Torbay and South Devon NHS Foundation Trust
Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital and via Microsoft Teams

29 April 2020 09:30 - 29 April 2020 11:15

AGENDA

#	Description	Owner	Time
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 1st April 2020, Outstanding Actions and Log of Deferred Items Approve 20.04.01 - Board of Directors Minutes Public.pdf 9 Public Board Log of Deferred Items.pdf 21	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive - Covid-19 Assurance Receive and Note Report of the Chief Executive.pdf 23	CE	
2.6	Integrated Performance Report - Month 12 Receive and Note Integrated Performance Report Month 12.pdf 31	DTP	
2.7	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 63	MD	

#	Description	Owner	Time
2.8	Education and Workforce Development Report - focus on Covid response Receive and Note Education and Workforce Report.pdf 77	CN	
2.9	Maternity Governance Safety Report Approve Maternity Governance Safety Report.pdf 85	CN	
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees Verbal		
3.1.1	Finance, Performance and Digital Committee - 27th April 2020 and Log of Deferred Items Receive and Note FPDC - Log of Deferred Items.pdf 93	Ch	
3.1.2	People Committee - 27th April 2020 and Log of Deferred Items Receive and Note People Committee - Log of Deferred Items.pdf 95		
3.2	Reports from Executive Directors		
3.2.1	Safe Staffing and Nursing Work Programme Receive and Note Safe Staffing and Nursing Work Programme Updat... 97	CN	
3.2.2	Chief Operating Officer Report Receive and Note Report of the Chief Operating Officer.pdf 115	CE	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.00 am, Wednesday 29th April 2020	Ch	

#	Description	Owner	Time
7	Exclusion of the Public	Ch	

INDEX

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 of 'good' and the ability to maintain sufficient progress to retain 'good' and achieve '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 ANNA DART LECTURE THEATRE, HORIZON CENTRE, TORBAY HOSPITAL ON WEDNESDAY 1ST APRIL 2020

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mrs J Lyttle	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
	* Mr J Welch	Non-Executive Director (part)
	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 D Stacey	Chief Finance Officer
	* Mrs J Viner	Chief Nurse
In attendance:	Mrs J Downes	Company Secretary
	Mrs S Fox	PA to Chief Executive

* via video-conference

		ACTION
44/04/20	**Board Corporate Objectives** The Board noted the Corporate Objectives.	
	PART A: Matters for Discussion/Decision	
45/04/20	**Apologies for Absence** Mr John Harrison, Chief Operating Officer, Ms Adel Jones, Director of Transformation and Partnerships and Mrs Jackie Stockman, Torbay Council Representative.	
46/04/20	**Declaration of Interests** There were no declarations of interest.	

47/04/20 **Minutes of the Board Meeting held on the 4th March 2020 and Outstanding Actions**

The minutes of the meeting held on the 4th March 2020 were approved as an accurate record.

The action log was reviewed and updated.

48/04/20 **Report of the Chairman**

The Chairman briefed the Board as follows:

- As a result of the Covid-19 Pandemic, and in accordance with Government directions, the Trust would not be holding Board meetings in public until further notice. This decision would be reviewed as the guidance evolved and further communications would be published in due course. The minutes and papers will continue to be published on our webpage. The Board will appreciate that this was an essential step to protect members of the public from unnecessary potential exposure to the virus.

- The Trust had received many offers of support in respect of Covid-19 and the Chairman wished to place on record his thanks to the public and the Trust's Governors for all the offers that had been received.

- The Chairman also wished to record his thanks and support to the Trust's staff and the amount of work that had been achieved in very little time to prepare for Covid-19 both in the acute hospital and community.

- Torbay Pharmaceuticals have commenced production of hand sanitisation products supplying NHS organisations in the South West.

- The Chairman asked the Board to ratify a decision taken by Chief Executive and the Chairman to fund £670,000 to support Covid-19 in the domiciliary care market for three months. Due to the quantum of the funding, the decision was reported to the Board for ratification.

- Mr Sutton expressed disappointment that the financial support did not extend to the care home market. The Chief Executive said that she was aware a phased response was being made to the domiciliary and care home market and that Devon County Council was leading on support for the care home sector in Devon and Torbay.

The Board of Directors formally ratified funding of £670,000 to support Covid-19 in the domiciliary care market.

49/04/20 **COVID-19 Assurance Report**

The Chief Executive's report provided assurance to the Board on the plans being put in place to manage the Covid-19 outbreak and she drew the Board's attention to the following:

- The Chief Executive wished to thank the Executive Directors for their support and flexibility to ensure that the Trust was in the best possible position to manage the outbreak.

- Staff have been hugely innovative both in the acute hospital and community, for example the production of hand gel at Torbay Pharmaceuticals (TP) where TP had stepped in to manage a gap in supply.

- Covid-19 was being managed as a major incident and was being overseen by the Trust's Safety, Security and Emergency Planning (SSEP) team. The Trust was working to national and regional guidance as it was received. The Company Secretary would be undertaking a piece of work to ensure that the Trust had oversight of all the guidance received and that it was being managed appropriately.

- Mr Welch, noting the need to step down some elective activity, asked if it would be possible to step up some activity before the surge of Covid-19 cases were received. The Chief Executive explained that the Trust was following national guidance in terms of what activity had been stood down and that detailed reviews at specialty level had been undertaken to categorise activity into five categories. National guidance required that category 4 and 5 were stepped down in order to maintain all urgent activity including cancer pathways.

- The Medical Director added that there was emerging evidence that some surgery, including cancer surgery, created an aerosol resulting in a high risk of infection for staff and so some surgery of this type has had to be stood down, in line with national guidance.

- The Trust had implemented alternative solutions to face to face meetings with patients, for example video meetings to ensure that patients were kept safe during the outbreak.

The Board of Directors received and noted the COVID-19 Assurance Report.

50/04/20 **Report of the Chief Executive**

The Chief Executive highlighted the following to the Board:

- One of the Trust's student apprentice nurses, Nina Henton-Waller, had been shortlisted for the Student Nursing Times Awards which celebrated outstanding nurses and their innovative work. The Chief Executive wished to congratulate Nina and said it reflected on the quality of training provided by the Trust, alongside Nina's hard work and passion.

- The Care Quality Commission (CQC) had commenced their inspection in March and feedback had been received. The second part of the CQC review would have been a well-led review, taking place this week, however this had been stood down in line with national guidance. It was unclear at this stage how this would affect the inspection process and any rating, as the CQC would not be able to triangulate data from

the first assessment review. The Chief Executive has asked to meet with the CQC to discuss the implications of halting the well-led inspection on the CQC inspection outcome. Confirmation of the meeting date was awaited.

- The Board noted that policy changes had been made by HM Treasury in respect of pension tax that had been affected some of the Trust's senior clinicians. The new changes came into force on the 1st April.

51/04/20 **Integrated Performance Report – Month 11**

Mr Welch left the meeting.

The Board noted the Month 11 Integrated Performance Report and the Chief Nurse highlighted the following to the Board:

Safety and Quality

- Safety and quality indicators for February were broadly on track with no issues to note.

- With the extreme nature of the Covid-19 outbreak, the Board needed to be aware that safety and quality would be significantly impacted with a reduction in elective and diagnostic capacity.

- The Board that a Safety Cell within the incident response structure had been established to monitor safety whilst other processes had been stood down. The Chief Nurse said that incidents continued to be monitored through the Datix system. The Chief Nurse provided assurance that the Safety Cell was keeping an oversight on all safety issues and would report to the Quality and Assurance Committee and the Board any urgent material issues.

Workforce

- Sickness absence for February remained static at 4.5%, this had significantly increased with large numbers of staff affected by Covid-19, including those who were required to self-isolate.

- It was expected that all workforce indicators would be significantly affected by the Covid-19 outbreak.

- A Workforce Cell had been established to manage the Trust's workforce to support the Covid-19 preparation and plans. The Board noted that the Trust currently had 1,003 Covid-19 related staff absences, which included c280 staff self-isolating.

- Mrs Matthews asked how many clinicians had returned to the Trust and it was noted that across the South West around 500 doctors, 900 nurses and 750 Allied Health Professionals had expressed an interest in returning to help.

- The Director of Workforce and Organisational Development explained that the process to allocate staff to Trusts was being managed centrally

and to date only two staff had been appointed to the Trust. She added that the region recognised that this was too slow and they had increased their capacity to improve their processes which included undertaking all the usual employment checks so that Trusts did not have to do this once staff were allocated to them.

- The Chairman asked if the Trust was an outlier in terms of numbers of staff absence for Covid-19 related issues and the Director of Workforce and Organisational Development said it was not. Most Trusts were experiencing an 18-22% absent rate, similar to this Trust.

- The issue of staff testing was raised and the Chief Executive said that she hoped this was resolved at a national level in the near future.

- Mr Balch noted that the report did not include workforce data, and said that he understood the reasons why this had not been possible. He asked that the data for the end of February was understood so that there was a baseline in place to understand the impact of Covid-19. DWOD

Performance

- The 4-hour emergency target had improved significantly in February 2020 to 82.2%, which reflected the improvements in patient flow as a result of the hard reset activity.

- The position on 52 weeks had improved from 80 breaches in January to 43 breaches in February. Additional activity to reduce the number of 52 week breaches to no more than 20 was planned throughout March. This activity was taken down in March due to the preparations for Covid-19 and as a result it was predicted there will be 58 patients waiting over 52 weeks by the end of March.

- All performance indicators would be at risk as a result of the Covid-19 outbreak and reporting requirements nationally have been amended accordingly.

- Dementia Find performance had slipped over the past two months, however was now improving.

- As elective activity needed to be stood down due to Covid-19, Quality Impact Assessments would be undertaken to understand the impacts of the action being taken and to ensure that patient safety was maintained. CX

- Mrs Matthews wished to place on record the comments made by Mr Welch in an earlier Board meeting that the actions taken by the Trust would realise improvements in performance by the year-end and that this was now starting to be achieved. She asked if there was a way of understanding how the Trust would have continued to improve its performance if Covid-19 had not occurred and the Chief Executive said that she would ascertain if this was possible.

- The Board noted that the Trust had put in place a Recovery and Resilience Cell to ensure that the Trust had plans in place for recovery following the outbreak.

- Mrs Lyttle said that she understood some patients had arrived at the Trust for treatment only to be informed that their treatment had been cancelled. She asked for assurance that patients were being informed of any cancellations. The Medical Director explained that in the early stages of Covid-19 planning, patients had been asked to arrive for treatment unless contacted by the Trust and he said that it might have been possible that a small number of patients might not have received a message to inform them of a cancellation, with was regrettable.

- The Medical Director explained that processes in place to protect patient safety would provide the opportunity to assess any impact on patients.

- Mr Richards asked what the new entry point for 52 weeks would be once business as usual resumed. The Chief Executive confirmed that the Recovery and Resilience Cell would focus on ensuring plans were in place.

Finance

- 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 the end of February was a £13.14m deficit prior to sustainability funding. This was a £8.53m adverse position against the phased YTD plan of £4.61m deficit.

- The Trust's pay run rate was broadly stable.

- The Trust's cash position had improved and was on plan at c£15m and above the minimum the Trust was expected to hold at this stage, and would support any addition Covid-19 costs.

- In the year to date, the Trust had delivered £10.0m of savings, which was £7.1m adverse to the original plan; of this £3.3m had been delivered recurrently.

- The Trust identified an annual savings requirement of £20.0m. Of this £10.7m savings had been identified, resulting in a £9.3m gap and representing a significant risk to the underlying financial performance and the opening position for next financial year.

- Capital expenditure as at M11 was £10.11m. The full year forecast was £18.77m therefore £8.66m remained to be spent. Given the uncertainty of next year's capital funding regime extra focus was being given to achieve this, but delivering this £8.66m of spend across March would be very challenging.

- The Finance Risk Rating continued to be a 4.

- Trust continued to forecast an adverse variance to plan of £15.0m in line with the month 6 position reported. There remained some risks to the delivery of the £15.0m adverse variance to control total such as

achievement of remaining CIP target (£1.7m), an adjustment to depreciation charges owing to a change in RICS guidance (£1.8m) and unforeseen costs due to operational pressures and Covid-19 incremental costs. Steps were being taken to mitigate these risks.

- Mr Sutton queried the impact of paying statutory sick pay (SSP) to staff. The Chief Finance Officer explained that a different regime was in place for SSP and that the issue of staff being able to roll annual leave over an extended period of two years was of more concern. The impact to the Trust could be in excess of £2m.

- The Board noted that usually if bank staff had shifts booked but did not work them, they were not paid, however if they did not work booked shifts due to self-isolation the Trust was required to pay them for the shifts they would have worked. The Director of Workforce and Organisational Development said that modelling was taking place to understand the potential cost.

- In respect of the forecast outturn the Chief Finance Officer highlighted risks to the Trust's year end position around RICS (Royal Institute of Chartered Surveyors) and other year-end adjustments, which had been reported at previous meetings. The Chief Finance Officer was in dialogue with the Trust's Regulators regarding the Trust's position.

Trust Board was requested to note the contents of the report and the significant impact that the Covid-19 outbreak was having on all aspects of the Trust's business.

The Board of Directors noted and received the Month 11 Integrated Performance Report.

52/04/20 **Partnership Working and Engagement Plan**

This report was deferred due to Covid-19 and in accordance with national guidance. The item would be logged for presentation at a future Board meeting.

53/04/20 **Education and Development Six Monthly Update**

This report was deferred due to Covid-19 and in accordance with national guidance. The item would be logged for presentation at a future Board meeting.

54/04/20 **Mortality Safety Scorecard**

This report was deferred due to Covid-19 and in accordance with national guidance. The item would be logged for presentation at a future Board meeting.

55/04/20 **2019 National Staff Survey Report**

The Director of Workforce and Organisational Development updated the Board on the Trust's local and national position in respect of 2019 Staff Survey findings and priorities for 2020:

- The report detailed some areas of good improvement in particular health and wellbeing, which reflected the work that had taken place over the last year in this area.

- Appraisals were not in line with the national average, but it was hoped the improvements to the process to make it more meaningful for staff would be reflected in future surveys.

- Improvements had been seen against Workforce Race Equality Standards (WRES) which reflected the work of the Equality Business Form and implementation of best practice.

- The Trust's staff engagement score had reduced and included areas such as safety and bullying and harassment. Work would take place to address these areas in the coming year.

- Local reports were now available and the Staff Experience Group would be working with hot spot areas in the Trust. This work would be overseen by the People Committee.

- Mr Balch asked if the CQC inspection supported the findings of the Staff Survey and the Chief Nurse said that the CQC's finding did reflect some of what was highlighted through the Survey.

- Mrs Matthews said that some of the data was contradicting in that evidence showed that staff health and wellbeing and morale were impacted by immediate managers and the report reflected that staff were happy with their immediate managers, but the staff engagement score had reduced. She suggested that it would be helpful if some work took place to understand the reason for this. DWOD

- Mr Balch stated that it was a useful report and would help the People Committee focus its workplan. It would also be helpful to triangulate the CQC report with th Staff Survey Report. The Chief Finance Officer also commented on the internal variations and asked what the Trust could learn from best practice. The Trust also needed to be aware of those areas that might be struggling. DWOD

The Board of Directors noted the content of the 2019 Staff Survey Report and approved the priorities for 2020, acknowledging that the Trust might need to revisit the priorities following Covid-19.

56/04/20 **Patient Led Assessment in the Clinical Environment (PLACE) 2019 scores and performance**

The report provided an update on the 2019 PLACE scores published in late January from the visits that happened within the Acute and Community sites in September and October 2019.

Key points:

- The Trust had performed very well in the assessment scoring above National and Southwest average in six of the eight PLACE domains.

- The scores for the main Hospital site for condition/appearance and dementia environment, that were expected to be lower due to the estate backlog and capital position, were only slightly below regional and national averages.

- The presentation of the food at the acute Trust had reduced the food score to just below average. This was being addressed through the recent implementation of a dedicated ward catering assistant which was having a material positive benefit on both the food service and the perception of the food service at ward level.

- The Board was reminded that the assessment was patient-led and required a minimum of 50% public to undertake the survey. The Director of Estates and Commercial Development wished to thank the Trust's Governors for their support in undertaking the assessments and to congratulate the Estates and Nursing teams for their hard work in helping to achieve such a good assessment.

- The Chairman asked the Director of Estates and Commercial Development to thank her staff on behalf of the Board. DECD

- Mr Sutton queried the dementia score in the acute hospital as the Trust had some dementia-friendly wards. The Director of Estates and Commercial Development explained that it was an assessment of the hospital as a whole, not just the dementia-friendly wards and this was noted.

The Board of Directors:

- **Formally received the place scores for 2019**
- **Placed on record the Board's thanks to the governors for their contribution and continued support for the PLACE assessments**
- **Formally recognised and congratulated the hard-working estates, facilities and nursing teams on the substantial achievement of excellent PLACE scores.**
- **Noted the implementation of the new catering assistant role to maintain and improve the food service.**

Governance Items

57/04/20 **Terms of Reference – Finance, Performance and Digital Committee (FPDC)**

The annual review of the Committee's Terms of Reference had been undertaken and the following changes agreed by FPDC:

- Inclusion of Transformation and CIP Group to report up to FPDC.
- Strengthening of oversight of Capital and Estates Programme section to include assurance of Trust compliance and safety and revenue, performance and risk consequences of capital schemes.
- Reference to Commercial Strategy replaced by 'commercial activities'.
- Strengthening of oversight of digital investments.

- Inclusion of reference to oversight of the Trust's subsidiaries, joint ventures and Torbay Pharmaceuticals, including financial reporting, review of annual plans and in-year delivery.
- Inclusion of reference to the Governor observer and rules for deciding the selection.
- Changes to the meeting administration section to reflect the revised meeting schedule.

The Board of Directors approved the revised Terms of Reference of the Finance, Performance and Digital Committee.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

58/04/20 **Charitable Funds Committee – 18th March 2020**

The Board noted that the meeting scheduled for the 18th March had been cancelled due to Covid-19. Mrs Lyttle said an issue to be discussed at the next meeting was management of Covid-19 fund-raising schemes

59/04/20 **Finance, Performance and Digital Committee – 24th March 2020**

Mr Balch reported that the Committee reviewed and agreed expedited arrangements to initiate expenditure and handle invoicing during the Covid-19 pandemic. Existing controls over approval of expenditure and payments would remain in place and clear procedures were in place to capture the costs of dealing with Covid-19.

The report was reviewed and noted.

60/04/20 **Quality Assurance Committee – 25th March 2020**

The Board noted that, if necessary, the Committee would meet outside of scheduled meetings if there were safety issues that required urgent attention.

The report was reviewed and noted.

Reports from Executive Directors

61/04/20 **Safe Staffing and Nursing Work Programme**

This report was deferred due to Covid-19 and in accordance with national guidance. The item would be logged for presentation at a future Board meeting.

62/04/20 **Chief Operating Officer Report**

This report was deferred due to Covid-19 and in accordance with national guidance. The item would be logged for presentation at a future Board meeting.

63/04/20 **Report of the Director of Estates and Commercial Development**

The report provided an update to the Board on Estates and Facilities Management key issues, performance and compliance for January and February 2020.

Key issues included:

- The cleaning scores continued to reflect a cleanliness level above the national standards

- An increased number of Estate Priority 1 jobs have been prioritised over P3 and P4 lower priority jobs with a drop in performance in these categories.

- Over the winter period the tonnage of clinical burn waste had increased due to the expected increasing infection rates from seasonal flu etc. As Covid-19 impacts this would be an escalating issue both in terms of capacity and also cost.

The Board of Directors received for information the:

- **Top line briefs for the months of January and February**
- **Compliance and Performance Reports and exceptions**

64/04/20 **Compliance Issues**

There were no compliance issues reported.

65/04/20 **Any Other Business Notified in Advance**

There was no business notified in advance.

66/04/20 **Date of Next Meeting – 9.30 am, Wednesday 29th April 2020**

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.	Provide the Board with regular briefings on the Coastal Consultation.	DTP	Due to Covid-19 the coastal consultation had been put on hold.	04/03/20
2.	Learning from recent major incident as a result of non-elective demand to be brought to a future meeting.	COO	This would be progressed part of the next phase of the Trust's incident plans.	04/03/20
3.	Provide workforce data for the end of February so there was baseline data pre-Covid-19.	DWOD		01/04/20
4.	Consider if there was capacity and ability to track how Trust performance would have continued to improve if Covid-19 had not occurred.	CX		01/04/20
5.	Undertake work to understand the Staff Survey findings in relation to staff engagement.	DWOD		01/04/20
6.	Triangulate Staff Survey data with CQC findings.	DWOD		01/04/20
7.	Thank Estates staff for their work to support a positive PLACE assessment.	DECD		01/04/20

Torbay and South Devon NHS Foundation Trust

Public Board of Directors

Parking Lot **Reviewed: date 1st April 2020**

Item action/issue/policy name	Date raised	Comment
Partnership Working and Engagement Plan	1st April 2020	Deferred to 27th May 2020
Education and Development Six Monthly Update	1st April 2020	Deferred to 29th April 2020
Mortality Safety Scorecard	1st April 2020	Deferred to 29th April 2020
Safe Staffing and Nursing Work Programme	1st April 2020	No report on 1st April 2020, reporting recommenced 29th April 2020
Chief Operating Officer Report	1st April 2020	No report on 1st April 2020, reporting recommenced 29th April 2020

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report – Covid 19 Assurance Report			**Meeting date**: 29 April 2020
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Director of Transformation and Partnerships Joint Heads of Communication		
Report provenance	Reviewed by Director of Transformation and Partnerships		
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: 29 April 2020
Report sponsor	Chief Executive	
Report author	Director of Transformation and Partnerships Joint Heads of Communication	

1 Trust key issues and developments update

Key developments to draw to the attention of the Board since the last Board of Directors meeting held on 1 April 2020 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Managing the COVID-19 outbreak

Devon has had a lower incidence of COVID-19 and proportionally fewer deaths than most parts of the country. The South West continues to have a lower total of COVID-19 deaths recorded than all other NHS regions, and a distinctly flatter growth curve. Of course, there is no room for complacency and we are working steadfastly to prepare for more difficult times ahead, as well as helping those who need it now.

Our focus since the last board meeting has been on continuing to deliver safe services across our organisation, creating new pathways to manage COVID-19 positive patients in Torbay Hospital and in our communities across Torbay and South Devon, as well as increasing staff testing in line with national guidance. We are also taking part in national clinical trials for COVID-19 treatments.

1.1.2 Arrangements for safe acute services

We have carried out service reconfiguration to ensure that urgent and emergency patients who are not COVID-19 positive can continue to safely receive the services they need.

Changes we have implemented across our acute services include:

- Working with Mount Stuart to carry out non-COVID-19, urgent surgery in its theatres
- Running our Emergency Department as a COVID-19 emergency hub, and creating a non-COVID-19 Emergency Department in our day surgery unit for non-COVID related emergency patients
- Running Newton Abbot Hospital as a non-COVID-19 hospital and transferring some urgent services here from Torbay Hospital – including cancer services and face to face outpatient services, where virtual appointments are not a viable alternative
- Rolling out the use of 'Attend Anywhere' to offer virtual rather than face to face outpatient consultations wherever possible
- Changed level 2 into a COVID-19 triage area and COVID-19 Discharge Lounge.

1.1.3 Personal Protective Equipment - PPE

Given the significant nationwide demand for PPE, the Department of Health and Social Care has taken over control of the delivery of PPE and is issuing stock according to the number of COVID-19 patients and average consumption rates through the national supply route. This new system ensures that PPE and equipment is going to areas most in need and works on a 'just in time' basis. The Trust has responded by ensuring all COVID-19 areas receive daily supplies, offering additional training for different types of masks received, and offering a local 'top-up' service as required. We have also been working with teams to ensure we use our PPE stocks appropriately, adhering to the national PPE policy.

We continue to have enough PPE to meet the high standards of care and hygiene we expect and are following national guidelines at all times.

1.1.4 Care at Home services

We established a dedicated Care at Home silver cell to focus on supporting our community services team and the wellbeing of people in their care. Our community teams, along with those providing adult social care and working in care homes, are the 'hidden frontline', as they support the most vulnerable people in their own homes and in community residential settings.

As an integrated organisation, we have close partnership links with our care homes and domiciliary care providers and are listening to and responding to their concerns, which have included the availability of PPE and testing for care home residents and staff. We have been working hard to ensure that all of our staff in our communities have the support and resources they need and have processes in place to ensure that we understand the issues and are able to respond swiftly and effectively in this challenging time.

We are following new national guidance, to swab before discharge ALL patients moving on to a residential or nursing home, or who will be receiving care at home from care agencies.

1.1.5 COVID-19 support from our communities

Our local communities have offered us amazing support – from manufacturing additional stocks of PPE and hand sanitiser to volunteering their time and offering free parking or food and drink for staff on shift. We have been overwhelmed by people's support and gratitude to the NHS, which has helped to boost staff morale. We are truly grateful for all the additional support we have received, and set up central arrangements to manage offers of help in a coordinated way.

We also established a corporate JustGiving account and our local communities have donated over £11,000 to say 'thank you' to our staff. All donations received are being put towards our COVID-19 response efforts, which as an Integrated Care Organisation, includes our partners in the community and voluntary sector. As part of the NHS Charities Together group our charitable fund will also benefit from the national funding raising efforts including the significant sums raised by Captain Tom Moore.

A central process is being developed to receive proposals for support against these charitable funds from teams and groups that we work with within our communities. This work is being led by the Director of Transformation and Partnerships and it is proposed will report through to the Charitable Funds Committee.

1.2 Valuing our Workforce, Paid and Unpaid

1.2.1 Workforce initiatives during COVID-19

Resourcing Hub

We have a new Resourcing Hub which brings together the different workforce pools within our organisation and this has created real collaborative working and a sharing of learning and ideas across teams. This will help us to build our new normal, looking at how we attract and retain our future talent will be key to our future success.

Already we have seen success stories with our volunteer team engaging with St Johns and Coastguards to see how we can share skills and expertise in our STP volunteer community. Anaesthetic colleagues delivered a presentation via zoom to over 100 interested vets and vet nurses, who were keen to volunteer their experience and skills in a clinical environment.

We are in the final stages of onboarding our first cohort of returners through the national Bring Back Scheme (BBS) and have been assigned 41 colleagues from nursing, Health Care Assistant (HCA), Allied Healthcare Professionals (AHP) and medical backgrounds.

In addition, the Resourcing Hub has been developing support for us in reassigning our existing staff and there have been 60 requests so far to re-assign staff to different areas of the Trust to support our Covid-19 response.

1.2.2 Health and Wellbeing

The wellbeing offer is constantly developing as a result of new intelligence and the changing environment, taking into account the needs of staff at their place of work and staff who are self-isolating or working from home. Modifications have been made to the way we work, considering the restraints of social distancing and the effect this has on communication.

We have focused our offer around the three national phases of staff needs: preparation phase, the active phase and the recovery phase. Within each of these phases the offer concentrates on psychological, physiological, organisational and social support.

Development of the suite of offers has been a mixture of **local offers including:**

- A support help line
- Keeping in touch service with home workers,
- Common room spaces,
- Coaching,
- Schwartz team support, sharing of information

This is in conjunction with the national offers from ‘OurNHSPeople’, which includes wellbeing support through a national app and help line.

Communication of the suite of offers has been mindful of the various ways staff like to receive their information and has been a mixture of: web pages, posters and leaflets via electronic and hard copy distribution, newsletter to those working from home, daily

briefing and screen savers. We have also launched an online 'staff room' accessible to all staff from any device, and have created an opt-in WhatsApp broadcast group to keep staff abreast of key developments and signpost to further information online. These communication channels are aimed particularly at those staff groups who do not have regular access to email during their working hours, and include information about wellbeing and offers for NHS staff as well as the latest news developments.

The main focus of our work is now maintaining support but also looking forward to the recovery phase and ensuring that we are ready to support staff through the current situation to its end.

1.3.1 Staff Car Parking

To support staff during this time, the Trust has temporarily relaxed car parking restrictions for staff across all Trust sites. Barriers are not in use and staff car parks can be accessed by all staff members regardless of whether they have a permit or not.

2. Chief Executive Engagement: April 2020

I continued to engage with external stakeholders and partners in April however, due to the pandemic and necessary social distancing, most meetings have been held remotely with the aid of digital technology. I have been very conscious of the need to keep in contact with and support our frontline staff, including meeting with teams who are dealing directly with COVID-19 positive patients.

Most of my time, both within the Trust and with our partners externally, continues to be focussed on COVID-19 preparedness and recovery planning.

Internal	External
• Staff Side • Freedom to Speak up Guardians • Staff at Springfield Court • Joint Local Negotiating Committee • Video blog sessions: o Regular COVID-19 updates	• Chief Officer for Adult Care and Health, DCC • Chief Executive, Torbay Council • Director of Adult Social Services, Torbay Council • Accountable Officer, Devon CCG • Devon Children's Family Partnership Executive Group Meeting • Children and Young Persons Partnership Board

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

3.1.1 Torbay Shielding hub

Nearly 3,000 of Torbay's most vulnerable residents are receiving support from a new Shielding Hub, led by Torbay Council and supported by the Trust's Healthy Lifestyles team. Food parcels and other essential supplies, wellbeing checks and healthy lifestyle advice are just some of the support that's being offered to thousands of Torbay's most vulnerable residents, who have been advised to shield at home for 12 weeks.

The hub, which was set up at the end of March, has 13 call handlers and four people working in distribution of food and PPE. Staff provide talk to the extra vulnerable residents about issues including:

- exercise
- mental health
- benefits advice
- eating and drinking regularly.

Comment: Many of our frontline NHS teams are treating people with COVID-19, and seeing first-hand the very real impact of this disease on people and their families. In addition, many of our staff, including our healthy lifestyles team, are working in people's communities alongside GPs, local authority staff and volunteers to support our most vulnerable people and keep them safe. We are really pleased to be partners in this shielding hub, led by Torbay Council, which focuses on the overall wellbeing needs of individuals. It's so important to focus on people's mental health and physical wellbeing, alongside the more practical support, such as food deliveries.

3.1.2 Teignmouth Hospital established as COVID-19 primary care hub

Groups of GP practices in Devon are setting up dedicated sites where symptomatic patients who require a more in-depth assessment, or people from self-isolating households, can be seen and treated for the virus and other conditions. To keep patients and practice staff as safe as possible, and in line with government guidance, patients with symptoms of COVID-19 may be directed to 'COVID-19 primary care hubs' if they need to be seen. Teignmouth Community Hospital is one of the places being used as a COVID-19 primary care hub, making use of the consulting rooms that are normally for outpatient clinics but are currently available due to the pandemic. The facility does not involve use of hospital beds and patients must be referred by their GP prior to attending.

This is a good example of collaboration between NHS partners and increased integration of services in response to the pandemic. Dawlish and Teignmouth GPs are providing the service for the patents registered at their practices.

Regarding other services at Teignmouth Community Hospital:

- Some day procedures continue
- Volunteering in Health staff are working from home. The charity's staff and volunteers continue to support people by phone
- The health and wellbeing team is still in place and operational
- Outpatient clinics have currently been stood down
- It is not being used as an inpatient facility

3.1.3 New NHS Nightingale Hospital to open early May

A new NHS Nightingale Hospital will be opened in Westpoint, Exeter to provide 200 extra beds for patients with COVID-19 symptoms, if needed. The NHS Nightingale Hospital Exeter brings the total to seven confirmed NHS Nightingale Hospitals across the country.

The new NHS Nightingale Hospital, hosted by the Royal Devon and Exeter NHS Foundation Trust, is expected to be ready for the first patients, if needed, during May, and will provide a regional resource of 200 beds for Devon, Cornwall and neighbouring counties to meet the care needs for patients who are seriously unwell due to their COVID-19 symptoms.

The five hospitals in Devon and Cornwall will continue to provide the majority of care for critically ill patients with COVID-19, and have plans in place to increase their critical care capacity up to 500 beds across both counties.

4 NHS England

4.1 NHS Volunteer Responders

NHS England and NHS Improvement are encouraging health and social care professionals to use NHS Volunteer Responders to refer people who are vulnerable and at risk for support in their communities. Support is available from volunteers in the following areas:

- **Check in and chat** - providing short term telephone support to individuals who are isolated
- **Community support** - providing collection of shopping, medication or other essential supplies
- **Patient Transport** - providing transport home for patients discharged from hospital
- **NHS Transport support** - providing transport for equipment, medical supplies between NHS services and other sites

5 Local Media Update

5.1 News release and campaigns highlights include:

During the pandemic we are maximising our use of local and social media as well as our website to ensure that our local population has correct information so that they are able to stay safe and healthy and access services appropriately. We have also promoted some of the amazing work of our staff are doing and thanks for the fantastic support we have received from local people.

BBC Spotlight /BBC Radio Devon
Doctors are concerned that some people who should be getting medical help for non-COVID-19 illnesses are staying away from hospital and not seeking help due to fears they might catch the virus. Dr Rob Dyer, Executive Medical Director, gave an interview to assure local people that, even during the pandemic, emergency services are there for them if they are unwell and need help.

A feature on the father and son doctors (consultant paediatrician - Yahya and first year junior doctor - Tayyib Mubasha) both work on the front line in Torbay Hospital, was also covered by the national media, and featured in the BBC's globally televised virtual concert to celebrate healthcare workers: One World: Together at home

Herald Express
Column from Liz Davenport thanking people for their support, giving advice on accessing services and thanking our amazing staff.

Torbay Times
Kelly Lawler, a Palliative Care Nurse, who features as she was selected as an 'NHS Hero' by the paper. She tells how she is supporting patients and colleagues during the pandemic

Mid Devon Advertiser/Totnes Times/Dartmouth Chronicle
South Devon College 3d print face shields to boost PPE stocks

Other social media posts, press releases and campaigns:

- Advice on staying at home to protect the NHS
- Launch of JustGiving page to support staff care for patients
- Thanks to all the volunteers supporting us with care
- Advice on how to communicate the current situation to children
- Encouragement to give blood
- Request for people to return no longer needed equipment
- Medical students celebrate graduation whilst social distancing
- Coronavirus can be caught by anyone, and spread by anyone
- One of our staff members sets up group to support others during grief
- Sharing the public thanks with our staff

6 Recommendation

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

Report of the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 12 2019/20 (March 2020 data)			Meeting date: 29 April 2020
Report appendix	Appendix 1- Month 12 - Focus Report Appendix 2 - Month 12 - Dashboard of key metrics Appendix 3 - Covid-19 Performance impact assessment		
Report sponsor	Director of Transformation and Partnerships Chief Finance Officer		
Report author	Head of Performance		
Report provenance	Performance briefing with Executive Directors (28 April 2020) Executive Director scrutiny (22 April 2020) Finance Performance Digital Committee (28 April)		
Purpose of the report and key issues for consideration/decision	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 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; • provide assurance to the Board that the Trust is on track to deliver the key milestones required by the regulator. The M12 report reflects the significant changes in our reported performance and likely impact in response to covid-19 escalation. Areas that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **receive and note** the documents and evidence presented.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** — Yes **Valuing our workforce** — Yes **Improved wellbeing through partnership** **Well-led** — Yes		

<table>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td>Yes</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>Yes</td><td>Risk score</td><td></td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
</table>
This report reflects the following corporate risks:

failure to achieve key performance standards;
inability to recruit/retain staff in sufficient number/quality to maintain service provision;
failure to achieve financial plan.

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Report title: Integrated Performance Report (IPR): Month 12 2019/20 (March 2020)		**Meeting date:** 29 April 2020
Report sponsor	Director of Transformation and Partnerships Chief Finance Officer	
Report author	Head of Performance	

1. Quality headlines

The Quality Improvement Group and Safety Cell have reported and recorded the national changes to safety data metrics. The Trust is still maintaining normal incident feedback and engagement metrics. The Quality Improvement Dashboard is being maintained with ISU Clinical Governance Coordinators being used in a different manner to ensure safety is a kept key priority in all the changes that are being undertaken. The Safety Cell, which is well represented with Executives, is reviewing safety on a weekly basis and ensuring, where necessary, Quality Equality Impact Assessments QEIA's) are being recorded and reviewed as services are impacted from the COVID-19 response.

The M12 Quality metrics are not highlighting any areas of concern. The COVID-19 preparations have seen additional Mortuary capacity and resilience put into place.

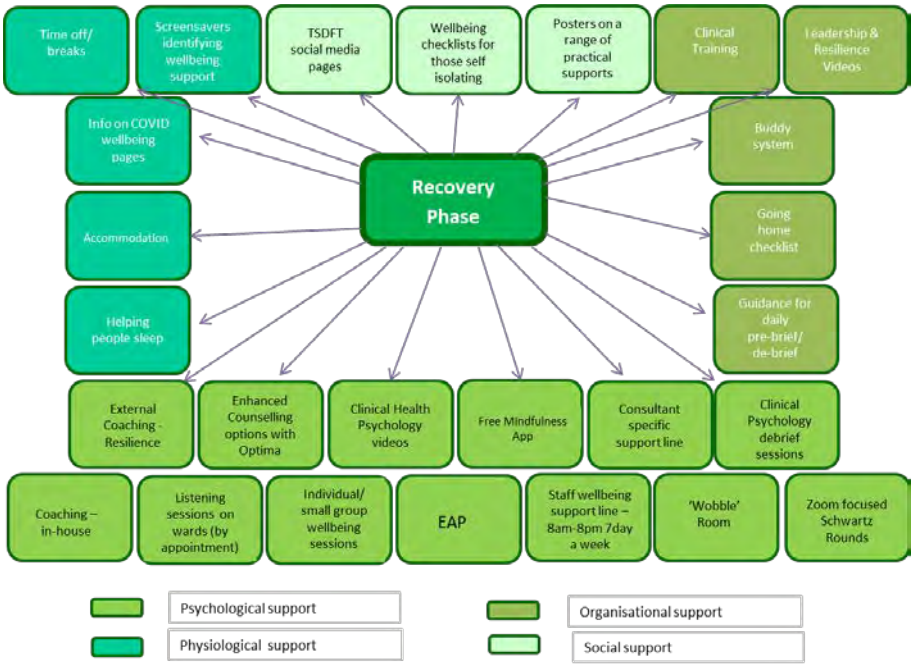
2. Workforce Headlines

In M12 normal performance metrics have not been included in the IPR dashboard for FPDC

During these unpresented times workforce have been focusing on:

Supporting Staff Wellbeing including those self-isolating

At no other time has health and wellbeing support been more important. A multi-disciplinary team has developed an overarching staff wellbeing plan, which describes the support offer during the 3 stages of the pandemic - preparation, active and recovery, as described by the British Psychological Society. Within each of these phases, the Physiological, Psychological, Social and Organisation offer is considered. An example of the cumulative support offer is summarised below;



Current work focuses around the development of resources for managers both in respect of wellbeing support available to them and management development, so they feel prepared to manage and lead their teams during these exceptional times. This incorporates some of the management passport modules, planned pre-COVID and therefore starts to incorporate, albeit in a different medium, some sense of business as usual.

Wellbeing calls are being undertaken for those shielding and self-isolating, by way of a check in and to make them aware of the support available to them. Currently, we are exploring the appetite for a modified form of Schwartz Rounds to help those shielding to connect and seek peer support around the emotional challenges they may be experiencing.

Managing Staff Reassignment

We have a new **Resourcing Hub** which brings together the different workforce pools within our organisation and has created real collaborative working and a sharing of learning and ideas across these teams. This will help us to build our new normal, looking at how we attract and retain our future talent will be key to our future success.

Already we have seen success stories with our **volunteer team** engaging with St Johns and Coastguards to see how we can share skills and expertise in our STP volunteer community. Anaesthetic colleagues delivered a presentation via zoom to over 100 interested vets and vet nurses who were keen to volunteer their experience and skills in a clinical environment. We are in the final stages of onboarding our first cohort of returners through the **national Bring Back Scheme** (BBS) and have been assigned 41 colleagues from nursing, HCA, AHP and medical backgrounds.

In addition, the Resourcing Hub has been developing support for us in **reassigning our existing staff** and there have been 60 requests so far re-assign staff to different areas. These providing support to ITU with 'proning' (turning patients onto their stomach) of ventilated patients, around the clock delivery of PPE to clinical areas, drivers needed to

deliver urgent items and call-handlers to provide information and signposting to different services in the community. This work will continue to develop post COVID-19.

Managing staff absence

A centralised recording process has been established with absences being reported to Workforce Information. Frequently asked questions are regularly updated to support managers in the management of staff absence.

3. Performance Headlines

The performance section has been reduced to incorporate the NHSI headlines for M12 part of the focus report. This describes a deterioration in end of year performance against the key NHSI performance metrics on access standards.

This month in response to the impact of COVID -19 there is an additional paper (COVID – 19 Activity and performance impact assessment) outlining the headline covid-19 activity and performance impact assessment.

4. Finance Headlines

- The financial position at 31st of March 2020 is a £24.45m deficit prior to sustainability funding. This is £20.65m adverse against the full year plan of £3.80m deficit. Included within the M12 position are incremental costs relating to COVID 19 of £0.95m (Pay £0.18m, non pay of £0.73m and loss of income £0.04m) matched by income from NHSI/E.
- The £20.65m adverse performance to control total is greater than the £15m which the Trust forecast at M6. The additional adverse movement of £5.7m relates to debt write off £2.2m, annual leave accrual £2.0m, RICS £1.8m, Impairment chargeable to I&E £0.8m offset by additional income/net improvement of £1.1m.
- The other movement at M12 which should be noted relates to the centrally-funded additional employers' pension contribution of £10.8m, whereby income was received from NHSI/E and fully offset by a corresponding pay cost - therefore net neutral to the bottom line financial performance.
- There is a net movement in re-categorisation of plan to budget of £2.48m relating to income, non pay and asset life changes due to the processing of the RICS valuation adjustment.
- Setting aside the factors above, the main variances for the year are as follows: Income - adverse by £5.08m (excluding the pensions adjustment) due to: lower income from contract healthcare £2.56m (£2m CCG risk share), Torbay Council IBCF £3.20m, private patient activity £0.55m, lower TP sales £0.84m and PSF £2.64m. Pay - adverse variance of £7.29m (excluding the pensions adjustment and annual leave accrual) due to undelivered CIP £5.57m, Bank £4.33m and Agency £2.34m (due to recruitment challenges, operational pressures and maternity/sickness cover), offset by Substantive vacancies £4.96m. Non pay - adverse variance of £6.74m due to overspend of £0.63m in Clinical supplies , undelivered Adult social care CIP £1.79m, Placed people £0.60m and operating costs £4.22m (debt write off £0.97m, provisions mainly due to change in discount

rate £0.41m, supported living £0.34m, residential stays £1.45m, nursing stay £0.43m, consultancy £0.31m and CFHD training £0.31m (matched by income), offset by underspends on Drugs £0.33m and non clinical supplies £0.18m.

- Total pay run rate in M12 (£35.0m) is £13.6m higher in comparison to previous month (M11 £21.4m). This includes £10.8m for the NHS Pension contribution paid centrally and £2.0m for the annual leave accrual. Therefore the underlying increase in run rate amounts to £0.8m and reflects increased Bank and Agency costs of £0.34m across all staff group and increases in substantive staff costs: medical staff £0.14m due to appointment and leave cover, pension settlement £0.14m, lower revenue to capital pay recharge £0.13m and £0.11m mainly due to COVID 19.
- Non pay expenditure run rate of £23.32m is £6.06m higher compared to M11 (£17.26m). This is due to higher spend in: clinical supplies and services £0.71m, non clinical supplies £0.07m (mainly COVID 19 related purchase matched by Income), Torbay council debt write off £2.2m, increase in bad debt provision £0.3m, domiciliary care increased provision £0.31m, supported living £0.17m due to backdated case, increased demand on intermediate care beds £0.28m, Children's IPP full year cost accrual £0.54m (matched by budget), increase in CFHD cost with DPT £0.16m, residential and nursing stays £0.58m, purchase of second hand IT license £0.32m, Regent house restoration due to lease expiring £0.44m and various operating cost £0.08 offset by lower spend in Drugs £0.11m (matched by Income).
- The Trust has an annual savings requirement of £20.0m. Of this £10.7m was delivered (£3.7m recurrent), resulting in a £9.3m shortfall.
- The full year Capital expenditure is £17.31m. This is £1.5m lower than the forecasted value, in part due to delays to items forecast for delivery in March, as a result of COVID.

Torbay and South Devon
NHS Foundation Trust

Integrated Performance Report

April 2020: Reporting period March 2020 (Month 12)

Section 1: PERFORMANCE

NHSI operational performance indicator focus

Section 2: FINANCE

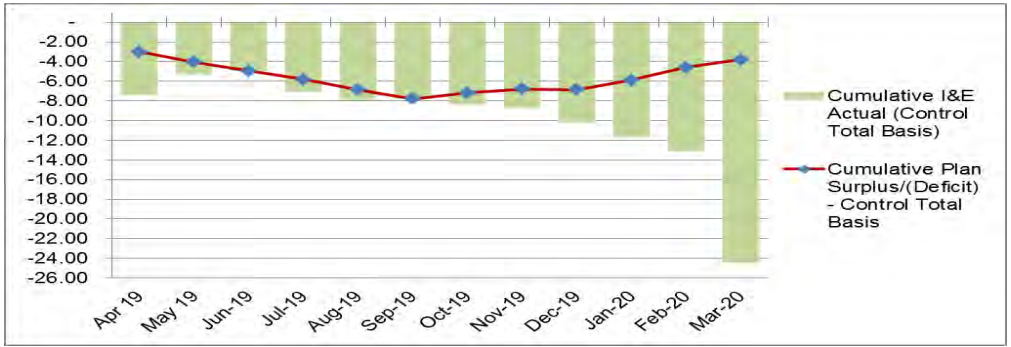
Finance Focus

NSHI Single Oversight Framework - Performance standards	National Standard	Trajectory M12	ICO performance M12	Risk
Patients Seen within 4 hours in A+E	**>95%**	**90%**	**86.1%**	**HIGH**
Risks identified: M12 has seen a significant shift in terms of performance and numbers attending ED to the coronavirus pandemic threat. Attendances reduced by 21% in March and 47% first 2 weeks of April compared to last year. This has meant the Emergency Department has been able to process patients in a more timely way and seen a reduction in delays waiting for admission. This is reflected in the monthly performance waiting times and levels of escalation recorded.	Management Action: The separation of facilities to manage the non COVID-19 and query COVID-19 pathways has been set up in March with the ED floor expanding into the day surgery unit. Whilst this is a temporary change, this together with the reduced number of attendances has greatly reduced overcrowding. The escalated COVID-19 ED will remain in place until the risk of having a surge in COVID-19 patients has passed.			
Patients waiting longer than 18 weeks from referral to treatment	**>92%**	**82%**	**76.16%**	**HIGH**
Risks identified: During March elective capacity has been progressively stood down to accommodate the plans to manage the predicted surge in COVID-19 related hospitalisations. Escalation plans have included the transfer of some urgent elective and cancer surgical treatments / outpatients to Mount Stuart Hospital which has been contracted to the NHS as part of the national response. A reduction in weekly referrals by 75% by the end of March reflecting the national lock down measures, meaning the overall numbers waiting at the end of March have reduced slightly. This impact is being seen with the lengthening of waiting times with both the number waiting over 52 weeks increasing to 53 and 76.16% over 18 weeks at month end.	Management Action: plans to maintain urgent and cancer related work has been prioritised. The adoption of non face to face clinical outpatient consultations has been progressed with telephone consultations implemented for urgent patients and the "Attend Anywhere" initiative being fast tracked. This is in a state of development with a project team now leading the implementation and wider roll out to increase outpatients capacity through these non face to face approaches. Mount Stuart facilities are being used as a non COVID-19 site to support the most urgent surgical treatments and outpatients requiring face to face consultation. The Director of Transformation and Partnerships is leading the COVID-19 resilience and recovery workstream.			
Cancer 62 day wait for first treatment from 2 week wait referral	**85%**	**85%**	**74.40%**	**MEDIUM**
Risks identified: At the end of March the headline performance is being maintained for treated patients. Urgent referrals have significantly reduced by 60% by end of March. We would expect these referrals to increase as restrictions are eased. This increase being recognised as a risk in our recovery planning. Reduced capacity for surgical treatment and diagnosis is also seen with the plans for COVID-19 escalation and is a risk to maintaining cancer access standards.	**Management Action:** Following an initial period of adjustment, plans are being implemented to support cancer pathways of care. Where facilities have been displaced these have been relocated and Mount Stuart Hospital is now established to provide surgical day case treatment and urgent outpatients. Radiotherapy and medical oncology has continued with near normal capacity. Arrangements remain in place to support the most urgent inpatient surgery using main theatres.			
Diagnostic tests longer than 6 weeks	**< 1%**		**11.27%**	**HIGH**
Risks identified: In M12 with the gradual reduction in diagnostic capacity for routine examinations as part of the COVID-19 response a deterioration in performance is reported. The forecast to achieve 2-4% by the end of March was on track however this target is missed with 11.27% of patients recorded as waiting over 6 weeks. This has further deteriorated in April. The limited capacity for routine diagnostic tests extending the time patients already on this list will be waiting.	Management Action: Despite the escalating COVID-19 position access for urgent diagnostics has been maintained. The mobile CT and MRI has been successfully established at Newton Abbot hospital. Plans will be reviewed as part of the recovery planning to establish increased routine capacity that will be needed once the restrictions are eased.			
Dementia Find - Not reported	**>90%**	**90%**	**94.20%**	**LOW**

Finance Focus

Summary of Financial Performance

Current Performance



	Plan for Period	Re-Categorisation	Budget for Period	Actual for Period	Variance to Budget	Annual Plan	Annual Budget
	£M	£M	£M	£M	£M	£M	£M
Income	496.18	(2.47)	493.71	499.44	5.72	496.18	493.71
Pay	(246.38)	(2.95)	(249.33)	(269.41)	(20.09)	(246.38)	(249.33)
Non Pay	(225.02)	2.93	(222.09)	(228.82)	(6.74)	(225.02)	(222.09)
EBITDA	**24.78**	**(2.48)**	**22.30**	**1.20**	**(21.10)**	**24.78**	**22.30**
Financing Costs	(20.08)	2.48	(17.60)	(19.24)	(1.64)	(20.08)	(17.60)
SURPLUS / (DEFICIT) inc PSF / MRET	**4.70**	**(0.00)**	**4.70**	**(18.04)**	**(22.74)**	**4.70**	**4.70**
NHSI Exclusions	(0.14)	0.00	(0.14)	(0.69)	(0.55)	(0.14)	(0.14)
Adjusted Surplus / (Deficit)	**4.56**	**(0.00)**	**4.56**	**(18.73)**	**(23.29)**	**4.56**	**4.56**
Less: PSF/MRET Income	(8.36)	0.00	(8.36)	(5.72)	2.64	(8.36)	(8.36)
YTD Surplus / (Deficit) (Excl PSF/MRET)	**(3.80)**	**(0.00)**	**(3.80)**	**(24.45)**	**(20.65)**	**(3.80)**	**(3.80)**
Cash Balance	3.83			10.14	**6.31**	**3.83**	**3.83**
Capital Expenditure	21.56	(2.79)	18.77	17.31	**(1.46)**	**21.56**	**19.61**
CIP Delivery	20.03	0.00	20.03	10.70	**(9.33)**	**20.03**	**20.03**

Key Points

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- Non pay expenditure run rate of £23.32m is £6.06m higher compared to M11 (£17.26m). This is due to higher spend in: clinical supplies and services £0.71m, non clinical supplies £0.07m (mainly COVID 19 related purchase matched by Income), Torbay council debt write off £2.2m, increase in bad debt provision £0.3m, domiciliary care increased provision £0.31m, supported living £0.17m due to backdated case, increased demand on intermediate care beds £0.28m, Children's IPP full year cost accrual £0.54m (matched by budget), increase in CFHD cost with DPT £0.16m, residential and nursing stays £0.58m, purchase of second hand IT license £0.32m, Regent house restoration due to lease expiring £0.44m and various operating cost £0.08 offset by lower spend in Drugs £0.11m (matched by Income).
- The Trust has an annual savings requirement of £20.0m. Of this £10.7m was delivered (£3.7m recurrent), resulting in a £9.3m shortfall.
- The full year Capital expenditure is £17.31m. This is £1.5m lower than the forecasted value, in part due to delays to items forecast for delivery in March, as a result of COVID.

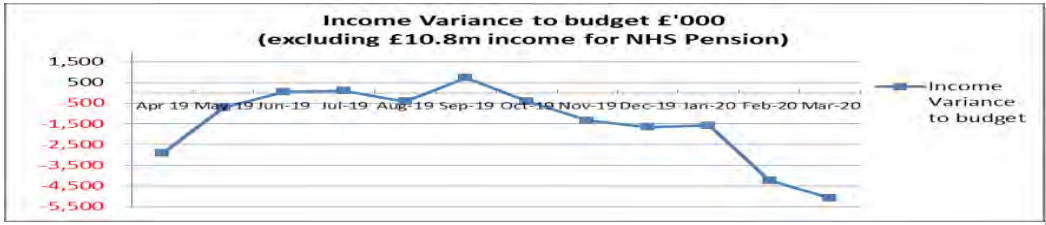
Summary of Financial Performance

	Month 12					Year to date (YTD)								
	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	36.94	(0.10)	36.84	46.37	9.53	444.27	(2.86)	441.41	447.61	6.19	(3.34)	9.53	444.27	441.41
Other Operating income	4.86	(0.19)	4.67	5.09	0.42	51.91	0.39	52.30	51.83	(0.47)	(0.89)	0.42	51.91	52.30
Total Income	**41.80**	**(0.29)**	**41.51**	**51.47**	**9.95**	**496.18**	**(2.47)**	**493.71**	**499.44**	**5.72**	**(4.23)**	**9.95**	**496.18**	**493.71**
Employee Benefits - Substantive	(19.66)	(0.26)	(19.92)	(34.31)	(14.40)	(240.20)	(2.38)	(242.59)	(260.33)	(17.74)	(3.34)	(14.40)	(240.20)	(242.59)
Employee Benefits - Agency	(0.38)	0.04	(0.34)	(0.73)	(0.38)	(6.18)	(0.56)	(6.74)	(9.09)	(2.34)	(1.96)	(0.38)	(6.18)	(6.74)
Drugs (including Pass Through)	(2.94)	0.10	(2.83)	(2.70)	0.14	(35.26)	1.24	(34.02)	(33.69)	0.33	0.19	0.14	(35.26)	(34.02)
Clinical Supplies	(2.27)	(0.03)	(2.29)	(2.69)	(0.39)	(26.47)	(0.20)	(26.67)	(27.30)	(0.63)	(0.24)	(0.39)	(26.47)	(26.67)
Non Clinical Supplies	(0.39)	0.02	(0.36)	(0.54)	(0.18)	(4.94)	(0.22)	(5.16)	(4.98)	0.18	0.36	(0.18)	(4.94)	(5.16)
Other Operating Expenditure	(12.78)	(0.38)	(13.16)	(17.40)	(4.24)	(158.35)	2.11	(156.24)	(162.85)	(6.61)	(2.38)	(4.24)	(158.35)	(156.24)
Total Expense	**(38.42)**	**(0.50)**	**(38.92)**	**(58.36)**	**(19.45)**	**(471.40)**	**(0.01)**	**(471.41)**	**(498.23)**	**(26.82)**	**(7.37)**	**(19.45)**	**(471.40)**	**(471.41)**
EBITDA	**3.38**	**(0.79)**	**2.60**	**(6.90)**	**(9.49)**	**24.78**	**(2.48)**	**22.30**	**1.20**	**(21.10)**	**(11.61)**	**(9.49)**	**24.78**	**22.30**
Depreciation - Owned	(1.12)	0.25	(0.86)	(3.04)	(2.18)	(12.86)	2.48	(10.38)	(12.37)	(1.99)	0.19	(2.18)	(12.86)	(10.38)
Depreciation - donated/granted	(0.07)	0.00	(0.07)	(0.07)	(0.00)	(0.86)	0.00	(0.86)	(0.89)	(0.03)	(0.03)	(0.00)	(0.86)	(0.86)
Interest Expense, PDC Dividend	(0.61)	0.00	(0.61)	(0.24)	0.37	(7.36)	0.00	(7.36)	(6.69)	0.66	0.29	0.37	(7.36)	(7.36)
Donated Asset Income	0.08	0.00	0.08	0.00	(0.08)	1.00	0.00	1.00	0.77	(0.23)	(0.14)	(0.08)	1.00	1.00
Gain / Loss on Asset Disposal	0.00	0.00	0.00	(0.01)	(0.01)	0.00	0.00	0.00	(0.07)	(0.07)	(0.06)	(0.01)	0.00	0.00
Impairment	0.00	0.00	0.00	(0.27)	(0.27)	0.00	0.00	0.00	0.01	0.01	0.28	(0.27)	0.00	0.00
SURPLUS / (DEFICIT) inc PSF / MRET	**1.66**	**(0.53)**	**1.13**	**(10.54)**	**(11.67)**	**4.70**	**(0.00)**	**4.70**	**(18.04)**	**(22.74)**	**(11.08)**	**(11.66)**	**4.70**	**4.70**
Adjusted Plan Position														
Donated Asset Income	(0.08)	0.00	(0.08)	0.00	0.08	(1.00)	0.00	(1.00)	(0.77)	0.23	0.14	0.08	(1.00)	(1.00)
Depreciation - Donated / Granted	0.07	0.00	0.07	0.07	0.00	0.86	0.00	0.86	0.89	0.03	0.03	0.00	0.86	0.86
Impairment	0.00	0.00	0.00	(0.53)	(0.53)	0.00	0.00	0.00	(0.80)	(0.80)	(0.28)	(0.53)	0.00	0.00
Adjusted Plan Surplus / (Deficit)	**1.65**	**(0.53)**	**1.12**	**(10.99)**	**(12.11)**	**4.56**	**(0.00)**	**4.56**	**(18.73)**	**(23.29)**	**(11.19)**	**(12.11)**	**4.56**	**4.56**
NHSI Adjustment to Control Total														
Remove PSF/MRET Income	(0.85)	0.00	(0.85)	(0.32)	0.52	(8.36)	0.00	(8.36)	(5.72)	2.64	2.12	0.52	(8.36)	(8.36)
SURPLUS / (DEFICIT) excluding PSF / MRET	**0.81**	**(0.53)**	**0.27**	**(11.31)**	**(11.59)**	**(3.80)**	**(0.00)**	**(3.80)**	**(24.45)**	**(20.65)**	**(9.07)**	**(11.58)**	**(3.80)**	**(3.80)**

- The in-month deficit for month 12 is £11.31m, which is adverse to the £0.81m budgeted position after NHSI exclusions. There is a net movement in re-categorisation of plan to budget of £0.53m in month relating to income, pay, non pay and asset life changes due to RICS valuation. The year to date position is a cumulative deficit of £24.45m.
- Patient care income is £9.53m higher than budget in month 12 due to £10.80m income from NHSI/E relating to centrally paid pension contribution (matched by Pay) and winter pressures funding £0.68m offset by £2.0m CCG contract income risk share; cumulatively patient care income is £6.19m higher than budget, further detail is within the income section.
- Other income is higher in M12 by £0.42m due to training income £0.55m (mainly CFHD offset by cost), increased R&D income £0.15m for trials and TP sales £0.26m due to increased demand on pharmaceutical products due to COVID 19 offset by PSF income £0.52m (not meeting the control total) and other £0.02m. Cumulatively other income is £0.47m lower than budget due to PSF income £2.64m and TP sales £0.84m offset by higher: Education, R&D, Grant and Training income of £1.69m, site services £0.07m, non patient services £0.73m due to activity, income received from insurance £0.13m; grants, rental, VAT reclaim and other services £0.44m.
- Pay expenditure of £34.95m is £14.68m higher than budget in Month 12 due to: use of Bank £0.58m, Agency £0.38m and Substantive staff £0.92m (undelivered CIP), annual leave accrual £2.0m and NHS pension cost paid centrally £10.8m (matched by Income). For the year to date, the pay position is £20.08m higher than budget, further information is within the Pay detail section.
- Non-pay expenditure is £4.67m higher than budget in Month 12 due to overspend in clinical supplies £0.39m, non clinical supplies £0.19m (both COVID 19 related demand) and other operating cost £4.24m (mainly debt write off £2.4m, increase in social care cost £1.46m (residential and nursing packages of care, domiciliary care, supported living cost and undelivered CIP) and various cost £0.38m) offset by lower Drugs cost £0.14m (matched by Income).
- Depreciation/amortisation costs is £2.01m higher than budget mainly due to RICS of £1.80m.

Income

Current Performance



Operating Income	Year to Date - Month 12					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Contract Healthcare	379.44	(2.19)	377.25	385.49	8.24	(1.94)	10.18
Council Social Care (inc Public Health)	51.84	(0.40)	51.44	48.23	(3.21)	(2.20)	(1.01)
Client Income	10.78	(0.65)	10.13	11.17	1.04	0.90	0.14
Private Patients	2.22	0.07	2.29	1.74	(0.55)	(0.54)	(0.01)
Other Income	0.00	0.30	0.30	0.98	0.68	0.43	0.25
Operating Income from patient care activities	**444.28**	**(2.87)**	**441.41**	**447.61**	**6.20**	**(3.34)**	**9.55**
Other Income	33.48	0.60	34.08	34.58	0.50	0.84	(0.34)
R&D / Education & training revenue	10.07	(0.21)	9.86	11.53	1.67	0.85	0.82
Provider Sustainability Fund (PSF) & MRET Income	8.36	0.00	8.36	5.72	(2.64)	(1.59)	(1.05)
Other operating income	**51.91**	**0.39**	**52.30**	**51.83**	**(0.47)**	**0.10**	**(0.57)**
Total	**496.19**	**(2.48)**	**493.71**	**499.44**	**5.73**	**(3.24)**	**8.98**

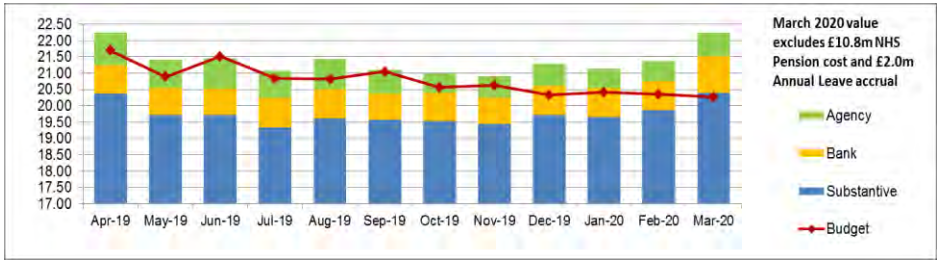
Contract income by Commissioner	Year to Date - Month 12					Previous Month	
	Plan	Recategorisation of plan	Budget	Actual	Variance to Budget	Variance to Budget - (adv)/+fav	Change
	£m	£m	£m	£m	£m	£m	£m
Devon Clinical Commissioning Group (CCG)	233.24	(1.00)	232.24	228.29	(3.95)	(1.32)	(2.63)
NHS England - Area Team	7.03	0.00	7.03	7.56	0.53	0.18	0.35
NHS England - Specialist Commissioning	31.31	(0.30)	31.01	30.82	(0.19)	0.08	(0.27)
Acute Income - Other Commissioners	10.92	(2.12)	8.80	20.42	11.62	(1.08)	12.70
Sub-Total Acute Income	282.50	(3.42)	279.08	287.09	8.01	(2.14)	10.15
Devon CCG (Placed People and Community Health)	95.56	0.00	95.56	95.56	0.00	0.00	0.00
Community Income - Other Commissioners	1.38	1.23	2.61	2.84	0.23	0.20	0.03
Sub Total Community Income	96.94	1.23	98.17	98.40	0.23	0.20	0.03
Operating Income from patient care activities	**379.44**	**(2.19)**	**377.25**	**385.49**	**8.24**	**(1.94)**	**10.18**

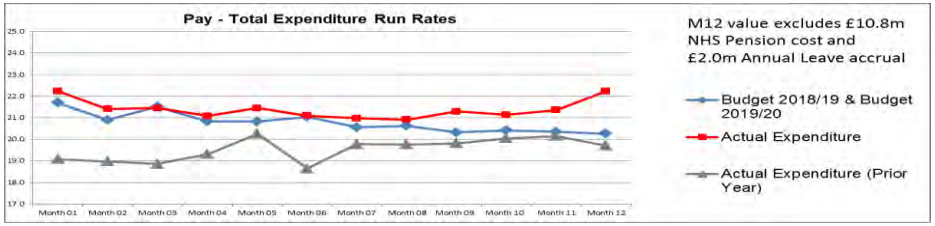
Key points

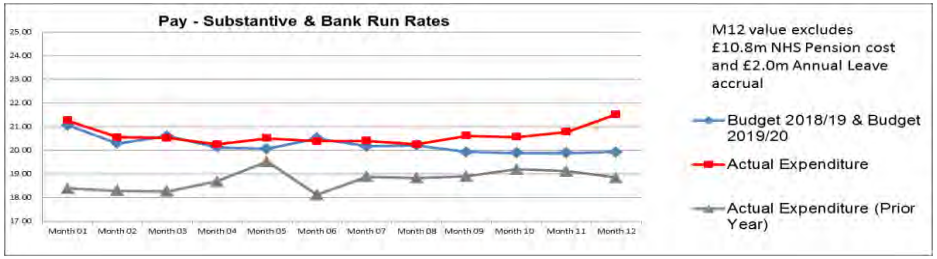
- The agreement of the Devon CCG income plan has been reflected in the position from month 2. No penalties have been assumed for 52 week waits. There is a contract reduction of £2.00m in M12 in respect of the risk share.
- Overall operating income is £5.73m ahead of budget for the full year.
- Operating Income from Patient Care Activities is ahead of budget by £6.20m. The main reason for this is linked to the £10.80m income from NHSI/E in respect of centrally paid pension contributions. There is a corresponding expenditure value to offset this within Pay.
- Income from contract healthcare is £8.24m ahead of budget, largely due to the £10.80 NHSI/E centrally funded pension contributions offset by CCG risk share of £2.0m and lower income from commissioners due to lower activity linked to 'out of area' patients.
- Council social care income is behind by £3.20m mainly due to not receiving IBCF income from Torbay Council.
- Client income is ahead by £1.04m as at M12 due to increase in contribution on residential and nursing stay, domiciliary and day care (matched by payment to providers).
- Private patient income is behind budget by £0.55m due to lower Outpatient activity.
- Other income is £0.68m ahead of budget at M12 due to winter pressures income.

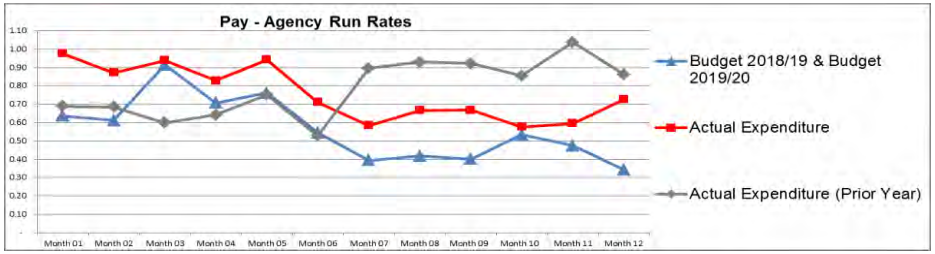
Pay Expenditure

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	(52.78)	(0.77)	(53.55)	(56.73)	(3.18)	(52.78)	(53.55)
Nursing and Midwifery	(57.87)	(0.36)	(58.23)	(60.07)	(1.83)	(57.87)	(58.23)
Other Clinical	(94.71)	(1.25)	(95.96)	(95.21)	0.75	(94.71)	(95.96)
Non Clinical	(41.02)	(0.56)	(41.58)	(57.39)	(15.81)	(41.02)	(41.58)
Total Pay Expenditure	**(246.38)**	**(2.94)**	**(249.32)**	**(269.40)**	**(20.08)**	**(246.38)**	**(249.32)**

Key points

- Total pay costs are showing an overspend against full year budget of £20.08m. This is due to undelivered CIP of £5.57m, overspend on Bank £4.33m, Agency overspend £2.34m, NHS Pensions paid centrally £10.80m (matched by Income) and annual leave accrual £2.0m offset by Substantive vacancies and underspends £4.96m.

- Agency overspend of £2.34m is due to increased use of Medical Staff £1.34m, Nursing staff £0.72m and non clinical/other staff £0.28m. This is due to challenges in recruiting for Medical and Nursing staff, maternity and sickness cover and operational pressures.

- Total pay run rate in M12 (£35.0m) is £13.6m higher in comparison to previous month (M11 £21.4m). This includes £10.8m for the NHS Pension contribution paid centrally and £2.0m for the annual leave accrual. Therefore the underlying increase in run rate amounts to £0.8m and reflects increased Bank and Agency costs of £0.34m across all staff group and increases in substantive staff costs: medical staff £0.14m due to appointment and leave cover, pension settlement £0.14m, lower revenue to capital pay recharge £0.13m and £0.11m mainly due to COVID 19.

- Agency run rate of £0.73m is £0.13m higher than the M11 value of £0.60m across all staff group.

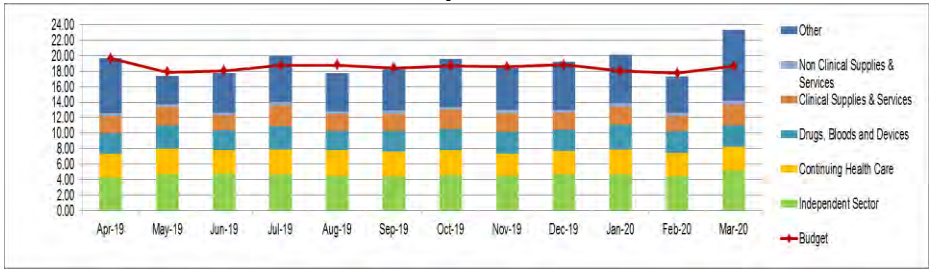
- The other clinical staff group variance of £0.75 to budget reflects challenges in recruitment in AHP and other scientific staff.

- The variance on Non clinical staff of £15.81m reflects the £10.80m NHS pensions paid centrally (matched by Income), £2.0m annual leave accrual and Transformational CIP schemes being held in central reserves at plan stage.

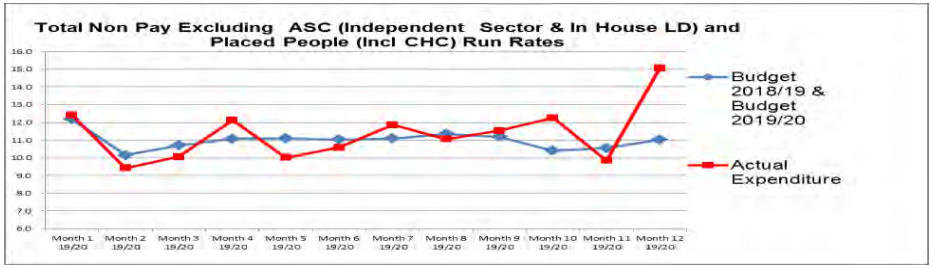
- The Apprentice levy balance at Month 12 is £1,570,123 (£1,552,747 at month 11). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

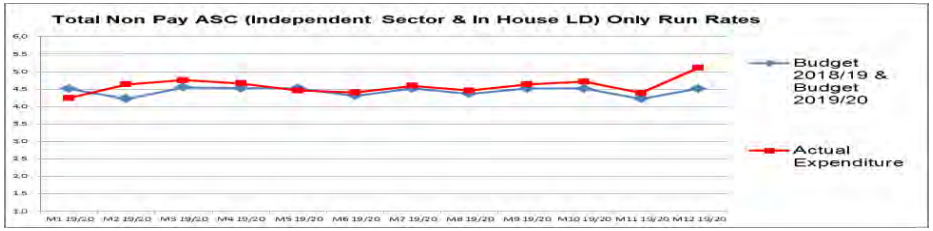
Non Pay Expenditure

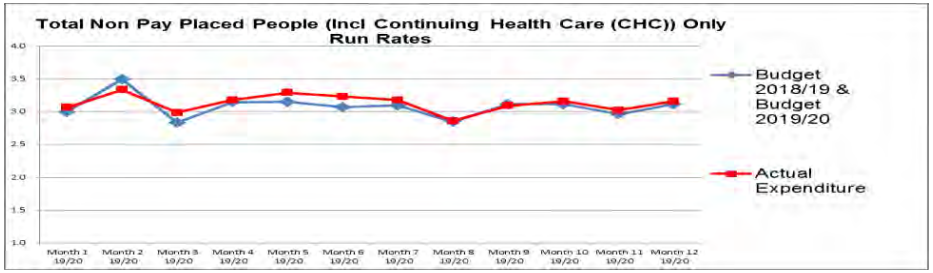
Current performance



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	(35.26)	1.24	(34.02)	(33.69)	0.33	(35.26)	(34.02)
Clinical Supplies & Services	(26.47)	(0.20)	(26.67)	(27.30)	(0.63)	(26.47)	(26.67)
Non Clinical Supplies & Services	(4.94)	(0.22)	(5.16)	(4.98)	0.18	(4.94)	(5.16)
Other Operating Expenditure	(75.70)	9.68	(66.03)	(70.25)	(4.22)	(75.70)	(66.03)
ASC (Independent Sector & In House LD)	(48.98)	(4.28)	(53.26)	(55.05)	(1.79)	(48.98)	(53.26)
Placed People (Incl Continuing Healthcare)	(33.67)	(3.29)	(36.95)	(37.56)	(0.60)	(33.67)	(36.95)
Total Non Pay Expenditure	**(225.02)**	**2.93**	**(222.09)**	**(228.82)**	**(6.74)**	**(225.02)**	**(222.09)**







Key Points

- Drugs, Bloods and Devices - Underspent by £0.33m mainly due to pass through for which income is similarly reduced for NHS England.
- Clinical Supplies – Spend is £0.63m higher than budget due to medical and surgical equipment £1.0m (£0.3m in M12 due to COVID 19 requirement matched by income), pacemakers £0.20m, contract tests £0.21m, lab medicine managed service £0.19m, appliances and furniture £0.24m, contract maintenance and service agreement £0.22m offset by Dressings £0.20m, chemical consumables £0.38m, prosthesis and devices £0.56m, TP finished goods £0.17m and various supplies £0.12m underspends.
- Non Clinical Supplies – underspend of £0.18m due to external service agreements (records management, storage and other non healthcare) £0.12m, CIP £0.20m and domestic supplies £0.04m offset by patient catering provisions for hospital sites £0.18m.
- Other Operating Expenditure - overspent by £4.22m due to debt write off £0.97m, provisions mainly due to change in discount rate £0.41m, supported living £0.34m, residential stays £1.45m, nursing stay £0.43m, consultancy £0.31m and CFHD training £0.31m (matched by income).
- Adult Social Care (Independent sector) - Overspend by £1.79m due to unachieved CIP and increased cost in packages of care.
- Placed People (including Continuing Healthcare) - overspend of £0.60m to date.

Balance Sheet

	Year to Date - Month 12			Previous Month YTD	
	Plan	Actual	Variance	Variance	Movement in Variance
	£m	£m	£m	£m	£m
Non-Current Assets					
Intangible Assets	12.93	9.78	(3.16)	(0.56)	(2.60)
Property, Plant & Equipment	181.67	182.67	1.00	(6.63)	7.63
On-Balance Sheet PFI	14.61	17.44	2.83	0.49	2.34
Other	1.14	1.23	0.09	0.05	0.04
Total	**210.36**	**211.12**	**0.76**	**(6.65)**	**7.41**
Current Assets					
Cash & Cash Equivalents	3.83	10.14	6.31	13.71	(7.40)
Other Current Assets	37.16	40.85	3.69	0.79	2.90
Total	**40.98**	**50.98**	**10.00**	**14.50**	**(4.50)**
Total Assets	**251.34**	**262.10**	**10.77**	**7.86**	**2.91**
Current Liabilities					
Loan - DH ITFF	(6.91)	(24.64)	(17.73)	0.00	(17.73)
PFI / LIFT Leases	(0.85)	(0.85)	0.00	(0.00)	0.00
Trade and Other Payables	(33.78)	(48.05)	(14.27)	(11.97)	(2.30)
Other Current Liabilities	(14.21)	(13.58)	0.63	0.66	(0.03)
Total	**(55.75)**	**(87.12)**	**(31.37)**	**(11.31)**	**(20.06)**
Net Current assets/(liabilities)	**(14.77)**	**(36.14)**	**(21.37)**	**3.19**	**(24.56)**
Non-Current Liabilities					
Loan - DH ITFF	(43.33)	(43.33)	0.00	(13.39)	13.39
PFI / LIFT Leases	(17.77)	(17.77)	(0.00)	0.00	(0.00)
Other Non-Current Liabilities	(13.94)	(9.66)	4.28	6.12	(1.85)
Total	**(75.03)**	**(70.76)**	**4.28**	(7.27)	11.54
Total Assets Employed	**120.56**	**104.22**	**(16.33)**	**(10.72)**	**(5.61)**
Reserves					
Public Dividend Capital	65.44	67.62	2.18	(0.18)	2.36
Revaluation	41.87	46.09	4.22	(0.01)	4.23
Income and Expenditure	13.25	(9.48)	(22.73)	(10.54)	(12.20)
Total	**120.56**	**104.22**	**(16.33)**	**(10.72)**	**(5.61)**

Key points

- Intangible Assets, Property, Plant & Equipment and PFI are £0.7m higher than planned. This is primarily due to year end revaluation £4.2m and receipt of donated building £0.7m, partly offset by reduced capex £4.2m.
- Cash is £6.3m favourable, principally due to interim loans offsetting the adverse SoCI position; and a high level of Trade and Other Payables.
- Other Current Assets are £3.7m higher than Plan, primarily due to income paid later than planned (incl NHSE 2018/19 contract over-performance £2.3m, TP customers £0.9m and COVID £0.8m) and delayed sale of assets £0.7m, partly offset by income received earlier than planned and absence of a PSF debtor £1.6m.
- Current DH loans are £17.7m higher than Plan, due to increased use of interim revenue loans (£14.7m) and the interim capital loan for Theatres (£3.0m). These loans are now classified as current, due to the national policy decision of DH to convert interim loans into PDC in 2020/21.
- Trade and Other Payables are £14.3m higher than Plan, largely due to income received earlier than planned (incl CCG CFHD £2.1m, CCG 2019/20 contract adj £2.0m and NHSE 2019/20 contract under-performance £1.0m), the timing of non-capital payments (incl Pharmacy £1.9m and Roche invoicing delay £0.9m) and annual leave accrual £2.0m.
- Other Non-Current liabilities are £4.3m lower than Plan, primarily due to a delay in the taking out of new finance leases as a result of delayed capital expenditure.

CIP Delivery: Current Month and Cumulative

Month 12 position:

The current month CIP target was £3m against which £0.7m was delivered, leaving a £2.3m shortfall.

2019/20 cumulative current year position

The 19/20 CIP target was £20m, against which £10.7m of CIP was delivered, leaving a £9.3m shortfall.
This can be broken down as follows:-

The Recurrent CIP target was £17.5m, against which £3.7m was delivered, leaving a Current Year Effect (CYE) of £13.8 recurrent shortfall (CYE-See note below)*

The Non-recurrent CIP Target was £2.5m against which £7.0m was delivered, generating a £4.5m recurrent surplus.

2019/20 CIP delivery shortfall carrying forward into 2020/21

The recurrent 2019/20 CIP target was £17.5m
Although the current year recurrent delivery was £3.7m, the Full Year Effect (FYE) of 19/20 recurrent scheme delivery was £4.1m. *(FYE-See note below*)*
The resultant £13.4m recurrent FYE shortfall carries forward into forming a significant part of the 2020/21 CIP target.

(*Note: CYE and FYE.

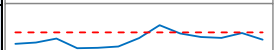
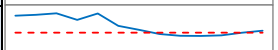
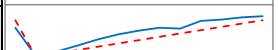
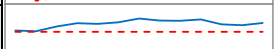
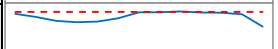
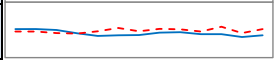
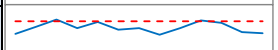
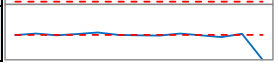
The 2019-20 recurrent current year effect (CYE) comprises a mix of 2019-20 CIP projects delivering 12 months of savings and projects starting part way through the year, delivering less than 12 months savings.
The recurrent Full Year Effect (FYE) shows how much these projects will deliver in 2020-21 and in future financial years, with a full 12 months of savings for all projects started in 2019-20.
Therefore the recurrent Full year effect delivery value will be higher than the Current year effect.)

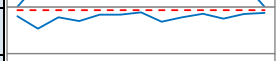
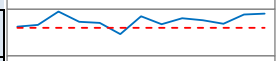
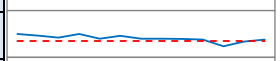
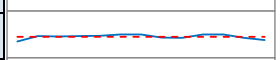
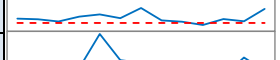
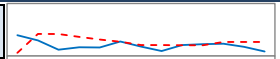
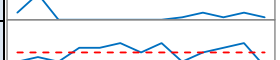
Year end CIP commentary

The Trust has had a number of challenges to manage in the current financial year and has been too dependent upon Non-recurrent CIP delivery to help close the delivery gap, hence a £13.4m (FYE) shortfall carrying into the next financial year. Pressure on project delivery resource and clinical managerial capacity meant that many potential CIP (Transformational) productivity opportunities were not progressed.
This was due to a number of issues; For example:
- During the year, managerial and clinical resources were re-prioritised and directed to manage an Acute beds crisis, when the Trust was almost continually in Opel 3 and Opel 4.
- Similarly the loss of Theatre capacity and, latterly the Covid 19 major incident, resulted in the redeployment of resources used to deliver CIP projects.

Although delivery resources have been further stretched into 2020-21 due to Covid 19, there is an urgent need to identify (and deliver) cash releasing CIP schemes to put the Trust onto a firm financial footing. This should include a post audit evaluation as to the reasons for non-delivery of the 19-20 CIP programme and the actions needed to resolve those issues, including the ring fencing of dedicated project management and delivery resourcing and strengthening of workforce planning function to ensure the trust can deliver its CIP target, reduce its deficit and meet its financial obligations whilst maintaining patient safety.

	ISU	Target	13 month trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Year to date
QUALITY LOCAL FRAMEWORK																	
Safety Thermometer - % New Harm Free	Trustwide	>95%		95.9%	96.3%	95.4%	96.8%	96.8%	97.3%	96.5%	96.8%	97.3%	96.2%	96.5%	98.0%	96.7%	96.7%
Reported Incidents - Severe	Trustwide	<6		1	0	0	1	1	1	2	0	1	1	0	0	0	7
Reported Incidents - Death	Trustwide	<1		0	0	0	1	0	0	2	0	1	0	0	2	0	6
Medication errors resulting in moderate harm	Trustwide	<1		0	1	1	0	0	0	0	0	0	0	0	1	1	4
Medication errors - Total reported incidents	Trustwide	N/A		50	32	48	39	46	61	38	45	57	45	51	59	45	566
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	2	0	0	0	0	0	0	0	0	1	2		5
Never Events	Trustwide	<1		0	0	1	0	0	0	0	0	1	0	0	0	0	2
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		5	2	7	4	2	5	2	5	7	4	1	5		44
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	2	2	2	0	0	0	0	2	0	8
Formal complaints - Number received	Trustwide	<60		33	13	22	23	34	24	25	28	30	14	32	20	17	282
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		90.5%	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.7%			91.2%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		91.5%	98.9%	100.0%	97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.9%	100.0%		98.4%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		96.3	106.6	106.6	115.4	116.6	111.1	102.8	99.1	100.2	105.5				102.6
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		104.0%	98.5%	91.7%	90.9%	90.1%	93.9%	88.9%	88.8%	89.6%	90.4%	91.3%	89.2%	88.9%	91.0%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		103.2%	98.5%	91.8%	93.7%	92.8%	100.3%	91.3%	91.6%	93.2%	91.7%	92.9%	91.4%	91.3%	93.3%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		0	4	42	12	36	63	34	0	42	0	204	108	0	545
Hand Hygiene	Trustwide	>95%		89.5%	92.2%	87.7%	93.8%	93.5%	95.2%	95.7%	96.1%	97.2%	94.1%	96.1%	93.5%	94.9%	94.2%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		60.7%	61.5%	54.8%	67.4%	63.6%	65.6%	51.6%	64.7%	78.6%	85.7%	84.6%	75.0%		
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		79.7%	93.8%	75.5%	79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	84.9%
Stroke - SSNAP level	Trustwide	N/A		C													
Follow ups 6 weeks past to be seen date	Trustwide	6400		5899	6240	6459	6803	6906	7393	6793	6694	6725	7243	6391	6147	7056	7056
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<3.8%		4.2%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.5%	4.5%			4.3%
Appraisal Completeness	Trustwide	>90%		78.9%	80.0%	80.0%	79.0%	80.0%	78.0%	78.0%	77.3%	78.0%	78.5%	80.1%	81.6%		78.0%
Mandatory Training Compliance	Trustwide	>85%		91.4%	89.5%	90.2%	90.9%	90.3%	90.8%	90.3%	90.6%	90.5%	90.4%	90.8%	90.4%		90.3%
Integrated Performance Report	Trustwide	10%-14%		9.7%	10.7%	10.7%	10.8%	11.2%	11.2%	11.3%	11.4%	11.4%	11.4%	11.7%	11.7%		

	ISU	Target	13 month trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		278	370	356	419	508	562	392	373	319	344	462	588	393	4693
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		137	149	185	97	101	112	189	305	230	198	190	235	175	1991
Timeliness of Adult Social Care Assessment assessed within 28 days of referral	Trustwide	>70%		76.1%	76.4%	77.0%	74.6%	77.0%	72.5%	71.1%	69.5%	68.9%	68.8%	69.0%	70.0%	70.7%	70.0%
Clients receiving Self Directed Care	Trustwide	>90%		91.7%	91.1%	90.8%	90.3%	90.3%	90.1%	89.6%	89.0%	89.0%	89.1%	89.3%	88.1%	87.7%	88.1%
Carers Assessments Completed year to date	Trustwide	40% (Year end)		29.3%	3.6%	7.8%	13.2%	18.6%	23.2%	26.7%	29.2%	28.4%	35.4%	36.6%	38.5%	39.6%	38.5%
Number of Permanent Care Home Placements	Trustwide	<=600		605	602	619	631	629	634	648	641	640	645	627	624	632	624
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET			170	186	201	228	219	206	184	176	192	202	191		202
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		300			54			109							109
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET		4.9%			5.6%			5.3%							5.3%
Safeguarding Adults - % of high risk concerns where immediate action was taken	Trustwide	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%	100.0%
CAMHS - % of patients waiting under 18 weeks at month end	Trustwide	>92%		90.3%	87.6%	83.9%	82.6%	83.2%	86.2%	91.7%	91.7%	92.4%	91.5%	91.3%	89.9%	78.8%	88.0%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET			532	550	514	567	563	569	594	530	556	558	530	520	520
Intermediate Care - No. urgent referrals	Trustwide	113		164	184	189	179	188	174	178	216	205	201	239	202	219	2150
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		257	258	249	220	196	202	204	226	230	212	211	186	202	2405
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		81.0%	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	80.8%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		81.2%	80.7%	81.8%	81.5%	81.1%	80.7%	80.4%	79.9%	80.0%	79.9%	79.8%	78.8%	76.2%	80.1%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		73.7%	79.9%	86.5%	78.8%	84.4%	77.4%	78.9%	72.9%	78.8%	85.9%	83.6%	75.3%	74.3%	79.6%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		10.1%	13.7%	12.1%	11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	11.5%
Dementia - Find - monthly report	Trustwide	>90%		88.9%	95.1%	88.1%	92.8%	98.7%	90.3%	88.5%	87.5%	94.4%	88.4%	81.9%	93.7%		90.7%

	ISU	Target	13 month trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3			5	5	5	4	6	3	8	2	4	4	5		51
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		79.9%	53.4%	77.7%	69.5%	83.4%	83.4%	88.3%	68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	77.8%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		38.8%	50.3%	97.5%	98.9%	98.9%	98.7%	97.3%	91.5%	100.0%	97.3%	97.1%	98.9%	95.5%	91.0%
Cancer - 28 day faster diagnosis standard	Trustwide			67.6%	65.2%	63.5%	63.6%	74.0%	73.3%	70.6%	71.8%	73.2%	71.9%	66.9%	74.5%	74.9%	70.4%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		96.2%	96.7%	99.5%	97.3%	97.0%	94.7%	98.5%	96.8%	98.0%	97.6%	96.8%	98.8%	99.0%	97.6%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		98.8%	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%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		100.0%	98.6%	96.9%	100.0%	95.9%	98.4%	95.9%	95.9%	95.8%	95.2%	89.5%	93.5%	95.2%	95.7%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		96.0%	94.7%	97.1%	96.8%	100.0%	93.9%	93.8%	94.7%	95.0%	97.1%	86.2%	91.4%	94.6%	94.8%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		70.0%	93.3%	90.9%	92.9%	93.8%	100.0%	100.0%	86.7%	85.7%	100.0%	100.0%	85.7%	76.5%	92.0%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			37	33	41	34	28	31	36	39	27	24	24	21	21	21
RTT 52 week wait incomplete pathway	Trustwide	0		82	71	59	83	84	105	89	79	69	71	80	43	0	0
On the day cancellations for elective operations	Trustwide	<0.8%		1.2%	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	1.3%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		6	3	3	6	19	9	8	8	7	3	3	10	5	84
Bed Occupancy	Overall System	80% - 90%		92.8%	93.9%	91.4%	90.5%	94.0%	95.3%	95.4%	95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	95.4%
Number of patients >7 days LoS (daily average)	Trustwide			131.9	134.4	130.6	125.5	124.8	128.3	131.7	127.4	121.5	120.1	128.1	130.3	119.8	128.9
Number of extended stay patients >21 days (daily average)	Trustwide			27.4	31.7	29.7	26.6	29.8	29.0	35.9	34.3	28.0	23.1	25.5	27.7	26.0	31.0
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		198	148	61	83	81	137	90	47	104	113	117	88	43	1112
Ambulance handover delays > 60 minutes	Trustwide	0		9	13	11	4	5	12	2	5	13	14	14	7	5	105
A&E - patients recorded as >60min corridor care	Trustwide			423	430	319	424	384	447	416	382	494	463	495	335	115	4704
A&E - patients with >12 hour visit time pathway	Trustwide			142	190	90	146	123	212	145	103	247	158	182	136	32	1764
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		3	11	0	0	0	0	0	0	1	3	1	3	1	20
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		1	2	1	4	4	5	3	5	1	3	4	5	n/a	37
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	3	4	1	0	1	0	3	1	1	0	0	n/a	14
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		63.6%	64.7%	63.8%	62.8%	67.2%	66.3%	67.1%	66.4%	63.0%	64.1%	65.7%	62.2%	71.0%	65.3%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		31.6%	29.1%	23.9%	29.4%	39.9%	38.2%	35.0%	32.6%	25.8%	36.8%	41.5%	40.5%	44.5%	34.4%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		81.8%	86.4%	77.3%	86.4%	86.4%	81.8%	68.2%	68.2%	77.3%	81.8%	81.8%	95.5%	68.2%	79.9%

	ISU	Target	13 month trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
Capital Service Cover	Trustwide	2		4	4	4	4	4	4	4	4	4	4	4	4		
Liquidity	Trustwide	4		3	3	3	2	2	3	4	4	4	4	4	4		
I&E Margin	Trustwide	1		4	4	4	4	4	4	4	4	4	4	4	4		
I&E Margin Variance from Plan	Trustwide			3	4	3	1	2	2	1	2	2	3	3	4		
Variance from agency ceiling	Trustwide	1		4	4	4	4	4	4	4	4	4	4	4	3		
Overall Use of Resources Rating	Trustwide			4	4	4	3	3	3	3	4	4	4	4	4		
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-7157	-6072	-925	-72	-1447	-1363	-473	-3022	-4464	-6555	-9693	-13294	-23577	
Agency - Variance to NHSI cap	Trustwide			1.24%	1.42%	1.21%	1.23%	1.14%	1.17%	0.98%	1.03%	1.06%	1.07%	1.01%	0.98%	0.87%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-8426	-628	-1191	-1296	-891	-239	-342	-1584	-2357	-2872	-4983	-7078	-9325	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-12019	48	501	893	1146	2637	3301	4420	6559	7632	8191	9595	4249	
Distance from NHSI Control total (£'000's)	Trustwide			-7096	-4861	-1213	91	-1248	-1019	58	-1651	-2833	-4616	-7648	-10926	-20367	
Risk Share actual income to date cumulative (£'000's)	Trustwide			7950	0	0	0	0	0	0	0	0	0	0	0	-2000	
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			2.5%	-2.4%	-0.4%	-1.8%	0.2%	-1.2%	-1.0%	-2.4%	-3.4%	-3.4%	-2.4%	-2.7%	-3.1%	-3.1%
Outpatients - Follow ups	Trustwide			4.9%	1.2%	0.9%	0.9%	1.9%	0.8%	1.5%	1.1%	0.7%	1.2%	1.3%	1.3%	0.2%	0.2%
Daycase	Trustwide			10.5%	5.6%	7.9%	4.0%	4.0%	2.9%	3.8%	2.5%	3.1%	2.8%	2.4%	1.8%	0.0%	0.0%
Inpatients	Trustwide			3.8%	2.9%	-1.6%	-4.2%	-3.0%	-0.6%	-1.7%	-2.2%	-0.3%	2.0%	4.5%	4.8%	3.6%	3.6%
Non elective	Trustwide			-2.3%	-1.8%	-0.9%	-2.9%	-3.5%	-4.5%	-3.4%	-2.3%	-1.7%	0.1%	0.5%	1.2%	0.4%	0.4%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			311	366	331	355	358	339	380	394	385	400	450	368	358	
Intermediate Care GP Referrals	Trustwide			78	108	86	96	96	81	87	98	85	94	125	89	78	
Average length of Intermediate Care episode	Trustwide			14.536	17.196	16.375	12.172	16.961	18.863	15.759	15.305	13.428	14.987	14.172	14.281	14.035	
Total Bed Days Used (Over 70s)	Trustwide			10430	11751	10385	9944	10176	10487	10372	10564	9903	10484	11576	10490		
- Emergency Acute Hospital	Trustwide			5938	6920	6336	5759	5911	5856	5776	6181	5900	6328	6879	6067		
- Community Hospital	Trustwide			3239	3168	2756	3031	2913	3366	3295	3180	3100	3174	3387	3147		
- Intermediate Care	Trustwide			1253	1663	1293	1154	1352	1265	1301	1203	903	982	1310	1276		

Torbay and South Devon
NHS Foundation Trust

Title: Integrated Performance Report - COVID-19 performance impact assessment.

Report By : Head of Performance **Date : 22nd April 2020**

1. COVID -19 response activity and performance impact assessment

The response to COVID-19 has meant significant changes to service provided and organisational priorities. On the 17th March Sir Simon Stevens wrote to all organisations setting out the actions required to prepare for the COVID – 19

- To increase capacity available to manage the anticipated rise in COVID-19 related hospitalisations, including the stepping down of all non-urgent outpatient appointments and surgery.
- Suspension of payment by results replaced by block income arrangements and additional arrangements to fund necessary building of capacity and National agreement to support capacity from the independent sector
- Stand down the current annual plan planning round, CQC inspections and setting of performance trajectories.

This M12 performance summary gives a summary against the NHSi performance standards to the end of March and highlights some of the significant changes that have been seen in response to the COVID-19 escalation.

Actions taken to escalate capacity for COVID-19 Hospitalisations

During March, the Trust mobilised plans to prepare the hospital for the anticipated surge in COVID-19 related hospitalisations. A summary of the main “estate” and “service” changes to date are listed below:

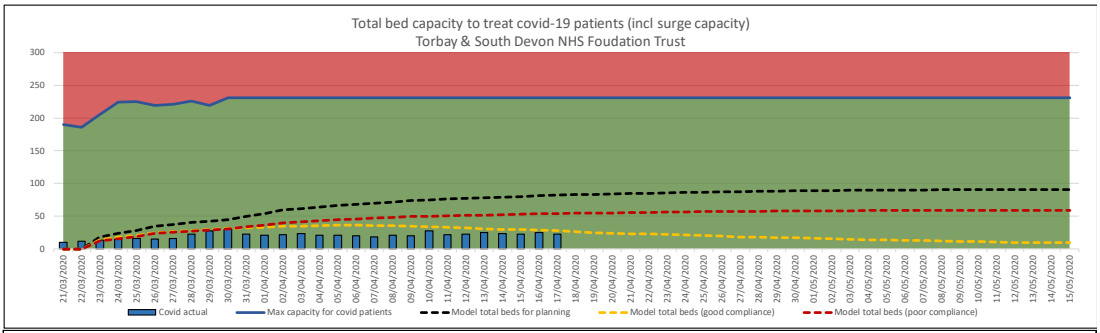
- Suspension of all elective non-urgent operating and diagnostic tests
- Suspend all non-urgent face to face outpatients
- Additional ICU surge capacity established in theatres recovery and special theatres to extend capacity from 14 to a maximum 46 ventilated beds
- Day surgery theatres repurposed to provide COVID Emergency Department

- Outpatients on level 2 repurposed to provide – COVID discharge facility – prepared and ready
- Cancer Inpatient Ward (Turner) and day treatment (RGDU) relocated to Newton Abbot Hospital
- Mount Stuart Hospital – as part of the national COVID escalation made available for NHS use to provide cancer / urgent elective DC surgery and 2 week wait clinics.
- Dermatology and oral surgery relocated to John Parks Unit
- Mobile CT/MRI scanner moved to Newton Abbot Hospital
- Introduction of programme to commence non-face to face telephone and video outpatient consultations using the "Attend Anywhere" application

The mobilisation of the changes outlined has been an outstanding achievement and meant the Hospital and community wider services were prepared for the expected surge in covid-19 related cases.

The latest data based on reported hospitalisation data and modelling suggests that the initial peak in COVID-19 admissions will fall within the escalated NHS capacity.

Graph 1: Total bed capacity to treat covid-19 patients



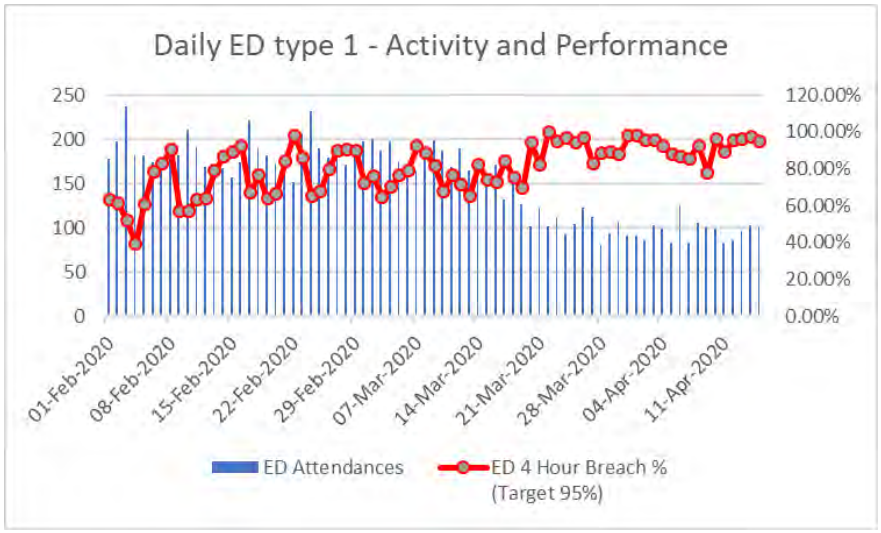
The latest model from NHSE/I (published on the 10th April) shows that the TSD would not be expected to exceed its available capacity (even exluding any additional surge capacity). Over the next month the gap between the maximum bed capacity for covid patients is approx 140 higher than the modelled level of demand for planning purposes. The actual daily sitrep is showing that demand is broadly following the 'poor' compliance with social distancing projection.

2. Performance and Activity impact

Below is an early assessment of the headline impact on activity and performance.

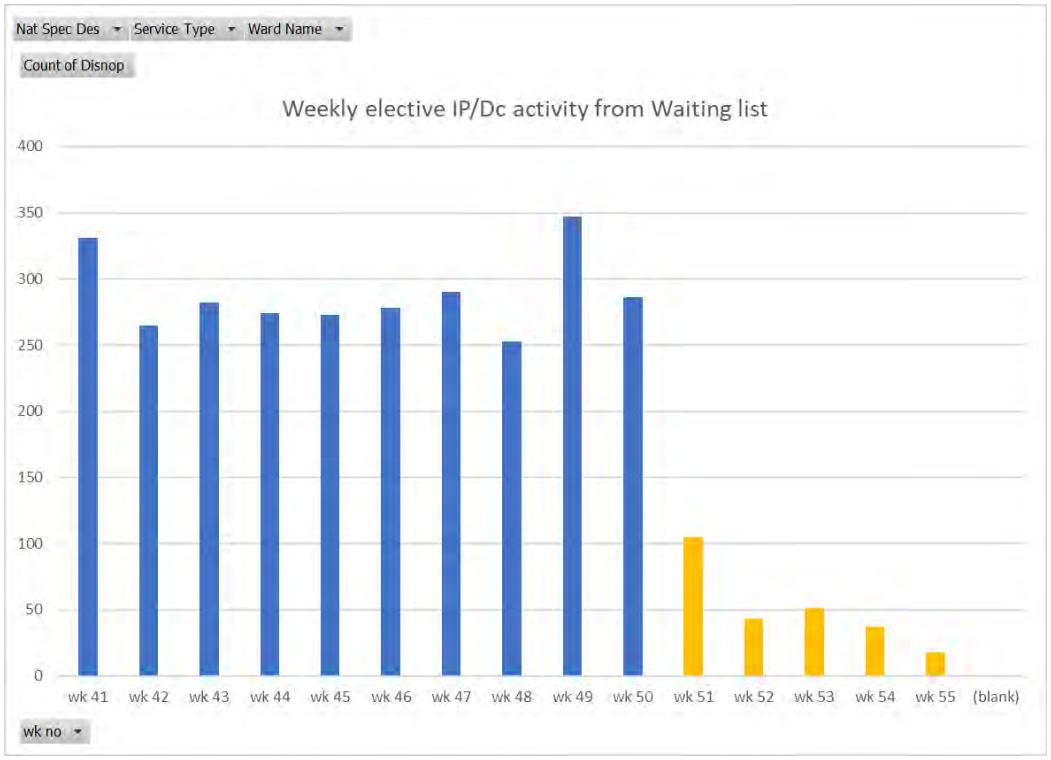
2.1 Emergency department - Activity and Performance

Activity levels reduced over the month from normal daily expected numbers at the beginning of March to approximately 50% in the last week of March. This change reflects the public response to the escalation of self isolation and ring fencing of NHS resources with advice across primary care and 111. The reduced activity having an impact on the reported performance and activity as seen in the graph below.



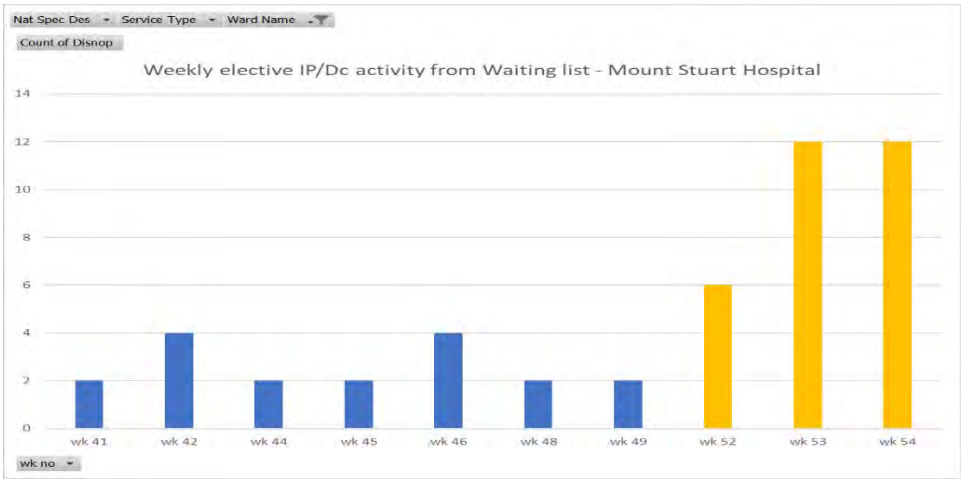
Looking ahead there is the likelihood that patients who are not attending the Emergency Department currently and self managing symptoms will require specialist advice and present over the coming weeks/months. As public advice is updated we would expect to see a rebound of demand for emergency care. This will need to be managed at National and local level with regard to the COVID-19 escalation capacity and overall demand.

2.2 Elective IP and DC activity



The dramatic stepping down of activity in mid March (week 51) is seen in the chart above. This reduction follows the closure of day surgery, eye theatre, endoscopy and cancellation of non-urgent inpatient theatre cases.

The establishment of the most urgent elective activity can be seen in the activity recorded at Mount Stuart Hospital below.



2.3 Elective OP activity

Since mid-March as indicated by Sir Simon Stevens letter there has been a stepping down of non-urgent outpatient activity – A number of specialties have maintained some routine activity using non-face to face contact with patients for both new and follow up activity.

The "Attend Anywhere" web based video consultation platform for the NHS is being implemented.

The current position (mid April) is an overall reduction of 63% in activity in the first 2 weeks of April.

The table below shows the latest 2 weeks of activity for 1st – 14th April 2020 for appointments seen (face to face or remotely) against available capacity. Specialties are ranked in order of % capacity used and banded as

- Green – Greater than 50%
- Amber - 25 to 50%
- RED -less than 25%.

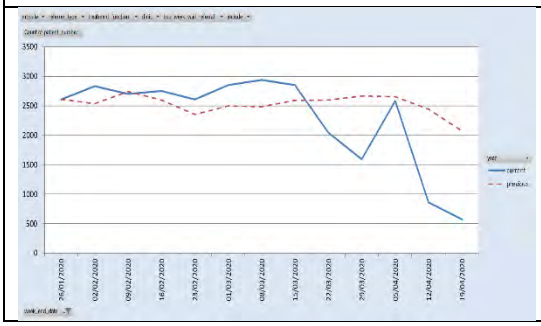
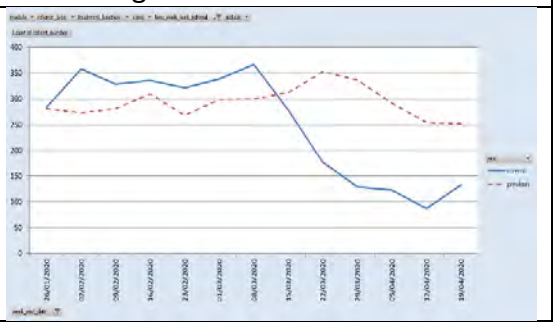
Utilised Clinic Capacity 01.04.2020 - 17.04.2020

Treatment Function Description	Total Appointments	Attended Appointments	% Attended
OBSTETRICS	199	160	80%
CLINICAL ONCOLOGY (previously RADIOTHERAPY)	287	218	76%
MEDICAL ONCOLOGY	171	116	68%
DERMATOLOGY	192	118	61%
AUDIOLOGY	179	94	53%
CLINICAL HAEMATOLOGY	134	68	51%
BREAST SURGERY	76	36	47%
PAEDIATRICS	193	90	47%
NEUROLOGY	66	30	45%
TRAUMA & ORTHOPAEDICS	350	151	43%
OPHTHALMOLOGY	650	272	42%
ORAL SURGERY	76	30	39%
GYNAECOLOGY	204	78	38%
DIABETIC MEDICINE	75	24	32%
RESPIRATORY MEDICINE	141	45	32%
UROLOGY	124	36	29%
RHEUMATOLOGY	159	43	27%
GASTROENTEROLOGY	204	49	24%
ORTHOPTICS	76	11	14%
CARDIOLOGY	425	54	13%
GERIATRIC MEDICINE	89	9	10%
ENT	127	12	9%
COLORECTAL SURGERY	109	9	8%
PHYSIOTHERAPY	56	4	7%
ANAESTHETICS	57	4	7%
ORTHODONTICS	91	0	0%
Total	4902	1825	37%

Showing specialties with > 50 appointment capacity

2.3.1 Outpatient Referrals

The two graphs below show the impact on total referrals received and 2ww referrals over last 12 weeks

All referrals – 75% reduction	Cancer urgent referrals – 60% reduction
	

2.4 Impact of RTT performance and waiting lists

Referral to Treatment (RTT) at the end of March 2020 has deteriorated due to the reduction in elective activity. This will continue into April and beyond until elective capacity is restored. Despite there being fewer new referrals up to 75% drop over historical levels, the routine patients on the waiting list will be progressively waiting longer. The forecast is for continued deterioration of the RTT metric as a higher proportion of patients wait over 18 and 52 weeks.

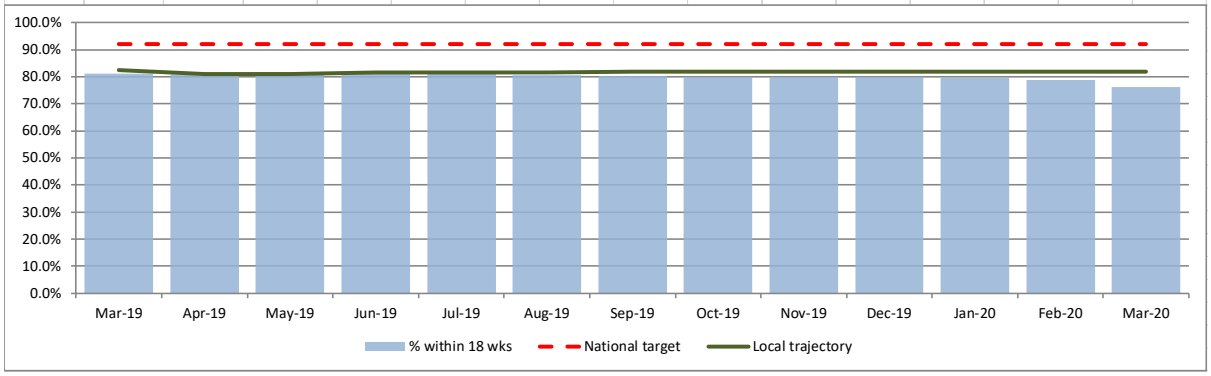
The overall number on waiting lists may not be increasing however we know that on resumption of more normal referrals patterns and clinic activity a backlog of patients will start to enter the RTT waiting list. The resumption of capacity to see routine patients in all setting including outpatients, diagnostics and treatments will be critical in offsetting the challenges we will face once the covid escalations are eased off.

It remains very early in the current crisis to start switching capacity with the priority remaining on having capacity to respond to any surge in covid patients. A planning cellis is being

RTT incomplete performance

Referral to treatment - Incomplete pathways

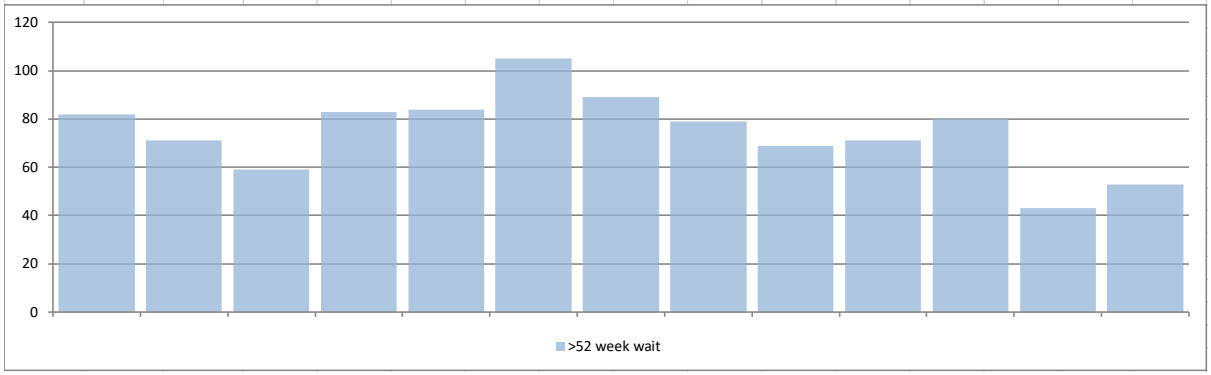
	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Incomplete <=18wks	15786	15357	16001	16057	16133	16059	16300	16509	16042	16302	16013	15627	15157
Incomplete >18wks	3660	3661	3550	3638	3763	3845	3985	4164	4016	4089	4052	4213	4757
% within 18 wks	81.2%	80.7%	81.8%	81.5%	81.1%	80.7%	80.4%	79.9%	80.0%	79.9%	79.8%	78.8%	76.1%
National target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Local trajectory	82.5%	81.0%	81.0%	81.5%	81.5%	81.5%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%



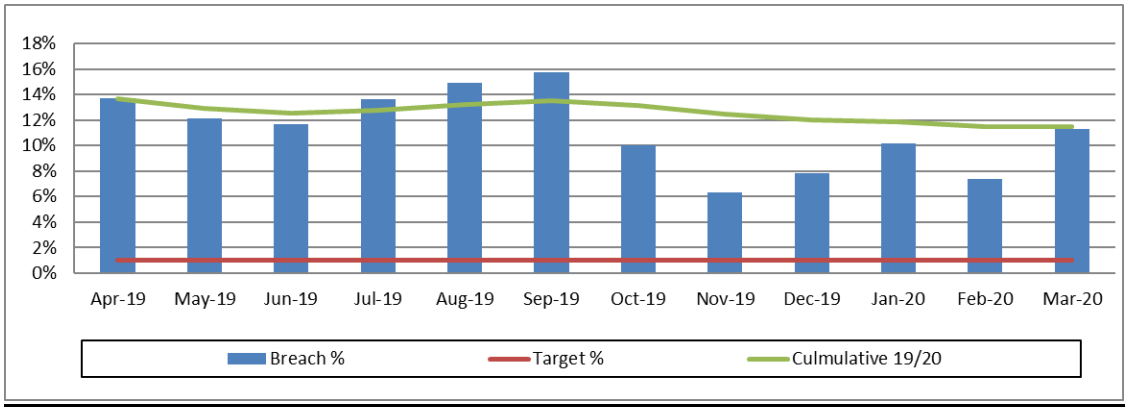
Patient waiting over 52 weeks

RTT incomplete pathways longer than 52 weeks

	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
>52 week wait	82	71	59	83	84	105	89	79	69	71	80	43	53



2.5 Diagnostic impact on activity and performance



Diagnostics activity is similarly impacted in March with the transition to COVID-19 escalation, with significant capacity for non-urgent activity from waiting lists being stood down by the end of March.

The current position is continued prioritisation on supporting the urgent and emergency pathways of care. We will see continued increases in the number of long waits until COVID-19 escalation and restrictions are relaxed. The visiting mobile capacity that has been supporting CT and MRI activity have been relocated to Newton Abbot Hospital. At this time the requested visits are being maintained.

2.6 Cancer Pathways

At the end of March there is little change recorded against the cancer key targets. Maintaining cancer pathways or care is a National priority and key t our resilience planning. However, we have now seen the reduction in urgent referrals overall of around 50-75%

along with a reduction in surgical treatment capacity with the transition to alternative capacity utilising Mount Stuart Hospital that will impact on the delivery of cancer standard.

Radiotherapy and medical day case treatment continue to be delivered albeit with constraints to normal capacity. The Cancer IP ward and medical day case unit being transferred to Newton Abbot Hospital.

		January 2020				February 2020				March 2020				Quarter 4 Total			
CWT Measure	Target	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	932	312	1244	74.9%	1062	189	1251	84.9%	1203	178	1381	87.1%	3197	679	3876	82.5%
14 Day - Breast Symptomatic referral	93%	75	2	77	97.4%	89	5	94	94.7%	63	3	66	95.5%	227	10	237	95.8%
31 Day 1st treatment	96%	187	8	195	95.9%	177	2	179	98.9%	205	2	207	99.0%	569	12	581	97.9%
31 Day Subsequent treatment - Drug	98%	113	0	113	100.0%	73	0	73	100.0%	59	0	59	100.0%	245	0	245	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	70	8	78	89.7%	57	4	61	93.4%	40	2	42	95.2%	167	14	181	92.3%
31 Day Subsequent treatment - Surgical	94%	25	5	30	83.3%	31	3	34	91.2%	35	2	37	94.6%	91	10	101	90.1%
31 Day Subsequent treatment - Other		19	0	19	100.0%	17	0	17	100.0%	13	0	13	100.0%	49	0	49	100.0%
62 day 2ww / Breast	85%	90	18	108	83.3%	76	27.5	103.5	73.4%	91	31.5	122.5	74.3%	257	77	334	76.9%
62 day Screening	90%	15	0	15	100.0%	6	1	7	85.7%	13	4	17	76.5%	34	5	39	87.2%
62 day Consultant Upgrade		5	1	6	83.3%	5	0.5	5.5	90.9%	0	0	0	100.0%	10	1.5	11.5	87.0%
104 day breaches (2ww) - TREATED	0	4.5				7.5				11.5				23.5			

3. Workforce headlines

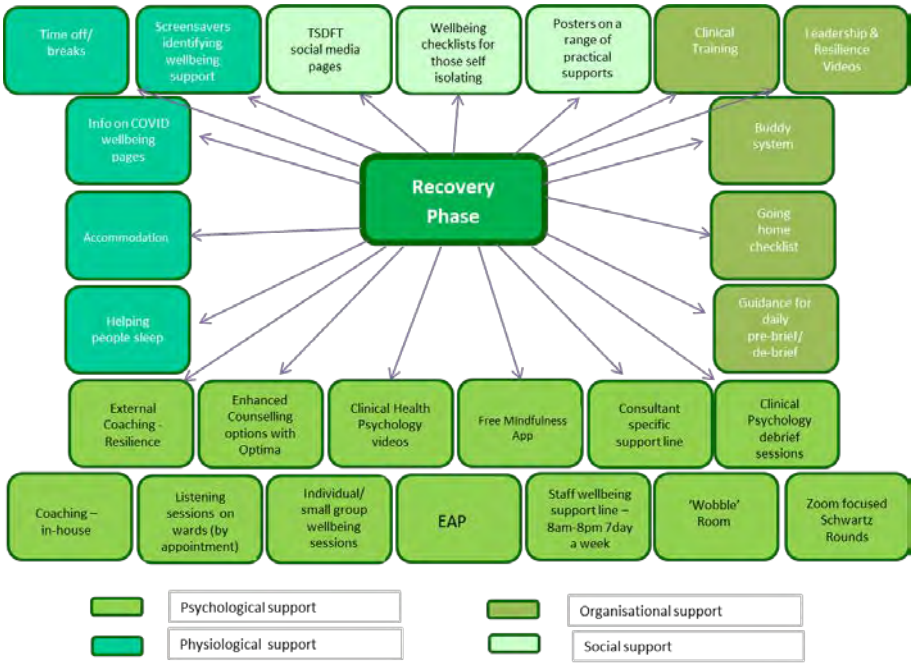
Performance Measurements	Mar Act.	Target
Current Mth Sickness	4.52%*	4.00%
12 Mths Sickness	4.46%	4.00%
Labour Turnover Rate	10.77%*	10%-14%
Achievement Review	78.66%*	90%
Mandatory Training Compliance	90.44%	85%

*March preliminary figs

Movements	Mar	12 Mths
Starters Heads	70	1171
Starters FTE	57.36	1052.79
Leavers Heads	77	830
Leavers FTE	66.15	680.90

Supporting Staff Wellbeing including those self-isolating

At no other time has health and wellbeing support been more important. A multi-disciplinary team has developed an overarching staff wellbeing plan, which describes the support offer during the 3 stages of the pandemic - preparation, active and recovery, as described by the British Psychological Society. Within each of these phases, the Physiological, Psychological, Social and Organisation offer is considered. An example of the cumulative support offer is summarised below;



Current work focuses around the development of resources for managers both in respect of wellbeing support available to them and management development, so they feel prepared to manage and lead their teams during these exceptional times. This incorporates some of the management passport modules, planned pre-COVID and therefore starts to incorporate, albeit in a different medium, some sense of business as usual.

Wellbeing calls are being undertaken for those shielding and self-isolating, by way of a check in and to make them aware of the support available to them. Currently, we are exploring the appetite for a modified form of Schwartz Rounds to help those shielding to connect and seek peer support around the emotional challenges they may be experiencing.

Managing Staff Reassignment

We have a new **Resourcing Hub** which brings together the different workforce pools within our organisation and has created real collaborative working and a sharing of learning and ideas across these teams. This will help us to build our new normal, looking at how we attract and retain our future talent will be key to our future success.

Already we have seen success stories with our **volunteer team** engaging with St Johns and Coastguards to see how we can share skills and expertise in our STP volunteer community. Anaesthetic colleagues delivered a presentation via zoom to over 100 interested vets and vet nurses who were keen to volunteer their experience and skills in a clinical environment. We are in the final stages of onboarding our first cohort of returners through the **national Bring Back Scheme** (BBS) and have been assigned 41 colleagues from nursing, HCA, AHP and medical backgrounds.

In addition, the Resourcing Hub has been developing support for us in **reassigning our existing staff** and there have been 60 requests so far re-assign staff to different areas. These providing support to ITU with 'proning' (turning patients onto their stomach) of ventilated

patients, around the clock delivery of PPE to clinical areas, drivers needed to deliver urgent items and call-handlers to provide information and signposting to different services in the community. This work will continue to develop post COVID-19.

Managing staff absence

A centralised recording process has been established with absences being reported to Workforce Information. Frequently asked questions are regularly updated to support managers in the management of staff absence.

Managing staff absences who self isolating

- Managing Staff sickness
- Managing staff reassignment
- Supporting staff well-being
- Key numbers

4. Quality headlines

The Quality Improvement Group and Safety Cell have reported and recorded the national changes to safety data metrics. The Trust is still maintaining normal incident feedback and engagement metrics. The Quality Improvement Dashboard is being maintained with ISU Clinical Governance Coordinators being used in a different manner to ensure safety is a kept key priority in all the changes that are being undertaken.
The Safety Cell, which is well represented with Executives, is reviewing safety on a weekly basis and ensuring, where necessary, Quality Equality Impact Assessments QEIA's) are being recorded and reviewed as services are impacted from the COVID-19 response.

The M12 Quality metrics are not highlighting any areas of concern. The COVID-19 preparations have seen additional Mortuary capacity and resilience put into place.

5. Next Steps

The planning round for 2020/21 has been suspended as a result of the Covid-19 pandemic with the financial plan being set for months 1-4 by NHSE. The recovery cell, that is being led by the Director of Transformation and Partnerships, as part of our major incident response, will oversee the development of business recovery with a new set of plans and trajectories to inform board. A significant analysis of the clinical impact assessment of the changes

made to respond to Covid-19 has been led by Dr John Lowes and will form part of the recovery plan.

A presentation of the contents of the recovery cell will be delivered to the Trust Board in private session.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Mortality Surveillance Scorecard			**Meeting date:** 29th April 2020
Report appendix	List any supplementary information as shown below: Appendix 1:		
Report sponsor	Medical Director		
Report author	Patient Safety and Experience Lead		
Report provenance	Data is taken from Hospital Episode Statistics and Dr Foster		
Purpose of the report and key issues for consideration/decision	The report provides a regular overview of mortality data. Standardised mortality rates remain within an acceptable range but are based on data from several months ago. The most recent unadjusted mortality data suggests a slight increase in total deaths in March 2020 which will require close observation.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors is asked to receive and note the report.		

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		**Risk score**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

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

Report title: Mortality Surveillance Score Card		Meeting date: 29/04/2020
Report sponsor	Medical Director	
Report author	Patient Safety and Experience Lead	

1.0 Introduction & Data Source

The indicators for this score card have been collated from a variety of data sources using defined methodology. The report is designed to give a top-level view of our bed-based mortality over time.

This report also includes Office for National Statistics (ONS) data.

The report also includes mortality cases reviewed via the Trusts Morbidity and Mortality form based on the Royal College of Physicians Structured Judgement Frame Work (SJF) looking at any lapses in care as well as good practice.

Data sourced includes data from the Trust, Department of Health (DH), ONS, and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group as well as local ISU governance groups.

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

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

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

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

Safety Indicator		Data Source	Target	RAG
Appendix 1 • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster 2016/17 benchmark Month DH SHMI data	Below the 100 line with an aim for a yearly HSMR ≤90	
Appendix 2 • Unadjusted Mortality rate - Including community mortality analysis		Trust Data ONS Data	Yearly Average ≤3%	3.06%
Appendix 3 • Dr Foster Alerts		Dr Foster	Zero alerts - CuSuM flags only	
Appendix 4 • Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	
Appendix 5 • Hospital Mortality		Trust Data Structured Judgement Framework M&M reviews		

2.0 Trust Wide Overview

The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at T&SDFT remain within the accepted range for our population and over a prolonged period.

That said, the cumulative HSMR, as reported in the data has risen above the 100 line but remains within expected limits.

ONS data has been included which shows deaths outside of hospital have increased during the coronavirus epidemic as against the same period in the prior years. Our in-hospital mortality has also shown an increase in the March data, which will need to be observed over the coming months.

Mortality from in-hospital Covid is being closely monitored and reported nationally.

3.0 Appendix 1 – Hospital Mortality

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

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

1A The HSMR is based on the *Diagnosis all* Groups using the Sept 19 monthly benchmark and analysed by Relative Risk - Trend / Month

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

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

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Chart 1 - HSMR by Month Jan 17 to Dec 19 (current month)
Chart one (as below) shows a longitudinal monthly view of HSMR. The latest month's data, Dec 2019, has a relative risk of **105.5** and whilst above the 100 line is still within the expected range

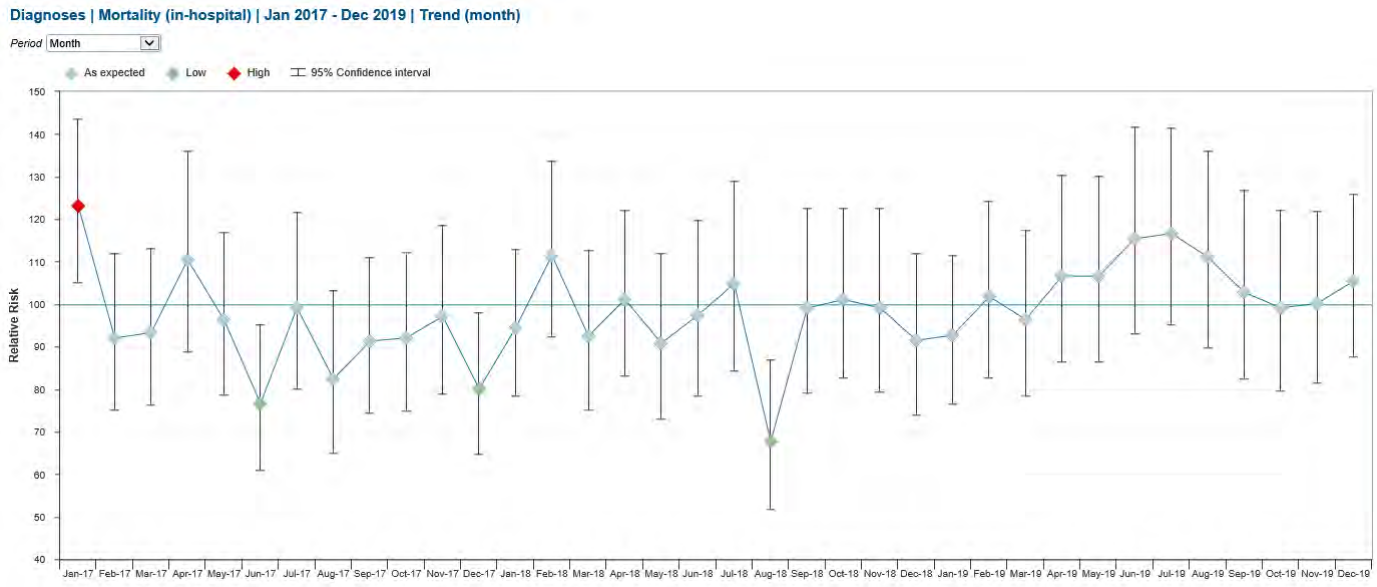


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly 12-month annual total is above the 100 line but below the standard deviation points which would signify an issue. This measure is being observed via the Mortality Surveillance group.

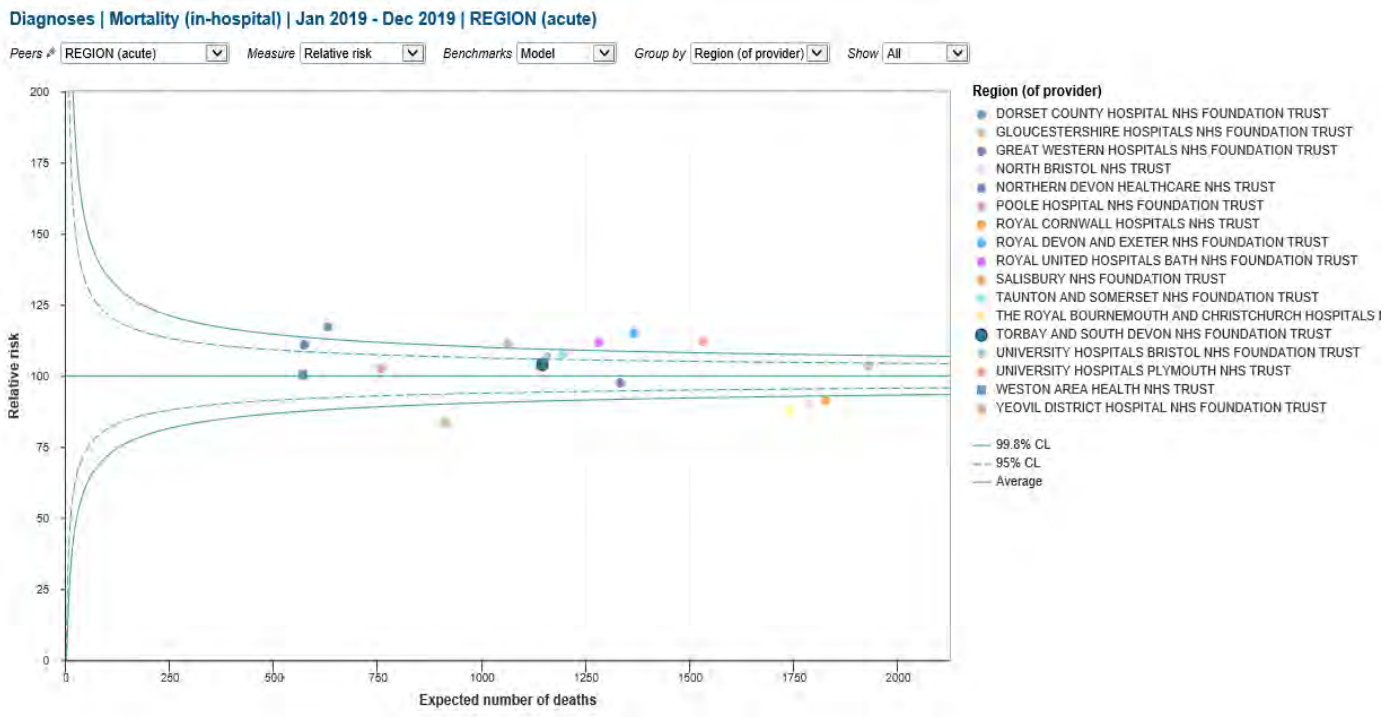
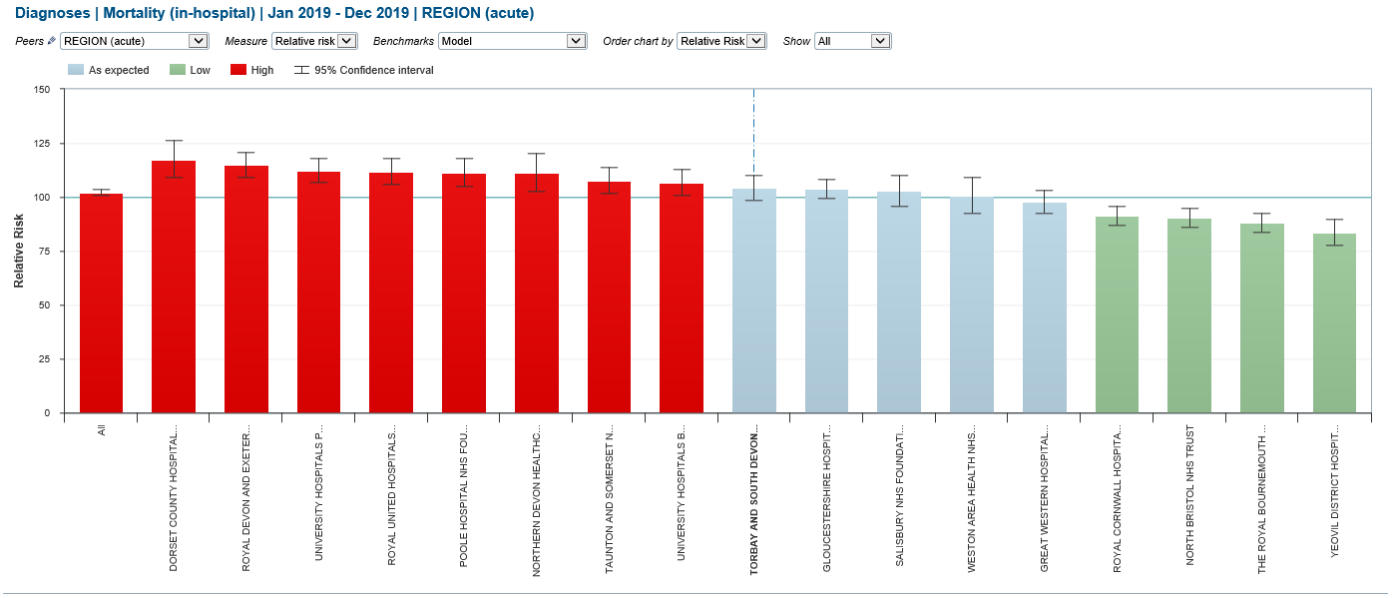


Chart 3 displays the above data as a Peer Comparison, ranked and as a bar chart. This is showing more local Trusts experiencing high HSMR's.



1B Summary Hospital Mortality Index (SHMI) Reporting Period Nov 2018 – Oct 2019

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective therefore, please note *the following data is based on the* **Nov 2018 – Oct 2019** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarterly periods with all data points within the expected range and trending over time at an average 90.

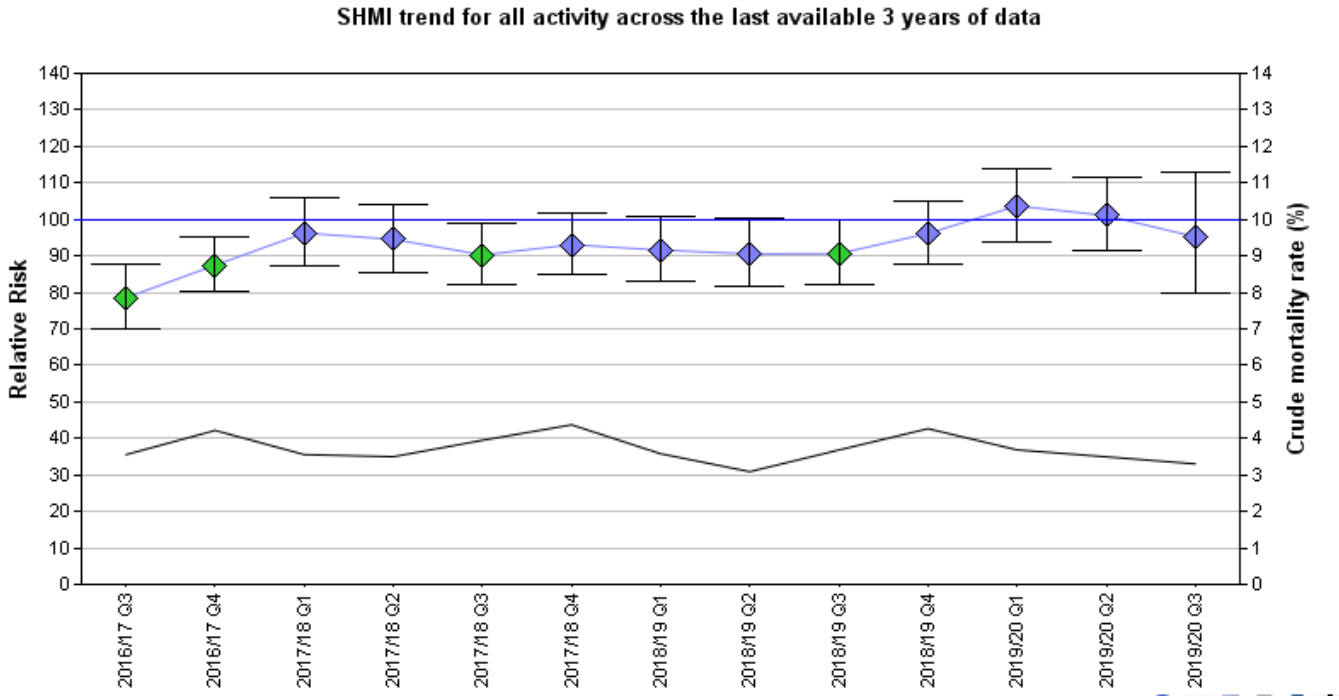
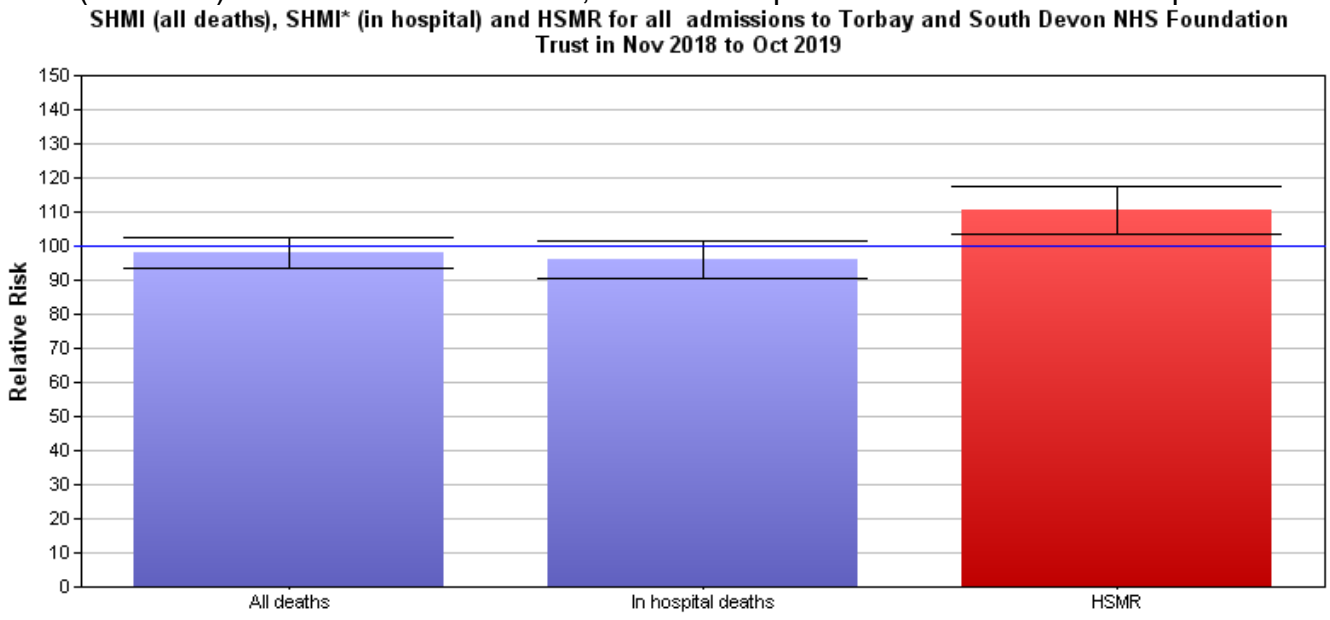


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison



The SHMI data within chart 5 are within expected range and show the in-hospital deaths at a very low relative risk. What this chart does highlight is the differential between HSMR and SHMI. The HSMR on this chart are highlight a risk in the Sept 18 – Aug 19 data. This is not evident in the HSMR analysis.

Chart 6, as below, expresses the 12-month rolling SHMI data by time period and is showing a SHMI below the 100 average.

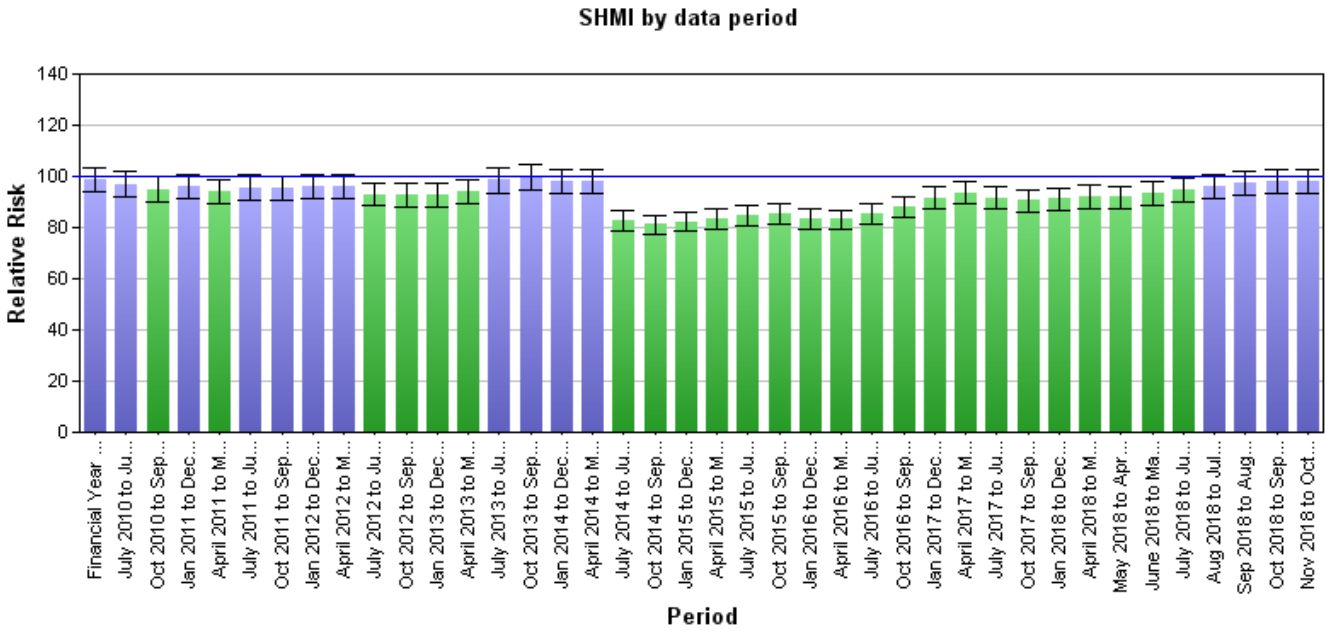
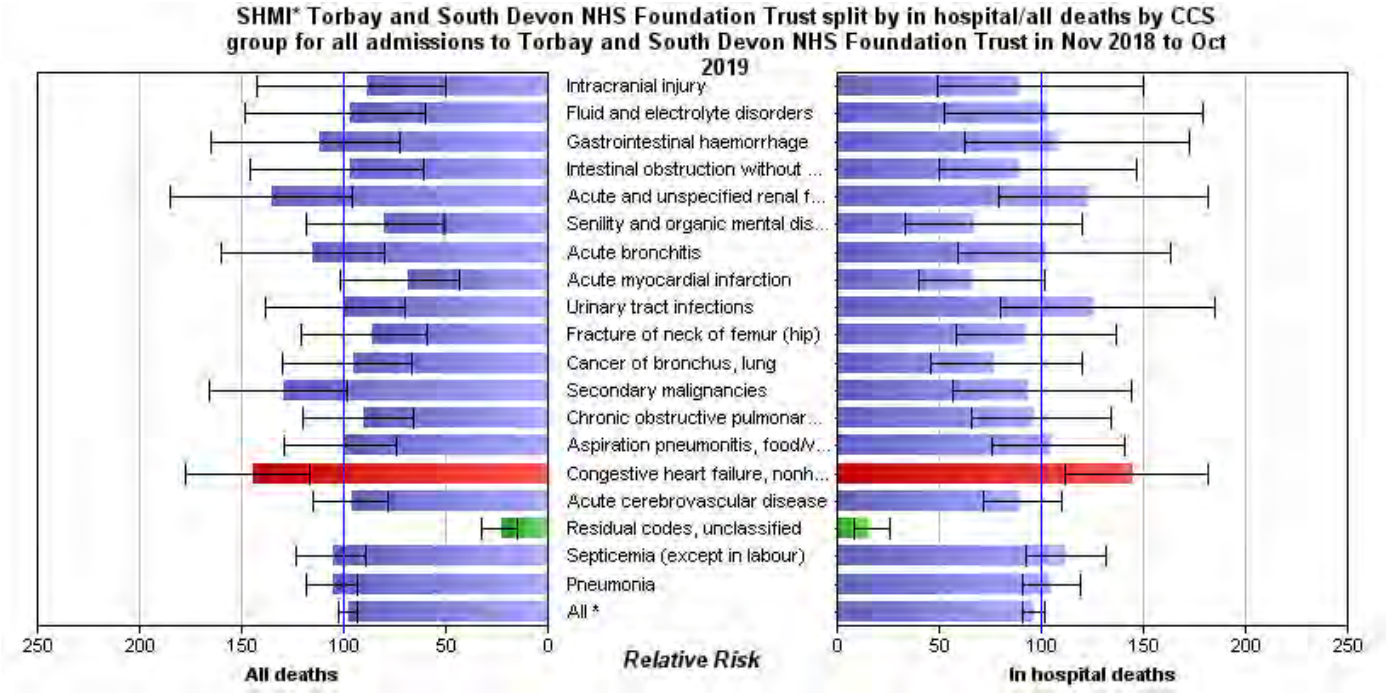


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Congestive cardiac failure. These areas have been discussed and Coding is working with information re the uploading of data and how this affects these alerts.



4.0 Appendix 2 – Unadjusted Mortality Rate

This data looks at the number of deaths in-hospitals and expresses this as an unadjusted death rate as a percentage, as well as by number and location across time

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

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 8, as below, highlights **t**he Trusts in hospital unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart shows the normal winter increase but also a rise in March. March's rise is partly explained by a reduction in activity due to covid changes. The following chart, which simply looks at 'number of deaths' is more helpful at this juncture.

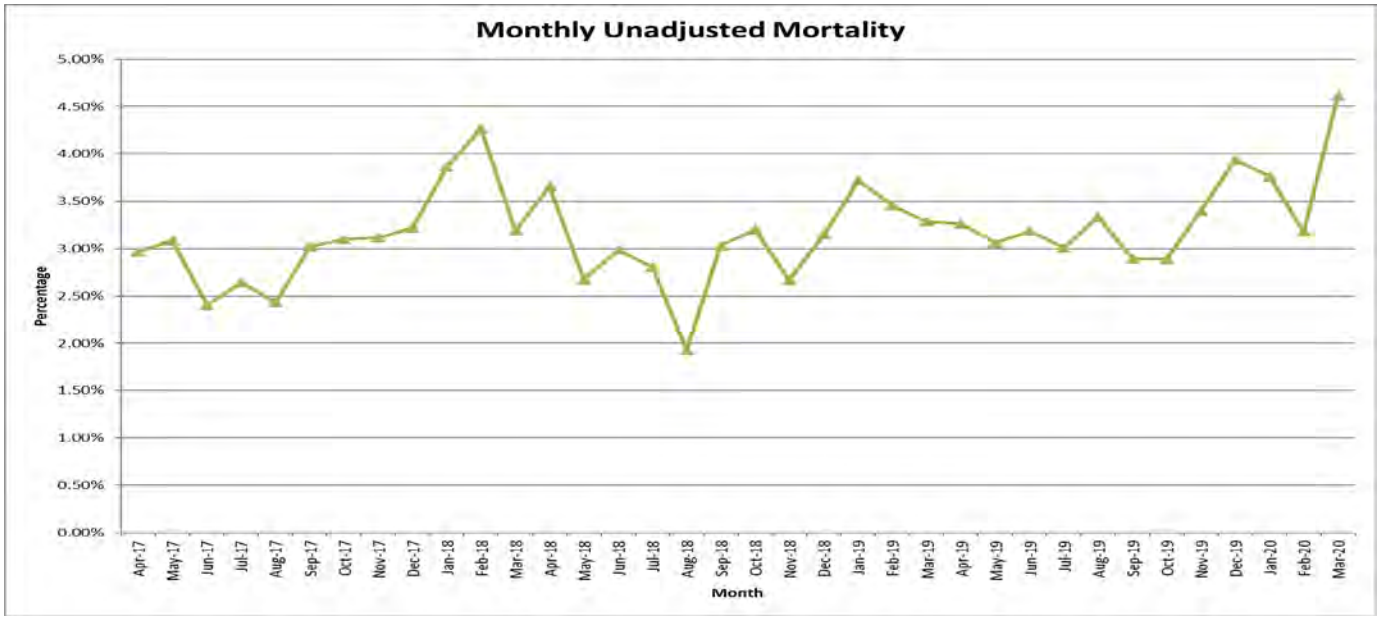


Chart 9 As below monthly hospital deaths by number – the blue shaded boxes show the winter peaks, with 19/20 showing a challenging Dec and Jan. The green shaded area shows the rise of the Corona virus pandemic with March recording its highest numbers over the three years shown. Whilst March recorded few corona deaths the following months will need to be observed closely.

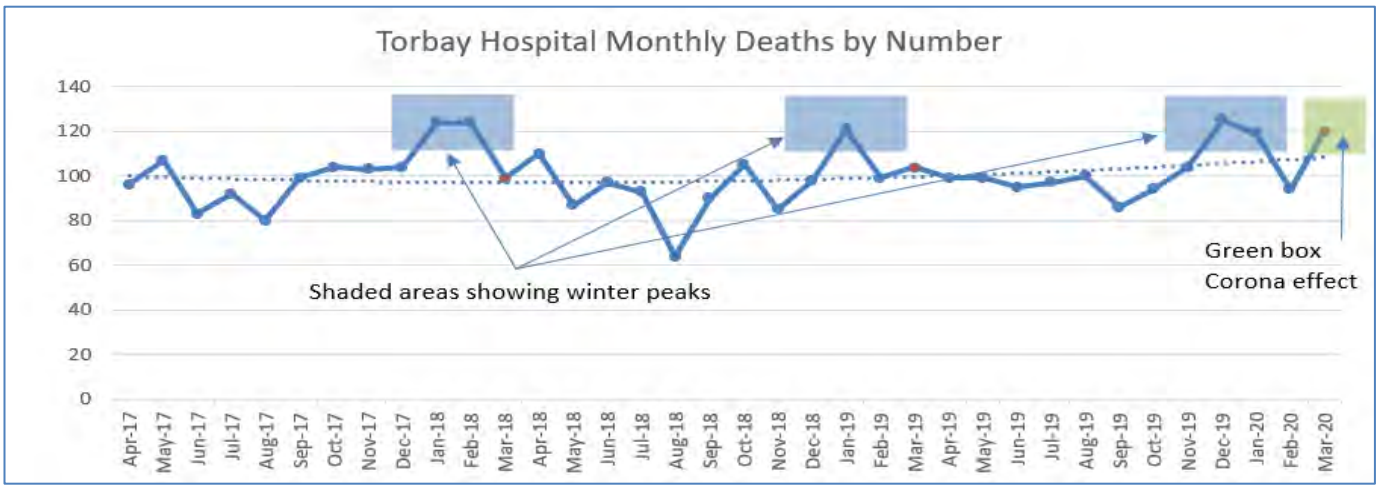


Chart 1, as below, records South West deaths outside of the hospital via the ONS. The data is weekly and shows a rise starting from the 27th March 2020 as compared to the prior year

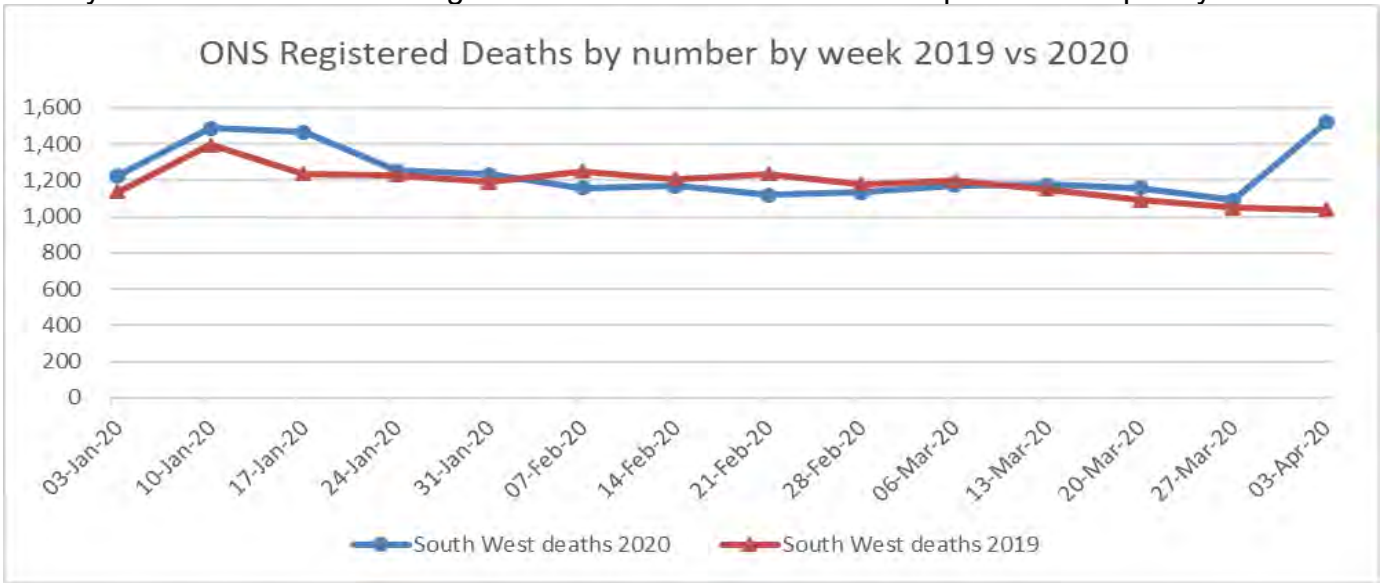


Table 2 – as overleaf, highlights mortality by ward by month over time

Ward/Month	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Sparkline
AINSLIE	4	0	1	1	2	1	4	3	3	2	2	1	2	1	0	1	2	4	1	1	5	2	3	1	5	
ALLERTON	6	10	6	4	5	3	4	4	3	6	0	4	7	4	8	4	5	4	3	9	3	7	10	6	6	
BRIXHAM	1	2	1	1	3	0	3	0	1	0	0	1	4	1	0	1	0	0	2	1	1	0	1	2	0	
CHEETHAM HILL	11	8	12	9	8	10	13	9	9	7	13	18	11	8	11	11	11	11	5	9	8	6	19	3	10	
CROMIE	9	2	2	2	3	1	1	2	3	6	1	2	5	4	4	5	2	2	4	4	5	6	3	2	3	
DART	0	3	1	1	3	1	2	1	2	2	2	2	5	0	3	1	1	1	2	2	2	1	1	0	3	
DAWLISH	3	3	4	4	1	0	0	1	1	5	6	3	3	3	2	0	0	5	2	4	0	2	6	4	0	
DUNLOP	7	5	3	8	3	6	7	2	6	3	6	5	4	7	5	5	4	3	5	7	5	9	8	2	10	
EAU3	4	9	6	7	10	5	7	5	0	3	12	5	5	8	1	6	10	13	8	6	7	6	5	6	7	
EAU4	11	12	2	7	6	3	7	8	8	8	6	5	5	7	6	8	8	8	3	5	15	11	6	8	13	
ELLA ROWCROFT	0	1	1	2	2	0	0	0	2	0	1	1	1	0	1	2	1	0	1	0	0	0	1	0	1	
FORREST	2	4	2	0	1	1	2	3	0	2	3	5	1	2	0	1	3	1	0	1	2	2	2	1	8	
GEORGE EARLE	14	6	16	9	10	7	9	13	11	16	17	12	11	11	8	12	9	5	10	7	14	16	14	12	11	
INTENSIVE CARE UNIT	6	10	8	6	8	5	8	13	6	4	9	6	6	10	10	9	11	11	10	7	10	11	9	8	6	
MIDGLEY	8	11	8	10	8	5	6	17	9	10	11	9	14	10	9	9	11	11	9	8	10	17	12	9	7	
SIMPSON	3	9	4	9	10	6	9	9	8	8	10	9	7	10	6	6	7	10	8	6	2	12	5	6	13	
TEIGN WARD	3	2	1	1	0	3	0	2	3	2	3	1	2	1	3	3	2	2	1	2	0	1	1	1	3	
TEMPLAR WARD	2	1	3	1	3	2	2	5	3	2	2	1	1	0	1	2	1	2	3	5	4	6	3	6	2	
TORBAY CORONARY CARE BEDS	1	3	1	2	2	0	2	2	0	1	3	0	2	1	1	2	0	0	1	1	4	1	0	2	4	
TURNER	3	9	5	13	5	5	3	6	5	10	8	6	2	8	9	5	7	6	7	7	6	8	6	8	5	
WARRINGTON	1	0	0	0	0	0	0	0	0	1	5	3	6	3	10	2	2	0	0	0	0	0	4	6	2	
Grand Total	99	110	87	97	93	64	89	105	83	98	120	99	104	99	98	95	97	99	85	92	103	124	119	93	119	

Table 2 –highlights mortality by location by month and is within the expected norms for each area

5.0 Appendix 3 - Dr Foster Alerts

Dr Foster utilises an alerting system, as below.
Triggers are raised when the expected number is exceeded by the actual number and Dr Foster also provides a guide should an alert occur. In the first instance the coding on each patient is looked at and amended as necessary, second to this is a notes review to confirm cause of death and coding. With the current dashboard, Pulmonary heart disease is being reviewed. Preliminary analysis does not show any areas of concern and a number of coding changes have been made.

Table 3

Relative risk & CUSUM alerts

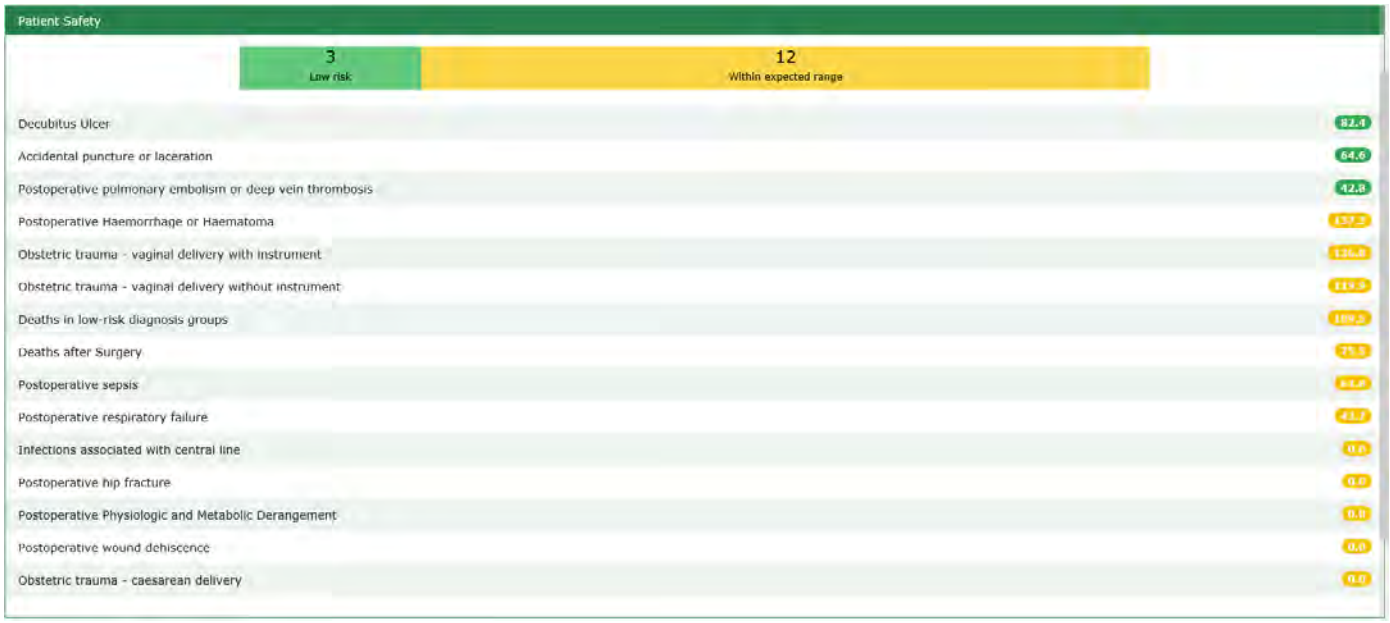
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	10	79286	1193	1147.4	1.5	104.0	
HSMR (56 diagnosis groups)		29977	1003	897.9	3.3	111.7	
Congestive heart failure, nonhypertensive		533	77	54.3	14.4	141.7	
Coronary atherosclerosis and other heart disease	1	884	15	6.3	1.7	236.6	
Essential hypertension	1	73	1	0.1	1.4	926.4	
Genitourinary congenital anomalies	1	29	1	0.0	3.4	3068.2	
Intestinal infection		743	18	9.4	2.4	192.0	
Menopausal disorders	1	59	1	0.0	1.7	4019.5	
Nonmalignant breast conditions	1	72	1	0.1	1.4	928.4	
Open wounds of head, neck, and trunk		195	5	1.5	2.6	325.6	
Other congenital anomalies	1	43	1	0.1	2.3	1015.8	
Other haematologic conditions	1	48	1	0.2	2.1	554.4	
Other perinatal conditions	1	275	4	2.0	1.5	204.4	
Peritonitis and intestinal abscess	1	29	5	3.5	17.2	141.4	
Pneumonia		1690	225	194.2	13.3	115.9	
Pulmonary heart disease	2	210	13	8.7	6.2	148.7	

6.0 Appendix 4 – Dr Foster Patient Safety Dashboard

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

The data was pulled on the 17th Apr 2020, 12 indicators are within the expected norm with 3 are in the low risk category

Table 4



8.0 Glossary of Terms

HSMR (Hospital Standardised Mortality Rate) - the case-mix adjusted mortality rate relative to the national average.

- **Relative Risk (RR)** - The ratio of the observed number of negative outcomes to the expected number of negative outcomes. The benchmark figure (usually the England average) is always 100; values greater than 100 represent performance worse than the benchmark, and values less than 100 represent performance better than the benchmark. This ratio should always be interpreted in the light of the accompanying confidence limits. All HSMR analyses use 95 % confidence limits.

CUSUM Alerts - CUSUM is short for ‘cumulative sum’. The charts show the cumulative sum of the differences between expected outcomes and actual outcomes over a series of patients. The total difference is recalculated for each new patient and plotted on a chart cumulatively (i.e. where one patient’s difference ends the next one starts). Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold. They indicate a series of events that have occurred that are sufficiently divergent from expectations as to suggest a systematic problem. Alerts are triggered when the CUSUM statistic passes through a set threshold. This is shown graphically on the charts by a black cross on the threshold. Once an alert has been triggered the chart is re-set to the mid-way point. This will mean that another run of negative outcomes compared with expected outcomes will trigger an alert in a shorter timescale. The threshold value determines when the CUSUM graph is deemed to be out-of-control (i.e. higher or lower than the benchmark). At this point an Alert is raised and the CUSUM value is reset to half the threshold. The value selected affects the probability that an Alert is a False alarm and the probability that a real alarm is successfully detected. A high threshold is less likely to trigger false alarms but is more likely to miss a genuine out-of-control condition, and vice versa for a low threshold. For example, if chosen "Maximum (99.9%)" the system will select the highest threshold which corresponds to a False Alarm Rate (FAR) that is less than or equal to 0.1% given the annual volume and

expected outcome rate of the analysis. With that threshold, only 0.1% of hospitals with in-control outcome rates (i.e. equal to the benchmark) will alert

Charlson Index of Comorbidities
Co-morbidity is assigned to the spell from assessing the secondary diagnoses codes, that are coded in the episode of care used to derive the primary diagnosis. In majority of cases this will be the first episode of care (on admission to hospital), however, where the primary diagnoses in the first episode of care is an R code, the system will look to the second episode of care to identify a clearer diagnosis, should one be available. In that case the secondary diagnoses of the second episode will be used. The Charlson Index of comorbidities is used both for the HSMR and the SHMI.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Education and Workforce Development Report – focus on Covid Response			Meeting date: 29 April 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Education & Workforce Development		
Report provenance	Education Team Leads Chief Nurse		
Purpose of the report and key issues for consideration/decision	• 6 monthly Board updates for information and assurance. • Current COVID-19 position and developments.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☒	**To approve** ☐
Recommendation	This report is for information and assurance only.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Education and Workforce Development 6-month report		Meeting date: 29 April 2020
Report sponsor	Chief Nurse	
Report author	Head of Education and Workforce Development	

1. Introduction

This is the 6 month Education Board report for Information and assurance. The focus of this report is on current COVID-19 deliverables and developments.

2. Discussion

2.1 Response and approaches to learning to support COVID-19

2.1.1 Use of Digital Technology

The initial response to COVID-19 was to stop all face to face training and new ways of delivering training have been developed at pace in order to respond to the training needs specific to COVID-19. Where possible training has moved to a complete digital format by using a range of technology available. This includes livestreaming, videos, E-learning, immersive VR, etc. Much of the production takes place in house, using the skills of the Digital Horizons Team. We are unique as a Trust to have these capabilities in house, for example we were the first Trust to produce online training for proning and have been approached by HEE to support their national livestreaming/digital learning agenda. In addition, a number of digital resources have been shared locally and nationally. This includes Moving and Manual Handling videos from UHP and Clinical Skills and Volunteers resources from HEE. The studio has been re-set up in the Horizon Centre (following its move to South Devon College) so we are able to produce content in house, including livestreaming, video and the daily Vlog. Although Education had already developed many online learning resources, COVID-19 has meant we have had to develop further and trial new ways of delivering education. This is proving very successful and we are continuing to review how we can develop this further.

2.1.2 Essential face to face training/blended learning

For some training a face to face element has to be maintained. For example, Resus, Moving and Manual Handling techniques and many clinical skills require a tactile element where you are required to see how a procedure is carried out physically in order to ensure staff are competent. This is particularly important for staff who are newly qualified or for non-clinical staff being reassigned in a clinical capacity. In these cases, a blended approach has been used to reduce the face to face element, by moving all theory to online resources. Online follow ups can be requested by staff and Q&A sessions provided for continued learning. Face to face training where possible is delivered via MS Teams, where clinical trainers can still interact with participants. This has proved very successful for some of our upskilling and induction programmes. Where physical presence is still required in part, we are using larger teaching spaces/rooms and much smaller groups sizes (4-5 staff) or delivering in one to one scenario.

2.1.3 Education Staff reassignment

Many staff from Education have been reassigned as per pandemic plans, including to the Communications Team, Recruitment, Project work e.g. public donations and clinical role re-deployment e.g. ED and ICU. Although most clinical trainers have had to continue in education to support the upskilling training demand. We have also reassigned staff across educational services, for example admin staff have trained to deliver mask fit training. Training and reassignment demand is reviewed daily and capacity realigned as required. We have had to be more flexible than ever, responding to the daily (sometimes hourly) changes in demand or practice (like everyone else). This is something that has felt out of many people's comfort zone, but that they have responded to in amazing ways, constantly shifting focus and thinking of new ways of working.

2.1.3 7-day Education Services

A number of education services are now running across 7 days in response to COVID-19. This includes:-

- A Mask fit testing/training 7 day rota for the provision of urgent/priority mask fit training.
- Upskilling programmes to meet the potential increased demand for staff required to support COVID-19. The clinical trainers have been running a 7-day rota to ensure this can be covered when required.
- A rota system has also been set up to provide 7-day cover of the studio for the Executive daily Vlog and Livestreaming requirements.

2.1.4 Other COVID-19 initiatives supported by Education

Education have supported a wide range of COVID-19 activity, here are some other examples:

We have re-purposed and now utilised 6 of our Education based ipads for patient/relative contact – 2 x Forrest, 2 x Cromie and 2 x Allerton. We also re-purposed 6 of our iphones (previously used for VR training) to enable internal staff communication amongst ICU teams.

Nick Peres is working with David Alderson to set up a remote arts and creativity group as part of the HeArTs programme, using Zoom and MS Teams to help with the current wellbeing agenda for staff.

The simulation team helped set up the wellbeing hub in Bayview, sourcing massage chairs and VR headsets.

We are working with one of the face visor team (Shan) a local resident to help supply other bits for the face masks which we have limited stock for (little connectors) and set up the 3d printers in the simulation room so we are able to prototype other parts - for instance we 3D printed a valve last week.

2.2 Summary of the COVID-19 Education and Training

2.2.1 HIVE COVID-19 page and reporting

The Hive contains all current COVID-19 related training and educational resources in one central place for staff. Here, staff can book direct on to training and access all the online training and resources available to support them. The link to these resources is available via the main COVID-19 Icon page and is continually being updated as more resources are developed in house and launched nationally, e.g. from HEE. Resources include national best practice guidance, for example PPE and Infection control advice from Public Health England. Here is a snap shot of the COVID-19 homepage:

We have been providing daily Sitrep reports for staff booking on to the upskilling programmes, which is provided to Silver command and kept on Icon. We have also developed reporting for Mask fit training, including information on mask type.

2.2.2 Upskilling programmes

Education are providing a full range of generic skills programmes and resources for staff who are required to upskill or refresh skills to support reassignment and for staff who are looking after patients with conditions they have not been exposed to before. This includes –

- Non-clinical support staff moving in to a clinical support role.
- Allied Health Professional staff upskilling to undertake nursing roles/tasks (Acute and Community).
- Non-clinical support staff (corporate) upskilling to undertake ward clerk roles/tasks.
- Clinical staff refresher courses for staff undertaking roles/tasks they are out of date with.

- Bespoke education and training for staff who require more specific training.
- Simulation support for more specialised training, e.g. Proning and ventilation.
- Learning resources for Staff Involved in Nursing Care to support them in the management of patients with COVID-19 and acute medical conditions.
- Rapid Response Community upskilling programme.
- Resuscitation upskilling course as a refresher for existing staff.

2.2.3 New staff joining the organisation

We have developed bespoke Induction programmes for new staff who are joining the organisation, whether this is for a substantive role or short-term role to support COVID-19. This includes:

- Newly registered nurses and doctors – including those joining the temporary register early to support COVID-19.
- Doctors and Nurses returning to practice to support COVID-19.
- Healthcare Assistant (HCA) Clinical Induction.
- Veterinary and Dental professionals supporting the organisation.
- Any education required to support Volunteers in addition to existing resources.

In addition, we have also developed bespoke Preceptorship including online group support sessions via MS Teams and online resources for all newly qualified staff.

2.3 Challenges and proposed solutions

2.3.1 Mandatory compliance rates

One of the main concerns is the impact of stopping face to face mandatory training has on compliance figures. Elements of Resus, Moving and Manual Handling and Conflict Resolution have to be delivered face to face. The overall compliance figures for the end of March were 90.44% and with an organisational target of 85% so there has been some capacity for a slight reduction in the overall rate. To avoid impacting compliance figures we would want to re-introduce the essential face to face training as soon as possible (please see next section) utilising some of the techniques we have started using during COVID-19 and ensuring compliance with social distancing etc. avoiding bringing people together where possible.

2.3.2 Perceived demand for upskilling versus actual

Up until now we have been planning for worse case predictions around the amount of COVID-19 positive patients and high numbers of staff required for reassignment. Hundreds of upskilling places were provided for training with only 50% of the initial demand being filled. As a result, we have reduced some of our upskilling programme places and this will free up capacity to reinstate some business as usual. Clarification is needed in regards to what reassignment roles/tasks are required so education can respond more accurately to demand and it has been suggested the resourcing hub could help with this.

2.3.3 Impact on staff who are reassigned

From feedback received from staff attending the upskilling programmes, there has been a lack of engagement and management support for staff who are being asked to be reassigned. Many of these staff have been very distressed when attending training with 50% or more of the session time been taken up by the trainers having to provide pastoral and wellbeing support. Some suggestions have been sent to the Workforce team including OD attendance at training for support and clarification of support for staff being reassigned.

2.3.4 Horizon Centre usage

The Horizon Centre has been in high demand with many requests for relocation of staff/services from 'red' areas from different sources. All requests are now referred back to Estates via the EFM Support Cell. The Medical Secretaries who were relocated are not social distance complaint and this is being reviewed by Estates. The Centre is also being used for medical devices equipment storage. The café is already closed and is being used as an additional storage space. We continue not to accept bookings for meetings as any capacity in the building will be prioritised initially to our HEE commissioned programmes being reinstated and Mandatory training. We have been recommending people continue to use MS teams for meetings, but this could continue as the norm to assist with future capacity in the building with new commissioned programmes due to start this September.

2.4 Future and next steps

2.4.1 E-Induction

We are in the process of developing this week an E-Induction for new staff joining the organisation. We will be using a similar format to the existing Trainee Doctor E-Induction package, which includes a combination of video, E-learning and written material via the Hive to support staff joining the organisation and reduce the face to face training required.

2.4.2 Returning to Business as Usual

We are starting to plan a staggered approach to reintroducing education business as usual. For many of our programmes we will continue to use a blended approach to learning, utilising the technology we have been using in response to COVID-19. For any essential face to face elements we would need to review what capacity there is to deliver this within the Horizon Centre which is currently being utilised for COVID-19 purposes.

Phase 1 is proposed as follows (from May) – *Please note plans are still being developed.*

Resus	To ensure compliance rates are maintained. Will be maintaining blended approach as developed for COVID-19. Some equipment has been loaned elsewhere in the organisation to support COVID-19 so this would need to be reinstated or more equipment bought. Places would be limited and have to be prioritised.
Moving and Manual Handling	To ensure compliance rates are maintained. Compliance had dropped slightly at the end of March to 81%. We will be maintaining a blended approach as developed for COVID-19. Places would be limited and have to be prioritised.
Maths test for newly qualified nurses	Continue as planned for next week but move to online once the current cohort is complete. This will be more efficient for future recruitment.
Trainee Assistant Practitioner Programme	Start up again in May for existing TAP's to ensure learners are ready for their assessments in August and subsequently ready to start work.
Corporate Induction	This will be reinstated from May and 100% online.

2.4.3 HEE Commissioned Programmes, Apprenticeships and CPD

A number of our current programmes commissioned by HEE would need reinstating between September 2020 and January 2021. We would need to confirm the Universities position in relation to medical training, but a draft plan has been proposed for nursing. We will also need to introduce the process for using the funded CPD for nurses as the first payment is due in Q1. We are currently liaising with other Trusts and HEE to agree the best approach. Most apprenticeships have continued through COVID-19 up to now and we would recommend we continue with new apprenticeship recruitment as planned from September onwards e.g. Advanced Care Practitioners.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance Safety Report (1 January – 31 March 2020).			Meeting date: 29 April 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity System (LMS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the membership of the Trust Board of the work being undertaken by the Maternity Governance Group. An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board. The Trust Board is asked to receive and note the report and the programme of work described.		
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 and to support the process of review of the reports on a quarterly basis.		

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	N	**Risk score**	
Risk Register	N	**Risk score**	

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

Report title: Maternity Governance Safety Report		**Meeting date:** 29 April 2020
Report sponsor	Chief Nurse	
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife	

1.0 Introduction

Torbay and South Devon Foundation Trust have various initiatives to improve the safety, care and experience of families using maternity services. As part of this governance approach maternity services, along with Neonatal and Paediatric services have robust processes in place to review and report mortality and morbidity.

The implementation of the third year of the Clinical Negligence Scheme for Trusts (CNST) supports the delivery of safer maternity care. The maternity incentive scheme applies to all trusts that deliver maternity services and are members of CNST. The scheme incentivises the implementation and evidencing of 10 key safety actions. For year 3, as with Years 1 & 2, the Board are required to have oversight of the actions and sign off that these have been implemented by the final submission date of the 17 September 2020.

Trusts that can demonstrate that they have achieved all of the ten safety actions will be eligible for a rebate on their maternity CNST contributions and will also receive a share of any unallocated funds.

In order for the Board to be sighted on progress and achievements, the maternity service provide a quarterly report to the Board. In addition, the maternity safety champions meet bi-monthly with the Executive Board Safety Champion, the Chief Nurse. This quarterly report will look back at the period 1 January 2020 – 31 March 2020.

NOTE: Due to the current COVID-19 NHS response, NHS Resolution have taken the decision to suspend the submission of the Year 3 CNST standards. However have encouraged maternity providers to continue to work towards the achieving the standards.

2.0 Review and monitoring of safety within maternity services?

2.1 Safety Improvement

The maternity and neonatal services continue to work on the Maternity and Neonatal Health Safety Improvement Programme. The local team have attended national and local learning events to support their project and improve their knowledge around quality improvement strategies. As well as continuing with the “Keeping Babies Warm” project, the QI methodology is now being used as part of normal practice in managing safety improvement and sharing learning. The local team are monitoring the results of their projects and in particular the documentation of the baby’s temperature within an hour of birth.

Following on from the results of the SCORE culture survey and to help improve communication the clinical teams are now using the strategy of sharing learning “**5 ways 5 times”.** This mean any safety message is communicated to all staff across

different methods, e.g. Email, WhatsApp, Facebook, verbally at handover and the displaying of posters in the clinic and staff areas.

Other safety improvement work is the adoption of an established quality improvement programme aiming to reduce harm and variability in the management of postpartum haemorrhage. The principles of the OBS CYMRU, Obstetric Bleeding Strategy for Wales are being followed by a local team including obstetricians, anaesthetists, midwives, hospital transfusion team, theatres and laboratory teams are working on the project with the aim to reduce harm associated with Postpartum Haemorrhage (PPH). The principles of QI are being used to adopt the principles.

2.2 Mortality and Morbidity

2.2.1 Perinatal Mortality Review Tool (PMRT)

The PMRT tool is now embedded in practice following its introduction in 2018. It has been used at the local multi-disciplinary case reviews to inform the reviews. There are clear reporting timescales. Unfortunately we were not able to achieve this in one case from the previous reporting period due to a 17+ week delay in receiving the Postmortem results. We have since learned that in these situations the PMRT can be completed and then re-opened to input the Postmortem results.

An additional standard is that there should be at least two obstetricians and two midwives present for each review. Locally we have been able to achieve this. We often have additional midwives and medical staff participate as we undertake the reviews as part of the junior medical staff teaching sessions.

During this reporting period, we had 2 stillbirths, these were babies who were born with no signs of life. Duty of candour was undertaken and both families were asked if they had any questions that they would like be included within the review of the care provided.

2.2.2 Healthcare Safety Investigation Branch (HSIB)

HSIB continue to investigate births and Maternal deaths that meet their referral criteria. In March 2020 HSIB informed Trusts that they would no longer routinely investigate maternity events involving cooled babies where there is no apparent neurological injury confirmed following therapy due to the current COVID-19 NHS response.

In the reporting timescale of January - March 2020 we had no cases that met the criteria. During this time period we received a final report from a case referred in February 2019. An action plan is in the process of being developed that considers the HSIB recommendations.

2.2.3 NHS Resolution

During the reporting period, the Trust has had no cases to report to the NHS resolution team as part of the Early Notification Scheme (ENS).

2.2.4 Saving Babies' Lives Care Bundle

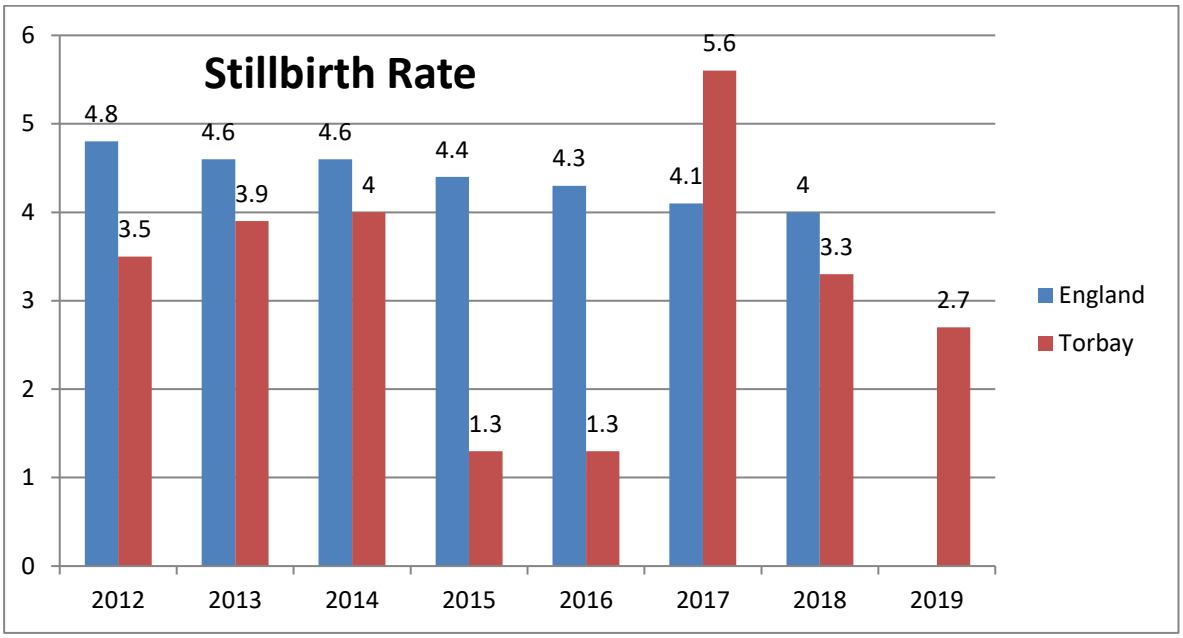
Saving Babies Lives Care Bundle Version 2 (SBLCB v2) was launched in March 2019. This builds on the existing bundle, but adds a fifth element (preventing preterm labour) for implementation. Initially there was an expectation that all elements will be

implemented by 31 March 2020 and the maternity team completed a benchmarking exercise and developed an action plan. A revised implementation timeline was produced with implementation by August 2020.
Following the benchmarking exercise, it was identified that it would not be possible to implement all aspects of the bundle without investment. The resources required will be additional Consultant Obstetric PAs, 0.4wte Band 7 Midwife and additional sonography capacity. Business cases have been developed and submitted.

Regular flash reports, completion of quarterly surveys and meetings are in place to support implementation of the action plan with the aim for full compliance by end of July 2020. This is monitored through our Maternity Governance meeting. In light of current circumstances, the SBLCB Version 2 tracker survey is being paused until further notice.

One of the aims of SBLCB v1 and v2 is to reduce the number of still birth. Our 2019 annual data is now available and has shown that the still birth rate has reduced at TSD for the 2nd year in a row. This is shown in Table 1 (Note: national comparative data is not yet available for 2018 & 2019)

Table 1: Annual Stillbirth Rate



2.2.5 Avoiding Term Admissions into Neonatal Units – ATAIN

There is ongoing collaborative work between the Maternity Service and Child Health in relation to ATAIN. The trust continues to report data to the ATAIN programme on a quarterly basis and has an ongoing action plan. ATAIN is a CNST key safety action, with progress against the action plan being shared with the Board Level Champion.

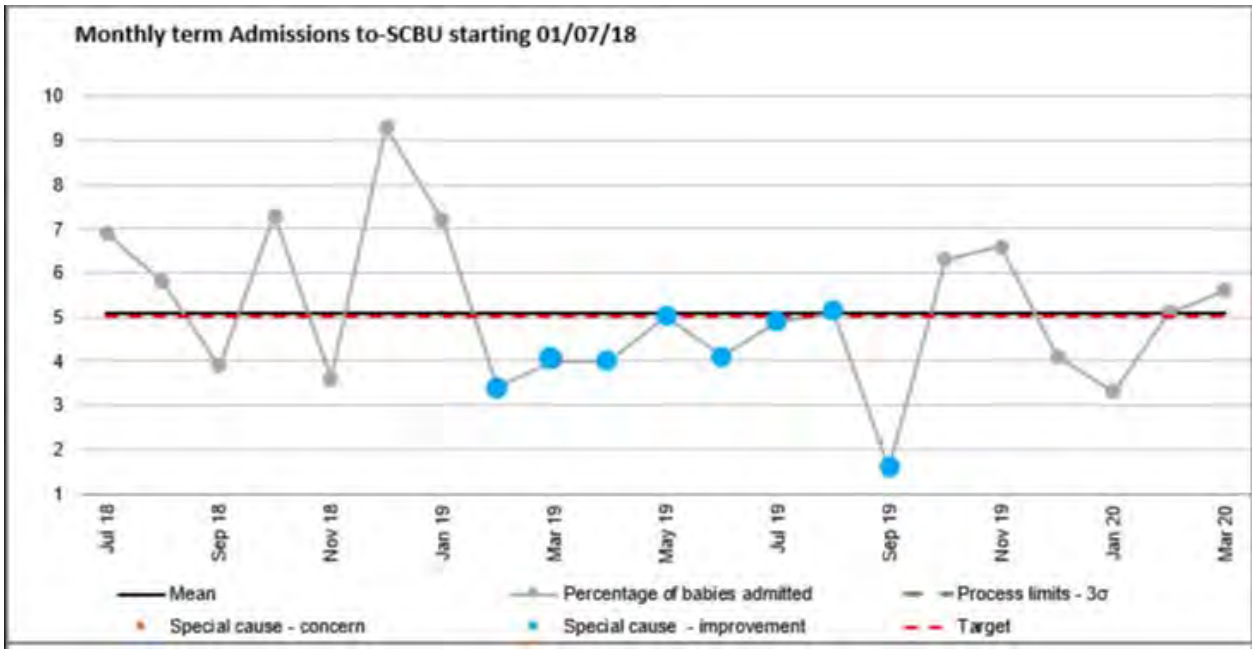
For this reporting period, 4.6% of term births were admitted to the Special Care Baby Unit. This is a decrease from the last reporting period and is under the target of 5% or less. For the year 2019/2020, 4.8% of term births were admitted to Special Care, which remains within the target figure.

See table 2 for monthly term admission to SCBU rate.

As a service we are at the limits of what we can achieve in relation to this important safety and quality action. This is due to space and capacity issues within the clinical area. The estates strategy for the Women's Health Unit, which has been approved but

is awaiting allocation of capital funding, includes provision of bespoke Transitional Care Facilities. This would enable us to continue our improvement journey to support the on-going care of babies with additional needs, but not requiring SCBU and ensuring mothers and babies are not separated.

Table 2 for Monthly Term Admission to SCBU Rate



2.2.6 Maternity Safety Champions

The Trust have two designated Safety Champions (a midwife and an obstetrician) within the Maternity Service who liaise regularly with the Board Level Safety Champion, which meets the CNST requirements. In addition, there is also a designated neonatal safety champion. Bi-monthly meetings for the year 2020 have been arranged between the Safety Champions and the Board Level Safety Champion.

Due to the current changes in National requirements of maternity services, the standards set out in Year 3 of CNST have been deferred. All processes are in place to resume the safety actions, once the COVID-19 response is stood down. However the safety champions continue to ensure safety activities continue and ensure that the Board Champion is regularly updated in relation to any safety concerns.

3.0 CNST: 10 Key Safety Actions

NHSR published the expected safety actions for year 3 of the maternity incentive scheme on 20 December 2019. Achievement of all 10 of the safety actions will result in a rebate of part of the CNST contribution to the Trust. There have been significant changes to the standards. For year 3, as with Years 1 & 2, the Board are required to have oversight of the actions and sign off that these have been implemented by the final submission date of the 17 September 2020.

Due to the current COVID-19 NHS response, NHS Resolution have taken the decision to suspend the submission of the Year 3 CNST standards. However have encouraged maternity providers to continue to work towards the achieving the standards.

The team continue to work towards achievement of the safety standards as they recognise the important role these standards play in improving safety within maternity

services. However, it has been previously noted that to fully achieve the standards, there will be a requirement for additional resource. Business cases have been developed and submitted to support achievement of the safety actions.

4.0 COVID-19

Maternity services have been identified as a priority service during the COVID-19 pandemic. As such, in March 2020, the maternity service in conjunction with the Trust developed a plan to support the continued provision of a safe maternity service. Any alterations to service provision meets guidance from Public Health England, and from the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives. The maternity plan has been developed in conjunction with anaesthetic, paediatric and infection prevention and control colleagues. This is reviewed on a weekly basis as a minimum and updated as indicated. Daily team 'huddles' were implemented to develop the plan, identify issues, agree team communication and provide support to each other. These were then reduced to 2-3 times a week as the plan was completed and embedded.

Staffing levels are being closely monitored and are currently at sustainable levels for midwifery. However the obstetric staffing levels could be destabilised. Planning at a Devon LMS level is being undertaken to ensure that resilience is maintained for obstetric staffing.

The clinical teams have been using Microsoft Teams to ensure that we are able to meet safely. This has been used effectively to maintain our governance structure and hold virtual meetings to ensure governance and risk continues to be reviewed and monitored.

5.0 Conclusion

The drive to improve safety in maternity services is a key part of the NHS Long Term Plan. Despite the challenges presented by the COVID-9 pandemic, the team are committed to ensuring the provision of a safe maternity service and continue to ensure that systems are in place to provide assurance.

There is still a requirement for investment by the Trust to fully implement and meet the 10 Key Safety Actions.

6.0 Recommendations

The Trust Board is asked to monitor the safety actions required by the CNST maternity incentive scheme, acting on new recommendations or actions as they arise or are completed.

FPDC

Parking Lot **To be reviewed: 27 April meeting**

Item action/issue/policy name	Date raised	Comment
Agenda Items deferred from 24 March		
Teignmouth Health and Well Being Centre		Activity ceased owing to Covid
STP long term planning		Activity ceased owing to Covid
2020/21 Annual plan		Activity ceased owing to Covid in accordance with national guidance
CIP plans		Activity ceased owing to Covid
Digital Strategy		Deferred
Actions to be deferred from 27 April		
Review of Health and wellbeing centre strategy		Activity ceased owing to Covid
Dartmouth Health and Well Being Centre – stage 1		Activity ceased owing to Covid
Children & Family Health Devon – draft report template for approval		Activity ceased owing to Covid & COO absence

Agenda items to be deferred from 27 April		
PIR schedule		Activity ceased owing to Covid – to review post-Covid

Committee/Group Name – People Committee – Proposed agenda items for 27 April 2020 meeting

Item action/issue/policy name	Date raised	Comment
Medical Workforce Group	27th April 2020	Defer to June 2020 – no meeting update
Non-Medical Workforce Group	27th April 2020	Defer to June 2020 – no meeting update
Equality Business Forum	27th April 2020	Defer to June 2020 – no meeting update
Temporary Staffing and Agency Group	27th April 2020	Defer to June 2020 – no meeting update
JLNC	27th April 2020	Extraordinary meeting scheduled for 23rd April 2020. Verbal update to be provided

Torbay and South Devon NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Safer Staffing and Nursing Work Programme Update			Meeting date: 29 April 2020
Report appendix	None		
Report sponsor	Chief Nurse and Deputy Chief Executive		
Report author	System Director of Nursing and Professional Practice – South Devon		
Report provenance	Executive Directors Quality Improvement Group		
Purpose of the report and key issues for consideration/decision	This is the monthly safer staffing report as required by the Chief Nursing Officer NHSE.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Note the contents		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Safer staffing and nursing work programme update		Meeting date: 29 April 2020
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. The information supplied and triangulated is for February and March 2020. This report will also reflect the safe staffing element during the commencement of COVID19.

2. Discussion

2.1 COVID 19 Staffing

The coronavirus, which causes the respiratory disease known as Covid-19, was first confirmed in the UK at the end of January 2020. While a number of people tested positive throughout February and in Torbay this was around week of the 24th February. However, infections in the UK bean to rise substantially towards the end of March.

2.1.2 During March the Trust operationalised the control and command function of a major incident, as part of this several workstream cells were then set up, these included;

- Clinical Operational Cell – which were the Trusts tactical COVID response plans, Care at home, Quality and clinical activity,
- Silver Staffing – set up of the staffing element of the workforce cell, swabbing set up,
- Workforce Cell – resourcing hub including recruitment, temporary staffing and reassignment, staff health and wellbeing, workforce planning and reporting
- Support Services Cell – procurement, PPE, estates and facilitates
- Safety Cell – reviewing all incidents, complaints, guidance related to quality reporting

2.1.3 As national guidance in relation to COVID was received, referenced upon and operationally implemented as part of the tactical COVID surge response, each element was considered in view of the staffing model that followed.

2.1.3.1 The national guidance identified that all category 4 and 5 elective activity were to be stood down, this presented a number of staffing groups available to be reassigned and they have been locally reassigned, or fall into a number of categories which includes shielding (which means that they are not able to be at work for 12 weeks).

2.1.3.2 ITU surge capacity identified a need for Red and Green areas, as well as increasing bed capacity, as part of this the national recommendations included requiring; **A** =-previous ICU experience **B** = no experience **C** = other Registered professionals.

Surge bed capacity	Ratio: Critical Care/ Bed-patient
9 (establishment)	1:1
14	1:1
21	1:2
29	1:3
36	1:6
46	1:6

Staff from reduced surgical activity were reassigned locally to upskill (with an educational package and shadow shifts) into one of the three categories During February and March ITU has maintained at less than their establishment bed numbers both in Green and Red ITU areas.

2.1.3.3 ED Surge plans include a Red and Green ED and therefore have expanded into the day case area – this has meant an increase in staffing requirement, a total of 26wte Registered nurses and health care assistants have been locally reassigned from reduced activity, again a supported framework of education upskilling and shadow shifts have been concluded

2.1.3.4 The level 2 outpatients area has been transformed temporarily to a RED Covid triage and discharge lounge, staff have been locally reassigned

2.1.3.5 Tower block (Cromie ward, Forrest ward, Allerton ward, and Hutchings) has been utilised as the COVID-19 ward areas whilst surgery activity is reduced; staffing for this area has been maintained by the current staffing levels; Forrest and Midgely staff have swapped due to Forrest being the area utilised for COVID-19 Non-Invasive Therapy. Staffing numbers are as per recommended nationally.

Ward	Bed utilisation	Staffing numbers
Allerton usually 29 beds	Using 28 beds – has 8 side rooms and using bed space for donning and doffing	LD X4 RGN x4 HCA ND x2 RGN x2 HCA
Cromie usually 26 beds – x2 being used for donning and doffing	24 - 7 of which side rooms being used for screens awaiting swab results	LD X4 RGN x4 HCA ND x2 RGN x2 HCA
Forrest usually 25 beds	x1 side room being used for doffing – has x 9 side-rooms	LD 5 RGN x 4 HCA ND 2 RGN X 2 HCA
Hutchings outpatients	22 beds	LD X4 RGN x4 HCA ND x2 RGN x2 HCA

LD = long day
ND = night duty

2.1.3.6 Hutchings ward has been configured to receive end of life patients with a staffing ratio of 1:10 RN to patient ratio, this follows the national guidance of end of life care.

2.1.3.7 All community hospitals have provided a surge plan for escalation of bed capacity, the staffing – patient ratio follows the national guidance of 1:10.

2.1.4 The national announcement that registered nurses and midwives who have retired or have not been on the nursing and midwifery council (NMC) for the last three years, have been asked to volunteer themselves to be accepted temporarily on a register. This is being managed regionally and at present we have 9 Registered nurses who we are welcoming back into the Trust.

2.1.5 Year 3 Student nurses who fulfil a specific criterion are also able to be registered onto the NMC register, as yet we do not have receipt of these numbers. Alongside our Year 3 students we have those Year 3 students who do not wish to be on a register but are being placed onto paid voluntary and will be working as a Band 4 Nursing Associate/Assistant Practitioner, these students will still fulfil the criteria of a year 3 student and will require supervision as per normal guidance.

2.1.6 We are still awaiting final confirmation from the national teams and NMC regarding our overseas nurses who will be able to join a temporary register and practice as a registered nurse.

2.1.7 As we continue within the current COVID-19 situation the continued monitoring and reporting there is we are assured that there is nursing and midwifery safe staffing in all inpatient areas within the Trust.

2.2 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. This month sees the changes nationally that now includes allied health care professionals and qualified nursing associates if they provide direct patient care as part of ward establishments, at present Torbay and South Devon NHS Foundation Trust does not include allied health care professionals and qualified nursing associates.

Currently during COVID-19 the national reporting and collation of data was stood down towards the end of March, however they were able to complete this and we are currently still capturing this information locally

The model hospital dashboard was updated in December 2019 to show the national median data remains at 7.7 Total: i.e 3.6 RN & 4.1 HCA.

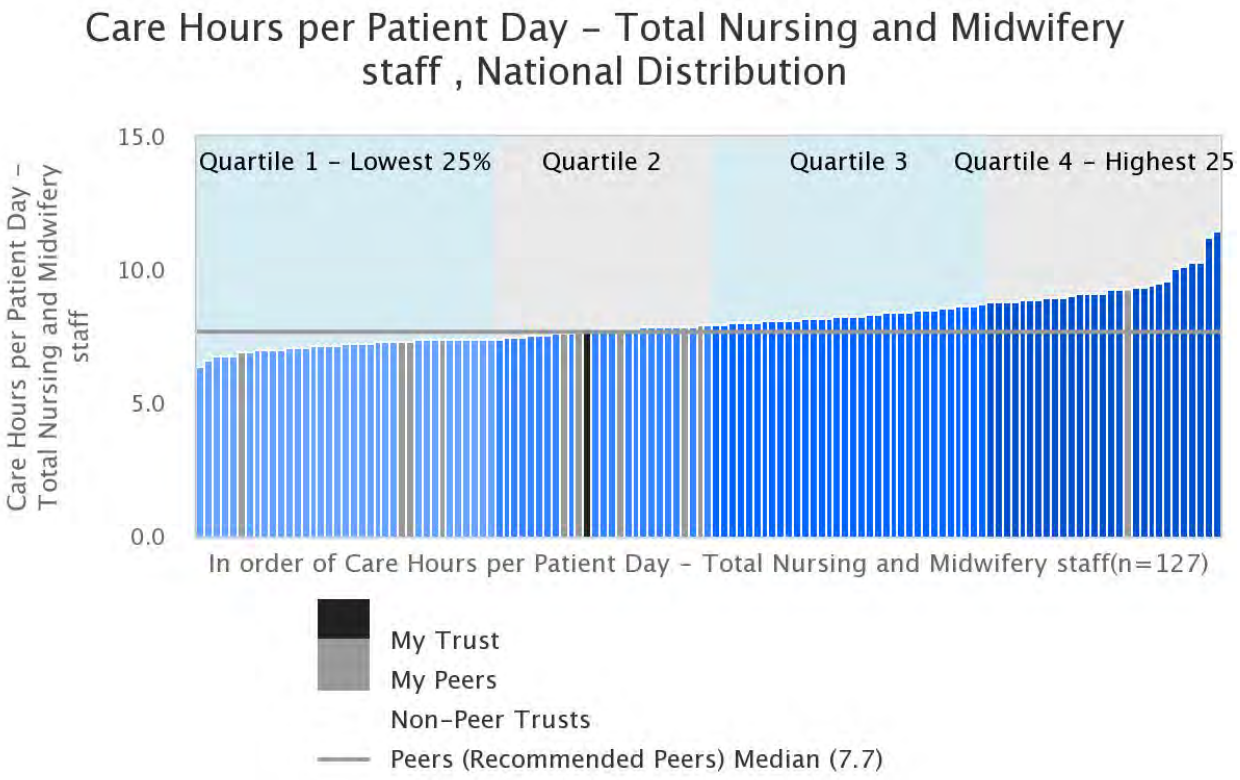
The Table below shows the Trust CHPPD position for March 2020 alongside national median data and peer regional data. The Trust is now in between the national and peer RN range at 4.44 and significantly above the national and peer for HCAs at 4.96.

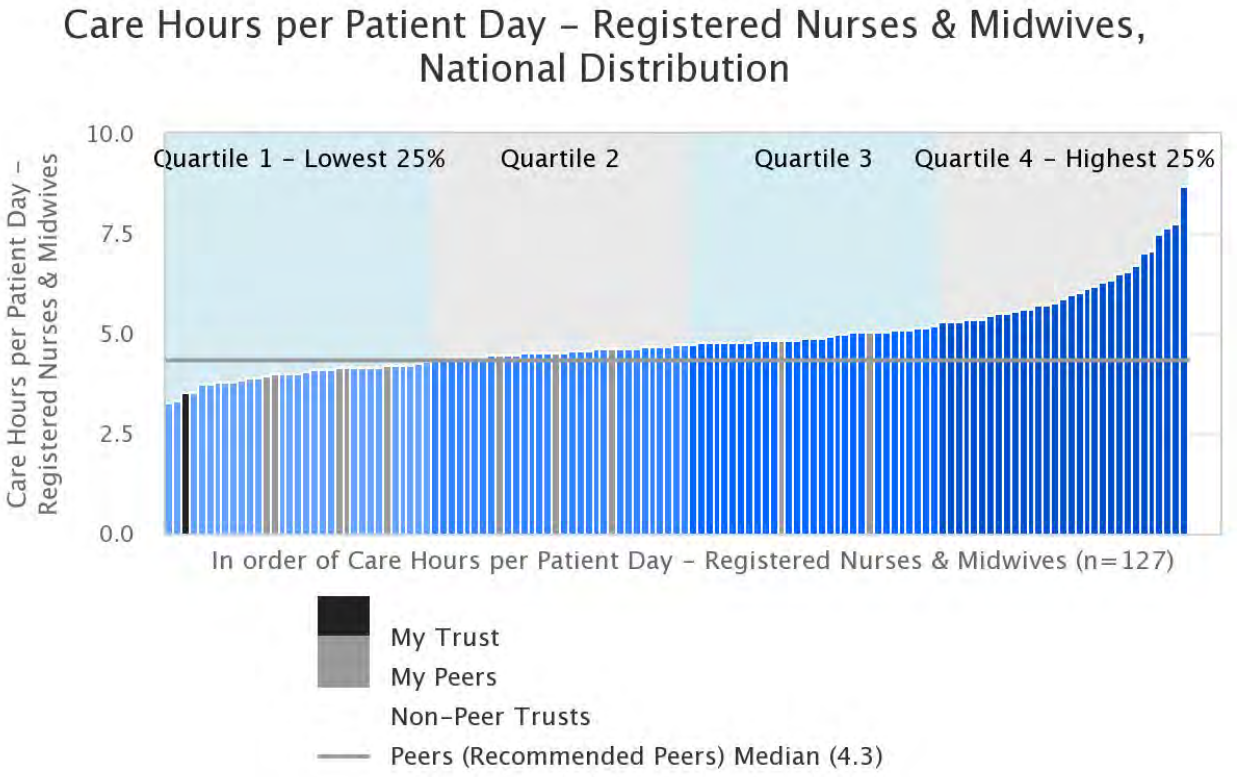
For March 2020 our position in the Trust has demonstrated that our overall comparison total CHPPD is 9.40 against a national median of 7.9 (National data is December 19). The RN CHPPD position demonstrates a significant increase in comparison to last month 4.44 for March in comparison to 3.95 for February; we still have further improvement within our recruitment to RN positions to be comparable against our peers and national data, however due to the current situation of COVID-19, the bed occupancy of the organisation through February and March has significantly altered, demonstrating a positive RN position.

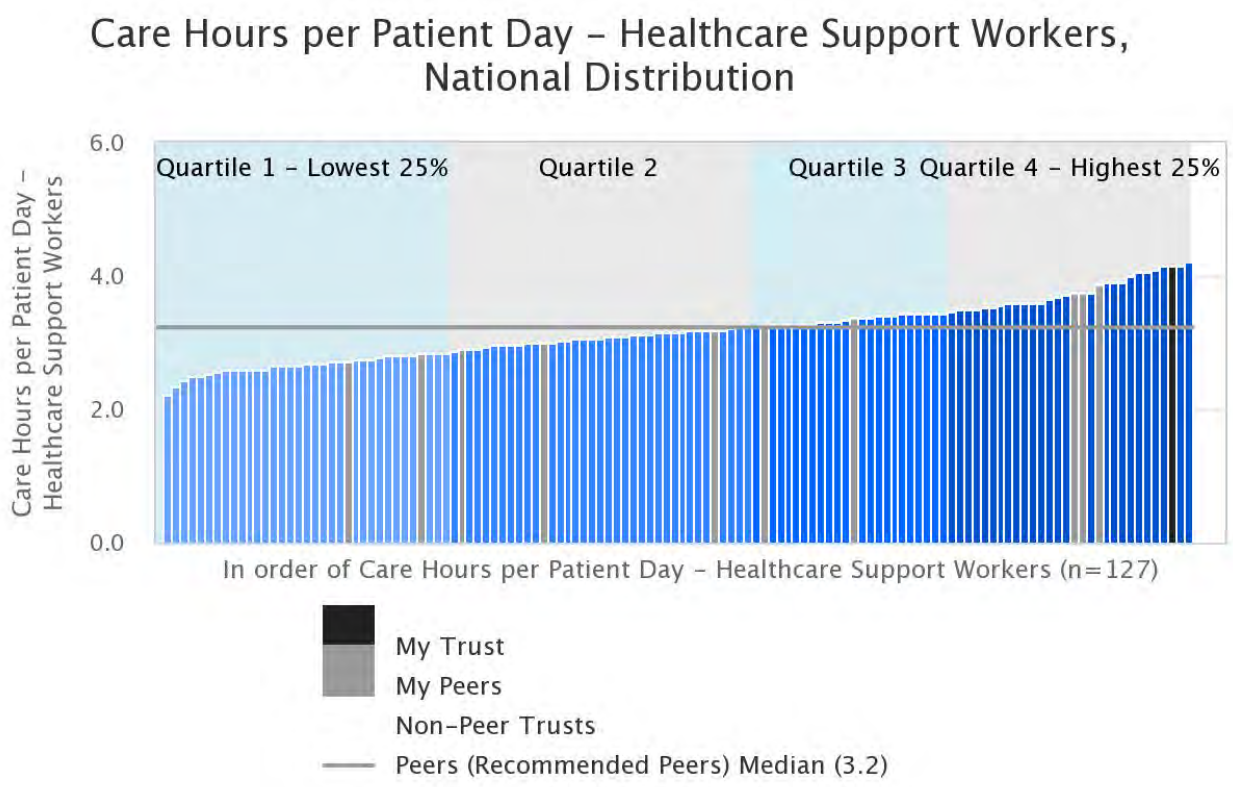
HCA CHPPD position has increased from February 3.93 to March 4.96 remaining an outlier in relation to our peers and national position (see below graphs from model hospital), we know that this is due to current situation of COVID -19, as well as enhanced supervision and backfill for unfilled RN shifts where it is deemed safe. Alongside the reconfigurement of the Trust COVID-surge response plans and Warrington ward remaining open to accommodate emergency surgical care. We are working on recruitment and retention solutions to address the registered nursing vacancies.

							Model Hospital		
	TSDFT March 2020	TSDFT February 2019	TSDFT January 2020	TSDFT December 2019	TSDFT November 2019	TSDFT Oct 2019	TSDFT Dec 2019	Peer – Region Dec 2019	National Median Dec 2019
Total CHPPD	9.40	7.88	7.96	7.56	7.83	7.74	7.6	7.7	7.9
RN/ RM CHPPD	4.44	3.95	3.69	3.54	3.64	3.67	3.6	4.3	4.7
HCA / MCA CHPPD	4.96	3.93	4.27	4.02	4.19	4.07	4.1	3.2	3.2

Model Hospital data – December 2019 data

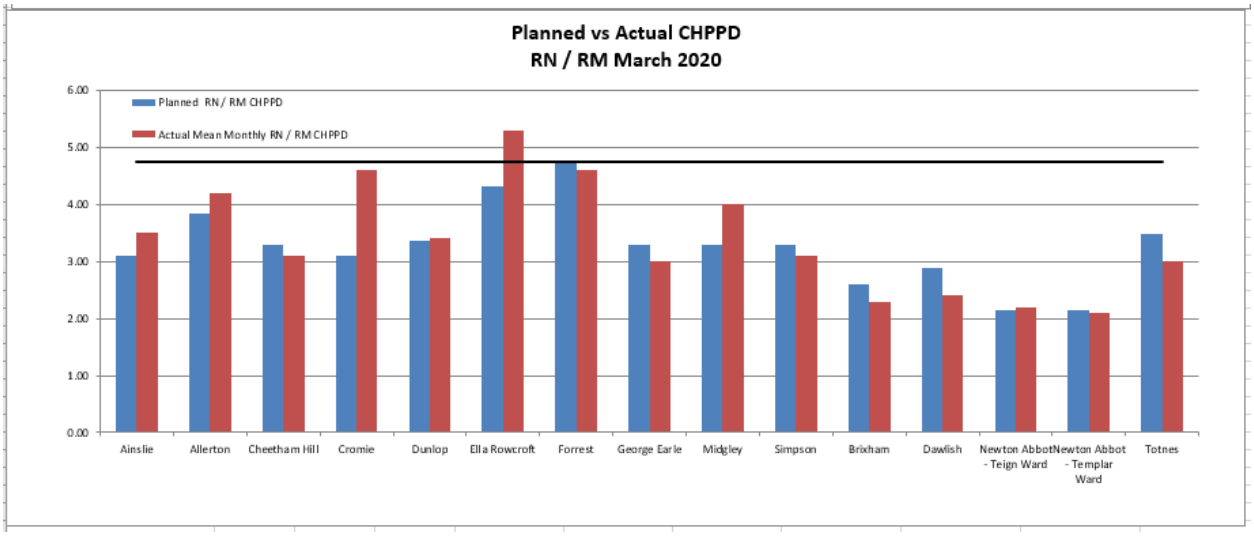




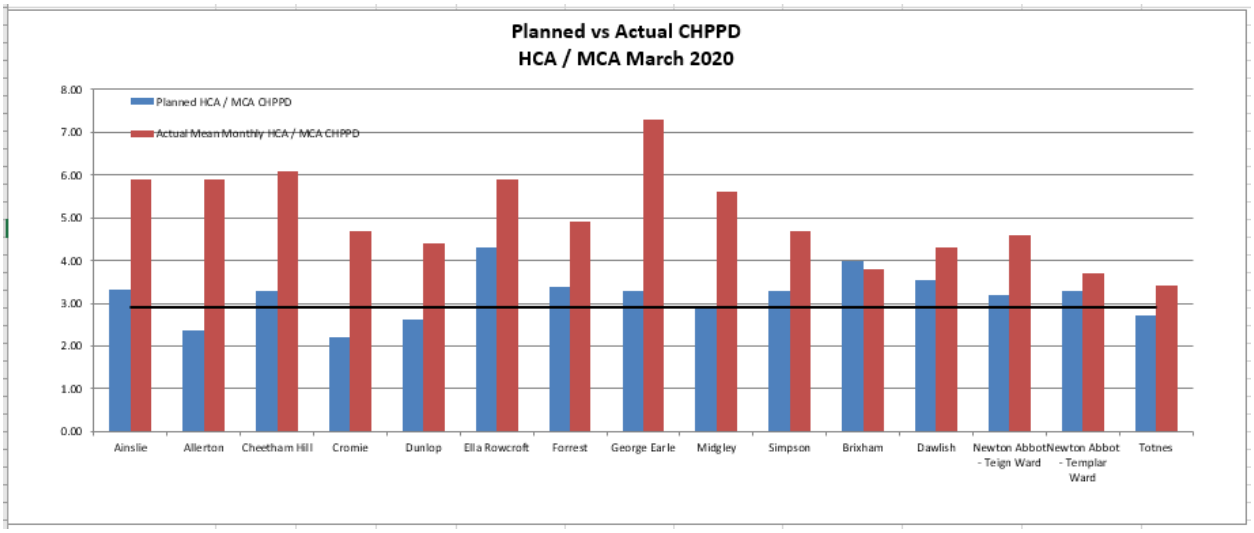


The graphs below illustrates the CHPPD data in March 2020 distributed by ward area, shown as a total of all nursing staff, and then separately for RNs and HCAs. The model hospital data should be viewed with caution as it relies on accurate input from providers and the accuracy is still being worked on.

The graphs overleaf 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 deemed appropriate and possible the wards cohort patients who require supportive observations. When there is shortfall in RN availability on a short term basis 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 graph above show that there are a number of areas where the actual RNs are above the current planned RN numbers; this in relation to the changes occurred within the organisation as a response to COVID-19 where areas have increased staffing numbers due to training and upskilling staff as we have reassigned staff to accommodate the surge within ICU and ED.



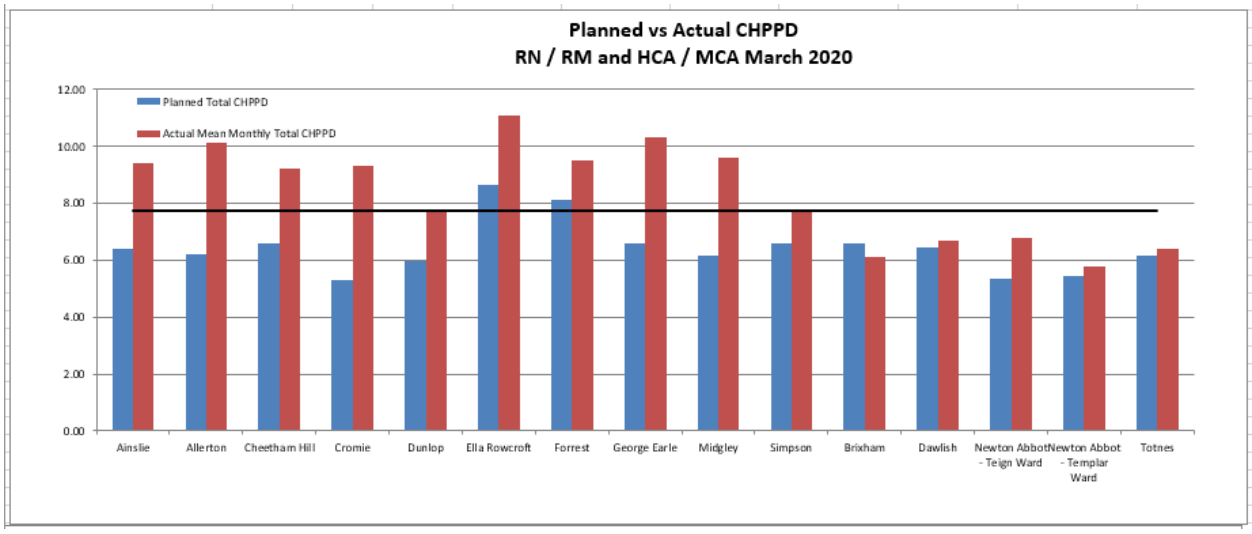
The graph above show that there are a number of areas above the current planned HCA numbers. A further review to understand this is being completed.

Safecare has provided Trust wide visibility of safe staffing across the organisation alongside real time acuity and dependency of patients within inpatient ward areas. As the changes to the ward areas in view of the response to the COVID-19 situation and reduced bed occupancy, there is not an accurate picture to be able to provide comparable analysis.

There are a number of areas where the RN/ HCA or both fell below planned levels, and there are also a few areas where the RN/HCA was above 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. Where the area is above planned levels this has been due to ward areas opening in view of the

The matrons and clinical site team balances rota pressures and organisational pressures across the organisation and discussions and reviews are informed at the control meetings throughout the day.



There has been a significant increase since January/February data on the number of areas where the actual RN/HCA or both are above the planned levels. Brixham are the only area for RN and HCA that have fallen below the planned levels.

The reasons for this include:

- Staff have left the organisation or moved to another ward area
- Temporary staffing are unable to fill some of the shifts
- Safecare has enabled visibility of acuity and dependency

Actions over next quarter:

- Due to the COVID-19 situation monitoring and reporting will continue as the situation for each inpatient area will remain fluid as an organisation we respond to the surges in different parts of the organisation.
- Overseas recruitment has currently on hold due to COVID-19 travel arrangements, this will be reviewed when the situation changes.
- Visibility and scrutiny of temporary staffing usage will continue with a review of the processes.

2.3 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.

2.3.1 The alert status for the organisation March 2020 is summarised in the table below, with the detail for February 2020 shown in brackets. The table

demonstrates that during March 2020 the Trust experienced more days at Opel 1and 2 and significantly less days at Opel 3, with no days in Opel 4.

Overall the Trust experienced 58% of the time in Opel 1 in comparison to last month which saw 20.6%, demonstrating 30 days out of 31 in either Opel 1 or Opel 2, which was 97% of the month.

TSDFT Alert Status March 2020	*No Days in Month*	*% days in Month*
Opel 1	*18(6)*	*58.06% (20.6%)*
Opel 2	*12(12)*	*38.7% (41.3%)*
Opel 3	*1(7)*	*3.22% (24.1%)*
Opel 4	*0(4)*	*0% (13.7%)*

2.4 Newton Abbot ISU - Emergency Department

The department is continuing to use resources from temporary staffing and have a number of staff reassigned due to our upskilling for COVID-19 surge.

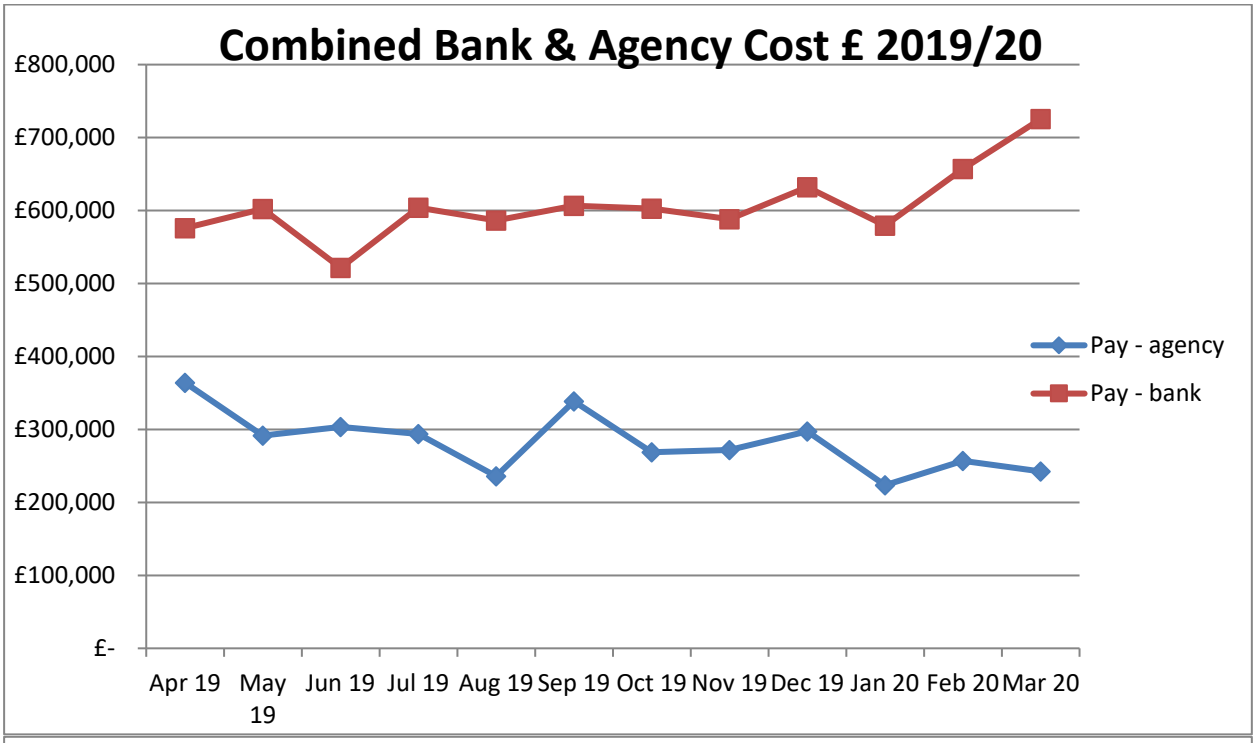
There were 2/31 shifts in March 2020 that were not filled at 100% RN, however these shifts were back filled with HCA's that were appropriate and ensured that the department was staffed safely.

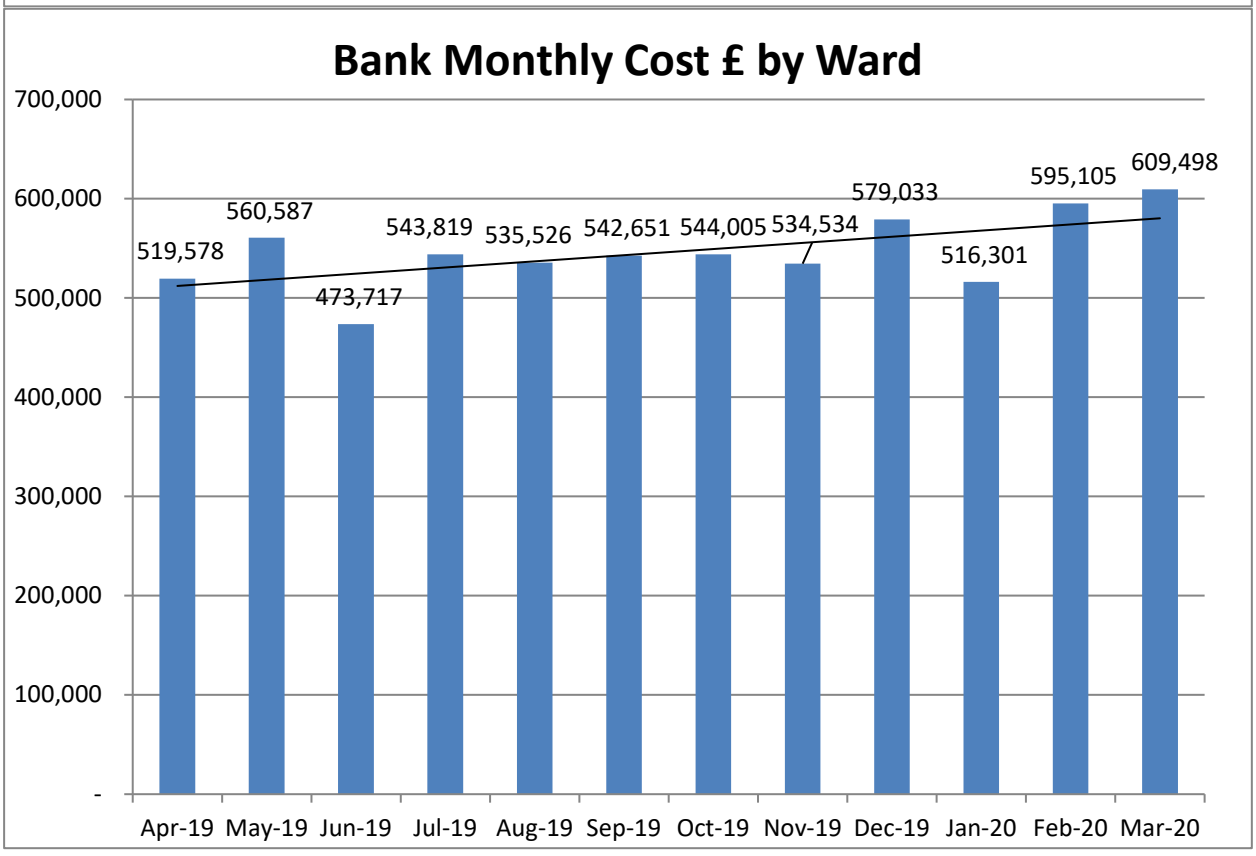
The actions below are still appropriate, however in relation to the workforce review and supportive framework, they have been temporarily stood down due to the COVID-19 situation, however plans to reinstate these in May 2020 in order to progress.

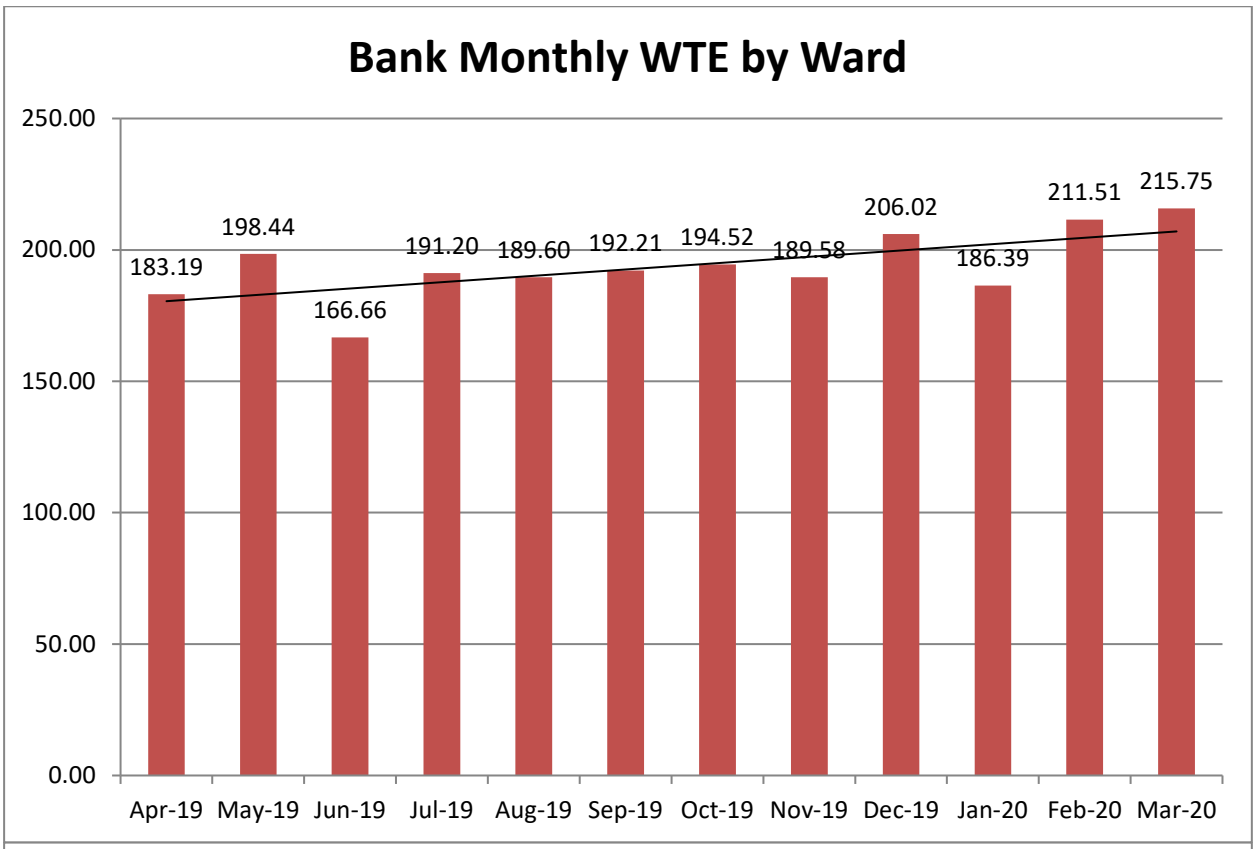
- The Baseline Emergency Staffing Tool (BEST) was used in 2016/17 to ensure staffing establishment was appropriate. At that time establishment was within expected benchmark but there were recommendations about shift pattern changes. This will be repeated within the next quarter to determine the skill mix and shifts timings, so that ED are fully informed and up to date with national guidance
- Interim solutions are in place to assist with both leadership and operational capacity.
- The ED supportive framework has been completed and shared with Newton Abbot ISU and ED triumvirate, plans are being pulled together with those involved which is being held by South Devon System Directors and the Executives.

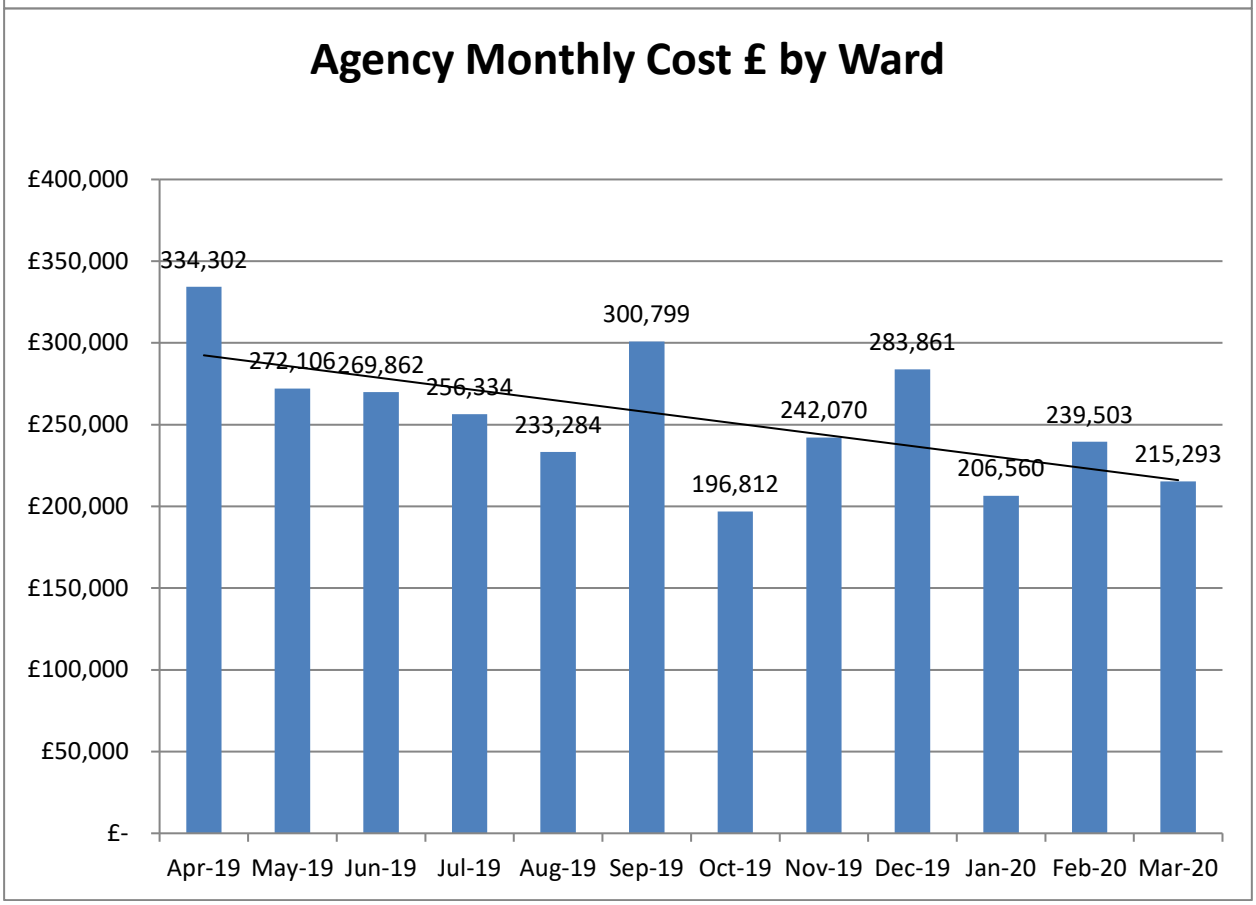
2.5 Nursing Agency spend

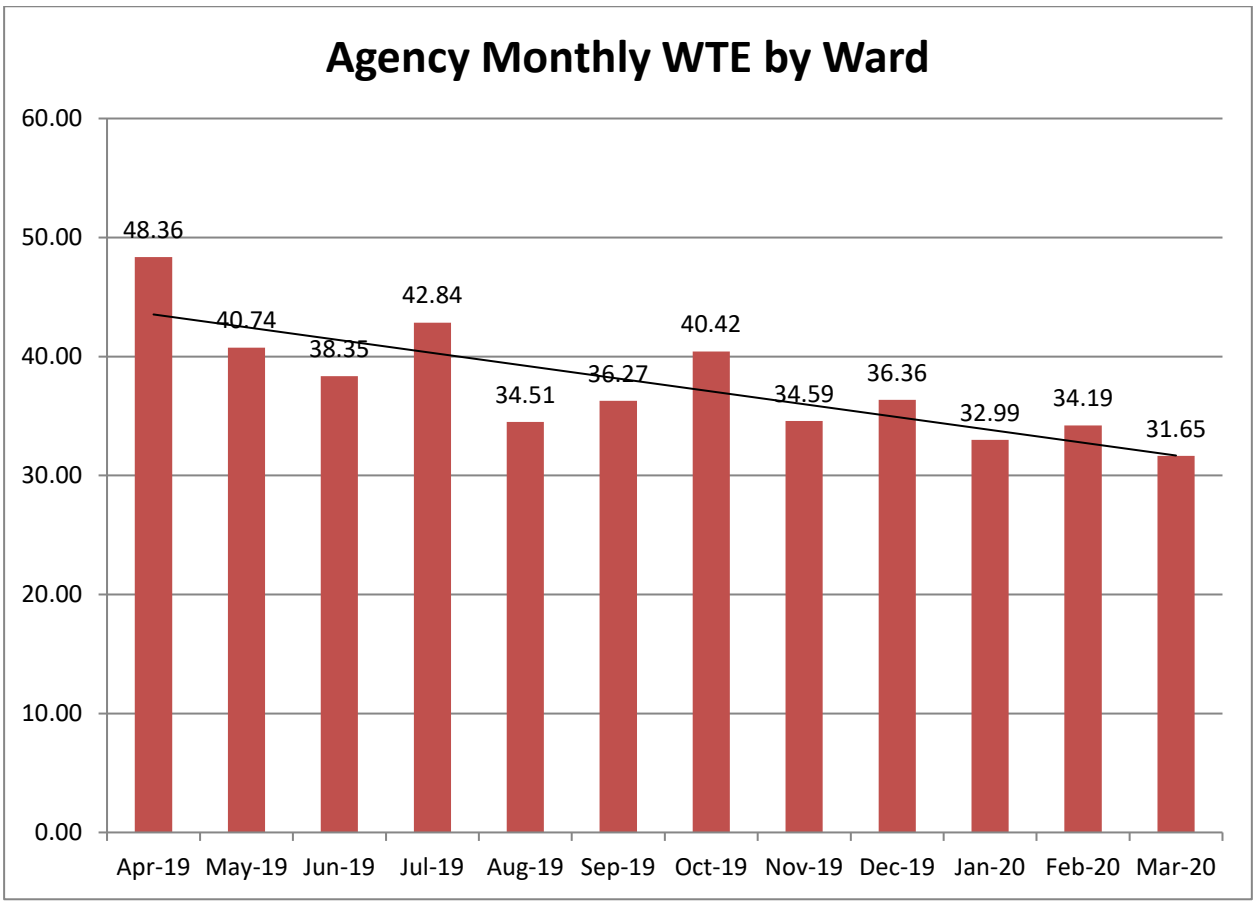
2.5.1 Nursing Agency Usage by month (£) and cost centre





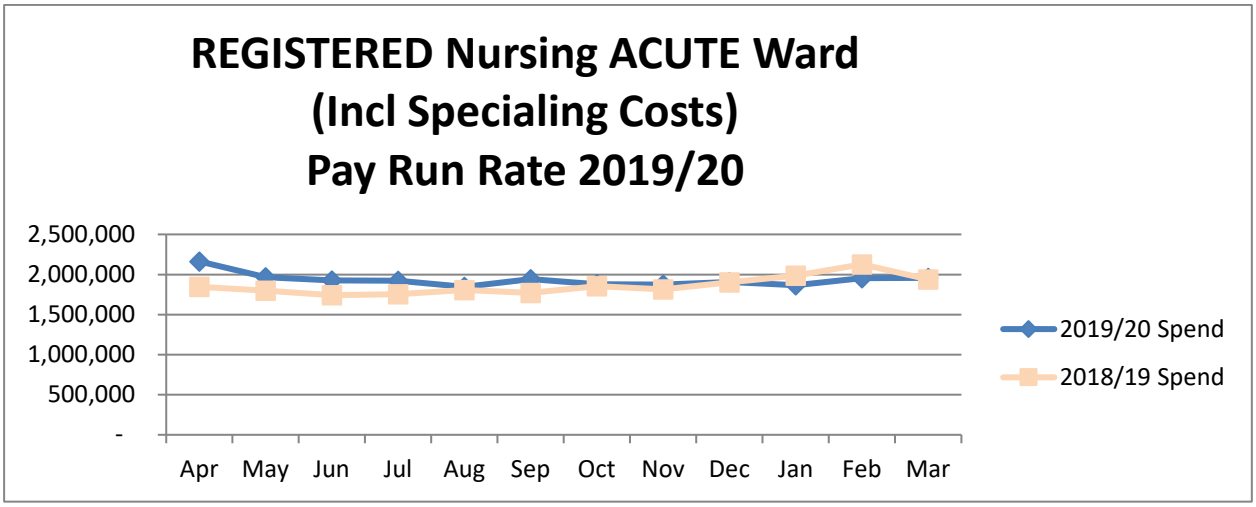

Bank Monthly WTE by Ward
250.00
200.00
150.00
100.00
50.00
0.00
183.19
198.44
166.66
191.20
189.60
192.21
194.52
189.58
206.02
186.39
211.51
215.75
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20

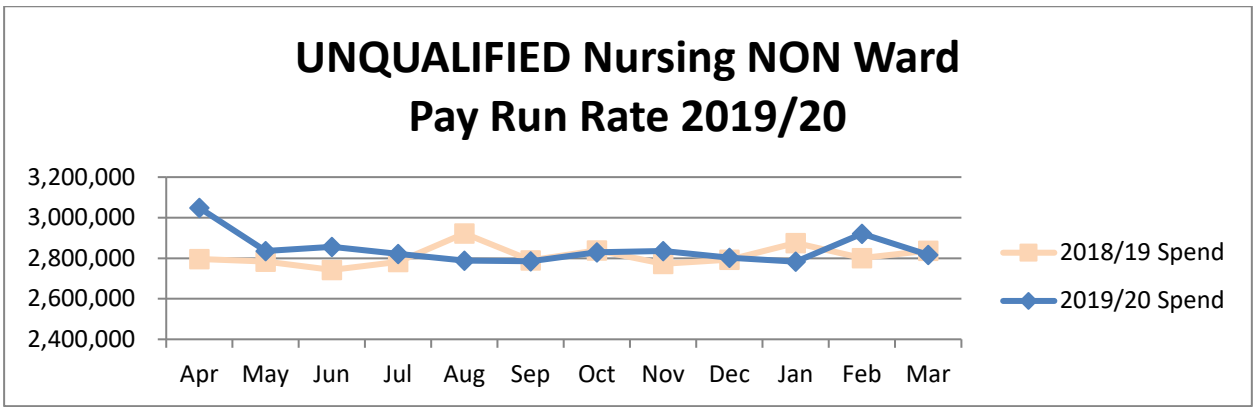

Agency Monthly Cost £ by Ward
£400,000
£350,000
£300,000
£250,000
£200,000
£150,000
£100,000
£50,000
£-
334,302
272,106
269,862
256,334
233,284
300,799
196,812
242,070
283,861
206,560
239,503
215,293
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20



There is significant underspend in ward and non-bed based nursing establishment budgets which offsets the overspend on agency. March figures suggest an overall RN budget for bed based care is £88K over budgeted establishment. For non-bed based RN there is an underspend of £699,197.

Agency spend as per above graphs it is tracked daily and reported weekly, current data shows a variable use but with overall reducing trajectory of usage.





2.5.2 Actions:

- The winter bank payment have been extended through the current COVID-19 situation and will be reviewed end of June 2020.
- The COVID-19 nursing and midwifery returns, students and overseas nurses joining the register will see an increase of registered nursing and midwifery within the Trust, exact numbers to be determined.

2.6 Nursing and midwifery vacancies

The recruitment strategies previously reported have resulted in an RN vacancy rate as at the end of March 2020 has maintained at 10.5% Registered midwives continue with a <1% vacancy rate. Current reporting has been stood down due to the current pandemic situation.

2.7 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;
KPI 1: Rosters published 6 weeks prior to commencement or
KPI 2: All contractual hrs are utilised when fully approval.

Due to the current pandemic response, the staff have been reassigned to other areas and therefore there is an inaccurate reflection of this report.

2.8 Quality and Safety

2.8.1 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 March 2020, the table below show that at the time the data was compiled 26 areas had not made a return this month, this is due to the COVID-19 pandemic response, which has meant that a number of areas had no activity or their activity has been reassigned in a different location providing a reduced service as per national response requirements.

There were 0 Red rated teams and 12 Amber rated teams for March 2020 are as detailed below:

Amber rated teams:

- Brixham hospital – vacancies, sickness
- Moor to Sea, Torquay, and Paignton and Brixham Occupational Therapy – recent retirement, vacancy, sickness related to the constraints within COVID-19
- Moor to Sea Physiotherapy – recent retirement, vacancy and short-term sickness
- Newton Abbot and Paignton and Brixham nursing – short term sickness and vacancy and retirement
- Social Care – Torquay – due to number of referrals, vacancies, short term sickness
- Community stroke and rehabilitation – sickness
- School nursing – reduced activity due to response to COVID-19 and staff reassigned
- ICU – number of reassigned staff and upskilling training
- ED – vacancies, sickness and number of reassigned staff to the area

The main theme is the reassignment of staff across the organisation in these services where activity has been temporarily stood down as the organisation responds to the pandemic, other reasons as described above are vacancies across nursing and allied healthcare professionals and short term sickness, alongside the number of appraisals outstanding.

Workforce and organisational development are working alongside the departments, sisters, matrons and associate directors of nursing and professional practice to develop action plans, which are being submitted to design a recruitment and retention strategy and workforce redesign.

The tables showing QuESTT scores for each clinical area are shown overleaf.

Quality Safety and Effectiveness Trigger Tool (QuESTT)

Torbay and South Devon NHS
NHS Foundation Trust

Service Rating	Level 0	Level 1	Level 2	Level 3
C. Hospital & MIU	<12	12-16	17-25	>25
Other	<16	16-24	25-35	>35

Service Type	Team	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
% Complete		99%	96%	93%	99%	95%	96%	98%	98%	96%	95%	94%	69%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		0	0	0	2	2	2	0	0	0	0	2	0
Total Amber (L1)		8	8	5	8	10	5	10	9	11	7	8	12
Total Green (L0)		74	72	72	72	67	73	71	72	69	72	68	45
Average Score		8.8	9.4	9.6	10.0	10.2	9.7	10.0	9.4	10.3	9.6	10.0	10.4
Acute	Ainslie	8	13	12	11	10	11	10	7	10	10	13	9
	Allerton	16	8	16	13	12	14	9	6	5	8	7	6
	AMU	13	14	5	5	11	6	8	6	8	5	3	5
	Anaesthetics	8	11	10	11	11	10	7	9	8	6	9	11
	Breast Care Unit	3	0	2	0	6	10	6	3	5	3	6	0
	Cath Lab	7	4	10	10	10	13	15	7	6	8	8	6
	Cheetham Hill	16	16	15	11	13	12	13	13	17	13	9	14
	Cromie	10	10	7	12	7	5	8	5	9	6	15	9
	DSU	13	13	14	10	9	12	15	13	9	6	12	
	Dunlop	7	3	5	4	5	6	7	6	7	5	6	11
	Early Pregnancy / Fertility Service	2	4	4	6	6	6	6	8	6	6	4	8
	EAU3	8	8		12		12	10	18	14	11		
	EAU4	11	8	7	18	11	8	7	6	5	9	5	6
	Ella Rowcroft	10	3	10	12	8	10	9	8	11	11	8	6
	Emergency Department	16	15	15	18	20	19	19	18	15	10	12	16
	Endoscopy	2	4	4	3	8	6	8	3	3	3	6	5
	Forrest	10	15	14	12	8	8	15	7	10	10	12	12
	General Theatres	9	11	11	9		15	7	15	13	7	7	
	George Earle	10	11	11	11	13	15		16	14	12	11	11
	Gynaecology Out-Patients Dept	6	8	9	9	7	7	8	3	7	7	5	11
	Hutchings	7	9	12	13	8	9	9	9	7	6	10	
	ICU	8	7	9	11	9	3	9	14	6	8	10	19
	Louisa Cary	8	4		6	7	3	9	3		5	7	4
	MAT / TAIRU	5	10	10	10	9	4	7	7	8	5	4	
	Maternity	5	7	13	12	12	14	13	9	10	15	13	15
	Midgley	7	11	14	9	3	7	9	8	11	7	11	
	OPD	2	2	6	6	6	3	2	4	6	11	6	
	Ophthalmology	9	13	8	15	15	13	14	13	15	12		10
	Ortho Theatres	16		15	14	13	14	15	14	12	15	11	11
	Pre-assessment	6	8	8	8	10	12	16	14	12	6	8	8
	Radiology	10	13		9	11	9	14	10	9	13	9	
	Recovery	5	8	12	8	10	11	15	15	14	11	10	
	RGDU	7	10	7	13	15	12	9	7	10	11	15	10
	SCBU	10	2		4	2	1	3	5		1	5	3
	Sexual Health		8	13	11	10	5	6	6	12	11	10	
	Simpson	14	8	9	8	11	11	9	11	12	10	10	15
	TCCU	7	3	5	4	8	9	14	10	6	7	11	12
	Turner	9	11	9	8		7	12	9	13		7	
	Urology	5	14		7	10	4	6	5	10	5	7	6
	Warrington	6	3							16		13	

Service Type	Team	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Community Hospital	Brixham	15	13	7	20	19	17	14	16	14	12	18	14
	Dawlish	6	7	0	1	0	3	3	3	5	5	3	3
	Newton Abbot Teign	9	11	16	11	16	9	7	10	10	10	10	
	Newton Abbot Templar	7	4	9	7	2	9	9	9	10	12	12	
	Totnes	8	7	7	6	12	9	7	11	8	11	12	9
MIU	Dawlish	7	9	14	12	14	9	9	12	11	11	12	8
	Newton Abbot	0	6	8	8	8	6	7	8	8	3	5	5
	Totnes	2	8	7	3	9	6	8	4	4	7	5	7
Community Stroke and Neurology	Torbay and South Devon	16	14	14	16	14		10	10		14	12	16
Infection Control	Infection Control	11	11	4	6	8	3	4	6	6	6	11	
LLTS	LLTS	8	7	6	7	6	5	6	8	6	6	6	10
Nursing	Brixham and Paignton	14	12	14	9	12	15	22	19	24	15	25	18
	Coastal	13	13	14	11	19	15	17	15	17	17	19	15
	Moor to Sea	6	7	10	12	15	8	15	20	16	15	18	
	Newton Abbot	12	11	10	14	19	15	11	15	20	14	20	21
	Torquay	6	6	9	11	6	9	12	17	9	13	11	
OOH Nursing	OOH Nursing	9	17	9	12	14	13	16	14	12	13	11	12
Specialist Nursing	Specialist Nursing	5	1	7	2	4	5	6	8	12			
Occupational Therapy	Brixham and Paignton	12	12	12	14	10	12	12	8	8	12	12	16
	Coastal	18	11	8	10	10	9	5	7	6	9	8	8
	Moor-to-sea	10	14	6	14	10	17	8	14	16	18	14	16
	Newton Abbot	8		11	9	19	13	19	9	13	13	9	
	Torquay	6	8	4	2	4	4	6	6	8	6	10	16
Physiotherapy	Brixham and Paignton	12	6	10	8	9	12	7	7	10	13	11	10
	Coastal	14	15	8	16	13	9	11	5	8	11	12	8
	Moor-to-sea	10	12	8	14	12	19	14	14	16	16	18	20
	Newton Abbot	12		11	9	17	11	13	9	9	13	11	
	Torquay	11	10	12	10	8	10	6	6	10	6	10	
Podiatry	Podiatry	20	22	23	32	26	27	22	22	24	22	24	
Public Health - Lifestyles	Lifestyles	7	5	11	3	0	7	5	1	5	9	2	11
Public Health - Nursing	Paignton and Brixham	10	8	6	6	6	8	4	4	6	8	8	12
	School Nursing	5	7	6	7	7	5	8	12	12	10	11	16
	Torquay	2	2	2	5	4	4	2	6	6	6	9	2
Public Health - Substance Misuse	Substance Misuse	4	6	8	10	6	4	4	2	0	4	3	
Social Care	Brixham and Paignton	8	12	10	12	10	10	14		10	14	10	
	Dawlish & Teignmouth	2	8	10	12	12	14	18	12	14	0	9	
	HADT - S. Devon	13	17	15	17	13	17	13	13	15	13	11	
	HADT - Torbay	5	11	13	8	13	10	9	7	17			9
	Newton Abbot	8	18	18	16	16	16	10	10	14	12		6
	Older People Mental Health - Torbay	4	10	4	8	4		2	2	0	2	0	8
	Torquay	12	16	12	10	16	12	10	14	12	12	12	20
	Totnes & Dartmouth	10	19	8	16	8	4	16	10	12	20	14	10
Tissue Viability	Tissue Viability	14	10	7	7	9	8	8	8	8	8	8	9

3 Conclusion

The report for March 2020 demonstrates that the organisation despite responding to the COVID-19 pandemic, have responded amazingly and there remains a number of safety measures in place to ensure that nursing establishments and fill rates are monitored and appropriate action is taken to maintain staffing levels. This is triangulated with the quality and safety metrics for each bed-based areas. These are robustly actioned both by the specialty matrons and senior sisters, alongside through the control room function.

This paper assures the Trust board that there is nursing and midwifery safe staffing in all inpatient areas within the Trust. The information is triangulated with the quality and safety metrics which demonstrate that these remain within the national requirements despite our current situation in responding to COBID-19 and a number of services and staff have been reassigned.

4 Recommendation

The board is asked to note the report.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			**Meeting date: 29 April 2020**
Report sponsor	Chief Executive		
Report author	Service Directors		
Report provenance	The report is informed by: • Minutes and papers from Children and family Health Devon Partnership Board • Executive Team meeting minutes • Covid -19 incident management plan		
Purpose of the report and key issues for consideration/decision	To provide an update on key operational issues		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Receive and note the 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		**Well-led**	X

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

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

External standards affected by this report and associated risks

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

Report title: Report of the Chief Operating Officer		Meeting date: 29th April 2020
Report sponsor	Chief Executive	
Report author	Service Leads	

1. Purpose

To report on key operational issues to include:

- Chief Operations Officer portfolio – interim arrangements
- Children and Family Health Devon Alliance
- Community Dentistry
- Cancer services review
- Living well@home contract implementation

2. Chief Operating Officers' Portfolio

John Harrison Chief Operating Officer remains on a period of extended leave, in the interim Shelly Machin and Cathy Williams, Service Directors for Torbay and Devon, have been taking the lead in overseeing the operational portfolio whilst holding key roles in the Covid-19 response plan. To support them additional capacity has been secured and members of the Executive Team have taken on individual pieces of work as appropriate.

To ensure resilience in this arrangement pending John's return to work, Jayne Carroll's secondment from Devon CCG has been extended to allow her to take a leadership role in support of the System Directors with a particular focus on business as usual and operational recovery. This arrangement will be reviewed again at the end of June. Jane Sangoor has been asked to take an ongoing role in project implementation to enable rapid delivery of operational priorities. This arrangement will be reviewed on a monthly basis.

3. Children and Family Health Devon

It is a year since the provider alliance secured the contact to delivery community services in Devon with the Trust being prime contractor. It is fair to say that it has been a challenging year for staff as we started the work to develop robust services delivery plans, recruit to key roles, establish effective governance arrangements and begin the task of transforming services in line with the model agreed as part of the tender process.

It is clear that as we start year 2 that we are behind the trajectory set. To inform how this will be recovered a proposal is being presented to the Partnership Board on 27 April recommending that we complete a rapid review of the last 12 months with a view to agreeing a revised plan with alliance partners.

The alliance agreed that it was necessary to strengthen leadership arrangements in the alliance. A Service Director role has been established and we are currently going through the recruitment process. In recent weeks a number of high number of high calibre individuals have come forward who have had an interest in the post.

4. Community Dentistry

The community Dentistry Team led by Dr Firoozeh Curran has taken the initiative in responding to the need to establish emergency dental hubs for people who are unable to access their routine dentist through this Covid- 19 period. The dental services which has been established will be available 7 days a week.

5. Cancer Services

There is a clear focus on cancer services through this covid- 19 period. The Cancer Alliance has recently commissioned a programme of work aimed at improving compliance with cancer standards. Shelly Machin will be representing the Trust on this group and will work with clinical leads across Trust specialities to ensure learning.

6. Living well@home Contract Implementation

The arranging support team seamlessly took over the Mears contract for domiciliary care delivery in Torbay on 1st April welcoming a number of new providers into the local market. The current Covid situation has impacted in a number of different ways as a number of clients are having their care delivered by family members unable to work during this period, and a number who are not wanting people in their homes due to concerns around virus spread. The Proud to Care campaign has also attracted a large number of people interested in this type of work.

7. Recommendation

The Board is asked to note the content and information and provide challenge and seek further assurances as required.