before NHSI exclusions.
- Cumulatively the Trust deficit is £1.82m against a budget deficit of £2.84m.
- Income is behind budget by £640k in Month 7 and behind budget cumulatively by £1.91m (majority of this relating to SCG Pass through Payments).
- Pay expenditure is £560k less than budget in Month 7 and £2.33m lower than budget cumulatively. This reflects the phasing of budgets and savings targets.
- Non-pay expenditure is £200k higher than budget in Month 7 but £620k lower than budget cumulatively, again reflecting phasing of budgets and savings targets.
- The challenge increases considerably as the year progresses to reduce costs and meet savings targets in line with phasing in order to achieve the control total. CIP plans have been identified in full and we must now focus on ensuring their complete delivery along with the management of the residual cost pressures identified in final budget setting and arising during the year for the Control Total to be achieved.

Income

Current Performance



Operating Income	Year to Date - Month 7					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Contract Healthcare	176.11	2.27	178.38	176.79	(1.59)	(0.77)	(0.82)
Council Social Care (inc Public Health)	25.16	1.31	26.47	27.10	0.63	0.59	0.04
Client Income	5.59	0.13	5.72	5.71	(0.01)	(0.00)	(0.00)
Private Patients	0.98	0.06	1.04	0.97	(0.07)	(0.05)	(0.01)
Other Income	0.41	(0.01)	0.40	0.45	0.05	0.05	0.01
Operating Income from patient care activities	**208.25**	**3.76**	**212.01**	**211.02**	**(0.98)**	**(0.20)**	**(0.78)**
Other Income	23.41	(1.75)	21.66	20.76	(0.89)	(1.21)	0.31
Research and Education	4.97	0.29	5.26	5.22	(0.04)	0.14	(0.17)
Sustainability & Transformation funding	2.62	0.00	2.62	2.62	(0.00)	0.00	(0.00)
Other operating income	**31.01**	**1.47**	**29.54**	**28.61**	**(0.93)**	**(1.07)**	**0.14**
Total	**239.25**	**2.29**	**241.55**	**239.63**	**(1.91)**	**(1.27)**	**(0.64)**

Contract income by Commissioner	Year to Date - Month 7					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
South Devon & Torbay Clinical Commissioning Group	97.46	2.17	99.63	99.59	(0.03)	(0.03)	0.00
North, East & West Devon Clinical Commissioning Group	3.04	0.02	3.06	3.18	0.12	0.07	0.05
NHS England - Area Team	4.60	0.08	4.68	4.05	(0.64)	(0.46)	(0.17)
NHS England - Specialist Commissioning	17.78	0.09	17.88	16.93	(0.95)	(0.65)	(0.30)
Other Commissioners	4.63	(0.04)	4.59	4.43	(0.16)	0.23	(0.39)
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	47.10	0.05	47.15	47.17	0.01	0.01	0.00
Other Commissioners	1.50	(0.11)	1.39	1.45	0.05	0.05	0.00
Operating Income from patient care activities	**176.11**	**2.27**	**178.38**	**176.79**	**(1.59)**	**(0.77)**	**(0.78)**

MEMO - CCG Block Adjustment	Year to Date - Month 7					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Plan - (adv)/+fav	Change
	£m			£m	£m	£m	£m
CCG Block adjustment	(5.20)	(1.19)	(6.39)	(2.39)	4.00	4.42	(0.42)

Key points

- Overall operating Income from Patient Care Activities is behind plan by £0.98m.
- Within this, there is a variance of £1.59m on income from contract healthcare. This reflects a reduction in 'Pass Through Activity of £1.3m, as well as being £0.4m behind in Outpatients, offset by being £0.1m above plan in admitted patient care. There is a corresponding underspend in pass through expenditure to offset that element of the variance.
- At Commissioner level, variances are marginal except for NHS England contracts. The NHS England Specialist Commissioning contract is £1m behind plan, £0.8m of this relates to reduced pass through income. The NHS England Local Area contract is £0.6m behind plan, with Outpatients being the biggest variance at just under £0.5m behind plan and other cost and volume £0.1m behind plan.
- The Trust has included a proportion of the £3.1m additional income from Torbay Council matched to SSP profiling. The Trust has also included 7/12 of expected £1.2m funding from DCC relating to the iBCF.

Income

Other Operating Income	Year to Date - Month 7					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Plan - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
R&D / Education & training revenue	4.97	0.29	5.26	5.22	(0.04)	0.14	(0.17)
Site Services	1.28	0.05	1.32	1.33	0.01	(0.05)	0.06
Revenue from non-patient services to other bodies	3.15	(0.94)	2.21	2.20	(0.01)	(0.01)	0.00
Sustainability Transformational Funding (STF) Income	2.62	0.00	2.62	2.62	(0.00)	0.00	(0.00)
Risk Share Income	2.04	(2.04)	0.00	0.00	0.00	0.00	0.00
Misc. other operating revenue	16.94	1.19	18.13	17.23	(0.89)	(1.14)	0.25
Total	**31.01**	**(1.47)**	**29.54**	**28.61**	**(0.93)**	**(1.07)**	**0.14**

Other Operating income is behind budget by £0.93m, principally as a result of:

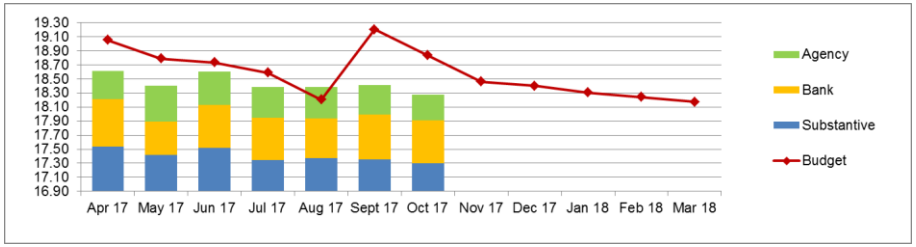
- Systems Savings plan income is behind plan by £1.3m for the year to date. On a full year basis £5.4m is forecast against a target of £7.2m.
- Income earned by Torbay Pharmaceuticals is £389k less than budget. The Torbay Pharmaceuticals Board has agreed a recovery plan and is expecting now to achieve planned surplus levels by the year end. With this, in part being achieved through cost management, some income variance may continue.
- E Prescribing income received is £384k more than planned.
- R&D, and Education income behind budget by £38k

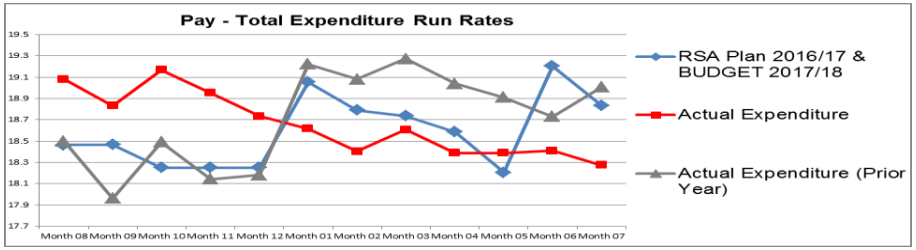
The Trust has accrued £2.96m of income from South Devon and Torbay CCG as agreed and provided by the CCG in Month 7, relating to System Wide Savings schemes advised, delivered and passing to the Trust.

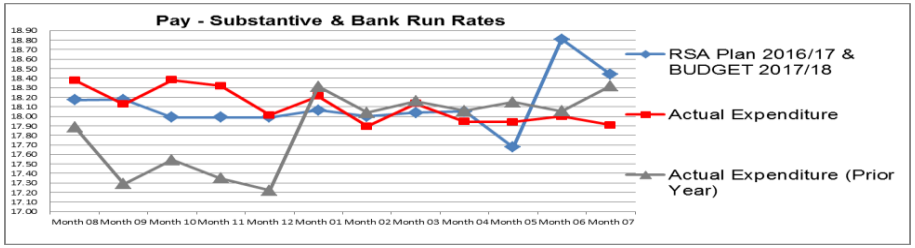
STF funding of £2.62m has been accrued and included in the year to date figures, reflecting anticipated receipt for Months 1 to 7.

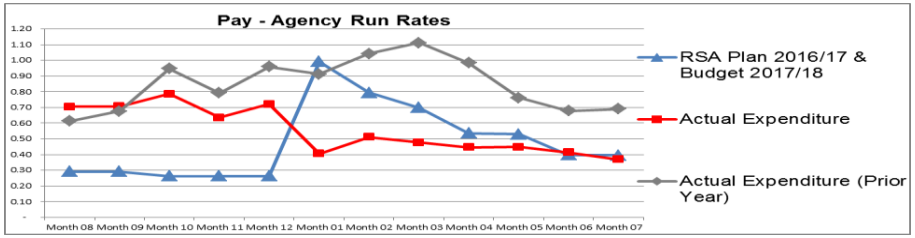
Pay Expenditure

Current Performance









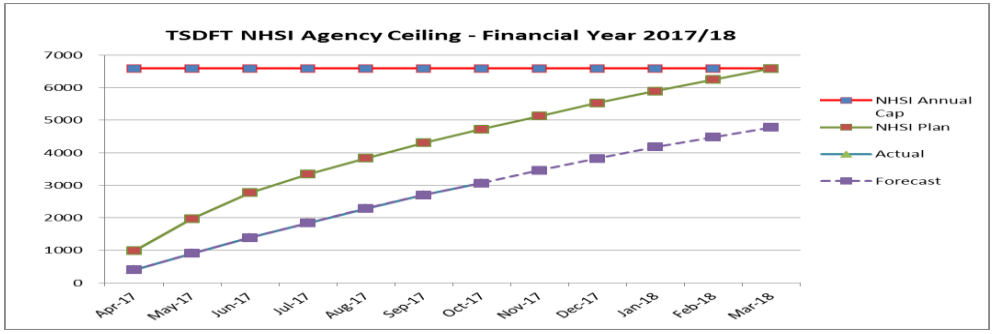
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(32.24)	1.64	(30.61)	(29.44)	1.16	(55.23)	(52.36)
Nursing and Midwifery	(54.58)	0.12	(54.46)	(51.64)	2.81	(91.62)	(91.34)
Other Clinical	(27.69)	(0.96)	(28.65)	(26.39)	2.26	(47.33)	(49.20)
Non Clinical	(15.13)	(2.57)	(17.70)	(21.62)	(3.91)	(23.14)	(30.10)
Total Pay Expenditure	**(129.64)**	**(1.77)**	**(131.42)**	**(129.09)**	**2.32**	**(217.32)**	**(223.00)**

Key points

- To reflect the latest budgeted position, there has been a year to date adjustment to month 7 of £1,470k to reduce the SSP savings target currently categorised as pay, and which is now replaced with additional income following conclusion of Risk Share Agreement negotiations. The chart to the left therefore presents a more realistic reflection of the extent to which run rates of expenditure now need to reduce for target to be achieved.
- Based on this, total pay costs are showing an underspend against budget for the year to date by £2.32m and £560k in Month 7.
- Substantive and Bank pay costs are underspent by £1.05m, and agency costs are underspent by £1.28m.
- In setting the annual plan, agency budgets were set in line with the agency cap. Work in the period between then and final budget setting achieved a significant reduction in forecast agency spend, requiring a 'budget transaction', held in reserves, to maintain the integrity of the plan. As a consequence, when reviewed at service level, the main area of overspend in substantive costs shows in reserves. At Service Delivery Unit (SDU) level, there are underspends within most SDUs except in Research and Development which is £73k overspent.
- The agency underspend is reflected in Reserves, offset by overspends in Medicine (£1.06m) in Emergency, Respiratory, General Medicine and Care of the Elderly, Community Services (£0.42m) in Public Health CAMHS, Women and Child's Health (£0.27m) in Child's Health, Radiology and Lab Medicine. This continues to reflect the filling of vacancies achieved through the redeployment of staff affected by bed closures, made possible through the care model implementation.
- Run rates in substantive and bank pay have decreased overall by £90k from the previous month, (substantive £56k and bank £34k). There are reductions in Corporate Services and Women and Child's Health, with additional costs in Surgery (mainly Ophthalmology and Theatres).
- Agency run rates, have reduced again in October and average spend has been circa £440k per month since the beginning of the financial year.

Pay Expenditure

Agency Spend Cap



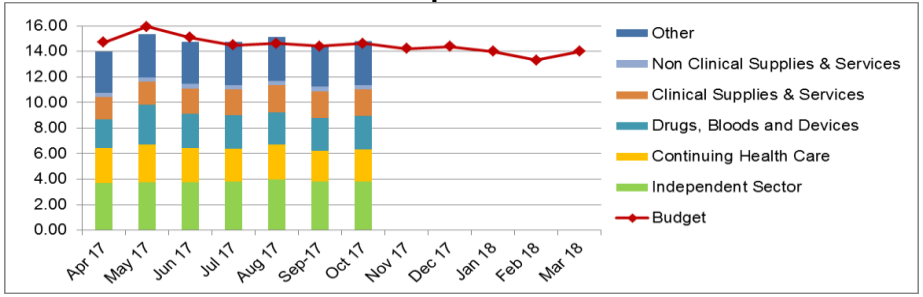
Agency - All Staff Groups	April	May	June	July	August	September	October	YTD 2017-18
	£m	£m	£m	£m	£m	£m	£m	£m
Agency Plan 2017/18 (NHSI Ceiling)								
Planned Agency Cost	(0.99)	(0.98)	(0.80)	(0.56)	(0.49)	(0.48)	(0.42)	(4.72)
Total Planned Staff Costs	(19.06)	(19.01)	(18.89)	(18.31)	(18.26)	(18.18)	(17.93)	(129.64)
% of Agency Costs against Total Staff Cost	**5%**	**5%**	**4%**	**3%**	**3%**	**3%**	**2%**	**4%**
Agency Actual Costs 2017/18								
Agency Cost	(0.41)	(0.51)	(0.48)	(0.45)	(0.45)	(0.41)	(0.37)	(3.07)
Actual Staff Cost	(18.63)	(18.41)	(18.79)	(18.44)	(18.56)	(18.00)	(18.77)	(129.59)
% of Agency Costs against Total Staff Cost	**2%**	**3%**	**3%**	**2%**	**2%**	**2%**	**2%**	**2%**
Agency Cost vs Plan	0.59	0.47	0.33	0.11	0.04	0.07	**0.05**	1.6
% of Agency Costs against Total Staff Cost	**-3%**	**-2%**	**-2%**	**-1%**	**0%**	**0%**	**0%**	**-1.3%**

Agency - Nursing	April	May	June	July	August	September	October	YTD 2017-18
	£m	£m	£m	£m	£m	£m	£m	£m
Agency Nurse Staff Cost	(0.11)	(0.14)	(0.15)	(0.06)	(0.07)	(0.09)	(0.09)	(0.70)
Actual Registered Nurse Staff Cost	(4.61)	(4.34)	(4.63)	(4.35)	(4.40)	(4.40)	(4.43)	(31.17)
% of Agency Costs against Nursing Staff Cost	**2%**	**3%**	**3%**	**1%**	**2%**	**2%**	**2%**	**2%**

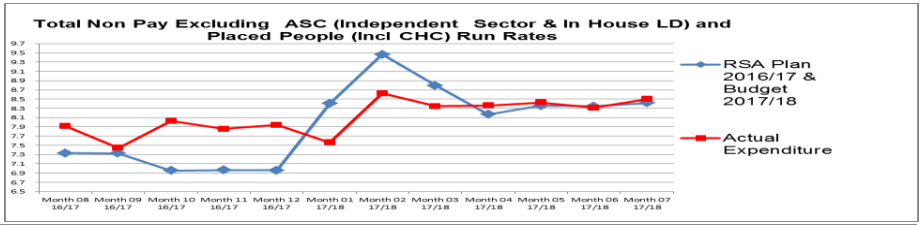
- Agency staff costs in Month 7 across all staff groups is £0.4m and £3.1m for the year to date. This is £1.6m lower than the NHSI plan.
- Medical agency spend is £1.8m which is £0.2m higher than the £1.6m plan.
- Nursing Agency spend is £0.7m for the year to date, £2.0m lower than the £2.7m plan.
- The full year forecast as at Month 7 is £4.8m, £1.8m lower than the NHSI cap of £6.6m.
- This continues to reflect the filling of vacancies achieved through the redeployment of staff affected by bed closures made possible through the care model implementation, and further supported by on-going review of Agency requirement, implementing tighter control on Agency use, staff flexibility and other initiatives.
- Although the Trust remains within the agency cap overall, individual price rates for Nursing and Medical staff are all above NHSI individual shift rates.

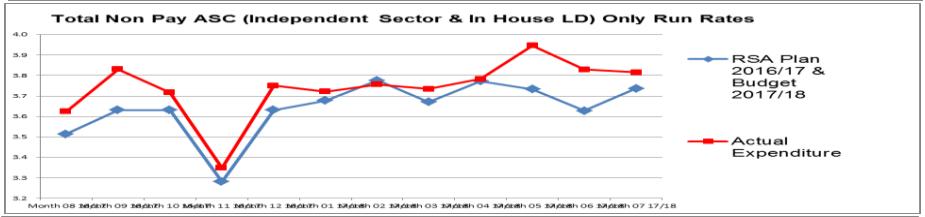
Non Pay Expenditure

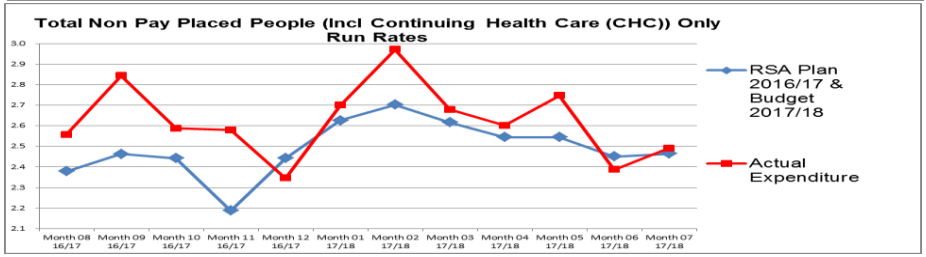
Current performance



	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Drugs, Bloods and Devices	(20.80)	0.10	(20.71)	(18.43)	2.28	(35.62)	(35.45)
Clinical Supplies & Services	(13.84)	(0.46)	(14.30)	(13.88)	0.42	(23.29)	(24.15)
Non Clinical Supplies & Services	(2.83)	0.03	(2.80)	(2.42)	0.38	(4.85)	(4.83)
Other Operating Expenditure	(19.01)	(3.13)	(22.14)	(23.40)	(1.25)	(29.50)	(35.84)
ASC (Independent Sector & In House LD)	(26.15)	0.16	(25.99)	(26.59)	(0.59)	(44.51)	(44.09)
Placed People (Incl Continuing Healthcare)	(18.59)	0.64	(17.95)	(18.58)	(0.63)	(31.52)	(29.43)
Total Non Pay Expenditure	**(101.23)**	**(2.66)**	**(103.89)**	**(103.29)**	**0.61**	**(169.30)**	**(173.80)**



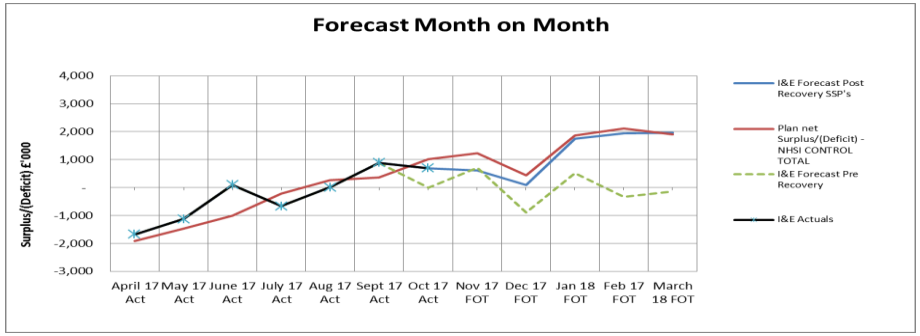


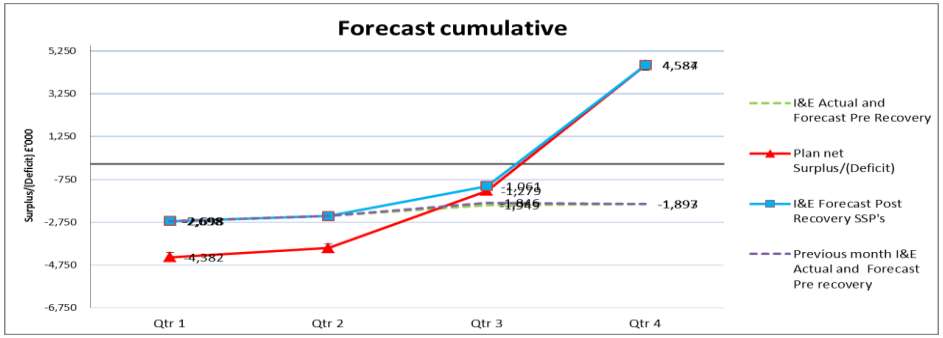


Key Points

- Drugs, Bloods and Devices - Underspent by £2.28m mainly due to pass through £1.79m for which income is similarly reduced.
- Clinical Supplies – Total underspend of £0.42m; £0.33m in Surgery, £0.15m Women and Child's Health, £0.11m Hospital Services with offsetting overspends in Estates Contract Maintenance, Community Services and Torbay Pharmaceuticals. Although underspent against budget, previous reports have highlighted an increase in run rates since the beginning of the financial year. Run rates have stabilised somewhat, with expenditure in line with budget in the month. This will be monitored closely for the remainder of the year.
- Non Clinical Supplies – Total underspend of £0.38m; £0.14m in Estates, £0.04m Hospital Services and £0.11m Health Informatics Team. Run rates have reduced by £0.01m on the previous month mainly in Estates.
- Placed People (including Continuing Healthcare) - Over spent by £0.63m, mainly in Adult Individual Patient Placements and reflecting an unachieved savings target. Run rates however have increased on the previous month by £0.10m.
- Adult Social Care - Over spent by £0.59m mainly as a result of a shortfall in the delivery of the Systems Savings Plan. Savings in this area are expected to increase later in the year.
- Other Operating Expenditure - Over spent by £1.25m reflecting:
  - Premises underspent by £0.11m, with run rates higher than the previous month by £0.06m.
  - Purchase of social care overspent by £0.74m due to Systems Savings Plan shortfall (savings target phased from month 4 onwards).
  - Other £1.27m overspent – allocation of cost pressures savings targets (£866k), Torbay Pharmaceuticals miscellaneous expenditure (£0.22m), Women and Child's Health (£0.36m), Medical Services (£0.54m), Community Services (£0.42m)
  - Purchase of Healthcare £0.27m overspent- Women and Child's Health for Radiology and Lab Test outsourcing (£0.17m) and Community Service intermediate care £0.20m, with an increase in run rate of £0.11m from the previous month.
  - Underspends in Education and Training £0.41m; Bad debt Provision £0.33m, Establishment £0.11m (mainly printing/stationery and postage), Transport and other costs £0.05m.

Forecast





Forecast position with mitigations	Plan £m	Forecast £m	Variance £m
Income			
Gross	403.02	401.20	(1.82)
Planned CIP	8.60	11.63	3.03
Net position	411.62	412.83	1.21
Pay			
Gross	(236.82)	(243.07)	(6.25)
Planned CIP	19.50	20.25	0.75
Net position	(217.32)	(222.83)	(5.51)
Non Pay			
Gross	(203.62)	(202.63)	0.99
Planned CIP	13.90	10.73	(3.17)
Net position	(189.72)	(191.90)	(2.18)
Total net position	4.58	(1.90)	(6.48)
Mitigations:-			
Further non recurrent schemes - yet to be identified			**4.98**
CCG - additional Risk Share Income			**1.50**
Gap			**0.00**

- The forecast variance to plan without mitigations, and assuming that all identified savings scheme deliver in full, remains at £6.48m.
- This reflects the cost pressure of £6.1m (£3.6m business planning cost pressures, net overspends of £2.5m).
- Mitigations to close this gap are additional non recurrent savings target have been set at SDU level £4.9m, and for which schemes are currently being developed, and £1.5m of risk share income / increase in SSP savings. An update on progress will be provided to both Finance, Performance and Investment Committee and Board.
- The net cost pressures of £2.5m flagged by operational teams in their forecasting process is being tested and challenged at SDU level through the Performance Review process. This same process is overseeing the development of plans to achieve the maximum level of additional savings and minimise the CCG contribution to Risk Share Agreement income.

Financial Position by SDU

Key Drivers

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Trust Total Position								
Income	235.60	2.90	238.49	237.02	(1.47)	408.40	404.36	411.47
Pay	(131.30)	(0.30)	(131.60)	(129.09)	2.51	(222.83)	(222.84)	(223.61)
Non Pay	(102.89)	(1.48)	(104.37)	(103.29)	1.08	(188.65)	(174.82)	(175.81)
Financing Costs	(11.81)	2.15	(9.66)	(9.42)	0.24	(5.39)	(20.24)	(16.54)
SSP Plans	7.55	(3.25)	4.29	2.96	(1.33)	5.43	18.30	9.25
Trust Surplus / (Deficit)	**(2.85)**	**0.01**	**(2.84)**	**(1.82)**	**1.03**	**(3.04)**	**4.76**	**4.76**
NHSI Exclusions	(0.09)	0.00	0.00	0.16	0.25	1.14	(0.17)	(0.17)
NHSI Adjusted Surplus / (Deficit)	**(2.94)**	**0.01**	**(2.84)**	**(1.65)**	**1.28**	**(1.90)**	**4.58**	**4.58**

The year to date position is a deficit of £1.82m against a budget deficit of £2.84m.

Forecast variance is showing a Trust wide deficit of £1.90m, being a gap of £6.48m behind the planned surplus of £4.58m (NHSI adjusted position). The £6.48m gap is before mitigations and assuming that all identified savings scheme deliver in full, and comprises £0.5m over delivery in the savings plan, £3.6m cost pressure gap in in final phase of business planning , and net cost pressures £2.5m.

Further analysis by at SDU level can be seen in the following tables:-

	Plan for Period	Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Community								
Income	0.57	0.15	0.72	0.86	0.14	1.49	0.97	1.23
Pay	(24.98)	0.28	(24.69)	(22.48)	2.21	(38.99)	(41.83)	(41.26)
Non Pay	(6.56)	1.56	(5.00)	(5.01)	(0.01)	(8.69)	(10.99)	(8.06)
Financing Costs	(1.05)	0.01	(1.04)	(1.03)	0.01	(1.77)	(1.81)	(1.77)
Surplus / (Deficit)	**(32.02)**	**2.01**	**(30.01)**	**(27.66)**	**2.35**	**(47.95)**	**(53.66)**	**(49.87)**

Underspend is related to the in year over achievement of savings from the decommissioning of Community Hospitals; DCC BCF underspend which nets off from a Trustwide perspective against Contract Income and slippage on vacancies; Lower than anticipated IC bed placement numbers.Phasing of CIP is also a factor in the YTD position with phasing loaded towards end of the year whilst savings have been achieved from M1.

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
ASC (Independent Sector & In House LD)								
Income	5.78	(0.00)	5.78	5.83	0.06	9.77	9.90	9.90
Pay	(0.76)	0.16	(0.60)	(0.73)	(0.13)	(1.26)	(1.31)	(1.02)
Non Pay	(26.15)	0.16	(25.99)	(26.59)	(0.59)	(45.39)	(44.51)	(44.09)
Surplus / (Deficit)	**(21.14)**	**0.32**	**(20.82)**	**(21.48)**	**(0.66)**	**(36.88)**	**(35.92)**	**(35.21)**

Overall £660k overspend entirely ASC driven, with £475k of this due to unachieved TWIP. Difference of circa £185k is largely due to overspends in both nursing care and home care (driven by high demand) and an under recovery of residential client income. Not seeing an equivalent drop in expenditure due to high unit costs across Torquay offsetting the saving in income.

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Placed People (includes Continuing Healthcare)								
Income	0.01	0.00	0.01	0.00	(0.01)	0.00	0.02	0.02
Pay	(0.72)	0.15	(0.57)	(0.47)	0.11	(0.88)	(1.24)	(0.99)
Non Pay	(18.59)	0.64	(17.95)	(18.58)	(0.63)	(31.75)	(31.52)	(29.43)
Surplus / (Deficit)	**(19.30)**	**0.79**	**(18.51)**	**(19.04)**	**(0.53)**	**(32.62)**	**(32.74)**	**(30.40)**

YTD overspend of circa £530k is driven by two main factors. The first is a £400k pressure in Adult IPPs caused by new high cost cases. The second is £455k due to unachieved TWIP. The latter is driven by adverse market conditions which make it very difficult to achieve any price based savings. The above has been partially offset by savings in CHC Torbay Nursing Homes and Intermediate Care.

Financial Position by SDU

Key drivers

	Plan for Period	Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Medical Services								
Income	53.30	(0.98)	52.31	51.04	(1.27)	87.71	91.47	89.60
Pay	(24.67)	0.20	(24.47)	(26.50)	(2.02)	(44.60)	(41.84)	(41.59)
Non Pay	(17.48)	1.26	(16.22)	(15.13)	1.09	(25.86)	(29.66)	(27.52)
Surplus / (Deficit)	**11.14**	**0.48**	**11.62**	**9.42**	**(2.20)**	**17.25**	**19.98**	**20.50**

Continued overspends within clinical ward areas, primarily on specialling costs on acute wards but also in A&E to cover vacancies with agency at a premium cost. Some underspending pay budgets coverted to recurring TWIP schemes in year now leaving vacancy factor largely unachieved. Underspends against pass through drugs and devices are offset with an underachievement of contract income.

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Surgical Services								
Income	46.93	(2.55)	44.38	43.81	(0.57)	73.87	79.12	74.65
Pay	(28.30)	0.09	(28.21)	(27.52)	0.69	(47.62)	(48.28)	(48.08)
Non Pay	(10.94)	(1.65)	(12.59)	(11.93)	0.65	(20.21)	(18.59)	(21.41)
Surplus / (Deficit)	**7.69**	**(4.11)**	**3.58**	**4.36**	**0.78**	**6.05**	**12.24**	**5.16**

Clinical Contract income down due to continued reduced level of elective surgery and ICU still not yet fully operational to planned level. Ward overspends within clinical ward areas, primarily on specialling costs, offset with underspend in ICU. Non pay underspend in drugs and clinical supplies. In month 7 Elective care and Drugs QIPP targets where allocated reducing our over all surplus.

	Plan for Period	Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Women's, Children's, Diagnostics and Therapies								
Income	27.62	(1.63)	25.99	25.91	(0.08)	44.61	47.38	44.53
Pay	(22.45)	0.76	(21.70)	(21.75)	(0.05)	(37.54)	(38.31)	(36.97)
Non Pay	(5.15)	0.13	(5.02)	(5.23)	(0.21)	(9.00)	(8.68)	(8.50)
Financing Costs	0.00	0.00	0.00	(0.00)	(0.00)	(0.00)	0.00	0.00
Surplus / (Deficit)	**0.02**	**(0.74)**	**(0.73)**	**(1.06)**	**(0.33)**	**(1.93)**	**0.39**	**(0.95)**

Unachieved SSP savings targets partially offset by continued underspends against vacant posts in Radiology & therapies that are difficult to recruit to. Radiology consultant vacancies partially offset by outsourcing services to external providers shown against non pay

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Corporate Services								
Income	101.40	7.92	109.31	109.57	0.26	190.94	175.49	191.53
Pay	(29.41)	(1.95)	(31.36)	(29.66)	1.70	(51.94)	(50.03)	(53.70)
Non Pay	(18.01)	(3.59)	(21.60)	(20.83)	0.77	(47.77)	(30.86)	(36.80)
Financing Costs	(10.75)	2.13	(8.62)	(8.39)	0.23	(3.62)	(18.44)	(14.77)
Surplus / (Deficit)	**43.22**	**4.51**	**47.73**	**50.70**	**2.97**	**87.62**	**76.17**	**86.27**

Favourable income variances within Education and Health Informatics are covering the under recovery within Torbay Pharmaceuticals, Research and the lower than anticipated donated asset income.
Pay underspends across corporate areas due to vacancies being held and non pay underspends are contributing to the achievement of TWIP targets

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
SSP Plans								
Income	4.24	(0.60)	3.64	2.96	(0.68)	5.43	7.26	6.62
Pay	1.66	(1.47)	0.19	0.00	(0.19)	0.00	5.52	0.62
Non Pay	1.66	(1.18)	0.47	0.00	(0.47)	0.00	5.52	2.01
Surplus / (Deficit)	**7.55**	**(3.25)**	**4.29**	**2.96**	**(1.33)**	**5.43**	**18.30**	**9.25**

SSP income behind planned year to date position by £0.68m
Pay and non pay forecast adverse variance due to original SSP target £11m; £3.06m of non pay budget has now been transferred to Independent Sector / CHC.

Items Outside of EBITDA

	Year to Date - Month 07			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Operating income/expenditure outside EBITDA					
Donated asset income	0.58	0.35	(0.24)	(0.33)	0.09
Depreciation/Amortisation	(8.47)	(6.22)	2.25	2.03	0.22
Impairment	0.00	0.00	0.00	0.00	0.00
Total	**(8.47)**	**(6.22)**	**2.25**	**2.03**	**0.22**
Non-operating income/expenditure					
Interest expense (excluding PFI)	(0.98)	(0.94)	0.03	0.03	0.01
Interest and Contingent Rent expense (PFI)	(1.05)	(1.03)	0.02	0.02	0.00
PDC Dividend expense	(1.31)	(1.28)	0.03	(0.00)	0.03
Gain/loss on disposal of assets	0.00	0.05	0.05	0.05	(0.00)
Other	0.00	0.00	(0.00)	0.00	(0.00)
Total	**(3.34)**	**(3.20)**	0.13	**0.10**	**0.04**
Total items outside EBITDA	**(11.81)**	**(9.42)**	**2.39**	**2.13**	**0.26**

Key points

- Donated asset income is £0.2m adverse to plan, due to a delay in these capital projects. This variance does not affect performance against the control total.
- Depreciation/Amortisation is £2.3m favourable to plan, largely due to the reassessment of asset lives in 2016/17 and the reduced level of capital expenditure in 2017/18.

Balance Sheet

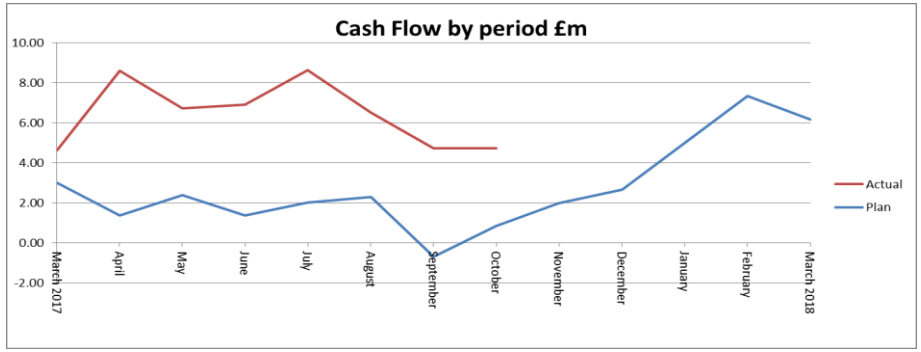
	Year to Date - Month 07			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Non-Current Assets					
Intangible Assets	10.88	8.41	(2.46)	(2.19)	(0.27)
Property, Plant & Equipment	171.52	155.06	(16.46)	(15.47)	(0.99)
On-Balance Sheet PFI	18.24	14.71	(3.53)	(3.51)	(0.02)
Other	1.79	2.28	0.49	0.52	(0.03)
Total	**202.42**	**180.45**	**(21.97)**	**(20.66)**	**(1.32)**
Current Assets					
Cash & Cash Equivalents	0.83	4.71	3.88	4.32	(0.44)
Other Current Assets	25.03	31.84	6.81	4.80	2.01
Total	**25.86**	**36.55**	10.69	**9.12**	**1.57**
Total Assets	**228.28**	**217.00**	**(11.28)**	**(11.54)**	**0.26**
Current Liabilities					
Loan - DH ITFF	(7.12)	(6.87)	0.25	0.25	0.00
PFI / LIFT Leases	(0.70)	(0.73)	(0.04)	(0.04)	0.00
Trade and Other Payables	(30.08)	(35.36)	(5.28)	(5.01)	(0.27)
Other Current Liabilities	(1.95)	(1.96)	(0.01)	1.19	(1.20)
Total	**(39.85)**	**(44.92)**	**(5.07)**	**(3.60)**	**(1.46)**
Net Current assets/(liabilities)	**(13.99)**	**(8.36)**	**5.63**	**5.52**	**0.11**
Non-Current Liabilities					
Loan - DH ITFF	(68.42)	(60.43)	7.99	6.77	1.23
PFI / LIFT Leases	(19.85)	(19.88)	(0.03)	(0.05)	0.02
Other Non-Current Liabilities	(3.94)	(3.87)	0.07	(0.02)	0.09
Total	**(92.20)**	**(84.18)**	**8.03**	6.70	1.33
Total Assets Employed	**96.23**	**87.91**	**(8.32)**	**(8.44)**	**0.12**
Reserves					
Public Dividend Capital	(61.87)	(62.22)	(0.35)	0.00	(0.35)
Revaluation	(46.23)	(36.32)	9.92	9.92	0.00
Income and Expenditure	9.03	8.81	(0.22)	(0.22)	(0.00)
Total	**96.23**	**87.91**	**(8.32)**	**(8.44)**	**0.12**

Key points

- Non-current assets are £22.0m lower than planned, principally due to the reduced levels of 2016/17 asset revaluation and 2017/18 capital expenditure.
- Cash is £3.9m favourable to Plan, as explained in the commentary to the cash flow statement.
- Other Current Assets are £6.8m higher than Plan, largely due to income received in arrears (NHS England £2.5m, Torbay Council £2.1m and STF income £1.7m).
- Trade and Other Payables are £5.3m higher than Plan, largely due to a favourable change in the phasing of payments by the local CCG, offset by the paying down of the capital creditor.
- DH loans (non-current) are £8.0m lower than Plan, largely due to the delay in obtaining approval for new loans.
- PDC reserves have increased by £0.4m due to the first instalment of PDC relating to the GP streaming project.

Cash

Current Performance



	Year to Date - Month 07			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Opening Cash Balance (incl Overdraft)	**3.00**	**4.64**	**1.64**	**1.64**	**0.00**
Cash Generated From Operations	8.37	7.25	(1.12)	(0.54)	(0.58)
Working Capital movements - debtors	2.79	(3.90)	(6.69)	(4.67)	(2.01)
Working Capital movements - creditors	(0.16)	4.79	4.95	4.64	0.30
Capital Expenditure (accruals basis)	(15.85)	(2.66)	13.19	11.69	1.50
Net Interest	(1.72)	(1.56)	0.16	0.03	0.14
Loan drawndown	8.58	0.49	(8.09)	(6.87)	(1.23)
Loan repayment	(2.51)	(2.36)	0.15	0.15	0.00
PDC Dividend paid	(1.12)	(1.03)	0.10	0.10	0.00
Other	(0.54)	(0.94)	(0.40)	(0.76)	0.36
Closing Cash Balance (incl Overdraft)	**0.83**	**4.71**	**3.88**	**5.40**	**(1.52)**

Key points

- The actual opening cash balance was £1.6m favourable to the planned opening cash balance.
- Cash generated from operations is £1.1m adverse, largely due to the favourable SoCI variance of £1.0m excluding the favourable variance relating to depreciation (£2.3m), which is a non-cash item.
- Debtor movements are £6.7m adverse, including income received in arrears (NHS England £2.5m, STF income £1.7m and Torbay Council income £2.1m).
- Creditor movements are £5.0m favourable largely due to the phasing of payments by the local CCG, offset by the paying down of the capital creditor.
- Capital expenditure is £13.2m favourable, largely due to the delay in starting schemes.
- Loan drawdown is £8.1m adverse, largely due to the delay in obtaining approval for new loans.

Capital

Current Performance

	Year to date Mth 07 - Based upon Operational Plan (March 17)				Full Year Plan		
	Plan £m	Budget £m	Actual £m	Variance to Budget £m	Plan £m	F'cast to NHSI £m	Variance £m
Capital Programme	16.42	6.12	2.65	(3.47)	29.58	16.60	(12.98)
Significant Variances in Planned Expenditure by Scheme:							
HIS schemes	4.30	1.73	0.42	(1.31)	7.38	3.84	(3.54)
Estates schemes	10.27	2.99	1.30	(1.69)	19.03	9.33	(9.70)
Medical Equipment	0.85	0.91	0.46	(0.45)	1.46	1.43	(0.03)
Other	0.00	0.05	0.03	(0.02)	0.00	0.87	0.87
PMU	0.68	0.44	0.44	0.00	1.16	0.88	(0.28)
Contingency	0.32	0.00	0.00	0.00	0.55	0.25	(0.30)
Anticipated slippage	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Prior Year schemes	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	16.42	6.12	2.65	(3.47)	29.58	16.60	(12.98)
Funding sources							
Secured loans	0.00	0.49	0.49	0.00	0.00	0.67	0.67
Unsecured loans	8.58	0.00	0.00	0.00	14.71	1.83	(12.88)
Finance Leases	0.00	0.00	0.00	0.00	0.00	0.87	0.87
Disposal of assets	1.18	0.00	0.00	0.00	4.00	0.88	(3.12)
PDC	0.00	0.00	0.90	0.90	0.00	0.90	0.90
Charitable Funds	0.42	0.58	0.35	(0.23)	1.00	1.00	0.00
Internal cash resources	6.24	5.05	0.91	(4.14)	9.87	10.45	0.58
Total	16.42	6.12	2.65	(3.47)	29.58	16.60	(12.98)

Key points

Operational Plan. Capital expenditure plan of £29.58m, dependent upon: -

- New Independent Trust Financing Facility (ITFF) loans totalling £14.7m,
- Planned sale of Community properties and Kemmings Close totalling £4.1m,
- Delivery of NHSI revenue control total and consequently full access to STF.

Current position: -

- Gap in the revenue forecast to deliver the NHSI control total.
- Asset disposal proceeds in 2017/18 will be less than planned.
- Forecast underspend in (non-cash) depreciation charge being used to offset other cost pressures which have cash requirements.
- Consequently, in order to maintain solvency, the Trust's actual capital expenditure in 2017/18 will be substantially less than that planned.
- Value of approved schemes to date totals £12.0m.
- £2.8m of schemes being held subject to business cases and greater assurance around full CIP delivery
- Plan is to reapply for loans to support ED/UCC and Theatre capital schemes. If successful total capital outlay in 1718 is forecast to be £1.8m.

Actions outstanding

- Present Quality Impact Assessment to the Trust Board for those schemes that were planned for progression in 2017/18 but which are not currently part of the prioritised schemes.

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	31,721	18,660	18,716	56	-71	0%
Elective	4,560	2,524	2,051	-473	-269	-19%
Non-Elective Emergency	28,344	16,681	17,168	487	279	3%
Non-Elective Non-Emergency	3,479	2,044	1,925	-119	-97	-6%
Non-Elective CDU	3,930	2,279	2,609	330	279	14%
Non-Elective AMU	1,648	1,064	1,510	446	282	42%
TOTAL APC	**73,682**	**43,252**	**43,979**	**727**	**403**	2%
New	103,112	61,722	59,093	-2,629	-2,555	-4%
F-Up	275,127	162,452	151,443	-11,009	-9,546	-7%
TOTAL OPA	**378,239**	**224,174**	**210,536**	**-13,638**	**-12,101**	-6%
A&E	76,280	46,089	48,112	2,023	1,823	4%

Activity variances to plan -Month 7

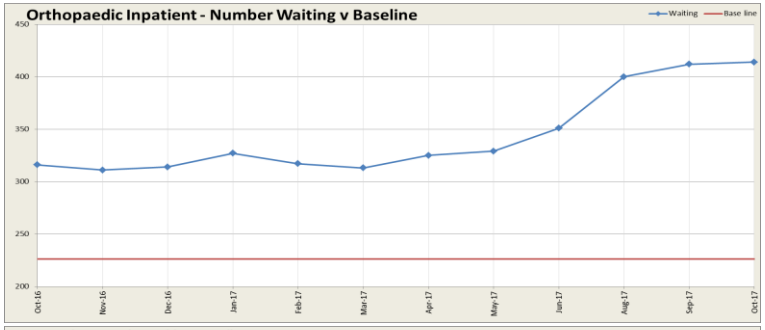
Activity variances for M7 and M6 against the contract activity plan are shown in the table opposite. In M7 there is a continued trend of underperformance to commissioned plan for elective activity: The main variation is against elective inpatients (19% behind plan, 13% last month) and outpatient follow up appointments (7% behind plan, the same as last month).

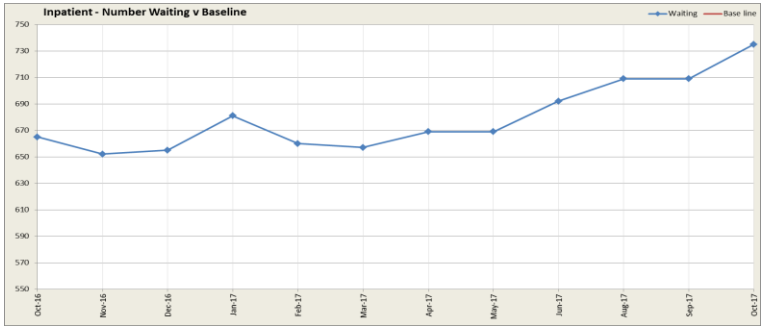
At treatment function level the greatest variance is in orthopaedics with 148 inpatient cases behind plan (£670k). A number of decisions have been taken to not replace clinical staff in particular some 'training and middle grade' posts at this time. It is noted that the newly introduced therapy led interface services have been successful in reducing the conversions to surgery.
For follow ups, the specialty with greatest variance against plan is Dermatology 2,700 appointments behind plan (£370k)

SDU's are completing a review of areas that are significantly off plan and reporting this analysis to the Executive Quality and Performance review meetings.

The underperformance against commissioned elective activity plan has been escalated as a concern. The underperformance is one of the factors behind the deteriorating RTT performance. This is currently being reviewed. **The committee is asked to note:**

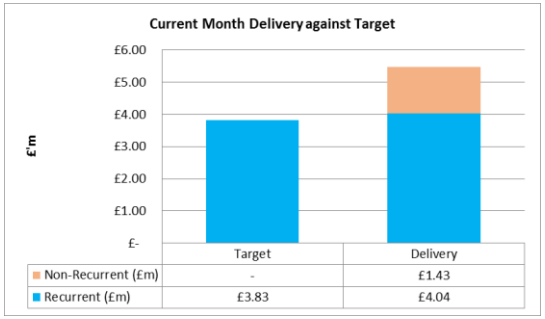
- The activity plan is based on the assessment of actual capacity and therefore does not include any historical waiting list initiative activity.
- Risk Share Agreement mitigates any immediate income risk.
- Activity underperformance is contributing to cost savings on non pay consumable items.
- Risk remains that reduced elective activity will increase waiting times and impact on RTT performance and patient experience.
- The RTT risk and assurance group are maintaining the performance oversight with the RTT position and forecast reviewed at individual team level.
- Referrals over a rolling 12 month period are remaining at historical levels .
- The winter plan to escalate bed capacity and medical cover during December / January and beyond if needed is likely to have a further impact on elective activity.
- Overall waiting list number for inpatient are now increasing reflecting the increase in orthopaedics numbers waiting inked to this underperformance in activity.

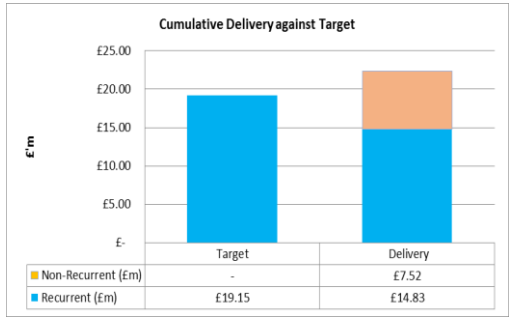




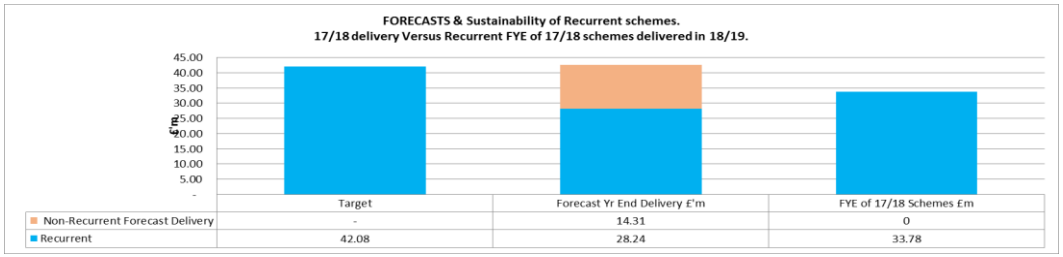
CIP Delivery: Current Mth, Cumulative & Forecast

a) Current Month and Cumulative to Current Month Delivery against Target





b) Year End Forecast Delivery against Target and Recurrent FYE forecast delivery.



a) Current Month and Cumulative to Current Month Delivery against Target

Summary>

-Current Month Surplus: £1.6m

-Cumulatively Surplus: £3.2m

Commentary>

The current month improvement is predominantly due to the backdated phased effect of £4m income received from the Local Authority /risk share agreement. This was built into the year end forecast, last month.

b) Year End Forecast Delivery against Target and Recurrent FYE forecast delivery.

Target: The CIP target shown is £42.1m. This comprises £41.7m of CIP and £1.3m of Income Generation Saving proposals.

Target: **£42.1m**
Yr End Forecast Delivery: **£42.6m**
Surplus: **£0.5m**

Mitigated by:
-Further SDU Slippage **-£0.6m**

F/Cast: Recurrent FYE of 17/18 projects: £33.8m

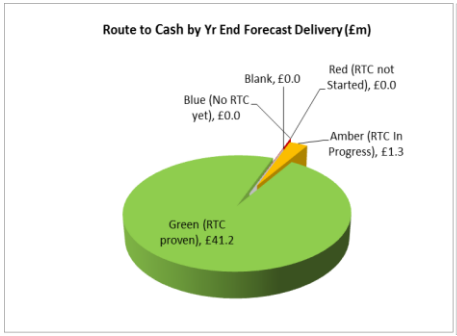
Risk: Presumes all schemes listed deliver (See Delivery Assurance)

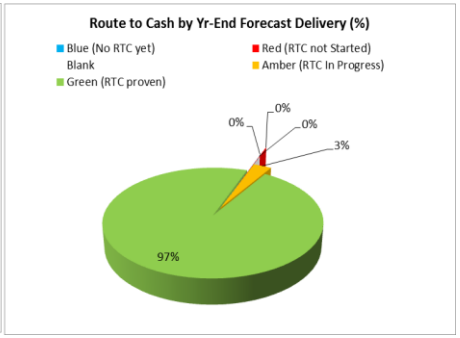
Month 7 Note:

The above position represents the most current position, based on information that became available after we had submitted the Month 7 result to NHSI.

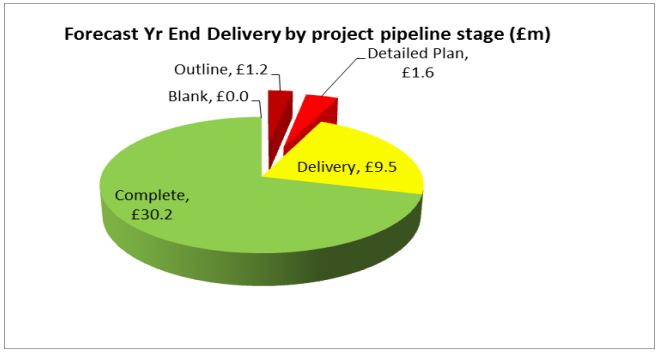
CIP- Delivery Assurance - Yr end delivery forecast-

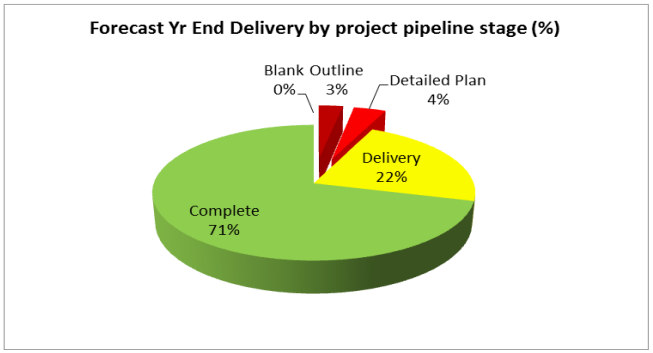
c) CIP Delivery Assurance- Route to Cash





d) CIP Delivery Assurance:- Pipeling stage





(c) CIP Delivery Assurance:- Route to Cash

The vast majority of the £42.6m forecast delivery has a proven route to cash, i.e: £41.2m (97% of forecast delivery total) with £1.3m (3% of forecast delivery total) identified as having a route to cash analysis in progress.

(d) CIP Delivery Assurance:- Pipeline stage

Of the projects comprising the £42.6m forecast delivery:

£39.7m (93%) are either Complete, and delivering savings or in "Delivery" stage whereby the project is finalised but savings awaited.

£2.9m (7%) relates to schemes in outline or in detailed plan stage. However these projects are constantly being reviewed to scope delivery potential.

This demonstrates a strong level of delivery assurance.

Operational Performance Focus

Performance Summary

STP / NHSI operational plan - Monitored indicators

Indicator	National Standard	Operational plan trajectory (M7)	Trust performance (M7)
A&E 4hr waits (STF)	95%	92.0%	92.7%
RTT 18 week waits	92%	90.7%	84.04%
62 day Cancer waits	85%	85%	85.8%
Diagnostics waits < 6 weeks	99%	No trajectory	96.8%

NHSI Operational Plan indicators. (Month 7)

A+E - The STF operational performance standard in October for time spent in accident and emergency department has been met.

RTT - The RTT position is not met - plans to prevent further deterioration have been agreed. Forecast year-end performance 86% with no patient waiting over 52 weeks.

Cancer - The standard for urgent suspected cancer referral and treatment within 62 days has been met. The forecast is to achieve the standard in Q3.

Diagnostics - The diagnostics standard is not met but has improved from last month. Dexa scan waiting times have improved with the successful relocation to community setting. The greatest number of long waits are for routine MRI.

Areas highlighted requiring improvement

4 hour standard - The STF trajectory for Accident and Emergency waiting times has been achieved in October with 92.7% against the trajectory of 92.0%. STF funding (30% ED performance related) for Q3 is assessed against both the delivery of the GP streaming pathway and aggregate 4 hour performance. The aggregate target performance for achievement of STF in Q3 is 91.32%.

RTT - The RTT performance has improved slightly in October with 84.04% against the trajectory of 90.7%. This remains below the National standard 92%.
An assessment of current plans has been completed. This confirms a forecast to achieve revised forecast of 86% by 31st March 2018. Further opportunities to improve performance are being considered by teams along with contingencies to manage the risk of winter pressures by reducing scheduled elective capacity.
The number of longest waiting patients over 52 weeks has increased to 26 at the end of October. Operational teams have confirmed that the action plans already agreed will target these longest wait patients and that there will be no patients waiting over 52 weeks by 31st March 2018.
The RTT Risk Assurance Group chaired by the Deputy COO meets biweekly and continues to review issues being escalated from operational team meetings and maintain oversight against compliance to RTT booking chronology and data quality.

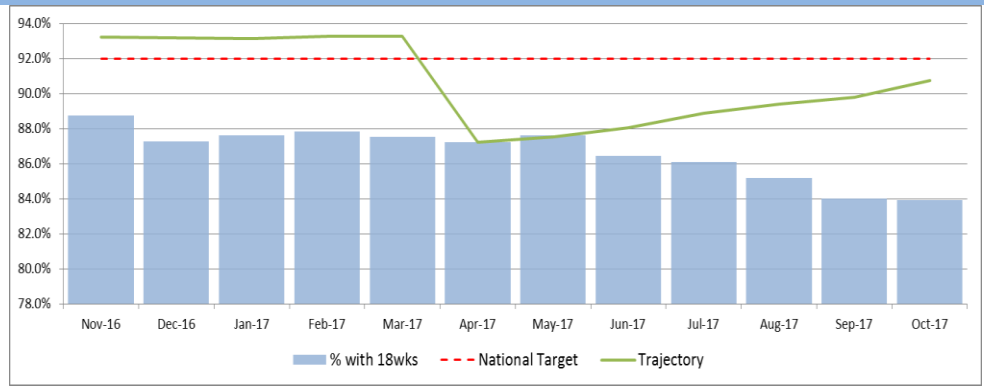
Cancer standards -
October 62 day – 85.7%. Validation and data quality review will continue to the end of November prior to final upload at the beginning of December.
During September and October additional colonoscopy lists have been run on Saturday mornings as part of the agreed initiative to reduce these waiting times. Improvement in the Lower GI 62 day pathway performance following the reduction in wait for colonoscopy is now expected.
There continues to be capacity issues with Urology Skin and Lung pathways.
The 2 week standard from urgent referral to first appointment (all sites) remains below target in October however is expected to be compliant in November. This reflects the reduction in waits for Dermatology urgent referral over the last 6 weeks. The Breast symptomatic waiting times improved and achieved 95% in October against the 93% standard. The impact on cancer pathways from histopathology service capacity risk is being assessed.

Diagnostic waits - The number of patients with a diagnostic wait over 6 weeks reduced in October to 114 (3.2%) from 153 (3.9%) in September. This improvement reflects improvement in Dexa scan waits following the successful relocation of the unit to Paignton Hospital. MRI waiting times have increased in October. As part of a bid to improve performance against cancer targets mobile van visits are being scheduled in the coming months.

NHSI Indicator - Referral to Treatment

Specialties with highest numbers of patients over 18 weeks RTT

	>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Trauma & Orthopaedics	284	126	410	79.65
Upper Gastrointestinal Surgery	223	38	261	62.77
Pain Management	44	206	250	63.56
Urology	205	43	248	78.89
Cardiology	23	222	245	81.07
Gastroenterology	119	119	238	83.29
Rheumatology		193	193	72.43
Ophthalmology	110	50	160	90.70
Neurology	4	149	153	72.97
Dermatology	1	122	123	90.39
Respiratory Medicine		121	121	82.21



At the end of October, 84.04% (84.01% last month) of patients waiting for treatment had waited 18 weeks or less at the Trust from initial referral for treatment. This is assessed as RED as the performance is not in line with the agreed trajectory of 90.7% and remains below the 92% national standard.

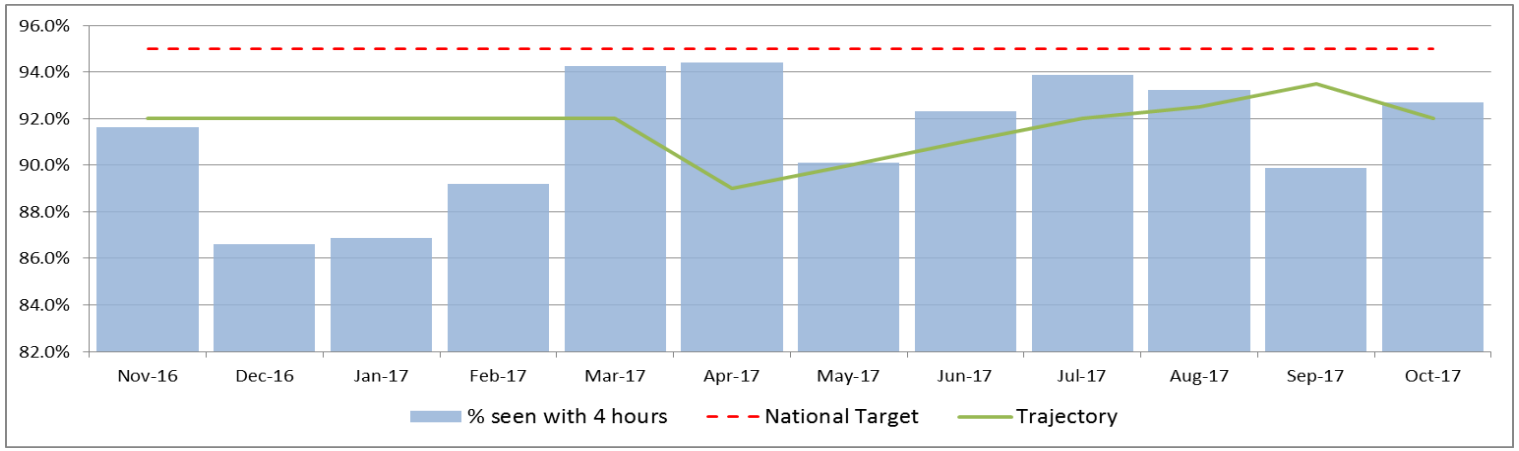
A revised trajectory for delivery of RTT within the 18 week standard has been agreed across the STP. The revised target is to maintain the performance achieved in July 2017; for TSDFT this is 86.1%. An assessment has been made by specialty and this confirms that the revised trajectory can be achieved from current plans.
The STP have further committed to remove all over 52 week wait patients by 31st March 2018

The challenge of managing and reducing demand remains key to the longer term delivery of the RTT standard. Business planning for 2018-19 is underway with. The introduction of "pre choice triage" a process to offer advice against referrals before a patient is called for an appointment and project to reduce follow up appointments are both priority areas to implement.

52 week monitoring - At the end of October, 26 patients were waiting longer than 52 weeks (16 in September). There has been some delay in setting up the additional operating lists for UGI, however, surgeons have now confirmed availability and lists being booked. A request for locum support has been made to secure the additional activity approved as part of this plan.
The forecast is that there will be no patients waiting over 52 weeks for treatment 31st March 2018.

Governance and monitoring: All RTT delivery plans are reviewed at the bi-weekly RTT and Diagnostics Assurance meeting chaired by the Deputy Chief Operating Officer (DCOO) with the CCG Commissioning Lead in attendance.

NHSI indicator - 4 Hours - Time spent in Accident and Emergency Department



The STF trajectory for Accident and Emergency waiting times has been achieved in October with 92.7% discharged or transferred within 4 hours against the trajectory of 92.0%. STF funding (30%) is assessed against both the delivery of the GP streaming pathway and aggregate 4 hour performance over each quarter performance. The aggregate performance for achievement of STF in Q3 is 91.32%

A reduced number of days assessed as Opel 3 (RED) recorded in October to the September position. This indicates that overall system pressures on patient flow in October were reduced. The operational difficulties in the care home and domiciliary care sector remain; however the system has stabilised following actions taken to support the capacity during October.

Escalation status

	June	July	August	September	October
Opel 1	15	30	15	4	12
Opel 2	10	1	11	9	14
Opel 3	5	0	4	17	5
Opel 4	0	0	1	0	0

Winter resilience planning. The trust has done extensive planning to provide assurance to commissioners and NHS England on our plans to manage emergency demand over the winter period. A winter plan and whole system process has been signed off at the urgent care delivery board.

Part of the plan to increase resilience to winter pressures are linked to the 7 big work programmes agreed last month. These schemes were initially agreed as a response to the operational pressures experienced in September. Each scheme has executive lead with progress summary below:

Big 7 workstreams - progress update 16th November 2017

Winter resilience scheme	Update	RAG
Increased support to community services: domiciliary care packages and an extended rapid response service.	• Met with Mears to support recruitment and retention plans • Additional rapid response capacity being recruited • New provider identified to support capacity over Christmas • New pathways being established to support access to rapid response from Hospital with ongoing assessment of need before long term care agreed • Productivity improvements being targeted in rapid response teams	
Improved single point of referral to community services for all patients ready for discharge.	• Referral form development to be used across all localities • Pilot to be run in Brixham • Clinical criteria for nurse led discharge in place • Discharge team now working from community • 5 week pilot of IC in reach to ' pull' appropriate patients from inpatient services	
Increase intermediate care at home volumes and acuity of case mix to enable less bed based placements.	• IC, RADS, District Nursing and MAAT Team involved • JD's reviewed to take account of new requirements • Engagement with community staff • Out of hours nursing and MAAT priorities • Working with Primary care and SWAST on direct referral pathways to IC	
Ambulatory pathways - optimise services to full capacity to maximise patients benefiting from these ambulatory and diagnostic functions both in and out of hours.	• Alternative pathways identified for 5 patients groups • Years data compared with ambulatory care directory setting out scale of the opportunity • Clinical leads identified with requirement to set out plans for 4 next 4 weeks and 4 months • Proof concept being tested in Fab week	
Use of technology to provide better management of frequent flyers and support to residential care homes.	• Collecting baseline data on admissions from care homes • NHS mail accounts being put in place in care homes • Identified risk stratification tools • Identification of ' frequent flyers'	
Winter Leadership: dedicated team to manage the Winter Plan and on site operational management function.	• Team in place • Links established with wider system leadership teams • Site management team specified • Visit to RD&E to look at model • Job descriptions written • Executive approval to progress to recruitment	
Communication, engagement and information strategy.	• Overarching communications plan internal and external being implemented • Links made with each of the priority areas • Overarching data set being established building on system measures identified • Capacity identified in Information team to respond to priority areas as required	

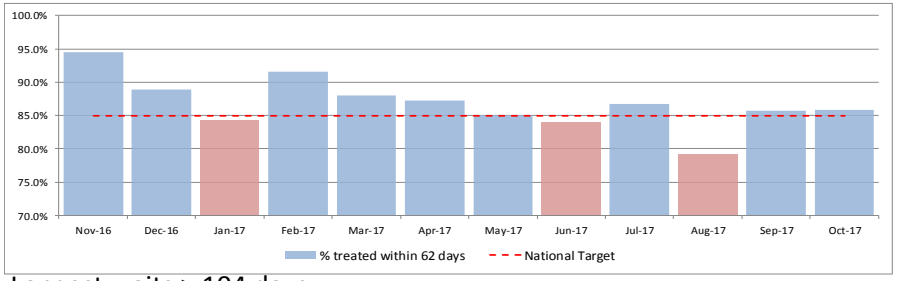
The 7 big scheme leads are meeting on a weekly basis to maintain pace and to ensure barriers to implementation rapidly resolved.

Cancer treatment and cancer access standards

CWT Measure	Target	October 2017 Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	735	419	1154	63.7%
14 Day - Breast Symptomatic referral	93%	76	4	80	95.0%
31 Day 1st treatment	96%	166	7	173	95.95%
31 Day Subsequent treatment - Drug	98%	109	0	109	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	51	3	54	94.4%
31 Day Subsequent treatment - Surgical	94%	23	1	24	95.8%
31 Day Subsequent treatment - Other		34	0	34	100.0%
62 day 2ww / Breast	85%	81	13.5	94.5	85.7%
62 day Screening	90%	13.5	1	14.5	93.1%
62 day Consultant Upgrade		6	0.5	6.5	92.3%

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

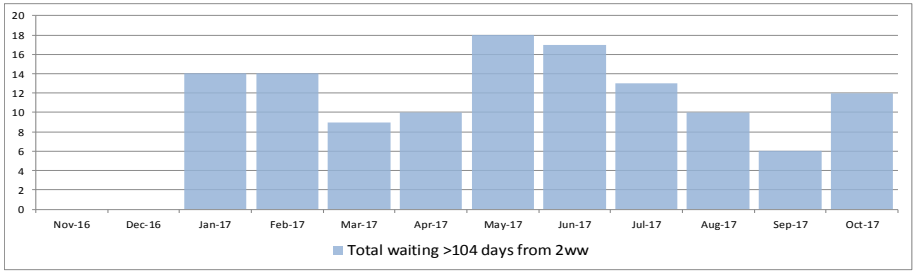
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
1st treatments (from 2ww)	91	99	101	77	83	62.5	97.5	106	94.5	120	98	95
Breaches of 62 day target	5	11	16	6.5	10	8	14.5	17	12.5	25	14	13.5
% treated within 62 days	94.5%	88.9%	84.2%	91.6%	88.0%	87.2%	85.1%	84.0%	86.8%	79.2%	85.7%	85.8%
National Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Longest waits > 104 days

Cancer - Patients waiting >104 days from 2ww

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Cancer not discounted	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	9	6	4	7
Confirmed cancer	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	4	2	5
Total waiting >104 days from 2ww	n/a	n/a	14	14	9	10	18	17	13	10	6	12



Cancer standards - Two cancer treatment time standards have not been met in October. Table opposite shows the October performance:

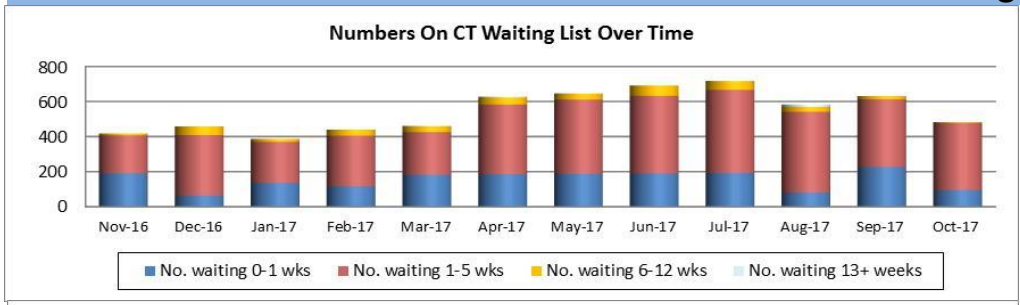
Urgent cancer referrals 14 day 2ww - This position is being driven by the capacity pressures in Dermatology 323 (77% all breaches) and Lower GI 44 breaches (10%). The capital works to increase clinic capacity and relocate Dermatology clinic activity to the John Parks Unit are completed however the recovery plan relies on the continued support from locum doctors whilst substantive posts remain vacant, this remains a challenge. Good progress has been made throughout October and the 2ww standard is now being delivered in November.

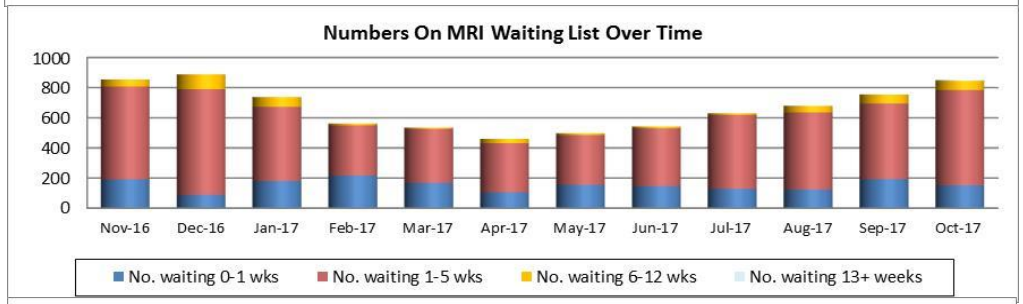
31 day from diagnosis to 1st treatment - 7 breaches of standard - combination of capacity cancellation and patient choice - no new operational risks identified. Forecast to deliver in Q3.

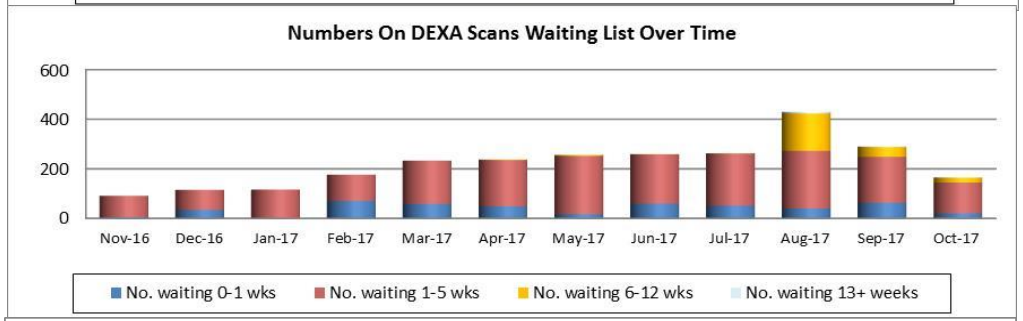
Cancer 62 day standard was met in October (85.7%) standard 95%.
The forecast for the Quarter 3 position is achievement of the standard.
The breaches are in the following cancer pathways:
Urology = 3 Lower / Upper GI = 5 Lung = 5
The capacity pressures and delays in the diagnostic phase of the pathways are being targeted together with scheduling of additional theatre capacity.
Additional list have been undertaken to reduce colonoscopy waits that had increased recently following a change in pathway "direct to test". These waiting times have now reduced to 16 days from 42 days. The team anticipate booking within 14 days and to maintain that position going forward.

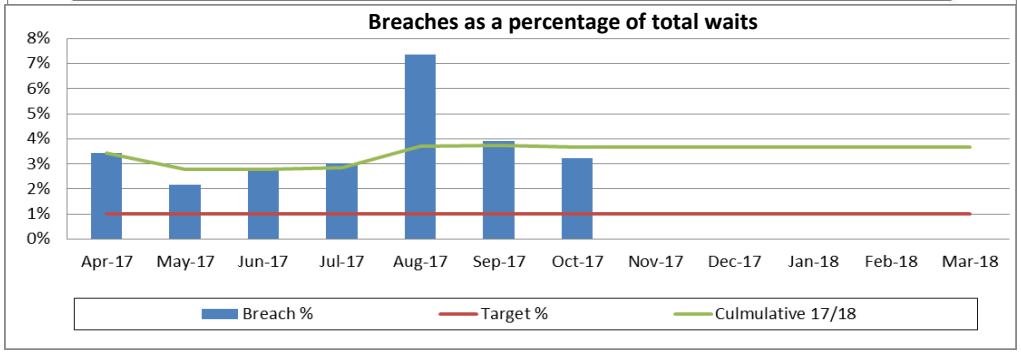
Longest waits > 104 days.
The most recent guidance from NHSE is that there will be a zero tolerance on the number patients who have confirmed cancer and receive treatment after 104 days from December 2017. To facilitate our early warning of these patients reaching 104 days a 90 day trigger has been established in internal monitoring reports and these patients to be further reviewed at MDT. This validation and escalation process is demonstrating gradual reduction in these longest waiting pathways.

NHSI indicator - Diagnostic waits









The number of patients waiting over 6 weeks at Month 7 continued to decrease from 3.92% to 3.21% of total patients waiting in October; this is above the national target of 1%.
The highest number of long waits being identified in MRI with 66 patients over 6 weeks (50% of total long waits).

MRI focus update

The MRI service consists of 2 scanners delivering 15,000 scans per year. This serves demand from OP/GP and IP referral sources. Overall 82% of the scans are for elective OP/GP requested and 13% are IP referrals. Demand for complex and thus long examinations is increasing, e.g. MR Cardiac, MR Prostate, Whole Body MR. Growth in demand 5.5% PA.
The service runs Mon-Fri 08:00-20:00 and Sat/Sun 09:00-17:00.

Staffing - Currently there are 6.0WTE Radiographers in the service, with 1.4WTE vacancy factor (total establishment 7.4WTE)

Mobile unit for Cancer Alliance funding - There are 15 scan days booked totalling up to 300 patient visits. This should reduce the MR waiting list to around 600, which will still fail to make MRI fully 6WW compliant, though will improve the picture considerably. To reach full compliance will likely require additional outsourcing and full utilisation of MR capacity through recruitment.

Options to increase capacity:

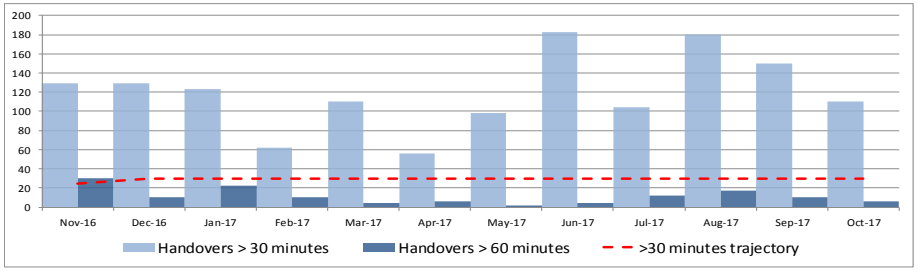
- recruit to vacant posts / seek agency staff;
- mobile MRI service for 10-15 days and then periodically at a cost of £13,000 per 5 day visit, plus reporting costs.

Demand management. Work is being undertaken with commissioners to agree how demand levels for both CT and MRI scans vary across different areas and referral routes. The plan is to complete this analysis and establish a demand management programme to support capacity planning in 2018/19.

Other Performance Exceptions

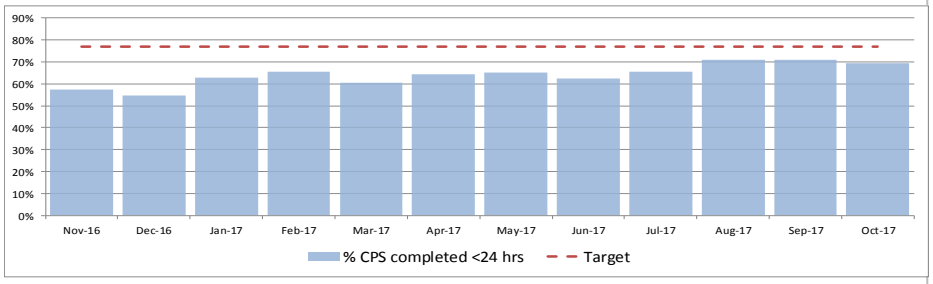
Ambulance handovers

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Handovers > 30 minutes	129	129	123	62	110	56	98	183	104	180	150	110
Handovers > 60 minutes	30	10	22	10	4	6	2	4	12	17	10	6
>30 minutes trajectory	25	30	30	30	30	30	30	30	30	30	30	30



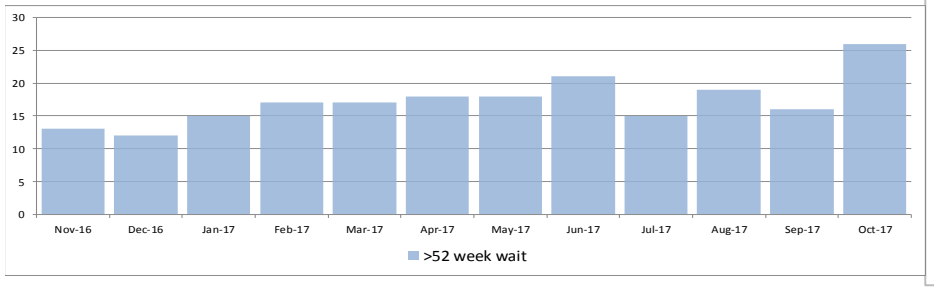
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Discharges	1102	1079	1258	1230	1355	1079	1239	1204	1179	1268	1239	1269
CPS completed within 24 hours	1916	1981	2004	1883	2234	1674	1905	1925	1803	1787	1746	1825
% CPS completed <24 hrs	58%	54%	63%	65%	61%	64%	65%	63%	65%	71%	71%	70%
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%



RTT Incomplete Pathways longer than 52 weeks

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
>52 week wait	13	12	15	17	17	18	18	21	15	19	16	26



Ambulance Handover

The number of ambulance Handovers delayed over 30 minutes remains above planned levels. The Emergency Department continues to meet regularly with the Ambulance Trust and have an escalation plan in place when handovers start to become delayed. The longest delays being those over 60 minutes are being managed with low levels being maintained.

Care Planning Summaries (CPS)

Improvement remains a challenge to complete CPS's within 24 hours of discharge. The challenges remain with the manual processes and duplication of information already recoded . The strategy is to reduce the manual entry requirements and demands on junior doctor time by increasing the automatic transfer of data from existing electronic records. Prioritisation of junior doctor time also remains a challenge. Weekly performance is shared with all teams.

52 week waits

The number of people waiting over 52 weeks at the end of October increased to the highest level recorded with 26 patients waiting at the month end over 52 weeks for first treatment (16 in September).
The specialties are:

Upper GI	15
Urology	8
Cardiology	2
Rheumatology	1

Additional operating capacity has been approved for Urology and Upper GI however this is proving difficult to realise.
Teams have now confirmed plans are in place to have no patients waiting over 52 weks by 31st March 2018. The longest waits by time band are below

Row Labels	Count of wait_band
>52-62 weeks	21
>62-72 weeks	4
>72 weeks	1
Grand Total	**26**

Social Care and Public Health Metrics - October

'Torbay Social Care KPIs	2017/18 full year target	2017/18 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	92%	92%	93%	On target
% clients receiving direct payments	28%	27.1%	24.2%	Below target. Performance remains static but target is increasing. The Trust intends to improve take up through My Support Broker and work with the voluntary sector.
% clients receiving a review within 18 months	93%	93%	88%	Below target. Clients in care homes are now being reviewed by location rather than date for efficiency. Many clients at home are being reviewed by 'My Support Broker' and these are being done in the most efficient order.
Timeliness of social care assessment	70%	70%	78%	On target
No. of permanent care home placements (snap shot)	617	627	632	Within agreed tolerance
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	599.0	599.0	554.0	On target
Carers receiving needs assessment, review, information, advice, etc.	43%	25.1%	33.9%	On target
% carers receiving self directed support	85%	85%	79%	Below target. A higher proportion of Emotional Support Vouchers redeemed at the start of the financial year have caused this drop in performance as ESVs are not counted as self-directed support. Situation being monitored by carers
% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	100%	100%	On target
% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	7.6%	On target
% Adults with learning disabilities in paid employment	4.0%	4.0%	3.5%	Below target. Complexity of the client group and limited employment opportunities in the Torbay area make this a challenging target but the Trust are exploring working with voluntary organisations to improve paid employment opportunities. Trust also reviewing data quality of recording. This KPI involves a relatively small number of clients and 2 additional people in paid employment would meet target.

The Social Care metrics relate to the Torbay LA commissioned services. Comments against indicators are shown in the dashboard above. The metrics and exceptions are also reviewed at the monthly Executive Quality and Performance Review meetings. The headline risks currently being managed are:

- Nursing and residential home market and capacity;
- Domiciliary care provider not meeting service level demand and contract queries raised;
- Emergency Duty Service - recruitment issue, now been adressed staff to start in January 2018;
- Continuing Health Care (CHC) for placed people volume and price pressures.

Public Health Services			
CAMHS - % Urgent referrals seen within 1 week	68%	68%	82%
CAMHS - % patients waiting under 18 weeks at month end [B]	92%	92%	100%
% of face to face new birth visits within 14 days *	95%	95%	84%
Children with a child protection plan * [B]		..	254
4 week smoking quitters Q1 ** [B]		50	80
Opiate users - % successful completions of treatment Q1 ** [B]		8.0%	8.4%

Public Health

The Public Health metrics are reviewed with commissioners and at the Community SDU board: The headline messages for Public Health performance are:

- CAMHS - waiting times from referral to assessment and commencement of treatment remain good.
- Health visiting - The metric is reporting 82% compliance however the service confirm that no New Birth Visits have been missed. Babies in Special Care unit may not be reviewed. The team are continuing to work to improve the reporting with the use of the new PARIS system.

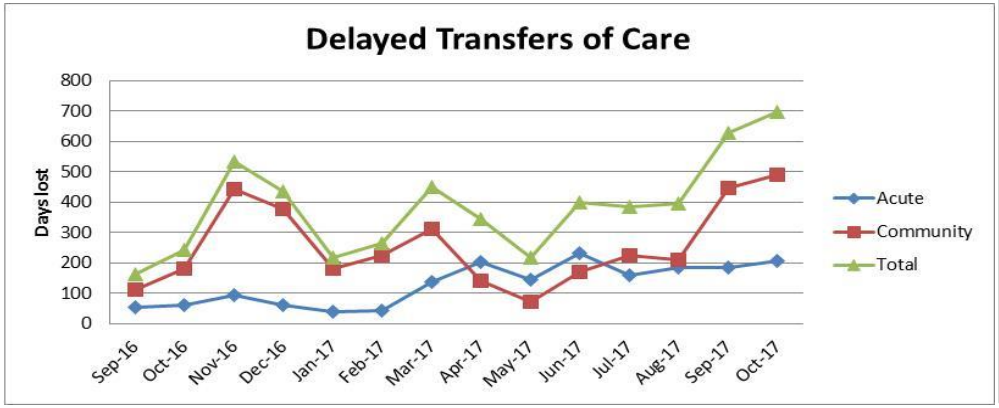
Community Services

Community Hospital Dashboard - Summary of Key Measures - October-17

	Act. 15/16 Outturn	16/17 Year End Target	Target Oct 17	Oct-17	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges							
Total Admissions (General)	1,830	2,520	213	238	1,649	1,466	↑
Direct Admissions (General)	292	252	21	17	150	143	→
Transfer Admissions (General)	1,538	2,268	192	221	1,499	1,323	↑
Stroke Admissions	277	281	23	22	177	157	↑
Transfers from CH to DGH	258	124	10	3	26	70	↓
Beds							
Occupied Bed Days	30,725			3,108	20,388		
Bed Occupancy [1]	85.5%	90.0%	90%	92.7%	89.3%	90.0%	
Available Bed Days	33,001			3,354	22,839		
Bed Days Lost to Delays[2]	2,472	1,274	107	490	1,846	747	↑
Bed Days Lost to Bed Closure (General)	892	1,462		1	40	624	↓
Length of Stay							
Delayed Discharges				71	246		
Average Length of Stay - Overall (General)	14.5		0.0	10.9	10.8	0.0	↓
Average Length of Stay - Direct Admissions	9.6	12.0		9.7	8.5	12.0	↓
Averale Length of Stay - Transfer Admissions	15.2	12.0		11.1	11.0	12.0	↓
Average Length of Stay - Stroke	18.1	18	18.0	12.5	15.0	18.0	↓
Long LoS (>30 days)	201	361	24	18	88	185	↓
MIUs							
Total MIU Activity [3]	32,696	40,479	3,151	3,102	24,982		
New MIU Attendances	27,037	34,746	2,716	2,641	21,531	22,007	→
All Follow Up Attendances	3,559	5,733	105	461	3,451	3,704	↓
MIU Four Hour Breaches	3	1	0	0	0	1	
Average Waiting Time (Mins) - 95th Pctile	41	45	45	48	46	45	

[1] RAG criteria for Bed Occupancy is: Green: 80% to 90%; Amber: 77% to 80% or 90% to 93%, Red: < 77% or > 93%, Purple: >=110%
[2] RAG criteria for Bed Days Lost to Delays: Green: <= 0% below or equal to target level, Amber: > 0% to <= 10% above target level, Red: > 10% above tar
[3] RAG rating for Total MIU Activity has been removed as different criteria are now set for new and F/Up attendances.

	17/18 Year End Target	17/18 YTD Target	17/18 YTD Actual	YTD Variance No.	YTD Variance %
Community Based Services					
Nursing activity (F2F)	199,889	117,195	117,852	657	1%
Therapy activity	74,545	43,485	39,159	4,326	10%
Outpatient activity	98,399	57,428	57,215	213	0%
No. intermediate care urgent referrals **[B]**	3,041	1,775	1,232	543	31%
No. intermediate care placements	1,665	976	624	352	36%
Intermediate Care - placement average LoS **[B]**	12	12	17.8	6	48%



The Community Hospital Dashboard highlights.

1. Community Hospital admissions remain over plan. The number of community admissions in October reflect the increased system pressures and number of days the unscheduled care system was in escalation of Opel 2 or above. The bed occupancy level increased to 93% (89% in August) and length of stay remaining constant at 10 days.
The impact from the overall reduction in bed numbers in both the acute and community settings is being closely monitored. In response to the September urgent care performance a number of programmes of work have been agreed as described earlier in this report to build capacity for alternatives to both community and acute bed based care.

2. MIU attendances are in line with plans. There have been no unexpected consequences following the closure of Paignton and Brixham MIU's. Waiting times in MIU's are being maintained with a median time of 46 minutes. No 4 hour breaches are reported in Month 7.

Community based services highlights

Nursing - Community nursing activity is tracking the same levels of activity as last year, in line with target.

Intermediate Care (IC) placements - The year to date average length of stay in IC placements remains above target, but has reduced in the last month to 13.3 days from 16 days . Teams have been focusing on reviewing all patients with a longer length of stay.
There remains variation between different Zones in the utilisation of IC and the percentage of referrals that convert to placement - this is being reviewed as part of the wider ICO evaluation work.

Delayed Transfers of Care

Teams continue to focus on the accurate recording of delays along with proactive planning with all partners for complex patients. In October the community hospital recorded delays have remained high. As in September this is not a great surprise as pressure from restricted care home bed availability and capacity to deliver packages of care remains a significant operational challenge. We are, however, reviewing these delays to understand more closely the causes and also ensuring that there have been no changes in the data collection processes.

Quality Focus

Quality and Safety Summary

Quality and Safety Summary

The following areas of good performance are noted:

1. The Hospital Standardised Mortality Rate (HSMR) remains in a positive position for the months of February to June (please note Dr Foster has a three month Data lag) July's data has a rate of 92.4 which is good and remains below the 100 average line. The overall yearly mortality is in line with the Trusts Unadjusted Mortality and the DH's Summary Hospital Mortality Index (SHMI).

Trust wide work is on going via clinical coding and the Mortality Surveillance Group in reviewing mortality on a monthly basis. This group feeds into the Trusts mortality dashboard and mortality scorecard which are presented to the Board.

2. Incident reporting continues to be well supported and all areas of the Trust are reporting within expectations. Themes and issues are collated on a monthly basis and help inform the 5 point Safety Brief and Clinical Alert System. All serious incidents are reported on the Strategic Executive Information System (STEIS) and via the National Reporting and Learning System upload. Serious incidents are managed in the Service Delivery Units and are presented to the Serious Adverse Events group for learning and sharing Trust wide. This group has links with the Improvement and Human Factors teams.

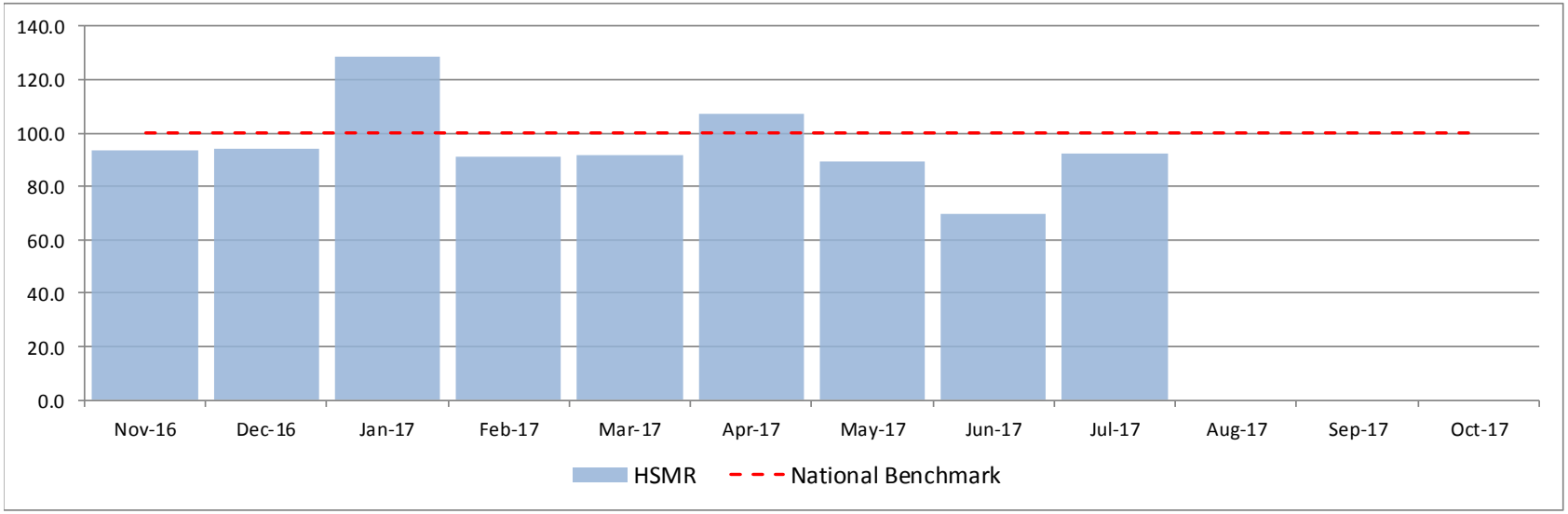
3. Infection Control are reporting a strong monthly hand hygiene compliance rate 99% and levels of Clostridium Difficile (CDT) remain low.

4. The Venous thromboembolism (VTE) drop in compliance has been noted and escalated to the Medical Director and will be included for discussion at the forthcoming Quality and Performance Review meeting .

Quality and Safety - Mortality

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
HSMR	93.7	93.9	128.4	91.1	91.5	107.0	89.1	70.0	92.2			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100



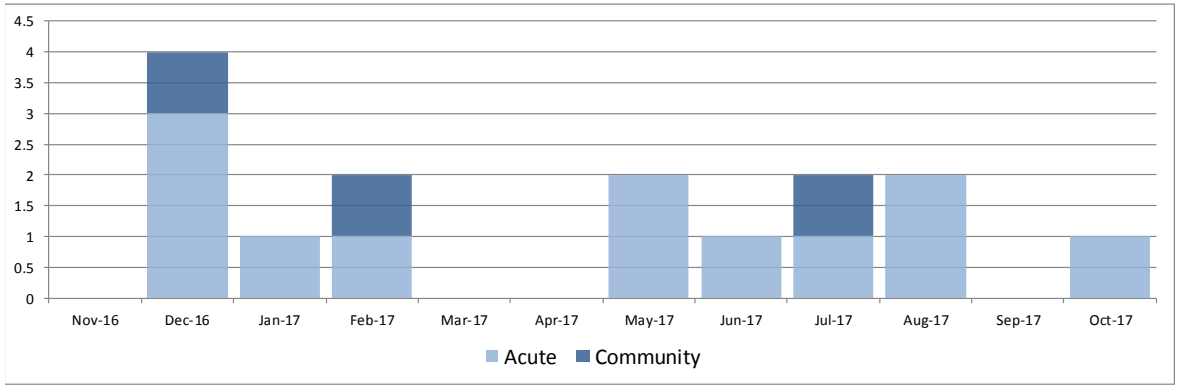
Trustwide mortality is reviewed via a number of different metrics however, Dr Foster allows for a standardised rate to be created for each hospital and therefore this is a hospital only metric. This rate is based on a number of different factors to create an expected number of monthly deaths and this then is compared to the actual number to create a standardised rate. This rate can then be compared to the English average, the 100 line. Dr Fosters mortality rate runs 3 month in arrears due to the national data submission timetable and therefore, Dr Fosters mortality has to be viewed with the Trusts monthly unadjusted figures.

The latest data for Dr Fosters HSMR is showing a low relative risk of 92.2 an increase on last month (national benchmark 100), which is positive and mirrors the general trend of the Trust. Mortality does has a cyclical nature and tends to rise during the colder months.

Quality and safety - Infection control

Number of Clostridium Difficile cases

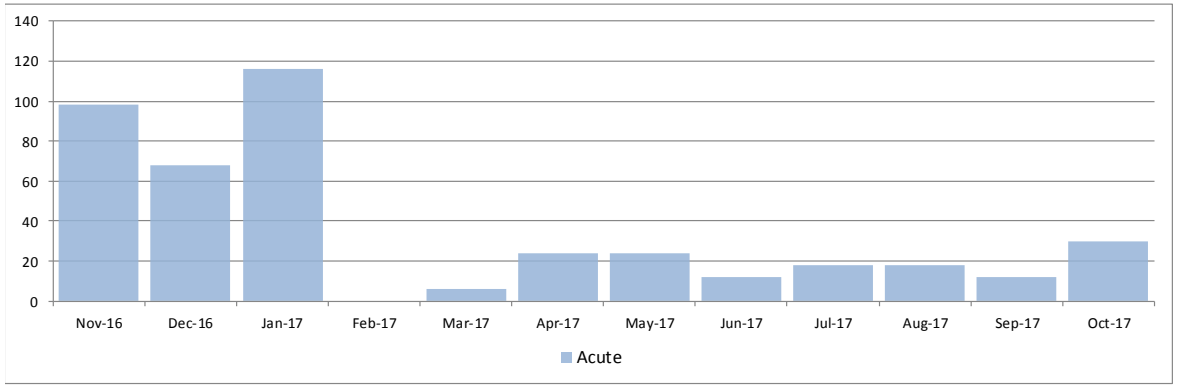
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Acute	0	3	1	1	0	0	2	1	1	2	0	1
Community	0	1	0	1	0	0	0	0	1	0	0	0



There is one CDT reported infection in October.
Against reported lapse in care , of the 8 cases reported to date 3 have been assessed as a lapse in care. Two being in the acute and one in community hospital bed based care.
Easch of the reported cases undergo a root cause analysis. Learning from these is used to inform feedback to teams and review of systems and processes.

Infection Control - Bed Closures (acute)

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Acute	98	68	116	0	6	24	24	12	18	18	12	30



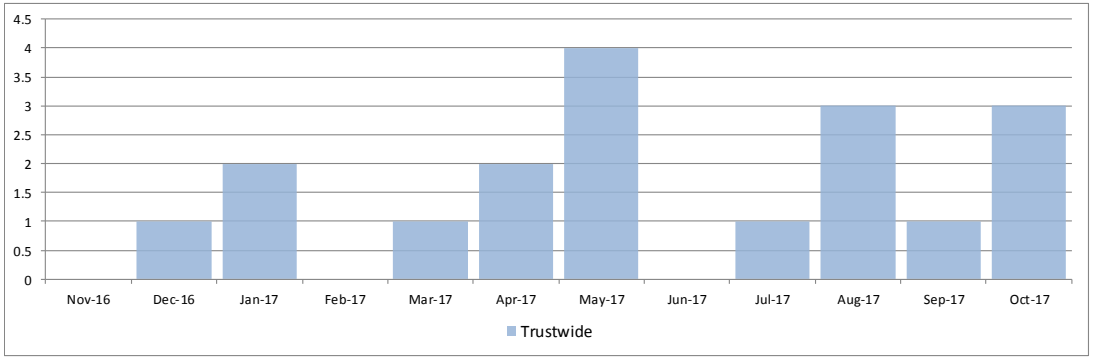
The Infection Control Team continue to manage all cases of potential infections with individual case by case assessment and control plans. The continued low number of bed days reported as lost due to bed closures from infection control is 30 in October. This is a positive indication of the robust processes and practices that are in place.

Hand hygiene compliance scores in all areas continue to be high with 98% recorded in October.

Quality and safety - Incident Reporting

Reported Incidents - Major and Catastrophic

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Trustwide	0	1	2	0	1	2	4	0	1	3	1	3

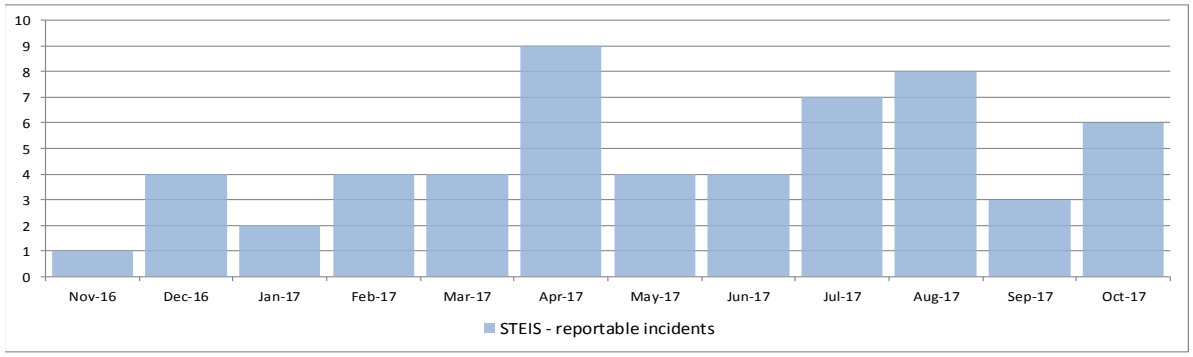


The Trust reported three serious incident in October.
2* Drug and Alcohol incidents
1* Radiology incident

All incidents are reported on the incident reporting system Datex.
All those categorised as major or catastrophic are discussed at a weekly incident review meeting. This then directs the process of management and further reporting of the incident e.g. STEIS reportable / SAE (Serious adverse events group)

STEIS Reportable Incidents

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
STEIS - reportable incidents	1	4	2	4	4	9	4	4	7	8	3	6



The Trust reported 6 incidents on STEIS from across the ICO in October .

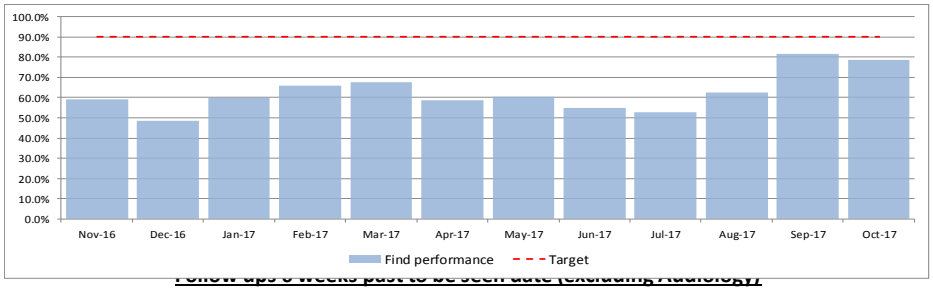
The incidents included 3 falls resulting in :
2 fractures
1 head injury,
1 neonate sent for cooling in Derriford
1 radiological incident
1 self harm incident

All incidents have followed normal reporting procedures and are being investigated with feedback to the patients and local teams.

Quality and safety - Exception reporting

Dementia - Find

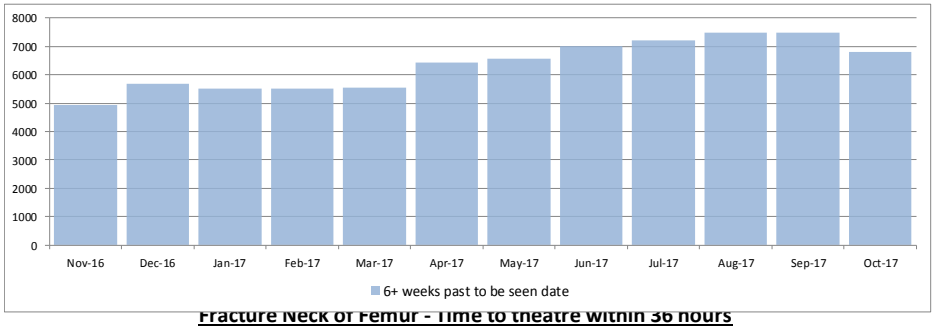
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Numerator	353	322	391	411	461	323	424	372	308	360	455	301
Denominator	533	577	595	574	613	499	632	603	496	520	536	383
Find performance	59.2%	48.6%	59.9%	65.8%	67.8%	58.9%	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



The NHSI Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors.
The improved performance has been maintained in October however remains below the required standard of 90%.
The interim solution to use a HCA to review daily all patients meeting the criteria for screening. is contributing to this improvement.
The switch to recording on Nerve Centre is the longer term solution. Roll out is imminent . This will remove duplication and loss of data from transcribing from written records into the care planning summary.

Follow ups 6 weeks past to be seen date (excluding Audiology)

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
6+ weeks past to be seen date	4941	5683	5512	5518	5548	6429	6550	6999	7209	7496	7477	6790

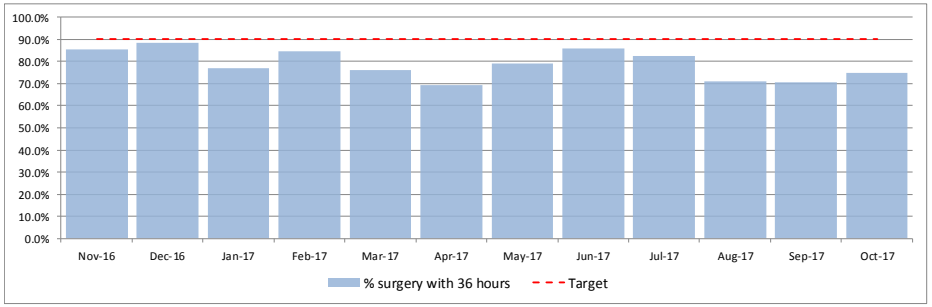


The number of follow ups waiting for an appointment greater that 6 weeks past their 'to be seen by 'date remains a concern. A review is being carried out to address areas of the greatest increase and determine if there is any increased clinical risk or opportunities for changing the clinical management of these patients.
In these latest reports Audiology has been removed due to data anomaly. The specialties with the highest numbers are shown below:

Specialty	Apr-17	Sep-17
OPHTHALMOLOGY	2902	3710
RHEUMATOLOGY	1318	1146
DERMATOLOGY	252	397
PAEDIATRICS	453	332
ENT	194	247

Fracture Neck of Femur - Time to theatre within 36 hours

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Patients	34	44	52	26	46	39	29	36	34	31	34	28
Surgery with 36 hours	29	39	40	22	35	27	23	31	28	22	24	21
% surgery with 36 hours	85.3%	88.6%	76.9%	84.6%	76.1%	69.2%	79.3%	86.1%	82.4%	71.0%	70.6%	75.0%
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%



The average time to theatre for patents admitted with Fracture neck of femur is not meeting the best practice threshold. This is being escalated through the quality and performance executive review meeting.

Workforce Focus

Workforce - Workforce Plan

Planned Staff In Post

	16/17	17/18	18/19	19/20	20/21	21/22
	In-post	In-post	In-post	In-post	In-post	In-post
Prof Scientific and Tech	293.27	291.93	286.43	279.43	273.43	273.43
Additional Clinical Services	1069.54	1067.50	1049.50	1036.76	1032.76	1032.76
Administrative and Clerical	1290.56	1239.22	1146.22	1142.22	1138.22	1136.22
Allied Health Professionals	403.74	403.05	376.97	368.60	367.59	367.59
Estates and Ancillary	390.66	339.53	339.53	339.52	339.53	339.53
Healthcare Scientists	91.46	91.46	91.46	91.46	91.46	91.46
Medical and Dental	433.73	433.73	433.73	433.73	433.73	433.73
Nursing and Midwifery Registered	1189.81	1133.36	1090.36	1075.18	1070.27	1070.27
Students	1.49	1.49	1.49	1.49	1.49	1.49
Substantive Staff Total	**5164.27**	**5001.28**	**4815.70**	**4768.40**	**4748.49**	**4746.49**
Bank Prof Scientific and Tech						
Bank Additional Clinical Services	154.00	50.00	40.00	30.00	30.00	30.00
Bank Administrative and Clerical	24.36	7.22	7.22	5.42	5.42	5.42
Bank Allied Health Professionals	1.20	1.00	1.00	1.00	1.00	1.00
Bank Estates and Ancillary	43.13	12.78	12.78	9.58	9.58	9.58
Bank Healthcare Scientists						
Bank Medical and Dental						
Bank Nursing and Midwifery Registered	29.00	15.00	10.00	10.00	10.00	10.00
Bank Students						
Bank Workers Total	**251.69**	**86.00**	**71.00**	**56.00**	**56.00**	**56.00**
Agency Prof Scientific and Tech	6.25	1.25	1.25	1.25	1.25	1.25
Agency Additional Clinical Services						
Agency Administrative and Clerical	4.00					
Agency Allied Health Professionals	6.25	1.25	1.25	1.25	1.25	1.25
Agency Estates and Ancillary						
Agency Healthcare Scientists						
Agency Medical and Dental	17.00	16.20	16.20	16.20	16.20	16.20
Agency Nursing and Midwifery Registered	40.00	26.00	26.00	26.00	26.00	26.00
Agency Students						
Agency Workers Total	**73.50**	**44.70**	**44.70**	**44.70**	**44.70**	**44.70**

The table opposite shows the planned substantive staff in post and planned temporary workforce over the next 5 years by staff group.

This plan takes into account the effect of the care model, trust wide improvement programmes, reductions in the vacancy factor etc.

Workforce - Plan v Actual

Planned Workforce 2017/2018

Staff Group	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018
	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post
Add Prof Scientific and Technic	293.27	293.16	293.05	292.94	292.87	292.80	292.43	292.33	292.22	292.11	291.99	291.93	291.93
Additional Clinical Services	1,069.54	1,069.36	1,069.26	1,069.12	1068.99	1068.87	1068.71	1068.52	1068.33	1068.10	1067.88	1067.66	1067.50
Administrative and Clerical	1,290.56	1,287.98	1,285.41	1,282.83	1278.65	1275.20	1271.76	1266.60	1261.44	1256.28	1250.27	1244.25	1239.22
Allied Health Professionals	403.75	403.57	403.63	403.63	403.46	403.46	403.46	403.30	403.30	403.30	403.11	403.11	403.05
Estates and Ancillary	390.66	388.09	385.53	382.96	378.79	375.37	371.94	366.80	361.66	356.52	350.53	344.54	339.53
Healthcare Scientists	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46	91.46
Medical and Dental	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73	433.73
Nursing and Midwifery Registered	1,189.81	1,184.86	1,182.22	1,178.54	1175.14	1171.75	1167.46	1162.37	1157.28	1151.20	1145.27	1139.34	1133.36
Students	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49	1.49
Planned Substantive Staff Total WTE	**5,164.27**	**5,153.71**	**5,145.79**	**5,136.70**	**5,124.59**	**5,114.14**	**5,102.45**	**5,086.61**	**5,070.92**	**5,054.20**	**5,035.74**	**5,017.52**	**5,001.28**

Actual Workforce 2017/2018

Staff Group	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018
	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post
Add Prof Scientific and Technic	295.47	297.23	296.89	294.47	298.28	286.21	286.06	278.68					
Additional Clinical Services	1,073.29	1,070.59	1,075.01	1,076.72	1,068.81	1070.32	1068.69	1059.85					
Administrative and Clerical	1,292.95	1,268.78	1,265.77	1,267.43	1,258.83	1259.13	1256.09	1244.10					
Allied Health Professionals	405.45	401.10	402.55	400.26	401.56	403.33	403.50	396.19					
Estates and Ancillary	392.86	380.83	378.78	375.22	375.56	372.50	368.07	363.74					
Healthcare Scientists	91.85	92.27	91.47	90.47	91.13	88.13	89.13	94.23					
Medical and Dental	435.50	456.88	452.43	451.28	488.13	468.13	467.03	465.11					
Nursing and Midwifery Registered	1,196.66	1,178.26	1,174.32	1,173.08	1,161.42	1161.89	1166.97	1168.77					
Students	1.50	2.50	2.00	2.00	2.00	2.00	0.00	0.00					
Actual Substantive Staff Total WTE	**5,185.53**	**5,148.43**	**5,139.21**	**5,130.91**	**5,145.74**	**5,111.65**	**5,105.54**	**5,070.66**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Planned V Actual 2017/2018

Staff Group	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018
	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post	In-post
Add Prof Scientific and Technic	-2.20	-4.07	-3.84	-1.53	-5.41	6.59	6.37	13.65					
Additional Clinical Services	-3.75	-1.23	-5.75	-7.59	0.18	-1.45	0.02	8.67					
Administrative and Clerical	-2.39	19.20	19.64	15.41	19.82	16.07	15.67	22.50					
Allied Health Professionals	-1.70	2.48	1.08	3.37	1.90	0.13	-0.04	7.11					
Estates and Ancillary	-2.20	7.26	6.75	7.74	3.23	2.87	3.87	3.06					
Healthcare Scientists	-0.39	-0.81	-0.01	1.00	0.33	3.33	2.33	-2.77					
Medical and Dental	-1.77	-23.15	-18.70	-17.55	-54.40	-34.40	-33.30	-31.38					
Nursing and Midwifery Registered	-6.85	6.60	7.91	5.46	13.72	9.86	0.49	-6.40					
Students	-0.01	-1.01	-0.51	-0.51	-0.51	-0.51	1.49	1.49					
Variance Substantive Staff Total WTE	**-21.26**	**5.27**	**6.58**	**5.79**	**-21.15**	**2.49**	**-3.10**	**15.94**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Medical and Dental staff numbers from April 2017 includes the adjustment for hosting a cohort of GP Trainees

Total year reductions to date are 114.87 as at the end of October towards the 162.99 target by the end of March 2018 and 15.94 ahead of plan

The table opposite shows the planned substantive WTE changes from the opening position at the 31.03.2017 for each month of the financial year until the 31.03.2018.

The plan is to reduce the overall headcount to 5001 WTE substantive staff in post at the end of the financial year.

This table also shows the outturn against the plan at the 31.03.2017 and for each month of the year to date. Monthly WTE against plan will continue to be monitored and included in this Integrated Performance Report each month.

The outcome at the end of October 2017 for substantive WTE staff is a reduction of 114.87 FTE year to date aganst the year target of 162.99 by the end of March 2018. This is 15.94 ahead of the plan for October.

The increase in Medical and Dental staff numbers from April 2017 includes the adjustment for hosting a cohort of GP Trainees.

Workforce - by staff group

Staff in Post by staff Group

Table 1

Staff Group	2015 / 09	2015 / 12	2016 / 03	2016 / 06	2016 / 09	2016 / 12	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10
Add Prof Scientific and Technic	274.87	271.26	270.11	269.99	282.27	285.36	295.47	297.23	296.89	294.47	298.28	286.21	286.06	278.68
Additional Clinical Services	1,016.24	1,028.82	1,039.05	1,035.41	1,058.88	1,071.48	1,073.29	1,070.59	1,075.01	1,076.72	1,068.81	1,070.32	1,068.69	1,059.85
Administrative and Clerical	1,345.55	1,340.31	1,342.79	1,347.28	1,340.26	1,343.18	1,292.95	1,268.78	1,265.77	1,267.43	1,258.83	1,259.13	1,256.09	1,244.10
Allied Health Professionals	403.03	405.49	398.12	395.43	397.08	404.03	405.45	401.10	402.55	400.26	401.56	403.33	403.50	396.19
Estates and Ancillary	389.95	392.72	389.27	403.99	399.86	402.69	392.86	380.83	378.78	375.22	375.56	372.50	368.07	363.74
Healthcare Scientists	92.69	89.80	91.59	89.89	93.75	92.39	91.85	92.27	91.47	90.47	91.13	88.13	89.13	94.23
Medical and Dental	425.99	418.77	414.22	408.00	437.41	434.01	435.50	456.88	452.43	451.28	488.13	468.13	467.03	465.11
Nursing and Midwifery Registered	1,182.09	1,187.12	1,197.97	1,178.16	1,192.73	1,207.26	1,196.66	1,178.26	1,174.32	1,173.08	1,161.42	1,161.89	1,166.97	1,168.77
Students	5.69	5.69	5.09	5.09	3.90	2.90	1.50	2.50	2.00	2.00	2.00	2.00	0.00	0.00
Grand Total	**5,136.11**	**5,139.99**	**5,148.21**	**5,133.23**	**5,206.14**	**5,243.31**	**5,186.13**	**5,148.43**	**5,139.21**	**5,130.91**	**5,145.74**	**5,111.65**	**5,105.54**	**5,070.66**

Table 2

Staff Group	2015 / 09	2015 / 12	2016 / 03	2016 / 06	2016 / 09	2016 / 12	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10
Bands 1 - 7	4461.09	4478.25	4492.38	4487.66	4531.51	4570.31	4525.20	4467.81	4462.16	4456.01	4434.46	4421.27	4418.27	4385.30
Band 8 and Above	249.02	242.97	241.61	237.57	237.22	238.99	225.36	223.74	224.62	223.62	223.15	222.15	220.25	220.25
M&D	425.99	418.77	414.22	408.00	437.41	434.01	435.57	456.88	452.43	451.28	488.13	468.23	467.03	465.11
Grand Total	**5,136.11**	**5,139.99**	**5,148.21**	**5,133.23**	**5,206.14**	**5,243.31**	**5,186.13**	**5,148.43**	**5,139.21**	**5,130.91**	**5,145.74**	**5,111.65**	**5,105.54**	**5,070.66**

Table 3

Staff Group	2015 / 09	2015 / 12	2016 / 03	2016 / 06	2016 / 09	2016 / 12	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10
Bands 1 - 7	86.86%	87.13%	87.26%	87.42%	87.04%	87.16%	87.26%	86.78%	86.83%	86.85%	86.18%	86.49%	86.54%	86.48%
Band 8 and Above	4.85%	4.73%	4.69%	4.63%	4.56%	4.56%	4.35%	4.35%	4.37%	4.36%	4.34%	4.35%	4.31%	4.34%
M&D	8.29%	8.15%	8.05%	7.95%	8.40%	8.28%	8.40%	8.87%	8.80%	8.80%	9.49%	9.16%	9.15%	9.17%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 4

Staff Group	2015 / 09	2015 / 12	2016 / 03	2016 / 06	2016 / 09	2016 / 12	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10
Non-Executive Directors	14.00	7.00	6.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00
Grand Total	14.00	7.00	6.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00

Table 5

Staff Group	2015 / 09	2015 / 12	2016 / 03	2016 / 06	2016 / 09	2016 / 12	2017 / 03	2017 / 04	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10
Chief Executive	2.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Clinical Director - Medical	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Director of Nursing	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Finance Director	2.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Other Directors	3.00	3.00	4.50	4.61	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Grand Total	9.00	7.00	8.50	8.61	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00

Notes: In addition to the 9.00 WTE Executive Directors shown above in 2015/09 there were 2 further Senior Managers as TSDHCT acting in Executive Director Roles and remunerated accordingly.
A further 2 Directors from SDHFT at 2015/09 were also covering Director Roles at TSDHCT
At 2015/09 the role of Medical Director at TSDHCT was vacant
In total across SDHFT and TSDHCT there would normally have been a compliment of 14.00WTE Executive Directors
Medical and Dental staff numbers from April 2017 includes the adjustment for hosting a cohort of GP Trainees
Total year reductions to date are 114.87 as at the end of October towards the 162.99 target by the end of March 2018 and 15.94 ahead of plan

The tables opposite show the WTE in post figure by staff group for each month from September 2015, the month before the Integrated Care Organisation (ICO) commenced, up to October 2017.

Table 1 shows current whole time equivalent staff in-post by staff group from September 2015 (prior to the ICO commencing) to October 2017.

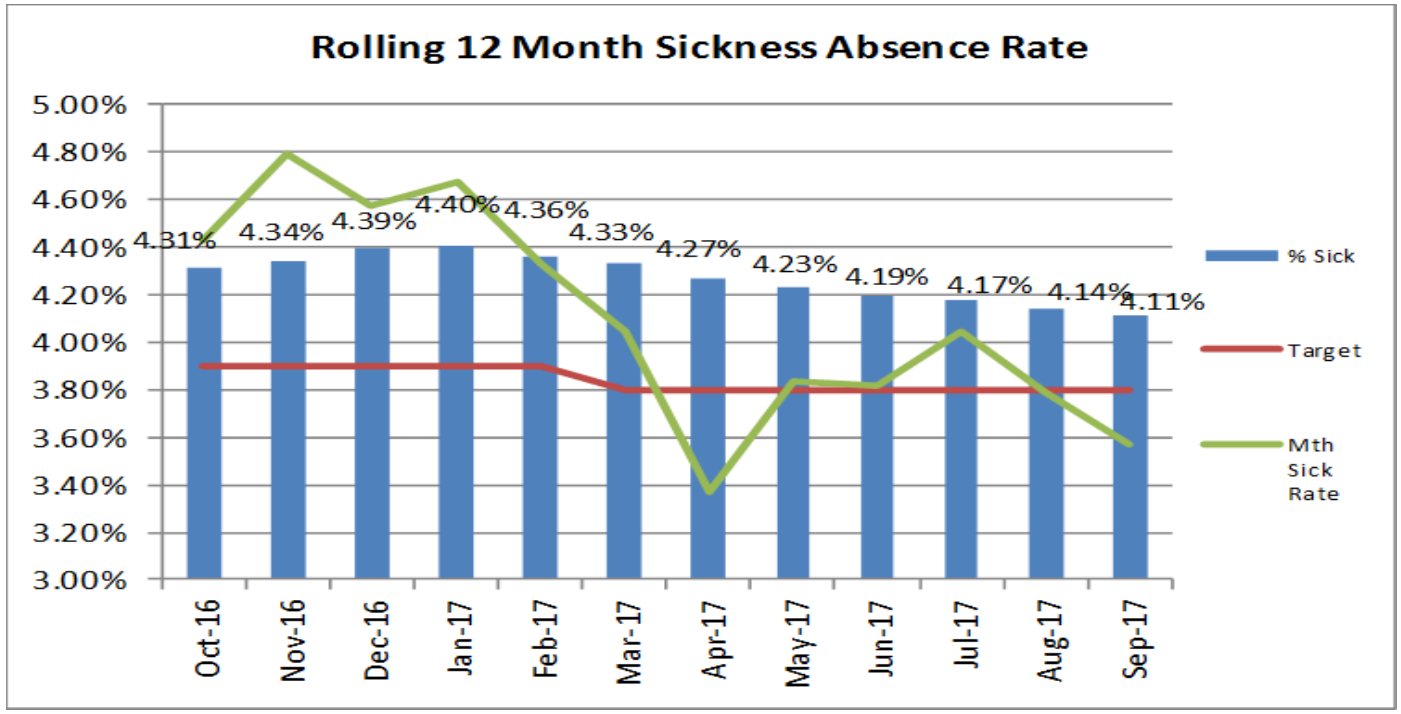
Table 2 shows the number of staff by pay bands. Those staff in band 8 are predominantly in management roles.

Table 3 shows the same pay bands by ratio.

Tables 4 and 5 show the number of Non-Executive Directors and Executive Directors over the same period.

Workforce - Sickness absence

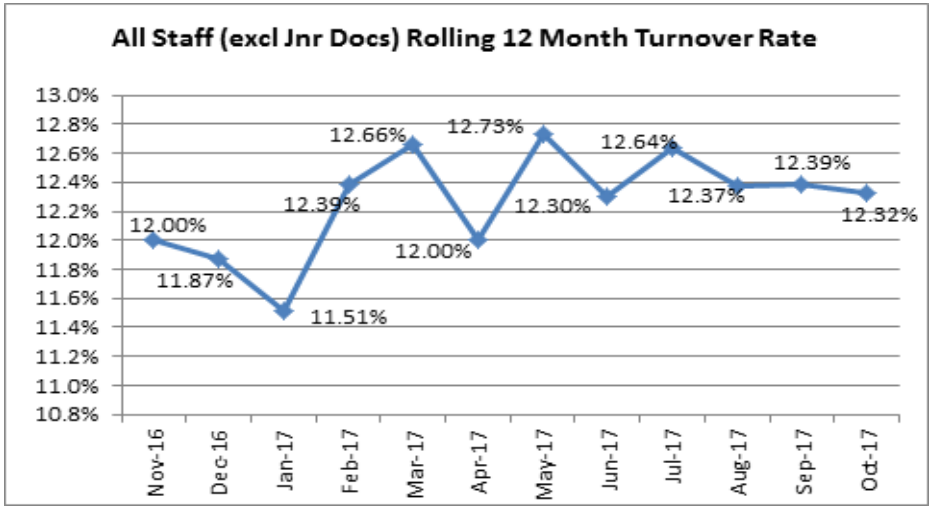
Rolling 12 month sickness absence rate - (reported one month in arrears)



- The annual rolling sickness absence rate of 4.11% at the end of September 2017 represents the eighth 12 monthly reduction in a row from the high of 4.40% in January. This is against the target rate for sickness of 3.80%.
- The sickness figure for the month of September was 3.57 % which is the fourth time in 6 months the montly sickness total has been below 3.80% however seasonal trends need to be monitored going forward.
- The Attendance Policy has been ratified and a programme of training for managers and awareness sessions for staff will be rolled out.
- A Health & Wellbeing Charter is being developed.
- The absence action plan is reviewed and monitored by the Workforce & OD Group.

Workforce - Turnover

All Staff Turnover

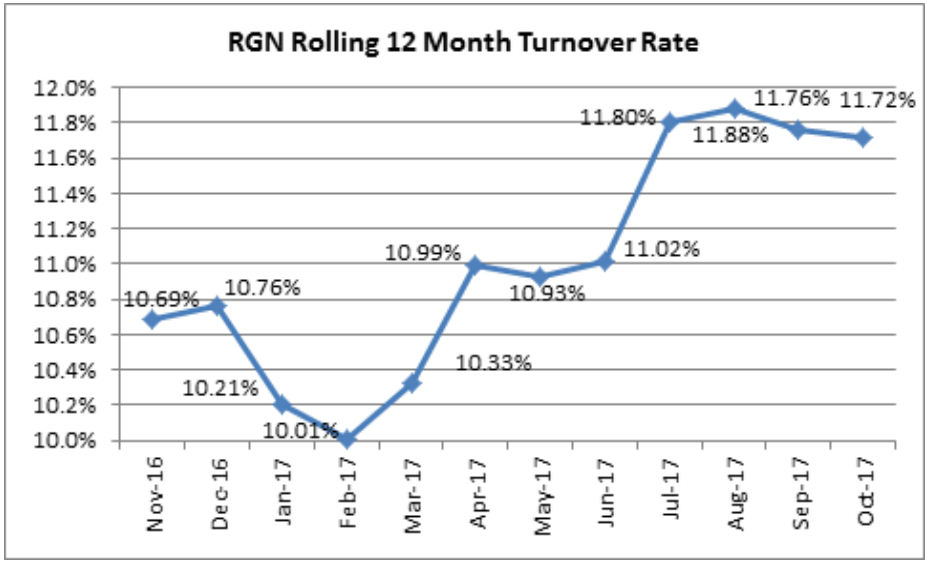


All Staff Rolling 12 Month Turnover Rate

The following graph shows that the Trusts turnover rate was 12.32% for the year to October 2017. This is a slight reduction from last month's 12.39% and within the target range of 10% to 14%.

The recruitment challenge to replace leavers from key staff groups remains significant.

RGN Turnover



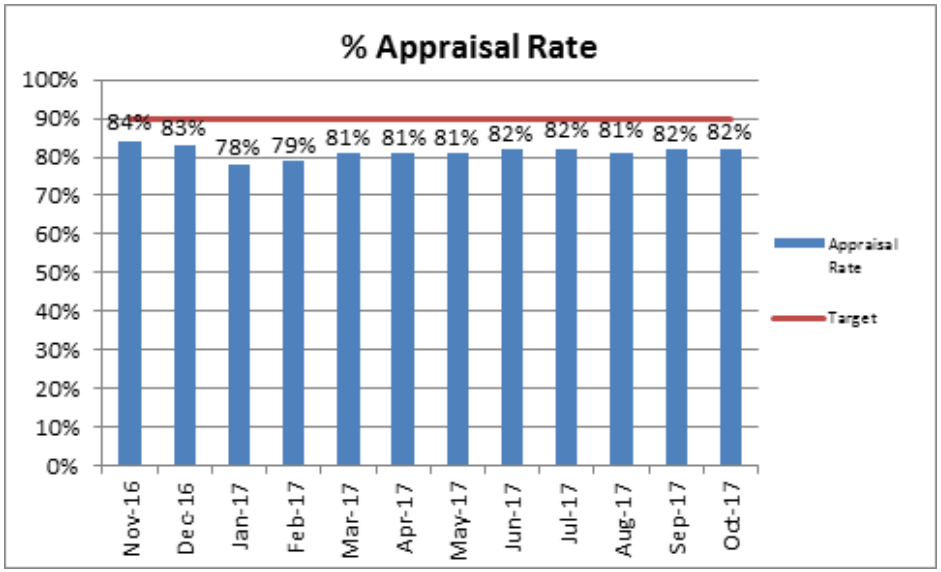
RGN Rolling 12 Month Turnover Rate

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, which maximises the use of all supply routes including overseas recruitment, return to nursing, growing our own etc.

The turnover rate for this staff group has continued to stay within the target range of 10% to 14%.

There are approximately 300 qualified nurses aged 55 and over and the ratio in this age range has doubled over the last 10 years and continues to be reviewed.

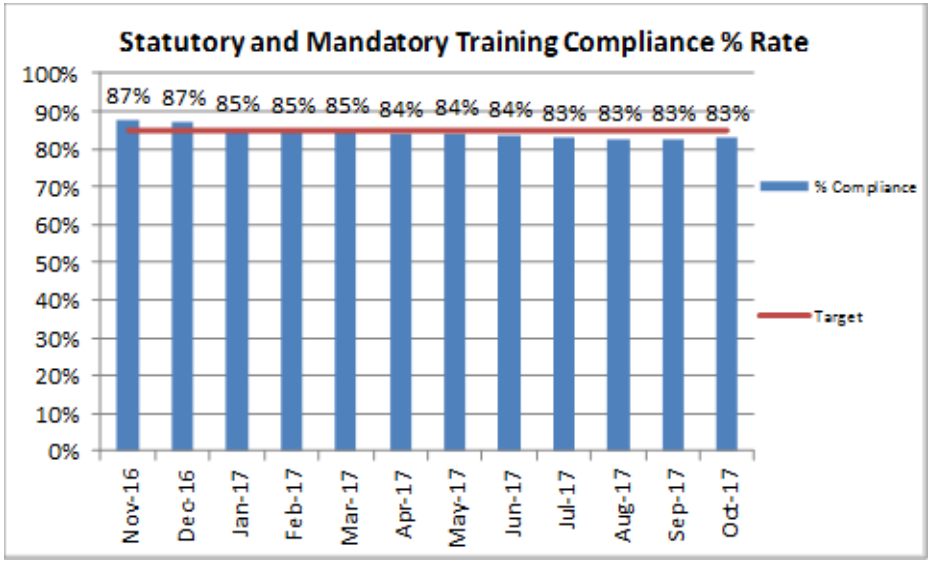
Workforce - Appraisal and training



Appraisal - The appraisal rate for October is at 82% against a target rate of 90%. Managers are provided with detailed information on performance against the target.

Members of the HR team are contacting individual managers to discuss progress in areas that are particularly low and offer additional support.

Appraisal rates are also an agenda item for disucssion at senior manager meetings and quality and performance review meetings.



Statutory and mandatory training - The Trust has set a target of 85% compliance as an average of 9 key statutory and mandatory training modules. The graph shows that the current rate has increase slightly to 83.16% from 82.85% and is close to the target rate of 85%.

An action plan to further improve the rate has been developed and progress against plan will be monitored through the Workforce and OD Group.

Individual modules that remain below their target are detailed in the table below:

Module	Target	Performance
Information Governance	95% and above	74.54%
Conflict Resolution	85% and above	83.43%
Fire Training	85% and above	78.24%
Infection Control	85% and above	76.73%
Manual Handling	85% and above	76.07%

Workforce - Agency

Agency Spend as at Month 7

The Trust's annual cap for agency spend, set by NHSI, for the next two years is £6.58 million per year.

The table below shows the current agency spend by staff group for 2017/18 compared to the total agency expenditure plan.

As at Month 7 the Trust is overachieving against the plan by £1,658K and is on target to achieve the NHSI cap by the end of March 2018.

FINANCIAL YEAR 2017/18 - ACTUAL SPEND

	2017/18 Target	M1	M2	M3	M4	M5	M6	M7	YTD M7
Plan - Total Agency		991	984	801	568	485	479	415	4723
Total Medical and Dental	*3,211,963*	*213*	*293*	*246*	*287*	*277*	*227*	*208*	*1752*
Consultants		156	213	157	197	222	185	203	1333
Career/Staff Grades		0	0	0	0	0	0	0	0
Trainee Grades		57	80	89	90	55	42	5	419
Total Registered Nurses	*2,786,595*	*112*	*136*	*147*	*63*	*71*	*86*	*92*	*707*
Total Scientific, Therapeutic and Technical	*317,033*	*38*	*50*	*54*	*74*	*74*	*72*	*61*	*423*
• Allied Health Professionals		11	10	1	6	9	9	7	53
• Other Scientific, Therapeutic and Technical Staff		7	22	28	44	42	40	34	217
• Health Care Scientists		20	18	25	24	23	23	20	153
Total Support to clinical staff	*36,000*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*1*
• Support to nursing staff		1	0	0	0	0	0	0	1
• Support to Allied Health Professionals		0	0	0	0	0	0	0	1
Total Non-Medical, Non-Clinical Staff Agency	*199,750*	*37*	*30*	*33*	*22*	*26*	*28*	*6*	*182*
TOTAL PAY BILL AGENCY AND CONTRACT	**6,586,000**	**401**	**509**	**481**	**446**	**448**	**413**	**367**	**3065**
Over (Under) Spend		-590	-475	-320	-122	-37	-66	-48	-1658

Nursing and HCA Bank and Agency

The use of nursing agency is predominantly used in the Accident & Emergency Department. The Associate Director of Nursing (Workforce) is currently undertaking a review of the establishment. The use of high cost agency is mainly for last minute specialist roles eg mental health, SCBU (80 hours for October 2017) which is a reduction since the previous month.

In addition during October 17 the equivalent of 53.17 WTE Bank RGNs were used.

All Healthcare Assistant shifts are filled through the internal bank. In October 2017 the equivalent of 133.3 WTE Bank HCAs were used across the Trust.

The table below shows the split between agency and bank for Nursing & HCA shifts:

Nursing & HCA: Bank and Agency Usage

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
WTE Requested	210	218	224	229	238	248	242
WTE Covered by Bank	178	183	194	200	206	209	200
WTE Covered by Agency	17	18	15	13	9	9	12
WTE Unassigned	15	18	15	16	23	29	30
Total WTE Covered	195	200	209	213	215	218	212

Scientific, Therapeutic and Technical Agency

The largest use of agency in this staff group is CAMHS, which is currently part of a national project, which includes funding for agency staff. For the month of October 2017 this amounted to £34k of the £61K expenditure.

The other areas using agency include cardiology, radiography and mortuary. In Cardiology there has been increased levels of sickness and vacancies within the team which has required additional hours of locum cover. Radiography have used Agency Advanced Practitioner Ultrasonographer to cover off vacancies in both the AHP and Consultant groups. This is under close review pending recent recruitment. There will be a lead in period for the newly recruited team members. It is anticipated that agency will reduce and possibly cease from late January. Following the outcome of an inspection the Mortuary has an action plan in place which includes recruiting permanently to a Band 5 position. The recruitment process is being instigated and it is anticipated that the agency will cease by the end of March 2018.

Medical and Dental Agency

Medical and Dental agency expenditure reduced by a further £19k in Month 7. The use of medical agency is mainly attributable to a number of consultant vacancies and gaps in the junior doctor rotas.

The number of agency trainee grades dropped considerably in October 2017 and this correlates with an increase in the number of shifts that were filled through the newly established medical bank, which increased from 5 shifts in September 2017 to 25 shifts in October 2017.

The Trust is also part of the STP Medical Agency Group which is reviewing the number of agencies used (currently in the region of 50) in order to reduce and then activley work with those agencies to reduce rates.

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
NHS I - FINANCE AND USE OF RESOURCES																	
4	Capital Service Cover	2		4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Plan			4	4	3	3	3	3	4	4	4	4	4	4	4	4
4	Liquidity	4		2	2	3	3	3	3	4	4	4	4	4	4	4	4
	Plan			2	2	2	2	2	2	4	4	4	4	4	4	4	4
4	I&E Margin	1		4	4	4	4	4	4	4	4	4	4	4	4	3	3
	Plan			3	3	3	3	2	2	4	4	4	4	4	4	4	4
4	I&E Margin Variance from Plan			3	3	4	4	4	4	1	1	1	1	1	1	1	1
4	Variance from agency ceiling	1		3	3	3	3	3	3	1	1	1	1	1	1	1	1
	Plan			2	2	1	1	1	1	4	4	4	4	3	3	2	2
4	Overall Use of Resources Rating			3	3	4	4	4	4	3	3	3	3	3	3	3	3
FINANCE INDICATORS - LOCAL																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)			-3053	-5439	-7.639	-9934	-12.922	-15310	-173	-261	389	-479	-732	-543	-1123	
4	Agency - Variance to NHSI cap			-1.45%	-1.38%	-1.33%	-1.32%	-1.28%	-1.27%	3.03%	2.72%	2.38%	2.00%	2.00%	1.41%	1.27%	
4	CIP - Variance from PBR plan - cumulative (£'000's)			1114	-403	-1287	-2354	-3518	-2430	-562	1093	1392	822	1942	1475	3114	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)			6792	9269	12002	17176	18254	17324	2116	4021	6106	7708	9560	11689	13770	
4	Distance from NHSI Control total (£'000's)			-1902	-3493	-4887	-7083	-7924	-9549	234	581	1696	1247	997	1503	1201	
4	Risk Share actual income to date cumulative (£'000's)			5836	5844	7169	8389	8637	9107	-236	-579	-192	-124	-98	0	0	

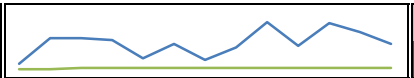
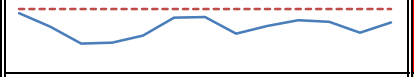
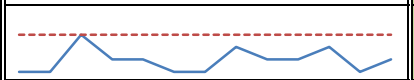
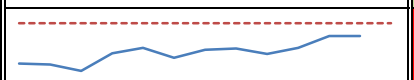
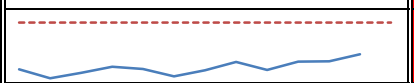
Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

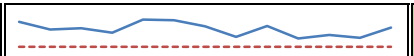
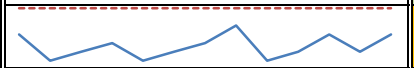
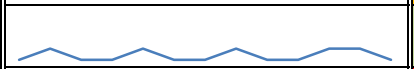
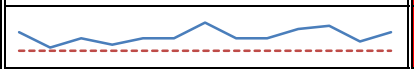
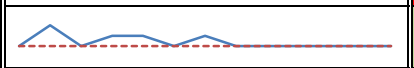
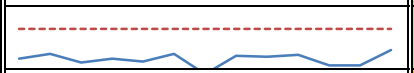
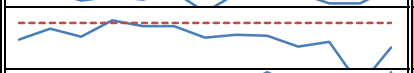
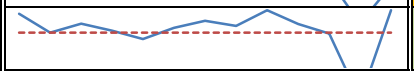
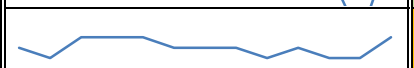
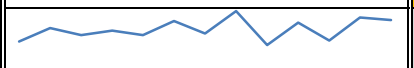
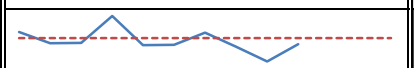
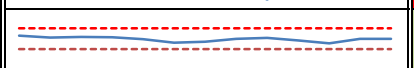
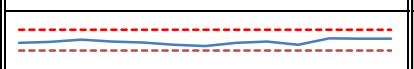
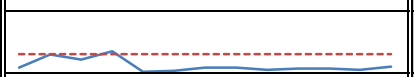
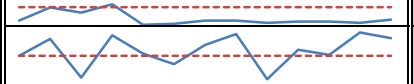
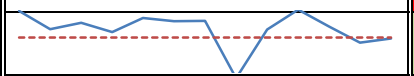
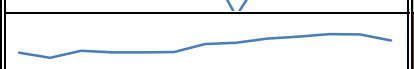
NOTES

* For cumulative year to date indicators, (operational performance & contract indicators) RAG rating is based on the monthly average

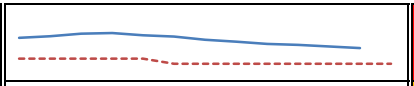
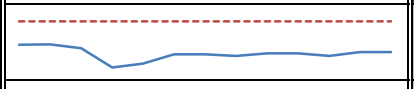
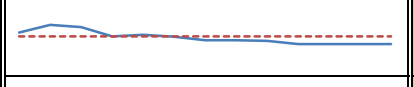
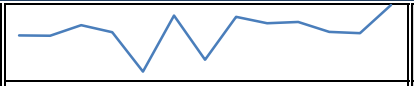
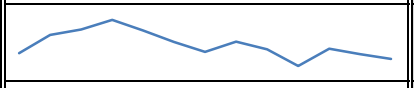
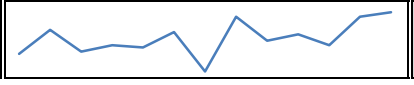
[STF] denotes standards included within the criteria for achieving the Sustainability and Transformation Fund

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
NHS I - OPERATIONAL PERFORMANCE (NEW SINGLE OVERSIGHT FRAMEWORK FROM OCTOBER 2017)																	
1	A&E - patients seen within 4 hours [STF]	>95%		95.5%	91.6%	86.6%	86.9%	89.2%	94.2%	94.4%	90.1%	92.3%	93.9%	93.2%	89.9%	92.7%	92.4%
	A&E - trajectory [STF]	>92%		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	89.0%	90.0%	91.0%	92.0%	92.5%	93.5%	92.0%	92.0%
1	Referral to treatment - % Incomplete pathways <18 wks	>92%		89.4%	88.7%	87.3%	87.6%	87.8%	87.5%	87.2%	87.6%	86.4%	86.1%	85.2%	84.01%	84.04%	84.0%
	RTT Trajectory			93.1%	93.2%	93.2%	93.1%	93.3%	93.3%	87.2%	87.5%	88.0%	88.9%	89.4%	89.8%	90.7%	90.7%
1	Cancer - 62-day wait for first treatment - 2ww referral	>85%		83.1%	94.5%	88.9%	84.2%	91.6%	88.0%	87.2%	85.1%	84.0%	86.8%	79.2%	85.71%	85.71%	84.5%
1	Diagnostic tests longer than the 6 week standard	<1%		1.7%	1.8%	4.7%	2.9%	1.6%	1.7%	3.4%	2.2%	2.8%	3.0%	7.3%	3.9%	3.2%	3.7%
1	Dementia - Find - monthly report	>90%		49.4%	59.2%	48.6%	59.9%	65.8%	67.8%	58.9%	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%	64.0%
LOCAL PERFORMANCE FRAMEWORK 1																	
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<18 (year)		0	0	1	0	0	0	0	2	0	1	2	0	0	4
1	Cancer - Two week wait from referral to date 1st seen	>93%		72.0%	67.8%	88.2%	96.2%	97.0%	98.0%	83.6%	81.8%	86.5%	74.3%	65.3%	61.1%	63.7%	73.6%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		95.8%	97.9%	95.9%	89.3%	94.6%	96.2%	54.8%	97.8%	94.8%	74.0%	17.1%	69.7%	95.0%	73.9%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		98.4%	98.4%	97.6%	95.5%	98.0%	99.4%	99.2%	99.4%	97.1%	98.8%	98.6%	98.9%	95.95%	98.3%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	99.8%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		97.3%	97.0%	100.0%	94.7%	96.0%	96.2%	96.4%	100.0%	98.3%	95.3%	100.0%	98.1%	94.4%	97.5%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		96.7%	96.6%	93.9%	97.7%	96.7%	100.0%	96.9%	93.5%	97.0%	97.2%	100.0%	91.1%	95.8%	95.6%
1	Cancer - 62-day wait for first treatment - screening	>90%		93.8%	85.7%	85.7%	92.3%	100.0%	100.0%	100.0%	87.0%	100.0%	100.0%	100.0%	100.0%	93.1%	97.0%
1	Cancer - Patient waiting longer than 104 days from 2ww									10	18	17	13	10	6	12	12
1	RTT 52 week wait incomplete pathway	0		11	13	12	15	17	17	18	18	21	15	19	16	26	26
1	Mixed sex accomodation breaches of standard	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%		1.3%	1.1%	1.0%	1.1%	0.7%	0.6%	0.9%	1.4%	0.6%	0.7%	0.6%	1.0%	1.1%	0.9%
1	Cancelled patients not treated within 28 days of cancellation *	0		0	0	6	1	1	1	0	2	7	4	3	3	4	23

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
LOCAL PERFORMANCE FRAMEWORK 2																	
1	Ambulance handover delays > 30 minutes	0		44	129	129	123	62	110	56	98	183	104	180	150	110	881
	Handovers > 30 minutes trajectory *			25	25	30	30	30	30	30	30	30	30	30	30	30	210
1	Ambulance handover delays > 60 minutes	0		2	30	10	22	10	4	6	2	4	12	17	10	6	57
1	A&E - patients seen within 4 hours DGH only	>95%		93.4%	87.9%	81.1%	81.4%	84.3%	91.5%	91.8%	85.1%	88.1%	90.5%	89.9%	85.5%	89.6%	88.6%
1	A&E - patients seen within 4 hours community MIU	>95%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	0	1	2	0	0	0	0	0	0	0	0	0	0
1	Number of Clostridium Difficile cases - (Acute) *	<3		0	0	3	1	1	0	0	2	1	1	2	0	1	7
1	Number of Clostridium Difficile cases - (Community)	0		0	0	1	0	1	0	0	0	0	1	0	0	0	1
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		58.1%	57.5%	54.5%	62.8%	65.3%	60.7%	64.5%	65.0%	62.5%	65.4%	71.0%	71.0%	69.5%	66.9%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		28.4%	22.4%	26.2%	30.3%	28.7%	23.7%	27.9%	33.4%	28.1%	33.6%	33.8%	38.5%	25.1%	31.4%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		86.4%	86.4%	81.8%	95.5%	72.7%	86.4%	72.7%	81.8%	81.8%	86.4%	86.4%	90.9%	86.4%	83.8%

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
QUALITY LOCAL FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		97.8%	96.9%	97.1%	96.6%	98.1%	98.0%	97.3%	96.1%	97.3%	95.9%	96.3%	96.0%	97.2%	96.6%
1	Reported Incidents - Major + Catastrophic *	<6		3	0	1	2	0	1	2	4	0	1	3	1	3	14
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		0	1	0	0	1	0	0	1	0	0	1	1		3
1	Never Events	0		1	0	0	0	0	0	0	0	0	0	0	0	0	0
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		6	1	4	2	4	4	9	4	4	7	8	3	6	41
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		0	2	0	1	1	0	1	0	0	0	0	0	0	1
1	Formal Complaints - Number Received *	<60		29	34	25	29	26	34	13	32	31	33	22	22	38	191
1	VTE - Risk assessment on admission - (Acute)	>95%		93.2%	94.4%	93.5%	95.3%	94.7%	94.7%	93.4%	93.7%	93.6%	92.4%	92.9%	88.0%	92.3%	92.3%
1	VTE - Risk assessment on admission - (Community)	>95%		99.2%	95.0%	97.0%	95.4%	93.5%	96.1%	97.6%	96.5%	100.0%	96.9%	94.7%	80.0%	100.0%	
1	Medication errors resulting in moderate to catastrophic harm	0		1	0	2	2	2	1	1	1	0	1	0	0	2	5
1	Medication errors - Total reported incidents (trust at fault)	N/A		41	56	48	53	48	64	50	75	37	62	42	68	65	399
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears	<100%		108.1%	93.7%	93.9%	128.4%	91.1%	91.5%	107.0%	89.1%	70.0%	92.2%				101.4%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		102.9%	101.2%	101.7%	101.3%	99.5%	96.2%	97.2%	100.0%	100.8%	98.4%	95.5%	100.0%	100.0%	98.8%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		97.4%	98.2%	100.5%	98.7%	97.6%	95.5%	94.4%	97.4%	98.5%	95.6%	101.6%	101.4%	101.4%	98.5%
1	Infection Control - Bed Closures - (Acute) *	<100		24	98	68	116	0	6	24	24	12	18	18	12	30	138
1	Hand Hygiene	>95%		95%	98%	92%	98%	95%	94%	97%	99%	91%	96%	95%	99%	98%	96%
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		67.9%	85.3%	88.6%	76.9%	84.6%	76.1%	69.2%	79.3%	86.1%	82.4%	71.0%	70.6%	75.0%	
1	Stroke patients spending 90% of time on a stroke ward	>80%		94.9%	84.6%	88.2%	82.9%	90.9%	89.1%	89.2%	57.1%	84.5%	95.6%	86.0%	77.1%	79.4%	81.4%
1	Follow ups 6 weeks past to be seen date (excluding Audiology)	3500		5491	4941	5683	5512	5518	5548	6429	6550	6999	7209	7496	7477	6790	6790

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges (Community) *	16/17 Avg 315		180	441	375	179	223	310	142	72	261	225	211	445	490	1846
1	Number of Delayed Transfer of Care (Acute)	16/17 Avg 64		61	93	59	39	41	138	202	144	230	159	185	184	205	1309
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		69.0%	68.8%	69.4%	69.8%	70.7%	71.2%	78.8%	72.9%	73.9%	74.6%	75.9%	77.2%	78.3%	77.2%
3	Clients receiving Self Directed Care	>90%		92.3%	92.3%	92.0%	92.2%	92.5%	92.0%	92.0%	92.8%	92.6%	92.8%	92.9%	93.6%	93.1%	93.6%
2	Carers Assessments Completed year to date	40% (Year end)		30.0%	32.5%	34.9%	35.8%	37.0%	38.3%	4.4%	8.7%	17.0%	20.7%	24.8%	31.1%	33.9%	31.1%
	Carers Assessment trajectory			23.3%	26.7%	30.0%	33.3%	36.7%	40.0%	3.6%	7.2%	10.8%	14.3%	17.9%	21.5%	25.1%	25.1%
3	Number of Permanent Care Home Placements	<=617 (Year end)		641	649	649	636	636	642	634	629	619	634	637	638	632	632
	Number of Permanent Care Home Placements trajectory			625	623	622	620	619	617	639	637	635	633	631	629	627	627
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		156	177	191	191	189	219	231	240	239	238	248	254		248
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET				157			157			272			80		80
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET				7.8%			7.8%			7.8%			8.4%		8.4%
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%	100.0%	100.0%	100.0%	100.0%
1	Bed Occupancy	80% - 90%		92.7%	93.4%	87.9%	88.7%	86.1%	88.2%	89.7%	91.3%	88.4%	80.7%	89.2%	93.2%	92.7%	93.2%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		87.1%	89.1%	94.2%	100.0%	100.0%	96.3%	87.9%	82.8%	92.9%	90.7%	98.1%	98.5%	100.0%	98.5%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET		610	602	579	593	609	597	603	601	599	608	574	579	596	579
1	Intermediate Care - No. urgent referrals	113		120	124	160	199	151	149	164	175	177	184	185	158	189	1232
1	Community Hospital - Admissions (non-stroke)	NONE SET		226	267	297	310	278	258	205	241	247	225	253	240	238	1649

Corporative Objective		Target 2017/2018	13 month trend	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Year to date 2017/18
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears) Rolling 12 months	<3.8%		4.31%	4.34%	4.39%	4.40%	4.36%	4.33%	4.27%	4.23%	4.19%	4.17%	4.14%	4.11%		4.11%
2	Appraisal Completeness	>90%		83.91%	84.00%	83.00%	78.00%	79.00%	81.40%	81.42%	81.00%	81.66%	81.66%	81.00%	82.00%	82.00%	82.00%
2	Mandatory Training Compliance	>85%		86.00%	88.00%	87.38%	85.00%	85.41%	84.90%	84.00%	84.00%	83.86%	83.00%	83.00%	83.00%	83.00%	83.00%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		12.61%	12.00%	11.87%	11.51%	12.39%	12.66%	12.00%	12.73%	12.30%	12.64%	12.37%	12.39%	12.32%	12.32%
CHANGE FRAMEWORK																	
3	Number of Emergency Admissions - (Acute)			3015	3012	3088	3036	2754	3155	2840	3148	3101	3111	3040	3030	3231	21501
3	Average Length of Stay - Emergency Admissions - (Acute)			2.9	3.1	3.2	3.3	3.2	3.0	2.9	3.0	2.9	2.7	2.9	2.9	2.8	2.9
3	Hospital Stays > 30 Days - (Acute)			15	26	16	19	18	25	7	32	21	24	19	32	34	169

Appendix 2

Torbay and South Devon NHS
NHS Foundation Trust

Title:	**Follow up patients waiting over six weeks beyond alloacted date**		
Report to:	Board of Directors		
Prepared By:	John Harrison Deputy COO	**Contributors:**	Operational delivery managers
Date Prepared:	17/11/2017	**Date of Meeting:**	N/A

Introduction:

This report has been prepared at the request of the Executive Team in response to concerns raised by the Executive and Board of Directors about the increased delays to follow ups in a range of specialities. The Executive has mandated a three stage process to quantify, address and manage the the performance concerns:

1) The preparation of a 'status report' for each specilaity which sets out the current position and actions already underway. This report will then be used as a product to inform the next stage of the process…..

2) A 'lock in' workshop, with senior clinicians and managers, to consider the issues raised by the status report and identify sustainable solutions that will be own by clinical teams.

3) The output of the workshop will include action plans and improvement trajectories, for each speciality, which will be managed via the Clinical Management Group (CMG) and presented to the Quality Assurance Committee.

This paper constitutes the status report required as the first stage of the process. As such the report reviews follow up waiting list data since April 2013 and considers the current position. The aim is to understand the clinical risks inherent in the current waiting list position, the actions the teams are taking to reduce the waiting times and the clinical risk management processes in place.

It is noted that measuring patients waiting over 6 weeks is a proxy for clinical risk as some patients waiting less than 6 weeks may represent a greater risk than some of those waiting far longer. This will be variable by specialty and within specialty. Some teams, for example opthalmology, have introduced systems to risk stratify the patients acording to the treatements they are waiting for. This enables waiting times to be managed dynamically within the patient management system acording to clinical risk. It is understood that all teams are not operating in this way, however each has confirmed that clinical teams have oversight of the lists and actively review patients waiting for clinical risk.

Summary:

Many teams have reported specific actions underway that are already starting have have the impact of reducing waits for follow up and this is evident in the analysis below. This particularly the case for Ophthalmology, Rheumatology, Paediatrics and Urology. Other teams such as Cardiology, Dermatology and Oral Surgery have described their plans however improvement is not yet evident.

Appendix 2

In the sections that follow aggregate data for follow up waiting is analysed, to identify headline issues, before reporting and considering the position in specific specialities.

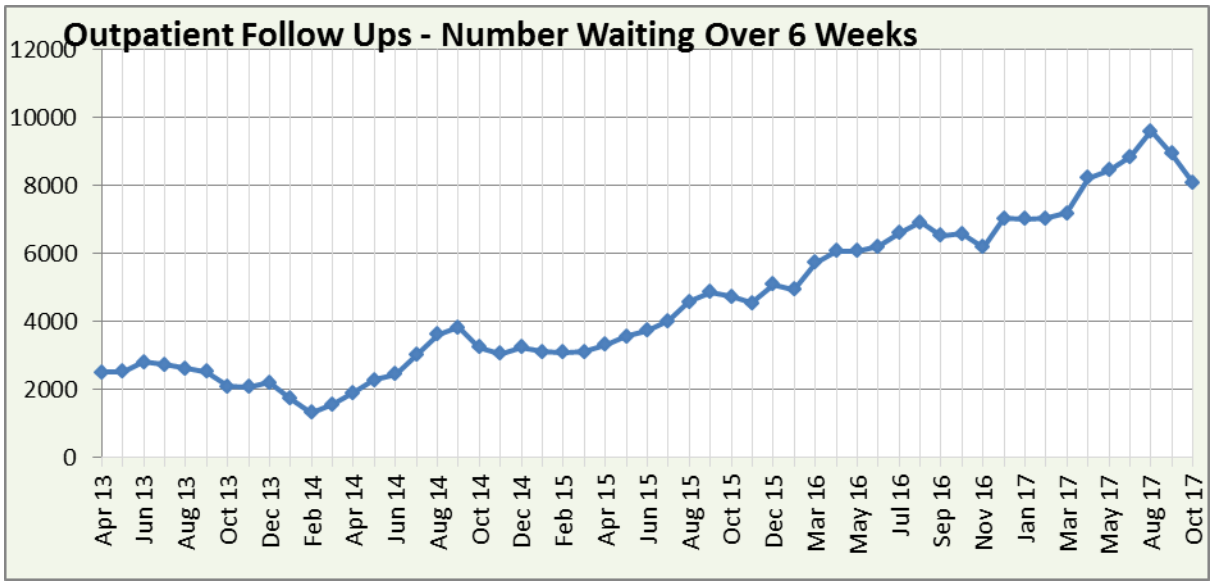
In line with the process manadated by the Executive the next step will be to hold a 'lock in ' workshop to develop plans aimed improving performance. In the interim the RTT and Diagnostics Risk and Assurance Group will continue to monitor improvements where these are evident and to seek trajectories, and specific details on timing and imapct, from those teams where this is not yet happening.

Appendix 2

Headline Analysis of Aggregate Data

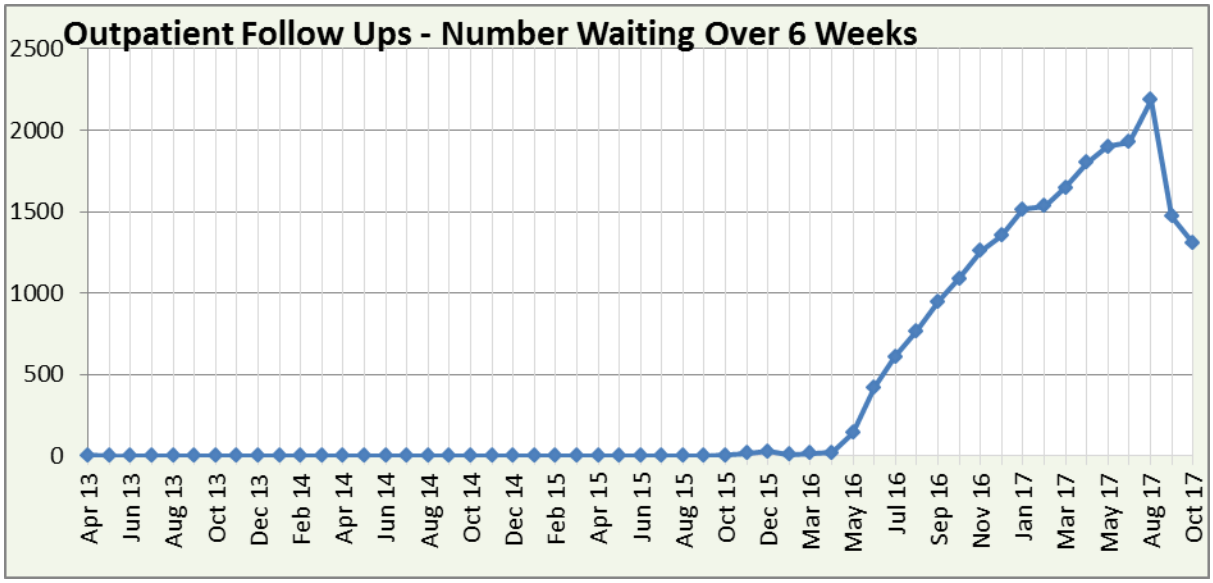
Total follow up list 6 weeks past to be seen date reduced in September and October 17 = 8,089 down from 9,608 in August 2017. This is against a background of persistent increases since February 2014.

Total



Within the overall position Audiology is a special cause as the impact of the 3 year follow up under the AQP contract is just starting. A change to the pathway has been agreed with commissioners this will quickly bring the audiology position back to zero from the current level of 2,000. The imapct is already evident as the patients are being contacted and appropriately removed from the follow up list.

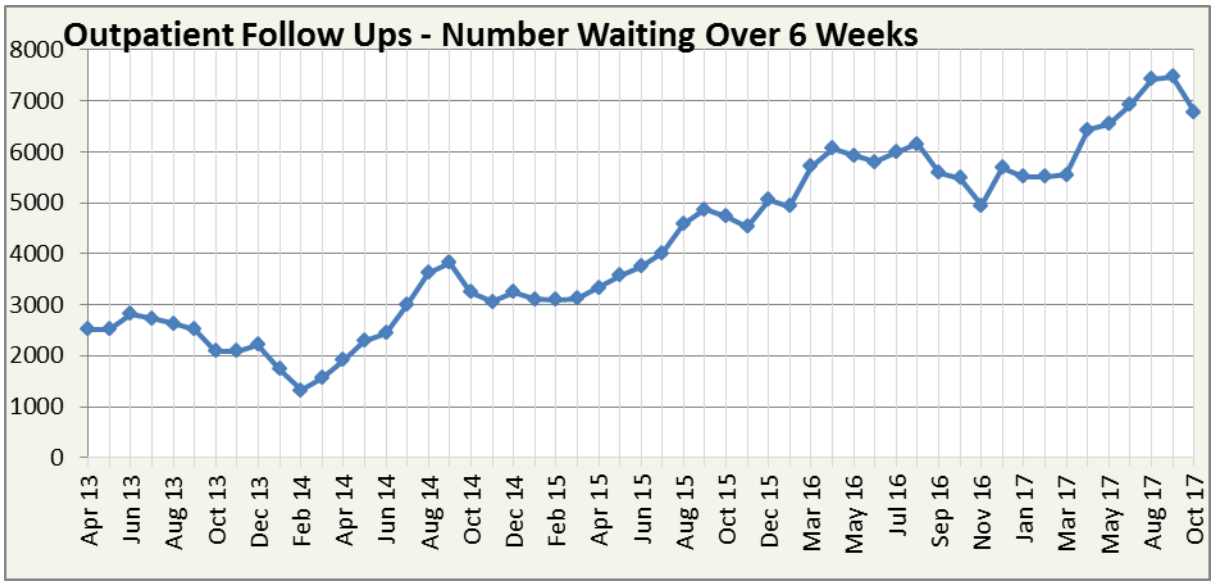
Audiology Only



It is therefore advisable to view the follow up position excluding the audiology list.

Appendix 2

Total excluding audiology

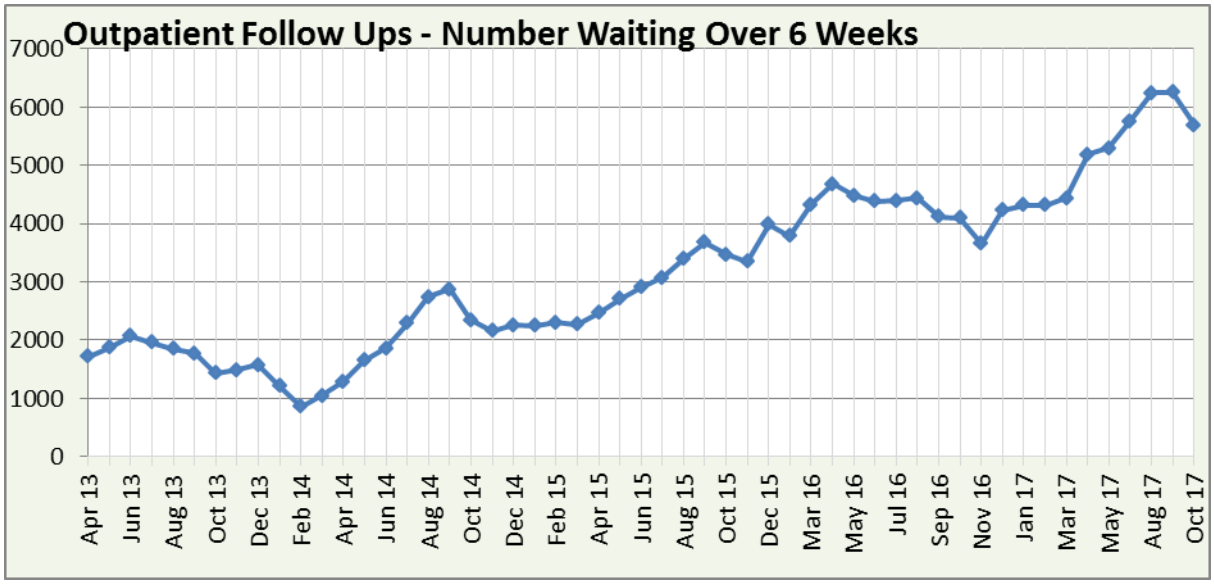


The specialties that comprise 85% of the current total backlog over 6 weeks are as follows;

Ophthalmology	3,206
Rheumatology	1,113
Dermatology	405
Paediatrics	303
Cardiology	231
Oral Surgery	221
Urology	220

The movement over time is explained by reviewing these 7 specialties;

Sum of Opthalmology, Rhemaltology, Dermaology, Paediatrics, Cardiology, Oral Surgery, Urolgoy

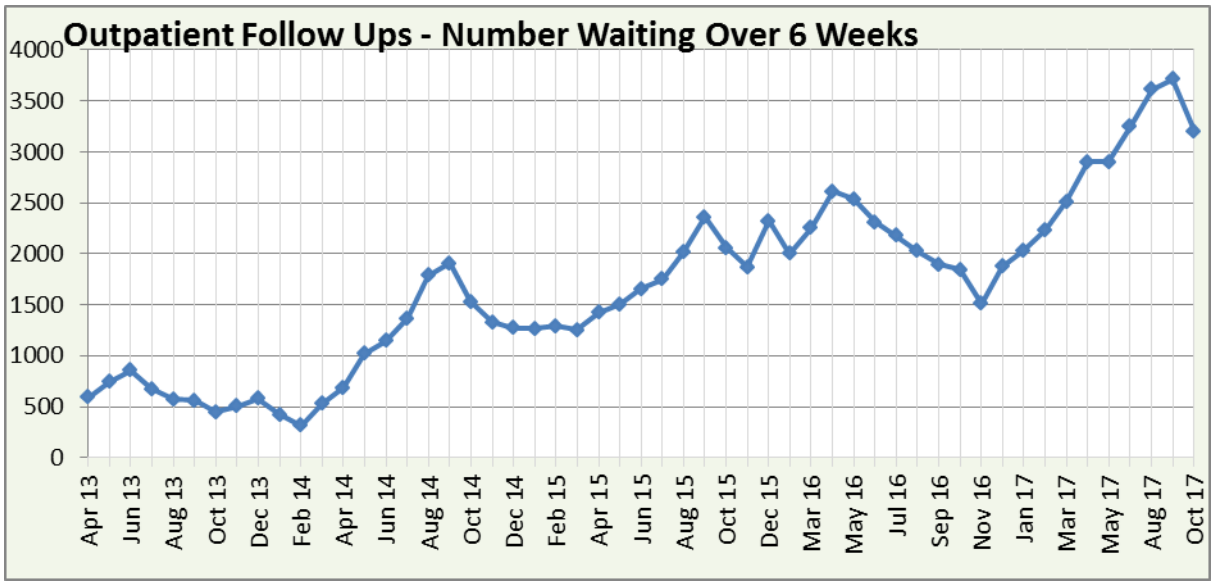


Each of these 7 specialties is now analysed seperately and where possible comments included from the teams concerned. The intention is to enable the team to explain the factors behind the increases, confirm the plans to reduce the waiting times and explain the governance process in place to manage the clinical risk. Each team has been asked to contribute their own narriatve below.

Appendix 2

Analysis by Speciality

1) Ophthalmology



Factors behind the increase:

A very challenged long term condition, the most risk is in the 0-6 weeks that is not shown here.
New treatments -
2006 Lucentis (Ranibizumab)for Wet AMD
2010 Lucentis for RVO
2012 Lucentis for DME
National problem and huge increase in patient appointments required
Expected population increase and age demographic change to worsen position in 5-10 year plan.
Lack of space, lack of equipment, lack of IT resource, lack of staff training and all are inextricably linked.

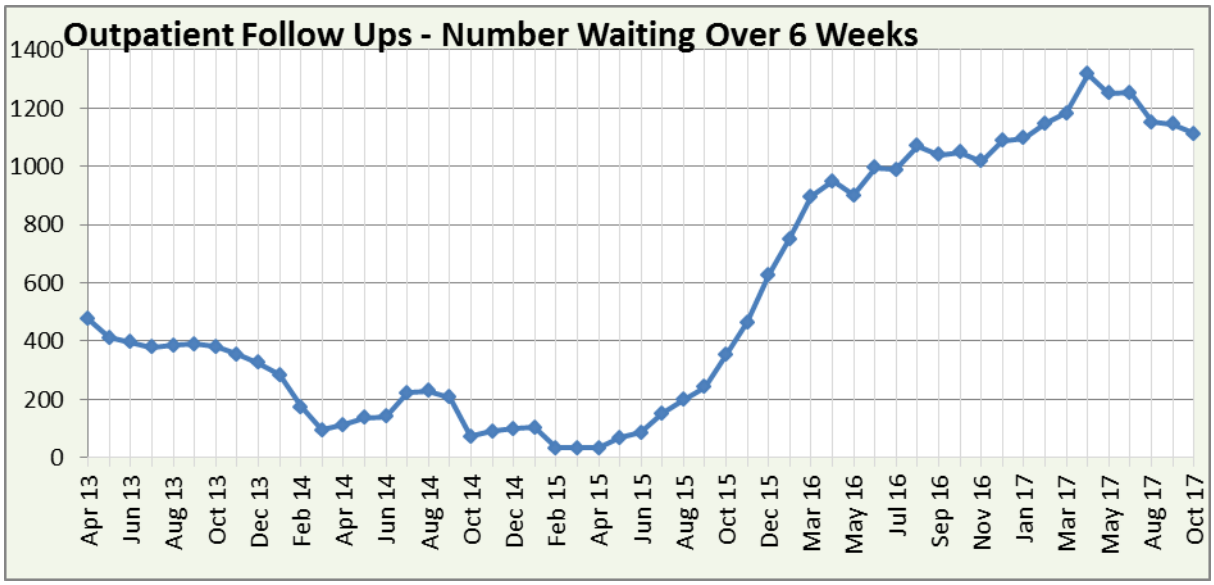
Plans to reduce waits

New mega Macular on Monday AM
Mega Macular on Tuesday AM
Virtual Medical Retina
Virtual Glaucoma
Extended Glaucoma
Redesigned Eye casualty
Non responders
Saturday clinics for highest priority patients

Governance process to manage clinical risk

Sub-specialty analysis to define highest risk
Named consultant for each sub-specialty list
Monthly review by sub-specialty
Weekly review by Ophthalmology team to move resources to most urgent need

2) Rheumatology



Factors behind the increase:

2015/16	Maternity Leave (limited cover available via locum)
2016/17	Long-term sickness
	SpR vacancy
	GP Trainee vacancy

Plans to reduce waits:

Consider discharging patients who have had x2 letters inviting them to book an appt

Review of pending lists to identify patients who can be:

- Moved to 2 year f/up from 1 year f/up (change in service)
- Virtually reviewed and removed from f/up pending list
- Reviewed in a nurse-led clinic
- Seen by Registrar / GP Trainee

Appointed an additional consultant 7PAs per week – await start date (likely to be March 2018). The new appointee will be focussed on reducing backlog of follow ups initially which should produce a reduction of 50 patients per month.

Attempting to identify a locum consultant to start immediately (unsuccessful so far). Investigating if Senior SpR currently in service could run additional paid sessions. If we are successful in identifying a locum we could achieve a reduction of approx. 100 per month. If the SpR agrees to additional clinics we could reduce by approx. 40-50 per month

The backlog therefore, if the above three proposals are achieved, could reduce the f/up backlog by potentially up to 150 patients a month from now until March.

With the additional consultant potentially starting in March 2018 this will increase further.
(IDENTIFYING SPACE FOR ADDITIONAL CLINICS WITH NEW CONSULTANT AND LOCUM / SPR CLINICS IS LIKELY TO BE PROBLEMATIC WITH THE CLOSURE OF TAIRU)

Appendix 2

Governance process to manage clinical risk:

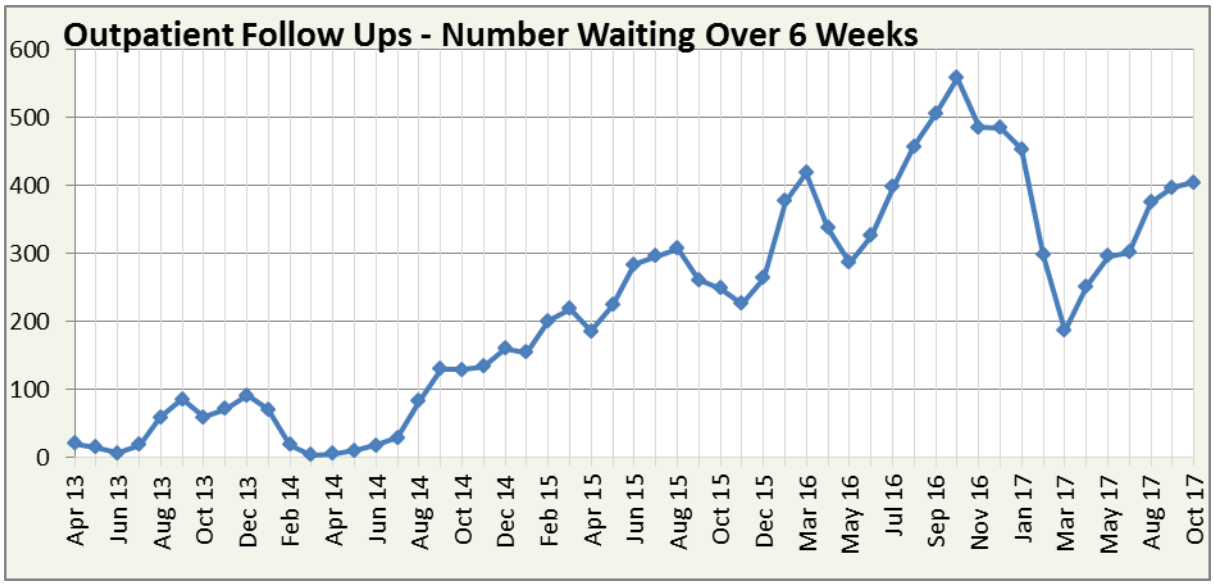
On risk register

Pending list review will identify any patients who require more urgent f/up

Reserved slots created in clinics for patients identified through review of pending list

Patients booked chronologically unless otherwise specified (patients on biologics drugs with problems will take priority)

3) Dermatology



The most recent information available indicates the number over 6 weeks has reduced to 376 as a result of the actions listed below.

Factors behind the increase:

Dr L, Locum left in April 2017
Due to the increase in TWW demand all appropriate available slots have been converted to meet the rising demand in TWW referrals.
Specialty Drs have been appointed but are not yet autonomous. One commenced Maternity Leave September 2017. 2nd Dr commenced September 2017.

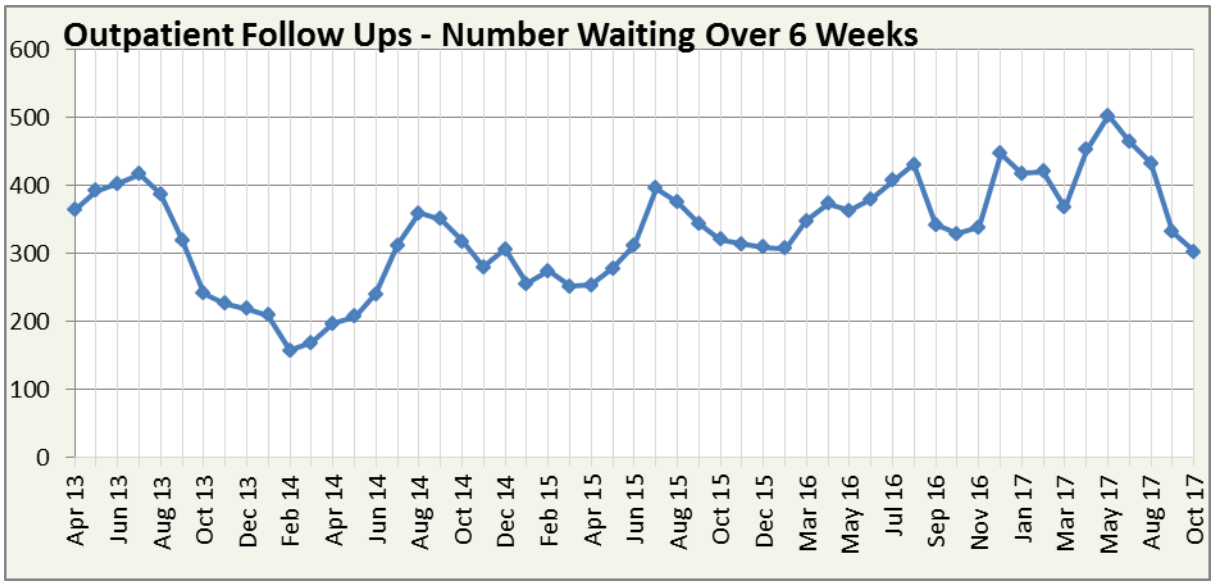
Plans to reduce waits

Conversion of clinics to Polyclinic model
Specialist Nurses are following up patients were appropriate
Extra ad-hoc clinics for urgent follow ups are prioritised
Extra minor op clinics undertaken

Governance process to manage clinical risk

Validation of follow up pending lists – ongoing
Follow up backlog includes Minor Ops – currently 88 – actively managed by Practice Manager and Nurse Manager
All minor ops forms have been reviewed within the last week and where possible, reassigned to specialist nurse clinics instead of doctors to help manage the demand and ensure all available capacity is utilised
Urgent follow ups are being seen and booked straight into clinics
Routine placed on pending list

4) Paediatrics



Factors behind the increase:

The number of patients waiting has considerably reduced over the past few months and this capacity is entirely dependent on the number of middle grades on the rota which is currently fully staffed. However prior to September 2017 we only had 3 on the 1:6 rota and the number will reduce to 4.5 in March 2018.

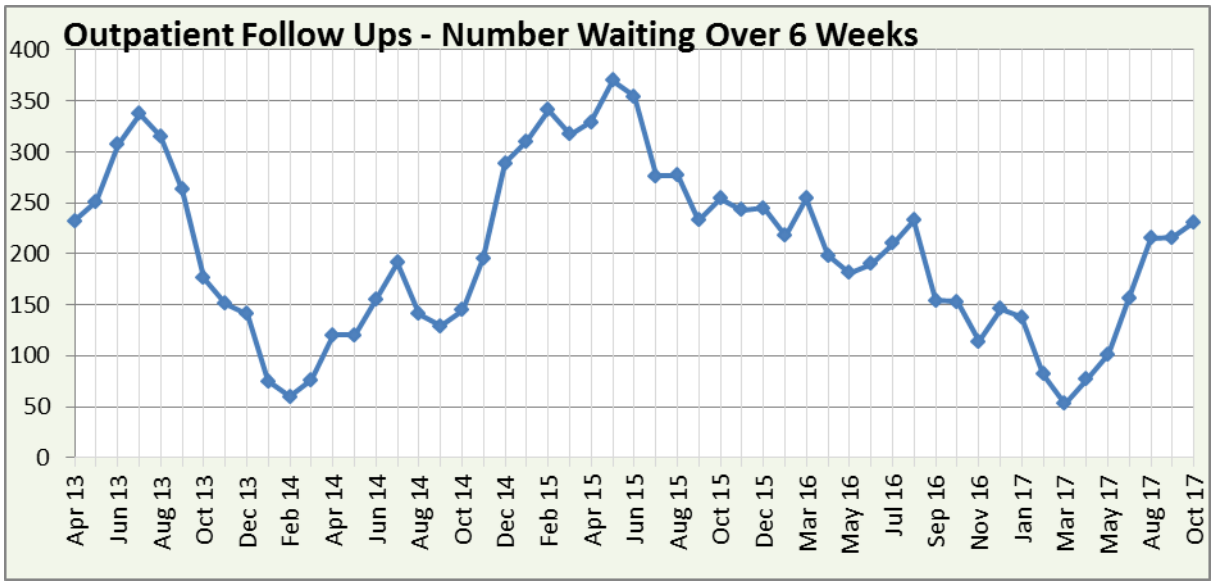
Plans to reduce waits

We have recruited to 2 new/replacement consultant posts (started in October) and there is a further Consultant starting in February which will help with the FUP's. However the majority of the FUP's are in Community and we are still in the process of defining a new Community Paediatrician post that will then be advertised.

Governance process to manage clinical risk

FUP lists and information are shared with the Consultants on a regular basis and they review their lists as required. These 300 patients are shared amongst 16 Consultants.

5) Cardiology



Factors behind the increase:

Lack of capacity and loosing pace with new referrals
We currently are adding approximately 20 patients to the backlog list each week.

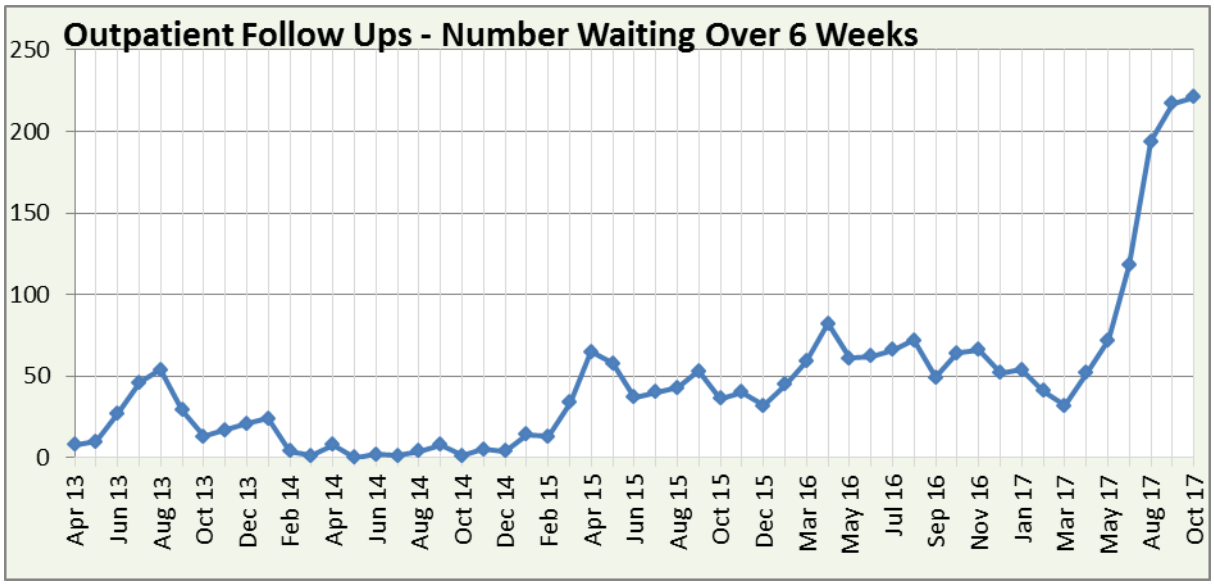
Plans to reduce waits

The team is exploring extra clinics, to deal with the long waiters, reviewing Job Plans to look at increasing clinic capacity longer term. Consideration of 'Waiting Lists initiatives' may be necessary to really get on top of the waits.

Governance process to manage clinical risk

The team is reviewing the referral processes to ensure appropriately prioritised waits. They are also actively managing the list each week to ensure appropriate clinical priorities are achieved.

6) Oral Surgery



Factors behind the increase:

Vacancy at Consultant level – Locum Consultant left in February and then middle grade left in May 2017, unable to recruit a Consultant as per plan as no suitable applicants.

New cohort of junior staff are less experienced than expected as the plan in 2017 was to recruit 2x DCT's at DCT level 3. Have appointed Trust grades instead as DCT's pulled out at last minute. From a service perspective they are able to undertake far less work

Plans to reduce waits

Interviewing for Middle grade for 6 months to cover vacant Consultant post on Wednesday 22 November

Plan to re-advertise Consultant post in December 2017

Reviewing the pathway and follow up for Tongue ties -

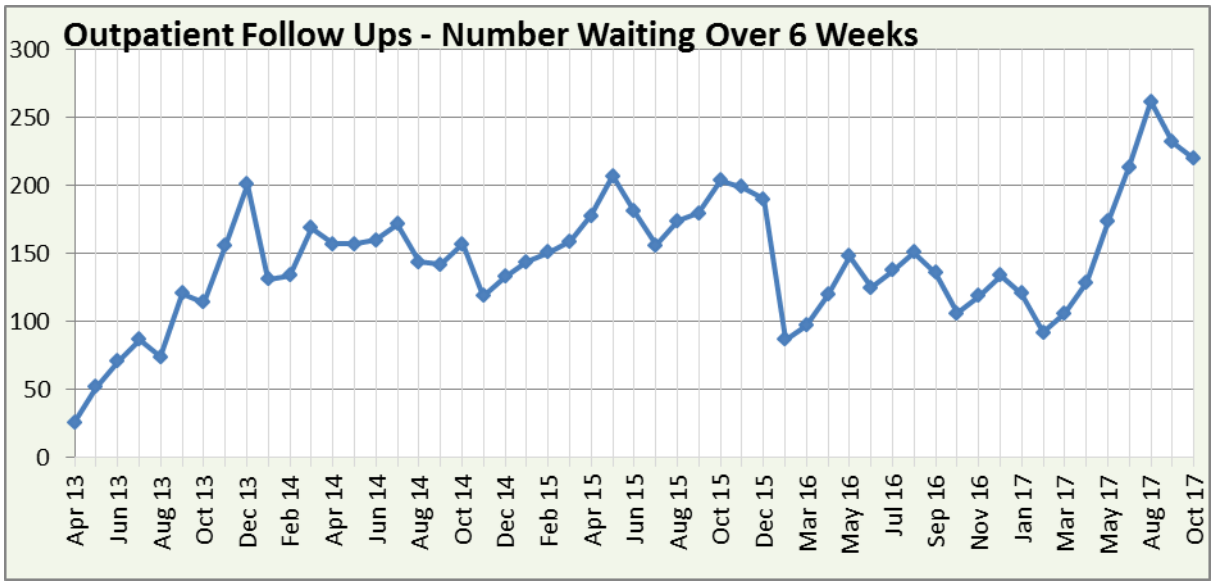
To actively review notes for the 21 patients waiting over 30 weeks

Discussion with team to look at any further reductions in follow ups that can be actioned

Governance process to manage clinical risk

All cancer patients are seen within the Head TW/OF clinics and have red dots placed on the slip for further appointments to denote they are cancer patients and therefore follow ups are booked.

7) Urology



Factors behind the increase:

New consultant started late 2016 and required training to support Paediatrics, lack of capacity while this happened.

Having to prioritise cancer patients and urgent new appointments. This will likely worsen the follow up position.

Plans to reduce waits

Have to resolve the 2WW and urgent new capacity first that may be detrimental to the routine follow up position.

Discuss follow up requirement and have protocols in place where possible.

Governance process to manage clinical risk

At current level risk is not deemed high compared to 2WW and urgent patients

Discussed at Governance meeting.

PERFORMANCE DIGEST

NHS
Torbay and South Devon
NHS Foundation Trust

See dedicated page on ICON for more detailed information

October 2017

Safety & Quality (Oct data)

Cancelled operations
1.1% [<0.8%]

Stroke patients
90% of time spent on stroke ward
79.4% [>80%]

Safety thermometer
(harm free care)
97.2% [>95%]

Infection control bed closures (acute)
30 [<100]

Dementia find*
78.6% [>90%]

occupied
92.7%
[80% - 90%]

Serious incident reported on the STEIS system
6 [0]

Colour of arrow - current RAG* rating
Arrow - improved, declined or remained static from previous month

Key Targets (Oct data)

- ED* and MIU* less than 4hr wait: **92.7%** [>92% trajectory]
- Cancer: 62-day wait for first treatment - 2 week referral: **85.7%** [>85%]
- 18 week referral to treatment (RTT): **84.04%** [>92%]
- Referral to treatment (RTT) 52 week wait: **26** [0]
- Diagnostics wait over 6 weeks: **3.2%** [<1%]
- Delayed discharges community hospitals: **490** [315 - 16/17 average]
- % of CAMHS* patients waiting under 18 weeks: **100%** [>92%]
- Care planning summaries % completed within 24hrs of discharge (weekday): **69.5%** [>77%]

Finance £

To achieve our plan we need to save.....**£42.1m**
Already saved..... £22.35m
Additional savings planned... £20.25m
} **£42.6m**
Over-delivery of savings.....**£0.5m**
Having achieved this we now need to focus on managing cost pressures totalling **£5m**

Feedback

"*"Over the weekend my father of 93yrs was hospitalised after suffering a stroke which left my mother (who is partially sighted, early dementia) of 92 without her carer. Within two hours from the initial contact, Social Services had all of mums needs covered, amazing. They were so helpful, explaining everything, keeping me up to date at every stage. I really can't praise them enough, Thank you Torquay Social Services you are amazing."*"

Torquay Social Services

Staff (Oct data)

Total staff
(Sept)
WTE: 5105.54
(in post)

Appraisal rate
82% [>90%]

Sickness
(Sept)
4.11%
[<3.8%]

Mandatory training
83% [>85%]

12 month staff turnover
12.32%

Media (Oct data)

@TorbayandsouthdevonFT
86 new page likes
38,221 people reached

@TorbaySDevonNHS
130 new followers
23,100 tweet impressions

TSDFT website
107,116 page views
02:03 avg. session time (mins)

OPEL (Oct data)

Operational alert status

1 12 days
2 14 days
3 5 days
4 0 days

***Footnotes:**

- **CAMHS** - Child and Adolescent Mental Health Service
- **Dementia find** - identifying dementia patients
- **ED** - Emergency Department
- **MIU** - Minor Injury Unit
- **OPEL** - Operational Pressures Escalation Levels
- **RAG** - Red, amber, or green
- **STEIS** - Strategic Executive Information System
- **Targets** - target given in [brackets]
- **WTE** - Whole Time Equivalent

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Winter Plan		
Lead Director	Chief Operating Officer		
Corporate Objective	• Safe, quality care and best experience • Improved wellbeing through partnership		
Corporate Risk/ Theme	• Failure to achieve key performance standards • Failure to achieve financial plan		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The report provides the Board of Directors with an update on development of a winter plan that delivers a clinically safe service and meets the requirements of national access standards to ensure compliance with the STF		
Key Issues/Risks	Key points of note: • The Trust has a winter plan and internal escalation plan that has been approved by A&E Delivery Board and will be overseen by the Winter Leadership Team Key operational risks and issues: • Domiciliary care availability, especially for the complex patient • A vulnerable care home market • Remodelled Acute and Community bed stock- not tested through winter • Clinical and nursing workforce capacity • End of life, domiciliary and hospice care		
Recommendations	To **note** the assessment and consultation undertaken to ensure provision of a winter plan appropriate to respond to local need, satisfy national requirements and deliver eligibility for STF in quarter 4. To **note** the existence of residual risks to delivery and provide challenge to the acceptance of currently described mitigating actions		
Summary of ED Challenge/Discussion	The Executive Team have been engaged in the development of the plan and oversight of the work programmes that support it. The Executive have required: • The winter leadership Team to provide weekly updates on delivery • Action to address short falls in domiciliary care • Access to appropriate action cards to direct the control room activity in escalation		

	• Improvements in information available in the control room to inform decision making • Application of the Accountability Framework to ensure all standards are being delivered The Executive Team noted the feedback from NHSE/I regional senior officers who have commended the Trust's winter plan as 'best in class' and have sought our agreement to share our plan with other Trusts.
Internal/External Engagement inc. Public, Patient & Governor Involvement	Engagement with multiple external stakeholders through the local and regional A&E delivery board
Equality & Diversity Implications	All changes are subject to quality and equality impact assessments. No specific issues identified.

MAIN REPORT

Report to	Board of Directors
Date	6 December Trust
Lead Director	Chief Operating Officer
Report Title	Winter Plan

1 Purpose

The report provides the Board of Directors with oversight of the winter planning process in order to:

- Provide assurance that the Trust has an agreed plan to optimise resilience over the winter period
- Demonstrate the system wide engagement and partnership working in the development of the plan
- Demonstrate compliance with national requirements
- Confirm that the plan has been through all appropriate approval processes

2 Provenance

The report is informed by the following:

- Minutes and actions of the local A&E Delivery Board
- Minutes and actions from the Patient Flow Board
- Minutes and actions of the Devon wide A&E Delivery Board
- Communication and feedback from NHS E and NHS I

3 Background

Winter planning is influenced by both national and local drivers. The national winter planning process commenced in August 2017 with the publishing of a national framework detailing 24 areas for compliance, with the most recent national submission and feedback from NHS England in November. Additionally, a series of local debriefs and planning events were commenced in July to seek feedback on key areas of development through learning from the last winter as well as existing or emerging risks.

Winter leads have been nominated from across the service delivery units and partner agencies who have participated throughout August and September in development of the plan. In response to this planning a number of key risks have been identified below:

Risks to the Organisation of non delivery

- A clear national priority has been placed upon winter preparedness. Failure to deliver upon this priority will have significant impact on organisational reputation and will incur increased scrutiny and performance challenge from our regulators.

- Eligibility to financial support through the Sustainability and Transformation Fund (STF) in Quarter 4 is predicated in part on delivery of the 95% 4 hour standard in March 2017

Risks to delivery of the winter plan

- A tendency for a more complex/dependant case mix leading to an increase in length of stay (LOS) and a subsequent impact on capacity especially in relation to ICU, paediatrics and respiratory patients
- Reductions in timely discharge of patients due to increased demand for health & social care support and any reduction in capacity in the community care sectors.
- Impact of infection outbreaks on patient numbers and LOS, demand for services and staff absence due to sickness
- Reduced bed availability due to sustained infection (e.g. Norovirus) outbreaks
- Increased ambulance attendances and peaks in arrivals resulting in ED delays
- Adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work

Our assessment of winter resilience is then formed on the basis of our ability to minimise the identified risks through the impact of three complimentary work streams

- the effectiveness of our winter plan
- our organisational response to escalation
- the impact of our business as usual continuous improvement

One of the high profile impacts of the winter planning process was the development of the "big 7" change projects, which are expected to provide benefit to the system going into the winter. These projects were developed as a result of an engagement exercise with staff and is a response to our local assessment of risk

4 The Winter Plan

A comprehensive winter plan document has been produced and was approved by the Board in November which details work across 9 domains with the stated aim of:

- understanding the pressures and demand patterns on urgent and emergency care
- providing enough resilience to enable achievement of our contractual performance and quality standards.

The plan was developed in response to national guidance and in response to local debriefing and planning events attended by a wide range of staff. The Chief Operating Officer holds executive responsibility for the winter plan with delegated responsibility being shared with Head of Operations within the ICO and the Commissioning Manager for Urgent and Emergency Care within the CCG.

The local plan has been shared at various stages of development with NHS England, Patient Flow Board and local and Regional A&E Delivery Boards to ensure good visibility with our partners and to ensure synergy between the ICO winter plan and the wider system plan.

A brief summary of the key domains within the winter plan are shared below for information.

Occupancy levels and capacity

In previous years, occupancy levels have been reduced to 85% pre-Christmas to provide some operational headroom, which has been successful in supporting non elective requirements over the festive period. We will therefore be reducing elective operating from mid-December and throughout January to ensure that our resources are focussed on our emergency pathway. Additional to reducing elective inpatient activity, we have taken a number of actions to focus teams and resources towards non-elective activity that would not be normally sustainable with the levels of planned activity throughout the rest of the year.

Prevention of avoidable 4-hour breaches within the emergency department

The Emergency Department (ED) continues to review urgent and emergency care pathways to reduce delays and maximise the opportunity for admission avoidance. The ED team have undertaken a significant amount of quality improvement work to ensure that the service is adequately resourced and that workforce capacity matches required demand.

New ways of working have been implemented and enhanced throughout 2017, which will positively Impact on pressures within ED. In order to support real time feedback and learning, a weekly meeting has been introduced from November 2017, chaired by the Head of Operations and supported by the CCG, with clinical speciality leads to review all breach trends with the aim of identifying themes to eliminate all avoidable breaches.

From 1st October 2017 the ED primary care streaming service has been in operation, providing a 7 day per week pathway to access primary care expertise, both in and out of hours, for patients who attend ED with a primary care need. This new pathway supports the existing procedure for redirecting appropriate patients to primary care established in 2016/17 aimed at ensuring that patients are redirected to the most appropriate source of care to meet their needs.

Organisation response to de-escalation

A refreshed Escalation Policy has been developed in preparation for winter, learning lessons for the implementation of this new system of working established in 2016.

Key improvements will include:

- Service Delivery Unit (SDU) ownership of action cards which relate to each OPEL level
- Revised dashboards to ensure that data quality is optimised.
- Wider representation from across the health and social care community at control room meetings at OPEL 2 and above.

Throughout the winter period, the CCG will increase their input to the ICO control processes with further commitments for support during times of escalation. There has additionally been a strengthening of capability within our regulators with the appointment of a Winter Director who will be available to support systems with their de-escalation activities as required.

Arrangements for business continuity over Christmas and Bank Holidays

The number of weekend and bank holiday days over the festive period means a predictable decrease in system capacity and capability. The winter plan therefore provides specific attention to staffing levels over this period and describes expectations for key speciality availability.

Arrangements for provision of alternatives to admission

Maximising the benefits of the integrated health and care services provided by the Trust is key to avoiding unnecessary admissions and our Care Model is focused on maintaining independence and keeping people well at home.

The Trust has a number of initiatives in place aimed at supporting high risk groups within our population to avoid admissions, these include:

- Building on the enhanced integrated health and social care teams in each of the five localities, which were initially established in 2016/17. The teams comprise of intermediate care nursing, therapy, medical cover, pharmacy, community nursing, social workers, social care reablement, rapid response and wellbeing coordinators.

- These Health and Wellbeing Teams are designed to support patients in their own home to reduce the need for hospital based care and cascade advance warnings and briefings where appropriate. Care homes have access to the Health and Wellbeing Team to better support the management of their residents and reduce non-elective admissions.

Additional to these initiatives, we expect benefits to be seen from improved support to care homes made possible through deployment of the Better Care Fund (BCF) as well as impact from the newly established frailty team working within the emergency department, and making better use of technology such as the local admission avoidance app.

Management of high-risk patient groups

Several high-risk patient groups are specifically targeted within the winter plan with descriptions of augmented support arrangements in place. It is expected that these support arrangements will both respond to patient need such that they do not need acute hospital support, or make specific arrangements to expand the acute hospital offer if this is thought to be the most appropriate response for these patients.

Management of patient flow and effective discharge processes

The winter plan details the activities that will be undertaken to both support good patient flow within the Trust's hospital system as well as to manage specific risks during any periods of reduced patient flow. Key areas to highlight include:

- Management of early day discharge
- Response to long waits for admission within the emergency department
- Management of surge or waits for handover within the ambulance service
- Review of patients with a longer length of stay to ensure appropriate management

Arrangements for infection prevention and control

The winter plan focusses on the Trust's approach to management of Influenza and Norovirus as the two highest risk events. These plans have been tested through a table top exercise in November and detailed action cards have been included within the Trust's Escalation Policy

5 Business as usual continuous improvement

Additional to business continuity and de-escalation arrangements, 7 key projects have been identified as a focus of continual improvement over winter. These actions have been developed as a result of an engagement exercise with staff and responds to areas of risk identified during that process. Each project has an executive lead with an expectation to make a significant contribution to winter resilience as well as make the sustainable improvement step towards delivery of the STF requirements at the end of quarter 4.

- Increasing capacity to support people at home through domiciliary care packages and care at home
- Single point of referral to all localities for all patients who are ready for discharge
- Optimising intermediate care and integration of the district nursing function, with the potential for increasing capacity to respond to increased volume and acuity and reducing reliance on a bed based care response to this increased demand.
- Maximise Ambulatory care provision, to further optimise this as a patient pathway to expedite flow and avoid inpatient admission.
- Use of technologies, maximising the opportunities of Visimeet, including extending within care homes to allow virtual access to education and advice to avoid admissions, as well as a way to support frequent ED attenders with improved access to care plans, especially where the service users needs cross service providers.

- Establish a winter leadership team, a team with dedicated time to lead the hospital around winter, a 'fast track' site management team which can react promptly to increasing pressures and mitigate the risks associated with increasing escalation status', with a named medic or a named nurse to drive this.
- Communication, engagement and Information, improving access to timely, good quality intelligence information across the health community, including the development of an engagement plan, involving staff in understanding and delivering the plan.

Weekly oversight and scrutiny of these plans is provided by the Chief Operating Officer with continuing management through Flow Board.

6 Process of Assurance and sign off

The Torbay and South Devon winter plan forms part of a wider Devon STP winter plan. Several versions of the plan have been developed following feedback from NHS England, local and regional stakeholder groups as well as continuing revised guidance actively being generated from the Department of Health.

Feedback from NHS England in September highlighted some areas for development, and following these amendments the feedback received regarding our November submission has been described as a best practice example nationally.

An overview of the oversight and approval process is detailed below:

- Initial submission to NHS England as part of the wider Devon STP winter plan 31st August 2017
- First Review at Patient Flow Board 13th September 2017
- Feedback received from NHS England 14th September 2017 with recommendations
- First review at local A&E Delivery Board 27th September 2017
- Second Review at Patient Flow Board 11th October 2017
- Second submission to NHS England submitted 13th October 2017
- First review at Devon A&E Delivery Board 17th October 2017
- Third review at Patient Flow Board 8th November 2017
- Third submission to NHS England following further guidance submitted 20th November 2017
- Second Review at local A&E delivery board 29th November 2017
- Trust Board December 2017

7 Monitoring of Delivery - Winter Leadership Team

A winter leadership team has been agreed to oversee the implementation of the Winter Plan including completion, evaluation and updates to the Trust OPEL Policy and establish a site management function 24/7.

The winter team comprises of:

Liz Davenport, Chief Operating Officer	Executive Lead
Ian Currie, Deputy Medical Director	Clinical Lead
Cathy Bessent, Deputy Director of Nursing	Nurse Lead
Cathy Gardner, Head of Operations	Management Lead

The winter team reports to the Patient Flow Board, and meets on a weekly basis and provides weekly updates to the Executive Directors on the effectiveness of the plan.

8 Summary of Risks and Issues

Domiciliary care availability, especially for the complex patients:

- Intensive discussions continue between ICO and Mears relating to support with recruitment and retention.

- Priority 1 of the “big 7” activities is intended to provide more resilience to the Dom Care system.
- A vulnerable care home market.
- Experience during the year of several care homes experiencing quality or safeguarding issues.
- Reduced care home bed availability in September impacted on bed occupancy within the Trust’s hospital system.
- Impact is seen both in reducing available beds but also in requiring input from community clinical team to support the home in crisis.
- Priority 3 of the “big 7” activities is intended to increase capability to manage a greater acuity of patient in a home environment as an alternative to bed based options.
- This will provide some contingency to a reduced care home capability through the winter period.

Remodelled Acute and Community bed stock:

- Reduced contingency to support deficiency elsewhere in the system.
- Escalating bed stock is part of the trust escalation plan.
- Ability to introduce additional beds is dependant on the availability of sufficient clinical staff.
- Priority 4 of the “big 7” activities is intended to increase the number of patients arriving for assessment who are managed in a non bed based environment therefore further reducing the demands upon the bed base.
- Priority 6 of the “big 7” activities develops the management capability to ensure that escalation responses to system pressure do not rely on escalation beds.

Clinical and nursing workforce

- There continue to be a level of vacancies within our clinical teams that means there is a lack of resilience to respond to any high sickness absence.
- Reducing the number of beds within the ICO reduces the total number of clinical shifts that will be expected from our teams.
- The winter plan focusses on rostering over the times of peak demand.
- The infection control plan includes effective levels of vaccination within the workforce to protect from seasonal influenza.
- By reducing demands within the inpatient elective pathways we allow for a focus of resource to the highest priority areas.

End of life, domiciliary and hospice care:

- Predictable reduced capability within community services leads to greater numbers of patients requiring end of Life support within the acute environment when this may not be their preferred option.
- Priority 1 of the “big 7” activities increases capability within the rapid response teams to with the intention that end of life patients are the first priority to be supported at home.

9 Recommendations

The Board is asked to note the assessment and consultation undertaken to ensure provision of a winter plan appropriate to respond to local need, satisfy national requirements and deliver eligibility for STF in quarter 4.

To also note the existence of residual risks to delivery and provide challenge to the acceptance of currently described mitigating actions

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Mortality Safety Scorecard		
Lead Director	Medical Director		
Corporate Objective	Safe, quality care and best experience		
Corporate Risk/ Theme	Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'.		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The Safety Scorecard has been redesigned to provide focus on mortality. Other aspects of safety and quality of care are included in the Integrated Performance Report. This scorecard is reviewed at the Mortality Surveillance Group and is a key part of the assurance provided, alongside a new public facing mortality dashboard which will be launched in December 2017. The mortality dashboard will contain the outcomes, learning and actions from individual mortality reviews, including an assessment of 'avoidability' of death. The aim is to include all patients. There is particular focus on patients with mental health problems and learning disability.		
Key Issues/Risks	The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at TSDFT have been within the desirable range for our population over a prolonged period. However, early in 2017 a divergence in HSMR and SHMI was identified. Detailed analysis of the reasons behind this has been undertaken with the support of Dr Foster and NHSI. The outcome of the deep dive has been discussed in detail at Quality Assurance Committee (QAC) in June 2017. Both HSMR and SHMI are susceptible to changes in characterisation of different forms of Trust activity and it is likely that, at present in TSDFT, both are affected by recent changes in the Trust and in particular by new service models. We believe that this underlies the reasons for divergence of the 2 measures. HSMR is likely to be falsely high and SHMI may be falsely low. Overall crude mortality shows a reduction over time. Dr Foster and NHSI support the view agreed at QAC that there is not an underlying problem in relation to mortality within the Trust but that recording is affecting our reported rates. It is likely that changes in coding of admissions as a result of increasing ambulatory care is resulting in a reduction in coded comorbidities, affecting the standardisation of mortality data. It has been agreed that there should be a change in coding of ambulatory care patients to more accurately reflect their management. This will be in line with reporting in the other STP acute		

	organisations. The effect of changes in coding is expected to take some months to show through because of the lag in mortality reporting. Detailed monitoring will continue with the support of NHSI. The deep dive that has been undertaken and the improved understanding it provides will make our data more reliable for the longer term and will improve our ability to monitor the impacts of service development.
Recommendations	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.
Summary of ED Challenge/Discussion	Detailed analysis of the potential effects of reclassifying some Trust activity has been undertaken and the executive team are assured that none is expected.
Internal/External Engagement inc. Public, Patient & Governor Involvement	The data contained in this report is discussed at the Quality Improvement Group and at Mortality Surveillance Group. These groups have CCG, Governor and patient representation.
Equality & Diversity Implications	None

MAIN REPORT

Report to	Trust Board of Directors
Date	6 December 2017
Lead Director	Medical Director
Report Title	Mortality Safety Score Card

Introduction & Data Source
The indicators for this score card have been collated from a variety of data sources using defined methodology. The report is designed to give a top level view of our bed based mortality over time and by week and weekend split. Data sourced includes data from the Trust, Department of Health (DH) and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, Quality Assurance Committee and Mortality Surveillance Group as well as local governance groups.

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 err.

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 which may be a signal of improvement or of a process starting to err.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		**Data Source**	**Target**	**RAG**
Appendix 1 • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster 2016/17 benchmark Month DH SHMI data	Aim for a yearly HSMR ≤90	
Appendix 2 • Unadjusted Mortality rate		Trust Data	Yearly Average ≤3%	
Appendix 3 • Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	

Appendix 1

This metric looks at the two main standardised mortality tools and is therefore split into:

1A – Dr Foster Hospital Standardised Mortality Rate (HSMR) and
1B – Department of Health Summary Hospital Mortality Index (SHMI)

1A The HSMR is based on the *Diagnosis all* Groups using the 16/17 monthly benchmark and analysis by Trend Month

Our HSMR Measure aim is to reduce and sustain the HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated.

Chart 1 - HSMR by Month Jan 16 – Aug 17

The headline monthly view of HSMR is showing a relative risk of 78.47– this may change as more data is processed by Dr Foster, but follows the 3 prior month's data points of being below the 100 line which is very encouraging.

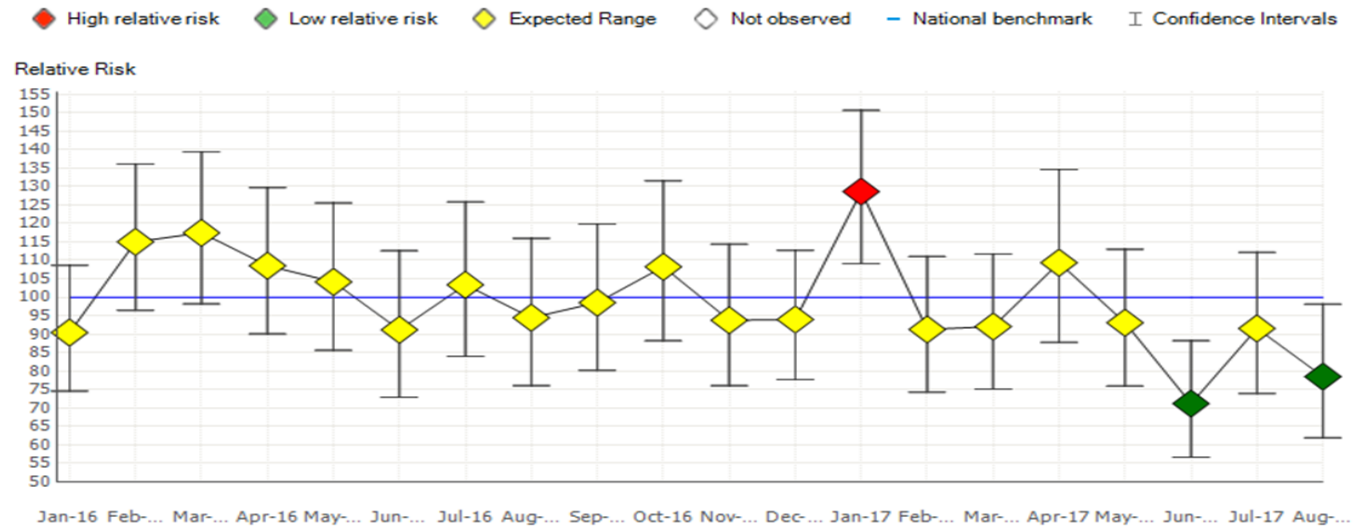


Chart 2 HSMR from January 2014 – June 2017 as a longitudinal view

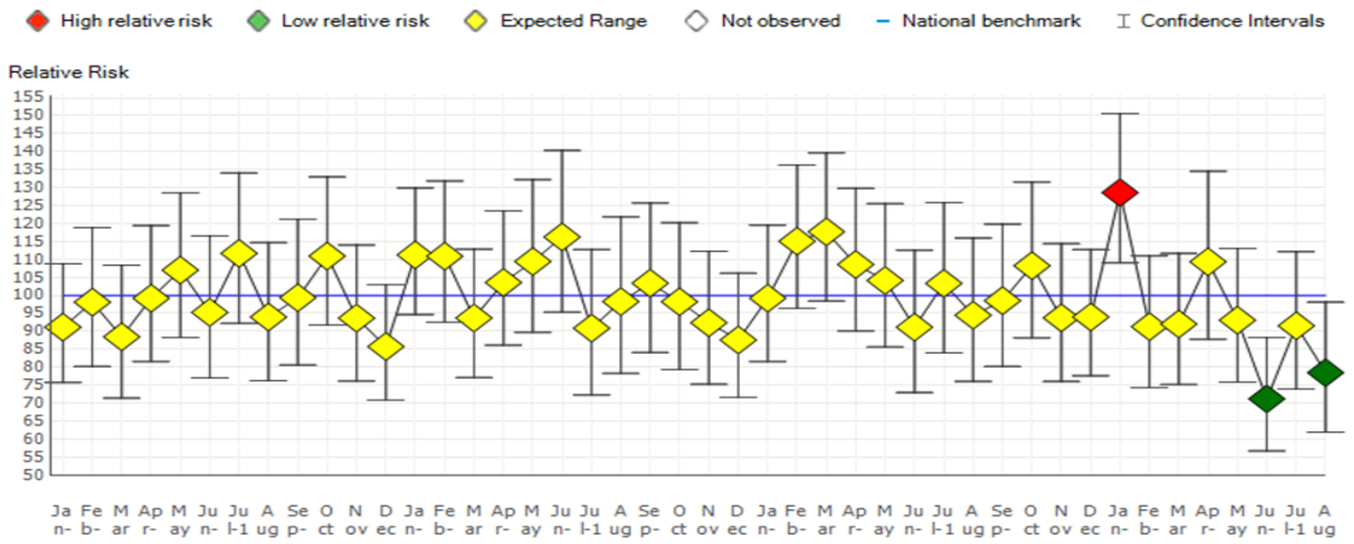


Chart 2 allows a larger view of HSMR over time. The relevance of this chart highlights the natural variation mortality brings, with peaks of mortality occurring within the winter periods. The chart also highlights Jan 17 as being the only month to have ever recorded a 'high relative risk score'. As mentioned previously the August 17 figure will be prone to change as Dr Foster process more data.

Chart 3 & 4 Weekday and Weekend HSMR patterns.

The following 2 charts show the pattern of HSMR according to day of admission via a rolling 12 monthly perspective. Noted, there is a rise in weekday HSMR, as against the English average, but this is balanced by a significant fall in weekend HSMR (Chart3). There is no clear explanation for a real change in mortality of this order, over such a timescale. Detailed analysis carried out with the support of Dr Foster and NHSI suggests that the apparent change may relate to a change in coding of comorbidities. Changes are being made to coding which will reduce the impact of coding of comorbidities. The impact will take some months to show through in these figures because of the long time frame. Ongoing monitoring will identify further unexpected changes.

Chart 3

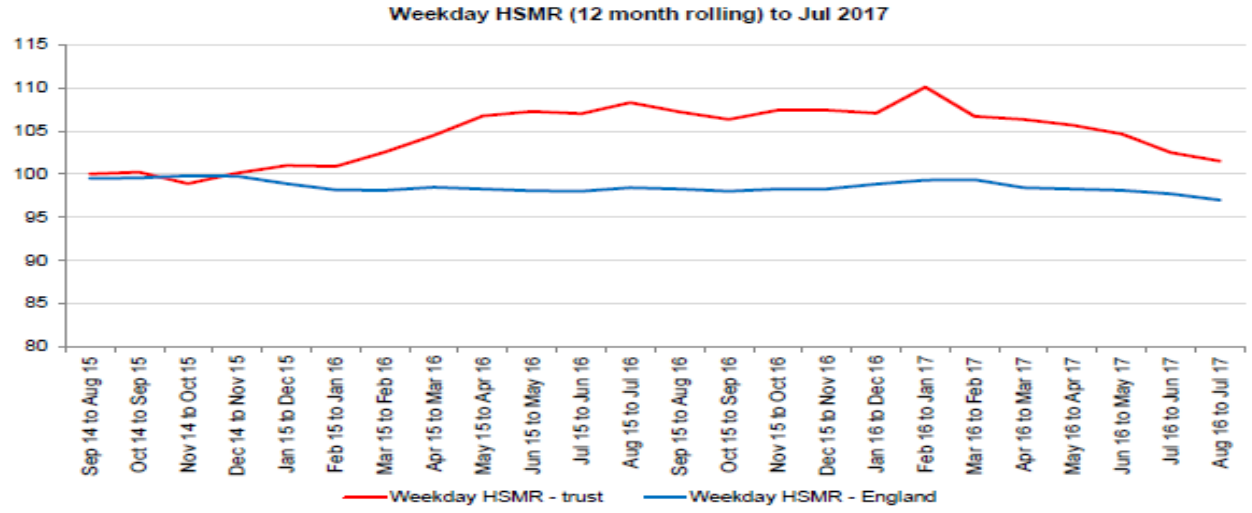
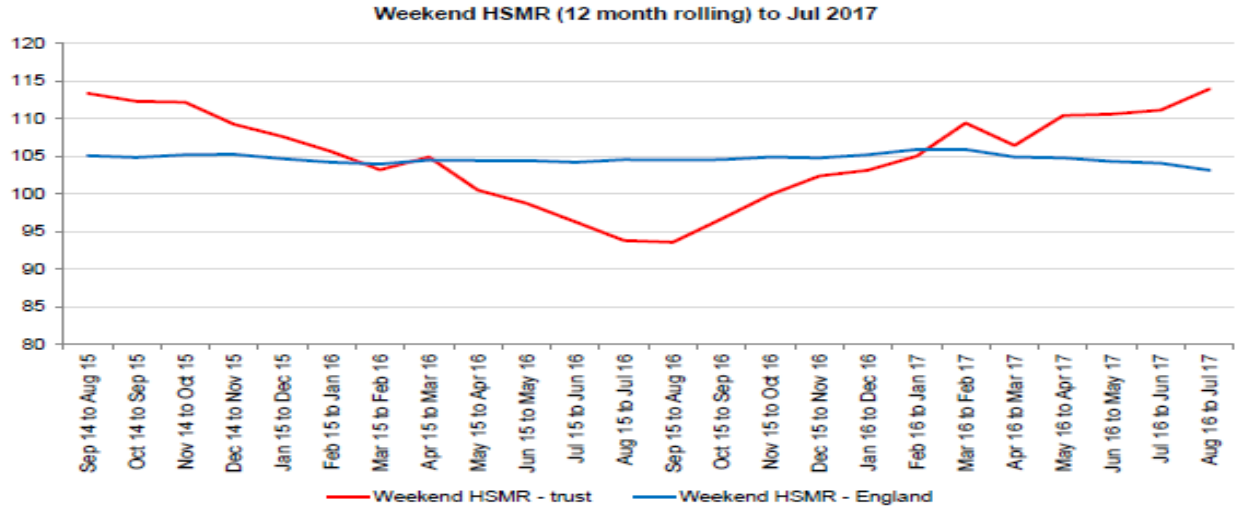


Chart 4



1B Summary Hospital Mortality Index (SHMI) Reporting period April 2016 – Mar 2017

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 based on the **Jan 2016 – Mar 2017** data release.*

Chart 5, as below, highlights SHMI by quarter period with all data points within the expected range and trending below our 90 target which is very positive.

Chart 5

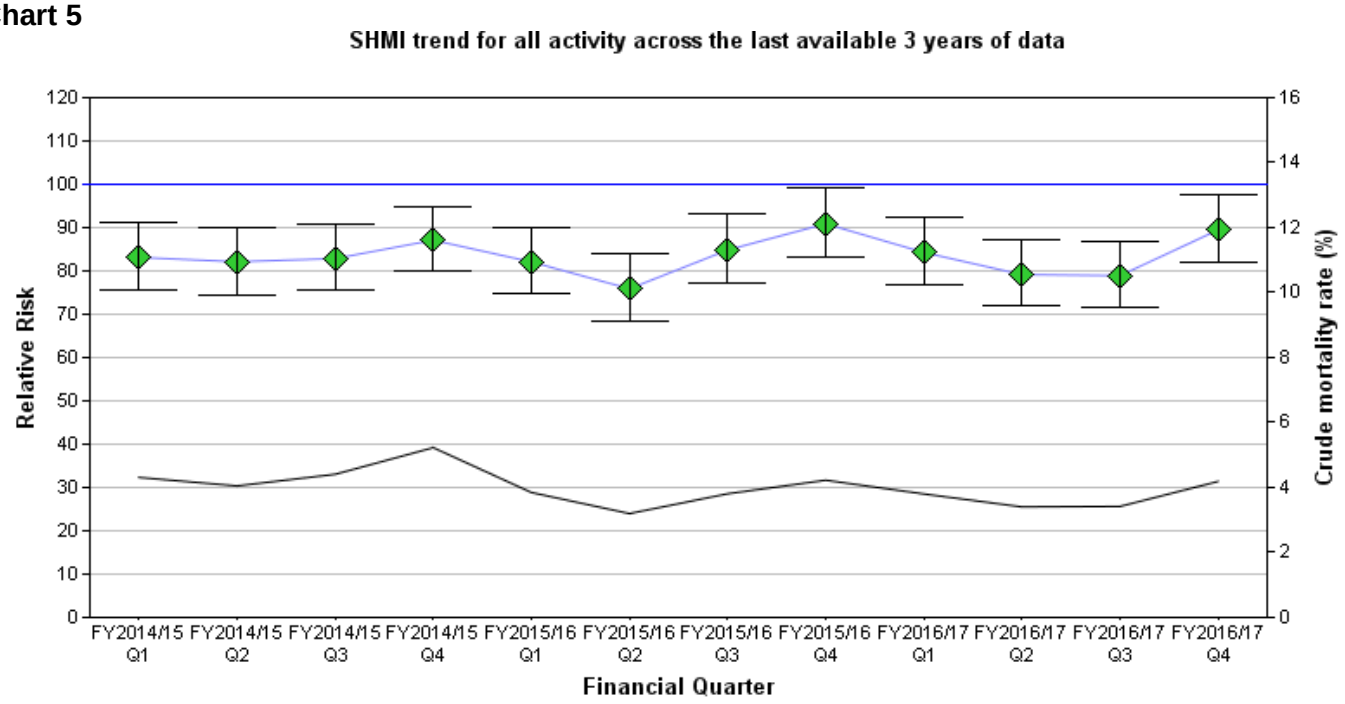


Chart 6 SHMI all deaths, SHMI in hospital deaths and HSMR comparison

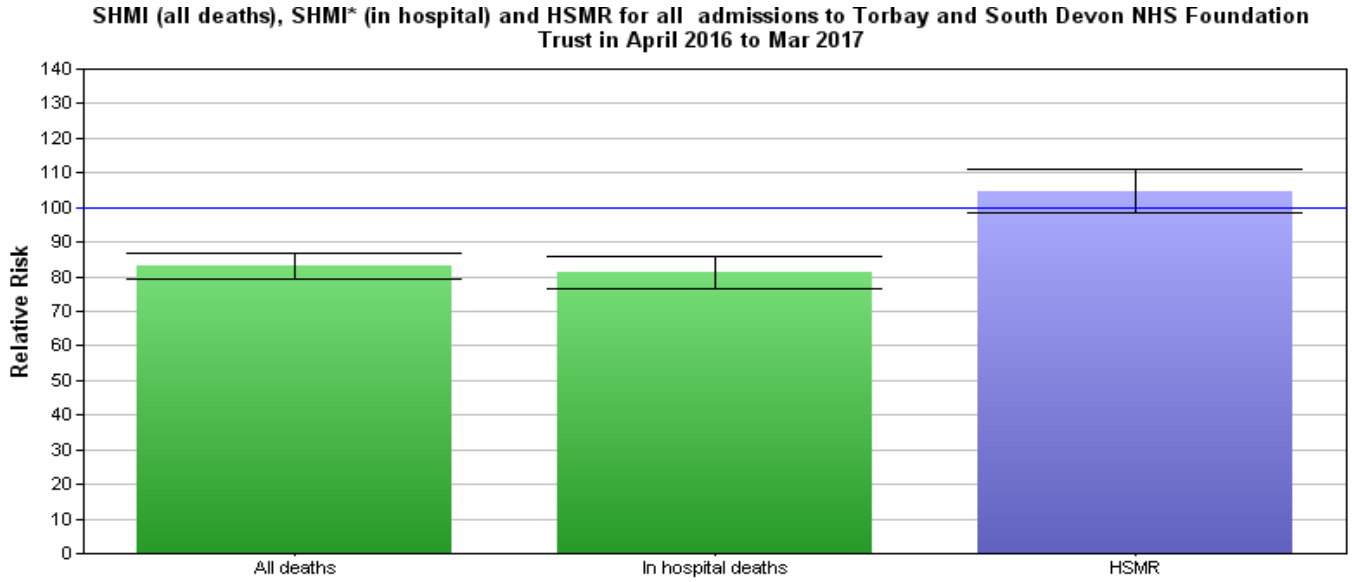


Chart 6 (as above) records all SHMI deaths, deaths in hospital and HSMR for the time period July ***Jan 2016 – Dec 2016***. The SHMI data are within expected range and show the in-hospital deaths at a very low relative risk. What this chart does highlight is the differential between HSMR and SHMI.

Chart 7 shows the 12-month rolling SHMI data by time period and demonstrates a significant fall at the time of establishment of the ICO which is likely to be related to a change in reporting rather than a 'real' reduction in mortality. Reduction in community hospital admissions and a change in the means of reporting during 2017 may result in a rise in SHMI, though none is apparent to date. The results remain very encouraging.

Chart 7 12 month rolling SHMI data.

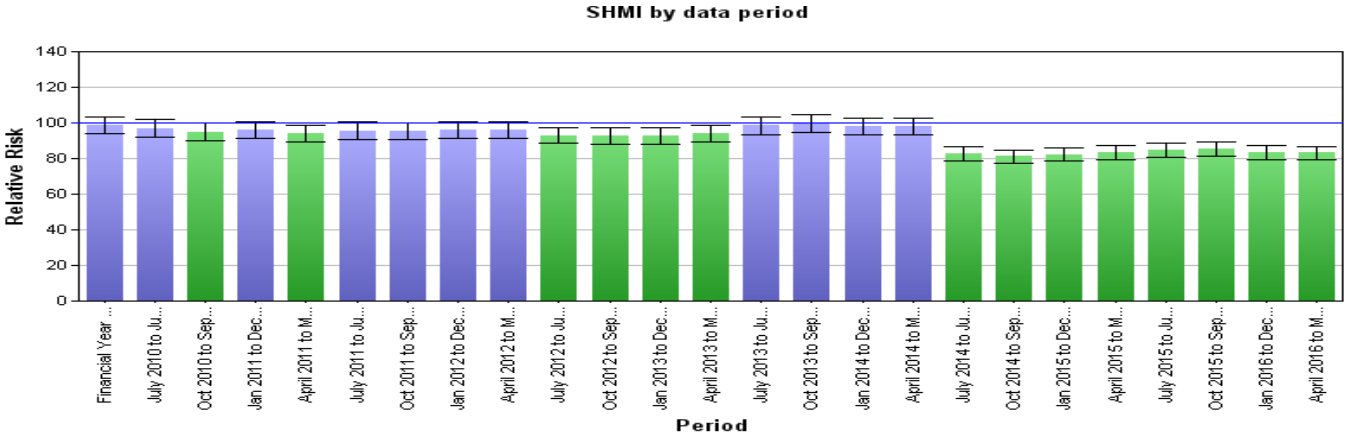
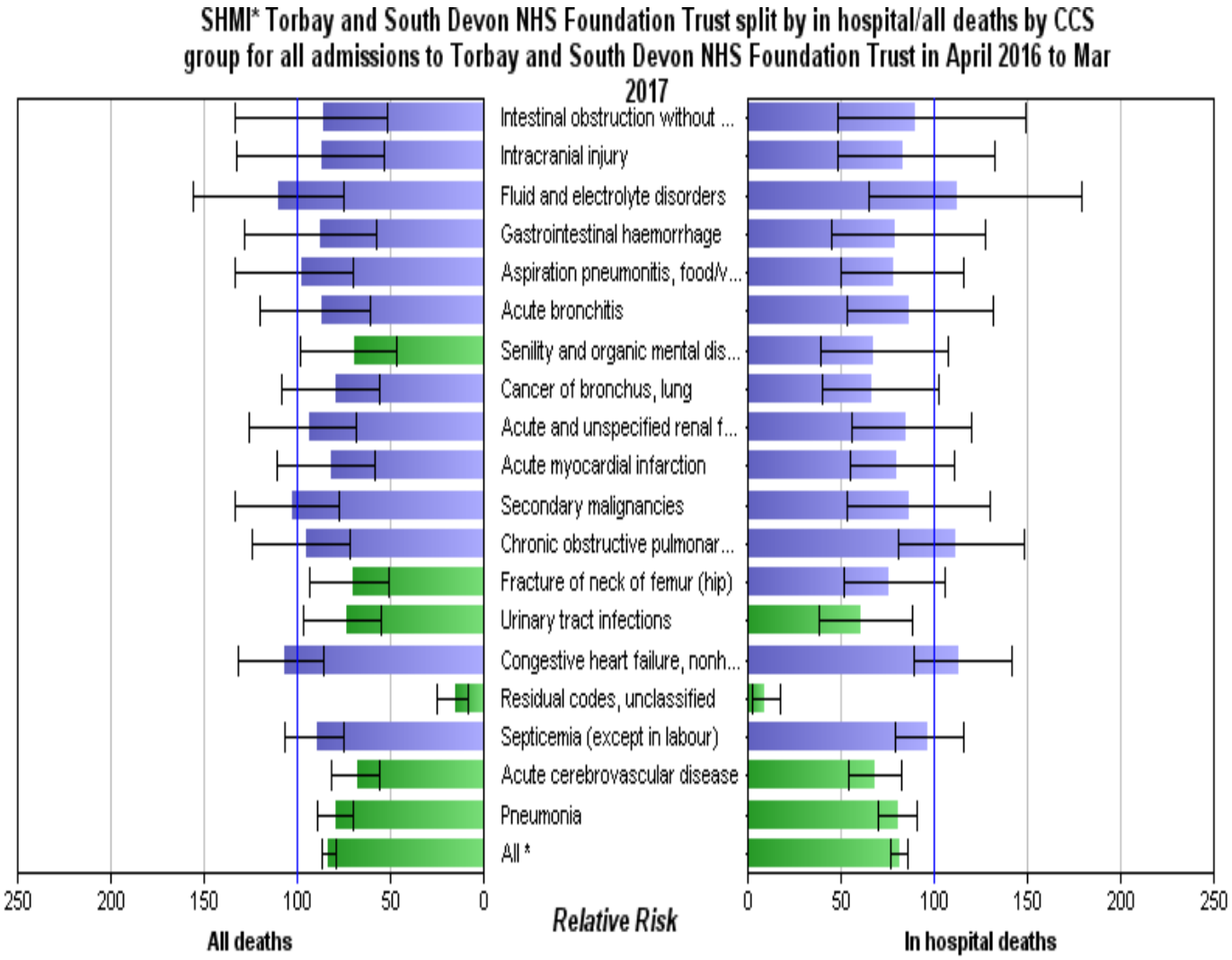


Chart 8 SHMI by diagnostic group.

This 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). All areas are within *normal range* or are performing *better than the norm*.



Appendix 2

This data looks at the number of deaths in hospitals and expresses this as an unadjusted death rate as a percentage

This percentage is defined as the monthly unadjusted or 'raw' mortality. It is calculated 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.

Chart 9 The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI. After a winter peak in January, the numbers have reduced and this is in line with the cyclical nature of mortality, as demonstrated within the graph. The average unadjusted value outside of January has remained below the 3.0% target for 2017.

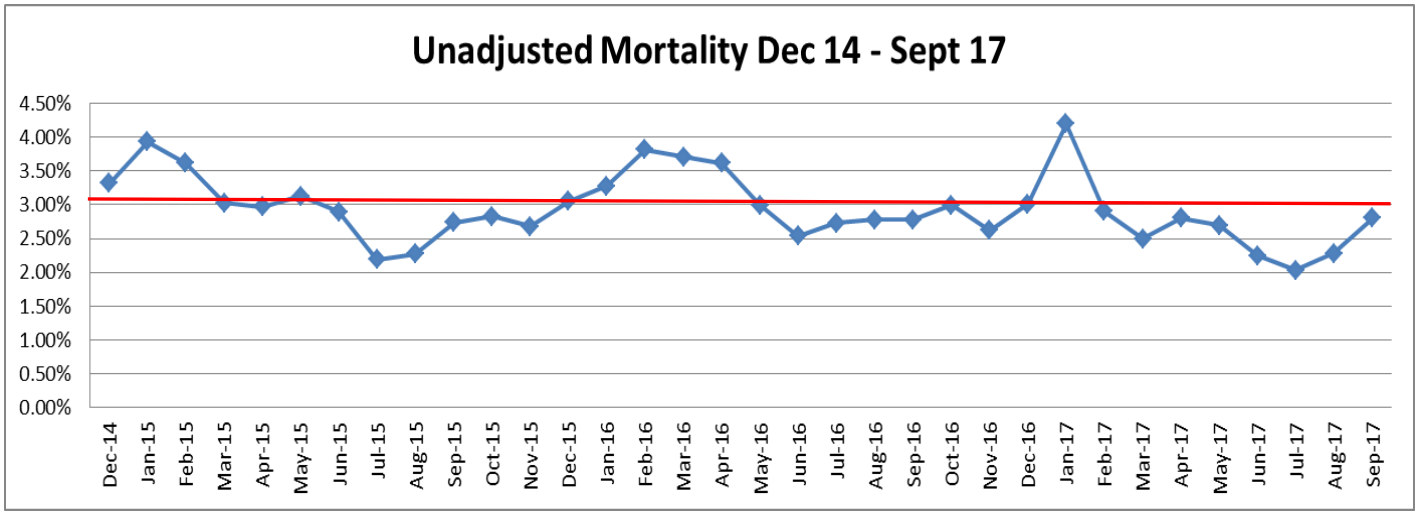


Chart 10 highlights the monthly mortality by number of deaths within the hospital based care setting. Please note either the sharp rise in winter Jan 15 and 17 or a more prolonged period shown in Feb/Mar 16

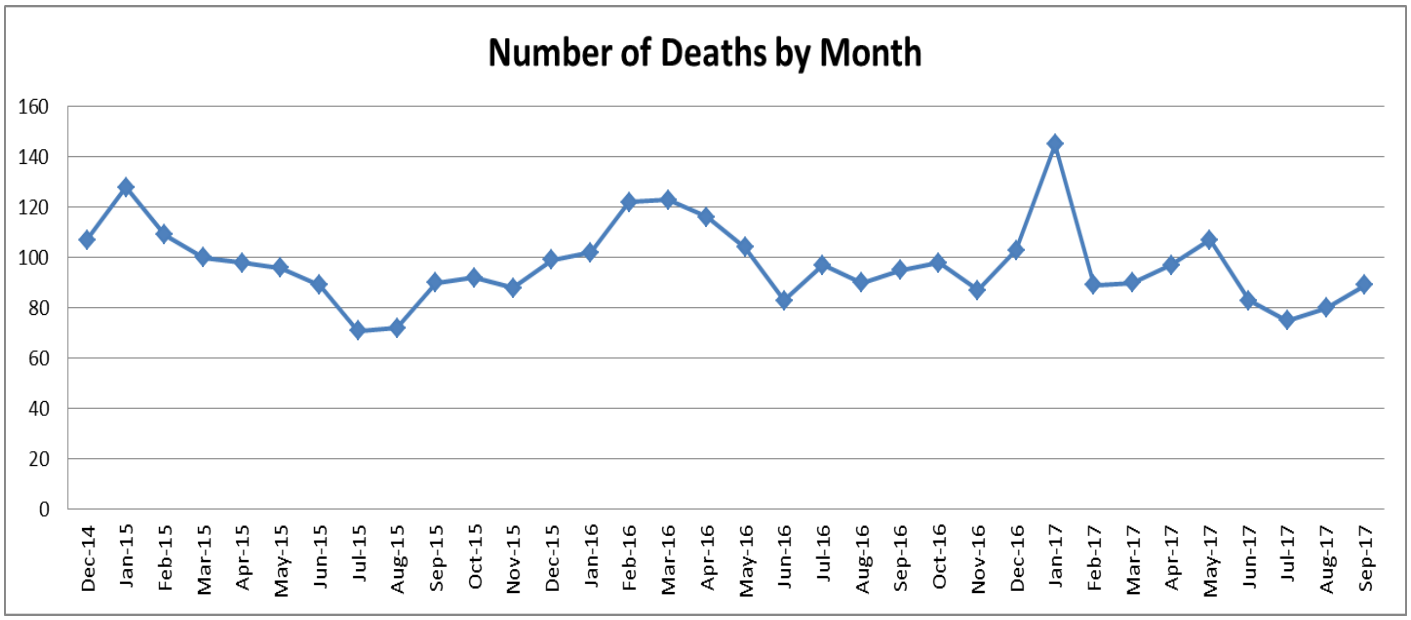
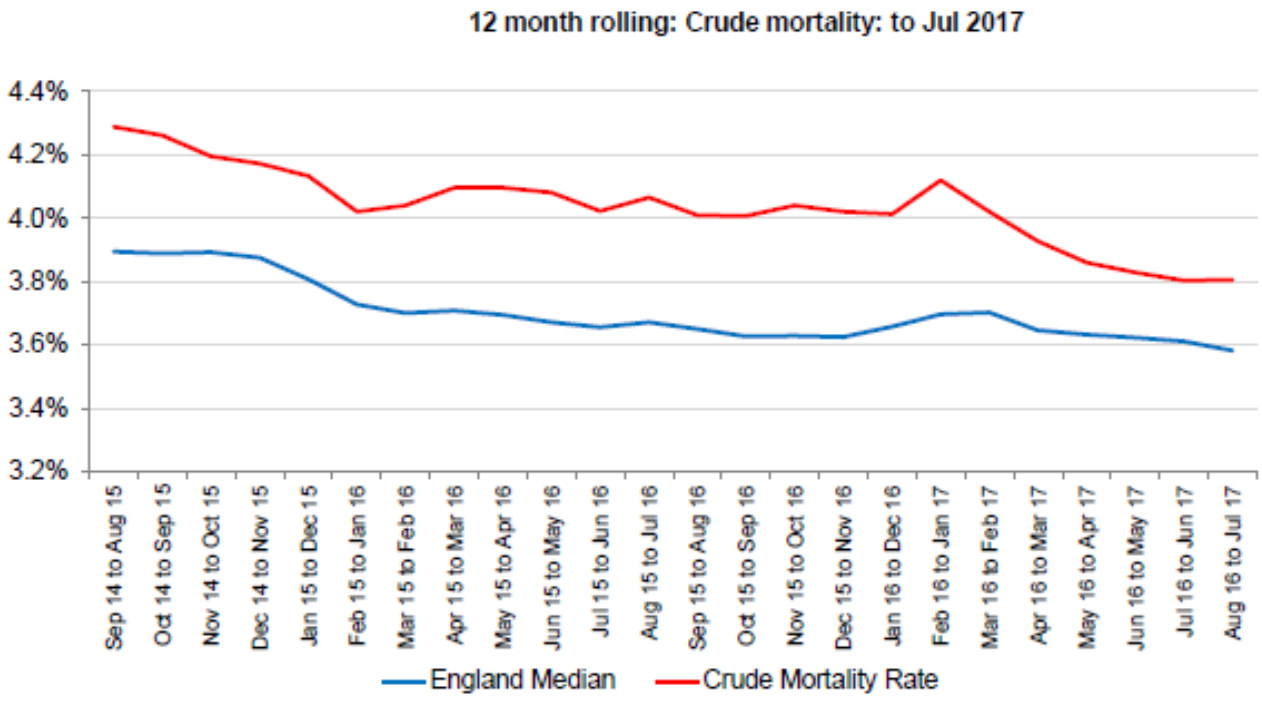


Chart 10

Chart 11 shows the crude mortality rate against time and compared to national level. Note that TSD crude (un-standardised) mortality is higher than the national average reflecting our age distribution and comorbidities. The graph demonstrates a reduction in in-hospital death since 2015 which mirrors the national picture.



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 in turn are based on procedure codes used in the NHS.

The date range for this data is August 2016 to July 2017 and all of the 15 indicators are within the expected norm, 4 are performing better than expected.

Chart 12

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk	
Deaths in low-risk diagnosis groups*	25,204	19	13.6	0.8	0.5	140	
Decubitus Ulcer	7,877	287	396.5	36.4	50.3	72	
Deaths after Surgery	421	41	35.8	97.4	84.9	115	
Infections associated with central line*	13,854	0	0.7	0.0	0.0	0	
Postoperative hip fracture*	19,108	0	1.1	0.0	0.1	0	
Postoperative Haemorrhage or Haematoma	16,094	11	6.8	0.7	0.4	162	
Postoperative Physiologic and Metabolic Derangement*	13,460	0	1.5	0.0	0.1	0	
Postoperative respiratory failure	12,222	4	10.3	0.3	0.8	39	
Postoperative pulmonary embolism or deep vein thrombosis	16,318	20	39.9	1.2	2.4	50	
Postoperative sepsis	448	3	4.2	6.7	9.5	71	
Postoperative wound dehiscence*	597	0	0.5	0.0	0.9	0	
Accidental puncture or laceration	60,467	62	75.7	1.0	1.3	82	
Obstetric trauma - vaginal delivery with instrument*	226	4	16.5	17.7	72.8	24	
Obstetric trauma - vaginal delivery without instrument*	1,208	33	38.5	27.3	31.9	86	
Obstetric trauma - caesarean delivery*	550	0	2.1	0.0	3.9	0	

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Education & Development End of Year Report		
Lead Director	Chief Nurse		
Corporate Objective	Safe, quality care and best experience Valuing our workforce Well led		
Corporate Risk/ Theme	Failure to achieve key performance / quality standards. Inability to recruit / retain staff in sufficient number / quality to maintain service provision. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	This is the end of year 6 month report for Education and Development, for the Trust Board's information and assurance. The report highlights performance over the last 6 months and core priorities for the next 6 month period. Of particular note is the Trust's performance in the annual quality assurance visit from Health Education England across the South West. The main priorities for the next 6 months will be to implement the new education directorate structure and develop the education and development strategy.		
Key Issues/Risks	• Mandatory training compliance – strategy to be agreed to address non-compliance, interim action plan in place to target the most non-compliant areas. Paper to go to Board in February 2018 with update. • Leading staff through the implementation of the proposed new directorate structure. • Increase in staff time delivering training in the health and social care settings – will need to consider travel, parking, facilities, etc. Scoping exercise has taken place and this will be discussed with Lesley Darke. • Developing an education strategy that is joined up with Workforce, OD and QI strategies, for a holistic approach to education and development. • Meeting the cost saving plan for 2018-19 – the senior team restructure and directorate structure will contribute to this. • Delivering the new academic programmes being implemented including new nursing programmes and Year 3 and 4 medical student programmes. Action plans are being developed – a new multi-professional approach to placement management will be introduced.		

	• Facilities review – this is required due to the increasing number of academic programmes – this will include teaching space, accommodation, etc. Included in this is the development of a business case for a new Sim-Man. • Education and training compliance reporting – a proposal will be going to the Execs to agree which system to use for reporting, ESR to the Hive. A decision is needed urgently as staff are directed to ESR not the Hive via the automated email system for ESR and therefore it is creating dual training records in both ESR and the Hive. • Costing to deliver the new degree nurse apprenticeship due to start September 2018 – paper to go to Board in February 2018. • PVI sector education plan – 12 month commitment to offer free education covering the priorities – dementia, End of Life, Pressure ulcer care, falls, infection control. This is reliant on the Hive for the provision of the digital learning and access to book on to face to face courses. •
Recommendations	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.
Summary of ED Challenge/Discussion	• Performance as per the HEESW annual quality assurance visit noted. • Directorate restructure progressing but aware this could be distracting. Staff are being supported through the process. • Education and development strategy to link to STP system strategy. • The Hive and ESR proposal to move to a single system for education and training delivery and reporting. • Reviewing clinical workflow to create time to access to e-learning, options are being explored and will be presented in Q4.
Internal/External Engagement inc. Public, Patient & Governor Involvement	Private Voluntary Independent sector partners Plymouth University Health Education South West
Equality & Diversity Implications	n/a

Performance (June – December 2017)

1. Number of core learner/student placements delivered

Placement Type	Number of placements	Expected outcomes
Postgraduate Medical trainees (F1's – ST's) and Trust Doctors	238	
Year 1-4 Medical Students (PCMD)	17	
Year 5 Medical students (PCMD & St Georges)	89	
Physician Associates	11 (6 students, 5 qualified)	
Apprenticeships	96 (82 existing staff in substantive posts, 14 new)	All 14 new apprenticeships expected to become permanently employed
Traineeships (Project search, PLUS, Employability hub)	8	1 has gained permanent employment, the others are still on programme
Work experience placements	125	
Trainee Assistant Practitioners (TAPs) 1st Year	34	
TAP's 2nd Year	38	
Student nurses (Year 1-3)	250	
Sponsored student nurses	19	AHP's going on to nursing
Preceptorship	43	
Bridging	17	
Return to Practice	7	
Critical care degree	15	
Nursing Associates	9	
CPD	42 Multi-professional registrants paid for degree masters programme	
	25 non-medical prescribers	
Total number of placements/ learners	**1083**	

2. Educational facilities

2.1 Horizon Centre usage:

The majority of educational programmes and mandatory training runs out of the Horizon Centre, although we are seeing an increase in education being delivered out in clinical practice, expanding education outside of the Horizon Centre will be a a priority ongoing. Over the last 6 months the Horizon Centre has been utilised as follows:

Room utilisation overall summary	**Utilisation %**
Total Hours Available	22176
Total Hours Used	16183
Utilization Total	72.98%

Room utilisation by Day	**Hours available**	**Total hours used**	**Utilization %**
Monday	4536	3087.75	68.07%
Tuesday	4536	3432.25	75.67%
Wednesday	4368	3813	87.29%
Thursday	4368	3200.75	73.28%
Friday	4368	2598.75	59.50%
Saturday	0	35	-
Sunday	0	15.5	-

2.2 TREC Upgrade:

In August 2017 the Workforce and OD Group approved phase one of the upgrading of the TREC lecture Theatre located next to the Horizon Centre. Phase one will see the replacement of the projector and control panel etc. The Group agreed that the more extensive refurbishment should be considered as part of the wider education facilities review which is required as a result of our extended academic partnerships with Plymouth and Exeter Universities.

This has been funded by the education trust fund and by external grants. The department have been awarded £7.5 K from HEESW for the Virtual Reality lab and we have a joint bid with South Devon College for HEFCE funding (result this week) and another HEE bid pending.

Trust fund was felt appropriate (and it went to charitable funds committee) as the output of Belmont Court below will be for the benefit of patients which is the object of the fund. Also the Trust had suggested that where possible charitable funds should be used for equipment – hence TREC upgrade proposed and this went to Charitable Accounts Committee as well and approved. Had a meeting with Lesley and she is aware of this.

2.3 Belmont Court:

In September 2017 the Board approved a business case for the development of Belmont Court in to a digital Horizons education hub. Matt Halkes is currently developing the digital horizons strategy.

2.4 Doctors Mess implementation of a rest/sleep room

In August 2017 works were completed on an extension of the Doctors mess facilities. Funds were approved from education and from the League of Friends to support the implementation of an addition room for use as a quiet rest/sleep room.

3. Quality Assurance Outcomes

3.1 Health Education England across the South West (HEESW) Annual Visit

In November 2017 HEESW visited the Trust for their annual review of education programmes. For the first time the visit took a multi-professional approach reviewing medical, nursing and AHP programmes. Overall the visit was very positive. O&G were visited by a team from HEESW due to feedback received from the GMC survey where trainees had raised their concerns regarding training in the department. The outcome of this visit was very positive – positive highlights included:

Medical
Overall satisfaction is still increasing
Handover has improved
Clinical supervision has improved
Supportive environment for learning

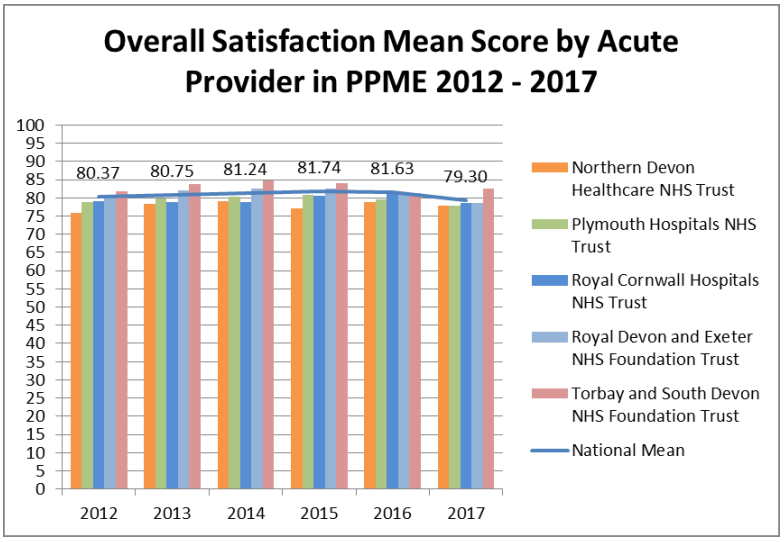
Non-medical
Induction, timetabling and communication is good
Patient care
Effective placements
Supporting fitness to practice
All learners know what to do if witness unacceptable practice
Trust has good relationship with Universities and HEESW
Active involvement in programme and curriculum development
Multi-professional preceptorship

In general
Clear governance and good leadership
Positive culture for education and learning
Proactive and engaged education team

3.2 National GMC Trainee Survey:

For the 6th year in a row the organisation was rated top in the peninsula for trainee doctor overall satisfaction across all training programmes.

Trainee Doctor 'overall satisfaction' scores

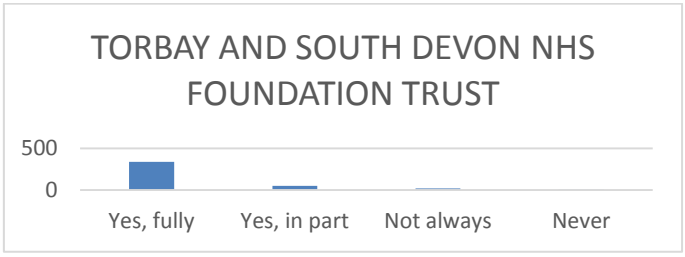


3.3 Nursing and Allied Health Care Professionals:

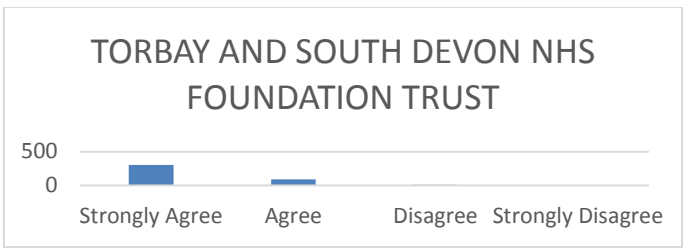
HEESW reported that the organisation had met all the requirements of the quality assurance indicators.

Plymouth University Learner Feedback summary (Nursing):
'I felt enabled to make the most of the learning opportunities'

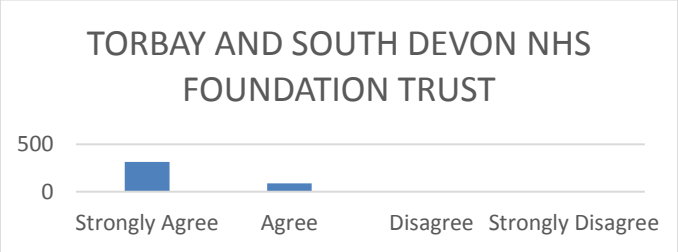
'Overall I have felt supported in my placement'



'Overall this placement was a good learning environment'



'I would be happy for friends or family to be cared for in this placement'



3.4 Quality Mark:

The Skills for Health Quality Mark is an award that recognises the superior delivery of learning and training The quality mark assessment for the organisation goes to panel on the 21st November. Below is the initial feedback we have received on our performance thus far:

Domain 1. Ethics and values - The ethics and values of the Trust are excellent. There is a consistent message across all levels of management, trainers and learners when asked about the value base of the trust and the emphasis placed on continuous development.

Domain 2. Health sector engagement/awareness - Across all teams there are diverse backgrounds and experience levels which enable a thorough insight and appreciation into the needs of employers and learners from all levels. Knowledge of sector legislation and practice is excellent ensuring that learners are provided with the most up to date knowledge and skills possible.

Domain 3. Learning excellence - Amongst clinical staff there are strong auditable evidence trails for reflective practice however from a training perspective the level of reflection differs between teams and the formality of reflection is also varied. There is no single policy or process that must be followed to ensure that any reflection, regardless of how detailed can be utilised to facilitate improvement in own practice and the sharing of best practice.

Domain 4. Effectiveness of quality assurance arrangements -During both observations of teaching undertaken during the onsite assessment the engagement of learners, enthusiasm of learners and trainers and validity of training was excellent. Currently there is no standardised approach to development, delivery, evaluation and impact monitoring.

4. Mandatory Training Compliance:

Mandatory training compliance target: 85%
Currently reporting for mandatory training compliance comes from ESR.

Month	June	July	August	September	October	November
Overall compliance %	84%	83%	83%	83%	Not available	Not available

A Mandatory training action plan has been developed to address non-compliance – this included offering additional courses, developing bespoke training, providing training in the clinical setting for small groups and the further development of digital resources to shorten face to face training. A proposal is in development to explore the possibility of providing

protected time for those staff who work 12 hour shifts as it is difficult for them to ring-fence time to complete e-learning during the course of the working day. This will be presented to the Workforce and OD Committee in Q4.

5. Objectives achieved:

5.1 Cost Saving plan:

The Education directorate met its cost saving plan for 2017/18- 2017/18 summary:

Education									
				WTE	WTE	Budget	Budget	Spend	Variance
				Budge	Actua	Full year	Apr-Oct	Apr-Oct	Underspenc
						949,685	597,553	508,572	-88,981
			Pay	71.65	68.22	7,769,922	4,575,099	4,533,328	-41,771
			NP			937,920	532,833	684,822	151,989
			Income			-7,758,157	-4,510,379	-4,709,578	-199,199
				71.65	68.22	949,685	597,553	508,572	-88,981
Adjusted for TWIPS			Pay	78.47	68.22	7,897,472	4,642,164	4,533,328	-108,836
			Vacancy Fa	-3.00		-76,964	-44,987		44,987
			NP			923,194	524,247	684,822	160,575
			Income			-7,809,336	-4,555,451	-4,709,578	-154,127
			TWIPS	-3.82		15,319	31,580		-31,580
				71.65	68.22	949,685	597,553	508,572	-88,981
TWIPS Savings Position						Latest Position			
	Target					-249,192			
	Target H&VC					-109,314			
	GAP Tfr					-17,279			
						-375,785			
Achieved	Head of Education					70,078			
	IT Trainer MARS					33,564			
	B2 Admin support					22,622			
	B3 Admin support					19,427			
	Vacancy professional Education					6,007			
	IT Trainer resign ation May 2017					32,406			
	Increased income courses					10,000			
	HEE Sponsorship					8,000			
	Placement Income					169,000			
	Course spending reduction					20,000			
	Overacheived					15,319			

5.2 Directorate review and Restructure

One of the priorities for the Interim Head of Education post was to review the education directorate and implement a new structure to deliver more community focused, multi-professional and integrated education and training. Phase one of the restructure includes the mandatory, clinical education, vocational, resus, simulation, clinical skills and employability teams. Following the review process, the proposed new structure was presented to staff on the 14th November as the launch of a 30 day staff engagement period. Following this, formal consultation will start on the 16th January 2018 with implementation planned to start in early March 2018.

New structure purpose –

The new integrated education team will redesign education and training to support the developing needs of staff, learners and patients in our health and social care community. The team will work alongside our staff in their roles and tailor education and training to ensure it is relevant, effective and supports the development of confidence as well as competence.

Phase two of the directorate review will include the following teams - centre admin team, digital education, IT training, medical education and OLM team. The review of these functions will start in January 2018.

The senior restructure is currently under formal consultation with recruitment processes taking place in December 2017.

5.3 Education strategy Staff engagement

The Interim Head of Education has run all staff engagement sessions for staff to feedback on their experience of education and training and put forward their ideas for the revised education strategy.

Summary of feedback from staff so far –

Positive about the Hive – easy to use
Mandatory training needs review – face to face training is repetitive
All training needs to be in one place – to include coaching, leadership and management
CPD opportunities need to be marketed – process needs to be clear
Need links between recruitment, appraisal, CPD
Need to celebrate staff achievements e.g. Masters, as well as apprenticeships
Corporate Induction needs review – can we include some pre-learning via the Hive
Compliance reports are not accurate
Staff are asked to do mandatory training that they don't see as relevant to them
Need to join up the education strategy with workforce, OD and strategy
Why doesn't all training sit under education it is confusing for staff not having it managed in one place
Different leadership and management pathways are confusing – what is the recommended pathway?
Need to engage with staff and get out in the community finding out what staff need
Education needs to be more flexible
Staff need a complete catalogue of training in one place
Not enough training to prepare managers for their roles – practical need to know basics rather than a management course.
Confusing whether to use ESR or the Hive for training – the ESR emails are confusing
Focus needs to move away from mandatory training and more towards CPD
Needs to be a holistic approach to education

5.4 Medical Student Expansion

The Trust Board approved a paper proposing the implementation of Year 3 and 4 programmes for Plymouth University Peninsula School of Medicine (PUPSMD) in July 2017.

5.5 Private, Voluntary and Independent Sector Education

During October 2017 a Training Needs Analysis was sent to the PVI sector in the Torbay locality. The purpose of the exercise was to determine demand for a number of training and educational needs and establish engagement via free sign up to a knowledge hub and access to the digital learning library on the HIVE learning management system. The PVI sector will have the opportunity to sign up to this free resource up to January 2018 for a 12 month period. An action plan has been developed prioritising the following areas:

- End of Life
- Dementia
- Falls / Moving & Manual Handling
- Pressure ulcer care
- Infection control

In addition we will be supporting completion of the care certificate through the Knowledge Hub and access to apprenticeship programmes. There has been a very positive response to the offer with care home and domiciliary providers encouraging staff to access the learning opportunity. It is anticipated that this will benefit service users and the Trust.

We will be prioritising the intermediate care teams and Torbay sector in the first instance. To evaluate the impact we will be assessing current competence and confidence in January 2018 and then assess the same cohort in June 2018. The education offer will be reviewed at the end of 2018.

5.6 Apprenticeship Programme development and Levy

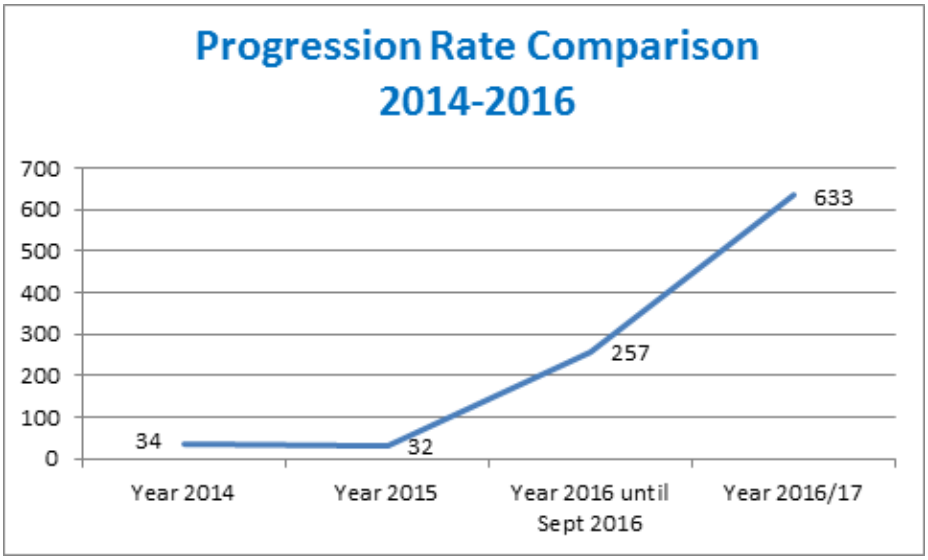
The apprenticeship portfolio has expanded to include new rotational apprenticeship schemes in partnership with the Council and Rowcroft.

Currently we are on track to meet the £1.2m Levy and target to have 2.3% of the workforce in apprenticeships. We would need approximately 136 apprenticeships to meet the 2.3% and have 82 staff currently in apprenticeship programmes. In previous years we have exceed 136.

5.7 Employability Hub

The Trust has seen significant success in employability traineeships and placements via Project Search, Step Programme, Way Finder, Work experience, etc. 91% of referrals have resulted in a placement with the organisation and 90% of trainees have gained employment as a result.

Number of placements:



5.7 Nursing associate programme pilot

This Trust was one of the first Trusts in the south west to pilot the new Nursing Associate programme which provides entry in to degree nursing programmes or as a standalone profession.

5.8 International nurses 'bridging' Programme

We have continued to deliver and develop a training programme for the international nurses recruited from the Philippines. The delivery of the programme is very resource heavy and we are currently using additional bank staff to support the programme. Planning for the groups expected over the next 12 months is currently underway.

5.9 Work experience month Event

The Trust hosted its largest work experience event as part of the employability strategy and in support of the launch of work experience month. Over 300 students from local schools attended the event where a wide variety of care professions were showcased.

5.10 New Exeter Nursing Degree Programme

The education team have started working with Exeter University in their development of a new nursing degree programme. Alison Marchbank, Senior Lecturer from Exeter University visited the Trust on the 21st November to meet with matrons, staff and students.

5.11 Vital signs training

We have introduced new vital signs training for staff in the immediate care teams. Enhanced scenario based vital signs training will be developed in the New Year.

5.12 Treatment escalation plan (TEP) education

We have developed and delivered ward-based training on two pilot wards, with positive feedback from staff. The aim is to put this on the Hive for all new staff to the Trust. Three videos have been made around TEP with support from hospital staff and junior doctors.

These are due to be released imminently. We will be developing further training with staff who have to have difficult conversations with patients and relatives around end of life issues.

Priority objectives for the next 6 months (January – June 2018)

6. Overarching Priorities

6.1 Develop an education and development strategy

The staff engagement exercise is due to finish at the end of November and the first draft of the revised strategy will be developed in December 2017. The education and development strategy will develop a joined up strategy for the organisation working in collaboration with Workforce, OD and Strategy. The focus will be on redesigning delivery models, ensuring clear career pathways are available for all staff and that staff are supported in their professional development.

6.2 Implement a new integrated education directorate structure.

This will be key in delivering the priorities of integrating educational delivery in to practice, expanding education in the community and supporting the prevention and self-care agenda.

6.3 Meeting our cost saving plans

Initial plans to meet our cost saving:

- The directorate restructure – reduction of Band 6 posts – exact cost saving to be identified.
- The senior restructure will see a reduction of 1 x Band 8a post
- Increase income via educational contracts with the Universities and Colleges.
- Income from apprenticeships

6.4 Education Facilities review

This review will include a proposal for the temporary use of community facilities to delivery education and training, whilst we establish a longer term plan for delivery away from the main Torbay Hospital site. Plans will be put in place to manage the implementation of the new academic programmes which for the most part will take place in the Horizon Centre.

6.5 Implementation of annual education business plans

Education Leads will develop annual business plans for their area of responsibility which are aligned to the overarching strategy. These will be reviewed at the monthly education leads planning meeting.

7 Mandatory training

Develop a strategy for new ways of delivering mandatory training to drive up compliance rates and improve user experience. A number of different options are available for consideration including:

- Reduce the amount of training required by extending compliance period by a year e.g. once every two years instead of annually. Other Trusts have agreed similar arrangements for topics such as moving and manual handling. The mandatory training strategy will be developed in Q4 with a recommendation to the Workforce and OD committee.
- Develop a staff mandatory training MOT survey to establish knowledge and understanding of mandatory training and to determine if further training is required.

- Expand in-situ mandatory training opportunities – this is already happening in some areas for example basic life support..
- Implement further e-learning courses to shorten the amount of training staff have to attend face to face training, where relevant, e.g. basic life support.
- Introduce an annual one day training day for all staff which is rostered in advance.

8 Specific education programmes

8.1 Implement the new Year 5 medical undergraduate programmes

From August 2018 the Trust will host year 5 undergraduate placements for the new Plymouth and Exeter medical schools. Over the next few months the education team will be working with the medical schools to plan the implementation of the new programmes. The agreement is for the Trust to host 30 students from Plymouth and 20 students from Exeter.

8.2 Project plan the implementation of Year 3 and 4 medical undergraduate programmes for PUPSMD

Plans will continue for the implementation of the year 3 and 4 programmes. A meeting between the Plymouth medical school and the education team will take place in December to develop a project plan. The next step will be for the medical school and education team to visit the relevant departments to discuss placements.

8.3 Project plan the implementation of the new Exeter nurse degree programme

This has been deferred to September 2019. The Trust is actively involved in the development of the new nurse degree programme and will continue to support its development in early 2018.

8.4 Implement the nursing degree apprenticeship pilot due to start September 2018

The NMC and University of Plymouth have just agreed to pursue with the implementation of the new nursing degree apprenticeship as planned from September 2018. A meeting is taking place with Health Education England at the end of November to establish the costs to the organisation for delivering the programme and these will be presented at the next Workforce and OF Group for consideration.

8.5 Continuation of the nursing associate programme

The education team will continue to support the development of the nursing associate training programme and implementation of the role in the organisation. A marketing event is planned for the new year with South Devon College to promote the role and opportunity.

9 Continued Professional Development

The education team will review and update the study leave policy with clear links to the staff achievement review (appraisal) and access to Continued Professional Development. A meeting is taking place with the professors from the University of Plymouth in December to discuss plans to develop master's level CPD opportunities. A paper outlining the new CPD process and access to opportunities will be presented at the January Workforce and OD Group meeting and will be launched to staff at the end of January 2018. This has been developed in partnership with the HEE and the CCG. A key priority will be to make access to CPD fair and equitable to all staff.

10 The HIVE (LMS)

The digital education team will continue development of the Hive Learning Management System. Staff have reported a positive experience of the Hive but remain confused over whether ESR OLM or the Hive is the learning management system for the organisation. The Executive team have made a decision to move to the Hive as the principle reporting system for mandatory training. In addition the education team are making plans to provide a digital learning hub located in the library to support staff in their digital learning and confidence in using the Hive and digital learning approaches.

11 Digital Literacy

One fifth of staff currently do not have an IT account or email. In order to use digital learning in our education strategy we must meet the challenge of improving the digital literacy of the workforce – operating with an "open to all' approach. This will be achieved through embedding IT training support in to the new education roles being introduced in the new structure who will be working alongside staff.

12 Adoption of new technology

A key part of the education strategy will be to develop ways of embracing new technology to enhance learning, for example virtual reality (VR). This will be piloted in the new year. There are fantastic opportunities to use patient VR as a way to improve their care and overall experience of health and social care.

13 Wellbeing

The education team will work with Organisational Development to support the development of a wellbeing strategy – linking in to specific projects such as the junior doctor led quality improvement project on wellbeing.
The education team will implement a pastoral Tutor role for all staff to access across the organisation. In addition an Associate Director of Medical Education for trainee doctor support will be implemented, in line with other Trusts.
Through the directorate review and development of the strategy education will embed resilience, coaching and strengths based approaches in to education and training. Education staff will be well placed to support this as they work alongside teams.

14 Private, Voluntary and Independent Sector:

Phase two will see the continued distribution of the Training Needs Analysis across the other localities to establish training needs and engage PVI sector organisations. For Torbay the education team will develop a education plan for the next 12 months – prioritising intermediate care and the five priorities as set out by the Execs. A key priority will be to evaluate the impact of the PVI education plan through a survey of current competence and confidence of staff, which will take place in January 2018 and a review at 6 months' time, in June 2018. The education team will support the development of a workforce plan for the 'care force'

Apprenticeships:

Continued development of apprenticeship opportunities across the organisation for new and existing staff. We will be working with South Devon College in the development of new apprenticeships. We will be planning the delivery of apprenticeships for the PVI sector with South Devon College.

The planned implementation of the new degree apprenticeships in September 2018 will support plans to expand the apprenticeship portfolio and support the development of our workforce. We will also be implementing the new Masters programmes to support development opportunities for staff. This will ensure we maximise use of the £1.2m Levy.

CLiP Ward (Collaborative learning in practice)

The first phase of wards undertaking the CLiP ward concept will start in January 2018. The education team will review the impact of CLiP ward and sharing good practice event – this is planned for April 2017.

Deliver Actions from the Quality assurance processes

At the annual HEESW visit a number of actions were recommended:

- Implement consistent process for learner feedback across the directorate.
- Ensure consistency of departmental level induction for learners
- Review Hospital at Night as this continually is raised as an issue for trainee doctors on those rotas
- Plan for increased ODP placements
- Plan for the requirement for increased placements in the community 'closer to home' setting
- Maintain mentor register, whilst standards are reviewed.
- When the Guardian for safe working report is published, HEESW would like a copy

Next report due: June 2018

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6 December 2017		
Report Title	Board Assurance Framework		
Lead Director	Director of Finance		
Corporate Objective	Well led		
Corporate Risk/ Theme	All		
Purpose	**Information**	**Assurance**	**Decision**
		✓	
Summary of Key Issues for Trust Board			
Strategic Context	This report provides the Board of Directors with the latest version of the Board Assurance Framework (BAF) as at attachment one for approval. The BAF continues to receive detailed reviews and any changes are reflected in the attached document. Further scrutiny and enhancements will continue to take place throughout the year by the Risk Group, Executive Team and various committees. On 13 October 2017, the Audit and Assurance Committee meeting received an updated BAF. Two Corporate Level Risks (1695 and 1815) were highlighted to the Committee for a more in-depth review. At least two deep dive reviews continue to take place at each meeting of the Audit and Assurance Committee (except May's meeting), the Quality Assurance Committee (QAC) and Finance, Performance and Investment Committee (FPIC). A 'heat map' to summarise the Board Assurance Framework on one page, supported by the detail can be found as at attachment two.		
Key Issues/Risks	The overarching corporate risk themes are as follows: 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 / quality 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. Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'. Risks are grouped under these headings in the Corporate Risk Register, with detail carried through to ensure there is a clear link with the operational risk management systems and to enable clear description of planned management actions.		
Recommendations	1. The Board of Directors reviews, comments and accepts the latest version of the Board Assurance Framework as at attachment one. 2. The Board of Directors discusses whether any new strategic risks need to be incorporated onto the Board Assurance Framework.		

Summary of ED Challenge/Discussion	At their meeting on 21 November 2017, the Executive Team agreed to add a new risk related to JAG (Joint Advisory Group) Gastrointestinal Endoscopy accreditation. This risk is in the process of being added to Datix. The Executive Team agreed the BAF on 28 November 2017. The Executive Team would welcome any other feedback from the whole Board to assist the Company Secretary in developing the document for 2018/19 but as per section 2.5, acknowledges a meeting has been arranged between the Director of Finance, Director of Strategy and Improvement and Company Secretary to drive further improvements in 2018.
Internal/External Engagement inc. Public, Patient & Governor Involvement	The Board Assurance Framework and supporting risk registers should identify all possible issues against the Trust's ability to deliver its strategic and supporting objectives. If equality and diversity are key business objectives as per patient, client, public, service user and governor involvement, then these would be recorded on one of the risk registers and/or Board Assurance Framework. A governor observer regularly attends the Audit and Assurance Committee, Finance, Performance and Investment Committee and Quality Assurance Committee.
Equality & Diversity Implications	None identified.

MAIN REPORT

Report to	Board of Directors
Date	6 December 2017
Lead Director	Director of Finance
Report Title	Board Assurance Framework

1. Background Information

1.1 The Board Assurance Framework (attachment one) is reviewed primarily by the Audit and Assurance Committee and the Board of Directors. Accountability for recording the information is with the Executive Leads. The Company Secretary oversees the Board Assurance Framework and key risk registers e.g. Surgical Services Delivery Unit. The Corporate Risk Register will be reviewed regularly by the Executive Team e.g. following a Risk Group meeting.

1.2 Assurance may be recorded within the risk registers, but more importantly is that assurance is captured within the Board Assurance Framework. The risk registers are reviewed primarily by the different Groups/Service Delivery Unit and the Risk Group. Accountability for capturing the information is with the Service Delivery Units or Departmental Leads.

2. Positional Update

2.1 The Risk Group continues to conduct deep dives at its monthly meetings e.g. Medical Service Delivery Unit, Torbay Pharmaceuticals and Health Informatics Services.

At the last meeting on 21 November 2017, the Risk Group challenged some of the recent risks identified by the Executive Team rather than individual SDUs. The Risk Officer continues to look at risk themes at each meeting using a combination of soft intelligence from Executive Directors\SDU leads and analytical information from Datix e.g. risks, incidents as well as using reports like CLICC and deep dives.

At the most recent meeting of the Risk Group a deep dive was conducted for the Women's, Children's, Diagnostics and Therapies Division. The SDU management team were requested to review Maternity risks currently sitting below corporate level, to ensure that this remained appropriate when triangulated with reported incidents.

2.2 Key Performance Indicators (KPI's) for the Risk Group are better than target and are therefore not a cause for concern or escalation.

2.3 The weekly Executive Team meeting continues to receive a report from the Risk Group after every meeting.

2.4 A new risk management session for Service Delivery Units and departmental leads has been arranged for 28 November 2017. The Chief Operating Officer / Deputy Chief Executive and Director of Finance are the lead directors.

2.5 The Director of Finance, Director of Strategy and Company Secretary are meeting on 10 January 2018 (scheduled meeting in November and December cancelled due to Finance peer review and higher priority meeting respectively) to discuss the current Board Assurance Framework, options for including more strategic risks following the recent Board development session and the opportunity for an annual review of its style and structure taking on board best practice from other trusts.

2.6 Since the last Board meeting a new section (section 3) has been created to show detailed changes since the BAF's last review.

3. Audit of Detailed Changes

Corporate Theme 1 : Available capital resources are insufficient to fund high risk / high priority infrastructure /equipment requirements / IT Infrastructure and systems		
DRM ID	**Title**	**Observation**
1050	Special Theatres Ventilation.	Due to be updated following in depth discussion at FPIC on 24/10/2017
1083	Insufficient Capital Funding and Backlog of Maintenance.	No change.
1159	Current IT Systems & Infrastructure Will Not Meet Future Demands.	**New Assurance:** Ctrl 4-5 £110k capital approved at FPIC to invest before 31 March 2018 in cyber security to mitigate 11 out of the 12 outstanding May 2017 CareCERTS by October 2018. £90k capital approved from April 2018. £252k revenue approved from April 2018. **New Potential Assurance:** Ctrl 5-6 Following discussion at CIEG 15/11/2017 there is a possibility of an integrated finance capital and revenue identification process that does not mean we have capital approved for IT schemes which cannot be spent due to there being no approved revenue. **New Gap in Assurance** Ctrl 4-5 All but one of the 12 CareCERTS addressed by October 2018.
1231	Failure to Raise Sufficient Capital.	**New Assurance:** Ctrl 1-3. RSA Now signed. **Update Potential Assurance:** Ctrl 1-3. Board released second Capital tranche, but items with revenue consequences held pending assurance on control total delivery. New Gaps in Assurance: Ctrl 1-3. £6.5m additional forecast reduction required to achieve control total. Ctrl 1-3. SDU asked for forecast reduction plans for £5m Ctrl 1-3. CCG asked for SSP delivery increase by £1.5m

Corporate Theme 2 : Failure to achieve key performance / quality standards		
1070	Achievement of 4-Hour Standard.	Removal of Controls 7-8 Replaced with: 7. Trial for 'see and treat' during FAB week 13/11 - 20/11). 8. Trial completed for RADS project - aim for improvements in early discharge. Assurances adjusted.
1101	Medical Retina Demand.	**New Assurance:** Ctrl 2. Mega clinics now running Monday and Tuesday. Saturdays have now been converted to reduce the Medical Retina backlog. **Updated Actual Assurance:** FROM: Ctrl 8. 'Two more pieces of equipment have arrived and been installed' TO: Ctrl 8. 'Three out of four pieces of equipment have arrived and been installed' **Updated Potential Assurance** FROM: Ctrl 8. Last piece of equipment purchased TO Ctrl 8. Last piece of equipment purchased but on hold due to IT resource prioritisation.
1110	Follow up Appointments are Followed up in Agreed Timescales.	**New Potential Assurance:** Ctrl 1. Each speciality to review "Lost to follow up"
1266	Poor Patient Experience and Quality of Care.	Control 3 updated. Gap In Control 3. removed.
1815	High Quality Patient Tracking to Avoid any Unnecessary CWT Breaches.	**New Assurance:** Ctrl 1-2. Managed leave arrangements to ensure minimal staffing away at one time to maximise staff capacity.
1998	Human Tissue Act 2004 Non-Compliance.	No change.
Corporate Theme 3 : Inability to recruit / retain staff in sufficient number / quality to maintain service provision		
1697	Difficulty in Recruiting Service Critical Staff.	No change
Corporate Theme 4 : Lack of available Care Home / Domiciliary Care capacity of the right specification / quality		
1695	Mears Personal Care Delivery, Failure Concerns Across Torbay & South Devon.	DRM ID No 1974 (12) linked to this risk. **New Controls:** 12..Incidents that our staff report relating to care homes in the Torbay Localities (Torquay, Paignton & Brixham) are notified to TSDFT QAIT Team for investigation and interventions

		as required. 13. Incidents that our staff report relating to Mears in the Torbay Localities (Torquay, Paignton & Brixham) are notified to Cathy Williams, Jon Anthony, Nigel Sutton and Emma Bewes. 14. Non safeguarding concerns incidents relating to MEARS (or a sub-contractor of MEARS) are notified to MEARS via their secure NHS email address for them to investigate and respond to David Hickman within 14 working days using an agreed template. 15. Incidents relating to MEARS (or a sub-contractor of MEARS) which raise possible Safeguarding concerns incidents are notified to the persons in control 13 and also to the TSDFT safeguarding alert email address in the 1st instance for triage prior to provider notifications. **New Assurances:** Ctrl 10. Judy Saunders has completed on-site visit with Mears to support their recruitment processes. Follow up visit also planned. Ctrl 11-14 Daily monitoring of incidents and escalation of Mears related incidents are managed my CSDU Clinical Governance Lead. David Hickman. (New) Ctrl. 15. Breach of contract notice has been issued. Resulted in fortnightly meetings. Ctrl 1 -17 Due to the level of concerns, decision has been made to put the service into a "Whole service safeguarding process" under a S42 process.
Corporate Theme 5 : Failure to achieve financial plan		
1223	Financial Sustainability Risk Rating.	Reduction in linked risks score: DRM ID No 75 (CLR) Viability of Care Homes and Nursing Homes. (12 down from 16) **New Assurance:** Ctrl 1-10 New RSA Signed **New Gaps in Assurance:** Ctrl 1-10. SDU asked for forecast run rate reduction plans for £5m. (New) Ctrl 1-10.CCG asked for SSP deliver to be improved to plan further £1.5m. (New)
1236	Increase in Overspends on the Independent Sector.	**New Assurances:** Ctrl 6. Outcome of judicial review consultation process. Judicial review ruled in the Council's favour. Ctrl 1-10. Fran Mason has secured on-going nursing Home provision in Torbay

		New Gaps in Assurances: Ctrl 1-10. SDU asked for forecast run rate reduction plans for £5m. Ctrl 1-10.CCG asked for SSP deliver to be improved to plan further £1.5m.
1239	Failure to Secure Better Care Fund Monies.	**New Control:** 14. New risk share agreement signed with CCG and Council. **New Assurance:** Ctrl 1-14 Quarter 1 & 2 achieved. Ctrl 14. Agreement Signed. **New Gaps in Assurances:** Ctrl 1. Forecast requires further £6.5m of financial improvement to achieved Control total. Ctrl 1-4. SDU's asked to populate £5m additional actions to address. Ctrl 11. CCG asked to push SSP schemes for full delivery.
Corporate Theme 6: CQC rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'		
1095	Safer Care - No Delays in ED.	**New Control:** 10. SWAST and ED initiative with use of 'expected cards' to highlight if patients could be directed elsewhere e.g. AMU/EAU3. *The Risk Officer is in the process of collecting new assurances for this control.*
1504	Delays to Mental Health Pathways.	No change.

3. Attached to this Report

Attachment one - Board Assurance Framework
Attachment two - Board Assurance Framework Heat Map

Torbay and South Devon NHS
NHS Foundation Trust

A Datix Risk Module Report

Actual Risk Details												Assurances			
ID	Sub-Objective	Risk Type	Department	Risk Owner	Organisational Objectives	Rating (Initial)	Description	Controls in place	Gaps in Control	Rating (Current)	Last Reviewed	Next Review Due	Actual Assurances in Place on Existing Controls	Potential Assurances on Existing Controls	Gaps in Assurances on Existing Controls	Senior Responsible Officer
1050	Corporate Theme 1 : Available capital resources are insufficient to fund high risk / high priority infrastructure /equipment requirements / IT Infrastructure and systems	Corporate Level Risk	Estates Operations	Calcut, Rae	1. Safe, Quality Care and Best Experience	25	Cause: Due to age and condition of plant etc possible major failure in Special Theatres (Acute). Effect: Loss of Surgical Activity. Linked to Risk: DRM ID No 1473 Maintenance of Inpatient Theatres & DSU & Ophthalmic Theatres (12)	1. Enhanced maintenance / normally scheduled Planned Preventative Maintenance (PPM.) 2. Plan in place to replace theatres (medium to long term). 3.Operational contingency plan in place. 4. Monitoring, reporting and escalation of critical failure.	5. New theatres scheduled for completion 2017/18. 6. No option to replace equipment in the short-term.	25	11/10/2017	11/11/2017	Ctrl 1. Detailed maintenance and engineering performance data and records, held on the electronic backtraq system. Live and real time performance of the mechanical and electrical systems shown on the electronic Building Management System (BMS). Annual insurance inspection, Annual authorised engineer assessment of systems. Ctrl 2. Design fees funded in the phase 1 capital released. Air handing in recovery scheduled to be funded in the second tranche of capital. Scheme to replace the theatres will not proceed other than to final design in 2017/18 due to lack of capital and non approval of the business case for a loan sat with NHS England for approval.	Ctrl 3. Revised/approved contingency plan. Ctrl 4. Capital Infrastructure and Environment Group report to Finance, Performance and Investment Committee.	Ctrl 1. Regular maintenance being undertaken but serviceability of unit is not guaranteed. Ctrl 1. Maintenance access to plant is poor and heat trimmer batteries giving independent temperature to each theatre are non operational. System temperature has been set to give optimum temperature to theatre A, with theatre B not attaining suitable temperature at times. **(Updated with correct locations)** Ctrl 2. No approval of business case to replace theatres given at this point in time.	Director of Estates (Lesley Darke)
1083	Corporate Theme 1 : Available capital resources are insufficient to fund high risk / high priority infrastructure /equipment requirements / IT Infrastructure and systems	Corporate Level Risk	Estates	Darke, Lesley	1. Safe, Quality Care and Best Experience, 4. Well Led.	25	Cause: Lack of available capital funding to spend on backlog maintenance and contingency for Estates emergency expenditure. Effects: A. Failure of key plant or building fabric resulting in impact on service delivery. B. Harm to individual staff, patients or member of the public from deteriorating infrastructure.	1. Risk assessment, prioritisations and approval process in place to manage highest risks. High risk elements prioritised in the capital programme. 2. Robust planned preventative maintenance regime in place. 3. PPM performance and critical failures reported and monitored monthly via Capital Infrastructure and Environment Group, Finance, Performance and Investment Committee, Infection Prevention and Control, exceptions to the Board of Directors. 4. Responsible Persons in post (statutory). 5. Rolling programme for testing in place. 6. Capital allocation identified to deliver action plan. 7. Annual review of system management by externally appointed Authorising Engineer. 8. Asset register in place. 9. Estates Strategy presented to Private Board in May 2016. 10. Board has approved plan based on actively considered risks versus maintaining a cash balance.	11. Seek additional appropriate capital allocation to reverse deteriorating trend and reduce current catastrophic risk level. 12. Insufficient funds allocated to reduce risks. 13. Robust planned preventative maintenance regime in place - failing.	25	14/11/2017	14/12/2017	Ctrl 2. Robust planned preventative maintenance regime in place. Ctrl 3. Scheduled Finance reports provided to Board and Executive Team through the Finance, Performance & Investment Committee. Ctrl 3. Scheduled Financial reports provided to the Board by the Executive Team. Ctrl 3. Scheduled development reports provided to the Board and Executive Team by the Senior Business Management Group. Ctrl 3. Scheduled Infrastructure and Environment reports provided to Board and Executive Team by the Infrastructure and Environment Group. Ctrl 1,3,7,8,9. Scheduled Progress and KPI's reports provided to Board and Executive Team as depicted in the Governance Reporting Structure including but not limited to: - PPM performance and critical failures reported monthly - exceptional reporting to Board. - Monthly monitoring of departmental PPM records in place. - Patient environment issues reported to infection - Prevention & Control Committee. Ctrl 4. Responsible Persons in post (statutory) Ctrl 5. Rolling programme for testing in place. Ctrl 1,6. Capital allocation identified to deliver action plan. Ctrl 10. Approved plan.	None identified.	Ctrl 6. Future Board decision to provide more funding.	Director of Estates (Lesley Darke)
1159	Corporate Theme 1 : Available capital resources are insufficient to fund high risk / high priority infrastructure /equipment requirements / IT Infrastructure and systems	Corporate Level Risk	IT Operations and Informatics	Holtne, Gary	4. Well Led.	20	Cause: Lack of available capital funding to spend on IT infrastructure and IT Systems. Effects: A. Failure of key IT infrastructure and IT systems resulting in impact on service delivery. B. Lack of cyber security investment may expose the Trust to risk of fines equal to 4% of Turnover or £ capped at £17M following a successful cyber-attack similar to the May 2017 "Wannacry" attack. NHS Digital (for NHS England) are highlighting the number of CareCERTs they have mandated that Trusts have mitigated. We currently have 12 unmitigated and are flagging as an outlier regionally. Note: Our plans are predicated on an on-going capital investment plan to ensure optimum performance of service. Linked to Risks: DRM ID No 1158 Malware Attack. (15) DRM ID No 1161 Meeting the Information Governance standards set by Connecting for Health, supported by Monitor. (15) DRM ID No 1162 Business Continuity and Information Security. (8) DRM ID No 1168 National Programme for IT HSCIC. (20) DRM ID No 1172 Quickest Access to Diagnosis and Treatment. (8) DRM ID No 1173 Strategic Hardware Platform. (16) DRM ID No 1174 Increasingly Software Companies Are Changing Their Licensing. (16) DRM ID No 1181 Unauthorised Staff May Have Inappropriate Access. (3) DRM ID No 1183 Cost Pressure Relating To Support of IHCS. (9) DRM ID No 1719 IM & T Strategy to Support Care Model Delivery (5) DRM ID No 1723 Lack of Shared or Centralised Care Records Across the System. (9 down from 12)	1. ICT Strategy with supporting policies and procedures e.g. Business Continuity Plans 2. Well-developed IM&T service. 3. Upgrade current key systems to mitigate effect. 4. IT Projects and Programme governance in place and linked to organisation's executive groups. IM&IT Group reports, reports to Finance, Performance and Investment Committee. 5. Investment planning to maintain and develop infrastructure capacity. 6. Continued IM&T Strategic investment. Risk assessment based on need and prioritised accordingly. 7. Continual review of emerging technology and adoption where suitable. 8. Minimising critical failure. 9. Management of failure. 10. Internal audit reviews 11. Actions following Information Commissioners Office visit (Sept 2015).	Ctrl's 5.6.7 Insufficient funds allocated to reduce risks.	16	12/11/2017	12/12/2017	Ctrl 1. ICT Strategy in place and approved every four years. Ctrl 2. Service Desk user surveys. Ctrl 4. Information Asset Support Team Manager processes. Ctrl 4. Agenda's, reports and minutes/notes. Ctrl 4-5 £110k capital approved at FPIC to invest before 31 March 2018 in cyber security to mitigate 11 out of the 12 outstanding May 2017 CareCERTS by October 2018. £90k capital approved from April 2018. £252k revenue approved from April 2018 **(New)** Ctrl 5. IT Projects Group minutes and IT Projects Dashboard Ctrl 6. Annual capital plan (infrastructure). Ctrl 7. Annual capital plan (projects). Ctrl 8. HIS TeamTalk minutes. Ctrl 10. Internal Audit Reports e.g. IT Projects Cradle to Grave (Feb 16) Information Asset Owner Business Continuity Planning (Oct 14) Ctrl 11. Action plan in place and monitored/reviewed by the Information Governance Steering Group. Ctrl 1-11 IA Report - SDU Governance arrangements. (May 2017)	Ctrl 1. External assessment as part of Digital Roadmap/STP programmes. Ctrl 5-7. Finance monthly capital expenditure reports. Ctrl 5-6 Following discussion at CIEG 15/11/2017 there is a possibility of an integrated finance capital and revenue identification process that does not mean we have capital approved for IT schemes which cannot be spent due to there being no approved revenue. **(New)** Ctrl 8-9. HIS Board/IM&IT Group regarding system failures. Escalated to Board via Finance, Performance and Investment Committee.	Ctrl 3. Upgrade current key systems to mitigate effect. Ctrl 4-5 All but one of the 12 CareCERTS addressed by October 2018 **(New)**	Strategy and Improvement (Ann Wagner)
1231	Corporate Theme 1 : Available capital resources are insufficient to fund high risk / high priority infrastructure /equipment requirements / IT Infrastructure and systems	Corporate Level Risk	Finance	Muskett, Rodney	4. Well Led.	25	Cause: Financial position or national capital restrictions limit ability to access Loans or PDC. Effect: Inability to fund necessary infrastructure developments.	1. All measures to maintain I&E performance. 2. Relationship management with ITFF. 3. Savings Risk High given target levels.	4. Board to approve most significant capital risks with a limited capital programme pending confidence in revenue position. 5. Trust needs revised capital plan based on liquidity position and to agree solution with NHS I. 6. Draft Heads of Terms requires CCG to pay cash based on £18m System wide savings plans being covered.	25	10/11/2017	20/12/2017	Ctrl 1-3. NHS Improvement indicating over commitment to current capital allocation nationally. Currently looking unlikely that loan applications will be released. Driver to consider other funding mechanisms such as PFI to keep investments 'off balance sheet'. ~~Ctrl 1-3. Board considered RSA at July board and other Partners considering in July too.~~ Ctrl 1-3. RSA Now signed. (New)	Ctrl 1-3. Board has approved a critical list of capital for 2017/18 in April. ~~Ctrl 1-3. Executive reviewing next tranche of schemes for consideration for 2017/18.~~ Ctrl 1-3. Board released second Capital tranch, but items with revenue consequences held pending assurance on control total delivery **(Updated)**	Ctrl 1-3. Assurance over CIP full CIP delivery, ability to access ITFF loan finance. Ctrl 1-3. £6.5m additional forecast reduction required to achieve control total. **(New)** Ctrl 1-3. SDU asked for forecast reduction plans for £5m **(New)** Ctrl 1-3. CCG asked for SSP delivery increase by £1.5m **(New)**	Finance, Performance and Investment Group (Paul Cooper)

ID	Sub-Objective	Risk Type	Department	Risk Owner	Organisational Objectives	Rating (Initial)	Description	Controls in place	Gaps in Control	Rating (Current)	Last Reviewed	Next Review Due	Actual Assurances in Place on Existing Controls	Potential Assurances on Existing Controls	Gaps in Assurances on Existing Controls	Senior Responsible Officer
1070	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	Emergency Services	Houlihan, Lisa	1. Safe, Quality Care and Best Experience	20	Cause: Patient demand exceeding capacity within the ED department. Effect: Failure of the 95% standard, poor patient experience and possible adverse clinical outcomes as patients not cared for in the correct environment. Linked to Risk: DRM ID No 1242 Poor Patient Experience in ED. (15) DRM ID No 1264 Delays to first clinician. (12)	1. Good data analysis available - ED dashboard linked with control room - good and accurate weekly data sheets produced to monitor performance. 2. New medical O drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier. 3. Escalation policy in place. 4. 3 x daily control meetings with real-time information and appropriate management responses. 5. Ward discharge coordinators have daily meetings to review ward discharges. 6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED. ~~7. Policies and procedures.~~ ~~8. On call executive rota.~~ 7. Trial for 'see and treat' during FAB week 13/11 - 20/11) **(New)** 8. Trial completed for RADS project - aim for improvements in early discharge. **(New)**	9. Safer bundle piloted in all areas which are applicable - not same monitored process in all ward areas. 10. Programme of bed configuration started but not yet complete. 11. Phlebotomy resource limited due to sickness and recruitment issues 12. Linkage of the overcrowding risk score not formally linked to the escalation policy. Need for better OPEL linked escalation. 13. Potential new pressure will be added to department until all available/allocated MIU's have radiology cover for full opening hours, meaning patients can be consistent re-directed or encourage to self present for appropriate conditions. - Update MIU NAH Radiology cover 7/7 (Opening hours 9-5.	20	25/10/2017	30/11/2017	Ctrl 1. Scheduled performance, progress and KPI report provided to Executive Team and Board via Quality Assurance Committee. Progress reports distributed to governors. Ctrl 1. Up-to-date action plan. Ctrl 4-5,7. Agenda's, papers, minutes/notes. Ctrl 2. After Action Reviews (AARs) post incidents Ctrl 3. Up-to-date policies and procedures ~~Ctrl 8. Up-to-date on-call executive rota.~~ CQC self-assessment Ctrl 1,8. External independent assessment (Oct 16) **(Adjusted)** Ctrl 1-8. IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory. Ctrl 1-8. Positive CQC report - August 2017 (see documents)	Ctrl 1. Combined patient flow action plan.	None Identified.	Chief Operating Officer (Liz Davenport)
1101	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	Ophthalmology	Westacott, Derren	1. Safe, Quality Care and Best Experience	20	Cause: Inability to meet Medical retina demand for follow-up patients within sub-specialties within ophthalmology. Effect: Increased risk of loss of vision for patients not seen on a timely basis.	1. Reviewing patients to ensure clinical priority is achieved in appointments but unable to reduce this number without affecting other sub-specialties backlogs. 2. Running additional clinics including virtual clinics. 3. We now include the clinic accommodation at Newton Abbot within our timetables which will enable improved utilisation. 4. We have instigated a timetable review and meetings are on going. 5. Utilisation of clinic activity within Newton Abbot 6. Established clinic timetable. 7. PTL monitoring and tracking in place. 8. Extra clinical space is now complete and new equipment is being purchased. 9. Virtual clinics now running in trial phase to establish best use of the time and equipment as well as issues with other sub-specialties.	10. Despite putting control in place there are still 4000 patients waiting passed to be seen by date. 11. Capacity levels still fluctuate over bank holidays and Dr holidays.	16	10/11/2017	18/12/2017	Ctrl 1-3.Patients all have an allocated consultant responsible for their care. Ctrl 1-4. The list of patients are regularly sent to the consultants so that they are aware of the delays. Ctrl 1. The list of patients are monitored at sub-specialty level to ensure higher risk patients are prioritised. Ctrl 2. Mega clinics now running Monday and Tuesday. Saturdays have now been converted to reduce the Medical Retina backlog. **(New)** Ctrl 2-3. Work to increase the accommodation has been completed and extra clinics are now running. Ctrl 5. Agenda's, Minutes and Reports from these meetings. Ctrl 6. Completed the timetable with the new rooms, this control is in place and working effectively. Ctrl 7. Weekly PTL meeting. Ctrl 8. Three out of fours pieces of equipment have arrived and been installed. **(Updated)** Ctrl 9. We are currently running at about 90% of expected final capacity. Ctrl 1-9 IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory.	Ctrl 1.Continued work to increase capacity for the patients most at risk. Ctrl 1. Action Learning Set with GP's and Commissioners discussing progress and further work that can be done to help. Ctrl 8. Last piece of equipment being purchased, but delayed due to IT resource prioritisation. (Updated)	Ctrl 4. Continued growth in demand may outstrip new capacity.	Chief Operating Officer (Liz Davenport)
1110	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	All Departments	Foster, Neal	1. Safe, Quality Care and Best Experience, 4. Well Led.	16	Cause: Lack of a robust follow-up appointment process across the Trust. Effect: Patients at risk of disease progression. Consequences are for poor patient care, poor patient experience, adverse impact on the reputation of the Trust and may leave the Trust open to litigation.	1. Documented / updated process in place. 2. Random sample of 2,500 outpatient records identified some failures in the old system. No failures identified in the new system. 3. Bank staff employed to review all outstanding patient records, this is being monitored by our service improvement manager. 4. Trust Board report.	5. Long-term IT solution. 6. Systematic report for all patients with a follow-up 7. Completed review of 1,509 day case records to identify any lost to follow up patients.	16	10/11/2017	18/12/2017	Ctrl 1. Approved process. Ctrl 2. All patients identified as lost to follow up have had a root cause analysis completed. Ctrl 2. All patients in Urology have had their initial review. Ctrl 2. Tests of new system not identified any patients lot to follow-up. Ctrl 4. Scheduled performance, progress and KPI reports provided to Finance, Performance and Investment Committee and Board. Ctrl 4. Agenda's, papers, minutes/notes. Ctrl 1-4 IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory.	~~Ctrl 1 Approved action plan.~~ Ctrl 1. Each speciality to review "Lost to follow up" **(New)** Ctrl 2. Routine reporting from PAS. Ctrl 3. Completed review of all outstanding records.	None identified.	Chief Operating Officer (Liz Davenport)
1266	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	All Departments	Foster, Neal	1. Safe, Quality Care and Best Experience	15	Cause: Supply and demand imbalance in surgical division across most specialities to meet waiting time, leading to an inability to deliver elective and urgent care access standards. Effect: Poor patient experience and quality of care, reputational impact for the community and the Trust, regulator intervention and commissioners seeking to apply financial penalties. Linked to Risks: DRM ID No 1103 General Surgery (Upper UGI, Achieve RTT within the 18 weeks target. (15) DRM ID No 1104 Urology, Achieve RTT within the 18 weeks target. (15) DRM ID No 1295 Ear Nose and Throat, Outpatient & Inpatient RTT (15) DRM ID No 1311 Failure to meet RTT's in Dermatology. (20) ~~DRM ID No 1464 Trauma & Orthopaedics. (15)~~ **Closed** DRM ID No 1523 Pain Service. (15)	1. Performance reporting and action plans via directorate meetings, RTT/Diagnostic Risk & Assurance Group (meets fortnightly with COO and operational leads), governance meetings, DGM meetings, Divisional Board meetings, Senior Business Management Group, Executive Team meeting, Finance, Performance and Investment Committee and Trust Board. Reports shared with the CCG. 2. Waiting list management process 3. Operational teams identifying additional capacity on an ad hoc basis i.E. Extra lists (**Updated)** 4. Support from other specialties within Surgery taking on some of this backlog of work on specific patients i.e. Hernias and Lap Choles helping to create additional capacity for this group. 5. Established clinic timetable. 6. PTL monitoring and tracking in place. 7. Policies and procedures.	8. Saturday list until the end of the year - dependent on number of theatre and medical staff volunteering. 9. Insufficient training grades resulting in consultants having to action down. 10. Inability to outsource complex patients - outsourcing ceased due to funding considerations with the CCG. 11. Funding considerations not supporting recruitment of consultant surgeons. 12. Approved business case for additional consultants.	15	10/12/2017	18/12/2017	Ctrl 1. Scheduled performance, progress, KPI and action plan reports provided to Executive Team and Board via Quality Assurance Committee. Ctrl 1,4. Agenda's, papers, minutes/notes Ctrl 2,6. Weekly PTL meeting. Ctrl 3. Investment. Ctrl 3. Additional weekend lists. Ctrl 5. up-to-date timetable Ctrl 7. up-to-date policies and procedures. Ctrl 1-7. IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory.	Ctrl 1. Enhanced reporting Ctrl 1-7 Surgical SDU has submitted a paper to Exec Board seeking funding to do additional list for UGI and Colorectal to reduce 52 weeks waits. (Approved 19/09/2017)	Ctrl 1. The quality safety and user experience impacts of under performance are not fully measured and reported. ~~Ctrl 3. Unable to continue Sat/overtime work, Financial position has meant that all over time had ceased this year causing a slow deterioration in our position~~	Chief Operating Officer (Liz Davenport)
1815	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	Cancer Services	Bell, Christine	1. Safe, Quality Care and Best Experience	15	Cause: Continued increase in demand on 2ww pathways and 62 day cancer pathways. A. Reduced capacity within Breast radiology to support TA clinics, causing breaches against breast 14 day and 2ww pathways. B. Reduced flexibility to provide additional capacity within surgical specialities affecting ability to achieve the 62 day cancer target. C. Reduced capacity in Dermatology senior medical team to provide sufficient capacity to maintain 2ww target. Effect: Risk of Trust not achieving quarterly cancer standards, specifically 2ww, 14 day breast symptomatic and 62 day targets.	1. Weekly workload review and task allocation with MDTCs and escalation of problems. 2. Achievement of CWT targets and up-to-date with patient tracking 3. MDT Co-ordinator now in post. 4. Monitor performance of CWT and report back to Risk and Assurance group fortnightly.	5. Additional clinical capacity ceased, which has impacted ability to escalate cancer patients. 6. Inability to recruit to consultant posts (locum and substantive posts).	15	09/11/2017	04/12/2017	~~Ctrl 1. Skill mix review undertaken which has resulted in band 2 admin support for MDTC to enable capacity to focus on patient tracking. .~~ Ctrl 1-2. Managed leave arrangements to ensure minimal staffing away at one time to maximise staff capacity. (New) Ctrl 2.4. Daily validation and escalation by CWT manager to manage performance. Ctrl 1-3 The staff are working additional hours where possible to manage the workload to cover vacancies within the data team. Ctrl 3. MDT Co-ordinator now in post.	~~Ctrl 1. Managed leave arrangements to ensure minimal staffing away at one time to maximise staff capacity. .~~ **None Identified.**	Ctrl 1. Capacity to manage demand, specifically in diagnostics. Ctrl 1. Escalation policy not working as robustly as needed. Ctrl 3. Extra hours only available whilst vacancies held. Ctrl 1-3. Controls in place as far as MDTC admin concerned. Cancer Services have no control over capacity in Breast and Dermatology.	Chief Operating Officer (Liz Davenport)

ID	Sub-Objective	Risk Type	Department	Risk Owner	Organisational Objectives	Rating (Initial)	Description	Controls in place	Gaps in Control	Rating (Current)	Last Reviewed	Next Review Due	Actual Assurances in Place on Existing Controls	Potential Assurances on Existing Controls	Gaps in Assurances on Existing Controls	Senior Responsible Officer
1998	Corporate Theme 2 : Failure to achieve key performance / quality standards	Corporate Level Risk	Laboratory Medicine	Goldsworthy, Keith	1. Safe, Quality Care and Best Experience, 4. Well Led.	25	Cause: Following an inspection by the Human Tissue Authority the Trust has been found to be non-compliant with the Human Tissue Act 2004 (HTA) requirements. Effects: Failure to meet the regulations of the can have major consequences to the organisation. 1. Potential suspension of services provided by the mortuary, i.e. Storage of bodies and performing post mortems which would have a financial and reputational impact on the Trust, 2. Potential incurrence of fines for the Trust and there is the option of potential imprisonment for the Designated Individual. Linked to Risk DRM ID No. 1961 Human Tissue Act 2004 Non-Compliance. (15 down from 16) . Linked for continuity.	1. Working assurance group set up to clear findings reported by the HTA. 2. Separate risk record(DRM ID no. 1961) created to manage non-corporate risks to achieve compliance. 3. Revisit by HTA Inspectors on 15/08/17, provided positive comments with regards to progress to date.	None Identified.	20	07/11/2017	30/11/2017	Ctrl 1. Working assurance group, Minutes and Action Points. Ctrl 2. Progress and Reviews of Risk 1961 and its associated Actions and reduction from 16 to 15. Ctrl 3. Positive feedback from resent Inspection.	None Identified.	None Identified.	Women's, Children's, Diagnostics & Therapies Service Delivery Unit (Keith Goldsworthy)
1697	Corporate Theme 3 : Inability to recruit / retain staff in sufficient number / quality to maintain service provision	Corporate Level Risk	Human Resources	Falcão, Judy	1. Safe, Quality Care and Best Experience, 2. Improved Wellbeing Through Partnership, 3. Valuing Our Workforce, 4. Well Led.	16	Cause: National shortages mainly due to the deficit between the numbers required and the number of training places. Effect: Difficulties in delivering on corporate objectives and national targets. Increase in temporary workforce usage including agency leading to budget overspends. Linked to Risks: DRM ID No 668 Risk of Not Covering the EDS Rota Due to Staff Shortages) (15) DRM ID No 1073 Timely And Effective Access To Neurology Service. (20) DRM ID No 1080 Emergency Services, inability to recruit experienced Senior (middle grade) doctors (15) DRM ID No 1149 Child Health, Cannot sustain a full middle grade rota and 6 person rota (9) down from (16) DRM ID No 1464 Trauma & Orthopaedics, Foot & Ankle Consultant. (15) Closed. DRM ID No 1736 General Medicine, George Earl Ward, Staffing level inadequate. (20) DRM ID No 1830 Cancer Services Vacancy for Breast and Colo-rectal Clinical Oncology. (15) DRM ID No 1953 Haematology Consultant Capacity. (15) DRM ID No 1955 Lack of Breast Radiologists. (16) DRM ID 2005 Restorative Dental Consultant Vacancy (20)	1. Recruitment updates are reported to Board bi-monthly as part of Workforce Report. 2. Medical Recruitment is being looked at as part of the Trust's Recruitment Strategy working groups. 3. Performance Report identifies where compliance with RTT/ED/STC impacted by workforce shortage. 4. Nursing workforce strategy in place including capacity plan that identifies demand and supply routes (including overseas nursing, redesign and vocational career pathways) monitored by Workforce and OD group. 5. E-Rostering system in place for nursing staff. 6. Restricted use of agency staff. 7. Use of bank staff wherever possible. 8. Additional support from current staff. 9. Risk discussed at Local level with escalation process for risks. 10. 15+ being linked to this risk. 11. Risk discussed at HR SDU meetings. R+R Groups. Workforce OD Group, Quality & SDU Performance meeting, Nursing working board group meeting, Risk Group meeting, Executive Team meeting, Audit & Assurance meeting and Trust Board meeting. 12 STP Workforce Strategy Group reviewing hard to fill vacancies. 13. Plans monitored by the Executive Vacancy Risk Group to manage vacancies and redeployment during the care model implication should lead to reduction in the vacancy gap for nursing.	Ctrl 2. Link between requirement to train additional staff and sufficient capacity to deliver placements for students and other trainees. Ctrl 5. E-Rostering system not in place for all staffing groups.	16	02/11/2017	30/11/2017	Ctrl 1-4,6,7,9,11 Scheduled performance, progress, KPI and action plan reports provided to Executive Team and Board via Workforce and Organisational Development Group meetings. Ctrl 3,10. Reports cross referenced with entries on Datix Risk Module and report to Executive Team and Board via Risk Group meetings. Ctrl 4. Plans monitored by the Executive Vacancy Risk Group to manage vacancies and redeployment during the care model implication should lead to reduction in the vacancy gap for nursing. Ctrl 5. E-Rostering guidelines in place and management working with HR_OD to ensure effective implementation. Ctrl 11-13. Agenda's, reports and minutes/notes and feedback.	Ctrl 8. Overtime being offer to current staff to cover shifts where applicable.	Ctrl 5. Guideline can not be implemented if staffing group is not on E-Roster.	HR & WP (Judy Falcão)
1695	Corporate Theme 4 : Lack of available Care Home / Domiciliary Care capacity of the right specification / quality	Corporate Level Risk	Personal Care Service	Machin, Shelly	1. Safe, Quality Care and Best Experience, 2. Improved Wellbeing Through Partnership	20	Cause: Lack of management processes and staff at Mears as evidenced by the Care Quality Commission and Health watch reports and the care failure in Torbay over the weekend of 25 - 28 August and additional issues during and since the beginning of October. Effects - Adequate and sufficient volume of Torbay provision that effects: A. Safety and quality of care delivered to clients compromised due to failure to visit/provide double handed care. B. Delayed discharges across the Acute and Community hospitals. C. Lack of public confidence in the provider and the Trust. D. Impact on the residential and nursing home market capacity as winter pressures start. E. Increased level of complaints. F. Risk to organisational strategy for the new model of care development. Linked to Risks: DRM ID No 75 (CLR) Viability of Care Homes and Nursing Homes. **(12 down from 16)** DRM ID No 631 Insufficient Capacity for Domiciliary Care. (8) Closed DRM ID No 1398 Mears Contract. (12) Closed DRM ID No 1671 Mears Personal Care Delivery Failure Concerns Across Torbay & South Devon. (8) Closed DRM ID No 1974 Unsourced Packages of Care.(12) **(New)**	1. Provider of Concern process invoked to hold the provider to account. 2. Senior Managers time released to lead the operational response and action plan. 3. Weekly operational review meeting overseeing delivery of action plan by Mears. 4. Daily review of the Outstanding package of care list daily calls with provider to anticipate any issues. 5. Sample of Mears clients contacted by the Trust to see and perform a light touch review. 6. Off contract protocol in place to procure Domiciliary Care from alternative sources. 7. Liaison with Devon County Council. 8. Working with the Communication Team re media responses and letters to clients. 9. Monitor of complaints and incidents. 10. Mears are incentivising staff and their sub contractors to promote better retention and take up of work. 11. Incidents that our staff report relating to care homes and care providers in the south Devon area are notified by David Hickman to DCC **12.Incidents that our staff report relating to care homes in the Torbay Localities (Torquay, Paignton & Brixham) are notified to TSDFT QAIT Team for investigation and interventions as required. (New)** **13. Incidents that our staff report relating to Mears in the Torbay Localities (Torquay, Paignton & Brixham) are notified to Cathy Williams, Jon Anthony, Nigel Sutton and Emma Bewes. (New)** **14. Non safeguarding concerns incidents relating to MEARS (or a sub-contractor of MEARS) are notified to MEARS via their secure NHS email address for them to investigate and respond to David Hickman within 14 working days using an agreed template. (New)** **15. Incidents relating to MEARS (or a sub-contractor of MEARS) which raise possible Safeguarding concerns incidents are notified to the persons in control 13 and also to the TSDFT safeguarding alert email address in the 1st instance for triage prior to provider notifications. (New)** 16.Breech of contract notice issued to Mears re the care failure over the bank holiday, specifying required improvement actions **(Was 12)** 17. Options Appraisal completed and to be sent to the board for consideration. **(Was 13)**	18. KPI's and performance reports remain inadequate from Mears. 19. Staff training in Mears on MCA/DOL's not adequate. 20. Capacity and Quality within the subcontractor market not confirmed. 21. Torbay's wider domiciliary care market has limited capacity and will incur higher cost implications. 22. Other organisational priorities at a time of change impact on senior managers time.	16	15/11/2017	15/12/2017	Ctrl 1. 3. 7. 12 Agenda's, papers, minutes/notes. Ctrl 1. CQC report Ctrl 1. Healthwatch report Ctrl 4. 11 Reports logged and notes reported on. Ctrl 5. List of clients Ctrl 5. Up-to-date protocol Ctrl 6. Protocol in place to use other providers other than Mears.Ctrl 8. Letters to clients Ctrl 4. 9. Complaint and incident reports. Ctrl 1-10 IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory. Ctrl 10. Judy Saunders has completed on-site visit with Mears to support their recruitment processes. Follow up visit also planned. **(New)** Ctrl 11-14 Daily monitoring of incidents and escalation of Mears related incidents are managed my CSDU Clinical Governance Lead. David Hickman. **(New)** Ctrl. 15. Breach of contract notice has been issued. Resulted in fortnightly meetings. **(New)** Ctrl 1 -17 Due to the level of concerns, decision has been made to put the service into a "Whole service safeguarding process" under a S42 process. **(New)**	Ctrl 1. CQC follow-up review Ctrl 1. Healthwatch follow-up review Ctrl 1. Release from provider of concern process Ctrl 2. Receipt of Mears action plan. Ctrl 2. CQC oversight of plan. Ctrl 10. Staff training records Ctrl 10. Staff turnover rates within Mears and sub-contractor.	Ctrl 1-12. Capacity analysis of domiciliary care sector.	Chief Operating Officer (Liz Davenport)

ID	Sub-Objective	Risk Type	Department	Risk Owner	Organisational Objectives	Rating (Initial)	Description	Controls in place	Gaps in Control	Rating (Current)	Last Reviewed	Next Review Due	Actual Assurances in Place on Existing Controls	Potential Assurances on Existing Controls	Gaps in Assurances on Existing Controls	Senior Responsible Officer
1223	Corporate Theme 5 : Failure to achieve financial plan	Corporate Level Risk	Finance	Muskett, Rodney	4. Well Led.	25	Cause: Inability to meet total recurrent CIP savings target. Effect: Results in a failure to achieve the business plan objectives for 2017/18. Linked to Risks: DRM ID No 75 (CLR) Viability of Care Homes and Nursing Homes. **(12 down from 16)** DRM ID No 1196 (CLR) Supporting the Delivery of the CIP Plans through HR Workforce Strategies & Support. (12 down from 16) DRM ID No 1228 Spend On Variable Staffing. (15)	1. Performance reports at Senior Business Management Group, Efficiency Delivery Group, Joint Executive meeting for SWSP, Finance, Performance and Investment Committee, Financial Improvement Scrutiny Committee and Board. 2. Deep dives on schemes undertaken at Efficiency Delivery Group and Finance, Performance and Investment Committee. 3. Programme office and management function established, monitoring and reporting delivery of schemes. 4. Regular updates provided to the Social Care Programme Board. 5. Exec-led performance monitoring of SDUs/support directorates. 6. CIP plan established for 2017/18. 7. Trust-wide improvement programme for 2017/18 onwards with potential savings verified with reference to external reports. 8. Executive sponsors and management leads identified for schemes. 9. Executive Check and Challenge meetings. 10. NHS-E and NHS-I monthly review process under the NHS E Capped Expenditure Programme.	Ctrl 2,4. Schemes do not yet meet target level.	20	10/11/2017	20/12/2017	Ctrl 1. Scheduled Progress and KPI reports provided to Board via Finance, Performance and Investment Committee. Ctrl 1-2,4-5. Agenda's, papers, minutes/notes from these meetings. Ctrl 1. Approved budgets to Board via Finance, Performance and Investment Committee. Ctrl 3,8. Agreed CIP schemes registered with the Programme Office. Ctrl 1. Bi-weekly review of CIP delivery via Efficiency Delivery Group. Ctrl 3. Programme office exception reporting Ctrl 3,8. Programme office distributing scheme updates / flash reports to scheme leads and executive sponsors. Ctrl 9-10 Executive has considered draft report form Mark Hacket and incorporated agreed actions into the PMO plans. Ctrl 1-10. Board Considered RSA and additional income from Torbay Council £4m at last meeting. Ctrl 1-10 New RSA Signed. **(New)**	Ctrl 6-7. PwC as external auditor. Ctrl 1,6-7. NHS Improvement feedback / letters. Ctrl 6-7. Audit South West review of CIP. Ctrl 6-7. Future publication of reference costs. Ctrl 6-7. Future publication of Carter process. Ctrl 1,6-7,9. Performance report demonstrating full delivery. Ctrl 6. Progress on CIP delivery plans and progress on further CIP scheme identification.	Ctrl 1-10. CIP Schemes do not yet fully cover the required target and in year cost pressures to be validated. Ctrl 1-10. SDU asked for forecast run rate reduction plans for £5m. **(New)** Ctrl 1-10.CCG asked for SSP deliver to be improved to plan further £1.5m. **(New)**	Strategy and Improvement (Ann Wagner)
1236	Corporate Theme 5 : Failure to achieve financial plan	Corporate Level Risk	Personal Care Service	Machin, Shelly	4. Well Led.	20	Cause: Increased expenditure on the Independent Sector (Placed People, Adult Social Care) budgets. Effect: This could lead to un-budgeted overspend and effect the Trust's ability to achieve the current business plan objectives.	1. Performance reporting through Service Delivery Units, Finance, Performance and Investment Committee and Board. 2. Placed People Oversight Group. 3. Standing Financial Instructions (SFIs) and Scheme of Delegation 4. ICO joined Devon County Council, Torbay Council, Plymouth Council, NEW Devon CCG and South Devon and Torbay CCG 2017/18 fee setting process. 5. Policies and procedures for care planning and package approval. 6. Care home fee model and care market consultation process. 7. Policies and procedures for outside of fee rate. 8. Joint Role to oversee market development across the system. 9. We are working on a number of schemes to reduce spend and increase threshold into social care spend-these are identified on the CIP smart sheet schedule. 10. A new Health and Social Care Uplift Committee is in place reporting to Executives, that considers all uplift requests from providers.	11. Torbay Council consultation responses could result in increased cost if accepted. 12. Outcome of Torbay Council judicial review unknown. 13. Universal standard use of NHS contract 14. Inability to attract packages of care within agreed fee structure. .	16	08/09/2017	08/10/2017	Ctrl 1.Scheduled progress, performance and KPI reports provided to Finance, Performance and Investment Committee and Board. Ctrl 1-2,8. Agenda's, reports, minutes/notes. Ctrl 3. Board approved SFIs and Scheme of Delegation. Ctrl 4. Agreed process Ctrl 5,7. Up-to-date policies and procedures. Ctrl 6. Agreed care home fee model and care market consultation process. Ctrl 6. Outcome of judicial review consultation process. Judicial review ruled in the Council's favour. **(New)** Ctrl 8. Person now in post and liaising with providers and teams. Ctrl 9. Evidence Recorded in smartsheets with fortnightly presentations to Mark Hackett. Ctrl 10. Committee in place, minutes and agenda of meeting available. Ctrl 1-10. Fran Mason has secured on-going nursing Home provision in Torbay. **(New)**	Ctrl 4. Benchmark rates of expenditure. Ctrl 4. Potential use of a combined Devon County Council fee model. Ctrl 4. Market strategy. ~~Ctrl 6. Outcome of judicial review consultation process.~~	Ctrl 1. Board report detailing output of client level audit / review. Ctrl 1-10. SDU asked for forecast run rate reduction plans for £5m. **(New)** Ctrl 1-10.CCG asked for SSP deliver to be improved to plan further £1.5m. **(New)**	Chief Operating Officer (Liz Davenport)
1239	Corporate Theme 5 : Failure to achieve financial plan	Corporate Level Risk	All Departments	Muskett, Rodney	4. Well Led.	25	Cause: Failure to achieve control total. Effect: Failure to achieve Sustainability and Transformation (STF) and subsequent impact on financial performance plan. Damage to risk rating and reputation with the regulator.	1. Annual plan control total. 2. Performance reporting and escalation through Service Delivery Units, Finance, Performance and Investment Committee, Financial Improvement Scrutiny Committee and Board. 3. Core financial controls. (Budget setting, Standing Financial Instructions / Scheme of Delegation) 4. Cash management, cash planning and working capital in place. 5. Reporting to regulators. 6. Engagement with regulators to ensure aspects of the Single Oversight Framework covered. 7. Assistance from NHS-I with Mark Hackett. 8. Building relationships with NHS-I team. 9. NHS-I monthly review process under the NHS E Capped Expenditure Programme. 10. Board considering revised RSA/PBR at next meeting. 11. Trust Board CCG and Council all approved the New RSA 12. CCG taking RSA to NHS E 13. NHSE approved CCG 2017/18 Plan as part of CEP process so CCG can now sign 2017/18 contract. 14. New risk share agreement signed with CCG and Council. **(New)**	Ctrl 1-2. Sufficient detailed CIP plans to cover, a Risk share contract challenge and deliver the control total. Ctrl 1-2. Cross referencing gaps in CIP and income. Ctrl 8. Building relationships with new NHS Team. ~~Ctrl 10-11-13 Signed contract for 2017/18and RSA 1 & 2.~~ 15. System wide savings plans being developed. 16. SDU asked to work up £5m contingency plan.**(New)**	25	10/11/2017	20/12/2017	Ctrl 1-14 Quarter 1 &2 achieved. **(New)** Ctrl 1,4-5. NHS Improvement returns (routine and ad hoc) Ctrl 2. Agenda's, papers, minutes/notes. Ctrl 2. Self-certifications. Ctrl 2,4. Detailed monthly cash flow forecasts, monthly closing cash balance/budgets and year-end cash balance process. Ctrl 3. Board approved SFIs and Scheme of Delegation. Up-to-date policies and procedures for budget setting. Ctrl 5. NHS Improvement correspondence to Trust. Ctrl 7-10. Executive has considered draft report form Mark Hacket and incorporated agreed actions into the PMO plans. Ctrl 1-14. Board considered ICO risk share agreement at 1st July meeting and issued letter to Partners. Ctrl 1-14. Council Oversee and Scrutiny recommended same conditions to full council. Ctrl 1-14. CCG governing body meeting 18/7/2017. Ctrl 14. Agreement Signed. **(New)**	Ctrl 1. Approved plan Ctrl 5-6. NHS Improvement segmentation. Ctrl 2-4. PwC use of resources assessment (3 Es) Ctrl 2-4. Internal audit reviews (CIP, review of Standing Financial Instructions / Scheme of Delegation) ~~Ctrl 1-14. Board review of Risk share agreement.~~ Ctrl 1-14. Partner organisations taking same review to their own governance committees.	~~Ctrl 1-14. Full Council, CCG Governing body and NHS E approval.~~ Ctrl 1. Forecast requires further £6.5m of financial improvement to achieved Control total. **(New)** Ctrl 1-4. SDU's asked to populate £5m additional actions to address. **(New)** Ctrl 11. CCG asked to push SSP schemes for full delivery. **(New)**	Chief Operating Officer (Liz Davenport)
1095	Corporate Theme 6: CQC rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'	Corporate Level Risk	Emergency Services	Houlihan, Lisa	1. Safe, Quality Care and Best Experience	20	Cause: Overcrowding due to exit block and capacity issues throughout the hospital meaning no flow through department. Effect: Non-achievement of ED quality standards, delayed ambulance handovers. No capacity creates delays to patient assessment, diagnostics, treatment and represents a clinical risk to patients. Linked to Risk: DRM ID No 1276 Lack of side rooms in Orthopaedic wards (10)(Closed)	1. Intentional rounding and departmental escalation policy in conjunction with hospital escalation plan. Challenging when there are high rates of admission and low rates of discharge i.e. Unable to adjust thresholds further to allow a patient to go home. 2. Two hourly board rounds during high volume situations; pilot use of overcrowding score to be used in conjunction with Trust wide actions. 3. Early escalation of capacity problems to on-call teams. Escalation to Bronze and Silver command in SWAST. 4. ED dashboard will support greater understanding of ED pressures 5. Performance closely monitored through ED governance process and trust flow board 6. Policies and procedures including clear SOP's 7. On call executive rota/potential creation of site management team. 8. 3 x daily control meetings with real-time information and appropriate management responses. 9. Ward discharge coordinators have daily meetings to review ward discharges. 10. SWAST and ED initiative with use of 'expected cards' to highlight if patients could be directed elsewhere e.g. AMU/EAU3 **(New)**	Ctrl 1: Freeing up ward capacity. Late discharged remain a problem. Ctrl 3: Review required of the support to be provided to the department by the 104/110 bleep holder to be instigated. (See comment about site management team).	15	13/10/207	30/11/2017	Ctrl 1. These are audited monthly by the departmental Senior Sisters and 2 hourly escalation sheets held in department of internal actions taken. Ctrl 2. Evidence available via internal escalation record sheets. Ctrl 3. Part of internal escalation plan. Ctrl 4. SAFER bundle rolled out on EAU4 in/2016 - ALAMAC no longer in use as replaced by ED dashboard and internal escalation tool. Ctrl 5,8,9. Agenda's, papers, minutes/notes. Ctrl 6. Up-to-date policies and procedures. Ctrl 8. Up-to-date on call executive rota. Ctrl 1-9. CQC self-assessment. Ctrl 1-9. IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory. Ctrl 1-9. Positive CQC report - August 2017 (see documents)	Ctrl 3. New pilot on EAU3 where direct medical and surgically expected patients are being transferred to reduce overcrowding in dept. Ctrl 10. New SWAST and ED initiative. **(New)**	None identified.	Chief Operating Officer (Liz Davenport)
1504	Corporate Theme 6: CQC rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'	Corporate Level Risk	Emergency Services	Houlihan, Lisa	1. Safe, Quality Care and Best Experience	15	Cause: 2-3 Occurrence's weekly where vulnerable patients are admitted to the EAU's awaiting Mental Health Beds. Effects: A. Delays in transferring patients to appropriate units due to bed availability. B. Poor patient experience. C. Huge strain placed on these wards, often requiring extra staffing to support, adding stress/workload for ward teams.	1. Situation regularly escalated. (Averaging weekly occurrence) 2. Extra staffing can be requested via temporary staffing (as available). 3. Psychiatric liaison team available in hours. 4. Manager on call and/or Executive team 5. Appropriate discussion in progress with Devon Partnership Trust.	6. Not enough mental health bed capacity. 7. Reduced mental health staffing overnight means long delays for review and support. 8. Not an appropriate place of safety. 9. EAU staff do not have specific mental health training.	15	25/10/2017	30/11/2017	Ctrl 1. Escalated and control room informed. Ctrl 2. Bank Staff and Records from temporary staffing. Ctrl 3. Devon Partnership Trust rota documented and available on request. Ctrl 4-5. Patient Flow Board Meeting Minutes Ctrl 1-5 IA Report - SDU Governance arrangements. (May 2017), Assurance level satisfactory. Ctrl 1-5. Positive CQC report - August 2017 (see documents)	None Identified.	None Identified.	Chief Operating Officer (Liz Davenport)

Board Assurance Framework (BAF) Heatmap

Torbay and South Devon NHS
NHS Foundation Trust

Current Risk Rating

BAF Heatmap		Likelihood		
		3. Possible	4. Likely	5. Almost Certain
Consequence	5. Catastrophic	15	8 9 17 **20**	1 2 4 15 **25**
	4. Major	12	3 6 7 11 12 **16** 14	5 10 13 **20**
	3. Moderate	9	12	16 **15**

Trust Strategic Objectives 2016/18

❶ = Safe, Quality Care and Best Experience
❷ = Improved wellbeing through partnership
❸ = Valuing our workforce
❹ = Well led

Risk Title:

1. Corp Theme 1, DRM ID No 1050 “Special Theatres Ventilation.” ❶
2. Corp Theme 1, DRM ID No 1083 “Insufficient Capital Expenditure.” ❶❹
3. Corp Theme 1, DRM ID No 1159 “Current IT Systems & Infrastructure Will Not Meet Future Demands.” ❹
4. Corp Theme 1, DRM ID No 1231 “Failure To Raise Sufficient Capital” ❹
5. Corp Theme 2, DRM ID No 1070 “Outpatient & Inpatient RTT” ❶
6. Corp Theme 2, DRM ID No 1101 “Medical Retina Demand.” ❶
7. Corp Theme 2, DRM ID No 1110 “Follow Up Appointments Are Followed Up In Agreed Timescales.” ❶❹
8. Corp Theme 2, DRM ID No 1266 “Poor Patient Experience And Quality Of Care” ❶
9. Corp Theme 2. DRM ID No 1815 “High Quality Patient Tracking to Avoid any Unnecessary CWT Breaches.”❶
10. Corp Theme 2. DRM ID No 1998 “Human Tissue Act 2004 Non-Compliance. ❶❹
11. Corp Theme 3, DRM ID No 1697 “Inability to Attracted Service Critical Staff.” ❶❷❸❹
12. Corp Theme 4, DRM ID No 1695 “Mears Personal Care Delivery, Failure Concerns Across Torbay & South Devon.” ❶❷
13. Corp Theme 5, DRM ID No 1223 “Financial Sustainability Risk Rating” ❹
14. Corp Theme 5, DRM ID No 1236 “Increase In Overspends On The Independent Sector” ❹
15. Corp Theme 5, DRM ID No 1239 “Failure To Secure Fund Monies” ❹
16. Corp Theme 6, DRM ID No 1095 “Safer Care - No Delays in ED.” ❶
17. Corp Theme 6, DRM ID No 1504 “Delays to Mental Health Pathways” ❶

Torbay and South Devon NHS
NHS Foundation Trust

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting dates:	6 November 2017
Report by + date:	David Allen, 10 November 2017
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:

Mortality review report – Medical Director
QAC noted the arrangements made for the Mortality Surveillance Group, which will now be a third element of the work of the Quality Improvement Group (QIG). The group meets regularly, attendance issues are being addressed and the dashboard has been designed – when populated this will be a public-facing document providing information on learning from mortality. QAC noted the risks and assurance provided and the considerable work undertaken to date, in particular, that of the deaths so far reviewed 97% were clearly unavoidable and in only 3% was there even slight evidence of avoidability.

Shortfall in radiology resource – Deputy COO
The committee noted the contents of the detailed report and the efforts made to date to address this issue but recognised that a clear action plan would be required to address the demand and capacity issues identified. The committee noted that in general the various services were only able to be delivered with significant staff overstretch. The next step should be a business plan designed to improve the patient and staff experience. QAC felt that until such time that this was available the report provided only limited assurance.

Workforce and Organisational Development group report - Deputy Director Workforce
The group meets regularly on a bi-monthly basis and is monitoring very closely at every meeting progress with action plans on sickness management and appraisal rates. Slow progress is being made, with sickness absence still costing the Trust approximately £500k per month. A new IT system for appraisals is due to be introduced in December 2017 and HR staff are contacting individual managers who have not carried out appraisals to ensure that the appraisal rate is increased. QAC felt the report provided only limited assurance on those areas.

Key Decision(s) Made:

- That the wording of BAF Risk number 1266 “supply and demand imbalance in surgical division “ is reviewed
- To receive details of the Safeguarding S.11 report at a future meeting

Recommendation(s):

1. To note this report and its key actions and decisions

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	28 November 2017
Report by + date:	Robin Sutton, 29 November 2017
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issue(s) to highlight to the Board (Month 7):

1. For assurance, the Month 7 Integrated Finance and Performance report (new format) was reviewed by the Committee. Month 7 remained broadly in line with plan with an actual deficit of £1.77m against a planned deficit of £2.84m. Identified potential savings schemes for the year total £42.6m against a cost reduction target of £40.7m and an income generation target of £1.3m. Any slippage in delivery will put the control total and Q4 STF funding at risk. Additional cost pressures of over £6m are planned to be mitigated by further SDU savings and risk share income.

2. Performance was reviewed, the delivery of national operational standards for 4 hour ED treatment time being 92.7% against 92% trajectory and a 95% standard, Cancer 62-day performance being 85.8% against a standard of 85%. RTT was 84.4% against a standard of 92%. The number of long waits (over 52 weeks) increased to 26 against a standard of zero. Dementia screening was 78.6% against a standard of 90%.

3. The NHSI monthly self-certification form and financial narrative for Month 7 was approved by the Committee.

4. For assurance, a monthly Deep Dive was undertaken by the Committee into the Trust's CIP 2018-19 agreed bed reduction savings plan, the presentation highlighted the risk presented by the lack of available domiciliary care services.

5. The business case for the Outpatients Pharmacy Dispensary expansion was approved by the Committee and the potential use of equipment leasing to assist in funding this business case.

6. Updates to the 2018/19 Business Planning Process was presented to the Committee for assurance, this highlighted the likely scale of savings targets required for 2018/19 and the impact of not achieving the recurring CIP savings in 2017/18.

7. The Torbay Pharmaceuticals financial report for October 2017 was reviewed by the Committee for assurance. The Committee agreed to raise the year end forecast position with the TP Board.

8. The latest Finance Risk Register was provided for information and the BAF risk numbers 1159 (*Lack of available capital funding to spend on IT infrastructure and IT Systems*) and 1237 (*South Devon and Torbay CCG and Torbay Council financial positions becoming increasingly challenged*) were reviewed and discussed. 1237 is in the process of being downgraded as a corporate level risk and therefore does not appear on today's Board Assurance Framework.

9. The monthly HISD Report was provided for information purposes and covered a progress report on planning for GDPR and a report on the delays in implementing E prescribing. The Committee agreed to refer GDPR to Audit and Assurance.

10. The Committee reviewed a paper on Capital and Cash, highlighting that the cash impact from cost pressures was likely to be offset by slippage in capital spend.

11. The Senior Business Management Group summary report from the 9 November 2017 and verbal feedback from the EDG meeting on 17 November 2017 were provided to the Committee for information. The Committee supported the Executives proposed approach in resolving difficulties with the current Sexual Health tender.

Key Decision(s)/Recommendations Made:

As above.

Name: Robin Sutton (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6 December 2017		
Report Title	Report of the Chief Operating Officer		
Lead Director	Chief Operating Officer		
Corporate Objective	• Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well led		
Corporate Risk/ Theme	• Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems • Failure to achieve key performance standards • Inability to recruit/retain staff in sufficient number/quality to maintain service provision • Lack of available Care Home/Domiciliary Care capacity of the right specification/ quality. • Failure to achieve financial plan • Delayed delivery of integrated care organisation (ICO) care model		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The report provides the Board of Directors with an update on operational work programmes managed by the Chief Operating Officer.		
Key Issues/Risks	Key points of note: • Winter plans are in place supported by a Leadership Team reporting to the Chief Executive • There is an opportunity to bid for winter resilience monies aimed at delivering measurable improvements in performance • The Care Model is developing to including changes in working practices and building partnerships with other organisations including mental health services • The plans to develop a multi- agency Health and Wellbeing Centre at Riverview progress despite risks emerging in relation to public perception of a delay and challenges to delivery of nursing care at Riverview. • The identification of additional resources to increase Nursing Home and Domiciliary capacity in Torbay		

	• Timeline to implement the new Operational Delivery structure will be published with the most senior level in place by April 2018 The operational risks highlighted include: • Delivery of NHSI Single Oversight Framework performance standards including 4 hour wait, RTT, 52 week waiters and diagnostics • Increasing demand in ED impacting with risks to service resilience • Sustainability of MIU capacity and availability of radiographers • Compliance with HTA standards – Mortuary • Care home and domiciliary care capacity to support care at home • Clinical recruitment challenges affecting capacity in specialities including ED, Dermatology, Neurology, Histopathology, Endoscopy and CAMHS • Impact of extended hours for the medical take on RTT compliance in some specialities • Delays to follow up - high levels in Ophthalmology and Audiology • CIP plans are not yet fully at target with actions and cost pressure have emerged in year that require active management to mitigate risk to financial plan delivery • Emergency Duty Service resilience • Delays in mental health pathways • Histopathology capacity and impact on cancer pathways
Recommendations	To **consider** the assurance provided in the report and to provide further challenge on the risk mitigation in place
Summary of ED Challenge/Discussion	
Internal/External Engagement inc. Public, Patient & Governor Involvement	The changes to care model have been subject to a period of formal consultation with the public. No other issues identified.
Equality & Diversity Implications	All changes are subject to quality and equality impact assessments. No specific issues identified.

MAIN REPORT

Report to	Board of Directors
Date	6th December 2017
Lead Director	Chief Operating Officer
Report Title	Report of the Chief Operating Officer

1 Purpose

To provide the Board of Directors with an update on operational work programmes

2 Provenance

The report is informed by the following:

- Minutes and action log from the Care Model Delivery Group
- Care Model Delivery Group Risk Register
- Minutes and action log from Senior Business Management Team
- Minutes and action notes from the A&E Delivery Board
- Market Management Development Group Minutes
- Feedback from Service Delivery Units

3 Winter Escalation Plan

There is an on-going focus on delivery of winter plans and compliance with the improvement trajectory for A&E performance. To enable this NHS I and NHS E are putting additional support in place to include a National Situation Room that will oversee delivery and provide support 24/7 and the appointment of a Regional Improvement Directors for winter that for the South West is Anthony McKeever. The Trust has made contact with Mr McKeever and is making arrangements for an early visit.

In the budget, an allocation was made to the NHS to support winter resilience. There is no defined criteria for allocation of the resource but it was made clear at the NHS E and NHS I Winter planning event that money would be released based on discussions held between the National Director for Urgent and Emergency Care and local system leaders within the next 2 weeks. The indications are that funding would be allocated where there is clear evidence that the investment would lead to a measurable improvement in performance. In certain circumstances it was agreed that there may be some flexibility to use agency staff where there was limited pool of staff available to meet the need.

In the Trust a Winter Leadership Team has been put in place reporting directly to the Chief Executive that will have responsibility for overseeing implementation of all aspects of the winter plan. The Team led by the Chief Operating Officer, Liz Davenport includes the Head of Operations Cathy Gardner, Deputy Medical Director Ian Currie and Deputy Director of Nursing and Professional Practice, Cathy Bessent. The Team will have oversight on a day-to-day basis but will also have responsibility for leading the Trust response to Opel 3 and Opel 4.

The Team will work to an internal escalation plan that has been developed with clinicians and other key stakeholders taking into account the changes to the Care Model. The plan was submitted to NHS England on 20 November and was reviewed by the Regional Director. Initial feedback was positive and we expect more detail to be made available shortly. A final submission including detail of the plan for Christmas will be submitted in December.

To support effective monitoring of delivery the Information Team has been preparing an improved data report, which can monitor activity to the level of the patient. Our experience is that access to good quality information is key to informing our system response to demand. The Team is to be commended for its work to achieve this improvement in information given multiple demands on their time.

Flow Board in the Trust and the A&E Delivery Plans will receive regular reports on delivery against the plan as will the Board of Directors.

A more detailed paper on the content of the plan will be presented elsewhere on the Board agenda.

4 Care Model Delivery

The Care Model Delivery Group continues to meet on a bi- monthly basis overseeing development and implementation of the Care Model. In recent meetings the focus has been on:

- Care Model - chapter 2 development lead by the Strategy and Service Improvement Team
- Delivery of the STP mandated Integrated Care Blueprint for Devon
- Culture change – developing our compelling narrative. This is being informed, in part, by an organisation called 'ICE Creates' that is engaging with staff and key stakeholders across Torbay and South Devon
- New ways of working to include My Support Broker
- Delivering the changes required to support winter ' 7 big things'
- Service Evaluation
- Securing funding to support Care Model Development
- Cost Improvement Planning for 2018/19

The Group is keen to ensure that there effective ways of monitoring the impact of the changes to the Care Model on people who use services and monitoring of delivery of expected outcomes. To this end plans work is being completed on Care Model Metrics.

Agreement has also been reached with Devon Partnership Trust (DPT) to develop an integrated model of physical and mental health care within the Health and Wellbeing centre in Totnes. If successful the intention will be to roll out the approach across all 5 localities.

5 Riverview

The Trust and partners continues to make strenuous efforts to take forward the plans to create a Health and Wellbeing centre at Riverview in Dartmouth that brings together the Health and Wellbeing centre with the local GP practice, pharmacy services and a Care Home.

The Project is complex and challenging to deliver but continues to be a key priority for Trust and partners. Project risks have emerged in recent in weeks, which include:

- Public concern about the perceived delay in bringing the project forward
- Inability for the current Care Home to provide Nursing care on a sustainable basis due to workforce and capacity concerns resulting in 4 people requiring transfer to another facility
- Temporary cessation of Intermediate Care placements at Riverview

The Trust has been working with Devon County Council and local stakeholders to address the immediate issues including communication and engagement with the Care Home Provider and the local community. In addition the Trust and CQC are providing practical support to the Care Home as it seeks to make the improvements required.

The process to identify a new provider continues with one organisation expressing an interest in taking over the delivery of the Care Home including nursing beds. The current provider has indicated that they are keen to engage with DCC and the Trust to ensure a smooth transition of care services.

6 Care Home and Domiciliary Care capacity

The Risk Register details risks of insufficient capacity in the Care Home and Domiciliary Care as a risk to delivery of the care model. The position has been aggravated in recent months by home closures and restrictions on new referrals while service improvements are made as a result of safeguarding processes. In response to these concerns the Trust with partners have taken forward 2 projects:

- ***Nursing homes*** – Torbay Council and Trust staff have successfully secured a new provider for a home in the Bay that was due to close with a loss of 55 beds. The joint work and commitment to on-going support to the home while the new provider makes improvements to the service offered has minimised disruption for residents and ensured that much needed capacity has been retained.

- ***Domiciliary Care*** - The Trust continues to work closely with its partner Mears but both organisations have identified capacity concerns over winter. This has been responded to with the commissioning of additional short-term capacity. This will create additional resilience and improve access to care packages for people at the end of life. The new team will start work at the end of November and will work for 20 weeks. In addition to this as part of the winter plan additional capacity has been recruited for Rapid Response to enable people to be discharged home with an initial package support while needs for longer-term support is assessed. This forms part of the 7 ' big things' for winter plan.

7 Operational Delivery Structure

A period of engagement with staff and key stakeholders on the new delivery structure has concluded. The reference group considered all aspects of the feedback and a set of recommendations were presented to the Executive Team.

The Executive Team approved a delivery structure with the following features:

- Community facing, integrating hospital and community services managed at community level
- Joined up clinical professional and operational leadership incorporating General Practice
- Clear lines of accountability and links to Local Authority governance systems
- 3 levels of leadership to include 2 senior Leadership Teams, Devon and Torbay facing
- 5 Community Delivery units aligned to localities managing locality health and care services and a number of services arranged by Care Group
- 1 Hospital Delivery Unit that coordinates the hospital based infrastructure
- A team structure sitting below the Community Delivery Units built around key delivery functions

The intention is to start the formal part of the consultation phase with staff directly impacted by the changes. The Timetable is as follows:

- Consultation – commencing 22 January 2018
- Final plan 1 March 2018
- Commencement of interview s March 2018
- Senior Teams in place 1 April 2018

8 Voluntary Sector Partnership

The first meeting of the Voluntary Sector Partnership Board was held in November with membership from the 2 Umbrella Voluntary services Organisations, Healthwatch, Academic Health Science Network (AHSN), Torbay Council, South Devon and Torbay CCG and the Trust. Terms of reference for the meeting were discussed and agreed and priorities identified. The intention is that the group will focus on areas that support delivery of the Care Model. These areas include:

- Transport
- Hospital Discharge
- Community resilience and development
- Prevention and early intervention

The group will use the next meeting to focus on the following:

- Transport- following on from the Hackathon in 2017
- Heat map of voluntary sector organisations across Devon and Torbay to identify areas of risk
- Financial plan

9. Operational Issues

52-week waits – In line with predictions there has been an increase in the number of people waiting over 52 weeks for treatment (26 in October) this number is expected to increase further in December ahead of a reductions in early 2018. The Teams are implementing plans in line with the agreements reached with the Executive Team. The Teams remain confident that 52-week waits will be eradicated by end of March through the running of additional sessions, re- prioritisation of day theatre activity and the recruitment of additional locum staff. The teams however have been asked to develop a contingency plan. The mutual aid framework is being utilised where appropriate to secure additional support.

Delayed transfer of care (DTOC) – there has been a strong focus on DTOC levels which is seen to be a key to ensuring resilience in the Trust's hospital system over winter. Torbay and South Devon have reported a low level of DTOC previously but in September there was an increase in delays reported both in Acute and Community Hospitals. This contributed to a reduced performance against the 4-hour standard. This increased level of DToC has been linked to reduced capacity within Care home and the domiciliary sector and an increase in the time spent by community staff supporting care homes needing improvement. There is a risk that if DTOC trajectories are not met Councils will have elements of the Improved Better Care Fund removed. Poor performance might result in the CQC undertaking a review of DTOC in the local system. Internal Audit has been commissioned to complete a review of processes to support learning and on-going improvement

Financial plans- The bi- monthly check and challenge meetings continue, chaired by the Director of Finance and the Chief Operating Officer. The focus of the last series of meeting has been on plans to address in year cost pressures.

Delays to follow up –The Board and Executive Team have been concerned about increasing delays to follow up. The Executive Team has commissioned 2 pieces of work and analysis of the delays by Clinical speciality and a workshop with clinicians aimed at developing a plan to reduce all delays. The first piece of work detailing numbers by speciality was presented to the Executive Team. The paper details particular risks emerging in cardiology with some improvements in Ophthalmology and Audiology. The Clinical Management Group will be tasked to develop a supporting plan. Details of the current position is included as part of the performance report.

Histopathology capacity- An improvement Group has been established chaired by the Medical Director and Chief Operating Officer to lead the plan to address capacity gaps in histopathology, which has arisen as a result of retirements and failure to recruit. The longer-term plan is based on the recommendations of the Acute Services Review of this service. Solutions include access to mutual support from RD&E for Breast services where the risk were assessed as most significant.

10. Summary of Operational risks and issues

Risk registers are maintained by all services and projects with risks reviewed through the monthly quality and performance meetings with deep dives at the Risk Committee on a scheduled basis.
The operational risks highlighted include:

- Delivery of NHSI Single Oversight Framework performance standards including 4 hour wait, RTT, 52 week waiters and diagnostics
- Increasing demand in ED impacting with risks to service resilience
- Sustainability of MIU capacity and availability of radiographers
- Compliance with HTA standards – Mortuary
- Care home and domiciliary care capacity to support care at home
- Clinical recruitment challenges affecting capacity in specialities including ED, Dermatology, Neurology, Histopathology, Endoscopy and CAMHS
- Impact of extended hours for the medical take on RTT compliance in some specialities
- Delays to follow up - high levels in Ophthalmology and Audiology
- CIP plans are not yet fully at target with actions and cost pressure have emerged in year that require active management to mitigate risk to financial plan delivery
- Emergency Duty Service resilience
- Delays in mental health pathways
- Failure to secure JAG accreditation following a self assessment exercise in October 2017

11. Recommendations

The Board is asked to consider the assurance provided in the report and provide advice on any further actions to enhance the risk mitigation described in this paper.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Chief Nurse Report		
Lead Director	Chief Nurse		
Corporate Objective	Safe, quality care and best experience Well led		
Corporate Risk/ Theme	Failure to achieve key performance standards		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	**Quality Account update** The Quality Account priorities are set annually by partners and stakeholders including the CCG, Healthwatch, governors and service users. **CQUINs** The Commissioning for Quality and Innovation priorities are set by local providers from a national long list.		
Key Issues/Risks	**Quality Account:** The outpatient redesign of service led by Dr Joanne Watson is underway with good clinical engagement and key objectives identified. **CQUINs**: Achievement of two of the CQUINs is in doubt. The first relates to the identification and screening of ward inpatients who are at risk of sepsis that are identified and receive antibiotics in one hour. Currently there is no joined up IT system that facilitates tracking through from ED to the wards. The second relates to reduction of antibiotic use but a national shortage of Piperacillin resulted in escalation to national team as Trusts unable to achieve. We await CCG guidance on next steps.		
Recommendations	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.		
Summary of ED Challenge/Discussion	Executives discussed the resilience of staff over the winter pressure period and the need to continue face to face engagement to hear from staff directly. The Chief Nurse attends Ward Manager / Sister meetings to ensure concerns are escalated directly and promptly to Executives.		

	The Trust response to the revised Prevent framework was noted and will be monitored through the Quality Improvement Group.
Internal/External Engagement inc. Public, Patient & Governor Involvement	CCG membership of QIG Governor membership of QIG
Equality & Diversity Implications	None

MAIN REPORT

Report to	Board of Directors
Date	6th December 2017
Lead Director	Chief Nurse
Report Title	Chief Nurse Report

Purpose: To update the Board of the Chief Nurse Portfolio

1.0 Quality Account & CQUIN update for Quarter 2

The status of the quarter 2 CQUIN and Quality accounts are outlined below. 2c is currently indicated as red due to resourcing issues and 2d has no RAG status as we are waiting guidance from the CCG whether the Trust is required to undertake this CQUIN as per the guidance due to a national shortage of certain antibiotics. The Sepsis return is due at the end of the month. 2c will continue to show a RAG rating of red having no electronic inpatient screening tool for sepsis.

Title	Self-assessment
QA Priority 1: to develop and use a core multidisciplinary standardised risk assessment booklet and nursing care plan assessment booklet for all adult inpatients on any ward in the Trust.	This has been printed and is ready for distribution in Q3.
QA Priority 2: to redesign outpatients in order to make these services more patient-centred and use resources effectively.	Good clinical engagement and objectives identified
QA Priority 3: Provide safe, proactive and timely discharge of patients with more patients discharged earlier in the day and reduced delayed transfers of care and reduced length of stay.	SAFER methodology used Criteria led discharge developed and piloted.
QA Priority 4: Provide reliable, accurate and timely information at the point of handover on all inpatient wards at Torbay hospital through the implementation of a new hand held electronic tool called Nervecentre.	Nervecentre implementation on track. Well received by nursing staff
QA Priority 5: Improve our patient experience measures so they more fully reflect our service users' experience of care in the integrated care organisation.	Northhumbria real time patient survey in progress
CQUIN1a: NHS Staff Health & wellbeing Achieving a 5 % point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. **Year 1 (17/18)** The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey	Improvement work in progress. Staff survey in progress

CQUIN1b: Healthy Food for staff , patients & visitors 1.) Maintaining the four changes that were required in the 2016/17 CQUIN) Introducing three new changes to food and drink provision: a.) (**70% year 1**, 80% year 2) of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices with added sugar and milk based drinks. b.) (**60% year 1**, 80% year 2) of confectionery and sweets do not exceed 250 kcal. c.) At least (**60% year 1**, 75% year 2) of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g	As above
CQUIN1c: Flu Achieving an uptake of flu vaccinations by frontline clinical staff of 70%	Flu Vaccination programme underway. Staff uptake variable
CQUIN2a: Sepsis The percentage of emergency patients who met the criteria for sepsis screening and were screened for sepsis =>90%	Information due 30/11/17
The percentage of inpatient patients who met the criteria for sepsis screening and were screened for sepsis= >90%	Information due 30/11/17
CQUIN 2b: Sepsis The percentage of emergency patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour >90%	Information due 30//11/17
The percentage of inpatient patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour >90%	Information due 30/11/17
CQUIN 2c: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. – Empiric review of at least 25% of cases in the sample	This may not be achieva ble due to lack of clinical capacity. Process still to be determined.
CQUIN2d: Reduction in antibiotic consumption per 1,000 admissions	This may not be achievable due to national shortage of alternative antibiotics
CQUIN 4d: Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.	Working with DPT on process to identify and manage cohort.

2.0 **Safer Staffing Report**:

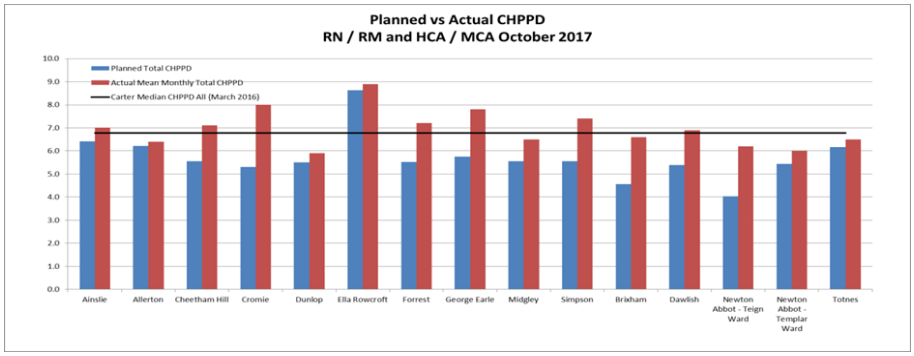
Purpose of the Briefing

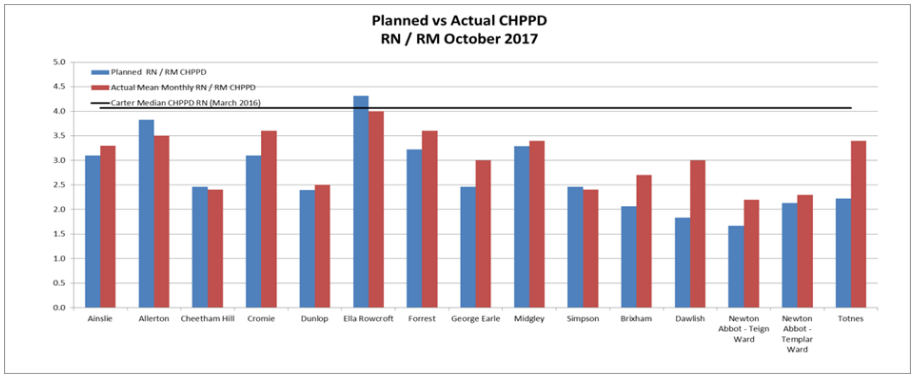
The purpose of this briefing is to provide information and assurance regarding the Nursing and Midwifery Safer Staffing levels over the previous month.

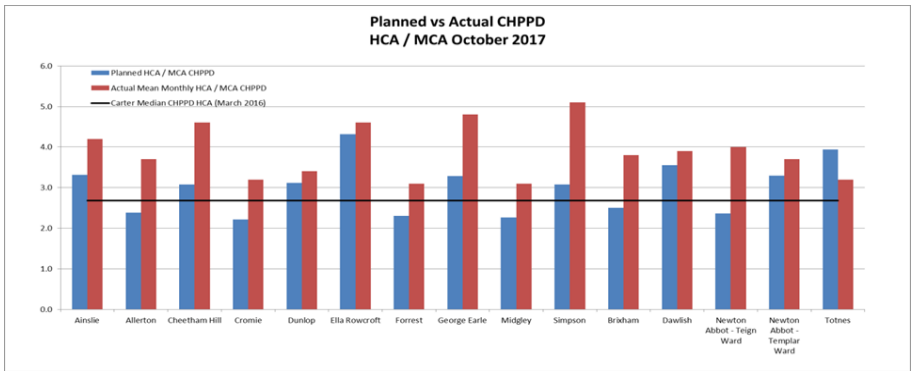
On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. The model hospital dashboard has now been updated to show the national median data which is summarised below from September 2016 to October 2017.

The Table below shows that whilst the Trust is over its planned total (RN + HCA) staffing levels in several areas and above the national Carter Median of 7.76 overall, the trust is below the national CHPPD range of 4.74 for RN's (TSDFT 4.12) and above the national 2.91 for HCA's (TSDFT 4.03).

	TSDFT October 2017	TSDFT September 2016	National Median September 2016
Total CHPPD	8.15	7.84	7.76
RN/ RM CHPPD	4.12	3.73	4.74
HCA / MCA CHPPD	4.03	4.11	2.91







The graphs above show that there are a number of areas that are above the planned RN numbers.

Cromie ward had 3 newly qualified nurses who required a supernumerary induction period increasing the need for bank to ensure safety was maintained and the correct level of support provided. The HCA figures reflect the specials required which has also included RMN cover where appropriate authorisation has been sought.

Midgley is showing over for HCA's due to the increased ward dependency, the over planned RN's is due to supernumerary staffing. Forrest ward have had short term sickness with both band 2 and band 5's and are currently carrying a 2.07 WTE band 5 vacancies. Ainslie had 3 newly qualified staff nurses start in October who would have been in a supernumerary status for 2 – 3 weeks from their start dates which accounts for the slightly over figure RN's. HCA's is for specials and for backfilling band 5 gaps with band

2's when unable to cover with registered nurses. Totnes have extra RN on Monday and Thursday as there is no discharge coordinator to progress discharges. There is an HCA discrepancy which is unclear as roster shows fully staffed and 1:1 in place as well as increase in beds. There has been some sickness which was back filled with the overall ward workforce. Brixham hospital is over planned HCA usage due to 1:1 requirements 24 hours a day which remains on-going at this time. Dawlish have several RNs vacancies and are constantly out to advert. Additional HCA's are used to backfill when required.

Table 1 below shows where there is less than the planned staffing level. These are due to maternity absence, vacancy or sickness.

Table 1:

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	7.0	3.3	4.2
Allerton	6.2	3.8	2.4	6.4	3.5	3.7
Cheetham Hill	5.5	2.5	3.1	7.1	2.4	4.6
Coronary Care	5.8	5.8	0.0	8.4	7.8	0.6
Cromie	5.3	3.1	2.2	8.0	3.6	3.2
Dunlop	5.5	2.4	3.1	5.9	2.5	3.4
EAU3	6.3	3.6	2.8	12.2	5.9	5.8
EAU4	7.2	3.8	3.4	9.6	5.0	4.2
Ella Rowcroft	8.6	4.3	4.3	8.9	4.0	4.6
Forrest	5.5	3.2	2.3	7.2	3.6	3.1
George Earle	5.8	2.5	3.3	7.8	3.0	4.8
ICU	20.4	20.4	0.0	26.6	26.6	0.0
Louisa Cary	6.7	4.2	2.4	17.9	9.3	8.6
John Macpherson	4.0	2.3	1.7	19.6	13.6	6.0
Midgley	5.5	3.3	2.3	6.5	3.4	3.1
SCBU	6.9	6.9	0.0	10.5	8.2	2.4
Simpson	5.5	2.5	3.1	7.4	2.4	5.1
Turner	7.9	3.6	4.2	9.0	4.0	5.0
Brixham	4.6	2.1	2.5	6.6	2.7	3.8
Dawlish	5.4	1.8	3.6	6.9	3.0	3.9
Newton Abbot - Teign Ward	4.0	1.7	2.4	6.2	2.2	4.0
Newton Abbot - Templar Ward	5.4	2.1	3.3	6.0	2.3	3.7
Totnes	6.2	2.2	3.9	6.5	3.4	3.2

Organisational status:

The alert status for the organisation for September and October is set out below. This provides an indication of operational pressure.

TSDFT Alert Status -Sept	No Days in Month	% days in Month
Opel 1	4	13.33%
Opel 2	9	30.00%
Opel 3	17	56.67%
Opel 4	0	0%

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TSDFT Alert Status - Oct	No Days in Month	% days in Month
Opel 1	12	38.71%
Opel 2	14	45.16%
Opel 3	5	16.13%
Opel 4	0	0%

Maternity Services:

We are still awaiting the final report from birth rate plus however from the audit that was undertaken in September, the initial results show the trust currently has the correct number of clinical and non-clinical midwives and Band 3 Maternity Support Workers to effectively and safely run the maternity service.
The service however currently has 5 midwife vacancies which will be advertised in due course. It is anticipated these posts will easily be able to be recruited to. The team have reported feeling under pressure due to the number of staff on maternity leave and long term sick. The Interim Senior Midwifery Manager is reviewing staffing levels daily to ensure appropriate cover.

Further Nursing Workforce Programme Updates:

Recruitment & Retention:

Table 2:

	Budget	In-post	Vacancy	Vacancy Factor
Midwifery	86.92	86.76	0.16	0.18%
RN	1192.62	1095.42	97.21	8.15%
Total	**1279.54**	**1182.18**	**97.36**	**7.61%**

Table 2 above shows an overall vacancy factor for 7.6% for nursing and midwifery. Trust recruitment & retention campaigns continue with a new trust recruitment steering group in place to review marketing and values based recruitment.

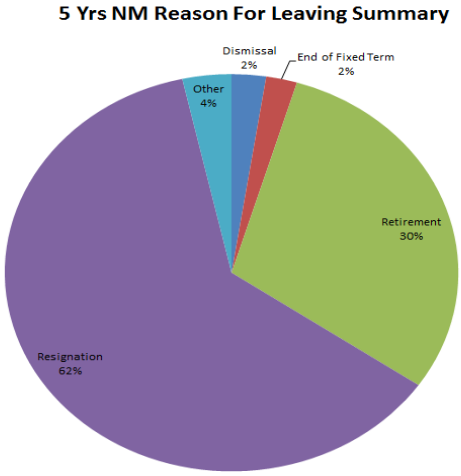
We have targeted our third year students that started in September and have invited them to drop in sessions to discuss career opportunities and why work in Torbay. Only three students showed interest so far. A further invite will be cascaded to our current second year students that have recently commenced placement in the Trust and due to qualify September 2018.

We have also relaunched our rotation programme where all newly qualified nurses will now join the rotation programme. This will run in the same way as our international nurses welcome to the trust meetings and three month "How are you settling in" review meeting. The programme incorporates Medicine, Surgery and a Community placement with a view to extend this to the speciality areas at the end of the first rotation.

Our Forth cohort of nurses from the Philippines is arriving on the 30th November and will be entered on to the trust Induction and OSCE preparation programme. Cohort 3 is due to take their first Objective Structured Clinical Examination (OSCE) attempt Mid December 17. Although there has been a long lead in period to the nurses arriving with the International English Language Test System (IELTS) challenges, the number of nurses deployed to the Trust has been hugely positive with a 100% pass rate of the OSCE exam so far.

The NMC have also recently launched the acceptance of a further English Language Test called the Occupational English Test (OET) alongside the IELTS. This is following months of discussion and consultation with regards the challenges faced by Trusts with international nurses struggling to reach level 7 in writing. This is a welcomed decision and the NMC will be further reviewing IELTS during the next 6-12 months.
We will be offering the conversion from IELTS to OET to our nurses in the Philippines who still remain committed to coming to work with us in Torbay and are awaiting further news on accredited OET exam centres.

A piece of work is underway to understand how nursing & midwife staff numbers might change over the next 5 years. These are shown in the graphs below:

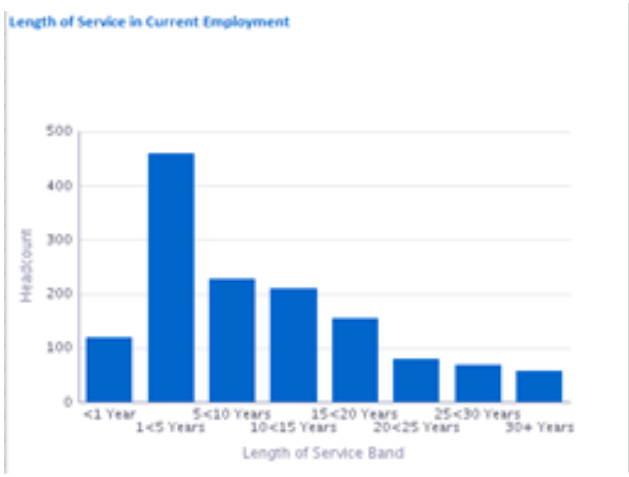


62% of leavers over the past 5 years have been due to resignations. Reasons include the following:

Adult & child dependants, better reward package, health, incompatible working relationships, lack of opportunities, promotion, relocation, further education or training and work life balance.

Unknown reasons and relocation count for the highest number 38.6% of the total number of resignations.
The first chart below shows 450 staff have been in post for less than 5 years as our highest figures with over 450 in post for less 5 years and over 100 in post for less than a year.

The second chart shows the Trusts current age profile of staff, this shows that the as an organisation we have a large number of staff in the 46-70 age range. This equates to approximately 740 staff that could retire over the next 5 years.



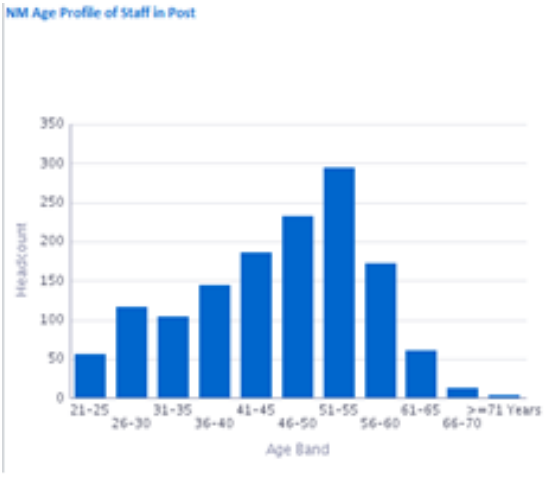


Table 3 below shows 470 Registered nurses and Midwives could retire over the next year. With the second table below showing 17.74% of the Trust registered nurses & midwives are aged 56 and over and could retire at any point.

Table 3:

Group	Retirements Due	3 Months	6 Months	9 Months	12 Months
N&M Aged 55	**295**	**309**	**315**	**323**	**339**
N&M Aged 60	**100**	**103**	**111**	**122**	**131**

	Oct-17		Oct-15		Oct-12		Oct-07	
Age Band	**Headcount**	**%**	**Headcount**	**%**	**Headcount**	**%**	**Headcount**	**%**
21-25	56	4.04	63	4.46	47	3.33	26	2.02
26-30	122	8.80	105	7.43	81	5.74	88	6.84
31-35	107	7.71	107	7.57	130	9.21	153	11.89
36-40	146	10.53	156	11.03	165	11.69	184	14.30
41-45	185	13.34	203	14.36	227	16.08	266	20.67
46-50	231	16.65	276	19.52	307	21.74	261	20.28
51-55	294	21.20	271	19.17	249	17.63	184	14.30
56-60	171	12.33	163	11.53	149	10.55	94	7.30
61-65	60	4.33	55	3.89	48	3.40	28	2.18
66-70	12	0.87	13	0.92	7	0.50	3	0.23
>=71 Years	3	0.22	2	0.14	2	0.14	0	0.00
Grand Total	**1,387**	**100.00**	**1,414**	**100.00**	**1,412**	**100.00**	**1,287**	**100.00**
56 & above	246	17.74%	233	16.48%	206	14.59%	125	9.71%

From the information above, a significant programme of work will need to be undertaken to look at ways to retain this cohort of staff along with succession planning and how to attract college leavers into the healthcare setting.

E-rostering:

The Executive team have supported the big bang approach with Allocate which will be kick started over the coming weeks. The aim is for all clinical areas to be live by the start of the new financial year.

The NHSI 90 day community Roster efficiency programme Progress continues and reports and data analysis will be presented once the programme further develops. The initial Plan Do Study Act (PDSA) is underway at Brixham hospital ensuring staff are working their contracted hours.

Quality and Safety Monitoring:

There is a robust quality and safety monitoring process in place to identify ares of pressure promptly. Patient incidents are monitored monthly by the senior nursing teams and reported through the monthly Quality Improvement Group (QIG) as a dashboard. In addition, each clinical area completes the monthly Quality, Safety and Effectiveness Trigger Tool (QuESTT) which triggers actions as highlighted in the escalation procedure. The Deputy Director of Nursing & Professional Practice 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.

The QuESTT Dashboard is displayed in the tables below for the Acute & Community Hospitals inpatient areas. The report is now including non-bed based nursing and therapies so as to give a broad overview of staffing trigger points. In October 2017 the dashboard identified seven teams' triggered amber and no teams triggered red or Purple.

Service Type	Team	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
Acute	Louisa Cary	9	9	4	6	4	3	2	2	9	8	11	9
	MAT / TAIRU	5	3	4	4	5	6	3	2	5		2	
	Maternity	10	6	8	13	14	15	11	13	15	14	12	14
	Midgley	11	11	10	9	5	2	6	6	3	8	8	4
	OPD	7	6	9	5	10	5	7	4	2	3	4	2
	Ophthalmology	8	13	9	7	9	8	11	12	8	13	7	7
	Ortho Theatres	16	16	17	17	19	17	14	15	14	13	15	14
	Pre-assessment	1	6		4	4	4	4	4	2	2	4	2
	Radiology	16	13	13	11	11	13	13	11	13		15	14
	Recovery	9	8	9	11	11	7	10	9	9	9	7	7
	RGDU	12	8		7	5			7	10	16	7	8
	SCBU	7	6	9	11	9	3	8	3	8	10	7	9
	Sexual Health	8	6	8		8	6	10	7	9	11	13	10
	Simpson	8		9	13	10	6	5	5	7	6	10	8
	TCCU	0	0	4	2	4	2	4	6	6	4	3	0
	Turner	5	7	2	5	4	5	4	6	7	8	7	14
	Urology	8	14	10	12		14	9	6	6	7	4	7
Community Hospital	Brixham	11	6	9	10	7	11	7	0	5	10	7	11
	Dawlish	2	0	0	0	0	0	3	3	4	4	3	5
	Newton Abbot Teign	10	14	12	12	9	11	7	7	8	6	10	14
	Newton Abbot Templar	8	8	6	8	4	2	4	2	6	6	3	3
	Totnes	2	10	11	12	10	6	2	11	10	8	7	4
MIU	Dawlish	2	0	4	5	0	2	4	0	0	6	4	0
	Newton Abbot	0	2	0	2	0	0	2	2	6	2	0	0
	Totnes	0	0	0	0	0	0	0	0	2	4	0	0
Community Stroke and Neurology	Torbay and South Devon							10	10	10	14	8	10
Infection Control	Infection Control	16	10	14	14	11	4	3	5	7	8	8	8
LLTS	LLTS	6	5	7	4	6	6	4	5	7	7	5	5
Nursing	Brixham and Paignton	25	14	12	10	11	17	13	12	7	12	9	9
	Coastal	12	15	17	20	19	27	21	23	22	15	12	9
	Dartmouth and Totnes	16	11	7		4	10	5	14	13	13	7	7
	Moorlands	18	10	10	16	14	15	17	16	21	17	17	11

Service Type	Team	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
Nursing	Newton Abbot	7	2	12	8	13	12	14	8	14	14	15	14
	Torquay	9	7	9	11	10	7	6	11	8	12	5	8
OOH Nursing	OOH Nursing	15	14	20	7	16	12		13	13	13	12	21
Specialist Nursing	Specialist Nursing	14	14	10	10	14	12	18	14	14	10	16	12
Occupational Therapy	Brixham and Paignton	8	4	12	8	4	6	2	9	12	7	8	2
	Coastal	14	23	26	14	6	22	16	12	6	8	13	11
	Moor-to-sea				23	24	22	10	18	6	10	10	12
	Newton Abbot	15	17	16	12	18	16	14	18	12	14	14	11
	Torquay	0	0	4	4	6	18	4	2	2	6	16	16
Physiotherapy	Brixham and Paignton	10	9	8	9	6	6	10	13	10	15	14	14
	Coastal	16	13	24	18	8	14	10	9	4	8	11	15
	Moor-to-sea				25	22	10	8	8	8	10	6	10
	Newton Abbot	17	15	18	20	18	16	14	18	14	18	18	15
	Torquay	21	18	20	23	13	21	24	14	12	14	8	6
Podiatry	Podiatry	19	18	14	16	15	16	15	15	17	17	19	19
Public Health - CAMHS	CAMHS	10	10	10	10	6	6	4	6	8	8	8	10
Public Health - Lifestyles	Lifestyles	9	6	8	13	9	7	9	9	8	9	7	10
Public Health - Nursing	Brixham	4	5	2	2	2	0	5	0	0	0	3	0
	Paignton	8	8	11	10	10	9	10	12	10	10	4	
	School Nursing	6	6	7	7	7	7	9	9	8	10	7	9
	Torquay North	0	0	0	0	2	2	2	2	2	2	2	2
	Torquay South	4	2	2	2	4	4	3	4	2	4	2	3
Public Health - Substance Misuse	Substance Misuse	4	6	6	8	8	4	6	6	9	8	10	10
Social Care	Brixham and Paignton	12	8	10	12	12	12	10	14	15	12	12	12
	Dawlish & Teignmouth	2	2		2	2	4	2	4	2	2	12	8
	HADT - S. Devon	15	11	12	12	15	15	15	13	11	17	17	19
	HADT - Torbay	9	23	17		11	11	11	10	11	14		17
	Newton Abbot	10	4	6	8	8			16				16
	Older People Mental Health - Torbay	8	8	10	8	10	2	4	2	0	2	0	2
	Torquay	12				12	8	10	8	10	10	14	14
	Totnes & Dartmouth		6	10	10	14	14	10	12	12	20	14	14

Service Type	Team	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
Tissue Viability	Tissue Viability	9	10	7		8	8	8	6	7	8	12	10

Teign Ward - Trigger: Vacancies and increased demand
Action: recruitment underway

Out of Hours Nursing – vacancies and increased demand.
Action: recruitment underway.
Torquay Occupational Therapy – vacancies.
Action: recruitment underway.

Podiatry - Trigger: Staff shortages on the day due to sickness absence of 4 staff
Number of Incident investigations outstanding
Action: 6 posts currently out to recruitment

Social Care HDAT - Torbay & S. Devon & Newton Abbot
Trigger: This is due to the complexity of patients and demand. There have been three care homes closed during this time due to safeguarding processes and therefore a lack of capacity. There are current issues with regards the provision of domiciliary care.
Action: Contingencies are in place and monitoring of services. Weekly meetings are in place with domiciliary care provider.

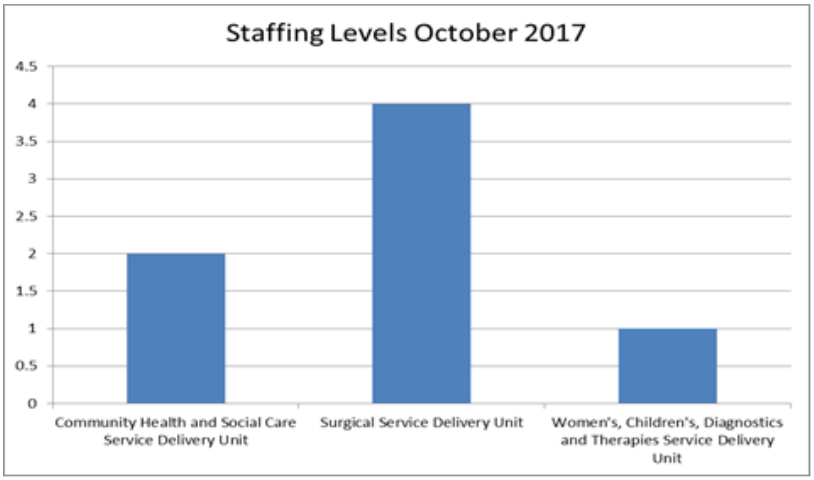
Staffing Incidents and Red Flags:

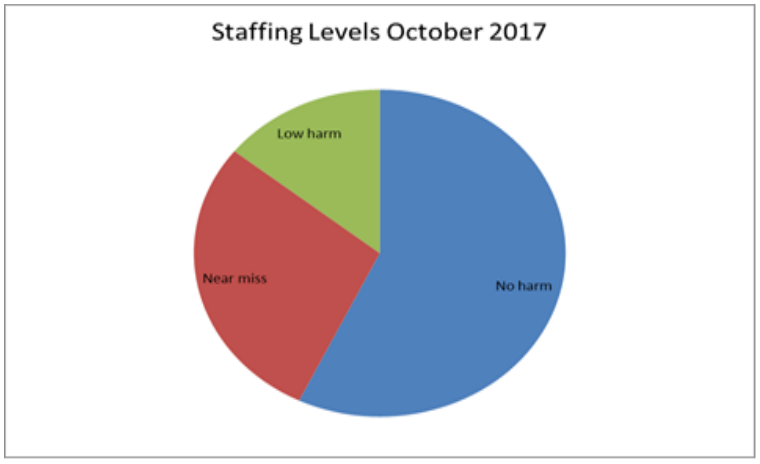
Staffing Incidents and red flags are monitored monthly by the SDU Associate Director of Nursing Workforce and are monitored alongside the Trust Quality Dashboard in relation to Falls, Medication errors, Pressure Ulcers & CHPPD. These are discussed at the monthly SDU Quality and Performance meetings and escalated to the Quality Improvement Group (QIG) as necessary. There is a slight increase in the number of Medication errors reported for September with the moderate harm trajectory increasing overtime. This will be explored at QIG.

As & from December 2017, staffing levels will be able to be triangulated directly with clinical care and assessment in the Datix incident reporting system

Staffing Incidents October 2017:

There were 7 nursing / midwife related staffing incidents reported during October. Two were near misses due to two patients requiring 1:1 specialing and lack of availability of staff and the lack of domiciliary care for a patient which was referred back to the Trust. No harm came to the patients.





3.0 Response to RCOG National Maternity and Perinatal Audit – Clinical Report 2017.
Based on births in NHS maternity services between 1st April 2015 and 31st March 2016.

The audit looked at 11 key maternal and neonatal outcome measures, all were within benchmark with the exception of:

% babies with low APGAR score	All sites mean 1.2%	Trust 3.5%	Higher than expected for a site of this size (above 99.8% control limits)

The RCOG audit shows that Torbay is an outlier with a greater number of babies having a low APGAR than the benchmark cohort. APGAR is a measure of the physical condition of a new born infant. It is obtained by adding points (2, 1, or 0) for: **A**ppearance**, P**ulse, **Gr**imace, **A**ctivity, and **R**espiration, a score of ten represents the best possible condition. The test is usually given to a baby twice: once at 1 minute after birth, and again at 5 minutes after birth.

The APGAR test is a subjective measure to assess whether a new born needs medical assistance. 1.2% of babies born at term in Britain have an Apgar score of less than 7 at five minutes of age, which is associated with short and long term morbidity. This proportion varies between maternity services, from 0.3% to 3.5%, despite adjustment for case mix. The rate in Torbay has increased from 1.9% in 2014-15 to 3.5% in 2015-16. Analysis of the 16/17 data suggests that % low APGAR will remain higher than the cohort mean.

The measure is clinically important as it is a marker of need for early neonatal assistance and much further downstream for poor neonatal outcome such as hypoxic ischaemic encephalopathy (HIE). However our actual rate for HIE is very good being in the lowest centile bracket suggesting that we may be over-estimating low APGARs. HIE is much more clinically important as a diagnosis of poor outcome unlike low APGAR which is principally a marker of increased risk but in whom majority of neonatal outcomes will still be good. The only maternal group which was over-represented with low APGAR score was women having category 2 C-Sections which we are exploring further whilst auditing low APGAR scores monthly.

The maternity team have investigated this variance through an audit of 49 cases but have identified no specific issues or themes, blood gases taken at the time were normal and there have been no adverse outcomes for the babies. Most of the babies with low APGAR were born via C-Section category 1 or 2. The team have a 30 minute decision to delivery interval target for cat 1 CS, which were all met. For cat 2 it is 75 minutes and it was not met in 3 cases, however there were no adverse outcomes. The team are also monitoring term admission to SCBU to determine if there is a correlation between low APGAR and admission to Special Care Baby Unit. A rolling audit of low APGARs will be monitored through the monthly SDU clinical effectiveness meetings and presented to the maternity assurance meeting with local benchmarking bimonthly. Performance will be monitored through the Trust Maternity Services Quality Improvement Group and reported to the Trust Quality Improvement Group and Quality Assurance Committee.

This data has been brought to the attention of Dr Siba Paul, neonatal lead in advance of Neonatal Peer Review QA NHSE next week on Tuesday 5th Dec.

4.0 Prevent Compliance Update Report:

This report provides the Trust with a current position statement in response to the Chief Nursing Officer's letter dated 14th November 2017 titled: NHS Commissioned Services Prevent Compliance – March 2018.

The report is divided into two parts. Part one will focus on the specific questions in the above letter. Part Two will provide a wider overview of Prevent from a Trust perspective.

<u>Part 1 – Response to questions in letter attached (page 2)</u>

Does the Trust have clear policies and procedures that support staff in making quality referrals of those at risk of radicalisation.

The Trust does have a current policy in place. The policy provides an overview of Prevent, how staff can access support and how to make a referral if they have a concern. The policy includes nationally agreed flowcharts for consistency of approach with other organisations.

The policy has just been reviewed and is currently in draft format. This reflects the need to maintain awareness of emerging themes within Prevent and their local implications. The only outstanding matter for this document relates to training which is referred to below. Once this is resolved the revised policy will be submitted for approval. Timescale is estimated at mid-end January 2018.

Does the Trust have a training needs analysis that has been validated in line with the Prevent Training and Competencies Framework 2017 that demonstrates the numbers of staff that need basis awareness training and those that need level 3 training.

The Learning and Development team have been asked to consider this new framework and make recommendations to meet the requirements of the framework. A meeting is scheduled with the training team for 11th December to consider the framework and its training implications.

Until such time, there is a training framework in place that is identified in current policy. This is supported by data from the OLM which is already reported to CCG. Current data identifies that 85% of our staff have received HealthWRAP Prevent Training. This is training that is delivered by an accredited Home Office Prevent Trainer.

A clear delivery plan that has been approved by commissioners that will ensure training compliance is achieved by 31st March 2018.

This date is noted and will direct agreed actions from the meeting planned 12th December. The training team have the framework so we (Joanna Williams and I) will ensure the training team have a proposal to present at the meeting on the 11th December. I would suggest this is reported to Integrated Safeguarding Committee on an on-going basis to monitor feasibility / progress.

Assurance that plans are in place to submit Prevent dataset into the Unify2 system by 30th December 2017 (Q3)

Systems are in place to submit Prevent data-sets into the Unify system by 30th December 2017 as agreed with the Performance, Information and Contracting Team.

Systems of assurance from Ward to Board that Demonstrates that prevent has been embedded into safeguarding.

- Prevent is a theme at induction training and in other safeguarding training frameworks.
- 85% of staff has undertaken Prevent HealthWRAP training.
- Torbay Safeguarding Adult Practitioner Forum hosted a Prevent forum in October 2017. Supported by Senior Police Counter Terrorism colleagues and other local key stakeholders. Information disseminated to attendees. Follow up event planned early 2018 specific to adult social care practitioners.
- ISC have been briefed on Counter Terrorism Local Profile (CTLP)
- Trust representative at Torbay and Devon Prevent Partnership Board
- Core representation at Torbay Channel Panels
- Strong and effective links with Safer Community teams and local Police Prevent Team
- Goal to develop icon information page to include CTLP recommendations – end of December / early January. This will give -

- Improved access to policy and guidance
- Prevent information e.g. different types of ideologies, resource materials etc.
- Organisational Lead information
- Training (WRAP and beyond)
- ‘big red button’ reporting link

Part 2 – General

- We maintain close links with colleagues referred above to maintain good awareness of current threats / risks and local implications.
- Integrated Safeguarding Committee has been informed of regional Prevent operational activity.
- Engagement in Prevent partnership task and finish group activity to support local and organisational Prevent agenda.
- CTLP agrees that regionally there are robust processes in Devon and Cornwall for referring individuals to Prevent case management
- Prevent Lead is informed of and has been consulted on local implications of Operation Dovetail (i.e. Home Office transfer of responsibility to LA (safer communities) from Police of case management of the Channel programme.
- The Trust works closely with local resilience partnerships to ensure responses to national incidents are reviewed locally.

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Estates and Facilities Management and Health and Safety: Issues and exception report		
Lead Director	Director of Estates and Commercial Development		
Corporate Objective	Safe, quality care and best experience Valuing our workforce Well led		
Corporate Risk/ Theme	Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems Failure to achieve key performance standards Inability to recruit/retain staff in sufficient number/quality to maintain service provision		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
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	• **Estates Maintenance performance:** The performance of both planned preventative and responsive maintenance has been challenged over the last few months as a result of an increasing workload on the service and some consequential significant change within the Estates department. The management team have taken action to address the increasing risks associated with an ageing estate and implemented a new extended day and 7 day rota alongside a change in working practices making the issue, recording and completion of work orders more efficient and effective. The new operational model has created additional posts within the department but also released c£250,000 of savings. The drop in performance has in the main been related to gaps in staffing whilst recruitment takes place. As a result in a changed approach in October, a successful recruitment campaign has enabled the team to fill all vacancies and the estates department, as of November has a full complement of staff. Performance is therefore expected to improve to standard by December 2017. A robust risk assessment process has provided assurance to the Executive and the Capital, Environment and Infrastructure Group (CEIG) throughout this time, that significant and high risks are and have been prioritised and actioned. The Trust Board can therefore take assurance that the organisation has not been exposed to significant risk of non-compliance during this period. A significantly more effective and efficient service is now in place to meet the increasing needs of the organisation and to provide an		

	safe and secure patient environment on a sustainable basis.
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	Reflection on the success of the change in approach to recruitment. Recognition of the significant change process that has taken place within the department. And thanks to the estates management team in anticipation of the improved performance in December 2017 and to the incumbent estates staff who have worked above and beyond to covered the staff gaps and particularly the on-call rota to keep the organisation safe.
Internal/External Engagement inc. Public, Patient & Governor Involvement	Governor sits on the Capital Infrastructure and Environment Group (CIEG) – (previously Workstream 5).
Equality & Diversity Implications	The Disability Awareness Action Group (DAAG) considers and is involved in all EFM development proposals.

Torbay and South Devon NHS
NHS Foundation Trust

MAIN REPORT

Report to:	Trust Board
Date:	6th December 2017
Lead Director:	Director of Estates & Commercial Development
Report Title:	Estates and Facilities Management and Health and Safety: Issues and exception report

1. EFM Performance report for October 2017

Table 1 below identifies performance and variances for September 2017 and October 2017. Any area of concern for the attention of the Board with appropriate explanation and action to a resolution is shown in Table 2.

Table 1: October 2017 Scorecard Indicator

Green ✓	Amber !	Red ✘	Sept 2017 Position	Oct 2017 Position
Improving Indicators				
3.2: % of Total tonnage Recycled Waste			!	✓
3.7: Waste to Energy			!	✓
4.4: % of near misses against total incidents reported			✘	✓
Deteriorating Indicators				
1.2: Statutory PPM % success against plan			!	✘
4.3: Non-patient incidents resulting in moderate harm			✓	!
5.2: Number of fire alarm activations			!	✘

Table 2: Areas with Specific Cause for Concern		Timeline
1.10/1.12/1,14 /1.2	% Reactive work resolved within target – Urgent – P2 <1- 4 Days, Routine - P3 & Routine - P4 and 1.2 Statutory maintenance completion.	
Explanation	Although still in the red zone there was an improvement in actual jobs completed in time for P2, P3 and P4 categories. New starters require familiarisation and training so activity is not yet up to full productivity. Actual completion of P2 jobs raised in month for Acute site is 86%.	
Action	Recruitment has continued, with 1 new starter in October and 8 new starters during November. Staffing is now up to complement. Management focus will be on P2 completion and balancing it with PPM completion. A robust risk assessment has been in place throughout this period to ensure that High and significant PPM and Statutory risk has been prioritised and completed. Consequently the Trust Board can take assurance that the immediate maintenance risks in the infrastructure and patient environment have been addressed.	Dec 2017
5.1	78% of Staff receiving Fire Training during month	
Explanation	Percentage of staff receiving mandatory fire safety training remains lower than target. Whilst the training remains in place there has been a drop in attendance in front line services, where activity pressures are felt most acutely.	
Action	The Fire Safety Officer will monitor the training returns from all departments and will contact areas with low attendance with a view to agreeing and taking some bespoke training to operational teams if required. Attendance by division will be reported via the Divisional management structure.	Nov 2017
5.2	Number of fire alarm activations	
Explanation	Unprecedented number of unwanted fire signals (false alarms) predominately caused by; burnt food and steam activations, 7 in total, in the residencies.	
Action	All residents have been reminded of the need for kitchen doors and shower room doors to be kept closed at all times and that no food should be left unattended.	Nov 2017
6.3	No. of Silvers/Bronzes trained/in date on Level 2a	
Explanation	RED due to staff out of date on their 2 yearly training	
Action	Continue to remind all staff that this training is available on line or face to face with dates booked. Attendance by division will be reported via the Divisional management structure.	Dec 2017
6.4	No. of non ED command roles trained/in date on Level2a training (Comms, HR, Resources, 110, Bloods, P3, P2, Radiology, Theatres, SSEP)	
Explanation	Number of staff with training has dropped due to 2 yearly compliance	
Action	Continue to advise staff that training is now available on line; and remind to complete the training. Attendance by division will be reported via the Divisional management structure.	Dec 2017

1.1 Recommendations

The Trust Board is asked to note the highlighted risks and issues and assurance presented in the EFM and H&S report.

EFM Key Performance Indicators Month 7 – October 2017

	Area			Target	Monthly Performance												Current year to date (Complete Months)		Risk Threshold		
	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	RAG Thresholds		
	Estates																				
1.1	Number of Statutory PPM items planned per month			Variable	480	557	531	498	595	538	582							540.1			
1.2	Statutory PPM % success against plan			97%	77%	76%	87%	85%	93%	86%	79%						95%	83.3%	R<85%	A85-96%	G>97%
1.3	Number of mandatory PPM items planned per month			Variable	441	421	570	409	542	438	445							466.6			
1.4	Mandatory PPM % success against plan			95%	87%	92%	88%	93%	93%	86.3%	87%						95%	89.5%	R<85%	A85-94%	G>95%
1.5	Number of routine PPM items planned per month			Variable	238	166	184	201	201	193	190							196.1			
1.6	Routine PPM % success against plan			70%	77%	77%	90%	99%	93%	80%	72%						70%	84.0%	R<60%	A60-69%	G>70%
1.7	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	164	164	54	48	50	55	49							83.4			
1.8		Emergency – P1	<2 Hour	95%	98%	99%	93%	100%	100%	98%	99%						95%	98.1%	R<90%	A90-94%	G≥95%
1.9		Urgent – P2	Total Requests	Variable	279	266	335	265	312	249	314							288.6			
1.10		Urgent – P2	<1- 4 Days	90%	70%	61%	73%	79%	77%	78%	73%						90%	73.0%	R<85%	A85-89%	G≥90%
1.11		Routine – P3	Total Requests	Variable	364	345	447	577	555	453	478							459.9			
1.12		Routine – P3	<7- 14 Days	85%	68%	61%	77%	71%	67%	66%	65%						85%	67.9%	R<75%	A75-84%	G≥85%
1.13		Routine P4	Total Requests	Variable	61	83	117	143	93	77	97							95.9			
1.14		Routine P4	<30 Days	75%	52%	65%	74%	49%	43%	46%	53%						75%	54.6%	R<65%	A65-74%	G≥75%
1.15	Number of Estates Internal Critical Failures			0	0	0	6	0	1	1	0						0	1.3	R1	-	G0
	Cleaning																				
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%	100%	100%	100%	100%						98%	99.9%	R<95%	A95-97%	G≥98%
2.2	Compliance High Risk Cleaning Audit			95%	99%	98%	98%	98%	98%	98%	98%						95%	98.1%	R≤89%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	99%	99%	99%	99%	99%						85%	99.0%	R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	99%	99%	99%	99%	99%	99%						75%	99.0%	R<70%	A70-74%	G≥75%
2.5	No. of Environmental (food hygiene/Waste) Events			0	0	0	0	0	0	0	0						0	0.0	R1	-	G0
	Waste																				
3.1	Total Tonnage per month all waste streams			Variable	182.8	164.7	186.1	175.86	158.2	148.9	171.4							169			
3.2	% of Total tonnage Recycled Waste			>47.1%	46.6%	44.4%	48.6%	47.3%	42.8%	43.5%	48.4%						>47.1%	45.8%	<40%	40.1-46.9%	>47.1%
3.3	% of Total tonnage Landfill Waste			<5%	0%	0%	0%	0%	0%	0%	0%						<5%	0 %	>15%	5.1-14.9%	<5%
3.4	% of Total tonnage of Clinical Non-Burn waste			14-24.9%	15.2%	16.5%	15%	16.0%	16.7%	17.6%	16.3%						14-24.9%	16.2%	>25%	<10.1-13.9%	14-24.9%
3.5	% of Total tonnage of Clinical Burn waste			4.1-7.9%	4.9%	5.9%	5%	8.3%	7.0%	6.4%	7.0%						4.1-7.9%	6.4%	>8%	<4%	4.1-7.9%
3.6	% of Total tonnage of Clinical Offensive waste			5.1-9.9%	6.5%	7.8%	7.4%	7.2%	8.3%	6.9%	6.7%						5.1-9.9%	7.2%	<5%	>10%	5.1-9.9%
3.7	Waste to Energy			<24%	26.6%	25.5%	23.9	21.2%	26.2%	25.8%	21.6%						<24%	24.4%	>35%	24-34.9%	<24%
3.8	Total Waste to Energy			Variable	31.55%	34.0%	29%	30%	33.2%	32.1%	28.6%							31.2%			
3.9	Number of Waste Audits undertaken per month			15	17	17	15	15	15	15	15						15	15.6	R>13	A13-14%	G15
3.10	% of Compliant Waste Audits			100%	100%	100%	100%	100%	100%	100%	100%						100%	100.0%	R<80%	A80-84%	G≥85%

Public

3.11	% Compliance of Statutory Waste Audits	100%	100%	100%	100%	100%	188%	100%	100%						100%	100.0%	R≤89%	A90-94%	G≥95%
	Health & Safety																		
4.1	Number of serious/RIDDOR Incidents	3	3	6	2	3	8	1	1						3	3.4	R≤6	A4-5	G≤3
4.2	Non-patient incidents resulting in minor harm	35	27	28	29	34	19	35	23						35	28.0	R>39	A36-39	G<36
4.3	Non-patient incidents resulting in moderate harm	4	4	1	5	11	4	2	5						4	4.6	R>7	A5-7	G≤4
4.4	% of near misses against total incidents reported	20%	25%	31%	23%	25%	30%	14%	33%						20%	25.0%	R<15%	A15-19%	G≥20%
4.5	% of Staff receiving H & S training in month	85%	88%	87%	87%	87%	86%	87%	87%						85%	87.0%	R<80%	A80-84%	G≥85%
	Fire																		
5.1	% of Staff receiving Fire Training during month.	85%	83%	81%	80%	80%	78%	78%	78%						85%	80.0%	R<80%	A80-84%	**G≥85%**
5.2	Number of fire alarm activations	9	6	10	11	4	9	10	18						9	9.7	R≥14	A10-13	**G≤9**
5.3	Fire alarm activations attended by the Fire Service	2	0	1	1	1	1	1	0						2	0.7	R≥5	A3-4	**G≤2**
5.4	No. of Fires	0	0	0	0	0	0	0	0						0	0	R1	-	**G0**
5.5	Number of Fire audits undertaken for ' high risk' locations	9	9	9	9	9	9	9	9						9	9.0	R<7	A7-8	**G>8**
5.6	Number of Fire audits Undertaken for 'medium/normal' locations	8	8	8	8	8	8	8	8						8	8.0	R<5	A5-7	**G>7**
5.7	'high risk' risk fire assessments in date	27	27	27	27	27	22	27	27						27	26.3	R<25	A25-26	**G≥27**
5.8	'medium risk' fire risk assessments in date	45	45	45	45	45	45	45	45						45	45.0	R<42	A42-44	**G≥45**
5.9	'low risk' fire risk assessment in date	84	84	84	84	84	84	84	84						84	84.0	R<80	A80-83	**G≥84**
	Emergency Preparedness Response & Resilience																		
6.1	Number of fully completed/in date BC plans	117	107	107	107	107	107	108	107						117	107	R<100	A100-109	**G>109**
6.2	No. of on call directors trained on Level 3 major incident core competency	9	9	9	9	9	9	9	9						9	9.0	R<6	A6-7	**G≥8**
6.3	No. of Silvers/Bz's trained/in date on Level2a	20	20	22	12	12	12	12	12						30	14.6	R<24	A24-26	**G≥27**
6.4	No. of non ED command roles trained/in date on Level 2a training (Comms, HR, Resources, 110, Bloods, P3, P2, Radiology, Theatres, SSEP)	168	82	86	98	107	114	114	114						168	102.1	R<120	A120-135	**G>135**
6.5	No. of staff trained/in date on Level2b control room operations	10	19	19	19	19	19	19	19						10	19.0	R<7	A7	**G≥8**
6.6	Exercise Discovery	10	0	7	7	7	10	10	10						10	7.3	R<5	A5-9	**G≥10**

REPORT SUMMARY SHEET

Meeting Date	6th December 2017		
Report Title	Workforce and OD Board Report		
Lead Director	Director of Workforce & OD		
Corporate Objective	• Safe, quality care and best experience • Improved wellbeing through partnership • 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 • Delayed delivery of integrated care organisation (ICO) care model		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	• To update the Board on the activity and plans of the Workforce and Organisational Development Directorate as reported to and assured by the Workforce and Organisational Development Group (WODG). • To provide the Board with assurance on workforce and organisational development issues.		
Key Issues/Risks	• **Sickness absence -** The rolling sickness absence rate has continued to decrease and at the end of September was at 4.11% The monthly rate was at 3.57% against the target of 3.80% which is the fourth month the actual rate has been below target. • **Agency -** The Trust is under planned agency expenditure. At Month 7 the spend was below plan by £1,610,000 and the Trust is on target to achieve the NHSI cap by the end of the year. Further information on the above is contained in the integrated Performance Report. • The quarter 2 Staff Family and Friends Test was completed in September, as reported in section 5. • The launch of the Achievement Review Process which replaces the Performance Development Review will commence later this month as outlined in section 6. • Progress with the Flu Campaign and CQUIN achievement is reported in section 7, with 39.5% uptake against the target of 70% of frontline staff		
Recommendations	The Trust Board is asked to consider the assurance provided by the contents of this report and to identify any areas for further focus or action.		
Summary of ED	• Regarding 2.18 Executives have agreed to adopt 'the Hive' system and		

Challenge/Discussion	review in 12 months • The low uptake of staff Flu Vaccination was discussed and the Chief Executive has issued a letter to all staff as required by NHSE to encourage uptake and to request signed declination forms where staff elect not to receive the vaccination.
Internal/External Engagement inc. Public, Patient & Governor Involvement	Governor Observer on Workforce and Organisational Development Group
Equality & Diversity Implications	There are no implications identified

MAIN REPORT

Report to	Board of Directors
Date	6th December 2017
Lead Director	Director of Workforce and OD
Report Title	Workforce and Organisational Development Directorate Report

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 (WODG) Directorate as reported and assured by the Workforce and Organisational Development Group.
- To provide the Board with assurance on workforce and OD issues.

2. Workforce and OD Group

2.1 Workforce and OD Group Actions

The WODG met on Thursday 16th November 2017. The following summarises discussions and agreed actions.

2.2 Risk Register

The WODG noted that Risk 1196 'Suppporting the Delivery of the CIP Plans through HR Workforce Strategies & Support' had been reviewed and the rating for the risk has been reduced to amber.

2.3 Governance

The Terms of Reference for The Workforce and Organisational Development Group were reviewed to ensure they remain fit for purpose. Agreement was reached on minor updates to the paperwork which will be circulated with the minutes.

2.4 Workforce Plan 2017/2018

The plan was considered against the target of 5001.30 wte substantive staff in post at the end of the financial year. It was noted that at the end of September 2017 the reduction to date was 80 wte and continues to be very close to the overall run-rate. Further detail is included in the Trust's Integrated Performance Report.

2.5 Workforce Planning Process 2018/19

The WODG noted that the workforce planning process for 2018/2019 will align with the business planning process. The recently held workshop to support the process was attented by over 50 Managers. Further detail is included in Section 3.

2.6 ESR Self-service

The WODG were informed that national changes to the Electronic Staff Record system (ESR) at the end of September have enabled improved functionality. This will allow the Workforce team to start transferring staff from Rosterpro (where e-rostering is unnecessary) and electronic time sheets for time and attendance recording to ESR.

2.7 Staff Engagement

The WODG were asked to assure progress against the Staff Engagement and Communication Strategy Work Programme, further information is contained in Section 4.

2.8 Staff Family and Friends Test

The revised approach towards the Friends and Family test was implemented in June, allowing all staff to contribute to the short survey three times a year. The survey now includes two local questions around staff engagement and incident reporting – areas which were identified as priorities from the 2016 national staff survey. Further information is contained in Section 5

2.9 2017 National Staff Survey

The national NHS Staff Survey went live on 22nd September 2017. The response rate of 35% on 28th November 2017 is not as high as in previous years and a range of interventions are planned to encourage staff to complete the survey.

2.10 Initiatives to Support Improved Attendance

The WODG assured progress against the action plan to support improved attendance following the deep dive into sickness absence. The plan will be reviewed again at the next meeting, as the winter months are known to have the greatest impact on attendance.

2.11 Temporary Staffing Policy

The WODG endorsed the Policy that has been developed by the Trustwide Temporary Staffing and Agency Taskforce. The policy underpins the well-established processes and supporting documentation adopted by the temporary staffing team.

2.12 Substantive & Temporary Workforce Additional Payment Review

A range of local payments which fall outside of Agenda for Change were considered. Agreement was reached that an options appraisal would be developed for Executive agreement on the way forward.

2.13 Achievement Review Launch

The launch of the new Achievement Review process was discussed. The new approach will introduce a move away from a traditional appraisal model towards a positive, strengths-based approach, one of the cultural aims of the ICO. Further information is contained in Section 6.

2.14 Flu Campaign

The programme of work to encourage staff to have the flu vaccination is underway. The Group were informed that a 70% take up rate from front line staff is required to achieve the CQUIN requirement. Further information is included in Section 7.

2.15 Wellbeing Staff Forum

The WODG were informed that the wellbeing staff forum has been refreshed with good attendance at the recent meeting. The theme throughout the session was to ensure an holistic approach to wellbeing so that staff are feeling supported and valued.

Sub-groups to support areas of focus e.g. mental health have been set up and will be meeting during November and December to move the projects forward.

2.16 Private, Voluntary and Independent Sector (PVI) Workforce and Educational Plan

The workforce initiatives to support recruitment, retention and develop care capacity across the PVI were agreed. Further information is contained in Section 8.

2.17 Mandatory Training Action Plan

The action plan to support an improvement in mandatory training was endorsed and agreement reached to review progress at regular intervals.

2.18 The Hive/OLM Options Appraisal

The WODG were asked to consider an options appraisal on the future use of Learning Management Systems. Further information will be presented to the Executive Team in order that a decision on the way forward can be made.

3. Workforce Planning Process 2018/19

Service level workforce planning will form part of the Trust's annual workforce planning process. A workshop to support this process was well received in October with over 50 attendees.

The aim of the workshop was to enable Managers to identify, plan and monitor their workforce and development needs in accordance with service delivery requirements. The workshop provided the opportunity to discuss key issues and challenges, workforce demand forecasting and strategies to close identified gaps.

A range of areas of focus were identified to include succession planning, talent management and career planning. Projects to further develop and proioritise the work will be planned as the next stage in the process.

4. Staff Engagement

Progress continues to be made with the staff engagement work programme.

The 'Back to the floor' programme was introduced recently with the aim of enabling senior managers to work alongside front-line staff to experience the day to day reality of the front line.

The Executive Team are role modelling the introduction of the initiative. The programme will be extended and other Senior Managers will be encouraged to spend time shadowing front line teams.

After each 'back to the floor' shift a short blog or video is produced and published on ICON. This summarises the experiences and includes:

- a short description of the department - to support organisational learning about diverse services
- observations and experiences
- actions that will be taken to make improvements departments wish to progress and ensure good practice is shared and embedded.

In addition, the Chief Executive and Chairman will continue to hold monthly joint 'What matters to you' staff engagement session.

5. Family and Friends Test

The quarter 2 survey was completed during the month of September and 1045 staff responded representing a response rate of 17%. This compares to a 20% response rate in quarter 1.

The findings for the Trust are detailed below, and compared to the findings in quarter 1. As can be seen there has been an increase in the percentage of staff responding positively to recommendation for work and care. Staff engagement has remained consistent with 54% of staff who responded rating staff engagement as extremely good or good. However there has been a reduction in positive responses for incident reporting.

Quarter 2 Findings

Response rate - 17%

How likely are you to recommend the Trust to friends and family if they needed care or treatment?

Quarter	1 Extremely likely	2 Likely	3 Neither likely or unlikely	4 Unlikely	5 Extremely unlikely	6 Dont know	Grand Total
1 - June	495 (40%)	543 (44%)	142 (11%)	30(2%)	14 (1%)	15 (1%)	1239
2 - September	417 (40%)	484 (46%)	102 (10%)	26 (2%)	8 (1%)	8 (1%)	1045

How likely are you to recommend the Trust to friends and family as a place to work?

Quarter	1 Extremely likely	2 Likely	3 Neither likely or unlikely	4 Unlikely	5 Extremely unlikely	6 Don't know	Grand Total
1 - June	262 (21%)	510 (41%)	227 (18%)	152 (12%)	81 (7%)	7 (1%)	1239
2 - September	222 (21%)	436 (42%)	211 (20%)	108 (10%)	59 (6%)	9 (1%)	1045

How would you rate the fairness and effectiveness of procedures for reporting errors, near misses and incidents?

Quarter	1 Extremely fair and effective	2 Fair and effective	3 Neither fair / effective or unfair / ineffective	4 Unfair and ineffective	5 Extremely unfair and ineffective	6 Not completed	Grand Total
1 - June	184 (15%)	677 (55%)	324 (26%)	43 (3%)	9 (1%)	2	1239
2 - September	134 (13%)	553 (53%)	311 (30%)	44 (4%)	3 (0%)		1045

How would you rate staff engagement in the organisation?

Quarter	1 Extremely good	2 Good	3 Average	4 Poor	5 Very poor	Grand Total
1 - June	120 (10%)	542 (44%)	403 (33%)	139 (11%)	35 (3%)	1240
2 - September	103 (10%)	461 (44%)	365 (35%)	97 (9%)	19 (2%)	1045

Local findings have been shared with the SDU Senior Management team and comments reports will follow. SDU's will be asked to use this data to continually inform their local staff experience action plans.

6. Achievement Review Launch

The new Achievement Review process was launched on 21st November 2017. The new approach moves away from the traditional appraisal model towards a positive, strengths-based approach, one of the cultural aims of the ICO. The launch will include:

- Bite-sized training sessions for staff and managers
- Promotion at key meetings across the organisation
- Guidelines and underpinning principles of the achievement review
- Revised policy to reflect the shift from appraisal to achievement review
- Promotional blog written by the Director of Workforce
- Promotional Buzz conversation focussing on the key points
-

7. Flu Campaign

The table below demonstrates the numbers of staff who have received a flu vaccination split by staff group. The CQUIN relating to the uptake of the flu vaccination states that 70% of frontline clinical staff need to have received their flu vaccination for the CQUIN to be achieved.

Category	Yes	No	Grand Total	%
AHP/Scientist/Technical	295	330	625	47.20%
Doctors/Dentists	285	360	645	44.19%
Non clinical	639	1028	1667	38.33%
Nursing/Mid	581	787	1368	42.47%
Support workers	963	1634	2597	37.08%
Unknown (Hon)	3	93	96	3.13%
Grand Total	**2766**	**4232**	**6998**	**39.53%**

8. PVI Sector Workforce and Education Plan

There are a number of workforce initiatives and programmes of work in progress across the Community PVI sector that are being undertaken in isolation without overarching strategy and co-ordination. There is a need to establish the work, gaps in training, ensure consistency and facilitate a quality, coherent, care capacity across the system. This will ensure efforts and resources are best applied /optimised.

The aim of the plan is to develop a care capacity and workforce by undertaking a training needs analysis, introducing careers pathways, training and access to the training hub. Focus will be concentrated on recruitment and retention of staff and identification of how the system is retaining the workforce. This will identify gaps, duplication and a baseline for a move to bring initiatives together.

It is planned that the initiatives, supporting groups, activities and training in respect of Nurses / HCAs are mapped to include the following information:

- What are the outcomes and when will they be evident / make an impact
- Where are the linkages to other activities
- Where is the funding coming from to sustain each initiative/activity, how much and for how long
- How does this link with the data capture for strategy development e.g completion of primary care data (Blue Stream) and social care data (National Minimum Data Set).

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date	6 December 2017		
Report Title	Report of the Director of Strategy and Improvement		
Lead Director	Director of Strategy and Improvement		
Corporate Objective	♦ Safe, quality care and best experience ♦ Well led		
Corporate Risk/ Theme	♦ Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems ♦ Failure to achieve key performance standards ♦ Inability to recruit/retain staff in sufficient number/quality to maintain service provision ♦ Lack of available Care Home/Domiciliary Care capacity of the right specification/ quality. ♦ Failure to achieve financial plan		
Purpose	**Information**	**Assurance**	**Decision**
	✓	✓	
Summary of Key Issues for Trust Board			
Strategic Context	The report provides the Board of Directors with an update on the following national developments and details impact/risk for the Trust: • The revised 2017/18 Single Oversight Framework issued by NHS I for implementation from October 2017 • The new General Data Protection Regulations that come into force from May 2018 The Finance, Performance and Investment Committee considered detailed briefings on both developments at its meeting on 28th November 2017.		
Key Issues/Risks	**Single Oversight Framework** • One of the key changes of note is the inclusion of 'Dementia Challenge' as an operational indicator. Performance for month 7 was 78.6% against the 90% standard. Full achievement of the standard remains a challenge pending the roll out of Nerve Centre technology. Currently performance against this standard is not linked to STF allocations. • Under the revised SOF, assessment of a Trust's financial position will include the results of a Use of Resources ('UoR') assessment, in addition to the monthly finance risk rating and other relevant information on financial performance. In addition to being used by NHS Improvement, the UoR assessment will form part of the CQC's assessment process for Trusts.		

	• Trusts will continue to be segmented so that NHS I can target its support capacity. Directors have assessed the Trust's current performance against the segmentation criteria and assume the organisation will remain in Segment 2 (targeted support). **General Date Protection Regulations** • All UK organisations that process the personal data of UK residents are required to comply with the new regulations which are more extensive in scope and application than the current regulations. The most significant change is the increase in the fine that the Information Commissioner's Office (ICO) will be able to impose should non-compliance or a breach of the new regulations occur – the cap on fines has been raised from £500k to £17m per breach (at the discretion of the ICO. • Full compliance by 25 May 2018 is unlikely to be a realistic goal for a large percentage of NHS organisations - a significant factor in this is the absence to date of any specific prescriptive advice as to how an NHS organisation would attain full GDPR compliance. • Through a program of identifying personal data processed by the Trust, and compliance of the relevant legal basis' under which said data is collected, stored and processed, the Trust will mitigate risk sanctions for unnecessary or inappropriate processing. An in-progress action plan and clear pathway for the escalation of risks identified to Executives and onward to the board will demonstrate to the ICO an appropriate level of corporate awareness that will help mitigate the overall risk. • This approach has been discussed and adopted by most, if not all, of the NHS organisations across the South and South West, and within the local STP.
Recommendations	To **consider** the assurance provided in the report and to provide further challenge on the risk mitigation in place
Summary of ED Challenge/Discussion	**Revised Single Oversight Framework** • The new dementia find indicator will be monitored from M7 but will not be included in the STF assessment of performance in the current year. Current performance does not meet the required standard and requires technology implementation to achieve sustained delivery. • Noted that the Use of Resources rating will also be used by the CQC in their forthcoming well-led assessment. • The Trust's support categorisation is expected to remain in Segment 2 (targeted support). Under NHS I's targeted support offer the Trust brought in Mark Hackett to support delivery of the financial improvement plan. Directors are considering the benefit of securing similar support to enable sustained service improvement. **General Data Protection Regulations** • The extent of the changes in requirements and impact on current systems and practice is extensive • Full compliance is unlikely to be achieved for many years • The significant rise in the fine that can be imposed for non-compliance and breaches represents a major corporate and system financial risk • Capacity to ensure the organisation is prepared and supported to deliver is under review including at STP level

Internal/External Engagement inc. Public, Patient & Governor Involvement	Single Operating Framework will be communicated to Governors and staff through usual communication channels GDPR requires extensive ongoing internal communications and engagement so staff aware of requirements and what it means for them in practice.
Equality & Diversity Implications	No specific issues identified.

MAIN REPORT

Report to	Board of Directors
Date	6th December 2017
Lead Director	Director of Strategy and Improvement
Report Title	Report of the Director of Strategy and Improvement

1 Purpose

To provide the Board of Directors with an update on two important national developments that impact on the Trust, namely:

- Revised Single Operating Framework issued by NHS I last month for implementation from October 2017
- New General Data Protection Regulations that come into force from May 2018

2 Provenance

The report is informed by the following:

- Minutes and action log from the Finance, Performance and Investment Committee
- Corporate Risk Register
- Minutes and action log from the IM&TG and IGSG
- Minutes and action log from Quality and Performance Reviews
- Minutes and action log from SBMT
- Reports from Internal Audit
- Feedback from Service Delivery Units

3 NHS I Revised Single Oversight Framework (SOF)

3.1 Background

The first version of the SOF was published in 2016. It is used by NHS I to identify NHS providers' support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

NHS I monitor provider performance under each of these themes and consider whether support is required to meet the standards required in each area. This assessment framework is used to categorise Trusts into one of four segments:

1. Maximum autonomy.
2. Targeted support.
3. Mandated support.
4. Special measures.

3.2 Framework refresh

A refresh of the Single Outcomes Framework has just been published by NHS I. Changes have been made in response to a recent feedback exercise. NHS I have not proposed any changes to the underlying framework – ie there are no changes to the 5 themes outline above; NHS I's approach to monitoring, how support needs are identified and how providers are segmented.

There are some changes to performance and quality metrics used by NHS I to assess providers' performance under each theme and the indicators that trigger consideration of a potential support need. These updates reflect changes in national policy and standards, other regulatory frameworks and the quality of performance data, to ensure that NHS I's oversight activities are consistent and aligned. The main changes are summarised in the table below.

Table 1: NHS I SOF 2017/18 Summary key changes by theme

Theme 1 : Quality of care		
Added	**Removed**	**Amended**
Ecoli bacteraemia bloodstream infection rates to quality indicators	Aggressive cost reduction plans metric from list of quality indicators	
Medticillin-sensitive staphylococcus aureus rates to quality indicators	Hospital standardised mortality ratio weekend (DFI) from list of quality indicators for acute providers	
	Emergency readmission rates from list of quality indicators for acute providers	
		Change to triggers of potential support needs regarding quality of care; CQC rating of "inadequate" or "requires improvement" in overall rating, or against any of the safe, effective, caring or responsive key questions
Theme 2: Finance and use of resources		
Added	**Removed**	**Amended**
Reference to the new Use of Resources (UoR) framework with explanation of how UoR assessments will be used under the SOF		
"Finance and use of resources score" is relabelled as "finance score"		

Theme 3: Operational performance		
Added	**Removed**	**Amended**
Dementia assessment and referral standards for acute providers	Patients requiring acute care who receive a gatekeeping assessment as standard for mental health providers	Where relevant, NHS I will use performance against the national standard rather than the Sustainability and Transformation Fund (STF) trajectories as the trigger of potential needs in relation to operational performance standards
Reduction in inappropriate adult mental health out-of-area placements as standard for mental health providers		Ambulance response time standards (updated to reflect the new standards, indicators and measures that have been introduced for ambulance providers through the Ambulance Response Programme)
Data Quality Maturity Index – Mental Health Services Data Set (MHSDS) Data score replaces previous standards for submitting "priority" and "identifier" metrics to MHSDS		
Theme 4: Strategic change		
Added	**Removed**	**Amended**
NHS I will review the assessment of system-wide leadership in relevant Sustainability and Transformation Partnership (STP) ratings when considering providers performance under this theme		
Theme 5: Leadership and improvement capability		
Added	**Removed**	**Amended**
Reference to NHS I and CQC new, fully joint well-led framework and guidance on developmental reviews		

3.3 Key points to note

Operational performance:
The changes outlined in Table 1 have been reflected in the Month 7 Integrated Performance Report.

One of the key changes of note is the inclusion of the 'Dementia Challenge' as an operational indicator. This metric has been included in past performance reports in readiness of this change. Performance for month 7 (the first month in which formal reporting against this indicator is required by NHS I) was 78.6% against the 90% standard. Sustained achievement of this standard remains a challenge pending the roll out of Nerve Centre technology. Currently performance against the dementia find standard is not linked to STF allocations.

Provider segmentation:
Segmentation enables NHS I to take an overview of the level and nature of support required across the provider sector, and to target its support capacity as effectively as possible.

The segment in which a provider is placed is determined by the level of support NHS I has determined is appropriate – universal, targeted or mandated.

Against the original SOF, the Trust was put into Segment 2 – targeted support. This is kept under regular review by NHS I. Against the revised framework, Directors believe the segmentation will remain the same.

Use of Resources assessments:
Under the revised SOF, assessment of a Trust's financial position will include the results of a Use of Resources ('UoR') assessment, in addition to the monthly finance risk rating and other relevant information on financial performance.

The purpose of the UoR assessment is to understand how effectively Trusts are using their resources to provide high quality, efficient and sustainable care for patients.

The assessment considers the use of resources under a number of themes: Clinical Services; People; Clinical Support Services; Corporate Services, procurement, estates and facilities; and also incorporates the Trust's finance risk rating. The assessment is based on performance against a number of metrics; additional data collected by NHS Improvement; NHS Improvement's local intelligence; and evidence gathered on a structured onsite assessment.

In addition to being used by NHS Improvement, the UoR assessment will form part of the CQC's assessment process for Trusts.

UoR assessments started in October 2017 and all non-specialist acute Trusts are expected to have been assessed by the end of 2019.

4 General Data Protection Regulations

4.1 Background

The new General Data Protection Regulations (GDPR) come into force on 25 May 2018.

All UK organisations that process the personal data of UK residents are required to comply with the new regulations which are more extensive in scope and application than the current regulations. The most significant change is the increase in the fine that the Information Commissioner's Office (ICO) will be able to impose should non-compliance or a breach of the new regulations occur – the cap on fines has been raised from £500k to £17m per breach (at the discretion of the ICO).

Full compliance by 25 May 2018 is unlikely to be a realistic goal for a large percentage of NHS organisations. A significant factor in this is the absence to date of any specific prescriptive advice as to how an NHS organisation would attain full GDPR compliance.

The GDPR applies across all member states of the EU but its reach is far wider: any organisation anywhere in the world that provides services into the EU that involve processing the data of EU citizens will have to comply.

As the NHS handles personal data, it is required to comply with the GDPR, regardless of Brexit. The new regulations come into force before the UK leaves the EU and the government has confirmed the regulations will apply – this position has been confirmed by the Information Commissioner.

4.2 Trust's response

An extensive action plan is currently under development, with supporting staff communications and engagement plan, and a clear pathway for the escalation of risks identified to Executives and onward to the board will demonstrate to the ICO an appropriate level of corporate awareness that will help mitigate the overall risk.

The action plan is structured around 12 steps (with 136 actions to ensure compliance) recommended by the ICO, namely:

- Awareness
- Information you hold
- Privacy notices
- Individuals rights
- Subject access request
- Legal basis
- Consent
- Children
- Data breaches
- Privacy impact assessments
- Data protection officer
- International

This approach has been adopted by most of the NHS organisations across the South and South West, and within the local STP.

Through a program of identifying personal data processed by the Trust, and compliance of the relevant legal basis' under which said data is collected, stored and processed, the Trust will mitigate risk sanctions for unnecessary or inappropriate processing.

South West Audit are providing support and assurance to ensure the action plan covers all areas required by the ICO.

The Trust has also asked the STP to consider a system wide response to ensure consistency and to maximise scarce resource.

4.3 Governance and oversight

Clearly the new regulations represent a significant change to current systems, processes and practice. Non-compliance and breaches pose a significant risk in terms of the scale of potential fines.

Governance and oversight has been considered by the Finance, Performance and Investment Committee on behalf of the Board and confirmed as follows:

- Action plan to be monitored for compliance at the Information Governance Steering Group (IGSG) with support of the SIRO (Director of Finance) and Caldicott Guardian (Deputy Medical Director)
- Assurance to be sought by the IM&T Group and provided to FPIC for reporting to Board
- Audit and Assurance Committee to be asked to provide further oversight
- South West Audit to provide independent assessment of readiness and compliance

The first draft of the action plan has been circulated to the FPIC for information at this stage. Of the 136 actions – 13 are complete.

I will be the Executive lead with overall responsibility for overseeing the development and implementation of the action plan and ongoing compliance with the regulations.

5 Recommendations

To consider the assurance provided in the report and provide a further challenge on the risk mitigation in place