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

Board Room, Hengrave House, Torbay Hospital, Torquay, TQ2 7AA
23 May 2018 13:00 - 23 May 2018 14:30

AGENDA

#	Description	Owner	Time
	In case of fire - if the fire alarm sounds please exit the Board Room immediately in a calm and orderly fashion. On exiting, turn left, exit the building through the sliding doors and assemble in Hengrave House Car Park.		
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 2nd May 2018 and Outstanding Actions Approve 18.05.02 - Board of Directors Minutes Public.pdf 9	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Interim Chief Executive Review Report of the Interim Chief Executive.pdf 27	ICE	
2.6	Strategic Issues		
2.6.1	Devon Sustainability and Transformation Partnership Update Report - Devon STP Hosting Agreement Approve Devon STP Hosting Agreement.pdf 41	DSI	
3	Delivery Issues		

#	Description	Owner	Time
3.1	Integrated Quality, Performance,Finance and Workforce Report - Month 1 Review Integrated Performance Report.pdf 55	DSI/DoF/DWOD	
4	Governance Issues		
4.1	Clinical Incident Report Information Clinical Incident Report.pdf 111	CN	
4.2	CQC Draft Inspection Report Summary Information CQC Draft Inspection Report Summary.pdf 161	CN	
4.3	Mortality Surveillance Scorecard Information Mortality Surveillance Scorecard.pdf 171	MD	
4.4	Revised Audit Committee Terms of Reference Approve Revised Terms of Reference for Audit Committee.p... 183	CS	
5	Governors' Questions Discuss	Ch	
6	PART B: Matters for Approval/Noting Without Discussion		
6.1	Reports from Board Committees Assurance		
6.1.1	Finance, Performance and Investment Committee - 22nd May 2018 (Verbal) Information/Assurance	RS	
6.1.2	Audit and Assurance - 23rd May 2018 (Verbal) Information/Assurance	ST	
6.2	Reports from Executive Directors		

#	Description	Owner	Time
6.2.1	Report of the Chief Nurse - Safe Staffing Information Report of the Chief Nurse - Safer Staffing.pdf 199	CN	
6.2.2	Report of the Medical Director - Medical Workforce Update Information Report of the Medical Director.pdf 215	MD	
6.2.3	Report of the Interim Chief Operating Officer Information Report of the Interim COO.pdf 221	ICOO	
6.2.4	Report of the Director of Estates and Commercial Development Information Report of the Director of Estates and Commercial D... 229	DECD	
6.2.5	Report of the Director of Workforce and Organisational Development Information Report of the Director of Workforce and OD.pdf 243	DWOD	
6.3	Compliance Issues		
6.4	Any Other Business Notified in Advance	Ch	
6.5	Date of Next Meeting -9.00 am, Wednesday 4th July 2018	Ch	
6.6	Exclusion of the Public	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems.
2. Failure to achieve key performance / quality standards.
3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision.
4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.
5. Failure to achieve financial plan.
6. Care Quality Commission's rating 'requires improvement' and the inability to deliver sufficient progress to achieve 'good' or 'outstanding'.

Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST BOARD OF DIRECTORS MEETING HELD IN THE BOARD ROOM, TORBAY HOSPITAL ON WEDNESDAY 2ND MAY 2018

PUBLIC

Present:	Sir Richard Ibbotson		Chairman
	Mrs J Lyttle		Non-Executive Director
	Mr P Richards		Non-Executive Director
	Ms V Matthews		Non-Executive Director
	Mr R Sutton		Non-Executive Director
	Mrs S Taylor		Non-Executive Director
	Mr J Welch		Non-Executive Director
	Ms L Davenport		Interim Chief Executive
	Mr P Cooper		Director of Finance
	Dr R Dyer		Medical Director
	Mrs J Falcão		Director of Workforce and Organisational Development
	Mr J Harrison		Interim Chief Operating Officer
	Mrs J Viner		Chief Nurse
In attendance:	Mrs D Butler		Deputy Director of Strategy
	Mrs S Fox		Board Secretary
	Ms J Gratton		Head of Communications
Governors:	Mrs W Marshfield	(Lead Governor)	Mr K Adams
	Mrs C Day	Mr P Coates	Dr C Davidson
	Mrs A Hall	Mrs L Hookings	

ACTION

78/05/18 **User Experience Story**

The User Experience Story was presented by Jill Breyley, Wellbeing Co-Ordinator for Volunteering in Health, Dr Matt Fox, GP lead for Coastal Locality, and Felix Gradinger, Researcher in Residence.

The Story concerned Mary who cared for Bob, her husband, who had dementia. Through integrated support from the Integrated Care Team and Volunteering in Health (the teams share offices) Bob was able to die at home. Following his death Jill was able to support Mary during the grieving process through to Mary being one of the first participants on the HOPE course. Mary is now supporting others on the course and also providing administrative support for Volunteering in Heath.

Much of this support has been made possible through the joint working of both teams and it was felt that in order to move forward better communication between systems would be necessary. It would also help prevent admissions to hospital because people who were having difficulties would be identified and managed earlier.

The Interim Chief Executive said that this work really encapsulated the care model and the focus on putting people and their needs first and to enable them to find strategies to manage any health problems.

Mr Coates asked how this work fitted into social prescribing and Mr Gradinger said that social prescribing was around providing social activities for people, and the Volunteering in Health project provided a dedicated link work and intervention for 3 months – however they both fitted very well together.

Mrs Marshall asked how the team would work to enable participants to get to know each other better and so be able to support each other. Ms Breyley explained that the participants on the HOPE course were encouraged to meet up together outside of the course and also they were trying to set up specific groups eg stoma care, which would be run by the patients/carers with support from volunteering in health.

The Board thanked the team for their presentation.

79/05/18 **Board Corporate Objectives**

Noted.

PART A: Matters for Discussion/Decision

80/05/18 **Apologies for Absence**

Apologies were received from the Director of Estates and Commercial Development, Director of Strategy and Improvement, Mrs J Marshall and Councillor J Parrott.

81/05/18 **Declaration of Interests**

Nil.

82/05/18 **Minutes of the Board Meeting held on the 11th April 2018 and Outstanding Actions**

The minutes of the meeting held on the 11th April 2018 were approved as an accurate record.

83/05/18 **Report of the Chairman**

The Chairman reported on the following:

- Several of the Winter Thank You events had taken place and have been very well supported.

- All staff have now moved back to the Annex site following the recent fire. It had been possible to reopen the nursery the day after the fire and the response provided from clinical operational teams was noted – very few patients had been cancelled as a result.

- The Chairman and Interim Chief Executive attended a full Council meeting recently where the meeting formally received the Local Government Chronical Award for Health and Social Care, won jointly with the Trust.

84/05/18 **Report of the Interim Chief Executive**

The Interim Chief Executive briefed the Board as follows:

- **Teignmouth Consultation** – the CCG was leading, with the support of the Trust, a consultation in respect of the provision of primary care and voluntary sector services on one site. A programme of engagement sessions were planned over the next few weeks to gain the views of the community and stakeholders. This was in keeping with the Trust's model of care, however one issue concerned the 12 rehabilitation beds at Teignmouth Hospital. The model of care implemented in the coastal locality has resulted in those beds now not being required as the care was delivered in the community or in people's own homes. Any change to this commitment would be subject to formal consultation.

- **Dartmouth** – the local community have asked for a meeting with key stakeholders following the disappointing news that Riverview cannot be progressed. The Trust and its partners remained committed to finding a solution for the people of Dartmouth.

- **CQC Draft Report** – the draft report has been received and the Trust has submitted a factual accuracy report back to the CQC. The Trust has met with the CQC and the meeting was very positive in terms of the outcome of the report, the results of which demonstrate the work undertaken by staff across the Trust to address transformational change and also improvements identified by the CQC following their last visit. It was expected that the final report would be published on the 17th May.

- **Operational Plan** – this would be discussed later in the meeting, but the Interim Chief Executive wished the Board to be aware that the Trust was still experiencing significant challenges in terms of pressure in the system.

- **STP** – Sophia Christie has been identified as the Chief Executive for the STP and Accountable Officer for the CCG. Her appointment was subject to Ministerial approval which had not yet been received. In the interim Simon Tapley was undertaking the Accountable Officer role for NEW Devon and the South Devon and Torbay CCGs.

- **Plymouth Hospital Trust** has changed its name to University Hospitals Plymouth NHS Trust to reflect its strong partnership with Plymouth University.

Mr Sutton asked if any other sites had been identified for Dartmouth and the Interim Chief Executive said that there were some alternatives, but that due to commercial sensitives they could not yet be named.

Mrs Lyttle asked for assurance that, given the operational pressures that have been affecting the Trust over the past 18 months, the Trust had not taken too many beds out of the system. The Interim Chief Executive explained that the Trust's Operational Plan for the coming year took account of the Trust's capacity needs and ability to meet demand, and also that of patient safety and experience. She said the Trust would need to ensure it could flex capacity to meet demand and do that safety. She added that beds were not always the answer – the Care Model was based on providing care in the homes of patients and reduce the need for beds in the acute setting. The Interim Chief Operating Officer added that the availability of side rooms to manage infection control issues was something that would enable flow to continue when, for example, the Trust was managing a flu outbreak. It was noted that that investment requests from the Service Delivery Units this year were around how to improve flow and requests for additional staffing for example in ED.

Mr Welch queried the fact that the Trust would be receiving, in the form of a bonus, some of the unearned STF funding and he asked how this could be communicated to staff who have worked very hard in the past year to meet targets and find savings etc. The Director of Finance explained that the Trust was informed of the bonus at a very late stage of the financial year and was not aware that it would be made. He said that the bonus was based on two things – partly on over-achieving the Control Total and also on accepting the Control Total irrespective of whether it was delivered. Therefore the bonus reflected the hard work over the last year to get to the point of overachievement and this needed to be reflected in the messaging to staff.

Strategic Issues

85/05/18 **Devon Sustainability and Transformation Partnership Update Report**

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 now produced monthly following the Programme Delivery Executive Group (PDEG) meetings. This is the fifth update, following the meeting of PDEG on 16 March.

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 of 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 Friday 20 April are as follows:

- System development meeting with Regulators
- Organisational Development and Design
- Proposed Devon Strategic Outcomes Framework
- Health Navigator / economic modelling
- Acute Services Review
    - Service Delivery Networks – principles and indicative levels for approval
    - Acute Service Reviews – guiding principles for agreement.
- STP Estates Strategy – next steps

Risk
As previously identified, the main risk to the Trust remains having the leadership and clinical capacity to engage in and inform STP programmes and work streams 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 Board noted the report.

Mrs Matthews queried the statement in the report that the Trust was fully engaged with the Devon STP Strategy against the statement in previous meetings that the best way the Trust could support the STP was to deliver its own targets. The Chairman said that the Trust had not changed its approach – it needed to deliver its targets in order to support the wider STP, in particular because the STP was viewing delivery of the Care Model as best practice. It also gave the Trust influence at STP level.

Mr Sutton queried the STP's influence on the Trust's estate plans and asked if it was in a position to submit the Wave 4 plans and move quickly if required. The Chairman stated that the STP estates function was not yet established and said that he did not feel this would impact on the Trust's plans as he could not see any intent for the STP to have an approval role as they did not have any legal standing. The Director of Finance added that, in respect of the Trust's Emergency Department development, there was a need for the STP to reference the development as part of their estates strategy, but the decision-making sat at NHSI level.

Mr Richards queried any output from STPs to justify the investment in them and the Medical Director stated that a lot of practical improvements at a clinical level had been realised for example how services were delivered to reduce risk and improve quality. Mr Richards asked how the Board had a part in influencing/ signing off the work of the STP and ensuring there was more transparency to the process. The Chairman stated that this issue had been raised at the STP Collaborative Board several times and said that the STP was a grouping not just of NHS Trusts, but also local political bodies and getting them to agree a common purpose was difficult. The Interim Chief Executive added that the STP Chief Executive was leading a piece of work to review ways of working and the STP's strategy so that more clarity could be

provided.

The Board noted the progress of the Devon STP

Delivery Issues

86/05/18 **Integrated Quality, Performance, Finance and Workforce Report – Month 12**

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 Improvement (NHS I) of achieving a £4.7m surplus by 31st March 2018.

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

- 70% is dependent on delivery of the Trust's financial plan to deliver the agreed Control Total; and
- 30% is dependent on delivery of both (a) A&E performance at Trust and / or STP level and (b) achievement of A&E operational mile stones (such as GP streaming).

These thresholds were met in Quarter 1 and Quarter 2, for performance and year to date for the finance element; resulting in £4.22m secured/ accrued from the STF. The performance element of STF for Quarter 3 and Quarter 4 has not been accrued; the impact for the year is £1.137m.

NHS I are assessing Trust financial performance using the pre STF Control Total position. So the notification of non-achievement at Q3 or self-assessment of non-achievement of Q4 on the performance element of the STF does not impact on the assessment of financial performance.

Winter funding allocations:
On 15th December the Trust received details of the allocation of winter funding monies. The funding has been allocated nationally in two tranches. Firstly, acute Trusts were allocated funds on a 'fair shares' basis to reflect the cost of emergency and urgent elective activity across winter that is already in operational plans and is being incurred by providers. The allocation is based on emergency services activity in Trusts with a Type 1 A&E. This was to enable a corresponding improvement in the reported Month 7 forecast outturn financial position.

The second tranche of funding was the subject of discussions between individual Trusts, their NHS I Regional Director and the National Director of Urgent and Emergency Care. This additional winter funding was for new initiatives to improve A&E performance over winter and has been spent on the specific schemes set out below. Where the schemes involve the purchase of beds either in the acute provider or the community, the level of expenditure has to be agreed with the Regional Director before it is committed.

Table 1 – funding allocated to Torbay and South Devon

	Purpose of funding	Value
Tranche 1	To reflect existing costs of winter in plans. Expectation of corresponding improvement in M7 forecast position	**£0.6m**
Tranche 2	*provide additional Domiciliary Care, additional Rapid Response capacity, and additional voluntary sector capability; up to 15 beds per day released for management of acute patients*	**£0.396m**
	Development of a front door Rapid Assessment and Discharge Service (RADS); 5 per day - based on current performance of 7 patients seen per day and a 70% discharge rate	**£0.102m**
	In totality we expect the schemes in Tranche 2 to ensure you at least maintain your YTD, 92.4%, performance in Q4	**£0.498m**

The Trust has received Tranche 1 funding and has confirmed spending of Tranche 2, both these tranches are assumed in the forecast and notified to NHS I as such.

Regulatory Context - NHS I Single Oversight Framework:
The Single Oversight Framework (SOF) is used by NHS I to identify NHS providers' potential support needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability.

As previously reported NHS I have made changes to the SOF which applied from October 2017 onwards. 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 Segment One (maximum autonomy) to Segment 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 has not changed as a result of the revisions to the SOF.

An additional performance metric, associated with the identification of patients who have dementia, has been added to the framework by NHS I and has been included within the performance dashboard.

Key Issues/Risks

The headlines for Month 12 performance against the financial, operational, quality, change, and workforce frameworks established by the Trust are summarised in Section Two of the attached Integrated Performance Report, with the full performance frameworks being set out in Section Three, and underpinned by the attached Dashboard.

The key issues and risks to note are:

Finance:

- **Overall financial position:** The financial position for the financial year to 31st March 2018 is a surplus of £4.84m against a planned surplus of £4.76m, achieving the Control Total set by NHS Improvement. This excludes atypical items including revaluation benefit, charitable grant and Tranche 1 Winter Pressure monies. All actions previously described in the Trust's Financial Recovery plan for 2017/18 have been delivered; the final element, being the receipt of the balance of the Improved Better Care Fund being agreed by Torbay Council in March. This position excludes income in respect of Q3 & Q4 ED STF and includes MARS costs incurred in February. In transacting technical revaluation adjustments, an unconditional Charitable Fund grant and accounting for winter pressure funding, the final published accounts will show a higher surplus. The Trust has yet to hear whether it will be allocated any STF bonus allocation for 2017/18; the final reported position will, again improve in line with the amount, if any that is received.

  The delivery of this position, a significant turn-around of the £11m deficit incurred in 2016/17, is a tremendous achievement for the Trust. It reflects a huge amount of hard work put into delivering this result from Clinical, Support and Corporate teams, across the organisation. That effort is both recognised and enormously appreciated by the Board and the wider NHS system.

- **Year-end cumulative CIP savings delivery position:** The Trust has delivered £45.44m of CIP savings against our target of £42.08m (including income Generation target); resulting in a £3.36m over-delivery. This is an impressive position, given the significant target set this year. It represents a significant achievement across both delivery units and support services. The new CIP Programme management arrangements, together with more accurate forecasting methodologies have enhanced delivery assurance throughout the 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 11, the Trust had an actual use of resources risk rating of 2 (subject to confirmation by NHS Improvement and may change once the Bonus STF is confirmed). The Agency risk rating of 1 is on plan with the budgeted rating of 2.

- **Capital Spend:** The approved capital programme for 17/18 is significantly underspent. The approved budget for 17/18 totalled £13.3m. Actual outturn expenditure totals £6.1m. An assessment will be undertaken during April 2018 by the Executive Directors to determine the value of underspend that needs to be carried forward into 2018/19.

Summary of Performance Against Frameworks:

Framework	Number of KPIs	RAG Rating at the end of Month 12			
		Red	Amber	Green	Not Rated
National Performance Standards (trajectory)	5	4	0	1	0
Local Performance Framework	23	10	0	12	1 *(no target set)*
Community and Social Care Framework	15	3	1	7	4 *(no target set)*
Quality Framework	19	6	3	9	1 *(no target set)*
Workforce Framework	4	2	0	2	0

National Performance Indicators
Against the national performance standards, for Month 12 the Trust has delivered the following outcomes:

- **4 hour ED standard:** In March the Trust achieved 80.6% of patients discharged or admitted within 4 hours of arrival at accident and emergency departments. This is a fall on last month (81.1%) and is below the agreed Month 12 Operational Plan trajectory and national standard of 95%. Performance has improved in April; the A&E Performance Predictor (which is circulated daily) for the 16th April shows 87.2% of patients being discharged/admitted from ED and MIU within 4 hours.

- **RTT:** RTT performance has marginally declined in March with the proportion of people waiting less than 18 weeks decreasing from 82.4% in February to 81.6% in March. At the end of March 33 people were reported as waiting over 52 weeks against the target of zero. Operational pressures have continued to limit the number of elective inpatient admissions coupled with the two severe weather incidents in March cancelling elective capacity.

- **62 day cancer standard:** 79.0% (validated 14 April 2018) against the 85% national target is a deterioration on last month (83.1%). Current forecast for Q4 is 82.5%.

- **Diagnostics:** The diagnostics standard is not met with 8.9% over 6 weeks against the standard of 1%. The greatest number of long waiting patients over 6 weeks are for routine MRI. The deterioration being a result of lost capacity for routine patients to support the emergency pathways along with lost capacity in March from the weather related cancellations.

- **Dementia screening:** The Dementia Find standard has improved with 92.7% achieved against the standard of 90% for the first time. This is a significant achievement and aided by the allocation of HCA resource to support the wards over the last two months.

Local quality indicator performance variances to highlight

- **Delayed Transfers of Care** is becoming an area of national attention and is linked to securing the Better Care Fund. Performance in community hospitals has improved from 267 in February to 206 in March against a target of 315. The Acute site showed a decrease in delays 144 in February to 128 in March against a target of 64. Work is continuing with teams to make further improvements and keep delays to a minimum level.

- **Never event:** In March, one Never event is reported. Full investigation has been completed with the event assessed as low harm.

- **Follow up appointments waiting beyond the planned "to be seen by" date** increased from 6,761 in February to 7301 reported in March.

- **C Difficile infections**; 1 new acute infection is reported in March (0 in the community); this is not reported as a lapse in care.

Bed Closures due to Infection Control have decreased from 544 in February to 64 bed days lost in March.

The Board noted the following:

Performance

- The Trust was still struggling to meet the 4 hour standard, with low levels of discharge at weekends affecting flow in the week. A lot of work had taken place to review the Trust's Winter Plan and to define actions that could be taken in the short term to start to reset the system and meet the 4 hour target. Learning was being taken from both Cornwall and Plymouth in this respect.

- The 4 hour target for April was 88% (this required validation).

- RTT 52 Week Waits – the Trust had 33 people waiting over 52 weeks for treatment in March, which was disappointing as it had not been possible to achieve the Trust's target for zero. This number was likely to rise to c40 in April and in the main they were patients in Urology and Upper GI. The Board noted that the Urology team was ensuring that cancer patients were given priority and it was expected an improvement in the cancer position would shortly be seen. Headroom also needed to be incorporated into plans so that specialities could cope with unexpected events – eg the recent severe weather.

- The Board noted that there needed to be some investment made as part of the Trust's Operational Plan, so that performance could be improved and targets met.

- RTT 18 weeks – areas struggling to meet targets were Trauma and Orthopaedics (who had the single largest backlog); Urology; Ophthalmology; Upper GI; and Gastroenterology. Each team had plans in place to bring performance back to target and the SDUs were clear that they were accountable for managing performance and delivery of targets.

- Cancer – 62 day waits- performance had slightly improved in March (79.4%) and was also improving into April (85% - subject to validation). A risk to performance has been identified in May and June and this was reflected in the trajectories.

- Diagnostics for patients waiting over 6 weeks – this was at 9% and reflected the high volume of activity and also the recent severe weather. It would take a number of months to bring performance back down to around 3-4% in line with submitted trajectory.

- The trajectories for 2018/19 have been submitted as part of the Operational Plan and were consistent with planning guidance. The request was that they reflected a realistic view of performance. For example Trusts were asked to set a target for the 4 hour target of either the quarterly performance in the previous year or 90% - whichever was the lowest. The Trust had therefore set 90% for quarter 4 and it was likely there would be some pushback from NHSI in this respect.

The Chairman was pleased to note the plans in place to improve performance and cautioned against a system reset in isolation, as associated long-term system change would need to accompany the reset for it to be of value. This was acknowledged.

Mr Welch stated that he was disappointed in terms of the Trust's performance against targets, in particular that zero had not been met for the 52 week wait performance by the end of the financial year. He wished to place on record that he felt it was important the Trust met at least the lowest targets set by NHSI and this was acknowledged. The Interim Chief Executive added that this year the intention was to submit realistic plans, with a focus on safety and quality of care within the financial envelope given the Trust, but this had meant that the Trust's performance trajectories have had to reflect that aim.

Mrs Lyttle welcomed the detailed debate around performance and agreed that the Trust could not be in the same place this time next year, and suggested that, at STP level, decisions needed to be made around the potential to stop delivering some services so that Trusts could focus on core services and delivering those well.

The Interim Chief Operating Officer agreed but added that in addition the Trust needed to look at redesign of systems, for example the outpatient innovation programme of work that had just commenced, and to also work with vulnerable specialties to find the most effective way to manage care for those patients.

Finance

- The Trust had delivered a surplus, excluding exceptional items, of £0.65m ahead of plan for the end of year. This reflected a significant amount hard work by staff to reach this position and the Board wished to place on record its thanks to those staff for their hard work.

- The Trust had received a Winter Pressures Grant, which had been unexpected and not in plan, and a grant from the Trust's Charitable Fund. In addition, as previously discussed, the Trust had benefited from a STP bonus of £4m associated with meeting its financial targets and this would translate into cash for capital spend in 2018/19.

- Income had improved in month as a result of receipt of the Better Care Fund allocation. Pay was above budget, but was reducing. Agency spend had increased, but was still below the agency cap.

- There had been a significant underspend against plan which was due to the Trust not being able to secure loans and also because cash was only allocated during the year once there was confidence in the Trust's financial position, therefore delaying the start of capital projects.

- The Trust's Financial Improvement Plan had delivered in excess of £45m in the year which was due to a huge effort by staff and it was important to note that the Trust was in the top 3 of Trusts in the country in this respect and was being recognised nationally in terms of this achievement. This achievement must not be underestimated.

- Mr Sutton wished to reflect on the benefit to the Trust in the coming year of the Charitable Fund grant, which had been match-funded by the Centre. He said that this was a really good use of the funds to benefit the Trust in the coming year.

- The Board noted that the Trust's position was still subject to audit judgment, but there was no indication of any significant concerns.

Quality/Safety

- The Trust met its CDiff target for the third year running. This reflected the work of the Infection Prevention and Control team over the past year. The role of the Team in supporting the Trust over the winter should not be underestimated in terms of holding staff to account to manage infection issues appropriately with limited side rooms etc.

- Dr Dyer noted that the numbers of follow up appointments beyond planned date had increased and informed the Board that task and finish groups had been put in place to transform the Trust's approach to Outpatients and how it operated.

- Mrs Taylor asked what action was being taken to improve the Trust's performance against the VTE risk assessment target. The Chief Nurse reported that a member of staff had been put in place to translate the paper document into the electronic system and she hoped that in May/June an improvement in performance would be seen.

Workforce

- In terms of the Workforce Plan, an 84 wte reduction had been delivered against a plan of 162 wte posts.

- For the coming year it would be ensured the plan was dynamic and could be flexed to meet changes during the year. To this end the Workforce and Finance teams were working much more closely together to ensure there was a high level of confidence in terms of the plan and ensure consistency of information.

- Sickness had increased in January to just over 5%, which was due to the flu outbreak, and had now started to reduce.

- Improvements were starting to be made in respect of Achievement Review performance following a lot of work with managers around the new approach to the reviews.

- Mandatory training performance had also started to improve along with the introduction of more ways to undertake training.

The Board formally reviewed the documents and evidence presented.

Governance Issues

87/05/18 **Freedom to Speak Up Guardians Report**

Strategic Context

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

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

Key Issues/Risks

Since the last report to the Board in November 2017, 13 concerns have been raised through the Guardians.

Sarah Burns, Julia Pinder and Tierney Leaver from the Freedom to Speak Up Guardian team attended for this item. The following was discussed:

- Around 100 concerns had been raised with the team over the last 2 years. The majority of these were around processes not being followed; poor management or management skills; pressures of work; and decision-making around patient care and discharge of patients.

- It was felt that staff did not have a 'go to' person in their department with whom they could raise concerns and who was not their manager and the Guardians were filling this gap.

- The Team have done a lot of work with the Hotel Services Department over the past year and the result of this was just starting be realised, which was positive and showed the benefit of the Guardian role.

- Guardians acted as a first point of call for concerns. Guardians received training to help them undertake their role and provide support to staff when rising concerns. In the main staff came to Guardians after having raised concerns with managers and feeling that those concerns have not been acted upon and are not confident in escalating those concerns to the next level up.

- It was noted that some concerns would need to be dealt with through the HR route and Sarah Burns explained that the Guardians were trained to ensure that concerns were properly signposted and dealt with through the appropriate route.

- Mrs Lyttle queried the need for Community Guardians and it was noted that an advert had been placed for a Community Guardian and no expressions of interest had been received – it had been hoped that several applications would have been received. It was felt this was a reflection of the fact that the community did not yet fully understand the role and value of the Guardians. Mrs Lyttle added that she was also concerned about staff in the community feeling isolated when working and the role of the Guardian in supporting them.

- Mrs Hall queried the support Governors could provide to Guardians and Sarah explained that the National Guardian office encouraged Guardians to work with lots of different groups and this would include them attending Governor meetings to highlight the support provided by Guardians and their work. This would be further discussed outside of the meeting. CE/SB

The Interim Chief Executive thanked the Guardians for their report and asked if there was anything the Board could do to support them in their work. Sarah said that consideration around making the roles substantive was important because although the Trust had several Guardians in post, she and Julia Pinder were picking up most of the work and this was starting to be untenable.

Mr Welch, as the NED lead for the Guardians, stated that he engaged with the Guardians on a regular basis and suggested that the Trust needed to look at the issues raised, in particular through the work with Hotel Services, in case it was reflected elsewhere in the Trust. Sarah thanked Jon for his support and also that of the Interim Chief Executive.

The Board of Directors noted the contents of the report.

88/05/18 **Report of the Guardian of Safe Working Hours**

Strategic Context

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

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

Key Issues/Risks

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

- The level of reporting has fallen. The reasons for this change are discussed in the paper. The Guardian will develop a strategy for increasing reporting and other intelligence in relation to junior doctors' hours compliance. The level of completion of actions from the exception reporting is very low. An action plan will be drawn up by the new Guardian to improve completion.

- The Guardian of Safe Working Hours (GOSWH) post has been filled by Mr Shah Punwar, Consultant Orthopaedic Surgeon. He is completing a period of induction to the role.

- The Guardian has been focussing on the general surgical 'hotweek' which has been highlighted as the cause of a significant proportion of non-compliance with the new contract hours of working. Trials of new ways of working are in progress.

- Failure to recruit junior doctors, sickness and other absence or inability of some junior doctors to fulfil on-call commitments are also contributing to exception reporting. The education and medical HR departments are working together to mitigate the impact of those shortages.

The Trust's new Guardian of Safe Working Hours, Shah Punwar, attended the meeting and gave the following briefing:

- Shah had been in the post for around 2 months.

- Over the last two months 67 exception reports had been submitted, many of them are due to demands of working the hot week.

- A lot of the reports are from F1 doctors and action had already been taken to reduce demands on their time – for example they are due to start work at 7.30 am, but are coming in at 6.30 am to ensure they

have all the necessary information ready for their consultant. The work they are doing can be undertaken by other members of staff and administrative support was being put in place to support them. In addition the move to Nervecenter had presented some initial problems resulting in exception reports.

- Shah has been making contact with doctors who have produced exception reports, with support from the educational supervisors, to ensure the doctors feel supported and that issues are resolved.

The Chief Nurse asked Shah if he felt confident that the junior doctors were engaged in the Trust's Wellbeing Strategy. Shah said that there was a fine line between professionalism and working additional hours to finish a job or for training opportunities, compared to feeling obliged to work over contracted hours, and this needed to be drawn out of the exception reports and understood.

Mrs Lyttle queried the Trust's confidence in filling the vacant posts detailed in the report and it was noted that the Trust could not influence who applied for posts, but could find alternative staff to carry out some jobs to free up junior doctors.

The Interim Chief Executive thanked Shah for his report and for the work undertaken to support junior doctors manage their working hours. The Chairman reminded the Board that it had been suggested it would be useful for Board members to shadow some junior doctors and he had shadowed one in ED which he have found very valuable.

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

89/05/18 **Governors' Questions**

Mr Coates asked if it would be possible to include numbers as well as percentage data in performance reports. The Interim Chief Operating Officer noted that the information was contained in the report but would be reviewed to ensure visibility.

PART B: Matters for Approval/Nothing without Discussion

Reports from Board Committees

90/05/18 **Audit and Assurance – 13th April 2018**

Mrs Taylor provided assurance to the Board that the meeting was aware of the cyber security and GDPR risks the Trust currently held, and which would be discussed in the Private part of the meeting.

91/05/18 **Finance, Performance and Investment Committee – 24th April 2018**

Noted.

92/05/18 **Compliance Issues**

Nil.

93/05/18 **Any Other Business Notified in Advance**

Nil.

94/05/18 **Date of Next Meeting – 1.00 p m, Wednesday 23rd May 2018**

Exclusion of the Public

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

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1	Detailed report to be provided to February meeting on the STP's demand management strategy	DSI	**February Update** – the STP had not yet published its demand management strategy. **April Update** – the strategy had not yet been published. **Remove action** – will be brought to the Board once published	06/12/17
2	March Board Development Session to include a review of winter.	CEPA	**April Update** - the review of Winter and the Trust's winter plan was taking place and would be brought to the Board when complete.	07/02/18
3	Provide refresh of paper on the focus and structure of STP	DSI	**May Update** – this cannot be provided until the STP refresh has taken place. **Remove action** – will be brought to the Board once published	11/04/18
4	Consider regular updates to the Board on performance against the Staff Survey action plan	DWOD	**Completed**	11/04/18
5	Discuss how Guardians could work with Governors and other groups	CE/SB		02/05/18

Cover sheet for a report to the Trust Board of Directors					
Report title: Chief Executive's Business Update					**Date: 23 May 2018**
Report sponsor	Interim Chief Executive				
Report author	Director of Strategy and Improvement Joint Heads of Strategic Communications				
Report provenance	Report reviewed by Executive Directors and Interim Chief Executive				
Confidentiality	Public				
Report summary	An update from the Interim Chief Executive of key corporate, local system and national initiatives and developments since the last meeting of the board.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☐	**Review** ☒	**Decision** ☐	**Approve** ☐
Recommendation	The Board is recommended to **review** the report and **consider** implications on the Trust's strategy and delivery plans.				
Summary of key elements					
Strategic context	Strategic/corporate objectives this report aims to support: • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	This report is set in the context of the following corporate risks: • Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems. • Failure to achieve key performance standards. • Inability to recruit/retain staff in sufficient number/quality to maintain service provision. • Lack of available Care Home/Domiciliary Care capacity of the right specification/ quality. • Failure to achieve financial plan. • Delayed delivery of integrated care organisation (ICO) care model.				
Summary of scrutiny	This report has been reviewed by Executive Directors (15 May 2018) and the Interim Chief Executive (16 May 2018)				
Stakeholder engagement	This report is shared widely and forms the basis for Trust Talks, is published on the intranet and internet and is shared with Governors, MPs and other stakeholders				
Other standards affected	Nil				
Legal considerations	None				

Report title: Chief Executive's Business Update		Date: 23 May 2018
Report sponsor	Interim Chief Executive	
Report author	Director of Strategy and Improvement Joint Heads of Strategic Communications	

1 Trust key issues and developments update

Key issues and developments to draw to the attention of the Board since the last Board of Directors meeting held on 2 May are as follows:

1.1 Safe Care, Best Experience

Continued care model engagement

Teignmouth engagement
The Trust is supporting the South Devon and Torbay CCG in engaging with local people on options for changes to health and care services in the Teignmouth area of the coastal locality. This includes the idea of co-locating the health and wellbeing team along with some out-patient and physiotherapy services with local GP practices.

It is now three years since services in the coastal locality were reorganised so that Dawlish became the clinical hub and Teignmouth became the base for the health and wellbeing team, most outpatient clinics and it was planned that it would have rehabilitation beds. Over the past two years since the changes took effect, the multi-disciplinary health and wellbeing team has been able to support people at home or in a care home to such an extent that there has been no need to re-introduce the 12 rehabilitation beds at Teignmouth Hospital.

We are at an early stage in the process, where no decisions have been made, and where the views of local people can help shape any proposals for change. This is not yet a formal consultation – rather a chance to involve people early on in considering the range of options.

The suggestions under discussion are designed to improve services by:

- Making the best use of staff and resources
- Continuing to support people out of hospital unless hospital based care is clinically needed
- Tackling accommodation issues such as the unsuitability of an ageing hospital building in Teignmouth for the delivery of modern health and care services; a lack of expansion space in the town's three GP practices; a need to find a long term base for the area's successful health and wellbeing team
- Strengthening the close working between NHS and voluntary sector services
- Ensuring the future provision of services used by most local people in the town.

Local people are being asked what their views and thoughts are on the ideas and they can find out more by looking the information on the CCG website www.southdevonandtorbayccg.nhs.uk or attending one of the drop-in sessions being

held in Teignmouth and Dawlish. They can provide feedback via a written or online questionnaire. The engagement continues until 8 June 2018 after which feedback will be looked at and considered.

Dartmouth public meeting

The afternoon drop-in sessions and evening public meeting held in Dartmouth on Monday 14 May were very well attended. We are grateful to Father Will for offering St Saviour's Church as a venue, and to Sir Geoffrey Newman for Chairing the evening session, and enabling as many people as possible to share their views. People expressed a range of views during the afternoon session and were able to discuss their issues and concerns on a one to one basis. There was a Q&A format for the evening session and people expressed strong feelings on a range of issues, including:

- the availability of beds for short-term residential and nursing care
- domiciliary care capacity and support for carers
- ambulance response times to a remote population
- the collapse of River View and the subsequent failure of plans to develop a Health and Wellbeing Centre there
- the closure of Dartmouth Hospital
- fears about NHS services being outsourced

Comment: I attended the meeting with Simon Tapley, Interim Chief Officer and Director of Commissioning for the CCG, and a selection of our senior managers who have been involved in developing plans for services in Dartmouth. As well as answering people's questions on the night, in response to a challenge from Cllr Jonathan Hawkins, we undertook to provide a written response to the people of Dartmouth within 14 days on plans for Dartmouth Hospital, short-term bed-based care, and the development of a Health and Wellbeing Centre, which is currently being run from Dartmouth Clinic

Wellbeing Co-ordinators

The work of our Wellbeing Programme was featured on BBC Spotlight, Monday, 14 May and throughout the day on Radio Devon. A Wellbeing Co-ordinator and her client, Shaun were interviewed in the garden of a local mental health charity in Paignton, Daybreak, where Shaun is now helping out and training to be a peer mentor for others. Shaun has a degenerative spinal disease and had been living in a care home after a fall resulted in a brain injury. The Wellbeing Programme has helped him to re-engage with life, and his peer mentor training at Daybreak resulted from his attending a mental health recovery course there – all supported by his Wellbeing Co-ordinator. Local GP and Locality Lead Dr Andrew Thornton was also interviewed at Paignton Health and Wellbeing Centre. He endorsed the programme and stressed its importance in helping people in ways that enable them to re-connect with their lives and communities, with an improvement in their overall wellbeing and a resulting reduction in GP and hospital contacts.

1.2 Well Led

CQC inspection report

During February and March, the CQC visited five of our services: hospital maternity, hospital outpatients, hospital end of life care, community end of life and community children and young people. Inspectors also looked at how well-led the Trust is. As a

result of significant improvements made since their last visit, inspectors rated the Trust as 'good' overall and 'outstanding' for caring.

Hospital and community health services for children and young people are rated as good across all five domains – safe, effective, well-led, caring and responsive. Overall for the trust, the 'safe' domain remains as 'requires improvement'. This is down to issues such as the fabric and environment of some of our buildings and facilities, making sure all staff complete their mandatory training, ensuring regular equipment checks are completed and keeping documentation up to date. Maternity and community end of life care are also rated as 'requires improvement' – although with some observations of outstanding and good practice. The full report is available online at the CQC website.

Comment: We are delighted that the inspectors recognised the delivery strengths of our integrated services in Torbay and South Devon. Staff have worked tirelessly since the CQC last visited in 2016 to improve the patient experience, through focussing on what is important to each individual they see. We have made tremendous progress and delivered real quality improvements, whilst also managing to achieve our challenging financial target of saving £40m during the last year. We have been working in an exceptionally challenging environment, and our success is wholly down to the determination of all our teams to treat people as individuals and provide them with the best possible service. Of course, there are still areas we need to work on and we are already taking action to improve those areas where the CQC felt we needed to do more. Our aim now is to achieve a rating of good or outstanding across all our services when the CQC next visit us.

Delivering Today:
2017/18 Month 1 service delivery and financial performance headlines

Key service delivery and financial performance headlines for Month 1 from the integrated performance report to draw to the Board's attention are as follows:

National Performance Indicators
Against the national performance standards, for Month 1 the Trust has delivered the following outcomes:

- **4 hour ED standard:** In April 87.7% of patients were discharged or admitted within 4 hours of arrival at our Accident and Emergency Departments. This is an improvement on last month (80.6%) however it is below the operational plan trajectory of 90.1% and national standard of 95%. Performance has deteriorated in May - the A&E Performance Predictor (which is circulated daily) for the 15th May shows 84.86% of patients being discharged/admitted from ED and MIU within 4 hours.
- **RTT:** RTT performance has stabilised in April with the proportion of people waiting less than 18 weeks at 81.66% in April (81.6% in March). This is below the operational plan performance trajectory of 82.2%. At the end of April 43 people were reported as waiting over 52 weeks, against 33 last month.
- **62 day cancer standard:** at 82.1% (validated 9th May 2018) performance for April is below the 85% national target, although a small improvement on last month (79.7%). Current forecast for Q1 is 81.1%.

- **Diagnostics:** The diagnostics standard was not met in April with 11% of patients waiting over 6 weeks against the national standard of 1%.
- **Dementia screening:** The Trust met the Dementia Find standard of 90% for the first time with 99.2% achieved in April. This is a significant achievement and aided by the allocation of HCA resource to support the wards.

Financial Headlines

- **Overall financial position:** The financial position for the financial period to 30th April 2018 is a deficit of £1.27m against a planned deficit of £1.56m. Whilst still early in the financial year, indications are that run rates of pay expenditure remain broadly stable and, within that position there has been a reduction in agency spend on the rates experienced during the final quarter of 2017/18.Non-pay expenditure is underspent by a total of £0.55m
- **CIP savings delivery position:** The Trust has recorded £0.3m of CIP savings against our target of £1.12m for the month of April. Whilst behind plan, we are aware that some CIP schemes have yet to be loaded. This will be corrected in Month 2, which will mitigate this to a certain extent. Against the full year target of £26.93m, a total of £14m of schemes are currently registered in the Programme Office. It is clearly critical that further progress is made in identifying savings as a matter of priority; this needs to be an urgent focus of operational teams throughout the first quarter.
- **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 1, the Trust had an actual use of resources risk rating of 3 (subject to confirmation by NHS Improvement). The planned rating is also 3. The Agency risk rating of 3 is worse than the budgeted rating of 2.

Planning for 2018/19

As reported at May 2nd Board, Directors submitted the revised 2018/19 operational plan to regulators at the end of April confirming acceptance of the revised control total. Regulator response is awaited.

Teams are working to finalise investment priorities and savings plans. Key to delivery is the engagement and ownership of the service delivery groups who will have increased autonomy, investment and support to drive the changes necessary to improve experience of our service users and health and wellbeing of our staff.

Developing our strategy for the next 12 months and beyond

The Board participated in a successful development session facilitated by Dawn Butler and Jane Pightling on 2nd May. The output of the session included a proposal on 5 strategic priorities. These proposals will be used as a basis of structured engagement process with our staff and our partners commencing in the summer/ early autumn.

1.3 Valuing our Workforce, Paid and Unpaid

Winter drop-in sessions

The Chairman and members of the Executive Team hosted a series of drop-in events to meet informally with staff and volunteers to thank them for their exceptional efforts over what has been a very challenging winter. During the sessions, we met with a range of

staff and volunteers who have supported us, and it was good to be able to offer our personal thanks for their contributions. Although we had offered to pay our volunteers allowable mileage expenses, most of them said they did not wish to claim, as they regarded this as their opportunity to give something back to their local community. Many of them, however, were happy to join us for a cup of tea and a pastry, and shared their stories with us. We gained some really useful feedback during these events, which will contribute to our plans for winter 18/19.

Staff Friends and Family test

The Staff Friends and Family test has been live throughout May and we have been encouraging staff to use this forum to share valuable information about their experience at work. We then use this to make improvements in the workplace both for our staff and, in turn, our patients and service users. We know that if we can create the environment in which the experience as a member of staff is positive – then so will be the experience of our patients and service users.

Randomised Coffee Breaks

The 'Randomised Coffee break 'programme is one of the initiatives developed to engage and listen to staff and forms part of the Trust Staff Engagement and Communication strategy. This approach randomly connects people across the organisation and supports them to have a conversation about what matters. It has been used by many organisations such as NHS Fab Change Day, The Health Foundation, National Audit Office, and the Bank of England. It provides legitimacy to chat to people about things that are not directly work related so builds relationships and trust. There is no set agenda, people choose what they want to talk about. Nevertheless every time this approach has been used organisations report that there have been direct beneficial impacts on various projects and programmes. Totally random conversations, as well as some very useful work related conversations allow people to break out of silos and build new relationships in a very effective way. It is a really good way of revealing links within the organisation and encouraging us to collaborate.

Good news stories from our Service Delivery Units

- ***Shortlisting success for our Paignton and Brixham nurses:*** Our Paignton and Brixham community nurses have made the semi-finals for the outstanding team award in the Outstanding Care Awards for Devon and Cornwall 2018. The awards aim to celebrate the most dedicated individuals, providers and suppliers in the care industry across Devon and Cornwall. There are 21 award categories that reflect the diversity of community care life recognising not only outstanding staff, but innovative and best practice in the provision of care.

  The team were nominated for the way in which they pulled together during the recent snow to ensure people received the care they needed at such a vulnerable time. Like so many team across the Trust they went above and beyond. The team not only volunteered to go out in the day walking to patients around the area they live but also volunteered to go out at night to any emergency calls that could not wait. Staff volunteered to come in from leave and days off to ensure all the patients that needed to be seen were. The team also supported teams from other localities if that was where they lived and volunteer nurses from other localities also supported the team where possible to deliver outstanding care.

- ***Monitoring and Response Centre (MaRC) successful TSA Certification Achievement:*** Last month the MaRC service was audited under TSA, which is the services equivalent to CQC, and has successfully achieved and retained its accreditation status. The initial TSA Audit report includes some very positive comments such as:
    - "This is an efficiently managed and well-led service where staff are committed to ensuring positive outcomes for customers. It sits within the Torbay and South Devon NHS and enables customers to maintain independence with the safety-net of effective telecare."
    - "OCG Customer Feedback - There is an excellent level of customer satisfaction with the service. All customers who responded to the annual survey confirmed they are 100% satisfied with the quality, speed of response, helpfulness of staff and value for money."

- ***SPOT the difference:*** In 2017 SPOT Opportunities discussed with the Lifestyles Team opportunities to support healthy living and wellbeing as a peer activity. This was based on people with learning disabilities struggling with existing lifestyles and weight management programmes. The premise of the new approach was to empower people with learning disabilities to learn about healthier food options, increase activity and, through mutual support, lead to weight management.

  A series of workshops was designed to help participants understand healthy weight and eating, food labelling and physical activity. The initial results show that there has been a significant reduction in high fat/high sugar foods/drinks, an improvement in physical activity and a reduction in weight/BMI. The group's initial target was to lose 70lb by the NHS 70th Anniversary. However, they have already surpassed that target, by losing 91lb, so they are now changing their target into kilograms for the anniversary. They say this just shows how working proactively with peer support makes the world of difference.

- ***Surgical playwright:*** David Alderson, one of our consultant ENT surgeons, has written a play about surgical error which has been produced a number of times - most recently in London and Amsterdam at medical conferences. His work 'Trucut' brings up all sorts of issues around the different people and perspectives involved in surgical error. The production opens up meaningful discussion afterwards to explore the issues further. One of the discussion panel members in Amsterdam was Margaret Murphy, who is a WHO (World Health Organisation) patient advocate. David is now looking for funding opportunities that would enable him to make the play more widely available, with an accompanying workbook, in medical education – both at conferences and in medical schools.

2 Interim Chief Executive Internal and External Engagement: May

Internal	External
• Staff Side • Medical Staff Committee • Trust Talk (staff briefing) • Joint Consultative Negotiating Committee • Finance Team Meeting • Senior Matrons Meeting • Staff Drop in Sessions: - Kings Ash House	• STP Chief Executives' Meeting • STP Programme Delivery Executive Group • STP System Organisational Design Meeting • Director of Adult Services, Torbay Council • Director of Public Health, Torbay Council • Chief Officer for Adult Care and Health, Devon County Council • STP Chief Executive, Medical Director and Chief Operating Officer meeting • Devon A&E Board • Locality GP – Moor to Sea • Dartmouth Public Meeting • Teignmouth Consultation Events • Joint Executives' Meeting with CCG

3 Local Health and Care Economy Developments

3.1 Partnership updates

Devon Sustainability and Transformation Partnership (STP)

- **Hosting Agreement**: All partners to the Devon STP are being asked to sign up to a new Hosting Agreement whereby New Devon CCG (the Host) hosts the employment of any staff employed to work on the STP for the Devon health economy. The CCG has agreed to pay all costs and expenses arising from the employment of the Employees. Directors are seeking Board support to sign up to the agreement.
- **Monthly Update:** The next update from Devon STP will be circulated to the Board once available following the Programme Delivery Executive Group (PDEG) being held on 18 May.

Launch of the Torbay Clinical School:

The University of Plymouth Clinical Schools 4th annual conference was held at the Horizon centre on 16th May. At the event, the Torbay Clinical School launched to support clinical researchers and promote research and quality improvement. The conference celebrates research and development in practice through presentations, posters and discussion. The Multi-disciplinary Team from the Coastal Locality Team gave an inspiring presentation on their journey so far and the crucial role the researchers in residence have played in generating the evidence to show that the integrated model is improving care. There were other presentations from Trust staff sharing their research experience and how this is improving the care of people who use our services. At the end of the day, delegates said they had been inspired by the

passion and commitment of those engaged in research with many stating that they were now interested in doing their own research study.

Partnership between Digital Horizons and South Devon College
South Devon College has confirmed its agreement to form a partnership working arrangement with the Trust's Digital Horizons teams. The Digital Horizon teams have expertise in a range of digital technologies (digital media production, Livestream broadcasts including Hiblio and Young Persons Channel, immersive virtual reality, e-learning development, learning management systems, web services and video-conferencing) and are supporting their implementation across the Trust to aid the transformation of educational programmes and clinical pathways of care. South Devon College provides a range of digital technology courses and sees working alongside Digital Horizons as an excellent opportunity for their senior students to gain hands-on work experience.

The Digital Horizons team will create a dedicated training environment within the Belmont Court building for students to work on collaborative projects under the supervision of their College tutors. This builds on the current arrangements, where students undertaking heath and care related courses at the Colleges Centre for Health and Care Professionals on the Torbay Annexe site are provided with clinical placements in the Trust.

The College recently received funding for the building of the HiTech and Digital Centre at the Vantage Point Campus, which aims to ensure a supply of suitably qualified staff for local businesses, and sees this partnership with the Trust as an integral part of that strategy.

Local research contributes to study that could 'transform treatment'
This month, we celebrated international clinical trials day – and our best recruitment year in research. A major new study supported by research across the South West, including here in Torbay and South Devon, has found that tranexamic acid (TXA), a drug currently used to treat excessive blood loss from major trauma and childbirth, could transform the treatment of stroke patients. Focused on patients who had suffered a stroke as a result of bleeding in the brain (known as an intracerebral haemorrhage), the study showed a reduction in the amount of bleeding on the brain, serious complications and early deaths in the first week, for patients who had received the TXA treatment. The study showed no statistical significant change in death and disability at three months.

A total of 2,325 patients from across the world took part in the five-year international TICH-2 trial between 2013 and 2018. The study was funded by National Institute for Health Research (NIHR) Health Technology Assessment Programme. The vast majority of these patients (1,721) were recruited across 84 hospitals in the NHS in England with support from the National Institute for Health Research (NIHR). Across the South West, four hospitals – Royal Devon and Exeter NHS Foundation Trust; Taunton and Somerset NHS Foundation Trust; Torbay and South Devon NHS Foundation Trust and Yeovil District Hospital recruited a total of 60 patients.

Local dementia campaigner praises NHS Trust as Purple Angel dementia-aware
Following confirmation from local founder of the Global Purple Angel Dementia Campaign, Norrms McNamara, Torbay and South Devon NHS Foundation Trust has become the first health and social care provider in the world to have earned the status

of ‘Purple Angel dementia-aware.’ Just over 95 per cent of staff working in bed-based care across the Trust have received the Purple Angel dementia awareness training; and 92 per cent of staff across the whole Trust have had the training. This training enables staff to recognise dementia, and to know how to best communicate with and support someone living with the condition. For example, simply allowing more time to explain things and for the person to respond; using gestures or cues to help the person remember things; and encouraging them to carry familiar things with them such as a family photo. The Purple Angel symbol denotes staff have an understanding of dementia and are passionate about raising awareness.

Comment: I would like to sincerely thank Norrms and all the volunteers who support the Purple Angel campaign for their dedication. I also want to send out a huge thank you to all our staff and the Trust Board for embracing the initiative and for all the hard work involved in achieving this over the past four years.

3.2 Partner updates

CQC rates Devon Partnership NHS Trust as ‘good’.

A team of inspectors from the Care Quality Commission visited between November 2017 and February 2018 to check the quality of five core mental health services. CQC also looked specifically at management and leadership to answer the key question: Is the trust well led? The trust has been rated as Good overall and Good across all five key questions for being safe, effective, caring, well-led and responsive to people’s needs. Inspectors found particular improvement in the forensic inpatient/secure services which are now rated as Outstanding. Patients were fully involved in planning their care. Staff worked with patients to develop care plans that were recovery focused, person centred and reviewed these regularly with patient input. Patients were complimentary about the staff providing care and told inspectors they appreciated the way staff treated them with dignity and respect. On the well-led inspection, CQC found a strong, committed and knowledgeable board and senior leadership team who had a clear vision and set of values which centred around the key principle of continuous improvement.

Temporary suspension of birth services at Honiton and Okehampton extended

The Royal Devon and Exeter NHS Foundation Trust (RD&E) has extended the suspension of birth services at Honiton and Okehampton maternity units until mid-September 2018. The Trust took the decision last year to temporarily suspend births and subsequent in-patient stays at Okehampton and Honiton maternity units. This step was taken to maintain patient safety due to a combination of factors affecting the stability of the services at these sites and the other units it operates in Tiverton and Exeter.

4 National Developments and Publications

Details of the main national developments and publications since the May 2nd Board meeting have been circulated to Directors through the weekly developments update briefings. There have been a number of items of particular note that I wish to draw to the attention of the Board as follows:

4.1 Government

'Full health and social care integration' under new 10 year plan: Jeremy Hunt, has revealed his top priorities for the forthcoming "long term plan" for the NHS, which has been promised by the prime minister for the NHS's 70th birthday. The health and social care secretary said:

- the plan should include "full integration of the health and social care system"
- over the 10 year plan period, the NHS will need to become "massively more teched up"
- the plan is likely to identify "really big efficiency improvements" which can be made over 10 years

Meeting core performance targets, such as those for waiting in emergency departments and for planned operations, will be an "early milestone" for the NHS in the long-term plan.

Number of care homes falls by 735 in two years: Government figures reveal the number of care homes in England has fallen by more than 700 over two years. The figures released by ministers come after a financial analysis showed 148 care home businesses became insolvent in the last financial year – nearly double the number in the previous year. The figures from care minister Caroline Dinenage show the number of residential care homes fell from 12,191 at the beginning of 2016 to 11,615 this year. Of the 576 homes lost, 453 disappeared last year. Among nursing homes, 159 were lost over the two years. In total there were 735 fewer care homes by the start of 2018.

4.2 NHS England

Last-minute surgery cancellations at all-time high: The number of patients who had NHS operations cancelled at the last minute is the highest since quarterly records began in 1994. NHS figures show 25,475 operations were cancelled on the day they were due to happen between January and March of this year. Targets to treat 92% of patients within 18 weeks have also now been missed for more than two years, the statistics show, with more than 360,000 patients facing longer waits. Some 2,755, patients waited more than 52 weeks for NHS treatment compared to 1,528 in March 2017.

Judge rules in favour of NHS England accountable care contract: A high court judge has ruled in favour of NHS England in the first of two judicial reviews against its accountable care organisation (ACO) contract. Judge Mr Justice Kerr has ruled that the court did not find anything unlawful with the payment mechanism proposed by the ACO contract, after a challenge was brought against it by campaign group – 999 Call for the NHS.

Trusts to be asked to improve weekend discharge rate: Matthew Swindells, NHS England's operation and information director, says trusts will be asked to examine their weekend discharge rates, which are three-quarters lower than on Monday to Friday. It comes as NHS England looks to develop a new metric focused on discharge rates. Mr Swindells said one of the national metrics for next year will be around closing the gap between weekend and weekday discharge rates, to bring it as close as possible to a 1:1 ratio.

4.3 NHS Improvement

Breast cancer screening public communication campaign: NHS Improvement and NHS England this month launched a public communication campaign following the discovery that, due to a computer glitch, hundreds of thousands of women did not receive their last recall for breast cancer screening. This is impacting on all Trusts across England. A national helpline has been set up for anyone who is concerned 0800 169 2692.

Comment: We are working with colleagues across Devon to ensure we have a robust plan in place to deal with the likely impact.

4.4 Care Quality Commission (CQC)

CQC appoints new chief executive: The CQC has appointed Ian Trenholm as its new chief executive. Mr Trenholm will succeed Sir David Behan when he takes on the role from July,

4.5 NHS Providers and NHS Confederation

New Community Network to advocate for community services: NHS Providers has launched a new community network, in partnership with NHS Confederation. It is hoped that the network will be an influential voice for the community services sector, promoting for community services to play a leading role in the development of integrated systems.

4.6 NICE

First-hand advice on child abuse and neglect: NICE and the Social Care Institute for Excellence have published a new guide – *Getting help to overcome abuse: A Quick Guide for young people receiving support.* It is designed to help young people understand what is meant by abuse and neglect, and it describes how they might feel because of their experience. It also explains what young people should expect from services and what they should do if they are not happy with the support they are receiving. A list of organisations that can help is also included. The guide, based on the NICE guideline about Child abuse and neglect, was written by a group of young people who have experienced abuse and neglect.

4.7 NHS Supply Chain

Changes to NHS Supply Chain: The financial pressures on the whole of the NHS are well documented and we need to get the best value from every pound we spend. Nationally one way this is happening is through changes to NHS Supply Chain. The new supply chain has been designed to better leverage the power of the NHS on a

national scale by collaborating to deliver improved procurement and logistics support to the NHS. NHS Supply Chain will deliver clinically safe, high quality products for the best possible value, and aims to realise £2.4bn of savings in its first five years of operation which can be redirected to front-line services. 11 new specialist procurement functions are responsible for delivering medical goods. These expert providers (referred to as Category Tower Service Providers or CTSPs) will procure a range of products from compression bandages and wheelchairs through to implantable devices for the NHS at the best possible price. Benefits such as more standardised products and price reductions will be realised gradually over the coming months, and staff throughout the NHS are asked to use the NHS Supply Chain catalogue wherever possible. For more information on the new supply chain visit: https://www.supplychain.nhs.uk/icc

5 Local Media Update

- **BBC Spotlight** – filming for Wellbeing Co-ordination story
- **BBC Spotlight** – filming for neonatal crocheted caps piece
- **ITV** - filming with ITV for coastal locality engagement
- **Devon Live -** Revealed: Devon hospitals are STILL using controversial mesh – includes TSDFT
- **South Hams Gazette -** Council help sought over closed hospital – relates to Dartmouth Hospital
- **South Hams Gazette** – reporting of public meeting in Dartmouth
- **Dartmouth Chronicle** – Coverage of the drop-in and public meeting as well as local opinion on the hospital closure and Health and Wellbeing centre
- **Teignmouth Post** – Coverage of the engagement on the options for a new Health and Wellbeing centre coming together with local GP practices
- **Mid Devon Advertiser -** More specialist community care helping people to avoid hospital

News releases issued:

- Award of Purple Angel dementia-aware hospital
- Teignmouth engagement
- Maternity appeal for knitted hats results in 2000 donations from as far afield as Australia

6 Recommendation

The Board is recommended to **review** the report and **consider** implications on the Trust's strategy and delivery plans.

Cover sheet for a report to the Trust Board of Directors					
Report title: Devon STP Hosting Agreement					**Date: 23 May 2018**
Agenda item					
Report sponsor	Director of Strategy and Improvement				
Report author	Director of Strategy and Improvement				
Report provenance	Report reviewed by Executive Directors 15 May 2018				
Confidentiality	Public				
Report summary	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. The Trust is a core member of the Partnership. STP partners wish to enter into an agreement whereby New Devon CCG hosts the employment of any staff employed to work on the STP for the Devon health economy.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☐	**Review** ☒	**Decision** ☐	**Approve** ☒
Recommendation	The Board is recommended to **review** the Hosting Agreement and **authorise** the Interim Chief Executive to sign up to the Agreement on behalf of the Trust				
Summary of key elements					
Strategic context	Strategic/corporate objectives this report aims to support: • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	Currently the Trust's Medical Director is contracted to provide support to the STP therefore this agreement would cover that arrangement. The agreement confirms all costs, risks and liabilities will be met by the CCG				
Summary of scrutiny	The Hosting Agreement was reviewed by Executive Directors at their meeting on 15 May 2018 who recommend that the Board authorise sign up				
Stakeholder engagement					
Other standards affected					
Legal considerations	None – all risks and liabilities lie with the Host (New Devon CCG)				

DATED: 1st April 2018

EMPLOYEE AGREEMENT REGARDING EMPLOYMENT OF THE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

PARTIES IN AGREEMENT:

- NORTHERN, EASTERN AND WESTERN DEVON CLINICAL COMMISSIONING GROUP (NEWD CCG)
- SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP (SD&T CCG)
- DEVON PARTNERSHIP NHS TRUST (DPT),
- ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RD&E),
- UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST (UHPT)
- NORTHERN DEVON HEALTHCARE NHS TRUST (NDHT)
- LIVEWELL
- TORBAY AND SOUTH DEVON FOUNDATION TRUST (T&SDFT)

THIS AGREEMENT is dated 1st April 2018

BETWEEN

(1) **NEW DEVON CLINICAL COMMISSIONING GROUP** whose registered office is at Eastern Locality, Northern, Eastern and Western Devon Clinical Commissioning Group, Newcourt House, Old Rydon Lane, EXETER, EX2 7JU ('**NEWD CCG**') ('**The Host**')

(2) **The Partners:**

- **SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP (SD&T CCG)**
- **DEVON PARTNERSHIP NHS TRUST (DPT),**
- **ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RD&E),**
- **UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST (UHPT)**
- **NORTHERN DEVON HEALTHCARE NHS TRUST (NDHT)**
- **LIVEWELL**
- **TORBAY AND SOUTH DEVON FOUNDATION TRUST (T&SDFT)**

together, '**the Partners**'.

BACKGROUND:

(A) The Partners have entered into an arrangement known as '**the Sustainability and Transformation Partnership (STP)** in accordance with its terms of reference. The purpose of the STP is to protect and promote health and care services for patients in local health and care systems that are struggling with financial or quality problems, or sometimes both. This new partnership will build upon existing approaches to providing support and challenge to local systems.

(B) This Agreement governs the roles, duties and responsibilities of each of the Partners in relation to the other(s) arising from the employment of the Employees pursuant to the requirement of the STP.

(C) The Partners, wish to enter into an agreement whereby the Host, hosts the employment of any staff employed to work on the STP for the Devon health economy.

(D) This Agreement governs the roles, duties and responsibilities of each of the Partners in relation to the other(s) arising from the employment of the Employees.

(E) The Host has agreed to pay all costs and expenses arising from the employment of the Employees including the Salary and all Payments and Benefits and all risks and liabilities as set out in this Agreement. The cost of any STP expenses will be borne from a budget agreed by Directors of Finance.

(F) The Partners further agree that notwithstanding the terms of this Agreement, the Host shall continue to host the employment of the Employee under the terms and conditions of the Employment Contract.

AGREED TERMS:-

1. Interpretation

1.1. The definitions and rules of interpretation in this clause apply in this Agreement (unless the context requires otherwise).

Benefits	any payments, benefits and expenses (excluding Salary) to which the Employee/s is entitled in accordance with the Employment Contract in force and as reviewed and amended from time to time.
Confidential Information	information relating to the business, products, affairs and finances of the relevant Party for the time being confidential to the relevant Party and trade secrets including, without limitation, technical data and know-how relating to the business of the relevant Party or any of its suppliers, clients, customers, agents, distributors, shareholders or management.
Host Payments	such payments as may be required by law in connection with the Employment Contract, including without limitation obligations to account to any tax authority for income tax and/or Employee social security contributions under the PAYE system and obligations to pay employer social security contributions in each case wherever arising and including interest, fines and penalties in respect thereof.
Employment Contract	the terms of employment between the Host and the Employee at the date of this Agreement, a copy of which is attached at Schedule 1, subject to any changes in the Employee's salary or other benefits in accordance with the Host's usual procedures from time to time.
Sustainability and Transformation Partnership	plans to improve health and care services for people across Devon in a way that is clinically and financially sustainable. STP or any title substituted which is applicable to the CCG and the Partners for the programme of work agreed across the Devon system.
Intellectual Property Rights	patents, [utility models,] rights to inventions, copyright and [neighbouring and] related rights, [moral rights,] trade marks [and service marks], business names and domain names, rights in get-up [and trade dress], goodwill and the right to sue for passing off [or unfair competition,] rights in designs, [rights in computer software,] database rights, rights to use, and protect the confidentiality of, confidential information (including know-how [and trade secrets]) and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights

	to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.
Management Issues	all those matters under the Employment Contract requiring action, investigation and/or decisions by the Host including in particular (by way of illustration only and without limitation) appraisals and performance issues; pay reviews and the award of other payments and benefits under the Employment Contract; periods of annual, sick or other leave; absence of the Employee for any other reason; any complaint about the Employee (whether or not that would be dealt with under the Host's disciplinary procedure) and any complaint or grievance raised by the Employee (whether or not that would be dealt with under the Host's grievance procedure).
Employee	the role of all employees contracted to work for the STP.
Salary	The salary to which the Employee is entitled under the Employment Contract as reviewed annually in accordance with the terms of the Employment Contract.
Sites	The addresses given in this Agreement for each of the Partners and if different, any other address or locations pertaining to each of the Partners where the Employee/s is required to work.
Sustainability and Transformation Partnership budget	Any costs attributed to the STP, the budget to be held by the Host who has authority to use as required

1.2. The headings in this agreement are inserted for convenience only and shall not affect its construction.

1.3. A reference to a particular law is a reference to it as it is in force for the time being taking account of any amendment, extension, or re-enactment and includes any subordinate legislation for the time being in force made under it.

1.4. Unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular.

1.5 Any reference to the Partners shall where the context requires include a reference to their staff, employees, agents, sub-contractor and consultants and any party reasonably coming within each Party's control.

2. Commencement and Duration

2.1. This Agreement shall commence on 1st April 2018 and subject to clause 3.7 shall continue

until 31st March 2021 unless extended by a maximum of 12 months to 31st March 2022 or unless terminated earlier in accordance with clause 10.

3. The Employee's (Employment)

3.1. For the avoidance of doubt, the Partners agree and warrant to each other that any costs associated with termination of this Agreement including any redundancy costs howsoever incurred in connection with the Employment Contract shall unless specified elsewhere in this Agreement be shared equally between the Partners.

The Partners agree that when the STP comes to an end, the Partners will be obliged to a redeployment exercise for all employees concerned. Redeployment and suitable alterative roles will be offered by the Partners. Redundancy will be avoided wherever possible.

Where Redundancy cannot be avoided, the Partners agree to equally share any redundancy costs applicable.

3.2. In consideration of the hosting of the Employees by the Host, the Partners acknowledge and warrant that the Host is not responsible for the way in which the Employee provides services or for any acts or omissions of the Employee in performance of the Employment Contract or for any express or implied performance guarantees in respect of the Employee. The partners waive all and any claims that they may have against the Host arising out of any act or omission of the Employee.

3.3. The Host shall provide Employees pursuant to this Agreement on an exclusive basis for the duration of the Agreement and the Partners agree that the Employees shall, unless prevented by incapacity, devote the whole of their working time, attention and abilities to the STP.

3.4. The Partners shall not, and shall not require the Employee to do anything that shall breach the Employment Contract.

3.5. The Employer only may make changes to the Employment Contract which will normally be in line with Agenda for Change (AfC) recommendations. Where any of these changes affect any of the other Partners then the Employer will provide reasonable notice of the changes to be made.

3.6. The Host shall provide the Employee with such information and assistance as may reasonably be required to enable them to carry out their obligations.

3.7. The Host shall notify the Partners immediately upon receipt of notice of termination of the Employment Contract from the Employee.

3.8. Subject to clause 3.10 and 11.1(b), the Host may by unanimous written agreement of the Partners terminate the Employment Contract without notice for gross misconduct or negligence in accordance with the terms of the Employment Contract.

3.9. In the event of termination of the Employee's Employment Contract with or without notice to the Employee, then the Partners shall be liable for any loss, costs or expenses including redundancy in accordance with the provisions of clause 11 (Liability).

3.10. For the avoidance of doubt, where it is necessary to terminate the Employment Contract as a consequence of any act or omission of any of the Partners, including any circumstance where the Host elects to terminate the Employment Contract due to the breach of any of the provisions of this Agreement (whether negligent or otherwise) by the Partner/s, then the

Partner/s shall be solely liable for all costs arising from the termination of the Employment Contract, howsoever arising.

3.11. All documents such as notes, manuals, hardware and software provided for the Employee's use by the Partners respectively, and any data or documents (including copies) produced, maintained or stored on the Partners computer systems or other electronic equipment (including mobile phones), remain the property of those Partners.

4. Employee Welfare and Safety

4.1. The Partners warrant to each other that they shall at all times be solely liable for the Employees whilst on their respective Sites for whatever purpose during the period of the Agreement. The Partners further warrant that it shall fulfil all duties relating to the Employee's health, safety and welfare as if it was their employees whilst on their Sites.

4.2. The Partners warrant to the others that they shall at all times be liable for any demand or claim brought by the Employee in respect of any employment relations issue alleged or proven to have been carried out by the Partner's staff, employees, agents, consultants or sub-contractors.

4.3. Each of the Partners shall fully indemnify and keep indemnified the other Partner(s) at all times against any loss, injury, damage or costs (including the Partners reasonable legal costs and fees) suffered, sustained or incurred as result of any claim brought by the Employee arising out of or in connection with any breach of this clause [4] and of the warranties contained herein.

5. Payments

5.1. The Host shall pay the Employee's Salary, Benefits and Host Payments due to the Employees, make any payments to third Partners in relation to the Employee and make any deductions that it is required to make from the Employee's Salary and other payments.

5.2. The Host shall reimburse the Employee for any permitted expenses submitted by the Employee in accordance with the Employment Contract and in accordance with the Host's normal practices. Such expenses may include all reasonable travel, accommodation and other expenses necessarily incurred by the Employees during the period of the Agreement in or in connection with the exercise of the Employment Contract.

5.3. The Host shall pay all costs for the employees from the STP Budget.

6. Sustainability and Transformation Partnership Management

6.1. The Host shall be responsible for any Management Issues concerning the Employees for the duration of this Agreement and where relevant in accordance with this Agreement, shall consult with or obtain the prior written approval of the Partners.

6.2. The Partners shall provide any necessary information, documentation, access to its premises and employees and assistance (including but not limited to giving witness evidence) to the Host to deal with any Management Issues concerning the Employee whether under the Host's internal procedures or before any court or tribunal.

6.3. The Partners shall keep each other informed as soon as reasonably practicable of any other significant matter that may arise relating to the Employee or the Employment Contract.

6.4. The Partners shall use all reasonable endeavours to notify the others if any of them becomes aware of or if the Employee identifies and brings to their attention any actual or potential conflict of interest between the Partners for the duration of the Agreement.

7. Employee Leave

7.1. The Partners agree that the Employee shall be eligible for sick pay, holiday pay and any absence entitlements in accordance with the Employment Contract, and shall remain subject to the Host's approval and notification procedures. The Host shall each remain liable for all payments arising in respect of the Employee under this clause.

8. Confidentiality

8.1. The Partners each agree that they shall enter into separate confidentiality agreements with the Employee and the Partners warrant to the Host that it shall have no liability or responsibility for procuring that the Employee enters into any such agreements with the Partners.

8.2. The Partners acknowledge and confirm that the Employee shall have access to their respective Confidential Information during the course of the Agreement. Each Partner warrants to the others that none of them shall have any liability towards the other in respect of any acts or omissions of the Employee whether intentional, negligent or otherwise, in connection with breach of this clause 8 (Confidentiality).

8.3. The Partners shall:

(a) keep any Confidential Information relating to the other Partners that it obtains as a result of this Agreement secret for the duration of the Agreement and for the maximum period permitted by law following expiry or termination of the Agreement;

(b) not use or directly or indirectly disclose any such Confidential Information (or allow it to be used or disclosed), in whole or in part, to any person without the prior written consent of the relevant Partner;

(c) use all reasonable endeavours to ensure that no person gets access to the Confidential Information from it, its officers, employees or agents unless authorised to do so; and

(d) inform the other Partners immediately on becoming aware, or suspecting, that an unauthorised person has become aware of such Confidential Information.

9. Intellectual Property Rights

9.1. All Intellectual Property Rights in any information or material existing prior to the date of this Agreement shall remain the property of each Partner introducing such information or material. Each Partner shall grant each other a non-exclusive, non-transferable, irrevocable licence for non-commercial purposes to use all such pre-existing information and materials, including any Intellectual Property Rights in the same, during the duration of this Agreement and solely for the purpose of fulfilling a Partner's obligations arising from this Agreement but otherwise without a right to sub-licence. Such licence shall be terminable during the Agreement only in cases of material breach of the provisions of this licence.

9.2. Any new or future Intellectual Property Rights arising from or as a result of the STP shall be

jointly owned by the Partners. Each Partner grants to the other Partners a non-exclusive, non-transferable, irrevocable licence to use such new or future Intellectual Property Rights as it may own under this clause 9 for non-commercial purposes.

9.3. The Partners shall do, or procure to be done, all such further acts and the execution of all such other documents as may from time to time be required for the purpose of ensuring all new and future Intellectual Property Rights arising from this Agreement vest in the Partners.

10. Termination (of this Agreement)

10.1. The Partners acting jointly may terminate this Agreement by giving not less than 13 weeks unanimous written notice.

10.2. Subject to the provisions of clause 3.10 the Partners may terminate this Agreement with immediate effect without further notice for any serious or (after 21 days warning) repeated breach of the terms of this Agreement by the other Party.

Any early termination of the contract by any of the Partners will result in liability for that Partner for any loss, costs or expenses including redundancy in accordance with the provisions of clause 3.1. Costs will be dependent on the numbers of employees employed at that time and will be an average cost based on levels of service and based on one fifth of those estimated costs.

10.3. Any delay by the Host in exercising the right to terminate shall not constitute a waiver of such rights.

10.4. For the avoidance of doubt, the provisions of clauses 3.10, 4 (Health & Safety) and 11 (Liability) and any warranties given in this Agreement will continue to apply in full force and effect notwithstanding termination or expiry of this Agreement.

11. Liability

11.1 Each of the Partners shall fully indemnify and keep indemnified the other Partners at all times against any loss, injury, damage or costs and expenses (including the Partner's reasonable legal costs and fees) suffered, sustained or incurred as result of any claim or demand:

(a) for any breach of the terms of this Agreement whether negligent or otherwise, including breach of any express warranties given by the Partners contained in this Agreement;

(b) brought against either of the Partners by any person(s) or third party who is not a party to this Agreement in respect of any act or omission whether negligent or otherwise of the Employee. The Partners agree that any liability howsoever arising under this sub-clause (b) shall be between the Partners;

(c) by the Employee arising out of their employment by the Host including all redundancy costs whether statutory or otherwise arising from termination of the Employee's employment. Any liability howsoever arising under this sub-clause (c) shall be shared in accordance with the provisions of clause 3.9.

Nothing in this Agreement excludes or limits the liability of each of the Partners for i) death or personal injury resulting from negligence; ii) any damage of liability incurred by any Partner as a result of fraud or fraudulent misrepresentation by another Partner or iii) any

other liability which is incapable of being excluded or limited by law.

12. Freedom of Information Act 2000 - Party Co-operation

12.1 The Partners acknowledge that they are subject to the requirements of the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR) and the Partners shall assist and cooperate as necessary to comply with these requirements.

12.2 The Partners acknowledge that each Partner will nevertheless have continuing obligations to reply to requests for information which relates solely or mostly to that party's involvement in the STP.

12.3 The Partners shall ensure that all information produced in the course of the STP or relating to it is retained for disclosure and shall provide all necessary assistance as reasonably requested to enable any Partner to respond to a request for information in relation to the STP within the time for compliance and shall permit any Partner to inspect such records as requested from time to time.

12.4 The Partners acknowledge the fundamental importance of prompt and open communication between them in respect of FOIA and EIR matters and may decide between them the particular procedures or arrangements to be followed when dealing with certain requests for information.

12.5 The Partners warrant that any statutory and other constraints on the exchange of information will be fully respected, including the requirements of the Data Protection Act 1998 and the Human Rights Act 1998.

12.6 For the purposes of this clause 12, the Host shall assume the role of the Lead Partner and shall respond to all FOIA requests about the STP generally, however the Partners respectively shall each deal with requests about their individual involvement in the STP.

12.7 In the event that it appears that the information or request relates to the Host, or that the interests of the Host may be affected by the disclosure of the information, the Lead Party shall consult so far as it possible under applicable data legislation with the Host prior to providing any information.

13 Notices

13.1 Any notice given under this agreement shall be in writing and signed by or on behalf of the party giving it.

14. Disputes

14.1 Disagreements will normally be resolved amicably at working level of the Partners. In the event of failure to reach a consensus between the Partners then the dispute shall be referred to the respective CEOs of each Party for resolution as soon as reasonably practicable after such referral, but in any event within (10) ten business days.

14.2 If the Partners CEOs are unable to unanimously resolve the dispute in accordance with 14.1, the Partners agree to enter into mediation to settle such dispute and will do so in accordance with the Centre for Effective Dispute Resolution (**CEDR**) Model Mediation Procedure. Unless otherwise agreed between the Partners within 14 days of notice of the dispute moving to mediation, the mediator will be nominated by CEDR. To initiate the mediation a party must give notice in writing (**ADR notice**) to the other party to the dispute

referring the dispute to mediation. A copy of the referral should be sent to CEDR. Unless otherwise agreed, the mediation will start not later than 28 days after the date of the ADR notice. No party may commence any arbitration in relation to any dispute arising out of this agreement until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other party has failed to participate in the mediation, provided that the right to issue proceedings is not prejudiced by a delay.

14.3 If the Partners are unable to resolve the dispute in accordance with 14.1 and 14.2, then all disputes arising out of or in connection with this Agreement shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce by one or more arbitrators appointed in accordance with said Rules subject to the following:

(a) The seat or place of arbitration shall be Exeter, Devon.

(b) The Emergency Arbitrator Provisions shall not apply.

(c) The Partners agree to keep confidential the existence of the arbitration, the arbitral proceedings, the submissions made by the Partners and the decisions made by the arbitral tribunal, including its awards, except as required by applicable law and to the extent not already in the public domain.

15. Entire Agreement

15.1 This Agreement constitutes the entire Agreement between the Partners and supersedes and extinguishes all previous agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to the Agreement.

15.2 Each party acknowledges that in entering into this agreement it does not rely on and shall have no remedies in respect of any statement, representation, assurance or warranty (whether made innocently or negligently) that is not set out in this Agreement and no implied terms or warranties shall to the greatest extent permitted by law apply to this Agreement. Each party agrees that it shall have no claim for innocent or negligent misrepresentation or negligent misstatement based on any statement in this Agreement.

15.3 Nothing in this agreement shall limit or exclude any liability for fraud.

16. Variation

16.1 No variation of this agreement shall be effective unless it is in writing and signed by the Partners (or their authorised representatives).

17. Counterparts

17.1 This agreement may be executed in any number of counterparts, each of which when executed shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

18. Third party rights

18.1 A person who is not a party to this Agreement shall not have any rights under the Contracts (Rights of Third Partners) Act 1999 to enforce any term of this Agreement.

19. Governing Law

19.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject

matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

20. Jurisdiction

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this agreement or its subject matter or formation (including non-contractual disputes or claims).

21. Signed on behalf of:

SIGNED: DATE: FOR: **NORTHERN, EASTERN AND WESTERN DEVON CLINICAL COMMISSIONING GROUP (NEWD CCG)**

SIGNED: DATE: FOR: **SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP (SD&T CCG)**

SIGNED: DATE: FOR: **DEVON PARTNERSHIP NHS TRUST (DPT)**

SIGNED: DATE: FOR: **ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RD&E)**

SIGNED:

DATE: FOR: **UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST (UHPT)**

SIGNED: DATE: FOR: **NORTHERN DEVON HEALTHCARE NHS TRUST (NDHT)**

SIGNED: DATE: FOR: **LIVEWELL**

SIGNED: DATE: FOR: **TORBAY AND SOUTH DEVON FOUNDATION TRUST (T&SDFT)**

Cover sheet and summary for a report to the Trust Board of Directors					
Report title: **Integrated Performance Report: 2018/19 Month 1** **(April 2018)**				Date: 23 May 2018	
Report sponsor	Director of Strategy and Improvement Director of Finance				
Report author	Head of Performance				
Report provenance	Executive Director scrutiny (15th May 2018) Service Delivery Unit Quality and Performance Review meetings (17th May 2018) Finance, Performance, and Investment Committee (22nd May 2018)				
Confidentiality	Public				
Report summary	The Integrated Performance Report (IPR) sets out the headline performance for Month 1 (April) 2018/19. The report is provided in two parts: Part 1 – Headline summary of key issues and risks Part 2 – Focus reports provided by operational service and department leads giving greater detail of the key performance metrics highlighted in the report. The report to the Committee has two appendices: Appendix 1 – Dashboard of key performance indicators giving a rolling 13 month view of monthly performance metrics. Appendix 2 – Databook of key operational performance metrics giving greater granularity and graphical presentation of monthly performance metrics.				
Purpose	**Note** ☐	**Information** ☐	**Review** ☒	**Decision** ☐	**Approve** ☐
Recommendation	The Committee is recommended to **review** the documents and **review** the evidence presented.				
Summary of key elements					
Strategic context	This report supports the following corporate objectives: • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	This report reflects the following corporate risks: • Available capital resources are insufficient to fund high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems. • Failure to achieve key performance standards. • Inability to recruit/retain staff in sufficient number/quality to				

	maintain service provision. • Lack of available Care Home/Domiciliary Care capacity of the right specification/ quality. • Failure to achieve financial plan. • Delayed delivery of Integrated Care Organisation (ICO) care model.
Summary of scrutiny	This report has been subject to challenge, due diligence, and risk assessment by: Executive Director scrutiny (15th May 2018) Service Delivery Unit Quality and Performance Review meetings (17th May 2018) Finance, Performance, and Investment Committee (22nd May 2018)
Stakeholder engagement	This report is shared with Governors and contributes to a quarterly report considered by the Council of Governors. Governors are represented on the Finance, Performance and Investment Committee and Quality Assurance Committee where the integrated performance report is reviewed
Other standards affected	Delivery of CCG commissioning intentions Delivery of Torbay Council and Devon County Council Annual Strategic Agreement requirements
Legal considerations	Maintain Foundation Trust terms of authorisation. Delivery of NHS Improvement Single Oversight Framework for 1. Operational performance 2. Quality standards 3. Financial risk rating Delivery of NHS Constitution rights and standards

Torbay and South Devon NHS
NHS Foundation Trust

MAIN REPORT

Integrated Finance, Performance, Quality, and Workforce Report

Date of Report: **22nd May 2018**

Reporting Period: **Month 1**

Data Up To : **30th April 2018**

Version Control

Version	Meeting	Date of Circulation	Date of Meeting	Owner	This Version
Draft 1	Trust Executive	11/05/18	15/05/18	Paul Procter	☒
Published Report	FPI Committee	16/05/18	22/05/18	Ann Wagner Paul Cooper	☒
Published Report	Trust Board	17/5/18	23/5/18	Ann Wagner Paul Cooper	☒

Contents

Attached as Part 2 of the Report (in a single PDF):

- Quality Focus
- Workforce Focus
- Operational Performance Focus
- Finance Focus

Attached as Appendix (in separate PDF)**:**

- Dashboard

1. Introduction and Context

Purpose

The purpose of this report is to bring together the key areas of delivery (including, quality and safety, operational performance, workforce and finance) into a single integrated report to enable the Finance, Performance, and Investment Committee (FPIC) 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 Committee is assured that the Trust is on track to deliver the key milestones required by the regulator and will therefore secure Provider Sustainability Funding) 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 Quality Focus; Workforce Focus; Operational Focus; and Finance Focus and are supported by the following appendices:

Appendix 1: Board Dashboard (PDF file)

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

- Executive Director scrutiny (15th May 2018)
- Service Delivery Unit Quality and Performance Review meetings (17th May 2018)
- Finance, performance, and Investment Committee (23rd May 2018)

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

For 2018/19 the Trust submitted an Operational and Financial Plan to NHS Improvement (NHS I) confirming our intention to achieve the £1.7m Control Total and deliver required service performance standards to secure our designated share of the national Provider Sustainability Fund (PSF).

Delivery of the Control Total relies on the Trust, with its system partners, delivering a Systems Savings Plan of £26.9m.

In addition to financial delivery, access to a 30% of the PSF funding, allocated to the Trust for 2018/19, is also dependent on delivery of service standards relating to the national ED 4 hour wait standard and new GP streaming.

Regulatory Context: NHS Improvement Single Oversight Framework

The Single Oversight Framework (SOF) is used by NHS I to identify NHS providers' potential support needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability.

Using this framework NHS I segment providers into one of four segments ranging from Segment One (maximum autonomy) to Segment Four (special measures). The Trust remains (April 2018) assessed as being in Segment Two (targeted support).

2. Performance Headlines: Month 1 (April 2018)

Key headlines for, quality and safety, workforce standards and metrics, operational performance, and financial for Month 1 to draw to the Committee's attention are as follows:

2.1 Quality Headlines

There are 19 Local Quality Framework indicators in total of which 4 were RAG rated RED for April (5 RED in March) as follows in Table 1:

Table 1: Local Quality indicators RAG rated RED:

Standard	Target	Last month Month 12	This month Month 1
VTE – risk assessment on admission (acute)	>95%	86%	67.7%
Follow ups past to be seen date (excluding Audiology):	3,500	7301	7323
Fractured Neck of Femur	>90%	80%	79.4%
Stroke	>80%	92.3%	77.8%

Of the remaining indicators, 13 were rated GREEN, 1 AMBER and 1 not rated.

2.2 Workforce Headlines

Of the four workforce KPIs on the integrated dashboard 1 is RAG rated Green, and 3 RAG rated Amber as follows:

- **Turnover (excluding Junior Doctors)**: **GREEN** - the Trust's turnover rolling 12 month rate was 10.89% for the year to April 2018, which is within the target range of 10% to 14%.
- **Staff sickness/absence: AMBER -** The annual rolling 12 month sickness absence rate (one month in arrears) was 3.96% at the end of March 2018 (4.18% in February). This may show a sign of the seasonal impact starting to reduce. The rate still remains above target.
- **Mandatory Training rate**: **AMBER –** At the end of March 2018 the overall mandatory training rate was 82.79% against the target of >85%. The decrease is in main due to the lower rates of 'Resus and Prevent' which are the extra Making the Airway Safe Training (MAST) subjects.
- **Appraisal rate**: **AMBER -** The Achievement Review rate for April is at 80.75% against a target rate of 90% which is an increase from March which was 78.72%. 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 utilized to support and drive improvements.

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

- **Workforce Plan –** For 18/19 the workforce plan will be monitored against the plan submitted to NHSI. No report is available for Month 1.

- **Agency Expenditure –** The NHSI cap for 18/19 is £6,180,000. Progress will be reported against the revised cap.

2.3 Operational Headlines

2.3.1 Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 3 were RAG rated RED in April 2018 (3 in March 2018) as follows in Table 2:

Table 2: Community and Social Care Framework RAG Rated RED

Standard	Target	Last month Month 12	This month Month 1
Delayed transfers of care bed days (acute)	64 days per month	128	182
Carers Assessments completed Year to Date	40% Year end	42.2%	1.4% (3.0% M1 trajectory)
Community Hospital – admissions (non-stroke)	None set	235	227

Of the remaining indicators, 7 were rated GREEN, 1 AMBER, and 4 indicators do not yet have an agreed target.

Community Hospitals

Community Hospitals continue to perform with a lower length of stay (12 days) and maintaining the same activity levels seen prior to the closure of beds in April 2017.

Minor Injury Units (MIUs)

The community MIUs continue to deliver 100% of patients seen and treated within 4 hours with a median time of 45 minutes.

Torbay Services – Social care

There has been some successful recruitment for social workers which over the next few months will mitigate the risks in terms of reduced capacity. The SPOC (single point of contact) for safeguarding is under particular pressure currently but there are plans in place to mitigate risks and ensure continuation of appropriate and timely responses.
Change programmes are well underway and starting to deliver.
Performance remains strong within Public Health Services against a backdrop of current tendering for the majority of these services with Health and Torbay Council commissioners.
Older Peoples Mental Health services are developing their care Home Education and Support Team which is improving the quality of people with dementia in care homes and reducing cost.
Pressures within the domiciliary care market continue, and there have been a number of well attended engagement events with providers and stakeholders to develop the sector.

Continuing Health Care (CHC)

- National Framework for CHC has been revised and goes live in October 2018.
- NHSE monthly monitoring of all CHC providers on a number of quality performance areas. Biggest challenge for South Devon and Torbay is 28 day decision making. NHSE want 80% compliance by the end of Q3. Current activity is 40%
- Rolling out a new model of provision for CHC across Torbay and South Devon to support above changes.
- Personal Health Budgets to be the default position for Continuing Health Care funded homecare. Currently no infrastructure in place to deliver this. Have been accepted on a

mentoring programme by NHSE and are being mentored by Blackpool.

2.3.2 NHS Improvement Single Oversight Framework (SOF) National Performance Standards

Against the national performance standards, for Month 1 the Trust has delivered the outcomes in Table 3. Forecast risk against trajectory delivery is indicated as 'high' 'moderate' or 'minor'. Where the forecast risk is considered 'high' this is accompanied with a brief summary of management action.

Table 3: NHSI SOF National Performance Standards

Standard	Standard / target	Last month Month 12	This month Month 1	Risk
A&E - patients seen within 4 hours (PSF)	>92%	80.6%	87.7%	High
	Trajectory	(95%)	(90.1%)	
RTT – 18 weeks	>92%	81.6%	81.66%	High
	Trajectory	(90%)	(82.2%)	
Cancer – 62 day wait for first treatment – 2ww referral	>85%	79.7%	82.1%	Moderate
Diagnostic tests longer than the 6 week standard	<0.1%	8.9%	11.0%	Moderate
Dementia Find – monthly report	>90%	92.7%	99.2%	Minor

- **4 hour ED standard:** In April the Trust achieved 87.7% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments. This is an improvement on last month (80.6%) however below the operational plan trajectory of 90.1% and national standard of 95%.

  Risk: High – The delivery of the Q1 target of 92.2% for attainment of the Provider Sustainability Fund (PSF) can still be delivered however at a greatly reduced number of daily breaches of 8 per day (14/5/18) compared to the run rate in April of 37 patients waiting over 4 hours per day to be seen and leave the department.

  Management action: Led by the Head of Operations there is a rapid review to ensure all elements of patients flow are supported. The meeting of the Patient Flow Board on the 23rd May 2018 will be dedicated to evaluation of system performance and agreement of actions. Current work plan includes revisiting all processes of best practice to avoid unnecessary admission, facilitate rapid inpatient review and decision making. The SAFER programme led by matrons and the head of operations has been reactivated to meet weekly and refocus ward teams on proactive discharge planning to support optimum patient flow.

- **RTT:** RTT performance has stabilised in April with the proportion of people waiting less than 18 weeks at 81.66% in April (81.6% in March). This is below the operational plan performance trajectory of 82.2%. At the end of April 43 people were reported as waiting over 52 weeks against 33 last month. Operational pressures have continued to limit the

number of elective inpatient admissions along with continued capacity pressures in key outpatient specialties.

Risk: High – The forecast is that there is significant risk to delivering the increased levels of activity needed to maintain the 82% RTT performance with several specialties experiencing capacity and demand imbalances that will see a continued increase in access times. Finalisation of investment plans and capital allocation to support activity plans in Urology, Upper Gastrointestinal surgery, Colorectal Surgery, Dermatology and Diagnostics awaited.

The impact on trajectory from the proposed winter plan elective pause is to be evaluated and may increase risk against these plans.

Management action: Led by the Chief Operating Officer all at risk teams are providing plans by end of May. These plans will set out the agreed and required actions to deliver the activity increase over run rate and/or the productivity gains necessary to maintain the 82% RTT trajectory. There are already a number of agreed investments and links to capital plans for 2018/19 that are in train, however the timing of implementation is critical along with outstanding actions that need to be agreed.

- **62 day cancer standard: at** 82.1% (validated 9th May 2018) performance is below the 85% national target, although a small improvement on last month (79.7%). Current forecast for Q1 is 81.1%.

  Risk: Moderate – The increased backlog from lost capacity in Q4 remains in the system with deterioration in performance forecast in Q1. It is expected that actions being taken will bring performance back to target from July.

- **Diagnostics:** The diagnostics standard is not met with 11% of patients waiting over 6 weeks against the standard of 1%. The greatest numbers of long wait patients are in non obstetric ultrasound with an increase to 144 patients over 6 weeks from 44 last month. Other areas with long waits MRI (123) CT (66) cardiology (36) have remained similar to last month.

  The deterioration is due to lost capacity for routine patients to support the emergency pathways along with lost capacity in March from staffing pressures and re-bookings from the weather related cancellations.

  Risk: Moderate – Actions are being implemented to target the capacity for ultrasound and plans to support capacity for MRI and CT with additional outsourcing and mobile van visits are in place.

- **Dementia screening:** The Dementia Find standard is meeting the standard of 90% with 99.2% achieved In April. This is a significant achievement and aided by the allocation of HCA resource to support the wards.

  Risk: Minor – Good progress against delivering the standard being maintained.

2.3.3 Local Performance Indicators

In addition to the national operational standards there are a further 23 indicators agreed locally with the CCG, of which 10 were RAG rated RED in April 2018 (10 RED RAG rated in March). The indicators RAG rated RED are summarised in Table 4:

Table 4: Local Performance Indicators RAG Rated RED

Standard	Standard/ target	Last month Month 12	This month Month 1
Cancer 2ww urgent GP referral	>93%	71.7%	55.3%
Cancer 2ww – symptomatic breast	>93%	95.4%	92.8%
RTT waits over 52 weeks:	0	34	43
On the day cancellations for elective operations	<0.8%	4.5%	1.1%
Cancellations not readmitted within 28 days	0	21	16
Ambulance handovers > 30 minutes:	0	168	105
A&E patients (ED only):	>92.9%	72.3%	81.8%
Trolley waits in A&E > 12 hours from decision to admit	0	6	1
Care plan summaries % completed within 24 hrs of discharge weekdays:	>77%	60.5%	70.4%
Care plan summaries % completed within 24 hrs discharge weekend:	>60%	28.6%	30.5%

Of the remaining 13 indicators, 11 were rated GREEN, 1 AMBER, and 1 indicator does not yet have an agreed target.

2.4 Finance Headlines:

- **Overall financial position:**
  The financial position for the financial period to 30th April 2018 is a deficit of £1.27m against a planned deficit of £1.56m.

  Whilst still early in the financial year, indications are that run rates of pay expenditure remain broadly stable and, within that position there has been a reduction in agency spend on the rates experienced during the final quarter of 2017/18.

  Non-pay expenditure is underspent by a total of £0.55m.

- **Year-end cumulative CIP savings delivery position:** The Trust has recorded £0.3m of CIP savings against our target of £1.12m for the month. Whilst behind plan, we are aware that some CIP schemes have yet to be loaded. This will be corrected in Month 2, which will mitigate this to a certain extent. Against the full year target of £26.93m, a total of £14m of schemes are currently registered in the Programme Management Office. It is clearly critical that further progress is made in identifying savings as a matter of priority; this needs to be an urgent focus of operational teams throughout the first quarter.

- **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 1, the Trust had an actual Use of Resources risk rating of 3 (subject to confirmation by NHS Improvement). The planned rating is also 3. The Agency risk rating of 3 is worse than the budgeted rating of 2.

Torbay and South Devon NHS
NHS Foundation Trust

Integrated Performance Report

May 2018: Reporting period April 2018 - Month 1

Section 1 - PERFORMANCE

Quality Focus

Workforce Focus

Community and Social Care Focus

NHSI operational performance indicator Focus

Local performance metric exception

Section 2 - FINANCE

Quality Focus

Month 1 (performance to end of April 2018)

Quality and Safety Summary

The following areas of performance are noted:

1. The Hospital Standardised Mortality Rate (HSMR) remains in a positive position for the months of February 17 to January 18 (please note Dr Foster has a three month d ata lag). January data has a mortality rate of 91.2 which is good and remains below the 100 average line. Please not in previous years January has risen above the 100 benchmark due to the seasonal increase in unadjusted mortality. The overall yearly mortality is in keeping with the Unadjusted Mortality and the DH's Summary Hospital Mortality Index (SHMI) shown in the report.

As well as viewing the top line mortality figure any Dr Foster mortality alerts are also reviewed on a monthly basis, firstl y between Coding and Clinical Risk at a pre-arranged meeting and subsequently at the Mortality Surveillance Group and Quality Improvement Group (QIG).

2. Incident reporting continues to be well supported and all areas of the Trust are reporting within expectations. Themes and issues are collated o n a monthly basis and can be viewed via the Trust wide QIG Dashboard. The information collected helps inform the five point Safety Brief and internal Clinical A lert System. A new monthly Datix Digest has also been produced and includes a top ten themed review of each SDU. This is also sent out via ICO News to the ICO. These augment the QIG dashboard which is also sent out and available on Safebook.

3. Never event - No Never Events are reported in April.

4. STEIS - No Strategic Executive Information System (STEIS) reportable incidents are reported in April.

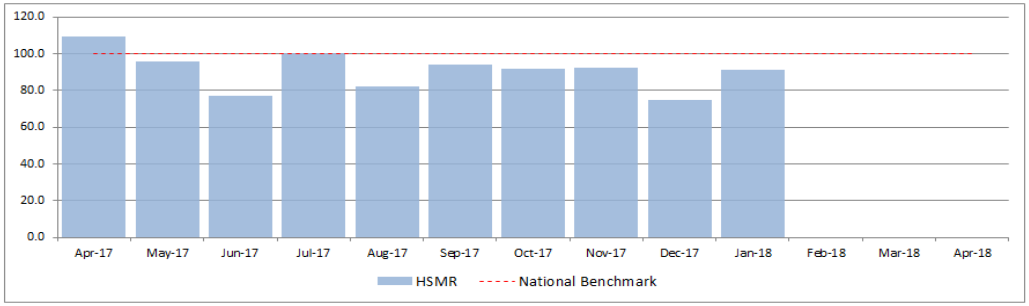
5. Infection Control are reporting a decrease in the number of bed days lost from infection control measures with just 6 bed days lost in April. This reflects where there have been bays closed on wards due to norovirus and flu containment.

6. The Venous Thromboembolism (VTE) drop in compliance in the Acute setting has been noted and escalated to the Medical Director and will be included for discuss ion at the forthcoming Quality and Performance Review meetings.

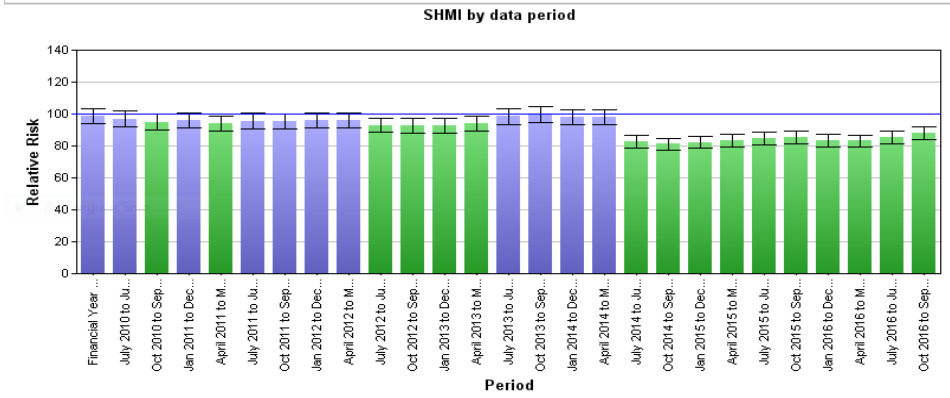
7. Clinic Follow ups - the number of patients waiting 6 weeks or more for a follow up appointment beyond the intended appointment date has remained static from last month and remains above target levels with several specialities having significant backlogs to clear. These are listed in the report.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
HSMR	109.2	95.6	77.0	100.3	82.1	94.2	91.7	92.1	74.8	91.2			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



Trust wide 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 is then compared to the actual number to create a standardised rate. This rate can then be compared to the English average, the 100 line. Dr Foster's mortality rate runs roughly three month in arrears due to the national data submission timetable and, therefore, Dr Foster mortality has to be viewed with the Trusts monthly unadjusted figures.
The latest data for Dr Foster HSMR is showing a low relative risk of 91.2, which is positive and mirrors the general trend of the Trust. Mortality does have a cyclical nature and tends to rise during the colder months. In this financial year, these being January and February 2018 and will have to wait to observe the data.

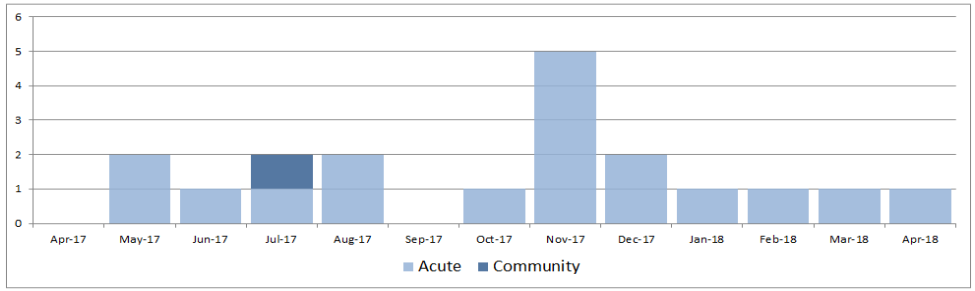


The SHMI data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital.
The data is released on a quarterly basis and the latest data release from the DH is October 2016 - September 2017 and records the Trusts at 87.8 against a national average benchmark of 100. This being a slight increase on last period July 2016 - June 2017 of 83.9. The SHMI has remained low for a sustained period of time.

A score of 100 represents the weighted population average benchmark.

Number of Clostridium Difficile cases

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Acute	0	2	1	1	2	0	1	5	2	1	1	1	1
Community	0	0	0	1	0	0	0	0	0	0	0	0	0



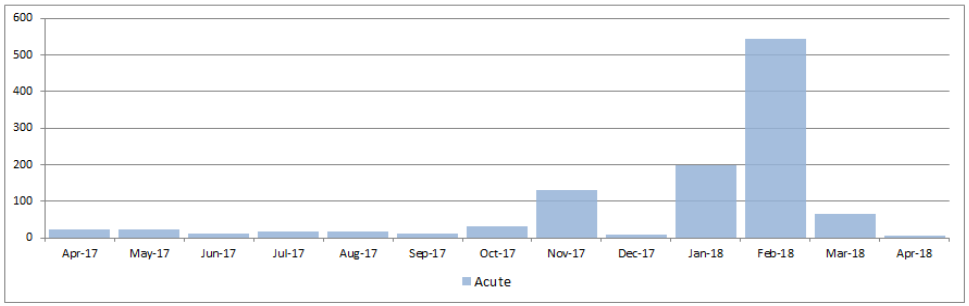
In April there is one C-diff reported against the acute setting. The full RCA is to be rcompleted at this time so is not recorded as a lapse in care (acute).

The Target for 18_19 set by NHSE is a total of 17 cases identified as a lapse in care.

Each reported case of Cdiff undergoes 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)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Acute	24	24	12	18	18	12	30	130	8	198	544	64	6

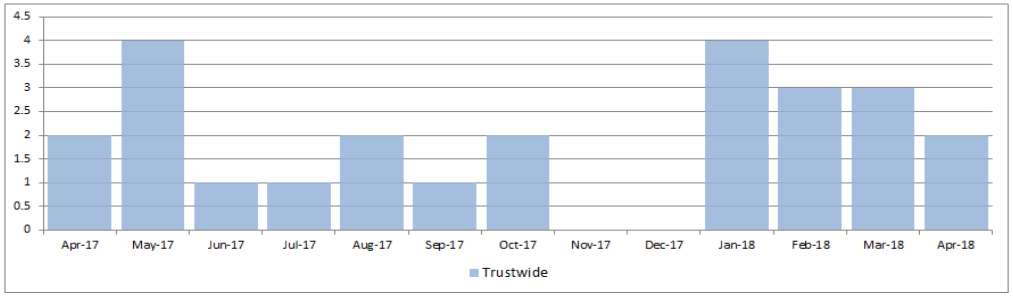


The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In April, there has been no significant outbreak issues to manage as seen in the graph opposite which records the number of beds closed from Norovirus or flu infection controls.

Reported Incidents - Major and Catastrophic

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Trustwide	2	4	1	1	2	1	2	0	0	4	3	3	2



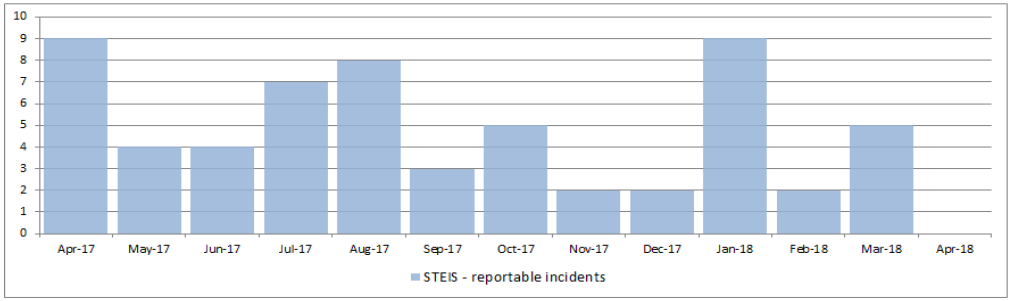
April 2018 the Trust recorded 1 serious incidents which is currently under investigation:

1: Unexpected death Totnes Hospital

Please note the severity of an incident may change once investigated.

STEIS Reportable Incidents

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
STEIS - reportable incidents	9	4	4	7	8	3	5	2	2	9	2	5	0



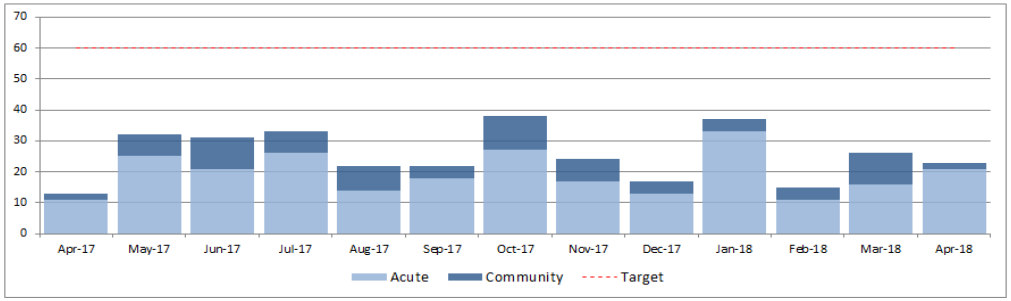
The Trust reported 2 incidents on the Strategic Executive Information System (StEIS). The incidents are:

1: Infection control in theatres
2: Maternity - mother and baby awaiting transfer to other provider

All incidents are being investigated for learning and sharing and have followed the Duty of Candour process .

Formal complaints

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Acute	11	25	21	26	14	18	27	17	13	33	11	16	21
Community	2	7	10	7	8	4	11	7	4	4	4	10	2
Total	13	32	31	33	22	22	38	24	17	37	15	26	23
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



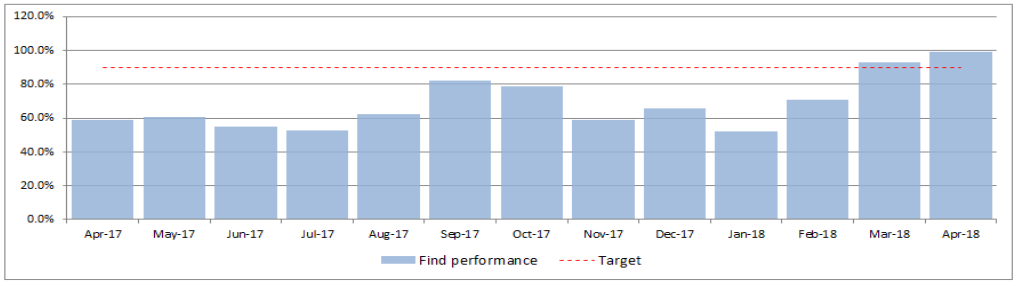
In April the Trust received 23 formal complaints.

The number of formal complaints are shown in the table opposite. This shows the split of 21 relating to the Acute site and 2 in the Community.

The main themes from the complainants are funding allocations, communication, attitude of staff, and treatment.
All complaints are investigated locally and shared with area/locality for leaning.

Dementia - Find

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Numerator	323	424	372	308	360	455	301	230	285	256	269	279	120
Denominator	499	632	603	496	520	536	383	390	435	491	380	301	121
Find performance	58.9%	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%	59.0%	65.5%	52.1%	70.8%	92.7%	99.2%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



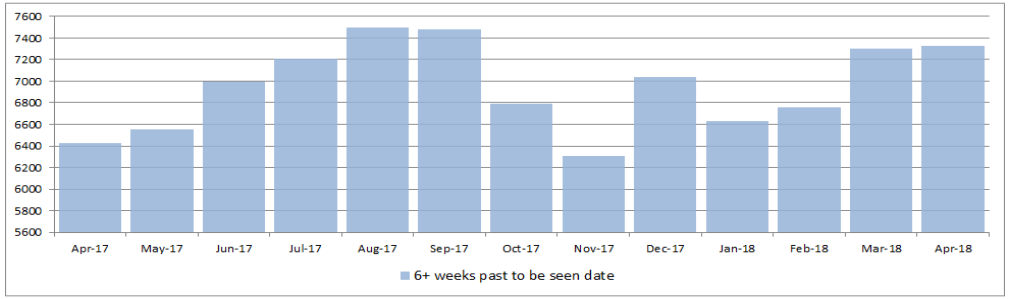
Dementia Find: The NHS I Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors.

The Dementia Find in April improved to 99.2% from 92.7% in March.

The improvement achieved with support from a Health Care Assisatant tasked to support wards.

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

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
6+ weeks past to be seen date	6429	6550	6999	7209	7496	7477	6790	6308	7041	6630	6761	7301	7323



Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in April to 7323 (7301 last month).

Agreed actions to target the areas with the greatest number are being monitored through the Performance Risk and Assurance Group.

The Quality Assurance Group are maintaining oversight on processes to identify and mitigate clinical risk against patients waiting beyond their intended review date.

Specialties with the greatest numbers of patients waiting longer than six weeks are shown in the table opposite with Ophthalmology having the highest number. These are across a number of common disease pathways and appropriate clinical risk and review measures are in place.

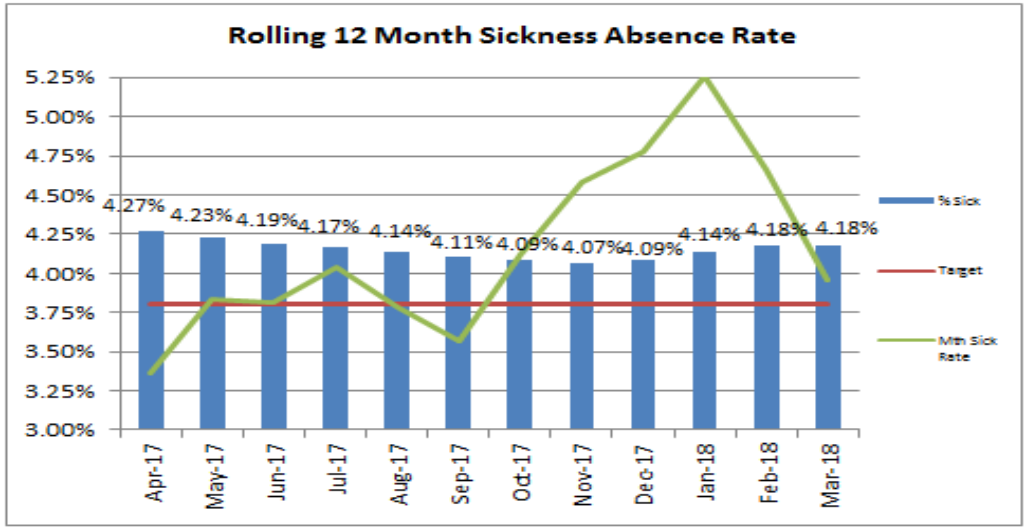
Specialty	Number beyond 6 weeks passed due date
Ophthalmology	3191
Rheumatology	1043
Urology	393
Paediatrics	392
Dermatology	388
Orthoptics	321
Cardiology	285

Workforce Focus

Month 1 (performance to end of April 2018)

Workforce - sickness absence

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



The annual rolling sickness absence rate of 4.18% at the end of March 2018 is the same as the previous month that may show a sign of the seasonal impact now starting to reduce. This is against the target rate for sickness of 3.80%.

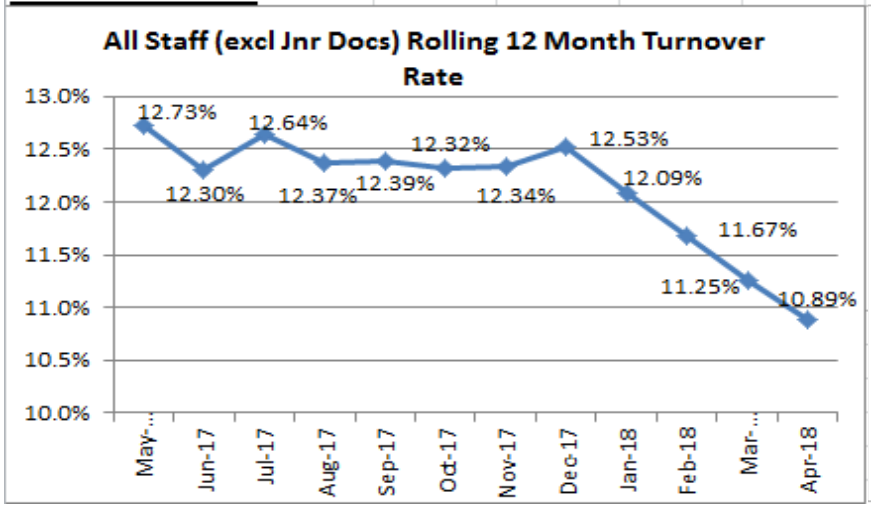
The sickness figure for March was 3.96% which is still higher than the 3.80 target but is the lowest monthly level since September 2017.

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.

All Staff Turnover

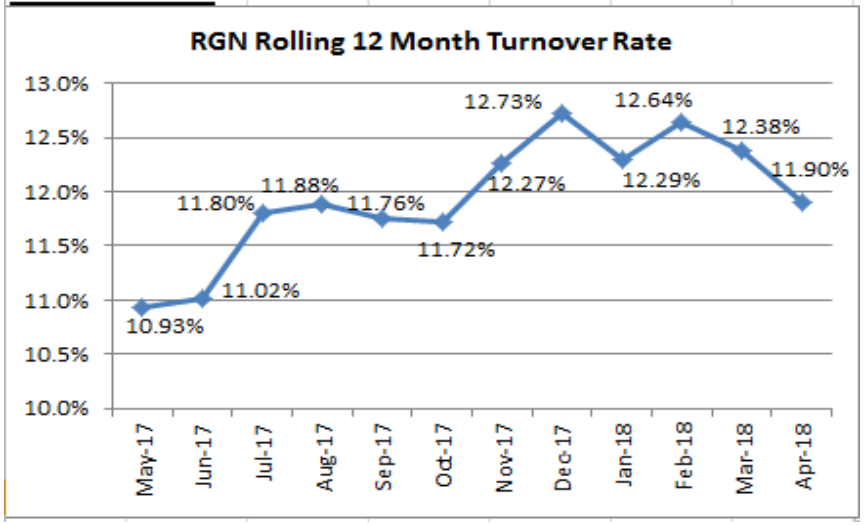


All staff rolling 12 Month Turnover Rate

The following graph shows that the Trusts turnover rate was 10.89% for the year to April 2018. This is a reduction from last month's 11.25% and within the target range of 10% to 14%.

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

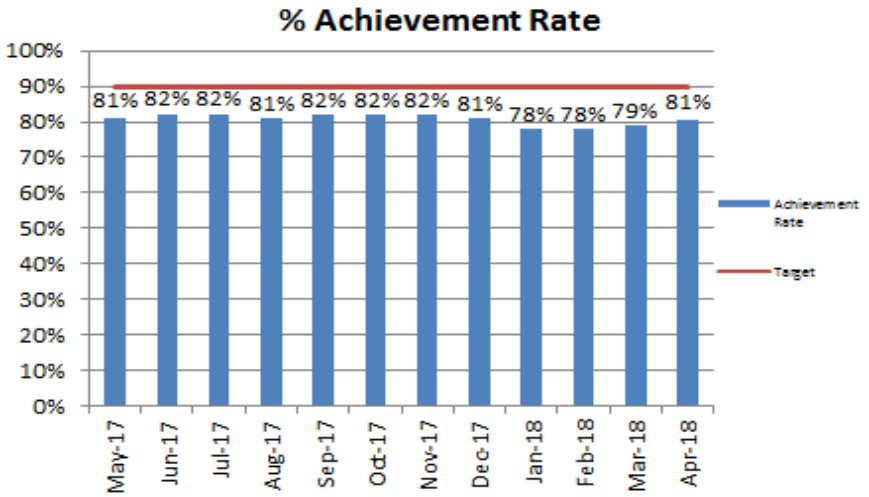
RGN Turnover

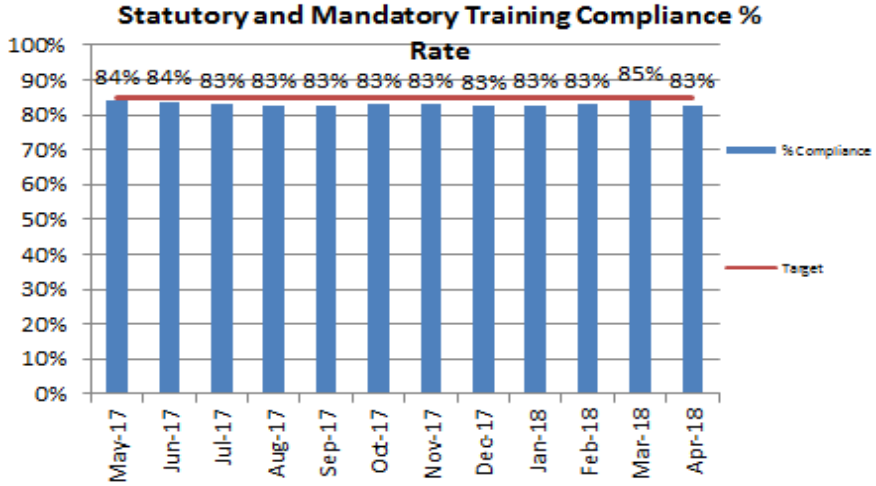


RGN Rolling 12 Month Turnover Rate

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% and reduced from March's 12.38% to 11.90% in April.





Achievement Review (Appraisal)
The Achievement Review rate for April is at 80.75% against a target rate of 90% which is an increase from March which was 78.72%. 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.

Achievement Review rates are also an agenda item for discussion 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 for the statutory and mandatory training modules which has increased to 11 subjects to align with the MAST Streamlining project. The graph shows that the current rate has reduced from 85.29% in March to 82.79% in April mainly due to the lower rates of Resus and Prevent which are the extra MAST subjects. The Trust holds all competencies completed in ESR to ensure we are complying with Core Skills Training Framework requirements as part of the NHS Streamlining agenda.
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:

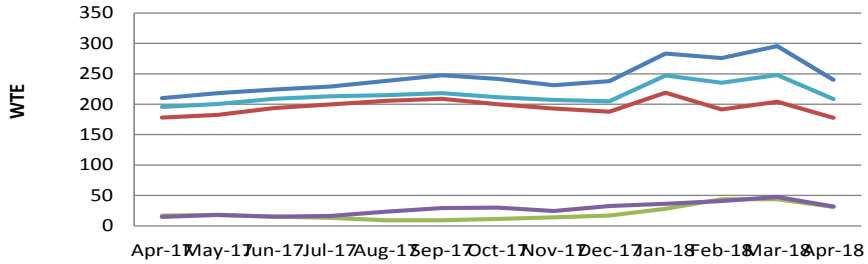
Module	Target	Performance
Information Governance	95% and above	75.23%
Conflict Resolution	85% and above	81.26%
Infection Control	85% and above	80.11%
Manual Handling	85% and above	79.66%
Resuscitation	85% and above	74.14%
Prevent Awareness	85% and above	74.47%

Agency Spend: The Trust's annual cap for agency spend, set by NHS I, for 17/18 was £6.58 million per year. The Trust successfully achieved the NHSI cap for 17/18. The NHSI cap for 18/19 has been revised and will be £6.18 million. The table below sets out the monthly plan for expenditure and WTE, progress will be monitored against the plan.

Torbay and South Devon NHS Foundation Trust
FY 2017/18 (Outturn) and FY 2018/19 Plan (Monthly)

AGENCY STAFF SPEND BY STAFF GROUP £000	Forecast Out-turn 31/03/2018 Year Ending £'000	Plan 30/04/2018 Month 1 £'000	Plan 31/05/2018 Month 2 £'000	Plan 30/06/2018 Month 3 £'000	Plan 31/07/2018 Month 4 £'000	Plan 31/08/2018 Month 5 £'000	Plan 30/09/2018 Month 6 £'000	Plan 31/10/2018 Month 7 £'000	Plan 30/11/2018 Month 8 £'000	Plan 31/12/2018 Month 9 £'000	Plan 31/01/2019 Month 10 £'000	Plan 28/02/2019 Month 11 £'000	Plan 31/03/2019 Month 12 £'000	Plan 31/03/2019 Year Ending £'000
Registered Nurses	£ 1,751	£ 280	£ 281	£ 273	£ 269	£ 264	£ 264	£ 259	£ 258	£ 310	£ 310	£ 309	£ 309	**£ 3,386**
Allied Health Professionals	£ 729	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	£ 53	**£ 636**
Other Scientific, Therapeutic and Technical Staff	£ 140	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	£ 4	**£ 48**
Health Care Scientists and Scientific, Therapeutic and Technical staff	**£ 869**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 57**	**£ 684**
Support to Nursing staff	**£ 3**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**	**£ -**
Medical and Dental Staff - Consultants	£ 2,187	£ 173	£ 189	£ 163	£ 141	£ 121	£ 141	£ 98	£ 92	£ 82	£ 98	£ 92	£ 98	**£ 1,488**
Medical and Dental Staff - Trainee Grades	£ 689	£ 50	£ 42	£ 33	£ 17	£ 12	£ 17	£ 20	£ 15	£ 10	£ 20	£ 15	£ 20	**£ 271**
Non Medical - Non-Clinical Staff Agency	£ 287	£ 33	£ 33	£ 33	£ 28	£ 28	£ 28	£ 28	£ 28	£ 28	£ 28	£ 28	£ 28	**£ 351**
Total pay bill - agency staff including capitalised staff	**£ 5,786**	**£ 593**	**£ 602**	**£ 559**	**£ 512**	**£ 482**	**£ 507**	**£ 462**	**£ 450**	**£ 487**	**£ 513**	**£ 501**	**£ 512**	**£ 6,180**
Whole Time Equivalent (WTE)														
Registered Nurses	46.3	39.1	38.9	37.8	37.0	36.3	36.1	35.3	35.1	34.6	34.4	34.2	34.0	34.0
Qualified Scientific, Therapeutic and Technical Staff	13.1	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Support to Nursing staff	0.1													
Medical and Dental Staff - Consultants	5.6	21.6	21.6	20.6	19.6	19.6	19.6	16.6	16.6	16.6	16.6	16.6	16.6	16.6
Medical and Dental Staff - Trainee Grades	9.2	2.9	1.9	1.9	1.1	1.1	1.1	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Total Non Medical- Non-Clinical Staff	3.1	4.1	4.1	4.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1
Agency staff (including, Agency, Contract and Locum)	77.3	75.7	74.5	72.4	68.9	68.1	67.9	63.8	63.7	63.2	63.0	62.8	62.6	62.6

Nursing & HCA - Bank and Agency Usage



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Total Requested: WTE	210	218	224	229	238	248	242	231	238	283	276	295	240
Total covered by Bank: WTE	178	183	194	200	206	209	200	193	188	219	191	204	178
Total covered by Agency: WTE	17	18	15	13	9	9	12	14	17	28	44	44	31
Total Unassigned: WTE	15	18	15	16	23	29	30	24	33	36	41	48	32
Total covered: WTE	195	200	209	213	215	218	212	207	205	247	235	248	209

Nursing and HCA Bank and Agency

The table opposite shows the split between agency and bank for Nursing & HCA shifts.

The use of the high cost off-framework agency reduced in April 2018 which has contributed to the cost reduction in month 1.

In addition during April 18 the equivalent of 59.1 WTE Bank RGNs were used.

All Healthcare Assistant shifts are filled through the internal bank. In April 2018 the equivalent of 121 WTE Bank HCAs were used across the Trust.

Medical and Dental Agency: The use of medical agency is mainly attributable to a number of consultant vacancies and gaps in the junior doctor rotas.
All medical agency workers are engaged through Direct Engagements which means that the Trust is compliant with HMRC IR 35 requirements.
The Medical Bank is supporting the gaps in the junior doctors rotas, which has reduced the cost of agency for this staff group.
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 actively work with those agencies to reduce rates.
In addition the Trust/STP is working with a recruitment agency to support with 'hard to fill' posts.

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.
Radiography: despite intentions that that use of agency would cease the demand in Ultrasound has grown and compounded by staff shortages. Therefore agency use continues with no end date in sight.
Mortuary: the band 5 post has been recruited to. Unfortuantely the band 4 technician resigned. Therefore agency use continues whilst a recruitment process is worked through.
Cardiology: are still requiring locum agency to cover vacancies although long term sickness has improved within the team. Locum use will be reducing by 1wte following recruitment into one of the senior physiologist positions after a planned two month handover and training period.

Community and Social Care Focus

Month 1 (performance to end of April 2018)

Social Care Programme Board

2018/19 Performance Scorecard to 30 April 2018

'Torbay Social Care KPIs	2018/19 full year target	2018/19 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	92%	92%	93%	On target
% clients receiving direct payments	28%	28.0%	26.0%	Below target. Performance expected to improve through use of 'My Support Broker' and work with the voluntary sector.
% clients receiving a review within 18 months	93%	93%	86%	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 also done in the most efficient order rather than date order.
No. of permanent care home placements (snap shot)	617	630	602	On target
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	599.0	584.6	470.7	On target
Carers receiving needs assessment, review, information, advice, etc.	43%	3.0%	1.4%	Below target. Impacted by a process change on care management system. Carers lead will review to ensure staff are following new process.
% carers receiving self directed support	85%	85%	81%	Within agreed tolerance
% 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%	8.4%	Within agreed tolerance
% Adults with learning disabilities in paid employment	4.0%	1.0%	1.0%	Below target. Recording reset in April 2018 to improve accuracy. Outturn expected to increase throughout year as reviews are completed.
% Adults with learning disabilities in settled accommodation	75%	75%	75%	On target
Number of days of delayed transfers of care (BCF)	2,439	..	..	KPI reported 1 month in arrears

The Social Care and Public Health metrics relate to the Torbay LA commissioned services. Comments against indicators are shown in the dashboard above. The metrics and exceptions are reviewed at the Torbay Social Care Programme Board (SCPB), monthly Executive Quality and Performance Review meetings and Community Board. The headline risks currently being managed are:

1. Nursing and residential home market and capacity: M*anaged via The Market Management group, with Torbay Council, CCG and trust members*.
2. Domiciliary care provider not meeting service level demand : *there is a comprehensive programme in place to address this issue, with a focus on partnership working, managing demand and strenghtening alternatives to resisdential care.*
3. Continuing Health Care (CHC) for placed people volume and price pressures.

Measure	Target 2018/2019	13 month trend	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2018/19
PUBLIC HEALTH SERVICES								
CAMHS - % Urgent referrals seen within 1 week	88.0%		100.0%	85.7%	100.0%	100.0%	100.0%	100.0%
CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%		98.9%	100.0%	98.3%	97.9%	97.8%	98.0%
% of face to face new birth visits within 14 days *	95.0%		91.2%	93.1%	93.7%	89.9%	92.0%	92.0%
Children with a child protection plan * [B]			176	160				
4 week smoking quitters (Quarterly) ** [B]			232					
Opiate users - % successful completions of treatment (Quarterly) ** [B]			7.8%					

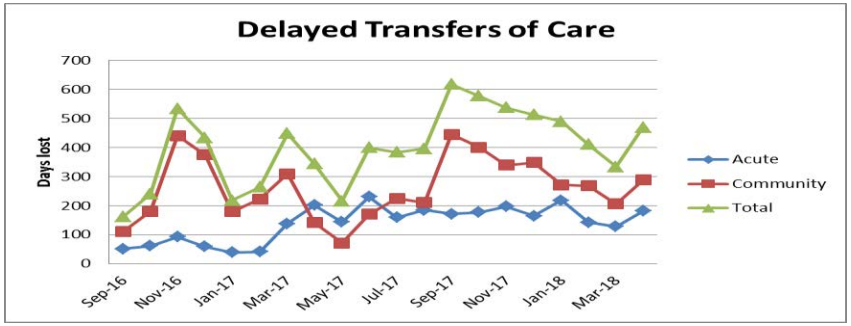
Public Health: The headline messages for Public Health performance are:

CAMHS - waiting times from referral to assessment and commencement of treatment remain good. Quarterly data in arrears for smoking, opiate users, and children with a protection plan to be updated next month.

Community Hospital Dashboard - Summary of Key Measures - April-18

	Target Apr-18	Apr-18	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges					
Total Admissions (General)	205	227	227	205	→
Direct Admissions (General)	22	26	26	22	↑
Transfer Admissions (General)	183	201	201	183	→
Stroke Admissions	20	29	29	20	↑
Transfers from CH to DGH	3	8	8	3	↑
Beds					
Bed Occupancy [1]	90%	92.9%	92.9%	90.0%	
Bed Days Lost to Delays[2]	266	288	288	266	→
Bed Days Lost to Bed Closure		5	5		
Length of Stay		*Rolling 3 months LOS*	*LOS Ytd Months*		
Delayed Discharges		44	44		
Average Length of Stay - Overall (General)		11.5	12.2		→
Average Length of Stay - Stroke	0.0	15.4	16.5	18.0	↓
Long LoS (>30 days)	14	16	16	18	↓
MIUs					
Total MIU Activity [3]	2,879	3,419	3,419		
MIU Four Hour Breaches	0	0	0	0	
Average Waiting Time (Mins) - 95th Pctile	45	44	44	45	

Measure	Target 2018/2019	13 month trend	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2018/19
COMMUNITY BASED SERVICES							
Nursing activity (F2F)	204,385		17,621	15,715	14,812	13,477	13,477
Therapy activity	65,415		5,771	5,066	4,411	4,962	4,962
No. intermediate care urgent referrals [B]	2,189		222	187	161	194	194
No. intermediate care placements	0		149	112	114	117	117
Intermediate Care - placement average LoS [B]	12.0		16.4	14.1	17.5	15.1	15.4



The Community Hospital Dashboard highlights

The planned levels of activity have been reset to reflect the 2017/18 baseline. In April admissions are slightly over plan and the length of stay increased over the 3 month rolling average of 11.5 days to 12.2 days in April 18. Bed occupancy increased to 93% being above the target (90%) for optimal patient flow.
The April Community Hospital performance metrics reflect the wider system operational pressure which has seen continued high levels of escalation to maintain emergency patient flow.
This has seen a continued use of additional Intermediate Care and Domiciliary Care capacity to support timely discharge and alternatives to community and acute bed based care.

Waiting times in MIUs are being maintained with a median time of 45 minutes.

Community based services highlights

Nursing Community nursing and community outpatients activity targets are reset to reflect 2017/18 activity levels. April is seeing expected levels of activity. There is an expectation that teams will deliver an overall increase in productivity.

Intermediate Care (IC) placements The year to date average length of stay in IC placements remains above target however reduced to 15.1 days in April from 17.5 days reported in March. 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 (DToC)
April is reporting an increase in the reported number of delayed discharge bed days. Close monitoring of delays is being maintained with weekly validation in place.

Operational Performance Focus

Month 1 (performance to end of April 2018)

STP / NHSI operational plan - Monitored indicators

Indicator	National Standard	Operational plan trajectory (M1)	Trust performance (M1)
A&E 4hr waits (STF)	95%	90.1%	87.70%
RTT 18 week waits	92%	82.20%	81.66%
62 day Cancer waits	85%	85.0%	82.10%
Diagnostics waits < 6 weeks	99.0%	>96%	89.0%
Dementia Find	90%	90%	92.70%

NHSI Operational Plan indicators (Month 1)

A+E: The STF operational performance trajectory in April is **not met**. The target set for Q1 Provider Sustainability Fund (SPF) is 92.22%. M1 performance leaves a target of no more that 8 breaches of the 4 hour standard per day by the end of June.

RTT: The RTT trajectory is **not met** - The continued cap on elective activity and emergency ecsalation have continued to be a factor in not achieving the 82% trajectory.

Cancer: The standard for urgent suspected cancer referral and treatment within 62 days **is not met** in April.

Diagnostics: The diagnostics standard is **not met with** 10.99% of patients waiting over 6 weeks against a target of 1%.

Dementia: The Dementia find standard is **met** .

4 hour ED standard: In April the Trust achieved 87.7% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Separtments. This is an improvement of last month (80.6%). The notable change is the reduction of patients presenting with Flu symptoms. The perfo rmance in M1 is below the trajectory of 90.1% being the level of performance achieved last year.

RTT (Target 92% / Trajectory 90.0%): RTT performance has been affected by the continued cap on elective capacity and diversion of clinical capacity to support the OPEL 4 escalation on non elective pathways. Teams where backlogs are forecast to increase (or have patients waiting longer than 52 week) are completing recovery plans that will be reviewed at the Performance Risk and Assurance group.

Patients waiting over 52 weeks: The number of very long wait increased in April with 43 reported waiting over 52 weeks at the end of April. The trajectory for reducing these long waits has been reset in our Operational Plan to clear all patients waiting over 52 weeks by the end of October 2018.

62 day cancer standard: The 62 day referral to treatment standard was not met in April at 82.1% (validated 9th May 2018). Action plans against the tw o week wait from urgent referral to appointment and the 62 day from urgent referral to treatment standards are being reviewed with teams. These plan s will be signed off and monitored through the bi-weekly Performance Risk and Assurance group and exceptions escalated to the monthly Quality and Performance Review meetings.

Diagnostic waits: The number of patients with a diagnostic wait over 6 weeks increased in April to 458 (11%) from 380 (8.95%) in March of to tal number waiting.
The biggest increase in is non-obstetric ultrasound. Staffing capacity has been an operational challenge in March and April. Additional locum support now in place now bringing total numbers waiting down although patients waiting over 6 weeks remain high and will reduce over the coming months. MRI a nd CT capacity remains a challenge ,however ,existing plans to bring in additional outsourced capacity with mobile vans is maintaing the numbers on the waiting list.

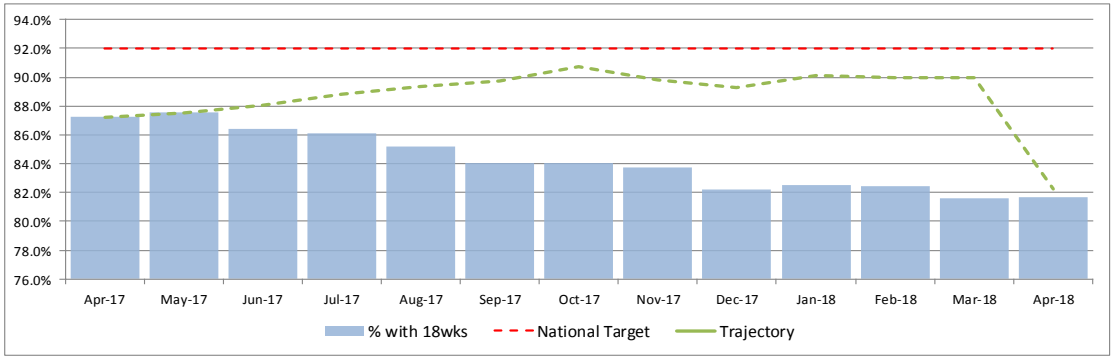
Specilities with highest numbers of patients waiting over 18 weeks RTT

	Incomplete RTT >18 weeks			
Submitted Spec	**IPDC**	**OP**	**% < 18wk**	**Total**
Trauma & Orthopaedics	476	103	71.71	579
Ophthalmology	300	59	83.82	359
Urology	224	81	74.56	305
Upper Gastrointestinal Surgery	204	64	63.54	268
Cardiology	11	211	81.12	222
Oral Surgery	111	95	83.98	206
Respiratory Medicine		203	73.39	203
Gastroen				199
Pain Man				177
Colorectal Surgery	95	62	77.95	157
Neurology	3	136	74.68	139
Paediatrics	5	112	86.73	117
Rheumatology	4	106	78.35	110

This table has been updated to reflect numbers for 81.66%

Referral to Treatment - Incomplete pathways

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Incomplete <18wks	15333	15526	15000	15140	15579	15403	15713	14945	14669	14752	14952	15386	15693
Incomplete >18wks	2245	2219	2353	2448	2711	2932	2985	2902	3173	3127	3186	3473	3524
% with 18wks	**87.2%**	**87.6%**	**86.4%**	**86.1%**	**85.2%**	**84.0%**	**84.0%**	**83.7%**	**82.2%**	**82.5%**	**82.4%**	**81.6%**	**81.7%**
National Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Trajectory	87.2%	87.5%	88.0%	88.9%	89.4%	89.8%	90.7%	89.9%	89.3%	90.1%	90.0%	90.0%	82.2%

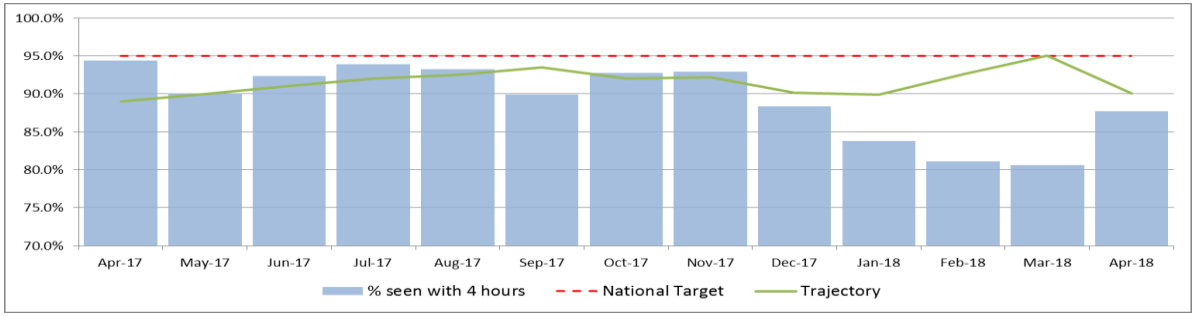


At the end of April 81.66% (81.6% last month) of patients waiting for treatment had waited 18 weeks or less at the Trust fro m initial referral for treatment against the 2018/19 trajectory of 82%. 2018/19 guidance states that RTT performance will be measured as the number of patients on an incomplet e pathway, will be no higher in March 2019 than in March 2018, in these terms April 18 = 19,217 (March 18 = 18,859). This is assessed as RED; the stabilisation in per formance seen in recent months has slipped due to operational pressures and slippage on schemes to increase capacity. Improvements have been seen, however, across the non -admitted (outpatient) pathways, although a number of risks still remain in Rheumatology, Neurology, Cardiology, and Respiratory medicine. The impact from reduced admiss ions for routine elective inpatient admissions remains a risk for Upper GI , Urology, Colorectal and Orthopaedics. Critical to achieving the improvement trajectory is the finalisation of the investment and capital spend to ensure benefits support trajectory along with quick recruitment to new and replacement posts / locum cover once signed off to ensure seamless provision of services.
As part of the STP planning guidance a revised M12 performance of 82% has been agreed and this is to be used as the baseline of activity forecasts in 2018/19. An assessment has been made by specialty and this confirms that the revised trajectory can be achieved from current plans, however, there i s an increased risk due to the continued operational pressures from emergency admission pathways to these plans.

Monitoring patients waiting longer than 52 weeks: At the end of April, 43 patients (target 45) were waiting longer than 52 weeks (33 in March). 2018/19 guidance states that patients waiting more than 52 weeks for treatment should be halved by March 2019. Operational plans confirm committment to a chieving no patients waiting over 52 weeks from December 2018. Plans to increase inpatients operating are being reviewed and to be implemented as soon as the elective c apacity controls for inpatient admission are lifted.

Governance and monitoring: All RTT delivery plans are reviewed at the bi-weekly Performance Riak and Assurance meeting chaired by the Interim Chief Oper ating Officer (ICOO) with the CCG Commissioning Lead in attendance.

NHSI indicator - 4 hours - time spent in Accident and Emergency Department



The Operational Plan trajectory for Accident and Emergency waiting times is not achieved in April with 87.7% of ED and MIU at tenders discharged or transferred within 4 hours against the trajectory of 90.1%.
April performance, however, improved over last month with an overall reduction in escalation status. In April, 19 days at Op el 1 and 2 being the lowest escalation since November 2017, suggesting a return to pre-winter levels of escalation. It is also noted that the number for patients presenting with Flu has tailed off to minimal levels. The escalation ward was descalated on 16th April 2018, however, reopened again following the early May Bank Holiday weekend as a result of retur ning to Opel 4 escalation.

Escalation status

Opel status	June	July	August	September	October	November	December	January	February	March	April
Opel 1	15	30	15	4	12	15	6	0	0	2	10
Opel 2	10	1	11	9	14	11	11	2	2	5	9
Opel 3	5	0	4	17	5	4	13	23	24	14	10
Opel 4	0	0	1	0	0	0	1	6	2	10	1
Performance	92.30%	93.90%	93.20%	89.90%	92.80%	92.90%	88.30%	83.80%	81.10%	80.60%	87.10%

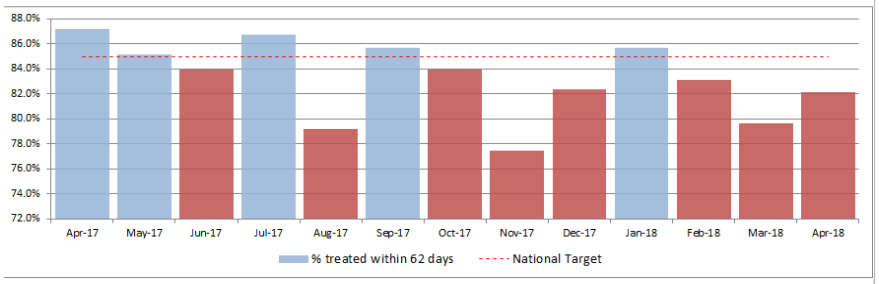
Overall system pressures remain high and in particular pressure on inpatient bed capacity. Following review of operational processes it is identified that some of the improvement initiatives and focus on patient flow have stalled in recent weeks. Led by the Head of Operations there is a rapid review and implementation of actions to ensure all element of patients flow are supported. This work is revisiting all processes of best practice to avoid unnecessary admission, facilitate rapid inpatient review and decision making. Critically is proactive discharge planning using the SAFER ward based initiatives to plan early discharge and maintain optimum patients flow.
Across community services work continues to optimise available capacity to support patients out of hospital. The enhanced level of Domiciliary Care and Intermediate Care support introduced through the care model remain in place.

12 hour Trolley wait - In April, no patients are reported as having a trolley wait from decision to admit to admission to an inpatient bed of over 12 hours.

CWT Measure	Target	April 2018 Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	742	478	1220	60.8%
14 Day - Breast Symptomatic referral	93%	71	5	76	93.4%
31 Day 1st treatment	96%	193	5	198	97.5%
31 Day Subsequent treatment - Drug	98%	66	0	66	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	61	1	62	98.4%
31 Day Subsequent treatment - Surgical	94%	33	0	33	100.0%
31 Day Subsequent treatment - Other		29	0	29	100.0%
62 day 2ww / Breast	85%	92	20	112	82.1%
62 day Screening	90%	7	0	7	100.0%

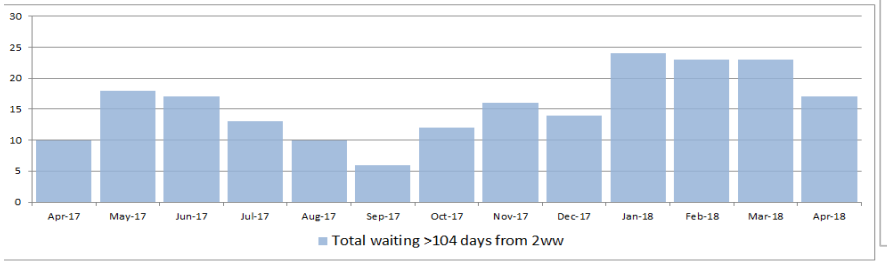
Cancer - 62 day wait for 1st treatment from 2ww referral

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
1st treatments (from 2ww)	62.5	97.5	106	94.5	120	98	84	97.5	85	94.5	83	91	112
Breaches of 62 day target	8	14.5	17	12.5	25	14	13.5	22	15	13.5	14	18.5	20
% treated within 62 days	87.2%	85.1%	84.0%	86.8%	79.2%	85.7%	83.9%	77.4%	82.4%	85.7%	83.1%	79.7%	82.1%
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%	85.0%



Cancer - Patients waiting >104 days from 2ww

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Cancer not discounted	n/a	n/a	n/a	9	6	4	7	12	13	15	15	11	10
Confirmed cancer	n/a	n/a	n/a	4	4	2	5	4	1	9	8	12	7
Total waiting >104 days from 2ww	10	18	17	13	10	6	12	16	14	24	23	23	17



Cancer standards - Table opposite shows the April performance (at 9th May validation point): *Note these figures are provisional and may change as final validation and data entry is completed for national submission, 25 working days following the month close.*
Two cancer treatment time standards have not been met in March:

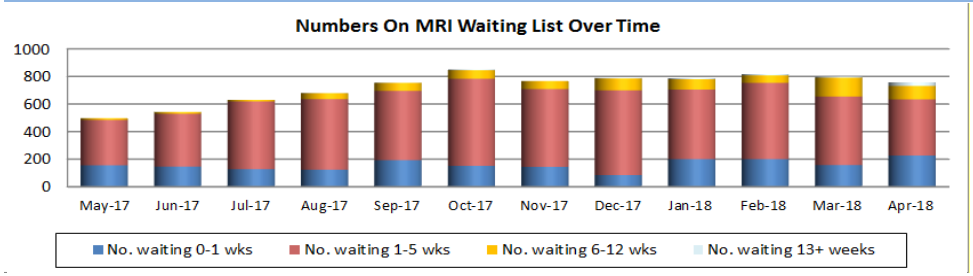
Urgent cancer referrals 14 day 2ww: At 60.8% this position is a deterioration from last month (71.7%). Dermatology is the main specialty that requires improvement with 282 1st seen greater than 14 days with Lower GI pathway 83 and Urology 57. Action plans across these specialties will be reviewed through Quality and Performance Review meetings.

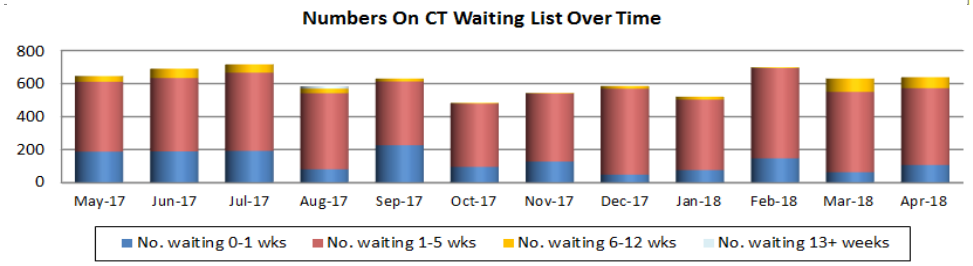
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard was not met in April at 82.1% (validated 9th May 2018). The backlog from lost capacity (weather related and emergency pressures) in Q4 is still being managed. Against the 20 reported breaches, specialties with the highest number of beaches of standard are: Urology 7, Skin 5, Lung 3, Lower GI 2.
Action plans are being reviewed through Quality and Performance Review meetings. The Trust is seeing an increase in number of 2-week wait referrals to Dermatology , Urology and LGI. This in part is a response to long routine waiting times and this will impact on the ability to achieve the time to treatment targets in coming months.

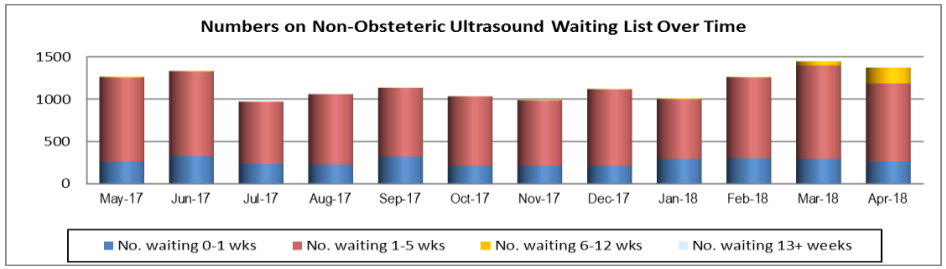
Longest waits greater than 104 days
In April, 9 Patients received treatment having a waiting time over 104 days (GI surgery 5, Lung 2, Urology 2).
The most recent guidance from NHS England is that there will be a zero tolerance on the number patients who have confirmed cancer and receive treatment after 104 days from December 2017.

To facilitate the 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 seeing a reduction in the longest waits with confirmed cancer, however, there remain pathways greater than 104 days being tracked from urgent referral where cancer has not been ruled out. At the end of April 17 patients were waiting over 104 days with confirmed or suspected cancer diagnosis.

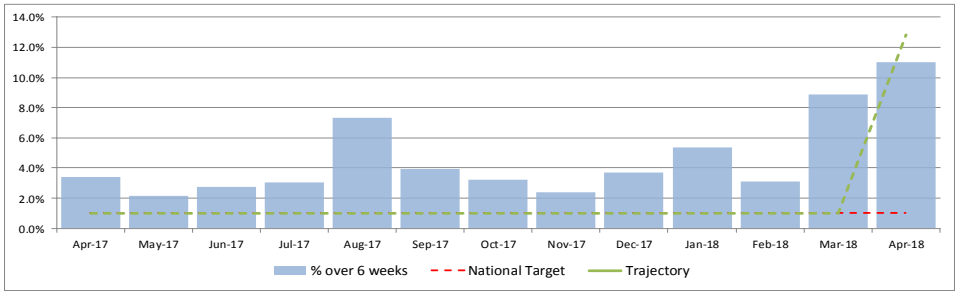
NHSI indictor - patients waiting over 6 weeks for diagnostics







	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Patients	3800	3792	3991	3763	3716	3900	3550	3382	3591	3550	4058	4283	4166
Waiting longer than 6 weeks	130	82	110	114	273	153	114	81	134	191	125	380	458
% over 6 weeks	**3.4%**	**2.2%**	**2.8%**	**3.0%**	**7.3%**	**3.9%**	**3.2%**	**2.4%**	**3.7%**	**5.4%**	**3.1%**	**8.9%**	**11.0%**
National Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Trajectory	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	12.84%



The number of patients with a diagnostic wait over 6 weeks increased in April to 458 (10.99% of total waiting) from 380 (8.9% of total waiting) in March.

Due to demand now reaching maximum in house capacity (which includes extended days and weekend working) waiting time compliance is regularly borderline within CT and MRI services. Utilisation of mobile van capacity remains in place to support maintenance of waiting times.

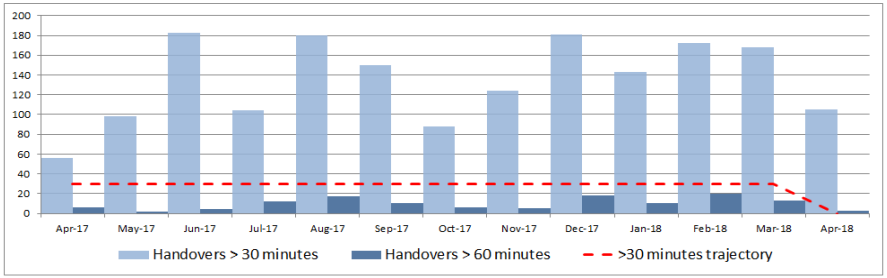
The highest number of patients with long waits in April is for non obstetric ultrasound - This is a result of disruption in March from rebooking patients following the adverse weather events coinciding with prolonged staff sickness. Additional staffing capacity now in place with waits stabilising and forecast to reduce the long waits during May and June.

There continues to be pressures from increasing demand across many areas with demand management and options to increase capacity reviewed as part of 2018/19 business planning.

Access to diagnostics and in particular radiology is critical for maintaining timely cancer diagnosis and supporting treatment pathways. The radiology service continues to prioritise these urgent referrals along with maintaining service levels to inpatients, however it does mean that overall some patients will wait longer for routine diagnostic tests.

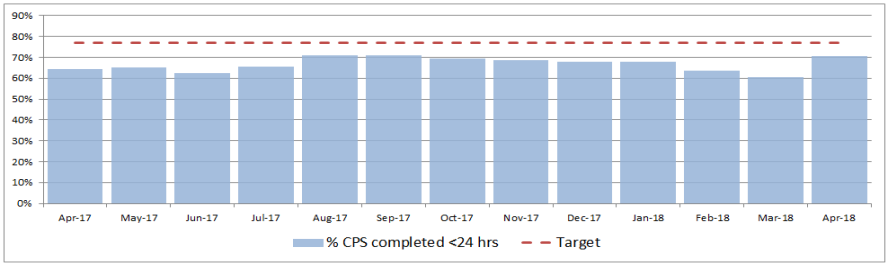
Ambulance handovers

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Handovers > 30 minutes	56	98	183	104	180	150	88	124	181	143	172	168	105
Handovers > 60 minutes	6	2	4	12	17	10	6	5	18	10	20	13	3
>30 minutes trajectory	30	30	30	30	30	30	30	30	30	30	30	30	0



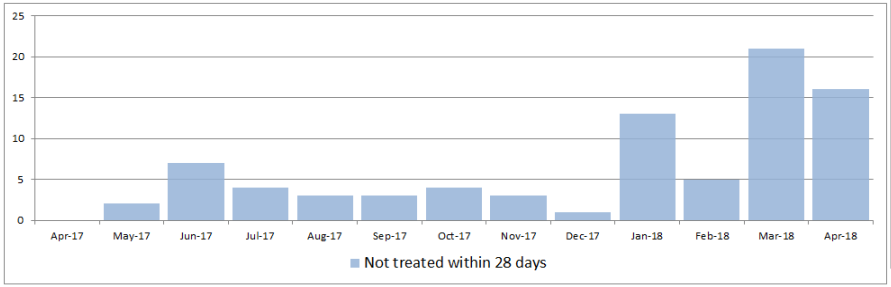
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Discharges	1079	1239	1204	1179	1268	1239	1269	1251	1104	1161	959	1014	1146
CPS completed within 24 hours	1674	1905	1925	1803	1787	1746	1825	1821	1625	1716	1511	1677	1628
% CPS completed <24 hrs	64%	65%	63%	65%	71%	71%	70%	69%	68%	68%	63%	60%	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%	77.0%



Cancelled patients not treated within 28 days of cancellation

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Not treated within 28 days	0	2	7	4	3	3	4	3	1	13	5	21	16



Ambulance Handover

The number of ambulance handovers delayed over 30 minutes remains above planned levels. The high levels of delays is a reflection of pressures on patient flow across the system with patients being held in the Emergency Department waiting for admission to hospital beds.

Regular meetings with the South West Ambulance Trust (SWAST) continue to manage these operational challenges. We routinely validate delays and these are now being reflected in the published data received from SWAST.

The longest delays being those over 60 minutes are being managed with clinical prioritisation and escalation processes in place.

Care Planning Summaries (CPS)

Improvement remains a challenge to complete CPSs within 24 hours of discharge with 70% achieved in April for weekday discharges against the internal target for improvement of 77%. The challenges remain with the manual processes and duplication of information already recorded. 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.

The current performance is slightly higher for the same period last year.

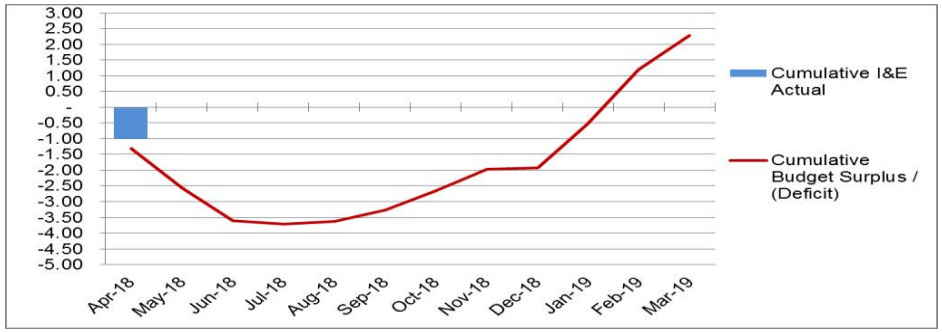
Cancelled operations

The weather events in March and high number of on the day cancellations had a big impact on the number of patients reported as waiting beyond 28 days in April to be readmitted following on the day cancellation.

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	33.11	1.19	34.31	34.14	(0.16)	419.12	418.96
Pay	(18.96)	0.01	(18.95)	(19.07)	(0.12)	(225.30)	(225.18)
Non Pay	(15.38)	0.00	(15.38)	(14.83)	0.55	(177.14)	(177.09)
EBITDA	**(1.23)**	**1.21**	**(0.03)**	**0.24**	**0.27**	**16.69**	**16.69**
Financing Costs	(1.28)	0.00	(1.28)	(1.25)	0.03	(14.41)	(14.41)
SURPLUS / (DEFICIT)	**(2.51)**	**1.21**	**(1.31)**	**(1.02)**	**0.29**	**2.28**	**2.28**
NHSI Exclusions	0.06	0.00	0.06	0.05	(0.01)	(0.56)	(0.56)
Plan Adjusted Surplus / (Deficit)	**(2.46)**	**1.21**	**(1.25)**	**(0.97)**	**0.29**	**1.72**	**1.72**
Remove STF Income	(0.31)	0.00	(0.31)	(0.31)	0.00	(6.15)	(6.15)
Variance to Control Total (Excl STF)	**(2.76)**	**1.21**	**(1.56)**	**(1.27)**	**0.29**	**(4.42)**	**(4.42)**
Cash Balance	2.90			3.55	**0.65**	**8.12**	

KPIs (Risk Rating)	YTD Plan	YTD Actual
Indicator	**Rating**	**Rating**
Capital Service cover rating	4	4
Liquidity rating	3	3
I&E Margin rating	4	4
I&E Margin variance rating	1	1
Agency rating	2	3
Finance Risk Rating	**3**	**3**

Key Points

- The Trust annual plan has been agreed by acceptance of the NHSI Control Total; a surplus of £1.725m, net of income from Sustainability and Transformation Fund (STF).
- The financial position at 30th April 2018 is reporting a £1.02m deficit, which is £0.29m better than the budgeted position. Excluding the income and expenditure not used by NHS Improvement in their assessment framework, performance against the published 'Control Total' (excluding (STF)), a deficit of £0.97m is recorded; £0.29m better than the budget for the year to date. NHSI Improvement are also measuring financial performance of the Trust against the Control Total excluding STF; on this metric the Trust is also £0.29m better than plan.
- The Trust has an annual savings target of £26.93m, with £14.0m currently forecast as deliverable for the current financial year. The phasing of the savings requirement increases from the second quarter of the year.
- Total pay run rates have increased by £0.17m in month; an estimation has been included for the annual pay award. This pay award cost has been offset by a decrease in total pay run rates of £0.14m.
- Non pay expenditure run rates have reduced by £1.55m this month; £1.39m is of this within Independent Sector / Continuing Healthcare.
- The CIP target for the period to 30 April 2018 is £1.12m, against which a total of £0.29m has been delivered; an adverse variance of £0.83m.
- The Trust, as this stage of the financial year, is forecasting delivery of the control total, although this remains subject to delivery of the savings plans. with the consequent risks attached.
- The Trust's Finance Risk Rating is a 3, in line with plan, at M01.

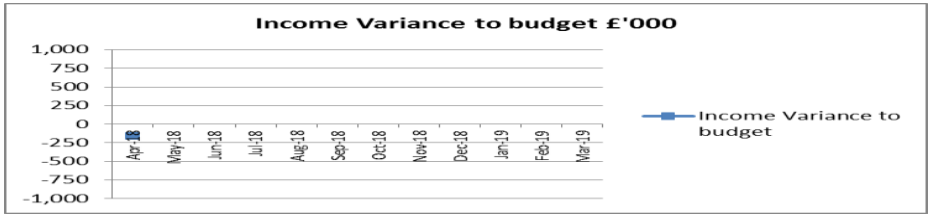
Summary of Financial Performance

	Month 01					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	29.77	1.19	30.96	30.68	(0.29)	29.77	1.19	30.96	30.68	(0.29)	0.00	(0.29)	372.14	371.98
Other Operating income	3.34	0.00	3.34	3.47	0.12	3.34	0.00	3.34	3.47	0.12	0.00	0.12	46.98	46.98
Total Income	**33.11**	**1.19**	**34.31**	**34.14**	**(0.16)**	**33.11**	**1.19**	**34.31**	**34.14**	**(0.16)**	**0.00**	**(0.16)**	**419.12**	**418.96**
Employee Benefits - Substantive	(18.37)	(0.02)	(18.39)	(18.39)	0.00	(18.37)	(0.02)	(18.39)	(18.39)	0.00	0.00	0.00	(219.12)	(219.03)
Employee Benefits - Agency	(0.59)	0.03	(0.56)	(0.69)	(0.12)	(0.59)	0.03	(0.56)	(0.69)	(0.12)	0.00	(0.12)	(6.18)	(6.15)
Drugs (including Pass Through)	(2.83)	(0.00)	(2.83)	(2.46)	0.37	(2.83)	(0.00)	(2.83)	(2.46)	0.37	0.00	0.37	(32.61)	(32.61)
Clinical Supplies	(2.06)	(0.00)	(2.06)	(1.97)	0.09	(2.06)	(0.00)	(2.06)	(1.97)	0.09	0.00	0.09	(23.87)	(23.89)
Non Clinical Supplies	(0.38)	0.00	(0.38)	(0.37)	0.01	(0.38)	0.00	(0.38)	(0.37)	0.01	0.00	0.01	(3.89)	(3.88)
Other Operating Expenditure	(10.11)	0.00	(10.11)	(10.03)	0.07	(10.11)	0.00	(10.11)	(10.03)	0.07	0.00	0.07	(116.76)	(116.71)
Total Expense	**(34.35)**	**0.01**	**(34.33)**	**(33.90)**	**0.43**	**(34.35)**	**0.01**	**(34.33)**	**(33.90)**	**0.43**	**0.00**	**0.43**	**(402.43)**	**(402.27)**
EBITDA	**(1.23)**	**1.21**	**(0.03)**	**0.24**	**0.27**	**(1.23)**	**1.21**	**(0.03)**	**0.24**	**0.27**	**0.00**	**0.27**	**16.69**	**16.69**
Depreciation - Owned	(0.70)	0.00	(0.70)	(0.69)	0.01	(0.70)	0.00	(0.70)	(0.69)	0.01	0.00	0.01	(8.73)	(8.73)
Depreciation - donated/granted	(0.06)	0.00	(0.06)	(0.05)	0.01	(0.06)	0.00	(0.06)	(0.05)	0.01	0.00	0.01	(0.74)	(0.74)
Interest Expense, PDC Dividend	(0.52)	0.00	(0.52)	(0.51)	0.01	(0.52)	0.00	(0.52)	(0.51)	0.01	0.00	0.01	(6.23)	(6.23)
Donated Asset Income	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.30	1.30
Gain / Loss on Asset Disposal	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
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)	**(2.51)**	**1.21**	**(1.31)**	**(1.02)**	**0.29**	**(2.51)**	**1.21**	**(1.31)**	**(1.02)**	**0.29**	**0.00**	**0.29**	**2.28**	**2.28**
Adjusted Plan Position														
Donated Asset Income	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.30)	(1.30)
Depreciation - Donated / Granted	0.06	0.00	0.06	0.05	(0.01)	0.06	0.00	0.06	0.05	(0.01)	0.00	(0.01)	0.74	0.74
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
Adjusted Plan Surplus / (Deficit)	**(2.46)**	**1.21**	**(1.25)**	**(0.97)**	**0.29**	**(2.46)**	**1.21**	**(1.25)**	**(0.97)**	**0.29**	**0.00**	**0.29**	**1.72**	**1.72**
NHSI Adjustment to Control Total														
Remove STF Income	(0.31)	0.00	(0.31)	(0.31)	0.00	(0.31)	0.00	(0.31)	(0.31)	0.00	0.00	0.00	(6.15)	(6.15)
Variance to Control Total Excluding STF	**(2.76)**	**1.21**	**(1.56)**	**(1.27)**	**0.29**	**(2.76)**	**1.21**	**(1.56)**	**(1.27)**	**0.29**	**0.00**	**0.29**	**(4.42)**	**(4.42)**

- The position for Month 01 is a deficit of £1.02m, which is £0.29m better than the budgeted position (£1.31m deficit) before NHSI exclusions.
- Income is lower than budget by £0.16m in Month 01.
- Pay expenditure is £0.12m higher than budget in Month 01; this is all within agency pay across the majority of pay types, with the exception of registered nursing. An estimate for the annual pay award has been included within the Month 01 position. The savings target is phased at its lowest in the first quarter of the year, increasing from Quarter 2.
- Non-pay expenditure is £0.55m lower than budget in Month 01, again the phasing of savings targets profiled at the lowest in the first quarter of the year.
- The challenge increases considerably as the year progresses to reduce costs and meet savings targets in line with plan in order to achieve the control total.

Income

Current Performance



Operating Income	Year to Date - Month 01					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	24.71	1.22	25.93	25.61	(0.32)	0.00	(0.32)
Council Social Care (inc Public Health)	4.03	0.00	4.03	4.03	(0.00)	0.00	(0.00)
Client Income	0.82	(0.01)	0.81	0.81	(0.00)	0.00	(0.00)
Private Patients	0.15	0.00	0.15	0.12	(0.03)	0.00	(0.02)
Other Income	0.06	(0.01)	0.04	0.11	0.07	0.00	0.06
Operating Income from patient care activities	**29.77**	**1.19**	**30.96**	**30.68**	**(0.29)**	**0.00**	**(0.28)**
Other Income	2.29	(0.00)	2.29	2.37	0.08	0.00	0.08
Research and Education	0.75	0.00	0.75	0.79	0.04	0.00	0.04
Sustainability & Transformation funding	0.31	0.00	0.31	0.31	0.00	0.00	0.00
Other operating income	**3.34**	**0.00**	**3.34**	**3.47**	**0.13**	**0.00**	**0.13**
Total	**33.12**	**1.19**	**34.31**	**34.15**	**(0.16)**	**0.00**	**(0.16)**

Contract income by Commissioner	Year to Date - Month 01					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	13.52	1.22	14.74	14.74	0.00	0.00	0.00
North, East & West Devon Clinical Commissioning Group	0.37	0.00	0.37	0.38	0.01	0.00	0.01
NHS England - Area Team	0.64	0.00	0.64	0.61	(0.02)	0.00	(0.02)
NHS England - Specialist Commissioning	2.55	0.00	2.55	2.22	(0.33)	0.00	(0.33)
Other Commissioners	0.50	0.00	0.50	0.56	0.06	0.00	0.06
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	6.93	0.00	6.93	6.93	0.00	0.00	0.00
Other Commissioners	0.19	0.00	0.19	0.17	(0.02)	0.00	(0.02)
Operating Income from patient care activities	**24.71**	**1.22**	**25.93**	**25.61**	**(0.32)**	**0.00**	**(0.32)**

	Year to Date - Month 01					Previous Month	
MEMO - CCG Block Adjustment	Plan	Recategorisa	Budget	Actual	Variance to	Variance to	Change
	£m			£m	£m	£m	£m
CCG Block adjustment	(0.54)	0.00	(0.54)	(0.06)	0.48	0.00	0.48

Key points

- Overall Operating Income from Patient Care Activities is behind plan by £0.29m.
- The main variance is within the specialised commissioning contract. Further analysis will be provided from month 2 onwards.

Income

Other Operating Income	Year to Date - Month 01					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	0.75	0.00	0.75	0.79	0.04	0.00	0.04
Site Services	0.19	0.01	0.20	0.18	(0.02)	0.00	(0.02)
Revenue from non-patient services to other bodies	0.31	0.01	0.32	0.37	0.05	0.00	0.05
Sustainability Transformational Funding (STF) Income	0.31	0.00	0.31	0.31	0.00	0.00	0.00
Misc. other operating revenue	1.80	(0.02)	1.78	1.84	0.06	0.00	0.06
Total	**3.34**	**(0.00)**	**3.34**	**3.47**	**0.13**	**0.00**	**0.13**

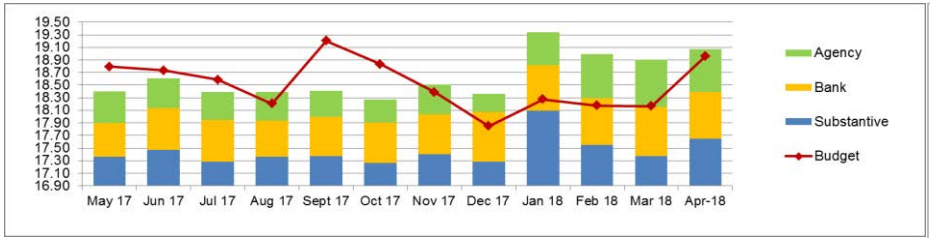
Other Operating income is ahead of the month 01 budget by £0.12m. Key headlines / variances are:

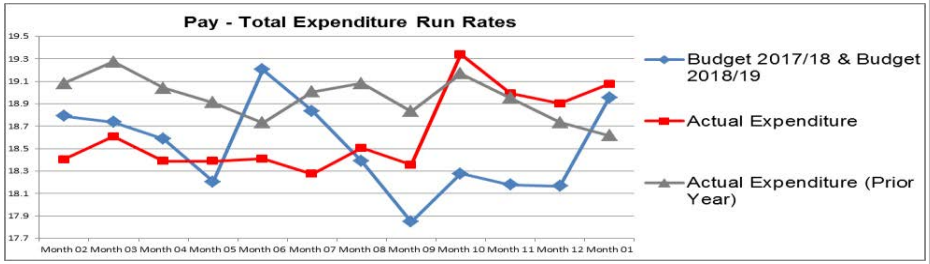
- Income earned by Torbay Pharmaceuticals is on budget
- R&D and Education income ahead of budget by £41k
- CAMHS income above budget by £23k due to continued external funding of placements
- STF income on budget
- Overachievement of income CIP £0.02m

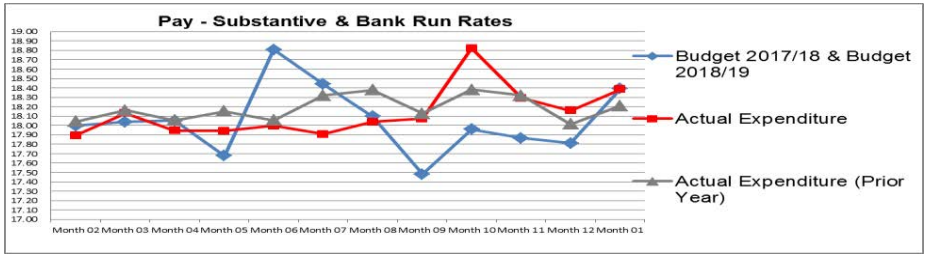
Annual STF funding of £6.18m has been budgeted for; at month 01, £0.31m has been included in the position.

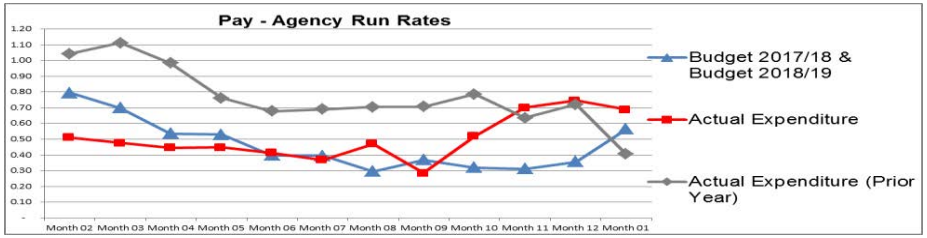
Pay Expenditure

Current Performance









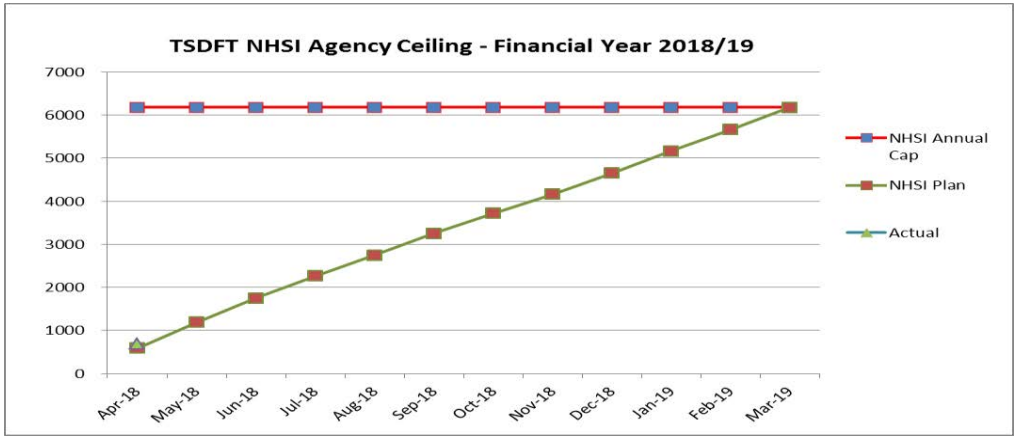
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(4.59)	0.00	(4.59)	(4.29)	0.30	(54.30)	(54.30)
Nursing and Midwifery	(7.33)	0.02	(7.31)	(7.48)	(0.17)	(88.06)	(87.77)
Other Clinical	(4.27)	(0.01)	(4.28)	(4.18)	0.10	(51.33)	(51.46)
Non Clinical	(2.77)	(0.00)	(2.78)	(3.12)	(0.35)	(31.60)	(31.64)
Total Pay Expenditure	**(18.96)**	**0.01**	**(18.95)**	**(19.07)**	**(0.12)**	**(225.30)**	**(225.18)**

Key points

- Total pay costs are showing an overspend against budget at Month 01 of £0.12m.
- Substantive and Bank pay costs are on budget, and agency costs are overspent by £0.12m.
- In setting the annual plan, agency budgets have been set in line with the agency cap. At Service Delivery Unit (SDU) level, there are overspends within most SDUs except in Medical Services which is £0.08m underspent.
- Agency spend is primarily in medical and registered nursing, with the largest spends in those categories within Surgery and Community Services.
- Run rates in substantive and bank pay have increased overall by £0.23m from the previous month (substantive increased £0.28m and bank decreased £0.05m). An estimation for the annual pay award, included in the Month 01 position would be expected to increase the run rate by £0.31m. On an inflation adjusted basis there has, therefore been a reduction in overall rates £0.08m (Month 12 included final MARS costs).
- Agency run rates have decreased during April by £0.06m, mainly within registered nursing staffing in Medical Services.

Pay Expenditure

Agency Spend Cap



Agency - All Staff Groups	April
	£m
Agency Plan 2018/19 (NHSI Ceiling)	
Planned Agency Cost	(0.59)
Total Planned Staff Costs	(18.97)
% of Agency Costs against Total Staff Cost	***3.1%***
Agency Actual Costs 2018/19	
Agency Cost	(0.69)
Actual Staff Cost	(19.07)
% of Agency Costs against Total Staff Cost	***3.6%***
Agency Cost vs Plan	(0.10)
% of Agency Costs against Total Staff Cost	***-0.5%***

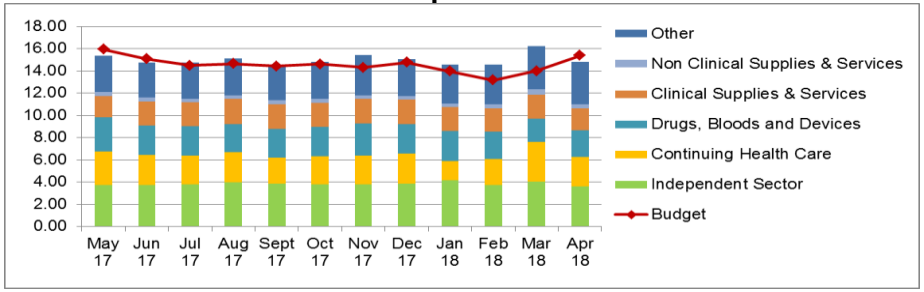
Agency - Nursing	April
	£m
Agency Nurse Staff Cost	(0.23)
Actual Registered Nurse Staff Cost	(4.65)
% of Agency Costs against Nursing Staff Cost	***5%***

Agency staff costs in Month 01 across all staff groups is £0.69m. This is £0.10m higher than the NHSI cap of £0.59m. The overall Agency cap for the Trust is £6.18m in FY 2018/19.

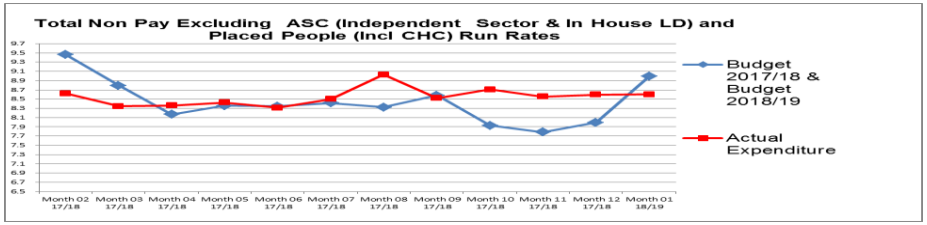
- Although higher than the plan by £0.1m, overall Agency usage is lower than in the previous 2 months.
- Medical agency spend is £0.30m at Month 01 which is £0.08m higher than the £0.22m plan.
- Nursing Agency spend at Month 01 is £0.23m, being £0.05m lower than the £0.28m plan. Spend in month is lower when compared to the last 2 months as the Trust cease to use more expensive Agency and further controls are put in place.
- The adverse Agency cost variances are in the following areas: Medical Staff, Ancillary (Domestic) and Other Clinical Staff, principally CAMHS for which income is received for the service). these overspends are offset by lower than planned spend in Nursing.
- The individual price rates for Nursing and Medical staff are all above NHSI individual shift rates.
- Actual staff cost for purposes of calculating the NHSI agency cap is based on pay amount of £19.07m (gross amount before deducting capitalised staff cost).

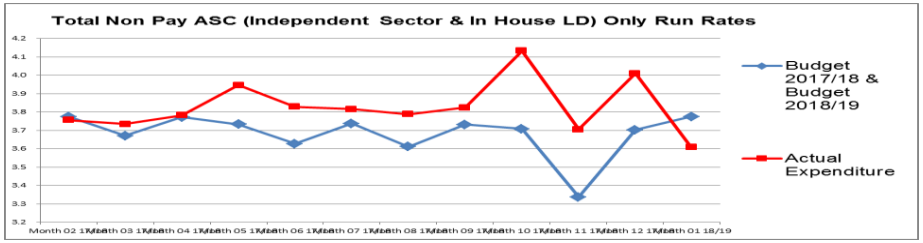
Non Pay Expenditure

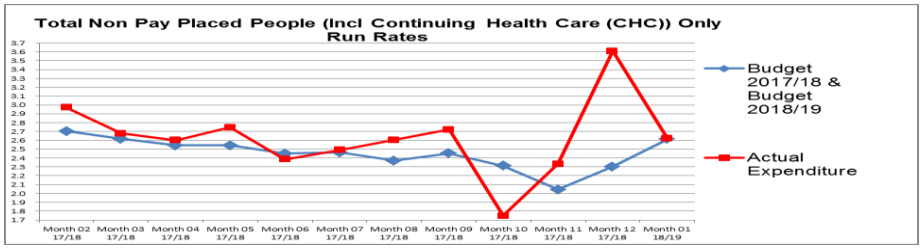
Current performance



	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	(2.83)	(0.00)	(2.83)	(2.46)	0.37	(32.61)	(32.61)
Clinical Supplies & Services	(2.06)	(0.00)	(2.06)	(1.97)	0.09	(23.94)	(23.96)
Non Clinical Supplies & Services	(0.38)	0.00	(0.38)	(0.37)	0.01	(3.88)	(3.87)
Other Operating Expenditure	(3.73)	0.00	(3.72)	(3.81)	(0.09)	(40.93)	(40.88)
ASC (Independent Sector & In House LD)	(3.78)	(0.00)	(3.78)	(3.61)	0.17	(44.02)	(44.02)
Placed People (Incl Continuing Healthcare)	(2.62)	0.00	(2.62)	(2.62)	(0.00)	(31.74)	(31.74)
Total Non Pay Expenditure	**(15.38)**	**0.00**	**(15.38)**	**(14.83)**	**0.55**	**(177.14)**	**(177.09)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.37m mainly due to pass through £0.16m for which income is similarly reduced for NHS England/ NEW Devon CCG related items.
- Clinical Supplies – Total underspend of £0.09m; underspends in Surgery and Estates offset with overspends in Community Services for set up costs associated with Assisted Lift Response Team (offsetting income received), overspends Medicine internal services provided, Womens and Children, external services and Torbay Pharmaceuticals. Run rates have decreased from Month 12 by £0.19m.
- Non Clinical Supplies – Total underspend of £0.01m; mainly in Estates in provisions and domestic cleaning equipment. Run rates have decreased by £0.11m on the previous month, mainly in Estates.
- Placed People (including Continuing Healthcare) - On budgeted position at month 01.
- Adult Social Care - Over spent by £0.17m mainly as a result of a shortfall in the delivery of the Systems Savings Plan.
- Other Operating Expenditure - Over spent by £0.09m reflecting:
  - Premises overspent by £0.07m, with run rates decreasing by £0.30m on last month. Overspend is primarily due to unachieved CIP.
  - Purchase of social care underspent by £0.01m .
  - Other £0.22m overspent – unachieved CIP (£0.17m) and investment reserve overspend in non pay (£0.15m) with an offsetting underspend in pay.
  - Purchase of Healthcare £0.13m overspent - Women and Child's Health for Radiology / Histology Medical services provided (£0.05m) and CT Scanning outsourcing (£0.02m), Medical Services outsourcing of Gastroenterology weekend working (£0.05m). Run rates have increased by £0.04m from the previous month.
  - Underspends in Education and Training £0.05m; Bad debt Provision £0.10m, Establishment and Transport £0.06m and Clinical Negligence / Consultancy £0.11m.

Financial Position by SDU

Key Drivers

	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
Trust Total Position							
Income	33.11	1.19	34.31	34.14	(0.16)	420.42	420.26
Pay	(18.96)	0.01	(18.95)	(19.07)	(0.12)	(225.30)	(225.18)
Non Pay	(15.38)	0.00	(15.38)	(14.83)	0.55	(177.14)	(177.09)
Financing Costs	(1.28)	0.00	(1.28)	(1.25)	0.03	(15.71)	(15.71)
SSP Plans	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Surplus / (Deficit)	**(2.51)**	**1.21**	**(1.31)**	**(1.02)**	**0.29**	**2.28**	**2.28**
NHSI Exclusions	0.06	0.00	0.06	0.05	0.00	(0.56)	(0.56)
Variance Against Plan Surplus / (Deficit)	**(2.46)**	**1.21**	**(1.25)**	**(0.97)**	**0.29**	**1.72**	**1.72**

The year to date position is a deficit of £1.02m against a budget deficit of £1.31m.

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	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Community							
Income	0.08	(0.01)	0.06	0.17	0.11	0.93	0.77
Pay	(3.37)	0.00	(3.37)	(3.28)	0.09	(40.15)	(40.13)
Non Pay	(0.78)	0.00	(0.77)	(0.78)	(0.01)	(9.34)	(9.30)
Financing Costs	(0.15)	0.00	(0.15)	(0.15)	(0.00)	(1.77)	(1.77)
Surplus / (Deficit)	**(4.22)**	**(0.01)**	**(4.23)**	**(4.04)**	**0.18**	**(50.33)**	**(50.43)**

The M1 underspend relates to phasing and allocation of TWIP. Further TWIP target will be journalled to Community Services from ASC and will offset the underspend in month 2.

	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
ASC (Independent Sector & In House LD)							
Income	0.85	(0.01)	0.84	0.84	0.00	10.16	10.16
Pay	0.06	0.00	0.06	(0.11)	(0.17)	0.91	0.91
Non Pay	(3.78)	0.00	(3.78)	(3.61)	0.17	(44.02)	(44.02)
Surplus / (Deficit)	**(2.87)**	**(0.01)**	**(2.88)**	**(2.88)**	**(0.00)**	**(32.95)**	**(32.95)**

Assumption at this early point in the year is that ASC and In House services will break even. Expectations will be refined as data becomes available. TWIP target to be re aligned with Community Services for month 2.

	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
Placed People (includes Continuing Healthcare)							
Income	0.00	(0.00)	0.00	0.00	0.00	0.02	0.02
Pay	(0.10)	(0.00)	(0.11)	(0.10)	0.00	(1.13)	(1.16)
Non Pay	(2.62)	0.00	(2.62)	(2.62)	(0.00)	(31.74)	(31.74)
Surplus / (Deficit)	**(2.72)**	**(0.00)**	**(2.72)**	**(2.72)**	**0.00**	**(32.85)**	**(32.88)**

Assumption at this early point in the year is that Placed People will break even. Expectations will be refined as data becomes available.

Financial Position by SDU

Key drivers

	Plan for Period	Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Medical Services							
Income	7.55	0.00	7.55	7.92	0.37	98.69	98.69
Pay	(3.73)	0.00	(3.73)	(4.13)	(0.40)	(44.39)	(44.39)
Non Pay	(2.21)	(0.00)	(2.21)	(2.12)	0.09	(24.80)	(24.80)
Surplus / (Deficit)	**1.60**	**0.00**	**1.60**	**1.66**	**0.06**	**29.50**	**29.50**

M1 underspend is mainly relating to block Income which is £371k greater than the plan for the period. This is helping to offset overspends against pay that include unachievd TWIP and overspends across wards, particularly against Warrington that remained open for part of April but is unfunded. Non Pay underspend includes underspends against pass through drugs & devices of £149k which is helping to offset on-going overspends in Emergency particularly in relation to provisions and enhanced cleaning and portering.

	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
Surgical Services							
Income	5.66	0.00	5.66	5.87	0.21	72.25	72.25
Pay	(3.96)	0.00	(3.96)	(4.02)	(0.06)	(46.40)	(46.40)
Non Pay	(1.82)	(0.00)	(1.82)	(1.54)	0.29	(19.48)	(19.48)
Surplus / (Deficit)	**(0.12)**	**(0.00)**	**(0.12)**	**0.32**	**0.44**	**6.38**	**6.38**

M01Patient related income does not contain a block adjustment at Divisional level. Other income is over recovering due to a 201718 transaction (£26k). Pay is over achieving on VF by £141k above the target of £93k. The bulk of this is held within TH in theatres and ICU. Other pay underspends are spread across the division and are off set by Medical pay is over-spends of £74k within GS,OP and TO and wards are over by £21k in M01 (£50k excluding allocation of central funding). Non pay is under-spending across the board by (£269k) excluding TWIP. The bulk is within TH. TWIP is under delivering by £117k. £100k in Non pay and 20k in pay. £4.134 under delivery FY.

	Plan for Period	Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Women's, Children's, Diagnostics and Therapies							
Income	3.64	0.00	3.64	3.52	(0.12)	46.09	46.09
Pay	(3.17)	(0.00)	(3.17)	(3.22)	(0.06)	(37.78)	(37.78)
Non Pay	(0.72)	(0.00)	(0.72)	(0.74)	(0.02)	(7.17)	(7.17)
Surplus / (Deficit)	**(0.25)**	**(0.00)**	**(0.25)**	**(0.44)**	**(0.19)**	**1.14**	**1.14**

The M1 overspend includes an overspend against clinical Income which is £124k behind the plan for the period. Pay is overspent by £60k but includes £75k for vacancy factor which is not being fully achieved. Non Pay overspend is mainly for the Histopathology breast services being hosted by RD&E.

	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
Corporate Services							
Income	15.35	1.22	16.56	15.83	(0.73)	192.27	192.27
Pay	(4.70)	0.01	(4.69)	(4.21)	0.48	(56.36)	(56.23)
Non Pay	(3.46)	0.00	(3.46)	(3.42)	0.03	(40.58)	(40.58)
Financing Costs	(1.13)	0.00	(1.13)	(1.10)	0.03	(13.93)	(13.93)
Surplus / (Deficit)	**6.06**	**1.23**	**7.28**	**7.09**	**(0.19)**	**81.40**	**81.52**

Income - For Month 01, Central Income holds the block adjustment for the Trust - this will be distributed to SDU's from Month 02
Pay - Underspent by £0.48m; Investment budget held in reserves has been accrued in non pay £294k; Pharmacy vacancies £38k, offset with unachieved CIP across the Corporate SDU
Non pay - Overall underspend £0.03m; Estates & Facilities underspends in domestics equipment/mats, provisions, legal costs; offset with overspend in investment budget held in reserves +£294k; Finance underspend in CNST Premium, general misc and provisions; HR underspend in legal professional costs.

Items Outside of EBITDA

	Year to Date - Month 01			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Operating income/expenditure outside EBITDA					
Donated asset income	0.00	0.00	0.00	0.00	0.00
Depreciation/Amortisation	(0.76)	(0.74)	0.02	0.00	0.02
Impairment	0.00	0.00	0.00	0.00	0.00
Total	**(0.76)**	**(0.74)**	**0.02**	**0.00**	**0.02**
Non-operating income/expenditure					
Interest expense (excluding PFI)	(0.13)	(0.12)	0.01	0.00	0.01
Interest and Contingent Rent expense (PFI)	(0.15)	(0.15)	(0.00)	0.00	(0.00)
PDC Dividend expense	(0.24)	(0.24)	0.00	0.00	0.00
Gain/loss on disposal of assets	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.01	0.00	0.00	0.00
Total	**(0.52)**	**(0.51)**	**0.01**	**0.00**	**0.01**
Total items outside EBITDA	**(1.28)**	**(1.25)**	**0.03**	**0.00**	**0.03**

Key points

- No noteworthy variances.

Balance Sheet

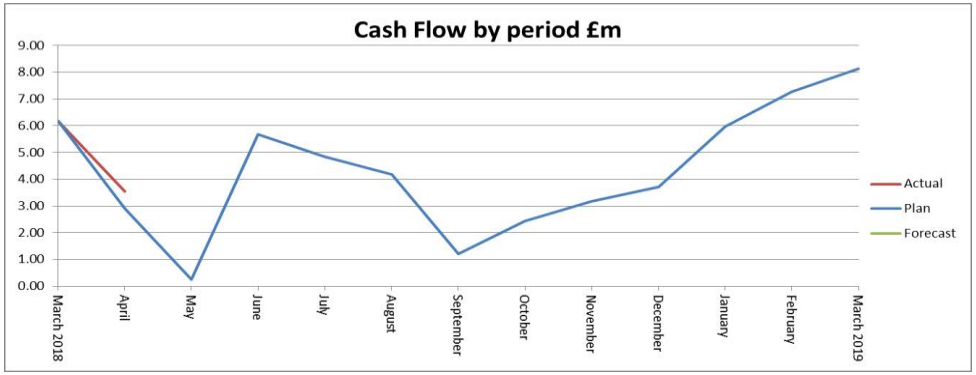
	Year to Date - Month 01			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Non-Current Assets					
Intangible Assets	8.89	8.36	(0.53)	0.00	(0.53)
Property, Plant & Equipment	164.73	164.14	(0.59)	0.00	(0.59)
On-Balance Sheet PFI	15.15	15.13	(0.02)	0.00	(0.02)
Other	2.37	2.36	(0.01)	0.00	(0.01)
Total	**191.14**	**189.99**	**(1.15)**	**0.00**	**(1.15)**
Current Assets					
Cash & Cash Equivalents	2.90	3.55	0.65	0.00	0.65
Other Current Assets	36.41	37.64	1.23	0.00	1.23
Total	**39.31**	**41.19**	1.88	**0.00**	**1.88**
Total Assets	**230.45**	**231.18**	**0.73**	**0.00**	**0.73**
Current Liabilities					
Loan - DH ITFF	(6.91)	(6.90)	0.00	0.00	0.00
PFI / LIFT Leases	(0.79)	(0.78)	0.01	0.00	0.01
Trade and Other Payables	(31.85)	(30.77)	1.08	0.00	1.08
Other Current Liabilities	(2.09)	(2.22)	(0.12)	0.00	(0.12)
Total	**(41.64)**	**(40.68)**	**0.97**	**0.00**	**0.97**
Net Current assets/(liabilities)	**(2.34)**	**0.51**	**2.85**	**0.00**	**2.85**
Non-Current Liabilities					
Loan - DH ITFF	(57.14)	(57.14)	0.00	0.00	0.00
PFI / LIFT Leases	(19.44)	(19.50)	(0.06)	0.00	(0.06)
Other Non-Current Liabilities	(4.79)	(4.94)	(0.14)	0.00	(0.14)
Total	**(81.37)**	**(81.57)**	**(0.20)**	0.00	(0.20)
Total Assets Employed	**107.43**	**108.93**	**1.50**	**0.00**	**1.50**
Reserves					
Public Dividend Capital	62.83	62.83	0.00	0.00	0.00
Revaluation	39.03	39.03	0.00	0.00	0.00
Income and Expenditure	5.58	7.07	1.50	0.00	1.50
Total	**107.43**	**108.93**	**1.50**	**0.00**	**1.50**

Key Points

- Non-Current Assets are £1.2m adverse. This is largely due to capex £0.9m lower than planned.
- Cash is £0.7m favourable to Plan, as explained on the commentary to the Cash Flow Statement.
- Other Current Assets are £1.2m higher than Plan, largely due to income received in arrears from NHSE.
- Trade and Other Payables are £1.1m lower than Plan, largely due to the paying down of the capital creditor £0.5m.

Cash

Current Performance



	Year to Date - Month 01			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Opening Cash Balance (incl Overdraft)	**6.17**	**6.17**	**(0.00)**	**0.00**	**(0.00)**
Capital Expenditure (accruals basis)	(1.34)	(0.38)	0.95	0.00	0.95
Capital loan drawndown	0.00	0.00	0.00	0.00	0.00
Capital loan repayment	0.00	0.00	0.00	0.00	0.00
Proceeds on disposal of assets	0.00	0.00	0.00	0.00	0.00
Movement in capital creditor	0.00	(0.54)	(0.54)	0.00	(0.54)
Other capital-related elements	(0.02)	(0.00)	0.02	0.00	0.02
Sub-total - capital-related elements	**(1.35)**	**(0.92)**	**0.43**	**0.00**	**0.43**
Cash Generated From Operations	(1.23)	0.24	1.47	0.00	1.47
Working Capital movements - debtors	(0.31)	(1.33)	(1.03)	0.00	(1.03)
Working Capital movements - creditors	(0.04)	(0.44)	(0.40)	0.00	(0.40)
Net Interest	(0.23)	(0.11)	0.13	0.00	0.13
PDC Dividend paid	0.00	0.00	0.00	0.00	0.00
Other	(0.11)	(0.06)	0.05	0.00	0.05
Sub-total - other elements	**(1.92)**	**(1.70)**	**0.23**	**0.00**	**0.23**
Closing Cash Balance (incl Overdraft)	**2.90**	**3.55**	**0.65**	**0.00**	**0.65**

Key points

- Capital-related cashflow is £0.4m favourable due to capital expenditure £0.9m favourable, partly offset by the paying down of the capital creditor £0.5m.

Other elements:

- Cash generated from operations is £1.5m favourable, largely due to a favourable phasing of income from the local CCG.

- Working Capital debtor movements is £1.0m adverse, mainly due to income received in arrears from NHSE

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	32,115	2,470	2,690	220		9%
Elective	3,378	285	258	-27		-9%
Non-Elective Emergency	29,875	2,317	2,325	8		0%
Non-Elective Non-Emergency	3,189	266	222	-44		-17%
Non-Elective CDU	4,576	344	408	64		19%
Non-Elective AMU	3,275	162	358	196		121%
TOTAL APC	**76,408**	**5,844**	**6,261**	**417**		7%
New	107,775	8,257	8,890	633		8%
F-Up	258,463	19,461	20,990	1,529		8%
TOTAL OPA	**366,238**	**27,718**	**29,880**	**2,162**		8%
A&E	79,143	6,567	6,587	20		0%

Activity variances to plan -Month 1

Activity variances for M1 against the contract activity plan are shown in the table opposite. In M1, Day Case and Outpatient activity was above plan but, Electives were below plan. Non Elective Emergency activity was on plan and both AMU and CDU activity were above plan.

A more detailed review of variances by specialty will start in month 2.

In 17_18 the underperformance against commissioned elective activity plan has been one of the factors behind the deteriorating RTT performance and increased waiting lists. **The committee is asked to note:**

Month 1 .....

Risk Share Agreement will continue to mitigate any immediate income risk from below plan activity.

Plans for 18_19 require overall increase in activity run rate to deliver the required improvement in access targets.

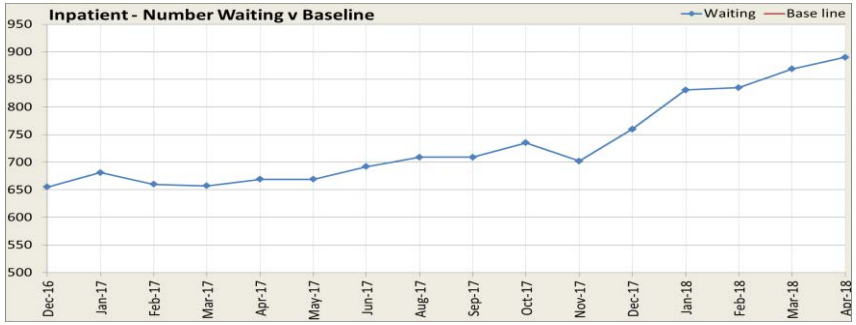
Risk remains that delays in increasing run rates will see further increase in waiting times and impact on achievement of RTT NHSI trajectory of 82%.

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.

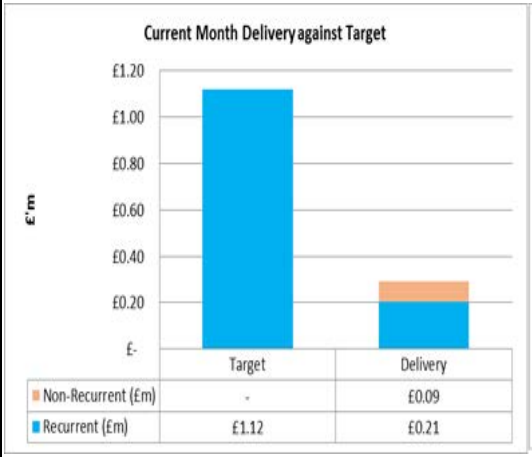
The winter plan for 18_19 to escalate bed capacity and medical cover during December / January 2019 and beyond if needed is likely to have a further impact on elective activity. Teams are being asked to bring forward plans to enable this planned winter support to emergency care.

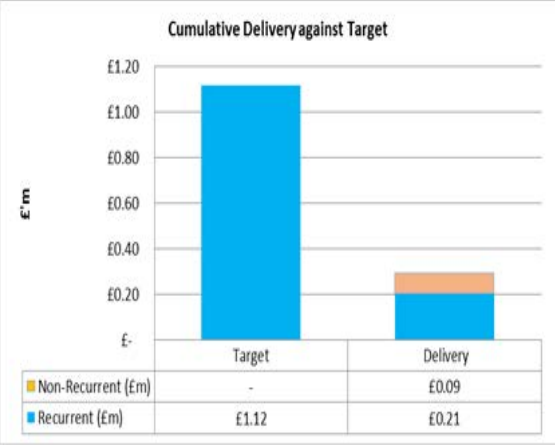
Overall waiting list number for inpatients have now increased above expected levels of normal variation and is considered a risk to patient experience and delivery of agree RTT trajectories.



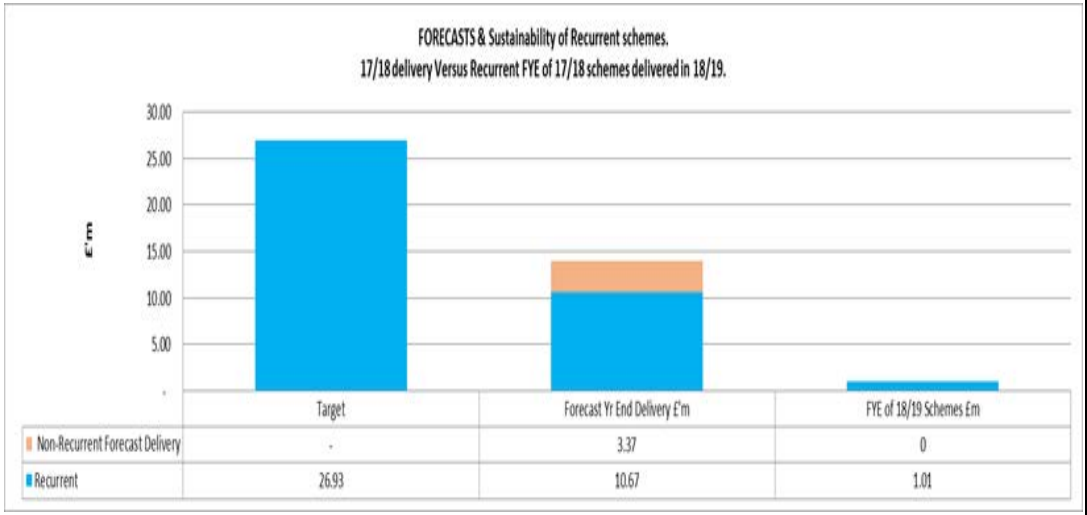
CIP Delivery: Current Mth, Cumulative & Forecast

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 Shortfall:** £0.8m

-**Cumulative Surplus:** £0.8m

Commentary>

Although there is an under-recovery against target, we are aware that some CIP schemes have yet to be loaded. This will be corrected in Month 2, which will mitigate this to a certain extent. Nonetheless, as mentioned previously, there is a need to identify additional savings opportunities to build sustainability and close the Gap.

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

Target: The CIP target shown is £26.9m

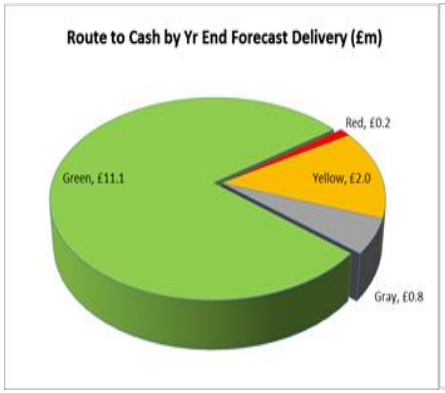
Target:	**£26.9m**
Yr End Forecast Delivery:	**£14.0m**
Shortfall:	**£12.9m**

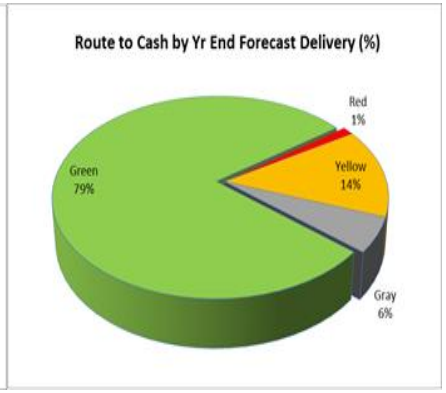
Forecast 19/20 Recurrent FYE of 18/19 projects: £1.01m. Please note the reported FYE value is not complete so please treat with caution, this will be refined in Month 2.

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

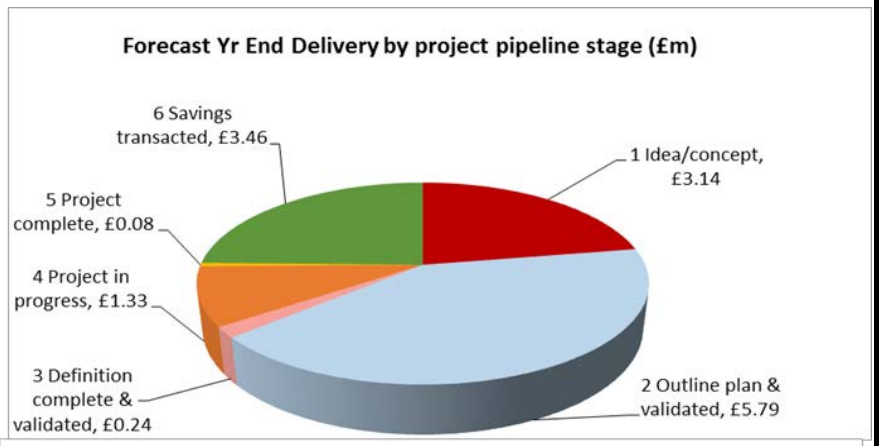
CIP- Delivery Assurance - Yr end delivery forecast-

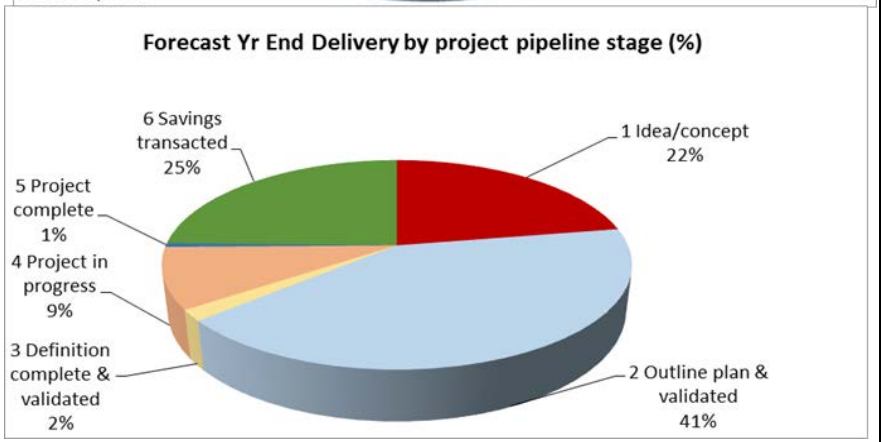
c) CIP Delivery Assurance- Route to Cash





d) CIP Delivery Assurance:- Pipeline stage





(c) CIP Delivery Assurance:- Route to Cash

Good progress is being made with identifying a Route to cash, for the schemes registered thus far, with 79% of the forecast delivery being categorised as "Green" RAG rating and 14% as Amber (yellow).

(d) CIP Delivery Assurance:- Pipeline stage

Of the projects comprising the £14.m forecast delivery:

£3.54m (26%) of projects are either Complete, and delivering savings or in "Delivery" stage whereby the project is finalised but savings awaited.

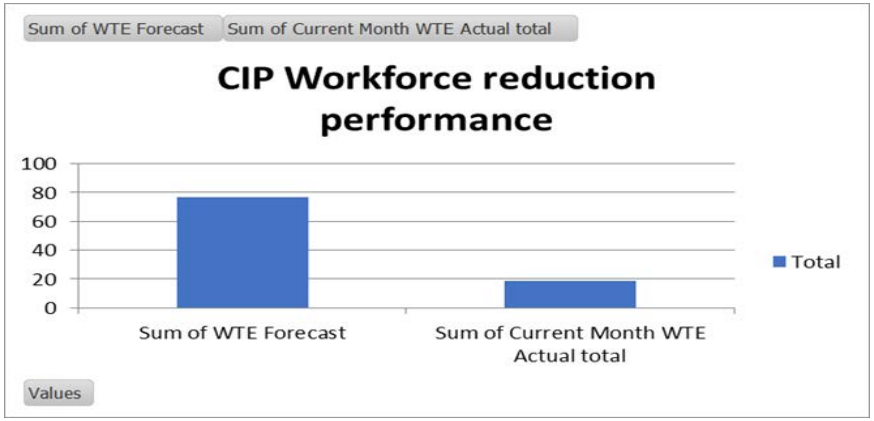
£1.33m (9%) relates to schemes which are in progress.

£0.24m (2%) relates to schemes where definitions are complete and validated.

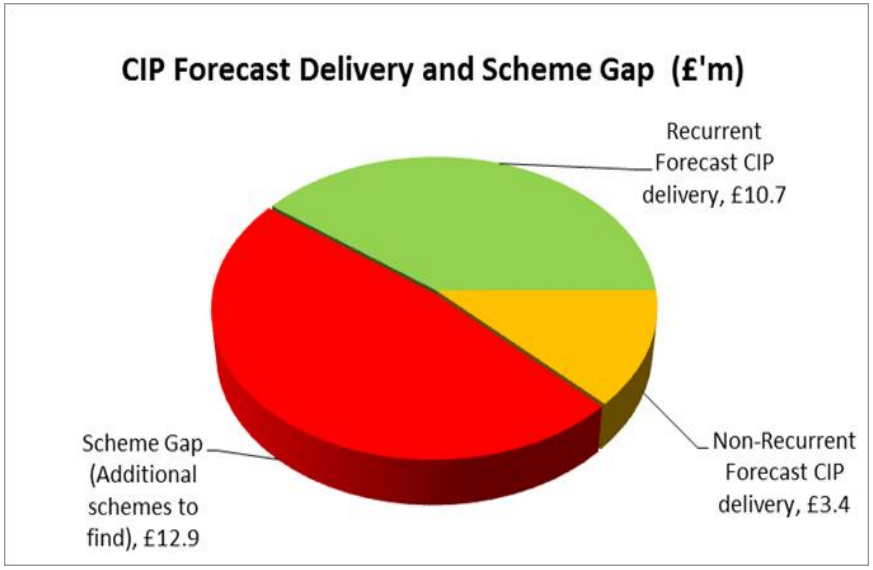
The remaining 63% of projects remain as Ideas or Outline plans that have been validated.
This represents a good level of progress so early in the year, albeit that there is a need for additional projects to be identified to close the Scheme Gap.

CIP- Delivery Assurance - Yr end delivery forecast-

e) CIP Workforce reduction against plan



f) CIP Scheme Gap- Value of additional schemes required to be identified



e) CIP Workforce forecast reduction against plan

The graph identifies that we have forecasted the removal of 18.87wte posts against the target of 76.88wte.

f) CIP Scheme Gap- Value of additional schemes required to be identified.

Presuming the forecast delivery value identified, there is a need to identify £12.9m of further savings schemes.

This can be partially mitigated through identifying opportunities from improving clinical efficiency (derived from Model hospital benchmarking);
Specific values are yet to be identified, but more schemes will need to found to ensure full programme delivery.

Corporative Objective		Target 2018/2019	13 month trend	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2017/18
QUALITY LOCAL FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		97.3%	96.1%	97.3%	95.9%	96.3%	96.0%	97.2%	96.4%	97.1%	96.2%	96.4%	97.8%	95.3%	95.3%
1	Reported Incidents - Major + Catastrophic *	<6		2	4	1	1	2	1	2	0	0	4	3	3	1	1
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		0	1	1	0	2	0	0	1	1	2	0	0		0
1	Never Events	0		0	0	0	0	0	0	0	0	0	0	0	1	0	0
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		9	4	4	7	8	3	5	2	2	9	2	5	2	2
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		1	0	0	0	0	0	0	0	1	1	0	0	0	0
1	Formal Complaints - Number Received *	<60		13	32	31	33	22	22	38	24	17	37	15	26	23	23
1	VTE - Risk assessment on admission - (Acute)	>95%		93.4%	93.7%	93.6%	92.4%	92.9%	88.0%	92.3%	92.6%	88.9%	93.0%	90.8%	86.0%	67.7%	67.7%
1	VTE - Risk assessment on admission - (Community)	>95%		97.6%	96.5%	100.0%	96.9%	94.7%	80.0%	100.0%	100.0%	69.4%	92.1%	80.0%	66.7%	100.0%	
1	Medication errors resulting in moderate to catastrophic harm	0		1	1	0	1	0	0	1	0	0	2	1	0	1	1
1	Medication errors - Total reported incidents (trust at fault)	N/A		51	76	37	64	43	68	64	48	42	55	49	40	42	42
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears	<100%		109.2%	95.6%	77.0%	100.3%	82.1%	94.2%	91.7%	92.1%	74.8%	91.2%				94.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		97.2%	100.0%	100.8%	98.4%	95.5%	100.0%	105.6%	104.2%	106.6%	105.2%	104.3%	106.6%	105.6%	105.6%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		94.4%	97.4%	98.5%	95.6%	101.6%	101.4%	103.2%	101.7%	105.6%	105.8%	100.4%	103.9%	103.2%	103.2%
1	Infection Control - Bed Closures - (Acute) *	<100		24	24	12	18	18	12	30	130	8	198	544	64	6	6
1	Hand Hygiene	>95%		97%	99%	91%	96%	95%	99%	98%	96%	95%	89%	96%	91%	97%	97%
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		69.2%	79.3%	86.1%	82.4%	71.0%	73.5%	68.6%	76.3%	71.4%	75.6%	71.0%	80.0%	79.4%	79.4%
1	Stroke patients spending 90% of time on a stroke ward	>80%		89.2%	57.1%	84.5%	95.6%	86.0%	77.1%	79.4%	83.3%	72.5%	84.4%	66.7%	92.3%	77.8%	77.8%
1	Follow ups 6 weeks past to be seen date (excluding Audiology)	3500		6429	6550	6999	7209	7496	7477	6790	6308	7041	6630	6761	7301	7323	7323

Corporative Objective		Target 2018/2019	13 month trend	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2017/18
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears) Rolling 12 months	<3.8%		4.27%	4.23%	4.19%	4.17%	4.14%	4.11%	4.09%	4.07%	4.09%	4.14%	4.18%	3.96%		3.96%
2	Appraisal Completeness	>90%		81.42%	81.00%	81.66%	81.66%	81.00%	82.00%	82.00%	82.00%	81.00%	78.00%	78.00%	79.00%	81.00%	81.00%
2	Mandatory Training Compliance	>85%		84.00%	84.00%	83.86%	83.00%	83.00%	83.00%	83.00%	83.00%	83.00%	82.79%	83.24%	85.00%	83.00%	83.00%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		12.00%	12.73%	12.30%	12.64%	12.37%	12.39%	12.32%	12.34%	12.53%	12.09%	11.67%	11.25%	10.89%	10.89%
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges (Community) *	16/17 Avg 315		142	72	261	225	211	445	401	340	348	272	267	206	288	288
1	Number of Delayed Transfer of Care (Acute)	16/17 Avg 64		202	144	230	159	185	172	177	197	165	218	144	128	182	182
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		78.8%	72.9%	73.9%	74.6%	75.9%	77.2%	78.3%	79.1%	79.1%	79.0%	78.5%	79.0%	78.7%	78.7%
3	Clients receiving Self Directed Care	>90%		92.0%	92.8%	92.6%	92.8%	92.9%	93.6%	93.1%	93.2%	92.8%	92.3%	92.5%	92.6%	92.6%	92.6%
2	Carers Assessments Completed year to date	40% (Year end)		4.4%	8.7%	17.0%	20.7%	24.8%	31.1%	33.9%	34.5%	35.9%	38.1%	41.1%	42.2%	1.4%	1.4%
	Carers Assessment trajectory			3.6%	7.2%	10.8%	14.3%	17.9%	21.5%	25.1%	28.7%	32.3%	35.8%	39.4%	43.0%	3.0%	3.0%
3	Number of Permanent Care Home Placements	<=617 (Year end)		634	629	619	634	637	638	632	637	634	629	608	604	602	602
	Number of Permanent Care Home Placements trajectory			639	637	635	633	631	629	627	625	623	621	619	617	630	630
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		231	240	239	238	248	254	235	198	176	160				
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET				80			156			232					0
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET				8.4%			7.9%			7.8%					0.0%
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%		89.7%	91.3%	88.4%	80.7%	89.2%	93.2%	92.7%	93.2%	92.4%	93.1%	95.0%	92.6%	92.9%	92.9%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		88.7%	83.7%	94.1%	92.0%	100.0%	98.4%	100.0%	100.0%	98.9%	100.0%	98.3%	97.9%	97.8%	97.8%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET		603	601	599	608	574	579	596	603	609	610	597	569	556	556
1	Intermediate Care - No. urgent referrals	113		164	179	181	182	181	151	200	204	171	222	187	161	194	194
1	Community Hospital - Admissions (non-stroke)	NONE SET		205	241	247	225	253	242	241	224	252	278	223	235	227	227

Corporative Objective		Target 2018/2019	13 month trend	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	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%		94.4%	90.1%	92.3%	93.9%	93.2%	89.9%	92.8%	92.9%	88.3%	83.8%	81.1%	80.6%	87.7%	87.7%
	A&E - trajectory [STF]	>92%		89.0%	90.0%	91.0%	92.0%	92.5%	93.5%	92.0%	92.2%	90.2%	89.9%	92.6%	95.0%	90.1%	90.1%
1	Referral to treatment - % Incomplete pathways <18 wks	>92%		87.2%	87.6%	86.4%	86.1%	85.2%	84.0%	84.0%	83.7%	82.2%	82.5%	82.4%	81.6%	81.7%	81.7%
	RTT Trajectory			87.2%	87.5%	88.0%	88.9%	89.4%	89.8%	90.7%	89.9%	89.3%	90.1%	90.0%	90.0%	82.2%	82.2%
1	Cancer - 62-day wait for first treatment - 2ww referral	>85%		87.2%	85.1%	84.0%	86.8%	79.2%	85.7%	83.9%	77.4%	82.4%	85.7%	83.1%	79.7%	82.1%	82.1%
1	Diagnostic tests longer than the 6 week standard	<1%		3.4%	2.2%	2.8%	3.0%	7.3%	3.9%	3.2%	2.4%	3.7%	5.4%	3.1%	8.9%	11.0%	11.0%
1	Dementia - Find - monthly report	>90%		58.9%	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%	59.0%	65.5%	52.1%	70.8%	92.7%	99.2%	99.2%
LOCAL PERFORMANCE FRAMEWORK 1																	
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<17 (year)		0	2	0	1	2	0	0	3	2	0	0	0	0	0
1	Cancer - Two week wait from referral to date 1st seen	>93%		83.6%	81.8%	86.5%	74.3%	65.3%	61.1%	63.1%	70.4%	76.0%	77.7%	67.4%	71.7%	55.3%	55.3%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		54.8%	97.8%	94.8%	74.0%	17.1%	69.7%	94.7%	95.1%	93.2%	94.6%	97.6%	94.5%	92.8%	92.8%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		99.2%	99.4%	97.1%	98.8%	98.6%	98.9%	95.5%	95.0%	98.0%	90.8%	96.1%	98.1%	97.47%	97.5%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		96.4%	100.0%	98.3%	95.3%	100.0%	98.1%	95.2%	100.0%	97.7%	96.3%	95.1%	100.0%	98.4%	98.4%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		96.9%	93.5%	97.0%	97.2%	100.0%	91.1%	95.8%	94.6%	100.0%	97.1%	97.1%	100.0%	100.0%	100.0%
1	Cancer - 62-day wait for first treatment - screening	>90%		100.0%	87.0%	100.0%	100.0%	100.0%	100.0%	87.1%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%
1	Cancer - Patient waiting longer than 104 days from 2ww				18	17	13	10	6	12	16	14	24	23	23	17	17
1	RTT 52 week wait incomplete pathway	0		18	18	21	15	19	16	26	36	42	29	33	34	43	43
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%		0.9%	1.4%	0.6%	0.7%	0.6%	1.0%	1.1%	0.7%	1.6%	0.9%	1.4%	4.5%	1.1%	1.1%
1	Cancelled patients not treated within 28 days of cancellation *	0		0	2	7	4	3	3	4	3	1	13	5	21	16	16

Corporative Objective		Target 2018/2019	13 month trend	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2017/18
LOCAL PERFORMANCE FRAMEWORK 2																	
1	Ambulance handover delays > 30 minutes	0		56	98	183	104	180	150	88	124	181	143	172	168	105	105
	Handovers > 30 minutes trajectory *			30	30	30	30	30	30	30	30	30	30	30	30	0	0
1	Ambulance handover delays > 60 minutes	0		6	2	4	12	17	10	6	5	18	10	20	13	3	3
1	A&E - patients seen within 4 hours DGH only	>95%		91.8%	85.1%	88.1%	90.5%	89.9%	85.5%	89.7%	90.0%	84.0%	77.2%	72.8%	72.3%	81.8%	81.8%
1	A&E - patients seen within 4 hours community MIU	>95%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	0	0	0	0	0	0	0	1	8	3	6	1	1
1	Number of Clostridium Difficile cases - (Acute) *	<3		0	2	1	1	2	0	1	5	2	1	1	1	1	1
1	Number of Clostridium Difficile cases - (Community)	0		0	0	0	1	0	0	0	0	0	0	0	0	0	0
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		64.5%	65.0%	62.5%	65.4%	71.0%	71.0%	69.5%	68.7%	67.9%	67.7%	63.5%	60.5%	70.4%	70.4%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		27.9%	33.4%	28.1%	33.6%	33.8%	38.5%	25.1%	35.9%	25.6%	28.0%	39.1%	28.6%	30.5%	30.5%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		72.7%	81.8%	81.8%	86.4%	86.4%	90.9%	86.4%	90.9%	90.9%	81.8%	90.9%	86.4%	81.8%	81.8%
NHS I - FINANCE AND USE OF RESOURCES																	
4	Capital Service Cover	2		4	4	4	4	4	4	4	4	4	3	3	2	4	4
	Plan			4	4	4	4	4	4	4	3	3	3	2	2	4	4
4	Liquidity	4		4	4	4	4	4	4	4	4	4	3	3	3	3	3
	Plan			4	4	4	4	4	4	4	4	4	4	4	4	3	3
4	I&E Margin	1		4	4	4	4	4	4	3	3	3	2	2	1	4	4
	Plan			4	4	4	4	4	4	4	3	3	2	2	1	4	4
4	I&E Margin Variance from Plan			1	1	1	1	1	1	1	1	1	2	2	1	1	1
4	Variance from agency ceiling	1		1	1	1	1	1	1	1	1	1	1	1	1	3	3
	Plan			4	4	4	4	3	3	2	2	2	2	2	1	2	2
4	Overall Use of Resources Rating			3	3	3	3	3	3	3	3	3	2	2	2	3	3

Corporative Objective		Target 2018/2019	13 month trend	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Year to date 2017/18
FINANCE INDICATORS - LOCAL																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)			-173	-261	389	-479	-732	-543	-1123	-2545	-3560	-4464	-5587	-3832	1469	
4	Agency - Variance to NHSI cap			3.03%	2.72%	2.38%	2.00%	2.00%	1.41%	1.27%	1.09%	1.05%	0.89%	0.65%	0.44%	-0.50%	
4	CIP - Variance from PBR plan - cumulative (£'000's)			-562	1093	1392	822	1942	1475	3114	3711	2813	2263	1565	3417	-820	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)			2116	4021	6106	7708	9560	11689	13770	14723	17672	19886	22110	22318	955	
4	Distance from NHSI Control total (£'000's)			234	581	1696	1247	997	1503	1201	89	495	-15	-674	2287	1488	
4	Risk Share actual income to date cumulative (£'000's)			-236	-579	-192	-124	-98	0	0	0	0	0	0	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

CHANGE FRAMEWORK																	
3	Number of Emergency Admissions - (Acute)			2840	3148	3101	3111	3040	3030	3232	3130	3176	3258	2913	3145	3103	3103
3	Average Length of Stay - Emergency Admissions - (Acute)			2.9	3.0	2.9	2.7	2.9	2.9	2.8	2.7	2.7	3.1	3.2	3.1	3.1	3.1
3	Hospital Stays > 30 Days - (Acute)			7	32	21	24	19	32	34	28	28	41	38	30	38	38

Cover sheet and summary for a report to the Board of Directors					
Report title: Clinical Incident Report				Date: 23rd May 2018	
Report sponsor	Chief Nurse				
Report author	Patient Safety Lead				
Report provenance	Executive Directors' meeting				
Confidentiality	No general review				
Report summary	The report is a summary of Clinical Incident reporting within and across the organisation. The report looks at the incident system, governance, culture and feedback to report as well as the main themes emerging from reported incident and work activity focused on these area The report also highlights areas of work for the coming year				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	For the board to review and approve the report, noting the structural changes to the organisation will create a distinct piece of to ensure the risk management system and reports adequately reflects this				
Summary of key elements					
Strategic context	Highlight which strategic/corporate objective(s) this recommendation aims to support • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	The report can be cross tabulated with the Quality Improvement Group Dashboard, Falls Group, Pressure Ulcer Group, Quality Performance Review Group and the Integrated Performance report and Dash board				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting dated				
Stakeholder engagement	Nil				
Other standards affected	The recommendations made in this report will impact upon: The local groups which manage the incident areas listed in the report				
Legal considerations	Nil effects to the NHS Constitution and nil to any equality, and diversity consideration, specifically in relation to race, religion, age, belief, gender, disability, or other protected characteristic.				

Clinical Incident Report Trustwide

April 2017 – Mar 2018

Report Background

Time period:
The report covers the time period April 2017 – March 2018, unless otherwise stated

Data & Graphical Presentation:
The report produces run charts, radar charts and bar charts taken from data the Trust enters onto Safeguard/Datix risk management reporting systems.

The run charts used are designed to look for *trends* and *shifts* in the data:
Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to go wrong.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to go wrong.

Narrative: Each aspect will include a narrative description and explanation of the data provided.

Data Sources:
- Datix: Trust Wide Risk Management including Incident reporting
- Dr Foster

Table 1: Incident Report Card

Safety Indicator		Data Source
Trustwide Clinical Incident Report Summary	Page 4	
Appendix 1 Total Number of Clinical Incidents Reported Trustwide & by Service Delivery Unit (SDU)	General Incident Reporting	Trust Risk Management System
Appendix 2 Number of Clinical Incidents by Actual Impact Trustwide & by Service Delivery Unit (SDU)		Trust Risk Management System
Appendix 3 Top 10 Causes of Incidents		Trust Risk Management System
Appendix 4 Never Events		Trust Risk Management System
Appendix 5 Slips Trips & Falls – in depth review	Specific Cause Groups	Trust Risk Management System
Appendix 6 Infection Prevention & Control		Trust Risk Management System
Appendix 7 Recognise and Rescue		Trust Risk Management System
Appendix 8 Medicines Safety – In depth Review		Trust Risk Management System
Appendix 9 Venous Thromboembolic Events (VTE) - Deep Vein Thrombosis (DVT) - Pulmonary Embolism (PE)		Trust Risk Management System
Appendix 10 Pressure Ulcers		Trust Risk Management System
Appendix 11 Unadjusted Mortality Hospital Standardised Mortality rate (HSMR) Summary Hospital Mortality Index (SHMI)	Assurance	TSDHFT - Information Team Dr Foster Dr Foster

Clinical Incident Report:

Introduction

The Trust operates and runs an on-line clinical incident reporting system. This is the first report derived solely generated from Datix. The system has evolved since inception in October 2016. Feedback suggests the system is easier to use and is available throughout the Trust via a computer. The system has been audited by Internal Audit and continues to be reviewed for adaptations and amendments.

Incidents are reported from all areas of the Trust and are managed locally, investigated by the manager and overseen by the relevant Matron and Division Governance co-ordinators / Medical Governance Leads. Where the severity of the incident is high, a root cause analysis investigation is carried out by the Service Delivery Unit (SDU)

The incident system, culture and feedback

- **Trustwide online incident reporting and training**
  To help with incident reporting, various guides, policies and videos have been created as well as bespoke teachings packages. These sessions augment the various instructions delivered at corporate induction and/or at local Governance meetings within the SDUs to ensure timely and accurate incident reporting.

  Specific training is also given to managers on a 1-1 or group basis to show them how to manage incidents through the system, give feedback to the reporter, analyse the data for trends and patterns and present the data in a dashboard format.

  The training packs all follow the incident management Standard Operating Procedures (SOPs), Guides and Policy which are available on the incident site.

- **Trustwide Incident Awareness, Governance and Reporter Feedback:** this has been a key outcome 17/18 which allows the creating of a system where people can report incidents from anywhere in the Trust and they can then instantly be seen by the manager and or relevant people and the reporter receives feedback.

  Once an incident has been entered onto the system, the form is electronically distributed to the most relevant staff members, based on location, harm level & speciality. This includes the clinical Executives being aware of serious incidents in real time as well as the local and senior managers.

  All incidents are reviewed centrally by the Patient Safety and Experience Lead and Manager (central team), as well as by the SDU Coordinators. The review includes assessing for correct coding, harm level and analysis for any immediate trends or themes. A weekly report is created which looks at the Moderate, Major and Catastrophic incidents and these are discussed at a weekly Incident Huddle with the Medical Director and Deputy Director of Nursing. Actions at this huddle are recorded as well as deciding if the incident should be referred to the Serious Adverse Events group (SAE), update provided to the Board or for

reporting on the Department of Health's (DH) Strategic Executive Information System (StEIS).

A further report is created based on Complaints, Incidents, Inquests, Coroners and CAS alerts (CLICC) which looks for themes and triangulation in the data and this is sent to the weekly Executive meeting

Monthly meetings with the Patient Safety and Experience Lead and Manager are held with the SDU Clinical Governance Coordinators; reviewing incident numbers, investigations for SAE, trends etc.

The information, trends etc., are then discussed at the Quality Improvement Group (QIG) which feeds upwards into the Quality Assurance Committee and downwards into the local SDU governance meetings, thus creating a continuous flow of information sharing.

Feedback is sent electronically from the reviewing manager to each incident reporter via a newly created mandatory section of Datix. The manager can select the resulting actions arising from the incident via a dropdown box or by free text. The outcomes section of the manager's form is also shared with the reporter.

Central team Incident feedback and activity: From reviewing all incidents we have created a monthly 5 point safety brief. This is based on the themes from the month's incidents and is sent Trustwide. An alert system is also used based on real time issues and again is sent Trustwide. We have also created the monthly Datix Digest, a bite site report of the month's incidents & complaints at the Trustwide and SDU level. This again is sent out Trustwide

The data from Datix is also fed into the QIG Dashboard which is housed on the Safebook site and distributed out to managers. The summary report from the dashboard is printed off is also sent to managers to post on their notice boards for staff perusal.

The Incident Policy as well as the standard operating procedures have been reviewed along with the RCA template form. These are all available on the intranet

Central Team & Duty of Candour this has been the second key focus for 2017/18 and the Datix system now has a suite of template DoC letters which can be adapted and personalised to each instance where Duty of Candour notification is required. The datix system also has a section for completion with DoC.

The Root Cause Analysis (RCA) investigation report form also includes a comprehensive DoC section which includes any specific questions the patient/ family want investigating and how they would like the feedback to be given to them. These changes have made a positive impact on DoC and have helped improve investigations, making them more open and inclusive.

Monthly training for DoC has been provided, utilising a short you tube video. The video follows a set process for instigating and following DoC which has been well received and will continue to be used in 2018/19. Root Cause Analysis Training has continued through the year with 50 staff attending

DH StEIS Reporting The Trust continues to report to the STEIS system in accordance with agreed national protocols. A lot of activity has taken place in this area to ensure our incidents are investigated in a timely way and meet the 60 day guidance to be with the CCG. At present we have no outstanding RCAs

Learning & Sharing from Serious Adverse Events Group (SAE)
All 'major/catastrophic' and 'major near miss' incidents are taken to the Trust's SAE Group for presentation, learning and acceptance of the RCAs and action plans. The action plans are now being recorded and updated on Datix. The group has created an SAE alerting system to help share learning and feedback to the SDUs. The group is also focused on ensuring DoC is completed and recorded on the RCA reports.

Internal Assurance and Review

- **Internal Audit** have undertaken a review of the incident system, including a staff questionnaire, the results of which state: *Overall the results of the feedback from the questionnaire and from interviews with staff suggest that Datix is an effective system for reporting incidents as 99% of staff know how to report an incident and 92% have reported an incident before.*

  The audit concludes, the Trust has a robust set of monitoring and reporting arrangements in place to ensure that incidents are considered, discussed and managed at a corporate level throughout the Trust and reported to the Board. Datix allows detailed reporting of incidents across the main governance forums; the Serious Adverse Event Reviews (SAE Group), Quality Improvement Group (QIG) and the SDU Quality and Performance Review (QPR) meetings. The Quality Improvement Group Dashboard is the key report that is used as the basis of reporting to these forums and to the Board

  The 4 actions arising from the Internal Audit review have all been completed.

  Internal Audit have also reviewed our DoC policy and procedures, as well as the practical application of the process. The report was positive, highlighting the key elements of DoC being applied in all the cases reviewed.

  The report highlighted only 4 actions and these have been completed

  From a corporate governance perspective both internal Audit reports, Incident Management and Duty of Candour, have been presented to the Quality Improvement Group who accepted these reports.

2017 National Staff Survey

Following the results of the national survey where incident reporting dropped two percentage points and the KF 30 question was below the national average, much of the above work to encourage reporting, sharing and learning was formulated. It is therefore encouraging to read the draft comments from the 2018 CQC inspection which are positive to incident reporting, its culture and management.

	2017	2016	National Ave
KF29 – Percentage of staff reporting errors, near misses or incidents witnessed in the last month	87%	89%	91%
KF 30 – Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.67	3.68	3.73

- **CQC - Well led *draft* Feedback on incidents and DoC.** In addition to our own reviews we have taken the comments and feedback available in the draft CQC report, included as below:

All of the CQC's comments highlight a culture where incidents can be reported, incidents are acted upon and feedback is given, but most importantly learning is taking place. This is very positive and will help us to continue our drive to maximise learning from each and every incident, including near misses.

For incident management the Trust received **no** *must do*, and only 2 *should do* actions in relation to incident reporting. These will for part of the actions for 2018/19

With regard to **Duty of Candour** the CQC said:
"The trust had encouraged an open and honest culture with patients and relevant persons. The duty of candour was embedded and well-evidenced. We looked at death reviews and incident investigations, which clearly demonstrated absolute honesty with the families and carers. There had been no attempt to disguise any mistakes and relevant apologies were made.

Further comments were made, all positive, and the Trust received **no** *must do*, or *should do* actions in relation to Duty of Candour.

Key Achievements 2017/18

- Policy and procedure development
- Simplifying the reporting process
- Creating internal Datix processes for monitoring incident management
- StEIS reportable includes RCAs completed within 60 days
- Duty of Candour letters and process
- QIG dashboard development targeting specific areas e.g., Maternity Deteriorating Patient

Specific Incident Harm Areas Summary

- **Medication safety – Appendix 8**
  The Trust has been actively encouraging the reporting of medication incidents, as this type of incident has typically been under reported. All medication errors are automatically sent to the Clinical Governance Pharmacist for review and action. Pharmacy has been particularly focusing on high risk medications and missed doses with the wards and departments. Through regular monthly audits and interventions, missed doses are showing a decrease. We have had no serious incidents with high risk medications this year

- **VTE Reporting– Appendix 9**
  All Deep Vein Thrombosis (DVT) and Pulmonary Embolisms (PE) diagnosed in patients who have had a hospital admission in the last 90 days are recorded on the incident system and are investigated. The investigation is led by a Consultant Haematologist and VTE Specialist Nurse, and the findings collated and shared with the teams involved. The key finding of the investigations notes excellent practice but does record a number of individual missed doses.

- **Recognise and Rescue– Appendix 7**

  The Trust is moving to review the deteriorating patient in a much more structured way with the aim of eradicating cardiac arrests through the principles outlined below.

  The start of this process was to create and assess the available data – please see Appendix and form a Deteriorating patient Group to manage filed of work. The data and group have been set up

- **Pressure Ulcers (PU) – Appendix 10**
  Pressure ulcer reporting is a well-established and embedded part of incident reporting. The Tissue Viability Service and Pressure Ulcer Steering Group drive this work and much has been achieved in:

  - Reviewing policy and procedure
  - Procuring pressure relieving mattresses for the A&E department that fit their trolleys
  - Leg ulcer training continues to be run at regular intervals
  - Spreading the use of the Skin bundle
  - Continuing the work of the Pressure Ulcer Project

- **Falls – Appendix 5**
  The falls number has reduced slightly, as against last year. The focus for the Trust is to continue to reduce the harm caused by falls. The Falls Nurse and Falls Group have worked hard to revise the Falls & Bed rail assessments, continue to implement the Lying and Standing blood pressure monitoring tool and review and enhance the education package. They have also worked hard to ensure the Fallsafe audit is undertaken monthly and shared with each area. The results of the audits are continuing to show improvement over time.

2018/2019 Plan

Datix locations & Internal restructure

Once the new restructured organisation is formalised a significant piece of work will be required to realign the Datix system to reflect this. Following on from the above, the template reports and feeds into the Data warehouse will also need to be rewritten and the QIG dashboard updated to receive this new data structure.

To continue to make incident reporting easier and more specific to the types of incident we will create a patient and a staff version to allow more specificity

Reporting of Diseases Dangerous Occurrence Regulations 2013 (RIDDOR)

In December 2017 a Memorandum of Understanding has been agreed between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE) with the support of the Local Government Association (LGA). It applies to both health and adult social care in England. The purpose of this MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public.

In essence this means we will report, as per norma, l to the HSE any RIDDOR incidents but if the incident affects a patient the CQC will become the investigating body with powers of prosecution. We are at present working with our local CQC inspector to understand how this will work, specifically with falls, as this is one area where the Trust does have patient RIDDOR incidents.

Training

Work has started with the external investigation trainer to train 30 investigators in Q3. This will bring a new skill set to our investigations

Continue with the 'Be Heard' Duty of Candour training to target 50 staff members

Continue with the Incident manager training to ensure at the local level managers have the skills and knowledge to manage their incidents. This will be achieved by 1-1, bespoke or group sessions. At least 1 session a quarter will be set up in the Horizons Centre

Specific Projects

Continue to develop the Recognise and Rescue page in the QIG dashboard to help inform the newly formed Deteriorating Patient Group

Create a specific Safer Surgery incident page for the QIG dashboard which will allow analysis across surgical data set including incidents, Normothermia Surgical Site Infections

Always Events are a detailed and specific format for ensuring a process is always completed to ensure standardisation and reduce error. The project is being run via the IHI and Department of Health. The work involves patient participation and in the pilot involves SCBU and Clinical Effectiveness. The always Event under test is what does the families of newly born babies want to be handed over from Maternity to SCBU. At present we are surveying families to ensure we meet their needs in this process. The aim for this week will be to complete and spread to three other areas.

CQC Action Plan - 2 should do's

Maternity

"Review the processes used to investigate serious incidents to increase the level of scrutiny and interrogation of information." Sept 2018

Outpatients

"Localised incident information should be available to the managers in main outpatients May 2018

Appendix 1
Total Number of Clinical Incident Reports Trustwide and by Service delivery Unit by Month by Year April 2017 – Mar 2018

Appendix 1 looks at the total number of Trustwide clinical incidents reported by month.

Chart 1, as below highlights the Trusts monthly reporting pattern for the financial year. The trend line is showing an increase of reported incident, which fits expectation. The National Reporting & Learning System states that organisations that report more incidents usually have a better and more effective safety culture, which is a key aim of the organization

Chart 1

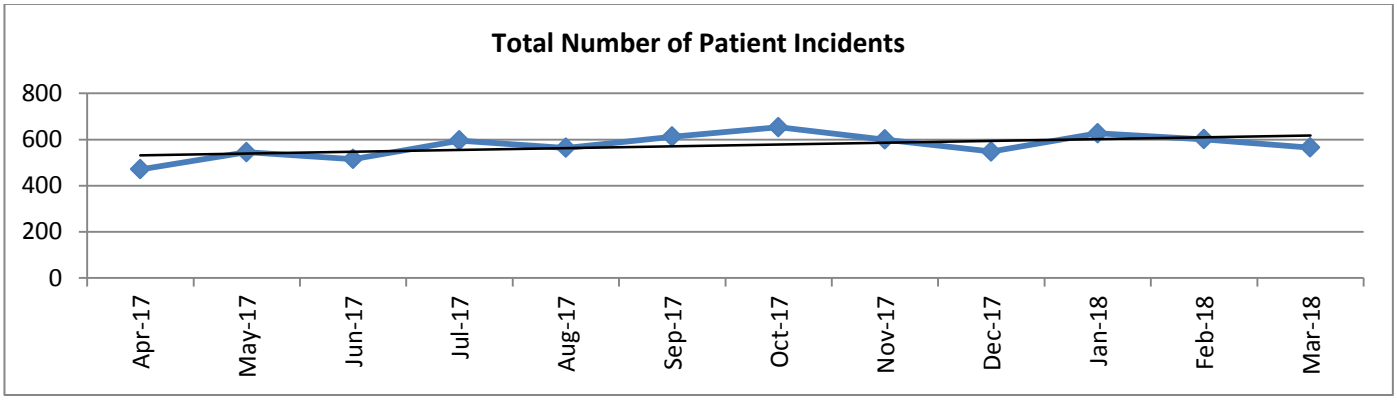
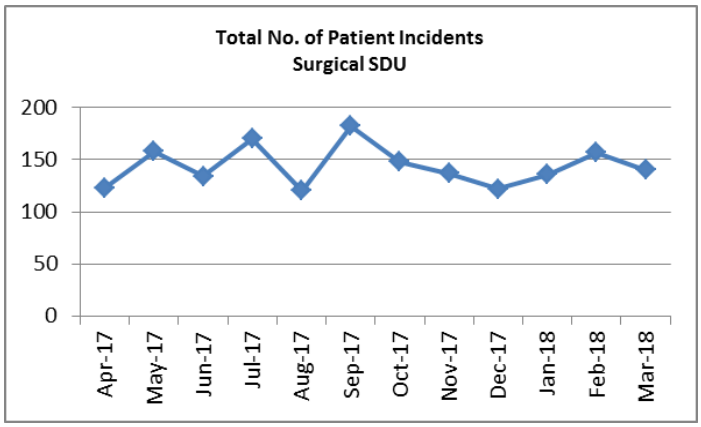
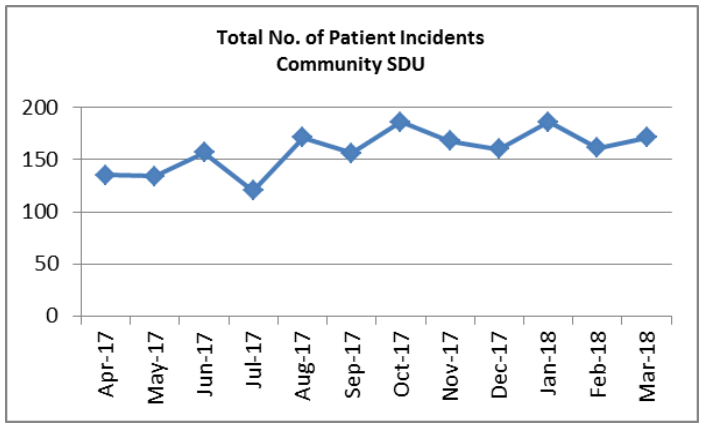
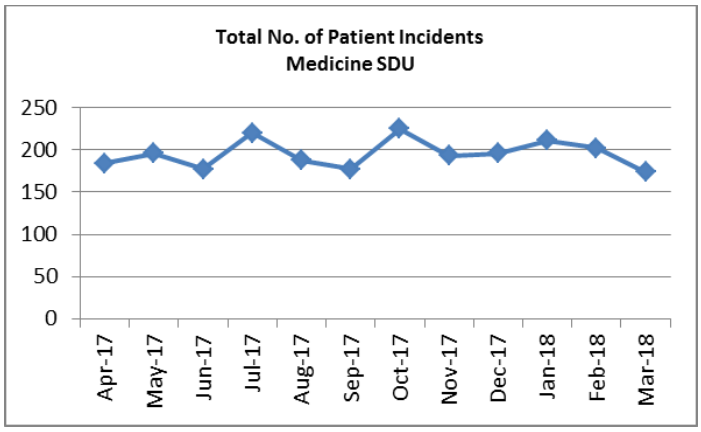


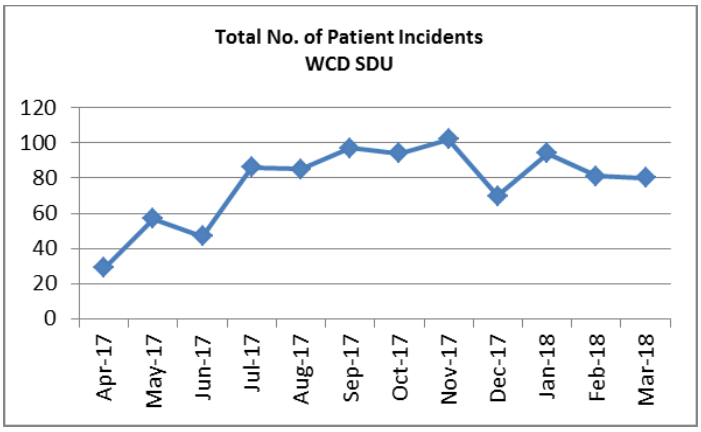
Chart 2 (4 charts) identifies the individual Service Delivery Units within the organisation and their monthly reporting patterns across the year (SDUs).

Chart 2





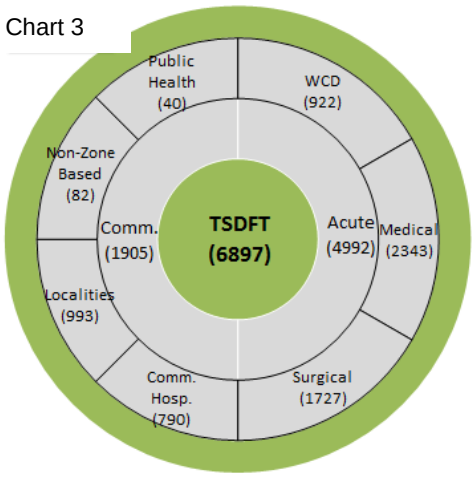




Again, all SDUs reporting are consistently and within the normal patterns of incident reporting. The small increase in Community SDU may be attributed to the increase in care provided by Intermediate and Social care.

The final chart, a radar chart, offers more granular information, highlight total yearly incident numbers reported for the areas described within the chart.

Chart 3



Against the internally set tolerance for the year, all are within expected range. At the monthly Quality Improvement Group and separate at the Quality Performance Review meeting, these charts are reviewed. Deviation from expected will be discussed in detail at these meetings as well as at the local SDU governance meetings

Trustwide Work Activity on Incident Reporting

To help achieve a healthy reporting culture, work has focused on allowing staff to easily report an incident from any computer and or use relevant help to do so , e.g. clinical incident team, managers, health and safety team etc., if they don't feel computer literate. This is borne out in the number and consistency of incidents reported across the organisation.

The Datix Administrator has also focused on preparing easy to follow help guides, short videos, and 'who does what' flow charts in incident management, all accessible from the incident reporting page and also from Safebook, the patient safety portal.

Much work has also been invested in returning feedback to the reporter, from the manager, on what has happened to mitigate or reduce the likelihood of the incident re-occurring. This is an automatic feature of the system and triggers once the manager closes the incident.

These feedback loops have also been the focus of the central team and distinct pieces of work have been utilised to create the monthly:

- Quality Improvement Dashboard
- Monthly Datix Review
- Datix Digest
- 5 Point Safety Brief

As well as the weekly:

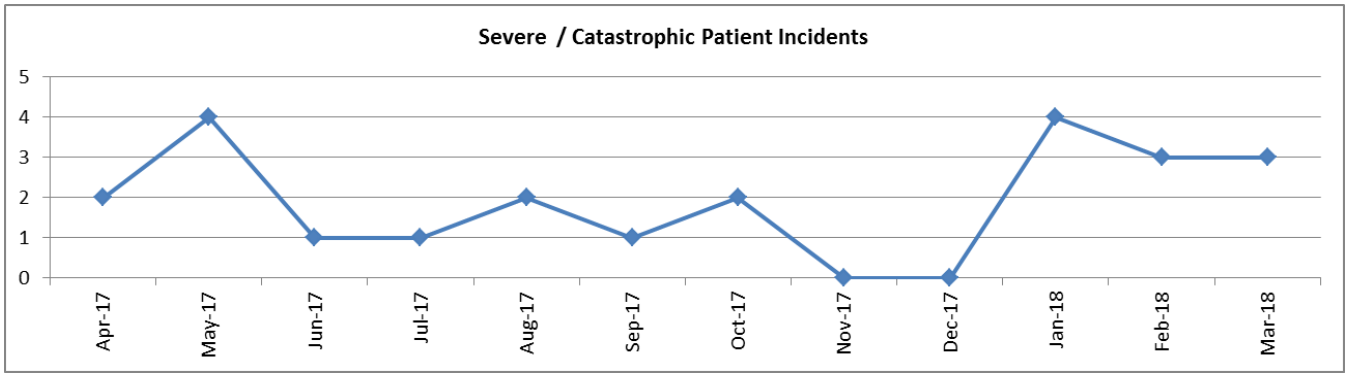
- Executive CLICC report
- Serious Incident Huddle

Once reported, the incident data has also been used to create the Quality Improvement Group dashboard. This dashboard is made available to all staff and emailed out to all managers to share and integrate for trends and patterns in their areas. The dashboard also allows triangulates with activity, complaints, length of stay etc., which can be fed back to local areas.

Appendix 2
Clinical Incidents by Actual Impact – Trustwide

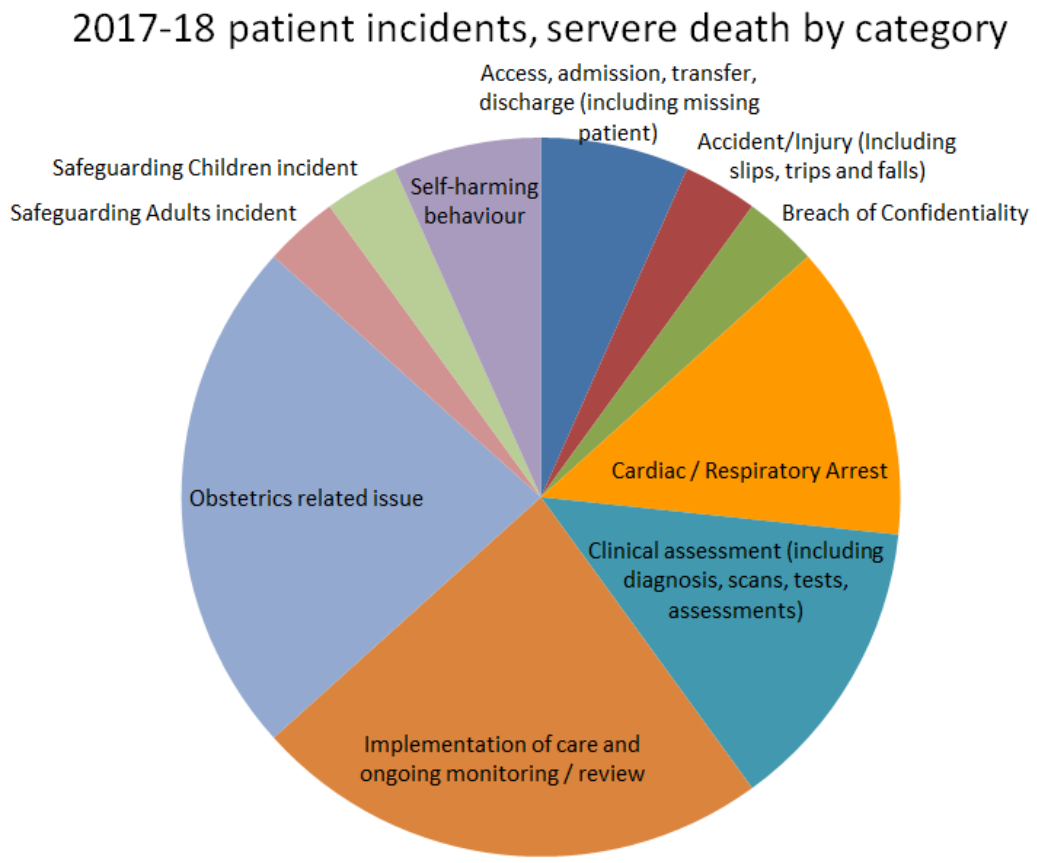
This set of data slides records Trustwide actual harm from the incident forms entered on the risk management system. Where incidents occur that are major and catastrophic an investigation is undertaken and the learning shared within the area and where necessary across the Trust.

Chart 4



The pie chart below highlights the incident category

Pie 1



Moderate incidents – Chart 5, are again incidents that cause a level of harm that the Trust investigates. Incidents within this category are largely VTE, pressure damage, falls, shoulder dystocia, post-partum haemorrhage, for which there are specific pieces of safety work attached to them.

The increase in moderate harm is largely down to the better reporting of pressure damage, particularly in the community setting as more and more patients are looked after in their own environment.

Chart 5

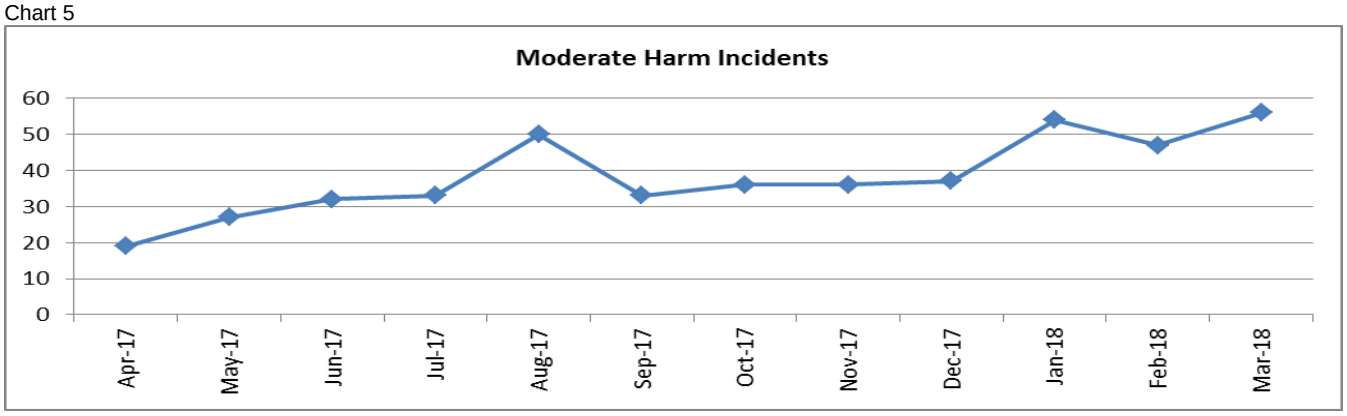


Table 2 gives a description of these harms and lists them by SDU

Table 2

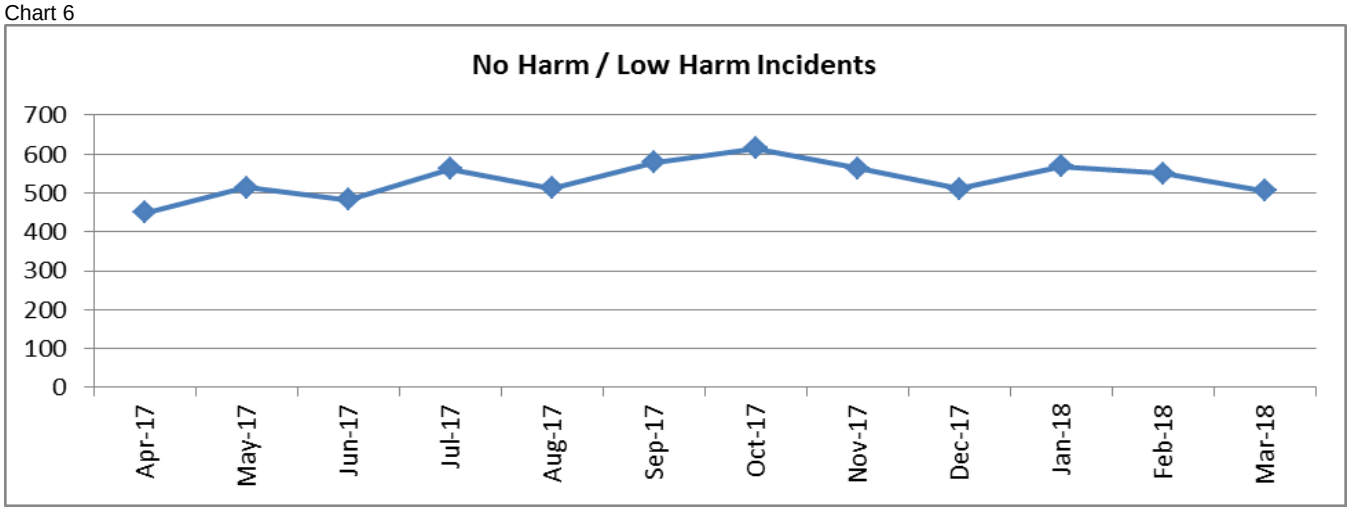
	Community Health and Social Care Service Delivery Unit	Medical and Emergency Service Delivery Unit	Surgical Service Delivery Unit	Women's, Children's, Diagnostics and Therapies Service Delivery Unit
Access, admission, transfer, discharge	1	1	0	0
Accident/Injury (Including slips, trips and falls)	10	10	3	1
Anaesthetics related incident	0	0	1	0
Cardiac / Respiratory Arrest	0	1	0	0
Clinical assessment diagnosis, scans, tests, assessments)	0	2	4	1
End of Life related issue	1	0	0	0
Implementation of care and ongoing monitoring / review	0	0	1	0
Infection Control Incident	0	1	1	0
Medical device / equipment	0	0	1	0
Medication related issue	1	2	4	0
Moisture Lesion	1	0	1	0
Obstetrics related issue	0	0	0	28
Pressure ulcer	246	18	8	25
Safeguarding Children incident	1	0	0	0
Skin Damage (not caused by pressure)	0	0	1	5
Treatment, procedure	0	2	6	3
Venous Thromboembolism Events (VTE)	4	27	6	1
Total	265	64	37	64

The pressure ulcers reported in the Community SDU, will include skin damage found when the Community staff visit and not necessarily caused in their care, please also see Appendix 11 which focuses on skin damage.

The safeguarding children incidents are where we have raised an alert as per policy, again not that we have caused a safeguarding children's alert

Chart 6 – as below highlights the vast majority of incidents recorded the Trust are low or no harm

Chart 6



Appendix 3
Most Frequently Occurring Cause Codes
12 Months Data Trustwide
Data obtained from Datix

The table below (table 3) shows the top ten most frequently occurring cause codes for 17/18, i.e. the codes that have been attributed to incidents most frequently reported regardless of harm level Trustwide. The table also includes the number of incidents reported by the SDUs. The 2 tables thereafter are specific to the community SDU and the three SDU's within the acute hospital.

The most frequently reported incident is for pressure damage, this is largely in the Community SDU and includes pressure damage recorded against patients in their own home, care or residential home, not necessarily caused by the Trust.

Table 3

Incidents by Category and Directorate					
	Community Health and Social Care Service Delivery Unit	Medical and Emergency Service Delivery Unit	Surgical Service Delivery Unit	Women's, Children's, Diagnostics and Therapies Service Delivery Unit	Total
Pressure ulcer	1351	329	137	114	1931
Accident/Injury (Including slips, trips and falls)	509	382	171	36	1098
Access, admission, transfer, discharge (including missing patient)	150	274	219	184	827
Medication related issue	209	282	183	86	760
Blood Transfusion and Blood Sample incident	21	336	159	83	599
Documentation (including electronic & paper records, identification and charts)	48	169	143	95	455
Implementation of care and ongoing monitoring / review	191	59	58	47	355
Treatment, procedure	33	121	109	67	330
Clinical assessment (including diagnosis, scans, tests, assessments)	14	88	90	80	272
Obstetrics related issue	0	0	2	238	240
Total	2526	2040	1271	1030	6867

Community Top 10

Table 4

Incidents by Category and Directorate		
	Community Health and Social Care Service Delivery Unit	Total
Pressure ulcer	1351	1351
Accident/Injury (Including slips, trips and falls)	509	509
Medication related issue	209	209
Implementation of care and ongoing monitoring / review	191	191
Access, admission, transfer, discharge (including missing patient)	150	150
Moisture Lesion	115	115
Medical device / equipment	74	74
Skin Damage (not caused by pressure)	62	62
Documentation (including electronic & paper records, identification and charts)	48	48
Consent, communication, confidentiality	44	44
Total	2753	2753

Falls are the second most frequently occurring event in Community SDU and much activity has taken place with the Community Falls lead – please see appendix 5. Medications, being third on the list, also has a specific focus and activity is included in Appendix 7.

Medical, Surgical, Women's & Children's SDU top 10

Table 5

Incidents by Category and Directorate				
	Medical and Emergency Service Delivery Unit	Surgical Service Delivery Unit	Women's, Children's, Diagnostics and Therapies Service Delivery Unit	Total
Access, admission, transfer, discharge (including missing patient)	274	219	184	677
Accident/Injury (Including slips, trips and falls)	382	171	36	589
Pressure ulcer	329	137	114	580
Blood Transfusion and Blood Sample incident	336	159	83	578
Medication related issue	282	183	86	551
Documentation (including electronic & paper records, identification and charts)	169	143	95	407
Treatment, procedure	121	109	67	297
Clinical assessment (including diagnosis, scans, tests, assessments)	88	90	80	258
Obstetrics related issue	0	2	238	240
Implementation of care and ongoing monitoring / review	59	58	47	164
Total	2040	1271	1030	4341

The above tables record the top 10 reported incidents within the acute hospital setting. The medical SDU is larger than the others, therefore will record more incidents.

The pattern is similar to the community in that Falls, Pressure damage and Medications will feature in the top 10. This pattern is mirrored nationally and why we ensure these types of incident are shared with the Falls, Pressure Ulcer and Medicines Management groups for their specialist knowledge and management.

All blood issues are taken to the Transfusion Group for analysis and the largest number of incidents raised in this category is due to forms or blood tubes incorrectly completed. The process therefore does not process these samples to ensure safety. Work in this area is consistently based on correct completion and the numbers in this area have dropped from the previous year

As a result of focused work within the Trust specifically around documents and transfers a new electronic handover system has been procured and is currently being tested called Nerve Centre. This new system will facilitate the instant handover of relevant information on transfer and discharge and it is envisaged that incidents in this field will reduce over the coming year.

This report is shared with the SDUs and specialty areas that can focus on the issues pertaining to their areas

Appendix 4
DH Never Event List
April 2017 – March 2018
Source Datix

A Never Event (NE) is defined by the National Patient Safety Agency (NPSA 2010) as a '*serious, largely preventable patient safety incident that should not occur if the available preventable measures had been implemented by healthcare providers*'.

The table below shows the Department of Health's (DH) 'Never Event' list for 2018.
The Trust has recorded one such event between April 2017 and March 2018. The patients received no harm and the incident has been thoroughly investigated. For comparison, in 2016/17 the trust had one Never Event.

Chart 7

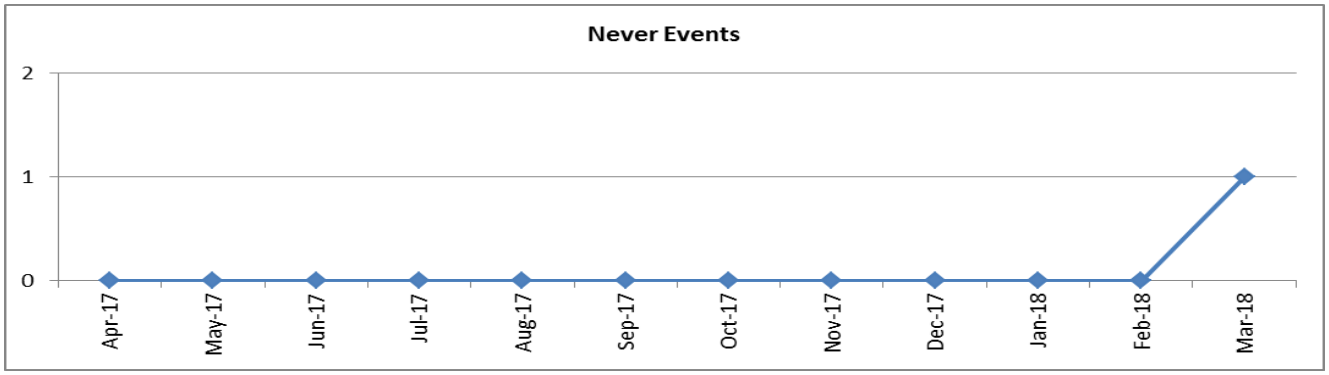


Table 5

	Description	
1.	Wrong site surgery	1
2.	Wrong implant / prosthesis	0
3.	Retained foreign object post-operation	0
4.	Mis - selection of a strong potassium containing solution	0
5.	Administration of medication by the wrong route	0
6.	Overdose of insulin due to abbreviations or incorrect device	0
7.	Overdose of methotrexate for non-cancer patients	0
8.	Mis - selection of high strength midazolam during conscious sedation	0
9.	Failure to install functional collapsible shower or curtain rails - Mental Health Trusts Only	0
10.	Fall from poorly restricted window	0
11.	Chest or neck entrapment in bedrails	0
12.	Transfusion or transplantation of ABO-incompatible blood components or organs	0
13.	Misplaced naso or oro-gastric tubes	0
14.	Scalding of Patient	0

The event was a *wrong site analgesic block* and falls under the category of Wrong site surgery. Once the analgesic block was administered, it was recognised as being on the wrong side and the correct side duly blocked. The patient received no harm and the investigation process has been started.

Appendix 5
Trustwide Clinical Incidents by Slips Trips & Falls
Source Datix QIG Dashboard

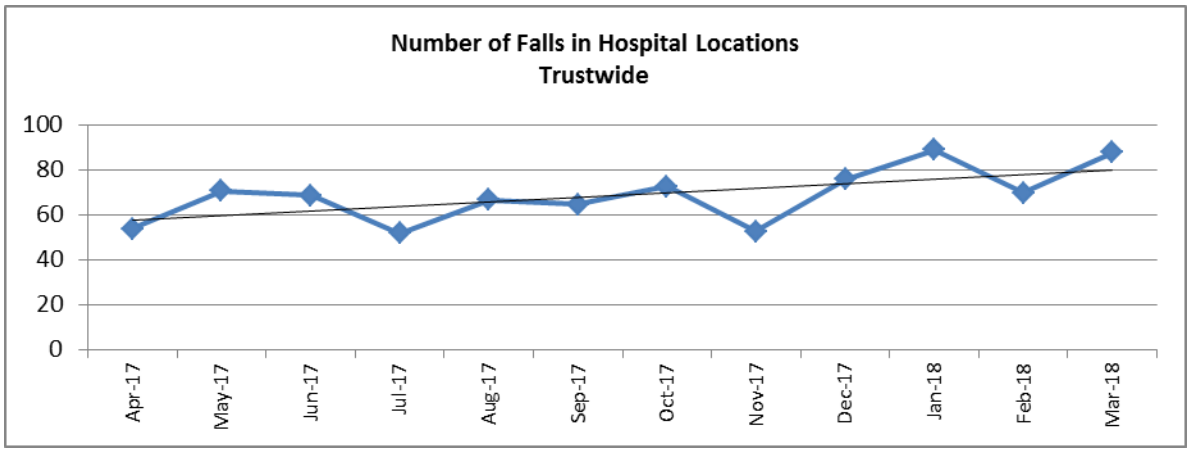
Falls are one of the most frequently occurring incidents within the trust. They occur in bed based care e.g. hospitals as well as in peoples own homes and/or other care environments in which they live. The data in this appendix records Trustwide falls by number, location, actual harm, time of fall and week/weekend split. Due to the frequency of falls, the QIG Dashboard has a specific section of falls for information and analysis and is shared with the local teams, areas and departments. The data is also shared with the Falls Steering Group to aid their work too.

The total numbers of falls experienced by our patients within our Trust has *reduced* on last year, which is to be welcomed.

Year	Total Number	+/-
2017/18	827	↓ **62**
2016/17	889	

The run chart, as below, shows the natural variation of falls through the year and also shows that they increase slightly over the winter period. This in part is due to the frailty of the patients looked after in the colder months and the severity of pressures experienced this winter.

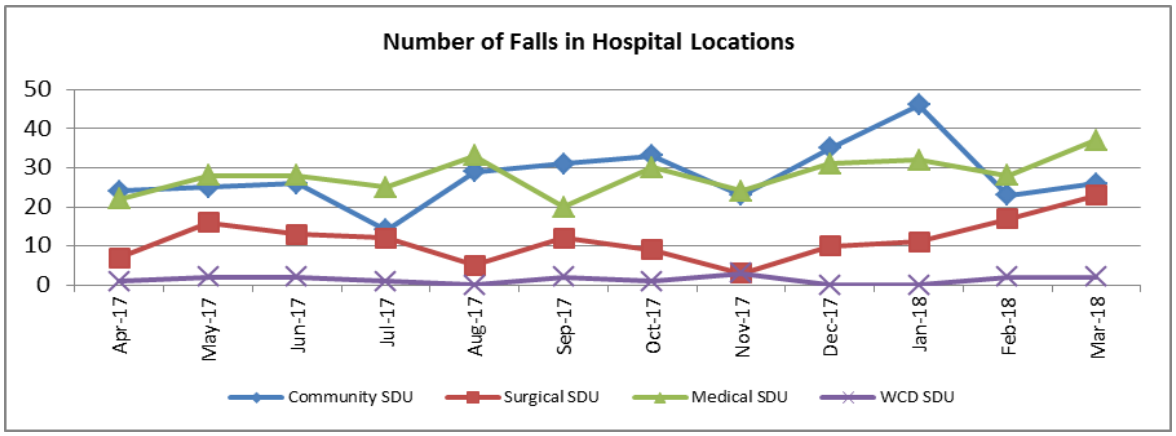
Chart 8



The next chart (9) highlights the individual SDU's and the number of falls per month they experience.

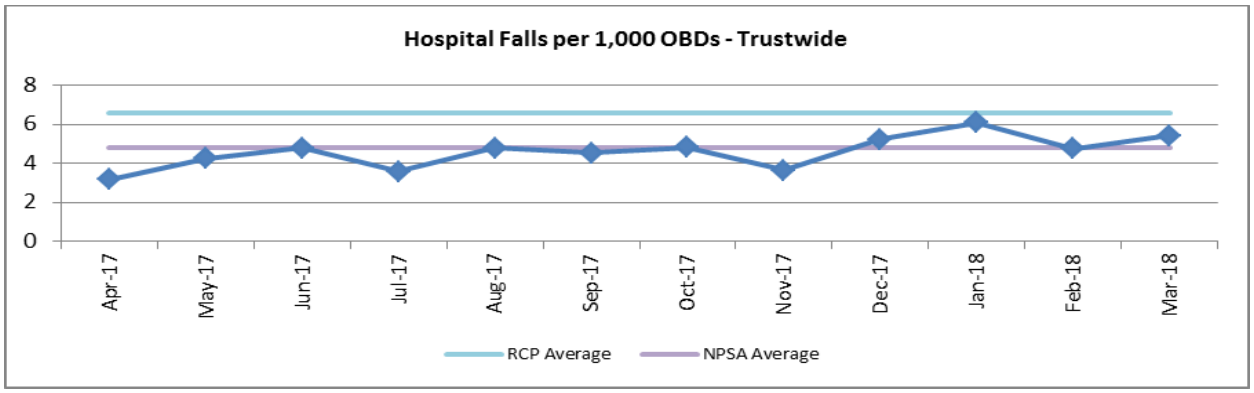
The rise in the winter period can now be seen manifesting in the Community SDU, particularly in January and in Medicine and Surgical SDUs in Feb and March as the winter pressures continued.

Chart 9



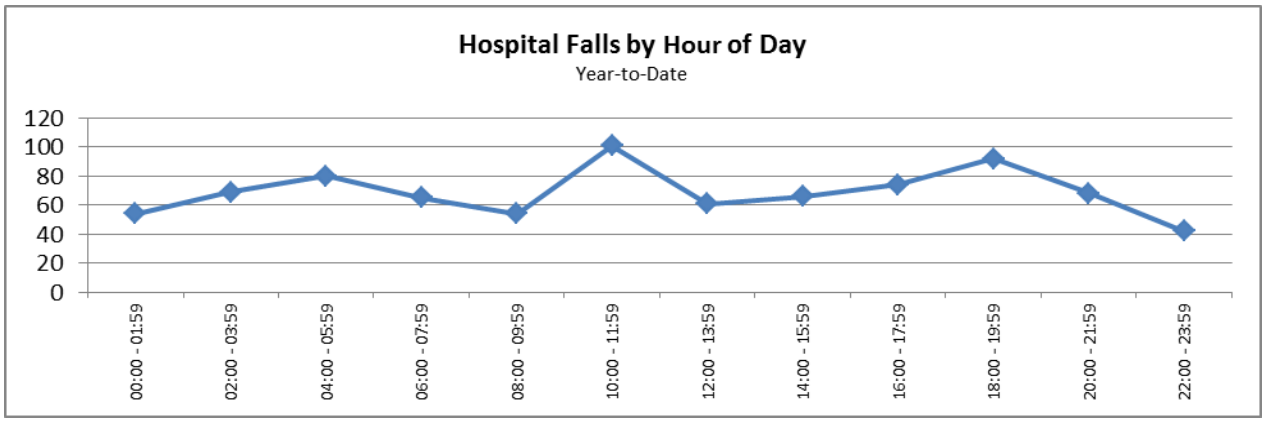
The following chart (10) takes the number of falls and divides them into 1,000 bed days to give a rate. This rate can then be benchmarked against other published rates to form a comparison. The higher line on the chart is the Royal College of Physicians fall rate, 6.6 and the lower line, the National Patient Safety Average, 4.8. The Trusts average rate is 4.6, performing better than the average.

Chart 10



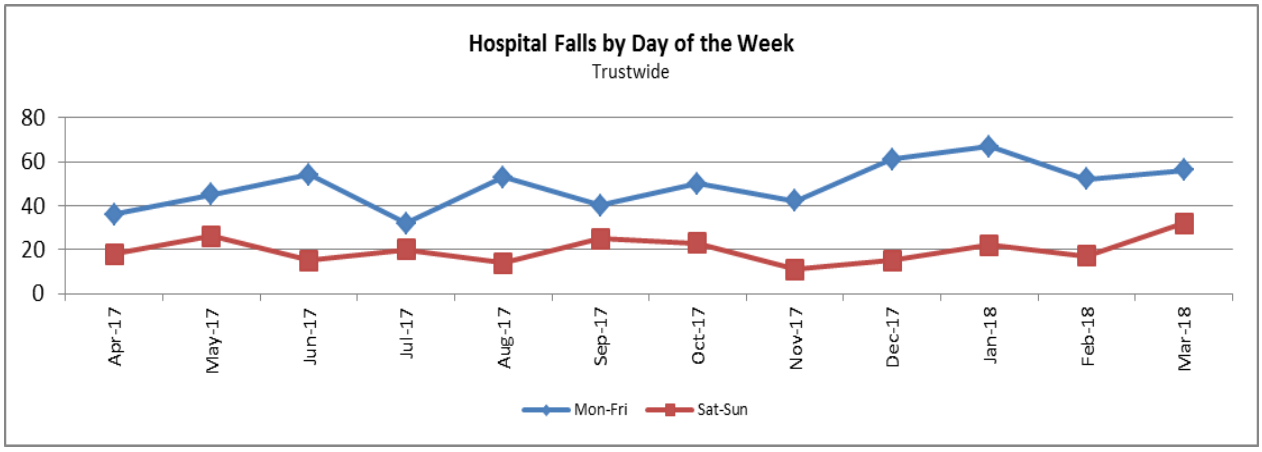
The time at which the falls occur is granular data that is captured and used by the falls team in education sessions, specifically to make staff aware of the trends and patterns of when patients are more likely to fall. Peak times, highlighted from the below chart are pre lunch and dinner.

Chart 11



When analysing the data over the weekday/weekend periods there is a marked reduction during the weekend which is therefore showing no adverse pattern of falls with the possible exception of March. The march data has risen above the yearly average and will need to be observed for relevance.

Chart 12



When the harm level from falls is analysed, these falls have all been in the *moderate category and* the chart below shows the relatively low number. In the data, no patterns have emerged re location or time and all have been investigated. The Trusts aim is to continue to reduce the number of falls so as to try and reduce the harm from these events to the lowest level possible.

Chart 13

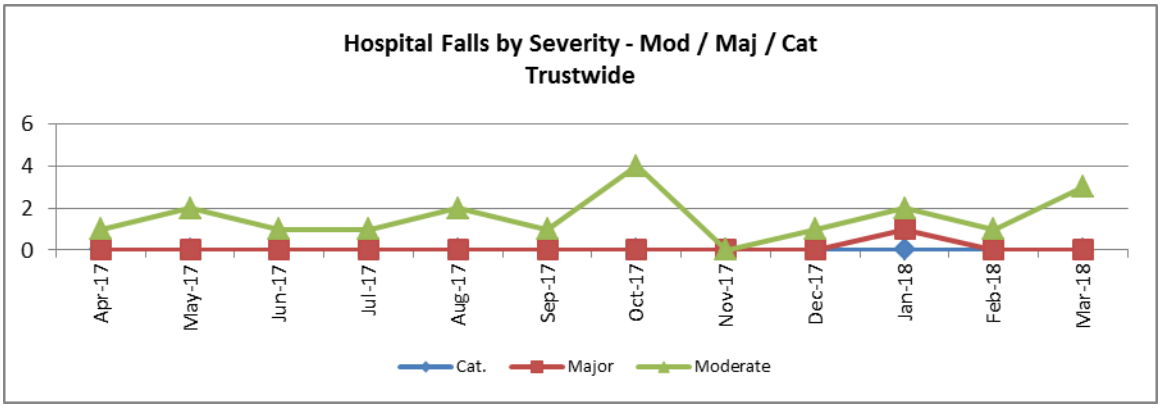
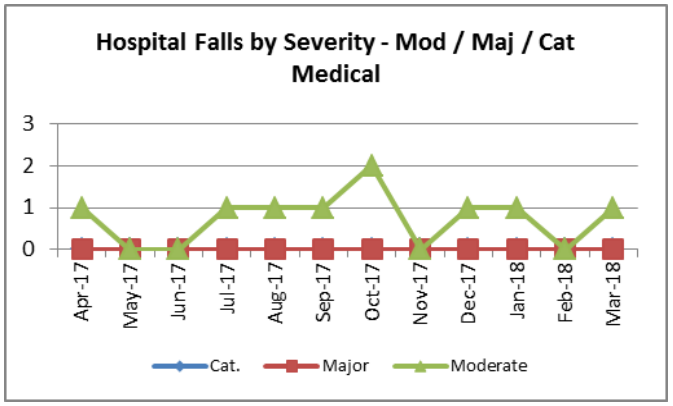
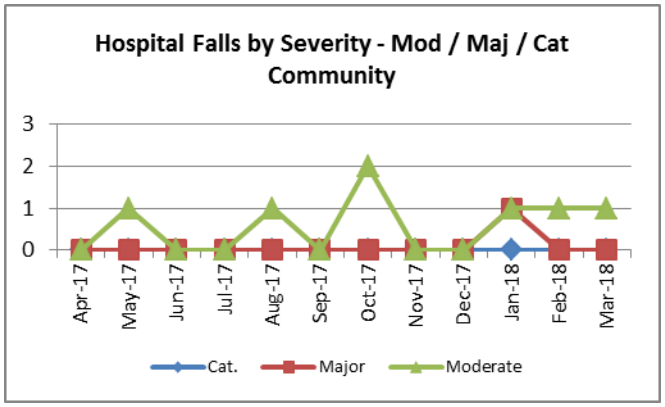
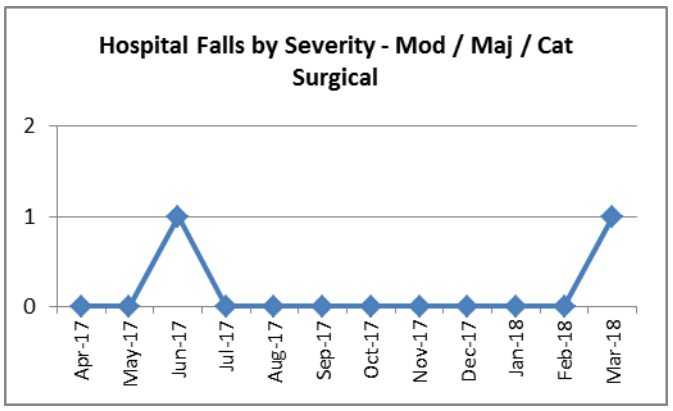
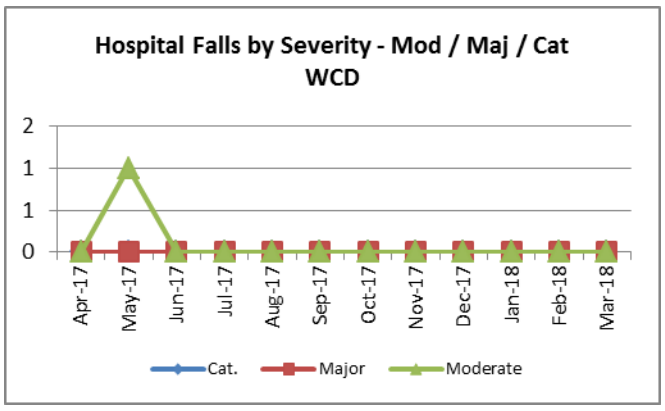


Chart 14 – 4 charts



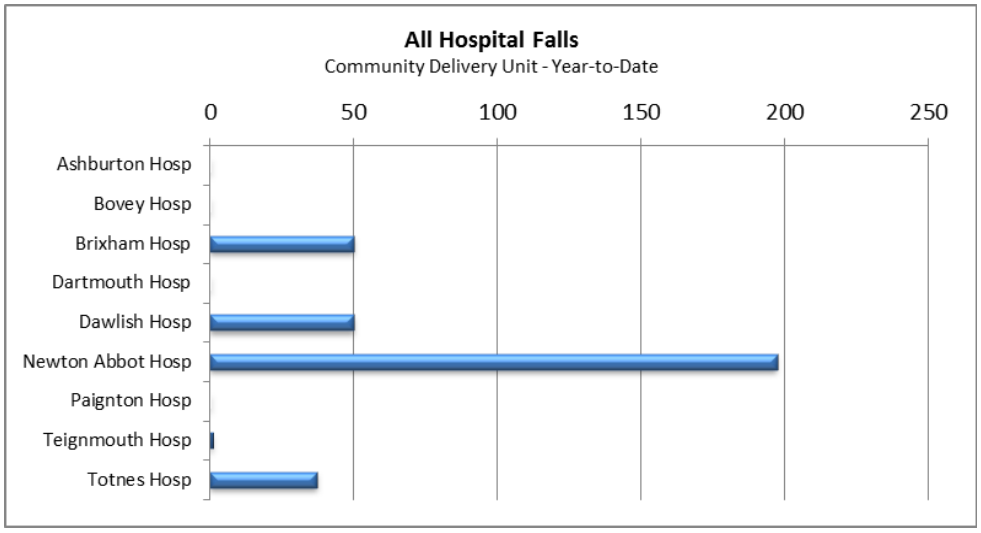






The remaining charts 15 - 18, as below, highlight falls by their location and number across the Trust and the distribution of each area is within expectation and in line with acuity and frailty of the patients.

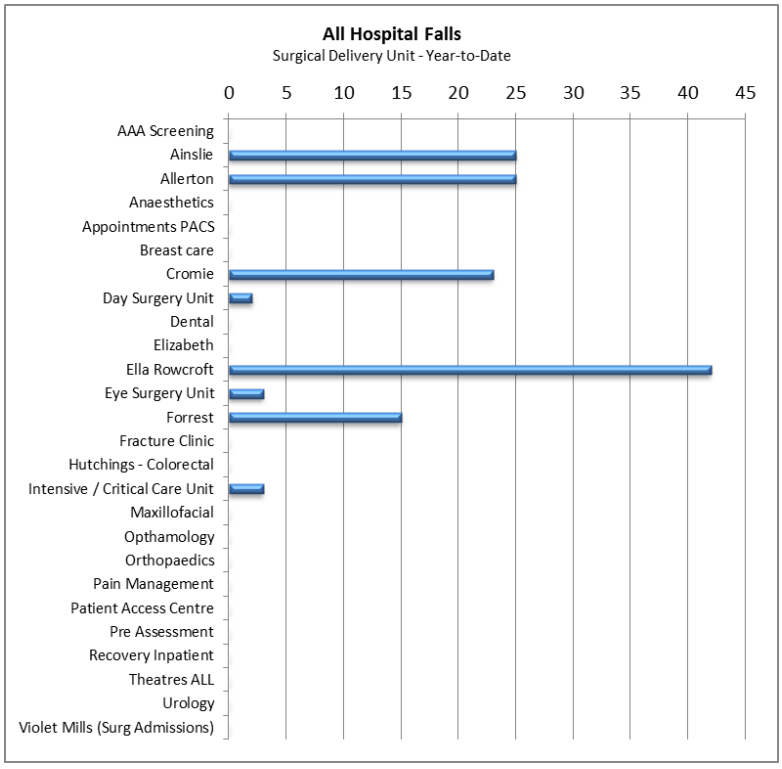
Community Service Delivery Unit chart 15



For context Newton Abbot hospital has two wards and has 3 – 4 times the bed capacity of the other smaller community hospitals.

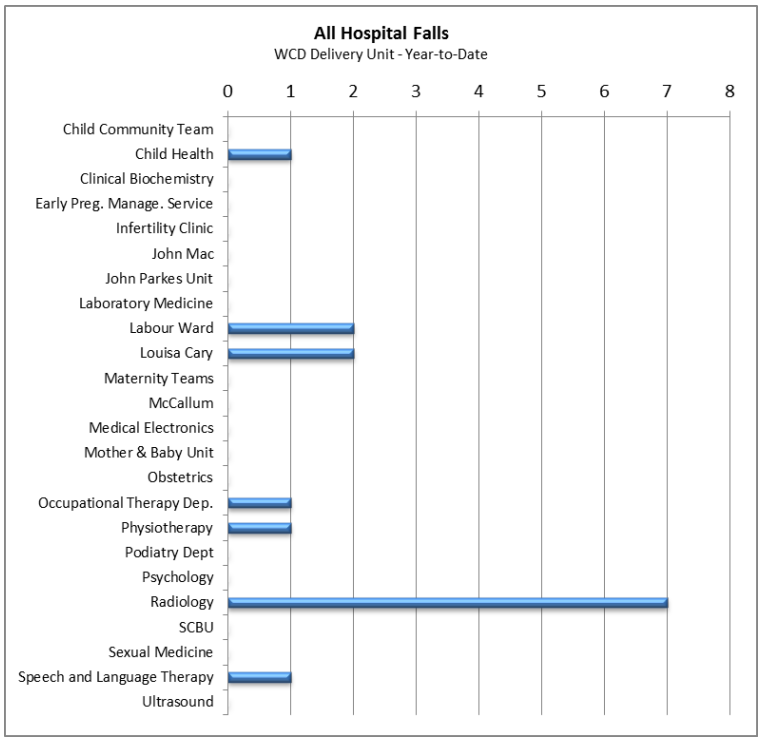
Surgical Service Delivery Unit

chart 16



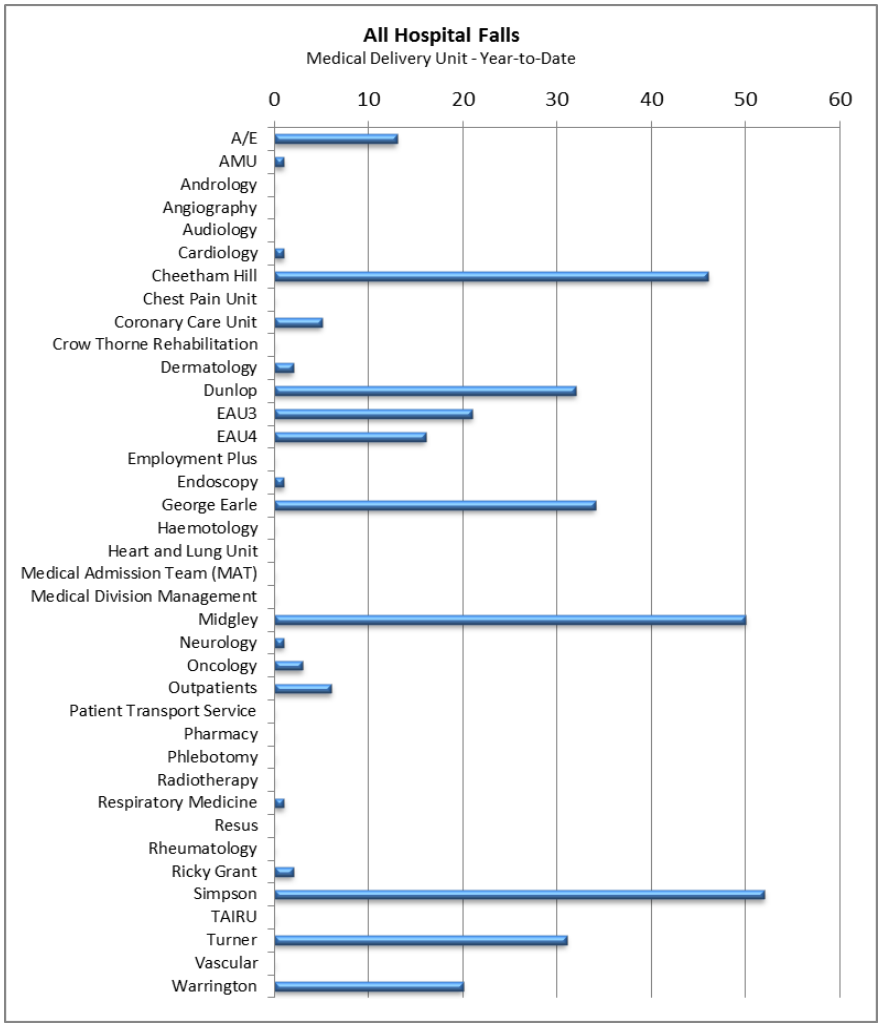
Women's, Children's & Therapies Service Delivery Unit

Chart 17



Medical Service Delivery Unit

Chart18



Falls Work to date

The Falls winter campaign was launched in December 2017 which was aimed at both *Bed Based* and *Non Bed based* care: The key messages included Cohorting, Patient & Bedrail assessments, Footwear, Blood Pressure reviews, Medication reviews and pre- discharge advice.

The Fall leads train and maintain the falls champions and link nurses across the Trust who promote falls prevention and falls health in their local areas. The falls champions and link nurses also undertake the Fallsafe link study days and undertake the monthly Fallsafe audits. The audit results are distributed to each area and are recorded on the QIG dashboard for analysis and interpretation.

The team have reviewed and train staff on the Falls and Bed Rails assessment tool and have updated the leaflets. These assessments are now available in the new Trustwide assessment booklet

The lying/standing blood pressure (LS bp) e-learning package, which is supported by an on-line discussion board and quarterly ***Hands on*** L/S bp training sessions are now augmented with new videos

The Falls Nurse also leads a comprehensive training program that again, is inclusive to all care provider staff, public and private. This joint training identifies 3 levels of falls training along with a flow chart diagram for ease of access

The Training packages and within the hospital, the Royal College of Physician's FallSafe project, are being used with audit to indicate the success of the work staff are doing to reduce falls and harm from falls.

Innovation: The Falls Nurse has created many videos on falls prevention, available on the educational Falls website and created many education modules to prevent falls including:

- Falls Training
- Advanced Training - Medical Risk
- Advanced Training - Sensory Loss
- Advanced Training - Multifactoral Falls Risk Assessment
- Advanced Training - Environmental Risk
- Advanced Training - Physical Risk
- Advanced Training - FallSafe 2 days a year for falls Champions/Link Staff
- Lying and Standing Blood Pressure
- Dementia and Falls
- Acute Medical Module

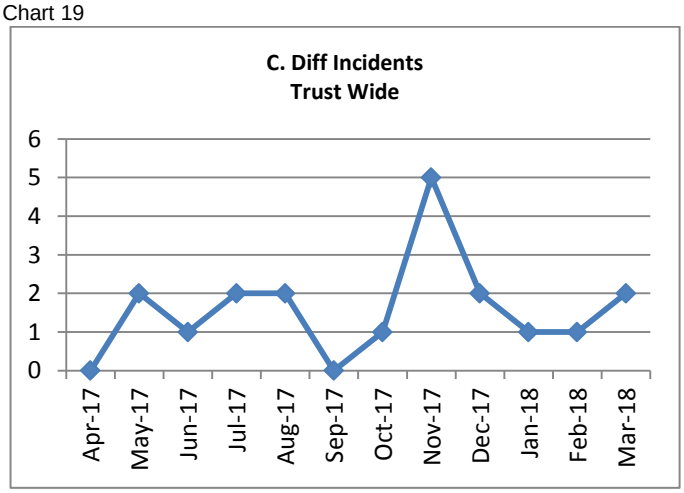
Educational Material 2017/18
The Falls Nurse has created a number of in-hospital leaflets or uses nationally available leaflets for both staff and patient education, below are a section and are available on the Falls intranet site

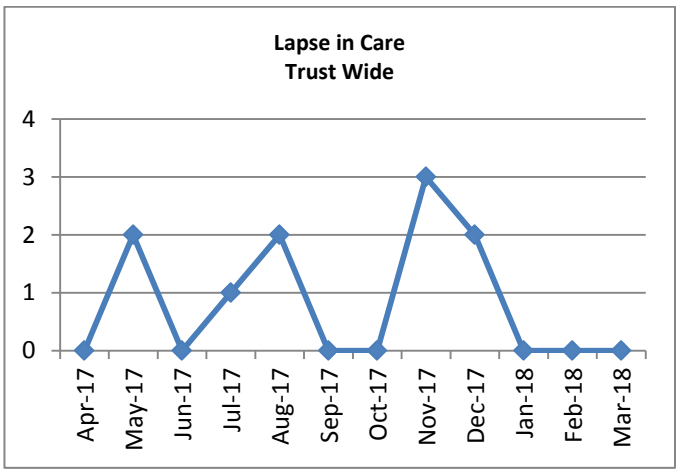
- Staying Steady
- What is Postural Hypotension
- Easy Read Falls Prevention
- Easy Read Observation Leaflet

Appendix 6
Infection Prevention & Control

This matrix is focusing on Clostridium Difficile incidents within the bed based side of the Trust

Chart 19

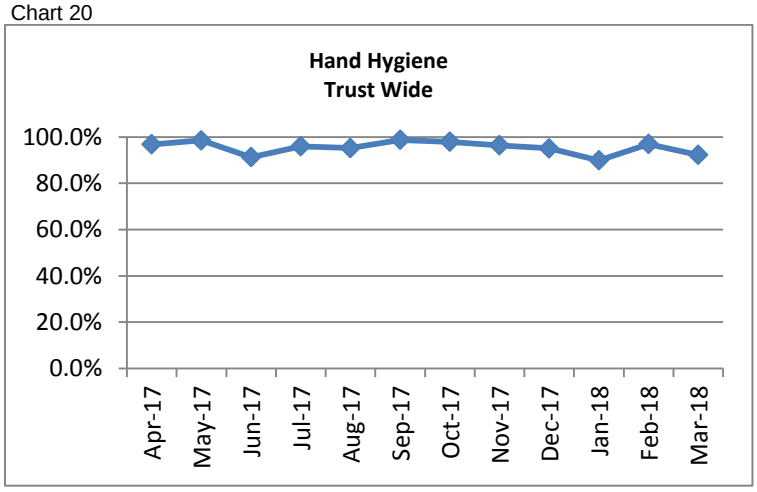




The Trust has met its yearly target but all C.Diff incidents are investigated by the Infection Control team and feedback give to the ward/department. One of the key aspects of the investigation is to look for any lapse in care which was material to the case, again the Trust met its target re lapses in care. Some of the main reasons attributed to a lapse in care would be a delay in sending a stool sample.

The second chart looks at hand hygiene compliance a key indicator of good infection control practices. The compliance within the Trust runs at an average of 95%, where this drops the area is re-audited until compliance is assured.

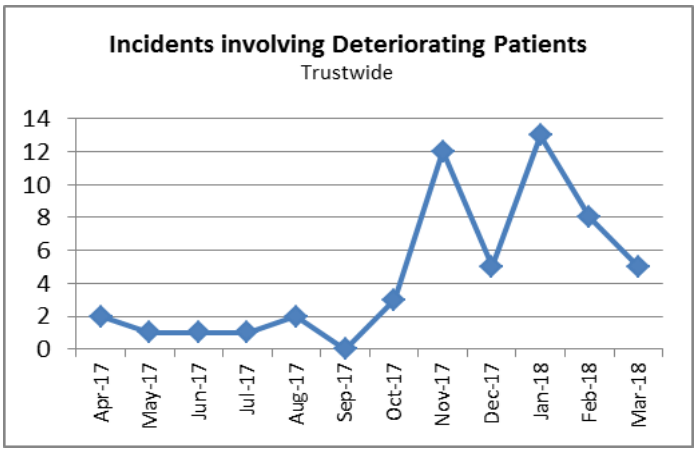
Chart 20



Appendix 7
Recognition and Rescue including
Cardiac Arrest, Vital Pac observations, Treatment Escalation Plans

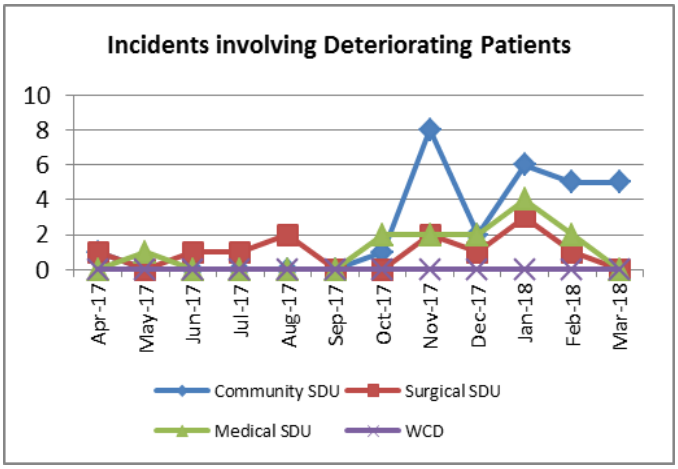
Rapid assessment and recognition of a patient who is deteriorating is a corner stone of any care system that fits hand in glove with a prompt response and appropriate treatment. The Trust has refocused this year in this area and a Deteriorating Patient (DP) group has been formed

Chart 22 – 2 charts



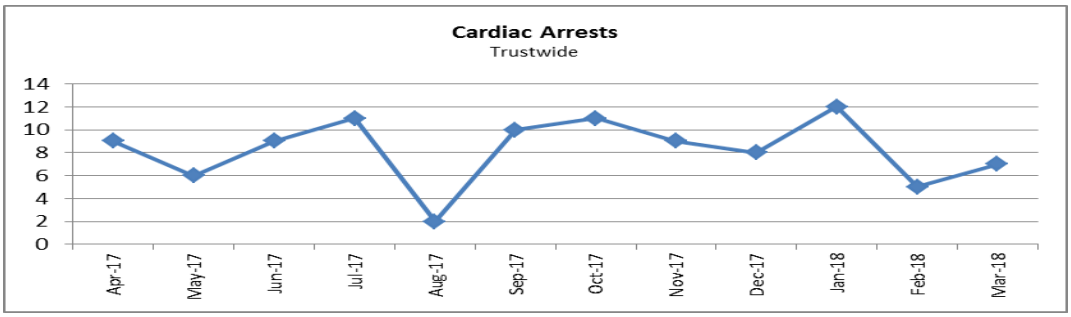
Work started around the October time to record incidents associated with the deteriorating patient, hence the distribution of the chart to help inform and direct activity

The opposite chart highlights the DP by SDU. As care is now provided in a variety of settings it is not surprising that DP issues are being picked up in the community stetting, particularly in Intermediate Care



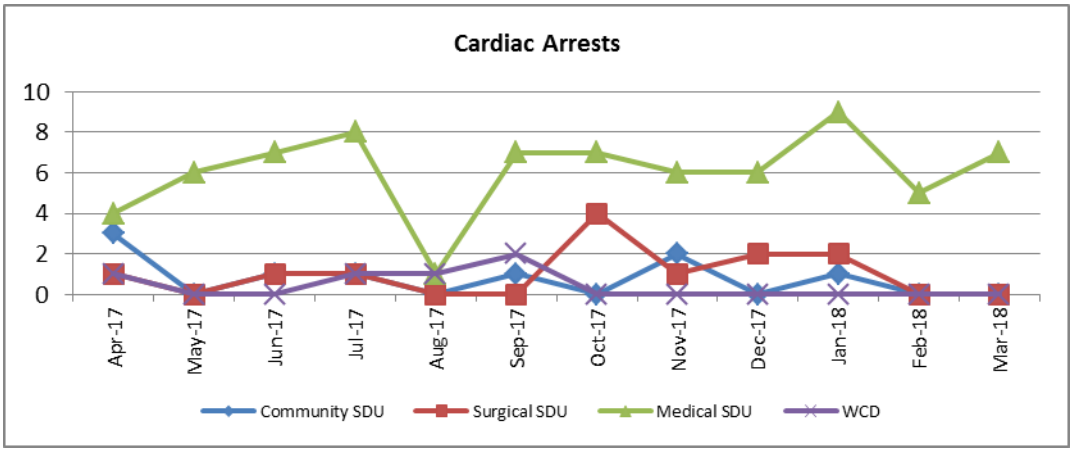
Traditionally activity has focused on, Sepsis or Cardiac Arrest (CA), these being very specific conditions with a set protocol to follow. Much work has gone into these areas and the CA numbers are low and reducing over the year – please see chart below

Chart 23



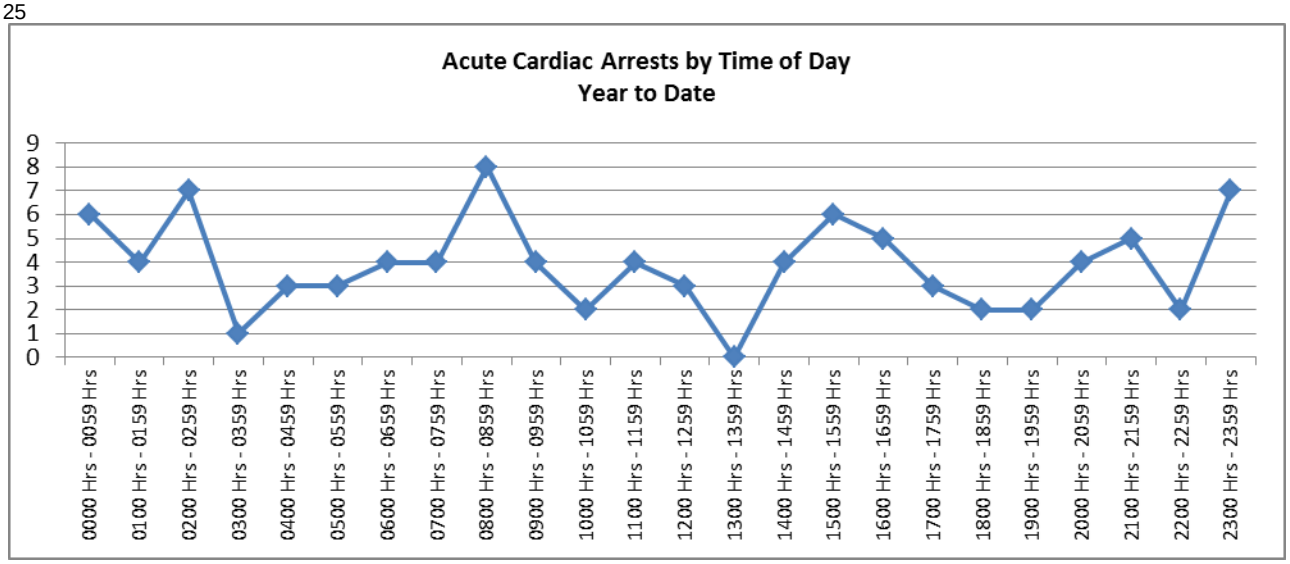
The distribution of arrests within the SDUs will fall more to Medicine so the below chart is within expectation.

Chart 24

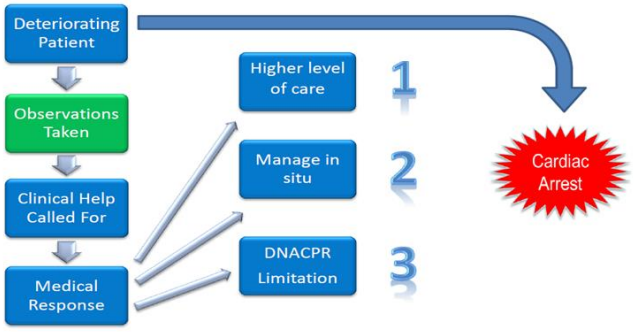


The next chart highlights arrests by time bands with peaks at the 2am, 8am and 11pm time bands. This level of data can help direct resus training

Chart 25



The following slide highlights how the Trust wants to move to managing the DP.

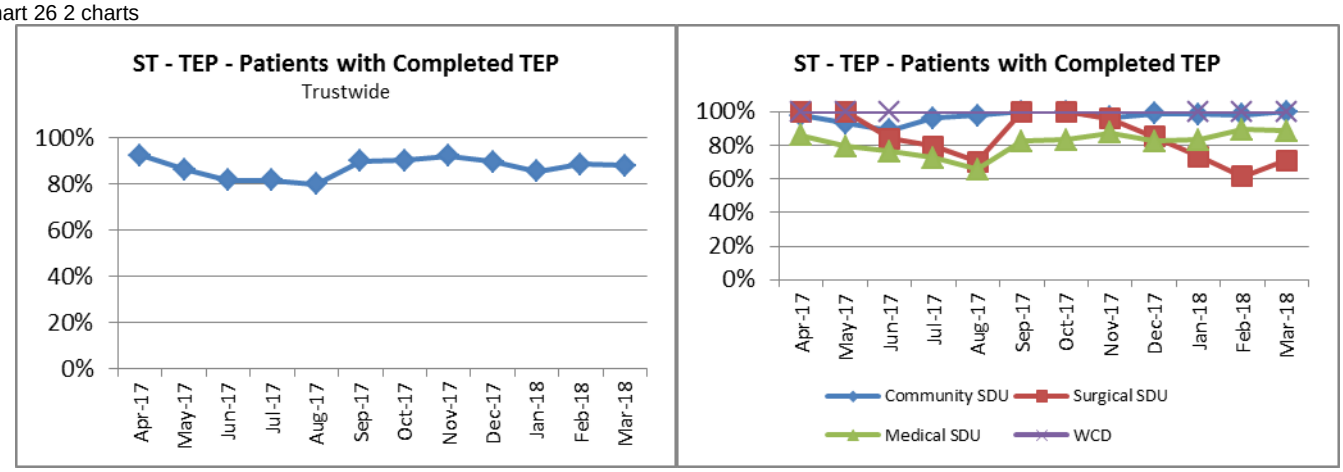


The aim is to identify and respond in one of three ways, refer to a higher level of care, treat in situ or apply a treatment escalation plan (TEPs).

Calls to outreach are monitored and triggered by a high Early Warning Score (EWS) and this system is well embedded.

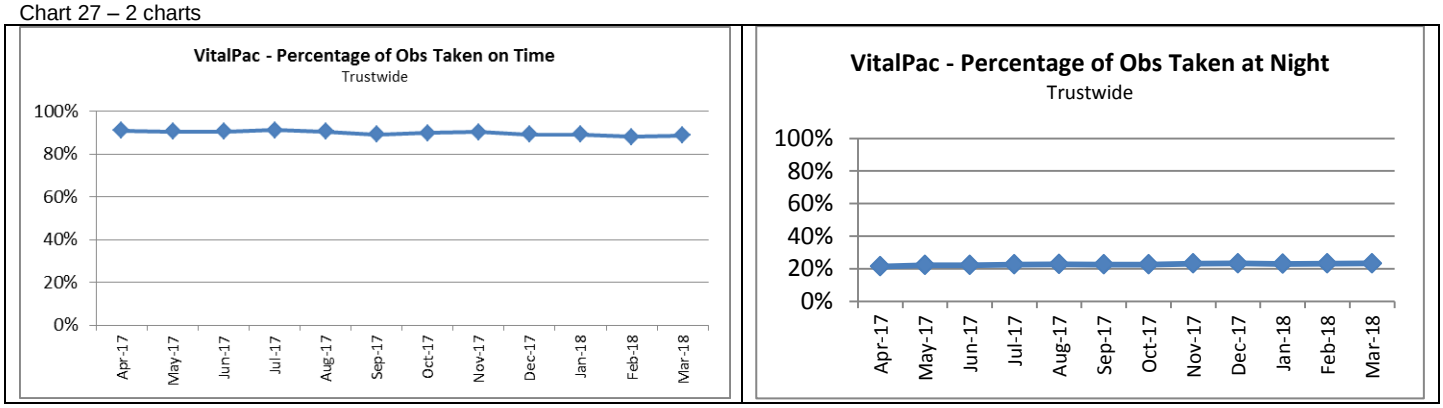
The Trust has been at the forefront of TEPs and our audits highlight a high compliance of patients having a relevant plan in place.

Chart 26 2 charts



The trust also has a well-established vital signs monitoring package, which is electronic and well used. The monthly data shows high compliance to patients having their EWS monitored both during the day and at night

Chart 27 – 2 charts



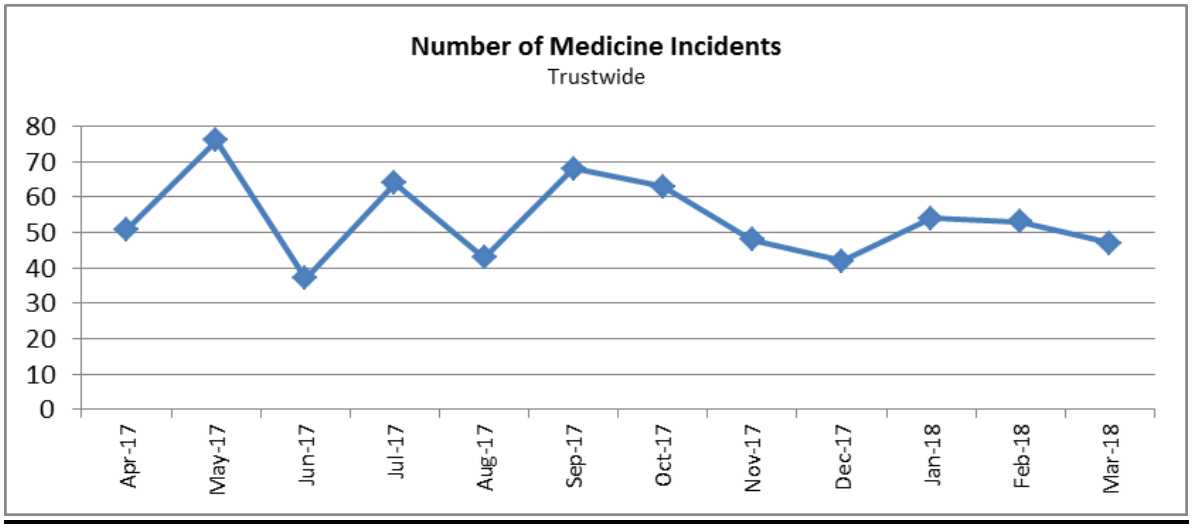
The work for the coming year will be to focus on the timely response to make sure it is suitable and sufficient. This will be achieved and monitored through the Deteriorating Patient Group.

Appendix 8
Trustwide Medication Safety
Please note the timescale as some charts run from Jan 2017 but all end in Mar 2018

This dataset looks at the Trust's patterns of medication incidents by number, harm, type, category and stage. All medication errors are reviewed by the Governance Pharmacist and are reported to the Medicines Management Committee. The reports help dictate the medicines management work that pharmacy undertakes.

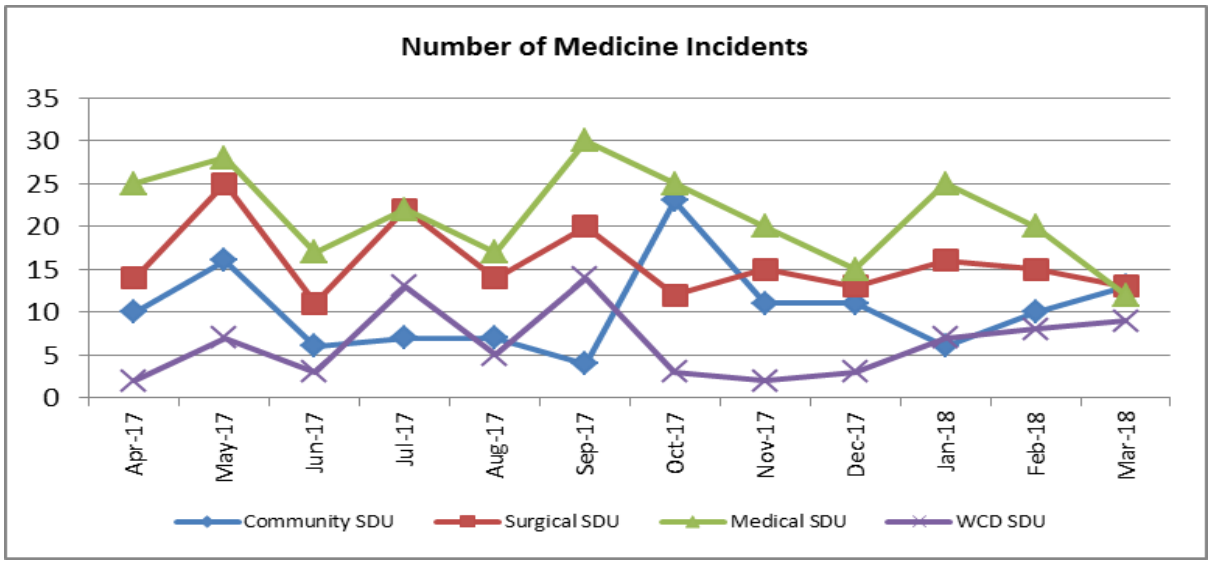
Trust Medication Incidents

Chart 28



We continue to see a slight decline in incident reporting over this year which was also evident last year too. Pharmacy have continued to encourage incident reporting through their newsletters and via the central team.

Chart 29

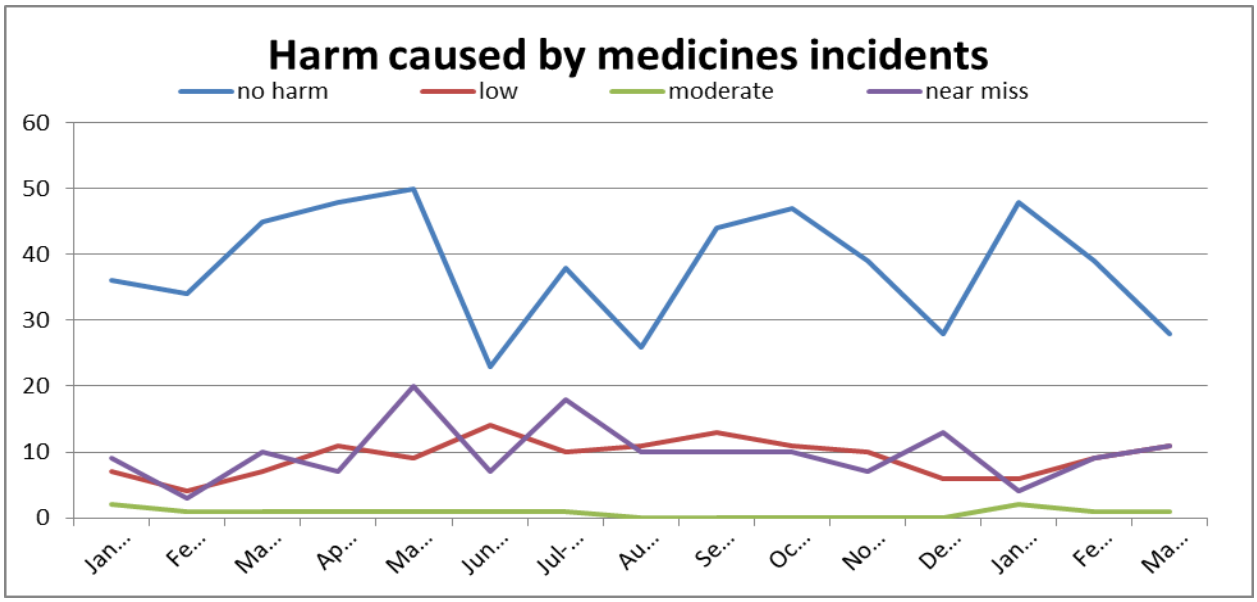


The above breaks incident reporting down to the SDU level

Harm

Nationally over 90% of incidents reported to the NRLS are associated with no harm or low harm and our rate this quarter was 99.4% which is good.

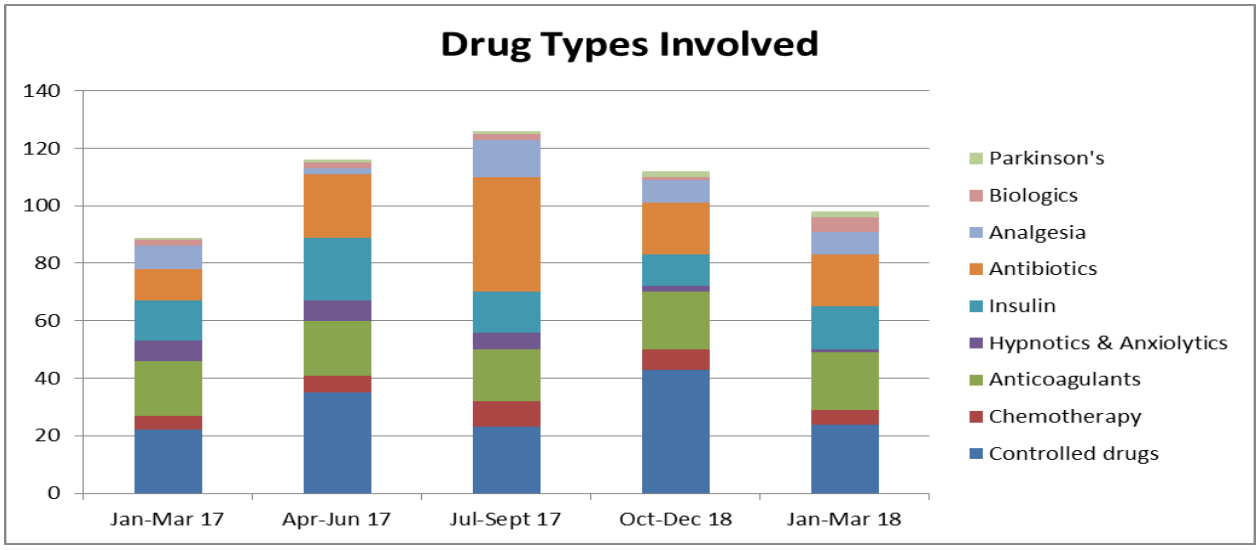
Chart 30



Of the incidents recorded as moderate, key learning's have including changes to ensure 'weight' is recorded accurately, and checks of hospital number, name age and date of birth are undertaken

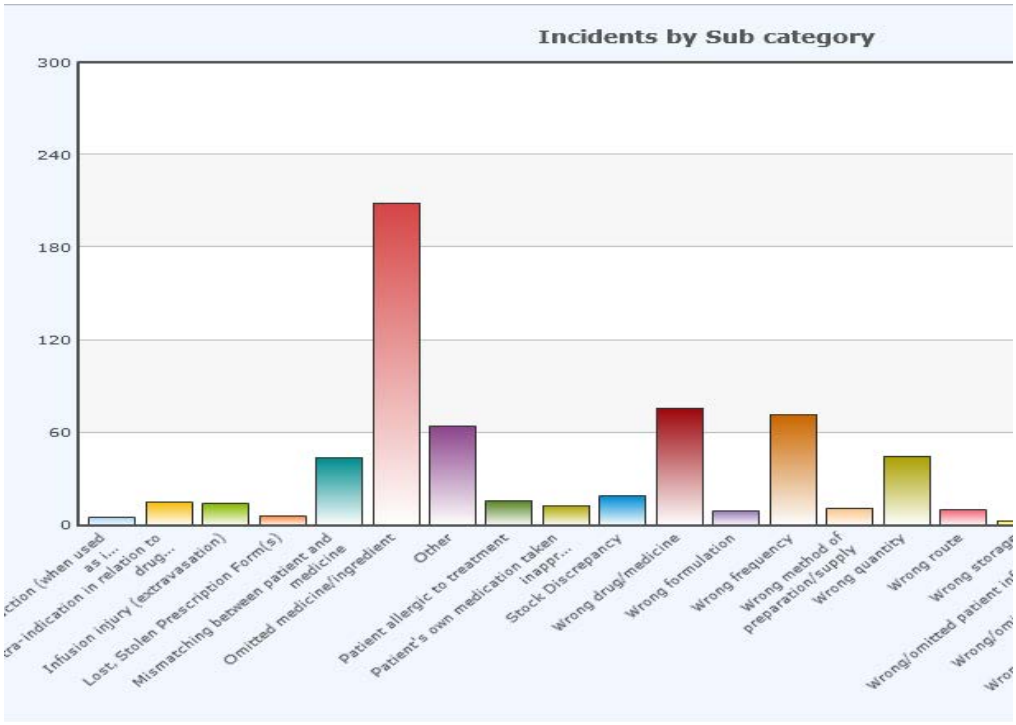
Type of Medicines in Incidents

Chart 31



Controlled drug incidents are mainly stock discrepancies highlighted by the daily checks and documentation issues with syringe drivers. The syringe driver incidents (deemed a medical device) are reviewed by the Medical Devices Support Officer to ensure any training needs are met.
Each medication type is shared with the associated pharmacist for trends or issues.

Chart 32

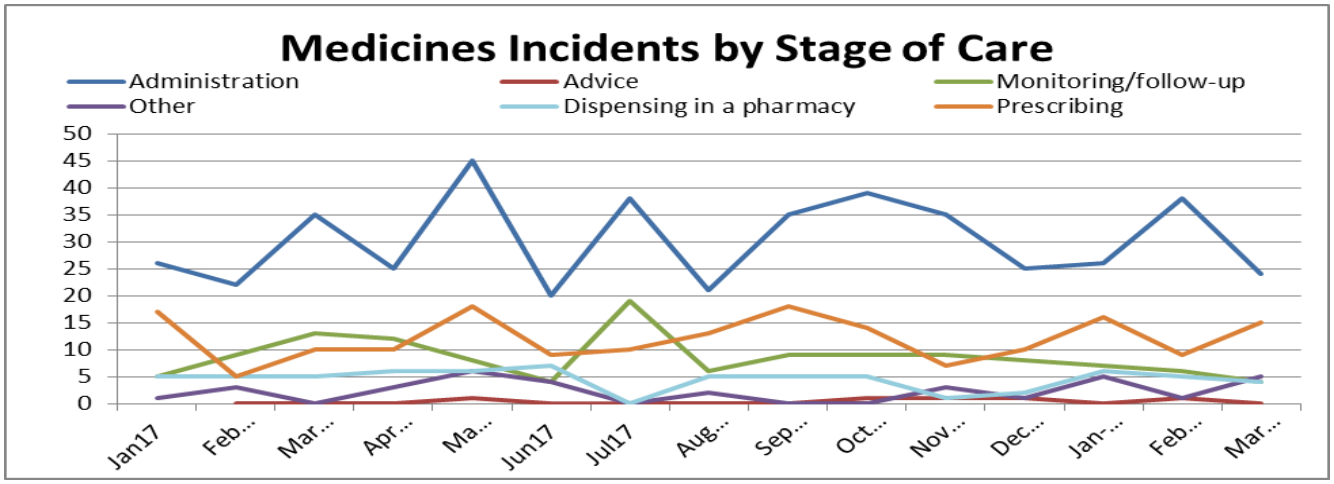


Categories of Medicines Incidents

Nationally the most frequently reported types of medication incidents to the NRLS involve the wrong dose, omitted/delayed medicines or the wrong medicine. Our top three are omitted medicines, wrong/unclear dose and wrong medicine

Breaking down the medicine incidents further by looking at the stage of care, this shows that the majority of incidents involve administration or prescribing. The “other” incidents were mainly documentation errors which don’t fit into the categories available.

Chart 33

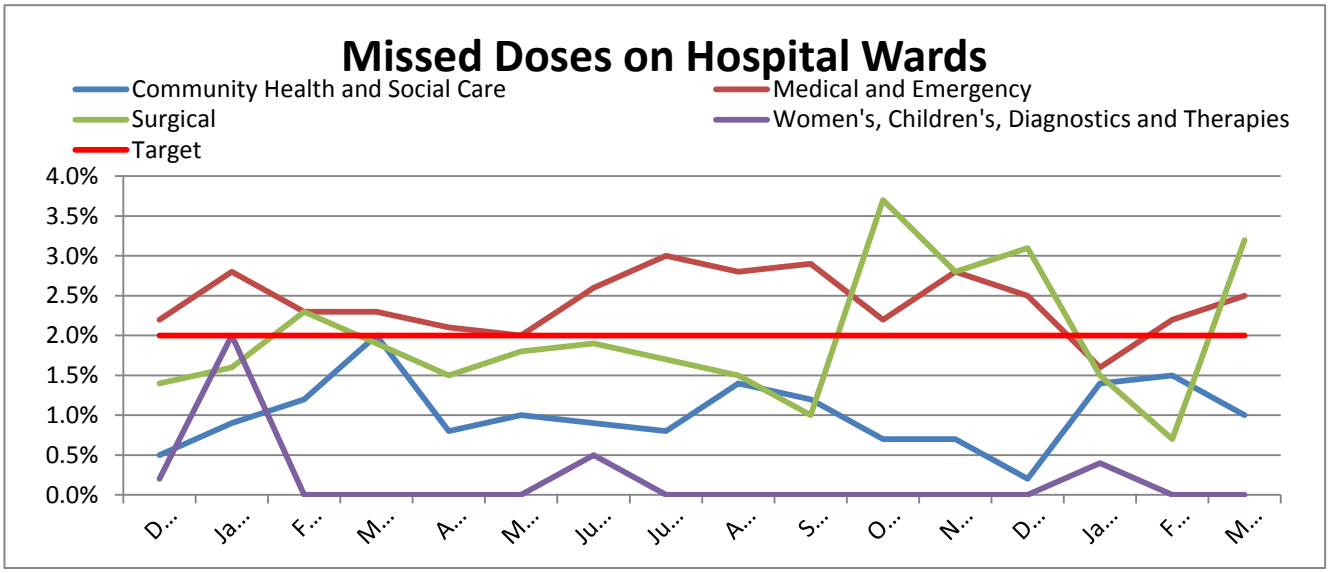


This information helps in planning training and also in the preparation and implementation of electronic prescribing

Missed Doses

Missed dose work continues and the wards are given feedback on this aspect of care. Two of the 4 SDUs are below target with more work required in Medicine and Surgery. The latter missed doses within the Surgical SDU may be as a result of more medical patients being housed on a surgical ward due to the winter plan

Chart 34



Medication: Some of the Key Action areas for 2017

Key Areas of Concern	Action	Date Due	Responsibility
Biologics	Monitor as no themes identified but an area where usage is increasing.	On-going	Senior Pharmacist
Controlled drugs	Audit actions: Daily checks Recording of patient's own CDs Documentation of receipt Ward information packs	Apr 18	Ward managers / Pharmacy MMTs
Paediatrics	Increase in incidents. Awaiting feedback.	May & Ongoing	SDU Coordinator
Home care	Issues to be raised at contract review meeting with all the companies and at the PPSA meeting.	Apr 18	Pharmacy Tech

EOL **Lack of timely access to medicines.**	**EOL Committee to review processes around PMARs & medicines supply and the JICB policy.**	**Ongoing**	**End of Life Consultant**
PGDs **Increase in requests.**	**For discussion at MMC.**	**Apr 18 and ongoing**	**MMC**
Allergies	**QI project**	**Oct 18**	**Senior Pharmacist**

Appendix 9
Trustwide Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE)

The Trust records all positive DVTs and PEs via the incident reporting system. The trigger for this is a positive scan, via radiology, and a hospital admission within the last 90 days, this being in line with NICE guidance.

According to the audits undertaken, the Trust is compliant with 95% VTE risk assessment on admission target set by commissioners. Where incidents are investigated data from the RCAs supports the audit in terms of patients receiving VTE risk assessment at the target of 95%.

From the investigations, in a few cases the main reason patients were consider not to have received appropriate treatment was due to a missed doses and one had missed calculated dose due to a weight issue. These have been fed back to the areas

RECOMMENDATIONS

1. Ensure that patients receive appropriate treatment by:
    a. accurately recording doses administered
    b. ensuring that any omitted doses are recorded in the medical notes
    c. when patients are moved to different areas the receiving ward is aware of any omitted/pending doses due
    d. dose is adjusted according to weight and if not appropriate the reason is documented in the medical notes

Appendix 10
Trustwide Pressure Ulcers

The following indicators on pressure ulcers will include total number hospital acquired, total identified on admission to SDHCFT, numbers by grade.

Chart 35 (below) highlights the increased reporting of all grades of pressure ulcer within the Trust. This is down to the increased surveillance and reporting the Trust has encouraged in this area of patient harm. The second chart shows the grade of PU by number and month. The vast amount of PU are in the grade 2 category chart 36

Chart 35

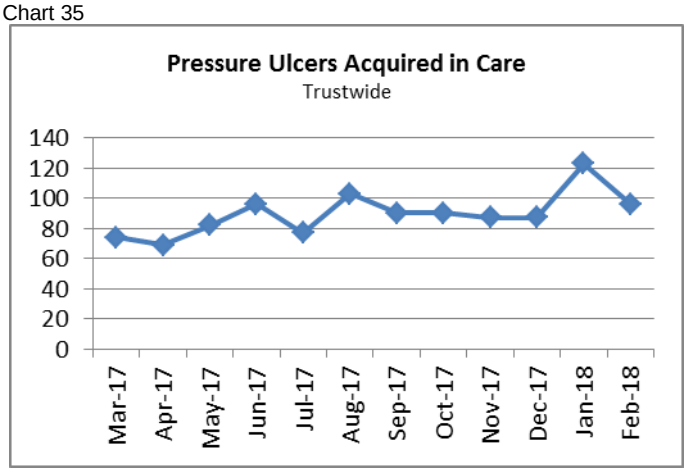
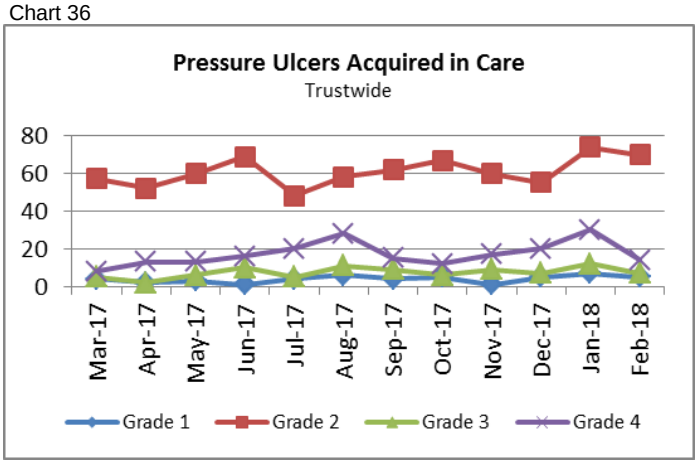
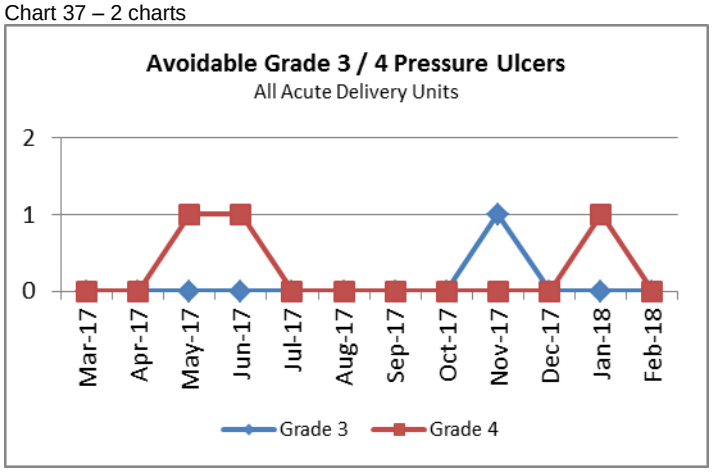


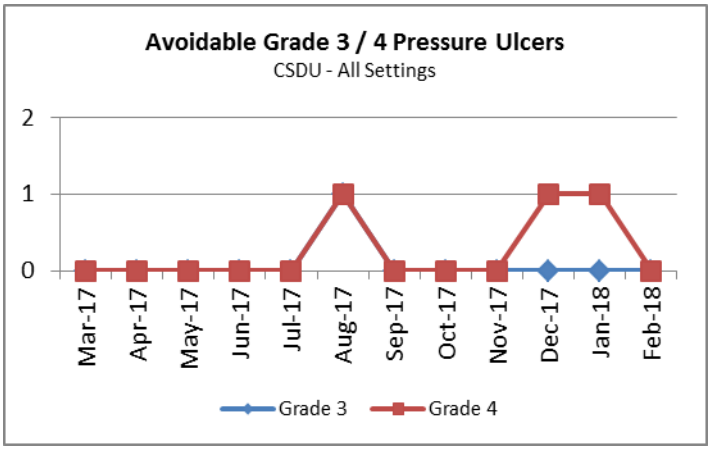
Chart 36



The following charts record the avoidable grade 3 and 4 PUs by acute hospital and community

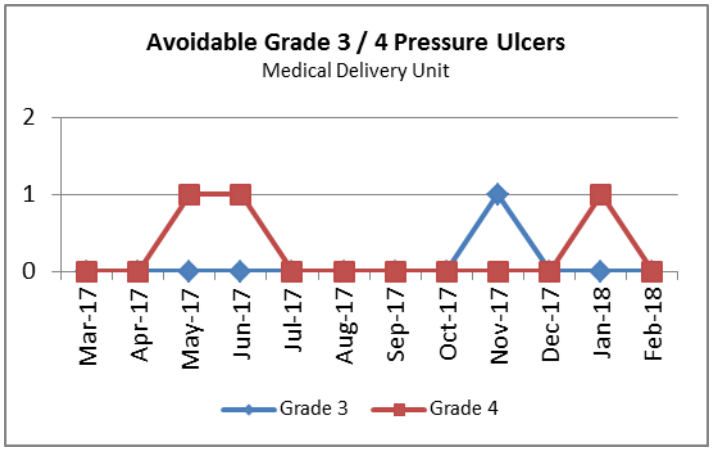
Chart 37 – 2 charts

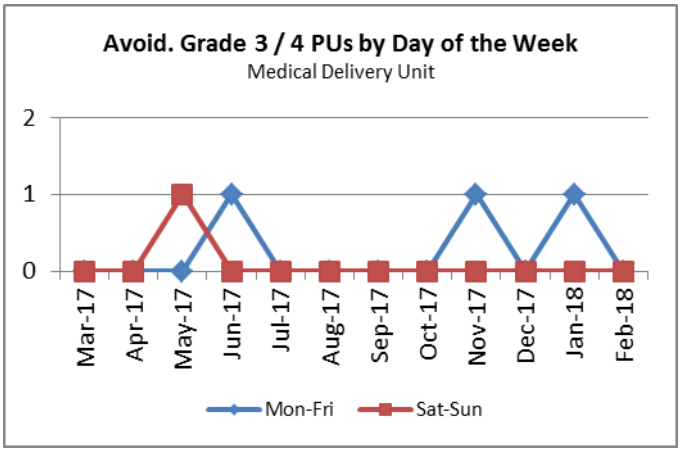


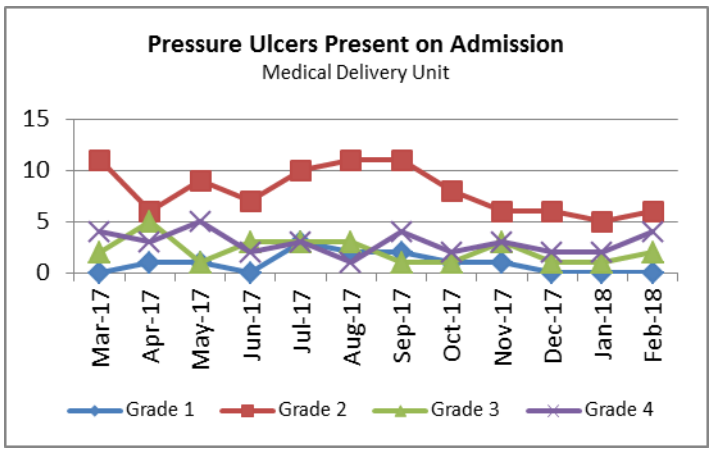


The following charts highlight avosibale PUs by SDU

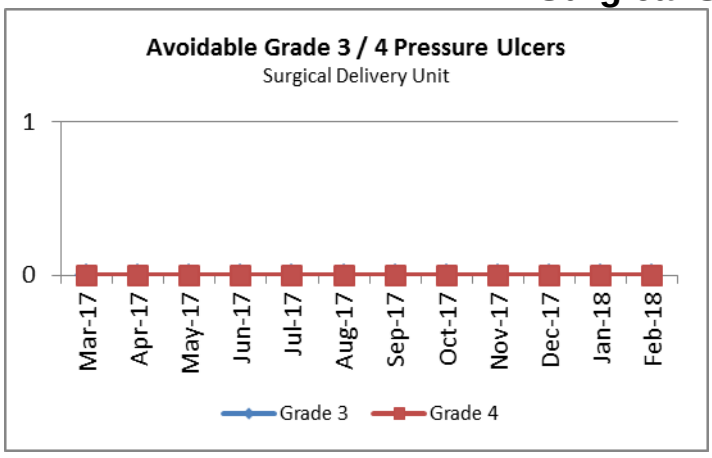
Medical SDU charts 38

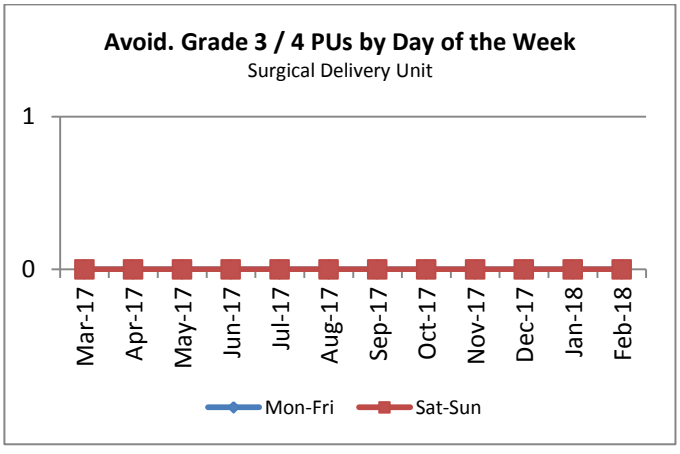


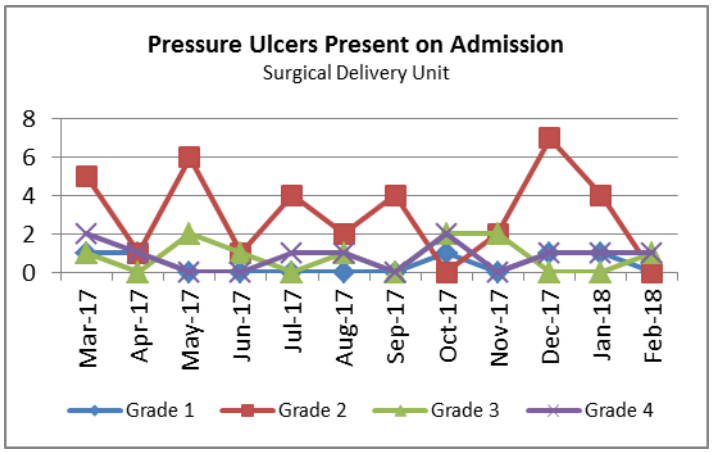




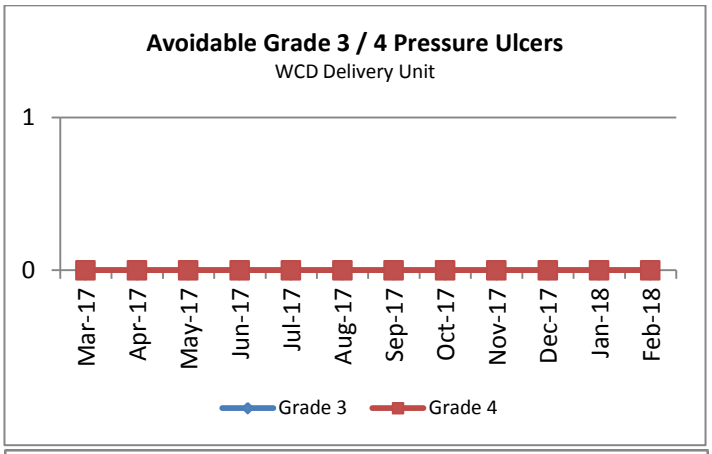
Surgical SDU charts 39

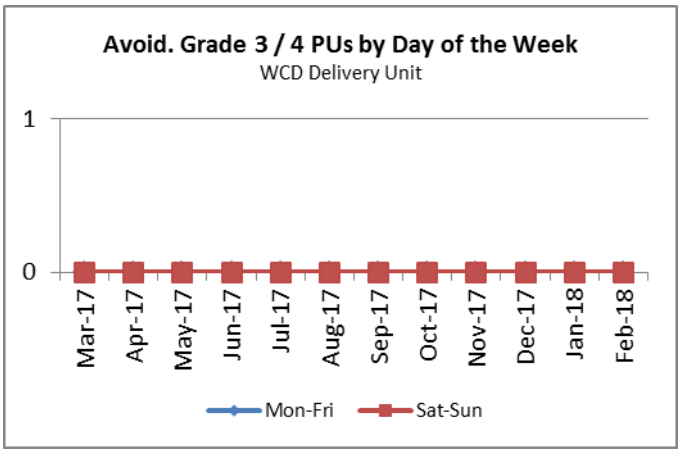


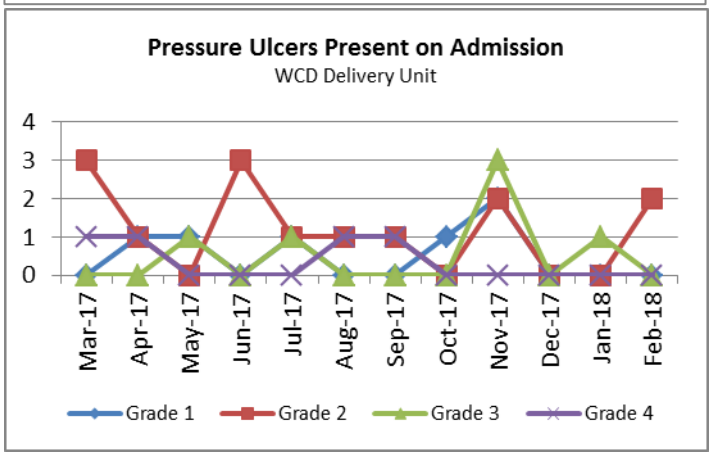




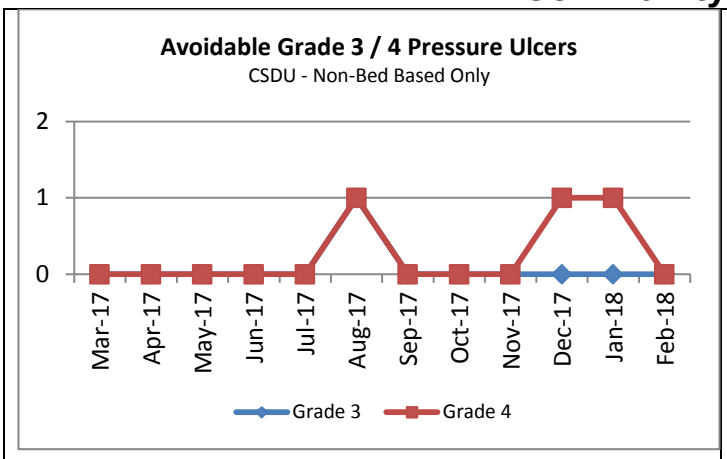
WCT SDU charts 40

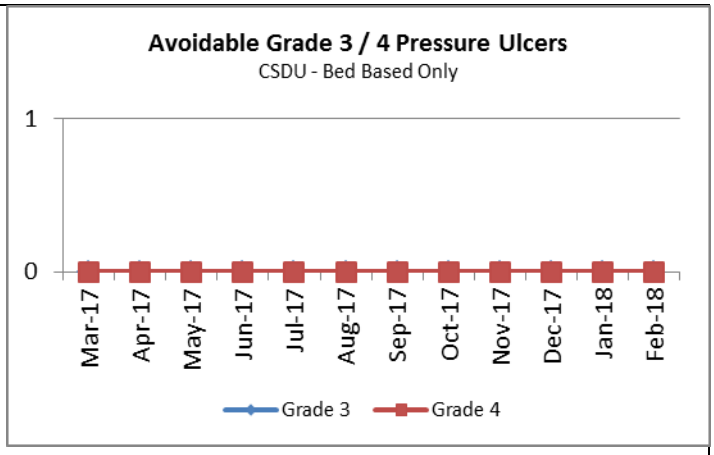


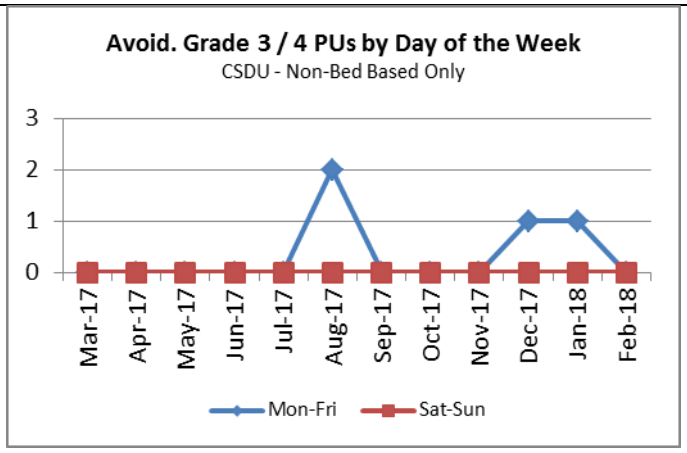


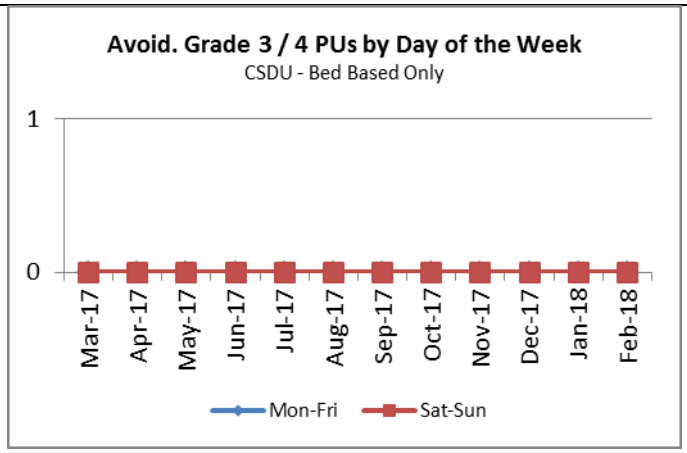


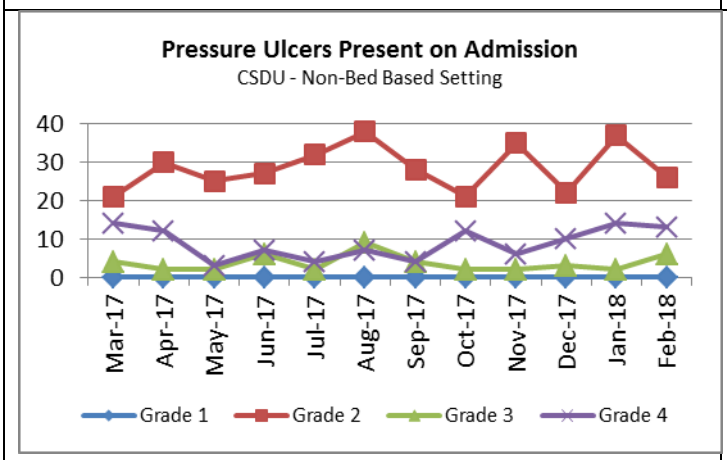
Community SDU charts 41

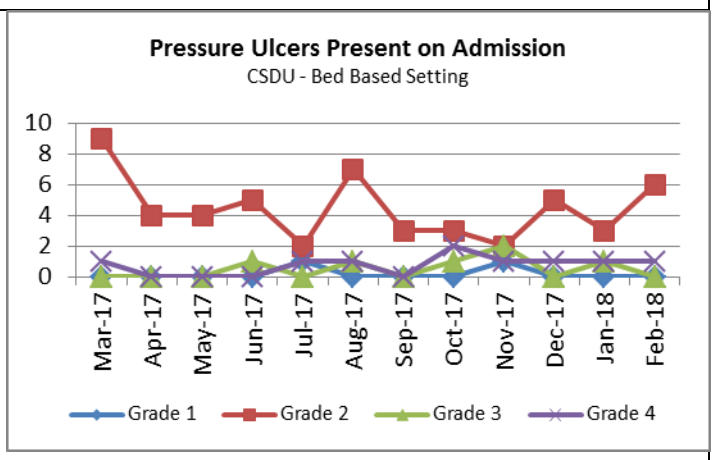












The work directed by the Tissue Viability Nurse and the Pressure Ulcer Steering Group to date includes:

- The current position within the Acute hospital is that we have had 4 Grade three or four (EPUAP) avoidable pressure ulcers against a target of 5.5 which provides evidence that we are currently 27.3% below our target level. This means Trust wide we have had 7 patients develop Grade three or four pressure ulcers which, given that two years ago we had an average of 17 per year, I think is a remarkable achievement.
- All Grade three and Four (EPUAP) pressure ulcers are reviewed buy the Tissue Viability Team with stickers placed in patients notes to indicate grade and origin of damage.
- All incidents forms relating to Pressure damage are reviewed by Senior Tissue Viability Team members to support Governance teams and advise as required re on-going investigations.
- All SSKIN chronologies are reviewed by Senior Tissue Viability Team members to support Governance teams and advise as required re ongoing investigations
- Weekly meetings are held between Senior Tissue Viability Team members and the ASDU Governance teams to ensure proactive review and investigation of Pressure Ulcer Incidents across the Unit.
- Daily contact is maintained between the between Senior Tissue Viability Team members and CSDU Governance to ensure proactive review and investigation of Pressure Ulcer Incidents across the Unit.
- Wards involved in the Collaborative initiative utilise the SSKIN bundle, and intentional care forms, for all patients to ensure Pressure areas are regularly monitored and appropriately documented.
- All areas across the CSDU continue to utilise the SSKIN bundle patients to ensure Pressure areas are regularly monitored and appropriately documented.
- All wards now have access to Formulary approved dressings which means all patients received appropriate Tissue Viability care at first point of contact.
- All Tissue Viability referrals are responded to, during weekdays, within a 24 hour window exceeding the Tissue Viability referral criteria.
- All patients continue to have access to high quality pressure relieving equipment to endure appropriate pressure relief, across all ward areas.

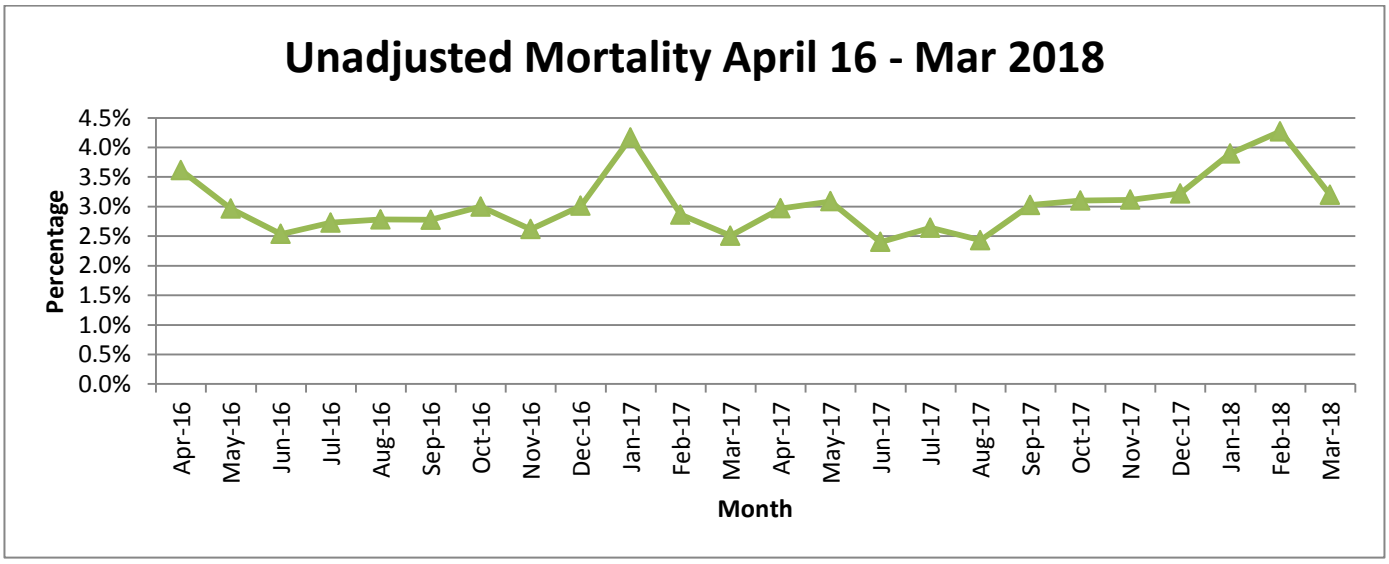
Appendix 11
Mortality

As a balancing measure this last section looks at mortality, both unadjusted (hospital data) and standardised through Dr Foster's Hospital Standardised Mortality rate (HSMR) data and the Department of Health's (DH) Summary Hospital Mortality Index (SHMI).

The hospital data is defined as the monthly unadjusted or 'raw' mortality and is computed as follows:

- Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).
- Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
- Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

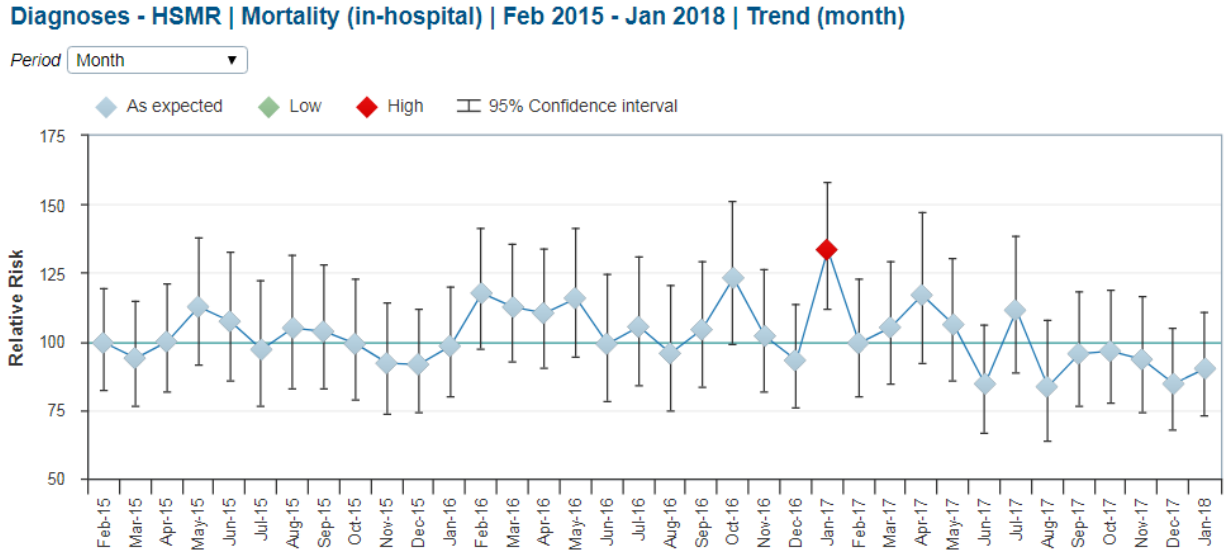
The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.



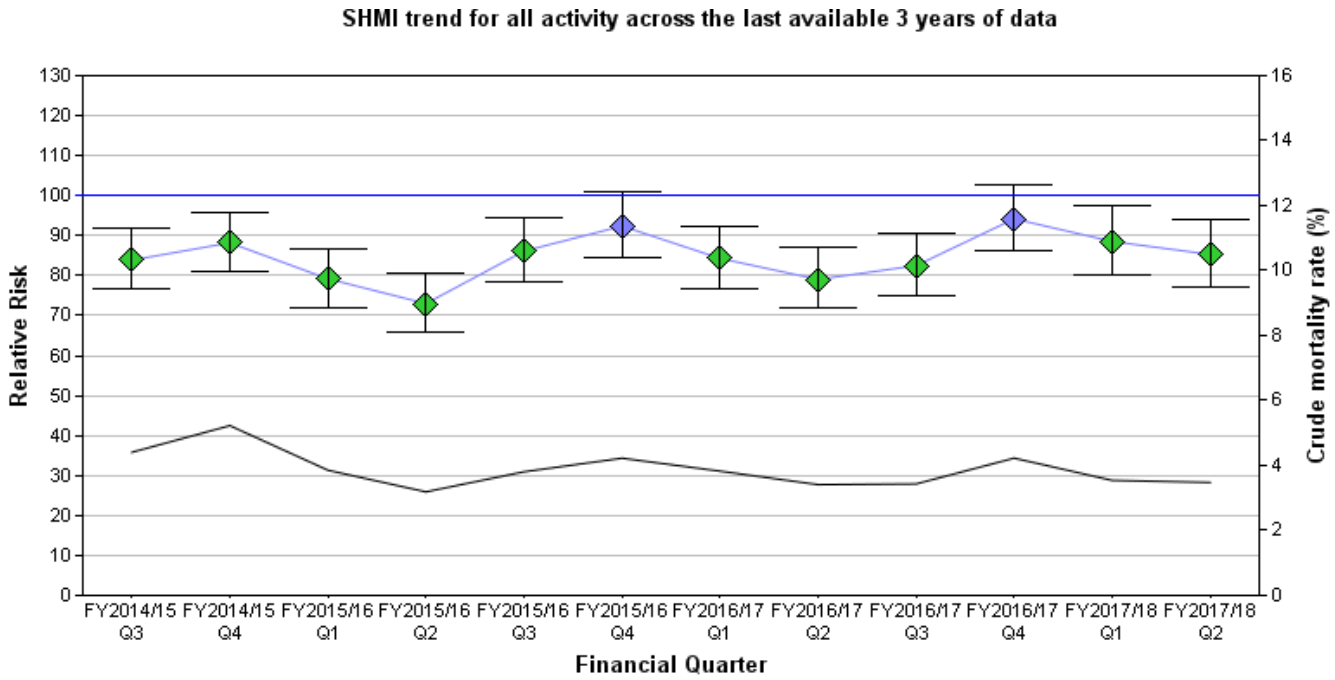
Comment
Mortality is seasonal and more deaths are naturally seen in the colder months of the year. Overall the trend is stable and in line with the Trusts median target of 3% mortality over the year.

The HSMR is calculated using various methods involving deprivation scores, the Charlson index, and comorbidity index.

The chart below shows Trend by Month over the time period Feb 2015 – Jan 2018 (the most current data point). For most of 17/18 the trend has been below the 100 average line, which is to be welcomed and highlights our mortality data to be in-line with our expectations and better than the national average.



The SHMI data, as below, which is produced by the Department of Health also remains in a positive position and performing better than the national average.



Taking into account, HSMR, SHMI and the unadjusted data the Trusts mortality is performing better than the national average which is to be encouraged. Our learning from deaths process have help highlight good practices which we share within the organization, including good clear communication via such tools as SBARP (Situation Background Assessment Recommendation Patient), consultant led care, multidisciplinary care, which includes the patient and family. The learning's have also highlighted early recognition of the

deteriorating patient with appropriate intervention, including Intensive Care outreach and vital signs observation.

Further work will follow in the coming year focusing on:

1. Appropriate referred into a higher level of care
2. Appropriately managed in situ
3. Appropriately apply a treatment escalation plan

The aim is to stream all deteriorating patients into one of these management groups with the aspirational goal of eradicating all cardiac arrests

Cover sheet and summary for a report to the Trust Board Meeting 23th May 2018					
Report title: 2018 TSDFT CQC Draft Inspection Report summary				Date: 23rd May 2018	
Report sponsor	Chief Nurse				
Report author	Cathy Bessent / Claire Burton				
Report provenance	First presentation of this summary. Full 2018 Draft Inspection Report previously made available to Board.				
Confidentiality	Draft Inspection Report confidential until publication of Final Inspection Report				
Report summary	This report summarises the following from the TSDFT Draft CQC Inspection Report, which reported on the findings of CQC inspections of five core services performed on 13th, 14th and 20th February 2018, and of the Trust leadership performed on 6th-8th March 2018: • Key messages / themes • Key comparisons to the Final Inspection Report from 2016. • Requirement notices and associated TSDFT timelines • CQC process next steps.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	For information only, as only the draft of the CQC Inspection Report is currently available.				
Summary of key elements					
Strategic context	Strategic aims supported: • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	On CQC website: TSDFT 2016 Final CQC Inspection Report TSDFT 2017 Final CQC Inspection Report				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting dated 15th May 2018 • CQC Assurance Group dated 23rd April 2018				
Stakeholder engagement	The following stakeholders were consulted during the compilation of this report: • Core service leads (action plans)				
Other standards affected	Compliance with Health and Social Care Act, as stated in Requirement Notices (table 2)				
Legal considerations	Compliance with Health and Social Care Act, as stated in Requirement Notices (table 2)				

Report title: 2018 TSDFT CQC Draft Inspection Report summary		Date: 23rd May 2018
Report sponsor	Chief Nurse	
Report author	Cathy Bessent / Claire Burton	

1. Introduction

1.1 Background

Torbay and South Devon NHS Foundation Trust (TSDFT) previously received an overall Care Quality Commission (CQC) rating of "Requires Improvement" in the inspection of February 2016. Following this, in May 2017, two core services were inspected: Urgent & Emergency Services, and Medical Care. These services were both rated "Good". This did not change the overall Trust rating, which remained as "Requires Improvement."

In January 2018, the Trust received notification of the dates of the Well-Led inspection to be undertaken 6th-8th March 2018. The Trust was also informed that at least three core services would receive an unannounced inspection in the lead up to the Well-Led inspection.

The CQC performed unannounced inspections on 13th, 14th and 20th February 2018 of five core services: acute maternity; acute outpatients; acute end-of-life care; community end-of-life, and community children and young people. However, both community core services had two weeks' notice due to the need to allow the Trust to gain patient consent in order for the inspectors to accompany home visits.

It should be acknowledged that these core service inspections were undertaken during a half-term week when some service leads were not available. The staff who responded did so informatively and with generosity of time. As with the 2016 inspection, the Trust was still experiencing significant winter pressure constraints.

On 6th-8th March 2018, the CQC performed the announced Well-Led inspection of the Trust leadership.

Following the February and March inspections, the Trust received initial high-level feedback which has previously been communicated to the Board. The full Draft CQC Inspection Report was received on 16th April 2018 and has been previously made available to the Board. The factual accuracy check of the Draft CQC Inspection Report was completed and comments submitted to time on 30th April 2018.

1.2 Aim

This report aims to summarise the key messages from the 2018 Draft CQC Inspection Report of TSDFT, highlight key comparisons to the Final CQC Inspection Report from 2016, state the 2018 Requirement Notices with TSDFT actions, and provide the next steps in the CQC process.

1.3 Purpose

The purpose of this report is to maintain the Board's awareness of TSDFT's CQC inspection status and provide early signalling of areas requiring action to improve the healthcare service provided.

2. Discussion

Key messages from the 2018 Draft CQC Inspection Report and comparison to the 2016 Final CQC Inspection Report.

The overall Trust rating is "Good" in the 2018 Draft Inspection Report, compared with "Requires Improvement" in the 2016 Final Inspection Report (see Table 1 for overall ratings per core service for 2018 and 2016).

Table 1: the overall ratings from CQC for each core service in the TSDFT Draft Inspection Report for 2018 and in the TSDFT Final Inspection Report for 2016.

Core Service	**2016 Overall Rating**	**2018 Overall Rating**	**Direction of travel from 2016 to 2018**
Acute maternity[1]	Good	Requires Improvement	↓
Acute outpatients[2]	Requires Improvement	Good	↑
Acute end-of-life care	Requires Improvement	Good	↑
Community end-of-life	Requires Improvement	Requires Improvement	→←
Community children and young people	Requires Improvement	Good	↑
Overall	**Requires Improvement**	**Good**	↑

[1]Maternity service was inspected in 2018. Maternity and gynaecology services were inspected in 2016.

[2]Outpatients service was inspected in 2018. Outpatients and diagnostic imaging were inspected in 2016.

General positive themes in the 2018 Draft Inspection Report include:

- Positive culture for incident reporting throughout the report
- Robust Duty of Candour process and evidence of implementation
- Learning from complaints
- Staff felt well supported by managers and senior leaders in the Trust.
- Inspectors noted improvements since the 2016 inspection. One such mention in the report states: "The integrated care organisation felt more connected than it had at our last inspection, and this was reflected in the staff feedback."

General themes requiring improvement in the 2018 Draft Inspection Report include:

- Not all staff completed mandatory training, including safeguarding training
- Multiple references to the cleaning of the environment and equipment in several settings, however, the only Requirement Notice relates to the Fracture Clinic environment.
- Care Plans, including those for end-of-life, were not consistently applied.

Of the CQC's five key questions, overall Trust ratings are lowest for Safe, with a frequently cited issue being failure to achieve the Trust's mandatory training compliance threshold.

Of the CQC's five key questions, overall Trust ratings are highest for Caring. As with previous inspections, the report contains numerous examples of where staff have gone the extra mile.

In the 2018 Draft Inspection Report, there are 13 "Must Do" improvements needed to improve and bring services in-line with legal requirements (i.e. Requirement Notices), compared with 47 in the 2016 Final Inspection Report.

In the 2018 Draft Inspection Report, there are 44 "Should Do" improvements required to comply with minor breaches that did not justify regulatory action, or avoid breaching a legal requirement in the future, or to improve services, compared with a total of 84 across all the final location reports for the 2016 inspection.

Table 2: 2018 Requirement notices - 13 "Must Do" improvements

#	Requirement Notice ("Must Do" improvement from CQC)	Core service inspected	Action (set by Trust)	Timeline	Monitoring Pathway
1	Ensure that all maternity staff has in-date mandatory training. *HSCA (RA) Regulation 18: Staffing*	Maternity	Monthly report being completed by education lead midwife.	In place and ongoing	Education Lead Midwife and Head of Midwifery through Maternity Clinical Governance Group
2	Review systems and processes to ensure equipment has had the correct safety checks and audits, with particular reference to resuscitaires. *HSCA (RA) Regulations 12: Safe care and treatment, and 15: Premises and equipment*	Maternity	1) Remind staff regarding the requirement and importance of checks 2) Band 7 midwives to take responsibility for ensuring complete 3) Spot checks by midwifery matron in relation to compliance	1) In progress – 31st May 2018 2) In place and ongoing 3) In place and ongoing	Midwifery Matron through Maternity Clinical Governance Group
3	Review systems and processes to ensure medicines have the correct safety checks and audits and that midwives are following the correct guidance when storing medicines out of fridges. *HSCA (RA) Regulations 12: Safe care and treatment*	Maternity	1) Remind staff regarding the requirement and importance of checks 2) Band 7 midwives to take responsibility for ensuring complete 3) Spot checks by midwifery matron in relation to compliance	1) In progress – 31st May 2018 2) In place and ongoing 3) In place and ongoing	Midwifery Matron through Maternity Clinical Governance Group
4	Ensure the use of maternal early obstetric warning score (MEOWS) assessments are completed and used effectively in line with all policy related to monitoring deterioration and post-operatively. *HSCA (RA) Regulations 12: Safe care and treatment*	Maternity	1) Weekly sampling of compliance 2) MEOWS chart to be updated 3) Relaunch MEOWS chart, including update for staff	1) In place and ongoing until assured compliance is embedded in practice 2) In progress – June 2018 3) August 2018	Education Lead Midwife through Maternity Clinical Governance Group

#	Requirement Notice ("Must Do" improvement from CQC)	Core service inspected	Action (set by Trust)	Timeline	Monitoring Pathway
5	The lead midwife for safeguarding and the nominated individual for safeguarding for the Trust should have the correct level of training to comply with national recommendations. *HSCA (RA) Regulations 13: Safeguarding service users from abuse and improper treatment, and 18: Staffing*	Maternity	*We have challenged the factual accuracy of this 'must do'.* *We do not have a lead midwife role. We have a Specialist midwife for safeguarding children, who has received the appropriate level of training.* 1) The Named Midwife for Safeguarding Children (new in post) to attend Level 4 training	1) External course booked 10th & 11th July 2018	Head of Midwifery through Maternity Clinical Governance Group
6	Ensure care-planning documentation is used consistently to assess and plan the needs of palliative care and end-of-life patients. *HSCA (RA) Regulations 9: Person-centred care*	Acute End-of-Life	1) New End-of-Life care documentation is being rolled out across the ward areas of the Trust during Q1 and Q2. 2) The Specialist Palliative Care lead nurse will undertake regular routine snapshot audits to monitor adoption and completion of the documentation. 3) Care planning in all areas is being reviewed by a small working party under the management of the Deputy Chief Nurse.	1) First cohort of wards by June 2018. 2nd cohort during July and August 2018. 3rd and final cohort by end September 2018. 2) To commence beginning Q2 3) 1st meeting of working party end of Q1.	1) The implementation is being led by the SPCT lead nurse and is being monitored through the ICO End-of-Life group. Improving standards of documentation is one of the specific issues on the EoL group workplan, which is monitored on a monthly basis through the EoL group. The EoL group sends an update reports to QIG each month with key issues escalated via the DDoN. 2) End-of-Life group and QIG 3) Through Senior Nurse Strategy Group
7	Ensure that Trust targets are met for the completion of mandatory training updates for both medical staff and nursing staff in the outpatients service. *HSCA (RA) Regulation 18: Staffing*	Acute Outpatients	1) Specialty Clinical Directors to undertake a review of medical staff mandatory training in their areas of responsibility. 2) Training dates to be allocated by individuals	1) by end of Q1 2) achieved during Q2/3.	Monitored through SDU governance Board and monthly QPR meetings with executive and senior manager groups.

#	Requirement Notice ("Must Do" improvement from CQC)	Core service inspected	Action (set by Trust)	Timeline	Monitoring Pathway
8	Ensure that Trust targets are met for the completion of safeguarding updates for both medical staff and nursing staff in the outpatients service. *HSCA (RA) Regulation 18: Staffing*	Acute Outpatients	1) Specialty Clinical Directors to undertake a review of medical staff safeguarding training in their areas of responsibility. 2) Training dates to be allocated by individuals	1) by end of Q1 2) achieved during Q2/3.	Monitored through SDU governance Board and monthly QPR meetings with executive and senior manager groups.
9	Ensure that the renovations for the fracture clinic continue as planned and are not delayed to address the risks identified around infection prevention and control, the environment, and privacy and dignity. *HSCA (RA) Regulations 15: Premises and equipment*	Acute Outpatients	1) Initial planning meeting to review scope of renovations to ensure best value in use of vanguard unit 2) 16-week programme to renovate the Fracture Clinic *To be confirmed*	1) Immediately following inspection - COMPLETE 2) Renovation work to commence on 30th April 2018 *To be confirmed*	Through SDU and Estates
10	The Trust must ensure the Mental Capacity Act 2005 is complied with. *HSCA (RA) Regulations 11: Need for consent*	Community End-of-Life	1) Training compliance will be reviewed across the Community SDU 2) Training dates to be identified and staff allocated training	1) Q1 2) Q2/3	SDU Board

#	Requirement Notice ("Must Do" improvement from CQC)	Core service inspected	Action (set by Trust)	Timeline	Monitoring Pathway
11	The Trust must monitor and have systems in place to ensure that all staff are up-to-date with their mandatory and role-specific training. *HSCA (RA) Regulation 18: Staffing*	Community End-of-Life	1) For the Trust mandatory training (e.g. fire, infection control etc), Community SDU to undertake a review of community staff mandatory training (Locality Managers/Community Leads) in the areas they are responsible for, by end Q1 2) Training dates to be allocated by individuals, achieved during Q2/3. 3) For the role-specific training (Syringe Drivers) By end of Q1 – New education facilitators will be appointed, and will be trained to train others. By end of Q1 – training compliance will have been reviewed across the Community SDU. 4) Training programmes will be established and staff identified to attend.	1) Q1 2) Q2/3 3) Q1 4) Q2/3	SDU Board
12	The Trust must take prompt action to manage and reduce reported risks. *HSCA (RA) Regulation 17: Good governance*	Community End-of-Life	*Awaiting further information from CQC to identify the issue for improvement.*		
13	The Trust must develop full governance processes to enable full oversight of the end-of-life care service and monitor and assess the service provide in order to measure quality outcomes for patients. *HSCA (RA) Regulation 17: Good governance*	Community End-of-Life	*Factual accuracy comments point out that oversight and governance is the same as for the Acute End-of-Life core service. CQC response awaited.*		

CQC Process: Next Steps

- The Final CQC Inspection Report is expected to be received from the CQC by 17th May 2018.
- The action plans will be reviewed and confirmed following receipt of the Final Inspection Report and the progress towards action completion will be monitored through the CQC Assurance Group and SDU Governance Boards.
- Communication to staff and stakeholders will occur following publication of the Final Inspection Report.
- The next TSDFT Engagement meeting with CQC is scheduled for 3rd July 2018. The proposed agenda from CQC follows a new, more prescribed, longer format than previously experienced. A CQC Inspector for Mental Health will be accompanying the regional CQC Inspectors, and staff Focus Group sessions have been requested by CQC. Agenda details yet to be finalised.

3. Conclusion

The 2018 TSDFT CQC Draft Inspection Report recognises significant improvements in the quality of the Trust's services since the 2016 CQC inspections and builds on the improved ratings of Urgent & Emergency Services, and Medical Care in the 2017 CQC inspection of these services.

The Trust was inspected during periods of significant operational pressure. That staff were able to respond with such positivity and pride in their services bears testament to the commitment and high calibre of our staff.

4. Recommendations

This summary Board Report is for information only. The final CQC Inspection Report is due 17th May 2018 and a verbal update will be provided should there be any material changes.

Cover sheet and summary for a report to the Trust Board of Directors					
Report title: Mortality Surveillance Scorecard				Date: 23rd May 2018	
Report sponsor	Medical Director				
Report author	Patient Safety Lead				
Report provenance	Mortality Surveillance Group and Quality Improvement Group				
Confidentiality					
Report summary	The Safety Scorecard has been redesigned to provide focus on mortality. Other aspects of safety and quality of care are included in the Integrated Performance Report. This scorecard is reviewed at the Mortality Surveillance Group and is a key part of the assurance provided, alongside a new public facing mortality dashboard which was launched in December 2017. The mortality dashboard will contain the outcomes, learning and actions from individual mortality reviews, including an assessment of 'avoidability' of death. The aim is to include all patients. There is particular focus on patients with mental health problems and learning disability. There is an expectation of review of the mortality dashboard at Board level on a quarterly basis. A snaphot of the dashboard is included in the body of the report.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	The Trust Board is asked to consider the risks and assurance provided within this report and to advise if further action is required.				
Summary of key elements	The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at TSDFT have been within the desirable range for our population over a prolonged period. In 2017 a divergence in HSMR and SHMI was identified and detailed analysis of the reasons behind this was undertaken with the support of Dr Foster and NHSI. The outcome of the deep dive, discussed in detail at Quality Assurance Committee (QAC) in June 2017, was that it is likely that a number of factors were affecting the recording of our mortality rather than a true deterioration in performance. • A change was made to recording of admissions to community hospitals in June 2017. • Improvements in completeness of coding have been made. Though the effect of these changes will take some months to show through in our SHMI and HSMR data because of the lag in mortality reporting, there is apparent correction of the previous divergence. Overall crude mortality shows a reduction over time, as does the HSMR rolling 12 month data, both of which are encouraging trends.				

	The snapshot of the mortality website demonstrates that a minority of deaths are being assessed for avoidability at the present time. This was highlighted by CQC in the well-led review, though progress at TSDFT is in line with other Trusts. An action plan is in place to improve completeness of reporting.
Strategic context	• Safe, quality care and best experience • Well-led
Dependencies and risk	None identified
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Quality Improvement Group • Quality Assurance Committee
Stakeholder engagement	The membership of Quality Improvement Group includes a patient representative and a representative of South Devon and Torbay CCG.
Other standards affected	None identified
Legal considerations	None identified

Report title: Mortality Surveillance Scorecard		Date: 23rd May 2018
Report sponsor	Medical Director	
Report author	Patient Safety Lead	

Introduction & Data Source

The indicators for this score card have been collated from a variety of data sources using defined methodology. The report is designed to give a top level view of our bed based mortality over time and by week and weekend split. The report also includes mortality cases reviewed via the Trusts Morbidity and Mortality form based on the Royal College of Physicians Structured Judgement Frame Work (SJF) looking at any lapses in care as well as good practice. Data sourced includes data from the Trust, Department of Health (DH) and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, Quality Assurance Committee and Mortality Surveillance Group as well as local governance groups.

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to err.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data which may be a signal of improvement or of a process starting to err.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		Data Source	Target	RAG
Appendix 1 • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster 2016/17 benchmark Month DH SHMI data	Aim for a yearly HSMR ≤90	
Appendix 2 • Unadjusted Mortality rate		Trust Data	Yearly Average ≤3%	
Appendix 3 • Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	
Appendix 4 • Hospital Mortality Dashboard		Trust Data Structured Judgement Framework M&M reviews		

Overview The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at TSDFT remain within the accepted range for our population and over a prolonged period. The latest trends continue to show `a low relative risk, which is welcome.

Work continues with our M&M mortality reviews and regular Dr Foster reviews with Coding are productive.

Appendix 1

This metric looks at the two main standardised mortality tools and is therefore split into:

- **1A – Dr Foster Hospital Standardised Mortality Rate (HSMR) and**
- **1B – Department of Health Summary Hospital Mortality Index (SHMI)**

1A The HSMR is based on the *Diagnosis all* Groups using the 16/17 monthly benchmark and analysis by Trend Month

Our HSMR Measure aim is to reduce and sustain the HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated.

Chart 1 - HSMR by Month Feb 16 – Jan 18

The headline monthly view of HSMR is showing a relative risk of **90.1**– this may change as more data is processed by Dr Foster, but follows the prior month's data points of being below the 100 line which is to be encouraged.

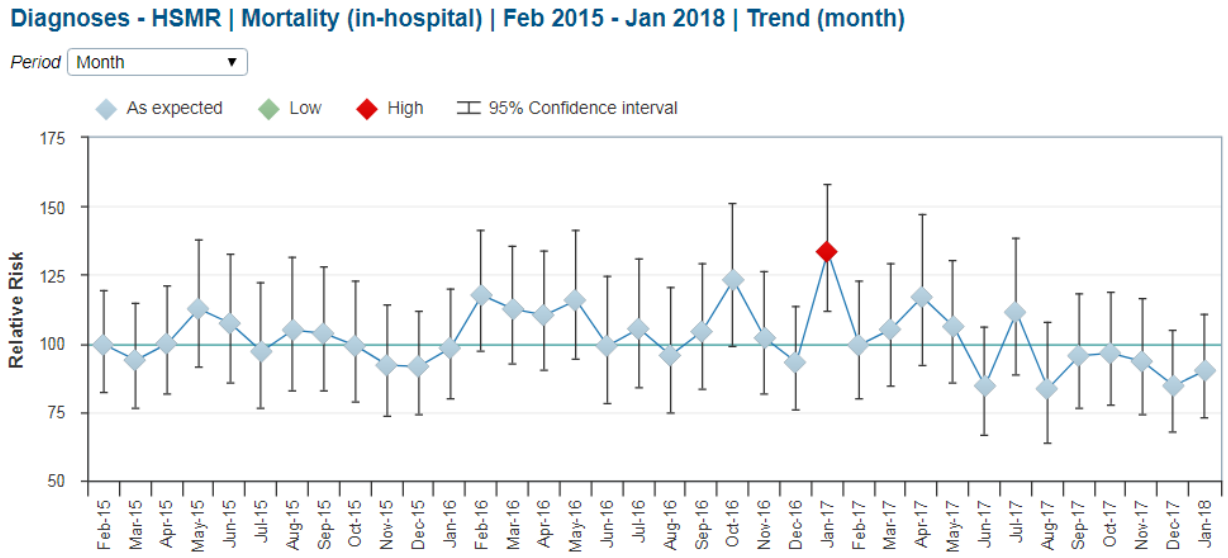


Chart 2 & 3 highlight Weekday and Weekend HSMR patterns to Oct 2017.

The following charts show the pattern of HSMR according to 'the day of admission' via a rolling 12 monthly perspective.

Chart 2 highlights weekday HSMR, as against the English average. This shows a peak rise in the Feb 16 – Jan 17 data, which rapidly returns back towards the 100 (average) line thereafter.

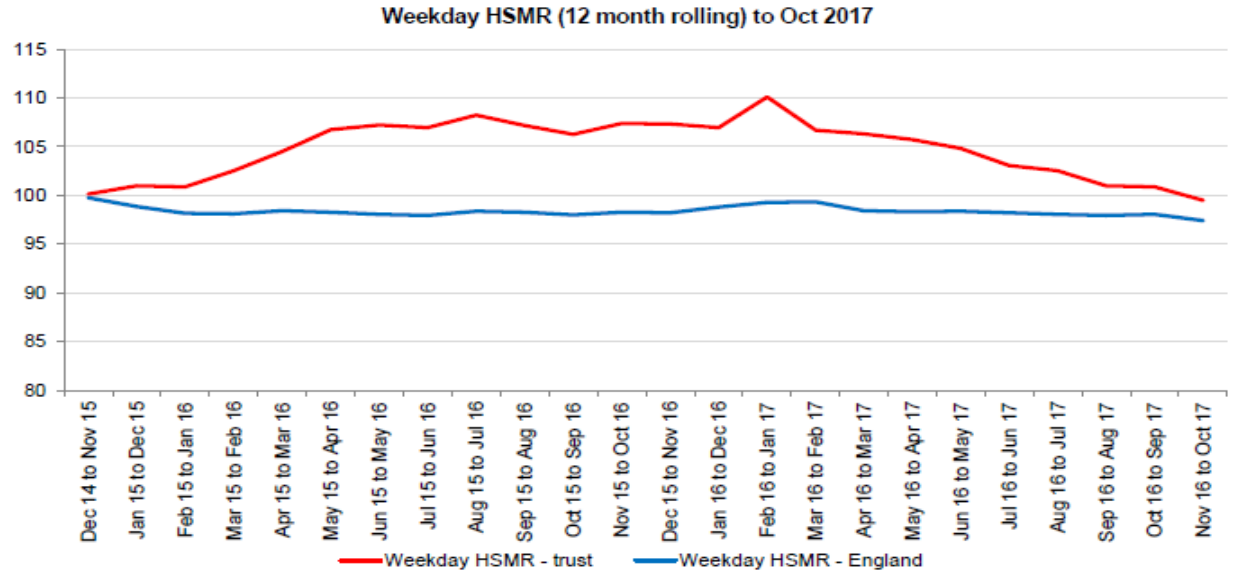
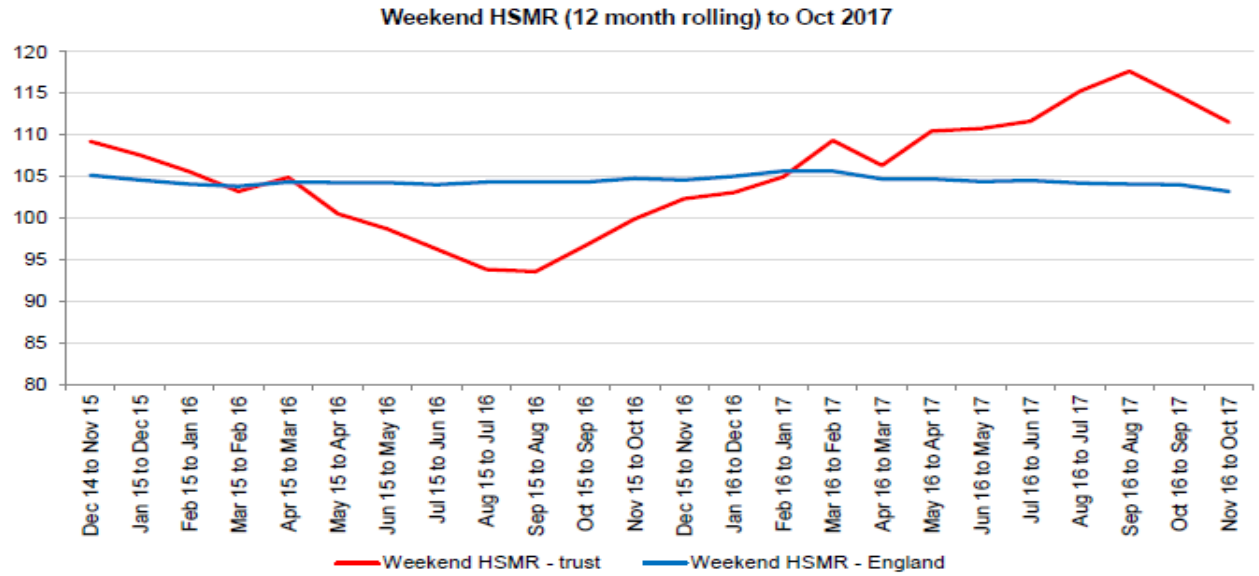


Chart 3 compliments the above chart and looks at weekend HSMR. The previous rise in the data is reducing consistently.



1B Summary Hospital Mortality Index (SHMI) Reporting period Oct 2016 – Sept 2017

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective; therefore, please note *the following data is based on the* **Oct 2016 – Sept 2017** *data release.*

Chart 4, as below, highlights SHMI by quarter period with all data points within the expected range and trending below our 90 target which is very positive.

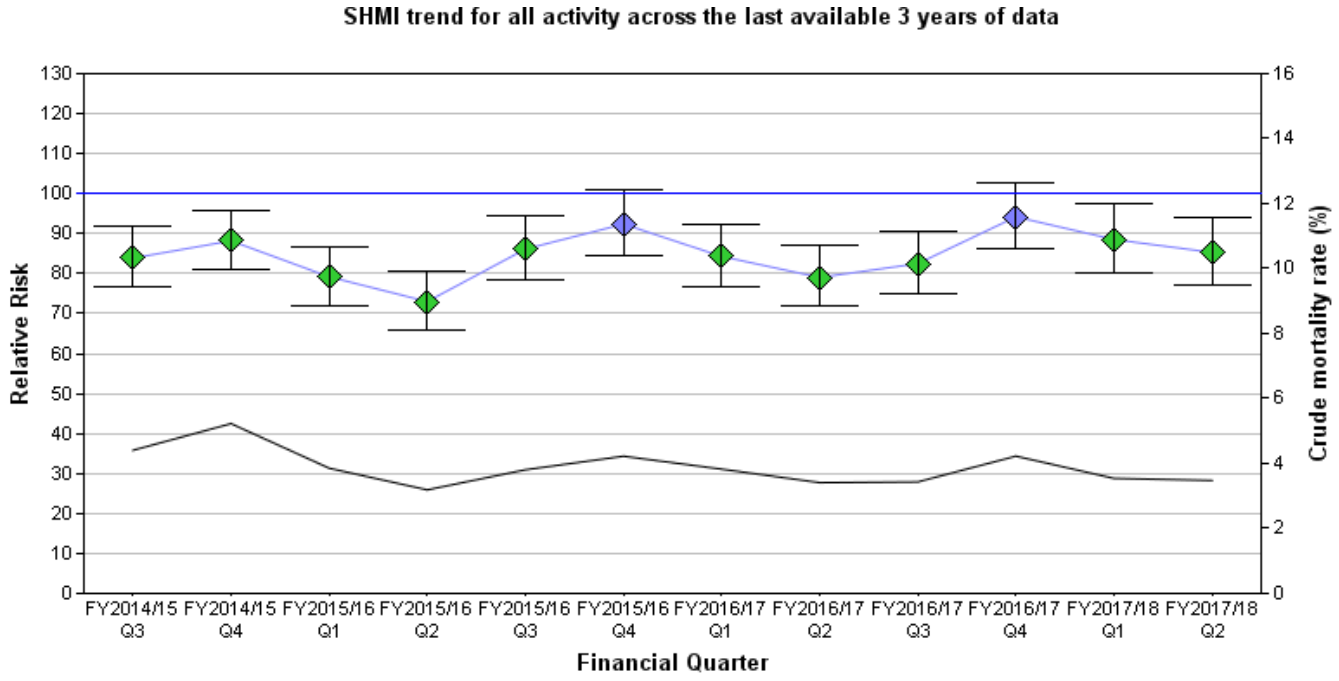


Chart 5 SHMI all deaths, SHMI in hospital deaths and HSMR comparison

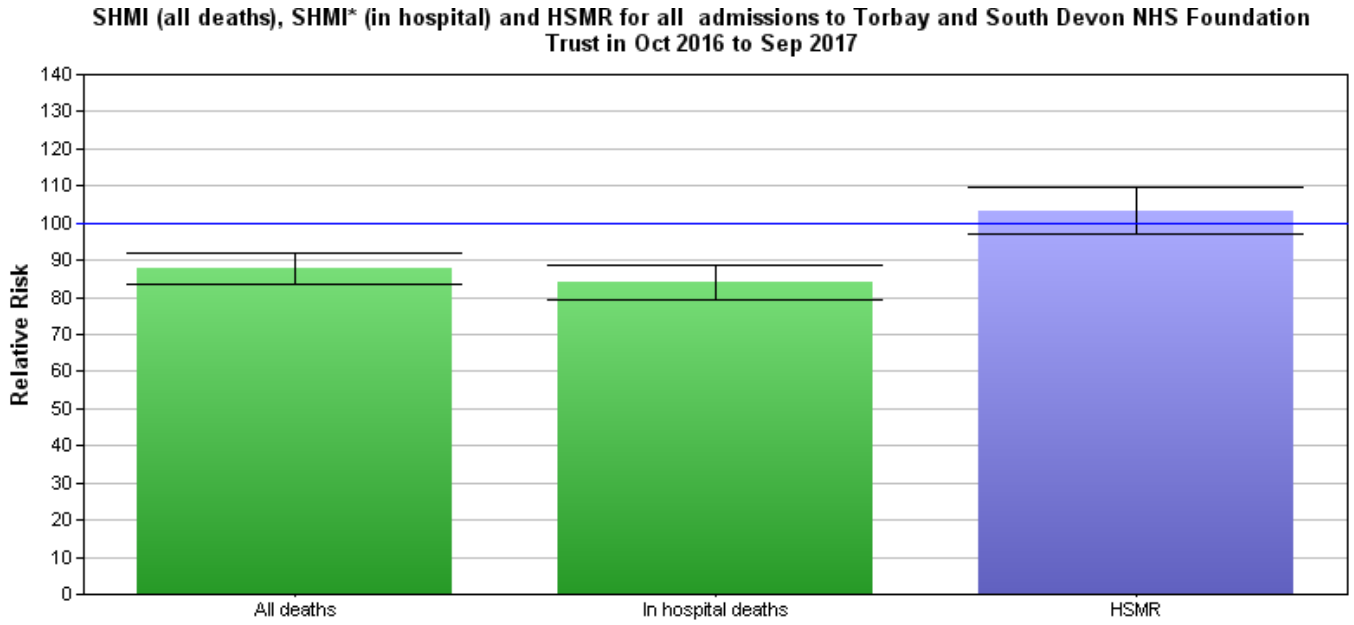


Chart 5 (as above) records all SHMI deaths, deaths in hospital and HSMR. The SHMI data are within expected range and show the in-hospital deaths at a very low relative risk. What this chart does highlight is the differential between HSMR and SHMI.

Chart 6 shows the 12-month rolling SHMI data by time period and demonstrates a significant fall at the time of establishment of the ICO which has remained low

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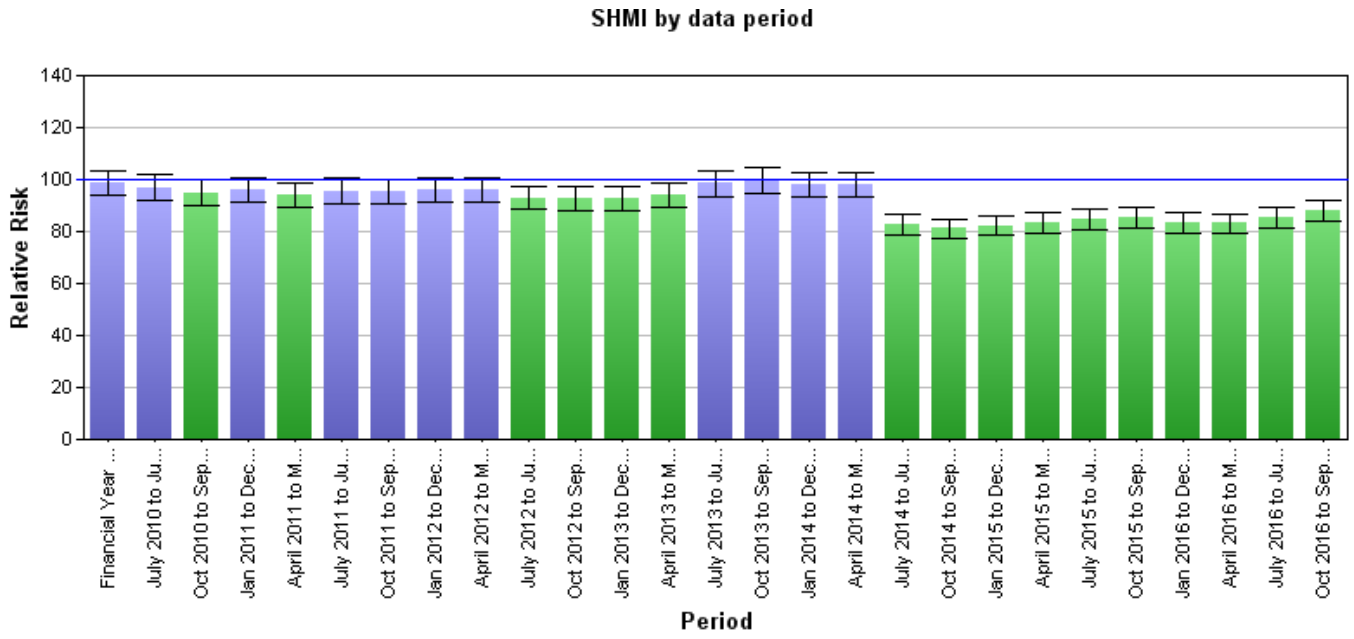
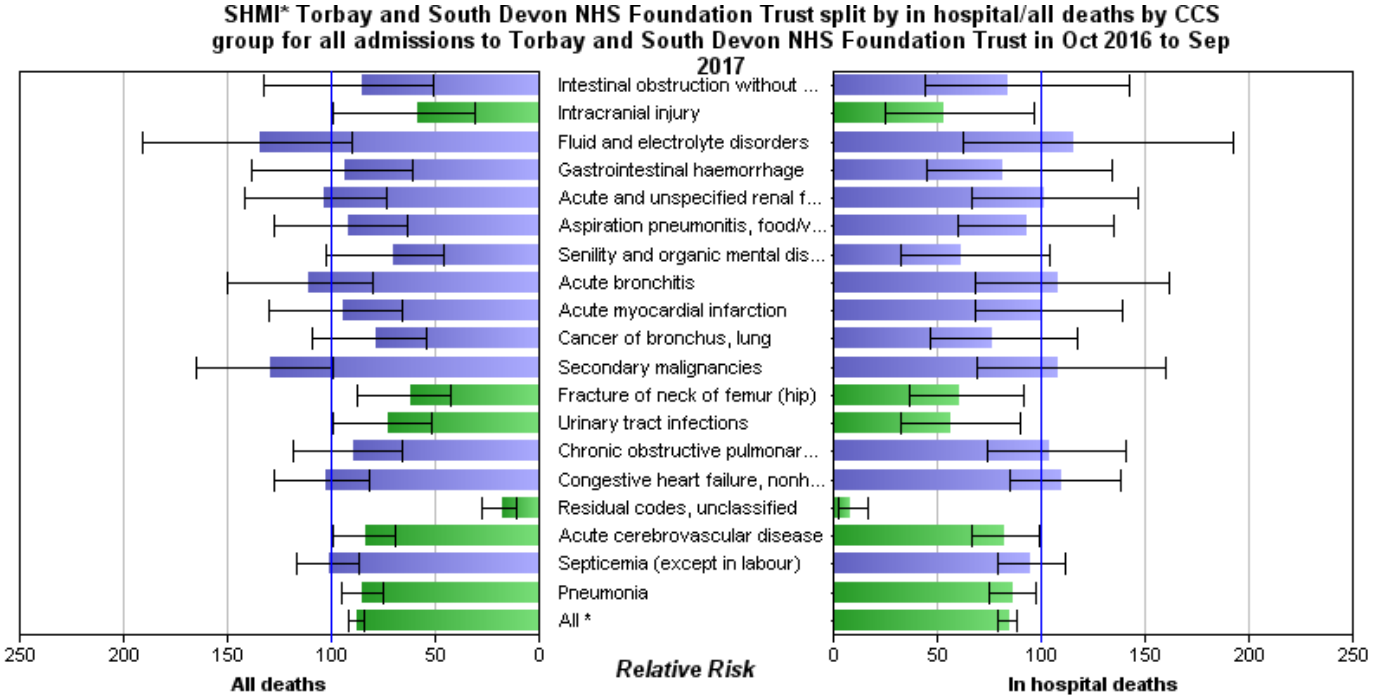


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm*.



Appendix 2

This data looks at the number of deaths in hospitals and expresses this as an unadjusted death rate as a percentage

This percentage is defined as the monthly unadjusted or 'raw' mortality. It is calculated as follows:

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).
Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 8 The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI. Mortality rises in the winter periods and this year the peak months have been Jan & Feb 201 The HSMR data – chart 1 has remained low despite this rise which is good.

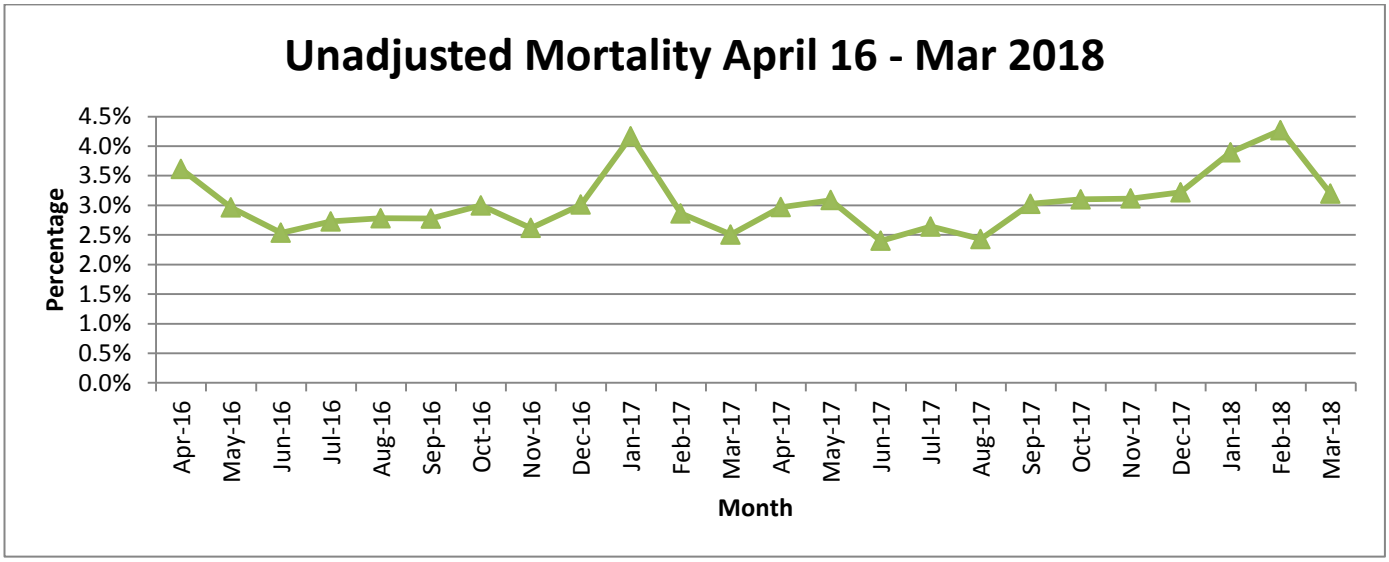


Chart 9 highlights the monthly mortality by number of deaths within the hospital based care setting. Please note either the sharp rise in the winter Dec 16. Jan/ Feb 2018 appear to be the peak winter periods for this year, as opposed to the spike experienced in Jan 2017

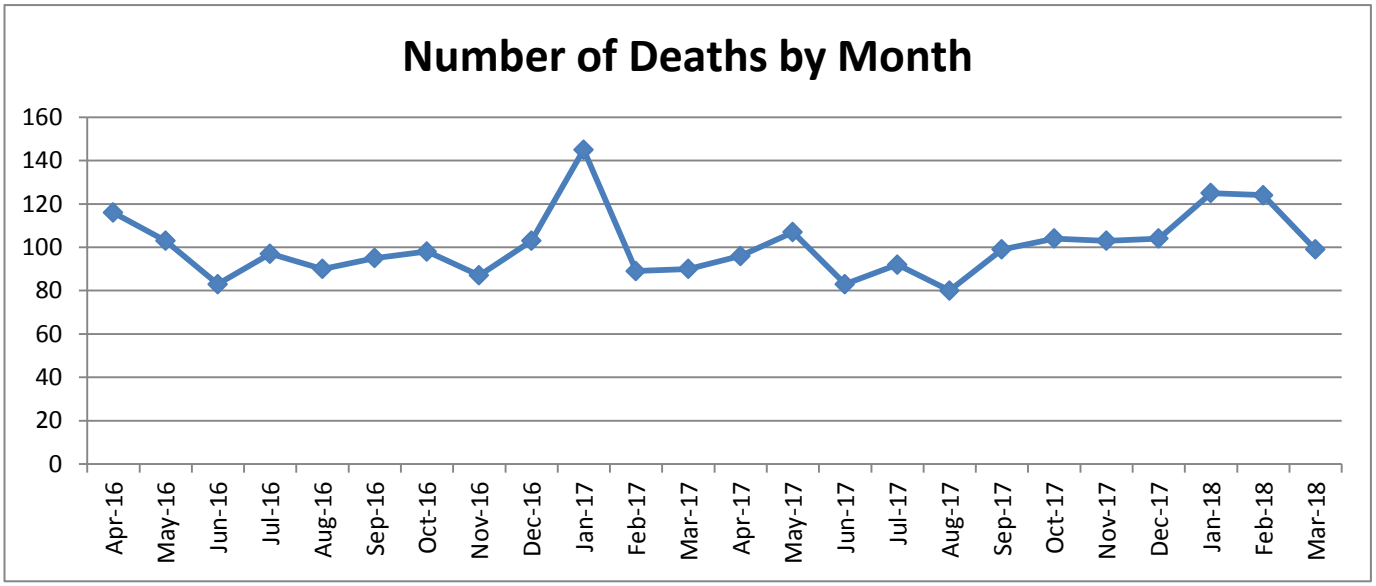
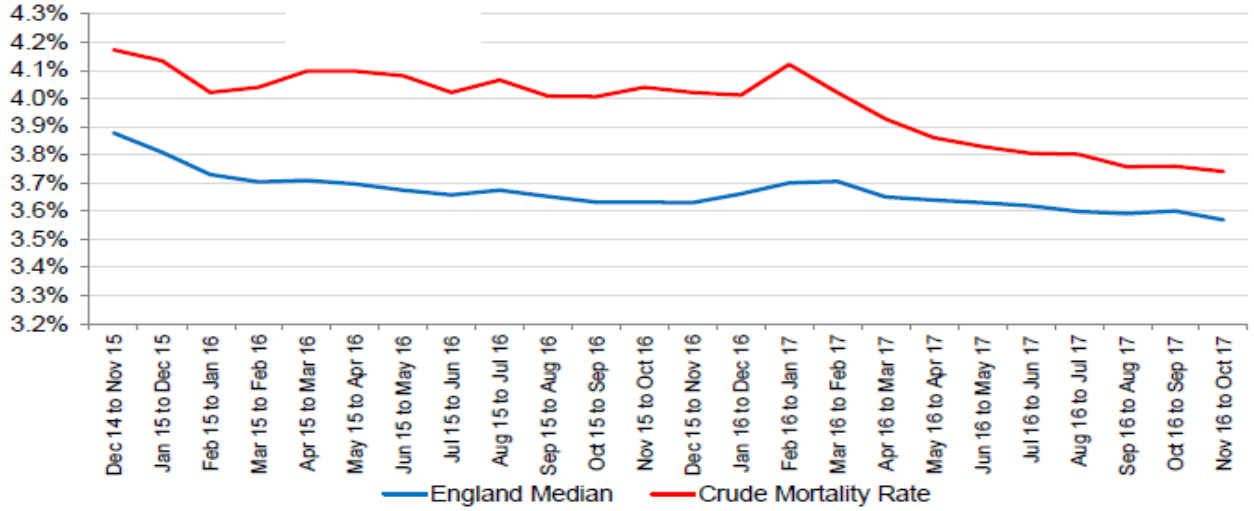


Chart 10 shows the crude mortality rate against time and compared to national level. Note that TSD crude (un-standardised) mortality is higher than the national average reflecting our age distribution and comorbidities. The graph demonstrates a reduction in in-hospital death since 2015 which mirrors the national picture.

HSMR 12 months rolling Crude Mortality to Oct 2017

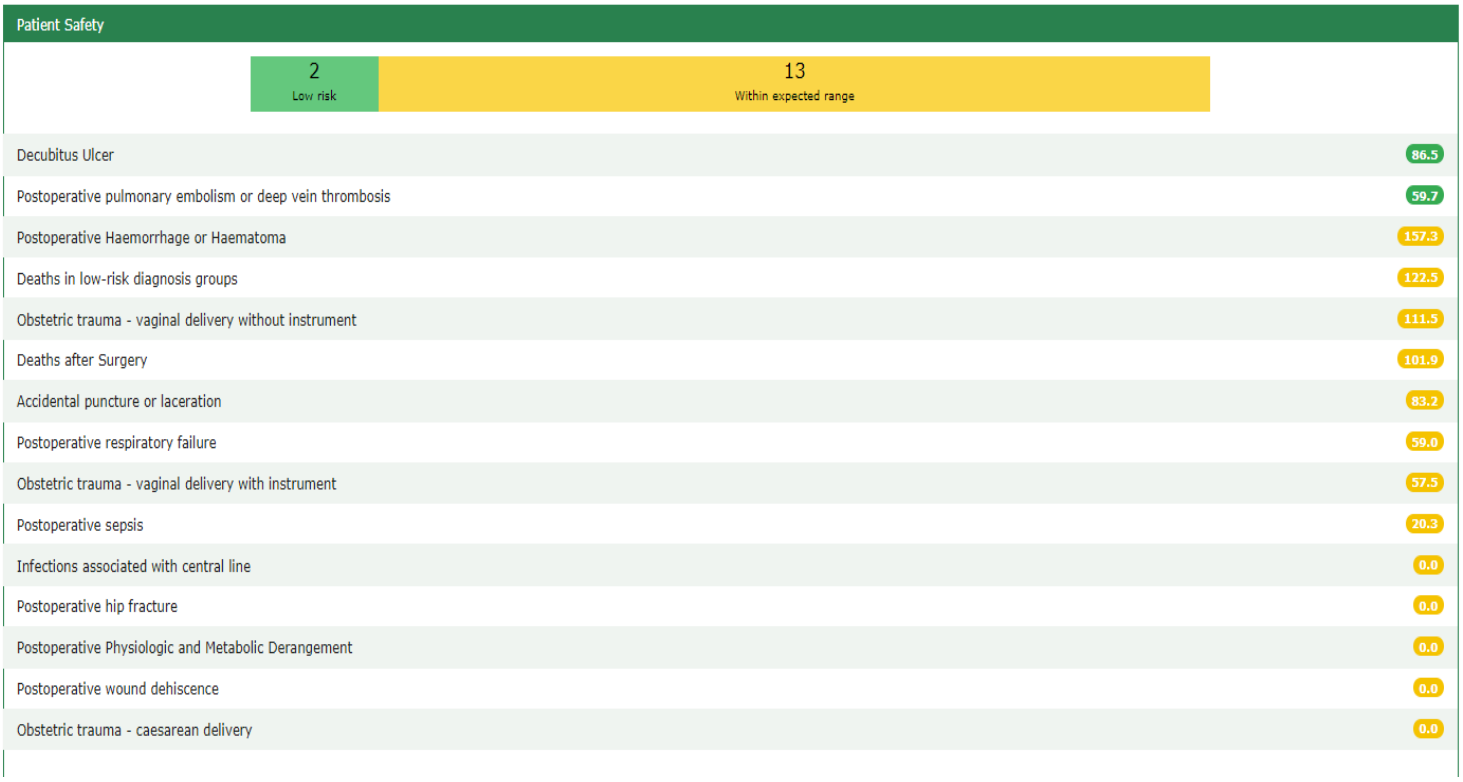


Appendix 3

Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which in turn are based on procedure codes used in the NHS.

The date range for this data is Dec 16 to Nov 2017 and all of the 15 indicators are within the expected norm, 2 are performing better than expected.



Appendix 4

Trust Mortality Dashboard

The following page highlight the number of mortality reviews undertaken by quarter and the Structured Judgement Framework (SJF) assessment assigned to each review. The aim is review all deaths in the Trust. Good progress has been made but we are not yet reviewing all deaths. An action plan has been agreed to achieve this aim. To date of the mortality cases reviewed only 1 has have been deemed potentially avoidable.

Avoidability of death is subjective and a difficult concept. Along with STP partners consideration is being given to an alternative conclusion in relation to gaps in care that may have contributed to the death.

orbay and South Devon NHS
NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust: Learning from Moratlity Dashboard

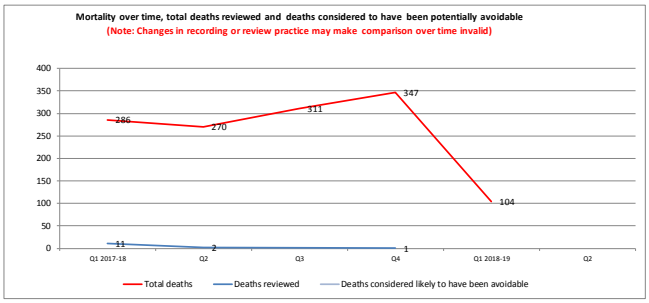
Department of Health

Summary of total number of deaths and total number of cases reviewed under a judgement review methodology — March 2017-18

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable
(does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (Mortality Score = 1)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
99	124	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
347	311	1	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1214	0	14	0	1	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by Mortality Methodology Score

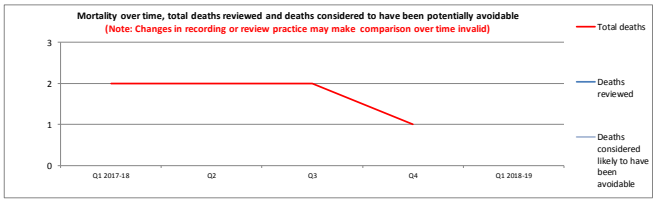
Score 1 Probably avoidable			Score 2 Possibly avoidable but not very likely (less than 50:50)			Score 3 Not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	6.5%	This Quarter (QTD)	29	93.5%
This Year (YTD)	1	0.5%	This Year (YTD)	8	4.0%	This Year (YTD)	193	95.5%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	0	0	0	1	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Cover sheet and summary for a report to the Board of Directors					
Revised Terms of Reference for the Audit Committee				23rd May 2018	
Report sponsor	Chairman				
Report author	Interim Company Secretary				
Report provenance	Executive Directors' meeting 15 May 2018				
Confidentiality	Public				
Report summary	The attached revised Terms of Reference are recommended to the Audit Committee for adoption. The final draft was concluded following consultation with the Board, Internal Audit, and the Risk Officer.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☐	**Review** ☐	**Decision** ☐	**Approve** ☒
Recommendation	The Committee is recommended to approve the revised Terms of Reference for adoption by the Committee and recommend the draft for ratification by the Board.				
Summary of key elements					
Strategic context	This recommendation aims to support all four corporate objectives: • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	The success of the Audit Committee will depend on the quality of intelligence and reports provided to it by authors and workability of its annual cycle of business which will be managed by the Company Secretary.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting dated 15 May 2018 Prior to that, the Board had opportunities to comment on the draft and to make amendments as required. The Internal Auditor was consulted and made contributions to the final draft.				
Stakeholder engagement	As above.				

Other standards affected	The recommendations made in this report will support compliance with: • NHS Constitution, the Trusts FT Provider License, the FT Constitution, Standing Orders, Standing Financial Instructions, the Monitor FT Code of Governance, the Single Operating Framework, NHSLA, and Care Quality Commission requirements.
Legal considerations	There is no assessed negative impact on any inclusion, equality, or diversity in relation to race, religion, age, belief, gender, disability, or other protected characteristic.

Terms of Reference - Audit Committee

The HFMA's NHS audit committee handbook of March 2018 notes that care organisations working together as systems to deliver more integrated care present major [new] governance challenges. And that means an expanding agenda for audit committees. However:

"The core role of this statutory committee remains unchanged. It should help NHS governing bodies as they review and continually re-assess their system of governance, risk management and control, to ensure that it remains effective and fit for purpose."

The handbook highlights the implications for audit committees of 1) Partnership working at scale, 2) governance between organisations, 3) alliances of providers working together, clinical commissioning group committees in common and shared back office arrangements, 4) Sustainability and transformation partnerships (STPs) and accountable care systems (ACSs) while not statutory bodies, need to be part of the governance arrangements for population-based integrated health systems, 5) the committee will need to fully understand these complex arrangements and consider the implications for the organisation – including accounting arrangements, risk management procedures, potential conflicts of interest and information flows, 6) the committee also has a key role in reviewing any mergers and acquisitions and the arrangements to comply with the integrated support and assurance process (ISAP) for novel contracts, 7) committees have a crucial role in providing assurance to the board that the organisation is properly managing cyber-risk, and 8) the other major addition of note is guidance on working with regulators. The role of the audit committee is to oversee, be aware of and ensure action plans relating to the regulatory requirements are monitored and delivered. This should include STP progress dashboard, NHS England's improvement and assessment framework, NHS Improvement's single oversight framework and the methodology for assessing how providers use their resources, as developed by the Care Quality Commission and NHS Improvement.

By
Interim Company Secretary
for
TRUST BOARD OF DIRECTORS

Terms of Reference - Audit Committee

Document Data			
Committee Name	Audit Committee	**Author**	Interim Company Secretary
Document Type	Terms of Reference	**Executive Lead**	Company Secretary
Document Status	Draft	**Review Cycle**	12 months
Approval Authority	Trust Board of Directors	**Next Review Date**	May 2019

Document Control			
Approval Date	**Version**	**Revision**	**Description**
12 April 2018	3	Version	Terms of Reference "Audit and Assurance Committee"
23 May 2019	4	Major revision	To reflect applicable NHSI guidance, ICSA standards, HFMA March 2018 Audit Committee Handbook, and Internal Auditor advice

Table of Contents

1. INTRODUCTION

1.1 The Audit Committee (the **Committee**) is a statutory[1] committee established by the Trust Board of Directors (the **Board**) to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management, and internal control.

1.2 These Terms of Reference are to support the NHS foundation trust's ability to comply fully with the requirements of the National Health Service Act 2006 (the **2006 Act**) and the Health and Social Care Act 2012 (the **2012 Act**), guidance from the Department of Health and Social Care (the **DHSC**), and the NHS Foundation Trust Code of Governance (the **Code**) developed by Monitor and retained by NHS Improvement (**NHSI**) in relation to governance, risk management, and internal control.

1.3 To ensure that the power and activities of the Audit Committee are undertaken in a transparent and accountable manner the Code recommends that the committee's terms of reference should be made publicly available.[2]

2. PURPOSE AND FUNCTION

2.1 The purpose and function of the Committee is to:

2.1.1 independently and objectively monitor, review and report on the suitability and efficacy of the Trust's provisions for governance, risk management, and internal control (where necessary, recommend the installation of revised provisions or other remedial action);

2.1.2 monitor the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance, and review significant financial reporting judgements contained in them;

2.1.3 review the effectiveness of the Trust's internal audit, counter fraud, external audit, and clinical audit functions.

2.2 In discharging its purpose and function, the Committee shall seek to provide evidenced assurance to the Board that an appropriate system of risk management and internal control is in place to ensure that business is conducted in accordance with the law and proper standards, and affairs are managed to secure economic, efficient, and effective use of resource regarding value for money as directed by the Board.

3. AUTHORITY

3.1 The Committee is a non-executive Committee of Board and has no executive powers, other than those specifically delegated in these Terms of Reference. It is authorised by the Board to:

3.1.1 investigate any activity within its terms of reference and to seek any information it requires from any employee of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required;

3.1.2 to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4. MEMBERSHIPAND ATTENDEES

4.1 All independent Non-executive Directors shall be members of the Committee, at least one of whom shall have recent and relevant financial experience.

[1] Schedule 7 to the National Health Service Act 2006 (NHS Act 2006) at paragraph 23(6) provides that a foundation trust must establish a committee of non-executive directors as an audit committee, to perform such monitoring, reviewing and other functions as are appropriate.

[2] Code provision C.3.2, NHS Foundation Trust Code of Governance, Monitor, July 2014.

4.2 Appointments to the committee shall be for a period of up to three years, which may be extended for one further three-year period,[3] provided the Non-executive director concerned remains independent.[4]

4.3 The Chair of the committee shall be an independent non-executive director, but shall not be the Chairman of the Board, or senior independent director, or vice-chair of the board of directors.[5] In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.4 The Chairman of the Board shall not be a member of the Committee.

4.5 Only members of the committee have the right to attend committee meetings.[6] However, the Internal and External Auditor,[7] Local Counter Fraud Specialist, and Director of Finance[8] shall be invited to attend meetings of the committee to present reports and answer any questions arising from their reports.

4.6 Other non-members may be invited to attend all or part of any meeting as and when appropriate.[9]

4.7 The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

4.8 The Chair of the Finance, Performance, and Investment Committee, the Chair of the Quality Assurance Committee, and the Senior Independent Director, shall be members of the Audit Committee.[10]

4.9 The Director of Finance or their deputy shall be invited when required if not in the capacity of non-clinical executive lead director.[11]

4.10 The Medical Director or Chief Nurse or their deputy shall be invited when required in the capacity of clinical executive lead director.[12]

4.11 The Chief Executive shall be required to attend, at least annually, to discuss the process for evaluation of evidence to support the Annual Governance Statement.[13] [14]

[3] A non-executive director may be appointed for a longer period of six years in total. However, such extensions should be subject to rigorous scrutiny.

[4] 'Rotation of members will be a matter of judgement for the organisation's Chair and Board, but a balance needs to be struck between bringing in a fresh perspective and maintaining an experienced membership that has established effective relationships with those that attend the Committee. Any conflicts of interest should be dealt with in accordance with existing codes that operate within the organisation', p37, NHS Audit Committee Handbook, HFMA in association with Department of Health, 2011. 'The value of ensuring that committee membership is refreshed, and that undue reliance is not placed on particular individuals should be taken into account in deciding chairmanship and membership of committees', supporting principle B.1.e, NHS Foundation Trust Code of Governance, Monitor, July 2014.

[5] The Healthy NHS Board 2013: Principles for Good Governance, p16, NHS Leadership Academy, 2013. The guidance suggests that the vice-chairman for the board of directors should not be chairman of the audit committee either.

[6] 'Only the committee chairman and committee members are entitled to be present at meetings of the nominations, audit or remuneration committees, but others may attend by invitation of the particular committee', supporting principle B.1.f, NHS Foundation Trust Code of Governance, Monitor, July 2014.

[7] The external auditor should especially be invited when the committee is discussing matters of corporate governance, internal control, risk management and value for money. NHS Audit Code for NHS Foundation Trusts, paragraph 4.15, Monitor, March 2011.

[8] According to Appendix A, NHS Audit Committee Handbook, HFMA, 2014, 'The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings' p56. However, as NHS foundation trusts have acquired some freedom from Department of Health direction, they may or may not decide to incorporate this recommendation.

[9] This can include the chairman of the NHS foundation trust, Code provision C.3.1, NHS Foundation Trust Code of Governance, Monitor, July 2014.

[10] Local provision

[11] Local provision. According to Appendix A, NHS Audit Committee Handbook, HFMA, 2014, 'The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings' p56. However, as NHS foundation trusts have acquired some freedom from Department of Health direction, they may or may not decide to incorporate this recommendation.

[12] Local provision.

[13] As recommended in the specimen terms of reference contained within p56, Appendix A, NHS Audit Committee Handbook, HFMA,

4.12 Executive Directors shall be invited to attend as appropriate.

4.13 At least once a year the Committee shall meet privately with the External and Internal Auditors.

4.14 The Company Secretary shall attend meetings of the Audit Committee to provide advice and guidance and to support the annual appraisal of the Committee[15].

5. QUORUM

5.1 The quorum necessary for the transaction of business shall be 3 members, all of whom must be independent Non-executive Directors.

5.2 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. SECRETARY

6.1 The Trust Executive shall arrange for the provision of support services including distributing materials and minuting meetings.

6.2 Notice of each meeting confirming the venue, time, and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than 5 clear (working) days before the date of the meeting. Supporting papers shall be made available no later than 3 clear (working) days before the date of the meeting but ideally at the same time as the agenda.

6.3 Draft minutes shall be made available promptly to the Chair and members of the Committee. Once authorised by the Chair of the Committee, the draft minutes shall be distributed to the other members of the Board.

6.4 The Chair shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest with matters on the agenda or related matters.

6.5 Declarations of Interest shall be managed by the Chair and recorded in the minutes and if appropriate, the Register of Declarations of Interest.

7. FREQUENCY OF MEETINGS

7.1 The Committee shall meet a minimum of five[16] times a year, including the meeting dedicated to the Annual Report and Accounts, and at such other times as the Chair shall require to enable the Committee to discharge all its responsibilities[17].

7.2 The Board, Chief Executive, External Auditors, Head of Internal Audi, or Company Secretary may request an additional meeting if they consider it necessary.

2014.

[14] As recommended in the specimen terms of reference contained within p56, Appendix A, NHS Audit Committee Handbook, HFMA, 2014.

[15] Although not a provision in the NHS Foundation Trust Code of Governance, the Code notes the trust [company] secretary plays an integral part in the flow of good information between the board and its committees, providing guidance and offering advice to the directors and governors on governance matters affecting the trust.

It is part of the secretary's role to provide guidance to ensure that the board and its committees are properly constituted and advised in order that they fulfil their collective responsibility. There needs to be clear co-ordination between the board and its committees; this is where the trust secretary would normally act as a valued intermediary. ICSA, 2015.

[16] The frequency with which the committee needs to meet will vary and may indeed change from time to time. Para. 2.6, Guidance on Audit Committee, Financial Reporting Council, recommend the committee meet at least three times per year. HMT's Audit and Risk Assurance Committee Handbook recommends four times per annum as a minimum. The HFMA recommends 5 meetings including Annual Report and Accounts.

[17] The frequency and timing of meetings will differ according to the needs of the foundation trust. Meetings should be organised so that attendance is maximised (e.g. by timetabling them to coincide with board meetings).

7.3 Outside of the formal meeting programme, the committee chair shall maintain a dialogue with key individuals involved in the Trust's governance, including the Chairman, the Chief Executive, the Finance Director, the External Audit lead partner, and the Head of Internal Audit[18].

8. REVIEW OF PERFORMANCE AND TERMS OF REFERENCE

8.1 The Committee shall, at least once a year, review[19] its own performance, constitution, and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

9. DUTIES

9.1 The Committee shall follow the guidance set out in 'NHSI guidance for Foundation Trust Audit Committees titled 'Governance over audit, assurance, and accountability: (accompanying the risk assessment framework). [20]

9.2 The Committee shall be guided by the guidance set out in the HFMA Audit Committee Handbook dated March 2018.

9.3 The Committee shall carry out the duties set out in these terms of reference for the Foundation Trust and any major subsidiary undertakings.

10. STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

The Board has delegated responsibility to the Committee, as set out in Standing Orders and Standing Financial Instructions[21] as follows:

10.1 advise the Board on all internal audit and counter fraud services, external audit services, and related matters;

10.2 discuss problems and reservations arising from any audit work and any matters arising which the Auditors may wish to discuss (in the absence of Executive Directors and other management where necessary);

10.3 review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives;

10.4 monitor compliance with Standing Orders and Standing Financial Instructions[22];

10.5 periodically review the evidence on which the Assurance Framework is predicated, and consider the gaps in control and evidence;

10.6 monitor implementation of the policy on standards of business conduct;

[18] Financial Reporting Council's Guidance on Audit Committees, para. 2.10

[19] Main principle B.6.a, The NHS Foundation Trust Code of Governance, Monitor, July 2014.

[20] The former Monitor Audit Code for NHS foundation trust audits was withdrawn on 1 April 2015. From that date, NHS foundation trust auditors instead use the Code of Audit Practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General. The NAO's Code of Audit Practice applies to foundation trust auditors rather than the trusts themselves. NHS foundation trusts should refer to NHSI guidance titled 'Governance over audit, assurance, and accountability'. However, element of the Monitor Audit Code for FTs has been retained in these Terms of Reference as it continues to reflect common practice.

Condition 4 of the NHS provider licence as applied to NHS foundation trusts (condition FT4(3)) requires foundation trusts to have regard to guidance on good corporate governance issued by Monitor/NHSI).

The 'Governance over audit, assurance, and accountability' document constitutes guidance for the purposes of condition FT4(3). The guidance may also be relevant to foundation trusts' compliance with condition FT4(5)(a) and (d) – the requirements to establish and effectively implement systems and/or processes to ensure compliance with the trusts' duty to operate efficiently, economically, and effectively and for effective financial decision-making, management, and control. NHS foundation trusts are expected to comply with this guidance and must disclose in their annual report if they do not, together with the reasons for the divergence.

[21] SFI 2.1.1 and SO 4.8.1

[22] Audit and Assurance [sic] Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board of Directors). (SO 3.13.5)

10.7 review the suitability of financial and related information systems and monitor the integrity of the financial statements;

10.8 review significant financial reporting judgments;

10.9 review policies and procedures in respect of fraud and bribery set out in the Service Condition 24.2 of the NHS Standard Contract 2018/19 and receive the Counter Fraud Plan, Progress Report, and the Annual Report;

10.10 review schedules of losses and compensation and make policy recommendations to the Board where necessary;

10.11 review the annual financial statements prior to submission to the Board;

10.12 provide an independent and objective view on financial probity[23];

10.13 ensure external audit services[24] are cost-efficient.

11. FINANCIAL REPORTING

The committee shall monitor the integrity of the financial statements of the foundation trust and any other formal announcement relating to its financial performance, reviewing significant financial reporting issues and judgements which they contain.[25]

The committee shall also review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement (the **AGS**) relevant to the work of the committee.

The Committee shall:

11.1 ensure the integrity of the Annual Report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and the judgements which they contain;

11.2 review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement;

11.3 review the consistency of, and changes to, accounting policies both on a year-on-year basis and across the Trust and its subsidiary undertakings;

11.4 review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements); and,

11.5 review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, considering the views of the External Auditor.

12. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee shall extend the oversight and scrutiny role of the Board in relation to the suitability, reliability, and robustness of the processes of risk management and control, and to provide a view on the veracity of any statement on internal control and the Annual Governance Statement.[26]

This requires the Committee to consider the work of any other Board committee, including in relation to quality[27], and Finance.

[23] SFI Ref 2.1.1

[24] SFI Ref 2.4.1

[25] Code provision C.3.2, NHS Foundation Trust Code of Governance, Monitor, July 2014.

[26] The Healthy NHS Board 2013: Principles for Good Governance, page 15, NHS Leadership Academy, 2013.

[27] NHS Improvement (NHSI) and the Care Quality Commission (CQ) define 'quality' as a product of: patient safety, clinical effectiveness,

The Committee shall:

12.1 review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the Trust's activities (financial, clinical, and non-clinical), that supports the achievement of the organisation's objectives;

12.2 review the adequacy of risk and control related disclosure statements, the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

12.3 review the Board Assurance Framework (the **BAF**) document and supporting processes that assess and record the achievement of corporate objectives, the effectiveness of the management of principal[28] risks and the appropriateness of disclosure statements;

12.4 review the policies for ensuring compliance with relevant regulatory, legal and code of conduct/ethics requirements, any related reporting and self-certifications, and work related to counter-fraud as required by the NHS Counter Fraud Authority;

12.5 review evidence provided by Internal and External Auditors, directors, and managers, including evidence of compliance with systems of risk management and internal control together with indicators of their effectiveness.

13. CLINICAL GOVERNANCE AND CLINICAL AUDIT

The Committee shall:

13.1 receive the Clinical Audit Annual Plan and Clinical Audit Annual Report and monitor progress (reports) at each meeting;

13.2 review the maintenance of systems relating to 'Clinical Governance' and Clinical Audit, and seek evidence of the quality and effectiveness of the clinical risk management function, including the efficacy of:

13.2.1 the process for Clinical risk management and mitigation,

13.2.2 the processes for learning from incidents and the distribution of lessons learnt, and

13.2.3 systems for bringing clinical research into action.

14. INTERNAL AUDIT AND COUNTER FRAUD

The Committee shall monitor the effectiveness of the Internal Audit function established by management, which meets mandatory Internal Audit standards and provides appropriate independent assessments to the Committee, Chief Executive and Board. The Committee shall:

14.1 monitor and review the quality and effectiveness of the foundation trust's Internal Audit function in the context of the trust's overall risk management system;[29]

14.2 consider and approve the remit of the Internal Audit function and ensure it has adequate resources and appropriate access to information to enable it to perform its function effectively and in accordance with relevant professional standards. The committee shall also ensure the function has adequate standing and is free from management intervention or other inappropriate restrictions;

14.3 approve the appointment and removal of the head of the Internal Audit function;

14.4 review and approve the annual Internal Audit Strategy and Plan;

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and the experience of patients.

[28] As set out in the Annual Plan and reported on in the Annual Report. To TSDFT, this means the Corporate Risks.

[29] Unless a risk committee expressly addresses this. Code provision C.3.2, The NHS Foundation Trust Code of Governance, Monitor, July 2014.

14.5 ensure the Internal Auditor has direct access to the Chairman of the Board, the Committee Chair, and the Company Secretary, and remains accountable to the Committee;

14.6 receive a report on the results of the Internal Auditor's work periodically;[30]

14.7 review and monitor the responsiveness of management to the findings and recommendations of the Internal Auditor, and ensure coordination between Internal and External Auditors to optimise use of audit resources;

14.8 meet the head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the Internal Audits carried out.[31]

14.9 require and review sufficient evidence to concluded that there is an effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board;

14.10 require that the Internal Auditor has adequate access to resources and information, including the BAF, to enable it to perform its function effectively and in accordance with the relevant professional standards;

14.11 keep under review the independence and objectivity, capability, and capacity of the Internal Auditor and the effectiveness of the audit process;

14.12 at least once every 5 years, consider the suitability of the Internal Audit and Counter Fraud services and consider re-tendering for these services;

14.13 satisfy itself that the Trust has adequate arrangements in place for counter fraud that meet the required NHS Counter Fraud Authority standards and review the outcomes of work in these areas;

14.14 review policies and procedures in respect of fraud and bribery set out in the Service Condition 24.2 of the NHS Standard Contract 2018/19 and receive the Counter Fraud Plan, Progress Reports and the Annual Report; and,

14.15 monitor the policies and procedures relating to counter-fraud, bribery, and anti-corruption activities as set out in the Service Condition 24.2 of the NHS Standard Contract 2018/19 and performed by the NHS Counter Fraud Authority. Receive reports on non-compliance.

15. EXTERNAL AUDIT

The Committee shall:

15.1 consider and make recommendations to the Council of Governors (the **CoG**), in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

15.2 work with the CoG to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the CoG;

15.3 discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

15.4 assess evidence that the External Auditor complies with the Code of Audit Practice[32] issued by the National Audit Office (the **NAO**) on behalf of the Comptroller and Auditor General;

15.5 discuss with the External Auditors their evaluation of audit risks, assessment of the Trust,

[30] Para. 4.18, Guidance on Audit Committees, FRC.

[31] Supporting principle, C.2.d, The NHS Foundation Trust Code of Governance, Monitor, July 2014, states that the head of internal audit should have a direct reporting line to the board of directors or the audit committee.

[32] https://www.nao.org.uk/code-audit-practice/

and the impact on the audit fee[33];

15.6 approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees to enable an adequate audit to be conducted;

15.7 agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, considering relevant guidance;

15.8 review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process;

15.9 review the work and findings of the External Auditor and assess the suitability of management's responses to their work;

15.10 review all External Audit reports, including the report to those charged with risk management and internal control (before its submission to the Board), and any work undertaken outside the annual audit plan, together with a considered view on the appropriateness of management responses;

15.11 meet the External Auditor at least once a year, without management present to discuss their remit and any issues arising from the audit; and,

15.12 at least once every 10 years, consider the suitability of the External Auditor and the value of re-tendering External Audit services.

16. COMPLIANCE, SPEAKING OUT POLICY

The Committee shall:

16.1 review the adequacy of the Trust's arrangements for its employees and contractors to raise concerns in confidence about possible wrongdoing in financial reporting, fraud, bribery, corruption, clinical quality, patient safety, bullying, harassment, discrimination, or other serious matters;

16.2 monitor and receive evidence of compliance with the Trust's Speaking Out Policy. This shall include evidence that the policy allows for proportionate and independent investigation of such matters and that appropriate follow-up action is taken;

16.3 Monitor the policies and procedures relating to counter-fraud, bribery, and anti-corruption activities as set out in the Secretary of State Directions and performed by the Counter Fraud and Security Management Service. Receive reports on non-compliance;

16.4 review regular reports from the counter-fraud compliance officer and keep under review the adequacy and effectiveness of the Trust's policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

16.5 review reports on non-compliance with these policies.

17. BUSINESS CONDUCT

The Committee shall:

17.1 ensure that the Trust has an effective Standards of Business Conduct Policy and Gifts & Hospitality Policy that takes account of NHS England's Managing Conflicts of Interest in the NHS Guidance as issued in February 2017; and,

17.2 ensure that a regular audit is undertaken so that the Trust has assurance that all relevant staff and especially decision makers (as defined by the NHS England Guidance) are adhering to these policies

[33] i.e. was the work required of the Auditor significantly complex due to complex risk factors present in the Trust, and did that cost the Trust more?

18. OTHER BOARD ASSURANCE FUNCTIONS

18.1 The Committee shall review the findings of any reviews undertaken by Regulators, Inspectorates, peers, and professional bodies and consider their implications for the governance of the Trust.

18.2 The Committee shall review the work of other Board Committees or Sub-committees whose work can provide relevant evidence to support the Committee's objectives. This may relate to any internal control measures underpinning the Board's ability to govern the Trust effectively. This shall include at a minimum the work of the Quality Assurance Committee and the Finance, Performance, and Investment Committee.

19. REPORTING RESPONSIBILITIES

In the interests of transparency and accountability, the Health and Social Care Act 2012 requires at least one member of the Board to attend the Annual Members Meeting to present the Annual Report and Accounts, and the Auditor's report.[34]

The UK Corporate Governance Code recommends that the Committee Chair should be the person responding to questions regarding the Committee's area of responsibility.[35]

19.1 The Committee Chair shall:

19.1.1 report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities and make whatever recommendations to the Board it deems appropriate on any area within its remit (particularly where action or improvement is considered necessary);

19.1.2 where the External Auditor's contract is terminated in disputed circumstances, report on the removal process and the underlying reasons for removal to the CoG and notify NHSI[36];

19.1.3 raise with the Board any concerns where there may be evidence of ultra vires[37] transactions, or improper activities or if there are other important matters;

19.1.4 write to NHSI to raise these matters where the actions of the Board are deemed to be insufficient in responding to the concerns raised;

19.1.5 sign the Annual Report of the Audit Committee; and,

19.1.6 attend the Annual Members Meeting to respond to any questions on the Committee's report to the CoG in the Annual Report.

19.2 The Committee shall:

19.2.1 report to the Board annually on its work in support of the Annual Governance Statement (the **AGS**), specifically commenting on the fitness for purpose of the BAF, the completeness and degree of integration of risk management in the organisation, the nature of governance arrangements and the results of the annual Committee self- assessment;

19.2.2 make necessary recommendations to the CoG on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate,

19.2.3 make a statement in the Annual Report on the full auditor appointment process, and where the CoG decides to not accept the recommendations of the

[34] Section 157, Health and Social Care Act 2012.

[35] The UK Corporate Governance Code, E.2.3, Financial Reporting Council, September 2014.

[36] Code provision C.3.7, NHS Foundation Trust Code of Governance, Monitor, July 2014.

[37] Beyond the scope of legal remit, outside of legal powers.

Committee, a statement setting out (a) an explanation of the Committee's recommendation in relation to the appointment, reappointment, or removal of the External Auditor and (b) the reasons the CoG has chosen not to accept those reasons;

19.2.4 make a statement in the Annual Report on any non-audit services provided by the External Auditor, and if so, how auditor objectivity and independence is maintained;

19.2.5 report such matters to the CoG relating to audit activities that it considers require action and/or improvement, highlighting recommendations;

20. OTHER MATTERS

The committee shall:

20.1 have access to sufficient resources to carry out its duties, including access to the trust secretariat for assistance as required;

20.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

20.3 consider laws and regulations, the provisions of the NHS Foundation Trust Code of Governance and other applicable rules, as appropriate;

20.4 review every decision to suspend the foundation trust's standing orders; and,

20.5 oversee any investigation of activities which are within its terms of reference and act as a Court of Last Resort.

21. MODEL AGENDA

21.1 Topic 1: Chair's welcome and declarations of interest

21.2 Topic 2: Minutes and Actions

21.3 Topic 3: Financial reporting

21.4 Topic 4: Governance: leadership, risk management and internal control

21.5 Topic 5: Quality: clinical governance and clinical audit

21.6 Topic 6: Internal audit

21.7 Topic 7: External audit

21.8 Topic 8: Counter Fraud

21.9 Topic 9: Compliance, speaking out policy, business conduct

22. COMMITTEE SCHEMATIC

To follow on completion of governance review.

Cover sheet and summary for a report to the Trust Board					
Report title: Safer Staffing				Date:23rd May 2018	
Report sponsor	Chief Nurse				
Report author	Associate Director of Nursing Workforce				
Report provenance	Executive Director Meeting				
Confidentiality	Public				
Report summary	This is the 6 monthly safer staffing report as required by the CNO NHS England. The report also gives a progress report of the Nursing Workforce Programme streams.				
Purpose (choose 1 only)	**Note** ☐	**Information** ✓ ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	The Board is recommended to review the document and review the evidence presented.				
Summary of key elements					
Strategic context	Highlight which strategic/corporate objective(s) this recommendation aims to support • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	Registered Nurse Recruitment remains a challenge both locally and nationally.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting dated 15th May 2018				
Stakeholder engagement	None				
Other standards affected	CQC safety domain				
Legal considerations	None				

Report title: Report of the Chief Nurse – Safer Staffing	Date: 23rd May 2018
Report sponsor	Chief Nurse
Report author	Associate Director of Nursing Workforce

1. Purpose of the Report

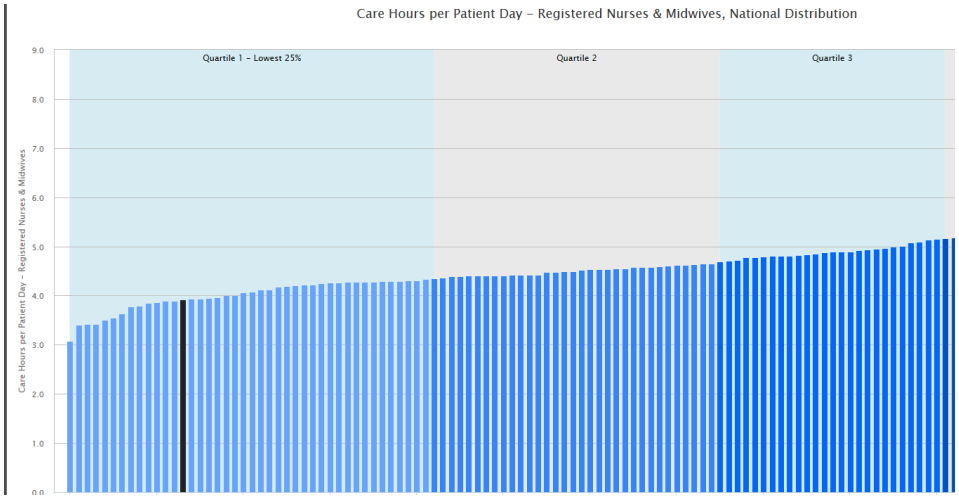
The purpose of this Report is to provide information and assurance to the Board regarding the Nursing and Midwifery Safer Staffing levels and the subsequent underpinning workstreams as part of the Nursing Workforce Programme Board.

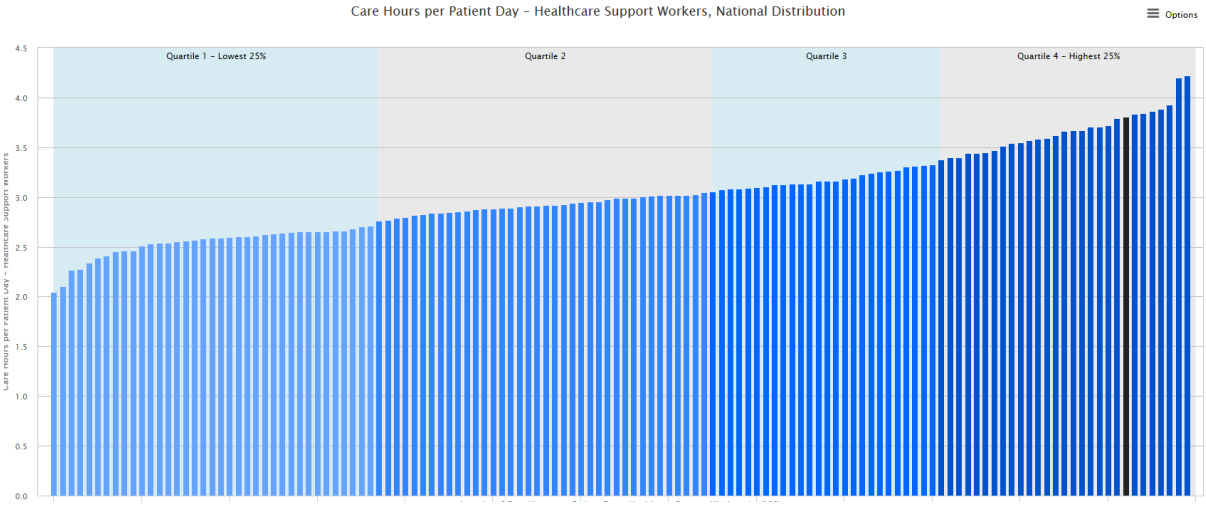
On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset.

The model hospital dashboard was updated in September 2016 to show the national median data which is 7.76 Total, 4.74 RN & 2.91 HCA.

The snapshot below is taken from the Model hospital and shows the Trust is above the National total CHPPD at 7.7 in January 2018, below for Registered Nurses and above for HCA's (Data currently shown in Model hospital)

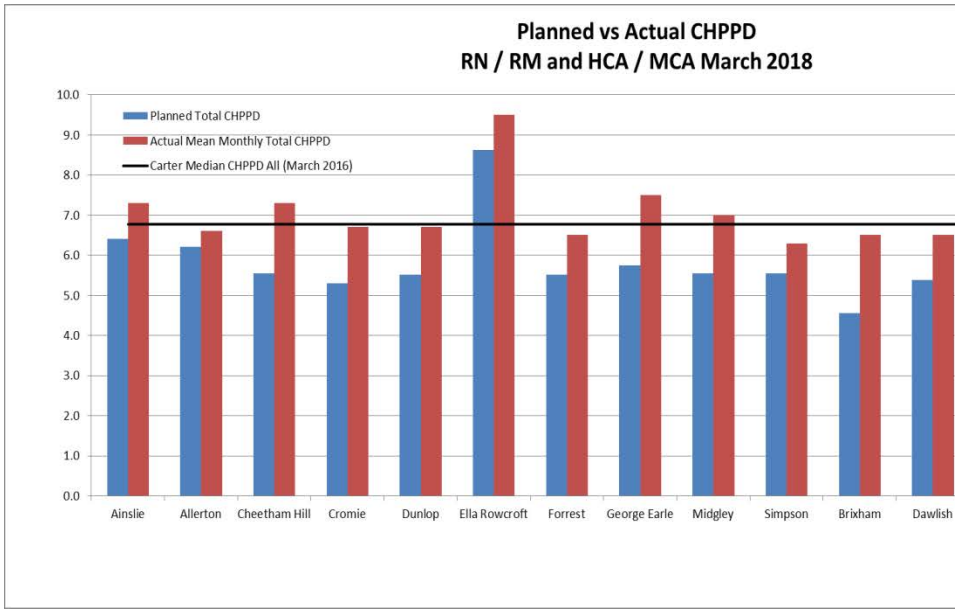
This is reflected in the distribution chart below showing the Trust is in the lowest quartile for RN's nationally and the highest quartile for HCA's.

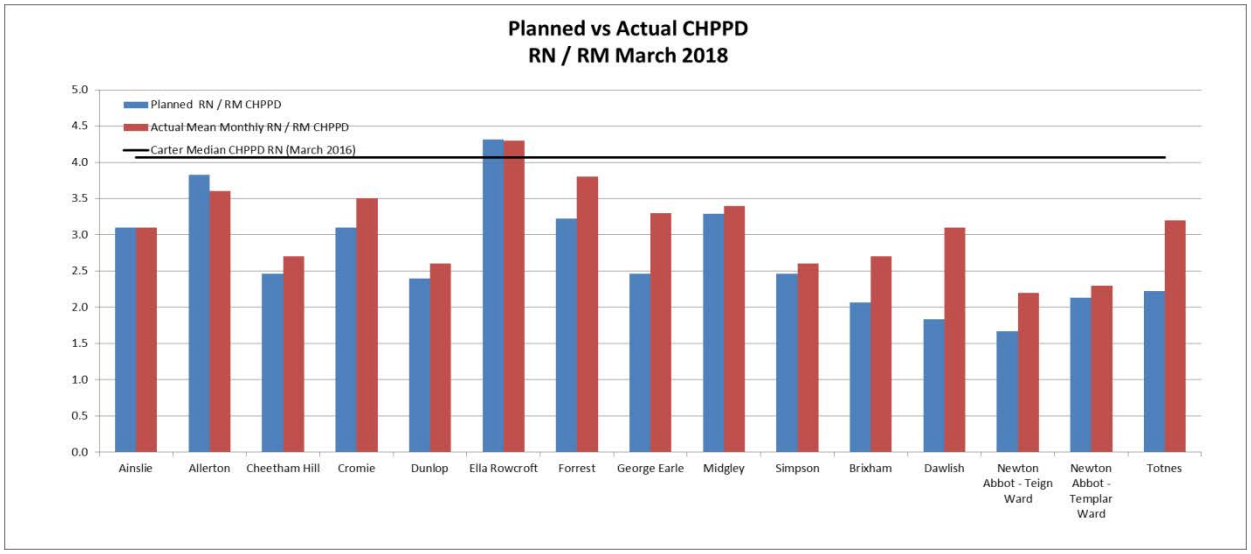


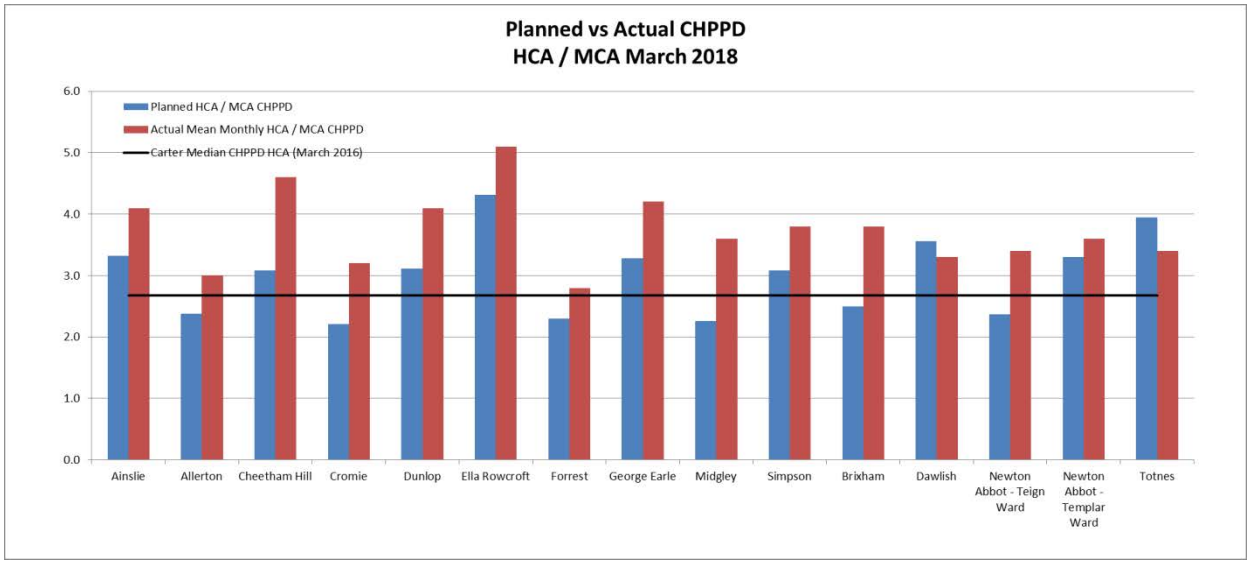


The Table below shows that whilst the Trust is over its planned total (RN + HCA) staffing levels in several areas and below the national Carter Median of 7.76 overall, the trust is still below the national CHPPD range of 4.74 for RN's (TSDFT 4.00) and above the national 2.91 for HCA's (TSDFT 3. 78).

	TSDFT March 2018	TSDFT September 2016	National Median September 2016
Total CHPPD	7.78	7.84	7.76
RN/ RM CHPPD	4.00	3.73	4.74
HCA / MCA CHPPD	3.78	4.11	2.91


Planned vs Actual CHPPD
RN / RM and HCA / MCA March 2018
Planned Total CHPPD
Actual Mean Monthly Total CHPPD
Carter Median CHPPD All (March 2016)
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Ainslie
Allerton
Cheetham Hill
Cromie
Dunlop
Ella Rowcroft
Forrest
George Earle
Midgley
Simpson
Brixham
Dawlish


Planned vs Actual CHPPD
RN / RM March 2018
Planned RN / RM CHPPD
Actual Mean Monthly RN / RM CHPPD
Carter Median CHPPD RN (March 2016)
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Ainslie
Allerton
Cheetham Hill
Cromie
Dunlop
Ella Rowcroft
Forrest
George Earle
Midgley
Simpson
Brixham
Dawlish
Newton Abbot - Teign Ward
Newton Abbot - Templar Ward
Totnes


Planned vs Actual CHPPD
HCA / MCA March 2018
Planned HCA / MCA CHPPD
Actual Mean Monthly HCA / MCA CHPPD
Carter Median CHPPD HCA (March 2016)
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Ainslie
Allerton
Cheetham Hill
Cromie
Dunlop
Ella Rowcroft
Forrest
George Earle
Midgley
Simpson
Brixham
Dawlish
Newton Abbot - Teign Ward
Newton Abbot - Templar Ward
Totnes

The graphs above and table below in Appendix 1 show that there are a number of areas that are above the planned RN & HCA numbers.

The Opel Status for organisation throughout March has been at unprecedented levels and as a result many wards have had increased dependency and pressures through the Month.

Midgley is showing over for HCA's due to the increased ward dependency throughout the Month.

Forrest ward have had increased 1 to 1 special for HCA's and have an extra overseas RGN with in the numbers.

Ainslie has had a number of patients requiring specialing and therefore needed additional HCA support.

It has been agreed that Totnes have extra RN on Monday and Thursday as no discharge coordinator to progress discharges this is on-going at this time.

Brixham hospital is also over their planned HCA usage due to 1:1 requirements 24 hours a day which remains on-going at this time along with George Earl too. Cheetham Hill have experienced a minimum of 2 1 to 1 specials per shift hence the over planned HCA numbers. This was agreed into the budget moving forward yet to be reflected in the figures the budget has not been adjusted to reflect this however this should be from April 18.

Simpson – Have had numerous 1 to 1 specials requiring increased staffing and Dawlish too with an increased demand for Escorts to main site for CT's .

2. Organisational Alert Status

An organisational Opel status is published and shared with our partner organisations on a daily basis.

which provides an indicator of the operational pressures experienced within the system. This is summarized within this report, as it provides a good proxy indicator of the wider organisational pressures and climate the wards are working within, and which may impact on our staffing decisions.

The alert status for the organisation for the month of March 2018 is summarised in the table below.

TSDFT Alert Status	No Days in Month	% days in Month
Opel 1	2	6.45%
Opel 2	5	16.13%
Opel 3	14	45.16%
Opel 4	10	32.26%

3. Medical Services Delivery Unit and Emergency Department

The medical SDU has recently submitted their safer staffing requirement which has been approved by the Finance Committee. The submission is reflective of current requirements to enable three Registered Nurses on duty at night and the change in acuity & dependency of the patients. It also reflects the essential supervisory ward manager time of two days per week. This will be reflected in the coming CHPPD information once the staff are in post.

The table below details the daily planned, actual and % fill rates for nurse staffing in the Emergency Department.

The total fill rate for March 2018 was 96.3% for RN and 110.8% for HCA. There are a number of new bank HCA's undergoing observation shifts and for specialing patients. The department was in OPEL 3 for 14 days and OPEL 4 for 10 days which increased pressure on the department throughout the majority of March.

		Total Planned shifts		Total Actual Shifts		RN Shift	HCA Shift
		RN	HCA	RN	HCA	fill rate	Fill Rate
Thu	01/03/2018	19	13	19	12	100.0%	92.3%
Fri	02/03/2018	19	13	17	13	89.5%	100.0%
Sat	03/03/2018	19	13	20	18	105.3%	138.5%
Sun	04/03/2018	19	13	22	17	115.8%	130.8%
Mon	05/03/2018	19	13	20	14	105.3%	107.7%
Tue	06/03/2018	19	13	20	13	105.3%	100.0%
Wed	07/03/2018	19	13	20	16	105.3%	123.1%
Thu	08/03/2018	19	13	20	15	105.3%	115.4%
Fri	09/03/2018	19	13	20	16	105.3%	123.1%
Sat	10/03/2018	19	13	17	16	89.5%	123.1%
Sun	11/03/2018	19	13	18	16	94.7%	123.1%
Mon	12/03/2018	19	13	22	13	115.8%	100.0%
Tue	13/03/2018	19	13	20	14	105.3%	107.7%
Wed	14/03/2018	19	13	20	15	105.3%	115.4%
Thu	15/03/2018	19	13	12	15	63.2%	115.4%
Fri	16/03/2018	19	13	19	13	100.0%	100.0%
Sat	17/03/2018	19	13	18	16	94.7%	123.1%
Sun	18/03/2018	19	13	18	16	94.7%	123.1%
Mon	19/03/2018	19	13	20	11	105.3%	84.6%
Tue	20/03/2018	19	13	20	13	105.3%	100.0%
Wed	21/03/2018	19	13	19	16	100.0%	123.1%
Thu	22/03/2018	19	13	19	17	100.0%	130.8%
Fri	23/03/2018	19	13	21	13	110.5%	100.0%
Sat	24/03/2018	19	13	17	16	89.5%	123.1%
Sun	25/03/2018	19	13	21	17	110.5%	130.8%
Mon	26/03/2018	19	13	20	16	105.3%	123.1%
Tue	27/03/2018	19	13	27	15	142.1%	115.4%
Wed	28/03/2018	19	13	21	18	110.5%	138.5%
Thu	29/03/2018	26	17	20	17	76.9%	100.0%
Fri	30/03/2018	33	21	21	19	63.6%	90.5%
Sat	31/03/2018	40	25	21	17	52.5%	68.0%
	Total	**574**	**388**	**553**	**430**	**96.3%**	**110.8%**

4. Maternity Services

Maternity Services**:**

We are still awaiting the final report from birth rate plus however form the audit that was undertaken in September, the initial results show the trust currently has the correct number of clinical and non-clinical midwives and Band 3 Maternity Support Workers to effectively and safely run the maternity service.

Maternity services are actively recruiting to vacant posts and are proactively managing sickness in conjunction with HR. There has been a significant amount of planned surgery for our staff group, whilst levels of stress are also high. We are working with the organisational development team to look into this.

5. Further Nursing Workforce Programme Updates

5.1 Recruitment & Retention

The Trust recruitment & retention campaigns continue with a new trust recruitment steering group in place to review marketing and values based recruitment.

We have targeted our Second year students that started in September and have invited them to drop in sessions to discuss career opportunities and why work in Torbay. There are 7 firm offers for the rotational nurse programme where the newly qualified nurses have completed all recruitment checks. There are a further 5 with in the recruitment process and being chased regularly. Planning is already in place for a September 2018 recruitment day as the previous one proved a success. There will be monthly open sessions for all students held in the main reception and these are due to be advertised within the trust and on social media to promote the programme..

We have also re launched our rotation programme where all newly qualified nurses will now join the rotation programme. This will run in the same way as our international nurses welcome to the trust meetings and three month “How are you settling in” review meeting. The programme incorporates Medicine, Surgery and a Community placement with a view to extend this to the speciality areas at the end of the first rotation. We have planned a nurse Rotation recruitment day which looks to be a success just by reviewing the planned attendees.

We have the beginnings of a Fifth Cohort from the Philippines and are now waiting for a few more nurses to join the group in order for us to be able to bring them over to the UK.

Cohort 3 and 4 have all passed there OSCE’s and are now an established RN on the wards they are placed. The Trust has a 100% success rate to date. A

The NMC have also recently launched the acceptance of a further English Language Test called the OET (Occupational English Test) alongside the IELTS.

An overseas progress review paper will be presented shortly to the Executive Directors with further recommendations in terms of workforce planning.

5.2 E rostering

Allocate E rostering system has now gone live with all pilot, bank and phase 1 clinical areas using the system. This was achieved on time with the Trust having signed up to the 12 week “Big Bang” approach.

This means there are now in excess of 100 areas that are active on the Allocate system with phase 1 and pilot areas all using Health roster. All other areas requesting bank staff are also accessing Allocate to do so and the Trust will be turning off the paper timesheet process at the end of May with all timesheets being electronic on the 1st June.

We are now working through the initial teething problems as expected with any new system and will be going forward with the next phase of Safe Care commencing 1st June 2018 followed by Auto roster in August 2018.

There is now an Allocate support page for staff with use full resources attached including some FAQs for bank and substantive staff. We have also provided links for direct access to Health Roster and the Bank systems for ease.

The feedback to date has been a positive one with areas feeling it is an easier and quicker system to use once they have had their training.

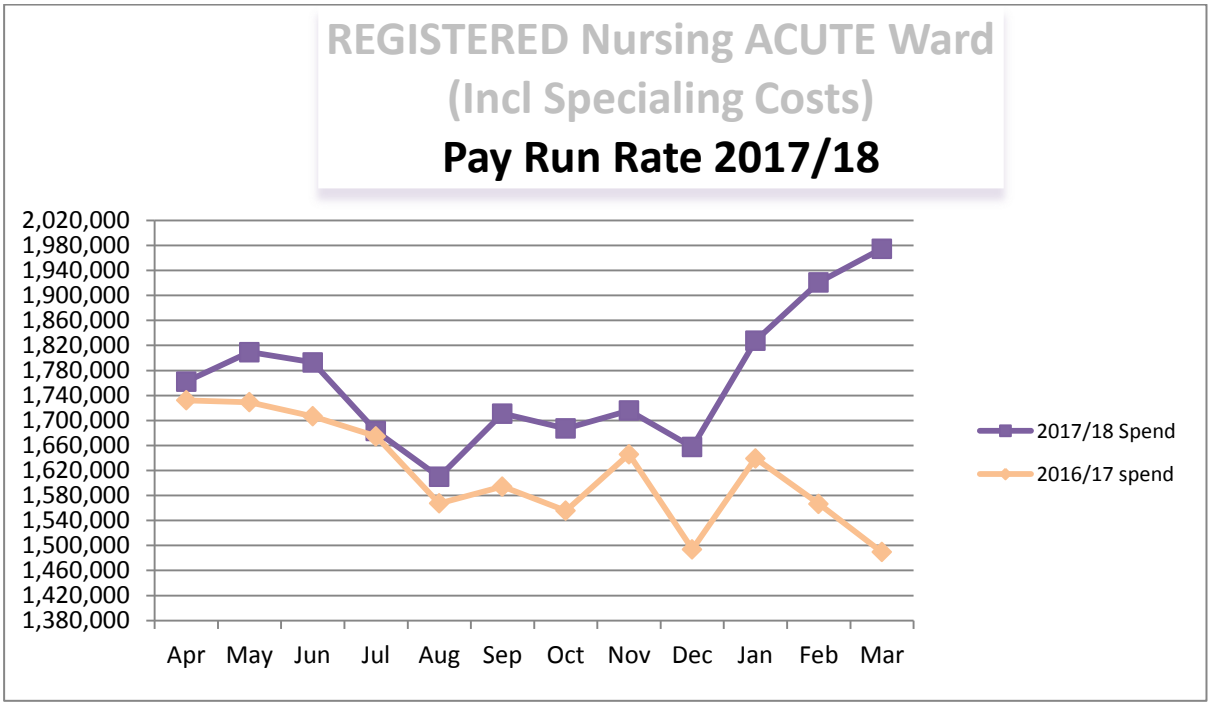
5.3 Agency Spend

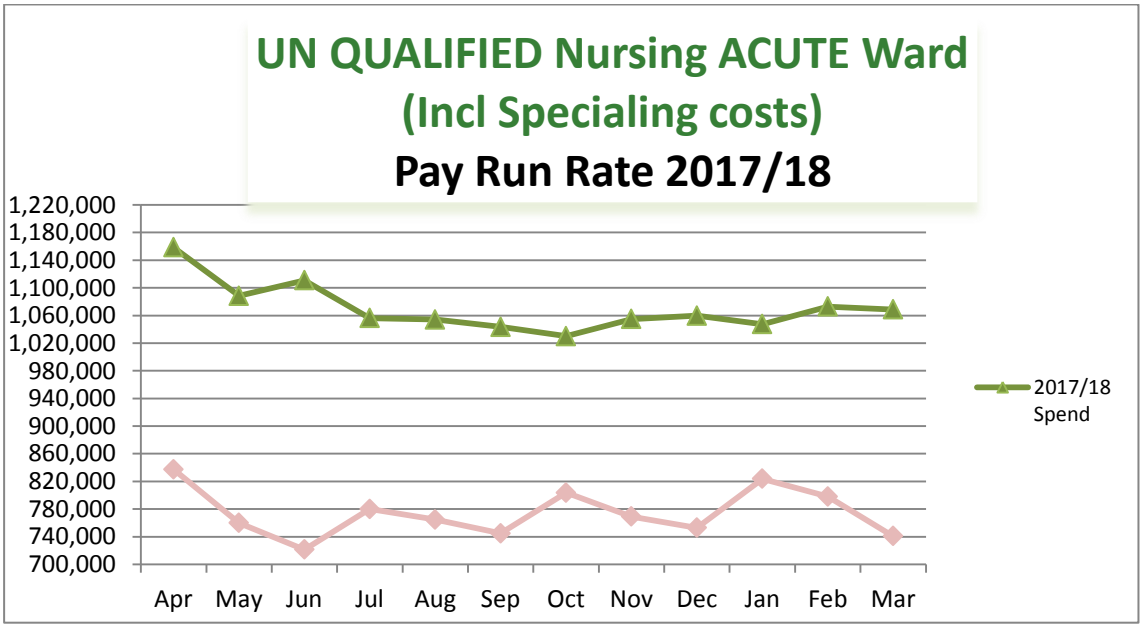
Although an unprecedented amount of work has been undertaken to manage and control agency overspend, quarter 4 came with overwhelming operational pressures and the Trust being in OPEL 3 and 4 for most of the quarter. The acuity and dependency of the patients was high and with it came the Flu outbreak. Warrington ward was open at full escalation for all of this time and staffing levels were a challenge and all non-ward based staff were redeployed to ensure patient safety was maintained.

A number of patients were requiring 1:1 enhanced care and a number of CAHMS patients required 2:1 Registered Nursing supervision. A number of agency temporary placements were required to ensure service needs were met which included a number of Thornbury placements at that time.

This has now ceased with the aim to bring agency spend back into alignment. The new bank pool initiative is now working well with the cessation of enhanced payments to bank shifts unless part of the pool which requires full flexibility in place of work and the need to work across the ICO.

The graphs & Tables below show the agency use for Registered Nurses and bank usage for non-Registered staff and the total Nursing agency spend v NHSI agency Cap:





The Table below shows the total agency spend for Nursing is £1.753m. This equates to £1.392m under the NHSI agency cap for Nursing of £3.14m.

B	*Actual Year to Date Nursing Agency Spend £m*												
Month	*April*	*May*	*June*	*July*	*August*	*September*	*October*	*November*	*December*	*January*	*February*	*March*	*FY 2017-18*
Spend in Month £m	(0.112)	(0.136)	(0.147)	(0.063)	(0.071)	(0.086)	(0.092)	(0.103)	(0.086)	(0.187)	(0.291)	(0.379)	(1.753)
Total Nursing Spend £m	(4.613)	(4.340)	(4.634)	(4.354)	(4.399)	(4.396)	(4.430)	(4.470)	(4.440)	(4.680)	(4.849)	(4.725)	(54.330)
% Agency over Total	2%	3%	3%	1%	2%	2%	2.1%	2.3%	1.9%	4.0%	6.0%	8.0%	3.2%
Year to Date Spend £m	(0.112)	(0.248)	(0.395)	(0.458)	(0.529)	(0.615)	(0.707)	(0.810)	(0.896)	(1.083)	(1.374)	(1.753)	

C	*Variance Agency Cap versus Actual Spend £m (B-A) - (Overspend)/Underspend*												
Month	*April*	*May*	*June*	*July*	*August*	*September*	*October*	*November*	*December*	*January*	*February*	*March*	*FY 2017-18*
in Month £m	0.590	0.559	0.365	0.215	0.131	0.107	0.036	0.017	0.026	(0.112)	(0.223)	(0.319)	1.392
Year to Date £m	0.590	1.149	1.514	1.729	1.860	1.967	2.003	2.020	2.046	1.934	1.711	1.392	
Distance from Cap %	-84.05%	-82.25%	-79.31%	-79.06%	-77.86%	-76.18%	-73.91%	-71.38%	-69.54%	-64.10%	-55.46%	-44.26%	
UOR* Agency Rating	1	1	1	1	1	1	1	1	1	1	1	1	

6. Quality & Safety

There is a robust quality and safety monitoring process in place to ensure patient care is not compromised in any way. Patient incidents are monitored monthly by the senior nursing teams and reported through the monthly Quality Improvement Group (QIG) as a dashboard. In addition, each clinical area completes the monthly Questt tool which triggers actions as highlighted in the escalation procedure. The Deputy Director of Nursing & Professional Practice & standards ensures contact is made for any area triggering an amber score and ensures appropriate action is taken place.

A weekly huddle takes place with the Chief Nurse, Associate Directors & Deputy Directors of Nursing to discuss staffing, safety & quality issues and concerns. These are closely monitored in terms of acuity of patients, safe staffing levels and any use of agency/temporary staff. In addition staffing levels and ward status is discussed three times a day at the control meetings with the Matron of the week, Senior Nurses and on call manager.

The Questt Dashboard is displayed in the tables below for the Acute & Community Hospitals inpatient areas:

The report is now including non-bed based nursing and therapies so as to give a broad overview of staffing trigger points.

In March 2018 the dashboard identified eleven teams' triggered amber and no teams triggered red or Purple.

Service Type	Team	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
% Complete		95%	95%	98%	98%	95%	96%	94%
Total Purple (L3)		0	0	0	0	0	0	0
Total Red (L2)		1	0	0	0	0	0	0
Total Amber (L1)		9	5	7	3	6	7	8
Total Green (L0)		71	76	76	80	75	75	72
Average Score		8.4	8.2	7.9	7.9	8.6	8.3	8.9
Acute	Ainslie	12	9	10	9	9	10	8
	Allerton	11	16	12	10	11	12	14
	AMU	2	0	4	2	2	0	
	Anaesthetics	10	7	8	9	5	8	7
	Breast Care Unit	6	8	0	4	0	2	1
	Cath Lab	5	4	1	2	1	9	1
	Cheetham Hill	4	6	7	5	7	5	5
	Cromie	7	12	4	8	9	5	4
	DSU	7	8	5		8	9	11
	Dunlop	6	5	8	5	7	1	
	Early Pregnancy / Fertility Service	0	5	0	0	2	2	0
	EAU3	10	7	3	10	3		12
	EAU4	5	6	4	4	5	5	11
	Ella Rowcroft	5	7	10	4	5	8	8
	Emergency Department	13	12	16	11	14	16	
	Endoscopy	4	9	9	10	5	4	4
	Forrest	7	7	5	7	8	5	6
	General Theatres	12	15	8	8	8	9	12
	George Earle	8	12		12	14	12	15
	Gynaecology Out-Patients Dept	10	7	7	3	3	3	7
	Hutchings	7	7	8	4		14	19
	ICU	2	10		10	6	7	4
	Louisa Cary	3	2	2	9	8	11	9

Service Type	Team	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Acute	MAT / TAIRU	6	3	2	5		2		6	6	12	11	3
	Maternity	15	11	13	15	14	12	14	16	11	9	11	12
	Midgley	2	6	6	3	8	8	4	11	9	13	9	15
	OPD	5	7	4	2	3	4	2	2	6	6	3	5
	Ophthalmology	8	11	12	8	13	7	7	7	10	5	6	8
	Ortho Theatres	17	14	15	14	13	15	14	13	13	8	15	15
	Pre-assessment	4	4	4	2	2	4	2	6	2	2	2	4
	Radiology	13	13	11	13		15	14	15	13	13	15	
	Recovery	7	10	9	9	9	7	7	7	5	5	6	5
	RGDU			7	10	16	7	8	12	15	17	13	19
	SCBU	3	8	3	8	10	7	9	3	11	8	8	5
	Sexual Health	6	10	7	9	11	13	10	8	8	19	15	
	Simpson	6	5	5	7	6	10	8	12	11	8	11	11
	TCCU	2	4	6	6	4	3	0	2	4	6	11	4
	Turner	5	4	6	7	8	7	14	13	15	12	12	17
	Urology	14	9	6	6	7	4	7	8		9	9	9
Community Hospital	Brixham	11	7	0	5	10	7	11	7	5	9	13	11
	Dawlish	0	3	3	4	4	3	5	3	3	3	7	3
	Newton Abbot Teign	11	7	7	8	6	10	14	15	17	17	12	14
	Newton Abbot Templar	2	4	2	6	6	3	3	2	9	5	7	7
	Totnes	6	2	11	10	8	7	4	6	8	16	9	8
MIU	Dawlish	2	4	0	0	6	4	0	2	4	7	5	2
	Newton Abbot	0	2	2	6	2	0	0	5	3	5	2	2
	Totnes	0	0	0	2	4	0	0	0	2	0	3	7
Community Stroke and Neurology	Torbay and South Devon		10	10	10	14	8	10	10	8	16	16	10
Infection Control	Infection Control	4	3	5	7	8	8	8	6	3	10	11	9
LLTS	LLTS	6	4	5	7	7	5	5	4	4	4	4	4
Nursing	Brixham and Paignton	17	13	12	7	12	9	9	14	10	12	12	8
	Coastal	27	21	23	22	15	12	9	19	18	19	15	18
	Moor to Sea			16	21	17	17	11	11	11	9	13	14
	Newton Abbot	12	14	8	14	14	15	14	15	18	9	13	19
	Torquay	7	6	11	8	12	5	8	5	6	8	9	7

Service Type	Team	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017
OOH Nursing	OOH Nursing	12		13	13	13	12	21
Specialist Nursing	Specialist Nursing	12	18	14	14	10	16	12
Occupational Therapy	Brixham and Paignton	6	2	9	12	7	8	2
	Coastal	22	16	12	6	8	13	11
	Moor-to-sea	22	10	18	6	10	10	12
	Newton Abbot	16	14	18	12	14	14	11
	Torquay	18	4	2	2	6	16	16
Physiotherapy	Brixham and Paignton	6	10	13	10	15	14	14
	Coastal	14	10	9	4	8	11	15
	Moor-to-sea	10	8	8	8	10	6	10
	Newton Abbot	16	14	18	14	18	18	15
	Torquay	21	24	14	12	14	8	6
Podiatry	Podiatry	16	15	15	17	17	19	19
Public Health - CAMHS	CAMHS	6	4	6	8	8	8	10
Public Health - Lifestyles	Lifestyles	7	9	9	8	9	7	10
Public Health - Nursing	Brixham	0	5	0	0	0	3	0
	Paignton	9	10	12	10	10	4	
	School Nursing	7	9	9	8	10	7	9
	Torquay North	2	2	2	2	2	2	2
	Torquay South	4	3	4	2	4	2	3
Public Health - Substance Misuse	Substance Misuse	4	6	6	9	8	10	10
Social Care	Brixham and Paignton	12	10	14	15	12	12	12
	Dawlish & Teignmouth	4	2	4	2	2	12	8
	HADT - S. Devon	15	15	13	11	17	17	19
	HADT - Torbay	11	11	10	11	14		17
	Newton Abbot			16				16
	Older People Mental Health - Torbay	2	4	2	0	2	0	2
	Torquay	8	10	8	10	10	14	14
	Totnes & Dartmouth	14	10	12	12	20	14	14
Tissue Viability	Tissue Viability	8	8	6	7	8	12	10

6.1 Emergency Department

ED has triggered 21 due to the exceptional demands on the service with 93% of the time in February being in escalation. The department is carrying high levels of sickness absence and 13 wte vacancies being covered with agency temporary placements.

6.2 RGDU:

Trigger due to staff sickness, maternity leave and vacancy rate.

6.3 Teign Ward

Trigger - Teign Ward Newton Abbot Community Hospital due to vacancies, sickness and unusual demand on service (investigations etc.). Assistant Director and Senior Matron have agreed Your World Agency Support (3 RGN's) but limited help till post December. Four staff off long term sick all being managed with HR, with two possibly returning in January 2018.

Action - Associate Director of Nursing (ADN) has met with the ADN in workforce around getting support from the acute regarding back fill, Philippine recruitment and qualifying Nurse Associates.

6.4 Coastal Community Nursing

Trigger - Coastal Community Nursing due to vacancy rate, short and long term sickness, appraisals not being completed due to service demands and shortages.

6.5 Physiotherapy/Occupational Therapy

Trigger: This was due to the OPEL status of the trust and resources being redirected as required including additional support on Warrington ward.

6.6 OOH Nursing:

Trigger: due to vacancy rate, short and long term sickness, vacancies slow to recruit into. Limited Temporary Staffing support.

6.7 Social Care HDAT Torbay & S. Devon & Newton Abbot

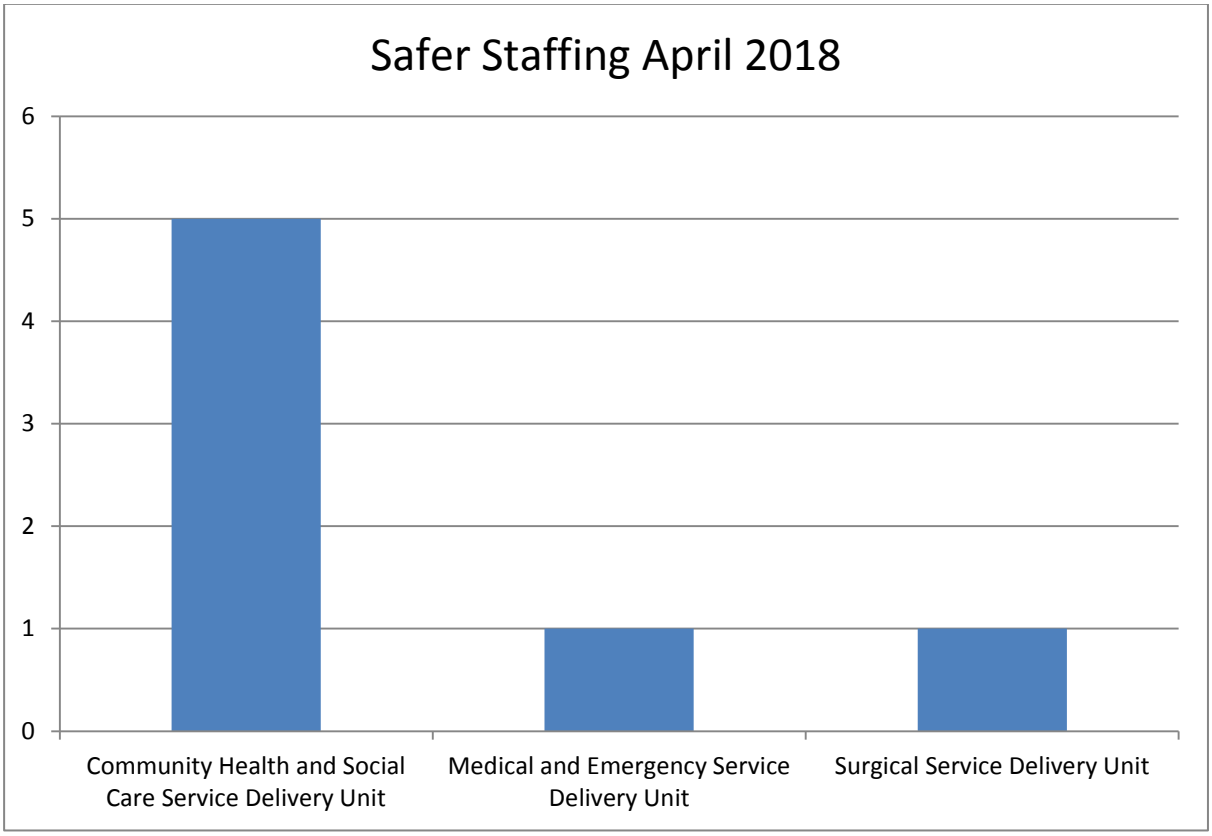
Trigger: This is due to the complexity of patients and demand. There have been three care homes closed during this time due to safeguarding processes and therefore a lack of capacity. There are current issues with regards the provision of domiciliary care.

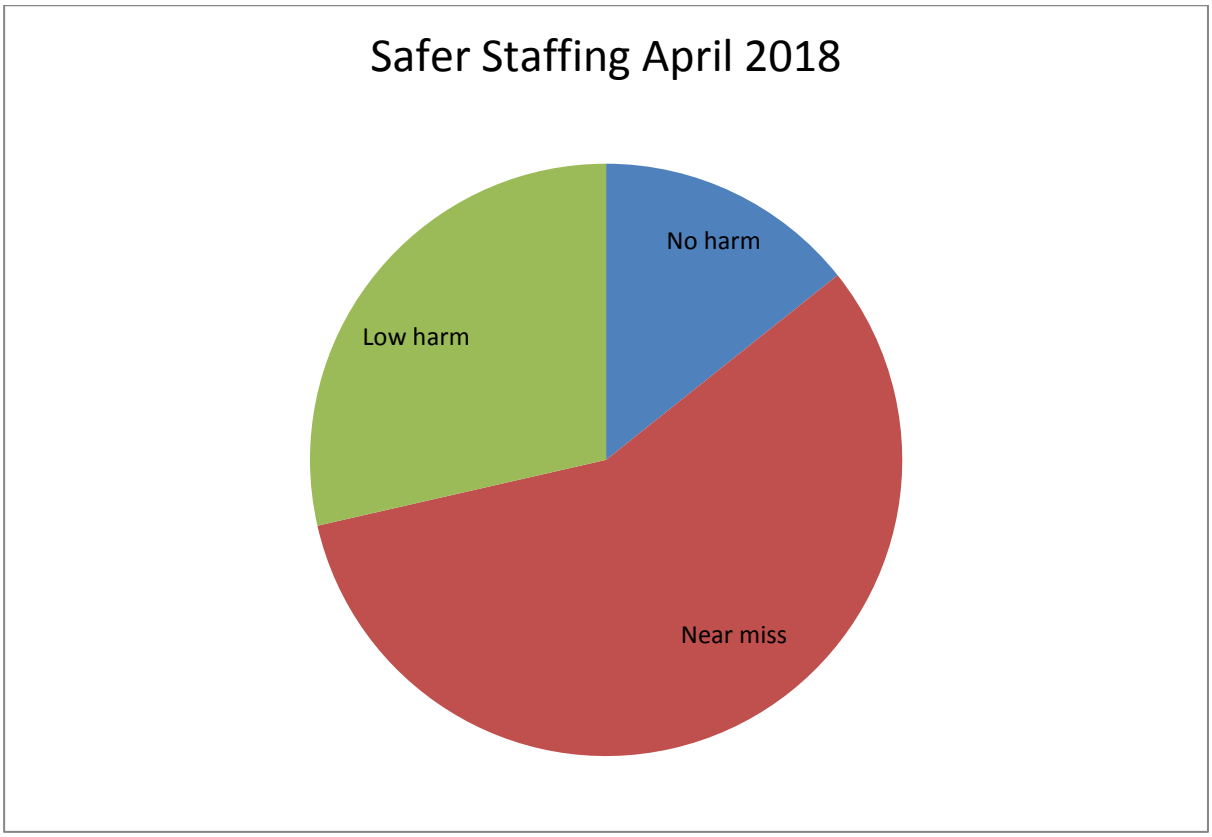
Action: Contingencies are in place and monitoring of services. Weekly meetings are in place with domiciliary care provider.

6.8 Staffing Incidents and Red Flags

Staffing Incidents and red flags are monitored monthly by the Associate Director of Nursing Workforce which are reported to the Quality Improvement group monthly. These are monitored alongside the Trust Quality Dashboard in relation to Falls, Medication errors, Pressure Ulcers & CHPPD.

There were 7 incidents relating to staffing levels during last month. Although four of these were recorded as near misses, this was due to the level of escalation and dependency of the clinical areas at this time and the challenges to meet the required staffing levels. No harm was caused.




Safer Staffing April 2018
No harm
Low harm
Near miss

Appendix 1 – Care Hours Per Patient Day for Acute and Community Setting Wards

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly HCA / MCA CHPPD
Ainslie	6.4	3.1	3.3	7.3	3.1	4.1
Allerton	6.2	3.8	2.4	6.6	3.6	3.0
Cheetham Hill	5.5	2.5	3.1	7.3	2.7	4.6
Coronary Care	5.8	5.8	0.0	8.9	8.2	0.7
Cromie	5.3	3.1	2.2	6.7	3.5	3.2
Dunlop	5.5	2.4	3.1	6.7	2.6	4.1
EAU3	6.3	3.6	2.8	8.5	4.7	4.4
EAU4	7.2	3.8	3.4	9.8	5.1	4.2
Ella Rowcroft	8.6	4.3	4.3	9.5	4.3	5.1
Forrest	5.5	3.2	2.3	6.5	3.8	2.8
George Earle	5.8	2.5	3.3	7.5	3.3	4.2
ICU	20.4	20.4	0.0	24.6	24.6	0.0
Louisa Cary	6.7	4.2	2.4	16.1	9.1	7.0
John Macpherson	4.0	2.3	1.7	11.6	7.5	4.2
Midgley	5.5	3.3	2.3	7.0	3.4	3.6
SCBU	6.9	6.9	0.0	15.3	12.1	3.2
Simpson	5.5	2.5	3.1	6.3	2.6	3.8
Turner	7.9	3.6	4.2	8.5	3.4	5.1
Brixham	4.6	2.1	2.5	6.5	2.7	3.8
Dawlish	5.4	1.8	3.6	6.5	3.1	3.3
Newton Abbot - Teign Ward	4.0	1.7	2.4	5.6	2.2	3.4
Newton Abbot - Templar Ward	5.4	2.1	3.3	5.9	2.3	3.6
Totnes	6.2	2.2	3.9	6.6	3.2	3.4

Key Explanatory notes

RN = Registered Nurse / Registered Children's Nurse

RM = Registered Midwife

HCA = Healthcare Assistant

MCA = Maternity Care Assistant

Red cells indicate the mean monthly Care Hours per Patient Day (CHPPD) were below that planned and agreed as the budgeted safe staffing level for the ward. Measures to ensure safety are managed on a daily basis by the ward manager and matron.

Cover sheet and summary for a report to the Trust Board of Directors					
Report title: Report of the Medical Director				Date: 23rd May 2018	
Report sponsor	Medical Director – Medical Workforce Update				
Report author	Medical Director				
Report provenance	Executive Directors meeting Medical Joint Local Negotiating Committee				
Confidentiality					
Report summary	Resilience of the medical workforce has been the cause of some concern. The report describes the challenges and actions being taken to address concerns.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	The Trust board is asked to consider the content of the report, the concerns and risks in relation to medical staff and the actions being taken to mitigate those risks.				
Summary of key elements	The report summarises progress in relation to: • Clinical Excellence Awards (CEA). The Trust is implementing the new CEA process as mandated whilst assessing the financial impact. • Job Planning Review. Good progress is being made in implementation of the job planning policy. • The Trust is in the second wave of streamlining of junior doctor appointments • The recent IT problem relating to Specialist Registrar post offers is not expected to cause any material difference to the Trust, though it has been a cause of concern for doctors. • The Trust is contributing to the STP review of recruitment and has engaged an agency with the aim of increasing recruitment from overseas. • The report includes a summary of recruitment over recent months. The position in relation to vacant posts is stable but with some remaining areas of challenge.				
Strategic context	• Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	The resilience of medical workforce is included in the corporate level risk register.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting dated • Risk Management Group dated				

Stakeholder engagement	Medical Joint Local Negotiating Meeting March 2017
Other standards affected	None identified
Legal considerations	None

Report title: Report of the Medical Director - Medical Workforce Update		Date: 23rd May 2018
Report sponsor	Medical Director	
Report author	Senior Medical HR Manager	

1. Introduction

The aim of this report is to provide Trust Board with an update on some of the issues affecting the medical workforce.

There have been concerns relating to the resilience of the workforce in some areas. The report provides information relating to recent recruitment and details of the plan to improve recruitment.

2. Clinical Excellence Awards

Government sign off has now been received for the future process of Clinical Excellence Awards (CEAs) for Medical staff. The new process came into effect from 1st April 2018 with a review in 2021.

CEAs will become a contractual requirement, calculated at 0.30 per full time equivalent (FTE) (the Trust's current calculation is based on 0.20 per FTE). The awards will be non-pensionable and non-consolidated, paid up to 3 years only and paid annually by lump sum with no Annual Pay Award uplift. All current CEA award holders will be protected at least until 2021.

The Trust must implement the new process. As assessment of the financial impact of implementation is being undertaken, with the support of the finance department.

We have completed the NHSI return requesting information on our past two CEA rounds in order that more information to understand the impact of the reformed scheme can be gathered.

The revised process has been discussed at the Medical Joint Local Negotiating Committee (JLNC) with agreement that the CEA Committee will meet on Thursday 26th April to draft the new local process for the 2018 CEAs.

Applications for National CEA opened on 13th February and closed on 12th April, 1 individual has applied and been supported by the Trust.

3. Job Planning

The revised Job Planning policy was discussed at the March Medical JLNC, it was agreed it would be circulated for final comment with an understanding that the policy would be ratified by end of April. Medical HR will be working with Directorates to understand the key changes of the policy and how this influences future job planning processes. In addition the Medical HR team continues to work with Directorates to customise the Allocate Job Planning system to make it more relevant to specialities thus allowing job plans that are fit for purpose.

The Job Planning Implementation group continues to meet and oversee the implementation of the new job planning process including monitoring the achievement of the project action plan. There is excellent progress in securing engagement of the clinical directors and clinical leads in the implementation of the new process.

4. Streamlining Doctors in Training Recruitment

We continue to work to adopt the 6 key principles of the National Streamlining of trainee recruitment, as a Fast Follower of the National Pilot. We were able to test the key principle relating to Competencies in ESR and 12 week KPI, however the other Principles have been more difficult and both nationally and locally there are blocks to achieving ESR/TIS interface, Pre-Hire IAT information and Occupational Health Immunisations records being available in ESR. We are closely monitoring the information received from the National Programme Office and will endeavour to work towards the key milestones as appropriate. The National pilot was due to go live with all trainee doctors from August 2018 we wait to see if this timeframe will be postponed due to the current difficulties.

5. STP Corporate Services Support Review – Recruitment

A series of workshops are being held for each service area within the scope of the HR review – Occupational Health, Recruitment and Payroll. The purpose of the workshops is to brief the service areas on the CSSR programme and scope for this review, to collaborate and seek their expertise and experience in the understanding of the current service provision and to explore in more detail for the possibility and viability of sharing at greater scale across the NHS in Devon. At the request of the Medical Directors Medical Recruitment has been included as part of these discussions. The Medical HR Manager attended the first workshop on 27th March and will be attending the now combined Recruitment and Payroll workshop on 25th April.

The Workshops are considering the following areas:

- Identify areas of current best practice across the STP
- Identify quick wins for streamlining/standardisation
- Agree suite of service KPIs to enable improvement measurement
- Service improvement facilitation to support design of potential integrated services
- Recruitment/payroll conversations to explore integration between these two services to identify areas of overlap/benefit
- Identify areas of risk in current service delivery and mutual support offer

The Regional Medical HR Managers group will be working together to inform the agenda for Medical HR Recruitment.

An external agency, Remedium Ltd, has been engaged by the STP to support recruitment to the Trust where there are hard to fill vacancies. Initial contact has been made with the agency and response is awaited.

6. Current Medical Recruitment (as at 18 April 2018)

Current Permanent Medical Vacancies / Appointments

Grade	Specialty	Status
Consultant (2 posts 1 x replacement and 1 x new)	Histopathology	Closed 18 March 2018 – Recd 1 applicant Interviews 28 March 2018 – appointed due to commence 31 July 2018
Consultant (replacement)	Clinical/Medical Oncology	Re-advertised – closed awaiting to hear from dept
Consultant (replacement)	Haematology	Re-advertised – closes 27 May 2018 – no applications so far.
Locum Consultant	Haematology	Advertised – closes 27 May 2018 – no applicants so far.
Consultant (new)	Dermatology	The department are continuing to advertise whilst they assess their options.
Consultant (replacement)	Respiratory	Interviews held and appointed – candidate withdrew. Re-advertised with a closing date of 3 April 2018. Arranging Interview date
SAS	Stroke	Awaiting further instructions from department.
Consultant (replacement)	Orthodontist	Currently being advertised – closed 4 March 18 – no applications. Awaiting instructions from dept.
Consultant (new)	Oral & Maxillo Facs	Interviewed 3 April 2018 – appointed due to commence 16 May 2018.
SAS	Trauma & Orthop	Interviewed 3 April – appointed commencement date tbc
Locum Consultant	Urologist	Closed 4 March 18 – Interviews 10 April 2018 candidate cancelled due to family reasons trying to arrange another date.
Locum Consultant	Anaesthetist	Interviewed 18 April 18 – appointed start date to be confirmed (Aug 18?)
SAS (Fixed Term)	Breast Care	Putting on NHS Jobs and will arrange interview date.
Locum Consultant	Ophthalmologist	Closed 18 April – shortlisting taking place
Consultants x 2 (replacements) 1 x Corneal 1 x Medical Retina	Ophthalmologist	Corneal closes on 14 May – no applicants so far. Medicals Retina closes on 25 April – 4 applicants so far
Consultant	ENT	Joint appointment with RD&E, closed 15 April. Interviews being held 3 May at RD&E
Consultant	Diabetes & Endocrinology	Interviews held – appointed to commence 18 June 2018

Cover sheet and summary for a report to the Trust Board of Directors					
Report title: Report of the Interim Chief Operating Officer				Date:23rd May 2018	
Report sponsor	Interim Chief Operating Officer				
Report author	ICOO with contributions from SDU leads				
Report provenance	The report is the product of business transacted through the SDU Board's and other support committees, the Torbay ASC Programme Board the Market Development Executive Group				
Confidentiality	Public				
Report summary	• Work to support continued development of the independent sector and to optimise the care model through Partnership Boards is progressing well and described in the report. • Key priorities identified in the Trusts Operational Plan are being taken forward, these include the ward staffing in the Hetherington block. • The Trust SDU's are in the process of finalising the delivery plans (developments and CIP) for 2018/19. There is a clear understanding of the challenges and options for resolving capacity gaps. The challenge of identifying solutions to close the savings position is managed by the SDU's and reviewed through the Quality and Performance and Efficiency Delivery meetings with the Executive.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☒	**Decision** ☐	**Approve** ☐
Recommendation	The Trust Board is asked to **review** the content of the report and **require** further assurances as may be necessary to secure confidence that the issues raised are being managed effectively.				
Summary of key elements					
Strategic context	Highlight which strategic/corporate objective(s) this recommendation aims to support • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	Delivery of the NHSI operational standards and other strategic objectives are monitored and exception reported through the Trust Integrated Performance Report. The Community SDU supported by the Performance Team is developing a refresh of the measurement used to support assessment of community health and care services.				
Summary of scrutiny	This report has been reviewed by the Interim Chief Executive and the SDU Leads.				

Stakeholder engagement	The following stakeholders were consulted during the compilation of this report: • Clinical and operational teams through various meetings including the Senior Business Management Team and Quality and Performance Meetings. • Trust Board at the development session in February • NHS and Local Authority Commissioners • NHS I - Regulators
Other standards affected	The recommendations made in this report will impact upon: • NHS I Performance Standards • Trust Operational Plan Trajectories
Legal considerations	No legal considerations

Report title: Report of the Interim Chief Operating Officer		Date:23rd May 2018
Report sponsor	Interim Chief Operating Officer	
Report author	Interim Chief Operating Officer and SDU Leads	

1. Purpose

To provide the Board of Directors with an update on operational work programmes

2. Operational plans

The Service Delivery Units (SDUs) have been finalising their operational plans following sign off and submission of the Trust Operating Plan on 30 April 2018. The plans detail how the services will deliver against the agreed performance trajectories and the quality and safety improvements required to deliver safe accessible care, patient and staff experience. The teams as part of the process have considered investment priorities required to support transformation, address capacity gaps as a result of clinical vacancies and cancellation of activity over the winter period. The capacity gaps have increased as a result of the particular challenges that we have had experienced as a result of the snow in March that resulted in a significant reduction in diagnostic and elective surgical interventions planned. This requires teams to plan for a significant increase in activity beyond that planned through capacity planning.

Each of the Service Delivery Units have a CIP target and work progresses to identify how these savings will be delivered over the next year. There remains a gap in the plan, which is subject to on-going review through the Quality and Performance Reviews and Efficiency Delivery Group (EDG).

3. Community Services

3.1 Domiciliary care collaboration event - designing care

The Trust's prime domiciliary care provider, Mears and our partner providers, the council and ICO came together in the second of a series of facilitated sessions to work on designing care for our population.

The session was energetic and engaged and teams across our providers have agreed to continue to work together on a number of change projects. This includes working during non-face to face carer down time on heath prevention and social isolation initiatives, linking with the Trusts wellbeing coordinators. Significant progress was made on truly collaborative delivery. A number of additional hours of care have also been secured for the Dartmouth population which will come in to delivery in early June.

3.2 Minor Injury Units (MIU)

A review of MIU delivery and performance over the last 12 months since closure of Brixham and Paignton has shown increases in the activity at Newton and Totnes as expected following the consultation. Newton Abbot MIU 2017/18 total attendances 21,536 = 9.2% increase on 2016/2017. Totnes MIU 2017/18 total attendances 8,859 -

19% increase on 2016/17 there were a total of 3 breaches of the 4 hour standard in this 12 month period.

3.3 Homelessness project Torbay

The Team has worked with 27 specifically identified clients with a range of needs the team and have delivered some excellent results which has included a measurable reduction in ED attendances since commencement of the project. A full paper and presentation to the board will be planned for September.

3.4 Partnership Boards

New groups are being established in each locality to take forward implementation of the care model including engagement on the implementation of Health and Wellbeing centres in Dartmouth and Teignmouth.

3.5 Internal Audit - Delayed transfers of care (DTOC)

The Audit and Assurance Committee received a copy of the improvement plan to address the issues identified during the audit of DTOC reporting in the Trust. The Committee was satisfied that this addressed the areas of risk identified in the report that had been assessed as having limited assurance.

4. Surgery

The Surgical Team have highlighted the following issues for attention in this month's report:

4.1 Capacity

The team have highlighted capacity gaps that are impacting on delivery of core standards including RTT and 52 weeks waits, cancer 2-week pathways and the 62-day cancer standard. The specialities that continue to have the most significant concerns include:

- Ophthalmology
- Colorectal
- Upper GI
- Urology

The drivers for the capacity gaps include vacancies, increased demand, re- booking of cancelled activity, changes to on call arrangements, job plan changes and availability of appropriately timed theatre capacity.

The teams are developing plan in response to these challenges, which in a number of cases requires recruitment of locum staff. The Trust is also exploring options under the mutual aid arrangements that have been agreed between organisations in the Devon STP.

4.2 Breast screening recall for women between 68- 71 years

In early May the Trust was briefed on the failure of the national screening programme to re- call women between 68 and 71 years for routine screening. In response to this issue the Trust has been working with partner agencies to ensure that all people who require follow up screening are offered an appointment within the required timescale of October 2018. The Trust has capacity gaps in radiology, which with out external support would result in a risk to delivery of the target.

4.3 Theatre efficiency project

A programme of work continues to be developed to support improved utilisation of theatre capacity through out the Trust. A new role has been created and appointed to which supports innovation and new ways of working leads the work programme. The programme of work will help inform our Theatre redevelopment strategy.

4.4 Getting it Right First Time (GIRFT)

A number of clinical specialities in the SDU have taken part in the GIRFT review process with each of the teams charged to identify 5 areas where improvements can be made resulting in an improved experience for people who use services and improved efficiency and cost effectiveness. The specialities include, Ophthalmology, Orthopaedics, Urology and the Emergency Department.

5. Medicine and Urgent and Emergency Care

There are a number of common themes in the Medicine and Emergency care SDU with clinical and operational capacity being material to the Teams ability to address the key risks including to delivery of performance standards for RTT, cancer 2 week wait, 62 day and the follow up backlog.

5.1 Clinical capacity

The specialties include cardiology, dermatology, endocrinology, gastroenterology, neurology and respiratory. Improvement plans are being reviewed for each of the specialties and risks being monitored through the Risk Register

5.2 Operational capacity

Sickness absence, vacancies and delays in recruitment pending the planned changes to the delivery structure have had an impact on capacity to progress programmes of work in the SDU. This is being addressed by the SDU leadership team but is acknowledged as having impact on planning capacity.

5.3 Nursing establishment – Hetherington wards

The Team have identified this as a priority for investment in 2018/19 as a key enabler to delivery of key clinical and workforce priorities on the ward. It is also recognised that this will reduce reliance on temporary staffing. The Team are due to commence recruitment to these posts shortly.

5.4 Internal audit- Winter Plan

A report completed by our Internal Audit team has given significant assurance in relation to our Winter Plan for 2017/18. The feedback will, along side the winter review of learning, inform the plan for 2018/19

5.5 4-hour improvement trajectory

The Executive Team have been concerned about the on-going challenge in meeting the 4-hour standard in line with our submitted trajectory following the winter period. The Medical Director and Head of Operations have commissioned a review of the data so that we can better understand the factors that are contributing to the position. The Flow Board will oversee this work and a work plan is due to be developed following the next meeting on 23 May 2018.

5.6 Ambulance Handover standard

South Western Ambulance Service (SWAST) has introduced a new handover standard for all Emergency Departments in an effort to reduce delays in meeting the new response time standards. SWAST continue to report challenges in consistent delivery of the standard in our department. Work continues in partnership with SWAST to look at our ways of working in order to address these risks. The Devon A&E Delivery Board is overseeing this work

5.7 Emergency Care floor redevelopment

The Programme of work to build the business case for the redevelopment of emergency care facilities is underway under the leadership of the Dr Kate Lissett and Cathy Gardner. The team plan to host a redesign engagement event on 22 June 2018.

6. **Women's Children's and Diagnostics**

The Team has faced a number of the challenges set our by the other SDUs but in addition to this has been involved in a number of service development priorities.

6.1 Sexual Health Tender

The Team have been working with the lead provider Northern Devon Healthcare Trust to develop the mobilisation plan for the Sexual health Service which was awarded earlier this year. The new Service is due to go live in July 2018.

6.2 Children and Young People tender

A significant amount of clinical and operational time is being prioritised to the development of the response to the tender for children's services with the latest part of the submission uploaded on Wednesday 16 May 2018. The team are continuing to work collaboratively with Alliance partners and our bid writing team preparing for the next stage of the process in early June 2018.

7. Recommendations

The Trust Board is asked to **review** the content of the report and **require** further assurances as may be necessary to secure confidence that the issues raised are being managed effectively.

Cover sheet and summary report to the Trust Board of Directors	
Report title: EFM and Health and Safety Performance report for March and April 2018	Date: 23rd May 2018
Report sponsor	Director of Estates and Commercial Development
Report author	Director of Estates and Commercial Development
Report provenance	Capital Infrastructure and the Environment Group
Confidentiality	Public Board
Report summary	**Critical Estate Failures:** A Critical Estates failure are defined as an incident or event caused by an interruption to or loss of estates infrastructure that results in significant risk to and or impacts on the delivery of clinical services. These incidents would normally require out of the ordinary actions to be taken to maintain the safety of services, patients and staff. Six critical estates failures were reported in March and four in April, five of which were declared major incidents. This level of critical failure is abnormal and was due to adverse weather as well as the increasing age of the estate. The enhanced maintenance that has been put in place to address the aged plant significant infrastructure backlog has not able to fully mitigate the risk. The Trust Board is aware of this escalating risk and has made the decision to prioritise capital for both estates and IT investment as matter of urgency. In May, three significant bids (one estates, two IT) totalling £27.3m over 5 years have been submitted through the STP capital process for funding in wave 4. An STP prioritisation panel has agreed that these can be progressed to the next stage for consideration of wave 4 funding so the Trust has more work to do on the draft templates. The next deadline is for 95% completed bid templates submitted by the 1st June. **Maintenance performance:** The performance of statutory and mandatory planned preventative maintenance has improved. The Capital Infrastructure and Environment Group continues to oversee the detailed performance data to ensure that that the organisation is not exposed to significant risk of non-compliance. **Performance Metrics:** A revised set of performance indicators and reports have been approved by the Capital infrastructure and Environment Group for the 18/19 financial year. This now includes a separate report for Health and safety to strengthen the reporting around Health and Safety, security and violence and aggression performance metrics and incidents (Annex 2).

Purpose	Note ☐	Information ☒	Review ☐	Decision ☐	Approve ☐
Recommendation	The Board is recommended to note for information the Trust EFM and H&S performance for March and April 2018. A further update will be provided for information in August 2018				
Summary of key elements					
Strategic context	• Safe, quality care and best experience • Valuing our workforce • Well-led				
Dependencies and risk	Risk of significant failure of infrastructure due to a lack of available capital for investment.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting 15 May 2018 • Capital Infrastructure and Environment Group 16 May 2018				
Stakeholder engagement	The following stakeholders were consulted during the compilation of this report: • CORPS security & manned guarding provider • Staff-side (Health and Safety meeting dated 19 March 2018)				
Other standards affected	The recommendations made in this report will impact upon: • Compliance with Safe Environment Assessment (regulator CQC) • Compliance with Health and Safety Legislation (regulator HSE) • Compliance with Fire Safety Legislation (regulator Fire Service)				
Legal considerations					

Report title: EFM and Health and Safety Performance report for March and April 2018	Date: 23rd May 2018
Report sponsor	Director of Estates and Commercial Development
Report author	Director of Estates and Commercial Development

1. Introduction

The purpose of the report is to provide information to the Trust Board on Estates, Facilities and Health and Safety performance for March and April 2018 through the presentation of a range of performance indicators. This information detailing performance, performance exceptions and rectification measures are provided to the Board every two months.

2. Discussion

The table below identifies performance variances and any area of concern for the attention of the Board with appropriate explanation and action to a resolution. The detailed indicators are shown in Annex 1.

March and April 2018 performance indicators

Green ✓ / Amber ! / Red ✘	February Position	March Position	April Position
Improving Indicators			
4.4: % of near misses against total Incidents	!	✘	!
Red rated Indicators with no change			
1.10: % Reactive work resolved within target – Urgent – P2 (1- 4 Days)	✘	✘	✘
1.12: % Reactive work resolved within target– Routine – P3 (<7-14 Days)	✘	✘	✘
1.14: % Reactive work resolved within target– Routine – P4 (<30 Days)	✘	✘	✘
1.15: Number of Estates Internal Critical failures	✘	✘	✘

Areas with Specific Cause for Concern		**Timeline**
1.10	% Reactive work resolved within target – Urgent – P2 (1- 4 Days)	
Explanation	Issues are within the acute site, staff focussed on completion of statutory PPMs (maintaining the safety of the organisation). There were 2 exceptional snow events during March, declared as critical incidents by the Trust, which impacted on the Estates departments' ability to carry out 'normal' service. An emergency service only was in place during these times with responses to heating and pipework issues plus other essential grounds work relating to snow clearance prioritised.	
Action	The EFM senior management team will review the demand and capacity work undertaken by the estates team, with a view to prioritising workload and matching resources to demand.	May 2018
1.12, 1.14	% Reactive work resolved within target – Routine – P3 (<7-14 Days) and Routine – P4 (<30 Days)	
Explanation	Issues are within the acute site, staff focussed on completion of statutory PPMs (maintaining the safety of the organisation). There were 2 exceptional snow events during March, declared as critical incidents by the Trust, which impacted on the Estates departments' ability to carry out 'normal' service. An emergency service only was in place during these times with responses to	

	heating and pipework issues plus other essential grounds work relating to snow clearance prioritised.	
Action	The EFM senior management team will review the demand and capacity work undertaken by the estates team, with a view to prioritising workload and matching resources to demand.	May 2018
1.15	Number of Estates Internal Critical failures	
Explanation	There were 4 critical failures in March	
Action	1. No available mains water in the podium block (MI) – This was connected to the snow event and was a result of loss of water to the area to the South of the Hospital. South West Water provided water bowsers to provide continuation of service 2. Hetherington small plant room flood – Age related pipe leak. Water affected fire alarm panel and fire alarm service for the Hetherington ward block. – now repaired 3. High Voltage cable fault resulted in a temporary loss of power – area of fault isolated and cable repaired. 4. CR1 data room failure and loss of IT systems across the Trust (MI) – This was connected to the ability of the plant to cope with the exceptionally cold weather which caused the air conditioning to fail and thus the temperature of the data room to rise.	

2.1 Performance Indicators

A revised set of performance indicators and reports have been approved by the Capital infrastructure and Environment Group for the 18/19 financial year. This includes a separate report for Health and safety to strengthen the reporting around Health and Safety, security and violence and aggression performance metrics and incidents.

2.2 Summary of any performance issues/exceptions related to Health and Safety and Security

April 2018 had the lowest number of incident reported over the last 13 Months with only 22 non-clinical health and safety incidents being reported on Datix. There is no clearly identifiable reason for this drop in reporting just a general reduction across all categories. The Health and Safety team will keep a watching brief on these numbers.

Assaults on staff due to a clinical reason have increased from 96 to 104, non-clinical assaults have remained static at 16. The Capital infrastructure and Environment group have asked for a short life working group to be established under the direction of the H&S committee to provide assurance on the actions that are being taken to support and train staff in our vulnerable areas (medicine, ED, theatres and the Children's wards) After action reviews have taken place on all the major incidents feeding into a lessons learnt action plan. The fire officer will start fire evacuation drills from this month to test our evacuation plans.

3. Conclusion

The performance for estates facilities and health and safety for February and March is reflected in mainly green indicators. Indicators around mandatory and statutory maintenance have improved as planned following the transformation of the estates operations service.

The number of critical estates incidents remains a concern. There is a development programme in place subject to funding, that will replace all aged critical ventilation across the Trust, medical air and vacuum plants which will have a significant impact on the Trusts backlog and failures of plant due to age. A bid for £19m additional funding to address Estates backlog has been submitted to the STP for progression as part of the wave 4 bids due in in June 2018.

As a result of the learning from some of the critical; incident after action reviews (AAR) work is about to commence on a full review of the resilience and vulnerability of the Trust plant and infrastructure to temperature extremes targeted at business continuity key risk areas (such as IT hubs/theatres etc). The subsequent development of a plan will ensure that all plant replacements are resilient to both extreme heat and cold temperature extremes and that is no single point of failure.

The Estates operations team continues to undertake enhanced planned maintenance with a view to keeping the elderly plant in as good condition as possible to prevent failures.

4. Recommendations

The Trust Board is asked to review the information provided in this report and note the contents.

EFM Key Performance Indicators Month 1 – April 2018

Area				Target		Monthly Performance											Current year to date (Complete Months)		Risk Threshold		
Ref	Description			Monthly	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Target	Yr Avg	RAG Thresholds		
	Estates																					
1.1	Number of Statutory PPM items planned per month			Variable	513	515													515			
1.2	Statutory PPM % success against plan			97%	86%	93%												97%	90%	R<85%	A85-96%	G>97%
1.3	Number of mandatory PPM items planned per month			Variable	423	420													420			
1.4	Mandatory PPM % success against plan			95%	86%	90%												95%	88%	R<85%	A85-94%	G>95%
1.5	Number of routine PPM items planned per month			Variable	175	148													148			
1.6	Routine PPM % success against plan			70%	79%	91%												70%	85%	R<60%	A60-69%	G>70%
1.7	% of Reactive work resolved within target	Emergency – P1	66	Variable	66	80													80			
1.8		Emergency – P1	100%	95%	100%	100%												95%	100%	R<90%	A90-94%	G≥95%
1.9		Urgent – P2	250	Variable	250	234													234			
1.10		Urgent – P2	79%	90%	79%	74%												90%	77%	R<85%	A85-89%	G≥90%
1.11		Routine – P3	502	Variable	502	423													423			
1.12		Routine – P3	72%	85%	72%	67%												85%	69%	R<75%	A75-84%	G≥85%
1.13		Routine P4	78	Variable	78	113													113			
1.14		Routine P4	65%	75%	65%	54%												75%	60%	R<65%	A65-74%	G≥75%
1.15	Number of Estates Internal Critical Failures			0	6	4												0	5	R1	-	G0
	Cleaning																					
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%											98%	100.0%	R<95%	A95-97%	G≥98%
2.2	Compliance High Risk Cleaning Audit			95%	98%	99%	98%											95%	98.5%	R≤89%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	99%											85%	99.0%	R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	99%	99%											75%	99.0%	R<70%	A70-74%	G≥75%
2.5	No. of Environmental (food hygiene/Waste) Events			0	0	0	0											0	0.0	R1	-	G0
	Waste																					
3.1	Total Tonnage per month all waste streams			Variable	169.34	169.34	167.69												169			
3.2	% of Total tonnage Recycled Waste			>47.1%	52.6%	52.6%	49%											>47.1%	52.0%	<40%	40.1-46.9%	>47.1%
3.3	% of Total tonnage Landfill Waste			<5%	0	0	0											<5%	0%	>15%	5.1-14.9%	<5%

3.4	% of Total tonnage of Clinical Non-Burn waste	14-24.9%	15%	15%	15.4%											14-24.9%	15.2%	>25%	<10.1-13.9%	14-24.9%
3.5	% of Total tonnage of Clinical Burn waste	4.1-7.9%	7.1%	7.1%	6.9%											4.1-7.9%	7%	>8%	<4%	4.1-7.9%
3.6	% of Total tonnage of Clinical Offensive waste	5.1-9.9%	7.1%	7.1%	9.4%											5.1-9.9%	8.0 %	<5%	>10%	5.1-9.9%
3.7	Waste to Energy	<24%	18.4%	18.4%	19.3%											<24%	18.8%	>35%	24-34.9%	<24%
3.8	Total Waste to Energy	Variable	25.5%	25.5%	26.2%												25.9%			
3.9	Number of Waste Audits undertaken per month	15	15	15	15											15	15	R>13	A13-14%	G15
3.10	% of Compliant Waste Audits	100%	100%	100%	100%											100%	100.0%	R<80%	A80-84%	G≥85%
3.11	% Compliance of Statutory Waste Audits	100%	100%	100%	100%											100%	100.0%	R≤89%	A90-94%	G≥95%

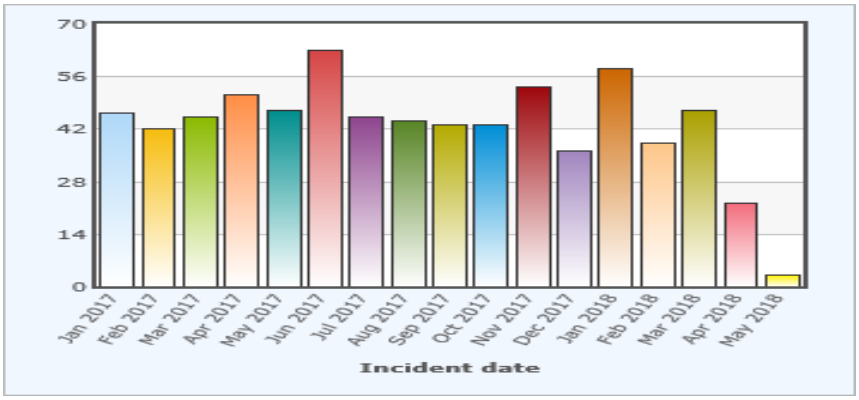
Report to:	Capital Infrastructure and Environment Group
Date:	May 2018
Report From:	Safety, Security & Emergency Planning Team
Report Title:	Health and Safety and Security Performance Update

1. Health and Safety

For this report the graphical analyses of the incidents reported have been taken direct from the Trust incident reporting system Datix.

Chart 1 below shows the monthly number of incidents reported since January 2017, an average of 45 per month. April 2018 had the lowest number of incident reported over the last 13 Months with only 22 non-clinical health and safety incidents being reported on Datix. There is no clearly identifiable reason for this drop in reporting just a general reduction across all categories.

Chart 1 - Incidents per month



1.2 Severity

The charts below and overleaf show the severity of the incidents over the last 13 months.

Chart 2 - Major/Severe

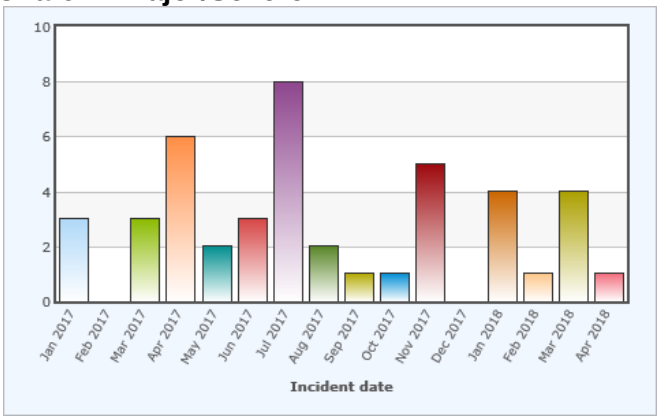
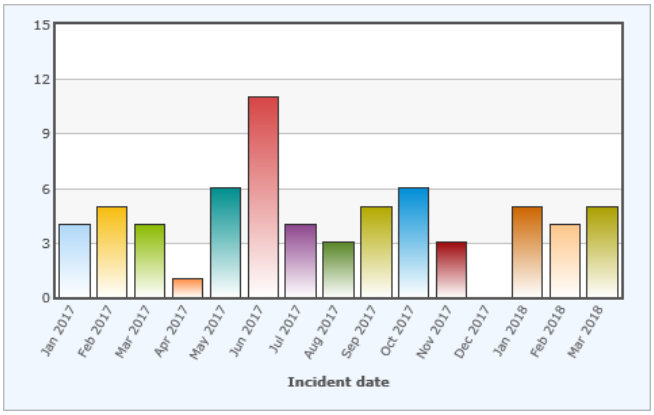


Chart 3 - Moderate



There was 1 incident classed as severe which was reported to the Health and Safety Executive (HSE) in April There were no incidents classed as moderate in April.

Chart 4 - Low Harm

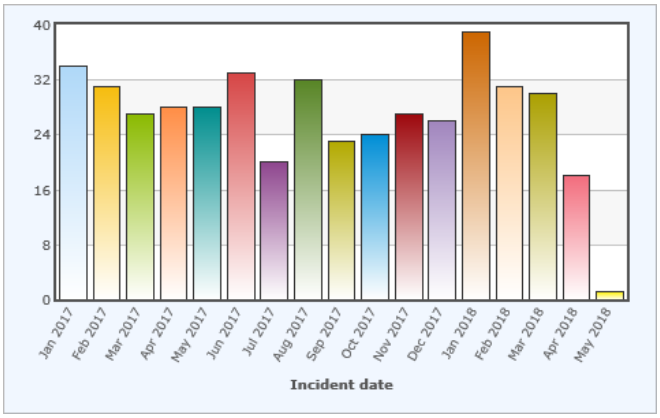
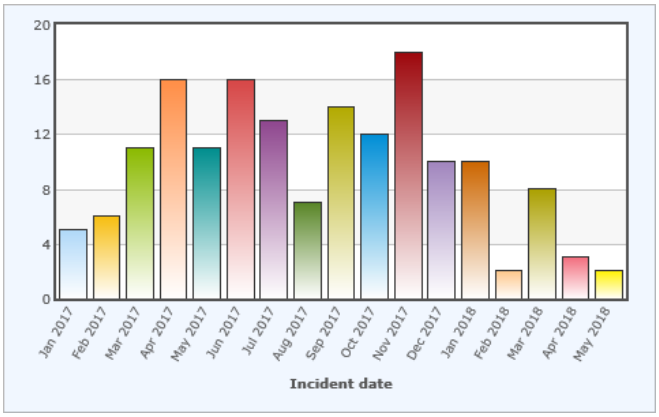


Chart 5 - Near Miss



There 3 near miss incidents reported in April 2018 and only 18 low harm incidents.

1.3 Categories of Incident

The Chart 7 below shows a breakdown of the top 6 categories of incidents so far this year with 'needle stick incidents' being the top cause with 23 incidents being reported so far this year although there is a monthly reduction overall.

Chart 7 - Top 6 categories 2018

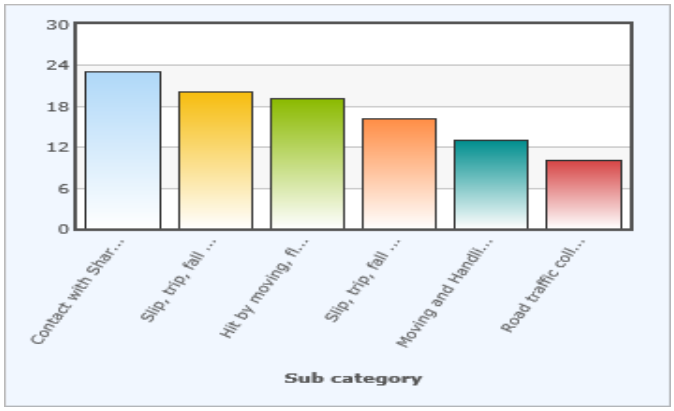
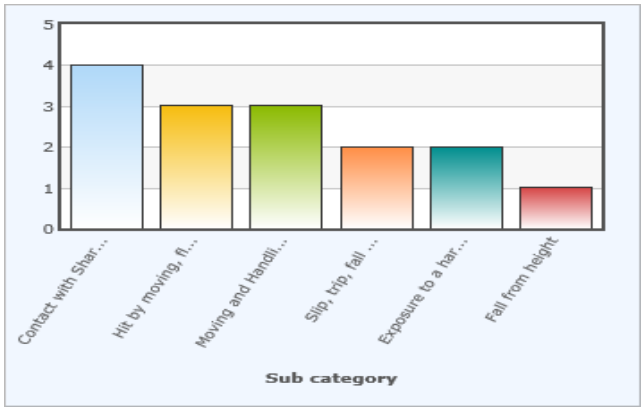


Chart 8 – Top 6 categories April 2018

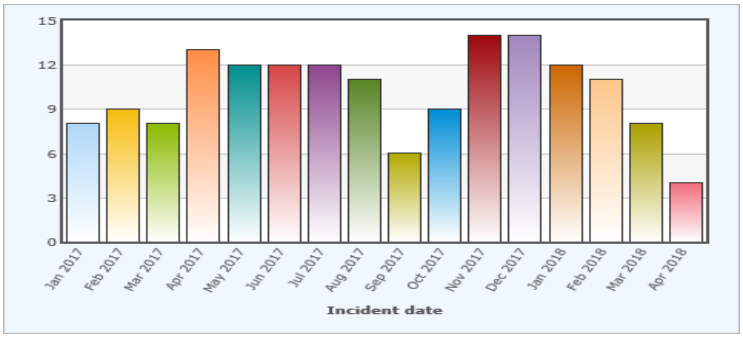


Charts 8 above shows that 'Needle stick incidents' with 4 incidents being reported was also the highest cause of incidents in April.

1.4 Sharps

Chart 9 below shows that there has been a gradual reduction in sharps incidents since November last year.

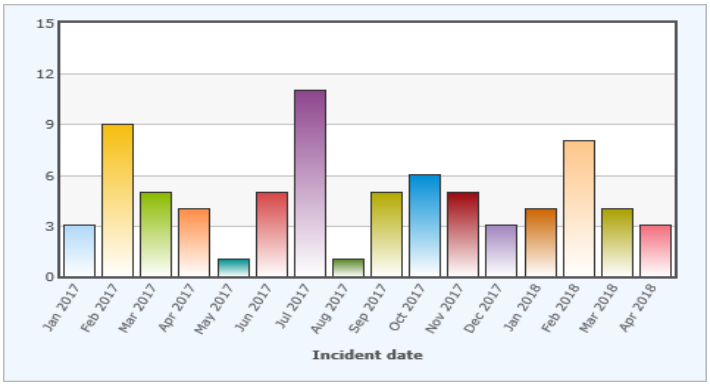
Chart 9 - Sharps Incidents



1.5 Hit by Moving, falling or flying object

Chart 10 below, gives a monthly breakdown these incidents that have been reported since January last year.

Chart 10



1.6 Manual Handling

Charts 11&12 below, illustrate the number of reported Manual Handling incidents. There was 1 non-patient handling incidents reported during February and 3 patient-handling.

Chart 11 - Patient

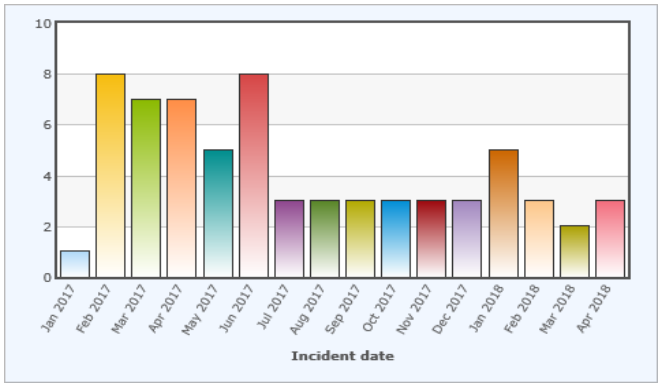
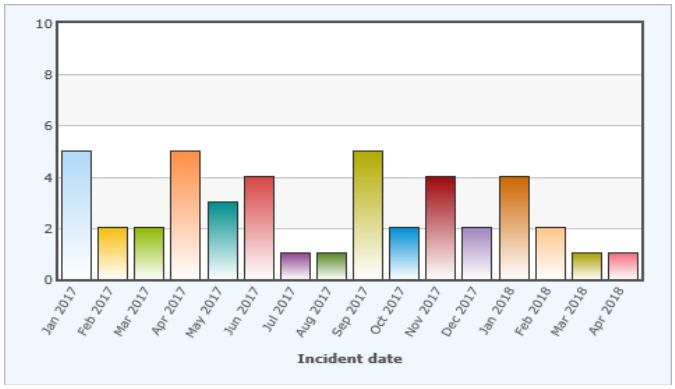


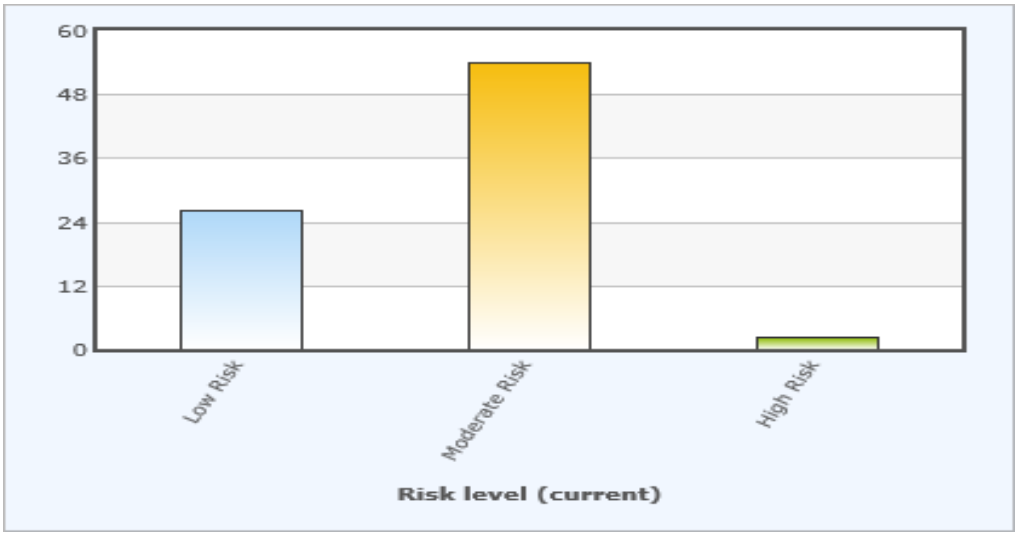
Chart 12- Non Patient



2. Risks

Currently there are 81 Health and Safety Risks on the Trust Risk register. The Chart 13 below shows that of these 53 are classed as moderate, 26 classed as low risk and 2 high risks. The 2 high risks concern the ageing and ineffective street lighting in the acute setting which is linked to 2 RIDDOR reported incidents and the lack of segregation of pedestrians from large delivery vehicles in the area by the fracture clinic at level 1 at main hospital site. Works to improve this location are planned to start in June.

Chart 13 - Current H&S Risks



3. Incidents affecting Patients

The health and safety team reported 1 patient related incident to the HSE in April.

4. Meeting with CQC inspector.

There was a meeting with a lead CQC inspector on the first of May to discuss the management of patient related RIDDOR incidents, due to the fact that CQC now have responsibility for the investigation of these incidents. One of the main concerns was the delay in reporting this category of serious incidents to the HSE and the length of time taken to complete investigations. The H&S committee afre considering a recommendation to shorten the time for investigation into RIDDOR events.

5. Security and Fire

Security headlines

- a slight increase in the number of incidents across the monthly period, largest category threatening and abusive behaviour
- threatening and abusive behaviour has increased from just over 10 last month to 15 this month
- assaults due to a clinical reason have increased from 96 to 104, non-clinical assaults have remained static at 16
- One safeguarding investigation due to theft at a client's house
- A lone worker reliance devices audit has been instigated which may be a saving of circa £60k
- Violent person markers panel took place. Current numbers persons the Trust has taken action against are as follows:

Step 2	non-physical assault	9
Step 2	physical assault – clinical reason	0
Step 2	physical assault – non-clinical reason	3
Step 3	non-physical assault	1
Step 3	physical assault – clinical	0
Step 3	physical assault – non-clinical	0
Step 3	treatment withdrawn temporarily	0

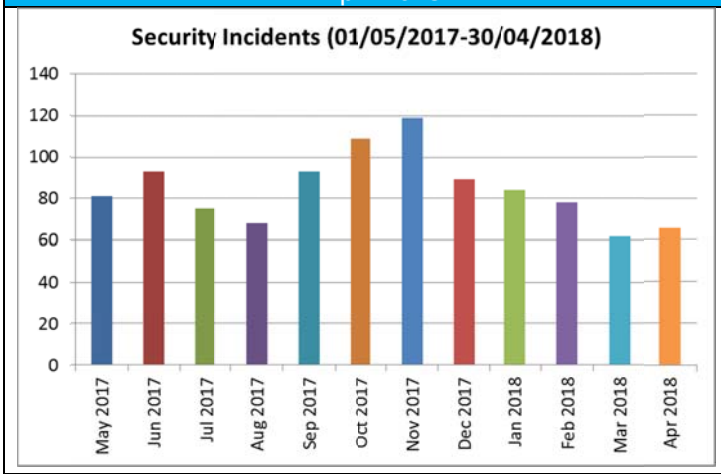
- Currently 14 security incidents being investigated for violent marker sanction

Fire headlines:

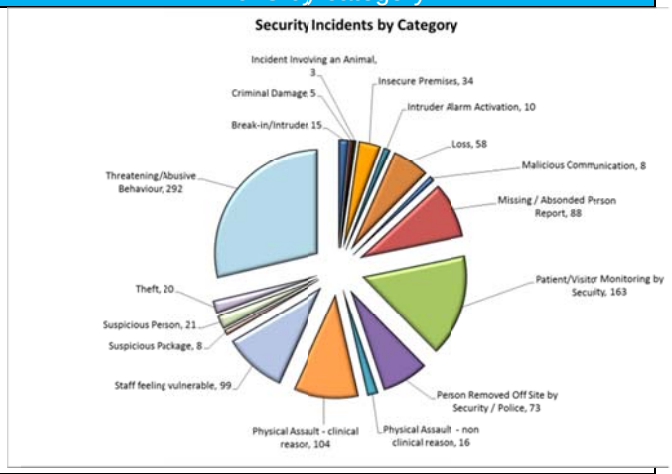
- All High, Medium and Low Fire Safety Risk Assessments are in date and compliant
- The fire officer will start fire audits and fire evacuation drills from this month

Monthly totals of security incidents from 1st May 2017 to 30th	Security incidents from 1st May 2017 to 30th April

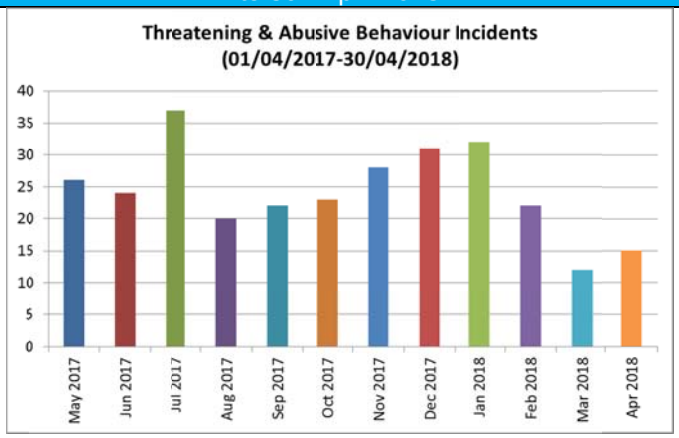
April 2018



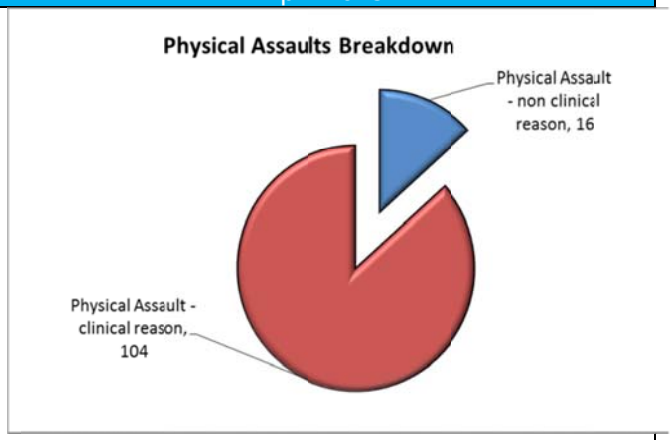
2018 by category



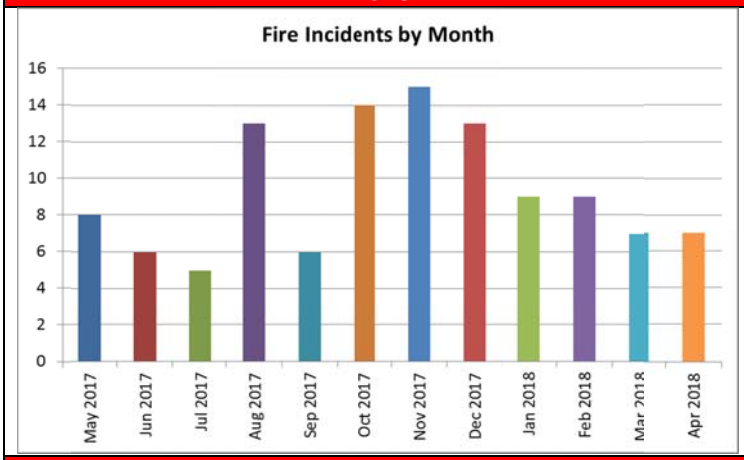
Monthly totals of "threatening behaviour" from 1st May 2017 to 30th April 2018



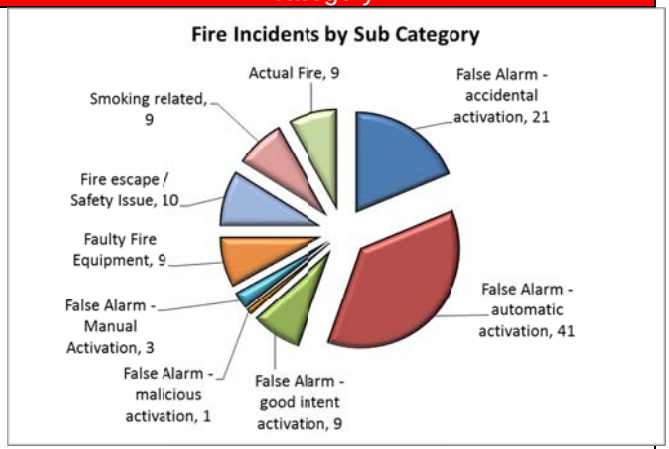
Number of Physical Assaults 1st May 2017 to 30th April 2018



Monthly totals of fire incidents from 1st May 2017 to 30th April 2018

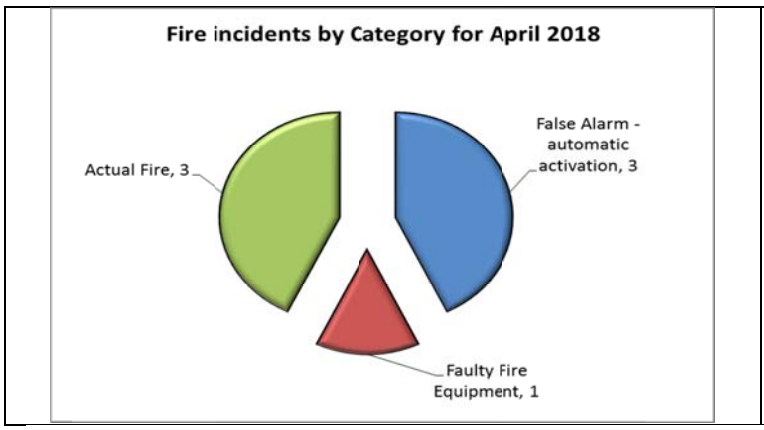


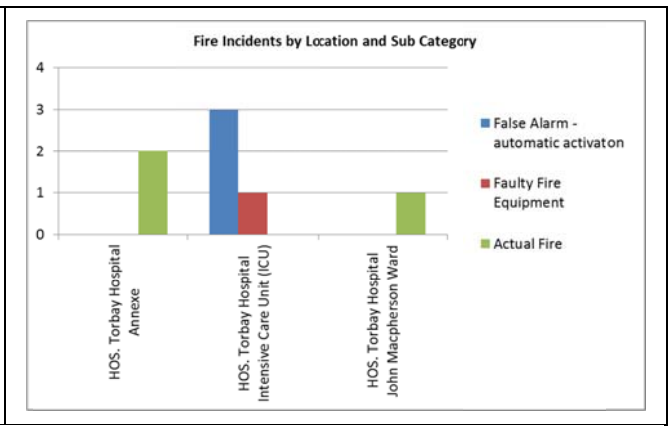
Fire incidents from 1st May 2017 to 30th April 2018 by category



Monthly total of fire incidents for April 2018 by category

Monthly total of fire incidents for April 2018 by location

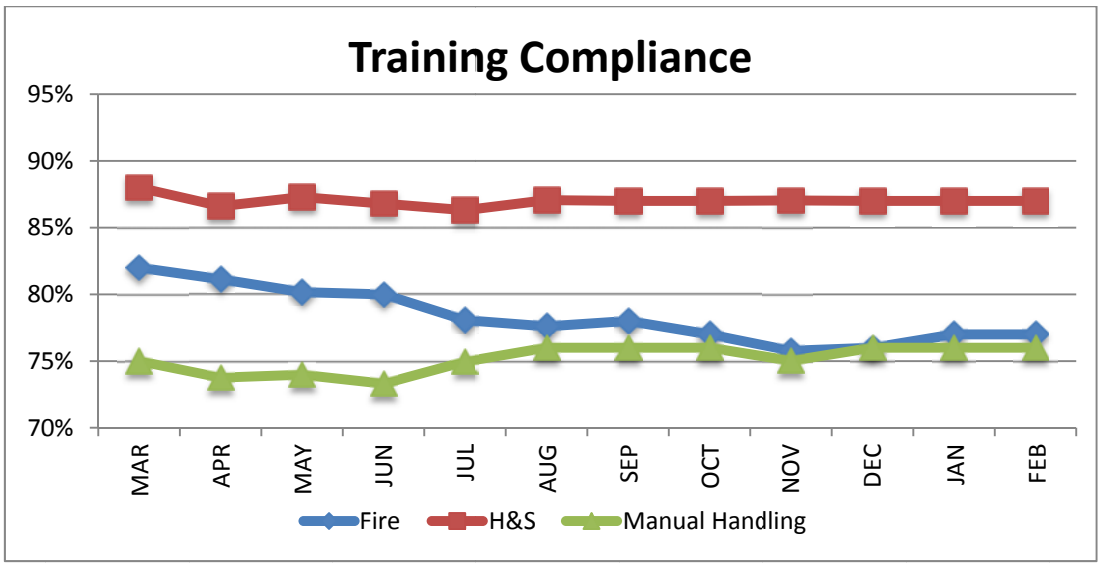




3. Training

The mandatory training figures for the Trust can be seen in Chart 14 below. Manual Handling and Fire training are currently below the Trust target of 85%, standing at 76% and 77%.

Chart 14 - Training Compliance



6. Recommendations / Conclusion

The members are asked to note the Health and Safety performance report for April 2018.

Cover sheet and summary for a report to the Trust Board of Directors					
Report title: Workforce & OD Board Report				Date: 23rd May 2018	
Report sponsor	Director of Workforce & OD				
Report author	Human Resources Manager				
Report provenance	Workforce & OD Group – 3rd May 2018				
Confidentiality	Public				
Report summary	• To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported to and assured by the Workforce and Organisational Development Group. (WODG). • To provide the Board with assurance on workforce and organisational development issues.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☒	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	This report is for information.				
Summary of key elements					
Strategic context	This report aims to demonstrate the Workforce and OD support of the following strategic/corporate objectives : • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	Risks are reviewed as part of the agenda of Workforce & OD Group. The risk register was reviewed and actions noted. The Group also identified potential additional risks:- ➢ Long term planning in line with the STP in relation to Workforce Strategy for the next 3-5 years regarding Medical, Nursing and AHP staff. ➢ Strategy to release staff to undertake Mandatory Training which is embedded into 'business as usual'. ➢ Strategy to be put in place to ensure new education programmes provided clearly indicates impact on resources/estates.				

Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Workforce & OD Group on 3rd May 2018
Stakeholder engagement	The following stakeholders are members of the Workforce & OD Group: • Governor • Non-Executive Director • Trust representatives
Other standards affected	The information in this report will impact upon: • CQC Well Led Domain
Legal considerations	All equality and diversity implications have been considered in each of the areas outlined in this report.

Report title: Workforce & OD Report		Date: 23rd May 2018
Report sponsor	Director of Workforce & OD	
Report author	Human Resources Manager	

1.0 Introduction

The purpose of this report is to:

- update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group.

- provide the Board with assurance on workforce and OD issues.

2.0 Workforce & Organisational Development Group: Key Notes

The Group met on 3rd May 2018. The following summarises the discussions and key actions:

- The risk register was reviewed and actions noted. The Group also identified potential additional risks:
  - Long term planning in line with the STP in relation to Workforce Strategy for the next 3-5 years regarding Medical, Nursing and AHP staff.
  - Strategy to release staff to undertake Mandatory Training which is embedded into 'business as usual'.
  - Strategy to be put in place to ensure new education programmes provided clearly indicates impact on resources/estates.
- The Non-Clinical Workforce Programme Board has been re-established with revised terms of reference and membership. Plans are in place to establish the Medical Workforce Programme Board, subject to the identification of medical Chairperson. Since the meeting James Powles, ENT Consultant has agreed to chair the Board.
- Achievement reviews (appraisals) are showing a slight improvement, further work is being undertaken to improve the uptake and achieve the Trust target of 90%.
- Whilst staff turnover is within an acceptable range, the Trust requires a better understanding of the reasons staff leave the organisation. Work is underway to review the leavers process, including improving the use of exit questionnaires. In addition a process has been put in place to review the experience of new starters to the Trust, to gain feedback on areas which could be enhanced and therefore improve the retention of new staff.
- In order to ensure consistency, reporting against the workforce plan for 18/19 will mirror the monthly information submitted to NHSI. This will also enable any variations and adjustments to be identified at an early stage.
- End of Life education strategy was approved. Further details are provided in Section 3.
- The Apprenticeship Strategy will be re-launched in line with the Government's 2020 Vision. A working group will be established to ensure consistency and equity in relation to the use of the apprenticeship levy. Further details are provided in Section 4.

- Workforce Equality Annual Report was noted. Further details are provided in Section 5.
- The wholeness approach to Health and Wellbeing was discussed, further details are provided in Section 8.

3. End of Life Education Strategy

This policy provides a framework and guidance on the delivery of education for all staff employed by Torbay and South Devon NHS Foundation Trust. The level, or tier, of education required will be dependent on an individual's role within the Trust. As a health and social care employer organisation the Trust is in a unique position to influence and significantly improve palliative and end of life care for our population. The mode of delivery will be a blended approach of traditional face to face teaching, new initiatives such as 'train the trainer' and the EOL Ambassadors Group, and new technologies (HIVE, HIBLIO and national IT resources)

A key recommendation of the Devon wide EOLC Health Needs Assessment 2017 is wider training in end of life care across all sectors, an ambition echoed by the Devon STP Advance Care Planning working group.

A key priority in the Torbay and South Devon End of Life Care Strategy for Adults (2016-2020) produced by the EOLC Board is that:-

Provision of education and training to the workforce to deliver high quality end of life care to build a commonality of understanding of why end of life care is important in our system

The strategy outlines how, over the next three years, the Trust will achieve the 'Ambitions in end of life care' (2014).

Each year around 500,000 people in England die. For each person, there are many around them who are affected by caring, grief and loss. The National End of Life Strategy 2008 set a determined path to improve the quality and experience of care for all. Following withdrawal of the Liverpool Care Pathway for the dying patient (2014) the `One Chance to get it Right` document (2014) described five priorities of care that must be in place to care for patients in the last days of life.

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the patients' needs and wishes and these are regularly reviewed.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.

5. An individual plan of care, which includes symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

More recently The Ambitions for Palliative and End of Life Care, a National Framework for local action 2015 – 2020 is a continuation of this work. It builds on the extensive national efforts made over the previous seven years and broadens its reach and challenge to the whole community. The Trust is committed to ensuring these ambitions become a reality. Such success will not just happen, but require leadership and commitment from all parts of the organisation.

The Ambitions Framework recognises the important role of the communities within end-of-life-care. The inclusion of concepts such as 'each community is prepared to help' is the desire to form new and improved partnerships between communities and professional services. This is why, as a Trust, the introduction and provision of work included in the new 'Ambitions Framework' is so important in our everyday work. Building on the information previously available to us to achieve the best end of life care, we will include the 6'C's.

Every health and social care employee needs to be competent and up to date in their knowledge and practice to enable them to play their part in delivery of excellent end of life care (EOLC). It is vital that every professional has a framework for their education, training and continuing professional development to achieve and maintain their competence.

The EOL education policy is integral to the successful delivery of the Trust EOL strategy.

4.0 Apprenticeship Strategy

The purpose of the Trust's strategy is to:-

The English Apprenticeship 2020 vision document outlines the Government's plan to increase the quality and quantity of apprenticeships to reach a commitment of 3 million apprenticeships by 2020; doubling the annual level of spending on apprenticeships between 2010/11 and 2019/20 in cash terms to £2.5bn, which will be funded by the apprenticeship levy.

The national policy changes will have financial and reporting implications for the NHS. The apprenticeship levy, payable from April 2017 and charged at 0.5% of the total pay bill, will be used to support the training and assessment of apprentices, including existing staff.

Under the Public Sector Apprenticeship Targets Regulations 2017 prescribed groups and public sector bodies with 250 or more staff in England have a target to employ an average of at least 2.3% of their staff as new apprentice starts over the period of 1 April 2017 to 31 March 2021.

The charge to the Trust in 2017/18 is £874k, paid to the HMRC. The government automatically adds 10% to the funds in the Trust's apprenticeship service account so the funding available to spend is higher. Funds that are not used will expire 24 months after they entered the Trust's account.

ensure that the Trust achieves the national target

- the levy is utilised efficiently and effectively to meet the needs of the Trust
- support staff in undertaking suitable qualifications
- attract staff through the apprenticeship route
- develop career pathways for hard to recruit professions

5.0 Workforce Equality Annual Report 2017

The report highlights work to advance equality in the Trust and identifies trends in equality requiring action (report available on request).

Following the recommendations from last year's report, the Trust will continue to frame objectives around the Equality Delivery System (EDS) – which has been a mandate for NHS Trusts from April 2015.

The highest levels of non-disclosure are apparent for Religion and Belief (25%), Sexual Orientation (24%) and Disability (10%). The Trust does need to continue to stress the importance of equality monitoring and address these primary areas of under-representation through the recruitment process.

The Equality Business Forum was founded in 2015 to, on behalf of the Trust Board of Directors, monitor, develop, extend and improve the Trust's work on the workforce equalities and inclusion agenda. The Forum is specifically responsible for overseeing the implementation and development of the Trust's workforce equalities agenda, holding the organisation to account. This workforce focus will allow the Forum to focus on the business of the organisation, providing the Trust Board with robust assurance on the delivery of the agenda. The Forum consists of Chairs from existing staff network groups and will influence positive change to advance equality. For instance, in relation to the high levels of non-disclosure of equality monitoring data, the Equality Business Forum will be responsible for identifying, developing and implementing practical solutions to improve in this area.

Key considerations for the year ahead are to focus on our ageing workforce. The data) shows that 55% of our workforce is between 41-60 years. There is a genuine risk that many of our staff will leave in quick succession taking with them unquantifiable levels of experience, organisational history and potentially leaving significant gaps in service provision that could have an impact on the organisation. The Trust needs to ensure that our workforce plans and succession

plans are in place and make strides to being creative about how we can use such things as the apprenticeship levy as a pro-active way of designing roles for the future.

This age group are sometimes referred to as the “sandwich generation”. By this it is meant they could be caring for ageing relatives, looking after grandchildren along with possibly coping with health concerns and working. Therefore an area of focus will be how the Trust creates a supportive, flexible environment to ensuring that members of staff feel able to manage their work and life in a productive way.

Monitoring requests for flexible working, and reasonable adjustments and completing the new Workforce Disability Standards (August 2018) will help to focus on areas such as coming into work when you are unwell, have reasonable adjustments been made, sickness, harassment, equal opportunities. This would link into the wellbeing agenda and give staff the support they need to be able to work for longer.

The data obtained in the report will be used in collaboration with other Equality Standards such as the Equality Delivery System (EDS), the Workplace Race Equality Standard (WRES) and in August 2018 the introduction of Workplace Disability Equality Standard (WDES). Specifically, these Standards aim to identify and subsequently address the barriers which exist for many minority staff leading to poorer experiences of the workplace. Furthermore, consideration must be afforded to the demographics of the Trust Board and staff in senior positions in relation to representation.

6.0 Agenda for Change – Terms and Conditions of Service

The NHS Staff Council has reached agreement on a refresh of the NHS Terms and Conditions of Service (Agenda for Change).

The framework agreement (21 March 2018), forms the basis on which NHS trade unions are currently consulting with their members. The trade union consultation will run until the 31 May 2018. Should the trade union consultation result in acceptance of the details set out in the framework agreement, this will result in a three year pay deal as well as the reform of the pay scales.

The key changes will include:

Pay

- Starting salaries increased across all pay bands.
- New pay structure with fewer pay points – overlapping pay points removed initially followed by further pay points.
- New system of pay progression.
- Top of pay bands to be increased by 6.5 per cent over the three years (apart from band 8d and 9 which will be capped at the increase of Band 8c).
- Minimum rate of pay in the NHS to be set at £17,460 from 1 April 2018 – this will be ahead of the Living Wage Foundation Living Wage rates.

Structural changes

- Band 1 to be closed to new starters from 01 December 2018. The NHS Staff Council to agree a process for this, including upskilling Band 1 jobs to Band 2 roles during the 3 years of the pay deal.
- Bands 2 to 4 and 8 to 9 will only have two pay points in the new structure. Bands 5 to 7 will have three.
- Staff below band 8 will have the opportunity to reach the top of their pay band more quickly than under the current pay system.
- The time it takes for bands 8 to 9 to reach the top remains unchanged.
- Re-earnable pay remains for those staff that have reached the top of their pay band in bands 8c to 9

Other changes

- Terms and conditions amendments to:

  - include enhanced shared parental leave

  - child bereavement leave

  - a national framework on buying and selling leave.

- Unsocial hours payments while off sick to be paid only to those earning at or below £18,160.
- Unsocial hours percentage rates for Band 1 – 3 to be adjusted in line with increases to basic pay.

Future NHS Staff Council work programme

- Programme of work to improve health and wellbeing to support better attendance levels and reduce sickness absence.
- To explore the alignment between Agenda for Change and other senior NHS pay arrangements.
- NHS Staff Council to negotiate provisions for apprenticeship pay.
- NHS Staff Council to undertake work on exploring the scope for a collective framework agreement on bank and agency working.
- Monitor the impact of any deal e.g. equality impact.

NHS Pay Review Body

- NHS Pay Review Body retains its standing remit and will look at the progress of implementation and its impact.
- This monitoring role will also consider the future use and values of RRPs and High Cost Area Supplement (HCAS) payment.

The Trust is currently reviewing the potential implications of the proposed new arrangements and developing a plan to assist with the implementation.

7. Staff Friends & Family Test – Quarter 4

The quarter 4 survey was completed during the month of February. By the time the survey closed 471 staff had responded to the survey representing an 8% response rate. This compares to a response rate of 17% in quarter 2 and 20% in quarter 1.

The quarterly findings for the year are detailed below and the following observations made;

- The propensity to recommend care has remained fairly consistent across the year with a positive score between 84% and 86%. Similarly the negative score has remained consistent at 2%. This is better than the national average which reported in Quarter 2 that 80% of staff would recommend and 6% would not recommend their organisation for care.

- The propensity to recommend work has increased gradually across the quarters from a positive score of 62% in quarter 1 to 65% in quarter 4. The negative score has remained consistent between 7% and 8%. The national average in quarter 2 was 63% would recommend and 19% would not recommend their organisation as a place to work.

- In regards to the perceived fairness and effectiveness for reporting errors we have seen a slight decline over the course of the year, with a positive score of 70% reducing to 66% in quarter 2 and 4. The negative score has increased marginally form 4% in quarter 1 and 2 to 5% in quarter 4. This would echo the findings from the National Staff Survey

- There has also been a slight decline in the perception of staff engagement, with a positive score of 54% in quarter 1 and 2, reducing to 50% in quarter 4. Similarly the negative score has increased in quarter 4 to 15%.

How likely are you to recommend the Trust to friends and family if they needed care or treatment?

Quarter	1 Extremely likely	2 Likely	3 Neither likely or unlikely	4 Unlikely	5 Extremely unlikely	6 Don't know	Grand Total
1 - June	495 (40%)	543 (44%)	142 (11%)	30 (2%)	14 (1%)	15 (1%)	**1239**
2 - September	417 (40%)	484 (46%)	102 (10%)	26 (2%)	8 (1%)	8 (1%)	**1045**
4 - February	216 (46%)	186 (39%)	42 (9%)	15 (3%)	7 (1%)	5 (1%)	**471**

How likely are you to recommend the Trust to friends and family as a place to work?

Quarter	1 Extremely likely	2 Likely	3 Neither likely or unlikely	4 Unlikely	5 Extremely unlikely	6 Don't know	Grand Total
1 - June	262 (21%)	510 (41%)	227 (18%)	152 12%)	81 (7%)	7 (1%)	**1239**
2 - September	222 (21%)	436 (42%)	211 (20%)	108 10%)	59 (6%)	9 (1%)	**1045**
4 - February	103 (22%)	201 (43%)	88 (19%)	45 (10%)	32 (7%)	2 (0%)	**471**

How would you rate the fairness and effectiveness of procedures for reporting errors, near misses and incidents?

Quarter	1 Extremely fair & effective	2 Fair & effective	3 Neither fair/ effective or unfair/ ineffective	4 Unfair & ineffective	5 Extremely unfair & ineffective	6 Not completed	Grand Total
1 - June	184 (15%)	677 (55%)	324 (26%)	43 (3%)	9 (1%)	2	**1239**
2 - September	134 (13%)	553 (53%)	311 (30%)	44 (4%)	3 (0%)		**1045**
4 - February	78 (17%)	232 (49%)	136 (29%)	20 (4%)	5 (1%)		**471**

How would you rate staff engagement in the organisation?

Quarter	1 Extremely good	2 Good	3 Average	4 Poor	5 Very poor	Grand Total
1 - June	120 (10%)	542 (44%)	403 (33%)	139 (11%)	35 (3%)	**1240**
2 - September	103 (10%)	461 (44%)	365 (35%)	97 (9%)	19 (2%)	**1045**
4 - February	0%	203 (50%)	145 (36%)	45 (11%)	15 (4%)	**408**

The findings for the SDU's will be shared shortly and comments reports will follow. SDU's will be asked to use this data to continually inform their local staff experience action plans.

8.0 Health & Wellbeing Strategy

The Health & Wellbeing Strategy was discussed and three priorities for the Trust have been identified:

- Coaching approach – available to all
- Modelling – senior team to model behaviours in order to change the culture of the organisation
- Communicate the wholeness approach to support the Health and Wellbeing agenda.

The diagram below shows the wholeness approach: