Torbay and South Devon NHS Foundation Trust
Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital, Torquay, TQ2 7AA and Microsoft Teams
27 May 2020 09:30 - 27 May 2020 11:30

AGENDA

#	Description	Owner	Time
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 9		
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 29th April 2020 and Outstanding Actions Approve 20.04.29 - Board of Directors Minutes Public.pdf 11	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive Receive and Note Chief Executive's Report.pdf 25	CE	
2.6	Integrated Performance Report - Month 1 Receive and Note Integrated Performance Report - Month 1.pdf 35	DTP	
2.7	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 85	MD	

#	Description	Owner	Time
2.8	Guardian of Safe Working Hours Information Report of the Guardian of Safe Working Hours.pdf 99	MD	
2.9	Annual Self-Declaration Certification Provider Licence Approve Annual Self-Certification Provider Licence Condition... 105	CS	
2.10	Clinical Incident Annual Report Information Clinical Incident Annual Report.pdf 115	CN	
2.11	Freedom to Speak Up Guardian Report Receive and Note Six Monthly Report of the Freedom to Speak up Gu... 155	DWOD	
2.12	Annual Infection Prevention and Control Report Approve Annual Infection Prevention and Control Report.pdf 161	CN	
2.13	Supporting the Quality and Safety of Care in Care Homes during Covid-19 Receive and Note Supporting the Quality and Safety of Care in Care... 193	CN	
2.14	Ethics Committee Terms of Reference Approve Ethics Committee Terms of Reference.pdf 199	CS	
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Finance, Performance and Digital Committee - 27th April and 22nd May 2020 Receive and Note FPDC Chair's Report 27.04.20.pdf 207	C Balch	

#	Description	Owner	Time
3.1.2	Finance, Performance and Digital Committee Annual Report Receive and Note Finance, Performance and Digital Committee Annu... 209	C Balch	
3.1.3	People Committee - 27th April 2020 Receive and Note People Committee Chair's Report 27.04.20.pdf 217	V Matthews	
3.1.4	People Committee Annual Report Receive and Note People Committee Annual Report.pdf 219	V Matthews	
3.1.5	Charitable Funds Committee - 13th May 2020 Receive and Note Charitable Funds Committee Chair's Report 13.05.2... 225	J Lyttle	
3.1.6	Quality Assurance Committee - 22nd May 2020 Receive and Note	J Lyttle	
3.2	Reports from Executive Directors		
3.2.1	Six Month Safe Staffing and Nursing Work Programme Receive and Note Six Month Safe Staffing and Nursing Work Program... 227	CN	
3.2.2	Report of the Director of Estates and Facilities Management Receive and Note Report of the Director of Estates and Commercial D... 255	DEFM	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.30 am, Wednesday 24th June 2020	Ch	
7	Exclusion of the Public	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems.
2. Failure to achieve key performance / quality standards.
3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision.
4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.
5. Failure to achieve financial plan.
6. Care Quality Commission's rating 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 AND VIA MICROSOFT TEAMS ON WEDNESDAY 29th 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	Executive Medical Director
	* Mrs J Falcao	Director of Workforce and Organisational Development
	* Ms A Jones	Director of Transformation and Partnerships
	* Mr D Stacey	Chief Finance Officer
	* Mrs J Stockman	Torbay Council Representative
In attendance:	* Mr I Currie	Acting Medical Director
	* Mrs N Goswell	System Director of Nursing and Professional Practice
	Mrs S Fox	PA to Chief Executive

* via video-conference

		ACTION
67/04/20	**Board Corporate Objectives** The Board noted the Corporate Objectives.	
	PART A: Matters for Discussion/Decision	
68/04/20	**Apologies for Absence** Apologies for absence were received from Mrs Jane Viner, Chief Nurse, Mr John Harrison, Chief Operating Officer and Mrs Jane Downes, Company Secretary.	

69/04/20 **Declaration of Interests**

There were no declarations of interest.

70/04/20 **Minutes of the Board Meeting held on the 1st April 2020, Outstanding Actions and Log of Deferred Items**

The minutes of the meeting held on the 1st April 2020 were confirmed as an accurate record and log of deferred items noted.

71/04/20 **Report of the Chairman**

The Chairman briefed the Board as follows:

- Board meetings and Board Sub-Committee meeting appeared to be working well being held via Microsoft Teams.
- Weekly System Chairs meetings were being held. System Chief Executives and Councils would be joining the meeting being held later in the week.
- The Chairman was holding weekly meetings with the Non-Executive Directors to ensure they were kept up to date with current issues.
- A Governor Nomination and Remuneration Committee was held last week to inform Governors of the outcome of the Chairman and Non-Executive Director annual appraisal process.
- Governors have been receiving weekly updates from the Trust to ensure they were being kept up to date with developments.

72/04/20 **Report of the Chief Executive – Covid-19 Assurance**

The Chief Executive briefed the Board as follows:

- There has been a reduction in the number of Covid-positive patients being treated in the acute hospital.
- There has been an increase in the number of people presenting to the Trust with non Covid-related health issues, which was welcomed as there has been concern that people were not presenting to hospital when they needed to. It was noted that there has been a media initiative to encourage people to come to hospital and assurances that it was safe for them to do so.
- A number of care homes have residents with Covid symptoms and as an Integrated Care Organisation the Trust has been able to act quickly to provide support in the community where it was needed. This support was being co-ordinated through the Care at Home Cell.
- Modelling suggested that the peak of Covid-related cases in the South West was lower than expected due to the impact of social distancing

and self-isolation. The Board would be receiving a presentation on further modelling later in the meeting. The Chief Executive wished to place on record her thanks to clinical and operational teams for the amount of clinically-led change that had taken place to get the Trust ready to manage Covid cases.

- The Trust has received support from its partners across the system in planning for Covid.

- The availability of Personal Protective Equipment (PPE) remained an area of concern, however there were now two clear lines of delivery for PPE and the Trust was ensuring that supply was aligned to priority areas. Availability of masks and mask fit training was also an area of concern, however the region was now focusing supply of masks based on priority.

- The Trust's health and wellbeing offer to staff has been extended to the care home sector to ensure care home staff had access to the same level of support as staff in the Trust. In addition, primary care was being supported with the establishment of a Covid Primary Care Hub based at Teignmouth Hospital.

- The location of the Nightingale Hospital in Exeter had changed, and this would be discussed further later in the meeting. The Nightingale Hospital would be flexed to provide support to the system not just over the next few months but into the winter to provide resilience.

Mr Sutton queried the plans for testing in care homes in Torbay and South Devon. The Chief Executive explained that there was a well-co-ordinated programme of work in place which was being led by the Chief Executive of University Hospitals Plymouth in her role as Chair of the Peninsula Pathology Network, to increase testing, which would include care homes. One of the two mobile testing centres being established for the South West would be in Torbay. In the short term, capacity for testing could be accessed in Plymouth and Exeter, but the turnaround was felt to be too long so an alternative provider was in the process of being sourced. It was noted that people were only being tested if they were showing signs of Covid, apart from patients who were discharged from hospital prior to transfer to a care home.

The Director of Estates and Commercial Development provided assurance that where necessary the Trust was proactively swabbing entire care homes. It was noted that this was not in line with guidance from Public Health England, however it was felt to be the right action to take where necessary.

Mrs Matthews asked how the Trust planned to retain the good work that had been achieved through the current crisis and it was noted that there would be a presentation on the recovery plan later in the meeting. Mrs Matthews then asked if there were any costs associated with the change in location of the Nightingale Hospital and it was noted that there was some design costs, but these were transferrable to the new location. The Executive Medical Director said that the main reason for the change in venue was modelling suggested that the facility would be required for a longer period of time that originally expected and the Westpoint facility was only available for a short period of time.

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

73/04/20 **Integrated Performance Report – Month 12**

The Director of Transformation and Partnerships provided assurance to the Board that the work that had taken place to step down services followed clear governance processes to understand any impact to patients and that work to stand back up services would be managed ensuring that impact to patients and services was understood. The work would also take account of the need to manage a Covid and non-Covid hospital and this work was being led by the Recovery Cell.

Quality headlines

The Quality Improvement Group and Safety Cell had reported and recorded the national changes to safety data metrics. The Trust was still maintaining normal incident feedback and engagement metrics. The Quality Improvement Dashboard was being maintained with ISU Clinical Governance Coordinators being used in a different manner to ensure safety was a key priority in all the changes that were being undertaken.

The Safety Cell was reviewing safety on a weekly basis and ensuring, where necessary, Quality Equality Impact Assessments (QEIA's) were being recorded and reviewed as services are impacted from the COVID-19 response.

The Month 12 Quality metrics were not highlighting any areas of concern. The Covid preparations have seen additional Mortuary capacity and resilience put into place.

Bed occupancy had reduced and staff had been redeployed to other areas of the Trust, which was reflected in the staffing metrics which showed that some wards were under staffed against normal occupancy levels.

Mrs Lyttle provided assurance that the Quality Assurance Committee was content with the governance processes being followed and that she also had weekly meetings with the Chief Nurse in case any areas of concern needed to be escalated.

Workforce Headlines

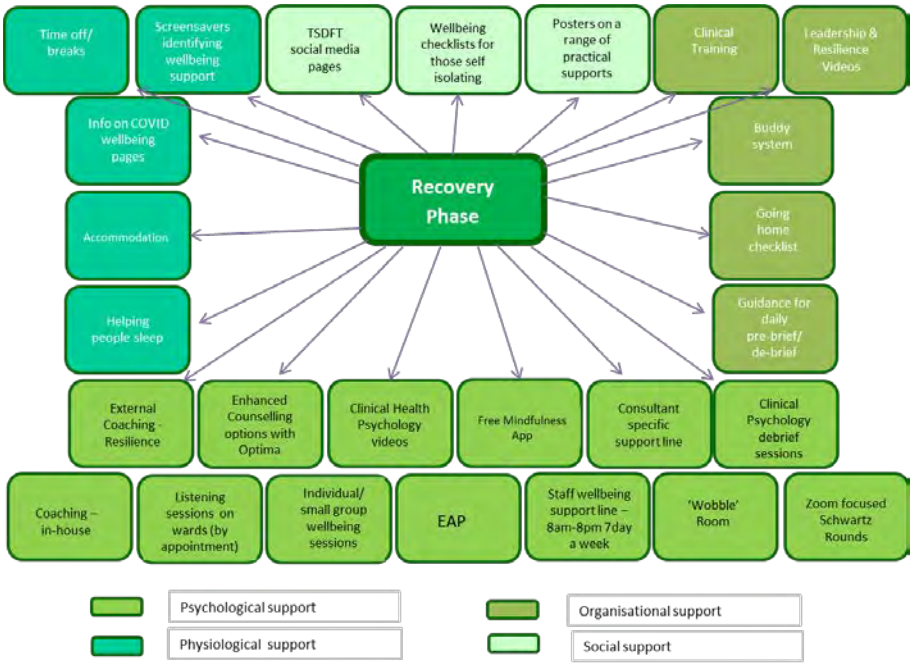
In Month 12 the standard performance metrics have not been included in the IPR dashboard.

Performance was discussed at the recent People Committee and the need to now go back to normal performance monitoring and assurance was provided that workforce data would be available for the next Board meeting. Assurance was also provided that there was a clear audit trail attached to decision-making, managed through the Workforce Cell.

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 described the support offer during the three 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 was considered. An example of the cumulative support offer is summarised below:



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

Wellbeing calls were being undertaken to those shielding and self-isolating, by way of a check in and to make staff aware of the support available to them. Currently, the Trust was 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

A new Resourcing Hub has been established which brings together the different workforce pools within the organisation and has created real collaborative working and a sharing of learning and ideas across these teams. This will help to build the new normal, looking at how the Trust attracts and retains future talent.

Already there have been success stories with the Trust's volunteer team engaging with St Johns and Coastguards to see how skills and expertise could be shared in the 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. The Trust was in the final stages of onboarding the 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 to reassign existing staff and there have been 60 requests so far to reassign staff to different areas. These included 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 would continue to develop post Covid.

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.

Mrs Matthews noted the reduction in staff absence due to Covid-related issues and the increased number of volunteers the Trust had received.

Performance Headlines

The performance section has been reduced to incorporate the NHSI headlines for Month 12 part of the focus report. This described a deterioration in end of year performance against the key NHSI performance metrics on access standards.

The 4-hour target had improved to 86% in March, however it was noted there had been a 21% reduction in attendances in the month. Attendances had now started to increase. Performance in April was currently at 90%.

18 Week performance was 76% against a trajectory of 82% in March which reflected the need to stand down elective activity. A lot of work had been undertaken to provide outpatient appointments remotely and the Trust had received national endorsement for its work and the use of 'NHS Attend Anywhere'. Twelve specialties were currently live on the app with another 15 preparing to go live.

There had been a 75% reduction in referrals.

Some elective work had been transferred to Mount Stuart including cancer activity and the Trust was working to optimise the use of Mount Stuart. Professor Balch noted the need to include use of Mount Stuart given the small number of cases currently being treated at the facility and this was acknowledged.

Services for cancer and urgent patients had been maintained, however urgent referrals had reduced by 60% and this was expected to increase significantly.

The Trust's performance team were modelling how this peak in activity could be managed.

An area of concern was in respect of diagnostic activity with a reduction in period to 7.3% and this was being addressed as part of the Trust's recovery plan.

Mrs Matthews asked if the deterioration in performance was as predicted or if there were any outliers and the Director of Transformation and Partnerships said that it was as expected and was mirrored across the country.

Mrs Lyttle asked if the Trust understood the reasons for patients not attending booked appointments during the current crisis and the Director of Transformation and Partnerships said that it was felt patients were making their own judgments on whether they felt it was safe to attend appointments or not. She added that a lot of work had been undertaken to encourage people to attend for appointments and provide assurance that it was safe for them to do so.

The Chairman reflected on the ability of patients to be able to see their GPs and how this might affect attendances to the Trust. The Executive Medical Director said that in general GPs in Torbay and South Devon were managing demand. He added that the Government had removed the need for consent for secondary care to access primary care records and this was to be welcomed.

The Chief Executive added that the Trust needed to be mindful that the Covid pandemic was not yet over and that this needed to be balanced with the need to step back up activity and also to be able to be agile if Covid cases increased and services needed to be stepped back down again.

Mrs Matthews stressed the importance of being proactive with communication to provide assurance to the public that it was safe to attend appointments and to also manage expectations. The Chief Executive agreed and said that once the modelling was fully understood, and agreement had been reached with the Trust's commissioners around prioritisation, communication could take place.

Finance Headlines

- The financial position at 31st of March 2020 was a £24.45m deficit prior to sustainability funding. This was £20.65m adverse against the full year plan of £3.80m deficit. Included within the Month 12 position were incremental costs relating to Covid 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 was greater than the £15m which the Trust forecast at Month 6. The additional adverse movement of £5.7m related to debt write off £2.2m, annual leave accrual £2.0m, RICS £1.8m, Impairment chargeable to Income and Expenditure £0.8m offset by additional income/net improvement of £1.1m.

- The other movement at Month 12 which should be noted related 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 was 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 Royal Institution of Chartered Surveyors valuation adjustment.

- Setting aside the factors above, the main variances for the year were 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 integrated Better Care Fund £3.20m, private patient activity £0.55m, lower Torbay Pharmaceutical sales £0.84m and Provider Sustainability Funds £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 Children and Family Health Devon training £0.31m (matched by income), offset by underspends on drugs £0.33m and non-clinical supplies £0.18m.

- Total pay run rate in Month 12 (£35.0m) was £13.6m higher in comparison to previous month (Month 11 £21.4m). This included £10.8m for the NHS Pension contribution paid centrally and £2.0m for the annual leave accrual. Therefore, the underlying increase in run rate amounted to £0.8m and reflected 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.

- Non pay expenditure run rate of £23.32m was £6.06m higher compared to Month 11 (£17.26m). This was due to higher spend in: clinical supplies and services £0.71m, non-clinical supplies £0.07m (mainly Covid 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 Individual Patient Placement full year cost accrual £0.54m (matched by budget), increase in Children Family Health Devon cost with Devon Partnership Trust £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 was £17.31m. This was £1.5m lower than the forecasted value, in part due to delays to items forecast for delivery in March, as a result of Covid.

- Looking to the new financial year, the Board noted that the Financial Delivery Group meetings had been reinstated to ensure there was a focus on financial delivery in 2020/21, and service and practice opportunities were maximised following Covid.

Mr Sutton raised CIP performance and the need to keep a focus on performance and said he welcomed the reintroduction of the Financial Delivery Group meetings. The Chief Finance Officer agreed and said the biggest risk for the Trust was around the independent sector as a driver of the Trust's financial performance. He said that the Trust would work with the Council through the Recovery Cell on this issue.

Professor Balch asked if the cost of supporting the care home sector during Covid was being recorded and the Chief Finance Office confirmed that it was, and that the Trust, Council and partners were very clear about the financial impact of any decisions being made.

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

74/04/20 **Mortality Safety Scorecard**

The Acting Medical Director briefed the Board on the data provided through the Mortality Safety Scorecard. He reminded Board members that the data was usually around three months out of date and that in the main the Trust was in expected ranges up to December 2019.

The Board noted the variance in data on the Unadjusted Mortality Rate and noted this was due to the fact that the Trust had stood down activity due to Covid and had less beds occupied in the Trust resulting in an increase percentage against a lower bed occupancy than normal.

The Board also noted emerging data during Covid which was subject to local review and would be subject to a more detailed review at sub-committee level and at the next Board meeting.

The Board of Directors received and noted the Mortality Safety Scorecard.

75/04/20 **Education and Workforce Development Report – focus on Covid response**

The Board noted the work that had been undertaken by the Education and Workforce team to support the Trust's Covid response:

- Some staff had been reassigned to support clinical services.
- All face to face training had been stood down and was now being delivered via various different platforms. This included induction sessions which were now being delivered online.
- A training video had been developed to show how to prone patients in ICU which was now being used nationally.
- Mask fit training was being delivered seven days a week.
- Upskilling support was being provided to staff.
- As the Trust moved back to business as usual training would be stood back up again.

Mrs Matthews queried the statement in the report that staff have found the reskilling and reassignment process stressful and asked what action had been taken to support staff and managers. The System Director of Nursing and Professional Practice explained that she did not have that level of detail, but did have some information from the Freedom to Speak Up Guardians that was being used to support managers and staff. Some members of staff who had been reassigned have done a video detailing their experience of the process which has been very well-received.

Mr Sutton asked if the training around mask fit, PPE and infection control was being made available to domiciliary and care homes and the System Director of Nursing and Professional Practice confirmed that it was. The Director of Estate and Commercial Development added that to support PPE training a flow chart has been developed for use in care homes.

Professor Balch asked if the capacity provided from the Trust's subsidiary company, Health Care Innovations LLP was being exploited and also asked if the Trust was working with universities to discuss educational training once the pandemic was over. The System Director of Nursing and Professional Practice explained that the use of digital technology was being maximised and that regular meetings were being held with university leads. She added that the Trust's Years 2 and 3 training programmes have been updated to provide a blended learning facility.

The Director of Workforce and Organisational Development informed the Board that as a result of the learning from the redeployment of staff, it was apparent that departmental plans around workforce in the event of a major incident were not robust. She said a framework was being developed that would define that how staff would move to a 'reservist' role if required in the future.

The Board of Directors received and noted the Education and Workforce Development Report.

76/04/20 **Maternity Governance Safety Report**

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

The System Director of Nursing and Professional Practice informed the Board that NHS Resolution have suspended the CNST Year 3 standards and it was not clear if they would be reinstated in the current year or not. They have, however, encouraged Trusts to continue to work towards the standards.

The report detailed the improvements to safety that had been made within the Maternity Department including the improvement made to ensure an obstetrician and midwife were present for each review and the use of the perinatal priority review tool.

HSIB (Healthcare Safety Investigation Branch) have informed the Trust they would no longer routinely investigate events involving cooled babies where there was no apparent neurological injury. The Board noted that between January 2020 - March 2020 the Trust had not had any cases that met this criteria.

An updated Saving Babies' Lives Care Bundle had been received which included a fifth element to prevent preterm labour. It was noted that this would be implemented by August 2020.

The Board noted that there had been a reduction in the annual still birth rate in the Trust for the second year in a row.

Covid and Non-Covid areas had been identified within Maternity and planning and regional level was taking place to ensure there was resilience for obstetric staffing.

Mrs Lyttle said she welcomed the report and was pleased to note that many of the improvements that had been made were embedded and were now 'business as usual' for the service.

The Trust Board reviewed and noted the contents of the report and supported the process of review of the reports on a quarterly basis.

PART B: Matters for Approval/Noting without Discussion

77/04/20 **Finance, Performance and Digital Committee – 27th April 2020 and Log of Deferred Items**

The Board noted that the Log of Deferred items had been updated at the meeting on the 27th April and asked that the updated version was circulated to the Board of Directors. | CEPA

The meeting also discussed the Trust's capital programme and the changes to the capital regime for the new financial year, uncertainty around how they would be applied and how they might affect the Trust.

78/04/20 **People Committee – 27th April 2020 and Log of Deferred Items**

This item was deferred to the next meeting.

Reports from Executive Directors

79/04/20 **Safe Staffing and Nursing Work Programme**

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

The Board of Directors received and noted the Safe Staffing and Nursing Working Programme.

80/04/20 **Report of the Chief Operating Officer**

The Board of Directors considered the report of the Chief Operating Officer.

The Board of Directors received and noted the report of the Chief Operating Officer.

81/04/20 **Compliance Issues**

There were no compliance issues.

82/04/20 **Any Other Business Notified in Advance**

There was no any other business discussed.

83/04/20 **Date of Next Meeting – 9.30 am, Wednesday 27th May 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 workforce data for the end of February so there was baseline data pre-Covid-19.	DWOD	The data was as follows: February / March Month Sick % 4.53 / 4.82 12 Month Sick % 4.42 / 4.47 Turnover % 12.74 / 11.81 Appraisal % 81.57 / 78.66 Training % 90.41 / 90.44	01/04/20
2.	Consider if there was capacity and ability to track how Trust performance would have continued to improve if Covid-19 had not occurred.	CX	The Board received this information as part of the IPR Report and Trust Recovery Plan.	01/04/20
3.	Undertake work to understand the Staff Survey findings in relation to staff engagement.	DWOD	The need to take this work forward was discussed at the April People Committee following areas of work being stood down due to Covid. This work would now commence and progress reported at the next Board Meeting.	01/04/20
4.	Triangulate Staff Survey data with CQC findings.	DWOD	See above	01/04/20
5.	Thank Estates staff for their work to support a positive PLACE assessment.	DECD	Completed	01/04/20
6.	Include updated Log of Deferred Items for the Finance, Performance and Digital Committee with the Board Minutes.	CEPA		29/04/20

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 27 May 2020
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Director of Transformation and Partnerships Joint Heads of Communication		
Report provenance	Reviewed by Executive Directors 20 May 2020		
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: 27 May 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 29 April 2020 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Managing the COVID-19 outbreak

We have continued to operate a Gold and Silver command system to ensure our response to the pandemic has been properly managed and co-ordinated throughout. Thankfully we have continued to see a relatively low level of people needing care for COVID-19 in Devon. However, we are well prepared should there be a spike.

Our focus has continued to be on delivering services across our Trust that are safe for patients who have COVID-19 and also for those who do not have the virus but have other urgent healthcare needs. We have managed this by ensuring the pathways can be kept separate with very strict infection control measures adhered to.

As numbers of COVID-19 patients we are seeing continue to decline, we are increasingly focussing on the restarting of urgent services. We have a recovery cell in place that is overseeing how we reinstate our services, reflecting requirements within the letter from NHSE CEO, Sir Simon Stevens. We are carefully taking the learning from our COVID surge preparation, and using this to re-design our services to ensure that we can deliver the care our local population needs sustainably and maintain our ability to cope with any future surges in COVID cases. We are working in partnership with trusts across Devon to ensure that we utilise all of our resources to deliver care for local people.

1.1.2 Arrangements for safe services

We have continued to provide emergency and urgent care across the majority of our services throughout. In order to do this safely we reconfigured how the services were provided and we have now built on that service reconfiguration so that we can now begin to step up other services. We are now beginning to provide less urgent care and are putting plans in place to step up activity across a full range of services to safely provide care. To do this effectively we are prioritising services with the greatest clinical need such as cardiology, diabetes and respiratory.

Changes we have implemented across our acute services include:

- 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 hub 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.
- Trialling the use of thermal imaging for patients and staff who are accessing elective services as part of our Newton Abbot Hospital green site. We will also start trialling a similar approach in the level 4 entrance on the Torbay Hospital site.
- 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.
- Very positive joint working and collaboration between the Trust and Ramsay Healthcare to use Mount Stuart hospital as a COVID-19 free site. This is supporting the Trust to safely provide urgent elective surgical and outpatient activity.

There are challenges in assuring patients that our services continue to be safe. It is particularly important that we support local people to feel confident that they should take up the offer of elective surgery. We have put a number of measures in place to ensure sites can be kept safe by separating care provide to patients with COVID-19 from those who do not have the virus. In addition to putting in measures that ensure services are safe, it is vital that we communicate this to the public so that they have confidence to access care. We are doing this in a number of ways including in all our direct patient communications, through media and social media campaigns and importantly working with GPs so that they reassure their patients in their phone calls and letters. We are beginning to see the results of this with increased numbers using our services.

1.1.3 Community services - Care Homes

We continue to provide regular and close support to care homes in our area. The dedicated community silver cell continues to focus on supporting our community services team and the wellbeing of people in their care. This includes working with care providers to ensure they have the PPE they need and where there are outbreaks of the virus in care homes, that providers are fully supported to continue to care for residents safely. This has included providing enhanced staffing levels from our own highly trained workforce to support care homes who have experienced difficulty.

We have received very positive feedback from our local providers who we have been able support during this difficult time. Our enhanced care response has also been commended by the Care Quality Commission and Public Health England.

We continue to follow 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. We have put in place a responsive plan which enables us to rapidly swab both residents and staff in the event of a suspected outbreak to enable a rapid support plan to be enabled.

Our programme to support enhanced health care in care home is underway, which supports care homes to access advice and support from our community teams. Digital solutions are being tested in some care homes to support accessing advice and guidance where care homes are concerned about their residents. This programme will be implemented fully in all care homes over the next year.

1.1.4 Shielding Hub

In partnership with Torbay Council we have a team supporting vulnerable people who have been asked to 'shield' during the pandemic. Originally 3,400 people were identified as requiring additional support and that number has grown with 6,000 people now on the database. The team has been providing these vulnerable people with a range of support such as for mental health and wellbeing and to give healthy lifestyle advice as well as with essential supplies.

1.1.5 COVID-19 support from our communities

Our local communities have continued to offer us amazing support for which we are ever grateful. 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 small team to co-ordinate arrangements to manage offers of help. Anybody wishing donate goods and services is advised to email donations.tsdft@nhs.net for advice and guidance.

Generous local people have donated a fantastic £17,500 on our corporate JustGiving account to say 'thank you' to our staff. All donations received are being put towards our COVID-19 response efforts. As part of the NHS Charities Together group our charitable fund are also benefitting from the national funding raising efforts. We have already been able to set up some areas for staff to relax in as well as provide care packages to support them. We are now planning some other projects that will see the money used to improve some of the facilities for staff to support them to care for their patients.

1.1.6 Supporting our communities

We are increasingly seeing the benefits of our integrated care organisation ethos of partnership and the importance of supporting our communities to remain healthy and well in these adverse times. Access for people who require help and support is available through our Talking Points and our health and wellbeing team of co-ordinators continue to provide invaluable support during this challenging time.

As part of our ethos of partnership and commitment to wellbeing, we have ensured that we have provided donations of food to our local food banks and have agreed to make it possible for people to donate to our local food bank alongside our Just Giving page to ensure that we are here to support people with meeting their basic needs for food.

1.2 Valuing our Workforce, Paid and Unpaid

1.2.1 Workforce initiatives during COVID-19

Our Resourcing Hub continues to develop and establish itself, and has now resolved 70 requests to ensure that services have the workforce capacity they need to deliver their service. Most recent activity has been: reassign staff to support mask fitting training to

create a new temporary dedicated training team, helping with capacity and consistency; our swabbing team to help increase numbers of testing; and finally reassigning both staff and engaging volunteers with our donations team to help them manage the huge generosity from the community.

The Resourcing Hub is continuously learning and in response to feedback and planning for future, a new 'Supporting Reassignment - Guidance Pack' has been produced with a strong emphasis on wellbeing. This has already been used in supporting both new and existing reassignments.

We have also set up a network of 16 co-ordinators to ensure we have a quick response to requests for staffing support within the Trust. This network is capturing and sharing learning so that the right support can be given.

Our people's wellbeing is a constant focus for this group and our regular 'network check in calls' are a valuable time to reflect and share, to ensure continuous learning is embedded in how we approach our people resourcing and reassignment.

The National Bringing Back Staff scheme is still live and we have five nurses that have been currently deployed into our workforce. This scheme has also has created opportunities for the hub to develop relationships with new contacts across the Devon Strategic Transformation Partnership which will support our move into new ways of working.

1.2.2 Health and Wellbeing

We continue to both provide a high level of support and events, all focussed on supporting the wellbeing of our staff. Over the past few weeks we have seen staff engage in: two plant sales, distributing our new 'Hug in a Heart' cards, joining the 'HeArTs and mind virtual sessions and access 'The Sanctuary' (rest space within Bay View). All of these events have had very positive feedback.

There are a number of areas we are providing staff support including:

- Through joint working between the Wellbeing and Psychology teams we are providing support for any staff who have suffered a bereavement
- Supporting teams and individuals through virtual platforms, and we are also providing facilitation support to some teams and individuals face to face whilst ensuring social distancing and safety throughout
-

Evaluation of the use and impact of our health and wellbeing support as an organisation, is a priority over the coming weeks, as we move into the next phase.

1.2.3 Virtual HOPE Programme for Staff

The Trust has launched a virtual HOPE (Help to Overcome Problems Effectively) programme, specifically aimed at staff working in the Trust. This is a particularly stressful and anxiety-provoking time for NHS staff, and we want to ensure that we look after our staff and their wellbeing as much as we can. The courses which run for six weeks will support staff to prioritise their own wellbeing, increasing a sense of control and resilience.

2. Chief Executive Engagement: May

I continued to engage with external stakeholders and partners in May 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 • Joint Local Negotiating Committee • Shielding Support Team • Video blog sessions:	• 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 • System Chief Executives • Care Quality Commission Leads • Principal, South Devon College

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

3.1.1 Health and Care Innovation

Health and Care Innovations LLP (HCI) (our joint venture with Rocklands Media Ltd) has secured a six-month contract with NHSX to create a national video library or around 600 videos to support clinicians in all trusts (acute, community, mental health) and CCGs, primary care and PCNs amongst others. This will aim to minimise the number of face-to-face appointments, and to support programmes such as video and telephone consultations etc. It won't be as powerful as a dedicated local library but it will be a first step on that journey for these organisations. It will be rolled out through the NHSX deployment team, regional AHSNs and regional NHSX representatives. HCI will then provide resources to the organisations to enable them to use the library. HCI are moving into implementation rollout now alongside the NHSX team, who have allocated a project manager to the task. NHSX will lead on setting the context and need with HCI providing the guidance on "how to".

3.1.2 New NHS Nightingale Hospital to open in June

The need for acute care for patients suffering from COVID-19 has been thankfully lower than anticipated which has allowed for some changes to the planning for new NHS Nightingale Hospital in Exeter. It has been decided to change the location to Sowton Industrial Estate in Exeter rather than the original Westpoint site.

Work to build the latest NHS Nightingale hospital is now underway and it is expected to be completed in mid to late June with 120 beds for Devon, Cornwall and neighbouring counties to support the existing hospital network. As we move into the next phase and towards recovery the hospital could also be used for those patients with less severe problems associated with COVID-19 – and for those who are recovering after a period in hospital.

Once it has opened, the hospital will be operated by the Royal Devon and Exeter NHS Foundation Trust on behalf of all the hospitals in Devon and Cornwall. The five hospitals in the peninsula will continue to provide the majority of care for critically ill patients with COVID-19.

To support the maximum number of beds (120), 450 NHS clinical staff from across the region would work at the hospital. Until they are required, staff will remain on standby – at their existing hospitals or workplaces.

4 NHS England/Improvement

4.1 NHSE confirm the improvements of stronger partnerships will continue

NHSE's Chief Operating Officer has said that the NHS and partners will be able to 'lock in' improvements to their work by putting whole-system planning at the heart of coronavirus recovery plans. As part of the effort to respond to the COVID-19 health emergency, NHS and local government staff have been fast-tracking new technology, new partnerships and new ways of working, to make services easier and more convenient for residents. Integrated care systems (ICSs) have been central to the coordination and delivery of this response, bringing together hospitals, care homes, GPs and others to plan for immediate and future needs. This has included important initiatives between NHS and local government, such as mutual aid agreements.

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
The pilot of the body heat scanner used to detect a raised temperature people going into Newton Abbot Hospital was covered on the TV news as we ensure the safety patients and staff. This is thought to be the first example in England of such technology being used and is the result of a partnership with the University of Plymouth.

Junior doctors graduate early to help Trust - We welcomed 20 new Doctors to the Trust who have chosen to graduate from Medical School early and join our organisation over the next few months to support our services in Torbay, and to support the NHS.

Herald Express

- Staff jumping for joy with homemade scrubs
- Celebrating VE day – Photo of Staff on Ricky Grant celebrating is main photo
- Churston Ferrers Grammar School have produced more than 200 visors to be used by care homes and community nursing staff
- Seven-year-old raised money during a 20-mile walk for Torbay Hospital as they helped treat her parents and saved her dad who was in a coma with COVID symptoms
- £8m mental health unit on Torbay Hospital receives planning go ahead
- Devon restaurant gives Muslim Trust staff food boxes for Ramadan

Torbay Weekly

- Parents reassured Torbay Hospital is ‘safe’ as new ward decorated by children
- NHS staff in singing and dancing tribute to fellow key workers
- Open letter from our CEO and Chairman thanking local people for their support

Breeze FM

- Torbay Pharmaceuticals distributing hand sanitiser nationwide
- The Trust has received over 100 scrubs for healthcare workers from a group of voluntary seamstresses called The South Devon Scrubs Angels

Other social media posts, press releases and campaigns

In just one week in May we reached over 63,000 people on Facebook and nearly 30,000 people on Twitter

- Thank you to local people and businesses for their amazing support during the pandemic with lots of different donations from money on our Just Giving page to scrub bags and visors
- Testing facilities in Torbay
- Support for mental wellbeing
- Competitions for children – draw your ‘Workforce of the Future’
- Celebrating International Day of the midwife
- Promoting Hand Hygiene
- Seven-year-old, Beth who walked and danced 20 miles to raise money for the Trust
- Torbay Pharmaceutical supporting the effort by making hand sanitiser
- Marking VE Day

- How to access services
- Welcoming our new doctors to the Trust
- Celebrating International Nurses Day
- Surprise thank you from Superman actor, Dean Cain
- Mother and daughter student nurses
- Congratulations to our Staff Hero winners

6 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 1 2020/21 (April 2020 data)			Meeting date: 27 May 2020
Report appendix	Appendix 1- Month 1 2020/21 - Focus Report Appendix 2 - Month 1 2020/21 - Dashboard of key metrics		
Report sponsor	Director of Transformation and Partnerships Director of Finance		
Report author	Head of Performance		
Report provenance	Performance briefing with Executive Directors (12 May 2020) Executive Director scrutiny (19 May 2020) Finance Performance Digital Committee (22 May 2020)		
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 M1 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 Committee is asked to **review** the documents and evidence presented to formulate a recommendation to the Trust Board.		

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

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

Board Assurance Framework	Yes	**Risk score**	25
Risk Register	Yes	**Risk score**	25

External standards affected by this report and associated risks	

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

This report reflects the following corporate risks:

- Failure to achieve key performance standards
- Inability to recruit/retain staff in sufficient number/quality to maintain service provision
- Failure to achieve financial plan

Report title: Integrated Performance Report (IPR): Month 1 2020/2021		**Meeting date:** 27 May 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 maintaining normal incident feedback and engagement metrics. The Quality Improvement Dashboard is being maintained and shared with ISU leadership teams. The ISU Clinical Governance Coordinators are being utilised differently to ensure safety is a kept key priority in all the changes to service delivery that are being undertaken.

The Safety Cell, which is well represented with Executives, is reviewing safety on a weekly basis and ensuring, where necessary, Equality Impact Assessments (EQIA's) are being recorded and reviewed as services are impacted and recovered from the COVID-19 response.

The M1 Quality will be reviewed at the Quality Assurance Committee.

Many of the quality metrics remain on target, however the focus report gives further detail against the Quality metrics exceptions being reported against:

- Stroke – time spent on the stroke unit, which is related to specific interventions in the stroke unit in April for temporary infection control measures, which should be resolved in May's report.
- VTE - assessment on admission performance as reported on our electronic systems remains a challenge due to data entry issues. This is being addressed through a project to improve discharge information.
- Follow up appointments passed their intended to be seen date has increased as a direct result of the Covid-19 impact. Digital solutions to support non-face to face appointments are being utilised and through the recovery cell, the outpatient work-stream is undertaking a programme of work to ensure that all priority activity is stood up safely, swiftly and maximises the opportunity for transformation. The Quality Assurance Group continues to monitor this risk.

2. Workforce Headlines

Workforce Highlights and response to Covid-19

In April, the Trust continued to respond to COVID-19 with work across the following areas:

1. Activated the Workforce Pandemic Flu Policy
2. Create Workforce Information/Advice Hub
3. Create Training and Development Plan
4. Create a Staff Health and Well Being Plan
5. Establish Resourcing Hub
6. Develop Workforce Plans to Support Surge Acute, Community and Nightingale

Performance exceptions and actions

Of the four workforce KPIs on the IPR dashboard two are RAG rated Green, two RAG rated Red as follows:
Turnover (excluding Junior Doctors): **GREEN -** The Trust's turnover rate now stands at 10.54% for the year to April 2020.

Staff sickness/absence: RED - The annual rolling sickness absence rate was 4.51% to end of March 2020. The monthly sickness figure for March was 4.86% mainly due to extra sickness due to Covid and the highest sickness rate for any March over the last 10 years.

Mandatory Training rate: **GREEN** - The current rate is 90.41% for April 2020 against a target of 85 The Covid escalation having little impact on compliance as staff continue to do on-line training and most renewal periods are no longer annually.

Appraisal rate: **RED -** The Achievement Review rate for the end of April 2020 was 71.57% which has been impacted by the call to stand down appraisals due to Covid as the end of March was 78.66 %.

3. Performance Headlines

The focus report describes the month 1 position against key performance metrics showing a deterioration in the key NHSI performance metrics against elective access standards. This is expected as activity levels for planned care have reduced significantly due to the COVID emergency response.

Performance against the 4-hour standard for patients attending the emergency department however has improved to 94% as a result of the lower activity levels and availability of impatient beds.

M1 activity summary below:

	Last year M1	This year M1	%
OP New	8,887	2,925	33%
OP F/up	21,340	10,272	48%
DC elective	2,842	1,021	36%
IP elective	271	102	38%
Emergency IP	2,339	1,305	56%

We are now entering the covid-19 recovery phase and starting to see services recommencing elective outpatients, diagnostic, therapies and surgical activity. This return of capacity is however constrained by compliance with social distancing / Infection Prevention control requirements/ available facilities (theatres and outpatient clinic) and patient engagement. It is forecast that capacity for non-urgent elective services will remain below historical levels for some time.

Whilst plans are being prepared and implemented for stepping back routine services, the urgent and cancer related service will continue.

An impact assessment against access standards and forecast will be prepared once recovery plans can be fully assessed. It is clear however that it is likely that access standards for routine activity will deteriorate further as we see a return to increased level of referral and emergency admissions and our capacity remains below historical levels.

4. Finance Headlines

- NHSI/E mandated Trusts to show a break-even position after adjusting for Donated items; the Trust's underlying M1 position is a surplus of £0.34m.
- Patient care income block is £0.80m higher than budget due to additional income from CCG for COVID related expenditure. Similarly, £0.25m is received from Torbay Council for ASC income. Client contribution is higher by £0.13m linked to additional activity and other income is lower by £0.68m due to the following: non-patient related services £0.42m, car parking £0.13m as the Trust now offer free parking to staff, and R&D income £0.13m due to reduced trials.
- Pay expenditure of £22.67m is £1.71m higher than the 3 month average run rate. This is due to increased pay due to COVID of £0.87m (matched by income), annual leave accrual of £0.75m in month and higher bank use £0.09m. There is a reduction in Agency use of £0.14m due to operational changes in a number of clinical areas due to COVID.
- Non-pay expenditure (Other) is £0.75m lower than the average mainly due to lower Drugs cost of £0.63m as a result of clinical activity reduction and various other cost £0.12m due to COVID impact.
- Independent sector non-pay cost (ASC, placed people for health including CHC) have increased by £1.37m in M1 due to a number of COVID related payments, largely relating to financial assistance to providers and payments for voids

totalling £1.0m (matched by Income). Price uplifts paid to providers, growth and delayed CHC assessments account for £0.37m.

- It is assumed that COVID related costs and income loss is fully reimbursable by NHSI/E - a total of £2.31m has been included in M1.
- Financing cost increased by £0.22m due to Depreciation now showing the increased cost of RICS adjustment.

5. **Recommendations**

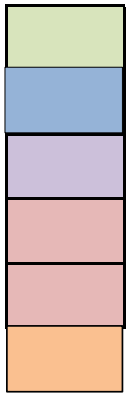
The Board is asked to review the performance information and action to address performance issues.

Torbay and South Devon
NHS Foundation Trust

Integrated Performance Report

May 2020: Reporting period April 2020 (Month 1)

Section 1: PERFORMANCE



Quality Focus
Workforce Focus
Community and Social Care Focus
NHSI operational performance indicator focus
Local performance metric exception
Children and Family Health Devon

Section 2: FINANCE

Finance Focus

Quality Focus

Month 1 (performance to end of April 2020)

Quality and Safety Summary

Quality Headlines and Covid-19 response

Safety and Quality Covid response

Covid Safety Cell - The aim of the safety cell is to provide urgent clinical leadership, governance support guidance to the incident and complaints functions and to enable prompt identification of themes in the context of the Covid-19 pandemic.

The group reviews information relating to incidents and complaints to determine the most appropriate level of investigation and manager responses to quality issues as they emerge in the context of the response to the Covid-19 pandemic including Equality impact assessments (EQIA).

Clinical Governance weekly reviews - During this period a weekly virtual meeting has been held with the Integrated Service Unit clinical governance coordinators who have reported any quality and Safety issues into the Patient Safety and Experience Lead.

Between the two groups all serious incidents and complaints have been managed and normal business maintained

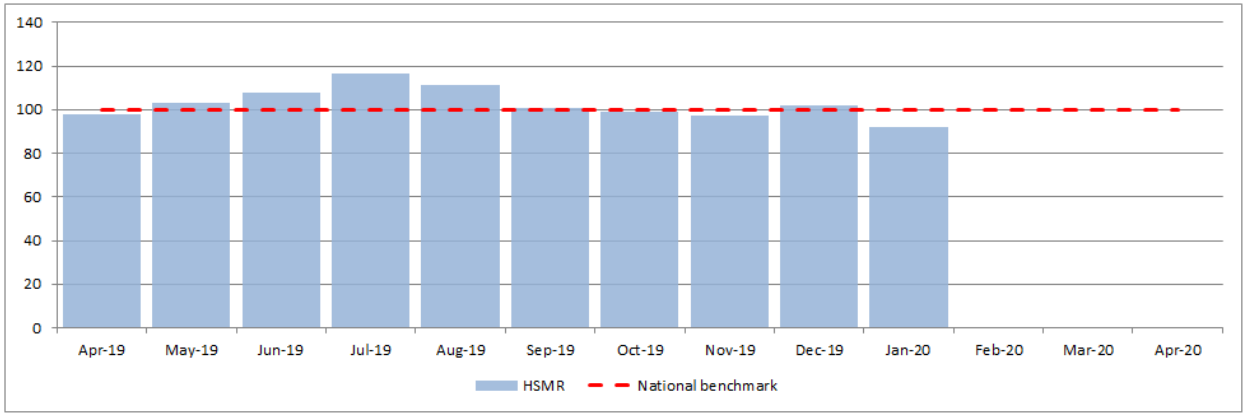
Performance exceptions

Standardised Mortality rates - It s too early to see the impact of COVID-19 in any benchmarking mortality data to compare our local data to National benchmarking - It is clear however that to date the prevalence of COVID-19 have been variable across the country as well as the diferential between hospital and non hospital deaths.

Quality and Safety - Mortality

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

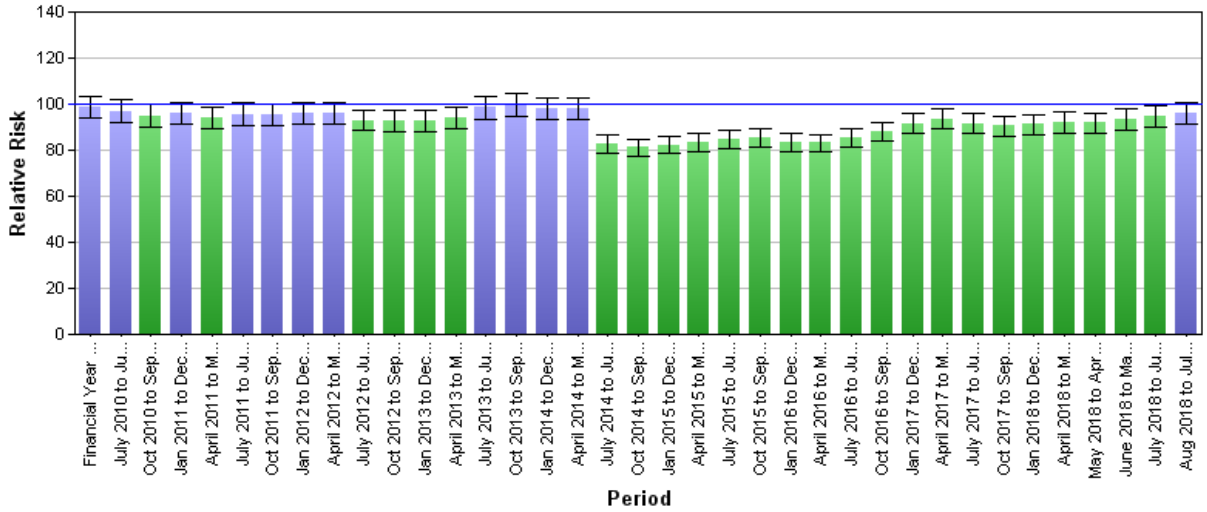
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
HSMR	97.8	103	108	116.5	111.3	101	98.8	97.5	102.2	92	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



Trust wide mortality is reviewed via a number of different metrics, however, Dr Foster allows for a standardised rate to be created for each hospital and, therefore, this is a hospital only metric. This rate is based on a number of different factors to create an expected number of monthly deaths and this is then compared to the actual number to create a standardised rate. This rate can then be compared to the English average, the 100 line. Dr Foster's mortality rate runs roughly **three month in arrears**.

The latest data for Dr Foster HSMR is showing a relative risk of 92, which is below the national benchmark. Being 3 month in arrears it is too early to se any impact from COVID 19

SHMI by data period



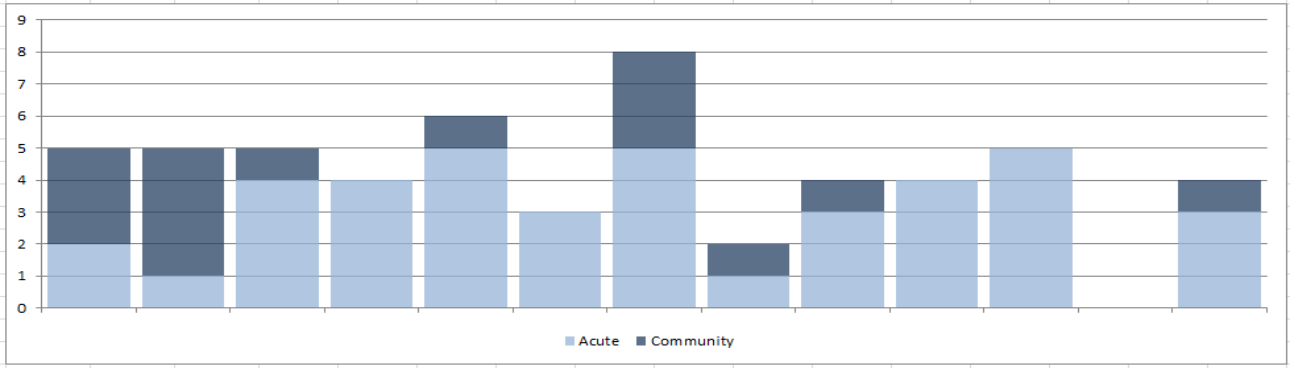
The Summary Hospital Mortality Index (SHMI) data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trusts at 90.58 against a national average benchmark of 100. Latest data for period August 2018 –to July 2019.
SHMI, HSMR, and Dr Foster alerts are reviewed through the Mortality Surveillance Scorecard at the Quality Improvement Group.

A score of 100 represents the weighted population average benchmark.

Quality and Safety - Infection Control

Number of Clostridium Difficile cases

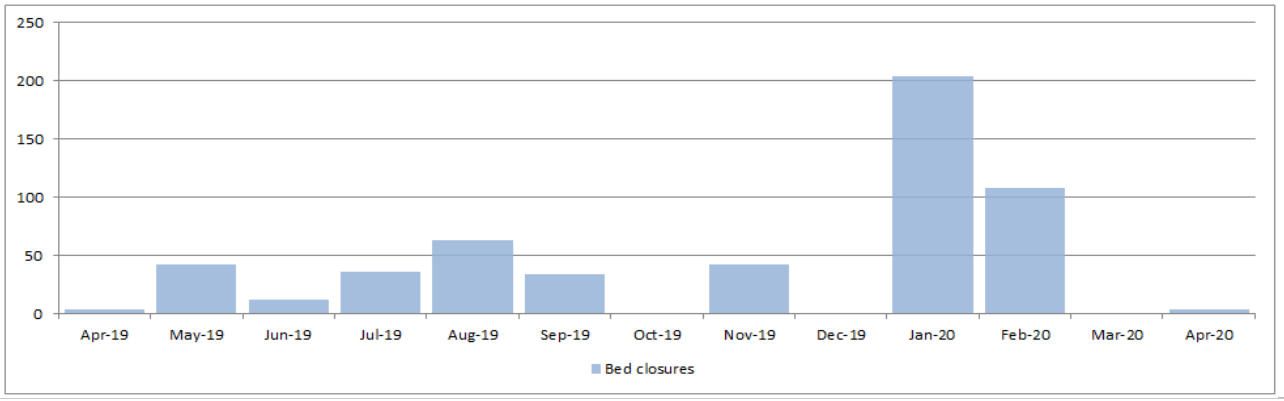
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Acute	2	1	4	4	5	3	5	1	3	4	5	0	3
Community	3	4	1	0	1	0	3	1	1	0	0	0	1



Each reported case of C-diff undergoes a Root Cause Analysis; learning from these is used to inform feedback to teams and review of systems and processes.

Infection control - Bed closures (Acute)

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Bed closures	4	42	12	36	63	34	0	42	0	204	108	0	4



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

In April, there were 4 bed days lost to diarrhoea and vomiting infection control issues.

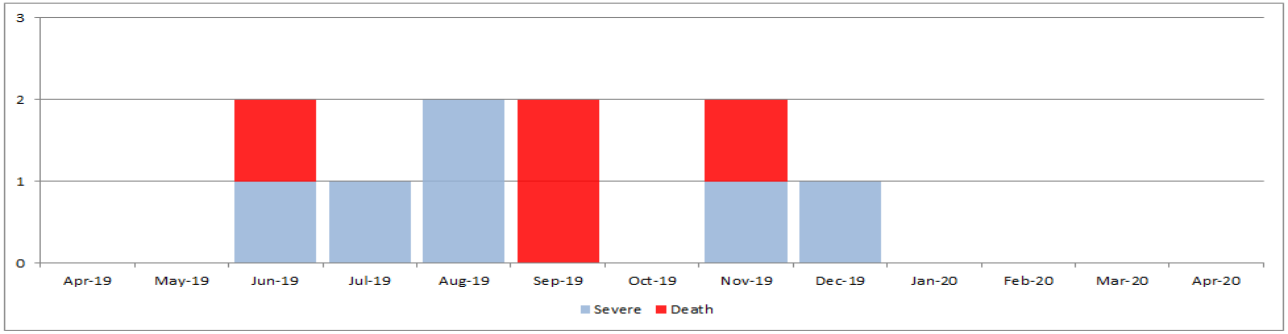
COVID-19

During the COVID-19 response there continues to be changes to Infection Prevention Control (IPC) procedues reflecting National guidance. This ranges from the use of PPE and specific requiements for different clinical areas, visiting policy, enhanced cleaning, testing of all admissons for COVID-19 and managing ward bays to lower occupancy levels.

Quality and Safety - Incident reporting and complaints

Reported Incidents - Severe and Death

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Severe	0	0	1	1	2	0	0	1	1	0	0	0	0
Death	0	0	1	0	0	2	0	1	0	0	0	0	0



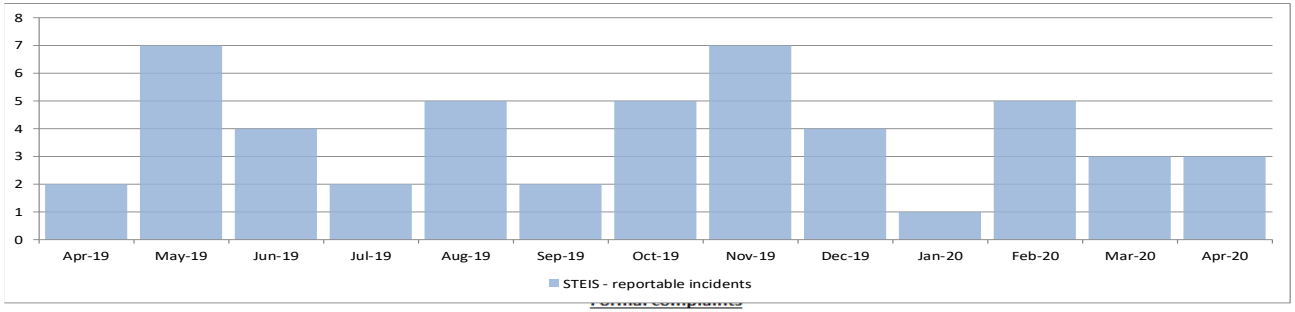
In April no severe or deaths incidents we reported.

Routine reporting of ncident has been maintained throughout the COVID-19 response.

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

STEIS Reportable Incidents

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
STEIS - reportable incidents	2	7	4	2	5	2	5	7	4	1	5	3	3

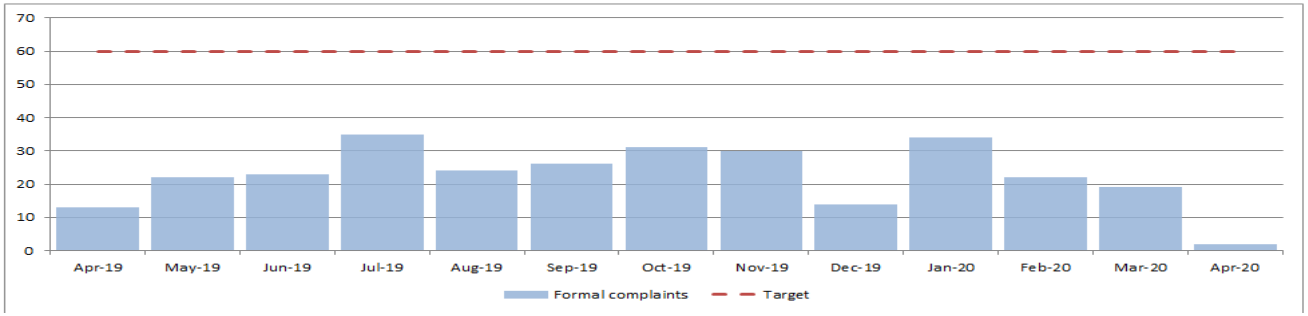


The Trust reportedthree incidents in April on the Strategic Executive Information System (StEIS).

The sites of recorded incident is
1. Health and well being team - NA ISU
2. Theatres - Coastal ISU
3. Labatory medicine P+B ISU

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

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Formal complaints	13	22	23	35	24	26	31	30	14	34	22	19	2
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



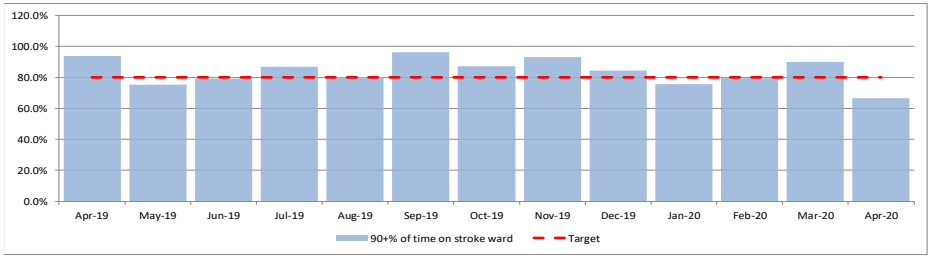
In April the Trust received 2 formal complaints. - This level is clearly a result of the COVID-19 response with greatly reduced activity and changes in patients engagement with our services.

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

Quality and Safety - Exception Reporting

Stroke

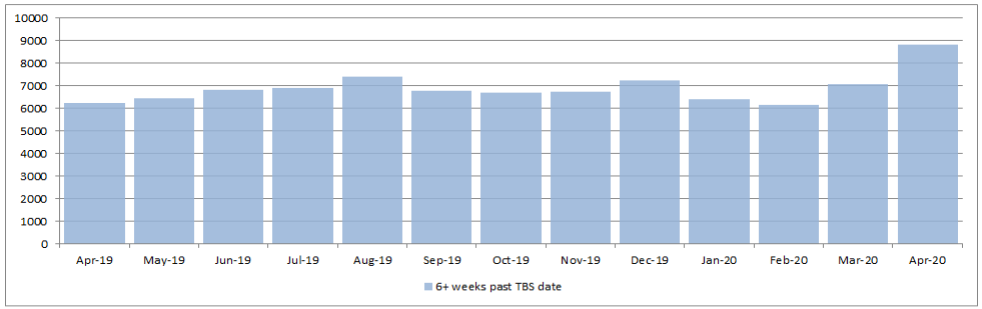
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
90+% of time on stroke ward	93.8%	75.5%	79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Stroke: The percentage of patients spending greater than 90% of time on the stroke ward from admission has decreased. In April the stroke ward was decanted due to covid infection and transferof some patients to non stroke wards. This temporary infection control measure for the stroke unit has impacted on the reported performance for April.

Follow ups 6 weeks past to be seen by date

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
6+ weeks past TBS date	6240	6459	6803	6906	7393	6793	6694	6725	7243	6391	6147	7056	8824

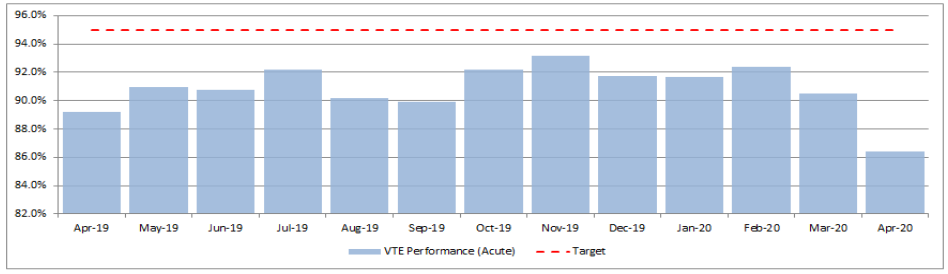


Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in April to 8824. This is a direct result of the COVID-19 response and the standing down of routine outpatients services in April. Telephone and video clinics have allowed clinicians to continue to give advice to patients. Increasing this capacity will be key to managing future clinical risk whilst capacity for face to face appointments remains limited.

The Quality Assurance Group maintain oversight and assurance regarding any harm to patients and review plans to mitigate clinical risk against patients waiting beyond their intended review date.

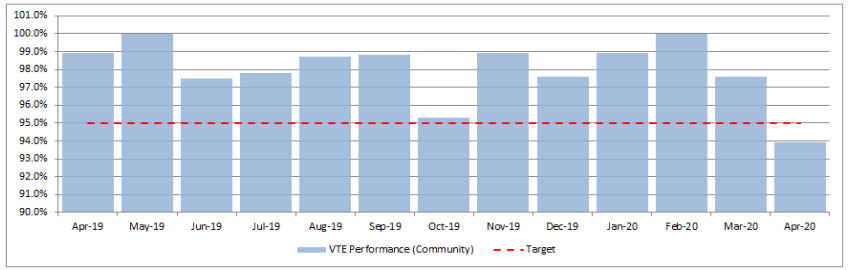
VTE risk assessment on admission - (Acute)

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
VTE Numerator	5488	6001	5568	5936	5792	5487	6196	6129	5743	6303	5768	4482	2325
VTE Denominator	6151	6597	6137	6441	6425	6104	6721	6577	6262	6875	6246	4952	2690
VTE Performance (Acute)	89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE risk assessment on admission - (Community)

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
VTE Numerator	93	85	77	89	77	85	81	90	82	92	93	81	31
VTE Denominator	94	85	79	91	78	86	85	91	84	93	93	83	33
VTE Performance (Community)	98.9%	100.0%	97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE: VTE performance in the acute setting remains below the standard of 95% at 86.4% and is not met in the community with 93.9%. Compliance with the reporting of VTE assessments remains a risk and is related to the process of capturing the information in a paper form and accurate transcribing onto the electronic discharge data collection. This remains a challenge and is part of a programme to improve discharge data collection.

Workforce Focus

Month 1 (performance to end of April 2020)

Workforce Summary

Workforce Highlights and response to Covid-19

In April, the Trust continued to respond to COVID-19 with work across the following areas:

1. Activated the Workforce Pandemic Flu Policy
2. Create Workforce Information/Advice Hub
3. Create Training and Development Plan
4. Create a Staff Health and Well Being Plan
5. Establish Resourcing Hub
6. Develop Workforce Plans to Support Surge Acute, Community and Nightingale

Performance exceptions and actions

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

Turnover (excluding Junior Doctors): **GREEN**

The Trust's turnover rate now stands at 10.54% for the year to April 2020.

Staff sickness/absence: RED

The annual rolling sickness absence rate was 4.51% to end of March 2020. This is against the target rate for sickness of 4%. The monthly sickness figure for March was 4.86% which is an increase from the 4.54% as at the end of February and mainly due to extra sickness due to Covid. March 2020 has been the highest sickness rate for any March over the last 10 years.

The Workforce and OD directorate are actively working with departments to ensure that absence is robustly managed. In addition a variety of wellbeing events are being arranged to support staff with their health and wellbeing.

Mandatory Training rate: **GREEN**

The current rate is 90.41% for April 2020 against a target of 85% and this is only a marginal drop from the 90.44% in March showing the Covid situation has had little impact on compliance as staff continue to do on-line training and most renewal periods are no longer annually.

Appraisal rate: **RED**

The Achievement Review rate for the end of April 2020 was 71.57% which has been impacted by the call to stand down appraisals due to Covid as the end of March was 78.66 %.

Agency Expenditure – As at Month 01 the Trust Agency spend was is £0.512m

Workforce - WTE

FTE Staff in Post (NHSI staff Groups from ESR month end data)

NHSI Staff Grp	2015/09	2016/09	2017/09	2018/09	2019/09	2020/03	2020/04	Change since ICO	% Change
Allied Health Professionals	420.56	411.16	401.50	408.83	486.15	474.03	471.65	51.08	12.15%
Health Care Scientists	89.69	92.75	92.13	91.28	90.91	93.66	93.05	3.36	3.74%
Medical and Dental	425.99	437.61	497.69	505.21	535.17	512.83	511.28	85.28	20.02%
NHS Infrastructure Support	1114.22	1099.87	1006.29	1004.70	1083.45	1085.14	1087.06	-27.16	-2.44%
Other Scientific, Therapeutic and Technical Staff	301.99	309.19	350.35	356.62	365.33	373.03	379.09	77.09	25.53%
Qualified Ambulance Service Staff	1.00	4.00	5.60	6.72	7.59	6.72	7.72	6.72	672.00%
Registered Nursing, Midwifery and Health visiting staff	1187.78	1193.74	1169.78	1166.50	1204.15	1199.91	1194.63	6.84	0.58%
Support to clinical staff	1593.74	1656.67	1613.65	1691.26	1807.54	1825.21	1872.50	278.76	17.49%
Grand Total	5134.99	5204.99	5136.99	5231.12	5580.29	5570.54	5616.97	481.98	9.39%

This information is reviewed at the People Committee, a sub-committee of the Trust Board.

Pay Report Summary

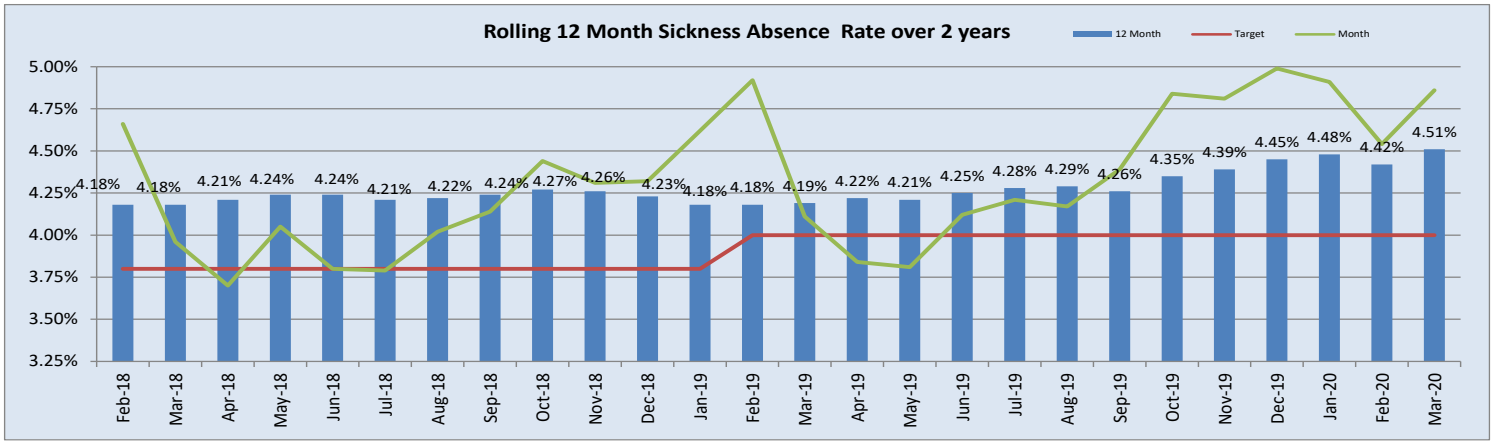
APRIL

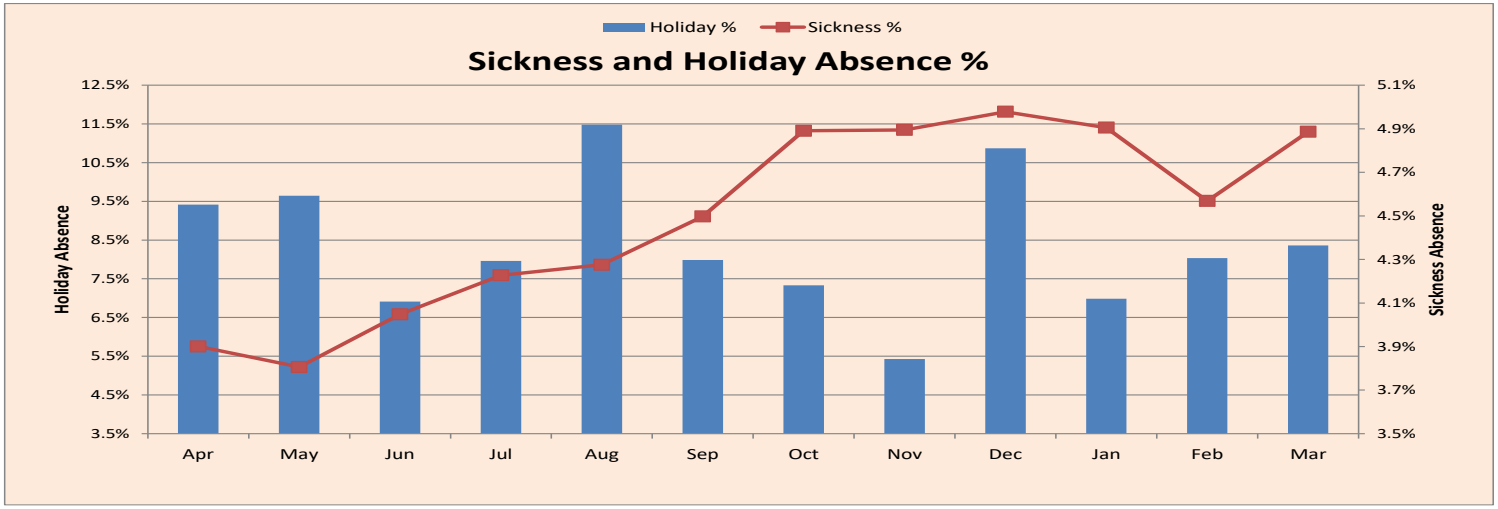
Cost	£
Substantive	£20,687,275
Bank	£1,227,269
Agency	£511,982
Total ACTUAL, £	£22,426,526

WTE Worked	WTE
Substantive	5674.56
Bank	352.25
Agency	81.61
TOTAL WTE worked	6108.41

Workforce - Sickness Absence

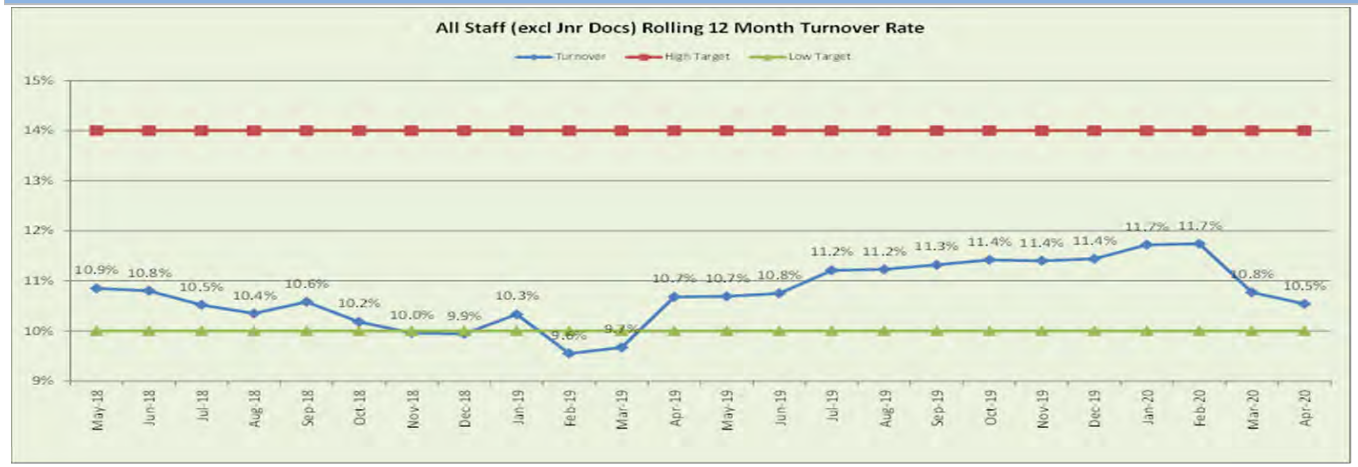
Rolling 12 month sickness absence rate - (reported one month in arrears)





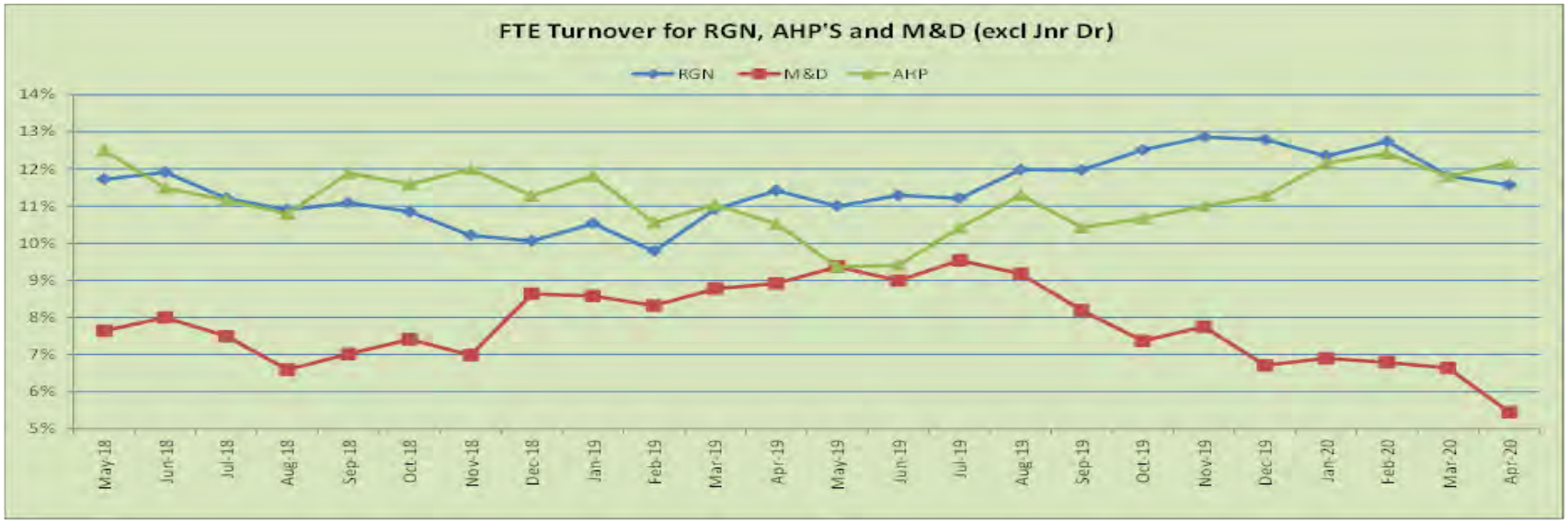
The annual rolling sickness absence rate was 4.51% at the end of March 2020which is an increase from Febuary's which stood at 4.42%.
The monthly sickness figure for March was 4.86 % which is a reduction from the 4.54% as at the end of Febuary.
March 2020 has been the highest figure for a month of March in the last 10 years and this had been due to the increased sickness due to Covid.
As Covid has impacted the ability for many staff to take planned holiday closer monitoring of holidays will be included monthly to ensure visibility is increased
.

Workforce - Turnover



All Staff Rolling 12 Month Turnover Rate

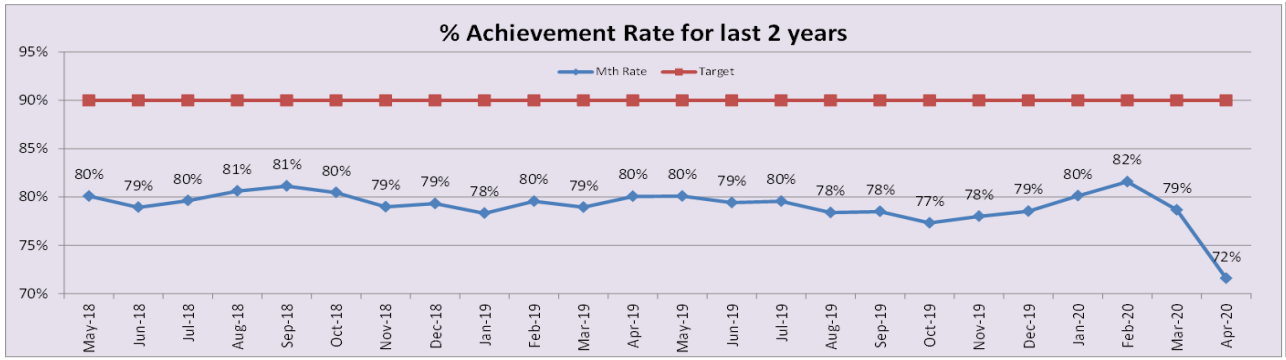
The graph shows that the Trusts turnover rate now stands at 10.54% for the year to April 2020 which is a decrease from 10.77% in March.



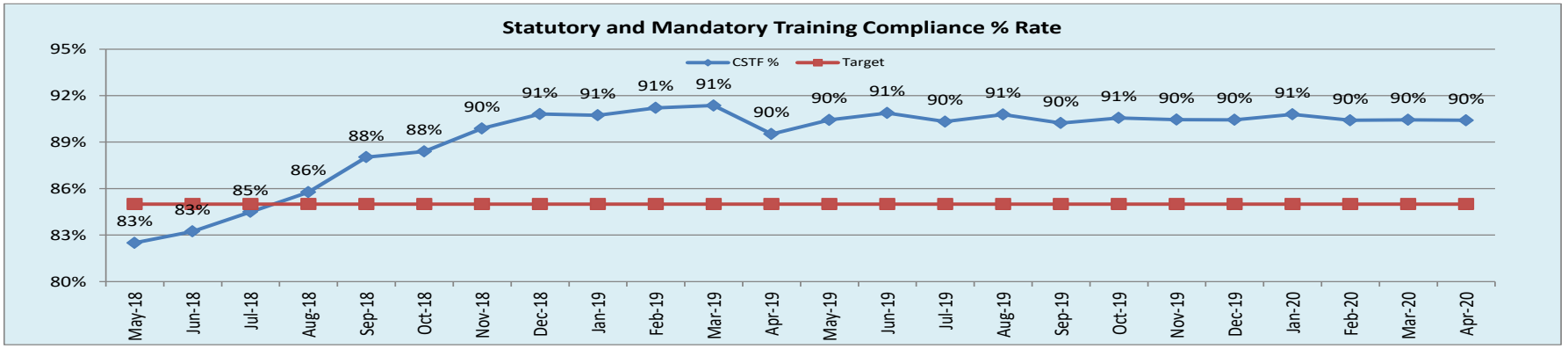
RGN Rolling 12 Month Turnover Rate

This recruitment challenge includes Registered Nurses , Medical and Dental staff, and AHP Specialties due to the supply shortage as reported elsewhere and for which the Trust has a long term capacity plan to address, which maximises the use of all supply routes including overseas recruitment in some staff groups, return to practice, growing our own etc.

Workforce - Appraisal and Training



Achievement Review (Appraisal)
The Achievement Review rate for the end of April was 71.57% which is a large reduction from the 78.66% in March due to the prioritising of Covid activity. Managers are provided with detailed list of all staff and their appraisal status.



Statutory and mandatory training The Trust has set a target of 85% compliance as an average for the statutory and mandatory training modules which is against the 11 subjects which align with the MAST Streamlining project from April 2018. The graph shows that the current ra te is 90.41% for April which is a small decrease from the 90.44% in March and shows the Covid activity has had little impact on overall complina ec as staff h ave continued to take on-line training.

Individual modules that remain below their target are detailed in the table below and also included are the specific levels for Safeguarding:

Safeguarding Adults Compliance

Apr-20					Apr-20		
Level 1	Level 2	Level 3&4	Level 5	Level 6	Level 1	Level 2	Level 3
6553	4002	528	43	5	2527	3376	698
6322	3561	446	37	5	2395	2825	513
96.47%	**88.98%**	**84.47%**	**86.05%**	**83.33%**	**94.78%**	**83.68%**	**73.50%**

Safeguarding Children Compliance

Module	Target	Performance
Information Governance	95% and above	85.79%
Manual Handling	85% and above	78.94%

Workforce - Agency Expenditure

The table below shows the agency expenditure by staff Group for April - only Actual numbers available for April.

Torbay and South Devon NHS Foundation Trust	Monthly Values
Total Agency Spend Financial Year 2020/21	**M1**
Registered Nurses	**169**
Scientific, Therapeutic and Technical	**52**
of which Allied Health Professionals	**39**
of which Other Scientific, Therapeutic and Technical Staff	**13**
Support to clinical staff (HCA)	**-1**
Total Non-Medical - Clinical Staff Agency	**220**
Medical and Dental Agency	**213**
Consultants	**106**
Trainee Grades	**107**
Non Medical - Non-Clinical Staff Agency	**79**
Total Pay Bill Agency and Contract	**512**

Community and Social Care Focus

Month 1 (performance to end of April 2021)

Community and Social Care Summary

Community Highlights and Covid-19 response

The Care at Home "Silver Command" was set up on Monday 16 March 2020, in accordance with the Trust's Major Incident Management plan, to respond to the COVID-19 outbreak.

The Care at Home Silver Command has the responsibility to:

1. Provide clear co-ordination and leadership in response to the COVID-19 outbreak in relation to community sites and community teams in Torbay and South Devon.
2. Provide clear co-ordination and leadership in response to the COVID-19 outbreak in relation to teams in Devon who are employed by the Trust under the terms of the Alliance for Children and Family Health Devon (CFHD).
3. Provide multi-agency leadership around:
    a. social care provision (e.g. domiciliary care and care homes)
    b. primary care
    c. voluntary sector
    d. local authority
    e. children and family's multi-agency partners (in relation to CFHD)

In order to discharge priorities a model of working was developed to focus effort and resources towards the areas of high priority and where services are likely to see a surge in demand to levels that are going to stretch community services significantly over the coming months. The Operating model consists of:

1. Critical Community Care Response and Rising Risk Group
2. Community Palliative Care
3. Hospital Discharge and Onward Care
4. Community Hospitals

This model is supported by the following Operating Model Plans:

a. Children and Family Health Devon COVID-19 response
b. Critical Community Care & Rising Risk Group
c. End of Life Care Action Plan
d. Discharge and Onward Care
e. Care Home Strategic Approach & Financing & Domiciliary Care Plan

An assessment of community pressures is made each day with a detailed SITREP reporting 7 days a week to monitor the key resources and system pressures along side the business as usual reporting and operational control.

Performance exceptions and actions

In April, there has been continued significant changes in services and service demand from the COVID-19 response across community hospital and community services. Newton Abbot Hospital has been utilised as a Hub for non covid specialist care. This has included the transfer of the cancer ward, cancer chemotherapy day unit and cardiac testing from Torbay hospital. Totnes Hospital has been dedicated to covid step down care. Community MIU capacity has reduced reflecting the drop in demand. Performance dashboards are being reviewed across the ISU's with the focus being to maintain the required COVID-19 response levels and to support the recovery of non covid services.

Social Care and Public Health Metrics performance metrics - Torbay

Social Care Programme Board

2020/21 Performance Scorecard to 30 April 2020

Torbay Social Care KPIs	2019/20 full year target	2019/20 YTD target	Outturn YTD	Comment
% clients receiving a review within 18 months	93%	93%	82% (93%)	Below target (2375 / 2908).
Timeliness of social care assessment	80%	80%	70% (80%)	Below target (141 / 202). Step decrease in Aug19 following calculation changes highlighted by internal audit. Reports provided to teams and changes planned to paris referral to improve data quality.
Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	21.5 (14)	A low outturn signifies better performance. Below target (16 admissions compared to challenging target of 10)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	86.8% (83%)	On target.
Carers receiving needs assessment, review, information, advice, etc.	36%	36%	2.2% (3.0%)	Below target (52 / 2362). Impacted by late recording and COVID19.
% carers receiving self directed support	85%	85%	100% (85%)	On target.
% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	100%	.. ..	No high risk concerns raised.
% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	7.2% (8.0%)	A low outturn signifies better performance. On target.
% Adults with learning disabilities in paid employment	7.0%	7.0%	8.9% (7.0%)	On target.
% Adults with learning disabilities in settled accommodation	80%	80%	79.3% (80.0%)	Within agreed tolerance.

Measure	Target 2020/21	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Year to date 2020/21
PUBLIC HEALTH SERVICES																
CAMHS - % Urgent referrals seen within 1 week	88.0%		66.7%	50.0%	100.0%	100.0%	100.0%	100.0%	50.0%	75.0%	75.0%	100.0%	40.0%	75.0%	66.7%	65.0%
CAMHS - % patients waiting under 18 weeks at month end [B]	92.0%		87.6%	83.9%	82.6%	83.2%	86.2%	91.7%	91.7%	92.4%	91.5%	91.3%	89.9%	78.8%	65.0%	88.0%
% of face to face new birth visits within 14 days *	95.0%		88.6%	96.8%	93.0%	91.7%	91.5%	90.4%	96.0%	95.5%	97.6%	85.5%	89.9%	76.4%	79.8%	79.8%
Children with a child protection plan * [B]			170	186	201	228	219	206	184	176	192	202	191	194		194
4 week smoking quitters (Quarterly) ** [B]	200				54			109								109
Opiate users - % successful completions of treatment (Quarterly) ** [B]					5.6%			5.3%								5.3%

The Social Care and Public Health metrics above relate to the Torbay LA commissioned services. The metrics and exceptions are reviewed at the Torbay Social Care Programme Board (SCPB), monthly ISU system leadership Assurance and Transformation meetings.

Public Health Torbay :

Through April, the COVID-19 response patient facing services have had to manage with limited capacity with only essential services maintained. As we move forward assessment of priorites to support the most vulnerable patients will direct resources to ensure key services and patient care is maintained.

Performance for month 1 shows that many of the key indicators have seen a deterioration in performance. Risks and actions needed will be assessed as part of recovery plans.

Since April 2019 Torbay CAMHS is part of the wider Devon Children's services alliance. Work is progressing to integrate reporting for the new combined services and are reviewed through the Alliance board and governance.

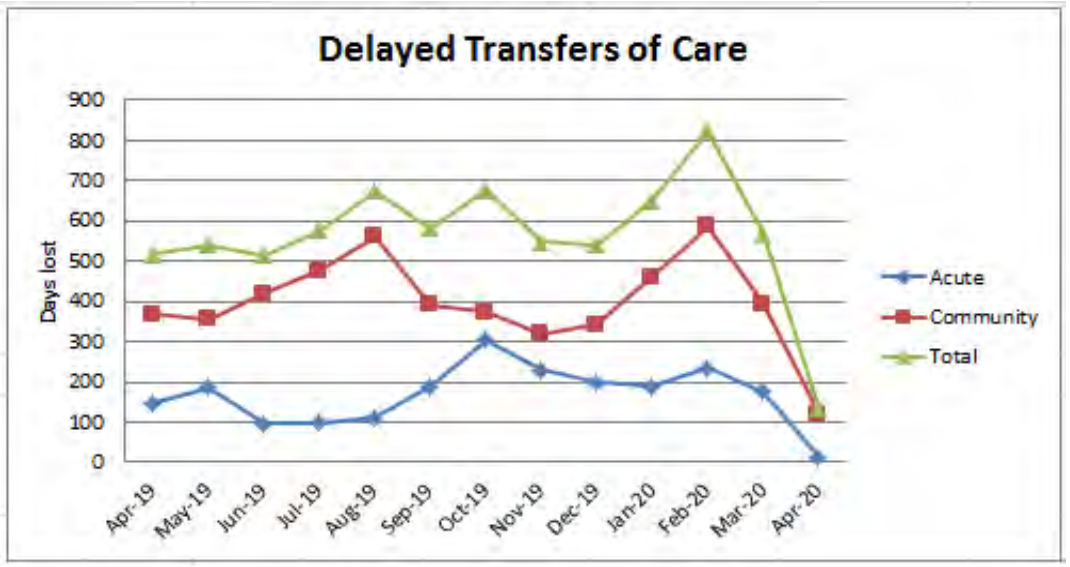
Quarterly data is shown in arrears for smoking, opiate users, and children with a protection plan.

Community Services

Measure	Target 2020/21	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Year to date 2020/21
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			16,204	17,437	15,730	16,630	14,576	13,298	13,845	12,392	10,852	10,582	9,261	8,467	6,390	6,390
Therapy activity	65,415		5,122	5,249	5,144	6,660	5,609	6,184	6,574	5,800	5,247	6,019	5,140	4,161	2,163	2,163
No. intermediate care urgent referrals [B]	0		184	189	179	188	174	178	216	205	201	239	202	219	231	231
No. intermediate care placements			75	69	85	76	73	63	59	60	52	78	49	39	8	8
Intermediate Care - placement average LoS [B]			18.9	18.2	15.8	17.3	16.9	18.1	20.7	16.1	17.5	18.7	22.0	20.8	25.5	25.5

Community Hospital Dashboard - Summary of Key Measures - April-20

	Act. 19/20 Outturn	Apr-20	Total
Admissions / Discharges			
Total Admissions (General)	2,596	138	138
Direct Admissions (General)	242	12	12
Transfer Admissions (General)	2,354	126	126
Stroke Admissions	256	0	0
Transfers from CH to DGH	238	40	40
Beds			
Bed Occupancy [1]	95.1%	54.6%	54.6%
Bed Days Lost to Delays[2]	5,086	121	121
Bed Days Lost to Bed Closure	57	13	13
Length of Stay			
Delayed Discharges		25	25
Average Length of Stay - Overall (General)	13.1	13.5	11.3
Average Length of Stay - Direct Admissions	10.7	11.7	13.5
Average Length of Stay - Transfer Admissions	13.4	13.6	11.1
Average Length of Stay - Stroke	18.7	19.7	12.8
Long LoS (>30 days)	246	5	5
MIUs			
Total MIU Activity	41,656	3,561	3,561
New MIU Attendances	37,118	3,111	3,111
All Follow Up Attendances	4,518	450	450
Planned Follow Up Attendances	3,305	338	338
Unplanned Follow Up Attendances	1,213	112	112
MIU Four Hour Breaches	3	1	1
Average Waiting Time (Mins) - 95th Pctile	53	49	53



The Community Hospital Dashboard should be reviewed in the context of the significant changes in services and service demand from the COVID-19 response.

Operational Performance Focus

Month 1 (performance to end of April 2021)

NHS I Performance indicator Summary

NHSI Single Oversight Framework Performance Standards

NSHI Single Oversight Framework - Performance standards	National Standard	Trajectory M1	ICO performance M11	Risk
Patients Seen within 4 hours in A+E	>95%	90%	94.1%	HIGH
Risks identified: Apri, has seen a continued low number of overall attendances being 46% of activity reported for April 2019. The low numbers have supported good compliance with the 4 hour standards for time spent in the Emergency Department with 94.1% being seen and treated within 4 hours. We are starting to see a gradual increase in ED activity and in particular patients requiring admission. This increase is predicted to continue with the easing of essential movement restrictions. Managing this increase with reduced bed occupancy and dual covid and non covid pathways will present a challenge.	**Management Action:** Operational teams are reviewing plans for managing covid pathways and current demand to ensure pathways remain resilient and safe alongside the needs to consider the stepping back of services for more routine non emergency patient pathways. Due to covid ED curent location in the day surgery unit, the design of the expanded Emergency Department in the short and medium term is critical to ensure capacity for both emergency and non emergency care is maintained.			
Patients waiting longer than 18 weeks from referral to treatment	>92%	82%	69.1%	HIGH
Risks identified: RTT performance in April has deteriorated with the proportion of people waiting less than 18 weeks at 69.25% against the national standard of 92%. The total number of incomplete pathways (waiting for treatment) is 19,878 a reduction of 117 from March due to the reduced referrals. Patients waiting over 40 weeks continue to increase with 640 at the end of April; an increase of 252 from March. 52 week waits: For April, 93 people will be reported as waiting over 52 weeks , this being an increase on last month's 53.	**Management Action:** Operation focus remains on maintaining urgent and cancer related work. Increasingly, and following National guidance teams are looking at plans to step back up increasing amounts of non urgent capacity. Elective capacity will be impacted by social distancing and IPC precautions. 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 for video based consultations. Mount Stuart facilities are being used as a non COVID-19 site to support the most urgent surgical treatments. Teams are now moving to recovery planning in line with the National Guidance led through the Recovery Cell and the Devon COVID-19 Restoration and Transformation Plan.			
Cancer 62 day wait for first treatment from 2 week wait referral	85%	85%	70.5%	MEDIUM
Risks identified: At the end of April the 62 day treatment headline performance is 72.8% (target 85%) with other Cancer pathway standards being maintained. Urgent referrals reduced by 50% in April but have since started to increase to around 80% in the last two weeks to 18th May. Teams continue to prioritise capacity to see, diagnose and treat patients on cancer pathways.	**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 with the Ricky Grant Day unit and cancer inpatient ward relocated to Newton Abbot Hospital. Arrangements remain in place to support the most urgent inpatient surgery, using main theatres.			
Diagnostic tests longer than 6 weeks	< 1%	??	47.7%	HIGH
Risks identified: In April, activity levels have reduced along with demand for routine tests. Patients already on the waiting list for routine tests are not being seen and waiting times now increasing with 47.7% of patients on the diagnostic waiting list at the end of April waiting over 6 weeks (up from 11.3% at the end of March).	**Management Action:** Access for urgent diagnostics has been maintained during the COVID-19 escalation. Procedures that are Aerosol Generating (including Colonoscopies and CT colonoscopies) continue to be severely restricted. Plans are now being reviewed to step back up routine diagnostic capacity where possible and to support the re-establishment of Referral to treatment pathways. We expect to see an increase in activity however there will continue to be a backlog of tests as demand is also expected to increase.			
Dementia Find - Not reported	>90%	90%	94.20%	LOW

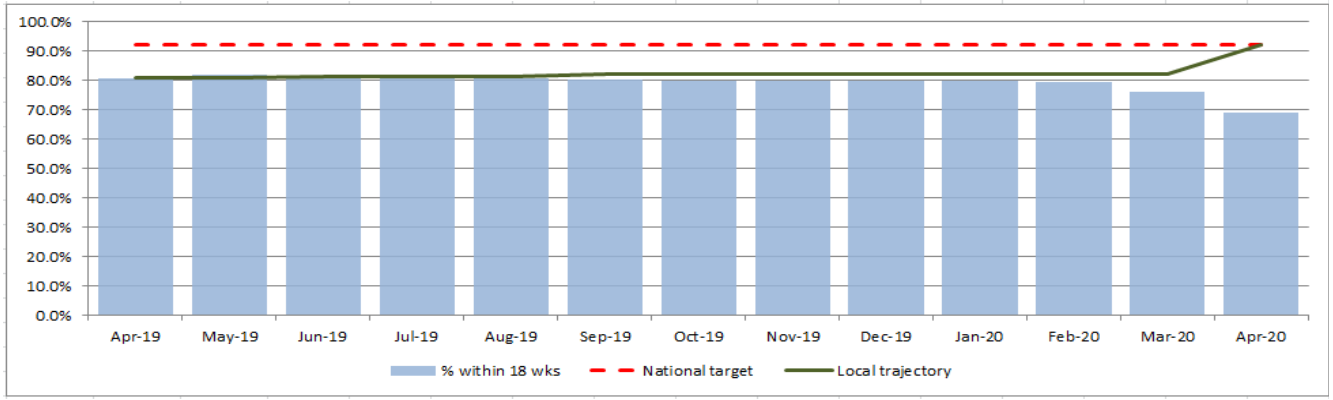
NHSI Indicator - Referral to Treatment

Services with greater than 100 patients waiting over 18 weeks

April 2020 Incomplete 92% Table - National Specialty

	Incomplete IPDC>126	Incomplete Outpatients >126	Grand Total	% <18wks
Plastic Surgery	111		256	56.64
Respiratory Medicine		119	499	76.15
Oral Surgery	105	23	878	85.42
Colorectal Surgery	74	86	531	69.87
Gynaecology	104	58	875	81.49
Pain Management	40	168	673	69.09
Neurology	1	257	628	58.92
Dermatology		269	817	67.07
Gastroenterology	104	204	1345	77.1
Paediatrics	4	307	1240	74.92
ENT	46	381	1452	70.59
Upper Gastrointestinal Surgery	265	167	834	48.2
Cardiology	63	379	1414	68.74
Urology	215	247	1296	64.35
Trauma & Orthopaedics	527	422	2229	57.42
Ophthalmology	776	251	2997	65.73
Grand Total	2471	3641	19878	69.25

Referral to Treatment - Incomplete pathways



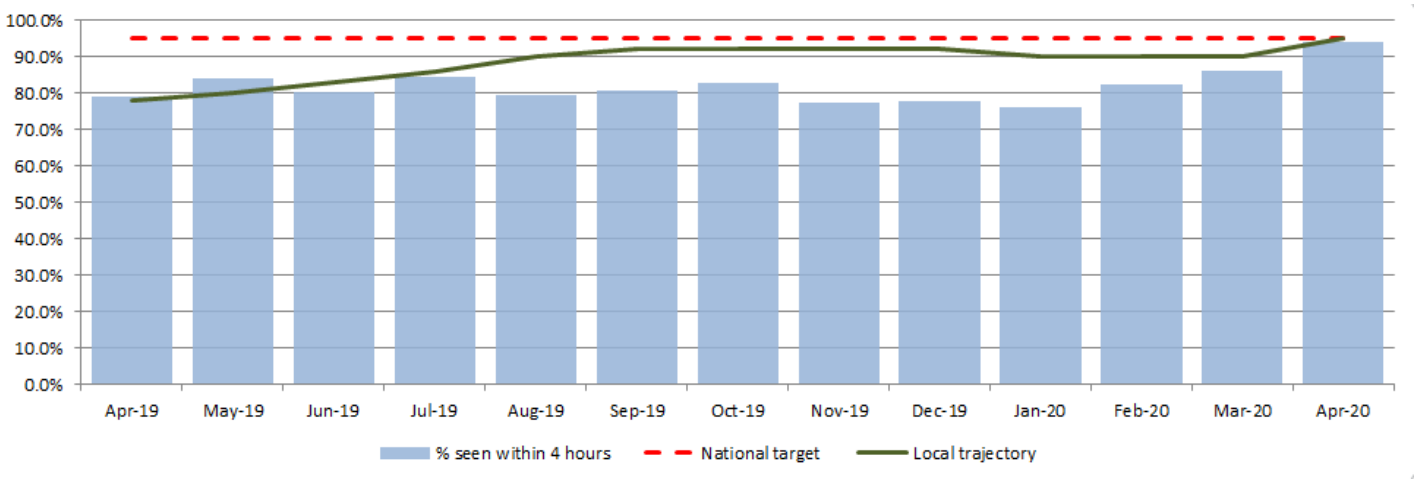
Referral to Treatment - RTT: RTT performance in April has deteriorated with the proportion of people waiting less than 18 weeks at 69.25%; this is behind the Operational Plan trajectory of 82% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has decreased to 19,878 a reduction of 117 from March, as per previous years the national requirement of having a total waiting list size equal to or less that our 31.03.2020 remains.
Patients waiting over 40 weeks continue to increase with 640 at the end of April; an increase of 252 from March, (the largest total April-18).

52 week waits: For April, 93 people will be reported as waiting over 52 weeks , this being an increase on last month's 53. The impact of COVID-19, both for primary and secondary care continues to adversely affect overall performance, with referral rates 60% down and activity, in month 1, 42.5% of the monthly average M1-M11 2019/20.
Teams are now moving to recovery planning in line with the National Guidance through the Recovery Cell and the Devon COVID-19 Restoration and Transformation Plan.

Recovery planning : Initial forecasts show that capacity to treat routine priority patients will continue to be constrained from the loss of theatre capacity in particular day surgery unit and the loss of operational productivity from enhanced infection prevention and control protocols. Timely access to diagnostics and capacity for outpatients consultations that require a face to face interface, will remain a challenge whilst complying with covid-19 operational and patient distancing constraints. Our initial forecasting is therefore not showing confidence in reducing RTT waiting times in the short term. Longer terms plans will need the full implementation of New models of care particularly in the delivery of non face to face consultations and also address historical infrastructure and capacity constraints in theatres and diagnostics.
The recovery cell is working with teams to bring back as much capacity as possible in a coordinated way and working with the wider local health system. The full implication of maintaining COVID-19 resilience and recovery plans for RTT will take time to mature.

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

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



Operational delivery: The Emergency Department has see considerable changes with the covid escalation and the creation of COVID emergency department taking over the footprint of the day surgery unit. The reduced activity seen in April and additional space has facilitated an improvement against the 4 hour standard. Indications are that activity level are starting to increase and caution is needed to ensure capacity is retained to manage a return to expected levels of attendance and admission.

Improvement work streams: The three' task and finish' groups leading on the improvement work have been temporarily stood down during the COVID-19 escalation. The recovery planning work however is building on the principles laid down to ensure that both short and medium term strategy for managing emergency attendances and admissions reflects the requirements for improvements to front door emergency pathways, patient flow and community response.

12 hour Trolley wait : In April no patient is reported as having a trolley wait from decision to admit to admission to an inpatient bed of over 12 hours.

Ambulance Handovers : In April there are no ambulance delays over 60 minutes .

Escalation status

Opel status	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Opel 1	0	6	0	0	0	2	0	0	0	0	5	17	25
Opel 2	8	15	4	5	3	13	12	3	8	7	12	13	5
Opel 3	16	3	18	22	21	11	19	18	15	19	8	1	0
Opel 4	6	4	8	4	7	4	0	9	8	5	4	0	0
Performance	79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%

Cancer treatment and cancer access standards

CWT Measure	Target	April 2020			
		Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	431	107	538	80.1%
14 Day - Breast Symptomatic referral	93%	26	1	27	96.3%
31 Day 1st treatment	96%	171	5	176	97.2%
31 Day Subsequent treatment - Drug	98%	51	0	51	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	41	3	44	93.2%
31 Day Subsequent treatment - Surgical	94%	28	1	29	96.6%
31 Day Subsequent treatment - Other		13	0	13	100.0%
62 day 2ww / Breast	85%	75	30	105	71.4%
62 day Screening	90%	11	4	15	73.3%
62 day Consultant Upgrade		1	1	2	50.0%

Urgent cancer referrals access times have extended in Month 1. Referrals have reduced with 538 urgent referrals recieved compared to 1396 last year. Teams have however maintained services through the covid escalation and the current access times and change in numbers waiting are set out below:

Site	Wait & Setting	2ww Backlog @01/04/2020	2ww Backlog @ 01/05/2020
Skin	10 days (F2F)	29	62
H & N	<14 days (Telephone)	17	25
Lower GI	7 days (Telephone) – 10 days (F2F @ MSH)	27	37
Urology	10 Days (F2F) Swabbing appt required for Consult/Proc etc.	63	34
Breast	14 days (F2F)	35	43
Gynae	7 days (F2F)	17	17
Haem	7 days (Telephone)	1	0
UPGI	7 days (Telephone	6	9
Lung	7 days (F2F & Telephone)	3	6

Cancer standards - The table above shows the position for April 2020 (as at 15 May 2020). *Final validation and data entry is completed for national submission, 25 working days following the month close and at the end of the quarter.*

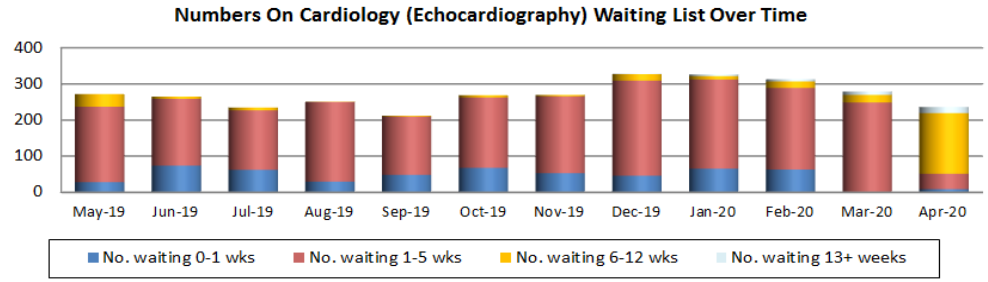
Urgent cancer referrals 14 day 2ww: At 80.1% in April this remains below the standard of 93%, however as a pilot site for developing the new standard for "28 days from referral to diagnosis" some variance in performance is expected as this new pathway is introduced. See tables above for current 2ww waits and backlogs by site.

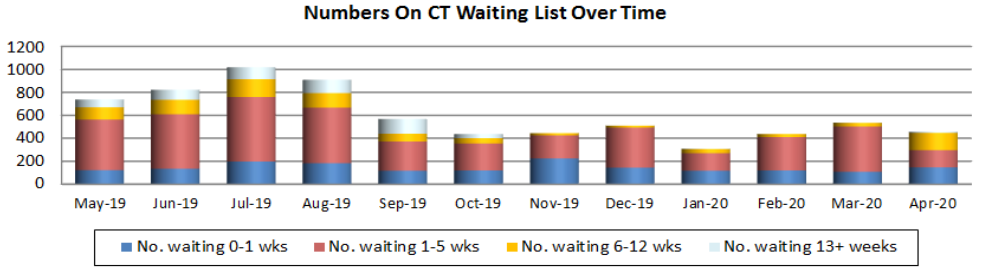
28 days From Referral to Diagnosis: Performance dipped in April to 59.9%, form 72.4 in March; current May forecast has recovered to 79.1% - slightly ahead of the standard of 75%

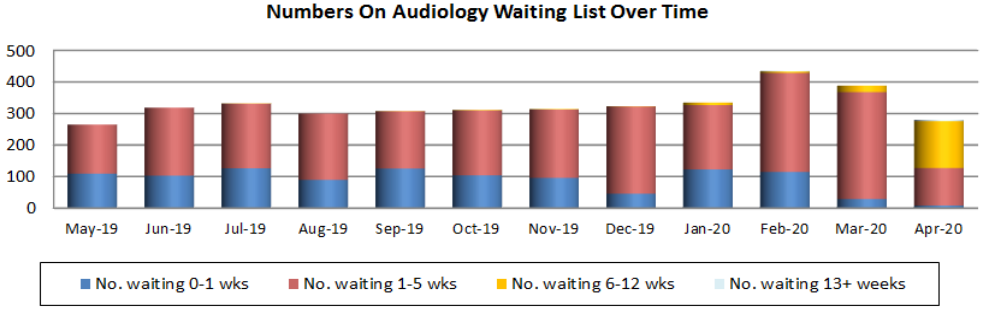
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard is forecast not met in April at 71.4%.
With the Trusts ongoing response to COVID-19 risk remains in the pathways for Urology and Skin.

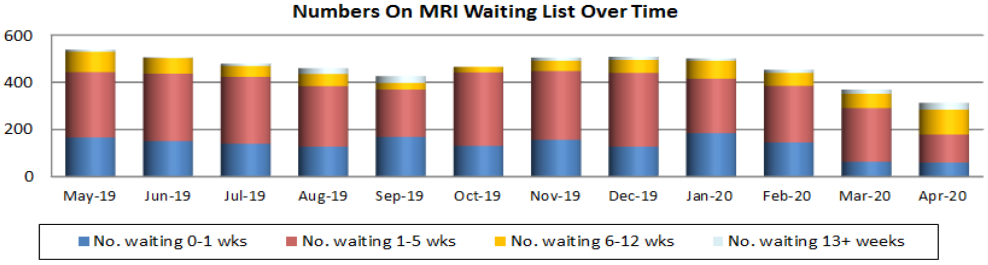
Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In April, 5 patients with confirmed cancer were treated beyond 104 days. The number of patients being tracked over 62 days is being maintained with no significant change to historical levels.
There are 29 patients on a 104 day open pathway , these patients are reviewed and managed through Cancer Services via the RTT Risk and Assurance Group.

NHSI indictor - patients waiting over 6 weeks for diagnostics



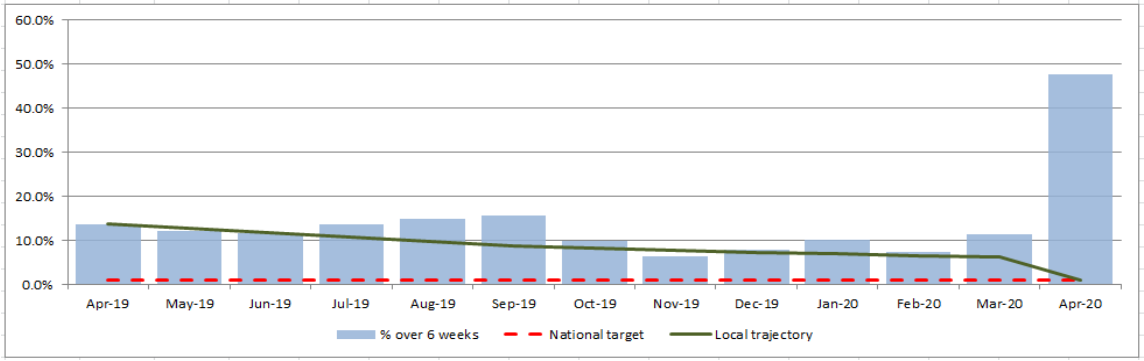






Diagnostic tests longer than the 6 week standard

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Patients	575	454	454	527	535	460	282	182	240	264	207	299	1080
Waiting longer than 6 weeks	4201	3746	3893	3862	3586	2926	2823	2865	3051	2600	2816	2652	2266
% over 6 weeks	13.7%	12.1%	11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	47.7%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local trajectory	13.7%	12.7%	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%	6.9%	6.6%	6.2%	1.0%



In April, there is a significant increase in the percentage of patients with a diagnostic waiting time over 6 weeks to 47.7% (1080 patients > 6 weeks) from 11.3% (299 patients > 6 weeks) in March. All modalities are continuing to see with appropriate IPC precautions patients with urgent need.

The increase is a result of reduced activity from ceasing service to all but urgent patients as part of the COVD-19 response and the large reduction in new referrals.

Backlogs have increased in all diagnostic modalities.

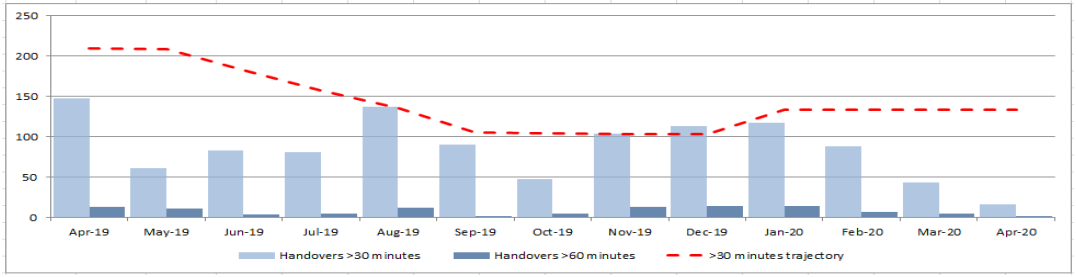
The additional capacity from insourcing through mobile vans or visiting clinical teams has been greatly reduced or ceased.

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

Other performance exceptions

Ambulance handovers

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Handovers >30 minutes	148	61	83	81	137	90	47	104	113	117	88	43	16
Handovers >60 minutes	13	11	4	5	12	2	5	13	14	14	7	5	1
>30 minutes trajectory	210	209	183	157	136	105	104	103	103	133	133	133	133

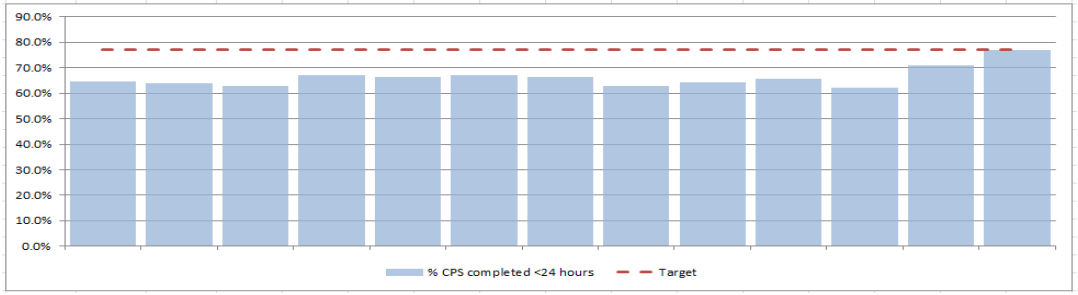


Ambulance Handover

The number of ambulance handovers delays decreased in April reflecting the reduced activity levels and low crowding in the department facilitating timely handover.

Care Plan Summaries completed within 24 hours of discharge - Weekday

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Discharges	1690	1818	1526	1804	1593	1566	1815	1627	1668	1683	1560	1376	885
CPS completed within 24 hours	1094	1160	959	1212	1056	1051	1206	1025	1069	1106	970	977	682
% CPS completed <24 hours	64.7%	63.8%	62.8%	67.2%	66.3%	67.1%	66.4%	63.0%	64.1%	65.7%	62.2%	71.0%	77.1%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%



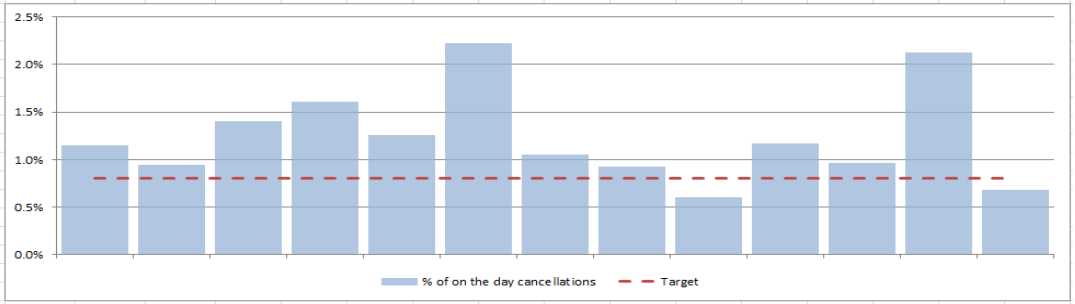
Care Planning Summaries (CPS)

Improvement is seen in the percentage of patients with a CPS completed within 24 hours of discharge. This is a reflection of the reduced activity seen in the month and a result of a major transformation push planned for April to make this a mandatory requirement.

Challenges remain however with the manual processes and duplication of information already recorded. The strategy is to reduce the manual entry requirements and demands on junior doctor time by increasing the automatic transfer of data from existing electronic records.

On the day cancellations for elective operations

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Cancellations	37	33	45	56	41	72	38	33	19	43	32	56	8
Elective spells	3218	3502	3198	3481	3248	3237	3616	3567	3133	3667	3332	2631	1174
% of on the day cancellations	1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



Cancelled operations

In April the number of operations completed is greatly reduced and this has also seen a reduction of the number of cancelled on the day of surgery for hospital reasons decreased to 8 . This represents under 1% of all elective procedures undertaken.

Headline Acute activity comparisons to last year

Outpatient M1 comparison

treatment_function	setting	2019/20 Actual Sum of event	2020/21 Actual Sum of event	Activity %
Urology	F-Up	395	221	56%
Breast Surgery	F-Up	498	281	56%
Colorectal Surgery	F-Up	232	70	30%
Vascular Surgery	F-Up	236	17	7%
Trauma & Orthopaedics	F-Up	1603	734	46%
Ear Nose & Throat	F-Up	816	52	6%
Ophthalmology	F-Up	4294	1864	43%
Oral Surgery	F-Up	519	108	21%
Anaesthetics	F-Up	841	29	3%
General Medicine	F-Up	353	5	1%
Gastroenterology	F-Up	512	233	46%
Endocrinology	F-Up	230	108	47%
Clinical Haematology	F-Up	383	359	94%
Diabetic Medicine	F-Up	262	129	49%
Cardiology	F-Up	2175	317	15%
Dermatology	F-Up	1018	725	71%
Respiratory Medicine	F-Up	838	186	22%
Neurology	F-Up	221	324	147%
Rheumatology	F-Up	598	360	60%
Paediatrics	F-Up	743	494	66%
Obstetrics	F-Up	753	925	123%
Gynaecology	F-Up	523	207	40%
Podiatry	F-Up	508	83	16%
Orthoptics	F-Up	517	136	26%
Audiology	F-Up	1747	412	24%
Medical & Clinical Onco	F-Up	2503	2148	86%
	sum	23318	10527	45%

Elective Admitted Care - M1 comparison

treatment_function_description	setting	2019/20 Actual Sum of event	2020/21 Actual Sum of event	Activity % previous year month average
Urology	Day Case	114	96	84%
Urology	Elective	36	11	31%
Breast Surgery	Day Case	42	11	26%
Colorectal Surgery	Day Case	28	1	4%
Colorectal Surgery	Elective	25	14	56%
Upper Gastrointestinal Surgery	Day Case	58		0%
Upper Gastrointestinal Surgery	Elective	18	2	11%
Trauma & Orthopaedics	Day Case	152	8	5%
Trauma & Orthopaedics	Elective	91	9	10%
Ear Nose & Throat	Day Case	58	1	2%
Ophthalmology	Day Case	216	18	8%
Oral Surgery	Day Case	86	26	30%
Plastic Surgery	Day Case	70	53	76%
Pain Management	Day Case	64	3	5%
Gastroenterology	Day Case	676	150	22%
Clinical Haematology	Day Case	285	185	65%
Cardiology	Day Case	93	14	15%
Cardiology	Elective	24	3	13%
Respiratory Medicine	Day Case	16	1	6%
Medical & Clinical Oncology	Day Case	562	333	59%
Neurology	Day Case	47	36	77%
Rheumatology	Day Case	87	37	43%
Paediatrics	Day Case	25	5	20%
Gynaecology	Day Case	116	12	10%
Interventional Radiology	Day Case	31	27	87%
	SUM	**9339**	**3369**	**36%**

Emergency Admissions - M1 comparison

treatment_function_de	setting	2019/20 Actual Sum of event	2020/21 Actual Sum of ent	
Colorectal Surgery	Non-Electi	141	91	65%
Upper Gastrointestinal Su	Non-Electi	166	68	41%
Trauma & Orthopaedics	Non-Electi	139	91	65%
Ear Nose & Throat	Non-Electi	36	12	33%
Accident & Emergency	Non-Electi	65	45	69%
General Medicine	Non-Electi	1470	902	61%
Cardiology	Non-Electi	20	18	90%
Paediatrics	Non-Electi	222	45	20%
Gynaecology	Non-Electi	35	13	37%
	SUM	2294	1285	56%

The tables above show the major specialties in term of contracted activity in the acute setting for new outpatient appointments and elective admitted care. The data compares the actual month 1 activity to the average monthly activity last year.

Emergency admissions is summarised in the table opposite and shows that recorded emergency admissions at 56% of historical monthly average for April.

The covid-19 response to maintain urgent elective care is reflected in the specialties seeing the greatest percentage of activity

Children and Family Health Devon

The Children and Family Health Devon integrated Performance report is reviewed through Torquay ISU and Alliance Board

Executive Performance Summary :

Access Times

The number of referrals received decreased through March due to the impact of the escalating COVID-19 escalation. Due to the immediate impact on the clinical teams and the need to revise service provision to respond to the pandemic in line with National guidance, we have seen a decrease in performance for a majority of services within Children with Additional Needs. We have started working with Informatics to develop modelling and forecasting for the coming months.

Work will continue to implement and monitor progress against the recovery plans

Workforce

Formal work force reporting is currently not available, however the CFHD team have been supporting colleagues to work differently i.e. virtual clinics where possible as well as ensuring staff who fall within the high risk or shielded category have the necessary provisions to work remotely.

Governance

The Transformation Lead for Quality has commenced in post and has started to review policies and SOPs that we're in situ at the time of transfer against organisational documents and operational delivery process.

18 week RTT performance

April 2020

Service	RTT longest wait	RTT percentage	caseload	change last month
CAMHS	61 weeks	65%	4109	279
Occupational Therapy	63 weeks	42%	1142	-56
Speech and Language Therapy	57 weeks	46%	3875	27
Autistic spectrum assessment team	100 weeks	16%	2252	230
Physiotherapy	28 weeks	88%	409	-63
Learning disability	23 weeks	95%	326	23

Finance Focus - Month 1

Contents

1. Overall Position - Executive Summary

Context

· The Trust submitted a draft financial Plan for financial year 2020/21 to NHS Improvement/England in March 2020, with the expectation that it would be fine - tuned and finalised in April 2020. This did not happen due to the COVID 19 pandemic.

· NHSI/E has issued the Trust a revised plan for the first four months this financial year, based on our run rate finances from months 8-10 of 2019/20 with adjustments and uplift as determined by NHSI/E. Based on this assessment the M1 to M4 value show a monthly deficit of £1.43m; a similar amount for top up income has been given by NHSI/E which show the revised plan of a breakeven position and it's this plan that the Trust monitor its finances for months M1-4.

· The key message from NHSI/E is that the Trust has to show a break-even position (excluding Donated items) each month on its reporting; any surplus or deficit is to be adjusted against the £1.43m top up income. Revenue and Capital costs incurred as result of COVID are reimbursed by NHSI/E.

· The focus this financial year is on run rate (i.e. change and trends in income and expenditure) monitoring and reporting to assess each ISU's financial performance during the first 4 months and ensuring that expenditure is controlled within the limits set by NHSI/E and represents value for money.

· The Capital plan for this financial year is still under discussion by scheme leads.

· CIP reporting is under review and external consultants have been engaged to make recommendation on the governance and process. It is expected that this CIP information will be available from month 5 onwards.

Key Questions

1. **What is our current financial performance for the period ending 30th April 2020?**

	YTD Plan as at M1	YTD Actual Position as at M1	Favourable/(Adverse) Variance
Overall Financial Performance (excluding PSF/MRET/Top up)	£1.43m deficit	£3.40m Deficit	£(1.97)m adverse*
Overall Financial Performance (including PSF/MRET/Top)	£0.00m	£0.00m	-

*The £1.97m adverse in M1 relates to additional income received for COVID related expenditure of £2.31m offset by reduction in top up income pertaining to £0.34m actual surplus achieved by the Trust in month.

2. **What is our Forecast Income and Expenditure performance for 2020/21?**

	Annual Plan	Forecast Outturn	Favourable/(Adverse) Variance
Overall Financial Performance (excluding PSF/MRET & NHSI Exclusions)			
Control Total Performance (including PSF/MRET & NHSI Exclusions)			

3. **What are the key underlying financial issues at System level which are contributing to the overall financial position that the Committee should be sighted on?**
   Please see System Table report within the key metrics and key drivers tables .

4. **What actions are being taken by the South Devon, Torbay and the Shared Corporate & Operations Systems to address these issues and by when?**
   Please see System Table report within the key metrics and key drivers tables .

Key Financial Information – Trustwide

		M1			YTD M1		
	£m	Budget	Actual	Variance	Budget	Actual	Variance
Income	Patient Income - Block	28.16	28.96	0.80	28.16	28.96	0.80
	Patient Income - Variable	3.43	3.42	(0.01)	3.43	3.42	(0.01)
	ASC Income - Council	4.00	4.21	0.21	4.00	4.21	0.21
	Other ASC Income - Contribution	0.85	0.98	0.13	0.85	0.98	0.13
	Other Income	4.77	4.09	(0.68)	4.77	4.09	(0.68)
	Total (A)	**41.21**	**41.65**	**0.45**	**41.21**	**41.65**	**0.45**
Expenditure	Pay - Substantive	(20.96)	(22.67)	(1.71)	(20.96)	(22.67)	(1.71)
	Pay - Agency	(0.65)	(0.51)	0.14	(0.65)	(0.51)	0.14
	Non-Pay - Other	(11.25)	(10.50)	0.75	(11.25)	(10.50)	0.75
	Non- Pay - ASC/CHC	(8.27)	(9.64)	(1.37)	(8.27)	(9.64)	(1.37)
	Financing Costs	(1.51)	(1.73)	(0.22)	(1.51)	(1.73)	(0.22)
	Total (B)	**(42.64)**	**(45.05)**	**(2.42)**	**(42.64)**	**(45.05)**	**(2.42)**
	Surplus/Deficit pre PSF/MRET/Top up/Donated Items and Impairment (A-B=C)	**(1.43)**	**(3.40)**	**(1.97)**	**(1.43)**	**(3.40)**	**(1.97)**
	PSF	0.00	0.00	0.00	0.00	0.00	0.00
	MRET	0.00	0.00	0.00	0.00	0.00	0.00
	Top up income	1.43	3.40	1.97	1.43	3.40	1.97
	Donated Transactions	0.00	(0.07)	(0.07)	0.00	(0.07)	(0.07)
	Impairment	0.00	0.00	0.00	0.00	0.00	0.00
	Total (D)	**1.43**	**3.33**	**1.90**	**1.43**	**3.33**	**1.90**
	Net Surplus/Deficit	0.00	(0.07)	(0.07)	0.00	(0.07)	(0.07)

- The budget shown on the table above is the M1-M4 values notified by NHSI/E as the basis of comparison during the COVID reporting period based on average of months 8-10 of FY 2019/20 with adjustments and uplift determined by NHSI/E and top up income of £1.43m which would result in a breakeven position.
- NHSI/E mandated Trusts to show a break even position after adjusting for Donated items; the Trust's underlying M1 position is a surplus of £0.34m.
- Patient care income block is £0.80m higher than budget due to additional income from CCG for COVID related expenditure. Similarly £0.25m is received from Torbay Council for ASC income. Client contribution is higher by £0.13m linked to additional activity and other income is lower by £0.68m due to the following: non patient related services £0.42m, car parking £0.13m as the Trust now offer free parking to staff, and R&D income £0.13m due to reduced trials.
- Pay expenditure of £22.67m is £1.71m higher than the 3 month average run rate. This is due to increased pay due to COVID of £0.87m (matched by income), annual leave accrual of £0.75m in month and higher bank use £0.09m. There is a reduction in Agency use of £0.14m due to operational changes in a number of clinical areas due to COVID.
- Non-pay expenditure (Other) is £0.75m lower than the average mainly due to lower Drugs cost of £0.63m as a result of clinical activity reduction and various other cost £0.12m due to COVID impact.
- Independent sector Non pay cost (ASC and Placed people (Health including CHC) have increased by £1.37m in M1 due to a number of COVID related payments, largely relating to financial assistance to providers and payments for voids totalling £1.0m (matched by Income). Also price uplifts paid to providers, growth and delayed CHC assessments account for £0.37m.
- It is assumed that COVID related costs and income loss are fully reimbursable by NHSI/E - a total of £2.31m has been included in M1.
- Financing cost increased by £0.22m due to Depreciation now showing the increased cost of RICS adjustment.

Statement of Financial Position

	Month 01		
	Prior month £m	Actual £m	Change £m
Non-Current Assets			
Intangible Assets	12.12	11.86	(0.26)
Property, Plant & Equipment	180.32	180.21	(0.12)
On-Balance Sheet PFI	17.44	17.41	(0.03)
Other	1.23	1.23	(0.00)
Total	**211.12**	**210.71**	**(0.41)**
Current Assets			
Cash & Cash Equivalents	10.14	44.43	34.29
Other Current Assets	40.85	40.44	(0.40)
Total	**50.98**	**84.87**	**33.89**
Total Assets	**262.10**	**295.58**	**33.48**
Current Liabilities			
Loan - DH ITFF	(24.64)	(24.64)	0.00
PFI / LIFT Leases	(0.85)	(0.85)	0.00
Trade and Other Payables	(48.05)	(77.48)	(29.42)
Other Current Liabilities	(13.58)	(13.71)	(0.13)
Total	**(87.12)**	**(116.67)**	**(29.55)**
Net Current assets/(liabilities)	**(36.14)**	**(31.80)**	**4.33**
Non-Current Liabilities			
Loan - DH ITFF	(43.33)	(43.33)	0.00
PFI / LIFT Leases	(17.77)	(17.69)	0.07
Other Non-Current Liabilities	(9.66)	(9.60)	0.06
Total	**(70.76)**	**(70.62)**	**0.13**
Total Assets Employed	**104.22**	**108.28**	**4.06**
Reserves			
Public Dividend Capital	67.62	71.75	4.13
Revaluation	46.09	46.09	0.00
Income and Expenditure	(9.48)	(9.55)	(0.07)
Total	**104.22**	**108.28**	**4.06**

Key points

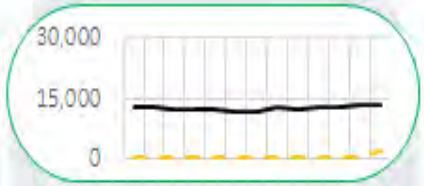
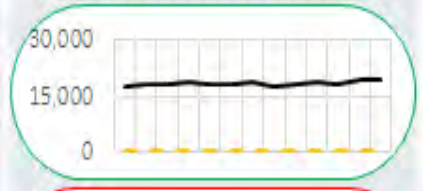
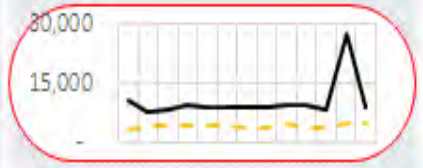
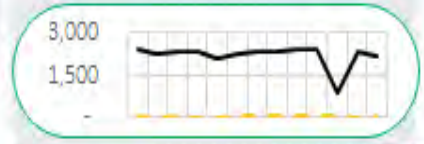
The Trust is currently preparing a balance sheet Plan to cover the COVID period and beyond, as clarification is received from NHSI/E of the applicable financial framework. In the absence of a finalised plan, balance sheet reporting at M01 is being compared against the prior month.

- Intangible Assets, Property, Plant & Equipment and PFI have reduced by £0.4m since the prior month. This is largely due to M01 depreciation £1.3m having exceeded M01 capital expenditure £0.8m.
- Cash has increased by £34.3m, as explained in the commentary to the cash flow statement.
- Other Current Assets have reduced by £0.4m, largely because payment of debtors and the reduced level of new debtors has exceeded the additional COVID funding debtor
- Trade and Other Payables have increased by £29.4m, largely due to M02 block income received in advance to a value of £31.4m.
- PDC reserves have increased by £4.1m due to receipt of interim revenue support in month. This was applied for before the Covid-19 financial arrangements were introduced and was based on the draft 2020-21 plan.

2. Key Metrics

Board Table of Key Metrics

Total Expenditure
Other Income
Contract Income

	Drivers	Actions Taken:	Tick charts £'000
South System & Shared operations	Reduced Elective spend of £800k in coastal, using run rate average, (across supplies and consultants costs), no change M2S or NA. Shared Ops COVID costs offset by Income.	Performance/waiting list review Required for COVID recovery to then be forecast £.	
Torbay System	£1m in IS Run rate for (ASC & CHC) 'COVID discharge' offset by income. £400k drop in P&B on drugs and outsourced tests. No material change in Torquay.	Radiology backlog to be quantified and recovery plan costed. Run rate on drugs expected to increase as activity stands back up.	
Corporate (inc. Financing, R&D, TP, IA)	M12 (annual leave accrual £2m, Dep'n & Impairment £4.5m, £10m ERS pension recognition. Exec directors & EFM run rate unchanged. PP & R&D Income lost.	Annual leave on-going risk to backlog and backfill requirements. Backlog maintenance & IT to be reviewed. IFRS 16 accounting on hold. TP sales back to average run rate.	
CFHD	Billing from DPT in E12ths trued up in month 11 & 12, to be accounted for on actuals in 2020/21. Delay in consultation and IT developments	Risk for backlog and remote working without appropriate IT kit.	
Contract Income	£10m of pension recognition gross up at year end offset in Corporate above. Fixed Income months 1-4 for CCG & SWSCG. Council new 20/21 Contract.	Guidance for months 5-7 expected shortly. Council are funding £2m towards COVID Hospital discharge for the period. Balance has been requested from CCG/Health COVID funds.	

The Trust Contract Income has been blocked for 4 months (April 20 to July 20). COVID top up payments are in place for any assumed shortfall; assuming Trust's will deliver a breakeven position, HEE and Council income are blocked at 20/21 rates. Other income is expected to remain in place within the System positions. COVID spend for Hospital discharge sits within the Torbay system and COVID acute spend within the South system, both are net neutral positions pending submission and NHSI review, but these expenditure costs will impact the run rates displayed.

2. Key Drivers of Financial Position

Drivers of System Financial Position

Key System Issues	ISU	Financial Commentary/Key Drivers
CFHD	CYP	Children's consultation remains paused. Vacancies within the service, social distancing backlog issues. IT systems not yet implemented as reliant on the consultation.
Torbay Pharmaceuticals	PMU	Contribution from TP back to average levels post a surge in month 12 orders around COVID.
Corporate	EFM	Average pay increase due to staff numbers at low band levels seeing an increase across the pay scales. Increase in SLA Income.
	Exec. Directors	Executive directors run rate remains constant as not variable around activity levels
	Financing Costs	Small increase in estimated financing costs pending further capital guidance
	Other	Reduction in R&D Income from clinical trials, staff redeployed. Pharmacy department costs maintained. Prospective COVID payment included in reserves Other Income. Year end accounting adjustments made in reserves (£2m depreciation, £2m annual leave accrual, and £10m pensions grossing up)
South System	Coastal	Coastal run rate has dropped due to activity driven consumables and supplies and a reduced consultant pay spend on RTT work.
	Newton Abbot	Small decrease in average run rate for bank and agency across emergency departments
	Moor to Sea	No material change in run rate – assumes most staffing in Moor to sea are substantive based – £220 k average run rate across last years bank and agency
Torbay System	Independent Sector	Increase in run rate for adult social care and continuing heath care by £1m to be recovered by COVID hospital discharge scheme. Expected to be £3m over the first quarter. A further £0.8k is the increase in average costs from the beginning of 2019/20 to month 1 2020/21. A large proportion of this would have been included in the Trust March plan (not the NHSI plan). The variance against the NHSI plan is £400k.
	Torquay	No overall change to average run rate, low user of bank and agency across the period.
	Paignton and Brixham	No change in average pay run rate for P&B, Clinical supplies including drugs and labs consumables has dropped by £500k in month, activity related.
Contract Income	Patient Income	Contract Income is the Block given by NHSI averaging months 7-8 of 2019/20. A specialty level plan will be created for monitoring purposes.

Income & Expenditure Run rate

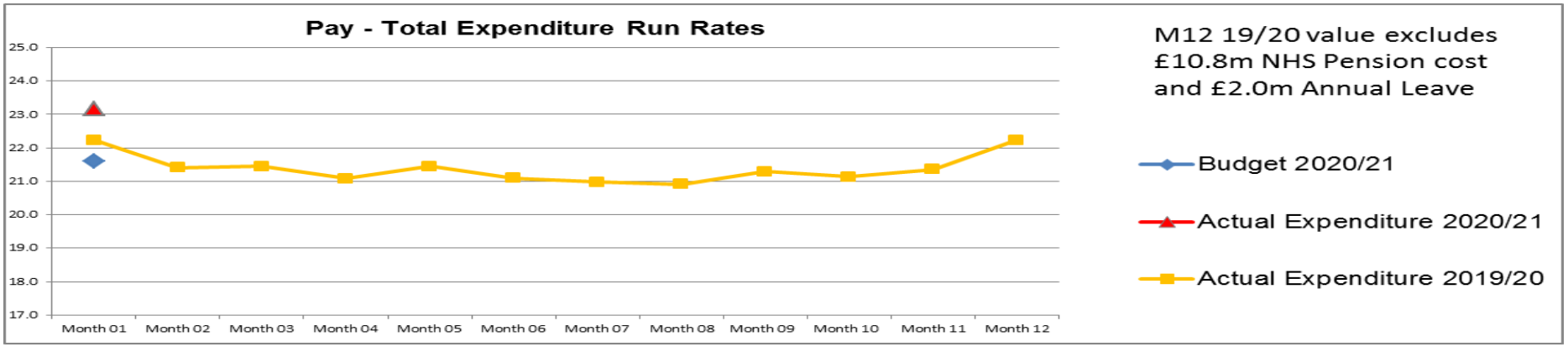
(Surplus)/Deficit		Monthly Run Rates													Year to Date			
System Desc	ISU Description	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Sum of 2020/21 Expenditure YTD	March Plan YTD	NHSI Budget YTD	Variance to Budget YTD
Children and Family Health Devon (CFHD)		2,341	2,268	1,977	2,619	2,034	2,188	2,278	2,291	2,168	2,285	798	2,479	2,168	2,168	2,215	2,215	-47
Pharmacy Manufacturing Unit Total		-276	-251	-256	-464	-464	-482	-316	-401	-526	-328	-478	-939	-396	-396	-182	-182	-214
Shared Corporate Services	Estates & Facilities	1,631	1,513	1,594	1,952	1,595	1,713	1,400	1,642	1,691	1,550	1,808	1,787	1,598	1,598	1,685	1,685	-88
	Executive Directors	2,813	3,050	2,802	2,436	2,760	2,628	3,179	2,715	3,019	2,864	2,822	2,907	2,818	2,818	3,263	3,263	-444
	Financing Costs	1,086	1,712	1,042	1,292	1,267	1,243	577	1,148	471	1,348	770	3,038	1,472	1,472	1,391	1,391	80
	Internal Audit	1	2	-3	0	0	0	0	0	0	0	1	1	0	0	0	0	0
	Pharmacy Services	362	322	283	291	357	406	390	350	249	369	356	379	390	390	382	382	8
	Research & Development	120	-35	16	-11	-52	29	31	-6	-36	8	49	-82	132	132	17	17	115
	Reserves & Other Income	1,904	-2,756	-1,679	92	-671	-730	-224	-433	-192	-280	-460	15,223	-308	-308	688	-1,896	1,588
	SDH Developments	-17	-6	-1	11	-13	-41	-5	-17	1	-11	-13	-15	-6	-6	-7	-7	2
Shared Corporate Services Total		7,900	3,801	4,055	6,063	5,244	5,249	5,348	5,399	5,202	5,847	5,333	23,238	6,096	6,096	7,418	4,835	1,262
Shared Operations Total		901	856	782	792	737	714	644	739	795	839	896	1,760	940	940	871	871	69
South Devon	Coastal	6,409	6,343	6,307	7,048	6,110	6,204	6,413	6,647	6,469	6,637	6,510	6,636	5,626	5,626	6,153	6,153	-527
	Moor to Sea	1,949	1,982	1,867	1,901	1,871	1,989	1,872	1,905	1,891	1,780	1,847	1,736	1,845	1,845	1,864	1,864	-19
	Newton Abbot	3,442	3,488	3,343	2,426	3,005	2,649	2,727	2,958	2,869	3,031	3,059	3,144	2,872	2,872	2,883	2,883	-10
South Devon Total		11,801	11,812	11,517	11,375	10,987	10,842	11,012	11,509	11,229	11,447	11,415	11,516	10,342	10,342	10,899	10,899	-557
Torbay	Independent Sector	7,513	8,168	8,245	8,236	8,039	7,945	8,088	7,611	8,056	8,204	7,703	8,603	9,913	9,913	8,501	8,501	1,413
	Paignton & Brixham	6,628	6,456	6,034	7,335	6,572	6,720	6,905	6,802	6,597	6,951	6,664	6,912	6,285	6,285	6,915	6,915	-630
	Torquay	3,303	3,262	3,338	2,683	3,124	3,202	3,478	2,784	3,295	3,298	3,412	3,339	3,210	3,210	3,156	3,156	54
Torbay Total		17,444	17,886	17,618	18,254	17,735	17,867	18,471	17,196	17,948	18,453	17,780	18,854	19,409	19,409	18,572	18,572	837
Grand Total		40,112	36,373	35,692	38,639	36,271	36,378	37,438	36,734	36,816	38,543	35,744	56,908	38,559	38,559	39,793	37,210	1,350
Contract income		-32,620	-39,474	-36,777	-37,081	-36,014	-37,079	-37,052	-36,649	-36,328	-37,255	-34,902	-46,374	-38,486	-38,486	-35,666	-37,215	-1,270
Total Trust		7,492	-3,101	-1,085	1,558	257	-701	386	85	488	1,288	842	10,534	74	74	4,127	-6	79

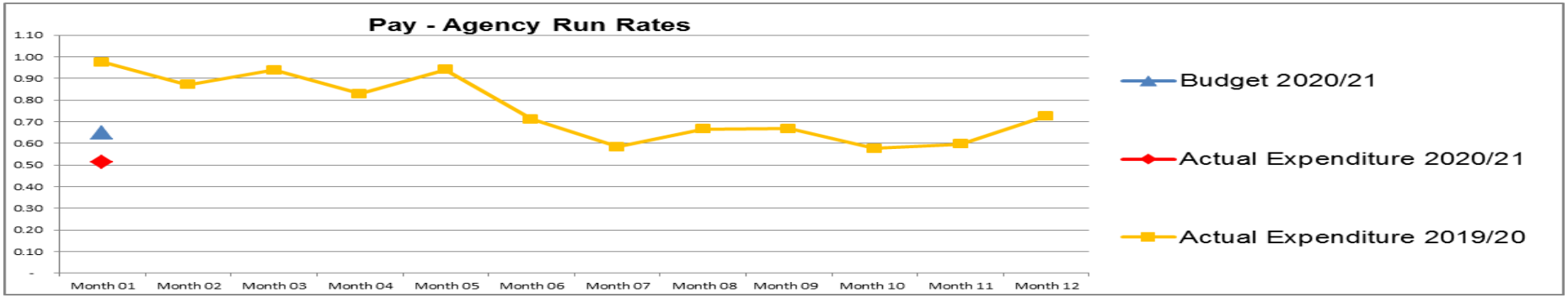
Change in Financial & Activity Performance - M12 to M1

		Plan	Mar-20	Apr-20	Change	% Change		Apr-19	*% change*
Activity Drivers	A&E Attendances	9,607	6,679	4,459	-2,220	-33%		*9,952*	-55%
	Elective Spells	3,248	2,573	1,123	-1,450	-56%		*3,113*	-64%
	Non Elective Spells	3,207	2,757	1,801	-956	-35%		*3,247*	-45%
	Outpatient Attendances	25,791	24,848	13,197	-11,651	-47%		*30,227*	-56%
	Adult CC Bed Days	280	249	202	-47	-19%		*280*	-28%
	Paeds CC Bed Days	186	256	116	-140	-55%		*186*	-38%
Bed Utilisation	Occupied beds DGH		8,973	5,399	-3,574	-40%		*10,220*	-47%
	Available beds DGH		12,078	12,080	2	0%		*11,014*	10%
	Occupancy		74%	45%	-29%	-39%		93%	-52%
Resource Consumption	Medical Staff Costs - £000's	4730	4,764	4,750	-14	0%		*4,711*	1%
	Nursing Staff Costs - £000's	5033	5,162	5,247	85	2%		*5,410*	-3%
	Temp Agency Costs - £000's	648	727	512	-215	-30%		*975*	-48%
	Total Pay Costs - £000's	21609	22,239	23,182	943	4%		*22,227*	4%

Pay Expenditure

Current Performance

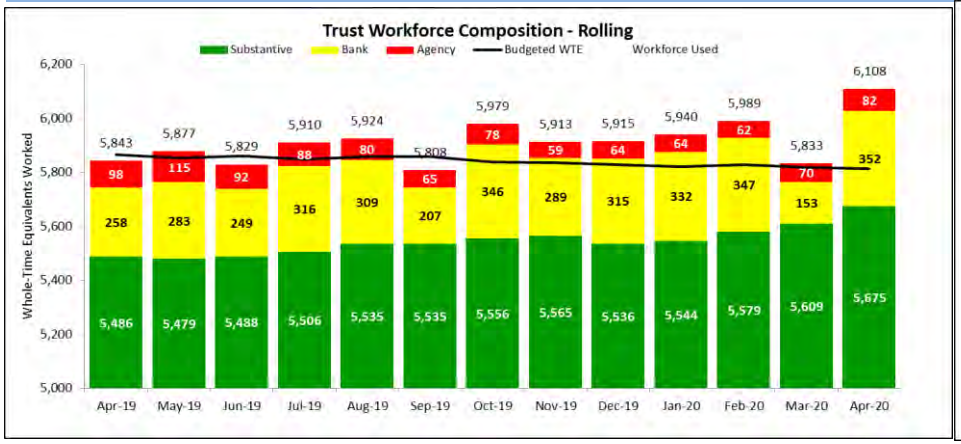


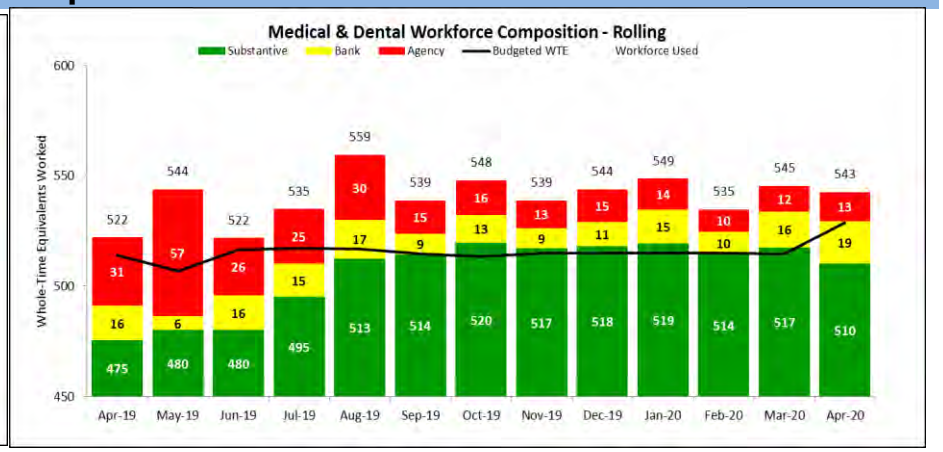


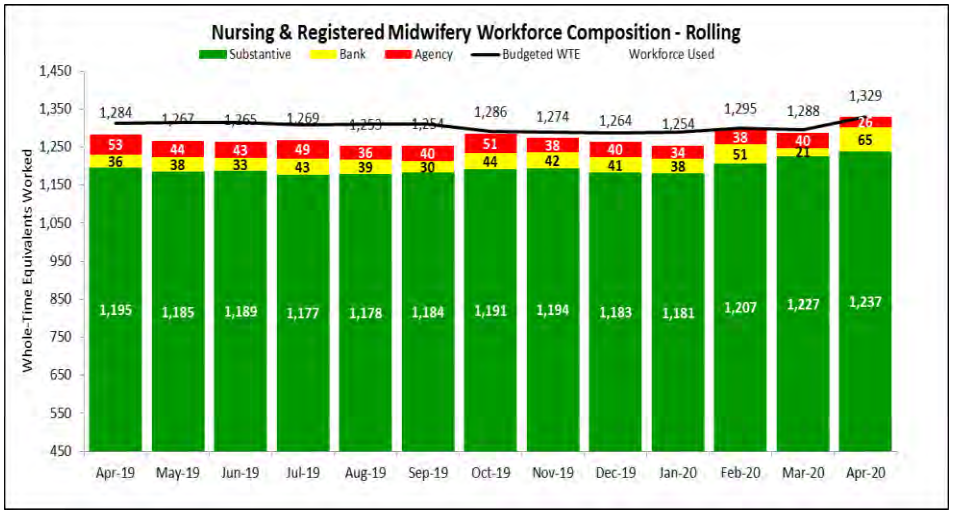
Key points

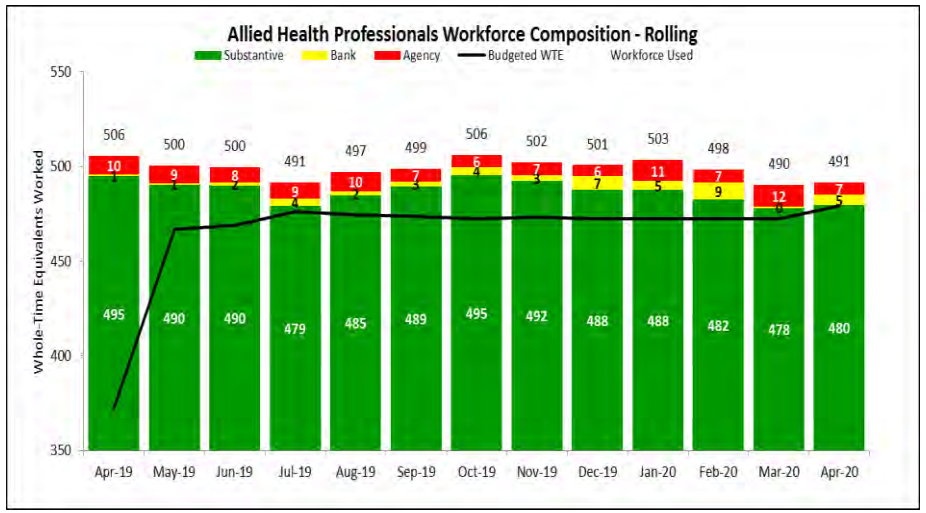
- Total pay run rate in M1 (£23.18m) is £0.94m higher in comparison to previous month (M12 £22.24m excluding £10.8m for the NHS Pension contribution paid centrally and £2.0m for the annual leave accrual).
- The increase is mainly due to annual leave accrual in month of £0.75m due to COVID 19, bank use and AfC pay uplift offset by lower Agency cost due to change in operational services due to COVID.
- There is £0.87m of pay costs related to COVID for which income is expected to be received. The breakdown is as follows: additional shifts of existing workforce £0.34m, backfill for higher sickness absence £0.5m and workforce expansion £0.03m.
- The Apprentice levy balance at Month 1 is £1,596,596 (£1,570,123 at month 12). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

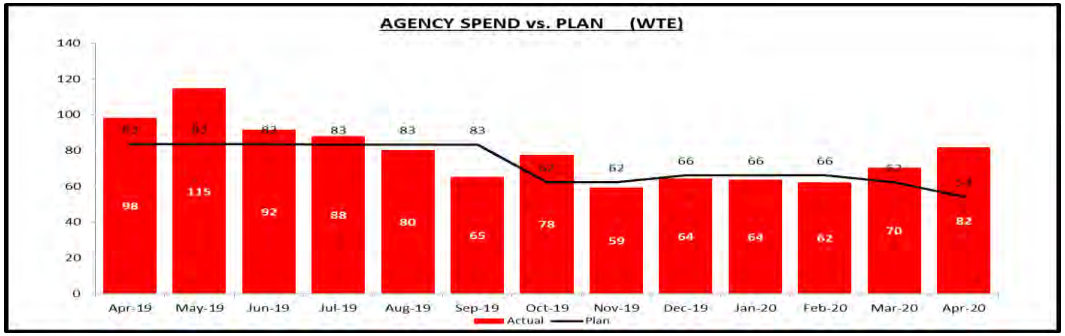
Workforce Composition



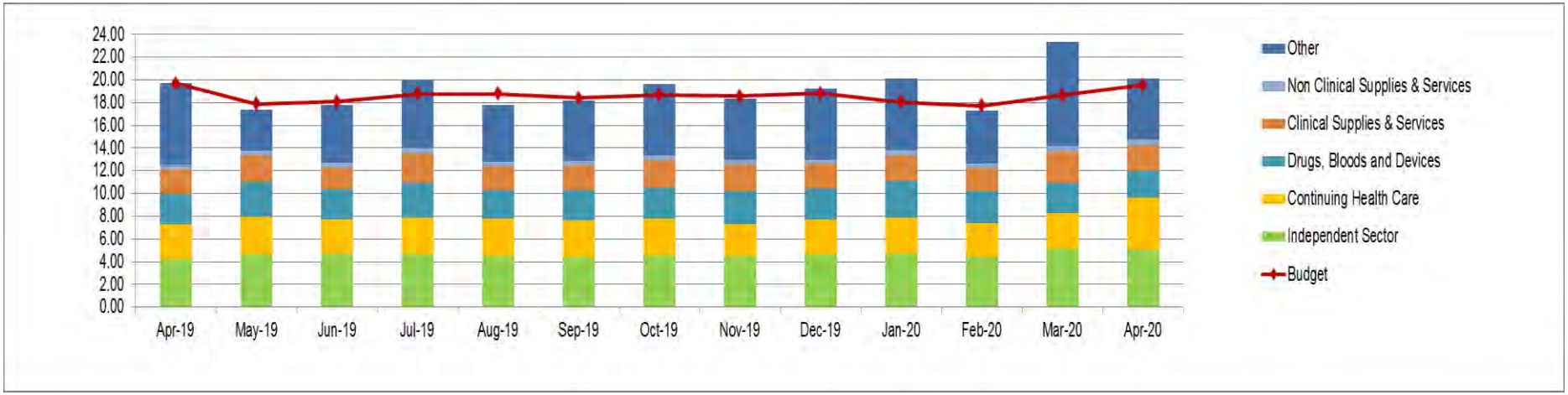








Non Pay Expenditure



Key Points

- There has been a reduction in run rate spend on Drugs, Bloods and Devices (£0.40m) and Clinical supplies and services (£0.35m) linked to activity reduction across various services (Theatres, Cancer, Urology, General medicine and other services) due to COVID.
- There is similar reduction in Non Clinical Supplies spend of £0.10m due to lower cost of patient catering provisions due to less patient admission/stay as a result of COVID.
- Other Operating Expenditure reduction in run rate spend of £3.71m. This is due to a number of material adjustments in M12 which did not recur in M1 such as: provision for Torbay Council bad debt of £2.55m, cost of restoring Regent House due to lease expiring £0.44m, purchase of Windows 10 license £0.32m and reduction in professional services linked to CFHD IAPT training of £0.40m.
- Adult Social Care (Independent sector) - spend in M1 is in line with March 2020 spend.
- Placed People (Health including Continuing Healthcare) increase of £1.4m in month. Within these there are a number of COVID related payments, largely relating to financial assistance to providers and payments for voids totalling £1.0m (matched by Income from the Council and CCG). In addition to this, providers were paid inflationary uplifts from the 1st of April and this will have contributed to the increase since March along with growth and backdated CHC assessment cost.
- There is £1.31m of non pay costs in M1 relating to COVID for which income is expected to be received. This comprise of the following costs: testing £0.09m, remote management of patients £0.19m, increase in ITU capacity £0.25m, segregation of patient pathways £0.19m, national procurement £0.49m, decontamination £0.04m, and various other £0.06m.

Cash and Working Capital

	Month 01		
	Prior month	Actual	Change
	£m	£m	£m
Opening cash balance (net of working capital facility)	**(9.68)**	**(15.59)**	**(5.91)**
Capital Expenditure (accruals basis)	(6.91)	(0.85)	6.06
Capital loan drawndown	3.00	0.00	(3.00)
Capital loan repayment	(1.41)	0.00	1.41
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	0.19	(0.86)	(1.05)
Other capital-related elements	2.98	(0.06)	(3.04)
Sub-total - capital-related elements	**(2.15)**	**(1.76)**	**0.39**
Cash Generated From Operations	(6.90)	1.73	8.62
Working Capital movements - debtors	(0.42)	0.17	0.59
Working Capital movements - creditors	4.46	30.26	25.80
Net Interest	(0.68)	(0.16)	0.51
PDC Dividend paid	(1.71)	0.00	1.71
Other Cashflow Movements	1.47	4.06	2.59
Sub-total - other elements	**(3.77)**	**36.05**	**39.82**
Closing cash balance (net of working capital facility)	**(15.59)**	**18.70**	**34.29**

Closing cash balance	10.14	44.43	34.29
Closing working capital facility	(11.00)	(11.00)	0.00
Closing interim revenue support facility	(14.73)	(14.73)	0.00
Closing cash balance (net of working capital facility)	**(15.59)**	**18.70**	**34.29**

Better payment practice code	**Paid in year**	**Paid within target**	**% paid within target**
Non-NHS - number of bills	14,019	12,538	89.4%
Non-NHS - value of bills (£k)	22,924	18,919	82.5%
NHS - number of bills	233	145	62.2%
NHS - value of bills (£k)	3,364	1,962	58.3%
Total - number of bills	14,252	12,683	89.0%
Total - value of bills (£k)	26,288	20,881	79.4%

Key points

The Trust is preparing a balance sheet Plan to cover the COVID period and beyond, as clarification is received from NHSI/E of the applicable financial framework. In the absence of a finalised Plan, cashflow reporting at M01 is being compared against the prior month.

The NHS response to COVID includes measures significantly to support Trusts' cash positions, as can be seen below. While NHSI/E has not clarified the financial framework for the post COVID period, the Trust has been assured that Trusts which do not accept their control totals will continue to be able to access interim revenue funding .

- Capital-related cashflow is £0.4m favourable to the prior month. Capital expenditure was £6.1m lower than the exceptional level incurred in the prior month. However, capital expenditure in the prior month had been largely offset by receipt of capital loans and new finance leases, which have not been received in M01.

- Total capital expenditure in M01 was £0.85m. The principal components were continuing expenditure on the loan-funded Theatres scheme (£0.21m) and the PDC-funded community IT scheme (£0.17m). A separate report regarding capital will be considered at FPDC.

Other elements:

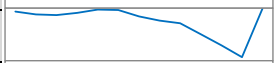
- Cash generated from operations is £8.6m favourable to the prior month. This is principally due to the significantly increased level of NHS block income, calculated to enable Trusts to achieve a break even during the COVID period.

- Working Capital creditor movements is £25.8m favourable to the prior month, largely due to the impact of M02 block income received in M01 £31.4m being greater than the impact of the increase in deferred income which was experienced in M12.

	ISU	Target	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	0	1	1	2	0	0	1	1	0	0	0	0	0
Reported Incidents - Death	Trustwide	<1		0	0	1	0	0	2	0	1	0	0	0	0	0	0
Medication errors resulting in moderate harm	Trustwide	<1		1	1	0	0	0	0	0	0	0	0	1	1	0	0
Medication errors - Total reported incidents	Trustwide	N/A		32	48	39	46	61	38	46	59	45	52	60	45	19	19
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		2	0	0	0	0	0	0	0	0	1	2	0		0
Never Events	Trustwide	<1		0	1	0	0	0	0	0	1	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		2	7	4	2	5	2	5	7	4	1	5	3	3	3
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	2	2	2	0	0	0	0	2	0	1	1
Formal complaints - Number received	Trustwide	<60		13	22	23	35	24	26	31	30	14	34	22	19	2	2
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		89.2%	91.0%	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%	86.4%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		98.9%	100.0%	97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%	93.9%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		97.8	103	108	116.5	111.3	101	98.8	97.5	102.2	92				101.7
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		98.5%	91.7%	90.9%	90.1%	93.9%	88.9%	88.8%	89.6%	90.4%	91.3%	89.2%	88.9%	88.9%	88.9%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		98.5%	91.8%	93.7%	92.8%	100.3%	91.3%	91.6%	93.2%	91.7%	92.9%	91.4%	91.3%	91.3%	91.3%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		4	42	12	36	63	34	0	42	0	204	108	0	4	4
Hand Hygiene	Trustwide	>95%		92.2%	87.7%	93.8%	93.5%	95.2%	95.7%	96.1%	97.2%	94.1%	96.1%	93.5%	94.9%	99.1%	99.1%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		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%		93.8%	75.5%	79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%	66.7%
Stroke - SSNAP level	Trustwide	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	
Follow ups 6 weeks past to be seen date	Trustwide	6400		6240	6459	6803	6906	7393	6793	6694	6725	7243	6391	6147	7056	8824	8824
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<3.8%		4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.5%	4.5%		4.5%		4.3%
Appraisal Completeness	Trustwide	>90%		80.0%	80.0%	79.0%	80.0%	78.0%	78.0%	77.3%	78.0%	78.5%	80.1%	81.6%		71.6%	78.0%
Mandatory Training Compliance	Trustwide	>85%		89.5%	90.2%	90.9%	90.3%	90.8%	90.3%	90.6%	90.5%	90.4%	90.8%	90.4%		90.1%	90.3%
Turnover (exc ms Docs) Rolling 12 months	Trustwide	10%-14%		10.7%	10.7%	10.8%	11.2%	11.2%	11.3%	11.4%	11.4%	11.4%	11.7%	11.7%		10.5%	

	ISU	Target	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		370	356	419	508	562	392	373	319	344	462	588	393	121	4693
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		149	185	97	101	112	189	305	230	198	190	235	175	14	1991
Timeliness of Adult Social Care Assessment assessed within 28 days of referral	Trustwide	>70%		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%	70.0%
Clients receiving Self Directed Care	Trustwide	>90%		91.1%	90.8%	90.3%	90.3%	90.1%	89.6%	89.0%	89.0%	89.1%	89.3%	88.1%	87.7%	85.0%	88.1%
Carers Assessments Completed year to date	Trustwide	40% (Year end)		3.6%	7.8%	13.2%	18.6%	23.2%	26.7%	29.2%	28.4%	35.4%	36.6%	38.5%	39.6%	2.2%	38.5%
Number of Permanent Care Home Placements	Trustwide	<=600		602	619	631	629	634	648	641	640	645	627	624	632	628	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				54			109								109
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET				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%		87.6%	83.9%	82.6%	83.2%	86.2%	91.7%	91.7%	92.4%	91.5%	91.3%	89.9%	78.8%	65.0%	88.0%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		532	550	514	567	563	569	594	530	556	558	530	520	532	520
Intermediate Care - No. urgent referrals	Trustwide	113		184	189	179	188	174	178	216	205	201	239	202	219	231	2150
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		258	249	220	196	202	204	226	230	212	211	186	202	138	2405
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		79.1%	84.2%	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%	94.1%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		80.7%	81.8%	81.5%	81.1%	80.7%	80.4%	79.9%	80.0%	79.9%	79.8%	79.5%	76.2%	69.1%	69.1%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		79.9%	86.5%	78.8%	84.4%	77.4%	78.9%	72.9%	78.8%	85.9%	83.6%	75.3%	71.8%	70.5%	70.5%
Diagnostic tests longer than the 6 week standard	Trustwide	<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%	47.7%	47.7%
Dementia - Find - monthly report	Trustwide	>90%		95.1%	88.1%	92.8%	98.7%	90.3%	88.5%	87.5%	94.4%	88.4%	81.9%	94.3%	98.0%	98.4%	98.4%

	ISU	Target	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-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	0	4	4
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		53.4%	77.7%	69.5%	83.4%	83.4%	88.3%	68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	80.1%	80.1%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		50.3%	97.5%	98.9%	98.9%	98.7%	97.3%	91.5%	100.0%	97.3%	97.1%	98.9%	95.1%	96.3%	96.3%
Cancer - 28 day faster diagnosis standard	Trustwide			65.2%	63.5%	63.6%	74.0%	73.3%	70.6%	71.8%	73.2%	71.9%	66.9%	74.5%	74.8%	60.4%	60.4%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		96.7%	99.5%	97.3%	97.0%	94.7%	98.5%	96.8%	98.0%	97.6%	96.8%	98.8%	99.0%	97.1%	97.1%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		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%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		98.6%	96.9%	100.0%	95.9%	98.4%	95.9%	95.9%	95.8%	95.2%	89.5%	93.5%	97.7%	93.2%	93.2%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		94.7%	97.1%	96.8%	100.0%	93.9%	93.8%	94.7%	95.0%	97.1%	86.2%	91.4%	100.0%	96.6%	96.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		93.3%	90.9%	92.9%	93.8%	100.0%	100.0%	86.7%	85.7%	100.0%	100.0%	85.7%	76.5%	73.3%	73.3%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			33	41	34	28	31	36	39	27	24	24	21	21	19	19
RTT 52 week wait incomplete pathway	Trustwide	0		71	59	83	84	105	89	79	69	71	80	43	53	95	95
On the day cancellations for elective operations	Trustwide	<0.8%		1.1%	0.9%	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%	0.7%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		3	3	6	19	9	8	8	7	3	3	10	5	46	46
Bed Occupancy	Overall System	80% - 90%		93.9%	91.4%	90.5%	94.0%	95.3%	95.4%	95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	54.6%	95.4%
Number of patients >7 days LoS (daily average)	Trustwide			134.4	130.6	125.5	124.8	128.3	131.7	127.4	121.5	120.1	128.1	130.3	119.8	100.5	128.9
Number of extended stay patients >21 days (daily average)	Trustwide			31.7	29.7	26.6	29.8	29.0	35.9	34.3	28.0	23.1	25.5	27.7	26.0	22.6	31.0
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		148	61	83	81	137	90	47	104	113	117	88	43	16	16
Ambulance handover delays > 60 minutes	Trustwide	0		13	11	4	5	12	2	5	13	14	14	7	5	1	1
A&E - patients recorded as >60min corridor care	Trustwide			430	319	424	384	447	416	382	494	463	495	335	115	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			190	90	146	123	212	145	103	247	158	182	136	32	66	66
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		11	0	0	0	0	0	0	1	3	1	3	1	0	0
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		2	1	4	4	5	3	5	1	3	4	5	0	3	3
Number of Clostridium Difficile cases - (Community)	Trustwide	0		3	4	1	0	1	0	3	1	1	0	0	0	1	1
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		64.7%	63.8%	62.8%	67.2%	66.3%	67.1%	66.4%	63.0%	64.1%	65.7%	62.2%	71.0%	77.1%	77.1%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		29.1%	23.9%	29.4%	39.9%	38.2%	35.0%	32.6%	25.8%	36.8%	41.5%	40.5%	44.5%	57.3%	57.3%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		86.4%	77.3%	86.4%	86.4%	81.8%	68.2%	68.2%	77.3%	81.8%	81.8%	95.5%	68.2%	95.5%	95.5%

	ISU	Target	13 month trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-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	0	
Liquidity	Trustwide	4		3	3	2	2	3	4	4	4	4	4	4	4	0	
I&E Margin	Trustwide	1		4	4	4	4	4	4	4	4	4	4	4	4	0	
I&E Margin Variance from Plan	Trustwide			4	3	1	2	2	1	2	2	3	3	4	2	0	
Variance from agency ceiling	Trustwide	1		4	4	4	4	4	4	4	4	4	4	3	3	0	
Overall Use of Resources Rating	Trustwide			4	4	3	3	3	3	4	4	4	4	4	4	0	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-6072	-925	-72	-1447	-1363	-473	-3022	-4464	-6555	-9693	-13294	-23577	0	
Agency - Variance to NHSI cap	Trustwide			-1.42%	-1.21%	-1.23%	-1.14%	-1.17%	-0.98%	-1.03%	-1.06%	-1.07%	-1.01%	-0.98%	-0.87%	0.00%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-628	-1191	-1296	-891	-239	-342	-1584	-2357	-2872	-4983	-7078	-9325	0	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			48	501	893	1146	2637	3301	4420	6559	7632	8191	9595	4249	0	
Distance from NHSI Control total (£'000's)	Trustwide			-4861	-1213	91	-1248	-1019	58	-1651	-2833	-4616	-7648	-10926	-20367	0	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	0	0	0	0	0	0	-2000	0	
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			-2.4%	-0.4%	-1.8%	0.2%	-1.2%	-1.0%	-2.4%	-3.4%	-3.4%	-2.4%	-2.7%	-3.1%	-67.1%	-67.1%
Outpatients - Follow ups	Trustwide			1.2%	0.9%	0.9%	1.9%	0.8%	1.5%	1.1%	0.7%	1.2%	1.3%	1.3%	0.2%	-51.9%	-51.9%
Daycase	Trustwide			5.6%	7.9%	4.0%	4.0%	2.9%	3.8%	2.5%	3.1%	2.8%	2.4%	1.8%	0.0%	-64.1%	-64.1%
Inpatients	Trustwide			2.9%	-1.6%	-4.2%	-3.0%	-0.6%	-1.7%	-2.2%	-0.3%	2.0%	4.5%	4.8%	3.6%	-62.4%	-62.4%
Non elective	Trustwide			-1.8%	-0.9%	-2.9%	-3.5%	-4.5%	-3.4%	-2.3%	-1.7%	0.1%	0.5%	1.2%	0.4%	-44.5%	-44.5%

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Mortality Surveillance Score Card			Meeting date: 27th May 2020
Report appendix	List any supplementary information as shown below: Appendix 1:		
Report sponsor	Medical Director		
Report author	Patient Safety & Experience Lead		
Report provenance	This report is informed by a range of data sources using defined methodology including Hospital Episode Statistics and Dr Foster Report presented at Executive Directors meeting 26th April 2020 Report is presented at the Mortality Surveillance Group		
Purpose of the report and key issues for consideration/decision	To provide information on the mortality of patients who have used the inpatient services of the Trust and assurance of any associated risks and actions. The report is a record of the Trust's mortality as viewed through a number of different metrics – The main HSMR and SHMI are within expected range. It also includes some Covid-19 related data in Appendix 4.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To review the information included in this report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	
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		**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Report title: Mortality Surveillance Score Card		Meeting date: 27th May 2020
Report sponsor	Medical Director	
Report author	Patient Safety & 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		

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.

ONS data has been included which shows deaths outside of hospital have increased during the corona 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 on a daily basis and reported nationally. Covid is also being reviewed via a weekly mortality report which looks at our in hospital and total mortality for our community.

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 Oct 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 Feb 17 to Jan 20 (current month)
Chart one (as below) shows a longitudinal monthly view of HSMR. The latest month's data, Jan 2020, has a relative risk of **92.0** and is within the expected range.

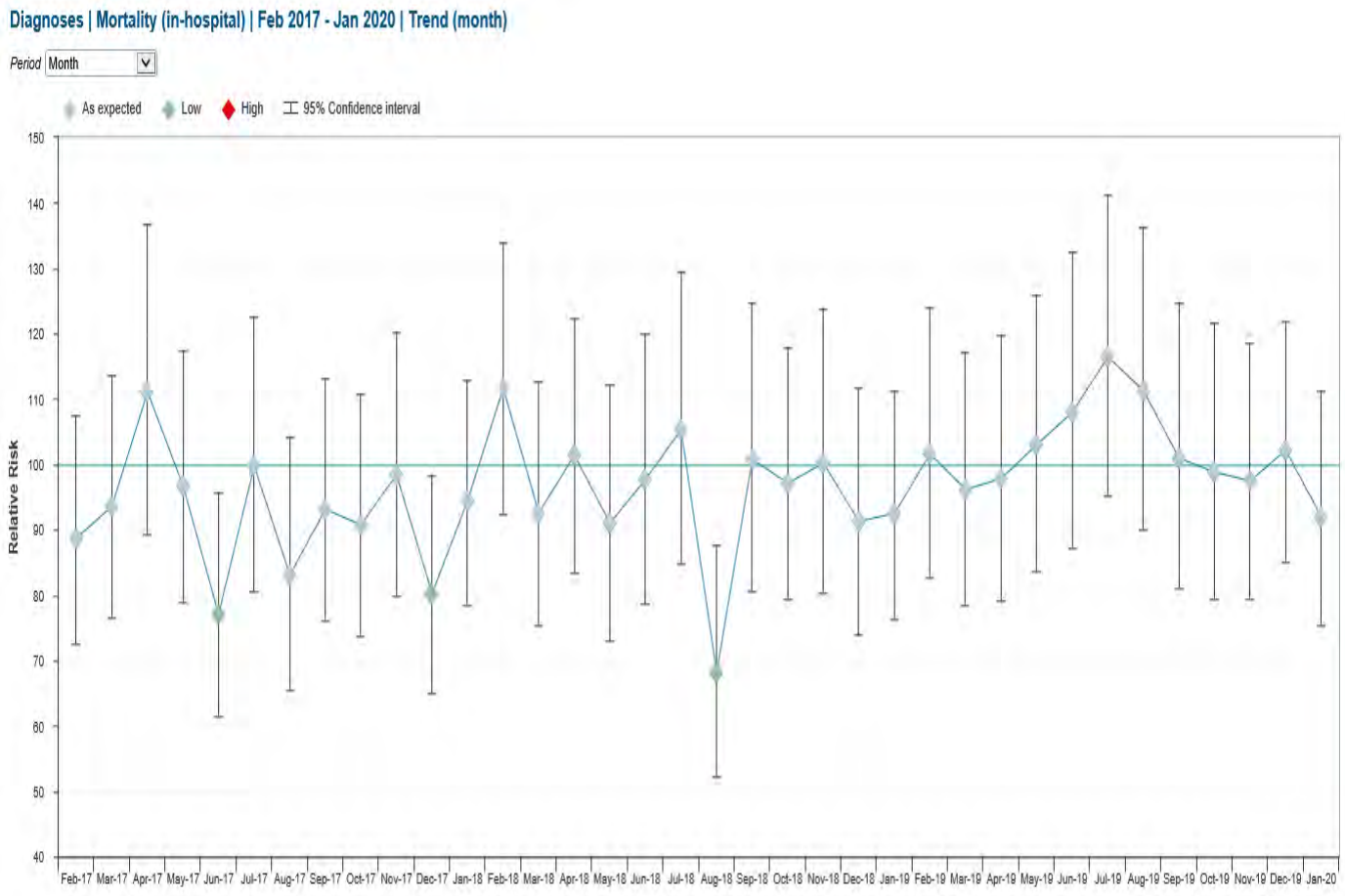


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12 month annual total. The monthly 12 month annual total is above the 100 line but below the standard deviation points which would signify an issue. This measure is being observed via the Mortality Surveillance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

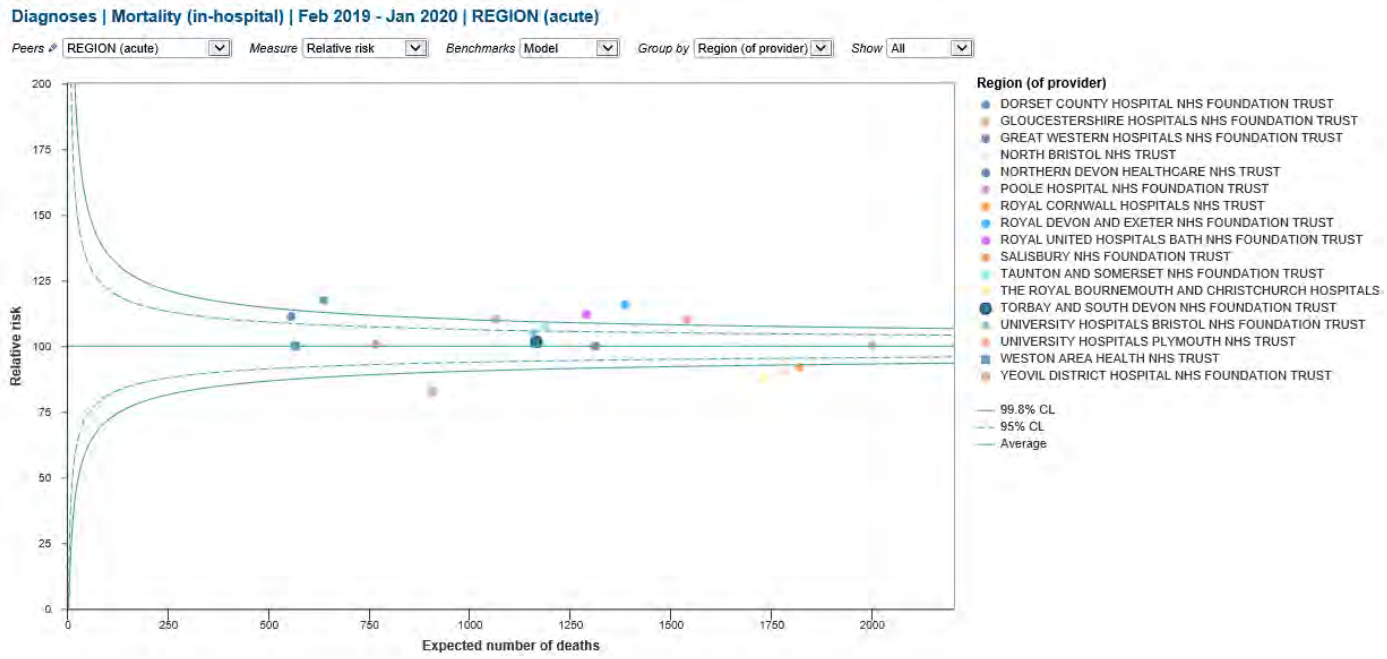
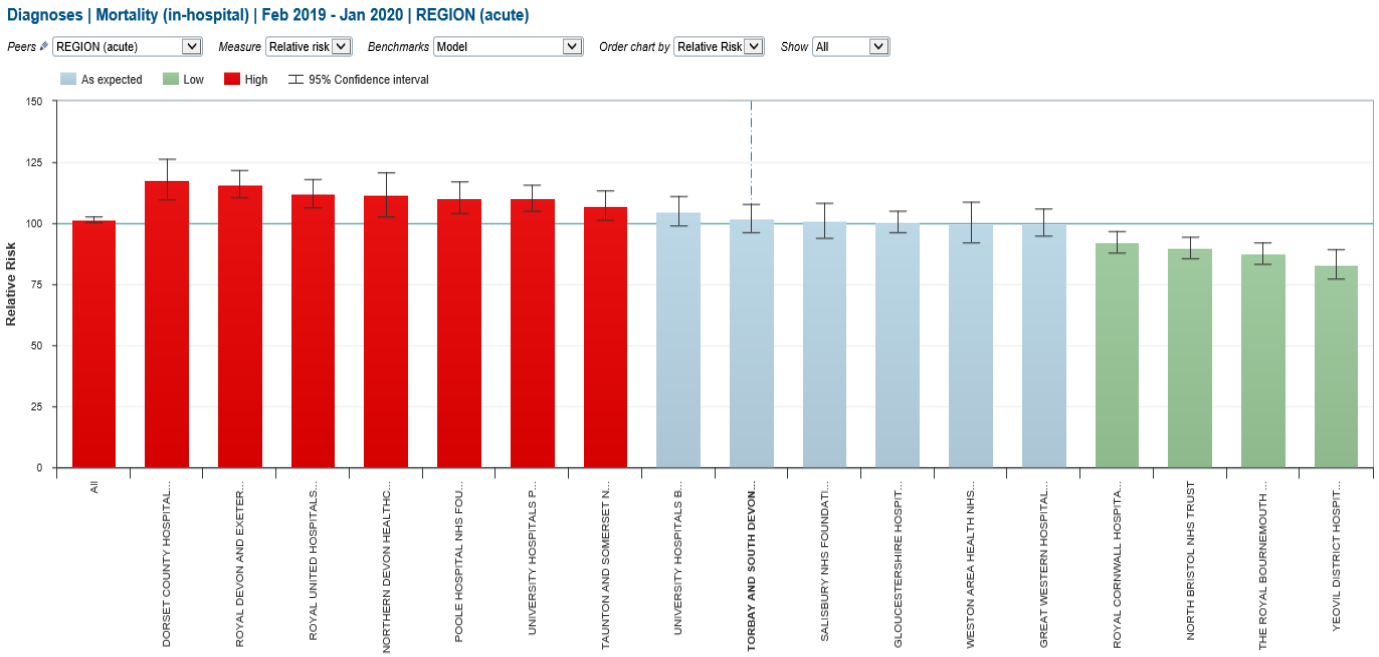


Chart 3 displays the above data as a Peer Comparison, ranked and as a bar chart. This is showing more local Trusts experiencing high HSMR's.



1B Summary Hospital Mortality Index (SHMI) Reporting Period Dec 2018 – Nov 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* **Dec 2018 – Nov 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.

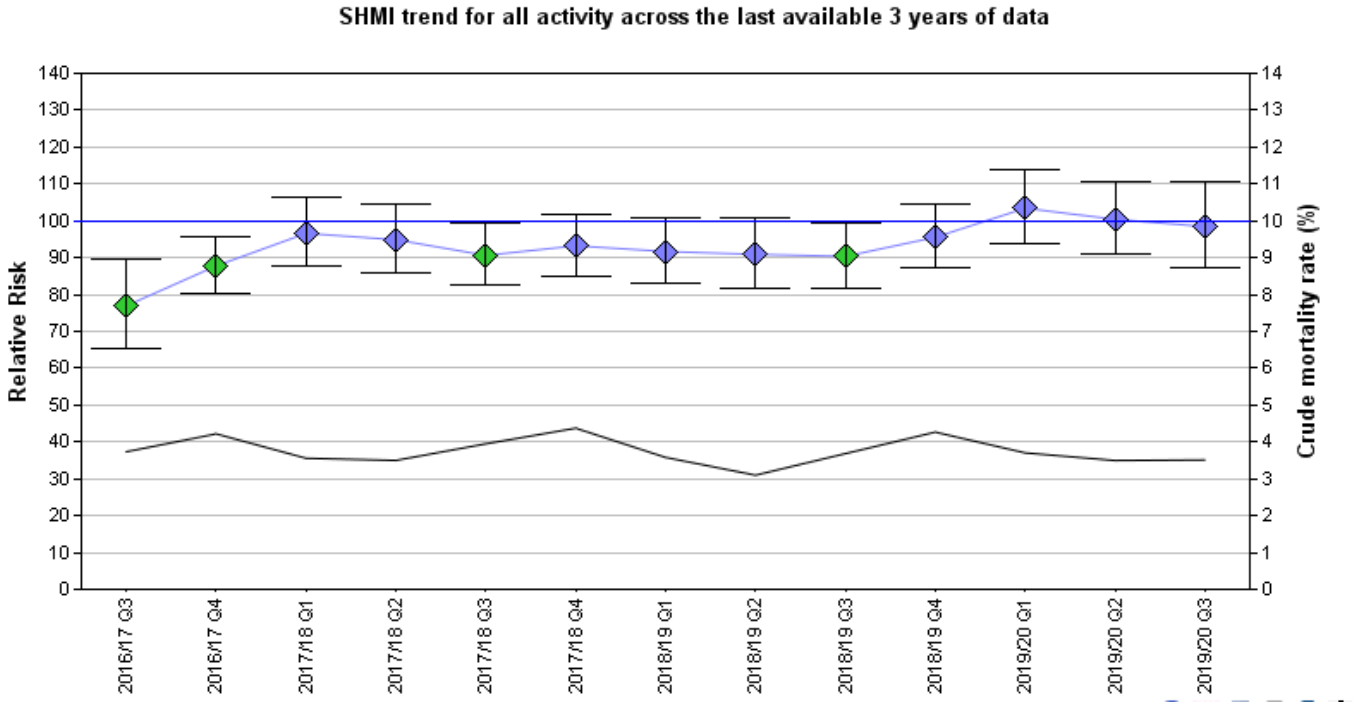
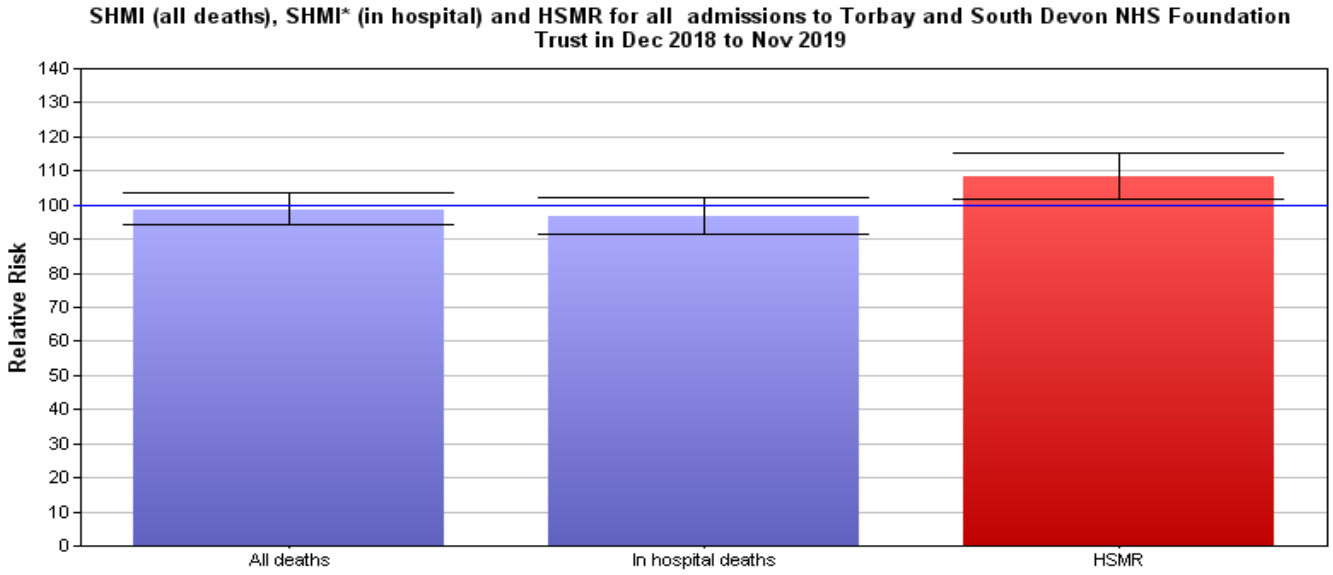


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison



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 highlighting a risk in the Dec 18 – Nov 19 data. This is not evident in the HSMR analysis when we have tried to run this time period.

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

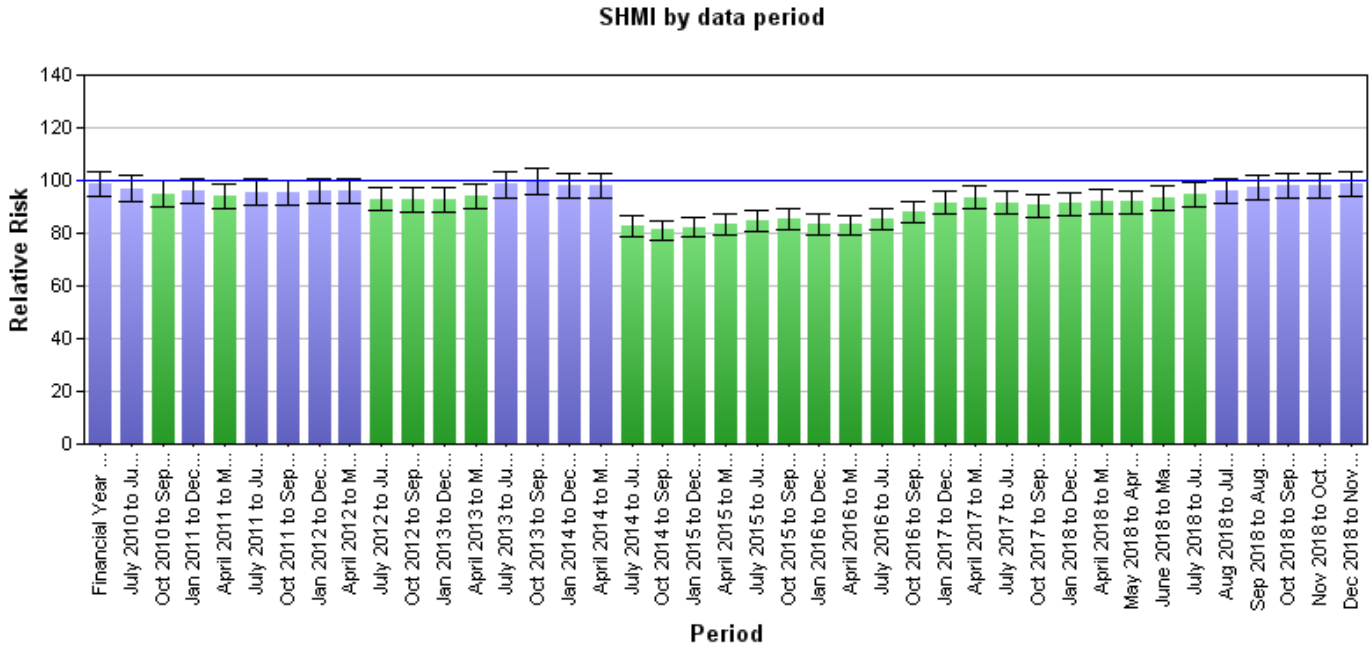
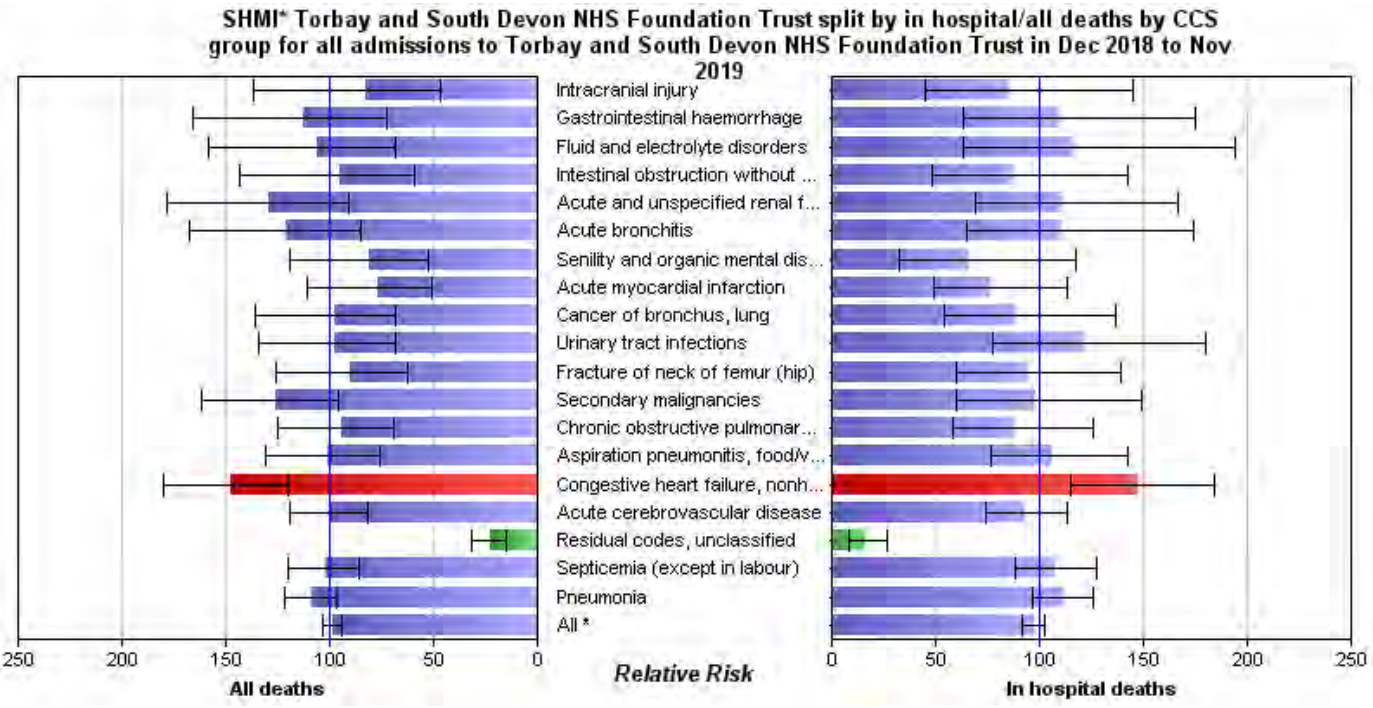


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Congestive cardiac failure. These areas have been discussed 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 overall admissions during Covid surge and hence the denominator is reduced. 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.

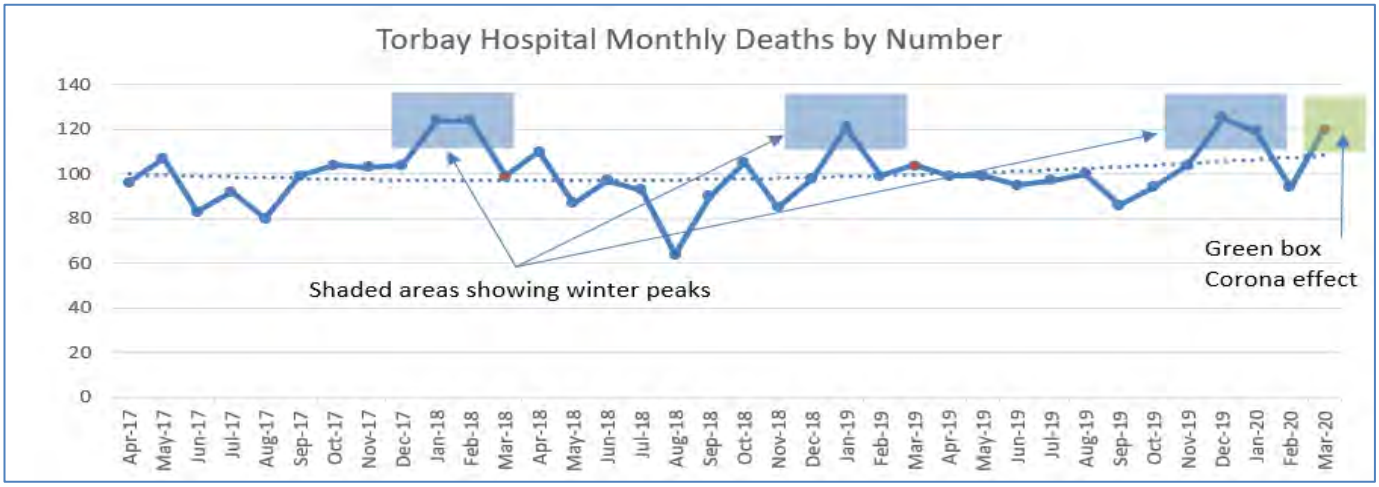
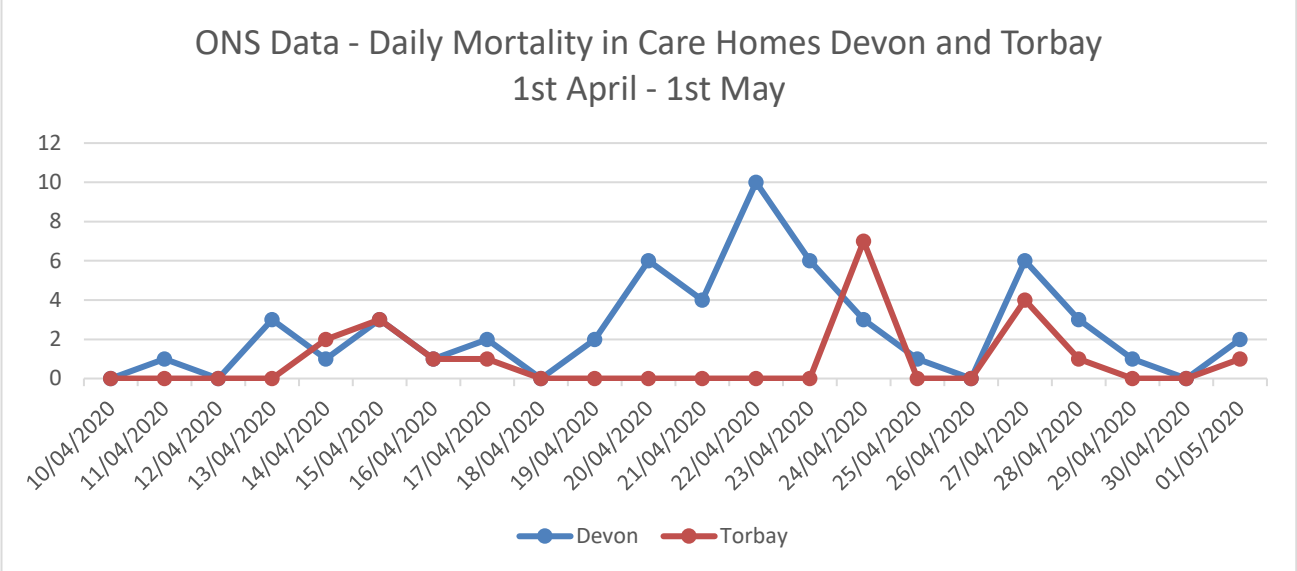


Chart 10, as below, records ONS daily data from care homes in Torbay and Devon 1st April 2020 – 1st May 2020



Charts 11 and 12 highlight in hospital and out of hospital deaths with a comparator year

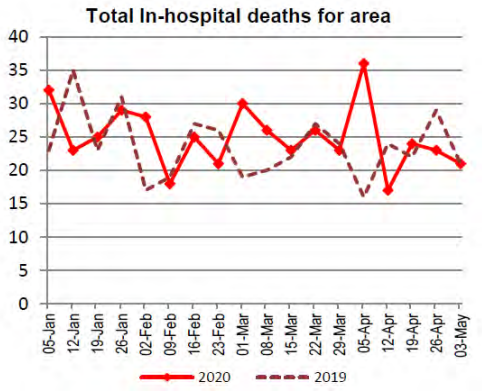


Chart 11

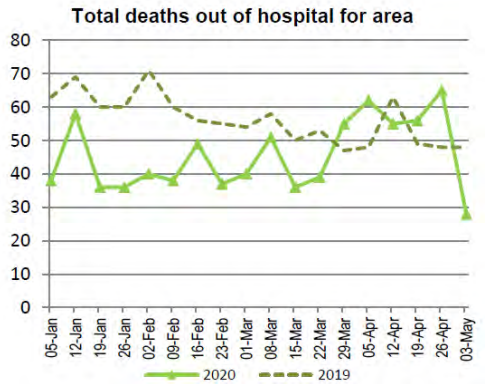


Chart 12

The 3rd May data point, on chart 12, will be subject to data lag and will change once more data is available. What the charts highlight are a peak rise in, in-hospital deaths week 5th April and a general rise in total mortality from the 22nd March.

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

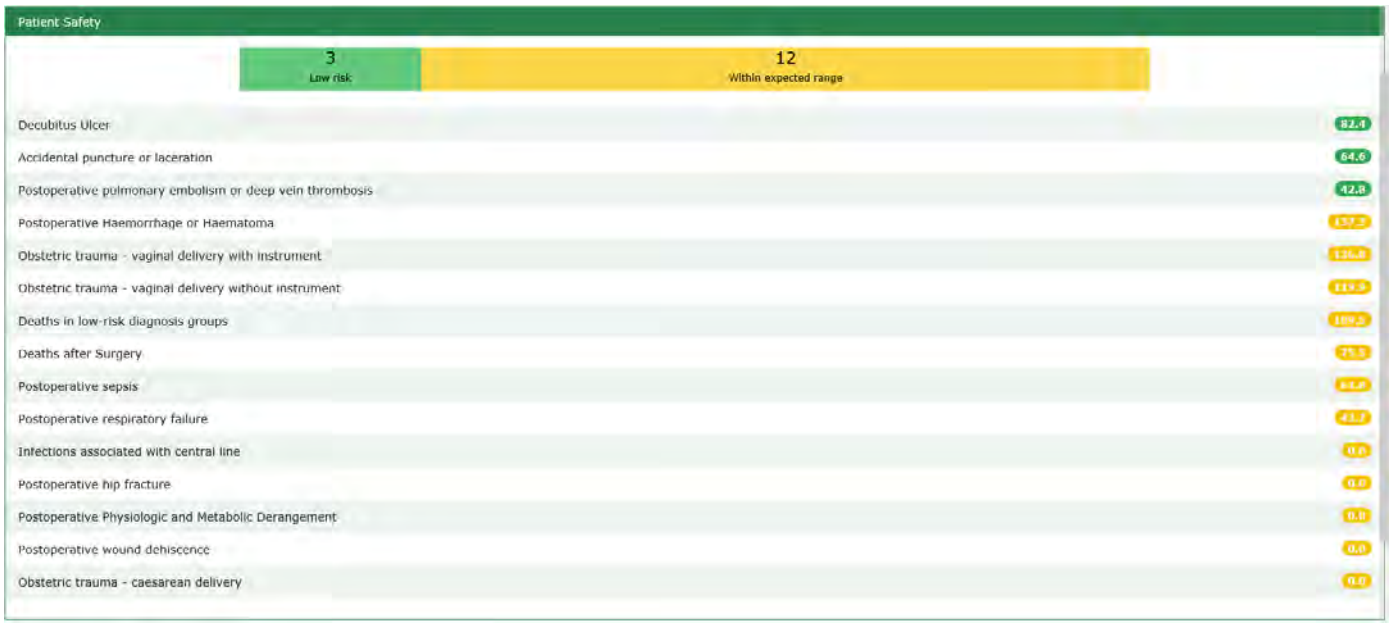
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	10	79286	1193	1147.4	1.5	104.0	
HSMR (56 diagnosis groups)		29977	1003	897.9	3.3	111.7	
Congestive heart failure, nonhypertensive		533	77	54.3	14.4	141.7	
Coronary atherosclerosis and other heart disease	1	884	15	6.3	1.7	236.6	
Essential hypertension	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 6th May 2020, 12 indicators are within the expected norm with 3 are in the low risk category

Table 4



7.0 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: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			**Meeting date:** 27 May 2020
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Dr Ed Berry, Consultant in Emergency Medicine and GOSWH		
Report provenance			
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation			

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Guardian of Safe Working Hours – Doctors and Dentists in training		Meeting date: 27 May 2020
Report sponsor	Medical Director	
Report author	Dr Ed Berry, Consultant in Emergency Medicine and GOSWH	

1. Executive Summary

The following report concerns the time period of 11th of February 2020 up to the 11th of May 2020 based on the Exception Reports submitted by the Junior Doctor workforce.

- The Coronavirus pandemic has required significant changes in work patterns for all tiers of staff. Junior doctors have been required to work different rotas often in different specialties. Interim 'surge' rotas have commonly not been wholly compliant with Junior Doctor Contract changes of 2019, but allowable under the 'exceptional circumstances' of the COVID pandemic.
- Rotas are currently being returned to normal in line with de-escalation from the 'surge' period. The safe de-escalation and re-organisation of the hospital
- We are grateful to our Junior Doctors for being flexible, hard-working and highly professional in the face of significant change.
- The definition of 'Standby shifts' could make a significant number of 'surge' rotas subject to a Guardian fine if raised as an exception report. The definition and resultant remuneration of stand-by shifts is currently being negotiated through Medical JLNC.

The COVID Pandemic and the wholesale change of junior doctors and their rotas has slowed progress on last quarter's actions these will be revisited in the coming months.

2. Introduction

- The following report aims to ensure Junior Doctors are working contracts compatible with the Junior Doctor Terms and Condition of Service 2016, that are sustainable and fair and that they are able to claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities or complete career enhancing objectives.

- NHS Employers and the BMA have produced a joint statement on the application of contractual protections during the pandemic, recognising that during this current crisis it may not be realistic to maintain all of the contractual limits and that a more pragmatic approach will be necessary. NHS Employers and the BMA agree that when not possible to implement, relevant working hours restrictions and rest requirements in the TCS will be suspended and that the Working Time

Regulations 1998 (WTR) will be the fall-back position for the duration of the pandemic.

- All new and amended rota patterns require a work schedule or equivalent mechanism for the purposes of correct hours and pay calculation, to ensure that there is appropriate remuneration for all work done. As specified in schedule 2 of the TCS, no individual should suffer financial detriment as a result of changes made to their working pattern that is outside their control.

3. Exception Reports

There have been 38 Exception Reports in the period 11th of February 2020 up to the 11th of May 2020. This is a clear reduction from 98 in the three months prior to this (and the 215 ERs in the last quarter of 2019). This is likely to represent junior doctor professionalism and good will during the Coronavirus pandemic.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Acute Medicine	3	0	3	
Emergency Medicine	6	0	6	
Gastroenterology	7	7	0	
General Medicine	11	2	9	
Obstetrics and Gynaecology	2	2	0	
Paediatrics	3	3	0	
T+O, general surgery, paeds and ITU	6	2	4	Due to the way Allocate searches, this is hard to tease out.
Total	38	16 (42%)	22 (58%)	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	21
F2	6
CT1-3	5
ST 4-9	6
Total	38

Table 3 – Nature of Exception

Additional Hours	33
Educational	1
Rota Concern	4

There are a number of unusual themes associated with the Coronavirus pandemic. In exceptional circumstances junior doctor rotas can be designed non-compliant with the Junior Doctor Contract to ensure patient safety. A number of these rotas contravened the standard Junior Doctor contract of 2016, which is allowable in these circumstances (Guardian fines remain from the Junior Doctor contract 2016, but otherwise safeguards revert to the Working Time Regulations of 1998). Particular issues with our 'surge' rotas include:

1. Extremely high weekend frequency – as high as 7 of every 8 weekends worked (depending on definition of and inclusion of 'standby shifts').
2. High frequency of 'stand-by' shifts – a shift whereby a doctor has to come to work if other doctors become sick. Specialties were advised to plan for up to 40% staff sickness and therefore built in the provision of standby to ensure adequate cover. The BMA considered these as 'worked shifts' and have recommended they should be paid as such. Junior Doctor representatives for the Trust have made a formal request through JLNC for the Trust to pay stand by shifts as a normal working day (regardless of whether the shift was worked) as per the BMA guidance.
3. Too many hours rostered in a 168hr period (depending on classification of stand-by shifts).
4. Significant loss of expected training and educational opportunities.
5. Secondment to a new specialty for the duration of the 'surge period'.
6. Difficulties in the ability to take annual leave during the COVID period.

It is also worth recognising that as a result of the pandemic Health Education England reached a decision that all planned rotations due to take place during the "delay phase" of COVID-19 will cease, with trainees being asked to stay in their present working environment. This has meant that trainees have missed the opportunity to gain experience in their next placement. The four UK Statutory Education Bodies (HEE, NES, HEIW and NIMDTA), the Medical Royal Colleges and the General Medical Council are working together to minimise the impact of any delayed attainment of capabilities due to current circumstances, and will ensure that these circumstances are taken into consideration in ARCP and recruitment and selection processes.

Table 4 – Outcome of Exceptions

TOIL	3	No further action includes outcomes where discussion is enough to close the ER or Dr behavior can be modified to avoid further circumstances.
Payment	13	
No compensation required	0	
Agreed no further action required	0	
Outstanding	22	

4. Comment on Exception Reports

Despite exceptionally low numbers of Exception Reporting, only 42% have been actioned, it is recognised that it is due to competing priorities of educational and clinical supervisors during the surge period.

5. Rota Reviews

During the month of April, 181 of our trainee doctors were either reassigned or had their rotas changed in order to support COVID. Those specialties which were not covering COVID were also required to change their rotas to accommodate the fact that some of their trainees had been reassigned. In total we have seen rota changes affecting approximately 252 trainees.

Each of these trainees will be required to be provided with a work schedule containing a breakdown of the pay for each rota that they have been working on. Rotas will need to be cross referenced to ensure there where required individual trainees are paid any pay enhancements due to them. Medical HR are currently undertaking this complex and time-consuming piece of work.

Some pandemic 'surge rotas' remain in use – notably including the Emergency Department and IRT areas of the acute response. These rotas have a high weekend frequency which is difficult to support given the current low level of use and the hospital's policy of de-escalation. De-escalation will present difficulties providing adequate shift cover but will protect the Junior Doctors involved.

The Emergency Department middle grade rota remains in discussion between HR, the middle grades and ED support staff. Due to significant differences between Staff Grade, Associate Specialist and Registrar contracts, agreement has been difficult. It will be important to strike a balance between the two to ensure Registrars have an equitable rota in the future.

There a number of rotas, such as the orthopaedic SHO rota, which will need to be altered once junior doctors have been returned from their 'surge' ED/IRT rotas.

6. Fines

There have been no Guardian fines for this period.

7. Summary

Overall, all departments appear compliant and supportive of their Junior Doctors. The Coronavirus pandemic has presented unique challenges to the Junior Doctors, their rotas and the administerial staff designing/monitoring them. As the initial surge period finishes and the de-escalation begins it is presenting an entire suite of new problems.

Junior Doctors, workforce practitioners and rota coordinators have shown admirable flexibility, professionalism and diligence in the face of the COVID pandemic.

It is testament to our junior doctor's professionalism and sense of duty that none of the issues highlighted in this report have been raised in individual exception reports. In the current period of de-escalation, rotas are being returned to normal in keeping with the National Terms and Conditions of Service for Trainee Doctors 2016

The priority for the coming quarter is correct provision of the National Terms and Conditions of Service for Trainee Doctors 2016 through de-escalation, advertising the Exception Reports process for both junior doctors and supervisors and developing the infrastructure to sign off all incomplete exception reports.

Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Annual Self-Certification: Provider Licence Conditions			Meeting date: 27.05.20
Report appendix			
Report sponsor	Chief Executive		
Report author	Company Secretary		
Report provenance	Reviewed by Executive Directors 12.05.20 and Audit Committee 26.05.20		
Purpose of the report and key issues for consideration/decision	NHS Foundation Trusts are required to self-certify whether or not they have complied with: 1. Conditions of the NHS Provider Licence 2. Required resources available if providing commissioner requested services 3. Complied with governance arrangements The aim of the self-certification is for providers to carry out assurance that they are in compliance with the conditions. NHSI guidance dated June 2018 setting out the requirements for self-certification and the deadlines in which Board approval and subsequent publication of the self-certifications has not been revised and therefore it is assumed that the deadline dates still stand. Compliance with Condition G6 and CoS7, **is required by 31 May 2020**. Compliance with Condition FT4(8,) **is required by 30 June 2020.** This report sets out assurance and provides evidence of how the Trust has achieved compliance with its Licence Conditions.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve sign-off of the Provider Licence Self-Certifications and authorise the Chairman and Chief Executive to sign the declarations on behalf of the Board.		

Summary of key elements	
Strategic objectives supported by this report	

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

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

Board Assurance Framework	**X**	**Risk score**	9
Risk Register	n/a	**Risk score**	

Failure to achieve the standards required for a 'good' CQC rating

External standards affected by this report and associated risks	

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

Report title: Annual Self Certification: Provider Licence Conditions		**Meeting date:** 27.05.2020
Report sponsor	Chief Executive	
Report author	Company Secretary	

1. Introduction

1.1 NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

1.2 The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and it is up to providers to how they carry out this process.

2. Discussion

2.1 In previous years, declarations have been made to two deadlines:

(i) Compliance with General Condition 6 and Continuity of Service Condition 7 of the NHS Provider Licence – by 31 May; and
(ii) The provider has complied with required governance arrangements (Condition FT4(8)) – by 30 June

2.2 Assuming that the deadlines remain the same as in previous years, the Board is asked to note the timetable for completion and consider the following evidence as assurance that the conditions have been complied with.

Compliance with General Condition 6 and Continuity of Service Condition 7 of the NHS Provider Licence

2.3 The Board will make two declarations, these are:

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

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

Governance arrangements (Condition FT4(8))

2.4 Under the governance condition, NHS Foundation Trusts submit a corporate governance statement within three months of the end of each financial year. The governance condition requires Board to confirm:

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

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

2.5 There is no set process for assurance or how conditions are met and how this is done is at the Provider 's discretion. However, what is important is that the Boards understands and can sign off the stated compliance. Furthermore, there is no formal requirement now to make a return to NHS Improvement though it may spot check the process followed at selected trusts to ensure they have carried out the self -certification process. Providers will be required to supply the information they have used or provide any documentary evidence, such as Board minutes, papers etc.

2.6 Appendix 1 sets out a detailed self -assessment against the requirements of Condition FT4 which underpin the Trust's overall compliance with Condition G6. From this assessment, it is recommended that the Trust's takes assurance that it is operating in line with both Provider Licence Conditions.

2.7 In support of the evidence provided in Appendix 1, and the for the purpose of self-certification against Condition G6 and Condition 7, the Board should take account of the additional following sources of evidence:

- Relevant papers presented to the Board of Directors
- Relevant papers presented to the Board sub-committees: Quality and Assurance Committee, Finance, Performance and Digital Committee, People Committee and the Audit Committee
- The Risk Management Strategy, Board Assurance Framework and Corporate Risk Register
- CQC Registration, and 'GOOD' overall and recognised as well-led
- Accreditation with the NHS Resolution (previously NHS Litigation Authority)
- NHS Improvement Oversight Framework
- Opinions on assurance from the Trust's Internal Audit Programme

2.8 For the purposes of self-certification for Condition G6, the Board should take in to account the following sources of assurance:

- Director of Workforce and OD report to the Board – covering all workforce KPIs including workforce numbers
- Integrated Performance Report – covering KPIs and workforce plan
- Trust Talk
- NHSI workforce establishment returns – monthly part of financial reporting

2.9 For the purposes of training, governors participated in the following:

- Council of Governors - quarterly meetings included presentations by Executive Directors and Non-Executive Directors
- Board to Council meetings – bi-annual meetings included presentations and interactive workshops covering annual planning process and participation
- CQC Well-led presentation and discussion led by the Chief Nurse
- Attendance by several Governors at the National Governors Conference hosted by NHS Providers
- Monthly network meetings with the Chairman covering Chair's briefing from the private session of Board meetings, presentations by the Executive Team on topical subjects and by staff members on matters of interest chosen by Governors
- Events for Foundation Trust members on topical health issues
- Annual Members Meeting covering the annual report and accounts presented by the Chief Executive, Director of Finance and External Auditor and featuring presentation by clinicians and health professionals on topical health issues

3 Conclusion

3.1 Based on the evidence stated on Appendix 1 and above, it is proposed that this provides the Board with robust and sound evidence that '*confirmed'* statements against each of the conditions can be declared.

4 Recommendation

4.1 The Board is asked to approve declarations of '***confirmed***' against each of the Condition statements and authorise the Chairman and Chief Executive to sign the self-certification declarations.

Corporate Governance Statement - FT4 NHS Improvement 27.05.2020

1.	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Board has the following governance arrangements in place to manage its corporate governance arrangements: - - Board and Committee structure - Management and Directorate structure - Arrangements for assessing the Board's performance and effectiveness (including a Board Development Programme) - Quality governance arrangements - Compliance regimes to support regulatory requirements - eg for the Care Quality Commission and NHS Improvement - Clinical Audit Plan - Quality Improvement Programme - Internal Audit Annual Plan - Counter Fraud Programme - Risk and Control Framework - External Audit scrutiny and support - Information Governance arrangements - Standing Orders, Standing Financial Instructions and Scheme of Delegation The Trust's governance arrangements have been supported by: - Annual Operational Plan for 2020 - 2023. - The Board having a good balance of skills and experience: Executive Directors have defined portfolios of responsibilities and Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. - Succession planning arrangements - the Trust is actively recruiting to an Executive Director vacancy. - Annual self-declaration from all Board members to a Code of Conduct, the Code of Governance and the Nolan principles. This is compliant with the Care Quality Commissions Regulation 5 – Fit and Proper Persons and support the annual declaration from the Board as against its full compliance with this regulation. - Committee Reporting Structure - which enables a focus on and scrutiny of quality and safety issues, workforce matters and financial planning and control. - Reporting and assurance sub-structure of ISU's with triumvurate leadership and clinically led - Board Assurance Framework and combined Risk Register which details the risk to the delivery of the Trust's strategic aims.

		The robustness of the Trust's corporate governance arrangements is validated through the Care Quality Commission's rating of "good" (including an assessment against the Well Led Framework).
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	The Trust responds to all relevant guidance issued by NHS Improvement through the actions of the CEO and the Executive Team. The Chief Executive's Report at every Board meeting also highlights any guidance issued by regulators.
3.	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	a. The Trust has Board approved Standing Orders, Standing Financial Instructions and a Scheme of Delegation. There are Terms of Reference for each Committee of the Board and effectiveness is assessed annually and following every meeting. Each Committee has a forward plan and cycle of business. b. The Board has a well-established Committee structure that provides for effective review, scrutiny and decision making on the priority areas of the Board's business and a clear focus on and scrutiny of quality and safety issues, workforce matters and financial planning and control. This and an underpinning infrastructure of supporting management meetings enables the Board to discharge its responsibilities and duties effectively and efficiently. c. The composition of the Board is well balanced has a broad range of skills and experience. Executive Directors have defined portfolios of responsibilities and Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. There is a clear reporting and assurance structure within the Clinical Directorates which has a triumvurate leadership team led by a Clinical Director. Job descriptions define duties, responsibilities and accountabilities across the management team and throughout the organisation.
4.	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	a/b/c The Board ensures that the Trust meets necessary legislative requirements which include Care Quality Commission compliance. Various operational groups ensure that the Board of Directors is assured that the organisation, decisions and business of the trust is monitored effectively. The Trust's SMART transformation programme is testing new ways of delivering care that are more consistent and based upon clinical evidence; it is also looking at more efficient and effective ways of working through digital opportunities. The overarching aim is to make best use of our resources within the current constraints of growing demand and financial challenges. It is an ambitious programme that is driven to improve the care we provide, to enable our staff to spend more time with the people they are supporting and to increase our efficiency as a NHS organisation. The Board has a number of points of assurance which

	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements	include integrated performance reporting, financial performance, declarations and Annual Accounts, External Audit and Internal Audit reports and statements. d. Our Annual Governance Statement provides a positive statement that we consider ourselves to be a Going Concern. Financial decision making and management and control systems are set out in the Trust's Standing Financial Instructions and Scheme of Delegation. The Trust has a Finance, Performance and Digital Committee which scrutinises financial planning, control and review and approves investment opportunities in accordance with its delegated authority limits and undertakes a pre-Board review of investments in excess of that limit. The ISUs are held to account for their financial performance and cost improvement targets are set for all Units. e. The Board has an agreed governance reporting structure and sequence of meetings though the timing of these is being reviewed to enable timely consideration of relevant and up to date information to make decisions. f. Risks that may affect us in delivering our strategic aims and risk any associated compliance are set out in the Board Assurance Framework which is regularly updated through Executive Director and Committee review. g. The Trust has an annual planning process which is led by the Programme Management Office (PMO); the PMO also supports the delivery of and reporting on Trust Business Plans. h. A range of governance, risk and control processes are in place to ensure that the Trust remains compliant with its legal requirements.
5	The Board is satisfied that the systems and/or processes referred	a. The Trust has three Executive Directors who have a clinical background: The Chief Nurse, Medical Director and the Chief Executive, and two qualified accountants: The Chief Finance

	to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Officer and the Chief Operating Officer. A corporate governance advisor is also supporting the improvement of a range of governance processes and systems. In all, this provides excellent leadership and focus on the quality, safety and effectiveness of services. All Directors are set annual objectives and agree a development plan with the CEO; they are appraised at least annually. b. The Trust has a Quality and Assurance Committee that meets every other month and provides assurance to the Board on matters of quality and safety; it is chaired by a Non-Executive Director. Agendas are informed by standing items, items taken from a forward plan and any topical matters, such as changes in legislation of policy. Governance meetings take place on a monthly basis at ISU level and their focus is on the quality and safety of the operational delivery of services; these meetings are led by the ISU operational director. The Chief Nurse and Medical Director work together on measures to improve patient safety and experience and clinical effectiveness. A comprehensive structure of management meetings looks at a range of specific aspects of quality and safety and are attended by a cross section of multi-professional staff and managers. The Quality and Assurance Committee and ISU Governance Groups consider a range of reports which relate to the quality and safety of Trust services, as well as reviewing relevant risks as detailed within the ISU risk registers. c/d. The overall reporting and assurance framework is based on a sequence of meetings which has recently been reviewed to ensure that the information being considered is timely and accurate. The Trust has a well-established informatics team which assists with performance reporting. Each of the Executive Directors has a defined portfolio of responsibilities which clarifies their accountabilities. There is framework for risk management and a means of escalating concerns about internal control to the Audit Committee. The Trust has significantly invested in its information and IT systems to support the availability of the most timely and accurate data. e. All members of the Board are actively engaged in quality and safety initiatives. As a matter of course, the Trust takes in to account the views of others through the feedback received from complaints, compliments, incident review, ongoing stakeholder meetings and discussions. One of the NEDs has been appointed as the NED link to the 'Freedom To Speak Up Guardian' for the Trust. Duty of Candour is a statutory duty that requires the Trust to be open and candid if someone is harmed when in our care. During the year we have continued to provide training for staff about the ways in which we approach someone and apologise when things go wrong. We have provided education via resources on our internal web, information leaflets and regular meetings including our Senior Management and operational governance groups, Quality and

		Assurance Committee and our public Board meetings where reports are shared across our services to encourage learning. f. This is set out in the systems and processes described above. In addition to formal channels, such as the 'Freedom To Speak Up' service, the CEO and Chair operate an "open door" policy for staff or members of the public. In addition, managers make themselves readily available as a point of contact for concerns or for the speedy resolution of issues.
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Executive Directors have defined portfolios of responsibilities. Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. The Chief Executive considers the capacity of the Executive team on an ongoing basis. Regular 1:1 supervision sessions and weekly Executive meetings enable the CEO and the Executives to maintain a focus on delivery priorities. The Senior Leadership Team has been established supported by a Senior Management Team. The Clinical Directorates provide strong clinical and managerial leadership supporting the Executive Team in ensuring service delivery. There is an Annual self-declaration from all Board members to a Code of Conduct, the Code of Governance and the Nolan principles. This is compliant with the Care Quality Commissions Regulation 5 – Fit and Proper Persons and support the annual declaration from the Board as against its full compliance with this regulation.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Clinical Incident Report			**Meeting date:** 27 May 2020
Report appendix	Appendix 1: Trust Wide Clinical Incident Report, April 2019-March 2020		
Report sponsor	Chief Nurse		
Report author	Patient Safety & Experience Lead		
Report provenance	Weekly Executive Group		
Purpose of the report and key issues for consideration/decision	The report is a yearly review of clinical incidents within the organisation, the culture management and learning form the reports and any areas of concern not addressed by the incident reports. The report highlights a system where staff can report incidents from across the trust, they are reviewed and managed at various levels, feedback is given and where necessary specialist areas use this information to help training and patient care. The report also highlights the more serious incidents are investigated and Duty of Candour is taking place.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To note the document and the process of incident management, which will continue through the ISU's QIG and QAC.		

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report title: Clinical Incident Report		Meeting date:
Report sponsor	Lead director's title Chief Nurse	
Report author	Author's Title Patient Safety and Experience Lead	

Trustwide
Clinical Incident Report

April 2019 – Mar 2020

Table 1: Incident Report Card

Safety Indicator		Data Source	Rating
Trustwide Clinical Incident Reporting Summary	Page 5		
Incident Themes Summary: Medication Incidents, Pressure Ulcers, Communication, Falls	Page 8		
Integrated Service Unit Learning and Sharing	Page 11		
Report Background	Page 39		
Appendices	Page 40		
Total Number of Clinical Incidents Reported Trustwide & by Integrated Service Unit (ISU)	General Incident Reporting	Trust Risk Management System	
Number of Clinical Incidents by Actual Impact Trustwide & by Integrated Service Unit (ISU)		Trust Risk Management System	
Top 10 Causes of Incidents		Trust Risk Management System	
Never Events		Trust Risk Management System	
Slips Trips & Falls	Specific Cause Groups	Trust Risk Management System	
Infection Prevention & Control		Trust Risk Management System	
Recognise and Rescue – Deteriorating Patient		Trust Risk Management System	
Medicines Safety		Trust Risk Management System	
Pressure Ulcers		Trust Risk Management System	
Unadjusted Mortality Hospital Standardised Mortality rate (HSMR) Summary Hospital Mortality Index (SHMI)	Assurance	TSDHFT – Information Team Dr Foster Dept Health	

1. Trustwide Incident Summary

1.1 The incident system, culture and feedback

The Trust operates and runs an on-line clinical incident reporting system.

Incidents are reported from all areas of the Trust and are managed locally, investigated by the manager and overseen by the relevant Matron and the Integrated Service Unit (ISU) Governance Co-ordinators / Medical Governance Leads. Where the severity of the incident is high, an investigation is carried out by the relevant Coordinator and these are reviewed and actioned by the ISU. The investigations may also be taken to the Serious Adverse Events Group for Trustwide learning and sharing.

- **Trustwide online incident reporting and training**
  To help with incident reporting, various guides, policies and videos have been created and or upgraded all of which are shared on the intranet. Training is also provide on a bespoke basis to individuals or groups. Training is also delivered at corporate induction and/or at local governance meetings to ensure timely and accurate incident reporting.

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

  The table below records specific training numbers (April – Dec) and excludes Corporate Induction and training delivered by the Governance Co-ordinators.

Who	How many
Managers	5 managers
Administrators or support staff (clerical/admin)	10 staff
Whole team or whole service including drop in sessions	3 training sessions circa 30 staff
Specialty or service leads	7 staff
Ward Manager or senior nursing staff	10 staff
Total	62 staff

- **Trustwide Incident Awareness, Governance and Reporter Feedback:**
  Once an incident has been entered onto the system, the form is electronically distributed to the most relevant staff, managers, based on location, harm level & speciality. The Clinical Executives and System Leads are also part of the electronic distribution and are made aware of any serious incidents in real time.

- **Policies and Procedures**
  These remain current and up to date. The expected new Serious Incident policy from NHSEI has been delayed and will form part of the 20/21 work plan.

- **Trustwide Incident Oversight**
  The weekly incident huddle remains a key facet of incident oversight and at his meeting all Moderate, Severe and Catastrophic incidents are reviewed with the Medical Directors, Deputy Director of Nursing (formally retired Dec 2019) and System leads. Actions at this huddle are recorded and relevant incidents are then referred to the Serious Adverse Events group (SAE), reported on the Department of Health's (DH) Strategic Executive Information System (StEIS) or kept in the ISU for local review.

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

  Monthly meetings are held with the Patient Safety and Experience Lead and the ISU Clinical Governance Coordinators. Here total incident numbers, themes/trends, investigation, are reviewed and any learning shared.

  The information, trends etc., are then discussed at the Quality Improvement Group (QIG) via the Trust's dashboard and by exception, and are then reported upwards into the Quality Assurance Committee and downwards into the local ISU governance meetings, thus creating a continuous flow of information sharing.

  Feedback is sent electronically from the reviewing manager to every person who has reported an incident. This is via a mandatory section of Datix. The manager can select the resulting actions arising from the incident via a dropdown box or by free text. The outcomes section of the manager's form is also shared with the reporter.

  Incident feedback and activity: From reviewing all incidents a monthly 5-point safety brief is created and distributed Trustwide. An alert system is also used based on real time issues and again is sent Trustwide. We have also created the monthly Datix Digest, a bite site report of the month's incidents & complaints at the Trustwide and ISU level. This, again is sent out Trustwide – Examples are included as Appendix One

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

  Duty of Candour (DoC) this has been a key focus for 2019/20 and the Datix system now has a suite of template DoC letters which can be adapted and personalised to each instance, where Duty of Candour notification is required. The datix system also has an electronic section for the completion of DoC, which is the same layout as on the Case review and RCA forms, thus ensuring consistency.

Monthly training for DoC has been provided, with over 120 places offered. The session continues to utilise a short interactive video and are well attended.

Investigations and Training
The Root Cause Analysis (RCA) investigation report form has been modified this year to reserve RCA investigations for very specific, complex investigations. This will be directed by the weekly incident review. The reason for this change is to ensure the right level of investigation for the right incident. The RCA process was being applied to all incidents and creating an unnecessary time burden which was slowing down the investigation and learning process.

For local investigations a new Case Review form has been created and tested which contains a comprehensive DoC section, including a section for specific questions the patient/ family want investigating. These changes have made a positive impact on DoC and have helped improve investigations, making them more open and inclusive and timely.

Investigation training has also continued monthly through the year with circa 50 staff attending.

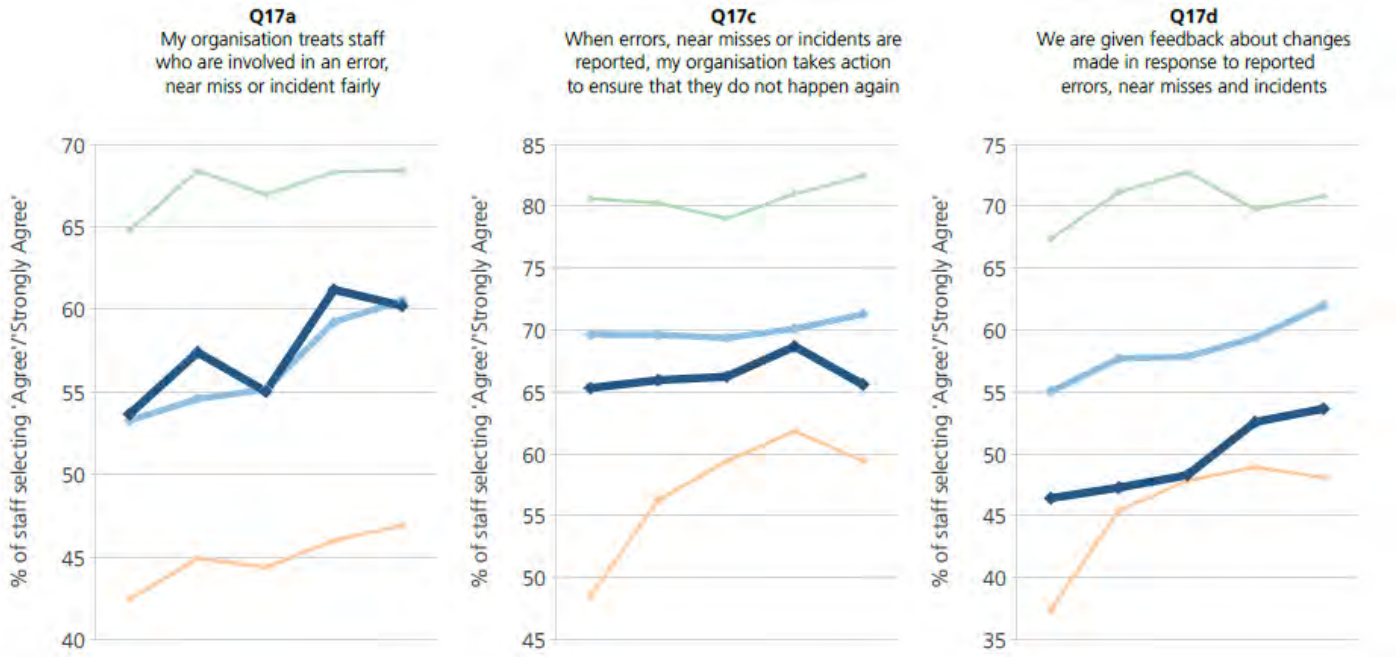
DH Strategic Executive Information System (StelS Reporting)
The Trust continues to report to the STeIS system in accordance with agreed national protocols. A lot of activity has taken place in this area to ensure our incidents are investigated in a timely way and meet the 60 - day guidance to be with the CCG.

We have reported 51 serious incidents on the system. At present we have no outstanding RCAs waiting to be sent to the CCG.

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

2019 National Staff Survey

The National staff survey is always anticipated to gain a perspective into the staffs views on incident reporting, culture and management. In the latest release, the trust score is on the national average line, for *'my organisation treats staff involved in an incident fairly'*. Slightly below the national average for *'appropriate actions taken to ensure an incident does not happen again'* and below average for '*feedback post an incident'.* Whilst despite the work undertaken during the year focusing on these areas, more focused activity is needed and they will form part of the 20/21 work plan to increase our position.



2.0 Specific Themed Area Summaries and Actions

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

  During 19/20 Pharmacy have also sent out over 15 alerts to support the safe use of medicines where there have been safety issues and supply problems. We have maintained our weekly huddle to review concerns with the supply of medicines, to monitor our usage and to put actions in place to best mitigate any impact on our services.

  Six Supporting Medicines Safety newsletters were published during 19/20 covering a range of topics including advice on controlled drug record keeping, the risk of omitting immunosuppressants and advice on preparing for a CQC visit with regards to medicines. (see Appendix Two)

  Insulin safety: A trial of a pocket information card for junior doctors and nursing staff, along with targeted education for all staff prescribing, administering & monitoring insulin has been created. This trial will be continued and extended in the coming year.

Insulin Hypoboxes were added as an item on our stock lists to ensure they are part of the pharmacy top-up. A contents list will be attached to the hypo boxes to facilitate the refilling of the boxes after use. This is as a result of issues where hypoboxes where not maintained correctly.

We worked to raise the profile of incidents in theatres & PACU with the diabetes team on the use of VRIII charts. The diabetes team provided education sessions. A further action plan was developed with one of the anaesthetists and these have been well received.

Controlled drugs (CDs) audits and incidents have continued to highlight issues with record keeping and an eLearning package is in development.

The use of bottle adapters has been implemented, with the aim of reducing wastage when drawing up liquid controlled drugs. A small trial showed a reduction in the discrepancies between the recorded and actual quantities of liquid controlled drugs and although incident numbers are small there has been a reduction in reported liquid discrepancies.
We have updated the process of obtaining the signature of staff authorised to order controlled drugs to improve checks and reduce the risk of staff fraudulently getting their signatures authorised.

A policy on the administration of medicines has been developed to clarify who within the Trust can administer medication, under what authority they can administer e.g. via a prescription, their accountability & competence to do so.

Numerous patient group directions have been developed and implemented to enable nurse led clinics / care to provide the best care to patients in a timely and effective way without compromise to patient safety.

- **Communication**
  Is always a key element in any incident, whether it be verbal or non-verbal and the incident is often due to a breakdown in communication, misunderstanding or lack of communication.

  In 2019/20 SystemOne has been implemented into the Coastal and Newton Abbott localities This moved staff from using paper and two IT systems to just one IT system with the ability to see GP information for the first time, where appropriate.

  SystemOne has enabled them to be able to have access to a patient record regardless of where the staff member is normally based. Previously, if the patient was not known to them, they did not have the full information of the patient and their health concerns.

  The team are now able to access the full patient record. They are able to see information in their office and in a patient's home via a laptop in real time.

  This has reduced communications issues and created a safe system for staff and patients

- **Pressure Ulcers (PU)**

Background
The Tissue Viability is a service works across both primary and secondary care, accepting referrals from all healthcare providers within these areas. The service takes responsibility for pressure ulcer prevention, education, monitoring, complex wound care, equipment provision (including overseeing rental activity) and providing assurances to all ISU management teams.

2019/20 Pressure Ulcer Incidences
There has been a 6% reduction in reported Category, (Cat.), 2/3/4 pressure ulcers when compared to same period 2018/2019. Equates to 117 less pressure ulcers reported.
The reduction is also reflected in a 6.5% reduction in pressure ulcers acquired in our care when compared to 2018/2019. Equates to 69 less pressure ulcers acquired in our care.
Slight increase (3) in Cat.3 pressure ulcers both reported and acquired in our care during year 2019-2020.

Of the 233 reported Cat.3/4 pressure ulcers acquired in our care for the period 2019-2020, 5 were declared to STEIS as being due to lapses in care by TSDFT staff.

Of these 5 pressure ulcers, 2 were on a specialist ward and related to a specific medical condition. This has been investigated and work is ongoing to develop a comprehensive guidance plan for patients admitted with this medical condition in order to reduce the risk of pressure damage occurring for future patients. Bespoke pressure ulcer prevention training is in place for this team.

Four of the ISUs have had no pressure ulcers where there has been an established lapse in care for 12 months, which is a testament to the education and support supplied by the TV team and the hard work of the staff within these ISUs. Support and an education programme is being given to the remaining ISU by the TV team.

April 2020 approx. 28% reduction in reported Category 2/3/4 pressure ulcers from April 2019 – due to reduced patient levels and/or reduced reporting, in particular Cat.2 pressure ulcers.
April 2020 approx. 25% reduction in reported Category 2/3/4 pressure ulcers acquired in our care – due to reduced patient levels and/or reduced reporting, in particular Cat.2 pressure ulcers.

Pressure Relieving Procurement
The team have purchased and rolled-out 150 very high specification hybrid mattresses for the Hospital leading to the reduction in rental and usage of Nimbus 3 alternating mattresses from £220 to £50 per day. This has enhanced individual patient's experience, allowing for easier and earlier mobility from bed whilst providing high level pressure area care. This will provide a cost saving of approx. £126,000 for the year 2020/2021 with ongoing savings year on year.

- **Slip Trips and Falls**

The focus for the Trust is to continue to reduce the harm caused by falls as well as trying to minimise the falls risk. 2019/20 has seen an increase in the previous year of 84 but a

general reduction over the Winter period. This is encouraging as the Falls team ran a winter falls prevention campaign.

The Falls team and Falls Group have worked to create a new falls handling and bed rails form for wards, which has reduced in size and is easier to complete.

The Supportive Observations policy has been amended and there have been brief changes to post fall guide to ensure no further escalation of injury. The Clinical Site Managers have also agreed to manage inpatient, post falls, for any potential spine injury.

6 specialist Raizer chairs have been purchased, the Training for use of them is ongoing and the SOP and accessibility thereof is available on the falls webpage.

Falls training has continued throughout the year, and the lying and standing Blood pressure training is now available in eLearning.

Falls Winter Campaign completed with a reduction in falls over the Winter period.

3.0 Integrated Service Unit Learning and Sharing

Below are a small selection of changes following incidents from the ISUs

'Improved communication between acute and community hospital regarding supervision of patient and if

IC Teams to ensure a balanced skill mix visits each IC patient (OT/Physio and IC Nurse) to ensure all aspects of care and assessments are completed for any patients on the caseload

Process changes in RAA which has reduced mislabelling of blood bottles

All IC team members required to complete SSKIN Bundle Assessments. OT, Physio, SWIC and IC Nurses all required to complete this. All areas checked must be listed in the patient's

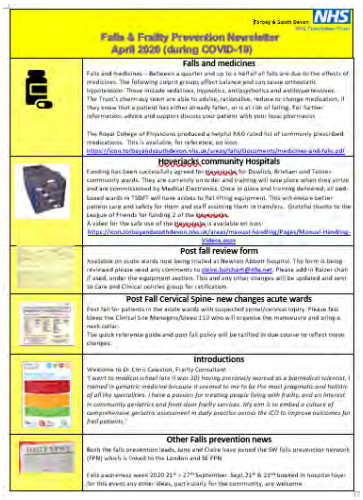
Covid patient information leaflets have now been attached to swabs informing them of the process of how they will get their results.

Lateral transfers must take place with at least 3 persons. Communication Trust wide to all staff via the Trust Wide Clinical Safety Brief. The Manual handling team will reinforce this at mandatory manual handling training sessions.

Blood transfusion paperwork to be amended to include a section related to patient weight. Screen savers also put on to remind staff of TACO

4.0 Key Achievements 2019/20

- Restructuring the QIG dashboard to reflect the new ISU structures
- Restructuring Datix to reflect the new ISU structures
- Children and Family Health Devon included into the Risk Management system
- Continued simplifying of the reporting process
- Creating Case Review template for rapid investigations
- StEIS serious incidents completed within 60 days
- Continued focus on Duty of Candour
- Continued focus on feedback and learning
- Continuing to develop the QIG dashboard which now includes sections on: End of Life, Lower Limb and ED data (SHINE)
- Speciality Newsletters


Falls & Frailty Prevention Newsletter
April 2020 (during COVID-19)

Falls and medicines

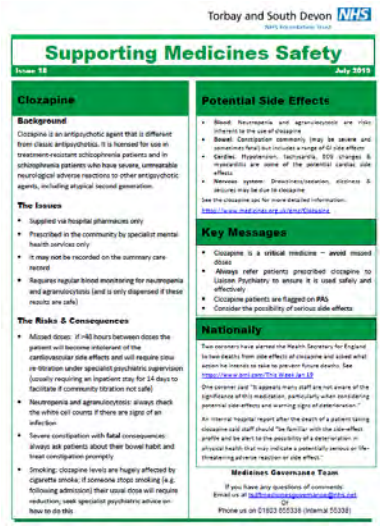
Hoverjacks community Hospitals

Post fall review form

Post Fall Cervical Spine- new changes acute wards

Introductions

Other Falls prevention news


Torbay and South Devon NHS

Supporting Medicines Safety

Issue 18 July 2019

Clozapine

Background

The Issues

The Risks & Consequences

Potential Side Effects

Key Messages

Nationally

Medicines Governance Team


Falls & Frailty Prevention Newsletter
Pulsnary 2020

Winter Falls Prevention Campaign

Pilot Projects

Raizer chairs- Torbay Wards

NEW CQUINs 19/20 to prevent hospital falls

5.0 Workplan for 2020/21

- New 3 year Safety Strategy
- Create a monthly staff survey process re incident feedback and Learning
- Implement the new Serious Incident policy once released from NHSEI
- Create an audit programme with Clinical Effectiveness based on the incident intelligence
- ISU and Central Governance alignment
- Alignment of Clinical Effectiveness and the new ISUs Governance structures
- Better use of Trustwide Data to guide process and policy through ISU and Central Governance
- Recruit into the vacant Datix Administrators post
- Incorporate the Medical Examiners module into the Datix Risk management System
- Create a CQC module in Datix
- Create closer links with Research and Development

Total Number of Clinical Incident Reported Trustwide and by Service delivery Unit by Month by Year April 2019 – Mar 2020

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

Chart 1, as below highlights the Trusts monthly reporting pattern for the financial year. The overall trend shows an increase of reported incident (table 1), which fits expectation. The National Reporting & Learning System states that organisations that report more incidents usually have a better and more effective safety culture. This being a key aim of the organization. Table 1 shows a comparison in total clinical incidents reported over a number of years.

The dip, noticeable in the march data point, is as a direct result of the Corona virus epidemic. As the Trust responded to the crisis and activity and patient numbers dramatically decreased, so therefore did the number of reported incidents.

Chart 1

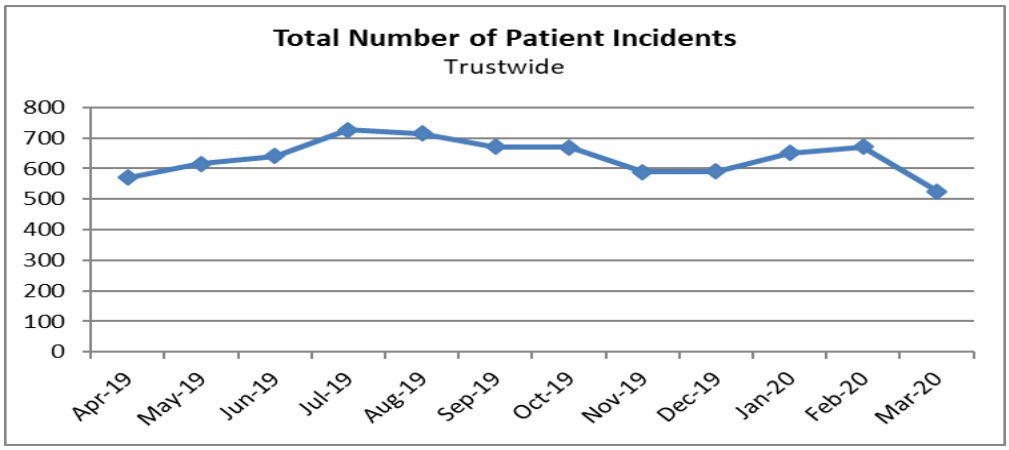
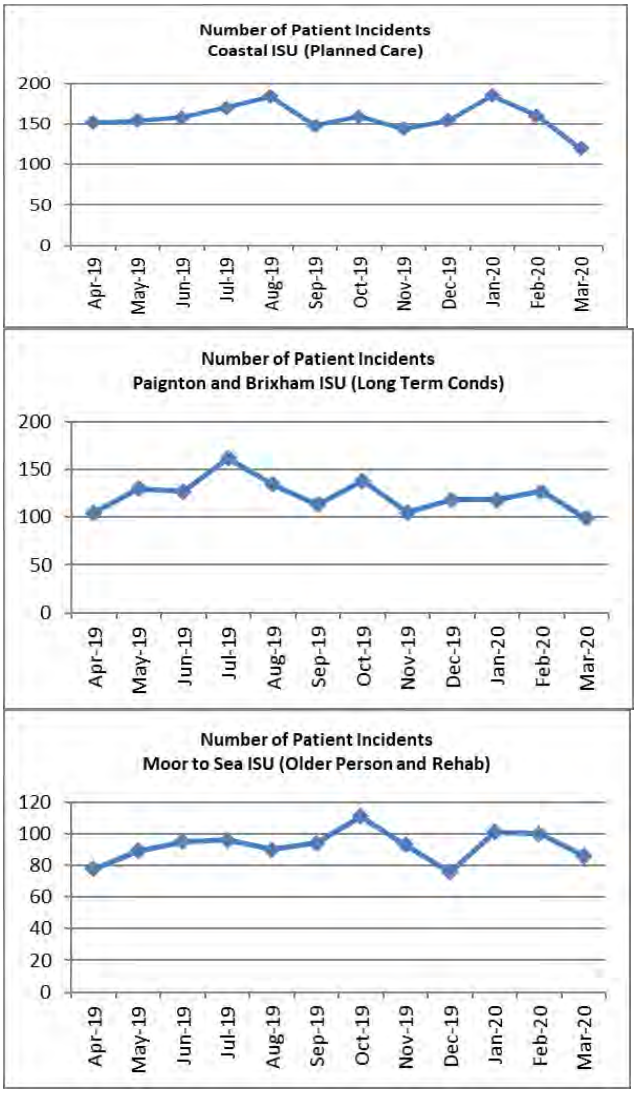


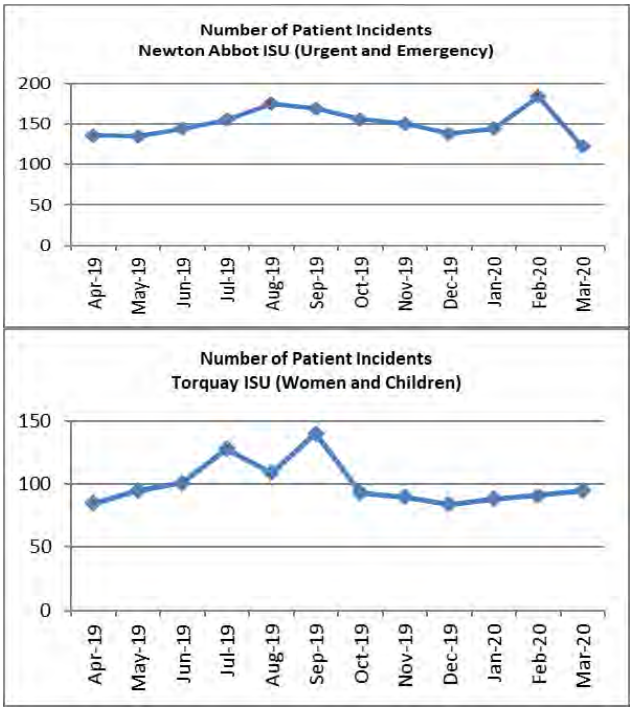
Table 1

Financial Year	2019/2020	2018/2019	2017/2018	2016/2017
Number of Incidents Reported	7633	7255	6525	7056

Chart 2 (5 charts) identifies the individual Integrated Service Units within the organisation and their monthly reporting patterns across the year (ISUs).

Chart 2

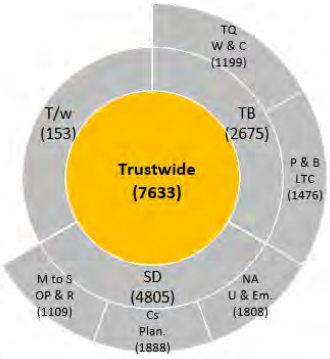




Again, all ISUs are reporting consistently and within the normal patterns of incident reporting.

The final chart, a radar chart (3), offers more granular information, highlight total yearly incident numbers reported by the Trust, System and ISUs.

Chart 3



Clinical Incidents by Actual Impact – Trustwide

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

Severe & Catastrophic Incidents

Chart 4

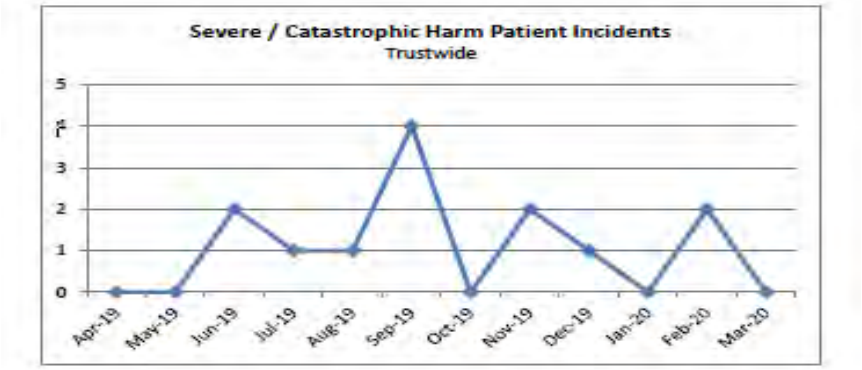


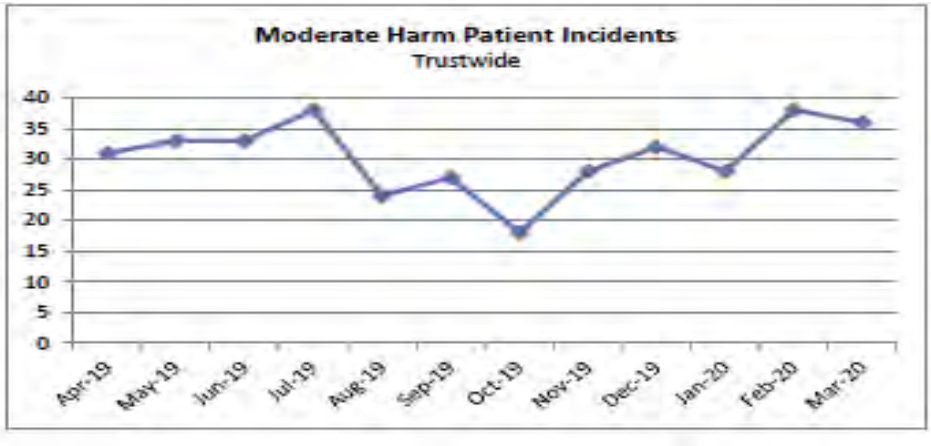
Table 2

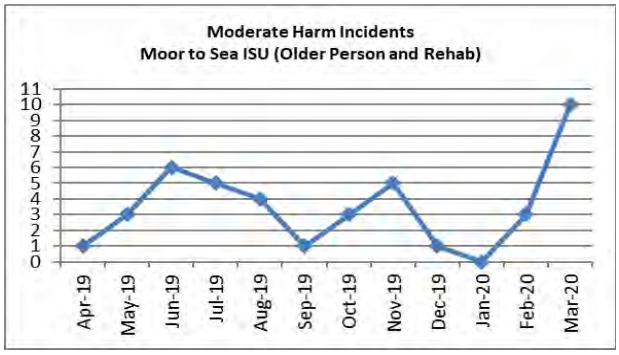
By Area	By Number
Coastal	5
Newton Abbott	3
Paignton Brixham	2
Torquay	2
Moor to Sea	1

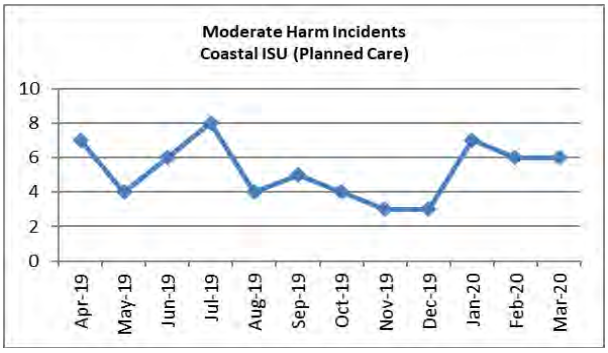
In this category issues have included a medical device, deteriorating patient, diagnostic uncertainty, a missed diagnosis, PE. All have been through the Serious Adverse Events group

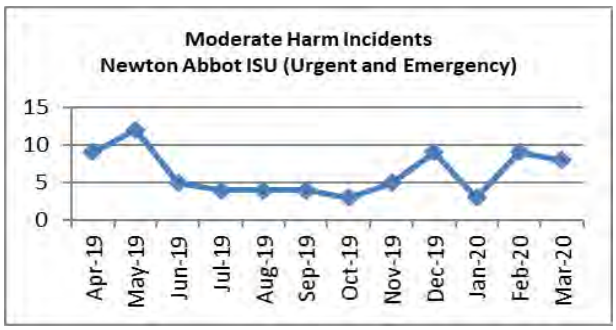
Moderate incidents, are incidents that cause a level of harm that the Trust investigates and the numbers are below as chart 5, and by ISU as chart 6

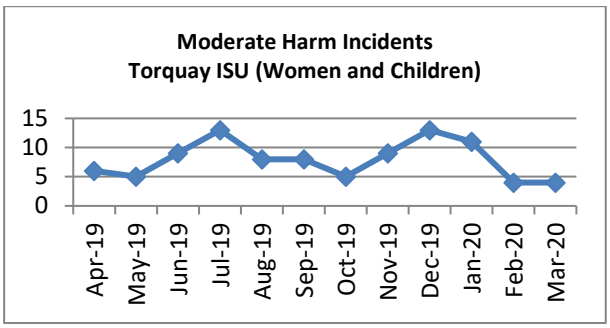
Chart 5











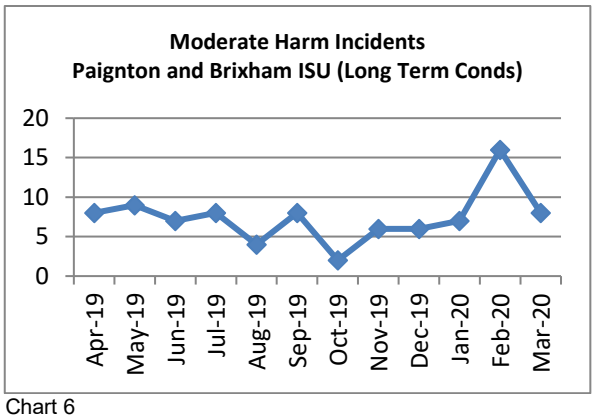


Chart 6

The spike in incidents for the Moor to Sea ISU in March is related to an increase in pressure ulcer incidents in patients own home and under investigation.

Table 3, as below, gives a description of these harms. The most frequently occurring moderate harm category is the reporting of pressure damage, particularly as more and more patients are looked after in their own environment. This reporting does not mean all pressure damage is caused by the Trust, rather we report skin damage whenever we see it, regardless of care setting.

Other common causes of moderate harm include falls, shoulder dystocia, post-partum haemorrhage, for which there are specific pieces of safety work attached to them. Falls and Pressure ulcer are looked at in depth on page 18 and 34.

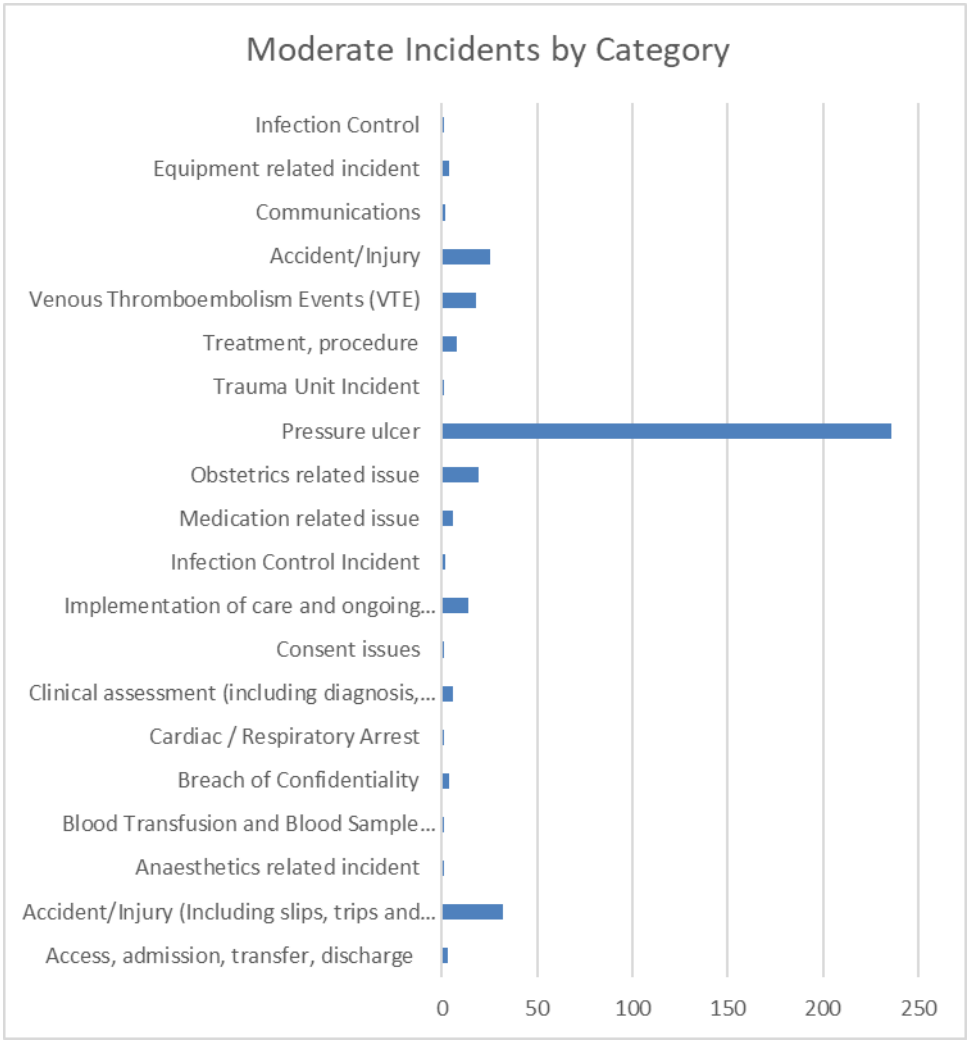
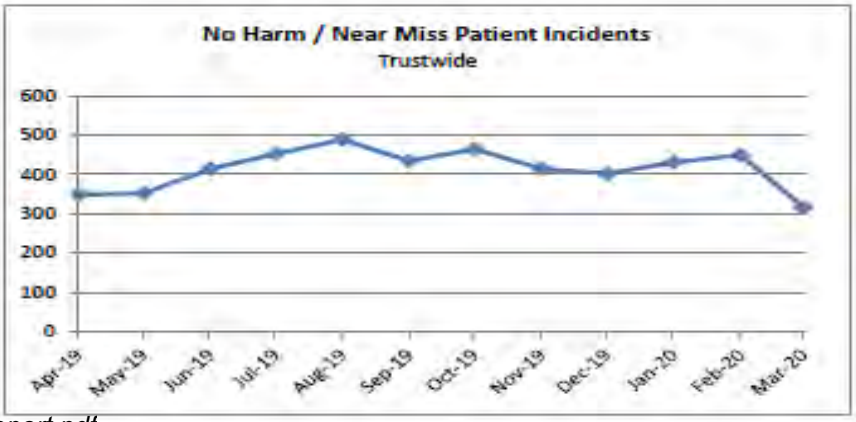


Table 3

Chart 7 – as below highlights the vast majority of incidents recorded the Trust are low or no harm incidents

Chart 7



Most Frequently Occurring Cause Codes

The table below (table 4) shows the top ten most frequently occurring cause codes for 19/20, i.e. the codes that have been attributed to incidents most frequently reported regardless of harm level Trustwide. The table also includes the number of these incidents as reported by the ISUs.

The most frequently reported incident is pressure damage, this is across all ISUs and includes pressure damage recorded about patients in their own home, care or residential home, not necessarily caused by the Trust. Security record all their activity via the Datix system and this will be reviewed for 20/21 as not all of their activity is a clinical incident

Medications, Falls Pressure ulcers are reviewed separately on pages 18 & 34, respectfully

Table 4

Area	Torquay ISU	Paignton Brixham ISU	Newton Abbot ISU	Coastal ISU	Moor 2 Sea ISU
Pressure ulcer	199	291	348	131	117
Security related incident	80	99	415	96	120
Accident/Injury (Including slips, trips and falls)	33	130	220	152	173
Medication related issue	78	98	90	107	67
Access, admission, transfer, discharge	72	39	84	124	39
Documentation (including electronic & paper records, identification and charts)	52	76	36	96	9
Infrastructure (e.g. staffing, facilities, environmental health)	89	46	50	92	20
Accident/Injury	29	47	27	60	30
Implementation of care and ongoing monitoring / review	34	101	50	55	29
Communications	55	43	33	58	15

DH Never Event List: April 2019 – March 2020

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

The table below shows the Department of Health's (DH) 'Never Event' list for 2020.
The Trust has recorded two such events between April 2019 and March 2020. The patients received no harm and the incident has been thoroughly investigated. For comparison, in 2016/17 the trust had one Never Event.

Chart 8

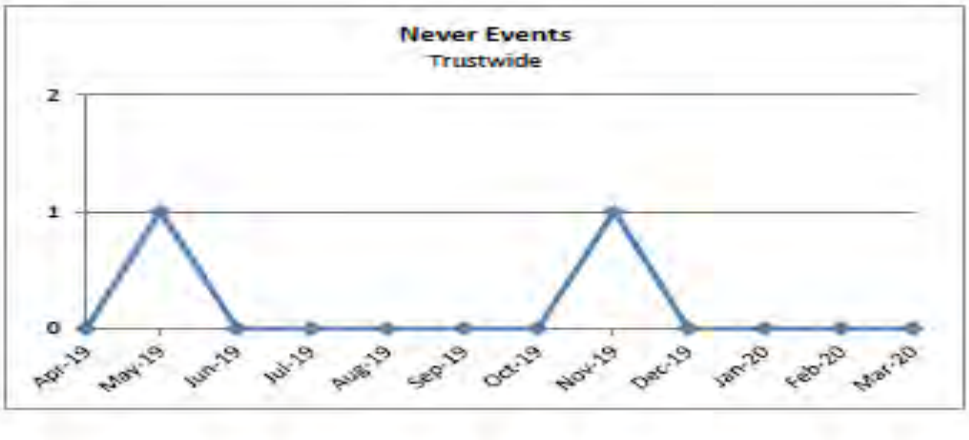


Table 5

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

The 2 recorded Never Events were under the category wrong site surgery and included a *wrong site analgesic block and removal of a malignant skin lesion on the wrong side.* The patients received no harm and both have been investigated with learnings put in place. The investigations followed a human factors approach, which incorporated processes changes to try prevent reoccurrence through safety checks.

Trustwide Clinical Incidents by Slips Trips & Falls

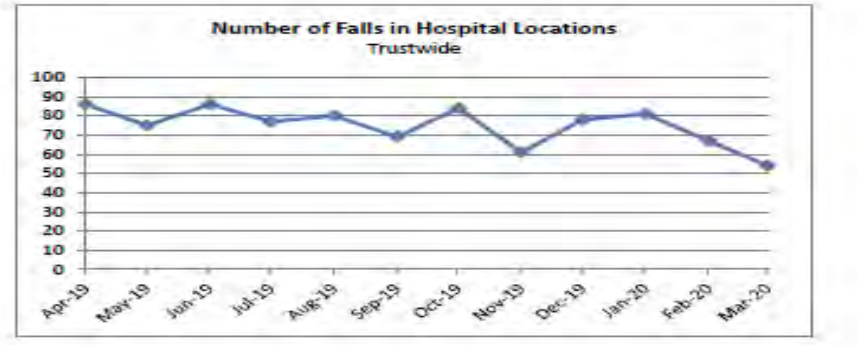
Falls are one of the most frequently occurring incidents within the trust. They occur in bed-based care e.g. hospitals as well as in peoples own homes and/or other care environments in which they live. The data in this section records Trustwide falls by number, location, actual harm, time of fall and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

The total numbers of falls experienced by our patients within our Trust has increased on last year, which is slightly concerning due to the activity and work put in by the falls team.

Year	Total Number	+/-
2019/20	1027	↑84
2018/19	943	

The run chart, as below, shows the natural variation of falls through the year and also shows a decrease over the winter period. This is encouraging as the team have carried out a winter falls prevention campaign. Traditionally the colder months have seen a rise in falls, often with frailer patients and this reduction is welcome

Chart 9



The next chart (10) highlights the individual ISU's and the number of falls per month they experience.

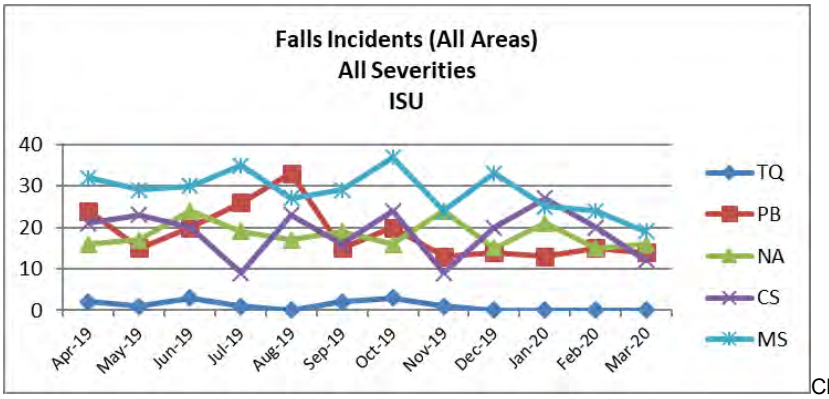


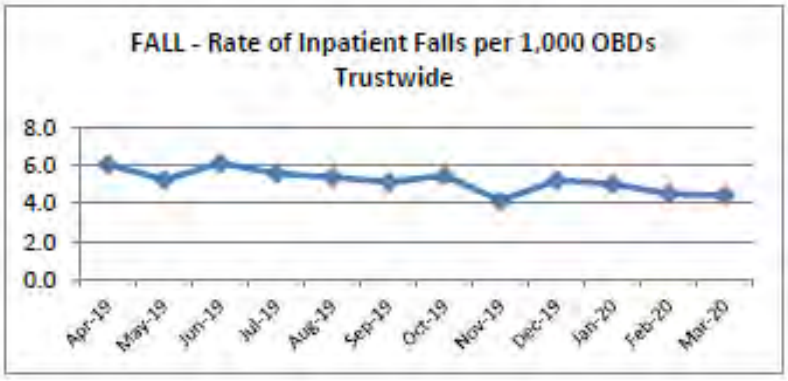
Chart 10

Key: TQ Torquay, PB Paignton Brixham, NA Newton Abbott, CS Coastal, MS Moor to Sea

The ISUs with the frailest patients tend to have the most falls and they are MS, NA, CS.

The following chart (11) takes the number of falls and divides them into 1,000 bed days to give a rate. This rate can then be benchmarked against other published rates to form a comparison. The Royal College of Physicians average fall rate is 6.6 and, the National Patient Safety Average is 4.8. The Trusts average rate is 4.8, which is good.

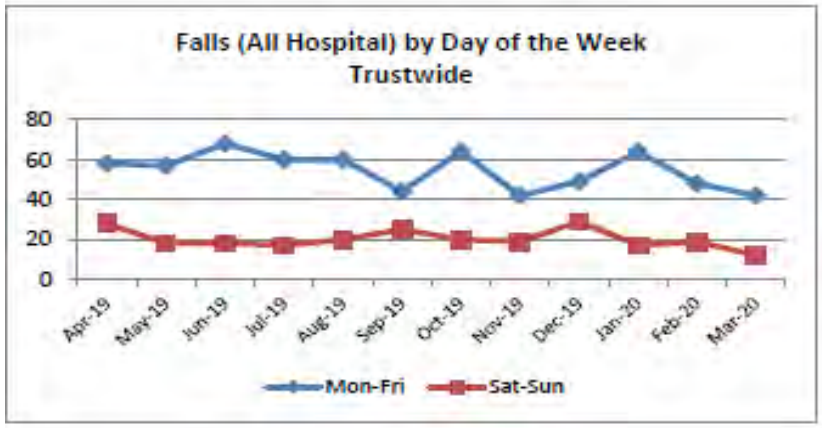
Chart 11



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

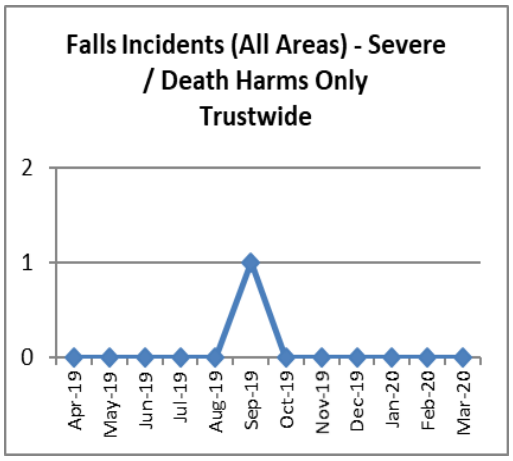
When analysing the data over the weekday/weekend periods there is a marked reduction during the weekend which is therefore showing no adverse pattern of falls

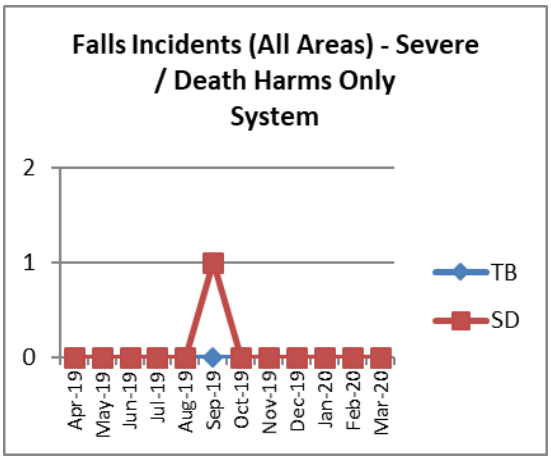
Chart 12



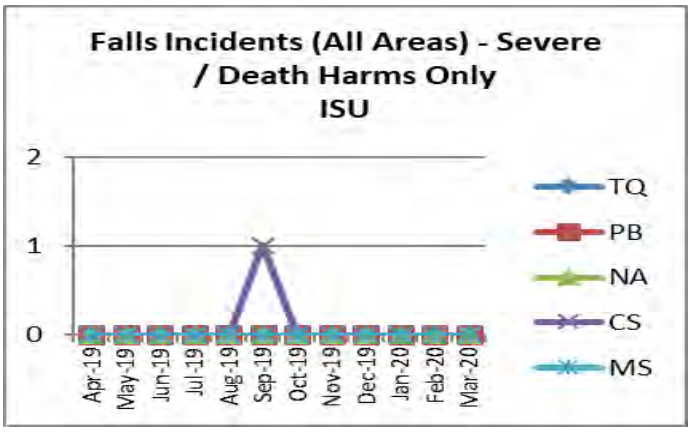
When the harm level from falls is analysed, fatalities from falls are rare.

Chart 13 (3 charts)



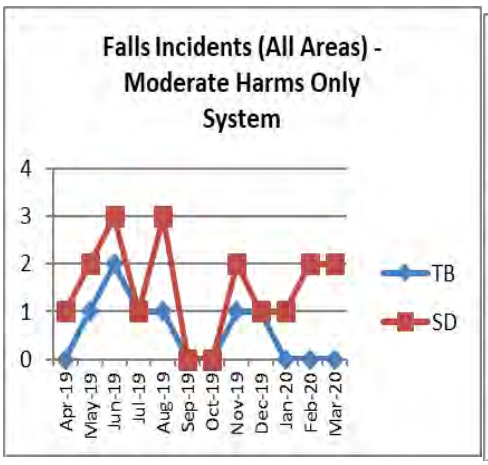


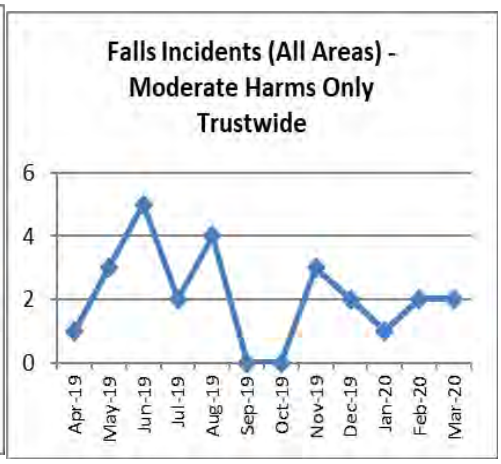
Key: TB Torbay System, SD South Devon System

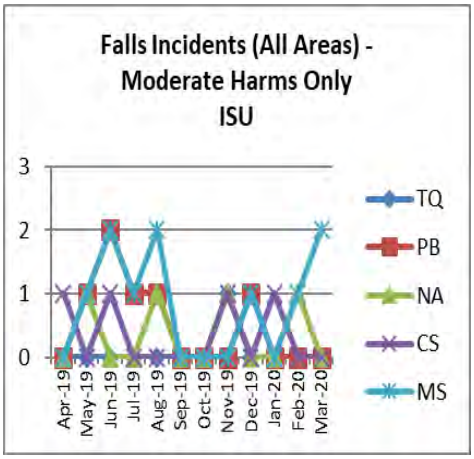


Moderate harm incidents are as below

Chart 14 – 3 charts







Trustwide moderate category falls have been reducing over the year and these categories will include fractures. From 2020/2021, any long bone fracture will be classified as major and therefore a rise will be seen in this category. This change will be annotated onto the data charts. All fractures of long bones are reported on STEIS and taken to the Falls group for learning and sharing. The group uses this data to direct activity and resources in terms of new equipment, activity mats etc.

The Trusts aim is to reduce the number of falls so as to try and reduce the harm from these events to the lowest level possible.

Falls activity

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

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

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

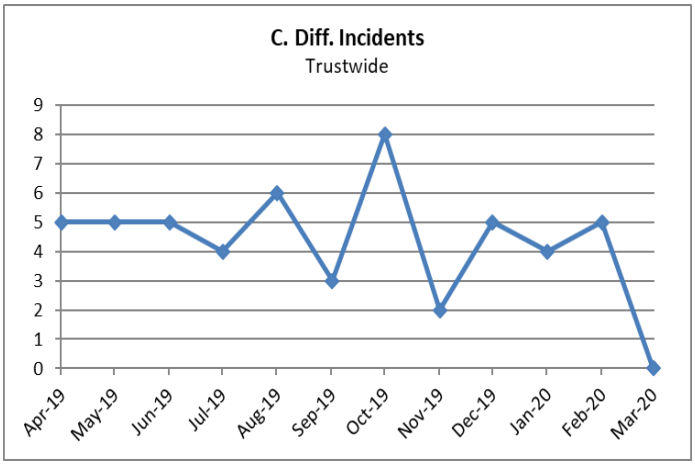
The Falls Nurse also leads a comprehensive training program that again, is inclusive to all care provider staff, public and private.

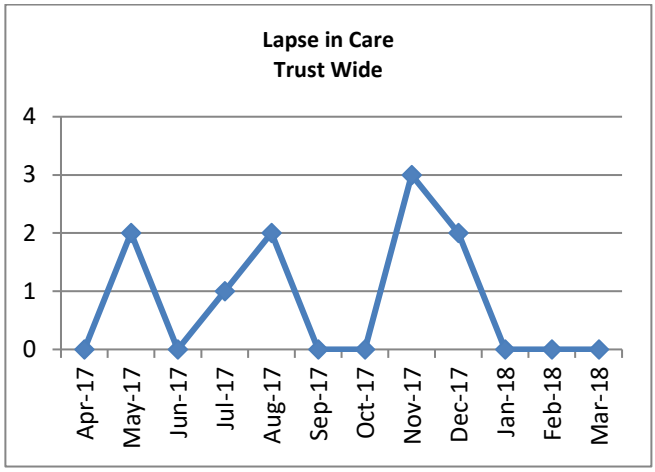
The Training packages and within the hospital, the Royal College of Physician's FallSafe project, are being used with audit to indicate the success of the work staff are doing to reduce falls and harm from falls.

Infection Prevention & Control

This matrix is focusing on Clostridium Difficile incidents within the Trust

Chart 15 2 charts

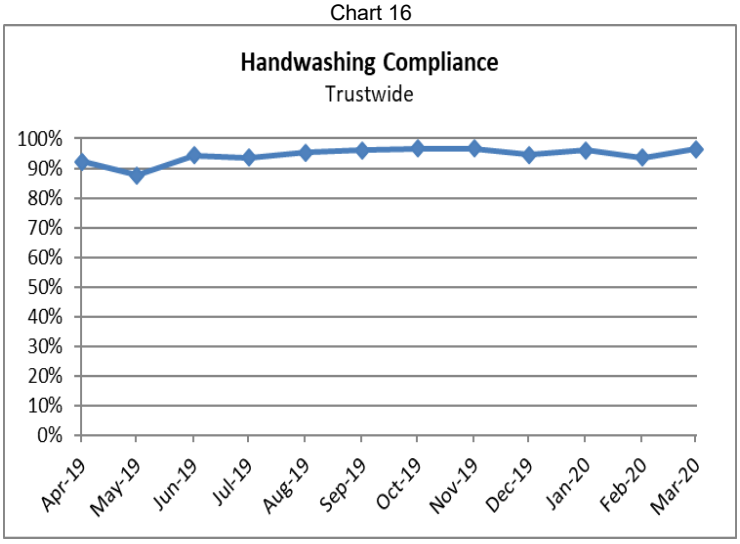




The Infection Prevention and Control Team investigate all C.Diff incidents and feedback give to the ward/department. A full board report is presented by the Infection Control team in May and the detail of the work and finds can be found there. The section is included in this report for completeness.

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

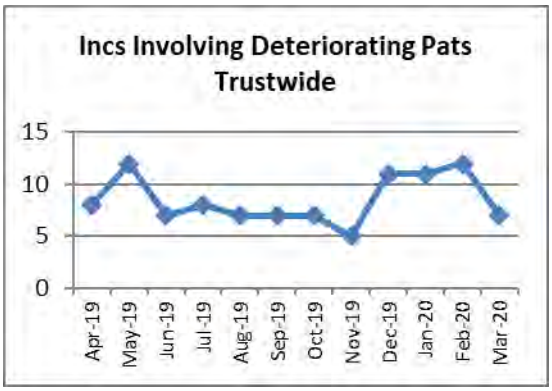
Chart 16



Recognition and Rescue including Cardiac Arrest, Vital Pac Observations, Treatment Escalation Plans

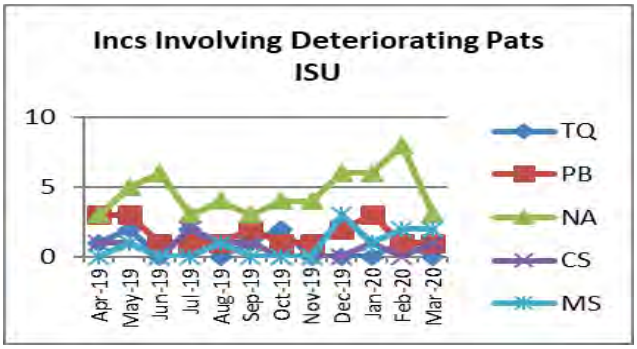
Rapid assessment and recognition of a deteriorating patient (DP) is a corner stone of any care system and requires a prompt response and appropriate treatment.

Chart 17 – 2 charts



The incidents of deteriorating patients rise a little during the winter period when the hospital's cohort of patients tends to be frailer and/or includes more complex patients.

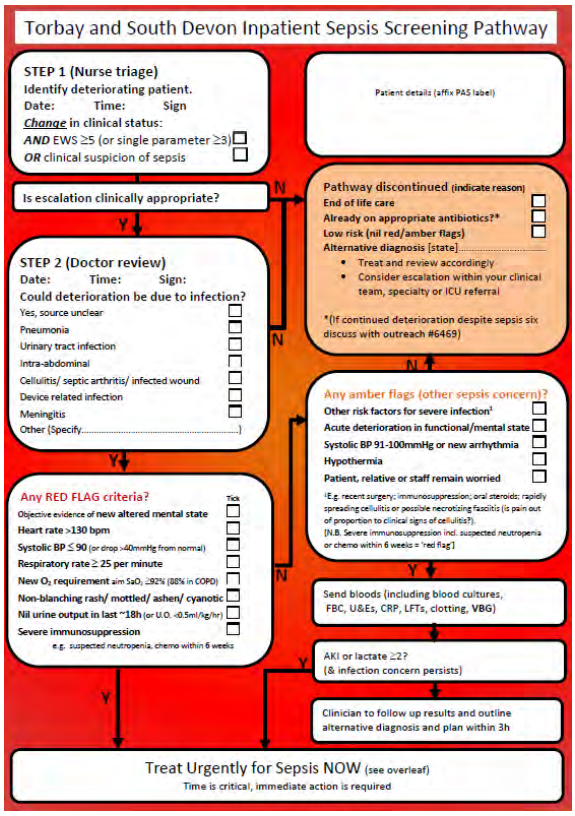
The opposite chart, highlights the DP by ISU. As care is now provided in a variety of settings it is not surprising that DP issues are being picked up in the community stetting, particularly in Intermediate Care. That said the ISU recording the most DP incidents is NA which has the most acute wards.

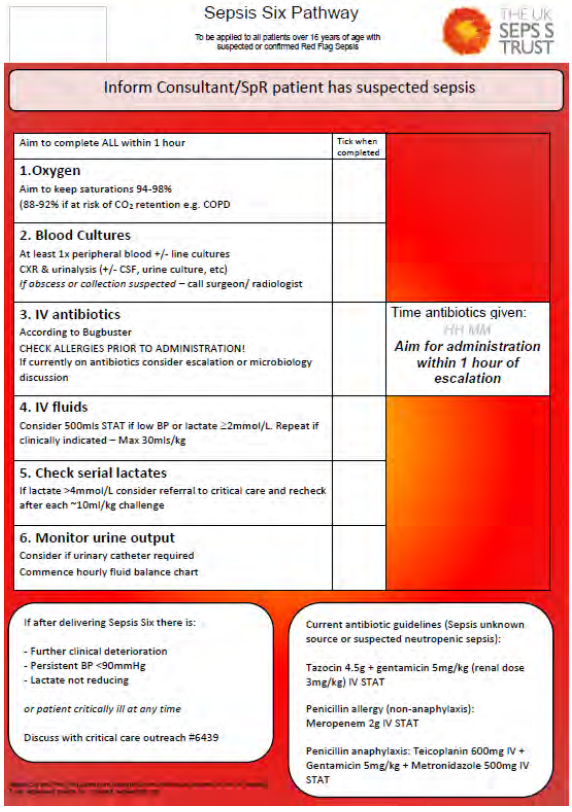


Traditionally activity has focused on, Sepsis or Cardiac Arrest (CA), these being very specific conditions with a set protocol to follow.

The sepsis protocol has been re-written this year and launched in February. Audited work will follow later in the year, post immediate corona virus response.

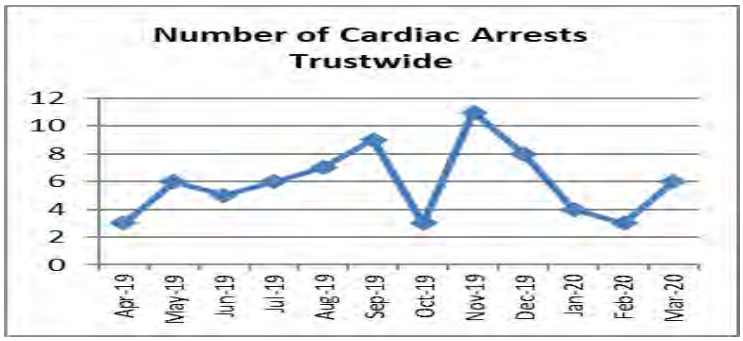
The new protocol is as below





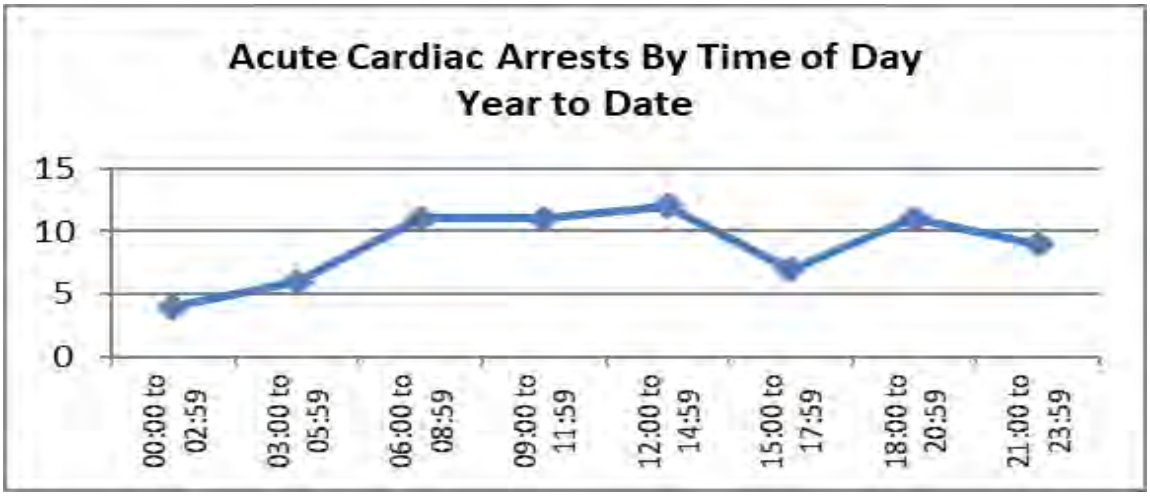
Much work has gone into Cardiac arrest, recognition and treatment thereof and the numbers are low and reducing over the year – please see chart below

Chart 18



The next chart highlights arrests by time bands. This level of data helps direct resus training.

Chart 19

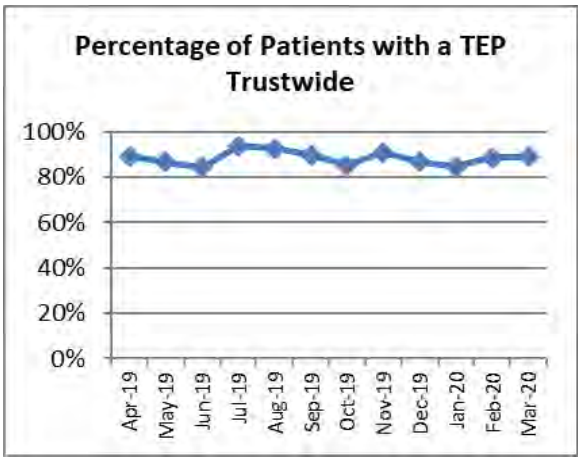


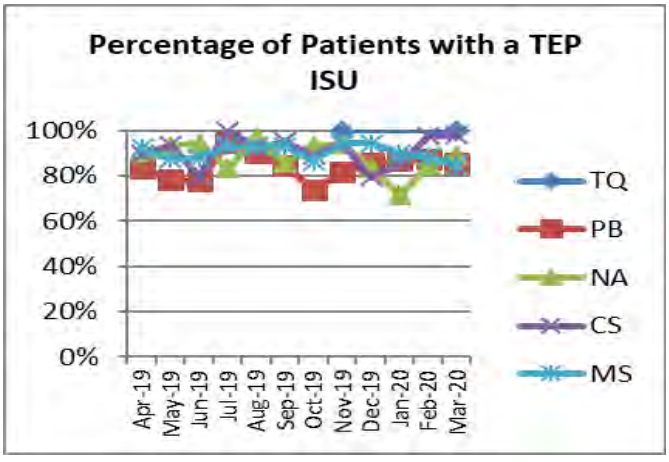
The aim when responding to a DP is to identify and respond in one of three ways, refer to a higher level of care, treat in situ or apply a treatment escalation plan (TEPs).

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

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

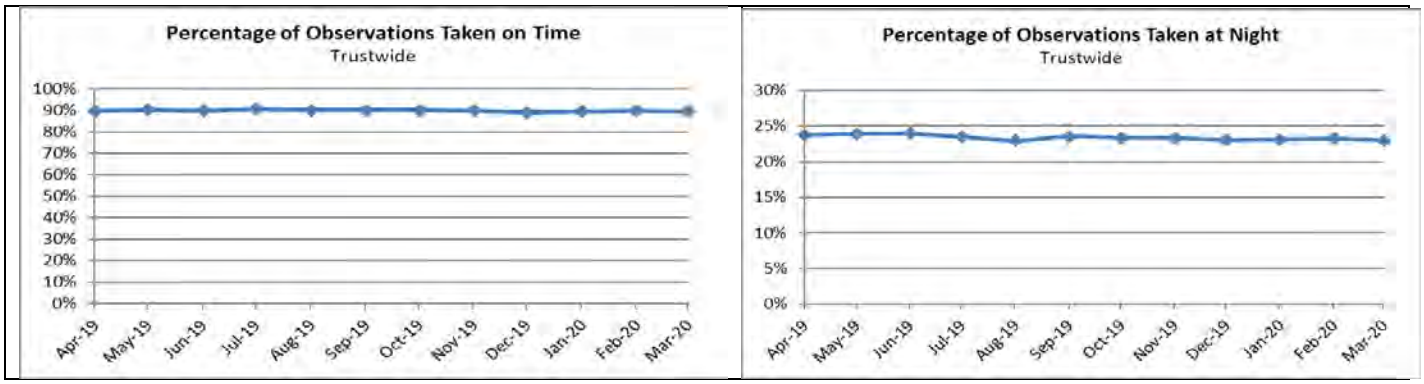
Chart 19 2 charts





The trust also has a well-established vital sign monitoring package, which is electronic and well used. The monthly data shows high compliance to patients having their EWS monitored both during the day and at night. The target for daytime is 80% and 20% for night time.

Chart 20 – 2 charts



More work will follow in this area in 20/21 via the new Director of Patient Safety and the Deteriorating Patient group. One key area will be the introduction of the new NEWS2 system of vital observations.

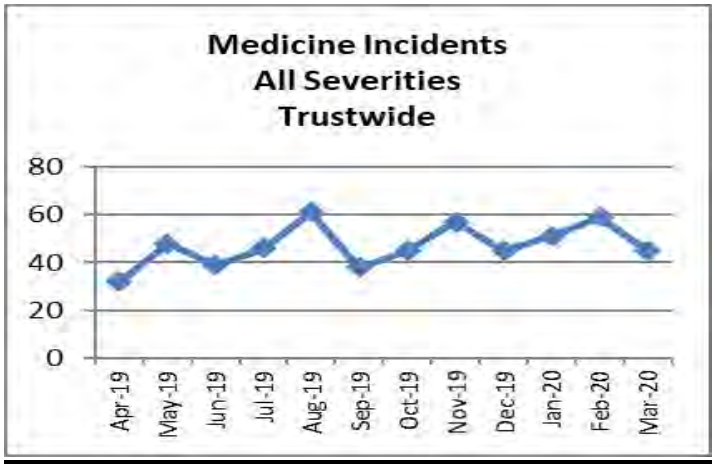
Trustwide Medication Safety

Please note the timescale as some charts run from Jan 2019 but all end in Mar 2020

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

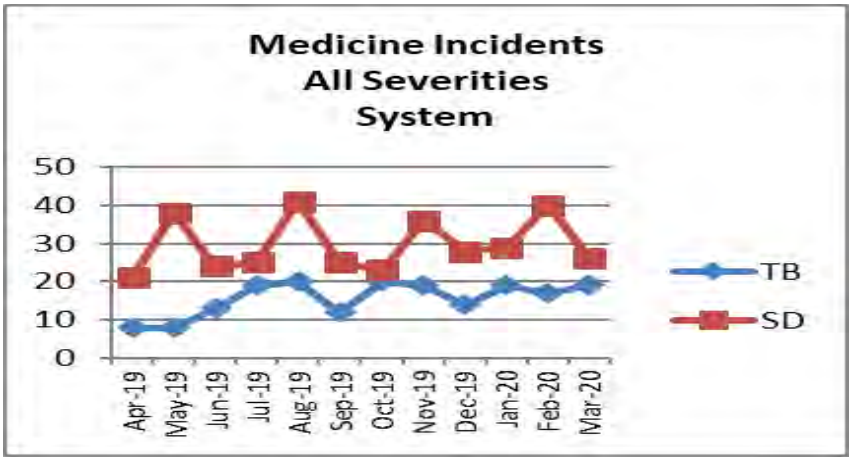
Trust Medication Incidents

Chart 21



We have seen an increase in incident reporting over this year. Pharmacy have been encouraging incident reporting through their newsletters and via the central team. Traditionally medicine incidents have been under reported, this being a national trend.

Chart 22 records the above incidents down to the System level first then at ISU level



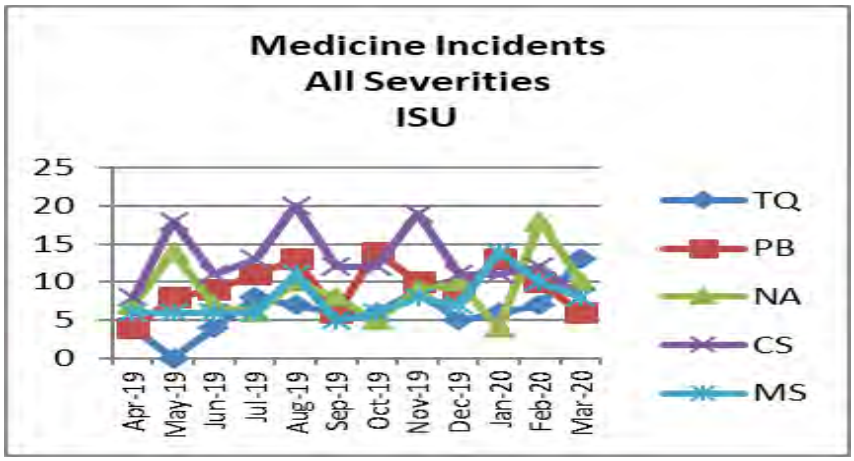
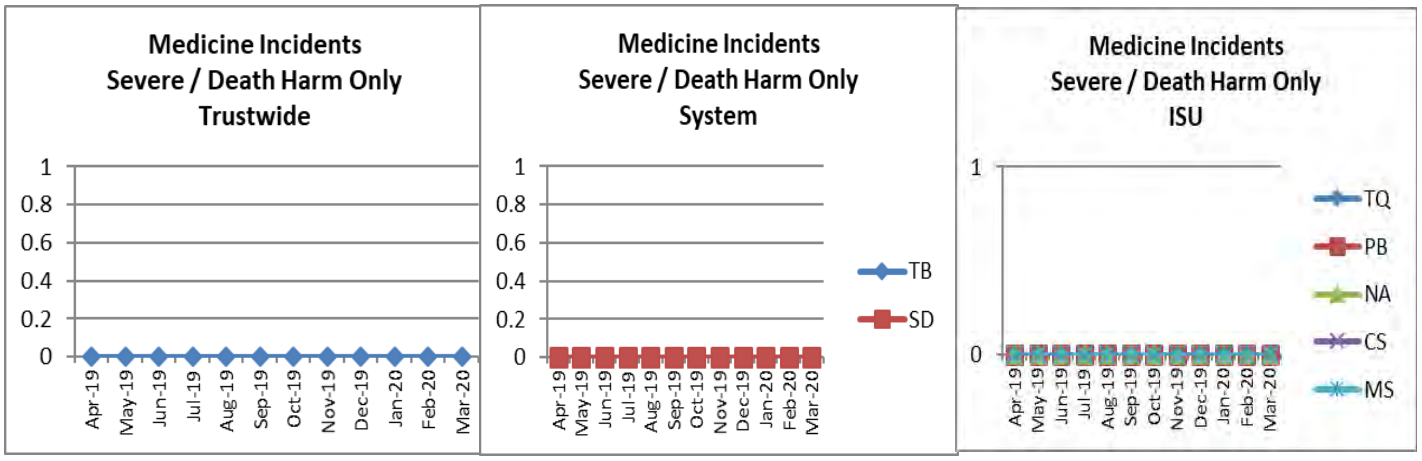


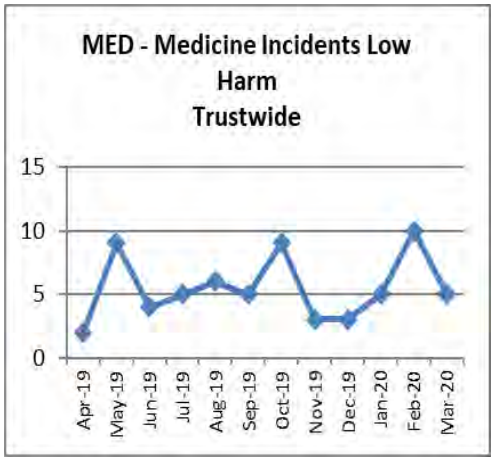
Chart 22

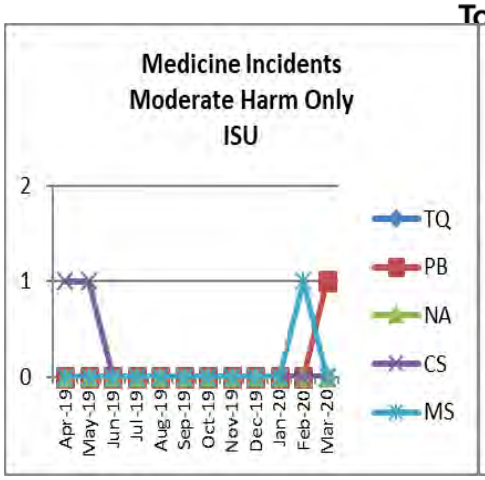
Harm levels of Medicines in Incidents

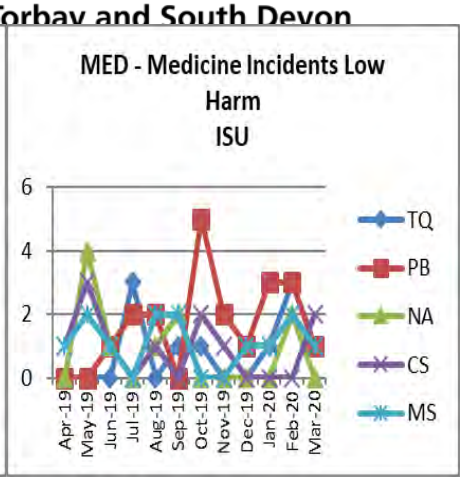
Chart 23



The above shows serious harm from medication incidents at an all-time low, this being very encouraging.

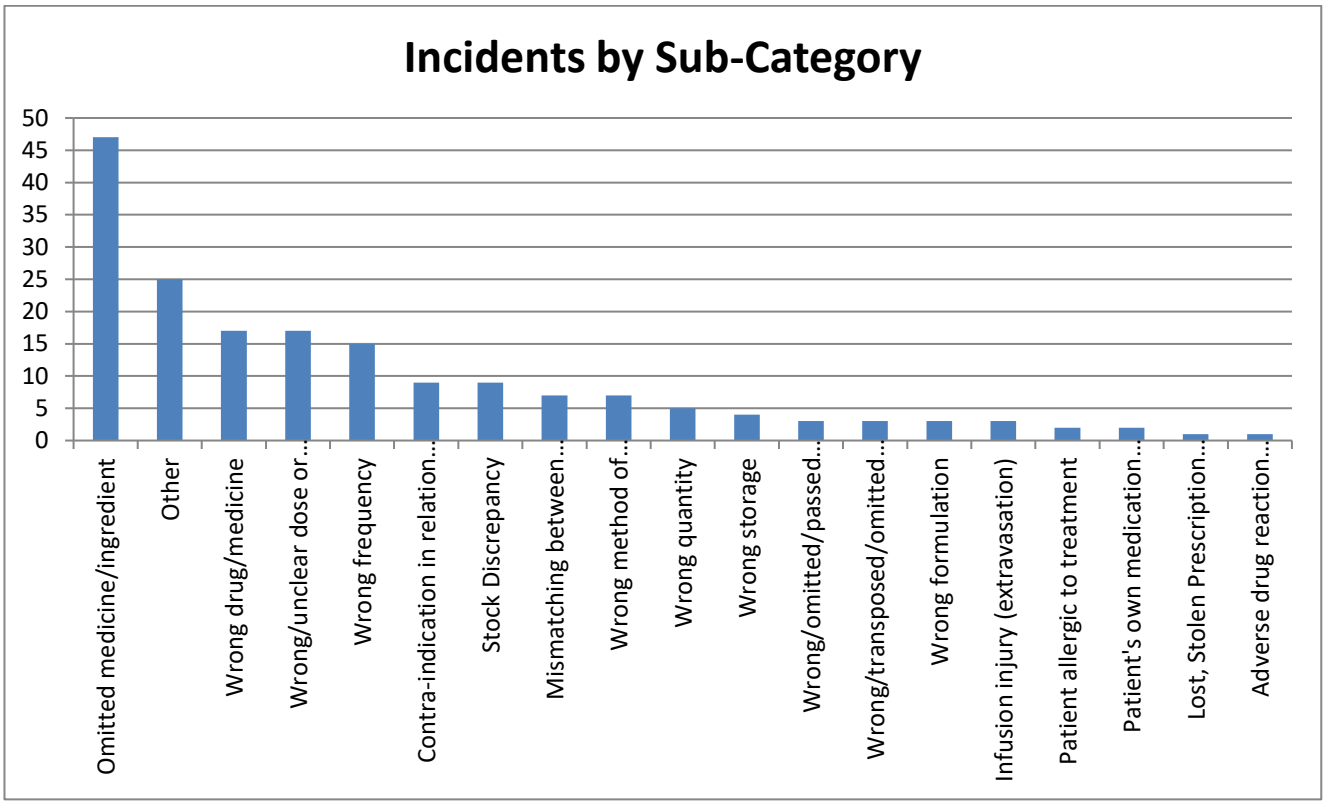






Most medication incidents result in low harm events, chart 24 as above.
Of the moderate incidents there have been very few over the year and all have been investigated.

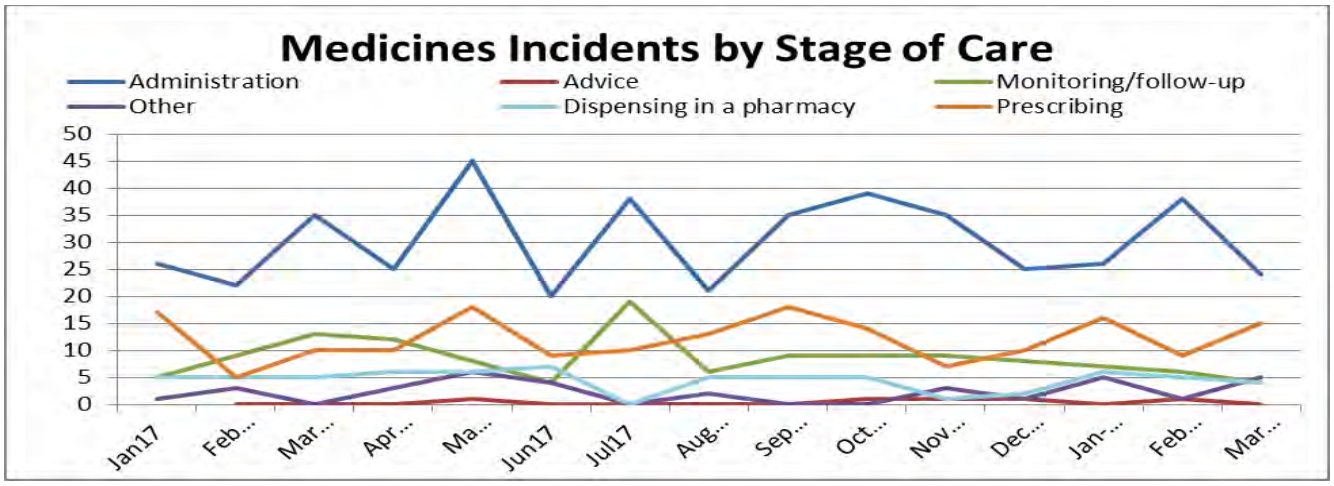
When medication incidents are investigated further by looking at frequency and type, the following chart is generated (chart 25)



And when comparing our trust, nationally the most frequently reported types of medication incidents to the NRLS involve the wrong dose, omitted/delayed medicines or the wrong medicine. Our top three incidents are omitted medicines, wrong/unclear dose and wrong medicine.

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

Chart 26



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

Missed dose work continues and the wards are given feedback on this aspect of care. This work was restarted in Oct 2019 and the data will be presented at the Medicines Management Group

Medication: Some of the Key Action areas for 2020 following on from incident reporting

Key Areas	Action	Date Due	Responsibility
Controlled drugs:			
Recording of patient's own CDs	To test the CD stickers in another ward (previously trialled on Turner) to get data on time saved & ensure process works.	Feb 20	Kate Wormald / Briony Herbert
Daily checks	Trial of stickers to potentially show a reduction in the time it takes to complete daily checks.	Feb 20	Action are in process but final sign off delayed by Corona
General issues	Development of controlled drug eLearning package.	Mar 20	

	Feedback meetings held with individual areas to promote understanding of the CD audit & areas of non-compliance. Also to provide suggestions & support for any changes.	Jan 20	
Insulin: **Insulin awareness right insulin / dose / time / device**	Working with diabetes team to implement a training & support package for wards. Being tested on Ainslie ward. Still working towards mandatory eLearning	Feb 20	Caroline Harding / Chris Redford / Kate Wormald
EPMA: **Reporting**	Medicines governance liaising with the EPMA team.	Ongoing through the project	EPMA Team

Trustwide Pressure Ulcers

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

Chart 27 (below) highlights the increased reporting of all grades of pressure ulcer within the Trust. This is down to the increased surveillance and reporting the Trust has encouraged in this area of patient harm. The second chart shows the grade of PU by number and month. The vast amount of PU are in the grade 2 category chart 28

Chart 27

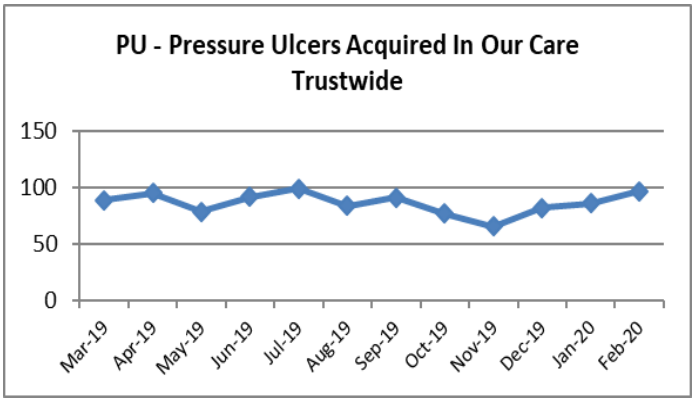
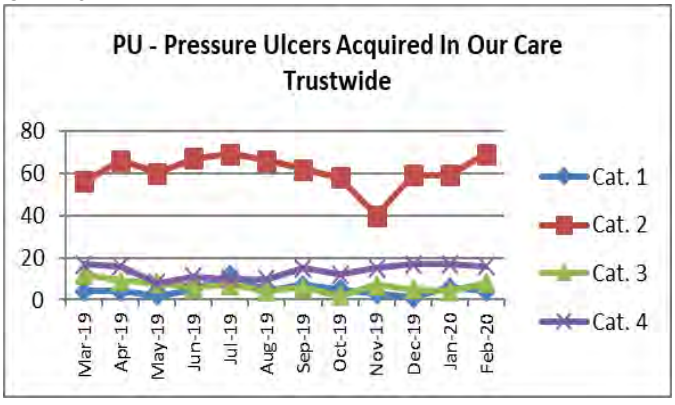
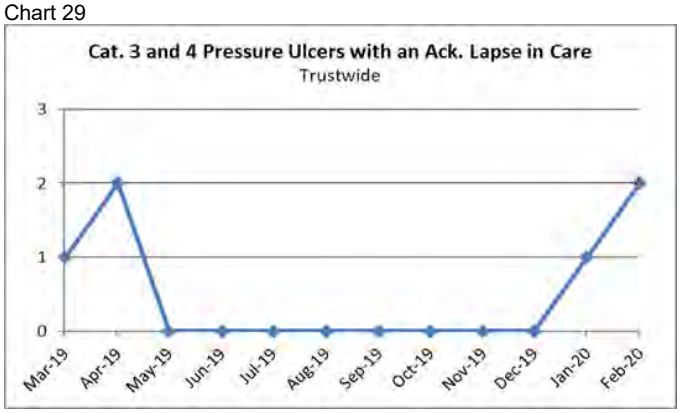


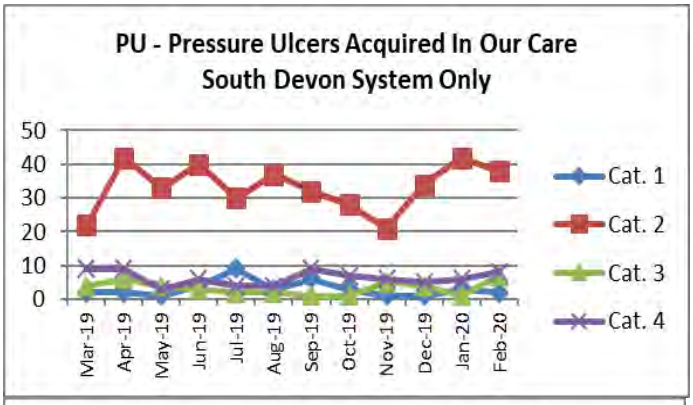
Chart 28

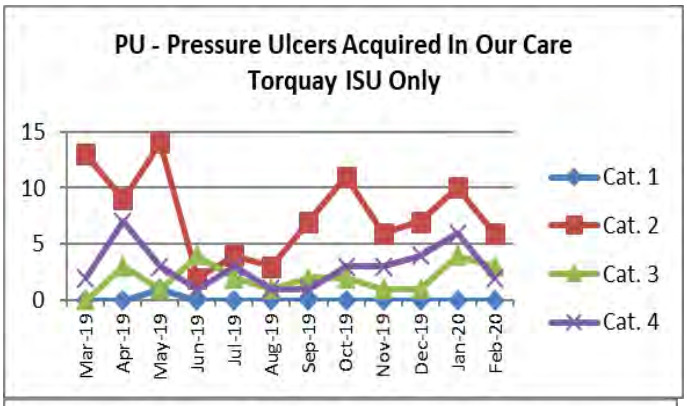


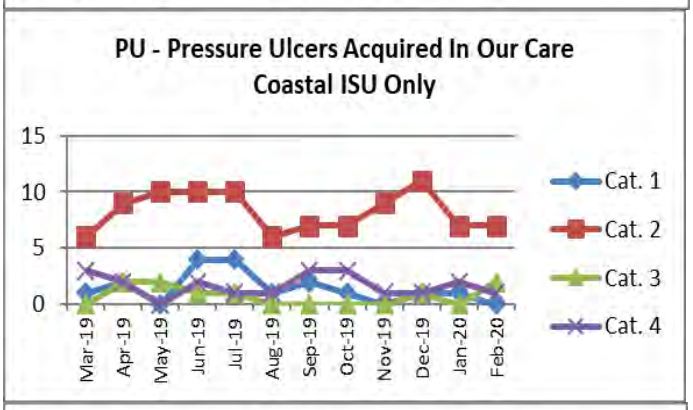
The following charts highligt PUs by lapse in care, aquired in our care and by ISU

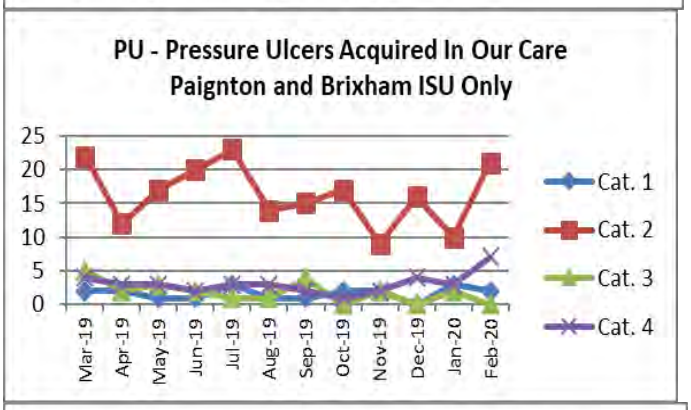
Chart 29

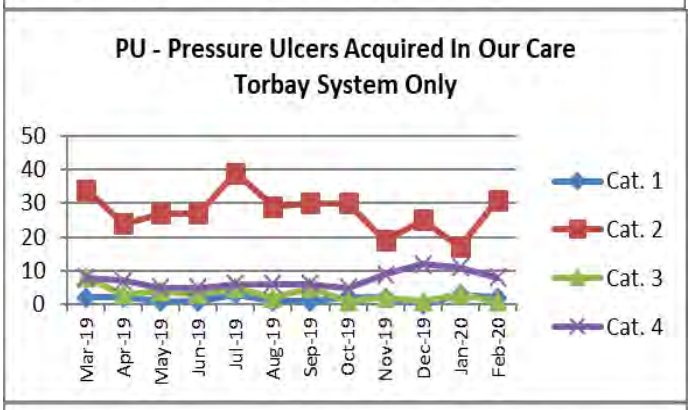


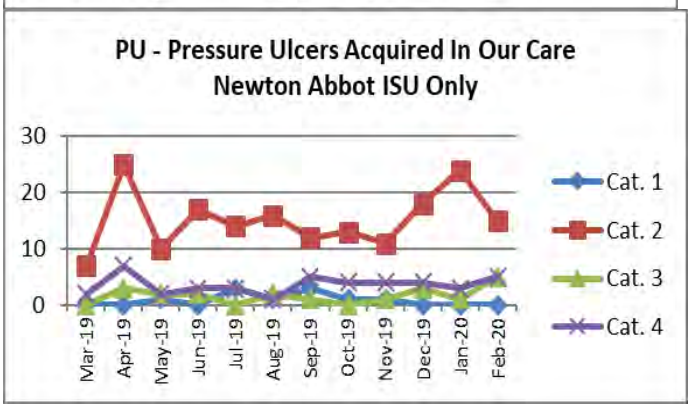


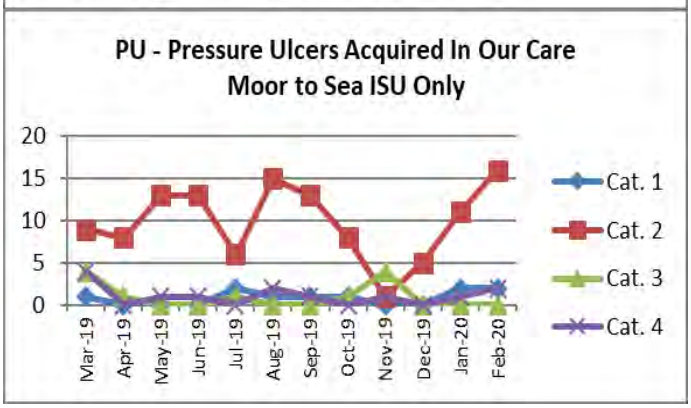






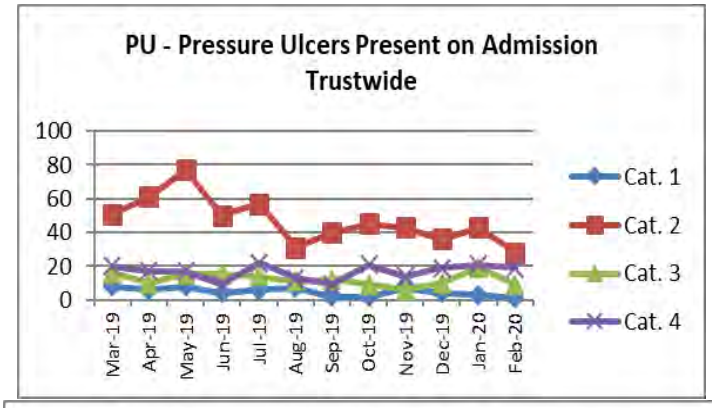


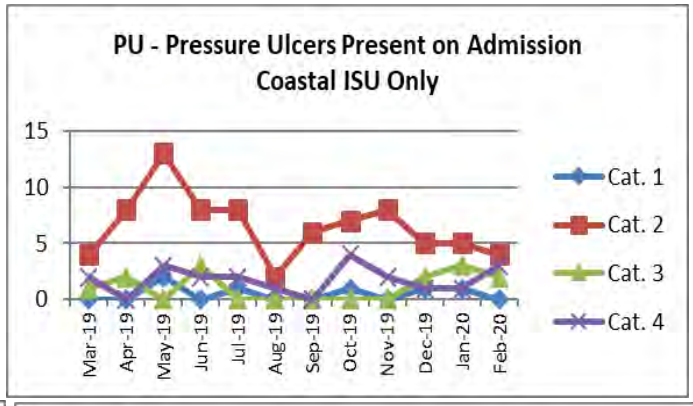


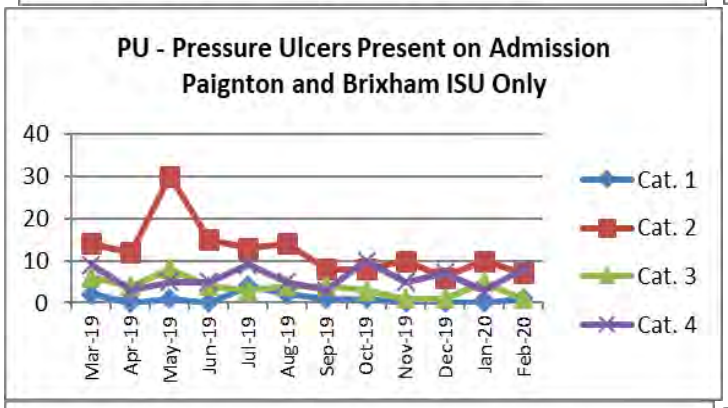


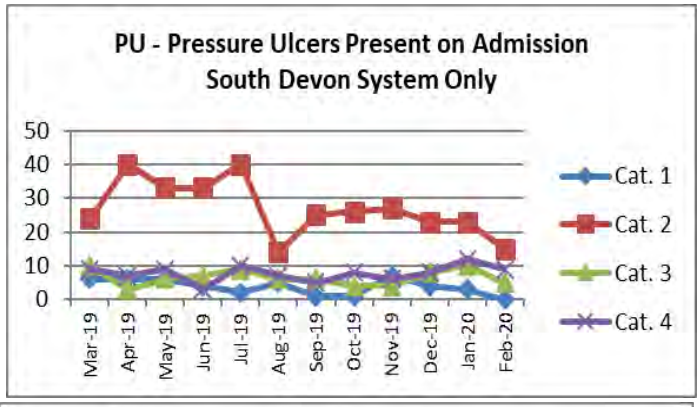
The following charts highlight available PUs by ISU

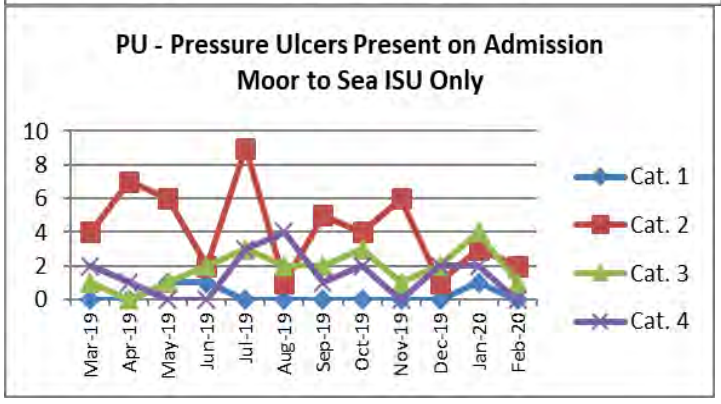
Charts 30

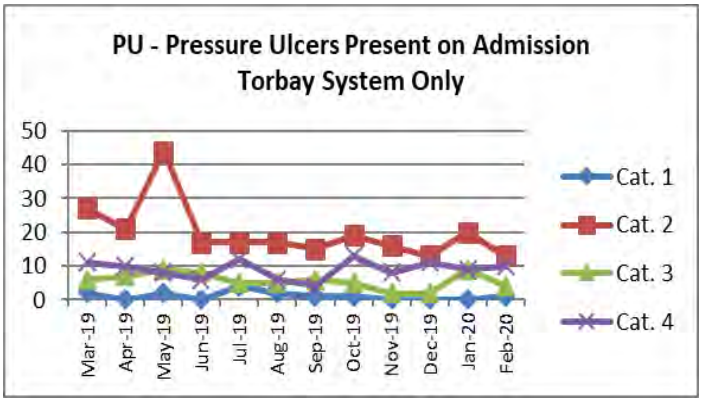












The work directed by the Tissue Viability Nurse and the Pressure Ulcer Steering Group to date includes:

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

Mortality – Hospital and Mortality with 30 days of Discharge

As a balancing measure this last section looks at mortality using: Unadjusted Hospital Mortality data, Dr Foster's Hospital Standardised Mortality Rate (HSMR) and the Department of Health's (DH) Summary Hospital Mortality Index (SHMI).

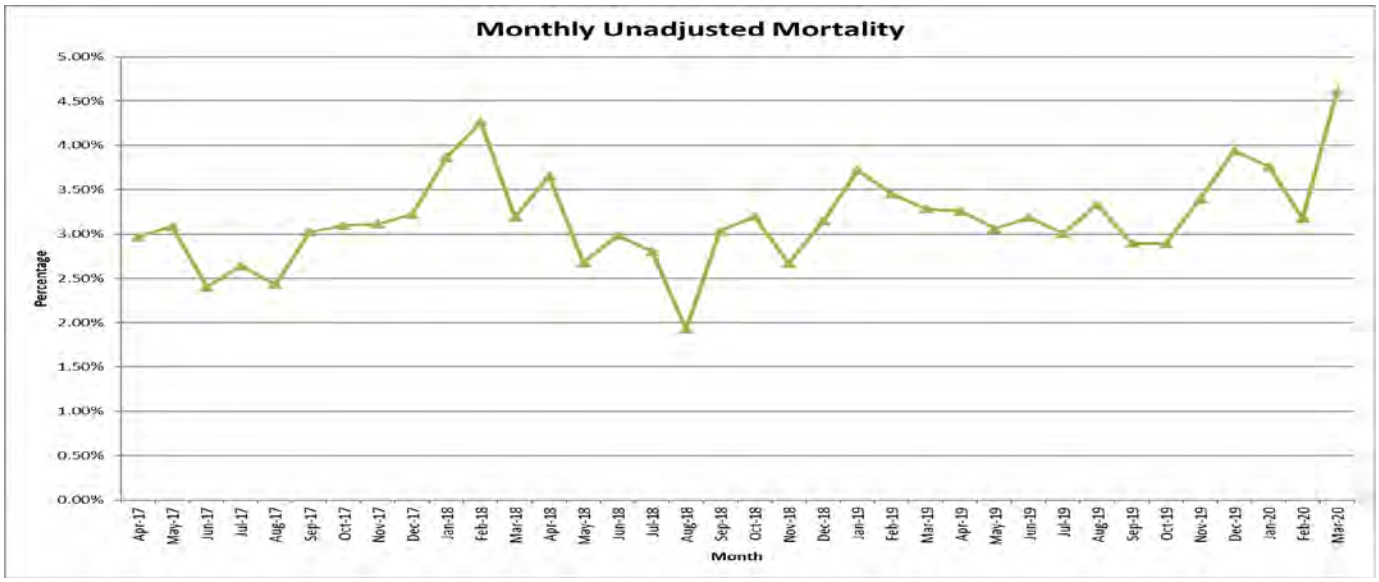
The Unadjusted hospital data is defined as the monthly unadjusted or 'raw' mortality and is calculated as follows:

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

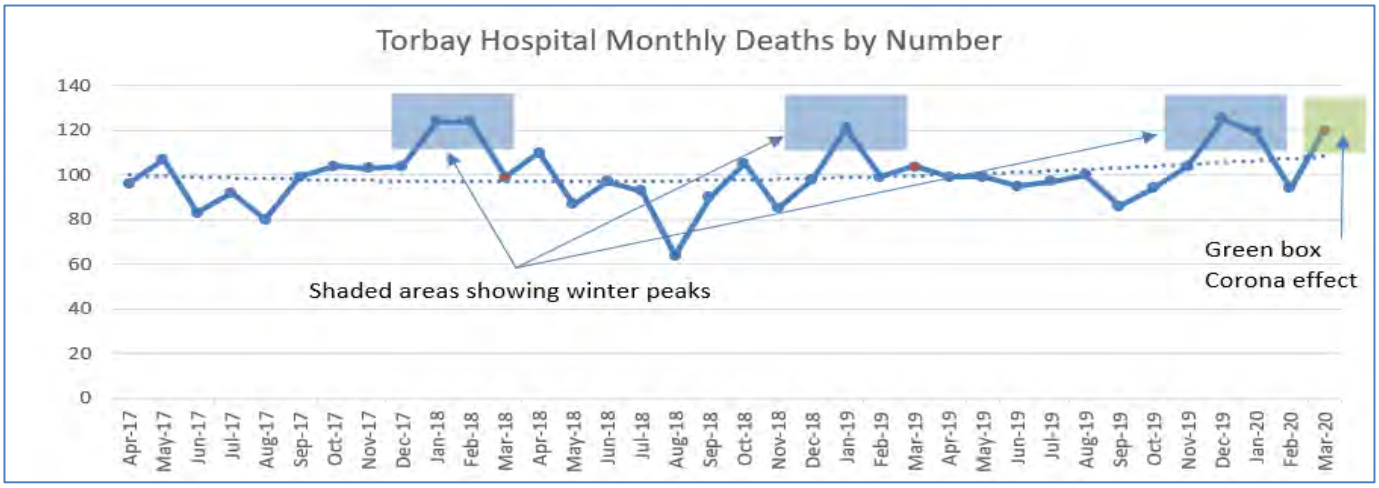
- Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).

- Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

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

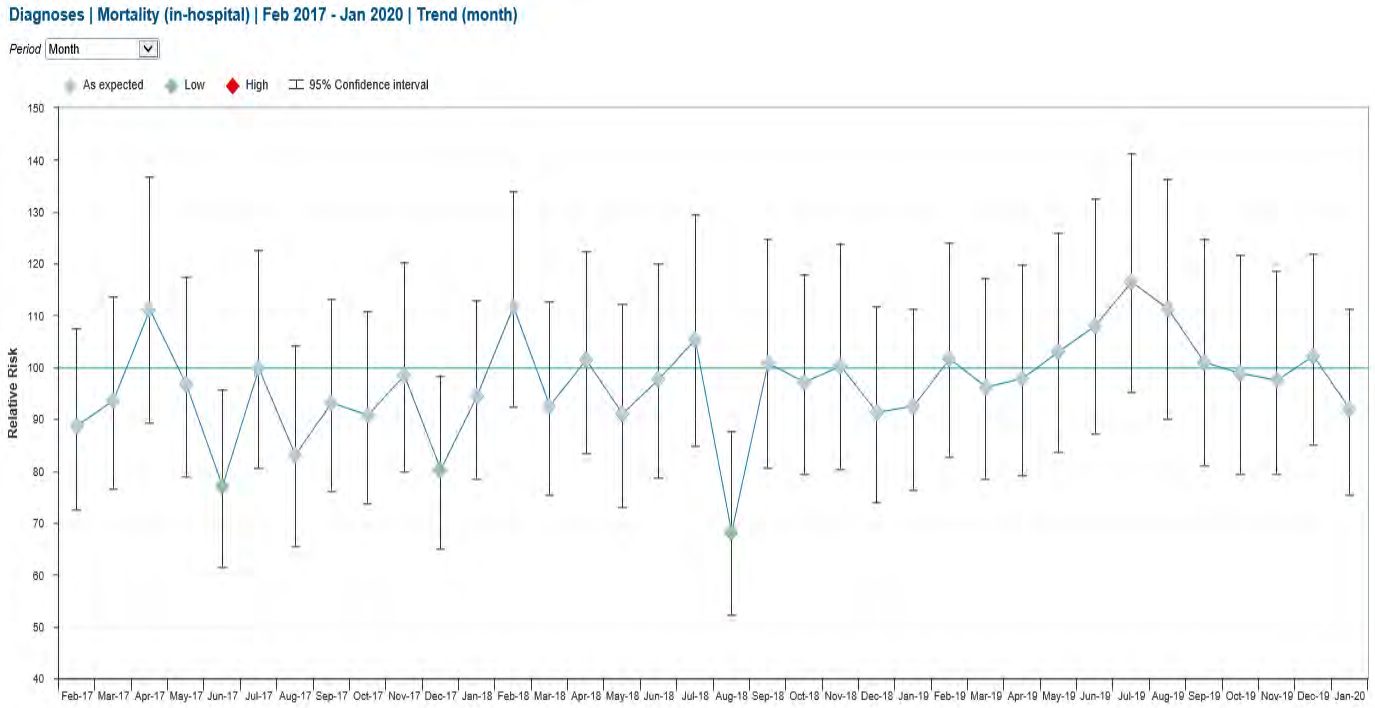


Monthly Unadjusted mortality has been averaging 3.25% prior to winter, with month mortally numbers of around 90 – 95 and within expectation. Mortality is seasonal and Winter saw a peak over two months, December & January before it started to reduce in February. March saw an unexpected rise possibly due to the Corona virus effect. This is being monitored on a weekly basis through April May.

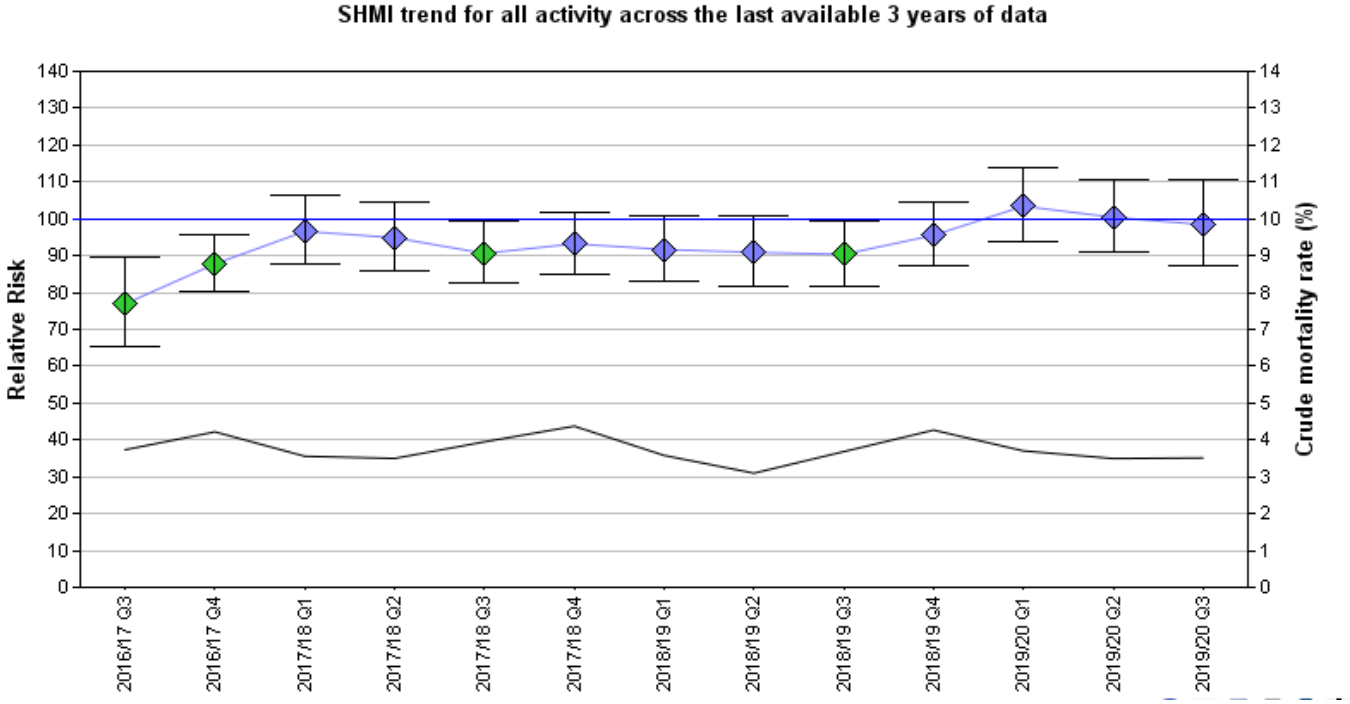


The HSMR is calculated using various methods involving deprivation scores, the Charlson index, and comorbidity index.

The chart below shows Trend by Month over the time period Feb 2017 – Jan 2020 (the most current data point). For all of 19/20 the trend has been within the expected range, no data points are flagged as high by Dr Foster.



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



Considering, HSMR, SHMI and the unadjusted data the Trusts mortality is performing as expected which is to be encouraged. Our learning from deaths process have help highlight good practices which we share within the organization, including good clear communication via such tools as SBARP (Situation Background Assessment Recommendation Patient), consultant led care, multidisciplinary care, which includes the patient and family. The learning's have also highlighted early recognition of the deteriorating patient with appropriate intervention, including Intensive Care outreach and vital signs observation.

Further work will follow in the coming year, focusing on the Medical Examiners, which are now in post and introducing the service

Report Background

Time period:
The report covers the time period April 2019 – March 2020, unless otherwise stated

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

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

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

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

Data Sources:

- Datix: Trust Wide Risk Management including Incident reporting
- Dr Foster
- Department of Health

Appendix 1


DATIXDigest
NHS
Torbay and South Devon
NHS Foundation Trust
January 2020
INCIDENTS
Logged in the system compared with previous month
935 incidents reported in Dec 2019
741 incidents affecting patients Dec 2019
85 incidents affecting other Dec 2019
595 incidents no harm/near miss Dec 2019
61 incidents moderate harm Dec 2019
3 incidents severe harm or above Dec 2019
Top 5 patients incidents December 2019
Pressure ulcer
Accident / Injury
Documentation
Security
Access, Admission, Transfer, Discharge
COMPLAINTS
and other feedback
compared with previous month
201 feedback registered in Dec 2019
14 complaints registered in Dec 2019
106 concerns/comments in Dec 2019
27 compliments registered in Dec 2019
49 signposting/advice given in Dec 2019
Top 3 complaints issues December 2019
Alleged Competence/negligence
Attitude of Staff
Other
Top 3 Complaints issues November 2019
Alleged incompetence/negligence
Effectiveness
Attitude of Staff
LITIGATION
compared with previous month
4 cases received December 2019
Central Alerting System
Alerts can be found on ICON Incident Pages - Patient Safety Alerts
new alerts
5 Medical device alerts
1 Patient Safety alert
2 Supply disruption alerts
Closed Alerts
3 Medical device alerts
1 Supply disruption alert
Outstanding alerts
1 Patient safety alerts
1 Estates & facilities alerts
STAFF INCIDENTS
compared with previous month
109 incidents affecting staff in December 2019
Top 3 staff incidents in December 2019
Security / Crime
Accident & Injury
Other
DATIX pages are on ICON
For training, queries, access, dashboards: Datix Administrator Elaine Yersin (01803 6)56991 elaine.yersin@nhs.net
Datix Asset Owner: Patient Safety Lead Steve Carr (01803 6)56455 steve.carr@nhs.net
See out incident pages in ICON for Patient Safety Information: Safebook, advice, policies, guidance, safety alerts

For circulation to all relevant medical, nursing & AHP staff via safety briefing or handover

NHS
Torbay and South Devon
NHS Foundation Trust

--- *Five point clinical safety brief* ---

The clinical safety brief relates to issues or comments that have been raised via incident reporting & can be used to highlight patient safety awareness for staff.

1.	**Please be reminded of the importance of good record keeping:** Record keeping demonstrates that staff have exercised their professional accountability & fulfilled their legal & professional duty of care. The quality of record keeping is a reflection of the standard of an individual's professional practice & is a mark of a safe, skilled practitioner. It is an integral part of clinical practice and is an essential tool in promoting high quality care.
2.	**For all care areas, e.g. hospitals or intermediate care, please ensure you undertake lying & standing blood pressure as part of the falls assessment risk.** This is in addition to observations undertaken as part of the new admission process. If this cannot be undertaken, it is important to document the reason why.
3.	**Please note that the organisation must report any food allergy related patient safety incidents via their incident reporting systems.** Ensuring that any incidents involving food allergens, are investigated & any learnings identified are communicated to others & relevant actions taken, regardless of whether actual harm has been caused.
4.	Please remind nursing staff to ensure that the **when completing 'Last Offices' on the ward,** it is the responsibility of the nurse to place the paperwork, that goes with the deceased patient to the mortuary, into the clear pocket on the outside of the body bag BEFORE the porters are called to transfer the patient. Any injuries sustained whilst carrying out procedures on the deceased must be reported to the Nurse in Charge & a Senior Manager. Note that the Falls Policy still applies, including being checked by a doctor before the deceased is transferred from the ward. Nursing staff need to be available on the ward to assist the portering staff with any lateral transfer of the deceased.
5.	**As part of your routine checks, can you please ensure the hypoglycaemic box is kept in a consistent location & checked as per policy & after use.** We have had a number of incidents reported where a box was empty and/or items were missing.

Visit the **'Safebook' intranet site** for info & guidance on patient safety issues, including Sepsis, Never Events, Duty of Candour, Safety Alerts, Mortality, incident investigations & much more. Search 'Safebook' from the ICON home page or access via the incident reporting home page.

Steve Carr, Patient Safety Lead March 2020

Torbay and South Devon NHS Foundation Trust

Report to the Board of Directors			
Report title: Freedom to Speak Up Guardian Six Monthly Board Report			Meeting date: 27th May 2020
Report appendix			
Report sponsor	Executive Director of Workforce and Organisational Development		
Report author	Sarah Burns Lead Freedom to Speak Up Guardian		
Report provenance	Freedom to Speak Up Guardians		
Purpose of the report and key issues for consideration/decision	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation			

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Freedom to Speak Up Six Monthly Board Report		Meeting date: 27th May 2020
Report sponsor	Executive Director for Workforce and Organisational Development	
Report author	Sarah Burns Lead Freedom to Speak up Guardian	

1. Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. The main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change. Speaking up and the matters that speaking up highlights should be welcomed and seen as opportunities to learn and improve. It is the behaviour of executive and non-executives which is reinforced by managers that has the biggest impact on organisational culture. How a Director or manager handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is. The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry 3 as part of the well led domain of inspection.

Promoting an open and transparent culture is clearly led by the Chief Executive, Lead Non-Executive and Lead Executive for Speaking Up. They are supportive and quick to respond as well as role modelling the behaviours and values of the Trust. In all cases where the support of an Executive has been asked for it has been given and action has followed. System Directors are also promoting and supporting a culture of speaking up. There is still work to do in supporting senior and middle management to listen and respond when workers speak up.

2. Assessment of cases

Since the last Board report in November there have been 32 concerns raised through the Freedom to Speak Up Guardians:

The main themes from the concerns:
Bullying and Harassment (9) – None have gone to formal disciplinary after investigation
Patient Safety (2)
Failure to follow process (2)
Diversity and Inclusion (1)
Staff Safety (7)
Culture of organisation (8)
Fraud (3)

Staff group speaking up:
Medical (1)
Nurse (4)
Midwife (2)
AHP (8)
Senior Manager (1)
HCSW/AP (10)
A&C (4)
EFM (2)

Speaking up by Integrated Service Unit:
Torquay (8)
Paignton and Brixham (4)
Coastal (2)
Moor to Sea (10)
Newton Abbot (4)
Operations (2)
EFM (2)

The numbers of cases remain the same as received in the previous six months. The highest number of staff who spoke up were from the support worker group. A number had spoken up individually about the same issue which is reflected in the South Devon system having the largest number of speaking up cases at 16. In comparison to neighbouring trusts the data for quarter three shows Torbay cases at 15, Royal Devon & Exeter at 10 with North Devon and Derriford not formally submitting any data.

Bullying and harassment and culture of the organisation continue to be the two main reasons staff speak up. In most cases their concerns have been previously raised with line managers with staff not feeling listened to and little or no action in response. To address this Bullying and Harassment now forms part of induction and management training. A round table discussion with representatives from across the Trust was held to discuss underlying issues associated with incivility and bullying and harassment. Work has started on a Just Learning Culture in how we address conflict and promote mediation to include training on having difficult conversations associated with performance. The Bullying and Harassment policy has been revised and there is a planned launch to include a network of anti-bullying advisors to support and signpost. This had been planned for early April but due to Covid-19 preparations had been delayed. This will be launched as soon as possible.

Staff safety cases were concerns related to personal protective equipment, social distancing measures and reassignment during Covid-19. These concerns were escalated and the response to this was picked up daily as part of the Command Structure dedicated PPE Cell and the Workforce Cell communications. Guidance packs for Managers to include risk assessments on working safely with Covid-19 and social distancing were also produced in partnership with Staffside and Freedom to Speak Up support. Executive Vlogs have regularly encouraged reporting of concerns around Covid-19 issues.

3. Patient safety/worker experience issues

In November a listening session was held in the Emergency Department after concerns were raised with senior management. Over 50 staff took part in the session that identified both poor patient and staff experience. Staff shared difficult and emotional experiences which were reflected in a feedback report. The report highlighted concerns in the lack of basic patient care and safety and for the psychological safety of the staff. There has been reluctance for these issues to be recognised by some groups of staff therefore the Supportive Improvement Framework was introduced and a programme of work and action plan is now underway. This work is being actioned by the ED triumvirate and a weekly update for assurance against the actions in the plan is led by the Chief Executive. The Lead Guardian is also supporting this work to ensure the voice of staff is not lost in the process. The People Committee in March received a verbal

update from Natasha Goswell on next steps in the supportive framework and will be keeping the committee regularly briefed.

In February and March a listening session was held in Radiology. The feedback to the staff and senior management has been put on hold due to Covid-19 preparations. Key themes have been identified and a plan to address these will need to be developed.

Also during March we received an increased number of anonymous letters in the See Something Say Something green boxes. Poor staff experience was highlighted in the letters from various departments. One department within the Moor to Sea ISU had a barrier to staff being able to speak up effectively. This referred to the recruitment of family members in a position. of power. This has been addressed with senior managers and a programme of support and awareness training of how to speak up has started. Further discussion and review of the Relationships at Work policy and recruitment practices will lead into a broader piece of work around the development of a resourcing hub following learning from COVID

Freedom to Speak Up fits into wider patient safety and worker experience. Safety culture and staff engagement are one of the areas that has been identified for further work within the local staff survey findings and is fundamental to how staff feel about and are able to perform at work. Local Staff Survey indicators including reporting and witnessing unsafe practice are used as a measure of confidence in being able to speak up. A roundtable discussion on safety culture with key stakeholders is being led by the Staff Experience lead in response to this. The guidance for Boards from the National Guardian Office and NHSE/I recommends that guardians have access to applicable sources of data and other information to enable triangulation of speaking up issues. This would enable proactive identification of patterns, trends and potential areas of concerns.

4. Action taken to improve FTSU culture

Action to increase the visibility of the Guardians has included visits to community sites where there have been no cases of speaking up. This work will continue now that the Trust is entering the recovery phase of Covid-19. Digital induction now includes a video and information on contact details for the guardians but face to face induction will also be delivered on request. We are seeking to identify Freedom to Speak Up Champions in areas and with staff who find it difficult to speak up to include BAME workers, bank workers, students and volunteers.

Freedom to Speak Up and the importance of speaking up has been included in the Covid-19 Vlog led by Liz Davenport and Gold command. Reminders of the importance of and how to speak up to continue to be part of regular communications.

By using examples from the 100 voices campaign, a volume of anonymised speaking up cases from NHS Trusts, we can share experiences and learning with our staff.

To consider the implementation of an anonymous speak up button for safety concerns and learning during the recovery phase and planning for business as usual after Covid-19.

The National Guardian Office has developed a policy review framework that will help guardians to take a fresh look at their organisation's speaking up policy, from the perspective of the person speaking up. This will be helpful for the review of the Trust's Raising Concerns (Whistleblowing) policy due this year.

5. Feedback from speaking up:

"Thank you so much for meeting with us today, we can genuinely say we feel so relieved to have someone we feel is listening to our concerns. "

"Thank you for all your work to help me and others"

"Completely in admiration for the work you are doing with patient care at the centre which is how it should be"

6. Recommendations

For the Freedom to Speak Up Guardians to have access to safety data that could be compared to identify wider issues. This would include patient complaints, patient claims, serious incidents, near misses and never events.

Review of the Relationships at Work policy and recruitment practices for wider learning and improvement to prevent barriers to speaking up and improve worker experience.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Annual Infection, Prevention & Control Report		**Meeting date:** 27 May 2020
Report appendix	Appendix 1: Infection Prevention & Control Annual Report 2019/2020	
Report sponsor	Chief Nurse	
Report author	Consultant Microbiologist	
Report provenance	Infection, Prevention & Control Group (IP&CG) The Quality Assurance Committee	
Purpose of the report and key issues for consideration/decision	Under the Executive leadership of the Chief Nurse, the Infection Prevention and Control Team (IP&CT) of Torbay and South Devon NHS Foundation Trust (TSDFT) lead the strategy and operational support to ensure a safe patient journey. The IP&CT provides advice (building works outbreak/pandemic management), education, audit, action plans, reporting and support in hospital and community-based care. The IP&CT have liaised with the Integrated Service User Leads. The IP&CT work within the NHS Operating Framework (NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm) providing assurances to the commissioners. The Infection Prevention & Control Group (IP&CG) meet quarterly and ensure the IP&C Annual Forward Plan and the IP&C Strategy is followed. The IP&CG report to the Quality Improvement Group (QIG) each quarter. Issues are escalated to the Quality Assurance Committee (QAC) as appropriate. TSDFT IP&CT works closely with Public Health England (PHE) and the System Infection Prevention Lead, NHS Devon CCG. From 1/4/19 to 31/3/20 the Trust reported: One MRSA blood stream infection (BSI) and the Trust target was zero. For 2019/2020 NHS Devon CCG stated that Local flexibility (on targets) is under discussion at a national level. Targets should be viewed in a system context; more as ambitions than targets. The reason NHSI changed the CDI target was because it changed the reporting definitions for Healthcare acquired CDI in 2019/20 and this was to align England and Wales with USA and European definitions. NHSI and the CCGs are aware that this change in CDI definition in 2019/20 will more than double the reported numbers of Healthcare acquired CDI in 2019/20 compared with 2018/19. The ambition for this Trust was 36.	

	The changes to the Clostridium difficile infection (CDI) reporting to Public Health England (PHE) and NHSI for financial year 2019/2020 were as follows • reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission. For 2019/2020 cases reported to the healthcare associated CDI will be assigned as follows: Hospital onset healthcare associated **(HOHA):** cases that are detected in the hospital 48 hours after admission = 15 Community onset healthcare associated **(COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks =37 Board were notified in October 2019 that some IP&C incidence was outside the national Fingertips benchmark which showed the Trust to be an outlier for Escherichia Coli, MSSA and MRSA incidence. The DIPC provided a report in December 2019 setting out possible reasons for this: • The Public Health England (PHE)'s Fingertips data is not Age Adjusted. • TSDFT is 'Sepsis Aware', and has a higher compliance with taking blood cultures when compared with other trusts and this leads to ascertainment.

Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☒

Recommendation	A continued focus on the Saving Lives peripheral cannula and urinary catheter care audits & re-audit until 95% compliance is reached. Ensure Hand Hygiene audits are submitted from all clinical areas in the hospitals and community care and that a standard of 95% is reached. IP&C still need to obtain IP&C assurances from the ISUs that IP&C and Antimicrobial Stewardship forms part of their Governance reporting.
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

The following stakeholders were consulted during the compilation of this report:
- Members of the Infection, Prevention & Control Group.

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- The Quality Assurance Group.
- Public Health England.
- System Infection Prevention Lead, NHS Devon CCG.

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

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<tr><td>Board Assurance Framework</td><td></td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>x</td><td>Risk score</td><td>20</td></tr>
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Replace ventilation in Endoscopy 3 and continue General Theatre ventilation upgrade.

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<tr><td>External standards affected by this report and associated risks</td><td>

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<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
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The recommendations made in this report will impact upon:
NHS Operating Framework - NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.

Legal considerations
An equality impact assessment has ensured that this report does not discriminate or disadvantage people whilst advancing equality and does not affect particular 'Inclusion Health' groups less favourably than the general population. This reports complies with the legal framework provided by the Mental Capacity Act 2005 and supports the Code of Practice.

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Torbay and South Devon NHS
NHS Foundation Trust

V. 14 5 2020

Infection Prevention & Control Annual Report 2019/20

And Annual Forward Plan 2020/21

S Hoque DIPC
L Kelly Lead IPCN

Ratified Infection Prevention and Control Group
Reviewed by the Quality Assurance Committee
Board date 27 May 2020

Contents

Summary

The Infection Prevention & Control Team (IP&CT) work within the NHS Operating Framework (part of the NHS Outcome framework domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm). Regular reports on IP&C targets are issued to NHS Devon Clinical Commissioning Group (NHS Devon CCG). The IP&CT are members of the NHS Devon CCG's Devon Community Infection Management Service (CIMS) which has been funded to develop and provide system-wide, community IP&C and Antimicrobial Stewardship capability across the county.

The Infection Prevention & Control Group (IP&CG) meet quarterly and ensure the IP&C Annual Forward Plan and the IP&C Strategy is followed and report to the Quality Improvement Group quarterly. The IP&C Annual Report written by the Director of Infection Prevention & Control (DIPC) together with the trust's Assurance Framework affirms to the Trust Board, that IP&C risks are managed correctly.

Exception reports are received from the Decontamination Group, the Environment Group, the Water Safety Group, the Critical Ventilation Group and the Joint Estates, Facilities & IP&C Group. The IP&CT meet with Assistant Directors of Nursing and Professional Practice (ADNPPs) from the five Integrated Service Units (ISU) each quarter to write a report for the IP&CG meeting.

The COVID19 Pandemic has disrupted the usual meetings from March2020 up to June2020. The IP&C Meeting was not quorate in November 2019. For Q4 the COVID19 changed IP&C priorities and the team were in the forefront of planning, advising on procurement and use of PPE (Personal Protective Equipment).

The Trust reported one MRSA blood stream infection from 1/4/19 to 31/3/2020 and the Trust target was zero. The Trust reported 52 attributable *Clostridium difficile* (*C difficile*) infections, against an NHSI contractual target of 36 attributable *C. difficile.* (https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/). NHSI has charged the CCGs with an Ambition to reduce Healthcare associated E. coli blood stream infections by 50% per year from 2017 to 2024.

1. Introduction

The aim of this report is to provide assurance to the board on infection, prevention and control (IP&C) within the Integrated Care Organisation (ICO) as well as to patients, staff, public, Providers and Commissioners. The report also sets out the 2020/21 Annual Forward Plan, Key Performance Indicators (KPIs) and Strategy of the IP&CT.

The IP&CT consists of the Director of Infection Prevention & Control (DIPC) at 6 sessions a week, the Lead IP&C Nurse (Lead IP&CN), IP&C nurses & support staff;

0.8 8a (Lead IPCN)
3.0 band 7
1.6 band 6

2.8 band 4 TAPS/APS
1 band 6 vacancy

2. *Clostridium difficile* Infection (CDI)

Targets for C. difficile:
For 2019/2020 NHS Devon CCG stated that Local flexibility (on targets) is under discussion at a national level. Targets should be viewed in a system context; more as ambitions than targets. Trusts should continue to do what they have been doing and focus on quality of reviews and prioritising patient care.

The changes to the Clostridium difficile infection (CDI) reporting to Public Health England (PHE) and NHSI for financial year 2019/2020 were as follows

- reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.
- Compared to last year at TBH site we had 15 CDI this is an excellent result.

For 2019/2020 cases reported to the healthcare associated infection data capture system will be assigned as follows:

Hospital onset healthcare associated **(HOHA):** cases that are detected in the hospital 48 hours after admission = 15
Community onset healthcare associated **(COHA):** cases that occur in the community (or
within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks =37

There has been one *C. difficile* outbreak, defined as more than one patient with the same type of *C. difficile* on a ward within 28 days. From 24/4/19 to 4/6/19 six in-patients were diagnosed with CDI at Newton Abbot hospital, After Action Reviews (AARs) were performed for all six patients and two outbreak meetings were held on 23/5/19 and 25/6/19. On Templar ward there were two types of CDI so one incident of person to person spread and on Teign ward there was one type of CDI so two instances of person to person transmission.

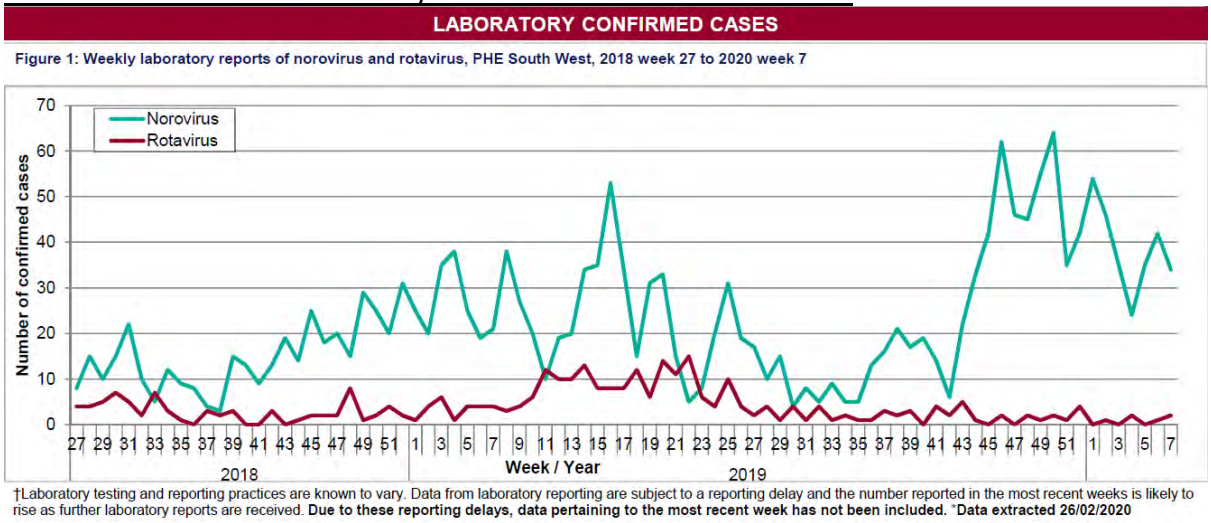
From the AARs 11 actions were set and included weekly audits against the C. difficile policy, such as commode cleaning checks, antibiotic prescribing and isolation. The actions were all satisfactorily completed except for the requirement for Newton Abbot hospital to have an increased courier service and Point of Care Testing (POCT), they were to continue to use taxis for out of hours specimens and medication. An extra shift of cleaning from 14:00 to 22:00, 7 days per week was implemented. Subsequently, there has been no further person to person spread of CDI across TSDFT.

3. Norovirus and other Viral Gastroenteritis

From April 2019 to March 2020 there were four ward closures due to either Norovirus or viral gastroenteritis. This compares with 2018/19 which had no ward closures.
Templar ward from 10/5/19 to 13/5/19 with one patient positive for Norovirus and retrospectively it was found that a household member vomited the day of the patient's admission. Four other patients had diarrhoea but all were negative for Norovirus.
Midgley ward from 20/8/19 to 22/8/19 because 7 patients developed diarrhoea but no cause was found.
Midgley ward 7/1/2020 to 13/1/2020 because 12 patients and 7 staff were symptomatic and Norovirus was confirmed.
Dunlop ward 3/2/2020 to 4/2/2020 because 3 patients has diarrhoea and vomiting no cause found.

Rainbow Nursery was assisted by IP&CT in December 2019 because 11 children and 7 staff had diarrhoea and vomiting and there had been previous cases in November. A deep clean including removing radiator covers was arranged over a weekend and hydrogen peroxide vapour was used in the toilets. Advice was given to obtain easily removed radiator covers so that future cleaning will not be hindered.

PHE's South West Laboratory confirmed cases of Norovirus



4. Outbreaks and COVID19

This year there were four ward closures due to Norovirus or viral gastroenteritis, one due to FluA. For Q1 2020/2021 there was a COVID19 ward closure on George Earl ward, this was managed within a few days and all staff and patients were screened. Other trusts in the SW have reported ward closures due to COVID19.

Hospital/ward	Main actions from Outbreak meetings	Actions completed
Templar ward from 10/5/19 to 13/5/19 with one patient positive for **Norovirus** and retrospectively it was found	Affected bays, sluice, toilets and corridors had a deep clean. Enhanced Cleaning for one week after the ward was re-opened.	Yes yes

that a household member vomited the day of the patient's admission. Four other patients had diarrhoea but all were negative for Norovirus.		
Midgley ward closed from 20/8/19 to 22/8/19 because 7 patients developed **diarrhoea** but no cause was found.	Affected bays, sluice, toilets and corridors had a deep clean. Enhanced Cleaning for one week after the ward was re-opened.	Yes yes
Midgley ward closed from 7/1/2020 to 13/1/2020 because 12 patients and 7 staff were symptomatic and **Norovirus** was confirmed.	Affected bays, sluice, toilets and corridors had a deep clean. Enhanced Cleaning for one week after the ward was re-opened.	Yes Yes
Dunlop ward closed 3/2/2020 to 4/2/2020 because 3 patients has **diarrhoea and vomiti**ng no cause found.	Affected bays, sluice, toilets and corridors had a deep clean. Enhanced Cleaning for one week after the ward was re-opened.	Yes Yes
Templar ward closed 23/1/2020 to 27/1/2020 because 6 patients had **FluA** (confirmed on testing). Two staff off sick with Flu symptoms.	Obtained Rydon ventilation reports because side rooms along one corridor affected. Hand hygiene training for pastoral staff. Checked Flu sickness in Therapists.	Yes Yes Yes
George Earle closed 7/4/2020 and IP&C opened ward on 11/4/2020. Management opened ward 14/4/2020 due to Covid 19	Enhanced cleaning, HPV of vacated areas and COVID19 swabs of all patients on George Earle and all staff who had worked there from 1/4/2020 to 7/4/2020 Requests were made that the G. Earle staff did not work in Green areas until 16/4/2020. Any staff that were tested positive were advised to self-isolate and only return to work on 16/4/2020, if well and afebrile for 48hours. The whole of G Earle was deep cleaned and re-opened on 14/4/2020 (could have opened on 11/4/2020 but management decided to keep it closed). Patient information leaflets on COVID19 were given to patients and a copy was sent to relatives. An Occupational Health letter was sent to all staff being tested by the ward manager. Introduction of all staff wearing appropriate PPE in Green areas.	Yes Yes Yes Yes Yes Yes Yes

ICU was not closed to admissions in November 19. VRE isolated.	3 VRE so two cross infections and ICU Deep cleaned	Yes

COVID19

The first community Torbay COVID19 patients were diagnosed on 1/3/2020 and had returned from holiday in northern Italy and the subsequent PHE Containment screening led to the closure of two GP practices and one secondary school for around two weeks. All the COVID19 infected persons at this time were handled nationally being sent to High Consequence Infectious Diseases (HCID) sites across England.

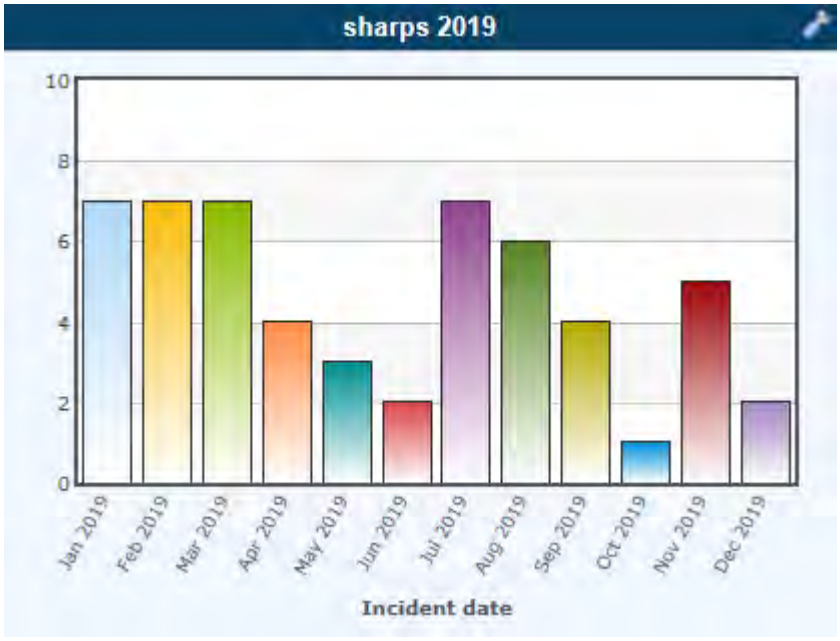
From around 9/3/2020 COVID19 positive patients were admitted to Torbay hospital to dedicated COVID19 (Red) wards. Eventually, the Acute Site COVIS Response Plan and Estimate was developed creating RED, AMBER and GREEN wards and clinical areas throughout Torbay hospital. By the end of Q4 2019/2020 Torbay microbiology had performed 822 COVID19 tests and there were 79 positive tests, of which 16 were Torbay hospital staff. Of the 63 in-patients who were COVID19 positive, 23 died. IP&CT worked well to meet the challenge of a new onset Pandemic that will occur every 100 years approx.

IP&CT worked closely with Community teams, PHE, Local Authority and CCG to assist with managing this Pandemic in the Community. Virtual ward rounds in Care homes as well as Care home visits were performed by the IPC&T.

5. Investigation of Sharps Injuries and Splash incidents

IP&CT partake in the Trust's Sharps Safety Group and the work includes introducing sharp safe peripheral cannulae for <2 yr olds in Paediatrics, continuing to upload training videos on to HIVE about using Sharp safe devices and ensuring that Non-sharp safe Risk assessments are completed. An external audit on sharps was performed by Becton Dickinson (BD) and results with action plans were feedback to the audited wards and A&E department.

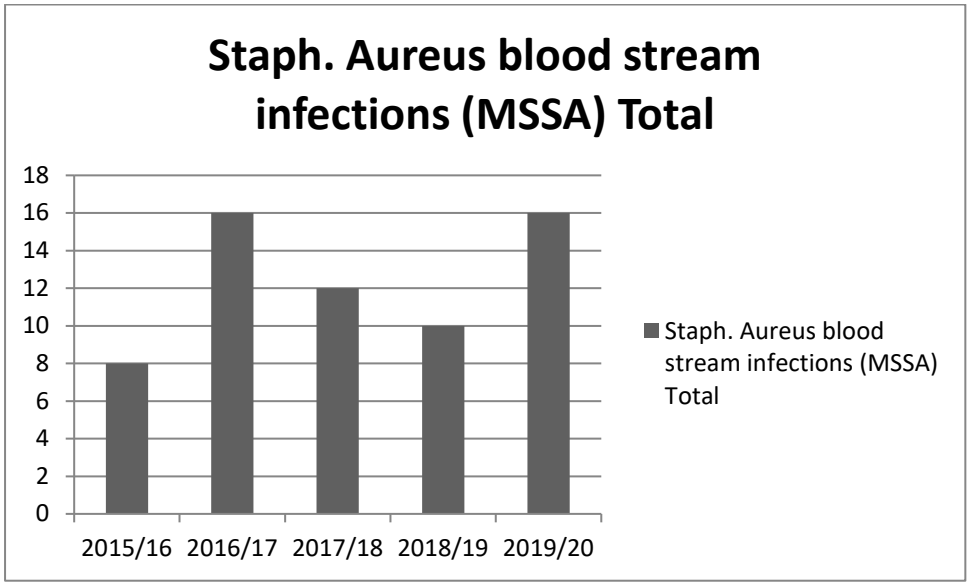
TSDFT Sharps injuries reported on Datix



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

There has been one, TSDFT acquired, MRSA bacteraemia and this was thought to be due to a collection contaminant because the patient had a severe skin condition and was known to be colonised with MRSA and at the time the blood cultures were taken the patient was well. Several hours later there was an acute abdominal event, not related to an MRSA BSI. There were no actions from the root cause analysis apart from checking the Coroner's report which showed a catastrophic bleed from a duodenal ulcer.

Staph. aureus Healthcare Acquired blood stream infections (MSSA) April 2015 to March 2020



The Staph aureus positive blood stream infections that occur 48 hours after a hospital admission all have a root cause analysis and the actions are reported every quarter at the Infection Prevention & Control Group Meeting. The increase in 2019/2020 was not due to any single factor, two were on Turner and related to CVCs, one patient was post-op after an aneurysm repair, one patient was admitted with a pressure sore, two patients had endocarditis, one was related to a peripheral cannula, one related to an ascitic drain and for the others the source was unclear.

7. *E. coli* blood stream infections (BSI) and Antibiotic Resistance

E.coli BSI Ambitions

From 1/4/2017 the HCAI Data Capture System run by PHE's Mandatory Surveillance Team produced baseline data for E coli blood BSI and set an ambitious target of halving the number of healthcare acquired E coli BSI, by 2024.

The TSDFT action plan to reduce E.coli blood stream infections included:

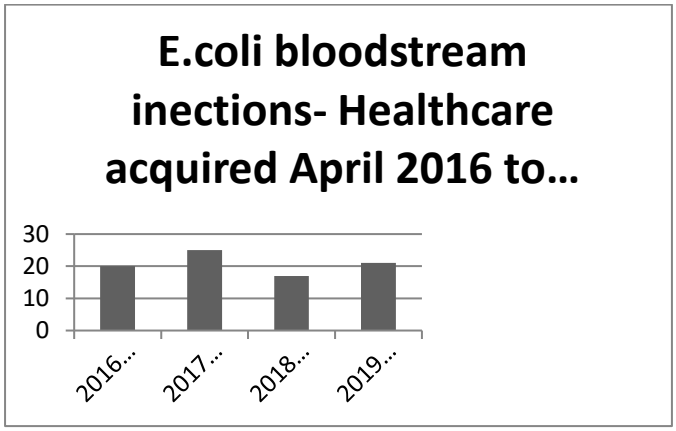
- Participating in the CQUIN 2019/2020 CCG 1b: Improving appropriate antibiotic prophylaxis for elective colorectal surgery in adults – Q1 to Q3 = 100%
- CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People – Q1=10%, Q2=38%, Q3=67%.

The DIPC has escalated to TSDFT Management the need for a Torbay hospital Continence Advisor and has joined the TSDFT Hydration Group because these are the Drivers set by the Devon IP&C Forum.

IP&CT review of case notes of all TSDFT E. coli, Klebsiella and Pseudomonas aeruginosa BSIs that are HCAIs and set actions, if required, which are entered onto Datix.

This year the Intensive Care Unit (ICU) has joined the PHE's Infection in Critical Care Quality Improvement Programme (ICCQIP) of surveillance of BSIs on ICU and this will be a useful benchmarking exercise for future use.

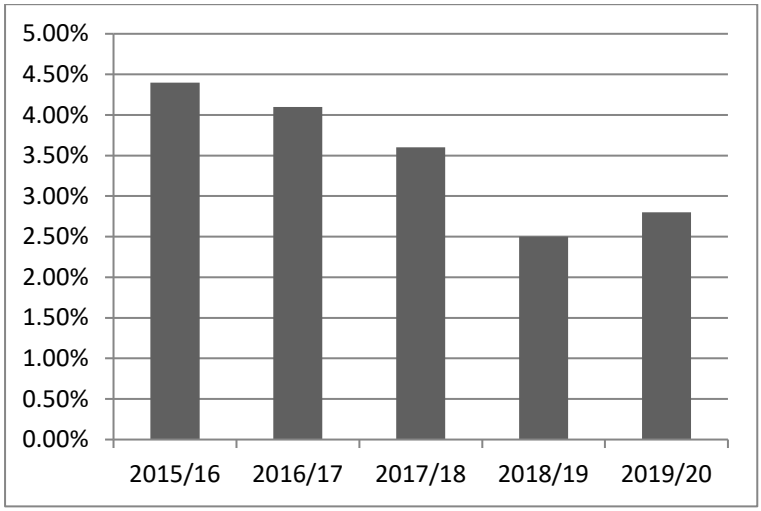
E.coli bloodstream infections- Healthcare acquired April 2016 to March 2020



Antibiotic Resistance

Extended Spectrum Beta-Lactamase (ESBL) producing *Escherichiae coli* bacteria in blood cultures are one of the markers of antibiotic resistance in bacteria. Below the graph shows the total rate of ESBLs in blood cultures most of the E. coli BSI are from admissions from the community. In the UK, the Surveillance Atlas of Infectious Diseases reports the level of E. coli ESBLs in 2016 to be 9.2%.

ESBL producing E.coli blood stream infections. April 2015 March 2020



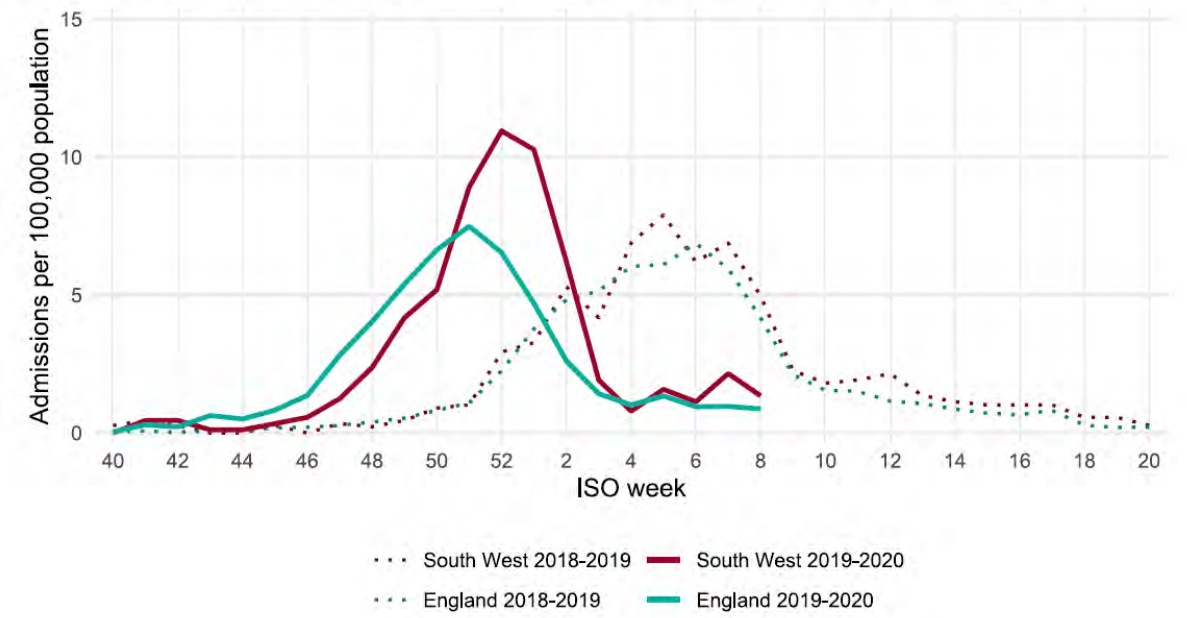
Carbapenemase Producing Enterobacteriaciae (CPE) are bacteria that have resistance mechanisms against the third-line antibiotics. This means that if a patient develops a serious infection with a CPE then treatment is likely to be sub-optimal. In 2019/20 there was zero CPE acquired at TSDFT.

8. Seasonal Influenza

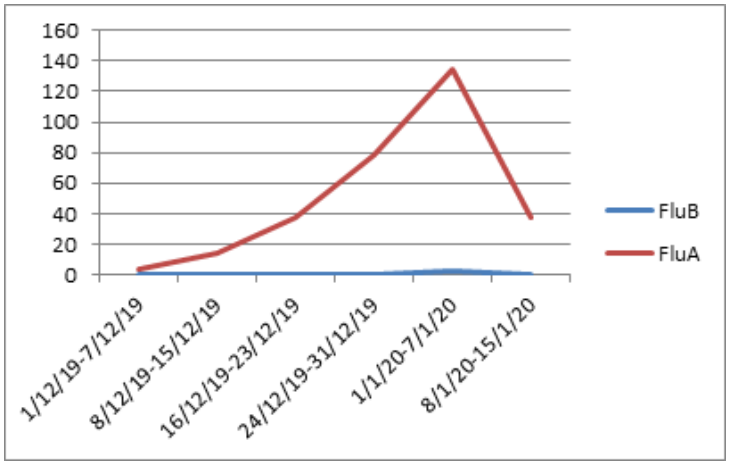
From 1/12/19 to 30/3/2020 we had 305 positive Flu A tests and 11 positive Flu B tests. Compared with 2018/19 where we had 520 positive Flu A tests. Of the 316 positive Flu A tests around 65% were admitted.

Severity - four patients were admitted to ICU, none required transfer for ECMO. The 2019/20 Flu season is summarised by PHEs data see graph below and by TSDFT's graph of FluA cases below.

Figure 3. Hospital admissions with confirmed influenza – USISS sentinel scheme



TSDFT FluA positive results 2019-20



Seasonal Influenza staff vaccination

For the 2019/20 Flu season, the year-end position was 69.7% of front-line staff vaccinated. The national CQUIN requirement was achieving a flu vaccination uptake of 80% frontline staff. The Exec sponsor appointed a Seasonal Flu vaccination lead who ran monthly meetings with managers and facilitated vaccination sessions and peer vaccinators. There were roving vaccinators this year.

9. Performance of Infection Control against Infection Control Key Performance Indicators for 2019/2020

The performance against the KPIs was poor in 2019/20 and the DIPC cannot ascribe this to any single cause. The MRSA BSI is probably a collection contaminant. The Staph aureus BSIs were from many different sources. The Hospital onset C. difficile has been redefined this year but there was a C.difficile outbreak. Most E.coli BSIs are related to the urinary tract but we have not had many related to urinary catheters.

Annual Programme of Work 2019/2020 TSDFT:		Action/ Leads	Planned Completion date	RAG rating & date made
1i MRSA Control & MRSA /MSSA blood stream infection	**KPI one– stay within CCG / DH Targets for MRSA bacteraemia (none)**	**DIPC**	**March 2020**	**Red Total =1**
	Internal KPI two- Reduce MSSA bacteraemias by 5% (no more than 9)	**DIPC**	**March 2020**	**Red total=16**
1ii C.difficile control	**KPI three – stay within CCG / DH Ambition for *C. difficile*** Ambition =36.	**All ICNs & DIPC**	**March 2020**	**Amber total=57**
1iii E. coli blood stream infection (BSI)	**CCG/DH Ambition to Reduce E coli BSI by 50% by 2024** **(Baseline 2016/17 =24)**	**All ICNs & DIPC**	**March 2020**	**Amber total =21**
2 Saving Lives	Saving Lives Clinical Audits for Hand Hygiene (HH), Peripheral cannula care (PC), Central venous cannula care (CVC), Urinary catheter care (UC) must all score at least **95%** compliance within each calendar month. <u>All results after re-audit.</u> If compliance <95% a re-audit must be received by IP&C within 15 days. Antimicrobial prescribing aim to score at least **85%** compliance.	**All ICNs & DIPC** **Antimicrobial Team**	**March 2020** **March 2020**	HH=97% PC=96% CVC=97% UC=97% **Green Total=97%** **Amber Total 80%**
3 Norovirus	Reduce by 10%, the number of in-patients that acquire symptomatic Norovirus infection, from another in-patient.	**All ICNs & DIPC**	**March 2020**	**Green Total=30**

	Target= 10% reduction in target from 2018/19<70 (10% reduction from 76).			

10. Report on Community based IP&C Activity

The Community Services and Intermediate Care Services have been performing and submitting Hand Hygiene Audits, Saving Lives audits for peripheral cannula care, central venous cannula care and urinary catheter care and Saving Lives audits for urinary catheter insertion. Results are jointly reviewed by the ISU ADNPP, the Lead ICN and DIPC on a quarterly basis and if required Action Plans are set and followed up by the IP&CG Meeting, as required.

Domiciliary Care:
IP&C have requested data from some of the Providers on Annual Mandatory Infection Prevention & Control Training, results of Field Checks, Spot Checks and Observations on Hand Hygiene. In future the IP&CT will liaise with the Torbay Quality Assurance & Improvement Team (QAIT) and provide IP&C support for those that require it.

Care/nursing homes:
The IP&CT have visited and advised on Care homes that have had concerns raised by CQC or QAIT. This has been a constructive exercise and will continue as part of the Devon Infection Prevention and Control Management Team which has been funded by the CCG to deliver support to community and primary care as part of a service level agreement to prevent and respond to infections in Care homes and Domiciliary care. Funding has been released by the CCG to increase staffing to allow this to continue/expand and will include outbreak management, education and audit. Outbreak management will hopefully allow the homes to open more quickly and ensure good communications between secondary and primary care

11. Antimicrobial Stewardship

The prescribing policy is documented in CG1098. Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) and paediatrics (CG1118) on the Trust intranet site and the Apple and Android App. Called BugBuster3000. The Antimicrobial Team (AMT) consists of a Consultant microbiologist and an Antimicrobial Pharmacist.

The AMT performs Antimicrobial Saving Lives audits for five areas (allergy status recorded, appropriate cultures taken before antibiotics, indication given, duration specified & evidence of review) on all in-patient wards every month. These results are fedback to teams each month and reported to the IP&CG Meeting as part of the Saving Lives reports. In addition the ISUs have been requested to exception report at their governance meetings and the DIPC will be checking that this is occurring.

The AMT's Antimicrobial Stewardship 6-Month Plan: October 2019 – March 2020

Objective	Completion
Establish a system for surveillance of antimicrobial resistance: • Create Path Manager queries to monitor local resistance rates • Calculate local resistance rates for antimicrobials in current guidelines and monitor quarterly	31 Dec 2019
Review Trust antibiotic guidelines: • Review local antimicrobial resistance rates • Literature search and review of evidence re efficacy and safety of antimicrobial • Ensure optimisation of dose and duration • Ensure compliance with NICE prescribing guidelines and document the reason for any exceptions • Aim to reduce selection pressure for multi-drug resistant organisms	30 Mar 2020
Reinstate monthly antimicrobial audits: • Feed results back to ward teams • Identify any areas that require improvement and work with clinical teams to improve results	30 Nov 2020
Horizon scanning: • Maintain awareness of new antimicrobials in Stage II and III trials • Evaluate need for bringing new agents on to the formulary and guidelines	Ongoing
Investigate alternative platforms to Bug Buster for hosting Trust guidelines	30 Mar 2019 implement Q2 2020
Complete annual report at end of financial year	30 Mar 2019

PHE's Fingertips database is a benchmarking tool but it's weakness is that there is no Age Adjustment and Torbay has an elderly population so will always be an outlier.

Benchmarking: TSDFT/ PHE's Fingertips 2019/20 dataset (Not Age Adjusted)

Indicator (rate per 1000 admissions)	TSDFT	England same Trust type	Comment on Benchmark
Total antibiotic prescribing DDDs	4,746	4,798	Green
Carbapenem prescribing DDDs	76	67	Amber

For E coli blood stream infection (BSI) resistance data, from admissions from the Community and from TSDFT, only 2.8% (2.5% in 2018/19) were Extended Spectrum Beta-Lactamase producers (see graph in section 7 on E coli BSI). TSDFT used a combination of Tazocin and Gentamicin antibiotics to treat septic patients so we monitor resistance rates in E coli BSI's. Only 0.7% (0.7% in 2018/19) of E coli were

resistant to both antibiotics, 6.8% (3.9% in 2018/19) were resistant to Tazocin alone and 8.0% (6.3% in 2018/19) were resistant to gentamicin alone.

12. Decontamination

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

The Hospital Sterilization & Decontamination Unit's (HSDU) Washer Disinfectors and Sterilisers for surgical instruments have all servicing and testing up to date. The Reverse Osmosis Water Systems that supply the Washer Disinfectors and Sterilisers are also serviced and satisfactory. The HSDU have an annual compliance audit carried out by a Notified Body called SGS (Societe Generale de Surveillance), appointed on behalf of the MHRA. The successful 2019/2020 audit shows that the HSDU continues to be accredited to the Medical Devices Directive 93/42/EEC and allows the department to continue to supply sterile medical devices outside of the Trust.

The Endoscopy Washer Disinfectors' (EWD) servicing and water tests are satisfactory. Endoscopy has a submitted a business case for EWD replacement. The annual audit and training for areas using the high level disinfection with the Tristel (chlorine dioxide) Tri-wipe and Tristel Duo Systems was trustwide and was satisfactory.

A Business Case for a centralised Medical Devices Library and a Centralised Decontamination area which will decontaminate hospital beds has been submitted.

13. Water Safety

Water Systems Management Group
This group meets every quarter to review water safety and ensure compliance with HBN 01-04 and this year has started to report to the Capital Infrastructure and Environment Group(CIEG). The Legionella water test results, Pseudomonas water test results, Flushing logs, Non-conformance reports and the ORCA copper and silver concentrations are reported to the Water Safety Group.
TSDFT has appointed Paul Carroll as the Authorised Water Engineer and he will update the TSDFT's Water and Hydrotherapy Pool Policies.

Pseudomonas testing of augmented care areas twice yearly did not reveal any sites positive for pseudomonas.

Legionella pneumophila serotype 1 has not been isolated in any water outlets this year.

The copper/silver ORCA system, at Torbay hospital, has been compliant for silver and copper ions in Q3. For Q1 & Q2 TSDFT requested actions from ProEconomy, the company that installed the ORCAs.

There have been numerous sewage leaks in the Tower block and a sewage pipe survey reveals that either a new sewage stack is required ot to re-configure sluices and a business case has been submitted. The Community hospitals have Water Safety commissioned to Churchills and the Zetasafe System is used to provide assurances to the IP&CG.

The trust-wide Legionella Risk Audit was completed in November 2018 by Healthy Buildings International and all results and the non-compliances have been resolved by Estates but there are some were the risks of remediation are too high.

14. Critical Ventilation

Critical ventilation is required to prevent healthcare acquired infection and is a vital part of patient safety.

Ultra clean air theatres require engineering checks twice a year and all other specialist ventilation require annual engineering checks.
All areas have passed except Main Recovery.

Theatres 1&2 have old air handling units and this is on the Estates Risk Register as 25 with a planned replacement.

This year the Special theatres were upgraded with a new vertical AHU and both theatres have ultra-clean air and a plan to reduce the 52-week waiting list is underway.

The Day Surgery Recovery had the air handling unit replaced and this year.

15. Surveillance & Audits

Infection Prevention Society (IPS) Audits
The IP&CT perform these audits every 3 years in over fifty wards/departments/hospitals and Community nurses. The actions that are derived from these audits are divided into those for the Ward Manager, Estates and Hotel Services.

The IP&CT checks that all the outstanding actions have been completed by liaising with ADNPPs, Matrons, Ward Managers, Estates and Hotel Services.

Most of the outstanding actions are due to insufficient capital to repair the estate or replace worn equipment.

The Community Dental Services at Castle Circus and Albany Road are audited by the Dental team and assurances are sent to IP&C.

Monthly Saving Lives Audits & Hand Hygiene Audits

The IP&CT perform these audits for Care of Peripherally Inserted Cannulae, Care of Centrally Inserted Catheters and Care of Urinary Catheters. The results are emailed

to the Ward Managers, Matrons, AND/PPs and Consultants, the pass score is 95% and the results are displayed on the ward dashboards outside each ward. When a pass is not achieved the Ward manager is to repeat the audit within 15 days. All results are displayed on ICON at the IP&C site. The re-audit of Saving Lives when 95% is not reached has become a KPI on the Annual Forward Programme and the results are put on the ward quality performance tool called QuESST.

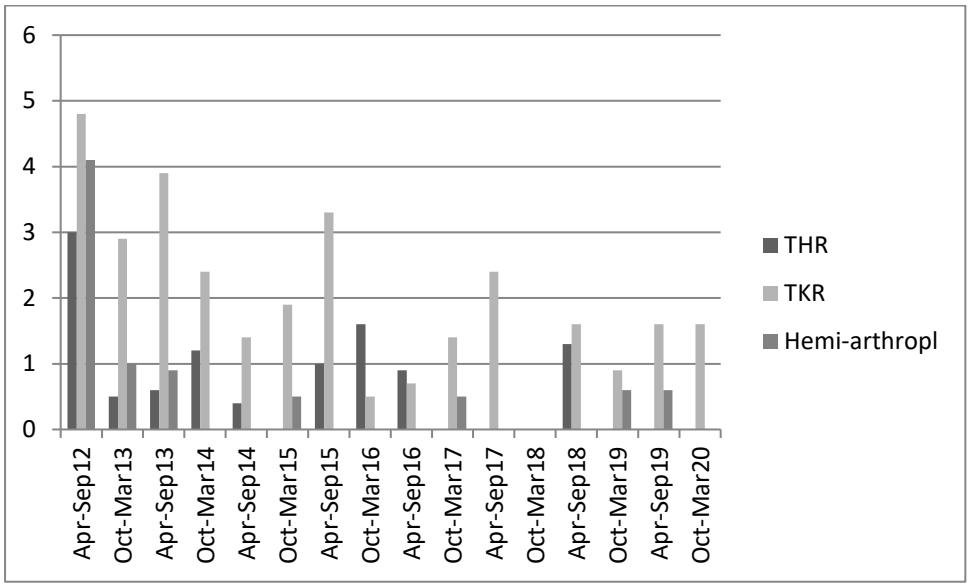
Surgical Site Infection Surveillance (SSIS)

The national surveillance is run by PHE and every year it is compulsory to do total hip replacement (THR) and total knee replacement (TKR) SSIS. This is only done for a 3 month period and the post-discharge surveillance is only 3 months when it should be a year. For this reason IP&C work with T&O and run a Lab-based ward SSIS using internationally recognised definitions and post-discharge surveillance for a year. The results from 2015 to 2020 can be seen below and for THRs, TKRs and fracture neck of femur internal fixations called hemi-arthroplasties, the infection rates should be <1%.

National SSIS data from PHE

Date SSIS done	TSDFT infection rate	National infection rate
TKR Oct-Dec 2019	0%	0.3%
THR April-June 2019	0%	0.4%

TSDFT Lab-based ward SSIS for Orthopaedics April 2015 to March 2020



Getting It Right First Time (GIRFT)

The IP&CT and the Matron for Trauma and Orthopaedics (T&O) meet weekly on Ainslie & Ella Rowcroft wards to check compliance against the TSDFT's T&O ring fencing Policy G 1681 each week and send a compliance report to Operations and the T&O Department. For 2019/2020 Caesarean Section GIRFT was performed instead of the PHE's SSIS.

Peripherally Inserted Central Catheter (PICC) Surveillance

Peripherally Inserted Central Catheters (PICCs) are used when centrally placed venous access is required. Surveillance of central venous catheter (CVC) infection, provides assurance that staff and patient training, competency, equipment and follow-up care are all in place and functioning well. Central line–associated bloodstream infection (CLABSI) is a term used only for surveillance purposes to identify blood stream infections that occur in the population at risk (patients with central lines).

Our CLABSI rate in 2019, in Haem/ Oncol is 0.7 and in General patients is 1.2 and this is satisfactory.
In general a CLABSI rate of <2 per 1,000 Device days is the benchmark to be achieved.

This data is fed back to the VAT team and ISUs via the Infection Prevention & Control Group.

Results are divided into General and Haem/Oncol specialities and summarised below.

	General	Haem/Oncol
2015/16	0	0
2016/17	0.6	1.0
2017/18	0	0
2019/2020	1.2	0.7

Hand Hygiene Wipes for Patients after using a Commode July 2019

To reduce Gram negative blood stream infections (eg. E coli) it is important that patients' hands are cleaned after toileting. The Clinell single-use hand wipes and dispensers were introduced in 2016 and this is an audit to check compliance. From the results the action plan below was sent to Matrons.

Action plan to improve Hand Hygiene Wipes for Patients after using a Commode

Issue	Action	Whom	When
No hand wipes dispensers on the wards at Brixham & Dawlish community hospital	Hand wipes dispensers to be taken to Brixham & Dawlish community hospital by IP&C team on next visit	IP&C team	31st July 2019
	Hand wipes dispenser to be put on the wall by the estates team	Ward manager to contact estates	August 2019
Patients stated that they did not have hand hygiene offered to	Email Ward Managers on Cheetham Hill & Aisnlie to remind	IP&C team	24th July 2019

them after using the commode/toilet	staff to offer hand hygiene to patients after commode use.		

Isolation Audit Results May 2019 Aims &Objectives

Infection Prevention & Control Team (IP&CT) undertook an audit of the in-patient isolation facilities:
Reasons for isolation
Cleaning of Side Rooms (SR)
Availability & use of Personal protective equipment (PPE)
Door Closure
Correct signage
Number of siderooms in the ICO
Total number of SRs in the TRUST = 142
Total Number of SRs audited = 101

Reason for isolation; Cleaning; PPE Availability & use

ISU	SR occupation for isolation	Patients in bays requiring isolation	SR Cleaning	Availability & Use PPE
Torquay	20%	0	100%	100%
Paignton & Brixham	82%	0	100%	82%
Newton Abbot	48%	1	44%	100%
Coastal	68%	1	88%	95%
Moor to Sea	27%	0	100%	100%
Total	49%	2	86%	95%

Isolation Room Action Plan and To be Re-audited in May 2020

Action	**By When**	**By Whom**
Report isolation audit results & actions at IP&C group.	28/11/2019	IP&CT
Determine exactly which side rooms require auditing (i.e. only SRMs required for isolation or all SRMs regardless of use) and adjust the Isolation Audit Tool accordingly.	April 2020	IP&CT
Separate provision of PPE and appropriate use of PPE in the isolation audit tool	April 2020	IP&CT
Paignton/Brixham SDU – Warrington, Midgley, Turner need to improve compliance with keeping isolation doors shut. Midgley need to have masks available when appropriate.	Results fed back at audit. November 19	Ward Managers/ Staff
Newton Abbot SDU – Teign, Templar, EAU 3&4 need to improve compliance with keeping isolation doors shut. Templar, EAU3&4 to improve compliance with correct door signage.	Results fed back at audit November 19	Ward Managers/ Staff

ICU, EAU4 need to improve compliance with side room cleaning. Templar had 1 patient who need isolation		
Coastal SDU – Allerton to improve door closure compliance. Allerton need to improve compliance with correct door signage. Allerton, Cromie to improve compliance with side room cleaning. Ainslie had1 patient who needed isolating in a bay. Allerton need to improve compliance with use and disposal of PPE	Results fed back at time of each audit November 19	Ward Manager/ Staff
Moor to Sea SDU - George Earle, Simpson need to improve compliance with keeping isolation doors shut. Cheetham Hill to improve compliance with correct door signage	Results fed back at audit November 19	Ward Manager/ Staff

Community Acquired E coli Blood Stream Infection (BSI) Audit for July 2019

The audit was done to identify risk factors and find out if patients with a community acquired / onset E coli BSI experienced a delay in review by GP's just prior to admission.

Results

16 patients were identified as E coli positive in a blood culture within 48hrs of admission, compared with 21 in July 2018 (24% reduction).
Symptoms of the E.coli BSI came on within 24 hours.
42% were over 80 years old and most had a history of urinary tract infections and the rest a history of cholecystitis.
Of the six patients who contacted their GP, for two the GP called an ambulance, three were given antibiotics (correct prescribing in all three) and one was given no advice.
In conclusion there were no obvious factors that we could target to reduce community E. coli BSIs apart from the recognised issues of hydration and continence advice in the elderly.

16. Estates and Facilities (from CIEG meeting April 2020)

COVID-19 works and activity has been the priority for the EFM Operational teams. The global COVID-19 Pandemic has seen a rapid increase in cases in the UK and EFM has been at the forefront of delivering the infrastructure to support the Trust in repurposing of the ED, wards, Outpatients areas and Community sites to accommodate a potential surge of cases. In brief, during the latter end of February and throughout March, all elective clinical activity was scaled back and the ED department was reconfigured into Red (COVID-19 Positive) and Green (Non-COVID-19) areas, occupying Day Surgery and Level 3 Eye Surgery areas. The Level 2 Outpatients area has become a Red Discharge Lounge, the Tower Block wards have been subdivided to provide COVID-19 bays, the General Theatres Recovery Area into a Green ICU, with the main ICU being designated as the RED ICU, Special Theatres A+B have been prepared to become extra ICU beds, and the

Hetherington Block and the Old Hospital wards have been scoped to receive additional COVID-19 patients if required. Associated assessment pods, Donning and Doffing areas, road and door accesses have also prepared and numerous reception area screens have been built. In the Community settings, Brixham, Dawlish and Totnes Hospitals have been assessed for receiving additional COVID-19 patients. The MGPS has been fully tested to identify any potential limitations in the oxygen supply system's ability to provide the expected demand for Ventilators, CPAPs and other oxygen therapy systems required to treat the more serious COVID-19 Patients.

A great deal of work has been undertaken by the Facilities Team, including rescheduling cleaning, portering and waste teams, training staff in new cleaning and other FM procedures in COVID-19 areas, providing food and drinks to staff and generally extending the hours of all services to ensure the Trust's response to COVID-19 is adequately supported. A dramatic increase in consumption of scrubs across the Trust clinical sites during the COVID-19 outbreak has been a continuing challenge for the FM Teams.

17. PHE's Fingertips Benchmarking data for TSDFT.

PHE has uploaded national data to facilitate benchmarking across AMR local indicators. These are publically available data intended to raise awareness of antibiotic prescribing, AMR, HCAI, IPC and AMS; and to facilitate the development of local action plans.

The Annual results are a year behind and listed below for information.
The PHE data is not adjusted for population demographics so will not take into account the elderly population that we have.

The DIPC has requested that PHE check TSDFT's denominator data because PHE Fingertips has an out of date Denominator for Torbay & South Devon trust (TSDFT) that is too small and leading to high infection rates on Fingertips.

A MESS datasheet from 2012/13 gives a denominator of **124,446.**
The Fingertips datasheet for rolling annual average to Oct19 gives a denominator of **119,330.**

Around **2016/17** TSDFT became an ICO, where the Community hospitals joined the acute trust and the **beds increased to 547 (about an extra 130 beds**).
From 2018/19 all the C difficile cases from the Community hospitals were reported as part of TSDFT Acute hospital and not as part of the CCG anymore.
This is why the DIPC has concerns that the PHE's Fingertips Denominator data is currently incorrect.

The PHE's Head of Team & Consultant Epidemiologist replied:
I would additionally note on the area profile page it currently appears the Trust has high rates of E. coli, Klebsiella spp. and MSSA bacteraemia indicators, which may suggest a common issue related to the denominator. TSDFT awaits a final decision from PHE.

Benchmarking: TSDFT/ PHE's Fingertips 2019/20 dataset (not corrected for Population age)

Indicator (rate per 100,000 beddays)	TSDFT	SW same Trust type	Comment on Benchmark
E. coli BSI	27.9	23.9	Amber
Klebsiella BSI	13.5	8.1	Red
Pseudomonas BSI	2.5	2.8	Green
MRSA BSI	0.8	0.3	Red
MSSA BSI	15.2	8.1	Red
C. difficile infection	27	14.2	Red
PLACE Cleanliness score	1.0	0.98	Green

Key: BSI= bloodstream infection, MRSA= Meticillin Resistant Staph aureus, MSSA= Meticillin Sensitive Staph aureus.

18. IP&C KPIs & Annual Forward Plan 2020/21

Key Performance Indicators (KPIs) 2020/21

1.	Comply with DHs: MRSA blood stream infection & NHSI's new Healthcare onset healthcare associated & Community onset healthcare associated Clostridium difficile targets & the CCG's E. coli blood stream infection ambition.
2.	Saving Lives Clinical Audits for Hand Hygiene, Peripheral cannula care, Central venous cannula care, Urinary catheter care must all score at least **95%** compliance within each calendar month. If compliance <95% a re-audit must be received by IP&C within 15 days. Antimicrobial prescribing aim to score at least **85%** compliance.
3.	Ensure that the number of in-patients that acquire symptomatic Norovirus infection, from another in-patient does not exceed 70.

Annual Forward Plan 2020/21 are responsibilities for Localities & monitored by the Infection Prevention & Control Group (IP&CG)

1	Ensure IP&CT has staffing to complete the new CCG lead Community responsibilities in Care homes, Primary Care and Domiciliary care. Ensure TSDFT has a DIPC that Chairs the IP&CG and that Terms of Reference for this Group are updated with the new Trust Matrix Management structure. Meetings - attending those approved by CN, DIPC & Lead IP&CN, instigating, providing reports and obtaining assurances *Health & Social Care Act 2008 Code of Practice Criterion 1.*

2	Environmental risks to Infection, Prevention and Control identified and request that Localities place them on their Risk Registers. Cleaning non-compliance entered on Datix and reviewed at Environment Group Escalate Red Flag cleaning non-compliance to Capital Infrastructure and Environment Group (CIEG) Chaired by Head of Estates. Care homes used for Intermediate Care and have a CQC Requires Improvement Notice, will be supported by the IP&CT. *Health & Social Care Act 2008 Code of Practice Criterion 2*
3	Assurance on Water Safety obtained from the Water Safety Group. Water Safety Group outputs monitored by CIEG. *Health & Social Care Act 2008 Code of Practice Criterion 2*
4	Assurance on Critical Ventilation obtained from Associate Director of Estates and Facilities Critical Ventilation outputs monitored by CIEG *Health & Social Care Act 2008 Code of Practice Criterion 2*
5	<u>Ensure compliance with the three KPIs for 2020/21:</u> MRSA Blood Stream Infection (BSI)=0 C difficile =36 E coli BSI= 50% reduction from 2016/17 (24) to 2024(12) Hand hygiene monthly audits =95% Peripheral cannula care audits =95% Central venous cannula care audits =95% Urinary catheter care audits =95% Antimicrobial prescribing audits =85% Norovirus HCAI <70 *Health & Social Care Act 2008 Code of Practice Criterions 3,4 & 6.*
6	Partake in PHE's National Surgical Site Infection Surveillance (SSIS) of Total Hip Replacements & Total Knee Replacements. And Targeted SSIS if required. In house PPE & Isolation audit-June20, Glove audit- March 21, CVC surveillance- March 21, Continuous Deep Orthopaedic SSIS- March 21, Patient hand hygiene after commode use March 21, monthly Diarrhoea/Vomit & Peripheral cannula audit, monthly Matrons' audits.

	After Action Reviews for venous cannula related blood stream infections, Staph aureus blood stream infections and HCAI due to Clostridium difficile. Casenote reviews of Gram negative blood stream infections. *Health & Social Care Act 2008 Code of Practice Criterion 3*
7	TSDFT IP&C Mandatory training >85% TSDFT IP&C Induction >99% Hotel Services Video mandatory training >85% Domiciliary Care Providers' IP&C Mandatory training >94% *Health & Social Care Act 2008 Code of Practice Criterion 5*
8	Safe patient placement in high risk areas and non-compliance is defined as >2 per calendar month/per ward. Safe patient placement in medium risk areas and non-compliance is defined as >3 pcm/per ward. After Action Reviews performed if non-compliant *Health & Social Care Act 2008 Code of Practice Criterion 7.* *Trust policies Isolation G0394, Seasonal influenza G2062, ER, HCU, Ainslie G1681*
9	Ensure that appropriate Seasonal influenza point of care testing is available. *Health & Social Care Act 2008 Code of Practice Criterion 8*
10	Ensure that all IP&C policies and IP&C patient information leaflets are up to date *Health & Social Care Act 2008 Code of Practice Criterion 9*
11	Review all Sharps and Splash injuries and ensure appropriate follow-up is instigated and escalate learning from the investigation to the Sharps Safety Group. *Health & Social Care Act 2008 Code of Practice Criterion 10*

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

Background

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

1. Strategic Objectives

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

2. Ambitions

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

3. External Reporting

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

Infection Prevention & Control Group Terms of Reference
Torbay and South Devon NHS Foundation Trust Infection Prevention and Control Group

Constitution and Terms of Reference

1. **Title**
The Committee shall be known as the Infection Prevention and Control Group (IPCG).

2. **Strategy**
To drive delivery of a Torbay and South Devon Infection Prevention and Control programme which follows the whole patient journey through the local health system.

Obtain Assurances from the TSDFT Localities that this is performed and report the findings and exceptions to the Quality Improvement Group then the Quality Assurance Committee then to the Trust Board.

3. **Function**

a. Send an Annual Infection Prevention & Control Report to the Board and set Annual Infection Prevention and Control Forward Plan.
b. Monitor progress against Annual Plan and escalate significant risks to the Trust Board.
c. Review national guidance and statutory changes, and take appropriate actions.
d. To receive infection prevention and control assurances (eg. from Associate Directors of Nursing and Professional Practice and where appropriate Associate Directors of Operations) and take / recommend appropriate actions. This includes;
    i. Audit and Surveillance
    ii. Incident reports
    iii. Root cause analyses
    iv. Training
    v. Estates issues
e. To receive assurances on Water Safety and Critical Ventilation from Estates.
f. To receive assurances from the Decontamination and Patient Environment Groups.
g. Monitoring the infection prevention and control Risk Register and escalating any unmanaged or exceptional risks to the Quality improvement Group and if required escalate to the Quality Assurance Committee.
h. Ensure there is a current Major Outbreak Plan as part of the health community contingency planning. Ensure that there are escalation processes in place as required eg. Increased Incidence meetings, etc.

4. Membership

The membership of the Infection Prevention and Control Group should include:-

a) Director of Infection Control and Prevention / Executive Lead
b) Lead Infection Control Nurses and or deputies
c) Non-Executive Director
d) Associate Directors of Nursing and Professional Practice or representative
e) Head of Operations
f) CCDC/ Public Health England or representative
g) Patient Safety Lead or representative
h) Representative Governor (service user)
i) Antimicrobial Lead Pharmacist
j) Director of Estates and Facilities or representative(s);

k) Quality & Safety representative from CCG

When required the following people will be invited

a) Decontamination Lead
b) Clinical Specialties
c) Information / Performance analyst
d) Care Quality Commission Lead
e) AHP Representative
f) Occupational Health Physician or Nurse
g) Clinical Site Manager
h) Others as appropriate

5. Frequency of Meeting

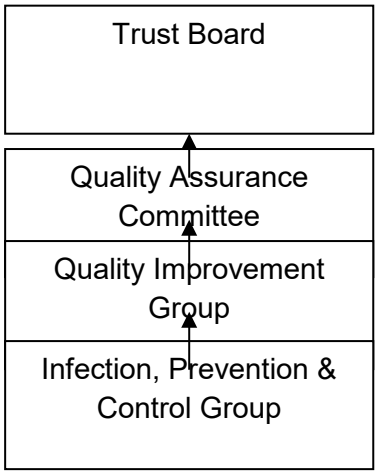
The meetings are quarterly.

For the committee to be quorate 60%, must be present and include either a Director of Infection Prevention and Control / Executive Lead.

6. Distribution of minutes

Minutes will be distributed to members, Chair of Quality Improvement Group and invitees as appropriate.

7. Accountability Arrangements



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Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Supporting the Quality and Safety of Care in Care Homes during COVID-19			**Meeting date:** 27 May 2020
Report appendix	No Appendices		
Report sponsor	Chief Nurse		
Report author	System Director for Nursing and Professional Practice (Torbay)		
Report provenance	This report has been shared with the Care at Home Covid-19 cell.		
Purpose of the report and key issues for consideration/decision	This report is being presented to the Board to share the experience and learning of a COVID-19 outbreak in care homes and the collaborative system wide response		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To undertake a multi -agency Swartz round based on this experience.		

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**	

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

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

External standards affected by this report and associated risks

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

Report title: Supporting the Quality and Safety of Care in Care Homes during COVID-19		**Meeting date:** 27 May 2020
Report sponsor	Chief Nurse	
Report author	System Director for Nursing and Professional Practice (Torbay)	

1. Introduction

The purpose of the report is to provide the board with insight into the system wide partnership response mobilised during a COVID-19 out-break within a number of care homes. The aim was to ensure the ongoing quality and safety of care to residents was sustained at a time of extreme challenge.

The care homes across Torbay and South Devon are an integral part of our care provision across the system. In Devon there are 481 homes which include 86 care homes in Torbay and 62 in South Devon.

Care homes provide care to some of the frailest people in our local population. Many of these residents have complex, health and care needs that are best met within their own home. The model of mobilising a range of teams and services to support within the care homes at a time of significant challenge is an effective appropriate model to adopt. During the first phase of COVID-19 twenty homes have been affected to date which included a combination of residents and staff. Two homes experienced large out breaks which impacted on both staff and residents. In response the Integrated Care Organisation (ICO) with a number of partners across the system, including public health England NHS Devon Clinical Commissioning Group, General practice and Torbay local Authority, mobilised a range of support services and teams to meet the identified gaps promptly and effectively.

The ability to rapidly mobilise a team with the capacity and competence to complement the care home workforce resulted in a proportionate and appropriate response to mitigate the risk of temporary reduction to substantive staff, capacity and competence to meet the changed presenting health and care needs of residents due to COVID-19, manage social isolation and social distancing and sustain quality and safety of care. The outbreaks were well managed and spread of covid-19 infection was limited.

2. Discussion

The risk to delivering high quality care due to a covid-19 out- break in a care home and the urgent action to mitigate the risk has resulted in significant learning. From this learning a suite of measures and resources have been enhanced or developed that can be mobilised effectively within a supportive framework.

2.1 Care Home Proactive Support Package

Through collaboration a proactive support package has been developed for our care home provision across both Torbay & South Devon, working closely with Torbay Council and Devon County Council colleagues to provide a co-ordinated and consistent process. This includes:

- Daily calls from the Quality Assurance Improvement Team (QAIT), Infection Prevention and Control Team (IPCT) & Community Service Managers (CSM) to all homes that have positive tested residents and/or staff.
- Twice weekly calls to all other homes.
- Daily calls with CSM's, Associate Directors of Operations (ADO), QAIT and IPCT to review all care homes with a current outbreak or who are awaiting swab results, to implement and review a plan for support.
- Swab process that runs in tandem with the Public Health England process for all symptomatic residents and staff in care homes, domiciliary care agencies, supportive living and those in the community awaiting placement in a care home or admission to Rowcroft hospice. Swabs collected by the community health and well- being teams, couriered to Torbay laboratory, and results processed and home informed within 24 hours.
- The community nursing team in -reach to review all the residents' clinical presentation to identify any symptomatic patients and advises and supports on the correct use of Personal Protective Equipment (PPE). The staffing and existing management structure is also reviewed to ensure the safe delivery of care is given to residents by familiar staff who can identify any changes in the residents' presentation. Any concerns are highlighted to the Community Service Manager and escalated if appropriate or managed at a locality level.
- IPCT offer each home with an outbreak a virtual walk-round to offer advice on handwashing facilities, PPE use (including donning and doffing areas), managing the environment and co-horting residents where necessary, training and signposting to further guidance.
- Weekly newsletters go to care homes, which includes any new guidance, advice and training materials.
- PPE provision is managed through a request system via QAIT, with the use of volunteer drivers if the homes are unable to collect the same day when required.
- Implementation of volunteers who are supporting homes who have requested, to help with 1:1 support with people who are purposefully walking, maintaining contact with loved ones unable to visit, restocking and preparing PPE in the home, making drinks and helping with meal times for those who are isolated in their rooms.
- Clinical support which includes a bespoke response based on residents needs including general practitioner medical reviews , registered nurses and support workers undertaking shifts within homes with substantive staffing gaps, social workers and leadership where required.
- Ancillary support including enhanced cleaning and catering support where required

The paper outlines the learning and the suite of resources that have been developed from this experience. A comprehensive multi agency action plan is formulated to centrally coordinate the response and manage the mitigating actions and progress. As we move forward within the COVID-19 pandemic the suite of resources can be operationalised to support care homes and adopt an early proportionate response, mobilising system wide partners and focusing on our collective responsibility that continuity of safe quality care within care homes is sustained.

In addition to the above, a plan has been written which describes how we will support care homes over and above that described in our proactive process. The plan describes a step approach to cover all stages of outbreak management, as well as market failure for one or more homes in our area.

2.2 Implementation of Enhanced health in Care Homes (EHCH)

The Enhanced Health in Care homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents their family and care home staff. The model consists of seven key elements:

- Enhanced primary and community care support
- Multidisciplinary Team support including coordinated health and social care
- Falls prevention, reablement and rehabilitation including strength and balance
- Palliative and end of life care
- Joined up commissioning and collaboration between health and social care
- Workforce development
- Data, Information Technology and Technology

Fully embedding the model can only be achieved through collaborative system wide working between primary care, local authority, community services, voluntary sector , care homes and Clinical Commissioning Group . The implementation of EHCH forms part of the NHS Long Term plan (2019), the NHS standard contract for community and mental health and Primary Care Networks via the direct enhanced service for 2020/21. The Government ambition is to have full implementation by 2024.

Covid-19 has necessitated an increased focus on this work including the NHS England and NHS Improvement publication on 1 May “COVID-19 response : Primary and community health support care home residents.”

As an integrated organisation, there is an established EHCH delivery group formed in September 2019, which includes all stakeholders across the system. A launch in January 2020 provided an opportunity to show case work to date and consider as a system work streams for 2020/21. One of these work streams is the implementation of the RESTORE 2 tool within care homes.

Due to the focus on the demands of COVID-19 over the last three months the programme of work has paused but we are now reinstating the EHCH delivery group which includes rapid implementation of RESTORE 2.

RESTORE2 is an evidence based tool where care home and domiciliary care staff are trained to undertake vital signs of residents/clients with a change in their presentation that may indicate they are becoming unwell. These changes can then be reported to the GP, 111 or urgent response service and provides clarity on the status of the resident using recognised parameters and a consistent language. RESTORE2 will have specific benefits in supporting early recognition of potential covid-19 and enable an appropriate health and care response.

In partnership with the Academic Health Science Network, local authority, SW Care Managers Networks and Domiciliary Care providers’ pilot work has commenced to deliver this programme to care homes and domiciliary care providers across the foot print.

3. Conclusion

The experience and learning has facilitated the development of a range of resources and tools that can be effectively deployed across our system to support our partners within care homes should the need arise. A Schwartz round will be planned in the near future to enable reflection of the experience with colleagues. The implementation of RESTORE2 as part of the EHCH has been expedited as a key enabler to recognising and responding to changes in residents' health and care presentation and support early appropriate health and care response and intervention.

4. Recommendations

The Board is asked to note the content of the report.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Ethics Committee Terms of Reference			**Meeting date**:27/05/20
Report appendix	n/a		
Report sponsor	Ian Currie, Acting Medical Director		
Report author	Company Secretary		
Report provenance	Review by Ethics Committee		
Purpose of the report and key issues for consideration/decision	The Board approved the establishment of an Ethics Committee at its meeting on 29 April 2020. The Ethics Committee has developed a Terms of Reference that has been reviewed by the Committee and agreed for presentation to the Board for approval.		
Action required	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve the Ethics Committee Terms of Reference.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Torbay and South Devon
NHS Foundation Trust

ETHICS COMMITTEE

TERMS OF REFERENCE

Version:	**1.0**
Approved by:	**Ethics Committee**
Date approved:	**13 May 2020**
Approved by:	**Board of Directors**
Date approved:	**27 May 2020**
Date issued:	**27 May 2020**
Review date:	**April 2021**

ETHICS COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Ethics Committee ('the Committee').

1.2 The Committee will adhere to, and be cognisant of the Trust values at all times.

1.3 The Committee will be cognisant of the national ethical framework and guidance from appropriate and relevant bodies including but not limited to, GMC, RCN and BMA.

1.4 The Committee will abide by the Trust's principles that is to promote equality and work to address health inequalities and to improve access to all its services for those people who share a protected characteristic and those who do not.

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Trust Board ('Board'). Its constitution and terms of reference are subject to review and amendment by the Trust Board.

2.2 The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1 The Committee has been established as the forum to consider the Trust's overarching moral and ethical principles, in order to provide the best quality health care to its patients during the current Covid-19 pandemic and post-Covid-19.

3.2 The Committee will provide assurance to the Board of Directors that:

(i) appropriate ethical and moral reasoning is being applied to clinical decisions and novel treatments;
(ii) a framework to enable ethical decisions, to be made in accordance with the law and the principles of moral and natural justice, have been agreed; and

(iii) all patients are entitled to treatment with no arbitrary criteria being applied (such as those defined by the Equality Act as having protected characteristics) outside recognised clinical criteria and the realities of demands of the service.

3.3 In due course the Committee will function as an Ethics Committee for the Trust for continuing clinical and other matters.

4. Powers

4.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

4.2 The Committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

4.3 The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

4.4 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

4.5 The Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board.

4.6 Provided due care has been taken with the discharge of their duties, the Committee will be covered by the Trust with legal advice and liability insurance.

5. Duties and responsibilities

5.1 The Committee is empowered to seek assurance, raise concerns and make recommendations to the Board of Directors pertaining to the committee's role and duties.

5.2 The Committee will strive to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not, as set out in the Public Sector Equality Duty and the Equality Act 2010.

5.3 The duties and responsibilities of the Committee shall be:

5.3.1 To make recommendations to the Board of Directors in respect of ethical and moral reasoning when thresholds for treatment, ceilings or treatment or withdrawal of treatment needs to be implemented.

5.3.2 To oversee the work of the Clinical Ethics Advisory Panel ('Panel'), (once established) and approve their Terms of Reference.

5.3.3 To provide the Board of Directors with a summary of all cases/decisions made by the Panel.

5.3.4 To ratify guidelines for the escalation, ceiling of treatment and withdrawal of treatment for patients during the Covid-19 epidemic and to evidence that the guidelines are informed by the appropriate ethical and moral frameworks.

5.3.5 To consider requests by clinicians for the use of novel therapies using an evidence-based approach and to make recommendations to the Trust Medical Director or Deputy Medical Directors and Board of Directors, if appropriate.

5.3.6 To establish a clinically responsive committee to support clinicians when faced with an ethical or moral dilemma, or if making difficult clinical decisions where there are no existing clinical guidelines to refer to, or if there are specific reasons for going against existing or contradictory guidelines.

5.3.7 Where clinicians are used to making these decisions and they feel able to follow existing processes for escalating, imposing ceilings of treatment or withdrawing treatment there will be no expectation that the Panel will need to be consulted.

6. Membership and Attendance

6.1 Core membership shall be made up of the following:

- Acting Medical Director
- Deputy Medical Director
- Chief Nurse
- System Director of Nursing and Professional Practice
- Chaplaincy representative

6.2 The following shall attend in an advisory capacity:

- Medical Ethics Advisor
- Trust Chairman, Lay-Advisor
- Company Secretary, Governance Advisor

6.3 Members of the Committee shall be permitted to nominate a deputy to attend a meeting in their absence.

7. Chair

7.1 The Acting Medical Director shall act as Committee Chair. In their absence, Chief Nurse shall be appointed as acting Chair for the meeting.

8. Meeting Administration

8.1 The Committee shall be supported by the Company Secretary (or their nominee), whose duties in this respect will include:

(i) Issuing the meeting agenda and reports.
(ii) Keeping a record of decisions made.
(iii) Ensuring matters requiring notification to the Trust Board are actioned.

9. Quorum

9.1 The quorum necessary for the transaction of business shall be 3 members, of which the Acting Medical Director or Chief Nurse must be present.

9.2 Deputies shall count towards the quorum.

9.3 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

10. Frequency of Meetings

10.1 During Covid-19, the Committee shall meet on a fortnightly basis.

10.2 Post-Covid-19, the Committee shall revert to quarterly meetings.

11. Meetings

11.1 The agenda will be sent out to the Committee members at least three days prior to the meeting date, together with any other associated papers.

11.2 Urgent items may be raised under ‘any other business’.

11.3 Meetings, other than those regularly scheduled as above, shall be summoned by the Committee Secretary at the request of the Chair.

12. Reporting

12.1 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes shall be presented to the next meeting for approval.

12.2 An annual report will be presented by the Committee Chair to the Trust Board.

12.3 The Chair of the Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

13. Conduct of Meetings

13.1 Except as outlined above, meetings shall be conducted in accordance with the provisions of the Trust's Standing Orders.

14. Review

14.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

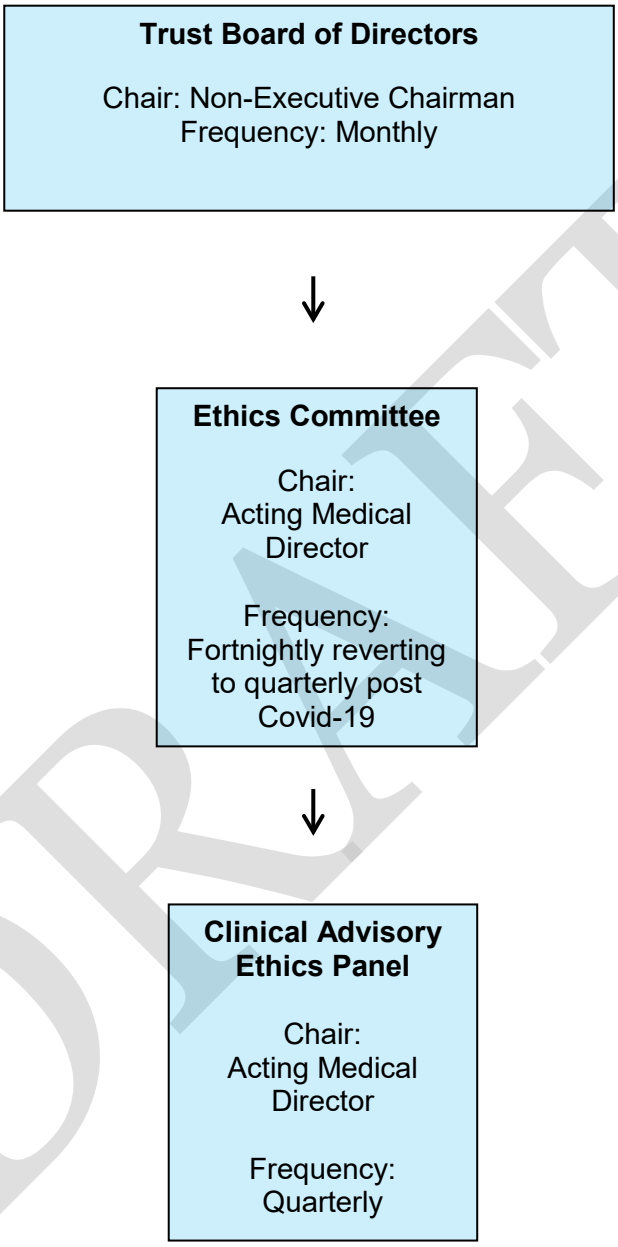
14.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

15. Monitoring Effectiveness

15.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will, once a year, lead an effectiveness review of the Committee. The following will be undertaken and reported to the next meeting of the Committee:

- the objectives set out in section 3 were fulfilled; and
- agenda and associated papers were distributed three days prior to the meeting taking place.

Appendix 1: Reporting Structure



Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	27th April 2020
Report by + date:	Chris Balch, 28th April 2020
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issues to highlight to the Board (Month 12, March 2020):

1. For assurance the Committee reviewed the Month 12 Financial Performance, which is a £24.45m deficit, which is £20.65m adverse to the full year plan of a £3.80m deficit.

2. The Trust's full year deficit is greater than the £15m forecast submitted to the regulator at Month 6. The additional adverse movement of £5.7m is due to debt write off of £2.2m, annual leave accrual of £2.0m, adoption of RICS guidance on depreciation of assets of £1.8m and positive and negative movement in income and expenditure.

3. The Trust has delivered £10.7m of an annual CIP target of £20m of which £3.7m are recurrent savings.

4. Full year capital expenditure was £17.31m which was £1.5m lower than forecast due in part to delays in supplies due to Covid 19.

5. For assurance the Committee was provided with information on both capital and revenue expenditure in incurred in responding to the Covid 19 emergency to the end of March as submitted to NHSI.

6. The Committee received information on financial planning for the first 4 months of 2020/21 which follows national guidance. This aims to enable the Trust to achieve a breakeven position. Uncertainty over the financial position during this period will reduce once figures for April are reported.

7. Financial planning and budgeting for the remaining 8 months of 2020/21 remains subject to uncertainty over the progression of Covid-19 and the timescale for the return to 'business as normal'.

8. The Committee reviewed the IPR which showed significant improvement in ED waiting times but an expected deterioration in referral to treatment targets, 52 week waits and diagnostic testing. These changes are largely consequential on the impact of Covid-19.

9. The Committee received a report on Treasury management which provided assurance on the management of cash held by the Trust. Currently cash reserves are in a strong position due to accelerated payments from commissioners.

10. The Committee were informed about changes in the funding of future capital investment which will be allocated through the STP and will consider the use of finance leases. This is giving rise to uncertainty over the size and scope of the Trust's programme for 2020/21, particularly in respect of cross year and prior commitments which total £14.79m. HIP2 and Wave 2 funding for 2020/21 of £3.12m and not affected by this new arrangement.

11. The Committee received updates to the Risk Register in respect of Covid-19.

12. The Committee noted the positive response of the HIS team to the Covid-19 emergency which has enabled business continuity and innovative ways of working. The lessons learnt will form an important input to the Digital Strategy work on which has been subject to delay.

13. Reports were received and noted on:

    - SDHIP's progress with proposals for Dartmouth and Teignmouth H&WCs
    - Torbay Pharmaceuticals financial performance
    - Health Care Innovations

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Chris Balch (Committee Chair)

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Report of the Finance, Performance and Digital Committee			**Meeting date**: 22 May 2020
Report appendix	n/a		
Report sponsor	Chris Balch, Committee Chair		
Report author	Company Secretary		
Report provenance	Reviewed by Finance, Performance and Digital Committee - 22 May 2020		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide assurance that the Finance, Performance and Digital Committee has carried out its obligations in accordance with its Terms of Reference. The report summarises the activities of the Committee from April 2019 to March 2020.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive and note the Annual Report of the Finance, Performance and Digital Committee.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

NHS
Torbay and South Devon
NHS Foundation Trust

FINANCE, PERFORMANCE AND DIGITAL COMMITTEE

ANNUAL REPORT

2019/20

1. INTRODUCTION

1.1 The Finance, Performance and Digital Committee (the 'Committee'), in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 This report covers the work the Committee has undertaken at the meetings held during 2019/20. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

1.3 The Committee has powers delegated to it by the Board to

(i) oversee, co-ordinate review and assess the financial, performance and digital management arrangements; including monitoring the delivery of the NHS Long Term Plan and supporting Annual Plan decisions on investment and business cases.
(ii) provide the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on the financial viability and sustainability of the Trust.
(iii) provide detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board.
(iv) assess and identify risks within the finance, performance and digital portfolio and escalating this as appropriate.
(v) make recommendations, as appropriate, on financial, performance and digital matters to the Board.
(vi) determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions as set out in the Trust's Standing Orders.
(vii) oversee the development of and approval of the Trust's medium term financial strategy
(viii) maintain a watching brief over the strategic direction of the Devon STP as informed by relevant national policy, and informing the Board of such.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to:

(i) advise the Board on all aspects of key performance, financial and investment issues to enable sound decision-making;
(ii) provide assurance in respect of financial, performance and digital related matters along with business planning; and
(iii) provide assurance that corrective action has been initiated and managed where gaps are identified in relation to financial, performance and digital risks.

1.5 The Committee Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This is includes the Deputy Director of Finance and others who may be required to attend as necessary.

2.1.2 Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation, specialist areas of expertise, attending Board of Directors and Council of Governors meetings, visiting services and talking to staff.

2.1.3 The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

2.1.4 Compliance with a number of the key responsibilities is evidenced by the following areas of work the Committee has received assurance on during 2019/20:

Financial performance

- Received and reviewed in detail the Financial Plan for 2019/20 looking at the key financial risks associated with the plan
- Received progress reports in regard to the development of the annual plan
- Reviewed in detail the financial performance reports at each meeting, noting the underlying deficit and consequential impact on the longer-term financial outlook
- Received the year-end financial out-turn prior to being reported to Board
- Received progress repots against the Trust's Cost Improvement Plan
- Received confirmation of the outcome of the reference costs

- Received assurance on the Trust's financial risk rating
- Received assurance on the Trust's agency spend and pay reports
- Reviewed the Trust's capital programme
- Received progress reports on the STP Long Term Plan
- Reviewed financial performance of the Trust's subsidiaries and business divisions
- Sought assurance as to the systems and processes in place for developing an action plan that will monitor the delivery of the Model Hospital findings
- Received the outputs and findings of the KPMG Review

Performance

- Reviewed the performance section of the integrated performance report at each meeting and reviewed assurance on the actions taken to improve performance related issues
- sought assurance on demand and capacity issues and compliance with national standards

Digital

- sought assurance on the Trust's approach to potential digital risks
- received assurance reports from the Information Management and Technology Group
- received digital related business cases for approval eg windows 10 and Children and Family Health Devon, desktop IT devices
- received bespoke reports to inform to Trust's Digital Strategy eg SIRIUS IT Report and Health Informatics Review
- received assurance on the development of the Trust's Digital Strategy
- received progress report on the Trust compliance with GDPR

Estates

- received reports and business cases relating to the Trust's estate eg sale of land at Yannons Farm, disposal of Bovey Tracey Hospital
- reviewed the Trust's proposals for health and wellbeing centres from a financial perspective and approved business cases eg Teignmouth Health and Wellbeing Centre

Governance

- received business cases for approval in accordance with the Trust's scheme of delegation and where appropriate recommended approval by the Board
- developed a programme of post implementation reviews and received reports on such

- received reports from the Trust's subsidiaries and business divisions ie Torbay Pharmaceuticals
- received risk register reports relating to the scope of work of the Committee
- received the Board Assurance Framework in relation to those risks pertaining to the scope of the Committee
- received reports from Groups reporting to the Committee
- developed a Committee workplan for the year
- reviewed the meetings cycle and agreed a change to the reporting timetable
- undertook a Committee effectiveness self-assessment
- reviewed the Committee's Terms of Reference

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF') in relation to those risks within the scope of the Committee.

3.2 The Committee review of the BAF focussed on finance, performance and digital related risks. Deep-dives in to specific risks were commissioned on a risk-based approach.

3.3 MEMBERS AND MEETINGS

3.3 During 2019/20, the Committee met on a monthly basis. The meetings were quorate all times.

3.4 A review of Non-Executive Directors portfolios took place in 2019. As a result, the Committee membership and chairmanship was reviewed and changed. Rob Sutton acted as Committee Chair until September 2019. Chris Balch

replaced Robin Sutton as Committee Chair in October 2019. Other Committee changes took place. Record of Committee attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Chris Balch (Chair part-year)	9 (12)
Robin Sutton (Chair part-year)	10 (12)
Vikki Matthews	4 (6)
Paul Richards	3 (6)
Sally Taylor	3 (6)
Jon Welch	2 (6)
Executive Directors	**Number of meetings attended**
Dawn Butler, Interim Director of Strategy and Partnerships	3 (3)
Paul Cooper, Director of Finance	3 (5)
Dave Killoran, Interim Director of Finance	4 (4)
Dave Stacey, Chief Finance Officer	3 (3)
Lesley Darke, Director of Estates and Commercial Development	7 (12)
John Harrison, Chief Operating Officer	11(12)
Adel Jones, Director of Transformation and Partnerships	7 (9)
Jane Viner, Chief Nurse	11 (12)

4.3 Senior management representatives also in regular attendance included – Deputy Director of Finance, Company Secretary and Corporate Governance Manager. A Governor observer was also in attendance.

5. COMMITTEE EFFECTIVENESS

5.1 In accordance with the Committee's terms of reference an annual assessment of committee effectiveness was undertaken to ensure continual improvement. Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2020/21 were reported to the Committee actioned accordingly.

6. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to formal submission to the Trust Board.

Chris Balch
Chair, Finance, Performance and Digital Committee
May 2020

Torbay and South Devon NHS
NHS Foundation Trust

Report of People Committee Chair to the Board of Directors

Meeting date:	27th April 2020
Report by:	Vikki Matthews
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☐
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☐ or Private ☒

Key issues to highlight to the Board:

- **COVID Risk** – the Committee reviewed risk 2772 , the overarching Covid workforce risk, and sought assurance in three areas that had been raised at the previous meeting relating to employee wellbeing, volunteers/returners and staff absence. For assurance to the Board, the Committee reviewed data which showed the following:
    a. The number of volunteers/returners now trained and placed in to roles at the Trust had risen from 2 to 49 since the last meeting and the DWFOD confirmed that the initial processing issues had now been resolved.
    b. The absence data showed that the numbers of Covid related absences had reduced from 845 to 745 at the time of the meeting (27/4) and that projections showed an ongoing decline
    c. The DWOD shared the work of the workforce cell and the Committee were assured that there is an appropriate focus on employee health and wellbeing during the Covid period

- **Communication** – whilst recognising a number of the issues relating to delivery that the Trust is having to deal with, there was also a sense that some of the great work and successes from the last few months may not have been fully communicated. Examples included the success of the volunteer programme, the work to induct and place NHS returners, the support provided to local Care Homes and the increase in Covid testing.

- **Workload** – the Board and the People Committee had previously raised concerns about the impact on frontline and support staff during the Covid pandemic. By way of assurance, a report was requested from the HR/OD team outlining the work that will be prioritised during this period and the work that will be hibernated. The Committee were content that the right priorities had been identified and received assurance from the DWOD that the workload for her team, as for the whole organisation, was under regular review.

- **Appraisals** – activity relating to annual appraisals has been stood down during the Covid period as part of the reprioritisation exercise. The Committee agreed with the decision but asked that feedback to staff continues via other channels.

Key decision(s)/recommendations made by the Committee:
[list any approvals made by the Committee here eg business cases, Regulator statements, report &a/c's]

1. Recommendation related to communication
2. Recommendation relating to appraisal feedback

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Report of the People Committee			**Meeting date**: 27 May 2020
Report appendix	n/a		
Report sponsor	Vikki Matthews, People Committee Chair		
Report author	Company Secretary		
Report provenance	Reviewed by People Committee 27 April 2020		
Purpose of the report and key issues for consideration/decision	In line with best practice, an annual report from the People Committee is presented setting out how the Committee has met its Terms of Reference. The report summarises the activities of the People Committee since it was established in October 2019 to March 2020.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Annual Report of the People Committee for the period from October 2019 to 31 March 2020.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Torbay and South Devon
NHS Foundation Trust

PEOPLE COMMITTEE ANNUAL REPORT

2019/20

1. INTRODUCTION

1.1 The People Committee was established as a Board sub-committee in October 2019 in response to the increasing focus on workforce issues and the publication by NHS Improvement of the NHS Interim People Plan in June 2019.

1.2 The Committee, in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.3 In establishing the committee and agreeing the Terms of Reference, the Committee was mindful of the breadth and scope of work. Accordingly, the Committee work programme was devised to enable sufficient depth of discussion relevant to each topic over the first year of its operation.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to provide assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, diversity and inclusion.

1.3 The purpose of this report is to provide assurance that the People Committee has carried out its obligations in accordance with its Terms of Reference.

1.4 This Annual Report summarises the activities of the Trust's People Committee ('the Committee') for the year 2019/20 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the People Committee has oversight for the Board:

- national workforce guidance and strategies
- People Plan and associated activity/implementation plan(s) to support Trust forward strategy
- key people and workforce performance metrics and targets for the Trust
- assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee
- effectiveness of staff communication and levels of staff engagement
- strategic people and workforce issues at national and local level

1.6 The Committee also acted as an early point of contact for the Freedom To Speak Up Guardian to raise concerns prior to reporting to Board and the Trust's Freedom to Speak up Guardian attends the Committee meetings.

1.7 The Chair escalates those matters that the People Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 Since the Committee was established in October 2019, the Committee has focussed on delivery of the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Review of the Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring.
- A deep-dive in to the 'Valuing our Workforce' section of the Board Assurance Framework.
- Received reports on progress against development of the Trust People Plan.
- Reviewed the Workforce information including pay and absence information.
- Reviewed talent management and succession planning arrangements.
- Received reports on the Workforce Transformation Programmes.
- Triangulated information to reconcile headcount and finance data.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting. This included progress against the Trust's people Plan, workforce dashboard information and a report brought by the Freedom to Speak Guardian.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF').

3.2 The Committee review of the BAF focussed on workforce related risks and included a deep-dive of the well-led section. Further deep-dives were commissioned on a risk-based approach.

3.3 The Committee's review of the Corporate Risk Register focussed on workforce related risks. A programme of deep-dives was delayed due to the constraints on management time following the onset of the Covid-19 Pandemic. This work is set to re-commence in 2020/21.

4. MEMBERS AND MEETINGS

4.1 During 2019/20, the Committee met formally on five occasions. The meetings were quorate all times.

4.2 All Non-Executive Directors (except the Chairman) are members of the Committee. Sally Taylor acted as Committee Chair. Record of their attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Vikki Matthews (Chair)	3 (3)
Chris Balch	3 (3)
Jon Welch	3 (3)
Executive Directors	**Number of meetings attended**
Judy Falcao	3 (3)
John Harrison	2 (3)
Jane Viner	1 (3)

4.3 Senior management representatives also in regular attendance included – Associate Directors of Workforce and OD, System Directors, Associate Directors of Nursing and Professional Practice, Freedom to Speak Up Guardian, Company Secretary and Corporate Governance Manager. A Governor observer was also in attendance.

5. COMMITTEE EFFECTIVENESS

5.1 The Committee will undertake an annual assessment, once it has been established and operating for 12 months to ensure continual improvement.

5.2 Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2020/21 will be reported to the People Committee in Q4 2020/21.

Vikki Matthews
Chair, People Committee
May 2020

Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting date:	13th May 2020
Report by + date:	Jacqui Lyttle, Committee Chair 14th May 2020
This report is for:	Information☐ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Board:

1. The committee received assurance from Investec that whilst our portfolio has seen a reduction in value, largely in UK equities, it is protected from further major exposure risk by the prudent disinvestment in the retail and hospitality sector.

2. The committee received assurance from Investec that they have sufficient delegated authority to manage our investment portfolio, in the current volatile economic environment.

3. The committee received assurance that our investment portfolio strategy did not require any adjustment and that the disciplined process of high-quality investment management by Investec was limiting our current and short-term risks.

4. The committee received a very detailed report on COVID related donations from the currently seconded donations manager. To date we have received £106k of COVID related donations £81k from NHS Charities Together (NHS CT) and £25k from the trusts Just Giving page. The committee were assured that these funds were being managed in accordance with normal Charity Commission requirements. Plans were in place to ensure that the donations are spent in line with the specific requirements of the donors with emphasis on the health and wellbeing of staff and patients.

5. The committee was assured that COVID donations are being managed according to current trust charitable funds procedures and compliant with SFIs albeit with a simplified procurement administrative process being introduced to expedite requisitions relating to COVID related funds.

6. The committee chair can confirm that there were no risks that needed escalating to the board

Key Decision(s)/Recommendations Made:

1. The COVID pandemic has highlighted the pressures on local food banks with many not having enough food to meet demand. This clearly has a detrimental impact on the health and wellbeing of our local population. As COVID donations continue to rise, the committee considered the risks of not being able to spend the specific donations received. To ensure that all COVID donation income is maximised the committee felt it was appropriate to have a new just giving button aimed at food banks on the trust website along site the existing one.

2. The committee should have considered the sale of £350k of investments in March but due to the advent of COVID this proposal was not considered. The committee were assured that whilst there is an ongoing need to sell investments to fund the spending down of accumulated fund balances, there was no need for any urgent sales due to the recent slowdown of expenditure and the proportion of the portfolio currently held in cash and less volatile investments such as government bonds. The committee agree to revisit the proposal at its next meeting in June.

3. The committee were informed that further donations were likely from NHS CT (they have only distributed 20% of funding received to date, with future tranches expected to be accessed by formal bids) and that there was a risk that without careful management and specific bid writing expertise the trust may not maximise its funding opportunities. The committee agreed to look to secure the expertise of a specialist bid writer.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Six Month Safer Staffing and Nursing Work Programme Review			**Meeting date:** 27 May 2020
Report appendix	None		
Report sponsor	Chief Nurse and Deputy Chief Executive		
Report author	System Director of Nursing and Professional Practice		
Report provenance	Executive Director Meeting Non-Medical Workforce Strategy group		
Purpose of the report and key issues for consideration/decision	This is the six monthly safer staffing report as required by the Chief Nursing Officer NHS England. The report also gives a progress report on the Nursing Workforce Programme streams.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The Trust board to note the contents of the paper and ongoing commitment to systematically reviewing safe nursing staff establishment across the Trust.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	X	**Risk score**	12
Risk Register	X	**Risk score**	16

External standards affected by this report and associated risks

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

Registered Nurse Recruitment remains a challenge both locally and nationally. There is a growing confidence that the newer routes to Registered Nursing programmes are having a positive effect. These routes do require significant mentorship time from the clinical areas and need to be factored into establishment reviews. It is important to recognise that patient quality and safety are maintained.

Report title: Six Month Safer Staffing and Nursing Work Programme Review		**Meeting date:** 27 May 2020
Report sponsor	Chief Nurse and Deputy Chief Executive	
Report author	System Director of Nursing and Professional Practice	

1.0 Introduction

The NHS England Nursing Quality Board mandated regular reports to Trust Boards in guidance published in 2016 and updated in 2017 and again in 2018.

Over the past three years there have been a number of guidance publications regarding safe staffing. NICE 2016, NQB 2016, 2017, 2018 RCN 2017, NHSI 2017/18. This report updates the Board on progress against safe staffing guidance.

2.0 Discussion

2.1 Nursing Quality Board (NQB) Toolkits

In January 2018 the NQB published a series of resources to inform safe staffing. These included acute adult inpatients, district nursing, mental health, learning disability and maternity. These were followed in June 2018 by the publication of resources for children's and young people's services, neonatal care and emergency care. Together these provide a comprehensive guide to inform safe staffing reviews and for setting appropriate establishments. Each document has specific recommendations which the Associate Directors of Nursing are implementing.

NQB Publications	Trust
Acute Adult Inpatients	Ward staffing assessed using the Safer Nursing Care Tool. In 2018 an electronic rostering system was implemented to monitor establishment. In September 2019 the Safecare within electronic rostering was implemented.
District Nursing	The Trust commissioned a community nurse productively a review of district nurse staffing. The report has been included in Board reports.
Mental Health	The electronic rostering safe staffing tool enables consideration of the additional needs of those with a cognitive issue requiring additional supervision.
Learning Disability	The electronic rostering safe staffing tool enables consideration of the additional needs. We continue to work with the CCG and local authority.
Maternity	The Birth Rate Plus tool was utilised in 2017 to review and set establishment. The findings remain current. The Board received the NQB six monthly update.

Children & Young People	The PANDA tool was used in 2017 to set establishment. The findings remain current. An assessment against the NQB recommendations has been completed and included within the August 2019 Board report
Neonates	BadgerNet, Dinning and BAPM standards are used to set establishment level. The NQB update was included in the August 2019 Board report.
Emergency Care	The Baseline Emergency Staffing Tool was used in 2017 to set establishment and recently completed – awaiting results. The findings remain current. An assessment against the NQB guidance has been completed and included within the August 2019 Board report.

Each NQB's guidance document states that providers:

- **Must** deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- **Must** use an approach that reflects current legislation and guidance where it is available.

2.2 NHSI Safe Staffing Guidance

In support of the NQB, the NHSI published 'Developing Workforce Safeguards in October 2018. This document has a number of recommendations some of which link to the Standing Operating Framework (SOF) and the CQC inspection process:

	NHSI guidance (2018)
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.
2	Trusts must ensure the three components are used in their safe staffing processes: evidence-based tools (where they exist) professional judgement outcomes
3	NHSI will base assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.
4	NHSI will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures. As part of this yearly assessment NHSI will also seek assurance through the Standing Operating Framework, in which a provider's performance is monitored against five themes: • quality of care • finance and use of resources • operational performance

	strategic change leadership and improvement capability.
5	As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.
6	Trusts **must** have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
7	They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
8	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources, This must also be linked to professional judgement and outcomes
9	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
10	As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
11	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
12	Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments
13	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

Whilst there is evidence to support compliance for nursing, medical and allied health professional staff, there is further work to be undertaken to ensure all professional groups meet the standards. There a are a number of specialist roles where vacancies have been difficult to fill. Podiatrists, Systemic Anti-Cancer Therapy nurses and Emergency Department nurses including paediatric have had vacancies that have impacted on service provision. The Chief Nurse and Medical Director will work with the Director of Workforce and OD to provide the required report in Q2 2019/2020.

2.3 NHSI Yearly Assessment

Within the SOF, the organisational health section contains information on monthly staff sickness, staff turnover and the volume of temporary staffing a trust uses, as well as the annual staff survey. These are high level organisational metrics that NHSI will continue to analyse.

In addition, NHSI assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual trusts. These will be available from 'board to ward' and sourced from ESR, e-rostering and financial systems, as well as a quality dashboard reviewed by the trust board.

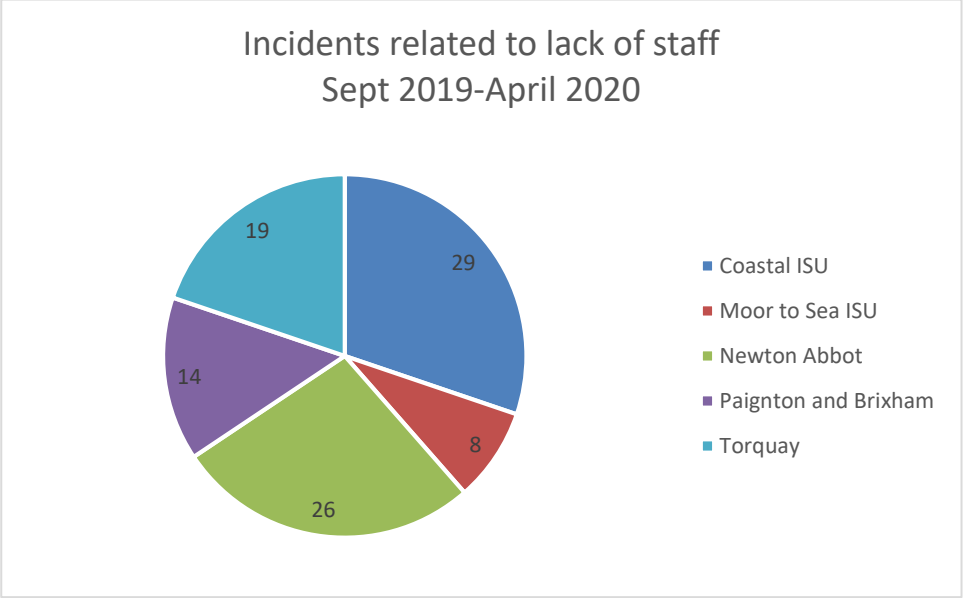
The Trust annual governance statement has been amended to include a statement specifically about staffing. In addition, The NHSI Single Oversight Framework (SOF) is designed to help trusts attain and maintain CQC ratings of 'good' or 'outstanding'. The SOF describes how NHSI oversee NHS trusts and foundation trusts. Their performance is monitored against five themes (quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability) and helps determine the level of support we may offer them. This report provides an update on safe staffing using these 6 key performance themes.

2.4 Quality

2.4.1 Staffing Datix reports

When reported onto the Risk Management System (Datix), incidents are categorised for primary and secondary causal factors. The information below shows the staffing incidents reported for Sept 2019 until April 2020.

Distribution of incidents where category is lack of staff, or staffing levels by Integrated service unit for incidents were a total of 96 incidents over a 6 month period.



These recorded incidents have not caused patient harm.

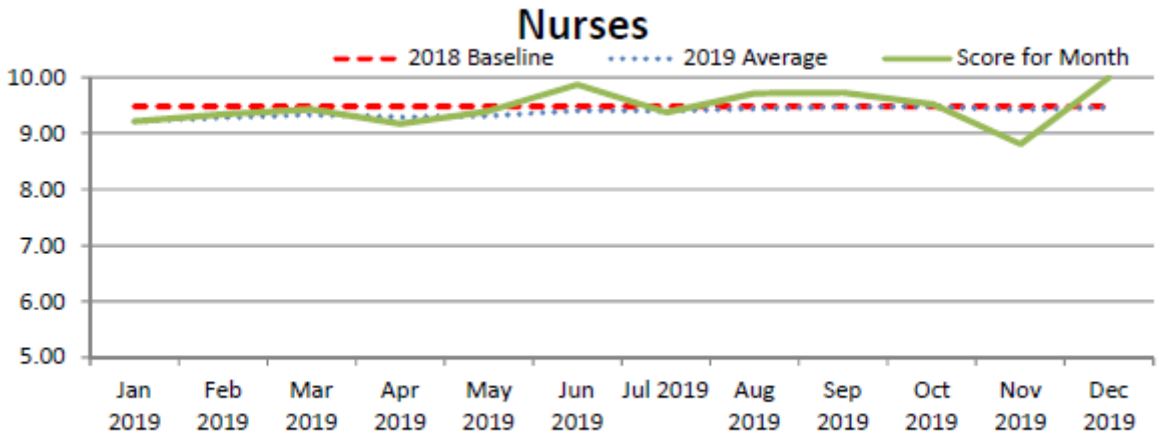
Nurses and other staff are encouraged to complete incident forms if they judge staffing to be unsafe. Actions are taken at the time and validated with feedback to the areas. This information is triangulated with nursing establishment data, nursing staff verbal reports, Freedom to Speak Up reports, RCN feedback, operational activity data such as OPEL status and safety walks.

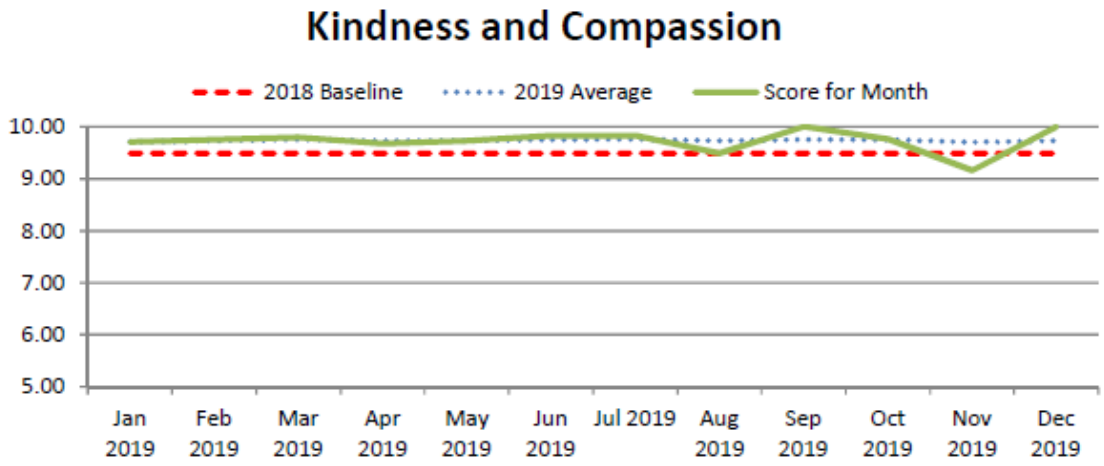
2.4.2 Complaints

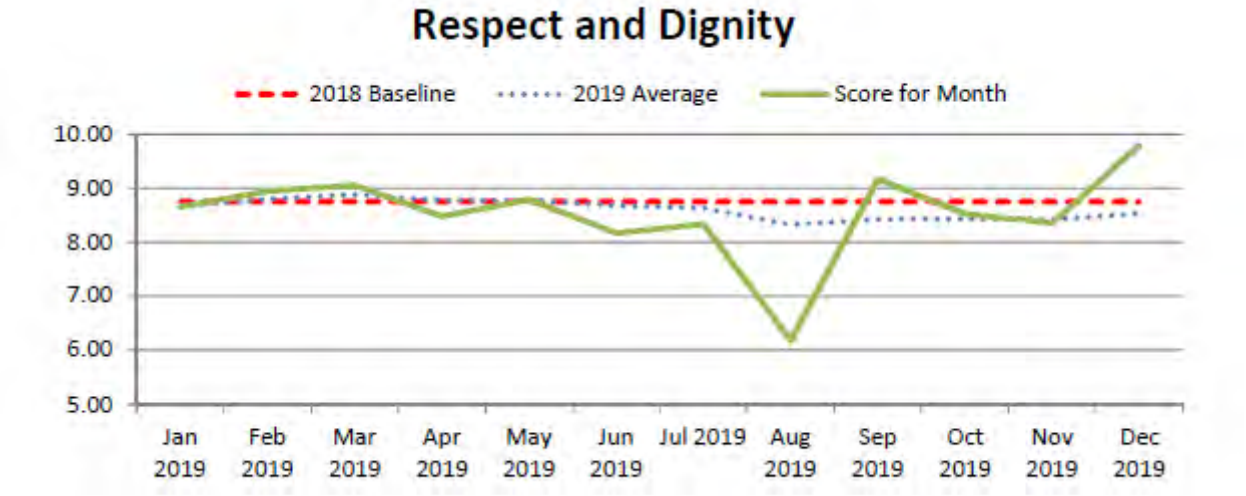
There are no complaints where nursing staff shortages are a factor. There are no complaints relating specifically to staff shortages. Issues pertaining to care coordination, including assessments and discharge planning are periodically raised and these are investigated and addressed through the integrated service units. A more in depth report will be provided in the annual Feedback and Engagement which will presented to Trust Board. Due to Covid 19 pandemic during March and April 2020 we have seen a reduction in complaints overall and there are none that pertain to lack of staff or staffing levels.

2.4.3 Real time patient feedback

Patients in bed based care are asked for their feedback in the form of a questionnaire asked by staff and volunteers not involved in the care of patients in the ward. Currently the wards included in the Patient Experience Network show that for the questions relating specifically to nurses the responses are consistently good. The chart relating to kindness and compassion is not specific to nursing staff but is a good proxy indicator of satisfaction. Due to Covid 19 pandemic during February, March and April 2020 no real time data has been collected as the collection relies on volunteers attending to assist with the completion.







Our 'Working with Us' panel also undertake a similarly worded survey of a sample of patients, the data presentation is still work in progress. However, feedback over the last 6 months (small numbers) the questions relating to nursing staff interaction show that all patients reported positively to having confidence in the nursing treating them, respect and dignity and to the question regarding staff kindness.

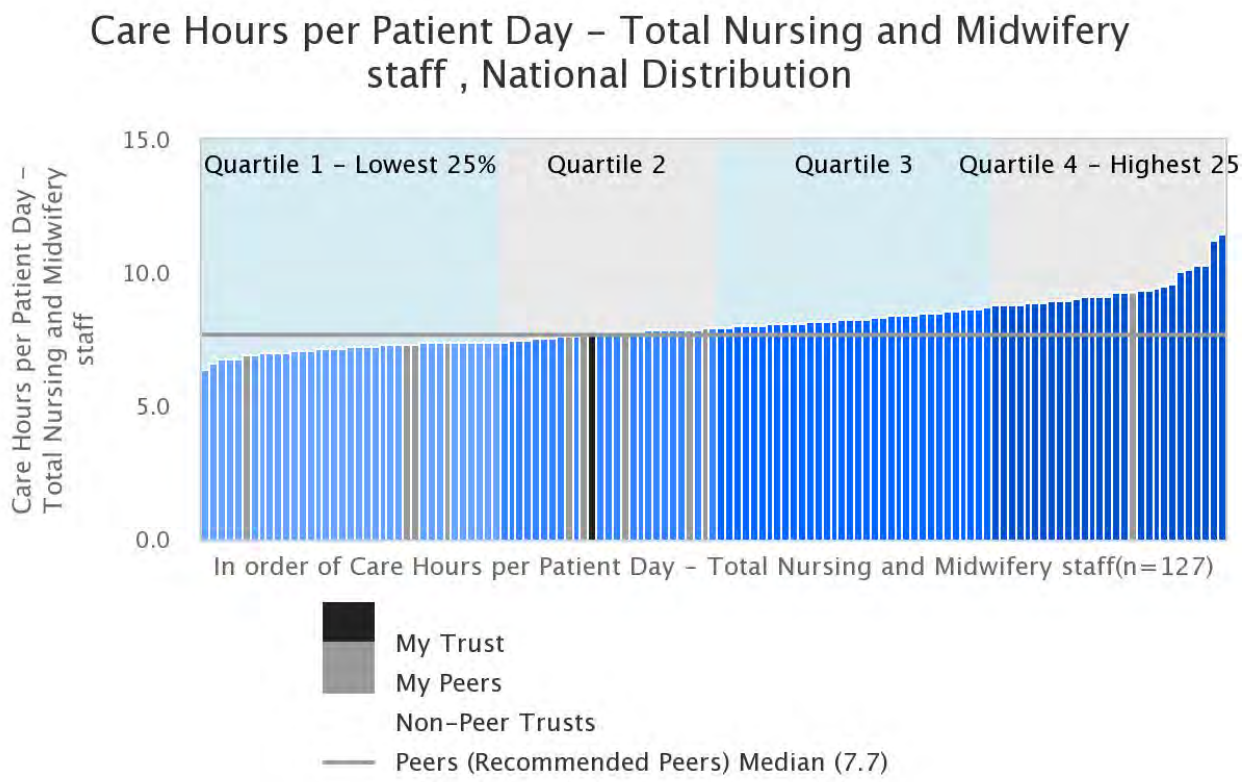
The patient feedback results are reported through the Quality Improvement Group (QIG) meetings, and to the Board in the annual Feedback and Engagement Board report.

2.4.4 Model Hospital quality measures

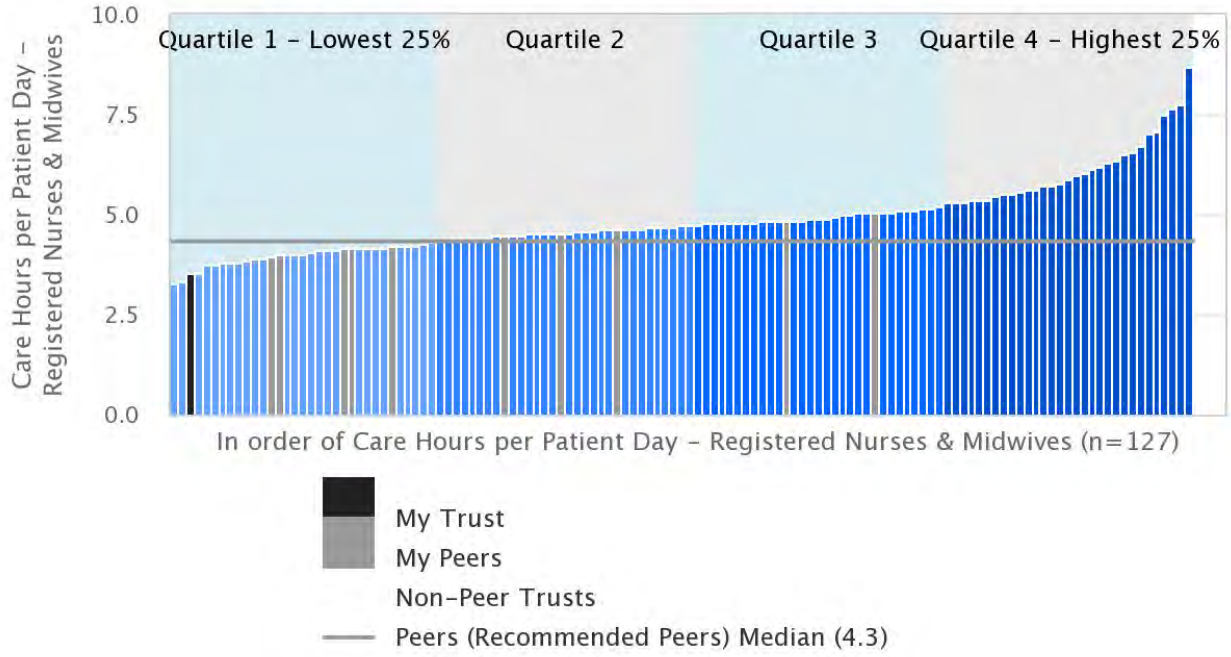
									Model Hospital		
	TSDFT Apr-20	TSDFT Mar-20	TSDFT Feb-19	TSDFT Jan-20	TSDFT December 2019	TSDFT Nov-19	TSDFT Oct-19	TSDFT Sep-19	TSDFT Dec-19	Peer – Region Dec-19	National Median Dec-19
Total CHPPD	14.31	9.4	7.88	7.96	7.56	7.83	7.74	8.17	7.6	7.7	7.9
RN/ RM CHPPD	7.22	4.44	3.95	3.69	3.54	3.64	3.67	3.92	3.6	4.3	4.7
HCA / MCA CHPPD	7.08	4.96	3.93	4.27	4.02	4.19	4.07	4.25	4.1	3.2	3.2

The table above shows the comparison between our Trust and the national and peer data. To note that the above has not been updated nationally since December 2019 as reporting has been stood down due to COVID 19. The value shown for RNs demonstrates an improving picture as recruitment to vacant posts improves, please note that March and April 2020 data represents the standing down of elective activity for categories 4 and 5 and reassigning staff to areas where the Trust has provided COVID 19 surge plans. The CHPPD figure demonstrates a steady increase in RNs, however we maintain an elevated picture for HCAs compared to the national median which is largely attributed to the needs of patients requiring higher levels of support and observation to maintain safety.

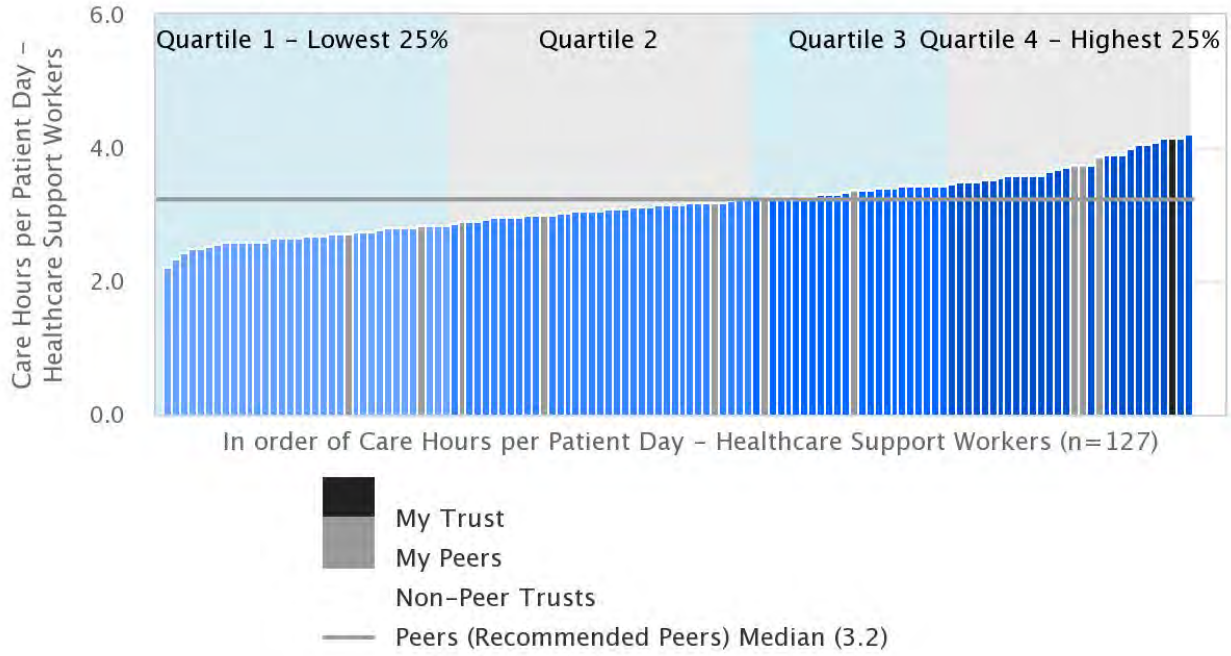
2.5 Model Hospital data – December 2019 data

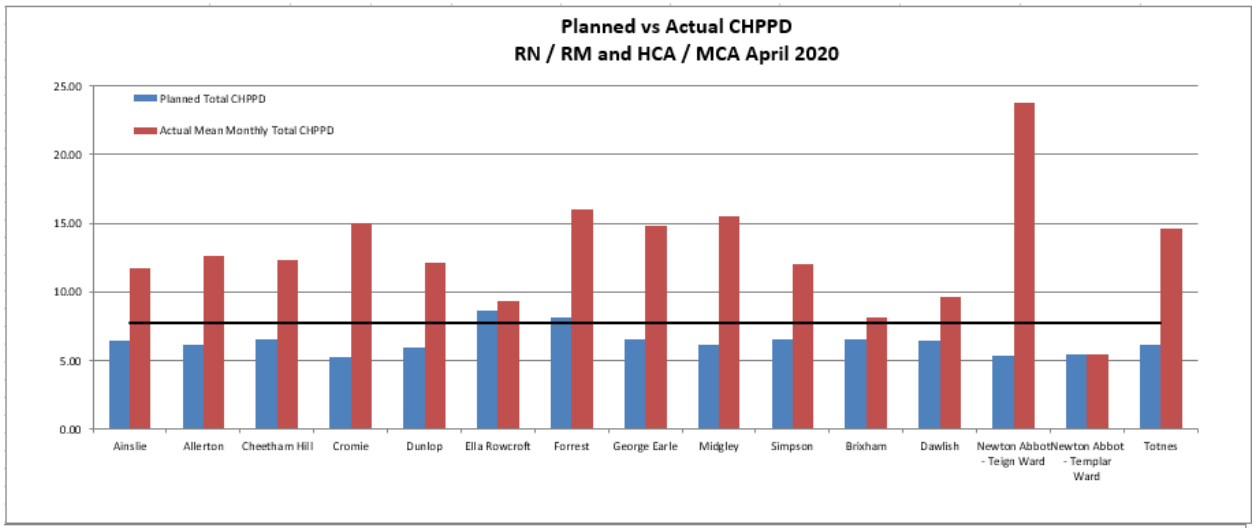


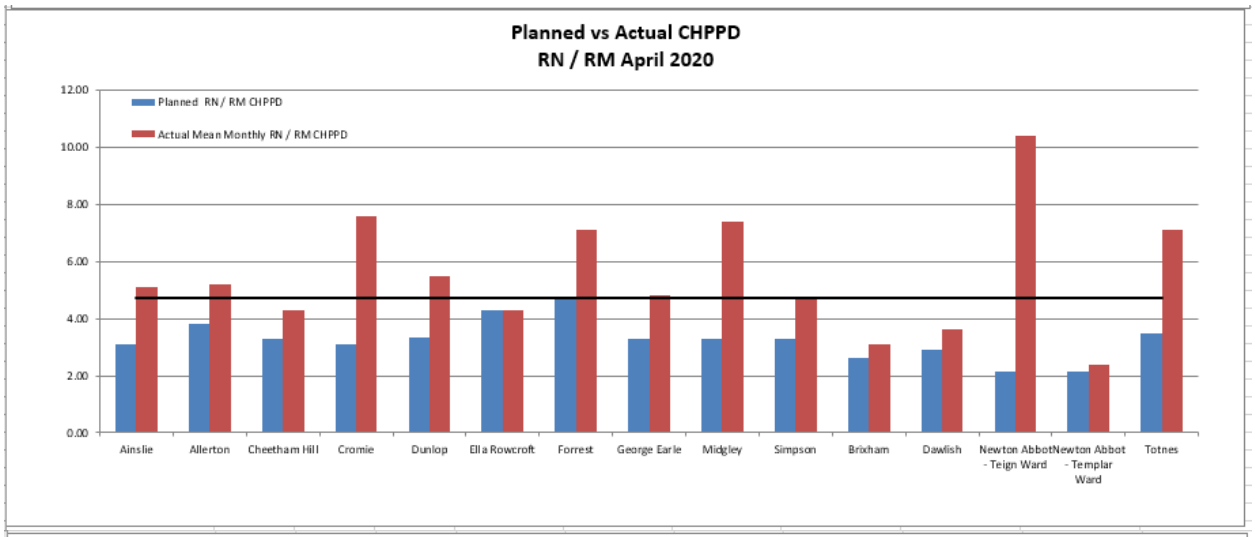
Care Hours per Patient Day - Registered Nurses & Midwives, National Distribution

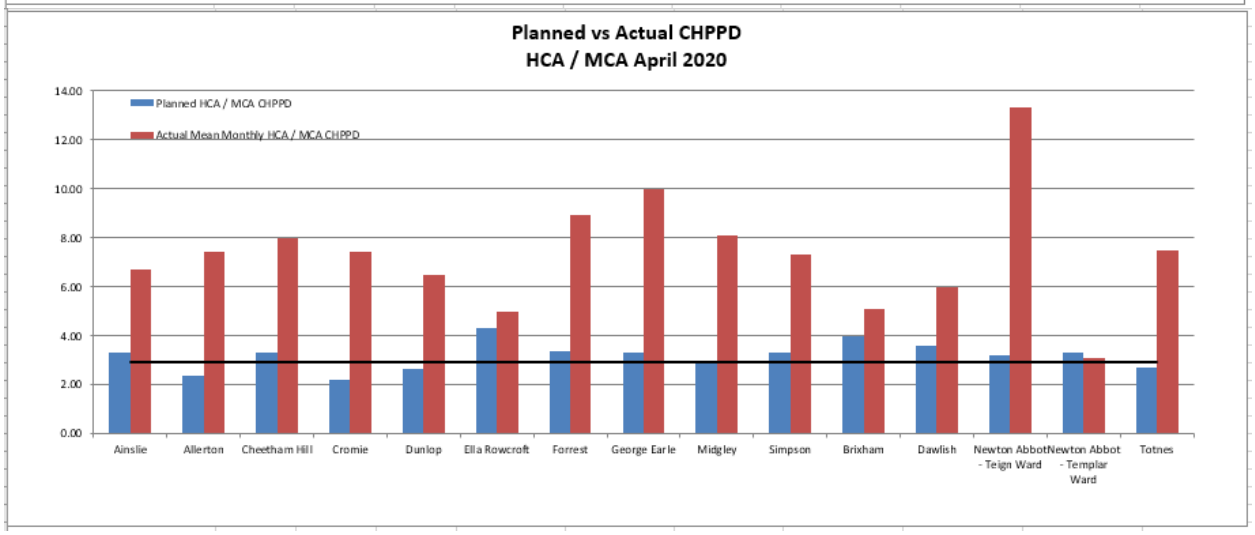


Care Hours per Patient Day - Healthcare Support Workers, National Distribution









The three graphs above show the Trust monthly data for CHPPD against the Model Hospital benchmark. For registered nurses / midwives and HCAs, the actual number exceeds the planned numbers, this is due to the Trust response to prepare the Trust for COVID 19 surge, see below.

2.6 COVID 19 Surge Staffing response

The coronavirus (COVID 19), 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.

During March and April 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

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.

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. 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 a 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.

3. The Emergency Department (ED) Surge plans include a Red and Green ED and therefore have expanded into the daycase 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

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

5. Tower block 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

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.

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.

8. Rapid response and community nursing teams have been supported with reassigned staff.

9. The Trust response to care homes has included reassigning staff for short periods of time to assist with the significant staff shortages due to covid.

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 seen over 12 Registered nurses who we processed to return, however we have had 4 that have withdrawn or not completed paperwork, leaving 8 we are welcoming back into the Trust, who have been assigned to ED, ICU, Brixham hospital following their induction and upskilling programme.

Year 3 Student nurses who are being placed onto paid voluntary placement 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. We have welcomed over 75 students to the Trust.

Our International nurses who fulfil specific criteria are able to join the register early this has enabled 4 of our international nurses to complete and be a registered nurse.

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.

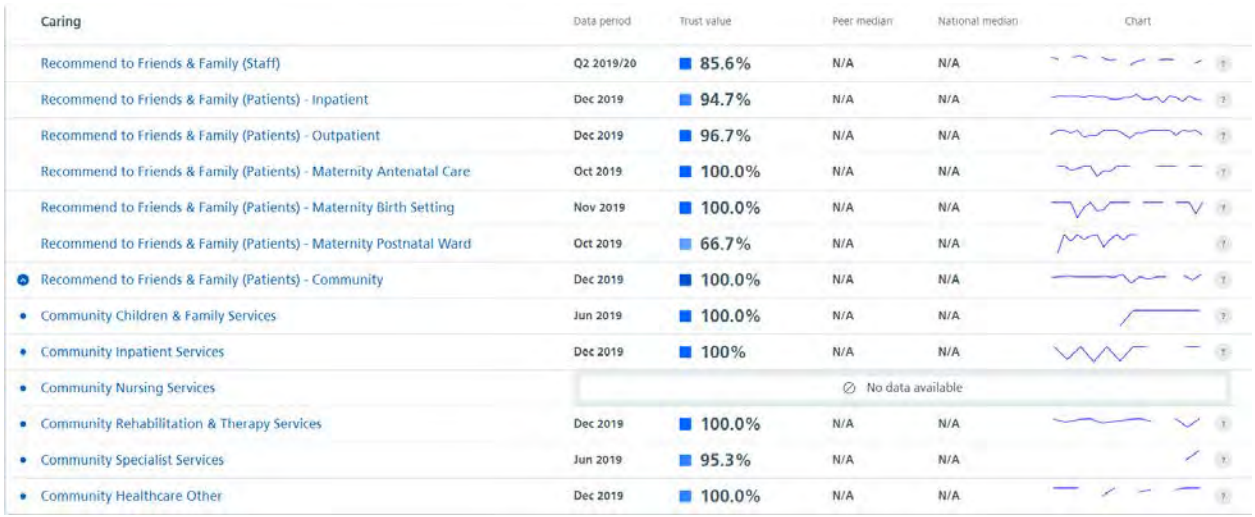
2.7 Quality measures

Model Hospital data (depending on when the national teams upload the data – this can be several months behind) shown below for December 2019 shows the Trust to be comparable with Peer and National dataset within the following measured quality measures:

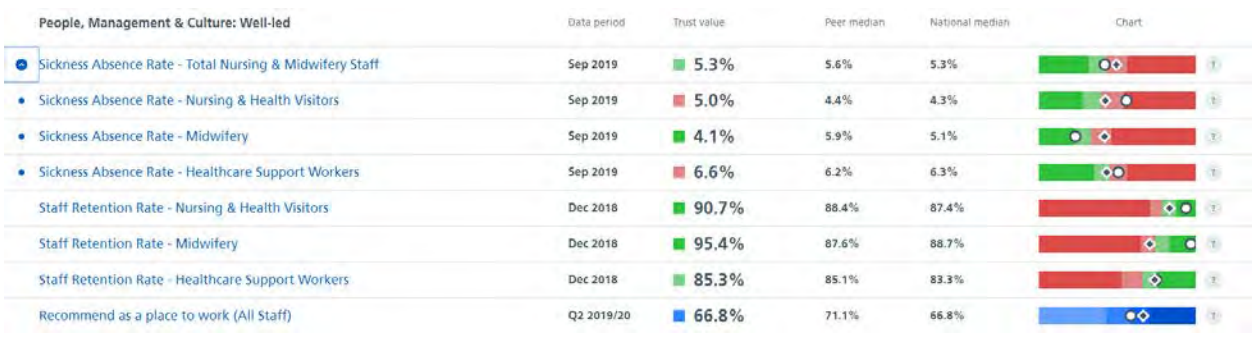
Friends and family staff test, Friends and family test inpatients, outpatients, maternity and community. Staff retention rates for nursing, midwifery and healthcare support workers show the Trust is higher in comparison to peer and national figures.

The Trusts harm free care is slightly lower in comparison to our peers and national figures. As a Trust our urinary tract infection rates with or without a catheter are better than our peers and national figures Harms from falls are higher than benchmark but this Trust data will include those sustained in intermediate and community care, this also recognises that we have high reporting of falls as we would encourage. VTE data is under review to identify both the recording and reporting.

Our response to Delayed Transfer of Care (DTOC) remains lower than our benchmarked peers and nationally.



Caring	Data period	Trust value	Peer median	National median	Chart
Recommend to Friends & Family (Staff)	Q2 2019/20	85.6%	N/A	N/A	
Recommend to Friends & Family (Patients) - Inpatient	Dec 2019	94.7%	N/A	N/A	
Recommend to Friends & Family (Patients) - Outpatient	Dec 2019	96.7%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Antenatal Care	Oct 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Birth Setting	Nov 2019	100.0%	N/A	N/A	
Recommend to Friends & Family (Patients) - Maternity Postnatal Ward	Oct 2019	66.7%	N/A	N/A	
Recommend to Friends & Family (Patients) - Community	Dec 2019	100.0%	N/A	N/A	
Community Children & Family Services	Jun 2019	100.0%	N/A	N/A	
Community Inpatient Services	Dec 2019	100%	N/A	N/A	
Community Nursing Services		No data available			
Community Rehabilitation & Therapy Services	Dec 2019	100.0%	N/A	N/A	
Community Specialist Services	Jun 2019	95.3%	N/A	N/A	
Community Healthcare Other	Dec 2019	100.0%	N/A	N/A	



People, Management & Culture: Well-led	Data period	Trust value	Peer median	National median	Chart
Sickness Absence Rate - Total Nursing & Midwifery Staff	Sep 2019	5.3%	5.6%	5.3%	
Sickness Absence Rate - Nursing & Health Visitors	Sep 2019	5.0%	4.4%	4.3%	
Sickness Absence Rate - Midwifery	Sep 2019	4.1%	5.9%	5.1%	
Sickness Absence Rate - Healthcare Support Workers	Sep 2019	6.6%	6.2%	6.3%	
Staff Retention Rate - Nursing & Health Visitors	Dec 2018	90.7%	88.4%	87.4%	
Staff Retention Rate - Midwifery	Dec 2018	95.4%	87.6%	88.7%	
Staff Retention Rate - Healthcare Support Workers	Dec 2018	85.3%	85.1%	83.3%	
Recommend as a place to work (All Staff)	Q2 2019/20	66.8%	71.1%	66.8%	

Safe	Data period	Trust value	Peer median	National median	Chart
Proportion of Patients with Harm Free Care	Dec 2019	88.9%	94.8%	93.8%	
Proportion of Patients with Harm from a Fall	Dec 2019	0.4%	0.4%	0.4%	
Proportion of Patients with New VTE	Dec 2019	3.2%	0.2%	0.4%	
Proportion of Patients with New Pressure Ulcers	Dec 2019	1.6%	0.5%	0.8%	
Proportion of Patients with a UTI and Catheter	Dec 2019	0.7%	0.9%	0.7%	

Responsive	Data period	Trust value	Peer median	National median	Chart
Delayed Transfer of Care (DTOC)	Dec 2019	542	578	610	

2.8 Quality Effectiveness and Safety Trigger Tool (QuESTT)

This report provides each clinical team with an opportunity to rate their level of risk regarding safety, effectiveness and experience. The overall RAG score is composed of 14 elements such as staff absence, clinical caseload, incidents and complaints. The tool also enables the use of professional judgement to highlight pressure. Data is submitted and collated monthly to highlight areas for focus. This report is monitored and managed by the Integrated service units and Trust Quality Improvement Group a sub group from Quality Committee.

To note that during March and April 2020 as part of the Trusts COVID 19 surge plans and response, the blank areas represent those areas that were either repurposed for the surge plans or not utilised as activity was stood down and staff were reassigned.

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	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020
% Complete		96%	93%	99%	95%	96%	98%	98%	96%	95%	94%	70%	86%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		0	0	2	2	2	0	0	0	0	2	0	1
Total Amber (L1)		8	5	8	10	5	10	9	11	7	8	12	12
Total Green (L0)		72	72	72	67	73	71	72	69	72	68	46	58
Average Score		9.4	9.6	10.0	10.2	9.7	10.0	9.4	10.3	9.6	10.0	10.4	10.7
Acute	Ainslie	13	12	11	10	11	10	7	10	10	13	9	9
	Allerton	8	16	13	12	14	9	6	5	8	7	6	9
	AMU	14	5	5	11	6	8	6	8	5	3	5	6
	Anaesthetics	11	10	11	11	10	7	9	8	6	9	11	12
	Breast Care Unit	0	2	0	6	10	6	3	5	3	6	0	2
	Cath Lab	4	10	10	10	13	15	7	6	8	8	6	1
	Cheetham Hill	16	15	11	13	12	13	13	17	13	9	14	13
	Cromie	10	7	12	7	5	8	5	9	6	15	9	8
	DSU	13	14	10	9	12	15	13	9	6	12		
	Dunlop	3	5	4	5	6	7	6	7	5	6	11	10
	Early Pregnancy / Fertility Service	4	4	6	6	6	6	8	6	6	4	8	8
	EAU3	8		12		12	10	18	14	11			16
	EAU4	8	7	18	11	8	7	6	5	9	5	6	5
	Ella Rowcroft	3	10	12	8	10	9	8	11	11	8	6	8
	Emergency Department	15	15	18	20	19	19	18	15	10	12	16	13
	Endoscopy	4	4	3	8	6	8	3	3	3	6	5	10
	Forrest	15	14	12	8	8	15	7	10	10	12	12	6
	General Theatres	11	11	9		15	7	15	13	7	7		10
	George Earle	11	11	11	13	15		16	14	12	11	11	14
	Gynaecology Out-Patients Dept	8	9	9	7	7	8	3	7	7	5	11	7
	Hutchings	9	12	13	8	9	9	9	7	6	10		7
	ICU	7	9	11	9	3	9	14	6	8	10	19	16
	Louisa Cary	4		6	7	3	9	3		5	7	4	
	MAT / TAIRU	10	10	10	9	4	7	7	8	5	4		2
	Maternity	7	13	12	12	14	13	9	10	15	13	15	12
	Midgley	11	14	9	3	7	9	8	11	7	11		8
	OPD	2	6	6	6	3	2	4	6	11	6		6
	Ophthalmology	13	8	15	15	13	14	13	15	12		10	3
	Ortho Theatres		15	14	13	14	15	14	12	15	11	11	13
	Pre-assessment	8	8	8	10	12	16	14	12	6	8	8	10
	Radiology	13		9	11	9	14	10	9	13	9		
	Recovery	8	12	8	10	11	15	15	14	11	10		20
	RGDU	10	7	13	15	12	9	7	10	11	15	10	8
	SCBU	2		4	2	1	3	5		1	5	3	
	Sexual Health	8	13	11	10	5	6	6	12	11	10		11
	Simpson	8	9	8	11	11	9	11	12	10	10	15	10
	TCCU	3	5	4	8	9	14	10	6	7	11	12	12
	Turner	11	9	8		7	12	9	13		7		8
	Urology	14		7	10	4	6	5	10	5	7	6	10
	Warrington	3							16		13		

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

The areas rated as either Red or amber the causes have been as follows:

- Vacancies, either staff have been appointed but staff is not in post or not recruited to as yet.

- Sickness absence and maternity leave, this has been especially increased due to the COVID 19 restrictions of staff needing to shield due to underlying conditions, or through COVID related sickness and requirement to self-isolate.

- Case load prioritisation and reassignment of staff, including the need for upskilling

- Appraisal training and mandatory training has been another issue for completion over the last 6 months, however we are expecting an increase in completion due to our COVID 19 response plans has provided more time to complete.

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2.9 Operational Performance

2.9.1 This report includes the organisational Opel status reflecting pressures in the system and provides a proxy indicator of the effects on staffing. The table below shows the number of days the Trust was at each Opel level for June with May figures shown in brackets. The impact of OPEL 4 is the need to staff additional bedded areas for escalation. Whilst OPEL 4 is the result of escalated demand and lack of capacity, it also contributes to inefficiency and stress as staff work harder to respond but can be less productive.

Previous Data

Opel status	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Opel 1		6				2					5	
Opel 2	8	15	4	5	3	13	12	3	8	7	12	
Opel 3	16	9	18	22	21	11	19	18	15	19	8	
Opel 4	6	1	8	4	7	4		9	8	5	4	
Performance	79.06%	84.16%	80.29%	84.28%	79.36%	80.72%	82.65%	77.30%	77.89%	76.19%	82.24%	

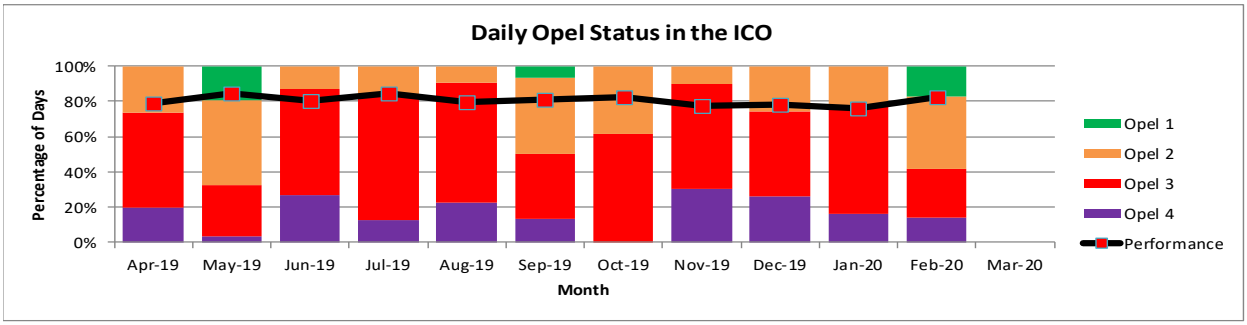
Opel status	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Opel 1		19%				7%					17%	
Opel 2	27%	48%	13%	16%	10%	43%	39%	10%	26%	23%	41%	
Opel 3	53%	29%	60%	71%	68%	37%	61%	60%	48%	61%	28%	
Opel 4	20%	3%	27%	13%	23%	13%		30%	26%	16%	14%	

Current Month

Opel status	Opel 1	Opel 2	Opel 3	Opel 4
	1	4	1	

Opel 1	Opel 2	Opel 3	Opel 4
17%	67%	17%	

Performance
82.05%



TSDFT Alert Status	*No Days in Month April 2020*	*No Days in Month March 2020*	*% days in Month April 2020*	*% days in Month March 2020*
Opel 1	***30***	***18***	***100%***	***58.06%***
Opel 2	***0***	***12***	***0%***	***38.7%***
Opel 3	***0***	***1***	***0%***	***3.22%***
Opel 4	***0***	***0***	***0%***	***0%***

Trust 4 hour performance is well below the local and national trajectory. This is impacting on safety, quality and effectiveness. Nursing staff participate in the national emergency flow interventions to address this. However, since the COVID 19 response commencing late February 2020 we have seen less attendances to ED and therefore this has improved flow. The learning from the changes that have occurred as part of the COVID 19 response are being included within the transition to recovery post COVID 19.

2.9.2 SAFER

- S- Senior review
- A-all patients have an expected date of discharge
- F-flow to the wards commences at the earliest opportunity following assessment.
- E-early discharge
- R-review patients with extended LoS > 7 days.

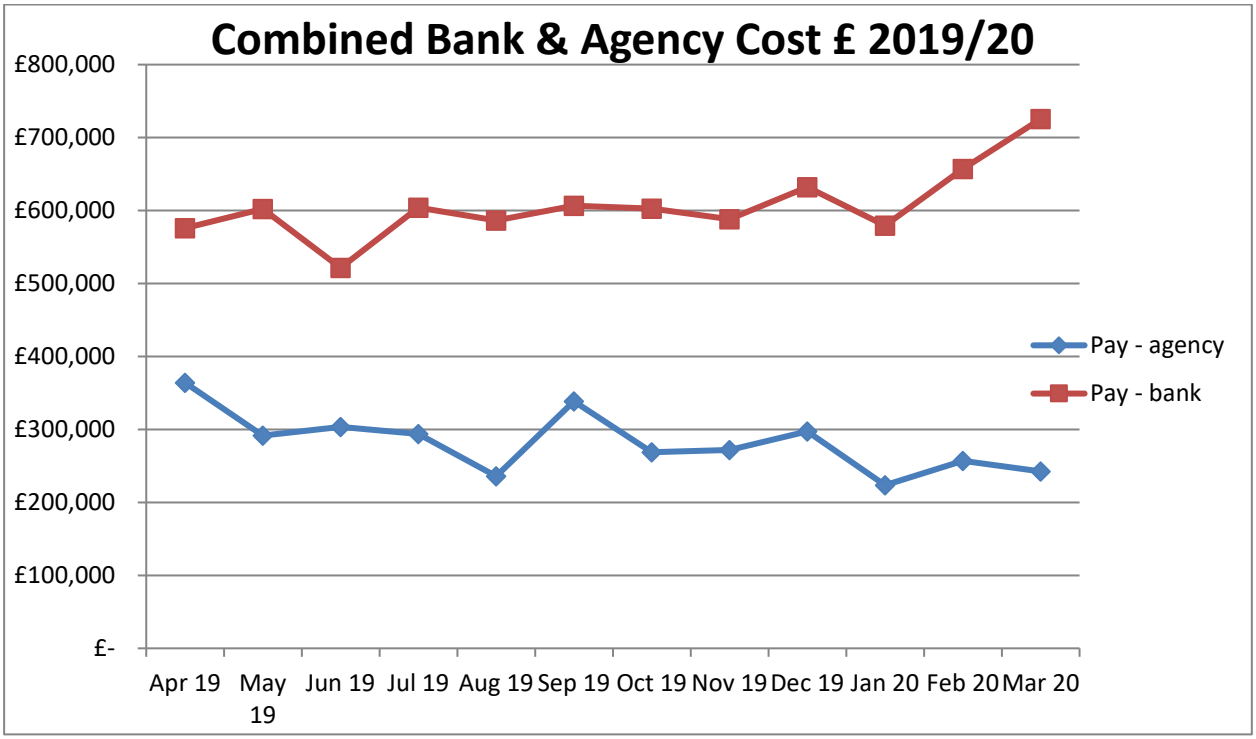
Trust work on the SAFER programme continues, with wards undertaking reviews of all patients each day and communicating planned discharges to the operational control meetings. Overall as a Trust we remain not fully compliant recognising areas for improvement, following recent ECIST feedback and continued support, the Trust is urgently reviewing its approach to the early in the day patient discharge as the numbers of patients leaving their wards before 12 midday are not sufficient to enable early flow from the assessment areas. This work is being monitored through weekly quality calls with our CCG, NHS England and NHS Improvement colleagues and respective A&E delivery Boards.
There has been an improvement within this over the last 6 months in relation to discharge as we enacted our winter plan and included a hard reset for gold and silver patients ready for discharge, this has proved successful and we continue to build on this.

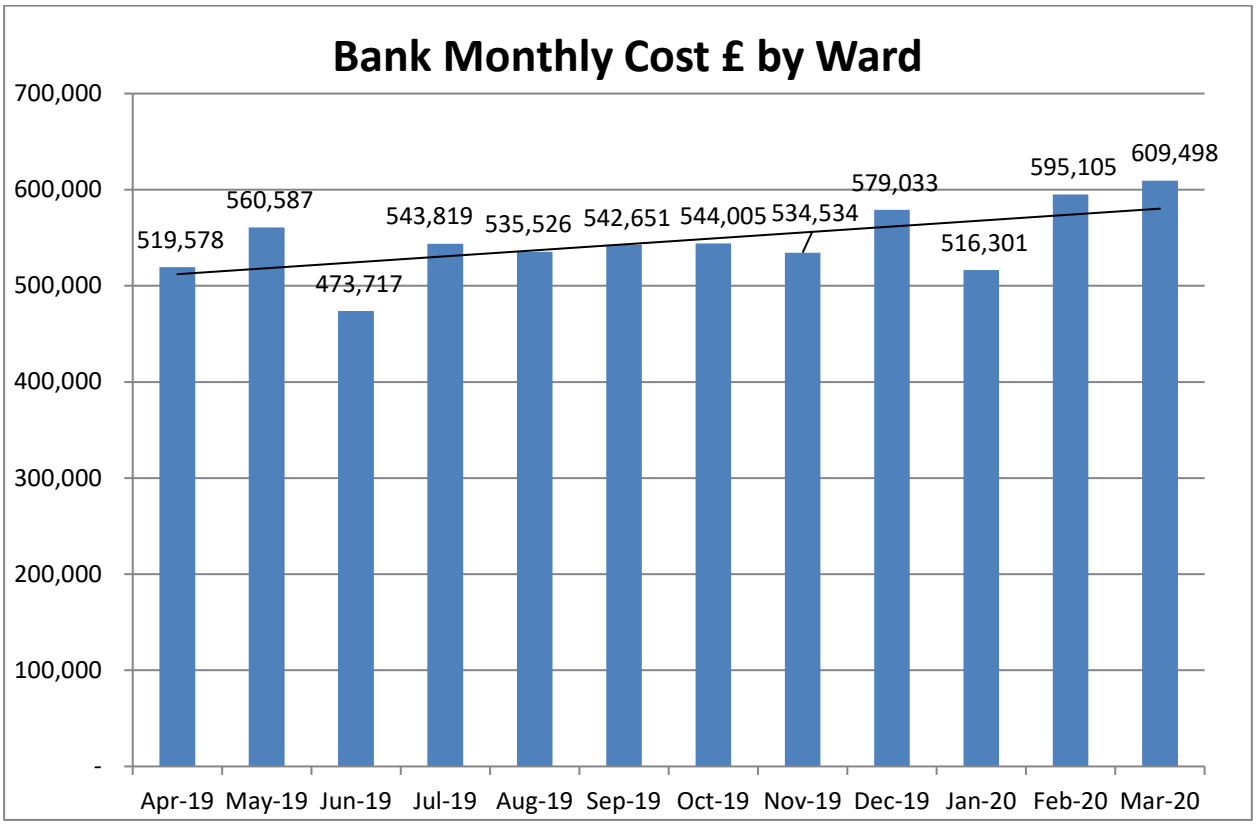
2.9.3 Red2Green

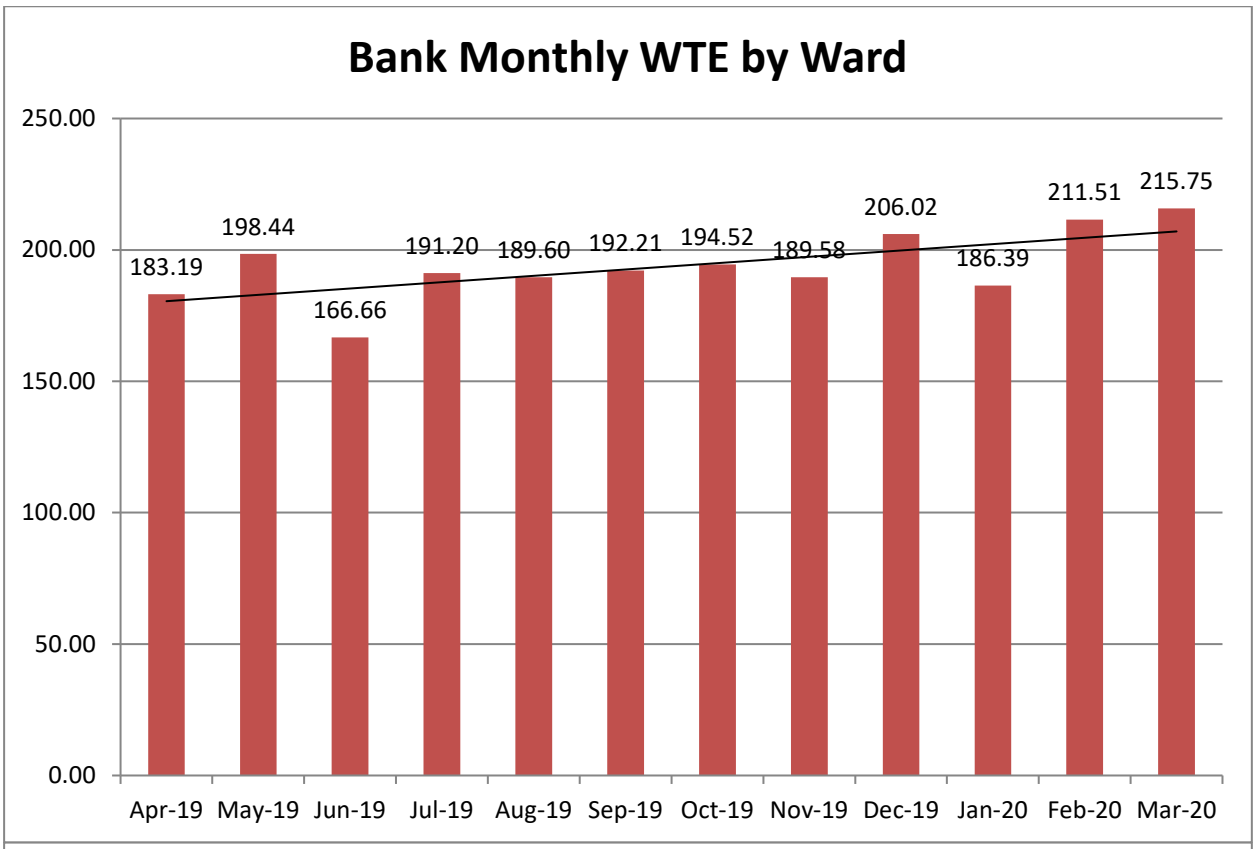
Red2green days identify and evaluate the days in a patient stay which do not add value i.e. red days. These are usually days where the patient is experiencing unnecessary delays in their care pathway. As part of the work described above, a review of delays are examined to identify any themes and in preparing interprofessional standards. Overall, the Trust is compliant with Red2Green recognising areas for improvement.

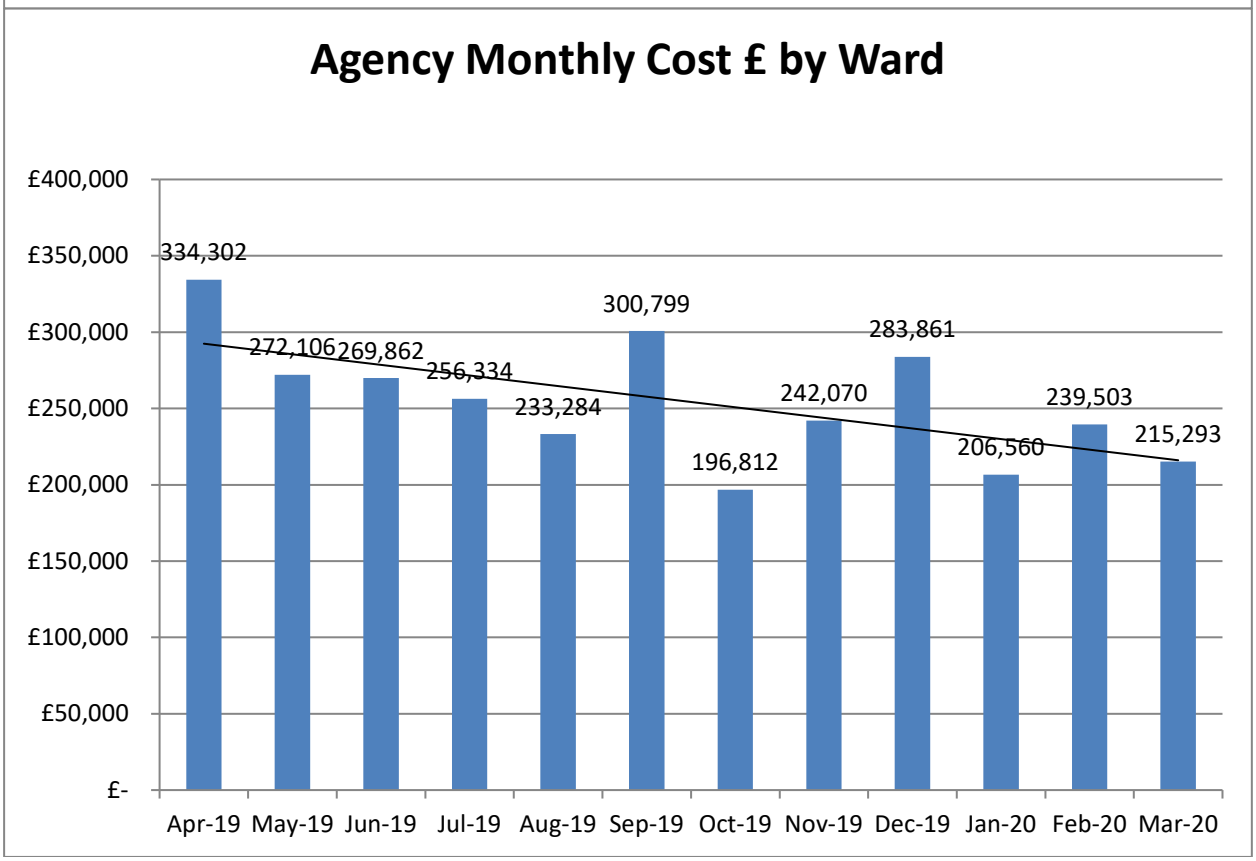
2.10 Finance and Resources

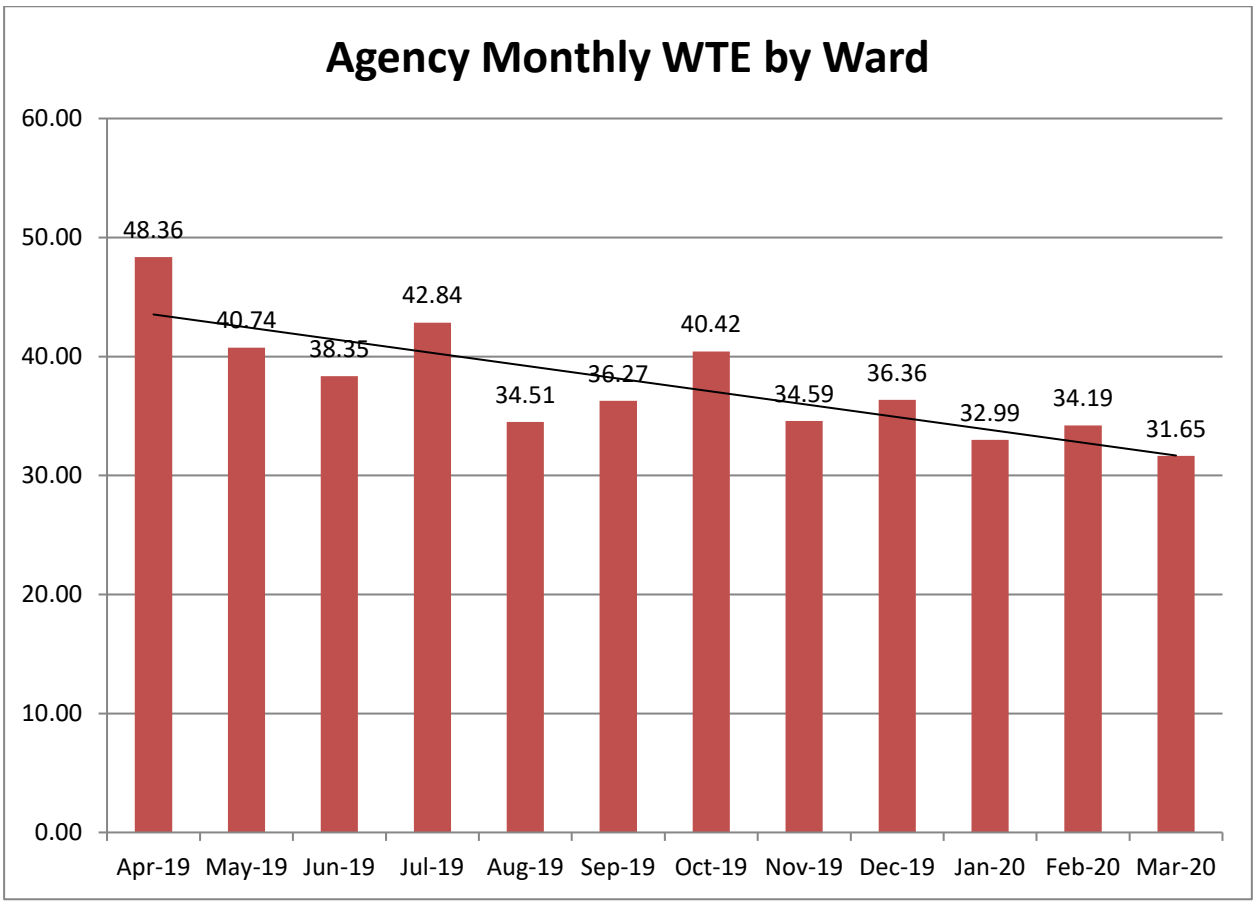
2.10.1 Ward establishment/bank and agency spend:





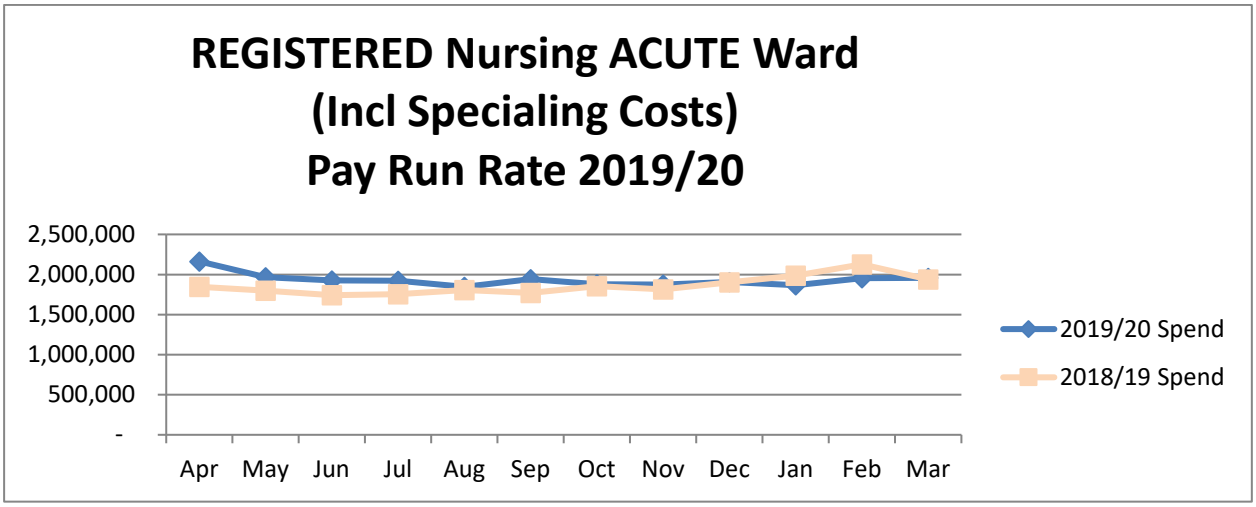

Bank Monthly WTE by Ward
250.00
200.00
150.00
100.00
50.00
0.00
183.19
198.44
166.66
191.20
189.60
192.21
194.52
189.58
206.02
186.39
211.51
215.75
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20

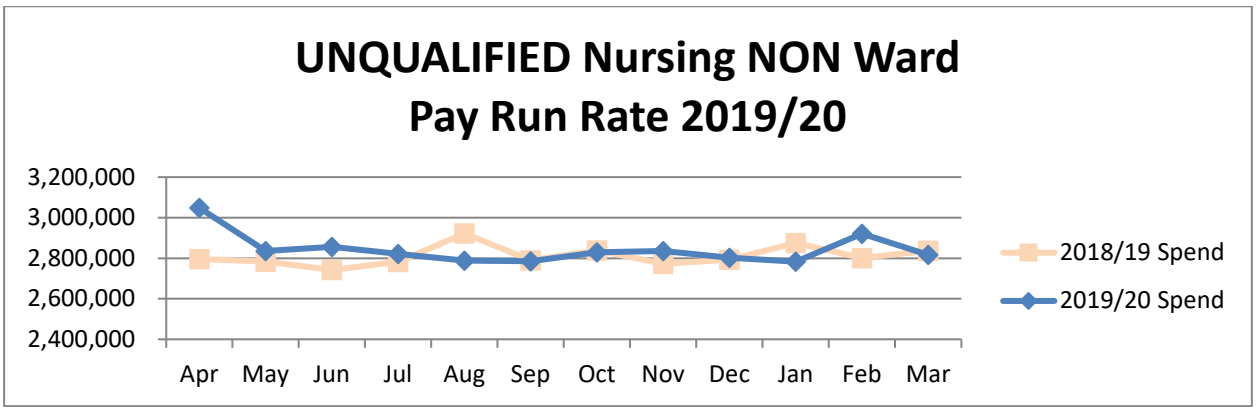

Agency Monthly Cost £ by Ward
£400,000
£350,000
£300,000
£250,000
£200,000
£150,000
£100,000
£50,000
£-
334,302
272,106
269,862
256,334
233,284
300,799
196,812
242,070
283,861
206,560
239,503
215,293
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20



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.





2.10.2 Nursing Agency

- The winter bank incentive payment have been extended through the current COVID-19 situation and a decision to cease this has been made to end on 31st May 2020.
- The COVID-19 nursing and midwifery returns, students and overseas nurses joining the register has seen an increase of registered nursing and midwifery within the Trust.

2.11 Nursing and midwifery vacancies

The recruitment strategies previously reported have resulted in an RN vacancy rate as at the end of April 2020 is 9.5% Registered midwives continue with a <1% vacancy rate. Current reporting has been stood down due to the current pandemic situation.

The top spending areas over the last 6 months:

- Emergency Department (comprising A&E, EAU 3&4, AMU and Emergency Practitioners)
- George Earle
- Warrington Ward as this was utilised as winter escalation and also for surgical patients during COVID 19
- Turner ward – SACT nurses
- There is a spend associated with coronavirus and this has been included in the figures

- **Emergency Department** – in 2016, the establishment was increased to support increased demand in Resuscitation and the Paediatric pathway. Recruitment has been slow due to local and national shortage of A&E nurses. The team have had a number of strategies to recruit including 'growing our own', secondments, flexibility between A&E, EAU and AMU staff, appointments from other areas of the Trust, and more recently overseas recruitment. Despite these efforts the department still has a number of vacancies, with increased absence management not being completed. Most of the leavers move to other roles within the Trust; however we have seen the introduction of other initiatives nationally which has driven recruitment of roles such as ENPs being recruited to the Primary care networks. As a trust we are working with our partners across Devon to establish workforce redesign which will benefit ED. The supportive framework identifies a number of issues which the department are working to solution, this includes restructuring their leadership roles and clarity of roles and

responsibilities, and includes an updated review of the staffing model which is being reviewed and been supported by ECIST and ATTAIN.

- **George Earle Ward** – in 2017, the establishment was increased to support safer staffing following the acceptance of a previous business case, which has seen incremental changes within the establishment. Recruitment to these vacant posts have been slow

- **Warrington Ward** – The reopening of Warrington for winter escalation has required a number of substantive staff to be placed on secondment. This has left some gaps in RNs and temporary staffing have unfilled rotas due to instability of the ward. With the provision of surgery on the ward due to covid response this has closed the ap of staffing due to the reassignment of staff.

- **Turner ward** - Due to SCAT nurses leaving this has led to gap within the workforce which has then required support to fulfil the gaps and a reliance on bank and agency.

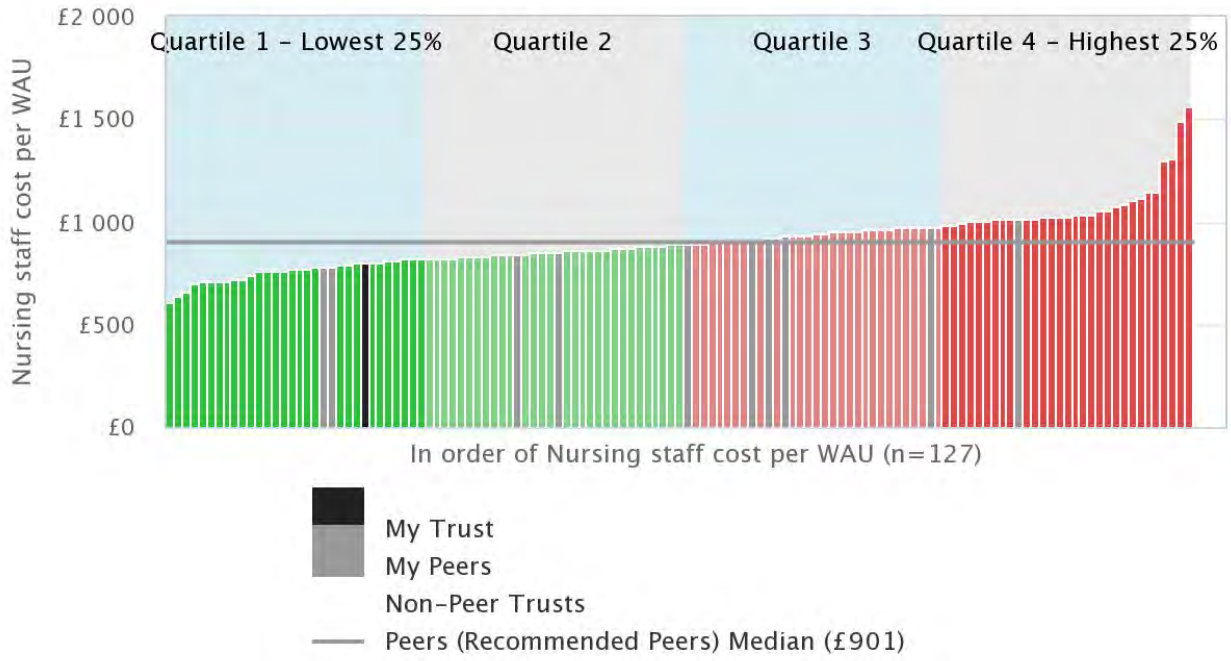
2.12 Model Hospital Staffing

The latest model hospital data shows this Trust is in the lowest 25% for weighted adjusted unit (WAU) cost.

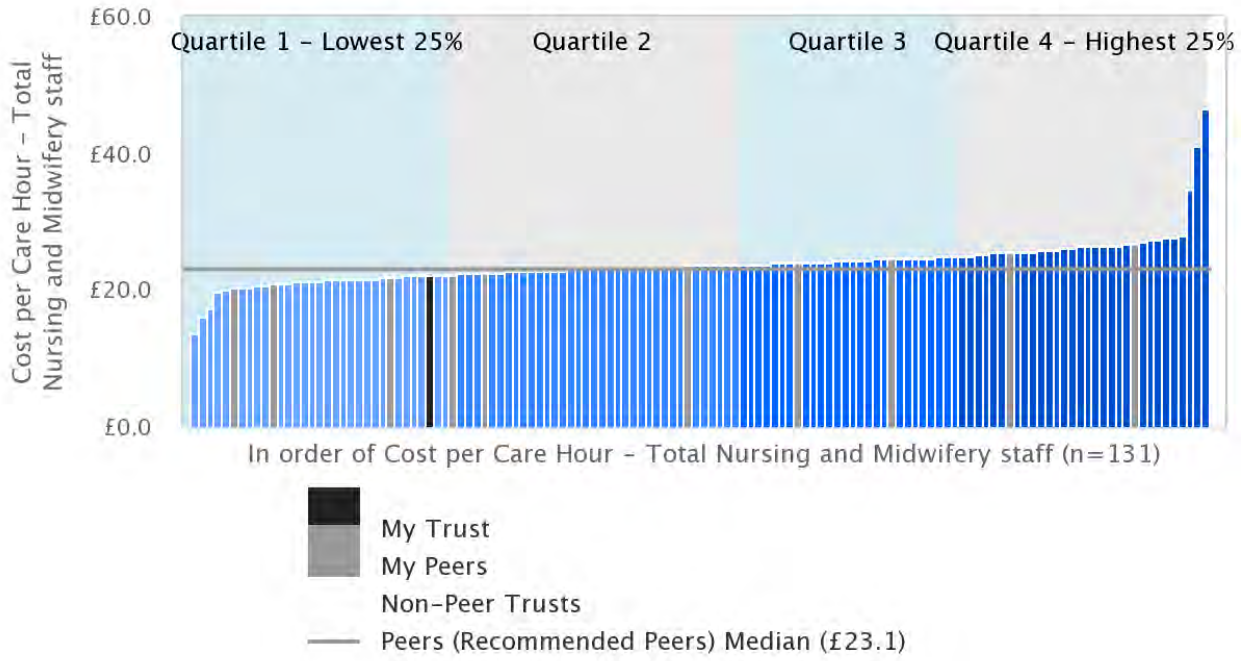
Money & Resources	Data period	Trust value	Peer median	National median	Chart
Total Nurses Health Visitors & Midwifery (FTE)	2018/19	1,935.0	2,863.8	2,169.2	
Average Staff Cost - All Nursing Health Visitors & Midwifery Staff	2018/19	£36,725	£36,771	£37,589	
Nursing staff cost per WAU	2018/19	£802	£901	£892	
Money & Resources (Legacy)	Data period	Trust value	Peer median	National median	Chart
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£611.0	£732.6	£710.1	
CHPPD	Data period	Trust value	Peer median	National median	Chart
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Dec 2019	7.7	7.7	8.0	
Care Hours per Patient Day - Total Nursing and Midwifery staff	Dec 2019	7.7	7.7	7.9	
Care Hours per Patient Day - Total AHPs staff	Dec 2019	0.0	0.0	0.0	
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£22.2	£23.1	£23.7	
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£175.7	£180.3	£189.6	

The Trust has lower than national benchmark total FTE for nursing and midwifery. Recruitment is ongoing with local and international recruitment.

Nursing staff cost per WAU, National Distribution



Cost per Care Hour - Total Nursing and Midwifery staff, National Distribution



2.13 Strategic Change

The Devon STP are monitoring and managing nursing vacancies through the STP Workforce Strategy Group. At present across Devon there are over 900 nurse vacancies in acute and community care; this figure takes account of all AfC bands although not surprisingly the greatest proportion of these vacancies are within band 5 (444). Actions to address this include:

2.13.1 The Devon overseas - recruitment objective is to implement regular cycle of Devon careers fairs for all health and social care recruitment, and promotion of careers to children and young people. Deliver targeted local recruitment campaigns, the first of these were completed. PDEG previously agreed the NHS Devon system approach to international recruitment of nurses undertaken with Cpl Healthcare. This approach has not delivered the number of international nurses that were expected and therefore we have continued our Trust approach and utilising we have also utilised Yeovil's approach and been able to take 17 nurses from this approach, we are reviewing continuing with this to enhance our Trust approach.

2.13.2 Promoting Devon - A plan for a National advertising campaign to promote Devon as a place to work has been discussed. The 'Growing Devon's current and future health and social care workforce' campaign called 'Proud to Care Devon' has begun and we have seen a number of apprenticeships occur within the Trust that incudes nursing associates and health care assistants.

2.13.3 Retire and return - Work has been started to create a system wide policy to enable retire and return for workers across health and social care system in Devon - attracting more retired workers back through flexible employment approaches. The COVID 19 response has enabled this to occur in an advanced nature, this has provided 8 registered nurses at present.

2.13.4 New and developing roles

- Nursing Associates (NAs) band 4: The second cohort of 10 NAs are working through their programme due to qualify . These will be deployed as agreed in the ward workforce plan. The NQB published an improvement resource for the deployment of nursing associates in secondary care in November 2018 which is being used to guide future planning. A further cohort has been postponed in January 2020 due to COVID 19 and we therefore will be commencing in September which will be a further 10.

- Assistant Practitioners (APs) band 4: The Trust has a well-established AP role that enables progression to registered nursing through the Foundation Degree route. The Trust has seen the Nursing Associate role being the preferred route, we will continue recruiting into these roles.

- Maternity Support Workers (MSWs) band 4: The MSW is a well-established band 4 role in our integrated maternity service. The establishment review using Birth Rate Plus in 2018 confirmed the ratio of Midwives to MSW was right.

- Physician associates (PAs) band 7: The Trust has 20 PAs deployed according to service need. The General Medical Council (GMC) have agreed to be the nominated regulatory responsible for PA's. This allows the Trust to utilise this role as formal part of medical workforce redesign. The programme is on hold currently as we review workforce plans.

- Advanced Clinical Practitioners (ACPs) band 8a: The Trust is currently reviewing all advanced practice roles and mapping to the ACP Health Education England and NHS Improvement framework to identify this workforce and include a structured process to map the medical, nursing and professional practice within the workforce redesign. A further 3 have joined the ACP programme within the Emergency Department and we continue to work in partnership with HEE and are working with the STP for a Devon wide approach to ACPs.

- Student Nurses (band 5): The 2018 Operating Plan guidance recommends that STP Trusts ensure all qualifying student nurses who meet NMC registration standards are offered full employment. The Trust is proactive in engaging with students in their final year to offer posts prior to qualifying. The University of Plymouth confirm that the last cohorts were offered full employment at one of the STP Trusts. Following a successful bid to NHSI the Trust is expanding the number of student nurses by 27. The Trust is also working in collaboration with University of Exeter in the supply of student nurses as they run their first pre-registration cohort in September

- Apprenticeships: The Trust has a well-established apprenticeship program that enables progression from entry level band 2 care roles to Registered Nursing and beyond.

2.14 Leadership and Improvement Capability

2.14.1 Vacancies

Data over the last 6 months shows the Trust has over 90 RN vacancies and less than 20 non-registered nursing vacancies across the Trust. The total Nursing and Midwifery workforce is circa 1,950 which gives a vacancy rate of 9.5% which is on the higher end of the national expected of 7-11%.

Of the 90 RN vacancies, majority are band 5 acute, with over 11 are band 5 community. 14 are ED vacancies. Vacancy & absence is exacerbated by an RN sickness rate of 4.85% pre COVID 19 and maternity leave.

STP data shows the Trust to be comparable to other Devon Trusts for vacancies and sickness.

In addition to the new and developing roles described above in section 5, we have a number of recruitment and retention initiatives including:

- Skill mix review
- Return to Practice
- Effective use of bank
- e-rostering – Allocate Healthroster and Safe care
- Establishment reviews

- Workforce Plans
- Sickness management

2.14.2 Investment in nursing leadership

Restructure increases the number of senior nurses to support the monitoring and strategy.

Ward / Department Manager development has been supported and ongoing throughout 2019 and 2020. A review of this is being planned for late 2020 and ensuring that the requirements map to the nursing and midwifery excellence (Pathway to excellence – NHSI CNO collective leadership programme of which we are one of 14 pilot sites) and to the Ward leaders handbook published n October 2018.

2.14.3 Role redesign

Work is underway to review existing roles to ensure they map to the new organisational structure and the focus on prevention, strengths based approaches and self-organising teams. The senior nursing review has been completed and the band 8 Matron post have been reviewed and an outcome reached, formal monitoring and expectations are being mapped currently to form KPIs mapped to the recently published Matron Handbook by NHSI.

There is work underway for multi-professional exploration of the opportunity to include AHP and therapy roles to create a single professional workforce for a ward or department. This has been successfully piloted through COVID 19 and the trust will learn from this experience and build upon this.

2.15 Quality Improvement (QI)/Research Projects

The QIG dashboard is compiled each month pulling data from all Trust sources. The dashboard can be interrogated for each level of service delivery i.e. from Trust level, and through the SDUs down to ward/team level. This enables identification of specific QI projects such as falls safe, pressure ulcer reduction and ward processes. Safe staffing QI projects link to the Quality Account priorities. The presentation of progress on Q1 of the 20/21 priorities was presented to Trust Board. Assurance that progress had been made on the 19/20 priorities was provided:

- Electronic Prescribing and Medicines Administration programme (EPMA)
- Community IT system
- Carers experience of care across the Urgent and Emergency Pathway

2.16 Allocate Health Roster

Implementation of the Allocate Health Roster continues and a stock take of where we are with the implementation has been conducted. Work is ongoing to improve the integrity and accuracy of staffing data. KPIs are published and shared with the Integrated Service Units e.g. timely publication of the roster, and

are discussed and actions planned. Elements of retraining to ensure proficiency are being undertaken.

2.17 Allocate Safe Care

SafeCare implementation was rolled out in September 2019 to support the completion of healthroster and provide realtime staffing and patient acuity as quickly as possible. This work will benefit from the reintroduction of senior nurse input over 12 months. A review and learning of this is now being conducted 6 months after implementation and further improvements are being discussed

2.18 Quality Account

A long list of priorities were identified:

- EPMA
- Community digital record
- Supporting carers in the Emergency Department

Q1 detailed evaluation of these projects will be shared within Trust Board report in July 2019.

2.19 CQUINS

The CQUINS relating to staff have not been concluded for 2020/2021 due to the COVID 19 pandemic, however 2019/20 were:

CQUIN 1: Achieving an uptake of the flu vaccine by frontline clinical staff of 80%. As of A review of lasts years attainment and planning for this year has begun, more detailed information will be shared through the report presented at Trust Board.

CQUIN 3: Achieving 80% of older inpatients receiving key falls prevention actions. The Associate Director of Nursing and Professional Practice for Moor to Sea is working with the falls prevention team regarding delivery and a more detailed report will be presented at Trust Board.

2.20 Research

The clinical school has seen a number of staff successful in research bids and undertaking pre-doctoral and doctoral study. The clinical school held a successful conference for the second year, there were many displays of research and QI studies being undertaken by professional practice staff.

Dr Susie Pearce is working with Trust staff to undertake a research evaluation into the benefits of the Private, Voluntary and Independent Sector education for domiciliary care staff and patients. The research is ongoing.

Dr Susie Pearce is also working with Trust staff to explore the benefits of the community hub multidisciplinary team working on staff. This research continues.

3. Conclusion

This report provides an update on safe staffing using the 6 key performance themes provided by The NHS England Nursing Quality Board mandated regular reports to Trust Boards in guidance published in 2016 and updated in 2017 and 2018.

The Trust safe staffing report provides evidence of benchmarking from model hospital, this Trust has seen improvement in CHPPD and remain in the lower quartile for WAU cost, and quality measures compared to our peers and nationally. The Trust has seen an improvement in the reduction of bank and agency costs, although there is further work to do in this arena, along with the efficiency and effectiveness of electronic rostering and Safecare.

4. Recommendations

The board are asked to note the contents of this six monthly Safe staffing report.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Estates and Facilities – Top line briefs, EFM performance, compliance and exception report		Meeting date: 27/5/2020
Report appendix	Appendix 1 – Estates Performance and Compliance Report	
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director, Estates and Facilities Operations	
Report provenance	Capital Infrastructure and Environment Group EFM Performance and Compliance Group Executives	
Purpose of the report and key issues for consideration/decision	The report is intended to provide an update to the Board on EFM key issues, performance and compliance for March and April 2020 **Top Line Brief** **EFM Performance** Despite the pressures of the CQC Preparation and significant estates COVID-19 works EFM Performance and Compliance remain good across all areas with all estates statutory and mandatory planned preventative maintenance prioritised. This is a remarkable achievement by the estates team. The Facilities team have also performed exceptionally well under pressure. A great deal of work has been undertaken including rescheduling cleaning, portering and waste teams, training staff in new cleaning and other FM procedures in COVID-19 areas, providing food and drinks to staff 24/7 and generally extending the hours of all services to ensure the Trust's response to COVID-19 is adequately supported. All this whilst maintaining excellent performance standards. **Risks** The well documented risks of the capacity and condition of the Estates and engineering infrastructure has been exposed during the planning and management of the COVID 19 surge. The key issues are summarised below: • **Medical Oxygen** - limitations around aged pipework and capacity in areas where high dependency patients could be placed e.g. Louisa Cary, Tower Block (has less provision than Hetherington) • **Ventilation** - Lack of appropriate ventilation systems to ensure negative or neutral pressure rooms in the right locations for COVID 19 patients	

	• **Building Management system** – Inability to control temperatures – because of lack of control of the BMS system when rooms are sealed or individual areas are sealed • **Single rooms** – the same number of individual rooms has led to bed capacity issues where one patient has been isolated in bay with the capacity for six beds. • **Windows** – Where windows have been sealed due to their condition staff and patients were not able to access fresh air as the doors were closed. • **Air conditioning** - is not recommended in a COVID area - some areas depend on this for cool air in the summer e.g. ED. • **Waste Storage** – The lack of waste storage areas combined with an increase in Clinical waste has presented significant storage, logistical and infection control issues to be overcome. • **Building Condition** - General condition of building e,g. taped up floors did not help cleaning regimes • **Space** - Lack of suitable office space to enable safe social distancing, and the requirement to reduce the bed numbers per bay has led to capacity issues. • **50-year-old building design** – lack of flexibility in the building design led to a significant amount of work to ensure that fire evacuation routes were not compromised when creating Green and Red Routes The Medical Gas Pipeline System has been fully tested to identify any potential limitations in the oxygen supply system's ability to provide the expected demand for Ventilators, CPAPs and other oxygen therapy systems required to treat the more serious COVID-19 Patients. It is fair to say that the engineering capacity and the condition of the estate has been a constraining factor on the Trust's clinical capacity to meet the COVID 19 demand. As would be expected in dealing with Covid 19 pandemic the Trust has seen an increase in the amount of Clinical waste. The increased financial consequence of this will be manged via the same process as for other Covid cost pressures. A risk assessment has been undertaken where activities affecting compliance have had to be suspended whilst the system has been in COVID surge and lockdown. These have been placed in the risk register with a score of 6 representing a low risk to the Trust. Activities will re-commence as soon as is possible. The risk areas are:

	Fire Damper Testing Following the Fire AE Audit, compartmentation of the Tower, Podium, Hetherington, Theatres and Women's Health Block it was established that 38% of the Fire dampers were not accessible and therefore unable to be tested. Remedial works in this area was being prioritised. However, this work has now been put on hold due to the restrictions imposed by COVID 19. The absolute compliance score for Fire damper testing remains at 62%, of those tested, 99% functioned correctly. The risk of a failure of a fire damper to work in the event of a fire is assessed on this basis as a low risk. A contractor is waiting to commence remedial works to improve access to Fire Dampers for testing once safe access can be provided. **Portable Appliance Testing** The contract for PAT Testing has been awarded and testing commenced within the Trust. This work has now been put on hold due to the access restrictions imposed by COVID 19. The Electrical Services Manager is currently reviewing areas which are safe to access and will reinstate the testing programme as soon as possible. PAT testing is done every 12 months and all items are in use daily. Emergency faults are reported as needed. A significant issue related to a delay in PAT testing is unlikely and therefore of low risk. Work will re-commence as soon as Covid restrictions and safe working will allow. **Fixed Wire testing** Fixed wire testing involves testing the electrical installations and systems that conduct electricity around the building. It covers all of the electrical wiring in a building and includes main panels, distribution boards, lighting, socket outlets, air conditioning and other fixed plant. This test is done every 5 years. The tender for the five-year tests has been returned and the contractor appointed. Work has started in community sites around COVID 19 restrictions. Work however is Acute site unable to start due to COVID 19 restrictions. Annual safety tests are undertaken and there is a planned preventative maintenance programme in place for electrical systems. It is therefore unlikely that a delay to the completion of the fixed wire testing within the required 5-year period will cause a significant issue and therefore risk to the Trust. Work will re-commence as soon as Covid restrictions and safe working will allow. ***The summary report is attached with the EFM Compliance and Performance dashboard appended at Appendix 1 for information.***

Action required (choose 1 only)	For information ☐	To receive and note ☒	To approve ☐

Recommendation	The Trust Board are asked to receive and note the: • Top line briefs for EFM for the months of March and April 2020 • EFM Compliance and Performance Reports and exceptions
Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks	

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

Torbay and South Devon
NHS Foundation Trust

Report title: Estates and Facilities – Top line briefs, performance and exception report		**Meeting date: 27/5/2020**
Report sponsor	Director of Estates and Commercial Development	
Report author	Associate Director, Estates and Facilities Operations	

1. Estates and Facilities Operations – Key Issues and Exceptions report for March and April 2020.

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the months of March and April 2020 and should be read in conjunction with the associated Section 2 Performance Table.

Table 1 below identifies the Key Performance Indicators variances for Estates and Facilities performance for the month of March and April 2020. Any areas of specific cause for concern for the attention of Trust Board are shown with appropriate explanation and action to achieve a resolution is shown at Table 2 below.

Table 1: Scorecard Indicator.

Green □	Amber!	Red □	**March**	**April**
Deteriorating Indicators				
Waste - % Total tonnage recycled waste per month			!	□
Improving Indicators				
Estates – urgent % P2 completed in < 1-4 days			□	!
Estates - Routine % P4 completed in <30 Days			□	□
Red rated Indicators with no change				
Estates – Internal Critical Failures			□	□
Estates - Fire Dampers Compliance - % in date			□	□
Estates – Portable Appliance Testing - % in date			□	□
Waste - % of Total tonnage of Clinical Burn waste per month			□	□

Table 2: Areas with Specific Cause for Concern	
Estates	**Estates Critical failures March and April 2020**
Explanation	1. Fire alarm detectors within Women's Health unit showing fault. System is still operational but indicator lamps not operating. This is due to age of system. This panel was due to be replaced in March, but work has been delayed due to COVID access restrictions. Work to continue once access to areas are safe for contractor to carry out work. 2. Gas leak outside LINAC – This removed supply for a period. Gas pipework repaired and put back in service 3. Tower Lift B – Contractor replaced Control Board, lift back in action 4. Nitrous Oxide Store at Totnes - Break in – restored security arrangements. 5. Water Leak at Kitson Hall - pipework leaking – works completed to identify location of leak and repair.
Estates	**Fire Dampers Compliance - % in date**
Explanation	Following the Fire AE Audit, compartmentation of the Tower, Podium, Hetherington, Theatres and Women's Health Block is being prioritised. This work has now been put on hold due to the restrictions imposed by COVID 19. A contractor is waiting to commence remedial works to improve access to Fire Dampers for testing once safe access available. The absolute compliance score for Fire damper testing remains at 62%, of those tested, 99% functioned correctly.
Estates	**Estates – Portable Appliance testing - % in date**
Explanation	The contract for PAT Testing has been awarded to SSE and testing commenced within the Trust although this work has now been put on hold due to the access restrictions imposed by COVID 19. The Electrical Services Manager is currently reviewing areas which are safe to access and will reinstate the testing programme as soon as possible.
Waste	**% Total Tonnage of Clinical Burn Waste per month**
Explanation	Pre-acceptance audits are on hold for some areas, until the end of July as agreed by the Environment Agency due to COVID- 19. Waste stream quantities have significantly reduced (by a total of 35 tonnes) mainly due to the reduction of routine and elective clinical activity whilst the Trust responds to COVID-19. Weekly Confidential waste console in-house collections are continuing and the contractor, Restore, intends to resume collections 27th May. Biosystems pilot is on hold until June 2020, with the intention to implement in the Hetherington Wards. Clinical Waste at the Acute site continues to be incinerated, although this has reduced this month by approximately 10 tonnes as clinical activity has fallen due to covid-19. A date is being set to re-audit the waste.
Estates	**Fixed Wire Testing Compliance - % in date**
Explanation	Tender returned and contractor appointed. Works to start in community sites pending COVID 19 restrictions. Acute site unable to start due to COVID 19 restrictions
Estates	**LEVs Testing Compliance - % in date**
Explanation	Survey in progress to capture all LEVs in use across the Trust. All LEVs that are recorded in the Estates Insurance Inspection Schedule are in date. A number of additional LEVs (Histopathology, Pharmacy, and Microbiology) are already being tested under existing External Maintenance Contract regimes.

Estates	Gas Appliance Compliance - % in date
Explanation	Work is underway to verify assets at Totnes, Ashburton and Paignton Hospitals. All other Gas appliances are in date for testing.
Estates	**Pressure Systems Compliance - % in date**
Explanation	All pressure vessels are in date for insurance inspections following resequencing. The Competent Person (PSSR) is re-verifying the relief pressures for our safety valves, and an exchange programme will be instigated to reset / replace units as required. Significant progress has been made to improve records and monitoring, this is continuing to ensure redundant assets are removed from monitoring and archived.

Estates and Facilities Operations Compliance Issues and Exceptions.

Main exceptions –

- Medical Gases Pipe Systems – The Medical Gases Policy final draft has been reviewed at the Medical Gas Committee and forwarded for final approval by the Health and Safety Committee.

2. Estates and Facilities Operations Action Plans

Action Plans

- **Fire** – Progress of the AE (Fire) Action plan continues to be monitored by the Head of SSEP.
- **EHO** –continued monitoring of the HACCP document and food safety within the ward kitchens. The "New ways of working" trial continues to be successful, and catering audits on the trial ward have seen 100% compliance around food safety on the trial wards. All wards within the Hetherington Unit are now transferred to the New Ways of Working Model, with the intention extend the trial to remaining wards through June.
- **Waste** – All clinical waste continues to be incinerated due to non-compliance of waste being received by the contractor from the Trust. The clinical waste contractor was on site on 2nd March 2020 to raise awareness to all staff via a roadshow in the Main Entrance raising awareness of the new Bio-System for waste segregation.
- **HSE** –- progress of the EFM actions within the overall Trust HSE action plan continues to be monitored by the Site Services Lead. Prime concerns are failed lighting at Cadewell Lane, and NHS Procurement vehicles reversing, without trained Banksmen, in the Fracture clinic area. A meeting was held with the Head of Procurement to review the processes which were put in place following the issuing of the HSE improvement notice.
- **Compliance** – The Canty Compliance Audit score remains at 72.3%, reflecting recent Ventilation Systems appointment confirmations.

Appendices:

Appendix 1 – EFM Performance and Compliance Dashboard

Domain	Estates & Facilities Operations Performance Data April 20 for May 20 Report	2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			2020-21 Quarter One			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Estates - Planned & Reactive work Performance	Total PPMs planned per month (not KPI)	979	1,374	1,051	1,178	1,067	1,206	951	1,057	1,094	1,060	1,100	1,124	910	0	0		9957	1089	Variable	13			Not a KPI - an indicator of volumes
	Statutory PPMs planned per month	347	796	443	444	398	430	364	386	411	432	377	407	368				5603	431	Variable				
	Statutory PPM % success against plan	98%	98%	96%	100%	95%	100%	98%	98%	90%	99%	96%	96%	95%					97%	97%	85%	85%	97%	
	Mandatory PPMs planned per month	485	422	441	505	449	552	431	438	519	443	481	521	422				6109	470	Variable				
	Mandatory PPM % success against plan	97%	100%	97%	99%	99%	98%	98%	97%	94%	99%	97%	99%	99%					98%	97%	85%	85%	95%	
	Routine PPMs planned per month	147	156	167	229	220	224	156	233	164	185	242	196	120				1696	188	Variable				
	Routine PPM % success against plan	67%	58%	80%	89%	85%	87%	67%	93%	68%	83%	77%	95%	85%					80%	90%	60%	60%	70%	
	Total Reactive Requests per month (not KPI)	851	910	974	1154	793	814	1028	1042	944	1038	915	722	507	0	0		8510	899	Variable	13			Not a KPI - an indicator of volumes
	Emergency - P1 - requests per month	97	60	80	83	95	88	98	86	98	85	131	79	6				1086	84	Variable				
	Emergency - % P1 completed in < 2hours	100%	99%	99%	99%	99%	98%	100%	100%	100%	100%	91%	100%	100%					99%	97%	90%	90%	95%	
	Urgent - P2 - requests per month	94	139	128	215	117	116	120	146	94	121	126	89	105				1169	124	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	98%	91%	85%	79%	87%	95%	87%	92%	93%	87%	93%	81%	89%					89%	97%	85%	85%	90%	
	Routine - P3 - requests per month	543	564	604	686	487	510	668	664	520	655	531	428	350				5246	555	Variable				
	Routine - % P3 completed in < 7 Days	90%	81%	82%	78%	73%	79%	72%	83%	74%	70%	63%	68%	90%					77%	97%	75%	75%	85%	
	Routine - P4 - requests per month	117	147	162	170	94	100	142	146	232	177	127	126	46				1310	137	Variable				
	Routine - % P4 completed in < 30 Days	86%	80%	79%	81%	79%	81%	67%	77%	49%	52%	61%	47%	85%					71%	97%	65%	65%	75%	
	Estates Internal Critical Failures per month	3	0	3	5	2	5	4	5	2	3	5	3	2				42	3.2	0	2	1	0	Fire Alarm, Gas Leak
Estates - Statutory / Mandatory Compliance Performance	Fire Alarm Testing Compliance - % In date		100%	100%	99%	98%	99%	99%	98%	99%	98%	99%	100%	100%				Stat	99%	97%	85%	85%	97%	
	Emergency Lighting Compliance - % In date		99%	99%	98%	99%	100%	99%	99%	97%	100%	99%	99%	99%				Stat	99%	97%	85%	85%	97%	
	Fire Extinguisher Compliance - % In date		97%	96%	98%	97%	97%	97%	97%	98%	98%	97%	97%	97%				Stat	97%	97%	85%	85%	97%	Ext Contractor reports
	Fire Dry Risers Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Fire Hydrants Compliance - % In date		0%	0%	0%	0%	0%	100%	100%	100%	100%	100%	100%	100%				Stat	58%	97%	85%	85%	97%	
	Fire Dampers Compliance - % In date		93%	93%	93%	93%	93%	95%	62%	62%	62%	62%	62%	62%				Stat	78%	97%	85%	85%	97%	99% of tested Fire Dampers are good - see narrative
	Fire Supression Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Fixed Wire Testing Compliance - % In date		93%	93%	94%	93%	94%	94%	94%	94%	94%	94%	94%	94%				Stat	94%	97%	85%	85%	97%	
	Portable Appliance Testing - % in date		100%	100%	100%	100%	100%	100%	95%	83%	83%	83%	83%	70%				Mand	91%	97%	85%	85%	95%	PAT test regime delayed due to COVID -19. to be restarted as soon as contractpor safe to work. Outlying buildings to be done first
	HV Equipment Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Generator Servicing Compliance - % In date		92%	92%	92%	92%	92%	38%	23%	38%	77%	100%	100%	100%				Mand	78%	97%	85%	85%	95%	
	Generator Load Test Compliance - % In date		92%	92%	92%	92%	92%	38%	23%	38%	77%	92%	92%	92%				Mand	76%	97%	85%	85%	95%	
	Lightning Protection Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Auto Door Inspection Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Mand	100%	97%	85%	85%	95%	
	LEVs Testing Compliance - % In date		96%	96%	96%	92%	92%	92%	89%	89%	89%	92%	92%	92%				Stat	92%	97%	85%	85%	97%	
	Critical Vent Varification Compliance - % In date		97%	98%	94%	100%	97%	97%	100%	100%	100%	98%	100%	100%				Stat	98%	97%	85%	85%	97%	
	Kitchen + Extract Duct Cleaning - % In date		94%	94%	94%	94%	100%	100%	100%	100%	77%	77%	100%	100%				Stat	94%	97%	85%	85%	97%	
	Gas Pipework Compliance - % In date		95%	96%	71%	82%	93%	93%	86%	100%	100%	100%	100%	100%				Stat	93%	97%	85%	85%	97%	
	Gas Appliance Compliance - % In date		100%	100%	100%	100%	100%	100%	96%	97%	96%	96%	100%	100%				Stat	99%	97%	85%	85%	97%	
	Landlord Gas Appliances Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	97%	97%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Pressure Systems Compliance - % In date		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	100%				Stat	95%	97%	85%	85%	97%	A different 5% to be completed each month. All in operation equipment in date.
	Window & Restrictor Insp Compliance - % In date		95%	96%	96%	96%	94%	96%	96%	96%	96%	96%	96%	96%				Mand	96%	97%	85%	85%	95%	
	Asbestos Inspections Compliance - % in date		75%	75%	80%	81%	93%	95%	95%	91%	91%	91%	91%	90%				Stat	87%	97%	85%	85%	97%	KAH, Theatres, Walnut + Union to be reinspected
	Water Safety Checks - works % in date		98%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	98%				Stat	98%	97%	85%	85%	97%	Data From Shire Management System
	Edge protection Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Ladder Inspection Compliance - % In date		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data April 20 for May 20 Report	2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			2020-21 Quarter One			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Porters	Porters - Total Tasks per month	8451	9275	8590	9292	8630	8346	9100	8704	8711	9197	8290	8798	8006				113390	8722	Variable				Not a KPI - an indicator of volume
	Porters - Bloods Tasks per month	2278	2471	2422	2438	2218	2174	2393	2287	2186	2427	2256	2308	2330				30188	2322	Variable				
	Porters - Patient Transfer Tasks per month	2096	2445	2144	2316	2289	2219	2217	2117	2169	2078	1964	1875	1249				27178	2091	Variable				
	Porters - Notes Tasks per month	1542	1735	1521	1795	1623	1560	1928	1863	1698	1982	1725	1857	1330				22159	1705	Variable				
	Porters - Urgent Tasks per month	186	180	160	178	182	183	194	174	174	209	162	192	101					175	Variable				
	Porters - Routine Tasks per month	7939	8827	7156	8786	8146	7841	8600	8266	8272	8685	7829	8373	7640					8182	Variable				
	Porters - Booked Tasks per month	326	268	274	327	302	322	306	264	265	303	299	233	265					289	Variable				
Cleaning	Scores - Brixham Hosp - High Risk	99%	99%	99%	99%	99%	98%	98%	98%	98%	98%	98%	98%	98%					98%	95%	90%	90%	95%	
	Scores - Brixham Hosp - Significant Risk	97%	99%	100%	100%	98%	98%	99%	97%	98%	99%	98%	98%	98%					98%	85%	80%	80%	85%	
	Scores - Brixham Hosp - Low Risk	100%	100%	100%	100%	100%	99%	97%	94%	98%	98%	97%	97%	97%					98%	80%	75%	75%	80%	
	Scores - Dawlish Hosp - High Risk	100%	100%	100%	100%	99%	98%	99%	98%	99%	100%	98%	98%	98%					99%	95%	90%	90%	95%	
	Scores - Dawlish Hosp - Significant Risk	100%	100%	100%	100%	100%	100%	99%	98%	99%	99%	98%	98%	98%					99%	85%	80%	80%	85%	
	Scores - Newton Abbot Hosp - High Risk	99%	100%	99%	99%	99%	100%	98%	97%	99%	98%	98%	98%	98%					99%	95%	90%	90%	95%	
	Scores - Newton Abbot Hosp - Significant Risk	99%	99%	100%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%					98%	85%	80%	80%	85%	
	Scores - Newton Abbot Hosp - Low Risk	97%	100%	99%	99%	99%	99%	99%	99%	98%	98%	98%	98%	98%					99%	80%	75%	75%	80%	
	Scores - Paignton H+WBC - High Risk	96%	100%	100%	100%	99%	99%	99%	98%	98%	98%	98%	98%	98%					99%	95%	90%	90%	95%	
	Scores - Paignton H+WBC- Significant Risk	98%	100%	99%	99%	99%	99%	99%	98%	98%	98%	99%	99%	98%					99%	85%	80%	80%	85%	
	Scores - Paignton H+WBC - Low Risk	98%	99%	99%	99%	99%	98%	98%	95%	96%	96%	95%	95%	95%					97%	80%	75%	75%	80%	
	Scores - Teignmouth Hosp - Very High Risk	100%	100%	100%	100%	99%	99%	99%	99%	98%	98%	98%	98%	98%					99%	98%	95%	95%	98%	Theatres Areas
	Scores - Teignmouth Hosp - High Risk	100%	100%	100%	100%	100%	99%	99%	99%	98%	98%	98%	98%	98%					99%	95%	90%	90%	95%	
	Scores - Teignmouth Hosp - Significant Risk	99%	100%	100%	99%	99%	99%	99%	99%	97%	97%	95%	95%	95%					98%	85%	80%	80%	85%	
	Scores - Torbay Hosp - Very High Risk	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	98%	98%	98%					99%	98%	95%	95%	98%	Theatres Areas, Turner, ICU, A+E.
	Scores - Torbay Hosp - High Risk	97%	99%	98%	98%	98%	98%	98%	97%	97%	99%	98%	98%	98%					98%	95%	90%	90%	95%	
	Scores - Torbay Hosp - Significant Risk	98%	99%	99%	99%	98%	99%	98%	95%	96%	98%	98%	98%	98%					98%	85%	80%	80%	85%	
	Scores - Torbay Hosp - Low Risk	85%	97%	100%	97%	97%	98%	98%	95%	95%	95%	95%	95%	95%					96%	80%	75%	75%	80%	
	Scores - Totnes Hosp - High Risk	99%	99%	100%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%					98%	95%	90%	90%	95%	
	Scores - Totnes Hosp - Significant Risk	99%	99%	99%	96%	96%	100%	95%	97%	98%	98%	98%	98%	98%					98%	85%	80%	80%	85%	
	Scores - Totnes Hosp - Low Risk	98%	98%	100%	90%	90%	94%	95%	94%	96%	98%	97%	97%	97%					96%	80%	75%	75%	80%	
	HPV Cleans per month	11	21	31	35	21	22	41	20	20	28	21	25	39				222	26	Variable				From Porter data HPV data
	Deep Cleans per month	854	887	801	880	779	746	805	789	774	1010	835	1090	1275				7315	887	Variable				From Porter data Deep Clean Categories (x5) data
	Annual Deep Cleans per month	7	4	1	5	9	34	9	4	4	4	12	13	2				77	8	Variable				Added Sep 19 from Porter data Periodic Cleans (Rooms).
	Critical Cleaning Failures	1	0	0	1	0	0	0	0	0	0	0	0	0				2	0.2	0	2	1	0	

Domain	Estates & Facilities Operations Performance Data April 20 for May 20 Report	2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			2020-21 Quarter One			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Accom	Boyce Court Occupancy Void Costs	0	381	340	1,323	0	479	329	329	0	0	0	0	0				3181	244.7	Variable	2000	2000	1000	IVs in arrears. 68 Flats, charges if 95%-70% full. Budget £24,312
	On-Site - Staff Accomodation Income	34,142	31,084	19,398	19,883	22,385	24,508	25,730	25,304	28,937	25,708							257079	25708	Variable	19256	19256	24391	Annual budget - £308,099
Catering	Patient Meals provided per month	31452	31461	31429	31458	31536	31557	31143	31351	33303	29375	30300	21822	19290				284690	29652	Variable				
	Meals purchased at Bayview Restaurant per month	3874	3917	4027	5848	5413	5769	6389	6292	5384	5732	5539	5071	2894				46913	5088	Trend				
	Meals purchased at Horizon Café per month	2791	2843	2807	2886	1991	2835	3035	3066	2022	2425	2547	1575	0				24276	2371	Trend				
	Red Catering Trays per month	748	763	724	784	798	783	738	759	793	787	792	752	708				6890	764	Trend				Need to establish data collection method
	% of Catering Food Waste per month	2.0%	2.0%	3.0%	4.2%	3.9%	4.3%	4.1%	4.7%	4.4%	4.9%	5.3%	5.5%	6.1%					4%	5%	10.0%	10.0%	5.0%	
	EHO Audit Scores - Acute	2	2	2	3	3	3	3	3	3	3	3	3	3					2.8	5	2	2	4	
	EHO Audit Scores - Brixham Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	EHO Audit Scores - Dawlish Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	EHO Audit Scores - Newton Abbot Hospital	4	4	4	4	4	4	4	4	4	4	5	5	5					4.2	5	2	2	4	
	EHO Audit Scores - Totnes Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	Catering Audits					28	36	32	38	26	37	32	26	16					30.1	5	25	25	30	Added Sep 19
Waste	Total Tonnage all waste streams per month	161.0	185.0	161.7	182.1	165.3	175.3	176.1	148.0	179.2	178.9	151.0	161.0	125.2				1533.7	165.4	Trend				
	% of Total tonnage Recycled Waste per month	47.4%	49.5%	50.1%	51.6%	46.4%	52.7%	47.2%	41.1%	53.3%	53.1%	44.2%	48.3%	45.1%					49%		40.0%	40.0%	47.0%	
	% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					0%		5.0%	5.0%	2.0%	
	% of Total tonnage of Clinical Non-Burn waste per month	10.1%	9.1%	10.7%	9.9%	10.6%	8.9%	9.4%	12.7%	5.5%	5.7%	1.3%	1.5%	1.4%					10%	100%	11.0%	9.0%	10.0%	
	% of Total tonnage of Clinical Burn waste per month	10.8%	10.1%	10.5%	10.6%	11.0%	10.1%	11.1%	12.3%	20.1%	19.8%	33.5%	31.7%	32.9%					12%	100%	13.0%	9.0%	11.0%	Theatre Waste is incinerated to avoid contaminated waste being sent to contractor.
	% of Total tonnage of Clinical Offensive waste per month	11.9%	10.6%	10.6%	11.9%	11.6%	10.9%	11.5%	13.7%	6.2%	6.5%	2.6%	2.3%	1.7%					11%		12.0%	10.0%	11.0%	
	% of Total Tonnage Waste to Energy	19.9%	20.8%	18.1%	16.0%	20.4%	17.4%	20.7%	20.1%	15.0%	16.2%	18.4%	16.2%	18.8%					19%		35.0%	35.0%	24.0%	
	Total Waste to Energy (tonnes)	30.6	29.0	28.6	25.6	31.4	27.5	31.9	48.1	35.0	37.0	27.8	26.0	23.6				287.7	30.9	Trend				This figure does not necessarily match the % of the total
	Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	Trend	90%	90%	95%	15 Audits per month

Domain	Estates & Facilities Operations Performance Data April 20 for May 20 Report	2019-20 Quarter One			2019-20 Quarter Two			2019-20 Quarter Three			2019-20 Quarter Four			2020-21 Quarter One			Trend	YTD 2019 to 2020	Average to date	Target 2019-20	RAG Threshold			Comments
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Workforce	Total Estates and Facilities Staff (FTE)	387	391	392	393	390	394	398	398	398	398	394	390	403	0	0			394		13			Update no of Months in V94 for av in T94
	Estates Staff	34	34	34	34	32	34	34	35	37	38	37	35	39					35					
	Facilities Management	23	23	22	22	21	21	20	20	20	20	20	22	21					21					
	Hotel Services - Catering	33	33	33	33	33	33	33	33	33	32	31	33	32					32					
	Hotel Services - Domestic	223	227	230	231	230	231	234	234	233	232	232	226	235					231					
	Hotel Services - Other	74	74	74	74	75	76	78	78	76	76	74	73	76					75					
	Achievement Review Compliance %	92%	95%	95%	93%	85%	85%	85%	85%	90%	89%	89%	87%	84%					89%	95%	80%	80%	90%	No input from WIT for March 2020.
	Sickness Absence % (Month Sick Rate)	3.8%	3.0%	2.3%	4.5%	4.2%	5.1%	5.9%	5.0%	5.2%	5.5%	5.5%	5.3%						4.6%	3%	3.8%	3.8%	3.5%	1 month in arrears. Domestics 8%
	Mandatory Training - Conflict Resolution	93%	96%	97%	93%	96%	95%	95%	94%	94%	95%	96%	95%	94%					95%	90%	75%	75%	85%	
	Mandatory Training - Equality & Diversity	96%	98%	98%	98%	98%	95%	97%	97%	97%	96%	97%	94%	94%					97%	90%	75%	75%	85%	
	Mandatory Training - Fire Training	96%	98%	97%	97%	98%	94%	97%	98%	95%	94%	95%	92%	89%					95%	90%	75%	75%	85%	
	Mandatory Training - Health & Safety	95%	96%	98%	98%	98%	96%	98%	97%	97%	97%	98%	97%	95%					97%	90%	75%	75%	85%	
	Mandatory Training - Infection Control	94%	96%	96%	97%	96%	94%	94%	94%	95%	94%	93%	92%	91%					94%	90%	75%	75%	85%	
	Mandatory Training - Information Governance	94%	94%	94%	95%	97%	93%	94%	93%	92%	90%	91%	88%	86%					92%	95%	85%	85%	95%	Estates - 74%
	Mandatory Training - Moving & Handling	97%	98%	99%	97%	96%	92%	95%	94%	96%	95%	96%	91%	91%					95%	90%	75%	75%	85%	
	Mandatory Training - Safeguarding Adult Level 1	96%	99%	98%	99%	98%	98%	98%	97%	99%	97%	98%	97%	95%					98%	95%	80%	80%	90%	
	Mandatory Training - Safeguarding Children	95%	96%	97%	98%	98%	96%	97%	97%	98%	97%	98%	94%	93%					97%	95%	80%	80%	90%	
	Mandatory Training - Resuscitation	91%	92%	94%	94%	96%	93%	94%	94%	94%	97%	94%	92%	91%					94%	90%	75%	75%	85%	Estates 77%
	Mandatory Training - Basic Prevent Awareness	97%	99%	99%	99%	98%	97%	97%	97%	98%	93%	98%	97%	95%					97%	90%	75%	75%	85%	
Safety	EFM Serious/RIDDOR incidents	1	0	0	0	0	0	0	0	0	0	0	0	0				1	0.1	0	2	1	0	
	EFM incidents resulting in moderate harm	2	0	2	1	2	0	1	2	1	0	1	0	1				13	1.0	0	3	3	1	
	EFM incidents resulting in minor harm	1	5	4	5	10	5	8	5	2	4	7	3	3				62	4.8	0	8	8	4	All involving Covid Waste - failure to meet local standards
	EFM incidents resulting in no harm	2	11	10	12	8	6	10	13	12	11	12	11	13				131	10.1	0	15	15	8	
	CAS Alerts active and in Progress	9	8	7	7	5	3	3	2	2	4	4	5	3					5	Variable				Includes 2 requiring no response
	CAS Alerts Overdue for Completion	5	7	6	5	4	1	2	1	1	1	1	1	1					2.8	0	2	2	0	IT Zebra Printers CAS Alert