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

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

7 August 2019 09:00 - 7 August 2019 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	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence - Director of Finance, Director of Workforce and Organisational Development Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 3rd July 2019 and Outstanding Actions Approve 19.07.03 - Board of Directors Minutes Public.pdf 9	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive Review Report of the Chief Executive.pdf 25	CE	
2.6	Integrated Performance Report - Month 3 Receive and Note Integrated Performance Report - Month 3.pdf 37	DTP/DoF/DWOD	

#	Description	Owner	Time
2.7	Pathway to Excellence Approve Pathway to Excellence.pdf 99	CN	
2.8	Annual Report of the Responsible Officer Relating to Medical Appraisal and Revalidation Approve Annual Report of the Responsible Officer relating to... 105	MD	
2.9	NHS Resolution Maternity Incentive Scheme - Year 2 Approve NHS Resolution Maternity Incentive Scheme - Year... 143	MD	
2.10	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 179	MD	
3	PART B: Matters for Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Audit Committee - 17th July 2019 Information	Ch	
3.1.2	Quality Assurance Committee - 24th July 2019 Information	Ch	
3.1.3	Finance, Performance and Digital Committee - 30th July 2019 Information 2019.07.30_FPD_Cttee_Report_to_Board.pdf 191	Ch	
3.2	Reports from Executive Directors		
3.2.1	Safe Staffing and Nursing Work Programme Information Safe Staffing and Nursing Work Programme.pdf 193	CN	

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3.2.2	Report of the Director of Estates and Commercial Development Information Report of the Director of Estates and Commercial D... 217	DECD	
3.2.3	Chief Operating Officer Report Receive and Note Report of the Chief Operating Officer.pdf 229	COO	
3.2.4	Report of the Director of Workforce and Organisational Development Information Report of the Director of Workforce and Organisatio... 243	DWOD	
3.2.5	Devon Sustainability and Transformation Partnership Update Receive and Note STP Update.pdf 249	DTP	
3.2.6	Guardian of Safe Working Hours Update Information Report of the Guardian of Safe Working Hours.pdf 263	MD	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.00 am, Wednesday 2nd October 2019	Ch	
7	Exclusion of the Public	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARD ROOM, TORBAY HOSPITAL
ON WEDNESDAY 3RD JULY 2019

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Professor C Balch	Non-Executive Director
	Mrs J Lyttle	Non-Executive Director
	Mr R Sutton	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	Mr J Welch	Non-Executive Director (from item 109/07/19)
	Ms L Davenport	Chief Executive
	Mrs D Butler	Interim Director of Transformation and Partnerships
	Mr P Cooper	Director of Finance
	Mrs L Darke	Director of Estates and Commercial Development
	Mrs J Falcao	Director of Workforce and Organisational Development
	Mr J Harrison	Chief Operating Officer
	Professor J Viner	Chief Nurse
	Councillor J Stockman	Torbay Council Representative
In attendance:	Dr I Currie	Deputy Medical Director
	Mrs J Downes	Company Secretary
	Mrs S Fox	PA to Chief Executive
	Ms J Gratton	Joint Head of Communications
	Dr S Hoque	Director of Infection Prevention and Control (for item 114/07/19)
	Mrs V Sheen	Head of Physiotherapy
	Mr W Thomas	Liaison

Governors:	Mrs W Marshfield	Mr M Birch	Mr B Bryant
	Mr P Coates	Dr C Davidson	Mr G Goswell-Munro
	Mrs A Hall	Mr J Hawkins	Mrs L Hookings
	Mrs M Lewis	Mrs E Welch	

		ACTION
103/07/19	**Board Corporate Objectives** The Board noted the Trust Corporate Objectives.	

104/07/19 **User Experience Story**

The User Experience Story was presented by Caroline, a patient with a complex medical history spanning over 20 years originating from a birth defect. Caroline told the Board about her history and the support she had received from the Tissue Viability Service throughout her life. The service has provided, in particular, expert care in terms of dressings both as an inpatient and in the community.

In sharing her story, Caroline reflected on the difficulties of accessing Torbay Hospital for a wheelchair user, and that she was fortunate in that she could attend Dawlish Hospital for her appointments, which was wheelchair accessible. Caroline added that when she had been admitted to hospital unexpectedly the fact that she was at risk of tissue damage in a very short space of time was not flagged up as a risk and she suggested that this was an area the Trust might like to address. In addition, nurses on wards did not know how to apply specialist dressings for people at risk of tissue damage.

In closing, Caroline said that she could not stress enough the excellent support she has received from the Tissue Viability service, and in particular the head of the service, Ms McKenzie and how fortunate she felt to be able to access the service when it was required.

The Chief Executive reflected on the fitness of purpose of the Trust's estate and the need to ensure the Trust's population could access any of the Trust's buildings easily and she said that the Trust was actively trying to find solutions to improve accessibility. The issue of sharing information was also part of the Trust's aspiration, but was harder to solve, however again the Trust was trying to find a solution. Finally, she wished to highlight the very positive relationship that Caroline clearly had with Ms McKenzie and how, if staff were well supported in their job it positively impacted on their relationships with the people that used the Trust's services.

In respect of nurses on wards not knowing how to apply specialist dressings, the Chief Nurse reminded the Board that general ward nurses would not have that expertise, however wards did need to ensure they contacted the tissue viability services for expert advice. Ms McKenzie added that wards now had access to good dressings and that the service was working to put in place a process for wards to inform them if a tissue viability patient had been admitted.

The Board thanked Caroline for attending the Board and for sharing her story.

PART A: Matters for Discussion/Decision

105/07/19 **Apologies for Absence**

Apologies of absence were received from Mrs Vikki Matthews, Non-Executive Director, Mr Paul Roberts, Non-Executive Director and Dr Rob Dyer, Medical Director.

106/07/19 **Declaration of Interests**

There were no declarations of interest.

107/07/19 **Minutes of the Board meeting held on the 29th May 2019 and Outstanding Actions**

The minutes of the meeting held on the 29th May 2019 were confirmed as an accurate record.

108/07/19 **Report of the Chairman**

The Chairman began by welcoming Mr Jonathan Hawkins (Nominated Governor for Devon County Council), Mrs Jackie Stockman (Torbay Council Representative) and Mr Gary Goswell-Munro, new Torbay Governor, to the meeting.

The Chairman then reported on the following:

- Mrs Matthews and Mr Richards were not present at the Board meeting as they were representing the Non-Executive Directors on behalf of the Board at a STP Chairs and Non-Executive Directors Development session in Exeter.

- With the Chief Executive, he had met with the new Chair and Chief Executive from Rowcroft Hospice. At that meeting they discussed some new initiatives from Rowcroft that had begun to have a positive impact and areas where both organisations could better work together.

- The Chairman thanked the Governors, and in particular Mrs Hall, for their involvement in the Staff Heroes event held on the 4th June, which was well-attended and received a lot of positive feedback. The Board noted that the Staff Heroes Annual Awards Event was being held on the 26th September.

- Dame Suzi Leather, Chair of the Sustainability and Transformation Partnership (STP) would be joining the Board Strategy Session on 3rd September.

- The Devon STP Chairs meeting and STP Collaborative Board were both held on the 5th June.

- The Chairman thanked those Board members and Governors who were able to attend the Education Celebration Event and Annual Volunteers Tea Party on the 7th June.

- The Chairman and Chief Executive signed the Armed Forces Covenant on the 11th June which declared the Trust's support for serving veterans and their families within the Trust's footprint. It would also provide excellent training opportunities for the Trust, with particular opportunities for reservists.

- The Board, at its Strategy Day last week, received a presentation on the future demographics for Devon which spoke to the need to change the way in which the Trust operated so that it could manage the challenges that the future would present.

- The Chairman and Chief Executive had been invited, along with other system leaders, to meet the Chief Executive of the NHS later in the month.

- The Chairman wished to place on record his thanks to Stephen Criddle, Principal and Chief Executive of South Devon College, who would be retiring over the summer.

- Finally, the Chairman wished to thank the Director of Finance on behalf of the Board, who was leaving the Trust at the end of July, for his support and guidance over the last nine years.

The Board received and noted the report of the Chairman.

109/07/19 **Report of the Chief Executive**

The Chief Executive briefed the Board as follows:

- Her thanks to the Director of Finance for his support, commitment and energy to the Executive Director team and the organisation over the past nine years. She reminded the Board that the Director of Finance had led the Trust's bid to become an ICO, and more recently led the significant programme of change required to support the Trust's challenging financial position.

- The Board noted that, at a time when operational activity usually lessened over the summer months, this had not been the case and staff had raised concerns around the level of demand in the system alongside the requirement to implement transformation programmes and the impact this was having on staff morale. It was important the Board heard these concerns and responded to staff. It was noted that the Chief Nurse, with Executives, would continue to engage with staff to find acceptable solutions.

- In terms of responding to the challenges being faced by the Trust, the Board noted that the Trust was working with a number of external organisations to support the work around urgent care, with programmes that was supported by evidence from those organisations.

- As the Board would recall, the Theatres A and B had to be closed and refurbished. It had been hoped that the work would be completed in the summer, however following a need to undertake additional work on the building infrastructure, they would not open until mid-September. Simulation training would take place during the latter stages of the building work so that the reopening of the theatres would not be delayed.

- The Trust's Day Surgery Unit had recently won two awards at the International Ambulatory Conference in Portugal which was a reflection of the innovative work that had taken place to realise a 20% increase in day surgery activity. This learning was now being shared across the Devon system.

- Primary Care Networks (PCNs) became live on the 1st July and the

Trust was keen to harness the energy and opportunities that PCNs would bring. PCNs were broadly aligned to the Trust's locality structure and would give an opportunity to work collaboratively with primary care to further the Trust's integration journey.

- The STP Interim Chief Executive, Philippa Slinger, had commenced in post on 1st July for an 18 month term of office. She would support the STP to move from a STP to an integrated care system aligned to the NHS Long Term Plan, and to ensure the system had a robust operating plan for the system that was deliverable.

The Chairman noted that, in respect of PCNs, it might be necessary for the Trust to amend its boundaries to match those of the PCNs and this was noted. Mr Welch said that he was concerned that PCNs would add an extra layer of management to the system. The Chief Executive responded and said that the ambition was that PCNs would expand the range of services offered and also provide additional capacity. It was expected that by working collaboratively it would reduce the number of people coming to hospital or accessing emergency care. The challenge for the Trust would be work with PCNs to develop integrated pathways.

Mrs Lyttle said that she felt that PCNs were the natural next step of the Trust's care model and as the Trust's boundaries were already broadly aligned to those of the PCNs, it was well-placed to take forward this opportunity.

The Director of Workforce and Organisational Development added that PCNs would help to support the need to solve the workforce challenges that remained in the system and this was acknowledged. It was noted that a joint group was in the process of being set up to look at how to manage workforce recruitment across the PCN and Trust, and also to take forward the model of health and wellbeing hubs and use these as vehicles to gain funding.

The Board received and noted the report of the Chief Executive.

Strategic Issues

110/07/19 **Devon Sustainability and Transformation Partnership Update**

The Board noted that there were no issues requiring discussion.

Delivery Issues

111/07/19 **Integrated Performance Report – Month 2**

The IPR sets out the headline performance for Month 2 (May) 2019/20 against the key quality and safety, workforce, performance, and financial standards that together represent the Trust's Operational Plan for 2019/20. The Trust's final Operational Plan, developed in the context of the wider Devon STP, was submitted on 23 May 2019 to show an acceptance of the Trust's £4.3m surplus control total. This was the direct result of the planned transformation programme reflected in the Devon STP plan, driving improved efficiency and enabling additional income being applied to the challenges described by this Trust in its last submission in April.

Performance: Against the national NHS I Single Oversight Framework:

In May, the Trust did not meet the following national performance standards or agreed planned improvement trajectories:

- Urgent care 4 hour standard: 84.2% (local trajectory 90% / national standard 95%)
- Referral to Treatment times (RTT): 81% (local trajectory 81.5% / national standard 92%)
- Cancer 62 day wait for first treatment from urgent referral: 84.5% against standard 85%
- Diagnostic waiting times: 12.1%% over 6 weeks (target 1%)
- Dementia Find: 88.3% (against standard 90%)

The Chief Operating Officer reported as follows:

- Performance was broadly in line with trajectory, however risks to delivery of targets remained.

- As reported in the Chief Executive's report, Theatres A and B would not be operational until later than expected, and also Theatres 1, 2 and 6 had not been operational for a period of time last week, highlighting the vulnerably of the Trust's infrastructure. Other risks included continuity of service being reliant on a small group of staff, mainly in the medical workforce, resulting in a continued need to use agency and locum staff to cover any gaps. In addition, support from the Royal Devon and Exeter and University Hospitals Plymouth Trusts had been secured to support the Trust's oncology service.

- As reported by the Chief Executive, the Emergency 4 hour performance was not at the standard that the Board expected, but it was inside the Quarter 1 agreed trajectory. The Chief Operating Officer assured the Board that actions were in place to improve performance and that the Trust was receiving support from NHSI and Emergency Care Intensive Support Team (ECIST) in this respect.

Quality

The Chief Nurse reported as follows:

- Focus was being given to improve the timeliness of vital signs in the minors area of the Emergency Department.

- Given the regularity of the Trust being on Opel 4 the Executive Directors were reviewing how the Opel criteria was being applied.

Mrs Lyttle queried the reduction in performance associated with the distribution of care planning summaries; the reputational risk to the Trust in respect of cancer standards; and how the Trust could support staff given the current pressures.

The Chief Executive agreed that demand had increased and that that the Trust needed to maintain focus and commitment to the work to improve performance and allow it to be embedded, which would then provide a longer term benefit and headroom for the Trust. She reminded the Board of the data discussed at the Board Strategy session in June that showed the future

demographic for the Trust's footprint and detailed a growth in acuity based on the numbers of people over 85 and the expected use of services. The model for the future needed to be able to accommodate this expected need.

The Chief Executive added that the Trust had a strong programme of work in place with good clinical leadership, but the challenge was to create the headspace to allow staff to do the right things that would make a difference whilst dealing with demand.

In respect of Mrs Lyttle's query about cancer performance it was noted that the Trust was working with the Royal Devon and Exeter NHS FT to look at providing a joint service that would be more resilient. Councillor Stockman reported that a member of her family had been referred to the breast service and had received an excellent service with everything being resolved very quickly.

The Chairman reflected in the need for the Trust to hold its nerve whilst the new ways of working were implemented and embedded, and that if the Trust continued to work in the same way as it did now it would not be able to support the expected increase in demand in the future.

Finance

The Trust 's Control Total for 2019/20 had been confirmed as a deficit of £3.80m, excluding income relating to Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) totalling £8.36m.

- The financial position as at 31st of May 2019 showed a £5.27m deficit, which was £1.29m behind the budgeted position.
- The Trust has an annual savings target of £17.5m of which schemes to a value of £14.4m have been identified resulting in a £3.1m gap. In addition there was a requirement to have an STP solution to the additional cost of the change in valuation methodology of assets under the latest Royal Institution of Chartered Surveyors (RICS) guidance. This equates to £2.5m for which no plans had yet been identified. The total CIP gap was therefore £5.6m.
- This report showed that schemes with a full year value of £1.9m had been transacted. The remaining £12.5m, though scoped had yet to be fully supported with detailed plans and, as such must be seen as holding some risk of delivery. Reflecting both this, and the gap in overall forecast delivery, urgent work was underway with all budget holders to develop additional cost control measures to cover the shortfall.
- The CIP target for year to date was £1.3m of which £0.1m had been delivered; an adverse variance of £1.2m due to undelivered pay and non-pay schemes.
- Total pay run rate in Month 2 (£21.41m) was in line with month 1 when the one off agenda for change pay award payment of £0.86m was discounted.
- Non pay expenditure run rate of £17.39m in Month 2 was in line with previous month.
- Capital expenditure as at Month 2 was £1.06m which was £0.50m underspent. The full year plan was £21.56m.

- The Finance Risk Rating remained at 4 at Month 2, primarily due to the adverse ratings for I&E Margin variance and agency spend.

The Director of Finance reported as follows:

- The report detailed a variance to plan of £1.3m, however due to processing issues a further £400,000 income had been received, so the Trust was now c£900,000 away from plan.

- Savings plans of £14m were in place, however only a small percentage of this had been translated into firm plans. Meetings were taking place with operational teams to discuss and agree cost improvement plans. At present this was an area of risk for the Trust.

- Negotiations continued to agree how risk would be managed against the STP savings plan, however it was still not clear how the plan would be delivered and what the Trust's risk exposure to this would be. The system was under some pressure to resolve this issue.

Workforce

The Director of Workforce and Organisational Development reported as follows:

- The Board noted that sickness absence in May had decreased to 3.78%, with a rolling figure of 4.20%. The Trust benchmarked favourably against its comparators and for nine of the last 12 months had achieved the lowest sickness rate compared to others.

- Turnover was within agreed tolerances.

- Appraisal performance was at 80% and mandatory training 90% which was felt to be positive given the current pressures on staff.

The Board of Directors reviewed noted the integrated performance report.

112/07/19 **NHS Long Term Plan (LTP) – Shaping our Future Strategy**

The report considered the strategic importance of the Long Term Plan in shaping the direction of the Integrated Care Organisation.

The report sets out:

- The approach that had been adopted to link the Long Term Plan with the organisation's operating plan for 2019/20 and the organisation's long term strategic view.

- The process that had been put in place to assess the organisational readiness to implement the key deliverables set out in the LTP.

- Provision of a framework that informed the Board of the key strategic aims and the key deliverables for each of the key areas of focus and critically what this meant for the Trust as an organisation both strategically as well

as at service delivery level.

- The key deliverables that would be delivered by wider system partners including commissioners, general practice, mental health providers and public health.

The Director of Transformation and Partnerships briefed the Board as follows:

- The framework in the report aimed to build awareness and knowledge at operational level. Service leads had been encouraged to consider the plan for their service area and the paper discussed the Trust's readiness for the plan and if any actions needed to be taken to meet the plan's desired outcomes.

- The framework also discussed the deliverables for the Trust and its partners, and how this could be achieved – the PCNs were part of this solution.

- The Trust's business planning process would be used to ensure that teams included the LTP strategy in their plans.

- The risk for the Trust would be to describe a set of changes that were the right one to support its population within the resources available.

The Director of Estates and Commercial Development expressed some disappointment in the LTP in respect of estates and a commitment to capital investment, the disconnect between improved clinical outcomes, and the need for an improved environment to facilitate this aim.

Professor Balch reflected on the amount of work contained in the LTP and the need for the Trust to prioritise as it could not deliver everything and this was acknowledged. It was also noted that the Trust had already achieved some of the aims of the LTP and in this respect was better placed than other Trusts.

The Board formally noted the contents and approved the approach set out in the report.

113/07/19 **Developing Devon's Long Term Plan**

The report set out:

- The timeline for the various activities which need to be completed to deliver a 5-year system long term plan (LTP).
- The governance arrangements to support the development of the plan.
- The key matters to be addressed as part of the system transformation required to deliver the NHS Long Term Plan key deliverables and any key local requirements.
- The link between the Long Term Plan and the local System Operating Plan for 2019/20 with respect to deliverables and existing plans.
- The plan for engagement to ensure staff and community involvement in the planning process at system, locality and place level.
- The key steps to ensure the system was set up to deliver the required transformation through the development of the Integrated Care System

and the Strategic Commissioning function.

The Director of Transformation and Partnerships drew the Board's attention to the following:

- The paper was being presented to all Boards across the Devon system to ask Boards to sign up to and approve the governance process to shape the Devon System five year LTP.

- Directors of Strategy were meeting regularly to ensure the work was taken forward at pace and in addition a system workshop was being held later in the month to set out the direction of travel and agree key deliverables for the Devon system.

- As part of the process there was a need to discuss with communities how they wished to influence the plan and to work with the statutory sector to deliver care to the population served by the Trust. These conversations would take place between the 11th July and 15th September and a proposal around how these would be facilitated was in the process of being agreed.

- The Board was asked to take note of the processes that were being put in place to move to a single system plan; timescales for stakeholder engagement and that the latest framework gave some clarity around the financial architecture to enable resources to flow to the priorities set out in the LTP.

Councillor Stockman informed the Board that there was some unease from partners around the speed at which this process was moving and the need to ensure that engagement with communities was undertaken correctly. To this end an extraordinary meeting of the Health and Wellbeing Board at the end of July had been called to discuss this item only, to ensure the plan was progressed accordingly.

The Board formally noted the contents and approved the approach set out.

114/07/19 **Annual Infection Prevention and Control Report**

The Director of Infection Prevention and Control attended and presented the Annual Report.

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 ensure a safe patient journey.

The IP&CT provided advice, education, audit, action plans, reporting and support in hospital and community based care, and liaised with the Locality Leads.

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 to the commissioners.

The Infection Prevention & Control Group (IP&CG) meet quarterly and ensure the IP&C Annual Forward Plan and the IP&C Strategy was 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.

From 1/4/18 to 31/3/19 the Trust reported:

- One MRSA blood stream infections (BSI) against the Trust target of zero.

- Twelve acute trust, attributable *Clostridium difficile* (*C difficile*) and nine patients defined as a 'lapse in care' but did not cause acquisition and zero lapses in care that led to acquisition, against a contractual target of 17 'lapses in care leading to acquisition'. This was set against the 17 attributable infections in 2017/18 so there had been a reduction by five patients.

- There had been a small outbreak of flu on SCBU with a need to close the unit for four days to allow all mothers, babies and staff to be screened and a deep clean to take place.

- Due to the heatwave last year legionella testing took place at both Totnes Hospital and Paignton Health and Wellbeing Centre, and samples of legionella had been found. Remedial works had been undertaken and community testing now followed the same regime as the acute trust.

- All targets had been met, and the Trust's Patient-Led Assessments of the Care Environment (PLACE) report was excellent. The Director of Infection Prevention and Control said that this was in part due to the decision to increase the numbers of cleaning staff in the Trust.

Mrs Lyttle commended the report and the work of the Infection Prevention and Control Team. She raised the issue of a lack of single rooms and the difficulty with patients needing to be isolated when single rooms were being occupied by patients who were, for example, end of life or had complex needs and asked how the Trust made sure infectious patients were able to be isolated when necessary. The Director of Infection Prevention and Control acknowledged these difficulties and said that it was a very difficult balance to manage. The Director of Estates and Commercial Development added that the use of side rooms was co-ordinated by the Trust's Site Management Team, who understood how each room was being used so that they could co-ordinate use and ensure arrangements were made for patients who ideally needed a side room, when one was not available.

The Chief Executive welcomed the report, and highlighted the work of the Infection Prevention and Control team and the role the team played in supporting patients pathways into and out of hospital.

It was noted that there had been three CDiff outbreaks in Templer Ward at

Newton Abbot Hospital. The CDiffs had been two different types and it was not known if it was patient to patient transmission or not. There had also been three outbreaks on Teign Ward and these were all the same type. Regular meetings were held to manage the infection, alongside weekly audits and since then there had not been any new outbreaks. The cleaning regime at the hospital had also been brought in line with that at the acute trust.

In closing, the Chairman thanked the Director of Infection Prevention and Control and her team for the work they undertook to support the running of the Trust and also the Trust's cleaning team, in their role in supporting infection control.

The Board of Directors received and noted the report.

Governance Issues

115/07/19 **7 Day Week Assurance Report**

The Board formally noted that a virtual meeting had taken place to approve the 7 Day Week Assurance Report.

PART B: Matters for Approval/Noting without Discussion

Report from Board Committees

116/07/19 **Charitable Funds Committee – 12th June 2019**

The Board noted the report of the Chair of the Charitable Funds Committee.

117/07/19 **Finance, Performance and Digital Committee – 25th June 2019**

The Board noted the report of the Chair of the Finance, Performance and Digital Committee.

Reports from Executive Directors

118/07/19 **Safe Staffing**

The Board noted the monthly Safer Staffing Report as required by the Chief Nursing Officer NHSE.

The Board of Directors noted and reviewed the contents of the Safe Staffing Report.

119/07/19 **Carers' Update**

The report highlighted the national and local deterioration in carer experience and the Trust response.

The Board had previously approved Trust involvement in the Triangle of Care approach advocated by Devon STP. This was now being implemented and promoted throughout the Trust.

The Board of Directors reviewed and noted the Carers' Update Report.

120/07/19 **Trust Quality Accounts**

The Board noted Quarter 1 performance against the Quality accounts as follows:

- Priority 1: Off plan –exception report with recommendations being escalated via EPMA Group to Clinical IT Group and to Executive.
- Priority 2: Off plan with actions
- Priority 3: On plan

The Board of Directors received and noted the Trust Quality Accounts Report.

121/07/19 **Annual Review of University of Plymouth Clinical Schools**

The report followed up from the report submitted to the Board in October 2018. It described the progress towards the previously reported goals and potential goals for the coming year.

The report highlighted areas within the Trust where the Torbay and South Devon Clinical School continued to grow and develop. Recently it had brought significant new opportunities in the shape of a pre-doctoral and doctoral fellowship scheme in collaboration with the Torbay Medical Research Fund. This local scheme, the first in the South West, had already had a notable impact locally with raised awareness of clinical academic careers generally, providing tangible opportunities for staff to focus on, and for staff to incorporate research within their careers.

The future challenge was to sustain and continue to grow on the successes to date. Further development was dependent on the development of nursing, midwives, social workers, care staff and allied health professional career pathways to incorporate research, service development and leadership opportunities. It was also dependent on increased capacity of the Torbay and South Devon Clinical School.

The Board of Directors received and noted the University of Plymouth Clinical Schools Annual Report.

122/07/19 **Adult Social Care Annual Account 2018/19**

The Board approved the Annual report for Adult Social Care which described the current adult social care performance and key initiatives.

The Board of Directors approved the Adult Social Care Annual Account 2018/19.

123/07/19 **Maternity Governance Safety Report**

The report informed the Board of the work being undertaken by the Maternity Governance Group.

An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report would be presented to the Trust Board.

The Trust Board of Directors:

- **noted and agreed the safety actions required by the CNST maternity incentive scheme. Any new recommendations or actions would be raised in future Board reports.**
- **noted and agreed the Obstetric staffing action plan.**
- **noted and agreed the ATAIN action plan.**
- **noted the requirement to provide sign off that it has had sight of evidence of compliance with all 10 Key Safety Steps and the Trust requirement to submit a declaration by noon on 15 August 2019.**

124/07/19 **Report of the Director of Estates and Commercial Development**

The report presented for assurance, the summary, outcomes and actions taken as a result of two compliance reports commissioned by the Trust. Of note were the following:

- The Trust was carrying considerable risk due to the condition and age of the estate and whilst it was unable to improve the condition without substantial investment, it was critical that the Board could be assured of its compliance safety via regular maintenance and inspection and the assurance provided via robust policies and procedures.
- The reports were undertaken by qualified and independent external experts and reviewed the current robustness of policies and procedures in place around compliance, to be used for internal improvement and assurance.
- The Trust's estates statutory compliance was assessed as adequate but providing limited assurance. The main areas requiring improvements were around the availability of job specific and dynamic risk assessments, condition of plant rooms and record keeping. Although identifying areas of good practice the fire report detailed some concerns around some documented policies and procedures; the robustness of the Trust risk assessments; and some operational practices. No risks identified in either of the reports reached the Trust Board threshold and were not deemed critical, ie placing patients or the public at risk.
- Improvement plans were in place, and as a result a number of changes have already been made to further strengthen compliance and address the highlighted issues. Both reports and improvement action plans have been presented to Capital Infrastructure and Environment Group (CIEG) who had received assurance on the risks and implementation of actions. CIEG was overseeing both the completion of the actions via a new Divisional compliance group and assurance.

Mr Welch reflected that the report clearly articulated the concerns around the Trust's estate that the Director of Estates and Commercial Development had

been highlighting for some time, and this was acknowledged.

The Board of Directors noted the report and took assurance on the:

- **Continued on-going actions to address compliance and minimise the risk in our aging estate.**
- **The positive outcomes and changes made to strengthen compliance and safety across the Trust.**
- **New strengthened compliance assurance reporting format**
- **The new divisional and Trust governance and reporting arrangements for EFM compliance.**

125/07/19 **Report of the Interim Director of Transformation and Partnerships**

It was noted that the directorate's portfolio had changed in April from Directorate of Strategy and Improvement to the Directorate of Transformation and Partnerships. This report gave assurance that the Transformation and Partnership Directorate was focussing on the work that best positions the Trust to create, enable, and add value across the organisation.

The report set out the work plan for the Directorate, how success would be measured, and future focus. The report provided a summary of key support the Directorate was providing against the five strategic stepping stones and detail around on-going work to support delivery and strategic planning.

The Board noted the workplan included in the report, which reflected the emphasis on transformation and partnerships and which would serve as a handover for the new Director when she commenced in post later in July. The Board also acknowledge the work of the team to evaluate the ICM Phase One.

The Board of Directors received and noted the report.

126/07/19 **Compliance Issues**

There were no compliance issues raised.

127/07/19 **Any Other Business Notified in Advance**

The Lead Governor wished to place on record her thanks to the Director of Finance for his support to the Council of Governors and to wish him well for the future.

129/07/19 **Date of Next Meeting – 9.00 am, Wednesday 7th August 2019**

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	Set up a small group to review the F2SUG Board Self-Assessment.	DWOD	Work was ongoing – remove from action sheet.	08/05/19
2	Set up a Board sub-group to establish a F2SUG Work Programme.	DWOD	Work was ongoing – remove from action sheet.	08/05/19
3	Future Clinical Incident Reports to include the percentage of patients compared to the total number of patients for the most frequently occurring risks.	CN	This would be included in the next report. Remove from action sheet.	29/05/19
4	Future Guardian of Safe Working Hours reports to include overall numbers of junior doctors compared to exception reports made for comparison purposes.	MD	The Chairman was aware that the Medical Direct was taking this piece of work forward – remove from action sheet.	29/05/19

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 7 August 2019
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Company Secretary Joint Heads of Strategic Communication		
Report provenance	Reviewed by Executive Directors July 2019		
Purpose of the report and key issues for consideration/decision	To provide an update from the Chief Executive on key corporate matters, local system and national initiatives and developments since the previous Board meeting.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Chief Executive's Report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	20
Risk Register	X	**Risk score**	25

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	X
NHS Improvement	X	**Legislation**	
NHS England	X	**National policy/guidance**	X

- 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.
- Failure to achieve financial plan.

Report title: Chief Executive's Report		Meeting date: 7 August 2019
Report sponsor	Chief Executive	
Report author	Company Secretary Joint Heads of Strategic Communication	

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 3 July 2019 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Theatres update

The refurbishment of the Theatres A and B is continuing and following a period of clinical testing will re-open in mid-September.

This will complete the first phase of our refurbishment. Plans are already underway to replace the air handling in our post-operative recovery area which will be our next phase followed by the refurbishment of two further theatres in the next financial year.

High humidity within theatres has also been an issue during the recent spell of hot weather. This is due to the age and condition of the ventilation systems and controls resulting in the inability to modulate the balance between humidity and temperature. An additional chiller has been installed and the operational, clinical and estates teams are working alongside each other to micro-manage the operation of the ventilation system on an hourly and daily basis to achieve the best environment we can and minimise the impact on patient activity.

Comment:
Our staff have been phenomenal in keeping services running over the past eight months. They have kept waiting lists under constant review to prioritise people in greatest clinical need and those who have been waiting the longest. Many teams have worked at evenings and weekends or started their days earlier in order to make the best use of our available theatre capacity. Thanks to a raft of contingency measures put in place, we are managing to treat 20% more patients through our day surgery unit and 5% more through our main theatres. We have also started a clinical services transformation programme to identify how we can improve people's experience and address waiting times for the longer-term.

1.1.2 Dartmouth Health and Wellbeing Centre

The plans for a new health and wellbeing centre in Dartmouth have received a triple boost. The local NHS, South Hams District Council (SHDC), Dartmouth Medical Practice and other partners are working together to build a state-of-the-art new home for GP and NHS services in the town. The new building will be light, airy and built to modern health and energy standards. The aim of the new centre is to bring many local health services under one roof, for the benefit of people in Dartmouth. It will provide a

wide range of services formerly provided at Dartmouth Hospital and currently offered by the Trust at Dartmouth Clinic, which was re-purposed as an interim health and wellbeing centre in 2017. It would also house Dartmouth Medical Practice, Dartmouth Caring, and retail outlets such as a pharmacy.

On 18 July 2019, South Hams District Council's Executive approved the business case for the scheme, which sets out the way it will be funded and built and how the council will lease the building to the head tenant, Torbay and South Devon NHS Foundation Trust (TSDFT). The new centre is set to be built on land currently used as an overflow for the park and ride at the top of town. The council previously agreed the principle of developing a Health and Wellbeing Centre for Dartmouth in December 2018 and the scheme is subject to design, planning permission and lease agreements.

Dartmouth Town Council has appointed Cllr Ged Yardy to set up a local health and welfare working group. Cllr Yardy is attending a meeting with the existing stakeholder group on 27 August, which Sarah Wollaston MP will also be attending, along with the CCG and the Trust. The purpose of this meeting is to consider how best to continue engaging with the local community in the development of health and wellbeing services for their area, including proposals for the new Health and Wellbeing Centre.

Comment:
We are continuing to work with the local Working Group on the plans for the new health and wellbeing centre. Key to this is how we engage with local people so they are able to be fully engaged on the developments, including ensuring that we have regular and consistent communication.

1.1.3 Successful bid submission by Community Dentistry

We are very pleased to announce that the Trust's Community Dentistry Team has been successful in the recently submitted bid to NHSE in procuring Supervised Tooth Brushing Pilot for 110 schools and nurseries in the TQ Postcode area.

This is in order to establish evidence-based effective interventions in areas of Devon where children are at high risk of poor oral health and reduce young children's experience of dental decay with their associated treatment needs such as multiple extractions under general anaesthetic. This is fantastic news and adds to the Trust's portfolio of services, prevention within the community as well as strengthening our position in the market for future commissioning opportunities.

In order to increase the uptake of this worthwhile project by the schools and nurseries we are encouraging everyone to spread the message and make every contact count with patients, friends and family of children between the ages 3-5 years old attending schools/nurseries in TQ postcode areas.

1.1.4 Community Nursing

Trust staff have been working with consultants from Meridian since September last year to review the efficiency of community services. One of the findings of the review is that by organising our community nursing services differently, taking full account of the different geographical footprints and demographics of our localities, we can provide the same level of service and increase face to face contact with patients.

Our partnership with other organisations across health and care has allowed some things that have traditionally been done by the NHS to be done by others, enabling our staff to use their specialist skills to better effect. Our community nursing teams will continue to play a vital role in delivering services to local communities.

Under the new way of working, there will be a different skill mix within some teams to meet changes in demand and to ensure we can offer the right care at the right time, in the right place, and better aligned with new ways of working,.

Our community nursing teams have already successfully implemented new ways of working in Torquay and, more recently, Newton Abbot and we are now looking to introduce changes in our remaining three localities – Coastal, Paignton and Brixham and Moor to Sea. These changes will be made over time whilst continually reviewing quality and safety of the service being delivered.

Vacancies will be reviewed as they arise and for some staff we are looking to utilise their skills within other nursing services. We accept that this may take some time to achieve and we are keen to work with our teams to progress this together, recognising how important our nursing workforce is to delivering care. We will support staff through any changes and continually, monitor and review the service provided, listening to their thoughts to ensure that our new ways of working takes account of their views.

1.1.5 Opening hours temporarily changed at Dawlish and Totnes Minor Injuries Units

Opening hours at Dawlish and Totnes Minor Injuries Units (MIUs) have been temporarily reduced due to short term staff shortages. The move is intended to ensure continued quality and safety across all centres and the units are still open when most patients use them. The temporary opening hours, which are in operation now, are:

- Dawlish MIU, Dawlish Community Hospital, Barton Terrace, EX7 9DH
    - MIU opening hours: 10am to 6pm, seven days a week
    - X-ray opening hours: 1.30pm to 5pm, Monday to Friday (no change)

- Totnes MIU, Totnes Community Hospital, Coronation Road, TQ9 5GH
    - MIU opening hours: 9am to 6pm, seven days a week
    - X-ray opening hours: X-ray 9am to 1pm, seven days a week (no change)

Opening hours at Newton Abbot MIU are unchanged and the service continues to run as normal from 8am – 8pm, seven days a week. The X-ray service also continues unchanged at Newton Abbot from 9am to 5pm seven days a week.

We have been facing a number of workforce challenges due to staff sickness and turnover and are actively recruiting and training staff so that we can to return to normal opening hours as soon as possible.

1.2 Well Led

1.2.1 Month 3 - Performance against the NHS Improvement Single Oversight Framework

In June, the Trust did not meet the following national performance standards:

- **Urgent Care 4-hour ED standard:** In June, the Trust achieved 80.3% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments (ED); last month (May) the Trust achieved 84.2%.
- **Referral to Treatment - RTT:** RTT performance has been maintained in June at 81.52%. This is very slightly ahead of the Operational Plan trajectory of 81.5% but below the national standard of 92%.
  For June, 83 people will be reported as waiting over 52 weeks, this being an increase on last month's 59 but is below the agreed recovery trajectory (110 in June). This remains ahead of our plan, however, the continued loss of capacity in main theatres due to ventilation upgrading work and refurbishment remains a challenge. The two theatres affected are scheduled to be back in operation in mid-September.
- **62 day cancer standard:** At 79.5% for June and 81.3% for Q1 (as of 12 July 2019) forecast performance is below the 85% national standard, and slightly below the recovery trajectory (79.8%). Our action plans and performance forecast show that performance will continue to be below plan until the end of Q2 when improvement is expected to be seen. A significant element of achieving the 62 day treatment standard is the 14 day from urgent referral to appointment. In June we forecast to achieve 71.1% for urgent two week wait referrals to be seen in clinic.
- **Diagnostics:** The diagnostics standard was not met in June with 11.7% of patients waiting over 6 weeks against the standard of 1%. This is an improvement from last month (12.1% in May) and in line with our recovery trajectory 11.75%. The performance reflects capacity pressures in both CT and MRI waiting times and recent improvement in echocardiography waiting times. Mobile scanner visits are scheduled to maintain capacity to match demand in both CT and MRI.

Comment:
The significant pressure on our services we have been experiencing continues. We are closely monitoring the impact on patient experience and safety is kept to a minimum this to ensure those who are waiting are doing so safely.

1.2.2 Month 2 performance against 2019/20 Plan

- **Overall financial position:** The financial position at control total level as at 30 of June 2019 is a £4.94m deficit, which is slightly better than the £4.96m planned deficit. The Trust, at this stage of the financial year, is forecasting delivery of the control total, although this remains subject to delivery of the savings plans,

national outcome on 52 week penalties and finalisation of contract discussions including STP risk share with the consequent risks attached and mitigation of variable staffing pressures. The control total will not be achieved without significant further progress in the detailed specification and subsequent delivery of CIP plans.

This position to date and forecast both excludes any penalties for 52 week waits (the assumption is that they will either not be applied or will be returned in full) and no STP risk share has been applied in the position.

- **CIP savings delivery position:** The Trust has an annual savings target of £17.5m of which £14.5m of schemes have been identified resulting in a £3.0m gap. (In addition there is a requirement to have an STP solution to the additional cost of the change in valuation methodology of assets under the latest Royal Institution of Chartered Surveyors (RICS) guidance. This equates to £2.5m for which no plans have yet been identified.) The total CIP gap is therefore £5.5m. Of the forecast delivery £2.72m is fully developed and assured. The remainder remains at either outline or definition stage and therefore remains at some risk. The control total will not be achieved without further progress on the detailed specification and subsequent delivery of CIP plans.

  The CIP target for year to date is £2.0m of which £0.7m has been delivered; an adverse variance of £1.3m due to undelivered pay and non-pay schemes.

- **Capital expenditure**: Capital expenditure as at month 3 is £1.86m which is £0.74m underspent against budget. The full year plan is £21.56m, however NHSI are currently undertaking a review of Capital Departmental Expenditure Limit (CDEL) allocations to Trusts.

1.3 Valuing our Workforce, Paid and Unpaid

1.3.1 Appointment of Interim Director of Finance

Following the announcement last month that Paul Cooper, Director of Finance would be leaving the Trust to join Cornwall Partnership NHS Foundation Trust, the Trust has successfully appointed an Interim Director of Finance, David Killoran. David will start with us on 12 August and will formally take up the Board level position on 1 September. The recruitment process for the substantive role of Chief Financial Officer has commenced and is progressing to plan with interviews scheduled to take place on 6 September 2019.

1.3.2 Maternity services awarded the prestigious Baby Friendly Initiative

The accreditation from UNICEF, the United Nations Children's Fund recognising best practice standards for mothers and babies, was given following an inspection of the maternity service by assessors from the Baby Friendly Initiative (BFI). This is a re-accreditation because maternity services have previously met the standards.

1.3.3 Joanna Broderick – RCNi Nurse Award

Jo, who works for Children and Family Health Devon, won the Child Health category of the RCNi Nurse Awards marking nursing excellence and innovation. She has been

recognised for developing a guideline for weaning babies off oxygen, transforming care for families in Devon.

Jo devised a safe, structured oxygen-weaning guideline for ex-premature babies with chronic neonatal lung disease. This has halved the time taken to wean babies off oxygen, reduced the number of community nurse visits, enabled families to get back to normal life sooner and improved service efficiency.

1.3.4 Lisa Pullen – Awarded Queen's Nurse Title

Lisa Pullen, a community children's nurse with Children and Family Health Devon has been awarded the prestigious title of Queen's Nurse. Lisa was awarded the nationally important title by the Queen's Nursing Institute at a ceremony in London, recognising her high standards of community nursing practice.

Lisa works as Clinical Service lead for Specialist Children's Community Nursing (Eastern Devon) for Children and Family Health Devon.

2. Chief Executive Engagement: July

I continue to meet with external stakeholders and partners. Meetings I have attended during July are shown below.

Internal	External

• Medical Staff Committee
• Staff Side
• Joint Local Negotiating Committee
• Meeting with Junior Doctors
• Endoscopy Kit handover with League of Friends
• Video blog sessions:
  ○ STP Lead Chief Executive
  ○ Trust Receptionists
  ○ Trust Sensory Team
	• Interim Director of Adult Services and Housing, Torbay Council
	• Director of Public Health, Torbay Council
	• Meeting with the Interim Accountable Officer, Devon CCG
	• Clinical Chair, Devon CCG
	• Director of Commissioning, Devon CCG
	• STP Chief Executive
	• STP Chief Executives' Meeting
	• Chief Officer, Adult Care & Health Digital Transformation & Business Support, DCC
	• South West Regional Talent Board
	• Chief Executive, Torbay Healthwatch
	• Chief Executive, NHSI/E
	• Devon System Meeting with NHSI/E
	• Delivery and Improvement Director, NHSI/E
	• Chief Financial Officer, NHSI/E
	• Regional Director of Finance, NHSI/E
	• SDT Improvement Board
	• Devon A&E Delivery Board
	• Chief Executive, Royal Cornwall Hospitals Trust
	• Children and Young Persons Partnership Board

3 Local Health and Care Economy Developments

3.2 Partner and partnership updates

3.2.1 Healthwatch engagement on NHS Long Term Plan

Healthwatch England commissioned local champions Healthwatch Torbay, Plymouth and Devon to engage with our local population and service providers to gather their views about the NHS Long Term Plan. They held a number of focus group workshop sessions in the local community and promoted two surveys developed nationally by NHSE - a generalised survey and a specific condition survey.

They have now published their report of this engagement.

In total, there were **540** general survey responses, **221** specific condition survey responses, and **170** attendees on the focus group workshops across Devon – **nearly 1,000 people**. Of the survey respondents, the majority (66%) were aged over 55, female (65%) and 'White British' (92%).

The following is a brief summary of the key themes and issues discussed for each of the open-ended questions for both the NHSE surveys and the focus groups, categorised by the three NHSE priority areas for the future: **Prevention**, the **role of the community** and **Technology**.

Prevention

- Respondents would like to see the NHS focus on preventative medicine and early detection of illness.
- Patients in Devon would like to see a reduction in the time they wait to see their GP or receive a referral.
- Patients said they would benefit from greater continuity of care and the opportunity to be treated by the same staff when possible, with many emphasising the importance of building trust and rapport with staff.
- Many respondents felt that the NHS would benefit from better communication between services, allowing a more integrated or holistic approach to their treatment.
- Patients feel that their medical treatment should be a joint decision made in partnership with staff, and that information should be made more easily available in order to support them in making their choices.
- Having access to domiciliary or locally-based care is of high importance to many, however respondents have concerns about the accessibility and quality of care in their area. These concerns are exacerbated by a lack of public transport in areas of Devon.
- Respondents are concerned about the quality and affordability of local residential homes.
- Autism, dementia, and mental health respondents reported the least satisfaction from their experience of care, reporting long waiting times and difficulty accessing support. Overall, cancer respondents reported the shortest waiting times and easiest access to support.

Role of the Community

- Focus group responses of patients with specific conditions (e.g. dementia, heart and lung diseases, and cancer) showed that patients with dementia had a more negative overall experience than those with cancer or heart and lung diseases.
- Focus group participants talked about the importance of mental health awareness and overcoming the stigma of the condition in receiving diagnosis and treatment.
- Many are concerned about access to resources in the local area, with those in rural areas describing difficulties in travelling to GP and hospital appointments.
- Adequate end-of-life planning is important to people in Devon. However, many respondents expressed concerns about the current quality of end-of-life care in the NHS; some mentioned the negative experiences of relatives or spouses.
- Cancer services showed that the emphasis on the responsiveness to their needs have made a significant improvement when compared to other conditions. On the whole Cancer and Heart & Lung experienced effective follow through of care, whereas people with Dementia did not. In this latter category responses were more often provided from a carer perspective.

Technology

- People in Devon would like to see improvements in the use of technology and online services. Many would like to see more of their GP services available online, particularly the ability to view their full, unabridged medical record.
- However, multiple respondents expressed concern that their local services are too reliant on online services, often at the expense of the elderly or those who cannot use or access a computer. It is important to many in Devon that GP services remain accessible to those who have difficulty using the internet.
- Focus group responses of patients with specific conditions (e.g. dementia, heart and lung diseases, and cancer) also expressed anxiety about a future where personal contact is replaced by technology.
- People in Devon consider timely and consistent communication to be very important
- Patients have concerns about the management and security of their personal data.

The full report is available to view at. www.healthwatchtorbay.org.uk/about-us/meetings-reports/ .

3.2.2 '*Better for You, Better for Devon'* - Devon Long Term Plan

Devon is developing a local version of the national NHS Long Term Plan, called 'Better for You, Better for Devon'. The plan will make sure we are fit for the future, providing high-quality care and better health outcomes for people and their families, through every stage of life. Here in Devon, as well as incorporating the feedback from Healthwatch, we are undertaking a period of engagement (running from 11 July to 5 September 2019) to develop our own Long Term Plan. The aim of the engagement is to make sure our local plan is relevant to local needs and clearly sets out our shared vision for the future. The plan will focus on improving people's health and mental health, and supporting people to stay well.

Our local engagement plan will feed into the Devon plan and will focus on the key areas of resilient communities and specialist services. Our Governors, foundation trust members and members of the public will all have the opportunity to have their say on

the Devon plan. A short survey will also be available soon on our website. We are also carrying out a series of focussed face to face engagement sessions to gain further feedback. Once this engagement period comes to an end we will inform our local community what we intend to do as a result of what they have told us.

4 National Developments and Publications

Details of the main national and regional developments and publications since the last Board meeting on 3 July have been circulated to Directors through the weekly developments update briefings. The items of particular note that I wish to draw to the attention of the Board as follows:

4.1 Government

4.1.1 New Ministerial Team

The new Prime Minister has confirmed that Matt Hancock will remain as SoS for health and Social Care. Chris Skidmore, MP for Kingswood, has replaced Stephen Hammond, MP for Wimbledon, at the Department of Health and Social Care. Mr Skidmore most recently served as universities minister and interim minister of state for energy and clean growth. His brief at DHSC will include Brexit, finance, efficiency, commercial, capital and estates, operational performance, workforce, and transformation and provider policy. The other health ministers are Caroline Dinenage, Seema Kennedy, Jackie Doyle-Price and Nicola Blackwood.

4.2 NHS England and NHS Improvement

4.2.1 New deputy chief people officer announced

Em Wilkinson-Brice will be joining from Royal Devon and Exeter Foundation Trust, where she was deputy chief executive and chief nurse. The new role will support the delivery of the long-term plan and also develop and implement the NHS' people plan, NHSE/I said.

4.2.2 Guidance to prepare for no-deal Brexit issued

Further to the direction from the Professor Keith Willett the EU NHS Exit Strategic Commander in addition to the SRO, the Trust has now identified a suitably trained EU Exit Trust lead. The Team we have been requested to establish will consist of the SRO, two emergency planning officers and the established leads from procurement and workforce

The team will follow direction from the SW Region EU Exit Planning team to ensure that the Trust has:

- Full contingency plans in place to ensure safe services for patients can continue to be provided in the event that the UK leaves the EU without a deal.
- A coordinated team in place to oversee EU exit preparations.
- Undertaken a deep dive into department specific EU exit plans to confirm that suppliers or services are prepared.
- Undertaken exercising and testing of contingency plans and preparations.

- Attended regional events to confirm the operational response and what is needed at a local level.
- A robust command brief published for the EU exit period.

4.2.3 Freedom to Speak Up Guidance for Boards

As a result of detailed feedback from trusts, NHSE/NHSI have revised guidance on our expectations of boards and board members encouraging staff to speak up about issues of patient care, quality or safety and now offer supplementary resources and a streamlined self-review tool.

5 Local Media Update

5.1.1 News release and campaigns highlights:

- Advice and guidance for local people to not only use the right services when they need care this summer but to look at ways they can help themselves to stay well by hydration and sun protection.
- Celebration of a number of awards and achievements such as Baby Friendly Accreditation, Education awards as well as individual achievements of Queen's Nurse title.
- How trained therapy dog, Lulu, is helping people in our Intensive Care Unit.
- Support for young people affected by drug or alcohol use – how we can support and keep people safe including helping people to become aware of known risks and side effects.
- Encouraging people to apply for a whole range of roles in the Trust as well as celebrating the graduation from the well-renowned internship scheme 'ASPIRE', based at Torbay Hospital.
- Our HOPE programme is now available right across the Torbay and South Devon area and includes some condition specific courses including for people living with diabetes
- Calling on people who are inspired by research to forge a better future for patients by becoming a Research Champion?
- Thank you to the many people and groups who have generously raised money to support our care.

6 Recommendation

Board members are asked to **review** the report and **consider** any implications on the Trust's strategy and delivery plans.

JD/CF/JG
31/07/2019

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Integrated Performance Report (IPR): Month 3 2019/20 (June 2018)		Meeting date: 7 August 2019
Report appendix	Month 3 - IPR Part 1 Month 3 - Focus Report Part 2 Month 3 - Dashboard	
Report sponsor	Interim Director of Transformation and Partnerships Director of Finance	
Report author	Head of Performance	
Report provenance	System Performance, Quality, and Finance Group (11 July 2019) Executive Director scrutiny (23 July 2019) Finance, Performance, and Digital Committee (30 July 2019)	
Purpose of the report and key issues for consideration/decision	The IPR sets out the headline performance for Month 3 (June) 2019/20 against the key quality and safety, workforce, performance, and financial standards that together represent our Operational Plan for 2019/20. Our final Operational Plan, developed in the context of the wider Devon STP, was submitted on 23 May 2019 to show an acceptance of the Trust's £4.3m surplus control total. This is the direct result of the planned transformation programme reflected in the Devon STP plan, driving improved efficiency and enabling additional income being applied to the challenges described by this Trust in its first submission in April. Areas that the Board will want to focus on where the Trust is off trajectory are highlighted below and detailed in the attached main report. **Performance: against the national NHS I Single Oversight Framework:** In June, the Trust did not meet the following national performance standards or agreed planned improvement trajectories: • **A&E**: STF Trajectory (83%) **not met** - performance for June (80.3%) • **RTT**: RTT performance has seen little change in June with 81.52% of people waiting less than 18 weeks, slightly ahead of the Operational Plan trajectory of 81.50%. Against 52 weeks we have seen an increase from 59 last month to 83, however, this remains within our plan trajectory of 110. • **Cancer:** National standard not met in June at 79.6% against standard of 85% and improvement trajectory of 80.4%. Recovery plans to deliver standard in Q2 are in place with weekly monitoring and escalation through Chief Operating Officer.	

- **Diagnostics**: The diagnostics trajectory is **not met with** 88.3% of patients waiting under 6 weeks. This is in line with our recovery trajectory to deliver improved performance in Q4 to achieve 96% against the National standard 99%.

Finance

- The Trust has a Control Total for the year of a deficit of £3.80m, which excludes income relating to Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) totalling £8.36m.
- The financial position at this control total level as at 30th of June 2019 is a £4.94m deficit, which is slightly better than the £4.96m planned deficit. (Assuming any 52 week fines would be returned, no STP risk share has been applied at Q1 and contract discussions are ongoing with Torbay Council over its contributions to ASC in 2019/20).
- At Q1 the Trust assumed it will earn the PSF and MRET funding of £1.64m having met the control total. An additional PSF income for FY 2018/19 of £0.27m was notified to the Trust.
- Total pay run rate in M3 (£21.4m) is in line with previous month.
- Non pay expenditure run rate of £17.8m is higher by £0.4m compared to M2 mainly due to increased spend in social care offset by underspend on IT licence costs being deferred to next year and slippage of investment to later in the year.
- The CIP target for year to date is £2.0m of which £0.7m has been delivered; an adverse variance of £1.3m due to undelivered pay and non-pay schemes.
- The Trust has an annual savings target of £17.5m of which £14.5m of schemes have been identified resulting in a £3.0m gap. (In addition there is a requirement to have an STP solution to the additional cost of the change in valuation methodology of assets under the latest Royal Institution of Chartered Surveyors (RICS) guidance. This equates to £2.5m for which no plans have yet been identified). The total CIP gap is, therefore, £5.5m. Of the forecast delivery £2.72m is fully developed and assured. The remainder remains at either outline or definition stage and therefore remains at some risk. The control total will not be achieved without further progress on the detailed specification and subsequent delivery of CIP plans.
- Capital expenditure as at M3 is £1.86m which is £0.74m underspent against budget. The full year plan is £21.56m, however NHSI are currently undertaking a review of Capital Departmental Expenditure Limit (CDEL) allocations to Trusts.
- The Finance Risk Rating has risen to a 3 at M3, primarily due to the achievement of the Q1 I&E plan.

The Trust, at this stage of the financial year, is forecasting delivery of the control total, although this remains subject to delivery of the savings plans, national outcome on 52 week penalties and finalisation of contract discussions including STP risk share with the consequent risks attached and mitigation of variable staffing pressures. The control total will not be achieved without significant further progress in the detailed

<table>
<tr><td></td><td colspan="3">specification and subsequent delivery of CIP plans.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information
☐</td><td>To receive and note
☒</td><td>To approve
☐</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board is asked to review the documents and note the evidence presented.</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td colspan="3"><table>
<tr><td>Safe, quality care and best experience</td><td>Yes</td><td>Valuing our workforce</td><td>Yes</td></tr>
<tr><td>Improved wellbeing through partnership</td><td></td><td>Well-led</td><td>Yes</td></tr>
</table></td></tr>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td colspan="3"><table>
<tr><td>Board Assurance Framework</td><td>Yes</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>Yes</td><td>Risk score</td><td></td></tr>
</table></td></tr>
<tr><td>External standards affected by this report and associated risks</td><td colspan="3"><table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
</table>
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.
• Failure to achieve financial plan.</td></tr>
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Torbay and South Devon NHS
NHS Foundation Trust

MAIN REPORT

Integrated Quality, Workforce, Performance, and Finance Report

Date of Report: **30 July 2019**

Reporting Period: **Month 3 2019/20**

Data Up To : **30 June 2019**

Version Control

Version	Meeting	Date of Circulation	Date of Meeting	Owner	This Version
Draft 1	Trust Executive	19/07/19	23/07/19	Paul Procter Dawn Butler	☒
Published Report	FPD Committee	26/07/19	30/07/19	Dawn Butler Paul Cooper	☒
Published Report	Trust Board	01/07/19	7/08/19	Dawn Butler Paul Cooper	☒

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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

1.1 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 Finance, Performance, and Digital Committee (FPDG) and Trust Board to:

- take a view of overall delivery, against national and local standards and targets, at Trust and Integrated Service Unit (ISU) level;
- consider risks and mitigations;
- determine whether the Committee is assured that the Trust is on track to deliver the key milestones required by the regulator and will therefore secure Provider Sustainability Funding and ultimately retain our license to operate.

1.2 Report Format

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

Appendix 1: Board Dashboard (PDF file)

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

- Executive Director scrutiny (23 July 2019)
- Finance, Performance, and Digital Committee (30 July 2019)

1.3 Operational Plan 2019-20

The board will be aware that on the 23rd May we resubmitted our operating plan to NHSI which described a significant change in our Trust financial position. The Trust resubmitted plan reflects the agreement reached by the STP with regulators and which has in turn informed a new STP operating plan also submitted on the 23rd May.

The headlines of our Trust Operating plan are:

- The Trust ***accepts the 2019/20 £4.3m surplus control total.*** This is the direct result of the planned transformation programme reflected in the Devon STP plan, driving improved efficiency and enabling additional income being applied to the challenges described by this Trust in its last submission in April.

- The Trust continues to make a **4.4% efficiency assumption** in this submission **at a value of £17.5m.** This submission has been updated to reflect the additional £2.5m CIP related to Royal Institute of Chartered Surveyor (RICS) changes on guidance relating to Modern Equivalent Asset (MEA) valuation driving an increase in Capital charges which will require an STP wide solution. This increases the total savings requirement to £20.0m.

1.4 Devon System Context: (extract from STP Plan)

The Devon System Operating Plan for 2019/20 is focused on balancing both financial and service priorities, which will be a significant challenge given our forecast of increases in demand for services. The NHS system was set a challenging control total deficit of £43m, with recognition of a further £25m relating to the withdrawal of Commissioner Sustainability fund. We are therefore aiming to deliver a gross system deficit of £70m, in return for which we will earn £56m of additional, external sustainability funding. To deliver this and deal with the significant performance challenges to address, including eliminating

52-week waits, meeting core national standards for cancer (2-week and 62-day waits) and improving A&E performance, we have set ourselves an ambitious plan, requiring system wide transformation and maximum focus on delivery throughout 2019/20.
The system will deliver this position by;

1. Managing demand and activity growth down by 2% from previous planning assumptions through the changes described in the transformation plan for the system.
2. Accelerating shift in delivery mode from inpatient to day case and day case to outpatient to the performance of best in Devon
3. Increasing anticipated non-recurrent benefits from system investment
4. Developing a system risk share to drive collective delivery

The overriding principle of the risk share will mirror the collaboration that the STP has operated under since 2016/7 in that "we will work collectively to deliver for all partners against the individual targets set within the system position. If one organisation fails then this is a failure to us as a system and all efforts will be deployed to avoid this eventuality".
This commitment is set out in the Devon STP Memorandum of Understanding signed by all parties in December 2016 for the period to March 2021.

1.5 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 (from May 2018) assessed as being in Segment Two (targeted support).

2. Performance Headlines: Month 3 (June 2019)

Key headlines for quality and safety, workforce standards and metrics, operational performance, and financial delivery for Month 3 to draw to the Board's attention are as follows:

2.1 Quality Headlines

There are 20 Local Quality Framework indicators in total of which 4 were RAG rated RED for June (5 RED in May) as follows in Table 1:
Table 1: Local Quality indicators RAG rated RED:

Standard	Target	Last month Month 2	This month Month 3
STEIS	0	8	4
VTE – risk assessment on admission (acute)	>95%	90.9%	91%
Fractured Neck of Femur	>90%	73.3%	62.5%
Follow ups past to be seen date (excluding Audiology):	3,500	6459	6803

Of the remaining indicators, 10 were rated GREEN, 4 AMBER, and 2 not rated.

2.2 Workforce Headlines

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

- **Turnover (excluding Junior Doctors)**: **GREEN** - the Trust's turnover rate now stands at 10.75% for the year to June 2019 which is an increase from 10.69% in May.
- **Staff sickness/absence: RED –** The annual rolling sickness absence rate was 4.21% at the end of May 2019 which is a minor decrease from April which was 4.22%. This is against the target rate for sickness of 4.00%. The monthly sickness figure for May was 3.81% which is a decrease from the 3.84% as at the end of April.
- **Mandatory Training rate**: **GREEN** – At the end of June 19 the rate was 90.88%. This means that the Trust is now achieving the target rate for mandatory training of 85%.
- **Appraisal rate**: **AMBER -** The rate for the end of June was 79.41% which is a decrease on the 80.08% as at the end of May.

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

- **Workforce Plan –** As at end of June 2019 the variance of workforce worked was 30.82 wte below budget.
- **Agency Expenditure –** As at end of June 2019 the Trust is underachieving against the plan by £875K.

2.3 Operational Headlines

2.3.1 Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 5 were RAG rated RED in June (5 in May 2019) as follows in Table 2:

Table 2: Community and Social Care Framework RAG Rated RED

Standard	Target	Last month Month 2	This month Month 3
Delayed discharges (Community)	16/16 Avg 315	356	419
Delayed transfers of care bed days (acute)	64 days per month	185	97
Number of permanent care home placements	<=617 year end	619 (May trajectory of 600)	631(June trajectory of 600)
Bed occupancy	80%-90%	91.4%	94%
CAMHS % of patients waiting under 18 weeks at month end	>92%	83.2%	79.1%

Of the remaining indicators, 6 were rated GREEN, 0 AMBER, and 4 indicators not rated.

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

Against the national performance standards, for Month 3 the Trust reported the following 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	Target / Trajectory	Last month Month 2	This month Month 3	Risk
A&E - patients seen within 4 hours (PSF)	>92%	**84.2%**	**80.3%**	HIGH
	Trajectory	**80%**	**83%**	
RTT – 18 weeks	>92%	**81%**	**81.52%**	HIGH
	Trajectory	**81%**	**81.5%**	
Cancer – 62 day wait for first treatment – 2ww referral	>85%	**84.5%**	**79.6%**	HIGH
Diagnostic tests longer than the 6 week standard	<1%	**12.1%**	**11.7%**	HIGH
Dementia Find – monthly report	>90%	**88.3%**	**93.3%**	LOW

4-hour ED standard:

In June, the Trust achieved 80.3% of patients discharged or admitted within 4 hours of arrival at Accident and Emergency Departments (ED); last month (May) the Trust achieved 84.2%.

Risk: High - Performance in June reflects the continued high level of escalation with delays primarily attributed to availability of inpatient beds and crowding in ED. The escalation ward has remained open in this period. Closing the escalation beds and maintaining capacity to have assessment beds on EAU3 remains key to delivering the full benefit realisation of the investments in front door assessment model and to deliver the planned performance improvement.

Management action:
The three workstreams previously described to underpin service improvement and deliver the performance improvement are all making good progress.
The three groups are:

1. **Emergency floor and front door assessment**

Key outcome areas:

- ED/ speciality interface;
- same day emergency care/ admission avoidance;
- front door processes;
- Acute Care Model.

2. **Ward processes and patients flow**

Key outcome areas:

- establish clinical criteria for discharge for every urgent inpatient by MDT within 24 hours of admission and expected date of discharge;
- optimise structure and function of SAFER methodology, leadership and ownership see ECIST comments;
- optimise weekend discharge: consultant, junior doctors, ward clerk, pharmacy, community hospitals, residential / nursing homes, PTS;
- use Red2Green data to inform next Quality Improvement programmes;

3. **Home first: Community interface pre and post- acute care.**

Key outcome areas:

- to optimise intermediate care across all localities;
- expand the role of trusted assessor to other residential and nursing homes;
- Discharge to Assess project;
- optimising work of discharge hub;
- link with Joint Emergency Team to support discharge of ED patients who do not require inpatient care;
- diagnostic only pathway;
- development of urgent care centres;

Complementary indicators regarding 4 hour standard: We closely monitor our performance against a number of clinical quality markers and internal standards for clinical review and decision making across pathways of care.
In May and June we have seen a significant reduction in the number of ambulance delays, waiting over 30 and 60 minutes, for handover. We are also reporting that we have not recorded any delays over 12 hours for patients to be admitted to a hospital bed.
We have since December 2018 seen a significant increase in the number of emergency attenders above historical levels. Further work is being done with commissioners to understand the driver for this increase and to support our operational teams to manage this increased demand. It is also noted that other providers are experiencing similar patterns of demand and continue to be in high escalation to maintain satisfactory patient flow.

Referral to Treatment - RTT:

RTT performance has been maintained in June at 81.52%. This is slightly ahead of the Operational Plan trajectory of 81.5% and below the national standard of 92%.
For June, 83 people will be reported as waiting over 52 weeks, this being an increase on last month's 59 and is below the agreed recovery trajectory (110 in June). This is good progress and ahead of our plan, however, the continued loss of capacity in main theatres due to ventilation upgrading work and refurbishment remains a challenge. The two theatres affected are scheduled to be back in operation in mid-September.

Risk: High There is significant risk to delivering the increased levels of activity needed to maintain the 82% RTT performance and reduce the longest waits over 52 weeks to Zero by March 2020 as set out in our future Operating Plans for 2019/20.
Orthopaedics is the area experiencing the greatest loss of capacity from the theatres remedial works and consequent impact on these performance standards over the coming months.

Management action: Led by the Chief Operating Officer, plans are monitored through the RTT Risk and Assurance meeting with any outstanding risk escalated.

62 day cancer standard:

At 79.5% for June and 81.3% for Q1 (as of 12 July 2019) forecast performance is below the 85% national standard, and slightly below the recovery trajectory (79.8%). Our action plans and performance forecast show that performance will continue to be below plan until the end of Q2 when improvement is expected to be seen.
A significant element of achieving the 62 day treatment standard is the 14 day from urgent referral to appointment. In June we forecast to achieve 71.1% for urgent two week wait referrals to be seen in clinic. Plans are on track to bring colorectal referral to appointment waits to 14 days. Urology plans are in place, with waits coming down slower than anticipated (currently at 4 to 5 weeks)

Risk: High
Management action: Recovery plans are in place and include the continuation of locum capacity whilst substantive appointments are made in several key specialties (dermatology and colorectal surgery). NHSI Cancer Improvement Team is now working with the Cancer Services to provide assurance of robust recovery plans that have now been completed and shared with commissioners against which we will provide monthly updates.

Diagnostics:

The diagnostics standard was not met in June with 11.7% of patients waiting over 6 weeks against the standard of 1%. This is an improvement from last month (12.1% in May) and in line with our recovery trajectory 11.75%.
The performance reflects capacity pressures in both CT and MRI waiting times and recent improvement in echocardiography waiting times.
Mobile scanner visits are scheduled to maintain capacity to match demand in both CT and MRI.

Risk: High Actions agreed include maintaining plans for MRI and CT mobile visits. The availability of mobile scanner is not guaranteed

together with the constraints of having only one suitable on site location to provide this service. NHSI Elective Care Team is working with the Radiology team to develop improved waiting time analysis and capacity planning.

Dementia Screening:

The Trust achieved the Dementia Find standard in June at 93% against the target of 90%.

2.3.3 Service delivery items escalated for Board attention –

Theatres

Work continues with the refurbishment of two of Torbay Hospital's theatres (A and B), which have been closed since November 2018, following the failure of an air handling unit. The completion of these remedial and upgrading works is scheduled for mid-September. In June, we have experienced further mechanical failure in theatres 1 and 2, although limited to a 24 hour closure. This further highlights the need to address the wider theatre estate resilience.

Once the refurbished theatres (A&B) are back and operating to full capacity operational teams are scheduling to continue with the interim arrangement of working extended days and weekend lists to help catch up on lost activity over the duration of the refurbishment works.

System Improvement Board

Given our performance and financial challenges, in partnership with the CCG, a System Improvement Board is now meeting to focus on addressing barriers to delivery and driving and supporting improvements in quality and patient experience, performance and finances to give assurance to Boards, Commissioners, Regulators and the community we serve.

2.3.4 Local Performance Indicators

In addition to the national operational standards there are a further 25 performance indicators agreed locally with the CCG, of which 10 were RAG rated RED in June (10 RED RAG rated in May). The indicators RAG rated RED are summarised in Table 4:

Table 4: Local Performance Indicators RAG Rated RED

Standard	Standard/ target	Last month Month 2	This month Month 3
Number of C Diff cases – lapse of care - ICO	< 17 a year Monthly average =2	3	1
Cancer 2ww urgent GP referral	>93%	77.6%	71.1%
RTT waits over 52 weeks	0	60	83
On the day cancellations for elective operations	<0.8%	0.9%	1.4%
Cancelled patients not treated within 28 days of cancellation	0	3	6
A&E patients (ED only)	82.5%	75.9%	69.9%
Number of C Diff cases - Acute	<3	1	4
Number of C Diff cases - Community	0	6	1
Care plan summaries % completed within 24 hrs of discharge weekdays:	>77%	64.2%	62.5%

Standard	Standard/ target	Last month Month 2	This month Month 3
Care plan summaries % completed within 24 hrs discharge weekend:	>60%	24.5%	31.2%

*Cancer figs are confirmed 2 months in arrears and may change once full validation and histology complete

Of the remaining indicators, 10 were rated GREEN, 1 rated AMBER, 1 data unavailable** and 3 indicators do not have an agreed target.
**Cancer: symptomatic breast patients – June performance data not available. A recent change in clinic bookings has required a change of process to collect data. However, data for June is indicating a performance above 90% (un-validated) against a national target of 93%.

2.4 System leadership team updates

The new operational System Leadership Teams have commenced internal governance processes to provide assurance to the Board against the delivery of key quality, finance, performance, and workforce metrics under the new system operational structure.

The IPR will continue to focus on and provide analysis at whole system level against key quality, performance, workforce, and finance metrics. In future reports, the IPR will provide a regular operational update from Torbay and South Devon leadership teams against key risks and challenges.

Work is ongoing to map existing performance metrics to each of the new Integrated Service Units (ISU's) and for these reports to be available from July 2019.

At the latest meeting of the senior management teams the following operational highlights and risks are reported by Integrated Service units (ISU):

Torbay System

Torquay ISU – focus on Children's and public health services

- CHC assessment within 28 days – good progress is being made following implementation of actions to target backlog in reviews.
- Deprivation of Liberty (DOLS) Safeguards: Overall there are approximately 500 cases pending which has remained static for the last 2-3 years. Upon receipt all applications are triaged using the ADASS triage tool to separate high, medium and low priority DOLS applications. The numbers of High priority DOLS are increasing and currently stand at 76, of these 57 are renewals. The reason for the increase in high priority is linked to having sufficient capacity of Best Interest Assessors within the team and work is currently being explored to recruit into a secondment until September 2020
- Special Educational Needs and Disabilities (SEND) Ofsted inspection has taken place on the 9th July
- GIRFT review scheduled for Paediatrics
- Long waits across several Paediatric and Children and Family Health Devon services are a focus for improvement.

Paignton and Brixham ISU – Focus diagnostics, cancer, medical specialties and women's services

- Diagnostics capacity in CT and MRI with potential cost pressures to increase the level of mobile van support required to maintain access standards

- Potential impact of Pension IR35 or ability to maintain levels of additional sessions to support radiology service delivery and reporting.
- Oncology staffing – Mutual support arrangement in place with RD&E to cover short term vacancies.
- We have commenced the planning stage to work more closely with RD&E on the joint management of neurology cardiology and dermatology services to increase our resilience to demand and staffing pressures being experience by both organisations.

South Devon System

Coastal ISU – Focus Elective Care

- Ahead of plan to reduce RTT over 52 week waits.
- Theatre upgrade works scheduled for completion by mid-September.
- Additional capacity being planned from this point to deliver the trajectory of improvement against our longest waits for elective surgery.
- Improvement work on theatres productivity continues with good engagement and adoption of improved processes.
- A scheduled visit by MP Ann Marie Morris scheduled for August.

Newton Abbot ISU – Focus emergency services

- ED and MIU nurse staffing pressures. Potential impact on scheduled hours of operation and continued need for bank and agency.
- CQC engagement event June at Newton Abbot Hospital raised some concerns regarding staffing levels and these are being addressed.
- Social worker assessment delays impacting on discharge pathways of care.
- Significant reduction (50%) in Ambulance handover delays following improvement work
- Good progress against service improvement work steams for unscheduled care is being made with tests of change to ED and emergency floor assessment processes, wards and home first.

Moor to Sea ISU – Focus older people, therapy and Devon CC shared services

- Operational pressures identified in relation to:
    - Stroke medical staffing and locum cover – 2 substantive appointments made.
    - Ward nursing older people
    - Increased risk with domiciliary care capacity across ISU
- Community productivity work ongoing with community nursing and starting to review Intermediate care team workloads and capacity.
- Additional 200 hours per week agreed to support Domiciliary care capacity

5 Financial Headlines:

Overall financial position: The financial position at the NHS Improvement Control total level at 30th of June 2019 is a £4.94m deficit, which is slightly better than the £4.96m planned deficit. (52 week fines have been assumed to be returned in full or not applied, no STP risk share has been applied at Q1 and discussions are continuing with Torbay council over its contributions to ASC in 2019/20).

Total pay run rate in M3 (£21.45m) is in line with previous month.

Non pay expenditure run rate of £17.8m is higher by £0.4m compared to M2 mainly due to increased spend in social care offset by underspend on IT licence costs being deferred to next year and slippage of investment to later in the year.

CIP savings delivery position: The current month position shows a £0.1m shortfall against £0.7m target. There is a cumulative shortfall of £1.3m against a £2.0m target.

The Trust has an annual savings target of £17.5m of which £14.5m has been identified resulting in a £3.0m gap. In addition there is a requirement to have an STP solution to the additional cost of the change in valuation methodology of assets under the latest Royal Institution of Chartered Surveyors (RICS) guidance. This equates to £2.5m for which no plans have yet been identified. The total CIP gap is therefore £5.5m. Of the forecast delivery £2.72m is fully developed and assured. The remainder remains at either outline or definition stage and therefore remains at some risk. The control total will not be achieved without further progress on the detailed specification and subsequent delivery of CIP plans.

Capital: The capital expenditure as at M3 is £1.86m which is £0.74m underspent against budget. The full year plan is £21.5m, however NHSI are currently undertaking a review of Capital Departmental Expenditure Limit (CDEL) allocations to Trusts.

Use of Resources Risk Rating: The Finance Risk Rating has risen to a 3 at M3, primarily due to the achievement of the Q1 I&E plan.

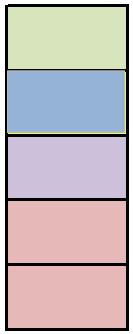
The Trust, at this stage of the financial year, is forecasting delivery of the control total, although this remains subject to delivery of the savings plans, national outcome on 52 week penalties and finalisation of contract discussions including STP risk share with the consequent risks attached and mitigation of variable staffing pressures. The control total will not be achieved without significant further progress in the detailed specification and subsequent delivery of CIP plans.

Torbay and South Devon NHS
NHS Foundation Trust

Integrated Performance Report

July 2019: Reporting period June 2019 (Month 3)

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 3 (performance to end of June 2019)

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 June 2019
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 to March 2019 (Dr Foster has a three month data lag). March data has a mortality rate of 921.5 which is within expected limits. 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 at diagnosis and procedure level are also reviewed on a monthly basis. These reviews start with a focus on coding and clinical review to patient level as needed with any concerns subsequently escalated 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 Quality Improvement Group (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.

3. Never Event - No Never Events occurred in June

4. STEIS - 4 Strategic Executive Information System (STEIS) reportable incidents where reported in June.

5. Infection Control - For the year-to-date there are 15 CDiff cases reported with 8 of these reported as a lapse in care. There are 12 reported bed days lost in June from infection control measures.

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 slightly increased from 61459 in May 2019 to 6803 in June 2019.

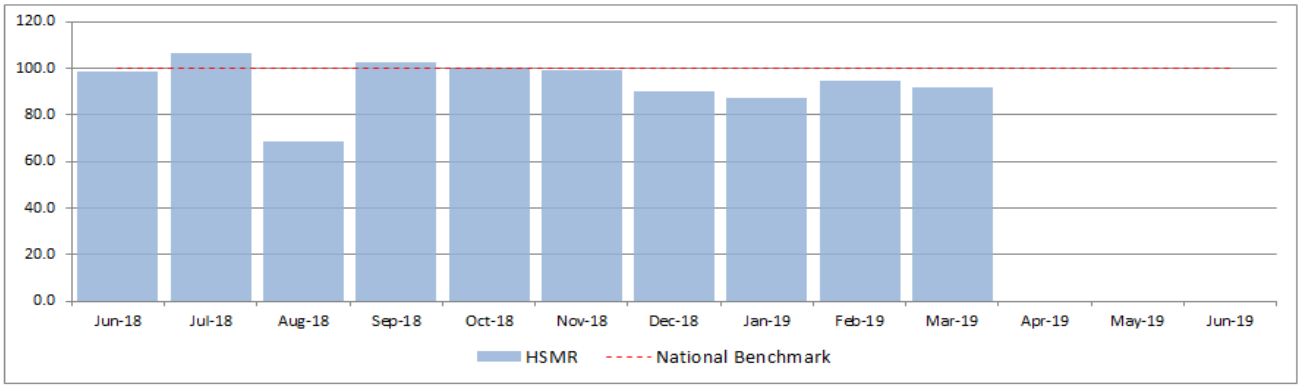
7. VTE - The VTE performance has been both flagged by NHSI and within our own reporting structures. Our reported performance is consistently below the standard of 95% with May at 90.9% and June at 91%. The Safety Thermometer audits provide assurance that the clinical assessments are being made, however, we have struggled in recent months to complete accurate recording of this data into the electronic discharge system.

8. Dementia screening - the standard for screening patients after admission to hospital is met with 93.3% achieved against a standard of 90%.

Quality and Safety - Mortality

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

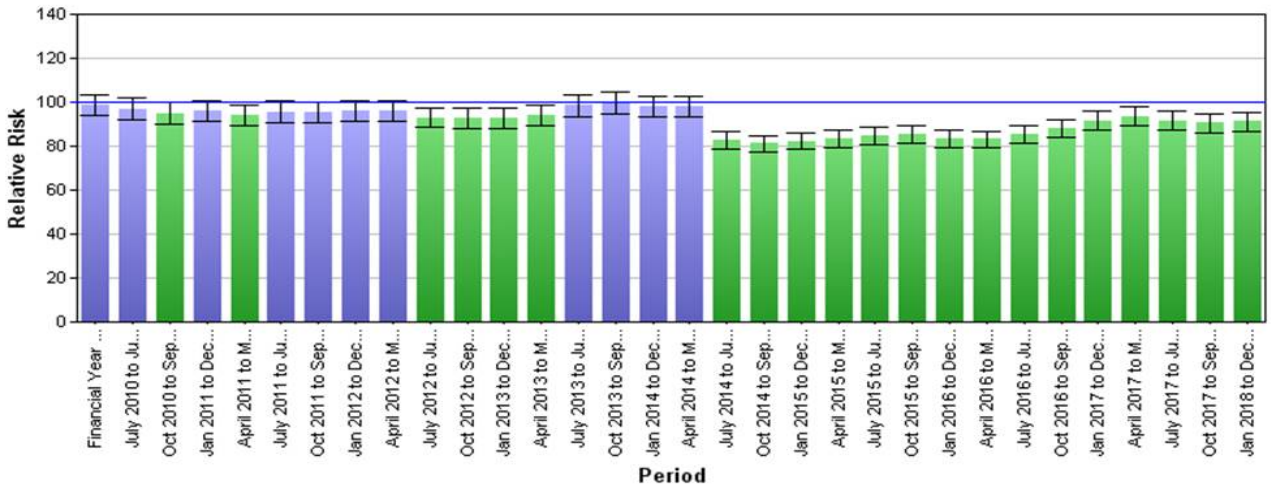
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
HSMR	98.5	106.3	68.7	102.3	99.8	99.0	89.8	87.5	94.7	91.5			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



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 91.5 which shows a better than benchmark rate (100 = national benchmark rate).

SHMI by data period



The SHMI data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trusts at 91.11 against a national average benchmark of 100.

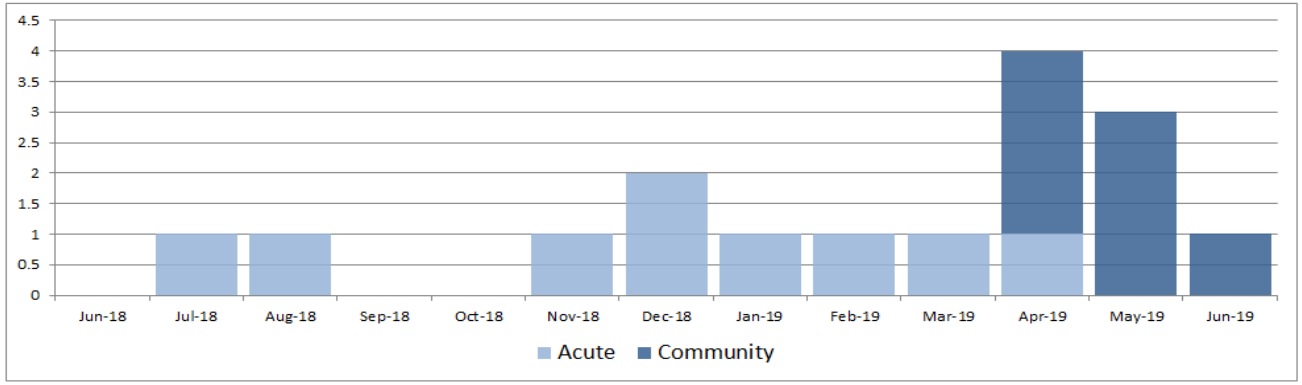
SHMI, HSMR, and Dr Foster alerts are reviewed through the Mortality Surveillance Scorecard at the Quality Improvement Group.

A score of 100 represents the weighted population average benchmark.

Quality and Safety - Infection Control

C Diff. Lapse in Care

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Acute	0	1	1	0	0	1	2	1	1	1	1	0	0
Community	0	0	0	0	0	0	0	0	0	0	3	3	1



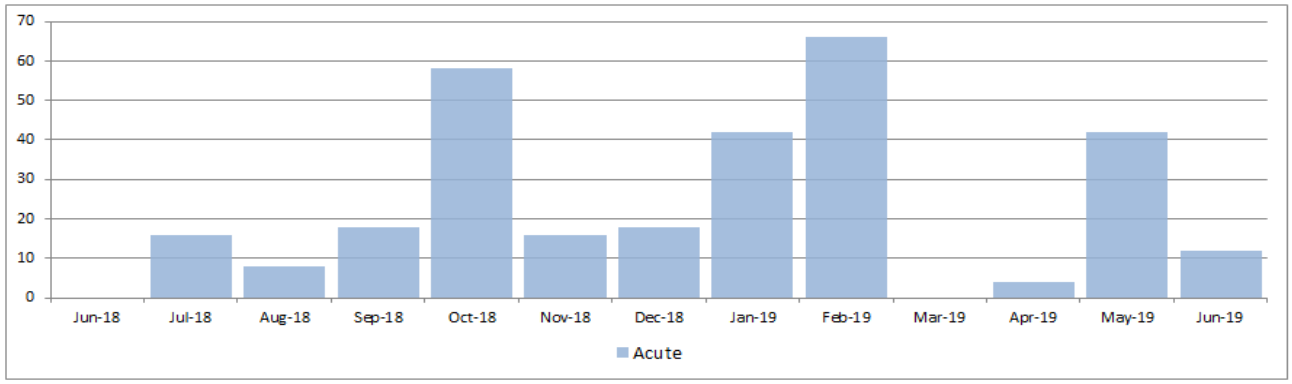
In June there was one reported C-diff case.

The cumulative total is 15 cases with 8 reported 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)

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Acute	0	16	8	18	58	16	18	42	66	0	4	42	12



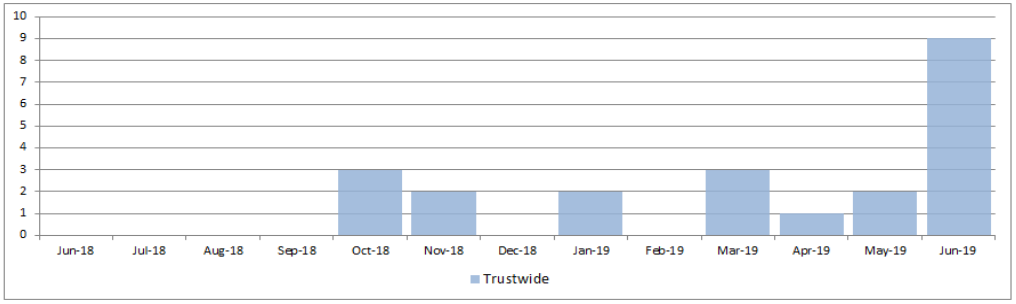
The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In June, there were 12 bed days lost due to infection control issues, bed closures has remained very low as seen in the graph opposite which records the number of beds closed from infection management controls.

Quality and Safety - Incident reporting and complaints

Reported Incidents - Major and Catastrophic

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Trustwide	0	0	0	0	3	2	0	2	0	3	1	2	9



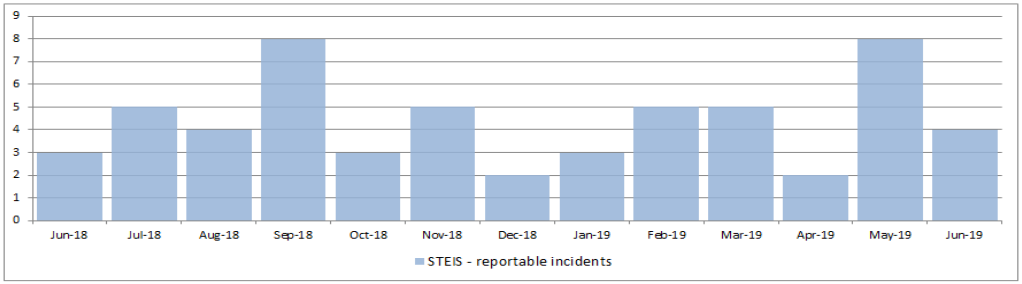
In June the Trust recorded four incidents as Major or Catastrophic which will follow normal process of investigation: The sites of recorded incidents are:

1. Obstetrics related issue
2. Implementation of care and ongoing monitoring / review
3. Access, admission, transfer, discharge (including missing patient)
4. Clinical assessment (including diagnosis, scans, tests, assessments)

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

STEIS Reportable Incidents

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
STEIS - reportable incidents	3	5	4	8	3	5	2	3	5	5	2	8	4



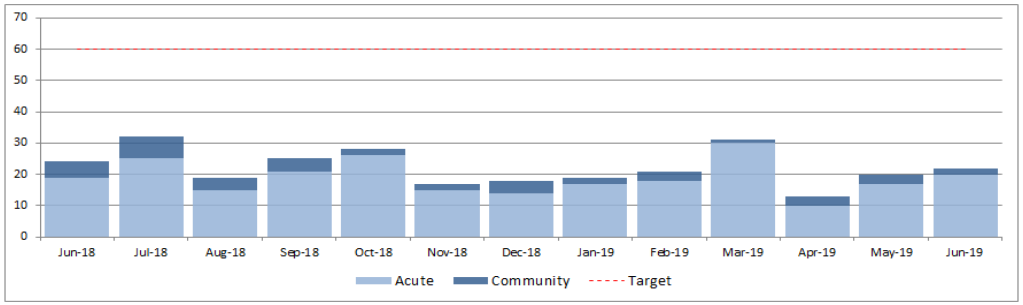
The Trust reported four incidents in June on the Strategic Executive Information System (StEIS).

1. Slips/trips/falls meeting SI criteria
2. Slips/trips/falls meeting SI criteria
3. Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
4. Diagnostic incident including delay meeting SI criteria (including failure to act on test results)

All incidents are being investigated for learning and sharing and have followed the

Formal complaints

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Acute	19	25	15	21	26	15	14	17	18	30	10	17	20
Community	5	7	4	4	2	2	4	2	3	1	3	3	2
Total	24	32	19	25	28	17	18	19	21	31	13	20	22
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



In June the Trust received 22 formal complaints.
The number of formal complaints are shown in the table opposite. This shows the split of 20 relating to the acute site and 2 in the community.

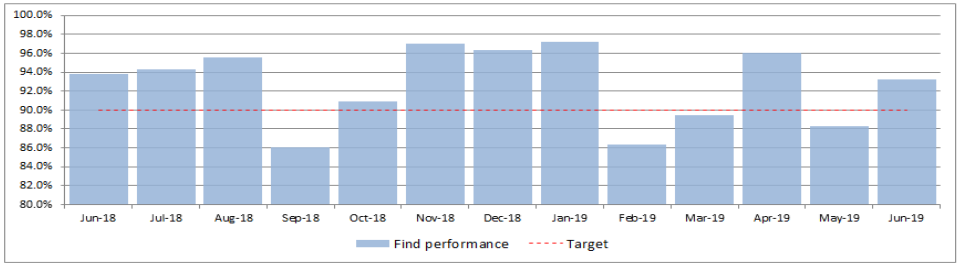
The main themes from the complainants are assessment, care, and treatment.

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

Quality and Safety - Exception Reporting

Dementia - Find

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Numerator	467	427	479	428	481	490	478	522	452	509	531	471	429
Denominator	492	447	495	482	542	514	504	544	516	572	562	535	460
Find performance	93.8%	94.3%	95.6%	86.0%	90.9%	97.1%	96.3%	97.2%	86.3%	89.4%	96.1%	88.3%	93.3%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

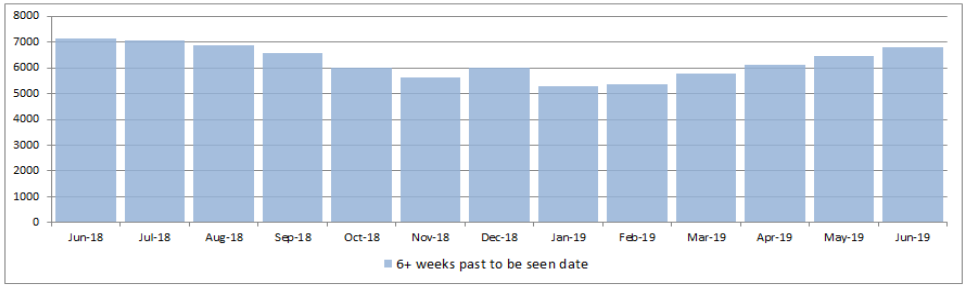


Dementia Find: The NHS I Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors. The Dementia Find performance continues to meet the standard of 90%.

The Trust has not achieved the Dementia Find standard in June with 93.3% against the target of 90%.

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

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
6+ weeks past to be seen date	7144	7063	6858	6566	6020	5630	5993	5300	5356	5783	6103	6459	6803



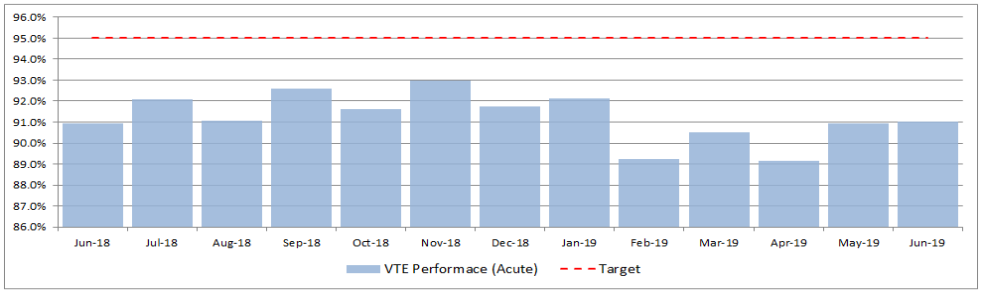
Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in June to 6803 (6459 last month).

A review of the areas with increases is being carried out to report to the Quality Assurance Group, with a focus on understanding future capacity and trajectory along with any clinical risks that needs to be escalated.

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

VTE Risk assessment on admission - (Acute)

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
VTE Numerator	5755	5962	5944	5361	6085	5744	5267	6036	5103	5549	5477	5995	5594
VTE Denominator	6328	6474	6526	5791	6642	6177	5740	6552	5718	6130	6143	6592	6145
VTE Performace (Acute)	90.9%	92.1%	91.1%	92.6%	91.6%	93.0%	91.8%	92.1%	89.2%	90.5%	89.2%	90.9%	91.0%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE: VTE performance has improved in June at 91.% but remains below the standard of 95%. Resources on wards to support consistent recording into reporting systems remain a challenge.

The "safety thermometer" audits which look at all notes on a single day in the month confirm that actual assessment performance is being maintained at 96% against the target of 95%.

Workforce Focus

Month 3 (performance to end of June 2019)

Page 9	Workforce Plan
Page 10	Sickness absence
Page 11	Turnover
Page 12	Appraisal and Training
Page 13	Agency

Workforce

Budgeted WTE 2019/20

Staff Group	Budget WTE Apr-19	Budget WTE May-19	Budget WTE Jun-19
Medical And Dental	514.05	506.82	516.36
Nursing And Midwifery Registered	1,312.75	1,315.42	1,315.30
Support To Clinical Staff	1,917.43	1,931.14	1,928.04
Add Prof Scientific and Technic	476.34	368.67	370.38
Allied Health Professionals	372.39	466.80	469.13
Healthcare Scientists	90.59	90.59	90.59
Administrative And Estates	1,181.38	1,171.91	1,169.87
Total Staff Budgeted WTE	**5,864.93**	**5,851.35**	**5,859.67**

Budgeted WTE 2019/20: The table opposite shows the WTE changes from the opening position at the 31.03.2019 for each month of the financial year to date. The budget includes all contracted hours worked (including overtime) plus bank and agency.

Actual Worked 2018/19: This table shows the outturn against the plan for each month of the year to date as at the end of February 2019.
The outcome at the end of June 2019 for WTE worked is a decrease in worked WTE of 47.68 staff in month against plan.
The adjustment between Month 1 and Month 2 within Add Prof Scientific & Technic and Allied Health Professionals staff groups is due to the reclassification of some staff following the transfer of staff for the CYP service.

Actual Worked 2019/20

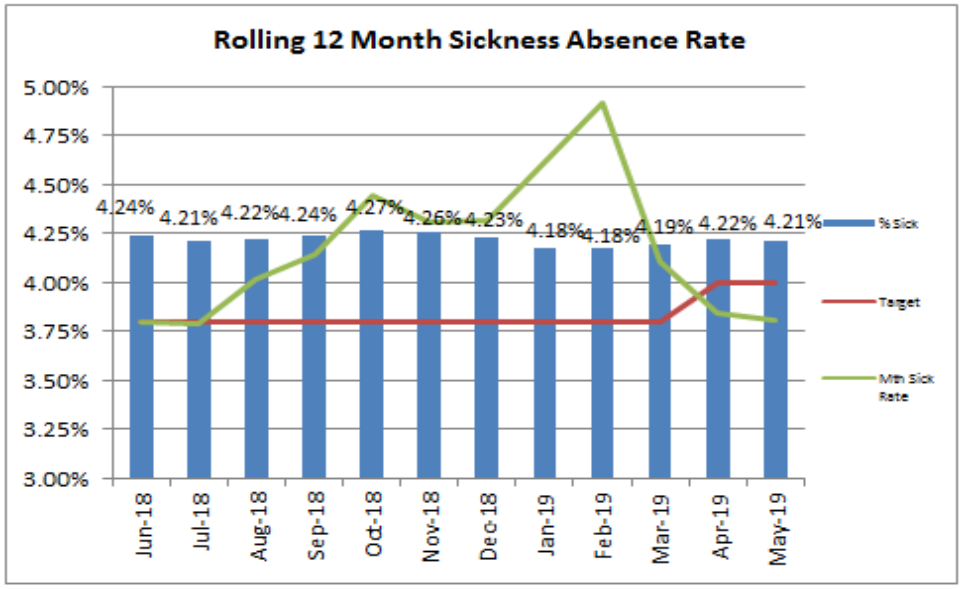
Staff Group	Worked WTE Apr-19	Worked WTE May-19	Worked WTE Jun-19
Medical And Dental	521.99	543.74	521.64
Nursing And Midwifery Registered	1,283.58	1,266.84	1,264.67
Support To Clinical Staff	1,843.41	1,868.85	1,830.90
Add Prof Scientific and Technic	366.18	365.48	371.15
Allied Health Professionals	505.70	500.47	499.57
Healthcare Scientists	100.42	98.49	106.52
Administrative And Estates	1,221.36	1,232.65	1,234.40
Total Staff Worked WTE	**5,842.65**	**5,876.53**	**5,828.85**
movement		33.89	-47.68

Variance to Budget 2019/20

Staff Group	Variance WTE Apr-19	Variance WTE May-19	Variance WTE Jun-19
Medical And Dental	7.94	36.92	5.28
Nursing And Midwifery Registered	-29.17	-48.58	-50.63
Support To Clinical Staff	-74.02	-62.29	-97.14
Add Prof Scientific and Technic	-110.16	-3.19	0.77
Allied Health Professionals	133.31	33.67	30.44
Healthcare Scientists	9.83	7.90	15.93
Administrative And Estates	39.98	60.74	64.53
Any Others - Provisions	0.00	0.00	0.00
Total Staff Worked WTE	**-22.28**	**25.18**	**-30.82**

Workforce - Sickness Absence

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



The annual rolling sickness absence rate was 4.21% at the end of May 2019 which is a minor decrease from April which was 4.22%. This is against the target rate for sickness of 4.00%.

The Monthly sickness figure for May was 3.81% which is a decrease from the 3.84% as at the end of April.

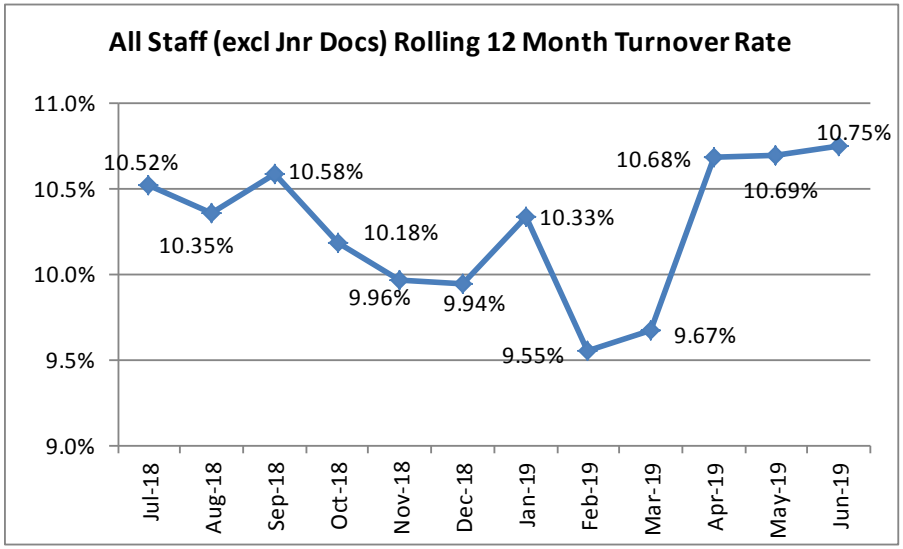
The Attendance Policy has been ratified and a programme of training for managers and awareness sessions for staff will be rolled out.

A Health & Wellbeing Charter is being developed.

The absence action plan is reviewed and monitored by the Workforce & OD Group.

Workforce - Turnover

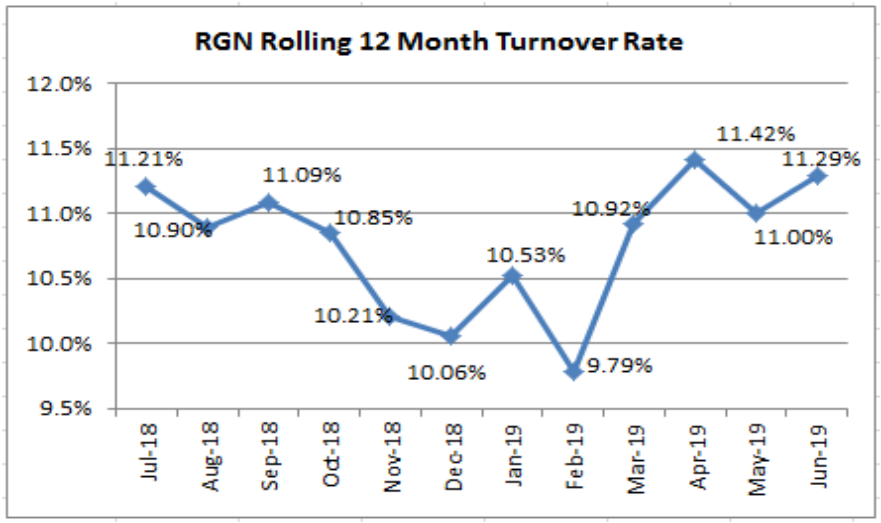
All Staff Turnover



All Staff Rolling 12 Month Turnover Rate

The graph shows that the Trusts turnover rate now stands at 10.75% for the year to June 2019 which is an increase from 10.69% in May.
The recruitment challenge to replace leavers from key staff groups remains significant.

RGN Turnover

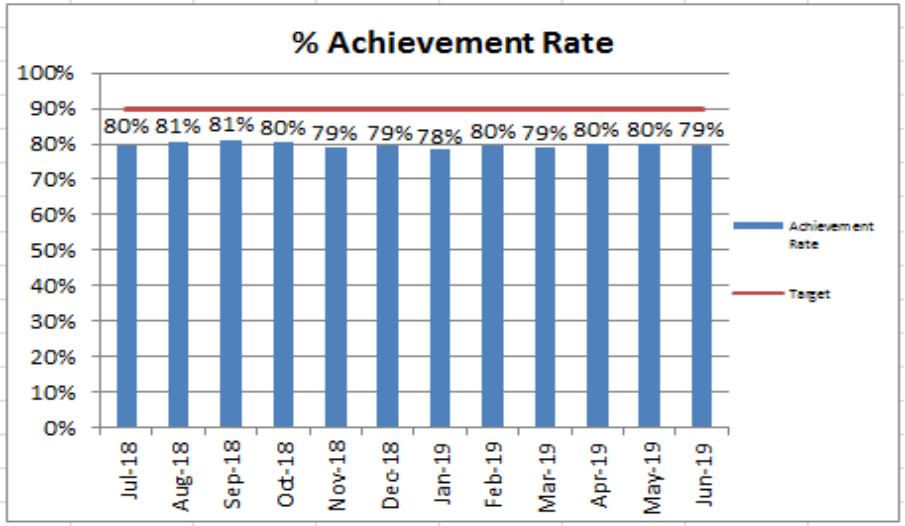


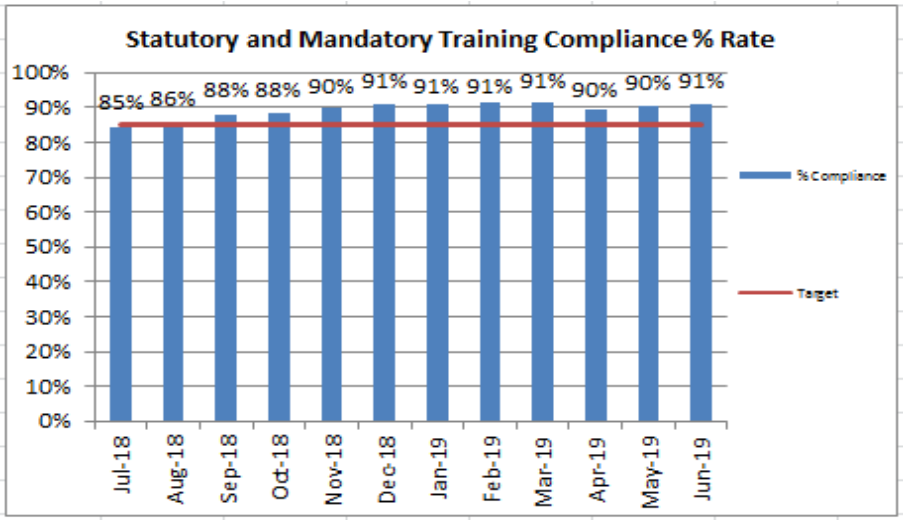
RGN Rolling 12 Month Turnover Rate

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 is within the range of 10% to 14% and for the 12 months ending in June 2019 stood at 11.29% which is an decrease from last months 11.00%.

Workforce - Appraisal and Training





Achievement Review (Appraisal) - The Achievement Review rate for the end of June was 79.41% which is a decrease on the 80.08% as at the end of May. 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 is against the 11 subjects which align with the MAST Streamlining project from April 2018. The graph shows that the current rate is 90.88% for June which is an increase from the previous months 90.43% in May . All staff are now receiving a monthly email containing their current compliance , plus budget holders are also receiving a monthly update which has helped the increase in compliance. Improved data quality checking of the Hive has enabled more accurate transfer of information to ESR. The Trust holds all competencies completed in ESR to ensure we are complying with Core Skills Training Framework requirements as part of the NHS Streamlining agenda.
An action plan to further improve the rate has been developed and progress against plan will be monitored through the Workforce and OD Group.
Individual modules that remain below their target are detailed in the table below:

Module	Target	Performance
Information Governance	95% and above	88.20%
Safeguarding Children	90% and above	85.07%

Workforce - Agency Expenditure

Agency Spend as at Month 03: The Trust's annual cap for agency spend, set by NHSI, is £6.18 million per year.
The tables below shows the current agency spend by staff group for 2019/20 compared to the total agency expenditure plan. As at month 3 (end of June 19) the Trust is underachieving against the plan by £875K. This is predominently within the medical workforce which was £711K overspent in month 3.

Total Agency Spend
Financial Year 2019/20

	Monthly Values M1	M2	M3
Plan - Total Agency (see breakdown below)	636	636	636
Actual Spend			
Non-Medical - Clinical Staff Agency			
Registered Nurses	363	293	303
Scientific, Therapeutic and Technical	45	29	80
of which Allied Health Professionals	45	28	75
of which Other Scientific, Therapeutic and Technical Staff		1	5
Support to clinical staff (HCA)	1	-1	
Total Non-Medical - Clinical Staff Agency	409	321	383
Medical and Dental Agency			
Consultants	401	409	363
Trainee Grades	146	122	149
Total Medical and Dental Agency	547	531	512
Non Medical - Non-Clinical Staff Agency	19	20	43
Total Pay Bill Agency and Contract	975	872	938
Over (Under) Spend	339	236	302

Plan	M1	M2	M3
Registered Nurses	£ 284	£ 284	£ 285
Technical staff	£ 48	£ 48	£ 48
Allied Health Professionals	£ 47	£ 47	£ 47
Other Scientific, Therapeutic and Technical Staff	£ 1	£ 1	£ 1
Support to Nursing staff	£ -	£ -	£ -
Total Non-Medical - Clinical Staff Agency	£ 332	£ 332	£ 333
Medical and Dental Staff - Consultants	£ 251	£ 251	£ 251
Medical and Dental Staff - Trainee Grades	£ 42	£ 42	£ 42
Total Medical and Dental	£ 293	£ 293	£ 293
Non Medical - Non-Clinical Staff Agency	£ 11	£ 11	£ 12
Total pay bill - agency staff including capitalised staff	£ 636	£ 636	£ 638

Total pay bill - agency staff including capitalised staff	£ 636	£ 636	£ 638

Variance - Over (Under) Spend	M1	M2	M3
Non-Medical - Clinical Staff Agency			
Registered Nurses	79	9	18
Scientific, Therapeutic and Technical	-3	-19	32
of which Allied Health Professionals	-2	-19	28
of which Other Scientific, Therapeutic and Technical Staff	-1	0	4
Support to clinical staff	1	-1	0
Total Non-Medical - Clinical Staff Agency	77	-11	50
Consultants	150	158	112
Trainee Grades	104	80	107
Total Medical and Dental Agency	254	238	219
Non Medical - Non-Clinical Staff Agency	8	9	31
Total Pay Bill Agency and Contract	339	236	300

Community and Social Care Focus

Month 3 (performance to end of June 2019)

Page 17 Social Care and Public Health Metrics

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

Page 18 Community services

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

Social Care and Public Health Metrics performance metrics - Torbay

Social Care Programme Board

2019/20 Performance Scorecard to 30 June 2019

Torbay Social Care KPIs		2019/20 full year target	2019/20 YTD target	Outturn YTD	Comment
ASC-1C pt1	% clients receiving self-directed support	94%	94%	90% (94%)	Within agreed tolerance.
ASC-1C pt2	% clients receiving direct payments	28%	28%	25.6% (28.0%)	Below target (415 / 1618). Further development of P.A. market and review of Standard Operating Procedure expected to improve performance.
D-40b	% clients receiving a review within 18 months	93%	93%	86% (93%)	Below target (2347 / 2723).
NI-132	Timeliness of social care assessment	80%	80%	75% (80%)	Below target (355 / 476). Data quality report to be produced as per audit recommendation
ASC-2A pt1	Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	21.5 (14)	A low outturn signifies better performance. Below target (16 admissions).
ASC-2D	Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	87.1% (83%)	On target.
NI-135	Carers receiving needs assessment, review, information, advice, etc.	36%	36%	13.2% (9.0%)	On target.
ASC-1C pt1b	% carers receiving self directed support	85%	85%	87% (85%)	On target.
QL-18	% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	100%	.. ..	No high risk concerns raised.
TCT-14b	% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	7.9% (8.0%)	A low outturn signifies better performance. On target.
ASC-1E	% Adults with learning disabilities in paid employment	7.0%	7.0%	8.1% (7.0%)	On target.
ASC-1G	% Adults with learning disabilities in settled accommodation	80%	80%	77.0% (80.0%)	Within agreed tolerance.

The Social Care and Public Health metrics above 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.

Corporative	Measure	Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
PUBLIC HEALTH SERVICES																	
	CAMHS - % Urgent referrals seen within 1 week	88.0%		100.0%	66.7%	50.0%	100.0%	66.7%	100.0%	50.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	67.0%
	CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%		94.1%	96.2%	93.7%	86.2%	91.9%	90.0%	93.7%	89.4%	90.8%	90.3%	87.1%	83.2%	79.1%	83.0%
	% of face to face new birth visits within 14 days *	95.0%		94.1%	92.1%	91.0%	96.2%	97.8%	94.6%	90.9%	92.2%	90.9%	93.8%	88.6%	95.8%	91.3%	91.9%
	Children with a child protection plan * [B]			166	166	168	170	146	148	172	170	186	183	170	186		186
	4 week smoking quitters (Quarterly) ** [B]			61			138			192				300			300
	Opiate users - % successful completions of treatment (Quarterly) ** [B]			7.5%			7.1%			5.4%				4.9%			4.9%

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

CAMHS - Target referrral to treatment (18 week) waiting times are not achieved in june. Since April Torbay CAMHS is part of the wider Devon Childrens services alliance. Work is progressing to integrate reporting for the new combined services and are reviewed through the Alliance board.

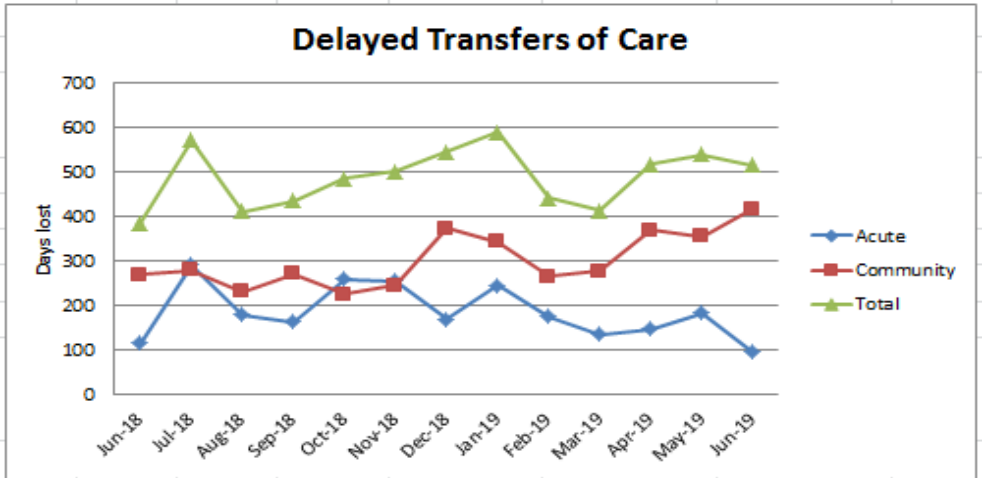
Quarterly data is shown in arrears for smoking, opiate users, and children with a protection plan.

Community Services and Social Care metrics

Community Hospital Dashboard - Summary of Key Measures - June-19

	Act. 18/19 Outturn	19/20 Year End Target	Target Jun 19	Jun-19	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges							
Total Admissions (General)	2,927	2,927	217	219	726	675	→
Direct Admissions (General)	294	294	29	24	78	77	↑
Transfer Admissions (General)	2,633	2,633	188	195	648	598	→
Stroke Admissions	305	305	34	24	69	93	↓
Transfers from CH to DGH	242	242	29	11	59	74	↓
Beds							
Bed Occupancy [1]	91.6%	90.0%	90%	94.0%	93.1%	90.0%	
Bed Days Lost to Delays [2]	3,305	0	0	419	1,145	0	
Bed Days Lost to Bed Closure	329			2	25		
Length of Stay							
Delayed Discharges				46	148		
Average Length of Stay - Overall (General)	10.9			11.3	11.3		
Average Length of Stay - Direct Admissions	8.1	8.5	8.5	10.6	10.6	8.5	↑
Average Length of Stay - Transfer Admissions	11.3	11.5	11.5	11.4	11.4	11.5	↓
Average Length of Stay - Stroke	15.2	0.0	0.0	15.5	15.5	18.0	↓
Long LoS (>30 days)	171	171	14	22	49	39	↑
MIUs							
Total MIU Activity [3]	41,788	41,788	4,032	3,718	11,051		
New MIU Attendances	36,179	36,179	3,519	3,333	9,785	9,614	↑
All Follow Up Attendances	5,609	5,609	137	385	1,266	1,709	↓
Planned Follow Up Attendances	4,382	4,382	419	279	949	1,442	↓
Unplanned Follow Up Attendances	1,227	1,227	94	106	317	267	↑
MIU Four Hour Breaches	5	5	0	0	2	1	
Average Waiting Time (Mins) - 95th Pctile	49	49	49	57	54	49	↑

Corporate	Measure	Target 2019/20	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
COMMUNITY BASED SERVICES																
	Nursing activity (F2F)		17,657	18,193	17,603	16,162	18,344	17,736	16,370	16,906	15,122	15,029	15,521	15,876	12,681	44,078
	Therapy activity	65,415	6,029	5,948	5,804	5,104	6,019	6,007	4,802	5,373	5,180	4,717	5,157	5,225	4,971	15,353
	No. intermediate care urgent referrals [B]	2,059	163	173	159	162	182	182	157	189	156	164	181	188	175	544
	No. intermediate care placements		73	92	89	90	93	86	77	96	83	73	76	68	85	229
	Intermediate Care - placement average LoS [B]	12.0	17.3	16.0	12.2	14.3	15.8	15.4	15.4	18.1	13.6	18.7	18.7	18.3	15.3	17.5



The Community Hospital Dashboard highlights
Bed occupancy remains above planned levels to maintain capacity to respond to escalation pressures. The Number of bed days lost due to delays in June is 419(May 356).

Minor injury Units
In June 2 patients are recorded as having waited over 4 hours to be seen and treated.

Community based services highlights:
Nursing Community nursing and community outpatient activity targets are being reviewed through the productivity work currently underway. The latest month can show a lower level of activity to plan due to data entry lag.

Intermediate care urgent referrals There remains variation on rates of referral across different Integrated Service Units and this is being picked up through the locality review / Enhanced Intermediate Care meetings. Through the Community Productivity Programme there is a continued focus on the quality and consistency of data recording. The introduction of "SystmOne" community IT system in Coastal locality has been welcomed and already improving the quality of information available to support clinical staff and accurate reporting of activity.

Intermediate Care (IC) placements The year to date average length of stay in IC placements remains above target (12 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 and productivity work. There is an increasing number of delays waiting for social care assessment and implementation of packages of care from intermediate care placement.

Transfers of Care (DToC)- The number of bed days reported as lost to delayed transfers of care decreased in June. Teams continue to validate and escalate delays on a daily basis. The discharge HUB, a single point of contact for patients residing in both Torbay Authority and Devon County Council catchments, is established and helping manage delays where simple packages of care are required.

Operational Performance Focus

Month 3 (performance to end of June 2019)

Page 18	**NHSI indicators performance summary**
Page 19	**Referral to Treatment**
Page 20	**4-hour Standard for time spent in the Emergency Department and Minor Injuries Units**
Page 21	**Cancer treatment and cancer access standards**
Page 22	**Patients waiting over six weeks for diagnostics**
Page 23	**Other performance exceptions**

NHS I Performance indicator Summary

STP / NHSI Operational Plan - Monitored indicators

Indicator	National Standard	Operational plan / revised trajectory (M3)	Trust performance (M3)
A&E 4hr waits (PSF)	95%	83.0%	80.3%
RTT 18 week waits	92%	81.5%	81.52%
62 day Cancer waits	85.0%	80.4%	79.6%
Diagnostics waits < 6 weeks	99.0%	88.3%	88.3%
Dementia Find	90%	90%	93.3%

NHSI Operational Plan indicators (Month 3)

Annual plan trajectories : It is noted that the annual plan trajectories reflect performance at the end of M12 18_19. The table below sets out our monthly trajectory of improvement. as agreed in our annual plan submission.

A&E: STF Trajectory (83%) **not met** - performance for June (80.3%) .

RTT: RTT performance has seen little change in june with 81.52% of people waiting less than 18 weeks, slightly ahead the Operational Plan trajectory of 81.50%. Against 52 weeks we have seen an increase from 59 last month to 83 however this remains within our plan trajectory of 110.

Cancer: National standard not met in June 79.6% against standard of 85% and improvement trajectory (80.4%) - Recovery plans to deliver standard in Q2 are in place with weekly monitoring and escalation through Chief Operating officer.

Diagnostics: The diagnostics trajectory is **not met with** 88.3% of patients waiting under 6 weeks. This is in line with our recovery trajectory to deliver improved performance in Q4 to achieve 96% against the National standard 99%.

Dementia: The Dementia find standard is reported at 93.3% achieving the 90% standard**.**

NHSI - Annual Plan submitted performance trajectories

Indicator	National Standard	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Accident and Emergency 4 hours	95%	78%	80%	83%	86%	90%	92%	92%	92%	92%	90%	90%	90%
Diagnostics Test Waiting Times	1%	13.65%	12.73%	11.75%	10.76%	9.74%	8.70%	8.26%	7.80%	7.33%	6.94%	6.55%	6.15%
Referral to Treatment % incomplete	92%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%
RTT - 52 weeks	0%	94	103	110	120	115	103	75	47	32	22	12	0
Cancer Waiting Times - 62 Day GP Ref	85%	78.3%	79.8%	80.4%	82.8%	85.1%	85.5%	85.1%	85.1%	85.5%	85.3%	85.3%	85.3%

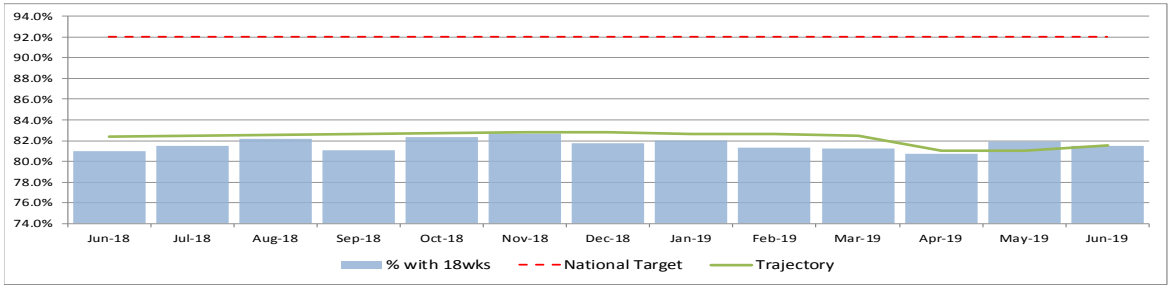
NHSI Indicator - Referral to Treatment

Services with >100 patients over 18 weeks

Submitted Spec	Total >18wks	Grand Total Incomplete Pathways	% < 18wk
Gastroenterology	133	1549	91.41
Orthodontics	143	279	48.75
Cardiology	166	1408	88.21
Oral Surgery	167	1258	86.72
Neurology	173	541	68.02
Urology	187	1138	83.57
Colorectal Surgery	240	711	66.24
Upper Gastrointestinal Surgery	418	824	49.27
Trauma & Orthopaedics	648	2073	68.74
Ophthalmology	748	2372	68.47
Grand Total	3629	19641	81.52

Referral to Treatment - Incomplete pathways

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Incomplete <18wks	15693	15416	15385	15204	15664	15522	15100	15111	15094	15772	15357	16002	16012
Incomplete >18wks	3688	3494	3338	3558	3354	3254	3366	3322	3472	3636	3661	3537	3629
% with 18wks	**81.0%**	**81.5%**	**82.2%**	**81.0%**	**82.4%**	**82.7%**	**81.8%**	**82.0%**	**81.3%**	**81.3%**	**80.7%**	**81.9%**	**81.5%**
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	82.4%	82.5%	82.6%	82.7%	82.7%	82.8%	82.8%	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%

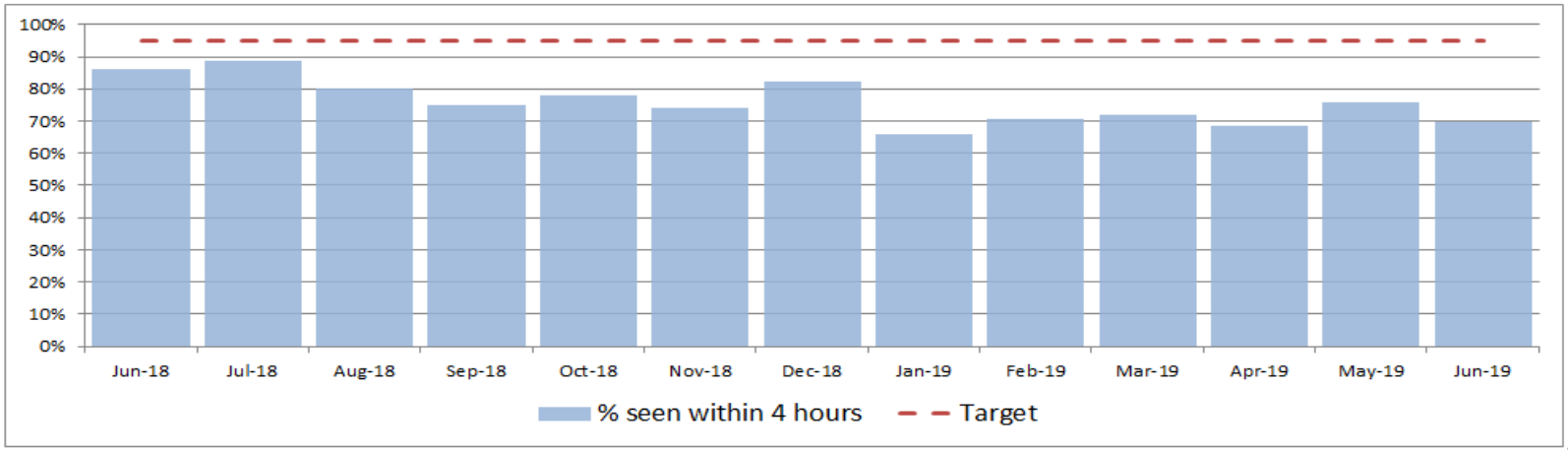


Referral to Treatment - RTT: RTT performance has stabilised in June with the proportion of people waiting less than 18 weeks platauing at 81.52%, slightly ahead the Operational Plan trajectory of 81.50% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has increased to 19,641 in June which is an increase of 102 from May and 381 above our revised trajectory . We continue to remain above our 31st March 18 position (increases are being seen in Gastroenterology 243, Cardiology 162, Respiratory 89, Dermatology 82, Oral Surgery 77, Oral Surgery 77, ENT 64, Neurology 32, Colorectal 32, Clinical Neuro-Phys 30, and Urology 30). For June , 83 people will be reported as waiting over 52 weeks, this being an increase on last month's 59 but remains ahead of our re-forecast position of 110. The increase was planned for in the profile of the trajectory in anticipation of staff taking annual leave as well as the ongoing issues with Theatres A and B. July's forecast position at present is 95 against a trajectory of 120, teams are continuing to working on mitigating actions.
Theatres remedial works - current anticipated completion date is the 16th September 2019
The Chief Operating Officer will update separately on the immediate impact and the development of options to address this loss of operating capacity and ongoing fragility of the theatre estate. Plans to mitigate the lost capacity include weekend working and outsourcing. Good progress is being made with successful in the uptake of weekend lists (being temporarily stood down in August), extended day surgery lists and continuation of outsourcing patients to the Nuffield (Plymouth). Work is also ongoing through DRSS to identify capacity across the STP both NHS and independent sector and match available capacity to Trusts with the longest waiters.

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. The risk has further increased with the closing of two operating theatres. As a result of the theatre closures the delivery of the RTT trajectory for total waits and longest waits will need to be reassessed once plans are agreed. Orthopaedics is the area likely to experience the greatest loss of capacity. Recruitment and backfill in accordance to the approved investment plans however are progressing and improvements in capacity being seen in other areas.
Whilst the RTT performance has remained fairly static the number of people waiting over 52 weeks has decreased in March and overall numbers waiting over 40 weeks have continued to remain fairly static with a current 5% reduction since July 18(July– 415 to June 19–393). It has been agreed that Trauma and Orthopaedics will retain protected beds to support routine inpatient elective surgery to reduce the number of cancelled operations through the winter months.

Management action: Led by the Chief Operating Officer plans are monitored through the Cancer / RTT Performance Risk and Assurance meeting with any outstanding risk escalated to the monthly Executive led Quality and Performance Review meetings.

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



Operational delivery: The Operational Plan trajectory for Accident and Emergency waiting times (less than 4 hours) is not met in June (83% trajectory) with 84.2**%** (84.2% last month) against the trajectory of 80%.

Escalation: In June there were 0 days at Opel 1 and 8 days at Opel 4, the highest level of escalation; this being significantly higher to levels of performance for same period last year. The current level of performance remains a significant risk as we continue to focus on the improvement programme.

Improvement work streams: The three' task and finish' groups are making good progress with initiating tests of change and are reporting back to the ED delivery board and Improvement board with commissioners. The 3 groups are :

- Emergency floor and front door assessment - To improve the timeliness of clinical review, quality and safety of urgent and emergency patients from initial presentation to discharge or specialist care on an inpatient ward.
- Wards - To improve the quality, safety and minimise length of stay for urgent and emergency patients on inpatient wards.
- Home First - To enable safe and effective urgent and emergency care as close as possible to patients' home.

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

Ambulance Handovers : In June we have seen a further reduction in the number of ambulance delays over 60 with 4 reported - This improvement in lost hours is reflective of the work we have been doing within the department and with SWAST to streamline our handover processes .

Escalation status

Opel status	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Opel 1	26	22	7	0	0	1	9	0	0	1	0	6	0
Opel 2	4	7	9	8	14	12	13	1	5	10	8	15	4
Opel 3	0	3	15	22	15	14	7	22	20	16	16	3	18
Opel 4	0	0	0	0	2	3	2	8	3	4	6	4	8
Performance	90.89%	92.70%	87.20%	83.80%	85.10%	82.20%	87.60%	76.40%	79.80%	81%	79.10%	84.20%	80.30%

Cancer treatment and cancer access standards

		April 2019				May 2019				June 2019				Quarter 1 Total			
CWT Measure	Target	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	749	647	1396	**53.7%**	1073	308	1381	**77.7%**	864	351	1215	**71.1%**	2686	1306	3992	**67.3%**
14 Day - Breast Symptomatic referral	93%	73	72	145	**50.3%**	112	3	115	97.4%	0	0	0	100.0%	185	75	260	**71.2%**
31 Day 1st treatment	96%	211	7	218	96.8%	197	2	199	99.0%	183	6	189	96.8%	591	15	606	97.5%
31 Day Subsequent treatment - Drug	98%	60	0	60	100.0%	64	0	64	100.0%	56	0	56	100.0%	180	0	180	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	72	1	73	98.6%	64	2	66	97.0%	43	0	43	100.0%	179	3	182	98.4%
31 Day Subsequent treatment - Surgical	94%	17	1	18	94.4%	33	1	34	97.1%	29	1	30	96.7%	79	3	82	96.3%
31 Day Subsequent treatment - Other		20	0	20	100.0%	37	0	37	100.0%	23	0	23	100.0%	80	0	80	100.0%
62 day 2ww / Breast	85%	108	28	136	**79.4%**	101	17.5	118.5	85.2%	90	25	115	**78.3%**	299	70.5	369.5	**80.9%**
62 day Screening	90%	13	1	14	92.9%	10	1	11	90.9%	12	1	13	92.3%	35	3	38	92.1%
62 day Consultant Upgrade		4	0.5	4.5	88.9%	5	1	6	83.3%	5	0	5	100.0%	14	1.5	15.5	90.3%
104 day breaches (2ww) - TREATED	0	10.5				6				7				23.5			

Cancer standards - Table above shows the forecast for June and Q1 (as at 16th July 2019). *Final validation and data entry is completed for national submission, 25 working days following the month close and at the end of the quarter.*
Two cancer standards are not met in June

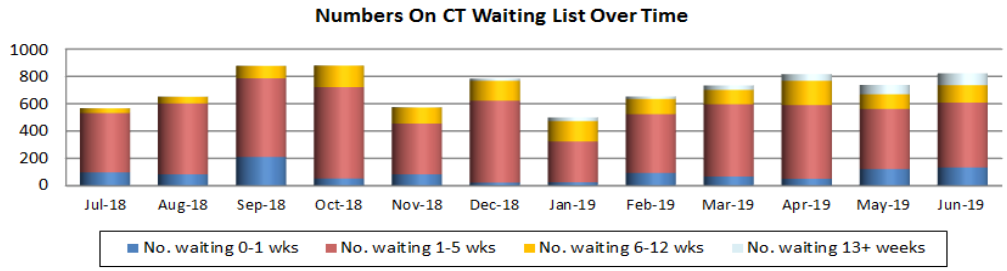
Urgent cancer referrals 14 day 2ww: At 71% in June this remains below the standard of 93%.
A revised trajectory of improvement has been shared with the STP showing improvement to comply with standard by August 2019.

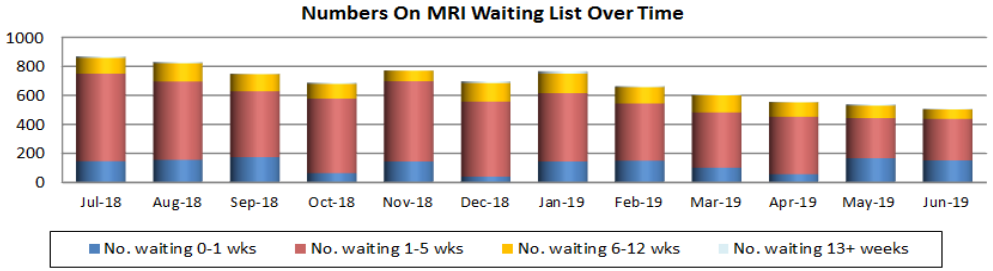
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has not been met in June at 78.3%.
Significant risk remains in the pathways for Urology and Lower GI linked to the capacity constraints and long wait for first appointment.

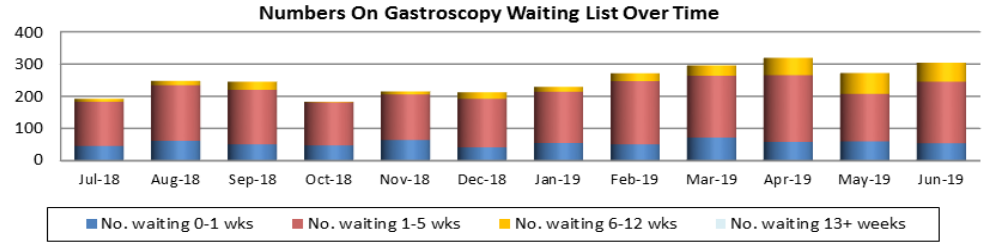
Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In June 7 patients with confirmed cancer were treated > 104 days. The number of patients being tracked over 62 days is being maintained. with no significant change to historical levels.

**Cancer: symptomatic breast patients – June performance data not available. A recent change in clinic bookings has required a change of process to collect data. However, data for June is indicating a performance above 90% (un-validated) against a national target of 93%.

NHSI indictor - patients waiting over 6 weeks for diagnostics







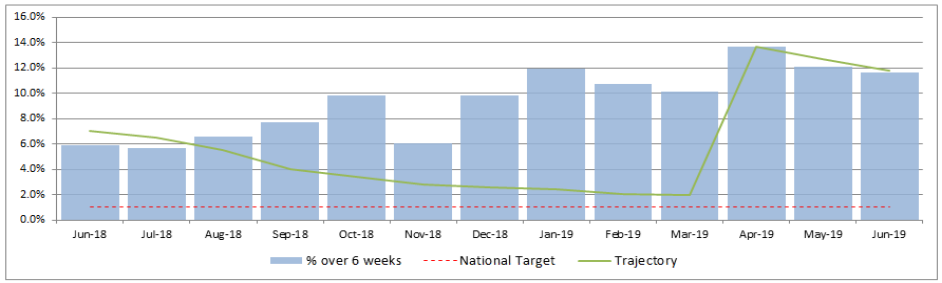
The percentage of patients with a diagnostic wait over 6 weeks has improved in June to 11.7% (454 patients) and is in line with planned trajectory. Last month 454 patient s waited longer than 6 weeks representing 12.1% of total patients waiting.
Due to demand now exceeding maximum in house capacity (which 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 this capacity shortfall. Recovery plans confirming actions to increase outsourcing and manage waiting times and cover the CT scanner replacement programme have been reviewed and approved.

The highest number of patients with long waits in June is for CT 215, MRI 69 and Gastroscopy 59 patients over 6 weeks. In CT there is a complex cohort of patients requiring cardiac contrast scans and virtual colonoscopy that form the majority of the patients showing as longest waits.
It is noted that waiting times have reduced for echocardiography tests following equipment replacement and additional sessions to catch up the backlog.

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.

Diagnostic Tests Longer than the 6 week standard

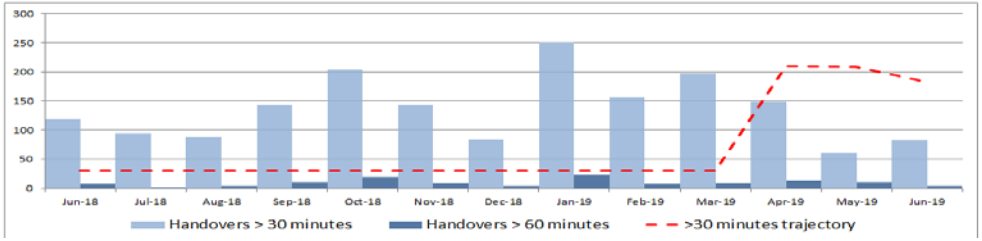
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Patients	3939	3352	3377	4173	4027	3705	3863	3385	3934	4186	4201	3746	3893
Waiting longer than 6 weeks	231	191	222	323	396	225	379	405	421	423	575	454	454
% over 6 weeks	5.9%	5.7%	6.6%	7.7%	9.8%	6.1%	9.8%	12.0%	10.7%	10.1%	13.7%	12.1%	11.7%
National Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Trajectory	7.03%	6.48%	5.54%	4.01%	3.40%	2.79%	2.55%	2.44%	2.08%	1.95%	13.65%	12.73%	11.75%



Other performance exceptions

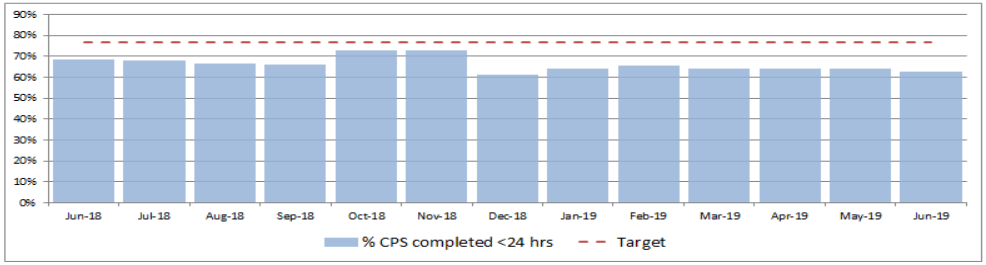
Ambulance handovers

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Handovers > 30 minutes	119	94	88	144	204	143	84	251	156	198	148	61	83
Handovers > 60 minutes	8	1	4	10	19	9	4	23	8	9	13	11	4
>30 minutes trajectory	30	30	30	30	30	30	30	30	30	30	210	209	183



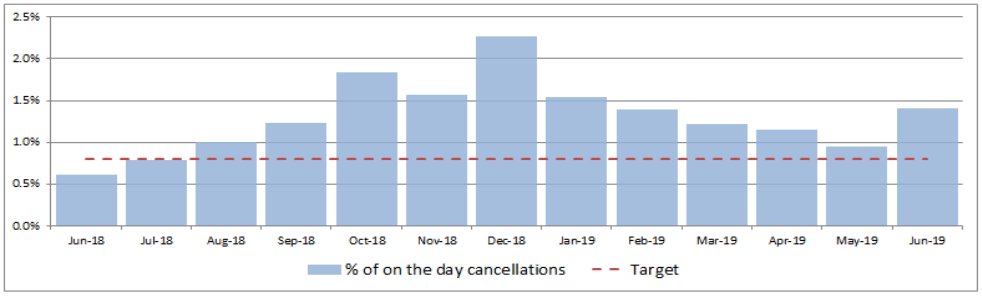
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Discharges	1221	1225	1239	1016	1345	1283	864	999	896	938	954	1035	848
CPS completed within 24 hours	1779	1804	1859	1535	1851	1767	1405	1554	1361	1460	1483	1618	1357
% CPS completed <24 hrs	69%	68%	67%	66%	73%	73%	61%	64%	66%	64%	64%	64%	62%
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%



On the day cancellations for elective operations

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Cancellations	20	26	33	37	69	53	63	53	42	39	37	33	45
Elective spells	3286	3325	3292	3010	3766	3389	2782	3432	3016	3196	3218	3502	3198
% of on the day cancellations	0.6%	0.8%	1.0%	1.2%	1.8%	1.6%	2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



Ambulance Handover

The number of ambulance handovers delayed over 30 minutes is below the planned trajectory. June, has seen a continuation of teh improvement seen in May in recorded delays > 30 mins and > 60 mins. This is a reflection of the service improvement work done in collaboration with SWAST and our ED teams to ensure efficient hand over. This is despite the continued pressures on patient flow across the system and patient delays in ED waiting for admission to hospital bed. 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.

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.

Cancelled operations

In June, the number of operations cancelled on the day of surgery for hospital reasons increased to 45. This represents 1.4% of all elective procedures undertaken. In June we experienced further theatre failure with a ventilation plant issues resulting in a 24 hour shut down of two theatres and interim remedial works. This contributing to 10 of the recorded cancellations on the day of surgery seen in June.

Finance Focus

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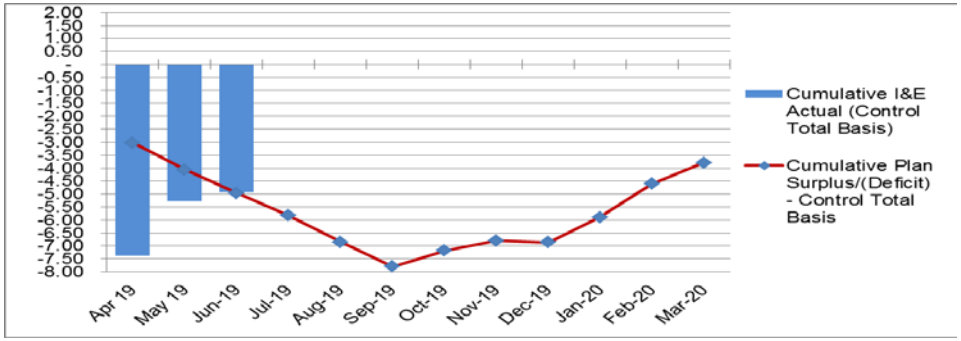
Summary of Financial Performance

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	122.33	(0.85)	121.48	121.53	0.05	496.18	495.76
Pay	(63.01)	(1.10)	(64.10)	(65.09)	(0.98)	(246.38)	(248.36)
Non Pay	(57.71)	2.07	(55.64)	(54.91)	0.73	(225.02)	(222.57)
EBITDA	**1.61**	**0.12**	**1.73**	**1.54**	**(0.20)**	**24.78**	**24.82**
Financing Costs	(4.90)	(0.01)	(4.91)	(4.84)	0.06	(20.08)	(20.12)
SURPLUS / (DEFICIT)	**(3.29)**	**0.11**	**(3.17)**	**(3.31)**	**(0.13)**	**4.70**	**4.70**
NHSI Exclusions	(0.03)	0.00	(0.03)	0.28	0.31	(0.14)	(0.14)
Plan Adjusted Surplus / (Deficit)	**(3.32)**	**0.11**	**(3.21)**	**(3.03)**	**0.18**	**4.56**	**4.56**
Remove PSF/MRET Income	(1.64)	0.00	(1.64)	(1.91)	(0.27)	(8.36)	(8.36)
Variance to Control Total (Excl PSF/MRET	**(4.96)**	**0.11**	**(4.85)**	**(4.94)**	**(0.09)**	**(3.80)**	**(3.80)**
Cash Balance	2.89			8.65	**5.76**	**3.83**	**3.83**
Capital Expenditure	2.75	(0.15)	2.60	1.86	**(0.74)**	**21.56**	**21.56**
CIP Delivery	2.00	0.00	2.00	0.71	**(1.30)**	**20.03**	**20.03**

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

Key Points

- The Trust has a Control Total for the year of a deficit of £3.80m, which excludes income relating to Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) totalling £8.36m.
- The financial position at this control total level as at 30th of June 2019 is a £4.94m deficit, which is slightly better than the £4.96m planned deficit.
- At Q1 the Trust assumed it will earn the PSF and MRET funding of £1.64m having met the control total. An additional PSF income for FY 2018/19 of £0.27m was notified to the Trust.
- Total pay run rate in M3 (£21.4m) is in line with previous month.
- Non pay expenditure run rate of £17.8m is higher by £0.4m compared to M2 mainly due to increased spend in social care offset by underspend on IT licence costs being deferred to next year and slippage of investment to later in the year.
- The CIP target for year to date is £2.0m of which £0.7m has been delivered; an adverse variance of £1.3m due to undelivered pay and non pay schemes.
- The Trust has an annual savings target of £17.5m of which £14.5m has been identified resulting in a £3.0m gap. (In addition there is a requirement to have an STP solution to the additional cost of the change in valuation methodology of assets under the latest Royal Institution of Chartered Surveyors (RICS) guidance. This equates to £2.5m for which no plans have yet been identified.) The total CIP gap is therefore £5.5m. Of the forecast delivery only £2.72m (19%) is fully developed, the remainder is at either outline or definition stage and therefore subject to risk of non-delivery.
- Capital expenditure as at M3 is £1.86m which is £0.74m underspent against budget. The full year plan is £21.56m however NHSI are currently undertaking a review of Capital Departmental Expenditure Limit (CDEL) allocations to Trusts.
- The Finance Risk Rating has risen to a 3 at M3, primarily due to the achievement of the Q1 I&E plan.
- The Trust, at this stage of the financial year, is forecasting delivery of the control total, although this remains subject to delivery of the savings plans, national outcome on 52 week penalties and finalisation of contract discussions including STP risk share with the consequent risks attached and mitigation of variable staffing pressures. The control total will not be achieved without significant further progress in the detailed specification and subsequent delivery of CIP plans.
- This position to date and forecast both excludes any penalties for 52 week waits (the assumption is that they will either not be applied or will be returned in full) and no STP risk share has been applied in the position.

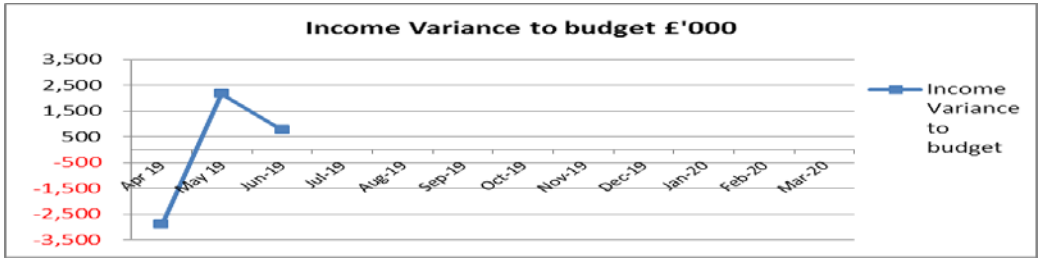
Summary of Financial Performance

	Month 3					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	36.86	0.07	36.93	36.78	(0.16)	110.61	(0.89)	109.72	108.87	(0.85)	(0.69)	(0.16)	444.27	443.71
Other Operating income	3.94	0.07	4.01	4.94	0.93	11.72	0.04	11.76	12.66	0.90	(0.03)	0.93	51.91	52.04
Total Income	**40.80**	**0.14**	**40.94**	**41.72**	**0.77**	**122.33**	**(0.85)**	**121.48**	**121.53**	**0.05**	**(0.72)**	**0.77**	**496.18**	**495.76**
Employee Benefits - Substantive	(20.08)	(0.52)	(20.60)	(20.51)	0.09	(61.10)	(0.84)	(61.94)	(62.30)	(0.36)	(0.45)	0.09	(240.20)	(241.29)
Employee Benefits - Agency	(0.64)	(0.28)	(0.91)	(0.94)	(0.02)	(1.91)	(0.26)	(2.16)	(2.78)	(0.62)	(0.60)	(0.02)	(6.18)	(7.08)
Drugs (including Pass Through)	(2.94)	0.28	(2.66)	(2.61)	0.05	(8.81)	0.23	(8.59)	(8.33)	0.26	0.21	0.05	(35.26)	(34.34)
Clinical Supplies	(2.19)	0.04	(2.15)	(1.97)	0.18	(6.52)	0.00	(6.51)	(6.48)	0.03	(0.15)	0.18	(26.46)	(26.45)
Non Clinical Supplies	(0.43)	0.10	(0.33)	(0.39)	(0.06)	(1.29)	0.01	(1.28)	(1.15)	0.13	0.20	(0.06)	(4.88)	(4.88)
Other Operating Expenditure	(13.22)	0.29	(12.93)	(12.83)	0.11	(41.08)	1.82	(39.26)	(38.95)	0.31	0.20	0.11	(158.42)	(156.90)
Total Expense	**(39.49)**	**(0.10)**	**(39.59)**	**(39.26)**	**0.34**	**(120.71)**	**0.97**	**(119.74)**	**(119.99)**	**(0.25)**	**(0.59)**	**0.34**	**(471.40)**	**(470.93)**
EBITDA	**1.31**	**0.04**	**1.35**	**2.46**	**1.11**	**1.61**	**0.12**	**1.73**	**1.54**	**(0.20)**	**(1.31)**	**1.11**	**24.78**	**24.82**
Depreciation - Owned	(1.04)	(0.00)	(1.05)	(0.70)	0.35	(3.10)	(0.01)	(3.11)	(2.78)	0.33	(0.02)	0.35	(12.86)	(12.91)
Depreciation - donated/granted	(0.07)	0.00	(0.07)	(0.07)	0.01	(0.22)	0.00	(0.22)	(0.20)	0.01	0.01	0.01	(0.86)	(0.86)
Interest Expense, PDC Dividend	(0.62)	0.00	(0.62)	(0.61)	0.01	(1.83)	0.00	(1.83)	(1.79)	0.04	0.04	0.01	(7.36)	(7.36)
Donated Asset Income	0.08	0.00	0.08	0.00	(0.08)	0.25	0.00	0.25	0.00	(0.25)	(0.17)	(0.08)	1.00	1.00
Gain / Loss on Asset Disposal	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	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	(0.07)	(0.07)	(0.07)	0.00	0.00	0.00
SURPLUS / (DEFICIT)	**(0.34)**	**0.04**	**(0.31)**	**1.09**	**1.39**	**(3.29)**	**0.11**	**(3.17)**	**(3.306)**	**(0.13)**	**(1.52)**	**1.39**	**4.70**	**4.70**
Adjusted Plan Position														
Donated Asset Income	(0.08)	0.00	(0.08)	0.00	0.08	(0.25)	0.00	(0.25)	0.00	0.25	0.17	0.08	(1.00)	(1.00)
Depreciation - Donated / Granted	0.07	0.00	0.07	0.07	(0.01)	0.22	0.00	0.22	0.20	(0.01)	(0.01)	(0.01)	0.86	0.86
Impairment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07	0.07	0.00	0.00	0.00
Adjusted Plan Surplus / (Deficit)	**(0.35)**	**0.04**	**(0.32)**	**1.15**	**1.47**	**(3.32)**	**0.11**	**(3.21)**	**(3.03)**	**0.18**	**(1.29)**	**1.47**	**4.56**	**4.56**
NHSI Adjustment to Control Total														
Remove PSF/MRET Income	(0.55)	0.00	(0.55)	(0.82)	(0.27)	(1.64)	0.00	(1.64)	(1.91)	(0.27)	(0.00)	(0.27)	(8.36)	(8.36)
Variance to Control Total Excluding PSF/MRET	**(0.90)**	**0.04**	**(0.86)**	**0.33**	**1.20**	**(4.96)**	**0.11**	**(4.85)**	**(4.942)**	**(0.09)**	**(1.29)**	**1.20**	**(3.80)**	**(3.80)**

- The Control Total position in Month 3 is a surplus of £0.33m, which is £1.20m ahead of the budgeted position after NHSI exclusions. Included within this amount is additional income and lower operating costs in month (non pay and depreciation). For the year to date, the cumulative deficit of £4.94m is slightly better than budget.
- Clinical Income is lower than budget by £0.16m in Month 3 due to lower activity; cumulatively income is £0.85m lower than budget due to activity and pass through income. Other income is higher by £0.93m in M3 due to: additional FY 2018/19 PSF of £0.27m, Education and Training income of £0.47m, services to other organisations £0.27m, various other income £0.10m offset by lower Pharmacy £0.18m. *There are activity processing issues impacting on the income files that are possibly suppressing the position particularly in outpatients and also affecting the teams' ability to complete the specialty analysis.*
- Pay expenditure of £21.45m is slightly lower than budget in Month 3 due to: lower Substantive staff cost of £0.64m (due to vacancies) offset by higher Bank and Agency cost of £0.32m and undelivered CIP of £0.26m. For the year to date, the pay position is £0.98m higher than budget due to undelivered CIP £1.13m, Bank and Agency spend £1.60m offset by Substantive vacancies and underspends £1.75m.
- Non-pay expenditure is £0.27m lower than budget in Month 3 due to underspends in: Drugs £0.05m, clinical supplies £0.18m and operating expenditure £0.15m offset by slightly higher spend in non Clinical supplies of £0.06m and undelivered CIP of £0.04m. Year to date there is a net underspend of £0.73m due to lower spend in Drugs £0.26m (partly offset by SCG pass through income), clinical and non clinical supplies £0.16m and net operating cost of £0.31m. This is mainly due to IT licence costs being deferred to next year and slippage of investment spend to later in the year. There is undelivered CIP of £0.31m offset by further underspends in various non pay costs. Depreciation/amortisation costs is £0.35m lower than budget, primarily due to asset life changes.

Income

Current Performance



Operating Income	Year to Date - Month 3					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	94.40	(0.68)	93.72	92.62	(1.10)	(0.82)	(0.28)
Council Social Care (inc Public Health)	12.96	(0.10)	12.86	12.96	0.10	0.00	0.10
Client Income	2.70	(0.17)	2.53	2.80	0.27	0.17	0.10
Private Patients	0.56	(0.01)	0.55	0.40	(0.14)	(0.08)	(0.06)
Other Income	0.00	0.07	0.07	0.08	0.02	0.04	(0.02)
Operating Income from patient care activities	**110.61**	**(0.89)**	**109.72**	**108.87**	**(0.85)**	**(0.69)**	**(0.16)**
Other Income	7.56	0.07	7.63	7.90	0.27	(0.05)	0.32
R&D / Education & training revenue	2.52	(0.03)	2.48	2.84	0.36	0.03	0.33
Provider Sustainability Fund (PSF) & MRET Income	1.64	0.00	1.64	1.92	0.27	(0.01)	0.28
Other operating income	**11.72**	**0.04**	**11.76**	**12.66**	**0.90**	**(0.03)**	**0.93**
Total	**122.32**	**(0.85)**	**121.48**	**121.53**	**0.05**	**(0.72)**	**0.77**

Contract income by Commissioner	Year to Date - Month 3					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Devon Clinical Commissioning Group	58.31	(1.00)	57.31	57.27	(0.04)	0.00	(0.04)
NHS England - Area Team	1.77	0.00	1.77	1.75	(0.03)	(0.06)	0.03
NHS England - Specialist Commissioning	7.91	0.00	7.91	7.64	(0.26)	(0.52)	0.26
Other Commissioners	2.17	(0.04)	2.13	1.42	(0.71)	(0.18)	(0.53)
Sub-Total Acute Income	70.16	(1.04)	69.12	68.08	(1.03)	(0.76)	(0.27)
Devon CCG (Placed People and Community Health)	23.89	0.00	23.89	23.89	0.00	0.00	0.00
Other Commissioners	0.35	0.37	0.72	0.65	(0.07)	(0.06)	(0.01)
Sub Total Community Income	24.24	0.37	24.61	24.54	(0.07)	(0.06)	(0.01)
Operating Income from patient care activities	**94.40**	**(0.68)**	**93.72**	**92.62**	**(1.10)**	**(0.82)**	**(0.28)**

Key points

- The agreement of the Devon CCG income plan has been reflected in the position from month 2. No penalties have been assumed for 52 week waits and no STP/ CCG risk share has been applied in Q1.
- Overall operating income is £0.05m above budget for the year to date.
- Operating Income from Patient Care Activities in M3 is lower than budget by £0.85m.
- Within this, income from contract healthcare is £1.10m behind budget due to lower activity with: Specialist Commissioners and pass through income (matched by Cost); other commissioners re: dental, cath lab and various healthcare activity.
- Council social care income is ahead by £0.10m (*contract discussions are ongoing*).
- Client income is ahead by £0.27m as at M3.
- Private patient income is behind budget by £0.14m due to lower Outpatient activity.
- Other income is slightly ahead of budget as at M3.

Income

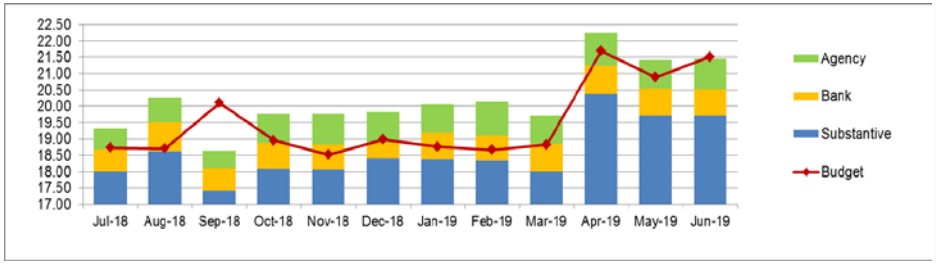
Other Operating Income	Year to Date - Month 3					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Plan - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
R&D / Education & training revenue	2.52	(0.03)	2.48	2.84	0.36	0.03	0.33
Site Services	0.59	0.03	0.62	0.65	0.03	0.04	(0.01)
Revenue from non-patient services to other bodies	1.20	(0.01)	1.19	1.21	0.02	(0.07)	0.09
Provider Sustainability Fund (PSF) & MRET Income	1.64	0.00	1.64	1.92	0.27	0.00	0.27
Misc. other operating revenue	5.78	0.05	5.82	6.03	0.21	(0.02)	0.23
Total	**11.72**	**0.04**	**11.76**	**12.66**	**0.90**	**(0.02)**	**0.92**

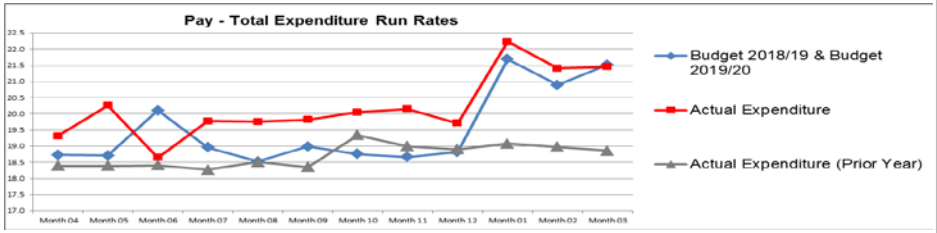
At Month 3, Other Operating income is £0.90m ahead of budget.
Key headlines / variances are:

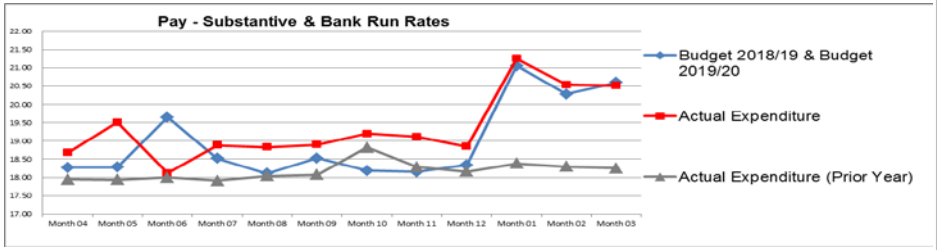
- R&D, Education and Grant income ahead of budget by £0.36m due to: higher SIFT/NMET/MADEL income of £0.18m and grant income of £0.33m for CYP training (matched by Cost) offset by lower apprentice levy paid to providers (matched by Cost) £0.08m and R&D income £0.07m.
- Site Services (Car Parking, Catering and Accommodation) income is slightly higher than budget by £0.03m.
- Non patient services to other bodies is slightly ahead of budget by £0.02m.
- Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) income is in line with plan having achieved the control total for Q1. An additional PSF income for FY 2018/19 of £0.27m was notified to the Trust.
- Other Income is higher than budget by £0.21m due to various income received £0.39m offset by lower TP sales of £0.18m.

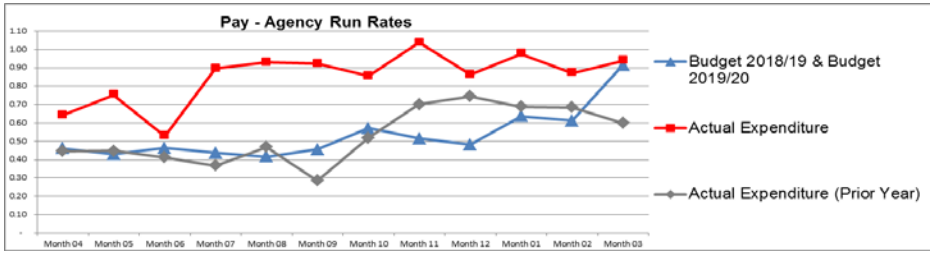
Pay Expenditure

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	(13.08)	(0.49)	(13.57)	(14.27)	(0.70)	(52.78)	(52.96)
Nursing and Midwifery	(14.89)	(0.09)	(14.99)	(15.38)	(0.40)	(57.87)	(58.25)
Other Clinical	(24.48)	(0.18)	(24.66)	(23.93)	0.73	(94.71)	(95.47)
Non Clinical	(10.55)	(0.33)	(10.88)	(11.49)	(0.61)	(41.02)	(41.67)
Total Pay Expenditure	**(63.00)**	**(1.10)**	**(64.10)**	**(65.08)**	**(0.98)**	**(246.38)**	**(248.36)**

Key points

- Total pay costs are showing an overspend against year to date budget at Month 3 of £0.98m. This is due to undelivered CIP £1.13m, Bank and Agency spend £1.59m offset by Substantive vacancies and underspends £1.74m.
- Substantive cost is lower than budget by £0.61m; Bank pay costs are £0.97m higher than budget, and agency costs are overspent by £0.62m (assessed against Budget).
- In setting the annual plan, agency budgets were set in line with the Agency Cap. At Integrated Service Unit (ISU) level, there are overspends within most ISUs due to continued reliance on agency staff.
- Agency overspend of £0.62m is mainly due to increased use of Medical Staff £0.48m and Nursing staff £0.10m.
- Total pay run rate in M3 (£21.45m) is in line with month 2.
- Agency run rate increased by £0.07m in M3 due to higher spend in Nursing and AHP.
- The Apprentice levy balance at Month 3 is £1,351,646 (£1,324,218 at month 2). The Trust's apprenticeship strategy is reviewed regularly and actions being taken are as follows: schemes are constantly developed, Trust colleagues are liaising with providers to offer a wide range of training/courses and the Trust is also looking to share the funding to partner organisations (per the Apprentice levy guideline). However the balance continues to grow and the risk of loss of unspent monies remains.

Pay Expenditure

Agency Spend Cap

Agency - All Staff Groups	April	May	June	YTD 2019-20
	£m	£m	£m	£m
Agency Plan 2019/20 (NHSI Cap)				
Planned Agency Cost	(0.64)	(0.64)	(0.64)	(1.91)
Total Planned Staff Costs	(21.57)	(20.71)	(20.71)	(63.00)
% of Agency Costs against Total Staff Cost	***2.9%***	***3.1%***	***3%***	***3.0%***
Agency Actual Costs 2019/20				
Agency Cost	(0.98)	(0.87)	(0.94)	(2.78)
Actual Staff Cost	(22.32)	(21.48)	(21.58)	(65.39)
% of Agency Costs against Total Staff Cost	***4.4%***	***4.1%***	***4%***	***4.3%***
Agency Cost vs Plan	(0.34)	(0.24)	(0.30)	(0.87)
% of Agency Costs against Total Staff Cost	***1.4%***	***1.0%***	***1%***	***1.2%***

Agency - Nursing	April	May	June	YTD 2019-20
	£m	**£m**	**£m**	**£m**
Agency Nurse Staff Cost	(0.36)	(0.29)	(0.30)	(0.96)
Actual Registered Nurse Staff Cost	(5.42)	(4.99)	(4.98)	(15.38)
% of Agency Costs against Nursing Staff Cost	***7%***	***6%***	***6%***	***6%***

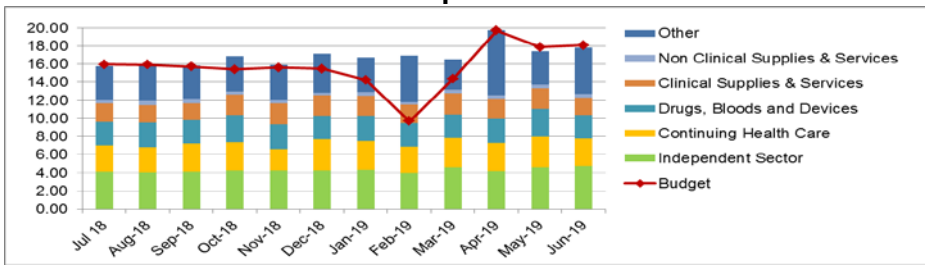
Agency - Medical Staff	April	May	June	YTD 2019-20
	£m	**£m**	**£m**	**£m**
Agency Medical Staff Cost	(0.55)	(0.53)	(0.51)	(1.59)
Actual Medical Staff Cost	(4.71)	(4.77)	(4.80)	(14.27)
% of Agency Costs against Medical Staff Cost	***12%***	***11%***	***11%***	***11%***

The overall Agency Cap for the Trust is £6.18m in FY 2019/20.

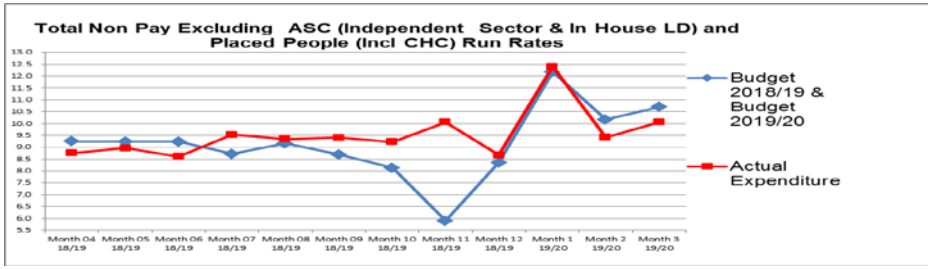
- Agency staff cost in Month 3 across all staff groups is £0.94m. This is £0.30m higher than the NHSI cap of £0.64m. The agency usage to date is £2.78m against a cap of £1.91m which is £0.87m higher.
- Majority of the adverse agency cost variance of £0.87m is within Medical staff £0.71m and Nursing £0.11m due to challenges in recruiting for these staff group and operational pressures.
- Medical agency spend is £0.51m in Month 3; year to date spend is £1.59m against a cap of £0.88m.
- Nursing agency spend in Month 3 is £0.30m which is slightly above plan. Spend in month increased slightly compared to M2.
- The individual price rates for nursing and medical staff are all above NHSI individual shift rates.
- The full year cap of £6.18m will be a challenging target to achieve given the rate of spend due to operational pressures, vacancy levels and difficulty in recruiting.
- The Trust recruitment initiatives are constantly reviewed and actions are being taken e.g. overseas nursing recruitment, medical staff recruitment and in house schemes like enhanced rate for HCA and Nursing bank pool.

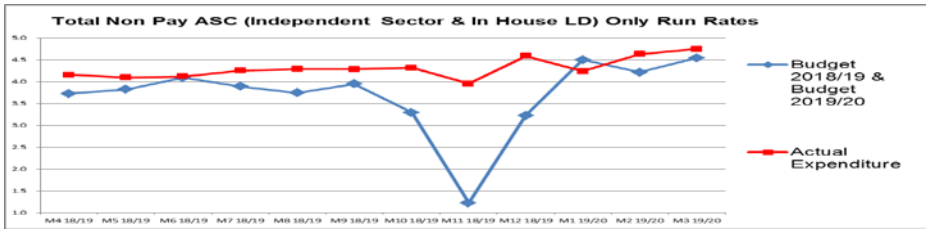
Non Pay Expenditure

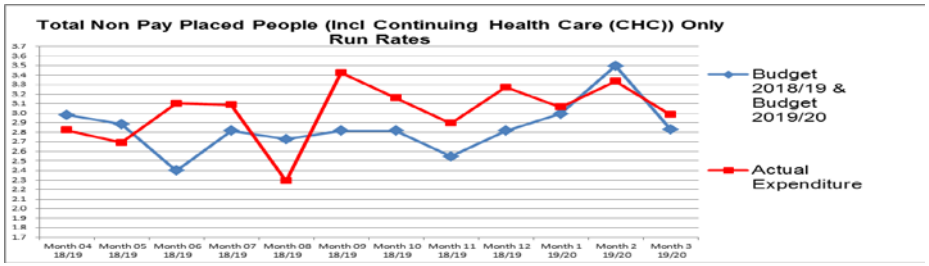
Current performance



	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	(8.81)	0.23	(8.59)	(8.33)	0.26	(35.26)	(34.34)
Clinical Supplies & Services	(6.50)	0.00	(6.50)	(6.43)	0.07	(26.46)	(26.39)
Non Clinical Supplies & Services	(1.29)	0.01	(1.28)	(1.15)	0.13	(4.88)	(4.87)
Other Operating Expenditure	(20.53)	3.85	(16.68)	(15.98)	0.70	(75.70)	(66.12)
ASC (Independent Sector & In House LD)	(12.19)	(1.08)	(13.27)	(13.64)	(0.36)	(49.03)	(53.38)
Placed People (Incl Continuing Healthcare)	(8.38)	(0.95)	(9.33)	(9.39)	(0.06)	(33.69)	(37.46)
Total Non Pay Expenditure	**(57.71)**	**2.07**	**(55.64)**	**(54.91)**	**0.73**	**(225.02)**	**(222.57)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.26m mainly due to pass through for which income is similarly reduced for NHS England.
- Clinical Supplies – Spend is £0.07m lower than budget.
- Non Clinical Supplies – underspend of £0.13m due to external service agreements (records management, storage and other non healthcare) £0.10m, domestic mats and textiles of £0.03m.
- Placed People (including Continuing Healthcare) - slight overspend of £0.06m to date.
- Adult Social Care (Independent sector) - Overspend by £0.36m mainly due to residential and domiciliary care spend £0.21m and unachieved CIP £0.15m.
- Other Operating Expenditure - underspent by £0.70m reflecting lower provision for Bad debt £0.30m, IT license cost deferral to next year of £0.63m and apprentice levy (matched by Income) and other cost cost £0.10m; offset by training cost for CYP £0.33 (matched by Income).

Financial Position by System

	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	122.33	(0.85)	121.48	121.53	0.05	496.18	495.76
Pay	(63.01)	(1.10)	(64.10)	(65.09)	(0.98)	(246.38)	(248.36)
Non Pay	(57.71)	2.07	(55.64)	(54.91)	0.73	(225.02)	(222.57)
EBITDA	**1.61**	**0.12**	**1.73**	**1.54**	**(0.20)**	**24.78**	**24.82**
Financing Costs	(4.90)	(0.01)	(4.91)	(4.84)	0.06	(20.08)	(20.12)
SURPLUS / (DEFICIT)	**(3.29)**	**0.11**	**(3.17)**	**(3.31)**	**(0.13)**	**4.70**	**4.70**
NHSI Exclusions	(0.03)	0.00	(0.03)	0.28	0.31	(0.14)	(0.14)
Plan Adjusted Surplus / (Deficit)	**(3.32)**	**0.11**	**(3.21)**	**(3.03)**	**0.18**	**4.56**	**4.56**
Remove PSF/MRET Income	(1.64)	0.00	(1.64)	(1.91)	(0.27)	(8.36)	(8.36)
Variance to Control Total (Excl PSF/MRET	**(4.96)**	**0.11**	**(4.85)**	**(4.94)**	**(0.09)**	**(3.80)**	**(3.80)**

Key Drivers

The financial position at control total level as at 30th of June 2019 is a £4.94m deficit, which is slightly better than the £4.96m plan.

Further analysis by Income and Expenditure categories at System level can be seen in the following tables:-

System	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
South Devon							
Income	42.16	0.03	42.20	41.93	(0.27)	165.50	165.62
Pay	(24.64)	(0.93)	(25.58)	(27.09)	(1.52)	(98.56)	(102.13)
Non Pay	(7.56)	(1.13)	(8.69)	(8.49)	0.20	(30.23)	(32.29)
Financing Costs	(0.45)	0.00	(0.45)	(0.45)	0.00	(1.79)	(1.79)
Surplus / (Deficit)	**9.52**	**(2.03)**	**7.48**	**5.90**	**(1.58)**	**34.92**	**29.40**

Pay overspent £1.5m - being £520kCIP shortfall, Care of the Elderly Senior Medical staff £221k, Emergency Nursing and Support agency staff £422k,General medicine locums £122k, General surgery wards £160k. Non pay underspend £205k mainly surgical division phasing RTT funding in first part of the year, offset with CIP shortfall, Rapid Response, Drugs and other non pay costs. Contract income adverse £270k due to activity.

	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
Torbay							
Income	59.44	0.89	60.33	60.23	(0.10)	236.65	240.21
Pay	(21.65)	(1.12)	(22.77)	(23.19)	(0.42)	(86.62)	(90.50)
Non Pay	(34.54)	(2.92)	(37.46)	(37.00)	0.46	(138.63)	(149.62)
Surplus / (Deficit)	**3.24**	**(3.15)**	**0.10**	**0.04**	**(0.06)**	**11.41**	**0.10**

Compared to budget YTD position is breakeven, although underpinning this there have been pay overspends (£420K) that have been offeset by non-pay underspends (£460K). Pay overspends are predominantly in the Paignton & Brixham ISU and linked to short term locum costs. With regard Non Pay, the material areas are Radiology underspends (budget phasing) and IBCF projects (process delayed for any new 2019/20 projects).

	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
Shared Operations							
Income	0.88	(0.04)	0.84	0.82	(0.02)	3.53	3.36
Pay	(1.85)	(0.01)	(1.86)	(1.83)	0.03	(7.39)	(7.43)
Non Pay	(0.41)	0.02	(0.39)	(0.33)	0.06	(1.64)	(1.55)
Financing Costs	(0.01)	(0.00)	(0.01)	(0.01)	0.00	(0.05)	(0.05)
Surplus / (Deficit)	**(1.39)**	**(0.03)**	**(1.42)**	**(1.36)**	**0.06**	**(5.55)**	**(5.66)**

Shared Operations is underspent by £60K mainly due to pay and non pay spend on Medical Electronics, Infection Control, HSDU, and Transport amounting to £80K offset by slightly lower income totalling £20K.

	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
Shared Corporate/TP							
Income	20.08	(1.73)	18.35	18.56	0.20	91.49	87.56
Pay	(14.86)	0.97	(13.90)	(12.97)	0.92	(53.81)	(48.30)
Non Pay	(18.51)	6.08	(12.43)	(12.14)	0.28	(68.25)	(52.89)
Financing Costs	(1.37)	0.00	(1.37)	(1.33)	0.04	(5.51)	(5.51)
Surplus / (Deficit)	**(14.66)**	**5.32**	**(9.34)**	**(7.89)**	**1.45**	**(36.08)**	**(19.14)**

Torbay Pharmaceuticals over budget by £180k - see separate Board paper.
Shared Corporate Services overall unachieved CIP target of £290k.
Estates & Facilities over budget by £49k - review commencing on Domestics pay overspend and estates purchased contracts.
Executive Directors underspent by £560k, of which £410k non pay, general underspends and Workforce Support in HR, slow start as the program is developed.
R & D overbudget by £58k due to underachieved income on commercial trials.
Reserves underspend in the balance of cost pressure reserve, budget phasing adjustments to match submitted workforce plan and M3 Trustwide recovery tems.
Contract Income is £525K ahead of plan due to additional PSF monies received relating to 2018/19, and an underspend on the bad debt provision.
Pharmacy Services year to date underspend £189k, of which £185k relates to pay vacancies.
Depreciation £330k favourable primarily due to asset life changes. Items outside control total: donated asset income £250k adverse; impairment £75k adverse.

Items outside of EBITDA

	Year to Date - Month 03			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Operating income/expenditure outside EBITDA					
Donated asset income	0.25	0.00	(0.25)	(0.17)	(0.08)
Depreciation/Amortisation	(3.31)	(2.98)	0.33	(0.02)	0.35
Impairment	0.00	(0.07)	(0.07)	(0.07)	0.00
Total	**(3.06)**	**(3.05)**	**0.01**	**(0.26)**	**0.27**
Non-operating income/expenditure					
Net interest expense (excluding PFI)	(0.47)	(0.43)	0.04	0.04	0.01
Interest and Contingent Rent expense (PFI)	(0.45)	(0.45)	0.00	0.00	0.00
PDC Dividend expense	(0.90)	(0.90)	(0.00)	(0.00)	(0.00)
Gain/loss on disposal of assets	0.00	0.00	0.00	0.00	0.00
Other	(0.01)	(0.01)	0.00	(0.00)	0.00
Total	**(1.83)**	**(1.79)**	**0.04**	**0.04**	**0.01**
Total items outside EBITDA	**(4.90)**	**(4.84)**	**0.05**	**(0.22)**	**0.28**

Key points

- Donated Asset Income is £0.3m adverse to Plan, due to delay in these charitable projects. NB this variance lies outside the NHSI Control Total.
- Depreciation/amortisation £0.3m favourable, primarily due to asset life changes.

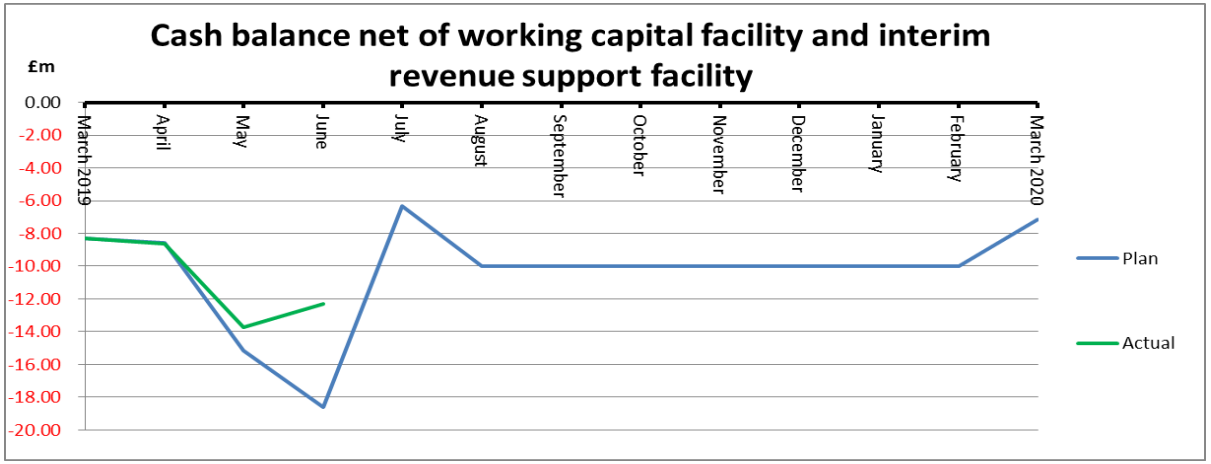
Balance Sheet

	Year to Date - Month 03			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Non-Current Assets					
Intangible Assets	11.90	11.81	(0.09)	(0.14)	0.05
Property, Plant & Equipment	174.19	173.70	(0.49)	(0.41)	(0.09)
On-Balance Sheet PFI	14.73	14.68	(0.05)	(0.04)	(0.01)
Other	1.14	1.12	(0.03)	(0.01)	(0.02)
Total	**201.97**	**201.30**	**(0.66)**	**(0.61)**	**(0.06)**
Current Assets					
Cash & Cash Equivalents	2.89	8.65	5.75	1.45	4.31
Other Current Assets	47.02	43.04	(3.98)	0.33	(4.31)
Total	**49.92**	**51.69**	**1.77**	**1.77**	**(0.00)**
Total Assets	**251.88**	**252.99**	**1.11**	**1.17**	**(0.06)**
Current Liabilities					
Loan - DH ITFF	(6.91)	(6.90)	0.00	0.00	0.00
PFI / LIFT Leases	(0.88)	(0.88)	(0.00)	(0.01)	0.01
Trade and Other Payables	(34.66)	(36.58)	(1.93)	(2.55)	0.62
Other Current Liabilities	(1.90)	(2.01)	(0.11)	(0.10)	(0.00)
Total	**(44.35)**	**(46.38)**	**(2.03)**	**(2.65)**	**0.62**
Net Current assets/(liabilities)	**5.57**	**5.31**	**(0.26)**	**(0.88)**	**0.62**
Non-Current Liabilities					
Loan - DH ITFF	(70.76)	(70.21)	0.55	(0.00)	0.55
PFI / LIFT Leases	(18.41)	(18.41)	(0.00)	0.01	(0.01)
Other Non-Current Liabilities	(6.72)	(6.37)	0.36	0.03	0.32
Total	**(95.89)**	**(94.98)**	**0.90**	0.04	0.87
Total Assets Employed	**111.65**	**111.62**	**(0.02)**	**(1.45)**	**1.43**
Reserves					
Public Dividend Capital	64.51	64.51	0.00	0.00	0.00
Revaluation	41.87	41.87	(0.00)	(0.00)	(0.00)
Income and Expenditure	5.27	5.25	(0.02)	(1.45)	1.43
Total	**111.65**	**111.62**	**(0.02)**	**(1.45)**	**1.43**

Key points

- Intangible Assets, Property, Plant & Equipment and PFI are £0.6m adverse. This is primarily due to capex £0.9m lower than planned, partly offset by depreciation £0.3m lower than planned.
- Cash is £5.8m favourable, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are £4.0m lower than Plan, primarily due to the CCG catchup contract payment being received one month earlier than planned £7.5m, partly offset by income received later than planned (including Torbay Council £3.8m).
- Trade and Other Payables are £1.9m higher than Plan, primarily due to the timing of non-capital payments £2.7m, partly offset by the paying down of the capital creditor £0.7m.

Cash



	Year to Date - Month 03			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Opening cash balance (net of working capital facility)	**(8.29)**	**(8.29)**	**(0.00)**	**(0.00)**	**0.00**
Capital Expenditure (accruals basis)	(2.76)	(1.86)	0.90	0.50	0.39
Capital loan drawndown	0.00	0.00	0.00	0.00	0.00
Capital loan repayment	(0.99)	(0.99)	0.00	0.00	0.00
Proceeds on disposal of assets	0.30	0.00	(0.30)	0.00	(0.30)
Movement in capital creditor	(1.53)	(2.27)	(0.74)	(0.38)	(0.35)
Other capital-related elements	0.92	0.23	(0.69)	(0.22)	(0.47)
Sub-total - capital-related elements	**(4.06)**	**(4.89)**	**(0.83)**	**(0.10)**	**(0.73)**
Cash Generated From Operations	1.61	1.54	(0.07)	(1.22)	1.15
Working Capital movements - debtors	(7.31)	(2.93)	4.37	(0.27)	4.65
Working Capital movements - creditors	0.58	3.21	2.63	2.91	(0.28)
Net Interest	(0.92)	(0.73)	0.19	0.13	0.06
PDC Dividend paid	0.00	0.00	0.00	0.00	0.00
Other Cashflow Movements	(0.23)	(0.23)	0.00	0.00	0.00
Sub-total - other elements	**(6.27)**	**0.86**	**7.13**	**1.55**	**5.58**
Closing cash balance (net of working capital facility)	**(18.62)**	**(12.32)**	**6.30**	**1.45**	**4.86**

Closing cash balance	2.89	8.65	5.75	1.45	4.31
Closing working capital facility	(11.00)	(11.00)	0.00	0.00	0.00
Closing interim revenue support facility	(10.52)	(9.97)	0.55	0.00	0.55
Closing cash balance (net of working capital facility)	**(18.62)**	**(12.32)**	**6.30**	**1.45**	**4.86**

Key points

The cash position is presented net of amounts drawn down from the working capital facility and interim revenue loan facility, in order to show the underlying cash position.

- Capital-related cashflow is £0.8m adverse largely due to delayed disposals £0.3m, the paying down of the capital creditor £0.7m, reduced finance lease usage £0.4m and reduced donated funding £0.4m, partly offset by reduced capital expenditure £0.9m.

Other elements:

- Working Capital debtor movements is £4.3m favourable, primarily due to the CCG catchup contract payment being received one month earlier than planned £7.5m, partly offset by income received later than planned (including Torbay Council £3.8m).

- Working Capital creditor movements is £2.6m favourable, largely due to the timing of non-capital payments £2.7m.

Use of Interim Revenue Support facility

Requests for use of the Interim Revenue Support facility have to be submitted around 6 weeks before the relevant month end. At the point that the M03 request was submitted, it was not known when the CCG contract catchup payment would be received. This catchup payment was received earlier than anticipated, resulting in the M03 cash balance being higher than planned.

Capital

Current Performance

	Year to date Mth 03			Full Year
	Budget £m	Actual £m	Variance to Plan £m	Budget £m
Capital Programme	2.60	1.86	(0.74)	19.03
Significant Variances in Planned Expenditure by Scheme:				
HIS schemes	0.17	0.15	(0.02)	4.80
Estates schemes	0.90	0.59	(0.30)	5.90
Medical Equipment	1.07	0.80	(0.26)	6.97
Other	0.00	(0.01)	(0.01)	0.00
PMU	0.58	0.32	(0.25)	2.13
Contingency	(0.11)	0.00	0.11	(0.78)
Planned slippage	0.00	0.00	0.00	0.00
Total	2.60	1.86	(0.74)	19.03
Funding sources				
Secured loans	0.00	0.00	0.00	0.00
Unsecured loans	0.00	0.00	0.00	0.00
Strategic Estates P'ship	0.00	0.00	0.00	0.00
Finance Leases	0.75	0.33	(0.41)	9.87
PDC	0.00	0.00	0.00	0.93
Charitable Funds	0.25	0.00	(0.25)	1.00
Disposal of assets	0.00	0.00	0.00	0.00
Other Internal cash resources	1.61	1.53	(0.08)	7.24
Total	2.60	1.86	(0.74)	19.03

Key Points

- In April 2019 the Trust submitted a capital plan of £19.0m. The capital budget was set at this level (see table).
- In May 2019 the Trust submitted a revised capital plan of £21.6m.
- In July 2019 the Trust was asked for a plan to reduce its CDEL (adjusted capital expenditure) by £3.3m from the April plan level. A proposal was submitted, achieving this reduction partly through reducing overall capital expenditure to £16.6m and partly through increasing planned capital disposals to £0.9m. At the time of writing, feedback to this proposal had not been received.
- At 30 June, capital expenditure was £0.7m underspent to budget (see table) and £0.9m underspent to the Plan (May version).

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	34,014	8,865	9,437	572	596	6%
Elective	3,640	964	862	-102	-54	-11%
Non-Elective Emergency	29,367	7,215	6,228	-987	-498	-14%
Non-Elective Non-Emergency	2,815	697	634	-63	-53	-9%
Non-Elective CDU	4,605	1,173	1,117	-56	-77	-5%
Non-Elective AMU	3,859	1,075	1,146	71	42	7%
TOTAL APC	**78,300**	**19,989**	**19,424**	**-565**	**-44**	-3%
New	107,867	27,725	26,925	-800	-1,085	-3%
F-Up	260,030	66,100	65,733	-367	-1,916	-1%
TOTAL OPA	**367,897**	**93,825**	**92,658**	**-1,167**	**-3,001**	-1%
A&E	79,199	20,317	20,440	123	369	1%

Activity variances to plan - Month 3

Activity variances for M3 against the contract activity plan are shown in the table opposite. In M3, Day Case activity is above plan. Non Elective Emergency activity is behind plan. AMU activity is above plan.

At treatment function level the greatest variance in day cases is within General Medicine where activity is 676 attendances above plan (in PBR terms £619K).

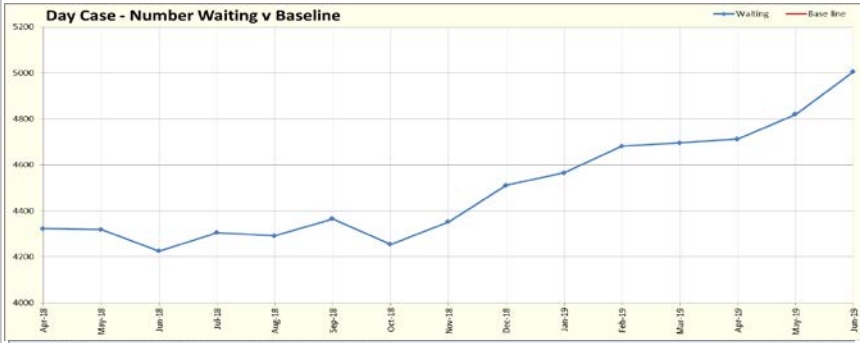
Within Outpatients, the specialties with the greatest variances are: Colorectal Surgery which is 238 New attendances above plan (in PBR terms £33k), and Vascular Surgery which is 695 attendances above plan (in PBR terms £7k). Oral Surgery is 192 attendances below plan (in PBR terms £-28k), and Ophthalmology is 267 attendances below plan (in PBR terms £-31k).

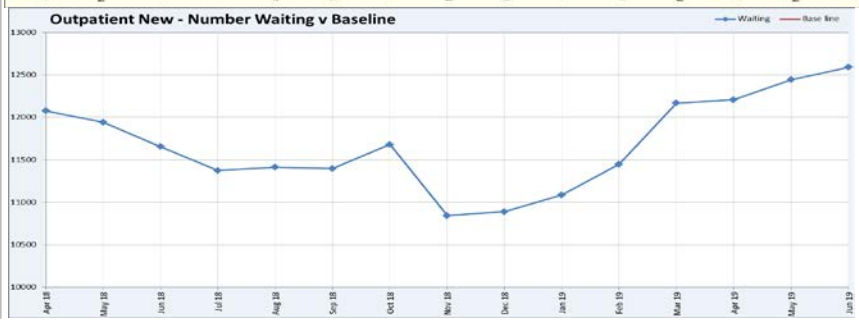
For Follow Ups, Respiratory Medicine is 366 attendances above plan (in PBR terms £34K). Ophthalmology is 965 attendances below plan (in PBR terms -£106k).

The committee is asked to note: Month 3 access standards.

Plans for 19/20 and beyond require overall increase in activity run rate to deliver the required improvement in access targets. Overall numbers of inpatient's waiting are being maintained at recent levels however we are seeing a continued almost unbroken trend in increasing number of patients waiting for new outpatient appointment since November 2018 and day case surgery or daycase interventions. This is of increasing concern given that our plans are to stabilise these increases and start to reduce the numbers and length of time patients are waiting.

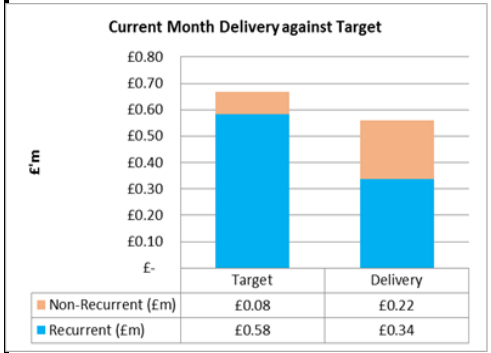
We are however, continuing to maintain progress against our trajectory of managing our longest waits over 52 weeks from referral to treatment (RTT).
The RTT risk and Assurance group are maintaining the elective waiting time (RTT and cancer) performance oversight at individual team level.
It is noted that new referrals over a rolling 12 month period are remaining at historical levels with 0% growth, however there is a large increase in the number referred on an urgent two week wait cancer pathway of 10% on the rolling year to date.

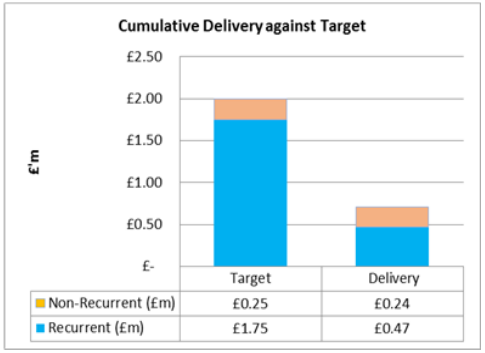




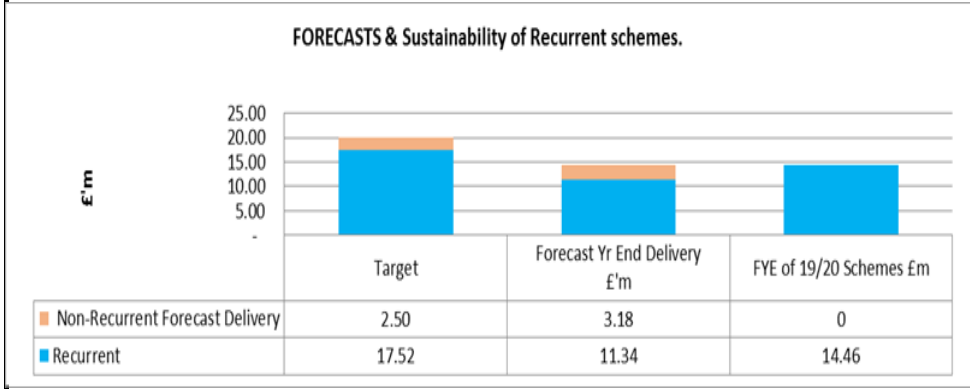
CIP Delivery: Current Month, Cumulative & Forecast

a) 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 variance**: £0.1m shortfall

-**Cumulative variance**: £1.3m shortfall

The current month position shows a £0.1m shortfall against £0.7m target. There is a cumulative shortfall of £1.3m against a £2.0m target.

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

Target:	**£20.0m**
Year End Forecast Delivery:	**£14.5m**
Shortfall:	**£5.5m**

Target: The CIP target shown is £20.0m of which £17.5m is recurrent and £2.5m is Non-Recurrent.

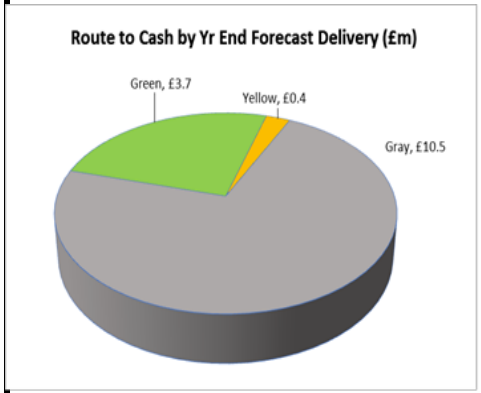
A total of £14.5m of Forecast Out-Turn delivery has been identified, resulting in a £5.5m shortfall FOT position.

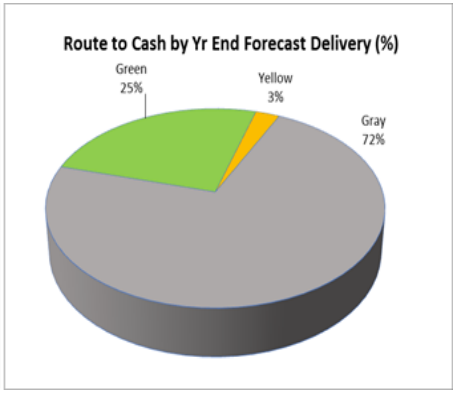
The FYE forecast delivery for 19/20 projects is £14.46m.

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

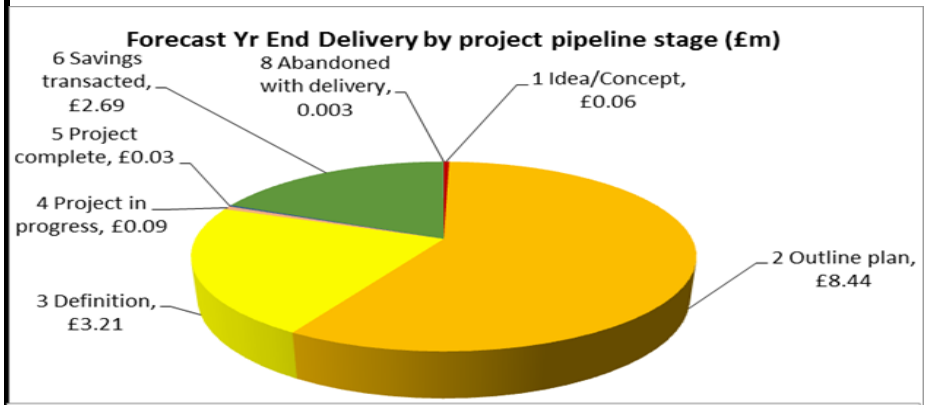
CIP- Delivery Assurance - Year end delivery forecast

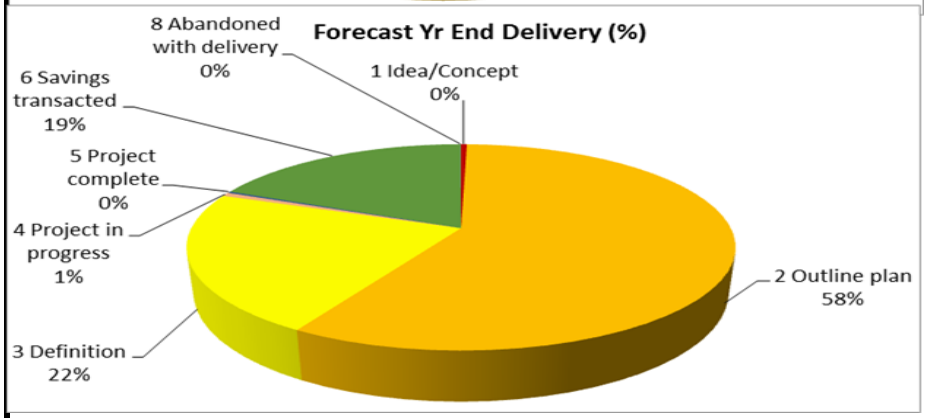
c) CIP Delivery Assurance- Route to Cash (RTC)





d) CIP Delivery Assurance:- Pipeline stage (£m)





(c) CIP Delivery Assurance for identified projects - Route to Cash

Steady progress is being achieved with £3.7m of projects rated as Green RTC. £10.5m rated as Grey (Predominantly Transformational schemes-RTC To be assessed) and £0.4m Amber/Yellow RTC.

A Route to Cash (RTC) is still being identified for £10.5m of the FOT value and most of these projects are categorised as Transformational.

(d) CIP Delivery Assurance:- Pipeline stage

Of the projects comprising the £14.5m forecast out-turn delivery:

£2.72m (19%) of projects are either delivering savings or are complete, pending savings delivery.

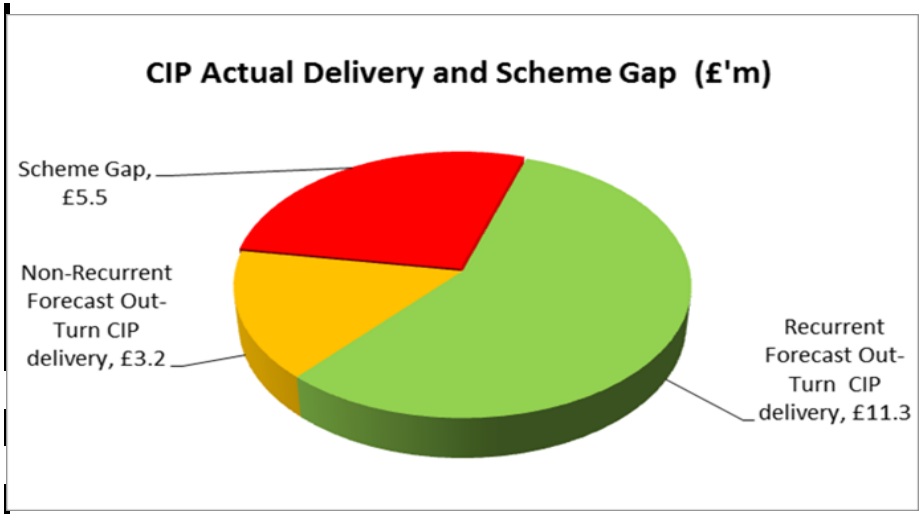
£0.1m (1%) relates to schemes which are in progress.

£11.65m (80%) relates to schemes where definitions are complete and validated or outline plans are validated.

£0.06m (0%) relates to schemes which are in Ideas/concept pipeline.

CIP- Delivery Assurance - Year end delivery forecast

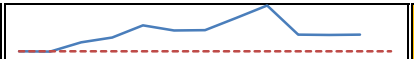
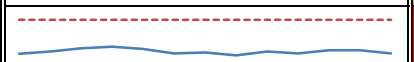
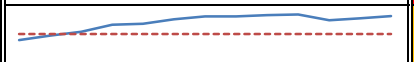
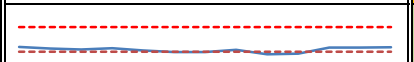
e) CIP Scheme Gap- Value of additional schemes required to be identified



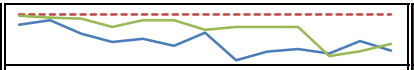
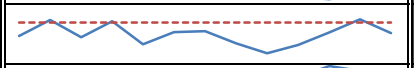
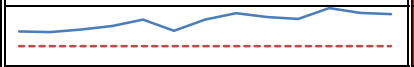
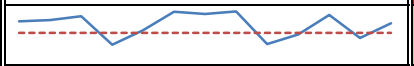
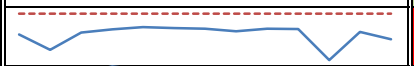
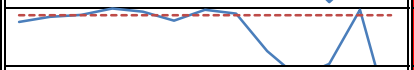
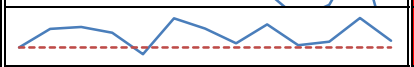
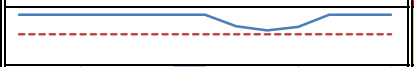
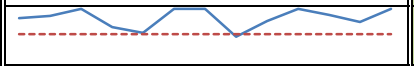
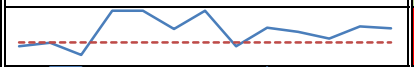
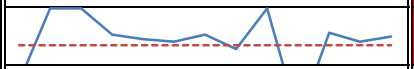
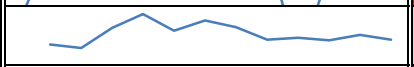
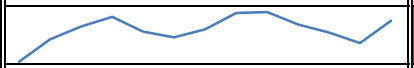
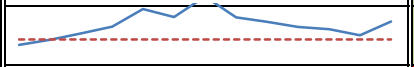
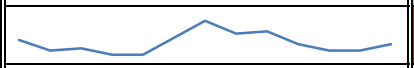
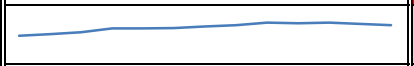
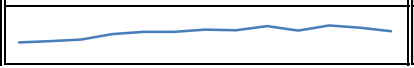
e) CIP Current year Scheme Gap- Value of additional schemes required to be identified

Assuming all schemes deliver against the current £14.5m Forecast out-turn, we would need to identify a further £5.5m of projects to deliver the Trust's CIP target.

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
QUALITY LOCAL FRAMEWORK																	
1	Safety Thermometer - % New Harm Free	>95%		98.0%	96.5%	96.8%	97.1%	97.5%	96.1%	96.9%	97.8%	96.4%	96.7%	96.3%	95.4%	96.8%	96.1%
1	Reported Incidents - Major + Catastrophic *	<6		0	0	0	0	3	2	0	2	0	3	1	2	4	7
1	Medication errors resulting in moderate harm	0		1	0	0	0	0	0	0	0	0	0	2	1	1	4
1	Medication errors - Total reported incidents (trust at fault)	N/A		40	57	40	38	57	55	33	67	42	51	34	54	47	135
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		0	0	0	1	0	0	1	2	0	1	2	0		2
1	Never Events	0		0	0	1	0	0	1	0	0	0	0	0	1	0	1
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		3	5	4	8	3	5	2	3	5	5	2	8	4	14
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	Formal Complaints - Number Received *	<60		24	32	19	25	28	17	18	19	21	31	13	20	22	55
1	VTE - Risk assessment on admission - (Acute)	>95%		90.9%	92.1%	91.1%	92.6%	91.6%	93.0%	91.8%	92.1%	89.2%	90.5%	89.2%	90.9%	91.0%	90.4%
1	VTE - Risk assessment on admission - (Community)	>95%		98.7%	100.0%	93.2%	100.0%	97.9%	96.8%	97.9%	97.7%	97.8%	91.5%	98.9%	100.0%	97.5%	98.8%
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears	<100%		98.5%	106.3%	68.7%	102.3%	99.8%	99.0%	89.8%	87.5%	94.7%	91.5%				94.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		104.0%	95.1%	99.0%	103.6%	105.7%	104.0%	102.4%	103.8%	104.0%	104.0%	98.5%	91.7%	90.9%	93.6%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		103.2%	97.3%	103.3%	105.0%	106.7%	103.2%	101.4%	102.1%	103.2%	103.2%	98.5%	91.8%	93.7%	94.5%
1	Infection Control - Bed Closures - (Acute) *	<100		0	16	8	18	58	16	18	42	66	0	4	42	12	58
1	Hand Hygiene	>95%		93%	84%	96%	95%	96%	92%	95%	94%	96%	90%	92%	88%	94%	91%
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		68.8%	63.4%	62.5%	66.7%	68.3%	71.1%	70.0%	67.5%	80.0%	78.4%	50.0%	73.3%	62.5%	62.0%
1	Stroke patients spending 90% of time on a stroke ward	>80%		87.8%	88.9%	92.9%	95.1%	93.5%	83.3%	85.5%	82.9%	89.1%	79.7%	93.8%	75.5%	79.1%	82.8%
1	Stroke - SSNAP level	No target		B	B	B	B	B	B	B	C	C	C				#N/A
1	Follow ups 6 weeks past To be seen date (excluding Audiology)	3500		7144	7063	6858	6566	6020	5630	5993	5300	5356	5783	6103	6459	[illegible]	[illegible]

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears) Rolling 12 months	<3.8%		3.80%	3.79%	4.02%	4.14%	4.44%	4.31%	4.32%	4.62%	4.92%	4.21%	4.20%	4.21%		4.21%
2	Appraisal Completeness	>90%		78.92%	79.61%	80.61%	81.12%	80.45%	78.97%	79.31%	78.31%	79.55%	78.93%	80.00%	80.00%	79.00%	79.00%
2	Mandatory Training Compliance	>85%		83.00%	84.50%	85.77%	88.03%	88.40%	89.88%	90.81%	90.73%	91.21%	91.36%	89.52%	90.20%	90.88%	90.88%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		10.80%	10.52%	10.35%	10.58%	10.18%	9.96%	9.94%	10.33%	9.55%	9.67%	10.68%	10.69%	10.75%	10.75%

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges (Community) *	16/17 Avg 315		270	292	232	272	226	247	375	344	266	278	370	356	419	1145
1	Number of Delayed Transfer of Care (Acute)	16/17 Avg 64		116	281	182	164	261	256	171	246	176	137	149	185	97	431
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		76.6%	71.5%	72.6%	73.5%	74.1%	74.5%	74.7%	74.8%	75.6%	76.1%	76.4%	77.0%	74.6%	77.0%
3	Clients receiving Self Directed Care	>90%		93.9%	93.9%	93.5%	93.0%	92.8%	92.0%	92.1%	91.4%	90.7%	91.7%	91.1%	90.8%	90.3%	90.8%
2	Carers Assessments Completed year to date	40% (Year end)		4.5%	6.8%	9.9%	13.3%	16.3%	19.9%	22.1%	23.7%	26.3%	29.3%	3.6%	7.8%	13.2%	7.8%
	Carers Assessment trajectory			9.0%	12.0%	15.0%	18.0%	21.0%	24.0%	27.0%	30.0%	33.0%	36.0%	3.0%	6.0%	9.0%	9.0%
3	Number of Permanent Care Home Placements	<=617 (Year end)		616	625	625	619	629	633	627	615	615	605	602	619	631	631
	Number of Permanent Care Home Placements trajectory			630	630	630	630	630	630	630	630	630	630	600	600	600	600
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		166	166	168	170	146	148	172	170	186		170	186		186
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET		61			138			192			300				
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET		7.5%			7.1%			5.4%			4.9%				
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%				
1	Bed Occupancy	80% - 90%		86.3%	86.7%	89.5%	90.7%	92.7%	92.5%	90.7%	94.3%	94.7%	92.8%	93.9%	91.4%	94.0%	91.4%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		94.1%	96.2%	93.7%	86.2%	91.9%	90.0%	93.7%	89.4%	90.8%	90.3%	87.1%	83.2%	79.1%	83.2%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET		560	584	605						485	474				
1	Intermediate Care - No. urgent referrals	113		163	173	159	162	182	182	157	189	156	164	181	188	175	544
1	Community Hospital - Admissions (non-stroke)	18/19 profile (+/- 10%)		217	238	267	238	259	256	236	279	222	257	258	249	219	726

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
NHS I - OPERATIONAL PERFORMANCE (NEW SINGLE OVERSIGHT FRAMEWORK FROM OCTOBER 2017)																	
1	A&E - patients seen within 4 hours	>95%		90.9%	92.7%	87.2%	83.8%	85.1%	82.2%	87.6%	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	81.2%
1	Referral to treatment - % Incomplete pathways <18 wks	>92%		81.0%	81.5%	82.2%	81.0%	82.4%	82.7%	81.8%	82.0%	81.3%	81.3%	80.7%	81.9%	81.5%	81.5%
	RTT Trajectory			82.4%	82.5%	82.6%	82.7%	82.7%	82.8%	82.8%	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%
1	Cancer - 62-day wait for first treatment - 2ww referral	>85%		78.1%	86.2%	77.6%	85.5%	74.0%	80.1%	80.6%	74.5%	69.6%	73.7%	79.9%	86.5%	79.6%	81.9%
1	Diagnostic tests longer than the 6 week standard	<1%		5.9%	5.7%	6.6%	7.7%	9.8%	6.1%	9.8%	12.0%	10.7%	10.1%	13.7%	12.1%	11.7%	12.5%
1	Dementia - Find - monthly report	>90%		93.8%	94.3%	95.6%	86.0%	90.9%	97.1%	96.3%	97.2%	86.3%	89.4%	96.1%	88.3%	93.3%	92.6%
LOCAL PERFORMANCE FRAMEWORK 1																	
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<17 (year)		0	1	1	0	0	1	2	1	1	1	4	3	1	8
1	Cancer - Two week wait from referral to date 1st seen	>93%		75.3%	62.1%	76.8%	79.5%	81.5%	80.7%	80.1%	77.9%	80.1%	79.9%	53.4%	77.5%	71.1%	67.1%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		87.0%	91.7%	93.3%	98.8%	96.0%	88.3%	97.8%	94.4%	61.6%	38.8%	50.7%	97.7%		68.3%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		96.0%	98.2%	98.4%	97.7%	95.2%	99.5%	98.2%	96.5%	98.7%	96.2%	96.7%	99.5%	96.77%	97.6%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.4%	98.8%	100.0%	100.0%	100.0%	100.0%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		97.8%	98.3%	100.0%	95.7%	94.3%	100.0%	100.0%	93.3%	97.1%	100.0%	98.6%	96.9%	100.0%	98.3%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		93.3%	93.9%	91.7%	100.0%	100.0%	96.6%	100.0%	93.3%	96.8%	96.0%	94.7%	97.1%	96.7%	96.4%
1	Cancer - 62-day wait for first treatment - screening	>90%		80.0%	100.0%	100.0%	92.9%	91.7%	90.9%	92.9%	88.9%	100.0%	70.0%	93.3%	90.9%	92.3%	92.3%
1	Cancer - Patient waiting longer than 104 days from 2ww				27	22	51	71	47	62	52	34	37	33	41	34	34
1	RTT 52 week wait incomplete pathway	0		41	64	77	87	72	66	74	91	92	79	71	60	83	83
1	Mixed sex accomodation breaches of standard	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%		0.6%	0.8%	1.0%	1.2%	1.8%	1.6%	2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%	1.2%
1	Cancelled patients not treated within 28 days of cancellation *	0		8	3	4	1	1	9	17	11	12	6	3	3	6	12
1	Number of standed patients >7 days (daily average)			90	95	101	115	114	116	122	126	134	132	134	131	126	
	Number of extended stay patients >21 days (daily average)			17	18	20	24	26	26	28	28	31	27	32	30	27	

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
LOCAL PERFORMANCE FRAMEWORK 2																	
1	Ambulance handover delays > 30 minutes	Trajectory		119	94	88	144	204	143	84	251	156	198	148	61	83	292
1	Ambulance handover delays > 60 minutes	0		8	1	4	10	19	9	4	23	8	9	13	11	4	28
1	A&E - patients seen within 4 hours DGH only	>95%		86.0%	88.6%	80.1%	75.0%	77.9%	74.3%	82.5%	66.1%	70.8%	71.9%	68.5%	75.9%	69.9%	71.4%
1	A&E - patients seen within 4 hours community MIU	>95%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	0	0	4	3	2	4	7	3	3	11	0	0	11
1	Number of Clostridium Difficile cases - (Acute) *	<3		1	1	1	2	0	1	2	2	1	1	2	1	4	7
1	Number of Clostridium Difficile cases - (Community)	0		1	0	0	0	0	0	0	0	0	0	3	4	1	8
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		68.6%	67.9%	66.6%	66.2%	72.7%	72.7%	61.5%	64.3%	65.8%	64.2%	64.3%	64.0%	62.5%	63.6%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		35.8%	34.9%	30.1%	34.9%	35.4%	34.5%	26.4%	32.0%	27.3%	29.7%	29.2%	24.2%	31.2%	28.2%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		81.8%	68.2%	63.6%	68.2%	77.3%	81.8%	77.3%	90.9%	77.3%	81.8%	86.4%	77.3%	86.4%	83.3%
NHS I - FINANCE AND USE OF RESOURCES																	
4	Capital Service Cover	2		4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Plan			4	4	4	4	4	4	4	4	4	4	4	4	4	4
4	Liquidity	4		3	3	3	4	4	4	3	3	3	3	3	3	2	2
	Plan			3	3	4	4	4	4	4	4	4	4	3	3	2	2
4	I&E Margin	1		4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Plan			4	4	4	4	4	4	4	4	3	2	4	4	4	4
4	I&E Margin Variance from Plan			2	2	2	2	2	2	2	2	3	3	4	3	1	1
4	Variance from agency ceiling	1		3	3	3	3	3	3	3	3	4	4	4	4	4	4
	Plan			2	2	2	2	2	2	2	2	2	1	2	2	2	2
4	Overall Use of Resources Rating			3	3	3	3	3	3	3	3	4	4	4	4	3	3

Corporative Objective		Target 2019/2020	13 month trend	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to date 2019/20
FINANCE INDICATORS - LOCAL																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)			-275	-175	-376	-734	-668	-1098	-1292	-2370	-5812	-7157	-6072	-925	-72	
4	Agency - Variance to NHSI cap			0.40%	0.89%	0.58%	0.50%	0.72%	0.92%	1.04%	1.09%	1.21%	1.24%	1.42%	1.21%	1.23%	
4	CIP - Variance from PBR plan - cumulative (£'000's)			-129	-402	-488	553	2006	1576	1150	-682	-6774	-8426	-628	-1191	-1296	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)			1531	1995	2527	4228	5782	6658	8854	11808	-14484	-12019	48	501	893	
4	Distance from NHSI Control total (£'000's)			-228	-117	-303	-633	-570	-986	-1159	-2292	-5722	-7096	-4861	-1213	91	
4	Risk Share actual income to date cumulative (£'000's)			0	0	0	0	0	0	599.5	2291	7624	7950	0	0	0	
INTEGRATED CARE MODEL																	
	Intermediate Care Referrals (All)			312	345	332	332	399	336	314	367	311	311	359	321	0	
	Intermediate Care GP Referrals			76	89	78	89	107	93	89	97	94	78	105	81	0	
	Average length of Intermediate Care episode			20.81	18.97	15.95	18.16	16.47	16.49	16.50	17.51	13.87	14.54	15.85	15.87	0.00	
	Total Bed Days Used (Over 70s)			10090	9319	9331	9267	10734	9536	9985	11768	9813	10430	11319	0		
	- Emergency Acute Hospital			5526	5145	5512	5343	6186	5512	5857	6777	5795	5938	6485	0		
	- Community Hospital			3021	2689	2708	2791	3138	2638	2939	3325	2903	3239	3168	0		
	- Intermediate Care			1543	1485	1111	1133	1410	1386	1189	1666	1115	1253	1666	0		
3	Number of Emergency Admissions - (Acute)			3125	3214	3310	2866	3057	3027	3049	3236	2848	3115	3082	3257	2971	9310
3	Average Length of Stay - Emergency Admissions - (Acute)			2.8	2.8	2.7	3.1	3.1	3.1	3.0	3.2	3.2	3.1	3.2	3.1	3.0	3.1
3	Hospital Stays > 30 Days - (Acute)			0	0	0	0	0	0	0	1	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	Public Health

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

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Pathway to Excellence			Meeting date: 7th August 2019
Report appendix	Route Map with Timelines.		
Report sponsor	Chief Nurse		
Report author	Chief Nurse		
Report provenance	Clinical Non-medical Workforce Group.		
Purpose of the report and key issues for consideration/decision	The Trust has been invited to submit an expression of interest to participate in an international program of quality accreditation, the Pathway to Excellence®. This program is supported by the Chief Nurse for England with 50% of the cost funded centrally. The Trust will be required to fund 50% of the cost and sources of internal and external funding are being explored.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	Board support Trust to participate in the Pathway to Excellence® program approval process. Progression is subject to successful application and confirmation of the required resources.		
Summary of key elements			

Strategic objectives supported by this report

Safe, quality care and best experience	x	**Valuing our workforce**	x
Improved wellbeing through partnership		**Well-led**	x

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	x	**Risk score**	12
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
NHS England	**x**	**National policy/guidance**	

The principle risk is the sourcing of 50% of the program fee.

Report title: Pathway to Excellence		**Meeting date: 7th** August 2019
Report sponsor	Chief Nurse	
Report author	Chief Nurse	

1. Introduction

This report sets out the opportunity to participate in the internationally recognised Pathway to Excellence program.

The Pathway to Excellence programme is a 'nursing excellence' framework that aims to provide a positive practice environment for nursing staff, NHS Improvement will be supporting 14 trusts for which Torbay has provided an expression of interest, if successful we will have to match the funding they will provide

2. Discussion

.
Within England this programme has already been successful in delivering results that benefit patients, these include a positve impact on reducing nursing vacancies, redcued pressure ulcer rates, within trajectory rates for C.Diff, MRSA, MSSA, a reduction in nursing complaints and improved national inpatient survey results for staff and patients. There are 6 standards within the pathway to excellence programme:

- Leadership
- Shared decision making
- Quality
- Safety
- Well-being
- Professional development.

The program focuses on developing a quality culture that promotes, recognises and celebrates excellence. A number of Trusts have participated including Nottingham University Hospital, Oxford University Hospital, University Hospital Leicester and Northampton General Hospital among others. Participation has been shown to improve recruitment and retention and it enhances the reputation of an organisation and demonstrates commitment to quality for staff and people who use services.

The route map at appendix 1 shows the timeline with pre-application actions between September 2019 and March 2020. This involves the collection of data and identification of pay and non-pay resources. In April 2020 the formal application is submitted and if accepted the program then commences and concludes in April 2021.

The program requires compliance with the criteria set out in the table below:

A designated Executive Director of Nursing (EDoN) who is in post and is ultimately accountable for the standards of nursing practice throughout the organisation.	✓
This EDoN must be in place at the time of application and must have a BSc or higher degree and these must have been awarded in Nursing.	✓
An agreed commitment to matched funding and the progression of the financial and operational commitments.	*This is being explored and the bid will not be progressed until this has been confirmed*.
The Executive Director of Nursing and Chief Executive have both been in post for 12 months or longer – or have experience in the delivery of the programme in a previous organisation.	✓
Staff survey results relating to job satisfaction, working environment, staff engagement and empowerment demonstrate that the Trust has scope and an appetite for improvement and/or a move to excellence.	✓
Confirmation from the organisation of executive support for progression through the Pathway to Excellence® Programme. This must include signed agreement from the CEO, EDoN and a Non-Executive Director.	*This will be actioned should Board approval be secured.*
Identification of a Non-Executive Director sponsor for the project.	*This will be actioned should Board approval be secured.*
Confirmation that they have identified and can release a senior member of nursing or midwifery staff to work as their local Pathway to Excellence® facilitator, with a 'dotted line' to the CNO SG:CL team in NHS England/ Improvement as part of a governance framework.	✓
An understanding of what the Pathway to Excellence® Programme will entail and demonstration of capacity and capability to proceed at pace towards the Pathway to Excellence® credentialing.	✓
Articulation of why the organisation wishes to participate and the desired outcome of the progression – is it as a Kitemark of quality or is there a specific area of work that requires improving.	*The Trust is seeking Kite Mark accreditation*
Commitment that the Pathway to Excellence® Programme is reported as an item at the organisation's public board meeting.	✓
The organisation agrees to continue on the Pathway to Excellence® Programme after the nationally funded two years and has the relevant budget planning and support in place to fund any future costs that are required, including re credentialing in 4 years' time.	✓
A commitment to work with the other Trusts as part of the Pathway to Excellence® Programme to share learning.	✓

The application process requires a gap analysis of high level oversight, realistic timeline and a realistic budget. This is undertaken between September 2019 and April 2020. The Trust will not be approved for the program until all progression criteria are met. The principle resource is the identification of a project lead to deliver the program which will come from an existing role. External sources of funding to meet other costs are being explored.

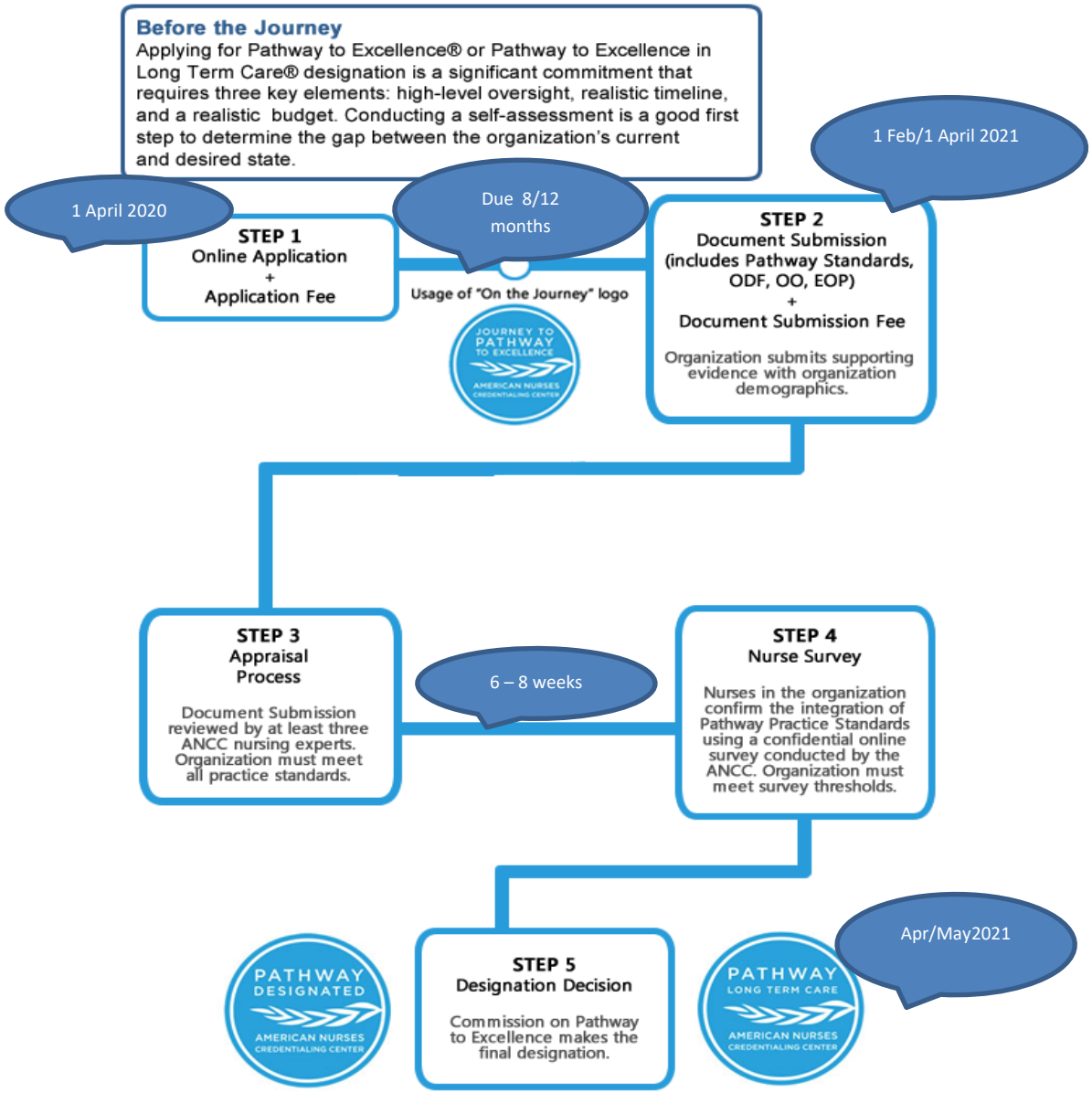
3. Conclusion

The Pathway to Excellence program is an internationally recognised system for accreditation of quality and safety in nursing and clinical practice. Participation provides the opportunity to provide evidence for quality throughout the Trust.

4. Recommendations

Board to support the Trust to participate in the Pathway to Excellence® program approval process. Progression will be subject to successful application and confirmation of the required resources.

Annexe One - Example Pathway to Excellence® Road Map timescales



Applicant organisation must designate one Executive Director of Nursing (EDoN) who is ultimately accountable for the standards of nursing practice throughout the organisation

1. The organisation must have a EDoN in place at the time of the application
2. The EDoN must have a **BSc or higher degree in Nursing**

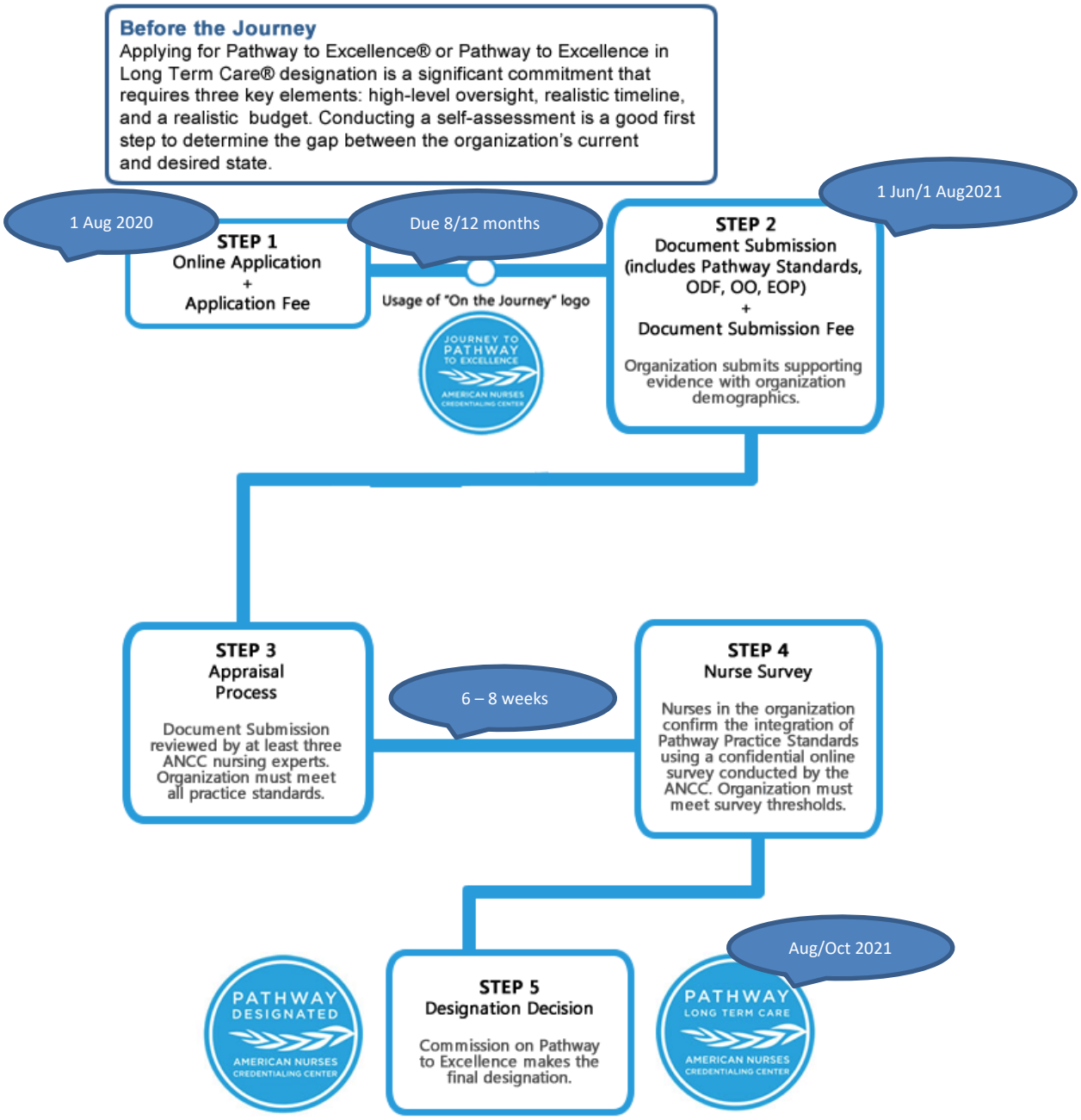
TIMELINES 1 September 2019 – March 2020 – *before formal application starts*

- Undertake your organisational self- assessment and gap analysis of organisational culture involving all levels of nurses – recommend survey monkey as a preparation first
- Develop timeline for gap analysis
- Complete organisation demographic information
- Identify education levels of direct care nurses
- Develop & establish Nursing & Midwifery strategy based on Pathway to Excellence®
- Develop & establish shared decision-making councils
- Introduce recognised staff reward and recognition scheme
- Develop partnership working outside organisation
- Develop partnership working with direct care nurse to initiate & enable health & well-being initiatives
- Develop communications plan

*******NB when submitting evidence, it is from the 3 years prior to the application commencing*******

ANCC fees
On line application fee – ($2500) **£1987.75**
Manuals (3) – ($429.950 **£341.85**
Applicant workshop (In USA) – ($499) **£396.75**
Pathway to Excellence® Appraisal process – ($73,500) **£58,439.85**
(Assumption 800 beds – $58,000 + $45 per additional bed over 700 + worst case scenario fees = $69,000 + $4,500)
NB applicant workshop does not include travel & subsistence allowance - national team is in discussion as to ANCC coming to England to deliver here.

Annexe One - Example Pathway to Excellence® Road Map timescales



Applicant organisation must designate one Executive Director of Nursing who is ultimately accountable for the standards of nursing practice throughout the organisation

1. The organisation must have a EDoN in place at the time of the application
2. The EDoN must have a **BSc or higher degree in Nursing**

TIMELINES 1 September 2019 – July 2020 – *before formal application starts*

- Undertake your organisational self- assessment and gap analysis of organisational culture involving all levels of nurses – recommend survey monkey as a preparation first
- Develop timeline for gap analysis
- Complete organisation demographic information
- Identify education levels of direct care nurses
- Develop & establish Nursing & Midwifery strategy based on Pathway to Excellence®
- Develop & establish shared decision-making councils
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Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation			Meeting date: 07 August 2019
Report appendix	List any supplementary information as shown below: Appendix 1: Comparator Report Appendix 2: AOA Trust data from 2014 – 2019 Appendix 3: Medical appraisals from 01 April 2018 – 31 March 2019		
Report sponsor	Medical Director		
Report author	Appraisal and Revalidation team.		
Report provenance	Discussion in the appraisal team meetings but no other formal presentation prior to this meeting.		
Purpose of the report and key issues for consideration/decision	This is the annual report relating to medical appraisal and revalidation presented by the Medical Director.		
Action required (choose 1 only)		**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to approve the contents of the Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation. The monitoring of appraisal and revalidation continues as described and reporting to the Board will be undertaken on an annual basis.		
Summary of key elements			

Strategic objectives supported by this report

Safe, quality care and best experience	Y	**Valuing our workforce**	Y
Improved wellbeing through partnership	Y	**Well-led**	Y

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	N	**Risk score**	
Risk Register	N	**Risk score**	

External standards affected by this report and associated risks	

Care Quality Commission	Y	**Terms of Authorisation**	Y
NHS Improvement		**Legislation**	
NHS England		**National policy/guidance**	Y

Report title: Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation		**Meeting date:** 07 August 2019
Report sponsor	Medical Director	
Report author	Appraisal and Revalidation team.	

1. Introduction

This is a summary of the annual report for Torbay and South Devon NHS Foundation Trust prepared by the Appraisal and Revalidation team as reported by the Responsible Officer/Medical Director. This data has been submitted to NHS England. This report addresses the requirement for Trust Board oversight and approval.

2. Discussion

There are no major issues of concern. A review of the Appraisal Process is underway to include the support required from the Appraisal Lead.

3. Conclusion

There are new challenges to the appraisal and revalidation system due to the changing nature of the medical workforce. This reflects the national position. There is an increasing proportion of temporary workforce who are connected to the organisation for a limited period of time and an increasing proportion of medical staff from overseas whose experience of appraisal and revalidation is different or limited. The report describes the actions that have been taken, or are planned, to meet these challenges.

4. Recommendations

The Trust Board is asked to approve the contents of the Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation. The monitoring of appraisal and revalidation continues as described and reporting to the Board will be undertaken on an annual basis.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

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Section 3 – Recommendations to the GMC 11
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Section 5 – Employment Checks 13
Section 6 – Summary of comments, and overall conclusion 14
Section 7 – Statement of Compliance 15

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Executive Board of Torbay and South Devon NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 30 May 2019

Action from last year: Not applicable.

Comments: Comparator data from NHS England records the Trust's total number of doctors who completed an appraisal between 01 April 2018 and 31 March 2019 as 87.9% compared to 89.3% for appraisal rates within same sector organisations. The Consultant and SAS medical body data remains comparable to same sector data however the appraisal figure for temporary or short term locum contract holders is lower than same sector data.

The Comparator report is attached as Appendix 1.

AOA Comparison data for this Trust from 2014 – 2019 is attached as Appendix 2.

Action for next year:

1. Focus on Locum doctors
2. Support for Overseas doctors
3. Review of revalidation and appraisal process by revalidation team

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Nil

Comments: Dr Rob Dyer continues as Responsible Officer. Appointment of Deputy RO to be considered.

Action for next year: No planned change.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/~~No~~

Action from last year: Not applicable.

Comments:

Action for next year: Continue.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Not applicable.

Comments: Individual doctors can connect themselves, sometimes in error, to the Trust's GMC list. These connections to the list can be made at any time so maintaining accuracy can be challenging.

Action for next year: Focus on the Locum pathway process.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Appraisal and Revalidation Policy reviewed.

Comments: Policy updated April 2019.

Action for next year: Continue to review and update policy.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Not applicable.

Comments: Independent Verification visit 21 September 2015.

Action for next year: Liaise with NHS England re peer review.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Not applicable.

Comments: This is our current challenge and work will be undertaken with Medical HR to review and formalise the locum doctor pathway. The Trust Doctor Lead maintains regular contact with the Trust Doctor body by group and individual meetings; teaching sessions and also carries out a significant number of appraisals for this group of doctors.

Action for next year: Formal process to be established for Locum doctors.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Not applicable

Comments: Doctors complete a Whole Scope of Practice form for inclusion in their annual appraisal. This provides a summary of their clinical work at any external organisation. A medical indemnity certificate should be provided for any private clinical work undertaken.

Action for next year: Monitor appraisal timelines.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Not applicable.

Comments: Missed appraisal to be identified, reasons understood and appropriate action taken. Whole Scope of Work and medical indemnity requirements for appraisal are discussed at Appraiser/Appraisee study sessions.

Action for next year: Continue to monitor and support with feedback to the Responsible Officer regarding late/missed appraisals.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Policy reviewed and updated in April 2019.

Comments: Approved by the Joint Local Negotiating Committee.

Action for next year: Nil. Next renewal date 2021.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Shortage of medical specialty appraisers. Comments: Challenging issue due to resignation and retirement of senior appraisers. Currently managed by the Appraisal Lead taking on additional appraisals. Action for next year: Active recruitment to the appraiser role.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Not applicable. Comments: Appraiser study sessions with external input eg GMC Regional Liaison Adviser sessions. Action for next year: Planned quarterly appraisal calibration sessions. WhatsApp Group for appraisers.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Not applicable. Comments: Quarterly reporting to NHS England. AOA report to NHS England. Annual report to the Trust Board by the Medical Director. External quality assurance is carried out by NHS England via an Independent Verification visit on a five yearly basis. Action for next year: Continue.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Not applicable.

Comments: One recommendation for consideration of fitness to practice has been made by the Medical Director. This was not related to Appraisal or Revalidation issues

Action for next year: Continue regular liaison meetings with the GMC Employment Liaison Officer who provides support in decision making around threshold for referral.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Not applicable.

Comments: All revalidation recommendations have been submitted to the GMC prior to or on the doctor's revalidation date. No late recommendations have been submitted. Revalidation recommendations are communicated to the doctor after submission via GMC Connect. Deferral recommendations are communicated to the doctor before submission to the GMC and an action plan is discussed with the doctor by the Appraisal Lead.

Action for next year: Continue.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Not applicable.

Comments: Serious Adverse Events Group attended by the Responsible Officer; liaison with Coroner's office; Incidents, Complaints and Litigation cases recorded on the Datix system. Liaison with the Patient Safety team.

Action for next year: Continue.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Not applicable.

Comments: Performance monitored by: annual appraisal; Complaints and incidents data via the Datix system; divisional performance data; departmental clinical governance meetings; Dr Foster data; Maintaining High Professional Standards policy; Transfer of information requests.

Action for next year: Continue.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Not applicable.

Comments: Maintaining High Professional Standards and Remediation Policy. Close liaison between Medical Director/Responsible Officer and the Medical HR team.

Action for next year: Continue.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Not applicable.

Comments: Following a Maintaining Professional Standards Investigation the Case Manager will meet with the Case Investigator and Medical Workforce team to debrief and consider any lesson that can be learned. These are communicated to the Medical Director/Responsible Officer. The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No individual will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010.

Action for next year: Continue

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Not applicable. Comments: Transfer of Information requested from previous organisation and provided, on request, to the doctor's next employer. Regular liaison meetings between the Responsible Officer and the GMC Employment Liaison Officer provide a forum to discuss any concerns about a doctor who may not be relocating to another employing organisation. Action for next year: Continue.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Not applicable. Comments: The Medical Director/Responsible Officer and Medical Workforce Business Partner meet on a regular basis with the GMC Employment Liaison Officer to discuss, in confidence, any concerns and agree the best way of handling these concerns balancing the safety of patients with supporting the clinician. Action for next year: Continue.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Not applicable. Comments: All medical staff, both substantive and locum, are subject to pre-employment checks as per the NHS Employers Employment Check Standards and NHS Employers Guidance on appointment of Locum Doctors. Action for next year: Continue.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/uksi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions

- Appointment to an additional Appraisal Lead role – new appointee in post from September 2018 but resigned from this role in June 2019.
- Rowcroft Hospice, as a small designated body, has come under the governance of this Trust's Responsible Officer who will provide revalidation recommendations to the GMC when appropriate.
- Revalidation team attended the NHS England Revalidation South Regional Conference on 16 October 2018.
- PReP appraisal system contract renewed until 2021.
- Appraisee Half day session held on 09 November 2018 including presentations from Premier IT and the GMC Regional Liaison Adviser (South West).
- Appraiser Half day session held on 14 December 2018.
- Non UK Graduate Overseas Doctors group established with regular meetings with the Appraisal Lead.
- Annual Organisation Audit and Statement of Compliance submitted to NHS England.

Actions still outstanding – Nil.

Current Issues

- Challenge of Locum and short term body of doctors.
- Lack of resilience within the revalidation team by the resignation of the joint Appraisal Lead.

New Actions:

- Focus on locum and short term doctor pathway.
- Review appraisal and revalidation process with Responsible Officer and Medical HR team.

Section 7 – Statement of Compliance:

The Foundation Trust Board of Torbay and South Devon NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Torbay and South Devon NHS Foundation Trust

Name: Sir Richard Ibbotson Signed: _ _ _ _ _ _ _ _ _ _

Role: Chairman

Date: _ _ _ _ _ _ _ _ _ _

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Tracy.calvert@nhs.net
Tel: 0113 825 3052

18 July 2019

Our Ref: 673
Publications Approval 000740

Dr Robert Dyer
Responsible Officer
Torbay and South Devon NHS Foundation Trust

Dear Dr Dyer

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 673 - Torbay and South Devon NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 18/19 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The 2018/19 slimmed down version of the AOA was designed to concentrate primarily on the quantitative measures of previous AOAs, the number of doctors with a prescribed connection and their appraisal rates. In this the sixth year of the AOA, I am pleased to report a continuing upward trend in the overall appraisal rate. This is extremely reassuring and I would like to thank you once again for your continued work. There is emerging evidence that creating the right environment for doctors to reflect on their clinical practice through appraisal is one which enables them to thrive and develop professionally. This benefits the patients that they look after and allows doctors to have confidence in their professional practice.

As well as revising the AOA, a review of reporting the other important aspects of the responsible officer function (monitoring of practice, responding to concerns, and identity/language checks) have moved to the annual Board report. The Board report, combined with the annual Statement of Compliance, has been re-designed to support a conversation within the designated body to review all the responsible officer's obligations and to agree an action plan for areas where further development is identified.
Assurance of the totality of the designated body's work on the responsible officer's duties will therefore be provided to the higher level responsible officer through both completion of the AOA and the statement of compliance, as signed off by the designated body's Board or equivalent management body.

Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Michael Marsh
Your local revalidation team's lead contact	Claire Brown
Your local revalidation team's contact details	england.revalidation-south@nhs.net

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2019. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing the required assurance to your higher level RO, and to NHS England.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Mike Prentice

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer
cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 862 returns from designated bodies (DBs) to the 2018/19 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2019

The following information is presented as per your own AOA submission.

Name of designated body:	Torbay and South Devon NHS Foundation Trust
Name of responsible officer:	Dr Robert Dyer
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - South West)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Claire Brown at england.revalidation-south@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2018/19 for the full indicator definitions if required.

2018/19 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	94 (97.9%)	851 (98.7%)

2018/19 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	225	28190	53177
2.1.2	Staff grade, associate specialist, specialty doctor	31	5592	12543
2.1.3	Doctors on Performers Lists	0	35	47422
2.1.4	Doctors with practising privileges	0	1	1870
2.1.5	Temporary or short-term contract holders	50	8870	22314
2.1.6	Other doctors with a prescribed connection to this designated body	0	689	7128
2.1.7	**Total number of doctors with a prescribed connection**	306	43377	144454

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	210 (93.3%)	93.5%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	26 (83.9%)	88.8%	88.2%
2.1.3	Doctors on Performers Lists	N/A	91.4%	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	33 (66.0%)	77.8%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	72.1%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	269 (87.9%)	89.3%	91.5%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	5 (2.2%)	4.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	2 (6.5%)	8.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	13 (26.0%)	17.1%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	22.5%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	20 (6.5%)	7.9%	6.4%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	10 (4.4%)	2.1%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	3 (9.7%)	2.4%	3.2%
2.1.3	Doctors on Performers Lists	N/A	8.6%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	4 (8.0%)	5.1%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	5.4%	1.6%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	17 (5.6%)	2.8%	2.1%

2018/19 AOA indicator SECTION 3:		Your organisation's response
3.1	The last Annual Board report was signed off on:	03/10/2018 00:00:00
	The last Statement of Compliance was signed off on:	14/08/2018 00:00:00

2018/19 AOA indicator SECTION 4: Comments		Your organisation's response
4.1		

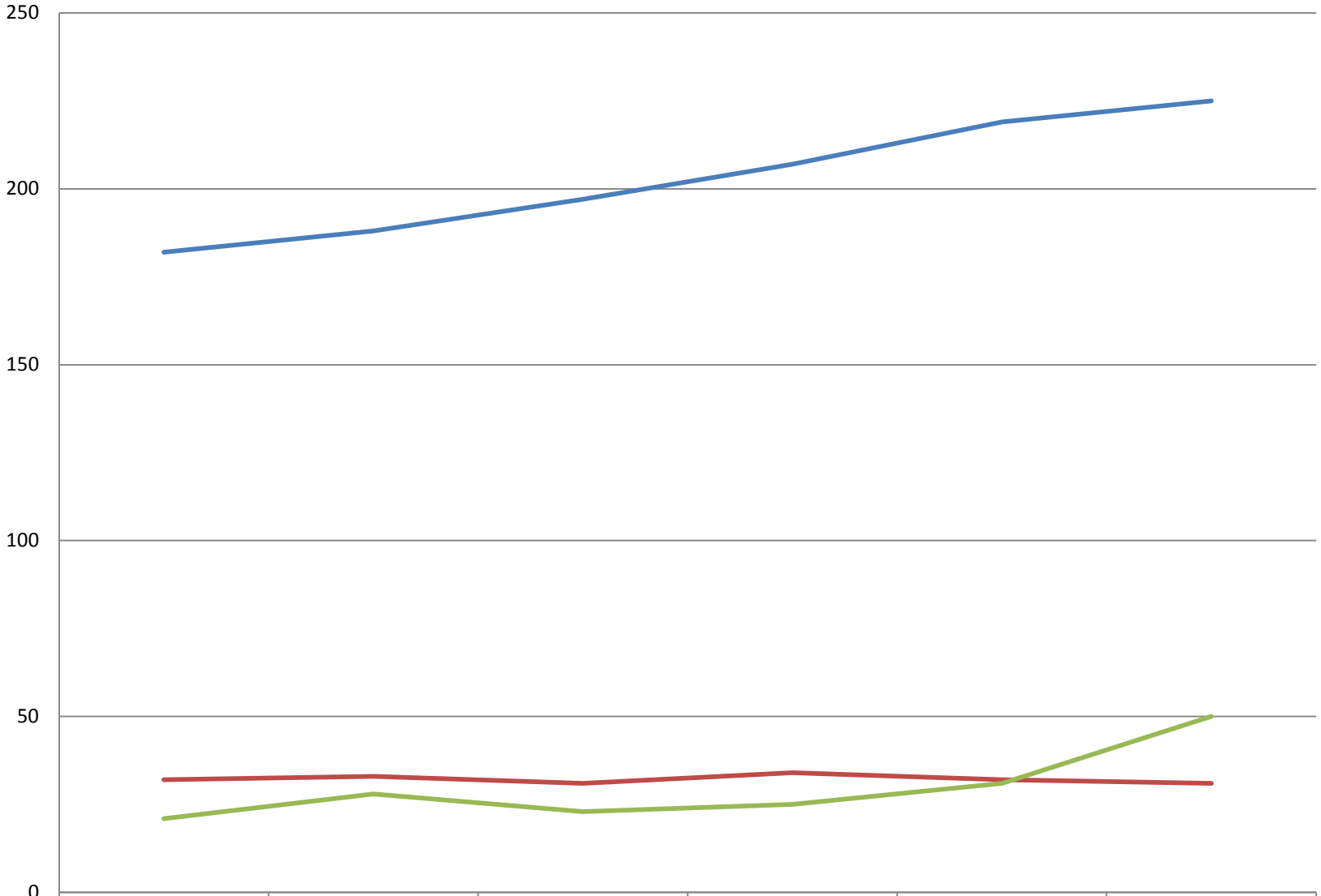
Appraisal data (AOA) 2014-2019

Dr Maree Wright

Appraisal Lead

May 2019

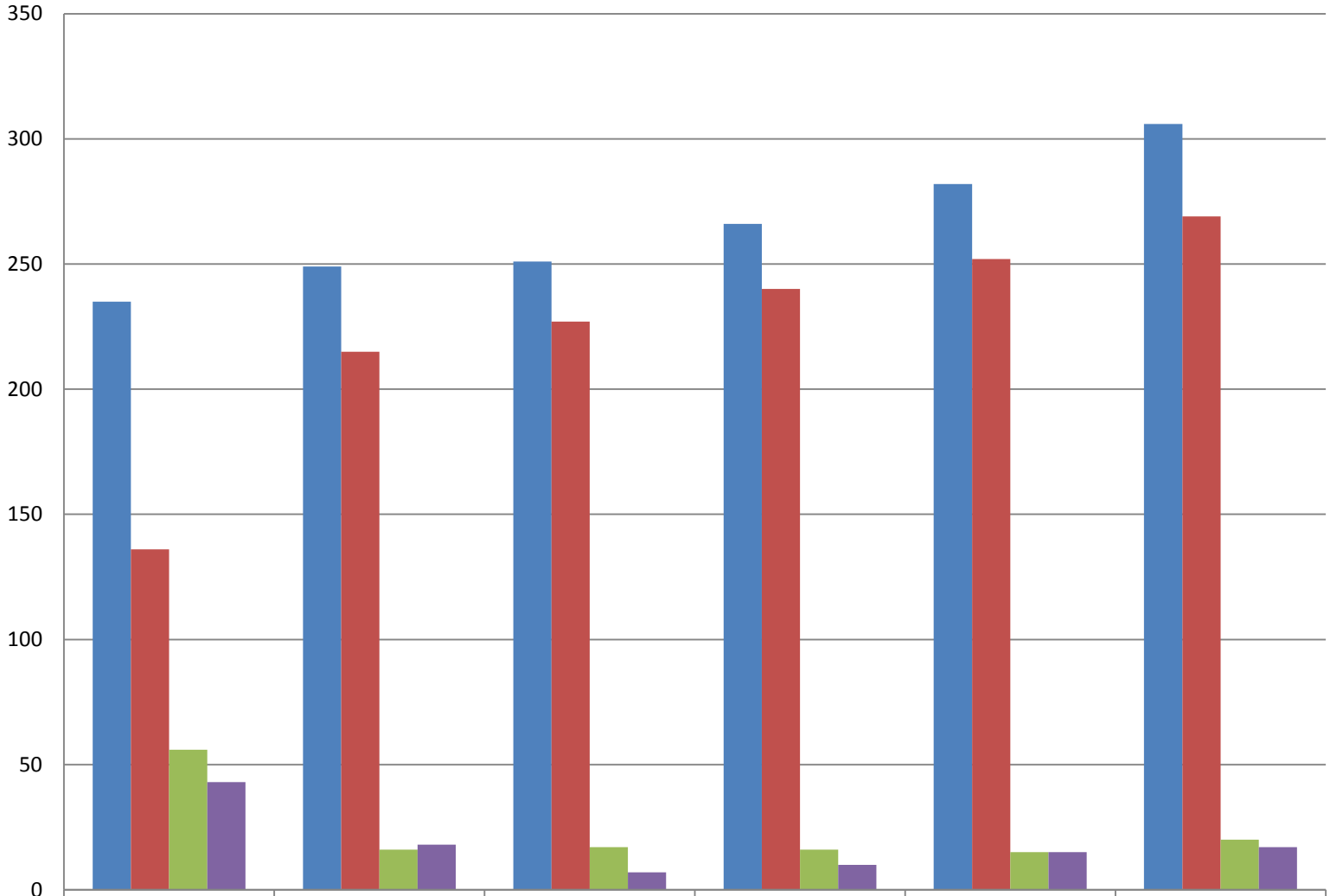
Number of doctors



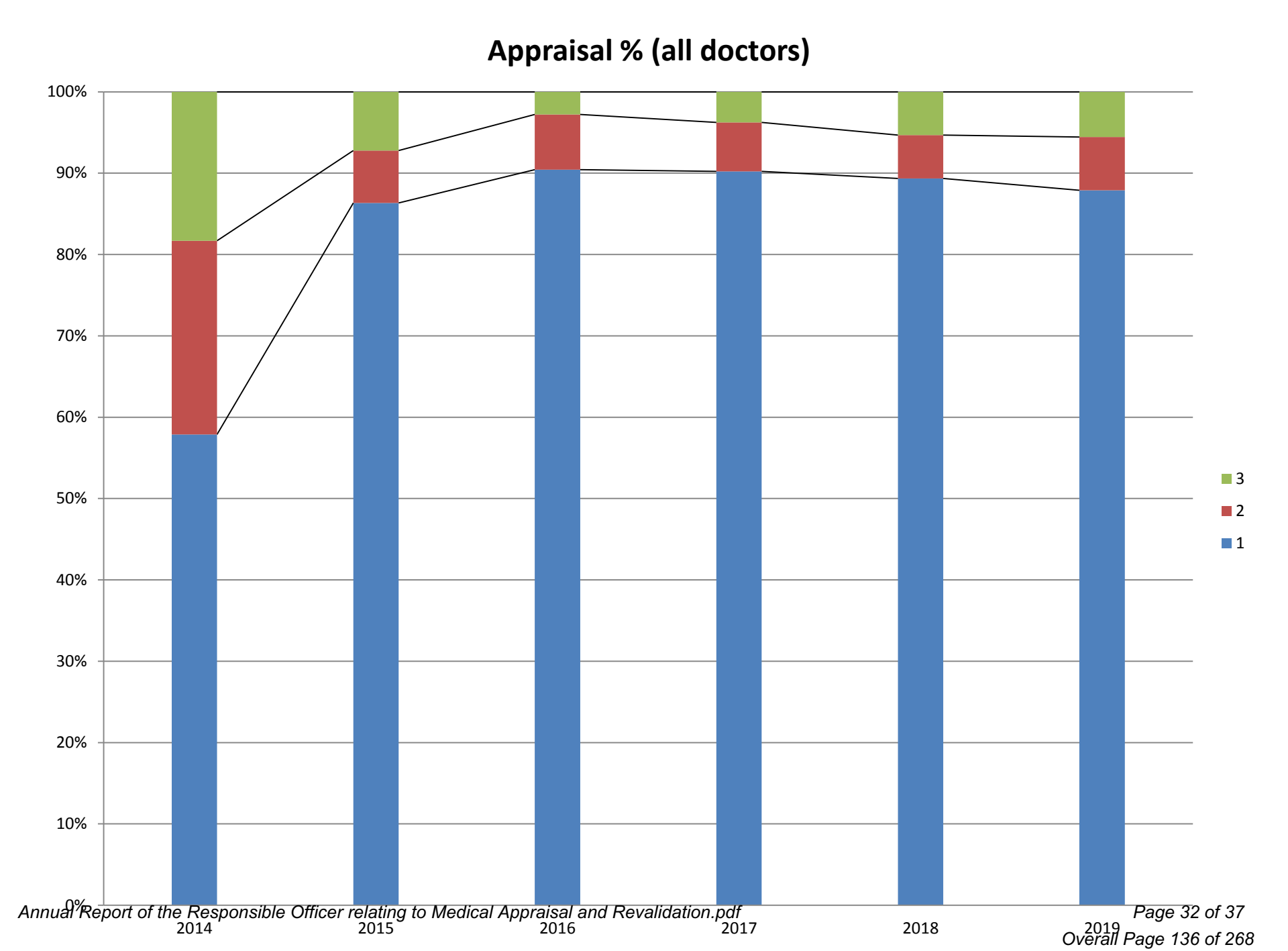
	2014	2015	2016	2017	2018	2019
Cons	182	188	197	207	219	225
SAS	32	33	31	34	32	31
Trust/locum	21	28	23	25	31	50

- 1= Completed appraisal in the year April-March
- 2= Approved missed appraisal in the year April-March
- 3=Unapproved missed appraisal in the year April-March

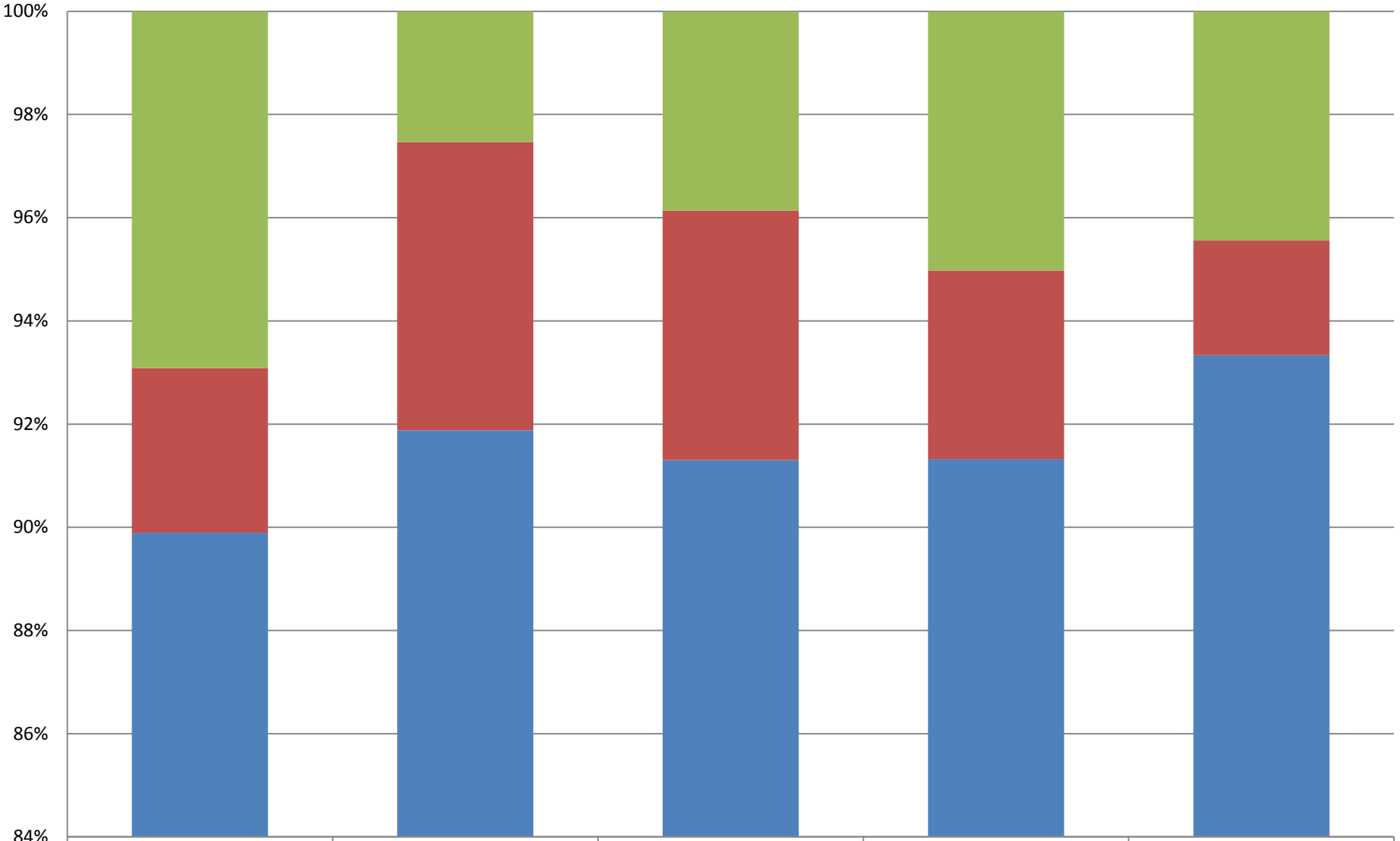
All prescribed connections- appraisal numbers



	2014	2015	2016	2017	2018	2019
Prescribed comnnections	235	249	251	266	282	306
1	136	215	227	240	252	269
2	56	16	17	16	15	20
3	43	18	7	10	15	17

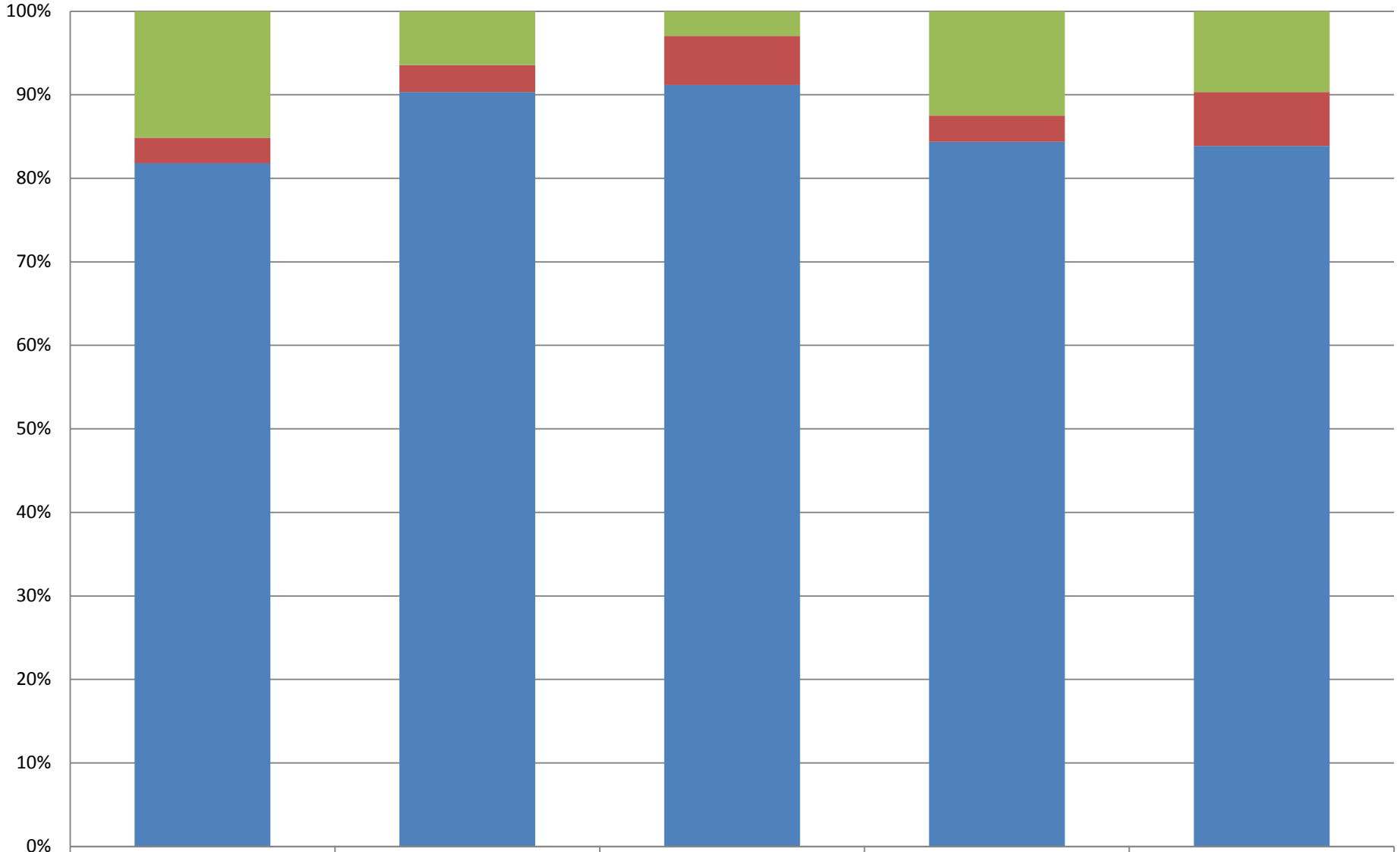

Appraisal % (all doctors)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2014
2015
2016
2017
2018
2019
3
2
1

Consultant appraisal %



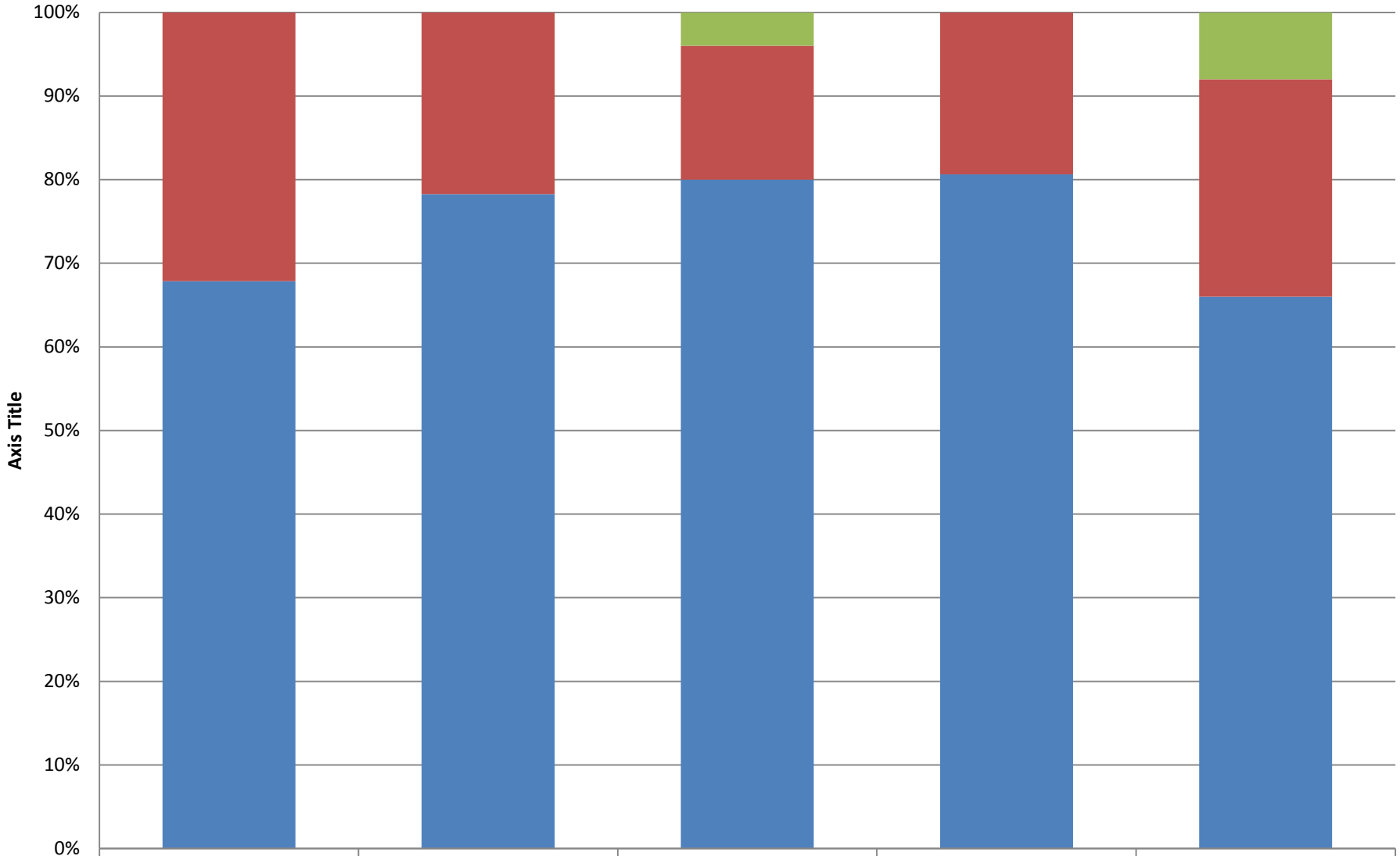
	2015	2016	2017	2018	2019
3	13	5	8	11	10
2	6	11	10	8	5
1	169	181	189	200	210

SAS appraisal %



	2015	2016	2017	2018	2019
3	5	2	1	4	3
2	1	1	2	1	2
1	27	28	31	27	26

Employed Locum/Trust doctor %



	2015	2016	2017	2018	2019
3	0	0	1	0	4
2	9	5	4	6	13
1	19	18	20	25	35

Summary

- Increased number of doctors with prescribed connection has increased over last 5 years
  - Consultants by 43
  - SAS no increase
  - Trust/locum increase by 29
- Completed appraisal rate in 2019
  - All doctors=87.9%
    - Consultant =93.3%
    - SAS= 83.8%
    - Trust/locum=66%
- Main challenge is with non-substantive post doctors

Appendix 3

Torbay and South Devon NHS Foundation Trust

Medical Appraisals from 01 April 2018 – 31 March 2019

The Trust had 49 trained appraisers actively carrying out appraisals as follows:

Number of appraisals completed 1st April 2018-31st March 2019	Number of appraisers
18	1
11	1
10	0
9	1
8	1
7	17
6	10
5	7
4	6
3	2
2	2
1	3
Mean	6
Median	6
Mode	7

Of the seven appraisers carrying out less than three appraisals, five have resigned from the appraiser role, one appraiser also appraises the Rowcroft medical doctors and one appraiser also carries out supervision reports for the departmental Medical Training Initiative doctors.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: NHS Resolution Maternity Incentive Scheme – Year 2			**Meeting date:** 7 August 2019
Report appendix	Appendix 1: Screen Shot of Board Declaration Form Appendix 2: Maternity Mandatory Training Position as of 30 June 2019. Appendix 3: Midwifery Staffing Report Appendix 4: Obstetric Anaesthesia Workforce Report		
Report sponsor	Medical Director (Maternity Safety Champion)		
Report author	Anne Marie Whiting, Clinical Governance Co-ordinator & Rachael Glasson, Head of Midwifery and Gynaecology		
Report provenance	This report contains the Trust's status and evidence in relation to compliance with NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 2 standards. Achievement of the 10 Safety Actions will result in a minimum rebate of the Trust's contribution to the incentive fund (calculated at 10% of our maternity premia).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide the Trust Board with a self-declaration of the Trust position in relation to achieving the standards set out within the CNST maternity incentive scheme. A summary of the evidence that supports the self-assessment is provided to enable the Trust Board to complete the declaration form to be submitted to NHS Resolution.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to review the report and evidence provided The Trust Board is asked to sign off that they have seen evidence of compliance with all 10 Safety Actions and to submit the declaration form by noon on 15 August 2019.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** X; **Valuing our workforce** X **Improved wellbeing through partnership** X; **Well-led** X		

Is this on the Trust's Board Assurance Framework and/or Risk Register	

Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks			

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Report title: NHS Resolution Maternity Incentive Scheme – Year 2		**Meeting date:** 7 August 2019
Report sponsor	Medical Director (Maternity Safety Champion	
Report author	Anne Marie Whiting, Clinical Governance Co-ordinator & Rachael Glasson, Head of Midwifery and Gynaecology	

1.0 Introduction

In January 2018, NHS Resolution launched the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme which was introduced to support the delivery of the Department of Health and Social Care's Maternity Safety Strategy. This strategy set out an ambition to reward those who have taken action to improve maternity safety and 10 maternity actions were developed to support this aim.

A second year of the scheme was launched in November 2018. The 10 maternity actions remained; however, additional requirements were added to each action. The Trust are required to make a self-declaration of achievement against the actions. This will be signed off by the Trust Board and submitted to NHS Resolution by 12.00 noon Thursday 15 August 2019. See appendix 1 for screenshots of self-declaration form
The Trust Board must sign a declaration confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
- The content of this form has been discussed with the commissioner(s) of the trust's maternity services.
- If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s).
- We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

The Board declaration form has four tabs:

- Tab1 – Guidance
- Tab 2 – A Safety Actions Entry Sheet
- Tab 3 – Action Plan Entry Sheet
- Tab 4 Board Declaration Form

Evidence of achieving all 10 actions will qualify the Trust for a minimum rebate of their contribution to the incentive fund (calculated at 10% of our maternity premia).
This report provides the Board with an overview of the status of each of the 10 safety actions and the evidence to demonstrate achievement of each action.

2.0 CNST Self-Assessment Summary of 10 Maternity Safety Actions

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Y
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Y
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Y
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Y
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Y
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Y
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Y
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Y

3.0 CNST: 10 Safety Actions. Summary of Evidence

No.	Safety Action	Requirement	Status and evidence
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	4/4 started within 4 month timeframe. 100% Database maintained of all cases that qualify for a PMRT.
		At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	3 cases fully reviewed within timeframe. 1 further case in progress – will be completed within 4 month timeframe. Currently 75% at time of completing Board report. Will be 100% at time of CNST submission
		In 95% of all deaths of babies who were born and died in your Trust (including any homebirths where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their babies death will take place and that their perspective and any concerns about the care of their baby have been sought.	4/4 cases parent(s) informed and questions sought.
		Quarterly reports have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans	8 May 2019 Quarterly report submitted for October – December 2018. No eligible cases. 3 July 2019 Quarterly report submitted for January – March 2019. 3 cases - details provided, along with summary of findings and actions taken. Next report due October 2019 will provide details of 4th case.

2	Are you submitting data to the Maternity Services Data Set to the required standard?	The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).	3/3 mandatory requirement passed. Email confirmation from NHS Digital.
			17/19 optional criteria met. Email confirmation from NHS Digital.
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme	Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.	Transitional care pathway developed in June 2018. Agreed at SCBU governance meeting. Maternity and Neonatal teams jointly agreed SOP detailing pathway. As service offer has developed, SOP has been changed to guideline.
		A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.	Established, via Badgernet IT system. Data is submitted directly from Badgernet to the SW Neonatal Operational Delivery Network (ODN), providing data on number of term admissions to SCBU and number of babies receiving care under a transitional model.
		An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.	Action plan developed in 2018. Agreed at Board level and with LMS and ODN. This is a live action plan that is regularly reviewed. It was recently amended and shared with the Board and SW ODN. The ODN have formally confirmed their approval of the plan in recognition of meeting CNST requirements on 30 June 2019
		Progress with the agreed action plans have been shared with your Board and your LMS & ODN.	Due to being just above the ODN target level for term admission, the team have been providing regular updates on our progress against our action plan to the ODN. Progress against the ATAIN action plan is shared with the Board through our quarterly governance report The action plan was recently

			updated with progress and new actions. This was shared at the Board meeting on 3 July 2019, with the ODN on 14 June 2019 and 29 July 2019, and discussed at the LMS safety and governance workstream on 22 July 2019
4	Can you demonstrate an effective system of medical workforce planning to the required standard	Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.	Report including action plan accepted at Trust Board meeting on 3 July 2019
		An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards	100% compliance. Board report submitted for Trust Board meeting on 7 August 2019
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard	A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	Formal Birthrate Plus © assessment of midwifery establishment completed in October 2017 and report received. Establishment set at right level therefore no action plan required. Establishment monitored monthly by midwifery matrons, plus midwifery ratio reported to SW Maternity Clinical network. Monthly staffing reports completed by Head of Midwifery reviewing midwifery staffing levels.
		The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service	The labour ward co-ordinator has supernumerary status. This is supported by our midwifery staffing document. Acuity tool in place to monitor any occasion where the co-ordinator is not supernumerary for any part of shift and actions taken to remedy this. During April to June 2019,

			there were 15 / 546 instances where the co-ordinator was not able to remain supernumerary. This is detailed in the bi-annual report submitted to the Board. None of these instances were planned and the co-coordinator. The majority were for very short periods, with two being for a longer period. In all instances the co-ordinator returned to supernumerary status as soon as was practicable. All instances are reviewed by the matrons and remedial action taken as indicated. Monitored on a weekly basis and reported ion monthly m
		Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)	Standard for women to receive 121 care in labour. This is monitored through our STORK IT system. The target is for 100% of women to receive one-to-one care. During the reporting period 96% of women receive this care. However our reporting system does not tell us for how long that woman did not receive on-to-one care. Anecdotally midwives report that this is usually for short periods of time, where they may be required to provide care for another woman whilst additional midwifery staffing is sought. As a senior team we are assured that one-to-one care is prioritised and action is taken to remedy the situation as soon as practically possible
		A bi-annual report that covers staffing/safety issues is submitted to the Board	Report submitted in March 2019 for period of July to December 2018 Second report submitted for August 2019 Board meeting covering January to June 2019

6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services.	Medical Director and Chief Nurse involved Maternity Service Improvement Plan where elements were considered and implemented. SBL care bundle in place. Board minutes demonstrate the maternity service progress and compliance.
		Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Quarterly reports sent to National Team. Final report in March 2019 noted full compliance
7	Can you demonstrate that you have a patient feedback mechanism for maternity service and that you regularly act on feedback?	User involvement has an impact on the development and /or improvement of maternity services.	A Devon-wide Maternity Voices Partnership (MVP) was commissioned in the latter part of 2018. The MVP is independent of any providers. Formal meetings were re-established in May 2019, with TSD having a user rep participating. The Local Maternity System in conjunction with the MVP commissioned a Devon-wide user engagement programme. This has been used to establish the priorities for developing maternity services across Devon. The MVP also participates in the Devon LMS Board meetings. Locally we engage with families regarding how to improve services. Examples include, changes to visiting times, development of leaflets, development of electronic resources. Engagement is through a number of mediums, with electronic appearing to be the favoured approach for women. We have active facebook pages – maternity and breast feeding, which is valued by women and their families. They are able to provide feedback, positive and areas for improvement. It also provides the service with the

			opportunity to feedback and changes. An example being changes to grandparent visiting hours following concerns being raised and an engagement activity taking place. Annually we receive the CQC survey of women views. We received feedback that women did not feel they were receiving enough information on postnatal contraception. In conjunction with women, we developed an information video for families to watch on the postnatal ward, or at home, which they then can discuss with their midwife. As part of duty of candour, with any serious incidents we ask the families to provide feedback, encourage them to ask any questions and meet with them to discuss the findings. Feedback and engagement are specific topics that are addressed at a number of meetings, including: LMS Board meeting, Maternity Clinical Governance meeting We also encourage women to feedback through the friends and family form, which is provided in paper and electronic format

8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies session within the last training year.?	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	As of 30.7.19, ≥ 90% of Obstetric medical staff, midwives and maternity support workers attended maternity emergencies and fetal monitoring training. As of 30.7.19, ≥ 90% of anaesthetic doctors have attended maternity emergencies training. See appendix 2 for details of attendance levels for each staff group.
9	Can you demonstrate that the trust safely champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	Medical Director is the Executive Sponsor for MNHSC. In addition he is the chair of the Devon LMS. Executive Sponsor engages with the trust nominated improvement leads. The local Team have attended National and Local Learning System events. Trust-wide, the System Medical Director is the Clinical Lead for the Maternity and Neonatal Health safety collaborative. The LLS have been working on the MatNeo project since Wave 1 in 2017. The local team attend LLS events in the South West.
		The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues	"Have your say" is a monthly feedback session that has been implemented for staff to raise any concerns with Maternity or Neonatal services. The dates have been emailed out for the year and a monthly

			invite reminder is sent. Any concerns are raised at the meeting with the Executive sponsor.
		The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	Only one concern has been raised to the Board level safety champions. Because of the nature of the concern feedback has been given back to those staff who raised the concern, providing reassurance that appropriate action has been taken.
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.	All qualifying incidents meeting criteria for Each Baby Counts reported 2/2 (100%) Database maintained by both Maternity and the Litigation services. Any cases are highlighted to the Board through the quarterly Board report. Email received from NHSR confirming both cases have been reported.

The evidence to support the 10 safety actions is stored electronically within the Maternity Services Shared Drive Dir_Man (\\sdhfs03): CNST 2018. This can be accessed by the senior staff within the maternity services to demonstrate compliance as required.

NHSR have provided technical guidance and conditions to support collation of evidence and completion of declaration. These can be accessed via the following link: https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two/
At the recent Devon Local Maternity System Safety and Governance Workstream, the 4 providers reviewed the position of each Trust to ensure that each had taken the same approach to benchmarking and providing evidence. The members of the workstream were assured that this was the case.

4.0 Conclusion

The Maternity Service has worked extremely hard to ensure that processes and systems are in place to meet the requirements set by NHS Resolution. These 10 key actions are designed to drive safety improvements within maternity and neonatal care.

This report provides a summary of the evidence of achievement of the 10 safety actions. The team have had confirmation from external bodies of achievement of standards for Safety Actions 1, 2, 3 & 10.

The Board are now required to review the evidence provided to assure themselves of achievement of the standards and to complete and sign the declaration.

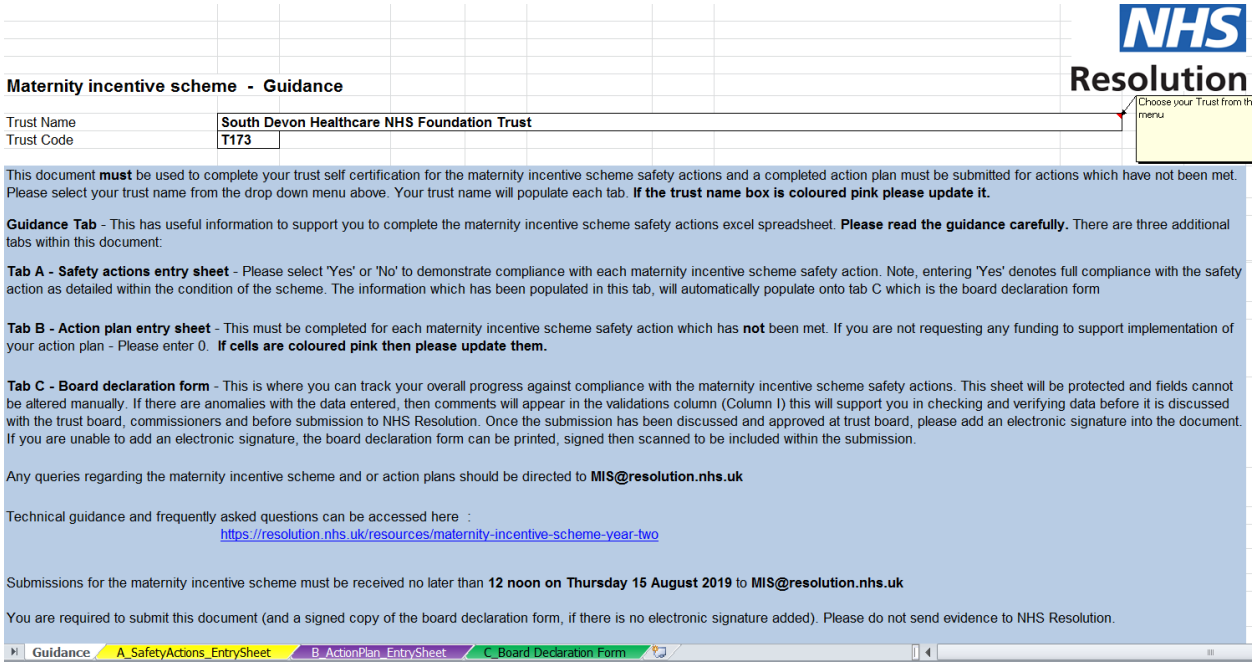
5.0 Recommendations

The Trust Board is asked to review the report and evidence provided.

The Trust Board is asked to sign off that they have seen evidence of compliance with all 10 Safety Actions and to submit the declaration form by noon on 15 August 2019.

Appendix 1: Screen Shots of Board Declaration Form

Tab 1: Guidance



Maternity incentive scheme - Guidance

NHS Resolution

Trust Name	**South Devon Healthcare NHS Foundation Trust**
Trust Code	**T173**

Choose your Trust from th menu

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

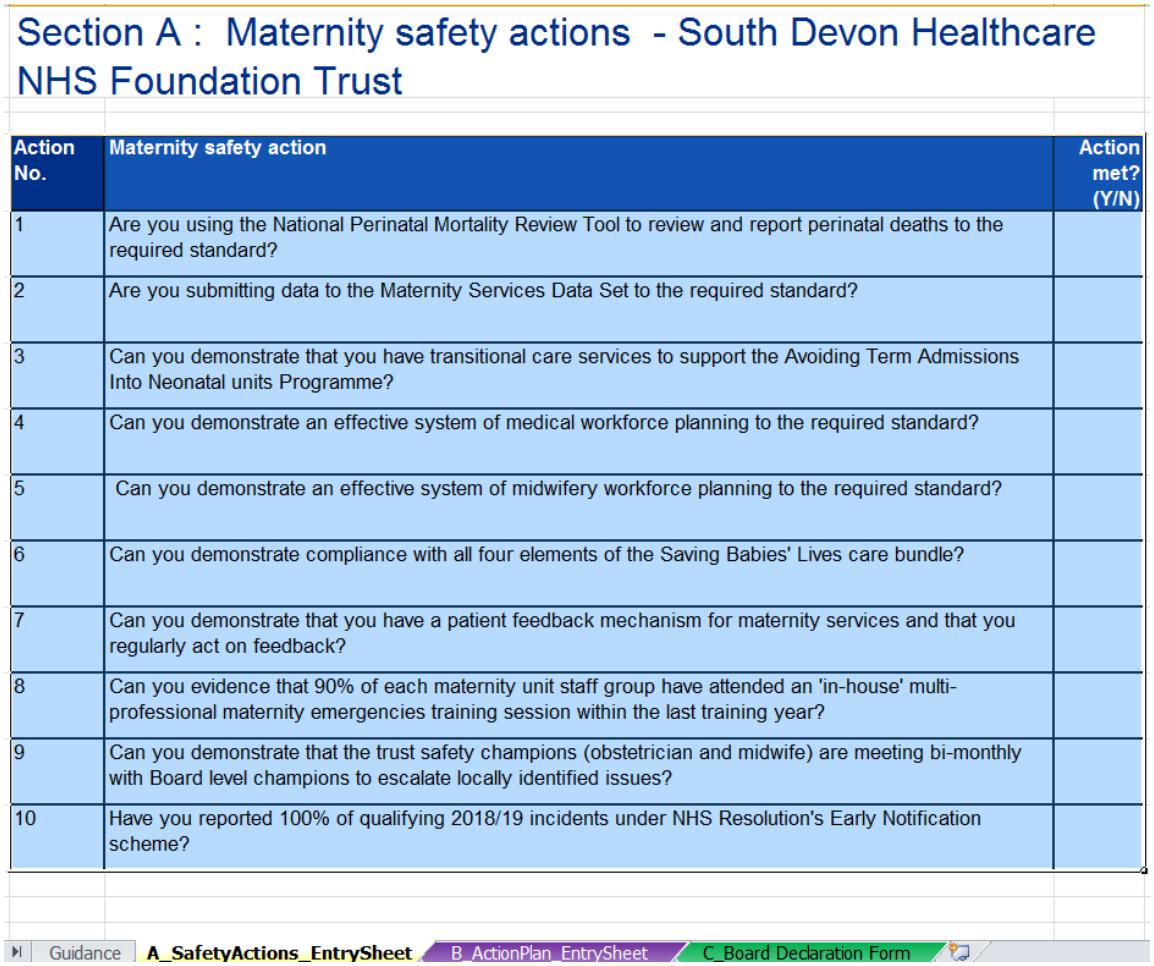
Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

Guidance | A_SafetyActions_EntrySheet | B_ActionPlan_EntrySheet | C_Board Declaration Form

Tab 2: Safety Actions Entry Sheet

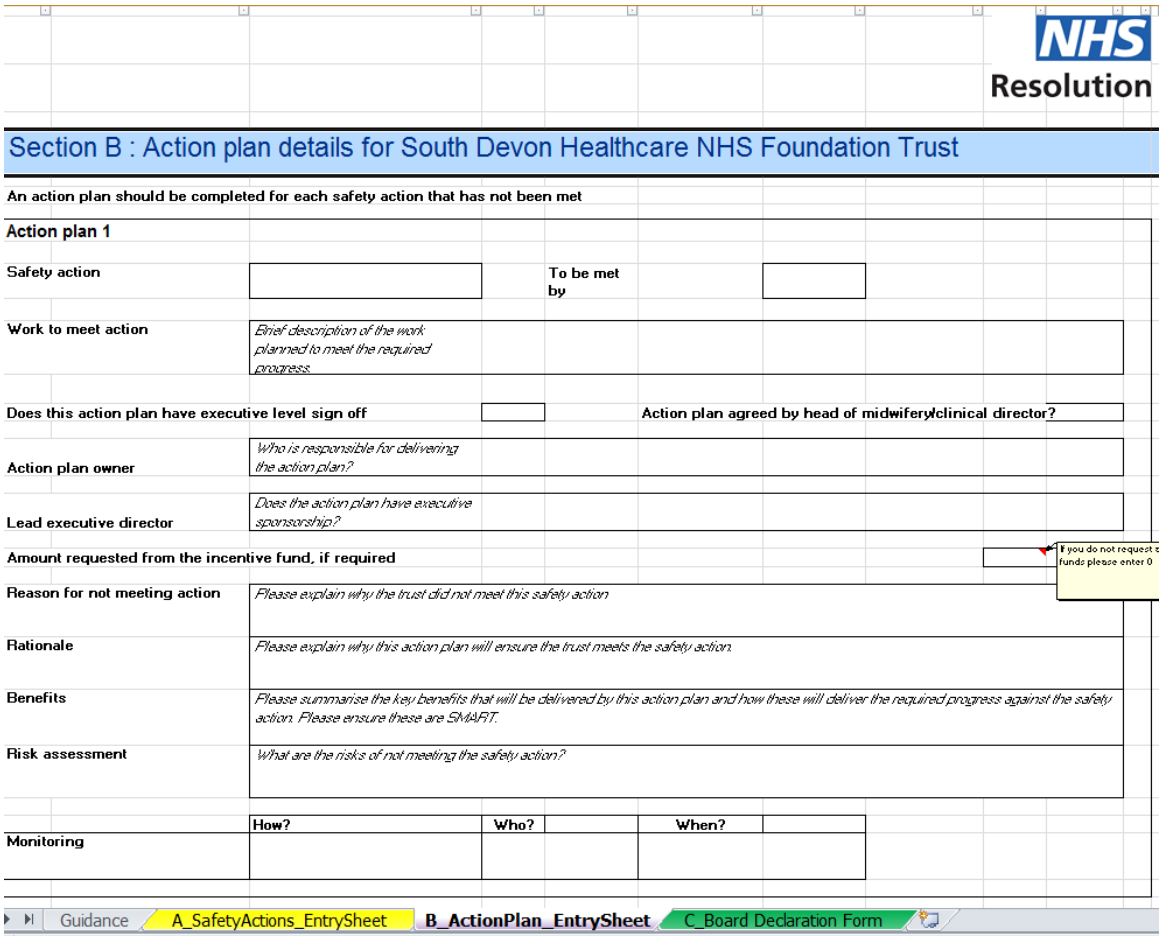


Section A : Maternity safety actions - South Devon Healthcare NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set to the required standard?	
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	

Guidance | A_SafetyActions_EntrySheet | B_ActionPlan_EntrySheet | C_Board Declaration Form

Tab 3: Action Plan Entry Sheet



NHS Resolution

Section B : Action plan details for South Devon Healthcare NHS Foundation Trust

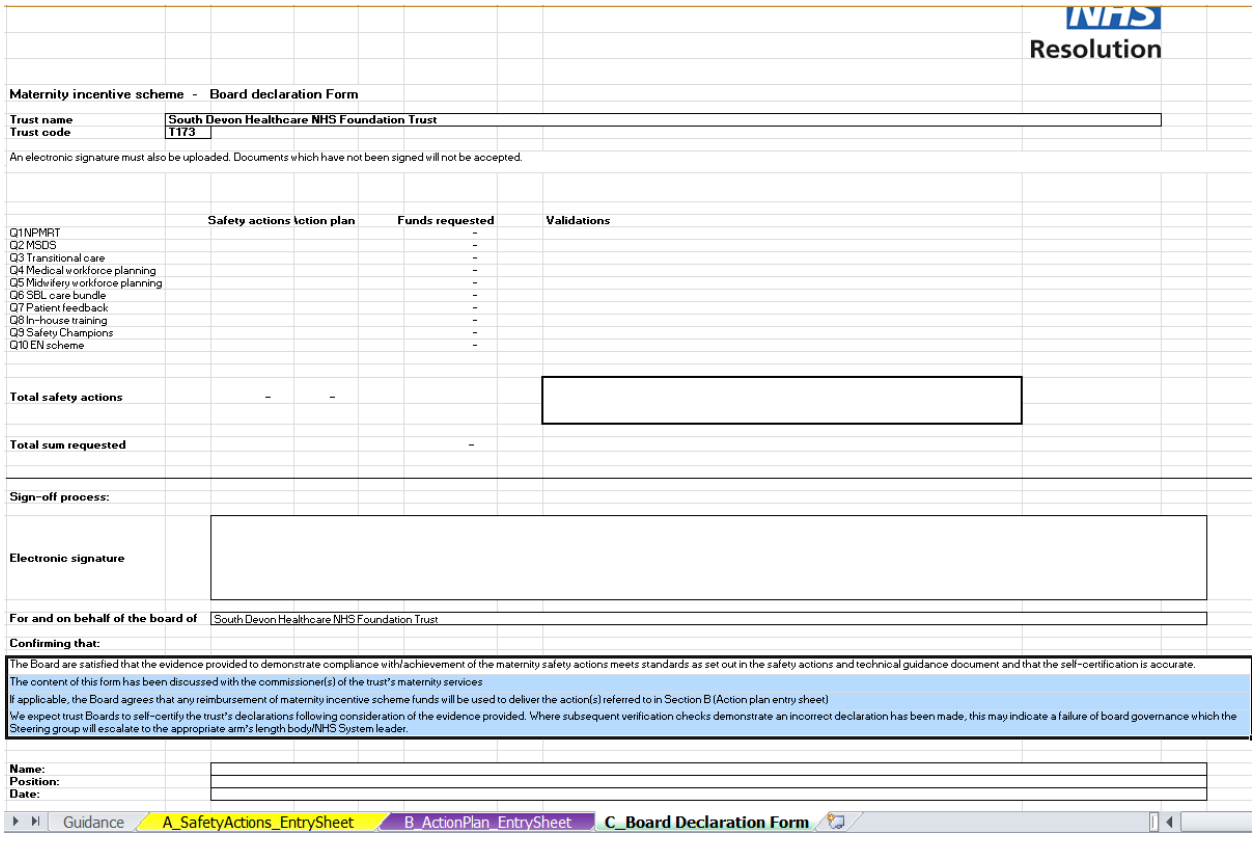
An action plan should be completed for each safety action that has not been met

Action plan 1			
Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			If you do not request a funds please enter 0
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Guidance | A_SafetyActions_EntrySheet | B_ActionPlan_EntrySheet | C_Board Declaration Form

Tab 4: Board Declaration Form



NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name	**South Devon Healthcare NHS Foundation Trust**
Trust code	**T173**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	**ction plan**	**Funds requested**	**Validations**
Q1 NPMRT			-	
Q2 MSDS			-	
Q3 Transitional care			-	
Q4 Medical workforce planning			-	
Q5 Midwifery workforce planning			-	
Q6 SBL care bundle			-	
Q7 Patient feedback			-	
Q8 In-house training			-	
Q9 Safety Champions			-	
Q10 EN scheme			-	
Total safety actions	-	-		
Total sum requested			-	

Sign-off process:

Electronic signature	
For and on behalf of the board of	South Devon Healthcare NHS Foundation Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

Guidance | A_SafetyActions_EntrySheet | B_ActionPlan_EntrySheet | C_Board Declaration Form

Appendix 2 – Maternity Mandatory Training Position as of 30 July 2019.

2019 Training Database Overview

Training day/session	Total staff eligible to attend	Total Midwives eligible	Total MCA's eligible	Total Obstetricians eligible	Total staff attended	Total Midwives attended	Total MCA's attended	Total Obstetricians attended	% staff attended	% of Midwives attended	% of MCA's attended	% of Obstetricians attended
Obstetric Update Day	164.0	115.0	30.0	19.0	158.0	107.0	29.0	18.0	96.3	93.0	96.7	94.7
Electronic CTG e-learning	127.0	108.0		19.0	119.0	100.0		19.0	93.7	92.6		100.0
Anaesthetics & Theatre Staff	31.0				29.0				93.5			

Trust Board meeting			
Report title: Midwifery Staffing Report			**Meeting date:** 7 August 2019
Report appendix	Appendix 1: June Midwifery Staffing Report		
Report sponsor	Chief Nurse		
Report author	Rachael Glasson, Head of Midwifery and Gynaecology		
Report provenance			
Purpose of the report and key issues for consideration/decision	There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through regular meeting between the Chief Nurse and the Head of Midwifery and though inclusion in the overall Chief Nurse staffing reports that are taken to the Board. Since September 2018, the maternity service produces a monthly report summarising the staffing establishment, sickness rates, red flag issues, escalation and actions. A copy of this is sent to the Chief Nurse. The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 2, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows: a) A systematic, evidence based process to calculate midwifery staffing establishment has been done b) The obstetric unit midwifery labour ward co-ordinator has supernumerary status (defined as having no caseload of their own during a shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour d) A bi-annual report that covers staffing / safety issues is submitted to the Board. This report covers the time period January 2019 to June 2019 and details compliance with the above standards.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	For the maternity service to continue to monitor midwifery staffing on a monthly basis and ensure meeting the recommendation set out by NHS Resolution That the Board receives and notes the report.		

Summary of key elements	
Strategic objectives supported by this report	

Safe, quality care and best experience	√	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	√

Is this on the Trust's Board Assurance Framework and/or Risk Register			
Board Assurance Framework		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks			
Care Quality Commission	√	**Terms of Authorisation**	
NHS Improvement	√	**Legislation**	
NHS England	√	**National policy/guidance**	√

Maternity Governance Safety Report		Date 7 August 2019
Report sponsor	Jane Viner, Chief Nurse	
Report author	Rachael Glasson, Head of Midwifery and Gynaecology	

1.0 Introduction

There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through regular meeting between the Chief Nurse and the Head of Midwifery and though inclusion in the overall Chief Nurse staffing reports that are taken to the Board.

Since September 2018, the maternity service produces a monthly report summarising the staffing establishment, sickness rates, red flag issues, escalation and actions. A copy of this is sent to the Chief Nurse.

NHS Resolution, published details of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 2, in late November 2018. This set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

(a) A systematic, evidence based process to calculate midwifery staffing establishment has been done

(b) The obstetric unit midwifery labour ward co-ordinator has supernumerary status (defined as having no caseload of their own during a shift) to enable oversight of all birth activity in the service

(c) Women receive one-to-one care in labour

(d) A bi-annual report that covers staffing / safety issues is submitted to the Board.

This report covers the time period January 2019 to June 2019 and details compliance with the above standards.

2.0 Midwifery Staffing Calculations (a)

NICE, Safe Midwifery Staffing for Maternity Settings (2015) recommend the use of the Birthrate Plus ® Workforce Planning Methodology Tool, along with the Birthrate Plus ® Intrapartum Tool.

During the latter part of 2017, the maternity service underwent a Birthrate Plus ® assessment. The initial findings were that there were no significant recommendations regarding variations to the establishment. This outcome was reported to the Board.

In June 2018 the final report received demonstrated that the existing midwifery establishment was set at the right level for the activity at that time. It noted that the midwifery establishment was 1.18wte over, whilst the support worker role was 1.65wte under established. This resulted in a -0.47 variance. During August 2018,

there had been no significant changes to the midwifery activity and therefore the service took the opportunity to undertake further skill mixing and 1wte midwifery post was converted to a 1.4wte support worker role. This meant that the establishment now matched the recommendations set out within the Birthrate Plus ® report.

In December 2018, the maternity service began to use the Birthrate Plus ® Intrapartum Tool in the trial format, with a view to rolling this out in the Spring of 2019. The tool moved from trial format to real-time data on 1 April 2019. This has enabled electronic monitoring of the acuity of women in our care, monitors supernumerary status and captures red flag incidents, including one-to-one care.

The senior midwifery team review the midwifery establishment on a monthly basis. This enables the team to identify any potential issues arising in the future and enables them to put contingencies into place.

3.0 Labour Ward (Delivery Suite) Co-ordinator Supernumerary Status (b)

Our maternity staffing document sets out that the delivery suite co-ordinator is a supernumerary role. Until the implementation of Birthrate Plus ® Intrapartum Acuity Tool it was not possible to capture data in relation to the supernumerary status. From the 1 April 2019 the delivery suite co-ordinators have been recording any instances where they have been unable to have supernumerary status.

2019	Instances where delivery suite co-ordinator is not supernumerary	Commentary
April	0	
May	2	The first instance was due to high acuity. The co-ordinator worked in a non-supernumerary capacity for a short period of time. The second instance was due to high acuity and unexpected staff absence. A number of actions were taken, which included the delivery suite co-ordinator overseeing staff working in a supernumerary role.
June	13	7 of the instances were single points in time, rather than whole shifts. Actions were taken to return the co-ordinator to supernumerary status as soon as was possible. There were no red flags during these instances. 6 of the instances related to 2 particular shifts. The first shift had an acuity of -1.65. One vacant shift had not been filled, however the escalation midwife was utilised. There was also no Maternity Care Assistant on duty and it was not possible to fill this shift. The co-ordinator was caring for postnatal women and not women in labour who require one-to-one care. The second occasion also had a vacant

		shift not filled. The acuity ranged from -1.45 to -0.20. The co-ordinator was overseeing a third year student midwife providing care in labour. On both of these occasions women did not receive 121 care in labour for short periods of time (red flag event).

Table 1: Summary of Delivery Suite Co-ordinator Supernumerary Status

During the three month period there were 15 instances out of 546 recording points. This equates to 2.7%. For all instances where the co-ordinator was not in a supernumerary capacity, this had not been the intention for that shift. Our midwifery establishment is set to enable the co-ordinator to be supernumerary and this is supported by our maternity staffing document.

For each shift, the co-ordinator will assess the workload and allocate staff accordingly. The service has a clear escalation plan and the co-ordinator has a number of actions that they can take at times of high acuity or if there is unexpected staff absence. Taking over the care of a woman on delivery suite is one of the last actions that the co-ordinator will do, however they will weigh up the balance of risk in taking this action. Should they deem this necessary, they will care for women who have low acuity, such as a postnatal woman and have minimal care requirements, to release a midwife to care for a woman who has higher acuity. This enables them to maintain their helicopter view of the maternity service. The co-ordinator will return to supernumerary status at her earliest opportunity.

June was an extremely busy month. The number of births was higher than average, plus the complexity of women appeared to be very high. At the same time, we saw a significant rise in the sickness rate for midwives. This was due to a variety of factors. This resulted in a number of shifts falling below the minimum recommended levels. However on the whole, the co-ordinator not being supernumerary coincided with high acuity rather than shift number below recommended level. With the exception of two instances, the co-ordinator was able to return to her supernumerary status as soon as was practicable.

From June, we have agreed that the matrons will review the acuity tool on a weekly basis and provide the Head of Midwifery & Gynaecology with a report outlining any instances where the co-ordinator is not supernumerary. They have been liaising with the co-ordinator to review the circumstances for the non-supernumerary period and identify if any actions are required as a result.

This will continue to be monitored and reported in the monthly staffing report. See appendix 1 for example of staffing report – June 2019.

4.0 Women receiving one-to-one care in labour (c)

The maternity service previously captured the number of women receiving one-to-one care in labour at four set points throughout a 24 hour period, every day. Since January 2019, we have changed how we monitored this KPI. Rather than points in time, it is now completed for each woman and recorded on the STORK maternity

system. This has improved data accuracy and as such we have noted a small dip in performance. This data is monitored and is one of the maternity specific questions on the QUESTT tool. The aim is to achieve 100%.

Time period	%
Jan 2019	97
Feb 2019	98
Mar 2019	96
Apr 2019	96
May 2019	95
Jun 2019	96

Table 2: Percentage of women receiving one-to-one care in labour.

The maternity service works extremely hard to ensure this standard is met as can be seen in Table 2. Over the six month time period, this equates to approximately 8 women per month not receiving one-to-one care in labour. However this raw data does not tell us for how long that woman did not receive on-to-one care. Anecdotally midwives report that this is usually for short periods of time, where they may be required to provide care for another woman whilst additional midwifery staffing is sought. As a senior team we are assured that one-to-one care is prioritised and action is taken to remedy the situation as soon as practically possible

5.0 Bi-annual report (d)

Prior to the CNST maternity incentive standards being published in November 2018, the maternity service had taken the decision to complete a monthly staffing report, which would be shared with all maternity staff team members. This was to ensure that staffing levels were closely monitored by the leadership team and that it provided transparency for the team and assurance that staffing was being monitored and actions taken. Appendix 1 provides an example of this report (June 2019).

Maternity staffing has previously been reported within the Chief Nurse Nursing Staffing Report. However, given the standards set by NHS Resolution, it has been decided to separate the midwifery report from the main nursing report.

This is the second specific maternity report, The biannual report will be completed 6 monthly, with the next report being due in January 2020.

6.0 Midwife:Birth Ratio

The midwife to birth ratio is calculated by dividing the total number of births by the whole-time equivalent number of midwives. The current national recommendation is a ratio of 1:28 midwives. It can be measured in two ways, firstly the total number of midwives excluding the Head of Midwifery (HOM) over the year's births. When calculated in this manner, the Midwife:Birth ratio at Torbay and South Devon (TSD) is **1:28.**

However, on a monthly basis, TSD are required to submit the Midwife:Birth ratio to NHSE South West to form part of the South West Maternity Network Dashboard. A standardised calculation is undertaken, which uses the current month's births and the whole-time midwifery establishment, excluding the HOM, midwifery matrons and specialist midwives. Table 3 details the Midwife:Birth Ratio that has been reported between January and June 2019.

Time period	Midwife:Birth Ratio
Jan 2019	1:29
Feb 2019	1:26
Mar 2019	1:30
Apr 2019	1:23
May 2019	1:27
Jun 2019	1:29

Table 3: Midwife:Birth ratio (exc. HOM, matrons and specialist roles)

7.0 Red flags

NICE guidance identifies a number of events that can be viewed as red flags. These are signs that there may not be enough midwives available. They identified 9 events, whilst locally we have added a further flag (denoted with an *).

- Activities that need to be done on time are delayed or cancelled.
- After giving birth, a woman has to wait for 60 minutes or more before she is washed or given stitches, if she needs them.
- A woman does not get the medicines she needs when she's been admitted to a hospital or a midwifery-led maternity unit.
- A woman has to wait 30 minutes or more to get pain relief when she's been admitted to a hospital maternity unit or a midwifery-led maternity unit.
- A woman who is in labour or who has a problem needing midwife care has to wait 30 minutes or more for assessment after the midwife has been alerted.
- A woman is not given a full examination when she reports she is in labour.
- There is a delay of 2 hours or more between coming in for an induction and the induction being started.
- Delays in spotting and acting on signs that the woman may have a serious health problem
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman in established labour
- Unable to provide an out of hospital birth when requested*

Red flags had started to be recorded in the latter part of 2018 via datix, however this was not a reliable source of capturing this data. From January 2019, a trial was undertaken capturing the data using the Birthrate Plus ® Acuity Tool. Following full implementation of the tool on 1 April 2019, it is now been possible to record red flag events and the action taken in response to these. Details of the red flags for the period April to Jun 2019 are detailed in table 4 overleaf.

Red flag	Descriptor	Incidence					
		Jan	Feb	Mar	Apr	May	Jun
RF1	Delayed or cancelled time critical activity				0	0	**1**
RF2	Missed or delayed care				0	**1**	**4**
RF3	Missed medication				0	0	0
RF4	Delay in providing pain relief				0	0	0
RF5	Delay between presentation and assessment				0	0	0
RF6	Full clinical examination not carried out when presentation in labour				0	0	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process				0	**1**	**3**
RF8	Delayed recognition of and action on abnormal vital signs				0	0	0
RF9	121 care in labour				0	0	**2**
RF10	Unable to facilitate out of hospital birth				0	0	**2**

Table 4: Midwifery Red Flag Events

The use of the acuity tool now enables us to track when red flags occur. See chart 1 overleaf for example of acuity data. From our analysis of the system, it can be seen that at times of high acuity the number of red flag events increase. The matrons review any red flag events with the co-ordinator, using the same process as the supernumerary status.

The level of red flags in June does correlate with how busy the unit was, however for all of the red flag instances a conscious decision was made to trigger the red flag to ensure safety across the whole service was maintained. None of the instances were due to omissions or lapses in care.

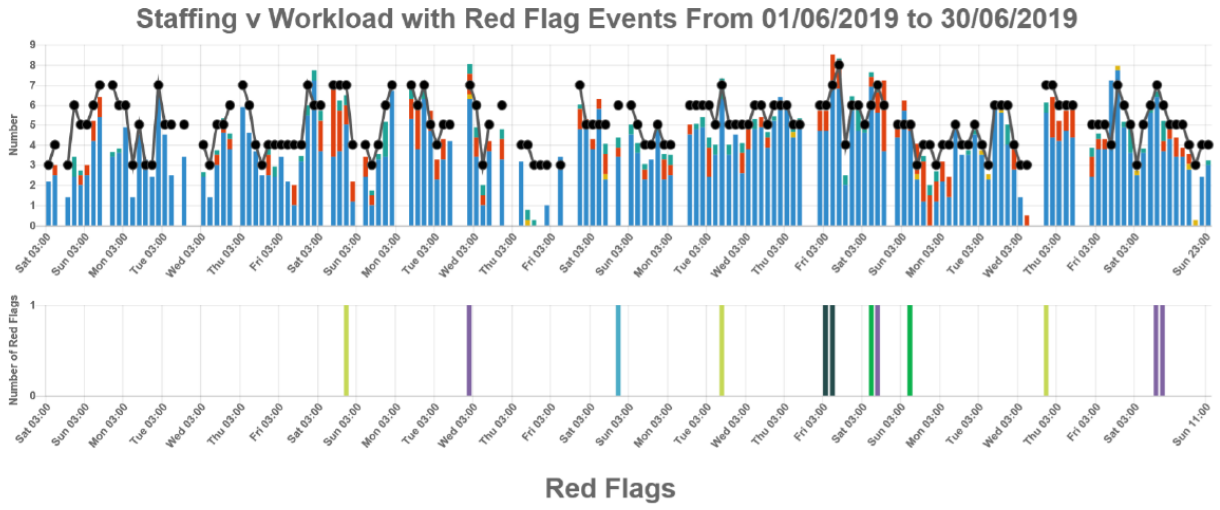


Chart 1: Staffing v Workload with Red Flag Events Example

8.0 Sickness

During the six month reporting period there had been a gradual reduction in level of absence due to sickness, however in June we noted an increase. The leadership team work proactively with the Human Resources department and staff members to support them to return to work as soon as they are fit to do so. This is monitored with our monthly staffing report, which can identify specific areas within the maternity service that may require additional support. This is also shared with staff.

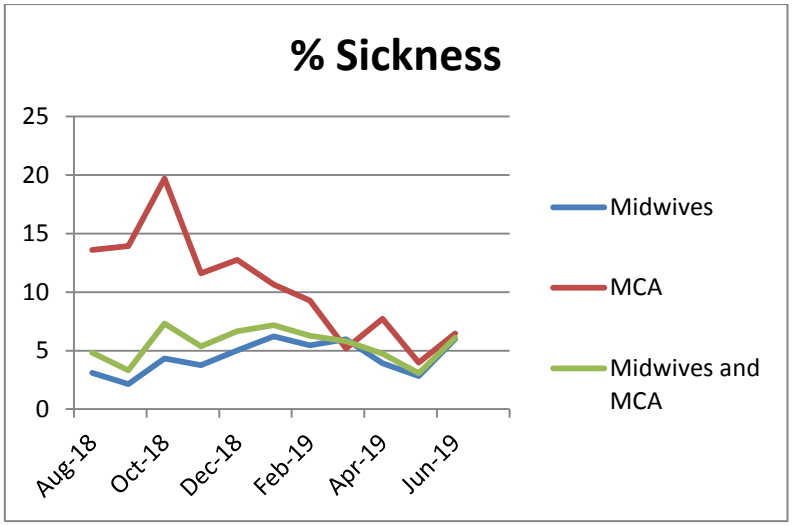


Table 5: Midwifery Sickness Percentage

9.0 Escalation

The maternity service has a clear escalation process for when demand exceeds capacity. This includes the use of an escalation on-call midwife outside of core working hours. This is monitored through the monthly staffing reports.

Time period	No. of Times Escalation Midwife Used
Jan 2019	3
Feb 2019	3
Mar 2019	4
Apr 2019	0
May 2019	1
Jun 2019	9

Table 6: Summary of escalation midwife usage

10.0 Conclusion

The midwifery staffing establishment is set at the right level, enabling effective deployment of staff across the service. This is monitored closely by the leadership team, who have instigated a monthly reporting system to enable this monitoring and improve assurance.

During the 6 month reporting period staffing levels were noted to be improving as sickness levels had reduced. However during June, it was noted to have increased. In addition June was an extremely busy month. This resulted in an increase in the number of red flag incidents.

We have a robust escalation process in place, which was utilised as needed. The introduction of the Acuity Tool has enabled closer monitoring of KPIs and review of any actions required. It has also enabled the data to be shared in a visual way with staff members.

11.0 Recommendations

For the maternity service to continue to monitor midwifery staffing on a monthly basis and ensure it is meeting the recommendation set out by NHS Resolution

That the Board receives and notes the report.

Appendix 1: June Maternity Staffing Report

Obstetrics and Gynaecology

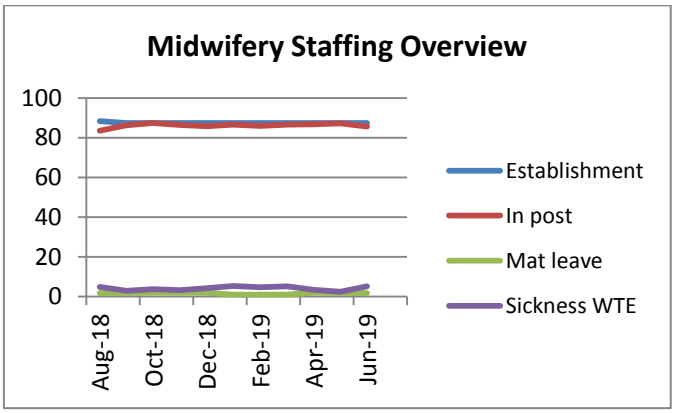
Maternity Staffing Report June 2019 | Finalised: 24/07/2019

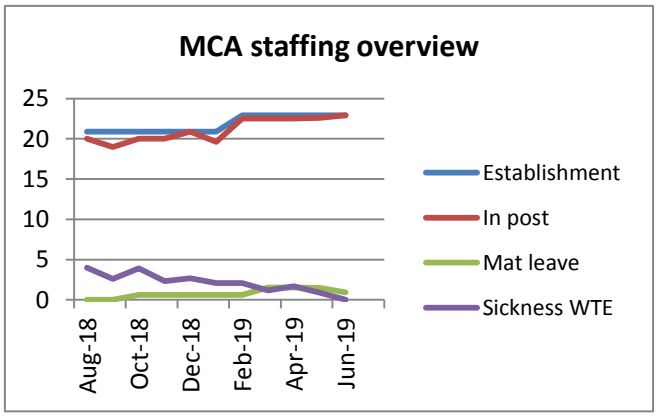
Author: Rachael Glasson & Jo Blackler

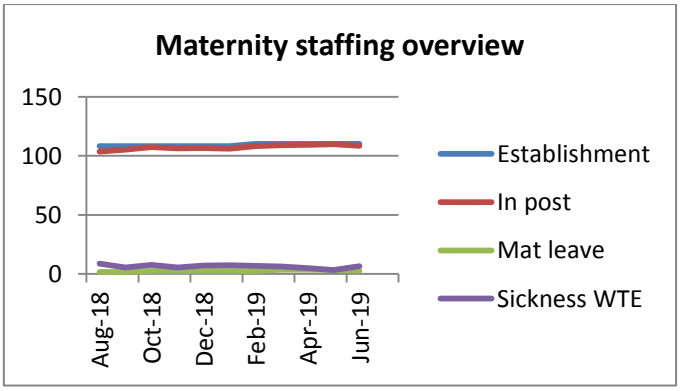
Torbay and South Devon NHS Foundation Trust

1. Summary position

Summary								
April 2019		**Establish-ment**	**In post**	**Mat leave**	**Mat leave cover**	**Sickness**		**Non-clinical duties**
						%	WTE	
Registered	Midwives	87.3	85.6	1.8	2.0	6.0	5.1	0
Trained non-registered	MCA	22.9	22.9	0.92	0.92	6.5	1.5	0
Total		**110.2**	**108.5**	**2.72**	**2.92**	6.1	6.6	**0**

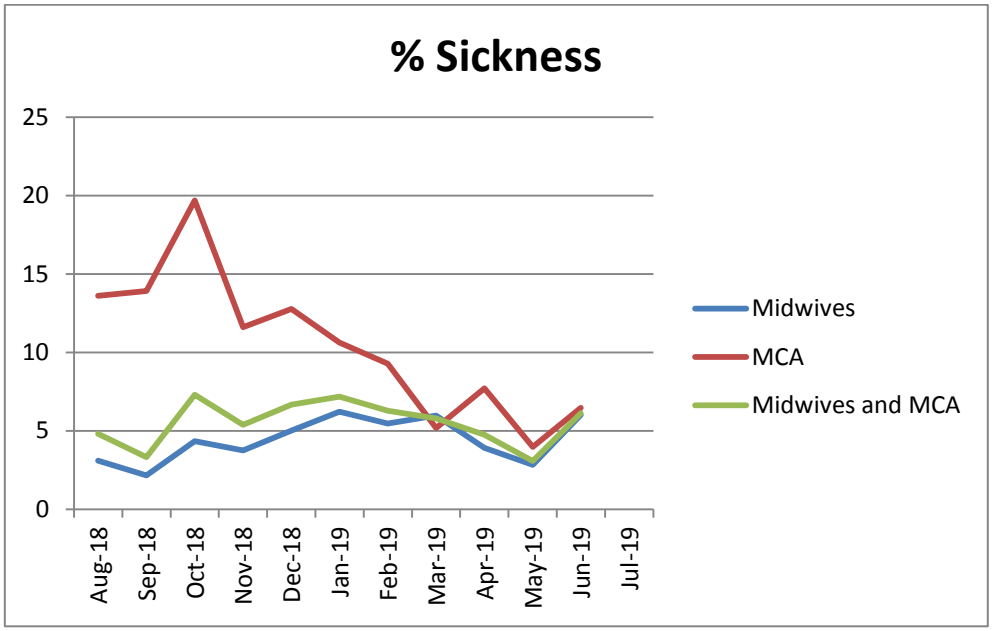






2. Break down of sickness by area and staff group

Team	Staff group	Hours	Episodes	Sickness days	Sickness hours	%
Meridian	Midwives	4826.71	5	67	287.8	5.96
	MCAs	2240.69	2	40	203	9.06
Coastal	Midwives	1269.64	2	16	75	5.91
	MCAs	225	1	5	22.5	10
Waterside	Midwives	1398.21	0	0	0	0
	MCAs	160.71	0	0	0	0
Riviera	Midwives	1623.21	3	33	120	7.39
	MCAs	176.79	0	0	0	0
Torview	Midwives	1328.57	2	58	234	17.61
	MCAs	504.64	0	0	0	0
Templer	Midwives	1366.07	4	36	105	7.69
	MCAs	8.036	0	0	0	0
ANC + Sp. MW	Midwives	642.79	0	0	0	0
	MCAs	401.79	1	2	15	3.73
Specialist & Management	Midwives	1215	0	0	0	0
Total	Midwives	13,670.20	16.00	210.00	821.80	6.01
	MCAs	3717.656	4	47	240.5	6.47
	Total	**17387.86**	**20**	**257**	**1062.3**	6.11

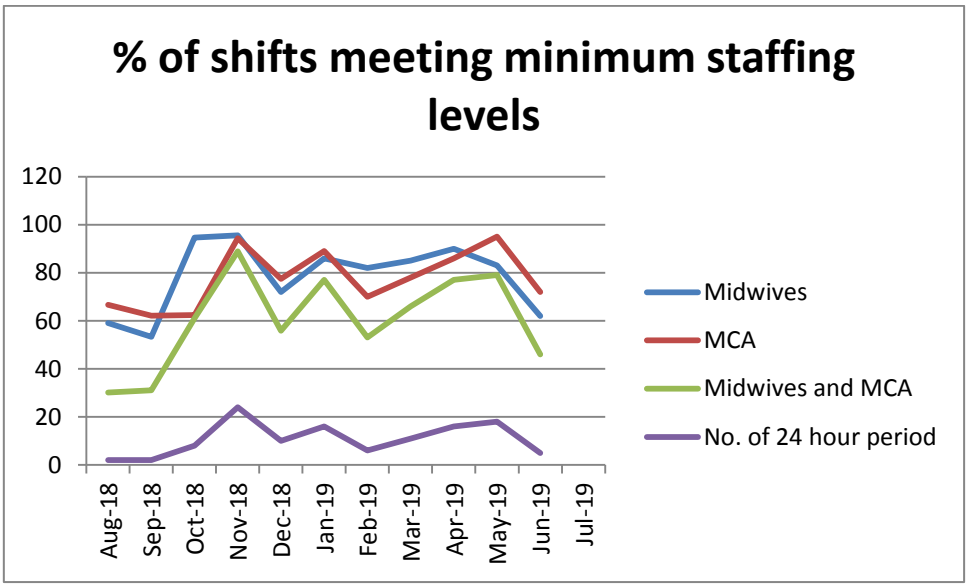


3. Staffing levels

Minimum staffing requirements:

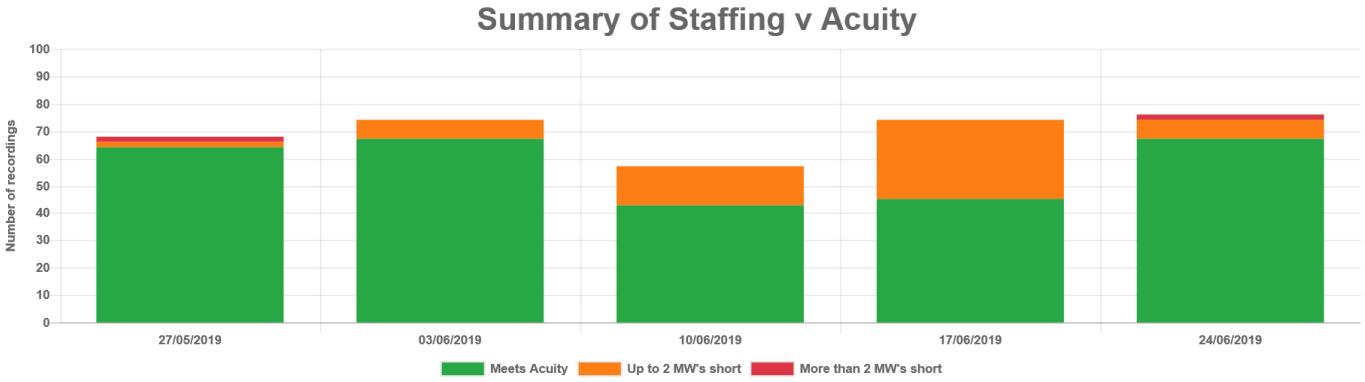
- 9 Midwives per shift (3 shifts per day)
- 3 MCA on early and late
- 2 MCA on night

June 2019		Midwives	No of midwifery shifts			MCA	No of MCA shifts		
	Total shifts	No of shifts <9	8	7	6	No of shifts <min	2 (day) 1 (night)	1	0
WC 27.5.19	6	1	1	0	0	4	4	0	0
WC 03.6.19	21	4	3	1	0	4	4	0	0
WC 10.6.19	21	6	6	0	0	2	2	0	0
WC 17.6.19	21	11	6	5	0	9	7	2	0
WC 24.6.19	21	12	10	2	0	9	6	3	0
Total	90	34	26	8	0	28	23	5	0
		38%				31%			
Summary		41/90 shifts with minimum staffing levels for MCA and midwives met (46%). 5 days in June with minimum staffing levels in place for 24 hour period.							



4. Acuity Tool Data

Reviewing the acuity tool identifies that 1% of shifts were recorded as having staffing levels more than two midwives short, 17% of shifts where staffing levels were up to 2 midwives short and 82% where staffing levels met the acuity level.

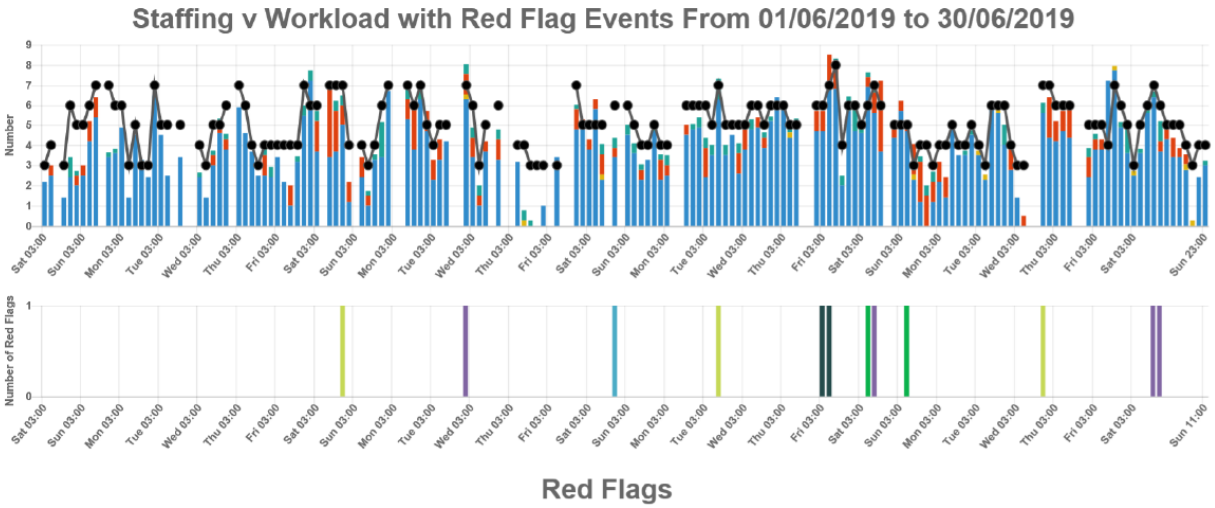


The tool records the actions taken to overcome shortfalls, including staffing, clinical and management factors.

5. Red flags

During June we had 12 red flag events reported.

Red flag	Descriptor	Incidence
RF1	Delayed or cancelled time critical activity	1
RF2	Missed or delayed care	4
RF3	Missed medication	0
RF4	Delay in providing pain relief	0
RF5	Delay between presentation and assessment	0
RF6	Full clinical examination not carried out when presentation in labour	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	3
RF8	Delayed recognition of and action on abnormal vital signs	0
RF9	121 care in labour	2
RF10	Unable to facilitate out of hospital birth	2



It can be seen that in the majority of instances that red flag events occurred at times of high acuity. It has been agreed that the matrons will review the acuity tool on a weekly basis,

identifying why any red flag events occurred and determining if any additional actions need to be considered.

6. Escalation

During June the escalation midwife was required on 9 occasions. The time required ranges from 60 minutes to 10 hours with the average length being 4 ½ hours. 4/9 shifts met the minimum staffing requirements and were required due to how busy the unit was. The remaining 5 shifts had 8 midwives on duty, with 4/5 shift being described as very busy.

7. Delivery Suite Co-ordinator has supernumerary status

Our establishment is set so that there are 8 midwives on duty each shift in addition to the delivery suite co-ordinator who has supernumerary status. This means that the co-ordinator must not be the primary care giver to a woman.

During June there were 13 instances recorded on the acuity tool where the delivery suite co-ordinator was not supernumerary. 7 of the instances were single points in time, rather than whole shifts. Actions were taken to return the co-ordinator to supernumerary status as soon as was possible. There were no red flags during these instances. 6 of the instances related to 2 particular shifts. The first shift had an acuity of -1.65. One vacant shift had not been filled, however the escalation midwife was utilised. There was also no Maternity Care Assistant on duty and it was not possible to fill this shift. The co-ordinator was caring for postnatal women and not women in labour who require one-to-one care. The second occasion also had a vacant shift not filled. The acuity ranged from -1.45 to -0.20. The co-ordinator was overseeing a third year student midwife providing care in labour. On both of these occasions women did not receive 121 care in labour for short periods of time.

8. One-to-one care in labour

All women in active labour should receive one-to-one care.

During June 96% women are recorded as receiving one-to-one care in labour.

It is a part of the ethos of our service to achieve this important standard, with our aim to achieve 100% compliance. Use of the intrapartum acuity tool enables us to review the activity to determine why this has not been achieved. The delivery suite co-ordinator will prioritise ensuring that women receive one-to-one care in labour and will minimise the length of time that midwives are not able to provide one-to-one care. This will mean re-allocation of workload, or identification of additional staff to work on delivery suite. During this time period, there were two red flag signifying that women had not received 121 care during that time period. These are outlined in section 7.

9. Midwife : Birth Ratio

It is recommended that an overall birth ratio of 1 midwife to 28 women should in place within maternity services. Overall as a maternity service our ratio is 1:28. This is dividing the total establishment of midwives working in clinical roles by the annual birth rate.

On a monthly basis, we report the midwife to birth ratio to the South West Network dashboard. This is calculated by dividing the monthly birth figures by the total establishment of midwives working in clinical roles.

For June, this was 1:29 as the number of births exceeded our monthly average.

10. Commentary

June has been an extremely busy month. The number of births was higher than average, plus the complexity of women appeared to be very high. At the same time, we saw a significant rise in the sickness rate for midwives. This is due to a variety of factors. This resulted in a number of shifts falling below the minimum recommended levels. These factors subsequently impacted on the number of red flags reported during June.

There was a tremendous all-round team effort witnessed to ensure that women continued to receive the safest care possible. The medical staff, MCAs and admin team fully supported the midwives during this time period. All staff went above and beyond.

The number of births for July is also predicted to be high and the level of sickness is not anticipated to reduce at this time. The senior team have considered how the risk can be mitigated. We also began our planning for the summer break. We do not plan any mandatory training days for August, however we recognised that staff may be attending other training such as Terema. We have postponed attendance until a later date in instances such as these. We have also cancelled the senior midwives meeting in August, with a plan to hold the meeting 'virtually'. We have also released know gaps to the bank well in advance to give staff opportunity to check if they can cover.

We completed a series of recruitment processes to ensure that all anticipated gaps / vacancies were filled. However due to a number of posts being internal moves, we have identified that we will have some short-term gaps during September. We are currently planning how this can be overcome.

11. Actions

- Monthly staffing report to be shared with the Chief Nurse, Torbay System Director of Nursing and Associate Director of Operations for Torquay Integrated Service Unit.
- Complete and submit 6 monthly midwifery staffing levels report for the Board
- Continue to robustly manage sickness
- Continue to monitor staffing levels, ensuring all actions possible have been taken to meet minimum staffing levels
- Continue to plan for August and September.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board			**Appendix 4**
Report title: Obstetric Anaesthesia Workforce Report			Meeting date: 7 August 2019
Report appendix	n/a		
Report sponsor	Medical Director (Maternity Safety Champion)		
Report author	Richard Hughes, Consultant Anaesthetic Lead for Maternity & Rachael Glasson, Head of Midwifery and Gynaecology		
Report provenance	The content of this report provides a benchmarking of Anaesthetic Clinical Services Accreditation as required by NHS Resolution		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide the membership of the Trust Board with a self-assessment of the standards set out in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 2 in relation to obstetric anaesthesia workforce. CNST standards require that the Board minutes formally record the proportion of ACSA standards met. In the future this report will become an Appendix to the Maternity Safety Report		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note the Obstetric Anaesthetic staffing report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	12
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Report title: Obstetric Anaesthesia Workforce Report		**Meeting date:** 7 August 2019
Report sponsor	Medical Director (Maternity Safety Champion)	
Report author	Richard Hughes, Consultant Anaesthetic Lead for Maternity & Rachael Glasson, Head of Midwifery and Gynaecology	

1.0 Introduction

NHS Resolution is operating it second year of the Clinical Negligence Scheme for Trusts (CNST) maternity scheme to continue to support the delivery of safer maternity care. This requires Trusts to undertake 10 safety actions.
Safety Action 4 requires Trusts to:

> demonstrate an effective system of medical workforce planning to the required standard'. One element is an action plan in place and agreed at Board level to meet Anaesthetic Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. Board Minutes should formally record the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met.

2.0 CNST ACSA Standards Benchmarking

Standard		Benchmark
1.2.4.6	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	In place
2.6.5.1	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident	In place
2.6.5.6	The duty anaesthetist for obstetrics should participate in labour ward rounds	In place

100% compliant with CNST required standards

3.0 Additional ACSA standards

The Trust achieved 2018 ACSA compliance, and is expecting an accreditation inspection in February 2020. There are a further 4 ACSA standards that are not currently part of the CNST requirements, but are noted within the CNST technical guidance. Standard 2.6.5.2 and 2.6.5.5 are compliant. There are two standards that are currently non-compliant.

Standard 2.6.5.3 – *'where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies'.* The wording has changed in the latest iteration of ACSA standards. This was published after the CNST technical guidance. This removes the "5 minute" definition but requires that non-obstetric work be delegated in the event of an obstetric emergency (GPAS 9.1.6). Between midnight and 8am this occurs by calling in the consultant on call from home, which may take up to 30mins. Policies describing roles and responsibilities of duty and on-call anaesthetists make it clear that obstetrics is the primary responsibility of these individuals. Therefore no further action required.

Standard 2.6.5.4 – *'medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)'*. Departmental staffing plan is for >90% labour ward and DA sessions (10 per week) to be staffed by consultant or associate specialist. This does not currently happen due to staffing shortages (estimated cover of these sessions 60-70%).

ACTION: This is being addressed through a recruitment process. Two funded full time anaesthetic consultants are starting in August/September and two further funded posts are being advertised imminently.

4.0 Conclusion

The three ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 are all in place (100%) and meet the requirements expected within CNST Safety Action 4.

There is a clear plan to ensure that all ACSA standards are met in preparation for the accreditation visit in 2020.

5.0 Recommendations

The Trust Board is asked to note the Obstetric Anaesthetic staffing report.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Mortality Surveillance Score Card			Meeting date: 7th August 2019
Report appendix	N/A		
Report sponsor	Medical Director		
Report author	Steve Carr, Patient & Experience Lead		
Report provenance	Data is taken from Hospital Episode Statistics and Dr Foster Reviewed by Executive Directors on 30th July 2019		
Purpose of the report and key issues for consideration/decision	To provide information on the mortality of patients who have used the inpatient services of the Trust and assurance on any associated risks and actions.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☒	**To approve** ☐
Recommendation	To review the information included in this report		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	Y	**Valuing our workforce**	
Improved wellbeing through partnership		**Well-led**	Y

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	N	**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS Improvement		**Legislation**	**Y**
NHS England		**National policy/guidance**	

Report title: Mortality Surveillance Score Card		Meeting date: 7th August 2019
Report sponsor	Medical Director	
Report author	Steve Carr	

1.0 Introduction & Data Source

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

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

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

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

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

Safety Indicator		Data Source	Target	RAG
Appendix 1 • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster latest benchmark Month DH SHMI data	Aim for a yearly HSMR ≤90	
Appendix 2 • Unadjusted Mortality rate		Trust Data	Yearly Average ≤3%	
Appendix 3 • Dr Foster Alerts		Dr Foster	Zero outliers / significant alerts	
Appendix 4 • Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	
Appendix 5 • Hospital Mortality		Trust Data Structured Judgement Framework M&M reviews		

2.0 Trust wide Overview

The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at T&SDFT remain within the accepted range for our population and over a prolonged period.

The latest trends continue to show the monthly trend 'as expected' and the 12-month rolling rate performing within the top third of the Southwest Hospitals. Mortality over the winter period has been lower than in previous years and read its peak in January. There are no Dr Foster outlier alerts.

3.0 Appendix 1 – Hospital Mortality (HSMR and SHMI)

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

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

1A The HSMR is based on the *Diagnosis all* Groups using the Mar 18 monthly benchmark and analysed by Relative Risk - Trend / Month

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

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

Chart 1 - HSMR by Month Dec 15 – Nov 18
Chart one (as below) shows a longitudinal monthly view of HSMR as well as highlighting the current month. The latest month's data, Mar, has a relative risk of **91.5.**

Mortality over 17/18 has been very positive and lower that the preceding years.

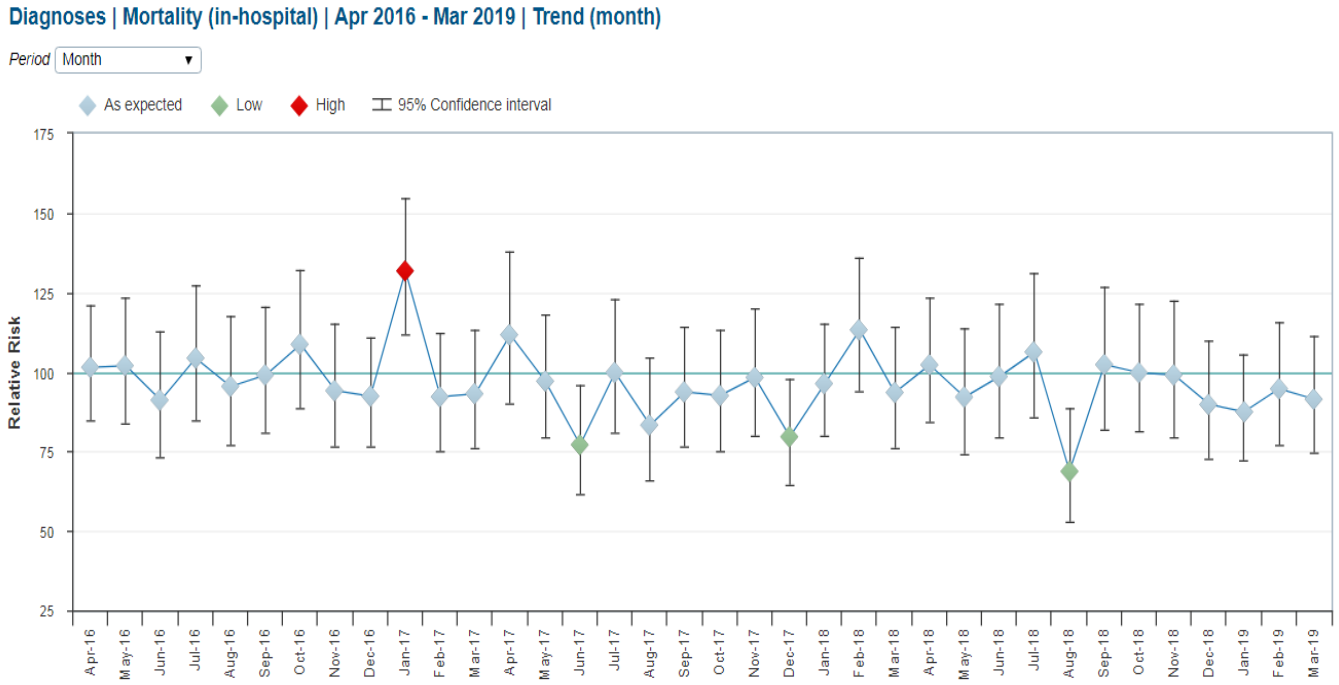


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12 month annual total – Apr 17 to Mar 19. Torbay and South Devon are in the top third performing trusts.

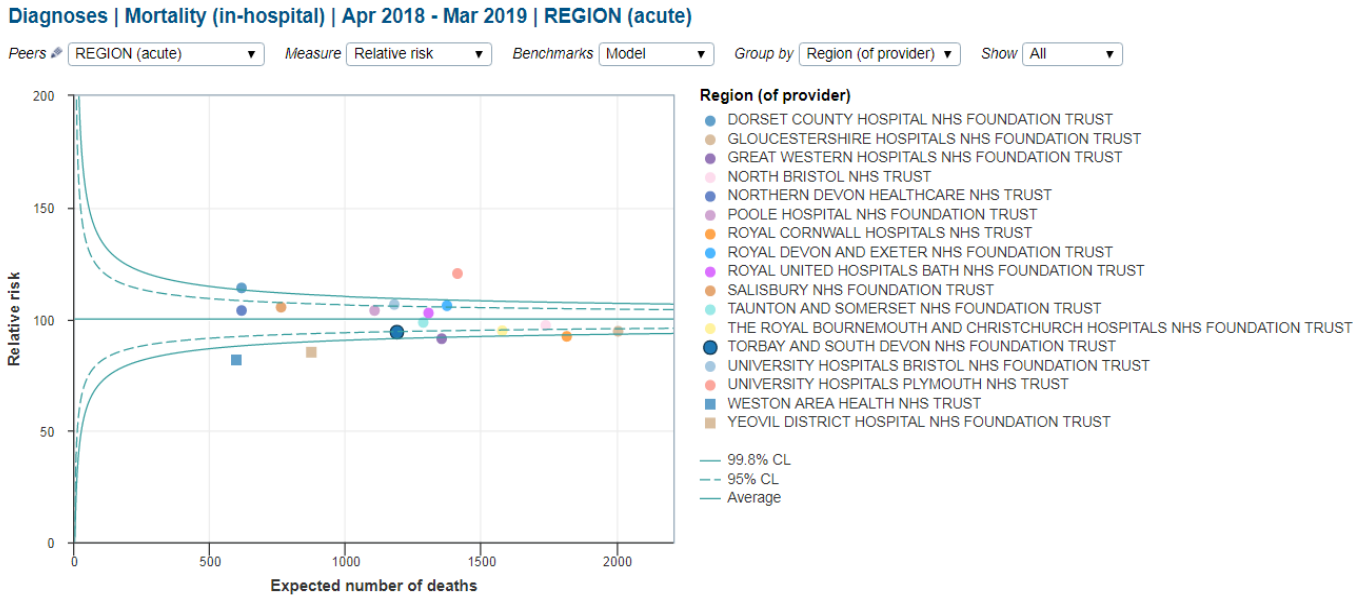
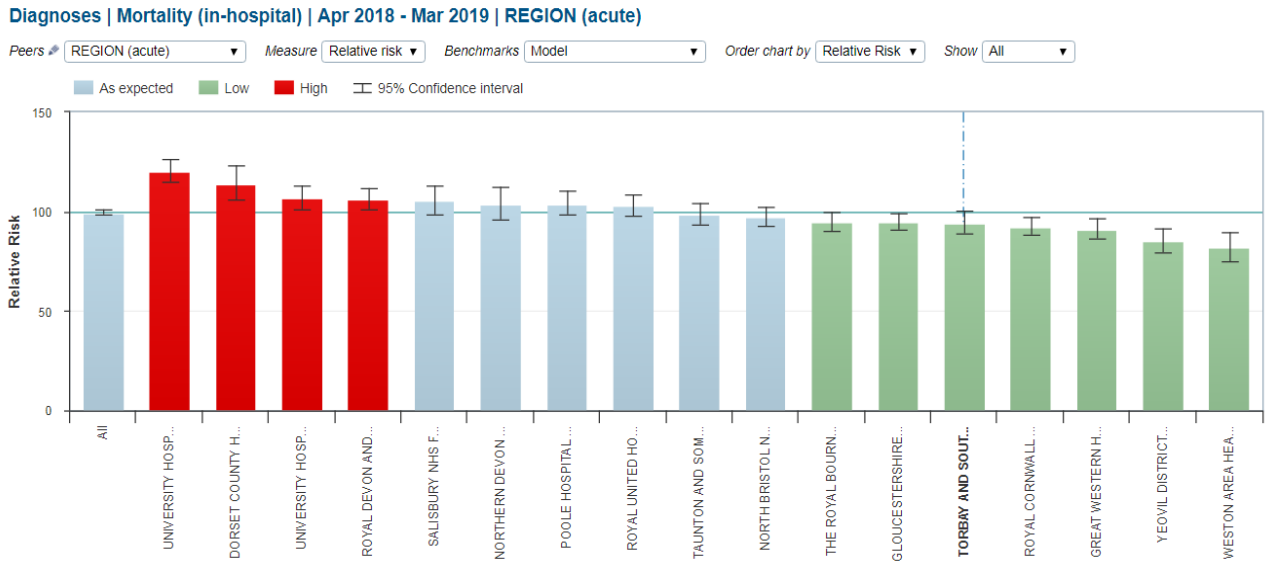


Chart 3 displays the above data as a Peer Comparison, ranked and as a bar chart. T&SDFT are within the top third



1B Summary Hospital Mortality Index (SHMI) Reporting Period Jan 2018 – Dec 2018

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective therefore, please note *the following data is based on the* **Jan 2018 – Dec 2018** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarter period with all data points within the expected range and trending over time at our 90 target.

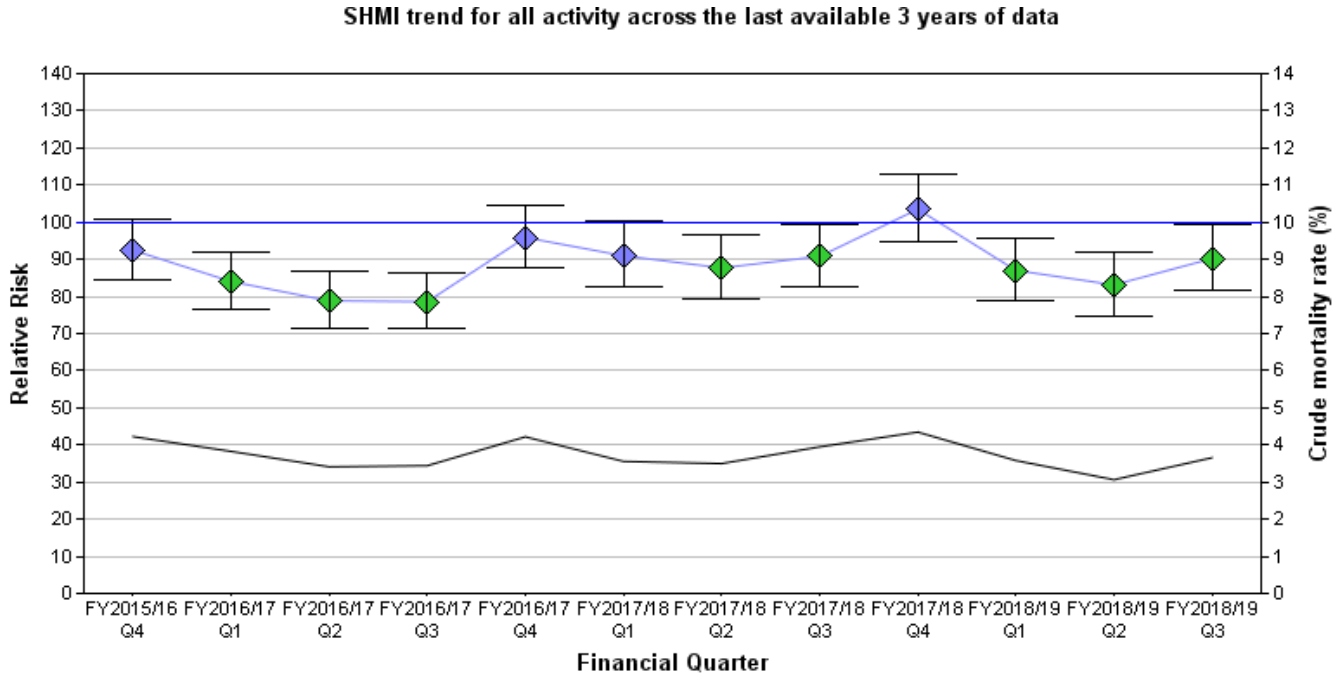


Chart 5 Detailing - SHMI all deaths, SHMI in hospital deaths and HSMR comparison

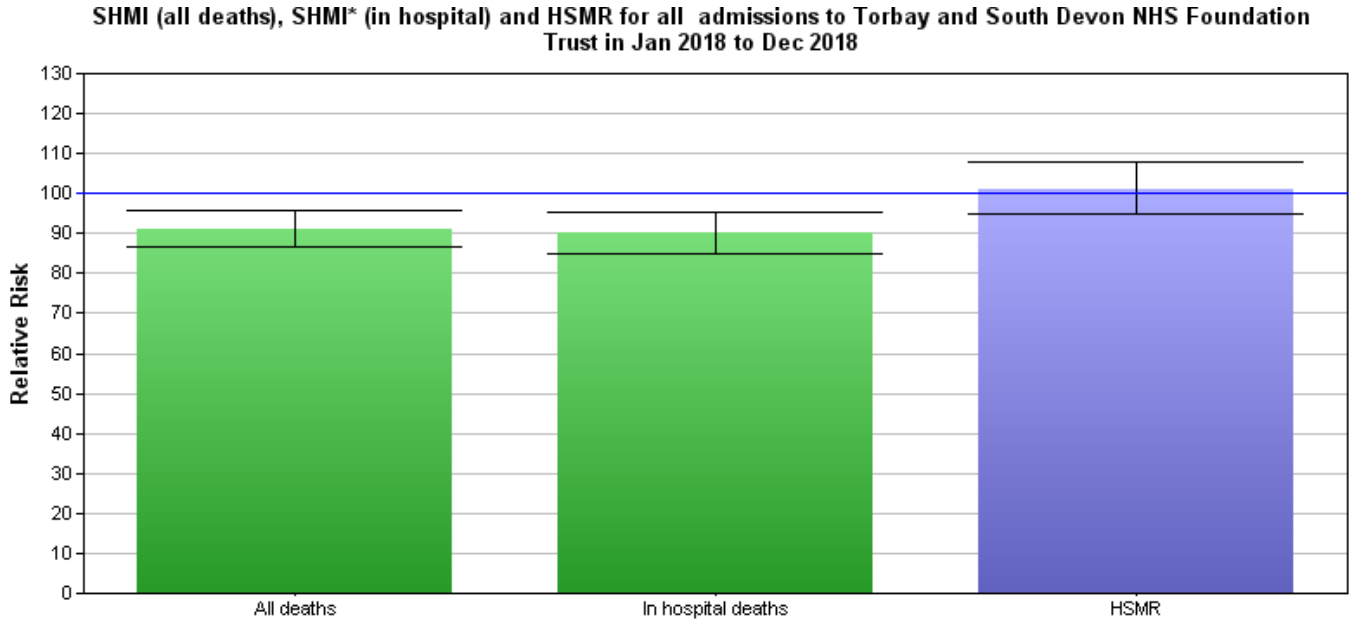


Chart 5 (as above) records all SHMI deaths, deaths in hospital and HSMR. The SHMI data are within expected range and show the in-hospital deaths at a very low relative risk. What this chart does highlight is the differential between HSMR and SHMI.

Chart 6, as below, expresses the 12-month rolling SHMI data by time period and is showing a SHMI below the 100 average.

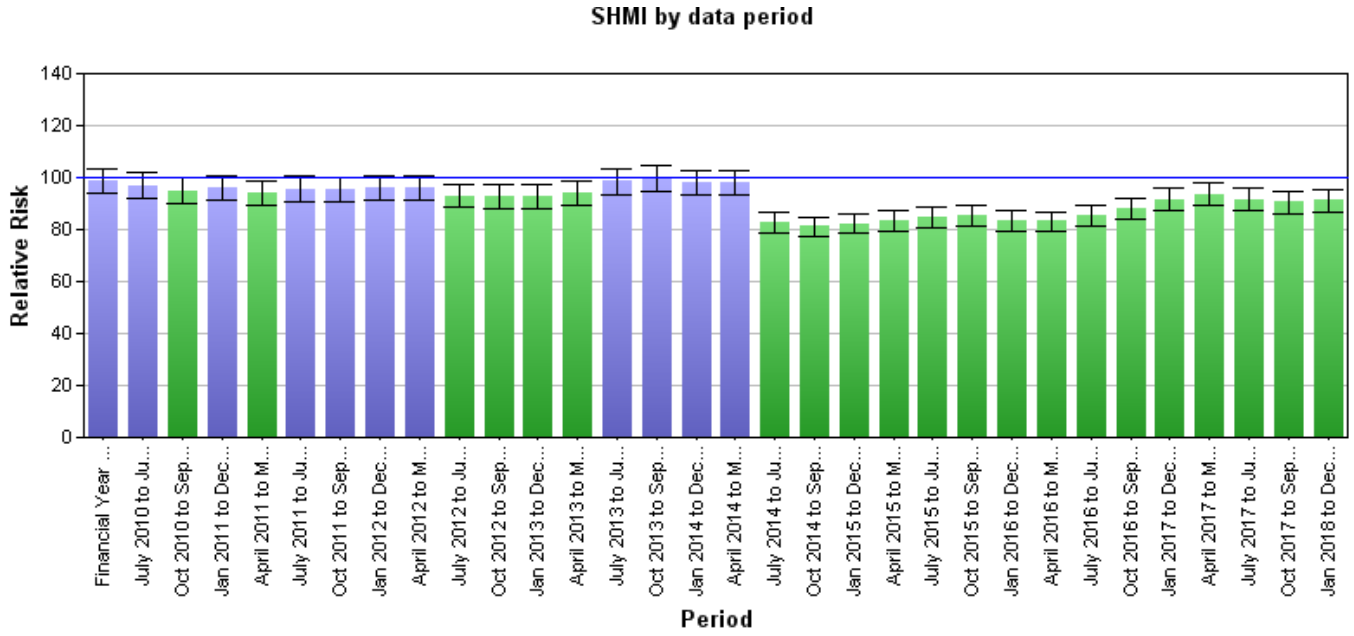
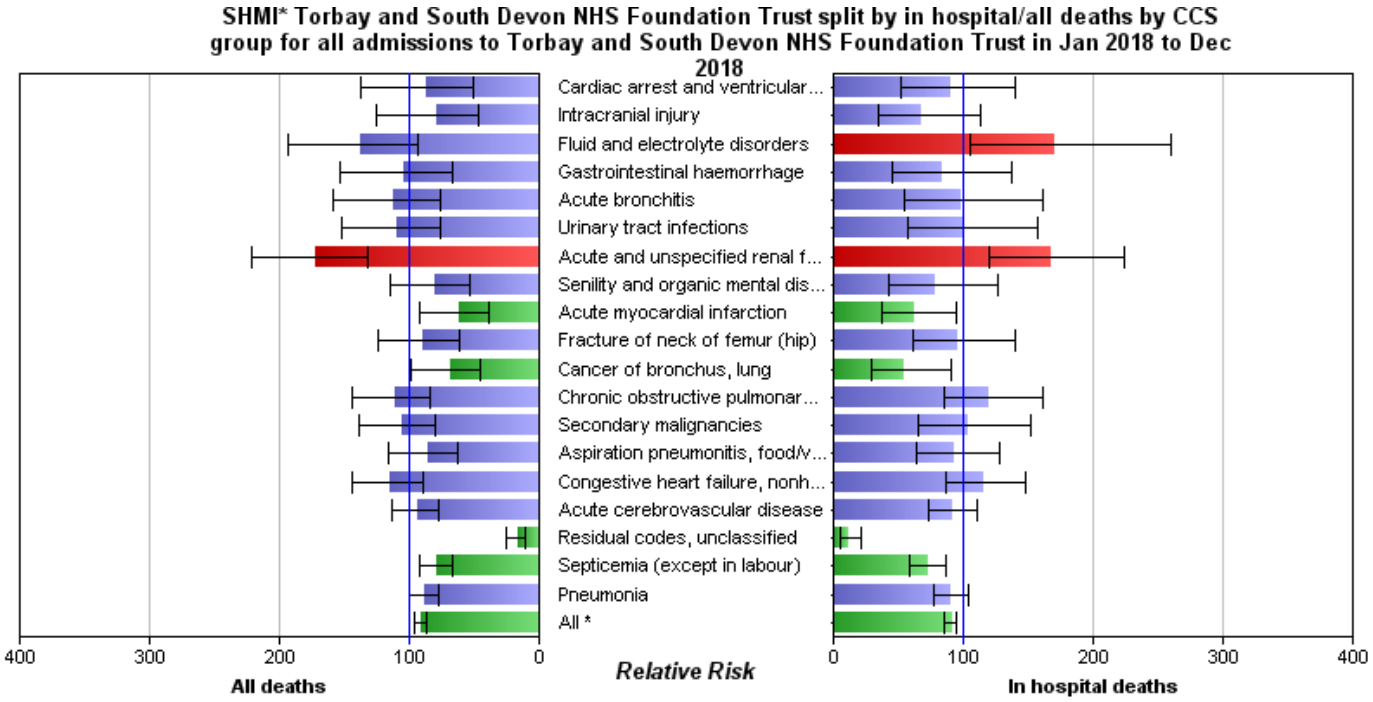


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Acute and Unspecified Renal Failure (A&URF). This will be discussed at the Mortality Surveillance group for relevance and planned action



4.0 Appendix 2 – Unadjusted Mortality Rate

This data looks at the number of deaths in-hospitals and expresses this as an unadjusted death rate as a percentage, as well as by number and location across time

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

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 8, as below highlight **t**he unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI. Mortality rises in the winter periods and for winter 18/19 the peaks appear lower than in the previous years

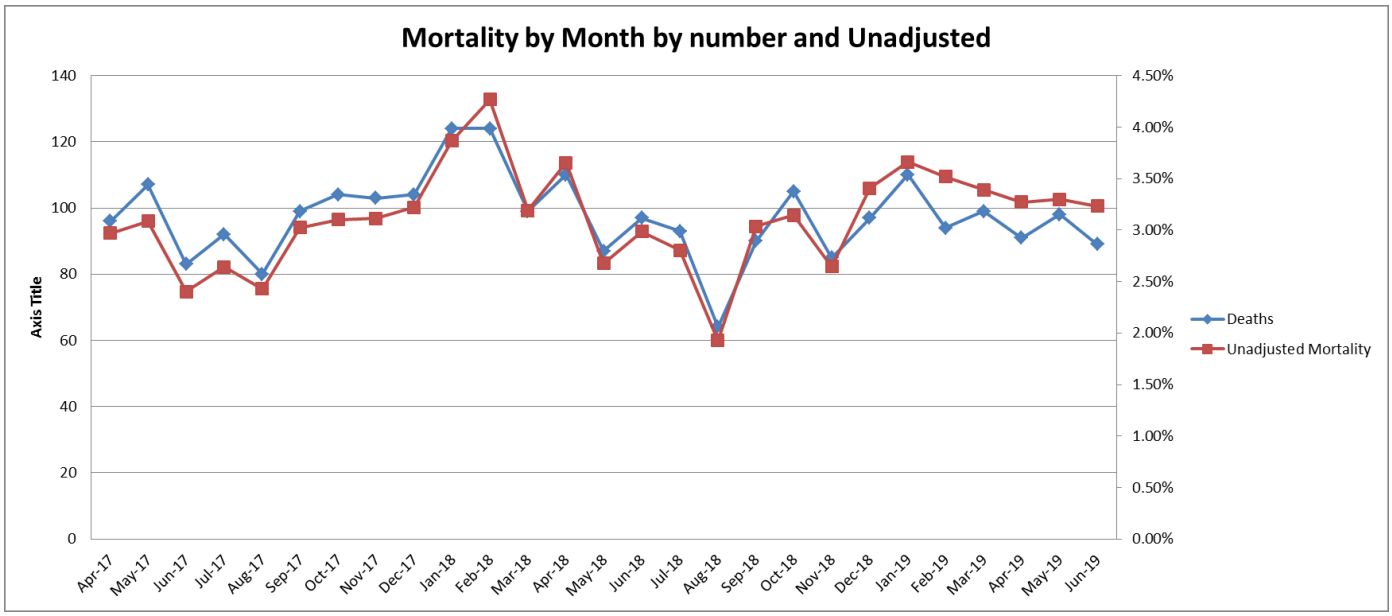


Table 2 – as below records highlights mortality by location by month and is within the expected norms for each area

AREA	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	sparkline
AINSLIE	1	0	1	4	4	0	1	1	2	1	4	3	3	2	2	1	2	1	0	1	
ALLERTON	3	4	5	2	6	10	6	4	5	3	4	4	3	6	0	4	7	4	8	4	
BRIXHAM	1	3	2	1	1	2	1	1	3	0	3	0	1	0	0	1	4	1	0	1	
CHEETHAM HILL	15	19	12	10	11	8	12	9	8	10	13	9	9	7	13	18	11	8	11	11	
CROMIE	3	3	8	8	9	2	2	2	3	1	1	2	3	6	1	2	5	4	4	5	
DART	2	0	1	2	0	3	1	1	3	1	2	1	2	2	2	2	5	0	3	1	
DAWLISH	3	0	4	3	3	3	4	4	1	0	0	1	1	5	6	3	3	3	2	0	
DUNLOP	4	10	6	7	7	5	3	8	3	6	7	2	6	3	6	5	4	7	5	5	
EAU3	11	7	9	7	4	9	6	7	10	5	7	5	0	2	1	0	0	0	0	0	
EAU4	5	8	7	10	11	12	2	7	6	3	7	8	8	8	6	5	5	7	6	8	
ELLA ROWCROFT	0	1	1	0	0	1	1	2	2	0	0	0	2	0	1	1	1	0	1	2	
FORREST	2	3	5	3	2	4	2	0	1	1	2	3	0	2	3	5	1	2	0	1	
GEORGE EARLE	10	9	14	10	14	6	16	9	10	7	9	13	11	16	17	12	11	11	8	12	
INTENSIVE CARE UNIT	9	12	13	12	6	10	8	6	8	5	8	13	6	4	9	6	6	10	10	9	
MIDGLEY	9	8	12	13	8	11	8	10	8	5	6	17	9	10	11	9	14	10	9	9	
SIMPSON	6	4	6	9	3	9	4	9	10	6	9	9	8	8	10	9	7	10	6	6	
TEIGN WARD	3	3	1	3	3	2	1	1	0	3	0	2	3	2	3	1	2	1	3	3	
TEMPLAR WARD	4	2	1	5	2	1	3	1	3	2	2	5	3	2	2	1	1	0	1	2	
TORBAY CORONARY CARE BEDS	4	1	3	3	1	3	1	2	2	0	2	2	0	1	3	0	2	1	1	2	
TURNER	6	6	8	8	3	9	5	13	5	5	3	6	5	10	8	6	2	8	9	5	
WARRINGTON	1	0	4	4	1	0	0	0	0	0	0	0	0	1	5	3	6	3	10	2	
Grand Total	**103**	**104**	**124**	**124**	**99**	**110**	**87**	**97**	**93**	**64**	**90**	**105**	**85**	**97**	**110**	**94**	**99**	**91**	**98**	**89**	

5.0 Appendix 3 - Dr Foster Alerts

Dr Foster utilises an alerting system, as **Table 3** below. Triggers are raised when the expected number is exceeded by the actual number and Dr Foster also provides a guide should an alert occur. In the first instance the coding on each patient is looked at and amended as necessary, second to this is a notes review to confirm cause of death and coding. With the current dashboard, a number are new alerts, but have a very small denominator, these will be reviewed by Clinical Coding in the first instance.

Table 3

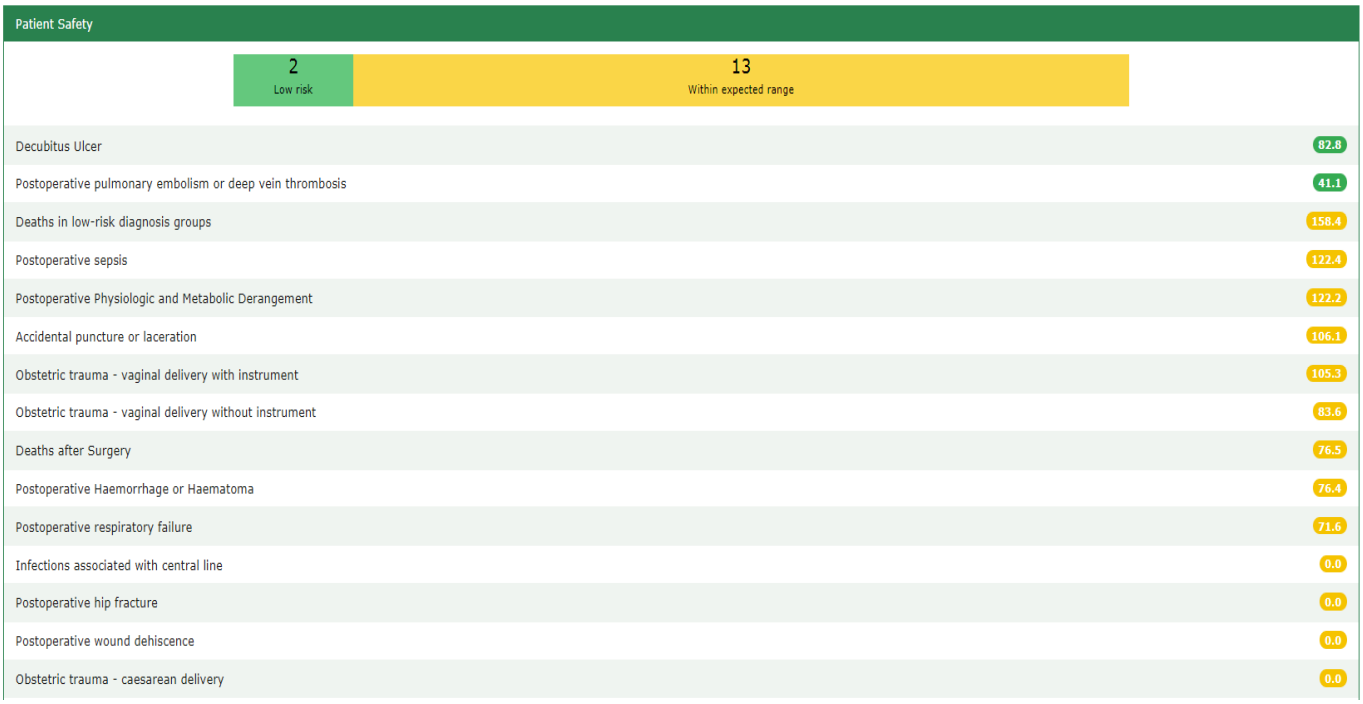
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	1 8	78048	1119	1188.9	1.4	94.1	
HSMR (56 diagnosis groups)	2	29334	932	946.3	3.2	98.5	
Acute and unspecified renal failure	1	237	37	23.4	15.6	158.1	
Disorders of teeth and jaw		1081	2	0.1	0.2	1724.5	
Nonmalignant breast conditions	1	71	1	0.1	1.4	830.4	
Other haematologic conditions	1	23	1	0.1	4.3	871.5	
Other perinatal conditions	1	284	6	2.0	2.1	295.4	
Parkinson's disease	1	24	3	1.1	12.5	275.2	
Peritonitis and intestinal abscess	1	26	5	3.5	19.2	141.2	
Phlebitis, thrombophlebitis and thromboembolism		87	3	0.6	3.4	500.9	
Pulmonary heart disease	1	181	16	6.5	8.8	244.4	
Respiratory failure, insufficiency, arrest (adult)	1	38	8	8.3	21.1	96.6	

6.0 Appendix 4 – Dr Foster Patient Safety Dashboard

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

The data was pulled on the 9th July 2018 and all of the 13 indicators are within the expected norm with 2 in the low risk category

Table 4



7.0 Appendix 5 – Hospital Mortality

Mortality Dashboard of the deaths reviewed this quarter - nil where reported as avoidable

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable
(does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (Mortality Score = 1)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
82	106	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
284	0	11	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1207	0	120	0	0	0

Total Deaths Reviewed by Mortality Methodology Score

Score 1 Probably avoidable			Score 2 Possibly avoidable but not very likely (less than 50:50)			Score 3 Not avoidable		
This Month	0	0.0%	This Month	1	4.5%	This Month	21	95.5%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	2.9%	This Quarter (QTD)	68	97.1%
This Year (YTD)	3	1.1%	This Year (YTD)	16	5.8%	This Year (YTD)	259	93.2%

8.0 Glossary of Terms

HSMR (Hospital Standardised Mortality Rate) - the case-mix adjusted mortality rate relative to the national average.

- **Relative Risk (RR)** - The ratio of the observed number of negative outcomes to the expected number of negative outcomes. The benchmark figure (usually the England average) is always 100; values greater than 100 represent performance worse than the benchmark, and values less than 100 represent performance better than the benchmark. This ratio should always be interpreted in the light of the accompanying confidence limits. All HSMR analyses use 95 % confidence limits.

CUSUM Alerts - CUSUM is short for 'cumulative sum'. The charts show the cumulative sum of the differences between expected outcomes and actual outcomes over a series of patients. The total difference is recalculated for each new patient and plotted on a chart cumulatively (i.e. where one patient's difference ends the next one starts). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold. They indicate a series of events that have occurred that are sufficiently divergent from expectations as to suggest a systematic problem. Alerts are triggered when the CUSUM statistic passes through a set threshold. This is shown graphically on the charts by a black cross on the threshold. Once an alert has been triggered the chart is re-set to the mid-way point. This will mean that another run of negative outcomes compared with expected outcomes will trigger an alert in a shorter timescale. The threshold value determines when the CUSUM graph is deemed to be out-of-control (i.e. higher or lower than the benchmark). At this point an Alert is raised and the CUSUM value is reset to half the threshold. The value selected affects the probability that an Alert is a False alarm and the probability that a real alarm is successfully detected. A high threshold is less likely to trigger false alarms but is more likely to miss a genuine out-of-control condition, and vice versa for a low threshold. For example, if chosen "Maximum (99.9%)" the system will select the highest threshold which corresponds to a False Alarm Rate (FAR) that is less than or equal to 0.1% given the annual volume and expected outcome rate of the analysis. With that threshold, only 0.1% of hospitals with in-control outcome rates (i.e. equal to the benchmark) will alert

Charlson Index of Comorbidities
Co-morbidity is assigned to the spell from assessing the secondary diagnoses codes, that are coded in the episode of care used to derive the primary diagnosis. In majority of cases this will be the first episode of care (on admission to hospital), however, where the primary diagnoses in the first episode of care is an R code, the system will look to the second episode of care to identify a clearer diagnosis, should one be available. In that case the secondary diagnoses of the second episode will be used. The Charlson Index of comorbidities is used both for the HSMR and the SHMI.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths.

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	30 July 2019
Report by + date:	Robin Sutton, 31 July 2019
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 issues to highlight to the Board (Month 3, June 2019):

1. For assurance the Committee reviewed the Month 3 Financial Performance, the control total deficit of £4.94m is £0.02m favourable to budget. The Q1 PSF was just achieved, no 52 week wait fines have been assumed. Against a CIP target of £20.0m, savings of £14.5m have so far been identified but the route to cash is challenging. The Trust is in the process of developing a detailed recovery plan with single oversight by Executives.

2. For assurance the Committee reviewed the Month 3 Performance Standards together with related management actions and mitigations. These standards continue to suffer from the impact of the ongoing operating theatre closures. Trajectory for the Q1 4 Hour A&E trajectory was achieved.

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

4. CIP delivery plans were discussed and additional assurance is required by Executives.

5. The business cases for Diagnostics, Teignmouth HWBC and Bovey Tracey Hospital were all approved by the Committee and go forward to Main Board.

6. For assurance the Committee received an update on the STP negotiation and risk share.

7. For assurance the Committee reviewed three risks (Risk Numbers 1083, 1159 and 1266) from the Financial, Digital and Compliance Risk Register.

8. Torbay Pharmaceuticals financial performance for June 2019 was reviewed by the Committee. Assurance was given that TP remains on track to achieve the budgeted contribution for the financial year.

9. The Committee noted the revised Capital Expenditure plans following NHSI requests to reduce plans by 20%.

10. SPQFG meeting report for 11 July 2019, CBEAG meeting of 4 July 2019 and CIEG meeting report of 24 July 2019 were noted by the Committee.

11. The Committee workplan for 2019 was reviewed and noted.

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Robin Sutton (Committee Chair)

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: **Safer Staffing and Nursing Work Programme**			Meeting date: 7th August 2019
Report appendix	Nil		
Report sponsor	Jane Viner, Chief Nurse		
Report author	Natasha Goswell, System Director of Nursing and Professional Practice		
Report provenance	Executive Director Meeting. Non-Medical Workforce Strategy group.		
Purpose of the report and key issues for consideration/decision	This is the six monthly safer staffing report as required by the Chief Nursing Officer NHS England. The report also gives a progress report on the Nursing Workforce Programme streams.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The ongoing commitment to systematically review safe nursing staff establishment across the Trust.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	12
Risk Register	X	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	X	**Terms of Authorisation**	
NHS Improvement	X	**Legislation**	
NHS England		**National policy/guidance**	

Registered Nurse Recruitment remains a challenge both locally and nationally. There is a growing confidence that the newer routes to Registered Nursing programmes are having a positive effect. These routes do require significant mentorship time from the clinical areas and need to be factored into establishment reviews. It is important to recognise that patient quality and safety are maintained.

Report title: Safer Staffing and Nursing Work Programme		Meeting date: 7th August 2019
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice	

1.0 Introduction

The NHS England Nursing Quality Board mandated regular reports to Trust Boards in guidance published in 2016 and updated in 2017.

Over the past three years there have been a number of guidance publications regarding safe staffing. NICE 2016, NQB 2016, 2017, RCN 2017, NHSI 2017/18. This report updates the Board on progress against safe staffing guidance.

1.1 Nursing Quality Board (NQB) Toolkits:

In January 2018 the NQB published a series of resources to inform safe staffing. These included acute adult inpatients, district nursing, mental health, learning disability and maternity. These were followed in June 2018 by the publication of resources for children and young people's services, neonatal care and emergency care. Together these provide a comprehensive guide to inform safe staffing reviews and for setting appropriate establishments. Each document has specific recommendations which the Associate Directors of Nursing are implementing.

NQB Publications	Rec's	Trust
Acute Adult Inpatients	10	Ward staffing assessed using the Safer Nursing Care Tool. In 2018 the Allocate HealthRoster / Safecare was implemented to monitor establishment.
District Nursing	12	The Trust commissioned a community nurse productively a review of district nurse staffing. The report has been included in Board reports.
Mental Health	17	The Allocate safe staffing tool enables consideration of the additional needs of those with a cognitive issue requiring additional supervision.
Learning Disability	29	The CCG are undertaking an STP review of LD services in 2019 to include staffing. The Trust Deputy DASS is leading a Trust review.
Maternity	14	The Birth Rate Plus tool was used in 2017 to set establishment. The findings remain current. The Board received the NQB update in December 2018.

Children & Young People	13	The PANDA tool was used in 2017 to set establishment. The findings remain current. An assessment against the NQB recommendations has been completed and included within the February 2019 Board report
Neonates	10	BadgerNet, Dinning and BAPM standards are used to set establishment level. The NQB update was included in the December 2018 Board report.
Emergency Care	13	The Baseline Emergency Staffing Tool was used in 2017 to set establishment. The findings remain current. The 2018 CQC inspection rated the ED good. An assessment against the NQB guidance has been completed and included within the February 2019 Board report.

Each NQB's guidance document states that providers:

- **Must** deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- **Must** use an approach that reflects current legislation and guidance where it is available.

1.2 NHSI Safe Staffing Guidance:

In support of the NQB, the NHSI published 'Developing Workforce Safeguards in October 2018. This document has a number of recommendations some of which link to the Standing Operating Framework (SOF) and the CQC inspection process:

	NHSI guidance (2018)
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.
2	Trusts must ensure the three components are used in their safe staffing processes: • evidence-based tools (where they exist) • professional judgement • outcomes
3	NHSI will base assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.
4	NHSI will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures. As part of this yearly assessment NHSI will also seek assurance through the

	Standing Operating Framework, in which a provider's performance is monitored against five themes: • quality of care • finance and use of resources • operational performance • strategic change • leadership and improvement capability.
5	As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.
6	Trusts **must** have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
7	They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
8	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources, This must also be linked to professional judgement and outcomes
9	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
10	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
11	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
12	Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments
13	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

Whilst there is evidence to support compliance for nursing, medical and allied health professional staff, there is further work to be undertaken to ensure all professional groups meet the standards. The Chief Nurse and Medical Director will work with the Director of Workforce and OD to provide the required report in Q2 2019/2020.

1.3 NHSI Yearly Assessment:

Within the SOF, the organisational health section contains information on monthly staff sickness, staff turnover and the volume of temporary staffing a trust uses, as well as the annual staff survey. These are high level organisational metrics that NHSI will continue to analyse.

In addition, NHSI assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual trusts. These will be available from 'board to ward' and sourced from ESR, e-rostering and financial systems, as well as a quality dashboard reviewed by the trust board.

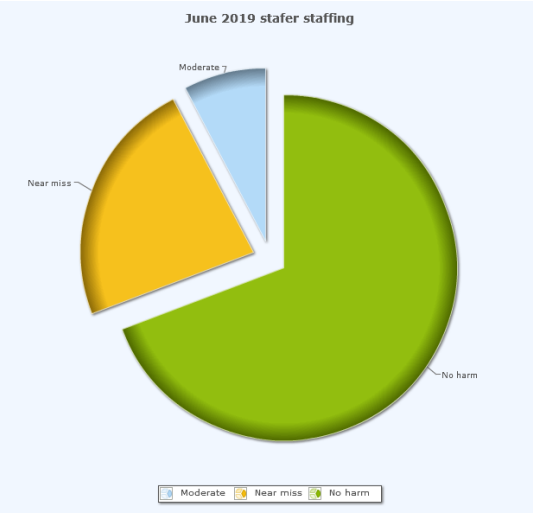
The Trust annual governance statement has been amended to include a statement specifically about staffing. In addition, The NHSI Single Oversight Framework (SOF) is designed to help trusts attain and maintain CQC ratings of 'good' or 'outstanding'. The SOF describes how NHSI oversee NHS trusts and foundation trusts. Their performance is monitored against five themes (quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability) and helps determine the level of support we may offer them. This report provides an update on safe staffing using these 6 key performance themes.

2.0 Quality

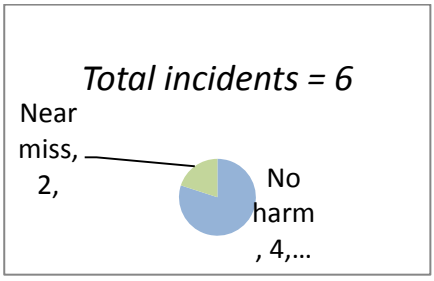
2.1 Staffing Datix reports:

When reported onto the Risk Management System (Datix), incidents are categorised for primary and secondary causal factors. The pie charts below show these separately. The information below shows the staffing incidents reported for M3 and for the whole of Q1.

Distribution of incidents where category is lack of staff, or staffing levels by severity for incidents in June 19, there were a total of 13 incidents

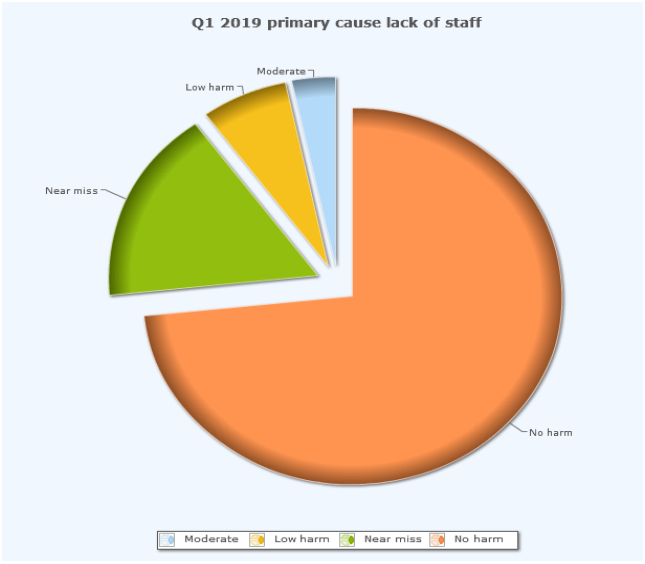


Distribution of incidents where the secondary causal category is lack of staff is recorded by severity for incidents in June 19.

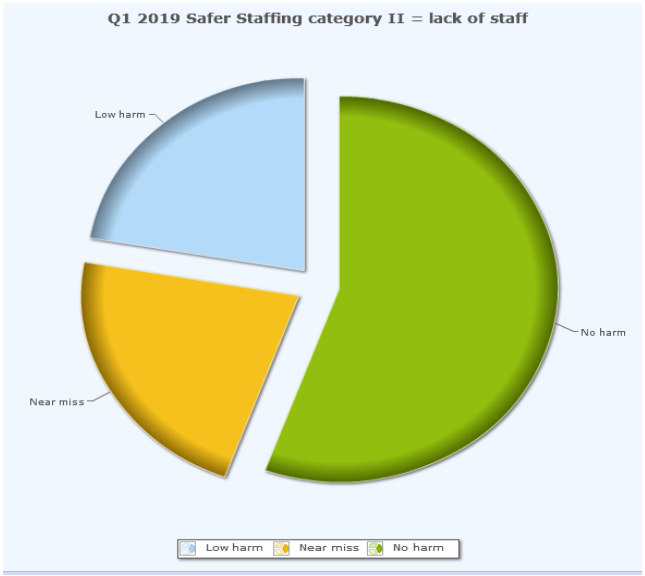


These recorded incidents have not caused patient harm.

The charts below show the primary and secondary causal factor by severity for staffing levels for Q1 2019. Total numbers of primary causal factors are 30 incidences and secondary causal factors are 9.



No Harm	22
Low harm	2
Moderate	1
Near miss	5
Total	***30***



No Harm	5
Low harm	2
Near miss	2
Total	***9***

The 4 low harm incidents are:

- Short notice sickness resulted in procedure cancellation – patient rebooked
- Due to no phlebotomy delay in obtaining blood results and reviewing them
- Patient Fall – no harm to patient
- Redeployment of staff nurse to another area leaving skill mix

Nurses and other staff are encouraged to complete incident forms if they judge staffing to be unsafe. In June as part of the CQC new inspection regime of engagement sessions, they attended the Trust in Newton Abbott hospital as part of their community core service engagement. During the engagement session staff raised some concerns in regard to staffing levels within Teign ward, The Associate Director of Nursing and Professional Practice completed a review with the hospital matron and took remedial action (see appendix 1). Recent feedback suggests that CQC and the team are satisfied that their concerns have been responded to. We will continue to monitor through our governance processes.

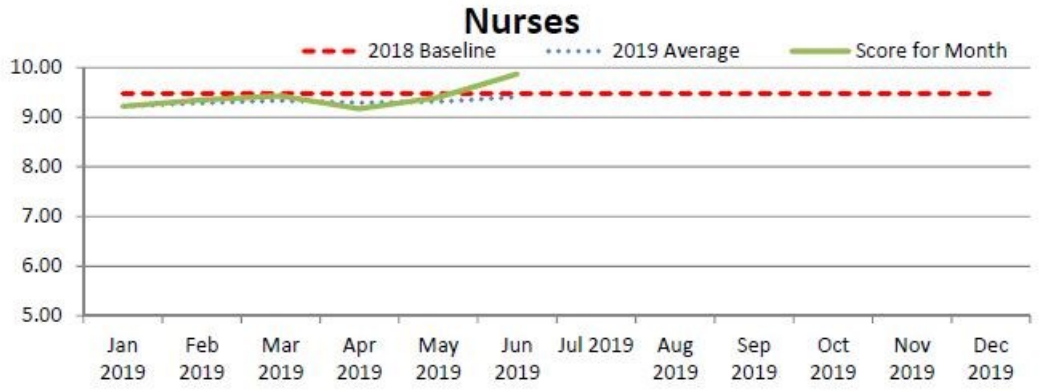
This information is triangulated with nursing establishment data, nursing staff verbal reports, Freedom to Speak Up reports, RCN feedback, operational activity data such as OPEL status and safety walks.

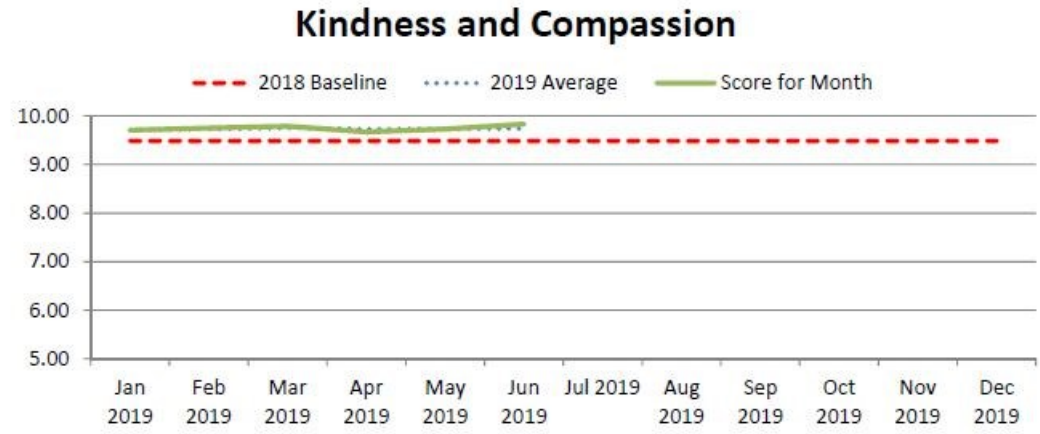
2.2 Complaints:

There are no complaints where nursing staff shortages are a factor. There are no complaints relating specifically to staff shortages. Issues pertaining to care coordination, including assessments and discharge planning are periodically raised and these are investigated and addressed through the integrated service units. A more in depth report will be provided in the annual Feedback and Engagement which was presented to Trust Board in April 2019. For Q4 we have seen 110 compliments relating to staff that were recorded with 41 in June 2019.

2.3 Real time patient feedback:

Patients in bed based care are asked for their feedback in the form of a questionnaire asked by staff not involved in the care of patients in the ward. Currently the wards included in the Patient Experience Network show that for the questions relating specifically to nurses the responses are consistently good. The chart relating to kindness and compassion is not specific to nursing staff but is a good proxy indicator of satisfaction.





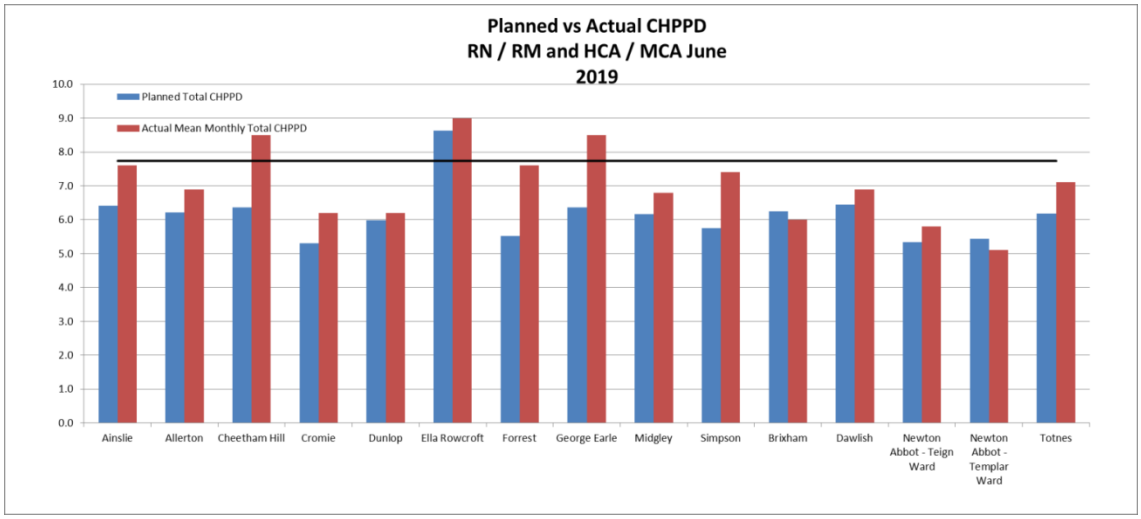
Our 'Working with Us' panel also undertake a similarly worded survey of a sample of patients, the data presentation is still work in progress. However, feedback in June 2019 (small numbers) the questions relating to nursing staff interaction show that all patients reported positively to having confidence in the nursing treating them, and to the question regarding staff kindness.

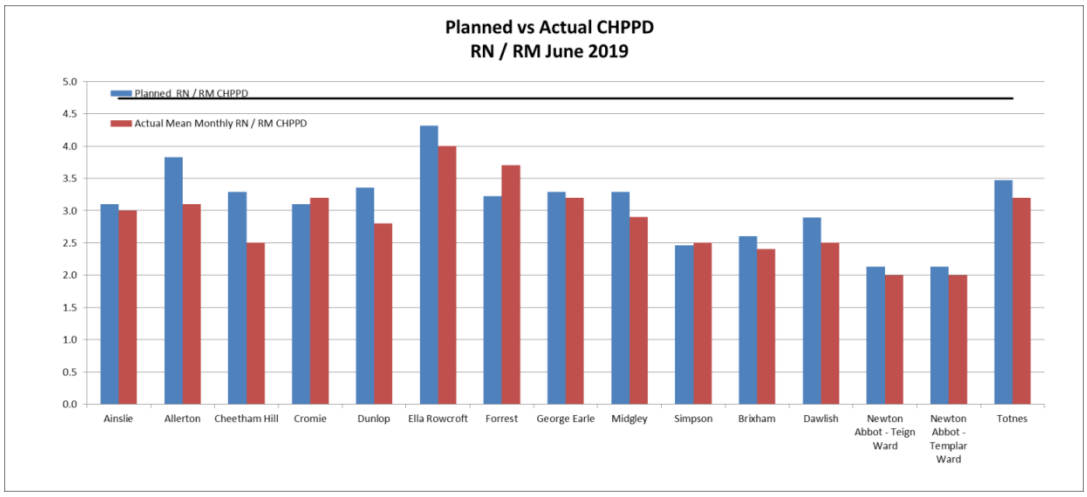
The patient feedback results are reported through the Quality Improvement Group (QIG) meetings, and to the Board in the annual Feedback and Engagement Board report.

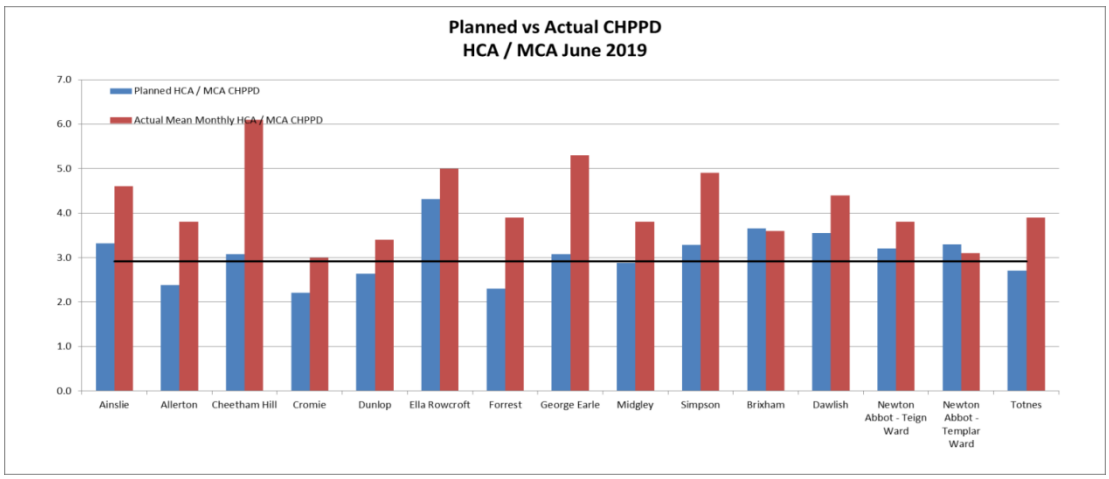
2.4 Model Hospital quality measures:

	TSDFT June 2019	TSDFT February 2019	National Median February 2019
Total CHPPD	7.70	7.88	7.9
RN/ RM CHPPD	3.70	3.95	3.9
HCA / MCA CHPPD	4.00	3.93	3.9

The table above shows the comparison between our Trust and the national data. The value shown for RNs demonstrates an improving picture as recruitment to vacant posts improves. The CHPPD figure for HCAs continues to show an elevated picture compared to the national median which is largely attributed to the needs of patients requiring higher levels of support and observation to maintain safety.







The three graphs above show the Trust monthly data for CHPPD against the Model Hospital benchmark. For registered nurses / midwives, in most areas the actual does not meet or exceed the planned. These wards were slightly below planned in June due to staff absence and the number of unfilled temporary staff to fill the RN gap. Most wards have higher than planned HCA to assist.

In all areas, the actual number of HCA exceeds the planned numbers. This is to meet the demand for additional observations, falls risk or other activity. Overall this Trust uses slightly more HCA staff (4.0) than the national median (3.9), this is a significant shift nationally over the last 6 months.

The daily Emergency Department staffing is shown in the table below. The department has above establishment in both RNs and HCA on majority of shifts, with the exception of 3 days where temporary staff were unable to fill this gap in RNs, however we utilised slightly more HCA staff. This is to cover the impact of increased OPEL 4 and the associated activity pressure. In additional the winter plan includes the use of the minor injuries area and the Acute Medical Unit for patients overnight during escalation. These areas are staffed by the ED nursing team.

2.5 June 2019 Emergency Department Daily Staffing:

		Total Planned shifts		Total Actual Shifts		RN Shift fill rate	HCA Shift Fill Rate
		RN	HCA	RN	HCA		
Sat	01/06/2019	19	13	19	15	100.0%	115.4%
Sun	02/06/2019	19	13	20	13	105.3%	100.0%
Mon	03/06/2019	19	13	20	15	105.3%	115.4%
Tue	04/06/2019	19	13	20	16	105.3%	123.1%
Wed	05/06/2019	19	13	19	15	100.0%	115.4%
Thu	06/06/2019	19	13	20	17	105.3%	130.8%
Fri	07/06/2019	19	13	20	16	105.3%	123.1%
Sat	08/06/2019	19	13	19	16	100.0%	123.1%
Sun	09/06/2019	19	13	20	17	105.3%	130.8%
Mon	10/06/2019	19	13	20	17	105.3%	130.8%
Tue	11/06/2019	19	13	20	16	105.3%	123.1%
Wed	12/06/2019	19	13	20	15	105.3%	115.4%
Thu	13/06/2019	19	13	20	16	105.3%	123.1%
Fri	14/06/2019	19	13	20	16	105.3%	123.1%
Sat	15/06/2019	19	13	19	15	100.0%	115.4%
Sun	16/06/2019	19	13	20	15	105.3%	115.4%
Mon	17/06/2019	19	13	21	14	110.5%	107.7%
Tue	18/06/2019	19	13	19	16	100.0%	123.1%
Wed	19/06/2019	19	13	20	17	105.3%	130.8%
Thu	20/06/2019	19	13	20	17	105.3%	130.8%
Fri	21/06/2019	19	13	21	15	110.5%	115.4%
Sat	22/06/2019	19	13	18	16	94.7%	123.1%
Sun	23/06/2019	19	13	19	16	100.0%	123.1%
Mon	24/06/2019	19	13	20	16	105.3%	123.1%
Tue	25/06/2019	19	13	20	17	105.3%	130.8%
Wed	26/06/2019	19	13	20	17	105.3%	130.8%
Thu	27/06/2019	19	13	19	17	100.0%	130.8%
Fri	28/06/2019	19	13	19	15	100.0%	115.4%
Sat	29/06/2019	20	13	18	15	90.0%	115.4%
Sun	30/06/2019	20	13	18	16	90.0%	123.1%

The ED has been successful in recruiting to vacant posts however there are still a number to be recruited to. As the new members of staff come into the rota they will be undertaking a planned programme of supernumerary working, i.e. shifts in addition to planned numbers 'on the floor'.

2.6 Quality measures:

Model Hospital data (depending on when the national teams upload the data – this can be several months behind) shown below for June shows the Trust to be comparable with Peer and National dataset within the following measured quality measures: Friends and family staff test, Friends and family test inpatients, outpatients, maternity and community. Staff retention rates for nursing, midwifery and healthcare support workers show the Trust is higher in comparison to peer and national figures.

The Trusts harm free care is slightly lower in comparison to our peers and national figures. As a Trust our urinary tract infection rates with or without a catheter are better than our peers and national figures Harms from falls are higher than benchmark but this Trust data will include those sustained in intermediate and community care, this also recognises that we have high reporting of falls as we would encourage. VTE data is under review to identify both the recording and reporting.

Our response to Delayed Transfer of Care (DTOC) remains lower than our benchmarked peers and nationally.

Caring	Data period	Trust value	Peer median	National median	Chart
Recommend to Friends & Family (Staff)	Q2 2018/19	85.6%	N/A	N/A	
Recommend to Friends & Family (Patients) - Inpatient	Jan 2019	96.9%	N/A	N/A	
Recommend to Friends & Family (Patients) - Outpatient	Apr 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Antenatal Care	May 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Birth Setting	May 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Postnatal Ward	Feb 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Community	Apr 2019	92.2%	N/A	N/A	

Staff Retention Rate - Nursing & Health Visitors	Dec 2018	90.7%	87.3%	87.4%	
Staff Retention Rate - Midwifery	Dec 2018	95.4%	88.7%	88.7%	
Staff Retention Rate - Healthcare Support Workers	Dec 2018	85.3%	81.6%	83.3%	

Safe	Data period	Trust value	Peer median	National median	Chart
Proportion of Patients with Harm Free Care	Feb 2019	90.8%	92.7%	93.8%	
Proportion of Patients with Harm from a Fall	Feb 2019	1.6%	0.5%	0.3%	
Proportion of Patients with New VTE	Feb 2019	0.8%	0.5%	0.4%	
Proportion of Patients with New Pressure Ulcers	Feb 2019	1.1%	1.1%	0.8%	
Proportion of Patients with a UTI and Catheter	Feb 2019	0.5%	0.8%	0.7%	

Responsive	Data period	Trust value	Peer median	National median	Chart
Delayed Transfer of Care (DTOC)	Mar 2019	415	603	579	

2.7 Quality Effectiveness and Safety Trigger Tool (QuESTT):

This report provides each clinical team with an opportunity to rate their level of risk regarding safety, effectiveness and experience. The overall RAG score is composed of 14 elements such as staff absence, clinical caseload, incidents and complaints. The tool also enables the use of professional judgement to highlight pressure. Data is submitted and collated monthly to highlight areas for focus. This report is monitored and managed by the Integrated service units and Trust Quality Improvement Group a sub group from Quality Committee.

Quality Safety and Effectiveness Trigger Tool (QuESTT)

Torbay and South Devon NHS
NHS Foundation Trust

Service Rating	Level 0	Level 1	Level 2	Level 3
C. Hospital & MIU	<12	12-16	17-25	>25
Other	<16	16-24	25-35	>35

Service Type	Team	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
% Complete		99%	94%	94%	94%	94%	95%	92%	95%	95%	99%	96%	93%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		0	0	0	0	0	0	0	0	0	0	0	0
Total Amber (L1)		4	6	11	6	3	9	10	9	8	8	8	6
Total Green (L0)		80	74	69	74	77	72	68	72	73	76	74	73
Average Score		8.7	8.7	9.5	9.0	8.7	9.1	9.8	9.8	9.4	8.6	9.2	9.4
Acute	Ainslie	10	12	14	11	14	17	12	11	10	8	13	12
	Allerton	13	14	13	14	11	12	15	12	13	16	8	16
	AMU	4	2			7	11		8	7	13	14	5
	Anaesthetics	6	7	6	9	9	10	10	8	7	8	11	10
	Breast Care Unit	6	6	6	8	4	4	6		4	3	0	2
	Cath Lab	4	4	6	4	3	4	3	10	0	7	4	10
	Cheetham Hill	10	13	15	10	13	17	17	14	17	16	16	19
	Cromie	12	8	14	10	8	11	15	16	11	10	10	7
	DSU	9	10	10	12	13	13	9	13	10	13	13	14
	Dunlop	10	10	6	6	4	4	5	3	5	7	3	5
	Early Pregnancy / Fertility Service	7	6	6	6	6	2	2		2	2	4	4
	EAU3	10	12	10	13		4	13	10	11	8	8	
	EAU4	7	8	8	8	8	9	7	10	8	11	8	7
	Ella Rowcroft	9	8	12	11	13	10	10	9	11	10	3	10
	Emergency Department	14	15	16	19	17	19	21	19	14	16	15	15
	Endoscopy	6	8	4	4		7	8	7	5	2	4	4
	Forrest	15	7	8	12	10	7	13	12	13	10	15	14
	General Theatres	7	11	11	8	15	13		11	9	9	11	11
	George Earle	9	9	13	10	8	9	12	12	10	10	11	11
	Gynaecology Out-Patients Dept	4	3	5	11	13	7	6		2	6	8	9
	Hutchings	10	10	9	8	7	5		4	8	7	9	12
	ICU	8	4		6	5		8	6	11	8	7	9
	Louisa Cary	6	8	13	15	11	11	2	2	15	8	4	
	MAT / TAIRU	8	5	7		9	9	4	3	10	5	10	10
	Maternity	13	12	11	13	7	9	13	8	11	5	7	13
	Midgley	16	11	10	8				15	15	7	11	14
	OPD	4	3	2	2	4	4	4	6	4	2	2	6
	Ophthalmology	11	10	9	14	11	8	9		12	9	13	8
	Ortho Theatres	16	16	16	15			15	14	15	16		15
	Pre-assessment	6	6	8	8	4	4	6	4	6	6	8	8
	Radiology	11	11			11	15	14	13	14	10	13	
	Recovery	9	6	5	7	6	4	9	8	8	5	8	12
	RGDU	5	5	6	7	14	8	15	5	5	7	10	7
	SCBU	10	7	6	3	13	10	9	11	3	10	2	
	Sexual Health	14	12	10	3	6	13	8	11	11		8	13
	Simpson	11	7	12	7	9	13	7	8	12	14	8	9
	TCCU	5	4	8	6	5	4	5	5	8	7	3	5
	Turner	6	7	6	7	10	10	8	9	12	9	11	9
	Urology	7	11	14	17	13	12	17	14		5	14	
	Warrington						5	8	6	3	6	3	

Service Type	Team	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Community Hospital	Brixham	9	13	11	8	10	13	9	9	14	10	11	12
	Dawlish	3	7	3	5	8	4	4	11	11	8	3	3
	Newton Abbot Teign	17	12	14	12	12	11	11	14	13	11	8	4
	Newton Abbot Templar	5	7	7	3	6	7	5	4	5	6	5	0
	Totnes	16	9	8	10	2	7	3	8	13	7	9	8
MIU	Dawlish	7	5	2	2	3	2	4	4	2	7	6	8
	Newton Abbot	5	2	2	0	2	2	0	2	1	2	4	3
	Totnes	0	3	7	3	3	3	3	3	6	2	2	0
Community Stroke and Neurology	Torbay and South Devon	16	16	10	10	10	10	10	8	12	10	10	12
Infection Control	Infection Control	10	11	9	4	4	4	4	9	5	6	10	6
LLTS	LLTS	4	4	4	6	6	6	9	5	10	10	6	7
Nursing	Brixham and Paignton	12	12	8	11	13	13	15	20	10	7	12	15
	Coastal	19	15	18	16	15	14	12	7	19	15	9	12
	Moor to Sea	9	13	14	12	9	8	7	17		20	15	18
	Newton Abbot	9	13	19	8	5	10	10	9	12	14	12	13
	Torquay	8	9	7	11	12	15	11	8	9	5	8	9
OOH Nursing	OOH Nursing	16		16	10	9	15	16	20	22	12	13	13
Specialist Nursing	Specialist Nursing	10	10	12	13	13	11	10	6	10	11	8	11
Occupational Therapy	Brixham and Paignton	8		16	12	14	10	12	12	10	18	14	16
	Coastal	17	19	12	19	12	9	10	14	16	18	19	24
	Moor-to-sea	10	10	12	12	10	12	12	14	14	10	8	12
	Newton Abbot	9	13	15	13	17	12	11	11	11	13	9	13
	Torquay	16	10	8	2	8	4	4	8	4	0	0	0
Physiotherapy	Brixham and Paignton	13	16	16	16	13	12	12	14	10	14	15	13
	Coastal	23	23		17	10	10	8	11	18	14	11	22
	Moor-to-sea	14	10	12	8	14	10	8	12	8	6	6	8
	Newton Abbot	15	19	15	13	15	10	7	9	9	13	11	15
	Torquay	8	6	8	8	10	8	6	4	8	6	4	8
Podiatry	Podiatry	17	18		17	16	15	16	20	16	16	16	18
Public Health - CAMHS	CAMHS	12	7	10	13	8	8	10	10	6	8	18	14
Public Health - Lifestyles	Lifestyles	7	6	9	9	9	11	9	11	8	2	3	1
Public Health - Nursing	Brixham	2	4	3	0	2	0	0	0	9	0	0	0
	Paignton	8	4	10	8	4	2	4	4	8	5	4	8
	School Nursing	14	10	4	9	10	11	12	10	2	7	4	8
	Torquay North	2	12	10	16	7	9	11		6	7	6	5
	Torquay South	4	4	5	3	2	5	2	3	2	2	4	1
Public Health - Substance Misuse	Substance Misuse	8	8	10	10	4	8	8	8	2	2	2	4
Social Care	Brixham and Paignton	16	12	20	14	13	16	14		12	13	10	12
	Dawlish & Teignmouth	2	4	4	9	8	6	14	4	16	8	12	8
	HADT - S. Devon			9	13	7		5	13	7	7	15	11
	HADT - Torbay	11	11	9	9	11	13	7	5	13	9	11	11
	Newton Abbot	16	16	20	20	14	18	14	11	14	14	12	8
	Older People Mental Health - Torbay	2	0	0	0	2	4	0	0	2	2	4	2
	Torquay	20	14	16	14	12	14	14		8	10	10	10
	Totnes & Dartmouth	20	6	10	10	10		12		8		10	12
Tissue Viability	Tissue Viability	7	10	8	7	11	5	9	5	8	7	7	

8 areas are rated as amber in June 2019; causes as follows:

- Podiatry - have 3 vacancies. Two vacancies have been appointed to but staff is not in post until June so will probably remain in amber until then for a while. The 3rd vacancy that has been filled and the staff member are completing induction. The team do not have locum agency staff to cover but some staff is working extra.

- Paignton / Brixham OT - due to sickness absence and maternity leave. The position is expected to improve as staff are now beginning to return from their sickness. The service is drawing resource temporarily from other services where it is available.

- Coastal OT and Coastal Physio –The severe pressure on staff is currently being mitigated by case load prioritisation. Bank options have already been thoroughly explored and exhausted and escalation to agency usage is being explored.

- Nursing Moor to Sea – due to staff sickness (short term & long term) and vacancies. Planned appraisals have been affected.

- Brixham Community Hospital – due to short term sickness and RN vacancies. Staffing issues had resulted in delay in appraisal completion. The QuESTT score has been fluctuating around the amber threshold in recent months. Unfortunately, the hospital will have further RN vacancies in the next few weeks.

- Allerton – due to vacancies and the patient cohort includes patients who require increased observations due to their acuity. Staffing gaps are being manged through temporary staffing and continual rota reviews

- Cheetham Hill – due to vacancies and long term sickness. The patient cohort includes a high proportion with acute confusion and additional staffing is required to maintain safety. The ward has recruited however; these staff are not yet in post. Staffing gaps are being manged through temporary staffing and continual rota reviews.

Six teams did not complete the return and this is being addressed within the integrated service units.

3.0 Operational Performance:

3.1 This report includes the organisational Opel status reflecting pressures in the system and provides a proxy indicator of the effects on staffing. The table below shows the number of days the Trust was at each Opel level for June with May figures shown in brackets. The impact of OPEL 4 is the need to staff additional bedded areas for escalation. Whilst OPEL 4 is the result of escalated demand and lack of capacity, it also contributes to inefficiency and stress as staff work harder to respond but can be less productive.

TSDFT Alert Status June 2019	*No Days in Month*	*% days in Month*
Opel 1	*0 (6)*	*0%*
Opel 2	*15 (15)*	*13.33%*
Opel 3	*9(9)*	*66.67%*
Opel 4	*1(1)*	*20%*

Trust 4 hour performance is well below the local and national trajectory. This is impacting on safety, quality and effectiveness. Nursing staff participate in the national emergency flow interventions to address this.

3.2 SAFER:

- S- Senior review
- A-all patients have an expected date of discharge
- F-flow to the wards commences at the earliest opportunity following assessment.
- E-early discharge
- R-review patients with extended LoS > 7 days.

Trust work on the SAFER programme continues, with wards undertaking reviews of all patients each day and communicating planned discharges to the operational control meetings. Overall as a Trust we remain not fully compliant recognising areas for improvement, following recent ECIST feedback and continued support, the Trust is urgently reviewing its approach to the early in the day patient discharge as the numbers of patients leaving their wards before 12 midday are not sufficient to enable early flow from the assessment areas. This work is being monitored through weekly quality calls with our CCG, NHS England and NHS Improvement colleagues and respective A&E delivery Boards.

3.3 Red2Green:

Red2green days identify and evaluate the days in a patient stay which do not add value i.e. red days. These are usually days where the patient is experiencing unnecessary delays in their care pathway. As part of the work described above, a review of delays are examined to identify any themes and in preparing interprofessional standards. Overall, the Trust is compliant with Red2Green recognising areas for improvement.

4.0 Finance and Resources:

4.1 Ward establishment / bank and agency spend M3:

Registered Nursing (RN) budget – Registered nurse spend on bank and agency for all ward and non-ward environments YTD is £1,091,102, which is £209,181 underspent. However we have seen the usage and spend increase year on year over the last 3 years. The Trusts areas of high usage are Emergency Department, EAU, and Healthcare of the older patients
Non-registered (HCA) nursing budget – YTD the budget spent on bank and agency for HCA across both ward and non-ward environments equates to £ 1,162,336 which is 351,228K overspent.

4.2 WTE agency usage to month 3:

Registered Nurse and Non-Registered Nurse spend YTD equates to 90.1 WTE equals 3,378.75 hours

4.3 Nursing Agency to Month 3:

The top 7 spending areas are highlighted in the table below:

- Those highlighted in the table below in amber represent the Emergency Department (comprising A&E, EAU 3&4, AMU and Emergency Practitioners) which has the highest usage at £445K (46%)
- Simpson Ward £86K (9%) highlighted in blue.
- Warrington Ward £72K (7%) highlighted in blue.

Cost Centre	Sum of 201901	Sum of 201902	Sum of 201903	Sum of Total
00101-Medical Division Directorates A&C staff	1,839	0	0	1,839
00700-EAU3 - Emergency Assessment Unit Level 3	23,417	13,987	12,918	50,321
00900-George Earle Ward	21,403	10,067	34,776	66,245
01025-Torbay Cardiac Centre (CPU)	1,328	0	1,020	2,348
01100-Dunlop Ward	4,471	1,755	10,737	16,963
01200-Turner Ward	820	24	3,760	4,604
01300-Midgley Ward	8,923	5,529	8,064	22,516
02000-Cheetham Hill Ward	12,749	8,977	11,741	33,467
02200-Simpson Ward	31,777	32,281	22,024	86,081
02300-Warrington Ward	30,938	29,832	11,046	71,816
04000-Allerton Ward	8,798	3,482	2,934	15,214
04100-Cromie Ward	12,592	11,275	6,417	30,284
04200-Forrest Ward	7,524	3,955	3,237	14,716
04300-Intensive Care Unit	4,108	6,767	14,312	25,187
05200-Ella Rowcroft	634	4,340	6,339	11,312
05300-Ainslie Ward	19,255	4,157	4,889	28,301
05900-Trauma Theatre (Old Day Theatre)	2,599	3,312	9,782	15,694
08300-Accident & Emergency	127,161	113,761	102,352	343,274
08302-Emergency Nurse Practitioners	11,652	12,479	10,570	34,701
08400-EAU4 - Emergency Assessment Unit Level 4	6,611	3,495	1,390	11,497
15600-Day Case Surgical Unit	5,797	0	3,551	9,348
19599-AMU	3,127	1,517	370	5,014
42700-Louisa Cary Ward	249	1,857	832	2,938
86103-Brixham Inpatients	5,411	5,959	2,128	13,499
86482-Totnes Dart Ward	356	2,660	1,248	4,263
86483-Totnes Minor Injury Unit	192	0	0	192
86501-Dawlish Hosp Genrl	2,575	0	0	2,575
86503-Dawlish MIU	1,040	-3,231	0	-2,192
86541-Templar Ward N Abbot	1,620	2,829	1,397	5,846
86547-Comm Minor Injury Servi	-1,691	0	5,104	3,413
86554-Stroke Unit Teign Ward	2,906	5,117	7,322	15,346
87704-CHC Staffing	3,793	5,540	3,236	12,568
Grand Total	**363,974**	**291,723**	**303,495**	**959,191**

- **Emergency Department** – in 2016, the establishment was increased to support increased demand in Resuscitation and the Paediatric pathway. Recruitment has been slow due to local and national shortage of A&E nurses. The team have had a number of strategies to recruit including 'growing our own', secondments, flexibility between A&E, EAU and AMU staff, appointments from other areas of the Trust, and more recently overseas recruitment. Despite these efforts the department still has a number of vacancies, with increased absence management being completed. Most of the leavers move to other roles within the Trust; however we have seen the introduction of other initiatives nationally which has driven recruitment of roles such as ENPs being recruited to the Primary care networks. As a trust we are working with our partners across Devon to establish workforce redesign which will benefit ED

- **Simpson Ward** – in 2017, the establishment was increased to support safer staffing following the acceptance of a previous business case, which has seen incremental changes within the establishment. Recruitment to these vacant posts have been slow

- **Warrington Ward** – Through a process the Trust agreed to reduce and close the escalation beds on Warrington for use of the ward to support estates programme of works around the Trust. Substantive staff who were on secondment were therefore going back to their original job/role. This has left some gaps in RNs and temporary staffing have unfilled rotas sue to instability of the ward.

4.4 Nursing Agency Cap:

Section A – Nursing Agency Cap – currently at £2,869K full year based on 19/20 Trust submission to NHSI.

M3 plan value is £284K; year to date amount is £852K. The profile of the spend is higher in the first 6 months.

A Plan	*Agency Cap submitted to NHS Improvement (NHSI) £3,386K*												
Month	*April*	*May*	*June*	*July*	*August*	*September*	*October*	*November*	*December*	*January*	*February*	*March*	*FY 2019-20*
In month £K	284	284	284	284	284	284	184	184	204	204	204	185	2,869
Year to Date £K	284	568	852	1,136	1,420	1,704	1,888	2,072	2,276	2,480	2,684	2,869	

Section B – Actual usage in Month is £303K – this is £11K higher than previous month's usage.

This presents 6.1% of total M3 Nursing spend of £4,982K.

Year to date spend is £959K.

B	*Actual Year to Date Nursing Agency Spend £K*												
Month	*April*	*May*	*June*	*July*	*August*	*September*	*October*	*November*	*December*	*January*	*February*	*March*	*FY 2019-20*
Spend in Month £K	364	292	303										959
Total Nursing Spend £K	5,415	4,986	4,982										15,383
% Agency over Total	7%	5.9%	6.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	6.2%
Year to Date Spend £K	364	656	959	959	959	959	959	959	959	959	959	959	

Breakdown by month and cost centre is in Appendix 1.

Section C – the actual spend to date is above the target (£107K), representing 12.56% adverse against the cap.

C	*Variance Agency Cap versus Actual Spend £K (B-A) - (Overspend)/Underspend*												
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
in Month £K	80	8	19										107
Year to Date £K	80	88	107										
Distance from Cap %	28.17%	15.49%	12.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
UOR* Agency Rating	3	2	2										

Section D – The projected full year spend as at end of M3 (based on straight line estimate before any mitigation = £959/3 X 12) is £3,836K which is £967K higher than the cap.

D	*Forecast and Actual Spend FY 2019/20 (Straightline projection before mitigation)*												
	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Actual	Total
Month	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***January***	***February***	***March***	***FY 2019-20***
Full Year Forecast £K	4,368	3,936	3,836										

4.5 Model Hospital:

The latest model hospital data shows this Trust is in the lowest 20% for weighted adjusted unit (WAU) cost, CHPPD cost.

Money & Resources	Data period	Trust value	Peer median	National median	Chart
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£611	£686	£710	
Total Nursing & Midwifery FTE	2017/18	1,850.1	1,845.3	2,096.6	
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Apr 2019	9.1	7.9	8.1	
Cost per Care Hour - Total Nursing & Midwifery Staff	Mar 2019	£22.21	£23.73	£23.65	
Cost per Patient Day - Total Nursing & Midwifery Staff	Mar 2019	£175.74	£185.61	£189.65	
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£35,472	£34,872	£35,334	

The Trust has lower than national benchmark total FTE for nursing and midwifery. Recruitment is ongoing with local and overseas recruitment.

5.0 Strategic Change:

The Devon STP are monitoring and managing nursing vacancies through the STP Workforce Strategy Group. At present across Devon there are over 900 nurse vacancies in acute and community care; this figure takes account of all AfC bands although not surprisingly the greatest proportion of these vacancies are within band 5 (444). Actions to address this include:

5.1 The Devon overseas - recruitment objective is to implement regular cycle of Devon careers fairs for all health and social care recruitment, and promotion of careers to children and young people. Deliver targeted local recruitment campaigns, the first of these were completed on 16 March 2019. In November PDEG agreed the NHS Devon system approach to international recruitment of nurses undertaken with Cpl Healthcare. This will be a monthly programme of

recruitment, on a rolling basis. Once current vacancies are filled we should continue to recruit at reduced scale to ensure a pipeline supply of registered nurses. This is yet to commence as there have been some issues and the system approach is reviewing our Trust approach and utilising this across the system rather than using Cpl Healthcare.

5.2 Promoting Devon - A plan for a National advertising campaign to promote Devon as a place to work has been discussed. The 'Growing Devon's current and future health and social care workforce' campaign called 'Proud to Care Devon' has begun and will be targeted at young people, with the right values, to choose a career in the health and social care sector. There are further discussions around next steps

5.3 Existing employed Nursing HCAs from international countries seeking full registration - A current trial being conducted at RD&E proving successful. Following a comms exercise completed within the Trust a number of potential candidates were identified and being supported through the process to achieve registration.

5.4 Retire and return - Work has been started to create a system wide policy to enable retire and return for workers across health and social care system in Devon - attracting more retired workers back through flexible employment approaches

5.5 New and developing roles:

- Nursing Associates (NAs) band 4: The first cohort of 10 NAs have qualified in January 2019. These will be deployed as agreed in the ward workforce plan. The NQB published an improvement resource for the deployment of nursing associates in secondary care in November 2018 which is being used to guide future planning. A further cohort is commencing in September which will be a further 10.

- Assistant Practitioners (APs) band 4: The Trust has a well-established AP role that enables progression to registered nursing through the Foundation Degree route. Currently 47 HCA staff are undertaking the AP qualification. Of the 47, 28 commenced in September 2018 (on a 2 year programme) and we have 19 in their second year. We presently have 6 AP's undertaking the level 6 BSc Nursing degree apprenticeship qualification with the University of Plymouth. More are anticipated in 2019/20. Each ward / dept includes AP in the establishment to an agreed scope. The Trust has 99 APs practicing currently.

  Both NA and AP programmes provide routes into RN degree programmes, and the Trust has 21 RNs all of whom were previously APs.

- Maternity Support Workers (MSWs) band 4: The MSW is a well-established band 4 role in our integrated maternity service. The establishment review using Birth Rate Plus in 2018 confirmed the ratio of Midwives to MSW was right.

- Physician associates (PAs) band 7: The Trust has 14 PAs deployed according to service need. A further 7 are undertaking training and due to quality in 2020. The General Medical Council (GMC) have agreed to be the nominated regulatory

responsible for PA's. This allows the Trust to utilise this role as formal part of medical workforce redesign.

- Advanced Clinical Practitioners (ACPs) band 8a: The Trust has 1 ACP newly appointed in Cancer Services. The Trust is currently reviewing all advanced practice roles and mapping to the ACP Health Education England and NHS Improvement framework to identify this workforce and include a structured process to map the medical, nursing and professional practice within the workforce redesign.

- Student Nurses (band 5): The 2018 Operating Plan guidance recommends that STP Trusts ensure all qualifying student nurses who meet NMC registration standards are offered full employment. The Trust is proactive in engaging with students in their final year to offer posts prior to qualifying. The University of Plymouth confirm that the last cohorts were offered full employment at one of the STP Trusts. Following a successful bid to NHSI the Trust is expanding the number of student nurses by 27. The Trust is also working in collaboration with University of Exeter in the supply of student nurses as they run their first pre-registration cohort in September

- Apprenticeships: The Trust has a well-established apprenticeship program that enables progression from entry level band 2 care roles to Registered Nursing and beyond.

6.0 Leadership and Improvement Capability:

6.1 **Vacancies**:

June data shows the Trust has 86 RN vacancies and 29 non-registered nursing vacancies across the Trust. The total Nursing and Midwifery workforce is circa 1,850 which gives a vacancy rate of 7.2% which is mid- point of the national expected of 6-8%.

Of the 86 RN vacancies, 45 are band 5 acute, 11 are band 5 community. 8 of these are ED vacancies and 15 are Critical Care. Vacancy & absence is exacerbated by an RN sickness rate of 4.53%, a Non-registered sickness rate of 5.77% and maternity leave.

STP data shows the Trust to be comparable to other Devon Trusts for vacancies and sickness.

In addition to the new and developing roles described above in section 5, we have a number of recruitment and retention initiatives including:

- Skill mix review
- Return to Practice
- Effective use of bank
- e-rostering – Allocate Healthroster and Safe care
- Establishment reviews
- Workforce Plans
- Sickness management

6.2 Investment in nursing leadership:

Restructure increases the number of senior nurses to support the monitoring and strategy.

Ward / Department Manager development has been supported throughout 2018 and this will continue in 2019. The ward managers have reported that this has enhanced their ability to respond to the rapidly changing context and to help their team resilience.

6.3 Role redesign:

Work is underway to review existing roles to ensure they map to the new organisational structure and the focus on prevention, strengths based approaches and self-organising teams. The senior nursing review has been completed and the band 8 Matron post have been reviewed and will progress during Q2, the band 7 ward / service manager posts will be reviewed within Q2-Q3. Staff are engaged in this process and will contribute to the final job descriptions and person specifications. This process will be multi-professional to enable exploration of the opportunity to include AHP and therapy roles to create a single professional workforce for a ward or department.

7.0 Quality Improvement (QI) / Research Projects:

The QIG dashboard is compiled each month pulling data from all Trust sources. The dashboard can be interrogated for each level of service delivery i.e. from Trust level, and through the SDUs down to ward/team level. This enables identification of specific QI projects such as falls safe, pressure ulcer reduction and ward processes. Safe staffing QI projects link to the Quality Account priorities. The presentation of progress on Q1 of the 18/19 priorities was presented to Trust Board. Assurance that progress had been made on priorities was provided:

- Electronic Prescribing and Medicines Administration programme (EPMA)
- Community IT system
- Carers experience of care across the Urgent and Emergency Pathway

7.1 Allocate Health Roster:

Implementation of the Allocate Health Roster continues and a stock take of where we are with the implementation has been conducted. Work is ongoing to improve the integrity and accuracy of staffing data. KPIs are published and shared with the Integrated Service Units e.g. timely publication of the roster, and are discussed and actions planned. Elements of retraining to ensure proficiency are being undertaken.

7.2 Allocate Safe Care:

SafeCare implementation is being rolled out to support the completion of healthroster and provide realtime staffing and patient acuity as quickly as possible. This work will benefit from the reintroduction of senior nurse input over 12 months.

7.3 Quality Account:

A long list of priorities were identified:

- EPMA
- Community digital record
- Supporting carers in the Emergency Department

Q1 detailed evaluation of these projects will be shared within Trust Board report in July 2019.

7.4 CQUINS:

The CQUINS relating to staff for 2019/20 are:

CQUIN 1: Achieving an uptake of the flu vaccine by frontline clinical staff of 80%. As of A review of lasts years attainment and planning for this year has begun, more detailed information will be shared through the report presented at Trust Board.

CQUIN 3: Achieving 80% of older inpatients receiving key falls prevention actions. The Associate Director of Nursing and Professional Practice for Moor to Sea is working with the falls prevention team regarding delivery and a more detailed report will be presented at Trust Board.

7.5 Research:

A successful bid was submitted by the Chief Nurse, Professor Mary Hickson and Dr Susie Pearce to the Torbay Medical Research Fund (TMRF) in December 2018. The TMRF have agreed to part fund a six year program of pre-doctoral and a Doctoral study for non-medical staff. The two successful candidates, one pre-doctoral and one doctoral study will start in October 2019.

Dr Susie Pearce is working with Trust staff to undertake a research evaluation into the benefits of the Private, Voluntary and Independent Sector education for domiciliary care staff and patients. The research will be completed in 2019.

Dr Susie Pearce is also working with Trust staff to explore the benefits of the community hub multidisciplinary team working on staff. This research will commence in 2019.

8.0 Conclusion

This report provides an update on safe staffing using the 6 key performance themes provided by The NHS England Nursing Quality Board mandated regular reports to Trust Boards in guidance published in 2016 and updated in 2017.

The Trust safe staffing report provides evidence of benchmarking from model hospital, this Trust is better in WAU cost, CHPPD and quality measures compared to our peers and nationally.

9.0 Recommendations

The board are asked to note the contents of the Safe staffing report.

Report to the Trust Board of Directors

Report title: Estates and Facilities – Top line briefs, performance and exception report		Meeting date: 7th August 2019
Report appendix	Appendix 1: EFM Performance and compliance information Appendix 2: Food safety briefing	
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director of Estates and Facilities Operations	
Report provenance	Capital Infrastructure and Environment Group EFM Compliance Group Executives	
Purpose of the report and key issues for consideration/decision	The report is intended to provide an update to the Board on key issues and performance/compliance.	

Top line Briefs

Humidity and Temperature Issues – Theatres

High humidity within theatres has been a major issue. This is due to the age and condition of the ventilation systems and controls resulting in the inability to modulate the balance between humidity and temperature. An additional chiller has been installed and the operational, clinical and estates teams are working alongside each other to micro manage the operation of the ventilation system on an hourly and daily basis to achieve the best environment we can and minimise the impact on patient activity.

Food Safety

The CIEG group received assurance on food safety and the detailed actions that have been taken within the Trust following guidance arising from the Listeria Outbreak elsewhere, and the recent Environmental Health Inspection. Report enclosed in Annex 2.

EFM Performance and Compliance

EFM performance remains good across the Board, with the new reporting formats providing enhanced assurance of compliance. Performance on routine planned preventative maintenance dropped in month as a result of focus on the unusually large number of Statutory maintenance tasks for the month. Formally there were no catastrophic estate failures in the month of June although theatres remain an on-going issue. The summary report is attached with the new performance report appended at Annex 1 for information.

Health and Safety Executive Re-inspection of Site Safety

The Trust received two improvement notices in March 2019 relating to the safety of the site, particularly the safety of some paths and vehicles reversing in areas where they may come into contact with pedestrians. In addition one advisory notice was received around the Patient Transport vehicle washing area. These notices were subsequently discharged following urgent action undertaken by the teams to the satisfaction of the HSE inspector. A comprehensive action plan has been in place since this time with a variety of further improvements and changes to procedures having been made. The team are confident that the changes and improvements made will provide assurance to the HSE inspector, on their re-visit scheduled for the 1 August, that the Trust takes the safety of its public, staff and site very seriously. A verbal update will be provided to the Board Meeting.

Action required (choose 1 only)	For information ☐	To receive and note ☒	To approve ☐

Recommendation	The Trust Board are asked to receive and note the: • Top line briefs for EFM for the months of May and June • EFM Performance Reports and exceptions in the new format • Food safety briefing and assurance provided to the Capital Infrastructure and the Environment Group in July 2019
Summary of key elements	
Strategic objectives supported by this report	

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register	

Board Assurance Framework	X	**Risk score**	25
Risk Register	X	**Risk score**	25

External standards affected by this report and associated risks	

Care Quality Commission	**X**	**Terms of Authorisation**	**X**
NHS Improvement	**X**	**Legislation**	**X**
NHS England	**X**	**National policy/guidance**	**X**

Legal, Financial and reputational implications of the consequence of any regulator enforcement notices/action.

Report title: Estates and Facilities – Top line briefs, performance and exception report		**Meeting date: 7th August 2019**
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director of Estates and Facilities Operations	

1. Purpose

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the Months of May and June 2019 and should be read in conjunction with the attached appendix (Annex 1 EFM Performance and compliance reports)

2. Estates and Facilities Operations– Key Issues and performance exceptions report for May and June 2019.

Table 1 below identifies the Key Performance Indicators and variances for Estates and Facilities performance for the months of May and June 2019. Any areas of concern for the attention of the Board is shown with appropriate explanation and action to achieve a resolution is shown at Table 2 below.

Table 1: May and June 2019 Scorecard Indicator.

Green ✓ / Amber ! / Red X	May Last Month	June This Month
Improving Indicators		
Estates – Internal Critical Failures	X	✓
Deteriorating Indicators		
Estates - Routine maintenance	!	X
Estates - Urgent – P3 <7 Days	✓	!
Safety - Incidents resulting in Moderate harm	✓	!
Red rated Indicators with no change		
Waste - % of Total tonnage of Clinical Burn waste	X	X
CAS Alerts Overdue for Completion	X	X

Table 2: Areas with Specific Cause for Concern	
Estates	**Routine PPM % success against plan**
Explanation	This is at 81% and 58% completion for May and June as priority is being given to Statutory and Mandatory maintenance of which there has been an unusually high number. This is expected to be back in balance next month.
EHO	**Decreased score from 5 to 2**
Explanation	EHO visit in December 2018 reduced score from 5 to 2. Action plan implemented to address issues and re-score has been applied for. The Trust is awaiting a re-visit.
Waste	**% of Total tonnage of Clinical Burn waste**
Explanation	Increase is due to theatre waste being changed to incineration over segregation concerns. CIEG has received an assurance report, and asked for further information. This disposal route for theatres waste creates the least risk in terms of financial penalties for appropriate non-segregation of waste. This indicator will therefore remain

	red.
Safety	**CAS Alerts Overdue for Completion**
Explanation	CAS Alerts are general and technical notices circulated from NHSE, that may or may not require action. The Number of Estates and Facilities overdue alerts has dropped significantly in the previous months, and continued effort is underway to reduce this to zero. Compliance is now monitored and reported through the monthly compliance group.

3. Estates and Facilities Operations Compliance Issues and Exceptions.

Main exceptions:

- Dry riser inspection – this is now out of date due to contractor failure to undertake the inspections. A new contractor has been appointed and will attend site in August.

- Fire Hydrants – It has now been agreed for the Fire Service to inspect the fire hydrants. Currently awaiting formalities to be in place and date will be agreed for inspection within the next week.

- Medical Gases Pipe Systems – A Designated Nursing / Medical Officer (MGPS) should be identified and formally appointed in line with HTM 02. – referred to the medical gasses group.

4. Estates and Facilities Top line Briefs.

4.1 Humidity and Temperature Issues in main theatres

As a result of the humid and hot weather over the last month, conditions of high humidity within theatres have been a major issue. This is due to the age and condition of the ventilation systems, controls and monitoring equipment. Consequently they are not able to modulate automatically to lower humidity and temperatures.

The Head of Estates Operations and Mechanical Services Lead are working with the Trust Authorised Engineer and other technical specialists to upgrade the monitoring and control systems for the ventilation to allow them to react automatically to the external conditions. Initially this will consist of remote temperature and humidity monitoring of the theatre areas combined with manual adjustment of the system, but will then be upgraded to system and area monitoring and automatic control of the system.

An additional chiller has been installed to provide extra chilled water capacity for the systems, and ensure resilience of the chilled water services.

The Estates Operations Team in the meantime continue to manually adjust the operation of the ventilation systems and are working closely with the clinical teams to try and achieve the best environment we can to reduce the impact on patient activity.

4.2 Waste

The Group received a detailed waste report and in particular assurance around Clinical Burn Waste. Rationale was provided to the group with regard to the necessity to transfer the theatre waste fully over to clinical burn waste due a waste segregation issue identified during a waste audit.

4.3 Lifting Operations and Lifting Equipment Regulations (LOLER)

The Group received a detailed report regarding compliance of patient hoists and their accessories under the Lifting Operations and Lifting Equipment Regulations (LOLER) and means for continued assurance. Lifting equipment which is used for lifting persons is regulated under LOLER and this includes patient hoists and lifts. The report detailed a number of issues relating to the tracking of hoists for annual insurance inspection. A strengthen of the system under the medical devices team was agreed. Audit of lifting appliances will be added to the Matrons regular checks.

4.4 Food Safety

Assurance was provided on food safety within the Trust. Detailed actions were described that have been taken following guidance arising from the Listeria Outbreak earlier this year when it was reported through the media that 9 NHS patients in the UK had been affected through an outbreak of Listeria from processed meat in pre-packed sandwiches. NHS England contacted all Trusts and the TSDFT Head of Facilities confirmed that the Trust does not procure products from the Good Food Chain Company.

In addition the Trust sandwich suppliers and the catering contractors on site (WH Smith and Aramark at Level 4 Main Entrance and the League of Friends on Level 2) were contacted. Statements were provided from the contractors which confirm they do not use the suppliers involved in the Listeria outbreak. All provided assurance to the Trust regarding the process and procedures they use to reduce the possibility of their food becoming contaminated and the system they have in place if a supplier notifies them of a contaminated food issue.

In an unrelated issue the EHO visit in December 2018 reduced score from 5 to 2. Action plan implemented to address issues and re-score has been applied for. We await the visit.

The food safety briefing is shown in Annex 2 for assurance.

5. Recommendations

The Trust Board is asked to receive and note the:

- Top line briefs for EFM for the months of May and June
- EFM Performance Reports and exceptions in the new format – Annex 1
- Food safety briefing provided to the Capital Infrastructure and the Environment Group in July 2019 – Annex 2

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data May - June 2019 for July 2019 Report	2018-19 Quarter Four			2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20								
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12					Constant Review	Cause for Concern	No Concerns	
Estates - Planned & Reactive work Performance	Total PPMs planned per month (not KPI)	1,071	956	1,080	979	1,374	0	0	0	0	0	0	0	0	0	0		5460	1365	Variable	4			Not a KPI - an indicator of volumes
	Statutory PPMs planned per month	403	369	398	347	796												2313	463	Variable				
	Statutory PPM % success against plan	98%	97%	98%	98%	98%													98%	97%	85%	85%	97%	
	Mandatory PPMs planned per month	453	444	432	485	422												2236	447	Variable				
	Mandatory PPM % success against plan	99%	98%	98%	97%	100%													98%	97%	85%	85%	95%	
	Routine PPMs planned per month	215	143	250	147	156												911	182	Variable				
	Routine PPM % success against plan	76%	76%	88%	67%	58%													73%	90%	60%	60%	70%	
	Total Reactive Requests per month (not KPI)	995	882	901	851	910	0	0	0	0	0	0	0	0	0	0		4539	1135	Variable	4			Not a KPI - an indicator of volumes
	Emergency - P1 - requests per month	56	71	47	97	60												331	66	Variable				
	Emergency - % P1 completed in < 2hours	99%	99%	98%	100%	99%													99%	97%	90%	90%	95%	
	Urgent - P2 - requests per month	188	120	135	94	139												676	135	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	91%	91%	95%	98%	91%													93%	97%	85%	85%	90%	
	Routine - P3 - requests per month	601	556	591	543	564												2855	571	Variable				
	Routine - % P3 completed in < 7 Days	79%	81%	80%	90%	81%													82%	97%	75%	75%	85%	
	Routine - P4 - requests per month	150	135	128	117	147												677	135	Variable				
	Routine - % P4 completed in < 30 Days	74%	73%	82%	86%	80%													79%	97%	65%	65%	75%	
	Estates Internal Critical Failures per month	6	2	4	3	0												15	3.0	0	2	1	0	
Estates - Statutory / Mandatory Compliance Performance	Fire Alarm Testing Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Emergency Lighting Compliance - % In date					99%													99%	97%	85%	85%	97%	
	Fire Extinguisher Compliance - % In date					96%													96%	97%	85%	85%	97%	
	Fire Dry Risers Compliance - % In date					100%													100%	97%	85%	85%	97%	Annual Testing in Progress
	Fire Hydrants Compliance - % In date					100%													100%	97%	85%	85%	97%	LAFB testing program about to commence.
	Fire Dampers Compliance - % In date					93%													93%	97%	85%	85%	97%	64% Pass, 29% No Access, 7% actually failed. RJ Urmson on site
	Fire Supression Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Fixed Wire Testing Compliance - % In date					93%													93%	97%	85%	85%	97%	
	HV Equipment Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Generator Servicing Compliance - % In date					92%													92%	97%	85%	85%	97%	
	Lightning Protection Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Auto Door Inspection Compliance - % In date					100%													100%	97%	85%	85%	97%	
	LEVs Testing Compliance - % In date					96%													96%	97%	85%	85%	97%	
	Critical Vent Varification Compliance - % In date					98%													98%	97%	85%	85%	97%	
	Kitchen + Extract Duct Clean Compliance - % In date					94%													94%	97%	85%	85%	97%	
	Gas Pipework Compliance - % In date					96%													96%	97%	85%	85%	97%	
	Gas Appliance Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Landlord Gas Appliances Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Pressure Systems Compliance - % In date					95%													95%	97%	85%	85%	97%	
	Window & Restrictor Insp Compliance - % In date					96%													96%	97%	85%	85%	97%	
	Edge protection Compliance - % In date					100%													100%	97%	85%	85%	97%	
	Ladder Inspection Compliance - % In date					100%													100%	97%	85%	85%	97%	
Porters	Porters - Total Tasks per month	9436	8287	8793	8451	9275	8590											52832	8805	Variable				Not a KPI - an indicator of volume
	Porters - Bloods Tasks per month	2457	2083	2383	2278	2471	2422											14094	2349	Variable				
	Porters - Patient Transfer Tasks per month	2346	2019	2297	2096	2445	2144											13347	2225	Variable				
	Porters - Notes Tasks per month	1640	1431	1432	1542	1735	1521											9301	1550	Variable				
	Porters - Urgent Tasks per month	1.8%	1.9%	2.1%	2.2%	1.9%	1.9%												2.0%	Variable				Percentage of Total Tasks
	Porters - Routine Tasks per month	95.3%	94.4%	94.5%	93.9%	95.2%	94.9%												94.7%	Variable				Percentage of Total Tasks
	Porters - Booked Tasks per month	2.9%	3.7%	3.4%	3.9%	2.9%	3.2%												3.3%	Variable				Percentage of Total Tasks

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data May - June 2019 for July 2019 Report	2018-19 Quarter Four			2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20								
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12					Constant Review	Cause for Concern	No Concerns	
Cleaning	Cleaning Scores - Brixham Hospital			97%	98%	98%	99%												98%	97%	90%	90%	95%	
	Cleaning Scores - Dawlish Hospital			97%	99%	98%	98%												98%	97%	90%	90%	95%	
	Cleaning Scores - Newton Abbot Hospital			97%	99%	99%	98%												98%	97%	90%	90%	95%	
	Cleaning Scores - Totnes Hospital			97%	98%	99%	98%												98%	97%	90%	90%	95%	
	Cleaning Scores - Acute Setting			95%	98%	98%	98%												97%	97%	90%	90%	95%	
	Compliance Very High Risk Cleaning Audit	99%	99%	98%	98%	98%	99%												99%	98%	95%	95%	98%	
	Compliance High Risk Cleaning Audit	98%	98%	97%	97%	97%	96%												97%	95%	90%	90%	95%	
	Compliance Significant Risk Cleaning Audit	98%	98%	98%	98%	98%	97%												98%	85%	80%	80%	85%	
	Compliance Low Risk Cleaning Audit	99%	99%	99%	96%	96%	98%												98%	75%	70%	70%	75%	
	HPV Cleans per month	25	11	13	11	21	31											112	19	Variable				From Porter data HPV data
	Deep Cleans per month	1018	1052	867	854	887	801											5479	913	Variable				From Porter data Deep Clean Categories (x5) data
	Critical Cleaning Failures	2	1	1	1	0	0											5	0.8	0	2	1	0	

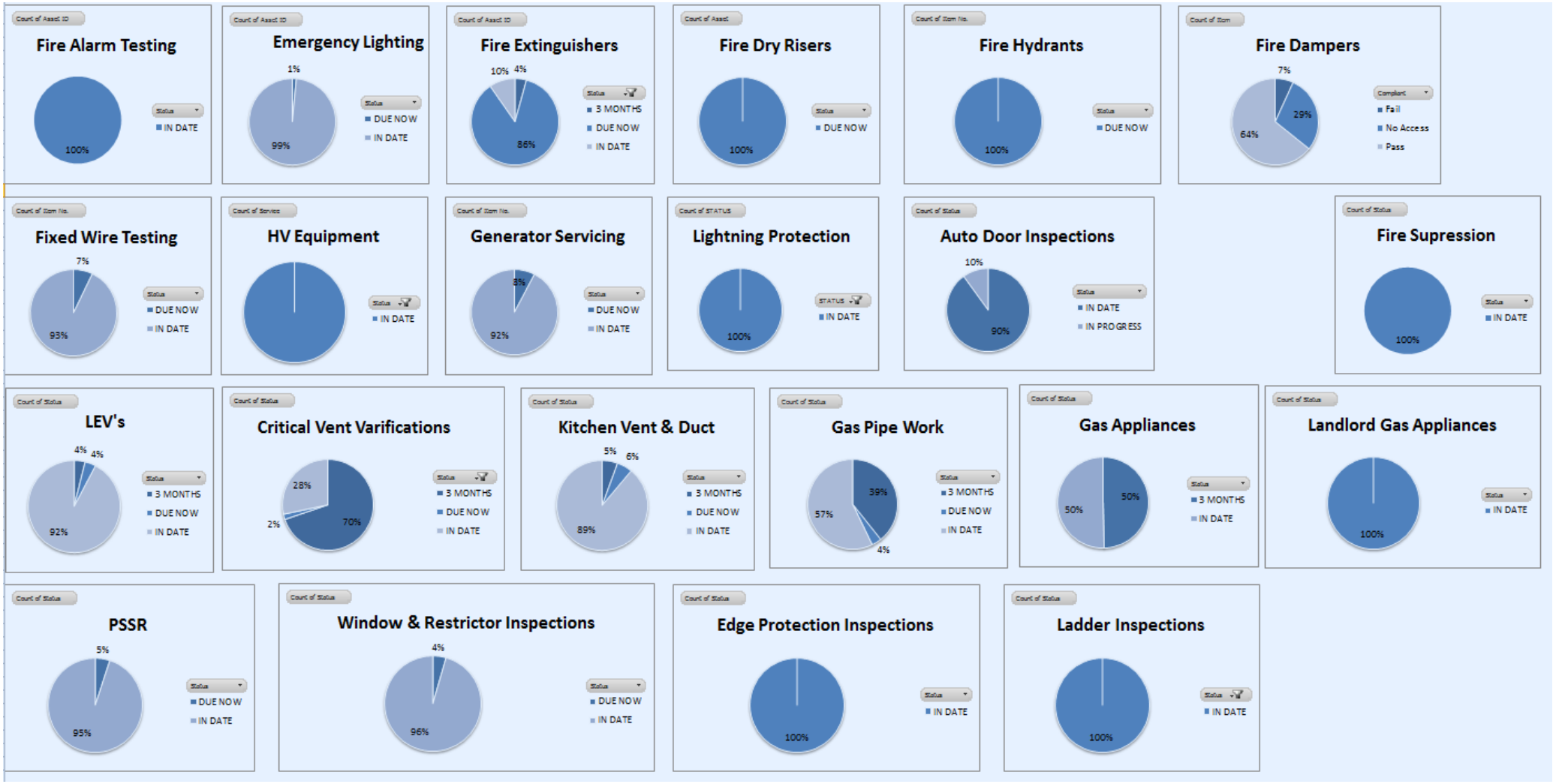
Domain	Estates & Facilities Operations Performance Data May - June 2019 for July 2019 Report	2018-19 Quarter Four			2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20								
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12					Constant Review	Cause for Concern	No Concerns	
Accom	Boyce Court Occupancy Void Costs	219	279	1224	0	381	340											721	407.2	Variable	2000	2000	1000	IVs in arrears. 68 Flats, charges if 95%-70% full. Budget £24,312
	On-Site - Staff Accomodation Income				34,142	31,084	19,398											84624	28208.0	Variable	19256	19256	24391	Annual budget - £308,099
Catering	Patient Meals provided per month				13976	14024	14247											42247	14082	Variable				
	Meals purchased at Bayview Restaurant per month				3874	3917	4027											11818	3939	Trend				
	Meals purchased at Horizon Café per month				327	314	307											948	316	Trend				
	Red Catering Trays per month				748	763	724											2235	745	Trend				Need to establish data collection method
	% of Catering Food Waste per month				2.0%	2.0%	3.0%												2%	5%	10.0%	10.0%	5.0%	
	EHO Audit Scores - Acute				2	2	2												2	5	3	4	5	
	EHO Audit Scores - Brixham Hospital				5	5	5												5	5	3	4	5	
	EHO Audit Scores - Dawlish Hospital				5	5	5												5	5	3	4	5	
	EHO Audit Scores - Newton Abbot Hospital				4	4	4												4	5	3	4	5	
	EHO Audit Scores - Totnes Hospital				5	5	5												5	5	3	4	5	
Waste	Total Tonnage all waste streams per month	202.9	168.6	152.5	161.0	185.0	161.7											1031.7	172.0	Trend				
	% of Total tonnage Recycled Waste per month	54.1%	50.4%	46.1%	47.4%	49.5%	50.1%												50%		40.0%	40.0%	47.1%	
	% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%												0%		15.0%	15.0%	5.0%	
	% of Total tonnage of Clinical Non-Burn waste per month	8.9%	9.8%	10.5%	10.1%	9.1%	10.7%												10%	100%	25.0%	14.0%	20.0%	
	% of Total tonnage of Clinical Burn waste per month	9.2%	10.7%	12.2%	10.8%	10.1%	10.5%												11%	100%	8.0%	4.0%	6.0%	
	% of Total tonnage of Clinical Offensive waste per month	9.5%	11.2%	12.0%	11.9%	10.6%	10.6%												11%		5.0%	10.0%	7.5%	
	% of Total Tonnage Waste to Energy	18.4%	17.9%	19.2%	19.9%	20.8%	18.1%												19%		35.0%	35.0%	24.0%	
	Total Waste to Energy (tonnes)	5.3	28.7	31.4	30.6	29.0	28.6											153.5	25.6	Trend				This figure does not necessarily match the % of the total
	Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%												100%	Trend	89%	89%	95%	15 Audits per month

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data May - June 2019 for July 2019 Report	2018-19 Quarter Four			2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Workforce	Total Estates and Facilities Staff (FTE)			380	387	391	392	0	0	0	0	0	0	0	0	0			388		4			Update no of reported months in V94 for correct average in T94
	Estates Staff			34	34	34	34												34					
	Facilities Management			23	23	23	22												22					
	Hotel Services - Catering			33	33	33	33												33					
	Hotel Services - Domestic			216	223	227	230												224					
	Hotel Services - Other			74	74	74	74												74					
	Achievement Review Compliance %			96%	92%	95%	95%												95%	95%	80%	80%	90%	
	Sickness Absence % (Month Sick Rate)			4.4%	3.8%	3.0%													3.7%	3%	3.8%	3.8%	3.5%	One month in arrears
	Mandatory Training - Conflict Resolution			95%	93%	96%	97%												95%	90%	75%	75%	85%	
	Mandatory Training - Equality & Diversity			97%	96%	98%	98%												98%	90%	75%	75%	85%	
	Mandatory Training - Fire Training			97%	96%	98%	97%												97%	90%	75%	75%	85%	
	Mandatory Training - Health & Safety			97%	95%	96%	98%												97%	90%	75%	75%	85%	
	Mandatory Training - Infection Control			95%	94%	96%	96%												95%	90%	75%	75%	85%	
	Mandatory Training - Information Governance			96%	94%	94%	94%												94%	95%	85%	85%	95%	Catering Team at 86.36%
	Mandatory Training - Moving & Handling			97%	97%	98%	99%												98%	90%	75%	75%	85%	
	Mandatory Training - Safeguarding Adult Level 1			97%	96%	99%	98%												97%	95%	80%	80%	90%	
	Mandatory Training - Safeguarding Children			97%	95%	96%	97%												96%	95%	80%	80%	90%	
	Mandatory Training - Resuscitation			90%	91%	92%	94%												92%	90%	75%	75%	85%	Hotel Services (Other) at 79.01%
	Mandatory Training - Basic Prevent Awareness			98%	97%	99%	99%												98%	90%	75%	75%	85%	
Safety	EFM Serious/RIDDOR incidents			0	1	0	0											1	0.3	0	2	2	0	
	EFM incidents resulting in moderate harm			1	2	0	2											5	1.3	0	3	3	1	
	EFM incidents resulting in minor harm			4	1	5	4											14	3.5	0	8	8	4	
	EFM incidents resulting in no harm			2	2	11	10											25	6.3	0	12	12	5	
	CAS Alerts active and in Progress	9	9	10	9	8	7												9	Variable				
	CAS Alerts Overdue for Completion	6	5	5	5	7	6												5.7	0	2	2	0	

Annex 1 Estates Compliance Monitoring

Estates Compliance – Status as at 12 July 2019.



Report to:	Capital Infrastructure and Environment Group/Trust Board
Date:	July 2019
Report From:	Associate Director Estates and Facilities Operations
Report Title:	Food Safety Briefing Paper

1. Purpose

The purpose of this paper is to provide assurance regarding food safety within the Trust to the CIEG group and Trust Board.

2. Background

2.1 Listeria Outbreak

On the 7th June 2019 it was reported through the media that 9 NHS patients in the UK had been affected through an outbreak of Listeria from processed meat in pre-packed sandwiches. After an initial investigation Public Health England confirmed the sandwiches were eaten before the 25th May 2019. Sadly 5 patients died and one still to be established.

After PHE investigation it was confirmed The Good Food Chain Company had provided the sandwiches which were linked to the outbreak. The company supplied 43 NHS trusts across the UK and they had been supplied with meat produced by North Country Cooked Meats which subsequently produced a positive test result for the outbreak strain of listeria. On the 26th June the Food Standards Agency (FSA) announced that The Good Food Chain Company and North Country Meats passed all checks with the FSA and have now been cleared to re-commence operations. However they will need to apply for accreditation again before they can directly supply the NHS.

NHS England contacted all Trusts and the TSDFT Head of Facilities confirmed that ***the Trust does not procure products from The Good Food Chain Company.***

In addition the Trust sandwich suppliers and the catering contractors on site (WH Smith and Aramark at Level 4 Main Entrance and the League of Friends on Level 2) were contacted. ***Statements were provided from the contractors which confirm they do not use the suppliers involved in the Listeria outbreak***. All provided assurance to the Trust regarding the process and procedures they use to reduce the possibility of their food becoming contaminated and the system they have in place if a supplier notifies them of a contaminated food issue.

2.2 Food Hygiene Rating

Following the visit by Environmental Health Officers in December 2018, Torbay Hospital was awarded a food hygiene rating of 2 “requiring some improvement”, this is a drop from the previous rating of 5 excellent. Inspectors found that some wards were holding chilled products in domestic fridges and the food safety management procedure (HACCP) required minor update.

The inspector was new to the Trust, and had the Trust been given the opportunity to challenge the revised rating it would have done so.

Action has been taken. All the domestic fridges on the wards have been replaced with commercial appliances and the HACCP updated accordingly. A request was submitted in February 2019 to Torbay Council for a re-inspection of the premises, this remains outstanding.

In addition, checks are in place to ensure the daily temperature checks of ward fridges are carried out and issues escalated accordingly, with any non-compliance addressed immediately by the Catering Manager. Catering audits have also been implemented to ensure compliance is being achieved. This is being monitored through the EFM Performance and Compliance Group and reported to the Capital Infrastructure and Environment Group.

3 Assurance

In summary the following actions have been taken in relation to food safety:

- Random temperature checks of sandwich deliveries
- Provision of a separate fridge for the sandwiches to be stored immediately upon delivery in the catering department
- Provided door fronted fridges in Bayview restaurant to ensure the temperature of sandwiches are kept at a constant temperature.
- Implemented cool boxes for delivery to wards for sandwiches and other chilled products
- All retail outlets, including the League of Friends, have been instructed by the Head of Facilities to remove sandwiches from open trollies used for selling items to staff and the public within the hospital where temperature controls are not in place. (the LoF now have a cool box on their trolley)
- HACCAP procedures have been updated for all sites
- Commercial fridges have been provided to all ward kitchens
- Process implemented to ensure ward fridge temperatures are recorded correctly and issues escalated to the Catering Manager accordingly
- Additional catering audits implemented to ensure food safety compliance is satisfactory
- Additional monitoring of food safety audits through the EFM Compliance and Performance Group

6. Recommendation

The Capital Infrastructure and Environment Group and Trust Board are asked to note the content of this report and take assurance on the food safety processes within the Trust and the positive outcomes and changes made to strengthen food safety compliance across the Trust. Action plans will continue to be monitored through the new EFM governance and reporting arrangements.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Report from the Chief Operating Officer			Meeting date:7th August 2019
Report appendix	Structure Chart		
Report sponsor	Chief Operating Officer		
Report author	Chief Operating Officer		
Report provenance	The report has been considered by the executive group on the 30th July. Additionally the Elective Care and Cancer Risk and Assurance Group and the System Assurance and Transformation Group have informed the report. External content has been sourced from the Devon STP System Performance Group papers.		
Purpose of the report and key issues for consideration/decision	The report is presented to keep the Board update date with the work of the operational teams, and highlights the relative position of the Trust in relation to the performance standards. • The actions being taken forward to secure financial and operational performance are described. • Risk to delivery and mitigating actions		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to not the contents and conclusion in the report, provide challenge and seek additional assurances as may be required.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	x	**Risk score**	12
Risk Register	x	**Risk score**	12

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England		**National policy/guidance**	

	Risks are set out in the body of the report. The main risks relate to workforce and estates vulnerabilities in key high risk specialties.

Report title: Report from the Chief Operating Officer		**Meeting date: 7th August 2019**
Report sponsor	Chief Operating Officer	
Report author	Chief Operating Officer	

1. Introduction

The report provides context and assurance across 3 important aspects of operational delivery:

1) Finance - current position with respect to business as usual CIP, the processes and assurance in place to drive improvement.
2) NHSi Key Operational Standards – The relative position of the Trust and the plans in place to stabilise and improve performance. This section also covers risks to delivery and mitigations in place.
3) Operational Delivery Governance and transition update.

2. Discussion

2.1 Operational Delivery Business as Usual Cost Improvement Plan (CIP)

The System Teams and Integrated Service Units are focussing intensely on delivery of both the 2% recurrent CIP requirement and delivery of a range of controls designed to reduce spend in the immediate term. It is recognised in order to achieve the control total this will also include closing any in year gap on the transformational schemes, whilst progressing delivery of their strategically important programme of work.

Current Forecast

The total business as usual CIP is £8M plus a further £1.5M of additional slippage, £9.5M. The operational deliver teams share of this target is £7.6M. The balance to £9.5M has been applied to the Trust corporate functions. As of 19th July operational and clinical teams have identified a total of £3.9M against the target which includes £0.5M being identified from additional cost control measures. This leaves a net gap of £3.7M (as per the table below). This gap is reducing daily and following the most recent CIP assurance meetings (PIMS) further significant progress has been made. The value is being assessed and will be reported as a verbal update to the Board.

System CIP summary as at M3 201920

Target	Forecast delivery at M3	Vacancy review further savings	Cost control measure exercise JH	**Total revised delivery**	Gap
£ m	£ m	£ m	£ m	**£ m**	£ m
7.6	2.8	0.6	0.5	**3.9**	3.7

Processes and Assurance

The clinical leads across both systems and the ISU's have reviewed all vacancies. Following this exercise an initial proposal to reduce the recurring pay budget by £600K has been produced. This has the advantage of delivering recurrent CIP rather than delivering through enhanced cost controls. Thereby delivering CIP in a planned and sustainable way. The team have also recognised the need to go further and have introduced costs control measures designed to secure the £500K identified above. A further measure undertaken has been to review the list of cost pressures and in particular those that are not yet fully committed in the run rate. Much of this commitment related to the additional clinical activity assessed as necessary to secure performance trajectories. These are being reviewed to triangulate the current performance delivery, spend to date and the necessary activity to maintain trajectory. It is expected increased efficiencies in some areas such as theatres will mean that not all of the value set aside will be necessary.

The teams have also lodged significant values with the PMO office for schemes under development and have been asked to increase the focus on turning this quickly into programmed delivery. This includes a further review of cost pressures. Although this has happened multiple times already there is still the potential for more efficient delivery of some of the performance trajectories.

Partnership work with the RD&E Trust is also programmed to deliver more resilient and cost effective clinical services. In particular the Trust has high levels of non-substantive staffing in some specialties (eg dermatology) and continued challenges in securing robust supply. Reduced budgets are being targeted in this area as the Trusts in the South, East and North Devon Network support each other more effectively.

Risks to delivery and mitigating actions

The key risk to delivery of the position is the need to respond sometimes at very short notice to the ongoing vulnerabilities in our specialist workforce and to the vulnerability of the estates infrastructure. The additional disruption in theatres 1 to 6 in recent weeks has resulted in an increased need to outsource or put on additional theatres sessions out of hours. Securing additional activity from the current workforce is then increasingly challenging as a result of the pension tax impact on individuals.

Delivery of the new ways of working through the locality focussed delivery structure is becoming more embedded and teams are finding opportunities as a result that will over time support more resilient, sustainable and cost effective services. There is however an overhead of moving into the new structure in terms of learning and development both for individuals and across the new teams.

The governance and oversight of this programme is covered in the delivery structure section of the COO report.

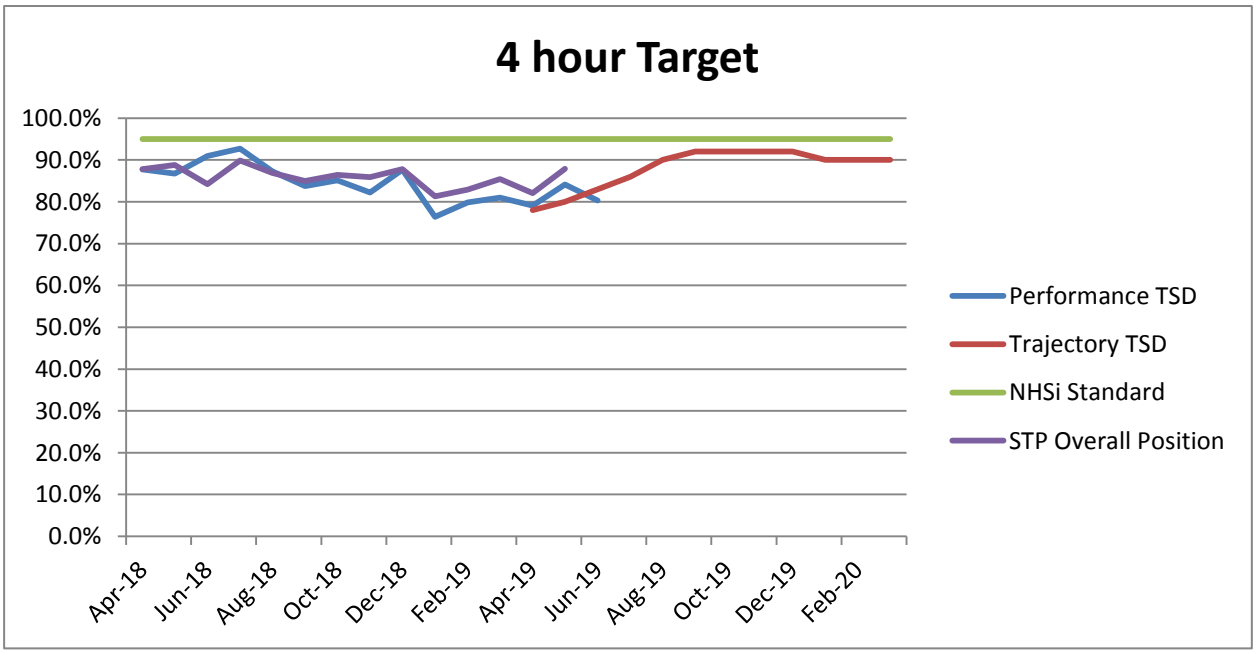
Conclusion

The delivery teams are making progress in closing the CIP gap but further work is needed using the existing processes to secure the position in full.

2.2 NHSi Key Operational Standards

The Trusts Integrated Performance Report focusses appropriately on the current performance position of the Trust. This report places the current performance in context over time and compared to our STP neighbours. The purpose is to set out the key drivers for performance, the action plans in place to secure trajectories, risks to delivery and the mitigation plans.

a) 4 Hour ED and MIU target



Drivers

Between April 2018 and December 2018 the Trusts 4 hour performance approximated to the Devon STP average, with some months marginally above and some marginally below. The graph above identifies since January 2019 4 hour performance has been below the Devon average. Analysis noted in the Integrated Performance Report identifies year on year growth rates between 4% and 5% in the 4 months January to April 2019. Within the constrained environment of the Trusts current ED and workforce capacity constraints this increase has impacted significantly on 4 hour performance. Variation in the number of ED attenders and increases in peak numbers of attenders on the busiest days has increased the pressures. There is significant variation in the number of patient discharges the Trusts manages with weekend levels being reduced. This variation is greater than is experienced at other Trusts and is not indicative of the benefits available as an ICO. The impact is a predicable restriction on safe patient flow through the system over the weekend and into the early part of the week.

Despite these pressures the Trust delivered the Q1 improvement trajectory; however it is recognised further work is necessary to secure confidence of delivery in Q2 and beyond as illustrated above the trajectory increases.

Actions

These are reported in detail the main IPR and are therefore not repeated here. The actions are clinically led across 3 work streams; Emergency Floor, Wards, Home First. The Head of Operations is completing a 1st quarter review of the actions to enable a stocktake and to be better able to describe the highest priority actions. This work will also include an impact assessment of the actions to support an assessment of when and how the Trust will secure the trajectory.

The primary focus is seeking to reduce variation in weekend discharge levels and a number of tests of change are being coordinated in August to support this aim.

Joint work with the commissioning information team will provide further analysis on the activity levels and support identification of system as well as Trust solutions.

Assurance processes

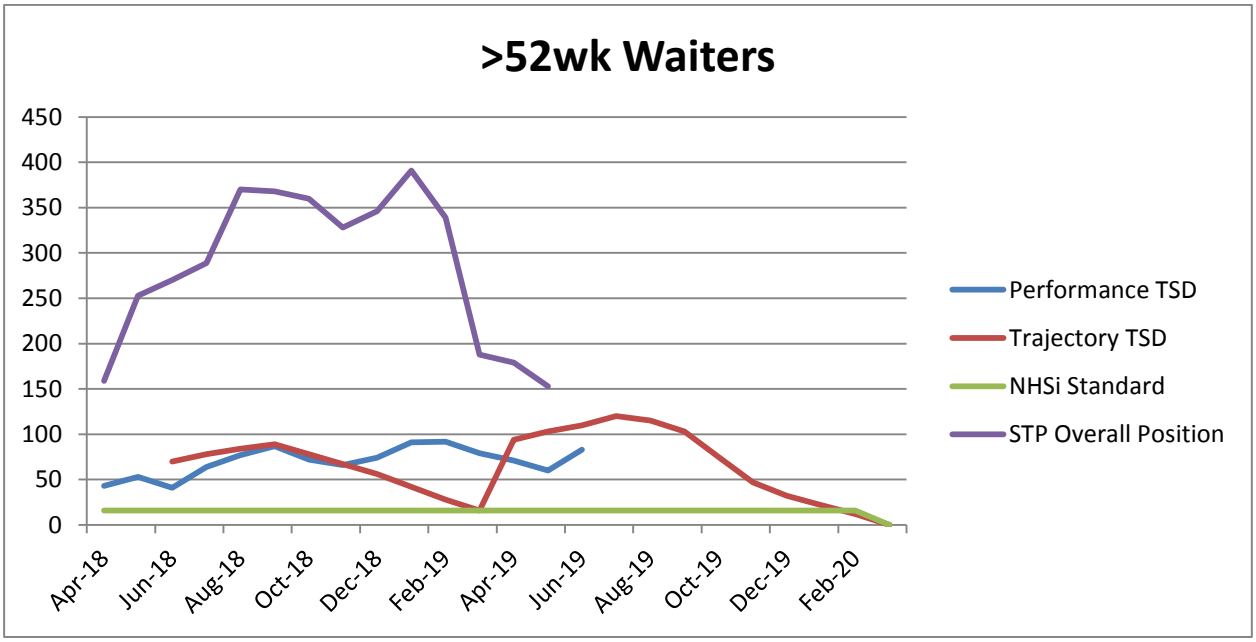
The South Devon system leadership team, COO and head of performance meet weekly with NHSi and the CCG to review the improvement actions and provide an understanding of the impact on performance. This is the 4 Hour Improvement Assurance Group and also provides assurance on performance for the week and review of operational readiness for the weekend ahead. A stocktake of all the activity supporting the delivery improvement including the system wide transformation is being developed to ensure visibility, connectivity and a focus on recovery; this will be reviewed weekly and will be a standing item at the A+ E delivery board.

Risks and mitigations

Continued pressure of activity levels, patient complexity and the variation of discharge levels represent the main risks to delivery. Creating a shared understanding with the CCG and NHSi of the demand pressures will be critical in securing appropriate responses to these pressures.

The stocktake of actions and prioritisation of tests of change to impact on the key drivers for performance is also critical and further information will be available by the time of the Board meeting.

b) Elective waiting times over 52 weeks



Drivers

In April 2018 the Trust set an improvement trajectory to reduce the number of patients waiting over 52 weeks to zero by 31st March 2019. The graph above illustrates how this was being managed within the trajectory until November 2018. However 2 theatres were then taken out of service in November and recovery actions were necessary to avoid the position deteriorating significantly. The Trust has been commended for these actions by NHSi which included extending day surgery, increasing utilisation of remaining theatres and weekend working. Patients were also offered the choice of transferring to local private hospitals.

As illustrated above the wider Devon system made some significant improvements towards March 2019 as other Trusts outsourced work and took other actions to reduce the numbers waiting 52 weeks.

Actions

The Trust continues to extend day surgery opportunities and provide weekend elective theatre activity. Reopening the 2 closed theatres in mid Spetember will provide the theatre capacity for increasing orthopaedic joints which has been the primary restriction since November 2018. Together with the Coastal ISU's plans to provide staffing for these theatres the team are confident of managing the 52 week position within the trajectory.

Other (non-surgical) teams are avoiding any patients waiting over 52 weeks through micro management of their waiting lists.

NHSi Information Analyst has supported the Trust in developing enhanced reporting infrastructure with robust predicative capabilities. This has been critical in secure early warning and enabling recover actions to be taken early.

Assurance and control

The Trusts Head of Elective Performance reviews the detail position across all specialties with teams every week and flags up concerns for escalated action as necessary. This feeds into the fortnightly Risk and Assurance Meeting with the COO and the ISU lead managers. As a result of the Trusts ability to demonstrate control and delivery within the improvement trajectory NHSi and the CCG have stepped down the external scrutiny processes.

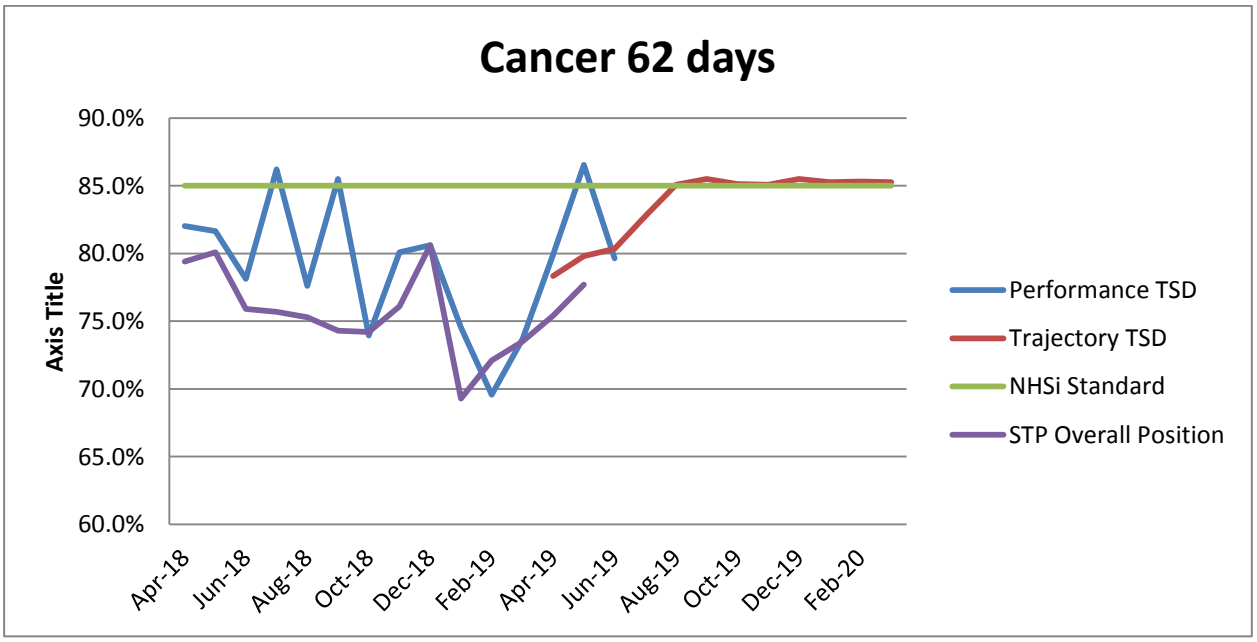
Risks and mitigations

The contribution from 2 new theatres opening is reflected in the improvement trajectory, reducing from September to zero by March 2020. The risk to delivery arising from the known vulnerabilities in the Trusts other theatres has been illustrated in recent weeks during the humid and hot weather. A number of times theatre lists have had to be taken down and patients rescheduled to protect capacity for patients with the highest clinical priority. This has impacted on the planned reduction in long wait patients but has not yet undermined the improvement trajectory. The team work from the estates and operational teams in theatres has been phenomenal. To date this has minimised the impact and enabled the trajectory to still be achieved.

However the risk increases every time these vulnerabilities occur and recovery is sometimes made more challenging as a result of clinicians not being able to provide additional sessional work without impacting negatively on their personal pension tax position.

To mitigate the teams are working to a trajectory of a minimum of 10% inside the annual planning trajectory. Early warning of risk is secure though the NHSi monitoring tool and the surgical team has developed a plan B to include further insourcing and outsourcing as options. This is all being managed within the financial envelope whist also securing the contribution to CIP as described in the finance section to this report.

c) Cancer treatment commencing within 62 days from a 2 week wait referral



Drivers

The Trust has remained ahead of (better than) the Devon position over this period, although as can be seen, the performance is variable. Increases in the number of 2 week wait GP referrals runs at approximately 8% with breast referrals up 13%. The clinical teams prioritise capacity across all elements of the pathway; outpatient, diagnostic and surgical for cancer patients and particularly once a diagnosis is made. Challenges in delivery of the 2 week wait standard have been experienced in urology, colorectal and dermatology. In order to treat within 62 days the 2 week wait stage of the pathway is important and at times is has taken 42 days (6 weeks) to see the patients in the outpatient clinics, leaving very little time to treat within the 62 day standard.

Actions

The dermatology team has secured activity from locum and insourcing providers. The team is also working with the RDE team to provide an alternative, lower cost, more resilient and sustainable solution. The urology and colorectal teams' action plans also include additional capacity which is commencing in the next few weeks and will reduce the variation in performance. However it is expected that performance will deteriorate in Q2 as it will take some weeks for the solutions to recent gaps in clinical capacity to feed through into improved performance.

Assurance and control

Detailed action plans for all pathways at risk of not delivering are in place. The cancer manager alongside the performance lead meets weekly with each team to review actions needed at patient level to secure improvement. Fortnightly review at the Risk and Assurance Meeting is in place to oversee actions with input from the CCG commissioning lead.

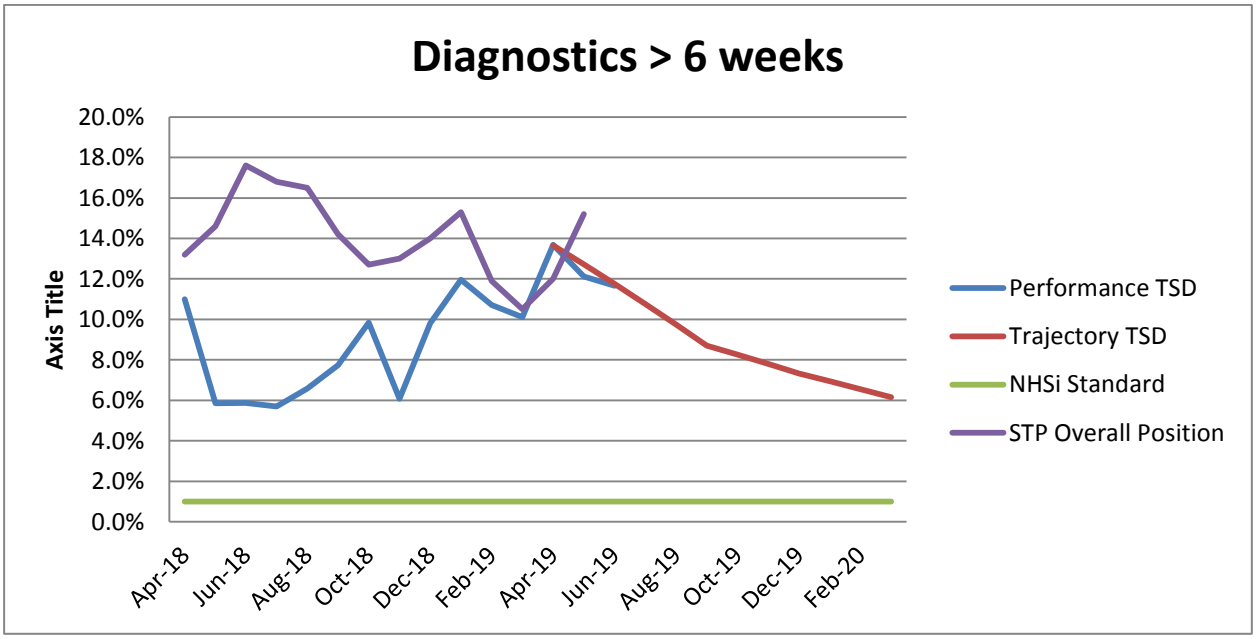
Risks and mitigations

The oncology element of the pathway is reliant on a very small team requiring subspecialist expertise. This means cross cover is more difficult and recent sickness in the team has highlighted again the benefits from working across the network as UHP and RDE have needed to support the Trust in recent weeks.

Oncology is being added to the lists of areas under STP / peninsula networked arrangements. It is in the Trusts interests to support the progress of this work as soon as possible.

Joint work between colorectal, diagnostic imaging and the endoscopy team is intended to support improvement in the colorectal pathways for cancer. This includes the use of insourcing capacity where necessary to maintain the colonoscopy waits in support of both the 6 week diagnostic and cancer 62 day standards.

d) Diagnostic waiting time (1% or fewer waiting over 6 weeks)



Drivers

The Trust performance has deteriorated over this period however it has largely remained ahead of the Devon position. All trusts have experienced growth in CT and MRI referrals and these 2 modalities are the primary reason for the deterioration in performance. The Trust also needs to replace an MRI and a CT scanner. The CT is planned for replacement in Q3 this year with the MRI in Q1 next year.

Actions

The primary risks for delivery of the standard are CT and MRI and these are covered in a detailed plan which has been presented to FPDC for approval, to QAC and to the Executive Group for input and assurance. The plans include additional capacity to enable the replacement programme for CT as well as delivery of the recovery trajectory.

Assurance and control

In common with 52 weeks and cancer standards the delivery of the diagnostic trajectory is monitored through the Risk and Assurance Group. As the aggregate performance includes other modalities such as endoscopy and echocardiography each has a detailed plan in place to secure the improvements necessary to enable the trajectory to be achieved.

Risks and mitigations

The replacement programme is necessary as the aging CT and MRI machines are vulnerable to breakdown. When this happens capacity is prioritised to keep inpatient tests running in support of patient flow and this has impact on the number of patients waiting over 6 weeks. This is not limited to the permanent Trust scanners, in July one of the visiting mobile units failed resulting in the need to reschedule around 100 patient scans and meaning that the 6 week performance will be impacted.

However the recovery plans include headroom and have been assessed using SPC modelling support from the NHSi lead who has been working with the trust over the past 8 months.

Conclusion

The areas identified in the report are those the regulator and the CCG focus on and which are impacting on the experience of our patients, staff and the reputational position of the Trust. Although the Trust is not delivering the national standards the position against the Devon average and against the Q1 trajectory is more positive.

All standards have action plans in place and strong governance including oversight from NHSi and the CCG.

The key challenges remain of securing improvement and stability in the urgent care pathway and eliminating 52 week waiting time.

2.3 Operational structure transition and governance update

The integrated service units have now been operating for 4 months. Each ISU have focused on creating the right opportunities to optimise the benefits from working as a locality based system. A clear focus for the teams is delivering the financial requirements. The PIMs meetings per ISU and the joint sessions create peer challenge and idea exchange. Additional assurance and challenge through the system leadership team is in place to reduce run rate and deliver workforce controls.

Engagement

The teams have held a number of stakeholder engagement events and have been looking at the skills and capacity across the newly formed partnerships.

Development

Development meetings continue every 2 weeks bringing together all the leaders with support from the organisational development team.

A 2 day developmental programme is taking place on 31st July and 1st August funded by the South West leadership academy with input from colleagues from the academy and senior leaders from Dorset County to understand how other systems have approached their integration journey.

2.4 Operational delivery system governance structure

The meeting flows have been developed to ensure there is a clear governance process from service level to board. The operational meetings at service are fed through to ISU assurance meetings which flow into the monthly Assurance and Transformation Group which is chaired by the system directors.

Following 3 months trialling the meeting architecture the scheduling has been adapted to ensure the flow of information and allows for full review of all performance and finance.

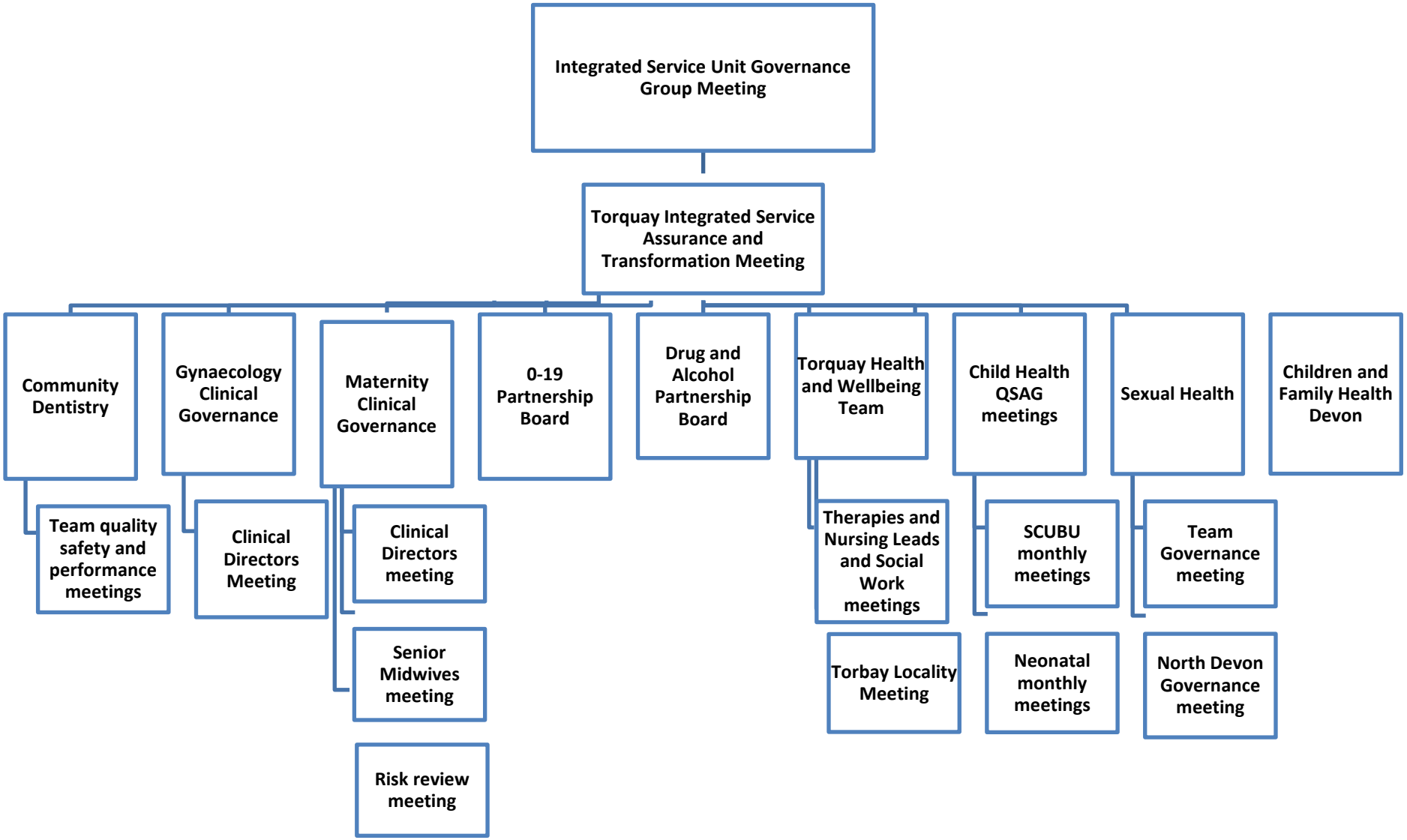
An example of the meeting structure detail at ISU level is attached to this report.

3. Conclusion

The new operational structure is embedding well; development of the leaders is ongoing. Engagement of all the operational teams to deliver the efficiencies required is delivering. The clinical and operational governance framework is almost complete.

4. Recommendations

The Board is asked to note the contents and conclusion in the report, provide challenge and seek additional assurances as may be required.


Integrated Service Unit Governance Group Meeting
Torquay Integrated Service Assurance and Transformation Meeting
Community Dentistry
Team quality safety and performance meetings
Gynaecology Clinical Governance
Clinical Directors Meeting
Maternity Clinical Governance
Clinical Directors meeting
Senior Midwives meeting
Risk review meeting
0-19 Partnership Board
Drug and Alcohol Partnership Board
Torquay Health and Wellbeing Team
Therapies and Nursing Leads and Social Work meetings
Torbay Locality Meeting
Child Health QSAG meetings
SCUBU monthly meetings
Neonatal monthly meetings
Sexual Health
Team Governance meeting
North Devon Governance meeting
Children and Family Health Devon

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Workforce & Organisational Development Report			Meeting date: 7th August 2019
Report appendix	N/A		
Report sponsor	Director of Workforce & OD		
Report author	Workforce & OD Business Partner		
Report provenance	Workforce & OD Group – 10 July 2019 Quality Assurance Committee – 24 July 2019		
Purpose of the report and key issues for consideration/decision	• 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) and Quality Assurance Committee (QAC). • To provide the Board with assurance on workforce and organisational development issues.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To note the content of this report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	X
Improved wellbeing through partnership	X	**Well-led**	X

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	X	**Risk score**	Multiple
Risk Register	X	**Risk score**	Multiple

External standards affected by this report and associated risks

Care Quality Commission	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	**X**
NHS England	**X**	**National policy/guidance**	**X**

Report title: Workforce & Organisational Development Report		Meeting date: 7th August 2019
Report sponsor	Director of Workforce & OD	
Report author	Workforce & OD Business Partner	

1. Introduction

This report seeks to provide update to the Board on the activity taking place within the Workforce and Organisational Development Directorate.

2. Workforce & OD Group – Key Notes

The Group met on 10 July 2019. The following summarises discussions and agreed actions:

- **Formation of new People Committee:** It was reported that the Corporate Secretary had reviewed the Governance structure within the Trust and recommended formation of an assurance committee to oversee the workforce agenda. This Group would report directly to the Committee and, as part of a wider review, the future of the current Programme Boards would also be considered.

- **PVI training.** It was reported that a costing model paper from October 2019 would be presented to the Foundation Trust Board for approval.

- **Liaison.** Supporting workforce analytics review, free service as part of our existing contract currently, with review and consideration of future options longer term. Following completion of Data Protection Impact Assessment an Information Governance risk and would be added to the Risk Register.

- **Winter Pressure Payments.** It was reported that results from the initiative were inconclusive. Various anomalies had been identified.

- **Workforce Transformation Programme:** Project Leads have been identified and the following areas identified for further review:
  - Workforce redesign
  - Agency and Bank
  - MARS and Vacancy review
  - Discretionary spending
  - On call pay
  - Apprenticeships
  - E-rostering

- **STP Workforce and OD update:** Key Activities Report compiled by the Sustainability and Transformation Partnership (STP) workforce team had been circulated with the agenda papers and it was reported that due to recent leavers there was uncertainty about the ability of the STP workforce team to co-ordinate these activities in future.

- **Rainbow Day Nursery:** A presentation was received from members of Rainbow Day Nursery and members of the Commercial Team. The proposal to expand the nursery facilities was noted by the Group who offered congratulations on the Nursery's Outstanding Ofsted rating. No decision could be taken due to the group not being quorate but unanimous support was given to the proposal which would be taken to the Charitable Funds Committee in September.

- **Local Induction Pilot:** A presentation was received on developments to The Hive site. These included:
    - Local e-induction site
    - E-induction for new doctors

- **Appraisal Data:** It was reported that there are inconsistencies with reporting appraisal data. Further work would be undertaken to clarify criteria for which staff groups should be excluded from annual reporting data.

- **Information Governance Training:** It was noted that there are issues with meeting the IG training target currently at an amber rating, reaching the national target of 95% had been recognised as challenging. The Trust's current rate was recorded as 89%.

- **Risk Register:** All actions noted as complete.

3. Key Metrics Summary

- **Turnover (excluding Junior Doctors)**: the Trusts turnover rate now stands at 10.75% for the year to June 2019 which is an increase from 10.69% in May.

- **Staff sickness/absence:** The annual rolling sickness absence rate was 4.21% at the end of May 2019 which is a minor decrease from April which was 4.22%. This is against the target rate for sickness of 4.00%. The monthly sickness figure for May was 3.81% which is a decrease from the 3.84% as at the end of April.

- **Mandatory Training rate**: At the end of June 2019 the rate was 90.88%. This means that the Trust is now achieving the target rate for mandatory training of 85%.

- **Appraisal rate**: The rate for the end of June 2019 was 79.41% which is a decrease on the 80.08% as at the end of May 2019.

4. Clinical Excellence Awards 2019

The 2019 Clinical Excellent Awards (CEA) has commenced with the deadline for applications of 28 June 2019. This year we have 182 eligible consultants which equates to a CEA fund of £164,673.64. As all 50 points were awarded in the 2018 round for a period of two years we have 55 points to award in the 2019 round.

A recent analysis of applications for CEA for the Gender pay gap report concluded that equal ratios of male and female staff have applied. Of those that applied 100% of female applicants and 82% of male applicants received an award.

5. Pension Lifetime Allowance

The recent Government changes to pensions limits and associated tax implications which saw a tapering of the annual allowance introduced for high earners and the reduction of lifetime allowances has been recognised nationally as causing major issues, especially amongst Medical and Dental staff and their ability/wish to work additional sessions. The Department of Health and Social Care have now opened a three month consultation on increasing the flexibilities around the NHS Pension scheme for senior clinicians affected by the pension tax. We have communicated this directly to medical staff and all other staff via the staff bulletin. The Executive team are fully briefed on the issues.

Medical Workforce have arranged for a company called Affinity Connect. Affinity Connect will be running a dedicated seminar to help individuals understand the annual and lifetime allowances. It will explain in greater detail what the pension limits is and how they may affect individuals. Staff can then access their paid service if they choose. It is important to note that The Trust **cannot** issue any advice only recommend that individuals seek their own independent Financial advice.

6. Review of Junior Doctors 2016 Contract

Following a period of negotiation between NHS Employers, the British Medical Association (BMA) and Department of Health and Social Care (DHSC) a framework agreement has now received ministerial clearance which would see investment over a four-year period in the contract for doctors in training.

The framework agreement sets out both the pay investment that will be made and the amendments to the 2016 junior doctors' contract.

The agreement covers the period from 1 April 2019 to 31 March 2023. In 19/20, this will mean a total investment of 2.3 per cent in the contract. In each of the three subsequent years (20/21-22/23) this will mean annual pay uplifts of 2 per cent and a further 1 per cent of additional investment in other terms within the contract.

The investment over the four years will be used to support changes anticipated within the 2016 contract discussions and/or which have arisen from the review of that contract between the parties:

- A new nodal point 5: This will be introduced for trainees at ST6 and above through a staggered approach and will replace the senior decision makers allowance as set out in the 2016 terms and conditions of service
- Weekend allowance uplift to ensure those working the most frequent weekends are remunerated more fairly
- An enhanced rate of pay for shifts that finish after midnight and before 4am
- An allowance for Less than Full Time (LTFT) trainees to recognise the additional costs LTFT doctors incur throughout training
- Changes to the academic flexible pay premium
- Extension of Section 2 transitional pay protection.

A number of additional provisions have also been agreed in the following areas:

- Safety and rest limits
- Exception reporting and guardian of safe working hours
- Work scheduling and code of practice
- Leave

- Locum work
- Equalities, LTFT and flexible training
- Facilities
- GP trainees

Next steps: Following ratification by the BMA the new terms will be introduced from August 2019 for doctors in training. This will put the contract on the same basis as all national NHS pay contracts with changes agreed in partnership between staff and employer representatives.

Local Impact: The Medical Workforce team are currently reviewing the proposed changes to understand the implications for department rotas and ways of working.

7. Education Celebration Week

The Education Celebration week took place during week commencing 3rd June with a final day of celebrations taking place on Friday 7th June, where nominated staff received their Education awards during an awards ceremony shared with our key stakeholders and Executive team. The education team plan to make the awards ceremony an annual event to celebrate staff success and valued contribution to education across the Trust.

8. STP Education Programme/Project Support

The Mental health training project is progressing well with the 'Complexities in Mental Health & Co-Morbidities training' being particularly popular across the STP. Three additional dates have been agreed as a result. Digital resources are currently being developed to be shared across the STP. At present this project is due to finish in August 2019 until we know what the longer term plan is for support of this project which we are currently discussing with the STP. The Intermediate Care Project has started and we are awaiting approval from the STP group on the proposed Intermediate care Competency Framework. The Human Factors project is being developed in partnership with Torbay Council and Tod Guest, Consultant Anaesthetist.

9. Physician Associate Sponsorship Programme

The Medical Workforce Programme Board agreed at their last meeting to pause the Sponsorship programme for 2 years as a result of ongoing cost pressures and lack of operational workforce plans to support the ongoing implementation of the role. The role will be reviewed as part of the wider workforce planning exercise and alongside the review of the Advanced Clinical Practitioner.

10. Radiography Training

Following liaison with the Radiography team, Medical Director, Plymouth and Exeter Universities, it was decided not to accommodate the new University of Plymouth Radiography programme from this September, due to capacity issues and an existing successful programme. In addition to expand entry in to this profession the radiography team are looking to develop an apprenticeship route with Exeter University.

11. Children & Family Health Devon

A formal consultation to restructure the services and associated staffing structure for CFHD is scheduled to commence in July. This is to implement to the service model submitted in the Alliance bid. A comprehensive consultation document has been drawn up and fully discussed with the Partnership Board and the Trade Unions. This will be a significant consultation exercise involving upwards of 600 staff and which will be led by Corinne Foy, Managing Partner of CFHD and supported by HR representatives from both TSDFT and DPT, the two Alliance partners that currently employ the CFHD staff. The aim is for the consultation to be concluded by the end of September, evaluation and then any necessary revision in October and implementation in November through to January 2020. It will involve very close partnership working between TSDFT and DPT and with the wider members of the Alliance in respect of facilitating any necessary redeployments.

Progress will be monitored through the CFHD Partnership Board and Workforce & OD Group.

12. Staff Engagement

A staff experience action plan has been developed by a multi-professional group to respond to:

- the gap analysis identified from the completion of the National Health and Wellbeing framework
- 2018 National Staff Survey findings
- local sickness absence data
- qualitative information gained from 1-1 discussion with staff who have been absent as a result of mental ill health

Progress continues to be made against the plan (Appendix A) and is reviewed regularly through the staff experience group which meet fortnightly.

13. Changes to NHSI Agency Rules

NHS Improvement has confirmed that following consultation, they will be making two changes to agency rules with effect from 16 September 2019. The changes will be:

- A restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts.
- A restriction on the use of admin and estates agency workers, with exemptions for IT and special projects.

More information on the consultation response and agency rules can be found on the NHS Improvement website.

The changes will impact primarily on the Facilities Department, who are currently looking at alternative options.

Report to the Trust Board of Directors		
Report title: STP monthly update		Meeting date: 7 August 2019
Report appendix	Devon STP June Update	
Report sponsor	Director of Transformation and Partnerships	
Report author	Interim Director of Transformation and Partnerships	
Report provenance	Report reviewed by the Executive Directors (30 July 2019)	
Purpose of the report and key issues for consideration/decision	To provide an update from the Devon STP on key matters and developments since the previous Board meeting. The Devon Sustainability and Transformation Partnerships (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. This update follows the Programme Delivery Executive Group meeting held on 21 June 2019. Key items to note are: **1 Developing Devon's Long Term Plan** PDEG discussed the process for developing Devon's response to the NHS Long Term Plan (LTP). Published in January 2019, the LTP outlines how the NHS needs to change to address the key pressures faced by staff, maximise the use of resources and accelerate the redesign of patient care. Devon, as for all systems, will be required to produce a 5-year plan to address the three key aims of improving the experience of care, improving the health and well-being of the population and improving cost effectiveness. **2 Update on the Integrated Care Model** The Integrated Care Model has been identified as one of the priority work programme for the STP and forms a core element of the system Operating Plan for 2019/20. The Integrated Care Model blueprint was approved by PDEG in November 2017. It provides a set of guiding principles that underline the way we work to deliver person-centred coordinated care, as well as critical success factors for delivery at LCP level. Key elements are: ▪ Connecting people with things that help them live healthy lives. ▪ Supporting people to stay well and independent at home.	

- Proactively avoiding dependency and escalation of illness.
- Connecting people with expert knowledge and clinical investigation.
- Easy access to urgent and crisis care.
- End-of-life care embedded at all levels.

The Executive Steering Group has met to agree the core priorities and critical success factors for delivery with a focus on impact and pace and scale of delivery.

3 Peninsula Clinical Services Strategy
Senior clinical leaders from across Cornwall and the Isles of Scilly and Devon continue to progress the work to develop a Clinical Services Strategy for both counties.

A project initiation document has been shared with all trusts, and the two CCGs in Devon and Cornwall.

The document sets out the purpose, objectives and approach for the Strategy development and is currently being considered by each of the partner organisation's boards to ensure awareness of and support for the work of the PCSS. This is expected to be completed shortly.

4 Prevention
The NHS Long Term Plan made a clear commitment to evidenced-based prevention and early intervention, a commitment which has been reinforced by our local system which has identified prevention as one of the five STP priorities. There has been agreement to spend a proportion of our growth monies in this area and submit a plan which confirms and builds upon this.

5 Better Births
Over 12,000 babies are born in Devon every year. Parents, siblings and health professionals all play a big part in a baby being born. It is important that people have the opportunity to share their experiences, good or bad and that we continually learn from those.

Over the summer of 2018, the Local Maternity System (LMS), consisting of health and care organisations, undertook 8 weeks of intensive engagement to gather the thoughts, experiences, and views of over 2,700 parents about births in Devon.

The engagement utilised online forums – such as Mumsnet and Facebook – as well as events with parents and parents-to-be – and explored the recommendations of NHS England's Better Births review. This national review focuses on personalised care, continuity of carer, postnatal and perinatal mental health care, digital records and the wider planning of maternity services.

The final report was presented to PDEG and it has now been published.

Action required (choose 1 only)	For information ☐	To receive and note ☒	To approve ☐
Recommendation	The Board is recommended to receive and note the implications on the Trust's strategy and delivery plans.		
Summary of key elements			
Strategic objectives supported by this report			

Safe, quality care and best experience	Yes	**Valuing our workforce**	Yes
Improved wellbeing through partnership	Yes	**Well-led**	Yes

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	Yes	**Risk score**	20
Risk Register	Yes	**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission	Yes	**Terms of Authorisation**	Yes
NHS Improvement	Yes	**Legislation**	
NHS England	Yes	**National policy/guidance**	Yes

Monthly STP Update Report for Boards, CCG Governing Body and Cabinet meetings of Devon STP partner organisations

June 2019

Introduction

The purpose of this regular report is to:

- Provide a **monthly update** that can be shared with Governing Bodies, Board and Cabinet meetings across STP partner organisations.
- **Ensure everyone is aware** of 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), in which all partner organisations in the STP are represented.

Content

This is the 13th monthly STP Update Report. It covers developments from the ***Strategic PDEG meeting held on Friday, 21 June 2019.***

The items covered in this Update Report are as follows:

1. Developing Devon's Long Term Plan.
2. Update on the Integrated Care Model (ICM) arrangements.
3. Peninsula Clinical Services Strategy.
4. Prevention.
5. Better Births.

1. Developing Devon's Long Term Plan

PDEG discussed the process for developing Devon's response to the NHS Long Term Plan (LTP). Published in January 2019, the LTP outlines how the NHS needs to change to address the key pressures faced by staff, maximise the use of resources and accelerate the redesign of patient care.

Devon, as for all systems, will be required to produce a 5-year plan to address the three key aims of improving the experience of care, improving the health and well-being of the population and improving cost effectiveness.

As part of this planning process, each system is expected to:

- Involve local communities and delivery partners in its development.
- Use evidence of population need to inform priorities and targeted action.
- Build upon the system existing agreed plans and strategies.
- Define how outcomes will be delivered and how local and national good practice initiatives will be adopted consistently across the system.
- Outline how financial stability and sustainability will be achieved.
- In addition, the system response will need to evidence progress to date and a plan towards becoming an Integrated Care System by April 2021.

The development of the Devon Long Term Plan will be managed through existing STP forums where possible. An additional meeting of the Directors of Strategy (or equivalent) from each organisation in the system has been convened on a fortnightly basis to ensure organisational and local inputs, to discuss progress and review draft outputs that contribute to the plan.

The final draft of the plan will be developed through this meeting for approval by PDEG, Collaborative Board and statutory organisations prior to publication. The Directors of Strategy are currently reviewing organisational input into the various STP work streams to ensure representation across the system in relevant areas, this will include strengthening clinical engagement in the work as necessary.

Updating the evidence base and 'case for change'

Work has commenced to update our understanding of population need, analyse projections of future demand for health and care services and refresh the case for change.

System Leaders workshop

In June, the Collaborative Board supported the proposal for a system leaders' workshop to:

- Recognise progress as well as intractable issues.
- Agree our refreshed case for change and system opportunities including the financial forward view.
- Enable a common understanding of national must do's and our local challenges.
- Affirm our vision, whilst also agreeing the difficult decisions the system will need to address in delivering Devon's Long Term Plan.
- Agree on what this means for delivery at system, locality, place / local communities

It is proposed that organisations nominate three representatives each to attend the workshop on 19 July 2019.

Engagement

A significant amount of engagement has already taken place in the Devon system in the last 2-3 years. Any gaps in existing engagement relating to LTP deliverables will steer engagement over the summer. The engagement is planned to start on 11 July 2019. This date has been chosen as it fits with the launch of the prevention/well-being engagement by Health and Well Being Boards. Work will be undertaken on giving the LTP engagement a recognisable brand/identity and a shared place to direct comments i.e. Twitter hashtag, online survey etc.

The engagement approach is as follows:

Tier 1 – strategic, county-wide engagement

This will include:

(i) Use of our new digital 'Citizen's Panel', made up of around 1,700 members of the public (totally representative of the population of Devon). The two proposed themes will be:

- *"How do we keep/encourage the digitally enabled to use our services?"*
- *"How do we better support children and young people with mental health challenges?"*

(ii) A survey of all Patient Participation Groups (PPGs) in Devon. Proposed theme is:

- *"What can we do to help people improve their own health. For the elderly, how can we help them to stay independent and in good health in their own home or care setting?*

(iv) Work with hard-to-reach groups and those who are seldom heard.

Tier 2 – Localities (led by four Local Care Partnership (LCP) areas)

Localities will engage on specific themes that are locally determined and reflect the specific local population need or challenges in the health and care system. Each LCP will be given the case for change, which they will adapt with their own local information and priorities. They have been asked to consider the following key stakeholder groups as part of their planned engagement activities:

- Councillors/districts/MPs.
- Local specialist groups i.e. One Northern Devon, East Devon Forum, Okehampton etc.
- Disease specific groups.
- PPGs.
- Local key players/public/patient and campaign groups.

In addition, engagement with staff will be should be facilitated across each LCP to enable staff in all Trusts, the CCG, each LA and with the STP Partnership Forum to contribute.

2. Update on the Integrated Care Model (ICM) arrangements

The Integrated Care Model has been identified as one of the priority work programme for the STP and forms a core element of the system Operating Plan for 2019/20.

The Integrated Care Model blueprint was approved by PDEG in November 2017. It provides a set of guiding principles that underline the way we work to deliver person-centred coordinated care, as well as critical success factors for delivery at LCP level. Key elements are:

- Connecting people with things that help them live healthy lives.
- Supporting people to stay well and independent at home.
- Proactively avoiding dependency and escalation of illness.
- Connecting people with expert knowledge and clinical investigation.
- Easy access to urgent and crisis care.
- End-of-life care embedded at all levels.

The ICM blueprint was devolved to localities to deliver in 2018 with each locality taking actions forward in alignment with existing locality structures and priorities. However, during the development of the Operating Plan for 2019/20, it became clear that the ICM was needed to drive change at a much faster pace and that it would be key to the reduction in demand for urgent care services.

This has necessitated the introduction of a rigorous and robust approach to managing the programme of work with nominated Chief Executive sponsorship and the establishment of an Executive Steering group comprising the Executive Leads in each LCP and subject matter experts from mental health, social care, primary care, finance and commissioning.

The Executive Steering Group has met to agree the core priorities and critical success factors for delivery with a focus on impact and pace and scale of delivery. The priorities have been identified as:

- **Risk stratification** to inform population health management:
  - Prevention focused.
  - Holistic approach to working with high-intensity users.
- **Social prescribing** and a GP-led community **MDT approach:**
  - Voluntary and community sector involvement.
  - Self-management, wellbeing coordination, care navigators, health coaches – with a focus on multi-morbidity and high intensity users.
  - Engagement with emerging Primary Care Networks.
- **Enhanced health in care homes:**
  - Implementation of national guidance.
  - Trusted assessor programme to expedite discharge and reduce length of stay.
  - Medication in care homes, red bags, dementia and end-of-life care.

Key Deliverables

The projected growth in demand for urgent care in Devon is in excess of national growth targets, driving higher costs and workforce pressures in our system.

Our population demographics contribute to this higher level of demand, but we are committed to do all possible to manage this demand more effectively with better user experience and we will work as a single Devon system to deliver this.

The ICM workstream is central to this and will be central to helping contain growth in demand for urgent care to the same level as our best-performing sub-locality. The 'Coastal' area of South Devon and Torbay has a well-established integrated care model, and forecasts 0.45% growth in demand. The team has therefore developed the trajectories below based on every area achieving the same level of performance.

NHS Devon @ Provider		Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019 /20
UHP	Total Non-Elective Admissions - 0 LoS	-82	-87	-87	-85	-88	-74	-85	**-588**
	Total Non-Elective Admissions - +1 LoS	-82	-85	-83	-85	-86	-80	-86	**-587**
	Total Non-Elective Admissions	**-164**	**-172**	**-170**	**-170**	**-174**	**-154**	**-171**	**-1175**
NDHT	Total Non-Elective Admissions - 0 LoS	-35	-37	-37	-36	-37	-32	-36	**-250**
	Total Non-Elective Admissions - +1 LoS	-35	-36	-35	-36	-37	-34	-37	**-250**
	Total Non-Elective Admissions	**-70**	**-73**	**-72**	**-72**	**-74**	**-66**	**-73**	**-500**
RDE	Total Non-Elective Admissions - 0 LoS	-69	-74	-74	-73	-75	-63	-72	**-500**
	Total Non-Elective Admissions - +1 LoS	-72	-72	-70	-72	-73	-68	-73	**-500**
	Total Non-Elective Admissions	**-141**	**-146**	**-144**	**-145**	**-148**	**-131**	**-145**	**-1000**
NHS Devon	Total Non-Elective Admissions - 0 LoS	-186	-198	-198	-194	-200	-169	-193	**-1338**
	Total Non-Elective Admissions - +1 LoS	-189	-193	-188	-193	-196	-182	-196	**-1337**
	Total Non-Elective Admissions	**-375**	**-391**	**-386**	**-387**	**-396**	**-351**	**-389**	**-2675**

The reduction in growth for urgent care equates to an in-year cost reduction of £4.5 million, with a further £10 million reduction required for 2020/21.

Performance indicators

In addition to the financial measures, the main key performance indicators for the ICM are listed below, the intention is to develop these to take account of learning from progress to date and the take account of developing ICM model.
Specific numbers and targets will be agreed at LCP level with consistent reporting to enable effective monitoring of impact.

Integrated Care Model Area of Priority	Outcome
Population Health Management	Increased use of Population Health Management tools (One Devon Dataset) and Risk Stratification Tools to identify those at risk and reduce health inequalities.
	Increased proportion of people identified by Risk Stratification Tools who receive support to prevent their needs from escalating
Enhanced Health in Care Homes	Percentage of Care Homes with a CQC rating of Outstanding or Good
	Number of Emergency Admissions (Direct Standardised Rates) from Care Homes.
	Number of Medicines Optimisation Reviews undertaken in Care Homes
	Percentage of people residing in a care home receiving a holistic comprehensive assessment, including a medication review, on an annual basis
	Increased support provided to Care Homes from Primary Care and Community Services
	Increased number of care home residents supported by Community Crisis Response Team to reduce Emergency Hospital Attendances / Admissions
Primary Care and Community Integration / Primary Care Networks / Enhanced Primary Care Teams	Number of people managed by a Multi Disciplinary Team as part of an Enhanced Primary Care Team
	Increased proportion of people who feel supported to manage their condition
	Increased number of people receiving care planning (physical, mental, emotional and social needs) with a focus on keeping individuals in their normal place of residence
	Reduced number of Emergency Admissions (Direct Standardised Rates) for Ambulatory Care Sensitive conditions.
	Prescribing outcomes that demonstrate safer, more appropriate and more efficient prescribing in Primary and Community Care (TBC)
	Increased percentage of patients with an involvement in making decisions about their care (GP Consultations)
	Increased proportion of carers who have been offered a carers assessment
Health and Wellbeing Hubs	Number of people with an identified need who report that attending a hub has helped them to manage an illness or long term disability
	Number of people with an identified need who report that attending a hub has led them to visit their GP less often
	Reduction in number of people attending their GP for social reasons
	Number of people who feel that they know more about what is available in their community as a result of using a hub.
	Number of people who report overall satisfaction with a hub

Evidence from the ICM Blueprint

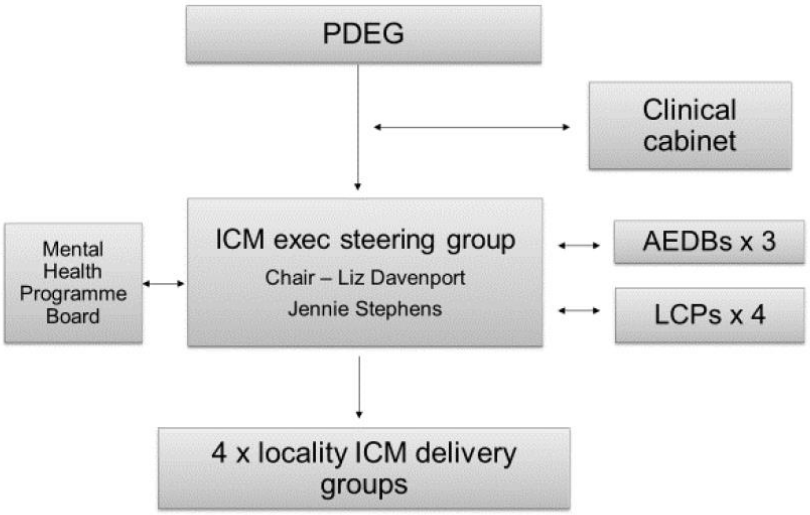
There is evidence emerging from the implementation of the ICM that it can result in changes to the pattern of service utilisation and improvements in patient outcomes and satisfaction with services. Evidence includes:

- More people cared for at home.
- Reduced Emergency bed usage for people over 65.
- Reduction in delayed transfers of care compared with national comparators.
- Fewer people over 65 admitted to care homes as their permanent residence.
- More people say they have a good social care related quality of life compared with comparator Group.

The South Devon locality commenced implementation earlier and has seen measurable changes in demand:

- Total A&E attendances reduced by 3.7% compared with a national increase of 5.7%.
- A&E attendances for over 65s reduced by 1.5% compared with a national increase of 13.8%.
- Total bed days reduced by 21.2% compared with national reduction of 2.1%.
- Bed days used by over 65s reduced by 27.8% compared with national reduction of 2%.
- Outpatient attendances reduced by 3.5% compared to a national increase of 10.9%.
- Outpatient attendances for over 65s reduced by 0.9% compared with a national increase of 13.2%.
- Improve self-management as measured by Patient Activation Measures (PAM).

Programme Governance



Further development of the ICM Blueprint

The ICM blueprint was developed at a point in time and it is our intention to incorporate further developments in integrated care into the model. The scope of the ICM Blueprint is vast, with crucial interdependencies with other workstreams. In order to ensure sustainable and transformative change, it needs to be embedded into the other transformation work including primary care networks, urgent care, mental health and prevention.

3. Peninsula Clinical Services Strategy (PCSS)

Senior clinical leaders from across Cornwall and the Isles of Scilly and Devon continue to progress the work to develop a Clinical Services Strategy for both counties.

A project initiation document has been shared with all trusts, and the two CCGs in Devon and Cornwall.

The document sets out the purpose, objectives and approach for the Strategy development and is currently being considered by each of the partner organisation's boards to ensure awareness of and support for the work of the PCSS. This is expected to be completed shortly.

The PCSS Leadership Group includes Trust Medical Directors and Chief Operating Officers and senior commissioners from both CCGs and NHS Specialised Commissioning and over the past two months this group has undertaken a risk assessment of the key service delivery challenges across the Peninsula. The result of this work is being presented to our system leaders for consideration and approval to proceed to more detailed service-specific work. The outcome of this process will be communicated to staff and key stakeholders week commencing 15 July 2019, including how to engage with and provide input to this early phase of the Strategy.

<u>Scope of the Strategy</u>

- The Peninsula Clinical Services Strategy is clinically-led and focuses on hospital-based physical health services. It takes into account of the contribution of and impact on mental health, primary care and community services where there are critical clinical interdependencies, fully engaging these services when redesigning models of clinical care for optimum service delivery and outcomes.

<u>Vision for the Strategy</u>

- Providing safe, high quality, affordable clinical care which provides equitable outcomes and timely access for the people of Cornwall and Devon through a sustainable network of local and specialist services that will attract and retain the high calibre workforce we need.

<u>Engagement and Involvement</u>

- This work is a key element of our STP response to the NHS Long Term Plan and public engagement on the Strategy will be part of the wider engagement process for both STP's Long Term Plan. The PCSS Leadership Group is committed to an inclusive process, and will seek input from subject experts across hospital, community, general practice and user experience as the work of the Strategy progresses.

4. Prevention

The NHS Long Term Plan made a clear commitment to evidenced-based prevention and early intervention, a commitment which has been reinforced by our local system which has identified prevention as one of the five STP priorities. There has been agreement to spend a proportion of our growth monies in this area and submit a plan which confirms and builds upon this.

In March 2019, PDEG agreed that in Devon we would:

i. Ring-fence £2 million of CCG growth allocation to invest in preventative projects with that sum principally focused on **primary prevention** and the priorities that have been set by the STP Prevention Working Group.
ii. Seek additional three-to-four large scale interventions that would have substantial in-year financial impact on the system with the focus aimed at driving the spread and implementation of prevention and self-care initiatives so that benefits can be achieved rapidly.
iii. Seek to increase the investment in prevention year on year.

In relation to item 'i' above (£2m primary prevention projects), following a prioritisation process the £2 million was agreed to be spent on the projects below:

APPENDIX 1 Scheme	Recommended intervention (s)	2019-20	2020-21	2021-22	2022-23
Introductory physical activity opportunities	Targeting mid-life and older adults with type-two diabetes, depression and anxiety alongside those at risk of frailty.	40	46	52	
National Diabetes Prevention Programme –needs referrals, promote across the system	Dedicated programme management support to generate referrals	40			
Community Infection Prevention and Control – develop a coherent offer across the system (short term impact)	Set up a community infection prevention and control team.	304.5	406	406	406
Falls and fracture prevention – strength and balance funded through iBCF, further work to be done regarding fracture liaison	Set up integrated falls & fracture prevention services in each of four localities	306.5	613	613	613
Social Prescribing – Some funding agreed in local areas need to continue to test and learn	Provision of services where there are gaps, develop framework for Devon SP	360	360		
Suicide prevention	Improve post-vention/bereavement support to those bereaved by suicide	87	87	87	87
Prevent poor mental health and suicide amongst men	Focused campaign, routine and manual labour 45-59	87	87	63	
Emotional Health and Wellbeing of CYP	Face to face counselling, online counselling, training in schools for EHWB, supervision of education staff who support CYP EHWB, bereavement support, self harm therapy model, psychoeducation programme, resilience building, supporting schools in delivering healthy relationships and behaviour resilience.	448.22	1543.3	1153.3	1153.3
Wider CVD prevention – AF, hypertension	Rollout of meds optimisation CVD review across Devon	150	150	150	150
System response to people with multiple and complex needs	System wide transformation to better respond to the needs of people with complex needs	205	360	360	360
	Total	**2,028**	**3,652**	**2,884**	**2,769**

In relation to item 'ii' (large scale projects with in-year financial impact), the decision was taken not to proceed with these proposals at this stage because of the challenging system financial position. However, some projects would be developed further for consideration in future years and, in parallel, discussions would take place about how we might support preventative projects where the financial payback exceeds 12 months.

5. Better Births

Over 12,000 babies are born in Devon every year. Parents, siblings and health professionals all play a big part in a baby being born. It is important that people have the opportunity to share their experiences, good or bad and that we continually learn from those.

Over the summer of 2018, the Local Maternity System (LMS), consisting of health and care organisations, undertook 8 weeks of intensive engagement to gather the thoughts, experiences and views of over 2,700 parents about births in Devon.

The engagement utilised online forums – such as M
umsnet and Facebook – as well as events with parents and parents-to-be – and explored the recommendations of NHS England's Better Births review. This national review focuses on personalised care, continuity of carer, postnatal and perinatal mental health care, digital records and the wider planning of maternity services.

The final report was presented to PDEG and it has now been published.

The main themes and findings in the report are as follows:

- ***Choosing where to give birth*** was a key topic of conversation. Depending on where people live in Devon choices are varied and, in some places, limited. People who opted for home births liked the less clinical environment, finding it less stressful. However, information was limited early on in pregnancy and often hospital birth was presented as the default option. There was not enough information, advice and reassurance about the safety of home births which many women would have found helpful. Those who opted to birth in a Freestanding Midwifery-Led Unit (FMU) liked the in-between option of hospital and home. The units were also seen as a great place for postnatal support and care but currently under utilised. Those who did not choose an FMU said they had concerns over safety. People wanted to be closer to the main hospitals in case anything went wrong. They did not want to take the risk of having to be transferred during the birth, from an FMU to a main hospital for further interventions. Choosing to labour at, or close to one of the four main hospitals, came down to safety and necessity. Those who opted for this did so because of the reassurance it brings, to be closer to clinicians if they needed a higher level of care. For some, the choice was taken away from them because of a specific health need which dictated this as necessary.
- ***Continuity of care:*** The people who look after women during pregnancy, labour and after the baby is born is very important to women and their families. Familiarity, reassurance and a 'friendly face' helps guide them through the journey. Women want to see the same health professionals, to build rapport and feel that the person caring for them knows them and their baby. Where this did not happen, women reported having difficulties later in pregnancy or health complications that were not picked up. This often happened to women who lived in very rural areas and fell between different health providers. Most mums said that they would prefer to see the same midwife/health visitor.
- ***Information and practice:*** Those who lived in very rural areas felt they often got missed or 'slipped through the net'. They were often missed for

appointments, overlooked for postnatal check ups and had limited access to support i.e. breastfeeding. Often the advice they got was conflicting as they did not see the same health professionals.

- ***Breastfeeding*** and support for feeding were identified as a priority area. Those who experienced difficulties also reported conflicting advice and information and lack of one-to-one support. Women described the pressures associated with breastfeeding and levels of expectation placed on them. Many attributed this as a key factor in developing postnatal mental health difficulties.
- Many people felt ***antenatal classes*** were missing a real opportunity. The information was often deemed unhelpful or not relevant. They were described as limited for women with more than one baby and lacked specificity for teenage mums. Women who were not first time mums felt it was often assumed they knew what to do. They felt something was needed for them as a group, especially for those who have had a significant gap between pregnancies.
- The ***quality of care*** that women and families receive was felt to be "good" overall. However, where care could be improved was in relation to shared decision making, parents want to be more involved in decisions concerning them and their baby. For babies that require specialist or onward care this was cited as extremely important, as parents are very anxious. More information and support is needed for those struggling with mental health pre and post birth (note: this engagement was conducted before the opening of the new specialist mother and baby unit in Exeter).
- ***Postnatal care:*** People expressed concerns about the lack of postnatal support and peer-to-peer opportunities in the community. Many cited the reduction of groups in children's centres and the impact of this on wellbeing, mental health and resilience of parent groups.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Report of the Guardian of Safe Working Hours			Meeting date: 7th August 2019
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Mr Shah Punwar, Consultant Orthopaedic Surgeon and GOSWH		
Report provenance	Reviewed by Executive Directors on 30th July 2019		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	Y	**Valuing our workforce**	Y
Improved wellbeing through partnership	Y	**Well-led**	Y

Is this on the Trust's Board Assurance Framework and/or Risk Register

Board Assurance Framework	Y	**Risk score**	12
Risk Register		**Risk score**	

External standards affected by this report and associated risks

Care Quality Commission		**Terms of Authorisation**	
NHS Improvement		**Legislation**	
NHS England		**National policy/guidance**	**Y**

Report title: Guardian of Safe Working Hours		Meeting date: 7th August 2019
Report sponsor	Medical Director	
Report author	Mr Shah Punwar, Consultant Orthopaedic Surgeon and GOSWH	

1. Introduction

This report covers a period of approximately three months from 18 April 2019 – 24 July 2019.

2. Exception Reports

This data is collated from the Allocate IT system. Due to systems and process constraints it is not possible to ascertain the total number of episodes against which exceptions may occur

Total number of Exception reports		**145**
Exception Reports submitted within the last 30 days		**42**
Exception Reports submitted within the last 7 days		**8**
Number by specialty/rota	Surgery/Paediatrics/ICU and T&O (F1)	**37**
	Surgery/ENT (F2)	**18**
	Surgery (ST3+)	**1**
	Medicine (F1)	**45**
	Medicine (F2)	**21**
	A&E (F2)	**5**
	ICU (CT)	**6**
	O&G (F2)	**10**
	Paediatrics (ST3+)	**2**
Nature of exception	Additional hours	**132**
	Variation in rota pattern	1
	Education	**12**
Outcomes	Time off in lieu (TOIL)	**49**
	Overtime payment	**36**
	No further action	**8**
	More information required	**1**
	Work schedule review	**1**
	Outstanding	**50**

3. Comment on Exception Reporting

- It is important to note that in June 2019, amendments to the 2016 JDC contract were agreed between the DOH and the BMA following a voting process.

- This effectively ends the dispute between the BMA and the DOH which was the cause of strike action in 2016.

- There are multiple changes to the exception reporting process as summarised below from the BMA website (italics):

    - *Terms and conditions of service have been amended to provide greater clarity on the types of activity that can be exception reported.*
    - *As well as all scheduled NHS work, any activities required for the successful completion of Annual Review of Competency Progression (ARCP) and any additional educational or development activities explicitly set out in the agreed personalised work schedule. This includes activities agreed between the doctor and their employer, such as quality improvement or patient safety tasks eg: attending a JDF, rota management or delivering teaching.*
    - *All professional activities that doctors are required to fulfil by their employer (e-portfolio, induction, e-learning, audits, mandatory training/courses)*
    - *Educational activities for personal development or career enhancing purposes, which are outside of contractual requirements/personalised work schedules and not essential for ARCP are not included.*
    - *The review process for exception reporting has also been addressed.*
    - *It has been noted that organisations have adopted different processes for who reviews exception reports further to agreement with their trainees. This has resulted in individuals other than the educational supervisor being nominated as the reviewer/actioner.*
    - *To reflect this existing practice, the reviewal process for exception reports should be a locally agreed process, which is jointly agreed by; the guardian, the Junior Doctor Forum, and the Joint Local Negotiating Committee. Regardless of the process that is agreed, all reports should be copied to a trainee's educational supervisor, irrespective of whether the educational supervisor is required to action all types of report.*
    - *The educational supervisor (or other nominated reviewer) must respond to exception reports within seven days of a report being submitted in order to review the report and discuss the reasons with the trainee and progress to agreeing an appropriate outcome*. *The guardian of safe working will have the authority to action any exception reports that have not been responded to.*

- The above guidance aligns with the Guardian's recommendation to appoint Clinical supervisors as exception report reviewers. In some cases Practice Managers may be suitable reviewers. This makes it much more likely that review meetings will occur within 7 days which is a very tight timeframe.

- Guardian and Educational Supervisor oversight is a sensible approach, regardless of who actually reviews reports.

- Further comment is made about pre-authorisation, payment for additional hours of work and conversion of untaken time off in lieu (TOIL) into pay:

    - *Doctors in their professional judgement may consider that it is necessary to work beyond the hours set out in their work schedule, in order to secure patient safety. The parties acknowledge that doctors will endeavour to seek approval for this with their clinical manager before or during the event, but recognise that this will not always be possible and fully support that doctors should be empowered to exception report whenever pre-authorisation is not possible.*
    - *Once an exception report has been submitted it will continue to be subsequently validated by the clinical manager, and an outcome agreed within seven days, to allow for payment for the additional hours worked.*
    - *Payment must be made for approved exception reports within a month, or within the next available payroll, of a report being approved for payment and agreed by all parties. There should be no additional administrative burden, such as submitting additional forms outside of the exception reporting process, to receive payment for an approved exception report.*
    - *Where TOIL is agreed by all parties as the outcome of an exception report, there will be a four-week window from the outcome being agreed for the trainee and rota manager to discuss and allocate the TOIL to a future shift in their working pattern before the end of that placement. In the instances where this does not occur, the TOIL should automatically be converted to pay after that four-week period. At the end of a placement, any untaken TOIL will be converted into pay.*

- Work is still required within Torbay and South Devon NHS Trust to ensure that there is no additional administrative burden in order to receive payment. Currently trainees have to submit separate authorised forms to payroll outside of the Allocate system. This emphasis on preauthorisation fits with the Guardian's efforts to embed responsibility for overtime working within individual departments.

- Returning to Torbay and South Devon NHS Trust reporting continues at usual levels, mainly from acute medical specialities.

- Excluding the minority of reports where educational opportunities are missed there are broadly speaking two types of reports related to overtime working.

- The first type are usually relating to small amounts of overtime work eg: half an hour due to delays in handover or completing urgent tasks. Where clear repeating patterns emerge, immediate steps have been taken by the Guardian to change rotas whilst remaining compliant. Successful examples of this approach include starting F1 hotweek rota at 7am and extending morning ED Handover.

- The second type are for much longer periods of time eg: 2-3 hours. These are usually due to volume of work and include reports where trainees have been asked to stay longer by seniors to complete tasks and help the team.

- It is these instances which put our juniors at risk of burnout and threaten safe working hours limits.

- These longer periods of overtime work often follow handover which is an ideal opportunity for senior clinicians to pre-authorise overtime work or facilitate juniors to leave.

- There continues to be a large number of outstanding and overdue reports on the system.

- There has now been an update to the Allocate system allowing outstanding reports to be closed down. This would only be done when trainees have rotated through their posts or left the Trust and ideally when an outcome has been recorded.

4. Engagement with Doctors

- As the current Guardian is now leaving to join another Trust it is important that the post is recruited to in a timely fashion.

- Recruitment emails have been sent out by the Medical Director and there has been positive interest. The current Guardian has met with an interested consultant to explain the role.

- The Guardian has recently met with the junior doctor LNC representative.

- The Guardian will be attending junior doctor induction August 7th 2019 and will discuss the amendments to the 2016 contract.

- GOSWH Oversight Group meetings will continue to follow Junior Doctor Forum meetings. The dates for these have been set over the next few months.

- A new chair of the Junior Doctor's Forum has been appointed.

5. Summary

- It is the view of the current Guardian that a policy of 'Professionalism and Pragmatism' is the best way forward to guard safe working hours for junior doctors.

- All doctors are expected to behave in a professional manner and this includes ensuring the safety of patients under their care. Engaging in effective handover, managing acutely unwell patients and completing discharge summaries are all part of this process. They should also expect to be treated in a professional manner by their supervising clinical and management teams, particularly when concerns about working hours are raised.

- There are numerous anecdotal incidents of overtime working where no exception reports are filed eg: very few reports from grades above F2. We need to understand further why this is. It is unequitable to reward those who decide to

report and not those who feel a professional obligation to work overtime or who are working within departments without a positive reporting culture.

- The old banding system based on diary card exercises went some way to address this issue.

- A pragmatic approach would be to acknowledge that the need for overtime working occurs on a daily basis, not all doctors will report and not all reports will be dealt with in the same fashion.

- A good example of a pragmatic approach is the response from the General Surgery department to numerous exception reports from juniors coming in very early to complete the Hotweek list and also being overwhelmed on surgical wards due to the volume of clinical work.

- A multifaceted approach, including changing the F1 rota, proactive overtime preauthorisation by the Practice manager and IT solutions led to real change. This was evidenced by a reduction in exception reports and good feedback from the foundation doctors.

- The General Surgery practice manager is happy to speak to other departments about dealing with their overtime working issues.

- A priority for the next Guardian should be to address the overtime working culture in General medicine through further engagement with the clinical lead and practice manager.

- On a personal level the outgoing Guardian would like to thank the Medical Director, Tracy Lyon and Leanne Davies for their support over the last year.

Shah Punwar
Guardian of Safe Working Hours