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

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

6 November 2019 09:00 - 6 November 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.		
	User Experience Story Information		
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 2nd October 2019 and Outstanding Actions Approve 19.10.02 - 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 6 Receive and Note Integrated Performance Report - Month 6.pdf 37	DTP/DoF/DWOD	

#	Description	Owner	Time
2.7	Operational Accountability and Governance Framework Approval Operational Accountability and Governance Frame... 105	CS	
2.8	Winter Plan Information Winter Plan.pdf 127	COO	
2.9	Clinical Services Transformation Progamme Approval Clinical Services Transformation Programme.pdf 163	MD	
2.10	Care Quality Commission Update Receive and Note Care Quality Commission Update.pdf 173	CN	
2.11	Emergency Preparedness Responsibilities Assurance Report Approval Emergency Preparedness Responsibilities Assuran... 183	DECD	
2.12	Freedom to Speak Up Guardian Six Month Report Receive and Note Freedom to Speak Up Six Monthly Board Report.pd... 187	DWOD	
2.13	Audit Committee Annual Report Receive and Note Audit Committee Annual Report.pdf 253	CS	
2.14	Audit Committee Terms of Reference Approve Audit Committee Terms of Reference.pdf 261	CS	
2.15	People Committee Terms of Reference Approval People Committee Terms of Reference.pdf 273	CS	

#	Description	Owner	Time
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Finance, Performance and Digital Committee - 29th October 2019 Information 2019.10.29_FPD_Cttee_Report_to_Board.pdf 281	Ch	
3.1.2	Audit Committee - 30th October 2019 Information	Ch	
3.1.3	People Committee - 24th October 2019	Ch	
3.2	Reports from Executive Directors		
3.2.1	Safe Staffing and Nursing Work Programme Information Safe Staffing and Nursing Work Programme.pdf 283	CN	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.00 am, Wednesday 4th December 2019	Ch	
7	Exclusion of the Public	Ch	

INDEX

Board Corporate Objectives.pdf....7
19.10.02 - Board of Directors Minutes Public.pdf....9
Report of the Chief Executive.pdf....25
Integrated Performance Report - Month 6.pdf....37
Operational Accountability and Governance Framework.pdf....105
Winter Plan.pdf....127
Clinical Services Transformation Programme.pdf....163
Care Quality Commission Update.pdf....173
Emergency Preparedness Responsibilities Assurance Report.pdf....183
Freedom to Speak Up Six Monthly Board Report.pdf....187
Audit Committee Annual Report.pdf....253
Audit Committee Terms of Reference.pdf....261
People Committee Terms of Reference.pdf....273
2019.10.29_FPD_Cttee_Report_to_Board.pdf....281
Safe Staffing and Nursing Work Programme.pdf....283

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 2ND OCTOBER 2019

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Professor C Balch	Non-Executive Director
	Mrs V Matthews	Non-Executive Director
	Mr R Sutton	Non-Executive Director
	Mr P Richards	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	Ms L Davenport	Chief Executive
	Mrs L Darke	Director of Estates and Commercial Development
	Dr R Dyer	Medical Director
	Mrs J Falcao	Director of Workforce and Organisational Development
	Mr J Harrison	Chief Operating Officer
	Ms A Jones	Director of Transformation and Partnerships
	Mr D Killoran	Interim Director of Finance
In attendance:	Mrs J Downes	Company Secretary
	Mrs S Fox	PA to Chief Executive
	Ms J Gratton	Joint Head of Communications
	Mrs J Phare	System Director of Nursing and Professional Practice

Governors:	Mrs W Marshfield	Mr M Birch	Mr G Goswell-Munro
	Mrs A Hall	Mrs L Hookings	Mrs M Lewis
	Mr P Lilly		

		ACTION
153/10/19	**Board Corporate Objectives** The Board noted the Trust Corporate Objectives.	
154/10/19	**User Experience Story** The User Experience Story was presented by Ms Julie Kemmner and Mr Dave Reddaway from the Community Dietetics Team. The story concerned a young man suffering from muscular dystrophy who had swallowing difficulties. He was referred to the Dietetics Team from the	

Speech and Language team. When he was first visited his weight was stable, but earlier this year it dropped significantly until the young man had a BMI of 12.4 and was frail and very poorly. The Team discussed with the young man and his family the option of a PEG tube so he could be fed directly into his stomach and this was something they wanted to try. However because he was so malnourished he needed to gain weight before that procedure could take place.

The young man therefore had a NG tube (down his nose) fitted in a short space of time and as a result he gained weight very quickly and was able to go on a family holiday to Florida.

On his return he started to have feeding/swallowing difficulties and again the tube needed to be replaced. Since then he has been able to manage and now has a much better quality of life at a stable weight and was now waiting to have the PEG tube fitted.

Ms Kemmner and Mr Reddaway wished the Board to be aware of how quickly this young man was able to be assessed and treated because they were called in once his problems with swallowing were recognised. It also meant the young man was able to be treated at an outpatient without the need for any hospital admissions.

It was noted that the Community Dietetics team were a small team, but they were keen to ensure that teams in the community were aware of the service they provided and they were trying to raise awareness of malnutrition and their role in supporting patients because very often teams missed the opportunity to call in the Dietetics team when they could have made a difference to a patient's well-being.

The Chief Executive reflected on the need for patients to have access to high quality food and how the team had made such a positive impact on this young man's life.

Mrs Matthews queried the missed opportunities and Ms Kemmner explained that the team was small (3.7 whole time equivalents) and was based at Torbay Hospital, but provided a service across the Trust's whole footprint. She said that the team worked hard to raise awareness, however they were not always called in to support other teams when earlier intervention could have made a difference. Ms Kemmner added that the team had a year's funding to support the teams in Newton Abbot and Torquay, but this was not equitable as the same funding was not provided for the other localities. In addition, the team have put in a bid for winter pressure funding to work with the CCG around hydration in care homes, as it was known that good hydration contributed to the prevention of admissions to hospital.

The Board thanked Ms Kemmner and Mr Reddaway for their presentation.

PART A: Matters for Discussion/Decision

155/10/19 **Apologies for Absence**

Apologies for absence were received from Mrs Jackie Stockman (Torbay Council Representative), Mrs Jacqui Lyttle (Non-Executive Director) Mr J

Welch (Non-Executive Director) and Mrs Jane Viner (Chief Nurse).

156/10/19 **Declaration of Interests**

There were no declarations of interest.

157/10/19 **Minutes of the Board Meeting held on the 7th August 2019 and Outstanding Actions**

The Board approved the minutes of the meeting held on the 7th August 2019 with one amendment – the Director of Transformation and Partnerships was present at the meeting. CEPA

158/10/19 **Report of the Chairman**

The Chairman briefed the Board as follows:

- With the Company Secretary he had undertaken a number of visits to community sites over the past few months and commended such visits to Board members.

- Following an appointment process, Mr David Stacey had been appointed to the post of Chief Finance Officer and would join the Trust in January. The Chairman wished to place on record his thanks to the Interim Director of Finance for the work he had already undertaken, and his continued support to the Trust.

- The annual Staff Awards event had been held at the end of September, and was a very well-received and successful evening. The Chairman thanked those involved in making the evening such a success including the Communications team and Governors, and in particular Mrs Hall. It was noted the event had been supported by Charitable Funds and external sponsorship.

- STP plans continued to take shape and Non-Executive Directors (NEDs) were involved in supporting this work. The Chairman said that it was important to understand NED involvement in this work and he would be asking the Company Secretary to consider how this was achieved to ensure that NED time was being used to best effect.

- The KPMG review of the Trust's finances was completed and the draft report had been received. The Chairman said that it was consistent with the Trust's understanding of the challenges.

- The Chairman recently attended the Hollacombe Day Centre Open Day and again, commended Board members to visit the facility if they were able.

- The Board noted that the Chair of the CCG had fed back to him how well the Trust had managed the recent information, communications and technology outage.

- The Trust's Annual Members Meeting was held last week with very positive feedback received about the day. The Chairman thanked the

staff of the Corporate Office who were involved in managing the event.

159/10/19 **Report of the Chief Executive**

The Chief Executive highlighted the following to the Board.

- The Trust had been named as one of 21 organisations across the NHS to receive a share of £100m seed funding to build business cases to develop an infrastructure and digital strategy. The amount of funding or timeline was not yet clear, however it was likely the investment period would be from 2025. The Trust would need to ensure that any plans were coherent with the wider STP system and that it was in the best possible position to optimise any investment as it was likely timelines would be tight.

- Mr Sutton reminded the Board that even with funding the Trust would need to continue with its current infrastructure for the next ten years and this was noted. The Director of Estates and Commercial Development added that with robust business cases the Trust could lobby to receive funding as soon as possible.

- Any solution would need to align to a clinical model that was fit for the future and that maximised the potential of the ICO, and this was recognised.

- The Trust experienced an IT outage 10 days ago. The Board was reminded that this was a risk on the Trust's risk register and that the Board had previously approved a business case for a new network. The Trust was currently in the procurement phase of the new network and it was likely it would be implemented in around 12-18 months. An after action review would be taking place following the outage, which would include assessing the network's vulnerability and if any further mitigating actions could be taken until the new system was implemented. In addition, it would review the Trust's business continuity plans and the operational response to the outage.

- The refurbishment of Theatres A&B had been completed and they would shortly be operational. The Chief Executive took the opportunity to thank the Director of Estates and Commercial Development and her team for all their hard work over the past few months.

- Work continued on Health and Wellbeing Centres to support the integrated care model. The Brixham Centre was now open and work had progressed on the Dartmouth model with agreement to progress with primary care and South Hams District Council. To take forward this work, the current working group had been stood down as it had achieved its aim of agreeing a location for the new centre. Work would now continue to engage with all key stakeholders on the next phase of the work and the implementation of the model.

- Chris Dixon, the Trust's Lead Research Nurse, had been selected to be part of the National Institute for Health Research 70@70 Research Leader Programme. This was a real credit to Chris and her passion and enthusiasm for research across the Trust.

- Dr Paul Andrews, one of the Trust's Consultant Physicians, had recently been successful in being awarded the Diploma in Forensic Medical Sciences by the Worshipful Society of Apothecaries.

- Finally, the Chief Executive reflected on the clinical presentations that were made at the recent Annual Members Meeting which highlighted the very innovative work that took place at the Trust and showed that it was at the cutting edge of innovation in many areas.

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

160/10/19 **Integrated Performance Report (IPR) – Month 5**

The IPR sets out the headline performance for Month 5 (August) 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.

Areas that the Board would want to focus on where the Trust was off trajectory were highlighted below.

Performance: Against the national NHSI Single Oversight Framework:
In August, the Trust did not meet the following national performance standards or agreed planned improvement trajectories:

- **A&E**: STF Trajectory (90%) **not met** - performance for August at 79.4%.

- **RTT:** RTT performance had been maintained in August at 80.2% against the Operational Plan trajectory of 81.5% and below the national standard of 92%. For August, 105 people would be reported as waiting over 52 weeks, this being an increase on last month (83), however remained in line with the forecast trajectory of 115.

- **Cancer:** At 76.6% for August forecast performance was below the 85% national standard, and below the recovery trajectory (85%). Action plans and performance forecast show that performance would continue to be below plan until the end of Q2 when further improvement was expected to be seen.

- **Diagnostics**: The diagnostics standard was not met in August with 14.9% of patients waiting over six weeks against the standard of 1%. This was deterioration from last month (13.6% in July). A revised plan would be brought to the November Finance, Performance and Digital Committee for consideration.

- It was acknowledged that more capacity was required to take forward the work to improve the 4 hour performance and the Chief Operating

Officer and Director of Transformation and Partnerships were working on a solution. The Urgent Care Programme Board was meeting twice a month to test plans and remove blockages to performance. It also reviewed the impact of changes and timings of actions.

- Work was taking place with Quality Improvement support and operational teams to build the same processes across all workstreams with a focus on reducing bed occupancy from c90% to 88% so that the assessment space in ED was always available.

- The Chairman reminded the Board that the Trust continued to perform below its key targets and that it needed to evidence improved performance to the regulators as soon as possible.

Financial performance against 2019/20 plan:

- The Trust had a control total for the year of a deficit of £3.80m, which excluded 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 31st of August 2019 was a £7.87m deficit, which was a variance of £1.38m adverse against budget of £6.49m. (52 week fines have been assumed to be returned in full or not applied, no STP risk share had been applied at months one to five and discussions were continuing with Torbay Council over its contributions to ASC in 2019/20).

- In months one to five the Trust had also assumed it would earn the PSF and MRET funding of £2.89m (this assumes the Trust could deliver the control total). An additional PSF income for 2018/19 of £0.27m was received by the Trust.

- Total pay run rate in Month 5 (£21.4m) was higher in comparison to previous month (Month 4 £21.1m); this included MARS value of £0.12m.

- Non pay expenditure run rate of £17.8m was lower by £2.20m compared to Month 4. Lower spend in Month 5 was due to: Drugs spend £0.56m (matched by Income); Clinical supplies £0.43m, impairment of receivables £0.19m, premises £0.38m, purchase of health/social care £0.15m, lower provision £0.18m and various cost £0.31m.

- The CIP target for year to date was £4.0m of which £3.7m had been delivered; an adverse variance of £0.2m due to undelivered pay schemes offset by additional income and non-pay schemes.

- The Trust had an annual savings target of £17.5m of which £14.5m had been identified resulting in a £3.0m 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 equated to £2.5m for which no plans have yet been identified.) The total CIP gap was therefore £5.5m. Of the forecast delivery only £8.1m (56%) was

fully developed, the remainder was at either outline or definition stage or therefore subject to risk of non-delivery. The control total would not be achieved without further progress on the detailed specification and subsequent delivery of CIP plans.

- The Capital expenditure as at Month 5 was £2.99m which was £2.46m underspent against the Month 5 budget of £5.44m. The full year forecasted spend presently stood at £17.68m which would result in an £1.08m overspend.

- The Finance Risk Rating remains a 3 at Month 5, with the agency rating adverse.

- The Trust, at this stage of the financial year, was forecasting delivery of the control total in line with NHSE/I guidance, although this remained subject to delivery of the savings plans, national outcome on 52 week penalties and finalisation of contract discussions including NHSE and Torbay Council contracts, the application of the STP risk share with the consequent risks attached and mitigation of variable staffing pressures.

- The control total would not be achieved without significant further progress in the detailed specification and subsequent delivery of CIP plans and management of cost pressures.

- To manage the financial gap a financial improvement programme was being put in place, along with some additional resource. There would be a focus on grip and control and a focus on reducing the cost base and run rate for the rest of the year, alongside fast-tracking improvements to delivery in the current year.

- The Chairman wished the Executive team to understand that they had the Board's support to undertake this work which, it was recognised, was going to cause some anxiety across the Trust.

- The Chief Executive reflected on the need to ensure the Trust had the right capacity and capability in the organisation to meet the scale of change that needed to take place. She added that the STP was considering how best to support Trusts in this respect.

- Mr Balch stressed the need, as the Trust was under external scrutiny in terms of its operational and financial performance, to show that it had grip and control to make improvements. Mr Sutton said he was fully supportive of the initiatives being implemented to manage the forecast position.

- Mr Richards said he was keen to understand how the reporting structure would work so that the Board understood the work that was taking place, when improvements were realised, and how the space would be created for executive directors to work at the level required and also to take forward initiatives such as a large capital programme. He said he would be interested in knowing how the additional headroom would be created to enable the STP work to continue at pace.

- The Chief Executive informed the Board that the STP had recognised that its call for capacity across organisations was above what was sustainable and that it was bringing in substantive capacity to support work and provide headroom.

Quality

- There had been five incidents in August that were reported on the Strategic Executive Information System (StEIS). Three related to slips, trips and falls, and two maternity. They would be fully investigated and any learning disseminated to teams.

- There had been two CDiff cases reported as lapses in care, and these would be investigated.

- The Trust was performing well against the Dementia Find target at 93%.

- The Trust was struggling to meet the Venous Thromboembolism (VTE target and performance was below the target of 95%. This related to recording of data, rather than undertaking assessments, and work was taking place to improve recording. It was noted that the Electronic Prescribing system had added complexity to the process.

Workforce

- Sickness absence in August was 4.16%, which was an increase on previous months and work was taking place to try to understand the drivers to this increase. Work continued to support staff through the Trust's health and wellbeing agenda.

- The Board had previously requested information on how the Trust compared with its neighbouring organisations in respect of sickness performance, and it was noted that for August the Royal Devon and Exeter had absences of 4.1% and Plymouth 4.3%.

- Turnover had also risen, and work was taking place around retention of staff and supporting teams. There was also the possibility of filling some vacancies through international recruitment.

- Statutory and mandatory training for August was at 91% which was an improvement and it was noted that the Education and Training Team continued to find alternative ways of proving training so that staff did not have to leave their place of work to undertake training.

- Appraisal performance had dipped in August. Work has taken place with the Integrated Service Units to address performance and in particular any 'hot spots'.

- Work was taking place to pull together all the work across the Trust around bank and agency and rostering to see what improvements could be made.

- The Chief Executive, on noting the themes from the report in terms of sickness and turnover, said that staff were tired and the Trust needed to ensure it supported its workforce and had robust plans in place as

the Trust moved into the winter period.

Strategy

- Work was taking place to redesign the governance structure to ensure that it met the Trust's governance and reporting requirements. There would be a single plan that was managed though ISUs, with allocated resource, to take forward transformational plans which had the right level of performance information and trajectories to support the work.

- The format in which financial and operational performance was reported to the Board was in the process of being reviewed and would be presented to the Board in the near future.

- Mr Richards suggested it would be helpful to have a costed plan that detailed the cost attached to meeting national targets. The Director of Transformation and Partnership explained that work was taking place to identify the cost of improvement and said that the only way the Trust could meet its targets was by redesign. It was acknowledged that this work was twofold – what improvement work could take place now and also the model of the Trust for the future.

- Mr Sutton raised the need for a zero based budget exercise. It was noted that in order for it to be effective there needed to be standardisation first and this was currently being discussed by the executive team.

- Mrs Matthews queried the consequence of not meeting targets on an individual or team basis and it was noted that a clearly understood accountability framework was being put in place.

- It was noted that teams needed to have the freedom to deliver targets and manage budgets, however grip and control needed to be centralised and that these needed to be managed side by side with the right approach.

The Board of Directors reviewed and noted the Month 5 Integrated Performance Report.

161/10/19 **Mortality Surveillance Scorecard**

The Medical Director presented the Mortality Surveillance Scorecard and informed the Board that concern had been raised at the Finance, Performance and Digital Committee in respect of the Hospital Standardised Mortality Rate (HSMR) figures. Before addressing this issue the Medical Director reminded the Board that the data showed that the Trust was performing well against national benchmarks and STP organisations. He added that the Trust was working with STP organisations to standardise the approach to data collection so that data was comparable.

The concern that had been raised in respect of HSMR data related to a raised data point, above 100, however this was still within the expected range. It was noted that this could be due to a statistical variation or coding issues and further information was awaited before taking any action. In addition, the number of unadjusted deaths showed an overall reducing trend, albeit with an

increase in the last month.

The Medical Director said that, in addition to this data, triangulation took place to test the evidence but said that more data was required to see if it was evidence of a trend or not. He added that the Summary Hospital Mortality Index (SHMI) data, which measured deaths up to 30 days after hospital admission, was positive.

The Trust was part of a national dashboard that reported on unavoidable deaths and performed well in this respect. The Board was reminded of the requirement to introduce a Medical Examiner role to review deaths to ascertain if there was any element of avoidability, and the Medical Director said that there was a Trust member of staff interested in fulfilling this role. National funding was available for the role and once it had been received the role would be put in place.

The Chairman commended the mortuary as a place to visit, following the work that had taken place to improve the facility. He said that the department was keen to demonstrate and explain the improvements that had been made.

The Chief Executive queried the process for reviewing deaths of anyone with learning disabilities and the Medical Director explained there was a separate clearly laid down process for anyone with a learning disability that reviewed their whole lifespan.

The Board of Directors reviewed and noted the Mortality Surveillance Scorecard.

162/10/19 **Trust Quality Accounts Performance**

The report provided an update against the three agreed Trust Quality Account priorities which were published as part of the Trust Annual Report and Account:

- Priority 1: EPMA (electronics prescribing and medicines administration programme) (Patient safety)
- Priority 2: Community IT system rollout (Clinical effectiveness)
- Priority 3: Carers & the Urgent & emergency care pathway (Patient experience)

The Board noted that performance against EPMA was not on plan due to technical reasons associated with embedding the scheme across what was a complex organisation.

The Board of Directors received the Trust Quality Accounts Performance Report.

163/10/19 **Safeguarding Children Annual Board Report**

The annual report informed Torbay and South Devon NHS Foundation Trust Board members on issues relating to the safeguarding of children in Torbay and South Devon. The Trust was a partner agency and had statutory duties outlined in the Children's Act and supported by "Working together to Safeguarding Children" 2019 guidance.

The report informed members of the activities of the Safeguarding Children Team and the activities of the wider safeguarding duties and activities completed by Trust staff, both directly and indirectly to safeguard children.

The Chief Nurse was the Executive Lead for Safeguarding and was supported by the Torquay System Director and the Named Professionals in this role.

The System Director of Nursing and Professional Practice drew the Board's attention to the following from the report:

- There were robust internal processes and systems in place and the service worked closely with its external partners to ensure children and young people were protected from harm.

- There were a number of services in the Trust that provided safeguarding services including maternity where c15% of women required support for their family and children.

- The Trust's Paediatric Liaison team worked across the organisation to train, support and share information with teams.

- Around 2,000 children a year were referred from the Trust's Emergency Department to the service.

- There had been changes to the national guidance in respect of child deaths and the need to fully investigate both expected and unexpected deaths. The Trust had fully adopted all requirements of the new guidance.

- There were a large number of children who had a Children Protection plan across Torbay and the Board noted that Torbay had areas of high deprivation.

- Supervision for public health nurses was at 100%.

- Work was taking place to improve the uptake of Level 3 training which for Aught 2019 was at 75% compared to a target of 80%.

- Following the Woods Report work had taken place to redesign the governance structure for child protection with a Torbay and Plymouth Safeguarding Children's Partnership being set up, below which sat local groups for Plymouth and Torbay.

- As reported to the Board previously, there was a challenge in managing children with behavioural and health issues and that children were often admitted to Louisa Cary which was not always appropriate. An escalation system was now in place to ensure that those children could be transferred to an appropriate place of care as soon as possible.

The Chief Executive reflected on the importance of starting well in life and working in support of Torbay Council in addressing their improvement plan. The System Director of Nursing and Professional Practice said that, with the

Chief Nurse, she was involved in the work to take forward the Ofsted recommendations and in particular the need for additional social worker capacity to review children who had Safeguarding Plans and those that returned to Plans.

The Chairman said that he had found that throughout the Trust safeguarding was provided by 'pockets' of staff and that it was difficult for him to understand how the service was provided and how they fitted into the organisation. He asked for assurance that providing the service in this way was the most effective, rather than bringing staff together into one team. SDNPP

Mr Richards raised the issue of the differences in provision of services for children between Torbay and the wider South Devon area and asked how this would be resolved in the future. The Chief Executive explained that this was one of the drivers for the Trust to bid as prime contractor for the Children and Young Persons Contract so that a fully integrated service across the Trust's footprint could be provided.

The Board of Directors noted the Safeguarding Children Annual Report.

164/10/19 **Safeguarding Adults and Deprivation of Liberty Safeguarding**

The annual report informed Board members on issues relating to safeguarding vulnerable adults in Torbay and South Devon. The Trust had delegated responsibility for Local Authority statutory safeguarding duties for adults on behalf of Torbay Council which was governed by The Care Act 2014.

In addition the Trust was a partner organisation working with Devon County Council and Torbay Council as a provider of health and care services. Devon County Council retained the lead for adult safeguarding in the South Devon footprint.

The Chief Nurse was Executive Lead for Safeguarding and was supported in this role by the Deputy Director of Adult Social Services and Named Professionals.

The System Director for Nursing and Professional Practice drew the Board's attention to the following:

- The Trust had two key indicators agreed with Torbay Council:
    - Percentage of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual – performance 100%.
    - Percentage of repeat referrals to adult safeguarding in 12 months – performance 8.15% (target 8%, and 6.75% in 2017/18). A multi-agency review was taking place to investigate the reasons for the high level of repeat referrals.
- Referrals for Deprivation of Liberty (DoLs) reviews were much higher than capacity and was a national issue. All applications were reviewed using a national tool to ensure the most urgent cases were addressed.

There was a limited number of specialist assessors to undertake this work.

- From the 1st October 2020 DoLs would be renamed ‘Liberty Protection Safeguards’. Under the new guidelines the CCG and local authority would become responsible bodies and have statutory responsibilities.

- The Quait Team continued to work with care homes to support clients and the homes to manage any safeguarding issues/concerns.

- There had been one adult safeguarding review in the last year and the action plan from that review was in the process of being finalised.

- There were robust governance processes in place to deliver the service including a high compliance with training and other standards.

The Chief Executive reminded the Board not to lose sight of the challenge to manage the number of DoLs referrals received. It was noted that the role of a Best Interest Assessor was difficult to recruit to and the demands on front line staff made it difficult for them to fulfil this role alongside their normal workload.

The Board of Directors noted the Safeguarding Adults and Deprivation of Liberty Safeguarding Annual Report.

PART B: Matters for Approval/Noting Without Discussion

Reports from Board Committees

165/10/19 **Finance, Performance and Digital Committee – 24th September 2019**

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

166/10/19 **Quality Assurance Committee – 18th September 2019**

The Board noted the report from the Chair of the Quality Assurance Committee.

Reports from Executive Directors

167/10/19 **Education and Workforce Development Six Monthly Update**

The Board noted the performance and developments over the last six months, and the core priorities set for the Department for the next six months.

The Board received the Education and Workforce Development six monthly update.

168/10/19 **Safe Staffing and Nursing Work Programme**

The Board noted the data contained within the Safe Staffing and Nursing Work Programme Report.

The Board of Directors received the Safe Staffing and Nursing Work Programme report.

169/10/19 **Report of the Director of Estates and Commercial Development**

The report provided an update to the Board on key issues, performance and compliance for July and August.

Top Line Briefs

Humidity and Temperature Issues – Theatres
High humidity within theatres continued to be a major issue.

Various standalone monitoring equipment had been ordered to assist with managing this issue in the short term. Long term solutions were in progress including the installation of humidity sensors within the Air Handling Units systems during September. The operational, clinical and estates teams continued to work together to minimise the impact on patient activity.

Performance
Key performance indicators remained good across all areas with all statutory and mandatory planned preventative maintenance completed to plan. Although the Urgent P2 indicator had deteriorated to red, the actual figures showed a % improvement in performance due to increased activity.

There were five catastrophic estate failures including the theatres which remained an on-going issue.

Estates Compliance
Significant progress had been made to improve the estates compliance score from 55% to 69.8% as a result of the appointment of Statutory Post holders, training across the Compliance Categories and improved working practice. Plant Room access and safety standards continued to be reinforced. Risk assessments and Safe Systems of Work were in the process of being embedded in EFM Operations Procedures.

Food Safety
The Environmental Health Officer (EHO) revisited on the 15th August resulting in an improved food hygiene rating of three being awarded. The EHO was satisfied with all processes in the main catering department but issues remained in the ward kitchens around food temperature monitoring and food labelling. The EHO had recommended the Trust review the hotel services provision at ward level to include a specific ward catering role rather than a generic post which was currently in place. This would provide the necessary assurance around food safety. The service review, in consultation with staff, commenced in October, led by the Associate Director EFM Operations.

The Board of Directors received and noted:

- **Top line briefs for EFM for the months of July and August**
- **EFM Compliance and Performance Reports and exceptions**

170/10/19 **Report of the Director of Workforce and Organisational Development**

The Director of Workforce and Organisational Development reminded the Board that the Staff Survey was live and asked them to promote completion

amongst their teams. She added that the Flu Immunisation Programme was also underway and encouraged the Board to have their flu vaccinations.

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

171/10/19 **Compliance Issues**

There were no compliance issues.

172/10/19 **Any Other Business Notified in Advance**

173/10/19 **Date of Next Meeting – 9.00 am, Wednesday 6th November 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.	Chairman to write to Mr Punwar to thank him for his work and support whilst undertaking the role of Guardian of Safe Working Hours.	Ch	**Complete**	07/08/19
2.	Amend minutes of the meeting held on the 7th August 2019 to reflect that the Director of Transformation and Partnerships was present.	CEPA		02/10/19
3.	Provide assurance that the framework of having safeguarding provided by groups of staff in different locations was the most effective way to provide the service.	SDNPP		02/10/19

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 6 November 2019
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Company Secretary Joint Heads of Communication		
Report provenance	Reviewed by Executive Directors October 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**	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**	
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:** 6 November 2019
Report sponsor	Chief Executive	
Report author	Company Secretary Joint Heads of 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 2 October 2019 are as follows:

1.1 <u>Safe Care, Best Experience</u>

1.1.1 New NHS Capital Funding – Torbay Hospital

We have now received a letter from the Secretary of State, Matt Hancock about the announcement of strategic investment of the Health Infrastructure Plan (HIP 2). This is the plan the Prime Minister announced saying that in the next ten years 40 hospitals would be built. You will recall that Torbay Hospital was one of those listed to receive 'seed' funding to support the initial stage.

The letter confirms the Torbay Hospital scheme is one of the projects that are green-lighted to proceed to the next level of development. It also says that there is a £100m pot of seed money in total being made available to kick start the next stage of developing a plan. The letter makes clear that schemes need to present a clear investment case to move to the next stage. It says the aim is that successful schemes should be underway and making good progress by 2025-30. We will be ensuring we are well placed to meet the requirements laid out so that we can take full advantage of the capital funding.

The Trust HIP 2 Plan with the support of the STP Long Term Plan is to provide facilities for the delivery of new models of care to enable a new smaller hot centre/hospital, elective centre and co-locate facilities. The Trust is working with NHSE, STP and partners to develop a strategic outline case within the next six months.

Comment: This confirmation is excellent and much needed news. We will ensure that a clear business case is produced to ensure we are ready to take full advantage of the funding opportunity.

We have also just received confirmation that the Trust has met the funding criteria for a replacement MRI scanner. This is great news and will provide welcome support for diagnostic improvement. This scanner comes alongside the Trusts existing plan to increase the number of CT scanners from 2 to 3 both are due to be installed early in 2020 / 21. Once complete these machines will enable faster scanning for patients increasing the number of scans and reducing reliance on mobile scanning capacity.

1.1.2 Theatres re-open
Theatres A&B have now reopened and took their first patients in October, following a £2.3m refurbishment to install up to date air handling equipment. The theatres had been out of action since November 2018, leaving the Trust 20 per cent short of its total theatre capacity. Since then, a number of other theatres have also been out of action intermittently, with issues arising in relation to the age and general condition of the facilities.

During the past 11 months, our staff have responded to the enormous challenge as a focussed team. They have worked together to ensure all patients waiting for surgery continue to receive safe care, and to mitigate the impact on waiting times. We managed to create additional capacity in-house, thanks to the phenomenal efforts of our staff and the outsourcing of some planned operations to Mount Stuart and the Plymouth Nuffield. Clinical our support services staff have worked extra hours, including at weekends, and run extra sessions in our day surgery theatres. As a result of these measures, we have managed to treat 20 per cent more patients through our day surgery unit (616 people) and eight per cent more (272 people) through main theatres. We are also on track to eliminate the number of people waiting longer than 52 weeks for their surgery by March 2020. The re-opening of these two theatres means that we are back to our full theatre capacity and importantly have the new clean air facilities give us considerable more flexibility, which will support us achieve our 52 week and RTT targets

This will be a phenomenal achievement, given the challenges we have faced. The superb team effort involved a wide range of staff across several departments, (including estates, theatres, day surgery, anaesthetics, pre-assessment and admissions, all surgical teams) all of which culminated in a Chairman's Staff Hero Award at our recent awards evening.

1.1.3 IT Outage
In October we suffered the second IT failure in recent months which appears to be due to issues with our ageing IT network. The Board has already signed off a business plan to replace our IT network and procurement is underway. Both the procurement and the network replacement are lengthy, involved and complex projects and is some way off from implementation. Following the latest incident, we have established a detailed investigation. This investigation will focus on what happened and why, and whether there is anything more we can do to strengthen our IT resilience between now and the delivery of a new network. We also want to review how we responded and what we could do better in future. The executive team have thanked staff for the fantastic response to the recent incident.

We are carrying out a full review which is being led by the Deputy Director of Nursing and will look at the management of the current IT risks and the adequacy of our risk mitigation measures and our business continuity in response to the potential impact on our services.

Comment:
We know that failure of our IT infrastructure represents a significant risk to the Trust - and any failure exacerbates a challenging operating environment. We are therefore ensuring that during the time it will take to procure and implement updated IT that we are as best prepared for any outage as possible.

1.1.4 Major incident
A serious bus crash occurred on 5 October between Totnes and Paignton, which was declared a major incident by the police.

The NHS response to the incident involved Devon CCG, Devon Doctors, SWAST and colleagues in acute hospitals in Bristol, Exeter and Plymouth. We were also supported by colleagues in Cornwall and Taunton in a co-ordinated, system-wide handling plan led by NHS England. NHS England passed on particular thanks from SWAST to our Trust for handling the major incident in such a professional and calm way, enabling them to turn ambulances around quickly.

A major incident structured debrief took place following the crash including with the Gold and Silver commanders. In addition 'After Action Reviews' took place to feedback from various non commander roles and all departments conducted their own team debrief, and feedback findings were collated. The feedback has been fully considered and lessons identified and are being acted on.

Comment:
I would like to thank all staff who responded to the callout and with their support we were able to respond well to the incident, and provide safe and timely care to all the casualties we received through our ED department.

1.1.5 Flu vaccine clinics
We have had a high uptake of staff receiving their flu vaccinations with over a third already vaccinated. This year we have a number of static clinics taking place as well as 'roving' clinics where vaccinators are out and about visiting clinical areas. All staff have been encouraged to take up the opportunity to have a flu vaccination to protect themselves, their families and our vulnerable patients.

1.1.6 Winter preparedness and action programme
The Winter Plan which has been developed in collaboration with stakeholders across South Devon and Torbay A&E Delivery Board is being put before the Board in a separate paper. The aim of the plan is to ensure quality, safety and operational resilience and to complement plans of partner providers, to ensure the delivery of safe and high quality services to the population of South Devon and Torbay during the winter period. Historical experience and lessons learnt, alongside the Five Year Forward View and "Refreshing NHS Plans for 2018/19" issued by NHSE and NHSI have been used to develop this plan. We have yet to receive 2019/20 guidance but will update according to any additional requirements.

Traditionally, the system experiences challenging winter periods with high levels of flu, high acuity impacting ED, ICU, Cardiology, Stroke, Paediatrics, Mental Health and increased demand to maintain patients within the community and at home. In addition adverse weather conditions, regular periods of surge demand and high levels of staff sickness also impact. In addition, the System Improvement Board commissioned a deep-dive review of activity across Torbay and South Devon in July 2019 which has also informed this Plan.

The potential impact on the patient experience is considerable and during the winter months we will aim to ensure:

- No avoidable deaths, injury or illness
- No avoidable harm
- No unnecessary waiting or delays
- No inequality of access to our services

1.2 Well Led

1.2.1 Month 6 - Performance against the NHS Improvement Single Oversight Framework

- **A&E:** The Operational Plan trajectory for Accident and Emergency waiting times (less than 4 hours) was not met in September (92% trajectory) at **80.7%** although an increase from 79.4% last month.

- **RTT:** RTT performance has decreased slightly in September with the proportion of people waiting less than 18 weeks at **80.35%;** this is behind the Operational Plan trajectory of 82% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has risen to 20,285, an increase of 380 from August and above our revised trajectory. For September, 89 people will be reported as waiting over 52 weeks (16 due to patient choice), this being a decrease on last month's 105 but remains ahead of our re-forecast position of 103. Although the September position is ahead of our forecast position, early indications are showing that we will not achieve our October and November trajectory, with October looking to be 110 against the trajectory of 75.

- **Cancer:** The national standard was not met in September with **77.7%** against standard of 85% and improvement trajectory (85.5%). Recovery plans to deliver the standard in Q2 are in place with weekly monitoring and escalation through the Chief Operating Officer.

- **Diagnostics:** The diagnostics trajectory was not met with 15.7% of patients waiting over 6 weeks. This is outside of our recovery trajectory to deliver improved performance in September to achieve the 10% target. Demand for CT, MRI and gastro diagnostics tests exceeded the maximum in-house capacity (which includes extended days and weekend working). Utilisation of mobile van capacity remains in place to support this capacity shortfall along with insourcing at weekends for Gastro lists. Waiting times have improved for MRI and recovery plans to increase CT Colon examinations have now commenced being the bulk of the longest waits for CT diagnostic tests. The revised trajectory confirms progress will be delivered against our plan to achieve 6% over 6 weeks by April 2020.

1.2.2 Month 6 performance against 2019/20 Plan

- **Overall financial position:** The financial position at control total level as at 30 September 2019 showed a £7.74m deficit, which is slightly ahead against the plan of £7.80m.

- **Regulator Protocol for Forecast change:** In line with the discussions at Board last month over the deterioration in forecast, the Trust has been working on

mitigation plans and agreeing the position and actions with internal and external stakeholders. This has resulted in the Trust formally reporting a variance to plan of £15.0m after expected mitigations.

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 £8.8m have targets identified resulting in a £8.7m 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 CIP planning gap is therefore £11.2m. The forecast outturn delivery value has reduced significantly following the conclusion of the deliverability peer review of the Trust's Transformational schemes. Subsequent to this review, we have appointed a Financial Recovery Director.

  The CIP target for year to date is £4.9m of which £4.6m has been delivered; an adverse variance of £0.3m due to undelivered pay schemes offset by additional income and non-pay schemes.

- **Capital expenditure**: Capital expenditure as at month 6 was £4.02m against the full year forecast of £17.93m.

1.2.3 Annual Plan 2020/21

Work has already commenced on the Annual Plan for 2020/21. An excellent session with our Governors took place on 23 October to discuss planning our future strategy to the needs of our local population. The discussion topics included workforce, digital, estate and clinical services. A further session is planned for the new year to inform Governors how their input, views and feedback from members and the public have influenced our future strategy.

1.2.4 People Committee

Our Trust's governance arrangements have been strengthened with the establishment of a new Board Committee – People Committee. The Committee, chaired by Vikki Matthews, Non-Executive Director held its first meeting in October and comprises Non-Executive Directors, Executive Directors and senior managers.

Comment: The establishment of a People Committee is particularly welcome as it will enable Board-level focus on the Trust's response to the National Interim People Plan and implementation of our own People Plan.

1.3 Valuing our Workforce, Paid and Unpaid

1.3.1 Staff Olympics

This year we held our first Staff Olympics which is aimed at bringing staff together in a variety of non-work activities. The aim is to support and encourage staff to do something that supports good wellbeing and events were grouped under Body, Mind and Soul. There was a whole range of activities on offer including a bake off, a sewing bee, general knowledge quiz, big screen and gaming and sports activities.

Our thanks to the Chief Nurse and Deputy Chief Executive, Jane Viner and her team for leading this event with such enthusiasm.

Comment:
We had a lot of enthusiastic people taking part in a wide range of events which was very uplifting. Feedback has been so positive we are thinking of repeating the event to include more venues across Torbay and South Devon. Supporting our staff to have good wellbeing is very important and we want to thank the Olympic Committee and the volunteers who donated their time and energy and everyone who took part..

1.3.2 Staff Survey

The national staff survey for 2019 was launched on 1 October 2019. Questionnaires are returned to an external survey contractor who administers the survey on our behalf. The survey findings are reported in a summary report and will be analysed by the Trust to identify improvements to staff health and wellbeing and making the Trust a better place to work. We are encouraging staff to complete the survey and share views and providing time during your working hours to do so. The survey closes on 29 November 2018.

1.3.3 Acting Medical Director

I am pleased to announce that Ian Currie has been appointed as Acting Medical Director for a fixed period of 12 months, from 1 December 2019. He will hold this role in addition to his role as Medical Director for the South Devon system. Ian's appointment will provide additional capacity within our medical leadership team, enabling Dr Rob Dyer to focus on strategic development for our Trust, including redeveloping our IT and estate. Rob will also retain the Trust Board accountability as Executive Medical Director.

The new arrangements will also allow Rob to focus on the role of Lead Medical Director for the Devon STP. He has held this role for the past two years, and it is becoming increasingly demanding of his time. Rob's STP role gives this Trust a strong voice at the heart of the Devon STP, as we develop clinical networking across the four acute trusts in Devon. From 1 December Ian will take on the day to day Medical Director roles including operational matters and Responsible Officer. Rob and Ian will communicate in more detail with those directly affected by the changes.

I am also pleased to report Dr Rob Dyer, Executive Medical Director recently received an award of a honorary associate Professorship from Plymouth University.

1.3.4 Developing Future System Leaders in Devon

Several members of staff, from clinical and non-clinical backgrounds are taking part in cohort 2 of the Devon System Leadership Development Programme that has been developed and run by the STP Organisational Development Leads of Devon. The programme has been designed to support co-designing and co-delivering the future for

Devon's provision of services and will also support the identification of future system talent and leaders. This is an opportunity for individuals to work on real clinical and non-clinical projects/pieces of work that will have real tangible impact across Devon whilst also developing critical skills and relationships with colleagues who work in Health, Social Care, private, voluntary and independent sectors including primary care and South West Ambulance Service.

1.3.5 Health and Wellbeing

In response to an identified gap where staff and teams were struggling with processing thoughts and feelings after an 'extraordinary event', a group of 20 staff across with clinical and non-clinical backgrounds undertook the Critical Incident Stress Management Training (CISM). In the last 2 months they have responded to 4 such events receiving highly positive feedback. The learning from this process so far is informing the future model and will in the future be referred to as 'Jigsaw' (referring to teams putting things back together).

The team of 20 Mental Health First Aiders that we have in the organisation are refocusing their approach to increase visibility in order to reduce stigma, raise awareness and be an initial response to those staff who are struggling.

Wellbeing and anti-bullying week commences on the 4 November. A number of activities and events including education talks, virtual reality relaxation sessions and neck and shoulder massage are being taken out to staff in clinical areas. In addition an Exec VLOG is planned during this week to share some of the actions that are being taken to raise awareness of incivility and the associated consequences.

2. Chief Executive Engagement: October

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

Internal	**External**

• Medical Staff Committee AGM
• Joint Consultative Negotiating Committee
• SPI Walk-around – Outpatients and Coastal Health and Wellbeing Team
• Staff Heroes
• Freedom to Speak Up Guardian
• Doctor Breakfast Meeting
• League of Friends Chairs Meeting
• Medical Director, NHS England
• Speaker at League of Friends Coffee Morning
• Video blog sessions:
    o Smokefree Policy
    o Social Care
    o Freedom to Speak up
	• Interim Director of Adult Services and Housing, Torbay Council
	• STP Chief Executives' Meeting
	• STP Programme Delivery Executive Group
	• Chief Officer, Adult Care & Health Digital Transformation & Business Support, DCC
	• Devon A&E Delivery Board
	• Children and Young Persons Partnership Board
	• Devon ICM Meeting
	• SDT System Improvement Board
	• Visit to Live Life Well Pilot (Barnstaple)
	• NHS South West Chief Executives Meeting
	• Opening Welcome for Devon wide Systems Leadership Programme

Guardians ○ Chronic Fatigue Syndrome/Multiple Sclerosis	• Devon Integrated Care System Conference • Devon Planning Review Meeting • Chief Executive, Torbay Council

3 Local Health and Care Economy Developments

3.1 Partner and partnership updates

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3.1.1 Devon Strategic Transformation Partnership

NHS Long Term Plan update

The first draft of the Devon version of the NHS Long-Term Plan, called 'Better For You, Better for Devon' was submitted to regulators in late September and following their comments an updated draft was submitted at the beginning of November . 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. Healthwatch Devon is producing an independent report on all the findings from the engagement.

3.1.2 Torbay Council

Consultation on new councils

Torbay Council is considering establishing new Town Councils in Torquay and Paignton to help protect services that Torbay Council will no longer be able to afford in the future and to give local people more say and control over services in their area. A consultation has taken place and closed on 25 October 2019. The council says the introduction of Town Councils could generate in the region of £1.47m for the proposed Paignton Town Council and £2.09m for Torquay Town Council. This could provide services such as parks, toilets, museums, seafront illuminations and events, but statutory services, such as social care, education or housing would remain with Torbay Council. More information can be found at www.torbay.gov.uk/new-town-councils

Risk Share Agreement

In October Torbay Council approved the arrangements build on the well-established and successful shared services with the Trust, acknowledging increasing need and demand for all partners. Practically, this means that the Trust will continue to provide Adult Social Care for Torbay Council, via integrated locality community teams. The agreement is to be based upon the following conditions:

- A capped financial commitment from Torbay Council per year of £45 million for core spend, plus £2 million additional funding to acknowledge the spend is currently unacceptably over this level for the period of the agreement
- A non-recurrent additional payment of £1 million in 2020/2021
- An acknowledgement that all parties need to work together to deliver savings of £2 million per year in respect of the costs of Adult Social Care
- That partners prioritise working together on an Adult Social Care Improvement Plan, and that the same is overseen by senior officers from all partners, which includes a review of governance so as to ensure the Council's appropriate involvement, and includes a joint approach to maximising estates and economic development opportunities in Torbay.

3.1.3 Devon County Council

Proud to Care campaign
A 'Proud to Care' advertising campaign has been launched by Devon County Council to attract people to care worker roles in domiciliary care and care homes. The campaign was initially developed to showcase the value of caring and the difference it can make to people's lives. This winter's campaign targets people aged 20-39 across Devon and Torbay by focussing on telling the stories of real people who are being supported to remain independent at home or living in a care home.

3.1.4 Torbay Safeguarding Children's Board

As of 29 September 2019 the new multi-agency safeguarding arrangements for Plymouth and Torbay merged becoming Plymouth and Torbay Safeguarding Children Partnership (PTSCP) delivering local arrangements in a joined up way which meets the key priority of safeguarding and protecting children and young people.

The PTSCP will coordinate safeguarding services, acting as a strategic leadership group in supporting and engaging others across Plymouth and Torbay, and implementing local and national learning from serious child safeguarding incidents, and child death reviews.

4 National Developments and Publications

Details of the main national and regional developments and publications since the last Board meeting on 2 October 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 <u>Government</u>

4.1.1 Pre-election guidance

Now that a general election has been called for 12 December, we are in a period of restricted activity and communication and are expected to follow the pre-election period guidance. In general, guidance is that, while we have a responsibility to keep running 'business as usual' (including EU exit planning), we shouldn't be doing anything new. This is because an incoming government may take a different view on the issue, and we shouldn't be doing anything, which may distract from the election campaign or be argued to give one participant in it an advantage. This means that, until after a new government has been formed, there should be:

- no new decisions or announcements of policy or strategy
- no decisions on large and/or contentious procurement contracts
- no participation by NHS representatives in debates and events which may be politically controversial

These restrictions apply in all cases other than where postponement would be detrimental to the effective running of services, or wasteful of public money. Full details are available on the NHS Providers website here.

4.2 NHS England and NHS Improvement

4.2.1 NHS Oversight Framework

The **NHS Oversight Framework for 2019/20** has replaced the provider Single Oversight Framework and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF).

The NHS Oversight Framework for 2019/20 outlines the joint approach NHS England and NHS Improvement will take to oversee organisational performance and identify where commissioners and providers may need support.

A new approach to oversight will set out how regional teams review performance and identify support needs across sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). This framework summarises how this new approach to oversight will work from 2019/20 and the work that will be done during 2019/20 for a new integrated approach from 2020/21.

Oversight will incorporate:
System review meetings: discussions between the regional team and system leaders, drawing on corporate and national expertise as necessary, informed by a shared set of information and covering:

- performance against a core set of national requirements at system and/or organisational level. These will include: quality of care, population health, financial performance and sustainability, and delivery of national standards
- any emerging organisational health issues that may need addressing
- implementation of transformation objectives in the NHS Long Term Plan.

In the absence of material concerns, the default frequency for these meetings will be quarterly, but regional teams will engage more frequently where system or organisational issues make it necessary.

4.2.2. New financial regime to 'reset regulatory relationships'

NHS England and NHS Improvement, are setting out how different approaches will be taken depending on a provider's budget position. Trusts currently in surplus (before receipt of provider sustainability funding) have not been given a control total next year, so will be able to set their own financial plan. Instead of "financial recovery funding" (FRF) – which will be made available to trusts in deficit – these stronger organisations will also be offered a one-off "transitional reward payment" worth 0.5 per cent of "relevant income", providing they deliver a surplus next year as well. For example, a provider with an annual income of £500m would receive £2.5m. Trusts currently in deficit would become eligible for two reward payments if they reach and maintain a balanced position. Organisations in deficit have been given control totals and specific "improvement trajectories" until 2023-24, as well as allocations from the FRF. These aim to gradually reduce the number of trusts and clinical commissioning groups in deficit, so that no organisation is in deficit by the end of the period.

4.2.3 Provider sector deficit grows to £800m in three months

The financial performance data for the first quarter of 2019-20 shows trusts reported a combined deficit of £806m for the first quarter, which is broadly similar to the position reported at the same stage in each of the previous two years. This position is £26m better the planned figure of £832m. The data suggests little improvement to the provider sector deficit, despite extra money being channelled in. The new five-year settlement for the NHS enabled around £1.4bn to go into payment tariffs this year. In theory, this was supposed to mean efficiency targets could be relaxed and the deficit could be further reduced. However, the first quarter data released by NHS England and NHS Improvement suggests a pretty small change to the efficiency requirement, and little improvement in the provider deficit. It indicates that in reality trusts are having to target savings of around 3.5% this year, well over the baseline tariff assumption of 1.1%, and roughly the same as they delivered in 2018-19 (against a 4.1% target).

4.3 Care Quality Commission

4.3.1. State of Health Care and Adult Social Care 2018/19

The annual report says that most of the care across England is good quality and overall is slightly improving. But the report says people do not always have good experiences of care. Increased demand and challenges around workforce and access they say are presenting particular barriers in some parts of the country. The full report can be read on the CQC website – www.cqc.org.uk/stateofcare

5 Local Media Update

5.1 News release and campaigns highlights:

- Coverage of our staff heroes award ceremony
- IT failure – information and reassurance that our plans were being acted on
- Support to quit smoking during the annual Stoptober
- Advertising and reporting on the Annual Member's Meeting
- Care worker recruitment campaign. A new campaign to recruit care workers has been launched, appealing to people to support others to live independently in Devon
- HOPE programme continues to support people living with long term conditions
- Encouragement to take up the offer of a Flu vaccination
- Children and Family Health stakeholder events to engage on the implementation of the vision

6 Recommendation

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

Torbay and South Devon
NHS Foundation Trust

<table>
<tr><td colspan="2">Report to the Trust Board of Directors</td><td></td></tr>
<tr><td colspan="2">Report title: Integrated Performance Report (IPR):
Month 6 2019/20 (September 2019)</td><td>Meeting date:
6 November 2019</td></tr>
<tr><td>Report appendix</td><td colspan="2">Month 6 - Part 1- IPR Summary Report
Month 6 - Part 2 - Focus Report
Month 6 - Dashboard of key metrics</td></tr>
<tr><td>Report sponsor</td><td colspan="2">Director of Transformation and Partnerships
Interim Director of Finance</td></tr>
<tr><td>Report author</td><td colspan="2">Head of Performance</td></tr>
<tr><td>Report provenance</td><td colspan="2">Executive Director scrutiny (22 October 2019)
Finance, Performance, and Digital Committee (29 October 2019)</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="2">The IPR sets out the headline performance for Month 6 (September) 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 last 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 September, the Trust did not meet the following national performance standards or agreed planned improvement trajectories:
A&E: STF Trajectory (90%) not met - performance for September at 80.7%.
RTT: RTT performance has seen little change in September with 80.4% of people waiting less than 18 weeks, behind the Operational Plan trajectory of 82%. Against 52 weeks we have seen a decrease from 105 last month to 89 this month and within our plan trajectory of 115.
Cancer: National standard not met in September with 77.7% against standard of 85% and improvement trajectory (85.5%) - 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 84.3% of</td></tr>
</table>

patients waiting under 6 weeks. This is outside of our recovery trajectory to deliver improved performance in September to achieve 90.3% against the National standard 99%.

Financial performance against 2019/20 plan:

- 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.
- In line with the discussions at Board last month over the deterioration in Forecast the Trust has been working on mitigation plans and agreeing the position, drivers and actions with internal and external stakeholders. This has resulted in the Trust formally reporting a variance to plan of £15.0m after expected mitigations.
- The financial position at this control total level as at 30th of September 2019 is a £7.74m deficit, which is slightly ahead against the plan of £7.80m.
  (52 week fines have been assumed to be returned in full or not applied, no STP risk share has been applied at months 1 to 6 and discussions are continuing with Torbay council over its contributions to ASC in 2019/20).
- In months 1 to 6 the Trust has also assumed it will earn the PSF and MRET funding of £3.51m (as the Trust has delivered the control total in that period). An additional PSF income for FY 2018/19 of £0.27m was received by the Trust.
- Total pay run rate in M6 (£21.1m) is lower in comparison to previous month (M5 £21.4m); mainly lower Agency spend.
  Non pay expenditure run rate of £18.2m is higher by £0.45m compared to M5. Higher spend in M6 is due to: Drugs spend £0.10m, clinical and non-clinical supplies £0.11m and various operating cost £0.24m.
- The CIP target for year to date is £4.9m of which £4.6m has been delivered; an adverse variance of £0.3m due to undelivered pay schemes offset by additional income and non-pay schemes.
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- The Trust has an annual savings target of £17.5m of which £8.8m have targets identified resulting in a £8.7m 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 plan is £20.0m, therefore the gap against plan is £11.2m. The Forecast outturn delivery value has reduced significantly following the conclusion of the deliverability peer review of the Trust's Transformational schemes. Subsequent to this review, we have appointed a Financial Recovery Director.

<table>
<tr><td></td><td colspan="3">

- The Capital expenditure as at M06 is £4.02m which is £2.84m underspent against the M06 budget of £6.85m. The full year forecasted spend presently stands at £17.93m which would result in a £1.33m overspend.
- The Finance Risk Rating remains a 3 at M06, with the agency rating adverse. The Rating is likely to drop to a 4 during the remainder of the financial year, given the increasing level of challenge incorporated in the Plan and the revised forecast.

</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">

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

</td></tr>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td colspan="3">

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

</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td colspan="3">

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

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>
</table>

MAIN REPORT

Integrated Quality, Workforce, Performance, and Finance Report

Date of Report: **18 October 2019**

Reporting Period: **Month 6 (September data) 2019/20**

Data Up To : **30 September 2019**

Version Control

Version	Meeting	Date of Circulation	Date of Meeting	Owner	This Version
Draft 1	Trust Executive	18/10/19	22/10/19	Head of Performance Director of Transformation and Partnerships	☒
Published Report	FPD Committee	24/10/19	29/10/19	Head of Performance Director of Transformation and Partnerships Interim Director of Finance	☒
Published Report	Trust Board	31/10/19	6/11/19	Head of Performance Director of Transformation and Partnerships Interim Director of Finance	☒

Contents

1. Introduction and Contents:

1.1 Purpose of report **2**

1.2 Report format **2**

1.3 Operational plan 2019-20 **3**

1.4 Devon STP context – this year's plan **3**

1.5 Regulatory context – Single Oversight Framework **3**

2. Performance Headlines: Month 6 (September 2019) 4

2.1 Quality Headlines: **4**

2.2 Workforce Headlines: **4**

2.3 Operational Headlines: **5**

2.3.1 Community and Social Care **5**
2.3.2 NHS Improvement Single Oversight Framework **5**
2.3.3 Service Delivery items escalated for Board attention **7**
2.3.4 Local Performance Indicators **8**

2.4 System Leadership Team update **9**

2.5 Finance Headlines **11**

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 (FPDC) 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 (22 October 2019)
- Finance, Performance, and Digital Committee (29 October 2019)

1.3 Operational Plan 2019-20

The Board will be aware that on the 23rd May 2019 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 6 (September 2019)

Key headlines for quality and safety, workforce standards and metrics, operational performance, and financial delivery for Month 6 to draw to the Committee's attention are as follows:

2.1 Quality Headlines

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

Table 1: Local Quality indicators RAG rated RED:

Standard	Target	Last month Month 5	This month Month 6
Reported Incidents - Death	0	0	1
Quality Effectiveness Safety Trigger Tool	0	2	2
VTE – risk assessment on admission (acute)	>95%	90.1%	89.9%
Fractured Neck of Femur*	>90%	n/a	n/a
Follow ups past to be seen date (excluding Audiology):	3,500	7393	6793

Of the remaining indicators, 12 were rated GREEN, 1 AMBER, and 2 not rated.

* the fractured neck of femur data for the % of cases into theatre within 36 hours is not available this month.

2.2 Workforce Headlines

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

- **Turnover (excluding Junior Doctors)**: **GREEN** - the Trust's turnover rate now stands at 11.32% for the year to September 2019 which is a slight increase from 11.23% in August.
- **Staff sickness/absence: RED** – The annual rolling sickness absence rate was 4.29% at the end of August 2019 which is marginal increase from July which was 4.28%. This is against the target rate for sickness of 4.00%. The Monthly sickness figure for August was 4.17 % which is a small reduction from the 4.21% as at the end of July.
- **Mandatory Training rate**: **GREEN** – The rate is 90.23% for September which is a small decline from the previous month at 90.78 in August. This means that the Trust is achieving the target rate for mandatory training of 85%.
- **Appraisal rate**: **AMBER –** September was 78.49% which is a small increase on the 78.38% at the end of August.

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 September 2019, based on WTE worked in the month, which includes bank and agency the Trust was 50.13WTE above plan. This was predominantly due to high bank usage of support to clinical staff.
- **Agency Expenditure:** As at end of September 19 the Trust is overspent against the plan by £1,460K.

2.3 Operational Headlines

2.3.1 Community and Social Care Summary

There are 15 Community and Social Care indicators in total of which 6 were RAG rated RED in September (6 in August 2019) as follows in Table 2:

Table 2: Community and Social Care Framework RAG Rated RED

Standard	Target	Last month Month 5	This month Month 6
Delayed discharges (Community)	16/16 Avg 315	562	392
Delayed transfers of care bed days (acute)	64 days per month	112	189
Clients receiving Self Directed Care	>90%	90.1%	89.6%
Number of permanent care home placements	<=617 year end	634	648
Bed occupancy	80%-90%	95.3%	95.4%
Community Hospitals – admissions (non-stroke)	18/19 profile +/- 10%)	204	202

Of the remaining indicators, 5 were rated GREEN, 1 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 6 the Trust reported the following outcomes in Table 3 below. 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 Single Oversight Framework Performance Standards

NHSI Indicator	National Standard	Trajectory (M06):	ICO Performance (M06):	Risk
Patients seen within 4 hours in A&E	>95%	92%	80.7% ⬇	HIGH
Risks identified Continued high level of escalation with delays attributed to availability of inpatient beds and crowding in ED. Plans are not progressing at the pace necessary to meet the expected performance improvement ahead of winter. Facilitating the daily availability of assessment beds on EAU3 remains the key to delivering this.	**Management action -** Additional resources to provide project management and QI support have been agreed to fast track implementation of changes that have been identified across the workstreams. The urgent care programme board meeting every 2 weeks is now established to oversee programme progress and provide senior clinical and operational decisions to support escalated actions..			
Patients waiting longer than 18 weeks from referral to treatment	>92%	82%	80.4% ⬆	HIGH
Risks identified - We continue to see increases in the number of patients waiting for new outpatient appointment and Day case treatments. This is a driver for the overall increasing number of incomplete pathways. With theatre A and B returning to operation this will support plans to target the longest wait patients. We are, however, forecasting to be off trajectory in October and November against the target to achieve zero over 52 weeks by March 2020.	**Management action –** RTT Risk and Assurance meets alternate weeks to review progress against delivery and risk. We are working with the STP to identify patient suitable for outsourcing. This includes compliance with the 26 week wait choice initiative which gives commissioners opportunity to contact patients to offer further choice of provider. Saturday lists will continue to run to the end of December. Continued insourcing to support ophthalmology and endoscopy capacity shortfalls. T&O and Upper GI continue to have the highest number of patients over 52 weeks.			
Cancer – 62 day wait for first treatment for a 2 week wait referral	85%	85.5%	77.7% ⬆	HIGH
Risks identified - Not meeting the 14 day from urgent referral to appointment target.	**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 have completed their work with the Cancer Services to provide assurance of robust recovery plans that have been shared with NHSI and Commissioners and will be updated on a monthly basis.			
Diagnostic tests longer than 6 weeks	1%	8.7%	15.7% ⬆	HIGH
Risks identified – We continue to be reliant on additional outsourcing to deliver sufficient capacity to meet demand for CT, MRI and colonoscopy. Access to diagnostics, and in particular radiology, is critical for maintaining timely cancer diagnosis and supporting treatment pathways.	**Management action** - There is a complex cohort of patients requiring CT cardiac contrast scans and virtual colonoscopy that form the majority of the patients showing as longest waits. There have been constraints in reporting capacity that has limited the volume of additional tests that can be performed. Additional outsourcing of reporting has been agreed and plans now in place to increase from early October the number of complex contrast scans that can be performed.			
NHS I indicator: **Dementia Find**	90%	90%	93.4% ⬆	LO

Colour of arrow – current Red/Amber/Green rating

Arrow – improved, declined or remained static from previous month ⬆ ⬇ ⬆

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 September (10 RED RAG rated in August). The indicators RAG rated RED are summarised in Table 4:

Table 4: Local Performance Indicators RAG Rated RED

Standard	Standard/ target	Last month Month 5	This month Month 6
CDiff – lapse of care	18 FY	16 ytd	19ytd
Cancer 2ww urgent GP referral	>93%	83.5%	88.4%
Cancer – 31-day wait for second or subsequent treatment - surgery	>96%	93.68%	93.5%
RTT waits over 52 weeks	0	105	89
On the day cancellations for elective operations	<0.8%	1.3%	2.2%
Cancelled patients not treated within 28 days of cancellation	0	9	8
A&E patients (ED only)	82.5%	67.5%	70.1%
Care plan summaries % completed within 24 hrs of discharge weekdays:	>77%	66.5%	67.4%
Care plan summaries % completed within 24 hrs discharge weekend:	>60%	38.2%	36%
Clinic letter timeliness - % Specialities within 4 working days	>80%	81.8%	68.2%

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

Of the remaining indicators, 9 were rated GREEN, 1 rated AMBER, and 3 indicators do not have an agreed target.

2.4 System Leadership Team updates

The Integrated Performance Report (IPR) will continue to focus on, and provide analysis at, whole system level against key quality, performance, workforce, and finance metrics.
This summary report section will reflect the key performance risks and challenges identified by ISU teams at the Assurance and Transformation meeting.
Work is ongoing to formalise the governance process and ensure that the ISU / system leadership teams have clear line of escalation through to executive and board. Work continues to map existing performance metrics to each of the new Integrated Service Units (ISU's).

At the latest meeting of the Assurance and Transformation Group on the 17th October 2019 the following operational performance highlights and risks were identified:

Torbay System

- Transformation plans are in development with good progress for Urgent and Emergency care however outpatients require pace and resources
- 52 week wait trajectory remains a challenge with a number of actions taking place including a piece of work to define urgency in order to support prioritisation which will have a positive impact on waits and will be shared with GPs to support discussions with patients and manage expectations.
- Implementation of a choice protocol which will allow further options for patient choice, but not disadvantage them on the waiting list.

- Our IT system remains fragile
- Our Estate infrastructure is challenging in a number of areas; Simpson, PAC, Theatres, co-location of Urgent and Emergency Floor
- Trust wide service governance structure and reporting is progressing well.
- The full impact of Brexit remains unknown however work is continuing.
- Workforce is impacting on the frailty pathway, stroke, medical rota, ENT and breast care vulnerability
- Staff have really welcomed the Staff hero awards & chairman's awards and the clinical schools conference awards.
- Winter plan is progressing well with a positive response at the Devon A&E delivery Board and further work is progressing quickly.
- The independent sector is challenged in terms of capacity and work is underway to address this.
- Theatres A&B are up and running and there is a maintenance plan being developed for theatres and we are working to ensure this does not disrupt activity

South Devon System

- GDPR and information sharing challenges across some services working with partners organisations in particular 0-19 and CFHD.
- Smoking at time of delivery reduced from 18% to 11% on trajectory to get to 6% by 2022
- Torbay HV service successfully reassessed for UNICEF baby Friendly level 3 –excellent feedback from the parents involved
- HV First visit post birth within 14 days achieving 89.88% (target 90%)
- Good progress with the co-design work with long term conditions work to reduce unnecessary appointments'
- Clear focus with the teams on grip and control and delivering the CIP
- Great progress on the enhanced health in care homes work with the imminent launch of the Red bag scheme
- LW@H Re-Procurement ongoing work to deliver our support at home model

2.5 Financial Headlines:

- **Regulator Protocol for Forecast change:** In line with the discussions at Board last month over the deterioration in Forecast the Trust has been working on mitigation plans and agreeing the position, drivers and actions with internal and external stakeholders. This has resulted in the Trust formally reporting a variance to plan of £15.0m after expected mitigations.

- **Overall financial position:** The financial position at control total level as at 30th of September 2019 is a £7.74m deficit, which is slightly ahead against the plan of £7.80m.
  (52 week fines have been assumed to be returned in full or not applied, no STP risk share has been applied at months 1 to 6 and discussions are continuing with Torbay council over its contributions to ASC in 2019/20).

Total pay run rate in M6 (£21.1m) is lower in comparison to previous month (M5 £21.4m); mainly lower Agency spend.
Non pay expenditure run rate of £18.2m is higher by £0.45m compared to M5. Higher spend in M6 is due to: Drugs spend £0.10m, Clinical and non clinical supplies £0.11m and various operating cost £0.24m.

- **CIP savings delivery position**: The current month position shows CIP delivery of £0.9m, a £0.1m shortfall against £1.0m target.
  The year to date CIP achieved is £4.6m, a cumulative shortfall of £0.3m against a £4.9m target.

- **CIP Forecast Delivery**: The Trust has an annual savings target of £17.5m of which £8.8m have targets identified resulting in a £8.7m 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 plan is £20.0m, therefore the gap against plan is £11.2m. The Forecast outturn delivery value has reduced significantly following the conclusion of the deliverability peer review of the Trust's Transformational schemes.
  Subsequent to this review, we have appointed a Financial Recovery Director.
- **Capital:** In May 2019 the Trust submitted a revised capital plan of £21.6m.
  In July 2019, NHSI requested that the Trust propose a reduced capital plan - this was proposed at £16.6m. However, following an increase in national funding, NHSI abandoned this request. The Trust's official capital plan therefore remains at £21.6m but the Trust has adopted the £16.6m proposal as its capital budget. The Capital expenditure as at M06 is £4.02m which is £2.84m underspent against the M06 budget of £6.85m. The full year forecasted spend presently stands at £17.93m which would result in a £1.33m overspend.
- **Use of Resources Risk Rating:** The Finance Risk Rating remains a 3 at M06, with the agency rating adverse. The Rating is likely to drop to a 4 during the remainder of the financial year, given the increasing level of challenge incorporated in the Plan and the revised forecast.

Integrated Performance Report

October 2019: Reporting period September 2019 (Month 6)

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 6 (performance to end of September 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 September 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 below the expected rate. In the latest month of data (M ay) the rate has increased to above the national benchmark at 111.3 (100 being the national benchmark). No increase in recorded deaths is show n only that a change is recorded case mix had lowered the calculated figure fro expected deaths in the month.

As well as viewing the top line mortality figure any Dr Foster mortality alerts at diagnosis and procedure level are also rev iewed 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 a nd Quality Improvement Group (QIG).

2. Incident reporting continues to be well supported and all areas of the Trust are reporting within expectations. Themes and issues are collated o n a monthly basis and can be viewed via the Trust wide 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 September.

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

5. Infection Control - For the year-to-date there are 19 CDIFF cases reported as a lapse in care. There are 34 reported bed days lost in September 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 decreas ed from 7393 in August to 6793 in September.

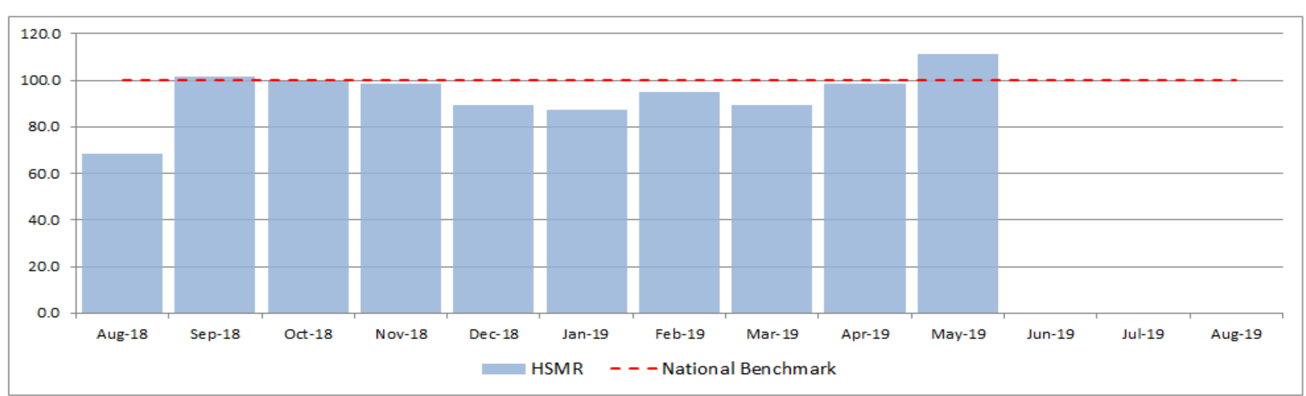
7. VTE - The VTE performance (acute) has been both flagged by NHSI and within our own reporting structures. Our reported performance i s consistently below the standard of 95% with September at 89.9%. The Safety Thermometer audits provide assurance that the clinical assessments are being made, however, w e 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 90.5% achieved against a standard of 90%.

Quality and Safety - Mortality

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

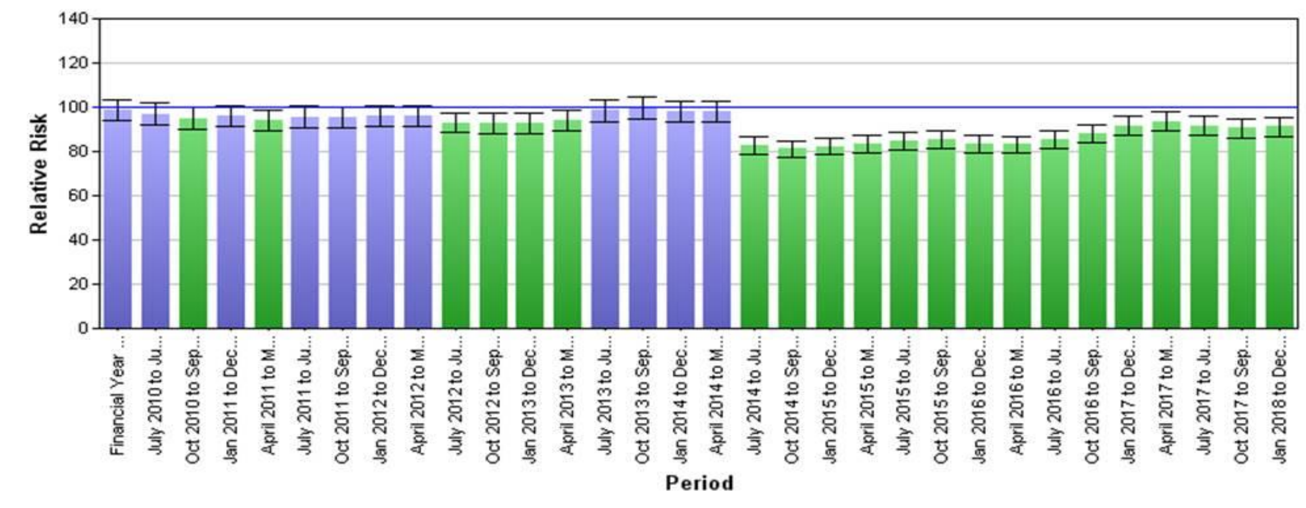
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
HSMR	68.4	101.6	99.3	98.4	89.4	87.1	94.8	89.5	98.4	111.3			
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



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**.

The latest data for Dr Foster HSMR is showing a relative risk of 111.3. It is noted that the number of observed hospital deaths has not changed . A review at diagnosis level will be done to highlight any potential

SHMI by data period



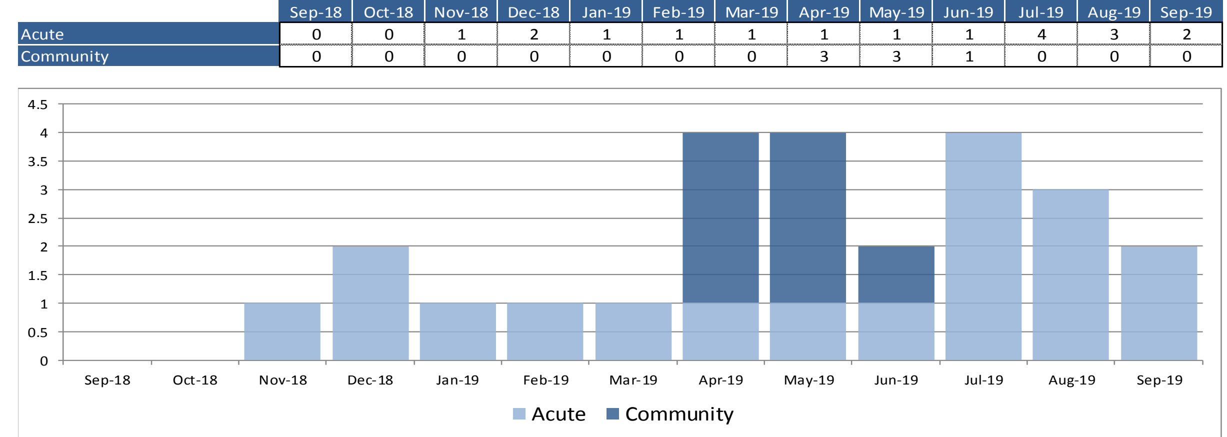
The SHMI data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trusts at 91.11 against a national average benchmark of 100.

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

Quality and Safety - Infection Control

C Diff. Lapse in Care



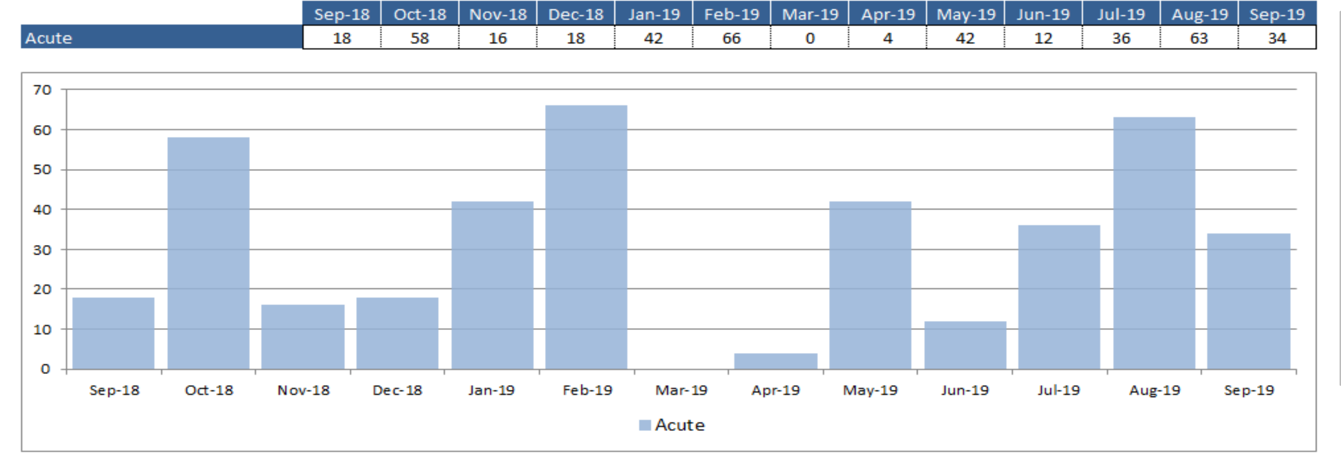
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Acute	0	0	1	2	1	1	1	1	1	1	4	3	2
Community	0	0	0	0	0	0	0	3	3	1	0	0	0

In September there was one reported C-diff cases as a lapse in care.

The cumulative total is 19 cases with 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)



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Acute	18	58	16	18	42	66	0	4	42	12	36	63	34

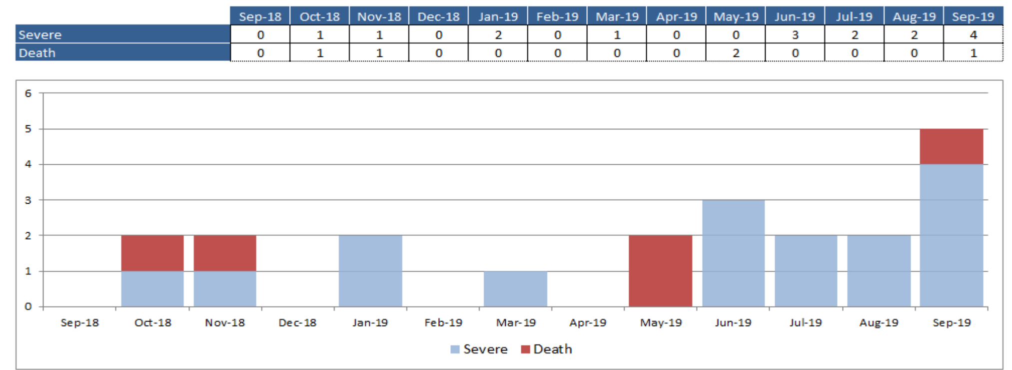
The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In September, there were 34 bed days lost due to infection control issues. In September there had been a number of individual bays closed at Torbay Hospital as part of infection control measures to manage potential spread of diarrhoea and vomiting.

Quality and Safety - Incident reporting and complaints

Reported Incidents - Severe and Death

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Severe	0	1	1	0	2	0	1	0	0	3	2	2	4
Death	0	1	1	0	0	0	0	0	2	0	0	0	1



In September the Trust recorded five incidents which will follow normal process of investigation: The sites of recorded incidents are:

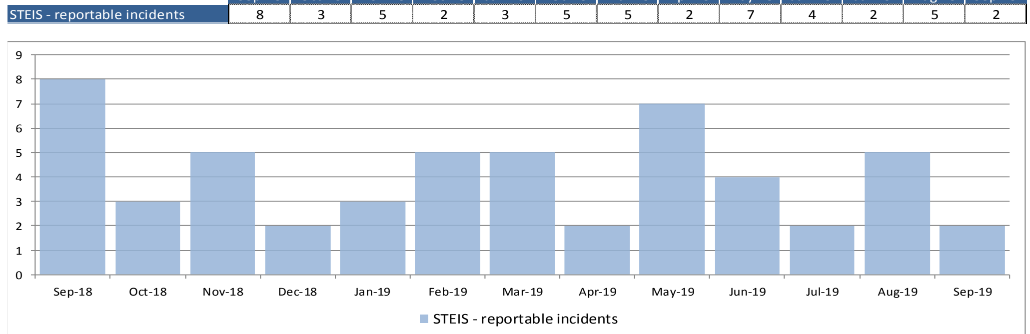
1. Theatres
2. Simpson
3. Eye Surgery Unit
4. Simpson
5. Orthopaedics

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

The Learning and Sharing from Serious Adverse Events Group meet once a month to review serious incidents and seeks assurance on actions for ISUs. The group also, where necessary, instigates Trust wide learning.

STEIS Reportable Incidents

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
STEIS - reportable incidents	8	3	5	2	3	5	5	2	7	4	2	5	2

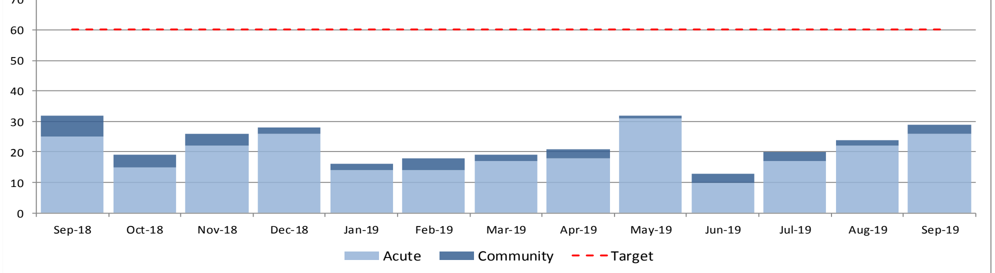


The Trust reported two incidents in September on the Strategic Executive Information System (StEIS).
The sites of recorded incidents are:
1. Major incident - IT failure
2. pt awaiting adult MH placement

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

Formal complaints

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Acute	25	15	22	26	14	14	17	18	31	10	17	22	26
Community	7	4	4	2	2	4	2	3	1	3	3	2	3
Total	32	19	26	28	16	18	19	21	32	13	20	24	29
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



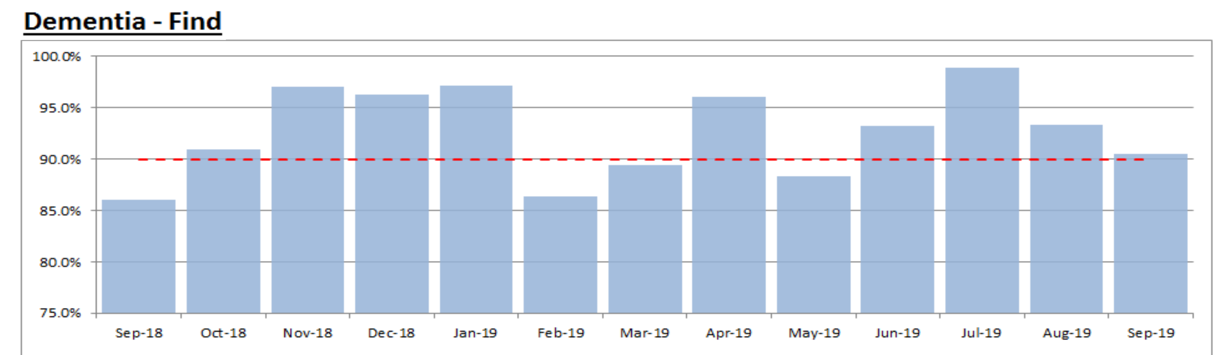
In September the Trust received 26 formal complaints.

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

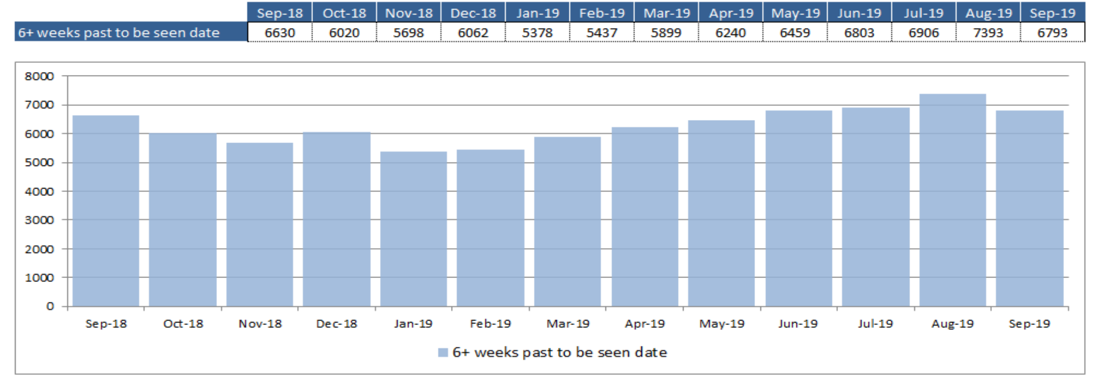


Dementia Find: The NHS I Single Oversight Framework (SOF) includes Dementia screening and referral as one of the NHSI priority indictors.
The Dementia Find performance continues to meet the standard of 90%.

The Trust has achieved the Dementia Find standard in August with 90.5% against the target of 90%.

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

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
6+ weeks past to be seen date	6630	6020	5698	6062	5378	5437	5899	6240	6459	6803	6906	7393	6793



Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' decreased in September to 6793 (7393 last month).
A review of the areas with increases has been reported 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 maintain oversight and assurance regarding any harm to patients and review plans to mitigate clinical risk against patients waiting beyond their intended review date.

VTE Risk assessment on admission - (Acute)

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
VTE Numerator	5360	6088	5757	5275	6045	5116	5557	5488	6001	5568	5936	5792	5487
VTE Denominator	5791	6643	6185	5735	6554	5725	6138	6151	6597	6137	6441	6425	6104
VTE Performace (Acute)	92.6%	91.6%	93.1%	92.0%	92.2%	89.4%	90.5%	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%
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 reduced in September at 89.9% and 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 96.5% against the target of 95%.

Workforce Focus

Month 6 (performance to end of September 2019)

Page 9	Workforce Plan
Page 10	Workforce Actual vs Plan (1)
Page 11	Workforce Actual vs Plan (2)
Page 12	Sickness absence
Page 13	Turnover
Page 14	Appraisal and Training
Page 15	Agency Part 1
Page 16	Agency Part 2

Workforce

NHSi Plan WTE 2019/20

Staff Group	**NHSi Plan WTE**	**NHSi Plan WTE**	**NHSi Plan WTE**	**NHSi Plan WTE**	**NHSi Plan WTE**	**NHSi Plan WTE**	**NHSi Plan WTE**
	Apr-19	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**
Medical And Dental	518.95	517.03	516.10	513.73	512.36	510.99	509.39
Nursing And Midwifery Registered	1,288.59	1,286.61	1,290.07	1,287.26	1,282.93	1,280.09	1,289.73
Support To Clinical Staff	1,825.11	1,822.43	1,831.04	1,824.53	1,818.02	1,814.55	1,802.59
Add Prof Scientific and Technic	385.95	384.48	382.99	381.45	379.90	378.36	376.78
Allied Health Professionals	427.42	425.90	424.35	422.72	421.09	419.46	417.78
Healthcare Scientists	106.64	106.50	106.35	106.20	106.04	105.89	105.73
Administrative And Estates	997.92	993.19	988.32	983.17	978.04	972.87	967.46
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHSi Plan WTE	**5,550.58**	**5,536.14**	**5,539.22**	**5,519.06**	**5,498.38**	**5,482.21**	**5,469.46**

Reasons for Movements From Above Plan to Latest Budget

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

Workforce

TOTAL ACTUAL WORKED - This includes substantive, bank and agency staff

Actual Worked 2019/20

Staff Group	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	521.99	543.74	521.64	534.83	559.44	538.83
Nursing And Midwifery Registered	1,283.58	1,266.84	1,264.67	1,268.52	1,253.22	1,253.77
Support To Clinical Staff	1,843.41	1,868.85	1,830.90	1,891.23	1,885.92	1,813.36
Add Prof Scientific and Technic	366.18	365.48	371.15	366.55	369.91	375.37
Allied Health Professionals	505.70	500.47	499.57	491.42	497.06	498.84
Healthcare Scientists	100.42	98.49	106.52	97.12	97.71	98.13
Administrative And Estates	1,221.36	1,232.65	1,234.40	1,259.89	1,260.91	1,229.36
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Worked WTE	**5,842.65**	**5,876.53**	**5,828.85**	**5,909.56**	**5,924.18**	**5,807.66**

Budgeted WTE 2019/20

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	514.05	506.82	516.36	517.02	516.75	514.47
Nursing And Midwifery Registered	1,312.75	1,315.42	1,315.30	1,309.19	1,311.24	1,310.42
Support To Clinical Staff	1,917.43	1,931.14	1,928.04	1,923.18	1,928.29	1,932.01
Add Prof Scientific and Technic	476.34	368.67	370.38	370.92	370.90	371.18
Allied Health Professionals	372.39	466.80	469.13	476.19	474.40	473.45
Healthcare Scientists	90.59	90.59	90.59	90.59	90.39	90.79
Administrative And Estates	1,181.38	1,171.91	1,169.87	1,161.12	1,165.79	1,165.46
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Budgeted WTE	**5,864.93**	**5,851.35**	**5,859.67**	**5,848.22**	**5,857.77**	**5,857.79**

SUBSTANTIVE STAFF

Actual Substantive Contracted 2019/20

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	474.73	469.89	470.37	464.76	573.25	510.40
Nursing And Midwifery Registered	1,195.89	1,196.70	1,199.62	1,193.32	1,195.90	1,198.33
Support To Clinical Staff	1,659.31	1,675.01	1,682.22	1,686.32	1,690.66	1,693.35
Add Prof Scientific and Technic	365.23	364.42	361.70	363.11	365.33	373.83
Allied Health Professionals	501.10	497.50	500.34	496.48	502.85	510.21
Healthcare Scientists	99.33	98.33	99.18	99.23	98.62	98.65
Administrative And Estates	1,154.34	1,169.57	1,173.94	1,182.85	1,189.06	1,185.79
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Worked WTE	**5,449.92**	**5,471.42**	**5,487.35**	**5,486.07**	**5,615.67**	**5,570.57**

Budgeted Substantive WTE 2019/20

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	493.72	486.72	496.37	497.28	497.12	496.24
Nursing And Midwifery Registered	1,225.33	1,232.26	1,232.14	1,226.03	1,228.31	1,228.05
Support To Clinical Staff	1,810.49	1,824.12	1,827.33	1,822.47	1,824.96	1,831.30
Add Prof Scientific and Technic	469.50	361.83	363.54	364.08	364.06	364.34
Allied Health Professionals	367.21	461.12	463.45	470.51	468.72	467.77
Healthcare Scientists	90.59	90.59	90.59	90.59	90.39	90.79
Administrative And Estates	1,135.49	1,128.92	1,128.88	1,134.01	1,138.68	1,139.45
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Budgeted WTE	**5,592.33**	**5,585.56**	**5,602.30**	**5,604.98**	**5,612.25**	**5,617.95**

As at Month 6 the Trust was budgeted for 5,857.79 WTE, to include bank and agency, however the total worked was 5807.66 WTE which is 50.13 WTE above plan. This was made up of the following:

Subtantive staff : 5570.57 WTE (47.38 WTE below plan)
Bank staff: 207.40 WTE (36.18 WTE above plan - this is predominently within Support to Clinical Staff and Admin and Estates)
Agency staff: 65.17 WTE (3.45 WTE below plan - this is predominently with Medical and Dental, although there is a downward trend in agency use for this staff group)

Workforce

BANK STAFF

Actual Bank Worked 2019/20

Staff Group	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	15.83	6.42	15.69	15.20	17.29	9.36
Nursing And Midwifery Registered	35.82	38.17	33.34	42.70	38.71	29.96
Support To Clinical Staff	149.74	177.89	141.26	191.43	188.26	126.32
Add Prof Scientific and Technic	0.71	0.51	1.12	1.18	0.86	0.81
Allied Health Professionals	0.90	0.75	1.63	3.72	2.11	2.68
Healthcare Scientists	0.74	0.54	7.35	-1.60	0.24	0.22
Administrative And Estates	54.45	58.59	48.64	63.38	61.87	38.05
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Worked WTE	**258.18**	**282.88**	**249.02**	**316.00**	**309.35**	**207.40**

Budgeted Bank WTE 2019/20

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	6.30	6.30	6.30	6.30	6.30	6.30
Nursing And Midwifery Registered	38.76	38.76	38.76	38.76	38.76	38.20
Support To Clinical Staff	106.94	107.02	100.71	100.71	103.33	100.71
Add Prof Scientific and Technic	0.00	0.00	0.00	0.00	0.00	0.00
Allied Health Professionals	0.00	0.50	0.50	0.50	0.50	0.50
Healthcare Scientists	0.00	0.00	0.00	0.00	0.00	0.00
Administrative And Estates	42.84	39.94	37.94	26.61	26.61	25.51
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Budgeted WTE	**194.84**	**192.52**	**184.21**	**172.88**	**175.50**	**171.22**

AGENCY STAFF

Actual Agency Worked 2019/20

Staff Group	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE	Worked WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	30.89	57.30	25.88	24.57	29.63	15.07
Nursing And Midwifery Registered	52.61	43.85	42.70	48.55	36.12	40.15
Support To Clinical Staff	0.00	-0.07	0.00	-0.14	0.00	0.00
Add Prof Scientific and Technic	-0.03	0.24	5.90	-1.43	1.88	0.79
Allied Health Professionals	9.97	9.44	7.95	8.60	10.17	6.71
Healthcare Scientists	0.00	0.00	0.00	0.00	0.00	0.00
Administrative And Estates	4.81	3.88	9.19	7.81	2.51	2.44
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Worked WTE	**98.24**	**114.65**	**91.63**	**87.97**	**80.31**	**65.17**

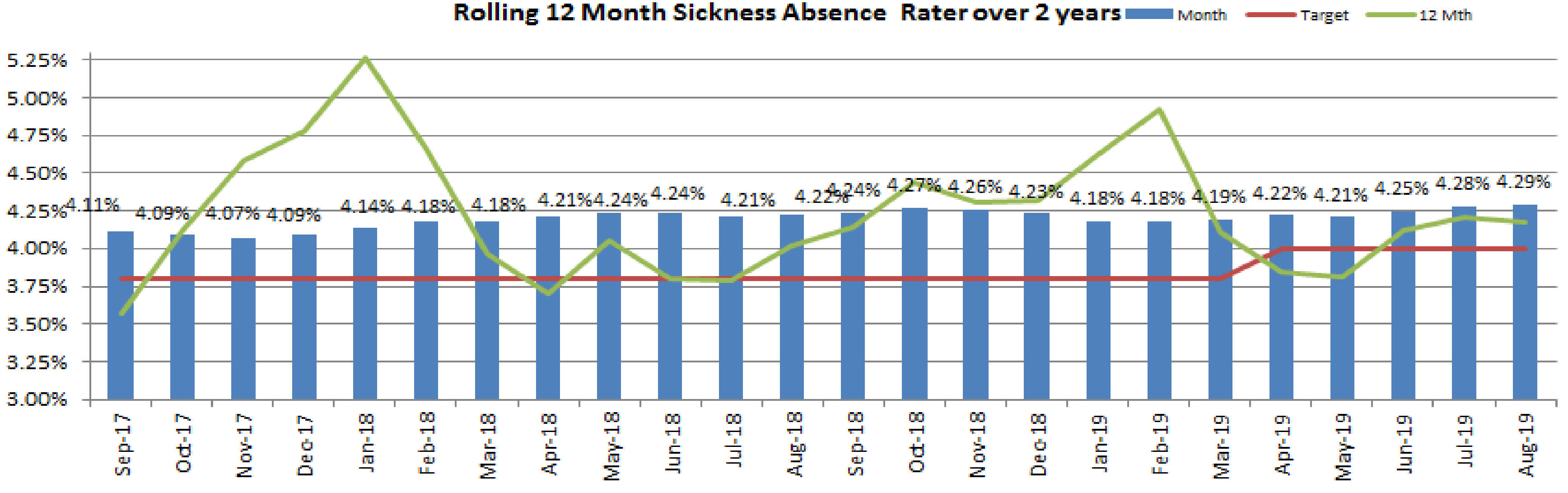
Budgeted Agency WTE 2019/20

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical And Dental	14.03	13.80	13.69	13.44	13.33	11.93
Nursing And Midwifery Registered	48.66	44.40	44.40	44.40	44.17	44.17
Support To Clinical Staff	0.00	0.00	0.00	0.00	0.00	0.00
Add Prof Scientific and Technic	6.84	6.84	6.84	6.84	6.84	6.84
Allied Health Professionals	5.18	5.18	5.18	5.18	5.18	5.18
Healthcare Scientists	0.00	0.00	0.00	0.00	0.00	0.00
Administrative And Estates	3.05	3.05	3.05	0.50	0.50	0.50
Any Others - Provisions	0.00	0.00	0.00	0.00	0.00	0.00
Total Staff Budgeted WTE	**77.76**	**73.27**	**73.16**	**70.36**	**70.02**	**68.62**

Please see notes on previous page.

Workforce - Sickness Absence

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



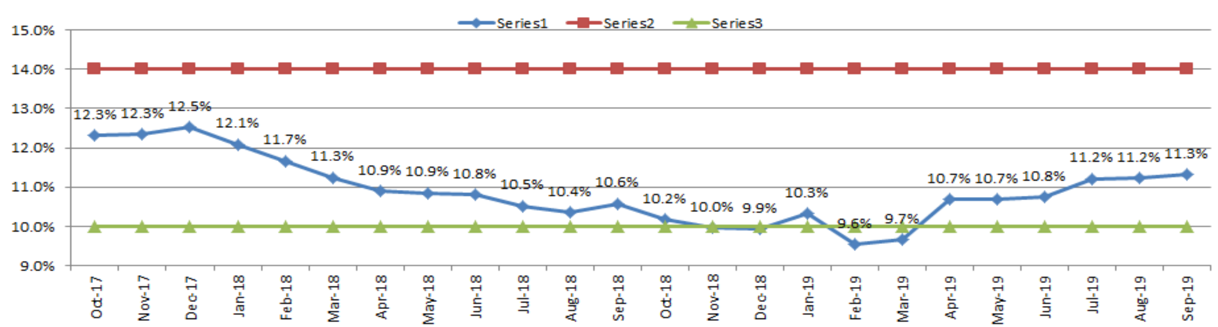
The annual rolling sickness absence rate was 4.29% at the end of August 2019 which is marginal increase from July which was 4.28%. This is against the target rate for sickness of 4.00%.

The Monthly sickness figure for August was 4.17 % which is a small reduction from the 4.21% as at the end of July.

April to August sickness is higher than the last 2 years over the same period and higher then the 10 year long-term average. The average sickness for the months October to March is 4.40% so we anticipate the monthly sickness rate to start increasing as we go through the Winter period.

Workforce - Turnover

All Staff (excl Jnr Docs) Rolling 12 Month Turnover Rate

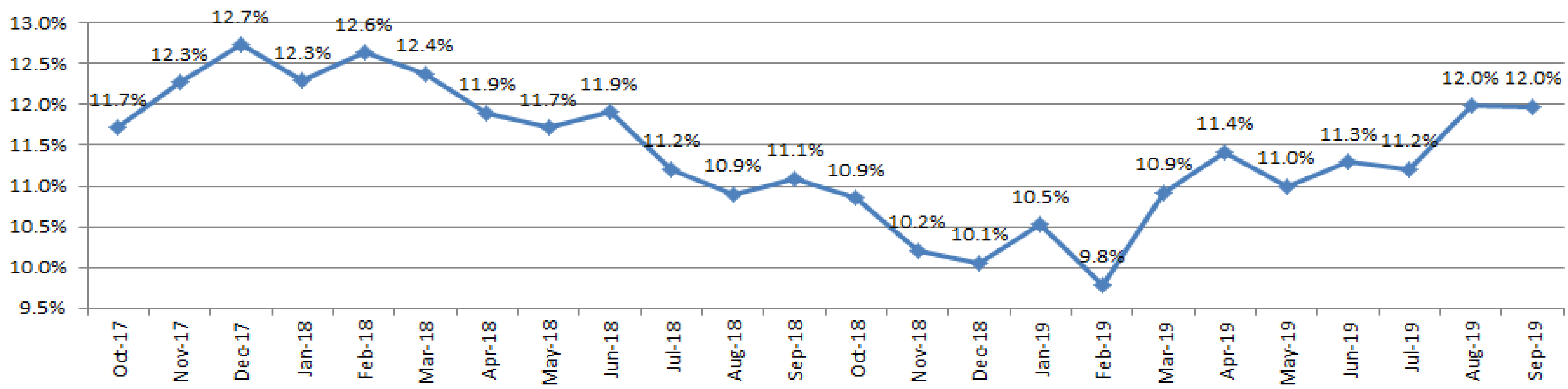


All Staff Rolling 12 Month Turnover Rate The graph shows that the Trusts turnover rate now stands at 11.32% for the year to September 2019 which is a slight increase from 11.23% in August.

There could be an increase in the Labour Turnover Rate figure next month when the recent MARS leavers are taken into account on top of the standard turnover.

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

RGN Rolling 12 Month Turnover Rate

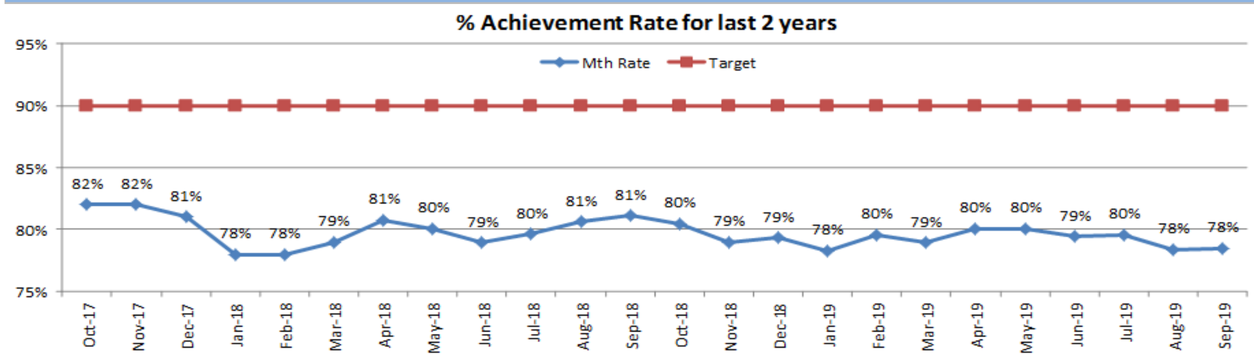


RGN Rolling 12 Month Turnover Rate

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 September 2019 stood at 11.97% which is very similar to the previous month of August which stood at 11.98%.

Workforce - Appraisal and Training

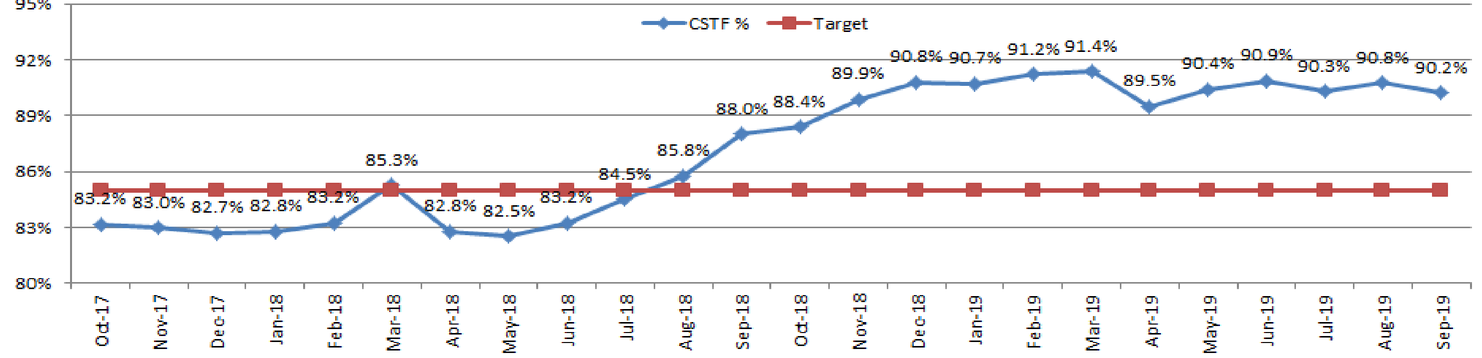


Achievement Review (Appraisal) -

The Achievement Review rate for the end of September was 78.49% which is a small increase on the 78.38 % as at the end of August. Managers are provided with detailed information on performance against the target.

The average Appraisal compliance over the last 3 years is 80% which is well below the target of 90% set by the Trust.

Statutory and Mandatory Training Compliance % Rate

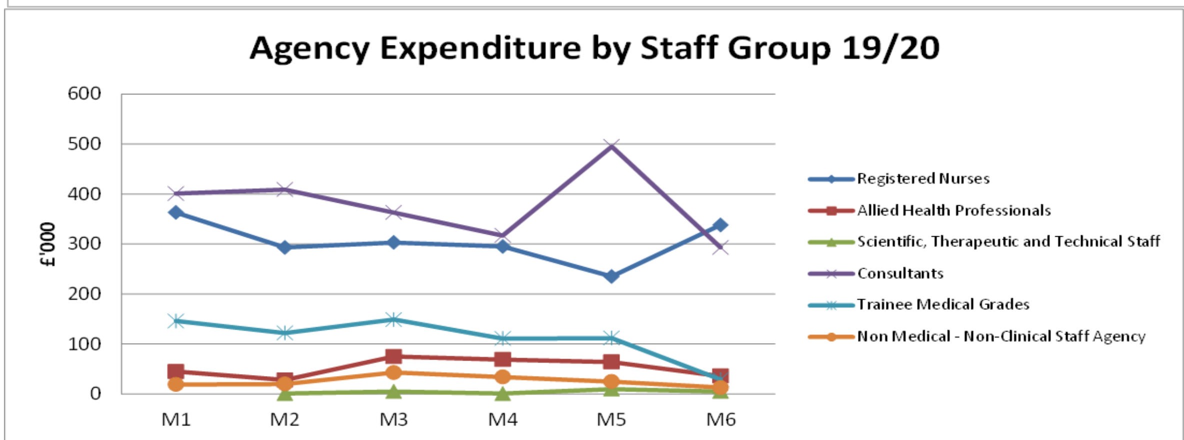


Statutory and mandatory training - The Trust has set a target of 85% compliance as an average for the statutory and mandatory training modules which is against the 11 subjects which align with the MAST Streamlining project from April 2018. The graph shows that the current rate is 90.23% for September which is a small decline from the previous months 90.78% in August . Individual modules that remain below their target are detailed in the table below:

Module	Target	Performance
Information Governance	95% and above	87.51%
Safeguarding Children	90% and above	86.04%

Workforce - Agency Expenditure

The graph below shows the Agency expenditure by Staff Group, whilst the table provides the detailed analysis. As at Month 6 the Trust is £1.460m above plan. This is predominantly due to agency spend on Medical and Dental staff which is £1.198m above plan, although there was a significant reduction in



Total Agency Spend
Financial Year 2019/20

	Monthly Values						NHSI YTD value (Cumulative)					
	M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**
Plan - Total Agency (see breakdown below)	636	636	636	633	633	633	636	1,272	1,908	2,541	3,174	3,807
Actual Spend												
Non-Medical - Clinical Staff Agency												
Registered Nurses	363	293	303	295	235	338	363	656	959	1,254	1,489	1,827
Scientific, Therapeutic and Technical	45	29	80	70	74	41	45	74	154	224	298	339
of which Allied Health Professionals	45	28	75	69	64	36	45	73	148	217	281	317
of which Other Scientific, Therapeutic and Technical Staff		1	5	1	10	5	0	1	6	7	17	22
Support to clinical staff (HCA)	1	-1		0			1	-	-	-	-	-
Total Non-Medical - Clinical Staff Agency	409	321	383	365	309	379	409	730	1113	1478	1787	2166
Medical and Dental Agency												0
Consultants	401	409	363	317	495	293	401	810	1,173	1,490	1,985	2,278
Trainee Grades	146	122	149	111	112	29	146	268	417	528	640	669
Total Medical and Dental Agency	547	531	512	428	607	322	547	1078	1590	2018	2625	2947
Non Medical - Non-Clinical Staff Agency	19	20	43	34	25	13	19	39	82	116	141	154
Total Pay Bill Agency and Contract	975	872	938	827	941	714	975	1847	2785	3612	4553	5267
Over (Under) Spend	339	236	302	194	308	81	339	575				

Workforce - Agency Expenditure

Torbay and South Devon NHS Foundation Trust
Total Agency Spend
Financial Year 2019/20

Plan - Total Agency (see breakdown below)

Over (Under) Spend	339	236	302	194	308	81	339	575				
Plan	M1	M2	M3	M4	M5	M6	M1	M2	M3	M4	M5	M6
Registered Nurses	£ 284	£ 284	£ 285	£ 283	£ 284	£ 284	£ 284	£ 568	£ 853	£ 1,136	£ 1,420	£ 1,704
Technical staff	£ 48	£ 48	£ 48	£ 48	£ 48	£ 48	£ 48	£ 96	£ 144	£ 192	£ 240	£ 288
Allied Health Professionals	£ 47	£ 47	£ 47	£ 47	£ 47	£ 47	£ 47	£ 94	£ 141	£ 188	£ 235	£ 282
Other Scientific, Therapeutic and Technical Staff	£ 1	£ 1	£ 1	£ 1	£ 1	£ 1	£ 1	£ 2	£ 3	£ 4	£ 5	£ 6
Support to Nursing staff	£ -	£ -	£ -	£ -	£ -		£ -	£ -	£ -	£ -	£ -	£ -
Total Non-Medical - Clinical Staff Agency	£ 332	£ 332	£ 333	£ 331	£ 332	£ 332	£ 332	£ 664	£ 997	£ 1,328	£ 1,660	£ 1,992
Medical and Dental Staff - Consultants	£ 251	£ 251	£ 251	£ 248	£ 248	£ 248	£ 251	£ 502	£ 753	£ 1,001	£ 1,249	£ 1,497
Medical and Dental Staff - Trainee Grades	£ 42	£ 42	£ 42	£ 42	£ 42	£ 42	£ 42	£ 84	£ 126	£ 168	£ 210	£ 252
Total Medical and Dental	£ 293	£ 293	£ 293	£ 290	£ 290	£ 290	£ 293	£ 586	£ 879	£ 1,169	£ 1,459	£ 1,749
Non Medical - Non-Clinical Staff Agency	£ 11	£ 11	£ 12	£ 10	£ 11	£ 11	£ 11	£ 22	£ 34	£ 44	£ 55	£ 66
Total pay bill - agency staff including capitalised staff	£ 636	£ 636	£ 638	£ 631	£ 633	£ 633	£ 636	£ 1,272	£ 1,910	£ 2,541	£ 3,174	£ 3,807
Total pay bill - agency staff including capitalised staff	£ 636	£ 636	£ 638	£ 631	£ 633	£ 633	£ 636	£ 1,272	£ 1,910	£ 2,541	£ 3,174	£ 3,807

Variance - Over (Under) Spend	M1	M2	M3	M4	M5	M6	M1	M2	M3	M4	M5	M6
Non-Medical - Clinical Staff Agency												
Registered Nurses	79	9	18	12	-49	54	79	88	106	118	69	123
Scientific, Therapeutic and Technical	-3	-19	32	22	26	-7	-3	-22	10	32	58	51
of which Allied Health Professionals	-2	-19	28	22	17	-11	-2	-21	7	29	46	35
of which Other Scientific, Therapeutic and Technical Staff	-1	0	4	0	9	4	-1	-1	3	3	12	16
Support to clinical staff	1	-1	0	0	0	0	1	0	0	0	0	0
Total Non-Medical - Clinical Staff Agency	77	-11	50	34	-23	47	77	66	116	150	127	174
Consultants	150	158	112	69	247	45	150	308	420	489	736	781
Trainee Grades	104	80	107	69	70	-13	104	184	291	360	430	417
Total Medical and Dental Agency	254	238	219	138	317	32	254	492	711	849	1,166	1,198
Non Medical - Non-Clinical Staff Agency	8	9	31	24	14	2	8	17	48	72	86	88
Total Pay Bill Agency and Contract	339	236	300	196	308	81	339	575	875	1,071	1,379	1,460

Community and Social Care Focus

Month 6 (performance to end of September 2019)

Page 18 Social Care and Public Health Metrics

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

Page 19 Community services

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

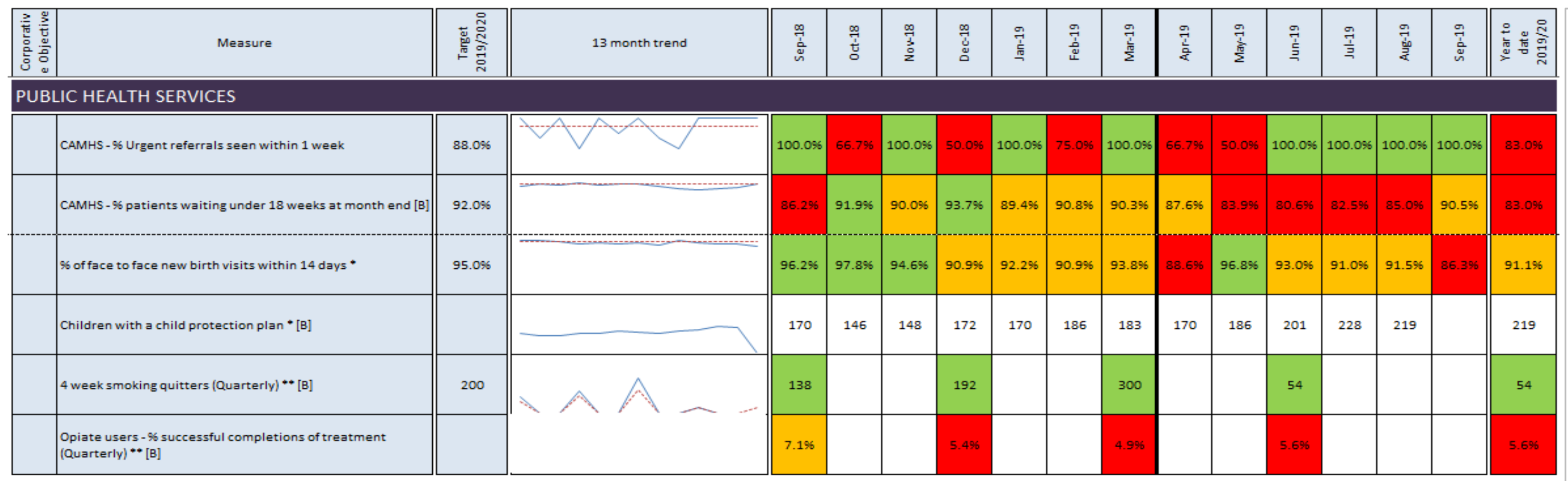
Social Care and Public Health Metrics performance metrics - Torbay

Social Care Programme Board

2019/20 Performance Scorecard to 30 September 2019

Torbay Social Care KPIs		2019/20 YTD target	Outturn YTD	Comment
ASC-1C pt1	% clients receiving self-directed support	94%	90% (94%)	Within agreed tolerance.
ASC-1C pt2	% clients receiving direct payments	28%	25.6% (28.0%)	Below target (419 / 1637). Further development of P.A. market, review of Standard Operating Procedure and internal communications update
D-40b	% clients receiving a review within 18 months	93%	83% (93%)	Below target (2385 / 2882). Decreasing trend.
NI-132	Timeliness of social care assessment	80%	71% (80%)	Below target (577 / 812). Outturn decreased in Aug19 following calculation changes highlighted by internal audit.
ASC-2A pt1	Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	24.2 (14)	A low outturn signifies better performance. Below target (18 admissions).
ASC-2D	Outcome of short term support - % reablement episodes not followed by long term SC support	83%	85.9% (83%)	On target.
NI-135	Carers receiving needs assessment, review, information, advice, etc.	36%	26.7% (18.0%)	On target.
ASC-1C pt1b	% carers receiving self directed support	85%	91%	On target.
QL-18	% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	.. ..	No high risk concerns raised.
TCT-14b	% Repeat safeguarding referrals in last 12 months	8.0%	7.7% (8.0%)	On target.
ASC-1E	% Adults with learning disabilities in paid employment	7.0%	8.5% (7.0%)	On target.
ASC-1G	% Adults with learning disabilities in settled accommodation	80%	79.3% (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 ISU system leadership Assurance and Transformation meetings .



Corporative Objective	Measure	Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
PUBLIC HEALTH SERVICES																	
	CAMHS - % Urgent referrals seen within 1 week	88.0%		100.0%	66.7%	100.0%	50.0%	100.0%	75.0%	100.0%	66.7%	50.0%	100.0%	100.0%	100.0%	100.0%	83.0%
	CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%		86.2%	91.9%	90.0%	93.7%	89.4%	90.8%	90.3%	87.6%	83.9%	80.6%	82.5%	85.0%	90.5%	83.0%
	% of face to face new birth visits within 14 days *	95.0%		96.2%	97.8%	94.6%	90.9%	92.2%	90.9%	93.8%	88.6%	96.8%	93.0%	91.0%	91.5%	86.3%	91.1%
	Children with a child protection plan * [B]			170	146	148	172	170	186	183	170	186	201	228	219		219
	4 week smoking quitters (Quarterly) ** [B]	200		138			192			300			54				54
	Opiate users - % successful completions of treatment (Quarterly) ** [B]			7.1%			5.4%			4.9%			5.6%				5.6%

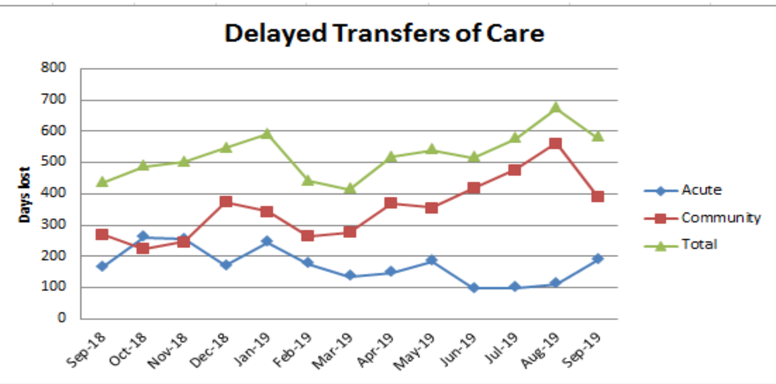
Public Health Torbay : The headline messages for Public Health performance are:
CAMHS - Target Referral to Treatment (18 week) waiting times are not achieved in September, with an improvement seen on August. Since April Torbay CAMHS is part of the wider Devon Children's services alliance. Work is progressing 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 - September-19

	Act. 18/19 Outturn	19/20 Year End Target	Target Sep-19	Sep-19	Total	YTD Target	Cum. Direction of Travel
Admissions / Discharges							
Total Admissions (General)	2,927	2,927	238	202	1,324	1,418	↓
Direct Admissions (General)	294	294	19	21	138	147	↓
Transfer Admissions (General)	2,633	2,633	219	181	1,186	1,271	↓
Stroke Admissions	305	305	26	19	125	160	↓
Transfers from CH to DGH	242	242	11	17	120	125	↓
Beds							
Bed Occupancy [1]	91.6%	90.0%	90%	95.4%	93.4%	90.0%	
Bed Days Lost to Delays [2]	3,305	0	0	392	2,607	0	
Bed Days Lost to Bed Closure	329			4	39		
Length of Stay							
Delayed Discharges				42	284		
Average Length of Stay - Overall (General)	10.9			14.0	12.5		
Average Length of Stay - Direct Admissions	8.1	8.5	8.5	10.7	10.6	8.5	↑
Average Length of Stay - Transfer Admissions	11.3	11.5	11.5	14.4	12.8	11.5	→
Average Length of Stay - Stroke	15.2	0.0	0.0	21.9	18.5	18.0	→
Long LoS (>30 days)	171	171	14	19	115	70	↑
MIUs							
Total MIU Activity [3]	41,788	41,788	3,730	3,744	23,446		
New MIU Attendances	36,179	36,179	3,195	3,331	20,893	20,289	↑
All Follow Up Attendances	5,609	5,609	129	413	2,553	3,319	↓
Planned Follow Up Attendances	4,382	4,382	409	301	1,868	2,693	↓
Unplanned Follow Up Attendances	1,227	1,227	126	112	685	626	↑
MIU Four Hour Breaches	5	5	0	0	2	2	
Average Waiting Time (Mins) - 95th Pctile	49	49	49	46	53	49	↑

Corporative Objective	Measure	Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
COMMUNITY BASED SERVICES																	
	Nursing activity (F2F)			16,162	18,344	17,736	16,370	16,906	15,122	15,029	16,196	17,434	15,727	16,633	14,525	12,185	92,700
	Therapy activity	65,415		5,104	6,019	6,007	4,802	5,373	5,180	4,717	5,279	5,364	5,320	6,800	5,749	5,690	34,202
	No. intermediate care urgent referrals [B]	2,059		162	182	182	157	189	156	164	184	189	178	186	174	173	1,084
	No. intermediate care placements			90	93	86	77	96	83	73	75	69	86	75	73	64	442
	Intermediate Care - placement average LoS [B]	12.0		14.3	15.8	15.4	15.4	18.1	13.6	18.7	18.9	18.2	15.6	17.3	15.1	18.6	17.4



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 September is 392 (July 562).

Minor injury Units

In September two patients were 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 -System roll out in teh Newton Abbot ISU commenced September 2019.

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 September. 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 discharge where simple packages of care are required. There are concerns that the number of patients being categorised as medical fit on our wards is increasing and a review of process to identify delayed transfers is being completed. As part of the urgent care improvement work the service improvement team is currently focussing on weekend discharges.

Operational Performance Focus

Month 6 (performance to end of September 2019)

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

NHS I Performance indicator Summary

STP / NHSI Operational Plan - Monitored indicators

Indicator	National Standard	Operational plan / revised trajectory (M6)	Trust performance (M6)
A&E 4hr waits (PSF)	95%	92.0%	80.7%
RTT 18 week waits	92%	82.0%	80.4%
62 day Cancer waits	85.0%	85.5%	77.7%
Diagnostics waits < 6 weeks	99.0%	90.3%	84.3%
Dementia Find	90%	90%	90.5%

NHSI Operational Plan indicators (Month 6)
Annual plan trajectories : It is noted that the annual plan trajectories reflect performance at the end of M12 2018/19. The table below sets out our monthly trajectory of improvement as agreed in our annual plan submission.

A&E: STF Trajectory (90%) **not met** - performance for September (80.7%).

RTT: RTT performance has seen little change in September with 80.4% of people waiting less than 18 weeks, behind the Operational Plan trajectory of 82%. Against 52 weeks we have seen a decrease from 105 last month to 89 this month and within our plan trajectory of 115.

Cancer: National standard not met in September with 77.7% against standard of 85% and improvement trajectory (85.5%) - 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** 84.3% of patients waiting under 6 weeks. This is outside of our recovery trajectory to deliver improved performance in September to achieve 90.3% against the National standard 99%.

Dementia: The Dementia find standard is reported at 90.5% achieving the 90% standard**.**

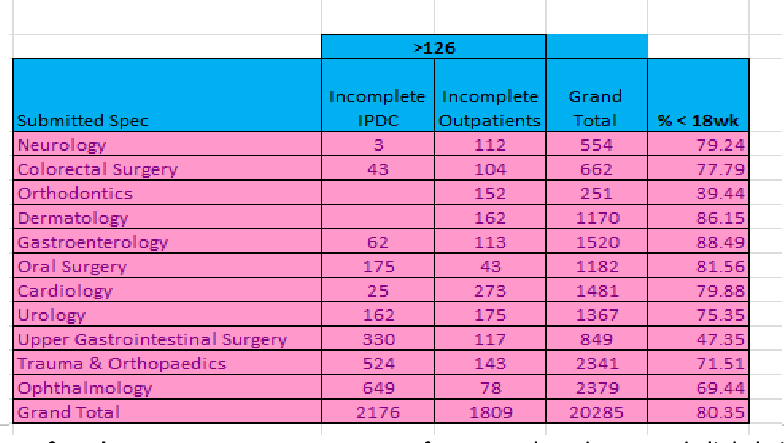
NHSI - Annual Plan submitted performance trajectories

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

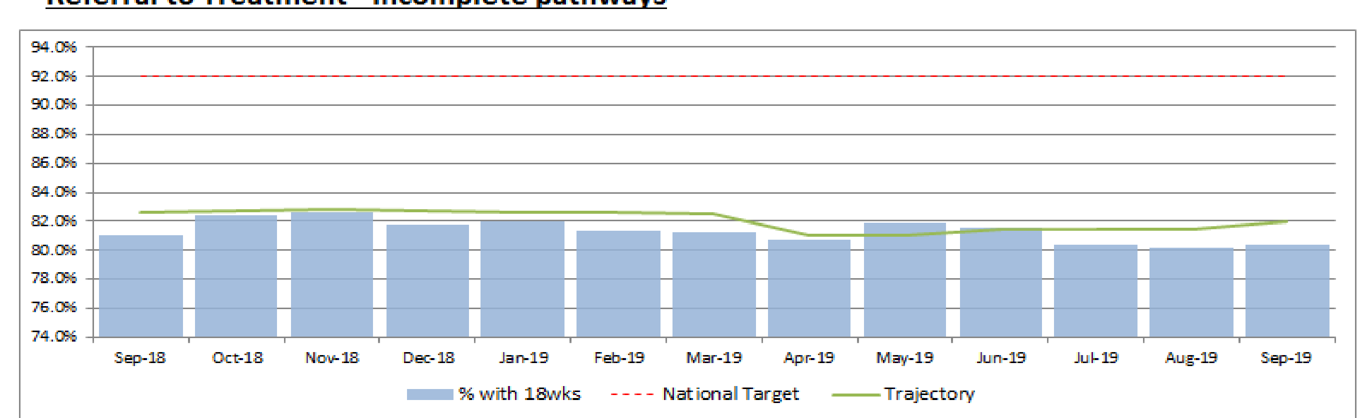
Services with greater than 100 patients waiting over 18 weeks

SEPTEMBER 2019 Incomplete 92% Table - National Specialty



	>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Neurology	3	112	554	79.24
Colorectal Surgery	43	104	662	77.79
Orthodontics		152	251	39.44
Dermatology		162	1170	86.15
Gastroenterology	62	113	1520	88.49
Oral Surgery	175	43	1182	81.56
Cardiology	25	273	1481	79.88
Urology	162	175	1367	75.35
Upper Gastrointestinal Surgery	330	117	849	47.35
Trauma & Orthopaedics	524	143	2341	71.51
Ophthalmology	649	78	2379	69.44
Grand Total	2176	1809	20285	80.35

Referral to Treatment - Incomplete pathways



Referral to Treatment - RTT: RTT performance has decreased slightly in September with the proportion of people waiting less than 18 weeks at **80.35%,** this is behind the Operational Plan trajectory of 82% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has risen to 20,285, an increase of 380 from August and above our revised trajectory .

For September , 89 people will be reported as waiting over 52 weeks (16 due to patient choice), this being a decrease on last month's 105 but remains ahead of our re-forecast position of 103. Although the September position is ahead of our forecast position , early indication are showing that we will be off trajectory for October - the trajectory has been re-profiled and we are forecasting delivery in October against the revised trajectory.

Theatres remedial works are now complete, but there have been snagging issues which are being addressed by the Theatre Manage r.

The Chief Operating Officer will update separately on the development of options to address the backlogs created by the loss of operating capacity and ongoing fragility of the theatre estate. The original plans to mitigate the lost capacity are being extended and include weekend working, outsourcing and insourcing. 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 as well as t he implementation of the 26 week choice initiative currently being piloted in T&O for foot and ankle patients.

Risk: High : The trajectory for reducing the number ofpatients waiting over 52 weeks shows a more rapid improvement from Month 5. Teams h ave reviewed plans with the Chief Operating officer and there is doubt that teams are able to deliver the additional activity needed to meet this improvement trajector y.

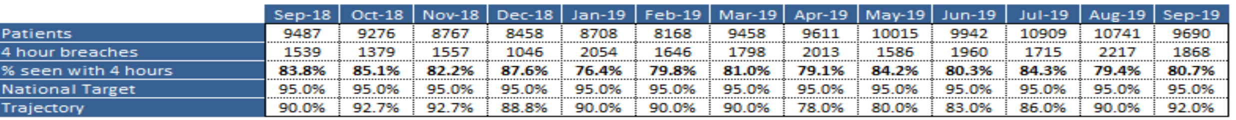
Delivery of the improvement trajectory remain reliant upon:

1. Theatres A and B returning to service week commencing 7th October 2019 - and run rate being maintained/increased;
2. Theatre staffing and rostering of lists able to fully utilise the available theatre capacity;
3. Continued us eof weekend lists and extended days;
4. Additional outsourcing as needed for procedure specific treatments arranged through the referral management service;
5. To protect elective inpatient capacity Trauma and Orthopaedics to retain protected beds through periods of escalation to reduce the number of cancelled operations through the winter months.

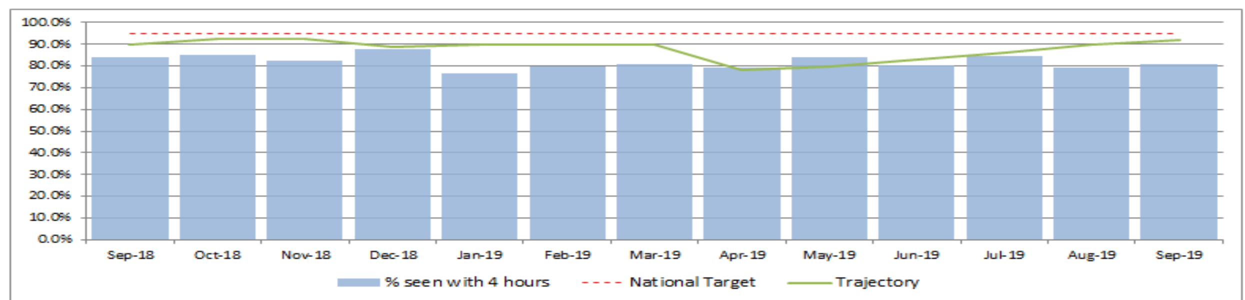
Management action: Led by the Chief Operating Officer plans are monitored through the Cancer / RTT Performance Risk and Assurance meeting with a ny outstanding risk escalated to the

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

A&E and MIU patients seen within 4 hours



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Patients	9487	9276	8767	8458	8708	8168	9458	9611	10015	9942	10909	10741	9690
4 hour breaches	1539	1379	1557	1046	2054	1646	1798	2013	1586	1960	1715	2217	1868
% seen with 4 hours	**83.8%**	**85.1%**	**82.2%**	**87.6%**	**76.4%**	**79.8%**	**81.0%**	**79.1%**	**84.2%**	**80.3%**	**84.3%**	**79.4%**	**80.7%**
National 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%
Trajectory	90.0%	92.7%	92.7%	88.8%	90.0%	90.0%	90.0%	78.0%	80.0%	83.0%	86.0%	90.0%	92.0%



Acute Care model - The acute care model is critical to delivery of improved ED performance by ensuring patients for medical review are fast tracked away from ED for medical assessment and initiation of treatment. Until we realise the benefits of the A+E rebuild we remain restricted by the current estate configuration and physical space to support this model, and remain reliant on having assessment beds available each day on the emergency ward (EAU3) adjacent to the Emergency department. The model also promotes direct admission to this area avoiding ED attendance and the use of our Ambulatory unit for patients who require assessment but not access to a bed - This unit is located on Level 2.

Operational delivery: The Operational Plan trajectory for Accident and Emergency waiting times (less than 4 hours) is not met in September (92% trajectory) with 80.7% (79.4% last month).
Escalation: In September there were 2 days at Opel 1 and 4 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 receiving additional improvement and project management support to ensure robustness of plans and to support system delivery over the coming months. The additional support in place builds on the excellent clinical engagement and clinical leadership established across the 3 workstreams. The improvement workstreams will be reporting back to the urgent care improvement board. Assessment of latest plans support an improvement trajectory to 84% by March 2010.
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 September, 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 September we have seen a decrease in the number of ambulance delays over 60 minutes with 2 reported .

Escalation status

Opel status	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Opel 1	0	0	1	9	0	0	1	0	6	0	0	0	2
Opel 2	8	14	12	13	1	5	10	8	15	4	5	3	13
Opel 3	22	15	14	7	22	20	16	16	3	18	22	21	11
Opel 4	0	2	3	2	8	3	4	6	4	8	4	7	4
Performance	83.8%	85.1%	82.2%	87.6%	76.4%	79.8%	81%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%

Cancer treatment and cancer access standards

CWT Measure	Target	August 2019 Within Target	August 2019 Breached Target	August 2019 Total	August 2019 Performance	September 2019 Within Target	September 2019 Breached Target	September 2019 Total	September 2019 Performance
14 Day - 2ww referral	93%	1093	217	1310	83.4%	1081	142	1223	88.4%
14 Day - Breast Symptomatic referral	93%	75	0	75	100.0%	72	4	76	94.7%
31 Day 1st treatment	96%	182	10	192	94.8%	205	3	208	98.6%
31 Day Subsequent treatment - Drug	98%	81	0	81	100.0%	48	0	48	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	62	1	63	98.4%	49	2	51	96.1%
31 Day Subsequent treatment - Surgical	94%	32	2	34	94.1%	29	2	31	93.5%
31 Day Subsequent treatment - Other		26	0	26	100.0%	34	0	34	100.0%
62 day 2ww / Breast	85%	82	24	106	77.4%	97.5	28	125.5	77.7%
62 day Screening	90%	16.5	0	16.5	100.0%	13	0	13	100.0%
62 day Consultant Upgrade		5	0.5	5.5	90.9%	2	0	2	100.0%

Cancer standards - Table above shows the forecast for September (as at 17 October 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.*
Three cancer standards are not met in September.

Urgent cancer referrals 14 day 2ww: At 88.4% in September this remains below the standard of 93%, however, improvement plans to increase capacity in Urology and lower GI pathways are on track.

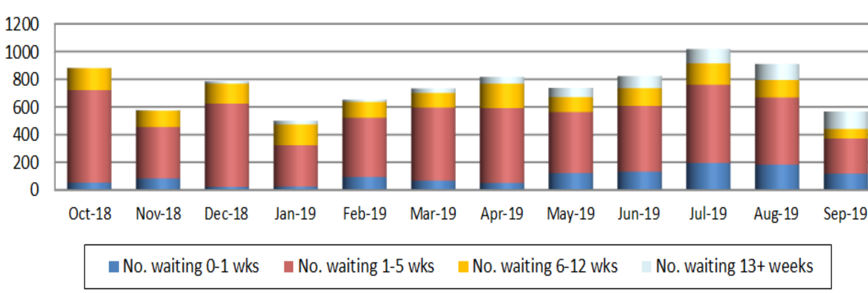
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has not been met in August at 77.7%.
Significant risk remains in the pathways for Urology and Lower GI however good progress with recruitment and plans to increase capacity are on track.

31 day subsequent treatment - surgical: The standard is not met in September with 93.5 % against a standard of 94%.

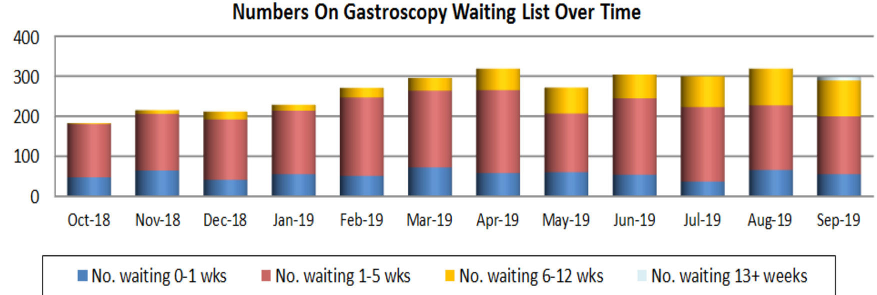
Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In September 5 patients with confirmed cancer were treated 104 days. The number of patients being tracked over 62 days is being maintained with no significant change to historical levels.
There are 43 patients on a 104 day open pathway , these patients are reviewed and managed through Cancer Services via the RTT Risk and Assurance Group.

NHSI indictor - patients waiting over 6 weeks for diagnostics

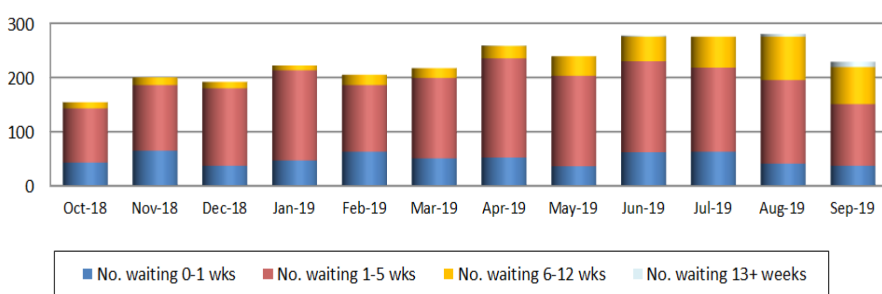
Numbers On CT Waiting List Over Time



Numbers On Gastroscopy Waiting List Over Time

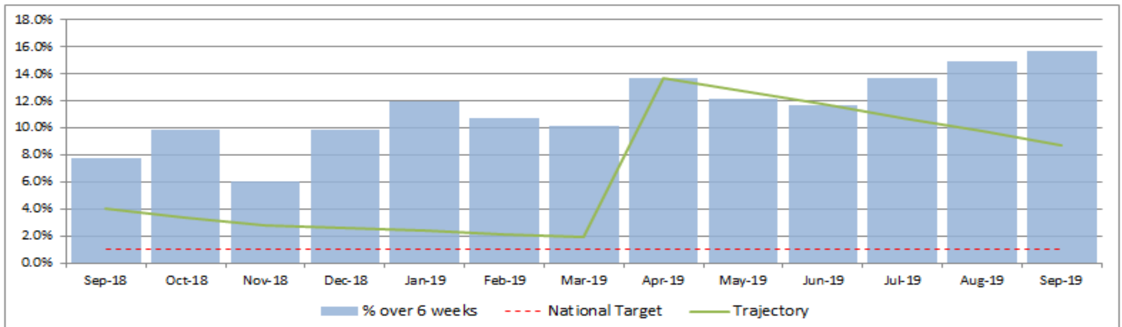


Numbers On Colonscopy Waiting List Over Time



Diagnostic Tests Longer than the 6 week standard

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Patients	4173	4027	3705	3863	3385	3934	4186	4201	3746	3893	3862	3586	2926
Waiting longer than 6 weeks	323	396	225	379	405	421	423	575	454	454	527	535	460
% over 6 weeks	**7.7%**	**9.8%**	**6.1%**	**9.8%**	**12.0%**	**10.7%**	**10.1%**	**13.7%**	**12.1%**	**11.7%**	**13.6%**	**14.9%**	**15.7%**
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	4.01%	3.40%	2.79%	2.55%	2.44%	2.08%	1.95%	13.65%	12.73%	11.75%	10.76%	9.74%	8.70%



The percentage of patients with a diagnostic wait over 6 weeks increased in September to 15.7% (460 patients) and is not in line with planned trajectory.

Demand for CT MRI and gastro investigations exceed the maximum in house capacity (which includes extended days and weekend working). Utilisation of mobile van capacity remains in place to support this capacity shortfall in CT and MRI.

For 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. Additional in house capacity is now in place (October 2019) with a plan to greatly reduce these waits by January 2020. This is needed to facilitate the replacement programme to upgrade our older CT machine that is prone to failure.

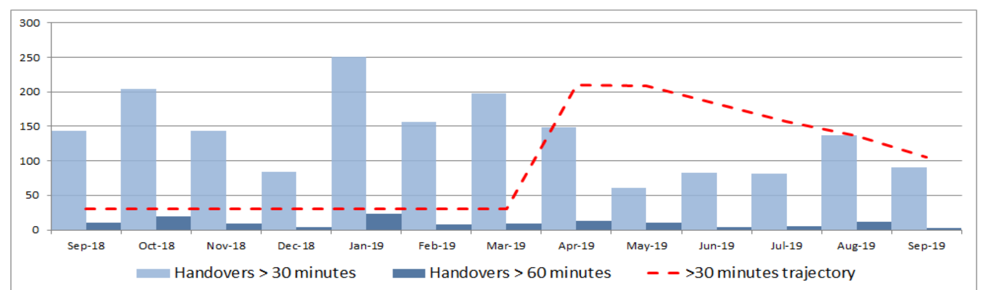
Insourcing at weekends to run additional colonoscopy lists is continuing with 1 in 3 weekends.

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

Other performance exceptions

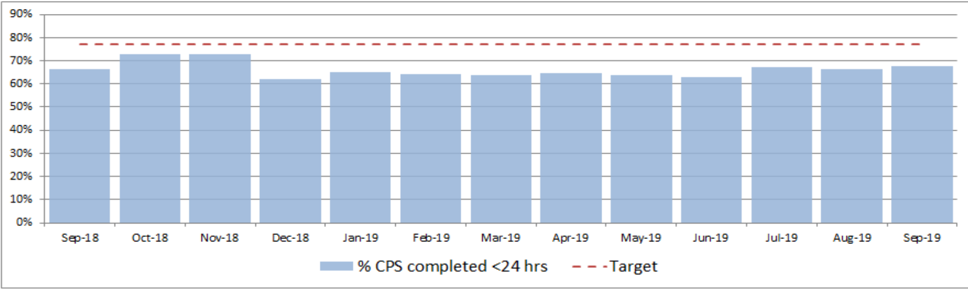
Ambulance handovers

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Handovers > 30 minutes	144	204	143	84	251	156	198	148	61	83	81	137	90
Handovers > 60 minutes	10	19	9	4	23	8	9	13	11	4	5	12	2
>30 minutes trajectory	30	30	30	30	30	30	30	210	209	183	157	136	105



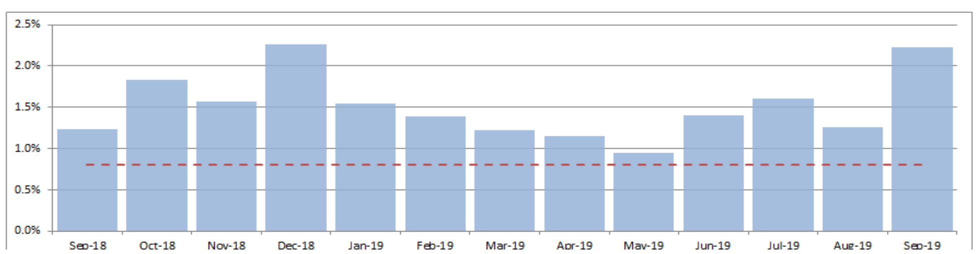
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Discharges	1016	1345	1283	1006	1135	976	1043	1094	1161	959	1214	1059	1056
CPS completed within 24 hours	1535	1851	1767	1621	1750	1525	1639	1690	1818	1526	1804	1593	1566
% CPS completed <24 hrs	66%	73%	73%	62%	65%	64%	64%	65%	64%	63%	67%	66%	67%
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

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Cancellations	37	69	53	63	53	42	39	37	33	45	56	41	72
Elective spells	3010	3766	3389	2782	3432	3016	3196	3218	3502	3198	3481	3248	3237
% of on the day cancellations	1.2%	1.8%	1.6%	2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%
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. 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 September the number of operations cancelled on the day of surgery for hospital reasons increased to 72. This represents 2.2% of all elective procedures undertaken.

Theatres A and B took their first patients from 14 October 2019 since being out of action since 6 November 2018 leaving the Trust 20% short of its total theatre capacity. Since then, a number of other theatres have also been out of action intermittently, with issues arising in relation to the age and general condition of the facilities.

The Team have worked together to ensure all patients waiting for surgery continue to receive safe care, and to mitigate the impact on waiting times. Although we have outsourced some planned operations to Mount Stuart and the Plymouth Nuffield, we have also managed to create additional capacity in-house, Clinical and support services staff have worked extra hours, including at weekends, and run extra sessions in our day surgery theatres. As a result of these measures, we have managed to treat 20% more patients through our day surgery unit (616 people) and 8% more (272 people) through main theatres. We are also on track to eliminate the number of people waiting longer than 52 weeks for their surgery by March 2020.

Finance Focus

Page 2 Summary of Financial Forecast
Page 3 Forecast
Page 4 Torbay System Forecast
Page 5 Southern System Forecast
Page 6 Summary Of Financial Performance
Page 7 Summary Of Financial Performance (2)
Page 8 Income
Page 9 Income (2)
Page 10 Pay Expenditure
Page 11 Pay Expenditure (2)
Page 12 Non Pay Expenditure
Page 13 Financial Position by System
Page 14 Financial Position by System (2)
Page 15 Items Outside of EBITDA
Page 16 Balance Sheet
Page 17 Cash
Page 18 Capital
Page 19 Activity
Page 20 Continuous Improvements Program (CIP)
Page 21 Continuous Improvements Program (CIP 2)
Page 22 Continuous Improvements Program (CIP 3)

Summary of Financial Forecast

The Regulator Protocol for Change to Forecast Outturn has been followed which requires governance within the Trust and STP before review at Regional office of the Regulator.

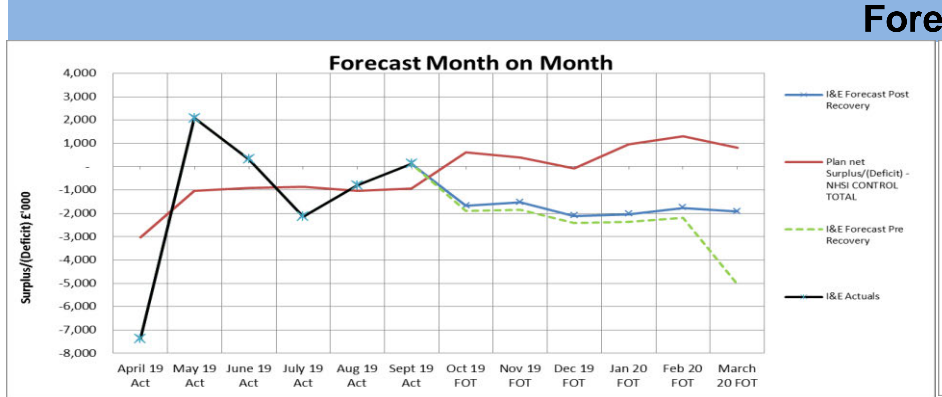
As discussed at Board last month the Trust has been working up recovery plans to mitigate the gross deficit variance forecast (to the control total) of £19.6m (at month 5).
The drivers for the deficit relate to income assumptions not materialising, STP income solution to RICS not materialising, transformation / CIP projects not delivering, bank and agency pay above capped levels, ASC/ CHC overspend, Increased turnover and sickness levels in key specialties have adversely affected the organisation, particularly in Emergency, Respiratory and Stroke and an over reliance on non-recurrent achievement of CIP in previous years.

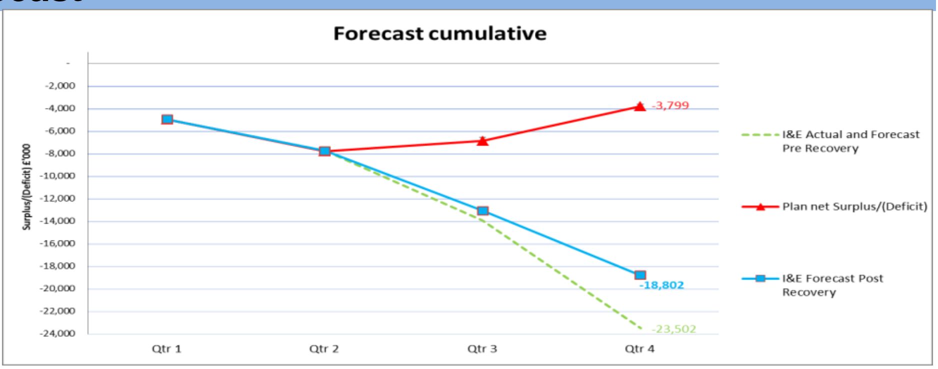
Progress made since last month is set out below:

	(Adverse) Favourable £000	(Adverse) Favourable £000
Forecast Outturn Variance against Plan (Based on Month 5)		(£19,600)
Current Assessed Impact of 2019/20 STP Risk Share Agreement		(£2,000)
Forecast Outturn Variance against Plan (prior to recovery actions)		(£21,600)
Recovery Actions since Month 5		£1,900
Forecast Outturn Variance against Plan (based on month 6)		(£19,700)
Additional recovery Actions		
Integrated Service Units	£1,600	
RICS Revaluation	£1,800	
Technical / further Reconvey Actions	£1,300	
		£4,700
Revised Forecast Outturn Variance against Plan		**(£15,000)**

The Trust has declared the revised forecast variance of £15m deficit under the protocol to the control total.

Forecast





Forecast position with mitigations	Plan £m	Forecast £m	Variance £m
Income			
Gross	493.15	486.22	(6.93)
Planned CIP	4.03	1.19	(2.83)
Net position	497.18	487.42	(9.76)
Pay			
Gross	(255.47)	(261.99)	(6.52)
Planned CIP	9.09	2.60	(6.49)
Net position	(246.38)	(259.39)	(13.01)
Non Pay			
Gross	(253.01)	(250.75)	2.26
Planned CIP	6.91	5.00	(1.91)
Net position	(246.10)	(245.74)	0.35
Net position Surplus/(Deficit)	**4.70**	**(17.72)**	**(22.42)**
Mitigations:-			
ISU/Corporate Recovery		1.60	1.60
RICS Revaluation		1.80	1.80
Technical/Further Recovery actions		1.30	1.30
Sub Total	**0.00**	**4.70**	**4.70**
Surplus/Deficit for the period	**4.70**	**(13.02)**	**(17.72)**
Less: Financing Items	(0.14)	(0.06)	0.08
Control Total (Including PSF)	**4.56**	**(13.08)**	**(17.64)**
Removal of PSF and MRET Income	(8.36)	(5.72)	2.64
Variance Against Control Total Excluding PSF	**(3.80)**	**(18.80)**	**(15.00)**

The Trust has implemented the NHSI protocol for a change to the forecast outturn a deficit of £18.8m, against a planned deficit of £3.8m (excluding MRET, PSF and Financing Items), a £15.0m adverse variance.

The Trust engages on an ongoing basis with the relevant stakeholders (CCG, NHSI/E, Torbay Council and STP partners) to review the revised position and seek joint solutions.

The bottom up forecast of £18.8m has the following drivers:
income assumptions not materialising, STP income solution to RICS not materialising, transformation / CIP projects not delivering, bank and agency pay above capped levels, ASC/ CHC overspend, Increased turnover and sickness levels in key specialties have adversely affected the organisation, particularly in Emergency, Respiratory and Stroke and an over reliance on non-recurrent achievement of CIP in previous years.

Other Risks and assumptions excluded from the forecast on the basis that there are mitigations in place:
•Assume 52 week penalties will not be applied
•Pension tax implications are currently being assessed
•Spec Comm – Oncology MDTs legacy and current year funding shortfall and contract challenges will continue at existing rate
•Impact of winter in excess of plans
•ASC/CHC price and volume - winter risk

Torbay Locality – M6 Forecast Overview of Variances

	Torquay	Paignton & Brixham	Total
	£m's	£m's	£m's
Contract Income & Pass Through Exp	1.0	0.9	1.9
Cost Pressures	1.4	2.7	4.1
Unachieved CIP	0.3	-	0.3
Underspends	(0.6)	(0.9)	(1.5)
Total	2.1	2.7	4.8

Contract Income /Pass Through Exp £1.9m (40%)

- Driven by Torbay Council income being £2.25m lower than originally budgeted for (note this is split 50-50 between Torquay and Paignton / Brixham). This is linked to the IBCF element of the contract income where we are now assuming £4m against an initial expectation of £6.25m.

Cost Pressures £4.1m (85%)

- Independent sector locality wide circa £1,040K
- Senior Medical Pay £800K
- Vacancy Factor £480K
- Purchase of Pacemakers £280K
- Cancer services Non Pay £200K (Lymphedema, Own Drugs & RDE SLA Increase)
- Sexual Health Contract Issue £180K
- Midwifery Pay £170K
- Ward Pay £230K (Turner, Midgely, Dunlop & Brixham Hospital)
- Cardio Technicians ££90K
- CHES Team Posts £70K
- Community Alarms £60

Unachieved CIP £0.3m (6%)

- The original target was £3.9m and therefore, at Month 6 just over £3.6m (92%) is forecast to be achieved.
- The outstanding balance of £300K sits within Torquay as Paignton / Brixham has nearly met its target.

Underspends / Slippage (£1.5m) (-31%)

- Radiology £350K (net figure pay/non pay)
- Public Health 0-19 £120K (note this could increase if new staff assumptions do not materialise.
- Child Health related £110K (link to CYP review required)
- Care Model Slippage £80K
- Obs & Gynae Non Pay £80K
- Tissue Viability Dressings £100K – possibly budget setting / accrual issues

Movement from M5

	£'ms
Month 5 Forecast Variance	6.2
Month 6 Forecast Variance	4.8
Decrease in Forecast Variance	**1.4**

- Forecast variance has decreased by £1.4m since M5 and this is primarily driven by £850K of Recovery Plans being built into the forecast in Month 6. In addition to this Paignton & Brixham has seen an improvement in pass through expenditure of circa £400K (a detailed review will be undertaken with the pharmacy team) during month 7 to validate and underspends.
- Recovery Plan are as follows:

ISU	Recovery Action	Total £000	Rec/Non Rec	ISU	Recovery Action	Total £000	Rec/Non Rec	Total £000
Paignton & Brixham	ASC	75	Rec	Torquay	ASC	75	Rec	
Paignton & Brixham	Non Recurrent Income	65	Non-Rec	Torquay	Non Recurrent Income	39	Non-Rec	
Paignton & Brixham	Locum Costs	102	Rec	Torquay	Sexual health	100	Non-Rec	
Paignton & Brixham	Delay CT replacement	90	Non-Rec	Torquay	Drugs & Alcohol	36	Non-Rec	
Paignton & Brixham	Provide CT Colon In House	66	Non-Rec	Torquay	Staffing efficiencies	23	Non-Rec	
Paignton & Brixham	Allocate	19	Rec	Torquay	Health Visitors relocated from Barton Surgery	18	Rec	
Paignton & Brixham	Recurrent Income	11	Rec	Torquay	Discretionary spend controls	70	Non-Rec	
Paignton & Brixham	Pacemakers	86	Rec					
	Total	514			Total	361		875

Forecast

Southern Locality – M6 Forecast Overview of Variances

	Coastal £m	Newton Abbot £m	Moor to Sea £m	Total £m
Conract Income & Pass Through Expenditure	0.0	0.3	0.0	0.3
Cost pressures	0.6	2.9	1.5	5.0
Unachieved CIP	1.7	0.7	0.1	2.5
Underspends	(0.7)	(0.9)	(0.5)	(2.1)
Total	1.6	3.0	1.1	5.7

Contract Income /Pass Through Exp £0.3m (5%)

- Variable income £0.3m adverse forecast against budget

Cost Pressures £5.0m (88%)

- A&E nursing £802k
- Acute Physicians £341k
- EAU3 & EAU 4 £375k
- Junior Doctors £470k
- Vacancy factor net £500k
- Ward Pay £468k (Community and Acute)
- Rapid Response and Reablement pay £280k
- Hospital Team Staffing £122k
- Night Sitting Service £115k
- Sen med Stroke £173k
- Community Services staff £328k
- Catheter suite equipment £237k
- Ward non pay £98k
- Community Services non pay £111k

Unachieved CIP £2.5m (44%)

- The original target was £3.8m. At Month 6 £1.24m (33%) is forecast to be achieved
- The outstanding balance of £2.5m ,with a gap of Coastal £1.7m, Newton Abbot £0.7m, and Moor to Sea £0.1m

Underspends / Slippage (£2.1m) (-37%)

- Community Neurological pay £114k
- ICU pay and non pay £201k
- Theatres non pay £242k
- Medical Division Senior Staff £80k
- George Earle ward £106k
- IC beds South Devon £35k
- Non pay wards and acute services £164k
- Non pay community services £88k

Movement from M5

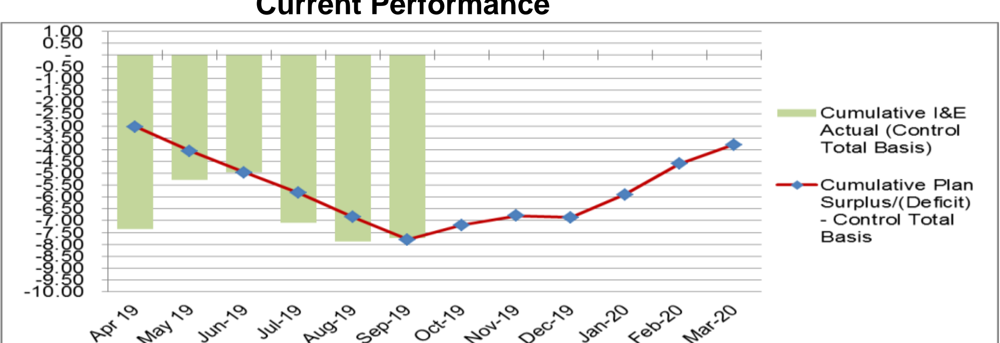
	£'ms
Month 5 Forecast Variance	6.0
Month 6 Forecast Variance	5.7
Decrease in Forecast Variance	**0.3**

- Forecast variance has decreased by £0.3m since M5 and this is primarily driven by £167K of Recovery Plans being built into the forecast in Month 6. In addition to this Coastal has seen an improvement in a revised forecast and reduction in expenditure, with an increase in Newton Abbot for winter pressures
- Recovery Plan are as follows:

Rec/Non Rec	ISU	Recovery Action	Total '£000
Non-Rec	Coastal	Allocate / Reduce non medical agency	77
	Moor 2 Sea	Community Neuro / Slippage in vacancies	80
Total			**157**

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	245.27	(1.24)	244.04	244.77	0.73	496.18	494.96
Pay	(125.31)	(1.48)	(126.80)	(128.70)	(1.90)	(246.38)	(249.36)
Non Pay	(114.27)	2.71	(111.56)	(110.85)	0.71	(225.02)	(221.47)
EBITDA	**5.69**	**(0.01)**	**5.68**	**5.21**	**(0.46)**	**24.78**	**24.12**
Financing Costs	(9.91)	0.33	(9.58)	(9.63)	(0.05)	(20.08)	(19.42)
SURPLUS / (DEFICIT)	**(4.22)**	**0.32**	**(3.90)**	**(4.42)**	**(0.52)**	**4.70**	**4.70**
NHSI Exclusions	(0.07)	0.00	(0.07)	0.46	0.53	(0.14)	(0.14)
Plan Adjusted Surplus / (Deficit)	**(4.29)**	**0.32**	**(3.97)**	**(3.96)**	**0.01**	**4.56**	**4.56**
Remove PSF/MRET Income	(3.51)	0.00	(3.51)	(3.78)	(0.27)	(8.36)	(8.36)
Variance to Control Total (Excl PSF/MRET	**(7.80)**	**0.32**	**(7.48)**	**(7.74)**	**(0.26)**	**(3.80)**	**(3.80)**

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
Cash Balance	1.00			4.90	**3.90**	**3.83**	**3.83**
Capital Expenditure	7.34	(0.49)	6.85	4.02	**(2.83)**	**21.56**	**16.60**
CIP Delivery	4.95	0.00	4.95	4.61	**(0.34)**	**20.03**	**20.03**

KPIs (Risk Rating)	**YTD Plan**	**YTD Actual**
Indicator	**Rating**	**Rating**
Capital Service cover rating	4	4
Liquidity rating	4	4
I&E Margin rating	4	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 September 2019 is a £7.74m deficit, which is slightly ahead against the plan of £7.80m.
- In months 1 to 6 the Trust has also assumed it will earn the PSF and MRET funding of £3.51m (as the Trust has delivered the control total in that period). An additional PSF income for FY 2018/19 of £0.27m was received by the Trust.
- Income has improved in month due to recognition of income from the CCG relating to activity transferred to Specialist commissioning, estates income from Devon Partnership Trust and other operating income.
- Total pay run rate in M6 (£21.1m) is lower in comparison to previous month (M5 £21.4m); mainly lower Agency spend.
- Non pay expenditure run rate of £18.2m is higher by £0.45m compared to M5. Higher spend in M6 is due to: Drugs spend £0.10m, Clinical and non clinical supplies £0.11m and various operating cost £0.24m.
- The CIP target for year to date is £4.9m of which £4.6m has been delivered; an adverse variance of £0.3m due to undelivered pay schemes offset by additional income and non pay schemes.
- The Trust has an annual savings target of £17.5m of which £8.8m have targets identified resulting in a £8.7m 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 plan is £20.0m, therefore the gap against plan is £11.2m. The Forecast outturn delivery value has reduced significantly following the conclusion of the deliverability peer review of the Trust's Transformational schemes. Subsequent to this review, we have appointed a Financial Recovery Director.
- Capital expenditure as at M6 is £4.02m. The full year forecast is £17.93m.
- The Finance Risk Rating remains a 3 at M06, with the agency rating adverse. The Rating is likely to drop to a 4 during the remainder of the financial year, given the increasing level of challenge incorporated in the Plan and the revised forecast.

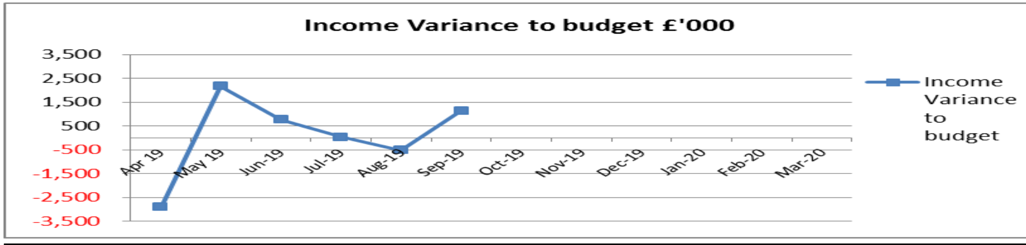
Summary of Financial Performance

	Month 6					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	36.85	(0.24)	36.61	37.08	0.47	221.77	(1.22)	220.55	219.05	(1.51)	(1.98)	0.47	444.27	442.91
Other Operating income	4.00	(0.20)	3.80	4.47	0.67	23.50	(0.01)	23.49	25.72	2.24	1.56	0.67	51.91	52.05
Total Income	**40.86**	**(0.44)**	**40.41**	**41.55**	**1.14**	**245.27**	**(1.24)**	**244.04**	**244.77**	**0.73**	**(0.41)**	**1.14**	**496.18**	**494.96**
Employee Benefits - Substantive	(20.13)	(0.37)	(20.50)	(20.38)	0.12	(121.50)	(1.12)	(122.62)	(123.43)	(0.81)	(0.93)	0.12	(240.20)	(241.99)
Employee Benefits - Agency	(0.64)	0.09	(0.55)	(0.71)	(0.17)	(3.81)	(0.36)	(4.18)	(5.27)	(1.09)	(0.93)	(0.17)	(6.18)	(7.37)
Drugs (including Pass Through)	(2.94)	0.10	(2.84)	(2.64)	0.20	(17.63)	0.61	(17.02)	(16.61)	0.41	0.22	0.20	(35.26)	(34.02)
Clinical Supplies	(2.17)	(0.11)	(2.29)	(2.17)	0.12	(12.99)	(0.13)	(13.11)	(13.33)	(0.22)	(0.34)	0.12	(26.46)	(26.66)
Non Clinical Supplies	(0.42)	(0.01)	(0.43)	(0.45)	(0.02)	(2.56)	(0.03)	(2.59)	(2.40)	0.19	0.20	(0.02)	(4.88)	(4.91)
Other Operating Expenditure	(13.21)	0.36	(12.85)	(12.96)	(0.12)	(81.10)	2.26	(78.84)	(78.52)	0.33	0.44	(0.12)	(158.42)	(155.87)
Total Expense	**(39.50)**	**0.05**	**(39.45)**	**(39.31)**	**0.14**	**(239.59)**	**1.23**	**(238.36)**	**(239.55)**	**(1.19)**	**(1.33)**	**0.14**	**(471.40)**	**(470.84)**
EBITDA	**1.35**	**(0.39)**	**0.96**	**2.24**	**1.28**	**5.69**	**(0.01)**	**5.68**	**5.21**	**(0.46)**	**(1.75)**	**1.28**	**24.78**	**24.12**
Depreciation - Owned	(1.07)	0.35	(0.72)	(0.89)	(0.17)	(6.27)	0.33	(5.95)	(5.59)	0.36	0.53	(0.17)	(12.86)	(12.21)
Depreciation - donated/granted	(0.07)	0.00	(0.07)	(0.08)	(0.00)	(0.43)	0.00	(0.43)	(0.43)	(0.00)	0.00	(0.00)	(0.86)	(0.86)
Interest Expense, PDC Dividend	(0.61)	0.00	(0.61)	(0.59)	0.01	(3.70)	0.00	(3.70)	(3.58)	0.12	0.11	0.01	(7.36)	(7.36)
Donated Asset Income	0.08	0.00	0.08	0.02	(0.06)	0.50	0.00	0.50	0.05	(0.45)	(0.39)	(0.06)	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)	**(0.31)**	**(0.04)**	**(0.35)**	**0.70**	**1.06**	**(4.22)**	**0.32**	**(3.90)**	**(4.42)**	**(0.52)**	**(1.57)**	**1.06**	**4.70**	**4.70**
Adjusted Plan Position														
Donated Asset Income	(0.08)	0.00	(0.08)	(0.02)	0.06	(0.50)	0.00	(0.50)	(0.05)	0.45	0.39	0.06	(1.00)	(1.00)
Depreciation - Donated / Granted	0.07	0.00	0.07	0.08	0.00	0.43	0.00	0.43	0.43	0.00	(0.00)	0.00	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)	**(0.32)**	**(0.04)**	**(0.37)**	**0.76**	**1.12**	**(4.29)**	**0.32**	**(3.97)**	**(3.96)**	**0.01**	**(1.11)**	**1.12**	**4.56**	**4.56**
NHSI Adjustment to Control Total														
Remove PSF/MRET Income	(0.62)	0.00	(0.62)	(0.62)	0.00	(3.51)	0.00	(3.51)	(3.78)	(0.27)	(0.27)	0.00	(8.36)	(8.36)
Variance to Control Total Excluding PSF/MRET	**(0.94)**	**(0.04)**	**(0.99)**	**0.13**	**1.12**	**(7.80)**	**0.32**	**(7.48)**	**(7.74)**	**(0.26)**	**(1.38)**	**1.12**	**(3.80)**	**(3.80)**

- The Control Total position in Month 6 is a surplus of £0.13m, which is better than the £0.99m budgeted deficit position after NHSI exclusions. There has been an improvement in the M6 position mainly in income. For the year to date, the cumulative deficit is £7.74m.
- Patient care income is £0.47m ahead of budget in month 6 due to activity and contract income; cumulatively income is £1.51m lower than budget due to: lower contract healthcare activity £0.67m, council income £0.95m, private patient income £0.30m offset by client income £0.41m. Other income is £0.67m higher in M6. Cumulatively other income is £2.24m higher than budget due to: PSF of £0.27m, Education, Grant and Training income of £0.39m, TP income £0.57m, income CIP £0.35m, non patient services £0.21m, site services £0.05m and various other income £0.39m.
- Pay expenditure of £21.09m is slightly higher than budget in Month 6 due to: use of Bank £0.21m, Agency £0.17m and CIP £0.30m offset by lower substantive staff cost of £0.63m. For the year to date, the pay position is £1.85m higher than budget due to undelivered CIP £1.63m, Bank and Agency spend £3.10m offset by Substantive vacancies and underspends £2.88m.
- Non-pay expenditure is £0.19m lower than budget in Month 6 due to underspends in: Drugs £0.20m and clinical supplies £0.12m offset by higher non clinical supplies £0.02m and operating expenditure £0.12m. Year to date there is a net underspend of £0.71m due to Drugs £0.41m, non clinical supplies £0.19m and operating cost of £0.33m offset by clinical supplies £0.22m.

Income

Current Performance



Operating Income	Year to Date - Month 6 Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Previous Month Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Contract Healthcare	189.36	(0.87)	188.49	187.83	(0.67)	(1.45)	0.79
Council Social Care (inc Public Health)	25.92	(0.20)	25.72	24.77	(0.95)	(0.73)	(0.22)
Client Income	5.39	(0.30)	5.09	5.50	0.41	0.45	(0.04)
Private Patients	1.11	0.01	1.12	0.82	(0.30)	(0.25)	(0.05)
Other Income	0.00	0.13	0.13	0.13	0.00	0.00	0.00
Operating Income from patient care activities	**221.78**	**(1.22)**	**220.55**	**219.05**	**(1.50)**	**(1.98)**	**0.48**
Other Income	14.96	0.17	15.13	16.71	1.58	1.12	0.46
R&D / Education & training revenue	5.03	(0.19)	4.85	5.23	0.39	0.17	0.22
Provider Sustainability Fund (PSF) & MRET Income	3.51	0.00	3.51	3.78	0.27	0.27	(0.00)
Other operating income	**23.50**	**0.01**	**23.49**	**25.72**	**2.23**	**1.56**	**0.67**
Total	**245.28**	**(1.24)**	**244.04**	**244.77**	**0.73**	**(0.42)**	**1.15**

Contract income by Commissioner	Year to Date - Month 6 Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Previous Month Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Devon Clinical Commissioning Group (CCG)	116.62	(1.00)	115.62	115.47	(0.15)	(0.09)	(0.06)
NHS England - Area Team	3.66	0.00	3.66	3.52	(0.13)	(0.13)	(0.00)
NHS England - Specialist Commissioning	15.82	(0.15)	15.67	15.75	0.09	(0.47)	0.56
Acute Income - Other Commissioners	4.74	(0.33)	4.41	3.88	(0.53)	(0.78)	0.25
Sub-Total Acute Income	140.83	(1.48)	139.35	138.63	(0.72)	(1.47)	0.75
Devon CCG (Placed People and Community Health)	47.78	0.00	47.78	47.78	0.00	0.00	0.00
Community Income - Other Commissioners	0.75	0.61	1.36	1.42	0.05	0.02	0.04
Sub Total Community Income	48.53	0.61	49.14	49.20	0.05	0.02	0.04
Operating Income from patient care activities	**189.36**	**(0.87)**	**188.49**	**187.83**	**(0.67)**	**(1.45)**	**0.79**

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 months 1 to 6.
- Overall operating income is £0.73m ahead of budget for the year to date.
- Operating Income from Patient Care Activities in M6 is lower than budget by £1.50m.
- Within this, income from contract healthcare is £0.67m behind budget due to lower activity with: Specialist Commissioners linked to pass through drugs and devices; and other commissioners re: dental and various healthcare activity.
- Council social care income is behind by £0.95m (*contract discussions are ongoing*).
- Client income is ahead by £0.41m as at M6.
- Private patient income is behind budget by £0.30m due to lower Outpatient activity.
- Other income is in line with plan at M6.

Income

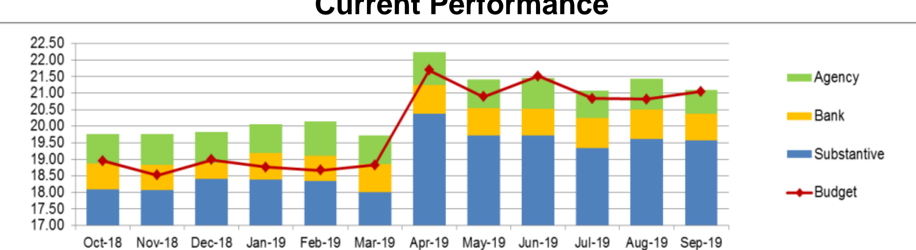
Other Operating Income	Year to Date - Month 6					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Plan - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
R&D / Education & training revenue	5.03	(0.19)	4.85	5.23	0.39	0.17	0.22
Site Services	1.15	0.06	1.21	1.27	0.05	0.05	(0.00)
Revenue from non-patient services to other bodies	2.39	0.15	2.55	2.76	0.21	(0.01)	0.23
Provider Sustainability Fund (PSF) & MRET Income	3.51	0.00	3.51	3.78	0.27	0.27	(0.00)
Misc. other operating revenue	11.42	(0.04)	11.37	12.68	1.31	1.08	0.23
Total	**23.50**	**(0.01)**	**23.49**	**25.72**	**2.23**	**1.56**	**0.67**

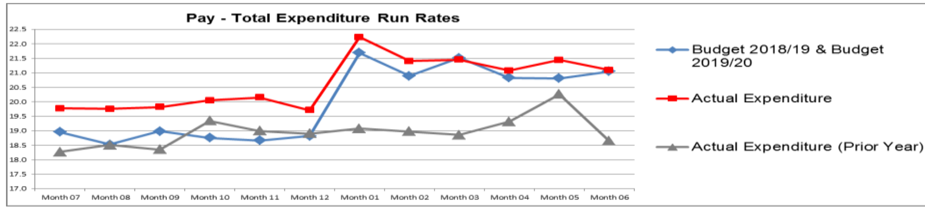
At Month 6, Other Operating income is £2.23m ahead of budget.
Key headlines / variances are:

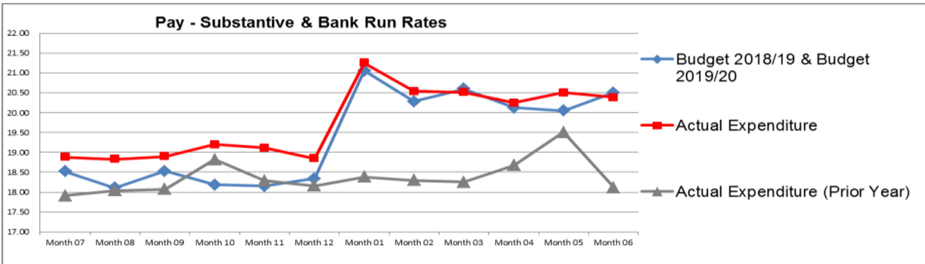
- R&D, Education and Grant income ahead of budget by £0.39m due to: higher SIFT/NMET/MADEL income of £0.05m and grant income of £0.44m for CYP training (matched by Cost) offset by R&D income £0.10m.
- Site Services (Car Parking, Catering and Accommodation) income is slightly higher than budget by £0.05m.
- Non patient services to other bodies is ahead of budget by £0.21m (matched by cost).
- Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET) income is in line with plan at £3.51m for months 1-6. An additional PSF income for FY 2018/19 of £0.27m was received by the Trust.
- Other Income is higher than budget by £1.31m due to income CIP £0.35m, higher TP sales of £0.57m (reprofiling of sales) and various income received £0.39m.

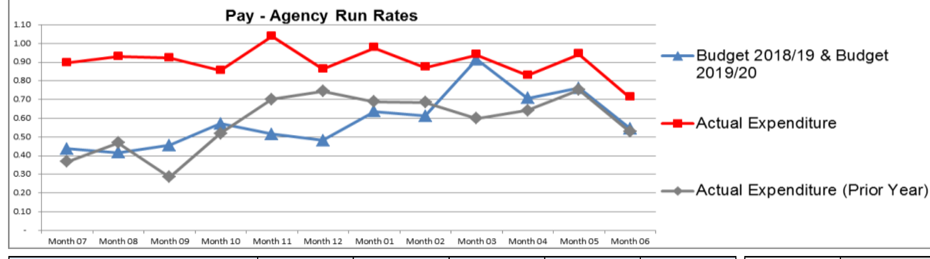
Pay Expenditure

Current Performance









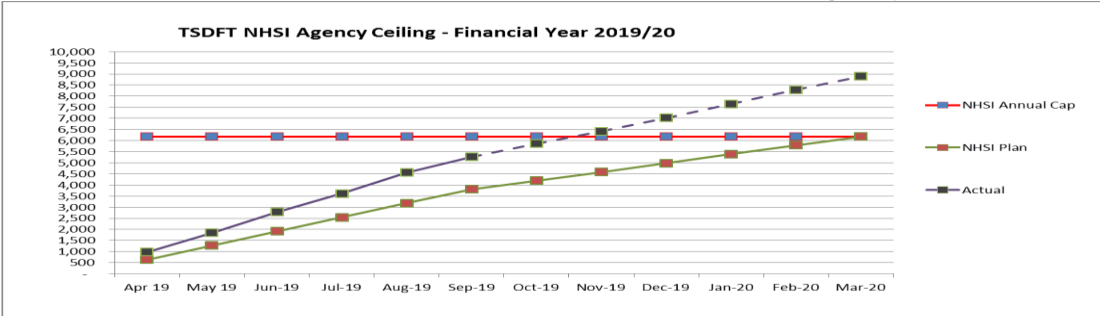
	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Medical and Dental	(26.60)	(0.58)	(27.18)	(28.29)	(1.10)	(52.78)	(53.85)
Nursing and Midwifery	(29.36)	(0.17)	(29.53)	(30.19)	(0.66)	(57.87)	(58.26)
Other Clinical	(48.31)	(0.45)	(48.76)	(47.50)	1.25	(94.71)	(95.77)
Non Clinical	(21.04)	(0.28)	(21.32)	(22.71)	(1.40)	(41.02)	(41.48)
Total Pay Expenditure	**(125.31)**	**(1.48)**	**(126.79)**	**(128.69)**	**(1.90)**	**(246.38)**	**(249.36)**

Key points

- Total pay costs are showing an overspend against year to date budget at Month 6 of £1.85m. This is due to undelivered CIP £1.63m, Bank and Agency spend £3.10m offset by Substantive vacancies and underspends £2.88m.
- 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 £1.09m is mainly due to increased use of Medical Staff £0.80m, Nursing and AHP staff £0.12m and non clinical/other staff £0.17m.
- Total pay run rate in M6 (£21.1m) is lower in comparison to previous month (M5 £21.4m).
- Agency run rate decreased by £0.23m in M6 due to lower spend in Medical staff £0.28 and other staff group £0.05 offset by higher Nursing agency cost £0.10m.
- The Apprentice levy balance at Month 6 is £1,533,028 (£1,466,721 at month 5). 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 has started to materialise**.**

Pay Expenditure

Agency Spend Cap



Agency - All Staff Groups	April	May	June	July	August	September	YTD 2019-20
	£m	£m	£m	£m	£m	£m	£m
Agency Plan 2019/20 (NHSI Cap)							
Planned Agency Cost	(0.64)	(0.64)	(0.64)	(0.63)	(0.63)	(0.63)	(3.81)
Total Planned Staff Costs	(21.57)	(20.71)	(20.71)	(20.77)	(20.77)	(18.78)	(123.32)
% of Agency Costs against Total Staff Cost	***2.9%***	***3.1%***	***3%***	***3%***	***3%***	***3%***	***3.1%***
Agency Actual Costs 2019/20							
Agency Cost	(0.98)	(0.87)	(0.94)	(0.83)	(0.94)	(0.71)	(5.26)
Actual Staff Cost	(22.32)	(21.48)	(21.58)	(21.20)	(21.55)	(21.25)	(129.39)
% of Agency Costs against Total Staff Cost	***4.4%***	***4.1%***	***4%***	***4%***	***4%***	***3%***	***4.1%***
Agency Cost vs Plan	(0.34)	(0.24)	(0.30)	(0.20)	(0.31)	(0.08)	(1.46)
Variance	***1.4%***	***1.0%***	***1%***	***1%***	***1%***	***0%***	***1.0%***

Agency - Nursing	April	May	June	July	August	September	YTD 2019-20
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Agency Nurse Staff Cost	(0.36)	(0.29)	(0.30)	(0.30)	(0.24)	(0.34)	(1.83)
Actual Registered Nurse Staff Cost	(5.42)	(4.99)	(4.98)	(5.00)	(4.87)	(4.94)	(30.19)
% of Agency Costs against Nursing Staff Cost	***7%***	***6%***	***6%***	***6%***	***5%***	***7%***	***6%***

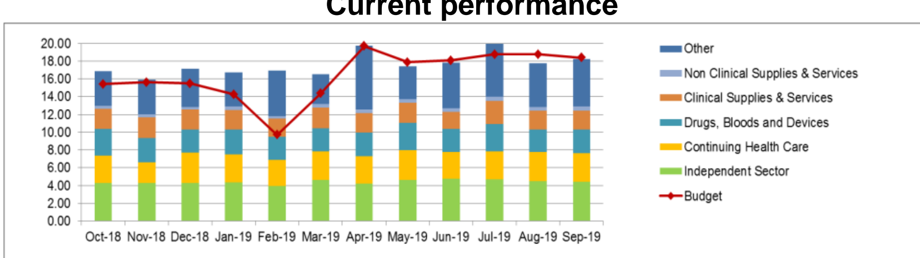
Agency - Medical Staff	April	May	June	July	August	September	YTD 2019-20
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Agency Medical Staff Cost	(0.55)	(0.53)	(0.51)	(0.43)	(0.61)	(0.32)	(2.95)
Actual Medical Staff Cost	(4.71)	(4.77)	(4.80)	(4.63)	(4.86)	(4.52)	(28.29)
% of Agency Costs against Medical Staff Cost	***12%***	***11%***	***11%***	***9%***	***12%***	***7%***	***10%***

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

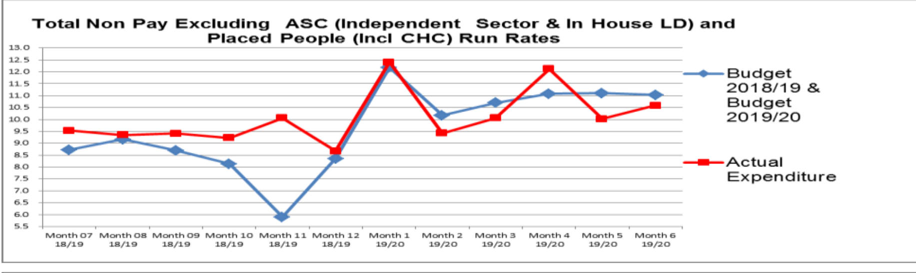
- Agency staff cost in Month 6 across all staff groups is £0.71m. This is £0.08m higher than the NHSI cap of £0.63m. The agency usage to date is £5.26m against a cap of £3.81m which is £1.46m higher.
- Majority of the adverse agency cost variance of £1.46m is within Medical staff £1.20m due to challenges in recruiting for this staff group and operational pressures.
- Nursing agency spend in Month 6 is £0.34m which is higher than plan. Spend in month increased by £0.10m compared to M5 mainly due to specialling and increased patient acuity.
- Medical agency spend is £0.32m in Month 6; year to date spend is £2.95m against a cap of £1.75m.
- The individual price rates for nursing and medical staff are all above NHSI individual shift rates.
- The forecast as at M6 is £8.88m before any mitigations, this is due to operational pressures, vacancy levels and difficulty in recruiting. This forecast will result in adverse variance of £2.7m.
- 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.

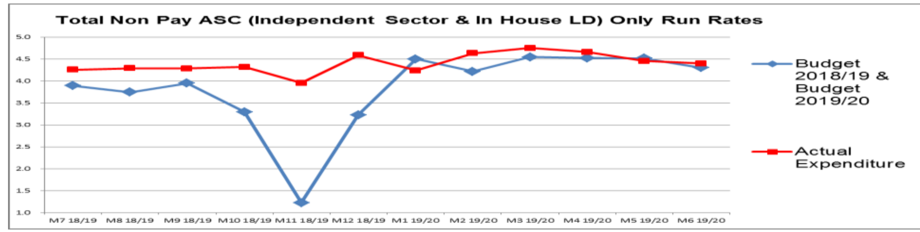
Non Pay Expenditure

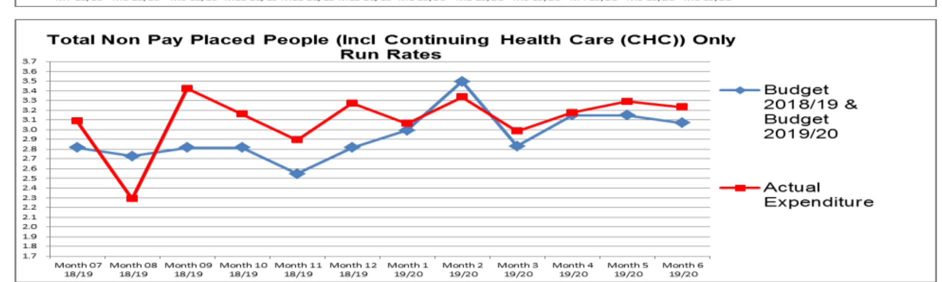
Current performance



Non Pay Expenditure	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	(17.63)	0.61	(17.02)	(16.61)	0.41	(35.26)	(34.02)
Clinical Supplies & Services	(12.99)	(0.13)	(13.11)	(13.33)	(0.22)	(26.46)	(26.66)
Non Clinical Supplies & Services	(2.56)	(0.03)	(2.59)	(2.40)	0.19	(4.88)	(4.91)
Other Operating Expenditure	(39.78)	6.26	(33.52)	(32.27)	1.25	(75.77)	(65.26)
ASC (Independent Sector & In House LD)	(24.49)	(2.14)	(26.63)	(27.16)	(0.53)	(48.98)	(53.26)
Placed People (Incl Continuing Healthcare)	(16.83)	(1.86)	(18.70)	(19.09)	(0.39)	(33.67)	(37.35)
Total Non Pay Expenditure	**(114.27)**	**2.71**	**(111.56)**	**(110.85)**	**0.71**	**(225.02)**	**(221.47)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.41m mainly due to pass through for which income is similarly reduced for NHS England and lower Drugs cost.
- Clinical Supplies – Spend is £0.22m higher than budget due to consumables, pacemakers, medical and surgical equipment £0.08m, appliances and furniture £0.15m, contract maintenance £0.13m, offset by Dressings £0.13m underspend.
- Non Clinical Supplies – underspend of £0.19m due to external service agreements (records management, storage and other non healthcare) £0.09m, CIP £0.10m, domestic mats and uniform £0.06m offset by hospitality provisions £0.06m.
- Other Operating Expenditure - underspent by £1.25m reflecting lower provision for Bad debt £0.83m, IT license cost deferral to next year of £0.63m, courses £0.19m, CIP achieved £0.25m, workforce support £0.22m and lower spend on stationery, postage and telephony £0.24m; offset by higher training cost for CYP £0.44m (matched by Income), CYP IT upgrade and phones £0.64m and other £0.03m.
- Adult Social Care (Independent sector) - Overspend by £0.53m mainly due to residential and domiciliary care spend £0.12m and unachieved CIP £0.41m.
- Placed People (including Continuing Healthcare) - overspend of £0.39m to date.

Financial Position by System

Key Drivers

The financial position at control total level as at 30th of September 2019 is a £7.74m deficit, which is slightly better than the plan of £7.80m.
Further analysis by Income and Expenditure categories at System level can be seen in the following tables which includes Forecast and variance against budget:-

System	Plan for Period	Re-Categori sation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
South Devon									
Income	82.94	(0.05)	82.89	82.49	(0.40)	164.98	165.50	165.45	(0.47)
Pay	(49.28)	(1.89)	(51.17)	(53.46)	(2.29)	(107.15)	(98.56)	(102.79)	(4.36)
Non Pay	(15.11)	(1.03)	(16.14)	(16.00)	0.14	(31.70)	(30.23)	(30.79)	(0.91)
Financing Costs	(0.90)	0.00	(0.90)	(0.89)	0.00	(1.79)	(1.79)	(1.79)	0.00
Surplus / (Deficit)	**17.65**	**(2.97)**	**14.68**	**12.13**	**(2.55)**	**24.35**	**34.92**	**30.08**	**(5.73)**

YTD - overspent £2.5m. Pay overspent £2.29m - being £633k CIP shortfall, Care of the Elderly Senior Medical staff £158k, Emergency Nursing Agency staff £618k, General medicine locums, Acute Physicians and Junior doctors £392k, wards being General surgery, Stroke, and Care of the Elderly £330k, Rapid Response teams £105k. YTD Non pay underspend £140k - underspends £531K Surgical division phasing RTT funding in first part of the year, Drugs £70k, offset with overspends in Equipment and premises costs £163k, Other expenses £60k, CIP shortfall £239k. Contract income £0.4m adverse.
Forecast £5.7m overspent- pay overspend £4.3m being CIP shortfall £1.6m, A&E £960k, Gen med £863k, Care of the Elderly £337k, Rapid Response, Reablement & Hospital team staffing £430k. Non pay £910k - CIP shortfall £1.0m, underspends £997k in Theatres, Opthalmoloogy, Head and Neck for drugs, equipment and services, offset with overspends in Gastro drugs & equipment £436k, Care of the Elderly drugs and other costs £103k, Cath lab equipment £228k, domicilliary care, travel and other community services £100k. Contract income £0.47m adverse.

	Plan for Period	Re-Categori sation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Torbay									
Income	118.67	2.03	120.70	119.89	(0.82)	238.70	236.65	240.65	(1.95)
Pay	(43.31)	(2.35)	(45.66)	(46.00)	(0.34)	(93.13)	(86.62)	(91.29)	(1.85)
Non Pay	(69.31)	(5.67)	(74.99)	(74.80)	0.18	(150.92)	(138.63)	(149.90)	(1.02)
Financing Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus / (Deficit)	**6.05**	**(5.99)**	**0.05**	**(0.92)**	**(0.97)**	**(5.35)**	**11.41**	**(0.54)**	**(4.81)**

Year To Date Compared to budget there is a **£970K overspend**.
The biggest contributor is a £820K under recovery on **income** with the material factor being lower Torbay Council income than budgeted for (£750K).
In addition to this there is an overspend of £340K on **pay** which is primarily driven by the Paignton & Brixham ISU where Medical pay (locum costs) are higher than budgeted for. **Non Pay** there is a £180K underspend resulting from slippage on IBCF schemes and a Radiology underspend where budgets are evenly profiled throughout the year but insourcing and replacement CT is profiled into the last half of the financial year.
Forecast - During the remainder of the financial year the Torbay position is set to deteriorate to an **overspend of £4.8m.** There is a forecast under recovery of **income** £2.0m (Torbay Council) and this is combined with a £1.8m pressure on **pay** which is driven by Medical Pay (Locum Costs), unachieved vacancy factor and ward overspends. Finally **non pay** is set to overspend by £1.0m due to cost pressures in the Independent Sector (Packages of Care impacted by volume & price issues).

Financial Position by System - continued

Key Drivers

The financial position at control total level as at 30th of September 2019 is a £7.74m deficit, which is slightly better than the plan of £7.80m.
Further analysis by Income and Expenditure categories at System level can be seen in the following tables which includes Forecast and variance against budget:-

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Shared Operations									
Income	1.77	(0.08)	1.68	1.68	0.00	3.38	3.53	3.36	0.02
Pay	(3.69)	(0.06)	(3.76)	(3.65)	0.11	(7.30)	(7.39)	(7.50)	0.20
Non Pay	(0.82)	0.02	(0.80)	(0.67)	0.13	(1.41)	(1.64)	(1.59)	0.18
Financing Costs	(0.02)	(0.00)	(0.03)	(0.03)	(0.00)	(0.05)	(0.05)	(0.05)	0.00
Surplus / (Deficit)	**(2.77)**	**(0.13)**	**(2.90)**	**(2.66)**	**0.24**	**(5.39)**	**(5.55)**	**(5.78)**	**0.39**

YTD - Shared Operations is underspent by £240K. Pay is £110k underspent mainly due to vacancies in Medical Electronics, Infection Control, HSDU and Clinical systems admin. Non pay is underspent by £130k mainly due to Equipment and Transport costs.
Forecast £394k underspent - Pay £196k underspent comprising overspends in bed management team & Hospital day and night £106k, offset with underspends £300k in Medical Electronics, Infection Control, HSDU,Transport and Clinical systems admin. Non pay underspent £183k in medical Electronics and Devices, Transport and Clinical admin systems software suppport.

	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Forecast	Annual Plan	Annual Budget	Variance between Forecast and Budget
	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M	£'M
Shared Corporate/TP									
Income	42.39	(3.13)	39.26	40.75	1.49	80.35	91.49	86.50	(6.14)
Pay	(29.03)	2.82	(26.20)	(25.59)	0.61	(51.70)	(53.81)	(47.78)	(3.92)
Non Pay	(35.73)	9.72	(26.01)	(25.48)	0.54	(49.76)	(68.25)	(52.26)	2.50
Financing Costs	(2.78)	0.00	(2.78)	(2.66)	0.12	(5.51)	(5.51)	(5.51)	(0.00)
Surplus / (Deficit)	**(25.15)**	**9.41**	**(15.73)**	**(12.97)**	**2.76**	**(26.62)**	**(36.08)**	**(19.06)**	**(7.57)**

Torbay Pharmaceuticals forecast on budget - see separate Board paper.
Shared Corporate Services overall over achieved CIP target by (£333k).
Estates & Facilities over budget by £374k - Domestics pay overspend, unachieved vacancy factor and estates purchased contracts above budget.
Executive Directors underspent by (£1,121k), of which £676k non pay; general underspends plus underspend in Workforce Support in HR, slow start as the program is developed along with slippage on IT Business Cases.
R & D under spent by (£22k) mainly due to variances within pay.
Reserves cost pressure £83k for SLA repayment, budget phasing adjustments to match submitted workforce plan and post ledger close adjustments of (£1,305k).
Pharmacy Services underspend (£34k), mixture of vacancies, additional income and additional non pay spend.
Financing costs £49k adverse: depreciation £375k favourable primarily due to asset life changes, net interest £121k favourable, offset by donated asset income £444k adverse and impairment £75k adverse, both outside control total.

Items outside of EBITDA

	Year to Date - Month 06			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Operating income/expenditure outside EBITDA					
Donated asset income	0.50	0.05	(0.45)	(0.39)	(0.06)
Depreciation/Amortisation	(6.71)	(6.02)	0.68	0.51	0.17
Impairment	0.00	(0.07)	(0.07)	(0.07)	0.00
Total	**(6.21)**	**(6.05)**	**0.15**	**0.05**	**0.11**
Non-operating income/expenditure					
Net interest expense (excluding PFI)	(0.98)	(0.86)	0.12	0.10	0.02
Interest and Contingent Rent expense (PFI)	(0.90)	(0.89)	0.00	0.00	0.00
PDC Dividend expense	(1.81)	(1.81)	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)	(0.02)	(0.00)	0.00	(0.01)
Total	**(3.70)**	**(3.58)**	**0.12**	**0.11**	**0.01**
Total items outside EBITDA	**(9.91)**	**(9.63)**	**0.27**	**0.15**	**0.12**

Key points

- Donated Asset Income is £0.5m adverse to Plan, due to delay in these charitable projects. NB this variance lies outside the NHSI Control Total.
- Depreciation/amortisation £0.7m favourable, primarily due to asset life changes.

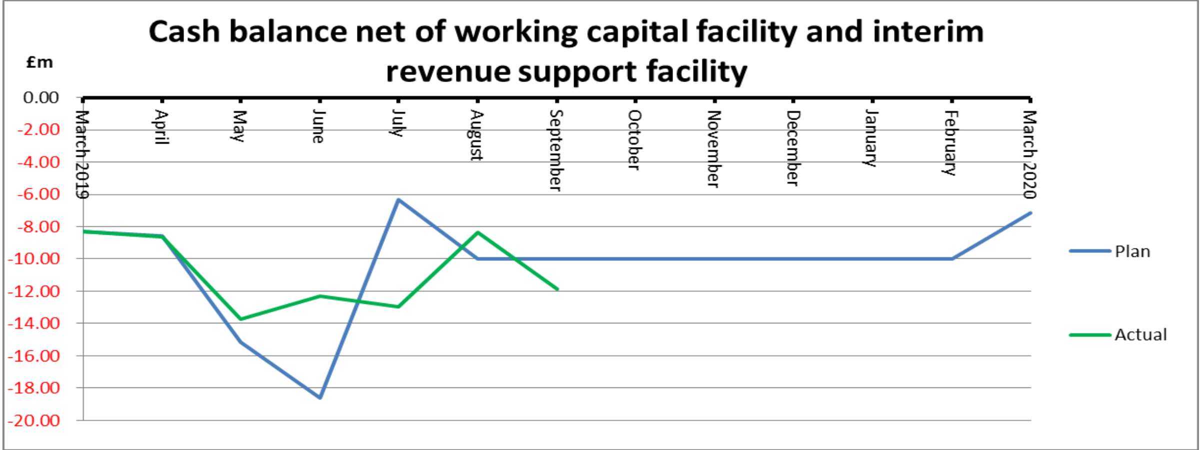
Balance Sheet

	Year to Date - Month 06			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Movement in Variance £m
Non-Current Assets					
Intangible Assets	12.30	11.62	(0.68)	(0.32)	(0.37)
Property, Plant & Equipment	175.03	173.10	(1.93)	(1.79)	(0.14)
On-Balance Sheet PFI	14.69	14.60	(0.09)	(0.07)	(0.01)
Other	1.14	1.13	(0.02)	(0.02)	0.01
Total	**203.16**	**200.45**	**(2.71)**	**(2.20)**	**(0.51)**
Current Assets					
Cash & Cash Equivalents	1.00	4.90	3.90	7.41	(3.52)
Other Current Assets	36.43	40.54	4.11	1.86	2.24
Total	**37.43**	**45.43**	**8.00**	**9.28**	**(1.27)**
Total Assets	**240.59**	**245.89**	**5.29**	**7.08**	**(1.78)**
Current Liabilities					
Loan - DH ITFF	(6.91)	(6.90)	0.00	0.00	0.00
PFI / LIFT Leases	(0.87)	(0.87)	0.00	0.00	0.00
Trade and Other Payables	(36.29)	(37.54)	(1.25)	(3.09)	1.84
Other Current Liabilities	(13.04)	(12.92)	0.12	(0.32)	0.43
Total	**(57.11)**	**(58.24)**	**(1.14)**	**(3.41)**	**2.27**
Net Current assets/(liabilities)	**(19.68)**	**(12.81)**	**6.87**	**5.87**	**1.00**
Non-Current Liabilities					
Loan - DH ITFF	(46.78)	(52.53)	(5.74)	(5.75)	0.00
PFI / LIFT Leases	(18.19)	(18.19)	(0.00)	(0.00)	(0.00)
Other Non-Current Liabilities	(7.42)	(6.41)	1.01	0.87	0.14
Total	**(72.40)**	**(77.13)**	**(4.74)**	(4.88)	0.14
Total Assets Employed	**111.09**	**110.51**	**(0.58)**	**(1.21)**	**0.63**
Reserves					
Public Dividend Capital	64.89	64.51	(0.38)	0.00	(0.38)
Revaluation	41.87	41.86	(0.01)	(0.00)	(0.00)
Income and Expenditure	4.33	4.14	(0.19)	(1.21)	1.01
Total	**111.09**	**110.51**	**(0.58)**	**(1.21)**	**0.63**

Key points

- Intangible Assets, Property, Plant & Equipment and PFI are £2.7m adverse. This is primarily due to capex £3.3m lower than planned, partly offset by depreciation £0.7m lower than planned.
- Cash is £3.9m higher than planned, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are £4.1m higher than Plan, primarily due to Torbay Council debtor £4.3m.
- Trade and Other Payables are £1.3m higher than Plan, primarily due to funding held for CCG £1.5m, the timing of non-capital payments £0.5m and income received in advance, partly offset by the paying down of the capital creditor £1.6m.
- Non-current DH loans are £5.8m higher than planned, due to delayed repayment of the Interim Revenue Support facility.
- Other Non-Current liabilities are £1.0m lower than Plan, principally due to reduced recognition of finance leases £1.0m.

Cash



	Year to Date - Month 06			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)	(7.35)	(4.04)	3.30	2.62	0.69
Capital loan drawndown	0.00	0.00	0.00	0.00	0.00
Capital loan repayment	(2.40)	(2.40)	(0.00)	0.00	(0.00)
Proceeds on disposal of assets	0.61	0.00	(0.61)	(0.30)	(0.31)
Movement in capital creditor	(0.52)	(2.08)	(1.55)	(1.48)	(0.08)
Other capital-related elements	2.00	0.23	(1.78)	(1.54)	(0.24)
Sub-total - capital-related elements	**(7.65)**	**(8.30)**	**(0.64)**	**(0.70)**	**0.06**
Cash Generated From Operations	5.69	5.21	(0.47)	(1.36)	0.89
Working Capital movements - debtors	2.97	(0.37)	(3.35)	(1.43)	(1.92)
Working Capital movements - creditors	2.14	4.94	2.80	4.58	(1.78)
Net Interest	(1.87)	(1.69)	0.18	0.57	(0.39)
PDC Dividend paid	(1.85)	(1.85)	0.00	0.00	0.00
Other Cashflow Movements	(1.13)	(1.50)	(0.37)	0.01	(0.38)
Sub-total - other elements	**5.95**	**4.74**	**(1.21)**	**2.36**	**(3.57)**
Closing cash balance (net of working capital facility)	**(10.00)**	**(11.85)**	**(1.85)**	**1.67**	**(3.52)**

Closing cash balance	1.00	4.90	3.90	7.41	(3.52)
Closing working capital facility	(11.00)	(11.00)	0.00	0.00	0.00
Closing interim revenue support facility	0.00	(5.75)	(5.75)	(5.75)	0.00
Closing cash balance (net of working capital facility)	**(10.00)**	**(11.85)**	**(1.85)**	**1.67**	**(3.52)**

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 £0.6m adverse, due in part to the paying down of the capital creditor £1.6m and delayed disposals £0.6m. While capital expenditure is £3.3m favourable, a significant proportion of this relates to assets due to have been funded through non-cash methods such as finance leases £1.2m and donations £0.5m.

Other elements:

- Cash generated from operations is £0.5m adverse, due to EBITDA £1.8m adverse.
- Working Capital debtor movements is £3.4m adverse, primarily due to Torbay Council debtor £4.3m.
- Working Capital creditor movements is £2.8m favourable, largely due to funding held for CCG £1.5m, the timing of non-capital payments £0.5m and income received in advance £0.6m.

Use of Interim Revenue Support facility

- The M06 position included cash balances and working capital loans both higher than planned. It was not feasible to offset the two, due to the inflexible nature of the working capital facilities.

Capital

Current Performance

	Year to date Mth 06			Full Year		
	Budget £m	Actual £m	Variance to Budget £m	Budget £m	Forecast £m	Variance £m
Capital Programme	6.85	4.02	(2.83)	16.60	17.93	1.33
Significant Variances in Planned Expenditure by Scheme:						
HIS schemes	0.57	0.28	(0.29)	2.93	3.26	0.33
Estates schemes	3.35	2.01	(1.34)	5.40	5.81	0.40
Medical Equipment	2.07	1.07	(1.00)	6.13	6.73	0.60
Other	0.00	0.00	0.00	0.00	0.00	0.00
PMU	0.87	0.66	(0.21)	2.13	2.13	0.00
Contingency	0.00	0.00	0.00	0.00	0.00	0.00
Planned slippage	0.00	0.00	0.00	0.00	0.00	0.00
Total	6.85	4.02	(2.84)	16.60	17.93	1.33
Funding sources						
Secured loans	0.00	0.00	0.00	0.00	0.00	0.00
Unsecured loans	0.00	0.00	0.00	0.00	0.00	0.00
Strategic Estates P'shi	0.00	0.00	0.00	0.00	0.00	0.00
Finance Leases	1.69	0.41	(1.27)	6.51	7.05	0.54
PDC	0.38	0.00	(0.38)	0.93	1.18	0.25
Charitable Funds	0.50	0.05	(0.45)	1.00	1.00	0.00
Disposal of assets	0.00	0.00	0.00	0.00	0.00	0.00
Other Internal cash resources	4.28	3.60	(0.68)	8.16	8.45	0.29
Total	6.85	4.02	(2.84)	16.60	17.93	1.33

Key Points

- In April 2019 the Trust submitted a capital plan of £19.0m. In May 2019 the Trust submitted a revised capital plan of £21.6m.
- In July 2019, NHSI requested that the Trust propose a reduced capital plan - this was proposed at £16.6m. However, following an increase in national funding, NHSI abandoned this request. The Trust's official capital plan therefore remains at £21.6m but the Trust had adopted the £16.6m proposal as its capital budget.
- At 30th September, year to date capital expenditure is £4.0m; £2.8m underspent to budget (see table) and £3.3m underspent to Plan.
- The capital forecast of £17.9m is £1.3m adverse to budget - principally due to reductions in anticipated slippage and procurement savings.

Activity

setting	Annual Plan	YTD Plan	YTD Actual	Cumulative variance Current Month	Cumulative variance Previous Month	% variance to plan
Day Case	34,014	17,605	17,451	-154	-306	-1%
Elective	3,640	1,875	1,755	-120	-66	-6%
Non-Elective Emergency	29,367	14,643	13,643	-1,000	-762	-7%
Non-Elective Non-Emergency	2,815	1,478	1,301	-177	-86	-12%
Non-Elective CDU	4,605	2,354	2,241	-113	-71	-5%
Non-Elective AMU	3,859	1,885	2,383	498	339	26%
TOTAL APC	**78,300**	**39,840**	**38,774**	**-1,066**	**-952**	-3%
New	107,867	54,325	53,533	-792	-832	-1%
F-Up	260,030	131,616	132,309	693	-465	1%
TOTAL OPA	**367,897**	**185,941**	**185,842**	-99	**-1,297**	0%
A&E	79,199	42,063	41,841	-222	54	-1%

Activity variances to plan - Month 6

Activity variances for M6 against the contract activity plan are shown in the table opposite. In M6, Day Case and Elective activity is behind 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 Urology where activity is 347 attendances below plan (in PBR terms £150K).

Within Outpatients, the specialties with the greatest variances are: Respiratory Medicine which is 271 New attendances above plan (in PBR terms £66k) and Colorectal Surgery which is 223 attendances above plan (in PBR terms £27k). Vascular Surgery is 457 attendances below plan (in PBR terms £-61k), and Ophthalmology is 484 attendances below plan (in PBR terms £-62k).

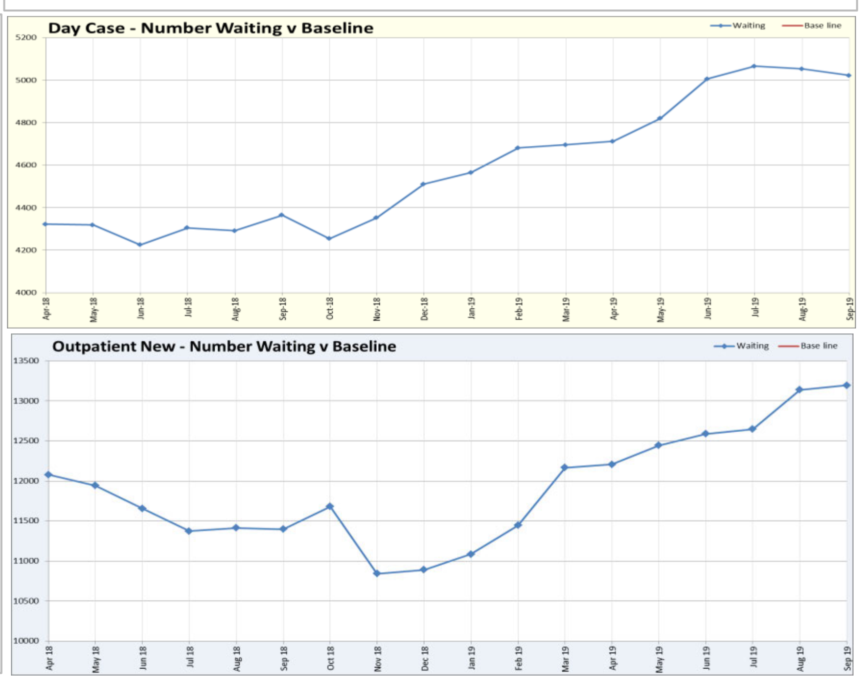
For Follow Ups, Gynaecology is 527 attendances above plan (in PBR terms £29K). Audiology is 588 attendances below plan (in PBR terms -£54k).

The committee is asked to note: Month 6 Access standards

Plans for 19/20 and beyond require overall increase in activity run rate to deliver waiting time 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 and Daycase admissions since November 2018. 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.

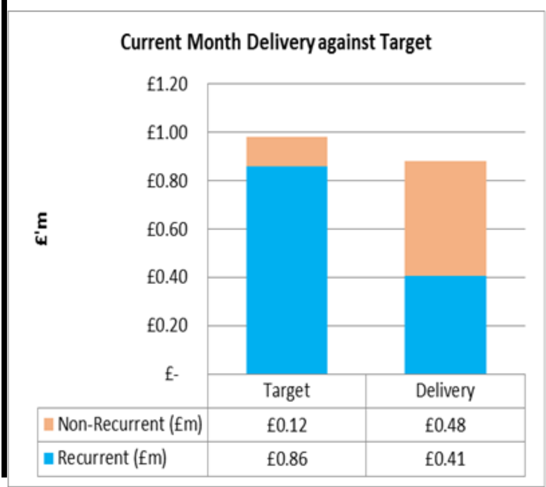
We have reported that we will be behind our trajectory for clearing patients waiting > 52 weeks RTT for October and November, however we we continue to forecast clearance to Zero by 31st of March 2020.

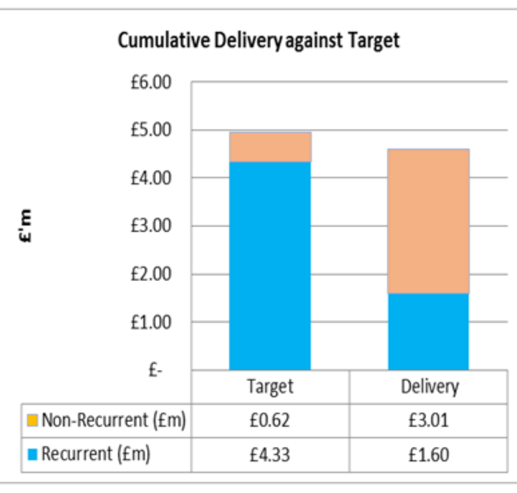
The RTT risk and Assurance group are maintaining the elective waiting time (RTT and cancer) performance oversight at individual team level.
It is noted that new referrals for initial outpatient assessment over a rolling 12 month period are remaining at historical levels with 1% growth, however there is a large increase in the number referred on a urgent two week wait cancer pathway of 10% on the rolling year to date.



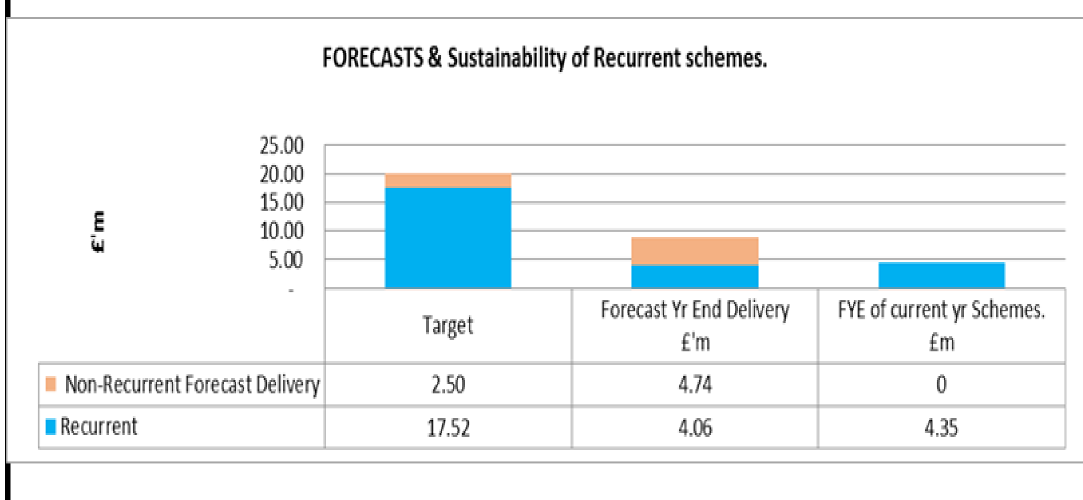
CIP Delivery: Current Month, Cumulative & Forecast

a) Current Month and Cumulative 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: £0.3m shortfall

The current month position shows CIP delivery of £0.9m, a £0.1m shortfall against £1.0m target.

The year to date CIP achieved is £4.6m, a cumulative shortfall of £0.3m against a £4.9m target.

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

Target:	**£20.0m**
Year End Forecast Delivery:	**£ 8.8m**
Shortfall:	**£11.2m**

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

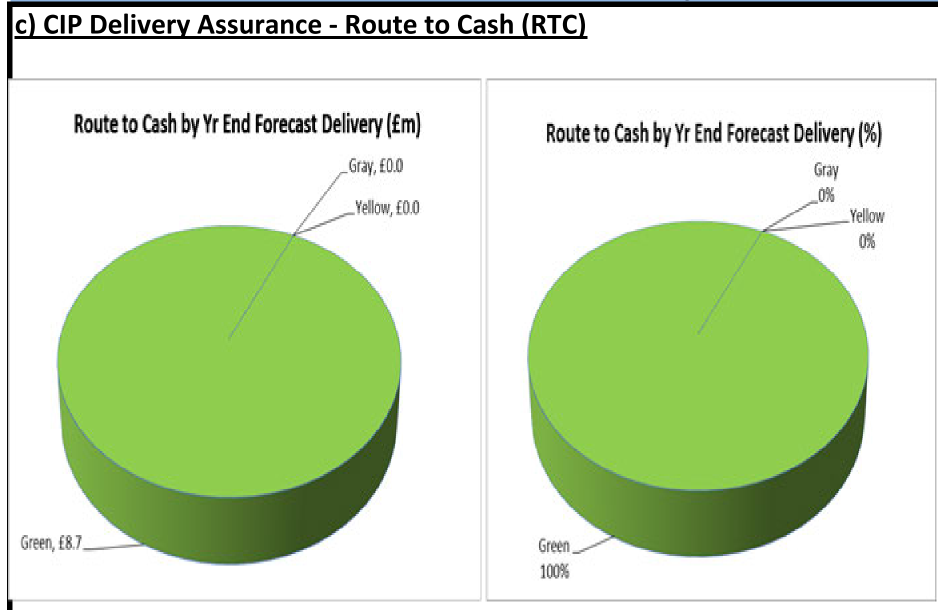
A total of £8.8m of Forecast Out-Turn delivery has been identified, resulting in a £11.2m shortfall FOT position.

The Full Year Effect forecast delivery for 19/20 projects is £4.4m against the £17.5m recurrent Target.

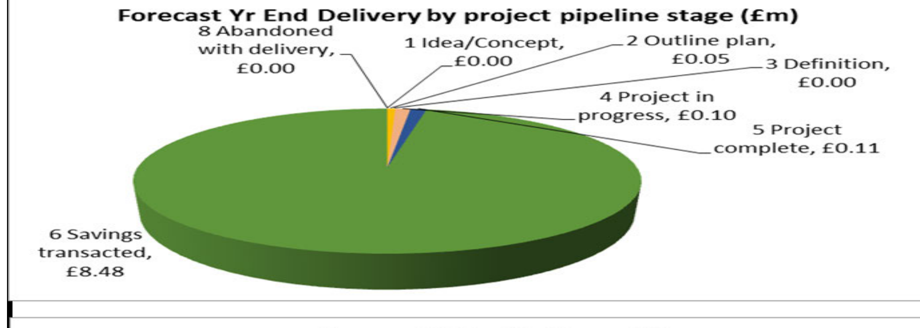
Risk: Presumes all schemes listed, deliver. (See Delivery Assurance).

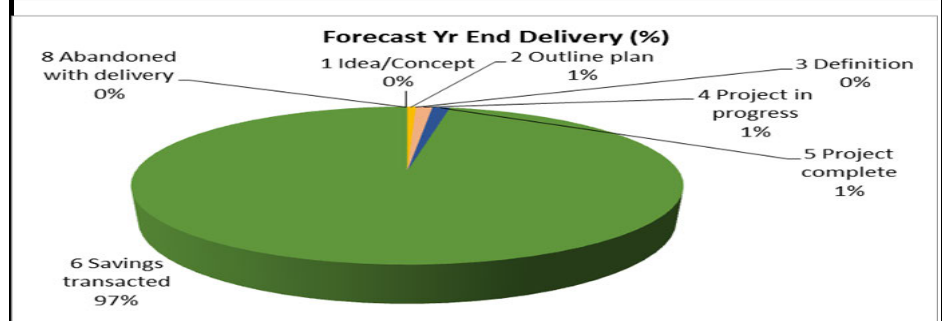
CIP- Delivery Assurance - Year end delivery forecast

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

The Forecast outturn delivery value has reduced significantly this month following the conclusion of the deliverability peer review of the Trust's Transformational schemes.

We had previously categorised the £6m relating to these projects as "Grey", meaning the Route to cash could not ascertained.

Subsequent to this review, we have appointed a Financial Recovery Director.

(d) CIP Delivery Assurance:- Pipeline stage

Of the projects comprising the £8.8m forecast outturn delivery:

£8.59m (98%) of projects are either delivering savings or are complete, pending savings delivery.

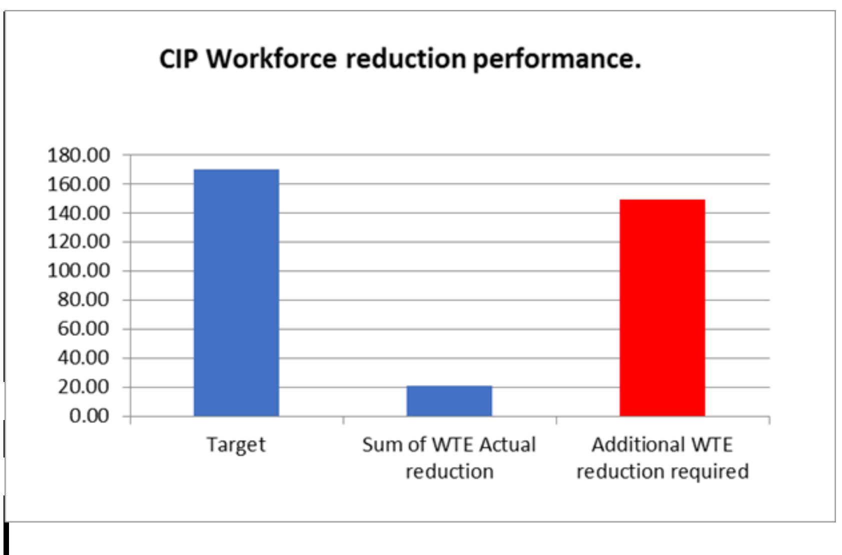
£0.10m (1%) relates to schemes which are in progress.

£0.05m (1%) relates to schemes where definitions are complete and validated or outline plans are validated.

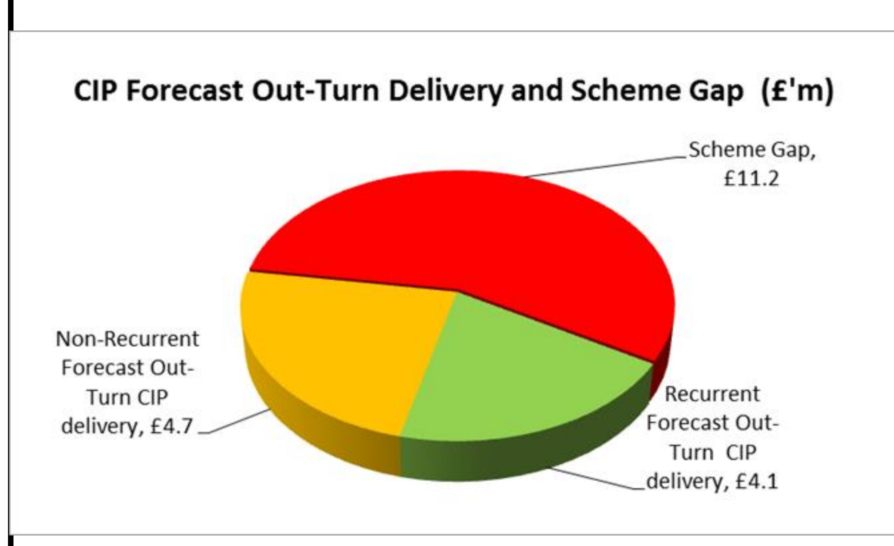
£0.00m (0%) relates to schemes which are in Idea/Concept stage.

CIP- Delivery Assurance - Year end delivery forecast

e) CIP Workforce reduction against plan



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



e) CIP Workforce forecast reduction

Based on the latest forecast we are significantly behind our workforce reduction target.

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

Assuming all schems deliver against the current £8.8m Forecast outturn, we would need to identify a further £11.2m of projects to deliver the Trust's current year CIP target.

QUALITY LOCAL FRAMEWORK

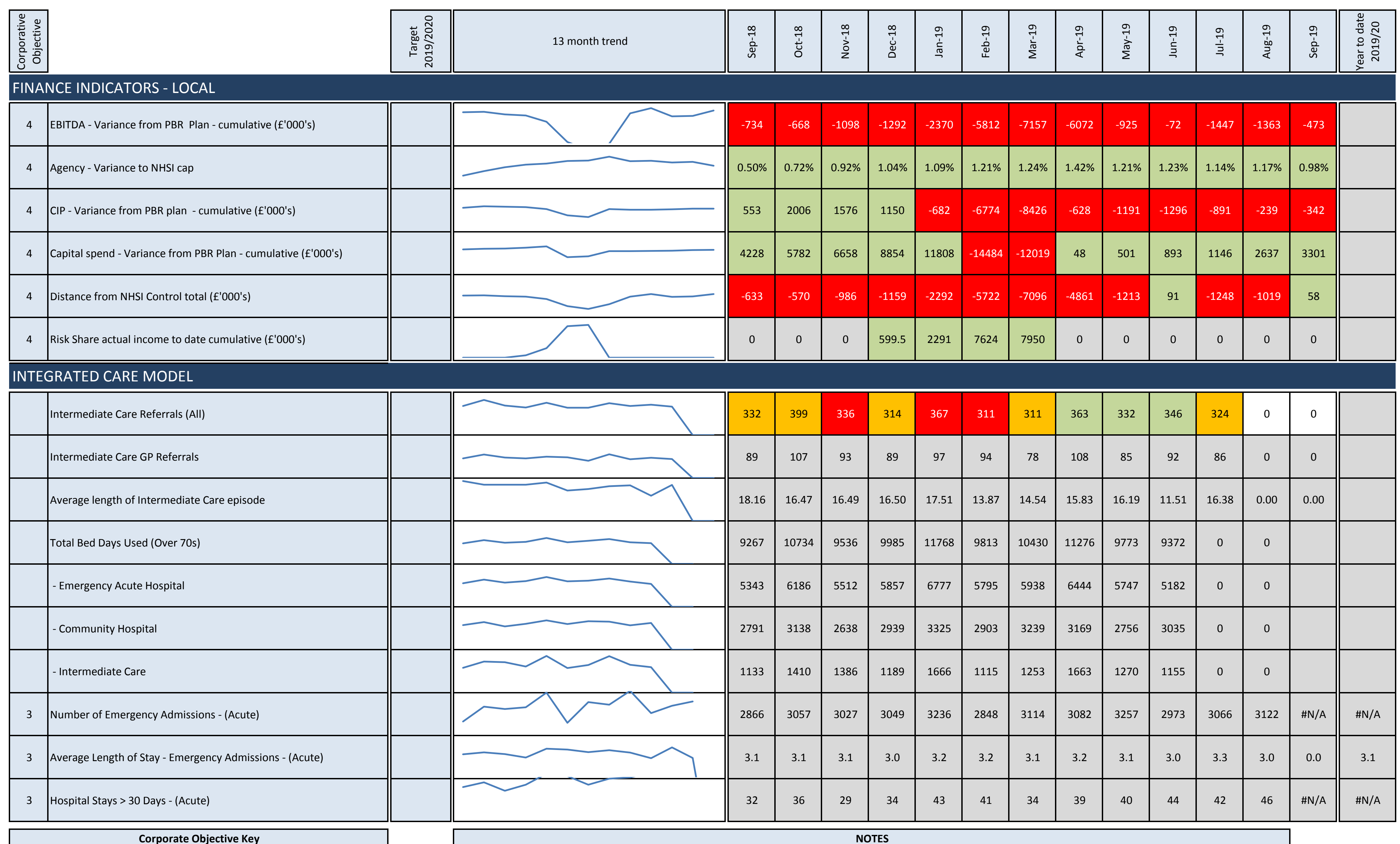
Corporative Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
1	Safety Thermometer - % New Harm Free	>95%		97.1%	97.5%	96.1%	96.9%	97.8%	96.4%	95.9%	96.3%	95.4%	96.8%	96.8%	97.3%	96.5%	96.5%
1	Reported Incidents - Severe *	<6		0	1	1	0	2	0	1	0	0	3	2	2	4	11
1	Reported Incidents - Deaths *	0		0	1	1	0	0	0	0	0	2	0	0	0	1	3
1	Medication errors resulting in moderate harm	0		0	0	0	0	0	0	0	2	1	0	0	1	0	4
1	Avoidable New Pressure Ulcers - Category 3 + 4 * (1 month in arrears)	9 (full year)		1	0	0	1	2	0	1	2	0	0	0	0		2
1	Never Events	0		0	0	1	0	0	0	0	0	1	0	0	0	0	1
1	Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	0		8	3	5	2	3	5	5	2	7	4	2	5	2	22
1	QUEST (Quality Effectiveness Safety Trigger Tool) - Red Rated Areas / Teams	0		0	0	0	0	0	0	0	0	0	0	2	2	2	6
1	Formal Complaints - Number Received *	<60		25	15	26	30	17	19	22	21	32	13	20	23	33	138
1	VTE - Risk assessment on admission - (Acute)	>95%		92.6%	91.6%	93.1%	92.0%	92.2%	89.4%	90.5%	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	90.5%
1	VTE - Risk assessment on admission - (Community)	>95%		100.0%	97.9%	96.8%	97.9%	97.7%	97.8%	91.5%	98.9%	100.0%	97.5%	97.8%	98.7%	98.8%	98.6%
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears	<100%		101.6%	99.3%	98.4%	89.4%	87.1%	94.8%	89.5%	98.4%	111.3%					94.7%
1	Safer Staffing - ICO - Daytime (registered nurses / midwives)	90%-110%		103.6%	105.7%	104.0%	102.4%	103.8%	104.0%	104.0%	98.5%	91.7%	90.9%	90.1%	93.9%	93.9%	93.1%
1	Safer Staffing - ICO - Nightime (registered nurses / midwives)	90%-110%		105.0%	106.7%	103.2%	101.4%	102.1%	103.2%	103.2%	98.5%	91.8%	93.7%	92.8%	100.3%	100.3%	96.2%
1	Infection Control - Bed Closures - (Acute) *	<100		18	58	16	18	42	66	0	4	42	12	36	63	34	191
1	Hand Hygiene	>95%		95%	96%	92%	95%	94%	96%	90%	92%	88%	94%	94%	95%	96%	93%
1	Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		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%		95.1%	93.5%	83.3%	85.5%	82.9%	89.1%	79.7%	93.8%	75.5%	79.1%	86.8%	80.4%	96.4%	85.2%
1	Stroke - SSNAP level	No target		B	B	B	B	C	C	C							#N/A
1	Follow ups 6 weeks past to be seen date (excluding Audiology)	3500		6630	6020	5698	6062	5378	5437	5899	6240	6459	6803	6906	7393	6793	6793

Corporative Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
WORKFORCE MANAGEMENT FRAMEWORK																	
2	Staff sickness / Absence (1 month arrears) Rolling 12 months	<3.8%		4.14%	4.44%	4.31%	4.32%	4.62%	4.92%	4.21%	4.20%	4.21%	4.25%	4.30%	4.29%		4.29%
2	Appraisal Completeness	>90%		81.12%	80.45%	78.97%	79.31%	78.31%	79.55%	78.93%	80.00%	80.00%	79.00%	80.00%	78.00%	78.00%	78.00%
2	Mandatory Training Compliance	>85%		88.03%	88.40%	89.88%	90.81%	90.73%	91.21%	91.36%	89.52%	90.20%	90.88%	90.32%	90.80%	90.25%	90.25%
2	Turnover (exc Jnr Docs) Rolling 12 months	10% - 14%		10.58%	10.18%	9.96%	9.94%	10.33%	9.55%	9.67%	10.68%	10.69%	10.75%	11.21%	11.23%		n/a

Corporative Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges (Community) *	16/17 Avg 315		272	226	247	375	344	266	278	370	356	419	508	562	392	2607
1	Number of Delayed Transfer of Care (Acute)	16/17 Avg 64		164	261	256	171	246	176	137	149	185	97	101	112	189	833
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		73.5%	74.1%	74.5%	74.7%	74.8%	75.6%	76.1%	76.4%	77.0%	74.6%	77.0%	72.5%	71.1%	72.5%
3	Clients receiving Self Directed Care	>90%		93.0%	92.8%	92.0%	92.1%	91.4%	90.7%	91.7%	91.1%	90.8%	90.3%	90.3%	90.1%	89.6%	90.1%
2	Carers Assessments Completed year to date	40% (Year end)		13.3%	16.3%	19.9%	22.1%	23.7%	26.3%	29.3%	3.6%	7.8%	13.2%	18.6%	23.2%	26.7%	23.2%
	Carers Assessment trajectory			18.0%	21.0%	24.0%	27.0%	30.0%	33.0%	36.0%	3.0%	6.0%	9.0%	12.0%	15.0%	18.0%	18.0%
3	Number of Permanent Care Home Placements	<=617 (Year end)		619	629	633	627	615	615	605	602	619	631	629	634	648	648
	Number of Permanent Care Home Placements trajectory			630	630	630	630	630	630	630	600	600	600	600	600	600	600
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		170	146	148	172	170	186		170	186	201	228	219		228
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET		138			192			300			54			0	
3	Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	NONE SET		7.1%			5.4%			4.9%			5.6%			0.0%	
1	Safeguarding Adults - % of high risk concerns where immediate action was taken to safeguard the individual [NEW]	100%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Bed Occupancy	80% - 90%		90.7%	92.7%	92.5%	90.7%	94.3%	94.7%	92.8%	93.9%	91.4%	90.5%	94.0%	95.3%	95.4%	95.3%
1	CAMHS - % of patients waiting under 18 weeks at month end	>92%		86.2%	91.9%	90.0%	93.7%	89.4%	90.8%	90.3%	87.6%	83.9%	80.6%	82.5%	85.0%	90.5%	85.0%
1	DOLS (Domestic) - Open applications at snapshot	NONE SET							485	474	532	550	514	567	563	569	563
1	Intermediate Care - No. urgent referrals	113		162	182	182	157	189	156	164	184	189	178	186	174	173	1084
1	Community Hospital - Admissions (non-stroke)	18/19 profile (+/- 10%)		238	259	256	236	279	222	257	258	249	218	195	202	202	1324

Corporative Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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%		83.8%	85.1%	82.2%	87.6%	76.4%	79.8%	81.0%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	81.4%
1	Referral to treatment - % Incomplete pathways <18 wks	>92%		81.0%	82.4%	82.7%	81.8%	82.0%	81.3%	81.3%	80.7%	81.9%	81.5%	80.4%	80.2%	80.4%	80.4%
	RTT Trajectory			82.7%	82.7%	82.8%	82.8%	82.7%	82.6%	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%
1	Cancer - 62-day wait for first treatment - 2ww referral	>85%		85.5%	74.0%	80.1%	80.6%	74.5%	69.6%	73.7%	80.2%	86.8%	79.2%	84.2%	77.4%	77.7%	80.8%
1	Diagnostic tests longer than the 6 week standard	<1%		7.7%	9.8%	6.1%	9.8%	12.0%	10.7%	10.1%	13.7%	12.1%	11.7%	13.6%	14.9%	15.7%	13.5%
1	Dementia - Find - monthly report	>90%		86.0%	90.9%	97.1%	96.3%	97.2%	86.3%	89.4%	96.1%	88.3%	93.3%	98.8%	93.4%	90.5%	93.5%
LOCAL PERFORMANCE FRAMEWORK 1																	
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<17 (year)		0	0	1	2	1	1	1	4	4	2	4	3	2	19
1	Cancer - Two week wait from referral to date 1st seen	>93%		79.5%	81.5%	80.7%	80.1%	77.9%	80.1%	79.9%	53.4%	77.5%	69.5%	83.4%	83.5%	88.4%	75.9%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		98.8%	96.0%	88.3%	97.8%	94.4%	61.6%	38.8%	50.7%	97.7%	98.9%	98.9%	100.0%	94.7%	86.1%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		97.7%	95.2%	99.5%	98.2%	96.5%	98.7%	96.2%	96.7%	99.5%	97.3%	97.1%	94.8%	98.56%	97.3%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	98.8%	98.4%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		95.7%	94.3%	100.0%	100.0%	93.3%	97.1%	100.0%	98.6%	96.9%	100.0%	95.9%	98.4%	96.1%	97.5%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		100.0%	100.0%	96.6%	100.0%	93.3%	96.8%	96.0%	94.7%	97.1%	96.8%	100.0%	94.1%	93.5%	96.2%
1	Cancer - 62-day wait for first treatment - screening	>90%		92.9%	91.7%	90.9%	92.9%	88.9%	100.0%	70.0%	93.3%	90.9%	92.9%	93.8%	100.0%	100.0%	95.3%
1	Cancer - Patient waiting longer than 104 days from 2ww				71	47	62	52	34	37	33	41	34	28	31	36	36
1	RTT 52 week wait incomplete pathway	0		87	72	66	74	91	92	79	71	60	83	84	105	89	89
1	Mixed sex accomodation breaches of standard	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	On the day cancellations for elective operations	<0.8%		1.2%	1.8%	1.6%	2.3%	1.5%	1.4%	1.2%	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.4%
1	Cancelled patients not treated within 28 days of cancellation *	0		1	1	9	17	11	12	6	3	3	6	19	9	8	48
1	Number of standed patients >7 days (daily average)			115	114	116	122	126	134	132	134	131	126	125	128	132	
	Number of extended stay patients >21 days (daily average)			24	26	26	28	28	31	27	32	30	27	30	29	36	

Corporative Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
LOCAL PERFORMANCE FRAMEWORK 2																	
1	Ambulance handover delays > 30 minutes	Trajectory		144	204	143	84	251	156	198	148	61	83	81	137	90	600
1	Ambulance handover delays > 60 minutes	0		10	19	9	4	23	8	9	13	11	4	5	12	2	47
1	A&E - patients seen within 4 hours DGH only	>95%		75.0%	77.9%	74.3%	82.5%	66.1%	70.8%	71.9%	68.5%	75.9%	69.9%	74.8%	67.5%	70.1%	71.1%
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		4	3	2	4	7	3	3	11	0	0	0	0	0	11
1	Number of Clostridium Difficile cases - (Acute) *	<3		2	0	1	2	2	1	1	2	1	4	0	0		7
1	Number of Clostridium Difficile cases - (Community)	0		0	0	0	0	0	0	0	3	4	1	1	0		9
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		66.2%	72.7%	72.7%	62.1%	64.9%	64.0%	63.6%	64.7%	63.9%	62.8%	67.3%	66.5%	67.4%	65.4%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		34.9%	35.4%	34.5%	29.5%	34.6%	27.9%	31.6%	29.1%	23.9%	30.0%	39.9%	38.2%	35.0%	32.5%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		68.2%	77.3%	81.8%	77.3%	90.9%	77.3%	81.8%	86.4%	77.3%	86.4%	86.4%	81.8%	68.2%	81.1%
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		4	4	4	3	3	3	3	3	3	2	2	3	4	4
	Plan			4	4	4	4	4	4	4	3	3	2	2	3	4	4
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	3	2	4	4	4	4	4	4	4
4	I&E Margin Variance from Plan			2	2	2	2	2	3	3	4	3	1	2	2	1	1
4	Variance from agency ceiling	1		3	3	3	3	3	4	4	4	4	4	4	4	4	4
	Plan			2	2	2	2	2	2	1	2	2	2	2	2	2	2
4	Overall Use of Resources Rating			3	3	3	3	3	4	4	4	4	3	3	3	3	3



Corporate Objective		Target 2019/2020	13 month trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year to date 2019/20
FINANCE INDICATORS - LOCAL																	
4	EBITDA - Variance from PBR Plan - cumulative (£'000's)			-734	-668	-1098	-1292	-2370	-5812	-7157	-6072	-925	-72	-1447	-1363	-473	
4	Agency - Variance to NHSI cap			0.50%	0.72%	0.92%	1.04%	1.09%	1.21%	1.24%	1.42%	1.21%	1.23%	1.14%	1.17%	0.98%	
4	CIP - Variance from PBR plan - cumulative (£'000's)			553	2006	1576	1150	-682	-6774	-8426	-628	-1191	-1296	-891	-239	-342	
4	Capital spend - Variance from PBR Plan - cumulative (£'000's)			4228	5782	6658	8854	11808	-14484	-12019	48	501	893	1146	2637	3301	
4	Distance from NHSI Control total (£'000's)			-633	-570	-986	-1159	-2292	-5722	-7096	-4861	-1213	91	-1248	-1019	58	
4	Risk Share actual income to date cumulative (£'000's)			0	0	0	599.5	2291	7624	7950	0	0	0	0	0	0	
INTEGRATED CARE MODEL																	
	Intermediate Care Referrals (All)			332	399	336	314	367	311	311	363	332	346	324	0	0	
	Intermediate Care GP Referrals			89	107	93	89	97	94	78	108	85	92	86	0	0	
	Average length of Intermediate Care episode			18.16	16.47	16.49	16.50	17.51	13.87	14.54	15.83	16.19	11.51	16.38	0.00	0.00	
	Total Bed Days Used (Over 70s)			9267	10734	9536	9985	11768	9813	10430	11276	9773	9372	0	0		
	- Emergency Acute Hospital			5343	6186	5512	5857	6777	5795	5938	6444	5747	5182	0	0		
	- Community Hospital			2791	3138	2638	2939	3325	2903	3239	3169	2756	3035	0	0		
	- Intermediate Care			1133	1410	1386	1189	1666	1115	1253	1663	1270	1155	0	0		
3	Number of Emergency Admissions - (Acute)			2866	3057	3027	3049	3236	2848	3114	3082	3257	2973	3066	3122	#N/A	#N/A
3	Average Length of Stay - Emergency Admissions - (Acute)			3.1	3.1	3.1	3.0	3.2	3.2	3.1	3.2	3.1	3.0	3.3	3.0	0.0	3.1
3	Hospital Stays > 30 Days - (Acute)			32	36	29	34	43	41	34	39	40	44	42	46	#N/A	#N/A

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

NOTES

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

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

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Operational Accountability and Governance Framework		**Meeting date:** 6 November 2019	
Report sponsor	Company Secretary		
Report author	Head of Business Development		
Report provenance	Approved by executive directors (and also shared with relevant Board sub-committees for information and feedback)		
Purpose of the report and key issues for consideration/decision	The report is presented in response to the Board's request for an update on the implementation of the Integrated Service Unit's operational and accountability governance framework, implemented in April 2019. The new structure has enabled a review of information reporting processes from 'front line services to Board'. Highlighted to the Board is the intention to shorten the reporting timeframe so that meetings of the Board will take place in the last week of the reporting month (ie one week earlier than present).		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☒
Recommendation	The Board is asked to: (i) receive and note the operational accountability and governance framework update; and, (ii) approve the proposed revision of corporate meeting dates (including the Board of Directors) to be implemented from April 2020.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

<table>
<tr><td rowspan="3">External standards affected by this report and associated risks</td><td>Care Quality Commission</td><td>X</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td></td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td></td><td>National policy/guidance</td><td></td></tr>
</table>

1. Introduction

1.1 The Trust implemented its new local-population-based operational structure in April 2019. The approach is aligned with the Trust's vision of holistic integrated services led by self-managing teams focussed on local communities. The attached paper describes the operational accountability and governance framework for the new shape of the organisation, including the monthly reporting cycle for:

- Quality
- Finance and performance
- Workforce

1.2 Some of the proposals within the paper (specifically those relating to the monthly meeting schedule and dashboard reports) will take time to fully implement due to:

- Interdependence of operational meetings with other elements of the Trust's corporate governance framework (e.g. reporting to Board sub-committees)
- Resource and time required to redesign business information systems and processes around new reporting requirements (which is currently a time-intensive manual process)

1.3 With the Board's approval all elements of the operational accountability and governance framework that can be implemented immediately will be, indeed much of the described architecture is already in place. It is proposed that the target date for substantial revision of meeting schedules and ISU-focussed dashboards should be April 2020, in line with the proposed compression of wider Board reporting timelines.

1.4 The operational governance framework under which the Trust is now operating is unique in health and care services as far as we can tell. The Trust is an international pioneer in this way of organising its services, and as such will be seeking to refine and improve the framework based on feedback from all those involved over the coming months. This may follow further developments to the system and "Integrated Service Unit" architecture to ensure we continue to provide the most efficient and effective patient-focussed services possible.

2. Implications beyond the scope of this report

2.1 This governance framework is focussed on the operational management of our core business on a day-to-day basis as part of the Trust's wider corporate governance framework. There are inter-dependencies with other areas that are out of the scope of this report, but which are referenced within and will be developed in parallel with the operational framework. These include:

- Information and reporting of quality and safety, financial and people matters to Board committee's as well as the Trusts improvement/transformation reporting.
- Scope/terms of reference of relevant groups including Board sub-committees

- Scheduling of meetings, particularly in context of the ambition to compress the Trust's reporting timetable such that information is summarised more quickly and relevant groups (including Trust Board) have access to more contemporary information

3. Conclusion and recommendations

3.1 This paper (and earlier iterations) has been reviewed by key operational stakeholders and the executive team in the course of its development. It has also been submitted to the three relevant sub-committee meetings (finance, quality and people) for consideration and feedback.

3.2 The Board is asked to:

(i) receive and note the operational and accountability governance framework; and,
(ii) approve the proposed revision of corporate meeting dates (including the Board of Directors) effective from April 2020.

ICO Operational Accountability and Governance Framework

Overview / Briefing Paper

VERSION FOR TRUST BOARD (v07)

Date: 6 November 2019

Sponsor: Jane Downes, Company Secretary

Author: Chris Winfield, Head of Business Development

Contents

1 Introduction, definitions and scope 2

2 Operational structure summary 3

3 Purpose and operational accountability flow 4

4 System and integrated service unit (ISU) leadership 5

5 Delegation of authority 7

6 Meeting schedules (monthly cycle) 9

7 Reports and distribution 10

8 Meeting agendas, membership and papers 13

9 Terms of reference and template documents 15

10 Improvement governance structure 16

11 ICO corporate governance structure 17

12 ICO operational structure 18

1 INTRODUCTION, DEFINITIONS AND SCOPE

Introduction

This document provides an overview of the operational accountability and governance framework for Torbay and South Devon NHS Foundation Trust, the Integrated Care Organisation (ICO). This framework was enacted following the operational restructure towards a "system-based model" implemented in April 2019 and details the reporting structure from front-line services, through Integrated Service Units (ISUs) to Trust Board.

The Trust's ambition is to provide fully integrated services designed around individual and family needs by moving towards self-managing teams aligned with local communities. This operational accountability and governance framework presents a significant step towards this aim with a locality-focussed architecture including delegation of acute hospital services to local teams. On-going refinement of the structure alongside workforce, clinical pathway and cultural developments will enable greater autonomy and freedom for local services within safe and appropriate boundaries in the coming months.

What does "governance" mean within the NHS?

The Audit Commission (2002) defined governance within the NHS as: "The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community."

…and "operational governance"?

The operational accountability and governance framework sets out the structures and processes for holding front-line services to account and providing assurance to the Trust Board. This includes reporting on **quality**, **performance, finances** and **workforce** for these services, understanding issues and risks, and ensuring that appropriate mitigating actions and plans are in place to address them.

How does this fit with other parts of the management structure?

This operational accountability and governance framework sits within the Trust's wider corporate governance framework, and operates in parallel with other formal governance structures such as clinical governance, information governance, the Scheme of Delegation and so on.

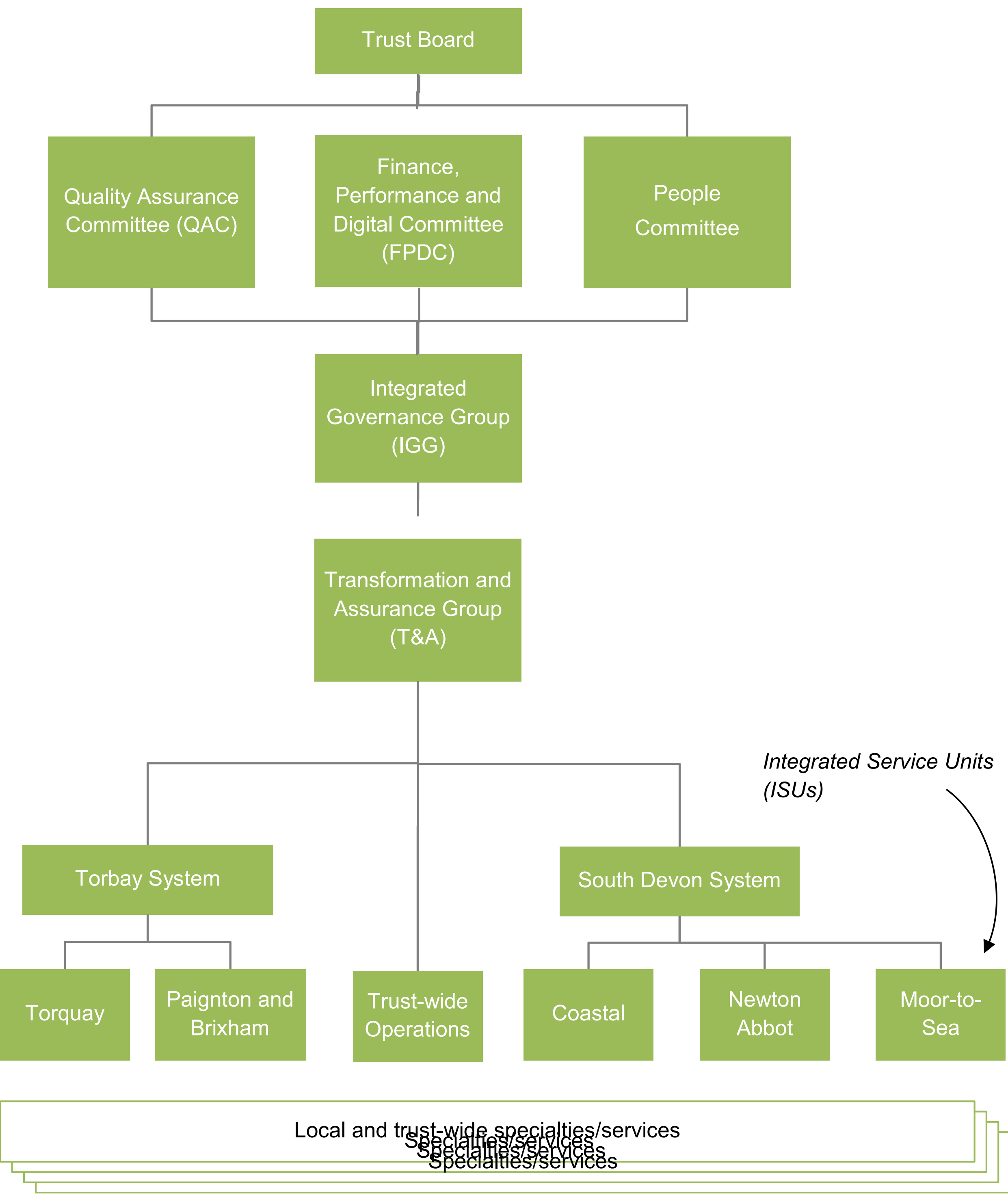
The Trust's management structure also includes other elements that bring leadership, change support, cultural development, analysis, and other important functions to a smooth operating, well performing and improving organisation. Examples of these functions which are outside of the formal accountability structure for the ISUs, but bring value beyond accountability include:

- Infection prevention and control group
- Improvement and Transformation support services
- IT Clinical User Group
- …and others

The wider corporate governance framework and other structures that are not part of the formal accountability framework for the ISUs are not discussed in detail in this document.

2 OPERATIONAL STRUCTURE SUMMARY

The following chart shows the main elements of the organisational structure that relate to operational delivery of front-line health and care services. For purposes of clarity, "back office" support functions and other supporting elements of the organisational infrastructure are not shown.

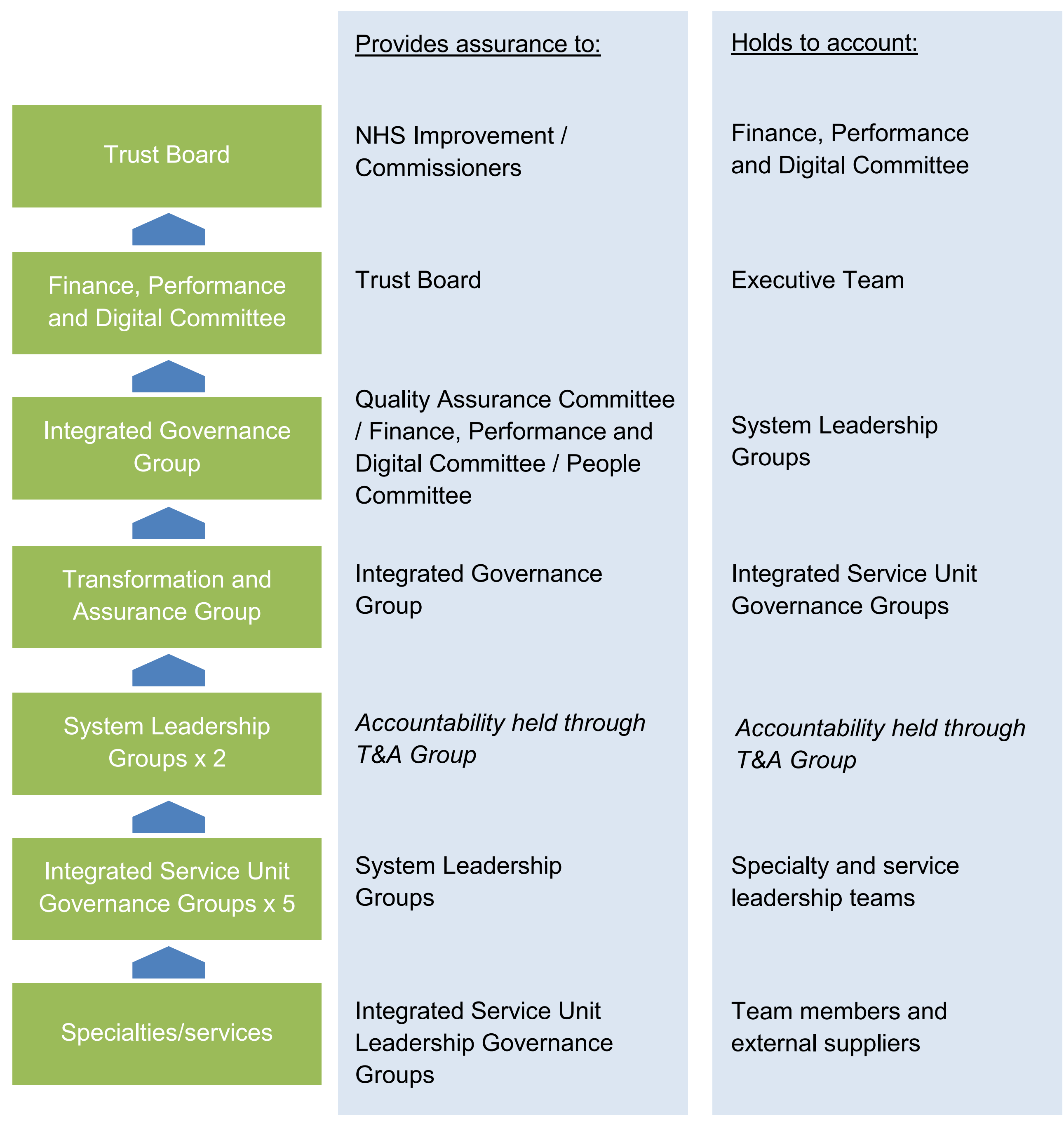


3 PURPOSE AND OPERATIONAL ACCOUNTABILITY FLOW

The primary purpose for each of the formal operational groups is to hold to account the groups and services reporting into it, while providing assurance to the group it reports into.

The following chart focuses on the formal accountability flow from front-line to Board, illustrating the "holding to account" and "providing assurance" relationships throughout.

Many of the groups will perform other functions (e.g. team management/approving business cases/etc.) which are set out in their terms of reference, but for clarity are not detailed here.



4 SYSTEM AND INTEGRATED SERVICE UNIT (ISU) LEADERSHIP

Torbay System
System Director of Medicine System Director of Operations System Director of Nursing and Professional Practice
Torquay Integrated Service Unit *Including Children's services, public health and continuing health care*
Associate Director of Medicine Associate Director of Operations Associate Director of Nursing and Professional Practice Associate Director of Midwifery and Professional Practice
Paignton and Brixham Integrated Service Unit *Including long term conditions and cancer services*
Associate Director of Medicine Associate Director of Operations Associate Director of Nursing and Professional Practice

See overleaf for South Devon System.

South Devon System
System Director of Medicine System Director of Operations System Director of Nursing and Professional Practice
Coastal Integrated Service Unit *Including planned care*
Associate Director of Medicine Associate Director of Operations Associate Director of Nursing and Professional Practice
Newton Abbot Integrated Service Unit Including urgent and emergency care
Associate Director of Medicine Associate Director of Operations Associate Director of Nursing and Professional Practice
Moor-to-Sea Integrated Service Unit Including healthcare of the older person, stroke and discharge hub
Associate Director of Medicine Associate Director of Operations Associate Director of Nursing and Professional Practice

5 DELEGATION OF AUTHORITY

The following table sets out key responsibilities and powers that are delegated (ultimately from the Board) to each layer of the structure, highlighting matters that need to be escalated to the level above. This illustrates the processes and policies set out in the Trust's scheme of delegation and Standing Financial Instructions (SFIs). Detail will be expanded in the terms of reference for each group.

* denotes functions that are anticipated to be delegated presently, but which are currently controlled centrally due to performance and financial challenges.

Layer	Role	Delegated operational authority	For escalation
Local services/ teams	To deliver services to agreed specifications within available resources	• Interpret service specification to deliver agreed outcomes • Manage staff, including: ➢ Recruitment* ➢ Ensure team understands the service purpose and objectives ➢ Clarifying individual roles & responsibilities ➢ Day-to-day management ➢ Providing training and support ➢ Performance management Managing the budget*, including: ➢ Purchasing consumables ➢ Paying salaries ➢ Agreeing contracts with third parties (e.g. rent, placements, etc.) • Secure other resources and support as required* • Engage with relevant stakeholders (specifically service users and commissioners as a minimum) • Identify and manage risks in the course of providing services • Escalating relevant issues where required • Reporting in to ISU leads	• All incidents • Risks and issues scoring 12+ • Financial transactions according to SFIs • External reporting and information submissions

Layer	Role	Delegated operational authority	For escalation
Integrated Services Units (ISU)	To be responsible for the health and well-being for a geographically defined community as well as specified cross-system services	• Guiding and supporting local teams • Recruiting and supporting team/department leads * • Managing service performance* • Delivering high quality and efficient cross-system services • Ensuring right balance of standardisation and local adaptations to community needs • Reporting in to system leads • Review of external reports/information submissions *	• All Serious Untoward Events • Risks and issues scoring 12+ • Financial transactions according to SFIs
System Leadership Groups	To coordinate services across ISUs and provide strategic direction for developments	• Providing strategic insight and direction to ISUs • Managing performance of ISUs • Recruiting and supporting ISU leads • Ensuring right balance of standardisation and local adaptations to community needs • Reporting to Trust Board • Accountability for oversight of all external reporting and submissions • Accountability for oversight organisational performance and quality • Accountability to meet all regulatory and statutory functions	• All Serious Untoward Events • Risks and issues scoring 15+ • Financial transactions according to SFIs
Trust Board	To provide over-arching corporate leadership and ensure smooth running of operational and support services	• Providing strategic insight and direction to Systems • Establishing Trust vision, objectives and values • Oversight of organisational performance and quality • Accountability to meet all regulatory and statutory functions	• Major incidents • OPEL escalation • Financial transactions according to SFIs

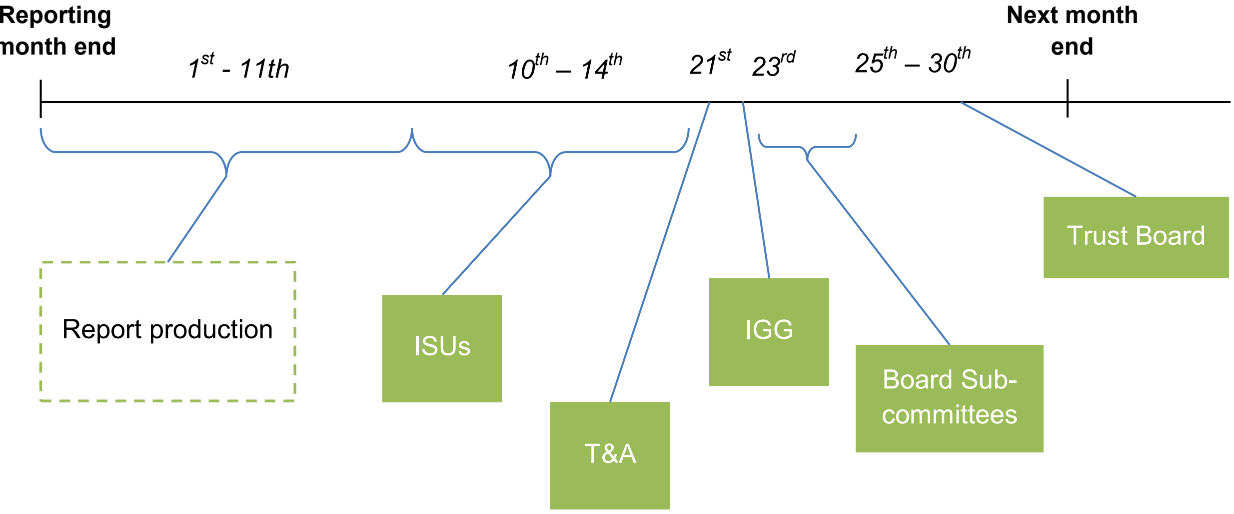
6 Meeting schedules (monthly cycle)

Normal schedule

The following table sets out the proposed timetable for regular monthly meetings:

	ISU	T&A (System level)	IGG	FPDC	Trust Board
Reporting dates	Finance reports (including WTE) ready by 8th working day of the month, with forecasts and dashboards including all other information ready by 11-14th of each month.				
Meeting schedule	Up to 7 days before T&A	Thursday before FPDC	Friday or Monday AM before FPDC	Week before Board	Last Wednesday of each month
Papers distribution	All agendas and papers to be distributed one week in advance of meetings, except for dashboards and highlight/escalation reports which should be provided at least 24 hours in advance.				

Therefore meetings in a typical month might take the following approximate form:



Notes:

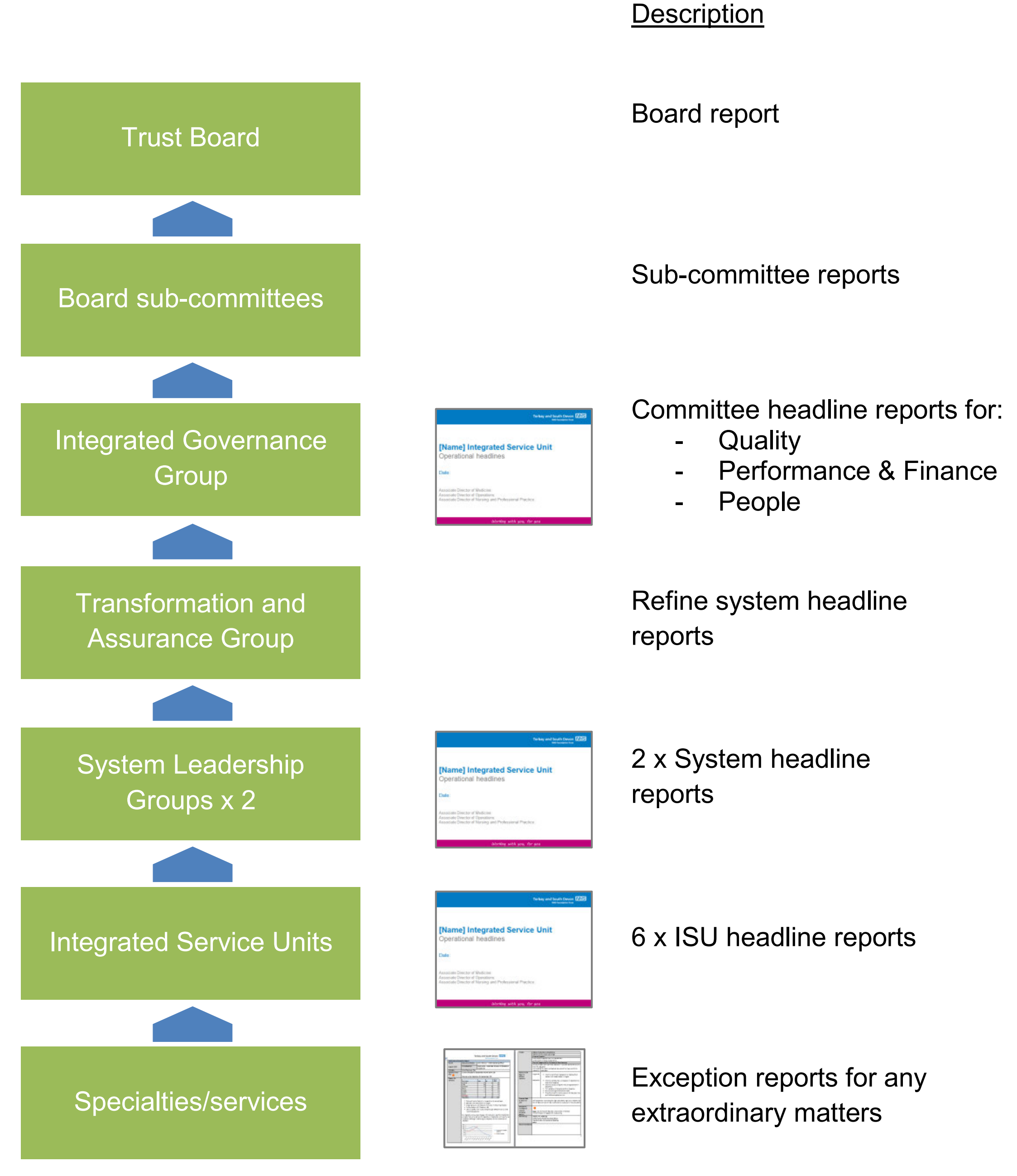
- Occasional changes are required to the regular schedule to account for calendar events (such as Christmas and bank holidays)
- Bringing the availability of dashboards closer to the start of the month (and thus providing more flexibility over meeting times) will rely on changes to business information systems and automation of what is currently a manual dashboard production process. This is discussed in the business information strategy and is the long-term goal for report production.
- It may take a number of weeks for the regular reporting and meeting cycle to fully embed, and some compromises have been required to meet clinical commitments in Autumn 2019. Special attention will be given to account for this in Transformation and Assurance meetings in the short term to ensure that relevant details from all ISUs are given sufficient attention.

7 Reports and distribution

Headline reports

The following chart illustrates the "headline reports" that are produced within the operational framework. These aim to summarise the most relevant information that needs sharing at each level, typically in bullet-point or brief narrative format, referring to measures/metrics where relevant. The reports are set out in powerpoint format as they typically provide a suitable outline for a presentation, complemented by reference to more detailed reports as required.

The exception to this is the "exception" reports which are typically prepared within individual teams, and which provide detailed analysis and plans in relation to individual operational issues that require escalation.



Detailed reports

This section describes the detailed reports to be distributed to each group in the operational framework. The first table ("Integrated dashboards") lists reports that are currently under development, but which will shortly be the primary source of information for all groups. Reports in the subsequent tables ("Quality" onwards) are all currently available.

Topic/report	Target ready date	ISU	T&A (System level)	IGG	Board Sub-committees
Integrated dashboards					
ISU level*	Apr 2020	Y	Y	N	N
System level*	Oct 2019	N	Y	Y	N
Trust level* (requires development)	Oct 2019	N	N	N	Y
Highlight reports (Brief summary including significant risks and issues alongside matters to escalate)	Oct 2019	Y	Y	Y	Y

** A working group has been established to design and develop dashboards for all levels. This work aims to be complete and automated by April 2020 with interim arrangements in place from October 2019.*

Topic/report	Target ready date	ISU	T&A (System level)	IGG	Board Sub-committees
Quality					
Umbrella dashboard (Locality quality report)	Now	Y	N	N	N
QIG dashboard	Now	Y	Y	Y	Y
Risk register (appropriate to each level)	Now	Y	Y	Y	Y
Infection prevention and control	Now	Y	Y	Y	Y
Quality accounts (quarterly)	Now	Y	Y	Y	Y
CQUINs (quarterly)	Now	Y	Y	Y	Y

Topic/report	Target ready date	ISU	T&A (System level)	IGG	Board Sub-committees
Performance					
Community hospital dashboard	Now	Y	N	N	N
ICO metrics	Now	Y	Y	N	N
Operational Locality Group (OLG) locality report	Now	Y	N	N	N
Social care programme board (Torbay only)	Now	Y	Y	N	N
NHSI metrics (service level breakdown)	Now	Y	Y	N	N
Delayed discharges	Now	Y	Y	N	N
Finance (£, CIP, WTEs)					
ISU finance report	Now	Y	Y	Y	Y
System finance report	Now	N	Y	Y	Y
Trust finance report	Now	N	N	Y	Y
Workforce (HR metrics)					
ISU workforce report	Now	Y	Y	Y	Y
System workforce report	Now	N	Y	Y	Y
Trust workforce report	Now	N	N	Y	Y

8 Meeting agendas, membership and papers

Standing agendas

In order to ensure there is clear line-of-sight from front-line service to board on the most critical matters, each of the formal governance groups will have a standing agenda to include the following items:

- Review of last meeting's minutes and actions
- Quality and safety
- Performance
- Finance (including cost improvement programme)
- Workforce
- Consideration of business cases where relevant
- Review of risk register and matters to escalate
- Any other business

The Integrated Governance Group and Transformation and Assurance Group will generally expect to be dealing with significant/strategic issues, only becoming involved with details where there is a significant risk or issue, or where matters relate to a corporate priority.

Membership and papers

Each group has membership defined according to the specific accountability requirements detailed earlier in the report alongside appropriate supporting roles. These are summarised below, and details may be found in each group's terms of reference.

It is important that each group has information to hand that is most relevant to the business it does. Reporting systems are being developed to meet these needs, and the following table sets out what is ultimately necessary at each level:

Group	Membership	Papers
Integrated Governance Group	• COO (Chair) Chair • Medical Director • Chief Nurse • Chief Finance Officer • Director of Transformation and Partnerships • Director of Workforce and OD • 2 x System leadership teams • Finance support • Performance support	• Previous meeting's minutes and actions • Reports described in the previous section of this document • Headline report detailing any exceptional risks and issues for each system, with a description of mitigating actions and plans as appropriate (template available) • Exception reports • Any business cases where relevant

Transformation and Assurance Group	• System Directors (Chair) • 2 x System leadership teams • 5 x ISU leadership teams • Finance support • Performance support • PMO support	• Previous meeting's minutes and actions • Reports described in the previous section of this document • Headline report detailing any exceptional risks and issues for each system, with a description of mitigating actions and plans as appropriate (template available) • Exception reports • Transformation progress reports including risk/issues register • Any business cases where relevant
System Leadership Teams x 2	• System Director (Chair) • System leadership Team • ISU leadership teams • Finance support • Performance support • PMO support	• Previous meeting's minutes and actions • Reports described in the previous section of this document • Headline report detailing any exceptional risks and issues for each system, with a description of mitigating actions and plans as appropriate (template available) • Exception reports • Transformation progress reports including risk/issues register • Any business cases where relevant
Integrated Service Units (ISUs) x 6	• ISU leadership team • Finance support • Performance support • PMO support	• Previous meeting's minutes and actions • Reports described in the previous section of this document • Headline report detailing any exceptional risks and issues for each system, with a description of mitigating actions and plans as appropriate (template available) • Exception reports • Transformation progress reports including risk/issues register • Any business cases where relevant

9 TERMS OF REFERENCE AND TEMPLATE DOCUMENTS

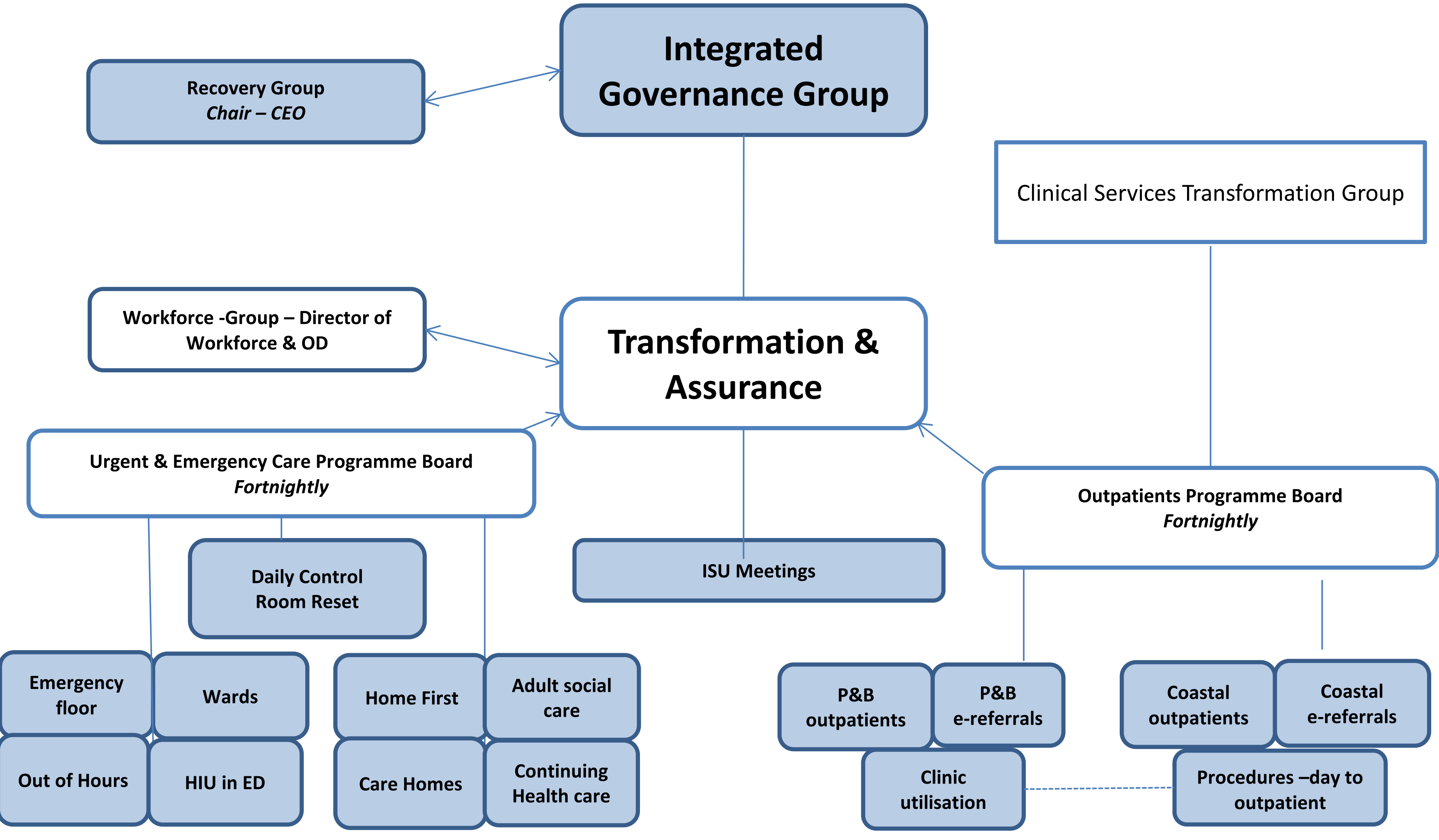
The terms of reference for all groups within the operational accountability framework are included within that of the Integrated Governance Group.

The following documents are available for review on request alongside this briefing paper:

- Terms of reference for the IGG (including T&A, ISUs and Trust-wide operations)
- A template headline report for presenting a monthly snapshot position at each level for submission to the level above.
- A template exception report, one of which should be completed each month for any operational matters that are materially outside of expected performance

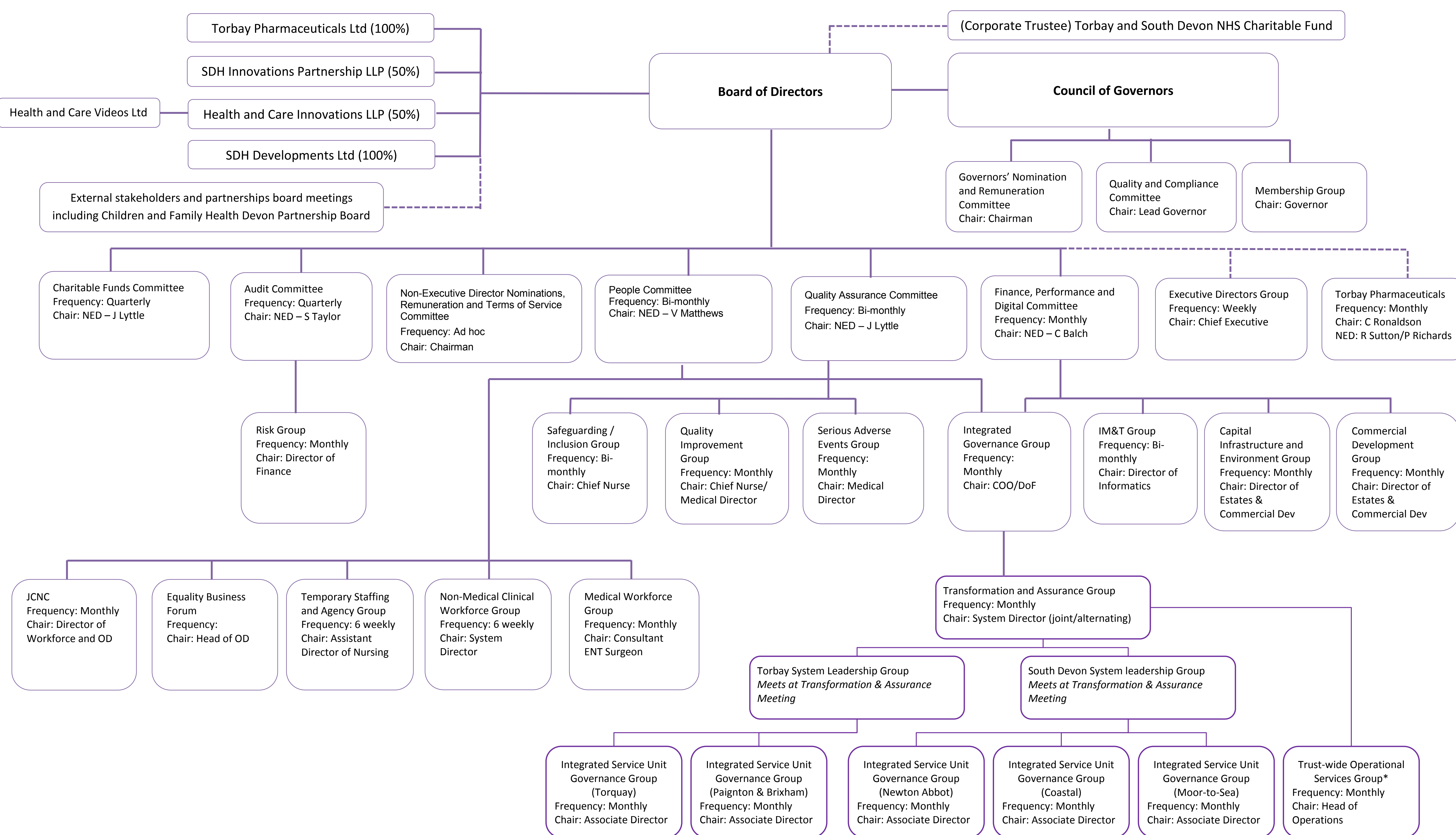
10 IMPROVEMENT GOVERNANCE STRUCTURE

The following chart describes the improvement governance structure as at October 2019. This is not part of the operational governance framework, but works closely with the IPG, T&A and ISU groups as shown below.



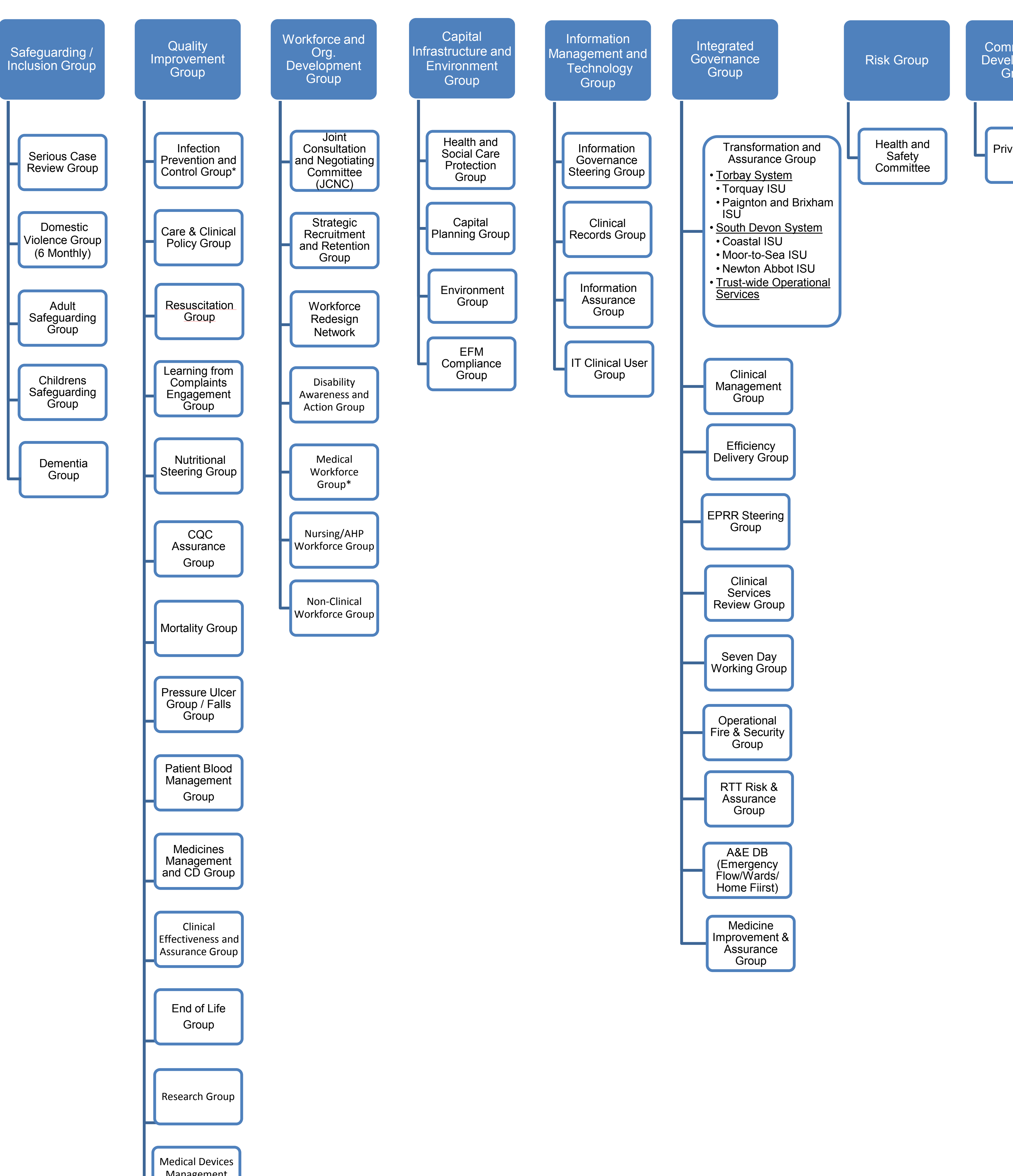
11 ICO CORPORATE GOVERNANCE STRUCTURE

Shown below is the current corporate governance structure and includes the reporting structure from integrated service unit level to the Board.



** Includes pharmacy, outpatients, infection Control, HSDU, PTS, transport and courier services*

12 ICO OPERATIONAL STRUCTURE



Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Winter Plan 2019/20			Meeting date: 6th November 2019
Report appendix	Trust Winter Plan Appendix 1 – Winter Initiatives Appendix 2 – Surge Capacity		
Report sponsor	John Harrison, Chief Operating Officer		
Report author	Cathy Gardner, Head of Operations		
Report provenance	The report is informed by the following: • Patient Flow Board: Winter Review 1/5/19 • Notes and Actions of the weekly Winter Planning meeting. • Minutes and actions of the local A&E delivery board • Minutes and actions of the Devon delivery board		
Purpose of the report and key issues for consideration/decision	The report provides the Board of Directors with oversight of the winter planning process in order to: 1.Provide assurance of optimal resilience over the winter period 2.Demonstrate the system-wide engagement and partnership working in the development of the plan 3.Demonstrate compliance with national requirements 4.Confirm that the plan has been through all appropriate approval processes		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To note the assessment and consultation undertaken to ensure provision of a winter plan appropriate to respond to local need, satisfy national requirements and deliver service improvement. To note the existence of residual risks to delivery and provide challenge to the acceptance of currently described mitigating actions		
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	X	**Risk score**	

External standards affected by this report and associated risks

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

Articulate any risks and implications arising from this report.

Public

WINTER PLAN 2019-20

1 Background

The Trust is an integrated organisation providing acute health care services from Torbay Hospital, community health services and adult social care in Torbay. This new way of working involves significant change, and strong clinical leadership as the focus is very much on clinical pathways rather than the traditional division of elective and emergency acute bed-based services, community health and social care provision.

The Trust has introduced a new operational delivery structure which came into effect on 1 April 2019. This means that the new model of care is delivered through five newly Integrated Clinical Service Units. This is the next step in aligning clinical pathways based within community localities. The Integrated Service Units are supported and enabled by a wide range of trust-wide services (eg pharmacy, patient transport, infection control etc.).

2 Introduction

The Winter Plan has been developed in collaboration with stakeholders across South Devon and Torbay A&E Delivery Board. The aim is to ensure quality, safety and operational resilience and to complement plans of partner providers, to ensure the delivery of safe and high quality services to the population of South Devon and Torbay during the winter period. Historical experience and facilitated 'lessons learnt' debrief events, alongside the Five Year Forward View and "Refreshing NHS Plans for 2018/19" issued by NHSE and NHSI have been used to develop this plan. We have yet to receive 2019/20 guidance but will update according to any additional requirements.

Traditionally, the system experiences challenging winter periods with high levels of flu, high acuity impacting ED, ICU, Cardiology, Stroke, Paediatrics, Mental Health and increased demand to maintain patients within the community and at home. In addition adverse weather conditions, regular periods of surge demand and high levels of staff sickness also impact. A full staff engagement exercise was undertaken after the winter period to encourage learning and feedback from these extreme conditions to inform improvements to this year's plan.

The potential impact on the patient experience is considerable and during the winter months we will aim to ensure:

- No avoidable deaths, injury or illness
- No avoidable harm
- No unnecessary waiting or delays
- No inequality of access to our services

The development of this Plan has been produced in association with key partners including South West Ambulance Services NHS Trust, Torbay Council, Devon County Council, Devon Doctors, South Devon & Torbay CCG. Key work has been led through the Devon A&E Delivery Board and using the local A&E Delivery Board as a vehicle for debate and approval for system and process improvements.

In addition, the System Improvement Board commissioned a deep-dive review of activity across Torbay and South Devon in July 2019 which has also informed this Plan.

3 South Devon and Torbay Impact Assessment

As part of the winter review and learning from winter 2018/19 several debrief and planning events have been held which identified key risks:

3.1 Workforce:

Assessed Risk:
- Capacity;
- Escalation and out of hours provision
- Staff resilience; sickness

Mitigation:
- Improved planning around peak periods particularly escalation.
- Robust rota management to ensure safe staffing levels.
- Weekend clinical co-ordination.
- Wellbeing programme of work
- Flu campaign.

3.2 Demand and Capacity

Assessed Risk
- Increased 65-75 patient categories, particularly Paignton and Brixham locality.
- LOS has increased by 1 day since May and July 2019
- Occupancy peaking at 96% – target reduction 4%

Mitigation
- Additional medical beds for Q4
- Focus on SDEC, AU and frailty pathways
- 4 clinical improvement work-streams.
- Torbay system – review of 65-75 age band.
- Target occupancy reduction of 4%.

3.3 Infection Control

Assessed Risk
- Flu forecasts high impact: ICU, Respiratory, Paeds, HOP

Mitigation
- Strong Flu Campaign and Infection Control management;
- Good uptake of vaccines across the Trust
- POC testing in ED to support clinical decision-making.
- Infection control team providing:
  - Proactive management and support to Torbay residential homes
  - Weekend I/C on-call rota during Q4

3.4 Primary care/Integrated urgent care services (IUCS)

.

Assessed Risk
- Primary care vulnerability at weekends and out of hours

Mitigation

- Resilience programme to improve primary care provision, 111 and Devon Doctors.
- Business continuity and extended services at peak periods.
- Development of detailed primary care dashboard
- Weekly Operational Look Forward meetings (WOLF) to review and manage risks.

3.5 Independent Market

Assessed Risk

- Vulnerability in domiciliary care provision and availability of care home beds

Mitigation:

- Community services: intermediate care, rapid response, re-ablement providing support to minimise any shortfall in provision.
- Discharge hub access 6 days a week
- STRATA allocation tool to improve allocation of PoC and placements.
- Market management.

3.6 All Age Mental Health Services

Assessed Risk

- Insufficient Inpatient adult capacity within region.
- 12 hour waits for onward treatment pathways.

Mitigation

- Improvement programme to include older person's mental health.
- Psych liaison service.
- Dedicated clinical protocols.
- Joint working with DPT.
- Police liaison.

3.7 EU Exit

Assessed Risk

- NHS Supply Chains
- Workfoce

Mitigation

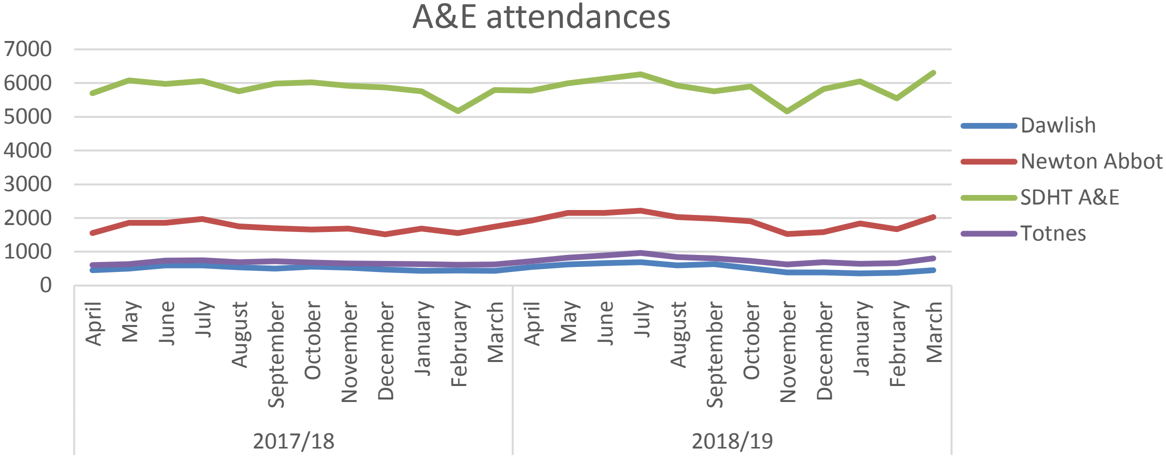
- Steering Group; weekly meetings; detailed plans
- Daily sitreps
- Refreshed business continuity plans.

4 Urgent and Emergency Capacity and demand

A priority in advance of winter has been accurate demand forecasting to inform capacity and winter preparedness. To consider correlations between demand, bed capacity and performance, a review of acute urgent care activity levels was commissioned by the System Improvement Board (SIB). Whilst overall it was evident that the Trust had not seen significant growth in emergency demand, specific trends impacting on performance were highlighted.

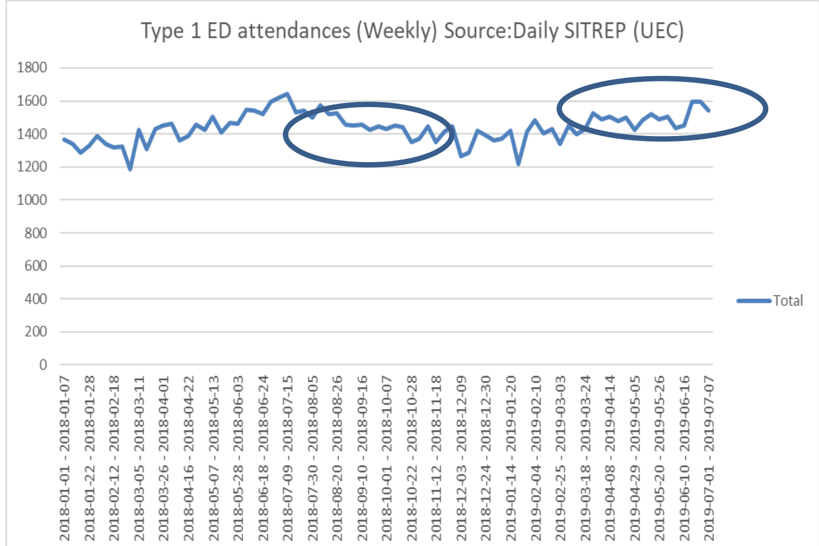
4.1 Attendances – ED and MIUs

There was a 0.8% increase in ED demand at the Trust from 2017/18 to 2018/19, however, the period between January and July 2019 saw 3% growth in activity (6% across the STP), with Friday attendances increasing by almost 8% over the whole year. MIU attendances were up by 11% and ambulatory care increased by 1.8%.



This demonstrates no significant growth year on year in terms of activity, and equates to half of the growth seen in other areas across Devon. The Trust has continued to experience significant challenges in terms of urgent and emergency patient flow across the local system, particularly in relation to surge demand.

4.2 ED Attendances – Deep dive January – June 2019

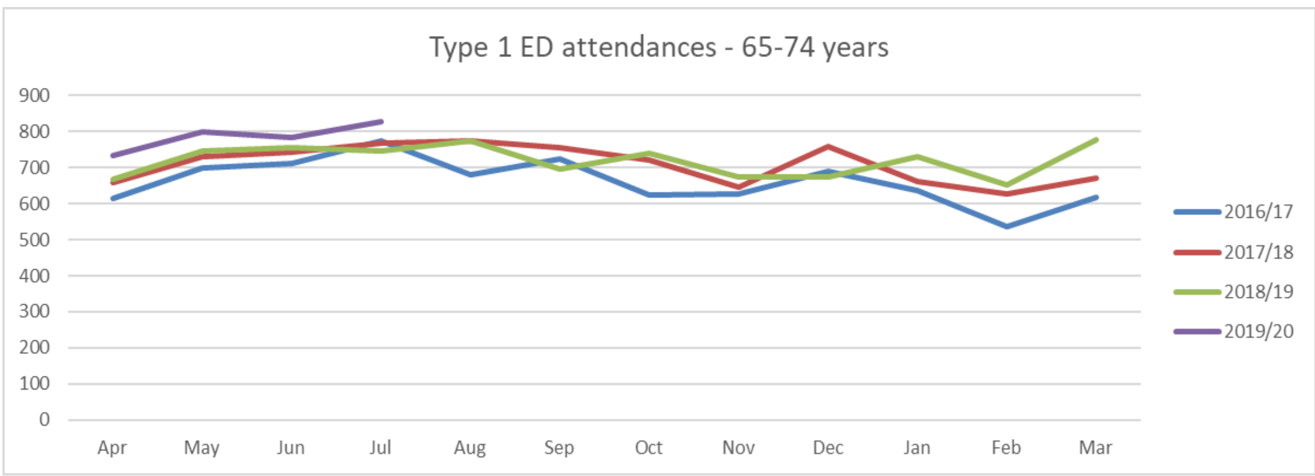


Whilst overall demand had been relatively stable, the Trust experienced growth in winter activity Q4 18/19 compared to 17/18, with 3.1% more attendances, returning to 2018 levels in May, June and July. This period of increased growth is repeated in Devon.

A deep dive of this period was undertaken to understand the key drivers.

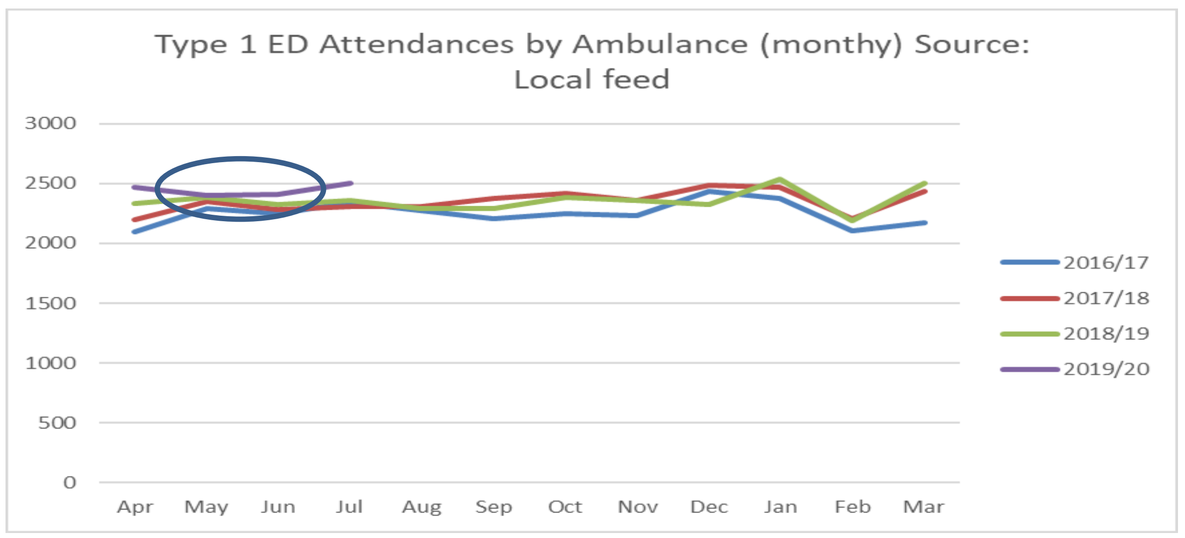
65+ age range

Some growth in the 65-75 age range Jan to March which is continuing to be above previous year's levels from April – purple line.



Ambulance Activity

There were 1.8% more Ambulance attendances during Jan-Jun 19 than the previous year. Particular growth seen during Apr-Jun and then remaining above 2018/19 levels in July – purple line.



The highest growth in ambulance activity was shown on Fridays, increasing by 7.6% against Jan-Jun 18.

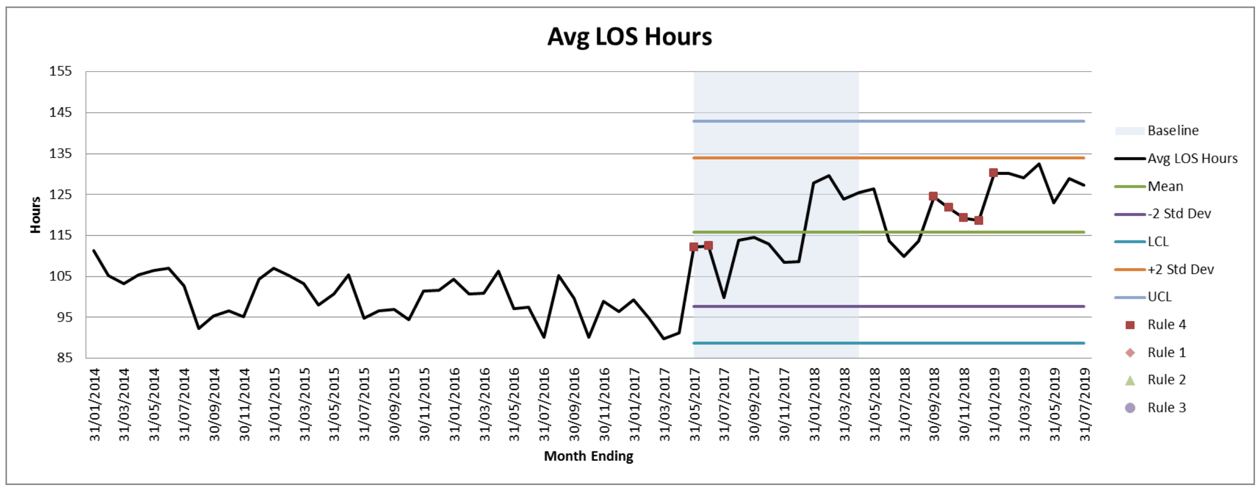
In summary the key points from the 6 month deep-dive analysis were:

- Front door increases were more significant during the specific winter period, up by around 3% - January to April in particular.
- Growth most significant on Friday – nearly 8%, followed by Thursday at 4.5% and Tuesday 3.7%.
- Ambulance arrivals for this period on Friday were up by nearly 10%.
- 1.8% more ambulance attendances overall (although this is lower than those in North and West Devon at around 5%).

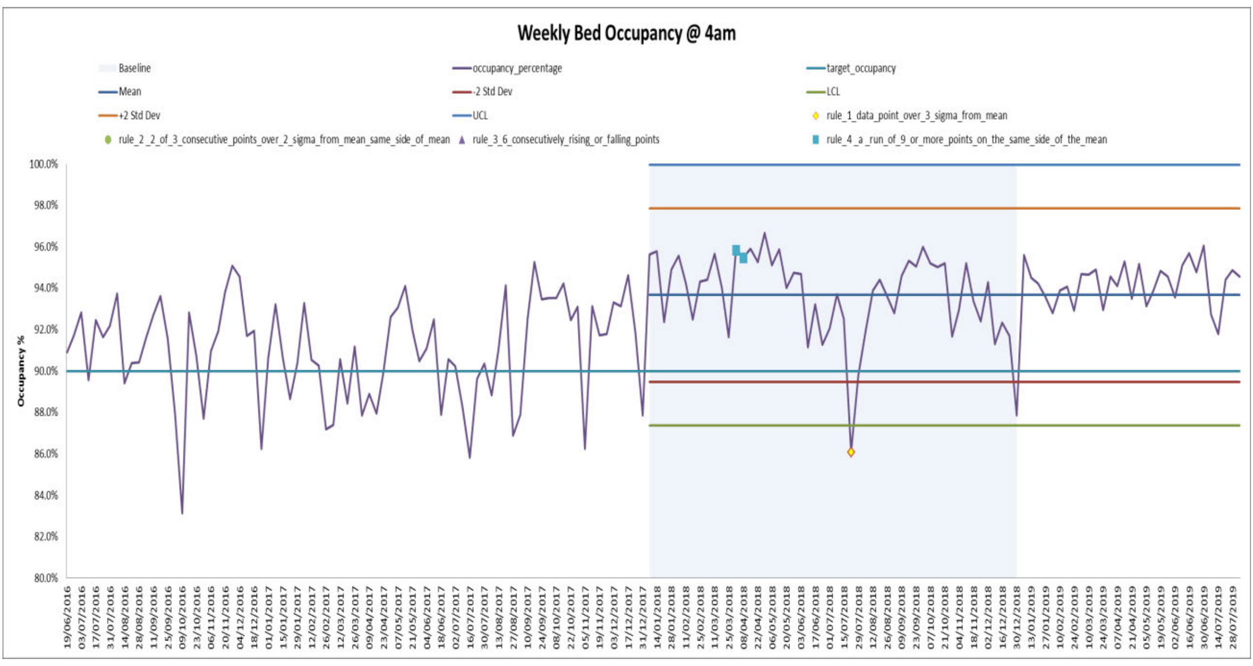
Certainly growth in ED attendances was seen during winter and spring but with levels reducing to 18/19 levels by the summer 2019.

4.3 Length of Stay and Bed Occupancy

The Trust's excellent previous stable and consistent position on length of stay has started to increase over the past 24 months from 105 hours (4.4 days) to 135 hours (5.6 days). The graph below illustrates this step change in non-elective length of stay, steadily increasing from May 2017 by around 1 day as at July 2019.



Bed occupancy has also been increasing from 90% at the end of 2017 to 94% in 2019 with weekly peaks of 96%. A key target for the Trust through its improvement programme is to reduce occupancy by 4% by March 2020.



4.4 Headlines from this detailed analysis:

Demand

- No significant ED year on year growth although MIU activity is up by around 11%; potentially as a result of MIU redesign.
- By locality activity growth is being seen mainly from Paignton and Brixham although activity still highest from Torquay followed by Newton Abbot.
- By GP Practice main growth areas: Buckland Surgery, Newton Abbot; Old Farm Surgery, Paignton and Brunel Medical Practice, Torquay.
- Main growth from those in the older age ranges: 65+
- Across Devon: ED referrals from 111 decreased;
- Ambulance arrivals are down and reduction in handover delays – particularly in Torbay and South Devon compared to the rest of the STP
- Whilst 3% lower than last year, TSD show a higher admission ratio than other acute Trusts at 39%. This is in part due to ED being the single access route for patients.

Admissions

- AU growth of 38% - enhanced capacity December 2018.
- Conversion rate dropping by 3%.
- No change to arrival by hour of day.
- Growth seen in 65+ age range.
- Reduction in core bed stock noted.
- Increased bed occupancy correlates with reduced ED performance.

Discharges

- DTOCs increased 7% (total);
- The data showed patients with a +21 day LoS had increased from January 2019.

Oct 19 update: with the additional scrutiny of weekly review meetings, this patient group is being managed effectively at the Trust target of less than 22 patients per day.

- Non-elective length of stay growth by around 1 day; strong correlation with ED performance.

4.5 Forecasting

Whilst the Trust saw a 3% growth in emergency activity during Q4 18/19, ED growth has flattened out to 0.5% this year. We are not anticipating significant non-elective growth but Flu forecasts suggest it will be a difficult Q4 in terms of high demand from our elderly, vulnerable population which will impact on acuity. Therefore we are preparing for demand to ICU, Respiratory and HOP wards and particularly management of side room capacity.

Christmas Eve 2018, a Monday, we saw very low numbers (160) largely due to low GP referrals. This year we are anticipating a very busy Monday and Tuesday prior to Christmas.

Last year we experienced very high demand during the middle weekend with particularly high number of patients attending on the Sunday before New Year.

SWASFT intelligence suggests key dates: 14th December, 21st December, 22nd December, 26th December and 1st January with which we agree and have mapped. Although key demand dates in terms of access to primary care and IUCS will be Friday 27th and Monday 20th and Tuesday 31st December 2019. The Trust has plans in place to ensure robust clinical rota coverage during this period.

	Sat 21	**Sun 22**	**Mon 23**	**Tues 24**	**Wed 25**	**Thurs 26**	**Fri 27**	**Sat 28**	**Sun 29**	
Christmas	224	217	195	170	165	225	209	204	225	
			30	**31**	**1**	**2**	**3**	**4**	**5**	
New Year			228	225	235	191	205	210	225	

The Public Health England flu forecasts suggest that it will be a difficult Q4 and December and January will be extremely challenging.

4.6 Additional Winter Bed Capacity

Given the detailed analysis of last year's activity we have made a series of assumptions based on:

- The timing of Christmas and New Year;
- Impact of Flu – which is likely to be at high levels during December;
- Theatre capacity: average daily impact on in-patient capacity.
- Numbers of fit to transfer patients (MFFD) remaining within acute beds;
- Average number of medical outliers.

From these assumptions the additional winter bed capacity has been modelled at 25 – with a strong emphasis on side room capacity and protection of emergency assessment space.

This additional capacity totalling 25 beds will be substantially established from January to March 2020:

- 18-bedded Medical Escalation Ward, Warrington - including 6 side rooms.
- 2 additional side rooms on Forrest Ward.
- 5 additional orthopaedic beds on Ella Rowcroft
- Point of care screening to reduce infection risk and maximise bed utilisation.

4.7 Surge Capacity has also been a key part of these winter plans (See Appendix 2) and this provides 17 escalation spaces at defined phases of the escalation process.

Elizabeth Ward has also been configured to provide an additional 12 bed environment in the event that business continuity measures are needed: decant space, discharge facility, overnight capacity.

5 Workforce

Key learning from last winter was the impact on the workforce of:

- Consistent high levels of escalation;
- Staff sickness absence;
- Reliance on agency staff;
- Ability to provide robust, resilient rota coverage.
- Business continuity at times of adverse weather or internal significant incidents.

As part of the Trust's business planning process 2018/19 high priority was given to winter feedback and across the medical SDU alone, £2.4 million was been invested in safer staffing levels on the wards, additional physicians, senior nurse leadership in ED and the medical workforce. The second phase of this investment and recruitment drive has been underway during 2019.

Last year the Trust introduced a new senior clinical team to provide consistent and robust site management cover 24/7. The team provide a central management function under the leadership of the Head of Operations. The team are made up of experienced urgent and emergency care senior nurses who work closely with the on-call managers, specialty areas and bed management team to ensure:

- Clinical and operational risks are mitigated;
- System issues are promptly facilitated;
- Receive and understand new or emerging risks associated with winter pressures;
- First line of escalation to ensure adherence to OPEL actions and de-escalation.

Their role includes enhancing the resilience of the existing team of bed managers, complex care discharge nurses and ward based discharge co-ordinators to maximise patient flow and generate early bed capacity.

During August and September, the Trust have been testing weekend clinical co-ordination to maximise the efficiency and improvements to the Hospital at Day/Night team both in terms of clinical ward support and the co-ordination of the junior doctors.

This involved the clinical team provide additional shift coverage at the weekends to:

- Clinical triage of calls from the wards;
- Receive all acute reviews and provide clinical advice and guidance and, where appropriate, downgrade the level of clinical requirement.
- Co-ordinate the diagnostic function eg. phlebotomy and cannulation service;
- Working with the pharmacy team ensure proactive management of TTA prescribing;
- Co-ordinate the medical team at the weekend to optimise discharge opportunities.

This improvement work forms part of the Trust's 7-day Strategy to maintain a robust service particularly during the weekend.

In addition it links closely with the SAFER principles promoted on ward bases. This involves clear Friday handover communication and particularly criteria-led discharge documentation for patients who can go home at the weekend without further medical input. It will improve clinical, diagnostic and process co-ordination at weekends to optimise ward tasks to support behavioural/cultural change towards weekend discharges.

Again this year the Trust is substantiating a team of nurses, led by a senior Matron, to provide flexible capacity as and when it is needed.

To supplement the clinical workforce during escalation, considerable work has been carried out across support services to provide resilience from office based teams including:

- Education and training;
- Quality Improvement project managers;
- HR and recruitment
- Finance and performance.

These support teams have specific action cards of activity, training and meetings to stand-down in the event of escalation. They have also identified secondary roles that they are trained and able to carry out to support direct clinical services in the event of staff shortages.

6 Staff Wellbeing and Resilience

Wellbeing of Staff has added emphasis during winter pressures.

<u>Staff will be able to access all of the standard services available already within the trust such as:</u>

- Coaching – confidential 1-2-1 sessions crating a safe space for conversations which could help staff to explore building resilience and wellbeing.
- Employee Assistance Programme – the assistance programme is accessed through telephone 24/I 365 days a year or through their web page. Offering support, advice and information.
- Schwartz Rounds – organised once per month providing an environment for sharing of emotions and feelings of working within the health care system
- HOPE – Self-care 6 week course looking at mindfulness, goal setting, fatigue, strengths, healthy eating and dealing with set backs.
- Random Coffee Breaks – making those connections with people you might not ever meet.
- Health promotion through a pilot reintroducing wellbeing boards are promoting – taking your breaks, ensuring you get enough sleep and a check list of things to do before you leave.
- Staff Benefits
- Mental Health Forum
- Closed wellbeing facebook dedicated solely for issues linked to staff wellbeing and only accessed by staff. **Whole-Beings Torbay & South Devon NHSFT**
- Mental Wellbeing Workshops and Training including:
    - F1 and F2 mental Health Wellbeing
    - Workshop – How do I support colleagues struggling with mental health
    - ‘Having that conversation’- workshop for managers looking after staff who are struggling

New opportunities and services coming on line for all staff during October and November ready for winter pressures are:

- New wellbeing pages - easy to use and easy to find pages and calendar
- Menopause group – first meeting in October brought together at the request of staff as a place to go to and discuss the issues affecting women (men also welcome)
- Mental Health First Aiders - Mental Health First Aiders will be proactively ensuring that their teams will have plenty of resources on hand to help with looking at their wellbeing awareness and reduce stigma. They will also be part of a network of staff who have signed up to have their contact numbers on the wellbeing pages
- JIGSAW – A new debriefing and defusing team ready to facilitate sessions across the Trust where staff have been affected by out of the ordinary events causing distress.
- New Mental health Leaflet – giving support and advice for staff who are looking to maintain their wellbeing or are struggling and need to find support
- New Carers Strategy
- New Reasonable Adjustment policy and guidance
- Promotion of Public Health England's 'Every Mind Matters'

Added measures throughout the winter season:

- Flu Campaign – aiming to vaccinate 80% of frontline staff. TSDFT also offer the vaccine to all staff ensuring the equality of accessing protection from flu in 2019
- Staff Olympics – opportunity for staff to engage is team events including:
  - Bake off
  - Sewing be
  - Art
  - Quiz
  - Retro games evening
  - Sport including, bubble football, relay racing

- Wellbeing and Anti-Bullying Week – scheduled for November again staff given the opportunity to access events and tasters including:
  - Massage
  - Mindfulness
  - Virtual reality relaxation
  - Various talks including Healthy Eating, Finance, Storytelling, healthy back, mental wellbeing.

The Staff Engagement Group have been mindful of, where possible, to go onto wards and out into the community with the events and to ensure that talks are filmed in order that the majority of staff can access.

- November Anti Bullying campaign – discussions and talks through November leading to training being rolled out to all staff

7 Programme of Improvement

The feedback presented to the Devon STP Urgent and Emergency Care Review of Winter 18/19 on 1st May 2019 outlined the following priorities:

Task	Lead	Start Date
Emergency Floor: to improve the quality and safety of care for emergency patients from presentation to discharge or specialist care. SDEC	Chair: Dr Catherine Blakemore	April 2019
Home First: to enable safe and effective care as close as possible to patients' home: Discharge Hub, Strata and Trusted Assessor	Chair: Dr Matthew Fox	April 2019
SAFER Wards: to improve the quality, safety and minimise length of stay for urgent and emergency patients on inpatient wards. Early discharge; R2G	Chair: Rhoda Allison	April 2019
7-day Services Review will make recommendations to ensure the OOH service provides the convenient, safe, effective, fair and sustainable service to meet patient demand.	Chair: Dr Andy Griffiths	April 2019

The Trust continues to experience significant challenges in terms of the management of urgent and emergency patients across our local system. The 4 hour standard has consistently not been achieved and the Trust is regularly working at high levels of escalation, particularly overnight and at weekends. The impact is felt by overcrowding in ED, increased levels of occupancy across bed bases and high demand for community services to compensate for issues within the care market.

These challenges have reinforced our commitment to these four key work streams and a need to continue to drive and develop this improvement work towards operational delivery. The improvement response is multi-faceted and system-wide.

High levels of ED demand does not in and of itself affect performance and performance has been consistently challenged since 2016.

Clear correlations can be seen with performance and bed occupancy. There is a negative correlation (-22%) between weekly bed occupancy and performance over the last 6 months; increased occupancy leads to decreased performance. This confirms the Trust's system-wide improvement assumptions that front-door demand is only part of the issue and should not be the sole focus of deteriorating A&E performance.

The requirement for incremental improvement across the whole urgent and emergency system of care is necessary to make material changes to performance.

In July 2019 the Trust completed a stock-take of system improvement work combining activity and performance with clinical and operational feedback and culminated in a targeted action plan to create capacity and increase system resilience. This urgent and emergency care improvement programme captures several projects and improvement initiatives under the four main work streams. The delivery of these actions is being led by the Chief Operating Officer and monitored through weekly meetings.

Each improvement programme is clinically led with assistance from the QI team utilising a model of improvement methodology to embed and sustain change. There is additional resource to operationalise the overall programme and metrics to demonstrate incremental changes and impact.

The challenge remains the ability of our systems to respond to the variation in both daily demand, influenced by changes in acuity and prevalence of illness in our population, including flu, and our ability to maintain planned levels of capacity including the independent care sector.

The next key steps include working with ECIST to complete system wide capacity and demand modelling. The Trust's care model strategy places considerable reliance on the independent sector and due to market issues this continues to introduce variation into the function of patient flow across our entire system.

8 Elective Plans

Due to issues with the Trust's estate infrastructure, 2 operating theatres have been closed during 2019. Eliminating our 52 week wait RTT position by the 31st March is a key priority and upgrades to Theatres A & B have been completed and were handed back on 7th October 2019. To this end a review of orthopaedic bed and theatre utilisation has been undertaken with mitigation in place to protect elective activity for the delivery of these improvements to the RTT position.

On the basis that we have, in previous years, had a period where we have fewer inpatients and more day-cases, this year it is essential that these plans are compatible with elimination of 52 week waits. These are summarised as follows:

- Implementing an elective pause in activity prior to Christmas. In-patient activity will be reduced for the period Monday 23rd December 2019 to Sunday 27th January 2020 with a managed incremental return to normal activity levels.
- To minimise the impact on RTT there will be a shift in the ratio between in-patient and day case pathways.
- To minimise elective cancellations and protect elective pathways, 5 additional beds will be opened on Ella Rowcroft protected for elective orthopaedics and screened trauma patients.
- To meet trauma demand, from mid December until early February a second trauma list will be scheduled each day to prevent delays between admission and surgery, to reduce length of stay
- During January, re-deployment of teams to support emergency workload e.g. anaesthetists, surgeons, theatre nurses and support staff.

9 Urgent and Emergency Care

9.1 Emergency Department

Ambulance Handover

The Emergency Department (ED) and South Western Ambulance Service Foundation Trust (SWASFT) are working together to improve the patient handover process, key to which is reducing the amount of time the patient waits for care to be passed from SWAST to the ED. Challenging targets have been set to reduce the amount of time lost for handovers taking more than 15 minutes and the number of handover time greater than an hour.

Whilst improvements have been made, the performance trajectory has only been achieved in two months for 60 minute delays and once for 15 minutes (see table below). Of the 19 hospitals in the south west region, the Trust is currently ranked 7th (1st being the worst performing) for 60 minute delays and 10th for 15 minutes delays.

	April trajectory	April performance	May trajectory	May performance	June trajectory	June performance	July trajectory	July performance	August trajectory	August performance
Number of handover +60 mins	10	13	9	11	8	4	5	5	5	12
Total time of handover delays +15mins	365	578	365	327	348	410	335	413	335	531

The department was visited by Emergency Care Improvement Support Teams (ECIST) Ambulance Improvement Manager in August. The visit was very positive and acknowledged the work already undertaken and recommended processes to review to support the compromised capacity and delayed movement including:

- ring-fenced assessment space for direct ambulance conveyance of GP referred patients,
- support for integrated frailty service and,
- increased conveyance to ambulatory unit.

The Clinical Commissioning Group continues to work closely with both ED and SWASFT with attendance at the fortnightly ambulance handover meeting and focused improvement work in May.

ED Escalation

The Trust has refreshed it escalation processes to ensure capacity is maximised across the system when ED experiences a surge in demand. The revised documentation includes updated triggers in ED taking into account complexity and available capacity.

The capacity within ED minors has been utilised more frequently for caring for sicker patients that has occasionally required diversion of appropriate patients to Newton Abbot. With the updated escalation plan, the intention is to reduce impact of surge on all aspects of the service.

Joint Emergency Team (JET) is the consolidation of the admission avoidance work at the front door to bring together nurses with acute therapists, social-care support and rapid response and increase utilisation of the hub. The aim is to maximise early assessment, avoid admission and provide supported discharge home. This also offers telephone triage in ED and improved medical response to the team. The team currently work from 8am until 6pm.

Psychiatric Liaison Service

The Liaison Psychiatry teams function well within ED providing timely and appropriate clinical assessments, interventions and guidance to ensure patients are seen in the most appropriate

setting. The service is available 24/7 providing practitioner led response in ED and a response with 24 hours to wards.

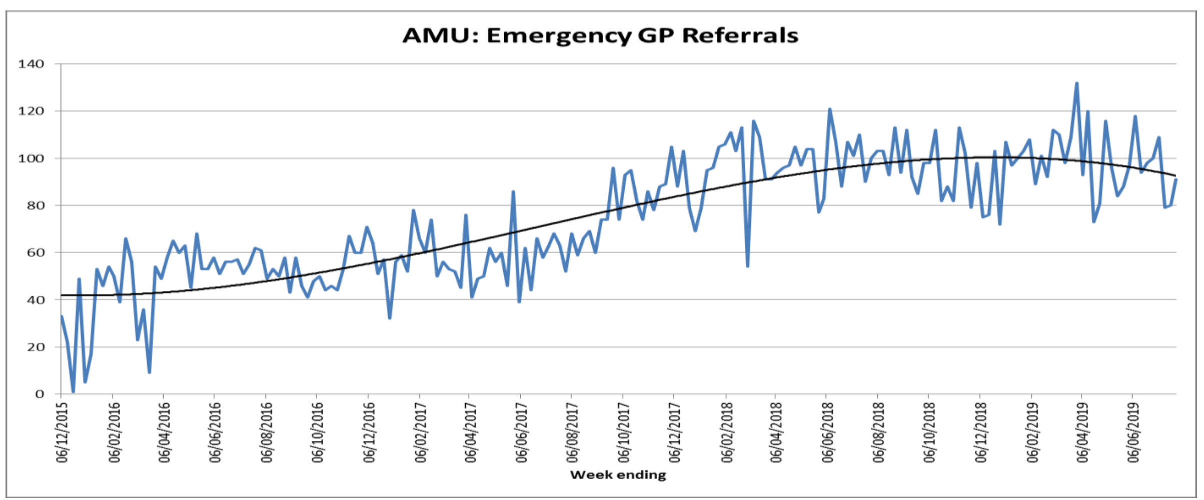
Work to expand the service to deliver CORE 24 (24 hour service, 7 days a week) have commenced however the ability to recruit into vacancies have proved challenging.

The Psychiatric Liaison team, working closely with the ED team have successfully achieved a reduction in ED attendances in an identified cohort of people who attend ED frequently with MH diagnoses. A multi-disciplinary team approach was taken to some individuals with complex problems whilst others required more simple individual interventions exploring the reasons for their frequent attendance. This approach remains in place for 19/20 as part of the national CQUIN.

A clear programme of work is being led by DPT focussing on mental health pathways, in partnership with all Devon Acute Trusts with a particular focus on reducing delays for patients.

9.2 Ambulatory Unit

The AU was expanded in December 2018 and growth in its utilisation is up by 38% (see graph below), linked in part to the enhanced capacity but also improvements in access to AU. In addition admission conversion rate has dropped.



In August the surgical team recruited two new surgical fellows allocated to the Ambulatory Unit to provide a new service for returning patients and reduce the need to admit patients overnight. The service allows surgical patients to be discharged overnight and to be reviewed by a senior doctor in a timely manner on the following day. The radiology department has provided four ultrasound scan slots between 0900 and 1000 that are specifically for returning ambulatory patients. This service reduces the time that the patients are waiting for investigations and review by a senior decision maker within the Ambulatory Unit. This will allow for streamlined surgical patient flow within the unit and increases capacity.

In addition to this the MIDOS application for the ambulance service has been updated with specific patient condition criteria suitable for the ambulatory unit. When the paramedic crews attend a patient in the community and have assessed their condition they are able to search the MIDOS application for appropriate places to take the patient. The wording for the Ambulatory Unit template on the application has been updated to ensure that the paramedic crews fully understand the function of the unit and the types of suitable patients. This template has been agreed on 6th

September and is now live and the SWASFT clinical lead has rolled-out the changes with the crews to improve the direct referrals to the unit from the ambulance service. The ambulance crew need to phone the Ambulatory Units' medical or surgical team en-route to ensure that the patient's details are handed over and there is capacity for the patient.

9.3 Primary Care Streaming:

The in hours on-site access to GPs ended earlier in the year after the GP practice gave notice on the contract. Discussions continue with the CCG and primary care leads who are identifying options including enhancing the GP presence in the ambulatory unit.

9.4 The Acute Assessment Model:

In December 2018 the Trust undertook a test of change to support a new method of acute assessment based on the urgent and emergency care strategy for the £13m re-design of the emergency care floor.

The model aimed to use the Emergency Assessment Unit 3 (EAU3) as a separate "receiving unit" for medical and surgical patients, taking both referrals from GPs and ED, with patients ideally spending less than 6 hours being assessed in the area before a decision is made to discharge or admit to an inpatient ward.

Delivering this model of care is a key priority and focused management to ring-fence this assessment space is supported by extended hours of AU and the increased bed capacity in Q4.

9.5 Frailty

From January 2020 we are aiming to introduce a more co-ordinated Acute Frailty pathway. JETs are already responsible for assessing, providing advice and interventions and co-ordinating discharge for patients – including those living with Frailty - from ED and the Emergency assessment Units. This offer will be enhanced, specifically for those patients living with frailty who are likely to have a length of stay ≤ 48 hours, with dedicated consultant support. This will operate Monday-Friday subject to staff availability, in the afternoon. Older people living with Frailty will be identified at the point of referral to Medicine and the Rockwood Clinical Frailty score recorded in the ED system, on the system for managing the medical take (the "O drive") & in their medical notes. Patients identified as appropriate for an Acute Frailty pathway will be seen both by JETs and a Consultant Geriatrician and a CGA initiated and appropriate communication sent to primary care & community services.

We will cohort our patients in one location which will serve as a short stay frailty unit to make best and most efficient use of expert resource and to have patients managed in a setting more appropriate to their needs. If this is possible, the unit would be jointly managed by Geriatricians working within the Acute Medicine & Healthcare of Older People teams.

We will also be trialling an ambulatory Frailty pathway for community services and Primary Care.

10 Acute hospital care

10.1 Ward flows and SAFER processes

ECIST have been supporting the Trust on work to improve the efficiency of ward flows this year. There is ongoing support from the Quality Improvement (QI) and Programme Management Office

(PMO) teams in this area. Since August 2019, there has been an additional medical team working with a particular focus on weekend discharges. Initial work with this team has focused on closer working with phlebotomy and pharmacy to expedite discharge. Current work involves continuing to work with ward teams during the week to strengthen SAFER meetings, particularly with a view to planning criteria led discharges over weekends.

Key areas concentrated upon are:

- Clearly recorded clinical criteria for discharge to enable nurse-led and weekend discharge
- Better communication between wards, bed managers and assessment units so patients start to be pulled into admitting wards before 10 am.
- Early identification and case management of likely complex discharges
- Red to Green days – challenging delays
- Medically fit patients are reviewed at daily MDT meetings and escalated to community services and teams as necessary.

This work will continue and be a key focus over winter.

In October 2019 additional has commenced with the support of ECIST to develop and support staff to implement a more robust approach to managing patient and carers' expectations.

Weekly meetings are held to review patients with lengths of stay over 21 days- these are an opportunity to reflect what other actions can be undertaken to maximize opportunities for earlier discharge. Agreed thresholds will trigger an escalated response from a multi-disciplinary team of health and social care leads to fast-track onward care decisions and actions.

10.2 Increasing enablement and fast tracking people with dementia for discharge

One Healthcare of the Older Person ward is piloting the ‘Moving Forward’ project - increasing enablement of ward patients through interactions with volunteers and schools on work experience, to reduce ‘pyjama paralysis’. The aim of the project is to reduce deconditioning and promote independence and earlier discharge. The project will also pilot the potential for early OT assessment and intervention for people with dementia with a view to fast tracking discharge and reducing levels of agitation through personalized care planning.

10.3 Supporting people to leave hospital sooner

MAT

The MAT team is expanding their work and is now piloting the support of patients requiring IV furosemide at home. They will work with IC to develop capacity for IC teams to support their ability to treat people at home.

THORT

The THORT respiratory team identify and support potential for earlier discharge, and can be used to avoid admission by intervening in ED. There have been some staffing shortages in the team so the Physiotherapy lead is currently scoping the potential for senior respiratory Physiotherapists to flex and provide this support to the front door.

The team are also working to review the COPD patients to identify how IC can support some of the home visits.

10.4 Intermediate care

Each ISU continues to have an Intermediate Care team – consisting of nurses, therapists and support workers with the aim of avoiding admission or facilitating earlier hospital discharge. Care is offered to support people in their own homes, or in nursing or residential homes.

Work has been undertaken to strengthen the provision of higher acuity interventions (such as IV antibiotics) in IC and further work is planned in October to strengthen links between the MAT team and IC to promote transfer of patients, and between IC and other community services to increase resilience and reduce duplication.

11 Paediatrics

During the winter months (October to March 2020) the number of beds on Louisa Cary will increase from 19 to 22 without going into escalation. If demand exceeds beyond the substantive 22 beds the Trust will implement its escalation plan.

Weekend Consultants will continue to be rostered as back-up to provide resilience given variability of paediatric demand.

CAMHS patients continue to be admitted to Louisa Cary all year round which impacts on the bed-based capacity above especially in the winter and is not a place of safety but is monitored closely with the help of the CAMHS crisis outreach service and the Trust Security Team as required.

DPT is working with a small team of Devon A&E Delivery Board representatives to review and implement an 'All Age MH protocol' to support treatment of patients and escalation of onward placements.

Development of the Children and Young persons (CYP) place of safety (POS) was completed in January 2019 which reduces the requirement to use ED for patient assessment.

12 Local Community Provision

12.1 Community Hospitals

The Trust operates 4 community hospitals with a total of 112 beds that are distributed as detailed in the table below. The Newton Abbot beds form a vital part of the care pathway for stroke and neuro patients along with supporting onward flow from Torbay Hospital. They also take appropriate neuro rehab patients direct from the Major Trauma Centre at Derriford. The community hospitals also accept direct admissions from the community via local GPs to help prevent unnecessary admissions via ED.

Hospital	Bed No	Escalation	Hospital	Bed No	Escalation
Brixham	Gen Med - 16 I/care – 4	No additional	Newton Abbot	Gen Med - 40 Stroke rehab – 15 Neuro rehab – 5	Release 2 GP beds
Dawlish	Gen Med - 16	Gen Med - 1	Totnes	Gen Med - 16	Gen Med - 1

12.2 Minor Injury Units

MIU staffing levels have been planned to meet anticipated capacity and demand over the winter period including bank holidays. MIUs will continue to support the Emergency Department over the winter period including supporting diverts of minors patients from ED during periods of escalation.

12-hour Radiology support is in place at times of peak demand.

12.3 Community Services

Community productivity has continued post the Meridian review in Q3 of 2018. The work has identified potential opportunities for realignment of resources within the community nursing teams, mapped against activity and demand. ISU's are currently reviewing what the realignment may look like and plans are being pulled together to deliver outcomes by March 2020. The same work is currently being undertaken with community therapies and intermediate care with a view to analysing activity, capacity and demand. In the same way as community nursing, a report will identify potential opportunities to ensure the workforce are able to deliver the right care to the right person in the most effective way possible.

A deficit in the availability of short term packages of care in comparison to demand has resulted in further investment in this sector with the aim of reducing this gap in capacity and demand and this is in addition to that which was commissioned last year. However, there remains capacity constraints within the independent sector with recruitment being cited as the largest challenge across Devon as well as nationally.

Additional investment has been provided for the Torbay Rapid Response teams to increase capacity over the winter period and improve the short term provision focussing on re-ablement for patients leaving hospital and reducing dependence on bed based care.

With the further development of intermediate care nursing and enhancing the links between community intermediate care and JETs within the Emergency Department, and the MAT team these improved links and relationships need to further enhance our offer this winter to ensure as many people as possible are supported to remain well at home or leave hospital quickly. Intermediate Care is focussing on ways to increase the acuity of patients supported alongside further work with Clinical Directors to increase referrals from GP practices to support admissions avoidance.

The Community Health Education Service (CHES) team are building on their success in Torbay and South Devon rolling out services to support people with dementia and behavioural issues within care homes.

12.4 Domiciliary care

Additional resource for social care for winter to support the domiciliary market has been commissioned. In Torbay this includes additional live-in capacity in domiciliary care of 650 hours which started on the 25th of October. This extra capacity will increase over the following months to maximise stability.

In South Devon a 200 hour block contract has been put in place to support EOL care specifically, with a further 100 hours to support Hospital discharges and support our short term offer services (Rapid response and SCR).

The Trust for Torbay and Devon County Council for South Devon continues to work closely with local domiciliary care providers to increase capacity where possible to provide support during the winter period.

Both areas are working with Therapists in-reaching into providers to review packages to liberate capacity where possible.

12.5 Care Homes Support for Admission Avoidance

The Trust's integrated care model is designed to support people to prevent ill health, promote wellbeing, maintain independence and stay well at home, this includes ensuring that people who are living in a care home are also able to stay at home where possible. Part of this work involves implementing the Enhanced Health in Care (EHCH) Framework with further gap analysis planned. A Torbay and South Devon EHCH delivery group has recently been set up that will oversee the implementation of the framework. This is a multiagency stakeholder group who will hold responsibility for addressing challenges and issues across the interface and ensuring a joining up approach to the implementation of the framework. Operational sub- groups are being developed that will focus on key elements of the EHCH framework providing flash reports that will submitted every six weeks to the delivery group.

Enhanced primary care support - the one care home, one practice recommendation has been implemented in areas where primary care capacity is available to support this initiative. Across Torbay and South Devon there are different models to achieve this aim. In South Devon the one care home one GP practice model is implemented and in Torbay the GP care home visiting service is in place. The GP Care home visiting services is externally provided to the practices by a multi professional team that undertake all visits requested by care homes, excluding those received later in the day which are provided by the GP practice. This team are able to provide continuity of care to residents in care homes, complete medication reviews ,develop positive relationships with care home staff , complete and review Treatment escalation plans where appropriate and prescribe "just in case" and end of life medication.

Across Devon the Medicines Optimisation in Care Homes (MOCH) scheme has provided dedicated pharmacy and pharmacy technician support to care homes to support medicine administration within homes including polypharmacy review to minimise harm. The MOCH teams form part of an integrated primary care, community and acute pharmacy offer aligned to the community-based health and wellbeing teams and the QAIT teams.

Throughout South Devon and Torbay the multidisciplinary ways of working have developed robust community based health and social care teams which include intermediate care, community nursing, therapy, social workers, social care re-ablement, rapid response services. Contracts are in place with nursing homes to provide intermediate care placements working under the principles of trusted assessor methodology.

Discharge coordinators are aligned to the community-based teams and a discharge to assess model has been implemented to enable complex assessment at home and care home assessments within 24 hours across Devon.

Clinical capacity to the Quality Assurance and Improvement Teams (QAIT), which offers dedicated support to care homes has been expanded via IBCF monies. QAIT are working with CCG and Public Health colleagues to develop a programme of training workshops for nominated individuals from care homes and domiciliary care providers to act as Health & Wellbeing Champions within their services. The training is delivered by key health and social care partners through quarterly sessions and will focus on a variety of topics including Falls, Respiratory & COPD, flu and infectious diseases, UTIs, sepsis and diabetes contributing towards admission avoidance

Through iBCF dementia support has been expanded through the development of the Care Home Education and Support Team (CHEST) with Devon Partnership Trust to provide dedicated Older Person's Mental Health support to care homes. The aim of this service is to ensure that care homes receive the support that they need to manage patients with dementia, by supporting care homes with particular patients during periods of escalation which may be causing management problems, and by educating staff around the management of dementia and thus building resilience in the care setting. This service will provide and agreed care pathway across Devon for managing behavioural and psychological symptoms in patients with dementia who live in care homes to reduce hospitals admissions by 30%. It will also develop resilience within care home settings and to have meaningful conversations about future care input with individuals with dementia or their families. Some of the key objectives are:

- Increased specialist support for staff
- Appropriate support for GP's whilst minimising inappropriate referrals
- Minimise high cost care packages in homes and reduce the level of high cost individual 1 to 1 care being requested
- Improved hospital discharge rates.
- Education for residential care home employees on managing patient specific issues
- A team approach to provide residential care homes with consistency of support and advice
- Learn from experience to create a centre of expertise

Through the iBCF we will trial the use of an Enhanced Health in Care Homes Framework Toolkit app to prompt care home staff to be curious about changes in a resident's behaviour. Having changes assessed at the earliest possible opportunity should mean any deterioration in either physical or mental health is identified and can be addressed and monitored proactively. The toolkit will also prompt care home staff to ensure each resident has an up-to-date and complete set of electronic notes (including TEP form) and escalation plans.

The End of Life Care STP group has developed a dedicated care homes e-learning training package for dementia and end of life care. The hospices across the county provide dedicated face to face end of life care training to homes.

In Devon there is a well-established Provider Engagement Network and in Torbay a Care Managers Forum the aim of these groups are to engage with providers.

The STP has a joint workforce development group and is part of the Proud to Care campaign which promotes careers in health and social care.

We are developing plans for the introduction of NHS email (NHSmail) into care homes and other care providers. NHS Digital is working to ensure information flows efficiently and securely across the health and social care system to improve patient and service user outcomes. As a system we want to integrate the care provided to people as much as possible. This means that we need to communicate with each other in a secure and safe way. We are supporting providers to join NHSmail. This means that we will be able to transfer information between providers and the hospital and GPs easily and securely supporting clinical care and support. The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool for data security which organisations need to complete before they can have NHS mail. We are supporting organisations to complete the Toolkit and then set up NHS mail accounts.

The trusted assessor programme has progressed across Torbay and South Devon care homes with 45 trusted assessors now in place. The aim of this model is to reduce delayed transfers of care from hospital due to the need for care homes to assess the individual.

A leadership development programme for care home managers is established across Torbay and aims to provide managers with a leadership skill set that includes:

- Reflection and analysis including self-evaluation and staff/setting skills ‘audit’ (diagnostic phase)
- Collaboration and openness – enjoyable group problem-solving, active listening, working across staff and resident groups, trying something new, challenging habitual behaviours
- Being proactive and taking ‘risk’ including when and how to bring in new expertise
- Individual drive – exploring personal and professional motivations
- Integrating skills and approaches - keeping the ‘home’ a happy place to live and work, supporting self and others through action learning, peer to peer mentoring / feedback

13 Ensuring safe and timely discharge

The Trust clearly outlines a strategy of patient independence and care closer to home moving away from the traditional model of bed-based care towards community provision. This is a model of prevention, re-ablement and draws upon a strength based approach to encourage independence and patient self-care. This has led to a low and sustained level of DToC rates and also consistently good performance in 7 and 21 day length of stay patients.

Key enablers to this are:

7.2 The Discharge to Assess (D2A) model with extended intermediate care capacity
7.3 Proactive management of delayed transfers of care (DToC) across all bed-bases
7.4 Improved patient flow: SAFER2 principles of best practice on all wards
7.5 Enhanced focus on 7-day service provision and discharge
7.6 Early escalation processes across health and social care with clear role centred actions
7.7 Management of the complex long stay (>10 day) patients across acute and community

13.1 Torbay Discharge Hub

The Discharge Hub provides a joint integrated service between South Devon and Torbay and is now fully established. It enhances and co-ordinates discharge pathways for patients reducing

multiple hand-offs of care. It ensures that patients have an opportunity to receive a short term offer that enables patients to become as independent as possible utilising the full range of community services. This service has been extended to 6 days to enhance the weekend discharge process.

The Discharge Hub manages the D2A pathway, which is embedded in South Devon and Torbay and work continues to increase the number and complexity of D2A referrals. The benefit of this team managing these patients is to ensure that the capacity across all the community Intermediate Care (IC) teams is utilised and localities with capacity can assist their neighbouring localities to ensure the patient does not experience a delayed discharge. This is achieved by the IC teams stretching their boundaries. The IC teams' capacity for Discharge to Access is reported to the Discharge Hub and they work collaboratively with the IC teams to maximise use of the available resources.

There is a local agreement which means that patients can access interim health funding for 4 weeks. This is based on a nurse led assessment. If there is a positive checklist that is completed in the Community, this funding will move to a full assessment for CHC and funding arrangements will follow that outcome. In Torbay there is step down funding from the ICO to care home placements based on clinical decision making – made between the hospital discharge team and the lead CHC nurse on the day. In addition in Torbay there is a risk share agreement in place between health and social care commissioners and the ICO which means in effect we have pooled budget arrangements for health and social care which supports the placement without prejudice system. There is a process in place whereby urgent funding requests are considered via a virtual High Cost Panel, with membership from the ICO, CCG and care co-ordinators. There is a project lead in post and a plan is completed and progressing with the project lead.

For off contract placements at times of escalation, Care Homes are accepting a referral direct from intermediate care teams rather than assessing clients face to face.

13.2 STRATA

Stata is a cloud based patient flow system which interfaces with the Trust's IT systems to enhance the patient's experience. This was introduced and implemented in July 2019 into the Torbay Hospital Discharge Team for patients requiring short term placements.

The aims are to:
- Reduce DTOC,
- Reduce the med fit numbers in acute and community beds,
- Ensure the patient is matched with the most appropriate care home bed
- Improve quality of care.

Strata matches the patient profile with the care home's bed attributes. This enhances the Trusted Assessor work and there is an understanding that Care homes can accept patients from the Strata referral without them physically assessing the patient in hospital.

Currently there are 14 early adopter homes however work and engagement groups have commenced to enrol all the Care Homes in Torbay under a Memorandum of Understanding

The vision is for Strata to be the platform for all Care Homes in Torbay and for Domiciliary Care.

Work has commenced with the CHC team and Devon County Council to involve them with Strata.

13.3 Torquay Locality Care Home Education and Support (CHES)

This is an MDT approach which consists of locality based staff supporting Care Homes. The Service works alongside the GP visiting service and visits patients to support the Home with patients who need extra input and support. The team consists of an OT, Pharmacist, Community Nurse, Social Worker and Dietician.

The aim is:

- Prevent any unnecessary hospital admissions with a truly MDT approach,
- Support the Care Homes with treatment and management of patients who they are concerned about;
- Provide training to the care staff if required to ensure they can manage a patient with clear objectives and escalation procedures.

The Service has been funded from existing budgets within the Torquay locality. The team work with the QAIT service.

Data is being collected and early feedback from the Care Homes is positive.

14 Patient Transport Services

The Trust benefits from its own excellent PTS service and crews operate every day of the year, to ensure that essential patient care and hospital discharges are fully supported.

This year the team has been working closely with SWASFT under a Memorandum of Understanding to provide GPs an alternative to SWASFT for the transfer of stable patients to Hospital. This is to ensure patients arrive promptly for their assessment and treatment to avoid any delays or potential admission. In addition this will support SWASFT to reduce some PTS demand and maximise their response time. The service is expanding bringing patients into the requested treatment area including A&E, AU, Community minor injury units and wards. A video of the PTS vehicles, equipment and crew capabilities has been circulated to the GP surgeries via the CCG to highlight the service for the GP's to call direct rather than SWAST.

The PTS service also provides a service for uninjured fallers (ALRT) who cannot get off the floor to be signposted by SWAST after a suitability triage to attend and lift the patient. The service is currently investigating the possibility of expanding its signposting process to allow other community services (Careline) and other piper alarm responders to be able to Triage and access the lifting team directly.

PTS also provide Intermediate Care with a responsive service with minimum delay to transport patients who need on the day upgrade of care into community homes to avoid admission to hospital.

All of the above PTS initiatives free up SWAST emergency ambulances, reduce admissions and ensure the best possible outcome for the patient and the Trust.

At peak times and during escalation the benefit of the Trust's own PTS service means that capacity can be flexed to meet discharge demand across the South Devon system.

During the adverse weather conditions the Trust's PTS 4 x 4 vehicles were valuable in our ability to safely transfer patients across our 5 localities.

15 EU Exit Plans

In preparation to EU Exit, the Trust has set up a Delivery Group which assists in responding to the key work-streams as part of EU Exit. As a Trust, we also have included Estates & Facilities, Operations, Communications, Adult Social Care and having a nursing representative as part of the group. The group has been at the forefront to respond to NHS England requests of information, notably a Temperature Check focusing on multiple elements across the Trust, and an Estates & Facilities specific assurance form. All of which is viewable on DATIX 2305.

Key preparatory actions as of yet have included drafting up a procedure to deal with the SITREP structure, which will integrate multiple elements across the Trust (all of the key work-streams and the Control Room), as well as a Shortage of Supplies (Pharmaceuticals, Medical Devices & Clinical Consumables, Non-Clinical goods) protocol to deal with issues.

Planning assumptions nationally are still being updated and progressed, therefore planning for the Trust has to remain quite fluid. We as a team envisage no issues with workforce internally within the Trust, but have suggestions to assist our Adult Social Care network through internal staffing and fuel arrangements. Deep dives are being conducted across the Trust for supplies of items that fall outside of the national arrangements, to ensure a continuity and resilience in supply chain and logistical items.

Delivery Group meetings are arranged on a weekly basis, to provide regular updates for members of the team to help focus and assist in progression for EU Exit planning and preparation. The key messaging from the latest Delivery Group meeting was:

- Linking with Domiciliary Care, Care Home and Local Authority providers for site of plans and attempting to put in place flexible working for TSDFT staff to assist in the Social Care sector in the event of staff disruption.
- The EU Settlement Scheme has fully been reimbursed to the Trust.
- There are concerns with regards to funding for out of hours arrangements for particular teams during the monitoring period, and teams are putting in place their own escalation procedures.
- Further checks regionally for the supply of radio-isotopes will be conducted, just to temperature check other hospitals.

16 24/7 Winter Leadership Arrangements

There are established arrangements in place both in and out of hours for matters to be escalated throughout the health and social care community. The CCG and local providers share on-call rotas to enable issues to be escalated where necessary in a timely manner whilst ensuring that all appropriate guidance is followed.

A winter leadership team is in place again this year to oversee the implementation of the Winter Plan including completion, evaluation and updates to the Trust OPEL Action Plan.

The winter team comprises of:

John Harrison, Chief Operating Officer	Executive Lead
Cathy Gardner, Head of Operations	Management Lead
Ian Currie, System Medical Director	Clinical Lead
Natasha Goswell, System Director of Nursing Professional Practice	Nursing Lead

The winter team reports to the A&E Delivery Board, and will meet on a weekly basis and provides updates to the Executive Directors on the effectiveness of the plan.

17 System Escalation

The OPEL Action Plan has been reviewed and updated in accordance with full capacity surge protocols in preparation for winter, learning lessons from the urgent and emergency improvement programme as well as the capacity and demand analysis.

A pan Devon Winter Plan incorporating agreed system-wide escalation triggers has been co-ordinated through the Devon Delivery Board to ensure consistency, resilience and mutual aid across the STP.

18 Integrated Partnership Plans

18.1 Ambulance

SWASFT have developed their Winter Assurance Plan for 19/20. It will cover from November through Easter 2020, recognising that “winter” pressures covers a longer period.

Key Deliverables

- Safeguard people’s welfare
- To enable the trust to continue to deliver services in line with commissioned performance standards
- To continue to be able to provide a confident, safe and effective response and specific and major incident during the winter period.
- To maintain the reputation and confidence of the trust among key stakeholders
- To provide assurance that the trust is as prepared for winter as possible.

Planning Assumptions

- Incidents will be higher in winter
- Incidents have increased by 2-6% in the last three years
- Expected increase for Christmas 5.9%
- Anticipating an 8.5% sickness rate over Christmas and 7% for the rest of winter
- Adding an additional 9% capacity for this time
- When it is colder bellow 8c during the day and 4c at night activity increases

Forecasting

SWASFT have put more resources into forecasting this year and estimate the five busiest days to be:
14th December 2984 calls expected
21st December 3005 calls expected
22nd December 2986 calls expected
26th December 2981 calls expected
1st January 3422 calls expected

Key Changes from 18/19

- More emphasis on forecasting
- New post in clinical hub to manage the flow
- Incident co-ordinator in the "winter Room"
- Spontaneous volunteers risk assessment and action cards
- Staff 4X4 guidance
- Review of escalation plan to reduce clinical hub demand
- Management of 11 calls during escalation
- Enhancing engagement with commissions and request for partners winter plans
- Stand down approach rather than stand up i.e. having rotas ready to cover rather than searching for people when needed.

Ambulance Handovers

Reducing ambulance handover remains a key priority for the Devon A&E delivery board. SWASFT will have a robust management system in place with a zero tolerance to holding patients in ED with a quick escalation process. There is a minimum target of 50% reduction in handovers over 60minutes.

We know that improving the position of hours lost to ambulance handover across the Devon hospitals will make a significant improvement to the ambulance service's capacity, hence the priority afforded to this by the board.

EU Exit

SWASFT have a plan for the UK exiting the EU working to the 9 priority areas identified by NHSE. It is a separate plan but will run in parallel with the Winter plan. There are less than 30 EU nationals working for SWASFT so they do not expect to be impacted by losing staff.

18.2 Mental Health

Winter headline schemes

- Crisis cafes
- Bed management
- 7-day rota for winter
- Transport office and 4x4, dedicated drivers
- Increasingly psych liaison, matched to demand
- Winter control room
- SIM pilots
- Soft roll out first response
- Escalation process including full capacity protocol
- CMHTs extension
- Winter manager
- SPA enhanced staffing

18.3 Integrated Urgent Care Service (IUCS)

- 111 on line
- Validation of 999 and ED dispositions
- Other support to the wider system.
- Clinical Advice Service / Out of Hours Primary Care

The Devon plan covers the STP strategy for IUCS winter schemes. The IUCS have developed their local assurance plans for approval by the A&E Delivery Board on 27th November 2019.

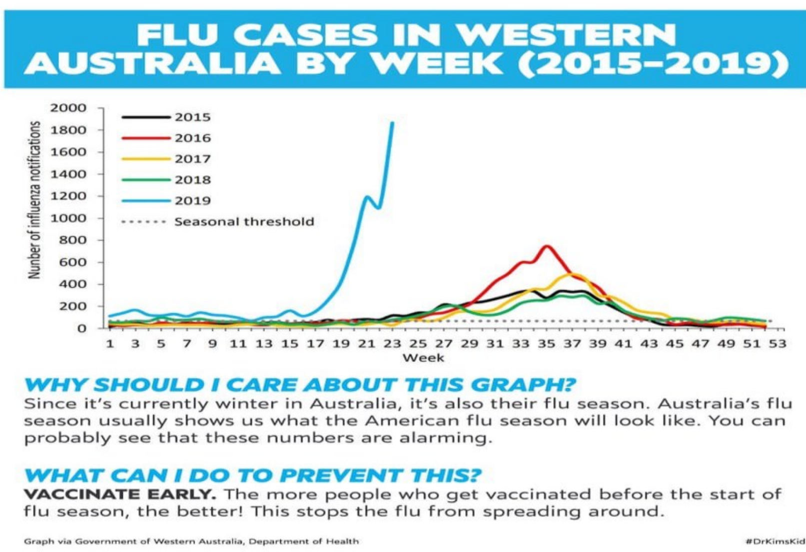
19 Infection Control including Flu

The winter plan focuses on management of influenza and norovirus because they are the two highest risk priorities. These plans will be tested through a table-top exercise in November and detailed action cards have been included within the escalation policy.

Influenza (Flu) Background

In the 2018 to 2019 season, PHE (Public Health England) reported low to moderate levels of influenza activity occurred with circulation of influenza A(H1N1)pdm09 followed by influenza A(H3N2) in the latter part of the season. Activity started in the first week of January 2019. But the flu season in Australia 2019 started early, shifted in time by about two months earlier than over the past five years. If this happens in the UK then the Flu activity would start in the first week of November and the vaccination of staff should be completed by then.

In the 2018 to 2019 season, Flu transmission resulted in high impact on secondary care with high hospitalisation rates and ICU admissions. The impact of A(H1N1)pdm09 was predominantly seen in the younger age groups (15-44 and 45-64 years) in both GP consultations and hospital and ICU/HDU influenza admissions which were the second highest seen in the last 7 years.



Influenza Vaccination

Vaccine uptake for health care workers in 2018 to 2019 increased to 70.3% compared to 68.7% in 2017 to 2018. TSDFT's Flu vaccination rate was 61%. For 2019/20 each organisation will monitor

uptake and report back monthly to the Strategic Flu Group using a reporting template as per Public Health England (PHE).

Frontline health and social care workers will be provided with flu vaccination by their employer. This will form part of each organisations' policy for the prevention of transmission of infection (flu) to help protect patients, residents, and service users as well as staff and their families. This includes staff in all NHS trusts, general practices, care homes, and domiciliary care.

TSDFT's Flu Plan

The full Flu Plan is in the trust policy CG2026 and recent improvements include:

- Additional side rooms have been created within the acute Hospital.
- 24 hour point of care flu testing in ED.
- Bay closure only if index patient present in a bay for 8 hours.
- Improve flu recognition and testing in community hospitals.
- Considerable pre-flu season education of front-line staff and communications throughout the Trust and including domiciliary care providers, intermediate care, rapid response and end of life team.
- Ward visits by the IP&CT(Infection Prevention & Control Team) and all staff communication with risk assessments, information about flu, isolation and testing.
- BIPAP sideroom kept available on Midgley.
- If Paediatric sideroom capacity is reached then discussion of cohorting with IP&C because all patients will need to be risk assessed and tested for Respiratory Viruses.
- IP&C will meet with the Domiciliary Care Provider to ensure that PPE and vaccination is available to their Workers.

Flu Action Plan August 2019.docx

Flu 19 Action cards Winter plan.docx

A multi-agency Flu Planning Group

This group has regular tele-conferences and have an action plan in progress which includes:

- Use of key public areas (e.g. Torbay museum) to educate and promote the vaccination
- Close liaison with Local Authorities to promote high vaccine uptake amongst employees with particular focus on frontline healthcare workers and other priority groups.
- SWAS will station an ambulance outside A&E so their staff can be vaccinated.
- Alignment of Flu Plans with Public Health Teams / Devon CCG.
- QAIT has sent out letter to all Care homes containing the NHS England and NHS Improvement South West link for information on managing vaccination and outbreaks. https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/care-guidance/
- Offering flu vaccines at out-patient clinics and to specific 'at risk' groups e.g. respiratory
- Effective flu vaccination programme being delivered in maternity services
- There is scope for Community Pharmacies to support in areas where the GP Practice has staff recruitment issues (Beacon Pilot)
- Public Health will monitor all outbreaks in education settings and share information with local Flu Committee
- PHE and Local Authorities are exploring ways of working with secure units, in particular the MOD secure unit in Plymouth, Devonport

- Flu vaccination is available from the beginning of October 2018 for all DPT staff, and some identified in-patient groups (OPNH, long stay i.e. secure and rehab patients as well as at risk groups including pregnant women)
- Peer and roving vaccinators recruited and trained in immunisation and all aspects of campaign throughout health provider organisations
- Flu vaccine champions recruited from all Directorates and professional groups, role specification provided
- Infection control link practitioners briefed on their role in promotion of flu vaccine
- Improved manager sign-up to the strategy, including briefing of senior staff
- Communications strategy using in-house materials, “flu fighter” materials, DH patient materials, vaccinator education, on-line news and social media.
- The access to antivirals protocol (out of season) is a pan Devon protocol.
- There is currently a specification being developed across Devon for in and out of season outbreak management in care homes.
- The Devon IP&C Forum will ensure Trusts support PHE with Flu outbreaks in Care homes.

Norovirus/ D&V

TSDFT has policies and protocols for managing Norovirus and D&V outbreaks in hospital/bed based care settings and this includes Enhanced Cleaning and Deep Cleaning requirements. The Norovirus Escalation Action cards are attached below.

Winter 2019
Norovirus D&V Action

When infection outbreaks occur in care homes they have the potential to negatively impact on patient flow across the system. The Devon IP&C Forum will ensure Trusts support PHE with Norovirus and D&V outbreaks in Care homes. Outbreak management in care homes will be managed by PHE and TSDFT collaboratively and this will streamline IP&C advice, cleaning and re-opening of care homes. TSDFT IP&CT have been working with care homes to pro-actively improve IP&C which may reduce cross-infection.

Dedicated Deep Cleaning resources, which include Hydrogen Peroxide Vapour (HPV), are in place at TSDFT to ensure a timely response across acute and community sites against outbreaks. There is a decant ward facility, on the acute site, available from Q4 onwards.

References

Surveillance of influenza and other respiratory viruses in the UK Winter 2018 to 2019
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807472/Surveillance_of_influenza_and_other_respiratory_viruses_in_the_UK_2018_to_2019-FINAL.pdf

Flu cases in Western Australia
https://www.google.com/search?q=MMWR+graph+of+australian+flu&rlz=1C1GGRV_enGB751GB751&source=lnms&tbm=isch&sa=X&ved=0ahUKEwip_8fYhtXkAhVVUBUIHfVgAJgQ_AUIEygC&biw=1440&bih=797#imgrc=1yiO9CDxRpI-vM:

20 Adverse Weather Planning

Following the 1 in 10 year weather event experienced in March 2018, when an unprecedented red alert was issued by the Met Office, arrangements for managing services during inclement weather are annually reviewed.

21 Communication and Public Messaging

The STP work together each winter on a system-wide winter communications and marketing plan to utilise public websites, social media, newspapers, outdoor and digital advertising and direct mail to help inform and advise the public on being prepared for winter, choosing the right service and what they can do to help themselves. Examples of the information included are:

- Self-care
- Planning ahead for colder months i.e. keeping their house warm, keeping medicines cabinet stocked, etc.
- Promoting flu vaccination to vulnerable groups
- Opening times and available services, especially over weekends and bank holidays
- Stay Well This Winter national campaign including NHS 111 (and online), pharmacy and extended GP access.

Other communication channels used include:

- Social media – especially to communicate urgent messages
- Utilisation of community teams to speak directly to service users, their carers and family and other healthcare professionals
- Messaging in GP surgeries
- Message in all-staff bulletins
- Press releases
- Outdoor advertising

Where there is heightened pressure/or an awareness that pressures are building within the local system communications are cascaded to partner organisations to alert and request assistance where possible, for example if the acute trust are experiencing pressures within the ED communications will cascaded to primary care, ambulance service and the public.

Torbay and South Devon NHS Foundation Trust publishes live waiting time information on their website, including the number of patients currently in the department and waiting to be seen for all Minor Injury Units (MIUs) and the Emergency Department, via the following link:
https://www.torbayandsouthdevon.nhs.uk/services/urgent-and-emergency-care/ed-miu-waiting-times/

22 Table Top Exercise

Surge including full capacity protocol; IT Failure: Business Continuity plans.

It is intended to undertake a cross-provider table top exercise, aimed at testing the actions, reactions and cross boundary communications between provider and commissioning organisations at the various stages of escalation. This is being organised by Jonathan Taylor-Edmondson, Head of Safety, Security and Emergency Planning.

23 Process of Assurance and Sign Off

The Torbay and South Devon winter plan forms part of a wider Devon STP winter plan. Versions of the plan have been developed following feedback from NHSI/England, local and regional stakeholder groups as well as continuing revised guidance actively being generated from the Department of Health.

An overview of the oversight and approval timeline is detailed below:

First review at South Devon A&E Delivery Board	25 Sep 2019
Initial submission to NHS England as part of the wider Devon plan	4 Oct 2019
Review at Devon Delivery Board	9 Oct 2019
Feedback from NHSE/NHSI on STP Plans	11 Oct 2019
Torbay & South Devon Trust Board	6 Nov 2019
STP submit Plans ahead of ECIST check and challenge	
STP submit KLOEs	8 Nov 2019
NHSE/I Winter Operating Model commenced/daily sitrep commence	11 Nov 2019
Weekly operational look forward (WOLF) meeting to commence	14 Nov 2019

APPENDIX 1 – WINTER SCHEMES

WINTER SCHEMES	OBJECTIVE	LEAD
Hospital discharge hub and social care referral process at weekends.	Maintain discharge focus at weekends and momentum to improve Monday discharge for complex patients.	Sarah Bradley
End of life programme of work: support for block book end of life personal care.	Admission avoidance programme.	Gill Horne
Enhanced site team providing clinical co-ordination 7-days a week.	Increase discharges Friday, Saturday and Sunday. Aim 5 extra discharges per day. Cumulative impact to reduce crowding in ED Sunday/Monday.	Cathy Gardner
High impact users – scheme to coach/support patients.	Reduction in use of ED.	Helen Davies-Cox
Overnight PTS with re-settlement HCA to maximise discharge opportunities for able patients to transfer home at night.	marginal but may support 2/3 additional discharges	Andy Knowles
GP visiting support to care homes.	Potential to reduce admissions.	Trevor Avis
Infection control nurses to be rostered 7-days a week to provide advice and guidance to weekend teams and support outbreak management.	Reduce bed closures and actively provide advice and guidance around flu and norovirus not only within acute and community beds but to our residential homes.	Lynn Kelly
Increase SDEC	Extended Ambulatory Unit to 20 hours 6am to 2am with potential for overnight at times of peak demand surge. Maximise throughput of ambulatory patients to meet demand and admission avoidance. Reduce default to admission and provide early access at 6am for ambulatory patients in ED. Reduce crowding in ED – potential for 5 additional patients to be managed in AU in these extended hours.	Sue Bramwell
Red bag scheme for care home residents – hospital transfer pathway	The red bag scheme provides a better care experience for care home residents by improving communication between care homes and hospitals. The dedicated red bag includes standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. This initiative is in place for Torbay and South Devon.	Jacquie Phare
Winter beds – Medicine	Open 18 bed Ward (6 side rooms) to provide additional bed capacity during Q4.	Cathy Gardner
Winter side rooms	Utilise 2 ward treatment rooms to substantiate 2 additional side rooms.	Sharon Boyne
Winter – RTT	Open 5 additional orthopaedic beds to maintain elective flow. POC testing on trauma ward to flexibly use both areas for clean trauma patients.	Sue Evans

Escalation Phases	OPEL status	Identified Area	Additional bed capacity	Additional resources required	Action card cross reference	Comments
PHASE 1 Existing OPEL Plan	OPEL 1	Utilise acute hospital day rooms for discharged patients Wards to utilise day rooms for early discharge: 12 by midday	(early access to 12 beds)	n/a	All Acute Medical and Surgical Wards	SAFER: Ensure that plans are in place to support the discharge of patients waiting in day rooms and that facilities are available to maintain patient experience whilst waiting.
	OPEL 1	Utilise community hospital day rooms for discharged patients All wards to identify one patient to be in the day room waiting for discharge: 4 by midday	(early access to 4 beds)	n/a	All community hospital wards	SAFER: Ensure that plans are in place to support the discharge of patients waiting in day rooms and that facilities are available to maintain patient experience whilst waiting.
	OPEL 1	Ella Rowcroft Review screened patients on Ainslie	flexible use of elective/trauma beds	Extra RN support and point of care testing for MRSA to maximise the use of additional beds	? Infection Control action card Surgical action card - T&O	Infection control plan
PHASE 2 Existing OPEL / Infection Control Plan	OPEL 2	Stroke beds/flex use dependent on demand Use of the ring fenced beds for non-stroke patients	0	n/a	Stroke / GE beds	Working with the specialty team
	OPEL 2	Dunlop Flexing across Cardiac and medical beds	0	n/a	Dunlop	Working with the specialty team
PHASE 3	OPEL 3	Forrest Ward/flex beds dependent on demand Weekend opportunity - whole bays (4 beds) to be converted from surgical to unscreen medical patients at a time.	0	n/a	Surigcal Action Card	Mainly at weekends and during elective pause.
	OPEL 3	Midgley procedure room	1	? staffing	Midgley Action card	Appropriate for generating bipap capacity on Midgley Ward
	OPEL 3	Recovery	Maximum 4	n/a	Surgical action card	Theatre patients having had surgery to be held in recovery rather than utilising ward beds. Appropriate to free up acute surgical beds overnight
	OPEL 3	NAH: Request early release of 2 GP beds	0	n/a	OPEL Plan	Early transfer of community patients before 3pm.
	OPEL 3	Dawlish - 1 additional esc bed	1	n/a	OPEL Plan	
	OPEL 3	Totnes - 1 additional escalation bed	1	n/a	OPEL Plan	
PHASE 4	Internal Critical Incident (prior to declaring OPEL 4)	Optimise AMU as a bedded facility overnight	6 Overnight	1 x RN and 1 x HCA, with additional support in the morning to bridge the gap between night and day shift (2 hours)	AMU action card	[this goes beyond the current plan to extend the opening hours of AMU from 6am to 2am for ambulatory patients]
	Internal Critical Incident (prior to declaring OPEL 4)	EAU3 GP direct assessment spaces (Bay 5)	Convert 4 trolleys to 4 assessment to beds	? staffing	EAU3 action card	Potential to negatively impact on patient flow from ED. Mainly applicable at night or weekends
PHASE 5	OPEL 4 - Decant/Discharge/O-night capacity	Elizabeth	12 (2 x 5 bed bays + 2 SRs)	Staffing: dependent on function	SOP	Options for use: Short term discharge lounge with mixed chair and bed capacity, to quickly free up ward capacity to manage a surge in ED attendances Or an overnight bedded area to provide additional capacity. Nurse staffing plan to be agreed via the Trustwide Temporary Staffing Group and the medical staffing plan to be agreed via the AMDs.
	OPEL 4	Simpson - dayroom	1	TBC	? SOP	12-hour max
	OPEL 4	George Earl - dayroom	1	TBC	? SOP	12-hour max
	OPEL 4	EAU4 - dayroom	1	TBC	? SOP	12-hour max
	OPEL 4	CCU - pacing room	1	TBC	? SOP	12-hour max
	OPEL 4	CPU - echo room	1	TBC	? SOP	12-hour max

Report to the Trust Board of Directors				
Report title: Clinical Services Transformation Programme – Baseline Findings and Update			Meeting date: 6th November 2019	
Report appendix	Nil			
Report sponsor	Medical Director			
Report author	Cath Parnell – Executive Support Manager			
Report provenance	Reviewed by Executive Directors on 29th October 2019			
Purpose of the report and key issues for consideration/decision	To provide an update on the baseline assessment of local clinical services undertaken by the Clinical Services Transformation Group.			
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☒	
Recommendation	The Trust Board is asked to note the contents of 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		Risk score	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

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

Report title: Clinical Services Transformation Programme – Baseline findings and Update		Meeting date: 6th November 2019
Report sponsor	Medical Director	
Report author	Cath Parnell – Executive Support Manager	

1. Introduction

In March 2019 the Clinical Services Transformation Group was convened with the aim of informing both the Trusts improvement programme for short / medium term operational planning and the development of the transformational long-term care model.

The initial focus of this group was to undertake a baseline assessment of local clinical services with a specific focus on the provision of Outpatients, Procedures and Same Day Emergency Care services factoring in national / regional requirements and commitments. The baselining work has highlighted:-

- areas of local innovation and good practice
- opportunities and avenues for sharing of good practice
- areas of potential process improvement
- areas requiring investment for improvement

In addition, the Trust is reinvigorating its approach to the Getting It Right First Time programme of reviews and action planning to further identify and explore areas of opportunity.

2. Outpatients

The current model of outpatient care has been under scrutiny at a national level with the Royal College of Physicians recommending changes and the Long Term Plan setting out proposals for reform. At a regional level the STP has committed to a general reduction in outpatient appointments of 15% with a 30 % reduction in follow up appointments with Trusts transforming services in support of following the Milton Keynes model that face to face consultations are only performed when there is no alternative possible.

In March 2019, with the support of McKinsey Associates, we commenced a detailed review of 4 specialties which identified a number of opportunities for the modernisation of the outpatient services in line with the STP aspirations. Following on from this the Trust further developed the methodology to include wider qualitative and quantitative assessments, to include readiness to change from organisational development and Quality Improvement skills perspectives, and applied this to 16 other specialties. This review focussed predominantly on medical outpatient activity.

Baseline assessment of current practices and innovation within the processes forming part of the standard outpatient pathway (Appendix One) has now been completed with the key findings, opportunities and barriers to change summarised in Appendix Two,

Three and Four. Further work continues to provide a similar baseline in relation to nursing and AHP outpatient activity.
.
In year opportunities for efficiencies in specialties with highest potential gain have been identified by the system leadership teams and are now being managed within the Outpatient Steering Group led by the Director of Transformation and Partnerships. The wider baselining work will underpin aspects of the Clinical Services Strategy and development of care model transformation as well as being a catalyst for similar transformation in other STP provider organisations through the STP Planned Care Group.

3. Procedures

The Trust is well known for its innovation in the movement of procedures from the traditional in-patient theatre to a day-case theatre setting and then into the outpatient setting. However, it is recognised that there remains variation in practice and completeness of the transformation. A review was undertaken, led by Dr Mark Feeney, Consultant Gastroenterologist and Lead for Endoscopy, focussing on the current status and opportunities of high volume specialties. This review indicated:-

- Circa 10% current day surgery activity could potentially be moved into a lower intensity setting
- Some specialties or types of activity demonstrate clear efficiency benefits by having their own managed spaces (e.g. Gastroenterology)
- Some specialties could co-locate / share spaces to drive efficiencies (e.g. Urology / Gynaecology)
- Appetite for minor procedures to be done within primary care linking to the development of Primary Care Networks (PCNs)
- Appropriate clinic/ procedure rooms, kit and workforce are currently limiting factors to realisation of these transformational benefits

The work feeds into the Outpatients Steering Group and will inform current business planning and the development of the Clinical Services Strategy.

4. Same Day Emergency Care

The NHS Long Term Plan stipulates the requirement for provision of Same Day Emergency Care (SDEC) for medical and surgical patients. Monitored by the NHSI SDEC programme a number of supporting CQUINs have also been adopted for pathway specific SDECs.

Dr Catherine Blakemore, Consultant Cardiologist is leading on a programme of work, including SDEC, which sits within the Trusts Urgent and Emergency Care Programme. Initial baseline analysis indicates 29.9% of all emergency admissions in 2018/2019 were discharged on the same day against a LTP target of 30%. Although close to target the group has identified areas for significant further improvement with benefits for patients through more timely investigation without an inpatient stay.

In addition, the Trust has commenced work on the Ambulatory Emergency Care Network (AEC) Accelerator Programme.

- Initial AEC case note and data review highlighted areas of good practice such as the provision of diagnostics to support SDEC
- Variation in the amount of SDEC which corresponds with times of escalation and bedding of the ambulatory areas
- Significant opportunities for increased SDEC with provision of additional hot slots, review of opening times and review of specific high volume conditions.
- The AEC programme team with work with the Trust to investigate these improvement opportunities over the next 6 months

5. Getting It Right First Time (GIRFT)

The GIRFT national programme, in place since 2016, was initially focused on surgical specialties but has expanded into other specialties such as Emergency Medicine, medical specialties and paediatrics. For many specialties the GIRFT reviews have been a positive experience with validation of good practice through peer review in the majority of areas in specialties reviewed.

As a Trust, GIRFT was initially managed within the targeted specialties however the national programme expansion offers the trust an opportunity to gain wider learning and maximise the potential to realise any clinical and efficiency benefits based on peer reviewed observations and benchmarked data analysis. We recognise that, as a Trust, we have not maximised the benefit of these reviews. As such planning is underway to centrally co-ordinate the GIRFT programme and establish it into the governance structure of the ISUs to support operational business planning along with informing the Clinical Services Strategy and development of the care model.

Progress on GIRFT includes:-

- 17 specialties have had a GIRFT review with a further 5 planned
- Review and update of all GIRFT recommendations and action plans underway
- Collation of common themes across all specialties
- Participation in joint NHS Benchmarking / GIRFT data collection exercises
- Participation in national GIRFT audits including Surgical Site Infections and Thrombosis
- Completion of Litigation 5 point plan and implementation of an action plan
- Action plan to build on existing work to gain Veterans Awareness accreditation
- Sharing of highlighted good practice and opportunities across the STP and within networks through the Planned Care Group and Peninsula Clinical Services Strategy.

6. Summary

The baselining analysis undertaken within each of the workstreams within the Clinical Services Transformation Programme has identified innovative and progressive service provision. However there are significant opportunities for further progression. This work will inform the development of the Trust's Clinical Services Strategy and be shared with the STP's Planned Care Group in support of decision making within wider health and social care provision for the community.

In year opportunities are being managed by the ISU's supported by targeted projects within the Urgent & Emergency Care Programme and Outpatients Steering Groups. Led by the Director of Transformation and Partnerships, progress and delivery is being tracked on Smartsheet and is governed by the Assurance and Transformation Group and the Integrated Governance Group.

Appendix One – Outpatient Baseline (based on McKinsey model)

Assessment of current practices at TSD

NHS
Torbay and South Devon
NHS Foundation Trust

Current practices in 20 specialties

Stage	Question	% specialties with limited evidence of innovation	% specialties with pockets of innovation	% specialties with evidence of Innovation
Primary care con-sultation	Are GPs able to access electronic hospital records?	100%		
	Do GPs have clear referral protocols and access to A&G services?	20%		80%
	Do referrals come through a single point of access and effectively triaged?	15%	75%	10%
Referral to out-patients	Do you pool routine referrals?	10%	29%	60%
	Can patients book and manage appointments online?	90%		10%
	Do you send automated reminders about upcoming appointments?	10%	5%	85%
	Do you use self check-in kiosks?	100%		
First outpatient appointment	Can patients upload their clinical information before the clinic? (In-clinic productivity)	100%		
	Are clinics paperless? (In-clinic productivity)	100%		
	Is consent done electronically (In-clinic productivity)	85%	5%	10%
	Do you automate booking, ordering and reporting of diagnostics? (In-clinic productivity)	50%	30%	20%
	Do you run group clinics?	50%	45%	5%
	Do you run one-stop clinics?	50%	15%	35%
Follow-up outpatient appointment	Do you have clinics run by non-medical staff?	10%	15%	75%
	Do you offer telephone consultations?	55%	25%	20%
	Do you offer video consultations?	100%		
	Do you have systematic patient-initiated follow-up?	75%	15%	10%
	Do you risk stratify patients to determine their follow up requirements?	35%	35%	30%
Admission or discharge	Do you provide patients with online or mobile access self-management information?	70%	20%	10%
	Do you provide patients with online or mobile access to communicate with clinicians remotely without the need for and outpatient appointment?	70%	20%	10%

Adoption of improvements varies between specialties. Non-traditional models (e.g. group clinics and one-stop clinics) have been adopted in some specialties but not others. No specialties have digitised the admin system.

Appendix Two – Outpatient Summary findings

Summary findings from assessment of current practice of 20 specialties

Process Theme	Key Findings
Primary Care Consultation	• GPs are not currently able to access electronic hospital records • GPs have clear referral protocols for most but not all specialties; some have access to A&G • Some referrals come through a single point of access, some partly & some not at all
Referral to Outpatients	• Not all specialties pool routine referrals • Only a very few specialties enable patients to book & manage appointments on-line • Most specialties send automated reminders about appointments
First Outpatient Appointment	• No specialties use self check-in kiosks • No specialties have paperless clinics • Few specialties hold group clinics • Only a few specialties run one-stop clinics • Variation in whether specialties automate booking, ordering & reporting of diagnostics
Follow Up Outpatient Appointment	• Majority of specialties have some clinics run by non-medical staff • Few specialties offer telephone consultations • No specialties offer video consultations • Most specialties do not have systemic patient initiated follow up
Admission or Discharge	• Most specialties do not provide patients with on-line access self management information • Most specialties do not provide patients with on-line or mobile access to communicate with clinicians remotely without need for an outpatient appointment • Some specialties use Patient Activation Measures scoring for patients but not in terms of remote monitoring & patient initiated appointments

Appendix Three – Outpatient Opportunities for innovation

Key Themes/Opportunities for innovation

Improvement themes	Examples of innovation that could be implemented by specialties
1 Only see the people who really need to be seen (for firsts and follow ups)	• Set up patient initiated follow up appointments for patients on PAM 3&4 • Review potential for GPSIs
2 Have the right professionals review patients	• Upskill nurses to take on clinics particularly follow ups • Explore if specialist nurses could run multi-specialty polyclinics • Develop more integrated working with community & primary care • Increase pooling of routine referrals
3 Increase non-face to face alternatives	• Implement telephone & video appointments • Increase patients seen in group clinics • Ensure access to clinicians remotely to receive advice without appointment
4 Improve productivity (e.g. move to a paperless system)	• Optimise administration processes eg allow patients to book & manage appointments on-line • Increase number of one-stop clinics • Ensure efficient clinic space & adjacencies to optimise staffing
5 Give patients control of their own care to improve their experience	• Implement patient initiated contacts/appointments • Increase patient information via digital solutions • Increase use of Apps for patients • Increase automation of booking, ordering & reporting of diagnostics

Appendix Four – Outpatients – key themes or barriers

Key Themes of Barriers

Theme	Barrier
Estates	• Room adjacencies & clean OP rooms • Space for growing demand • Space for group clinics
Operational Resource	• Project resource/support to undertake transformation work • Operational backfill to release people to undertake transformation work
Staffing	• New skill mixes of staff required • Vacancies/substantive roles filled by locums
IT/Digital	• Requirement for Apps, videos, telephone appointments • Booking system for patient initiated appointments
Finance	• To fund digital innovations • To fund estates requirements • To fund staffing requirements • Identifying benefits realisation

Report to the Trust Board of Directors			
Report title: Care Quality Commission update			Meeting date: 6th November 2019
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Quality and Compliance Manager		
Report provenance	CQC and Compliance Assurance Group Regular meetings with the CQC Review of CQC publications		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to maintain the Board's awareness of current CQC matters and provide early signalling of areas requiring action to improve the healthcare service provided.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors is asked to note the contents of 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**	

Report title: Care Quality Commission update		**Meeting date:** 6th November 2019
Report sponsor	Chief Nurse	
Report author	Quality and Compliance Manager	

1 Introduction

1.1 Aim

This paper aims to provide the following for the TSDFT Board:

- An update on previous TSDFT CQC inspections (section 2.1)
- An update on forthcoming TSDFT CQC inspections (section 2.2)
- An update on CQC's ongoing monitoring of the Trust (section 2.3)
- An update on TSDFT's CQC registration activity (section 2.4)
- A summary of progress on TSDFT Board's well-led self-assessment (section 2.5)
- A summary of the CQC's State of Care report (section 2.6).

1.2 Purpose

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

2 Discussion

2.1 Previous CQC inspections: 2018 well-led and core services

2.1.1 **Requirement Notices**

The CQC's Inspection Report published in May 2018 from the inspection of five core services and the well-led assessment of TSDFT listed ten Requirement Notices. The progress towards addressing these notices has been monitored through the CQC and Compliance Assurance Group (CQCCAG; formerly CQC Assurance Group).

At the August Board meeting, it was reported that CQCCAG had agreed that sufficient assurance and evidence of compliance had been received to formally close six of the ten Requirement Notices. At the subsequent August meeting of the CQCCAG, the last of the remaining Requirement Notices was closed by the group. Table 1 lists the Requirement Notices and the established business as usual assurance route for ongoing monitoring where required, is stated.

Table 1: 2018 CQC Inspection Requirement Notices with the business as usual assurance route for ongoing monitoring, now that the action plan is complete.

#	Core Service Inspected	Requirement Notice	Business as usual assurance route
1	Maternity	Ensure that all maternity staff have in date mandatory training.	Maternity Clinical Governance Group through to Torquay ISU Governance Group
2	Maternity	Review systems and processes to ensure equipment has had the correct safety checks and audits, with particular reference to resuscitaires.	Maternity Clinical Governance Group through to Torquay ISU Governance Group
3	Maternity	Review systems & processes to ensure medicines have the correct safety checks and audits and that midwives are following the correct guidance when storing medicines out of fridges.	Maternity Clinical Governance Group through to Torquay ISU Governance Group
4	Maternity	Ensure maternal early obstetric warning score (MEOWS) assessments are completed and used effectively in line with all policies related to monitoring deterioration and post-operatively.	Maternity Clinical Governance Group through to Torquay ISU Governance Group
5	Maternity	The lead midwife for safeguarding and the nominated individual for safeguarding for the trust should have the correct level of training to comply with national recommendations.	n/a
6	Acute End of Life Care	Ensure care planning documentation is used consistently to assess and plan the needs of palliative care and end of life patients.	End of Life Group through to Quality Improvement Group
7	Outpatients	Ensure that trust targets are met for the completion of mandatory training updates for both medical staff & nursing staff in the outpatients service.	Medical Director has oversight via ISU performance review. Mandatory Training Sub-Group through to Workforce and OD Group (recently disbanded; new reporting line to be determined)
8	Outpatients	Ensure that trust targets are met for the completion of safeguarding updates for both medical staff and nursing staff in the outpatients service.	Medical Director has oversight via ISU performance review. Mandatory Training Sub-Group through to Workforce and OD Group (recently disbanded; new reporting line to be determined)
9	Outpatients	Ensure that the renovations for the fracture clinic continue as planned and are not delayed to address the risks identified around infection prevention and control, the environment, and privacy and dignity.	n/a
10	Community End of Life Care	Ensure the Mental Capacity Act 2005 is complied with.	Adult Safeguarding Group through to Safeguarding/Inclusion Group through to Quality Assurance Committee

2.1.2 **Should Do Improvements**

The CQC's Inspection Report published in May 2018 from the inspection of five core services and the well-led assessment of TSDFT listed 47 "Should Do Improvements". The status of the actions towards addressing these improvements is as follows:

- Overall Trust, 7 of 9 are closed;
- Maternity, all 12 are closed;
- End of Life, 7 of 10 are closed;
- Outpatients, all 5 are closed;
- Community End of Life, all 6 are closed, and
- Community Children and Young People, 3 of 5 are closed.

Of the remaining 7 open "Should Do Improvements" none are RAG-rated as red, where "red" is requiring additional unplanned intervention. The Should Do Improvement action plan is regularly reviewed at the monthly CQCCAG meeting.

2.1.3 **Display of ratings requirement**

At the end of September 2019, the CQC announced an added requirement to Regulation 20A, for trusts that have had a Use of Resources assessment to display the rating on posters alongside their other CQC ratings. The poster document has been updated and is currently being printed and laminated ready for distribution around the Trust.

2.2 Forthcoming inspections

2.2.1 **Joint Targeted Area Inspections: Children's Mental Health, Devon**

A Joint Targeted Area Inspection(s) of Children's Mental Health, Devon is expected by the end of 2019. These inspections are undertaken by Ofsted, the CQC, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation).

These inspections focus on a deep-dive investigation into how local services respond to children and their families when children are living with mental ill health and children are subject to a child in need or child protection plan or are a looked after child.

This Devon inspection will be hosted by Devon County Council (DCC). The Director of Children's Services at DCC will be notified ten working days ahead of the onsite inspection. There will be an information request to be returned within five working days of the notification. The inspectors will be onsite for five days. A letter of inspection findings will be published.

It is expected that the focus of the inspection will be strongly on services provided by CAMHS (Devon Partnership Trust; DPT), although the Learning Disability and Autism Spectrum Disorder services provided by TSDFT could be included.

Prior to the inspection, a dry-run audit will be performed by DCC and providers, simulating the expected inspection approach of tracking (in-depth end-to-end look at the experiences of a small number of children) and sampling (targeted look at experiences of a greater number of children, focusing on points in their journeys).

2.2.2 **Well-led and core services inspections**

At the time of writing (24th October 2019), there are currently no known dates of forthcoming CQC inspections.

The CQC perform an announced well-led inspection of each provider approximately annually. TSDFT's last well-led inspection was 6th - 8th March 2018. Approximately 10-12 weeks before a well-led inspection, TSDFT will receive the Provider Information Request (PIR) from the CQC. Between receiving this request and the announced well-led inspection, TSDFT will receive an unannounced inspection of at least one core service. At the time of writing, the request for the PIR has not yet been received.

As well as the above programme of inspections, TSDFT may receive an announced or unannounced inspection at any time, in or out of hours.

In preparation for receiving the PIR, contact leads within TSDFT have been assigned specific information for which they are responsible for providing to the Quality and Compliance Manager within approximately five calendar days (to be confirmed on receipt of PIR). The full submission will be compiled for review by the Chief Nurse or deputy, and time allowed for amendment, approval and submission to the CQC within three weeks of receipt of the PIR in order to meet the CQC's timeframe. Resource to assist the Quality and Compliance Manager with the management of the PIR response has been identified.

A document titled "Preparing for a CQC inspection: An introduction and toolkit for team leaders and their teams" is being created by TSDFT to support teams and staff in being inspection ready. The document will provide: an outline of what to expect from a CQC inspection; top level generic trust information (e.g. values, vision, Exec and Chairman photos, ISU structure), and questions/checklists to help teams prepare themselves for an inspection. The draft will be reviewed at the next CQCCAG meeting.

Teams/services are producing one-page "Achievement summaries" as infographics or newsletters highlighting achievements since the last CQC inspection to help raise awareness of the progress and great work being done, within and across teams.

2.3 CQC's ongoing monitoring

2.3.1 **CQC-TSDFT Engagement meetings**

On 1st September 2019, Tracy Hipkin-Wale, replaced Sharon Hayward-Wright as the Trust's local CQC inspector (relationship holder), as part of numerous team changes for the CQC who aim to move inspectors after five years to prevent provider relationships getting too close and to maintain 'fresh eyes'.

Over the past six months, there have been several changes between Mandy Williams and Dan Thorogood as Inspector Manager. A further change as of 28th October 2019, will see Amy Bance becoming the Inspector Manager.

On Thursday 29th August, an inspector handover meeting was held at Torbay Hospital for an initial "meet and greet" with Tracy Hipkin-Wale, and handover of current issues being monitored.

Engagement meetings are held quarterly between TSDFT and the CQC, as part of the CQC's ongoing monitoring of providers, in-line with the CQC's 2016-2021 strategy. These meetings are written up with brief notes in the CQC's Engagement Meeting Record Tool, a final copy of which is sent by the CQC to NHS England and NHS Improvement.

As reported to the August Board meeting, the last meeting was held on Thursday 4th July 2019 at Newton Abbot Hospital and was attended by Dan Thorogood (CQC Inspection Manager) and Sharon Hayward-Wright (CQC Inspector) and focussed on the Community Health Services for Adults core service.

The next CQC-TSDFT Engagement meeting is scheduled for Wednesday 27th November 2019. From November onwards, these meetings will follow a slightly different format as preferred by our new local inspector which will include an interview with one Executive Director by the Inspector Manager each quarter. The Inspector will hold interviews with core services leads and will run staff engagement sessions, to include both core-service-specific focus groups (e.g. in November 2019 there will be Critical Care focus group) and non-core-service focus groups e.g. freedom to speak up guardians.

2.3.2 **CQC Insight**

The CQC Insight tool is designed to make CQC's activity more intelligence-driven as outlined in their strategy for 2016-2021. The Insight dashboard primarily enables CQC staff to monitor the quality of care and focus resources on where the risk is greatest.

Point-in-time extracts of TSDFT data on the CQC Insight tool are made available to TSDFT approximately monthly. The tool is still being developed by the CQC and it is common to see new measures appear from month to month. Each month the extract report is distributed for teams to check the Trust is already sighted on the measures, and 'new-this-month red flags' compared to the previous month, are highlighted.

2.3.3 **CQC follow up on specific events pertaining to services provided by the Trust**

As part of the ongoing monitoring of the Trust by the CQC, the local CQC inspector requests further information on specific events relating to services provided by the Trust, of particular interest such as specific complaints, safeguarding concerns, patient-related incidents, etc. All of these events are routinely managed internally by TSDFT through established processes and governance routes; when the information on the specific events requested becomes available it is passed to the CQC.

The CQC may also request a response from the Trust to feedback received directly by the CQC, in regards to the services provided by the Trust, to which the Trust will provide a timely response.

The number of such requests for further information received from the CQC within the last three months, for each category of event, is shown in Table 2.

Table 2: The number of requests received between 23rd July 2019 and 23rd October 2019, from the CQC for information on specific events, related to services provided by the Trust.

Event category	Number of requests
Direct feedback to CQC	0
Complaint to CQC	0
Never Event	0
Safeguarding concerns	6
NRLS	0
RIDDOR	0
Major incident	2

RIDDOR = (Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013; responsibility for which has been assumed by the CQC from the HSE); NRLS = National Reporting and Learning System.

In addition, the Trust has proactively reported to the CQC: one issue ahead of being aired on locally-televised news; one issue ahead of being discussed at Board; one major incident; one safeguarding and one StEIS-reported incident.

In responding to the safeguarding concern queries received from the CQC, a process change, taken through the Safeguarding/Inclusion Group, has been implemented to improve earlier and wider visibility within the Trust of information being reported to the CQC regarding safeguarding concerns.

2.4 CQC Registration: Torbay 0-19 Partnership

After consultation with the CQC Registration team, the Trust has recently received confirmation from the CQC that the current status of the Trust's registration with the CQC supports the services provided as part of the new Torbay 0-19 Partnership contract and therefore no changes are required to the Trust's registration status. However, the CQC advised that the Statement of Purpose should be updated highlighting the new services and the sub-contractors that the Trust is engaged with in relation to these services, and to submit as a Statutory Notification. Work on updating the Statement of Purpose is underway and the intention is to submit by the end of 2019.

2.5 TSDFT's Board well-led self-assessment

At the Board Development Session in November 2018, the Board discussed and self-assessed the Trust against a CQC rating of Outstanding for the eight key lines of enquiry (KLOEs) in the NHSI/CQC well-led framework dated June 2017. The Board discussed and agreed the: current state; evidence for the current state; gaps to Outstanding, and RAG-rated where "Red" is little or no evidence to support an Outstanding rating, "Amber" is some evidence or more assurance is required, and "Green" is sufficiently assured. No KLOEs were self-rated as "Red".

“Gaps” were defined as areas requiring additional strengthening to bring the Trust up to a CQC self-assessment rating of Outstanding. Progress made towards narrowing the gaps identified in the self-assessment has been in part facilitated by the development of the Torbay and South Devon Systems, which includes increased clinical leadership capacity.

In May 2019, the Executive Directors undertook to review progress towards closing the “gaps” to outstanding previously identified, with input from the System Directors and the Executive Director Deputies; progress updates were compiled in June 2019. The focus is currently being placed on gaps that were red-rated at this progress review.

2.6 CQC’s State of Care report 2019

On 15th October 2019, the CQC published their annual assessment of health care and adult social care in England in the “State of Care 2018/19” report. The full, summary and accessible information reports are at https://www.cqc.org.uk/publications/major-report/state-care. The CQC used quantitative and qualitative analysis of their inspections and ratings data published as at 31st July 2019, along with other information, including that from people who use services, their families and carers, to inform judgements on quality of care for this annual assessment.

The key messages as highlighted in subsequent CQC presentations on the State of Care are:

- People’s experience of care is determined by whether they can access good care when needed;
- People are struggling to get the right care at the right time in the right places, and risk being pushed into inappropriate care settings;
- Increased demand and challenges around access and workforce, risk creating a perfect storm.

Key issues in hospital and community health services:

- Safety remains a concern;
- Rising demand and struggle to provide high quality care.
  Urgent and emergency services continue to bear the brunt of increasing demand. July 2019 saw the highest ever monthly number of attendances at major emergency departments. “What used to be a winter problem is now happening in summer as well.”
- Continued challenge of recruitment and retention.

State of Care recommendations:

- Action from parliament, government, commissioners, providers and communities for:
  - More and better services in the community;
  - Innovation in technology, workforce and models of care;
  - System-wide action on workforce planning.
- Long-term sustainable funding for adult social care. The stability of the adult social care market remain a particular concern.

3 Conclusion

This report has provided an update to the Board on TSDFT’s current and recent CQC inspection, monitoring and registration activity. A summary of a key CQC review publication has also been provided.

4 Recommendations

The Board of Directors is asked to note the contents of the report.

Report to the Trust Board of Directors			
Report title: Outcome of the 2019 NHSE/CCG external assessment of the Trust against EPRR responsibilities and national standards.			Meeting date: 6th November 2019
Report appendix	Core standards action plan		
Report sponsor	Director of EFM and Commercial Development		
Report author	Director of EFM and Commercial Development Resilience Officer - EPRR		
Report provenance	• Executive Team • The NHSE area team responsible for emergency planning • The CCG		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Trust Board on compliance with legislation, standards and regulatory requirements relating to Emergency Preparedness Resilience and Response.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to • Formally receive the outcome and action plan of the NHS England/CCG EPPR performance and preparedness assessment for 2019 • Endorse the signing of the required assurance letter for NHS England to that effect.		
Summary of key elements			
Strategic objectives supported by this report	(see table below)		

Safe, quality care and best experience	x	**Valuing our workforce**	x
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	X	**Risk score**	12

*BC included on Risk Register

External standards affected by this report and associated risks

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

Report title: Outcome of the 2019 NHSE/CCG external assessment of the Trust against EPRR responsibilities and national standards.		**Meeting date:** 6.11.2019
Report sponsor	Director of EFM and Commercial Development	
Report author	Director of EFM and Commercial Development Resilience Officer - EPRR	

1. Introduction

This report provides information of the formal assessment by NHS England and the CCG of the Trust's EPRR performance against the core National standards for the year ending 2019. The Assurance process took place on the 11th October 2019.

The process measures our compliance against 64 core standards and a deep dive element. This year's deep dive focused on 20 elements in relation to extreme weather incorporating climate change and the effect on our estate.

The Trust Board are formally required to receive and sign off the outcome of the assessment and accompanying improvement plan in recognition of its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004).

2. Discussion

The Board can take assurance that the Trust is substantially compliant and green rated in 62 of the 64 EPRR core standards and will be compliant with 1 out of the 2* remaining amber rated standards, by April 2020.

*with the proviso that Data Protection complete their agreed action plan.

In addition to the assessment against core standards, a deep dive into the provision of Severe Weather Planning Performance against 20 criteria was undertaken. This year's Deep Dive includes five new questions on Long-term Adaption Planning for climate change, which have been included at the request of, and on behalf of, the Environmental Audit Select Committee of the House of Commons. The outcome was 15 out of 20 standards with a good rating. The areas of non-compliance were related to building adaptations to mitigate the risk of extreme heating and weather. These will only be resolved through new facilities.

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

Standards	Green	Amber	Red
50 core standards	48	2*	0
14 Hazardous Material and CBRN standards	14	0	0
20 Severe weather Standards Deep Dive	15	0	5

The two amber ratings are related to a small number of outstanding business continuity plans and the lack of a statement of compliance with the Data Protection toolkit from the Data Protection team.

One area of exceptionally good practice was noted in that a new document is now included within our business continuity plans to provide a quick and easy impact analysis for each department/ward to complete during a business continuity event. The completed impact analysis is sent directly to the Incident Command Centre (ICC) in order to facilitate Trust Silver to prioritise action according to need and impact. NHSE noted that this was a very positive way to manage an incident and have included this as an item of best practice to be shared with the wider EPRR community.

Since the assurance process the Trust has received its EPRR CBRN report conducted by SWAST. Within the report they have noted that although core standard 59 evidence states a rota is best practice evidence, they are confident that our current numbers of 36 team members along with the evidence of communications tests will be sufficient to provide the correct level of response to a CBRN incident therefore have passed us on this standard. NHSE have been contacted with the evidence to amend the outcome.

3. Conclusion

The Trust has been rated as substantially compliant for the assurance of EPRR core standards.

The attached action plan details the standards for improvement including business continuity. The climate change related items are rated as red although it is noted that these will be resolved with any new builds.

4. Recommendations

The Trust Board is asked to:

- Formally receive the outcome and action plan of the NHS England/CCG EPPR performance and preparedness assessment for 2019
- Endorse the signing of the required assurance letter for NHS England to that effect.

Appendix 1: Action Plan

Overall assessment:									
Ref	**Domain**	**Standard**	**Evidence - examples listed below**	**Organisation Evidence**	**Self assessment RAG** **Red (not compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
51	**Business Continuity**	**Business Continuity Plans**	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Individual BCP not complete	Partially compliant	Trust departments need to complete their BCPs	EPRR Lead	Feb-20	Work is continuing to provide BC workshops and one to ones in order to get plans completed. Executives to assist with the critical nature of BCP's to their respective teams
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Individual BCP not fully revised and completed	Partially compliant	Linked to 51	EPRR Lead	Feb-20	Linked to 51
59	**CBRN**	**Decontamination capability availability 24 /7**	Rotas of appropriately trained staff availability 24 /7	Good recruitment taking place - on plan. Pathway in place to track staff trained which stands at 36 out of 40.	Partially compliant	Will remain partially compliant due to model of delivery with volunteers	EPRR Lead	On-Going	38 team members working towards 40+
8	**Severe Weather response**	**Flood prevention**	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	[evidence file Deep Dive 021]	Non compliant	Privide assurance to NHSI that the Trust has in place a robust planned preventative maintenace programme in place which is the case. Monitired via the complaince group and CEIG. Site risk assessments reglularly carried out. Contractor in place for gutters and road drains. Clear process around escalation of drainage issues in place.	Head of Estates and Head of Facilities	Feb-20	Positive assurance to be provided to NHSI
17	**Long term adaptation planning**	**Overheating risk**	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	See Email [evidence file Deep Dive 023]	Non compliant	Evidence will need to be submitted	Associate Director of Estates and Facilities Head of Estates Operations	Feb-20	The Trust need to hold and record the specific areas of risk during season. These records will need to inform the risk register with an action plan of reductions in these areas.
18	**Long term adaptation planning**	**Building adaptations**	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	The Building is very compromised due to age and despite mitigating actions struggles to maintain normal business during extreme temperatures	Non compliant	Evidence will need to be submitted as regards BREEAM assessments and ratings	Associate Director of Property	Feb-20	Capital projects to ensure that climate change and hot /cold planning are included with all new builds and adaptations. All actions will need to be recorded within the records of any new projects.
19	**Long term adaptation planning**	**Flooding**	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	[evidence file Deep Dive 022]	Non compliant	Evidence will need to be submitted	Associate Director of Property	Feb-20	Capital/estates to consider new drainage when planning any modifications or new builds to the existing system.
20	**Long term adaptation planning**	**New build**	The organisation has relevant documentation that it is including adaptation plans for all new builds	Evidence was not provided to NHSE	Non compliant	Provide all BREEAM records for all new builds	Associate Director of Property	Feb-20	Capital will consider climate change effects within any new builds in line with the risks as identified from the Community Risk Register and Trust extreme

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Freedom to Speak Up Guardian Six Monthly Board Report			Meeting date: 6th November 2019
Report appendix	Appendix 1: Guidance for Boards on Freedom to Speak Up 2: Freedom to Speak Up Index Report 2019 3: A summary of speaking up learning and actions in response		
Report sponsor	Director of Workforce and Organisational Development		
Report author	Lead Freedom to Speak Up Guardian		
Report provenance	Freedom to Speak Up Guardians		
Purpose of the report and key issues for consideration/decision	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the contents of the report.		
Summary of key elements			

Strategic objectives supported by this report

Safe, quality care and best experience		**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		**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		**National policy/guidance**	x

Report title: Freedom to Speak Up Six Monthly Board Report		Meeting date: 8th May 2019
Report sponsor	Director of Workforce and Organisational Development	
Report author	Lead Freedom to Speak up Guardian	

1. Introduction

1.1 Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

1.2 In July 2019 updated guidance for Boards on Freedom to Speak Up was published by the National Guardian Office in collaboration with NHS Improvement/NHS England (Appendix 1). The self-assessment tool provided is regularly reviewed by the Lead Executive and Freedom to Speak Up Guardian. In September the tool was reviewed with stakeholders and key messages from the Speak Up vision and strategy will be used as reminders to staff that speaking up is integral to improving our culture. Embedding the strategy will include sessions with the System Leadership teams to ensure behaviours and actions are consistent with it.

1.3 The guide is aimed at senior leaders because it is the behaviour of executives and non-executives (which is then reinforced by managers) that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is. The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection. This guide forms part of the resource pack given to inspectors ahead of well-led inspections.

1.4 All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. Freedom To Speak Up is a fundamental part of that. An organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

1.5 Stakeholders including service users are part of the regular benchmarking against the self-assessment tool. We have rag rated against the speak up requirements and are green against 75% of requirements. Where we are rating amber or red we have a clear action plan that we will work to over the next six month period.

2. Discussion

2.1 Since the last Board report in May there have been 32 concerns raised through the Freedom to Speak Up Guardians. This is double the number in the previous six months and indicates that an increased number of staff are speaking up.

2.2 The main themes from the concerns raised are:

- Bullying and Harassment (9)
- Patient Safety (3)
- Failure to follow process (6)
- Diversity and Inclusion (3)
- Staff Safety (6)
- Culture of organisation (3)
- Fraud (2)

2.3 26 concerns have been raised by staff based on the acute site and 4 from community based staff. Nursing, midwifery and non-registered support staff are the highest staff groups that have raised concerns. This is followed by admin and clerical staff and allied health professions. We continue to work on forging links to reach medical staff, BME staff and temporary workers. Recruiting our newest Guardian who is a social worker by back ground has enabled us to raise awareness of the role to social care and safeguarding staff.

2.4 Bullying and Harassment continues to be the main theme of concerns raised from individuals and from pockets of staff within large departments. Work to support informal stages of resolution continues to be our focus and to support staff experiencing this behaviour. Working together with the Human Resources and Organisational Development a new policy has been written based on recommendations from the National Guardian Office. This accompanied by training on what bullying is and how it can be identified is to be launched during Anti-bullying and Wellbeing week starting week of the 4th November. Failure to follow process refers to lack of transparency regards recruitment practices. Staff safety relates to pressure in our system and adequate staffing to safely deliver services. Diversity concerns related to failure to implement reasonable adjustments.

2.5 Use of our See Something Say Something anonymous boxes continuous to be slow with concerns raised regarding individuals behaviour which have been too personal to publish.

2.6 Further support in the workplace is provided by 5 Freedom to Speak Up Champions This will increase to 8 due to the recruitment of 3 junior doctors who are currently waiting for training. The FTSU champions have guidance and support on a quarterly basis from the Guardians and a clear route of escalation for serious concerns. They are supporting our work in encouraging staff to feel safe and confident in speaking up.

2.7 Feedback included these responses:

- You have been so incredibly understanding, kind and supportive and have given me excellent guidance.

- Your position and the service you offer to people who may feel that they do not have a voice is imperative

- To be able to speak honestly and openly to a fellow professional who actively listened without prejudice and gave constructive feedback was invaluable.

- Yes I would speak up again, it's not something I've done before but it is reassuring to know that we have got support.

3. **Freedom to Speak Up Index Report 2019 (**Appendix 2**)**

3.1 The Freedom to Speak Up Index helps trusts understand how their staff perceive the speaking up culture.

3.2 The FTSU index was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey

3.3 The survey questions that have been used to make up the FTSU index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

3.4 Torbay and South Devon's rate for 2018 was 78% compared to the highest at 83% held by Gateshead Health NHS Foundation Trust for combined acute and community trust. In comparison locally North Devon Healthcare and Royal Devon and Exeter stand at 81%, University Hospitals Plymouth at 80% and Devon Partnership Trust at 79%.

4. **North West Ambulance Service NHS Trust – A summary of speaking up learning and actions in response** (Appendix 3)

4.1 Confirmation of role - The range of issues that a Freedom to Speak Up Guardian can support a worker to raise is not restricted to any particular type and instead covers a wide range of matters, including, but not limited to:

- concerns about unsafe clinical practice
- staffing and resource levels
- cultural concerns
- bullying and harassment
- training and improvement ideas

- personal employment issues
- dignity at work issues

5. Conclusion

5.1 Bullying and harassment continues to be the most common reason staff speak up. We are continuing to raise awareness of support for staff in speaking up specifically in the community. Feedback from users of the service is positive. Further guidance for Boards has been published and regular review of the self-assessment tool is in place led by the Executive lead, The Trust achieves a 78% rating in comparison with other similar trust in speaking up. Clarity on the scope of the Freedom to Speak Up role is confirmed in the most recent National Guardian Office case review.

6. Recommendation

The Board is asked to receive and note the contents of the report.

National Guardian
Freedom to Speak Up

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

NHS England and NHS Improvement

Contents

Introduction 2
About this guide 4
Our expectations 5
Conclusion 10

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

Since we first launched this guidance the NHS has published its interim People Plan, setting out its vision for people who work for the NHS to enable them to deliver the best care possible. Ensuring that everyone feels they have a voice, control and influence is at the forefront of the plan.

This guide supports boards to create that culture; one where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment. To support this, managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be welcomed and seen as opportunities to learn and improve.

We have aimed this guide at senior leaders because it is the behaviour of executives and non executives (which is then reinforced by managers) that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is.

Meeting the expectations set out in this guide will help a board create a culture responsive to feedback from workers and focused on learning and improving the quality of patient care and the experience of workers. Our expectations are accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU) will help boards to identify areas for further development.

The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection. This guide forms part of the resource pack given to inspectors ahead of well-led inspections.

Completing the self-review tool and developing an improvement action plan will help trusts to reflect on their current speaking up culture as part of their overall strategy and create a coherent narrative for their patients, workforce and oversight bodies. Details of the support available to do this are on page 10.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office, with input from a group of executives and non-executive directors (which included chief executives and chairs), FTSU Guardians and leading academics in culture and leadership.

The guide sets out our expectations, details individual responsibilities and includes supplementary resources.

We expect the executive lead for FTSU to use the guide to help the board reflect on its current position and the improvement needed to meet our expectations. Ideally the board should repeat this self-reflection exercise at least every two years.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But obtaining the FTSU Guardian's views would be a useful way of testing the board's perception of itself.

The improvement work the board does as a result of reflecting on our expectations is best placed within a wider programme of work to improve culture. This programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous, and building powerful and effective teams.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better culture. Equally, focusing on process and procedure at the expense of honestly reflecting on how you respond when someone speaks up will not improve the way the board leads the cultural improvement agenda. The attitude of the board to the review process and the connections it makes between speaking up and improved patient safety and staff experience are much more important.

We will review this guide in 2021. In the meantime, please provide any feedback to nhsi.ftsulearning@nhs.net

Our expectations

Behave in a way that encourages workers to speak up

All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. They also understand that an organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

Executive directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up. To this end executive directors:

- are able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from workers
- have insight into how their power could silence truth
- thank workers who speak up
- demonstrate that they have heard when workers speak up by providing feedback
- seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

Executive directors could test how their behaviour is perceived with direct and incidental feedback from staff surveys; pulse surveys; social media comments; reverse mentoring, 360° feedback and appraisals.

Demonstrate commitment

The board demonstrates its commitment to creating an open and honest culture where workers feel safe to speak up by:

- having named executive and non-executive leads responsible for speaking up, who can demonstrate that they are clear about their role and responsibility and can evidence the contribution they have made to leading the improvement of the trust's speaking up culture. **Section 1 of the supplementary information pack** sets out the responsibilities of the executive and non-executive lead

- including speaking up and other related cultural issues in its board development programme

- having a sustained and ongoing focus on the reduction of bullying, harassment and incivility

- sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up and taking action should this occur with these messages echoed in relevant policies and training. The executive lead for FTSU is responsible for gaining assurance that the experience of workers who speak up is a positive one

- investing in sustained and continuous leadership development

- having a well-resourced FTSU Guardian and champion model. **Section 2 of the supplementary information pack** sets out suggestions of how to assess your FTSU Guardian's capability and capacity

- supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up. **Section 3 of the supplementary information pack** sets out suggestions of how to evaluate the effectiveness of your communication strategy

- inviting workers who speak up to present their experiences in person to the board.

Have a strategy to improve your FTSU culture

Boards have a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement. The vision is supported by a strategy that has been developed by the executive lead for FTSU; this sits under the trust's overarching strategy and supports the delivery of other relevant strategies.

The board discusses and agrees the strategy and is provided with regular updates. The executive lead for FTSU reviews the FTSU strategy annually, including how it fits with the overall trust strategy, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they will be overcome; and whether the right indicators are being used to measure success.

It doesn't matter whether the strategy document is called a plan or a strategy; as long as the executive lead has well-thought-out goals that are measurable and have been signed off by the board. **Section 4 of the supplementary information pack** sets out suggestions for what should be in your strategy and provides a checklist to help with the evaluation of your strategy.

Support your FTSU Guardian

Boards demonstrate their commitment to creating a positive speaking up culture by having a well-resourced FTSU Guardian, supported by an appropriate local network of 'champions' if needed. FTSU Guardians need access to enough ringfenced time and other resources to enable them to meet the needs of workers in your organisation. See **Section 2 of the supplementary information pack.**

The executive lead and the non-executive lead, along with the chief executive and chair meet regularly with the FTSU Guardian and provide appropriate advice and support. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate urgent matters rapidly (preserving confidence as appropriate). **Section1 of the supplementary information pack** sets out the individual responsibilities of relevant executives.

Relevant executive directors ensure the FTSU Guardian has ready access to applicable sources of data and other information to enable them to triangulate speaking up issues and proactively identify patterns, trends, and potential areas of concerns. **Section 5 of the supplementary information pack** sets out the kind of data and other information you could triangulate.

Finally, executive directors encourage and enable their FTSU Guardian to develop bilateral relationships with regulators, inspectors, and other FTSU Guardians, and attend regional network meetings, National Guardian conferences, training and other related events.

Be assured your FTSU culture is healthy and effective

The board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers. **Section 6 of the supplementary information pack** sets out the different elements that the board should consider seeking assurance for.

Boards may need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- before a significant change such as a merger or service change
- when an investigation has identified a team or department has been poorly led or a culture of bullying has developed
- when there has been a service failing
- following a Care Quality Commission (CQC) inspection where there has been a change in rating

It is the executive lead's responsibility to ensure that the board receives a range of assurance and regular updates in relation to the FTSU strategy.

An important piece of assurance is the report provided in person by the FTSU Guardian, at least every six months and **Section 7 of the supplementary information pack** sets out the kind of information the board should expect to be in the FTSU Guardian's report. To be clear this should not be the only assurance the board receives.

Another important piece of assurance is an audit report of the trust's speaking up policy. The trust's speaking up arrangements must be based on an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and should be audited at least every two years. **Section 8 of the supplementary information pack** sets out what a comprehensive audit should cover. The audit report should not focus solely on FTSU Guardian activity but on the effectiveness of all the speaking up channels as well as the whole speaking up culture.

If the board is not assured its workers feel confident and safe to speak up, it should consider getting external support to understand what is driving that fear.

Be open and transparent with external stakeholders

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. Executives routinely discuss challenges and opportunities presented by the matters raised via speaking up with commissioners, CQC, NHS Improvement and their local quality surveillance groups. The board welcomes engagement with, and feedback from, the National Guardian and her staff.

The board regularly discusses progress against the FTSU strategy and (respecting the confidentiality of individuals) themes and issues arising from speaking up (across all the trust's speaking up channels) at the public board. The trust's annual report contains high level, anonymised data relating to speaking up, as well as information on actions the trust is taking to support a positive speaking up culture.

To enable learning and improvement, executive directors discuss learning from speaking up reviews, audits and complex cases among their peer networks. To support this learning, ideally, reviews and audits are shared on the trust's website.

The executive lead for FTSU requests external improvement support when required.

Conclusion

Meeting the expectations in this guide will help boards to send the message that ideas, concerns, feedback, whistleblowing and complaints are all seen as opportunities to stop and reflect on whether something could be done differently.

Valuing workers' opinions and acting on them, publicising the good that comes from speaking up, and making clear and unequivocal statements that you will not tolerate staff being victimised for speaking up, will all encourage workers to use their voice for the benefit of patients and their colleagues.

We have provided useful resources as supplementary information to this guide but if having completed your review you would like further support to improve aspects of your FTSU arrangements, please get in touch with:

- nhsi.ftsulearning@nhs.net for the following support to the executive lead:
  - review FTSU policy, strategy or action plans and provide feedback to bring them in line with national policy or recognised best practice
  - design and facilitate workshops to develop board understanding of speaking up and behaviour that encourages or inhibits it
  - host online surveys and facilitate focus groups with workers to identify issues, causes and solutions
  - facilitate an assessment of your trust's FTSU arrangements against national guidance and support the executive lead to build a FTSU improvement action plan
- enquiries@nationalguardianoffice.org.uk who will arrange for support for the FTSU Guardian in relation to their role.

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This publication can be made available in a number of other formats on request.

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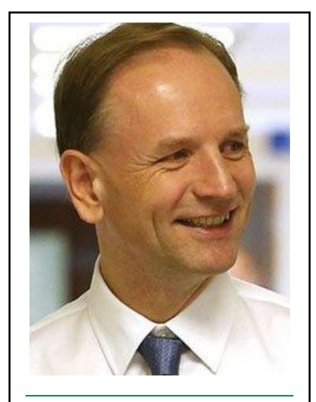
National Guardian
Freedom to Speak Up

Freedom to Speak Up Index Report 2019

Contents

Foreword by Simon Stevens, CEO NHS England and NHS Improvement	03
Foreword by Dr Henrietta Hughes, National Guardian for the NHS	04
Introduction	05
Survey questions and Freedom to Speak Up Index	06
Summary of results	08
Cambridgeshire Community Services NHS Trust	10
Liverpool Heart and Chest NHS Foundation Trust	11
Tees Esk and Wear Valleys NHS Foundation Trust	14
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	17
Increase and decrease in the Freedom to Speak Up Index 2015-2018	20
London Ambulance Service	22
Surrey and Borders Partnership NHS Foundation Trust	23
Conclusion and next steps	25
Annex 1: The Freedom to Speak Up Index	26
Acknowledgements	32

Foreword by Simon Stevens



Speaking out when you see something going wrong at work takes courage no matter what your job. When you work in the NHS – as a nurse, doctor, physio or in any other role – it can sometimes also feel a lonely and daunting experience. That is why we are determined to ensure we do everything possible to support those who make their voices heard on behalf of patients.

Freedom to speak up guardians can be a very powerful presence to ensure that NHS organisations – their management and boards – listen to concerns. NHS England is tripling funding and we now have 500 guardians in place across the country.

In the past, however, not every NHS organisation has done enough to make staff feel that they can speak out. That is why last year I asked the National Guardian to help measure how free nurses, doctors and other staff felt to raise concerns at different organisations.

Twelve months on there is encouraging progress in making NHS organisations more open and transparent. Our staff are world-class but if we want to help them to deliver the improvements in care and treatment set out in the NHS Long Term Plan we need to show them the same duty of care, compassion and empathy that we provide our patients.

A porter, nurse or consultant surgeon who speaks up is an invaluable part of any NHS organisation – they do so because they want the very best for their patients and their colleagues. And trusts that allow staff to speak out about issues are likely to deliver better outcomes for patients and will have happier staff.

The Freedom to Speak Up Index helps trusts understand how their staff perceive the speaking up culture. Trusts can compare their scores to others, buddy up with those that have received higher index scores and promote learning and good practice.

Already the index is having a significant impact, with 180 trusts (82%) having made progress in making it easier for staff to speak out since 2015, with London Ambulance improving its rating by 18%. This means more staff than ever before feel secure raising concerns if they see something unsafe and feel confident that if they were to make a mistake, they would be treated fairly by their trust.

But a more open and transparent working culture will not just mean happier staff, it will also mean happier patients too. Evidence consistently shows that a positive speaking up culture leads to better CQC ratings, and ultimately better care for our patients. And this is what drives over a million people to go to work for the NHS every day. It is everyone's responsibility to speak up when they see something that doesn't look right – and now more than ever, staff are doing exactly that.

Foreword by Dr Henrietta Hughes

Everyone needs to be valued and listened to and feel fairly treated at work. Nowhere is this more important than in health when it can be a matter of life or death. A positive environment and a supportive culture are key elements of the People Plan[1]. We have shown that a positive speaking up culture is often associated with higher performing organisations. Workers are the eyes and ears of an organisation and they should be listened to when considering patient safety and experience. The best leaders understand how important this is. These leaders create an inclusive speaking up culture where everyone's insight and expertise is valued, and all workers are empowered to speak up and contribute to improvements in patient care.

Culture is a term which can be interpreted in different ways. To some it might seem vague and difficult to pin down. Some organisations want their culture to change but do not know where to start or how to change. In our Freedom to Speak Up Guardian Surveys, we showed that guardians in organisations rated Outstanding by the Care Quality Commission were more positive in their perceptions of the speaking up culture[2]. To ensure speaking up becomes business as usual, the voices of other workers must also be involved. We have therefore created a single measure from four questions from the 2018 NHS Staff Survey[3].

This new Freedom to Speak Up Index, brought together by my office and NHS England, identifies the view of the staff on the speaking up culture in NHS Trusts and Foundation Trusts (FTs). For trust boards to be able to use a measure to learn more about their own Freedom to Speak Up culture, as experienced by their workforce, is an opportunity for improvement. This is not a perfect tool, as it is based on a sample of staff and there are additional limitations as students, volunteers and others are not included.

When it comes to establishing effective speaking up cultures, the highest scoring NHS trusts and Foundation Trusts featured in this report have shared their experience for the rest of the health system to learn from. They have had meaningful conversations with their workers, embraced opportunities to improve, followed guidance from my office and developed innovative ways to create and sustain a positive speaking up culture for their workforce.

The average FTSU Index score nationally has increased since 2015 and I am optimistic that this will continue to improve but not complacent about the organisations in which there is significant room for improvement. I call on leaders and Freedom to Speak Up Guardians in NHS trusts and FTs to use the index as a new measure for assessing the speaking up culture in their organisation. The insights of the organisations featured in this report will help you find comparable organisations with whom you can buddy up and learn from the best in the NHS. I encourage commissioners and regulators to use the FTSU Index to ask providers about their speaking up arrangements and to encourage improvement.

[1] https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/
[2] https://www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf
[3] https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/

Introduction

The Interim People Plan aims to 'to grow the NHS's workforce, support and develop NHS leaders and make our NHS the best place to work'. The plan says that in addition to recruiting extra staff, much more needs to be done to improve staff retention and transform ways of working. Secretary of State Matt Hancock MP has said that 'we need …. a more supportive culture to make that plan a reality'[4]. A positive speaking up environment where workers feel valued and listened to is fundamental to developing a supportive culture.

The events at Mid Staffs[5] and Gosport War Memorial Hospital[6] serve as reminders of the harm that can occur to patients when this type of culture does not exist. Following the publication of the Francis Freedom to Speak Up Review in 2015[7] Trusts and Foundation Trusts in England have appointed Freedom to Speak Up Guardians[8]. The network has now grown to over 1000 guardians, champions and ambassadors in NHS trusts and FTs, independent sector providers, national bodies and primary care organisations. Thousands of cases have been brought to Freedom to Speak Up Guardians since April 2017[9].

The National Guardian's Office has previously published survey reports that indicate that a positive speaking up culture is associated with higher performing organisations as rated by CQC. The annual NHS staff survey contains several questions that serve as helpful indicators of the speaking up culture. Working with NHS England, the National Guardian's Office has brought four questions together into a 'Freedom to Speak Up (FTSU) index'. This is to enable trusts to see at a glance how their FTSU culture compares with others. This will promote the sharing of good practice and enable trusts that are struggling, to 'buddy up' with those that have recorded higher index scores.

The results throughout are based on the results of the 2018 NHS annual staff survey. Where percentage point improvement is recorded, this is based on the overall changes recorded between 2015 and 2018.

Nationally the median FTSU score has improved since 2015. Some trusts have seen a rapid improvement in their FTSU index score and in others there has been a reduction in the score. We have included case studies from the best performing trusts of each type and those that have made the most significant improvement. These case studies detail the changes that trusts have made to engage with their workforce and develop a positive speaking up culture and the impact that this has made.

The Freedom to Speak Up Index for each trust and the CQC ratings for Overall and Well Led are included in Annex 1. The information is taken from the CQC website[10] and the annual NHS Staff Survey at the time of publication.

[4] https://www.england.nhs.uk/2019/06/more-staff-not-enough-nhs-must-also-be-best-place-to-work-says-new-nhs-people-plan/
[5] https://www.bbc.co.uk/news/health-21244190
[6] https://www.bbc.co.uk/news/topics/cx2pw2r8yp9t/gosport-hospital-deaths
[7] http://freedomtospeakup.org.uk/the-report/
[8] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf
[9] https://www.cqc.org.uk/sites/default/files/CCS119_CCS0718215408-001_NGO%20Annual%20Report%202018_WEB_Accessible-2.pdf
[10] https://www.cqc.org.uk/

Survey questions and FTSU Index

The FTSU index was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

The survey questions that have been used to make up the FTSU index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

Disability is
not a choice –
your attitude is
HEROES

Summary of results

Overall, the national median FTSU index has increased since 2015, and this pattern is reflected for all trust types:

	FTSU index			
Trust type	2015	2016	2017	2018
National	75%	77%	77%	78%
Acute Specialist Trusts	79%	79%	79%	81%
Acute Trusts	75%	76%	76%	77%
Ambulance Trusts	66%	69%	69%	74%
Combined Acute and Community Trusts	76%	77%	77%	78%
Combined Mental Health / Learning Disability and Community Trusts	78%	77%	79%	80%
Community Trusts	79%	80%	81%	83%
Mental Health / Learning Disability Trusts	74%	76%	77%	79%

The following represent the trusts with the highest FTSU index result for 2018, broken down by trust type:

Trust type	Trust	FTSU index value 2018
Community	Cambridgeshire Community Services NHS Trust	87%
Combined mental health / learning disability and community trust	Solent NHS Trust	86%
Acute Specialist	Liverpool Heart and Chest Hospital NHS Foundation Trust	86%
Acute	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	84%
Combined acute and community	Gateshead Health NHS Foundation Trust	83%
Combined mental health / learning disability	Surrey and Borders Partnership NHS Foundation Trust	81%
Combined mental health / learning disability	Northumberland, Tyne and Wear NHS Foundation Trust	81%
Combined mental health / learning disability	Tees, Esk and Wear Valleys NHS Foundation Trust	81%
Combined mental health / learning disability	Tavistock and Portman NHS Foundation Trust	81%
Ambulance	Isle of Wight NHS Trust (ambulance sector)	79%

Cambridgeshire Community Services NHS Trust: Visible leadership in action

"Our transparent and open culture has been built up over a number of years and during that time we have developed a style across the organisation that puts our people first. We have a long standing systematic 'back to the floor' programme in place that our senior leaders prioritise each month and this visibility and approach is positively received by our staff. Additionally, it is in the DNA of the organisation for all our leaders to be out and about every week, talking and listening to staff in an informal and low-key way. We have lots of examples through these visits of our staff sharing concerns and issues and feeling very comfortable and confident to speak up.

'it is in the DNA of the organisation for all our leaders to be out and about every week, talking and listening to staff in an informal and low-key way. We have lots of examples through these visits of our staff sharing concerns and issues and feeling very comfortable and confident to speak up'.

We support our managers to be leaders and have embedded compassionate leadership into our internal development programmes and our appraisal systems and processes.

'We support our managers to be leaders and have embedded compassionate leadership into our internal development programmes and our appraisal systems and processes'.

We developed our values with our staff over 8 years ago and we continually check that they remain valid today through talking with our staff. Our values and agreed set of behaviours are embedded in all that we do, and we spend time and energy on making sure we encourage people to speak up if they are concerned about anything. How our staff speak up is entirely up to them, there is never a wrong way. We are explicit at induction about them never worrying about telling the wrong person the most important thing if they are concerned about anything is to tell someone! They can raise concerns informally or formally and we work with them directly to agree how they wish their concern to be handled.

They can speak with their line manager; another member of their team; contact our Freedom to Speak Up Guardian or one of our Freedom to Speak Up Champions; link with our full-time staff side chair; speak with one of our Cultural Ambassadors or share directly with our Chief Executive or another member of our Executive team and we have lots of examples of when our staff have done this. We always provide feedback to individuals who raise concerns so that they are assured and confident that their issue/s have been dealt with. We also deal with concerns anonymously if requested to do so - the most important thing for us is that the concern is being heard and acted upon.

'..through the results our staff have fed back that they feel secure in raising concerns; that they are confident that we would deal with these and that they feel engaged and valued'.

We are very proud of our annual national staff survey results and have seen year on year improvements. We focus on a small number of improvement areas each year rather than everything and through the results our staff have fed back that they feel secure in raising concerns; that they are confident that we would deal with these and that they feel engaged and valued. We continue to make further improvements to ensure that we are an excellent employer and one of the NHS Best Places to Work."

'We are explicit at induction about them never worrying about telling the wrong person the most important thing if they are concerned about anything is to tell someone!'

Liverpool Heart and Chest Hospital NHS FT: Learning and Sharing to create an open and safe culture

Freedom to Speak Up Guardian Helen Turner with Mr Sanjay Ghotkar and the FTSU Charter

"Liverpool Heart and Chest Hospital is committed to FTSU and its principles, patient safety and staff experience are at the heart of everything we do. Our Board of Directors takes an active interest in concerns raised by staff, the process in which these are dealt with and supports an ethos of learning and sharing. The Trust's approach to FTSU is summed up by the Chief Executive's 3-point pledge which is widely communicated:

Please Speak Up – when you do:

I will listen
I will investigate, and if you let me know who you are you will receive feedback
I will keep you safe

A quarterly 'Freedom to Speak Up Summit' is chaired by the Director of Corporate Affairs /Executive Lead for FTSU and attended by the Chief Executive, Medical Director, Director of Nursing, Director of Workforce, Deputy Director of Nursing, Freedom to Speak up Guardian and Deputy Freedom to Speak up Guardian. The commitment of the Trust towards empowering staff to speak up, keeping both patients and staff safe is demonstrated by the membership of the group.
The purpose of the summit is to review the quarter's speak ups and triangulate data from staff experience and patient safety looking for trends, themes and any areas that maybe hotspots in order that any action can be identified and swiftly taken.

'The Trust is constantly innovating to ensure patient safety, the data produced for the summit includes the usual serious incidents, never events, incident reporting but also data from the daily trust wide safety huddle convened in the Chief Executive's office where current issues are raised and escalated immediately'.

Patient Safety

The Trust is constantly innovating to ensure patient safety, the data produced for the summit includes serious incidents, never events and incident reporting but also data from the daily trust wide safety huddle convened in the Chief Executive's office where current issues are raised and escalated immediately. Other data shared at the summit include HALT an innovation that was introduced at the Trust in 2015.

HALT is an acronym that stands for
Have you seen this?
Ask – did you hear my concern?
Let them know it is a patient safety issue
Tell them to **STOP** until it is agreed it is safe to continue

HALT empowers all staff no matter what grade and whether clinical or not to use the HALT process if they see a potential patient or staff safety incident. HALT has not only prevented 92 safety incidents to date, since its inception but has broken down hierarchical barriers that have traditionally existed in healthcare.
A monthly Learning and Sharing Forum brings together senior leaders, including ward and departmental managers to cascade learning, share examples and promote an open and safe culture.

HALT is an acronym that stands for
***H**ave you seen this?*
***A**sk – did you hear my concern?*
***L**et them know it is a patient safety issue*
***T**ell them to **STOP** until it is agreed it is safe to continue*

Staff Experience

> *'The "grass is greener" is an initiative which encourages staff who are leaving or thinking about leaving the Trust to understand their reasons and look at what we could do to reduce turnover and improve staff safety and experience'*

Workforce data is shared at the summit including an HR relations report, which includes the number of bullying and harassment, grievances/ET claims, disciplinaries, suspensions etc. Also, innovations such as 'grass is greener' data is shared and discussed. The 'grass is greener' is an initiative which encourages staff who are leaving or thinking about leaving the Trust to understand their reasons and look at what we could do to reduce turnover and improve staff safety and experience.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian (FTSUG) reports to the membership not just on concerns raised and action taken but also on national guidance and any actions the Trust needs to take to ensure best practice, this means benchmarking against case reviews, information from the latest NGO guidance and reporting on pertinent issues from the regional network groups and the national conference.

Learning from Freedom to Speak Up

Feedback from our staff has revealed that at times managers and those with supervisory roles have felt vulnerable about staff speaking up against them, sometimes as a result of unpopular management decision. In response to this we have worked with staff to develop an 'FTSU Charter' setting out clearly what can be expected both when you speak up and when you are spoken up about.

> *'we have worked with staff to develop an 'FTSU Charter' setting out clearly what can be expected both when you speak up and when you are spoken up about'.*

The focus on FTSU and Board level membership of the summit means that the Trust is proactive and not just reactive in dealing with matters of patient and staff safety and is constantly pushing the agenda forward through innovation."

Tees Esk and Wear Valleys NHS Foundation Trust: Speaking Up drives improvement

Freedom to Speak Up Guardian Dewi Williams

"We are using the principles identified within the 2017 Freedom to Speak Up Guardians survey as a framework for the description of how Tees, Esk and Wear Valleys NHS Foundation Trust has sought to make Freedom to Speak Up arrangements business as usual."

- **FAIRNESS.** The Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Freedom to Speak Up Guardian (FTSUG) Dewi Williams, was appointed in October 2016 following interview as part of a post retirement redeployment process. He currently works 18 ½ hours a week, and this is his sole employment.

- **REACH AND DIVERSITY.** We have a developing network of 'Dignity at work champions,' who support the FTSUG and who will be key to the success of our new Bullying and Harassment Resolution Procedure. We currently have 16 champions but hope to have around 40 by the end of the year. It is intended that they are present within each of the TEWV geographical localities and will be representative of protected characteristic groups. We also have a deputy FTSUG working one day a week, Barry Speak, who is a psychologist and works in a staff wellbeing service.

'We have a monthly awareness raising message attached to our electronic staff newsletter which communicates key messages and reminds staff about where they can get support with Speaking Up'.

- **COMMUNICATION.** We have a monthly awareness raising message attached to our electronic staff newsletter which communicates key messages and reminds staff about where they can get support with Speaking Up. The FTSUG also has an intranet page where staff can get contact details, see the policy, and get downloadable posters.

- **PARTNERSHIP.** We have developed a monthly in-house support forum. Staff from a range of staff wellbeing services get together to share intelligence, debrief, and support each other in what could otherwise be very isolated and challenging roles. Part of the FTSUG role is to meet as many people as possible to raise awareness. The FTSUG conducts regular staff training in all our sites. The opportunity is taken to conduct informal meetings with teams in those sites.

- **LEADERSHIP.** Board of Directors and Executive Management Team members undertake a series of planned visits each month to individual wards and departments throughout the Trust to engage directly with staff about service and workplace issues, including speaking up. The FTSUG meets at least bi-monthly with the chief executive and the director of human resources. He also meets regularly with many other senior managers as part of the role. He meets at least twice yearly with the executive and non-executive directors with responsibility for Speaking Up. They also deliver twice yearly board reports. Demonstrating board commitment to Speaking Up can be seen by our [staff] video which shares directors' values, beliefs, and commitment to ensuring that staff can feel safe to come forward.

'Board of Directors and Executive Management Team members undertake a series of planned visits each month to individual wards and departments throughout the Trust to engage directly with staff about service and workplace issues, including speaking up'

- **FEEDBACK.** At the conclusion of cases the FTSUG has asked two questions; would you do it again, and did you experience any detriment? Whilst getting many complimentary replies, the specific questions have been sporadic. We will be addressing this issue as part of an upcoming process review day. In addition to approaching their line manager, the Dignity at Work Champions and the FTSUG all TEWV staff can raise concerns electronically and anonymously, should they choose to do so. Each of these concerns are published within the TEWV e-bulletin along with the responses that are agreed by the Executive Management Team under the heading of 'You said, we did.'

In addition to approaching their line manager, the Dignity at Work Champions and the FTSUG all TEWV staff can raise concerns electronically and anonymously, should they choose to do so. Each of these concerns are published within the TEWV e-bulletin along with the responses that are agreed by the Executive Management Team under the heading of 'You said, we did.'

- **PROACTIVE AND REACTIVE ROLE. We are constantly reviewing how we are doing and improving practice.** We are to hold an event with some of those who have experience of conducting whistleblowing investigations, and some who have experienced being investigated, to look for opportunities to standardise and improve the experience for all involved. Initially the FTSUG role was predominantly reactive. However, are using our Staff 'Friends and Family' results to identify teams that may benefit from proactive support awareness raising, and training.
-
- **ATTENDING SUPPORT NETWORKS.** On appointment the FTSUG attended the initial training provided by the National Guardian's Office and has since attended updates delivered within the regional network. To date the FTSUG has been to three national conferences, and regularly attends the very useful and supportive regional meetings.

- **DATA MANAGEMENT.** We have a confidential data storage system. It has benefitted from being audited. Currently we only log issues raised with the FTSUG and we know that many more issues are raised with line managers and are successfully handled. However, we do not know exactly how many, and therefore are not able to quantify, or benefit from the potential shared learning. We aspire to developing an acceptable data gathering approach that will help us develop a library of experience from which we can share more learning."

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust: Reach and visibility to engage staff

Freedom to Speak Up Guardian Helen Martin with Tom Beaumont, Sally Papworth and Catherine Bishop

"In 2013 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust faced a number of significant challenges, including a poor CQC rating. A programme of improvement and culture change was introduced by our Board. Within this journey we heard staff in our cultural audit say that they wanted to feel safer in raising concerns, so we developed our culture of safety.

> *'we heard staff in our cultural audit say that they wanted to feel safer in raising concerns, so we developed our culture of safety'.*

A major part of this was the creation of our first Freedom to Speak Up Guardian (FTSUG) post. The Trust took guidance from the National Guardian Office (NGO) conference to ensure that the role was ring-fenced to meet its full requirements and that networking with national and local colleagues was encouraged to help develop and evolve the role.

> *'The Trust took guidance from the National Guardian Office (NGO) conference to ensure that the role was ring-fenced to meet its full requirements and that networking with national and local colleagues was encouraged to help develop and evolve the role'.*

We used feedback from our cultural audit to shape our own [framework]. Staff wanted easy access, more face-to-face interactions and visibility irrespective of ethnicity or background. Our Guardian devised a clear policy around speaking up, supported by a communications strategy.

Our guardian attended team meetings, delivered presentations including to trust induction, facilitated focus groups, as well as deployed our highly successful (and decorated) roaming trolley. The trolley rounds of our wards were often accompanied by our diversity team or one of our executives, demonstrating that we wanted to hear the voices of all our staff and as part of our Board commitment. Our Board developed a public statement of commitment and benchmarked our progress within interactive Board development session. They also receive regular feedback from our Guardian and support her wellbeing through supervision.

'The trolley rounds of our wards were often accompanied by our diversity team or one of our executives, demonstrating that we wanted to hear the voices of all our staff and as part of our Board commitment'.

The Trust built on our local and trust governance structure, with a renewed focus on learning from errors. This was underpinned with new incident reporting forms which encourage sharing and learning of good practice from errors as well as raising improvement ideas and issues. Both have made significant impacts to the reporting culture of RBCH.

Helen Martin, the Trust's Freedom to Speak Up Guardian, said: 'The key to all our work has been listening to our staff to develop a culture of safety and feedback. Raising concerns is something that should routinely be done and as part of an ongoing conversation. We continue to evolve our model and feel that we are in the best position to support our staff in our future organisation change.'

'..new incident reporting forms which encourage sharing and learning of good practice from errors as well as raising improvement ideas and issues. Both have made significant impacts to the reporting culture of RBCH'.

Our guardian has now expanded the role to a team of six ambassadors across a variety of professional backgrounds which has made speaking up more accessible. Helen is now also working across Royal Bournemouth and Poole hospitals, as our two trusts move towards merger. This ensures staff have access to FTSU teams while undergoing significant organisational changes.

Six years on and RBCH is seeing the benefits of the Trust-wide programme of improvement, including national leaders for safety culture and staff engagement. Helen Martin added, 'We are proud to see that RBCH is recognised as having the highest index score for 2018 for acute trusts further demonstrating the success of our cultural journey over the last six years'."

The 'Roaming Trolley' at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Increase and decrease in the FTSU index by individual trust

The table below shows the percentage point increase and decrease in FTSU Index value during the period 2015 – 2018 for 220 trusts.

Of these 220 trusts:

- 180 recorded an overall increase 2015 - 2018 in FTSU index (82%)
- 40 recorded an overall decrease 2015 – 2018 in FTSU index (18%)
- The highest overall increase was recorded by London Ambulance Service NHS Trust (18 percentage points)
- The greatest overall decrease was recorded by Wrightington, Wigan and Leigh NHS Foundation Trust (-4 percentage points)

Trusts with greatest overall increase in FTSU index

Trust	2015	2018	2015 - 18
London Ambulance Service NHS Trust	57	75	**18**
Isle of Wight NHS Trust (ambulance sector)	62	79	**17**
North East Ambulance Service NHS Foundation Trust	64	76	**12**
East Sussex Healthcare NHS Trust	66	78	**12**
South East Coast Ambulance Service NHS Foundation Trust	64	74	**10**
The Royal Orthopaedic Hospital NHS Foundation Trust	73	82	**9**
Sherwood Forest Hospitals NHS Foundation Trust	70	79	**9**
Isle of Wight NHS Trust (mental health sector)	69	77	**8**
Gloucestershire Care Services NHS Trust	74	82	**8**
Lincolnshire Partnership NHS Foundation Trust	72	80	**8**

Trusts with greatest overall decrease in FTSU index

Trust	2015	2018	2015 - 18
Great Western Hospitals NHS Foundation Trust	81	79	**-2**
Salisbury NHS Foundation Trust	82	80	**-2**
East and North Hertfordshire NHS Trust	75	73	**-2**
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	74	72	**-2**
King's College Hospital NHS Foundation Trust	77	75	**-2**
Great Ormond Street Hospital for Children NHS Foundation Trust	80	78	**-2**
James Paget University Hospitals NHS Foundation Trust	79	76	**-3**
Wrightington, Wigan and Leigh NHS Foundation Trust	81	77	**-4**

London Ambulance Service: 100 Voices Case Study

At London Ambulance Service NHS Trust (LAS), a paramedic spoke up to the Freedom to Speak Up Guardian, Katy Crichton, about a number of matters. The issues reported to Katy ranged from challenging behaviours to service-wide problems, such as a lack of training for new staff and inadequate capacity to deal with call volumes.

'I have seen significant changes in my place of work. It is a much more pleasant place to be. People are listened to and actions have been taken'

The paramedic told Katy, "I had sat in the office for several weeks worrying if I should speak to a colleague, a manager or a friend outside work. Occasionally, I would convince myself that I was exaggerating the state of affairs. Feeling isolated, I decided to contact the LAS guardian.

"My brief email prompted a very quick reply back from the guardian. We met a few days later in a coffee shop away from work and I already felt I was going to be taken seriously."

Katy escalated the matters and, with the involvement of the leadership team, including the Chief Executive, an action plan was established. After a couple of months, a review of the issues revealed that the actions had not gone far enough, and further measures were put in place, taking into account advice from the paramedic who spoke up.

'Listening to staff and learning from them is hugely important'

The paramedic said, "I have seen significant changes in my place of work. It is a much more pleasant place to be. People are listened to and actions have been taken."

As a result of the issues raised, the trust increased staffing levels in some areas, developed a new operational structure for the service, invested in additional training for staff, and monitored calls through a regular audit. Feedback from commissioners reported positive changes to the service and outcomes for patients.

Katy said, "We are very grateful that the paramedic felt able to come forward. By speaking up they have improved the working environment for themselves and for our patients.

"Listening to staff and learning from them is hugely important. It was particularly gratifying that the leadership team continued to listen, even after they had drawn up an action plan, and modified it based on further feedback. The ongoing experiences of the paramedic who spoke up really helped to address the problems in a comprehensive way."

'an email to the Guardian changed a lot, making the trust a better place to work and providing safer care for our patients'

The paramedic remarked when reflecting on their experience of speaking up, "One thing is for sure – an email to the guardian changed a lot, making the trust a better place to work and providing safer care for our patients."

Surrey and Borders Partnership NHS Foundation Trust: Joy at work

Freedom to Speak Up Guardian Lynn Richardson with Roopavathay Krishnan

"Surrey and Borders Partnership NHS Foundation Trust appointed its Freedom to Speak Up Guardian (FTSUG) through open competition in October 2016. The FTSUG came into post from April 2017 and since then has worked with the senior leadership and staff teams as part of our work to further develop the culture within our Trust.
SABP is a mental health and learning disability Trust with many sites spread across Surrey and North East Hampshire.

We have always aspired to be a diverse and inclusive Trust; one of our first activities when we were formed in 2005, led by our Chief Executive and Chair, was to coproduce our Vision and Values through a series of conversations with people who use our services, carers and families, other stakeholders and our staff. Our Values have guided us, as our "compass", and formed the foundations for our aspirations ever since. Building upon them we have placed great importance on our staff's

'one of our first activities when we were formed in 2005, led by our Chief Executive and Chair, was to coproduce our Vision and Values through a series of conversations with people who use our services, carers and families, other stakeholders and our staff. Our Values have guided us, as our "compass", and formed the foundations for our aspirations ever since'.

responses through the national staff survey and working closely with our Staff Networks to develop our practice as part of staff engagement.
Once our FTSUG was in post, we began to gain a rich intelligence through our quarterly Speaking Up reports. These enabled the senior leadership team to begin thinking about building upon Speaking Up, as part of our quality improvement approach, to build a workforce where our employees enjoy coming to work, are encouraged to develop their skills and by so doing, create a compassionate, caring culture for the people who use our services.

'Our Senior Leadership team undertook a programme of staff consultations with our workforce in the summer of 2018 in order to understand what gave our employees 'Joy At Work' but also where we needed to do better to improve their working experience'.

Our Senior Leadership team undertook a programme of staff consultations with our workforce in the summer of 2018 in order to understand what gave our employees 'Joy At Work' but also where we needed to do better to improve their working experience. We took away actions such as improved information technology needs and the re-introduction of water coolers. The important part of this exercise was for the voice of our staff to be heard by our senior leaders and this has been built upon since then. For example, we used to organise our own programme of Board and Governor "walkaround" visits with a checklist of things to look out for in our services. Since really listening to our staff, we now ask our teams to invite us to their service and encourage them to show us the things they are really proud of.

'we now ask our teams to invite us to their service e.g. to showcase for us the things they are proud of, rather than them feeling that we are checking up on them'

We also really wanted to welcome our new recruits into the organisation effectively and instil our belief in a speaking up culture. We changed our induction programme to make it shorter, based on feedback, and since our FTSUG has been speaking at that programme, we have had some excellent intelligence from our new staff on things we can improve upon. Our staff gain confidence by meeting our Guardian in person, either through induction or at team meetings/formal training events and we are pleased with our achievements to date in the first two years of our Raising Concerns approach.

'Our staff gain confidence by meeting our Guardian in person, either through induction or at team meetings/formal training events and we are pleased with our achievements to date in the first two years of our Raising Concerns approach'.

Conclusions and next steps

Listening to the voice of workers is fundamental to improving patient safety and experience and improving the working lives of our colleagues. At a time when the NHS workforce is under extreme pressure and trusts are seeking to recruit and retain staff the annual NHS Staff survey can provide vital insights into the experience of workers.

In our previous publications we have shown that the perceptions of Freedom to Speak Up Guardians are linked with the performance of organisations as shown by their overall CQC rating. Freedom to Speak Up is inspected as part of the CQC Well Led Domain. For trust Boards to be able to use information to learn more about their own Freedom to Speak Up culture, as experienced by their workforce, is an opportunity for improvement. This may help to open a new conversation with their workforce, as many of the trusts featured in this report have done, developing their own innovations, borrowing the innovations identified here or buddying with similar trusts with higher FTSU index scores.

For commissioners and regulators, this is potentially a lead indicator which can be viewed together with other information about safety, workforce and culture. The system needs to offer support, guidance and expertise to organisations where the workforce has indicated that there is room for improvement in the speaking up culture.

Not all organisations in the health service ask their workforce the same questions as in the NHS staff survey, therefore we have not been able to use the FTSU Index for primary care organisations, independent sector providers and national bodies who have Freedom to Speak Up Guardians. For these organisations, there are insights to learn from this report, in terms of leadership behaviours and listening to the ideas and concerns from the workforce. Similar survey questions could potentially be devised to develop a FTSU Index for national bodies and others. We will continue to track the progress of NHS trusts and Foundation Trusts as they develop positive speaking up cultures for their workforce. In this way we work towards speaking up being business as usual.

Annex 1

FTSU Index

FTSU index	Name of trust
87%	Cambridgeshire Community Services NHS Trust
86%	Solent NHS Trust
86%	Liverpool Heart and Chest Hospital NHS Foundation Trust
85%	Hounslow and Richmond Community Healthcare NHS Trust
85%	Northamptonshire Healthcare NHS Foundation Trust
84%	Leeds Community Healthcare NHS Trust
84%	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
84%	The Royal Marsden NHS Foundation Trust
84%	Lincolnshire Community Health Services NHS Trust
83%	The Christie NHS Foundation Trust
83%	Hertfordshire Community NHS Trust
83%	Sussex Community NHS Foundation Trust
83%	Gateshead Health NHS Foundation Trust
83%	Royal Brompton and Harefield NHS Foundation Trust
83%	Moorfields Eye Hospital NHS Foundation Trust
83%	Derbyshire Community Health Services NHS Foundation Trust
83%	Norfolk Community Health and Care NHS Trust
83%	Shropshire Community Health NHS Trust
82%	The Royal Orthopaedic Hospital NHS Foundation Trust
82%	Wirral Community NHS Foundation Trust
82%	Surrey and Sussex Healthcare NHS Trust
82%	Frimley Health NHS Foundation Trust
82%	Guy's and St Thomas' NHS Foundation Trust
82%	Northern Devon Healthcare NHS Trust
82%	Gloucestershire Care Services NHS Trust
82%	The Clatterbridge Cancer Centre NHS Foundation Trust
82%	Cambridgeshire and Peterborough NHS Foundation Trust
82%	Berkshire Healthcare NHS Foundation Trust
82%	Northumbria Healthcare NHS Foundation Trust
82%	Cumbria Partnership NHS Foundation Trust
82%	Harrogate and District NHS Foundation Trust
81%	Kent Community Health NHS Foundation Trust
81%	Cambridge University Hospitals NHS Foundation Trust
81%	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT
81%	South Warwickshire NHS Foundation Trust

81%	Airedale NHS Foundation Trust
81%	City Hospitals Sunderland NHS Foundation Trust
81%	Worcestershire Health and Care NHS Trust
81%	Tavistock and Portman NHS Foundation Trust
81%	East Lancashire Hospitals NHS Trust
81%	Surrey and Borders Partnership NHS Foundation Trust
81%	Kingston Hospital NHS Foundation Trust
81%	St Helens and Knowsley Teaching Hospitals NHS Trust
81%	University Hospital Southampton NHS Foundation Trust
81%	North Tees and Hartlepool NHS Foundation Trust
81%	The Newcastle upon Tyne Hospitals NHS Foundation Trust
81%	Northumberland, Tyne and Wear NHS Foundation Trust
81%	Royal Devon and Exeter NHS Foundation Trust
81%	Pennine Care NHS Foundation Trust
81%	West Suffolk NHS Foundation Trust
81%	Somerset Partnership NHS Foundation Trust
81%	Royal Surrey County Hospital NHS Foundation Trust
81%	North East London NHS Foundation Trust
81%	Midlands Partnership NHS Foundation Trust
81%	Tees, Esk and Wear Valleys NHS Foundation Trust
80%	Leicestershire Partnership NHS Trust
80%	Oxford Health NHS Foundation Trust
80%	Salisbury NHS Foundation Trust
80%	Dorset HealthCare University NHS Foundation Trust
80%	University Hospitals Coventry and Warwickshire NHS Trust
80%	Cheshire and Wirral Partnership NHS Foundation Trust
80%	Dudley and Walsall Mental Health Partnership NHS Trust
80%	Hertfordshire Partnership University NHS Foundation Trust
80%	Lincolnshire Partnership NHS Foundation Trust
80%	Mersey Care NHS Foundation Trust
80%	Central London Community Healthcare NHS Trust
80%	Oxleas NHS Foundation Trust
80%	North West Anglia NHS Foundation Trust
80%	University Hospitals Plymouth NHS Trust
80%	2gether NHS Foundation Trust
80%	Sheffield Children's NHS Foundation Trust
80%	Nottingham University Hospitals NHS Trust
80%	Tameside and Glossop Integrated Care NHS Foundation Trust
80%	Southern Health NHS Foundation Trust
80%	Queen Victoria Hospital NHS Foundation Trust
80%	East London NHS Foundation Trust
80%	East Cheshire NHS Trust
80%	Royal Papworth Hospital NHS Foundation Trust
79%	University Hospitals Bristol NHS Foundation Trust
79%	Poole Hospital NHS Foundation Trust

79%	South West Yorkshire Partnership NHS Foundation Trust
79%	Luton and Dunstable University Hospital NHS Foundation Trust
79%	Mid Cheshire Hospitals NHS Foundation Trust
79%	Sandwell and West Birmingham Hospitals NHS Trust
79%	Leeds Teaching Hospitals NHS Trust
79%	Isle of Wight NHS Trust (ambulance sector)
79%	North West Boroughs Healthcare NHS Foundation Trust
79%	Royal Berkshire NHS Foundation Trust
79%	North Staffordshire Combined Healthcare NHS Trust
79%	Central and North West London NHS Foundation Trust
79%	Great Western Hospitals NHS Foundation Trust
79%	Sherwood Forest Hospitals NHS Foundation Trust
79%	Chelsea and Westminster Hospital NHS Foundation Trust
79%	Cornwall Partnership NHS Foundation Trust
79%	Blackpool Teaching Hospitals NHS Foundation Trust
79%	Royal National Orthopaedic Hospital NHS Trust
79%	Leeds and York Partnership NHS Foundation Trust
79%	Sheffield Teaching Hospitals NHS Foundation Trust
79%	University Hospitals of Morecambe Bay NHS Foundation Trust
79%	Bolton NHS Foundation Trust
79%	Portsmouth Hospitals NHS Trust
79%	Bradford District Care NHS Foundation Trust
79%	Calderdale and Huddersfield NHS Foundation Trust
79%	The Walton Centre NHS Foundation Trust
79%	Homerton University Hospital NHS Foundation Trust
79%	West Hertfordshire Hospitals NHS Trust
79%	Gloucestershire Hospitals NHS Foundation Trust
79%	Devon Partnership NHS Trust
79%	Camden and Islington NHS Foundation Trust
79%	Sussex Partnership NHS Foundation Trust
79%	Yeovil District Hospital NHS Foundation Trust
79%	Bridgewater Community Healthcare NHS Foundation Trust
78%	Manchester University NHS Foundation Trust
78%	Buckinghamshire Healthcare NHS Trust
78%	Lancashire Teaching Hospitals NHS Foundation Trust
78%	Barnsley Hospital NHS Foundation Trust
78%	Wye Valley NHS Trust
78%	The Princess Alexandra Hospital NHS Trust
78%	Birmingham Community Healthcare NHS Foundation Trust
78%	West London NHS Trust
78%	Hull and East Yorkshire Hospitals NHS Trust
78%	Kettering General Hospital NHS Foundation Trust
78%	Alder Hey Children's NHS Foundation Trust
78%	Kent and Medway NHS and Social Care Partnership Trust
78%	Milton Keynes University Hospital NHS Foundation Trust

78%	Southend University Hospital NHS Foundation Trust
78%	Torbay and South Devon NHS Foundation Trust
78%	University College London Hospitals NHS Foundation Trust
78%	Greater Manchester Mental Health NHS Foundation Trust
78%	East Sussex Healthcare NHS Trust
78%	Bradford Teaching Hospitals NHS Foundation Trust
78%	Great Ormond Street Hospital for Children NHS Foundation Trust
78%	University Hospitals of Derby and Burton NHS Foundation Trust
78%	South Tyneside NHS Foundation Trust
78%	Birmingham Women's and Children's NHS Foundation Trust
78%	Warrington and Halton Hospitals NHS Foundation Trust
78%	Essex Partnership University NHS Foundation Trust
78%	Taunton and Somerset NHS Foundation Trust
78%	Dartford and Gravesham NHS Trust
78%	Northampton General Hospital NHS Trust
78%	Coventry and Warwickshire Partnership NHS Trust
78%	Barnet, Enfield and Haringey Mental Health NHS Trust
77%	Western Sussex Hospitals NHS Foundation Trust
77%	Rotherham Doncaster and South Humber NHS Foundation Trust
77%	Bedford Hospital NHS Trust
77%	Ashford and St Peter's Hospitals NHS Foundation Trust
77%	Stockport NHS Foundation Trust
77%	Brighton and Sussex University Hospitals NHS Trust
77%	The Royal Liverpool and Broadgreen University Hospitals NHS Trust
77%	Barts Health NHS Trust
77%	Nottinghamshire Healthcare NHS Foundation Trust
77%	East Suffolk and North Essex NHS Foundation Trust
77%	Hampshire Hospitals NHS Foundation Trust
77%	Mid Essex Hospital Services NHS Trust
77%	George Eliot Hospital NHS Trust
77%	Lancashire Care NHS Foundation Trust
77%	Isle of Wight NHS Trust (mental health sector)
77%	Wrightington, Wigan and Leigh NHS Foundation Trust
77%	Lewisham and Greenwich NHS Trust
77%	Basildon and Thurrock University Hospitals NHS Foundation Trust
77%	Imperial College Healthcare NHS Trust
77%	Walsall Healthcare NHS Trust
77%	Chesterfield Royal Hospital NHS Foundation Trust
77%	Dorset County Hospital NHS Foundation Trust
77%	Royal Free London NHS Foundation Trust
77%	Oxford University Hospitals NHS Foundation Trust
77%	Derbyshire Healthcare NHS Foundation Trust
77%	Humber Teaching NHS Foundation Trust
77%	The Royal Wolverhampton NHS Trust
76%	South Central Ambulance Service NHS Foundation Trust

76%	Salford Royal NHS Foundation Trust
76%	South London and Maudsley NHS Foundation Trust
76%	The Rotherham NHS Foundation Trust
76%	York Teaching Hospital NHS Foundation Trust
76%	The Hillingdon Hospitals NHS Foundation Trust
76%	North East Ambulance Service NHS Foundation Trust
76%	Sheffield Health and Social Care NHS Foundation Trust
76%	London North West University Healthcare NHS Trust
76%	Avon and Wiltshire Mental Health Partnership NHS Trust
76%	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
76%	Isle of Wight NHS Trust (community sector)
76%	Black Country Partnership NHS Foundation Trust
76%	University Hospitals of Leicester NHS Trust
76%	James Paget University Hospitals NHS Foundation Trust
76%	Whittington Health NHS Trust
76%	Liverpool Women's NHS Foundation Trust
76%	Birmingham and Solihull Mental Health NHS Foundation Trust
76%	South West London And St George's Mental Health NHS Trust
76%	Barking, Havering And Redbridge University Hospitals NHS Trust
75%	Countess of Chester Hospital NHS Foundation Trust
75%	North Bristol NHS Trust
75%	Croydon Health Services NHS Trust
75%	Mid Yorkshire Hospitals NHS Trust
75%	King's College Hospital NHS Foundation Trust
75%	University Hospitals Birmingham NHS Foundation Trust
75%	Royal United Hospitals Bath NHS Foundation Trust
75%	County Durham and Darlington NHS Foundation Trust
75%	Maidstone and Tunbridge Wells NHS Trust
75%	Aintree University Hospital NHS Foundation Trust
75%	The Dudley Group NHS Foundation Trust
75%	Royal Cornwall Hospitals NHS Trust
75%	Norfolk and Norwich University Hospitals NHS Foundation Trust
75%	Weston Area Health NHS Trust
75%	Norfolk and Suffolk NHS Foundation Trust
75%	Epsom and St Helier University Hospitals NHS Trust
75%	London Ambulance Service NHS Trust
75%	Pennine Acute Hospitals NHS Trust
75%	East Kent Hospitals University NHS Foundation Trust
74%	North Middlesex University Hospital NHS Trust
74%	St George's University Hospitals NHS Foundation Trust
74%	South East Coast Ambulance Service NHS Foundation Trust
74%	University Hospitals of North Midlands NHS Trust
74%	Worcestershire Acute Hospitals NHS Trust
74%	West Midlands Ambulance Service NHS Foundation Trust
74%	Northern Lincolnshire and Goole NHS Foundation Trust

74%	North West Ambulance Service NHS Trust
73%	Wirral University Teaching Hospital NHS Foundation Trust
73%	Isle of Wight NHS Trust (acute sector)
73%	South Tees Hospitals NHS Foundation Trust
73%	East and North Hertfordshire NHS Trust
73%	Southport and Ormskirk Hospital NHS Trust
72%	United Lincolnshire Hospitals NHS Trust
72%	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
72%	Medway NHS Foundation Trust
72%	South Western Ambulance Service NHS Foundation Trust
71%	North Cumbria University Hospitals NHS Trust
71%	Yorkshire Ambulance Service NHS Trust
70%	The Shrewsbury and Telford Hospital NHS Trust
70%	East of England Ambulance Service NHS Trust
68%	East Midlands Ambulance Service NHS Trust

Acknowledgements

We would like to thank everyone who has helped with the preparation of the Freedom to Speak Up Index and this report. This includes all the trusts featured, the survey team at NHS England and current and previous members of the team at the National Guardian's Office

National Guardian
Freedom to Speak Up

A summary of speaking up learning and actions in response

September 2019

Contents

Summary	3
Review findings and actions	6
Annex A	14

Summary:

1. The National Guardian's Office (NGO) reviewed the handling of two speaking up cases referred to it by workers from Northwest Ambulance Service NHS Trust ('the trust',) as the workers' referral information indicated that the trust's response to their speaking up had not been in accordance with good practice.

2. The office decided to review the cases referred to it because of the potential important learning that could be obtained.

3. The NGO visited the trust to gather information for its review in January and February 2019. It then held discussions with the trust about aspects of that information, before returning in May 2019 with colleagues from NHS Improvement[1] to discuss the provisional findings of the review with trust leaders and to agree actions in response.

4. The trust supported the review process by providing all requested information and by participating fully in the engagement process to discuss the review's findings.

5. As part of the review, NGO staff interviewed the workers who had referred their cases to the office and those in the trust responsible for responding to the matters they had originally raised. In addition, we met with senior leaders responsible for the trust's speaking up arrangements. The review also looked at relevant speaking up policies and procedures and how the trust had implemented the Freedom to Speak Up Guardian role.

6. At the time of the review the Trust had two full time Freedom to Speak Up Guardians, supported by a number of champions across the Trust, a lead Executive Director and a lead Non-Executive Director of Speaking Up. There were a range of policies and procedures in place to support the speaking up culture and evidence of both training and effective Board reporting.

7. The review found areas where the trust's response to the issues raised by the workers could be improved, including in relation to providing feedback on the progress of the trust's investigation into their concerns.

8. The review also found that there was lack of clarity among workers about the scope of the Freedom to Speak Up Guardian role and what matters they could support workers to raise.

9. In response to the potential lack of clarity, the NGO recommended that the trust developed a single policy to describe the available support and procedures in relation to speaking up.

[1] From 1st April 2019 NHS England and NHS Improvement are working together as a single organisation; see - https://improvement.nhs.uk/

10. A central feature of the review was an engagement process, involving the NGO, the trust's leaders and NHS Improvement, to discuss the review's findings and agree actions in response to its findings.

11. The review's findings and agreed actions are set out in a table below. Additional information from the NGO about the role of Freedom to Speak Up Guardians is also set out in Annex A.

The National Guardian's Office case review engagement process

12. The NGO trialled the engagement process described at paragraph 10 above as part of its revision of how it responds to the case review referrals it receives. Information on the NGO's revised case review process will be available on its webpages later in 2019.

13. The principal objective of the engagement process was to work in partnership with the referrers, the trust and NHS Improvement to ensure that a helpful outcome was achieved, which provided learning for the trust and the rest of the system.

Acknowledgements and thanks

14. We would like to thank the following individuals and organisations for their help and assistance in the completion of the report:

- Trust workers who have shared their experiences of speaking up in the organisation
- The trust's Freedom to Speak Up Guardians
- The leaders of the trust
- NHS Improvement

Findings and agreed actions

15. A summary of the review's findings is set out below, with the trust's actions in response to those findings. Additional information is provided in Annex A in relation to the findings in part 1.

16. In addition to those actions, the National Guardian's Office will also be revising its guidance on the recording of Guardians' cases, following issues raised during the review about the confidentiality of such records and access to them.

17. NHS Improvement will oversee the delivery of the trust's agreed actions and provide updates to the NGO as to the progress of their implementation.

18. Consistent with other NGO review reports, the office expects other NHS trusts to identify where the findings of this review apply to their own circumstances and take appropriate action to apply the learning described. For clarity, when making this decision, other trusts should refer to the report's findings, rather than the actions of the trust in response, as they apply to that trust's particular circumstances in this case.

What will happen next

19. The National Guardian's Office will continue to provide ongoing support to the trust, through its training and guidance for those delivering Freedom to Speak Up in the organisation.

Review findings and comments	Actions in response to findings
1. Speaking up policies The trust had two policies covering speaking up: (i) 'Raising Concerns at Work (Whistle Blowing) Policy and Procedure', based on the Public Interest Disclosure Act.[2] (ii) 'Freedom to Speak Up Policy', based on the 'Raising Concerns Policy for the NHS' produced by NHS Improvement.[3] The trust had developed the second policy as part of improvement work to respond to staff who raise issues. The purpose of a speaking up policy is to set out how workers can speak up and the support they can expect when they do so. Such policies include options for workers about who they can speak up to, including their line manager, supervisor, Freedom to Speak Up Guardian or others. They should be written in a way that is accessible, easily understood, and that encourages workers to speak up. The existence of multiple policies in the trust does not promote these objectives. The policies seen in the review included a focus on The Public Interest Disclosure Act. This has only limited relevance to speaking up culture and, therefore, this emphasis does not add to the clarity of the policies.	**The trust's actions in response are:** 1.1 Merge the two policies based around the current 'Freedom to Speak Up Policy' in relation to all matters raised by its workers. 1.2 Revise its Freedom to Speak Up Policy to reflect the content of the updated national policy, once NHS Improvement has completed its revision of the policy. 1.3 Advise all its workers of any revisions made to its policies which support its workers to speak up.

[2] https://www.legislation.gov.uk/ukpga/1998/23/contents
[3] https://improvement.nhs.uk/documents/27/whistleblowing_policy_final.pdf

A review by NHS Improvement of the national speaking up policy is expected to take place later in 2020. In addition, the NGO has produced a policy review framework to help organisations ensure that their speaking up policies clearly set out how their workers can speak up, to who and the support they will receive. This framework will be available soon on the NGO's webpages. We acknowledge the trust's recent attempts to identify learning from the speaking up cases at the centre of the NGO review and to improve processes to support speaking up.	
2. The scope of support from Freedom to Speak Up Guardians There was a lack of clarity regarding the scope of the role of the Freedom to Speak Up Guardians in the trust and whether there were certain types of issues that it was not within the Guardian's remit to support workers to raise. The remit of Freedom to Speak Up Guardians, as set out in guidance from the National Guardian's Office[4], is to provide support for workers to speak up, regardless of the type of matter involved. Further information about the scope of the Guardian role is set out in Annex A below. In response the trust told our review that they acknowledge that there had been a lack of clarity about the arrangements for managing cases raised through FTSU which are then investigated through HR processes, but it has always supported FTSU as a route to raise any type of concern.	**The trust action in response is:** 2.1 The trust's new speaking up policy will make it clear that all workers can seek support from the trust Freedom to Speak Up Guardian about any issue. 2.2 FTSU awareness has been delivered through mandatory training and is included at induction, and the Trust will continue to look for positive opportunities to train and promote FTSU.

[4] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

The trust also said it had identified learning from recent speaking up cases and had developed agreed protocols for ensuring that cases raised through the Freedom to Speak Up Guardian continue to be supported by them, regardless of the process through which the investigation was managed. Changes have already been made to the disciplinary policy and associated standard letters, to ensure that the right of access to the FTSU guardian is clear and other policies will be reviewed.	
3. Thanking workers for speaking up Two trust workers, who spoke up about serious issues concerning staff safety, reported that they had not been thanked for speaking up. The trust view on this point was different but acknowledged the workers' perceptions on the matter. This was not managed as well as it could have been in accordance with good practice, or the Freedom to Speak Up policy for the NHS.	**The trust action in response is:** 3.1 The trust's new speaking up policy will include a reference to thanking all workers who speak up. 3.2 The trust is continuing to train managers in investigation training to address this issue.
4. The independence of investigators into speaking up matters An investigation into the issues raised by the two workers was undertaken by an individual who both workers regarded as potentially conflicted and therefore not suitably independent.	**The trust's actions in response are:** The trust will review its relevant policies in relation to investigations to ensure that – 4.1 they take proper and reasonable account of workers' objections relating to the perceived independence of investigators, and that a clear rationale for any decisions regarding investigators is given to workers in response to such objections.

The trust told our review that it was aware of the potential conflict of interest. It explained it had assessed the risk associated with this and determined that it was not a conflict. This decision was made in line with its policies. It added that its investigation processes include an independent, senior review which looks at the quality of investigation, the outcome and recommendations and provides an extra layer of scrutiny and assurance as to fairness and objectivity. However, trust leaders acknowledged it could have done more to address the workers' concerns. The National Guardian's Office, in a previous case review report,[5] has recommended that the Department of Health and Social Care commissions guidance on investigations for NHS trusts. This should include guidance on selecting suitably independent investigators. The national speaking up policy for the NHS makes clear that investigations into matters raised by workers should be conducted by a 'suitably independent' person. Published guidance on conducting investigations from the Advisory, Conciliation and Arbitration Service[6] (ACAS) emphasises the need for processes to be conducted in 'fair' and 'reasonable' manner. It states that the perceptions of bias 'should be avoided wherever possible.'	4.2 they provide more transparency about the way in which the trust will manage potential conflicts of interest relating to investigations.

[5] https://www.cqc.org.uk/sites/default/files/20180620_ngo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf

[6] https://www.acas.org.uk/media/4483/Conducting-workplaceinvestigations/pdf/Conducting_Workplace_Investigations.pdf

It also sets out questions to be considered when choosing an investigator, which include considering whether the appointment would raise any concerns regarding conflicts of interest. ACAS provides training based on that guidance. Training for investigations specifically into clinical practice is also available from NHS Resolution.[7]	
5. Timeliness and handling of investigations In respect of the above investigation, the workers concerned felt they received insufficient feedback during the investigation, including as to its progress and how long it might take. The workers received formal feedback on the outcome of the investigation six months after first speaking up. The workers concerned were not told under which policy or procedure the trust was investigating their concerns. There was also evidence that staff involved in the investigation were unclear about this. The national speaking up policy for the NHS makes clear that workers should be kept updated with the progress of investigations.	**The trust's actions in response are:** 5.1 Ensure its revised speaking up policy includes the commitment to investigations being completed within reasonable timescales and for workers to be kept regularly informed of progress, particularly in circumstances where timescales become extended. 5.2 Continue the work it has commenced to improve tracking of HR-related investigations and that this is used proactively to provide oversight of investigation process. 5.3 Ensure that workers who speak up are clear on the policies under which their complaints are being investigated. 5.4 Review the trusts own protocols setting out the working arrangements between FTSUGs and HR to ensure that these principles are embedded.

[7] https://resolution.nhs.uk/ppa-training/

The trust's disciplinary processes already include a commitment to delivering investigations within a reasonable timeframe, taking account of the complexity of the case and its oversight and visibility of this is being improved through the implementation of a new HR case management system.	
6. Perceived attitudes towards female workers Some who spoke to our review expressed the belief that there were examples of poor attitudes demonstrated towards female workers who spoke up. In response, the trust provided evidence to demonstrate that it took the issue of equality, diversity and inclusion seriously and that, overall, its staff survey results show an improving picture in respect of the experience of women in the workplace.	**The trust will continue its work to improve the experience of women in the workplace, including:** 6.1 delivering 'women into leadership' programmes, that support the progression for women leaders in operational roles. 6.2 drawing up a gender action plan focused on improving the gender pay gap and the experience of women in the workplace. 6.3 rolling-out a range of training including Dignity at Work Training, Managing Healthy Workplace training, the Trusts 'BE Think Do' leadership training and a new course designed to tackle the issues of inappropriate banter in the workplace. 6.4 creating a joint management and staff side working group reviewing the trust's approach to tackling conflict in the workplace. 6.5 rolling-out bespoke leadership and management training within the service line where these workers worked to help enable the management team to support employees effectively. 6.6 utilizing a range of support interventions as part of its Health and Wellbeing Strategy.

	The Trust is also intending to implement a Working Towards an Outstanding Culture survey/audit. The work will be carried out and analysed by an independent organisation who are leaders in this field. The work will be designed through engagement with staff and will aim to focus on the cultural and leadership changes required to improved employee experience and well-being.
7. Mediation Following the investigation process described above, the trust offered mediation to the workers involved in the investigation. The trust explained that they did this entirely in accordance with their policies and procedures and that the process was entirely voluntary. The workers whose speaking up had triggered the investigation said that they did not want mediation. A staff member involved in the handling of the matter of mediation commented that the trust could have better communicated the proposed use of mediation to the workers concerned.	**The trust's actions in response are:** 7.1 Taking appropriate steps to ensure that managers and HR staff are up to date with existing guidance on explaining the value of mediation to workers.
8. Freedom to Speak Up and 'advocacy' The trust had appointed 12 volunteer FTSU 'champions' to support the work of the trust FTSU Guardians. They were described by some of the staff we spoke to as 'advocates.' It was clarified that the champions did not act as advocates or representatives for workers.	**The trust's actions in response are:** 8.1 The trust will ensure that the role of 'champion' is properly reflected in the policy review referred to in point 1 above. 8.2 The trust will also engage with the existing champions to ensure that their roles and responsibilities are clear, especially when individuals hold more than one voluntary role which may create conflict or create

Other than the name, the job roles' description was consistent with the function of champions and ambassadors as seen in other trusts. Concern was also expressed in some parts of the organisation that individuals with responsibility for supporting speaking up in the trust acted, at times, more as an 'advocate' for workers, where they appeared to take the side of a member of staff. The NGO is clear in its training[8] and published guidance[9] that those with responsibility for supporting workers to speak up must act impartially, ensuring that they 'remain objective and unbiased.' Where individuals responsible for supporting speaking up act or are perceived as acting as advocates for the views of individuals, they risk undermining the purpose and integrity of their speaking up position. At the same time, where those responsible for supporting workers to speak up do so in accordance with published training and guidance, in a robust and impartial way, trusts must ensure that they respond effectively to this support in accordance with good practice. The NGO will offer additional support to those with a speaking up role in the trust to address these matters.	confusion for those workers seeking support, such as peer supporter roles.

[8] https://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf
[9] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

Annex A:

The scope of the role of Freedom to Speak Up Guardians

The purpose of the Freedom to Speak Up Guardian role is set out in a job description, issued by the National Guardian's Office, issued in March 2018,[10] which states:

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported to speak up
- Barriers to speaking up are addressed
- A positive speaking up culture is fostered
- Issues raised are used as opportunities for learning and improvement

As implied by this summary, the range of issues that a Freedom to Speak Up Guardian can support a worker to raise is not restricted to any particular type and instead covers a wide range of matters, including, but not limited to:

- concerns about unsafe clinical practice
- staffing and resource levels
- cultural concerns
- bullying and harassment
- training and improvement ideas
- personal employment issues
- dignity at work issues

The NGO has observed in its case reviews that a barrier to speaking up has been created where workers are told by their employer that the matters they wish to speak up about are not within the scope of the Guardian to support.[11]

Many of the matters a Guardian can support a worker to raise will carry their own set of policies and procedures. In such circumstances, the Guardian can help a worker explore the best way to speak up under those processes, including helping them to understand their rights and obligations under that policy.

As stated in the job description, Guardians also promote learning and improvement within their organisation, helping to ensure that lessons learned from the issues raised by workers are actioned appropriately to deliver lasting improvement.

[10] https://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

[11] https://www.cqc.org.uk/sites/default/files/201801107-Nottinghamshire%20Healthcare%20NHS%20Foundation%20Trust%20A%20review%20of%20the%20handling%20of%20speaking%20up%20cases.pdf

The job description also makes it clear that Freedom to Speak Up Guardians should act '*independently, impartially and objectively*.' They should therefore neither act, nor be seen to act, as either the representative of an individual worker, or for an organisation, but instead be an independent arbiter for their organisation's speaking up processes, helping to lead cultural change and improvement.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Report of the Audit Committee			**Meeting date** 6th November 2019
Report appendix	n/a		
Report sponsor	Company Secretary		
Report author	Company Secretary		
Report provenance	Reviewed at the Audit Committee – 30 October 2019		
Purpose of the report and key issues for consideration/decision	The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference. The purpose of the Committee is laid down in its Terms of Reference. The purpose of this report is to provide assurance that the Audit Committee has carried out its obligations in accordance with its Terms of Reference. This Annual Report summarises the activities of the Trust's Audit Committee for the financial year 2018/19.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive and note the Annual Report of the Audit Committee.		
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**	X

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

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

AUDIT COMMITTEE ANNUAL REPORT

1 APRIL 2018 TO 31 MARCH 2019

1. INTRODUCTION

1.1 The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 The purpose of the Committee is laid down in its Terms of Reference. In summary, it oversees the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place, reviews the work and findings of External Audit, reviews the Trust's statutory accounts before they are presented to the Trust Board and maintains oversight of the Trust's Counter Fraud arrangements.

1.3 The purpose of this report is to provide assurance that the Audit Committee has carried out its obligations in accordance with its Terms of Reference.

1.4 This Annual Report summarises the activities of the Trust's Audit Committee ('the Committee') for the financial year 2018/19 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Audit Committee has oversight for the Board:

- Financial reporting
- Risk management
- External audit
- Internal audit
- The system of internal control
- Governance arrangements, including the work of other Board committees.

1.5 The Chair escalates those matters that the Audit Committee considers should be drawn to the attention of the Board when presenting minutes of the Committee's proceedings to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During 2018/19, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Regular review of the Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring.

- Review of the draft Annual Governance Statement.
- Received reports on progress against local counter fraud, internal and external audit plans and issues by exception.
- Agreed the external audit annual fee and work plan.
- Agreed the internal audit and local counter fraud annual work plans.
- Reviewed the draft annual accounts, draft annual report and draft quality report and recommended them for approval to the Trust Board.
- Reviewed specific Internal Audit reports and proposed actions for those areas identified with limited assurance (with the relevant Executive Director present when required) and monitored the follow-up of outstanding actions.
- Reviewed the effectiveness of Internal Audit, External Audit and the Local Counter Fraud Service.
- Reviewed the accounting policies, judgements and material misstatements of the Trust and made appropriate recommendations to the Trust Board.
- Reviewed External Audit reports and the Annual Audit Letter, including progress on implementation of recommendations.
- Conducted a series of deep dives considering risks to the organisation.
- Received a number of ad-hoc reports where, for example, changes to national regulations have been acknowledged as impacting on the Trust ie GDPR.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting. This included highlights of the results of the Internal Audit reports received at each meeting, providing more details in relation to those that were of limited assurance, which formed part of the evidence upon which the overall Head of Internal Audit opinion was based. They also included reports which considered the proper arrangements in place to secure economy, efficiency and effectiveness of resources and deep dive reviews in to potential risks.

2.3 Work of the Committee

2.3.1 External Audit – The Trust's external auditor is PricewaterhouseCoopers ('PwC'). The Committee reviewed progress and final audit reports and management letters for 2018/19. The timings associated with final agreement

of the Devon STP Plan (and control total) for 2019/20 impacted significantly on the timeline for final sign-off of the annual accounts by PwC. Submission of the annual report and accounts prior to the deadline was however achieved.

PwC have been the Trust's auditor for over 5 years. It is deemed good practice to market test external auditor periodically and therefore a full tendering exercise will be undertaken in 2019/20 with a view to appointing an external auditor in 2020.

2.3.2 Internal Audit – The Committee works with the Internal Audit team (ASW Assurance). The Committee reviewed and approved the Internal Audit Plan and detailed programme of work. The Internal Audit Plan embraced operational as well as financial and business areas, and the Committee received a range of reports during the year for consideration.

The internal audit work was completed in line with the plan for 2018/19, subject to any adjustments agreed by senior management and the Audit Committee.

The Committee was provided with the following reports recorded as *significant assurance:*

- Strategic Estates Partnership

The Committee was provided with the following reports recorded as *satisfactory assurance*

- Enhanced Intermediary Care
- Continuous Improvement Programme Arrangements
- Capital Expenditure Prioritisation
- Board Assurance Framework and Risk Management

In addition, the Committee received the following reports providing *limited assurance*

- Agency Booking Processes – Allied Health Professional Staff

As part of the annual reporting process, the Head of Internal Audit opinion stated that:

"*Significant assurance can be given that there is generally a sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls, which put the achievement of particular objectives at risk are appropriately managed".*

The Committee received regular internal audit progress reports and continue to monitor the completion of outstanding report recommendations through updates and progress reports. The Committee continued to highlight concerns about the delay in implementation of the overdue actions during 2018/19.

Since the year end the process by which ASW Assurance reported to senior management on progress in between Audit Committee meetings changed. ASW Assurance now attend the Trust Risk Committee for the purpose of reporting progress and highlighting key risks to achievement of their internal audit plan.

2.3.3 Counter Fraud - The Trust takes the prevention and detection of fraud seriously. Each year the Committee receives and considers the Annual Counter Fraud Plan, regular progress reports and updates, and the Annual Counter Fraud Report.

The Local Counter Fraud Specialist (LCFS) is invited to twice yearly to attend the Committee to give a presentation an update on the Plan, fraud prevention and cases reported and under investigation.

Of note during the year was the work undertaken to support the Company Secretary on the introduction of a new electronic process for declaring interests. This trust-wide process involved a raising awareness campaign, presentation and bespoke training to a number of high-risk areas.

3. RISK MANAGEMENT

3.1 During the year, the Committee continued to review the risk management approach across the Trust. The Committee reviewed the Corporate Risk Register and the Board Assurance Framework (‘BAF’).

3.2 The BAF focuses on the key risks against achievement of the Trust’s strategic objectives. The BAF is a ‘live’ document and is continuously reviewed and updated. This process is managed by the Company Secretary.

3.3 The Committee reviewed the BAF at each meeting to ensure there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, to ensure there are no major omissions.

3.4 The work of the Committee is not to manage the process of populating the BAF or to get involved in the operational development of the risk management

processes, either at an overall level or individual risk level. These are operational issues that the Committee is satisfied are being carried out appropriately by management.

3.5 The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the board of directors' to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

4. MEMBERS AND MEETINGS

4.1 During 2018/19, the Committee met formally on five occasions. The meetings were quorate all times.

4.2 All Non-Executive Directors (except the Chairman) are members of the Committee. Sally Taylor acted as Committee Chair. Record of their attendance is shown below:

Non-Executive Director	Number of meetings attended
Sally Taylor (Chair)	5 (5)
Jacqui Lyttle	3 (5)
Jacqui Marshall	5 (5)
Vikki Matthews	4 (5)
Paul Richards	3 (5)
Robin Sutton	4 (5)
Jon Welch	3 (5)

4.3 Senior management representatives also in regular attendance included – Director of Finance, Chief Nurse, Deputy Director of Finance, Company Secretary and Corporate Governance Manager. Other senior managers also attended at the Committee's invitation.

4.4 The Trust's internal auditor and external auditor were in attendance at every meeting.

5. CONCLUSIONS AND ACTIONS FOR 2019/20

5.1 The review identified that the Audit Committee has delivered the majority of the responsibilities as set out in the Terms of Reference, attendance at meetings has been quorate and the cycle of business has been completed.

5.2 Areas for action during 2019/20 include undertaking a self-assessment of the Committee’s effectiveness to identify any gaps in the Committee’s workings.

5.3 The Committee is invited to consider if there are any additional areas or focus of activity for development or inclusion that might lead to further improvement in the effectiveness of the Committee during 2019/20.

6. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to its formal submission to the Trust Board.

Sally Taylor

Chair, Audit Committee

October 2019

Report to the Trust Board of Directors			
Report title: Audit Committee Terms of Reference			Meeting date: 6th November 2019
Report appendix	N/A		
Report sponsor	Company Secretary		
Report author	Company Secretary		
Report provenance	Reviewed and agreed by the Audit Committee – 30 October 2019		
Purpose of the report and key issues for consideration/decision	Following publication by the HFMA of the NHS Audit Committee Handbook - fourth edition, a review of the Audit Committee Terms of Reference has been undertaken to ensure the Terms of Reference align with best practice. The changes that have been made are not significant and reflect in the main, updates to committee titles and names of external organisations eg NHS Resolution and NHSCFA. Minor updates have been made to the Terms of Reference following review at the Audit Committee on 30 October 2019 and the final version is presented to the Board for approval.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to approve the revised Audit Committee Terms of Reference.		
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**	X

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

Board Assurance Framework	n/a	Risk score	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

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

AUDIT COMMITTEE

TERMS OF REFERENCE

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Version:	1.0
Approved by:	Audit Committee
Date approved:	30 October 2019
Approved by:	Board of Directors
Date approved:	6 November 2019
Date issued:	6 November 2019
Review date:	October 2020

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

AUDIT COMMITTEE
TERMS OF REFERENCE

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1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Audit Committee ('the Committee'). The Committee is a non-executive committee of the governing body and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee will adhere to, and be cognisant of the Trust values at all times.

1.3 The Committee is constituted as a standing committee of the Trust Board ('Board'). Its constitution and terms of reference are subject to amendment by the Trust Board.

2. Purpose

2.1 The Committee will have primary responsibility for reviewing the effectiveness of the framework in place for the identification and management of risks and associated controls, corporate governance and assurance frameworks.

2.2 The Committee will have close working relationships with the Quality and Assurance Committee which has responsibility for oversight and monitoring of clinical risks.

2.3 The Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition the Committee shall:

- 2.3.1 Ensure independence of external and internal audit;
- 2.3.2 Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Committee; and
- 2.3.3 Monitor corporate governance (e.g. compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Powers

3.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

3.2 The Committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

3.3 The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

3.4 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3.5 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice at the expense of the organisation, subject to budgets agreed by the Board.

4. Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

4.1 Integrated governance, risk management and internal control

4.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisations objectives.

4.1.2 In particular, the Committee will review the adequacy and effectiveness of:

4.1.2.1 All risk and control related disclosures statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board and/or the Council of Governors.

4.1.2.2 Statements within the quality account' together with the external audit assurance.

4.1.2.3 The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks, the appropriateness of the above disclosure statements; and, the adequacy and effectiveness of risk appetite/risk appetite governance.

4.1.2.4 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications.

4.1.2.5 The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

4.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as

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appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.1.4 This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

4.1.5 As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality and Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Audit Committee, Chief Executive (as Accountable Officer) and the Board.

4.2.2 This will be achieved by:

4.2.2.1 Considering the provision of the internal audit service, the costs involved and any questions of resignation and dismissal.

4.2.2.2 Reviewing and approving the annual internal audit workplan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

4.2.2.3 Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

4.2.2.4 Ensuring that the internal audit function is adequately resourced and has appropriate experience and standing within the organisation.

4.2.2.5 Overseeing the continuing independence of the internal auditor.

4.2.2.6 Monitoring the effectiveness of internal audit and carrying out an annual review.

4.3 External Audit

4.3.1. The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

4.1.3.1.Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board and/or Council of Governors when appropriate).

4.3.1.2 Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

DRAFT

4.3.1.3. Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

4.3.1.3 Reviewing all external audit reports, including the report to those charged with governance, (before submission to the Board and/or the Council of Governors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

4.3.1.4 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

4.4 Other Assurance Functions

4.4.1. The Committee shall review the findings of other significant assurance functions, both internal and external and consider the risk implications for the governance of the Trust, including its subsidiaries.

4.4.2 These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or Regulators / Inspectors (eg Care Quality Commission, NHS Resolution Scheme etc), and professional bodies with responsibility for the performance of staff or functions (eg Royal College's, accreditation bodies etc).

4.4.3 The Head of Internal Audit and representative of external audit reserves the right to report directly to the Committee if they consider it necessary.

4.4.4 The Committee will review the adequacy of the clinical audit function.

4.4.5 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. This will particularly include the Trust's Quality and Assurance Committee, Board Committee's and any other risk management and assurance committees that are established.

4.4.6 In reviewing the work of the Quality and Assurance Committee, and issues around clinical risk management, the Committee should satisfy itself on the assurance that can be gained from the clinical audit function.

4.4.7 Where the Committee considers there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Committee should raise the matter with the Chairman of the Trust and report its findings to the Board of Directors.

4.5 Counterfraud

4.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.

4.5.2 In accordance with 3.2 of the NHS Counter Fraud Authority's *Fraud Commissioners Standards,* the Committee has:

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'stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHS Counter Fraud Authority's quality assurance programme'.

4.5.3 The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

4.6 Management

4.6.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall managements for governance, risk management and internal control.

4.6.2 The Committee may also request specific reports from individual functions within the organisation (eg clinical audit).

4.7 Financial Reporting

4.7.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.7.2 The Committee should ensure that the systems for financial reporting to the Trust, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.7.3 The Committee shall review the annual report and financial statements before submission to the Trust, focusing particularly on:

4.7.3.1 The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

4.7.3.2 Changes in, and compliance with, accounting policies, practices and estimation technique.

4.7.3.3 Unadjusted misstatements in the financial statements.

4.7.3.4 Significant judgements in preparation of the financial statements.

4.7.3.5 Significant adjustments resulting from the audit.

4.7.3.6 Letter of representation.

4.7.3.7 Explanations for significant variances.

4.8 Whistleblowing

4.8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently through the Trust's procedures eg Freedom to Speak Up Guardian or Local Counter Fraud Specialist.

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5. Reporting

5.1 The Committee shall report to the Trust on how it discharges its responsibilities.

5.2 The minutes of the Committee's meetings shall be formally recorded by the secretary and submitted to the governing body.

5.3 The Chair of the Committee shall draw to the attention of the governing body any issues that require full disclosure to the full governing body, or require executive action.

5.4 A summary report from the Committee will be presented to the next Trust Board meeting

5.5 The Committee shall receive a summary report from those Groups reporting in to the Committee.

5.6 The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

5.6.1 The fitness for purpose of the Board Assurance Framework.

5.6.2 The completeness and 'embeddedness' of risk management in the organisation.

5.6.3 The integration of governance arrangements.

5.6.4 The appropriateness of the evidence that shows the Trust is fulfilling regulatory requirements relating to its existence as a functioning business.

5.6.5 The robustness of the processes behind the quality accounts.

5.7 This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

6. Membership and Attendance

6.1 The Committee shall be appointed by the Board from amongst the independent, Non-Executive Directors of the Trust and shall consist of not less than three members. A quorum shall be three independent members. One of the members will be appointed Chair of the Committee by the Trust. The Chair of the Foundation Trust shall not be a member of the Committee.

6.2 The Chair of the Quality and Safety Committee will be a standing appointed member of the Committee.

6.3 The Chief Finance Officer and Chief Nurse and appropriate internal and external audit representatives shall normally attend meetings of the Committee.

6.4 The counter fraud specialist will attend a minimum of two committee meetings a year.

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6.5 The Chief Executive (in their capacity as Accounting Officer for the Trust) shall be invited to attend meetings and should discuss at least annually the process for assurance that supports the Annual Governance Statement. They should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

6.6 Other executive directors/managers, should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

6.6 Representatives from other organisations (for example, NHS Counter Fraud Authority) and other individuals may be invited to attend on occasion.

6.7 The Company Secretary (or their nominee) shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

6.8 At least once a year the Committee should meet privately with the external and internal auditors.

6.9 The Chair of the Council of Governors will appoint a Governor to attend the public meetings of the Committee for the purpose of observing the performance of the external auditor in line with the Governor's duty to appoint the Trust's external audit services. The appointment will be reviewed each year.

6.10 Members unable to attend a Committee meeting should inform the Secretary to the Committee as soon as possible in advance of the meeting, except in extenuating circumstances.

6.11 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

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7. Chair

7.1 One of the Non-Executive Directors shall act as Committee Chair. In their absence, one of the other Non-Executive Directors present shall be nominated and appointed as acting Chair of the meeting.

7.2 The Chair will liaise with the Committee Secretary to ensure the agenda, reports and documents and minutes are circulated to the Committee members in accordance with section 12.

8. Meeting Administration

8.1 The Committee shall be supported administratively by the Company Secretary (or their nominee), whose duties in this respect will include:

8.1.1. Agreement of the agenda with the Chair and attendees.

8.1.2 Preparation, collation and circulation of papers in good time.

8.1.3 Ensuring that those invited to each meeting attend.

8.1.4 Taking the minutes and helping the Chair to prepare reports to the Board.

8.1.5 Keeping a record of matters arising and issues to be carried forward.

8.1.6 Arranging meetings for the Chair eg, with the internal/external auditors or local counter fraud specialists.

8.1.7 Maintaining records of members' appointments and renewal dates etc.

8.1.8 Advising the Committee on pertinent issues/areas of interest/policy developments.

8.1.9 Ensuring that action points are taken forward between meetings.

8.1.10 Ensuring that Committee members receive the development and training they need.

9. Frequency of meetings

9.1 The Committee must meet as frequently as possible to enable it to discharge all its responsibilities. The Committee will meet at least 5 times each year at appropriate times in the reporting and audit cycle.

9.2 The Trust, Chief Executive, external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

10. Meetings

10.1 Items for the agenda must be sent to the Committee Secretary a minimum of 7 days prior to the meeting; urgent items may be raised under any other business.

10.2 The agenda will be sent out to the Committee members at least 5 days prior to the meeting date, together with the updated action schedule and other associated papers.

10.3 Meetings, other than those regularly scheduled as above, shall be summoned by the Committee Secretary at the request of the Chair.

11. Conduct of Meetings

11.1 Except as outlined above, meetings shall be conducted in accordance with the provisions of the Trust's Standing Orders.

12. Review

12.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

12.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

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13. Monitoring Effectiveness

13.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will, once a year, lead an effectiveness review of the Committee.

14. Access

14.1 The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

14.2 The Chair of the Committee shall be entitled to call and hold private meetings with the External Auditor and Internal Auditor.

Approved October 2019
Revised in accordance with HFMA NHS Audit Committee Handbook (fourth edition)

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Appendix 1
Members and required attendees of the Committee

Members (title)	Required at
Non-Executive Director ***(Chair)***	All meetings
All Non-Executive Directors (except Chairman)	All meetings
Attendees (title)	**Required at**
Chief Financial Officer	All meetings
Deputy Director of Finance	All meetings
Chief Nurse	All meetings
Company Secretary	All meetings
Risk Officer	All meetings
Internal Audit management representative(s)	All meetings
External Audit management representative(s)	All meetings
Local Counter Fraud Specialist	Half-yearly
Governor observer	All meetings
(For minutes) Company Secretary (or their nominee)	All meetings

Report to the Trust Board of Directors			
Report title: Terms of Reference - People Committee		**Meeting date:** 6 November 2019	
Report sponsor	Company Secretary		
Report author	Company Secretary		
Report provenance	Draft terms of reference reviewed and discussed with the NED Chair, People Committee, Director of OD & Workforce and senior managers, and reviewed by the People Committee 24 October 2019		
Purpose of the report and key issues for consideration/decision	The newly established People Committee reviewed the draft Terms of Reference at its first meeting held on 24 October. Comments made at that meeting have been considered and reflected in the attached final version for approval by the Board.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to approve the People Committee Terms of Reference		
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**	**X**

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**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**	

PEOPLE COMMITTEE

TERMS OF REFERENCE

Version:	0.6
Approved by:	People Committee
Date approved:	24 October 2019
Approved by:	Board of Directors
Date approved:	[6] November 2019
Date issued:	[xx] November 2019
Review date:	October 2020

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The People Committee ('the Committee') is formally established as a sub-committee of the Board of Directors of Torbay and South Devon NHS Foundation Trust.

1.2 The Committee will adhere to, and be cognisant of the Trust values at all times.

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Trust Board ('Board'). Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, diversity and inclusion.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the NHS People Plan and the Trust's People Plan and ensures alignment of work with the STP/ICS Workforce Strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

3.4 The committee will promote local level responsibility and accountability.

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4. Powers

4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

4.2 The Committee is accountable to the Board and any changes to these terms of reference must be approved by the Board of Directors.

4.3 The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

4.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

4.5 The Committee is authorised by the Board to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board.

4.6 The Committee reserves the right to hold meetings in private ie comprising of Committee members only.

5 Duties and Responsibilities

5.4 The Committee is required to:-

5.4.1 Review national workforce guidance and strategies, for example the NHS People Plan, and their applicability to the Trust.
5.4.2 Consider and recommend to the Board, the Trust's overarching People Plan and associated activity/implementation plan(s) to support Trust forward strategy.
5.4.3 Obtain assurance and monitor delivery of the People Plan through the associated activity/implementation plan.
5.4.4 Consider and recommend to the Board the key people and workforce performance metrics and targets for the Trust.
5.4.5 Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case.
5.4.6 Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance.
5.4.7 Review workforce related risks identified on the Corporate Risk Register and seek assurance in relation to risk mitigation and future activity/plans.
5.4.8 Review workforce related elements of the Integrated Performance Report and seek assurance on the adequacy of the Trust's performance against operational workforce metrics.
5.4.9 Conduct reviews and analysis of strategic people and workforce issues

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at national and local level and, if required, agree the Trust's response.

5.4.10 Review workforce performance and metrics at intervals to be decided by the Committee.

5.4.11 Provide assurance to the Audit Committee that that arrangements are in place to allow staff to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently.

5.4.12 Seek assurance on the adequacy and effectiveness of staff communication and levels of staff engagement

5.4.13 Seek assurance on any additional matter referred to the Committee from the Board.

6 Membership

6.1 The Committee shall consist of the following members:

- Non- Executive Director
- Non-Executive Director
- Non-Executive Director
- Director of Workforce and Organisational Development
- Chief Nurse
- Chief Operating Officer

6.2 One of the Non-Executive Directors shall act as Committee Chair. In their absence, one of the other Non-Executive Directors present shall be nominated and appointed as acting Chair for the meeting.

6.3 The following shall be required to attend all meetings of the Committee:

- One Associate Director of Workforce and OD
- One System Medical Director
- One System Director
- One System Director of Nursing and Professional Practice
- Company Secretary (or their nominee)

6.4 The following shall be invited to attend all meetings of the Committee:

- Freedom to Speak up Guardian
- Guardian of Safe Working
- Governor observer (see 6.5 for appointment process)

6.5 The process for selecting the Governor observer is a matter for the Chair of the Council of Governors and Governors. In the event that the nominated Governor observer is unable to attend a meeting, the Committee Chair will allow a substitute Governor to attend.

6.6 Other members/attendees may be co-opted or requested to attend as considered appropriate.

7 Attendance

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7.1 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

8. Quorum

8.1 The quorum necessary for the transaction of business shall be 3 members, of which two Non-Executive Directors and one Executive Director must be present.

8.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

8.3 Deputies will not count towards the quorum.

9. Administration

9.1 The Committee shall be supported by the Company Secretary or their nominee, whose duties in this respect will include:

- In consultation with the Committee Chair and Director of Workforce and Organisational Development develop and maintain the reporting schedule to the Committee.
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the group of scheduled agenda items.
- Agreeing the action schedule with the Chair and ensuring circulation.
- Maintaining a record of attendance.

10. Meetings

10.1 Meetings will be held on the following basis:

- Meetings will be held bi-monthly (every two months).
- Meeting duration will be no longer than 2.5 hours.
- Items for the agenda should be sent to the Committee Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under 'any other business'.
- The agenda with be issued by email to the Committee members and attendees, one week prior to the meeting date, together with the action schedule and other associated papers.
- An action schedule will be circulated to members following each meeting and

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must be duly completed and returned to the Committee Secretary for circulation with the following meeting's agenda and associated papers.

11. Reporting

11.1 The Committee will provide a report to the Trust Board of Directors in support of its work on promoting good management and assurance processes. The report shall include matters requiring escalation and key risks (as applicable).

11.2 The Committee will receive reports as per the meeting work plan.

11.3 A briefing from those Groups reporting up to the People Committee (see Appendix 1) detailing items for escalation and key risks (as applicable) will be received by the Committee along with exception reports as agreed.

12. Review

12.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

12.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

13. Monitoring effectiveness

13.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled; and
- An annual self-assessment on the effectiveness of the Committee is undertaken.

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Appendix 1

Groups reporting to the People Committee

Medical Workforce Group
Non-Medical Workforce Group
Equality Business Forum
Temporary Staffing and Agency Group

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

Meeting date:	29 October 2019
Report by + date:	Chris Balch , 29 October 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 6, September 2019):

1. For assurance the Committee reviewed the Month 6 Financial Performance, which is a £7.74m deficit, slightly ahead against the plan of £7.80m, subject to assumptions regarding 52-week fines, PSF risk share and contributions by Torbay Council to Adult Social Care (ASC) costs. As the Trust has delivered its control total to Month 6, it has also been assumed that it will earn PSF and MRET funding of £3.51m.

2. The Trust has delivered £4.6m of a £4.9m CIP target for Month 6. However following review of plans to meet the annual £20m CIP target, which includes the additional cost of the change in valuation methodology required under RICS guidance, only £8.8m is now expected to be delivered, resulting in an £11.2m gap. A Financial Recovery Board has been established and Financial Improvement Director appointed to focus efforts on delivering savings, working with ISUs.

3. For assurance, the Committee reviewed the Month 6 Performance Standards which remained challenged and are subject to ongoing management action to deliver improvements. The Trust is in the process of developing a detailed recovery plan.

4. NHSI self-certification for Month 6 was approved by the Committee. The Trust has now reported that it expects a variance to plan of some £15m. The principal drivers of this deterioration in financial performance have been identified as: shortfall of income from Torbay ASC and Agenda for Change Pay Top of Scale award; change in depreciation charge resulting from revised RICS valuation guidance; under-delivery against CIP targets; failure to adhere to Bank and Agency cap levels; increased staff turnover and sickness particularly affecting Emergency, Respiratory and Stroke; overspend on ASC; and over-reliance on non-recurrent CIP in previous years.

5. Capital expenditure at Month 6 is £4.06m, a £2.84m underspend against a budget of £6.85m However, full year capital spend of £17.93m is forecast to be £1.33m over budget. Discussions are underway with DH about the availability of additional capital funding, which would be directed towards diagnostics. However, the Trust's cash balances are likely to be under pressure by the year end with the result that an emergency loan of £3.6m is being sought for the cost of the recent Theatre refurbishment.

6. The Committee received a presentation from KPMG on their review of the Trust's financial governance arrangements and its underlying financial position. Key issues highlighted include the complexity of financial reporting, a disconnect between Finance and Operations and the challenges of being an Integrated Care Trust which carries the costs of ASC. The Committee was informed of work underway to streamline financial reporting. The new ISU structure is intended to improve the connection between operations and resourcing.

7. There was discussion around the Long-term Financial Plan being prepared by the STP. Concern was expressed about the top down approach being adopted, which does not take account of the need to transition from 2019-20, nor of the unique position of Torbay and South Devon as an Integrated Trust which carries the risk of ASC. It is imperative that the Trust challenges the modelling approach being used by the STP to avoid being presented with financial targets which lack credibility.

8. Business cases considered by the Committee:
   a) Newton Abbot Health and Wellbeing Centre
   Approval in principle was given for the Trust to enter into a long lease on Sherborne House in Newton Abbot town centre to develop it as a Health and Wellbeing Centre involving the closure and relocation of the Albany Clinic, the relocation of a local primary care practice (Cricketfield) and the transfer of support staff from Bay House. In approving the business case the Committee would like to see a deep dive into the way in which Health and Wellbeing Centres will help deliver the Trust's model of care and impact its performance measures.

   b) Agresso Finance business case
   Approval was given to the purchase of an updated accounting package. This is driven by the requirement that the Trust upgrades to Windows 10. It will also improve the Trust's capacity for financial management and reporting.

   c) Windows 10 – Accelerate Capital programme
   Due to the late submission of papers the Committee was not prepared to consider this business case. However in view of the timetable for the roll out of Windows 10 it was agreed that the Board be asked to consider this business case at its November meeting.

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9. For assurance the Committee reviewed three risks (Risk Numbers 2280, 2227 and 1070) from the Financial, Digital and Compliance Risk Registers.

10. Torbay Pharmaceuticals' financial performance for September 2019 was reviewed by the Committee.

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Chris Balch (Committee Chair)

<table>
<tr><td colspan="4">Report to the Trust Board of Directors</td></tr>
<tr><td colspan="3">Report title: Safer Staffing and Nursing Work Programme</td><td>Meeting date:
6 November 2019</td></tr>
<tr><td>Report appendix</td><td colspan="3">Nil</td></tr>
<tr><td>Report sponsor</td><td colspan="3">Chief Nurse and Deputy Chief Executive</td></tr>
<tr><td>Report author</td><td colspan="3">System Director of Nursing and Professional Practice – South Devon</td></tr>
<tr><td>Report provenance</td><td colspan="3">Executive Directors October
Quality Improvement Group</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">This is the monthly safer staffing report as required by the Chief Nursing Officer NHSE.</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 note the contents of the report.</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
</table>

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**	8
Risk Register	x	**Risk score**	16

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: Safer Staffing and Nursing Work Programme		Meeting date: 6th November 2019
Report sponsor	Chief Nurse and Deputy Chief Executive	
Report author	System Director of Nursing and Professional Practice – South Devon	

1. Introduction

The purpose of this report is to provide information and assurance monthly to the Board regarding the Nursing and Midwifery Safer Staffing levels.

2. Discussion

2.1 Model Hospital Data

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset.

The model hospital dashboard was updated in July 2019 to show the national median data which is 8.2 Total: i.e 4.8 RN & 3.3 HCA.

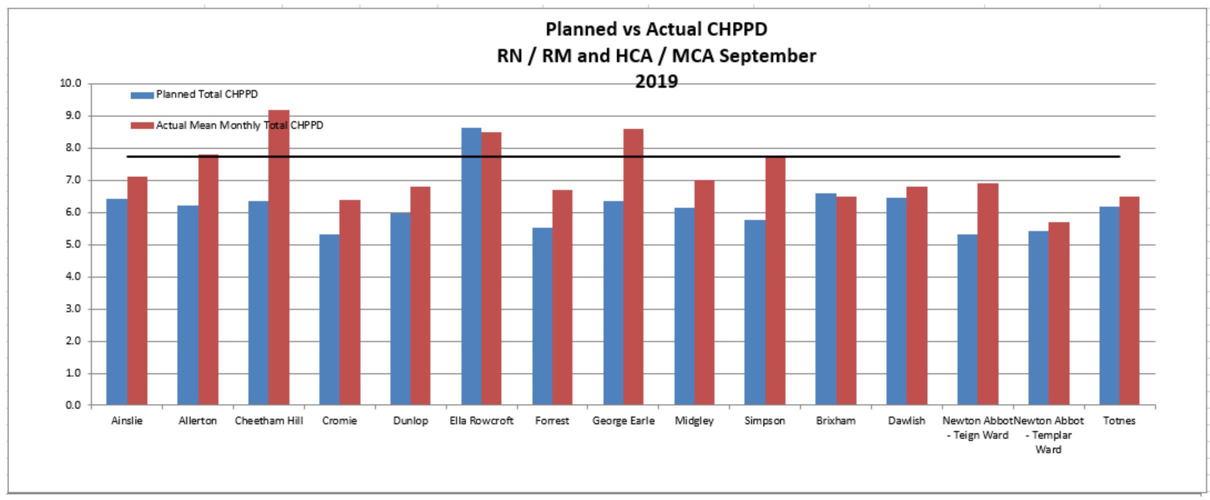
The Table below shows the Trust CHPPD position for September 2019 alongside national median data and peer regional data. The Trust is now below the national and peer RN range at 3.92 and above the national and peer for HCAs at 4.2.

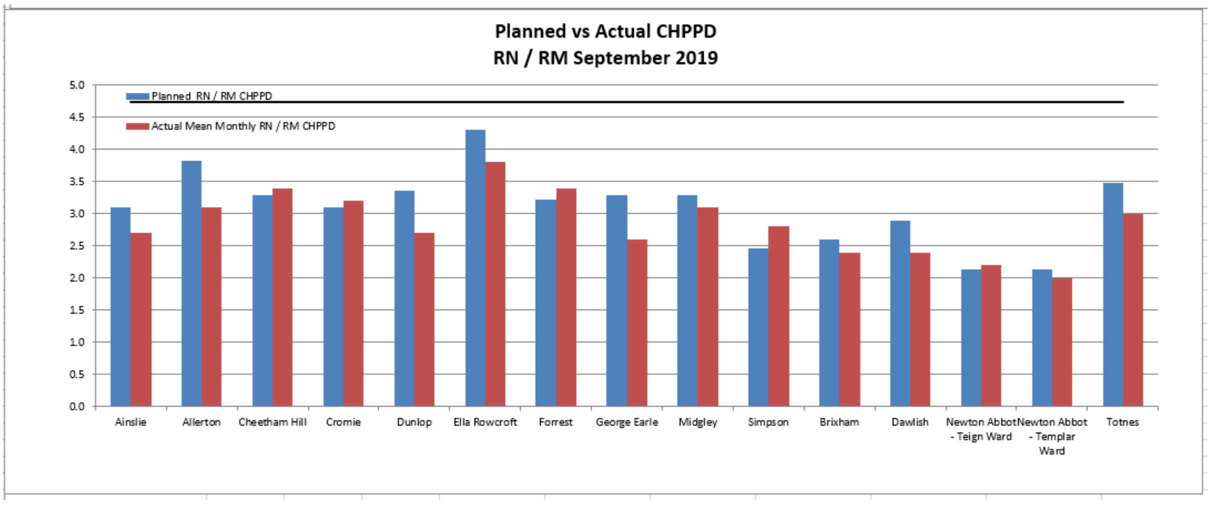
For September our position in the Trust has demonstrated that our overall comparison total CHPPD is 8.17 against a national median of 8.2 (National data is July 19). The RN CHPPD position demonstrates a slight improvement in comparison to last month 3.92 for Sept in comparison to 3.56 which is a result of recruitment; we still have further improvement within our recruitment to RN positions to be comparable against our peers and national. HCA CHPPD position remains higher in relation to last month and overall with our peers and national position and we are identifying the main reasons for this.

			Model Hospital		
	TSDFT Sept 2019	TSDFT Aug 2019	TSDFT July 2019	Peer – Region July 2019	National Median July 2019
Total CHPPD	8.17	7.67	7.9	7.8	8.2
RN/ RM CHPPD	3.92	3.56	3.7	4.5	4.8
HCA / MCA CHPPD	4.25	4.11	4.2	3.5	3.3

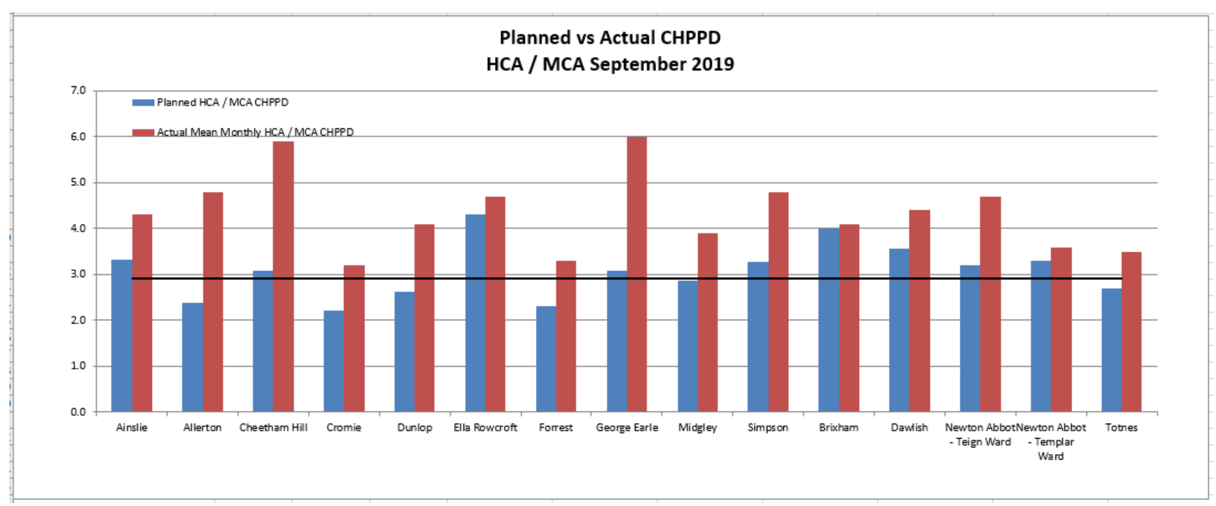
The graphs below illustrates the CHPPD data distributed by ward area, shown as a total of all nursing staff, and then separately for RNs and HCAs.

The graphs reflect a largely stable picture over the previous months. As before, the higher than planned use of HCAs is predominantly due to the additional requirements of patients requiring supportive observation; wards across the Trust continue to identify patients who require additional observational support, for example, to maintain safety due to confusion, behavioural difficulties and falls risks. Where appropriate and possible, the wards cohort patients who require supportive observations. Where there is shortfall in RN availability but is in accordance with the Carter safe staffing levels, if it is deemed appropriate additional HCAs are sourced. In this scenario the HCA does not replace the role of the RN, however their input is supportive in maintaining oversight of patient areas.





The graphs above also show that there are no areas where the actual RNs are above the current planned RN numbers. This demonstrates that this remains stable over the last 2 months.



A review of establishments has been completed and budgeted establishments are now reflected within Healthroster. Safecare module was launched on 2nd September; this has enabled Trust wide visibility of safe staffing across the organisation alongside real time acuity and dependency of patients within inpatient ward areas. As with any new change it has highlighted a number of new ways of working and identified areas where accuracy is required and is being addressed.

The table below provides CHPPD information, with the red highlighted boxes showing areas where the RN/ HCA or both fell below planned levels.

Where the ward RN levels are below planned, the clinical areas review the shifts and take action to deploy staff in other roles where this is possible or provide a HCA to support the area on the basis of risk, acuity and dependency of the area. An example of this would be where specialist nurses or the ADNPP provide support to the shift.

The speciality matrons and operational control function balances rota pressures across the organisation and discussions and reviews are held at the control meetings throughout the day.

The details of the reasons and actions are identified below the table

Care Hours Per Patient Day for Acute and Community Setting Wards September 2019

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly HCA / MCA CHPPD
Ainslie	6.4	3.1	3.3	7.1	2.7	4.3
Allerton	6.2	3.8	2.4	7.8	3.1	4.8
Cheetham Hill	6.4	3.3	3.1	9.2	3.4	5.9
Coronary Care	5.8	5.8	0.0	6.6	5.8	0.8
Cromie	5.3	3.1	2.2	6.4	3.2	3.2
Dunlop	6.0	3.4	2.6	6.8	2.7	4.1
EAU3	6.3	3.6	2.8	8.9	4.7	4.2
EAU4	7.7	4.3	3.4	8.6	4.5	4.1
Ella Rowcroft	8.6	4.3	4.3	8.5	3.8	4.7
Forrest	5.5	3.2	2.3	6.7	3.4	3.3
George Earle	6.4	3.3	3.1	8.6	2.6	6.0
ICU	20.4	20.4	0.0	31.4	27.4	4.0
Louisa Cary	6.7	4.2	2.4	15.1	10.9	4.2
John Macpherson	4.0	2.3	1.7	17.1	12.2	5.0
Midgley	6.2	3.3	2.9	7.0	3.1	3.9
SCBU	6.9	6.9	0.0	10.1	8.3	1.9
Simpson	5.8	2.5	3.3	7.7	2.8	4.8
Turner	7.9	3.6	4.2	9.2	4.2	5.0
Brixham	6.6	2.6	4.0	6.5	2.4	4.1
Dawlish	6.4	2.9	3.6	6.8	2.4	4.4
Newton Abbot - Teign Ward	5.3	2.1	3.2	6.9	2.2	4.7
Newton Abbot - Templar Ward	5.4	2.1	3.3	5.7	2.0	3.6
Totnes	6.2	3.5	2.7	6.5	3.0	3.5

There has been an improvement since last month on the number of areas where the actual RN/HCA or both have fallen below the planned levels.
There are a several reasons for the number of areas that have a reduction within their planned registered nursing numbers.

These include:

- Ensure robust temporary nursing staffing controls to maintain quality and safety and also manage our financial position in relation to temporary staffing usage.
- Temporary staffing are unable to fill some of the shifts
- Due to the implementation of Safecare in September, establishments within Healthroster have been reset, updated and triangulated with financial establishments for accuracy and robustness

Actions over next quarter:

- Reduction of unregistered staff undertaking enhanced supervision, through a programme of work in collaboration with South Devon College and volunteers
- Robust recruitment plans and visibility of this across the organisation
- Overseas recruitment trajectory will see 37 Registered nurses join the trust between November 2019 and February 2020
- Utilising new workforce planning tool as part of the NHS People Plan

2.2 Organisational Alert status

This report includes an overview of the organisational Opel status which provides an indicator of the operational pressures present within the system, and therefore is a proxy indicator of the effects on clinical staffing.

The alert status for the organisation for September 2019 is summarised in the table below, with the detail for August 2019 shown in brackets. The table demonstrates that during September the Trust experienced significantly more days at Opel 2 and a significant reduction in Opel 3 escalation than in August.

Overall the Trust experienced 40% of the time in Opel 3 in comparison to last month which saw 74% demonstrating 16 days out of 30 in either Opel 3 or Opel 4, which was 53.3% of the month. An improved position of Opel 2 status was had this month, which saw the trust experience this 30% more than last month.

TSDFT Alert Status September 2019	*No Days in Month*	*% days in Month*
Opel 1	*2 (0)*	*6.6%*
Opel 2	*12 (3)*	*40.0%*
Opel 3	*12 (23)*	*40.0%*
Opel 4	*4 (5)*	*13.3%*

2.3 Newton Abbot ISU - Emergency Department

The table below details the daily planned, actual and percentage fill rates for nurse staffing in the Emergency Department during September 2019. The department is continuing to use resources from temporary staffing, including use of nursing agencies to maintain staffing levels until the effects of recent recruitment are fully effective. The staffing skill mix is consistently balanced across the EAUs and ED with the senior nursing leaders.

It has been noted that there are some inaccuracies within the data (this includes double counting staff as the long day shift is split into two shifts, thus demonstrating RN shift rate above 100%) this is being reviewed and rectified to provide a more accurate account of the position within ED. This still demonstrates that some days ED actuals

have not gone below their planned shifts and usage of HCA's are higher than planned. There is a recruitment plan being provided in collaboration with workforce and organisational development to better understand the skill mix required and best use of marketing. There has been a marked improvement since August.

		Total Planned shifts		Total Actual Shifts		RN Shift fill rate	HCA Shift Fill Rate
		RN	HCA	RN	HCA		
Sun	01/09/2019	19	13	19	16	100.0%	123.1%
Mon	02/09/2019	19	13	20	16	105.3%	123.1%
Tue	03/09/2019	19	13	20	16	105.3%	123.1%
Wed	04/09/2019	19	13	20	16	105.3%	123.1%
Thu	05/09/2019	19	13	20	15	105.3%	115.4%
Fri	06/09/2019	19	13	20	15	105.3%	115.4%
Sat	07/09/2019	19	13	19	16	100.0%	123.1%
Sun	08/09/2019	19	13	19	15	100.0%	115.4%
Mon	09/09/2019	19	13	19	15	100.0%	115.4%
Tue	10/09/2019	19	13	21	16	110.5%	123.1%
Wed	11/09/2019	19	13	20	15	105.3%	115.4%
Thu	12/09/2019	19	13	20	14	105.3%	107.7%
Fri	13/09/2019	19	13	20	16	105.3%	123.1%
Sat	14/09/2019	19	13	19	16	100.0%	123.1%
Sun	15/09/2019	19	13	20	15	105.3%	115.4%
Mon	16/09/2019	19	13	20	16	105.3%	123.1%
Tue	17/09/2019	19	13	20	16	105.3%	123.1%
Wed	18/09/2019	19	13	20	16	105.3%	123.1%
Thu	19/09/2019	19	13	20	17	105.3%	130.8%
Fri	20/09/2019	19	13	20	16	105.3%	123.1%
Sat	21/09/2019	19	13	20	16	105.3%	123.1%
Sun	22/09/2019	19	13	18	16	94.7%	123.1%
Mon	23/09/2019	19	13	21	16	110.5%	123.1%
Tue	24/09/2019	19	13	20	15	105.3%	115.4%
Wed	25/09/2019	19	13	20	16	105.3%	123.1%
Thu	26/09/2019	19	13	20	15	105.3%	115.4%
Fri	27/09/2019	19	13	20	16	105.3%	123.1%
Sat	28/09/2019	20	13	18	18	90.0%	138.5%
Sun	29/09/2019	20	13	20	16	100.0%	123.1%
Mon	30/09/2019	21	13	18	15	85.7%	115.4%

2.4 Nursing Agency spend

Table A: Nursing Agency Cap is currently at £2,869K full year based on 19/20 Trust submission to NHSI. M6 plan value is £284K; year to date amount is £1,704K. The profile of the spend is higher and continues to rise

A Plan	Agency Cap submitted to NHS Improvement (NHSI) £2,869K											
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	

Table B: Actual usage in Month is currently at £338K this is £103K higher than previous month's usage and Year to date spend is £1,827K. This presents 6.8% of total M6 Nursing spend of £4,937K, which is an increase.

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	295	235	338							1,827
Total Nursing Spend £K	5,415	4,986	4,982	4,995	4,873	4,937							30,188
% Agency over Total	7%	5.9%	6.1%	5.9%	4.8%	6.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	6.1%
Year to Date Spend £K	364	656	959	1,254	1,489	1,827	1,827	1,827	1,827	1,827	1,827	1,827	

Table C: The actual spend to date is above the target (£123K), representing 7.22% 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	11	(49)	54							123
Year to Date £K	80	88	107	118	69	123							
Distance from Cap %	28.17%	15.49%	12.56%	10.39%	4.86%	7.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
UOR* Agency Rating	3	2	2	2	2	2							

Table D: The projected full year spend as at end of M6 (based on recent assessment of Finance Team) is £3,338K which is £469K higher than the cap. This is a worsening position in comparison to the last couple of months

D	Forecast for FY 2019/20 - based on Actual Spend M1 to M6, Projected spend M7 to M12												
	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Total
Month	April	May	June	July	August	September	October	November	December	January	February	March	FY 2019-20
Full Year Forecast £K	364	292	303	295	235	338	229	225	260	272	272	252	3,338

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Breakdown by month and cost centre is in Appendix 1 along with the change in spending from previous month. Majority of spend is within the two (2) areas identified below: Turner Ward increased by £39K – this is due to a patient in the ward requiring specialling for 3 weeks, this has now finished. Cheetham Hill increased by £39K due to ward dependency £10K and £19K specialling.

2.4.1 Nursing Agency Usage by month (£) and cost centre

The top 3 spending areas are highlighted in in the table below:

- Emergency Department (comprising A&E, EAU 3&4, AMU and Emergency Practitioners) has the highest usage at £672K (45%)
- Simpson Ward £108K (7.2%)
- George Earle Ward £101K (6.8%)

Actions:

- Review of the different payment structures within temporary staffing and provide a proposal in October in order to reduce the cost of temporary staff but retain quality and safety of the wards
- Ensure that each area has a robust recruitment plan that has a visible trajectory of staff starting and a reduction of temporary staff and agency.

3. Nursing and midwifery vacancies

The recruitment strategies previously reported have resulted in an RN vacancy rate as at the end of September 2019 of 9.8%, this is consistent with last month as we have received a cohort of overseas registered nurses. Registered midwives continue with a >1% vacancy rate.

Actions:

- As a trust we joined the NHSI Retention Collaborative in September; the plans of this will be reported through Executive Directors meeting and the People Committee.
- We have increased our student nurse capacity to commence in September, this includes the additional places provided to the new Academy of Nursing at Exeter University
- Our international recruitment continues to see new starters within the organisation and a trajectory of 37 joining the Trust from Nov 2019 -Feb 2020
- We are reviewing skill mixes within areas to identify new ways of working to provide different opportunities to our staff
- A robust recruitment strategy is being completed in alignment with the NHS long term plan and NHS interim People plan, for short, medium and long term recruitment.

Across the STP our Nursing vacancies have been consistently lower than our partners and we continue to monitor this with our internal recruitment and retention.

3.1 Electronic - E-rostering

There are 6 Key Performance indicators that monitor the efficiency and effectiveness of E-rostering across the Trust, these are below.

1. Rosters published 6 weeks prior to commencement
2. All contractual hrs are utilised when fully approval
3. All contractual hrs are utilised before over time assigned
4. Management hrs in line with Rostering guidelines
5. No of staff using employee online to request

6. Identifying areas that are not finalising payroll on time

The two areas of focus include KPI 1 and 2 for inpatient ward areas in order to assist with reducing the usage of temporary staffing. For roster period 5th August – 1st September 2019 there are no areas that are consistently compliant in KPI 1: Rosters published 6 weeks prior to commencement or KPI 2: All contractual hrs are utilised when fully approval.

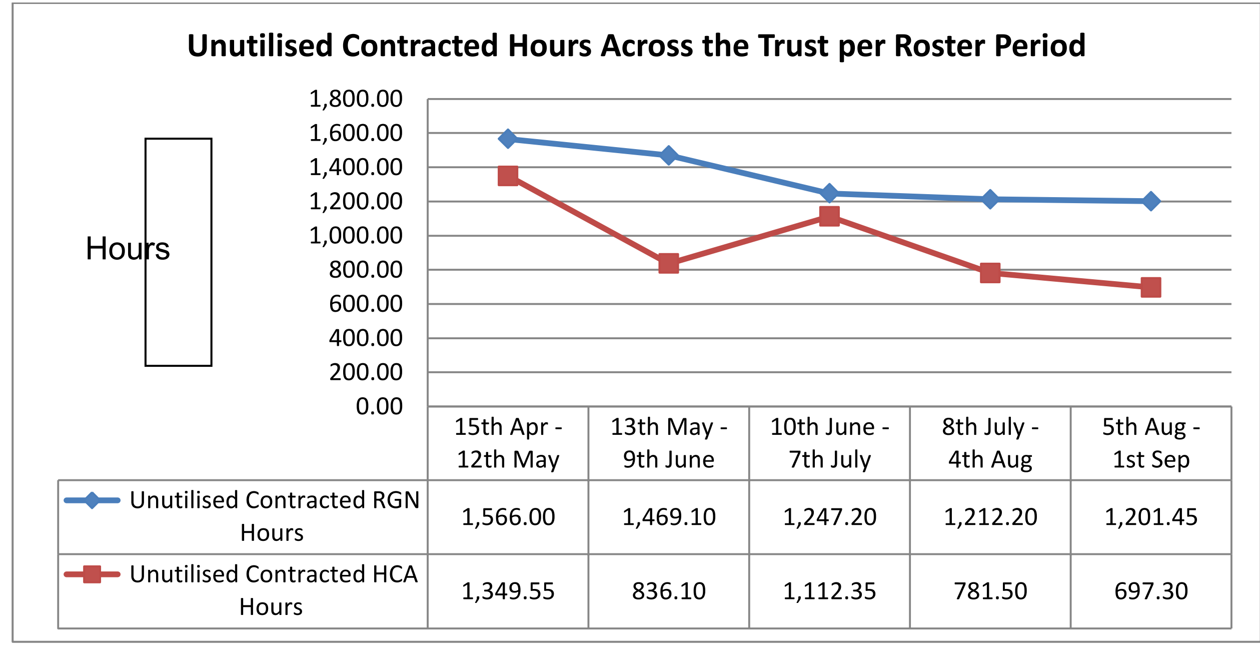
Actions over the next month:

- The Lead Associate Directors of Nursing for erostering alongside the newly appointed clinical lead are working alongside the sisters and matrons to improve the position of the KPIs in relation to rostering.
- The System Directors of Nursing and Professional Practice will be meeting with the Associate Directors of Nursing and Professional Practice, Matrons and Sisters urgently

The below chart shows the total underutilised contracted hours across the Trust, there is more detailed charts with the utilisation of contracted hours. The overall position shows that we have areas where there are efficiencies to be realised.
It has been noted that there are some inaccuracies within the data; this includes episodes of no counting in areas where there is maternity leave or someone has moved departments internally, this is being reviewed and rectified to provide a more accurate account of the position. This still demonstrates that underutilised hours are still in existence.

Actions over the next month:

- The Lead Associate Directors of Nursing for erostering alongside the newly appointed clinical lead are working alongside the sisters and matrons to improve the position of the KPIs in relation to underutilised hours to ensure.
- The System Directors of Nursing and Professional Practice will be meeting with the Associate Directors of Nursing and Professional Practice, Matrons and Sisters urgently.



4. Quality and Safety

QuESTT

Each clinical area completes the monthly QuESTT tool which triggers actions as highlighted in the escalation procedure. The Associate Directors of Nursing and Professional Practice ensures contact is made for any area triggering an amber score or above and that appropriate actions to mitigate the issues causing the increase in scores is taken, these are reported as part of the governance accountability framework to all relevant forums.

For September 2019, the table below show that at the time the data was compiled 2 areas had not made a return this month, this has been addressed with the areas and matrons responsible.

There were 2 Red rated teams and 5 teams with an amber rating for September 2019 are as detailed below:

Red Rated teams:

- Brixham community hospital – due to a number of vacancies and sickness, plans are in place to recruit and manage sickness, there is an improving picture
- Podiatry – mitigations in place in view of vacancies and sickness

Amber rated teams:

- HADT S Devon –due to vacancies, reduced capacity and numbers of new referrals
- NA Social care- due vacancy, sickness inc long term, 28 day assessment target not met.
- Newton Abbot OT - due to number of vacancies, short term sickness
- Newton Abbot Physio - due to number of vacancies, short term sickness
- Emergency Department – due to number of vacancies, short term sickness

The tables showing QuESTT scores for each clinical area are shown below.

Quality Safety and Effectiveness Trigger Tool (QuESTT)

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	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019
% Complete		95%	95%	95%	91%	95%	95%	99%	96%	94%	100%	96%	98%
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	2	2	2
Total Amber (L1)		6	3	9	10	9	8	8	8	5	8	10	5
Total Green (L0)		72	75	69	65	69	70	73	71	72	72	67	73
Average Score		9.1	8.9	9.3	10.0	10.0	9.6	8.8	9.5	9.6	10.0	10.2	9.7
Acute	Ainslie	11	14	17	12	11	10	8	13	12	11	10	11
	Allerton	14	11	12	15	12	13	16	8	16	13	12	14
	AMU		7	11		8	7	13	14	5	5	11	6
	Anaesthetics	9	9	10	10	8	7	8	11	10	11	11	10
	Breast Care Unit	8	4	4	6		4	3	0	2	0	6	10
	Cath Lab	4	3	4	3	10	0	7	4	10	10	10	13
	Cheetham Hill	10	13	17	17	14	17	16	16	15	11	13	12
	Cromie	10	8	11	15	16	11	10	10	7	12	7	5
	DSU	12	13	13	9	13	10	13	13	14	10	9	12
	Dunlop	6	4	4	5	3	5	7	3	5	4	5	6
	Early Pregnancy / Fertility Service	6	6	2	2		2	2	4	4	6	6	6
	EAU3	13		4	13	10	11	8	8		12		12
	EAU4	8	8	9	7	10	8	11	8	7	18	11	8
	Ella Rowcroft	11	13	10	10	9	11	10	3	10	12	8	10
	Emergency Department	19	17	19	21	19	14	16	15	15	18	20	19
	Endoscopy	4		7	8	7	5	2	4	4	3	8	6
	Forrest	12	10	7	13	12	13	10	15	14	12	8	8
	General Theatres	8	15	13		11	9	9	11	11	9		15
	George Earle	10	8	9	12	12	10	10	11	11	11	13	15
	Gynaecology Out-Patients Dept	11	13	7	6		2	6	8	9	9	7	7
	Hutchings	8	7	5		4	8	7	9	12	13	8	9
	ICU	6	5		8	6	11	8	7	9	11	9	3
	Louisa Cary	15	11	11	2	2	15	8	4		6	7	3
	MAT / TAIRU		9	9	4	3	10	5	10	10	10	9	4
	Maternity	13	7	9	13	8	11	5	7	13	12	12	14
	Midgley	8				15	15	7	11	14	9	3	7
	OPD	2	4	4	4	6	4	2	2	6	6	6	3
	Ophthalmology	14	11	8	9		12	9	13	8	15	15	13
	Ortho Theatres	15			15	14	15	16		15	14	13	14
	Pre-assessment	8	4	4	6	4	6	6	8	8	8	10	12
	Radiology		11	15	14	13	14	10	13		9	11	9
	Recovery	7	6	4	9	8	8	5	8	12	8	10	11
	RGDU	7	14	8	15	5	5	7	10	7	13	15	12
	SCBU	3	13	10	9	11	3	10	2		4	2	1
	Sexual Health	3	6	13	8	11	11		8	13	11	10	5
	Simpson	7	9	13	7	8	12	14	8	9	8	11	11
	TCCU	6	5	4	5	5	8	7	3	5	4	8	9
	Turner	7	10	10	8	9	12	9	11	9	8		7
	Urology	17	13	12	17	14		5	14		7	10	4

Service Type	Team	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019
MIU	Dawlish	7	6	8	6	6	5	7	9	14	12	14	9
	Newton Abbot	2	4	3	5	5	2	0	6	8	8	8	6
	Totnes	2	2	0	0	0	5	2	8	7	3	9	6
Community Hospital	Brixham	10	11	12	8	11	8	15	13	7	20	19	17
	Dawlish	8	3	3	5	3	7	6	7	0	1	0	3
	Newton Abbot Teign	11	8	4	14	10	9	9	11	16	11	16	9
	Newton Abbot Templar	6	5	0	5	8	9	7	4	9	7	2	9
	Totnes	7	9	8	8	7	8	8	7	7	6	12	9
Community Stroke and Neurology	Torbay and South Devon	10	10	12	13	15	18	16	14	14	16	14	
Infection Control	Infection Control	6	10	6	11	13	13	11	11	4	6	8	3
LLTS	LLTS	10	6	7	7	7	6	8	7	6	7	6	5
Nursing	Brixham and Paignton	7	12	15	16	12	16	14	12	14	9	12	15
	Coastal	15	9	12	13	18	17	13	13	14	11	19	15
	Moor to Sea	20	15	18	14	23	12	6	7	10	12	15	8
	Newton Abbot	14	12	13	18	15	15	12	11	10	14	19	15
	Torquay	5	8	9	9	9	6	6	6	9	11	6	9
OOH Nursing	OOH Nursing	12	13	13	20	22	22	9	17	9	12	14	13
Specialist Nursing	Specialist Nursing	11	8	11		4	4	5	1	7	2	4	5
Occupational Therapy	Brixham and Paignton	18	14	16	16	18	14	12	12	12	14	10	12
	Coastal	18	19	24	21	15	23	18	11	8	10	10	9
	Moor-to-sea	10	8	12	14	10	6	10	14	6	14	10	17
	Newton Abbot	13	9	13	7	5		8		11	9	19	13
	Torquay	0	0	0	0	4	2	6	8	4	2	4	4
Physiotherapy	Brixham and Paignton	14	15	13		14	12	12	6	10	8	9	12
	Coastal	14	11	22	18	19	12	14	15	8	16	13	9
	Moor-to-sea	6	6	8	12	6	14	10	12	8	14	12	19
	Newton Abbot	13	11	15	9	9		12		11	9	17	11
	Torquay	6	4	8	11	22	10	11	10	12	10	8	10
Podiatry	Podiatry	16	16	18	14	23	22	20	22	23	32	26	27
Public Health - Lifestyles	Lifestyles	2	3	1	5	4	1	7	5	11	3	0	7
Public Health - Nursing	Paignton and Brixham	5	4	8	10	12	10	10	8	6	6	6	8
	School Nursing	7	4	8	5	7	6	5	7	6	7	7	5
	Torquay	2	4	1	4	5	2	2	2	2	5	4	4
Public Health - Substance Misuse	Substance Misuse	2	2	4	6	4	4	4	6	8	10	6	4
Social Care	Brixham and Paignton	13	10	12	14	10	11	8	12	10	12	10	10
	Dawlish & Teignmouth	8	12	8	14	6	10	2	8	10	12	12	14
	HADT - S. Devon	7	15	11	15	11	11	13	17	15	17	13	17
	HADT - Torbay	9	11	11	11	9	17	5	11	13	8	13	10
	Newton Abbot	14	12	8	14	12		8	18	18	16	16	16
	Older People Mental Health - Torbay	2	4	2	2	4	0	4	10	4	8	4	
	Torquay	10	10	10		6	10	12	16	12	10	16	12
	Totnes & Dartmouth		10	12	11	15	14	10	19	8	16	8	4
Tissue Viability	Tissue Viability	7	7		10	13	7	14	10	7	7	9	8

5. Conclusion

This report shows that nursing establishments and fill rates are constantly monitored and appropriate action taken to maintain staffing levels, both by the specialty matrons and senior sisters and through the control room function.

6. Recommendation

The Board is asked to note the report.