Torbay and South Devon NHS Foundation Trust
Public Board of Directors

Board Room, Hengrave House, Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA

4 July 2018 09:00 - 4 July 2018 11:30

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	User Experience Story		
2	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
3	PART A: Matters for Discussion/Decision		
3.1	Apologies for Absence - Director of Estates and Commercial Development, Director of Workforce and Organisational Development, Medical Director, Mrs J Lyttle, Mrs S Taylor Note	Ch	
3.2	Declaration of Interests Note	Ch	
3.3	Minutes of the Board Meeting held on the 23rd May 2018 and Outstanding Actions Approve 18.05.23 - Board of Directors Minutes Public.pdf 9	Ch	
3.4	Report of the Chairman Note	Ch	
3.5	Report of the Interim Chief Executive Review Report of the Interim Chief Executive.pdf 25	ICE	
3.6	Strategic Issues		

#	Description	Owner	Time
3.6.1	Devon Sustainability and Transformation Partnership Update Report Review STP Update.pdf 41	DSI	
4	Delivery Issues		
4.1	Integrated Quality, Performance,Finance and Workforce Report - Month 2 Review IQPFW Report.pdf 57	DSI/DoF/DWOD	
5	Governance Issues		
5.1	Use of Resources Framework Note Use of Resources.pdf 117	DoF	
5.2	Annual Infection Prevention and Control Report Approve Annual Infection Prevention and Contorl Report.pdf 137	CN	
5.3	Annual Self-Certification Approve Annual Self Certification.pdf 173	CS	
6	Governors' Questions Discuss	Ch	
7	PART B: Matters for Approval/Noting Without Discussion		
7.1	Reports from Board Committees Assurance		
7.1.1	Finance, Performance and Investment Committee - 26th June 2018 Information 2018.06.26_FPI_Cttee_Report_to_Board.pdf 183	R Sutton	
7.2	Reports from Executive Directors		

#	Description	Owner	Time
7.2.1	Report of the Medical Director Information Report of the Medical Director.pdf 185	MD	
7.2.2	Report of the Interim Chief Operating Officer Information Report of the Interim Chief Operating Officer.pdf 197	ICOO	
7.2.3	Report of the Director of Strategy and Improvement Information Report of the Director of Strategy and Improvement... 205	DSI	
7.3	Compliance Issues		
7.4	Any Other Business Notified in Advance	Ch	
7.5	Date of Next Meeting -9.00 am, Wednesday 1st August 2018	Ch	
7.6	Exclusion of the Public	Ch	

INDEX

Board Corporate Objectives.pdf.....7
18.05.23 - Board of Directors Minutes Public.pdf.....9
Report of the Interim Chief Executive.pdf.....25
STP Update.pdf.....41
IQPFW Report.pdf.....57
Use of Resources.pdf.....117
Annual Infection Prevention and Contorl Report.pdf.....137
Annual Self Certification.pdf.....173
2018.06.26_FPI_Cttee_Report_to_Board.pdf.....183
Report of the Medical Director.pdf.....185
Report of the Interim Chief Operating Officer.pdf.....197
Report of the Director of Strategy and Improvement.pdf.....205

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 23RD MAY 2018

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mrs J Lyttle	Non-Executive Director
	Mr P Richards	Non-Executive Director
	Mrs J Marshall	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
	Mrs L Darke	Director of Estates and Commercial Development
	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
	Mrs A Wagner	Director of Strategy and Improvement
	Councillor J Parrott	Torbay Council Representative
In attendance:	Mrs M Trist	Corporate Governance Manager
	Ms J Gratton	Head of Communications
	Mr C Helps	Interim Company Secretary

Governors:	Mr K Allen	Mrs C Day	Mr P Coates
	Mrs E Welch	Dr L Archer	Mrs B Inger
	Mr B Bryant		

ACTION

95/05/18 **Board Corporate Objectives**

Noted.

PART A: Matters for Discussion/Decision

96/05/18 **Apologies for Absence**

Apologies were received from Cllr Parrott.

Apologies were noted from the following governors: Wendy Marshfield (Lead Governor) and Lynne Hookings, who were unable to attend owing to illness and injury – the Chairman wished them a speedy recovery on behalf of the Board.

97/05/18 **Declaration of Interests**

Nil.

98/05/18 **Minutes of the Board Meeting held on the 2nd May 2018 and Outstanding Actions**

The minutes of the meeting held on the 2nd May 2018 were approved as an accurate record subject to one minor amendment – amend "Consultation" to "engagement" at minute 84/05/18. CGM/SF

Open actions were reviewed for progress.

99/05/18 **Report of the Chairman**

The Chairman reported on the following:

- Chairman advised that the Chief Executive had had to postpone her planned visit to the Trust and it was hoped this could now take place in June.

- Chairman thanked the Executive Directors who had attended the staff "winter thank you" events with him. These had proved to be excellent opportunities to thank staff (including catering staff) and volunteers, for their extraordinary efforts during a very challenging period. Staff were pleased that the Trust Board wished to recognise their efforts and the interim Chief Executive said it had been very encouraging to hear at first hand positive feedback on how a safe and effective service had been maintained. The Chairman said there had also been some good lessons learned from this exercise

- On 15 May the Chairman had attended the opening of a new research facility at Derriford University Science Park, where the Trust's contribution as a key partner had been identified by the Vice Chancellor. The Chairman felt that the Trust should look to exploit this valuable local research facility. It was pleasing to note that candidates at several recent consultant interviews had also expressed an interest in research.

- Torbay Pharmaceuticals (TP) end of year performance had come in slightly above budget.

- The Chairman was pleased to report on a very positive meeting with the Leagues of Friends' Chairs which he had attended with the Interim Chief Executive on 22 May. The Chairs had been very positive about working with the ICO and some had already recognised the need to amend their Terms of Reference to reflect closer working with community services, rather than just the community hospitals.

100/05/18 **Report of the Interim Chief Executive**

The Interim Chief Executive briefed the Board as follows:

- **Teignmouth Engagement** – The Interim Chief Executive reported on the various suggestions under discussion for the improvement of services and advised that there had been a good level of involvement to date. The CCG-led engagement process would run until 8 June and on 24 June, the CCG Lead and the Trust's Interim Chief Executive would be meeting with the Teignmouth Hospital League of Friends.

- **Dartmouth public meeting** – The Interim Chief Executive reported on a meeting convened by the public on 14 May. The meeting had been very well attended and the Interim Chief Executive explained that the meeting had taken the form of a Question and Answer session and a range of issues had been discussed. It had been a very challenging meeting, but there was a clear strength of feeling at the loss of the community hospital, and concern at the delay in plans for the Health and Wellbeing Centre. As well as taking forward the specific issues raised, the meeting had highlighted some lessons on how best to continue to engage with the local community as part of an ongoing process. The Trust and CCG had agreed to provide a written response to the community within two weeks of the meeting.

- **Wellbeing Co-ordinators -** The Interim Chief Executive advised the meeting of a very positive story on BBC TV "Spotlight" on 14 May, and throughout the day on Radio Devon, regarding the help provided by Health and Wellbeing Co-ordinators in enabling people to reconnect with their lives and communities with a consequent improvement in their overall wellbeing and a resulting reduction in GP and hospital contacts.

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- **Well–Led – CQC inspection report -** The Interim Chief Executive was very pleased to inform the Board of the improved CQC ratings contained in the CQC report following their recent inspections. As a result of the significant improvements made since their last inspection, inspectors rated the Trust as "good" overall and "outstanding " for caring.

- **Developing our strategy for the next 12 months and beyond -** Members were advised of a successful development session on 2 May 2018, from which five strategic priorities had been identified. The next step would be to engage with staff, communities and the STP

- **Randomised Coffee Breaks -** The Interim Chief Executive reported on this initiative to improve staff engagement and communications to connect people across the organisation and discuss what really matters to them – it is hoped that this initiative will allow people from different areas of the Trust to develop relationships in a very effective way, and she thanked the Director of Workforce and Organisational Development for her support in setting up and publicising this initiative.

- The Director of Workforce and Organisational Development highlighted the link with the national Health and Wellbeing week taking place from

15 June and she invited Board members to become involved too with the various initiatives taking place during the week.

The Chairman informed the meeting of a question raised by Cllr Parrott regarding the numbers of patients who spend more than 4 hours in A&E, inviting the interim COO to respond . The interim COO advised that he would review and respond to this issue direct and also ensure that the issue was discussed at QAC. Mrs Taylor felt it important to recognise that the quality of service provided was not compromised, even when there were extended waiting times, and the Interim COO would include detail on this point too. A further issue raised by Cllr Parrott concerned the fact that plans still needed to be developed for £13m of the £26m CIP schemes for 2018/19. The DoF would contact Cllr Parrott direct to clarify the current position as plans had been developed to meet over half the required level of savings. — CGM /Interim COO; CGM/ DoF

The Chief Nurse updated the meeting on progress with various initiatives which had been implemented to help Dementia sufferers.

Mr Sutton asked about links between local research initiatives and products manufactured by TP. The Medical Director agreed that he would provide a full response to Mr Sutton outside the meeting. — MD

Strategic Issues

101/05/18 **Devon Sustainability and Transformation Partnership Update Report – Devon STP Hosting Agreement**

Report Summary

The Interim Chief Executive informed the Board that the proposals for the Devon STP hosting arrangement had been reviewed by the Executive Directors on 15 May and the Executives were recommending that the TSDFT Board authorise signing up to the arrangement. The Director of Strategy and Improvement advised that the proposal was a refresh of the previous agreement relating to core staff members and their role with the STP. All the STP's seven partner organisations had been asked to take the proposal to their Boards for discussion and formal approval.

There were no further issues raised and the Board approved the recommendation to sign up to the Devon STP Hosting agreement.

The Board formally reviewed the Hosting Agreement and authorised the Interim Chief Executive to sign up to the Agreement on behalf of the Trust.

Delivery Issues

102/05/18 **Integrated Quality, Performance, Finance and Workforce Report – Month 1**

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.

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.

The Director of Strategy and Improvement explained that the report had been discussed in detail at FPIC on 22 May. She explained the change of emphasis in the Trust's performance reporting to ensure that workforce and quality issues together with performance eon local quality indicators is discussed before issues relating to Finance and national performance standards.

Performance metrics were still being developed and the Director of Strategy and Improvement would welcome any feedback from members on this new style of report.

The Director of Strategy and Improvement also advised that the Performance Report should reflect progress on the 2018/19 operational plan which had been submitted in accordance with the required timescale, although to date no formal feedback had been received. The Trust still remained in NHSI segment 2 - Trusts requiring some targeted support.

The Director of Strategy and Improvement drew members' headlines to a new section "Quality Headlines" and explained that these would be reviewed by QAC, to ensure that information was triangulated between FPIC and QAC. On a specific issue, "VTE", this data was still being validated and further details would be included in next month's report. The MD said that VTE information had been reviewed at QIG, but members had not identified any major change in VTE performance.

The Director of Strategy and Improvement was pleased to report a general improvement in workforce indicators. Locality dashboards were currently being developed to demonstrate the breadth of community activity, including any delayed transfers of care. The Director of Workforce and Organisational Development advised that there had been a dip in statutory and mandatory training performance in-month, due in part to the increased numbers requiring Prevent training following new NHSI guidance.

Moving to current performance against national standards, members were advised of a very challenging position. The Flow Board would be reviewing these metrics and addressing concerns raised. The Interim COO confirmed that issues relating to resilience during periods of escalation would be

reviewed. The 52-week wait position had reduced in April, and it was hoped to achieve a total of no more than 60 patients waiting longer than 52 weeks by the end of June, with no patients waiting longer than 52 weeks by the end of Quarter 2. Mrs Lyttle confirmed that she would also be attending Flow Board, following the on-going challenge in meeting the 4 hour performance standard. She felt the discussion should focus on issues of quality, rather than statistical data regarding performance.

It was noted that the report focussed on areas for improvement rather than successes and it was important to recognise success, including the Dementia Find position was the best ever achieved.

The Month 1 financial position reflected the achievement of delivery targets, with the DoF confirming that the current focus for the finance team and EDG was on preparing plans to achieve the required level of savings for the year. Financial performance had been reviewed in detail at the previous day's FPIC, with a key issue being the agreed reduction in cash holdings to enable increased capital spend to take place. The Director of Estates and Commercial Development had attended the meeting to provide a detailed briefing on Capital Risks and the prioritisation programme for Estates expenditure, and FPIC had approved the release of £7m cash to enable immediate additional expenditure on capital projects.

Mr Sutton, as Chair of FPIC explained that the proposal had received the unanimous support of members, following a recommendation made to the committee following a discussion held previously at the private Trust Board.

The Chairman asked for members' views on the new-style performance report, noting that this was now a larger document, and included details requested by the NEDs. He would ask the Executive Directors to review the report to identify that all the information included was essential, and that it was easily understood by the public.

The Board formally reviewed the document and evidence presented.

Governance Issues

103/05/18 **Clinical Incidents Report**

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 areas.

The report also highlights areas of work for the coming year.

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 Dashboard.

Chief Nurse explained that the report had been prepared following the first full year of reporting incidents on the Datix system. The Chief Nurse was pleased to report that better feedback was now provided to staff reporting incidents, which would allow for improved learning across the Trust. The Chief Nurse explained that there was ongoing work to improve and refine the reporting and feedback process. She would be arranging for "always" events to be reviewed at QIG and QAC.

Mrs Lyttle commended the Chief Nurse on the quality of the report provided, which had improved substantially over the past few years. She would like to thank all teams involved in production of the report for their hard work, and the Chairman endorsed these thanks on behalf of the Board.

The Board reviewed the Report and approved the content, noting that changes to organisational structure would require the risk management system to be reviewed to ensure that it adequately reflected the new structure.

104/05/18 **CQC Inspection Report Summary**

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.

Chief Nurse thanked the Chairman for this opportunity to commend the work of various teams who had contributed to the increased standards reflected in the recent CQC report. The main positive themes reflected in the report were:

- Reporting culture
- Duty of Candour
- Learning from complaints
- Staff feeling supported
- The emergence of a truly integrated organisation

The CQC had made some very positive comments on the "well led" domain and had commended the Trust on the seamless process for the introduction of the interim Chief Executive. The Chief Nurse was particularly pleased to report that no formal actions had been requested by the CQC following the inspection, although they had commented on the complexity of the Trust's governance arrangements. The interim Chief Executive advised that she and the Chief Nurse had met with the CQC's relationship manager to identify any areas to focus on and the chairman confirmed his understanding that this would include (form "Safe" domain) Mandatory Training and Appraisals, documentation (especially care plans for people at end of life), and Environmental issues, especially the Fracture clinic. The Chief Nurse had already ensured that an action plan was being developed and implemented, including the challenge of ensuring that maternity services would receive a "good" rating at the next inspection. The Chief Nurse commented that the next challenge would be to achieve a rating of "Outstanding". The Chairman

felt that the good report received would provide assurance to the Trust's external partners and commissioners too.

The interim Chief Executive informed members of the importance of recognising the work undertaken to achieve this improved CQC rating, and she was pleased to report that he CQC inspectors had identified elements of performance which would indicate that the Trust had the ability to become an outstanding organisation. It was noted that very positive comments had been received from the Trust's partners and these could well influence future commissioning decisions.

The MD commented on areas of concern identified by the CQC, including long waits and patients with "Passed to be seen" dates. Access and waiting times were an issue but patient feedback was of excellent service once they were able to be seen. The interim Chief Executive confirmed that these areas had already been identified and the CQC was satisfied plans were in place. Mrs Lyttle commented on the challenging inspection process itself, but the 2018 inspection had felt very different form the 2016 inspection.

The Chairman felt that one difference from reading inspection reports on other Trusts was that TSDFT had a good level of self-awareness and had already identified areas where improvements were required, and there had been few surprises in the inspection report.

The Board noted the report.

105/05/18 **Mortality Surveillance Scorecard**

Report Summary

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 Medical Director reported on the improved reporting which now represented amore joined-up picture. SHMI reporting for the period October 2016 to September 2017 presented a very positive picture.

The Board formally reviewed the document and evidence presented.

106/05/18 **Revised Audit Committee Terms of Reference**

Report Summary

The 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.

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.

The interim Company Secretary explained the requirement of a revision of the Terms of Reference, to bring Trust arrangements in line with new NHSI guidance and the new HFMA Audit handbook. Considerable feedback had been received from Internal Audit and the Non-executive Directors: Mrs Taylor as Audit Committee Chair confirmed that the reviewed TORs had been discussed and reviewed in detail and confirmed that the committee had recommended the revised ToRs to the Board for approval.

The Board approved the revised Terms of Reference.

107/05/18 **Governors' Questions**

Mrs Day, Deputy Lead governor raised the following two questions on behalf of governors:-

> *The recent guidance from NHS England regarding zero tolerance on the number of patients who have confirmed cancer and receive treatment after 104 days is zero. The trust at the end of April had 17 patients who were still awaiting treatment. What assurance can the Board provide to governors as to the position regarding these 17 patients expected treatment commencing and what is the timeline for the Trust in achieving the required standard.*

The interim COO informed the meeting that measures were in place to assess any risk to patients and a review was taking place to ascertain how many had a wait of longer than 104 days.

(The Interim Company Secretary left the meeting at this stage.)

The interim COO informed the meeting that a review takes place for patients in breach of any cancer targets. A full breach analysis is conducted and signed off by the Clinical Lead to ensure the appropriate pathway for each patient. If there is any patient harm the risk is captured through the Datix system. A timeline is being worked on to reduce the number of patients waiting over 104 days to zero and to eliminate any 62 day breaches by the end of July – additional capacity would be required together with a review of suitable pathways to meet each patient's needs, recognising that some patients choose to delay their appointment which impacts on waiting times. Mrs Day commented on the importance of receiving timely histopathology

results for patients with complex pathways.

The Board participated in a development session in May following which 5 strategic priorities were proposed for the next twelve months and beyond.

What assurance can the trust provide that governors will be fully briefed and engaged with in a timely manner and what mechanism will be used to support this engagement given that we will have a responsibility to engage with our constituencies and be fully briefed in advance of the public engagement process commencing.

The Director of Strategy and Improvement provided assurance to the Board that governors would be fully involved with the engagement process. The Director of Workforce and Organisational Development would be co-ordinating the process to include staff governors and the Director of Strategy and Improvement would be leading on the public engagement process to include public governors: the Interim Chief Executive and Medical Director would lead on the STP engagement process. Planning was currently on-going and governors would be invited to contribute to the process. It would be invaluable to understand governors' views on areas to focus on and to develop a partnership approach to ensure the Quality and Safety of services provided by the Trust. - the engagement exercise would be a two-way process, including governors.

The Chairman felt it important to emphasise that that this would be an engagement rather than a consultation process, to ensure that service developments would meet the needs of the local population. , and the governors would have a key role to play. The Director of Workforce and Organisational Development was arranging for appropriate communications for the localities, to develop good relationships and facilitate co-design work.

Mr Coates raised a question around the availability of car parking at the site. The interim Chief Executive advised that car parking on hospital sites was always a difficult issue. The Director of Estates and Commercial Development had just finished a redevelopment of car parking arrangements at the site and Director of Finance confirmed that an additional 200 spaces had recently been made available. The Director of Strategy and Improvement explained that the more services that could be delivered at alternative locations, the less pressure there would be on car parking availability at the Acute site. The interim Chief Executive would discuss the issue of car parking with the Director of Estates and Commercial Development. CE/ DECD

On behalf of the governors, Mrs Day thanked the Executives for their responses and she will feedback accordingly to Mrs Marshfield, Lead Governor.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

108/05/18 **Finance, Performance and Investment Committee – 22nd May 2018**

Mr Sutton provided the meeting with a verbal report of the meeting held on 22

May 2018. The integrated performance report for Month 1 had been received and discussed by the committee. Reports had been received on the work of the Rapid Response and Discharge Teams, Estates and Capital Expenditure Risks and the Children and Young People's tender. The Anaesthetic Monitors Business case had been presented, and approved by the committee.

109/05/18 **Audit and Assurance Committee – 23rd May 2018**

Mrs Taylor was pleased to advise the meeting that both Internal Audit and External Audit had approved the Annual Report and Accounts, and also the quality Account, which had been discussed at the Audit and Assurance Committee meeting held earlier that day. The Chairman thanked all staff concerned for the quality of these reports, and the assurance these provided on the performance of the Trust.

110/05/18 **Report of the Chief Nurse – Safe Staffing**

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.

Dependencies and Risk

Registered Nurse Recruitment remains a challenge both locally and nationally.

The Board noted the report of the Chief Nurse.

The Board formally reviewed the document and evidence presented.

111/05/18 **Report of the Medical Director – Medical Workforce Update**

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.

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.

Dependencies and Risk

The resilience of medical workforce is included in the corporate level risk register.

The Board noted the report of the Medical Director.

The Trust Board noted the content of the report, the concerns and risks in relation to medical staff and the actions being taken to mitigate those risks.

112/05/18 **Report of the Interim Chief Operating Officer**

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 Service Delivery Units (SDUs) are in the process of finalising the delivery plans (developments and CIP) for 2018/19. The challenge of identifying solutions to close the savings position is managed by the SDUs and reviewed through the Quality and Performance and Efficiency Delivery meetings with the Executive.

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.

The Board noted the report of the Interim Chief Operating Officer.

The Board formally reviewed the document and evidence presented.

113/05/18 **Report of the Director of Estates and Commercial Development**

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).

Dependencies and Risk

Risk of significant failure of infrastructure due to a lack of available capital for investment.

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

The Board formally reviewed the document and evidence presented.

114/05/18 **Report of the Director of Workforce and Organisational Development**

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.

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.

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

The Board formally reviewed the document and evidence presented.

Compliance Issues

115/05/18 **Any Other Business Notified in Advance**

The Chairman informed the meeting of the interviews for STP Chair taking place on 1 June 2018. Cllr Parrot would be the sole local authority representative on the panel and the Trust would be represented by the interim Chief Executive.

116/05/18 **Date of Next Meeting –** 9.00 am, Wednesday 4th July 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.	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.	11/04/18
4	Discuss how Guardians could work with Governors and other groups.	CE/SB		02/05/18
5	Respond to query raised by Councillor Parrott regarding the number of patients who spend more than 4 days in A&E. To also ensure it was discussed at QAC.	ICOO/ CGM		23/05/18
6	DoF to contact Councillor Parrott to clarify savings plans.	DoF		23/05/18
7	MD to discuss links between local research initiatives and products manufactured by Torbay Pharmaceuticals.	MD		23/05/18

8	Discuss issue of car parking on the acute site with the DECD.	ICE		23/05/18

Cover sheet for a report to the Trust Board					
Report title: Chief Executive's Business Update					**Date: 4 July 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 (26 June)				
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 (26 May 2018) and the Interim Chief Executive (28 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: 4 July 2018**
Report sponsor	Interim Chief Executive	
Report authors	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 23 May are as follows:

1.1 Safe Care, Best Experience

Carter Report cites Torbay as integrated care pioneer

Our Trust was cited as an example of best practice in integration in a report by non-executive director of NHS Improvement, Lord Carter, published last month. The report says that up to £1bn could be saved by the NHS over the next three years through productivity improvements to mental health and community health services. It highlights how such services should play a much bigger role in providing more joined-up care for elderly patients, which would reduce both unnecessary hospital admissions and patients' length of stay. It found that community health staff spend just a third of their working day on patient care, and lack electronic records. The report recommends updating the use of technology and overhauling staff rostering.

Case study – Integrated care pioneer

In 2015 Torbay and South Devon NHS Foundation Trust changed its model of care to support its integrated care organisation status and better serve its increasingly ageing population. Bed occupancy audits showed that about a third of its beds were occupied by patients fit for discharge to community health services. The trust therefore expanded its intermediate care team to provide services over seven days and created health and wellbeing teams with an additional 60 staff to provide an alternative to hospital admission and care for patients in the community or at home.

As a result, the trust's community hospitals saw 35% more patients and reduced its average length of stay from 14 days to 10. The trust now cares for 40% more patients outside hospital and uses about 25,000 fewer bed days a year compared to 2015. This has meant that it has reduced its total number of beds, including community hospital beds by about 20%. Partly as a result of these changes, alongside other cost improvement plans, the trust achieved savings of £40 million in 2017/18.

New Brixham day centre now underway

The building of the 'Friends Centre' led by the voluntary sector in Brixham is progressing well and plans for the activities that will take place in the new centre are well underway. This new centre will contribute to the offer of health and wellbeing support in Brixham. The full range of services is yet to be determined but it will include access to wellbeing coordination to help reduce isolation and connect people to wider services, as well as services such as healthy lifestyles and carers support. There will also be a number of hireable spaces for people to book and use. The Trust is working in partnership with the Brixham Hospital League of Friends and voluntary sector organisation, Brixham Does Care, to build the centre. The League of Friends has

donated £800,000 to fund the build and they are also overseeing the build project. The centre will be known as 'The Friends Centre' recognising the generous contribution, time and commitment that the Brixham Hospital League of Friends have made to creating this new space for the people of Brixham. All of the services will be about enabling people to live their lives as health and as well as possible. Brixham Does Care will run The Friends Centre when it opens in the early part of 2019.

Teignmouth engagement ends

The six-week engagement period led by South Devon and Torbay CGG and supported by this Trust on bringing some health and care services together in a new building in Teignmouth has now ended. The engagement, which began on 30 April 2018 and ended on 8 June 2018 asked people for their views on options. People were invited to a number of drop-in sessions held in both Teignmouth and Dawlish and were also encouraged to complete a questionnaire which was available online as well as on paper. People were also able to email their thoughts.

The feedback is now being considered and a full report will be published in the coming weeks. If it is decided to pursue options that would mean a substantive change to the way services are provided a public consultation will take place.

Partnership Announced to Build New Dartmouth Health and Wellbeing Centre

South Hams District Council and the Trust have announced that they have identified a proposed new site for the Health and Wellbeing Centre on part of the overflow Park and Ride car park in Dartmouth. The plans are for the Council to provide the land and to construct a purpose-built Health and Wellbeing Centre to the NHS Trust's specification. It is intended that the new building will include the GP practice, a pharmacy, services that are currently being provided from the Dartmouth Clinic site and a base for voluntary sector organisations.

Publication of 2017 adult inpatient survey

The 2017 National Inpatient Survey results were released this week and have now been published on the CQC website. The survey samples patients aged 16 years and older who spent at least one night in Torbay Hospital during July 2017. Understanding what a stay in hospital is like for patients provides key information about the quality of services across England. This understanding can be used to encourage improvements both nationally and locally. The importance of positive patient experience is now well recognised across the NHS.

Comment: Our response rate was 48% which is lower than in 2016 (50.8%). This reduction is in line with national trends. Overall our Trust scored in the top 20% for 21 questions and in the bottom 20% for just 1 question. Areas where we were rated in the top 20% included:

- Keeping to planned admission dates
- Enabling patients to take their own medicines brought in from home (score was also significantly better than that for 2016 on this question)
- Positive views of nurses and team working
- Staff communication and information giving before operations and before leaving hospital
- Privacy
- Emotional support, pain management, respect and dignity.

- Discharge planning and support after leaving hospital
- Being given written/printed information about what you should or should not do after leaving hospital. (score was also significantly better than that for 2016 on this question)
- Doctors or nurses giving family or someone close all the information they needed to help care for the person (score was also significantly better than that for 2016 on this question)

We were rated in the bottom 20% for giving patients the opportunity to feedback on the quality of care. This is an important issue and one we were already working on. Since the autumn of 2017 the Trust has become a participant in a patient experience project to increase the numbers of patients in hospital being asked to give their feedback. The questions cover very similar elements of care as those considered in the National Inpatient Survey. Since January 2018, we have received detailed feedback from 619 patients across the 8 project areas. We are currently planning the next phase of this work as we continue to seek more robust ways of engaging with people who use our services. We have become aware that the uptake of the Friends and Family questionnaire has also fallen. This had been noted as part of our general governance monitoring and we are discussing a recovery plan.

1.2 Well Led

Care Quality Commission Use of Resources Assessment report

Following their recent inspection of the Trust, the CQC has now published their Use of resources report and confirmed their rating of GOOD. The full report and further details are included in a separate paper from Paul Cooper, Director of Finance. The improvements in the Trust's financial planning and delivery throughout 2017/18 contributed to an improvement in the Trust's overall well led ranking . Teams are to be commended for their approach to efficiency, safely reducing costs and best use of resources.

Delivering Today:
2017/18 Month 2 (May) service delivery and financial performance headlines

Key service delivery and financial performance headlines for Month 2 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 2 the Trust has delivered the following outcomes:

- **4 hour ED standard:** In May the Trust achieved 86.7% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments. This is a reduction on last month (87.7%) and below the operational plan trajectory of 92.1% and national standard of 95%.
- **RTT:** RTT performance has improved in May with the proportion of people waiting less than 18 weeks improving to 82.2% (from 81.6% in April) just 0.1% below Operational Plan trajectory of 82.3%. This slightly improved performance however has seen a 2.6 % increase (ie 500 more patients) in the total number

of patient waiting for treatment. At the end of May 53 people were reported as waiting over 52 weeks. An increase compared to 43 last month. Operational pressures and slippage of plans to recruit to posts have contributed to the position and delay in seeing a reduction in longest waits.

- **62 day cancer standard:** at 81.3% (validated 14th June 2018) performance is below the 85% national target, and a reduction on same point last month (82.1%). Current forecast for Q1 is 83.9%.
- **Diagnostics:** The diagnostics standard was not met with 5.9% of patients waiting over 6 weeks against the standard of 1%. This is an improvement on last month (11%) and ahead of our NHSI operational plan. Improvements in ultrasound and CT waits in May have contributed to this improvement. There will remain continued reliance on outsourcing to visiting mobile units for both MRI and CT along with backfill for staff sickness in ultrasound.
- **Dementia screening:** The Dementia Find standard is meeting the standard of 90% with 92.6% achieved In May. This is a significant achievement and aided by the allocation of heath care assistant resource to support the wards.

Financial Headlines

- **Overall financial position:** The financial position for the financial period to 31st May 2018 is a deficit of £1.27m against a planned deficit of £1.56m. (this is an improvement on Month 1 £2.09m deficit).
- **CIP savings delivery position:** the current month position shows a £0.1m surplus against plan; however cumulative year to date we have £0.8m shortfall against plan. Against the full year target of £26.93m, we have £18m of forecast delivery, resulting in a £8.9m shortfall forecast out-turn position. There is a net £4m increase from last month's forecast out-turn. The forecast full year effect of the recurrent savings delivery position estimate is £11.5m against the plan of £26.9m
- **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 2, 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.

2018/19 Operational Plan Submission

As reported previously, Directors submitted the revised 2018/19 operational plan to regulators at the end of April confirming acceptance of the revised control total. The Trust, in common with most other Trusts, received feedback from the regulators requesting that performance trajectories, workforce profiles and financial plans were revisited with the opportunity to improve/strengthen and resubmit by 20th June. Directors have reviewed and took the opportunity to revise the cash profile to reflect the additional investments in capital for core infrastructure (estate and technology) that the Board has previously endorsed. In private session Paul Cooper, Director of Finance will take the Board through the detail. A response from NHS I is awaited.

1.3 Valuing our Workforce, Paid and Unpaid

Health and Care Impact Network Event

Programme Director at NHS Digital, Cleveland Henry, visited the Trust last month to give the keynote address at our 4th mini health and care impact network event. He spent the day at Torbay Hospital, finding out about our digital innovations including our virtual reality developments in education and professional development; video conferencing to connect health care professionals and service users and NHS Quicker App to support urgent care patients to access the right place for them.. During his address he commented on the great work that is going on here. He used his session to talk about how technology can be harnessed to reduce the burden on the frontline – and needing to be sure, in a fast-moving environment, we don't use yesterday's technology to try to address tomorrow's problems.

NHS 70th Celebrations

A number of different activities are planned to celebrate this month's 70th anniversary of the NHS including

- An **NHS70 tea party** across the Trust where patients, visitors, staff and friends will be joining us to enjoy a celebration cake on the afternoon of the anniversary Thursday, 5 July 2018.
- 70 years in pictures: over the last few months photos have been taken of staff across the Trust that have been made into a **photo montage** in the shape of NHS 70. These can be seen in many of our buildings.
- On Saturday, 7 July 2018 we are holding a **celebration Ball** at the Riviera Centre in Torquay where staff from local NHS organisations will be joining us for an evening of celebration.
- **Media opportunities**: we have been taking part in a number of media opportunities to show our innovative care in the 21st century. Some examples of this will be covered on local TV and radio.
- **Social media**: we will be sharing images of the celebrations on social media during the anniversary as well as showing how health and care has changed over the decades and how we are at the forefront of integrated in 2018.

Recognition for Outstanding Care: Awards for our staff.

Congratulations to our hard working staff that recently won a prestigious Outstanding Care Award for Devon and Cornwall area. The awards developed by the Care Network Group, celebrate the most dedicated individuals, providers and suppliers in the care industry- going beyond the call of duty in their work across the region. Congratulations to the following:

- Health Care Assistant of the Year – Gold award - Mark Glover, Ainslie ward
- The Peoples Award - Bronze Award - Sara Asghari –Staff nurse, General Theatres
- Gold Award– Joint collective - 4x4 drivers who volunteered during the winter snow periods. One of these is Dr Kyle Stewart

Staff Heroes

On 26 June along with the Chairman and fellow Directors I had the great pleasure of presenting the latest set of staff hero certificates. People from across the full range of Trust services – health care support workers, clinicians, therapists, nurses, clinical and non clinical support staff (laboratories, estates, technology, Quality Improvement) –

being nominated by their colleagues, other teams and from patients and their families for going the extra mile. Their compassion and care shone through – including out of hours. A number of the nominations related to the kind and compassionate care our teams provide to people at their most vulnerable – at end of life – with testimonies from families of how in the worst of times we had made a difference and helped make things as best as they could be.

2 Interim Chief Executive Internal and External Engagement: June

Internal	External
• Staff Side • Medical Staff Committee • Trust Talk (staff briefing) • Carer Shadowing • Volunteer Tea Party • F1 Junior Doctors Presentation • Medical Staffing Thank You Event • Staff Heroes Event • Staff Drop in Sessions: Kings Ash House Torbay Hospital Totnes Hospital	• STP Chief Executives' Meeting • STP Programme Delivery Executive Group • Devon Children and families Alliance Dialogues sessions including with families and partner Board meetings • Director of Adult Services, Torbay Council • Chief Officer for Adult Care and Health, Devon County Council • Chief Executive Devon Doctors • Devon A&E Board • Joint Executives' Meeting with CCG • Joint Executives' Meeting with RDE • Devon County Council Health and Adult Care Scrutiny Committee • Devon County Council Health and Wellbeing Board Stakeholder Event • SW AHSN Chairman and Director of Corporate Services • Fireside Chat – Post Graduate Certificate in Leadership and Management – Exeter Medical School.

3 Local Health and Care Economy Developments

3.1 Partnership updates

Team from Torbay Meets the Minister

On 13 June a team from the Torbay Together partnership that included the editor of the Herald Express Jim Parker and our Director of Strategy and Improvement, Ann Wagner, met with Jake Berry the Minister for the Northern Powerhouse and Local Growth with local MPs Kevin Foster and Sarah Wollaston. The meeting was to promote Torbay opportunities and to deepen relationships with Government to support key developments including:

- Town Deal status for Torbay
- Support for university status for South Devon College
- Support for health & improved outcomes including how to access national funding for technology to support transformation

The meeting went well and the minister has agreed to pay a visit to Torbay this summer. Further details are included in the Director of Strategy and Improvement's update report included in the Board pack. The visit is all part of the Torbay Together *Now is the Time* campaign that the Trust is supporting. Details are included in the brochure attached to this report.

Academy of Nursing launch

We are a partner in the University of Exeter's new Academy of Nursing for the South West and last month attended its formal launch. This brings together Devon Partnership NHS Trust, Northern Devon Healthcare NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Torbay and South Devon NHS Foundation Trust, and a group of patients in Devon. The Academy is the first step in an ambitious plan to both educate more nurses in Devon and support existing nurses throughout the region to deliver the kind of exceptional care our patients rightly demand. We are linking the research and educational power of the University of Exeter with the excellent clinical skills of our nurses in Devon. The launch event included an exciting programme looking ahead to the future of nursing in Devon.

3.2 Partner updates

Royal recognition for Dartmouth Caring

Congratulations to Dartmouth Caring for receiving the Queen's Award for Voluntary Service in 2018. The Queen's Award, the highest available to voluntary sector organisations, is given to groups that can demonstrate excellence in volunteering. This royal seal of approval comes just one month before the Charity's 30th birthday. Some volunteers and staff will be presented with the award by Devon's Lord Lieutenant and the Queen's personal representative in the county, David Fursdon, at a special ceremonial event later in the year.

NDHT and the RD&E agree to a new collaboration

Northern Devon Healthcare NHS Trust (NDHT) and the Royal Devon and Exeter NHS Foundation Trust (RD&E) have reached agreement on a new collaboration between the two organisations. The collaboration aims to support NDHT to address the challenges it faces in continuing to provide acute services and to ensure that the health needs of the population of northern Devon continue to be met. With the support of NHS Improvement (NHSI), the two organisations have agreed that the RD&E will provide leadership and management support to NDHT for the next two years, with a dedicated senior management team based at each acute hospital site in Barnstaple and Exeter., Suzanne Tracey, currently Chief Executive at the RD&E, has become the Accountable Officer and Chief Executive of both organisations. Roger French, NDHT Chair, had signalled his intention to retire from the Board and will do so on the 30 June. As part of the agreement, James Brent (currently the RD&E Chair), has been appointed Chair of both trusts, although there will continue to be two separate Boards and separate statutory obligations.

University Hospitals Plymouth Trust and Livewell Southwest set up a joint board
The organisations have an ambitious target to integrate by April 2019 to create a new NHS organisation and be a fully integrated health and care organisation.
Livewell Southwest was set up as a community interest company in 2011 after community services were transferred from primary care trusts to other providers.
It provides care to a catchment population of around 270,000, mainly in Plymouth and surrounding areas, and has a turnover of £110m. In 2015 the company began providing social care in Plymouth under a £71m contract, making it one of the largest organisations of its kind in England. The new joint board between the trust and Livewell comprises both organisations' chief executives, deputy chief executives, chairs, one non-executive director each, and two directors of integrated care. Both organisations are selecting employees to make up a transformation team. In addition, the parties are streamlining processes for staff moving between the organisations. This is to help develop partnership arrangements ahead of commissioning intentions which are expected to be published by Northern, Eastern and Western Devon Clinical Commissioning Group in July.

Dame Suzi Leather DBE to chair Devon Sustainability and Transformation Partnership (STP)
A leader who has spent her life improving public services has been appointed to take the helm of Devon's health and care system. Dame Suzi Leather DBE, who grew up in Devon, will work closely with the leaders of Devon's Hospital Trusts, mental health providers, Local Authorities and NHS clinical commissioners to enhance NHS and care services.

Royal Devon and Exeter NHS Foundation Trust (RDE) invests in new Electronic Patient record (EPR) system
RD&E has received NHS Improvement approval to proceed with a new clinical transformation programme. As well as fundamentally improving the way services and care are delivered to patients, the programme will see paper-based patient records becoming a thing of the past. The MY CARE Programme is the cornerstone of a broader programme of change to transform the way that care is delivered and make services at the RD&E more clinically and financially sustainable for the future, enabled by new technology. The Trust's Board approved the MY CARE Programme including the go ahead for implementing a comprehensive electronic patient record (EPR) supplied by US-based healthcare technology company, Epic. Epic is an integrated platform, meaning that there is just one record for each patient and providers have the full picture of each patient's story. Detailed work is underway to commence the programme from September 18 with the plan spanning c.23 months prior to a planned go-live in the Summer of 2020.

Comment: the development presents both an opportunity and threat to the Trust – an opportunity to support clinical networks and make our own technology systems more resilient; a threat as the RDE are recruiting significant numbers of technology and change agent specialists that pose a potential threat to our team resilience; we are working with RDE to mitigate risks and maximise opportunities. In private session Directors will update the Board on potential opportunities and risks and seek support for a way forward.

DPT receives national award
Devon Partnership Trust (DPT) was a winner at the HSJ Value Awards 2018. It picked up the mental health award for reducing the number of patients being treated outside the region. As a pilot site, DPT developed a clinically-led model of care across eight partner organisations involving a single point of access for the region, standardised assessment criteria, a regional approach to bed management, and a repatriation scheme. This has resulted in 64 people being brought back to their home region, as well as increased provision for underprovided services, including women's services and forensic teams. The work has also contributed to national design works teams for community forensic teams, prison healthcare and women's services, as well as influencing NHS England plans for new care models programme.

4 National Developments and Publications

Details of the main national developments and publications since the Board meeting on 23 May 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 Gosport War Memorial Hospital scandal.

The doctor implicated in the deaths of at least 456 patients over 12 years working at Gosport War Memorial Hospital has said she was "doing her best for patients" in a pressurised part of the NHS. Last month a major inquiry concluded Dr Jane Barton was "responsible" for the practice of prescribing powerful and unnecessary opiates which killed as many as 650 patients between 1988 and 2000.

Could it happen here? Discussed at Serious Advents Events Group 20th June. For more than 5 years all deaths in community hospitals have been reviewed in detail (including use of opiate analgesic agents). Mortality rates in all community hospitals are reported to the Trust's Quality Improvement group (QIG) on a quarterly basis and are now also discussed at the Mortality Surveillance Group. Numbers of deaths in community hospitals are low.

As a result of community investment a greater proportion of patients are now managed in care homes or in their own homes. The Trust End of Life Group will undertake an audit of use of opiates in all settings to provide further information and assurance.

The case has again highlighted 'Whistle-blowing' in NHS organisations. It is important to point out that these issues took place a long time ago and the culture has changed. However, we continue to work through initiatives such as the Freedom to Speak Up Guardians to ensure that any staff concerned is able to raise their concerns and to demonstrate that the Trust acts on the basis of such information.

4.2 Government

Funding settlement linked to 'simple goals'
Jeremy Hunt has said that talks with government about a long-term settlement for the NHS are “difficult and ongoing” and any deal would be linked to new “simple goals”. Speaking at the NHS Confederation conference in June, he outlined several goals that would form part of any long-term settlement with the NHS. These goals would include:

- Waiting time standards for mental health that are “as strong and powerful as waiting time standards for physical health”
- Bringing up cancer survival rates to the “best in Europe”
- Transforming maternity safety up to the standard of Sweden
- To “truly integrate health and social care”

Tax rises for the NHS will be fair
The Prime Minister has said that any tax rises to support a £20.5bn boost to the NHS budget will be fair”, as she promised to end the “sticking-plaster” approach to health funding. Theresa May acknowledged that the public will have to pay “a bit more” in tax in order to fund the extra £394m a week going to the NHS in England in 2023/24. She repeated her claim that part of the increase will be funded by a “Brexit dividend”.

Breast screening update
Jeremy Hunt gave a written statement to the House of Commons to provide an update on progress contacting women who had not been contacted with their last screening appointment under the national breast screening programme. He confirmed that all women affected had been contacted by letter. He also gave an update on the total number of women impacted, and revised down to ‘less than 75’ the number of women whose lives would be shortened as a result of missing their final appointment – acknowledging the devastating impact on those people. Number of people affected has now been published by constituency, with local figures given as:

- Central Devon (Mel Stride MP) 524
- Newton Abbot (Anne-Marie Morris MP) 314
- Totnes (Dr Sarah Wollaston MP) 468
- Torbay (Kevin Foster MP) 360

Comment: We receive a weekly list of women who have contacted the national helpline and we are booking these in for a screening appointment as soon as we can. We have created additional capacity to do this by extending the working day on the mobile unit, and our staff have willingly worked additional hours. The direct phone calls through to the screening admin office have reduced substantially in the past week. We are confident that we will be able to manage the additional workload within the required timeframe, before the end of October 2018.

Health and Social Care Select Committee report on Integrated care: organisations, partnerships and systems

The Health and Social Care Select Committee (the Committee) has published the report of its inquiry into the development of new integrated ways of planning and delivering local health and care services. This inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). The report makes a series of recommendations including:

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.
- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention

4.3 NHS England

Four new 'integrated care systems' named

The new “integrated care systems” have been named by NHS England and NHS Improvement, as they continue to “finalise the details” of a financial regime for the existing ten ICS. The additional four are:

- Gloucestershire;
- Suffolk and North East Essex;
- West, North and East Cumbria; and
- West Yorkshire and Harrogate.

Comment:: There was an expectation that Devon STP would be included in the announcement. One of the entry criteria includes financial balance – the STP will not be eligible for the national programme until it is in financial balance. .

Q4 figures show rise in long-waiters

The number of patients waiting a year or more for elective treatment has risen by 75 per cent year-on-year, NHS Improvement data confirms. In March this year there were 2,647 patients who had waited more than 52 weeks for treatment, up from 1,513 in March 2017. The data was released as part of NHS Improvement’s quarter four summary, which collates data across the 2017-18 financial year. It showed an overall performance on the 18-week waiting time standard of 86.8 per cent, against a target of 92 per cent. This was a fall of 3.2 percentage points on the previous year. The position has significantly deteriorated in this calendar year with the number of year-plus waiters in March representing a 22 per cent rise on the total in February. The February figure was itself a 20 per cent increase on the total for January. NHS England has committed the service to doing no worse on the elective waiting time measures in March 2019 than it did in March 2018. The total national elective waiting list also reached 4.1m, higher than at any point since August 2007.

Comment: Our local system has mirrored the national picture with our Referral to Treatment (RTT) performance deteriorating to 81.58% from 87.54% in March 2017, and currently plateauing at around 81.6% . We have seen a similar deterioration in our 52 week wait position. In March this year, we had 33 people waiting longer than 52 weeks, up from 17 in March 17. Teams are developing recovery plans with the support of NHS I to address both RTT and 52 week wait issues.

Local plans still not good enough

Local NHS providers and commissioners were given a fresh warning that their plans will not deliver the capacity, productivity or length of stay improvements required for 2018-19. The warning came in a letter to local leaders from NHS emergency care chief Pauline Philip on 13 June setting out new guidance on reducing long hospital stays and a new national length of stay target. The target, confirmed this week by system leaders at the NHS Confederation annual conference, is to cut the number of patients spending more than three weeks in hospital by a quarter to free up 4,000 beds by December.

4.4 NHS Improvement

Doubts over plans to stop waiting list growing this year

Stemming growth in the waiting list for NHS operations in 2018-19 – as has been required by the government – remains “challenging” under current local plans, officials have said. NHS England chief financial officer Paul Baumann revealed the news as he presented a paper on the 2018-19 planning round to a joint board meeting of NHSE and NHS Improvement in June.

Reconfiguration of provider sector

NHS Improvement is to drive hospital and service level reconfiguration across the health service to deliver greater levels of clinical and financial sustainability. Under plans revealed at a joint board meeting between NHS England and NHSI held in June, the provider regulator said there was a “clear need to be more proactive in shaping the future provider landscape”. This will include organisational forms such as groups and chains of hospitals, suggesting the regulator will attempt to deliver more consolidation in the provider sector. This work will be led by a new joint strategic approach to configuration of the provider landscape with a single chief provider strategy officer based within NHSI.

4.5 NHS Improvement and NHS England news

NHS to return to single finance and performance regime

NHS England and NHS Improvement have announced they are moving to a single financial and operational planning and performance regime under a shared chief finance officer.

There will be a shared appointment for several top executive posts:

- A chief finance officer leading the integrated financial and operational planning and performance oversight process.
- An NHS nursing director/chief nursing officer for England.
- An NHS medical director..
- A national director for transformation and corporate development.

Other national directors in both organisations will take on responsibility for a number of ‘do once’ functions supporting both organisations, with shared governance and oversight.

NHSI is also creating several new national director roles: chief provider strategy officer; chief people officer; chief improvement officer (improving quality, access and efficiency); and chief commercial officer (estates, procurement and backoffice).

It is not yet clear which current national director roles are being scrapped. The aim is for all changes to be made by the end of this financial year.

One of the aims of the joint work is to reduce administrative costs for redeployment into frontline patient care.

5 Local Media Update

- **Devon Live -** Health services in Torbay and South Devon are now back on track – Torbay and South Devon NHS Foundation Trust now rated as “Good”
- **Devonlive -** Lengthy A&E waits in Devon's busy hospitals have sky rocketed – included TSDFT
- **Devonlive -** Isolation and stress identified by army of 17,000 unpaid Torbay carers – here Healthwatch Torbay report
- **Devonlive** - Plans go in for 'crucial' new hospital that will help solve county's mental health crisis – here
- **South Hams Gazette** Patients' group backs health trust over hospital closure – Dartmouth Patients Participation Group
- **South Hams Gazette -** The creation of the Dartmouth Healthcare Action Group – Response to statement issued by TSDFT and South Devon and Torbay CCG
- **Mid-Devon Advertiser -** Rally to save Teignmouth Hospital

News releases and campaigns:

- Local NHS and partners secure £1.3m to support Wellbeing Programme in Torbay and South Devon
- New Brixham day centre now underway
- Most people are happy with Paignton’s new Health and Wellbeing Centre, according to a new report, despite a few ‘teething’ problems
- Devon Macmillan dietitian busts healthy diet myths
- Congratulations to the winners of the Outstanding Care Awards
- Launch of the ‘Noise at Night’ campaign
- ‘Sock it to Sepsis’ campaign has been launched across a range of media channels

6 Recommendation

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

AW/JG/CF
27/06/18

Cover sheet for a report to the Trust Board					
Report title: Devon Sustainability and Transformation Partnership (STP) Updates for May and June					**Date: 4 July 2018**
Report sponsor	Director of Strategy and Improvement				
Report author	Devon STP System Lead Director for Corporate Affairs				
Report provenance	Reports reviewed by Executive Directors Group (26 June)				
Confidentiality	Public				
Report summary	An update from the Devon STP of the following key initiatives and developments from the last two meetings of the Programme Delivery Executive Group (PDEG). **May PDEG:** 1. Devon NHS system financial update – 2017/18 final position. 2. Progress in developing an STP-wide prioritised list of capital bids. 3. STP Two-year progress report document. **June PDEG:** 1. CCG joint working and progress towards creating a new single, strategic commissioner. 2. Local Authority cost pressures and social care funding. 3. Welfare Reform briefing and update. 4. Acute Services Review: o Current programme overview. o Service Delivery Network development. 5. Peninsula Pathology NHS Network update. 6. STP Wave 4 capital bid prioritisation.				
Purpose (choose 1 only)	**Note** ☐	**Information** ☐	**Review** ☒	**Decision** ☐	**Approve** ☐
Recommendation	The Board is recommended to **review** the reports and **consider** implications on the Trust's strategy and delivery plans.				
Summary of key elements					
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 update follows the				

	meetings of PDEG on 18 May and 15 June. All partner organisations in the STP are represented at senior level at PDEG. Liz Davenport, Interim Chief Executive attends to represent the Trust
Dependencies and risk	**Executive Directors have identified the following dependencies and risks:** • **Potential merger of the 2 CCGs to form a strategic commissioner**: whilst making strategic sense across the Devon STP footprint, this does pose a potential risk in terms of loss of coterminosity at place for South Devon and Torbay. The population focus for South Devon and Torbay will be a priority for the local system. • **Local Authority cost pressures and social care funding**: the forthcoming Government's green paper will set out the future funding for social care funding. Given our local demographic and further reductions would have a significant impact on our integrated care model. • **Acute Services Review (ASR)**: progressing the work of the ASR including the move to Service Delivery Networks is supported and in line with the Trust's priorities. We need to make sure we have the clinical and operational capacity to engage. • **Peninsular Pathology Network:** focus on the creation of a managed clinical network across Devon and Cornwall. Developments under consideration include consolidation of sites for low volume non-urgent tests; establishment of a Pathology Clinical Effectiveness Group and aspiration to deliver a single common IT platform could have an impact on the Trust. Trusts will be asked to endorse the approach. Paul Cooper, Director of Finance, will bring a strategic outline case to the Board in due course. • **STP Wave 4 capital bid prioritisation:** access to capital for estates and IT infrastructure is now through STPs. The Trust's bids for theatre upgrade and cyber security are included. Other bids including backlog maintenance will have to be progressed through a different funding stream. • **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 where appropriate.
Summary of scrutiny	Reports reviewed by Executive Directors Group (26 June)

Stakeholder engagement	This report is shared system-wide. Within our Trust it is published with board papers on the Trust website and is shared with the Board and Governors.
Other standards affected	Nil
Legal considerations	None

Update to	**Boards, Governing Bodies and Local Authority meetings of Devon STP partner organisations**
Date	**May 2018**
Title	**Monthly Update Report on Devon's STP**

Introduction

The purpose of this regular report is to:

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

Content

This is the seventh Update Report, and covers developments from the ***PDEG meeting held on Friday, 18 May 2018***. Key items covered at PDEG this month:

1. Devon NHS system financial update – 2017/18 final position.
2. Progress in developing an STP-wide prioritised list of capital bids.
3. STP Two-year progress report document.

1. Devon NHS system financial update – 2017/18 final position

PDEG was briefed on the excellent progress made by the NHS in managing its finances.

The NHS in Devon delivered huge efficiencies during the 2017/18 financial year as part of plans to reduce its historic financial deficit. The Devon NHS system ended the year with a deficit of £22.7 million, which was £38.9 million better than plan. This position was helped by additional income earned from national /central funding.

In order to achieve this, the NHS delivered savings of £156.6 million, a significant achievement. This was 93% of the planned target of £168.2 million savings.

NHS overspending has now reduced to £22.7 million, and Devon is planning for financial balance during 2019/20.

2. Progress in developing an STP-wide prioritised list of capital bids

PDEG was given an update on the progress with developing plans to submit a prioritised list of capital bids for the Devon system by 29 June 2018.

All STPs have been requested to submit STP-wide Wave 4 Capital Plans to NHS Improvement, NHS England and the Department of Health and Social Care.

As part of the process for bidding for capital, a Capital Prioritisation Panel has been formed, and its first meeting was held on 15 May 2018.

The Panel was constructed to reflect the diversity of the Devon STP and specific professional expertise.

The overall process and central guidance was reviewed, as well as progress in completing capital bids for 23 projects. Each bid was Banded High, Medium or Low. Those projects in the 'Low' band were removed from the current Wave 4 process.

Critically, the process is not considered as a one-off, but as a "live process" which enables Devon to produce a comprehensive capital plan whereby estates and digital expenditure are fully aligned to support delivery of our collective system priorities.

The starting point for the capital prioritisation was for all STP partners to identify their capital plans. These were reviewed with STP Finance to ensure compatibility with financial submissions.

The long-list had 170 line items with a total capital spend of £520 million. Each partner organisation reviewed the plans to identify which schemes required public capital and was sufficiently advanced to be viable candidates for a Wave 4 bid. This removed a large number of projects.

The end result is that 23 schemes were discussed by the Capital Prioritisation Panel, with a total capital requirement of £230 million.

These bids were segmented as follows:

Type	**Bids**	**Value (£ million)**
Primary Care	5	26.9
Backlog Maintenance (includes bids from all sectors)	5	45.7
Mental Health	1	8.0
Digital/IT	5	27.2
Equipment/Scanners	2	8.5
Acute Site- Clinical	4	64.1
Elective Orthopaedics STP provision	1	50.0
Total	**23**	**230.4**

Actions required to improve the robustness of schemes were identified and each project has been allocated a mentor from the Panel to provide assistance.

It is estimated that the total national "pot" for Wave 4 is around £1.2 billion, which equates to an average of £27 million per STP. However, the guidance clearly states that all bids will be evaluated on merit according to the national criteria and there is no "fair-share" allocation.

PDEG requested that the schemes were challenged and reviewed to ensure they supported plans to transform the Devon health and care system. Wave 4 bids will also be looked at in the context of local plans and tested against our STP strategy.

The longer-term key milestones and next steps are as follows:

- Submission of Wave 4 bids: 29 June 2018.
- STPs informed which Wave 4 capital bids have been successful: Autumn 2018.
- Capital available for successful bids (subject to business case and STP estates strategy approval): From April 2019. Note that none of the Wave 4 capital will be released during 2018/19.

3. STP Two-year progress report document

The Sustainability and Transformation Partnership (STP) has been a positive catalyst for Devon.

Over the past two years, it has helped leaders build a collaborative and system approach across the NHS and local government.

As a result, Devon is in a stronger position in which to further integrate services for the benefit of local people. Furthermore, the collective work by leaders has helped us tackle the historical challenges we have faced. As a result, our financial and service performance has improved.

The framework of the STP has helped the NHS in Devon to move away from being one of the three most challenged health systems in England to one of 14 systems making progress.

This progress is testament to the original strategy that was put in place in 2016.

An STP Two-year progress report was presented to PDEG that highlighted what the STP set out to achieve two years ago, what progress has been made to date and, importantly, signals what is now being taken forward for delivery in the Devon health and care system in the next three years.

The document is now being finalised and will be circulated shortly to all partners for them to share with staff and other audiences.

Update to	**Boards, Governing Bodies and Cabinet meetings of Devon STP partner organisations**
Date	**JUNE 2018**
Title	**MONTHLY UPDATE REPORT**

Introduction

The purpose of this regular report is to:

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

Content

This is the seventh Update Report, and covers developments from the ***PDEG meeting held on Friday, 15 June 2018***.

Key items covered at PDEG this month are as follows:

1. CCG joint working and progress towards creating a new single, strategic commissioner.
2. Local Authority cost pressures and social care funding.
3. Welfare Reform briefing and update.
4. Acute Services Review:
    - Current programme overview.
    - Service Delivery Network development.
5. Peninsula Pathology NHS Network update.
6. STP Wave 4 capital bid prioritisation.

1. CCG joint working and progress towards creating a new single, strategic commissioner

The ambition in Devon is to move towards fully integrating health and care services.

To turn this into reality, there a number of changes that are needed in how the two CCGs (NEW Devon CCG and South Devon and Torbay CCG) work together.

The two CCGs have, over the past year, been working jointly to create a stronger, clearer and more consistent health commissioning 'voice' for the whole of Devon.

However, there are two other developments required – the first to formally align the teams and staff from the two CCGs more closely together, and then consider formally merging the organisations.

PDEG was updated on what changes are being made to enhance closer working between the CCGs, and the benefits this has brought to date, and what the next steps are towards creating a new single, strategic commissioner for health and care for Devon.

Aligning the two CCGs

As the CCGs have worked more closely together for over a year, it has brought some immediate improvements and benefits.

It has helped remove duplication, simplified and speeded up decision making and it has helped harmonise policy developments. Working more closely has also helped the CCGs realise cost savings and efficiencies – and both CCGs have made combined savings of nearly £4 million on running costs in the past year.

Both CCGs are achieving much more together than we would have achieved working separately.

The CCGs embarked on a consultation process with staff between 3 April 2018 and 1 June 2018 on a new joint streamlined structure for the CCGs. Some of the main features of the proposed new arrangements include:

- Changes to Executive portfolios.
- An overall reduction in the number of senior posts.
- Greater consistency and equity in posts across the two CCGs.
- Updated line management and supervision arrangements.

Following comments from staff across both CCGs, changes have been made, such as a further reduction in overall posts, skills mix and the inclusion of Western commissioning into the proposed changes. As a consequence, the consultation period has been extended until 29 June 2018.

The expectation from NHS England is that the two CCGs would merge to form a single NHS commissioner as the basis for strategic commissioning for the future.

They would take on single responsibility for:

- Managing the overall annual NHS budget of £1.5 billion.
- Set strategic direction for the health services.
- Co-commissioning services.
- Developing plans for the future - including possible moves to take on more specialised commissioning services and primary care services from NHS England.
- Further developing joint and integrated working arrangements with Local Authority partners building on existing joint roles, integrated commissioning and pooled budgets where this is beneficial.

The views of STP partners would be sought before any final decisions are made.

Feedback from STP partners to date is that there are clear benefits of the CCGs "acting as one" and consistently presenting as one, with a single set of processes and decision-making arrangements.

There are 5 tests that NHS England would apply to any application for merger. The CCGs would need to register an interest by the 31 July 2018 deadline.

Ambitions for our system

The structural changes made to the CCGs are a key first part in plans to create a new single, strategic commissioner for health and care in Devon.

This will be an integral part of our aspiration to work more closely together as a system and better integrate health and care services.

Such an approach will aim to keep people living healthily and happily in their communities, with support from health and care professionals when this is required.

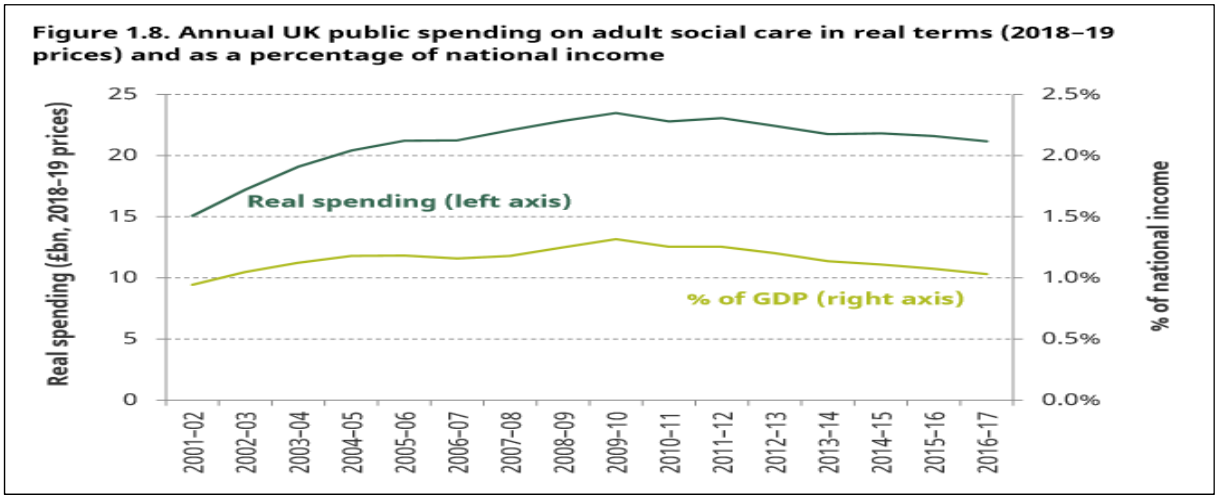
2. Local Authority cost pressures and social care funding

Between 2001/02 and 2009/10, public spending on social care followed a similar pattern to health with an average annual increase of 5.7%.

However, between 2009/10 and 2016/17 spending on adult care fell by 9.1%, while spending on health increased by 10.3%.

Reductions nationally have been made by:

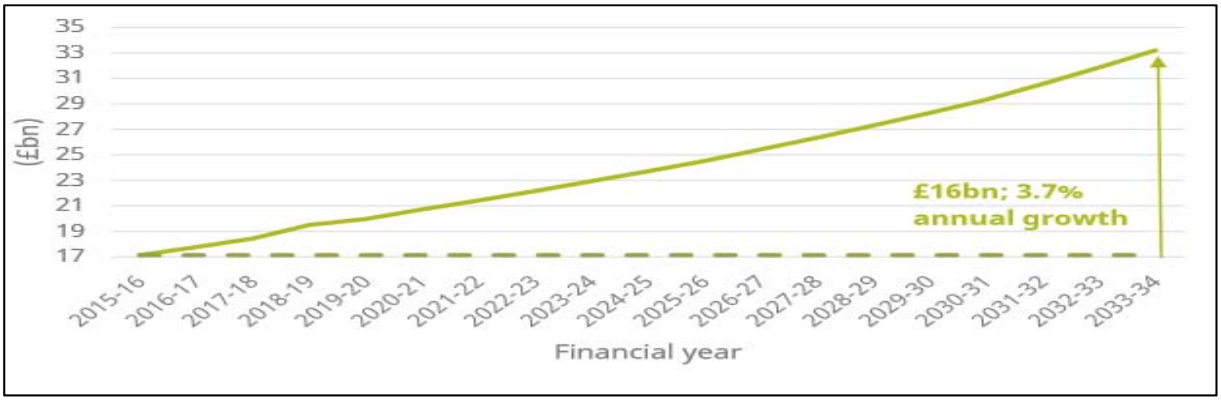
- Managing demand (promoting independence).
- Managing supply (provider fees).
- Reducing overheads.



In England it is estimated that 45% of residential/nursing placements are self-funded, and 170,000 people purchase personal care and related services. Eligibility is established by applying criteria defined in the Care Act 2014 through a local needs assessment.

The forthcoming Green Paper is expected to reopen the debate on adult social care funding. But it is likely to focus on older people and the balance between state and individual contributions.

On the basis that demand will grow according to demographic change and cost will grow by inflation, it is estimated that adult social care will require 3.7% annual growth to maintain current standards.



Devon, Plymouth and Torbay all spend close to the regional benchmark on adult social care per head of adult population.

The budget pressures on adult social care include:

- Increasing numbers and complexity of needs of people with disabilities, especially learning disabilities and autism, including through transition from children's services and as a consequence of changes to the benefits system.
- Increasing numbers and cost of children in care.
- Changing legislation and guidance increasing the demand of Deprivation of Liberty Safeguards assessments.
- Working with the NHS to reduce delayed transfers of care.

- The National Living Wage, with most provider staff paid at or near that level.
- The legal judgement on sleep-in shifts with responsibility for liabilities regarding back pay still to be clarified.
- Pressures from providers to pay a 'fair price for care' to secure sufficiency and quality of the personal care and residential nursing care markets.
- New duties introduced by the Care Act including regarding prevention and market management.

Some of the main opportunities and focus for savings in adult social care include:

- Focusing spend on ***preventive services*** where there is an evidence base for their impact avoiding, reducing or delaying demand for health and care.
- ***Promoting independence*** through strength-based practice.
- ***Supporting people at home*** rather than in hospital or residential/nursing settings.
- ***Ensuring people are appropriately financially assessed***, charges are realised as income, and self-funders are supported to make the best decisions.
- ***Supporting children in care*** by securing their adoption or fostering.
- Identifying more ***innovative ways of delivering public health***.
- ***Sharing management and support costs*** with each other and the NHS.
- ***Improving productivity*** of frontline staff.

Many of these opportunities and solutions centre on better working across health and care. Below are some of the examples both nationally and across Devon:

- The adult social care precept and other specific funding has encouraged councils to spend a greater proportion of their budget on care, ensuring it is relatively protected.
- The Better Care Fund and improved Better Care Fund have facilitated joint decision-making and have reduced unnecessary hospital admissions and delayed transfers of care.
- The Devon STP and the national policy priority of further integrating health and care has further encouraged local innovations:
    - The risk sharing agreement in Torbay through the Integrated Care Organisation covers the majority of health and care spend.
    - The joint health and care budget in Plymouth covers £290 million of shared and £340 million aligned gross funding.
    - The joint community-based health and care management and teams in Devon has matured over a decade with joint contracts for personal and residential/nursing care.

3. Welfare Reform briefing and update

PDEG was updated on the forthcoming roll out of Universal Credit in Devon and the possible implications for the County Council and partner organisations.

The general reduction in welfare support over recent years is converging with other factors to make life less economically secure for many working age households in Devon. Universal Credit aims to simply the benefits system and make work pay. Its main features are:

- Integration of six core benefits and tax credits into a single payment.
- A shift away from a mix of weekly, fortnightly, four-weekly and monthly payments to a standard monthly payment.
- A new monthly assessment system that will replace the annual assessment period for tax credits, with payment monthly in arrears.
- Payment of Housing Benefit to social tenants rather than direct to the social landlord.
- Introduction of a single recipient model where the award is paid into one bank account.
- The transition to Universal Credit will affect very many families in Devon. At June 2017 only 2,712 households in Devon were in receipt of Universal Credit but the eventual caseload is estimated at 67,580 (individuals) by 2022.

The long term impacts of Universal Credit are not yet known, and if the policy goals are realised the benefits for claimants and for public services will be positive. However, experience from pilot areas has shown short term impacts including:

- Increased pressure on care and health budgets.
- Increased demand for debt and money advice services.
- Increased demand for on line access and support.
- Reduced Council Tax receipts, at a time when they are becoming more critical to Local Authority funding.
- Increased pressure on social care, health and the police.
- Potential increased pressure on health services, such as:
    - Increased demand for GP consultations focusing on patient's social and economic concerns.
    - Increased demand for psychiatric services.
    - More antidepressant and antipsychotic use and increasing self-medication with drugs and alcohol.
    - Increases in A&E admissions due to alcohol and drug-related harm.

A number of actions and opportunities have been identified, including:

- Further joining up the approach to mental health, including promoting employment opportunities for people with different needs.
- Promoting and publicising opportunities for free digital access, and helping people moving to Universal Credit by assisting them to set up email accounts.
- Establishing a group to develop "private sector partnerships", with a pilot project in the Tiverton area.

PDEG Members were asked to consider if further work is needed on this issue.

4. Acute Services Review (ASR)

The Acute Services Review commenced in late 2016 with a series of Clinical workshops which focused on developing a set of “Best Care for Devon Standards” and a set of “Clinical Recommendations” for the future sustainability of services.

In order to take forward the review recommendations, a significant amount of work has been completed. This includes a detailed analysis of the financial viability of the clinical recommendations and introducing new ‘Service Delivery Networks’.

As an immediate priority, a ‘ground breaking’ Mutual Support Scheme was developed which aimed to avoid risk to patients through unplanned variation in capacity within services in Devon. This agreement is providing short term support, where needed, across a range of specialties and hospitals and is a pre-cursor to the development of full Service Delivery Networks (SDNs). The aim is to provide consistency of service in terms of quality, safety and access to people across Devon as close to their home as possible through the provider Trusts working collaboratively.

This new approach will require differences in contractual arrangements between providers to allow flexible use of the workforce and physical resources across Devon. Culturally this is a significant step for specialist services, and therefore reaching a conclusion on the principles and requirements has needed wide engagement, particularly with Trust and CCG Executive teams and clinical service leads.

The approach is highly consistent with the national direction of travel as set out by NHS England and NHS Improvement, who deem success as having a clear Clinical Strategy across the system, not just by individual Trust.

The ASR programme is currently far-reaching and covers many of the original areas – namely stroke and maternity services, as well as neurology, ear, nose and throat, dermatology, breast and intestinal failure services.

The programme now also oversees key national priorities, such as changes to pathology, radiology, cardiology, paediatric surgery, ophthalmology, orthopaedic and oncology (non-surgical) services.

ASR is now in a position where there are multiple priorities, including:

- Establishing the new Service Delivery Networks.
- Supporting/overseeing the Mutual Support Agreement.
- Programme managing individual projects.
- Ensuring that the Clinical Cabinet, Finance Working Group and PDEG members are kept informed and engaged.
- Working with neighbouring STPs, where the clinical model makes that appropriate to do so, and consider associate status where appropriate.
- Ensuring that a financial review of all projects is completed.
- Finalising care models for specific services based on initial clinical recommendations and how to implement these.

PDEG was asked to consider how the ASR programme is configured to ensure it can be sustained and, importantly, how it can be better resourced to deliver its objectives.

Service Delivery Networks (SDNs)

PDEG was provided with initial proposals for discussion around the resourcing and next steps for Service Delivery Networks.

A 'networked' approach to service delivery has been identified as a key enabler to achieve the clinical recommendations and ensure 'Best Care for Devon' standards are met.

Developing hospital networks to date have included:

- Agreement on the overall framework, which has three levels of Network for Devon.
- Approved indicative levels of all condition-specific Networks.
- Agreed finance, governance and clinical effectiveness principles.
- Approved outline Terms of Reference.

PDEG agreed key next steps as follows:

- Developing and gaining endorsement for the governance process for SDN's.
- Ensuring discussions by Medical Directors around principles and requirements for implementation include a review of potential areas where Cornwall or other STPs may be included.
- Describing Clinical lead role profiles and hosting arrangements – alongside operational management lead roles.
- Describing the SDN support, management and oversight function from a system perspective.
- Confirming the 'expression of interest' process for clinical leads.
- Finalising the Terms of Reference and governance.
- Facilitated session to develop and agree ways of working.
- Identifying a system executive sponsor for each SDN.

5. Peninsula Pathology NHS Network update

Progress is being made nationally to create 29 pathology networks across England, which could save the NHS £0.2 billion.

The Peninsula Pathology (South 1) NHS Network Board was established in December 2017, and is chaired by Ann James, Chief Executive of University Hospitals Plymouth. Membership includes Executive Directors, clinical and laboratory management representatives from the five acute Trusts across Devon and Cornwall, together with representatives from CCGs and primary care.

The Pathology Board is committed to working together, and with NHS Improvement, to develop the most efficient, effective and appropriate model of service delivery across the Peninsula. Given the significant workforce and service delivery challenges, there are opportunities to work together and to do things differently.

Partner organisations have agreed an approach that is fully transparent and mutually supportive, including a set of principles and behaviours, complete financial transparency and the sharing of intelligence on current pathology services.

The Peninsula Pathology Network Board provides the strategic direction and decision making for developing a new network. As part of its governance structure there is:

- A *Peninsula Pathology Effectiveness Group* (PPED): this works in a clinical commissioning capacity, underpinned by agreed quality criteria, in an approach which is consistent with the national GIRFT programme. Three initial workstreams have been identified to make progress, including primary care chronic disease monitoring, sexual health and immunology testing.
- A *Peninsula Pathology Delivery Group* (PPDG): this provides tactical and operational delivery support. It will work through the workforce, estates, logistics, IT, procurement and financial implications of recommendations and how best to implement them.

The Peninsula Pathology NHS Network is looking at a number of developments, including:

- Common quality policy/quality standards for tests and services across all sites.
- An evidence-based test directory, linked to delivering best practice and improvements in patient pathways.
- A test directory based on clinical pathways and with clear definitions of the expected quality of the tests (for example, turnaround time, minimum retest intervals, accuracy, sensitivity, specificity and cost).
- The consolidation, on less sites than currently, of low volume non-urgent tests and low volume tests requiring specialist/complex equipment and/or clinical knowledge. This includes the repatriation of some tests currently referred outside the Peninsula.
- Adoption of a principle that shares the re-location of low volume/complex non-urgent tests across all sites, to support service resilience and recruitment and retention improvements.
- An assurance that the cost, price and benefits of any service change are distributed equitably across organisations.
- Adoption of the Devon STP principles of mutual support to ensure continuing service delivery during normal operations and in times of crisis.
- An aspiration to deliver a single common IT platform or at the very least interoperability between systems to allow for the easy and safe transfer of work where required.

<u>Next steps</u>

The progress and approach was discussed at PDEG, and the way forward was endorsed. The Devon STP Clinical Cabinet has also endorsed the approach. This is an important development as part of the process of submitting a Strategic Outline Case for the Network by the end of July 2018.

CCGs and Trusts across the Peninsula will also be asked to endorse the approach outlined at PDEG, specifically the establishment of a Pathology Clinical Effectiveness Group.

6. STP Wave 4 capital bid prioritisation

PDEG reviewed and agreed the prioritised list of STP capital bids for submission on 29 June 2018.

The first meeting of the STP Capital Prioritisation Panel was held on 15 May 2018, with a second meeting on 6 June 2018. The Panel was tasked with confirming the evaluation criteria and weightings and then ranking all Wave 4 bids in priority order.

The panel confirmed use of the six evaluation criteria stated in the national guidance and agreed the following weightings:

Criteria	Question	Weighting
Deliverability	Will the project be successfully completed by March 2023?	20%
Patient Benefit & Demand Management	Will project deliver improved outcomes for patients?	20%
Service Need & Transformation	Does the project help the system deliver new ways of working in support of Devon STPs four strategic priorities?	20%
Financial Sustainability	Is the project affordable in annual revenue cost terms?	15%
Value for Money	What is the financial return on investment of the project?	15%
Strength of Estates Strategy (Including level of stretch on disposals)	To what extent does the project support and enhance the STP Estates Strategy	10%

The bids were discussed, then scored and placed in priority order, and 14 bids in total were recommended for submission for Wave 4 funding. The final stage was a "sense check" review of the 14 bids by the Panel members using their judgement and experience of local priorities. Bids were also assessed on the need to transform local services in line with STP priorities.

The total capital request from the 14 bids for Wave 4 was £138.56 million, and this was endorsed by PDEG.

Cover sheet and summary for a report to Trust Board					
Report title: **Integrated Performance Report: 2018/19 Month 2 (May 2018)**					Date: 4th July 2018
Report sponsor	Director of Strategy and Improvement Director of Finance				
Report author	Head of Performance				
Report provenance	Service Delivery Unit Quality and Performance Review meetings (21st June 2018) Executive Director scrutiny (26th June 2018) Finance, Performance and Investment Committee scrutiny (26th June 2018)				
Confidentiality	Public				
Report summary	The Integrated Performance Report (IPR) sets out the headline performance for Month 2 (May) 2018/19 against the key quality and safety, workforce, performance and financial standards that together represent our operational plan for 2018/19. Areas that the Board will want to focus on where the Trust is off trajectory are highlighted in the attached main report.				
Purpose	**Note** ☐	**Information** ☐	**Review** ☒	**Decision** ☐	**Approve** ☐
Recommendation	The Board is recommended to **review** the documents and **review** the evidence presented.				
Summary of key elements					
Strategic context	This report brings together key areas of delivery into a single integrated view so that the Board can consider performance in the round, review risks and mitigations, and determine whether it is assured the Trust is delivering for the populations of South Devon and Torbay and is on track to deliver key standards including those required by commissioners and the regulators.				
Dependencies and risk	This report reflects the following corporate risks: • 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.				

Summary of scrutiny	This report has been subject to challenge, due diligence, and risk assessment by: • Service Delivery Unit Quality and Performance Review meetings (21st June 2018) • Executive Director scrutiny (26th June 2018) • Finance, Performance and Investment Committee (26th June 2018) Feedback from Finance, Performance and Investment Committee: • Directors discussed the number of RAG rated indicators and the potential impact levels of performance including lengthening waiting times were having on the patient experience. Action plans to address were reviewed and potential need for additional investment recognised • Workforce reduction in excess of plan was considered, especially in relation to clinical/medical workforce; this was in context of increased agency costs, recruitment issues in some specialties, and national shortages. Recognition mutual support agreement across providers was supporting areas of critical need. • Performance against financial plan noted as on plan overall - acknowledgement further work to do to close gap to secure full year delivery. Increase in agency spend highlighted – recognition lag between recruitment and people starting so covering with agency. • Further refinements to the integrated report have been requested. This will form basis of Board development session that follows the Board on 4th July.
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 Quality, Workforce, Performance, and Finance Report

Date of Report: **4th July 2018**

Reporting Period: **Month 2**

Data Up To : **31st May 2018**

Version Control

Version	Meeting	Date of Circulation	Date of Meeting	Owner	This Version
Draft 1	Trust Executive	15/06/18	19/06/18	Paul Procter	☒
Published Report	FPI Committee	20/06/18	26/06/18	Ann Wagner Paul Cooper	☒
Published Report	Trust Board	27/06/18	04/07/18	Ann Wagner Paul Cooper	☒

Contents

1. Introduction and Contents: **1**

2. Performance Headlines: Month 2 (May 2018) **2**

2.1 Quality Headlines: **2**

2.2 Workforce Headlines: **2**

2.3 Operational Headlines: **3**

2.3.1 Community and Social Care **3**
2.3.2 NHS Improvement Single Oversight Framework **4**
2.3.3 Local Performance Indicators **5**

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, workforce, operational performance, and finance) into a single integrated report to enable the Board to:

- Take a view of overall delivery, against national and local standards and targets, at Trust and Service Delivery Unit (SDU) level.
- Consider risks and mitigations.
- Determine whether the Board is assured that the Trust is on track to deliver the key milestones required by the regulator and will therefore secure 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 a performance dashboard (Appendix 1).

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

- Service Delivery Unit Quality and Performance Review meetings (21st June 2018)
- Executive Director scrutiny (26th June 2018)
- Finance Performance and Investment Committee (26th June 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 Emergency Department 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 (May 2018) assessed as being in Segment Two (targeted support).

2. Performance Headlines: Month 2 (May 2018)

Key headlines for, quality and safety, workforce standards and metrics, operational performance, and financial delivery for Month 2 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 6 were RAG rated RED for May (4 RED in April) as follows in Table 1:

Table 1: Local Quality indicators RAG rated RED:

Standard	Target	Last month Month 1	This month Month 2
VTE – risk assessment on admission (acute)	>95%	89.5%	89.3%
Hospital standardised mortality rate (HSMR) – 3 mths arrears	<100	89.5	109.5
Medication Errors	0	1	2
Follow ups past to be seen date (excluding Audiology):	3,500	7323	7042
Fractured Neck of Femur	>90%	79.4%	78.8%
Stroke	>80%	77.8%	75%

Of the remaining indicators, 9 were rated GREEN, 3 AMBER and 1 not rated.

2.2 Workforce Headlines

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

- **Turnover (excluding Junior Doctors)**: **GREEN** - the Trust's turnover rate was 10.85% for the year to May 2018, which is within the target range of 10% to 14%.
- **Staff sickness/absence: RED -** The annual rolling sickness absence rate of 4.21% at the end of April 2018 represents a marginal increase from the previous month, and the rate still

remains above target. The sickness figure for April was 3.70% which is lower than the 3.80% target and is the lowest monthly level since September 2017

- **Mandatory Training rate**: **AMBER** – At the end of May 2018 the overall mandatory training rate was 82.50% from 82.79% in April mainly due to the lower rates of Resus and Prevent which are the extra mandatory and statutory training subjects.
- **Appraisal rate**: **AMBER -** The Achievement Review rate for May is at 80.08% against a target rate of 90% which is a slight reduction from April's 80.75%. 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 -** The workforce plan aims to have 5,424.13 worked WTE at the end of March 2019. As at end of May 2018, the Trust was exceeding plan by 159.69 wte.
- **Agency Expenditure –** At Month 2 the Trust was £78k above plan. Plans are in place to recover this situation.

2.3 Operational Headlines

2.3.1 Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 4 were RAG rated RED in May 2018 (3 in April 2018) as follows in Table 2:

Table 2: Community and Social Care Framework RAG Rated RED

Standard	Target	Last month Month 1	This month Month 2
Delayed transfers of care bed days (acute)	64 days per month	182	228
Carers Assessments completed Year to Date	40% Year end	1.4% (3.0% M1 trajectory)	3.1% (6.0% M2 trajectory)
Bed Occupancy	80% - 90%	92.9%	94.6%
Community Hospital – admissions (non-stroke)	None set	236	218

Of the remaining indicators, 7 were rated GREEN, 0 AMBER, and 4 indicators do not yet have an agreed target.

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

Against the national performance standards, for Month 2 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 1	This month Month 2	Risk
A&E - patients seen within 4 hours (PSF)	>92%	87.7%	86.7%	High
	Trajectory	(90.1%)	92.1%	
RTT – 18 weeks	>92%	81.66%	82.2%	High
	Trajectory	(82.2%)	82.3%	
Cancer – 62 day wait for first treatment – 2ww referral	>85%	82.5%	81.3%	Moderate
Diagnostic tests longer than the 6 week standard	<0.1%	11.0%	5.9%	Moderate
Dementia Find – monthly report	>90%	99.2%	92.6%	Minor

- **4 hour ED standard:** In May the Trust achieved 86.7% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments. This is a reduction on last month (87.7%) and below the operational plan trajectory of 92.1% and national standard of 95%.
  Risk: High – The delivery of the Q1 target of 92.2% for attainment of the Provider Sustainability Fund (PSF) is not met. Actions need to be implemented to bring performance back on to trajectory.

Management action: Led by the Chief Operating Officer and Head of Operations a renewed "Urgent Care Performance Action Plan" is being agreed together with an assurance process to manage the delivery of agreed actions and monitoring of performance to report to the Patient Flow Board. This includes reinvigoration of the SAFER programme led by matrons and the Head of Operations to maintain a weekly focus on ward team actions and progress to deliver proactive discharge planning to support optimum patient flow.

- **RTT:** RTT performance has stabilised in May with the proportion of people waiting less than 18 weeks improving to 82.2% just 0.1% below Operational Plan trajectory of 82.3%.

  This slightly improved performance however has seen 500 more patients (2.6%) increase in total number of patient waiting for treatment.

  At the end of May 53 people were reported as waiting over 52 weeks (local performance indicator Table 4). An increase compared to 43 last month. Operational pressures and slippage of plans to recruit to posts have contributed to the position and delay in seeing a reduction in longest waits.
  Risk: High –There is significant risk to delivering the increased levels of activity needed to maintain the 82% RTT performance standard and reduce the longest waits over 52 weeks. Several specialties continue to have 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 is awaited.

The impact on the RTT recovery plans 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 have provided plans outlining the actions needed and assessment of progress against these plans. These plans have been shared with the NHSI visiting team who have supported the proposed actions and confirmed that RTT monitoring systems and processes are robust. Investment decisions are now being confirmed and implemented. Outstanding risk will be escalated to the monthly Executive led Quality and Performance review meetings.

- **62 day cancer standard: at** 81.3% (validated 14th June 2018) performance is below the 85% national target, although a small improvement on last month (82.5%). Current forecast for Q1 is 83.9%.
  Risk: Moderate – The increased backlog from lost capacity in Q4 remains in the system with deterioration in performance forecast in Q1. Urology has seen waiting times to see urgent referrals extending to 5 weeks. This will put pressure on delivery of the overall 62 day target in future months. Actions agreed are expected to bring performance back to target however a revised trajectory of improvement can only be confirmed once implementation timelines of these final plans are known.

- **Diagnostics:** The diagnostics standard was not met with 5.9% of patients waiting over 6 weeks against the standard of 1%. This is an improvement on last month (11%) and ahead of our NHSI operational plan. Improvements in ultrasound and CT waits in May have contributed to this improvement. There will remain continued reliance on outsourcing to visiting mobile units for both MRI and CT along with backfill for staff sickness in ultrasound.
  Risk: Moderate – Actions agreed to continue the backfill capacity for ultrasound and support capacity for MRI and CT with additional outsourcing and mobile van visits scheduled.

- **Dementia screening:** The Dementia Find standard is meeting the standard of 90% with 92.6% achieved In May. This is a significant achievement and aided by the allocation of heath care assistant 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 performance indicators agreed locally with the CCG, of which 11 were RAG rated RED in April 2018 (10 RED RAG rated in April). The indicators RAG rated RED are summarised in Table 4:

Table 4: Local Performance Indicators RAG Rated RED

Standard	Standard/ target	Last month Month 1	This month Month 2
Cancer 2ww urgent GP referral	>93%	60.6%	55.7%
Cancer 2ww – symptomatic breast	>93%	93.4%	92.0%
RTT waits over 52 weeks:	0	43	53

Standard	Standard/ target	Last month Month 1	This month Month 2
On the day cancellations for elective operations	<0.8%	1.1%	1.4%
Cancellations not readmitted within 28 days	0	16	6
Ambulance handovers > 30 minutes:	0	117	97
Ambulance handovers > 60 minutes:	0	3	11
A&E patients (ED only):	>92.9%	81.8%	81.1%
Care plan summaries % completed within 24 hrs of discharge weekdays:	>77%	70.4%	70.4%
Care plan summaries % completed within 24 hrs discharge weekend:	>60%	30.5%	34.6%
Clinic letters timeliness - % specialties within 4 working days	>80%	81.8%	72.7%

Of the remaining indicators, 11 were rated GREEN, 0 AMBER, and 1 indicator does not yet have an agreed target.

2.4 Financial Headlines:

Overall financial position:

- The financial position for the period to 31st May 2018 is a deficit of £2.09m against a planned deficit of £2.56m.
- 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 £0.66m.

CIP savings delivery position:

- The current month position shows a £0.1m surplus. There is a £0.8m cumulative shortfall against plan.
- The CIP target, excluding "Balance to FYE of 17/18 schemes", is £26.9m against which we have £18m of forecast delivery, resulting in a £8.9m shortfall forecast out-turn position. There is a net £4m increase from last month's forecast out-turn.
- Further CIP opportunities are being scoped. This includes approximately £3m of non-recurrent opportunity, which would bring the FOT delivery shortfall down to £5.9m.
- An update will be provided next month.
- The forecast full year effect of the recurrent savings delivery position estimate is £11.5m against the plan of £26.9m.

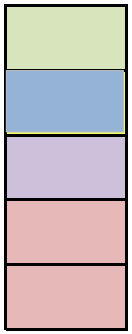
Use of Resources Risk Rating: NHS Improvement no longer publish a planned risk rating for Trusts, due to changes they have made to the risk rating calculation. However, at Month 2, the Trust had an actual Use of Resources risk rating of 3 (subject to confirmation by NHS Improvement). The Agency risk rating of 3 is worse than the planned rating of 2.

Torbay and South Devon NHS
NHS Foundation Trust

Integrated Performance Report

June 2018: Reporting period May 2018 (Month 2)

Section 1: PERFORMANCE



Quality Focus

Workforce Focus

Community and Social Care Focus

NHSI operational performance indicator Focus

Local performance metric exception

Section 2: FINANCE

Finance Focus

Quality Focus

Month 2 (performance to end of May 2018)

Page 3 **Quality and Safety Summary**
Page 4 **Mortality**
Page 5 **Infection Control**
Page 6 **Incident Reporting and Complaints**
Page 7 **Exception Reporting**

Quality and Safety Summary

Quality and Safety Summary

The following areas of performance are noted:

1. The Hospital Standardised Mortality Rate (HSMR) The on-going trend in the HSMR remains in a positive position for the months of May 17 to February 18 (please note Dr Foster has a three month data lag). February's data has a mortality rate of 109.5 which is within expected limits and is not flagging on the system as a concern. 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, firstly 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 on 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 Alert 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 May.

4. STEIS - Three Strategic Executive Information System (STEIS) reportable incidents where reported in May.
Grade 3 Pressure Ulcer Torquay I/C – Incident 16/03/2018 – Raised on STEIS 17/05/2018
Grade 3 Pressure Ulcer Coastal CN – Incident 29/03/2018 – Raised on STEIS 25/05/2018
Fall on Ainslie Ward – Incident 30/04/2018 – Raised on STEIS 02/05/2018

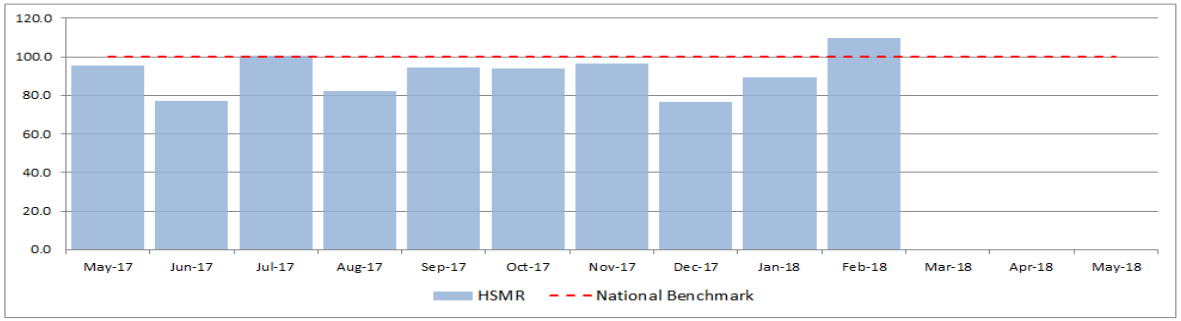
5. Infection Control are reporting a decrease in the number of bed days lost from infection control measures with just 4 bed days lost in May. This reflects where there have been bays closed on wards due to norovirus and flu containment.

6. Clinic Follow ups - the number of patients waiting 6 weeks or more for a follow up appointment beyond the intended to be seen by date has reduced from 7323 last month to 7042 in May. This remains above target levels with several specialities having significant backlogs to clear. These are listed in the report.

Quality and Safety - Mortality

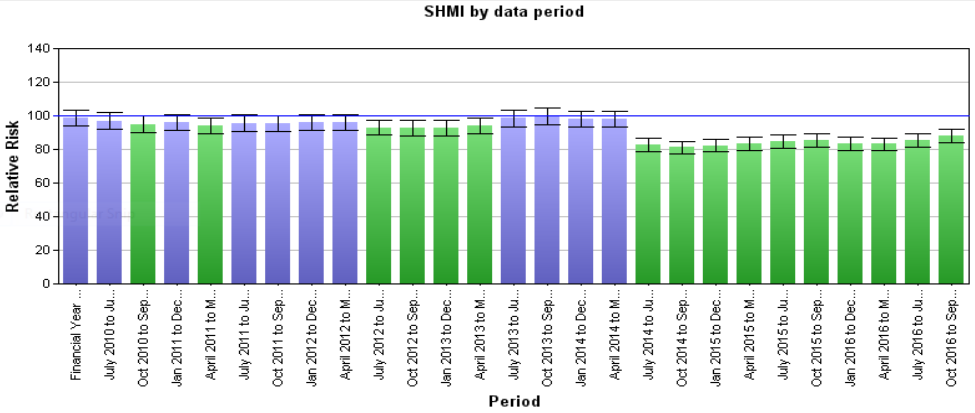
Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
HSMR	95.5	76.9	100.5	82.3	94.4	93.8	96.6	76.6	89.5	109.5			
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 relative risk of 109.5, which whilst above the 100 average is not flagging as a concern, viewed with the prior winter HSMR the Trusts position remmains 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.



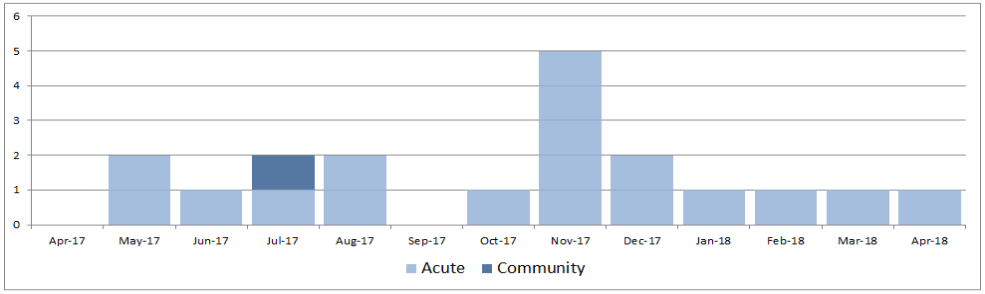
The SHMI data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital.
The data is released on a quarterly basis and the latest data release from the DH is October 2016 - September 2017 and records the Trusts at 87.8 against a national average benchmark of 100. This 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.

Quality and Safety - Infection Control

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



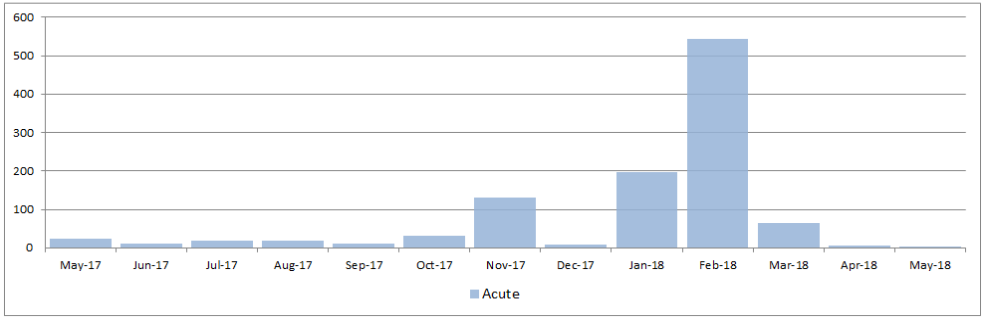
In May there are no reported C-diff cases.

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

Each reported case of C-diff 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)

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Acute	24	12	18	18	12	30	130	8	198	544	64	6	4



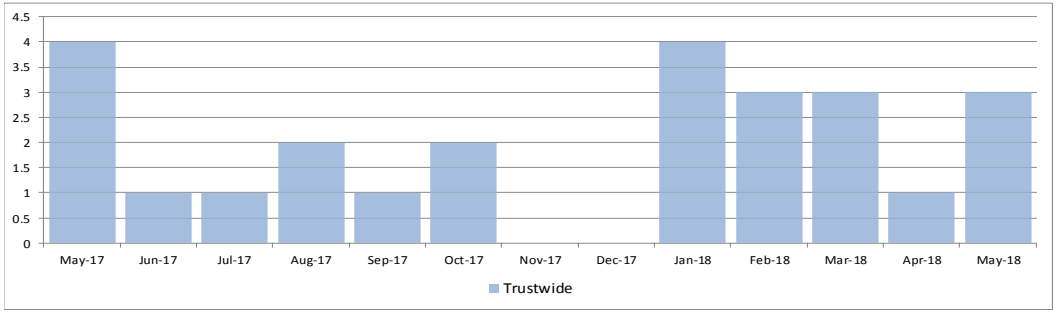
The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In May the low levels of bed days lost due to infection contol issues has remained very low as seen in the graph opposite which records the number of beds closed from Norovirus or flu infection controls.

Quality and Safety - Incident reporting and complaints

Reported Incidents - Major and Catastrophic

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



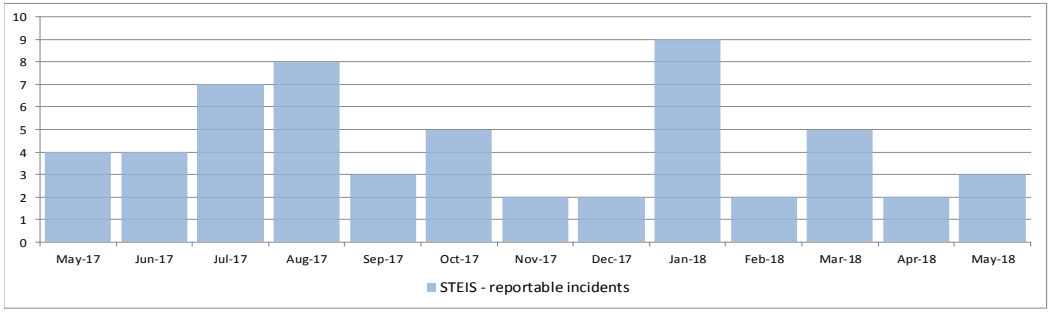
In May 2018 the Trust recorded 2 serious incidents which is currently under investigation:

1: 38307 - readmission to ED, delay in treatment
2: 38379 - delayed surgery delayed chemotherpay

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

STEIS Reportable Incidents

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



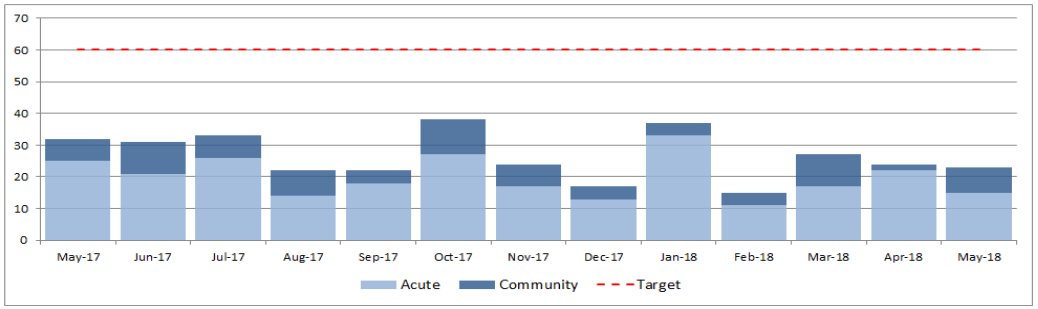
The Trust reported three incidents in May on the Strategic Executive Information System (StEIS).

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

- Grade 3 Pressure Ulcer Torquay I/C
- Grade 3 Pressure Ulcer Coastal CN
- Fall on Ainslie Ward

Formal complaints

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



In May the Trust received 23 formal complaints.

The number of formal complaints are shown in the table opposite. This shows the split of 15 relating to the Acute site and 8 in the Community.

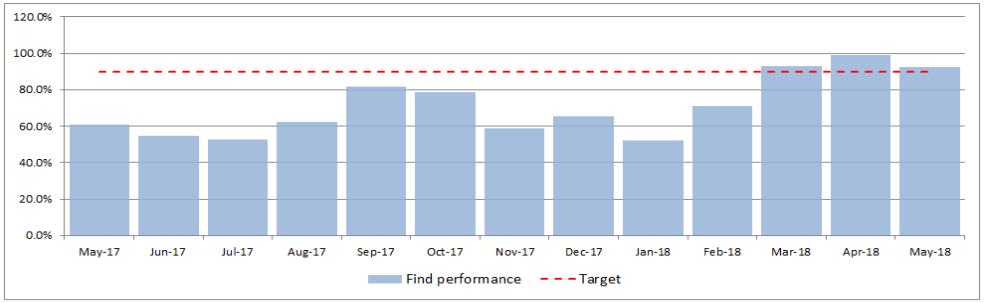
The main themes from the complainants are funding allocations, communication, attitude of staff, and treatment.

All complaints are investigated locally and shared with area/locality for leaning.

Quality and Safety - Exception Reporting

Dementia - Find

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Numerator	424	372	308	360	455	301	230	285	256	269	279	120	362
Denominator	632	603	496	520	536	383	390	435	491	380	301	121	391
Find performance	60.6%	54.9%	52.8%	62.4%	81.8%	78.6%	59.0%	65.5%	52.1%	70.8%	92.7%	99.2%	92.6%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



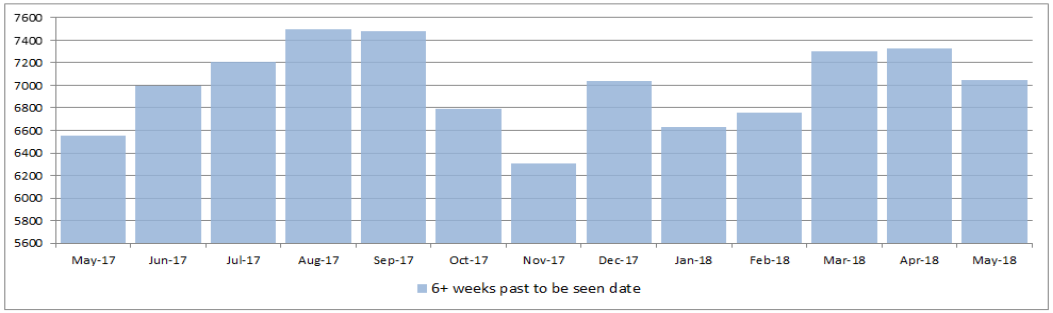
Dementia Find: The NHS I Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors.

The Dementia Find in May decreased to 92.6% from 99.2% in April.

The improvement is being maintained with support from a Health Care Assistant tasked to support wards with completing assessments and data entry.

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

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
6+ weeks past to be seen date	6550	6999	7209	7496	7477	6790	6308	7041	6630	6761	7301	7323	7042



Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' decreased in May 7042 (7323 last month).

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:
Ophthalmology 3211; Rheumatology 981; Dermatology 418; Paediatrics 406; Urology 401.

Workforce Focus

Month 2 (performance to end of May 2018)

Page 9	Sickness Absence
Page 10	Turnover
Page 11	Appraisal and Training
Page 12	Agency (1)
Page 13	Agency (2)

Workforce - Plan v Actual

Planned Establishment

The table below shows the workforce plan submitted to NHSI for the Financial Year 2018-2019. This is based on actual hours worked, including bank and agency.

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

NHSi Plan WTE 2018/19

Staff Group	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE	NHSi Plan WTE
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medical And Dental	518.95	517.03	516.10	513.73	512.36	510.99	509.39	507.79	506.19	504.14	502.10	500.06
Nursing And Midwifery Registered	1,288.59	1,286.61	1,290.07	1,287.26	1,282.93	1,280.09	1,289.73	1,286.76	1,289.71	1,286.55	1,283.37	1,280.20
Support To Clinical Staff	1,825.11	1,822.43	1,831.04	1,824.53	1,818.02	1,814.55	1,802.59	1,803.21	1,805.36	1,800.70	1,796.04	1,791.38
Add Prof Scientific and Technic	385.95	384.48	382.99	381.45	379.90	378.36	376.78	375.19	373.60	371.96	370.32	368.69
Allied Health Professionals	427.42	425.90	424.35	422.72	421.09	419.46	417.78	416.09	414.39	412.63	410.86	409.11
Healthcare Scientists	106.64	106.50	106.35	106.20	106.04	105.89	105.73	105.57	105.41	105.24	105.07	104.89
Administrative And Estates	997.92	993.19	988.32	983.17	978.04	972.87	967.46	962.06	956.55	950.91	945.18	939.51
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHSi Plan WTE	**5,550.58**	**5,536.14**	**5,539.22**	**5,519.06**	**5,498.38**	**5,482.21**	**5,469.46**	**5,456.67**	**5,451.21**	**5,432.13**	**5,412.94**	**5,393.84**

Reasons for Movements From Above Plan to Latest Budget

Skill Mix Reviews
Housekeeping - alignment of WTE to £'s
Monthly accrual estimates versus actual (mainly bank & agency)

Workforce - Plan v Actual

Budgeted WTE 2018/19

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medical And Dental	519.22	528.07	527.17	524.78	523.41	522.04	520.45	518.87	517.26	515.21	513.16	511.11
Nursing And Midwifery Registere	1,290.29	1,295.82	1,299.32	1,296.49	1,292.12	1,289.35	1,298.97	1,295.98	1,298.98	1,295.79	1,292.62	1,289.43
Support To Clinical Staff	1,822.16	1,810.17	1,818.78	1,812.29	1,805.76	1,802.30	1,790.36	1,790.98	1,793.09	1,788.45	1,783.76	1,779.12
Add Prof Scientific and Technic	383.17	381.22	379.71	378.18	376.63	375.09	373.50	371.94	370.33	368.70	367.07	365.43
Allied Health Professionals	459.04	462.20	460.65	459.01	457.37	455.72	454.08	452.37	450.67	448.94	447.19	445.39
Healthcare Scientists	102.78	102.66	102.50	102.36	102.18	102.03	101.88	101.71	101.56	101.38	101.20	101.02
Administrative And Estates	985.35	986.26	981.38	976.24	971.13	965.95	960.52	955.08	949.61	943.95	938.24	932.64
Total Staff Budgeted WTE	**5,562.01**	**5,566.39**	**5,569.50**	**5,549.35**	**5,528.60**	**5,512.47**	**5,499.76**	**5,486.93**	**5,481.49**	**5,462.43**	**5,443.25**	**5,424.13**

Actual Worked 2018/19

Staff Group	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medical And Dental	529.17	511.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Nursing And Midwifery Registere	1,235.71	1,217.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Support To Clinical Staff	1,721.32	1,727.74	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Add Prof Scientific and Technic	354.82	349.76	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Allied Health Professionals	436.51	442.97	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Healthcare Scientists	91.14	90.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Administrative And Estates	1,080.59	1,067.42	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Worked WTE	**5,449.27**	**5,406.70**										

Variance to Budget 2018/19

Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medical And Dental	9.95	-16.81										
Nursing And Midwifery Registere	-54.58	-78.65										
Support To Clinical Staff	-100.84	-82.43										
Add Prof Scientific and Technic	-28.34	-31.46										
Allied Health Professionals	-22.54	-19.22										
Healthcare Scientists	-11.64	-12.28										
Administrative And Estates	95.24	81.17										
Any Others - Provisions	0.00	0.00										
Total Staff Worked WTE	**-112.75**	**-159.69**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Budgeted WTE 2018/19: The table opposite shows the WTE changes from the opening position at the 31.03.2018 for each month of the financial year until the 31.03.2019.

The plan is to reduce the overall budget to 5424 WTE at the end of the financial year from 5562 WTE so a planned reduction of 137.88.

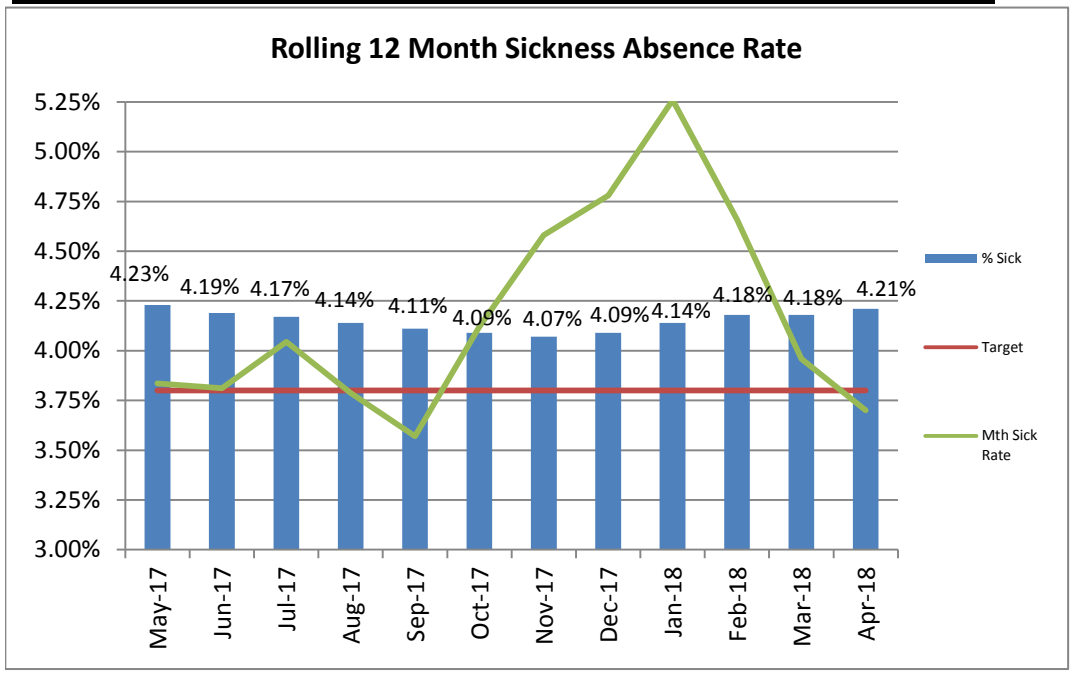
Actual Worked 2018/19: This table shows the outturn against the plan as at the end of May 2018 and for each month of the year to date. Monthly WTE against plan will continue to be monitored and included in this Integrated Performance Report.

The outcome at the end of May 2018 for WTE worked is a reduction in worked WTE of 159.69 staff against plan.

This is consists of a reduction in substantive staff of 199.98 in May 2018. The bank and agency worked WTE was 40.3 staff over plan.

Workforce - Sickness absence

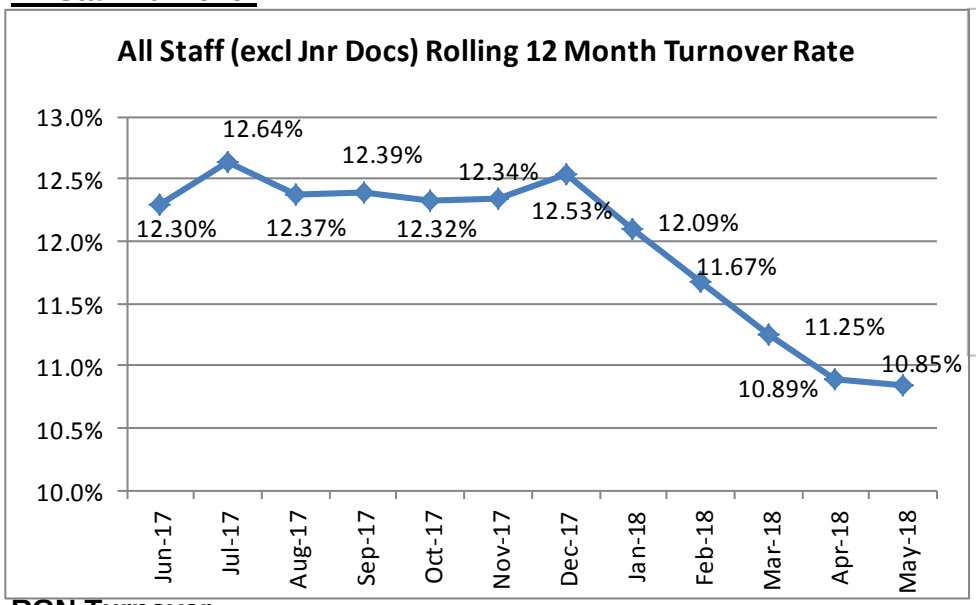
Rolling 12 month sickness absence rate - (reported one month in arrears)



- The annual rolling sickness absence rate of 4.21% at the end of April 2018 is the same is a marginal increase from the 4.18% in March and even though April's sickness is below target it is higher than the April 2017 figure and therefore the reason for the cumulative increase. This is against the target rate for sickness of 3.80%.
- The sickness figure for April was 3.70% which is lower than the 3.80% target and 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.

Workforce - Turnover

All Staff Turnover

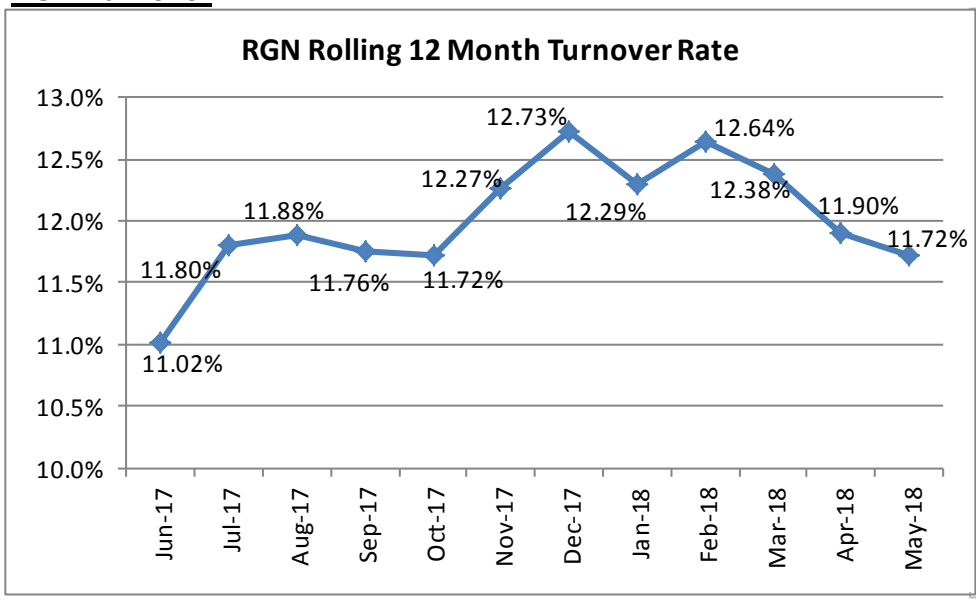


All Staff Rolling 12 Month Turnover Rate

The following graph shows that the Trusts turnover rate was 10.85% for the year to May 2018. This is a minor reduction from last month's 10.89% and within the target range of 10% to 14%.

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

RGN Turnover

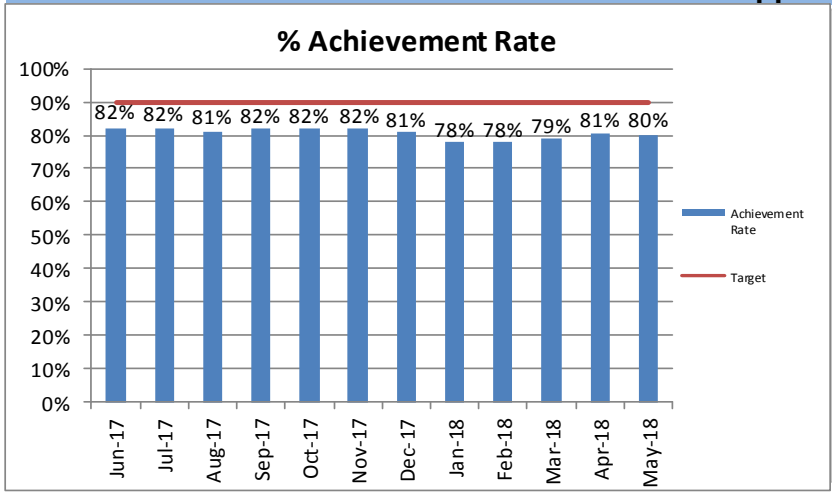


RGN Rolling 12 Month Turnover Rate

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 for the 12 months ending in May 2018 stood at 11.72% which is down from last months 11.90%.

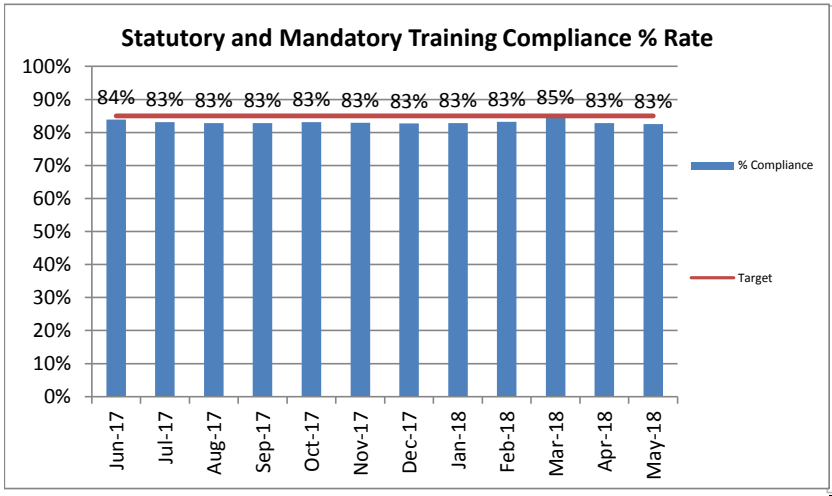
Workforce - Appraisal and training



Achievement Review (Appraisal) - The Achievement Review rate for May is at 80.08% against a target rate of 90% which is a slight reduction from April's 80.75%. 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 from April 2018. The graph shows that the current is 82.50% for May from 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. Compliance against 8 of the 11 MAST subjects increased in the last month

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

Module	Target	Performance
Information Governance	95% and above	76.10%
Conflict Resolution	85% and above	82.64%
Infection Control	85% and above	80.90%
Manual Handling	85% and above	78.75%
Safeguarding Children	90% and above	75.30%
Resuscitation	85% and above	74.26%
Prevent Awareness	85% and above	77.64%

Workforce - Agency

Budgeted Bank WTE 2018/19

Staff Group	Budget WTE Apr-18	Budget WTE May-18
Medical And Dental	6.30	6.30
Nursing And Midwifery Registere	43.20	41.70
Support To Clinical Staff	147.08	143.58
Add Prof Scientific and Technic	0.00	0.00
Administrative And Estates	37.65	37.65
Any Others - Provisions	0.00	0.00
Total Staff Budgeted WTE	**234.23**	**229.23**

Budgeted Agency WTE 2018/19

Staff Group	Budget WTE Apr-18	Budget WTE May-18
Medical And Dental	24.46	21.25
Nursing And Midwifery Registere	35.55	37.61
Add Prof Scientific and Technic	0.29	0.29
Allied Health Professionals	8.66	8.64
Healthcare Scientists	0.00	0.00
Administrative And Estates	4.15	4.15
Any Others - Provisions	0.00	0.00
Total Staff Budgeted WTE	**73.11**	**71.94**

The tables opposite show the bank and agency WTE budgeted and actual worked.

As at the end of May 2018, the bank usage was up against plan by 40.94 WTE, of which 37.37 were support to clinical staff.

Agency was 0.64 WTE below plan as at the end of May 18.

The WTE plan for agency is currently being reviewed to ensure achievement of the NHSI cap of £6.18m.

Actual Bank Worked 2018/19

Staff Group	Worked WTE Apr-18	Worked WTE May-18
Medical And Dental	3.70	3.53
Nursing And Midwifery Registere	37.07	35.03
Support To Clinical Staff	164.29	180.95
Add Prof Scientific and Technic	1.12	2.32
Allied Health Professionals	1.93	2.54
Administrative And Estates	53.66	45.80
Any Others - Provisions	0.00	0.00
Total Staff Worked WTE	**261.77**	**270.17**

Actual Agency Worked 2018/19

Staff Group	Worked WTE Apr-18	Worked WTE May-18
Medical And Dental	14.91	18.05
Nursing And Midwifery Registere	34.24	27.27
Support To Clinical Staff	-0.16	0.00
Add Prof Scientific and Technic	1.25	-2.90
Allied Health Professionals	11.29	19.35
Healthcare Scientists	0.00	0.00
Administrative And Estates	27.87	9.54
Any Others - Provisions	0.00	0.00
Total Staff Worked WTE	**89.40**	**71.30**

Variance to Budget Bank 2018/19

Staff Group	Variance WTE Apr-18	Variance WTE May-18
Medical And Dental	-2.60	-2.77
Nursing And Midwifery Registere	-6.13	-6.67
Support To Clinical Staff	17.21	37.37
Add Prof Scientific and Technic	1.12	2.32
Allied Health Professionals	1.93	2.54
Healthcare Scientists	0.00	0.00
Administrative And Estates	16.01	8.15
Any Others - Provisions	0.00	0.00
Total Staff Worked WTE	**27.54**	**40.94**

Variance to Budget Agency 2018/19

Staff Group	Variance WTE Apr-18	Variance WTE May-18
Medical And Dental	-9.55	-3.20
Nursing And Midwifery Registere	-1.31	-10.34
Support To Clinical Staff	-0.16	0.00
Add Prof Scientific and Technic	0.96	-3.19
Allied Health Professionals	2.63	10.71
Healthcare Scientists	0.00	0.00
Administrative And Estates	23.72	5.39
Any Others - Provisions	0.00	0.00
Total Staff Worked WTE	**16.29**	**-0.64**

Workforce - Agency

Agency Spend as at Month 02: The Trust's annual cap for agency spend, set by NHS I, is £6.18 million per year. The table below shows the current agency spend by staff group for 2018/19 compared to the total agency expenditure plan. As at Month 02 the Trust is underachieving against the plan by £78K, however there are plans in place to achieve the NHSI cap by the end of March 2019.

Torbay and South Devon NHS Foundation Trust													
Total Agency Spend													
Financial Year 2018/19													
	M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**Yr End**
Plan - Total Agency	593	602	559	512	482	507	462	450	487	513	501	512	6,180
Actual Spend													
Non-Medical - Clinical Staff Agency													
Registered Nurses	232	259											
Scientific, Therapeutic and Technical	86	105											
of which Allied Health Professionals	77	105											
of which Other Scientific, Therapeutic an	9	0											
Support to clinical staff	-1	1											
Total Non-Medical - Clinical Staff Agency	317	364	0	0	0	158	0	0	0	0	0	0	
Medical and Dental Agency													
Consultants	193	188											
Trainee Grades	104	88											
Total Medical and Dental Agency	298	277	0	0	0	227	0	0	0	0	0	0	
Non Medical - Non-Clinical Staff Agency	71	39											
Total Pay Bill Agency and Contract	686	680	0	0	0	413	0	0	0	0	0	0	
Over (Under) Spend	93	78	-559	-512	-482	-66	-462	-450	-487	-513	-501	-512	

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.
The other areas using agency include cardiology, radiography and mortuary. In Cardiology there has been increased levels of sickness and vacancies within the team which has required additional hours of locum cover.

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. 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.

Nursing & Midwifery: Due to the continued operational demands the use of high cost agency has continued, although there are plans in place to address this. This is the main reason for the expenditure being above plan.

Community and Social Care Focus

Month 2 (performance to end of May 2018)

Page 17 Operational headlines

Page 18 Social Care and Public Health Metrics

- Torbay LA social care programme board metrics
- Public health metrics including CAMHS

Page 19 Community services

- Community Hospitals
- Community services
- Intermediate care services
- Delayed Transfers of care

Community services and Social care Summary

Operational Headlines

Headline risks currently being managed are:

1. Nursing and residential home market and capacity: Managed 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.

Torbay Services –Health and 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 and recruitment remains ongoing. Social care change programmes are well underway and further progress on transformational change will be developed and delivered with the support of investment from iBCF.
- 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. The 0-19 tendering process is underway from Torbay Council with a broader range of services on offer.
- An engagement event with drug and alcohol staff across our system will be held in June to discuss opportunities to better align our services.
- Older Peoples Mental Health services are developing their care Home Education and Support Team which is improving the quality of care for people with dementia in care homes and reducing cost. Early indications from the project to develop bank workers in the Trust to cover one to one support for dementia clients in care homes is encouraging.
- 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. Further ongoing work is underway across the market to consider opprotunities for transformation.
- Community services are continuing their programme of work to maximise the benefits of the care model and engagment with GPs .
- The Hospital Discharge Hub which brings together services from South Devon and Torbay into a single contact point is well underway an due for implementation in early July.

South Devon Services - Social care

- The teams have been experiencing a significant level of safeguarding work within the care home sector, which has diverted resources and impacted on standard waiting lists.
- Ongoing pressure around timely CHC assessment impacting on the teams.
- The Disability Focus Leads are making good progress on working relationships with CHC in order to address disputes within the process.
- The new Care Homes contract and the changes within the process have caused some impact on the teams and their managers whilst they work through the initial changes that this presents.

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. The biggest challenge for South Devon and Torbay is 28 day decision making for new assessments. NHSE want 80% compliance by the end of Q3. Current activity is 40%. Monthly assurance meetings with NHSE tracking progress.
- To support the above changes a new model of provision base on CHC Hubs, is being rolled out across Torbay and South Devon. The hubs went live at the end of May and are now building to full capacity.
- In response to national directives Personal Health Budgets will need to become the default position for Continuing Health Care funded clients receiving care at home. Plans are being developed to deliver this for April 2019. Support to deliver these plans is being provided from the NSHE mentoring programme

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.

Social Care and Public Health Metrics performance metrics

2018/19 Performance Scorecard to 31 May 2018

Torbay Social Care KPIs	2018/19 full year target	2018/19 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	92%	92%	94% (92%)	On target
% clients receiving direct payments	28%	28.0%	26.6% (28.0%)	Within agreed tolerance
% clients receiving a review within 18 months	93%	93%	86% (93%)	Below target. Clients in care homes are now being reviewed by location rather than date for efficiency. Many clients at home are being reviewed
No. of permanent care home placements (snap shot)	617	630	605 (630)	On target
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	599.0	584.6	513.8 (585)	On target
Carers receiving needs assessment, review, information, advice, etc.	43%	6.0%	3.1% (6.0%)	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%	75% (85%)	Below target. Lower performance typical at start of reporting year when higher proportion of Emotional Support Vouchers compared to carer
% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	..	.. ..	No high risk adult safeguarding concerns raised.
% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	9.1% (8.0%)	Below target. Situation monitored by Safeguarding lead.
% Adults with learning disabilities in paid employment	4.0%	1.5%	1.0% (1.5%)	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% (75%)	On target
Delayed transfers of care from hospital (delays per day) - Torbay residents (BCF)	9.2	9.2	10.9 (9.2)	KPI reported 1 month in arrears Below draft NHSE target

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.

Measure	Target 2018/2019	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2018/19
PUBLIC HEALTH SERVICES															
CAMHS - % Urgent referrals seen within 1 week	88.0%	100.0%	100.0%	80.0%	100.0%	83.3%	66.7%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%
CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%	83.7%	94.1%	92.0%	100.0%	98.4%	100.0%	100.0%	98.9%	100.0%	98.3%	97.9%	98.5%	96.5%	97.0%
% of face to face new birth visits within 14 days *	95.0%	82.4%	79.2%	85.9%	90.6%	79.0%	96.8%	90.5%	91.2%	93.1%	93.7%	89.9%	92.0%	88.8%	90.2%
Children with a child protection plan * [B]		240	239	238	248	254	235	198	176	160	146	149	146		146
4 week smoking quitters (Quarterly) ** [B]			80			156			232			342			
Opiate users - % successful completions of treatment (Quarterly) ** [B]			8.4%			7.9%			7.8%			8.0%			

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

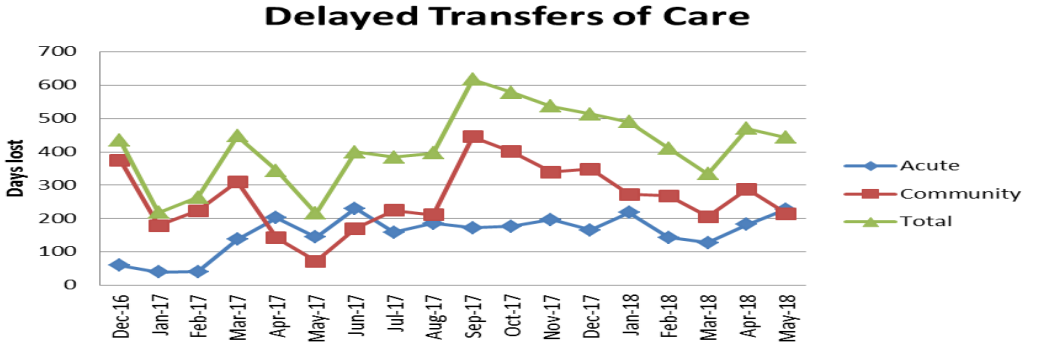
CAMHS - waiting times from referral to assessment and commencement of treatment remain good.
Quarterly data in arrears for smoking, opiate users, and children with a protection.

Community Services and Social Care metrics

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

	Act. 15/16 Outturn	16/17 Year End Target	Target May-18	May-18	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges							
Total Admissions (General)	2,841	2,841	241	218	454	446	↑
Direct Admissions (General)	274	274	26	26	51	48	→
Transfer Admissions (General)	2,567	2,567	215	192	403	398	→
Stroke Admissions	301	301	27	31	60	47	↑
Transfers from CH to DGH	52	52	20	17	45	34	↑
Beds							
Bed Occupancy [1]	90.9%	90.0%	90%	94.6%	93.8%	90.0%	
Bed Days Lost to Delays [2]	3,190	0	266	215	503	532	↓
Bed Days Lost to Bed Closure	99			2	7		
Length of Stay							
Delayed Discharges				41	85		
Average Length of Stay - Overall (General)	11			11.6	11.6		↓
Average Length of Stay - Direct Admissions	8.4	12.0	12.0	7.8	7.8	12.0	↓
Average Length of Stay - Transfer Admissions	11.3	12.0	12.0	12.0	12.0	12.0	↓
Average Length of Stay - Stroke	15.1	0.0	0.0	16.0	15.7	18.0	↓
Long LoS (>30 days)	171	171	14	12	27	32	↓
MIUs							
Total MIU Activity [3]	37,308	37,308	3,189	3,854	7,273		
New MIU Attendances	31,645	31,645	2,712	3,227	6,077	5,144	↑
All Follow Up Attendances	5,663	5,663	103	627	1,196	924	↑
Planned Follow Up Attendances [4]	4,857	4,857	411	535	1,023	799	↑
Unplanned Follow Up Attendances [4]	806	806	66	92	173	125	↑
MIU Four Hour Breaches	2	2	0	1	1	0	
Average Waiting Time (Mins) - 95th Pctile	28	45	45	47	46	45	

Measure	Target 2018/2019	13 month trend	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2018/19
COMMUNITY BASED SERVICES								
Nursing activity (F2F)	204,385		17,615	15,792	15,533	16,192	15,749	31,941
Therapy activity	65,415		5,771	5,066	4,411	5,421	5,171	10,592
No. intermediate care urgent referrals [B]	2,189		222	187	161	201	151	352
No. intermediate care placements	0		149	112	114	115	90	205
Intermediate Care - placement average LoS [B]	12.0		16.4	14.1	17.5	15.0	16.4	15.6



The Community Hospital Dashboard highlights

The planned levels of activity have been reset to reflect the 2017/18 baseline. In May stroke admissions and transfers back to the DGH are above plan.

The length of stay however (3 month rolling average) is being maintained at 11.6 days. Bed occupancy remains higher than target (90%) for optimal patient flow at 93.8%.

The Community Hospital performance metrics reflect the wider system operational pressure which has seen continued high levels of escalation to maintain emergency patient flow.

There remain capacity pressures to maintain levels of Intermediate Care and Domiciliary Care capacity to support timely discharge and alternatives to community and acute bed based care. The Patient Flow Board have done a review of system pressures experienced over last winter and against desired pathways of care, this exercise has informed a set of actions to build resilience and prepare for next winter.

Minor injury Units

Waiting times in MIUs are being maintained with a median time of 46 minutes.

Community based services highlights

Nursing Community nursing and community outpatient activity targets reflect 2017/18 outturn activity levels. May is seeing expected levels of activity. There is an expectation that teams will deliver an overall increase in productivity this year linked to the cost improvement initiatives of reducing placements.

Intermediate Care (IC) placements The year to date average length of stay in IC placements remains above target at 16.4 days. 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.

Transfers of Care (DToC)

The number of bed days reported as lost to delayed transfers of care (opposite) is being maintained with a reduction over last month. Close monitoring of delays is being maintained with weekly validation in place.

Operational Performance Focus

Month 2 (performance to end of May 2018)

Page 21	**NHSI indicators performance summary**
Page 22+23	**Referral to Treatment**
Page 24	**4-hour Standard for time spent in the Emergency Department and Minor Injuries Units**
Page 25	**Cancer treatment and cancer access standards**
Page 26	**Patients waiting over six weeks for diagnostics**
Page 27	**Other performance exceptions**

NHS I Performance Summary

STP / NHSI operational plan - Monitored indicators

Indicator	National Standard	Operational plan trajectory (M2)	Trust performance (M2)
A&E 4hr waits (PSF)	95%	92.1%	86.70%
RTT 18 week waits	92%	82.3%	82.20%
62 day Cancer waits	85%	78.1%	81.90%
Diagnostics waits < 6 weeks	99.0%	>90%	94.1%
Dementia Find	90%	90%	92.60%

NHSI Operational Plan indicators (Month 2)

A+E: The PSF (Provider Sustainability Fund) operational performance trajectory in May is **not met**. The target set for Q1 PSF is 92.22%. The Q1 PSF will not be met.

RTT: The RTT trajectory is **not met** - Recovery plans are being assessed and we are working with the NHSI support team to evaluate further opportunities for managing longest waits.

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

Diagnostics: The diagnostics trajectory is **met with** 94.1% of patients waiting under 6 weeks. This is ahead of our trajectory for May (90%) with the number of long waits reducing ahead of plan.

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

4 hour ED standard: In May the Trust achieved 86.7% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments. This is a reduction from last month (87.7%). The performance in M2 is below the trajectory of 92.1% being the level of performance achieved last year. Evaluation of the continued escalation pressures for emergency admissions has resulted in an updated action plan and is being led through the Patient flow board.

RTT (Target 92% / Trajectory 90.0%): RTT performance (82.2% of patient waiting for treatment under 18 weeks) improved however the total number of pathways awaiting treatment has increased in May.
Recent performance has been affected by the cap on elective capacity and slippage on recruitment to clinical posts. Teams have completedrecovery plans that indicated support needed to deliver the planned level of performance. These plans have been reviewed by NHSI as part of their recent visit to look at RTT planning and performance management. A summary of support required is given in the RTT focus report.

Patients waiting over 52 weeks: The number of patients waiting over 52 weeks increased to 54 by the end of May. 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 May at 81.9% (validated 14th June 2018). Action plans against the two week wait from urgent referral to appointment and the 62 day from urgent referral to treatment standards have been reviewed with teams. This indicated that there remains significant risk until clinical capacity is increased above current levels for Urology Surgery and Dermatology. Progress against these plans will be 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 improved in May to 256 (5.9%) from 458 (11%) in April of total number waiting.
This performance shows that actions taken with outsourcing for CT / MRI and ultrasound backfill is reducing long waits with performance ahead of our submitted operational plan trajectory. Increasing demand and sickness remain a risk.

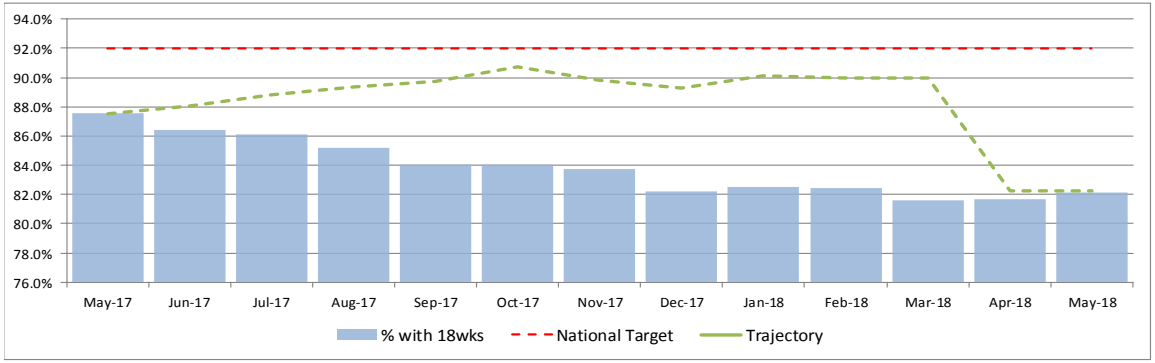
NHSI Indicator - Referral to Treatment

Specilities with highest numbers of patients waiting over 18 weeks RTT

	Incomplete RTT >18weeks			
Submitted Spec	IPDC	OP	% < 18wk	Total
Trauma & Orthopaedics	456	90	73.81	546
Urology	248	109	71.30	357
Ophthalmology	283	48	85.37	331
Upper Gastrointestinal Surgery	227	80	60.44	307
Oral Surgery	115	102	83.09	217
Respiratory Medicine		213	72.05	213
Cardiology	11	185	82.61	196
Gastroenterology	101	93	87.08	194
Colorectal Surgery	93	84	75.31	177
Pain Management	33	143	70.81	176
Neurology	2	126	76.21	128
Rheumatology	1	105	76.60	106
Dermatology	1	102	90.35	103

Referral to Treatment - Incomplete pathways

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Incomplete <18wks	15526	15000	15140	15579	15403	15713	14945	14669	14752	14952	15386	15693	16022
Incomplete >18wks	2219	2353	2448	2711	2932	2985	2902	3173	3127	3186	3473	3524	3750
% with 18wks	**87.6%**	**86.4%**	**86.1%**	**85.2%**	**84.0%**	**84.0%**	**83.7%**	**82.2%**	**82.5%**	**82.4%**	**81.6%**	**81.7%**	**82.2%**
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	87.5%	88.0%	88.9%	89.4%	89.8%	90.7%	89.9%	89.3%	90.1%	90.0%	90.0%	82.2%	82.3%



At the end of May 82.2% (81.66% last month) of patients waiting for treatment had waited 18 weeks or less at the Trust from initial referral for treatment against the 2018/19 trajectory of 82.3%. 2018/19 guidance states that RTT performance will be measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018, in these terms May 18 = 19,772 (March 18 = 18,859) showing an overall increase against March 2018. Critical to achieving the improvement trajectory is the finalisation of the investment and capital plans to ensure benefits support trajectory along with recruitment to new and replacement posts / locum cover. A summary of actions showing progress with those approved or awaiting approval is given on the next page.

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 is an increased risk due to slippage of implementing schemes and level of operational pressures that may be experience this coming winter requiring diverting resource to elective care to support emergency admission pathways.

In June the NHSI support team conducted a site visit over 2 days to review our RTT processed for monitoring and planning. Feedback from the visit identified:

- Weekly RTT planning and performance meetings observed to be working well with high levels of commitment from operational teams.
- Good assurance demonstrated that operational risks are being escalated into the Risk and Assurance Group.
- The main area for development is around development of recovery plan that currently does not offer adequate assurance. Recommendation that capacity planning and recovery plan templates provided by NHSI are used to give greater visibility of risk and impact of mitigations **– IMAS Support**
- Recommendation that PTL Meetings include view of cancer target challenges and secure support from cancer improvement team **– IMAS Support**

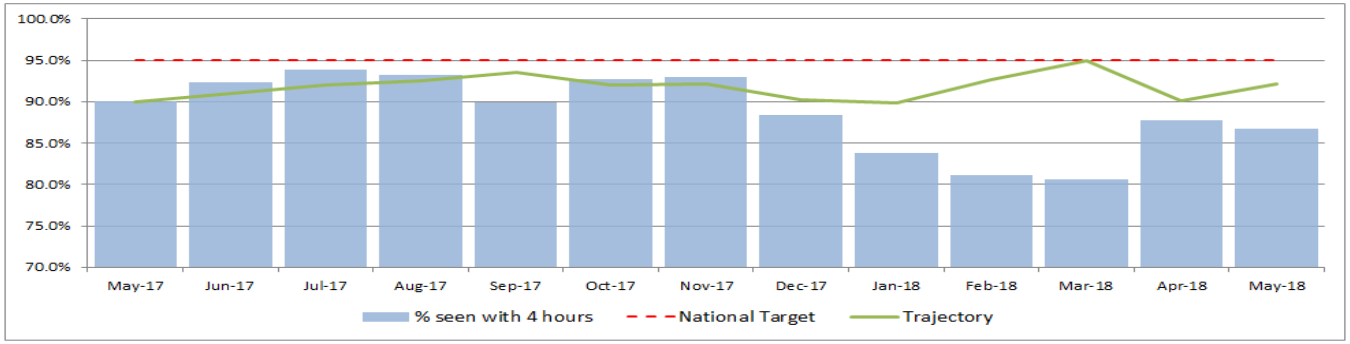
Monitoring patients waiting longer than 52 weeks: At the end of May, 53 patients (target 43) were waiting longer than 52 weeks (43 in March). 2018/19 guidance states that patients waiting more than 52 weeks for treatment should be halved by March 2019. Operational plans confirm commitment to achieving no patients waiting over 52 weeks from December 2018.

Governance and monitoring: All RTT delivery plans are reviewed at the bi-weekly Performance Risk and Assurance meeting chaired by the Interim Chief Operating Officer

NHSI Indicator - Referral to Treatment continued..

Summary of Actions from Recovery Plans	Action
COLORECTAL • Immediately recruit for a substantive 6th colorectal post. Until the post is filled, look to outsource activity to MSH, recruit agency/NHS locum on a fixed term. • Recruit additional nursing to support the extra outpatient activity • Recruit additional administrative support for the new consultant	Job description with CD for approval – advert to go out W/C 18.06.2018 To be approved To be approved
UROLOGY • Immediately recruit for a substantive 5th Urology post. Until the post is filled, look to recruit agency/NHS locum on a fixed term. • Recruit additional nursing to support the extra outpatient activity • Recruit additional administrative support for the new consultant • Laser proof Day Surgery theatre • Purchase new Cystoscopy scopes • Purchase new Laser • Additional outpatient clinic space at Torbay due to specialist room requirements, at Newton Abbot (additional equipment required). • Access to additional day surgery lists if the above solution are not implemented or do not reduce the demand on surgery within the capacity.	Job description with CD for approval – advert to go out W/C 18.06.2018 To be approved To be approved Business Case awaiting App Business Case awaiting App Business Case awaiting App To be agreed To be agreed
UPPER GI • Immediately recruit for a substantive 6th UPGI post. Until the post is filled, look to outsource activity to MSH, recruit agency/NHS locum on a fixed term. • Recruit additional nursing to support the extra outpatient activity • Recruit additional administrative support for the new consultant	Job description with CD for approval – advert to go out W/C 18.06.2018 To be approved To be approved
DERMATOLOGY • Recruitment to additional nursing posts for biopsies & simple minor ops - 2 HCAs, full time Band 5 and full time Band 6 Specialist Nurses. • Request for Locum Consultant Plastic Surgeon 8 PAs • Expand Poly Clinic model • Additional sessions internally • Continue with current locum usage • Demand management schemes	ECF's submitted With med Recruitment Being discussed Being discussed Being discussed

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



Operational delivery: The Operational Plan trajectory for Accident and Emergency waiting times (< 4 hours) is not achieved in May with 86.7% (87.7% last month) against the trajectory of 92.1%.
In May, 15 days were at Opel 1 and 2. This indicates a higher than expected level of escalation to that expected for the time of year given the reduction in Flu and winter pressures. Performance has not returned to the levels expected, with the operational plan trajectory of performance not being met. This deviation from planned performance has triggered NHSI to seek further assurance. NHSi are requiring plans to be shared and actions taken to bring performance back to predicted levels. The Patient Flow Board convened an additional extended meeting (23rd May) led by the Medical Director with clinical and operational leads to review process measures and identify areas for improvement based on experiences and performance over the winter. In addition to this operational leads have engaged with neighbouring trusts who have established recovery plans more recently in conjunction with NHSI support teams. This feedback is now informing the development of our strategy to support immediate improvement and prepare for next winter. The Urgent Care performance action plan is being led by the Chief Operating Officer.

Escalation status

Opel status	June	July	August	September	October	November	December	January	February	March	April	May
Opel 1	15	30	15	4	12	15	6	0	0	2	10	9
Opel 2	10	1	11	9	14	11	11	2	2	5	9	6
Opel 3	5	0	4	17	5	4	13	23	24	14	10	15
Opel 4	0	0	1	0	0	0	1	6	2	10	1	1
Performance	92.30%	93.90%	93.20%	89.90%	92.80%	92.90%	88.30%	83.80%	81.10%	80.60%	87.10%	86.70%

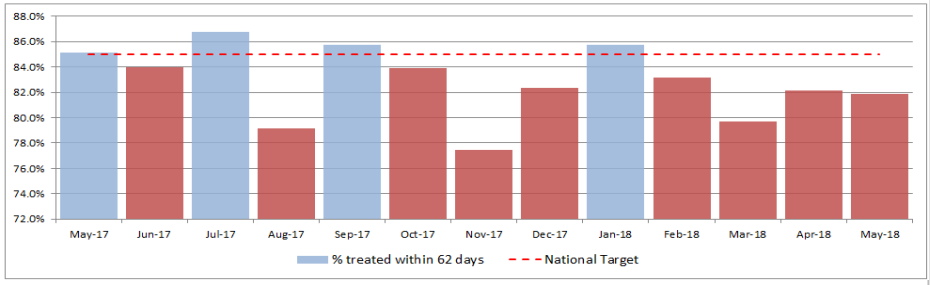
Care model : The system changes seen over the last year with the closure of community beds and increases in intermediate care team capacity is subject to a separate evaluation exercise. Indications are that reliance on bed based care has improved but there remains further potential to optimise the use of alternatives to admission / enhance early discharge together with using best practice across community health and social care teams. The peformance dashboard now included a set of metrics that describe longer the care model impact.

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

Cancer treatment and cancer access standards

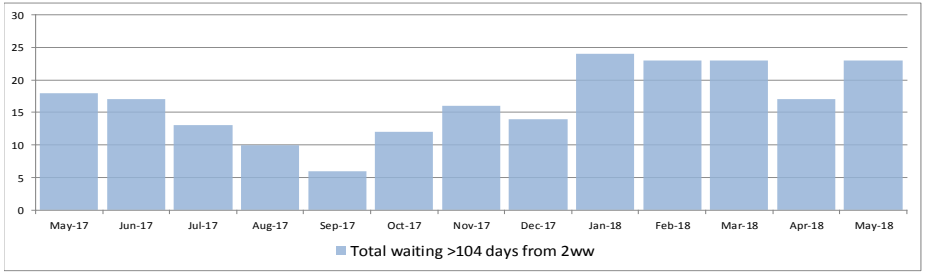
CWT Measure	Target	April 2018 Within Target	April 2018 Breached Target	April 2018 Total	April 2018 Performance	May 2018 Within Target	May 2018 Breached Target	May 2018 Total	May 2018 Performance
14 Day - 2ww referral	93%	738	479	1217	60.6%	687	546	1233	55.7%
14 Day - Breast Symptomatic referral	93%	71	5	76	93.4%	104	9	113	92.0%
31 Day 1st treatment	96%	185	4	189	97.9%	195	7	202	96.5%
31 Day Subsequent treatment - Drug	98%	68	0	68	100.0%	53	0	53	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	62	1	63	98.4%	60	1	61	98.4%
31 Day Subsequent treatment - Surgical	94%	36	0	36	100.0%	28	0	28	100.0%
31 Day Subsequent treatment - Other		31	0	31	100.0%	33	0	33	100.0%
62 day 2ww / Breast	85%	89.5	19	108.5	82.5%	95.5	22	117.5	81.3%
62 day Screening	90%	7	0	7	100.0%	7	0	7	100.0%
104 day breaches (2ww) - TREATED	0	8				8.5			

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
1st treatments (from 2ww)	97.5	106	94.5	120	98	84	97.5	85	94.5	83	91	106.5	121.5
Breaches of 62 day target	14.5	17	12.5	25	14	13.5	22	15	13.5	14	18.5	19	22
% treated within 62 days	85.1%	84.0%	86.8%	79.2%	85.7%	83.9%	77.4%	82.4%	85.7%	83.1%	79.7%	82.2%	81.9%
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

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



Cancer standards - Table opposite shows the May performance (at 14th June 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.
Three cancer treatment time standards have not been met in June:

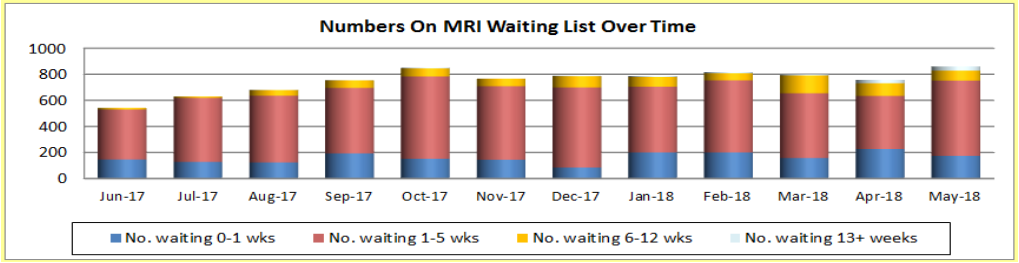
Urgent cancer referrals 14 day 2ww: At 55.7% this position is a deterioration from last month (60.6%). Waiting times have extended in Colo-rectal and Urology. These pathways are now not able to offer urgent appointments within 2 weeks of referral and will now impact on future delivery of the 62 day standard. Action plans across these specialties have been reviewed and additional capacity agreed however this will take some time to implement. The NHSI support team have reviewed our plans and are offering further support. Dermatology has additional capacity to reduce referral to first seen wait to 14 days, but has impacted on the referral to treatment waiting times.

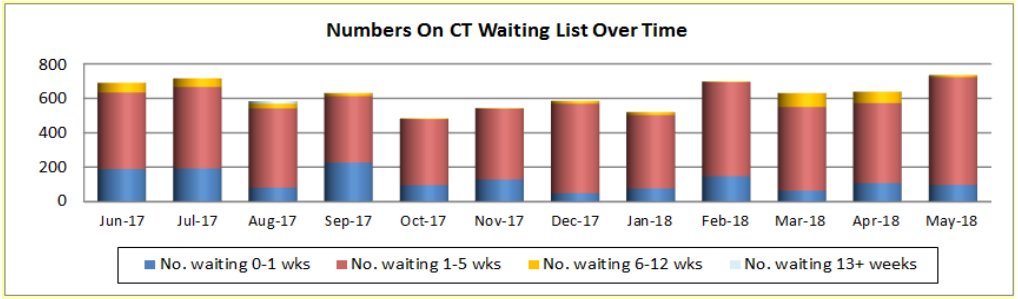
Urgent cancer referral 14 day breast symptomatic: At 92% the standard (93%) is narrowly being missed. Recent changes to support the service has increased resilience and is expecting to maintain performance at or close to standard. However, recent loss of capacity in Radiology will have an impact in the ability to offer timely assessment.

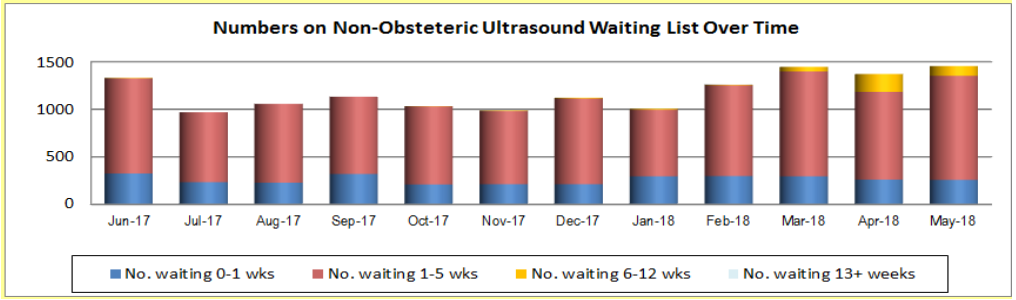
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard was not met in May at 81.3% (validated 14th June 2018). Predicted performance for June however is to achieve standard and the overall standard for Q1 can still be met. Against the 22 reported breaches, specialties with the highest number of beaches of standard are: Urology 14, Skin 3, Lung 2, Lower GI 3.
Longer waits for initial appointment will impact on performance in future months with increased breaches for Urology and lower GI pathways anticipated.

Longest waits greater than 104 days
In May, 10 Patients (3 shared breaches with RD+E = score 8.5) received treatment having a waiting time over 104 days (GI surgery 1, Thyroid 1, Urology 8).
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, capacity constraints in the indicated specialties are still preventing achievement of this standard. At the end of May, 23 patients were waiting over 104 days (17 last month) with confirmed or suspected cancer diagnosis. The extended waits for referral to first seen in Urology and Colo-rectal will increase the number of patients waiting over 104 days for treatment.

NHSI indictor - patients waiting over 6 weeks for diagnostics

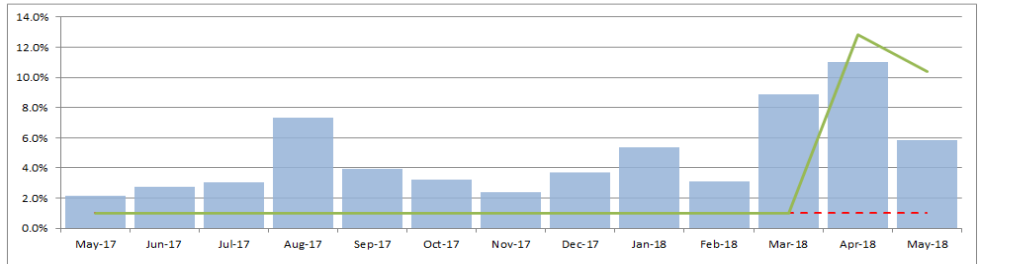






Diagnostic Tests Longer than the 6 week standard

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Patients	3792	3991	3763	3716	3900	3550	3382	3591	3550	4058	4283	4166	4370
Waiting longer than 6 weeks	82	110	114	273	153	114	81	134	191	125	380	458	256
% over 6 weeks	2.2%	2.8%	3.0%	7.3%	3.9%	3.2%	2.4%	3.7%	5.4%	3.1%	8.9%	11.0%	5.9%
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%	12.84%	10.42%



The number of patients with a diagnostic wait over 6 weeks decreased in May to 256 (5.9% of total waiting) from 458 (11.0% of total waiting) in April.

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 May 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.

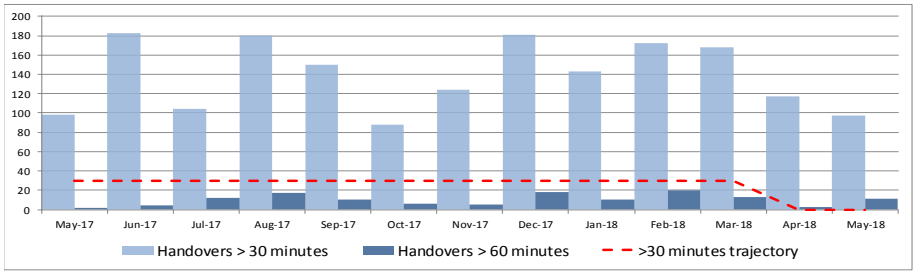
There continues to be pressures from increasing demand across many areas with demand management and options to increase capacity reviewed as part of 2018/19 business planning.

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.

Other performance exceptions

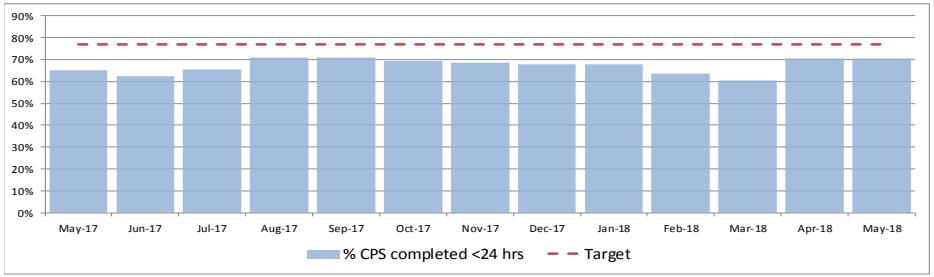
Ambulance handovers

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Handovers > 30 minutes	98	183	104	180	150	88	124	181	143	172	168	117	97
Handovers > 60 minutes	2	4	12	17	10	6	5	18	10	20	13	3	11
>30 minutes trajectory	30	30	30	30	30	30	30	30	30	30	30	0	0



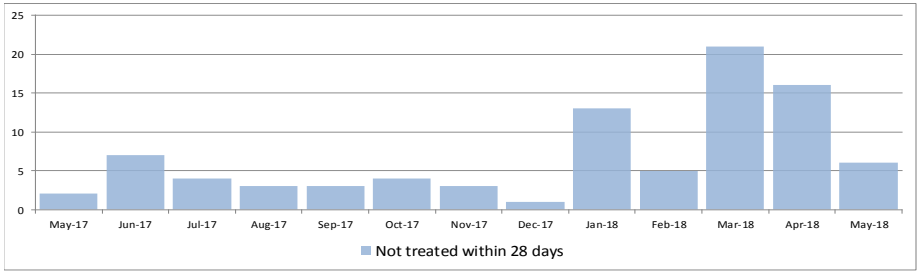
Care Plan Summaries completed with 24 hours of discharge - Weekday

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Discharges	1239	1204	1179	1268	1239	1269	1251	1104	1161	959	1014	1146	1298
CPS completed within 24 hours	1905	1925	1803	1787	1746	1825	1821	1625	1716	1511	1677	1628	1844
% CPS completed <24 hrs	65%	63%	65%	71%	71%	70%	69%	68%	68%	63%	60%	70%	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

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Not treated within 28 days	2	7	4	3	3	4	3	1	13	5	21	16	6



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 May 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

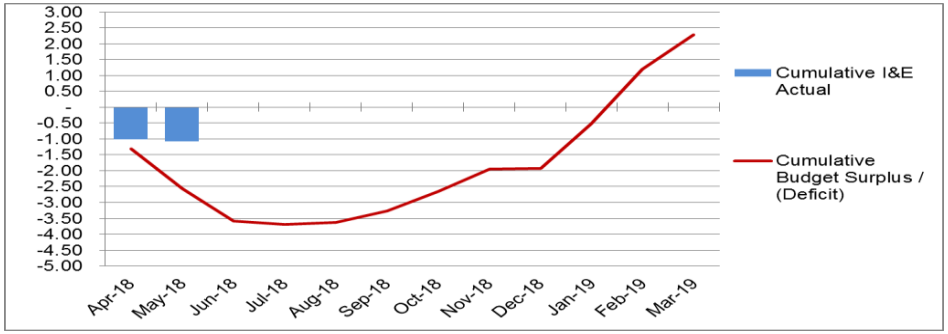
The number of patients requiring rebooking within 28 days has been reducing with 6 patients treatment in May having had to wait longer that 28 days following cancellation by the hospital. This is an improvement on the previous two months where there remained a backlog of patients to bring back in following the weather events in March and high number of on the day cancellations from emergency pressures.

Finance Focus

Page 2	Summary Of Financial Performance
Page 3	Summary Of Financial Performance (2)
Page 4	Income
Page 5	Income (2)
Page 6	Pay Expenditure
Page 7	Pay Expenditure (2)
Page 8	Non Pay Expenditure
Page 9	Financial Position by SDU
Page 10	Financial Position by SDU (2)
Page 11	Items Outside of EBITDA
Page 12	Balance Sheet
Page 13	Cash
Page 14	Activity
Page 15	Continuous Improvements Program (CIP)
Page 16	Continuous Improvements Program (CIP) (2)
Page 17	Continuous Improvements Program (CIP) (3)

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	67.97	0.94	68.91	68.64	(0.27)	419.12	418.68
Pay	(37.95)	0.15	(37.80)	(38.05)	(0.26)	(225.30)	(224.40)
Non Pay	(31.05)	(0.06)	(31.11)	(30.20)	0.91	(177.14)	(177.59)
EBITDA	**(1.02)**	**1.03**	**0.00**	**0.39**	**0.38**	**16.69**	**16.69**
Financing Costs	(2.57)	0.00	(2.57)	(2.47)	0.09	(14.41)	(14.41)
SURPLUS / (DEFICIT)	**(3.59)**	**1.03**	**(2.56)**	**(2.09)**	**0.48**	**2.28**	**2.28**
NHSI Exclusions	0.12	0.00	0.12	0.10	(0.02)	(0.56)	(0.56)
Plan Adjusted Surplus / (Deficit)	**(3.47)**	**1.03**	**(2.44)**	**(1.99)**	**0.46**	**1.72**	**1.72**
Remove STF Income	(0.61)	0.00	(0.61)	(0.43)	0.18	(6.15)	(6.15)
Variance to Control Total (Excl STF	**(4.09)**	**1.03**	**(3.06)**	**(2.42)**	**0.64**	**(4.42)**	**(4.42)**
Cash Balance	0.26			3.15	**2.89**	**8.12**	
Capital Expenditure	2.76	0.00	2.76	0.35	**(2.41)**	**17.63**	

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	n/a	1
Agency rating	2	3
Finance Risk Rating	**n/a**	**3**

Key Points

- The Trust has agreed its Operational Plan with NHS Improvement, including delivery of the Control Total; a surplus of £1.725m, includingincome from the Provider Sustainability Fund (PSF).
- The financial position at 31st May 2018 is a £2.09m deficit, which is £0.48m better than the budgeted position.
- Excluding the income and expenditure not used by NHS Improvement in their assessment frameworka deficit of £1.99m is recorded; £0.46m better than the budget for the year to date. NHS Improvement are also measuring financial performance of the Trust against the Control Total excluding PSF; on this metric the Trust is £0.64m better than plan.
- The 'Recategorisation column' in the table corrects the phasing of income in the Operatioanl Plan submission over the year to match that agreed with Commissioners. This has been addressed in the refreash of the Operational Plan and will not, therefore be a feature of future reports.
- The Trust is not expecting to earn the performance element of the PSF at Q1. This will not affect the assessment of financial performance by NHS Improvement but will reduce the available cash for capital by c£200K.
- The Trust has an annual savings target of £26.93m, with £18.0m idnetified schemes resgistered 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 reduced by £0.10m from month 01; an estimate has been included for the annual pay award.
- Non pay expenditure run rates have increased by £0.54m from last month, reflecting an increase in costs within the Independent Sector Continuing Healthcare. Despite this non-pay remains below budget, laregely reflecting underspends in investment reserves.
- The CIP target for the period to 31 May 2018 is £2.39m, against which a total of £1.47m has been delivered; an adverse variance of £0.92m.
- 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 at M02. The Agency spend rating is adverse to Plan.

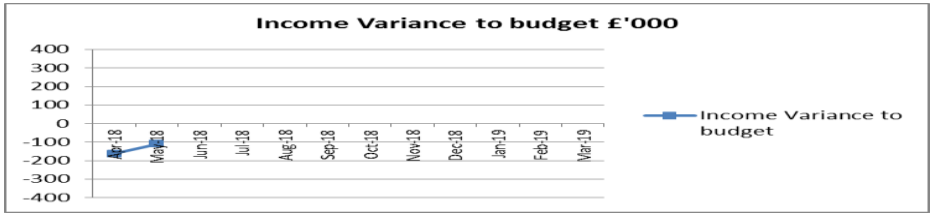
Summary of Financial Performance

	Month 02					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	31.30	(0.32)	30.98	30.88	(0.10)	61.07	0.88	61.95	61.56	(0.39)	(0.29)	(0.10)	372.14	371.35
Other Operating income	3.56	0.06	3.62	3.61	(0.01)	6.90	0.06	6.96	7.08	0.12	0.12	(0.01)	46.98	47.33
Total Income	**34.86**	**(0.26)**	**34.60**	**34.49**	**(0.11)**	**67.97**	**0.94**	**68.91**	**68.64**	**(0.27)**	**(0.16)**	**(0.11)**	**419.12**	**418.68**
Employee Benefits - Substantive	(18.38)	0.11	(18.27)	(18.29)	(0.02)	(36.75)	0.09	(36.66)	(36.68)	(0.02)	0.00	(0.02)	(219.12)	(218.32)
Employee Benefits - Agency	(0.60)	0.03	(0.57)	(0.68)	(0.11)	(1.19)	0.06	(1.13)	(1.37)	(0.24)	(0.12)	(0.11)	(6.18)	(6.08)
Drugs (including Pass Through)	(2.83)	0.00	(2.83)	(2.75)	0.08	(5.66)	0.00	(5.66)	(5.21)	0.45	0.37	0.08	(32.61)	(32.61)
Clinical Supplies	(2.10)	(0.02)	(2.13)	(2.22)	(0.09)	(4.17)	(0.02)	(4.19)	(4.19)	(0.00)	0.09	(0.09)	(23.87)	(24.01)
Non Clinical Supplies	(0.38)	0.01	(0.37)	(0.37)	(0.00)	(0.77)	0.01	(0.75)	(0.74)	0.01	0.01	(0.00)	(3.89)	(3.80)
Other Operating Expenditure	(10.35)	(0.06)	(10.40)	(10.02)	0.38	(20.46)	(0.05)	(20.51)	(20.05)	0.45	0.07	0.38	(116.76)	(117.17)
Total Expense	**(34.65)**	**0.08**	**(34.57)**	**(34.34)**	**0.23**	**(69.00)**	**0.09**	**(68.90)**	**(68.25)**	**0.66**	**0.43**	**0.23**	**(402.43)**	**(401.99)**
EBITDA	**0.21**	**(0.18)**	**0.03**	**0.15**	**0.12**	**(1.02)**	**1.03**	**0.00**	**0.39**	**0.38**	**0.26**	**0.12**	**16.69**	**16.69**
Depreciation - Owned	(0.70)	0.00	(0.70)	(0.69)	0.00	(1.40)	0.00	(1.40)	(1.38)	0.02	0.01	0.00	(8.73)	(8.73)
Depreciation - donated/granted	(0.06)	0.00	(0.06)	(0.05)	0.01	(0.12)	0.00	(0.12)	(0.10)	0.02	0.01	0.01	(0.74)	(0.74)
Interest Expense, PDC Dividend	(0.53)	0.00	(0.53)	(0.47)	0.05	(1.05)	0.00	(1.05)	(0.99)	0.06	0.01	0.05	(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)	**(1.08)**	**(0.18)**	**(1.26)**	**(1.07)**	**0.19**	**(3.59)**	**1.03**	**(2.56)**	**(2.09)**	**0.48**	**0.29**	**0.19**	**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)	0.12	0.00	0.12	0.10	(0.02)	(0.01)	(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)	**(1.02)**	**(0.18)**	**(1.20)**	**(1.02)**	**0.18**	**(3.47)**	**1.03**	**(2.44)**	**(1.99)**	**0.46**	**0.28**	**0.18**	**1.72**	**1.72**
NHSI Adjustment to Control Total														
Remove STF Income	(0.31)	0.00	(0.31)	(0.12)	0.18	(0.61)	0.00	(0.61)	(0.43)	0.18	0.00	0.18	(6.15)	(6.15)
Variance to Control Total Excluding STF	**(1.33)**	**(0.18)**	**(1.50)**	**(1.14)**	**0.36**	**(4.09)**	**1.03**	**(3.06)**	**(2.42)**	**0.64**	**0.28**	**0.36**	**(4.42)**	**(4.42)**

- The position in Month 02 is a deficit of £1.07m, which is £0.19m better than the budgeted position (£1.26m deficit) before NHSI exclusions. Year to date, the cumulative deficit of £2.09m is £0.48m better than budget.
- Income is lower than budget by £0.11m in Month 02; cumulatively £0.27m behind budget.
- Pay expenditure is £0.13m higher than budget in Month 02, mainly within agency pay (£0.11m) and 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 02 position in line with NHS I requirments. For the year to date, the pay position is £0.26m over budget. The savings target is phased at its lowest in the first quarter of the year, increasing from Quarter 2.
- Non-pay expenditure is £0.36m lower than budget in Month 02, and £0.91m under budget for the year to date. 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 02					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	51.23	0.75	51.97	51.53	(0.44)	(0.32)	(0.12)
Council Social Care (inc Public Health)	7.79	0.28	8.07	8.07	0.00	(0.00)	0.00
Client Income	1.64	(0.14)	1.50	1.54	0.04	(0.00)	0.04
Private Patients	0.30	0.01	0.30	0.27	(0.03)	(0.02)	(0.01)
Other Income	0.12	(0.02)	0.10	0.13	0.03	0.06	(0.03)
Operating Income from patient care activities	**61.07**	**0.88**	**61.95**	**61.56**	**(0.39)**	**(0.28)**	**(0.12)**
Other Income	4.80	0.06	4.86	5.09	0.24	0.08	0.15
Research and Education	1.49	0.00	1.49	1.56	0.06	0.04	0.02
Sustainability & Transformation funding	0.62	0.00	0.62	0.43	(0.19)	0.00	(0.19)
Other operating income	**6.90**	**0.06**	**6.96**	**7.08**	**0.12**	**0.13**	**(0.01)**
Total	**67.97**	**0.94**	**68.91**	**68.63**	**(0.28)**	**(0.16)**	**(0.13)**

Contract income by Commissioner	Year to Date - Month 02					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	28.45	1.02	29.47	29.47	(0.00)	0.00	(0.00)
North, East & West Devon Clinical Commissioning Group	0.83	(0.00)	0.83	0.74	(0.10)	0.01	(0.10)
NHS England - Area Team	1.28	(0.00)	1.28	1.27	(0.02)	(0.02)	0.01
NHS England - Specialist Commissioning	5.14	(0.00)	5.14	4.75	(0.38)	(0.33)	(0.05)
Other Commissioners	1.33	(0.31)	1.01	0.95	(0.06)	0.06	(0.11)
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	13.86	(0.00)	13.86	14.00	0.14	0.00	0.14
Other Commissioners	0.34	0.04	0.38	0.36	(0.02)	(0.02)	0.01
Operating Income from patient care activities	**51.23**	**0.75**	**51.97**	**51.53**	**(0.44)**	**(0.32)**	**(0.12)**

	Year to Date - Month 02					Previous Month	
MEMO - CCG Block Adjustment	Plan	Recategorisa	Budget	Actual	Variance to	Variance to	Change
	£m			£m	£m	£m	£m
CCG Block adjustment	(1.08)	0.00	(1.08)	(1.58)	(0.49)	0.48	(0.98)

Key points

- Overall Operating Income from Patient Care Activities is behind plan by £0.40m.
- Within this, there is a variance of £0.44m on income from contract healthcare. This reflects a reduction in pass through activity of £0.24m. New cost & volume activity is £0.025m behind plan. Radiotherapy and chemotherapy activity are £0.049m behind plan. Outpatients activity is £0.047m behind plan and elective activity is £0.053m behind plan. A&E is £0.028m behind plan.
- At Commissioner level, variances are marginal except for the NHS England Specialist Commissioning Contract which is £0.38m behind plan. This reflects a reduction in pass through income of £0.29m, as well as being £0.035m behind plan in Radiotherapy and £0.058m behind plan within admitted patient care activity.

Income

Other Operating Income	Year to Date - Month 02					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	1.49	0.00	1.49	1.56	0.06	0.04	0.02
Site Services	0.38	0.02	0.40	0.38	(0.02)	(0.02)	0.00
Revenue from non-patient services to other bodies	0.61	0.08	0.69	0.72	0.03	0.05	(0.02)
Sustainability Transformational Funding (STF) Income	0.62	0.00	0.62	0.43	(0.19)	0.00	(0.19)
Misc. other operating revenue	3.81	(0.04)	3.77	3.99	0.22	0.06	0.17
Total	**6.90**	**0.06**	**6.96**	**7.08**	**0.12**	**0.13**	**(0.01)**

At Month 02, Other Operating income is ahead of the cumulative budget by £0.12m.

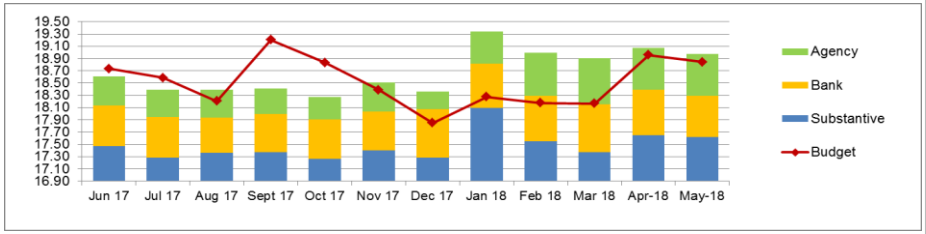
Key headlines / variances are:

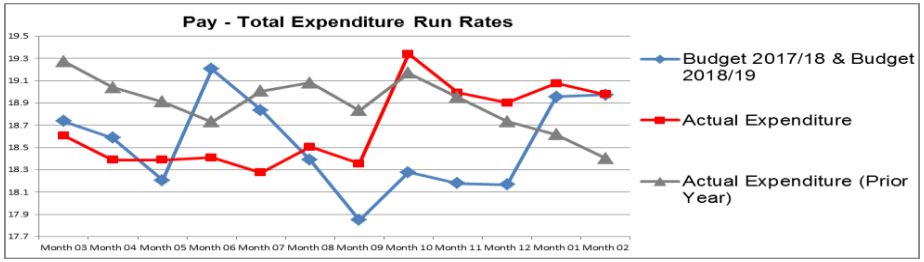
- R&D and Education income ahead of budget by £0.06m
- Overachievement of income CIP £0.19m
- Provider Sustainability Fund (PSF) income behind budget by £0.18m due to anticipated loss of A&E income for Months 1 and 2.
- Income earned by Torbay Pharmaceuticals £0.09m behind budget

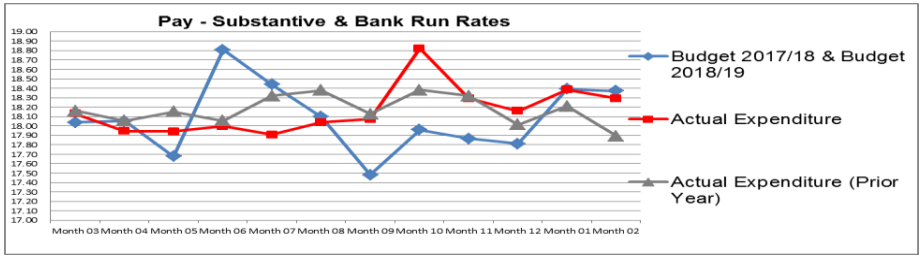
Annual PSF funding of £6.18m has been budgeted; at Month 02, £0.43m has been included in the position.

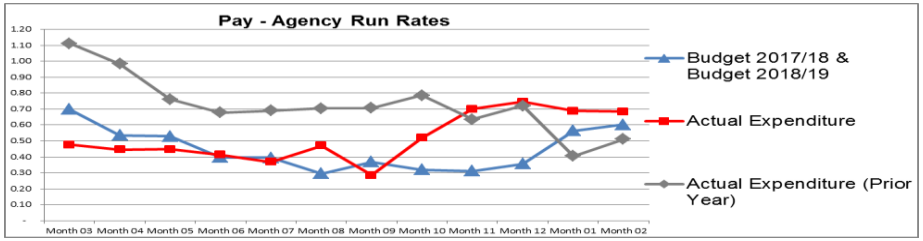
Pay Expenditure

Current Performance









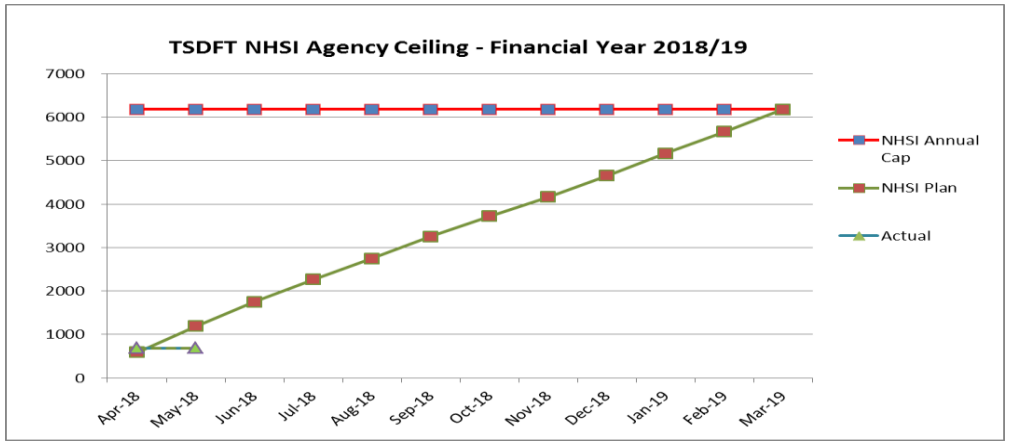
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(9.19)	0.16	(9.03)	(8.64)	0.39	(54.30)	(53.35)
Nursing and Midwifery	(14.67)	0.08	(14.59)	(14.77)	(0.18)	(88.06)	(87.55)
Other Clinical	(8.54)	(0.05)	(8.59)	(8.40)	0.19	(51.33)	(51.65)
Non Clinical	(5.54)	(0.04)	(5.58)	(6.24)	(0.66)	(31.60)	(31.85)
Total Pay Expenditure	**(37.95)**	**0.15**	**(37.80)**	**(38.05)**	**(0.26)**	**(225.30)**	**(224.40)**

Key points

- Total pay costs are showing an overspend against budget at Month 2 of £0.26m.
- Substantive and Bank pay costs are £0.02m over budget, and agency costs are overspent by £0.24m.
- 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 and Torbay Pharmaceuticals, which are £0.21m and £0.03m respectively underspent.
- Agency spend is primarily in medical and registered nursing staff, with the largest spends in those categories within Emergency Medicine, Surgery and Public Health in Community Services.
- Run rates in substantive and bank pay have reduced overall by £0.09m from the previous month (substantive decreased £0.03m and bank decreased £0.06m). An estimation for the annual pay award has been included in the Month 02 position.
- Agency run rates have reduced only slightly during May.
- The Apprentice levy balance at Month 2 is £810,367 (£763,916 at month 1) the Trust is currently at risk of not using levy monies before the rolling two year access window starts to close.

Pay Expenditure

Agency Spend Cap



Agency - All Staff Groups	April	May
	£m	£m
Agency Plan 2018/19 (NHSI Ceiling)		
Planned Agency Cost	(0.59)	(0.60)
Total Planned Staff Costs	(18.97)	(18.98)
% of Agency Costs against Total Staff Cost	***3.1%***	***3%***
Agency Actual Costs 2018/19		
Agency Cost	(0.69)	(0.68)
Actual Staff Cost	(19.07)	(18.98)
% of Agency Costs against Total Staff Cost	***3.6%***	***4%***
Agency Cost vs Plan	(0.10)	(0.08)
% of Agency Costs against Total Staff Cost	***-0.5%***	***0%***

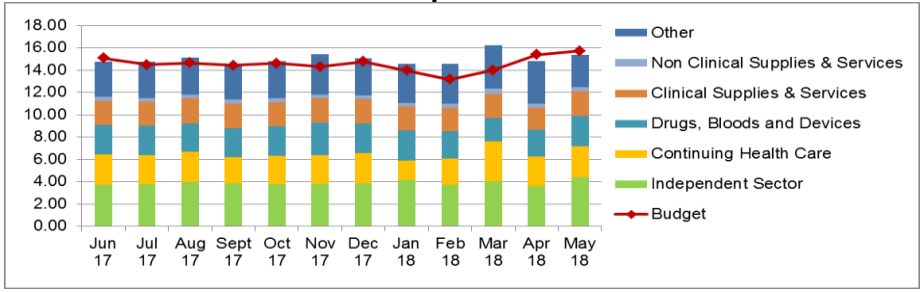
Agency - Nursing	April	May
	£m	**£m**
Agency Nurse Staff Cost	(0.23)	(0.26)
Actual Registered Nurse Staff Cost	(4.65)	(4.59)
% of Agency Costs against Nursing Staff Cost	***5%***	***6%***

Agency staff costs in Month 2 across all staff groups is £0.68m. This is £0.08m higher than the NHSI cap of £0.60m. The overall Agency cap for the Trust is £6.18m in FY 2018/19.

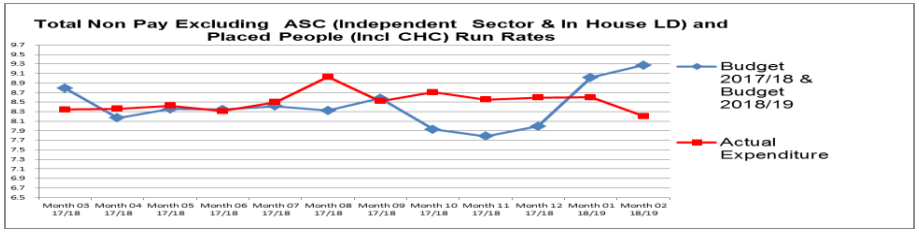
- Although higher than the plan by £0.08m, overall Agency usage has reduced in each of the last 2 months, albeit only margincally in May.
- Medical agency spend is £0.28m at Month 2 which is £0.05m higher than the £0.23m plan.
- Nursing Agency spend at Month 2 is £0.26m, being £0.02m lower than the £0.28m plan. Spend in month has risen by 11.6% from Month 1.
- The adverse Agency cost variances are in the following areas: Medical Staff, Ancillary (Domestic) and Other Clinical Staff, principally CAMHS). 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 £18.98m (gross amount before deducting capitalised staff cost).

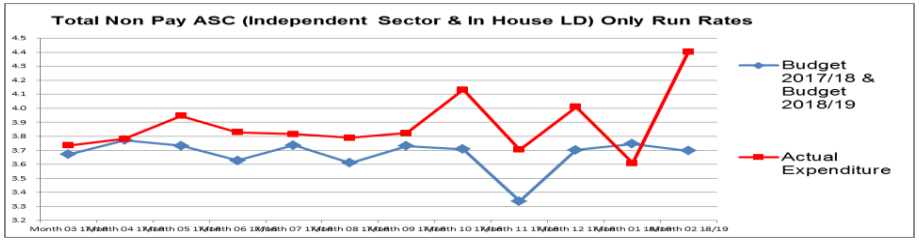
Non Pay Expenditure

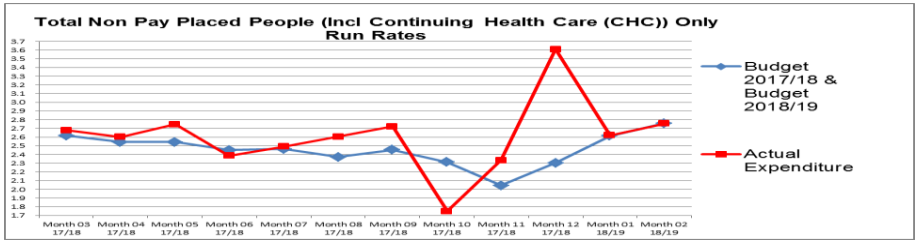
Current performance



	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	(5.66)	0.00	(5.66)	(5.21)	0.45	(32.61)	(32.61)
Clinical Supplies & Services	(4.15)	(0.02)	(4.18)	(4.18)	(0.00)	(23.89)	(24.04)
Non Clinical Supplies & Services	(0.76)	0.01	(0.75)	(0.74)	0.01	(3.88)	(3.79)
Other Operating Expenditure	(7.52)	(0.18)	(7.70)	(6.68)	1.02	(40.01)	(41.08)
ASC (Independent Sector & In House LD)	(7.62)	0.18	(7.44)	(8.01)	(0.57)	(44.99)	(43.71)
Placed People (Incl Continuing Healthcare)	(5.32)	(0.05)	(5.38)	(5.38)	0.00	(31.74)	(32.36)
Total Non Pay Expenditure	**(31.05)**	**(0.06)**	**(31.11)**	**(30.20)**	**0.91**	**(177.14)**	**(177.59)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.45m mainly due to pass through, £0.35m for which income is similarly reduced for NHS England.
- Clinical Supplies – Spend is in line with budget at Month 2; underspends in Surgery and Estates are offset by overspends in Medicine (internal services provided and contract maintenance), Womens and Children (external services, laboratory managed service and X-ray equipment) and Torbay Pharmaceuticals. Run rates have increased from Month 1 by £0.25m.
- Non Clinical Supplies – Total underspend of £0.01m; mainly in Estates, and in respect of provisions and domestic cleaning equipment. Run rates have increased by £0.01m on the previous month.
- Placed People (including Continuing Healthcare) - Aligned to budgeted position at month 02.
- Adult Social Care - Over spent by £0.57m mainly as a result of a shortfall in the delivery of the Systems Savings Plan.
- Other Operating Expenditure - Under spent by £1.02m reflecting:
  - Premises costs underspent by £0.41m; Investment reserve not yet utilised.
  - Purchase of social care underspent by £0.14m.
  - Other £0.04m overspent – unachieved CIP (£0.36m) offset with underspends in professional services and investment reserve not yet utilised.
  - Purchase of Healthcare £0.16m overspent - Women and Child's Health for Radiology / Histology Medical services provided (£0.10m) and CT Scanning outsourcing (£0.03m), Medical Services outsourcing of Gastroenterology weekend working (£0.05m). Run rates have increased by £0.06m from the previous month.
  - Underspends in Education and Training £0.07m; Bad debt Provision £0.19m, Establishment and Transport £0.11m and Clinical Negligence / Consultancy £0.21m.

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	67.97	0.94	68.91	68.64	(0.27)	420.42	419.98
Pay	(37.95)	0.15	(37.80)	(38.05)	(0.26)	(225.30)	(224.40)
Non Pay	(31.05)	(0.06)	(31.11)	(30.20)	0.91	(177.14)	(177.59)
Financing Costs	(2.57)	0.00	(2.57)	(2.47)	0.09	(15.71)	(15.71)
SSP Plans	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Surplus / (Deficit)	**(3.59)**	**1.03**	**(2.56)**	**(2.09)**	**0.48**	**2.28**	**2.28**
NHSI Exclusions	0.12	0.00	0.12	0.10	0.00	(0.56)	(0.56)
Variance Against Plan Surplus / (Deficit)	**(3.47)**	**1.03**	**(2.44)**	**(1.99)**	**0.48**	**1.72**	**1.72**

The year to date position is a deficit of £2.09m against a budget deficit of £2.56m.

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	0.16	(0.02)	0.14	0.32	0.18	0.93	0.84
Pay	(6.46)	0.14	(6.32)	(6.52)	(0.20)	(38.17)	(37.32)
Non Pay	(1.62)	(0.16)	(1.78)	(1.58)	0.19	(8.37)	(9.32)
Financing Costs	(0.30)	0.00	(0.30)	(0.30)	(0.00)	(1.77)	(1.77)
Surplus / (Deficit)	**(8.22)**	**(0.03)**	**(8.25)**	**(8.09)**	**0.17**	**(47.38)**	**(47.57)**

The underspend generally relates to phasing and YTD achievement of TWIP. The pay overspend and income overachievement net each other off.

	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	1.69	(0.13)	1.56	1.61	0.04	10.16	9.46
Pay	(0.15)	(0.01)	(0.16)	(0.22)	(0.06)	(1.08)	(1.01)
Non Pay	(7.62)	0.18	(7.44)	(8.01)	(0.57)	(44.99)	(43.71)
Surplus / (Deficit)	**(6.08)**	**0.04**	**(6.04)**	**(6.63)**	**(0.58)**	**(35.90)**	**(35.26)**

Assumption at this early point in the year is that the YTD position for ASC and In House services will break even with the exception of TWIP, which is expected to under-deliver by £58k as at M2. Expectations will be refined as data becomes available.

	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	0.00
Pay	(0.21)	0.03	(0.18)	(0.18)	0.00	(1.13)	(1.09)
Non Pay	(5.32)	(0.05)	(5.38)	(5.38)	0.00	(31.74)	(32.36)
Surplus / (Deficit)	**(5.53)**	**(0.03)**	**(5.56)**	**(5.56)**	**0.00**	**(32.85)**	**(33.46)**

Assumption at this early point in the year is that the YTD position for 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	15.83	0.00	15.83	16.31	0.47	98.69	98.69
Pay	(7.47)	0.00	(7.47)	(8.14)	(0.67)	(44.39)	(44.39)
Non Pay	(4.43)	(0.00)	(4.43)	(4.38)	0.05	(24.80)	(24.80)
Surplus / (Deficit)	**3.94**	**0.00**	**3.94**	**3.78**	**(0.15)**	**29.50**	**29.50**

Income from patient care activities is £439k greater than the plan for the period which is helping to offset overspends against pay that include unachieved TWIP and overspends across wards, particularly against Warrington that remained open for part of April but is unfunded and in Emergency due to continued high levels of agency to fill vacant posts. Non Pay underspend includes underspends against pass through drugs & devices of £212k 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	11.89	0.02	11.91	12.57	0.66	72.25	72.35
Pay	(7.91)	0.00	(7.91)	(8.10)	(0.19)	(46.40)	(46.40)
Non Pay	(3.65)	(0.02)	(3.67)	(3.39)	0.28	(19.48)	(19.58)
Surplus / (Deficit)	**0.33**	**(0.00)**	**0.33**	**1.07**	**0.75**	**6.38**	**6.38**

M02 Patient 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 £380k above the target of £185k. The bulk of this is held within TH in theatres and ICU. This is off set by Medical pay which is over-spent by £155k within GS,OP and TO, wards are over by £50k in M01 (£111k excluding allocation of central funding). Non pay is under-spending across the board by (£117k) excluding TWIP. The bulk is within TH. CIP has under delivering by £42k. £174k under in pay and over delivered in Non pay and other income. £4.618 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	7.49	0.04	7.53	7.59	0.05	46.09	46.36
Pay	(6.33)	(0.04)	(6.37)	(6.48)	(0.11)	(37.78)	(38.05)
Non Pay	(1.44)	(0.00)	(1.44)	(1.58)	(0.14)	(7.17)	(7.17)
Surplus / (Deficit)	**(0.28)**	**(0.00)**	**(0.28)**	**(0.48)**	**(0.20)**	**1.14**	**1.14**

Income from patient care activities is overachieving by £82k at month 2 which is helping to offset overspends against pay and non pay. Pay overspent but includes £150k for vacancy factor which is not being fully achieved. Non Pay overspends include costs for the Histopathology breast services being hosted by RD&E and outsourcing CT & MRI costs in Radiology which are not fully funded.

	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	30.90	1.02	31.93	30.25	(1.68)	192.27	192.28
Pay	(9.41)	0.03	(9.37)	(8.40)	0.97	(56.36)	(56.15)
Non Pay	(6.97)	(0.01)	(6.98)	(5.88)	1.10	(40.58)	(40.65)
Financing Costs	(2.27)	0.00	(2.27)	(2.17)	0.10	(13.93)	(13.93)
Surplus / (Deficit)	**12.26**	**1.05**	**13.31**	**13.80**	**0.49**	**81.40**	**81.55**

Income - For Month 02, Central Income holds the block adjustment for the Trust - this will be distributed to SDU's from Month 03
Pay - Underspent by £0.97m; Investment reserves £422k and Vacancies across the SDU including, Pharmacy £89k, Torbay Pharmaceuticals £107k, Education £135k offset with unachieved CIP across the Corporate SDU
Non pay - Overall underspend £1.10m; Contract Income bad debt provision under spent £190k, investment budget held in reserves £580k, Finance underspend in CNST Premium £141k, general misc and provisions; HR underspend in overseas recruitment costs.

Items Outside of EBITDA

	Year to Date - Month 02			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Operating income/expenditure outside EBITDA					
Donated asset income	0.00	0.00	0.00	0.00	0.00
Depreciation/Amortisation	(1.52)	(1.48)	0.03	0.02	0.01
Impairment	0.00	0.00	0.00	0.00	0.00
Total	**(1.52)**	**(1.48)**	**0.03**	**0.02**	**0.01**
Non-operating income/expenditure					
Interest expense (excluding PFI)	(0.27)	(0.25)	0.02	0.01	0.01
Interest and Contingent Rent expense (PFI)	(0.30)	(0.30)	(0.00)	(0.00)	(0.00)
PDC Dividend expense	(0.49)	(0.49)	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	0.05	0.05	0.00	0.05
Total	**(1.05)**	**(0.99)**	**0.06**	**0.01**	**0.05**
Total items outside EBITDA	**(2.57)**	**(2.47)**	**0.09**	**0.03**	**0.07**

Key points

- No noteworthy variances.

Balance Sheet

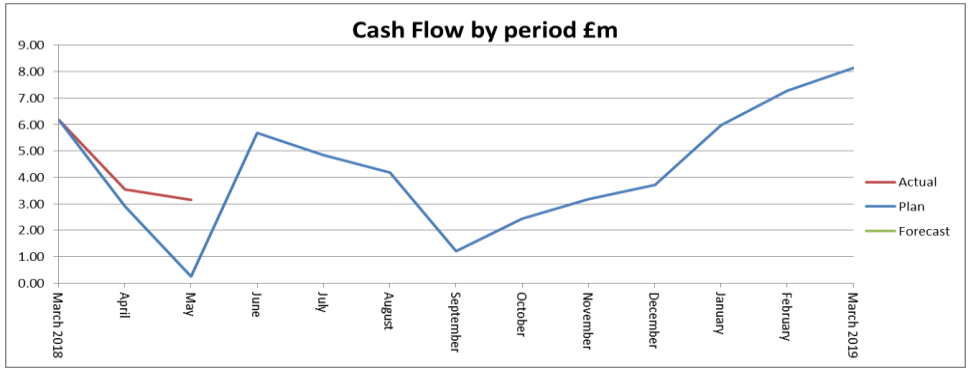
	Year to Date - Month 02			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Non-Current Assets					
Intangible Assets	9.04	8.40	(0.64)	(0.53)	(0.11)
Property, Plant & Equipment	165.25	163.55	(1.70)	(0.59)	(1.11)
On-Balance Sheet PFI	15.15	15.11	(0.04)	(0.02)	(0.02)
Other	2.37	2.37	(0.01)	(0.01)	0.01
Total	**191.81**	**189.42**	**(2.39)**	**(1.15)**	**(1.23)**
Current Assets					
Cash & Cash Equivalents	0.26	3.15	2.89	0.65	2.24
Other Current Assets	36.72	38.67	1.96	1.23	0.72
Total	**36.98**	**41.83**	4.84	**1.88**	**2.96**
Total Assets	**228.79**	**231.25**	**2.46**	**0.73**	**1.73**
Current Liabilities					
Loan - DH ITFF	(6.91)	(6.90)	0.00	0.00	0.00
PFI / LIFT Leases	(0.80)	(0.80)	0.00	0.01	(0.01)
Trade and Other Payables	(31.85)	(32.55)	(0.70)	1.08	(1.78)
Other Current Liabilities	(2.34)	(2.40)	(0.06)	(0.12)	0.06
Total	**(41.90)**	**(42.65)**	**(0.76)**	**0.97**	**(1.72)**
Net Current assets/(liabilities)	**(4.91)**	**(0.83)**	**4.09**	**2.85**	**1.24**
Non-Current Liabilities					
Loan - DH ITFF	(56.44)	(56.42)	0.02	0.00	0.02
PFI / LIFT Leases	(19.36)	(19.38)	(0.02)	(0.06)	0.04
Other Non-Current Liabilities	(4.74)	(4.93)	(0.20)	(0.14)	(0.05)
Total	**(80.54)**	**(80.74)**	**(0.20)**	(0.20)	0.00
Total Assets Employed	**106.35**	**107.86**	**1.50**	**1.50**	**0.01**
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	4.50	6.00	1.50	1.50	0.00
Total	**106.35**	**107.86**	**1.50**	**1.50**	**0.00**

Key Points

- Intangible Assets, Property, Plant & Equipment and PFI are £2.4m less than plan. This is due to capital expenditure being £2.4m lower than planned.
- Cash is £2.9m favourable to Plan, as explained on the commentary to the Cash Flow Statement.
- Other Current Assets are £2.0m higher than Plan, largely due to income received in arrears from NHSE.
- Trade and Other Payables are £0.7m higher than Plan, largely due to short term liquidity from Torbay Council £3m, partly offset by the paying down of the capital creditor.

Cash

Current Performance



	Year to Date - Month 02			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)	(2.76)	(0.35)	2.42	0.95	1.46
Capital loan drawndown	0.00	0.00	0.00	0.00	0.00
Capital loan repayment	(0.70)	(0.72)	(0.02)	0.00	(0.02)
Proceeds on disposal of assets	0.00	0.00	0.00	0.00	0.00
Movement in capital creditor	0.00	(0.73)	(0.73)	(0.54)	(0.19)
Other capital-related elements	(0.03)	(0.00)	0.03	0.02	0.01
Sub-total - capital-related elements	**(3.50)**	**(1.79)**	**1.70**	**0.43**	**1.27**
Cash Generated From Operations	(1.02)	0.39	1.41	1.47	(0.06)
Working Capital movements - debtors	(0.61)	(2.57)	(1.96)	(1.03)	(0.93)
Working Capital movements - creditors	(0.00)	1.47	1.47	(0.40)	1.87
Net Interest	(0.47)	(0.41)	0.06	0.13	(0.06)
PDC Dividend paid	0.00	0.00	0.00	0.00	0.00
Other	(0.29)	(0.09)	0.20	0.05	0.15
Sub-total - other elements	**(2.41)**	**(1.22)**	**1.19**	**0.23**	**0.96**
Closing Cash Balance (incl Overdraft)	**0.26**	**3.15**	**2.89**	**0.65**	**2.24**

Key points

- Capital-related cashflow is £1.7m favourable due to capital expenditure £2.4m favourable, partly offset by the paying down of the capital creditor £0.7m.

Other elements:

- Cash generated from operations is £1.4m favourable, due to the favourable YTD variance on EBITDA £1.4m.
- Working Capital debtor movements is £2.0m adverse, mainly due to income received in arrears from NHSE.
- Working Capital credit movements is £1.5m favourable, mainly due to receipt of short term liquidity support from Torbay Council £3m.

Capital

Current Performance

	Year to date Mth 02 - Based upon Operational Plan (April 18)				
	Plan £m	Budget £m	Actual £m	Variance to Plan £m	Variance to Budget £m
Capital Programme	2.76	2.76	0.35	(2.41)	(2.41)
Significant Variances in Planned Expenditure by Scheme:					
HIS schemes	0.78	0.78	0.16	(0.62)	(0.62)
Estates schemes	1.66	1.66	0.14	(1.53)	(1.53)
Medical Equipment	0.09	0.09	0.00	(0.09)	(0.09)
Other	0.00	0.00	0.00	0.00	0.00
PMU	0.23	0.23	0.05	(0.17)	(0.17)
Contingency	0.00	0.00	0.00	0.00	0.00
Anticipated slippage	0.00	0.00	0.00	0.00	0.00
Total	2.76	2.76	0.35	(2.41)	(2.41)
Funding sources					
Secured loans	0.00	0.00	0.00	0.00	0.00
Unsecured loans	0.00	0.00	0.00	0.00	0.00
Finance Leases	0.00	0.00	0.00	0.00	0.00
Disposal of assets	0.00	0.00	0.00	0.00	0.00
PDC	0.00	0.00	0.00	0.00	0.00
Charitable Funds	0.00	0.00	0.00	0.00	0.00
Internal cash resources	2.76	2.76	0.35	(2.41)	(2.41)
Total	2.76	2.76	0.35	(2.41)	(2.41)

Key Points

- Capital expenditure for the year to date is £346k representing a £2.4m underspend on pre approved schemes.

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	32,116	5,217	5,472	255	220	5%
Elective	3,379	575	574	-1	-27	0%
Non-Elective Emergency	29,875	4,896	4,694	-202	3	-4%
Non-Elective Non-Emergency	3,189	541	533	-8	-44	-1%
Non-Elective CDU	4,576	730	816	86	246	12%
Non-Elective AMU	3,275	386	701	315	14	82%
TOTAL APC	**76,410**	**12,345**	**12,790**	**445**	**412**	4%
New	107,775	17,788	18,104	316	2,344	2%
F-Up	258,463	41,917	43,085	1,168	4,543	3%
TOTAL OPA	**366,238**	**59,705**	**61,189**	**1,484**	**6,887**	2%
A&E	79,143	13,455	13,458	3	-2,397	0%

Activity variances to plan -Month 2

Activity variances for M2 against the contract activity plan are shown in the table opposite. In M2, Day Case and Outpatient activity is above plan. Non Elective Emergency and Non-Emergency activity is behind plan. Both AMU and CDU activity are both above plan. For AMU the activity phasing is based on 2017/18 actuals and there was a noticeable incremental increase in activity from September, and again in November. Therefore we will continue to see an overperformance throughout the year.

At treatment function level the greatest variance in day cases is within Gastro where activity is 162 attendances above plan (in PBR terms £100k).

Within Outpatients, the specialties with the greatest variances are, Dermatology which is 371 New attendances above plan (in PBR terms £34k), and Rheumatology which is 258 attendances above plan (in PBR terms £47k).

For Follow Ups, Dermatology is 366 attendances above plan (in PBR terms £84K), and Paeds are 387 attendances above plan (in PBR terms £42k).

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 2

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%. May performance predicted to again be under the trajectory target of 82.27%

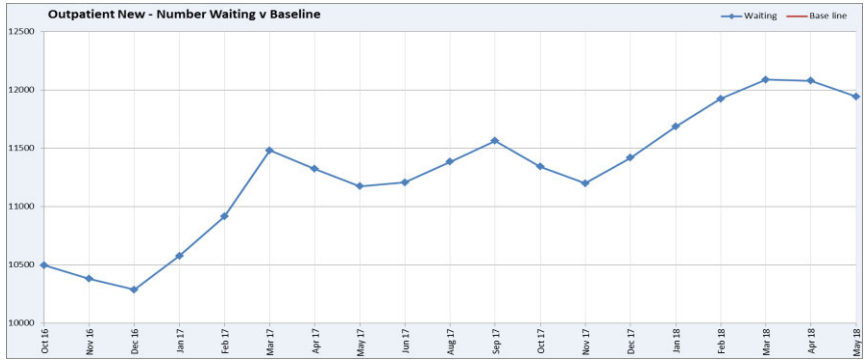
The RTT risk and Assurance group are maintaining the performance oversight with the RTT position and forecast reviewed at individual team level.

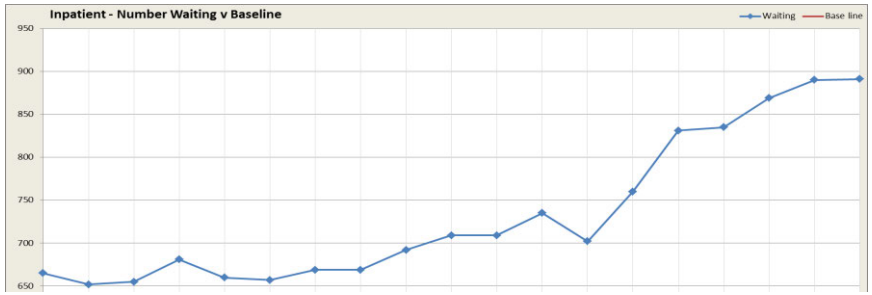
Referrals over a rolling 12 month period are remaining at historical levels.

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.

Current activity plans indicate that the additional activity is not being provisioned and is a further ask on top of recovering 14 day & 62day Cancer targets, reducing 52wk wait numbers and stabilising RTT performance to agreed levels.

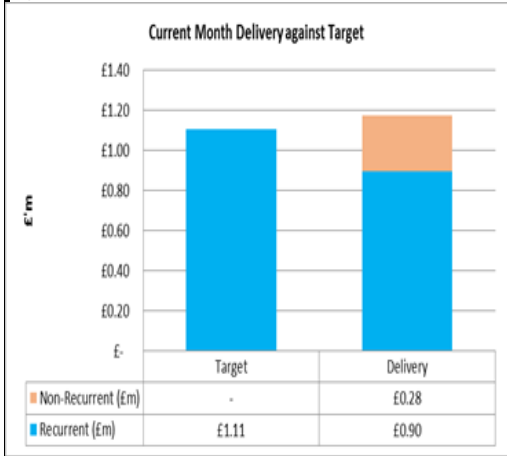
Overall waiting list number for inpatients have now increased above expected levels of normal variation and is considered a risk to patient experience and delivery of agree RTT trajectories.

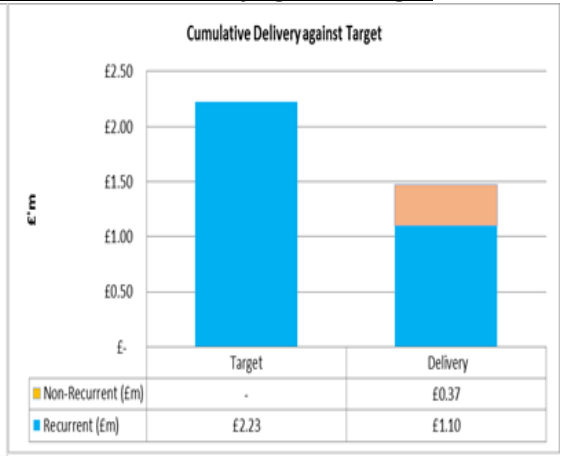




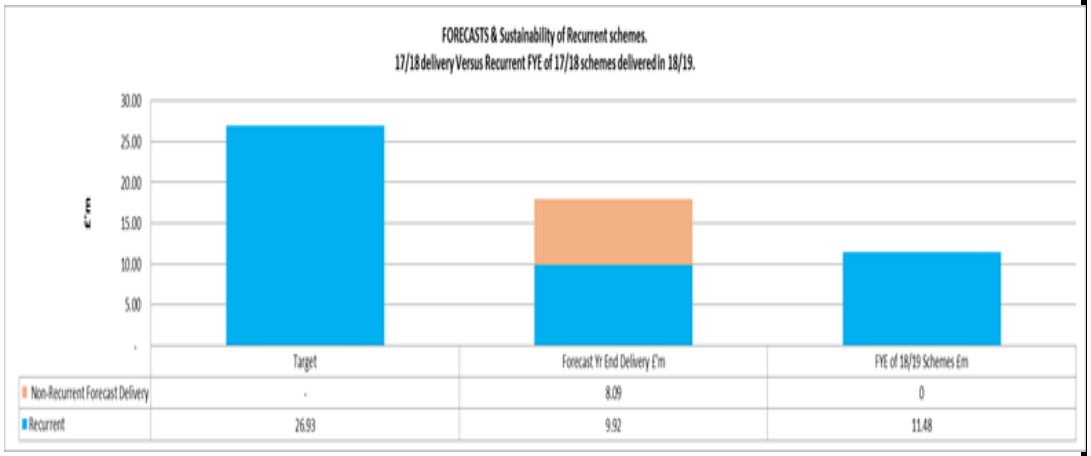
CIP Delivery: Current Mth, Cumulative & Forecast

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 Surplus:** £0.1m

-**Cumulative Shortfall:** £0.8m

Commentary>
The current month improvement reflects an element of backdated delivery.
There is a £4m improvement in the year end forecast but this is forecast to deliver in the latter part of the year.

Nonetheless there remains a need to identify additional savings oportuntities 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

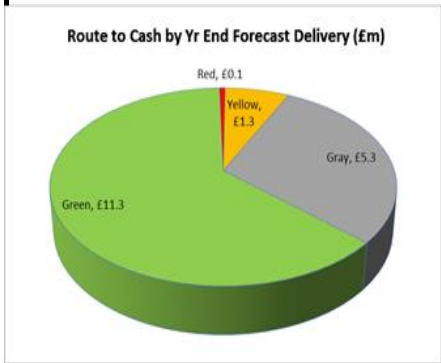
Target:	**£26.9m**
Yr End Forecast Delivery:	**£18.0m**
Shortfall:	**£8.9m**

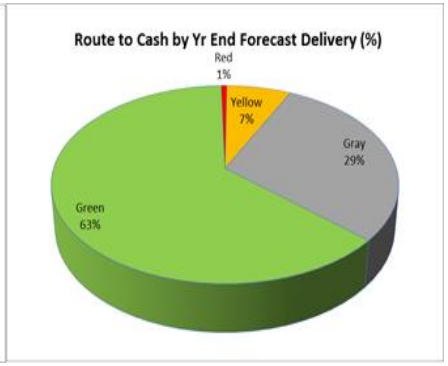
Forecast 19/20 Recurrent FYE of 18/19 projects: £11.5m.
This forecast position refelcts an arithetical extrapolation of the likely full year recurrent effect of 2019/20 delivery from the 2018/19 projects.

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

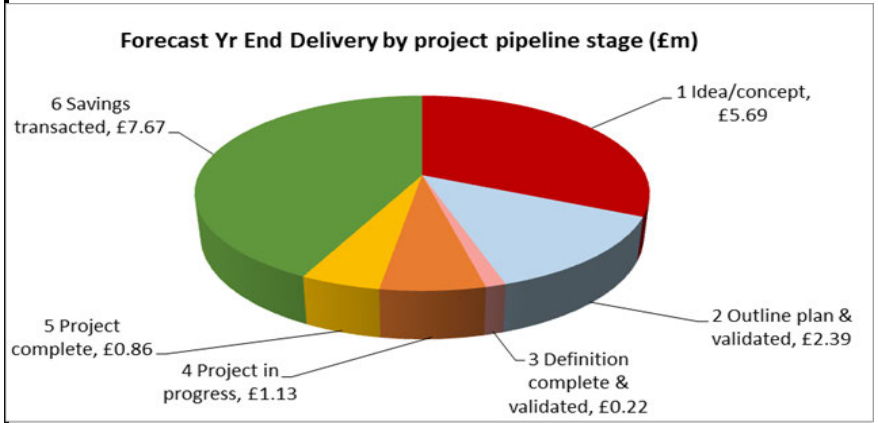
CIP- Delivery Assurance - Yr end delivery forecast-

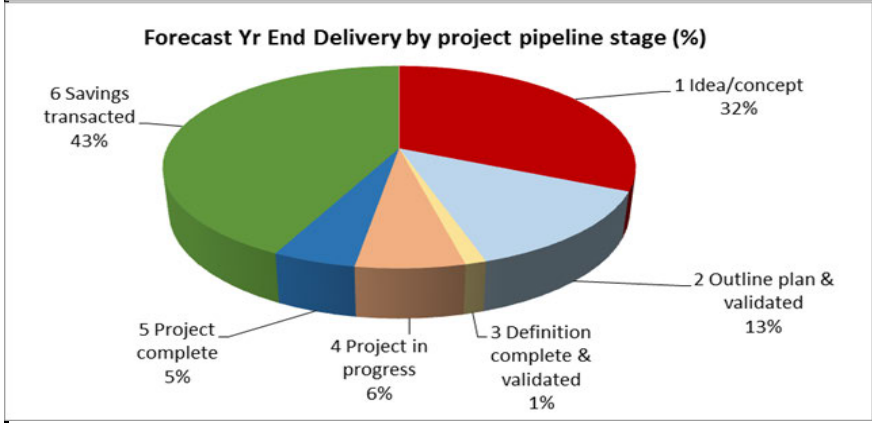
c) CIP Delivery Assurance- Route to Cash





d) CIP Delivery Assurance:- Pipeline stage





(c) CIP Delivery Assurance:- Route to Cash

We have seen a £4m net increase in forecast year end delivery this month, much of this is yet to have route to cash assesment made (showing as grey). Good progress continues to be made in moving projects to "Green" RAG and only 8% of projects remain in Red and Amber RTC..

(d) CIP Delivery Assurance:- Pipeline stage

Of the projects comprising the £18m forecast delivery:

£8.53m (48%) of projects are either Complete, and delivering savings or in "Delivery" stage whereby the project is finalised but savings awaited.

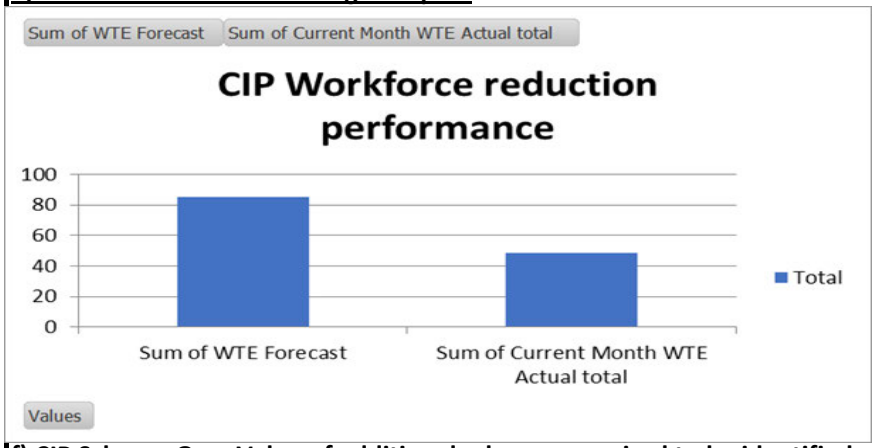
£1.13m (6%) relates to schemes which are in progress.

£5.91m (33%) relates to schemes where definitions are complete and validated.

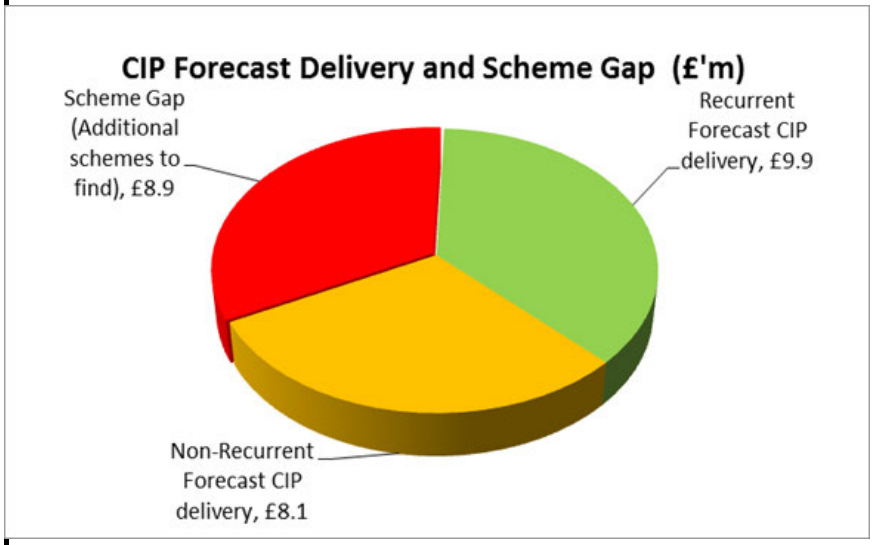
The remaining 13% of projects remain as Ideas or Outline plans that have been validated.
This represents a good level of progress so early in the year, albeit that there is a need for additional projects to be identified to close the Scheme Gap.

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

The graph identifies that we have forecasted the removal of 48 wte posts against the forecast of 85wte from the projects identified so far.

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

Presuming the forecast delivery value identified delivers at £18m, there is a need to identify £8.9m of further savings schemes.

This can be partially mitigated through identifying oportunities 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 deliviery.

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2017/18
QUALITY LOCAL FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		96.1%	97.3%	95.9%	96.3%	96.0%	97.2%	96.4%	97.1%	96.2%	96.4%	97.8%	95.3%	97.1%	96.2%
1	Reported Incidents - Major + Catastrophic *	<6		4	1	1	2	1	2	0	0	4	3	3	1	3	4
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		1	1	0	2	0	0	1	1	2	0	2	0		0
1	Never Events	0		0	0	0	0	0	0	0	0	0	0	1	0	0	0
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		4	4	7	8	3	5	2	2	9	2	5	2	3	5
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		0	0	0	0	0	0	0	1	1	0	0	0	0	0
1	Formal Complaints - Number Received *	<60		32	31	33	22	22	38	24	17	37	15	27	24	23	47
1	VTE - Risk assessment on admission - (Acute)	>95%		93.7%	93.6%	92.4%	92.9%	88.0%	92.3%	92.6%	88.9%	93.0%	90.8%	86.0%	93.5%	89.3%	91.3%
1	VTE - Risk assessment on admission - (Community)	>95%		96.5%	100.0%	96.9%	96.4%	97.9%	100.0%	97.5%	96.1%	98.9%	94.6%	100.0%	97.8%	97.9%	97.8%
1	Medication errors resulting in moderate to catastrophic harm	0		1	0	1	0	0	0	0	0	2	1	0	1	2	3
1	Medication errors - Total reported incidents (trust at fault)	N/A		76	37	64	43	68	64	48	42	55	49	40	42	47	89
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears	<100%		95.5%	76.9%	100.5%	82.3%	94.4%	93.8%	96.6%	76.6%	89.5%	109.5%				94.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		100.0%	100.8%	98.4%	95.5%	100.0%	107.3%	104.2%	106.6%	105.2%	104.3%	106.6%	105.6%	107.3%	106.4%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		97.4%	98.5%	95.6%	101.6%	101.4%	106.6%	101.7%	105.6%	105.8%	100.4%	103.9%	103.2%	106.6%	104.9%
1	Infection Control - Bed Closures - (Acute) *	<100		24	12	18	18	12	30	130	8	198	544	64	6	4	10
1	Hand Hygiene	>95%		99%	91%	96%	95%	99%	98%	96%	95%	89%	96%	91%	97%	94%	96%
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		79.3%	86.1%	82.4%	71.0%	73.5%	68.6%	76.3%	71.4%	75.6%	71.0%	80.0%	79.4%	78.8%	79.1%
1	Stroke patients spending 90% of time on a stroke ward	>80%		57.1%	84.5%	95.6%	86.0%	77.1%	79.4%	83.3%	72.5%	84.4%	66.7%	92.3%	77.8%	75.0%	77.1%
1	Follow ups 6 weeks past to be seen date (excluding Audiology)	3500		6550	6999	7209	7496	7477	6790	6308	7041	6630	6761	7301	7323	7042	7042

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2017/18
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears) Rolling 12 months	<3.8%		4.23%	4.19%	4.17%	4.14%	4.11%	4.09%	4.07%	4.09%	4.14%	4.18%	3.96%	3.70%		3.70%
2	Appraisal Completeness	>90%		81.00%	81.66%	81.66%	81.00%	82.00%	82.00%	82.00%	81.00%	78.00%	78.00%	79.00%	81.00%	80.00%	80.00%
2	Mandatory Training Compliance	>85%		84.00%	83.86%	83.00%	83.00%	83.00%	83.00%	83.00%	83.00%	82.79%	83.24%	85.00%	83.00%	82.00%	82.00%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		12.73%	12.30%	12.64%	12.37%	12.39%	12.32%	12.34%	12.53%	12.09%	11.67%	11.25%	10.89%	10.85%	10.85%
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges (Community) *	16/17 Avg 315		72	261	225	211	445	401	340	348	272	267	206	288	215	503
1	Number of Delayed Transfer of Care (Acute)	16/17 Avg 64		144	230	159	185	172	177	197	165	218	144	128	182	228	410
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		72.9%	73.9%	74.6%	75.9%	77.2%	78.3%	79.1%	79.1%	79.0%	78.5%	79.0%	78.6%	77.6%	78.6%
3	Clients receiving Self Directed Care	>90%		92.8%	92.6%	92.8%	92.9%	93.6%	93.1%	93.2%	92.8%	92.3%	92.5%	92.6%	92.6%	93.7%	92.6%
2	Carers Assessments Completed year to date	40% (Year end)		8.7%	17.0%	20.7%	24.8%	31.1%	33.9%	34.5%	35.9%	38.1%	41.1%	42.2%	1.4%	3.1%	1.4%
	Carers Assessment trajectory			7.2%	10.8%	14.3%	17.9%	21.5%	25.1%	28.7%	32.3%	35.8%	39.4%	43.0%	3.0%	6.0%	6.0%
3	Number of Permanent Care Home Placements	<=617 (Year end)		629	619	634	637	638	632	637	634	629	608	604	602	605	605
	Number of Permanent Care Home Placements trajectory			637	635	633	631	629	627	625	623	621	619	617	630	630	630
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		240	239	238	248	254	235	198	176	160	155	150	146		146
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET			80			156			232			342			342
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET			8.4%			7.9%			7.8%			8.0%			8.0%
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%		
1	Bed Occupancy	80% - 90%		91.3%	88.4%	80.7%	89.2%	93.2%	92.7%	93.2%	92.4%	93.1%	95.0%	92.6%	92.9%	94.6%	92.9%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		83.7%	94.1%	92.0%	100.0%	98.4%	100.0%	100.0%	98.9%	100.0%	98.3%	97.9%	98.5%	96.5%	98.5%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET		601	599	608	574	579	596	603	609	610	597	569	556	557	556
1	Intermediate Care - No. urgent referrals	113		179	181	182	181	151	200	204	171	222	187	161	201	151	352
1	Community Hospital - Admissions (non-stroke)	NONE SET		241	247	225	253	242	241	224	252	278	223	235	236	218	454

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-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%		90.1%	92.3%	93.9%	93.2%	89.9%	92.8%	92.9%	88.3%	83.8%	81.1%	80.6%	87.7%	86.7%	87.2%
	A&E - trajectory [STF]	>92%		90.0%	91.0%	92.0%	92.5%	93.5%	92.0%	92.2%	90.2%	89.9%	92.6%	95.0%	90.1%	92.1%	92.1%
1	Referral to treatment - % Incomplete pathways <18 wks	>92%		87.6%	86.4%	86.1%	85.2%	84.0%	84.0%	83.7%	82.2%	82.5%	82.4%	81.6%	81.7%	82.2%	82.2%
	RTT Trajectory			87.5%	88.0%	88.9%	89.4%	89.8%	90.7%	89.9%	89.3%	90.1%	90.0%	90.0%	82.2%	82.3%	82.3%
1	Cancer - 62-day wait for first treatment - 2ww referral	>85%		85.1%	84.0%	86.8%	79.2%	85.7%	83.9%	77.4%	82.4%	85.7%	83.1%	79.7%	82.5%	81.3%	81.9%
1	Diagnostic tests longer than the 6 week standard	<1%		2.2%	2.8%	3.0%	7.3%	3.9%	3.2%	2.4%	3.7%	5.4%	3.1%	8.9%	11.0%	5.9%	8.4%
1	Dementia - Find - monthly report	>90%		60.6%	54.9%	52.8%	62.4%	81.8%	78.6%	59.0%	65.5%	52.1%	70.8%	92.7%	99.2%	92.6%	94.1%
LOCAL PERFORMANCE FRAMEWORK 1																	
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<17 (year)		2	0	1	2	0	0	3	2	0	0	0	1	0	1
1	Cancer - Two week wait from referral to date 1st seen	>93%		81.8%	86.5%	74.3%	65.3%	61.1%	63.1%	70.4%	76.0%	77.7%	67.4%	71.7%	60.6%	55.7%	58.2%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		97.8%	94.8%	74.0%	17.1%	69.7%	94.7%	95.1%	93.2%	94.6%	97.6%	94.5%	93.4%	92.0%	92.6%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		99.4%	97.1%	98.8%	98.6%	98.9%	95.5%	95.0%	98.0%	90.8%	96.1%	98.1%	97.9%	96.53%	97.2%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		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%	100.0%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		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%	98.4%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		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%	100.0%
1	Cancer - 62-day wait for first treatment - screening	>90%		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%	100.0%
1	Cancer - Patient waiting longer than 104 days from 2ww				17	13	10	6	12	16	14	24	23	23	17	21	21
1	RTT 52 week wait incomplete pathway	0		18	21	15	19	16	26	36	42	29	33	34	43	53	53
1	Mixed sex accomodation breaches of standard	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%		1.4%	0.6%	0.7%	0.6%	1.0%	1.1%	0.7%	1.6%	0.9%	1.4%	4.5%	1.1%	1.4%	1.3%
1	Cancelled patients not treated within 28 days of cancellation *	0		2	7	4	3	3	4	3	1	13	5	21	16	6	22

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2017/18
LOCAL PERFORMANCE FRAMEWORK 2																	
1	Ambulance handover delays > 30 minutes	0		98	183	104	180	150	88	124	181	143	172	168	117	97	214
	Handovers > 30 minutes trajectory *			30	30	30	30	30	30	30	30	30	30	30	0	0	0
1	Ambulance handover delays > 60 minutes	0		2	4	12	17	10	6	5	18	10	20	13	3	11	14
1	A&E - patients seen within 4 hours DGH only	>95%		85.1%	88.1%	90.5%	89.9%	85.5%	89.7%	90.0%	84.0%	77.2%	72.8%	72.3%	81.8%	81.1%	81.5%
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%	99.9%	100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	0	0	0	0	0	0	1	8	3	6	1	0	1
1	Number of Clostridium Difficile cases - (Acute) *	<3		2	1	1	2	0	1	5	2	1	1	1	1	0	1
1	Number of Clostridium Difficile cases - (Community)	0		0	0	1	0	0	0	0	0	0	0	0	0	0	0
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		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%	70.4%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		33.4%	28.1%	33.6%	33.8%	38.5%	25.1%	35.9%	25.6%	28.0%	39.1%	28.6%	30.5%	34.6%	32.4%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		81.8%	81.8%	86.4%	86.4%	90.9%	86.4%	90.9%	90.9%	81.8%	90.9%	86.4%	81.8%	72.7%	77.3%
NHS I - FINANCE AND USE OF RESOURCES																	
4	Capital Service Cover	2		4	4	4	4	4	4	4	4	3	3	2	4	4	4
	Plan			4	4	4	4	4	4	3	3	3	2	2	4	4	4
4	Liquidity	4		4	4	4	4	4	4	4	4	3	3	3	3	3	3
	Plan			4	4	4	4	4	4	4	4	4	4	4	3	3	3
4	I&E Margin	1		4	4	4	4	4	3	3	3	2	2	1	4	4	4
	Plan			4	4	4	4	4	4	3	3	2	2	1	4	4	4
4	I&E Margin Variance from Plan			1	1	1	1	1	1	1	1	2	2	1	1	1	1
4	Variance from agency ceiling	1		1	1	1	1	1	1	1	1	1	1	1	3	3	3
	Plan			4	4	4	3	3	2	2	2	2	2	1	2	2	2
4	Overall Use of Resources Rating			3	3	3	3	3	3	3	3	2	2	2	3	3	3

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2017/18
FINANCE INDICATORS - LOCAL																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)			-261	389	-479	-732	-543	-1123	-2545	-3560	-4464	-5587	-3832	1469	664	
4	Agency - Variance to NHSI cap			2.72%	2.38%	2.00%	2.00%	1.41%	1.27%	1.09%	1.05%	0.89%	0.65%	0.44%	-0.50%	-0.50%	
4	CIP - Variance from PBR plan - cumulative (£'000's)			1093	1392	822	1942	1475	3114	3711	2813	2263	1565	3417	-820	-758	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)			4021	6106	7708	9560	11689	13770	14723	17672	19886	22110	22318	955	2413	
4	Distance from NHSI Control total (£'000's)			581	1696	1247	997	1503	1201	89	495	-15	-674	2287	1488	1486	
4	Risk Share actual income to date cumulative (£'000's)			-579	-192	-124	-98	0	0	0	0	0	0	0	0	0	

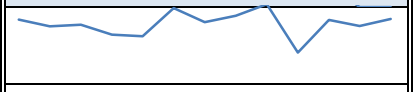
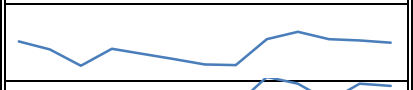
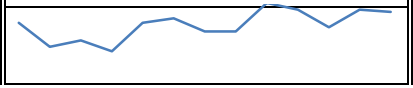
Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

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

INTEGRATED CARE MODEL																	
	Intermediate Care Referrals (All)			395	385	352	369	345	419	409	347	427	361	342	353	314	
	Intermediate Care GP Referrals			86	90	95	83	87	90	97	86	101	76	91	79	60	
	Average length of Intermediate Care episode			21.84	19.65	24.98	19.15	20.92	20.84	19.45	17.07	23.31	19.43	16.56	22.03	18.83	
	Total Bed Days Used (Over 70s)			9848	10385	8516	8689	9348	9337	10265	9505	11269	9965	10737	n/a	n/a	
	- Emergency Acute Hospital			5240	5671	4505	4942	5045	5090	5293	5281	6076	5811	5680	n/a	n/a	
	- Community Hospital			3000	2897	2576	2769	2935	2918	2963	2918	3427	2762	3051	n/a	n/a	
	- Intermediate Care			107	97	127	46	84	54	145	94	244	85	149	n/a	n/a	

Corporative Objective		Target 2018/2019	13 month trend	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year to date 2017/18
3	Number of Emergency Admissions - (Acute)			3148	3101	3111	3040	3030	3232	3130	3176	3258	2913	3145	3103	3152	6255
3	Average Length of Stay - Emergency Admissions - (Acute)			3.0	2.9	2.7	2.9	2.9	2.8	2.7	2.7	3.1	3.2	3.1	3.1	3.0	3.0
3	Hospital Stays > 30 Days - (Acute)			32	21	24	19	32	34	28	28	41	38	30	38	37	75

Cover sheet and summary for a report to the Trust Board					
Report title: Use of Resources				Date: 4th July 2018	
Report sponsor	Director of Finance				
Report author	Director of Finance				
Report provenance	This report has been considered by the Executive Directors and the Finance, Performance and Investment Committee.				
Confidentiality	This report is in the public domain.				
Report summary					
Purpose (choose 1 only)	**Note** ☒	**Information** ☐	**Review** ☐	**Decision** ☐	**Approve** ☐
Recommendation	The Board is asked to note that the Trust has been rated as **GOOD** in the Use of Resources assessment, as now published on the Care Quality Commission web site.				
Summary of key elements					
Strategic context	This report is relevant to the 'Well Led' corporate objective. In parallel with their inspection of the Well Led standard, the Care Quality Commission have, since 2017 undertaken a 'Use of Resources' review. The exercise compares levels of expenditure and performance against certain key efficiency indicators with other NHS and Foundation Trusts. The report, informed by a detailed comparative analysis and an in depth site visit conducted in February was published last week. The Trust has been awarded a rating of '**GOOD**'.				
Dependencies and risk	The report forms the final part of the Care Quality Commission's assessment of the Trust.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors, and • Finance, Performance and Investment Committee				
Stakeholder engagement	None				
Other standards affected	None				
Legal considerations	None				

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Liz Davenport, Interim Chief Executive
Torbay and South Devon NHS Foundation Trust
Torbay Hospital
Lawes Bridge
Torquay
Devon
TQ2 7AA

21 June 2018

Your account number: RA9
Our reference: INS2-4421814480

Care Quality Commission
Health and Social Care Act 2008
Use of Resources Assessment Report

Organisation name: Torbay and South Devon NHS Foundation Trust
Organisation ID: RA9

Dear Ms Davenport

Following our recent inspection of Torbay and South Devon NHS Foundation Trust we have enclosed a copy of our report of the findings. This report includes our rating of the care provided. Please make this report readily available for people who use the service.

We reviewed your comments relating to any factual inaccuracies in the draft report and have made a number of changes in the enclosed report. You can review our responses to your factual accuracy comments in the enclosed factual accuracy form.

We will publish this report on our website. When we have published this report you can see the contents and download a PDF version by clicking on this link.

www.cqc.org.uk/Provider/RA9

Once published, you can see this at any time by following these steps:

- Go to the CQC website www.cqc.org.uk.
- Click the appropriate tab for your type of service.
- Type in the name of your trust or hospital – if it appears automatically, click on it to jump to your profile page or click the 'search' button.

- Click on your trust or hospital, your report will be on your profile page.

Following the publication of your inspection report(s), a request for review can subsequently be made regarding **the approach to the ratings' process only**, purely in relation to how the ratings decisions were made and aggregated. If you think that we have not followed this process you can request a review. You must first tell us within 5 working days of the publication of your report(s) that you intend to request a review by submitting this online form:

http://webdataforms.cqc.org.uk/Checkbox/IntentionRequestReviewRating.aspx

You will then be provided with instructions on how to submit your full request for review. Any request for review will need to be submitted within 15 working days of publication of the report.

Post-Inspection Survey

Around 4-12 weeks after you have received your final inspection report CQC may email an invitation to take part in our Post-Inspection Survey**.** The email will usually be sent to the registered manager or registered person (e.g. nominated individual, partner, responsible individual). This is your opportunity to share your feedback on the inspection experience so we strongly encourage you to respond. We anonymise and amalgamate these survey findings and use them to help us learn and improve what we do. Some of the findings are also used for the CQC's public performance reporting.

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please include our reference number (INS2-4421814480) in any letter or email you send with the report.

Yours sincerely

Professor Ted Baker
Chief Inspector of Hospitals

Cc: Mary Cridge Head of Hospital Inspection

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Torbay and South Devon NHS Foundation Trust

Use of Resources assessment report

Lowes Bridge, Torquay, TQ2 7AA

Tel: 01803 614567
www.torbayandsouthdevon.nhs.uk/contact-us/

Date of site visit:
23 February 2018

Date of Publication:
26 June 2018

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

The Use of Resources rating for this trust is published by CQC alongside its other trust-level The trust has a significant level of backlog maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). Whilst the trust does not currently have the funding available to address all of this, it does have a prioritised risk-based capital plan, which is recognised at board level.

Proposed rating for this trust	**Good**

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 23 February 2018 and met the trust's executive team (including the interim chief executive), a non-executive director (in this case, the chair) and relevant senior managers responsible for the areas under this assessment's key lines of enquiry (KLOEs).

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Findings

Is the trust using its resources productively to maximise patient benefit?	Good ●

We rated use of resources as good because the trust demonstrated that it has used its resources effectively to deliver care to patients in an integrated care setting.

- We rated the trust's use of resources as good.
- The trust was one of the first integrated care organisations in the country, and provides acute, community health and social care services.
- The trust is part of a mature Sustainability and Transformation Partnership (STP) and has agreed a risk share arrangement with South Devon and Torbay Clinical Commissioning Group (CCG) and Torbay Council to promote provision of health and social care within a community setting.
- The trust is forecasting achievement of its financial plan for 2017/18. This includes delivery of £41.7m CIP, of which, £29.2m is recurrent CIP, which is a significant increase on previous years.
- The trust has one of the lowest Did Not Attend (DNA) rates in the country at 5.5%.
- The trust's pre-procedure elective bed days are slightly lower than the national median and it has reduced its length of stay throughout 2016/17 and 2017/18 whilst also reducing its bed base by 99 beds across its acute and community hospitals.
- The trust benchmarks well nationally for workforce metrics including high retention and low rates of sickness.
- Overall cost per Weighted Activity Unit (WAU) is in the 1st (best) quartile when compared nationally.
- The trust has a significant level of backlog maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). Whilst the trust does not currently have the funding available to address all of this, it does have a prioritised risk-based capital plan, which is recognised at board level.

However:

- The rate of emergency readmissions within 30 days (10.68%) is high compared to the national average. The trust had identified this and is undertaking a case note review to understand the drivers of emergency readmissions, particularly to understand whether it is a consequence if its integrated care model. As such, the trust is not yet able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.'
- The trust recognises that it could improve its granular understanding of activity within its integrated care model, specifically within non-elective and community care and the impact this has on its performance and use of resources.The trust reports that financing the introduction of community based IT systems will be critical in this endeavour.
- £10.5m of the trust's CIP achievement in 2017/18 will be non-recurrent.
- The trust is in the highest (worst) quartile against the national median for pre-procedure non-elective bed days at 0.99 days against the national median of 0.78.

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How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

- The trust has low DNA rates and benchmarks in the lowest (best) quartile for this metric at 5.5%. Since 2015, the trust has provided a text reminder service for patient appointments and reduced booking follow up appointments significantly in advance.
- The trust has pre-procedure elective bed days of 0.12 days, which is slightly better than the national median of 0.13.
- The trust's A&E performance in December 2017 was 88% against the 95% target; it met its Quarter 3 STF agreed trajectory of 91%.
- The trust has a number of interventions in place to reduce attendance at A&E. These include: use of a phone application that tells patients the waiting times at other services; allowing patients deciding to go elsewhere to exit the hospital carpark without paying; GPs within one locality working with nursing homes; multi-disciplinary teams including social care; and seven day services.
- The trust has engaged with the Get It Right First Time (GIRFT) team and has also agreed to compare results by specialities with other providers within the STP.
- The trust has a 30 day emergency readmissions rate of 10.68% which is among the highest rates in the country. The trust has taken some action in this area by conducting a coding review, which concluded that data issues are not affecting performance against this metric. It is now undertaking a case note review to understand the drivers of emergency readmissions on an individual patient level. At the time of the assessment, this review was not complete and the trust was not able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.
- The trust has pre-procedure non-elective bed days of 0.99 against the national median of 0.78. The trust is carrying out further analysis as to whether non-elective bed days are being overstated by patients transferring between community wards and its acute site.
- The trust's performance against the 62 day cancer metric has been declining from 83.3% in October 2016 to 77.7% in November 2017. The trust has experienced pressures particularly within urology and colorectal and is reviewing clinic templates and looking at ways to smooth capacity and demand across the patch including using diagnostic capacity from the independent sector.
- Referral to Treatment (RTT) performance was 82% in December 2017 against a national position of 87%. The trust is carrying out weekly reviews of patients in pressure areas and is re-directing resources accordingly, putting on additional sessions in urology and upper GI.
- Challenges were reported by the trust in diagnostic imaging capacity. This is linked to ageing equipment and a high risk of equipment breakdown which consequently reduces capacity and consequently the delivery of diagnostic standards. The trust has a defined equipment replacement programme, but this is dependent on capital availability.
- The trust reports that it faces workforce challenges within its histopathology service but feels it has proactively responded to these challenges through collaboration with neighbouring trusts and involvement in the delivery of a regional approach to service provision.

How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

- The trust performs well against workforce metrics with a staff retention rate of 87.69% which is higher than the national median. In addition, the trust's sickness rate is 3.62% which is marginally below the national average of 4%. The trust reports that it is aware of

the age and retirement profile of its workforce and is reviewing potential mitigations against the risk of future vacancy risks. This includes recruiting nurses internationally and working collaboratively with the STP to support medical vacancy pressures specifically in areas such as histopathology. The trust has also engaged with the local voluntary and charitable sector, to offer training and access opportunities to students and those already working in care settings.

- The trust's total pay cost per WAU is £1,883, putting it in the lowest (best) quartile and within this total both medical and nursing costs per WAU are below the national average. The Allied Health Professionals (AHP) cohort pay cost per WAU is £155, putting it in the highest quartile, but the trust reports this is a planned consequence of the its integrated care model, which includes increasing multi-disciplinary teams in the community and advanced practice roles, which results in higher AHP to nursing ratios.
- The trust reduced its bed base by 41 acute beds and 58 community beds during 2016/17 and 2017/18 and this has allowed it to review and consolidate its staffing levels. The trust has remained within the agency ceiling set by NHS Improvement throughout 2017/18.
- The trust reduced its pay bill from 2016/17 and 2017/18 and has seen a reduction in its pay expenditure run rate of approximately £800,000 a month between April and December 2017.
- The trust is in the process of moving to an improved electronic rostering system for nursing, which includes a safety module that has the ability to monitor safe staffing and acuity levels on a twice-daily basis.
- The trust acknowledges that consultant job plans are an area it can improve by increasing the number of consultants with an agreed job plan. The trust is currently undertaking a review of the job planning approach to improve compliance and efficiency.

How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?

- The trust benchmarks within the lowest quartile against the national median for pathology costs per test at £1.40 per test against an average STP peer group cost per test of £2.05 per test. The trust reports that it has achieved this by utilising advances in technology, which have enabled staffing levels and skill mixes to be reviewed and adjusted.
- The trust delivered 128% of its savings target on the top 10 medicines between April to December 2017, putting it at the higher end of achievement in this area across the country. The Trust holds 20 days of stock and is planning to reduce this further to 15 days to better manage stock efficiency.
- The trust is increasingly using technology such as video-conferencing facilities for staff to staff communication across its wide geographic community locale. In addition, the trust has utilised this for patient contact and considering a wider roll-out of this approach.
- The trust uses a paper based system to record activity within its community services. The trust is exploring opportunities to implement technology in this area to improve efficiency but this is dependent on capital funding.The trust's acute and community systems are not fully integrated; the trust has a clinical portal in place to enable communication which is under on-going development.
- The trust does not use electronic prescribing other than within chemotherapy. The trust reports that a community wide electronic prescribing system has been procured and is in implementation.The trust's locality pharmacists are prescribers and all trained pharmacists will be trained as prescribers in the future. There remains, however, a time lag between pharmacists qualifying and becoming prescribers, which would support the trust to speed up discharge, improve uptake of medicines by patients and reduce medicine errors.

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How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

- The trust benchmarks within the highest (worst) quarter for total non-pay costs per WAU. It has asserted that this metric is adversely affected by the inclusion of costs associated with running a pharmaceutical manufacturing unit and the provision of adult social care which are not comparable to most other trusts. Taking these costs out would result in its non-pay costs reducing towards the national median.
- Based upon a national data collection looking at costs in 2015/16, the trust's finance cost per £100m of turnover is above the national average (in the third quartile). However, the finance costs reported by the trust include overheads for social care services and a pharmaceutical manufacturing unit which are not incurred by other trusts and should be excluded for the purposes of comparison. If these costs are removed the trust's finance costs benchmark favourably against other trusts.
- HR costs per £100m of turnover are below average but as with finance costs, these also include cost elements that should be removed for the purposes of comparison and so the true picture will be better than indicated.
- The trust report that it has in the past market tested outsourcing its corporate services functions but could not find a supplier that was able to provide the services more efficiently.
- The trust provides payroll services both in-house and for several other NHS and independent organisations in the South West and while its cost per payslip is higher than the national average this is skewed by the costs of payslips provided for other organisations.
- The trust benchmarks as average against the national median for procurement costs.The trust is part of the Peninsula Purchasing and Supply Alliance which delivers procurement support across the South West. Based on a set of procurement processes and performance measures, the trust lies above the national mean. On price metrics the trust performs well demonstrating that it pays lower than average prices for comparable goods and services. The trust's process metrics are weaker though, partly driven by a lower percentage of non-pay spend being submitted for national benchmarking. However, this figure is again distorted by the trust having significant non-pay social care costs which should be adjusted for. If adjustments were made, the trust would be much closer to the national mean.
- Based on 2016/17 data, overall estates and facilities costs per square meter was above the national average at £336 per square metre compared with £326 per square metre but this does include relatively higher cost and more dispersed community services facilities, some of which have now been closed and will be sold. This should bring the trust below the average in future years.
- Estates and Facilities Management is provided in-house and services such as cleaning are higher than the national average. This includes a 24 hour Deep Clean team that supports out of hours discharge and cleaning of beds and single rooms. The trust asserts that its small bed base necessitates a responsive in-house team to clean beds quickly for other patients to use.
- The trust has identified energy as an area where it can improve efficiency with potential opportunities of around £400,000 based on 2016/17 data. It is currently seeking a strategic estates partner who it hopes can help in this area.
- The trust has significant levels of backlog maintenance within its capital expenditure plan and this is an area of concern for the Board. This reflects the estate's age; specifically within theatres, the air-handling unit and the emergency department (ED). In addition, the trust highlighted cyber-security as an area requiring investment.
- The trust has limited its capital expenditure to available cash and has made an STP capital

funding bid for ED provision.

How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

- The trust did not achieve its £2.3m surplus control total in 2016/17 and reported an £11m deficit for the year. Within this position, the Trust delivered £11.4m CIP, of which, £7.8m was recurrent and £3.6m non-recurrent.
- The trust has improved its financial performance in 2017/18 and is forecasting delivery of its 2017/18 financial plan and £4.7m surplus control total. This position includes forecast delivery of £41.7m of CIP, £29.2m of which is recurrent.
- A project management office (PMO) is in place to monitor savings and efficiencies at system, trust and division levels and a business support manager sits within each division. The trust implemented a cost-efficient and focused approach to establishing its PMO utilising external support in a targeted way which has maximised the delivery of savings.
- The trust is part of a mature STP which includes joint management of control totals, system wide savings plans, a joint review of acute services and mutual support in areas of pressure. Providers and commissioners within the STP have recently taken part in an open book 'peer review' process involving agreeing principles for financial planning, sharing draft financial plans and giving and receiving feedback on these.
- The trust has significant levels of backlog maintenance within its capital expenditure plan and this is an area of concern for the Board. In addition, the trust has stated its requirement for capital funding to support digital technology solutions within both corporate and clinical support services that it believes will unlock capacity and efficiencies.
- The trust has Model Hospital Capital Service Capacity and Liquidity scores of 4; the lowest on the Single Oversight Framework. It has an £11m working capital facility that it has not accessed to date.
- The trust has a pharmacy unit that makes sterile injectables and Total Parenteral Nutrition (TPN) TPN compounds. The unit makes a significant commercial income contribution to the trust and has a growth business plan in the medium term. In addition, the trust has a retail pharmacy unit which is a wholly owned subsidiary.
- The trust has patient level costing (PLCs) in place but does not include PLCs or service level reporting within its monthly reporting on the basis that it could distract from the emphasis on integration.

Outstanding practice

- Over the last two years, the trust has developed its integrated care model, increasing capacity within multi-disciplinary health and social care teams working with patients in the community and engaging the voluntary and third sectors. The trust has reduced its length of stay within community hospitals whilst closing beds in both its acute and community hospitals.
- The trust effectively uses a text message alert system for appointments and has one of the lowest DNAs in the country.

Areas for improvement

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- The trust has an emergency readmissions rate of 10.68% which is higher than its peer average and had further work to do to understand the drivers of readmissions and to be assured that this does not reflect a high risk of harm to patients.
- The trust has a capital expenditure plan with significant levels of backlog maintenance of £222 per square metre against a benchmark of £63. The trust has limited capital funding available and should develop a risk-based prioritised list of capital projects. The trust is seeking a strategic estates partner that can assist it in identifying efficiency opportunities.
- The trust could improve its understanding of activity within its integrated care model and specifically within non-elective and community care.
- Reviewing and updating consultant job plans to ensure the effective and productive use of the consultant workforce is an ongoing area of work for the trust. The trust acknowledges that its systems for recording community and acute activity are not integrated and that digital mobile technology would enable community teams to record activity and notes in situ. The trust is working to secure capital investment in its IT infrastructure.

Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service

	referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during

	the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.

Press F7 for spell check

Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs
Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework helps NHS Improvement identify NHS providers' potential support needs across five themes of quality of care, financial and use of resources, operational performance, strategic change, leadership and improvement capability.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.

Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit	The weighted activity unit (WAU) is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

Factual accuracy comments form for the draft report

Please complete this form and return:
By email to: HSCA_Compliance@cqc.org.uk or
By post to: CQC HSCA Compliance, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Account Number:	RA9
Our reference:	INS2-4421814480
Provider name:	Torbay and South Devon NHS Foundation Trust
Provider address:	Torbay Hospital, Lawes Bridge, Torquay, TQ2 7AA

Completed by (name(s))	Paul Cooper
Position(s)	Director of Finance
Date	7th June 2018

Use of Resources Report

Issue – eg typographical/numerical/other challenges or additional evidence (see sections A, B and C for descriptors)	**Page No**	**Key Question**	**Please describe the factual inaccuracy and provide copies of any additional evidence which you consider should be taken into account in the report.** *Evidence must relate to the position on the day of inspection.*	**Decision** ✓or X	**Response**
B Contextual	2	Summary Bullet point 8	In interview the Trust made clear that it had identified the potential link between emergency readmissions and the care model and that an audit process was underway. We suggest an amended wording as follows to reflect that: 'The rate of emergency readmissions within 30 days (10.68%) is high compared to the national average. The trust had identified this and is undertaking a case note review to understand the drivers of emergency readmissions, particularly to understand whether it is a consequence if its integrated care model. As such, the trust is not yet able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.'	✓	Accepted and amended.
B Contextual	2	Summary Bullet point 9	In interview, the Trust described a need for external funding to be secured in order to develop a fully risk assessed capital programme. We suggest an amended wording as follows to reflect that:	✓	After clarification with the trust, this has been amended to: • The trust has a significant level of backlog

			'The trust has a significant level of backlog maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). The trust has yet to secure sufficient capital resources and, therefore was not able to clearly articulate a risk-based capital prioritisation considering limited available capital funding.'		maintenance within its capital expenditure plan (£222 per square metre compared to a benchmark of £63 per square metre). Whilst the trust does not currently have the funding available to address all of this, it does have a prioritised risk-based capital plan, which is recognised at board level. Moved above 'however' section.
B Contextual	3	Summary Bullet point 10	In interview the Trust shared headline performance data but recognised that, without securing funging to invest in community based IT, a definitive proof of its care model would be difficult to achieve. We suggest an amended wording as follows to reflect that: 'Whilst publishing headline productivity data, the trust recognises that it needs to demonstrate a more granular understanding of activity within its integrated care model, specifically within community care and the impact this has on its performance and use of resources. Financing the introduction of community based IT systems will be critical in this endeavour.'	✓ partially	Changed to: 'The trust recognises that it could improve its granular understanding of activity within its integrated care model, specifically within non-elective and community care and the impact this has on its performance and use of resources.The trust reports that financing the introduction of community based IT systems will be critical in this endeavour. '
A Typographical	3	Clinical Bullet	Propose that 'December 2017/18' be replaced with 'December 2017' to ensure consistency throughout the report.	✓	Corrected.

		point 3			
B Contextual	3	Clinical Bullet point 4	In interview the Trust made clear that it had identified the potential link between emergency readmissions and the care model and that an audit process was underway. We suggest an amended wording as follows to reflect that: 'The trust has a 30 day emergency readmissions rate of 10.68% which is among the highest rates in the country. The trust has taken some action in this area by conducting a coding review, which concluded that data issues are not affecting performance against this metric. It is now undertaking a case note review to understand the drivers of emergency readmissions on an individual patient level. Until this review is completed, the trust is not able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care.'	✓ Partial	Amended to, 'At the time of the assessment, this review was not complete and the trust was not able to demonstrate a full understanding of the drivers behind this, including the link to discharges, or the potential impact on patient care. '
A Numerical Error	3	Clinical Bullet point 6	The 62 day cancer performance reported in the document is different to that held in the Trust's performance report. The performance report shows 77.4% rather than the 76.5% included in the assessment.	✓	Original had performance by number of cases rather than percentage. This has been corrected as as the October 2016 figure.
A Typographical	4	Workforce Bullet	Text reads: '….this has enabled it to review consolidate its staffing levels….'	✓	Corrected spelling/grammar.

		point 4	Suggested amendment: '…. this has enabled it to review and consolidate its staffing levels….'		
A Correction	4	Workforce	The report states that the Trust is moving to an electronic rostering system. The Trust already uses an electronic system and is, in fact moving to an improved, more user friendly system with better functionality. We suggest an amended wording as follows to reflect that: 'The trust is in the process of moving to an improved electronic rostering system for nursing, which includes a safety module that has the ability to monitor safe staffing and acuity levels on a twice-daily basis.'	✓	Accepted and amended.
B Contextual	4	Clinical support	The report does not mention that the Trust has procured and is in the process of implementing an electronic prescribing system. We suggest an amended wording as follows to reflect that: 'The trust does not use electronic prescribing other than within chemotherapy. A community wide electronic prescribing system has been procured and is in implementation. The trust's locality pharmacists are prescribers and all trained pharmacists will be trained as prescribers in the future. There remains, however, a time lag between pharmacists qualifying and becoming prescribers, which would support the trust to speed up discharge, improve uptake of medicines by patients and reduce medicine errors.'	✓	Updated to reflect that 'the trust reports that a community wide electronic prescribing system has been procured and is in implementation'.

B Contextual	6	Areas for Improvement Bullet point 3	At interview the Trust emphasised the need to secure capital investment in community IT systems. We suggest an amended wording as follows to reflect that: 'Reviewing and updating consultant job plans to ensure the effective and productive use of the consultant workforce is an ongoing area of work for the trust. The trust acknowledges that its systems for recording community and acute activity are not integrated and that digital mobile technology would enable community teams to record activity and notes in situ. The trust is working to secure capital investment in its IT infrastructure.'	✓	Accepted and amended.

CQC/NHSI use only

Responses prepared by (name)	J Crocker
Role	Finance Lead (Devon and Cornwall). Part of the assessment team.
Date	11/06/18
Responses reviewed by (name)	S Maunder
Role	Head of Finance (South West South)
Date	15/06/18

Cover sheet and summary for a report to the trust board		
Report title: Annual Infection , Prevention & Control Report		Date: 4th July 2018
Report sponsor	Chief Nurse	
Report author	Director of Infection, Prevention and Control	
Report provenance	Infection, Prevention & Control Group 21/6/18	
Confidentiality	Public	
Report summary	Under the Executive leadership of the Chief Nurse, the Infection Prevention and Control Team (IP&CT) of Torbay and South Devon NHS Foundation Trust (TSDFT) lead the strategy and operational support to prevent infection for the patient journey. The IP&CT provides advice, direction, audit, action plans, reporting and support in hospital and community based care. The IP&CT have liaised with the Locality Leads and have an IP&CT representative in each Locality. The IP&CT work within the NHS Operating Framework (NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm) providing assurances against the South Devon & Torbay Clinical Commissioning Group (SDTCCG) Healthcare Associated Infection commissioning intentions of November 2017. The Infection Prevention & Control Group (IP&CG) meet quarterly and ensure the IP&C Annual Forward Plan and the IP&C Strategy is followed. The IP&CG report to the Quality Improvement Group (QIG) each quarter. Issues are escalated to the Quality Assurance Committee (QAC) as appropriate. TSDFT IP&CT works closely with Public Health England (PHE) and a PHE consultant or nurse attends the IP&CG. The Trust reported zero MRSA blood stream infections (BSIs) from 1/4/17 to 31/3/18 and the Trust target was zero. Torbay Hospital reported 17 acute trust, attributable *Clostridium difficile* (*C difficile*) and 11 patients defined as a 'lapse in care', against a contractual target of 18 'lapses in care',(https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/). In 2016/17 there were 19 acute trust, attributable *Clostridium difficile* (*C difficile*) so there has been a reduction by two patients.	

Purpose (choose 1 only)	Note ☐	Information ☒	Review ☐	Decision ☐	Approve ☒
Recommendation	The cost pressure of flu' testing and control will be placed in next year's trust budget plans. A continued focus on the Saving Lives peripheral cannula and urinary catheter care audits & re-Audit until 95% compliance is reached. Ensure Hand Hygiene audits are submitted from all clinical areas in the hospitals and community care and that a standard of 95% is reached. IP&C still need to obtain IP&C assurances from the Community Service Delivery Unit (SDU) that all aspects of Care Homes, Community Nursing and Adult Social Care have IP&C integrated within their processes. The DH's ambition to reduce E.coli bloodstream infections by 50% by 2021 means that there is work required to set up systems to implement this change.				
Summary of key elements					
Strategic context	Highlight which This recommendation aims to support the following strategic/corporate objective(s): • Safe, quality care and best experience • Improved wellbeing through partnership • Valuing our workforce • Well-led				
Dependencies and risk	Available capital resources are insufficient to fund high risk/high priority infrastructure/ equipment requirements/ as per Corporate Risk Register. IP&C support Estates' decisions to: replace a non-compliant ventilation plant in Special Theatres and to build a sewage pipe stack in the tower block.				
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Infection Prevention & Control Group on 21/6/18				

Stakeholder engagement	The following stakeholders were consulted during the compilation of this report: • Members of the Infection, Prevention & Control Group. • Public Health England • Deputy Quality Lead of South Devon & Torbay Clinical Commissioning Group • A member of the trust Governors has overseen
Other standards affected	The recommendations made in this report will impact upon: • NHS Operating Framework - NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.
Legal considerations	An equality impact assessment has ensured that this report does not discriminate or disadvantage people whilst advancing equality. And does not affect particular 'Inclusion Health' groups less favourably than the general population. This reports complies with the legal framework provided by the Mental Capacity Act 2005 and supports the Code of Practice.

V. 21/6/18

Infection Prevention & Control Annual Report 2018/19

And Annual Plan 2018/19

S Hoque DIPC
L Kelly Lead IPCN

Ratified Infection Prevention and Control Committee June 2018
Board date July 2018

Contents

Summary

1. Introduction
2. *Clostridium difficile*
3. Norovirus and other viral gastroenteritis
4. Outbreaks and Serious Incidents Requiring Investigation
5. MRSA & MSSA bacteraemias
6. *E. coli* bacteraemias, ESBLs & CPEs
7. Seasonal Influenza
8. Performance of Infection Control against KPIs 2015/16
9. Report on Community based IP&C Activity
10. Antimicrobials
11. Decontamination
12. Water Safety
13. Critical Ventilation
14. Surveillance, Audit & Education
15. PHE's Fingertips Data for Benchmarking TSDFT.
16. Infection, Prevention & Control Annual plan for 2017/18
17. Torbay and South Devon Foundation Trust Infection Prevention and Control Strategy – April 2018 – March 2021

References

Appendices

Summary

The Infection Prevention & Control Team (IP&CT) work within the NHS Operating Framework (part of the NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm) providing assurances against the South Devon and Torbay Clinical Commissioning Group (SDTCCG) Healthcare Associated Infection commissioning intentions of November 2017.

The Infection Prevention & Control Group (IP&CG) meet every quarter and ensure the IP&C Annual Forward Plan and the IP&C Strategy is followed. The IP&CG report to the Quality Improvement Group quarterly. Exception reports from the Decontamination Group, the Environment Group, the Water Safety Group and the Joint Estates, Facilities & IP&C Group are received by the IP&CG. The IP&CT meet with Assistant Directors of Nursing (ADNs) from each Service Delivery Unit (SDU) each quarter to write a report for the IP&CG meeting.

TSDFT IP&CT works closely with Public Health England (PHE) and a PHE consultant or nurse attends the IP&CG and vice versa. The IP&CT are also members of the SDTCCG's HCAI Group. The Quality Lead of the SDTCCG reported the following, '*Torbay & South Devon NHS Foundation Trust Infection Prevention and Control team have worked collaboratively and proactively with the Clinical Commissioning Group and partner organisations over the last year to promote good quality infection prevention practices across our health and care system. The team have also improved their infection reviews and have undertaken thorough outbreak management when needed.'*

The Trust reported zero MRSA blood stream infections from 1/4/17 to 31/3/18 and the Trust target was zero. Torbay Hospital reported 17 acute trust, attributable *Clostridium difficile* (*C difficile*) and 11 patients defined as a 'lapse in care', against a contractual target of 18 'lapses in care'. (https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/). The Department of Health (DH) has charged the CCGs with an Ambition to reduce E. coli blood stream infections by 10% per year from 2017 to 2021 so although this is not TSDFT's immediate target the trust will aim to achieve this new target.

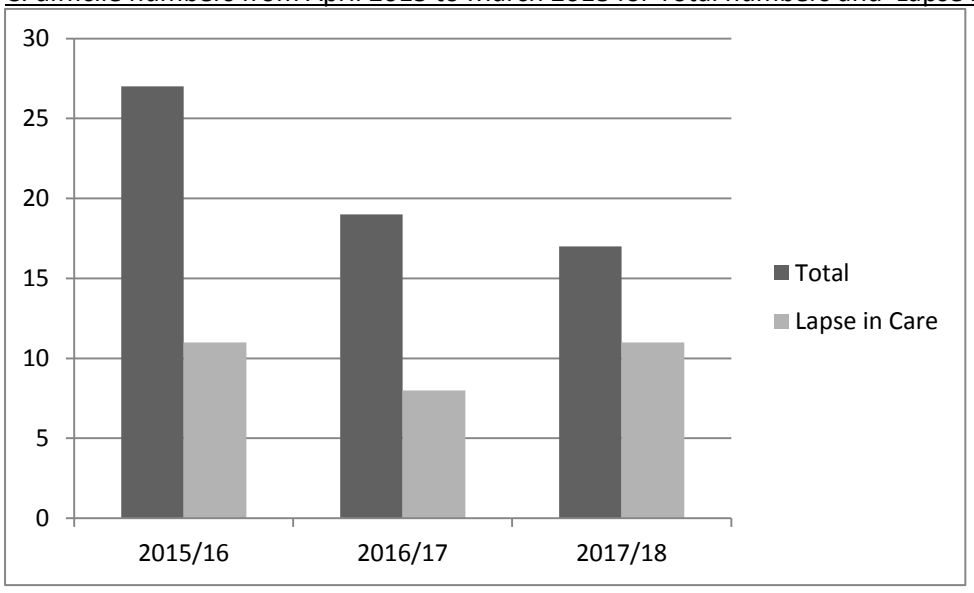
1. Introduction

The aim of this report is to provide assurance to the board on infection, prevention and control within the Integrated Care Organisation (ICO) as well as to patients, staff, public and Commissioners. The performance of the IP&CT and IP&C activities of TSDFT staff are reported in addition. The report also sets out the 2018/19 Annual plan, Key Performance Indicators (KPIs) and Strategy of the IP&CT.
The IP&CT consists of the Director of Infection Prevention & Control (DIPC) at 6 sessions a week, the Lead IP&C Nurse (Lead IP&CN), IP&C nurses & support staff;
Hospital based
0.8 8a (Lead IPCN)
2.0 band 7
2.6 band 6
3.0 band 4 TAPS/APS

2. *Clostridium difficile*

Targets for C. difficile:
The SDTCCG set the *C. difficile* toxin positive (CDT+) target measured by Enzyme Immunoassay (EIA), for Torbay Hospital, at no more than 18 'lapses in care' from 1/4/17 to 31/3/18. Torbay hospital had 11 'lapses in care'. For the Community hospitals an internal target of 4 'lapses in care' was set and there was one 'lapse in care'. All hospitals were within targets set for *C. difficile.*

C. difficile numbers from April 2015 to March 2018 for Total numbers and 'Lapse in Care' numbers.

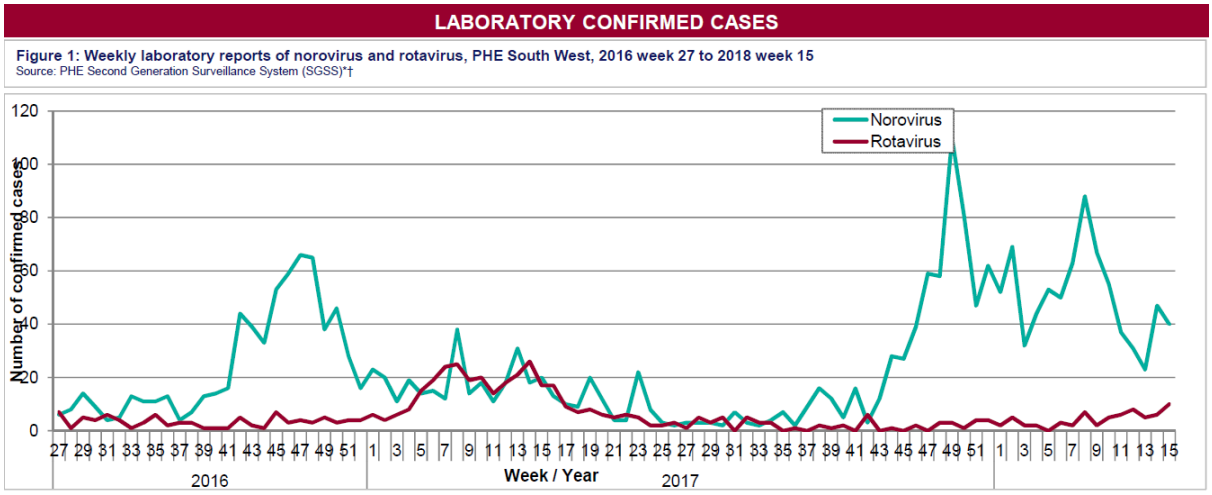


There has been one *C. difficile* outbreak defined as more than one patient with the same type of *C. difficile* on a ward within 28 days. This was on Allerton ward which resulted in 5 'lapses in care', because the side-room cleaning was not performed twice daily. There were two outbreak meetings and the actions from these included: the whole ward undergoing a

Deep Clean with Hydrogen Peroxide Vapour (HPV) in January 2018, the IP&CT initiating a programme of education for all of the trust's Domestic staff. In total from November 2017 to January 2018 there were 5 patients with *C. difficile* on Allerton and the typing on 4 patients was available and 2 strains of *C. difficile* were found in each of 2 patients. This means that there were 2 patients who acquired C. difficile from another patient on the ward.

3. Norovirus and other viral gastroenteritis

Much of the IP&C work to effectively risk manage Norovirus and other viral gastroenteritis is similar to that of *C. difficile* control. From April 2017 to March 2018 there were 7 ward closures (37 days total closure). This is similar to 2016/17 which had 10 ward closures (37 days total closure) and reassuring considering that the SW Norovirus activity was double in 2017/18 compared with 2016/17 (see PHE graph below).
Overall the KPI of individual ward closure for no more than 12 days was maintained. The IP&CT worked very closely with the Control Room and ward teams to achieve this.
The details are included in the Outbreak section below.



4. Outbreaks and Serious Incidents Requiring Investigation

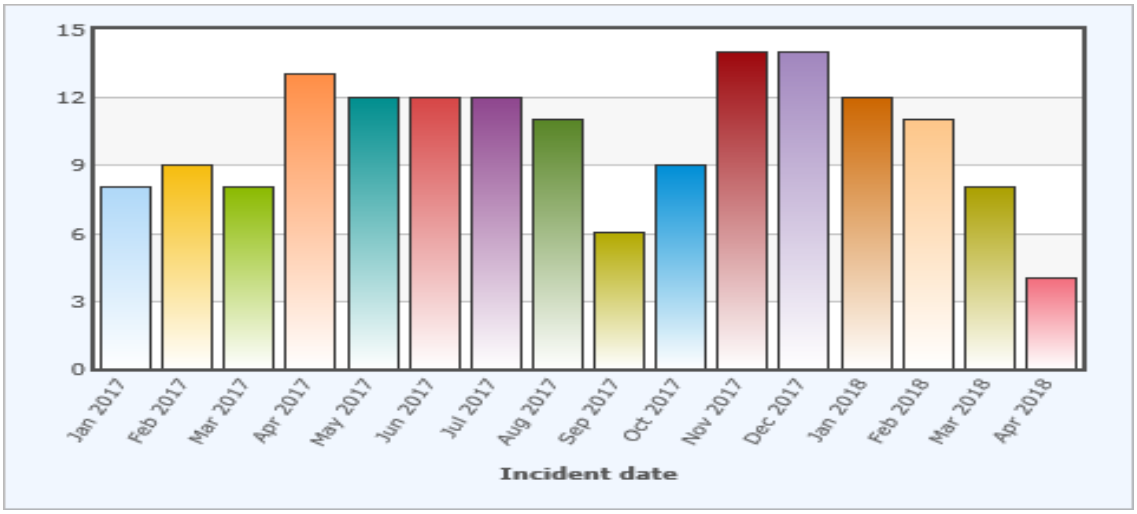
This was a challenging Winter with concurrent seasonal influenza and Norovirus which required tight surveillance, continuous risk assessments and correct deployment of cleaning resources to ensure that patients were safely placed and kept safe at all times. There were 9 Outbreak meetings from November 2017 to February 2018 and most were for Norovirus. There were only 2 Outbreak meetings addressing Influenza and this was because there were daily action plans made in the Control meetings for Influenza.

Hospital/ward	Main actions from Outbreak meetings	Actions completed
Allerton ward from November2017 to January2017 had 2 episodes of cross-infection due to *C. difficile.*	Review of cleaning schedules & IP&CT delivered training to Hotel Services staff.	Yes
Ainslie ward closure & Cromie ward bay closures in November2017 due to Norovirus.	Comms messaging to both trust and social media that Norovirus present in the trust and warnings about visiting if unwell, etc. Enhanced cleaning and terminal Deep clean.	Yes
Simpson ward closure in November2017 due to Norovirus.	Enhanced cleaning and terminal Deep clean.	Yes
Dart ward closure in December 2017 due to Influenza A diagnosed in 8 patients & 3 patients were transferred to Torbay.	Prophylaxis issued to non-infected patients. Commenced influenza risk-assessment tool for all patients. Introduced Point of Care Testing on EAU3. Enhanced cleaning and terminal Deep clean.	Yes
Simpson ward closure in January2018 due to Norovirus.	IP&CT tracked PHE site for affected Care homes and alerts taken to Control meeting. Enhanced cleaning and terminal Deep clean.	Yes
Teign ward closure in January2018 due to Norovirus.	Repeated Comms messaging to both trust and social media about staying away from the hospital until symptoms have resolved for 48 hours. Keep momentum with 'Packages of Care'. Request Rydon repair broken doors. Hand hygiene messages reinforced to staff. Enhanced cleaning and terminal Deep clean.	Yes
Ainslie ward closure in January2018 due to Norovirus.	All elective surgery cancelled. Daily SITREP & Exec briefings. Enhanced cleaning and terminal Deep clean.	Yes
Cheetham Hill & Dunlop wards closure in February2018 due to Norovirus.	Infected patients were moved to one ward and contacts kept separate from symptomatic patients. Enhanced cleaning and terminal Deep clean.	Yes
Influenza outbreak meeting in March2018.	Warrington ward had influenza patients and contacts in separate bays. EAU siderooms all filled with positive	Yes

	influenza A&B patients but still having 7 new influenza admissions per day. So cohort bays used. Enhanced cleaning and terminal Deep clean of all areas.	
Intensive Care Unit had cross infection with VRE in April2018.	All patients were screened and a total of 4 ICU patients had VRE but only 2 patients had the same type. Screening was performed for 4 weeks after the outbreak. Enhanced cleaning and terminal Deep clean.	Yes

Investigation of Sharps and Splash incidents

IP&C have assisted Health and Safety with the investigation, analysis and setting of action plans to reduce sharps and splash injuries from body fluids or substances containing body fluids. The work has involved liaising with Procurement and the Lead Diabetic nurse to update insulin sharp-safe equipment and with Horizon centre and the company representatives to roll out the education. Likewise for butterfly intravenous devices and the subcutaneous fluids needless system. This has resulted in a trustwide reduction in sharps and splash injuries thus greatly improving the well-being of staff.



5. MRSA & Meticillin Sensitive Staph. aureus (MSSA) blood stream infections

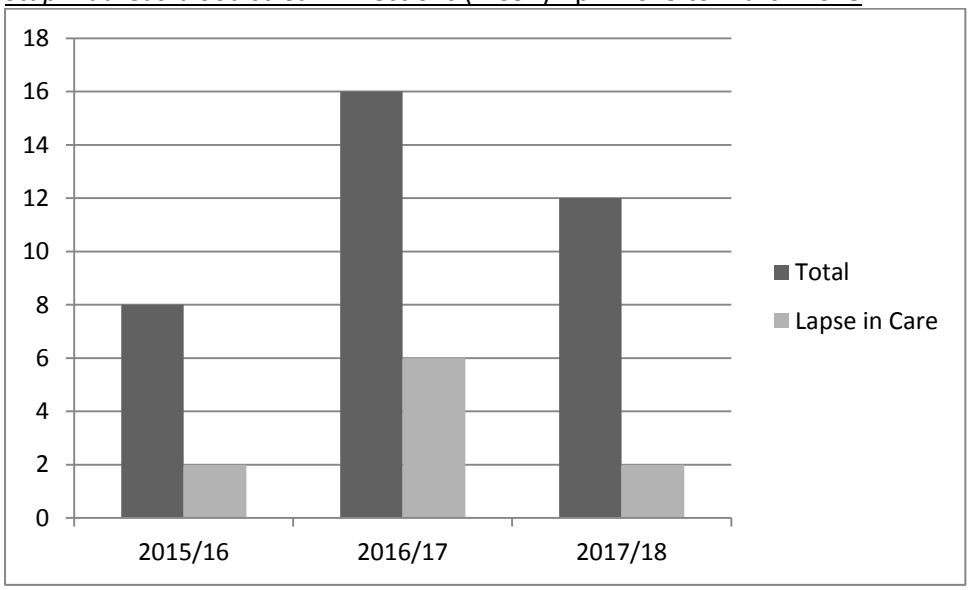
There have been zero, TSDFT acquired, MRSA bacteraemias.

There have been 12, TSDFT acquired, MSSA bacteraemias and KPI of a 5% reduction compared with last year was attained (target=15).
The root cause analyses (RCAs) concluded that the sources of the MSSA bacteraemias were:

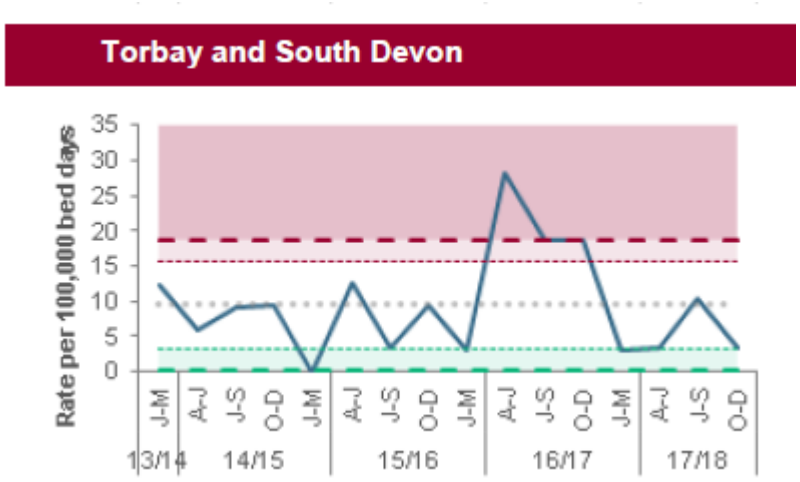
Cellulitis	3 patients
Infected eczema/ broken skin	2 patients
Hospital-acquired pneumonia	2 patients
Peripheral cannulae	2 patients
Spontaneous Bacterial Peritonitis	1 patient
Abscess	1 patient
Central venous catheter in place for 5 years	1 patient

The action plans of the RCAs are tabled at the IP&C Group Meetings and of the 12 TSDFT acquired bacteraemias it was deemed that 2 were a 'lapse in care'. This is an improvement from last year where 6 were a 'lapse in care', see graph below for a summary of the last 3 years.

Staph. aureus blood stream infections (MSSA) April 2015 to March 2018



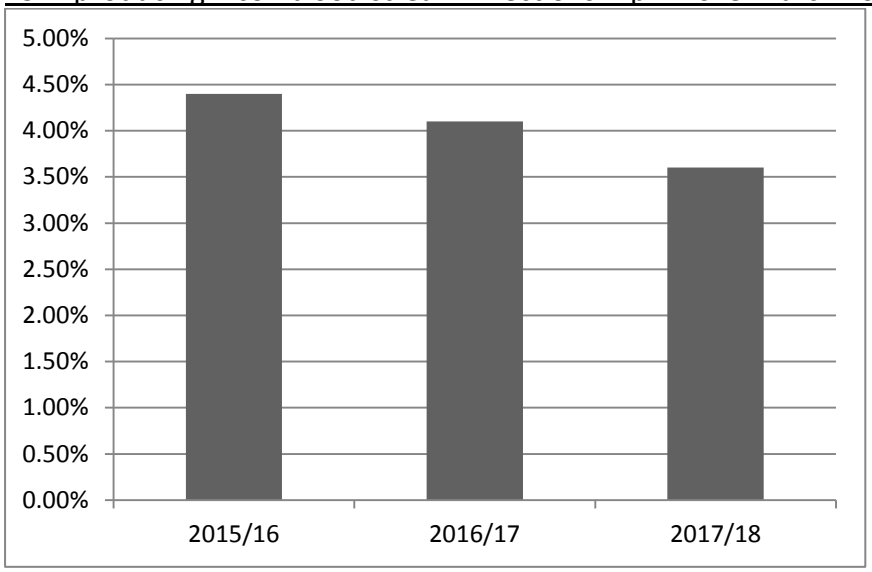
Also see section 16. PHE's Fingertips benchmarking data that shows TSDFT takes more blood cultures than average non-teaching hospital trusts and this can lead to ascertainment. Below is an extract from PHE's Mandatory Surveillance Report and shows that the rate of MSSA blood stream infections has reduced from 2016/17.



6. *E. coli* bacteraemias, ESBLs & CPEs

The rate of extended spectrum beta lacatamase (ESBL) producing *Escherichiae coli* bacteria in blood cultures is monitored and guides empirical antibiotic guidelines because ESBLs are one of the markers of antibiotic resistance in bacteria. Below the graph shows the total rate of ESBLs in blood cultures most of the E. coli blood stream infections are from admissions from the community. Only about 10% are from TSDFT. Reassuringly, the rate of ESBL E. coli blood stream infections is reducing year on year and this is in line with National data.

ESBL producing E.coli blood stream infections. April 2015 March 2018



From 1/4/2017 the HCAI Data Capture System run by PHE's Mandatory Surveillance team produced baseline data for E coli bacteraemias and set an ambition of halving the numbers in both Service Providers and CCGs, by 2021. The SDTCCG ambition for 2017/18 was 219 and was not achieved as the total E.coli blood steam infections were 233. Also TSDFT did not reach the internal 10% reduction target of 23 because there were 27 E coli blood stream infections.

The TSDFT action plan to reduce E.coli blood stream infections has been submitted to the SDTCCG and also forms part of the TSDFT Annual Forward Programme 2018/19.

Carbapenemase Producing Enterobacteriaciae (CPE) are bacteria that have resistance mechanisms against the third-line antibiotics. This means that if a patient develops a serious infection with a CPE then treatment is likely to be sub-optimal. In 2017/18 there was zero CPE in TSDFT & SDTCCG.

7. Seasonal Influenza

The seasonal influenza was significant in January & February 2018 and it was predominantly Influenza B and A type H3N2. This can be seen in the PHE's South West graph below.

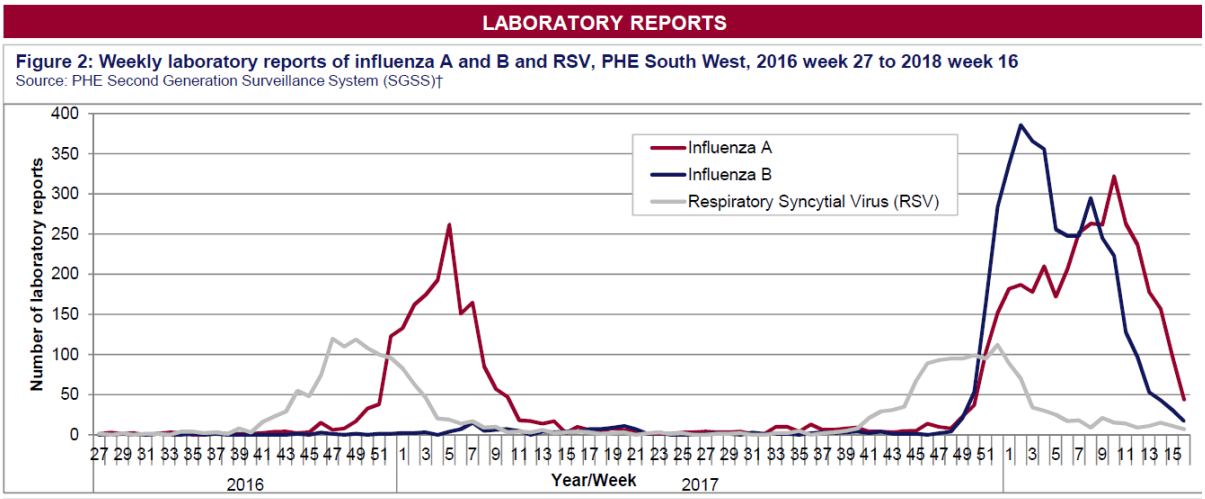


Figure 3: Weekly laboratory reports of rhinovirus, parainfluenza, adenovirus and metapneumovirus, PHE South West, 2016 week 27 to 2018 week 16 Source: PHE Second Generation Surveillance System (SGSS)†

The reason for the doubling of persons infected with influenza in the 2017/18 season was because of the new strain of influenza B called Yamagata and this strain was not included in the tri-valent influenza vaccine (but was included in the quadrivalent influenza vaccine). An interim analysis was done in the USA in February 2018, demonstrated the influenza vaccination programme was only 36% effective. The official analysis of the England & Wales' influenza vaccination programme is awaited.

Reassuringly, for the 2018/19 influenza programme the quadrivalent vaccine has been ordered by PHE for all over 65 year olds and for all Healthcare workers.

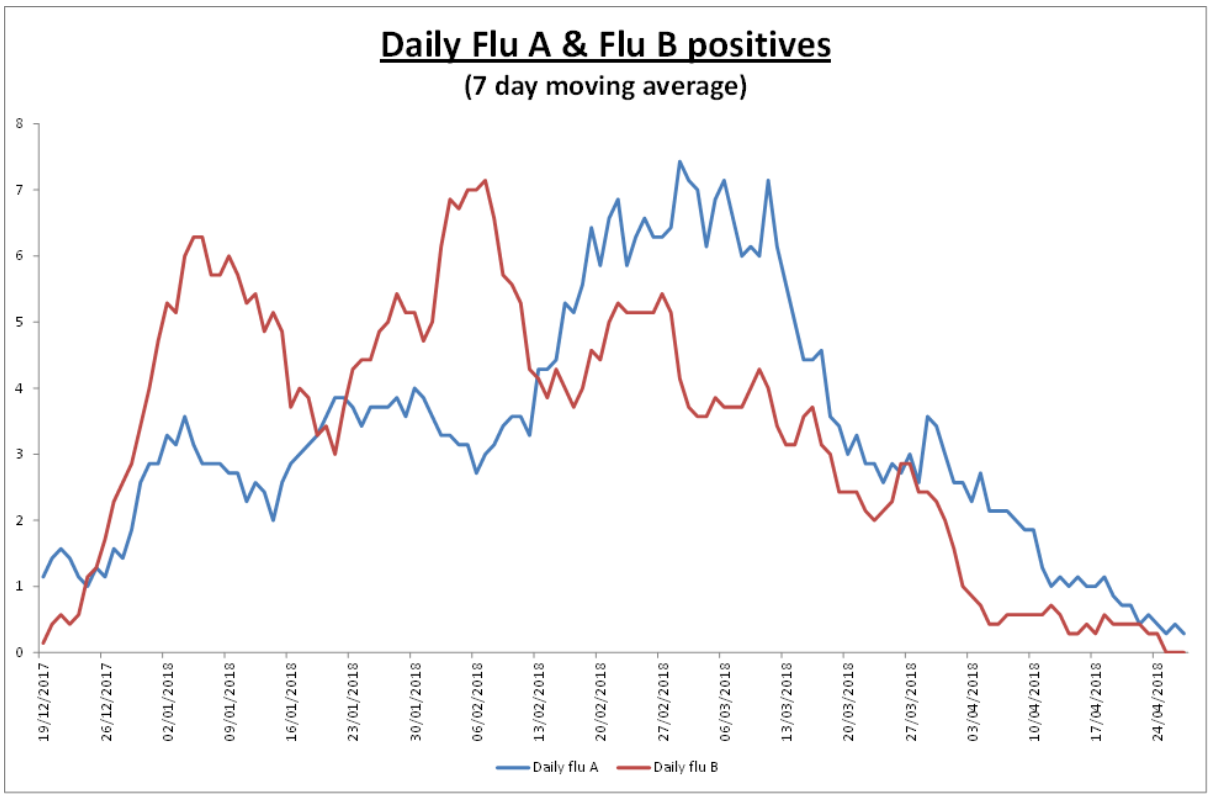
Influenza Testing

The TSDFT Microbiology Department uses the random access Cepheid system to check for Influenza RNA which means results are available within 1 hour from 9am to 5:30 pm. After 5:30pm a Point of Care Testing (POCT), Cepheid module was placed in EAU3 until 8:30am the following morning. Training was delivered to the HCA staff on EAU3 so that 24/7

influenza testing and results was available. This allowed rapid decisions on patient isolation improving patient & staff safety as well as patient flow.

From 13/12/17 to 27/4/18 there were 2,747 influenza tests done and 28% were positive, influenza A=14% & influenza B=14%. In 2016/17 there were 1,200 influenza tests performed. So in 2017/18 there were over an additional 1,500 tests performed and from informal communications with neighbouring trusts this was in line with the rest of the South West providers. This means that there was a cost pressure of around £130,000 to the trust in 2017/18 for influenza testing.

Graph showing TSDFT Influenza A & B testing performed from 19/12/17 to 24/04/2018



Influenza Ward Closures and Influenza Patient Contacts

However, in 2017/18 there was only one ward closure due to influenza and that was Dart ward at Totnes hospital that closed from 17/12/17 to 20/12/17 due to influenza A and was at the very beginning of the influenza season. This compares with 2016/17 were 2 wards closed, totalling 10days and there were 25 in-patients diagnosed with influenza on both wards.

In 2017/18 from January to February there were 106 influenza contacts from 27 index patients. There were 4 patients who appeared to acquire influenza from their contact so it is still necessary to isolate contacts. However, this compares favourably with the 25 in-patients that acquired influenza in 2016/17. At the start of this influenza season contacts were isolated for 5 days and there were no episodes of influenza cross-infection, the

duration was reduced to 3 days and the cross-infection rate appeared to be 7% which is well below the published rate of 15%.

There were Influenza Planning and Mop-up Meetings, tabled by IP&C, before and after the influenza season and attendees included the Facilities management Lead, Medicine Clinical Director, Acute admissions Consultant & Matron, Respiratory medicine Consultants and Matron, Operations lead, Community & Medicine Assistant Directors of Nursing, Community Governance lead and the Human Resources Exec and Chief Nurse were invited.

Actions from Investigation of Seasonal Influenza Planning & Mop-up Meetings

All the actions from the 2016/17 influenza planning process were completed. The actions below were developed after the multi-disciplinary meeting on 17th April 2018.

A Clinical Executive lead should be responsible for influenza	Chief Nurse stated that once new deputies are in place then Clinical Leadership of the Influenza Plan will be part of their role.
Influenza should be an agenda item on QIG & on the SDU Lead meetings.	
Request Comms send out TSDFTs sickness rate due to influenza-like illness.	It was 6.5% and send out in September 2018
Offer IP&C training to Execs	Booked for October 2018
Offer IP&C influenza training to Senior nurses	TBA September/ October 2018
Offer IP&C influenza training to A&E Nurse Trainer- If patients are going home do not test for influenza.	TBA September 2018
Offer IP&C influenza training to Junior Drs	TBA first Friday of December2018
DIPC to work with TSDFT Vaccination Workstream Lead :- Named peer vaccinators in all front-line areas Comprehensive list of all front-line workers Ask for reason that front-line worker refuses vaccination List of meetings attended by frontline workers that can be used to target vaccinations	Starting in May 2018.
IP&CT offer influenza education to wards during ward audits	TBA September 2018
Scope the feasibility for Tamiflu stickers for drug charts	TBA with Antimicrobial Pharmacist in July 2018
Cost pressure for 2018/19 influenza testing is a cost-pressure to go to Business Planning	May 2018
Point of Care Testing would ideally be 24/7 on EAU3 with a dedicated staff member. Also needs interfacing to a second point. Write Order-Comms Macros to prevent duplicate testing	Liaise with EAU3 Manager in June2018 Laboratory meeting to start process in June 2018

Management of seasonal influenza policy to be updated to incorporate:- Extend definition of an influenza contact from 4 hours to 8 hours in-patient stay in the same bay. Ensure Community hospital medical & nursing staff aware of influenza in December. Create 2 Risk Assessment Tools- one for when to test for influenza & one when isolation is required. Outline what should be done when TSDFT is on OPEL3 and there is increasing influenza.	Will be ratified at June or September 2018 IP&C Group.
Influenza budget to be raised with Finance Committee.	
Respiratory HDU to support high Acuity patients transferring to and from ICU.	Discuss with TSDFT COO in May 2018

8. Performance of Infection Control against Infection Control Key Performance Indicators for 2017/18

The comprehensive list of all the IP&CT Actions are held within the Annual Forward Plan.

Joint Annual Programme of Work 2014/15 TSDFT:		**Action/ Leads**	**Planned Completion date**	**RAG rating & date made**
i MRSA Control & MRSA /MSSA bacteraemia control	**KPI one– stay within CCG / DH Ambitions for MRSA bacteraemia (none)**	**DIPC**	**March 2018**	**Green =0**
	KPI two- Reduce MSSA bacteraemias by 5% (no more than 13)	**DIPC**	**March 2018**	**Green total=11**
ii C.difficile control & Norovirus outbreaks	**KPI three – stay within CCG / DH Ambitions for *C. difficile*** Total Number of 'Lapses In Care',is compliant at less than 18.	**All ICNs & DIPC**	**March 2018**	**Green lapse in care =11**
	KPI four – No ward closures due to Norovirus for > 12 days.	**All ICNs & DIPC**	**March 2018**	**Green=0**

iii Urinary catheter care/ESBLs/ E. coli bacteraemias	**KPI five - Reduce E coli bacteraemias by 10% in TSDFT (no more than 23).**	**All ICNs & DIPC**	**March 2018**	**Red total =27**

Not achieving the KPI for E.coli blood stream infections may be due to the patients with malignant disease. Of 27 patients with a TSDFT acquired E. coli BSI, 21 had a casenote review and 4 patients had metastatic malignany and 3 patients had haematological transplants (total is 26%). The other main cause is urinary catheter associated causing 19%. The Saving Lives Urinary Catheter Care, monthly audit was placed on QuESST in April 2018 and it is hoped that this will improve compliance with urinary catheter care.

9. Report on Community based IP&C Activity

Being an Integrated Care Organisation means there are innovative ways of working, for example there was a patient receiving assisted ventilation in a care home in the community and the patient required intravenous therapy over a longer period of time. The patient did not wish to have this therapy in the hospital so the Lead Nurse of the TSDFT's Vascular Access Team went to the patient. An aseptic technique was used to insert an intravenous line. Then the TSDFT's Medical Admissions Avoidance Team (MAAT) visited the patient in the care home to administer the intravenous therapy.

The Community areas have been performing and submitting Hand Hygiene Audits, Saving Lives audits for peripheral cannula care, central venous cannula care and Urinary catheter care and Saving Lives audits for Urinary catheter insertion. These are summarised in the table below and the IP&CT requested monthly audits but these may be changed to quarterly audits in the future.

Quarter 4 17/18 Saving Lives Audits for peripheral cannula care			
COMMUNITY HOSPITAL WARDS	**JAN**	**FEB**	**MAR**
BRIXHAM HOSPITAL WARD	40%	-	none
DAWLISH HOSPITAL WARD	none	none	none
NEWTON ABBOT - TEIGN WARD	80%	100%	100%
NEWTON ABBOT – TEMPLAR WARD	100%	-	58.3%
TOTNES – DART WARD	100%	100%	none

Quarter 4 17/18 Saving Lives Audits for Urinary catheter care			
	JAN	**FEB**	**MAR**
BRIXHAM HOSPITAL WARD	33%	100%	78%
DAWLISH HOSPITAL WARD	100%	100%	100%
NEWTON ABBOT - TEIGN WARD	-	100%	42%
NEWTON ABBOT – TEMPLAR WARD	44%	-	50%
TOTNES – DART WARD	100%	100%	100%
TORQUAY ZONE – COMMUNITY NURSES	100%	100%	100%
PAIGNTON/BRIXHAM CATHETER CLINIC	100%	-	-

Quarter 4 17/18 Saving Lives Audits for Central venous catheter Care			
CVC CLINIC	**JAN**	**FEB**	**MAR**
NEWTON ABBOT CVC CLINIC	-	-	100%

Community Matrons continue to audit the ward areas but IP&C have introduced audits to Minor Injury Units and out-patient areas.

Quarter 4 17/18 Matrons' Audits			
COMMUNITY HOSPITALS	**JAN**	**FEB**	**MAR**
BRIXHAM HOSPITAL WARD	100%	-	-
DAWLISH HOSPITAL WARD	100%	-	100%
NEWTON ABBOT – TEIGN WARD	100%	92%	-
NEWTON ABBOT – TEMPLAR WARD	100%	100%	-
TOTNES – DART WARD	100%	100%	100%
DAWLISH MIU	-	-	-
TOTNES MIU	-	-	-
NEWTON ABBOT MIU	100%	100%	
ASHBURTON HOSPITAL (OPD)	100%	100%	100%
BRIXHAM (OPD)	100%	-	-
DARTMOUTH CLINIC	92.86%	100%	92.86%
DAWLISH (OPD)	100%	-	100%
NEWTON ABBOT (OPD)	100%	92.86%	-
PAIGNTON (OPD)	-	-	-
TEIGNMOUTH (OPD)	100%	-	100%
TOTNES (OPD)	100%	100%	100%
ASHBURTON MSK PHYSIOTHERAPY		100%	100%
BOVEY TRACEY MSK PHYSIOTHERAPY	91.67%	100%	
BRIXHAM MSK PHYSIOTHERAPY	100%	100%	100%
DARTMOUTH MSK PHYSIOTHERAPY		100%	
DAWLISH MSK PHYSIOTHERAPY	-	-	-
NEWTON ABBOT MSK PHYSIOTHERAPY	92.86%	92.31%	
PAIGNTON MSK PHYSIOTHERAPY	92.31%	92.31%	
TEIGNMOUTH MSK PHYSIOTHERAPY	90.91%		
TORQUAY MSK PHYSIOTHERAPY	100%	92.31%	92.86%
TOTNES MSK PHYSIOTHERAPY		96.15%	

Quarter 4 17/18 Hand Hygiene Audits			
Community Hospital Wards	**JAN**	**FEB**	**MAR**
BRIXHAM HOSPITAL WARD	100%	100%	100%
DAWLISH HOSPITAL WARD	100%	100%	93.3%
NEWTON ABBOT – TEIGN WARD	100%	-	100%
NEWTON ABBOT – TEMPLAR WARD	100%	-	-
TOTNES – DART WARD	-	100%	100%
Community MIU			
DAWLISH MIU	100%	100%	-
TOTNES MIU	100%	100%	100%
NEWTON ABBOT MIU	100%	100%	100%
Community Catheter Clinics			
BRIXHAM/PAIGNTON CATHETER CLINIC	100%	-	-
DAWLISH CATHETER CLINIC	100%	-	-
NEWTON ABBOT CATHETER CLINIC	-	-	-
Lower Limb Clinics			
ASHBURTON LOWER LIMB CLINICS	-	-	-
BRIXHAM LOWER LIMB CLINICS	100%	-	-
DARTMOUTH CLINIC LOWER LIMB CLINICS	-	-	-
DAWLISH LOWER LIMB LOWER LIMB CLINICS	94%	-	90%
NEWTON ABBOT LOWER LIMB CLINICS	-	100%	-
PEMBROKE HOUSE LOWER LIMB CLINICS	-	100%	-
TOTNES LOWER LIMB CLINICS	-	-	-
MSK Physiotherapy			
ASHBURTON MSK PHYSIOTHERAPY	50%	-	-
BOVEY TRACEY MSK PHYSIOTHERAPY	-	-	-
BRIXHAM MSK PHYSIOTHERAPY	-	100%	-
DAWLISH MSK PHYSIOTHERAPY	-	100%	-
DARTMOUTH MSK PHYSIOTHERAPY	-	-	-
NEWTON ABBOT MSK PHYSIOTHERAPY	80%	-	-
PAIGNTON MSK PHYSIOTHERAPY	100%	-	-
TEIGNMOUTH MSK PHYSIOTHERAPY	-	100%	-
TORQUAY MSK PHYSIOTHERAPY	-	57%	-
TOTNES MSK PHYSIOTHERAPY	-	-	-
Community Nurses			
DAWLISH/TEIGNMOUTH COMMUNITY NURSES	-	-	-
PAIGNTON/BRIXHAM COMMUNITY NURSES	-	-	-
NEWTON ABBOT/BOVEY TRACEY COMMUNITY NURSES	100%	100%	100%
OUT OF HOURS COMMUNITY NURSES	100%	100%	100%
TORQUAY COMMUNITY NURSES	100%	100%	100%
TOTNES/DARTMOUTH/ASHBURTON COMMUNITY NURSES	-	100%	100%
Intermediate Care Teams			
DAWLISH/TEIGNMOUTH INTERMEDIATE CARE	-	-	-
PAIGNTON/BRIXHAM INTERMEDIATE CARE	-	-	-
NEWTON ABBOT INTERMEDIATE CARE	-	-	-

Domiciliary Care

IP&C have requested data from the Mears' Providers on Annual Mandatory Infection Prevention & Control Training – Content and Matrix of staff that have completed it. As well as the Mears' Providers Results of Field Checks, Spot Checks and Observations on Hand Hygiene. These assurances are yet to be received. There are 9 Providers in Torbay, they have a total of 49 Providers (6 not providing at present).
The Mears' direct employees Annual Mandatory Infection Prevention & Control Training – Content and Matrix of staff attended has been received and is satisfactory.

Care homes

IP&C have requested the IP&C audits that care homes complete from the Torbay Quality Assurance & Improvement Team (QAIT) and to date these have not been received. IP&C are waiting to meet the QAIT Lead to discuss this. The old CQC reports on Care homes do not give sufficient IP&C assurances, however the CQC inspections from 17/18 onwards will follow the new guidelines and will be able to give assurances (See: Shaping the Future CQC's strategy for 2016 to 2021-'What our strategy means for the health and adult social care services we regulate')

10. Antimicrobial Report

The Antimicrobial Team (AMT) provides Antimicrobial Stewardship throughout the Trust and the prescribing policy is documented in CG1098. Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) and paediatrics (CG1118) on the trust intranet site and the Apple and Android App. Called BugBuster3000.

The AMT consists of the Antimicrobial Pharmacist and Consultant Microbiologist. For 6 months in 2017/18 there was no Antimicrobial Pharmacist in post. In April 2018 and Antimicrobial Pharmacist B7 was appointed.

There are two Commissioning for Quality and Innovation (CQUIN) targets around antimicrobial prescribing. The first relates to the process of review; we are able to achieve this CQUIN in the Emergency Department for both adults & children with a compliance of 55%. Compliance within in-patient areas has not been achieved due to difficulties in, retrospectively, identifying those patients with sepsis.

The second CQUIN, reducing the prescribing of Tazocin and Meropenem, and all antibiotics, has been adversely affected by worldwide shortages of Tazocin.

The AMT audits the five key areas (Allergy status recorded, Appropriate cultures taken before antibiotics, Indication given, Duration specified & Evidence of review); these are in the Saving Lives background documentation and they form the core of the CQIN targets. This will be based upon ward pharmacists filling out the audit forms for their respective wards, the forms being scanned by Clinical Governance and automatically being loaded into a database. These 5 key items will appear on the trustwide performance dashboard.

A new system to tackle prescribing of Restricted Antibiotics will be introduced from April 2018. The Pharmacy dispenser will ask – "Have you discussed this with a microbiologist and, if so, who?". The pharmacist will make a note of any of these calls and pass it to the Antimicrobial Pharmacist that same day. The Antimicrobial Pharmacist (AP) will then check there for any Clinical Notepads on WinPath and also whether there are internal notes against significant specimens (eg blood cultures, tissues, joint fluids). If either of these sources show microbiologists recommending the restricted antibiotic, no further action is needed. If they don't,the AP will send an email to the microbiologist to discuss with the prescriber.

11. Decontamination

The bi-monthly Decontamination Group Meeting chaired by the Decontamination Lead provides assurance on compliance with the trust's decontamination policies and National policies from Medicines & Healthcare products Regulatory Agency (MHRA) April 2015 and best practice guidance. Exception reports are made to the IP&CG.

The weekly water test results from Torbay Endoscopy Unit are reviewed by the Endoscopy Managers and the DIPC. In April 2017 the endoscopy washer disinfector (EWD) called 'Spring', failed due to contamination with fungi. The asset was not used, disinfected and after 2 negative screens was used again. The EWD called 'Autumn', failed water tests and was not used for around 3 months from January 2018 to April 2018. The EWD called 'Winter, failed water tests in February 2018 and was used again in March 2018. There is a business case to replace all 4 EWDs in Endoscopy.

The Hospital Sterilization & Decontamination Unit's (HSDU) Washers for surgical instruments have all servicing up to date, The EWDs' servicing and water tests are all satisfactory and the Hot Reverse Osmosis System is also serviced and satisfactory. HSDU have an annual inspection carried out by an independent organisation called SGS (Societe Generale de Surveillance) and this was MDD 93/42/EEC compliant for 2017/18 after purchasing the correct batch label for gas plasma and updating the quality manual on how HSDU minimises contamination in the Cleanrooms.
The annual audit and training for areas using the high level disinfection with the Tristel (chlorine dioxide) Tri-wipe and Tristel Duo Systems was performed in Newton Abbot and Teignmouth clinics, which was satisfactory. The other areas are out-standing and will be picked up the the 2018/19 audit cycle.
The nebulisers are in the process of being moved to the existing centralised medical devices library for regular servicing and filter changes.

Plans for a centralised Medical Devices Library and a Centralised Decontamination area which will include hospital beds have been made into a Business Case and are held within the 5 year trust Capital projects strategy.

12. Water Safety

Water Systems Management Group
This group meets every quarter to review water safety and ensure compliance with HBN 01-04 including recent updates on Pseudomonas control. The Legionella water test results are reviewed as well as the flushing logs.
Pseudomonas testing of augmented care areas twice yearly did not reveal any sites positive for pseudomonas.
Legionella pneumophila serotype 1 has not been isolated. No outlets have had non-pathogenic Legionella species.
This is in spite of the copper/silver ORCA system being compliant only for silver ions and not copper ions. TSDFT is awaiting actions from ProEconomy, the company that installed the ORCAs.
There have been numerous sewage leaks in the Tower block and a sewage pipe survey reveals that a new sewage stack must be built and this is in the Capital planning for 2018/19.
In 2018/19 Estates will provide the CIEG & IPCG with quarterly water reports on issues with temperature control and microbial testing.
The Community hospitals have Water Safety commissioned to Churchills and the Zetasafe System is used to provide assurances to the IP&CG.
The trust-wide Legionella Risk Audit commences in May 2018 and will be performed by Healthy Buildings International and all results and action plans will be logged onto Records for Buildings.

13. Critical Ventilation

Critical ventilation is required to prevent healthcare acquired infection and is a vital part of patient safety.
Ultra clean air theatres require engineering checks twice a year and all other specialist ventilation require annual engineering checks. All areas have passed except Recovery and there are up-grading plans underway. Special theatres have a non-compliant system and this is on the Estates Risk Register as 25. Replacement theatres are on the Capital Plan for 2018/19. Day Surgery Theatre 1's supply air flow, volumes & air changes are below requirements.
Any remedial work identified by the Critical Ventilation Reports are placed on an Action Plan within Estates, responsibility for Critical Ventilation is now with the Mechanical Services Manager in the Estates Department and reviewed at the IP&CG.

14. Surveillance & Audits

Infection Prevention Society (IPS) Audits

The IP&CT perform these audits every 2 years and in 2016 over fifty wards/departments/hospitals were audited by the team. The actions that are derived from these audits are divided into those for the Ward Manager, Estates and Hotel Services.
For 2017/2018 the IP&CT has been checking that all the outstanding actions have been completed by liaising with those above.
The Operating theatre IPS audits are being completed.

Monthly Saving Lives Audits & Hand Hygiene Audits

The IP&CT perform these audits for Care of Peripherally Inserted Cannulae, Care of Centrally Inserted Catheters and Care of Urinary Catheters. The results are emailed to the Ward managers, Matrons, ADNs and Consultants, the pass score is 95% and the results are displayed on the ward dashboards outside each ward. When a pass is not achieved the Ward manager is to repeat the audit within 15 days. All results are displayed on ICON at the IP&C site. The re-audit of Saving Lives when 95% is not reached has become a KPI on the Annual Forward Programme and the results are put on the ward quality performance tool called QuESST.

Surgical Site Infection Surveillance (SSIS)

The national surveillance is run by PHE and every year it is compulsory to do total hip replacement (THR) and total knee replacement (TKR) SSIS. This is done for a 3 month period and deep and superficial infections are mixed together and the post-discharge surveillance is only 3 months as opposed to a year which is recognised by international groups. The PHE SSIS takes about 6 months to feedback the infection rates but it does allow a national benchmarking exercise. The results returned in 2017/18 for TKR & Large bowel surgery can be seen in the table below and both a better than the National averages.

National SSIS data from PHE

Date SSIS done	TSDFT infection rate	National infection rate
Oct-Dec2017 TKR	0.0%	0.6%
April-June 2017 Large bowel	7.0%	10.8%
Jan-March2018 THR	Results pending	

For the above reasons TSDFT DIPC and the CD for Orthopaedics liaise and perform laboratory based ward surveillance for all THRs, TKRs and fracture neck of femur internal fixations called hemi-arthroplasties. The results from 2015 to 2018 can be seen below. In general the infection rates should be <1% and in general have improved over time.

TSDFT Lab-based ward SSIS for Orthopaedics April 2015 to March 2018

	THR infections	THR infection rate	TKR infections	TKR Infection rate	Hemi-arthroplasty infections	Hemi-arthroplasty infection rate
April-Sept 2015	2 infections	193 ops **rate= 1%**	5 infections	153 ops **rate=3.3%**	0 infections	181 ops **rate=0%**
Oct 2015-March 2016	3 infections	188 ops **rate= 1.6%**	1 infection	210 ops **rate=0.5%**	0 infections	210 ops **rate=0%**
April-Sept 2016	2 infections	213 ops **rate= 0.9 %**	1 infections	149 ops **rate= 0.7%**	0 infections	117 ops **rate=0%**
Oct 2016-March 2017	0 infections	122 ops **rate= 0%**	2 infections	139 ops **rate= 1.4%**	1 infections	186 ops **rate=0.5%**
April-Sept 2017	0	140 ops **rate= 0%**	3 infections	123 ops **rate= 2.4%**	0	158 ops **rate= 0%**
Oct2017-March 2018	0	136 ops **rate= 0%**	0	89 ops **rate=0%**	0	162 ops **rate=0%**

Peripherally Inserted Central Catheter (PICC) Surveillance

Peripherally Inserted Central Catheters (PICCs) are used when centrally placed venous access is required.
Surveillance of central venous catheter (CVC) infections, provides assurance that staff and patient training, competency, equipment and follow-up care are all in place and functioning well.
The main CVCs are PICCS and although not truly central catheters, midlines are peripherally inserted lines which can remain in place for long periods.
There are two main ways of measuring the rate of CVC infections and that is as follows:

CRBSI (catheter related blood stream infection) is a rigorous clinical definition. It is not typically used for surveillance purposes.

CLABSI (central line–associated bloodstream infection) is a term used only for surveillance purposes to identify BSIs that occur in the population at risk (patients with central lines).
It is important to realise that the **CLABSI** infection rate will usually be higher than the **CRBSI** infection rate and when benchmarking it must be remembered to compare like with like. [i]

Results of CLABSIs are divided into General , Haematology/Oncology & Parenteral nutrition (PN) specialities

	General	Haem/Oncol	PN
2015/16	0	0	Not available
2016/17	0.6	1.0	Not available
2017/18	Pending	Pending	0

This gives reassurance that the CVC CLABSI rates are satisfactory. These results have been fed back to the VAT team and Service Delivery Units.

Antibiotic Prophylaxis Audit in Theatres

The DH set up an initiative in 2017 that aims to reduce healthcare associated Gram-negative bloodstream infections (BSIs) by 50% by 2021 and reduce inappropriate prescribing by 50% by 2021. Public Health England has focused on E. coli because it represents 55% of all Gram-negative BSIs. In order to achieve this, we are confirming implementation of quality standards from NICE QS49 – one of which is correct surgical antibiotic prophylaxis.
This is a retrospective, point prevalence audit, looking at 16 cases using patient Operation Notes and Anaesthesia Manager to look at timings of antibiotics for General Surgery and Urological Operations on one day. All timings for antibiotics were correct. All of cases had correct antibiotics used.
Comparing timings of antibiotics in emergency theatre with results from the audit in 2012 shows significant improvement, with 100% of patients receiving antibiotics (if used) within 30 minutes prior to incision.

Operation	Abx used	Correct Prophylaxis including timing
Laparoscopic Anti-reflux Fundoplication	None	Yes
Endoscopic retrograde pyelography and ureteric stent removal	Gent 240mg	Yes
Endoscopic R ureteric stent change	Gent 240mg	Yes
Transurethral resection of bladder tumour (TURBT) -re-resection	Gent 240mg	Yes
Transurethral resection of the prostate (TURP)	Gent 240mg	Yes
Right hemicolectomy and anastomosis (redo + excision of recurrent disease in small bowel)	Cefuroxime 1.5g and Metronidazole 500mg	Yes
Laser fragmentation of renal calculi and ureteric stent insertion	Gent 240mg	Yes
TURBT with urethral dilatation	Gent 240mg	Yes
Primary incisional hernia repair	Cefuroxime 1.5g	Yes
Laparoscopic total cholecystectomy	None	Yes
Primary inguinal hernia repair	None	Yes
Examination of Rectum under anaesthesia	None	Yes
R inguinal hernia repair (irreducible)	Co-amoxiclav 1.2g	Yes
Incision & drainage – axillary abscess	None	Yes
Incision & drainage – groin abscess	None	Yes
Femoral hernia repair, small bowel resection and anastomosis	Co-amoxiclav 1.2g	Yes

Glove Audit March 2018

The aim of this audit was to ensure that staff remove their gloves after performing task/between patients as per WHO 5 moments and that hands were washed or alcohol hand-gel was used after the gloves were removed.
IP&C staff audited wards in the hospitals using the Lewisham hand hygiene tool and WHO standards on glove use. The findings were satisfactory at 85%. Areas of non-compliance were addressed at the time of the audit. Non-compliance was due to inappropriate use and moving from one area to another wearing the same gloves.

	Yes	No
WHO 5 moments followed	85%	15%
Hands washed post removal	92%	8%
Glove use appropriate	85%	15%

15. PHE's Fingertips Benchmarking data for TSDFT.

PHE has uploaded national data to facilitate benchmarking across six domains:

- Supporting NHS England Initiatives
- Antimicrobial Resistance (AMR)
- Antibiotic Prescribing
- Healthcare-Associated Infections (HCAI)
- Infection Prevention and Control (IPC)
- Antimicrobial stewardship (AMS)

AMR local indicators are publically available data intended to raise awareness of antibiotic prescribing, AMR, HCAI, IPC and AMS; and to facilitate the development of local action plans. The data published in this tool may be used by healthcare staff, commissioners, directors of public health, academics and the public to compare the situation in their local area to the national picture.

It can be seen that most of the data is 2016/17 as 2017/18 data has not yet been made available. But for 2016/17 the C difficile rates and MSSA blood stream infection rates were high. These have both reduced in 2017/18 as shown by the rolling averages in February 2018.

The MRSA blood stream rates are extremely low and remain so in 2017/18.

The number of E. coli & Klebsiella blood stream infections that are admitted to TSDFT from the community are higher than the national average but the number of TSDFT acquired E. coli & Klebsiella blood stream infections is only just above average as seen by the rolling averages seen in February 2018.

The more recent data Q3 2017/18 shows that TSDFT takes more blood cultures and sends more stools for testing than average. That is good practice but it means we will have higher rates of ascertainment for blood stream infections and *C. difficile*.

Export table as image

Indicator	Period	South Devon Healthcare		Trust type	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
All C. difficile rates by reporting acute Trust and financial year	2016/17	94	73.0	37.6*	36.7	0.0		147.5
Trust-apportioned C. difficile rates by reporting acute Trust and financial year	2016/17	25	19.4	12.2*	13.2	0.0		82.7
All MRSA bacteraemia rates by reporting acute Trust and financial year	2016/17	2	1.6	2.3*	2.4	0.0		8.6
Trust-assigned MRSA rates by reporting acute Trust and financial year	2016/17	1	0.8	0.8*	0.9	0.0		4.4
CCG-assigned MRSA counts by reporting acute Trust and financial year	2016/17	1	1	159*	232	-	-	-
Third party-assigned MRSA counts by reporting acute Trust and financial year	2016/17	0	0	191*	276	-	-	-
All MSSA bacteraemia rates by reporting acute Trust and financial year	2016/17	105	81.5	32.6*	32.8	81.5		0.0
Trust-apportioned MSSA rates by reporting acute Trust and financial year	2016/17	22	17.1	7.8*	8.8	0.0		28.3
All E. coli bacteraemia rates by reporting acute Trust and financial year	2016/17	236	183.2	121.4*	115.9	0.0		183.2
Hospital-onset E. coli bacteraemia counts and rates by NHS acute trust and financial year	2016/17	27	21.0	20.2*	22.5	0.0		47.7
Blood culture sets per 1,000 bed-days performed by reporting acute Trust and quarter	2017/18 Q3	3,086	96.3	62.3*	63.5	0.0		223.9

Blood culture sets per 1,000 bed-days performed by reporting acute Trust and quarter	2017/18 Q3	3,086	96.3	62.3*	63.5	0.0		223.9
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute Trust and quarter	2017/18 Q3	1,007	31.4	-	13.8	0.0		64.0
Surgical Site Infection Hip Prosthesis by acute NHS Trust and financial year	2016/17	-	*	0.6	0.6	0.0		2.9
Surgical Site Infection Knee Prosthesis by acute NHS Trust and financial year	2016/17	0	0.0	0.5	0.6	0.0		3.1
Counts and 12-month rolling rates of trust-apportioned C. difficile infection, by reporting acute trust and month	Feb 2018	1	16.6	12.4	13.5	0.0		99.8
Counts and 12-month rolling rates of all MRSA bacteraemia cases by acute trust and month	Feb 2018	0	2.5	2.5	2.5	0.0		10.8
Counts and 12-month rolling rates of trust-assigned MRSA bacteraemia cases by reporting acute trust and month	Feb 2018	0	0.8	0.9	0.9	0.0		5.7
Counts and 12-month rolling rates of CCG-assigned MRSA bacteraemia cases, by reporting acute trust and month	Feb 2018	0	1.7	0.8	0.7	0.0		5.5
Counts and 12-month rolling rates of third-party-assigned MRSA bacteraemia cases by reporting acute trust and month	Feb 2018	0	0.0	0.8	0.8	0.0		6.0
Counts and 12-month rolling rates of trust-apportioned MSSA bacteraemia cases by reporting acute trust and month	Feb 2018	2	6.6	8.0	9.1	0.0		27.3
Counts and 12-month rolling rates of E. coli bacteraemia cases, by reporting acute trust and month	Feb 2018	14	185.9	126.4	118.6	0.0		189.7
Counts and 12-month rolling rates of E. coli hospital-onset cases by reporting acute trust and month	Feb 2018	2	25.7	20.3	22.4	0.0		68.1

Counts and 12-month rolling rates of E. coli hospital-onset cases by reporting acute trust and month	Feb 2018	2	25.7	20.3	22.4	0.0	 68.1
Counts and 12-month rolling rates of community-onset E. coli bacteraemia cases, by reporting acute trust and month	Feb 2018	12	160.2	106.1	96.2	0.0	 167.9
Counts and 12-month rolling rates of Klebsiella spp. bacteraemia cases, by reporting acute trust and month	Feb 2018	6	51.1	27.9	27.8	0.0	 69.2
Counts and 12-month rolling rates of Klebsiella spp. hospital-onset cases by reporting acute trust and month	Feb 2018	0	12.8	6.8	8.2	0.0	 53.3
Counts and 12-month rolling rates of community-onset Klebsiella spp. bacteraemia cases, by reporting acute trust and month	Feb 2018	6	38.3	21.1	19.6	0.0	 38.3
Counts and 12-month rolling rates of P. aeruginosa bacteraemia cases, by reporting acute trust and month	Feb 2018	0	10.9	11.8	12.6	0.0	 36.9
Counts and 12-month rolling rates of P. aeruginosa hospital-onset cases by reporting acute trust and month	Feb 2018	0	2.7	3.6	4.7	0.0	 23.3
Counts and 12-month rolling rates of community-onset P. aeruginosa bacteraemia cases, by reporting acute trust and month	Feb 2018	0	8.2	8.1	7.9	0.0	 16.0

16. IP&C KPIs & Annual Forward Plan 2017/18

KPIs - Three Key Performance Indicators (KPIs) apply to whole of 2018/19

1.	Comply with DHs: MRSA blood stream infection (target=0) & Clostridium difficile target (target=17) & assist with the CCG's E. coli blood stream infection target (internal target 10% reduction = 24 (10% reduction from 27)
2.	Saving Lives Clinical Audits for Hand Hygiene, Peripheral canulae care, Central venous canulae care, Urinary catheter care must all score at least **95%** compliance within each calendar month. If compliance <95% a re-audit must be received by IP&C within 15 days. Antimicrobial prescribing aim to score at least **85%** compliance.
3.	Reduce by 10%, the number of in-patients that acquire symptomatic Norovirus infection, from another in-patient. Target= 76 in-patients(10% reduction from 84).

Annual Forward Plan 2018/19 - Strategic Ambition: Complete 85% of the KPIs and actions within the IP&C Annual Forward Plan.

Actions	Review dates;	To be completed
a) IP&CT to participate in TSDFT meetings as deemed appropriate by the Chief Nurse, Lead IP&CT and Director Infection Prevention & Control. By attending or instigating or providing reports or obtaining assurances for/from the following: • Quarterly IP&C Group meetings • Quality Improvement Group (QIG) & Quality Assurance Group (QAC) • Capital Infrastructure and Environment Group (CIEG) & Services & Estates Operational Strategy Group (SOES). • Health & Safety (Sharps Safety Group) • Decontamination Group • Water Safety Group • CQC Assurance Group	Q1, Q2, Q3, Q4	March 2019

• Patient Flow Group • Pressure Ulcer Group • Environment Group • Matrons' and Community Leads Meetings • QAIT meetings • Mears & TSDFT meetings • Catheter Passport meetings • Seasonal Influenza Planning/Outbreak/De-brief meetings • Winter Planning Group • Flu Task Force Group b)By producing an Annual IP&C Report for the Trust board. ***Responsible; IP&CT-Quality Improvement Group.*** ***Strategic Objectives:- At all times have in place a fully functioning, highly visible Infection Prevention and Control Team (IP&CT) that reports to the Infection Prevention & Control Group (IP&CG) meeting every quarter.***		
a) Ensure compliance in Saving Lives Hand Hygiene, peripheral cannula care, central venous catheter care, urinary catheter care to a minimum of 95%. • By monthly auditing in hospitals, Community clinics , Community nursing & Intermediate care teams • By liaising with QAIT and ensuring IP&C is part of auditing processes for Care homes. ***Responsible; IP&CT-Quality Improvement Group.*** ***Strategic Objectives:- Achieve the DH targets for Clostridium difficile infections, MRSA blood stream infections and E coli bloodstream infections. & Ensure Integrated Care Organisation staff and patients are protected from infection.***	Q1, Q2, Q3, Q4	March 2019
Reduce non-compliance in Saving Lives antimicrobial prescribing to a minimum of 15%. • AMT feeding back monthly Saving Lives Antimicrobial audits to prescribers with Action Plans. • Ensuring the Saving Lives Monthly Antimicrobial Audit Results go on the Quality Improvement Dashboard (95-85% Green, 84-75% Amber, <74% Red) • By the SDU Leads displaying Antimicrobial Audits in a ward area seen by prescribers.	Q1, Q2, Q3, Q4	March 2019

• All B6 & B7 Pharmacists will have Antimicrobial Stewardship place in their job descriptions. • Teaching of all doctors new to the Trust at their Induction ***Responsible; IP&CT & Lead Pharmacist -Quality Improvement Group.*** ***Strategic Objectives:- Achieve the DH targets for Clostridium difficile infections***		
a) Reduce non-compliance with Safe patient placement in high risk areas to less than one per calendar month per ward. As measured by Datix or IP&CT. If non-compliance occurs this will trigger a root cause analysis with the relevant area. b) Reduce non-compliance with Safe patient placement in medium risk areas to less than three per calendar month per ward. As measured by Datix or IP&CT. If non-compliance occurs this will trigger a root cause analysis with the relevant area. By checking compliance against the following policies: • Isolation in a Hospital setting G0394 • Management of Seasonal Flu' G2062 • IP&C Policy for Ella Rowcroft ward (Elective Orthopaedics), Ella HCU & Ainslie ward (Trauma) G1681. ***Responsible; IP&CT & Operations-Quality Improvement Group.*** ***Strategic Objectives: Engage all staff from Board to Ward in pro-actively preventing healthcare acquired infections and make sure they understand the importance of IP&C.***	Q1, Q2, Q3, Q4	March 2019
Ensure each SDU maintains IP&C mandatory training at TSDFT target. • By reporting at the SDU Leads Meeting & poor performance by groups should be picked up, then the SDU Leads should request Action Plans for improvement. • The SDU Leads should escalate 3 consecutive months of Poor Performance at the Medical, Nursing and Management Quality Performance Teams meetings. ***Responsible; SDU Leads & Horizon Centre- Workforce & Organisational Development Group.*** ***Strategic Objectives: Engage all staff from Board to Ward in pro-actively preventing healthcare acquired infections and make sure they understand the importance of IP&C.***	Q2, Q4	October2018

a) Ensure the Environmental risks to infection are addressed in the Capital planning process and are on SDU Risk Registers. b) Ensure the Environment Group reports regularly to IP&CG and actions involving cleaning and Infection Prevention Society (IPS) Environmental audits & actions are completed. Keep the following issues under Risk Register review : • IPS Audits performed every 2 years including Community sites. • Special Theatres imminent failure. • Three Dental operating rooms need to be upgraded. • ED – majority of handwash basins (HWB) and IPS panels are non-compliant. • EAUs – insufficient siderooms. • Hetherington block – insufficient siderooms, no en-suite facilities in ward bays, beds too close together, patient toilets are adjacent to kitchens, offices share kitchen & toilet facilities with wards. • Fracture clinic insufficient HWBs & clean rooms. • Ainslie ward insufficient siderooms • Ensure Minor Surgical Procedures are performed in IP&C & HTMs compliant environments. c) Liaise with QAIT & the Community SDU to obtain assurances that Care homes & Intermediate Care remain compliant with legislation and guidance and remain overall CQC Compliant. • IP&C lead to meet with QAIT Nurse & QAIT lead • IP&C lead to meet with Intermediate care lead • IP&C lead to meet with Community SDU ADN/Manager quarterly d) Ensure all TSDFT IP&C policies are updated with the latest National guidance. ***Responsible; IP&CT & Capital Infrastructure and Environment Group & Services & Estates Operational Strategy Group, SDUs -Senior Business Management Group.*** ***Strategic Objectives: - Ensure Integrated Care Organisation staff and patients are protected from infection. Achieve the DH targets for Clostridium difficile infections, MRSA blood stream infections and E coli bloodstream infections.***	Q2, Q4	March19
Legionella /Pseudomonas Control, in Water Systems, are in place with an up-to-date Trust policy which is audited	Q2, Q4	March19

as required by L8 Approved Code of Practice & HTM01-04. • Receive bi-monthly Water Safety Reports from Head of Estates Operations • Receive Annual Report on Critical Ventilation from Head of Estates Operations. • Receive monthly flushing audits ***Responsible; IP&CT & Capital Infrastructure and Environment Group*** ***Strategic Objectives: - Ensure Integrated Care Organisation staff and patients are protected from infection.***		
Participate in PHE's Mandatory Healthcare Associated Infection Surveillance and any other surveillance to reduce the incidence of avoidable harm. • Surgical site Infection surveillance (SSIS) complete Total Knee Replacements, Total Hip Replacements & Abdominal hysterectomy. • PPE & Isolation audit • Glove re-audit • Weekly audits of peripheral cannula and D&V risk assessment in A&E and EAUs • Continuous, Deep SSIS TKR, THR & #NOF • Peripherally Inserted Central Catheter (PICC) Surveillance • Matrons Audits reviewed with ADNs and at Infection Prevention & Control Group Meeting • **RCAs** on patients with; C difficile toxin positive and Staph aureus blood stream infections occurring 48 hours after admission & Venous cannula infection both central & peripheral. • **Casenote reviews** & Action plans on patients with E. coli, Klebsiella spp & *Pseudomonas aeruginosa* blood stream infections occurring 48 hours after admission. Also E. coli, Klebsiella spp & *Pseudomonas aeruginosa* blood stream infections within 30d of discharge from a TSDFT in-patient stay. Also *C. difficle* positive patients within 30d of discharge from a TSDFT in-patient stay. ***Responsible; IP&CT-Quality Improvement Group.*** ***Strategic Objectives:- Achieve the DH targets for Clostridium difficile infections, MRSA blood stream infections and E coli bloodstream infections. & Ensure Integrated Care Organisation staff and patients are protected from infection. & At all times have in place a fully functioning, highly visible Infection Prevention and Control Team (IP&CT) that reports to the Infection Prevention & Control Group (IP&CG) meeting every quarter.***	Q1, Q2, Q3, Q4	March 2019

17. Torbay and South Devon Foundation Trust Infection Prevention and Control Strategy – April 2018 – March 2021 . Ratified 25/1/18

Background

The Health and Social Care Act 2008 *Code of Practice on the Prevention and Control of Infections and Related Guidance.* 2010, *Healthcare-associated infections* qs113 February 2016, *Prevention and control of healthcare-associated infections* qs61. April 2014 and *Healthcare-associated infections: prevention and control in primary and Community Care* cg139 March 2012 – all form the basis of the Torbay and South Devon Foundation Trust (TSDFT) Infection Prevention & Control (IP&C) Strategy. This Strategy will be implemented within the IP&C Annual Forward Plans and monitored by the Quality Improvement Group.

1. Strategic Objectives

I. Engage all staff from Board to Ward in pro-actively preventing healthcare acquired infections and make sure they understand the importance of IP&C.
II. Ensure Integrated Care Organisation staff and patients are protected from infection.
III. Ensure patients & staff with healthcare associated infections and infected with alert organisms and conditions are managed safely.
IV. At all times have in place a fully functioning, highly visible Infection Prevention and Control Team (IP&CT) that reports to the Infection Prevention & Control Group (IP&CG) meeting every quarter.
V. Achieve the DH targets for *Clostridium difficile* infections, MRSA blood stream infections and E coli bloodstream infections.

2. Ambitions

I. Set the IP&C Annual Forward Programme (AFP) each year and present to Execs.
II. Complete 85% of the KPIs and actions within the IP&C AFP.
III. Reduce non-compliance in Saving Lives Hand Hygiene, peripheral cannula care, central venous catheter care, urinary catheter care & antimicrobial prescribing to a minimum of 5%.
IV. Reduce non-compliance with Safe patient placement in highest risk areas to less than one per calendar month per ward. As measured by Datix or IP&CT.
V. Reduce non-compliance with Safe patient placement in normal risk areas to less than three per calendar month per ward. As measured by Datix or IP&CT. If non-compliance occurs this will trigger a root cause analysis with the relevant area.
VI. Ensure each SDU maintains IP&C mandatory training at TSDFT target.
VII. Ensure the Environment Group reports regularly to IP&CG and actions involving cleaning and Infection Prevention Society (IPS) Environmental audits & actions are completed.
VIII. Legionella /Pseudomonas Control, in Water Systems, are in place with an up-to-date Trust policy which is audited as required by L8 Approved Code of Practice & HTM01-04.
IX. IP&CT to participate in TSDFT meetings as deemed appropriate by the Chief Nurse, Lead IP&CT and Director Infection Prevention & Control.

X. Participate in PHE's Mandatory Healthcare associated Infection Surveillance and any other surveillance to reduce the incidence of avoidable harm.

3. External Reporting

Progress on the implementation of this Strategy will be reported to:
Care Quality Commission's Inspectors
Annually to the trust board.
South Devon & Torbay Clinical Commissioning Group (SDTCCG)

References

The Health and Social Care Act 2008: Code of Practice in the prevention and control of infections and related guidance. Department of Health 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123923.pdf

Prevention and control of healthcare-associated infections Quality Standard. 17 April 2014.
nice.org.uk/guidance/qs61
http://www.nice.org.uk/guidance/qs61/resources/infection-prevention-and-control-2098782603205

Healthcare-associated infections: prevention and control in primary and
community care. 28 March 2012. nice.org.uk/guidance/cg139
https://www.nice.org.uk/guidance/cg139/resources/healthcareassociated-infections-prevention-and-control-in-primary-and-community-care-35109518767045

Surveillance of Surgical Site Infections in NHS hospitals in England 2010/2011
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131972352

An interim analysis has been done by the CDC, USA published in MMWR on 16/2/18
(https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a1.htm?s_cid=mm6706a1_e)

https://academic.oup.com/cid/article/50/11/1462/505636

clinical attack rate of 11.7% and 15.1% for seasonal influenza A and 11.9% and 24.2% for seasonal influenza A and B in 2007 and 2008

National Institute for Health and Care Excellence (NICE) QS-049 Surgical Site Infection (October 2013);
nice.org.uk.guidance/qs49

NHS Improvement May 2017 Publication code: CG 28/17
https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/

Scottish Intercollegiate Guidelines Network (SIGN). Antibiotic prophylaxis in surgery. Edinburgh: SIGN; 2008. (SIGN publication no.104). [July 2008, updated 2014]. Available from URL: http://www.sign.ac.uk

Managing Medical Devices
Guidance for healthcare and social services organisations .April 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/421028/Managing_medical_devices_-_Apr_2015.pdf

Cover sheet and summary for a report to the Trust Board of Directors						
NHS Foundation Trust Self Certification Requirements					4th July 2018	
Report sponsor	Chief Executive					
Report author	Interim Company Secretary					
Report provenance	Executive Directors' meeting 26 June 2018					
Confidentiality	The paper should remain confidential as elements of it are for future publication and are in draft.					
Report summary						
Purpose (choose 1 only)	**Note** ☐	**Information** ☐	**Review** ☐	**Decision** ☐	**Approve** ☒	**Ratify** ☐
Recommendation	The Board is recommended to approve the self-certification drafted on behalf of the Board on 24 May following approval of the Annual Report and Accounts which contain the relevant audited assurances required for self-certification, coupled with the further evidence provided in this report.					
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	There is no identified risk associated with ratification of the self-certifications. There is regulatory risk associated with a failure to self-certify.					
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Internal and External Audit scrutiny of the Annual Report and Accounts • Board of Directors Meeting to approve the Annual Report and Accounts on 23 April 2018 • Executive Directors meeting dated 19 June 2018					
Stakeholder engagement	The primary stakeholder in relation to the risks and recommended provisions is the Board of Director.					

Other standards affected	The recommendations made in this report will impact upon compliance with: • The Trusts FT Provider License, the FT Constitution, the Monitor FT Code of Governance, the Single Operating Framework, NHSLA, and Care Quality Commission requirements.
Legal considerations	The Board has a legal and regulatory duty to abide by the conditions of its Provider License and the NHS Foundation Trust Code of Governance. This includes demonstrable, evidenced compliance with the standards set out in the self-certifications. 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.

Board Self-certifications May 2018		4th July 2018
Report sponsor	Interim Chief Executive	
Report author	Interim Company Secretary	

1. Background

1.1 NHS Improvement requires NHS Foundation Trusts to self-certify the following declarations annually:

- Condition G6(3) – the Trust has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);
- Condition CoS7(3) – the Trust has the required resources available to provide services if providing commissioner requested services. NHS foundation trusts designated as providing CRS must self-certify under Condition CoS7(3). Foundation trusts authorised before 1 April 2016 will have been specifically notified by their commissioner if they have been designated CRS. They do not need to complete the CoS7 declaration if they have not been notified.;
- Condition FT4(8) – the Trust governance systems achieve the objectives set out in the licence condition;
- Training of governors – governors have received sufficient training and guidance to carry out their roles.

1.2 The aim of the self-certification is for Trust Boards to assess whether they comply with these conditions. There is no process prescribed by NHS Improvement. Nonetheless, templates have been provided for Boards to use.

1.3 Boards must complete self-certification records no later than:

- G6/CoS7: 31 May 2018
- FT4 and training of governors: 30 June 2018.

1.4 The self-certification is not sent to NHS Improvement, but NHSI expects to conduct an audit of a selection of Trusts to check for evidence of self-certification.

2. Discussion

2.1 The Board self-certifications for 2017-2018 were compiled on 24 May 2018 following the Board's approval of the Annual Report, Annual Accounts, and Quality Report (Account). Together, the three elements of the Annual Report and Accounts set out audited and unaudited evidence of the Trust's compliance with the terms of its License.

2.2 Coupled with the opinions of the Internal and External Auditor on quality, risk management, internal control, financial control, and the CQC's well-led report, there is sufficient evidence to demonstrate on-going compliance. Furthermore, the Trust's financial planning for the forthcoming year sets out how the Trust

intends to continue the provision of safe services of the standard and quality the Trust has established.

2.3 For each of the confirmed statements available to the Board for the self-certification, there are similar statements available should the Board not have sufficient confidence in the evidence and outlook as presented in the Annual Report. These will be available during the Board's deliberations if necessary.

What is the Board confirming?

2.4 **For General Condition G6** – Systems for Compliance with Licence Conditions, the Board is required to respond "confirmed" or "not confirmed" to the following statement:

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

2.5

2.6 Note that licence condition G6 paragraph 2(b) requires that the ***systems and processes*** in place to identify risk to compliance with licence conditions are effective and regularly reviewed.

2.7 **For Continuity of Services Condition 7** – Availability of Resources (Commissioner Requested Services only), the Board is asked to certify that:

"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

2.8 Note that "required resources to continue to provide commissioner requested services" covers ***management, financial and staff resources, plus facilities and physical assets***.

2.9 **For Condition FT4(8)** – the Trust governance systems achieve the objectives set out in the licence condition, the Board is asked to confirm that:

The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

2.10 The final two elements the Board is required to confirm are that:

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

3. Evidence of Compliance

3.1 For the purposes of self-certification for Condition G6 and 2.6 Condition 7, the Board should consider the following sources of evidence:

(a) Relevant papers presented to the Board of Directors
(b) Relevant papers presented to Trust Board standing committees:

  (i) Quality Assurance Committee
  (ii) Finance, Performance, and Investment Committee
  (iii) Audit Committee

(c) The Risk Management Strategy, the Board Assurance Framework and Corporate Risk Register
(d) CQC registration and "Good" overall and recognised as well-led
(e) Accreditation with the NHS Resolution (was NHS Litigation Authority)
(f) NHS improvement Single Oversight Framework
(g) Opinions on assurance from External Auditors in relation to:

  (i) Annual Governance Statement
  (ii) Annual Accounts
  (iii) Quality Account

(h) Opinion on assurance from the Trust's Internal Audit programme on relevant topics including:

  (i) Risk Management & Assurance Framework
  (ii) Duty of Candour and Whistleblowing Procedures
  (iii) Financial Management: System Savings Plan Arrangements
  (iv) Debt Management – Adult Social Care Client Income
  (v) Payroll
  (vi) Creditors
  (vii) Combined Finance Audit Reviews
  (viii) Torbay Pharmaceuticals – Employment of Agency Workers
  (ix) Delayed Transfers of Care
  (x) Safeguarding Adults – DoLS
  (xi) Mortality Review Procedures
  (xii) Progress against Care Model Projects
  (xiii) Transition from Children's Services
  (xiv) Winter Planning
  (xv) Incident Reporting (Clinical)
  (xvi) Care Homes – Pricing, Quality and Contracting
  (xvii) Information Governance Toolkit
  (xviii) General Data Protection Regulation Preparedness – Position Statement
  (xix) Consultant Job Planning
  (xx) Governance – Trust Board Performance Management Reporting including quality, performance, and financial reporting
  (xxi) Strategic Estates Partnership
  (xxii) Year End Stock Take – Management Support to Finance Team
  (xxiii) Strategic Transformation Partnership (STP) Facilities

(xxiv) Management of Acute Hospital In-Patient Bed Changes Assurance Framework

3.2 For the purposes of self-certification for Condition G6, the Board should consider the following sources of assurance:

(a) Director of Workforce and OD report to the Board – Bi-monthly (this covers all Workforce KPIs including Workforce numbers
(b) Workforce and OD Group paper and notes – KPIs, Workforce Plan and Action plans/Strategies
(c) Integrated Performance Report – Monthly out to SDUs, Trust board – KPIs, Workforce Plan
(d) Trust Talk – Workforce KPIs presentation monthly
(e) NHSI workforce establishment returns – monthly part of financial reporting

3.3 For the purposes of training, governors participated in the following formal workshops:

(a) 26 April 17 CoG: Presentation on the Staff survey, COO Report – Care model implementation
(b) 19 July CoG: Presentation from COO on Quality of Care Homes, Food & Drink Strategy presentation by the Director of Estates and Commercial Development, Estates Strategy presentation by the Director Estates and Commercial Development
(c) 22 Sep 17 Annual Members meeting: presentations on Localities focusing on developments at Coastal, Rowcroft Hospice, Medical Revalidation
(d) 21 August 2017 - Meeting between governors and the Senior Independent Director
(e) 6 September 2017 - CQC Development Session
(f) 4 December 2017 - Meeting between governors and Senior Independent Director
(g) 31 January 2018 - CQC Well-Led Focus Group for Governors
(h) 16 Aug 17 - Board to CoG – Presentation and interactive session by Director of Strategy and Improvement on business Planning
(i) 25 Oct 17 - Board to CoG – Presentation and interactive session by Director of Strategy and Improvement on business Planning
(j) 21 March 18 – Strategic Estates Partnership workshop by Director of Estates and Commercial Development
(k) Governors also attended the independent training session provided by the Foundation Trust Governors' Association (FTGA).

3.4 In terms of engagement between the Board and Council, the Board should note that much of the evidence in the Annual Report and Accounts has been presented to Governors throughout 2017-18 through formal Council of Governors meetings, engagement sessions, and other meetings such as the Governors' Quality Assurance Committee.

3.5 Governors have attended meetings of the Board and the standing committees of the Board as observers. Governors have been engaged in the work of the Board and its Committee through 'question and answer' sessions, and other development activities. In addition to their induction programme, the Governors have benefited from a series of development session hosted by various Directors and members of staff. These sessions, when coupled with Governor-led PLACE

visits and other visits to Trust services are sufficient to enable the FT4 statement to be confirmed. Additionally, the governors received the External Auditor's report on the Quality Account, including quality indicators chosen by the governors. It is felt that governors have considered the evidence provided throughout the year in various fora.

4. Recommendation

4.1 Considering the full annual cycle of Board business completed in the Financial Year 2017-2018, the findings of external Regulators, the Head of Internal Audit Opinion, the Report by the External Auditor on the Quality Report (Account), and the wider sources of evidence set out in the Annual Report and Accounts, and the Board reports received in 2017/18, the Board is recommended to approve the self-certification.

5. Attached - Certification Templates

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

As set out in the Board approved 2017-2018 Annual Report and Accounts including the Quality Account. Notably, the Annual Governance Statement, performance report, balance sheet, quality report, the Internal and External Audit opinions, and the results of Care Quality Commission inspections conducted in-year.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Lis Davenport	**Name**	Richard Obbotson
Capacity	Interim Chief Executive	**Capacity**	Chairman
Date	24 June 2018	**Date**	24 June 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	1 Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	See content of the Annual Report 2017-2018 approved by the Board on 23 May 2018 for laying before Parliament. Annual Governance Statement, Quality Report, Internal and External Audit opinions, Care Quality Commission inspections.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Refer to Annual Report, including statements on internal control, Annual Governance Statement, Internal and External Audit Opinions, Quality Report.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	As for 1 and 2 above.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	As for 1 and 2 above.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		As for 1 and 2 above.	Please Respond
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	As for 1 and 2 above.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Liz Davenport

Signature _____ **Name** Richard Ibbotson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	26 June 2018
Report by + date:	Robin Sutton, 27 June 2018
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issue(s) to highlight to the Board (Month 2):

1. For assurance the Committee reviewed the Month 2 Financial Performance, which was broadly in line with plan.

2. For assurance the Committee reviewed the Month 2 Performance Standards together with related management actions and mitigations. Discussion focused upon achieving planned trajectories for the year.

3. NHSI self-certification submission for Month 2 was approved by the Committee.

4. The Committee endorsed the revisions to the 2018/19 Operational Plan which incorporated changes to CIP phasing, capital and cash.

5. For assurance a monthly deep dive was undertaken into Torbay Pharmaceuticals and specifically the metaraminol risk, this risk will be re-visited in six months.

6. For assurance, the Children and Young People's tender was reviewed, and this will be presented to the Board for approval prior to submission. Due diligence will be critical for risk mitigation.

7. Torbay Pharmaceutical's financial performance for May 2018 was discussed by the Committee for assurance, with the financials being in line with plan for Month 2.

8. Updates to the Finance Risk Register were reviewed and noted by the Committee and Board Assurance Framework Risks Numbers 2183 (CIP) and 2185 (Control Total Achievement) were reviewed.

9. The IM&T report from 7 June 2018 was provided for information and assurance together with the GDPR update report from 4 June 2018.

10. The processes for Reference Costs 2017/18 were approved by the Committee.

11. The Committee noted the publication by CQC of The Trust's "Use of Resources" report and the evaluation as "Good".

12. EDG and SBMG meetings for June 2018 were verbally referenced.

Key Decision(s)/Recommendations Made:

1. As above.

Name: Robin Sutton (Committee Chair)

Cover sheet and summary for a report to the Trust Board					
Report title: Report of the Medical Director - Medical Resilience and Workforce Report				Date: 4 July 2018	
Report sponsor	Medical Director				
Report author	Medical Director				
Report provenance	This report has been compiled from output of the Trust workforce group and recruitment team and the STP workforce and Acute Service Review teams.				
Confidentiality	Public				
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 both within the Trust and through the STP. There is an emerging concern in relation to junior doctor recruitment for August 2018. The Service Delivery Units have risk assessed the situation and identified short-term mitigations. However the result is likely to be additional financial pressure. A longer term strategy will be developed through the medical workforce group. Other aspects of medical workforce development are described, in particular the recently developed medical leadership programme.				
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 staffing and the actions being taken to mitigate those risks. The board is asked to note the content in relation to the Mutual Support arrangements requested or in place across the Devon STP, the need for support for some of our services and role of Trust employees in providing support to others under this arrangement.				

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 Trust Medical HR team is leading on the harmonisation across the STP of medical recruitment and of terms and conditions of service. • There is early benefit from the engagement of an agency with the aim of increasing recruitment from overseas. • Progress in relation to the development of a medical leadership programme for Clinical Service Leads and Associate Medical Directors • 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. • The early experience of implementation of the STP Mutual Support Agreement, the benefits to the Trust and the support that the Trust has provided to others and future development of Service Delivery Networks. • There are gaps in recruitment of junior doctors across the majority of areas of Trust activity. A risk assessment is being completed and a short term and longer term action plan is required.	
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 26 June 2018 • Risk Management Group • TSD Workforce Group • Acute Service Review Group, Devon STP.
Stakeholder engagement	The following stakeholders were consulted during the compilation of this report: • Medical Joint Local Negotiating Meeting 19 June 2018
Other standards affected	None
Legal considerations	None

Report title: Medical Resilience and Workforce Report		Date: 4 July 2018
Report sponsor	Medical Director	
Report author	Senior Medical HR Manager and Medical Director	

1. Introduction

The aim of this report is to provide Trust Board with an update on issues affecting recruitment and retention of the medical workforce.

There have been concerns relating to the resilience of the senior medical workforce in some areas in the Trust. In many cases the specialty areas that are fragile in TSDFT reflect national shortage areas and are also areas of concern in neighbouring Trusts.

The report provides information relating to recent recruitment and information about the actions taken at STP level to mitigate the risks of medical resilience. The TSDFT Medical Human Resources team are leading on many of the STP initiatives around medical recruitment and terms and conditions of service.

The Mutual Support Agreement of Devon STP was approved by Trust Boards and introduced in November 2017. Over the last 7 months there have been a number of requests for support reflecting short term capacity shortfall and longer term service fragility.

2. Medical Human Resources summary

2.1 Clinical Excellence Awards

As of 1st April 2018 CEAs became a contractual requirement, calculated at 0.30 per 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.

The new CEA process will work as follows:

Between 2018 and 2021, trusts should invest the value of an additional 0.3 points per eligible consultant each year. This means that by 2020/21 the value of points awarded will be equivalent to 0.9 per eligible consultant.

This level of investment reflects previous scheme arrangements where awards were paid on a consolidated basis until retirement. Under the new arrangements awards will be time limited and non-consolidated allowing for reinvestment of the released funds, which is combined with the new awards investment for the following year.

The CEA committee have advised that they wish the awards to be paid up to 2 years retaining our current local agreement that successful applicants may only apply every other year. This will be taken to JLNC on 3rd July for ratification.

National Guidance on the implementation and financial investment process has been delayed due to a difference of opinion between NHS Employers and the BMA although we understand that guidance should be issued in the coming weeks.

It is our intention to open applications for CEAs over the summer period with the CEA Committee meeting in the autumn to allocate awards.

2.2 Job Planning

The new Job Planning policy has been ratified at JLNC and has been issued. The Medical HR team are now attending Directorate meetings to provide a Q&A session of the implementation of new policy and will subsequently be holding training sessions on using the Allocate e-job plan system. 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.

2.3 Medical Leadership Programme

Last year the Trust introduced a Medical Leadership programme for our Clinical Leaders. The aims of the programme is as follows:

- For Medical leaders to feel more supported in their roles
- To support the sequential development of leadership skills and enable and support succession planning in medical leadership roles
- To inspire stronger clinical leadership within specialties and across the organisation

Our session in May provided the group with an update from our Chairman as to his role, the role of the Board, and Non-Executive Directors. The group then used the rest of the session for Action Learning Sets; a method of both individual and organisational development based upon small groups of peers meeting over time to tackle real problems or issues in their leadership roles.

The next session in June is a training course on Managing Doctors Performance and Behaviour delivered by the National Clinical Assessment Service (NCAS).

2.4 Remedium Recruitment Agency

Through Devon's Sustainability and Transformation Plan (STP), it has been agreed to engage with Remedium, an International Recruitment Agency to help fill some of our long term permanent medical vacancies. Remedium Partners are a global healthcare consultancy business with a focus on workforce transformation and strengthening the NHS substantive workforce.

Medicine have partnered with Remedium to interview 4 overseas doctors to fill their junior gaps. The interviews were successful and Medicine intend to offer a Fixed term contract at F2/CT1 level.

In addition Obstetrics and Gynaecology have made a successful Registrar appointment from overseas who will fill a vacancy gap on the registrar rota.

2.5 Leading on Medical Workforce for the STP

Both Medical HR Managers are taking lead roles for the STP in the development of Medical Workforce policies and processes. The aim is to provide a consistency of approach to the Medical Workforce across the STP. Work that is currently on-going and being led by Anna Alexander and Kelly Ebdon-Marks includes:

- **Recruitment Memorandum of Understanding** – this is an agreement that all STP Trusts will sign up to facilitating the efficient and effective movement of medical staff across the STP. As a result of this work we have been asked to modify the document so it is applicable to all NHS staff.

- **STP wide rates of pay for trainee locums –** through the Regional wide Medical HR Managers group the following rates have been proposed and agreed by the Medical Directors. Individual Trusts are now taking this through their JLNC arrangements.

Trainee Doctor Grade	Social Per hour	Unsocial (per hour) week nights 21:00-07:00 weekends Friday 21:00 to 07:00 Monday
F1	£25	£30
F2	£30	£35
ST & CT 1&2	£40	£45
ST3+	£60	£65

- **Retire & Return Process for Medics -** review of current processes/policies to encourage and assist retire and return for medical staff.

- **Additional Hours Payments –** To reach agreement for consistency across STP and write one STP wide policy.

- **STP Wide Recruitment Day –** The NHS Trusts within the STP in conjunction with Devon County Council are holding a recruitment fair to attract people to come and work in Devon. The fair will be aimed at Medics, Registered Nurses, Pharmacists, Physios, Occupational Therapists and Social Workers. We have teamed up with NHS Creative to provide some innovative marketing to advertise the event. The recruitment fair will be in September with the exact date still to be finalised.

2.6 Streamlining Doctors in Training (DiT) Recruitment

On 1st June 2018 the National Streamlining Project team advised that due to lack of funding they would no longer be able to support the national pilot sites. There is encouragement for us to continue with the process and nationally implementing the 6 Principles still remains the key priority to ultimately ensure that DiT have an improved experience each and every time they rotate. As a Trust we will continue to work with our other pilot sites RD&E and Derriford to test the process with the August rotation.

2.7 Medical Recruitment

Table 1 – Senior Medical Vacancies and recruitment.

Current Permanent Medical Vacancies / Appointments as of 21 Jun 2018			
Post Title	**Grade**	**Specialty**	**Comments**
Locum Medical Retina Consultant	Consultant	Ophthalmology	1 appointed – Started 11 June 2018
Specialty Doctor in Stroke Services	SAS	General Medicine - Stroke	1 shortlisted candidate declined interview offer – awaiting further instruction from manager as to re-advertisement
Consultant in Emergency Medicine	Consultant	Emergency Medicine	1 candidate shortlisted – interviews due 27 Jun 2018
Consultant in Acute Medicine	Consultant	Acute Medicine	Due to close 1 Jul 2018 – No applicants at present
Consultant Corneal Ophthalmologist	Consultant	Ophthalmology	3 candidates shortlisted – interviews due 27 Jun 2018
Locum Specialty Doctor in Breast Care	Consultant	Breast Care	1 candidate appointed – due to start 2 Jul 2018
Medical Retina Consultant	Consultant	Ophthalmology	1 candidate appointed – due to start 3 Aug 2018
Consultant ENT Surgeon	Consultant	ENT	Joint appointment with RD&E, closed 15 April. Interviews being held 3 May at RD&E – Awaiting outcome from Manager
Consultant Haematologist	Consultant	Haematology	Closing date extended to 14 Sep 2018 as no applicants received at present
Locum Consultant Haematologist	Consultant	Haematology	1 applicant appointed – due to start 1 Aug 2018
Locum Consultant in Urology	Consultant	Urology	Closed 4 Mar 2018 – Interviews 10/04/2018 candidate cancelled due to family reasons trying to arrange another date – Awaiting further instruction from manager
Specialty Doctor in Emergency Medicine (CESR)	SAS	Emergency Medicine	Closed 11 Jun 2018. 3 candidates shortlisted. No interview date set at present.
Consultant Community Paediatrician	Consultant		1 applicant – due to close 21 Jun 2018
Consultant Radiologist interest in Breast Radiology	Consultant	Radiology	Due to close 24 Jun 2018 – No applicants at present
Consultant in Clinical Radiology	Consultant	Radiology	Due to close 24 Jun 2018 – No applicants at present
Locum (Fixed Term) Specialty Doctor in	Consultant	Neurology	Due to close 28 Jun 2018 - 3 applicants. Provisional

Neurology			interview of 12/07/2018 set
Consultant in Non-Interventional Cardiology	Consultant	Cardiology	1 appointed – due to start 23 Jul 2018
Consultant in Oral & Maxillo-Facial Surgery	Consultant	Oral & Maxillo-Facial	1 appointed – due to start 2 Oct 2018
Locum Consultant in Anaesthetics	Consultant	Anaesthetics	1 appointed – due to start 13 Aug 2018
Consultant in Diabetes & Endocrinology	Consultant	General Medicine - Diabetes & Endocrinology	1 appointed – Started 18 Jun 2018
Consultant Histopathologist	Consultant	Histopathology	1 appointed – due to start 31 Jul 2018
Specialty Doctor in Trauma & Orthopaedics	SAS	Trauma & Orthopaedics	1 appointed – due to start 1 Aug 2018
Consultant in Interventional Cardiology	Consultant	Cardiology	1 appointed – due to start 16 Jul 2018
Consultant UGI Surgeon	Consultant	Upper GI	Advert Live with closing date of 23 Jul 2018 – No applicants at present
Locum (Fixed Term) Consultant in Colorectal	Consultant	Lower GI	Advert live with closing date of 23 Jul – No applicants at present
Consultant Urologist	Consultant	Urology	Advert live with closing date of 23 Jul 2018 – No applicants at present

2.8 Junior Doctor Recruitment

Significant concerns are emerging in relation to junior medical staffing across the Trust. There are numerous gaps in rotas from 8 August 2018. These have only very recently come to light because final placement allocations for August are only received from Health Education England in June. Recruitment to Trust posts is only just complete and for the first year there has been a failure to recruit to key posts in some specialties. This is reflecting the national recruitment position which did not affect us last year to the same extent as it affected some Trusts. The position is considered to be a result of the outcome of the junior doctor contract dispute of 2016. There is a particularly serious shortfall in the South West in GP training posts which contribute very substantially to some rotations in the Trust.

There are significant shortfalls in all Service Delivery Units, for the first time in Medicine and in Surgery. In Paediatrics problems have been experienced over the last 4 months due to failure to recruit or sickness resulting in the need for consultants to undertake resident night duties. This has had significant adverse impact on capacity for elective aspects of Paediatric care.

2.8.1 Short term actions.

The Medical Director has met with the clinical and operational leads of all SDUs. Each has agreed mitigating actions to reduce clinical risk and to maintain experience for junior doctors as much as possible. There will be adverse impacts of these actions, including unplanned financial pressure, potential for increased reporting through the Guardian of Safe Working Hours, reduced satisfaction reporting through the GMC survey and through training programmes. A summary of risks and mitigations will be presented by the Medical Director to the August Trust Board.

2.8.2 Longer term actions.

A longer term plan is needed to address junior medical workforce challenges. It will take 10 years for the announced expansion of medical school places to benefit the Trust. A coordinated action plan to mitigate against reduced junior doctor numbers and capacity is needed which is likely to include the development and employment of other health professionals in extended roles, change in care pathways and utilisation of technology as well as innovative recruitment solutions. The development of this plan is on the work programme of the Medical Workforce Group. An outline plan is required in 3 months. It is likely that a business plan for investment will be needed to support this plan.

3. Mutual Support Agreement of the Devon STP.

In November 2017 the Mutual Support Agreement (MSA) of the STP was implemented. In the following months there has been a number of requests for support. TSDFT has requested support on some occasions and has provided support on others. The MSA provides short term (3 months) support. In areas where a longer term solution is required the STP is coordinating a review of the service delivery model. In the majority of cases a Service Delivery Network (SDN) is being considered across Devon. Appendix 1 summarises the MSA requests that have been made to date.

4. Discussion

Some areas of concern in resilience of medical staffing remain. The Trust is working proactively to redesign pathways and to maximise opportunities for improving skill-mix within challenged services. The recruitment position is stable or improving in relation to senior medical posts in the majority of services. The Medical HR team are now leading on STP strategies to recruit and retain medical staff and to maximise flexibility of medical staff to work across the STP. The situation in relation to junior medical staff is the cause of considerable concern. Actions to mitigate the risks to patient care and to staff experience have been discussed.

The building of relationships and clinical networks across the STP is important to the resilience of medical specialties in the Trust. There is early evidence of benefit to patient safety and quality of care through greater collaboration of Trusts. The next stage is the development of Service Delivery Networks which is being led by the Medical Director in his role as Lead MD for the STP.

5. Recommendations

The Trust Board is asked to note the contents of the report and to acknowledge the importance of working across the STP in terms of resilience of medical specialties. TSDFT has both benefitted from and provided support to others through the MSA.

Appendix 1 - Mutual Support Agreement Tracker, Devon STP.

Mutual Support Request Tracker								
Update 20/06/2018								
	Date of Request	**Requesting Trust**	**Clinical Service**	**Support Agreed**	**Supporting Trust**	**Duration**	**Support Start Date**	**Further Action Required?**
1	?	PHNT	Breast Surgery	4 sessions per week, excluding travel time, dependant on Surgeon availability	RDE	1 month	02/01/2018	Appointment in Plymouth - on-going recruitment.
2	19/12/17	NDHT	Obstetrics & Gynaecology	4 days per fortnight labour ward Consultant support (2 days RDE, 2 days PHT) Gynae support not required at present	RDE & PHT	3 months + 3 months	18/01/2018	3 month extension agreed, with potential need for further 3 months and outstanding requirement to define model.
3	19/12/17	NDHT	Acute Medicine	Meeting in January. No immediate support required. Longer term model review.	N/A			All other Trusts contributing to review group led by MD of UHP
4	19/12/17	NDHT	Care of the Elderly	Twice weekly stroke ward rounds	RDE & TSD	1 month	08/01/2018	Ditto
5	19/12/17	NDHT	Diabetes & Endocrinology	None required at present - long term model review required.				RDE & TSD in discussion around model. Locum in place.
6	23/04/18	RDE & TSD	Haematology	Plymouth have offered to support TSD by transferring acute leukaemic inpatients (not activated). No support agreed for RD&E	UHP			SpR acting up in TSD for limited period. Agreed need for Devon and Cornwall review of Haematology service provision. Led by MD of TSD and operational lead from RDE.

7	01/05/18	RDE	Neurophysiology	Provided by independent provider (at high cost). Review of Devon provision required.				For discussion at MDs call 17052018. MD of UHP to explore capacity in service to provide more robust and less expensive service.
8	17/05/18	UHP	Radiotherapy	Support for prostate patients.	TSD and RDE	1 month		Outcome to be confirmed.
9	1/06/18	NDHT	Stroke	I day Stroke consultant from TSD to go to NDHT.	TSDFT	Ad hoc		Longer term capacity review required (linked to ASR)

Cover sheet and summary for a report to the Trust Board					
Report title: Report of the Interim Chief Operating Officer				Date: 4th July 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, Senior Business Management Team and other support committees, the Torbay Adult Social Care Programme Board the Market Development Executive Group				
Confidentiality	Public				
Report summary	• Operational plans have been finalised and the teams are securing the increase in capacity necessary to stabilise delivery and secure the commitments set out in the Trust plans. (RTT / Cancer and 4 Hours) • Significant progress in finalising the 4 hour improvement plan and enhancing the means of delivering the plan has been made. These enhancements are described in detail in the report. • Establishment of the Discharge Hub in the coming days and optimising this new development is expected to contribute significantly to optimise patient's experience of hospital discharge. • A conference of principle social workers across the region was an excellent example of local leadership. The event focussed on the asset based approach and the teams explored with each other the different approaches to secure the potential benefits from the 2014 Care Act. This learning will be taken forward with support from The National Development Team. There is lots of transferable learning to services across the ICO form this work. • The Trust has commenced formal consultation on the new delivery structure with those immediately impacted.				
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. This report provides more information on the plans in place to secure improvement in the performance standards.
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 or the business it relates to: • Clinical and operational teams through various meetings including the Senior Business Management Team and Quality and Performance Meetings. • NHS and Local Authority Commissioners • NHS I – Regulators • The Elective Care National Intensive Support Team
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:4th July 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. Overview

The Service Delivery Units (SDUs) have finalised the priority areas requiring additional capacity in order to secure the quality and performance standard improvements that were signed up to in the operational plan. This covers increased ward staffing, support for earlier senior decisions in the urgent care system and additional clinical capacity in elective, cancer services and diagnostic imaging. The investments are complimented with detailed action plans for the service and standard improvements. The Trust invited the National Intensive Support Team (IST) to review the elective (RTT) and cancer waiting times plans. Feedback from the IST was received on the 22nd June and will be reviewed and considered carefully as part of the roll out of the plans.

In advance of some of the substantive capacity being available the Trust is working with other NHS and private providers to secure short term increases in capacity in order to bring waits down as quickly as possible. This approach has already been successful in reducing waiting times for endoscopy and is now being explored for other specialty areas. In addition to areas requiring investment, the teams are also securing the required service improvements through innovation and redesign and some of these are described later in the report, including for example the establishment of the “Discharge Hub”.

NHS Improvement has recently conducted a review across the south of England of the key drivers of ED performance over winter. The indicators they have identified for system health seek to secure resilient delivery of the 4 hour standard. This is forming a corner stone of the work the Trust is doing to improve in this area. The indicators are not new to the Trust (bed occupancy levels, extended length of stay, variation in time of day of admission and discharge) however the evidence is very helpful in providing a framework for the improvements the Trust will drive over the coming weeks in advance of the autumn.

The Service Delivery Units CIP targets continue to be progressed however 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

The Discharge Hub

On Monday 9th July there will be a new way of referring patients with identified needs for a short term offer of care on discharge from hospital to the community teams and services. A Discharge Hub has been created to support and streamline discharge processes from both the Acute and Community Hospitals. The Discharge Hub has integrated existing teams from Devon County Council Hospital Discharge team, Care Direct Plus and ICO Staff; working together to provide a co-ordinated approach for facilitating safe discharges. The team will be based at St Edmonds in Torquay. The Discharge Hub triages referrals and enables the co-ordination of the most appropriate service and/or team to support the patient with their identified needs. The Discharge Hub team include, Social Care Assessors, Nurses, Health and Social Care Co-ordinators, Therapist and a Team Lead. This is an excellent initiative drawing together teams and expertise from our whole system and will be fundamental to improved patient experience of hospital discharge, flow of patients and a reduction in bed occupancy rates.

Social care conference

Our principle social worker facilitated an excellent gathering on June 19th sharing best practice and innovation from across the South West around how other areas have implemented the 3 conversation model and engagement with communities and the voluntary sector. The drive is to increase individual's strengths and ability to support themselves as well as increasing activity in low level interventions and prevention. All of our Social Workers are engaged in this agenda and will be further supported with by the National Development Team for inclusion who we have commissioned to provide a community led support programme.

4. Surgery

The Surgical Team highlighted gaps in capacity to meet demand in the following areas and these are all included in the process described above to secure rapid improvements.

- 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. This is being addressed through the revenue prioritisation process.

5. Medicine and Urgent and Emergency Care

This month the focus of the SDU report is emergency and urgent care.

4-hour improvement trajectory

Last month it was reported that the Medical Director and Head of Operations had commissioned a review of the system wide urgent care data to better understand the factors that are contributing to the Trusts lack of resilience in delivery of the 4 hour standard. The review is now complete and has been considered twice by the Flow Board since the last report. The Flow Board has finalised the resulting action plan and is putting the finishing touches to the enhanced process for overseeing, assuring and supporting delivery of the plan. The team has visited University Hospital Plymouth to observe their new processes which are credited with delivery of significant improvement in performance. This has resulted in the changes locally commencing from the 25th June that will be kept in place and adapted as required until improved performance and patient experience improvement is secured.

The Trust's new process includes a daily multi agency urgent care call to review the previous 24 hours activity and performance from across the urgent care system and a weekly 4 hour Improvement Delivery Board. The Board will oversee the improvement plans developed through the Flow Board and will report into the Flow Board. The group will use data the leads for each improvement plan have identified to measure the impact of their plans and to keep pace going on delivery between Flow Board meetings. The Board will also review evidence from the NHS Improvement (South) review of 4 hour performance drivers described earlier to ensure that we accommodate this learning in our improvement actions.

Action plan:

The headline areas identified in the action plan are as follows;

1) Safer 7 – optimisation of patient discharge from bed based care across 7 days
2) Optimising flow through rehabilitation pathways across the system
3) Management of the urgent care floor
4) Day to day management of the urgent care plan (information and delivery)

National developments

In support of improving patient's experience and bed capacity the National Director for Urgent and Emergency Care wrote to all CEO's on the 13th June. The letter set out a target to reduce the number of patients staying over 21 days in acute hospital beds by 25%. This target has been set for each of the 134 acute providers. The table attached to the letter sets out the target reduction and shows TSD FT had the 3rd lowest percentage 10.7% of bed days occupied by patients staying over 21 days, the national average is 21.5%. The Trusts target is a reduction of 3 from the 2017/18 average of 44, to have no more than 41 patients in acute hospital beds saying over 21 days.

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 Dr Kate Lissett. The initial redesign engagement event on 22 June 2018 was attended by many colleagues from across the system and has set the process off on an excellent course. The timescales are very short and the intention is to bring the Final Business Care to Board and seek approval from NHS England in March / April 19.

6. Women's Children's and Diagnostics

The Team has faced a number of the capacity challenges set out by the other SDUs particularly in radiology and in addition to this has been involved in a number of service development priorities.

Sexual Health Tender
The Team have been working with the lead provider Northern Devon Healthcare Trust to mobilise the new Sexual health Service which was awarded earlier this year. The new service commenced on the 1st July 2018.

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. The team are continuing to work collaboratively with Alliance partners and our bid writing team preparing for the next stage of the process which commenced at the end of June, with a submission date of 27th July 2018.

7. Delivery Structure

The consultation process for implementation of the Trust's proposed Delivery Structure started on the 18th June. The structure has been discussed and revised over the last year and brings together the management of acute, community and adult social care services under each of five new Community Service Delivery Units (CSDUs). The CSDU's align to the current Localities; Torquay, Paignton and Brixham, Moor to Sea, Newton Abbot and Coastal. In addition to the CSDU's, the structure includes two strategic System Delivery Teams one for Torbay and the other for South Devon. The model follows the principle of supporting the delivery of services in the ICO to maximise integration opportunities and to be community facing.

The consultation relates to those senior managers who are directly affected by the introduction of the System Delivery Teams and the CSDUs and these managers are all engaged in the process. Subject to the conclusion of the consultation process, recruitment to the structure will commence in September 2018.

8. Learning from the Systems Failure Resulting from the Annex fire

Following the annex fire previously reported the CEO has commissioned a review with support from the CCG to ensure learning is taken with a view to reducing the risk of reoccurrence and secures maximum learning from the events. The scope of the review will cover:

- Annexe Fire: what was the cause of the fire and was it preventable
- IT outage: why was there an outage and what resilience was in place and what resilience is now in place
- Communication: How were the risks identified and communicated to the command structure
- Generator failure: why did the supply from emergency generators fail
- Recovery: was there shared situational awareness during the recovery phase
- Summary of where we are today and residual risks

9. 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 for a report to the Trust Board					
Report title: Quarterly Report of the Directorate of Strategy and Improvement				**Date:** 4 July 2018	
Report sponsor	Director of Strategy and Improvement				
Report author	Deputy Director of Strategy, Performance and Planning				
Report provenance	Executive Directors – 26 June 2018				
Confidentiality	Public				
Report summary	This is the quarterly report for the Strategy and Improvement Directorate for the period Quarter 1 (April to June 2018) in the financial year 2018/19. It follows the same format as previous reports and provides an overview of the activities, outputs, and focus for each of the five core functions that constitute the Strategy and Improvement Directorate. This report provides information to the Board about critical areas of development that support the delivery of our organisation's and, where relevant, system objectives as part of our day-to-day operational business. Additionally, this report provides information about the wide range of activities that the directorate lead which are about planning for tomorrow, ensuring that the Board's strategic vision and plans are well communicated and well executed.				
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	It is important the Board is assured that the Strategy and Improvement Directorate is best positioned to create, enable, and add value across the organisation and health and care system especially in the context of the current challenges that are impacting across the whole of the NHS. Expertise and capacity within the directorate must be focussed towards the organisation's biggest strategic and delivery challenges to optimise the success of the organisation, its partnerships and support long term sustainability.				
Dependencies and risk	This report provides the Board with an overview of the key areas of development and activity for the Directorate. It highlights key areas of focus in the first section which include the next steps in the development of our strategy, and an overview of key areas for performance, quality improvement, strategic communications and the Health Informatics Service.				

	The second section provides a summary of key outputs for Quarter 1 of 2018/19 and a forward view for Quarter 2 for the financial year 2018/19, together with key performance indicators that reflect progress against important strategic objectives Key risks and mitigations include: • **age of critical IT systems**. The Board's decision to prioritise capital and revenue for IT (and other infrastructure) will enable some of the key risks to be mitigated • **workforce engagement** – we need to engage differently with the workforce. Our work with ICE creates and the engagement work being led by Judy Falcao, the Director of Workforce and OD will provide the framework to enable this to be achieved. As well as supporting organisation wide, the Directorate senior team is supporting work across the full directorate to improve team morale in response to the staff survey results feedback • **stakeholder engagement** – feedback and learning from partners and communities in Dartmouth confirms we need to rethink our approach to stakeholder engagement. This will be a priority for Q2 • **locality delivery model** – current support functions are arranged around the existing SDU structure. Teams are working on the transformation they need to support the new delivery structure. • **Operation plan delivery** – risks to performance and financial plans are well documented. The Directorate is providing support across all areas to secure the improvements necessary and provide assurance
Summary of scrutiny	The recommendations in this report have been subject to challenge, due diligence, and risk assessment by: • Executive Directors meeting - 26 June 2018 • Interim Chief Executive Review 28 June
Stakeholder engagement	The directorate is critically involved with the engagement of internal and external stakeholders and wider system partners. In particular ongoing strategic communications are focussed on supporting discussions underway in Dartmouth and Teignmouth Communities. The directorate is also working closely with colleagues in Human Resources and Organisational Development, giving focus to the conversations with our staff as part of building a clear story about the future of our local care services. This includes describing what will be different for people as result of accomplishing our strategic priorities.
Other standards affected	Careful consideration will need to be provided to issues of equality and diversity as we mould the strategic refresh and as we develop and refine business plans with each of our Service Delivery Units.
Legal considerations	None

Report title: Quarterly Report of the Directorate of Strategy and Improvement		Date: 4th July 2018
Report sponsor	Director of Strategy and Improvement	
Report author	Deputy Director of Strategy, Performance and Planning	

1. Introduction

This is the quarterly report for the Strategy and Improvement Directorate for the period Quarter 1 (April to June 2018) in the financial year 2018/19. It follows the same format as previous reports and provides an overview of the activities, outputs, and focus for each of the five core functions that constitute the Strategy and Improvement Directorate. These functions are:

- Strategy and Development;
- Planning and Performance;
- Quality Improvement;
- Strategic Corporate Communications; and
- Health Informatics Service.

This report provides information to the Board about critical areas of development that support the delivery of our organisation's and, where relevant, system objectives as part of our day-to-day operational business. Additionally, this report provides information about the wide range of activities that the directorate lead which are about planning for tomorrow, ensuring that the Board's strategic vision and plans are well communicated and well executed.

2. Quarter 1 2018/19 Overview

The templates appended to this report provide an overview of key outputs for Quarter 1 (April – June 2018) and a forward view look for Quarter 2 (July – September 2018) for each function. The key performance indicators help to convey progress against relevant areas of development.

2.1 Function Highlights

The following highlights are worthy of particular note:

Strategy and Development:

Care Model Delivery Group

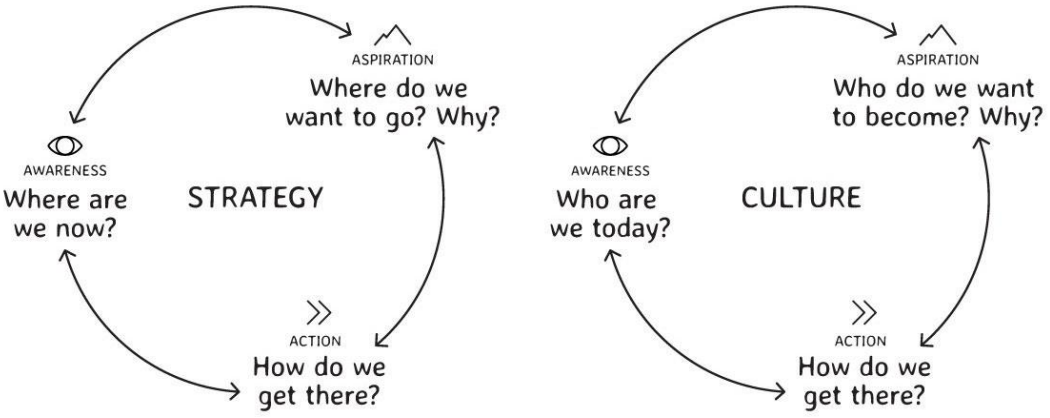
The Care Model Delivery Group (CMDG) met for the last time on the 20th June 2018. This marks the achievement of a significant system wide transformational change programme of which 90% of the 30 workstreams are either fully operationalised or are well underway. It is important that the care model changes continue to be reviewed and monitored to ensure that the changes are embedded and the full impact of the change is optimised.

One of the reasons for stepping down CMDG was a recognition that the ongoing oversight of the care model changes should take place as part of core operational and clinical business, thus helping to secure wider ownership for the care model, particularly within acute specialities who have been less involved in some of the changes. Each of

the 30 workstreams has been assigned to an existing group or divisional board and members of these groups will be responsible for ensuring set outcomes continue to be delivered.

The Next Steps in our Integrated Journey

Our journey as an integrated care organisation has reached an important milestone. We recognise that embedding change and sustaining a different approach to caring for people, supporting people to care for themselves and enabling communities across Torbay and South Devon to thrive, means that we must pay attention to 'who we are' and 'how we work' – our culture. How we invest in the wellbeing of our staff and support different ways of working through our new operational structure, is interdependent with our strategy for the next phase of our integrated journey as illustrated below.



Our Board development session on Wednesday 2nd May 2018 facilitated a discussion that helped to inform a clear and concise strategy that guides the work of our organisation in the next 12 months. The outputs of the session which have been articulated in a next steps document helped us to clarify the achievements that we want to celebrate in 12 months' time and in three years' time and enabled us to identify five key strategic strands of work that are critical to us moving towards accomplishing our future vision.

Our directorate is supporting the Human Resources (HR) and Organisation development (OD) teams in the development of materials which will be used to have a conversation with as many of our 6000 staff as possible about their view of our collective future and what they see as their contribution in supporting the five key strands of work and in helping to realise our aspirations.

Quality Improvement:

- Maternity improvements including debriefing of the Score survey. This will support improvements around staff wellbeing and culture.
- NHS Quicker and digital innovations including:
    - 'Technology is the Easy Bit' conference hosted by Health and Care Impact Network and Digital Horizons. Key note from National Programme Lead for NHS Digital innovation (Cleveland Henry) and show case of local innovations and learning including NHSquicker.

- Histopathology received a Staff Hero award recognising in-part QI support (Toni Boarer).
- NHSquicker has been submitted for an HSJ awards.
- The University of Plymouth supported by QI and the Deputy Medical Director have put in for a joint research grant to support the development of real time feedback tool for people being supported in the community.

Engagement and Communications:

Critical Incident communications - The Communications Team has supported the out of hours internal critical incidents which were declared due to IT disruption. A review is underway to consider how out of hours communications input can be supported to be more resilient as this is currently provided on a good will basis and does not afford us the ongoing resilience we require. Options being considered include formalising links with colleagues in the Devon STP.

Summary of key press releases:

University & NHS team up to launch pioneering Academy of Nursing (17 May)	A new Academy of Nursing will combine academic rigour with NHS expertise to raise standards of care.
CQC rates Trust as 'good' (17 May)	Torbay and South Devon NHS Foundation Trust has been rated as 'good' by Care Quality Commission (CQC) inspectors who recently visited the trust. **30k+ shares on Facebook**
Global knitting appeal crafts hats for Torbay's babies (4 May)	Torbay and South Devon NHS Foundation Trust's Maternity Services are celebrating after their appeal for knitted baby hats has seen over 2,000 donated from all over the world. **BBC Spotlight** **Devon Live** **Boost Torbay** **Popular on facebook** **Radio Devon**
Dates set to hear views on new health centre proposals (30 April)	Dates for public drop-in events to talk about the possibility of creating a new health and wellbeing centre to support a wide range of health needs in Teignmouth have been announced.
New radiotherapy machine opens at Torbay Hospital (12 April)	A new state-of-the-art cancer targeting Linear Accelerator (LINAC) is now open to service users at Torbay Hospital. The opening marks the end of a three-year investment programme designed to update and improve the Oncology facilities at the hospital.
Patient blood management makes the shortlist	Torbay and South Devon NHS Foundation Trust has been shortlisted in this year's Health Service

	Journal (HSJ) patient safety awards. **BBC Spotlight**
New breastfeeding master classes launched (10 April)	Torbay Hospital has launched a new breastfeeding master class for mums to be. The sessions are free and they are run by midwives. Mothers who are or have breastfeed are also on hand to answer questions that people may have.

Planning and Performance:

- **Operational Plan for 2018/19:** The Final Operational Plan for 2018/19 was submitted to NHS Improvement on 30 April 2018. Feedback provided by NHSI and a Trust response collated and submitted on 20th June 2018. Finalisation of investment plans for each of the SDUs in response to operational performance targets are now advancing in conjunction with key decisions to resolve financial gaps in CIP plans.

- **Performance Reporting:** Integrated quality, workforce, performance, and finance board report continues to be refined and in particular the report will evolve to reflect greater emphasis on:
  - Community and social care
  - Service user experience and feedback
  - ICO metrics.

  A survey of the recipients of the Integrated Board Report is underway to establish views on the format, content, and areas for improvement, with a non-executive seminar session planned for the 4th July 2018.

- **NHS Improvement service improvement visit:** A two day visit from the NHSI Service Improvement Team was hosted in June to review systems, processes, and plans for delivery of cancer and RTT targets. Positive feedback received and offer for further support in areas on cancer pathways and capacity planning.

- **Quality surveillance submission for specialist services:** The annual declaration of compliance has been complete with clinical teams for submission 30th June 2018.

- The performance team are supporting a review of activity and data recording across the **Children's and Young Persons** (CYP) teams.

Health Informatics Service:

- **Capital and Revenue Investment** – Following the Board decision regarding the financial strategy for the year 18/19, the process to agree the priorities for capital and associated revenue requirements is now nearing completion. Expectation is that by the next quarter the funding approvals will have been received and procurements will be underway.

- The **Service Desk** was successfully transitioned to the new service provider. This project mitigates the risk of a £400k cost pressure.

- Significant resource and support has been provided in response to **Infrastructure Issues** following the fire in the Annexe in April, which resulted in a number of zero-notice power failures to the computer room (CR1). The most recent power failure occurred within a few hours of the previous one and before the data synchronisation recovery was completed. This led to the IT system being unavailable for around four hours. Clinical teams needed to execute business continuity plans during this time and were commended for their professionalism and calm approach during this incident. The reinstatement of an uninterruptable power supply is a key priority for the Estates and Facilities Management team as this is the key mitigation to prevent a re-occurrence.

- **Project deliverables –** The priority projects which have been agreed by the Clinical Management Team continue to be delivered as planned. This includes the printing project completed in Q1 and now delivering recurring saving in 18/19. The Critical Care system also went live and the re-hosting of the radiology system was successfully implemented

- **Project enablers –** new projects are being scoped ready for implementation which support flow and care model optimisation. This includes the community IT project which supports Integrated Care. Our critical objective to enable “Tell my story only once” is dependent on investment yet to be agreed.

- **Service resilience –** teams are working on business cases to ensure scarce capital resources are targeted at areas of greatest need. Significant efforts are being invested in this quarter to try and secure STP-level capital funds.

- **Corporate compliance –** the team is supporting the organisation to ensure ongoing compliance with new GDPR legal requirements which came into force in May.

- **National Reporting –** the Emergency Care Data Set (ECDS) project is underway, although delays due to the ongoing infrastructure issues are impacting progress of the project. The go-live date is set for September 2018 and has been supported by national engagement to ensure wide awareness and support.

- **Cyber Security –** the first tranche of investment has enabled appointments to key posts that help to address the Care Certs. An onsite security re-assessment took place on June 19th by NHS Digital. The report following the re-assessment is expected in the next fortnight.

- **Children and Young Peoples’ Service –** the team are supporting the bid team with an IT strategy and mobilisation plan and supporting dialogue sessions as required.

- **Sexual Health –** the team have supported the Trust as a partner with North Devon in the successful bid to provide sexual health services. Support for the mobilisation phase is now underway.

2.2 System Contribution

The Directorate makes a significant contribution to system working at both local place level (South Devon and Torbay) and at the wider Devon Sustainability and Transformation Partnership (STP) system level. Examples of current involvement include:

- **Torbay Together** – strategic partnership across public, private and third sector organisations from across the Bay with a shared vision for an unrivalled quality of life for everyone who lives, works and enjoys being in Torbay. As part of the partnership's *Now is the Time* campaign, Torbay Together has created a lobby document to inform ministers from across a number of key portfolios – education, housing, health, coastal zones, regeneration, growth – of the ambition, opportunities and plans to improve life chances for people in the Bay and to seek support to go further faster. Representative from the partnership, (including the Trust's Director of Strategy and Improvement to represent the NHS), had a meeting in Westminster in June with Growth Minister Jake Berry and local MPs Kevin Foster and Sarah Wollaston to make a case for supporting investments in the Bay to secure economic and social growth. Jake Berry has agreed to visit the Bay during the summer to hear first-hand the challenges and opportunities we are pursuing together.
- **Ageing Well** – lottery funded partnership with third sector and public sector working together to support active healthy ageing. The Trust's Director of Strategy and Improvement represents the Trust on the Partnership Board. Current activities include setting up an Older Peoples Assembly and developing an All Age strategy
- **South Devon and Torbay System Partnership Group** – this replaces the System Delivery Board and is a forum where partners have the opportunity to inform the development of the place-based Local Care Partnership. The Trust's Director of Strategy and Improvement and Deputy Director of Strategy are both supporting the CCG in developing a fit for purpose partnership group.
- **Health and Well Being Boards –** Both of the Health and Well Being Boards that cover our populations (Devon and Torbay) have been reviewing their purpose, goals and work programmes. The Director of Strategy and Improvement has contributed on behalf of the Trust and helped to shape revised terms of reference
- **Devon STP programmes –** representatives from the Directorate are involved in a number of the STP work programmes including Mental Health and Learning Disabilities, Urgent Care, Acute Services Review, Shared Corporate Services, Workforce Planning; Digital and Children and Young People.
- **Devon Children and Families Alliance –** the Directorate is supporting the Alliance in developing proposals to transform the experience of children, young people and their families in response to the current re procurement opportunity
- **National profile:** As part of our plan to raise the profile of the care model nationally, the Trust and STP Directors of Strategy presented at a national conference in June (Health Plus Care 2018) in two sessions. Session 1 *"Mrs Smith 10 years on"* focussed on the Torbay and South Devon integration journey. In session two the Directors took part in a panel with other STP leaders in a session focussed on *Building the Relationships to Underpin Rapid Transformation.* The sessions, which were well received, attracted over 100 delegates at each.

3 Planning for Tomorrow

The following narrative highlights specific programmes of work that the Directorate is leading on/supporting to enable the organisation and local system to be sustainable, and better able to meet the health and care needs of the local population we serve within the resources available

3.2 Strategy and Development

Evaluating the Integrated Care Model
A document *'Why does Integrated Care Matter to Mrs Smith'* is being developed to distil key learning and a summary of progress achieved via the Care Model Delivery Group. This will help inform the wider evaluation of the Integrated Care Model that our Researchers in Residence are contributing too.

The options appraisal referred to below under the Quality Improvement section sets out a recommendation to extend the research in residence model for a further 12 months to enable an evaluation of the care model changes. This is resource dependent and is due to be considered by the executive team in mid-July.

Working with our communities to develop Health and Wellbeing Centres
We continue to work closely with our partners and local communities to realise our commitments to providing health and wellbeing centres in some of our towns. These facilities ensure local access to support, advice and care that people want to be able to have close by in their communities. Close working with Dartmouth community is important as we develop plans for a health and wellbeing centre recognising the strength of feeling of many people in Dartmouth, who feel unhappy at the loss of the Dartmouth and Kingswear Community hospital.

The engagement sessions which were run in Teignmouth have now concluded and the information gathered from speaking to a range of local people and groups is being reviewed and will inform proposals that will be consulted on later this year.

The building of the 'Friends Centre' led by the voluntary sector in Brixham is progressing well and plans for the activities that will take place in the new centre are well underway. This new centre will contribute to the offer of health and wellbeing support in Brixham.

Discussions with our local community and stakeholders are continuing about what future health and wellbeing centre provision looks like in Paignton, building on the very successful utilisation of the temporary health and wellbeing centre at the old Paignton Hospital site.

The Locality Health and Wellbeing Implementation groups are responsible for making sure that local people and our own staff are involved in shaping services in line with the vision for Health and Wellbeing Centres and Clinical Hubs. This includes the implementation groups for Newton Abbot and for Moor to Sea.

3.3 Quality Improvement

- The Outpatient Innovation Programme has been extended in scope to include cardiology and clinic room/resource scheduling as well as GIRFT and electronic referrals. This is a significant change programme that has the potential to change the way outpatient services are delivered in the future by being more tailored to what is important to people.
- Quality Improvement coaches are now supporting the £13m Emergency Department/urgent care project.
- The Researcher in Residence (RiR) options appraisal for supporting the on-going care model evaluation from spring 2019 has been completed and has been supported by Care Model Delivery Group for consideration by the executive team on July 13th.

3.4 Strategic Corporate Communications

The Communications Team continues to proactively look at new ways of communicating the vision and strategy of the Trust and its part in the STP with our staff and stakeholders.

Working in partnership with Organisational Development colleagues, the team is continuing to deliver and embed the staff Engagement and Communications Plan. We will also support the development of any agreed outputs from the ICE Creates research and narrative development and will be supporting increased staff engagement and communication around the ongoing development of our care model and service integration, based on what is important to people.

Other key priorities for the quarter ahead include:

- Leading internal and external communications on the collaborative NHS bid to run services for children and young people in Devon
- Reviewing the feedback received in Teignmouth and preparing for any consultation required
- The selection of a Strategic Estates Partner
- Events to mark the 70th anniversary of the NHS;
- Progressing changes to our website, including income generation proposals
- Promoting a new directory of service to staff and public
- Reviewing and re-launching staff recognition/award scheme;
- Continuing to seek and share people's success stories so that we can evidence the benefits of the new care model in practice;
- A wide range of business as usual activity, including staff and stakeholder newsletters.

3.5 Planning and Performance

2018/19 Business Planning

The Operational Plan for 2018/19 was finalised and submitted to NHSI on the 30th April 2018. Following feedback on our submission by NHSI, the trust took the opportunity to resubmit the plan on the 20th June 2018 reflecting our updated financial profile taking into account our commitment to investment in capital programmes.

Monitoring delivery of the aspirations, commitments, and targets set out in the plan are being delivered through a combination of:

- Development and sign off of Service Delivery Unit (SDU) delivery agreements against agreed standards and performance trajectories.
- Working alongside colleagues in operation teams to enable the information our systems yield to be understood, interpreted, and used to improve flow and inform decision making along our care pathways. Examples of this include tracking potential delays in treatment by examining individual patient pathways to predict and overcome the likelihood of delays.
- The routine production of performance dashboards, updates, and reports for the Quality and Performance Review Meetings and the monthly Finance, Performance, and Investment, and the Trust Board. These daily, weekly, and monthly processes furnish operational management teams, the Executive, Committee, and Trust Board with the information needed to understand and manage our services more effectively.
- Reviewing and updating these processes, and the underpinning dashboards and reports, throughout 2018/19 as our new organisational structures are established and bedded in.
- Developing new dashboards and reporting tools to support day to day operations as they are required i.e. Control Room Dashboard.

In parallel with this work to support and assure delivery in 2018/19 the team will be reviewing current planning processes in Quarter 1 of 2018/19 so that planning for 2019/20 can start in Quarter 2. We need this proactive approach so that we can breakout of annual planning cycles and move towards a continual development cycle.

3.6 Health Informatics Service

The development of innovative technology to enable change is critical to sustained delivery of the care model outcomes for our communities. Restrictions in capital funding for new technologies has and continues to be limited.

As well as continuing to deliver change projects to enable care model developments and pathway and workforce improvements, the HIS will be focussing on developing plans to ensure the organisation is safe and compliant with legislation changes.

Priority areas for 2018/19 include:

- Investment in renewing IT infrastructure to redress the lack of same over the past five years
- Ensuring organisation compliant with new GDPR legislation that came into force in May
- Support for the increased clinical engagement following the Medical Director, Chief Nurse and Chief Clinical Information Officers' initiative in this area.
- Mitigating risks of the ever-present and evolving cyber security threats
- Need for substantial investment to replace legacy equipment and systems – for example cost of a new patient administration, laboratory, theatre, cardiology, ED, pharmacy stock control, maternity, order comms and PACS systems; mobile devices for staff and service users;
- Strategy update – IM&T strategy update and link to digital and technology enabled care, incorporating the changed landscape with the RD&E EPIC implementation

- Workforce development – partnership with RD&E to avoid a ‘brain-drain’ following their advertising of 75 senior posts in IM&T to support their EPIC implementation.
- Shared service for appropriate HIS functions

4 Recommendations

The Board is recommended to:

- **review** the document; and
- **review** the evidence presented.

Executive Lead:

Ann Wagner
Director of Strategy and Improvement

Report Author:

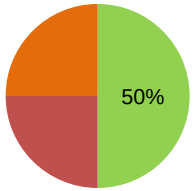
Dawn Butler
Deputy Director of Strategy, Performance and Planning

Strategy & Development

Team KPI Scorecard

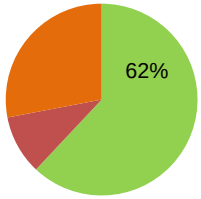
System Wide Savings Plan – Care Model 18/19 Target £1.7 million

System savings plan revised in light of current system performance.



Programme Delivery of Care Model Strategic Changes

This compromises all large scale programmes: VS partnership, IM&T enablement etc.

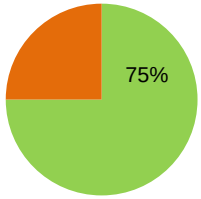


This shows that 62% of programmes are delivered, 28% are being implemented and 10% are at risk due to financial investment (HIS) and system wide capacity (mental health).

Strategy Update Development

Engaging organisation & partners in our strategy.

Remaining 25% relates to programme planned for Autumn which engages staff with describing our integrated future and their contribution to it.



Summary of Key Outputs for Q1 2018-19 and Forward View for Q2 2018/19

Supporting Delivery Today

- **The Care Model Delivery meets for the very last time on 20th June 2018.** The decision to stand down the fortnightly group reflects the move towards a new locality structure and new way of working where, care model delivery and strategy, will become a core part of business across all teams and groups. It also reflects that 90% of the work programmes have either been delivered in full or are being implemented and led operationally.
- The **Board Development Session** on Wednesday 2nd May 2018 facilitated a discussion to inform the development of a clear and concise strategy that guides the work of our organisation in the next 12 months. The outputs of the session which have been articulated in a next steps document identify **5 key strategic goals** that we will talk to staff about in the forthcoming staff conversations due to start in late summer.
- The **portfolio of strategy and development has come together with performance and planning** and is led by the Deputy Director for the directorate. This helps ensure strategic planning for tomorrow is integrated with system performance and embedded in operational delivery via business planning.
- **Locality Dashboards** and **System Metrics** are now used to inform the Integrated Board Report to provide a greater awareness and understanding by Board of how our integrated care system is responding to the care model changes.

Strategy - Planning for Tomorrow

- 'Why does Integrated Care Matter to Mrs Smith' – A document that provides a summary of progress delivered via the Care Model Delivery Group is being developed and will highlight key learning from the implementation of the Care Model over the last two years.
- This document together with the outputs of the work our researchers in residence have supported and the ICO system metrics dashboard will begin to provide an overview of the achievements and benefits of the integrated care model since we became an Integrated Care Organisation.
- Community development that is self-developing and self-sustaining and which supports healthy, safe and connected places in which people live is an integral part of the care model. Work is underway to consider how we evolve our approach to accelerate pace and increase inclusion to whole communities. This follows an initial scoping paper that was discussed at the Joint Executive group on 19th June 2018.

KEY: Delivered | In progress – on target | Remedial action required

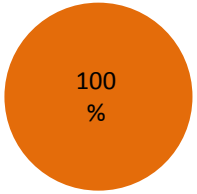
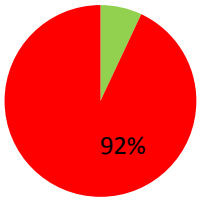
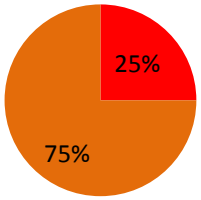
Dawn Butler – Deputy Director of Strategy, Performance and Planning

Quality Improvement (QI)

Team KPI Scorecard		Summary of Key Outputs for Q1 2018-19 and Forward View for Q2 2018/19 Supporting Delivery Today	Strategy - Planning for Tomorrow
Annual Quality Account which forms part of the Trust Annual report & accounts ready for publication for May 2018		Quality Account 17/18 – completed on time. Annual report (inc quality accounts) due to be published on the internet end of June.	New strategic programmes underway: • Nurse led/criteria led discharge • Outpatient transformation programme • £13m ED/AMU new build • Patient Experience Collaborative • Business planning and transformational change work • CQUINs 18/19 • NHS mail care homes – parked with CCG until new IG toolkit online and approach agreed with care home how to take forward. • Smoking and pregnancy • Health literacy & digital inclusion • Winter pressures- completed
Build capacity and capability in improvement methodology (IHI)		F1s/trust Fellows presented their QI project to the members of the Exec. Projects include H@D tasks, recycling, patient experience, antibiotic reduction, sepsis, neonates. Band 6 QI programme in development with nurses/AHPs and social workers with start date autumn 18. 1hrs QI taster sessions started and 3 day programmes starting autumn 18.	
ICO care model research completed by April 2019		Researcher in residence options appraisal paper completed on time for June CMDG. If supported then to Execs. Paper includes outcomes for the RiR impact survey. Two papers for publication due to be completed by end of June.	
Implementation of info flex surgical 'O'' drive by June 2018.		Surgeons have decided to use clinical portal to provide daily list of patients. Project closed and potential to revisit once embedded as part of daily work.	
NHS quicker (Devon & Cornwall Emergency App)		New website completed & live www.nhsquicker.co.uk and video to support use will be available form end of the month. Work presented to Cleveland Henry (NHS National digital innovation lead) at the Technology is the easy bit conference. App gone forward to HSJ awards – sharing information to improve care.	
Embed 'Trusted assessor' ways of working as part of the Five Year Forward View by the end of 2018		Memorandum of Understanding in place. On-going liaison with 5 local care homes to enable test of change. Planned test of change date Quarter 4.	
100% of inpatient wards with safer bundle in place by Oct 18 & 33% of discharges by midday		Stock take completed and SAFER Friday huddles re-launched and work on-going in Hetherington to check SOPS are in place and being used. Acute wards still struggling to hit midday requirements.	
Provision of ambulatory emergency care , at least 14hrs a day , 7 days a week by December 17		Business case drafted for AMU (phase 4) expansion. Interim measure whilst the new footprint is developed. Will support increased activity and safer working/experience. Due to go to Execs in June and shared with ED/AMU project board prior to approval.	
Pain management: To reduce the number of new patients waiting to be seen by 30% by December 2017.		Fibromyalgia - new pathway developed and data used to inform further development of the pathway. On-going work with Deputy Medical Director (QI) & Pain CD.	
Breast care histopathology redesign & relocation by April 2018		New system started from the 1st April. Few IT improvements on-going. QI Coach and team have received a staff heroes award for their work	
Development of a national resource discovery system by August 2018		Options appraisal on-going with Health Education England. Business case on target by July/August 2018.	

Susan Martin Associate Director, Quality Improvement

Health Informatics Service

Team KPI Scorecard	
HIS: The percentage of staff using EPR at the point of care	*Expected July 2018*
HIS: The percentage of information that Clinical Effectiveness are able to source electronically	*Expected July 2018*
HIS: The number of patient/citizens interacting digitally (for clinical purposes) *20,415*	
HIS: The number of clinical Improvement Champions	*Expected July 2018*
*HIS: Percentage of current year capital & revenue investment requirements formally approved**	
HIS: RAG-rated Priority IT Projects	

Summary of Key Outputs for Q1 2018-19 and Forward View for Q2 2018/19

Supporting Delivery Today

- Community IT Project – build underway for pilot in Coastal of SystmOne. Planned go live in Q3 2018.
- Number of admitted patient care episodes coded over the last four weeks: 7,799
- Medical records completeness of ward note keeping: 94%
- EA Server moved successfully.
- Work underway on Lymphedema system replacement.
- Critical Care Unit system went successfully live 12 June.
- Data Engineering met their reporting obligations despite challenging infrastructure problems.
- Preparations for GDPR compliance in place and reviewed by audit as appropriate.
- Radiology Information System Re-hosting – went live.
- IT Operations Resources significantly focused on mitigations required following the fire in the Annexe.

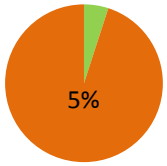
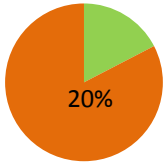
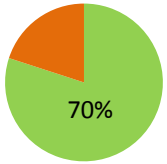
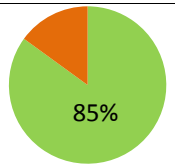
Strategy - Planning for Tomorrow

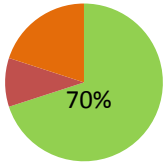
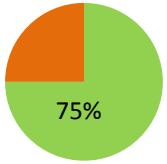
- Resolution on Capital and Revenue investment requirements to enable Trust's cyber security mitigations to progress.
- Appointment to cover senior manager long-term sickness absence will enable progress to be made on GDPR compliance and FoI performance.
- Need to revisit Document Management System business case delaying project.
- *The high percentage of investment requirements awaiting approval is due to there being revenue requirements attached to the capital spend. Execs agreed priorities for investment which are expected to enable progress from July 2018.
- Planning for EPMA go live well underway – changed approach to avoid issues encountered on the pilot.
- ECDS go live in September 2018.

KEY: **Delivered** **In progress – on target** **Remedial action required**

Gary Hotine – Director of Health Informatics

Planning and Performance

Team KPI Scorecard		Summary of Key Outputs for Q1 2018-19 and Forward View for Q2 2018/19	
		Supporting Delivery Today	**Strategy - Planning for Tomorrow**
2019/20 Business Planning		• Team demand and capacity plan support. • Supporting validation of improvement schemes. • Review process for 18/19 and prepare outline process for 2019/20 for Q2 implementation.	• Overall process of supporting SDU plans and presentations to the Trust Board. • Work with new organisational structure on format of business plans.
Delivery agreements 18/19 (20%)		• Delivery agreements to be drafted and signed off with SDU teams. • Operation of the framework will be reviewed and revised, to reflect experience and best practice elsewhere, in Q3/4.	• Work with teams on areas of variance against agreed deliverable outcomes agreed in Delivery Agreements through the Quality and Performance assurance process.
Quality and Performance Review Meetings		• Monthly meetings established and running well with all four operational SDUs.	• Operation and structure of the QPR meetings to be reviewed and revised, to reflect experience and emerging requirements of organisational structure and governance processes.
Integrated Performance Report		• Report being reviewed with survey to users to collect feedback for improvement. Report being extended to cover Patient Experience and wider ICO metrics.	• Adapt to reflect revised operational structures. • Increase resilience of the process and the effectiveness of organisational engagement. • Ensure that the action plan and feedback cycle is incorporated into report. • Provide internal escalation of performance actions.
Weekly Performance Update		• Weekly performance update on key indicators for Executive Team developed and instituted. VTE indictor recently added to weekly update. • Produced each Monday to Executive Directors with up to date (but unvalidated) data to assist trend spotting and decision making.	• To be kept under review to ensure data is relevant.
Control Room Dashboard		• Control Room Dashboard developed, implemented, and in use.	• Maintain the dashboard and update as necessary.

ED Activity Monitor and Predictor		• Predictor developed, implemented, and in use and is now circulated to key staff and managers as an automated process at 8am each morning. • Support the COO and head of operations in the action plan to deliver improved performance through control metrics and system escalation triggers.	• Maintain predictor and update as necessary. • Further develop the use of available information into meaningful and timely operational information for daily operational control and escalation as well as support review and analysis of wider service model performance.
People Waiting over 52 Weeks		• Good processes in place, with regular reports prepared and circulated to key operational mangers to summarise position and highlight people who have had to wait extended periods for treatment so that corrective action can be taken. • Team also accountable for final validation of the outturn position each month. • Trajectory to reach position where no one will wait longer than 52 weeks for treatment agreed.	• Ongoing need to prepare reports, progress chase with operational teams and validate outturn.
Collaborative working with CCG and STP variation group		• Good relationships developed with CCG and STP performance and BI teams through on-going relationship management and responding to enquiries from the CCG and STP in relation to performance management.	• To continue throughout 2018/19.

KEY: **Delivered** **In progress – on target** **Remedial action required**

Paul Procter – Head of Performance

Strategic Corporate Communications

Team KPI Scorecard		Summary of Key Outputs for Q1 2018-19 and Forward View for Q2 2018/19	
		Supporting Delivery Today	**Strategy - Planning for Tomorrow**
Regular communication channels	**Daily** • Web content review - In April and May **66,150 people** looked at a total of **232,395 pages**. • Frequent social media updates **Weekly** • Board Update • Staff Bulletin • Screen savers **Monthly** • Trust Talk and briefing • Back Pocket Board briefing • Stakeholder newsletter *Health and Care Insights*. **Reach** **298,657** Facebook post reach in Q1 **156,000** Tweet impressions in Q1 Top messages: • CQC Good rating • Clinical School launch • £13m funding for emergency services • Carers week • PJ paralysis • New Brixham Day Centre • NHS70 park run	Proactively released information and/or responded to the media 95 times (high number of media enquiries during recent severe winter weather) resulting in coverage of a range of subjects including: • Announcement of £13m funding for Torbay ED • Blood recycling • Hospital lockdown incident • Staff heroes during severe weather • Fantastic support from volunteer 4x4 drivers • Winter pressures/flu/norovirus • Staff survey results • Apprenticeships open day • LGA award for partnership working on new care model • Nursing recruitment day • Maternity survey feedback • Riverview Care Home in Dartmouth • Blood recycling first in South West • Award of contract to deliver sexual health services, as a sub-contractor to NDHT. • Produced briefings for key stakeholders throughout the quarter including local MPs. • Team act as the leads for STP communications within the Trust. In this role we have participated in the development of a number of key communications for staff, stakeholders, and the public.	• We will be continuing our campaign #ProudOfOurNHS that highlights the hard work and commitment of our staff • Engagement and consultation in Coastal locality • Procurement of CYP services and NHS partnership tender • Developing a new staff recognition/awards scheme • Working through localities to identify and share good news and success stories. • Developing plans for communicating the developments of the Trust in improving care as part of the NHS 70 celebrations. • Leading the development of strategic communications across the STP for the Local Care Partnership (South) and Planned Care. (Due to a potential conflict of interests, we are no longer leading communications for the Children's and Young People's workstream)

Jacqui Gratton/Corinne Farrell – Joint Head of Communications