Torbay and South Devon NHS Foundation Trust
Council of Governors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital.
13 December 2017 15:00 - 13 December 2017 17:00

AGENDA

#	Description	Owner	Time
1	Chairman's welcome and apologies: L Archer, L Darke, C Micklethwaite, A Proctor For information	Chairman	
2	Declaration of interests To receive	Chairman	
3	Minutes of the last meeting held on 22 September 2017 (enc) To approve 03 - 2017.09.22_DRAFT_CoG_minutes.pdf 5	Chairman	5 mins
4	Healthwatch (verbal) To receive	P Harris	15 mins
5	Chairman's report (verbal) To receive	Chairman	10 mins
6	Complaints process (verbal) To receive	tbd	15 mins
7	Chief Executive's report (enc) To receive 07 - 2017.12.13_CX_Report.pdf 13	Chief Executive	15 mins
8	Non-Executive Director reports (enc) To receive 08 - 2017.12.13_NED_Reports.pdf 111	NEDs	15 mins
9	Lead Governor's report including constituency reports (enc) To receive 09 - 2017.12.13_Lead_Governors_Report.pdf 121	W Marshfield	10 mins

#	Description	Owner	Time
10	Quality and Compliance Committee report (enc) To receive 10 - 2017.12.13_QCC_Report.pdf 135	W Marshfield	5 mins
11	Membership Group report (enc) To receive 11 - 2017.12.13_Membership_Development_Repor... 151	L Hookings	5 mins
12	Secretary's report (enc) To receive 12 - 2017.12.13_Secretarys_Report.pdf 199	CoSec	5 mins
13	Non-Executive Director Presentation (verbal) To receive	J Marshall	15 mins
14	Urgent motions or questions To receive and action	Chairman	
15	Motions or questions on notice To receive and action	Chairman	
16	Details of 2018 meetings (enc) 16 - 2017.12.13_Details of meetings for 2018.pdf 201	For information	
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Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING

HELD AT 12.30PM IN THE ANNA DART LECTURE THEATRE,

HORIZON CENTRE, TORBAY HOSPITAL

22 SEPTEMBER 2017

Governors

	* Richard Ibbotson (Chair)	
Lesley Archer	* Stuart Barker	* Derek Blackford
* Bob Bryant	Peter Coates	* Craig Davidson
* Carol Day	* Cathy French	Diane Gater
* Annie Hall	* David Hickman	* Lynne Hookings
* April Hopkins	Barbara Inger	Mary Lewis
* Paul Lilley	* Wendy Marshfield	Catherine Micklethwaite
Julien Parrott	* David Parsons	Andy Proctor
* Anna Pryor	Sylvia Russell	* Simon Slade
* John Smith	Sue Whitehead	Simon Wright

Directors

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

(* denotes member present)

In Attendance:	Richard Scott	Company/Corporate Secretary
	Monica Trist	Corporate Governance Manager and Note taker

Action

1. **Welcome and Apologies**

Apologies were received from: Lesley Archer, Peter Coates, Diane Gater, Barbara Inger, Mary Lewis, Catherine Micklethwaite, Julien Parrott, Andy Proctor, Sylvia Russell, Sue Whitehead, Simon Wright, Rob Dyer, Judy Saunders, David Allen, Jon Welch.

Chairman welcomed two newly-appointed staff governors, David Hickman and Anna Pryor, who provided a brief resume of their current positions to the CoG.

2. **Declaration of Interests**

There were no declarations of interests.

3. **Minutes of the Meeting held on 19 July 2017**

Chairman asked members to review these for accuracy and the minutes were approved as an accurate record of the meeting. There were two actions arising from the minutes which had been completed.

4. **Chairman's Report**

Chairman reported that his successful staff drop in sessions were continuing across various Trust locations and that in future these would be combined with the CEO staff engagement sessions. Two of these joint meetings had been held to date and had worked well. The most recent session had been at Paignton on 21 September, which had been well attended and staff had raised various questions. Governors were welcome to attend any future sessions.

Governors were provided with an STP update: M McAlinden was now STP Lead, sharing this role with the RD&E CEO. NHSE were paying a percentage of the CEO's salary to cover this role but the financial benefit was for the Trust not M McAlinden personally.

Chairman had chaired the last collaborative Board meeting whilst a permanent chair was being recruited and the main themes discussed were how to achieve a more efficient governance process and how to ensure resource is evenly allocated between Trusts. On 7 September a quarterly Chairs' meeting had been held, attended by DPT too, and with a presentation from NHS resolution (formerly NHSLA), which had included detail of the high cost of litigation in the NHS, with £2 billion being spent this year. For many claims the legal fees were far greater than the cost of the claim.

A Staff Heroes presentation had taken place on 12 September and Chairman thanked governors who had given their time and been involved in the process. This had been followed on the same day by a Community Hospital League of Friends meeting, who were content with the current direction of travel for the organisation. Chairman had also attended 40th Anniversary celebration of Torbay Hospital Radio and he thanked all volunteers involved with this successful service: Chairman was pleased to report that Kevin Foster MP and the Chairman of Torbay Council had also attended the event.

JM joined the meeting at this stage.

Chairman advised governors that CQC had asked to attend the December Trust Board to monitor progress towards "well-led" criterion and they wished to observe the meeting anonymously. There was a lengthy agenda for the 4 October Board and Chairman advised governors who attend that the meeting may well over run, if governors were only available to attend part of the meeting they would be welcome.

On 5 October Chairman and CEO were due to meet the Torbay elected mayor and Torbay Council CEO, who were important commissioners for the Trust, to discuss and clarify future plans. Chairman advised governors that the Healthwatch AGM was taking place on 18 October and all governors were welcome to attend. NED interviews were taking place on 20 October and governors who sit on the Nominations Committee were fully involved in the process.

There were no questions from governors for the Chairman.

5. **Appointment of the Lead Governor**

Chairman outlined the process to be undertaken and advised that the one candidate, Wendy Marshfield (WM) was being asked to provide a presentation on a successful achievement in her professional or personal life and any lessons learned.

SB joined the meeting at this stage.

WM spoke about being the lead director for a new specialist community hospital in Somerset. WM explained the challenges surrounding the project: - Estates, financial and political and the options appraisal undertaken to determine the best way forward. Various meetings and consultations were arranged with key stakeholders and voluntary associations as WM wished to ensure that the facilities provided fully met the needs of the patient group. WM explained the timelines for the project which was delivered on time and under budget in the summer of 2011. WM paid testament to all who had worked so hard together to deliver such a successful outcome.

Chairman thanked WM for her presentation and members present undertook a secret ballot to elect the Lead Governor.

6. **Chief Executive's Report**

CEO asked governors to note the information provided in her report and invited questions on the Trust's current position, which was based on the Month 4 performance report, as there had not been a Trust Board in September. CEO invited comments on the new format of the performance report. ED performance remained challenging and there had been some difficult days in September already. Freedom to Speak Up champions were now being appointed to work with the Trust's Freedom to Speak Up Guardians.

AH joined the meeting at this stage.

CEO was pleased to inform governors that the Trust was on target to achieve the £40m savings plan and this was the subject of extensive and ongoing scrutiny by the ED team. A revised risk share agreement with the CCG and Torbay Council was nearing completion, and it was hoped this would be ready for signing at 5 October Board meeting. CEO reported on further successful engagement with the voluntary sector and had attended the Volunteering in Health AGM. CEO was pleased to announce that £1m funding had been allocated for development of voluntary sector posts and chartermark awards for successful partner voluntary organisations were due to be presented shortly.

DSI would welcome governors' feedback on the new-style performance report, with the month five report being taken to October Trust Board and advised that NHSI were introducing the new single oversight framework for use from October 2017. Emergency Department (ED) pressures continued and the status had been raised to Opel 4 (highest level) on one occasion in September. DSI described current performance with regard to national performance targets, which were regularly reported to FPIC,QAC and the Workforce and Organisational Development Group.

DoF was pleased to advise that the financial surplus of £120k achieved in August was ahead of plan, although there was still currently a whole-year deficit forecast. Good progress had been made towards reinstatement of a Risk Share Agreement with commissioners. DoF reported on good progress in month five towards achievement of both the local and systems savings plan targets: this was good progress in the right direction although there was still more work to be done in identifying further schemes.

LG asked about management of sickness absence and the percentage of staff on long-term sick leave. CEO advised that although this figure was still above target there had been a reduction in the rate of absence for five consecutive months. CEO apologised for

the absence of the DWFOD as she was getting married shortly and LG congratulated DWOD on behalf of the CoG. LG asked if treatment was ever cancelled owing to staff sickness and COO advised that any cancelations are carefully tracked and the reasons reviewed – only a very small number of cancellations would be due to staff sickness.

JM, Chair of Workforce and Organisational Development Group, confirmed that the rate of sickness was absence was reducing slowly and this issue was regularly reviewed by the Group.

WM asked about factors impacting on ED performance and CEO confirmed that good performance was achieved when ambulance handovers, admissions and discharge processes were all working well together. When any one of these had problems, delays occurred. SB had identified the need to ensure care homes were supported as they had an important part to play in patient flow process. COO confirmed this area would be considered at a meeting of the A&E Delivery Board on 27 September.

CD commented on the improved format of the performance report. He asked about the STP funding requirement to provide GP streaming service and COO described the successful and innovative partnership approach with Harbour Medical practice and the successful funding bid which would mean the system would be implemented as required on 2 October – well within allocated budgets. This would provide a good building block for future joint working with Primary Care. CEO confirmed this would form part of mutually beneficial arrangements to help GPs run a 7-day streaming service on the hospital site. The funding obtained would be used to make required accommodation changes and to fund improvements in technology.

Chairman thanked CEO for her report.

7. **Non-Executive Director reports**

Following agreement at the August Board to CoG meeting, the following NED Chair reports were provided for governors to ask questions rather than receive information on their content:- 21 June Charitable Funds committee (Chair J Lyttle); 27 June, 25 July and 29 August Finance Performance and Investment committee - FPIC (Chair R Sutton); 28 June Quality Assurance committee – QAC (Chair J Lyttle); 2 August Annual report of the Audit and Assurance Committee (Chair S Taylor).

Chairman asked for governor questions, no questions were put forward.

Chairman then asked Governors to provide any feedback on the NED reports to the FT office. — All Govs

8. **Lead Governor's (LG) report including constituency reports**

LG thanked the Chairman and NEDs for the NED reports which had been well-received by Governors. LG asked governors to note the contents of the constituency reports provided with her LG report to CoG, she felt excellent progress had been made with developing the work of the constituencies over the past three years, there was now a better process and improved governor involvement. As she would be retiring as LG after today following the election by CoG of a new Lead Governor, CF took the opportunity to thank the Governors and staff of the FT office for the support given to her during her time as LG. She was sure the CoG would go from strength to strength in the future and wished her successor as Lead Governor and Deputy Lead governor well, as the CoG entered its next stage of development following the implementation of the Governor Strategy.

Chairman spoke about the governors' questions which had arisen from the constituency reports:-

- ICO communications would be covered at October Board to CoG. — CS
- Report on emergency care out of hours had been referred to COO. — COO
- Invite to Care Home provider. Chairman confirmed the CEO view that discussions were at a commercially sensitive stage and further engagement at the current time would not be helpful.
- Kings Ash parking – referred to DECD. — DECD
- Dartmouth – email to CEO from AD community services with responsibility for Dartmouth to be shared with governors. — CS
- Future of ward closure at Teignmouth hospital referred to COO – meeting to take place shortly.

Chairman thanked CF for her hard work as Lead Governor and presented her with some flowers in appreciation of her years of service on behalf of the CoG.

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

WM, as chair of Quality and Compliance Committee, introduced her report advising that the questions to NEDs had arisen from topics discussed by governors at Q&CC.

- Sally Taylor (ST) provided assurance on the End of Life (EoL) process as the EoL group meets regularly with the EoL consultant and it was felt good progress was being made and some surprise had been expressed by the Group at the recent CQC rating. All issues identified by CQC had been addressed and ST felt the service was moving in the right direction.
- Robin Sutton (RS) advised that Project Implementation Reviews (PIRs) on completed business cases were being brought to FPIC and the ICU PIR was due to be considered on 26 September.

WM thanked J Lyttle as Senior Independent Director (SID) for facilitating the development session with the governors on 6 September, which had been very helpful and thanks to Governors and SID were endorsed by the Chairman.

CoG received the draft notes of the Quality and Compliance Committee and supported its current work. Any governors wishing to become committee observors were asked to contact the FT office. WM would raise this issue at governor only meeting in October. — All Govs

10. **Membership Group report**

Lynne Hookings (LH) as Chair of Membership Group introduced her report and provided the following verbal update, advising that there had been negligible public engagement by all governors and that little use had been made of the table top stand and accompanying material.

LH was pleased to report on good progress since the last meeting and following recent engagement with the Communications Team, pop-up banners had been produced together with cards to encourage membership of the Trust. Potential new members could log on to the website through the link on the card and see the range of benefits available to them and join as members through the website. The Chairman's letter inviting members to the Annual Members Meeting taking place later in the day had asked members to provide

their email address to facilitate easier and more regular communications. LH would encourage fostering links with schools and encouraging younger members of the local population to join as members, following the reduction of the minimum age to 14. LH also encouraged governors and members to complete members' survey, which was available on line for the first time.

CEO commented that free IT access was available at various points throughout the hospital, including the library and Bayview restaurant and encouraged governors and members to make use of these facilities.

Chairman thanked LH for her commitment and support in the important area of Trust membership.

11. **Secretary's report**

CS opened his report by announcing the result of the Lead governor election; he was pleased to advise that Wendy Marshfield (WM) had been elected by a majority of the governors present. Chairman extended congratulations to WM on behalf of the CoG, acknowledging that C French remained Lead Governor until the end of the day, 22 September. CF extended her congratulations to WM on her appointment.

CS invited nominations from governors for the vacant governor observer posts as listed in his report. CS asked governors to consider the draft process for the election of Deputy Lead Governor: members discussed the proposals and it was agreed by all that close working with LG was essential. All agreed a brief presentation by potential deputy LG would be helpful and Deputy Lead Governor selection process as described at S2.8 and 2.9 of the CS report was agreed by the CoG, once Question 3 had been re-written.

It was agreed that an additional CoG meeting would be held on 25 October to appoint the new Deputy Lead Governor.

12. **Non-Executive Director Presentation**

Robin Sutton, Chair of Finance Performance and Investment Committee provided the following presentation on his role as NED:-

NED Presentation

- Robin Sutton
- Appointed Non-Executive Director May 2016
- Chair of FPIC
- Board Member of TP
- Member of Audit and Assurance
- Trust Board Member

Robin Sutton (RS) invited questions from governors on the work of FPIC, or his role of NED.

LG commented on the large agenda and therefore very lengthy meeting papers for FPIC. She asked RS whether he felt the information received form the Trust for the meeting enabled him to provide sufficient assurance to Governors. RS described the many challenges which he made to executive directors and service Leads at FPIC on various aspects of the agenda, including the monthly Integrated Finance, Performance, Quality and Workforce Report. He felt the Committee was very effective and efficient and explained the monthly system of deep dives with the subject of the deep dive for the next meeting (26 September) being Torbay Pharmaceuticals. If further information is asked for under any of the agenda items this is added to the Committee's action log and suitable relevant reports are provided for members.

John Smith (JS), as governor observer for FPIC thanked RS for his effective chairmanship of FPIC. He confirmed that the FPIC agendas are very lengthy and wide-ranging, with the meetings lasting from 3-4 hours a month. Members were kept well-informed of finance and performance issues. Chairman asked the NEDs who were present if they felt the committee structure was right and that duplication was being avoided between the business of the various high-level committees. CN felt the current structure helped to ensure there was triangulation of Financial, Quality and Safety and Performance information, with Quality Impact analyses being carried out regularly during the course of discussion.

Chairman thanked JS for his supportive comments and RS for his presentation and on-going contribution to the work of the Trust.

13. **Urgent motions or questions**

None received.

14. **Motions or questions on notice**

None received.

15. **Details of next meeting**

13 December 2017, 3pm, Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 13 December 2017

Agenda Item:	7
Report Title:	Chief Executive's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest from the Chief Executive and Executive Team covering issues arising since the last Council of Governors meeting on 22 September 2017.

1.2 Please note that the next Finance, Performance and Investment Committee is not due to take place until the 19 December 2017 therefore at the time of writing, this paper highlights the latest Trust position.

1.3 The report as at attachment one shows October's performance figures; all figures that were available as at 6 December 2017. If an up-to-date dashboard is available, this will be presented on the day of the meeting.

1.4 The information as at attachments one, two and three was presented at the Board of Directors meeting on 6 December 2017 and this is an opportunity for governors to ask questions rather than be advised of the report's content.

2. Decisions Needed to be Taken

2.1 Opportunity for governors to ask questions rather than receive information from board members. Board members may be asked by the Chairman to provide any new/appropriate information before seeking questions from the governors/audience. Please note that governor questions put forward in advance of the meeting may be taken first.

3. Attached to this Report

Attachment as presented at August's Finance, Performance and Investment Committee.

Attachment one	-	Chief Executive's Report
Attachment two	-	Integrated Finance, Performance, Quality and Workforce Report (Month 7)
Attachment three	-	Update and Progress on Devon's STP

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.

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%

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.

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.

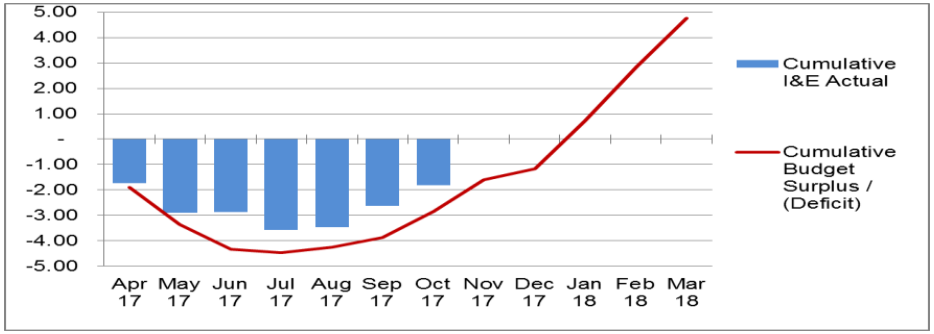
In addition to the workforce KPIs there are 2 further workforce indicators that are being tracked to provide assurance to the Board

- **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.

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'.

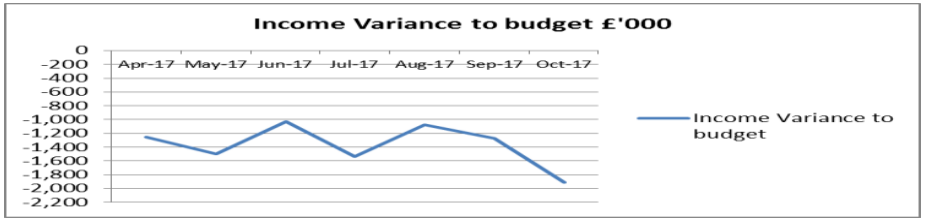
Summary of Financial Performance

	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:

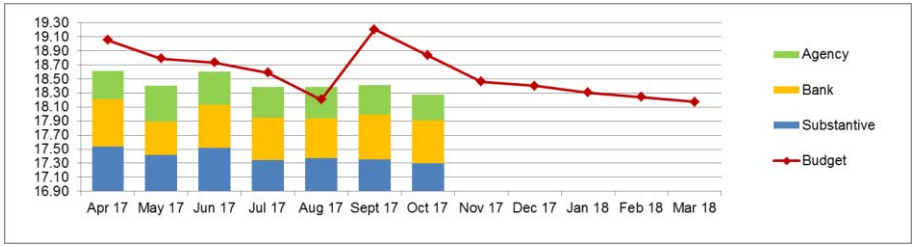
- Systems Savings plan income is behind plan by £1.3m for the year to date. On a full year basis £5.4m is forecast against a target of £7.2m.
- Income earned by Torbay Pharmaceuticals is £389k less than budget. The Torbay Pharmaceuticals Board has agreed a recovery plan and is expecting now to achieve 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

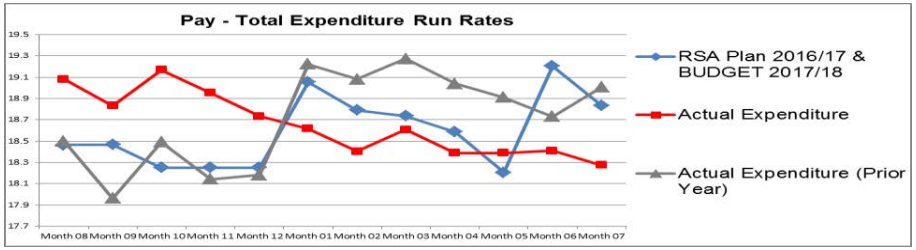
The Trust has accrued £2.96m of income from South Devon and Torbay CCG as agreed and provided by the CCG in Month 7, relating to System Wide Savings schemes advised, delivered and passing to the Trust.

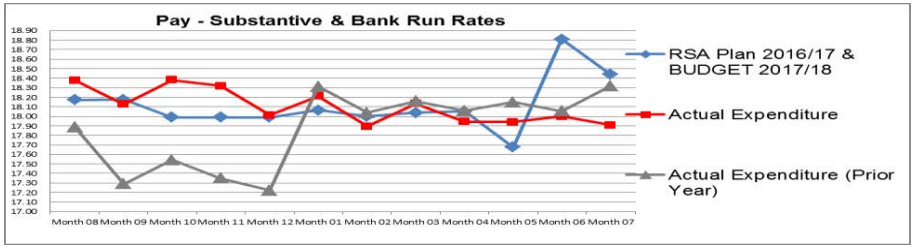
STF funding of £2.62m has been accrued and included in the year to date figures, reflecting anticipated receipt for Months 1 to 7.

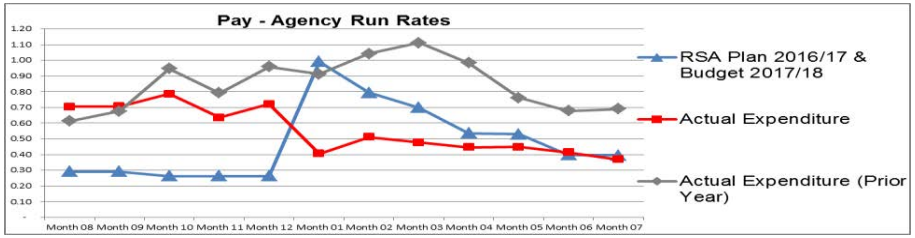
Pay Expenditure

Current Performance









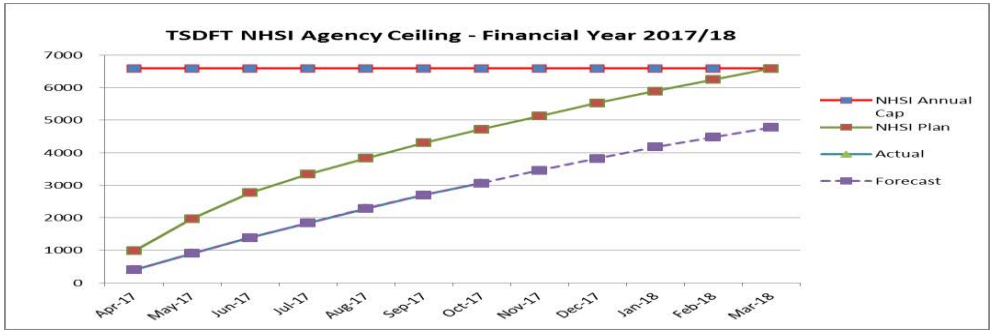
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(32.24)	1.64	(30.61)	(29.44)	1.16	(55.23)	(52.36)
Nursing and Midwifery	(54.58)	0.12	(54.46)	(51.64)	2.81	(91.62)	(91.34)
Other Clinical	(27.69)	(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



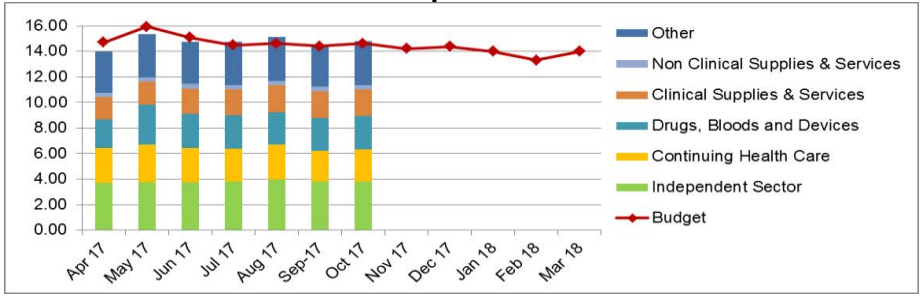
Agency - All Staff Groups	April	May	June	July	August	September	October	YTD 2017-18
	£m	£m	£m	£m	£m	£m	£m	£m
Agency Plan 2017/18 (NHSI Ceiling)								
Planned Agency Cost	(0.99)	(0.98)	(0.80)	(0.56)	(0.49)	(0.48)	(0.42)	(4.72)
Total Planned Staff Costs	(19.06)	(19.01)	(18.89)	(18.31)	(18.26)	(18.18)	(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%**

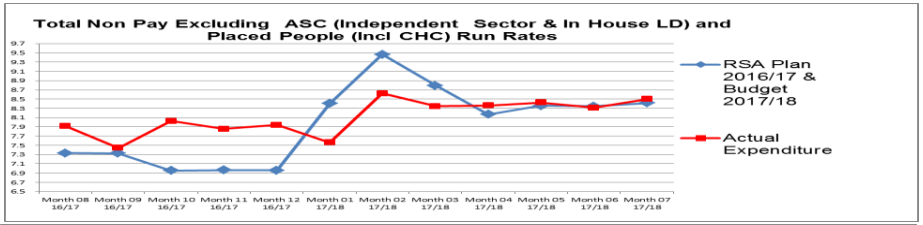
- Agency staff costs in Month 7 across all staff groups is £0.4m and £3.1m for the year to date. This is £1.6m lower than the NHSI plan.
- Medical agency spend is £1.8m which is £0.2m higher than the £1.6m plan.
- Nursing Agency spend is £0.7m for the year to date, £2.0m lower than the £2.7m plan.
- 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.

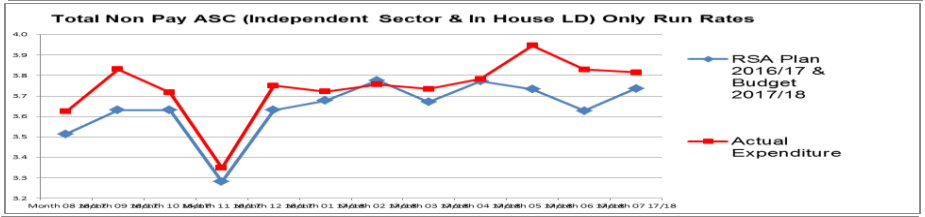
Non Pay Expenditure

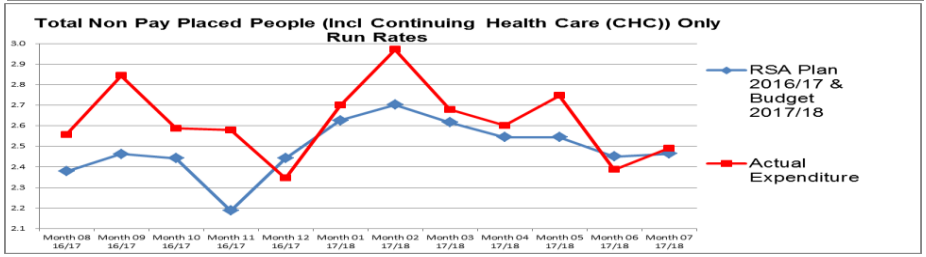
Current performance



	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)**



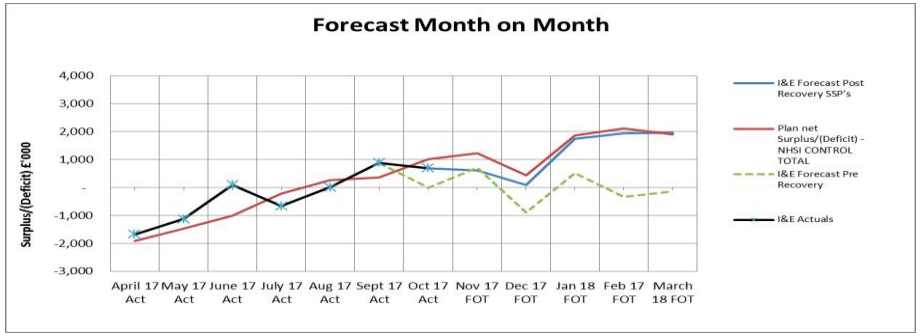


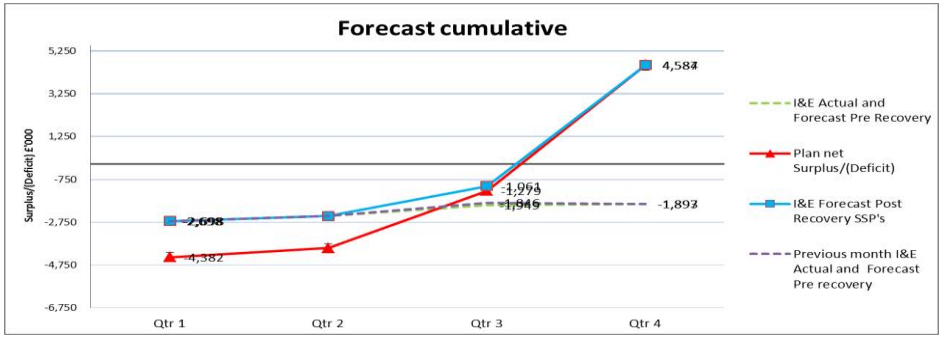


Key Points

- 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

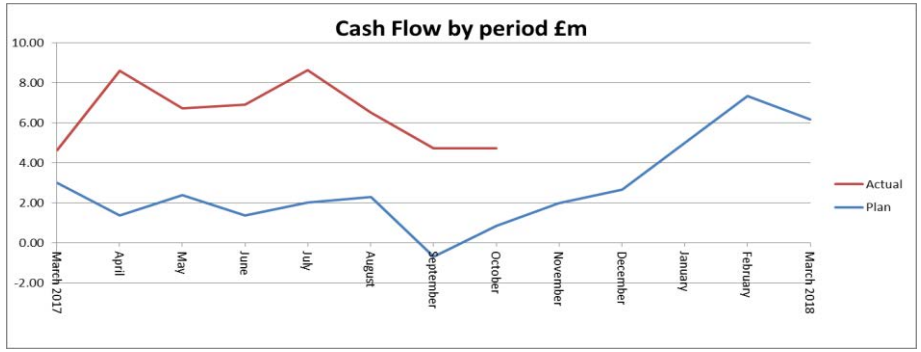
	Year to Date - Month 07			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Non-Current Assets					
Intangible Assets	10.88	8.41	(2.46)	(2.19)	(0.27)
Property, Plant & Equipment	171.52	155.06	(16.46)	(15.47)	(0.99)
On-Balance Sheet PFI	18.24	14.71	(3.53)	(3.51)	(0.02)
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

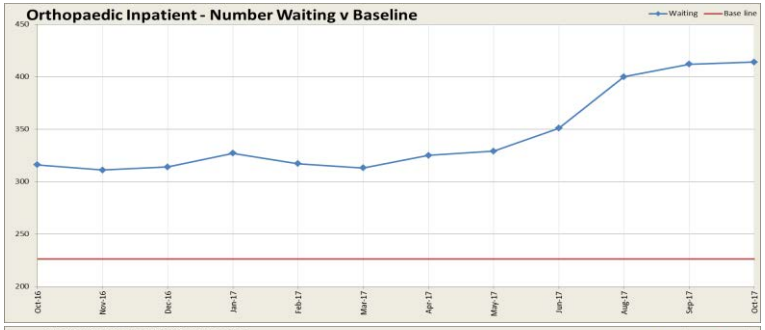
Activity variances for M7 and M6 against the contract activity plan are shown in the table opposite. In M7 there is a continued trend of underperformance to commissioned plan for elective activity: The main variation is against elective inpatients (19% behind plan, 13% last month) and outpatient follow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

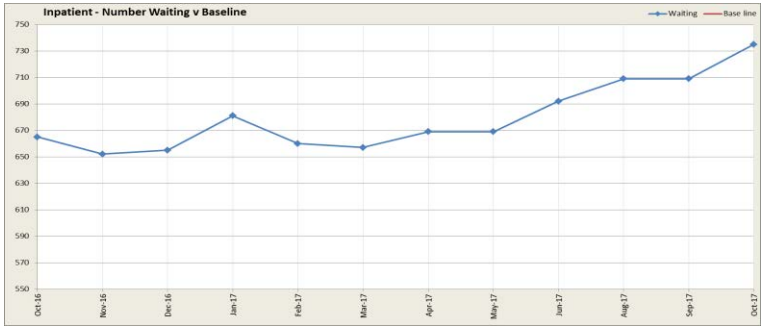
At treatment function level the greatest variance is in orthopaedics with 148 inpatient cases behind plan (£670k). A number of decisions have been taken to not replace clinical staff in particular some 'training and middle grade' posts at this time. It is noted that the newly introduced therapy led interface 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:**

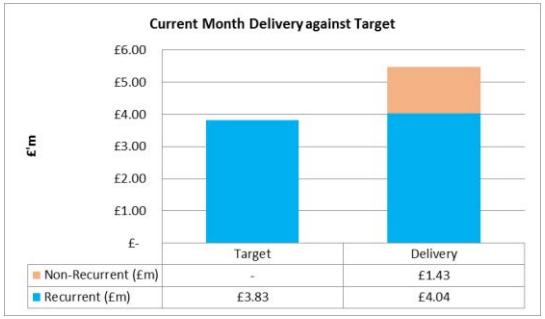
- The activity plan is based on the assessment of actual capacity and therefore does not include any historical waiting list initiative activity.
- Risk Share Agreement mitigates any immediate income risk.
- Activity underperformance is contributing to cost savings on non pay consumable items.
- Risk 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.

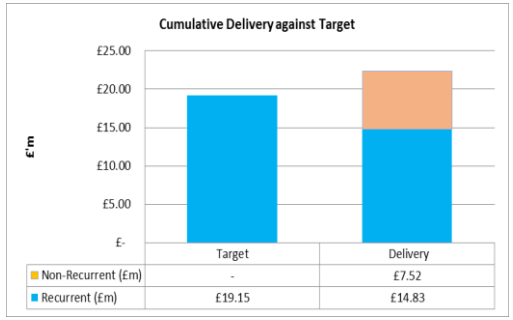




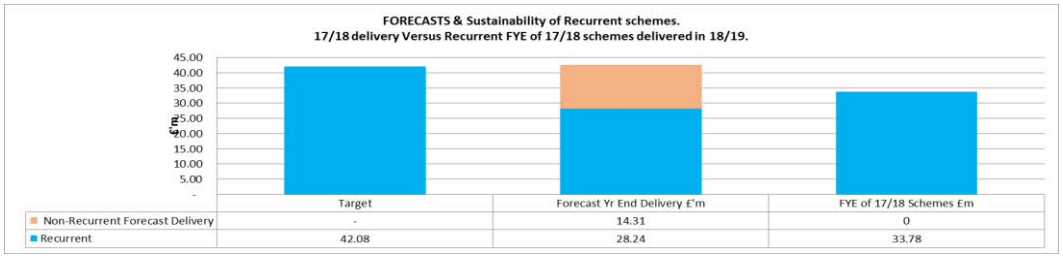
CIP Delivery: Current Mth, Cumulative & Forecast

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

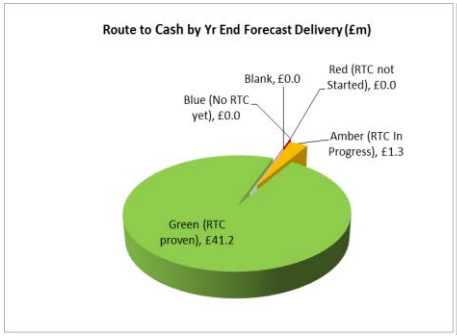
Risk: Presumes all schemes listed deliver (See Delivery Assurance)

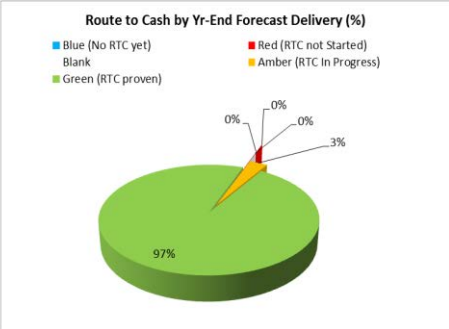
Month 7 Note:

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

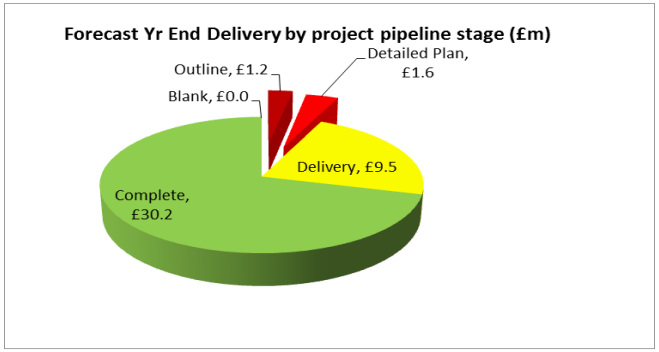
CIP- Delivery Assurance - Yr end delivery forecast-

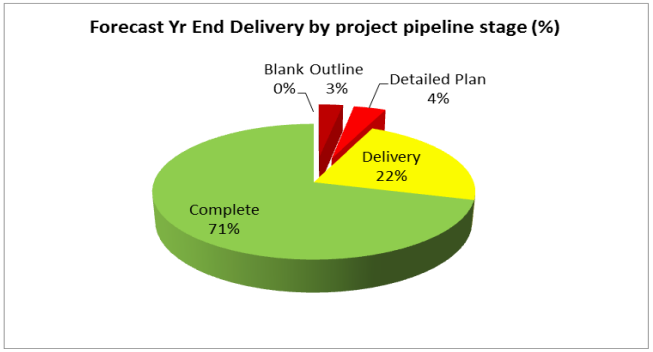
c) CIP Delivery Assurance- Route to Cash





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.

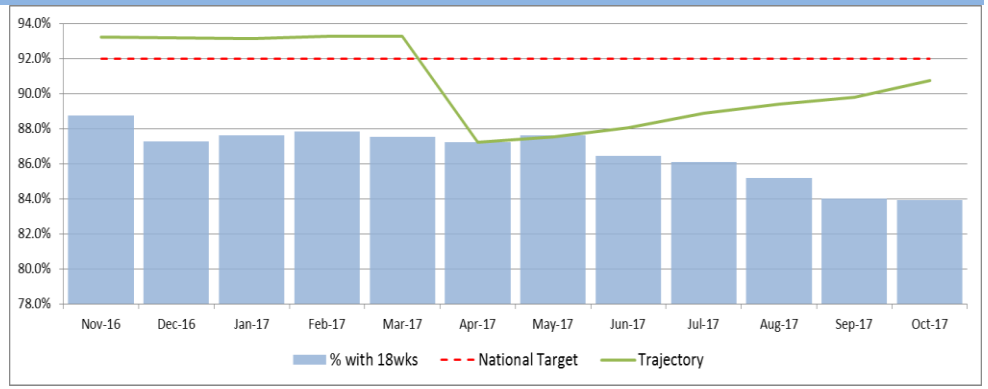
Cancer standards -
October 62 day – 85.7%. Validation and data quality review will continue to the end of November prior to final upload at the beginning of December.
During September and October additional colonoscopy lists have been run on Saturday mornings as part of the agreed initiative to reduce 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.

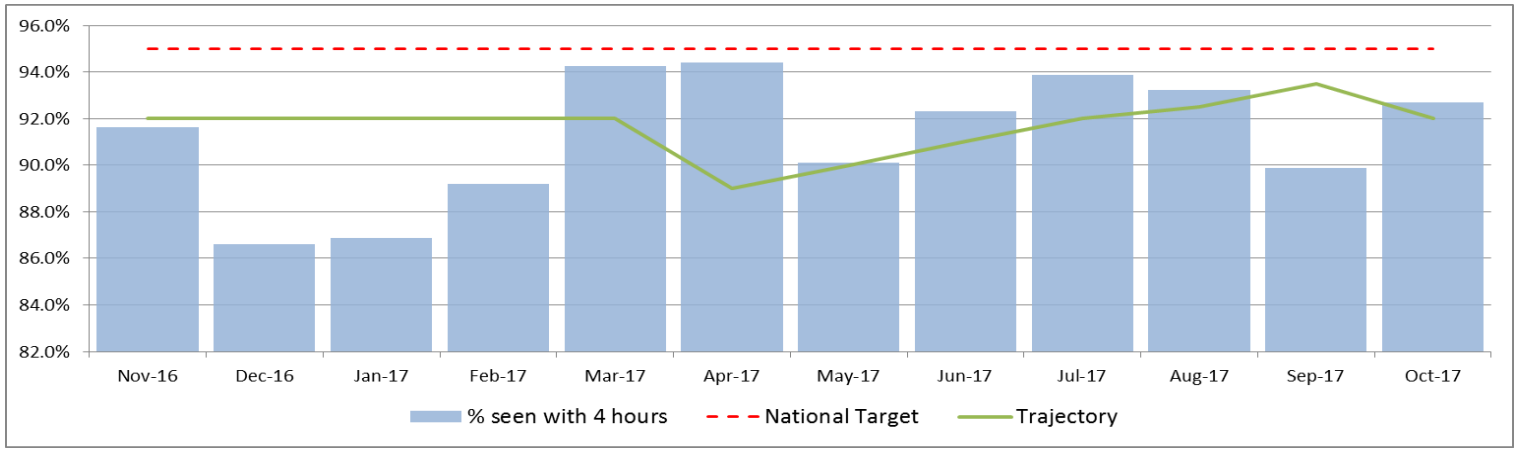
A revised trajectory for delivery of RTT within the 18 week standard has been agreed across the STP. The revised target is to maintain the performance achieved in July 2017; for TSDFT this is 86.1%. An assessment has been made by specialty and this confirms that the revised trajectory can be achieved 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	

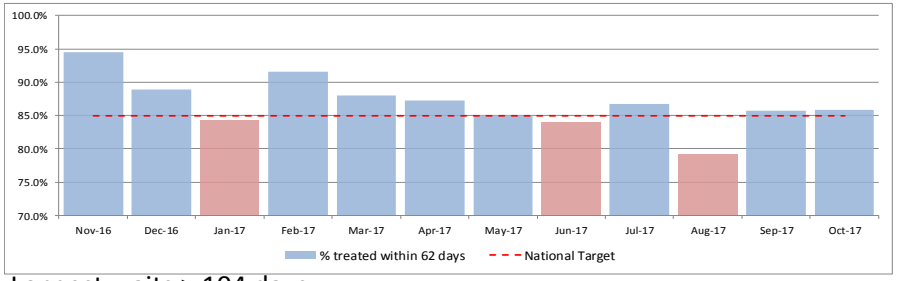
The 7 big scheme leads are meeting on a weekly basis to maintain pace and to ensure barriers to implementation rapidly resolved.

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

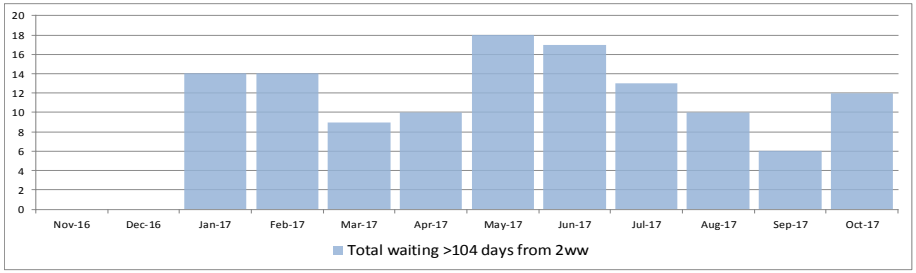
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
1st treatments (from 2ww)	91	99	101	77	83	62.5	97.5	106	94.5	120	98	95
Breaches of 62 day target	5	11	16	6.5	10	8	14.5	17	12.5	25	14	13.5
% treated within 62 days	94.5%	88.9%	84.2%	91.6%	88.0%	87.2%	85.1%	84.0%	86.8%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

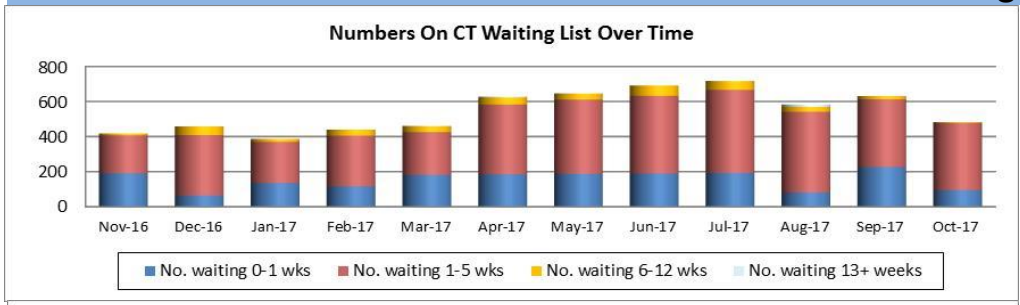
Urgent cancer referrals 14 day 2ww - This position is being driven by the capacity pressures in Dermatology 323 (77% all breaches) and Lower GI 44 breaches (10%). The capital works to increase clinic capacity and relocate Dermatology clinic activity to the John Parks Unit are completed however the recovery 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.

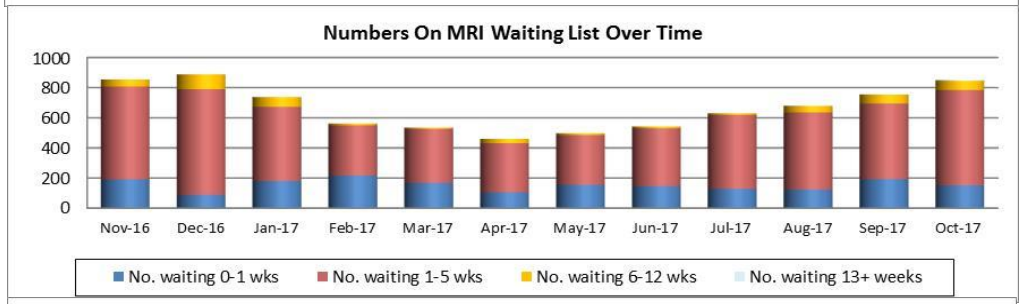
31 day from diagnosis to 1st treatment - 7 breaches of standard - combination of capacity cancellation and patient choice - no new operational risks identified. Forecast to deliver in Q3.

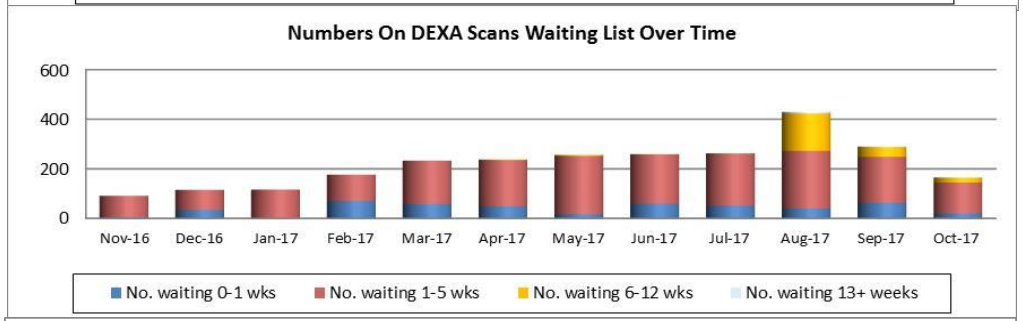
Cancer 62 day standard was met in October (85.7%) standard 95%.
The forecast for the Quarter 3 position is achievement of the standard.
The breaches are in the following cancer pathways:
Urology = 3 Lower / Upper GI = 5 Lung = 5
The capacity pressures and delays in the diagnostic phase of the pathways 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.

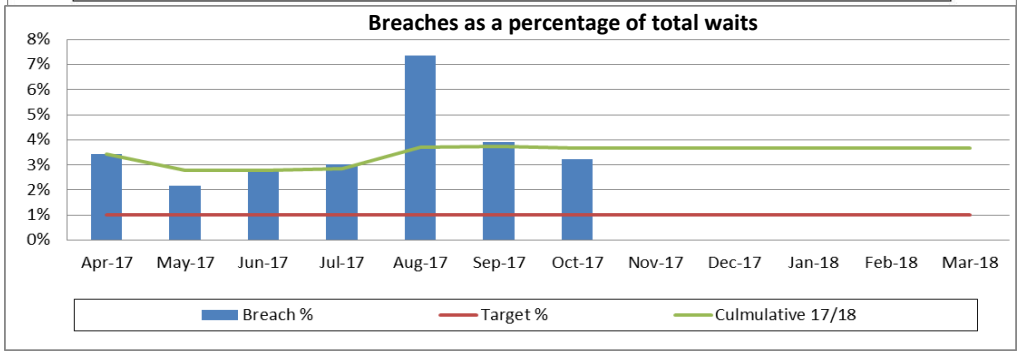
Longest waits > 104 days.
The most recent guidance from NHSE is that there will be a zero tolerance on the number patients who have confirmed cancer and receive treatment after 104 days from December 2017. To facilitate our early warning of these patients reaching 104 days a 90 day trigger has been established 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:

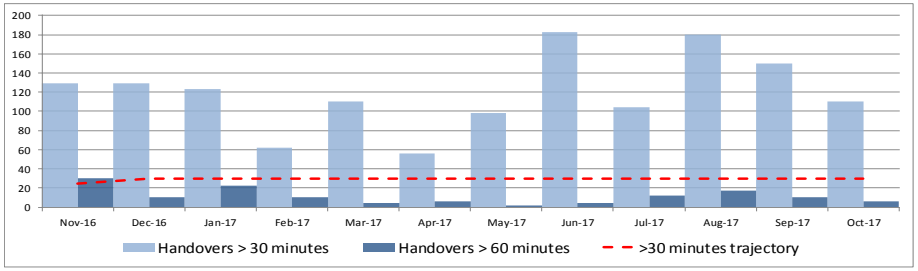
- recruit to vacant posts / seek agency staff;
- mobile MRI service for 10-15 days and then periodically at a cost of £13,000 per 5 day visit, plus reporting costs.

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

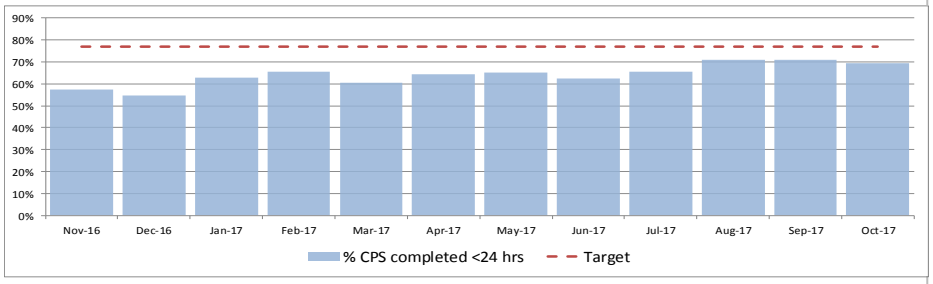
Ambulance handovers

	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



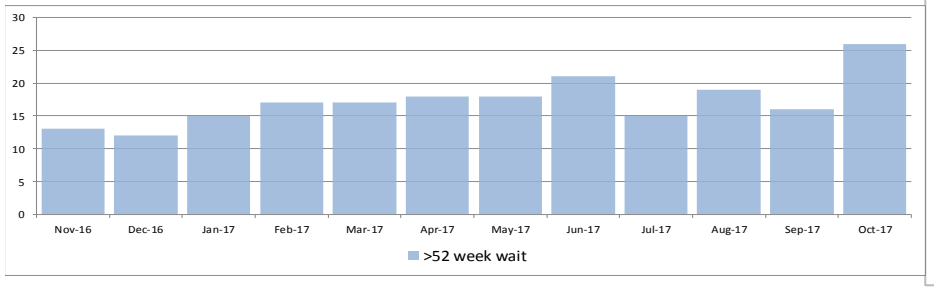
Care Plan Summaries completed with 24 hours of discharge - Weekday

	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.

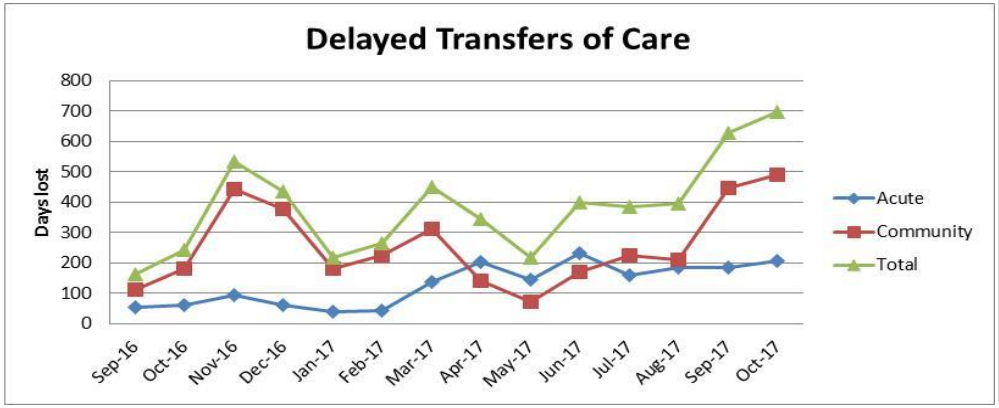
Community Services

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.

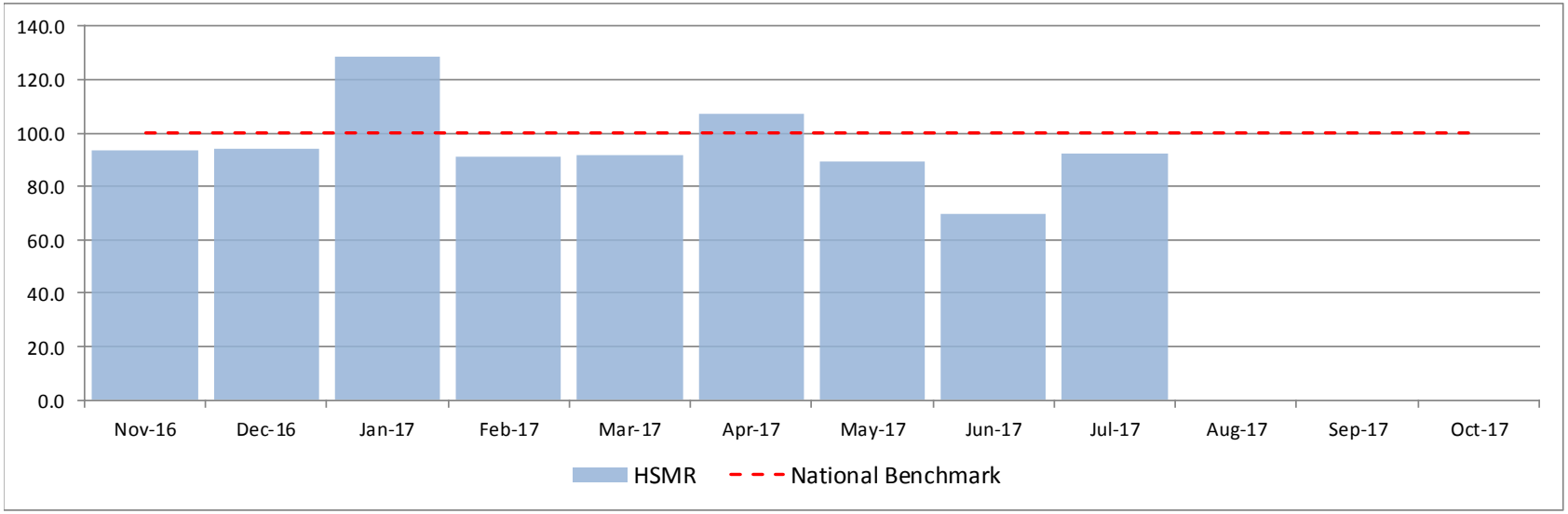
3. Infection Control are reporting a strong monthly hand hygiene compliance rate 99% and levels of Clostridium Difficile (CDT) remain low.

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



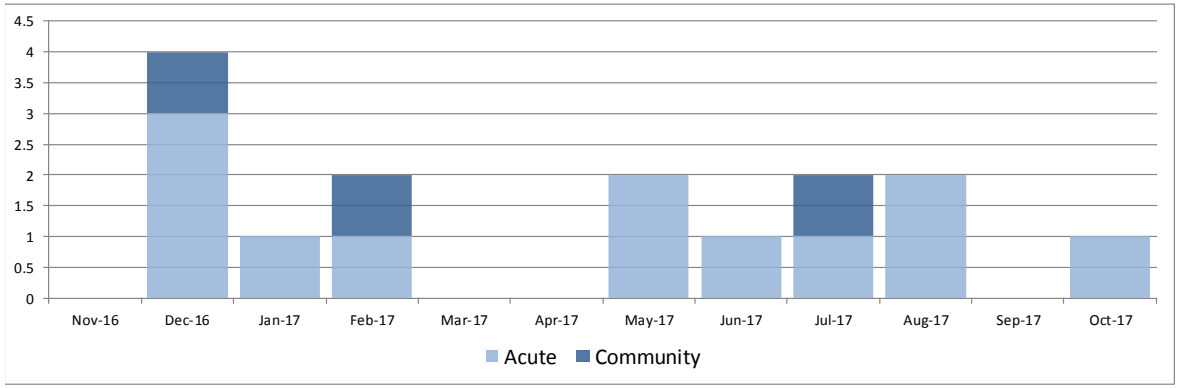
Trustwide mortality is reviewed via a number of different metrics however, Dr Foster allows for a standardised rate to be created for each hospital and therefore this is a hospital only metric. This rate is based on a number of different factors to create an expected number of monthly deaths and this 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

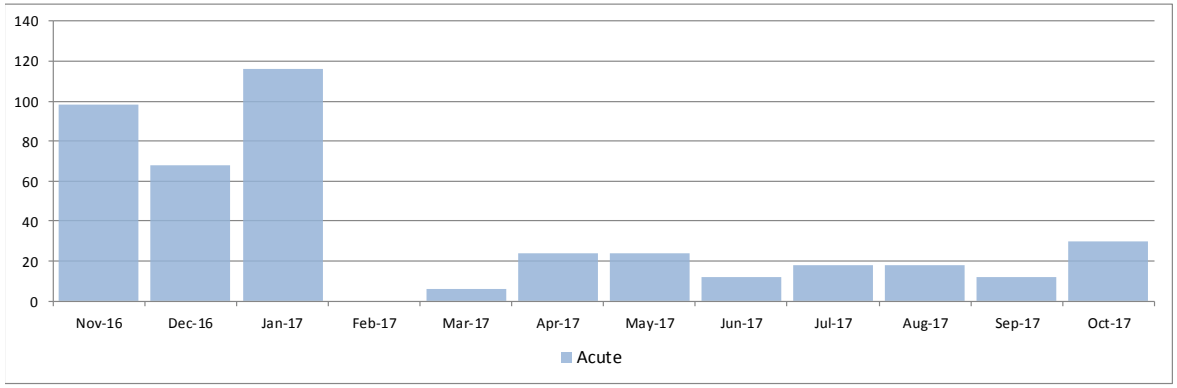
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Acute	0	3	1	1	0	0	2	1	1	2	0	1
Community	0	1	0	1	0	0	0	0	1	0	0	0



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



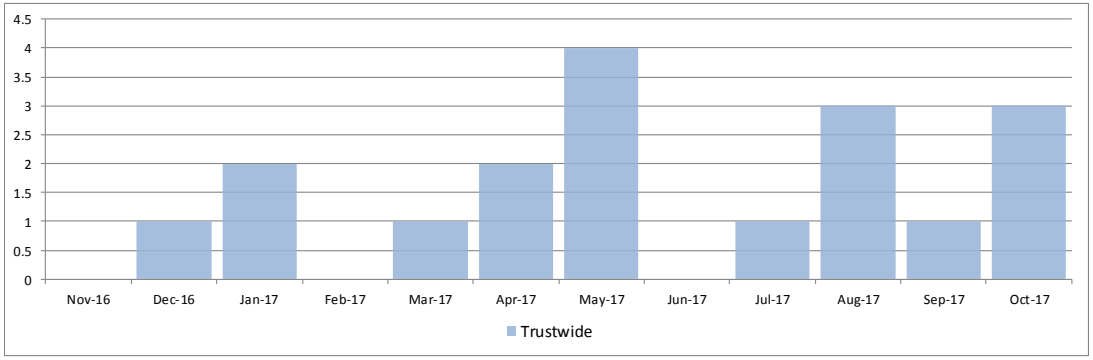
The Infection Control Team continue to manage all cases of potential infections with individual case by case assessment and control plans. The continued low number of bed days reported as lost due to bed closures from infection control is 30 in October. This is a positive indication of the robust processes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

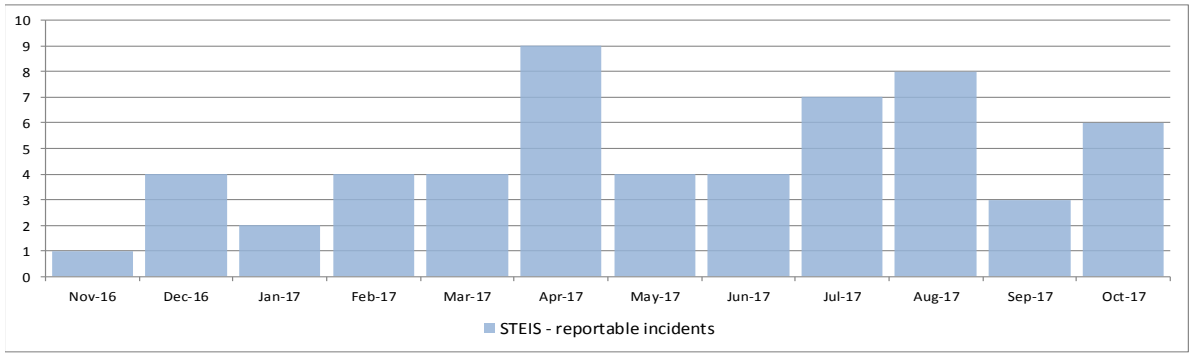


The Trust reported three serious incident in October.
2* Drug and Alcohol incidents
1* Radiology incident

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 .

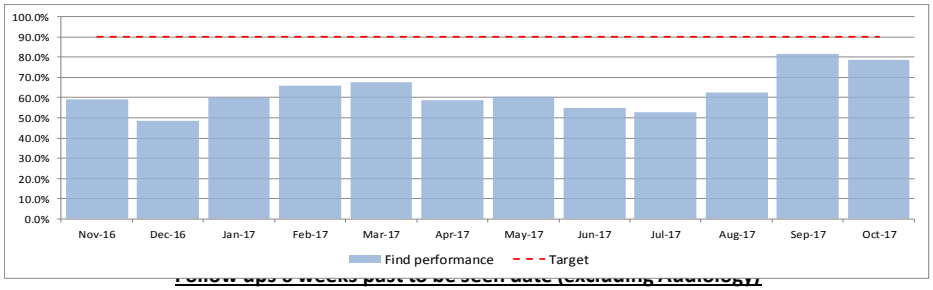
The incidents included 3 falls resulting in :
2 fractures
1 head injury,
1 neonate sent for cooling in Derriford
1 radiological incident
1 self harm incident

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

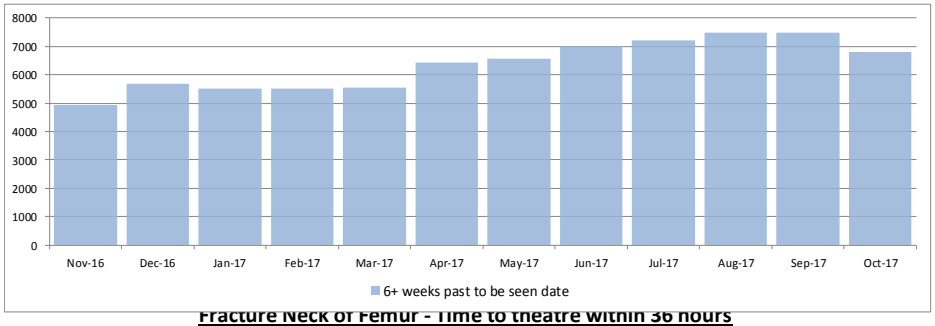
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Numerator	353	322	391	411	461	323	424	372	308	360	455	301
Denominator	533	577	595	574	613	499	632	603	496	520	536	383
Find performance	59.2%	48.6%	59.9%	65.8%	67.8%	58.9%	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%
Target	90.0%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

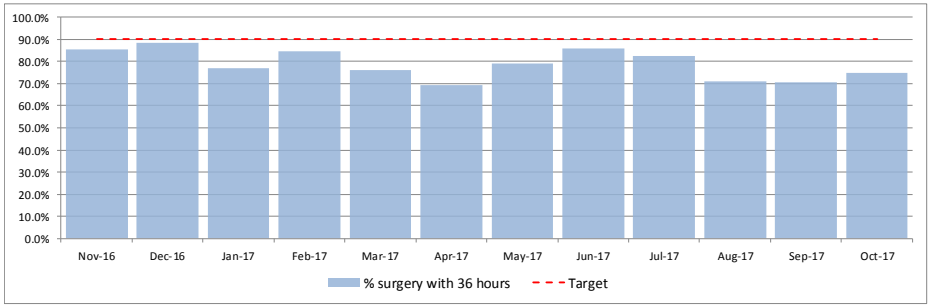


The number of follow ups waiting for an appointment greater that 6 weeks past their 'to be seen by 'date remains a concern. A review is being carried out to address areas of the greatest increase and determine if there is any increased clinical risk or opportunities for changing the clinical management 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.

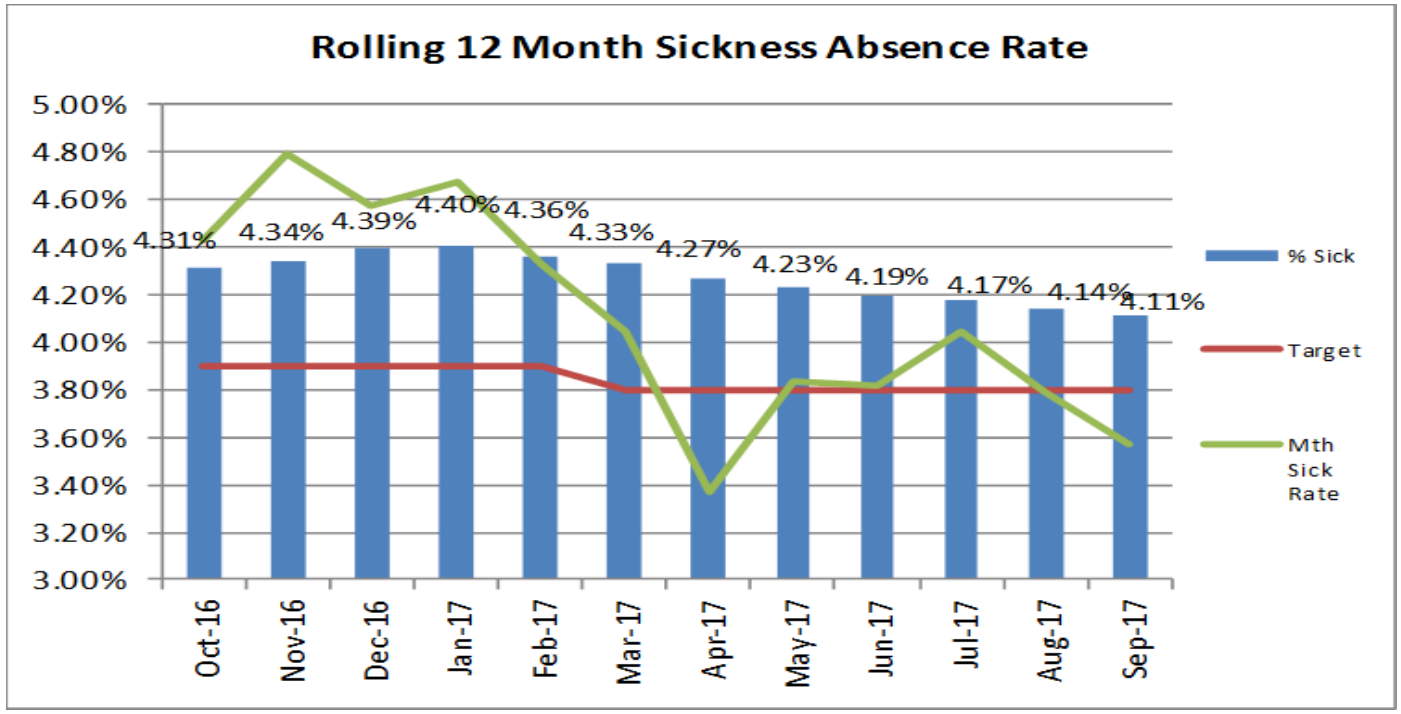
Table 2 shows the number of staff by pay bands. Those staff in band 8 are predominantly in management roles.

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

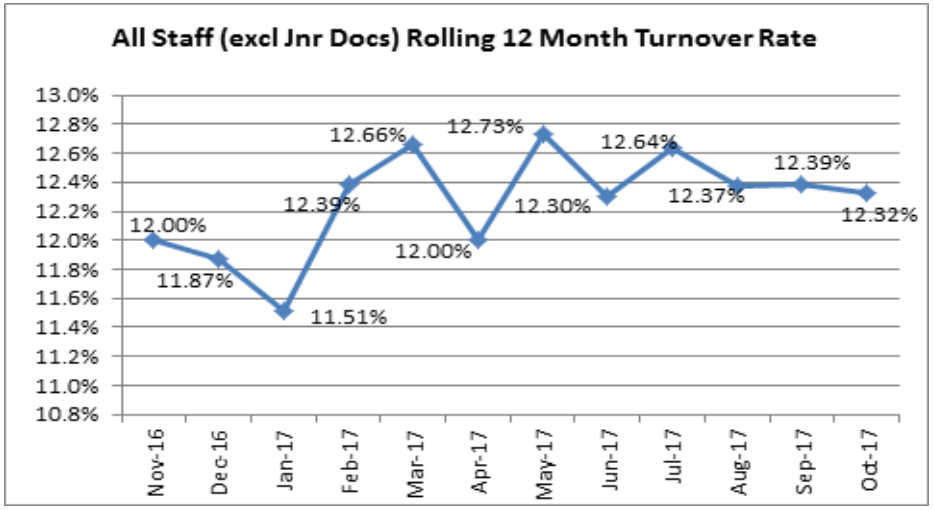
Rolling 12 month sickness absence rate - (reported one month in arrears)



- 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

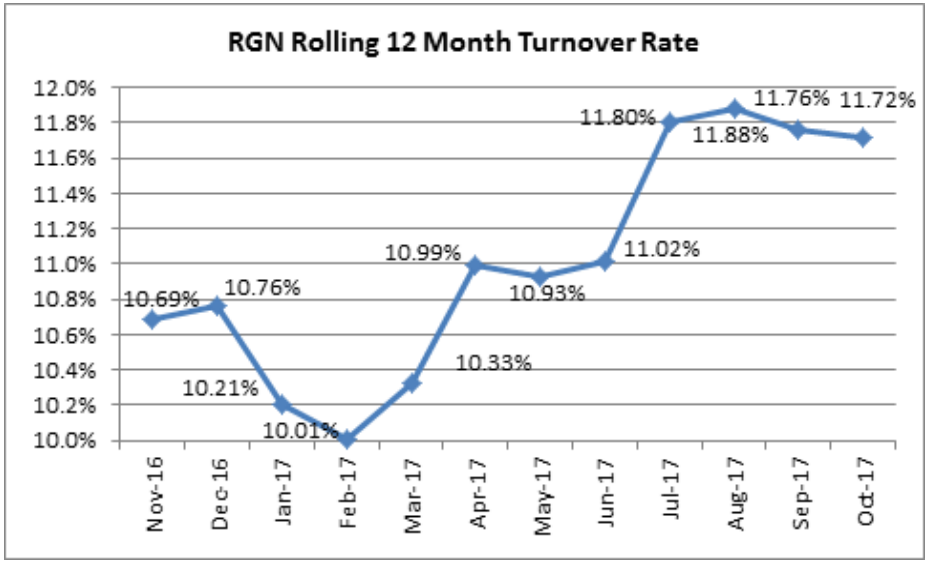


All Staff Rolling 12 Month Turnover Rate

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



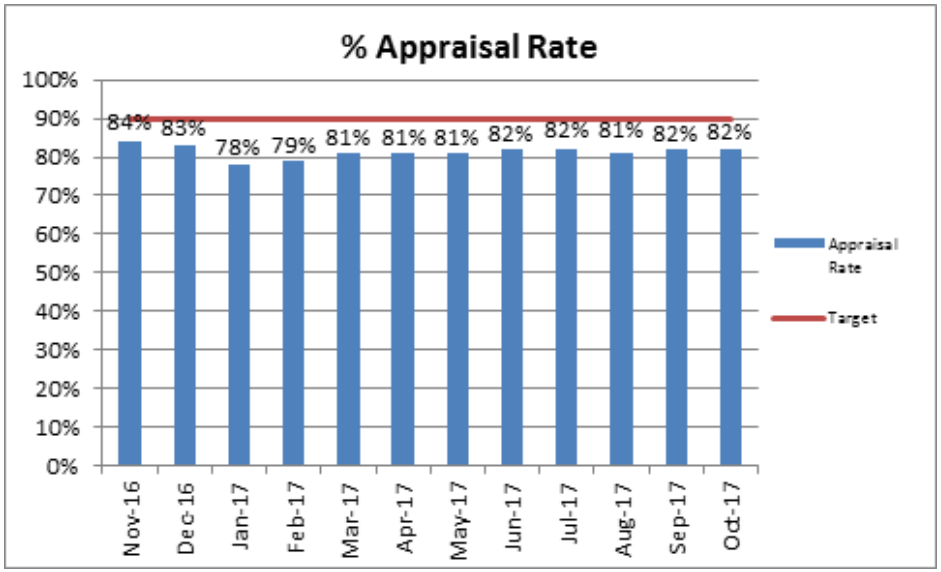
RGN Rolling 12 Month Turnover Rate

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.

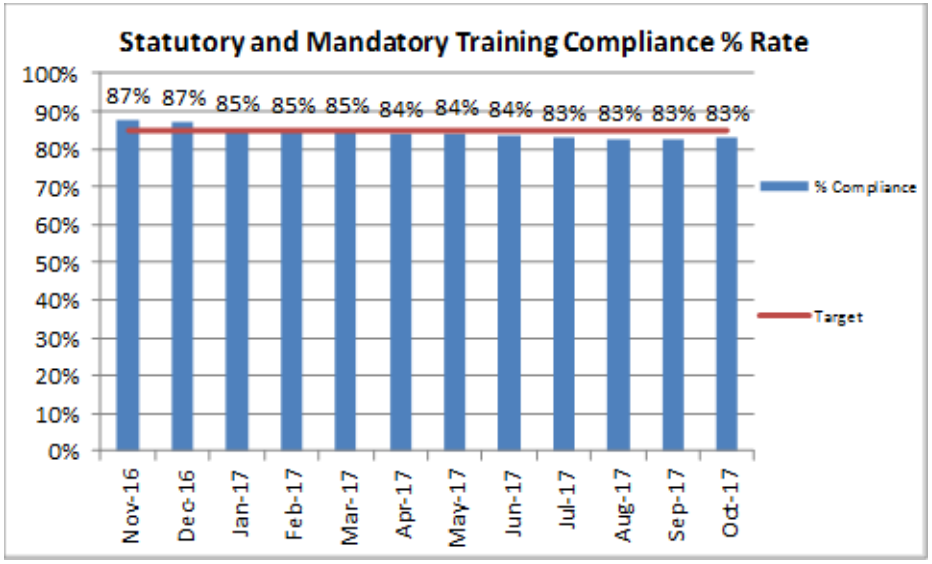
Workforce - Appraisal and training



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 and HCA Bank and Agency

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%		
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		
4	Distance from NHSI Control total (£'000's)			-1902	-3493	-4887	-7083	-7924	-9549	234	581	1696	1247	997	1503		
4	Risk Share actual income to date cumulative (£'000's)			5836	5844	7169	8389	8637	9107	-236	-579	-192	-124	-98	0	0	

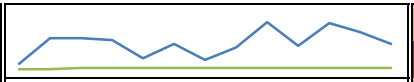
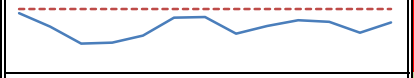
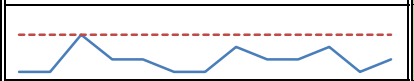
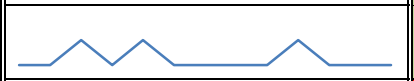
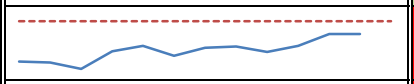
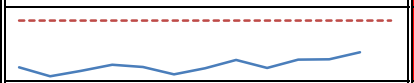
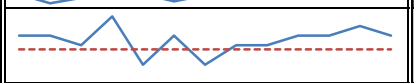
Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

NOTES

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

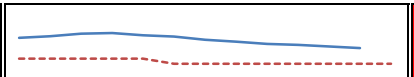
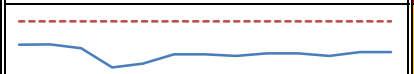
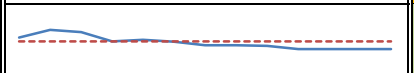
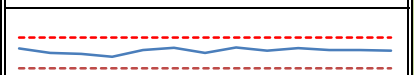
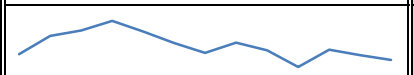
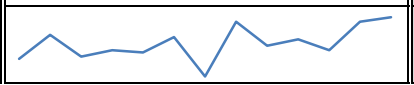
[STF] denotes standards included within the criteria for achieving the Sustainability and Transformation Fund

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		881
	Handovers > 30 minutes trajectory *			25	25	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%		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%
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		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		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
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		6	1	4	2	4	4	9	4	4	7	8	3		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		1
1	Formal Complaints - Number Received *	<60		29	34	25	29	26	34	13	32	31	33	22	22		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		
1	Medication errors - Total reported incidents (trust at fault)	N/A		41	56	48	53	48	64	50	75	37	62	42	68		
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%				
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%
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%
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%
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.

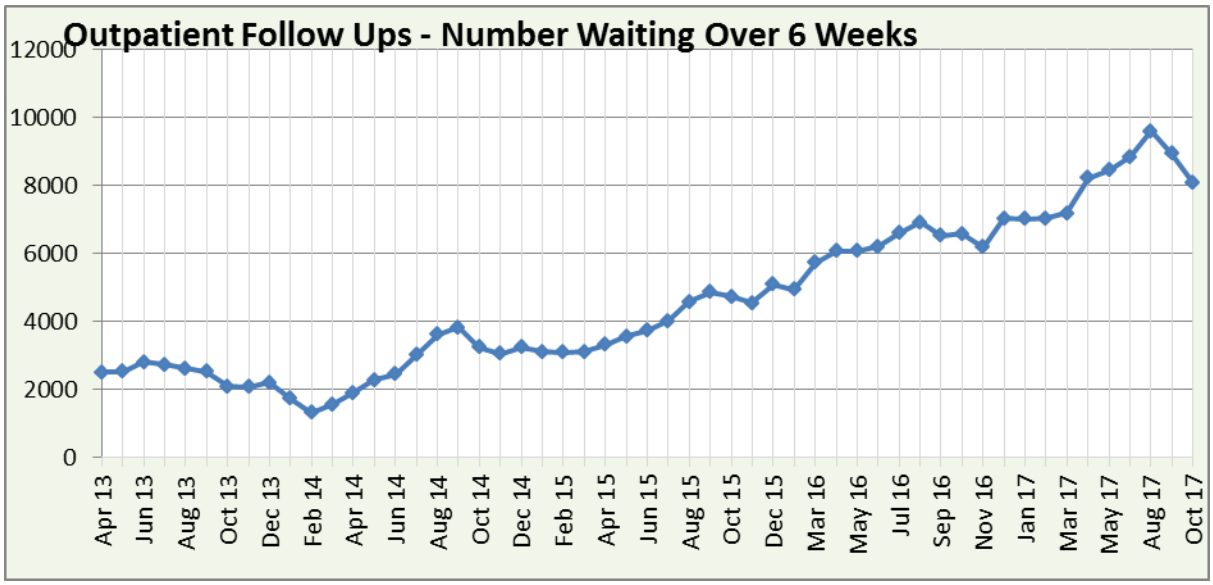
In line with the process manadated by the Executive the next step will be to hold a 'lock in ' workshop to develop plans aimed improving performance. In the interim the RTT and Diagnostics Risk and Assurance Group will continue to monitor improvements where these are evident and to seek trajectories,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

Appendix 2

Headline Analysis of Aggregate Data

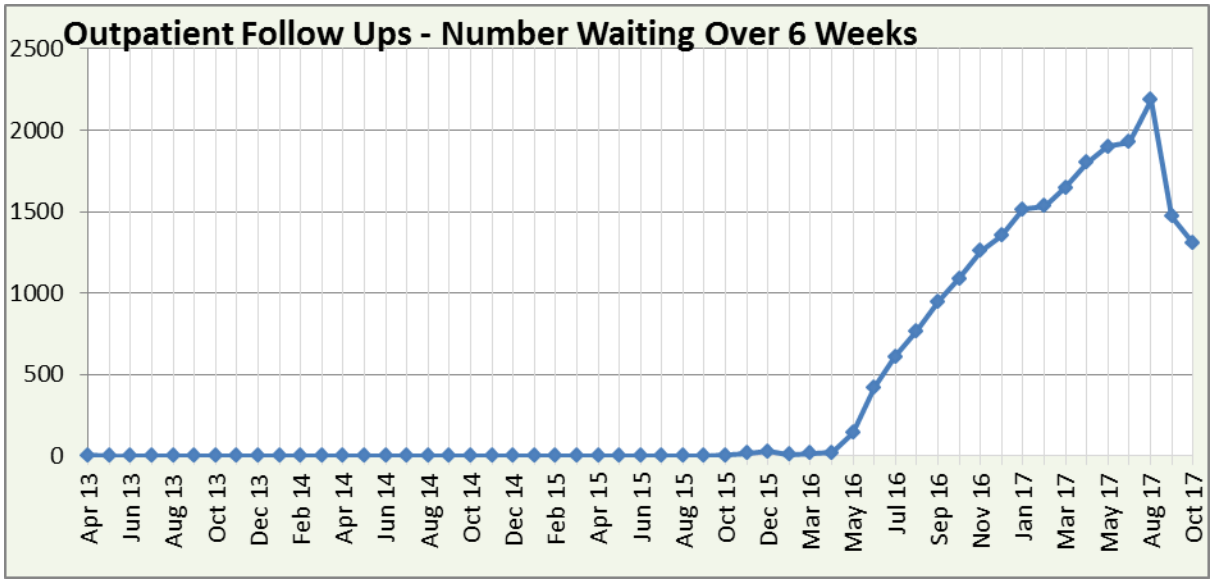
Total follow up list 6 weeks past to be seen date reduced in September and October 17 = 8,089 down from 9,608 in August 2017. This is against a background of persistent increases since February 2014.

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.

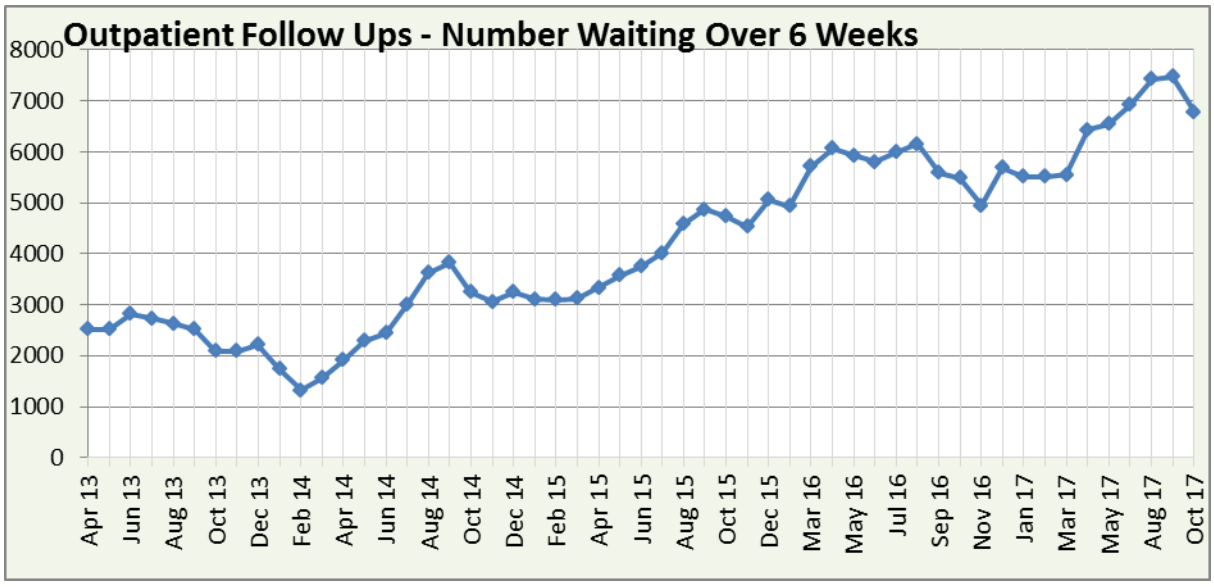
Audiology Only



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

Appendix 2

Total excluding audiology

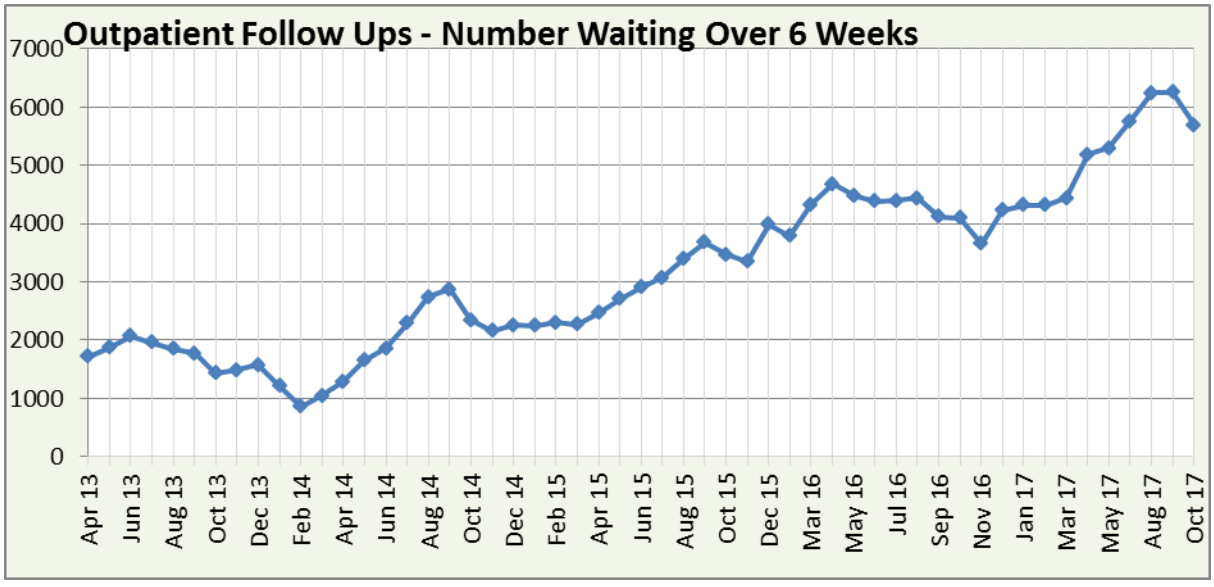


The specialties that comprise 85% of the current total backlog over 6 weeks are as follows;

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

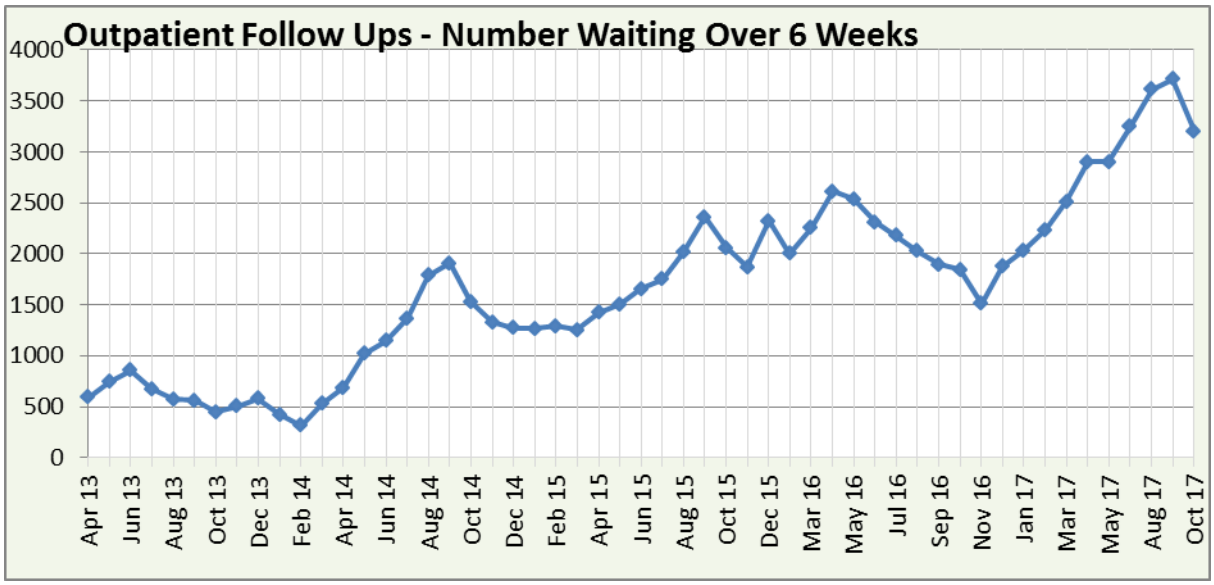


Each of these 7 specialties is now analysed seperately and where possible comments included from the teams concerned. The intention is to enable the team to explain the factors behind the increases, confirm the plans to reduce the waiting times and explain the governance process in place to manage the 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.

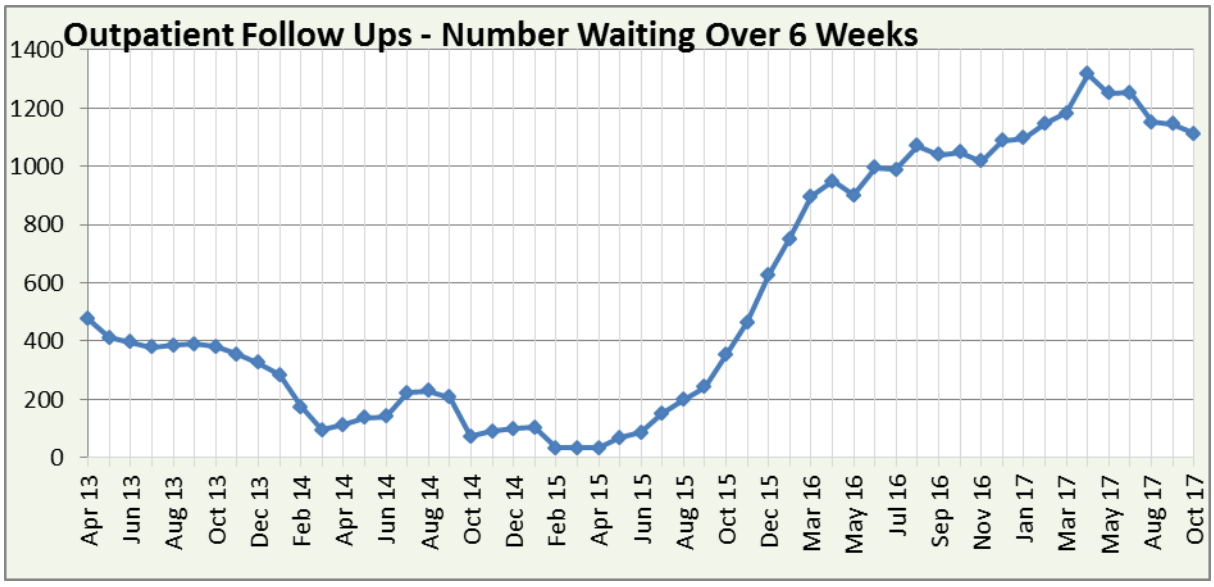
Plans to reduce waits

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:

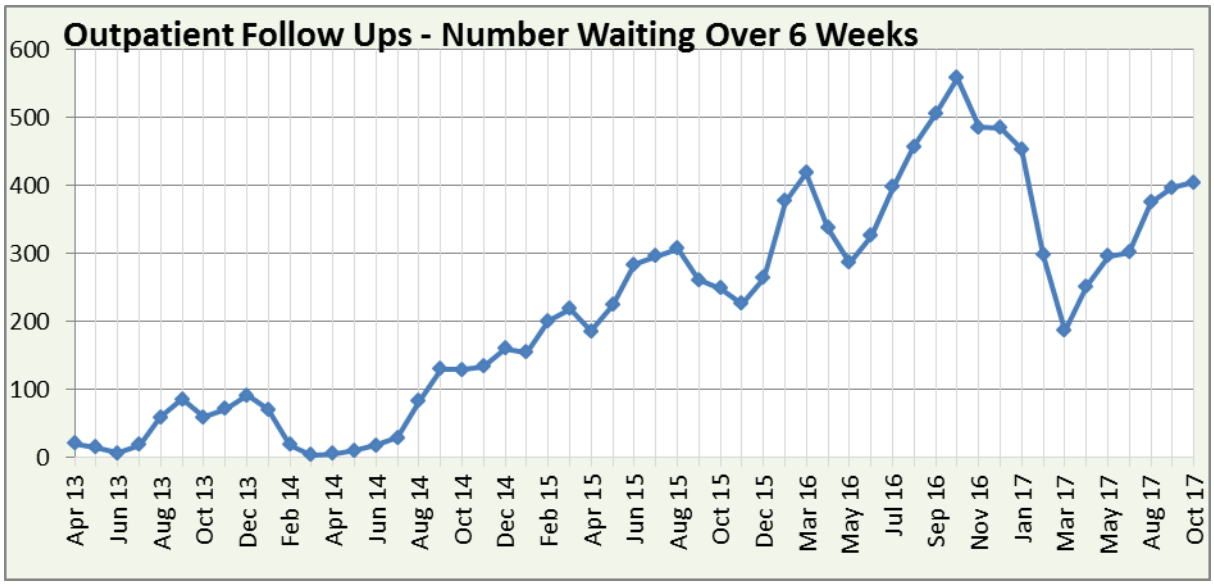
On risk register

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.

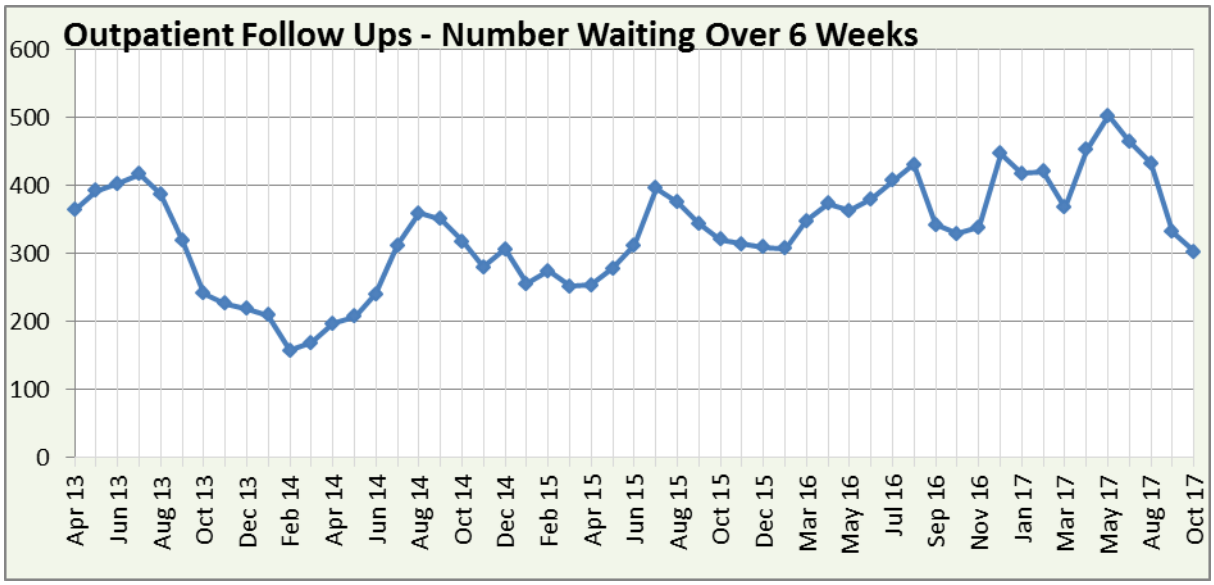
Plans to reduce waits

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.

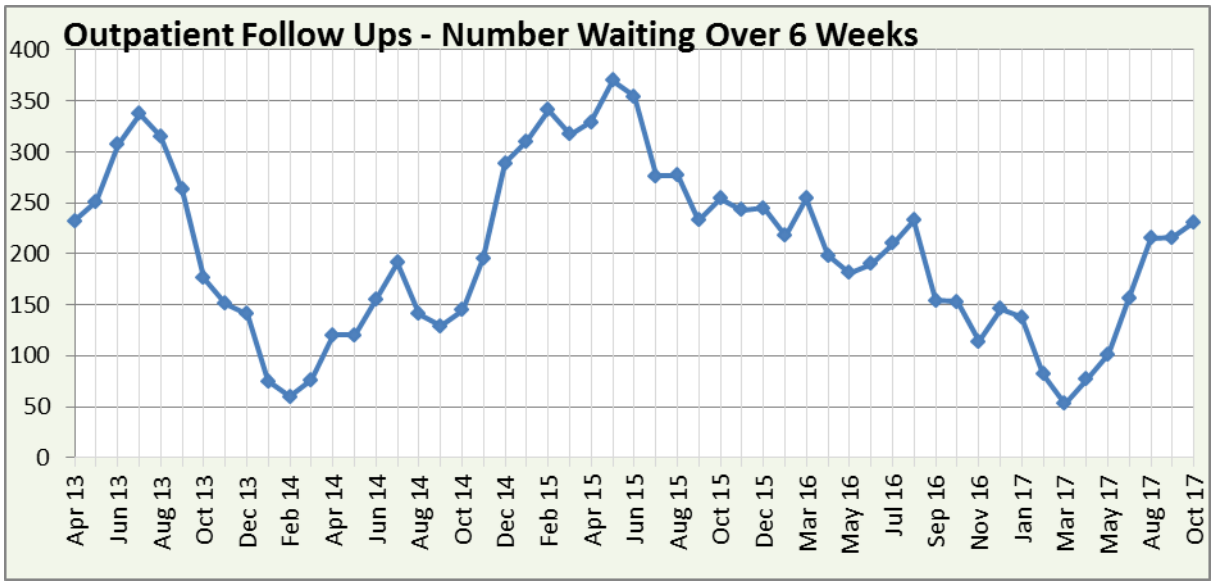
Plans to reduce waits

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.

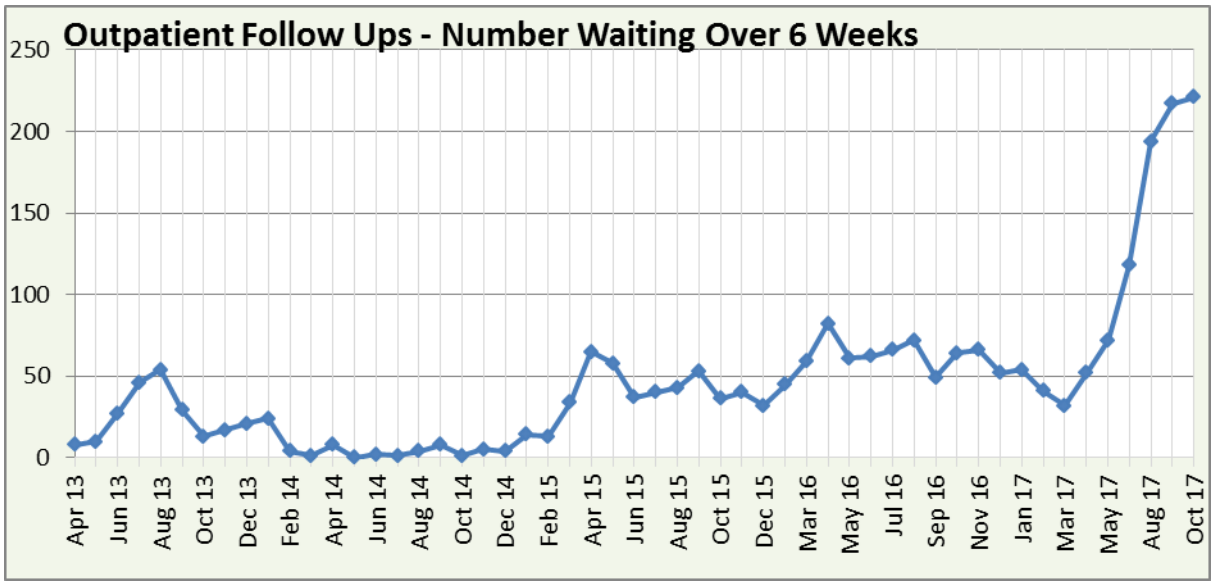
Plans to reduce waits

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 -

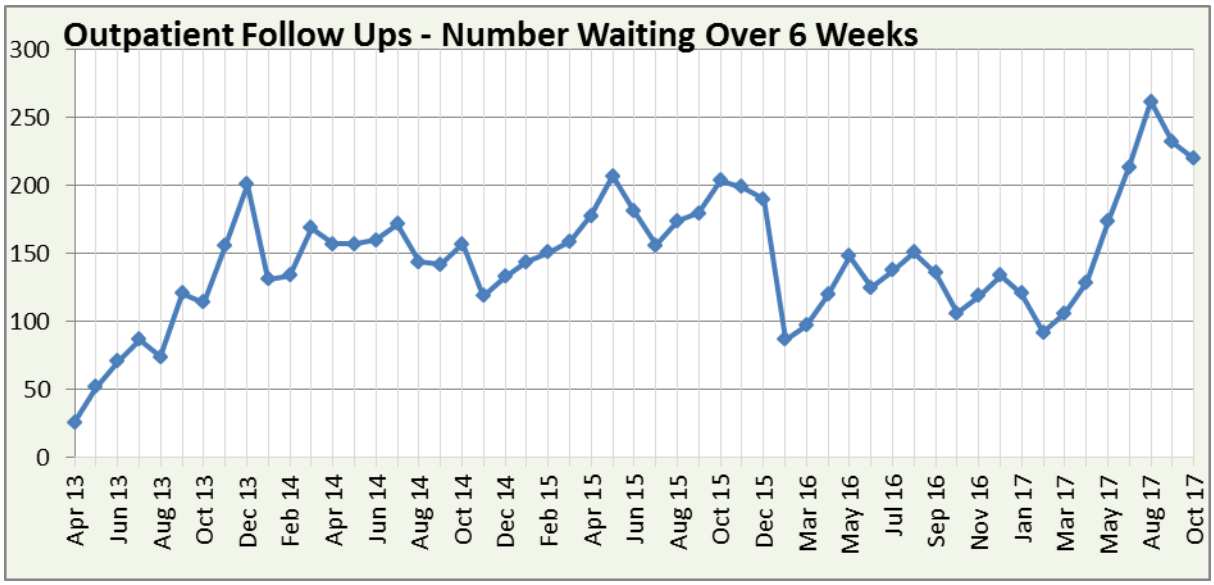
To actively review notes for the 21 patients waiting over 30 weeks

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	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.

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.

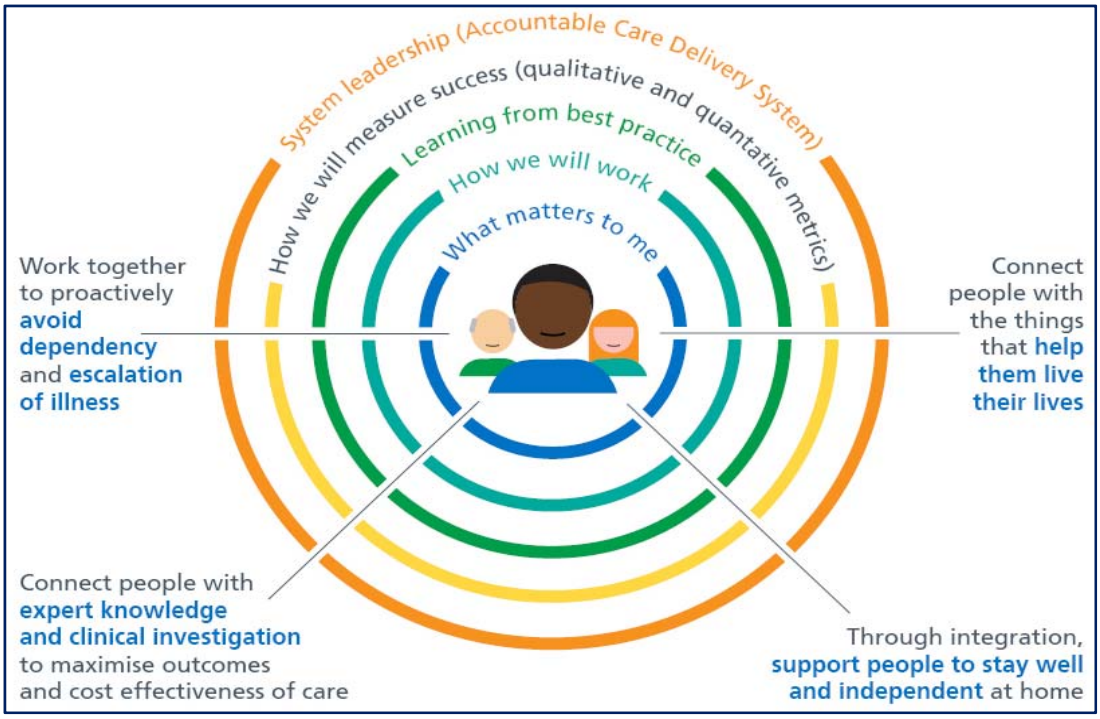
5. Integrated Care Model recommendations

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

Council of Governors

Wednesday 13 December 2017

Agenda Item:	8
Report Title:	Non-Executive Director (NED) Reports
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 As agreed at August's Board-to-Council of Governors meeting, offering governors the opportunity to put questions to the non-executive directors (NEDs).

1.2 The various reports as at attachment one have been presented since September in public Board of Directors' meetings and this is an opportunity for governors to ask questions rather than be advised of their content.

2. Decisions Needed to be Taken

2.1 Opportunity for governors to ask questions rather than receive information from the NEDs. NEDs may be asked by the Chairman to provide any new/appropriate information before seeking questions from the governors. Please note that governor questions put forward in advance of the meeting may be taken first.

3. Attached to this Report

Attachments as presented at public Board of Directors meetings since September's Council of Governors' meeting.

Attachment one - Various NED reports to Board over the past couple of months (in date order).

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	26 September 2017
Report by + date:	Robin Sutton, 27 September 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 5):

1. For assurance, the Month 5 Integrated Finance and Performance report (new format) was reviewed by the Committee. Month 5 remained broadly better than plan with an actual deficit of £3.5m against a planned deficit of £4.3m. Identified potential savings schemes for the year total £35.9m against a cost reduction target of £40.7m and an income generation target of £1.3m. The control total is at risk by a minimum of £6.2m, this is mitigated by potential income of £4m from Torbay Council and £4m of further SDU savings.

2. Performance was reviewed, the delivery of national operational standards for 4 hour ED treatment time being 93.2 % against 92.5% trajectory and a 95% standard, Cancer 62-day performance being 80.6% against a standard of 85%. RTT was 84.1% against a standard of 92%. The number of long waits (over 52 weeks) increased to 19 against a standard of zero. Concern was raised regarding the slippage in delivery which will put STF funding at risk.

3. The NHSI monthly self-certification form for Month 5 was approved by the Committee and will be supported by a financial summary paper.

4. For assurance, a monthly Deep Dive was undertaken by the Committee into the TP financial recovery plan.

5. The business cases for Primary Care GP streaming, Allocate Software and Mortuary Department were noted and approved by the Committee, further detail on the Mortuary Department spend was to be circulated.

6. Updates to the 2018/19 Business Planning Process was presented.

7. Papers on Elective Care Access Trajectory and Improved Better Care Fund were presented to the Committee and received approval.

8. The post implementation review of the ICU Facility was considered by the Committee, the project was delivered £0.1m under the revised budget of £14.9m and 4 weeks earlier than the revised timeline.

9. The latest Finance Risk Register was provided for information and risk numbers 1072 and 1083 were discussed in view of the likely the signing of the risk share agreement.

10. The monthly IMT Group Summary Report was provided for information purposes.

11. The changes to the Trust's Investment Policy was approved by the Committee.

12. The Senior Business Management Team summary report from the 14 September 2017 was provided to the Committee for information.

Key Decision(s)/Recommendations Made:

1) The Committee reviewed its current terms of reference and effectiveness and agreed to revisit these matters at the end of the financial year.

2) The Committee approved the proposal to DH for retaining capital overages from disposals.

Name: Robin Sutton (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	24 October 2017
Report by + date:	Robin Sutton, 25 October 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 6):

1. For assurance, the Month 6 Integrated Finance and Performance report (new format) was reviewed by the Committee. Month 6 remained broadly better than plan with an actual deficit of £2.46m against a planned deficit of £3.88m. Identified potential savings schemes for the year total £41.7m 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 STF funding at risk. Additional cost pressures are being mitigated by further SDU savings.

2. Performance was reviewed, the delivery of national operational standards for 4 hour ED treatment time being 89.9 % against 93.5% trajectory and a 95% standard, Cancer 62-day performance being 85.9% against a standard of 85%. RTT was 84.0% against a standard of 92%. The number of long waits (over 52 weeks) decreased to 16 against a standard of zero. Dementia find had improved to 81.4% from 62.4%. An update was provided on cancer access standards.

3. The NHSI monthly self-certification form for Month 6 was approved by the Committee and was supported by a financial summary paper.

4. For assurance, a monthly Deep Dive was undertaken by the Committee into the Trust's commercial strategy.

5. The business cases for the Mortuary Department, ICU 10th Bed and Cyber Security were approved by the Committee.

6. Updates to the 2018/19 Business Planning Process was presented to the Committee for assurance, this highlighted the likely savings targets required for 2018/19.

7. The Torbay Pharmaceuticals financial report for September 2017 was reviewed by the Committee for assurance.

8. The latest Finance Risk Register was provided for information and for the BAF risk numbers 1050 and 1231 were reviewed and discussed.

9. The monthly IM&T Group Summary Report was provided for information purposes.

10. The changes to the Trust's SFI's Scheme of Delegation and Standing Orders were approved by the Committee.

11. The Senior Business Management Team summary report from the 12 October 2017 and verbal feedback from the EDG meeting on 13 October 2017 were provided to the Committee for information.
Key Decision(s)/Recommendations Made:

Name: Robin Sutton (Committee Chair)

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 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

Council of Governors

Wednesday 13 December 2017

Agenda Item:	9
Report Title:	Lead Governor's Report
Report By:	Lead Governor
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Lead Governor arising since the last Council of Governors meeting on 22 September 2017.

2. Main Report

2.1 **Farewell to some of our Governors** – On behalf of the Council of Governors and Foundation Trust staff I would like to say a big thank you to those governors who have volunteered their time over many years and who have contributed in many different ways for the benefit of the Trust, the community in which it serves and more importantly our patients, clients and service users. We are sorry to see the following governors leave on 28 February 2018 and wish them all a healthy future:
- Cathy French, Teignbridge Governor\Lead Governor, full nine years in office;
- Sue Whitehead, Teignbridge Governor, one-year term; and
- Diane Gater, Staff Governor, three-year term.

2.2 **Appointment of new Non-Executive Directors (NEDs)** – On behalf of all the governors I would like to welcome our two new NEDs to the Trust; Paul Richards who started in November and Vikki Matthews on 1 December 2017. Both NEDs have been appointed for three years subject to annual performance reviews.

2.3 **Non-Executive Director Development Session with Governors** – In accordance with the agreed Governor Involvement Strategy (section 2.10) the Board-to-Council meeting scheduled for **21 March 2018** has now become a development session between the NEDs and governors. If any governors would like to put forward ideas, suggestion or topics for the session then please contact the Lead Governor and/or Deputy Lead Governor.

2.4 **Election of New Governors** – Elections for 2018 are due to commence shortly and in preparation for this, the Deputy Lead Governor and I have reviewed the information given to prospective candidates and have asked for some changes to be made. An 'election open day' is being arranged to support this round of elections to enable interested candidates to visit the Trust and hear first-hand from current governors on their role and experiences. On completion of the elections, it is proposed that the 'buddy' system is re-energised to offer the best possible support to new governors.

On behalf of the Council of Governors I would like to offer our best wishes to Barbara Inger and Lesley Archer who are standing for re-election.

2.5 **Holding to Account** – As per September's meeting, this item will be covered in private session. The Nominations Committee had to re-arrange its meeting from 21 November to 12 December hence a verbal update and one small slide for approval will be given at this Council of Governors' meeting.

2.6 **Constituency Reports** – Attached to this report are the latest constituency reports. Thank you to everyone who has taken the time to meet and produce their summaries. There will be an opportunity to discuss and agree the key priorities from all the reports and the Governor only meeting and then more formally at December's Council of Governors.

2.7 **NED Appraisal Process** – As at attachment two a new NED performance review process has been created by members of the Nominations Committee. Governors will be asked at the meeting to approve this process.

2.8 **Chairman's Appraisal Process** – As at attachment three a revised Chairman's appraisal process has been updated by members of the Nominations Committee. Governors will be asked at the meeting to approve this process.

2.9 **South West Governors Exchange Network (SWGEN)** – Craig Davidson, Annie Hall and myself attended the SWGEN on Tuesday 28 November 2017. A separate report has been circulated to all governors via email.

2.10 **Governor Involvement Strategy** – The document has been uploaded to the Trust's public website and is located in the 'Becoming a Governor' section.

2.11 **Governor Involvement Strategy Focus Group** – Any governor who is interested in taking part in this focus group is asked to contact the Lead Governor or Deputy Lead Governor.

2.12 **Governor portal (Ask)** – The Deputy Lead Governor will give a verbal update on this new development at the meeting.

2.13 **Promotion of Governors** – As at attachment four, a new governor poster has been designed to take us through to the early part of 2018 and will be promoted around Torbay Hospital and its satellite sites. The same design will be shown on all the Trust's television screens e.g. in the Horizon Centre and the new main entrance.

2.14 **Healthwatch** – On behalf of all the governors I would like to thank Pat Harris for attending today and for giving us the opportunity in the very near future to work more closely together.

2.15 **Governors meeting with the Senior Independent Director (SID)** – Thank you to all those governors who were able to attend the second session on 4 December 2017. Opportunity for governor feedback will be made available at December's governor-only meeting and then with the SID present at the private session of the Council of Governors.

2.16 **Governors Christmas lunch** – 11 Governors have confirmed. A couple of NEDs are hoping to join us as well as staff from the Foundation Trust Office.

2.17 **December's Governor-only meeting –** A brief agenda will be circulated before the meeting.

2.18 **Governor self-assessment session in February 2018** – This is an opportunity to look back at what went well for governors and to discuss what could be improved. It is also an opportunity to look ahead for 2018/19 and agree the Council of Governors' priorities. If any governors would like to put forward ideas, suggestions, topics for the day etc. then please contact the Lead Governor and/or Deputy Lead Governor.

3. Recommendations

3.1 As at section 2.3, any governor who would like to put forward ideas, suggestion or topics for the NED development session in March 2018 is asked to contact the Lead Governor and/or Deputy Lead Governor.

3.2 As at section 2.7, the Council of Governors accepts the Non-Executive Director performance review process.

3.3 As at section 2.8, the Council of Governors accepts the Chairman's appraisal process.

3.4 As at section 2.11, any governor interested in putting themselves forward for the Governor Involvement Strategy Focus Group is asked to contact the Lead Governor or Deputy Lead Governor.

3.5 As at section 2.17, if any governors would like to put forward ideas, suggestions, topics for the self-assessment session in February then please contact the Lead Governor and/or Deputy Lead Governor.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above/attached.
4.2 Approve the recommendations as at section 3.

5. Attached to this Report

Attachment one	-	Constituency reports from South Hams and Plymouth, Torbay and Teignbridge.
Attachment two	-	Draft performance review process for non-executive directors.
Attachment three	-	Draft appraisal process for Chairman.
Attachment four	-	Governor promotion.

Torbay and South Devon NHS
NHS Foundation Trust

CONSTITUENCY REPORT

Constituency:	South Hams
Meeting date:	Mon 4 Dec 2017
Governors present:	Simon Wright (SW) Peter Coates (PC) Craig Davidson (ACD)
Apologies:	None
Author of the report:	ACD

Agenda

1. Governors expressed their delight at progress of fellow governor who is expected to be discharged home for Xmas.

2. Minutes of meeting 11 Sept were reviewed.

   Matters arising : There has been a recent recirculation by CCG of SWAST categorisation of call outs and planned response times that had been launched mid year. Plans to request audit data to reflect the new arrangements in early 2018. Action ACD. SW commented on the failure of SWAST phone connections over the previous weekend due to a power cut. This has led to considerable disruption to callers trying to contact the emergency services.

3. Governor observer roles.

   ACD had stood in on one Audit & Assurance meeting and has taken over from Andy Proctor as observer on Quality Improvement Group. Concerns: New Data Protection Regulations in May 2018 are of major concern to many organisations. Auditors report the ICO "average" in preparedness.

4. Implementation/Dartmouth Health & Wellbeing Strategy Group meeting 22 Aug.

   Wendy Marshfield & Carol Day had represented COG. This, the first meeting of Strategy group, had been concerned with setting the scene for multi-agency working in the future and nothing contentious was discussed. The Implementation meeting that followed was, however, uncomfortable with a local councillor strongly expressing his anger at the way the ICO had handled advertising for a new care home provider and the closure of the IC nursing beds that had followed an unscheduled CQC inspection. ACD expressed disquiet and disappointment that governors were not being kept up to date by the ICO. SW & PC agreed.

5. **Updates from PPGs**
   PC reported that Chillington PPG largely happy. Ongoing concern over border issues with Plymouth. Electronic booking been rolled out at Norton Brooks. ACD reported that DMP had invited patients to sign up for e communication. Around 50% of those looking at new web site (800) had signed up. It was envisaged this would be a welcomed development eg patient can see results of investigations but some concern that might lead to more work for GPs when patients queried insignificant abnormalities. Metrics on all GP surgeries in South Devon were made available at the PPG meeting which made for interesting reading.

6. **Increasing links with constituency/Members**
   This had been discussed at recent SW Governors Study day (reported fully elsewhere). General view that was expressed was that hearing about individual concerns was less useful than triangulation through contact with GP practices, PPGs, the voluntary sector and local press. Some asked whether Members views should be valued above those of the general public.

7. **Governor matters**
   Support for mentoring of new governors was expressed and the hope that strengthening of the constituencies would strengthen COG and its effectiveness.

Date of next meeting. 19/2/18 10.0-12.0

Agenda items for Council of Governors, Board to Council Meetings

Name: Craig Davidson

Theme/subject: Communication with governors and with the general public.
Source e.g. Constituency meeting, PPGs, personal experience.

The recent failure to advise governors on specific news concerning Riverview had exposed inadequate communication by the ICO to its constituency governors. What plans does the ICO have to communicate more effectively? This question has been submitted previously but we are not aware of a response.

Theme/subject: Riverview development.

Governors continue to be concerned at the failure to see progress and alarmed at the negative effect each set back causes to the general public's perception of the Trust.

Details of Governor visits/external work

1. Implementation meetings.

2. Contact with Dartmouth Medical practice, Dartmouth Caring and Norton Brooks PPG

3. SW Governors study day, Taunton Nov 2017.

Matters requiring attention importance level (high) (medium) (low)
Please indicate

High The Governors seek assurance that the ICO is aware of the importance of communication and enquires how it plans to more effectively communicate with the media, with governors and with the general public?

<u>Topics of interest/agenda items for next constituency meeting</u>

1. Invite Care Home provider (Action SW).

2. Riverview implementation.

Minutes sent to Trust office for information/circulation 7/12/17

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

CONSTITUENCY SUMMARY SHEET

Constituency:	Teignbridge.
Meeting date:	27.11.17
Governors present:	Carol Day, Sylvia Russell, Annie Hall, Sue Whitehead, Barbara Inger, John Smith, Cathy French. In attendance: Richard Baker (Teignmouth Hospital Manager) and Gerald Lavers (Chairman of League of Friends).
Apologies:	David Parsons
Author of the report:	Cathy French

Agenda

1. Welcome
Cathy welcomed everyone to the meeting and thanked Richard Baker for hosting the meeting and for providing hot drinks.

2. Approval of Minutes of last meeting dated 4.9.17 held at 16 Beechwood Avenue (hosted by Annie)
Main concerns were about the mortuary organ donation and changes to the data protection act (report to Board covered).

3. Feedback from the constituency (all)
Gerald explained the role of the Teignmouth LOF. Since 2001 they had spent £1,284,472.86 on equipment for the Hospital. A further £22,594.84 had been committed for a Radio Frequency Generator, Physio Equipment, Portable ECG and a Roc.
Coaguchek. Gerald explained that departments or individuals approached the LOF committee with requests for funding. He said he had been unable to see the statistical evidence that the proposed rehabilitation beds were no longer needed. It was agreed to pursue this matter on his behalf.
Sylvia told us that there were no nursing home beds in Teignmouth and patients had to go to Dawlish or Newton Abbott. It was agreed to ask how many Teignmouth people had needed to do so.
Also, there used to be 40 residential care homes and now there were 10. It was agreed to ask what "spot contracts" there were in Dawlish and Teignmouth. Cathy thanked Gerald for coming to speak to us.
Gerald left the meeting.
Richard told us that the new information centre was having a positive effect on the community. We saw people waiting as we entered the hospital with a volunteer using an interview room. There was a diversity of leaflets on display.
Richard left the meeting.

4. Feedback from Governor Observer roles
John had given up his role as an observer on the Finance Committee.
Neither Annie or Sylvia held observer roles.
Carol had attended 2 meetings at Torbay Pharmaceuticals (meetings confidential) including an open debate concerning interviews.
Barbara (observer Equality and Diversity) had been told that she wasn't expected to attend a recent meeting.
Cathy had attended the monthly meetings of the CIEG. Her main concern remains our vulnerability to cyber-attack because of the ever shifting nature of the threat.

6. Concerns raised needing attention/explanation
a/ Teignmouth. The statistical evidence that we do not need rehabilitation beds in Teignmouth Hospital.
b/ Does the Trust have spot contacts? Teignmouth and Dawlish?
c/ What will happen to the legacy money if Paignton Hospital closes?

7. Any Other Business
Barbara volunteered to be the Lead for the group. This was agreed.

Date and time of next meeting – to be advised.

Minutes of this meeting (Author) Cathy French. 5.12.17

Agenda items for Council of Governors, Board to Council Meetings

Name:

Theme/subject:

Source e.g. Governor direct, Constituency meeting or Constituency member

Details of Governor visits/external work

1.

Matters requiring attention importance level (high) (medium) (low)
Please indicate

Topics of interest/agenda items for next constituency meeting

1.

Minutes dated …….Circulated to Trust office, Lead Governor / other Governors.

Yes **No**

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

Torbay and South Devon NHS
NHS Foundation Trust

Torbay Constituency

Meeting Date:	November 22, 2017 Boardroom Torbay Hospital
Governors present:	WM, LH, BB, PL
Apologies:	AP
Author of the report:	PL

Agenda

1.Welcome

2. Approval of Minutes of last meeting (6/9/17)

3. Agenda items for 13 Dec CoG

4. Appoint new chair / focus group member

5. Appoint minute taker

6. Christmas lunch / cards

7. Stakeholder group membership

8. CQC inspection

9. PPG liaison

AOB

Date and time of next meeting

Minutes of Meeting (PL)

WM welcomed the members, via tele conference facilities and gave apologies for AP

Minutes of last meeting approved by the members present

Matters arising;

- Mears contract, WM updated meeting, still ongoing concerns, Liz Davenport and CQC, monitoring

- Charitable funds, LH updated and said Rob Dyer had offered a seat. WM also updated the group present and stated that work is ongoing
- Readmissions, rates no higher and current position reported to board. WM advised that CEO is currently doing a deep dive into this
- Membership survey, additional input was made by CEO and Richard Scott, prior to questionnaire going out, for which we were grateful

3. WM advised that this was discussed this morning at Q&C meeting, inviting Qs to be sent in advance to WM

4. No agreement reached re vacant chair position, so will be managed for the foreseeable future on a rolling basis. BB to consider focus group position and pick up with WM when she is back in town.

5. Minute taker for time being to be appoint at the start of each meeting. PL agreed to take minutes for today's meeting

6. WM suggestion that instead of Christmas cards this year we consider giving an individual donation to the LoF. Felt this was a great idea but those still wishing to give cards could do both or still just give card. Left to the discretion of individuals

7. With no current feedback LH agreed to seek Richard Scott's help with how best to proceed

8. WM mentioned that this was fully discussed in the Q&C meeting this morning and plans were well in place. As Governors we will have a part to play in this, so it is vital that we are all fully aware of the values and principles. WM is seeking out what Qs were asked last time and with help from Jenny we can provide some guidance on what Qs we may be asked.

9. Nothing to report back. LH was still working hard to arrange a meeting with her local PPG, PL has a meeting with the Brunel PPG on 23rd so will be able to report back at our next meeting. BB still has regular interactions with his residents.
BB reported back on his recent DAG meeting which was well attend, and many actions set have now been delivered
Peer review undertaken at Dawlish reported by LH

AOB

WM raised the need for dedicated observers and ideally nominated deputies for each key group meeting. Too many going unobserved. Collectively we have a responsibility to support these groups

Feedback from the constituency;

Following concerns raised again at our last meeting by BB, WM reiterated that normal procedures to be strictly adhered to, but concerns were still being considered.

Feedback from Governor observer roles, sent to members following Q&C meeting

Next meeting to be scheduled for February 2018 TBA

Source e.g. Governor direct Constituency meeting or Constituency member

Details of Governor visits/external work

1 Peer review at Dawlish covered above. BB recent DAG meeting covered above

Topics of interest/agenda items for next constituency meeting

1. Chairperson vacant position plus that of note taker
2. Focus group member update
3. Stakeholder update from LH following her proposed meeting with RS

Minutes dated …….Circulated to Trust office, Lead Governor and all other Governors.

Yes No

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

Non-Executive Director (NED) Annual Performance Reviews

Timetable 2017-18

Ref	Provisional Process	Dates
1.	Nominations Committee, led by the Chairman, discusses and agrees the draft process for the NED annual performance reviews.	21 November 2017
2.	Council of Governors (CoG) agree the process for evaluating the NEDs.	13 December 2017
3.	Corporate Governance Manager (CGM) confirms the performance review date for each NED. Chairman and Lead Governor informed as present at each of the reviews.	Complete
4.	Lead Governor invites each of the constituencies to provide NED feedback using an agreed template.	w/c 15 January 2018
5.	Lead Governor reviews the constituency feedback and writes to the Chairman about each NED with suggested areas for discussion.	w/c 12 February 2018
6.	NED performance reviews with the Chairman and Lead Governor. The Chairman will lead on setting objectives for the NEDs and carrying out the performance reviews. NED annual declaration to be signed at this point in the process.	Two weeks w/c commencing 19 March 2018
7.	Chairman reports back to the Council of Governors on the NED performance reviews. Chairman confirms to the governors that each NED continues to be effective and demonstrates commitment to the role. The governors should agree the outcome of the evaluations.	18 April 2018
8.	Nominations Committee is informed of the individual NED objectives.	30 April 2018 via NHS email
9.	Nominations Committee, led by the Chairman, conducts mid-year review of each NED's objectives.	To be confirmed
10.	Chairman reports back to the Council of Governors on the NED mid-year reviews.	21 September 2018

Chairman's Annual Appraisal

Timetable 2017-18

Ref	Provisional Process	Dates
1.	Nominations Committee, led by the Lead Governor, discusses and agrees: • Draft process for Chairman's annual appraisal; • Who will conduct the appraisal?	21 November 2017
2.	Council of Governors (CoG) formally approves the Chairman's annual appraisal process.	13 December 2017
3.	Corporate Governance Manager (CGM) sets date for future Nominations Committee, Chairman's appraisal and informs relevant people.	31 December 2017
4.1	Draft letters for approval: Jacqui Lyttle, Senior Independent Director (SID) and Wendy Marshfield, Lead Governor (LG)	31 December 2017
4.2	Agree feedback questions for Chairman's appraisal – SID/LG/CGM	31 December 2017
5.1	Lead Governor to issue letter and feedback questionnaire to all governors. Return date	5 January 2018 15 January 2018
5.2	SID to issue letter and feedback questionnaire to all Board members Return date	5 January 2018 15 January 2018
6.1	Corporate governance manager to circulate anonymised comments to SID and LG	w/c 29 January 2018
6.2	SID and LG meet to discuss anonymised feedback from governors and Board members.	w/c 5 February 2018
7.	SID and LG send letter inviting Chairman to appraisal meeting including anonymised feedback and suggested areas for discussion.	w/c 12 February 2018
8.	Chairman to acknowledge SID/LG letter and respond accordingly.	28 February 2017
9.1	Nominations Committee, led by the Lead Governor, meets to discuss the Chairman's performance against his objectives (as agreed at CoG - April 2017).	Date to be confirmed
9.2	SID and LG conduct formal appraisal meeting with Chairman. The SID is expected to lead the actual appraisal. The focus of the Chairman's appraisal will be his performance as chair of the Board of Directors. Since the primary aim of the Chairman's work will be to lead the directors in executing the Trust's forward plan, the appraisal should consider carefully the Chairman's performance against pre-defined objectives supporting that aim**. Chairman's annual declaration to be signed at this point in the	Date to be confirmed

	process.	
9.3	Post-Appraisal meeting action:- • LG to confirm outcome with CGM. • Copy to Company Secretary for Council Governors meeting, April 2018. • Copy to Nominations Committee members (excluding the Chairman). • Copy to Chairman.	
10.1	SID/LG reports back to CoG on Chairman's appraisal process. SID should confirm to the governors whether, following the formal performance evaluation, the performance of the Chairman continues to be effective and demonstrates commitment to the role.	18 April 2018
10.2	CoG formally agrees Chairman's 2018/19 objectives.	18 April CoG
11.	SID/LG conducts mid-year review of Chairman's objectives.	To be confirmed
12.	SID/LG reports back to the Council of Governors on the Chairman's mid-year review.	21 September 2018

**Ref item 9.2 - *The fact that the focus of the Chairman's appraisal will be his performance as Chair of the Board of Directors does not mean that appraising the Chairman's performance as the chair of the Council of Governors is not a highly relevant part of the appraisal. Rather, it reflects the 2006 Act, which states that the Chairman of the Board of Directors also chairs the Council of Governors (and not the other way around), and the fact that it is for the governors to appoint, and remove, the Chairman and the other Non-Executive Directors. That said, the appraisal process should still be used to evaluate all relevant performance issues, including those relating to the Council of Governors, but these should not be the main issues for consideration in relation to re-appointment of the Chairman, in their capacity as a Non-Executive Director.*

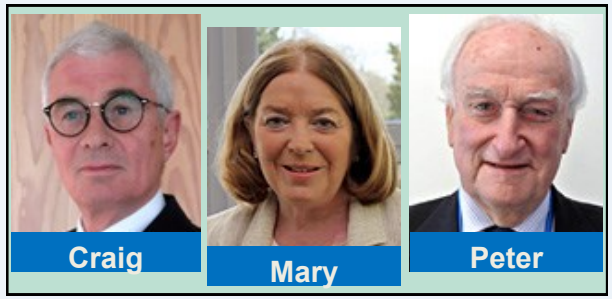
Page 25 - Your statutory duties - A reference guide for NHS Foundation Trust Governors, August 2013. Parallel

Your Foundation Trust Governors

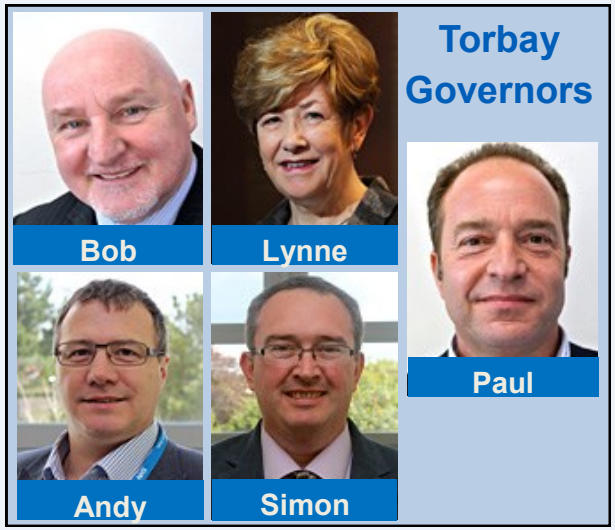
Torbay and South Devon NHS Foundation Trust

email foundationtrust.tsdft@nhs.net or visit www.torbayandsouthdevon.nhs.uk/

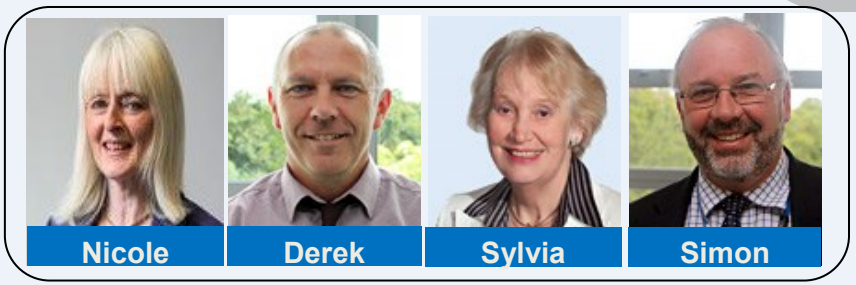
South Hams and Plymouth (eastern area) Governors



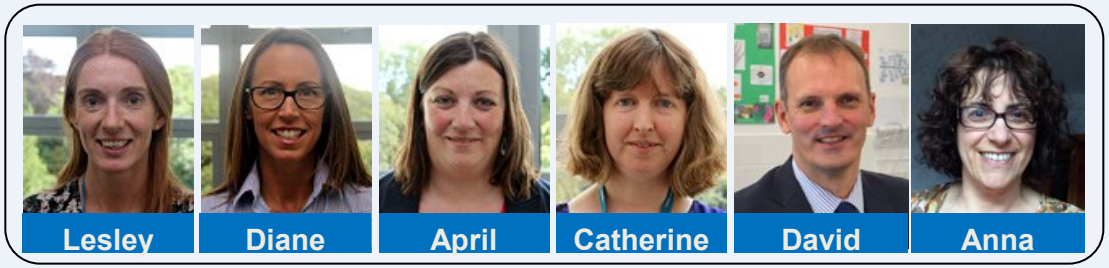
Torbay Governors



Appointed Governors



Staff Governors



Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 13 December 2017

Agenda Item:	10
Report Title:	Quality and Compliance Committee Report
Report By:	Wendy Marshfield
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Update report of the Quality and Compliance Committee (Q&CC) following their most recent meeting on 22 November 2017.

1.2 The draft notes of November's meeting are attached to this report.

1.3 The Chair of the meeting (Wendy Marshfield) will give a short verbal update on the day of the meeting.

2. Recommendations

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

2.2 The governors who are not currently observers of committees/groups are asked to contact the Lead Governor or Deputy Lead Governor to indicate interest.

3. Decisions Needed to be Taken

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

4. Attached to this report

Attachment one - Draft notes of November's Q&CC meeting.

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE QUALITY AND COMPLIANCE COMMITTEE MEETING

HELD IN THE BOARDROOM, TORBAY HOSPITAL

AT 10AM ON WEDNESDAY 22 NOVEMBER 2017

---

* Craig Davidson (CD)
* Lynne Hookings (LH)
* Wendy Marshfield (WM) – Chair (dialled in)
* John Smith (JS)
* Cathy French (CF)
* Paul Lilley (PL)
  Andy Proctor (AP)
  Sue Whitehead (SW)

*Denotes member present

In attendance
Jennie Dodge, Quality Assurance and Patient Safety Lead CCG (QAPSL)
Susan Martin, Quality Lead (QL)
Judy Falcão, Director of Workforce and Organisational Development (DWOD)
Carol Day (CDay)
Richard Scott, Company Secretary (CS)
Monica Trist, Corporate Governance Manager (CGM)
Jenness Barber, note taker (JB)

Action

1 Apologies

Apologies were received from Andy Proctor and Sue Whitehead.

2 Minutes of the last meeting

The minutes of the last meeting dated 6 September 2017 were **agreed** as accurate with the following amendment:

Agenda item 3, page 2, paragraph 4

WM reminded colleagues that the Trust ~~does know~~ had not known the value of equipment in the Trust and that this had been identified at Quality Improvement Group (QIG)

Matters arising

There were no matters arising.

3 Director of Workforce and Organisational Development

WM welcomed Judy Falcão, Director of Workforce and Organisational Development (DWOD), to the meeting.

DWOD has been in her role since August 2016 and has a broad portfolio which includes:

- HR services / payroll / pensions / workforce planning
- Organisational Development: Health and Wellbeing / management of leadership and development / organisational change / equality and inclusion
- Sustainability and Transformation Partnerships (STP): Corporate Services review / Chairmanship of Staff Partnership Forum
- Providing payroll services to Yeovil District Hospital and the CCG
- Providing HR advisory services to GP's

DWOD explained the structure of the meetings in that the Workforce and Organisational Development Group sits at the top and subgroups include Temporary Staffing / Equality. Medical Workforce have various forums and Workforce Board reports go to the Executive Director's meeting for check and challenge prior to Board.

Workforce Key Performance Indicators (KPI's) such as sickness reports go to line managers and these reports are collated to see how the organisation is performing and to make sure there is a sustainable workforce for the future.

DWOD is looking at how services could work differently through networking and investment in developing senior leaders skills and capabilities such as the HOPE programme – Helping Overcome Problems Effectively.

The Health and Wellbeing Strategy was a piece of work undertaken a couple of months ago which looked at staff sickness absence. The most common cause of sickness absence used to be back problems but the main reasons at the moment are mental health issues.

Estates and Facilities have tested a new recruitment model recently which included value based recruitment and this was very successful.

There has been the launching of the Achievement Review which replaces the staff appraisal. It has been changed so that staff take more ownership of their own appraisal process. The Staff Survey asked questions about whether or not have they had appraisals and also are they of value. Answers were taken on board and the Achievement Review was developed from this. The key risks are to ensure that the organisation attracts and maintains staff.

Work has been ongoing for the delivery of workforce cost improvement programmes and to drive down agency costs.

WM left the meeting at this point.

Some questions were put to DWOD.

- CF asked about the English language test that foreign nurses have to take to become employed in Great Britain and asked if this was putting some nurses off.
  DWOD said this is a national test and has become more difficult. Recruiting some foreign nurses can take up to 12 months for the completion of the recruitment process. A lot of support was offered to help them pass the test. Difficulty of the test has been raised nationally.

- CF asked if there was support for staff with mental health issues.
  DWOD said that this is managed at a local level with appraiser training.

- PL asked about contracting out of services and available resources to

undertake this work.
DWOD said that payroll services and HR advisory services to GP's generates income for the Trust – temporary staff may be recruited to deal with this work if required.

- JS asked how do foreign nurses approach the Trust. DWOD confirmed that Trust staff had been out to the Philippines to identify recruitment opportunities.

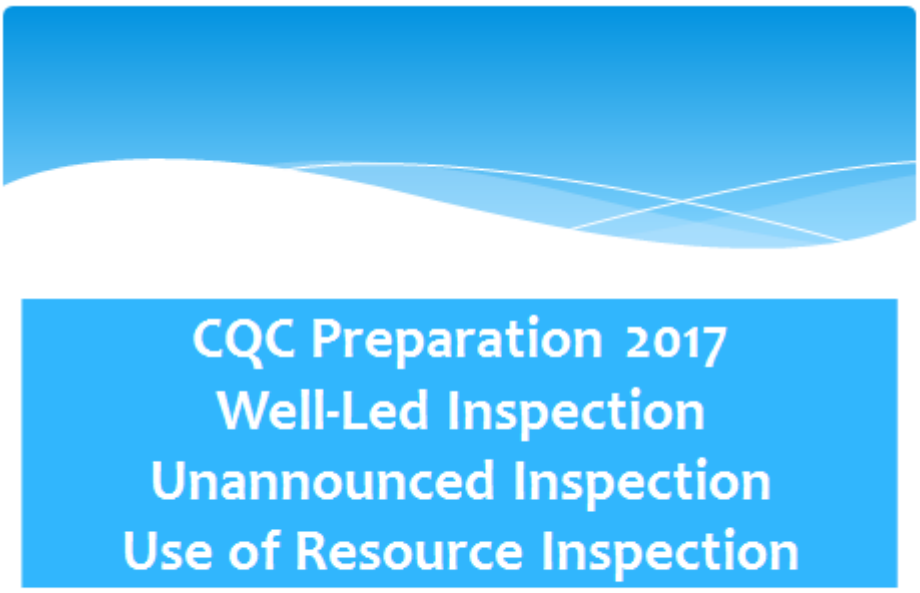
- CD asked about the HOPE programme.
  DWOD said that anyone can attend this programme which includes evaluation steps throughout and has a follow-up review after six months. DWOD had attended a recent training session herself and found it most interesting.

- PL commented that having sat on Workforce and Organisational Development Group last week there was a huge amount of work and challenges ahead and was pleased with all the different initiatives being trialled.

There were no more questions and the group thanked DWOD for attending the meeting.

4 CQC update

QAPSL informed the group that two inspections are forthcoming – one unannounced and one Well-led (the Well-led gives six weeks' notice).
QAPSL gave the following presentation:



Well-Led Framework Background

Recognised challenges;

- Expectation to improve performance and existing operations, in a context of rising demand for services and constrained funding.
- Expectation to join up local health and care systems through working with local system partners on sustainability and transformation plans (STPs).
- Not enough leaders with the skills and experience to address these challenges.
- Many organisational cultures still need strengthening. Nationally, NHS staff surveys show high levels of stress, bullying and discrimination at work.

The new framework integrates the structure and content of CQC's current five KLOEs with the ten questions in Monitor's well-led framework to create a new set of eight KLOEs;

Well-Led Framework Key Lines of Enquiry

Well-Led Framework
Gap Analysis

* Currently being completed

Well-Led Framework
Current Well Led Domain

	Well Led Domain				
CQC Service	Inadequate	Requires Improvement	Good	Outstanding	Not Assessed
Community Adult Social Care	0	0	1	0	0
Community Health Services	0	0	1	0	0
Substance Misuse Services	0	0	1	0	0
Children & Young People	0	3	1	0	0
Community Health Services	0	0	11	0	8
Critical Care	0	0	1	0	0
End of Life Care	0	0	2	0	0
Maternity & Gynaecology	0	4	1	0	0
Medical Care	0	0	11	0	5
Neonatal Services	0	0	0	0	0
Outpatients & Diagnostic Imaging	0	2	15	0	1
Primary Medical Care	0	0	5	0	5
Substance Misuse Services	0	0	1	0	0
Surgery	0	0	9	0	0
Urgent & Emergency Services	0	0	3	0	2
Total	0	9	63	0	21

Well-Led Framework
What does outstanding look like?

The Newcastle upon Tyne Hospitals NHS Foundation Trust

* Financial pressures were managed so that they did not compromise the quality of care.
* The trust actively promoted projects to support patient choice.
* Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff.
* The trust had a 'Freedom to Speak up' action plan in response to the Francis Report, which was monitored by the Trust Board.
* The trust had introduced Schwartz Rounds which provided a confidential forum for staff reflection and support. Seven Schwartz rounds were held up to almost 600 staff had attended the first seven rounds.

Well-Led Framework
What does outstanding look like?

Northumbria Healthcare NHS Foundation Trust

* Business Units held their own governance meetings with services and submitted quarterly integrated governance which showed evidence of review of incidents, complaints and risk registers.
* There was a 'can do' culture that is evident across the organisation with staff encouraged at all levels to make changes to services that would improve the quality of care to patients.
* Staff described 'The Northumbria Way' which was evident at all levels throughout the organisation. This focussed on engagement; patient and staff experience; trust values and communication.
* In critical care services, staff had been involved and engaged with the development of the new unit and it was clear that the leadership team had prepared staff well for the change.

Well-Led Framework
Comply or Explain

Trusts are expected to **comply** with a developmental review every 3 years or **explain** how assurance is gained via other routes where reviews do not take place.

Trusts can tailor their approach to developmental reviews – a standard proforma is below;

* Initial investigation to determine scope of review ✓
* Commissioning an external reviewer / Peer input
* Detailed Review
* Board Report & Action planning
* Letter to NHSI
* Implementing the Action Plan

Well-Led Framework
Inspection Summary

* The Well-Led Inspection will be announced- (approximately 12 weeks notice)
* Likely to be a small team of inspectors
* The inspection will involve a number of interviews and focus groups from all levels of staff within the organisation
* Requests for information for Well-Led can include self-assessments, governance structures, meeting minutes and actions etc.

Well-Led Framework Programme for preparation

- A self-assessment has been sent out for completion by Execs (due 31/10/2017) with request for RAG rating and evidence.
- This will be uploaded to the CQC Health Assure system with action plan.
- CQC & Compliance manager attending 3 x divisional boards to present on the well-led domain for their areas.
- CQC & Compliance manager to work with Organisation Development Leads to look for initiatives to promote pride in workforce.
- From December onwards communications team will promote relevant CQC information and staff initiatives as above.

Unannounced Inspection

Areas likely to be inspected are;

Area	Previous Rating
End of Life Care (EOLC)	Requires Improvement June 2016
Maternity & Gynaecology Services	Good June 2016
Outpatients	Requires Improvement June 2016
Community Hospitals	Requires Improvement June 2016

Unannounced Inspection Programme for preparation

* In Q3 EOLC, Mat & Gyn. and Outpatients will undergo a walkaround using the Clinical Quality Assessment Tool (CQAT). This will include various staff groups / levels and will require engagement with staff and patients.
* A review of each areas must do / should do actions from June 2016 CQC inspection with evidence of embedded actions as business as usual.
* Review of Provider Information Requests for each area to be refreshed in readiness for inspection.
* Targeted support to staff members in relation to preparing for interviews / focus groups.

Resources Framework & Inspection

Further to the Well-Led Framework CQC will be looking at NHSI's Use of Resources framework to ensure Trusts are using resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review.

This inspection is likely take place alongside the Well-led Inspection but will not take place alongside an announced / unannounced routine inspections.

An assessment team will undertake an analysis of trust performance against:

* a selection of initial metrics
* local knowledge of the trust
* other relevant evidence, such as Model Hospital data

A small team from NHS Improvement will then carry out a one-day site visit to interview the senior leadership team on the organisation's use of resources. Following this a brief report will be compiled and recommendation of rating will go to CQC.

Resources Framework
Key Lines of Enquiry KLOEs

Area	Key Lines of Enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical Support Services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate Services, procurement, EFM	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

Resources Framework
Rating Characteristics

Rating	Description
Inadequate	The trust is not making adequate use of its resources, putting at risk its ability to provide high quality, efficient and sustainable care for patients.
Requires Improvement	The trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.
Good	The trust is achieving good use of resources, enabling it to provide high quality and sustainable care for patients
Outstanding	The trust is achieving excellent use of resources, enabling it to provide high quality, efficient and sustainable care for patients.

The trust Use of Resources Framework rating will not affect the overall CQC rating and will be reported separately.

WM rejoined the meeting at this point.

4.1 KLoE's linked to committees/groups

WM reported that the governor observer reports for the committees and groups have now been updated with new KLOE's. CGM pointed out that the Company Secretary and Jane Viner, Chief Nurse, had looked at the KLoE's and selected which ones would be appropriate for the various committees and groups. It was **agreed** JB would send updated governor observer reports to the governor observers who sit on those various committees and groups. WM thanked CGM and JB for the work undertaken on KLoE's. JB

5. Quality update

QL informed the group that the Annual Quality Accounts Stakeholder meeting will be taking place during the afternoon of 2 February 2018. WM said that she would be attending in her role as Lead Governor and would like another governor from this Committee to attend as well and advised that she will consider after the meeting. At the stakeholder meeting circa five priorities for the Trust will be decided. WM

QL reported that Outpatients performance is proving to be a challenge and that the Executive Directors were thinking of planning a 'lock-in' session to establish an action plan along the lines of the recent ED action plan model.

QL informed the group of progress in the following CQUINS:
- Antibiotics;
- Shortage (national issue); and
- Resourcing.

It was noted that quality improvement work is ongoing.

Members were informed that NHS staff who work in NHS care homes are to have NHS email accounts.

6. Feedback from governor observers

WM acknowledged that the reports are far more comprehensive now and thanked all the governor observers who had written their reports for the meeting.

6.1 Safeguarding/Inclusion Group

Apologies had been noted from SW who is governor observer for this group.

6.2 Quality Improvement Group

CD reported that he attended QIG on 14 November and had no concerns. CD has agreed to cover QIG through to April's Committee Refresh.

6.3 Workforce and Organisational Development Group

PL had no concerns.

6.4 Capital Infrastructure and Environment Group

CF reported that she has some concerns over the following:

- A backlog of maintenance which is not being resolved.
- Gary Hotine (GH) spoke at the last Q&CC meeting of his concerns regarding the recent cyber-attack on the NHS. There is some capital for remainder of 2017/18 but no funding for revenue costs until 2018/19 and has been escalated to the Board.

CD said he feels that IT should be a top priority as the hospital may close if there is another cyber-attack.

QL added that the new links to the GP network brings added risks as well as advantages.

6.5 Finance, Performance and Investment Committee

JS had nothing to add to his reports.

6.6 Quality Assurance Committee

WM reported that RTT had been discussed at QAC.
With regard to Radiology, the services are outreaching 300 patients per month and that a paper is going to the Board in the New Year for replacement of some equipment.

6.7 Audit and Assurance Committee

CD attended 13 October meeting and said there was nothing to add.

6.8 Information Management and IT Group

It was noted that there is no governor observer on this Group.

Post meeting note – CD has now agreed to be Governor Observer on this group.

7. Reports from Non-Members

7.1 Infection Prevention and Control and Decontamination Group

No report for 21 September meeting as apologies were given from David Parsons.

7.2 Disability Awareness Action Group

Report received and noted from Bob Bryant for 20 September meeting.
WM reported that the Group met yesterday.

8. Annual workplan

The workplan was agreed as it was a standard workplan.

9. Prepare/discuss report to Council of Governors (CoG) on 13 December 2017

WM felt the number of governor observer roles should be revisited and will report back to December's CoG.

WM agreed to write her report at the beginning of December and it was **agreed** that Committee members would let WM know if they had anything to add. All

10. Decide which governor(s) attends the stakeholder meeting

Covered in agenda item 5.

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

Ann Wagner (AW), Director of Strategy and Improvement, has given presentations on the development of strategy for the Trust for 2019/20 and it was **agreed** to invite AW to the next meeting on 14 March to discuss strategy, her focus on improvement and how can governors be more involved. JB

AOB

- WM reported that Julien Parrott (Torbay Council Appointed Governor) has been replaced by Nicole Amil.

- It was **agreed** that an action sheet would be useful for this Committee's meetings. JB

- CF suggested that it would be a good idea if each constituency discussed what they would say if spoken to by the CQC during their visit. It was **agreed** CF would send an email to members of this Committee with questions that were asked during their last visit. QAPSL said she would also consider the type of questions that the CQC might put to governors. CF

Details of future meetings

2018

All in the Members Room, Hengrave House

14 March, 2pm – 4pm
13 June, 2pm – 4pm
7 September, 10am – 12pm
14 November, 2pm – 4pm

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 13 December 2017

Agenda Item:	11
Report Title:	Membership Group Report
Report By:	Lynne Hookings (Chair of Membership Group)
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Current update on the work of the Membership Group.

2. Background Information

2.1 The Membership Group meets on a quarterly basis (February, May, July and November) to consider and take forward the requirements placed on it by the Council of Governors. November's meeting had to be cancelled at short notice and was rescheduled for December.

2.2 Attachment one refers to the draft notes of December's meeting for your reference, information and approval. Unfortunately, the meeting was not quorate therefore recommendation one below asks the Council of Governors to agree all of the recommendations contained within the attached notes.

2.3 A verbal update on progress and outstanding items will be given by the Chair of the Membership Group at the Council of Governors meeting.

2.4 Attachment two contains the results of the recent public membership survey. Three additional reports for each of the three public constituencies are being created and will be shared with governors as soon as possible. The report provides all governors with the opportunity to see all of the feedback from those Foundation Trust public members who completed the online questions. Section 8 within the attached notes recommends that time is set aside at February's self-assessment session to agree the priority areas from the survey.

3. Recommendations

3.1 Council of Governors approves all of the recommendations within the attached notes.

3.2 Council of Governors supports the current work of the Membership Group.

4. Decisions Needed to be Taken

4.1 Comment and receive the report/attached information.

4.2 Approve the recommendation outlined above.

5. Attached to this Report

Attachment one - Draft notes of December's Membership Group meeting.
Attachment two - Results of the 2017 Membership Survey

Torbay and South Devon NHS
NHS Foundation Trust

NOTES OF THE MEMBERSHIP GROUP MEETING

HELD AT 10AM ON FRIDAY 1 DECEMBER 2017

IN TUTORIAL ROOM 2, HORIZON CENTRE

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* Cathy French (CF)
* Lynne Hookings (LH) – Chair
  Mary Lewis (ML)
  Staff Governor

* Denotes member present

In attendance
Claire Rowe, Communications (CR)
Richard Scott, Company Secretary (CS)
Monica Trist, Corporate Governance Manager (CGM)
Jenness Barber, note taker (JB)

		ACTION
1	**Apologies** Apologies were received from David Hickman, Mary Lewis, Catherine Micklethwaite, Anna Pryor. It was noted that due to apologies the meeting was not quorate and therefore any decisions will be taken to the next Council of Governors meeting.	
2	**Minutes of the last meeting held on 22 August 2017 and action tracker** The notes of the last meeting held on 22 August 2017 were confirmed as accurate. See separate action tracker.	
3	**Matters arising** • Discharge pack – there was some discussion as to whether the wording had been agreed at the last meeting. The action from the last meeting was for Membership Group members to send suggestions to CGM. This action remains.	LH/CF
	• It was **recommended** that staff governors work closely with the Director of Strategy and Improvement early in 2018 to agree appropriate questions for a future staff membership survey.	Staff Govs
	• 'Meet the Governors' sessions – it was **recommended** that Governors use the Main Entrance space on Level 4 for the governor stand on a monthly basis and to book this for six months in advance. It was further **recommended** that LH	LH LH

discusses this at the next Governor only meeting to agree a rota for manning the stand. CR offered help with promoting. It was **recommended** that LH agree a timeline with the Lead Governor regarding space at Newton Abbot and Torbay hospitals. Engagement is required across all three constituencies and not just in Torbay. LH

4 Feedback and Engagement Team Report

CGM informed the group that the Feedback and Engagement Team are giving a presentation on their work at December's Council of Governors meeting.

CGM had turned the information from PALS and Complaints into one report and this report was noted.

5 Update from the Working with Us Panel

The report was noted.

There was discussion regarding the understanding of the middle paragraph and it was agreed CS would clarify with the Team. CS

6 Membership recruitment

CR reported that the 'Have your say' campaign has gone up on some TV screens around the Trust e.g. Bayview Restaurant, Horizon Centre and Level 4 Main Reception.

LH was concerned that there was nothing at Dawlish Hospital. CF offered to take some membership cards to Dawlish Hospital at the weekend, however, LH felt that it is important that all membership material is at all public reception points.

CS reported that membership posters had been printed and will be circulated to all wards and community hospitals by 13 December. He went on to confirm that a new poster for the promotion of Governors would also be circulated to all areas / sites. The new poster attached to the Lead Governor's report at December's Council of Governors meeting would also be used on Trust TV screens.

CR continued with her presentation informing the group that an advertising test went live on 26 October which reached 4,578 people on Facebook and 35 clicked through to the final page. The age targeted was 18 to 65 years and there will be one Facebook post every week and two Twitter posts. This is not a costly exercise and Instagram will also be used aiming at 18 to 25 years.

CF asked whether this will link in with Staying Healthy campaign. CR advised links will be completed shortly.

CR reported that staff members are being encouraged by a screensaver in the Trust which asks them to invite family and friends to join. This advert also went into the All Staff Bulletin and on ICON. CR compared figures of new membership in that there have been 65 new members in the first month of advertising whereas there were only 70 in the whole of last year.

CS added that all email members now receive the monthly stakeholder newsletters. It was **recommended** CR would look into whether governors could have a regular slot within this letter. CR

CF suggested including the number of people who have clicked through to reading

about membership in a future report to governors.

CR will be including the advert in the online version of the Herald Express.

CF suggested to CR that she should also contact Matt Fox, GP at Barton Surgery and Lead GP for the CCG. CR

CR said she wanted to add the advert to the CCG and Healthwatch websites and is still working on the youth campaign.

CR reported that she has finished ML's case study and will send to CS for final approval. LH will ask Craig Davidson (South Hams Governor) if he could take a copy to ML. LH

CR would like to talk to a generic FT member and CF advised that she will be a generic member after the end of February next year when her term of office ends. She will have been a governor for nine years and CR felt this should be recognised. CR to discuss with Comms. CR

CS displayed the Foundation Trust Governors picture on screen and confirmed Lead Governor approval had been sought. CS pointed out that posters go out of date very quickly and so would have to be replaced regularly but on screen they can be updated easily. It was **recommended** Governors be used to help keep membership/Governor posters up-to-date around the various Trust locations. LH

CR said she will be adding 'Know your governors' to the Latest News on ICON next week. JB

It was noted that the CS was in the process of buying some card holders for the 'Have your say' cards and to put these on reception desks around various locations. CS said the membership banner was being displayed in Level 4 Main Reception.

CR left the meeting at this point.

LH asked if there were any issues regarding the FT Office budget and CS confirmed no issues at the present time.

LH and CF are keen to advertise membership / Governors on TV screens on an ongoing basis. It was **recommended** that CR talk to the Communications Manager about advertising more frequently without any drop offs in terms of display time away from the screens. It was noted that this should be a consistent message throughout the year and not just a periodic reminder. CR

7 Results of Membership Survey

CS commented that he was very disappointed with the number of responses to this year's survey but it was the first time the Trust had opted for online responses only rather than to use paper/postage and great expense. The Membership Survey link was sent to all 1,000+ email members and there were only 238 responses although most of these responses were measured, structured and thoughtful.

CF suggested selecting six questions from the survey to put on a form for governors' use at any future 'Meet the Governors' sessions.

LH felt concerned about the number of people who did not know what the ICO is and asked what is done with this information. It was noted that there will be an opportunity to re-affirm this lack of understanding in due course.

CS said that Governors will soon receive three separate reports for each of the three public constituencies. This will give each Constituency the opportunity to respond to the Council of Governors.

8 Preparation for 13 December 2017 Council of Governors meeting

It was **recommended** that CS attach the membership survey results (overarching document) to the Membership Group report that is given at December's CoG. It will then be for governors to decide the top priorities from the separate reports. It is **recommended** that time be set aside at the self-assessment session in February to agree the draft priorities before reporting back to the Board of Directors. CS CS/CGM

9 Healthwatch

The report circulated with the papers was noted.

It was also noted that Pat Harris, Chief Executive of Torbay Healthwatch, will be giving a presentation at December's CoG.

10 Any Other Business

None.

Details of next meeting

To be decided.

Trust Members Survey 2017

Torbay and South Devon NHS
NHS Foundation Trust

Full Report

Project Ref 0263

Produced by the Clinical Effectiveness Department, TSDFT

9 November 2017

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For more information about surveys, please contact
The Clinical Effectiveness Department, Bowyer Building, Torbay Hospital, Torquay.

Trust Members Survey 2017
Total Report

For 2017 the survey was conducted exclusively online, with access to the survey available on the home page of the public website

238 responses were received - breakdown by constituency.

			Post Codes
South Hams	32	13%	*TQ6, TQ7, TQ8, TQ9*
Teignbridge	67	28%	*EX6, EX7, TQ11, TQ12, TQ13, TQ14*
Torbay	130	55%	*TQ1, TQ2, TQ3, TQ4, TQ5*
Out of Area	4	2%	
Not completed	5	2%	
Total	238		

Section 1- Your Experience of our Hospitals

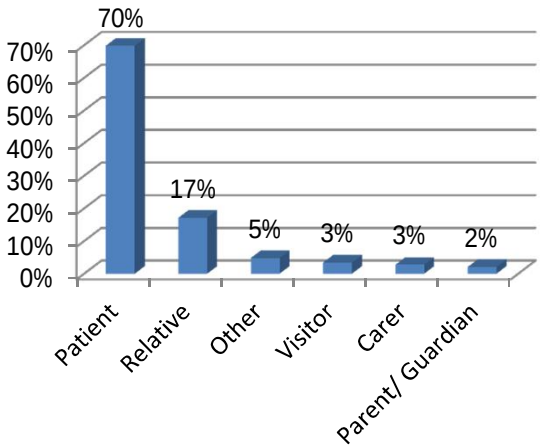
Q1 - Have you visited any of our hospitals since 1 April 2017?

No	80
Yes	158
Total	238

The remaining analysis for this section is based on the 158 responses who had visited the hospital in the timeframe.

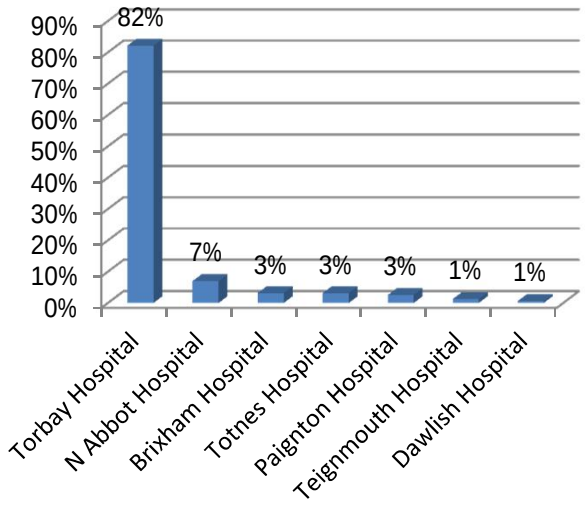
Q3 - On your last visit did you come as:

Patient	102	70%
Relative	25	17%
Other	7	5%
Visitor	5	3%
Carer	4	3%
Parent/ Guardian	3	2%
Total	146	
Not completed	12	
	158	



Q4 - Last location visited

Torbay Hospital	129	82%
N Abbot Hospital	11	7%
Brixham Hospital	5	3%
Totnes Hospital	5	3%
Paignton Hospital	4	3%
Teignmouth Hospital	2	1%
Dawlish Hospital	1	1%
Total	157	
Not Completed	1	
	158	

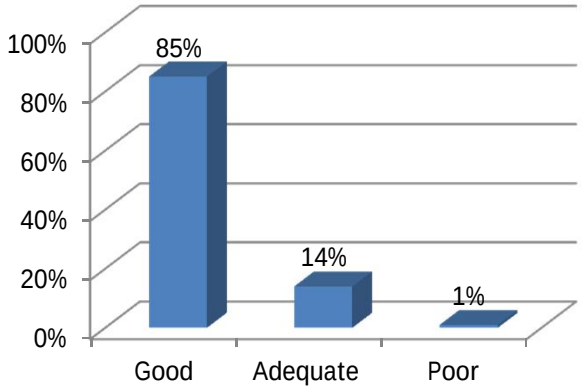


What was your perception of the quality and care of services offered?

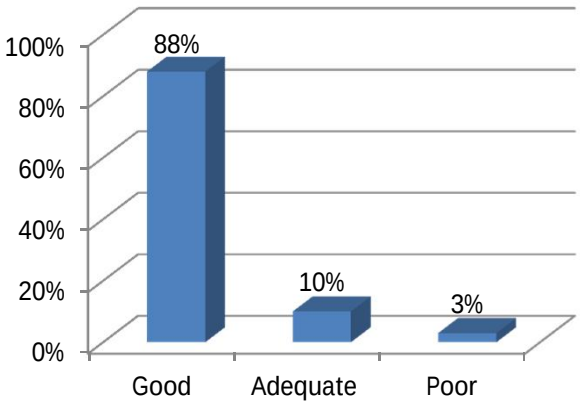
	Good	Adequate	Poor	Total	Not Completed	
Q5 - Were you greeted in a friendly and professional manner by all staff	134	22	1	157	1	158
	85%	14%	1%			
Q6 - Treated in a professional and efficient way	138	15	4	157	1	158
	88%	10%	3%			

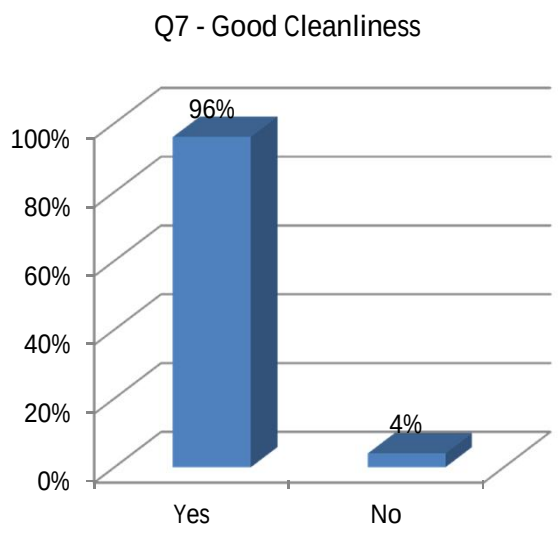
	Yes	No	Total	Not Completed	
Q7 - Cleanliness was good	149	6	155	3	158
	96%	4%			
Q8 - Directions/ Signage was helpful	143	14	157	1	158
	91%	9%			

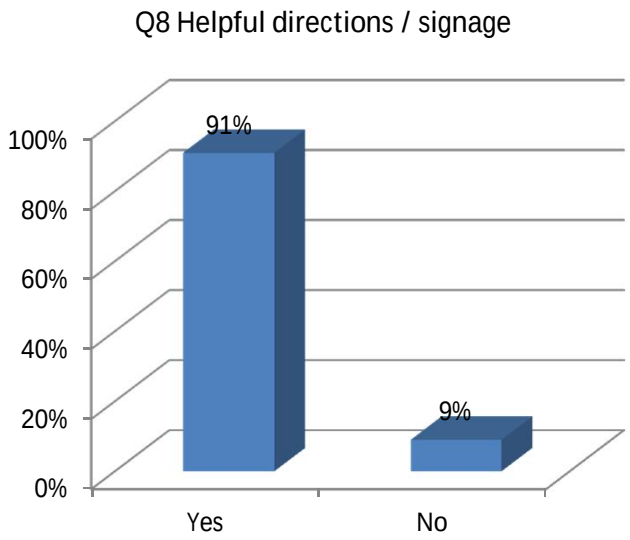
Q5 - Professional Greeting



Q6 - Professional treatment





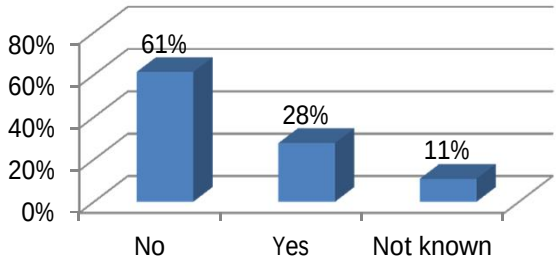


Q9 - If you have responded 'poor' or 'no' to Q5 to Q8, please comment
Please refer to comments appendix.

Section 2 - Integrated Care Organisation (ICO)

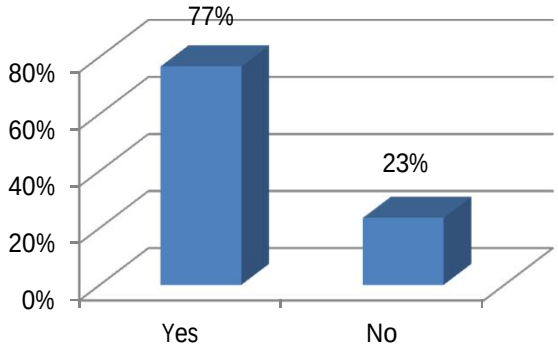
Q10 - Do you know what the ICO is and what this mean for your care?

No	146	61%
Yes	66	28%
Not known	26	11%
Total	238	



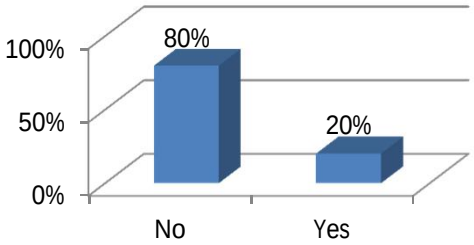
Q11 - Do you feel this integrated way of working since October 2015 has improved the way that health and social care is provided?

Yes	49	77%
No	15	23%
Total	64	
Question not answered	174	
	238	



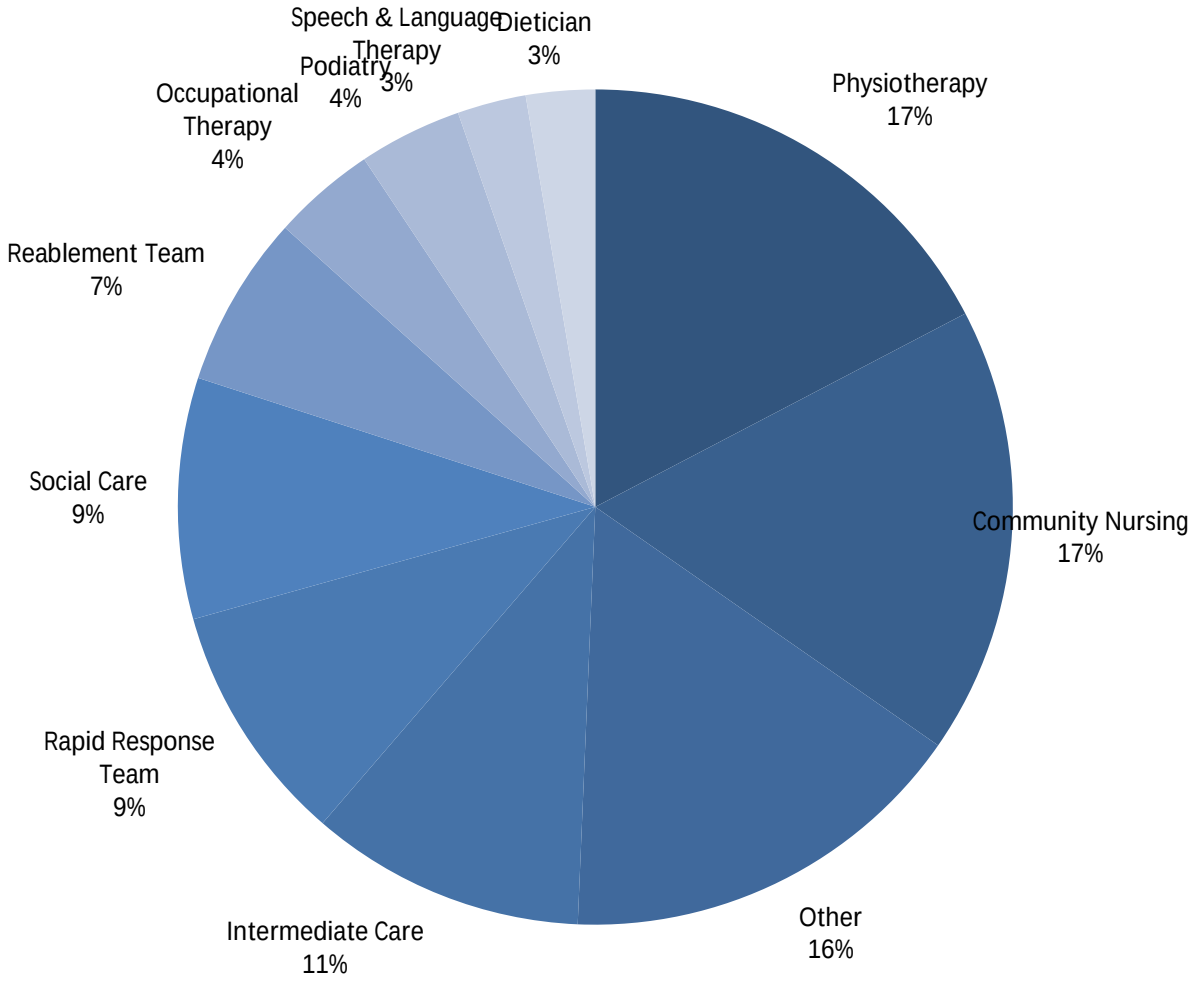
Q12 - Have you ever received health and/or social care services from Torbay and South Devon NHS Foundation Trust in your own home or in the community?

No	190	80%
Yes	48	20%
Total	238	



Q13 - For the 48 responders - services used (Responders could select more than one service)

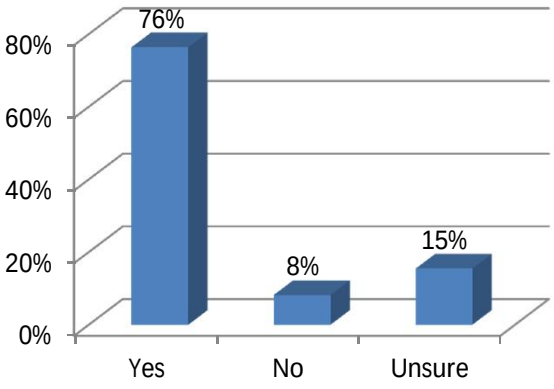
Physiotherapy	13	17%
Community Nursing	13	17%
Other	12	16%
Intermediate Care	8	11%
Rapid Response Team	7	9%
Social Care	7	9%
Reablement Team	5	7%
Occupational Therapy	3	4%
Podiatry	3	4%
Speech & Language Therapy	2	3%
Dietician	2	3%
Total	75	



Q14 - How did this/these service(s) benefit you?
Please refer to comments appendix.

Q15 - If you have a long term condition, is your care being managed efficiently?

Yes	84	76%
No	9	8%
Unsure	17	15%
Total	110	
I don't have a long term condition	128	
	238	



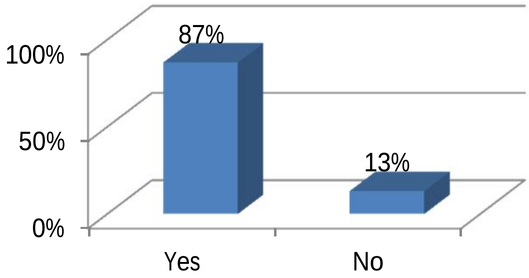
Q16 - How could your long term care be improved? Please provide one suggestion
Please refer to comments appendix.

Section 3 - Help us to shape future services

Minor Injury Units (MIU) and Accident and Emergency (A&E)

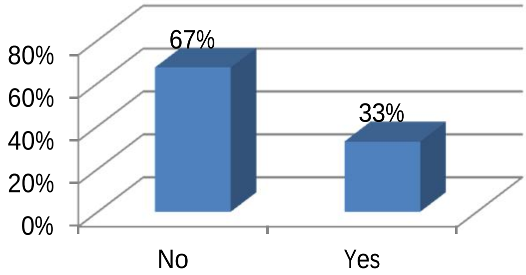
Q17 Are you aware that if you have a minor injury, or condition which you feel needs medical attention but is not an emergency, then rather than come to the A&E Department at Torbay Hospital you may be able to get treatment closer to where you live and more quickly by visiting one of our Minor Injury Units at Dawlish, Newton Abbot and Totnes Hospitals?

Yes	205	87%
No	31	13%
Total	236	
Question not answered	2	
	238	



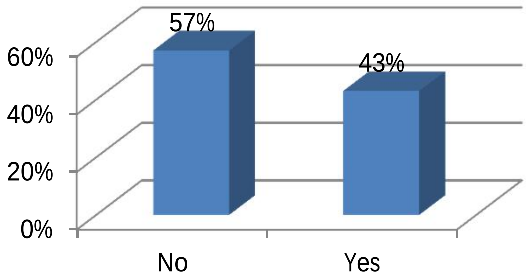
Q18 Are you aware that information about the actual waiting times in our A&E Unit and all our Minor Injuries Units is available, and updated every 5 minutes, on our website?

No	160	67%
Yes	78	33%
Total	238	



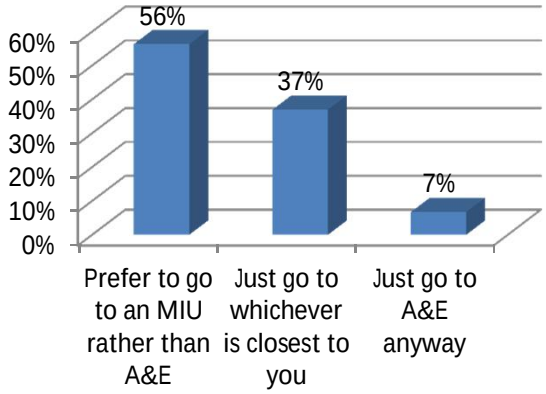
Q19 Are you aware that to help you decide on the best action to take information about the type of illnesses and injuries which can be treated at our Minor Injuries Units is available on our website ?

No	134	57%
Yes	101	43%
Total	235	
Question not answered	3	
	238	



Q20 If you had an illness or injury which could be treated at a Minor Injury Unit would you:

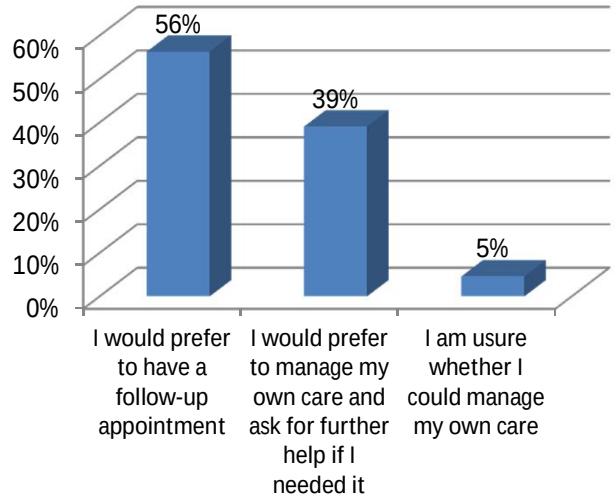
Prefer to go to an MIU rather than A&E	134	56%
Just go to whichever is closest to you	88	37%
Just go to A&E anyway	16	7%
	238	



Follow-up Appointments

Q21 After a person has had treatment at hospital they will be provided with information so that they know what they are meant to do either for themselves or with the help of others and what they should do if there are any problems. Some will also have a follow-up appointment booked for them to come back to the hospital and others will be told who to contact if they think they need to have a follow-up appointment.
Which of the following statements best describes your views:

I would prefer to have a follow-up appointment	134	56%
I would prefer to manage my own care and ask for further help if I needed it	93	39%
I am usure whether I could manage my own care	11	5%
Total	238	

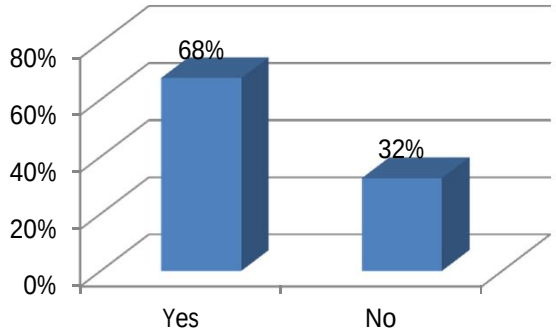


Q22 If you are unsure about managing your own care what information or support could we do to support you in managing your own follow-up? Please provide one suggestion.
Please refer to comments appendix.

Partnerships

Q23 The NHS is encouraging care closer to home with the aim of providing better care for patients, clients, families, carers and service users. Do you agree that your own bed is the best bed for receiving better care?

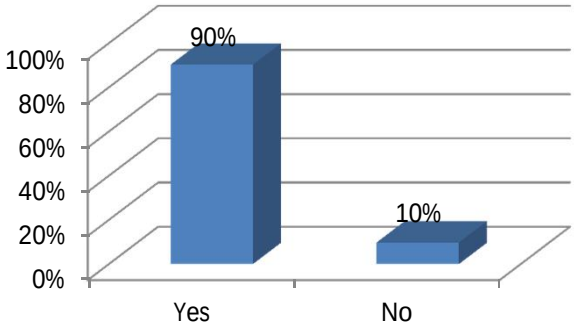
Yes	158	68%
No	76	32%
Total	234	
Question not answered	4	
	238	



Q23a Please explain your answer
Please refer to comments appendix.

Q24 Do you agree that Torbay and South Devon NHS Foundation Trust should work in partnership with other hospitals in the region to help improve services over a wider geographical area?

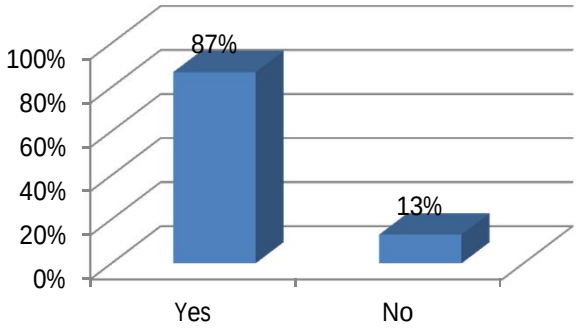
Yes	213	90%
No	23	10%
Total	236	
Question not answered	2	
	238	



Q24a Please explain your answer
Please refer to comments appendix.

Q25 Voluntary and community groups are key to our success. Would you support the use of Trust money for these types of groups to help improve the services offered to patients, clients, families, carers and service users?

Yes	199	87%
No	30	13%
Total	229	
Question not answered	9	
	238	

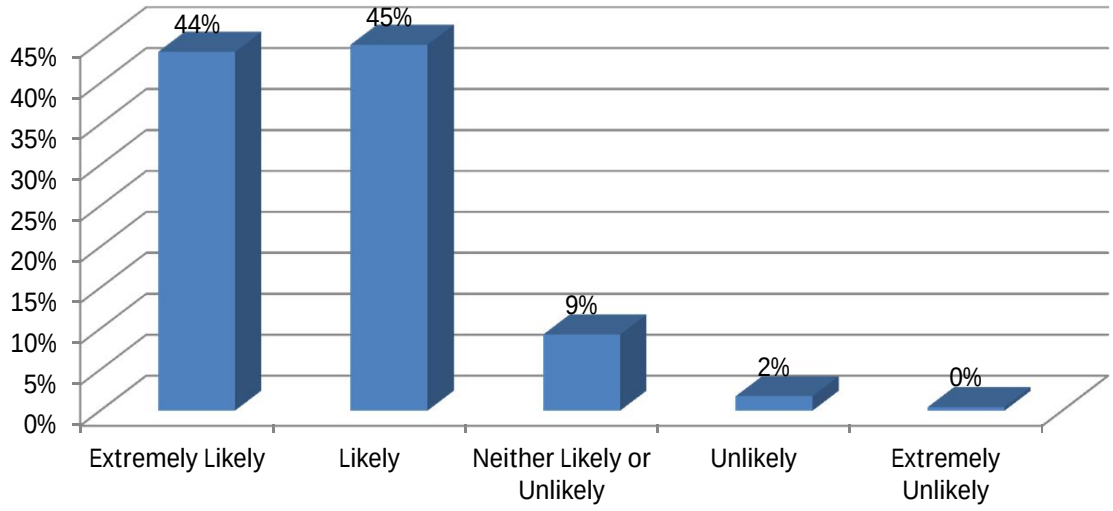


Q25a Please explain your answer
Please refer to comments appendix.

Section 4 - Overall opinion of the quality of care

Q26 If a friend or relative needed treatment, I would be happy with the standard of care provided by the Trust.

Extremely Likely	99	44%
Likely	101	45%
Neither Likely or Unlikely	21	9%
Unlikely	4	2%
Extremely Unlikely	1	0%
Total	226	
Don't know	12	
	238	

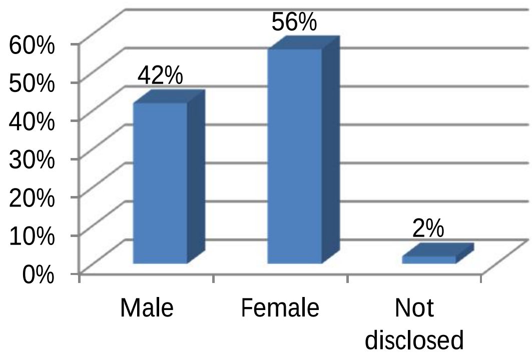


Section 5 - Demographics

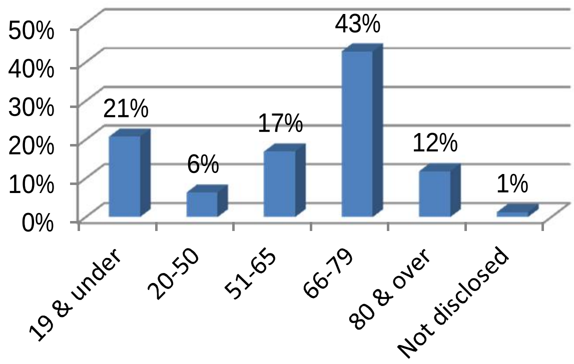
Gender / Age Group

Female	19 years & under	38	17%
	20 to 50 years	7	3%
	51 to 65 years	20	9%
	66 to 79 years	53	23%
	80 years & over	11	5%
	Total	129	56%
Male	19 years & under	7	3%
	20 to 50 years	8	3%
	51 to 65 years	19	8%
	66 to 79 years	46	20%
	80 years & over	17	7%
	Total	97	42%
Transgender	19 years & under	1	0%
	20 to 50 years		
	51 to 65 years		
	66 to 79 years		
	80 years & over		
	Total	1	0%
I do not wish to disclose	19 years & under	2	1%
	20 to 50 years		
	51 to 65 years		
	66 to 79 years	1	0%
	80 years & over		
	Total	3	1%
	Total	230	
	Questions not answered	8	
		238	

Gender



Age Range



Ethnicity

White	222	94%
Asian or Asian British	3	1%
Mixed	1	0%
Other	1	0%
Not Known	1	0%
Not disclosed	8	3%
Total	236	
Question not answered	2	
	238	

Appendix Comments

Section 1 – Your experience of our hospitals

Q9 – Comments on perception of the quality of care and services offered

I came with a suspected broken arm and was told that it was a sprain. 4 weeks later i was still in so much pain so came back and they told me that it had been broken and not sprained. (Responder No 189)

No indication how to get in during out of hours (Responder No 13)

I felt that there was some tardiness in the entrance, and the floors were not as clean as they should be. The sine age was not too helpful. Somewhat confusing. (Responder No 233)

I had to attend x-ray following fractured humerous, I was in a wheelchair and needed to use the toilet. The main cloakroom opposite reception was not in use, we followed signs to next nearest one (advised by member of staff) which directed us to a staff only area. (Responder No 75)

My husband was transferred to Cromie ward following surgery in the afternoon. I visited him at 6.30pm and he still had an oxygen cannula in his nose but it wasn't connected to any oxygen and left dangling on the floor. He also had pressure relieving boots on his heels but they weren't plugged in. An hour later I asked a student nurse if they should be switched on and she connected them to the machine but didn't turn it on! Being a retired nurse I was appalled at the lack of attention to detail. My husband felt he was mainly ignored, it felt to him as if it was too much trouble to even go over to him and ask him if he was alright. The following day he was discharged to the waiting room just after finishing his lunch where he remained, in pain and unable to sit down because of this, didn't have any cash on him to buy himself a drink and was there until 5pm when I collected him. He saw the ward sister twice in a 24 hour period and to say he had to get out of bed and was being discharged and also to ask him to wait in day room for his TTO's. Then no one came in to see if he was OK, in pain etc. Very poor aftercare. When I picked him up I tried to gain the attention of staff to let them know we were leaving and no one gave me any acknowledgement and everyone seemed to have a very long face and not very friendly. Compared to other areas of the hospital where staff are courteous, kind, caring and appear cheerful and which are just as busy. This is the one and only occasion I have ever had to complain about a ward. My husband says he felt as if he was in a cattle market, one in and one out of the beds. (Responder No 27)

Not easy to find clinic following move from previous location. (Responder No 223)

Rheumatology had moved from TIARU unit, receptionist was unsure where it had moved to. As they only had a vague idea where I needed to be I was sent to Level 2 reception. On the way to Level 2 reception one of the lifts had a sign saying

rheumatology was on Level 3. Better understanding by staff when a department moves, better signage for visitors (Responder No 90)
The accident and emergency department I found very depressing. Scruffy with little privacy when speaking with nurse and loud music from tv. Also very hot. , No hand sanitation. Staff behind desk, chewing or eating food. No communication of wait time. In all 4 hours. No-one really acknowledging you by name or informing as to who they were. (Responder No 107)
Unclear to the elderly relative I was with, they found it difficult to navigate around the hospital without help. Clearer signage or a coloured line on the floor to be followed would be helpful. (Responder No 26)
General cleanliness in waiting areas was poor . I noticed this on several visits over spring/summer (Responder No 235)
Given an apptment for a result of an arthroscopy. My papers said three weeks. It was 6 weeks. I saw the third specialist who could not provide any answers to my questions, nor give me adequate results. The comment was he was not my Dr and didn't know anything about my case. I asked why we were having this meeting. He replied Well we have to see you within 6 weeks so you got dropped into my tray and anyway I'm leaving today. What a waste of everyone's time and money. No wonder we have problems in the NHS. (Responder No 132)
I was taken in error to John Parks Unit and had to rely on a good Samaritan to take me to the main hospital where the appointment took place. Administrational error! (Responder No 152)
I was taken to John Parks Unit due to an administrative error and had to rely on a kind stranger to take me to the main building for my appointment in Dermatology! (Responder No 21)
it was just the waiting period only to be diverted to another hospital to have to wait for twice the amount of time to be treated there. (Responder No 187)
Need big signs coz they never saw the small signs as we often asking the people who are working when they are on their walking routines who were willing to give us the directions. Didn't like the colour zone signs!! (Responder No 51)
Signposting to Physiotherapy Department confusing. (Responder No 2)
Some of the signage is missing or not clear. For example; signage to the sexual medicine service / family planning is not visible. (Responder No 234)
the a and e department takes ages and they presume they know whats wrong before looking at the injured part (Responder No 207)
toilets did not have a very nice smell (Responder No 37)
Was attending with my sister, all staff very friendly and helpful apart from a male member of staff at the MRI department, he was very abrupt and unfriendly. (Responder No 106)

Section 2 – Integrated Care Organisation

Q14 – Comments on benefits of health and/or social care

all good (Responder No 1)
Child psychotherapy (Responder No 199)
Helped me and my family (Responder No 165)
helped me with my Bronchiectasis (Responder No 174)
helped my mental health improve dramatically (Responder No 164)
Saved journey to Torbay (Responder No 220)
The rapid response team were excellent and provided immediate benefit and support. For the rest: variable; fragmented; poorly organised . (Responder No 149)
10 daily injections following discharge from Torbay Hospital (Responder No 120)
Assisted with Depression (Responder No 200)
Eliminated need for hospital appointment (Responder No 128)
it enabled my husband to stay at home shortly before he died and supported me at a stressful time (Responder No 10)
giving me braces to help with my teeth (Responder No 167)
Health checks and staple removal following total right hip replacement (Responder No 29)
Helped enable me (as my husband's carer) to access services elsewhere in the community (Responder No 144)
I was in extreme pain with water retention which the nurses from NHS 111 fixed. (Responder No 157)
I was not the patient it was my husband and as I am his career I found it to be extremely helpful as did he (Responder No 66)
Much more comfortable than in a hospital office - was able to prepare for forthcoming surgery and treatment. Did not feel rushed - was very impressed with level of knowledge and compassion shown. (Responder No 139)
My wife had help with physio etc after breaking her hip in May 2016 (Responder No 34)
saved journey to hospital (Responder No 45)
very helpful after knee operation (Responder No 97)
aided rapid recovery (Responder No 70)
As far as they went they were fine but should have been more. (Responder No 58)
Equipment provided (Responder No 74)
Gave me exercises to help counteract problems caused by balance difficulties and lack of feeling in feet and lower legs (Responder No 101)
Helped me to feel supported (Responder No 186)
HELPED WITH VARIOUS HEAOTH CONDITIONS AND PREVENTION (Responder No 52)

Hugely I couldn't manage without them (Responder No 159)
I had care after an Operation (Responder No 130)
Initial treatment only after hospitalisation, rather than a trip to TAIRU. (Responder No 41)
Initially was difficult to get an appointment early enough... but whilst receiving the service very good. Follow up is poor and re-engagement with the service is slow again - i.e. have to start from scratch. can be up to six weeks wait again. :((Responder No 98)
Intermediate care was provided in June 2016 post-operatively and was essential for my recovery. This service was excellent. Community nurses checked on my progress and have recently helped with providing a flu vaccination etc. I visit the Endocrine unit at Torbay Hospital. They provide a brilliant service. (Responder No 238)
it helped after orthopaedic surgery to learn to climb stairs (Responder No 87)
it made me feel better (Responder No 202)
It was not very good (Responder No 77)
Operation Completed (Responder No 76)
Provided hand rails at top and bottom of stairs , and toilet seat with pull rails . Also advice on preventing falling. (Responder No 20)
they didnt (Responder No 216)
They were a vital help to my husband who was terminally ill. (Responder No 143)
To enable me with living in my own home, thus Service totally tailored to my needs in my home. (Responder No 114)
Too ill with Pneumonia to visit surgery - received prescription for antibiotics from visiting GP. In answer to Q15 my long term condition is Crohns and this is monitored by the Hospital specialist. (Responder No 222)
Very helpful (Responder No 68)
Yes (Responder No 16)

Q16 – How could your long term care be improved?

Not sure. Maybe follow up re flu vac (Responder No 17)
Nothing to add (Responder No 1)
Better funding, (Responder No 149)
I don’t see how it could! (Responder No 136)
I don't feel qualified to comment. (Responder No 91)
I doubt if it can be improved, my local surgery and Totnes and Torbay Hospitals provide regular monitoring of my diabetes and hypertension to a very high standard (Responder No 131)
it couldn't, its amazing at the moment (Responder No 174)

It's ok (Responder No 94)
more information (Responder No 124)
quicker appointments (Responder No 4)
An annual email from the stoma team (in this instance) to check. (Responder No 134)
Can't be improved (Responder No 141)
Easier online access (Responder No 67)
Have glaucoma and attend Eye Clinic at Newton Abbot Hospital. Last visits were in March 2016 and December 2016 ie 9 months apart. Next appointment will be 02 October (10 months since previous visit). I think 6 monthly visits would be more appropriate. (Responder No 43)
I am seeing a doctor in Torbay once a year concerning my cholesterol. There was time when I saw him before I had had a blood test on which result he based his advice. It would be better to send me a notification for having a blood test done BEFORE I see this doctor. (Responder No 105)
I answered yes as I have had a kidney transplant following chronic kidney disease and dialysis. Although the ongoing treatment is being supported by Royal Devon & Exeter hospital. (Responder No 75)
I do not know. (Responder No 157)
I have no reason to think that my husband's long term care can be improved as the cardiac specialists and everyone else we have come across in the hospital have been fantastic to him except the incidents mentioned on Cromie ward. (Responder No 27)
I think that when in hospital and a patient in bed requests a visit to the toilet this is sometimes met with reluctance by some staff to be dealt with as a priority when the patient is in obvious need.It makes the patient very distressed and made to feel like a nuisance. (Responder No 34)
Improve the waiting times for appointments (Responder No 172)
Knowing how to contact an appropriate person to ask questions when not slufficiently important to speak to our Doctor (Responder No 66)
more detailed information given (Responder No 176)
More help is needed with dealing with stress and relaxation in order to relieve pain rather than taking medication for it. (Responder No 144)
more proactive oversight (Responder No 28)
More up to date medicine. The medicine I am on is a very old one, as more modern medicines are available with better results, would it not be beneficial for both the patient and the hospital to bring patients medicine up to date. (Responder No 90)
My Surgery should inform me when my annual check up is due and not leave it me to remember to make appointments. This situation has been ongoing for a number of years even after notifying the surgery. (Responder No 33)
Not at the present time (Responder No 112)

Stop cancelled appointments (Responder No 224)
Unexpected waits in the radiotherapy suite are stressful, but probably unavoidable. (Responder No 128)
Waiting list time considerably reduced (Responder No 29)
A consultant led review of my conditions (Responder No 60)
A heart bypass would probably cure it. (Responder No 146)
A new knee (Responder No 18)
an urgent mri scan not a routine one (Responder No 119)
Any updates on stomas would help (Responder No 221)
Appointments within time period stated and appointments to go to hospital received before the date requested to go (Responder No 40)
Be aware of the possible progress of my condition to enable me to plan (Responder No 159)
being offered a wider range of treatment. (Responder No 216)
Better bus service. (Responder No 20)
Better GP services (Responder No 235)
Care provided is already excelent. (Responder No 76)
communication (Responder No 79)
cure my chest condition (Responder No 73)
early knowledge of operation date, if possible (Responder No 70)
Easier access to doctors appointment (Responder No 102)
Easier access to GPs and other professionals (Responder No 126)
Easy to access repeat prescriptions (Responder No 30)
Everyone tries very hard to help me. I think the quality of the construction of shoes would last much longer if manufacturers used better quality materials (Responder No 132)
finding a cure! (Responder No 36)
For better MS awareness in other medical/ surgical departments. I’ve found other departments overly concerned about me living with MS, and the MS effecting any treatment/ surgery they can offer. (Responder No 114)
Fund a bathroom ceiling hoist (Responder No 74)
Give Pharmacists responsibility for drugs. Isn't that supposed to be their field of expertise ? (Responder No 31)
Guidance on osteoporosis (Responder No 50)
I do not have any suggestions, it is well managed (Responder No 205)
I don't know, I don't know if I have a long term codition (Responder No 214)
Maybe if the Doctors reminded you of when you should make appointments especially if the dates at reception only go so far. Communication (Responder No 197)
Monitoring my heart (Responder No 156)

More co-ordination with the services (a more holistic approach) rather than a one - off per service approach. Still not talking to each other... having to tell your story over and over again. Information is not being shared quickly enough (or not being read before seeing you).... :((Responder No 98)
more help with using treatments (forgetting to take the treatments) (Responder No 218)
More people employed within CAMHS (Responder No 186)
More regular appointments would be appreciated as often the scheduled appt. is moved backwards - sometimes by 2 months (Responder No 8)
More staff (Responder No 123)
More support at home. (Responder No 217)
My pituitary tumour (now removed) has left me with partial sight, hence currently I do not drive (licence surrendered last year). Free patient transport to hospital appointments and then back home would be a great extension of an otherwise brilliant care service. (Responder No 238)
None .managed ok care only when necessary (have a colostomy) (Responder No 16)
Not applicable, as long term treatment was transferred to my own medical centre. (INR testing). (Responder No 41)
Nothing (Responder No 150)
nothing except a better room in outpatients for my visit for a nephrology visit. it was a very small room with no windows and rather claustrophobic.. (Responder No 87)
One to one occupational therapy. (Responder No 77)
Prompt follow up appointments (Responder No 32)
Quicker appointment times (Responder No 3)
Quite happy (Responder No 12)
Regular checkups by Dermatology, in order to identify further treatment requirements early (Responder No 137)
The care I receive is excellent. (Responder No 222)
training and calls on time (Responder No 37)
We did have some difficulty accessing the eye clinic for my wife via A&E. But i understand the difficulties that do occur (Responder No 230)
when advised further treatment is required by a consultant, there seems to be no advise as to who initiates this treatment. Does one, wait for the hospital department to contact the patient, contact their surgery or telephone the department direct. Knowing the mammoth work load all sections of have to endure daily is there a simple method to advise when treatment is scheduled. (Responder No 147)
written info to take home to read (Responder No 7)

Q22 If you are unsure about managing your own care, what information or support could we do to support you in managing your own follow-up? Please provide one suggestion.

Advice about whether follow-up was necessary ([perhaps a statement of the obvious?) (Responder No 62)
Depends on the problem but it would be helpful to have telephone number to contact for support (Responder No 162)
email doctor (Responder No 168)
Explanation at the point of initial contact. (Responder No 47)
The question is hypothetical as I would not know what type of care I would need, until I needed it. Sorry. (Responder No 155)
Don't know. That's why I put don't know (Responder No 235)
I needed a follow up to discuss the next move following an arthroscopy (Responder No 132)
One to one therapy (Responder No 77)

Section 3 – help us to shape future services

Partnerships

Q23 The NHS is encouraging care closer to home with the aim of providing better care for patients, clients, families, carers and service users. Do you agree that your own bed is the best bed for receiving better care? - Comments

I would worry that if my condition changed how I would still get the care I need and ASAP. I am unsure if this is financially motivated rather than patient centred (Responder No 17)
If something goes wrong, it will take longer to people respond to your emergency. Furthermore hygiene control will also inevitably be worse than in a hospital bed. (Responder No 95)
Because you'd have a homely environment, with individuals who care for you and, overall, you will feel more comfortable. (Responder No 177)
More comfortable enviroment. (Responder No 178)
More relaxed at home,. Have privacy. (Responder No 71)
There are not always the correct resources around or in your own bed. (Responder No 183)
As I am on my own, and my family live 200/300 miles away, it would depend on how incapacitated I was. (Responder No 140)
Anyone would rather be at home than have a poor hospital experience (Responder No 13)
Because at home you may not have someone to look out for you (Responder No 210)
Because i live over an hour away from my closest hospital so when i am in a lot of oain and really ill then i need to be treated quickly instead of driving for over an hour (Responder No 166)
because it is comforting (Responder No 165)
cannot pose this question with simple yes or.it will, for instance, depend on severity of illness, co-morbidity and social support available (Responder No 212)
Everyone feels more relaxed at home. I hate the idea of sleeping in a room with others and if it was a mixed sex ward I would refuse to stay (Responder No 124)
Fortunately, I have not yet experienced any condition necessitating any form of treatment or care at home (Responder No 131)
I believe that in hospital they are better equipped to give you better care (Responder No 190)
I live alone and would be likely to be unable to look after myself. I would have liked to go to Dartmouth Hospital to convalesce after a major operation if I needed one

(i.e. to a satellite hospital for Torbay as happened in the past). I am very unhappy that Dartmouth Hospital has been closed. (Responder No 62)
I think being at home is more familiar and allows adequate rest. (Responder No 163)
if something goes wrong the hostipl has anything you need (Responder No 215)
It is more comfotable in your own home. (Responder No 189)
It's better in your own comforts own (Responder No 94)
May well be alone in house and therefore any urgent care required would not be available. (Responder No 127)
People are in their normal states when at home, and care can be much better for less able patients etc. (Responder No 199)
PEOPLE FEEL MORE COMFTORABLE AT HOME WHICH MEANS THEY CAN FOCUS MORE ON RECOVERY (Responder No 188)
Poeple always feel better at home in their own environment (Responder No 91)
Providing hospital resources aren't needed. (Responder No 136)
roviding that a properly workable system is evolved which includes a better respect for carers from professionals and better funding is provided. The direct payments scheme is an excellent system but also is too restrictive and crosses too many budgets. Integrated commissioning does not seem to be happening and without it much resource can be wasted in departments protecting their own budgets. (Responder No 149)
shortage of hospital beds (Responder No 193)
Some people don't have the best living conditions so their own home may not be suitable (Responder No 185)
Sometimes home is best but at other times I feel patients are discharged too early and this can be frightening for them. (Responder No 220)
unless it is serious it can be treated at home (Responder No 164)
Yes, conditionally. If care can be provided efficiently and cost-effectively at home all well and good. However, if I were to have a condition needing hospitalisation then I would welcome being admitted as an inpatient. (Responder No 118)
It clearly depends on the nature of the illness where you are treated. (Responder No 120)
when health care can be managed at home it can encourage better recovery (Responder No 138)
Again, it depends on what I would need care for. I would be happy to be treated at home with say a broken limb, but not if I had a very serious illness. (Responder No 155)
although it may be more comfortable, having professionals that are in a hospital environment is more comforting in my opinion (Responder No 195)
at home, you feel more comfortable and safe (Responder No 167)
avoid hospitals if at all possible (Responder No 28)

because you feel happier and more relaxed (Responder No 168)
Being cared for in a familiar environment in my opinion will expedite my recovery. (Responder No 233)
Best place (depending on condition obviously) .... as long as support is available as required. Not convinced that this will be the case. (Responder No 223)
Care in own home is far preferable to hospital regime, provided that staff from the acute hospital who are nursing non-acute patients can be redeployed, together with the integration of social service staff to provide round the clock availability of care on demand. (Responder No 128)
Comfort and privacy (Responder No 184)
Depending on the illness or injury.. but generally I would prefer to be at home. (Responder No 75)
depends on problem and if monitoring is required extensively (Responder No 97)
Depends on the circumstance really. (Responder No 200)
Depends on what care is needed (Responder No 121)
Familiar surroundings, with family and friends close at hand - provided the care was being administered. (Responder No 142)
feel more vulnerable in own home (Responder No 4)
From my experience nursing my mother I know that being away from home was stressful to her. I would have liked more support from district nurses or similar, as we had very little medical support in caring for her. (Responder No 69)
Hospital wards tend to be noisy with frequent interruptions. Peace and quiet at home in familiar surroundings can be a great healer. (Responder No 43)
I avoid burdening the NHS unless absolutely necessary, so far this strategy has worked well. (Responder No 80)
I don't like being in hospital (Responder No 162)
I feel more comfortable at home, and would not be liable to catch any other infections. (Responder No 157)
I live alone (Responder No 141)
I live alone and remotely. I would therefore find it difficult to give myself care if immobilised (Responder No 47)
I live on my own and if I am unwell I cannot look after myself (Responder No 151)
I think I would get better quicker in my own home. (Responder No 105)
I think it helps people with long term conditions feel more safe and confident (Responder No 192)
I understand that the risk of infection is greatly reduced at home (Responder No 29)
I would prefer to be in the profession environment of a hospital if I was seriously ill. (Responder No 82)

I would rather sleep in my own bed but if my heart condition became unstable/worsens I would rather be in hospital where I could be observed and monitored. (Responder No 27)
If I was ill and needed care/treatment I would prefer to be somewhere with medical help close to hand. (Responder No 226)
In familiar surroundings with familiar people around and not the 'hustle and bustle' of dozens, if not hundreds, of people milling around nearby. (Responder No 100)
it encourages one to get better more quickly (Responder No 10)
It will depend of course on the situation but largely, being able to stay in familiar surroundings avoiding being surrounded by noise and possible infections would be preferable to being an inpatient. (Responder No 46)
It would be dependent on the level of care I would require. Recent experiences with elderly relatives make me feel that it would be better to be in a community hospital if need be, or a purpose built care centre where the level of care would be more effective. (Responder No 55)
It would be dependent on the level of care, but I feel that a hospital bed would be the best place (Responder No 227)
It Would Depend on the Type of care I needed (Responder No 103)
Less danger of infection; Quieter and more restful -especially at night; no travel and parking costs and inconvenience for family (including children) having to visit hospital; food tailored to immediate need; temperature of room under personal control; (Responder No 134)
Medical Emergency Treatment not available at home (Responder No 83)
more experienced professionals to hand, and more care is avalible (Responder No 180)
More experienced professionals to hand. (Responder No 181)
Much depends on the severity of the condition and whether professional help is needed - if it is a long term chronic condition that can be managed in the home even with outside help needed, then home is the best place to be (Responder No 42)
No place like home (Responder No 81)
Not always, sometimes it would be suitable, other times you might need specialist staff or equipment. (Responder No 90)
Not necessarily - depends on family/neighbour support, patient's condition (mental and physical), reliable support from paid carers (times, length of stay) (Responder No 111)
Not necessarily from what I hear from other people, care at home seems to be rather sparse. (Responder No 66)
Only if I don't need acute services. (Responder No 133)
Quieter, comfortable, and tea as I like it! ..... as long as I was looked after medically (Responder No 23)

self explanatory (Responder No 45)
sometimes agree but sometimes you get better care in hospital (Responder No 176)
Sometimes it is confusing to be away from normal everyday environment, particularly for the elderly or confused. (Responder No 26)
Stress does not help healing and visits to hospital are stressful - parking - waiting - risk of infection from other patients (Responder No 224)
Suggest home environment would aid recovery (Responder No 33)
surely each situation should be judged on its merits, risks and objectives. It's about time the NHS and social care services based care on outcomes and not what is cheapest or easiest (or what could potentially be 'swept under the carpet' (Responder No 57)
That's all well and good but social care is very very poor and there is a long waiting list even to be assessed. As for counselling my husband has been waiting for over 6 months now and recently received a letter to ask if he wanted to continue on the waiting list? (Responder No 144)
The familiarity of your own home is surely calming and beneficial for a faster recovery. The quiet and privacy of home cannot be attained in a ward environment. (Responder No 139)
The hospital has more specialist care equipment (Responder No 170)
This depends entirely on the circumstances which prevail at the time and what care is required (Responder No 112)
This is a poor question, it is a non-sequitur to the statement that precedes it. Care closer to home should always be a priority, but 'your own bed' being best is something that depends on individual circumstances, and it is not a straightforward yes or no question. (Responder No 54)
This is basically a short cut to saving money not better health care. (Responder No 67)
This really depends on what is wrong. Yes, some things can best be treated more comfortably in your own home but others not. Also some people do not like all different people calling at their home, particularly if they don't know who they are and if they keep changing.. (Responder No 107)
yes because a patient will feel more at ease and relaxed which could reduce some of their symptoms (Responder No 182)
You are able rest more easily at home, rather than in a hospital. (Responder No 171)
You are more relaxed in the home environment (Responder No 93)
You will always be more comfortable in your own environment (Responder No 172)
Your home and surroundings can help you to recover quicker and of course is much quieter (Responder No 34)
Your own facilities and bed are always going to be better. (Responder No 63)
this depends on the problem (Responder No 49)

A "normal" environment encourages a quicker recovery (Responder No 126)
A Patient should Heal better when he/she is in their own Surroundings, with Family and Friends visiting whenever to give support and help in any way they can, i.e. Physio or other exercises. (Responder No 130)
Allowing elderly patients to be treated in the comfort of their own home or people with illnesses where they don't feel comfortable in an outside environment. (Responder No 198)
Always better at home (Responder No 150)
anything is better than a noisy hospital ward - assuming home care is available (Responder No 119)
as a patient you sleep better at home and receive better nutrition. (Responder No 87)
As its my own bed and its an environment that I know. Also its quieter, and due to medical condition, I find hospital beds to narrow and fear rolling out of the normal hospital bed, due to my size. if I need to go in I would feel better if there was the opertunity of having aa bariatric bed wide enough. Rather than just being able to take my weight. (Responder No 52)
As long as I am mobile and do not require a level of care that would affect the health of my career I would prefer to be at home. If I required a greater level of care I would prefer Assisted or Nursing Home accomodation. (Responder No 222)
As my most urgently assumed care that would be required is likely to be an adrenal crisis (happened earlier this year), I found the ambulance paramedics to be fully on the ball and knew exactly what to do for me. Most impressive! (Responder No 238)
At home you may not have the equipment. (Responder No 213)
Because the food is better and there is someone there at all times. (Responder No 129)
Because we are deaf as there is no deaf awareness and not enough BSL or CSW interpreters in the wards as we can feel helpless and feel more comfortable at home where they can support better. (Responder No 51)
Being at home in familiar surroundings is inevitably less stressful and more conducive to recovery. It is usually easier to to get a good night's sleep at home than in a busy ward. (Responder No 156)
Being close to experts seems preferable. (Responder No 72)
Being in a home environment is clearly less stressful than being in a hospital situation where full and regular sleep is more difficult to achieve (Responder No 60)
Being in one's own bed implies independence. (Responder No 50)
Best to be in own home when possible - all equipment set up and better for carers (Responder No 74)
Can’t. Question is too simplistic. IF SERVICES WERE IN PLACE THEN OF COURSE HOME IS THE BEST PLACE. But we know they are not???? (Responder No 235)

Care in the community is not so reliable as that in a hospital. Obviously there are exceptions. Each case should be carefully assessed. (Responder No 65)
cares have medical expeerience (Responder No 37)
certainly the best but only if proper support is given (Responder No 15)
Depends how serious the illness is.... (Responder No 41)
Difficult question as it depends on what care you need and why you needed NHS in the 1st place. (Responder No 38)
even though it can be more comfortable, more prone to risk of infections due to surrounding not being as clean, (Responder No 179)
Everyone feels more comfortable in their own familiar surroundings. (Responder No 219)
Everything is measured using time. If healthcare professionals are not given enough time to visit a patient in the home, how can this be considered as better care? (Responder No 2)
Familiar and comfortable surroundings, and only patient. (Responder No 20)
familiar environment (Responder No 160)
feel more comfortable (Responder No 207)
Full time care not available in own home, dont think you plan to station nurses in everybody's house.! (Responder No 56)
Generally own bed, means it quieter, and more peaceful than a ward bed, as well as not being too hot and too much light to sleep. I do understand the needs of some patients need to be met on the wards at night, hence the lighting, heating and the noise! I've also had sleep disrupted due to demanding patients, some due to dementia or similar, and others because they choose to be demanding. I always admire the staff patience when dealing with both types. (Responder No 114)
Home is by far the more comforting option (Responder No 228)
Home is where the heart is (Responder No 53)
Home surroundings and support from family and friends go along way (Responder No 231)
Hopsitals are traumatic for patients and families and expose to additional risks (Responder No 209)
hospital beds are for constant care, walking wounded are best in their own homes if care is available (Responder No 147)
Hospital wards can be noisy, stressful places (Responder No 32)
Hospitals can be noisy and illnesses can be easily spread. This means that it will be harder to recover so being at home may be better. (Responder No 187)
Hospitals can sometimes make me feel uncomfortable (Responder No 218)
I am able-bodied, aged 88 this week and live alone. I expect to care for myself (Responder No 61)

i am more likely to get up and recover than being told when to get up (Responder No 7)
I am not sure about this. It would depend entirely on the illness. The problem being in your own home is the wait time for someone to see you should you take a turn for the worse. I used the 111 service when my elderly mother was violently ill, by the time the doctor came 2 hours later the panic was over. (Responder No 64)
I am surrounded by the comforts of home which makes me calmer. (Responder No 204)
I believe that specialist care should not be delivered in my own home and that I should have access to an in-patient bed if needed as I do not access medical support regularly therefore if I do it is because something is genuinely wrong. (Responder No 30)
I don't have any faith in care service providers. (Responder No 31)
I don't want to be in hospital (Responder No 159)
I expect to have professional care 24 - 7 (Responder No 24)
I feel more comfortable at home. (Responder No 217)
I live on my own so hospital care is better (Responder No 68)
I personally feel that I would be more comfortable if I have professional medical care that I need rather than being at home, even though being at home would be good. I think a hospice is better than being at home because it provides a homely feel to patients who need care. (Responder No 205)
I think it is better to be in one's own bed if there is someone to look after the person in an appropriate way otherwise especially after an operation it is best to be in hospital. (Responder No 5)
I think recovery and/or care in your own home is a much better option than to be in a hospital where family and friends might find it difficult to get to, and the home atmosphere must help matters. (Responder No 137)
I think that it depends on circumstances. (Responder No 44)
I want to be near any equipment which I may need in an emergency in future. One's own home can be a lonely and isolated place. And there's a dreadful sentimentality about dying at home. What's so good about that? I have only my husband in the world, and often people do not die peacefully wherever they die. Hospital for me please. (Responder No 104)
I wasn't really sure how to answer, as it must depend on the medical situation involved, what equipment might be needed for instance. (Responder No 101)
I would much prefer to be at home rather than in a strange bed. (Responder No 73)
I'd be much more relaxed at home (Responder No 22)
If a serious illness requiring hospital treatment I would expect that. Otherwise much happier in own home with some help if needed. (Responder No 59)

If I suffered from a serious illness I would feel more comfortable in a hospital bed (Responder No 186)
if you are unwell you feel safer in Hospital. (Responder No 84)
if your in your own bed it makes it feel more comftable (Responder No 206)
In some cases it is appropriate, allowing patients to feel more calm and generally happier, however within a hospital there is a greater range of facilities and more available in the case of emergency (Responder No 196)
In some medical conditions a hospital bed would be able to provide better care than being at home. (Responder No 35)
Isolated. (Responder No 232)
It depends how much care is needed. If many sets of carers are needed, it would be better ,cheaper and more company for a patient, to be in somewhere with a resident warden, a Community Hospital or in a subsidies Care Home. (Responder No 145)
It depends on the nature of the problem, but I would feel happier and more comfortable at home than in alternative accommodation. (Responder No 116)
It depends what is wrong with you of course (Responder No 146)
It very much depends on the nature of the illness or ailment, the individuals capabilities and mobilities and the support they have either from family or social/ community care. However I do mostly agree as I think hospital is the last place you want to be when you are sick. (Responder No 18)
keep your illness away from others, no one else wants it. (Responder No 216)
Less demands on Hospital services (Responder No 3)
Less noisy at night and home comforts. (Responder No 143)
Less stressful more comfortable (Responder No 102)
Living alone it would depend on what care would be available (Responder No 221)
More comfortable and relaxing which reduces your stress, this tends to make you recover if not more quickly more happily which is always beneficial. (Responder No 169)
More comfortable in own surroundings and can get better rest due to less distractions etc. (Responder No 106)
More relaxing environment in which to recover - however, in some cases I would welcome the assurance of not being left on my own - in the fear that I could relapse on my own (Responder No 8)
More restful in my home environment. (Responder No 48)
Much nicer to be at home if possible (Responder No 85)
Not always as you might feel scared and alone. (Responder No 197)
Not comparable to professional care. (Responder No 76)
Not if you need specialist treatment (Responder No 153)
Not necessarily. Paignton Hospial has been closed and it is very sad that we have lost it. Old people sometimes need care within hospital as they find it very daunting to

have to go to the toilet at night in their own home; they can fall. Obviously your own bed is best but there are times when hospital care is best. If I was ill my husband cannot help me, he needs help, I am his carer; there must be many other people like this. (Responder No 113)
people are more comfortable in familiar surroundings and why block a hospital bed if you can be treated at home. (Responder No 225)
People generally sleep better and feel more relaxed at home, which aids quick recovery. However, there will still be occasions when a hospital stay is best (Responder No 19)
Professional care exists in hospital. (Responder No 109)
Provided rest is the treatment! Nursing/medical care is best done by professionals. (Responder No 25)
Providing adequate services are available to provide backup care at home e.g. district nurses / social service care, I think care at home is best every time. However all service providers need to work together and enough funds need to be available to make this a viable option. (Responder No 86)
Providing diagnostic tools are not required (Responder No 230)
Question is too general, where the best bed is will depend upon the problem and the actual support available! (Responder No 122)
quieter at home (Responder No 79)
Recovery at home with support if necessary is safer than being in hospital being exposed to other infections etc (Responder No 161)
Recovery I believe would be quicker if at home (Responder No 40)
safe from mrsa etc (Responder No 70)
So hospital can deal with more urgent care (Responder No 99)
Staff to far stretched and do not have enough time to care properly (Responder No 123)
The answer to your question would depend entirely on the nature of the medical problem and the level of support available outside a hospital setting (Responder No 88)
The care in the home is toally inadequate (Responder No 39)
There is less chance of contracting an infection in my own home! (Responder No 21)
There is only a minimal chance of catching an infection in my own bed! (Responder No 152)
This assumes that my needs do not require hospital care. (Responder No 12)
This is not always the case and would be dependant on the circumstances (Responder No 234)
To be closer to family (Responder No 201)
Unfortunately, having worked in the health profession myself over many years I have seen how many people are unwilling and unable to know when and how to

care for themselves correctly. Many elderly, learning difficulty, dementia and single people can be left with an injury or illnesses which could be life-threatening and not realize it. They do not have the knowledge and the energy to provide the correct eating and drinking and pill taking/fluid intake to maintain recovery without the assistance of someone else, helping and encouraging them to do so. Many need help and guidance and many do not even know that they are deteriorating or indeed have injuries that need treating. It is my view that this model is really a cost cutting exercise and will result in increase use of resources not less. I am afraid that you cannot beat person centered care and hands on interaction with people in my book... people need to feel that they are being looked after - it is a human response. (Responder No 98)

Unless it is of a very serious nature, it is better to receive care, help and support at home. Hospital should be for serious cases. (Responder No 14)

Unsure of the meaning of the question (Responder No 117)

yes (Responder No 202)

Yes if there is someone confident they can look after me at home, if not, I would rather be in hospital than a stressful situation for someone else. (Responder No 158)

Yes so long as the support is real and sound, not just an ideal unrealised (Responder No 132)

yes. (Responder No 214)

You cannot answer a straight "yes" or "no" to Q23. But given no choice I would have to say "no" (Responder No 237)

You get peace and quiet in your own bed but no chance in a noisy hospital (Responder No 58)

You may feel the need to say that the situation is better than it is in order to go home, therefore not helping yourself and the situation could be made worse, but I think it depends on person and the illness. (Responder No 203)

You recover quicker at home. Also you can't get sufficient rest in hospital (Responder No 92)

your own environment for peace of mind. (Responder No 36)

Q24 Do you agree that Torbay and South Devon NHS Foundation Trust should work in partnership with other hospitals in the region to help improve services over a wider geographical area?

Not all hospitals are expertise in all areas so can learn from each other and expertise can be maintained (Responder No 17)

Because they would have better resources or more facilities that can be shared (Responder No 183)

Make services better for the public and more accessable. (Responder No 178)

More beneficial to the public. (Responder No 177)
Pooled resources mean more for less. (Responder No 71)
because then there will be a wider range of medical services around different areas (Responder No 166)
because then they can help a wider range of people (Responder No 164)
because they can all come together as one (Responder No 165)
For some treatments access to specialists and certain facilities will be required including those well outside of South West area, equally where partnership working can improve ledical provision and/or cost efficiencies this is useful but such working should not be used to reduce any local services. (Responder No 127)
Good liaison is the key to a great deal of better results (Responder No 220)
I agree simply because such a partnership is logical, common-sense and probably more cost-effective (Responder No 131)
I am presuming that this means they would all have access to your medical history. (Responder No 140)
I think that establishing connections with other hospitals can allow knowledge to be shared more effectively. (Responder No 163)
Integrated services provide wider cover without unnecessary communications (Responder No 91)
It is important to make the most efficient use of resources. (Responder No 62)
it makes financial sense (Responder No 124)
It's good to share ideas and help other hospitals (Responder No 210)
More integration of services can bring savings. (Responder No 149)
My nearest hospital is 1 hour away (Responder No 190)
Other hospitals are being closed so they must help everywhere. (Responder No 9)
self evident that cooperation required (Responder No 212)
Shared resources, where appropriate, can prove cost effective and effective! (Responder No 136)
Some places are isolated but still deserve adequate health care (Responder No 185)
The more links the better - skills, ideas and research can be shared to create a better overall healthcare system (Responder No 199)
There are some services which I believe Torbay cannot offer at present and will probably never do so, e.g. open heart surgery. It may also be sensible to share some specialties with Exeter or Plymouth where it is more cost-effective to do so. (Responder No 118)
To make travelling eaiser (Responder No 94)
all hospitals need to work together to provide the best service for the patients (Responder No 176)
All Hospitals should Work together anyway (Responder No 103)

An integrated healthcare system over the whole of Devon and surrounding areas can only be a good arrangement. (Responder No 43)
Anything that improves NHS services is a good idea (Responder No 162)
Anything that will reduce the pressure on the acute hospital will contribute to reducing bed-blocking, and stress on acute hospital staff , beds and equipment. (Responder No 128)
As technology has changed the nature of medicine beyond imagination, centres of excellence are hard to staff and equip efficiently if spread around too wide an area, thus by each hospital specialising in a particular aspect, such as endoscopy at Torbay, then that should be the centre of excellence for the whole area. (Responder No 42)
Avoiding needless duplication of services. (Responder No 100)
because they may have better care in some areas (Responder No 182)
Collaboration and working together make complete sense (Responder No 151)
Cooperation seems a reasonable way of improving services (Responder No 69)
Don't know. (Responder No 105)
Each hospital can help each other out and provide advice and information on the surrounding areas. (Responder No 195)
Each hospital has its specialities (Responder No 111)
Essential to free up Torbay beds and have patients nearer families when appropriate. (Responder No 134)
greater efficiency (Responder No 45)
Help more patients. (Responder No 171)
I believe it would relieve the pressure on hospitals if all hospitals worked together in an effort to reduce costs. (Responder No 226)
I believe that sometimes specialist facilities may have to be shared - but I was fortunate that when I had treatment for breast cancer (1998/99) almost all of it took place in Torbay Hospital. (Responder No 139)
I think the more expertise there is the better the outcome for people. (Responder No 107)
I thought it already did (Responder No 141)
if all hospitals are working together there will be an imporved quality of care (Responder No 180)
If it means someone could be seen sooner then it's a positive move but although they might have access to medical details of the patient continuity of care is also very important too as having to explain over and over again to different people is both tiring and exhausting. (Responder No 144)
If other hospitals have the capacity to help then it is a good thing. (Responder No 155)
In our area being wide spread and roads congested if you can be treated locally it is better for all (Responder No 34)

It makes sense (Responder No 81)
It probably helps the general community and development of the community (Responder No 200)
It will improve services, so it's a good idea. (Responder No 172)
It would be an advantage to utilize any available resources. (Responder No 157)
It would mean travelling for miles and hospital transport has become expensive now. (Responder No 27)
It's always good to share information and data, expertise and good practice. (Responder No 90)
its helpful (Responder No 4)
Joined up thinking! Could avoid duplication of effort? (Responder No 55)
Just common sense (Responder No 29)
KEEP COTTAGE HOSPITALS OPEN..... I would think they cost a little less than the main hospital, as they treat people who are recuperating, rather than in danger. The more friendly, family feel helps with recovery (Responder No 23)
Logical! (Responder No 227)
more specialised treatment can be provided in fewer centres (Responder No 10)
More/better facilities available in other units can only be good. (Responder No 63)
National heads the NHS name - we should not forget that title in any health context. (Responder No 47)
Need to be able to access the 'best' services. (Responder No 223)
Not enough information to answer this, so opted for YES as I prefer cooperation to competition (Responder No 80)
On the periphery of the area, attending a different hospital may be more convenient (Responder No 224)
Only if emergency response and waiting times are reduced (Responder No 33)
Partnership is always preferable as a modus operandi. (Responder No 54)
partnership is obviously a better approach (Responder No 28)
Providing the 'region' is not widespread requiring long journeys. (Responder No 121)
Self Explanatory (Responder No 83)
Services in our own local area should be concentrated on in the short term. (Responder No 66)
Shared knowledge is much better for all patients. (Responder No 75)
Shared services could improve overall services. (Responder No 26)
Sharing of expertise must be a good thing (Responder No 184)
Some services need a collaborative approach (Responder No 67)
Sounds as if an integrated provision will always be better. Maybe specialist provision targeted in specific areas. Also should improve communication and work in a joined up way. (Responder No 46)
the more the merrier (Responder No 167)

The NHS has become fragmented to a point where service levels vary depending on local area (postcode). Eg physiotherapy in Teignbridge area in past has been excellent. Now it's not so good but why the changes when it was working so well ? (Responder No 57)
This answer doesn't seem to need an explanation - a partnership in this way would seem an obvious step to take. (Responder No 142)
To ensure that all areas have equal access to services required. (Responder No 112)
To get care to more patients (Responder No 170)
travel could present a problemm (Responder No 138)
We need to know that all the available skills and resources are in the area and can be tapped into as and when (Responder No 233)
with all hospitals working together it can only give a better more complete service (Responder No 93)
Working with other hospitals means there is a mutual understanding of a good quality of care. (Responder No 181)
works well for outlying districts (Responder No 97)
wouldn't it be better if hospitals focused on the are they work within? (Responder No 192)
a larger range of experiences (Responder No 150)
Absolutely partnership and collaborative working is the way the NHS will service we should work together and not in competition with each other. (Responder No 18)
Again I have no idea what is involved in achieving this. The idea seem sexcellent. How practical is it and is it economically viable (Responder No 132)
All should be working in partnership as I believe this would improve care for all (Responder No 14)
Because it depends what services you want to improve. It's likely to be a 'zero sum' exercise, so improving one things is likely to be at the expense of something else. (Responder No 88)
Better choice of treatment if not specialised locally (Responder No 58)
Better communication is always a good way to improve. (Responder No 217)
But it seems to be about raw data and cost and not about patients and vulnerability - e.g. 3 buses to catch for non driving Brixham residents to Torbay Hospital or £44 for taxi return. (Responder No 232)
But not the private sector (Responder No 235)
By working together then I would expect that overall there would be greater efficiency both in cost and to the patient (Responder No 40)
can't see a reason not to (Responder No 15)
Centralized centres of excellence are good but we need to ensure that there is easy access to other hospitals and that there continues to be sufficient capacity to provide the services required without excessive waits. (Responder No 161)

Connections with people in the community, therefore helping people with more issues (like mental health, you could be helped nearer to your home but still e able to access emergency services if you need it) (Responder No 203)
Cooperation is generally good (Responder No 20)
Co-operation must be a benefit (Responder No 85)
Cost. (Responder No 50)
could improve medical cale and also customer quality (Responder No 179)
Could provide quicker treatment. (Responder No 48)
Efficiency (Responder No 49)
every aspect should be shared on a computer system so you could be seen easily at any hospital in the trust. (Responder No 87)
every day problems can be local more complicated cases should be regional (Responder No 7)
Expertise is then pooled. (Responder No 219)
Getting to big, focus on care for Torbay and don't spread to thinly. (Responder No 56)
good service. (Responder No 216)
Help spread the workload. (Responder No 41)
Hopefully the economies of scale will help control cost (Responder No 122)
I approve of partnerships (Responder No 61)
I believe it would mean longer waiting times for appointments since Torbay hospital is probably the one most GP's would refer patients to. (Responder No 152)
I believe patients should be treated as near to their own homes as possible. A wider geographical area could mean long travel times to other hospitals. (Responder No 21)
i do not wish to be sent to a hospital further away than Torbay hospital or Brixham Hospital that may not be up to the standard of Torbay, (Responder No 129)
I expect all of my services to be local. (Responder No 24)
I feel the trust area is large enough to cater for 90% of cases. (Responder No 12)
I think it should do everything possible to enable everybody gets a fair service wherever you are (Responder No 228)
I think that there should be a standard level of care which can only be achieved if the hospitals work together. (Responder No 169)
I think what we have in South Devon works well, if we begin to integrate services across the whole Devon geographical footprint, we risk services becoming even more thinly spread, over a much larger population. There is a risk with this that quality of care will decrease. (Responder No 108)
I would certainly encourage this if it means shorter waiting times, and the best service given by experts in their field. (Responder No 2)

I would have thought this obvious; the more people that pull in the right direction, the better. (Responder No 113)
I would really like to see this happen, but what about 3 or 4 years down the line where will we be then??. Want to work with other Hospitals in the Region?. Paignton wards closed now used more for Clinics , Dartmouth Closed. Now what would happen if some-one pulled the plug on Teignmouth and said they can use the minor injuries unit at Dawlish or Newton if more serious Torbay or Exeter (Responder No 130)
If it would help treat more people in a timely manner then it will be a good thing. (Responder No 64)
If one of the regional hospitals has a specialty that can be made avaliable it would make sense to have that centre as the regional centre (Responder No 52)
If there is pressure on one service in one area, then it would make sense to offer treatment in a less-pressured area if that other area is accessible to the patient. However, closing or reducing services in any area by definition increases pressure on related services across the board, and renders access to treatment more difficult for patients. (Responder No 116)
if you work together it makes things easier (Responder No 206)
Improvement is always a good thing (Responder No 68)
in order to expand expertise (Responder No 70)
In order to identify vacant beds and specialist departments, hospitals should be working together. (Responder No 137)
It can be expensive and stressful trying to get to a hospital appointment on time some miles from your home (Responder No 158)
It is usually better to have various opinions and options. (Responder No 5)
It seems common sense to me (Responder No 159)
It seems sensible the best type of treatment - easily - in the most apt situation (Responder No 8)
It will not making any different as it can go worse than getting better. (Responder No 51)
It would give access to more services and staff. (Responder No 65)
It's is wonderful to be in a ward close to home for ease of those visiting. (Responder No 114)
just do (Responder No 207)
Lack of communication is the source of many woes in life! (Responder No 25)
makes sense (Responder No 79)
Many patients are having to travel to other hospitals in order to receive early appointments and therefore travelling to other hospitals to get early appointments or received more specialised treatments is going to become the norm. (Responder No 98)

Maybe another hospital is closer. (Responder No 73)
Might help with reduced waiting times at times when the service is under pressure (Responder No 3)
more information gathered the better (Responder No 160)
More joined up working means less admin and paperwotk (Responder No 102)
More knowledge is better shared with different ideas etc. (Responder No 197)
multi-agency is beneficial for all (Responder No 30)
My analogy is Brexit or Remain. I am fervently remain. Strength in numbers. (Responder No 31)
My long-term neurological care is managed at RD&E and it is not always easy to transfer records between the two hospitals, so I take my own paper records with me. (Responder No 32)
need to as torbay seems unable to cope with routine things like MRI scans - assume no staff available to operate MRI which should be available 24/7 to keep costs down (Responder No 119)
Not if this means that you have to travel for extra miles to receive diagnosis and treatment (Responder No 44)
Offers better checks and balances of scarce resources (Responder No 156)
Only by sharing 'Cost-cutting ideas' ,all using best & most economical central medical suppliers (if they don't already) etc. Sharing learned answers when problems have been solved so that the same problem doesn't occur elsewhere. (Responder No 145)
Only if the partnership were to enable improvements in our own and other areas services by learning from each others experiences. Not as a method of passing residents over to cheaper areas which may be miles away in an effort to save money. (Responder No 222)
Other hospitals might have better equipment (Responder No 221)
outlying hospitals need help with knowledge and convenience for patients. (Responder No 36)
People move around (Responder No 209)
Problem shared... (Responder No 109)
Sharing expertise and services is sensible (Responder No 126)
Sharing resources/facilities/expertise makes sense. (Responder No 72)
Should lead to greater efficiency (Responder No 230)
So as to give better service all way around (Responder No 153)
So travel is reduced. (Responder No 143)
Some hospitals have better knowledge on certain things than others (Responder No 53)
South Devon can be a very busy place in the summer and he nearest hospital may not be the quickest to get to (Responder No 38)

spreading of best practice is good (Responder No 225)
tell me where the money coming from first (Responder No 37)
That seems to be what's going to happen anyway (Responder No 123)
The geographically spread out nature of Devon makes this vital. (Responder No 101)
The integration is working well at Torbay Hospital and extending this to other hospitals can only be beneficial. (Responder No 238)
The NHS should be a national service. Lose the expensive and pointless individual trusts. Should be run from the centre as originally designed. (Responder No 104)
There is still problems with the more local services that need to be looked at in my opinion. (Responder No 218)
This could work well in functions such as bulk purchase, but as we seem to be going towards specialist units in different locations I think attention needs to be given to travel distances and the patients ability to attend. (Responder No 86)
This is almost a joke! Brixham hospital is to be closed....if a heart attack etc happened timing essential, only place would be Torbay hospital.Brixam people left to die. If less serious what happens? To make hos. visits even worse,the only direct bus 67 has been stopped. Many elderly people do not drive. What is going on!!!!! (Responder No 59)
This may enable to get treated more quickly by visiting another facility. (Responder No 35)
This means the best for all (Responder No 22)
This only becomes necessary because of cutbacks in local services. (Responder No 146)
This should result in more specialist knowledge and experience being available (Responder No 60)
Though I would not like to travel any further than necessary, it is probably better for different hospitals to have expertise in different areas rather than duplicating expensive services (Responder No 19)
To call on the best facilities (Responder No 76)
Too much pressure on stretched resources (Responder No 74)
Torbay Hospital is such a good Hospital I think all is well as it is (Responder No 84)
use the different services available at all the hospitals. (Responder No 198)
When operational needs require, cooperation is essential to cover all emergencies. (Responder No 147)
Where possible care should be fluid across the regions (Responder No 234)
Working as a team is more joined up (Responder No 99)
Working in a partnership would give a wider availability to services (Responder No 231)
yes (Responder No 214)
Yes. (Responder No 213)

Yes. Although it feels better to have all services on your doorstep, in practice, all patients would want the best care undertaken by the most qualified staff. This may mean travelling further to gain access to the right services and professionals. (Responder No 237)

You can be treated nearer your home with the same level of care and it would give the trust a partnership which would hopefully boost staff and funds. (Responder No 205)

Q25 Voluntary and community groups are key to our success. Would you support the use of Trust money for these types of groups to help improve the services offered to patients, clients, families, carers and service users?

Because it depends what services you want to improve. It's likely to be a 'zero sum' exercise, so improving one things is likely to be at the expense of something else. (Responder No 88)

saves hospital staff (Responder No 150)

Seems a good idea to me (Responder No 101)

Should I ever require care at home I would prefer that to be managed and organised by the hospital service. (Responder No 25)

So many are struggling to give the best care with restricted resources. (Responder No 143)

Some financial support to groups can result in huge gains to the overall health of the trust. (Responder No 12)

support can be really useful for families going through rough times (Responder No 218)

The medical profession should not have to rely on volunteers. (Responder No 44)

The NHS is over worked and needs help. (Responder No 129)

The older one gets the more one needs services; so using the Trust money to help folk is a good use of the money. (Responder No 113)

The trust "dragged its feet" and missed a great opportunity to work with Anode, one of the best third sector organisations in the area. Services can be provided at a fraction of the public sector cost and if managed properly can work for the benefit of patients. There is a need however to 1) manage contacts with outside agencies correctly 2), support those agencies and share key information with access to good IT. (Responder No 237)

There are many skilled workers who are unpaid that should support the paid workforce. (Responder No 30)

These people are voluntary. (Responder No 146)

These types of support are vital but any financial support needs to be properly administered which leads to more and more admin. (Responder No 86)

they can help spread word and help more with funding (Responder No 179)
This would ease the pressure on already stretched staff numbers (Responder No 3)
This would mean more people getting the help they need (Responder No 22)
travel expenses should be paid to volunteers who other wise couldn't afford to volnteer (Responder No 87)
Unless it was well monitored, as I suspect some of the Trust money would be frittered away... (Responder No 41)
Voluntary and Community Groups are having to take up the slack where cuts in budgets are being made but their funding is also becoming more and more tight and difficult to find. They contribute to many aspects of support work to Carers, Cared-for and specific groups underpining the NHS and Social Care and feel that as they take on the roles that the NHS and Social Care are no longer frontline funding it would be good to offer this as part of their remit. (Responder No 98)
Voluntary and community groups can offer help that does not require the presence of medically trained staff. (Responder No 219)
Voluntary groups can provide useful and essential service at low cost (Responder No 14)
Volunteers can be hugely helpful but should never be relied on. And where are they magically going to come from? (Responder No 72)
Volunteers have helped within hospitals for years but do need the correct facilities and equipment to work with. H & S is important and NHS needs to support and train volunteers and ensure they follow guidelines. (Responder No 38)
volunteers need all the help they can get (Responder No 79)
Volunteers provide vital services (Responder No 102)
Volunteers, although wonderful, are not always reliable. (Responder No 65)
WE LOVE THE NHS WOOOOOO. TAKE MY MONEY. (Responder No 216)
We need more of these groups (Responder No 49)
Would like to see the real happenings than false pretences. (Responder No 51)
would prefere a medical trained person (Responder No 37)
yes (Responder No 214)
Yes but I don’t think it is safe to just rely on non professionals, however well intended. Nor do I believe it is reasonable to expect the viability of the NHS to rely on unpaid, non qualified volunteers. I worked as a volunteer until I felt I was really being put upon and expected to be treated like an employee. (Responder No 132)
yes but only for the very needy and after an in depth investigation (Responder No 147)
Yes if it would take the pressure off staff (Responder No 221)

Yes, but I feel it should be carefully monitored to ensure that funds are being used correctly and wisely. (Responder No 64)
you cannot have too much communication for these groups (Responder No 36)
You have already stated thats the key to your success (Responder No 123)

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 13 December 2017

Agenda Item:	12
Report Title:	Secretary's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Company Secretary following the last Council of Governors meeting on 22 September 2017.

1.2 The majority of items are included in the Lead Governor's report (agenda item 9) and will avoid being repeated below.

2. Main Report

2.1 **Election Timetable:**

Action	Date
Last Day for Publication of Notice of Election	02/01/2018
Deadline for receipt of nominations	18/01/2018
Publication of Statement of Nominations	19/01/2018
Deadline for candidate withdrawals	23/01/2018
Notice of Poll/Issue of ballot packs	02/02/2018
Close of Poll 5.00pm	27/02/2018
Count and Declaration of Result	28/02/2018

2.2 **Updated Policy:** An existing policy document titled '*Policy for Resolving the Differences between the Council of Governors and the Board of Directors'*. has been reviewed by the Lead Governor and Deputy Lead Governor. The document will be circulated as an appendix to this report.

2.3 **Distribution of membership and governor posters:** both sets of posters have been distributed to the following locations with a request to display in main entrances and other areas as appropriate. The posters will also be displayed throughout Torbay Hospital. Each poster has to be laminated to meet infection control standards.

- Ashburton and Buckfastleigh Community Hospital
- Bay House
- Brixham Community Hospital
- Castle Circus
- Dartmouth Clinic
- Dawlish Community Hospital
- Newton Abbot Community Hospital
- Paignton Community Hospital
- Teignmouth Community Hospital
- Totnes Community Hospital

The membership poster information is already being displayed on Trust TV screens and the rollout of the governor poster will be complete before 13 December. Governors on the Membership Group are aware of the ongoing project to link all TV screens across all the main sites.

2.4 **Meetings in 2018:** Agenda item 16 outlines some appropriate dates in 2018 for governors.

3. Recommendation

3.1 In reference to section 2.2, Council of Governors approves the '*Policy for Resolving the Differences between the Council of Governors and the Board of Directors'*.

4. Decisions Needed to be Taken

4.1 Note and comment on the information outlined above.
4.2 Approve the above recommendation.

5. Attached to this Report

Attachment one (to follow) - Policy for Resolving the Differences between the Council of Governors and the Board of Directors.

Torbay and South Devon NHS
NHS Foundation Trust

Agenda item 16

Council of Governors Meeting

Wednesday 13 December 2017 in the Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

As per the governor strategy document, please note that the Board-to-CoG meeting on 21 March has been removed and replaced with a development session with the non-executive directors. One further development session will be arranged for later in the year.

Future meetings:

2018

7 February	9am	Public Board
28 February	**1pm**	**Self-assessment**
7 March	9am	Public Board
21 March	**1pm**	**Development Session**
11 April	9am	Public Board
18 April	**3pm**	**Council of Governors**
2 May	9am	Public Board
23 May	1pm	Public Board
4 July	9am	Public Board
18 July	**3pm**	**Council of Governors**
1 August	9am	Public Board
15 August	**3pm**	**Board to Council of Governors**
21 September	***tbc***	**CoG / AMM event**
3 October	9am	Public Board
24 October	**3pm**	**Board to Council of Governors**
7 November	9am	Public Board
5 December	9am	Public Board
12 December	**3pm**	**Council of Governors**

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