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

Seminar Room 5, Horizon Centre, Torbay Hospital and via Microsoft Teams
29 July 2020 09:00 - 29 July 2020 12:00

AGENDA

#	Description	Owner	Time
	User Experience Story	Ch	
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence - Jane Viner, Chief Nurse Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 24th June 2020 and Outstanding Actions Approve 20.06.24 - Board of Directors Minutes Public.pdf 9	Ch	
2.4	Report of the Chairman Note	Ch	
2.5	Report of the Chief Executive Receive and Note Report of the Chief Executive.pdf 23	CE	
2.6	Integrated Performance Report - Month 3 Receive and Note Integrated Performance Report Month 3.pdf 37	DTP	
2.7	Covid Recovery Plan Approve Covid Recovery Plan.pdf 101	DTP	

#	Description	Owner	Time
2.8	Care Quality Commission Update Receive and Note Care Quality Commission Update.pdf 117	CN	
2.9	Assurance Framework for Seven Day Services Receive and Note Assurance Framework for Seven Day Services.pdf 135	AMD	
2.10	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 143	AMD	
2.11	Midwifery Staffing Oversight Report Receive and Note Midwifery Staffing Oversight Report.pdf 157	CN	
2.12	Maternity Governance Safety Report (1 April - 30 June 2020) Receive and Note Maternity Governance Safety Report.pdf 169	CN	
2.13	Torbay and South Devon Clinical School Annual Report Approve Torbay and South Devon Clinical School Annual Re... 179	CN	
2.14	Risk Management Strategy/Policy Approve Risk Management Strategy and Policy.pdf 191	CS	
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Finance, Performance and Digital Committee - 22nd June and 27th July 2020 Receive and Note June20_FPD_Cttee_Report_to_Board.pdf 231	C Balch	

#	Description	Owner	Time
3.1.2	People Committee 22nd June 2020 Receive and Note People Committee Report to Board Ref June 2020.... 233	V Matthews	
3.1.3	Quality Assurance Committee - 27th July 2020 Receive and Note	J Lyttle	
3.2	Reports from Executive Directors		
3.2.1	Safe Staffing and Nursing Work Programme Update Receive and Note Safe Staffing and Nursing Work Programme Updat... 235	CN	
3.2.2	Report of the Chief Operating Officer Receive and Note Report of the Chief Operating Officer.pdf 251	IDO	
3.2.3	Estates and Facilities Performance and Exception Report Receive and Note Estates and Facilities Performance and Exception... 257	CFO	
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.00 am, Wednesday 30th September 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 SEMINAR ROOM 6, HORIZON CENTRE, TORBAY HOSPITAL AND VIA MICROSOFT TEAMS ON WEDNESDAY 24TH JUNE 2020

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* 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
	Mrs L Davenport	Chief Executive
	* Mrs L Darke	Director of Estates and Commercial Development
	* Dr R Dyer	Executive Medical Director (part)
	* 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 Viner	Chief Nurse
In attendance:	* Mrs J Carroll	Interim Director of Operations
	* Mr I Currie	Acting Medical Director (part)
	* Mrs J Downes	Company Secretary
	Mrs S Fox	PA to Chief Executive
	* Mrs J Gratton	Head of Communications

* via video-conference

		ACTION
110/06/20	**Board Corporate Objectives** The Board noted the Corporate Objectives.	
	PART A: Matters for Discussion/Decision	
111/06/20	**Apologies for Absence** Apologies were received from Professor Chris Balch and Mrs Jacqui Lyttle, Non-Executive Directors, Mr John Harrison, Chief Operating Officer, and Mrs Jackie Stockman, Torbay Council Representative.	

112/06/20 **User Experience Story**

The Board listened to an interview from BBC Radio 4 with a young carer and her father from Torbay and her experiences of caring for her father, who had complex medical conditions and was required to shield during the Covid-19 outbreak.

The Board found the interview very humbling and highlighted the impact of Covid-19 on individuals and families in the community.

The Chief Executive informed the Board that the young carer was supported by the Torbay Youth Trust who were providing support for young carers in the Bay. She added that the Trust had a responsibility to consider how it could best support young carers who have a critical role to play, whilst ensuring their own needs were addressed. It was acknowledged that Covid-19 restrictions had put a particular pressure on all carers.

113/06/20 **Declarations of Interests**

There were no declarations of interest made.

114/06/20 **Minutes of the Board Meeting held on the 27th May 2020 and Outstanding Actions**

The minutes of the meeting held on the 27th May 2020 were confirmed as an accurate record.

The outstanding actions log was reviewed and updated.

115/06/20 **Report of the Chairman**

The Chairman briefed the Board as follows:

- The Chairman had met with nearly all of the Trust's new Governors. He wished to place on record his thanks for the continued support and engagement of Governors, particularly over recent months.

- The Chairman was a guest speaker at a recent Torbay Business Community Webinar where he was able to discuss the Trust Care Model with attendees.

- Interviews for the Chief Nurse position had taken place. It was envisaged the appointment process would conclude early week commencing 30th June.

- The Chairman and Chief Executive took part in a Facebook live panel led by Torbay Council on 18th June. Representatives from Education, Police, voluntary sector and Public Health also joined the panel. The event was very well attended and highlighted good collaboration between agencies.

Finally, the Chairman wished to formally thank both Mrs Viner, Chief Nurse and Mrs Darke, Director of Estates and Commercial Development, as this was their last Board meeting before retirement, for their commitment and support both to the Chairman personally and the Trust, over many years. The Chairman said that their contribution and positive legacy would remain in the Trust for a long time.

The Chief Executive, firstly addressing Mrs Viner, wished to thank her for her positive contribution on her and the wider team. She had provided support and guidance to the Chief Executive when she took on the role. She thanked Mrs Viner for her support in meetings, and ensuring Executive Directors focussed on the work that needed to be undertaken. She also wished to thank Mrs Viner for her approach to health and wellbeing of the Trust's workforce and more personally the executive director team. Mrs Viner's input and support throughout the recent CQC visit was noted, and finally her reputation as a professional lead not just in the Trust, but in the wider community was highlighted.

Mrs Viner thanked the Chairman and Chief Executive and said that she felt proud and privileged to have worked for the organisation over the past few years.

In addressing Mrs Darke, the Chief Executive thanked her for her tenacity and focus in holding executive directors to account and support in ensuring the hospital's estate supported the Trust's business. She also thanked Mrs Darke for the work she had undertaken in realising Health and Wellbeing Centres in the Trust's footprint and her work with stakeholders and the local community in this regard.

Mrs Darke thanked the Chairman and Chief Executive and said that she looked forward to supporting the Hospital Improvement Programme process in her new role.

116/06/20 **Report of the Chief Executive**

The Chief Executive briefed the Board as follows:

- The Chief Executive wished to place on record her thanks to the Trust's staff for their work on restoration and recovery during the post-Covid-19 phase.

- Antibody testing of staff had commenced and already over 1,000 staff had been tested.

- Staff were now required to wear face masks in public places and in environments where social distancing cannot be observed. The Chief Executive wished to thank the Trust's Infection Prevention and Control team for their support in ensuring the Trust was adhering to all guidelines.

- The Chief Executive wished the Board to note the support it has received from the local community over the past few months which has included in particular donations of food. To support the Trust's local

community the Trust had taken the opportunity to donate some of the food to the Torbay Food Alliance for those most at need.

- The Trust had now undertaken its factual accuracy check of the Care Quality Commission (CQC) report and submitted its response to the CQC. The outcome of the submission was not yet known and it was expected the final report would be published in the near future.

- The reappointment of the Chairman for a further year was welcomed and would enable the Trust to continue its integrated care strategy in the longer term.

- The Chief Executive reflected on the sad death of George Floyd in America and the need for all people irrespective of race, ethnicity etc to be treated on an equal basis. She said that in her role as a leader of the Trust, she had been speaking to senior clinical staff and the Trust's Black Asian Minority Ethnic (BAME) Lead to seek their views and personal feelings about the situation and any learnings for the Trust.

- A planning application had been submitted to South Hams District Council for the Dartmouth Health and Wellbeing Centre.

- Mrs Matthews welcomed the submission of the planning application for the Dartmouth Health and Wellbeing Centre and the work in respect of learning from George Floyd's death. Mrs Mathews offered her support to the Executive Directors in this respect and also in the work around staff health and wellbeing.

- Finally, the Chief Executive highlighted the work of the Trust's community dentistry team who had been personally supporting patients at Langdon Hospital, a secure mental health facility. She said the impact on the health and wellbeing of patients at this unit could not be under-estimated led through the support of the dentistry team.

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

117/06/20 **Integrated Performance Report – Month 2**

a) **Quality**

The Chief Nurse drew the Board's attention to the number of Clostridium Difficile cases (seven) and said a deep dive would be taking place to understand the reasons for this increase. The Board also noted incidents including a recent maternal death and fractured neck of femur.

The Chief Nurse reminded the Board that post-Covid-19, an increase in the number of complaints could be expected as patients reflected on their experiences.

b) **Workforce**

The Director of Workforce and Organisation drew the following to the Board's attention:

- Sickness reporting had been split into Covid-19 and non-Covid-19 sickness. In March there were around 1,000 members of staff absent due to Covid-19 related reasons. This had now reduced to around 400 with support being provided to staff to enable them to return to the work setting.

- Other sickness levels had improved to 4.12%. The Trust's wellbeing offer continued to be promoted and at present a health and wellbeing survey was being conducted.

- Staff antibody testing had been well-received with testing being provided to staff from the Clinical Commissioning Group; Devon Partnership Trust; and South Western Ambulance Service, as well as Trust staff.

- There continued to be a focus to increase the number of staff performance achievement reviews undertaken which had, for a long time, been an area of concern for the Board. The People Committee has agreed to undertake a detailed review of achievement reviews to try to understand the reasons why the Trust target level was not being met.

Mrs Matthews said she welcomed the review of the Trust's achievement review process and also wished to place on record her congratulations for reducing the number of Covid-19 related absence by over half.

The Chief Executive also welcomed the focus on achievement reviews, not only in relation to the number undertaken but also the quality of the reviews and how they supported staff given the impact on staff receiving the right level of support had a direct impact on patient experience.

Performance

The Interim Director of Operations drew the following to the Board's attention:

- There had been many challenges to performance over the last few months including loss of capacity due to Covid-19.

- Work had commenced to step up services. Around 90 different services had been approved to be reinstated, but capacity was restricted due to the need to observe infection prevention and control and social distancing guidelines. This was therefore having the impact of an increase in patient numbers on waiting lists and the length of waiting times.

- Close scrutiny was being applied to waiting lists to ensure patients were being prioritised and the impact of extended waits was understood.

- It was noted that patients, in some cases, were choosing not to have surgery due to the need to isolate for two weeks before and after surgery which was impacting on waiting times.

- Diagnostic waits had also increased, however due to the availability of a mobile scanner, scanner capacity had increased to 90% of pre-Covid-19 levels.

- Operational Teams were ensuring that they were working in innovative and creative ways in response to the current climate, which included different ways of providing outpatient appointments by using the NHS Attend Anywhere platform. At present around 25% of activity was virtual and work continued to increase this figure, alongside work to increase capacity to manage waiting times.

- Activity levels in the Emergency Department had increased as lockdown has been eased. Work was taking place, led by the Director of Transformation and Partnership, to review the configuration of the Trust's urgent and emergency provision.

- 'Check and Challenge' meetings were being held with the Integrated Service Units to ensure capacity was being maximised and other transformation opportunities explored.

- It was noted the CAMHS urgent referrals seen within one week data in the dashboard was incorrect and would be amended for the next meeting.

- The Board was reminded that teams were setting up services in a complex environment whilst trying to ensure capacity was maximised and social distancing and infection control guidance met.

The Director of Transformation and Partnerships said that the Trust needed to work with its primary care partners to ensure patients did not come to harm whilst on waiting lists. She added that Covid-19 had demonstrated the understanding that there was a link between bed occupancy and urgent care performance with improvements in the 4 hour target; 12 hour trolley waits; stroke targets; and care planning summaries. Learning from this would be taken forward for future planning.

Mr Richards reflected on the work that had taken place to date and the modelling and planning to step up services. He asked if the Board could receive a programme setting out when services might be back up and running so that timelines and a plan of work could be understood, alongside a communications plan. He added that the plan would have implications for the Trust's future strategy which needed to be understood.

The Interim Director of Operations informed the Board that analytic modelling had just been completed, with each service reviewing capacity and activity. Check and challenge sessions would then take place to review the data and assumptions to ensure capacity was being fully utilised. Once this work was completed it would be shared with the Board. In terms of communication, a communications plan was in the process of being agreed. This would be brought to the July Board meeting. DTP

The Chief Executive added that that Trust needed to work with the wider system to ensure that any health inequalities were minimised as a consequence of Covid-19. She added that the system Chief Executives were

looking at different ways of work to ensure equal access to services across Devon, supported by work at regional level. This work would also be informed by national guidance around Phase 3 Covid-19 planning, which was expected in the near future.

Mr Welch referred to the use of NHS Attend Anywhere and asked why more people were not using the option for video consultations. The Director of Transformation and Partnerships explained that support needed to be provided to patients to use the video option and the work internally that needed to take place to support clinical teams to work in different ways and support video consultations. She said she would provide regular updates to the Board on the uptake of NHS Attend Anywhere.

In respect of the improvements in the production of Care Planning Summaries, the Executive Medical Director reminded the Board that the Trust had been challenged for some time in terms of timely production of Care Planning Summaries. He said that Covid-19 had demonstrated the process to produce the summaries worked well and he reminded the Board of the benefit to patients and primary care of receipt of timely Care Planning Summaries.

The Executive Medical Director reflected on the increases in waiting times and the risks to patients due to long waits. He said that a weekly webinar was held with primary care colleagues and that at these meetings concerns had been raised by GPs around an apparent shift in activity due to different ways of working resulting in patients being sent to GPs for procedures such as blood tests and examinations. GPs had acknowledged that this might be appropriate, however it needed to be managed in a planned way. The Executive Medical Director said he would keep the Board updated on this work.

d) **Finance**

The Chief Finance Officer highlighted the following:

- A surplus of £3m for the year to date was reported, offset by additional costs due to Covid-19 of £4.8m, and funding from NHSI of £2.8m bringing the Trust to a break-even position.

- In addition to spend related to Covid-19 in the acute sector of £4.8m there had been spend in the independent sector of £1.8m.

- The Chief Finance Officer provided assurance that the Trust's current liability was in effect paid in advance as part of the new financial regime.

- The Trust's cash position was strong and the Trust continued to focus on timely payments to its suppliers.

- The Board was reminded that the new financial regime was viewed as temporary for months 1 to 4, and work was ongoing to produce a financial framework for months 5 to 12. The Chief Finance Officer said there would be some risk in the regime for the second half of the year, for example an expectation that Trusts would need to cover costs for

access to the private sector such as Mount Stuart Hospital, which was currently funded centrally. There was also a risk around displaced demand as it was known patients were not currently accessing care in a normal way.

- There were also risks around operational efficiency and productivity, with the impact of infection prevention and control and social distancing measures which would constrain capacity. The resilience of the Trust's workforce also needed to be considered and the need to ensure staff took appropriate breaks and booked annual leave.

- Finally, the Chief Finance Officer provided assurance that all Covid-19 spend was fully understood and recorded and that he was working with the regional and national teams in terms of the Trust's recovery plans.

Mr Sutton queried capital spend and the risks for the Trust. The Chief Finance Officer explained that the capital regime had not yet been finalised, and that he continued to work with the regional team with an aim to right-size the STP capital allocation. Alongside this there were technical mitigations that could be put in place around different types of capital spend at STP and national level. He added that a lot of work was taking place to triangulate and risk assess the Trust's internal capital programme and the Board noted that the only capital programmes that were being progressed were those that were already underway before the start of the new financial year.

The Board of Directors received and noted the Integrated Performance Report – Month 2.

118/06/20 **Covid-19 Infection Prevention and Control Public Health England Board Assurance Framework (BAF)**

The Chief Nurse explained that this report set out the Trust's position against the National Infection Prevention and Control BAF. The Chief Nurse wished to place on record her thanks to the Trust's Infection Prevention and Control Team for their work in supporting the Trust through the Covid-19 pandemic. In particular thanks were given to the Trust's Director of Infection Prevention and Control, Dr Selina Hoque, who was standing down from the role.

Dr Hoque had reviewed the BAF and approved the assurance provided against its requirements. The document would support the Trust to maintain its quality standards as it moved into the recovery phase of the pandemic. It was noted that the BAF would be reviewed and monitored by the Quality Improvement Group and Quality Assurance Committee.

The Board of Directors received and noted the Covid-19 Infection Prevention and Control Public Health England Board Assurance Framework.

119/06/20 **Volunteering and Covid-19**

The Board noted the huge impact to the Trust as a result of support from its voluntary sector partners during the Covid-19 pandemic.

It was noted that work was taking place to extend the scope of the Trust's volunteering offer and that roles and scope had been agreed in case of a second spike.

It was hoped the volunteering services team would be moved to be part of the workforce offer so the totality of the Trust's workforce was managed through the same framework. In addition, work was taking place with the Voluntary, Community and Social Enterprise sector around financial support for the services provided.

The Chairman reflected that one of the positives of the Covid-19 pandemic had been the close working relationships with the volunteering community and that those links needed to continue post-Covid-19. He also stated that financial support needed to be formalised as stated above.

Mrs Matthews said she welcomed the agreement to review volunteering as part of the remit of the People Committee which would enable there to be one understanding of the Trust's workforce capacity.

The Director of Workforce and Organisation Development wished to place on record her thanks to the Trust's Volunteering Team. She added that Covid-19 had also attracted people into volunteering who might not have been interested before; volunteers were also coming through national programmes and expressing an interest in supporting the Trust.

Mrs Taylor reminded the Board that volunteers needed to be managed and supported and receive training and development opportunities.

In receiving the report, the Board agreed that formal acknowledgment would be made to the Trust's VCSE sector partners in both South Devon and Torbay for their valuable contribution. CN

120/06/20 **Children and Family Health Devon Update**

The Chief Nurse presented the report which provided a high level overview for the service, marking the first year of the Trust becoming prime provider for the Children and Family Health Devon Alliance (the 'Alliance').

The following was then discussed:

- The Alliance was led by a Partnership Board and over the past year it had started to bring clarity to the structure and function of the Alliance.

- The Alliance provided two services for Torbay; nursing and therapies, and a Child and Adolescent Mental Health Service (CAMHS) for Devon Partnership Trust.

- The Board noted that over the past year there had been issues around performance, in particular the CAMHS and waiting times for the autism

assessment service. In terms of the autism service, capacity had increased, however funding was not sufficient to meet demand and therefore alternative models were being explored.

- Staff had been working to ensure they could still provide a service whilst maintaining social distancing guidelines.

- An increase of cases was expected post-Covid-19, including in areas such as Looked After Children and safeguarding. The report included detail on the plans to manage the expected increase.

- There had been various workforce challenges over the past year impacting on the service and was to be expected following transfer of a service to a new provider.

- Areas of focus for the next six months included the autism pathway; transformation workstreams; clarity around funding; CAMHS performance and delivery; and delivery of contractual and statutory responsibilities.

- The Chief Executive informed the Board that an external review of the first year of the Alliance had been commissioned and that a Director for the Alliance had just been appointed and would commence in post in August 2020.

The Chairman said that the Board should not underestimate the scale of change and implications of this following the inception of the Alliance, which was noted.

Mr Welch reflected that the Trust decided to lead the Alliance as it was the right thing to do for its population, and that it was a real achievement to see what had been achieved, notwithstanding the work that still needed to take place.

The Chief Executive said there was a level of risk in the service and that it would take some time to realise the right model to support the service and which would need to be the subject of ongoing Board debate and discussion.

The Board of Directors received and noted the Children and Family Health Devon Update Report.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

121/06/20 **Finance, Performance and Digital Committee – 22nd May and 22nd June 2020**

Mr Sutton reported that the meeting noted the Trust had reported a break-even position for months 1 and 2 2020/21 and was awaiting the detailed financial regime for months 5 to 12.

122/06/20 **People Committee – 22nd June 2020**

Mrs Matthews reported that the Committee had undertaken a deep dive into learning from Covid-19 from a workforce perspective, and a presentation of the 3 Horizon Programme to support learning from Covid-19. As previously reported at this meeting, a deep dive into the achievement review process would be taking place; and development of the Trust People Plan continued.

123/06/20 **Charitable Funds Committee – 17th June 2020**

Mrs Taylor reported that the Committee received an update on the charity's investment portfolio from the Trust's Investment Advisors who reported that the Trust's investments had lost some value, due to the downturn in the investment market following the Covid-19 pandemic.

The Committee had noted the work of the Covid-19 Donations Hub, led by Mr Paul Norrish, to benefit the Trust through charitable donations. Staff were being asked to make suggestions around how the donations received could be allocated.

The Committee also noted the work to support staff through health and wellbeing activities.

124/06/20 **Quality Assurance Committee – 22nd May 2020**

In the absence of Mrs Lyttle, the Chief Nurse reported that the meeting formally noted the resignation of Dr Selina Hoque as the Trust's Director of Infection Prevention and Control lead, and that Dr Joanne Watson had agreed to step into the role for a six month period whilst a permanent appointment was sought.

The Committee also discussed the need to triangulate information discussed at other Committees and other sources of information, eg the Staff and Patient surveys, to ensure the Committees did not work in isolation.

Finally, the Committee noted that the implementation of the Early Warning Scoring System, which had been scheduled to take place last year and was unfortunately delayed, would be implemented in June 2020.

The reports from the Board Committees were received and noted.

Reports from Executive Directors

125/06/20 **Safe Staffing and Nursing Work Programme Update**

The Board noted the ongoing work as the Trust moved into the Covid-19 recovery phase and acknowledged that staff were tired and the longer term impact of this was starting to be realised.

The Board received and noted the Safe Staffing and Nursing Work Programme Update.

126/06/20 **Report of the Chief Operating Officer**

The Interim Director of Operations informed the Board that work was taking place to look at how to adapt and manage the Trust's Urgent and Emergency Care Workforce and to establish a medical receiving unit to ensure patients were received direct into an assessment area without needing to go through the Emergency Department.

The Interim Director of Operations added that the Trust as an Integrated Care Organisation and its structure was crucial in terms of the Trust's response to Covid-19 and explained how it was able to work with partners across the system to deliver its response.

The Chairman reflected that the Trust's workforce have been clearly stretched over the past few months, and that the Trust would need to manage this, especially as winter pressures started to materialise later in the year.

The Board of Directors received and noted the report of the Interim Director of Operations.

127/06/20 **Compliance Issues**

There were no other items raised.

128/06/20 **Any Other Business Notified in Advance**

There was no any other business raised.

129/06/20 **Date of Next Meeting – 9.00 am, Wednesday 29th July 2020**

The meeting on 29th July would commence at 9.00 am.

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.	Ensure all aspects of the F2SUG work in relation to bullying and harassment were included in the Staffing Experience Plan and then circulate plan to the Board.	DWOD	This would be included as part of the work of the People Committee and oversight of the Freedom to Speak Up Guardians and the Staff Experience Plan.	27/05/20
2.	Discuss learning from other Trusts to support middle managers in their leadership roles with the Freedom to Speak up Guardian.	DWOD	This was an ongoing issue and it was agreed to remove from the action list.	27/05/20
3.	Provide timeline detailing when services would be stepped up post-Covid-19, including a communications plan to the July Board.	DTP		24/06/20

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 29 July 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 21 July 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 requirements for service recovery and transformation, including high risk/high priority infrastructure/equipment requirements/IT Infrastructure and IT systems.
- Failure to achieve key performance standards.
- Failure to achieve financial plan.

Report title: Chief Executive's Report		Meeting date: 29 July 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 24 June 2020 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Managing the COVID-19 outbreak

With a continued low incidence of COVID-19 across Torbay and South Devon, we have been able to step down our gold major incident response, whilst still operating our daily control meetings and silver operational cells. This gives us assurance that our COVID-19 planning and response is being managed appropriately and in line with the evolving situation across Devon. We also continue to provide a swift and well-managed response to new government initiatives and requirements in order to manage the outbreak, including reconfiguring services to allow for social distancing, anti-body testing and providing face masks in all our clinical settings whilst ensuring we have the capacity to properly focus on stepping up services.

1.1.2 Trust response – key highlights

- Active Board leadership and direction setting, seeking and securing assurance about impact on members of our community and working to build and maintain key relationships with our partners in support of our system response
- Benefits of operating as an integrated care organisation – consistent and shared approach and messaging with local authority and public health colleagues with joint support for care homes – fast track testing, increased medical visits, wellbeing support for staff, additional training and equipment
- Reconfiguring all our urgent and emergency services in order to be able to safely isolate and treat COVID-19 positive patients, effectively running two ICUs and Emergency Departments during the height of the incident.
- Newton Abbot Community Hospital as a non COVID-19 centre for cancer services and stroke temporarily to ensure segregation of services at the peak of the incident.
- Partnership with Mount Stuart private hospital to ensure that our most urgent elective patients were treated
- Increased use of digital technology – such as Attend Anywhere 'virtual outpatient clinics' and using MS Teams for remote meetings
- Fantastic partnership working with the voluntary sector to support people shielding in our communities

- Joint creation of a Torbay Food Bank Alliance to divert donations of food for NHS staff to those most in need in our communities
- Support for staff shielding, increased homeworking and new wellbeing initiatives (access to psychologists; new rest and relaxation spaces; telephone helplines; homeworking support group)
- Staff risk assessments, including for BAME staff, to ensure appropriate support can be targeted were completed by the end of July

1.1.3 Anti-body testing
We began our anti-body testing programme on 3 June and have had an excellent response, with most of our staff already having had a test. We, like many other Trusts, have seen a fairly low positive rate at around 4 per cent.

The antibody testing programme is providing information on the prevalence of COVID-19 in the peninsula, to help better understand how the disease spreads. It works alongside the swab testing programme, which confirms whether or not someone currently has the virus.

1.1.4 COVID-19 support from our communities
During the COVID-19 outbreak, the generosity and support we have received from our local communities has been extraordinary. We have received donations of numerous gifts such as self-care items for our staff as well as items such as scrubs and hand sanitiser. In order to ensure these donations are properly co-ordinated we established a small team to co-ordinate and ensure we can advise people on what gifts are most useful and ensure that they are distributed to where they are needed. Anybody wishing to donate goods and services is advised to email donations.tsdft@nhs.net for advice and guidance.

As well as receiving these gifts and donations from the local community we have received £81,000 from the national NHS Charities Together. We are putting all these generous donations to good use in supporting our staff care for patients.

We are in the process of bidding for a further £50,000 from NHS Charities Together and have sought the views of staff for what they think would be of most benefit. We have received some excellent ideas from across the Trust and a panel has evaluated these to ensure we can submit an excellent bid that will support our staff including those from BAME communities and those who have a disability. Our bid will be submitted at the end of July and we expect to hear the outcome in August.

1.1.5 Recovery planning
All our clinical teams are currently working on stepping up non-urgent services, whilst also being prepared to deal with any surge of COVID-19. Progress to date includes:

- Standing up services whilst ensuring our services comply with infection prevention and control measures, social distancing and extra support to shielded patients. Of 162 services identified to recommence 128 have been approved to do so and now 79 confirmed as fully operational, many using new technologies and improved pathways adapted to life with COVID-19. The remaining proposals are under continual review and receiving support from infection control, facilities, IT and other teams to recommence safely.

- COVID-19 infection prevention and control (IPC) measures lead to a reduction of physical capacity in all our facilities, which is compounded by our aging hospital estate.
- We continue to review of waiting lists to ensure those who are most unwell and who have waited the longest are prioritised for treatment
- We are developing plans to maximise and create additional capacity including building use of digital solutions for outpatients
- At the same time, we are maintaining our emergency response capabilities in anticipation of a potential second wave of COVID-19.
- We are working with partner organisations across the Devon STP to make best use of all resources available, including:
    - Use of the Exeter Nightingale to support diagnostic activity 7/7
    - Planning the designation of Torbay hospital as a green/amber site, to ensure that the Trust is able to maintain general services for our local population, through working in partnership with local providers, including NHS Nightingale to ensure that we are able to look after patients with Covid-19
- Teams and services across the Trust have shown fantastic levels of compassion, collaboration, and agility
- There has been a high level of engagement and collaboration between our services and the voluntary and community sector

We continue to advise people to access healthcare services, as we have taken steps to ensure that it is safe to do so.

As more services are re-started, we will keep our website up to date with all the latest information https://www.torbayandsouthdevon.nhs.uk/

1.1.6 Capacity and winter planning

Teams across the Trust are continuing to review their capacity and future plans to be able to meet anticipated activity levels through to March 2021. A key part of this is to assess our ability to meet both the urgent and routine demand and performance standards with the anticipated additional pressures that the winter period will bring.

We are also planning to put in place a comprehensive plan to ensure staff are able to access flu vaccinations when they become available from September. We will back this with a campaign to encourage high uptake right across the Trust.

1.1.7 Adult social care - Market development

A joint Council /Trust blueprint has been agreed for the long-term development of the adult social care market in Torbay. This will support the Local Authority to meet its statutory Care Act obligation to ensure an effective local care market is in place at any given time and will ensure the Trust always has access to the most appropriate services, in the right places and at the right cost and quality to serve the population of Torbay into the future.

Services need to:

- Be compliant with the Care Act 2014 by enabling a strengths-based approach to the meeting of assessed need, supporting customer choice and control over how their care and support needs are met, e.g. by widening use of personal budgets

for both health and care needs and helping people identify forms of care or support that increase self-reliance rather than dependence on state funding;

- Enable people, particularly those of working age, to have their care and support needs met in their own homes for as long as possible. The local authority will only commission residential care for people with nursing needs or very complex care needs and will reduce the amount of standard residential beds in Torbay, whilst commissioning further supported living options to ensure that more people are able to live well at home;
- Ensure that people from Torbay can have their care and support needs met in Torbay or its close environs whenever possible, rather than being in placed in out-of-area services that separate them from family, friends and local social networks.
- Strive to achieve the highest possible quality whilst being as cost effective as possible. Care provision within Torbay struggles with old buildings that increasingly struggle to meet modern standards of the delivery of complex care.

1.1.8 Adult Social Care - Market sustainability during and post-COVID

The ongoing Coronavirus pandemic has had a significant impact on commissioned care and support services for vulnerable adults in Torbay, including providers of domiciliary care, residential and nursing care, day care, supported living and outreach support. The Council and the Trust have worked together to implement a number of temporary measures to support the sustainability of the adult social care market throughout the crisis. These measures include:

- Direct provision of PPE via the Trust to ensure that no Torbay provider runs out of essential PPE items in what is still an extremely disrupted and costly supply chain. This measure was supported by a range of planned interventions designed to support the sustainability of the service by protecting residents and staff, such as ongoing infection control advice; pastoral support through daily direct contact and the setting up of constantly updated information resources; early implementation of local fast-track testing in care homes and deployment of NHS professionals into those care homes where staffing has been most affected by COVID-19 outbreaks.
- Financial support to care and support providers via targeted interventions, including:
    - A 20 per cent increase in hourly rates for domiciliary care providers to support staff retention / recruitment, allow for staff to cohort and cover PPE costs.
    - Covering the full cost of COVID-19-related PPE costs in residential care, supported living and outreach between March and June, followed by use of the discretionary element of the Infection Control Grant to make a payment for PPE for all providers in preparation for potential COVID-19 outbreaks going forwards.
    - Covering the costs of commissioned placement voids to ensure providers sustain a stable income.
    - Rapid disbursement of 75 per cent of the Infection Control Grant to ensure residential care homes can quickly implement a range of necessary infection control measures and stabilise their staffing requirements going forwards.

- Ensuring that £2 million from the funds allocated by the government to the Council for COVID-19 measures are used directly to support adult social care providers struggling with a range of COVID-related cost pressures such as agency staffing, increased costs within a disrupted market, difficulty collecting income from private clients.

1.1.9 HIP2 planning

In September 2019 TSDFT was identified as one of the Trusts included in the second wave of the Health Infrastructure Plan (HIP2) of investment in health infrastructure aimed at addressing critical safety issues in the NHS estate. In April 2020 the Trust signed a memorandum of understanding allowing the release of seed funding monies to support the creation of a Strategic Outline Case (SOC) for submission in June 2021. Programme planning is now underway to support this ambitious timescale.

Programme resourcing, aligned to the programme plan, is underway. The Trust has appointed a Hospital Redevelopment Programme Director to lead the work and a procurement exercise is currently being undertaken to secure management consultants to support the local teams to develop the SOC.

Work is commencing to refresh the Trust's Clinical Strategy incorporating learning and lived experiences from the transformational work undertaken as part of the COVID–19 pandemic response. It is recognised that digital is a critical enabler to the delivery the clinical strategy and the SOC, therefore a refresh of the Trust's Digital Strategy is being undertaken concurrently.

We are actively working with other HIP2 partners across the Peninsula in support a collaborative approach for future service design and provision

1.1.10 Other estates developments

Brixham: Before COVID-19 we were due to start a building project to enable Mayfield and Compass General Practices to take space in the Brixham Hospital building. This was paused during the pandemic, and the hospital was designated for use as community bed escalation capacity.

We are now actively working on the project again. A draft lease has been issued and service charges are now being prepared for consideration. The design layout has now been agreed with both practices and Trust matron and the specification is being prepared, ready to tender the construction package and start refurbishment of the space identified. This should take 16 weeks from agreement to occupation. The refurbishment is being funded by the League of Friends and both practices will sign up to a lease with the Trust for their occupation.

Bovey Tracey: The developer has submitted a planning application to demolish the hospital and repurpose the site for a small housing development. The Trust is awaiting the outcome of that decision, as it underpins our sale of the site.

Dartmouth Health and Wellbeing Centre: Planning application has been submitted and we await the response.

A planning application to develop a new Health and Wellbeing Centre in Dartmouth has been available for review and comment on the South Hams District Council Planning Portal since 3 June. The detailed design reflects revisions as a result of comments received during the engagement period, including retaining as many of the existing trees as possible. The new centre is a partnership project between the Trust, GPs, the CCG and the voluntary sector to bring together in one centre all statutory organisations involved in providing health and care for the people of Dartmouth and surrounding area.

We have been asked by the conservation officer to increase the wood cladding on the front and the architect is in discussions about this.

The Planning Authority process of determining the application is expected to take 13 weeks, and the website quotes a determination date of 2 September.

Newton Abbot Health and Wellbeing Centre: We are creating a new H&WBC in leased accommodation (Sherborne House) and signed an Agreement to Lease earlier this year with Teignbridge Council to occupy one and a half floors of the building with relocated services from Albany Street Clinic, as well as some staff groups currently housed in Bay House. Refurbishment work will begin later this year, with a plan to move in November. Ultimately Albany Street Clinic will be sold.

Paignton Health and Wellbeing Centre: We have refocussed our attention back onto the hospital site as the preferred site for H&WBC development. Development of plans has paused for the last few months and will restart again soon, subject to Torbay Council confirmation of the scope of the development.

Teignmouth Health and Wellbeing Centre: The aim is to have a purpose-built Health and Wellbeing Centre for the people of the Coastal locality in the centre of Teignmouth with health and wellbeing teams and the local GP practices co-located in accommodation that is fit for purpose.

A public consultation led by Devon CCG was postponed due to COVID-19 and is currently being kept under review, with a new date to be confirmed. The proposal, made up of four elements, is to:

a) Move high-use community clinics from Teignmouth Community Hospital to a new health and wellbeing centre in the centre of Teignmouth.
b) Move specialist outpatient clinics from Teignmouth Community Hospital to Dawlish Community Hospital
c) Move day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital.
d) Continue with the current model of community-based intermediate care, reversing a 2015 decision to establish 12 rehabilitation beds for patients from across Torbay and South Devon in Teignmouth Community Hospital.

The proposed Health and Wellbeing Centre development is at pre-planning discussion stage with Teignbridge District Council's planning department. The design of the development has been amended significantly, particularly around the Northumberland Avenue frontage, in response to conservation officer feedback. We are expecting a formal pre-planning response shortly, after which we will progress with our full planning application (subject to any matters that need to be addressed via design). The building is at the maximum capacity possible on the site available, and the discussions with heritage/conservation and the planning department have been extensive.

1.1.11 CQC inspection report

In March the Trust received an announced CQC inspection six of our services: medical care; surgical care; urgent and emergency care services; community inpatients; children and young people's services and maternity. Due to the pandemic the CQC stood down their planned inspections of our community services, and our Trust well-led review. Without a Trust well-led review, there can be no change to our overall CQC rating, which remains as 'good' overall, with 'outstanding' for caring.

The report, which has now been published, recognises significant areas of good and outstanding practice. The report also reflects how caring our staff are, with all services being rated good or outstanding in this domain. However, it also identified areas for improvement. We had already identified many of these areas and our plans to address these had been highlighted to CQC inspectors as part of our self-assessment. In addition, the CQC identified further areas that we must address to improve our services for local people and our staff.

We were disappointed that some of our ratings were lower than previously and especially the rating of inadequate for safe care in urgent and emergency services. This reflects our need to upgrade the aging infrastructure of the premises, the IT systems at Torbay Hospital and to ensure that we improve the flow of our patients through our hospital. We are well aware of this and know that our staff who deliver urgent care, always aim to provide the best possible services in a challenging environment. Plans are in place to address these issues, supported by significant capital investment to improve our urgent and emergency care services.

The full report can be read on the CQC website at: https://www.cqc.org.uk/provider/RA9

Comment

The report contains much that we can be proud of as well as other things that we need to improve and learn from and we are. We know we are constrained by our environment and facilities, and we have been awarded national HIP2 funding to address the shortcomings of our estate. Many of you will be involved in discussions around how we can transform our services for the future, and what we need from our estate and IT to support this.

I recognise the commitments of our staff and what they have achieved so far, and am grateful to all our staff for their dedication to achieving the excellent care that we all strive for. We will continue to fully embed our Integrated Service Unit structure and as the report recognises we know we have good leadership in place to achieve this.

1.1.12 Publication of the Independent Medicines and Medical Devices Safety Review

The Independent Medicines and Medical Devices Safety Review, Chaired by Baroness Cumberlege included a review of the use of vaginal mesh to treat prolapse or urinary incontinence or prolapse after childbirth. This Trust used the procedure between 1998 and 2018, after surgeons became concerned about international reports of complications arising from the surgery. Whilst successful for many women, for some, the side effects of their surgery have had a profoundly negative impact on their lives.

Comment
We have received the Cumberlege Report and are considering the detailed recommendations to identify any learning from this national review. We are very sorry that some women have experienced significant side effects following surgery. We will do all that we can to provide appropriate support for any woman who had this surgery at our Trust. We do not want anyone to suffer in silence. We encourage any woman who has had concerns since having a vaginal mesh procedure at Torbay Hospital to contact the Trust, so that we can offer the support and care they may need. If it feels difficult to contact the Trust, we would urge people to speak with Healthwatch, who have also been involved in supporting local women.

1.1.13 National Inpatient Survey 2019 - results

In the recent National Inpatient Survey the Trust has come out either better or equal to the national average in the latest Care Quality Commission (CQC) National Inpatient Survey which sought the views of inpatients treated in our hospitals. The Trust scored 83 per cent for the overall experience of inpatient services with improvements made in consulting directly with patients in its care.

The National Adult Inpatient Survey is part of a programme by the Care Quality Commission (the independent regulator of health and adult social care services in England) to collect feedback on the experiences of patients using services across the country. CQC published the national and Trust's results at this link

1.2 Valuing our Workforce, Paid and Unpaid

1.2.1 Chief Nurse appointment

Following a thorough recruitment process, and a number of very strong candidates, we are delighted that Debbie Kelly will join us as Chief Nurse on 1 August 2020. Debbie has recently returned from the Middle East, where she was Deputy Chief Nurse and Chief Nurse for Informatics at Sidra Medicine, Doha Qatar. Sidra Medicine is a Greenfield site that activated in January 2018 as the Tertiary paediatric Trauma Centre for Qatar, providing tertiary services to Women and Children (400 beds) across Qatar and the Gulf Co-operation Council. An experienced nurse, Debbie had previously held Board level posts in the NHS and was Deputy Chief Nurse for Barts Health NHS Trust from 2014 to 2017, including a period as Acting Chief Nurse. We look forward to welcoming Debbie to our team.

At the same time, we say a very fond farewell to Jane Viner, who retires as Chief Nurse on 31 July. Jane has been much appreciated for her professional integrity, her championing of staff and service users, and for the huge contribution she has made to integrating services across Torbay and South Devon.

1.2.2 Retirement of Director of Estates and Commercial Development

This month Lesley Darke is retiring from her role as the Director of Estates and Commercial Development. Lesley has driven our estates strategy and has been key in developing our business cases in a number of important areas including the Critical Care Unit, the Linac accelerators and the Health and Wellbeing Centres and very

importantly HIP2. We are pleased to say that Lesley's experience and passion will not be lost as she will be returning to support us on a part time basis on the further development of the Health and Wellbeing Centre programme.

1.2.3 NHS 72 Anniversary

As part of the NHS 72nd birthday celebrations, former Torbay Hospital nurse, Monica Bulman, spoke to the Prime Minister about her long career with the NHS and how much she loved nursing. Monica retired in 2018 after clocking up an astounding 66 years' service for the NHS. She worked on Hutchings Ward at Torbay Hospital as part of the specialist outpatient surgical clinic team for Endoscopy - she was one of the oldest and longest serving nurses in Britain. The NHS was launched on 5 July 1948 and Monica has worked for the NHS for 66 out of the 72 years since its creation.

1.2.4 Health and Wellbeing

As we continue to become used to a changed working environment, where people are returning from redeployment, coming back from shielding and working from home, a period of 'new normal' has to settle. To help support this a number of learning forums have been established as well as support materials for our shielding staff. We are very aware that we must be vigilant to the anxiety of the uncertainty created by Covid-19 and the impact of this on staff wellbeing. We continue to be proactive supporting those who are most affected by uncertainty including our BAME staff. We are starting to see a gradual increase in the number of people accessing internal wellbeing services such as coaching.

It is important that we learn from staff experience and what has been most helpful in supporting their wellbeing, so that we can build an effective future model of supporting our staff. An evaluation is currently being completed of the wellbeing offer. This project is reaching a conclusion and has received feedback from approaching a 1,000 staff either via a survey, focus group or one to one conversation.

2. Chief Executive Engagement: July

I have continued to engage with external stakeholders and partners; 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 • Video blog sessions	• Chief Officer for Adult Care and Health, DCC • Director of Adult Social Services, Torbay Council • Accountable Officer, Devon CCG

• Consultant Medical Staffing Committee • Partnership Forum • Trust Talk	• Devon Children's Family Partnership Executive Group Meeting • Children and Young Persons Partnership Board • System Chief Executives • System Chairs, Leaders, Directors of Adult Social Services Meeting • Improvement Partnership Board • Devon Health and Local Authority Chief Officers' Meeting • Nightingale Hospital Opening • Anthony Mangnall MP • Chief Executive, Healthwatch Torbay • Director of Public Health, Torbay Council • Secretary, Torbay Hospital League of Friends • Torbay Council Overview and Scrutiny Committee • Peninsula Partnership Board

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

Torbay Council – Chief Executive stands down

Torbay Council has announced that Steve Parrock is standing down from his role as Chief Executive of Torbay Council. Given the significant economic challenges following the pandemic and shared desire to focus on the economy it has been agreed that Mr Parrock will resume his fulltime role with Torbay Development Agency from 1 September 2020.

Torbay Council - Facebook Live engagement session held for local people

On 18 June Torbay Council hosted a Facebook Live Ask Us about COVID-19 event with a number of local partners. The event provided the community with the opportunity to ask questions about how we have been, and continue to respond to the pandemic. The Chairman and I joined colleagues from the council, police and Torbay Community Development Trust on the panel answering the questions.

It was a great opportunity to listen to the concerns and queries local people have as well as provide them with reassurance that health services are very much open for business and that we have put in place thorough measures to keep them and our staff safe. It was heartening to hear so much support.

We look forward to taking part on further live sessions.

To read more about the Live and see all the questions asked and their answer visit: https://www.torbay.gov.uk/health-and-wellbeing/public-health/coronavirus/covid-live/

3.1.1 Devon Sustainable Transformation Partnership (STP) - Update on Nightingale Exeter Hospital

Thankfully we have not seen as many numbers of COVID patients locally and this has meant as an STP we have not needed to use the Nightingale Hospital in Exeter to treat patients who have contracted the virus at this time. It has therefore been decided that the hospital facilities will be put to good use in supporting diagnostics to help local GPs and hospitals provide people with safer and faster access to tests for a range of conditions, including cancer.

However, if we do suffer from a surge in COVID cases the Nightingale hospital will be ready to support care. The hospital beds are specifically designed for people with COVID needs, and throughout this time the facility will remain ready to quickly revert to our primary purpose and receive patients with COVID, if the number of cases in the region rises significantly.

4 Care Quality Commission

4.1 Review to help health and care providers prepare for future pressures

To help providers of health and social care services learn from the experience of responding to COVID-19 around the country, the CQC is carrying out rapid reviews of how providers are working collaboratively in local areas. The first phase, between July and August, focuses on 11 Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) areas including Devon STP. The reviews will support providers across systems by sharing learning, helping to drive improvements and prepare for future pressures on local health and care systems. These reviews involve understanding the journey for people with and without coronavirus across health and social care providers. They will focus on the interface between health and adult social care for the over-65 population group.

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 up to date and accurate information, enabling them 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. Since the last board report, coverage has included:

Local support for staff wellbeing

Huge 'thank you' to all the local businesses who helped to create our temporary relaxation / wellbeing hub at Torbay Hospital for our staff. The space, at Bay View Restaurant, was completely transformed in to a relaxing area that staff could unwind in during what has been an incredibly stressful time for many. *Torbay Weekly*

Daughter whose father died of COVID-19 donates iPads to patients
A loving daughter whose father died from COVID-19 is helping keep hospital patients in touch with their families remotely with digital help. Aimee raised funds to buy the digital tablets which she gave to Torbay and South Devon NHS Foundation Trust as a way of patients reaching their loved ones and health professionals amid COVID restrictions on visitors. *Torbay Weekly*

South West NHS Trust's digital innovation goes national
Patients and health staff across England are set to benefit from a comprehensive online health and care video library, originating from Torbay. *Herald Express*

Other social media posts, press releases and campaigns

We continue to engage with tens of thousands of people via Twitter and Facebook as well as our own website. Recent topics include

- Celebrating the NHS 72nd birthday
- Supporting Pride
- How we are embracing digital innovations
- Opening the Acute Surgical Unit
- Continued thanks for the support of local people
- Advice on using our services
- Seeking volunteers
- Sending messages to loved ones in hospital
- Seeking nominations for our staff heroes
- Member of staff taking part in 'The Choir: Singing for Britain' which is presented by Choir Master, Gareth Malone
- Virtual Board meeting

6 Recommendation

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

Torbay and South Devon
NHS Foundation Trust

Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 3 2020/21 (June 2020 data)			Meeting date: 29 July 2020
Report appendix	Appendix 1 - Month 3 2020/21 - Focus Report Appendix 2 - Month 3 2020/21 - Dashboard of key metrics		
Report sponsor	Director of Transformation and Partnerships Director of Finance		
Report author	Head of Performance		
Report provenance	ISU and System governance meetings – review of key performance risks and dashboard Executive Directors – 21 July 2020 Assurance and Transformation – 23 July 2020 Integrated Governance Group – 24 July 2020 Finance, Performance and Digital Committee – 27 July 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 Finance, Performance, and Digital Committee (FPDC) and Trust Board to: • take a view of overall delivery, against national and local standards and targets, at Trust and Integrated Service Unit (ISU) level; • consider risks and mitigations; • provide assurance to the Board that the Trust is on track to deliver the key milestones required by the regulator. The M3 report reflects the significant changes in our reported performance and likely impact in response to covid-19 escalation. Areas that the Committee 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			

<table>
<tr><td>Strategic objectives supported by this report</td><td>
<table>
<tr><td>Safe, quality care and best experience</td><td>Yes</td><td>Valuing our workforce</td><td>Yes</td></tr>
<tr><td>Improved wellbeing through partnership</td><td></td><td>Well-led</td><td>Yes</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td>Yes</td><td>Risk score</td><td>25</td></tr>
<tr><td>Risk Register</td><td>Yes</td><td>Risk score</td><td>25</td></tr>
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</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
</table>

This report reflects the following corporate risks:

• failure to achieve key performance standards;
• inability to recruit/retain staff in sufficient number/quality to maintain service provision;
• failure to achieve financial plan.
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Report title: Integrated Performance Report (IPR): Month 3 2020/2021 (June data)		**Meeting date:** 29 July 2020
Report sponsor	Director of Transformation and Partnerships Chief Finance Officer	
Report author	Head of Performance	

1. Quality headlines

Performance exceptions
June's quality and safety report demonstrates that in relation to complaints, litigation and incidents we are seeing a return to our pre-covid levels of reporting and management.
For Standardised Mortality Rates we are still seeing that the latest available data is still pre-covid lockdown. For internal review during covid a weekly in-hospital and community wide report was created to monitor mortality. This has proved effective in realising ongoing issues for example the community care home mortality which is now showing lower than normal mortality and the in-hospital and community deaths reporting 'normal' expected levels.

Incidents
The Trust is continuing to learn from incidents to prevent harm to patients in our care and the Serious Adverse Events Group meet once a month to review all serious incidents. As part of this the ISU's provide clear actions that support instigation of Trust wide learning and sharing.
With 3 serious incidents in month these included:

- Patient fall in EAU4 (Newton Abbot ISU) resulting in a fractured hip.
- Breakdown of care package arrangements on discahrge - Paignton and Brixham ISU.
- Cardiac arrest in theatres - Coastal ISU.

VTE - assessment on admission as reported on our electronic systems remains a challenge, we have sought both nursing and medical leadership to put together a task and finish group to review and progress in order to improve and embed.
We have seen that Follow up appointments passed their intended to be seen date, has increased this is 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 review this.
We continue to maintain the quality metrics, the focus report gives further detail.

2. Workforce Headlines

Workforce Highlights and response to Covid-19

The Workforce Recovery Cell workstreams have been consolidated into six key areas of work.

A position paper was presented to the People Committee as a precursor to an Appraisals Deep Dive, indicating the approach and methodologies to be used. Deep dive has commenced with a first stage reporting back to the People Committee in August.

Our People Plan development had been formally paused due to the pandemic, however, the six key workstreams coordinated through the Workforce Recovery Cell will inform and dovetail a re-focussed approach to developing Our Plan. The national People Plan is due in the autumn, which will also inform and influence our local plan.

Work continues within the six workstreams of the Workforce Recovery Cell. In particular the response rate for the Health and Wellbeing survey was 10% of our people, supplemented by local focus groups and listening sessions. The themes analysed from these sources will inform:

- the future Health and Wellbeing support for our people
- the development of the leadership behavioural framework
- the Just and Learning practices and policy development
- future reassignments and emergency escalation planning

Performance exceptions and actions

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

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

The Trust's turnover rate now stands at 10.30% for the year to June 2020.

Staff sickness/absence: Red for 12 months and AMBER for current month

The annual rolling sickness absence rate was 4.54% to end of May 2020. This is against the target rate for sickness of 4%. The monthly sickness figure for May was 3.81% which is a decrease from the 4.12% as at the end of April.

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 89.92% for June 2020 against a target of 85% and this is only a small reduction from the 90.08% in May 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 June 2020 was 75.56% which has been impacted by the call to stand down appraisals due to Covid.

Agency Expenditure – As at Month 03 the Trust Agency spend was is £0.581m and year to date £1.558.

3. Performance Headlines

The Focus Report describes the Month 3 position against key performance metrics.

NHSI Performance Indicators

Urgent Care
Emergency pathways of care have continued to achieve the improved performance against the 4-hour standard with levels of escalation remaining at OPEL 2 or below. ED department continues to be expanded into the footprint of the Day Surgery Unit to enable a COVID ED response. A decision on the ED options appraisal and critical phase of planning for estate changes to the Emergency Department to ensure robust emergency care configuration and response is in place for winter, was scheduled to be made in July and is now likely to report to board in August.

Referral to Treatment
Activity levels are showing encouraging increases during June. We have seen, however, a corresponding increase in the number of new referrals received for specialist assessment increasing to 85% of pre covid-19 levels. Combined with reduced capacity resulting from the repurposing of the Day Surgery Unit footprint and the infection prevention and control requirements, capacity forecasts are currently only showing a return to around 50 to 60% pre covid levels. As a result waiting lists are increasing along with the number of non-urgent patients over 18 weeks RTT and in particular those now approaching and going beyond 52 weeks; the numbers of patients waiting longer 52 weeks has increased to 344 in June from 53 end of May. Teams are continually reviewing long waiters and responding to clinical escalation either from RTT pathway review, GP escalation, or patient contact, should a patient's condition deteriorate. A detailed impact assessment on waiting times and a further review of Quality Equality Impact Assessment (QEIA) is being carried out.

Cancer pathways
The focus on urgent and cancer pathways of care has seen the timeliness of cancer diagnosis and treatment maintained. This has been supported by the use of independent sector facilities at Mount Stuart Hospital and the proactive engagement of teams to maintain urgent pathways of care. Plans are being implemented to return the inpatient ward and chemotherapy delivery back from Newton Abbot Hospital to Torbay Hospital ensuring necessary infection control and social distancing measures are implemented.

Radiotherapy and medical oncology have continued with near normal capacity.

Diagnostics
Capacity to maintain pre-covid level of activity for diagnostic tests is a significant challenge with compliance to Infection Prevention, and Control and in particular those tests requiring aerosol generating procedures. A business case and capital bid have been submitted to create short term and longer term increases in capacity for endoscopy. Echo capacity has been escalated identifying capital requirements to increase machine capacity.

Children and Family Health Devon
During June, teams have continued to provide a clinical service to our most vulnerable and urgent patients, however, services for Children and Young People remain a concern and performance in all aspects of the referral to treatment targets continue to

be challenged. The Alliance Partnership Board oversee the quality improvement plans for these services. The Single Point of Access (SPA) – since February the backlog in processing referrals has reduced from 3 to 4 months to 48 hours.

Community Services
The ICO has been working closely with care home and domiciliary providers to support the safe flow of clients and enable the providers to continue to function. A Covid-19 resourcing panel created to support timely payment to the homes and providers is in place
Monitoring care home capacity and their ability to take new admissions via collating daily dashboards of capacity and issues relating to PPE and shielded clients is on-going.

Adult Social Care
An Adult Social Care Improvement Plan is in the early stages of developing a data-culture to inform performance, knowledge, and insights for effective decision-making. The Interim Associate Director of Operations and Interim Deputy Director of Social Care are engaged with developing the implementation of a revised governance structure to support the wider programme. The Social Care Programme Board has been disbanded and will be replaced by a joint ICO and Torbay Council Improvement Board with subcommittees for transformation and performance. This revised structure is expected to commence in September 2020. The improvement work has commenced and is being supported by the Torbay LA Programme Management Office (PMO)

4. Finance Headlines

The Trust submitted a draft financial Plan for financial year 2020/21 to NHS England / Improvement 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.
NHSE/I issued the Trust with a revised plan to cover the first 4 months of the 2020/21 financial year. This plan is based on the Trust's financial run rates from months 8-10 of 2019/20, with adjustments and uplift as determined by NHSE/I, and forms the basis of the block income payment the Trust is due to receive in months 1-4. Initially the plan leads to a monthly deficit £1.43m, for which a top up income payment is being made by NHSE/I in order to arrive at a breakeven position. The plan provided by NHSE/I is therefore the Control Total for the first 4 months, against which the Trust will monitor its finances. Guidance is expected shortly for the financial regime from month 5 onwards. The key message from NHSE/I 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 as a 'Truing' up adjustment. Revenue costs incurred as a result of COVID are reimbursed by NHSE/I, once an off-set to the underlying performance against this plan is calculated. The Council are making a small contribution towards the Hospital Discharge support to Care Homes at £1m for the 4-month period.

The Trust is also responsible for administering the Hospital Discharge COVID expenditure and the Care Home infection control fund from month 3 onwards.

The Trust is expecting a second tranche of hospital discharge income amounting to £1m from Torbay Council. Based on latest modelling the income/expenditure will be in months 7 to 10 (previously months 5 to 8), but there is a risk that the related costs will exceed this level.

There is a potential risk to Sexual Health income relating to Q1 of £0.2m. In the current arrangement the Trust is a sub-contractor to North Devon, who hold a contract for Sexual Health services with both Torbay Council and Devon County Council. The Council's have recently notified North Devon that they are only proposing to pay both Trusts on the basis of activity undertaken. The national guidance under PPN 02/20 for public bodies is to pay providers based on the average of 3 months historic income where contracts are on a PbR basis. The Trust/North Devon have written to both Councils to challenge this decision and discussions are underway. At present, the Trust has assumed full historic income for M1-3. If this is not the case, the risk would fall against our cost re-imbursement.

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, ensuring that expenditure is controlled within the limits set by NHSE/I and represents value for money.

The Capital plan for this financial year is still under discussion by scheme leads. All additional capital is subject to an STP agreed prioritisation claim, which is then aggregated up for National scrutiny and approval. A separate report will be tabled at the meeting.

5. Recommendations

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

July 2020 (Month 3): Reporting period June 2020

	Section 1: Performance
	Quality and safety
	Workforce
	Community and Social Care
	NHSI operational performance with local performance metric exceptions
	Children and Family Health Devon
	Section 2: Finance
	Finance

Quality and Safety- Executive Summary

Performance exceptions

June's quality and safety report demonstrates that in relation to complaints, litigation and incidents we are seeing a return to our pre-covid levels of reporting and management.

For Standardised Mortality Rates we are still seeing that the latest available data is still pre-Covid lockdown. For our own internal review a weekly in-hospital and community wide report was created to monitor mortality, which proved effective in realising ongoing issues for example the community care home mortality, this is now showing lower than normal mortality. The in-hospital and community deaths returning to the 'normal' expected levels that we would see.

Incidents

The Trust is continuing to learn from incidents to prevent harm to patients in our care and the Serious Adverse Events Group meet once a month to review all serious incidents. As part of this the ISU's provide clear actions that support instigation of Trust wide learning and sharing.

With 3 serious incidents in month these included:

- A patient fall in EAU4 (Newton Abbot ISU) resulting in a fractured hip.
- Implementation of care and on-going monitoring within Paignton and Brixham ISU.
- A cardiac arrest in theatres under the Coastal ISU.

VTE - assessment on admission as reported on our electronic systems remains a challenge, we have sought both nursing and medical leadership to put together a task and finish group to review and progress in order to improve and embed.

We have seen that Follow up appointments passed their intended to be seen date, has increased this is 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 review this.

We continue to maintain the quality metrics, the focus report below gives further detail against the quality metrics.

The Trust CQC inspection was held on the 10, 11 and 12th of March 2020. The planned community services inspection and Trust well-led inspections were stood down in response to the emerging Covid-19 emergency.

The CQC inspected six of our services:

- medical care
- surgical care
- urgent and emergency care services
- community inpatients
- children and young people's services
- maternity

The report includes 28 MUST do requirement notices that must be delivered and 43 SHOULD do actions.

Core Service	MUST Do actions	SHOULD Do actions
Trustwide	1	0
Emergency Department	8	6
Medical Care Services	9	12
Surgery	4	5
Maternity Service	4	11
Children and Young People	1	5
Community Inpatients	1	4

Themes emerging from the report include:

Mandatory training
Staff Appraisals
Mental Health Act and Mental Capacity Act
Equipment cleaning and servicing
Information systems
Governance processes
Estate – environment and storage

Achieved
Reported Incidents - Death
Never Events
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams
Formal complaints - Number received
Avoidable New Pressure Ulcers - Category 3 +
Infection Control - Bed Closures - (Acute)
Hand Hygiene – not yet available
Fracture Neck Of Femur - Time to Theatre <36
Stroke patients spending 90% of time on a stroke ward- not yet available
Strategic Executive Information System (STEIS)(Reported to CCG and CQC) - not yet available

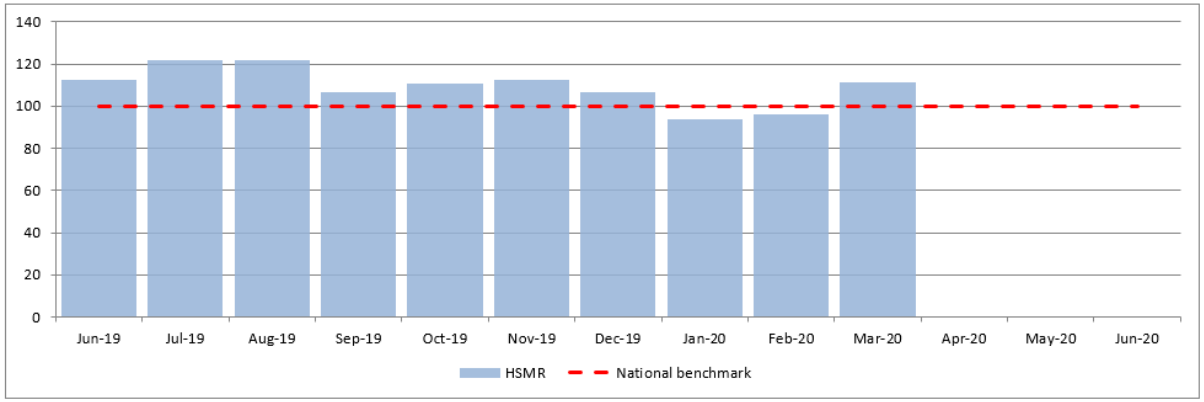
Not Achieved
Medication errors resulting in moderate harm
VTE - Risk Assessment on Admission (Acute)
VTE - Risk Assessment on Admission (Community)
Follow ups 6 weeks past to be seen date
Hospital standardised mortality rate (HSMR)

No target set
Medication errors - Total reported incidents

Under Achieved
Safer Staffing - ICO – Daytime
Safer Staffing - ICO – Night time
Reported Incidents – Severe

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

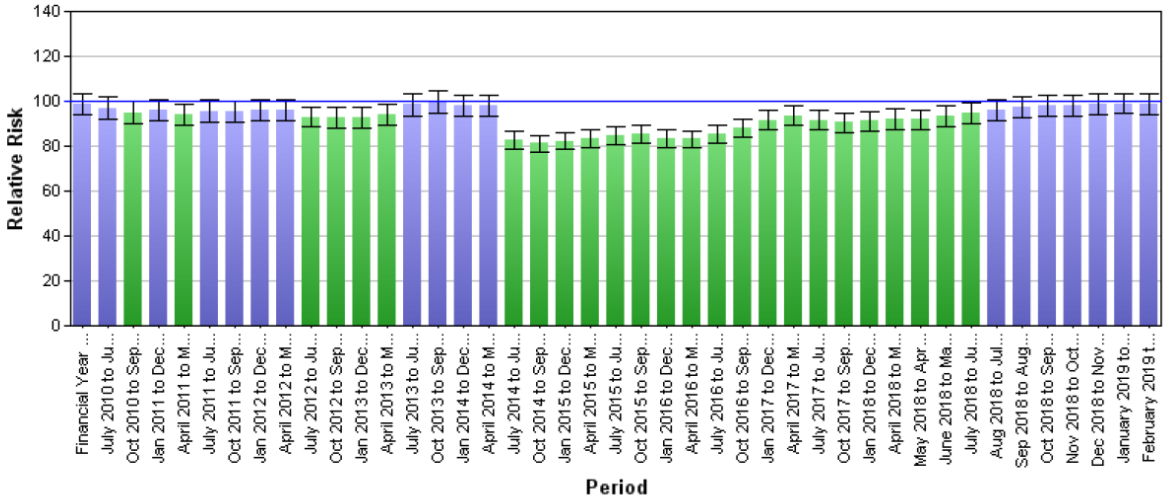
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
HSMR	112.2	121.5	121.9	106.3	110.7	112.5	106.7	93.5	95.9	111.5	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



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 111.5, which is above the national benchmark but remains within confidence levels and will be monitored over the next few months. There may be an impact on benchmarking from Covid-19.

SHMI by data period

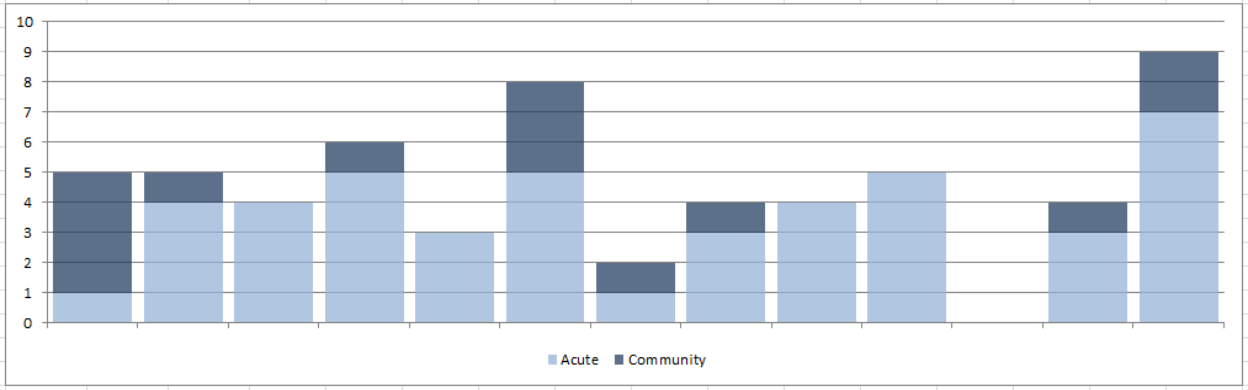


The Summary Hospital Mortality Index (SHMI) data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trust at 94.37 against a national average benchmark of 100. Latest data for period February 2019 to January 2020.
SHMI, HSMR, and Dr Foster alerts are reviewed through the Mortality Surveillance Scorecard at the Quality Improvement Group.

A score of 100 represents the weighted population average benchmark.

Number of Clostridium Difficile cases

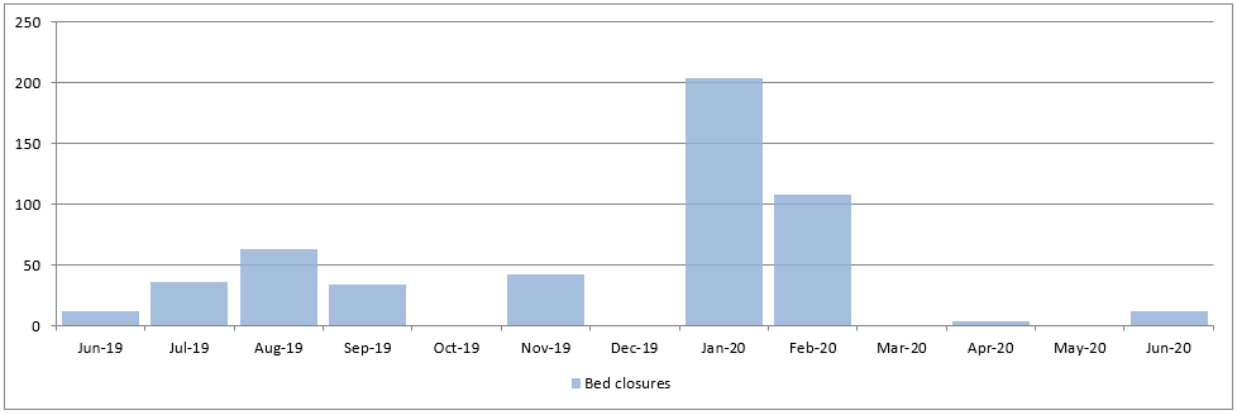
	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Acute	1	4	4	5	3	5	1	3	4	5	0	3	7
Community	4	1	0	1	0	3	1	1	0	0	0	1	2



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

Infection control - Bed closures (Acute)

	Jun-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
Bed closures	12	36	63	34	0	42	0	204	108	0	4	0	12



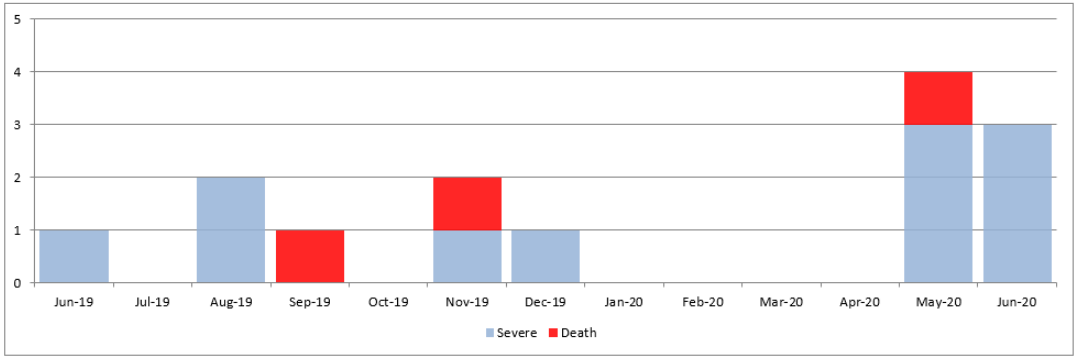
The Infection Control Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

In June there were 12 bed days lost to diarrhoea and vomiting infection control issues.

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

	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
Severe	1	0	2	0	0	1	1	0	0	0	0	3	3
Death	0	0	0	1	0	1	0	0	0	0	0	1	0



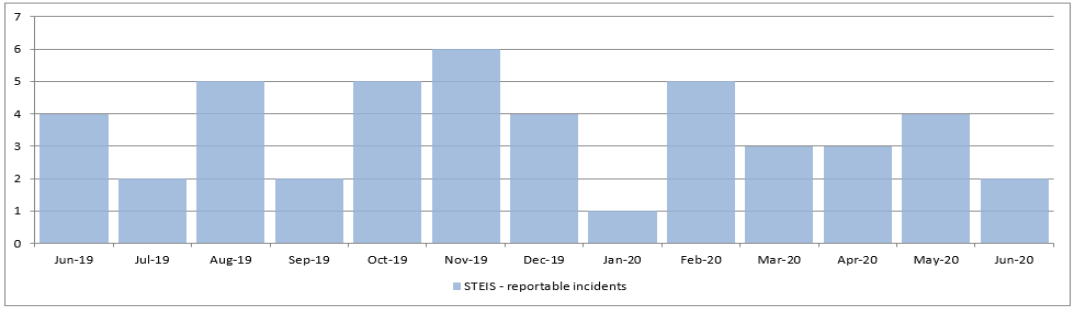
In June three severe incidents were reported:

1. A patient fall in EAU4 (Newton Abbot ISU) resulting in a fractured hip.
2. Implementation of care and on-going monitoring within Paignton and Brixham ISU.
3. A cardiac arrest in theatres under the Coastal ISU.

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 and sharing.

STEIS Reportable Incidents

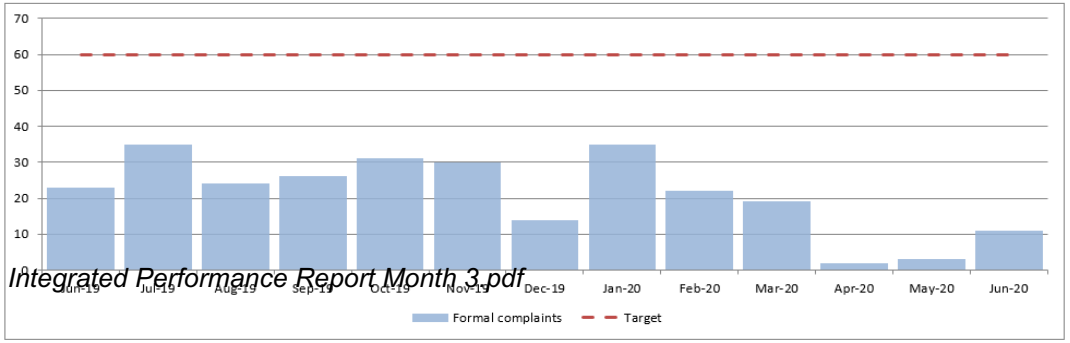
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
STEIS - reportable incidents	4	2	5	2	5	6	4	1	5	3	3	4	2



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

1. Slip trip and Falls – EAU4 fractured neck of femur
2. Maternity Delivery Suite – unexpected arrival of mother with active bleeding, baby born and transferred to Derriford for cooling.

	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
Formal complaints	23	35	24	26	31	30	14	35	22	19	2	3	11
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



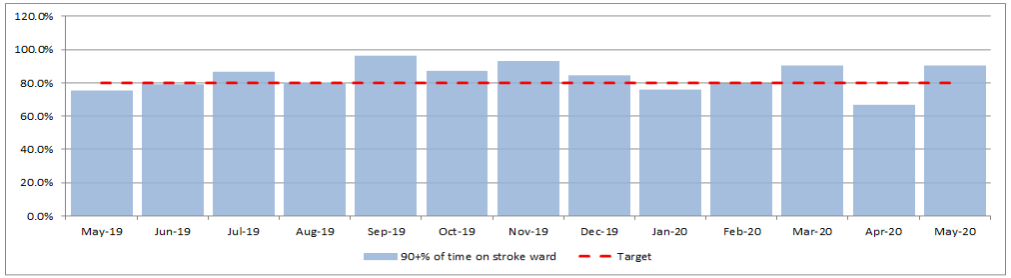
In June the Trust received 11 formal complaints; this level is clearly a result of the COVID-19 response with greatly reduced activity and changes in patients engagement with our services. Staff did note patients were continuing to contact the department and record concerns and compliments. The themes of these have been recorded in the weekly CLICC report. Complaint levels are returning to normal levels as activity increases.

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

Quality and Safety- Exception Reporting

Stroke

	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
90+% of time on stroke ward	75.5%	79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%	90.6%
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%



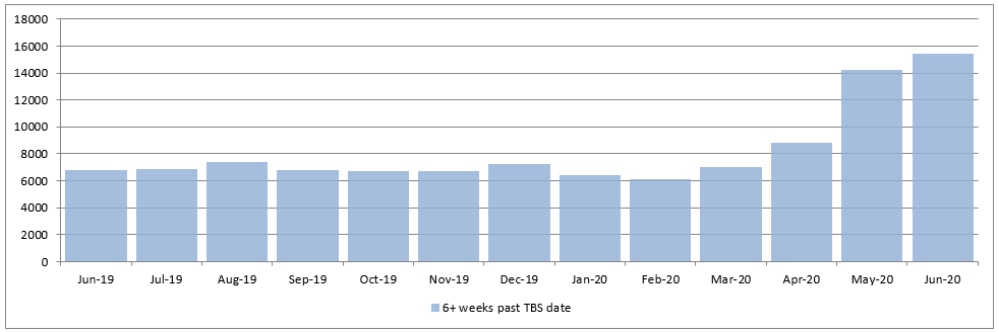
Stroke: The percentage of patients spending greater than 90% of time on the stroke ward from admission has increased to 90.6% against a target of 80%

Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased in June to 15398. 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.

A review of capacity plans is taking place along side an exercise to escalate patients deemed priority to be seen.
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.

Follow ups 6 weeks past to be seen by date

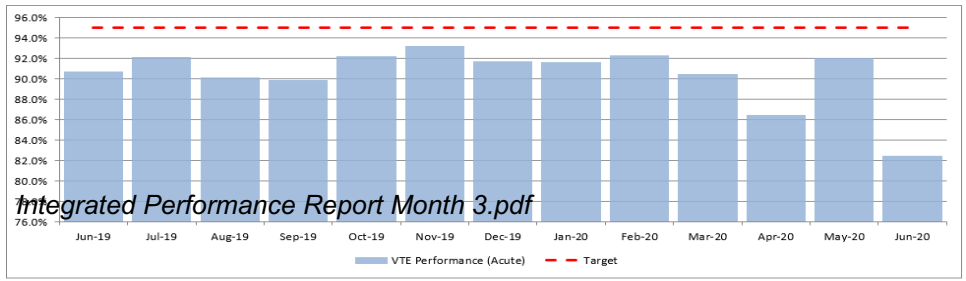
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
6+ weeks past TBS date	6803	6906	7393	6793	6694	6725	7243	6391	6147	7056	8824	14211	15398



VTE: VTE performance in the acute setting remains below the standard of 95% at 82.5% and has seen a decrease from May. 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.

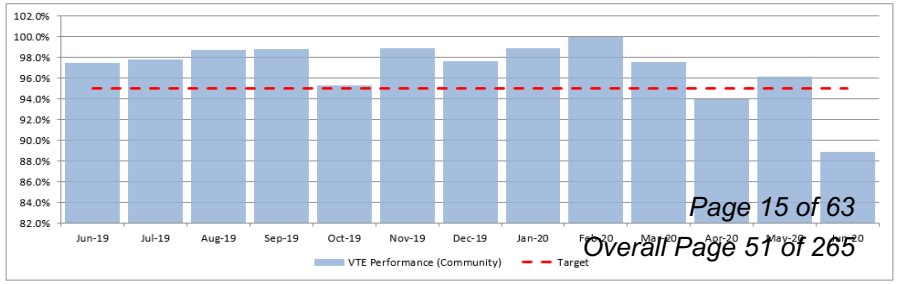
VTE risk assessment on admission - (Acute)

	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
VTE Numerator	5568	5936	5792	5487	6196	6129	5743	6303	5768	4482	2325	3158	3484
VTE Denominator	6137	6441	6425	6104	6721	6577	6262	6875	6246	4952	2690	3430	4225
VTE Performance (Acute)	90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%
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)

	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
VTE Numerator	77	89	77	85	81	90	82	92	93	81	31	25	40
VTE Denominator	79	91	78	86	85	91	84	93	93	83	33	26	45
VTE Performance (Community)	97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%
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%



Workforce Summary

The Workforce Recovery Cell workstreams have been consolidated into six key areas of work.
A position paper was presented to the People Committee as a precursor to an Appraisals Deep Dive, indicating the approach and methodologies to be used. Deep dive has commenced with a first stage reporting back to the People Committee in August.
Our People Plan development had been formally paused due to the pandemic, however, the six key workstreams coordinated through the Workforce Recovery Cell will inform and dovetail a re-focussed approach to developing Our Plan. The national People Plan is due in the autumn, which will also inform and influence our local plan.
Work continues within the six workstreams of the Workforce Recovery Cell. In particular the response rate for the Health and Wellbeing survey was 10% of our people, supplemented by local focus groups and listening sessions. The themes analysed from these sources will inform:

- the future Health and Wellbeing support for our people
- the development of the leadership behavioural framework
- the Just and Learning practices and policy development
- future reassignments and emergency escalation planning

Performance exceptions and actions
Of the four workforce KPIs on the IPR dashboard two are RAG rated Green, one Amber and one RAG rated Red as follows:

Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 10.30% for the year to June 2020.

Staff sickness/absence: Red for 12 months and AMBER for current month
The annual rolling sickness absence rate was 4.54% to end of May 2020. This is against the target rate for sickness of 4%. The monthly sickness figure for May was 3.81% which is a decrease from the 4.12% as at the end of April.
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 89.92% for June 2020 against a target of 85% and this is only a small reduction from the 90.08% in May 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 June 2020 was 75.56% which has been impacted by the call to stand down appraisals due to Covid.
Agency Expenditure – As at Month 03 the Trust Agency spend was is £0.581m and year to date £1.558.

Achieved
Mandatory Training Compliance
Turnover (exc Jnr Docs) Rolling 12 months

Not Achieved
Staff sickness / Absence Rolling 12 months(1 month in arrears)
Appraisal Completeness

Under Achieved

No target set

Workforce - WTE

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

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	2020/06	Change since ICO	% Change
Allied Health Professionals	420.56	411.16	401.50	408.83	486.15	474.03	468.05	47.48	11.29%
Health Care Scientists	89.69	92.75	92.13	91.28	90.91	93.66	93.82	4.13	4.61%
Medical and Dental	425.99	437.61	497.69	505.21	535.17	512.83	528.48	102.49	24.06%
NHS Infrastructure Support	1114.22	1099.87	1006.29	1004.70	1083.45	1085.14	1092.67	-21.55	-1.93%
Other Scientific, Therapeutic and Technical Staff	301.99	309.19	350.35	356.62	365.33	373.03	382.85	80.86	26.77%
Qualified Ambulance Service Staff	1.00	4.00	5.60	6.72	7.59	6.72	8.32	7.32	732.00%
Registered Nursing, Midwifery and Health visiting staff	1187.78	1193.74	1169.78	1166.50	1204.15	1199.91	1185.29	-2.50	-0.21%
Support to clinical staff	1593.74	1656.67	1613.65	1691.26	1807.54	1825.21	1899.55	305.82	19.19%
Grand Total	5134.99	5204.99	5136.99	5231.12	5580.29	5570.54	5659.03	524.05	10.21%

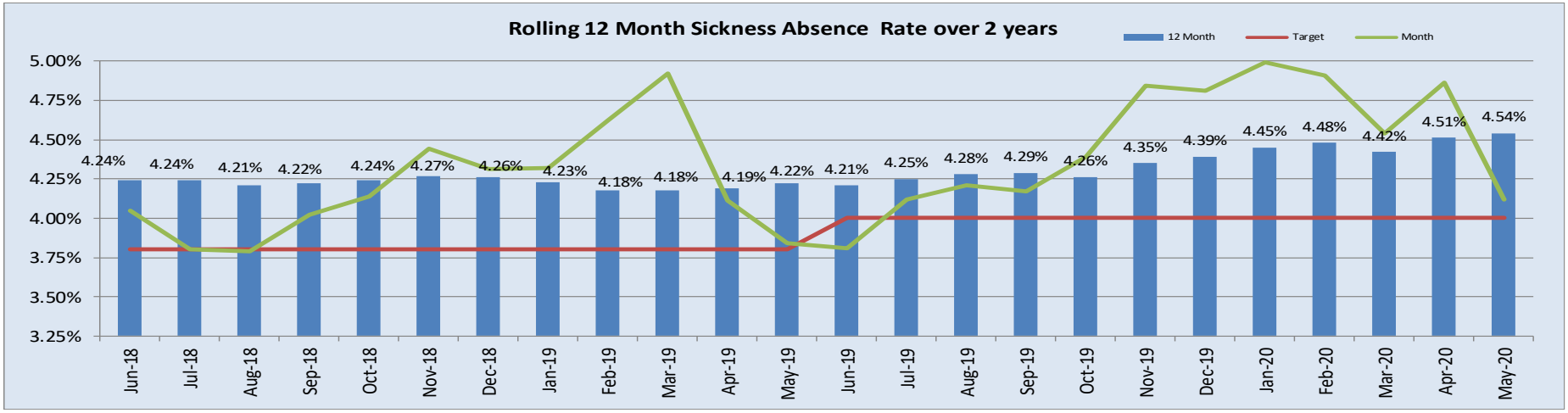
Pay Report Summary

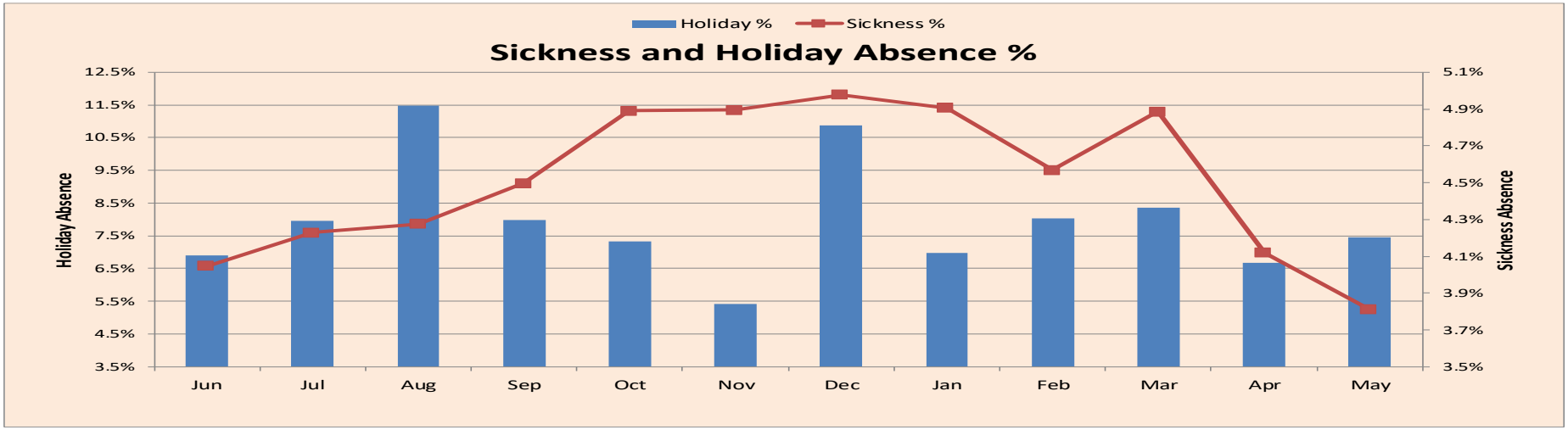
JUNE

Cost	£
Substantive	£21,208,528
Bank	£894,443
Agency	£580,586
Total Cost £	£22,683,557

WTE Worked	WTE
Substantive	5,650.32
Bank	227.25
Agency	102.35
Total Worked WTE	5,979.92

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



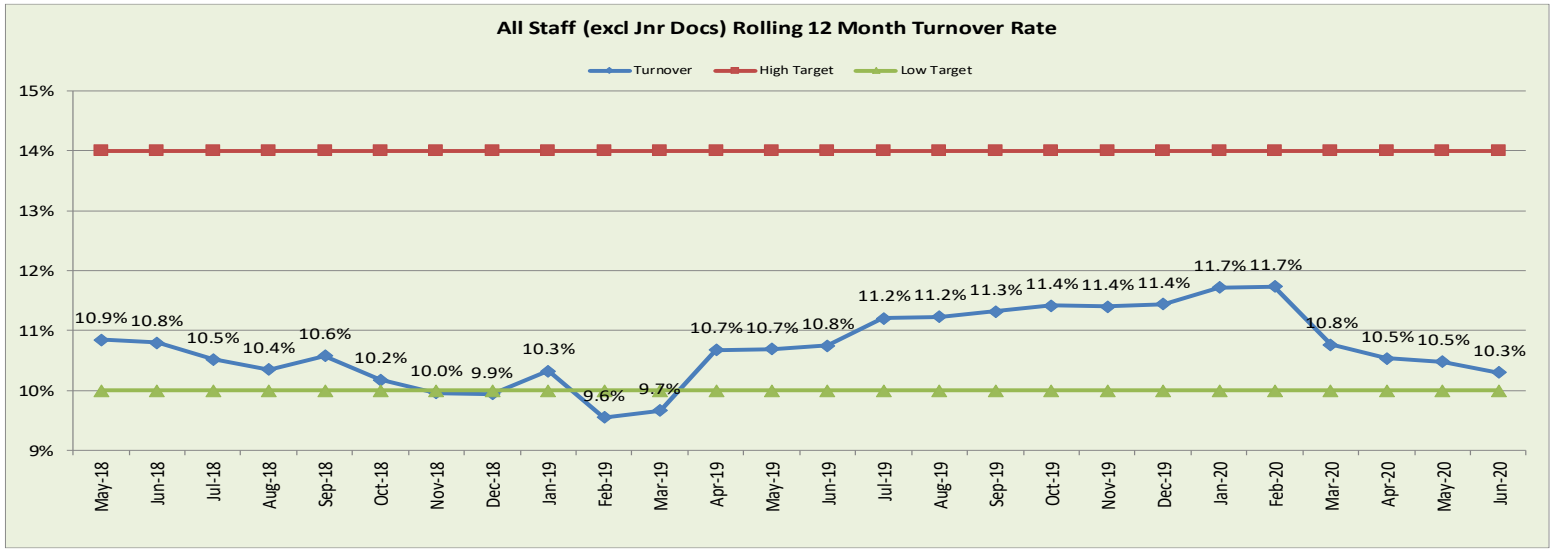


The annual rolling sickness absence rate was 4.54% at the end of May 2020 which is the same as April's which also stood at 4.54%.

The monthly sickness figure for May was 3.81 % which is a reduction from the 4.12% as at the end April.

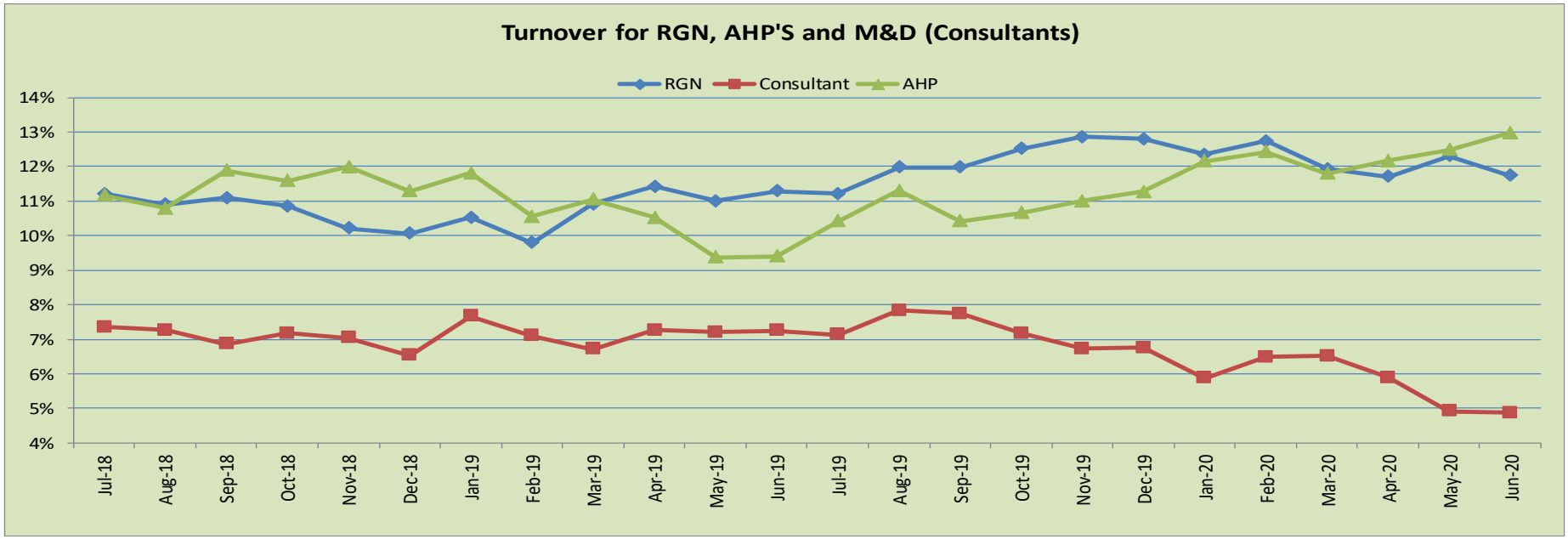
As Covid has impacted the ability for many staff to take planned holiday closer monitoring of holidays will be included monthly to ensure visibility is increased.

Workforce - Turnover

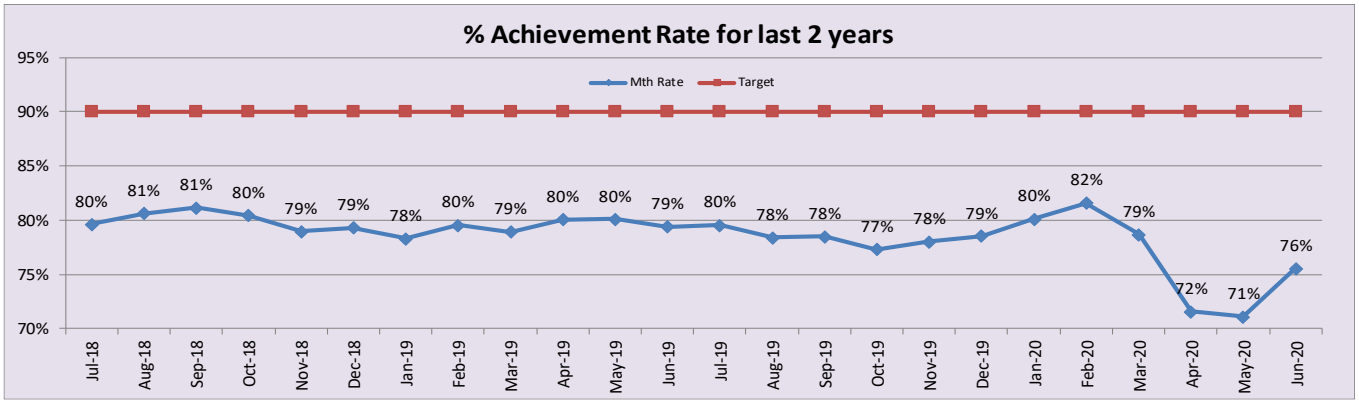


All Staff Rolling 12 Month Turnover Rate

The graph shows that the Trusts turnover rate now stands at 10.30% for the year to June 2020 which is a decrease from 10.48% in May.

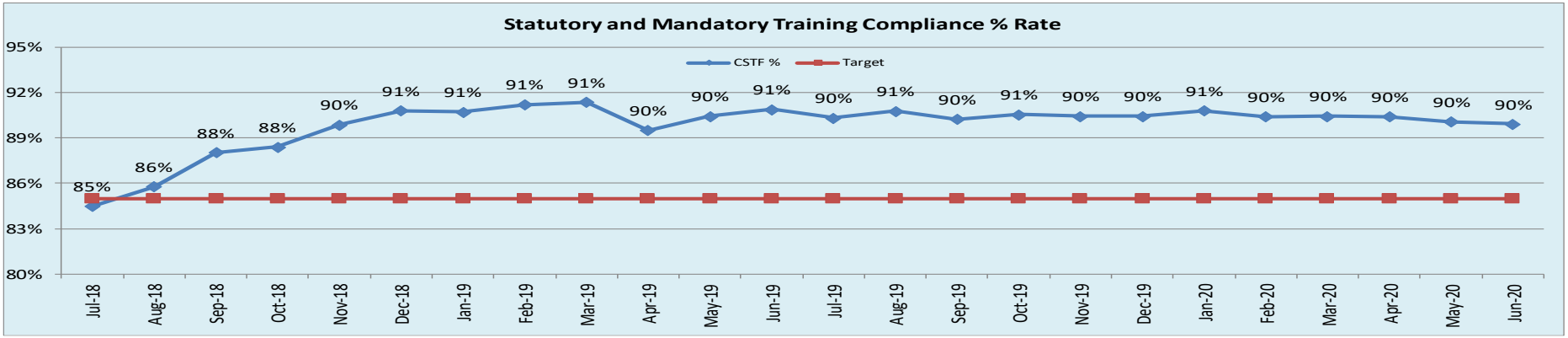


Workforce – Appraisal and Training



Achievement Review (Appraisal)
The Achievement Review rate for the end of June was 75.56% which is an increase from the 71.08% in May which is a result of a return of more BAU activity but also removing M&D staff from the overall calculation due to their professional body prioritising 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 rate is 89.92% for June which is a small decrease from the 90.08% in May and is the first time since December 2018 the overall compliance has been below 90% which is in part due to reduced F2F training for Manual Handling.
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

Jun-20					Jun-20		
Level 1	Level 2	Level 3&4	Level 5	Level 6	Level 1	Level 2	Level 3
6650	4085	534	44	6	2499	3407	744
6410	3652	415	36	5	2376	2832	503
96.39%	**89.40%**	**77.72%**	**81.82%**	**83.33%**	**95.08%**	**83.12%**	**67.61%**

Safeguarding Children Compliance

Module	Target	Performance
Information Governance	95% and above	85.11%
Manual Handling	85% and above	75.25%

The table below shows the agency expenditure by staff Group for May and Year to Date.
Both M&D and N&M have seen increases in Agency usage for June

Torbay and South Devon NHS Foundation Trust	Monthly Values			YTD
Total Agency Spend Financial Year 2020/21	Apr	May	Jun	
Registered Nurses	169	143	201	513
Scientific, Therapeutic and Technical	52	59	37	148
of which Allied Health Professionals	39	50	22	111
of which Other Scientific, Therapeutic and Technical Staff	13	9	15	37
Support to clinical staff (HCA)	-1	0	0	-1
Total Non-Medical - Clinical Staff Agency	220	202	238	660
Medical and Dental Agency	213	189	273	675
Consultants	106	69	130	305
Trainee Grades	107	120	143	370
Non Medical - Non-Clinical Staff Agency	79	74	70	223
Total Pay Bill Agency and Contract	512	465	581	1558

Adult Social Care

Community Highlights and Covid-19 response

- Working closely with care home and domiciliary providers to support the safe flow of clients and enable the providers to continue to function.
- A Covid-19 resourcing panel created to support timely payment to the homes and providers is in place
- Monitoring their capacity and ability to take new admissions via collating daily dashboards of capacity and issues relating to PPE and shielded clients.
- Engaging with a 7 day discharge processes to escalate and mange flow through the daily hard reset approach.

Adult Social Care Improvement Plan

- Early stages of developing a data-culture to inform performance. This will include leveraging measures in key areas of ASC and additional data that goes beyond just collecting numbers but turning those numbers into information, knowledge, and insights for effective decision-making.
- ASC Data culture will encompass values, behaviours, and attitudes amongst all staff that promote and enable use of relevant indicators as the driving force of decision making.
- Progress through the ASC Improvement Plan is dependent on understanding and measuring performance and vital component for success within the Plan. As such a crucial element to success there is a workstream dedicated to its future development.
- ASC data project will take a step by step approach to strength ASC's commitment to insightful decision-making as a formal improvement activity."
- The Interim Associate Director of Operations and Interim Deputy Director of Social Care are engaged with developing the implementation of a revised governance structure to support the wider programme. The Social Care Programme Board has been disbanded and will be replaced by a joint ICO and Torbay Council Improvement Board with subcommittees for transformation and performance. This revised structure is expected to commence in September 2020. The improvement work has commenced and is being supported by the Torbay LA programme management office (PMO)

Achieved
Number of Delayed Discharges (Community)
Number of Delayed Transfer of Care (Acute)
Timeliness of Adult Social Care Assessment assessed within 28 days of referral
Number of Permanent Care Home Placements
Safeguarding Adults - % of high risk concerns where immediate action was taken
Intermediate Care - No. urgent referrals

Not Achieved
Clients receiving Self Directed Care
Carers Assessments Completed year to date
Community Hospital - Admissions (non-stroke)

Under Achieved

No target set
Children with a Child Protection Plan (one month in arrears)
4 Week Smoking Quitters (reported quarterly in arrears)
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)
DOLS (Domestic) - Open applications at snapshot

Social Care and Public Health performance metrics - Torbay

The Social Care and Public Health metrics below relate to the Torbay LA commissioned services. The metrics and exceptions are reviewed at the monthly ISU system leadership Assurance and Transformation meetings. The Deputy Director of Social Care reviews all Adult Social Care (ASC) monthly metrics and escalate areas of concern. A revised governance structure is being implemented to commence in September. This will see an ASC improvement board with subcommittees of ASC transformation group and performance committee. This is expected to commence in September 2020.

Torbay Social Care KPIs Social Care Programme Board	2020/21 full year target	2020/21 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	82% (94%)	Below target (1385 / 1686) Impacted by reduced use of RAS for CLS. Paris assessment summary changes in progress.
% clients receiving direct payments	28%	28%	22.9% (28.0%)	Below target (386 / 1686). DPs will be addressed as part of the targeted response of the PMO workstreams.
% clients receiving a review within 18 months	93%	93%	81% (93%)	Below target (2356 / 2906).
Timeliness of social care assessment	80%	80%	73% (80%)	Below target (247 / 338). Audit have rated this KPI 'limited assurance' due to recording issues. 111 (25%) of assessments currently excluded from KPI as no matching referral. 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	27.0 (14)	A low outturn signifies better performance. Below target (20 admissions compared to challenging target of 10)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	85.2% (83%)	On target.
Carers receiving needs assessment, review, information, advice, etc.	36%	36%	10.1% (9.0%)	On target.
% carers receiving self directed support	85%	85%	95% (85%)	On target.
% of high risk adult safeguarding concerns where immediate action was taken to safeguard the individual	100%	100%	100% (100%)	On target.
% Repeat safeguarding referrals in last 12 months	8.0%	8.0%	10.3% (8.0%)	A low outturn signifies better performance. Below target (18 / 174)
% 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%	80.0% (80.0%)	On target.

Corporate Objective	Measure	Target 2020/2021	13 month trend	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	Year to date 2020/21
PUBLIC HEALTH SERVICES																	
	% of face to face new birth visits within 14 days *	95.0%		93.0%	91.7%	91.5%	90.4%	96.0%	95.5%	97.6%	85.5%	89.9%	76.4%	81.0%	84.5%	92.4%	86.2%
	Children with a child protection plan * [B]			201	228	219	206	184	176	192	202	191	194				194
	4 week smoking quitters (Quarterly) ** [B]	200		54			109						231				231
	Opiate users - % successful completions of treatment (Quarterly) ** [B]			5.6%			5.3%						6.1%				6.1%

Public Health Torbay : The COVID-19 response for patient facing services have had to manage with reduced capacity with only essential services maintained.

At month 3 teams are making assessments of their recovery plans risks and actions that will be needed to see a return to the capacity needed to meet ongoing demand.

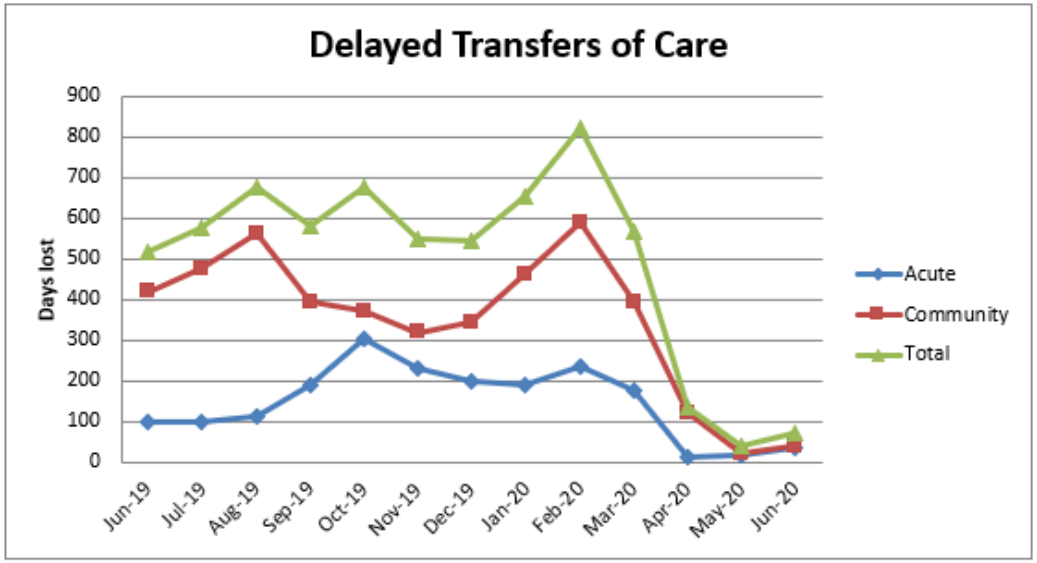
Quarterly data is shown in arrears for smoking, opiate users, and children with a protection plan.

Corporative Objective	Measure	Target 2020/2021	13 month trend	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	Year to date 2020/21
COMMUNITY BASED SERVICES																	
	Nursing activity (F2F)			15,730	16,630	14,576	13,298	13,845	12,392	10,852	10,582	9,261	8,467	6,658	7,417	7,832	21,907
	Therapy activity	65,415		5,144	6,660	5,609	6,184	6,574	5,800	5,247	6,019	5,140	4,161	2,242	2,785	3,308	8,335
	No. intermediate care urgent referrals [B]	0		179	188	174	178	216	205	201	239	202	219	230	246	258	734
	No. intermediate care placements			85	76	73	63	59	60	52	78	49	39	15	5	17	37
	Intermediate Care - placement average LoS [B]			15.8	17.3	16.9	18.1	20.7	16.1	17.5	18.7	22.0	20.8	25.5	40.2	44.3	33.6

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

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

	Act. 19/20 Outturn	Apr-20	May-20	Jun-20	Total
Admissions / Discharges					
Total Admissions (General)	2,596	138	172	222	532
Direct Admissions (General)	242	12	15	26	53
Transfer Admissions (General)	2,354	126	157	196	479
Stroke Admissions	256	0	0	7	7
Transfers from CH to DGH	238	40	85	102	227
Beds					
Bed Occupancy [1]	95.1%	54.6%	64.8%	74.7%	64.7%
Bed Days Lost to Delays [2]	5,086	121	21	38	180
Bed Days Lost to Bed Closure	57	13	50	13	76
Length of Stay					
Delayed Discharges		25	8	3	36
Average Length of Stay - Overall (General)	13.1	13.4	9.3	8.9	8.9
Average Length of Stay - Direct Admissions	10.7	10.2	7.2	6.0	6.0
Average Length of Stay - Transfer Admissions	13.4	13.6	9.5	9.2	9.2
Average Length of Stay - Stroke	18.7	19.7	14.3	12.8	12.8
Long LoS (>30 days)	246	5	0	1	6
MIUs					
Total MIU Activity	41,656	1,045	1,394	1,798	4,237
New MIU Attendances	37,118	967	1,275	1,618	3,860
All Follow Up Attendances	4,518	78	119	180	377
Planned Follow Up Attendances	3,305	66	83	141	290
Unplanned Follow Up Attendances	1,213	12	36	39	87
MIU Four Hour Breaches	3	0	0	0	0
Average Waiting Time (Mins) - 95th Pctile	53	41	40	41	41



Notes
Targets have not yet been set for the forthcoming year and so no RAG rating has been applied to the report.

Performance oversight from Chief Operating Officer/Interim Director of Operations

- Emergency pathways of care have continued to achieve the improved performance against the 4-hour standard with levels of escalation remaining at OPEL 2 or below. ED department continues to be expanded into the footprint of the day surgical unit to enable a COVID ED response. A decision on the ED options appraisal and critical phase of planning for estate changes to the emergency department to ensure robust emergency care configuration and response is in place for winter, will be made in July.

- Activity levels are showing encouraging increases during June. We have seen, however, a corresponding increase in the number of new referrals received for specialist assessment increasing to 85% of pre covid-19 levels. Combined with reduced capacity resulting from the repurposing of the day surgery unit footprint and the infection prevention and control requirements waiting lists are increasing along with the number of non-urgent patients over 18 weeks RTT and in particular those now approaching and going beyond 52 weeks. Teams are continually reviewing long waiters and responding to clinical escalation either from RTT pathway review, GP escalation, or patient contact, should a patient's condition deteriorate.

- The focus on urgent and cancer pathways of care has seen the timeliness of cancer diagnosis and treatment maintained.

- Capacity to maintain pre-covid level of activity for diagnostic tests is a challenge with compliance to Infection Prevention, and Control and in particular those test requiring aerosol generating procedures.

- The ongoing adoption of new ways of working including virtual clinics, advice and guidance and use of facilities over 7 days and extended days are part of the longer term recovery plans.

Operational Performance Quadrant

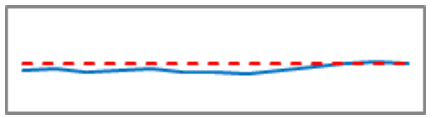
Achieved
Dementia - Find - monthly report
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - 31-day wait for second or subsequent treatment - Surgery
Cancelled patients not treated within 28 days of cancellation
Ambulance handover delays > 30 minutes
Trolley waits in A+E > 12 hours from decision to admit
Care Planning Summaries % completed within 24 hours of discharge – Weekday – **not yet available**
Clinic letters timeliness - % specialties within 4 working days
Bed Occupancy
Number of patients >7 days LoS (daily average)
Number of extended stay patients >21 days (daily average)

Under Achieved
A&E - patients seen within 4 hours
Ambulance handover delays > 60 minutes

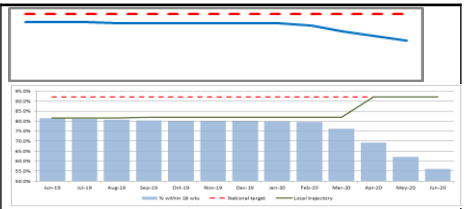
Not Achieved
Referral to treatment - % Incomplete pathways <18 wks
Cancer - 62-day wait for first treatment - 2ww referral
Diagnostic tests longer than the 6 week standard
Number of Clostridium Difficile cases reported - **not yet available**
Cancer - 62-day wait for first treatment - screening
Cancer - Two week wait from referral to date 1st seen
Care Planning Summaries % completed within 24 hours of discharge – Weekend - **not yet available**
RTT 52 week wait incomplete pathway
On the day cancellations for elective operations
Number of Clostridium Difficile cases - (Acute) - **not yet available**
Number of Clostridium Difficile cases - (Community) - **not yet available**

No target set
Cancer - 28 day faster diagnosis standard
Cancer - Patient waiting longer than 104 days from 2ww
A&E - patients recorded as >60 min corridor care
A&E - patients with >12 hour visit time pathway

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M3	June has seen a small increase in the number of attendances to ED compared to last year with activity levels staying around 60% of last year. The reported performance against the 4 hour standard for June is 94.8%. The number of patients requiring emergency admission has however continued to increase with June registering 86% of last June admissions up from 65% reported for May. As a result we have seen increased bed occupancy. Delays waiting for a bed and specialist review are identified as potential risks for the coming months.	As part of the continued recovery planning, operational teams with executive lead are testing and reviewing plans to reconfigure the emergency floor space as part of covid-19 escalation. This review is to ensure we can maintain our escalation response into winter with predicted increased levels of activity whilst reinstating where possible Day Surgery and other elective capacity. For emergency care our plans need to support continued segregation for covid-19 pathways and comply with social distancing. A decision is expected in July	 
	94.8%			
	Performance M2			
	96.5%			
	Target			
	95%			
	Risk level			
	HIGH			

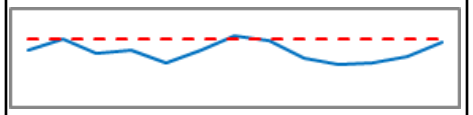
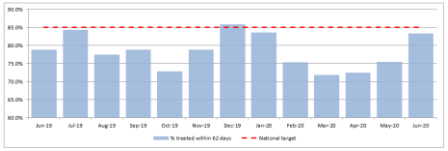
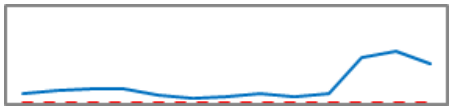
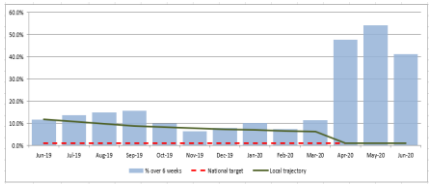
Trajectories		
M2	M3	M4
95%	95%	95%

Patients waiting longer that 18 weeks from Referral to Treatment	Performance M3	RTT performance has deteriorated with 56% of people waiting less than 18 weeks for treatment. The total number waiting for treatment is 21,439, an increase of 1,375 from May. Patients waiting over 40 weeks continues to increase with 1361 at the end of June, an increase of 381 from May. 344 people have been waiting longer than 52 weeks, an increase from 192 last month and from 53 at the end of March.	Operational focus is also on maintaining urgent and cancer related work to stepping back increased levels of routine activity. Our capacity forecasts are currently only showing a return to around 50- 60% pre covid levels. This being impacted by social distancing, infection prevention and control, PPE, and patient choice to not attend due to their ability to adhere to 2 weeks shielding prior to surgery. Non face-to-face clinical outpatient consultation is being progressed with telephone and video 'Attend Anywhere' consultations. Mount Stuart facilities are being used as a non-covid-19 site to support urgent surgical treatment.	
	56%			
	Performance M2			
	62.2%			
	Target			
	92%			
	Risk level			
	HIGH			

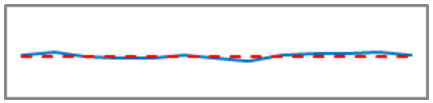
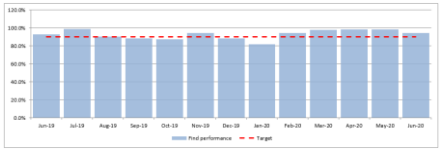
Activity variance vs previous year	M2	M3
Op new	- 56%	- 34%
Follow up	- 43%	- 29%
Day Case	- 58%	- 34%
Inpatient	- 50%	- 29%

Trajectories		
M2	M3	M4
92%	92%	92%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M3** **83.3%** **Performance M2** **75.5%** **Target** 85% **Risk level** **HIGH**	Performance against the 62 day referral to treatment standard in June is 83.3% (last month 75.5%) with other cancer pathway standards being maintained. Urgent referrals have increased to 87% of last years June level an increase from 61% last month. Teams continue to prioritise capacity to see, diagnose, and treat patients on cancer pathways. Continued reliance on the use of Mount Stuart is a risk, with the Day Surgery Unit unavailable, should this be withdrawn. The independent sector contract is currently out to national consultation.	Plans remain in place to support cancer pathways from referral, diagnosis and treatment. Plans are being implemented to return the inpatient ward and chemotherapy delivery back from Newton Abbot Hospital to Torbay Hospital ensuring necessary infection control and social distancing measures are implemented. Radiotherapy and medical oncology has continued with near normal capacity. Arrangements remain in place to support the most urgent inpatient surgery using main theatres.	  **Trajectories** M2: 85% M3: 85% M4: 85%
Diagnostic tests longer than 6 weeks	**Performance M3** **41.1%** **Performance M2** **54.3%** **Target** 1% **Risk level** HIGH	Activity levels have increased in June along with new referrals for diagnostic tests. Capacity for echocardiograph and endoscopy are significantly restricted and have the longest waits. Urgent diagnostic tests are prioritised leaving limited capacity to see routine patients in these areas. Progress is being made with the % of patients waiting beyond 6 weeks reducing to 41% in June from 54% in May however waiting times will remain a challenge for certain procedures. CT and MRI remain reliant on the insourcing and mobile van capacity.	Procedures that are aerosol generating (including colonoscopy and CT colonoscopy) continued to be severely restricted. A business case and capital bid have been submitted to create short term and longer term increases in capacity for endoscopy. Echo capacity has been escalated identifying capital requirements to increase machine capacity. Plans are being reviewed to step back up routine diagnostic capacity where possible and to support the re-establishment of RTT pathways. We expect to see a further increase in activity however there will continue to be a backlog of tests as demand is also expected to increase.	  **Trajectories** M2: 1% M3: 1% M4: 1%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M3	Completion of the Dementia Find assessment continues to achieve the standard of 90%.		
	94.4%			
	Performance M2			
	98.6%			
	Target			
	90%			
	Risk level			
	LOW			

Trajectories		
M2	M3	M4
90%	90%	90%

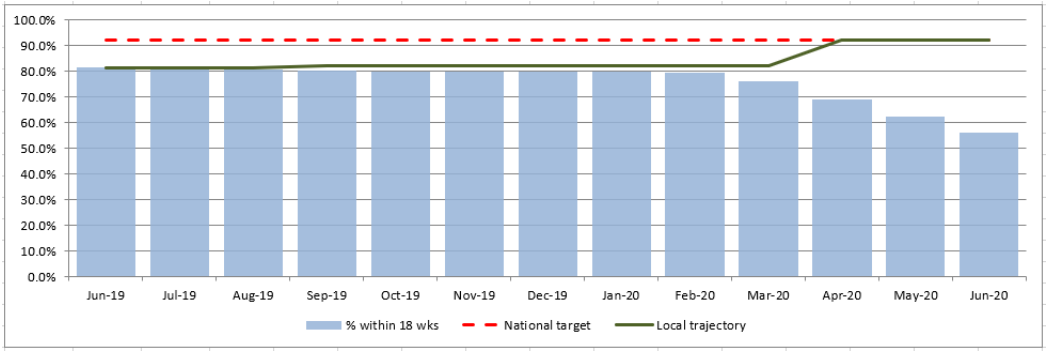
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

May 2020 Incomplete 92% Table

Submitted Spec	Incomplete IPDC >126	Incomplete Outpatients >126	Grand Total	% < 18wk
Orthodontics		105	138	23.91
Endocrinology		112	307	63.52
Respiratory Medicine	1	199	543	63.17
Colorectal Surgery	93	129	600	63
Gynaecology	140	161	961	68.68
Dermatology	2	330	1034	67.89
Neurology	1	350	650	46
Pain Management	83	332	773	46.31
Oral Surgery	250	204	1096	58.58
Gastroenterology	203	314	1466	64.73
Upper Gastrointestinal Surgery	339	180	908	42.84
Paediatrics	4	565	1288	55.82
Cardiology	129	440	1282	55.62
Urology	282	408	1513	54.4
ENT	115	591	1473	52.07
Trauma & Orthopaedics	649	797	2493	42
Ophthalmology	1000	605	3677	56.35
Grand Total	3426	6217	21949	56.78

Referral to Treatment – incomplete pathways



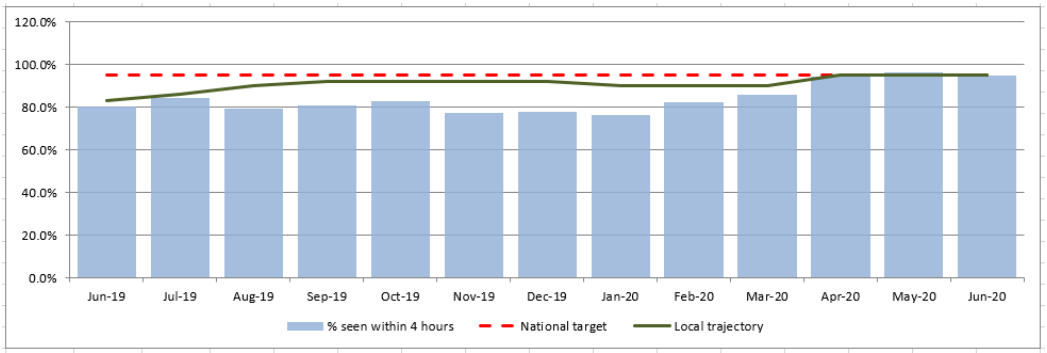
Referral to Treatment: RTT performance in June has deteriorated with the proportion of people waiting less than 18 weeks at 57.0%; this is behind the Operational Plan trajectory of 82% and national standard of 92%. The total number of incomplete pathways (waiting for treatment) has increased to 21,949 an increase of 1,884 from May.
Patients waiting over 40 weeks continue to increase with 1,361 at the end of June; an increase of 381 from May.

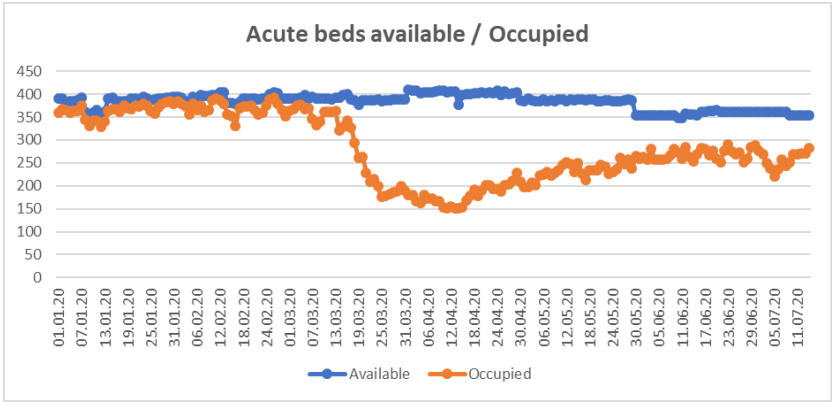
52 week waits: For June 344 people will be reported as waiting over 52 weeks , this being an increase on last month's 192. The impact of COVID-19, both for primary and secondary care continues to adversely affect overall performance, although referral rates are increasing, they remain below normal levels in Month 3, activity also remains down with only 53% new outpatient appointment, 41% follow-up, 52% day case and 47% inpatient compared to business as usual.
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 to 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

A&E and MIU patients seen within 4 hours





Operational delivery: The Emergency Department has maintained its covid-19 escalation and increased footprint taking over the Day Surgery Unit. In June, performance at 94.8% and continued to see few delays reported beyond 4 hours. We have seen a steady increase in ED attendances and emergency admissions. This has resulted in increased bed occupancy (75% June / 64% May) also described in the above chart showing occupied bed days. The available bed days have reduced slightly with the impact of social distancing in some ward areas. At the end of June we remain close to the level where access to an inpatient bed will start to cause delays, this is being closely managed of a daily basis to ensure any delays to discharge and ward processes are being escalated.

In response to the gradual return to levels of normal demand, teams are ensuring the initiatives developed through the improvement workstreams prior to covid are in place. This includes the staffing to support the rapid front door assessment with direct referral to specialist medial review, inpatient treatment and discharge pathways into community and home settings. All ward delays and long length of stay patients have daily review. The Emergency floor improvement workstream has re-commenced bi-weekly meetings.

Maintaining the segregation of potential covid patients at the front door remains a key requirement along with the deployment of staff to support in effect two emergency department systems of care; this will continue to be a challenge. As numbers of potential covid patients have reduced this now allows a review of staffing, pathways, and facilities needed to maintain this level of response and prepare for winter levels of emergency demand. An options appraisal is being carried out to determine this and to balance the risk of a prolonged loss of the Day Surgery Unit.

12 hour Trolley wait : In June, 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 June there are no ambulance delays over 60 minutes.

Escalation status													
Opel status	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
Opel 1	0	0	0	2	0	0	0	0	5	17	25	21	8
Opel 2	4	5	3	13	12	3	8	7	12	13	5	9	22
Opel 3	18	22	21	11	19	18	15	19	8	1	0	1	0
Opel 4	8	4	7	4	0	9	8	5	4	0	0	0	0
A&E Performance	80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%
Bed Occupancy	90.5%	94.0%	95.3%	95.4%	95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	75%

Cancer treatment and cancer access standards

CWT Measure	Target	April 2020				May 2020				June 2020			
		Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	451	103	554	**81.4%**	793	54	847	93.6%	959	93	1052	**91.2%**
14 Day - Breast Symptomatic referral	93%	26	1	27	96.3%	40	0	40	100.0%	85	4	89	95.5%
31 Day 1st treatment	96%	171	4	175	97.7%	127	1	128	99.2%	126	1	127	99.2%
31 Day Subsequent treatment - Drug	98%	53	0	53	100.0%	73	0	73	100.0%	77	0	77	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	40	3	43	**93.0%**	57	1	58	98.3%	61	0	61	100.0%
31 Day Subsequent treatment - Surgical	94%	28	1	29	96.6%	25	1	26	96.2%	23	0	23	100.0%
31 Day Subsequent treatment - Other		13	0	13	100.0%	22	0	22	100.0%	21	0	21	100.0%
62 day 2ww / Breast	85%	76.5	29	105.5	**72.5%**	56	18.5	74.5	**75.2%**	58	12	70	**82.9%**
62 day Screening	90%	11	4	15	**73.3%**	1	2	3	**33.3%**	2	1	3	**66.7%**
62 day Consultant Upgrade		1	1	2	50.0%	0	1	1	0.0%	0	0	0	100.0%
104 day breaches (2ww) - TREATED	0	5				2				5			

Cancer standards - The table above shows the position for Q1 2020 (as at 15 July 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 91.2% in June is below the standard of 93%. We have seen a continued increase in referrals with the number of urgent referrals with June being 87% (1,052 referrals) of the same period last year from 61% (847 referrals) in May.

28 days From Referral to Diagnosis: Performance in June is meeting the new standard set at 75% with to 80.8% reported.

NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard is forecast not met in June at 82.9%. (target 85%)

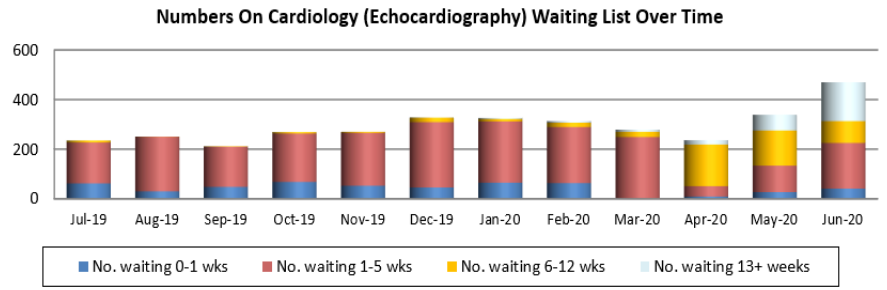
With the Trusts ongoing response to COVID-19 risk remains in the pathways for Urology and Skin. It is noted that good progress has been made by teams to continue to support an increase in capacity for the prioritisation of urgent surgical interventions and diagnostics within the constraints being worked with. The continued use of theatres and outpatient facilities at Mount Stuart Hospital remains a significant factor to maintain this capacity.

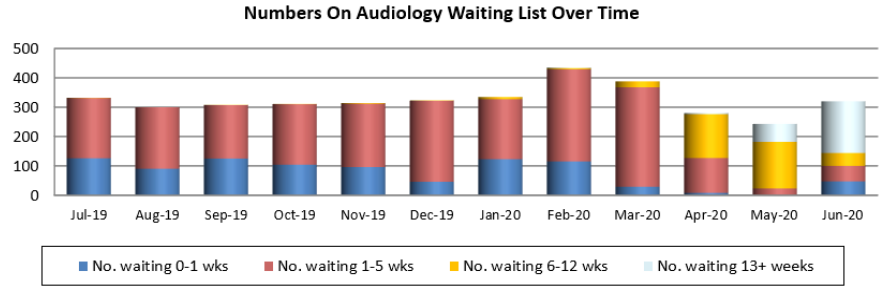
Longest waits greater than 104 days on the 62 day referral to treatment pathway:

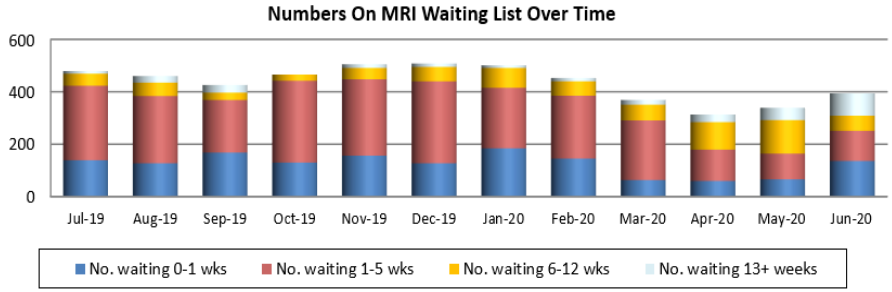
In June, 5 patients with confirmed cancer were treated beyond 104 days. The number of patients being tracked over 62 days is being maintained with no significant change to historical levels.

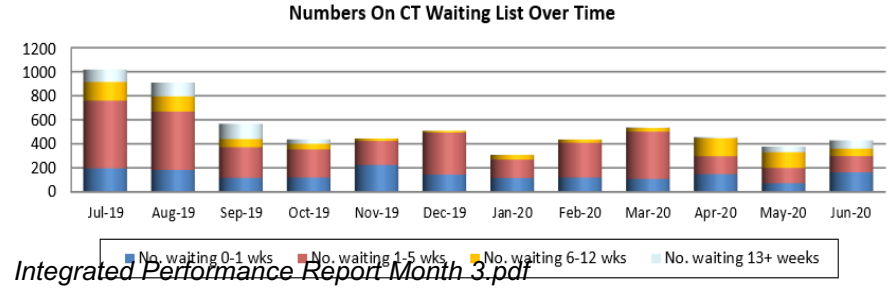
There are 51 patients on a 104 day open pathway. This represents a decrease on the 60 reported last month. All of the long wait patients are being tracked by the cancer tracker and capacity escalated as part of the RTT Risk and Performance Assurance Group.

NHSI indictor - patients waiting over 6 weeks for diagnostics



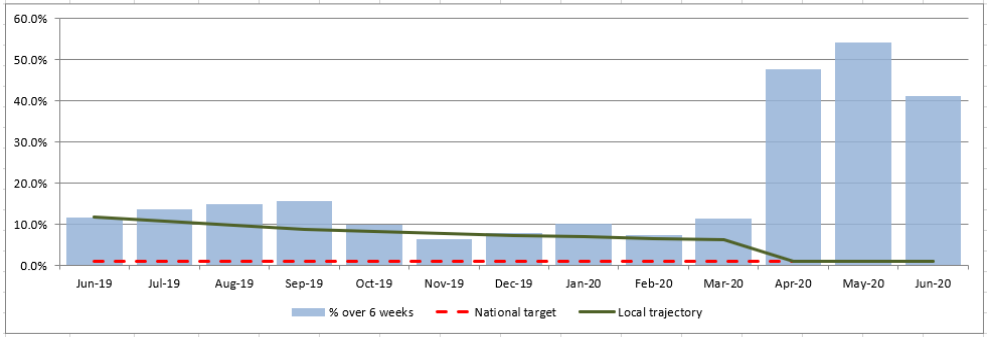






Diagnostic tests longer than the 6 week standard

	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
Patients	3893	3862	3586	2926	2823	2865	3051	2600	2816	2652	2266	2361	2883
Waiting longer than 6 weeks	454	527	535	460	282	182	240	264	207	299	1080	1282	1186
% over 6 weeks	11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%
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	11.8%	10.8%	9.7%	8.7%	8.3%	7.8%	7.3%	6.9%	6.6%	6.2%	1.0%	1.0%	1.0%



In June there has been a decrease in the percentage of patients with a diagnostic waiting time over 6 weeks to 41.4% from 54.3% in May. All modalities are continuing to see patients with urgent need with appropriate IPC precautions. The modalities with the greatest number of long waits are Echocardiography and Neuro physiology with teams are working on recovery plans.

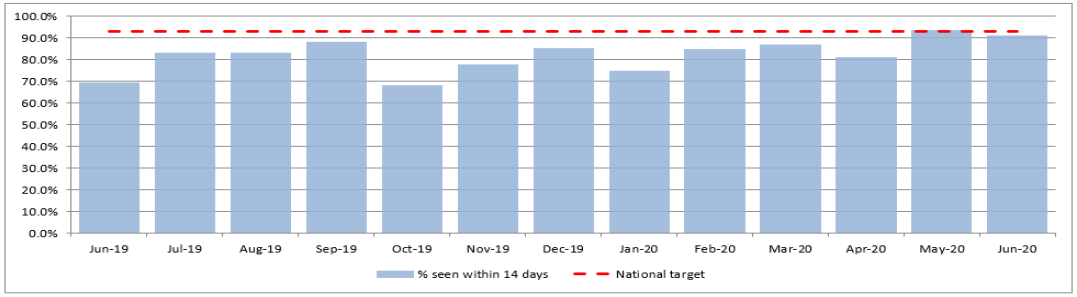
CT and MRI have seen a steady increase in capacity although dependent on the use of the additional capacity from insourcing through mobile vans.

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

Cancer - Two week wait referrals

	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
2ww referrals seen	1126	1491	1314	1229	1327	1459	1208	1241	1251	1397	554	847	1055
2ww breaches	343	247	218	144	422	324	177	313	190	180	104	54	92
% seen within 14 days	69.5%	83.4%	83.4%	88.3%	68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	81.2%	93.6%	91.3%
National target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

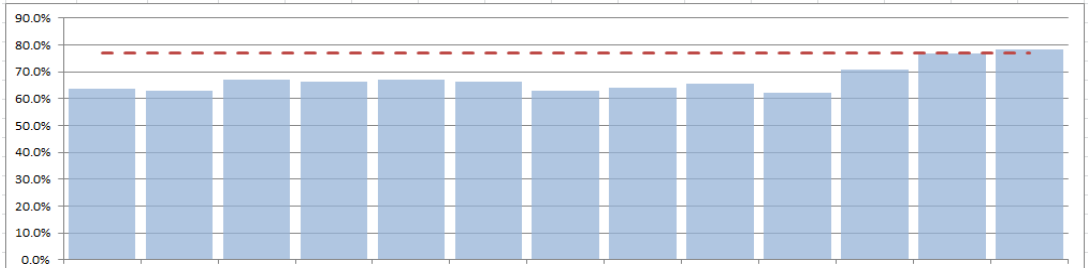


Cancer two-week wait referral

The number of cancer two-week wait referrals received has continued to increase and is now back to 85% of pre covid level. Performance although just below the 93% standard is 91.3% and reflects the work teams have done to ensure capacity for urgent cancer pathways is maintained.

Care Plan Summaries completed within 24 hours of discharge - Weekday

	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
Discharges	1818	1526	1804	1593	1566	1815	1627	1668	1683	1560	1376	885	1039
CPS completed within 24 hours	1160	959	1212	1056	1051	1206	1025	1069	1106	967	972	681	815
% CPS completed <24 hours	63.8%	62.8%	67.2%	66.3%	67.1%	66.4%	63.0%	64.1%	65.7%	62.0%	70.6%	76.9%	78.4%
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%

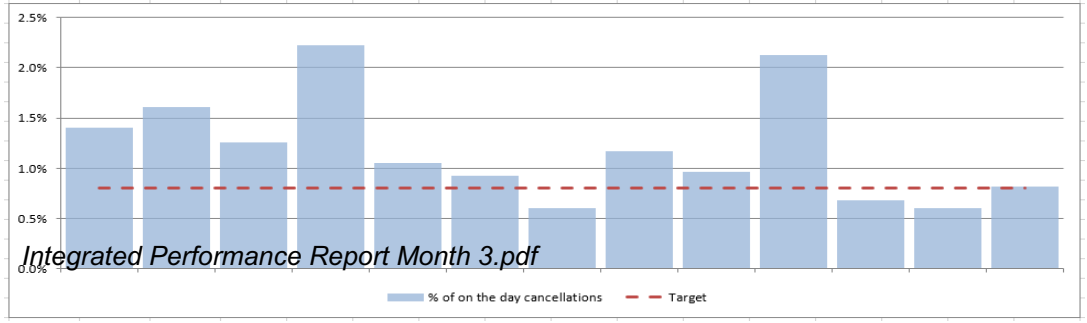


Care Planning Summaries (CPS)

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 emphasising that timely completion of CPS is 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

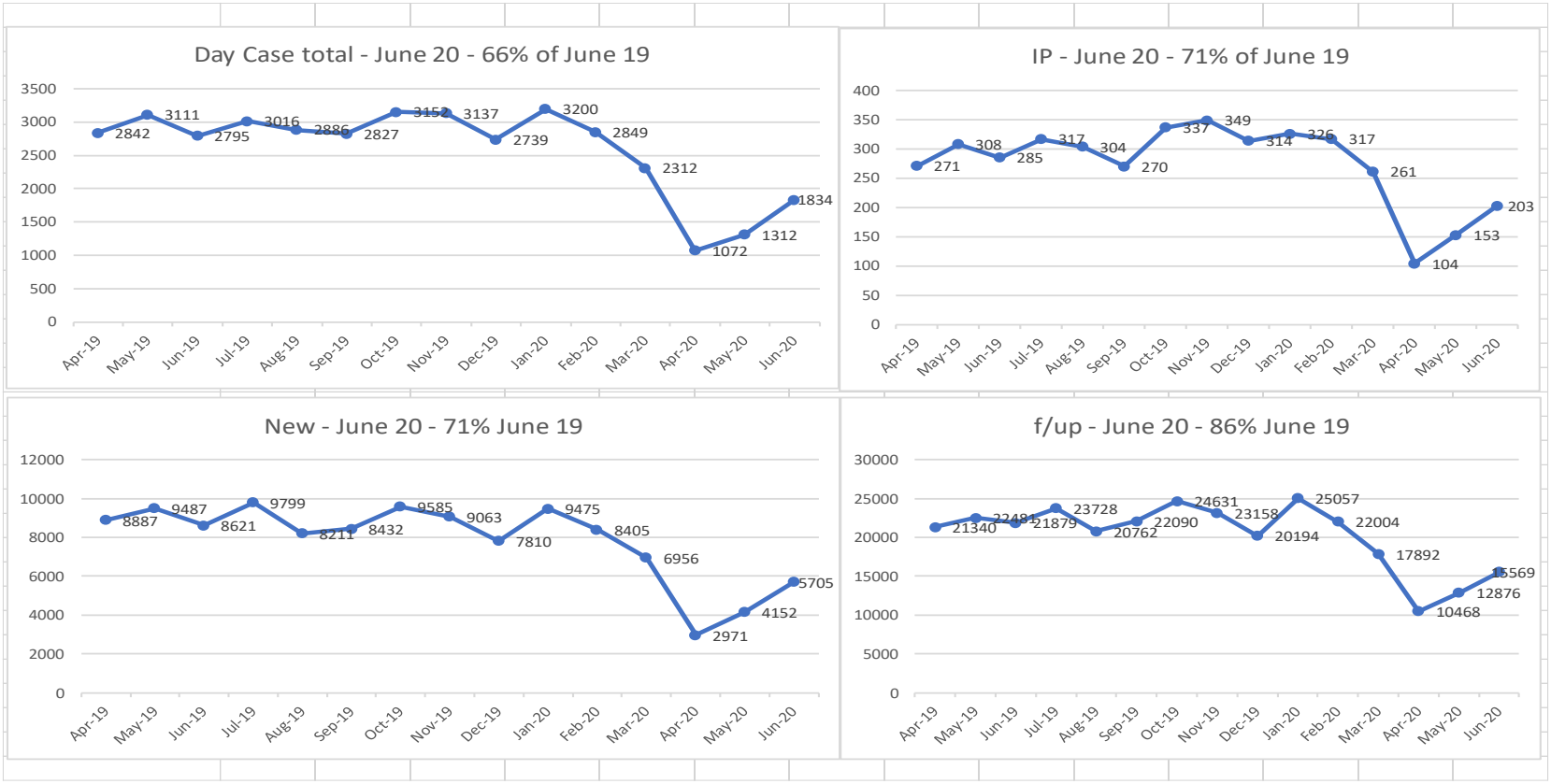
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Cancellations	45	56	41	72	38	33	19	43	32	56	8	9	15
Elective spells	3198	3481	3248	3237	3616	3567	3133	3667	3332	2631	1174	1503	1826
% of on the day cancellations	1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%
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 June the number of operations completed remains below expected levels due to covid-19 and this is reflected in the low number of cancelled operations on the day of surgery for hospital reasons. This represents 0.8% of all elective procedures undertaken.

Headline Acute activity comparisons to last year



The charts above show the monthly run rate of reported contract activity (PBR). This is showing a steady increase in activity with the percentage of activity compared to same month last year shown in the chart titles.

An exercise to forecast expected capacity to end of March 2021 is underway. This will then inform our initial challenge in increasing activity levels across all of the settings of care to meet the return to historical levels of demand expected. The risk of rapidly increasing waiting times is clear and whilst early efforts to maintain capacity for the most urgent pathways including cancer have been robust, there is an increasing risk of not having the capacity to meet routine demands. The business planning process over the coming months will be helping teams develop their recovery plans whilst the longer term plans will link to the Health Infrastructure Plan (HIP2) that are being worked on to address the challenges of aging estate and hospital capacity.

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

During June, teams have continued to provide a clinical service to our most vulnerable and urgent patients.
Against the Referral to Treatment access standards we have seen further challenge due to the on-going response to Covid-19 drastically reducing core clinical capacity. Teams have responded to these challenges and implemented virtual clinical consultation using telephone and video technology where possible. The impact of available estates across the Alliance remains a constraint along with staffing pressures to the step back increased levels of capacity. These risks are being quantified along with the impact on overall service level performance over the coming weeks.

Recovery planning - Operational teams are reviewing current capacity and operational risks will be sharing their capacity impact assessments and forward forecasts to July's Operational Performance meeting (27/7/20). Review of the longest waiting patients is highlighting that a data quality exercise is needed to ensure these longest waits are being correctly reported.

A significant risk continues however with RTT long waits for initial assessment and treatment together with caseloads being managed by teams as summarised in table below.

The Single Point of Access (SPA) – since February the backlog in processing referrals has reduced from 3 to 4 months to 48 hours.

At the June meeting of the Alliance Board the recruitment of additional resources were approved to increase support for the transformation programme and operational performance oversight.

18 week RTT Performance

Jun-20		RTT percentage < 18 weeks		caseload		
Service	RTT longest wait	Jun-19	Jun-20	Jun-19	Jun-20	change last 12 months
CAMHS	55 weeks	88%	65%	4370	3960	-410
Occupational Therapy	52 weeks	78%	39%	799	1214	415
Speech and Language Therapy	111 weeks	72%	38%	3879	4565	686
Autistic spectrum assessment team	118 weeks	31%	15%	1677	2271	594
Physiotherapy	64 weeks	92%	75%	533	695	162
Learning disability	31 weeks	90%	71%	322	334	12

1. Overall Position - Executive Summary

Context

· The Trust submitted a draft financial Plan for financial year 2020/21 to NHS England / Improvement 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.

· NHSE/I issued the Trust with a revised plan to cover the first 4 months of the 2020/21 financial year. This plan is based on the Trust's financial run rates from months 8-10 of 2019/20, with adjustments and uplift as determined by NHSE/I, and forms the basis of the block income payment the Trust is due to receive in months 1-4. Initially the plan leads to a monthly deficit £1.43m, for which a top up income payment is being made by NHSE/I in order to arrive at a breakeven position. The plan provided by NHSE/I is therefore the Control Total for the first 4 months, against which the Trust will monitor its finances. Guidance is expected shortly for the financial regime from month 5 onwards.

· The key message from NHSE/I 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 as a 'Truing' up adjustment. Revenue costs incurred as a result of COVID are reimbursed by NHSE/I, once an off-set to the underlying performance against this plan is calculated. The Council are making a small contribution towards the Hospital Discharge support to Care Homes at £1m for the 4-month period.

· The Trust is also responsible for administering the Hospital Discharge COVID expenditure and the Care Home infection control fund from month 3 onwards. Hospital Discharge expenditure is part of any truing up process, whereas the infection control monies are offset directly by the Council.

· The Trust is expecting a second tranche of hospital discharge income amounting to £1m from Torbay Council. Based on latest modelling the income/expenditure will be in months 7 to 10 (previously months 5 to 8), but there is a risk that the related costs will exceed this level.

· There is a potential risk to Sexual Health income relating to Q1 of £0.2m. In the current arrangement the Trust is a sub-contractor to North Devon, who hold a contract for Sexual Health services with both Torbay Council and Devon County Council. The Council's have recently notified North Devon that they are only proposing to pay both Trusts on the basis of activity undertaken. The national guidance under PPN 02/20 for public bodies is to pay providers based on the average of 3 months historic income where contracts are on a PbR basis. The Trust/North Devon have written to both Councils to challenge this decision and discussions are underway. At present, the Trust has assumed full historic income for M1-3. If this is not the case, the risk would fall against our cost re-imbursement.

· 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, ensuring that expenditure is controlled within the limits set by NHSE/I and represents value for money.

· The Capital plan for this financial year is still under discussion by scheme leads. All additional capital is subject to an STP agreed prioritisation claim, which is then aggregated up for National scrutiny and approval. A separate report will be tabled at the meeting.

Key Questions

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

	INCOME £'000s	EXPENDITURE £'000s	Net Position at month 3 £'000s	NHSI Plan YTD Month 3 £'000s	Favourable / (Adverse) Variance £'000s
Overall Financial Performance (excluding COVID/Top up)	126,505	120,631	5,874	0	5,874
COVID Expense and Council Income	1,500	10,480	-8,980	0	-8,980
COVID Top Up	2,885		2,885		2,885
Overall Financial Performance	130,889	131,111	-222	0	-222
Net Donated Accounting exclusions			222		222

The Trust has an underlying favourable variance of £5.9m prior to the impact of COVID amounting to c. £9.0m net expenditure. This off-set has caused an incremental COVID top up value of £2.9m. The Trust is expected to break even after excluding the donated accounting entries, which at YTD month 3 were a £222K cost to the Trust, where more depreciation has been recognised than income.

2 COVID Expenditure

There are 3 streams of COVID costs in the Trust Position:

1) Acute COVID spend ---> £6.9m YTD £9.1m FOT Month 4 Cumulative

2) Hospital Discharge ----> £2.8m YTD £3.3m FOT Month 4 Cumulative

3) Infection Control Care Homes --> £0.75m YTD £1.5m FOT Month 4 Cumulative

Total COVID spend over 4 months predicted at £13.9m

The Infection Control money is passported through the Trust from Torbay Council directly to Care Homes. The COVID guidance and funding came out in late May.

Hospital Discharge COVID spend is not part of NHSE/I monitoring for normal acute Trust's and would normally be seen in Council or CCG pooled funding arrangements. For the ICO this cost is committed in conjunction with all 3 parties, but is a variance from the 4 month run rate plan.

Acute COVID spend is collected by the Trust and is part of routine NHSE/I monthly reporting and expected to be an outlier to the revised plan.

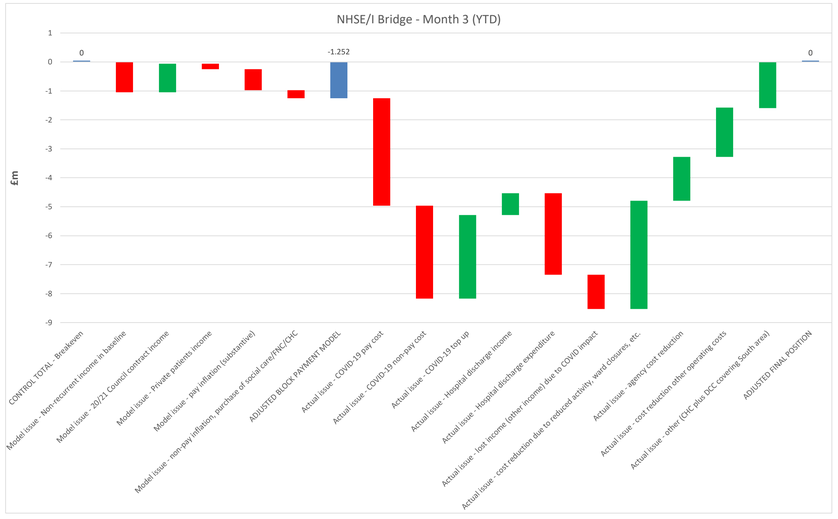
Outside of the 4-month Plan issued to the Trust by NHSE/I, the allowance for COVID income is any top-up required to deliver a break-even position. YTD at month 3 this is £2.9M, for 4 months it is estimated at £3.4M. This will therefore not equate to the COVID spend. (Note, there is no PSF or MRET in the 4 month plan or actuals).

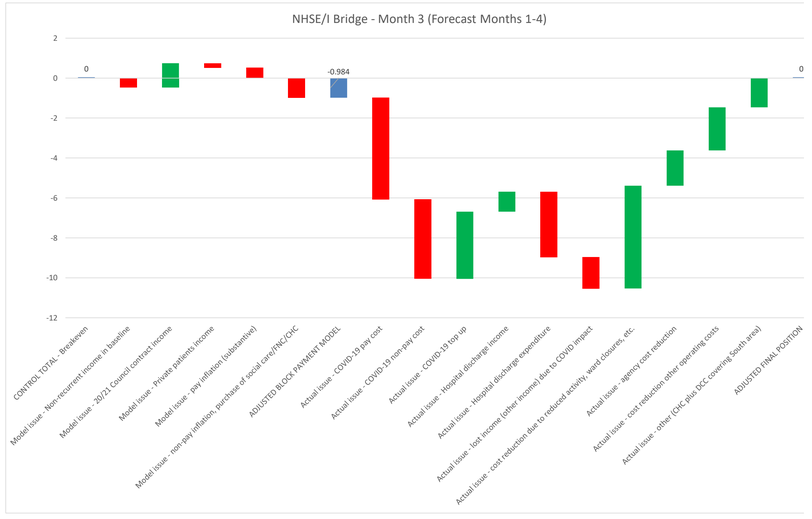
3 What is our Forecast Income and Expenditure performance for 2020/21?

The forecast is only required for months 1-4 under the current financial regime for COVID

	FOT INCOME £'000s	FOT EXPENDITURE £'000s	Net Position at month 4 £'000s	NHSI Plan YTD Month 4 £'000s	Favourable / (Adverse) Variance £'000s
Overall Financial Performance (excluding COVID/Top up)	169,527	161,742	7,785	0	7,785
COVID Expense and Council Income	2,452	13,788	-11,336		-11,336
COVID Top Up	3,357		3,357		3,357
Overall Financial Performance	175,336	175,530	-194	0	-194
Net Donated Accounting exclusions			194		194

4 NHSE/I Bridge - showing variance movement from initial plan, COVID acute, COVID other

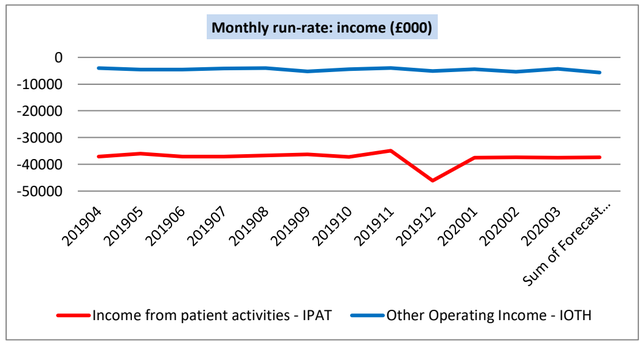




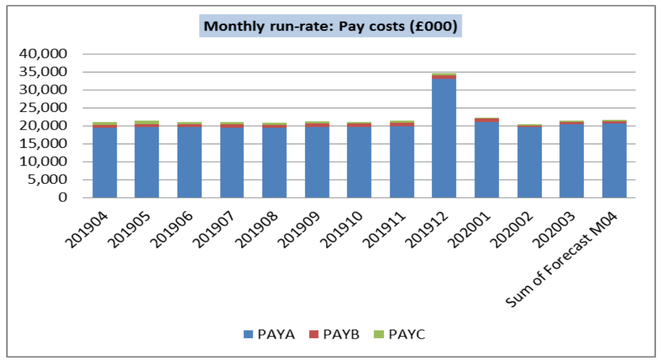
Key Risks and Mitigations to Forecast Outturn Delivery

1. What are the key risks and mitigations to the delivery of the forecast outturn position?

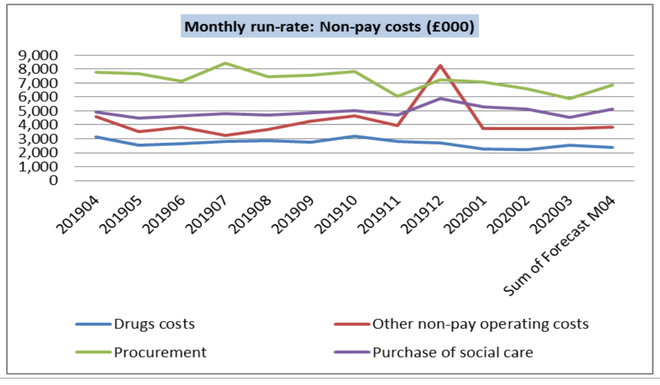
Non-COVID RELATED FORECAST



Key:
IOTH= Other Income
IPAT = Patient Income

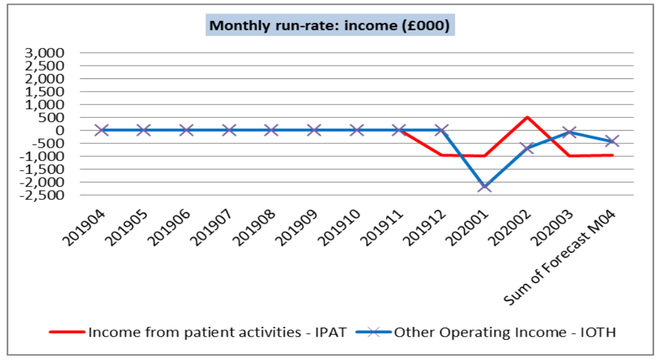


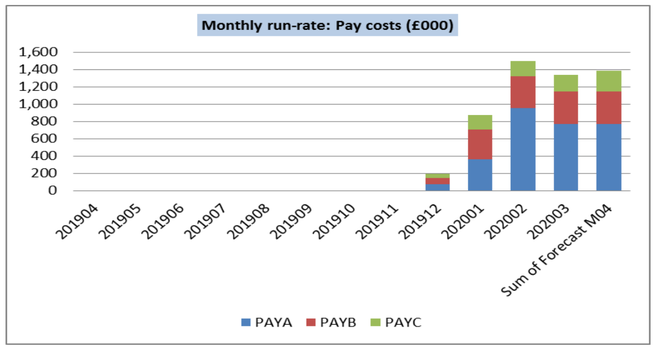
Key:
PAYA = Substantive
PAYB = Bank
PAYC = Agency

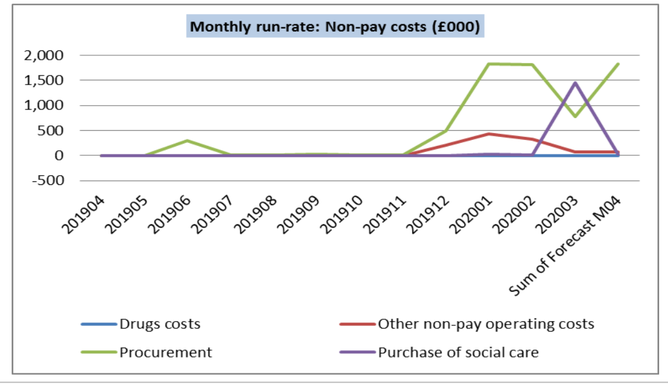


The Trust forecast is running at levels below the expected 4-month NHSE/I plan, due to spend reductions in elective categories; outsourcing, drugs and medical supplies as well as training, stationary, repairs and maintenance. Therefore the retrospective top up required to deliver a break even position can be offset by this under spend. It is expected the business as usual run rate will increase marginally in month 4 with step changes from month 5 onwards, mainly around elective clinical supplies. This can been seen above in the pay chart versus the reducing non-pay.
Risks for the Trust are the regime expected post month 4, and if any level of efficiencies will be required utilising favourable variances pre COVID. Also an ongoing risk around infection control and hospital discharge funding ceasing in the retrospective top-up and requiring urgent health assessments across all clients. This will require potential agency/outsourcing for this catch up.

COVID RUN RATE & FORECAST







COVID spend, after initial emergency set up costs is expected to level out in line with new guidance on setting services back up, unless another surge is seen. The forecast position for month 4 for COVID is £9m acute, an increase above Q1 of £2.1m.
Risks for the Trust are the continuation of the top-up fund, and absorbing the substantive costs back into normal business as usual, with a requirement to continue delivering break even. The infection control income and cost is expected to continue until September, and may now fall in line with NHS health guidelines if the current financial architecture is extended.

Key Financial Information – Trustwide

		M3			YTD M3		
	£m	Budget	Actual	Variance	Budget	Actual	Variance
Income	Patient Income - Block	28.16	28.16	0.00	84.48	84.48	(0.00)
	Patient Income - Variable	3.43	3.42	(0.01)	10.27	10.26	(0.01)
	ASC Income - Council	4.00	5.01	1.01	12.00	13.48	1.48
	Other ASC Income - Contribution	0.85	1.03	0.18	2.55	3.00	0.45
	Other Income	4.77	3.75	(1.01)	14.33	12.50	(1.84)
	Total (A)	**41.21**	**41.37**	**0.16**	**123.63**	**123.71**	**0.08**
					0		
Expenditure	Pay - Substantive	(20.96)	(22.10)	(1.14)	(62.88)	(66.20)	(3.32)
	Pay - Agency	(0.65)	(0.58)	0.07	(1.94)	(1.56)	0.39
	Non-Pay - Other	(11.25)	(10.05)	1.20	(33.48)	(30.58)	2.90
	Non- Pay - ASC/CHC	(8.27)	(8.41)	(0.14)	(25.10)	(27.23)	(2.13)
	Financing Costs	(1.51)	(1.79)	(0.28)	(4.52)	(5.32)	(0.80)
	Total (B)	**(42.64)**	**(42.93)**	**(0.29)**	**(127.92)**	**(130.88)**	**(2.96)**
					0		
	Surplus/(Deficit) pre PSF/MRET/Top up/Donated Items and Impairment (A-B=C)	**(1.43)**	**(1.56)**	**(0.13)**	**(4.29)**	**(7.17)**	**(2.88)**
					0		
	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	1.56	0.13	4.29	7.18	2.89
	Donated Transactions	0.00	(0.07)	(0.07)	0.00	(0.22)	(0.22)
	Impairment	0.00	0.00	0.00	0.00	0.00	0.00
	Total (D)	**1.43**	**1.49**	**0.06**	**4.29**	**6.96**	**2.67**
					0		
	Net Surplus/(Deficit)	0.00	(0.07)	(0.07)	0.00	(0.22)	(0.22)

- The budget shown in the table above is the M1-M4 values notified by NHSE/I 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 NHSE/I, and top up income of £1.43m which result in a breakeven position.
- NHSE/I mandated Trusts to show a break even position after adjusting for Donated items; the Trust's position include £7.18m COVID income (block top up £4.29m, true up income £2.89m).
- Patient care income block and variable are both in line with budget. In M3 The Trust received £0.75m infection control income passed through to care homes and a further £0.25m is received from Torbay Council for Covid support funding. Client contribution is higher by £0.18m linked to additional activity. Other income is lower by £1.01m due to lower TP sales £0.47m as a result of reduced demand, non patient care services £0.18m, car parking £0.13m, lower grant and education income £0.09m and various income £0.13m.
- Substantive Pay expenditure of £22.10m in M3 is £1.14m higher than the M8-M10 average run rate mainly due to the impact of COVID (£0.97m) across the various staff group. The increase is offset by lower agency cost £0.07m mainly in Nursing as patient activity is reduced.
- Non-pay expenditure (Other) is £1.20m lower than average due to Drugs cost £0.35m and Clinical supplies £0.19m - these are as a result of clinical activity reduction. There's a further reduction of £0.66m in various cost categories (training £0.12m, overseas recruitment circa £0.10m, transport and travel £0.29m, patient catering provision £0.10m and other £0.05m) as non clinical activities are delayed/put on hold due to COVID impact.
- Independent sector Non-pay cost (ASC and Placed people (Health including CHC) is £0.14m (net) higher in M3. This is due to a number of COVID related payments of £1.0m (consistent with M1/M2 run rate - largely relating to financial assistance to providers and payments for voids matched by Income) offset by cost reduction of £0.59m due to 2019/20 Childen's IPP (now picked up by CCG for which income will be similarly reduced) and less days in June resulting in lower daily care cost of £0.27m.
- Within the M3 year to date position COVID related costs incurred total £6.92m (pay £3.71m and non pay £3.21m). Further details have been included within the pay and non pay sections.
- Financing cost is higher in M3 by £0.28m due to: increased cost of RICS adjustment £0.20m and accelerated Depreciation of Intangibles £0.08m.

Statement of Financial Position

	Month 03		
	Prior month £m	Actual £m	Change £m
Non-Current Assets			
Intangible Assets	11.59	11.59	(0.01)
Property, Plant & Equipment	180.15	179.64	(0.51)
On-Balance Sheet PFI	17.38	17.34	(0.03)
Other	1.22	1.23	0.02
Total	**210.34**	**209.81**	**(0.53)**
Current Assets			
Cash & Cash Equivalents	45.10	47.56	2.46
Other Current Assets	42.14	41.58	(0.56)
Total	**87.24**	**89.14**	**1.90**
Total Assets	**297.58**	**298.95**	**1.37**
Current Liabilities			
Loan - DH ITFF	(24.64)	(24.64)	0.00
PFI / LIFT Leases	(0.85)	(0.85)	0.00
Trade and Other Payables	(80.11)	(81.93)	(1.81)
Other Current Liabilities	(13.71)	(13.74)	(0.03)
Total	**(119.31)**	**(121.16)**	**(1.84)**
Net Current assets/(liabilities)	**(32.08)**	**(32.02)**	**0.06**
Non-Current Liabilities			
Loan - DH ITFF	(42.61)	(42.34)	0.27
PFI / LIFT Leases	(17.62)	(17.54)	0.08
Other Non-Current Liabilities	(9.83)	(9.78)	0.06
Total	**(70.06)**	**(69.66)**	**0.40**
Total Assets Employed	**108.21**	**108.13**	**(0.07)**
Reserves			
Public Dividend Capital	71.75	71.75	(0.00)
Revaluation	46.08	46.08	(0.00)
Income and Expenditure	(9.62)	(9.69)	(0.07)
Total	**108.21**	**108.13**	**(0.07)**

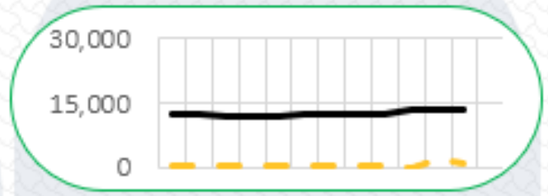
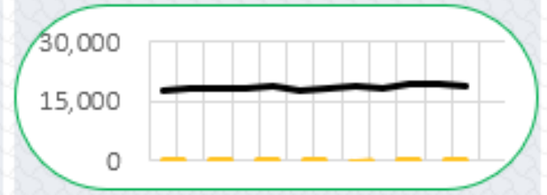
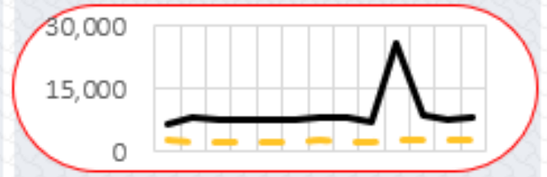
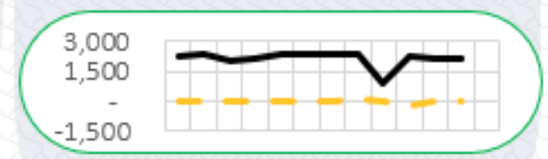
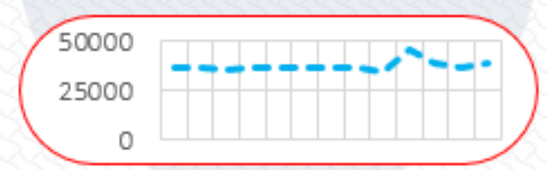
Key points

In the absence of a balance sheet plan agreed with NHSE/I, comparisons have been made against the prior month actual position.

- Intangible Assets, Property Plant & Equipment and PFI have reduced by £0.6m during the month. This is largely due to M03 depreciation £1.3m having exceeded M03 capital expenditure £0.8m.
- Cash has increased by £2.5m, as explained in the commentary to the cash flow statement.
- Other Current Assets have decreased by £0.6m, largely in respect of COVID topup funding received £2.8m and reduced TP debtors, partly offset by increased CCG debtor £1.5m and TC COVID support debtor £1.0m.
- Trade and Other Payables has increased by £1.8m, largely due to DPT CFHD funding £1.0m paid later than planned, accrual of PDC Dividend £0.3m and the timing of non-capital payments.
- Non-current DH loans have reduced by £0.3m due to scheduled repayments of capital loans.

Board Table of Key Metrics

Total Expenditure
Other Income
Contract Income

	Drivers	Actions Taken:	Tick charts £'000
South System & Shared operations	Run rate 13% below last years comparator, across temp staffing and clinical supplies, including outsourcing costs. On-going risk in DSU unavailable and use of Private hospital	Forecast to assume recovery of run rate excluding outsourcing but will not deliver pre COVID activity levels due to Infection control measures. ED new pathway not forecast/decision pending.	
Torbay System	Reduced acute activity, increased costs of Ind. Sector due to inflation plus VOIDs payments and unsourced packages of care delivered. COVID costs remain constant.	COVID hospital discharge guidance post July not yet known. Council infection control fund passported to Care Homes but needs retrospective audits in place.	
Corporate (inc. Exec Directors, Financing, R&D, IA)	EFM lost income £502k YTD. Reduced Education income expected. Risk to cost but benefit to workforce if overseas recruitment restarts.	All expenditure is forecast to increase across corporate services however income is not expected to recover to last years levels. Income drivers to be reviewed.	
CFHD	Recruitment in M10 last year FYE impact consultation still on hold. Vacancies are the main off-set to any CIP targets expected in the contract.	Interim staff review being undertaken pending new CFHD Director start date. New IT system pending consultation clinical model.	
Contract Income	COVID income prospective income is £1.4m per month. (excluding True up balances) True up YTD at £2.9m and expected to rise to £3.4 by end July	On-going block likely post month 4 with STP claims for any true up however expectation of CIP and break-even for providers.	

The reporting at month 3 has demonstrated that the Trust still has an underlying favourable position when compared to last years average, however this is in the main due to reduced elective drugs and supplies. Our COVID spend is £10.4m YTD (£3.6m Hospital Discharge/Infection control and £6.9m acute), of which £1.5m is TDC funded and the balance of £2.9m has been claimed as retrospective top-up income to deliver the break-even position YTD. The Forecast for month 4 increases our underlying trajectory of expenditure and a continuation of COVID costs, with Truing up income increasing by a further £0.5m. *(Note: This data set excludes TP.)*

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	Sales are forecast to increase but with a corresponding cost base leaving net surplus as expected pre COVID.
Corporate	EFM	Continued loss of EFM income delivery which will need consideration when new guidance received. Potential for STP to address items such as car parking on an STP wide basis.
	Exec. Directors	Run rate remains steady post reallocation to smooth revenue costs of new Windows investments. On going need for IT kit for COVID recovery and home working.
	Financing Costs	There is an expectation loan interest rate changes will increase the run rate later in the year.
	Other	COVID Trueing up income is £2.9m for Q1 and estimated at £3.4m by month 4, as run rates increase on BAU services again.
South System	Coastal	Elective costs are still low at month 3 and not expected to vary much by month 4. Awaiting Trust decision in July of Green site and continued use of DSU. Further guidance on the National contracts around private hospital use and outsourcing is expected shortly and will influence the month 5 onwards forecast potentially however the risk is this requires our staff to run these theatres.
	Newton Abbot	The emergency pathway options appraisal is underway but has not had a final version of costs and options agreed yet. This may increase the Trust's current run rate, and will also need to allow for Winter costs.
	Moor to Sea	There has been a small increase in returned BAU costs in month 3, but the purchase of healthcare costs remain low as activity delivery is low.
Torbay System	Independent Sector	The Hospital discharge spend continues at a cost of £3.3m expected by the end of month 4, of which TDC will contribute £1m to this period of cost. The Infection control fund will passport through £1.5m by month 4. FNC uplift and delivery of dom. care unsourced packages of care are an increase over last year along with inflation running higher than NHSI

Change in Financial & Activity Performance - M2 to M3

		Plan	May-20	Jun-20	Change	% Change		Jun-19	% change
Activity Drivers	A&E Attendances	9,929	6,053	6,689	636	11%		10,227	-35%
	Elective Spells	3,404	1,465	2,037	572	39%		3,080	-34%
	Non Elective Spells	3,139	2,199	2,500	301	14%		3,170	-21%
	Outpatient Attendances	28,708	17,028	21,274	4,246	25%		30,500	-30%
	Adult CC Bed Days	239	133	128	-5	-4%		241	-47%
	SCBU Bed Days	171	138	114	-24	-17%		171	-33%
Bed Utilisation	Occupied beds DGH		7,245	8,063	818	11%		10,096	-20%
	Available beds DGH		11,914	10,740	-1,174	-10%		10,719	0%
	Occupancy		61%	75%	14%	23%		93%	-19%
Resource Consumption	Medical Staff Costs - £000's	4,730	5,015	5,187	172	3%		4,796	8%
	Nursing Staff Costs - £000's	5,033	5,056	5,230	174	3%		4,982	5%
	Temp Agency Costs - £000's	648	465	581	116	25%		938	-38%
	Total Pay Costs - £000's	21,609	21,892	22,684	792	4%		21,452	6%

Key points

- **Activity Drivers:**
  We can see that in M3 activity has increased by about 25% again in overall terms from M2. A high level piece of work was undertaken, looking at Acute activity undertaken in M1&M2 and show how they believe this will increase in % terms between now and the end of March on a monthly basis by specialty. All Providers in Devon provided this information and the STP is monitoring against this as part of Phase 2, on a weekly basis. Following the above piece of work, specialties are expected to complete a more detailed bottom up piece of work to identify the activity they will deliver at a clinic/theatre session basis. All of this work will require assumptions to be made around space they will be given, theatre slots available, services being stepped up, PPE and staff/resource availability. These will be stated as part of each team's narrative. This will form part of the Trusts response to Phase 3 of the recovery agenda. Timeframes for the Phase 3 return are still not known.

- **Bed utilisation:**

In June we have seen a continued return to higher bed occupancy levels. This is being driven by the gradual return to pre covid levels of emergency admissions. June being 85% of pre covid levels. The number of available beds remain slightly reduced due to the reconfiguration of some wards for covid response and social distancing requirements. Overall our available General and Acute beds are 6% lower than pre covid levels. The risks of continued increasing bed occupancy is being escalated as part of recovery planning. The clinical and operational teams are ensuring all the best practices to avoid admission where possible, provide rapid assessment, review all internal delays and timely discharge are in place.

- **Resource Consumption (Pay):**
  There is an increase of £0.79m in pay due to: Substantive staff £0.61m (reversal in M2 of £0.75m for annual leave accrual offset by net pay increase of £0.15m. A material movement is within Medical Staff in General Surgey of 0.18m due to backdated job planning cost); bank staff £0.07m (mainly Trainee grades £.05m), agency cost £0.12m (Medical staff £0.08m (mainly in Emergency and Neurology cover for sickness and vacancy), Nursing £0.06 (mainly for COVID) offset by AHP £0.03m). Some patient activity is starting to return to pre COVID levels hence the general increase in pay.

Appendix 2 – System Finance Reports for Information

June 2020

FINANCE SCORECARD – South Devon System

South Devon system view;

Coastal ISU - Newton Abbot ISU - Moor to Sea ISU - Shared Operations - COVID Collection

FINANCE RUN-RATE – rolling 13 months

Run rate expenditure for first quarter is an average of £10.7m being 13% lower than pre Covid comparator of M8-M10 2019/20 (NHSI monitored) . Main driver being impact of COVID -19 reduction in patient activity with reduced costs across medical staff temporary staffing, and non pay supplies. Q1 pay is 4% lower, and non pay 41% lower.

INCOME MONITORING

NHS Contract Income has been blocked for months 1-4 at Trust level, and providers expected to breakeven even months 1-4. Further National guidance expected shortly. Shadow PbR monitoring will start later in the year. Other sources of income are various contracts and recharges.

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Innovation Projects/ £ CIP

No CIP is expected to be recorded to NHSI months 1 – M4 due to impact of COVID. Targets to be reset and issued M5 – 12, delivery of CIP within recovery workstreams, and revised business planning.

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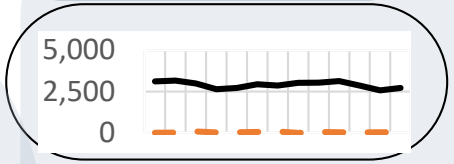
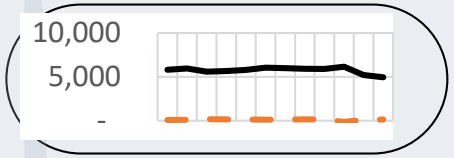
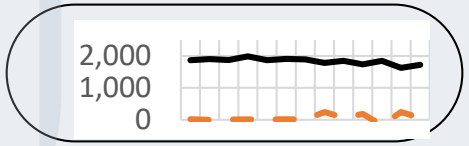
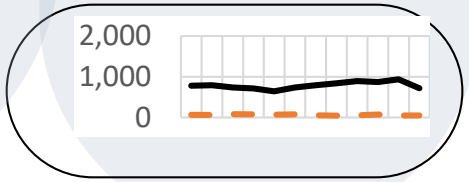
FORECAST REPORTING

Forecast estimate based on early activity assumptions shows run rates increasing c12% from M5 onwards - not at pre Covid levels. Dependent on standing back up of services, National guidance and performance targets, recovery workstream outcomes, ED pathway redesign, response to COVID - to be reviewed July.
Main focus going forward is developing recovery plans, financial impact, and scenario modelling for robust forecasting.

Board Table of Key Metrics – South Devon System

	Drivers	Forecast/ risk	Actions Taken:	Tick charts- 13 month actual rolling run rate
Newton Abbot ISU	Run rates higher M3 than previous months two months, but still following a lower than average trend due to impact of COVID. ED activity however increasing to more "normal" levels.	Response to COVID for red and green ED agreement due imminently. Forecast process to be refined when future services clarified. Reduced efficiency - increase cleaning, Social distancing etc. Run rates increase M5.	Workforce re modelling for ED pathway and flow -, business case drafted. Safer staffing impact t- business case in progress. Recovery plans developed / financial impact	
Coastal ISU	Reduction in surgical cases c70% due to COVID M1-M3. Further reduction M3 due to two Theatres closed for refurbishment, DSU not operational - pending ED decision.	52 week activity currently ceased pending guidance – growing backlog of patients. Assumption DSU not in use until further notice. Run rates increase M5 - latest activity assumptions. Risk increased costs response to COVID for Social distancing, IT, Sates to resume services.	Proposals being worked up for increasing capacity at specialty level. Some services resumed - limited capacity. Eye theatre in use from mid July - 50% capacity. Access 2 theatres at Mount Stewart Hospital. Recovery plans being developed/ financial impact.	
Moor to Sea ISU	Run rate M3 is higher than previous month, but continues to follow lower than average run rate trend. Purchase of healthcare NHS spend reduced reflecting lower patient activity. Some patient activity starting to return to more "normal" pre COVID levels.	Community services to be redefined to deliver on going and safer services in response to COVID. Run rates increase post M5 and rise as services resume, further modelling will be required when informed of further service changes.	Potential impact in run rates for "Hot" and "Cold" - pending decision.. New ways of working - virtual appointments, Attend Anywhere, etc. Recovery plan being developed / financial impact	
Shared Operations ISU	Run rates lower M3 mainly non pay, trend remains lower than average pre covid. This is unlikely to continue, cost increasing as patient activity resumes.	Increased cost and run rates due winter and other pressures, temporary staffing requirements on seasonal wards . Run rates increase M5	Run rates risk of Warrington and Elizabeth wards, seasonal demand.	

South System and Shared Operations costs overall are lower in Q1 by 12% compared to an average compared to that of M8-M10 2019/20. Pay costs lower bank and agency wards, ED and medical staff, non pay supplies due to the impact of COVID and reduced patient activity. Run rates will increase as activity increases, with further risk of IT, Estates and other costs. Risk also of staff resource availability as the year progresses, annual leave back log, sickness etc. COVID related incremental costs are c£6.9m for Q1, are recorded separately within Shared Operations ISU.

FINANCE SCORECARD – TORBAY SYSTEM

Paignton & Brixham ISU - Torquay ISU - Independent Sector - COVID 'Early Discharge'

FINANCE RUN-RATE – rolling 13 months

Average monthly expenditure is £18.9m for the last three month period compared to a previous average of £18.2m per month. This is being driven by COVID related costs of circa £1.2m (Early Discharge Independent Sector 'IS').

IS costs are also higher from April 20 due to Inflationary Uplifts (over 4%) and increased ASC costs (reduction in unsourced packages of care). However, offsetting this acute non pay costs are lower since April 20 due to reduced activity levels (particularly high cost drugs).

Pay has remained relatively consistent over rolling 13 month period.

NHS Contract Income has been blocked for months 1-4 at Trust level linked to NHSI issuing a 4 month plan for providers to break even. New guidance anticipated shortly for the remainder of the year.

Shadow PbR monitoring will start later in the year. Other sources of income are various contracts and recharges.

INNOVATION PROJECTS / £ CIP

The plan for the system to deliver CIP in 2021 was set in the NHSI plan March 20. The first 4 months are now void due to the impact of COVID, leaving targets to be reset and issued from month 5 to 12.

Schemes against these targets to be reviewed in conjunction with both recovery and revised business planning.

Cost base marginally lower in months 1-4 due to COVID heavily impacting activity levels, particularly in P&B. In months 5-12 cost base is modelled to slightly increase but the rate of this fluctuates and is impacted by some key assumptions on recovery plans developed, winter costs and national initiatives around COVID and funding agreements (Early Discharge & Infection Control Fund).

Moving forward the focus needs to be the development of recovery plans with financial considerations to facilitate more refined financial modeling.

INCOME MONITORING

FORECAST REPORTING

Board Table of Key Metrics – Torbay System

	Drivers	Risk	Actions Taken	Tick charts
P&B & Torquay ISU's	Reduced activity due to COVID resulting in increased waiting lists. Ongoing social distancing requirements makes Recovery / Standing back up services difficult (particularly Acute Services).	Waiting lists will increase and KPI's / standards won't be achieved unless additional financial cost is incurred (relating to EFM, IT and Pay areas). Even if finance is available some resources might simply not be available.	Recovery plans being developed with Financial impact as part of the template. Recovery plans also require Senior Managers approval.	
M1-4 Funding arrangements	A whole range of specialties within both Torquay and P&B are underspending but overall the Trust has to manage is Financial position to break even.	Specialties think that any underspends from Months 1-4 are available to be used to support Recovery Plans etc. for the remainder of the year.	Funding arrangements are communicated through formal reporting and governance routes within the Trust and updates to be provided once national guidance is released.	
Independent Sector	Increased costs due to COVID. From July funds being targeted to the relevant parts of the market funded by infection control fund. Early discharge from Hospital continues and new guidance awaited.	COVID will continue to impact the IS and that providers will demand that temporary financial assistance measures are put on a more formal permanent footing. No new guidance is received in relation to Early Discharge.	Strategy in place, based around known funding sources (grants). Offers to the market based on this Strategy and continued to be on a targeted approach.	

Underpinning the above is a reliance on staffing resources, be it within our own Trust or the Independent Sector providers. The ability to manage fatigue and annual leave requirements will be pivotal.

FINANCE SCORECARD – Corporate

Corporate system view:
Executive Directors, EFM, Pharmacy, SDU, R&D, IA, Financing and Reserves

FINANCE RUN-RATE – rolling 13 months

Corporate net expenditure is £816k lower (5%) than expenditure incurred in months 8-10 last year, but this is due to top-up income expectation for Covid-19 of £1.4m per month. Pay is 7% higher and non-pay 2% lower than month 8-10.

NHS Contract Income has been blocked for months 1-4 at Trust level. Shadow PbR monitoring will start later in the year. EFM income loss of £502k during M01-03 is reflected in the ISU. Education income reflects a provisional reduction in activity. Other sources of income are in line with prior months.

Innovation Projects/ £ CIP

The Corporate system budget for month 1-4 includes the CIP targets set out in the March version of the 2020 plan. The NHSI budget excludes CIP, but revised arrangements and targets are expected to be issued for month 5-12.

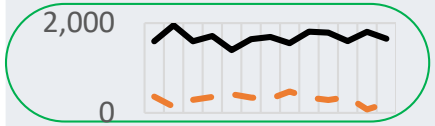
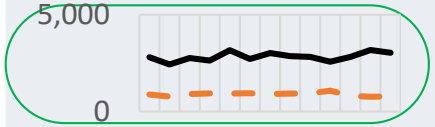
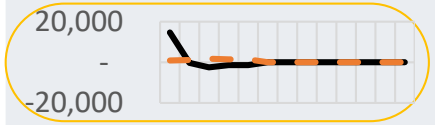
The initial forecast indicates that net expenditure will rise by 23% by the end of the year (compared with M08-M11):
Pay costs rise of 9% (£0.3m)
Non-pay costs rise of 10% (£0.4m)
Other income fall of 25% (£0.5m)
Assumptions in each of these areas will be reviewed and agreed with service leads during July

INCOME MONITORING

FORECAST £ REPORTING

Total Expenditure
Other Income
Contract Income

Corporate Table of Key Metrics

	Drivers	FOT/Variance Risk	Actions Taken:	Tick charts run-rate (£m)
EFM	Lost income (M01-03) of £502k reflected in ISU figures Expenditure expected to rise as activity across the Trust increases	ISU charge to Covid-19 of £174k risk of returning to the ISU position Stepped return of income included in the forecast as agreed with service leads	Increase in demand to be monitored Income assumptions to be reviewed/included based on national guidance	
Executive Directors	HIS non-pay profile has peaks in yr. Education & overseas nursing recruitment activity reduced due to Covid-19.	HIS spend profile does not reflect cost spread to the TSD across year Future impact of reduced training provision	HIS spend profile flattened across the year	
Reserves	£2m annual leave accrual from m12 now adjusted to nil £5.7m Covid-19 top-up income profiled between M01-04	Leave entitlement risk from cost of providing cover when leave peaks Uncertain that total value of top-up will be received	tbc	
Other ISUs	R&D trials activity reduced due to covid-19 Pharmacy ISU future pay risks	R&D trials income unlikely to recover in the short-term. Pharmacy recovering from short staff not reflected in allocation	R&D staff resources re-deployed	

Corporate services net costs are higher than the average of month 8-10 in 2019/20, after excluding the effect of the provisional Covid-19 top up income. Pay costs are 7% higher, non-pay costs are 2% lower, due to the overall reduction of activity across the Trust. Other income is reduced, due to the impact of Covid-19 on services and also collection of certain income centrally under the interim arrangements.

FINANCE SCORECARD – Children & Family Health Devon (CFHD) SYSTEM

CFHD System view

FINANCE RUN-RATE – ROLLING 13 MONTHS

Run Rate Expenditure in Apr and May is an average of £2.2m being 8.89% lower than the NHSI M8-10 2019/20 comparative. Pay is 8.20% higher, after Afc inflation of circa 2.9%, the balance is full year effect of posts that commenced M10 along with an accounting switch of recharges from non pay. Non pay 18.30% lower, M8-10 comparative had backdated estate and overhead recharges from DPT/TSD and non recurrent accruals for IT spend.

INCOME MONITORING

NHS Contract Income has been blocked for months 1-4 at Trust level and Providers are expected to breakeven Months 01-04. Further National guidance expected shortly. Other sources of income are 90% less (£0.11 average) than the M8-10 due to one off receipts of education and mobilisation recharges.

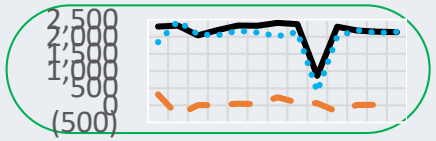
INNOVATION PROJECTS / £ CIP

No CIP is expected to be recorded to NHSI for months 01-04 due to the impact of COVID. Revised arrangements and targets are expected to be issued for month 5-12, along with revised business planning.

FORECAST £ REPORTING

The initial forecast indicates that net expenditure will remain at same levels of M01-03 by the end of the year, but will fall by -4.4% (£0.1m), compared to M08-10 average.
Pay costs rise of 15% £0.13m
Non-pay costs fall of -22% (£0.34m) *Mainly switch from non pay to pay of recharge costs*.
Other income fall of 93% £0.11m

CFHD Table of Key Metrics

	Drivers	FOT/Variance Risk	Actions Taken:	Tick charts 13 Month Actual Rolling Run Rate (£m)
CFHD	Expenditure Run Rate Consistent: Staff consultation remains on hold; high level of vacancies being main offset to any CIP targets expected in contract. Forecast does not include any VO income due to Covid block situation	Forecast for minimal fulfilment of vacancies and non commencement of consultation awaiting new CFHD Director start date. New IT system pending consultation of clinical model. VO work could incur costs above income levels if CCG do not agree with the VO value.	Vacancies under constant review. IT requirements will be assessed as service is evaluated. Constant evaluation being made on VO works.	

CFHD net expenditure for months 1-3 in 2020/21 is lower than the average of month 8-10 in 2019/20. Pay costs are 8% higher, due to inflation plus full year effect of posts commenced in Month 10 and a switch from non pay for the back office recharges from TSD; non-pay costs are 18% lower, Month 8-10 included back dated alliance costs which are now accounted for in equal 12th's plus a reduction in the surplus amount available for distribution across the Alliance. Other income is reduced by 90%, due to the impact of Covid-19 on services and also collection of certain income centrally under the interim arrangements. Contract Income remains on plan with small increase of 3% on M8-10.

INSERT FOR BOARD REPORT JUNE 2020:

ACUTE COVID 19 RETURN:

The Trust has submitted the following COVID returns in line with latest NHSI Guidance (embedded below) and templates issued:

COVID Return	June 2020
Capital Submission [1]	£0
Revenue Submission	£6,922,133

The basis for reimbursement is for costs incurred incrementally above those of normal business.

The Trust's COVID Revenue collection will be expanded as necessary to allow for costs collection of supporting the Nightingale Unit (hosted by the RDE). The Trust currently does not have any costs relating to Nightingale support.

COVID YTD Revenue Expenditure Summary Month 3

Covid 19 YTD Expenditure Month 3 2020/21	Total Expenditure PLAN M3 YTD £'000	Total Expenditure Actual M3 YTD £'000	Of Which COVID-19 Actual M3 YTD £'000
Total employee benefits excluding capitalised costs	64,833	67,757	3,712
Total operating expenditure excluding employee expenses	61,338	61,660	3,209
Total operating expenditure	**126,171**	**129,417**	**6,922**

COVID Revenue Forecast to month 4

NHSI has currently requested a forecast for four months to end of July 2020. COVID related spend from month 5 onwards to the end of the financial year will be provided once further guidance has been received from NHSI

Cost Centre Description	Expenditure	M3 YTD Expenditure	M4 FOT Expenditure
		£'000	£'000
COVID 19	Operating expenditure - Non Pay	3,210	3,968
	Operating expenditure - Pay	3,712	5,096
	Total	**6,922**	**9,064**

COVID Capital Costs and Submissions awaiting approval:

The cumulative costs incurred on capital expenditure up to 31st March 2020 were reimbursed to the Trust during early July 2020. Subsequent reimbursement of capital costs incurred up to the period up to 18th May 2020, (at which point the reclamation rules were changed) have yet to be approved by the National Team. Prospective claims submitted since 18th May 2020 have not been approved by the National Team either. Instead these Phase 2 claims are being consolidated into an overall Regional requirements list – date of draft submission to NHSE SW and Devon

STP being 15th July 2020. The combined value of capital claims for the period 1st April 2020 through to 18th May 2020 awaiting reimbursement totals £336,464.

COVID Detail Expenditure by month as at M3 2020/21

COVID 19 Expenditure by month 2020/21	202001	202002	202003	Total	spend + increased (-) reduced from previous month
	£'000	£'000	£'000	£'000	£'000
Accommodation	81	106	(131)	57	(237)
Decontamination	40	11	27	78	16
Direct porvision of Isolation pod	1	0		1	(0)
Enhanced PTS	3	3	1	7	(2)
Inc ITU capacitY,assisted respiratory etc	254	164	113	531	(51)
Other (catering)	17	3		20	(3)
PPE	413	443	294	1,149	(149)
Remote management of pateints	127	4	32	163	28
Remote working non patient activies	61	0		61	0
Segregation of patient pathways	187	225	198	610	(27)
Support staying at home models	32	20	33	85	13
Virus testing	90	168	190	448	22
Backfill for higher sickness absence	513	550	569	1,632	19
Existin workforce additional shifts	338	908	745	1,991	(163)
Expanding medical / nursing workforce	20	45	25	90	(20)
Total	**2,176**	**2,649**	**2,096**	**6,922**	**(553)**

It can be seen in the table above that at this stage the direction of spend from May to June correlates to the guidance in most areas. There are several factors that could impact movements and are as follows:-

- Patient activity
- Timings of pay claims for additional shifts, payroll cut-off date, payments in arrears
- Volume of work and purchases made in April - e.g. Segregation of Pathways, Remote Management of Patients, Remote working
- Estimate of accruals higher than actual costs
- Costs awaiting approval for COVID expenditure, timings of accruals
- Categorisation of spend areas may need further review by review of individual invoice for clarification and technical/ medical descriptions.

The System Directors of Nursing and Professional Practice have been asked to confirm all direct shifts coded to cost of COVID, and have responded the usage is correct, with the following rational:-

- Coastal – having to send staff to Mount Stuart as part of recovery but still needing to support areas and altering shifts to accommodate
- Newton Abbot – supporting a red/amber ED area to support potential Covid patients
- P&B – supporting return to work nurse for Covid
- M2S – bring back staff cover
- Torquay – Paediatrics cover for Red ED

The ISU's report of the 4 months of COVID spend under this financial architecture will be provided next month. Along with a summary of the Finance team process notes for this COVID architecture period.

HOSPITAL DISCHARGE COVID RETURN:

Due to the integrated nature of the Trust this element of COVID costs is a combination of Health and Adult Social Care (Torbay Council) funding streams (includes the Infection Control Fund).

Spend to date this financial year is circa £3.56m and towards this Torbay Council has contributed just under £1.5m. This is summarised in the table 1 with more detail provided below.

COVID Costs and Income	June YTD Expenditure £'000	June YTD Council Contribution £'000	Month 4 FOT YTD Expenditure £'000	Month 4 FOT YTD Council Contribution £'000
Hospital Discharge	2,813	750	3,272	1,000
Infection Control Fund	748	748	1,453	1,453
Total	**3,561**	**1,498**	**4,725**	**2,453**

Torbay Council have agreed an initial £1m contribution towards Hospital discharge, and we are awaiting formal confirmation on a potential further £1m support.

Infection control monies of £2,060 have been committed to Care Hoes via the Trust, and in addition to this there is a further £688K of funding available within the Infection Control Fund of which plans are currently being developed between the Trust and Torbay Council.

	Actual	Commit		July	Aug	Sept	Total
Area	April & June	April & June	YTD Total	July	Aug	Sept	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
EXPENDITURE							
Residential & Nursing Home VOIDS	229	99	328				328
Dom Care & Supported Living VOIDS	118	141	259				259
Early Discharge Packages Torbay	806	270	1,076	437	432	418	2,363
Dom Care LW@H Rate Uplift	191	133	324				324
Agincare (additional block contract)	38	28	66	22	22	21	131
Residential & Nursing Home Financial Assistance	324	436	760				760
Infection Control	748	-	748	705	705	575	2,733
Expenditure Total	**2,454**	**1,107**	**3,561**	**1,164**	**1,159**	**1,014**	**6,898**
INCOME							
Torbay Council COVID Core	750	-	750	250	-	-	1,000
Torbay Council – Infection Control Fund	748	-	748	705	705	575	2,733
Income Total	**1,498**	**-**	**1,498**	**955**	**705**	**575**	**3,733**
Early Discharge (Health COVID) Cost	**956**	**1,107**	**2,063**	**209**	**454**	**439**	**3,165**

Notes

(1) Above is based on initial offers ending on 30th June and Infection Control Fund being fully utilised.
(2) Residential & Nursing Home Financial Assistance is the expenditure area most difficult to calculate. A number of providers have not submitted any claims to date but could potentially do so. Also, this area from June onwards has strong links to the new Infection Control fund.
(3) Infection Control Fund – The above assumes 100% of the overall funding that Torbay Council has received.
(4) Early Discharges Packages – Guidance still required on repatriation with revised guidance anticipated very soon.

(5) There is potentially an additional £1m of Core COVID funding available from Torbay Council. Current planning is that this will be utilised in the second half of the financial year but this will be reviewed in line with main NHSI funding guidance.
(6) Health COVID cost is the value accounted for in the Trusts M3 financial position as submitted to NHSI.

COVID True Up Income:

The cumulative COVID True Up income value at M3 is £2.885m.

	ISU	Target	13 month trend	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	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		1	0	2	0	0	1	1	0	0	0	0	3	3	6
Reported Incidents - Death	Trustwide	<1		0	0	0	1	0	1	0	0	0	0	0	1	0	1
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	0	0	0	0	1	1	0	0	2	2
Medication errors - Total reported incidents	Trustwide	N/A		39	46	61	38	46	59	46	53	60	46	19	23	35	77
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	0	0	0	0	0	0	1	2	0	1	0		1
Never Events	Trustwide	<1		0	0	0	0	0	1	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		4	2	5	2	5	6	4	1	5	3	3	4	2	9
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	2	2	2	0	0	0	0	2	0	1	0	0	1
Formal complaints - Number received	Trustwide	<60		23	35	24	26	31	30	14	35	22	19	2	3	11	16
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		90.7%	92.2%	90.1%	89.9%	92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%	86.7%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		97.5%	97.8%	98.7%	98.8%	95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%	92.3%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		112.2	121.5	121.9	106.3	110.7	112.5	106.7	93.5	95.9	111.5				107.9
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		90.9%	90.1%	93.9%	89.8%	88.8%	89.6%	90.4%	91.3%	89.2%	88.9%	87.3%	85.4%	89.8%	87.5%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		93.7%	92.8%	100.3%	89.9%	91.6%	93.2%	91.7%	92.9%	91.4%	91.3%	89.0%	87.0%	89.9%	88.6%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		12	36	63	34	0	42	0	204	108	0	4	0	12	16
Hand Hygiene	Trustwide	>95%		93.8%	93.5%	95.2%	95.7%	96.1%	97.2%	94.1%	96.1%	93.5%	94.9%	99.4%	98.8%		99.1%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		62.5%	56.8%	77.4%	51.6%	63.4%	73.1%	76.9%	83.9%	82.4%	80.0%	80.0%	97.5%	91.7%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		79.1%	86.8%	80.4%	96.4%	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%	90.6%		80.1%
Follow ups 6 weeks past to be seen date	Trustwide	6400		6803	6906	7393	6793	6694	6725	7243	6391	6147	7056	8824	14211	15398	15398
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<3.8%		4.2%	4.3%	4.3%	4.3%	4.3%	4.4%	4.5%	4.5%		4.5%	4.5%	4.5%		4.3%
Appraisal Completeness	Trustwide	>90%		79.0%	80.0%	78.0%	78.0%	77.3%	78.0%	78.5%	80.1%	81.6%		71.6%	71.0%	75.6%	78.0%
Mandatory Training Compliance	Trustwide	>85%		90.9%	90.3%	90.8%	90.3%	90.6%	90.5%	90.4%	90.8%	90.4%		90.1%	88.0%	89.9%	90.3%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.8%	11.2%	11.2%	11.3%	11.4%	11.4%	11.4%	11.7%	11.7%		10.5%	10.5%	10.3%	

	ISU	Target	13 month trend	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	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		419	508	562	392	373	319	344	462	588	393	121	21	38	142
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		97	101	112	189	305	230	198	190	235	175	14	17	33	31
Timeliness of Adult Social Care Assessment assessed within 28 days of referral	Trustwide	>70%		74.6%	77.0%	72.5%	71.1%	69.5%	68.9%	68.8%	69.0%	70.0%	70.7%	70.0%	72.0%	73.1%	72.0%
Clients receiving Self Directed Care	Trustwide	>90%		90.3%	90.3%	90.1%	89.6%	89.0%	89.0%	89.1%	89.3%	88.1%	87.7%	85.0%	83.1%	82.1%	83.1%
Carers Assessments Completed year to date	Trustwide	40% (Year end)		13.2%	18.6%	23.2%	26.7%	29.2%	28.4%	35.4%	36.6%	38.5%	39.6%	2.2%	4.3%	10.1%	4.3%
Number of Permanent Care Home Placements	Trustwide	<=600		631	629	634	648	641	640	645	627	624	632	628	623	623	623
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		201	228	219	206	184	176	192	202	191	194				194
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		54			109						231				231
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET		5.6%			5.3%						6.1%				6.1%
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%
CAMHS - % of patients waiting under 18 weeks at month end	Trustwide	>92%		82.6%	83.2%	86.2%	91.7%	91.7%	92.4%	91.5%	91.3%	89.9%	78.8%	64.1%	59.8%		60.0%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		514	567	563	569	594	530	556	558	530	520	532	515	553	515
Intermediate Care - No. urgent referrals	Trustwide	113		179	188	174	178	216	205	201	239	202	219	230	246	258	467
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		220	196	202	204	226	230	212	211	186	202	138	172	222	310
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		80.3%	84.3%	79.4%	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%	95.2%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		81.5%	81.1%	80.7%	80.4%	79.9%	80.0%	79.9%	79.8%	79.5%	76.2%	69.3%	62.2%	56.0%	62.3%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		78.8%	84.4%	77.4%	78.9%	72.9%	78.8%	85.9%	83.6%	75.3%	71.8%	72.5%	75.5%	83.3%	76.5%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		11.7%	13.6%	14.9%	15.7%	10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%	47.2%
Dementia - Find - monthly report	Trustwide	>90%		92.8%	98.7%	90.3%	88.5%	87.5%	94.4%	88.4%	81.9%	94.3%	98.0%	98.4%	98.6%	94.4%	96.9%

	ISU	Target	13 month trend	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	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		5	4	6	3	8	2	4	4	5	0	4	9		13
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		69.5%	83.4%	83.4%	88.3%	68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	81.2%	93.6%	91.3%	89.8%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		98.9%	98.9%	98.7%	97.3%	91.5%	100.0%	97.3%	97.1%	98.9%	95.1%	96.3%	100.0%	95.5%	96.8%
Cancer - 28 day faster diagnosis standard	Trustwide			63.6%	74.0%	73.3%	70.6%	71.8%	73.2%	71.9%	66.9%	74.5%	74.8%	60.2%	80.9%	80.8%	75.0%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		97.3%	97.0%	94.7%	98.5%	96.8%	98.0%	97.6%	96.8%	98.8%	99.0%	97.7%	99.2%	99.2%	98.6%
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%		100.0%	95.9%	98.4%	95.9%	95.9%	95.8%	95.2%	89.5%	93.5%	97.7%	93.0%	98.3%	100.0%	97.5%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		96.8%	100.0%	93.9%	93.8%	94.7%	95.0%	97.1%	86.2%	91.4%	100.0%	96.6%	96.2%	100.0%	97.4%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		92.9%	93.8%	100.0%	100.0%	86.7%	85.7%	100.0%	100.0%	85.7%	76.5%	73.3%	33.3%	66.7%	66.7%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			34	28	31	36	39	27	24	24	21	21	19	42	68	68
RTT 52 week wait incomplete pathway	Trustwide	0		83	84	105	89	79	69	71	80	43	53	93	192	344	344
On the day cancellations for elective operations	Trustwide	<0.8%		1.4%	1.6%	1.3%	2.2%	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%	0.7%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		6	19	9	8	8	7	3	3	10	5	46	2	1	49
Bed Occupancy	Overall System	80.0%		90.5%	94.0%	95.3%	95.4%	95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	74.7%	59.7%
Number of patients >7 days LoS (daily average)	Trustwide			125.5	124.8	128.3	131.7	127.4	121.5	120.1	128.1	130.3	119.8	100.5	70.8	80.9	70.8
Number of extended stay patients >21 days (daily average)	Trustwide			26.6	29.8	29.0	35.9	34.3	28.0	23.1	25.5	27.7	26.0	22.6	18.1	18.7	16.1
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		83	81	137	90	47	104	113	117	88	43	16	9	19	44
Ambulance handover delays > 60 minutes	Trustwide	0		4	5	12	2	5	13	14	14	7	5	1	0	4	5
A&E - patients recorded as >60min corridor care	Trustwide			424	384	447	416	382	494	463	495	335	115	0	0	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			146	123	212	145	103	247	158	182	136	32	1	0	5	6
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		0	0	0	0	0	1	3	1	3	1	0	0	0	0
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		4	4	5	3	5	1	3	4	5	0	3	7	n/a	10
Number of Clostridium Difficile cases - (Community)	Trustwide	0		1	0	1	0	3	1	1	0	0	0	1	2	n/a	3
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		62.8%	67.2%	66.3%	67.1%	66.4%	63.0%	64.1%	65.7%	62.0%	70.6%	76.9%	78.4%		77.8%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		29.4%	39.9%	38.2%	35.0%	32.6%	25.8%	36.8%	41.5%	40.5%	44.5%	57.1%	54.1%		55.2%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		86.4%	86.4%	81.8%	68.2%	68.2%	77.3%	81.8%	81.8%	95.5%	68.2%	95.5%	86.4%	90.9%	90.9%

	ISU	Target	13 month trend	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	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
Capital Service Cover	Trustwide	2		4	4	4	4	4	4	4	4	4					
Liquidity	Trustwide	4		2	2	3	4	4	4	4	4	4					
I&E Margin	Trustwide	1		4	4	4	4	4	4	4	4	4					
I&E Margin Variance from Plan	Trustwide			1	2	2	1	2	2	3	3	4					
Variance from agency ceiling	Trustwide	1		4	4	4	4	4	4	4	4	3					
Overall Use of Resources Rating	Trustwide			3	3	3	3	4	4	4	4	4					
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-72	-1447	-1363	-473	-3022	-4464	-6555	-9693	-13294	-23577	218	524		
Agency - Variance to NHSI cap	Trustwide			-1.23%	-1.14%	-1.17%	-0.98%	-1.03%	-1.06%	-1.07%	-1.01%	-0.98%	-0.87%	0.79%	0.80%		
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-1296	-891	-239	-342	-1584	-2357	-2872	-4983	-7078	-9325				
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			893	1146	2637	3301	4420	6559	7632	8191	9595	4249	567	1112		
Distance from NHSI Control total (£'000's)	Trustwide			91	-1248	-1019	58	-1651	-2833	-4616	-7648	-10926	-20367	0	0		
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	0	0	0	0	-2000	0	0		
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			-4.8%	6.1%	-6.9%	-0.1%	-5.8%	-9.3%	-1.4%	1.1%	0.6%	-15.8%	-66.6%	-56.2%	-33.8%	-52.5%
Outpatients - Follow ups	Trustwide			1.0%	4.7%	-3.6%	5.2%	-0.6%	-2.3%	5.6%	3.0%	4.7%	-16.2%	-50.9%	-42.7%	-28.8%	-40.8%
Daycase	Trustwide			-2.9%	4.3%	-1.3%	8.5%	-3.0%	6.3%	1.4%	-2.6%	1.5%	-23.7%	-62.3%	-57.8%	-34.4%	-51.8%
Inpatients	Trustwide			-6.6%	3.9%	7.8%	-10.0%	-4.3%	10.1%	31.9%	16.8%	15.3%	-15.0%	-61.6%	-50.3%	-28.8%	-46.8%
Non elective	Trustwide			-6.5%	-5.1%	-9.0%	3.2%	4.8%	2.1%	14.9%	5.9%	11.6%	-10.9%	-44.4%	-35.4%	-21.1%	-33.8%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			355	358	339	380	394	385	400	450	368	358	430	503	497	
Intermediate Care GP Referrals	Trustwide			96	96	81	87	98	85	94	125	89	78	94	119	117	
Average length of Intermediate Care episode	Trustwide			12.172	16.961	18.863	15.759	15.305	13.428	14.987	14.172	14.281	14.035	10.131	8.9448	9.6653	
Total Bed Days Used (Over 70s)	Trustwide			9944	10176	10487	10372	10564	9903	10484	11576	10490	10430	11751	10385		
- Emergency Acute Hospital	Trustwide			5759	5911	5856	5776	6181	5900	6328	6879	6067	5938	6920	6336		
- Community Hospital	Trustwide			3031	2913	3366	3295	3180	3100	3174	3387	3147	3239	3168	2756		
- Intermediate Care	Trustwide			1154	1352	1265	1301	1203	903	982	1310	1276	1253	1663	1293		

Report to Trust Board of Directors			
Report title: COVID Recovery Plan			Meeting date: 29.7.2020
Report appendix			
Report sponsor	Director of Transformation and Partnerships		
Report author	Head of Business Development / Recovery Cell Lead		
Report provenance	Reviewed and amended at Recovery Cell Core Group 24.7.2020 Finance, Performance and Digital Committee 27.7.2020		
Purpose of the report and key issues for consideration	The paper summarises the recovery plans in response to Covid-19 developed by clinical and managerial leaders from the ISU's and system teams. This summary provides critical analysis of the assurance provided by the recovery plans, key risks to delivery and recommends that the structure for implementation is formally handed over to "Trust Business as Usual" assurance architecture.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to note the contents of the report and accept the recommendations for submission to board.		
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**	20
Risk Register		**Risk score**	

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**

Careful communication will avoid uncertainty about the role of meetings overseeing operational governance of the Trust

Report title: COVID Recovery Plan		**Meeting date:** 29.7.2020
Report sponsor	Director of Transformation and Partnerships	
Report author	Head of Business Development / Recovery Cell Lead	

1 INTRODUCTION

Background

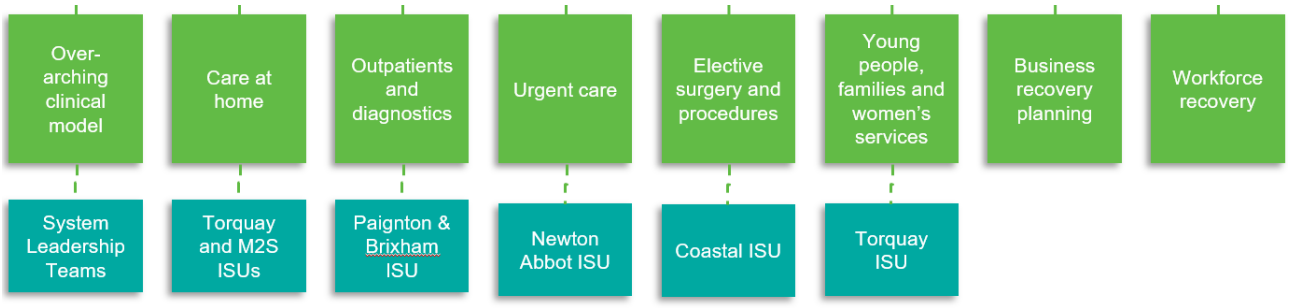
Following declaration of the Covid–19 major incident in February 2020, the trust focussed on day-to-day operational coordination in order to prepare for a surge in COVID patients, and many services were halted in order to build this capacity. National policy still requires some services (notably screening services) to remain closed. All services delivered by the Trust remain subject to ongoing social distancing guidance and infection prevention and control (IPC) measures that impose significant constraints on our ways of working.

When the surge failed to arrive in Devon, our organisation (alongside others nationally) started the process of recommencing services in a new "living with COVID" regime the like of which has never been seen in the NHS before. The recovery cell was established to put in place plans to recover the organisation such that it can deliver its business objectives within this context.

The Covid-19 Recovery Cell was created as part of the pandemic critical incident governance structure, which, in line with the Trust Major Incident Plan (MIP), is the cell that ensures that there are plans in place to recover the business objectives, prior to standing down a formal incident. The recovery cell was set up on the 29th April 2020 and the Executive Lead is the Director of Transformation and Partnerships.

The Covid-19 Recovery Cell has remained very closely aligned to the business as usual governance architecture. Key workstreams are led by the ISU clinical and managerial leaders, which will assist in the smooth transition from the major incident process to operational delivery.

2



The recovery cell (and associated plans) aim to:

1. **Minimise harm to patients and service users as a result of the pandemic, and optimise outcomes** through:
   - Prioritising service restoration and transformation on areas with greatest need/risk/impact
   - Maximising service capacity as rapidly as possible within COVID-related constraints

- Using technology and new pathways to increase effectiveness of services while living with COVID
- Restoring support services, corporate functions, business processes and normal organisational governance

2. **Prepare for the "new normal" and improve long term service resilience** through:
   - Learning from COVID-19 to inform on-going service design and transformation
   - Engaging with Devon-wide provider networks and transformation to build on strengths and mitigate weaknesses
   - Continuing to engage with service users, staff and community stakeholders to fulfil our organisational purpose

Critical success factors

The Trust agreed a set of strategic critical success factors, previously shared with the Board. These were to:

- Provide resilient emergency care for patients with COVID and non-COVID in separate locations
- Ensure that diagnostic and elective capacity is delivered safely and separately from COVID care
- Meet realistic safety, quality and performance standards for diagnostic, cancer and elective care services
- To support our talented and valued workforce
- Stay within our realistic target financial envelope
- Align to the system strategy of the North, East and South Devon collaboration
- Build on our unique contribution of leadership of integrated care
- Build on our unique contribution of leadership of day-surgery models

2 SCOPE

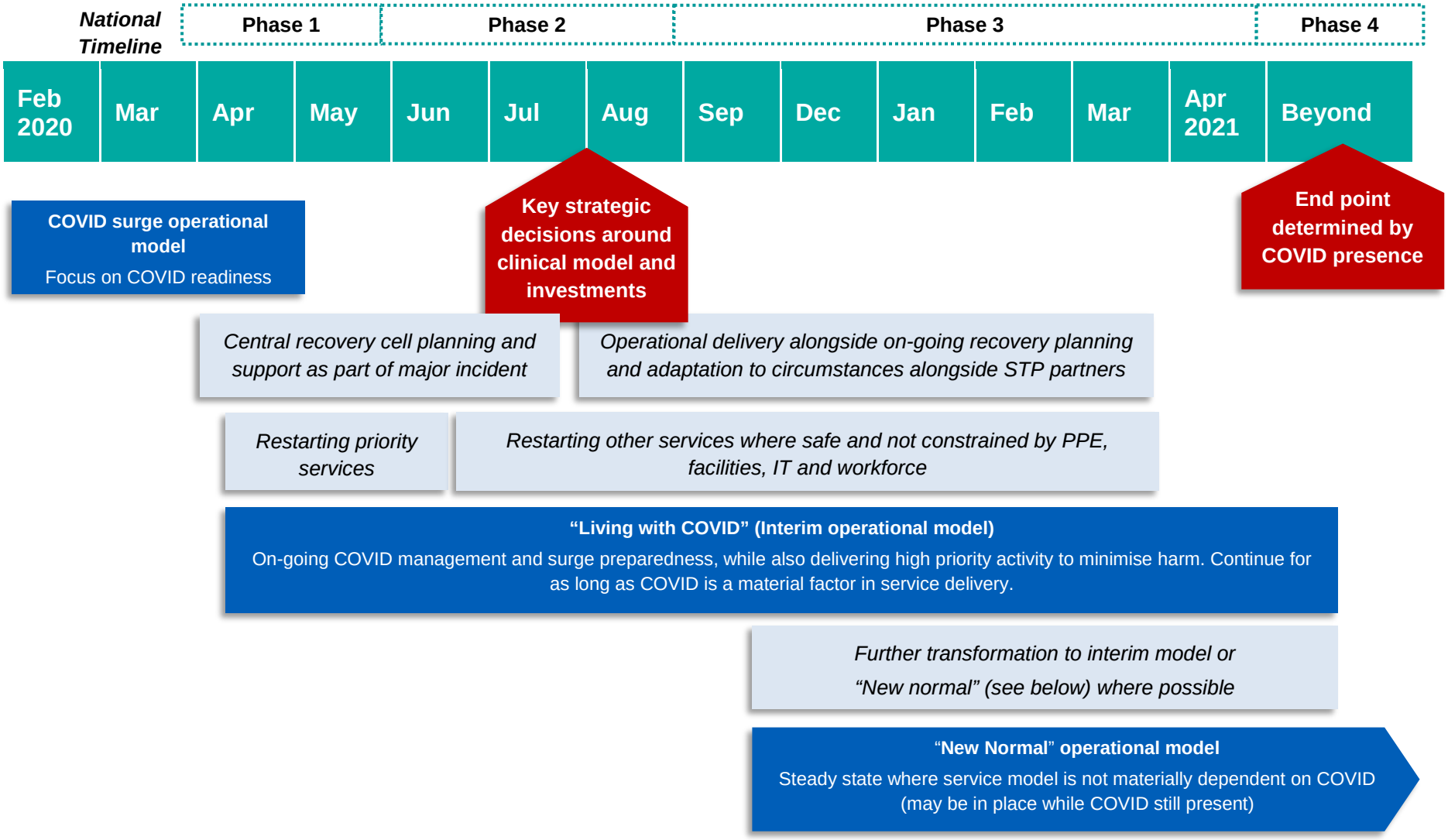
The scope of the recovery cell (and plans) includes:

1. Overseeing the process to stand up services that halted as a result of COVID
2. Develop plans for broader recovery from the disruption caused by COVID
3. Implement long standing service transformation aims where they aid recovery (e.g. shift to more care closer to home through tech enablement) [link to strategy]

There are many functions the recovery cell has provided to support this, including:

- Establishing governance structures, processes and tools to manage and support services restarting
- Develop a service control schedule and other facilities to provide an overview of service status in addition to compiling and sharing key messages for referrers (principally GPs) staff and public
- Operational and support service development facilitation, recovery project planning and analytical support
- On-going STP/CCG liaison in relation to recovery and transformation
- Development of a recovery plan explicitly linked to operational accountability for delivery, including the following components:

3 OVER-ARCHING TIMELINE



4 WORK-STREAM PLAN OVERVIEW AND ASSURANCE

Introduction

The aim of this section is to ensure that the Board understand the key outcomes from each workstream and how these outcomes will support the recovery of Covid-19. The Recovery Cell lead has provided an overview of the level of assurance provided by each work-stream, which critically assesses how robust the plans are within each work-stream and makes recommendations to Board on subsequent actions required from the ISU teams to provide full assurance on recovery.

In addition, this section provides an overview of each of the five clinical work-streams that will be continuing to the next phase of recovery (work-stream 1 will be standing down).

The plans within these work-streams vary in their level of complexity and some rely on Board action or external factors (e.g. availability of national capital) for their success. The following pages summarise key outputs for each work-stream, main dependencies, risks and gaps in assurance, and critical strategic decisions that over the course of the recovery period will need to be addressed by the Board.

Work-stream assurance

The following table summarises the relative level of assurance provided by our plans, and therefore how to prioritise our focus as recovery continues. This reflects the impact of factors outside of the control of relevant teams, and also the risk of harm to patients directly related to different areas. It aims to be as objective as possible while recognising that overall assurance in each area is to some extent a subjective evaluation that is not a direct sum of the component parts.

The aim of this analysis is to provide board with assurance that plans are in place, have clarity in the delivery of the “mission” and clear roadmaps in the route to success. A fully assured plan, will have all critical interdependencies fully understood and articulated, have a clear project structure and delivery support in place and a full set of risks and issues that may critically impact on the delivery of the work-stream objective.

Work-stream		Outputs	Plan	Risks, issues and dependencies	Support resourcing	Strategic decision dependencies	Risk of harm	Overall level of assurance
Evaluation scoring: *A – High level of assurance* *B – Medium assurance* *C – Low level of assurance*		*Are the deliverables clear and appropriate?*	*Is there a clear and detailed timeline?*	*Have dependencies and necessary mitigating actions been documented?*	*Is it clear how further planning and delivery will be supported?*	*Are the outcomes materially dependent on imminent strategic decisions?*	*Is there a significant risk of patient harm directly related to recovery of these services?*	*Summary level of assurance*
1	Over-arching clinical model including hospital operations	This work-stream will close as a formal part of recovery planning in the transition to operational ownership, although many of its functions around sharing clinical models and leadership will continue through the operational structure.						
2	Care at home recovery (Torquay & M2S)	B	C	C	B	Yes	Yes	**C**
3	Outpatient redesign and diagnostics recovery (P&B)	B	B	C	B	Yes	Yes	**B**
4	Urgent care pathway (NA)	B	B	C	B	Yes	Yes	**B**
5	Elective surgery and procedures (Coastal)	B	B	C	B	Yes	Yes	**B**
6	Young People, families and women's health (Torquay)	A	A	A	B	No	Yes	**B**
7	Business planning recovery	A	A	A	A	Yes	No	**A**
8	Workforce recovery planning	B	A	A	A	No	No	**A**

Summary of recovery work-stream assurance

- The "Care at Home" cell was set up to provide immediate response to providing support to community services and delivered this very effectively, during the incident. However, this is the only recovery workstream that does not reflect the organisations ISU structure and as a result the plans have been slow to be developed or owned. Immediate action has been undertaken to provide significant programme resource from the QI team and supported by Andy Griffiths to develop a plan with all ISU's that will deliver a transformation in the way we deliver urgent care in peoples homes and communities to reduce demand on the acute site and maintain the wellbeing of our local population. We do not have assurance at this time that plans are in place to deliver the necessary transformation and this will need to be a high priority for ongoing performance monitoring and management.

- Business planning and workforce recovery work-streams both have teams that are familiar with these kinds of planning processes, neither are reliant on major transformation (although both support it) and neither will directly lead to patient harm. Therefore, these are relatively low risk elements of the recovery plan and there is assurance in the delivery of these plans.

- The remaining work-streams have all put a great deal of effort into actually delivering recovery of their services alongside development of the enclosed plans. The shifting landscape and strategic uncertainties mean that their plans will need to adjust and improve in the coming weeks, and they will need appropriate project and change support to deliver this effectively. The impact of key constraints (notably IT hardware and appropriate facilities) means that effective coordination and support from relevant trust-wide teams (IT and EFM for instance) is crucial.

WORK-STREAM 2 – CARE AT HOME (SHELLY MACHIN)

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Safe continuity of community services	
Fully integrated 7-day discharge hub	
Embedded discharge to assess processes	
Transition from central management to dispersed ownership by ISUs	
Expansion of community capacity to meet strategic shift away from acute care alongside meeting Winter demands	

KEY DEPENDENCIES

- This work is critically dependent with the urgent care work-stream as the design of alternative pathways for services will require support from acute services to transform the way they deliver care outside of the hospital in partnership with primary care

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- Outcomes (in terms of availability and capacity trajectories for each service) unclear
- Immediate priorities and timeline for delivery unclear
- Operational ownership for different components unclear
- Risks and issues unclear
- The lead for this work-stream has presented the strategy and intent of the work to all ISU clinical and managerial leads and has requested that each ISU ensures that these outcomes are delivered in their communities.

NEXT STEPS/REQUIREMENTS OF BOARD

- The Director of Transformation and Partnerships has commissioned a significant amount of project resource to work alongside the clinical and managerial leaders to produce an assured plan, which will align to the winter plan.
- It is proposed that this work is monitored closely through the Project Management Office and reported to FPDC and the Transformation Committee with a view to an assured plan being in place by the end of August 2020, for swift delivery.
- The lack of plan for the transformation of our care at home services is a high risk to the organisation and it is proposed that a formal risk assessment is developed to ensure that this is well managed and fully overseen by Trust Board.
- The accountable officers for delivery remain the System Directors with Shelly Machin providing the lead co-ordinating role. Development and resourcing of the plan will sit within the governance architecture of the Transformation Group. Delivery of the plan will be overseen by the Transformation Group and will be the accountability of the Chief Operating Officer.

WORK-STREAM 3 – OUTPATIENTS AND DIAGNOSTICS (JOANNE WATSON)

Outpatients

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Directory of services finalised	31/08/2020
Attend Anywhere roll-out complete	31/08/2020
All outpatient services reach agreed "living with COVID" capacity, including 75% of activity being delivered non-face-to-face	01/09/2020
Trust-wide implementation of "Patient Initiated Follow-Ups" (PIFU) complete	31/12/2020
Reduce number of outpatient appointments by 30%	tbc
Outpatient service reach full capacity to meet on-going demands of local population	tbc

KEY DEPENDENCIES

- Access to sufficient IT hardware for remote working and virtual consultations
- Access to sufficient physical facilities for face-to-face services
- Appropriate coordination and systems support for space booking
- Clinical buy-in to ambition for virtually delivered services and remote working
- Likely requirement for standardisation of access and equity of waits across Devon

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- Inter-dependent with plans for the urgent and emergency care development which has held back the use of Level 2.
- Risks and issues don't have detailed mitigation plans
- Complexity and clinical concerns involved with transitioning to virtual services not fully explored and resolved
- Potential to more explicitly link recovery plan outcomes with national expectations re outpatient activity reductions
- Insufficient clinical challenge relating to ambition of capacity trajectories
- Insufficient capacity in project or managerial support to drive delivery
- Clinical space that is currently available is not being fully utilised

NEXT STEPS/REQUIREMENTS OF BOARD

- Director of Transformation has allocated clear dedicated project managers to support the delivery of the ambition and agreed with the workstream lead
- Clear communications from the Trust Board around the level of transformation required, ambition and opportunities require stronger focus. Dedicated support from the communications team will be provided.
- Ensure that the use of Level 2 outpatients is operationalised without delay while finalising the UEC options appraisal
- Invest in IT hardware to support remote working and virtual/hybrid consultations

Diagnostics

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Agree new cross-Devon framework for risk stratification and referral management	01/10/20
6 week diagnostic target met for respiratory diagnostics	01/10/20
6 week diagnostic target met for cardiology diagnostics	01/12/20
6 week diagnostic target met for endoscopy	Tbc
First new CT scanner operational (capital dependent)	01/04/21
First new CT scanner operational (capital dependent)	tbc

KEY DEPENDENCIES

- CCG and other provider collaboration to agree new risk and referral management framework to reduce inappropriate/low risk demand
- Significant reliance on capital availability for investment in endoscopy facilities and new CT scanners
- Access to Nightingale CT facilities and further Devon provider network capacity

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- While broad requirements and scope of recovery requirements are understood, the plans need further development and detail alongside analytical support
- Risks and issues don't have detailed mitigation plans
- Teams are very busy, stressed and demoralised, which hinders their capacity to plan
- Significant clinical risks due to cumulative effect of increasing waiting lists and delays without effective information to prioritise
- Significant issue across Devon and therefore the opportunity and strategic imperative to transform these services are high

NEXT STEPS/REQUIREMENTS OF BOARD

- Director of Transformation and Partnerships has allocated a new programme lead to support the delivery of the diagnostics and outpatients programme commencing 27.7.2020
- Challenging IPC turnaround times for diagnostic kit to be optimised to improve flow.
- There is a significant need to secure capital to invest in new facilities and scanners, business cases have been submitted. As a Board we will need to ensure that the criticality of the availability of this funding is understood across the STP and nationally.
- Build on relationship with Devon STP organisations to develop opportunities to expand capacity and provide mutual support to reduce waiting lists

WORK-STREAM 4 – URGENT CARE PATHWAY (CATHY WILLIAMS)

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Emergency floor footprint options appraisal signed off by Trust Board	29/07/20
Identification of alternative pathways to ED/re-direction	03/08/20
Ensure COVID testing process correct & in place	03/08/20
Agree location for COVID positive patients (RD&E?)	03/08/20
Agree process of care for COVID positive patients whilst awaiting transfer	03/08/20
Public communications on changes to UEC - positive PR on units and their purpose	01/09/20
Increase SRU attendances to agreed levels	28/09/20
Number of patients reduced in ED through transformed clinical pathways	31/03/21

KEY DEPENDENCIES

- Decision on Urgent and Emergency Care Options Appraisal required
- Delivery of effective models of alternatives to urgent care through the combined care at home work, provides limited assurance on the delivery of this plan.
- Development and successful implementation of appropriate urgent care pathways
- Wider system/national developments (e.g. “111 first”) and the ability for the system including 111 and SWAST to transform at pace
- This work will form the winter plan and is therefore business critical

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- The focus of this work-stream has been predominantly the UEC options appraisal, whilst this is important work to improve flow within the hospital, capacity constraints require a significant shift of focus to maximising the transformation opportunities of care at home or in the community.
- Risks and issues unclear
- Managerial and clinical commitment to delivering and building on the ICO vision is not sufficiently engaged to focus on transformation

NEXT STEPS/REQUIREMENTS OF BOARD

- The UEC Options Appraisal to report a conclusive recommendation to Trust Board.
- Director of Transformation and Partnerships has committed a significant amount of project resource to the delivery of this programme in conjunction with the care at home workstream.
- This is a significant risk to the organisation and the plan will require significant work to move from partial assurance to a fully assured plan. It is recommended that this work continues to receive high scrutiny from the Transformation Committee.
- Development of a clear plan and resourcing will be reviewed again at the end of August to address shortfalls in assurance through the Transformation Committee.
- Delivery of the plan remains the accountability of the System Directors, with Cathy Williams maintaining overall leadership, with Executive accountability for delivery resting with the COO.

WORK-STREAM 5 – ELECTIVE SURGERY (VERONICA CONBOY)

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Full utilisation of Mount Stuart Hospital	Complete
Short term capacity expansion ("Bridge 1") complete Inc. return of theatres 1, 2 and 3, return of day surgery and eye surgery recovery	31/10/20
Long term capacity expansion ("Bridge 2") complete Inc. Ambulatory Unit, Modular Day Surgery Unit, Surgical Admissions & Discharge Area	31/03/21
No patients waiting >52 weeks	tbc
Reduce the number of patients waiting >18 weeks	tbc

KEY DEPENDENCIES

- Capital investment in new facilities described in South West Capacity Plan
- ED Floor options and decision that will affect return of Day Surgery and Eye Surgery Recovery Area
- Blood Bank move that will free up Level 5 space that will be used for recovery
- IT hardware is required to enable some productivity improvements

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- Risks and issues don't have detailed mitigation plans
- Decision making around other services (principally ED/urgent care) will have a significant impact on elective capacity
- Significant reliance on capital development, including networked clinical solutions to recover the elective position and reduce risk of long waiting times
- Access to Mt Stuart's facilities is unlikely to be sustainable in the long term, and national direction for ongoing use of the independent sector is unclear
- Requirement for staff consultation could limit the benefits of weekend/OOH working
- National guidance and patient behaviours could limit productivity further (e.g. requirement for 2 week isolation pre/post procedures)

NEXT STEPS/REQUIREMENTS OF BOARD

- The plan is very well led by the Assistant Medical Director, with clear interdependent issues and actions being undertaken to address capacity shortfalls and risks.
- Board will need to be clear about the criticality of the business cases for capital investments (per South West Capacity Plan) and the impact of recovery and risk
- Finalise decisions relating to ED floor and use of day theatre/ophthalmology space
- Build support for development of surgical facilities as part of STP strategy for Devon

WORK-STREAM 6 – YOUNG PEOPLE, FAMILIES & WOMEN'S SERVICES (KATE LISSETT)

KEY OUTPUTS / WHAT WILL BE DELIVERED	WHEN
Support ED social distancing and flow for emergency Paediatric presentations (interim plan)	30/06/20
Outpatient Paediatric function available	06/07/20
Move back to Louisa Cary Ward	31/07/20
Return of midwifery services from Newton Abbot and review temporary re-provision of Whitelake MLU facilities	31/07/20
Reinstate face-to-face consultations and maintain remote consultations for Sexual Medicine	31/07/20
Reinstatement of the Special Care GA day case service for severe physical and mentally impaired patients.	31/07/20
Reopening of targeted 0-19 services	31/07/20

KEY DEPENDENCIES

- Enabling works on Louisa Carey

KEY RISKS/ ASSURANCE CONCERNS (IN ADDITION TO DEPENDENCIES)

- No major concerns, although clear capacity trajectories would provide further assurance

NEXT STEPS/REQUIREMENTS OF BOARD

- Focus on implementation
- No outstanding requirements of Board

5 KEY RISKS FOR THE BOARD

The below table summarises the main risks to the Trust's successful recovery and how our Board can contribute to management of these risks:

Risk	Escalation actions for the Board
Our recently submitted capital bids may not be successful, restricting the physical infrastructure available to our organisation to deliver services. This is particularly constrained due to the on-going social distancing and IPC measures, but also a reflection of factors around our ageing estate with which the Board will be familiar.	• Consider how we influence regional and national escalation in the capital planning and decision-making processes around: ➢ ED facility options ➢ Theatre capacity expansion options ➢ Endoscopy business case ➢ Paediatric facility adaptations ➢ Diagnostic facility options ➢ Community hospital refurbishment ➢ Other proposals that may arise • Influence the distribution of capital funds through: ➢ Raising the profile of our organisation within the Devon STP such that our community is prioritised appropriately ➢ Highlighting the requirement for new NHS facilities in Devon on the national stage, and the harm that will be done to local population if facilities remain inadequate
Devon System partners could make decisions to reconfigure services or allocate resources that are not aligned to local intent.	Maintain and build relationships with relevant stakeholders across Devon to improve our strategic intelligence and provide opportunities to work together to implement decisions accordingly.
Operational teams in existing governance structures may lack sufficient leadership capacity and change management expertise to successfully deliver recovery plans.	Support the on-going evaluation of recovery delivery and ensure that adequate support is in place, through the Transformation Committee particularly when competing pressures to deliver CIP, HIP2 and other projects arise. Continue to review and refine the operational governance structure to ensure it is as effective and efficient as possible.
There could be a further surge of COVID patients leading to service closures or extraordinary Winter pressures that are exacerbated by social distancing and IPOC constraints, bringing further disruption to "normal" services.	• Maintain a watching brief on external factors • Continue to encourage innovation and adaptability across the organisation • Continue to collate learning from recent months (per existing workforce work-stream activities) evaluate and share it accordingly

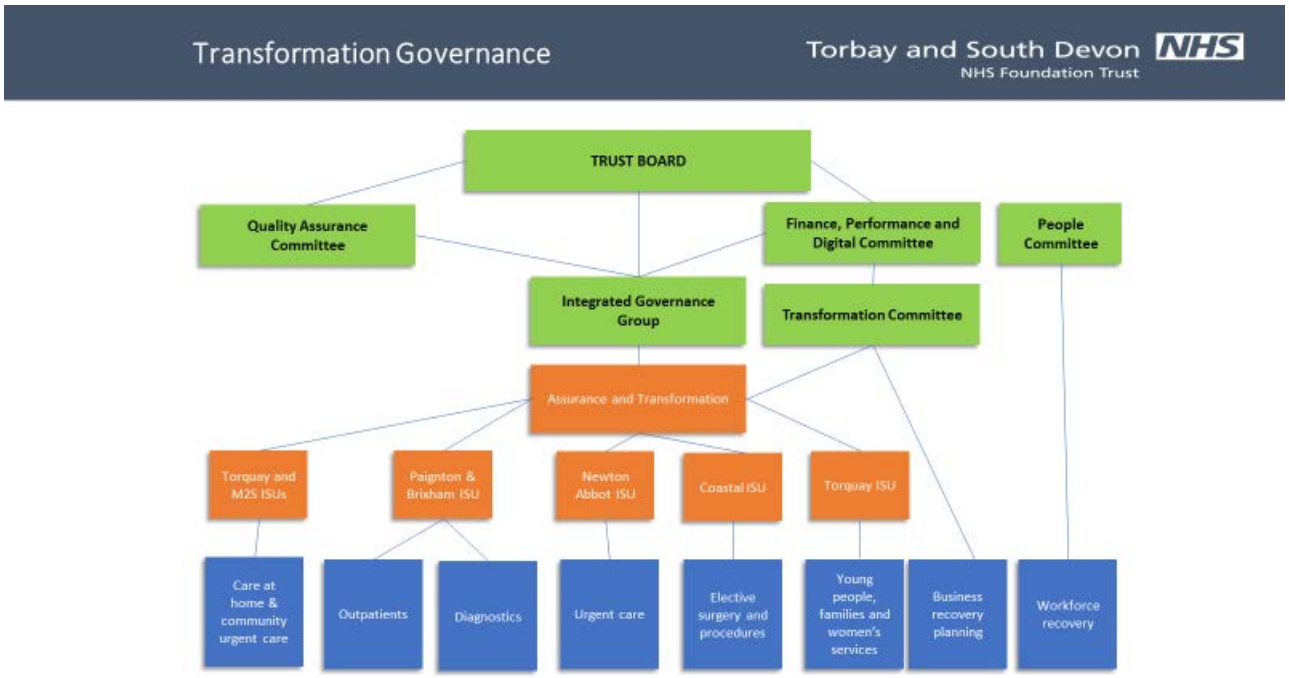
6 GOVERNANCE ARCHITECTURE AND ACCOUNTABILITY

In concluding the work of the recovery cell, the governance architecture for the further delivery and development of the plans will be covered through the Trust architecture as outlined below.

Responsibility for the development of the plans, resourcing of transformation programmes with adequate project management, improvement and information capability and performance monitoring of the plans will continue to sit with the Director of Transformation and Partnerships.

Responsibility for the delivery of the plans, to meet Trust objectives including the delivery of benefits will reside with the Chief Operating Officer, delivered through the System Leadership Teams.

The structure below, reflects the current agreed Trust architecture and articulates where the work from the recovery cell will now report into. The structure is intended to provide positive support, challenge and team-work with clear accountabilities to deliver these important and shared objectives.



7 RECOMMENDATIONS

The Board is requested to note the contents of the report and approve:

- Acceptance of the assurance status of the work-streams and actions recommended to address any assurance shortfalls
- Approve the recommendation of closure of the recovery cell and handover of the further development and delivery of the plans outlined to the “business as usual” structure as outlined in the governance table.
- Recognise the risks associated with the availability of capital as a key constraint to the recovery plan and reflect on any impact this has on the BAF scores or actions that board may need to take to mitigate the consequence of capital availability on recovery

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Care Quality Commission update			Meeting date: 29 July 2020
Report appendix	Appendix 1 – CQC Improvement Action Plan Appendix 2 – CQC Should Do Action Plan		
Report sponsor	Chief Nurse and Deputy Chief Executive		
Report author	Chief Nurse and Deputy Chief Executive System Director of Nursing and Professional Practice (South Devon) Quality and Compliance Manager		
Report provenance	Executive Directors		
Purpose of the report and key issues for consideration/decision	To update the Committee on the status of the CQC inspection report and to provide the draft action plan to address the requirement notices listed in the draft report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Note the contents		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	x	**Risk score**	16
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: Care Quality Commission Update		**Meeting date:** 29 July 2020
Report sponsor	Chief Nurse and Deputy Chief Executive	
Report author	System Director of Nursing and Professional Practice (South Devon) Quality and Compliance Manager	

1. Introduction

1.1 Aim

To provide a summary to the Quality Assurance committee on the status of the CQC inspection report and actions to date to address the requirement notices.

2. Discussion

2.1 Background

The Trust CQC inspection was held on the 10, 11 and 12th of March. The planned community services inspection and Trust well-led inspections were stood down in response to the emerging Covid-19 emergency. The CQC inspected six of our services:

- medical care
- surgical care
- urgent and emergency care services
- community inpatients
- children and young people's services
- maternity.

The draft report was received 15th May and the Trust had 20 days to check factual accuracy. This is a longer period that normal to recognise the additional pressure the Trust was under to respond to the Covid-19 pandemic. This provided the opportunity for a thorough review and time for the Board to consider. The Trust submitted a comprehensive factual accuracy response with specific challenge to the Emergency Department rating of inadequate for the safe domain.

The CQC confirmed that in view of the number of ratings that had moved from good to requires improvement they undertook a very thorough and independent review of the Trust submission. The final report was published 2nd July 2020. The report overview set out in the table 1 below highlights the changes since the last inspection.

Table 1

	Safe	Effective	Caring	Responsive	Well-led	Overall
ED	Inadequate ↓ Jun 2020	Requires improvement ↓ Jun 2020	Good →← Jun 2020	Requires improvement ↓ Jun 2020	Requires improvement ↓ Jun 2020	Requires improvement ↓ Jun 2020
Medicine	Requires improvement →← Jun 2020	Requires improvement ↓ Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Requires improvement ↓ Jun 2020	Requires improvement ↓ Jun 2020
Surgery	Requires improvement ↓ Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Requires improvement →← Jun 2020	Requires improvement ↓ Jun 2020	Requires improvement ↓ Jun 2020
Critical care	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Maternity	Requires improvement →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Requires improvement →← Jun 2020	Requires improvement →← Jun 2020
Gynaecology	N/A	N/A	N/A	N/A	N/A	N/A
Children & Young People	Good →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020	Good →← Jun 2020
End of Life	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Outpatients	Requires improvement May 2018	N/A	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Diagnostic Imaging	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement →← Jun 2020	Requires improvement ↓ Jun 2020	Good →← Jun 2020	Requires improvement ↓ Jun 2020	Requires improvement →← Jun 2020	Requires improvement ↓ Jun 2020
Overall Trust	Requires improvement May 2018	Good May 2018	Outstanding May 2018	Good May 2018	Good May 2018	Good May 2018

The report recognises significant areas of good and outstanding practice. We are particularly pleased that the hard work of our community health inpatient teams has been recognised, with a 'good' overall rating. It is excellent news that we have maintained the rating of 'good' for our acute services for children and young people. The report also reflects how caring our staff are, with all services being rated good or outstanding in this domain. This is something we are very proud of and there are many positive comments about staff compassion, kindness and care throughout.

The inspection took place during a period of significant challenge. We were still dealing with a very busy winter and in the initial response phase to manage the COVID-19 pandemic. We were also in the first year of our most significant organisational restructure to fully integrate community and acute services; which we know will help us provide consistently good care in the longer term.

As part of our passion for continuous improvement and commitment to providing high quality care, we had already identified areas for improvement and our plans to address these had been highlighted to CQC inspectors as part of our self-assessment. In addition, the CQC identified further areas that we must address to improve our services for local people and our staff. Themes emerging from the report include:

- Mandatory training
- Staff Appraisals
- Mental Health Act and Mental Capacity Act
- Equipment cleaning and servicing
- Information systems
- Governance processes

The report (see link https://www.cqc.org.uk/location/RA901) includes 28 MUST do requirement notices that must be delivered and 43 SHOULD do actions.

Core Service	MUST Do actions	SHOULD Do actions
Trust wide	1	
Emergency Department	8	6
Medical Care Services	9	12
Surgery	4	5
Maternity Service	4	11
Children and Young People	1	5
Community Inpatients	1	4

We pride ourselves on being a learning organisation that encourages recognition of the good, accepts that there is always room for improvement and welcomes the scrutiny and challenge of external regulators and stakeholders. As such we will ensure that we work together as a team to make the necessary improvements highlighted from this report.

The attached overarching CQC improvement action plan (appendix 1) provides detail on the 28 must do's and (appendix 2) on the 43 should do's. There are a number of the actions that have been reported in more than one core service, the decision to theme together to provide a coordinated plan was made and this will require a trust wide application to complete. Quality Improvement methodology will be utilised by the teams throughout the development and monitoring of the improvement action plan. This is so that the ISU's are able to demonstrate a more detailed, SMART response to the actions to maintain a robust ongoing sustainable plan that is embedded in practice.

Monitoring of the plan will be provided through the CQC assurance monthly meeting, all quality improvement evidence for each action will be provided and examined with executive validation and a RAG rating will be available using red, amber, green and blue for completeness. A dashboard will be provided monthly to Quality Improvement group to provide assurance and to demonstrate that the ISU's are progressing with the must do's and should do's and it is being embedded into practice.

We will all feel disappointment to see a reduction in some of our ratings and especially the rating of inadequate for safe care in urgent and emergency services. This reflects our need to upgrade the aging infrastructure of the premises, the IT systems at Torbay Hospital and to ensure that we improve the flow of our patients through our hospital. We are well aware of this and know that our staff who deliver urgent care, always aim to provide the best possible services in a challenging environment. Plans are in place to address these issues, supported by significant capital investment to improve our urgent and emergency care services.

It is also important to note that inspectors found areas of good care within urgent and emergency services and they noted several things including how patients were treated with compassion and kindness and that staff worked, even when under periods of challenge, with professionalism and empathy.

They reported that across every services that they visited they saw good practice, and that they saw outstanding practice in day surgery and children's and young people's services.

The report demonstrates that there is much still we can do to improve some aspects of care. There were a number of key areas for improvement including:

- keeping up to date with essential and mandatory training
- continuing to strengthen our record-keeping and governance processes,
- ensuring that the constraints of our environment and physical infrastructure do not adversely impact on care
- The care of those with mental health and mental capacity needs

The report helps us focus on those areas we need to address in order to achieve a 'good' rating at our next inspection. We have already developed an action plan to address those areas where the CQC identified a number of 'must do' actions, and we will continue to address all areas where we know further improvement is needed.

There is much in the report to celebrate and be proud of as well as other things that we need to learn from and we are. We know we are constrained by our environment and facilities, and we have been awarded national HIP2 funding to address the shortcomings of our estate. Many of you will be involved in discussions around how we can transform our services for the future, and what we need from our estate and IT to support this. We will continue to involve you in developing our plans. We also know we need to do more to fully embed our Integrated Service Unit organisational structure, and the report recognises that we have good leadership in place to deliver this.

Without a well-led inspection, there can be no change to our overall CQC rating, which remains as 'good' overall, and 'outstanding' for caring. The Trust are keen to maximise the opportunity for learning and improvement and for this reason have commissioned an independent well-led inspection in addition to the Governance review already planned. This will provide a holistic view of the Trust leadership and governance structure and provide a strong foundation on which to prepare for the next CQC inspection.

3. Recommendation

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

Ref No.	Requirement Notice (Must Do)	Theme	Trustwide / ISU	Timeframe	Accountable Operational Lead	Exec Lead	RAG Rating	Progress to date July 2020
M1 Trust	Ensure the trust has a clear oversight of compliance with resuscitation training levels, to include immediate and advanced life support training for adults and paediatrics, and can assure themselves their staff are up to date with their training needs.	Training - Resus	Trustwide	September	Associate Director of Education	Chief Nurse		The Trust Resuscitation policy clarifies levels of training for each role. Work has commenced to check current compliance and collate centrally.
M2 ISUs	Ensure the trust complies with the Mental Health Act and Mental Capacity Act legal frameworks.	MCA and MHA	Trustwide	November	System Medical Directors	Medical Director		Process to be agreed for internal process. Meeting held with Devon Chief Nurses to progress – task and finish group commenced
M3 ISUs	Ensure there is a wider hospital support when the emergency department is under pressure. The trust must ensure a proactive response to pressures in the ED.	Wider hospital support when ED pressured	Trustwide	Immediate	Associate Director of Operations	COO		Developing an improved record of the Trust proactive actions during escalation.
M4 ED	Ensure there are enough nursing staff with paediatric training working in the children's ED to meet the Royal College of Paediatrics and Child Health standards. This must include safe paediatric nurse cover when the department staff were called to resus and triage and ward areas.	Training - paed for nursing staff	Newton Abbot ISU	Immediate	Director of Nursing and Professional Practice (DNPP) South	Chief Nurse		Covid-19 has required a review and increase in paediatric nurse staffing in ED. The appointment of substantive staff is underway. Exploration of rotation with Louise Carey being explored.

M5 ED	Ensure the safety of the ED. The trust must ensure risk based clinical decisions are completed when using parts of the emergency department to board patients for long periods. This must include the safe staffing of the Minors area when used.	Risk	Newton Abbot ISU	October	DNPP South	Medical Director and Chief Nurse		Developing a QEIA tool to record the clinical decisions regarding ED boarding in the Torbay Hospital MIU. The BEST tool has been completed to include staffing MIU
M6 ED	Ensure all U&E service equipment is serviced in line with equipment service guidelines to ensure its safe use.	Equipment service	Newton Abbot ISU	June	System Director South	COO		Maximising the functionality of the new F2 database equipment flagging system
M7 ED	Ensure U&E service computer and printer systems are made efficient for staff, to support safe working practices and safe records available for discharges. The trust must also ensure safe log in facilities are available for all staff working in the emergency department.	IT	Newton Abbot ISU	March 2021	System Director South	Health Informatics Service Director		Upgrade to Symphony planned for June but this will not solve the interoperability issue.
M8 ED	Ensure U&E service governance is used effectively to drive and monitor change. This should include regular meetings and accurate recordings of meetings and action plans. The trust must ensure actions identified are completed and reviewed.	Governance	Newton Abbot ISU	September	System Director South	Chief Nurse		Interim Consultant Nurse and Interim ED Development Consultant to review U&E meeting structure, frequency & recording underway

M9 ISUs	Ensure core service staff have a working understanding of the Mental Capacity and Mental Health Acts to support patients with mental health needs. This working understanding must include the records needed to record mental health decisions made.	MCA and MHA	All ISUs	March 2021	DNPP South & Torquay	Medical Director and Chief Nurse		Current training provision to be reviewed. Need to consider the impact of OPEL 4 actions on education and training. To improve recording of staff compliance. Monthly reporting to QIG
M10 ISUs	Ensure core service staff are aware of their responsibilities and identification of patients who may require Deprivation of LibertySafeguards authorisations.	DoLS	All ISUs	September	System Medical Directors	Medical Director and Chief Nurse		As above
M11 ISUs	Ensure core service staff receive all mandatory training, including safeguarding and resuscitation training. The training provided must include all medical staff. The trust must also ensure records of training are maintained for all staff to be suitably trained.	Training - mandatory including safeguarding & resus	All ISUs	March 2021	DNPP South & Torquay	Medical Director and Chief Nurse		Mandatory training review underway in response to Covid-19
M12 ISUs	Ensure core service nursing staff appraisals are completed to enable staff with support and personal development.	Appraisals	All ISUs	September	DNPPs & Deputy MDs Torquay and South	Chief Nurse Medical Director		Focus on Nursing in Q2. Medical appraisals on hold until Oct 2020. This will impact compliance.
M13 ISUs	Ensure core services medicines are prescribed, recorded and stored safely.	Medicines	All ISUs	September	System Medical Directors	Medical Director		Pharmacy audit in place. Explore process for daily auditing of medicines storage
M14 ISUs	Ensure core service safety equipment is checked in line with trust policy.	Equipment	All ISUs	Immediate	DNPPs Torquay and South	COO and Chief Nurse		Daily Matron checking and auditing in place

M15 ISUs	Ensure core service premises are clear of clutter, the environment is not significantly damaged and is maintained in a way to not pose an infection risk, and equipment is stored safely and cleaned effectively.	Premises & equipment	All ISUs	March 2021	DNPPs Torquay and South	Director of Estates and Commercial Development		Explore options for maintenance expenditure within the context of HIP2 timeline.
M16 ISUs	Ensure core service records are stored securely and are kept in line with data protection legislation and make sure information governance processes are adhered to.	Governance & Data protection	Paignton & Brixham ISU, and Moor-to-Sea ISU	September	DNPPs Torquay and South	Chief Nurse and & Health Informatics Service Director		Exploring GDP requirements as actions had been taken in 2019 to ensure compliance.
M17 ISUs	Ensure there is a rolling equipment replacement programme	Equipment	All ISUs	March 2021	System Directors South and Torquay	Medical Director and COO		Options to be explored
M18 ISUs	Ensure all patients have the support required to be autonomous	Patients' needs	All ISUs	September	DNPPs Torquay and South	Medical Director and Chief Nurse		Patient Experience audits
M19 Mat	Ensure modified early obstetric warning score (MEOWS) is used consistently across the maternity service.	MEOWS	Torquay ISU	Immediate	Associate Director of Midwifery and PP	Chief Nurse		Audit process in place.
M20 Mat	Ensure maternity service checks on emergency equipment are completed to ensure they are safe and ready for use.	Equipment	Torquay ISU	Immediate	Associate Director of Midwifery and PP	Chief Nurse and COO		Audit process in place
M21 Mat	Ensure maternity service medical staff are trained to safeguarding children level 3.	Training - safeguarding children level 3	Torquay ISU	September	Associate Medical Director	Medical Director		Current training provision to be reviewed. Need to consider the impact of OPEL 4 actions on education and training. To improve recording of staff compliance. Monthly report to QIG

M22 Mat	Ensure maternity service audit is used effectively and action plans and improvements are monitored and recorded.	Audit	Torquay ISU	December	Associate Director of Midwifery and PP	Chief Nurse		tbc
M23	Ensure Community inpatients service substances that are hazardous to health are stored securely in a locked room which are inaccessible to patients and visitors.	Hazardous substances	4 ISUs: Paignton & Brixham, Newton Abbott, Coastal, & Moor-to-Sea	Immediate	DNPPs Torquay & South	Chief Nurse and Director of Estates and Commercial Development		Daily Matron audit in place

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S1	Urgent & Emergency Services	Review all areas of the emergency department to maintain them in a good state and minimise the risk of cross infection. Some areas of the emergency department needed repair. Some walls had been damaged on the main corridor and were being held in place by tape.	Premises - infection risk	Newton Abbot ISU	Associate Director of Nursing and Professional Practice	Director of Estates and Commercial Development
S2	Urgent & Emergency Services	Confirm all equipment is serviced in line with equipment service guidelines to ensure its safe use.	Equipment service	Newton Abbot ISU	Associate Director of Operations	COO
S3	Urgent & Emergency Services	Undertake a review of staff finishing induction to confirm they are competent and ready. The trust should make sure all staff are suitably skilled and confident to undertake their role.	Training - induction	Newton Abbot ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S4	Urgent & Emergency Services	To consider major incident administrative training for reception staff.	Training - major incident	Newton Abbot ISU	Associate Director of Operations	COO
S5	Urgent & Emergency Services	Review that enough staffing by the appropriate levels of staff are working in the emergency department. There were ongoing shortages of Band 7 nurses to manage the department so a lack of educational development and clinical support.	Staffing levels - ED	Newton Abbot ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S6	Urgent & Emergency Services	Keep under review that children were still visible to other waiting patients. This was not in accordance with design guidance set out in Health Building Note 15-01: Accident and emergency departments (April 2013), which recommends the children's waiting area "should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting." The space available was not conducive to meeting this guidance.	Premises - children's area	Newton Abbot ISU	Associate Director of Operations	Director of Estates and Commercial Development
S7	Medical Care	Review departmental risk register recording process. Review any entries that have not been reviewed within identified review dates. Consider recording process for actions complete and actions that are still outstanding.	Risk	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Operations	COO
S8	Medical Care	Review departmental risk register rating and downgrading processes. Consider prioritising the replacement of flooring on Simpson ward.	Risk	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Operations	COO and Director of Estates and Commercial Development
S9	Medical Care	Complete and record reassessment of venous thromboembolism (formation of blood clots) risk 24 hours after admission.	VTE	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Medical Director

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S10	Medical Care	Improve the completion of nutritional and fluid charts.	Nutrition charts	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Chief Nurse
S11	Medical Care	Consider reviewing the support given to the emergency department to support flow through the hospital.	Flow support for ED	Paignton & Brixham ISU, and Moor-to-Sea ISU	Head of Operations	COO
S12	Medical Care	Consider providing all staff with further training regarding the red2green or gold and silver systems.	Training - R2G or gold/silver	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	COO
S13	Medical Care	Consider re-educating staff in the emergency department on the admission criteria for ambulatory care.	Training - ambulatory admission criteria	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S14	Medical Care	Provide support for the ambulatory care team to make sure they feel respected and valued by their wider hospital colleagues.	Staffing - support	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Operations	Director of Workforce and Organisational Development
S15	Medical Care	Consider alternative storage arrangements for equipment so that day rooms can be used by patients.	Equipment - storage	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Director of Estates and Commercial Development and Chief Nurse
S16	Medical Care	Keep substances hazardous to health securely locked at all times.	Hazardous substances	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Chief Nurse

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S17	Medical Care	Review access to patient records and IT interfaces which limit accessibility.	IT and notes access	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Operations	Health Informatics Service Director
S18	Medical Care	Consider formalising the vision for the service within a written strategy.	Strategy	Paignton & Brixham ISU, and Moor-to-Sea ISU	Associate Director of Operations	Director of Transformation and Partnerhips
S19	Surgery	Create a strategy for the Coastal ISU with a clear vision and a set of values, with quality and sustainability as the top priorities.	Strategy	Coastal ISU	Associate Director of Operations	Director of Transformation and Partnerhips
S20	Surgery	Provide all staff with an annual appraisal in line with trust policy.	Appraisal	Coastal ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S21	Surgery	Improve the efficiency of preoperative assessments to be valid by the date of the patient's operation.	Pre-op validity	Coastal ISU	Associate Medical Director	Medical Director
S22	Surgery	Improve last minute cancellations of operations, and offer another date within 28 days.	Metric - Cancellations	Coastal ISU	Associate Director of Operations	COO
S23	Surgery	Improve mandatory training, refresher training, safeguarding and resuscitation training to be completed in line with trust policy.	Training - mandatory inc safeguarding & resus	Coastal ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S24	Maternity	Review cleaning procedures so all equipment is free from dust.	Equipment - cleaning	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S25	Maternity	Improve medical staff awareness of maternity safeguarding leads.	Safeguarding	Torquay ISU	Associate Medical Director	Medical Director
S26		Confirm all obstetricians are trained at the required level for safeguarding level 3 children.	Training - safeguarding	Torquay ISU		Medical Director
S27	Maternity	Improve the quality and recording of handovers to ensure women are kept safe when they move between sites or areas of the maternity unit.	Handovers	Torquay ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S28	Maternity	Review the consultant presence on the delivery suite.	Staffing - consultant	Torquay ISU	Associate Medical Director	Medical Director
S29	Maternity	Improve working relationships between consultants and midwives	Staffing - support	Torquay ISU	Associate Director of Nursing and Professional Practice	Director of Workforce and Organisational Development
S30	Maternity	Remind staff to record the use of 'fresh eyes' within notes.	Patient notes	Torquay ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S31	Maternity	Review the quality of WHO theatre audits for obstetrics and be assured areas of non-compliance are identified and actioned as required.	Audit	Torquay ISU	Associate Director of Operations	Medical Director and Chief Nurse

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S32	Maternity	Review the provision of mental health training for midwifery staff.	Training - MH	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse
S33	Maternity	Review the provision of bereavement support across the maternity pathway.	Bereavement	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse
S34	Maternity	Continue the culture review work currently underway within the maternity department.	Staffing - culture	Torquay ISU	Associate Medical Director	Director of Workforce and Organisational Development
S35	Children & Young People (Acute)	Continue to improve mandatory training compliance, to include safeguarding for medical staff.	Training - mandatory inc safeguarding	Torquay ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S36	Children & Young People (Acute)	Continue to review the medical staffing levels and rotas to enable adequate provision of training and service delivery.	Staffing levels - training	Torquay ISU	Associate Medical Director	Medical Director
S37	Children & Young People (Acute)	Mark all solution bottles with dispensing and expiry date stickers.	Equipment	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse
S38	Children & Young People (Acute)	Maintain accurate setting of the parameters of the refrigerator probe and report refrigerator temperature discrepancies with a range of between 2 and 8 degrees to the technical manager.	Equipment	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse

Should Do Ref No.	CQC Core Service	CQC Action (Should Do Improvement)	Theme	ISU	Accountable Operational Lead	Exec Lead
S39	Children & Young People (Acute)	Continue to assess the risk of accessing the treatment room through the medication preparation room on Louisa Cary ward.	Risk - environment	Torquay ISU	Associate Director of Nursing and Professional Practice	Chief Nurse and Director of Estates and Commercial Development
S40	Community Inpatients	Confirm staff are receiving supervision in line with the trusts' supervision policy.	Training - supervision	Paignton and Brixham ISU; Newton Abbot ISU; Coastal ISU; Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Medical Director and Chief Nurse
S41	Community Inpatients	Safely store equipment so there is not a risk to cause a hazard to patients, staff and visitors.	Equipment - storage	Paignton and Brixham ISU; Newton Abbot ISU; Coastal ISU; Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Chief Nurse and Director of Estates and Commercial Development
S42	Community Inpatients	Encourage advocacy and make this available for patients who would benefit from it.	Patients' needs	Paignton and Brixham ISU; Newton Abbot ISU; Coastal ISU; Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Chief Nurse
S43	Community Inpatients	Confirm staff have an understanding of how cultural, social and religious needs may relate to care needs.	Patients' needs	Paignton and Brixham ISU; Newton Abbot ISU; Coastal ISU; Moor-to-Sea ISU	Associate Director of Nursing and Professional Practice	Chief Nurse

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Assurance framework for Seven Day Services			Meeting date: 29/7/20
Report appendix	List any supplementary information as shown below: Appendix 1:		
Report sponsor	Medical Director, Dr Robert Dyer		
Report author	Acting Medical Director, Mr Ian Currie		
Report provenance	Executive Directors meeting		
Purpose of the report and key issues for consideration/decision	This is a report on the progress made by Torbay and South Devon Foundation Trust in relation to seven-day hospital services (7DS). This programme supports providers of acute hospital services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend and during weekdays. This work is built on 10 clinical standards (CS) developed by the NHS Services, Seven Days a Week Forum in 2013. Four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high-quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week. In addition to the 7DS clinical standards for all emergency patients, there are 5 urgent network clinical services which have been given priority: hyperacute stroke, paediatric intensive care, STEMI heart attacks, major trauma and emergency vascular surgery. The Trust has reported on hyperacute stroke and STEMI heart attacks. Other urgent networked clinical services are provided by neighbouring Trusts.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note the contents of the report and the risks and assurance highlighted. The monitoring of 7-day services continues as described and reporting to the Board will be undertaken on a bi-annual basis.		
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**		

Is this on the Trust's Board Assurance Framework and/or Risk Register	<table><tr><td>**Board Assurance Framework**</td><td></td><td>**Risk score**</td><td></td></tr><tr><td>**Risk Register**</td><td></td><td>**Risk score**</td><td></td></tr></table>
External standards affected by this report and associated risks	<table><tr><td>**Care Quality Commission**</td><td>**X**</td><td>**Terms of Authorisation**</td><td></td></tr><tr><td>**NHS Improvement**</td><td></td><td>**Legislation**</td><td></td></tr><tr><td>**NHS England**</td><td>**X**</td><td>**National policy/guidance**</td><td>**X**</td></tr></table> The seven-day services work is a major quality improvement initiative for all NHS acute Trusts in England. Trusts must demonstrate progress in providing safe and effective emergency care to patients seven days a week.

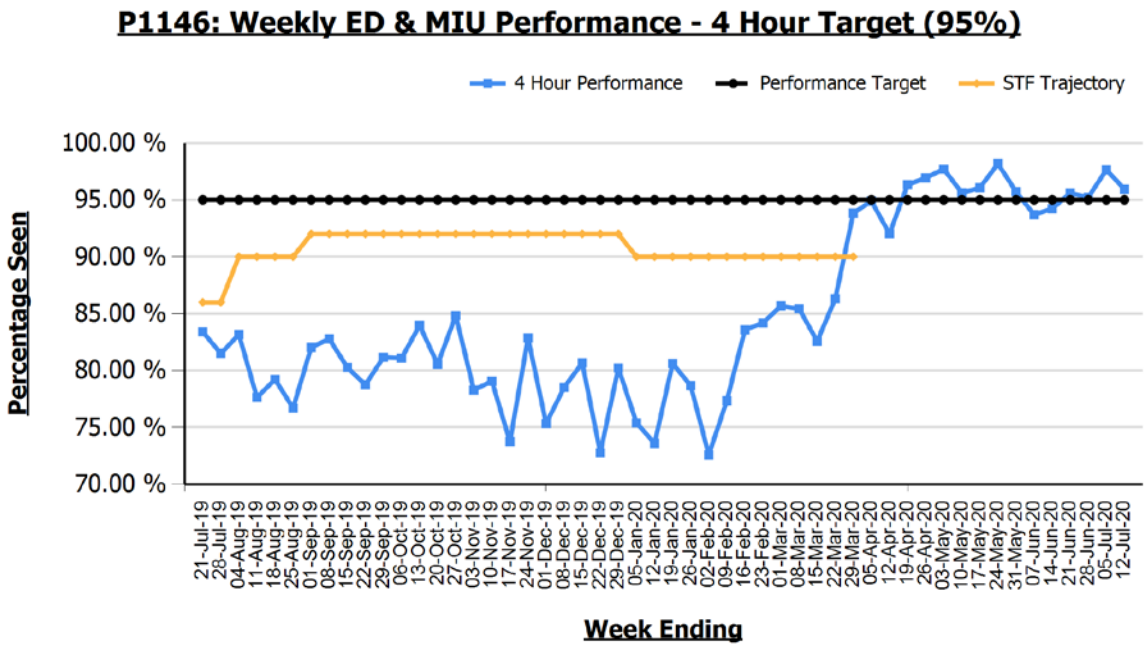
Report title: Assurance Framework for Seven Day Hospital Services		Meeting date: 29th July 2020
Report sponsor	Medical Director, Dr Robert Dyer	
Report author	Acting Medical Director, Mr Ian Currie	

Introduction

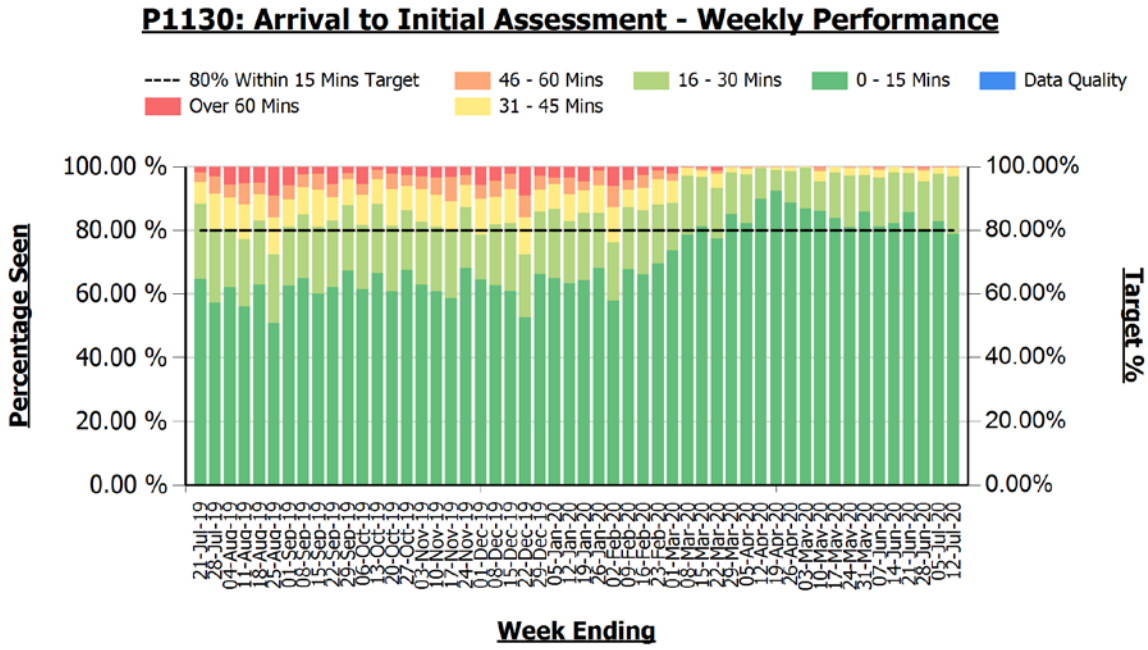
Since February 2019, three major workgroups have been developed to direct quality improvement in urgent and emergency care:

a) The Emergency Floor Group, is Chaired by Dr Catherine Blakemore and has focused work on i) Emergency front door work providing a rapid initial handover of ambulance patients (80% within 15 minutes) and rapid assessment by a clinician (median time less than 60 minutes) together with the introduction of an ED safety checklist to ensure a high standard of care ii) Internal Professional Standards between ED and other Specialities. This involves agreement that there should be minimal delay between referral from the Emergency Department and assessment by the specialist team. iii) Real Time Medical Take requires an assessment area which remains open to patients referred by GPs and ED for speciality assessment. It is essential that patients who require inpatient care are moved rapidly from the assessment areas to definitive inpatient beds iv) Same Day Emergency Care (SDEC) occurs on the ambulatory unit and was assessed in October 2019 as providing an excellent service achieving our target of providing SDEC at least 12 hours a day 7 days a week with a reduction in admission conversion rate. Work on providing SDEC for patients with pulmonary embolus, atrial fibrillation and community acquired pneumonia continues to develop as part of our CQUIN target.

   Over the last 6 months, mainly in response to Covid-19, Urgent and Emergency Care has changed significantly. On June 2020, an Acute Surgical Unit (ASU) was opened on Level 5 in the old ICU area. This ASU admits ambulatory and non-ambulatory emergency surgical patients referred by General Practice and also referred from the Emergency Department (ED). Currently, the Short Stay Paediatric Assessment Unit (SSPAU) is based on Ricky Grant Day Unit and admits emergency paediatric patients referred by General practice and from the Emergency Department. A Medical Receiving Unit (MRU) is currently occupying most of the Day Surgery Unit adjacent to the Emergency department and admits emergency medical patients referred by General Practice and from ED.
   The concept of an ‘Emergency Floor’ with specialist Medical, Surgical and Paediatric emergency assessment units working in partnership with the Emergency Department may have contributed to a significant improvement in Emergency Care as demonstrated by the improvements in 4hour target. Reduced ED attendances and lower bed occupancy during Covid-19 surge undoubtedly also contributed to this improvement shown below:



The Emergency Department specialises in assessment and management of adult and paediatric patients presenting with undifferentiated emergency conditions. The time from patient arrival in ED to initial assessment has also improved since March 2020 as shown the graph below:



b) The Wards Group is Chaired by Rhoda Allison and has focused work on i) embedding SAFER ward processes including regular senior review and early discharge of inpatients to enable early transfer of patients assessed on the emergency floor who require a definitive inpatient bed before 10am ii) Criteria

Led Discharge and Expected Date of discharge to be agreed with patients and carers by a multi-disciplinary team with 24hrs of admission (Clinical Standard 3). In particular, identification of patients who could potentially go home at weekend must be identified on the Friday ward round iii) Red to Green to identify barriers to discharge and will set internal professional standards around the timeliness of ward processes such as availability of diagnostics (Clinical Standard 5) and consultation by other medical teams iv) weekend processes includes a significant improvement initiative by Dr Andy Griffiths to develop better co-ordination of the clinical team at weekends to prioritise care and enable timely discharge. Clinical Standard 8 ensuring that emergency inpatients admissions have appropriate senior review will be addressed by this workgroup.

c) The Home First Group is Chaired by Dr Mathew Fox and has focused work including: i) enhanced intermediate care to ensure that the community team works together to extend care in the community including reablement and discharge to assess processes ii) improved transport support to enable more rapid transport of GP referred patients using our patient transport service iii) engaged and supported care homes iv) development of a community and acute frailty service with assessment of ED patients by a Rockwood score and an ambition to cohort frail patients requiring less than 48hrs inpatient stay in a specialist unit on an Acute Frailty Pathway. The existing multi-disciplinary joint emergency team (JET) will have their offer at ED enhanced by dedicated consultant support v) Exploring admission avoidance by working with partners in the CCG, SWAST and 111. This is particularly important to avoid crowded waiting areas in ED during Covid-19. The discharge hub extended opening to 7 days a week to enable complex discharge on every day. Clinical Standard 9 will be reviewed by this group.

d) A number of other workgroups include enhanced support to care homes from the community teams including GP visiting and improved visibility of care home bed availability using a Strata IT system with the discharge hub. The red bag initiative will improve communication between care homes and hospital and 45 Trusted assessors are now work with care homes to facilitate rapid discharge.

There are regular meetings where the work from the above groups is co-ordinated with input from strategic partners including primary care, SWAST, CCG, NHS 111, Devon doctors, DPT (Liaison psychiatry) (Clinical Standard 7) to develop an integrated approach to urgent and emergency care. In addition, there is a two weekly Urgent and Emergency Care programme board to provide a strategic overview of progress.

Discussion

The last six-month period of assessment is not comparable to previous reports due to changes in urgent and emergency care due to Covid-19 which affected the results March to June 2020. During this period, significant additional resources were devoted to Urgent and Emergency Care with changes to consultant rotas to provide 24/7 consultant availability in Acute and Emergency Medicine and Anaesthetics. This resulted in a significant improvement in time to review by Consultant Physicians with 100% of patients on assessment wards reviewed within the target of 14 hours from admission.

Reduced numbers of emergency admissions during Covid-19 surge and availability of inpatient beds, enabled a significant improvement in achieving the 4hour target for patients to be seen and either admitted or discharged in the Emergency Department. Recently, numbers of patients attending ED have begun to return to normal levels and in-patient occupancy has risen. Despite this increasing challenge, the 4hour target is maintained at 95% compliance. The development of new surgical, medical and paediatric assessment areas may have contributed to an enhanced emergency performance over the last few months

The Trust continues to provide good support to the emergency care with diagnostic services and consultant directed interventions.

Conclusion

Development of 7-day services work is embedded in the Trusts' overall improvement project for urgent and emergency care.

The main responsibility for urgent and emergency care sits within the Newton Abbot Integrated Service Unit under the South Devon System. Within this structure, three main workgroups have been developed to produce quality improvement in urgent and emergency care as documented above. The four priority clinical standards (2,5,6,8) are all mapped to quality improvement projects within the three main workgroups. Whilst challenges in delivery of the 14-hour target (CS2) and medical ward consultant assessment at weekends (CS8) remain, there are now named leads to address these under the above governance structure.

The presence of Covid-19 will provide an ongoing challenge to the delivery of urgent and emergency care and it is likely that further changes will be required to the urgent and emergency care estate, to the work and inter-relationship of the clinical teams and technological improvements particularly information technology. The impact of these changes will require close monitoring.

Recommendations

The board is asked to note this new assurance process and to receive a further report in November 2020.

TORBAY AND SOUTH DEVON 7 DAY SERVICES SELF ASSESSMENT JULY 2020

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Evidence Source 1. Acute Medicine: The "O drive" system provides a real time dashboard of the acute medical take. The data was accessed for the six month period December 2019 to May 2020. An average of 304 patients were referred to medicine per week (43 per day). This is a significant reduction on the previous 6 month period when 456 patients were referred a week (65 patients a day). This is a result of Covid 19. A consultant led, post take ward round was recorded for 67% of patients within 14 hours compared to 69% in the previous 6 months. The months March, April May were significantly better with 71% of patients seen within 14 hours by a consultant. Consultant led post take ward round within 14 hours occured in 92% of cases for patients on the ambulatory unit (AU) During the months March to May this figure was 100%. On the non ambulatory assessment units, 53% of patients were seen within 14 hours by a consultant and during March to May this figure was 77%. For patients admitted to speciality wards, a consultant review within 14 hours was recorded in 39% of cases and for March to May this figure was 40% . The "O drive" system, whilst imperfect, does enable a real time dashboard of the acute medical take and enables a RAG rating triage of patients enabling early senior review of the most acutely unwell patients. The O drive system is not an integrated electronic patient record thus consultant assessment may not be recorded or recorded later than the time of review. Furthermore, the start time recorded on the O drive is the time of referral to medicine, frequently this will be earlier than the time of admission recorded on our patient administration system. Same Day Emergency Care (SDEC) occurs on the ambulatory unit. In October 2019 an independent review of SDEC by the Ambulatory Emergency Care Network included a 50 case file review demonstrating that 95% of patients were treated in the correct location. In August 2019 the surgical team recruited two new fellows allocated to the Ambulatory Unit with dedicated diagnostic ultrasound	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	This standard was audited in September 2016. Sixty seven consultants managing emergency patients in the Trust responded to this survey. Microbiology, CT, ultrasound and upper GI endoscopy were rated as always or usually available by the majority of consultants. All ICU consultants are able to provide a basic echocardiogram as can the on-call interventional cardiology consultant. The technician led echocardiography service is looking to extend to provide 7 day service. MRI is available out of hours but would require discussion with on call radiology to organise.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available off site via formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	This standard was audited in September 2016. Sixty seven consultants managing emergency patients in the Trust responded to this survey. Critical Care, cardiac pacing, emergency general surgery, interventional endoscopy, stroke thrombolysis are available on site both within and out of hours. Interventional radiology is provided by a well established network with colleagues from RD&E. Renal replacement therapy can be provided in ICU by haemofiltration. Haemodialysis is available by a network arrangement with RD&E. Emergency radiotherapy is available but rarely used and would require organisation.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients on intensive care are seen twice daily by a consultant (achieved 100% in April 2018 audit). Patients admitted as an emergency to an inpatient ward should receive a daily review by a consultant unless this has been delegated to another competent member of the multidisciplinary team on the basis that this would not affect the patients' care pathway. TSDFT achieved this standard on the April 2018 audit on weekdays in 74% of cases and at weekends at 49 % of cases. Evidence Source 1 Consultant Job plans. Consultant job plans in General Surgery, T&O, paediatrics and obstetrics and gynaecology provide for consultant led ward rounds of emergency patients during weekdays and weekends. In medicine, consultant ward rounds occur daily on all wards during weekdays. At weekends in medicine daily consultant assessment occurs on the acute assessment areas (EAU3 & EAU4) and ambulatory care. On the remaining medical wards, consultant job plans provide for a 2 hour period midday for consultant assessment. Evidence Source 2 Local Clinical Audit. A project to improve weekend working commenced in August 2019. All inpatients are assessed on a Friday by multi-disciplinary teams and care plans developed including clinical criteria for discharge. Patients who could be potentially discharged over the weekend are collated by the Control room on Friday afternoon. On Saturday, improved co-ordination of the junior and senior medical staff, phlebotomists, pharmacy and nursing teams was undertaken by the clinical site team. Results: Since commencement of the project, weekend discharge numbers have improved from 170 on 2/8/19 to a peak of 225 on 13/9/19 with a steady trajectory of improvement. Clinical co-ordination on a Saturday has led to better prioritisation of the work of clinical teams. The Friday handover sheets and in particular criteria-led discharge can	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1. Although shared decision making is implicit for patient and clinician interaction, it is rarely explicitly recorded in the notes. Treatment escalation plans are an exception to this. The use of printed patient information sheets is rarely recoded for emergency patients. Standard 3 Work is required to identify the members of the multidisciplinary team needed to provide a holistic assessment of emergency patients within 24hrs of admission as an emergency patient. This is addressed a work group which seeks to embed the SAFER principles onto all wards. Standard 4. Handover is led by competent senior decision makers in the major acute specialities daily. Work is required to provide assurance that the handover process is accurately documented. Standard 7. Liasion psychiatry is available for both adults and children. The Liaison Psychiatry service has focused on their hour response times to ED. The latest flash report shows that despite staff shortages the hour target to ED was achieved in just below 80% (Oct 2019). The team continues to comply with the 24 hour target to the hospital wards achieving 88% within 24 hours. The Psychiatric Liaison team has worked with ED to reduce attendance in an identified cohort of patients who attend ED frequently with mental health problems. Standard 9. The development of community support services is a major component of the emergency offer. This includes development of integrated care and work with care providers and community hospitals. Recent developments include the discharge hub which is expanding to work 7 days a week over the winter and work to strengthen community care. The Home First workgroup has projects with named leads and support for i) Developement of the Frailty Service ii) Admission avaoidance iii) enhanced intermediate care iv) transport v) community support on discharge. Standard 10. Outcomes of emergency patients are monitored by a weekly multi-disciplinary team and a two weekly strategic meetings.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
This was audited by a 10 case note review of urgently admitted STEMI heart attack and stroke patients from March 2017. Improvements have occurred in acute medical assessment over the last 2 years. Acute Stroke is assessed by the national SSNAP audit data. There is a seven day specialist stroke nurse availability and 92.5% of patients presenting with acute stroke were assessed by a specialist nurse within 24 hours of "clock start" (national average 96.2%). There are only two stroke consultants (one a locum) at present but there is not a specialist stroke consultant rota. A stroke nurse consultant post will be advertised in August 2020. Thus, 60.6% of stroke patients were seen by a stroke consultant within 24 hours of "clock start", below a national average of 85.3% (April - June 2020 data).

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: July 2020 Mortality Score Card			Meeting date: 29th July 2020
Report appendix	List any supplementary information as shown below: Appendix 1:		
Report sponsor	Lead director's title: Medical Director		
Report author	Author's Title: Patient Safety & Experience Lead		
Report provenance	The report went to the Mortality Surveillance Group meeting 17th July 2020		
Purpose of the report and key issues for consideration/decision	The report is for monthly assurance and includes some Covid related data in appendix 4		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	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**	16
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**

The report is a record the Trust's mortality as viewed through a number of different metrics – The main HSMR and SHMI are within expected range

Report title: Mortality Surveillance Score Card		Meeting date: 29/7/20
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.

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

Data sourced includes data from the Trust, Department of Health (DH), and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group as well as local 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 • A. Hospital Standardised Mortality Rate (HSMR) • B. 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 • By number • By location		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 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) at T&SDFT remain within the accepted range for our population and over a prolonged period. The effect of Covid will, in the next few months, start to be evident in the HSMR data. This will be mainly be noticeable in a decrease in the Trust's overall activity and we will need to monitor this and the effect it has on our HSMR.

In March and April the overall in-patient activity in the Trust reduced due to Covid. As more seriously unwell patients remained in hospital during this period, the unadjusted number of deaths, expressed as a percentage of in-patient activity, rose in April. The following two months have seen a decrease in deaths and a rise in activity and the unadjusted number has stabalised to its usual norm.

Covid deaths continue to be closely monitored on a daily basis and are reported in national returns. Covid has also been reviewed via a weekly mortality report which looks at our in-hospital and total mortality for our community, this has now changed to a monthly report.
Included in this report, Appendix 7, is a review of learning from deaths reviews that have taken place in quarter 1 (Apr 20 – June 20). This data also includes deaths related to learning disabilities, neonatal, maternal, serious incidents and complaints. This section will continue to be developed over the coming months to include other reviews including ICU and ED metrics.

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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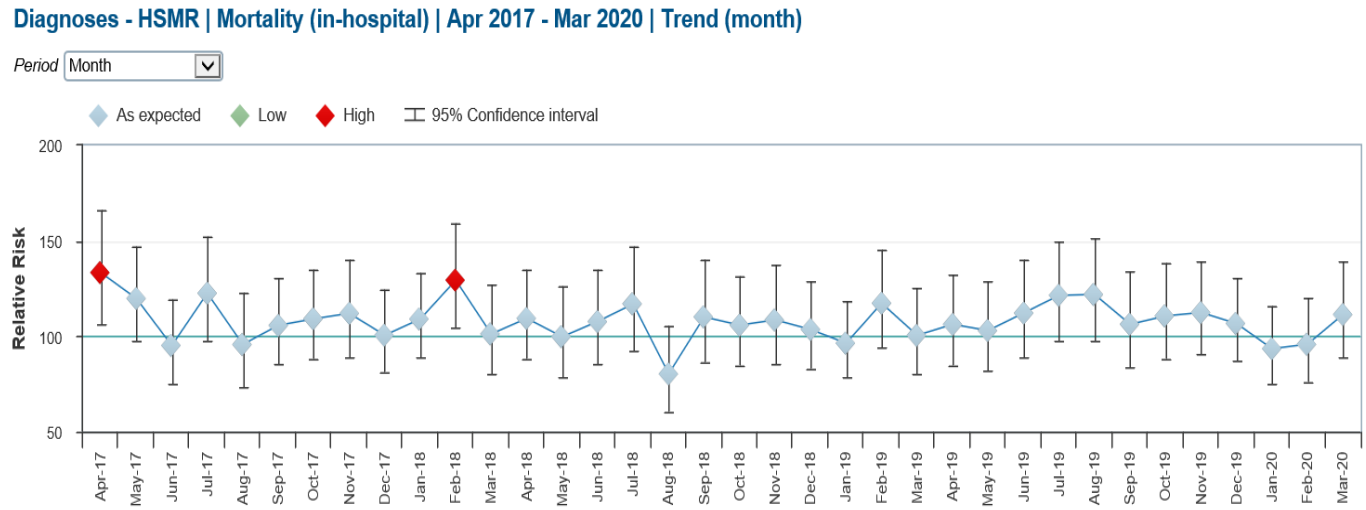
Chart 1 - HSMR by Month Feb 17 to Jan 20 (current month)
Chart one (as below) shows a longitudinal monthly view of HSMR. The latest month's data, March 2020, has a relative risk of **111.5** but is within the expected range (chart 2).

C1



C2

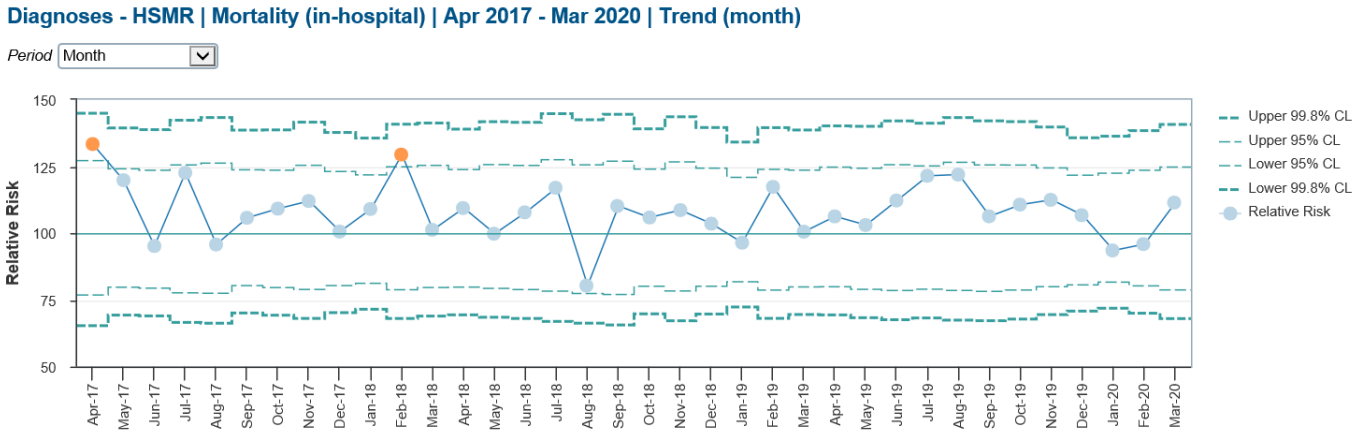


Chart 3, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly 12-month annual total is above the 100 line but well within the 95% confidence intervals and hence within an acceptable range. This measure is being observed via the Mortality Surveillance Group (MSG)

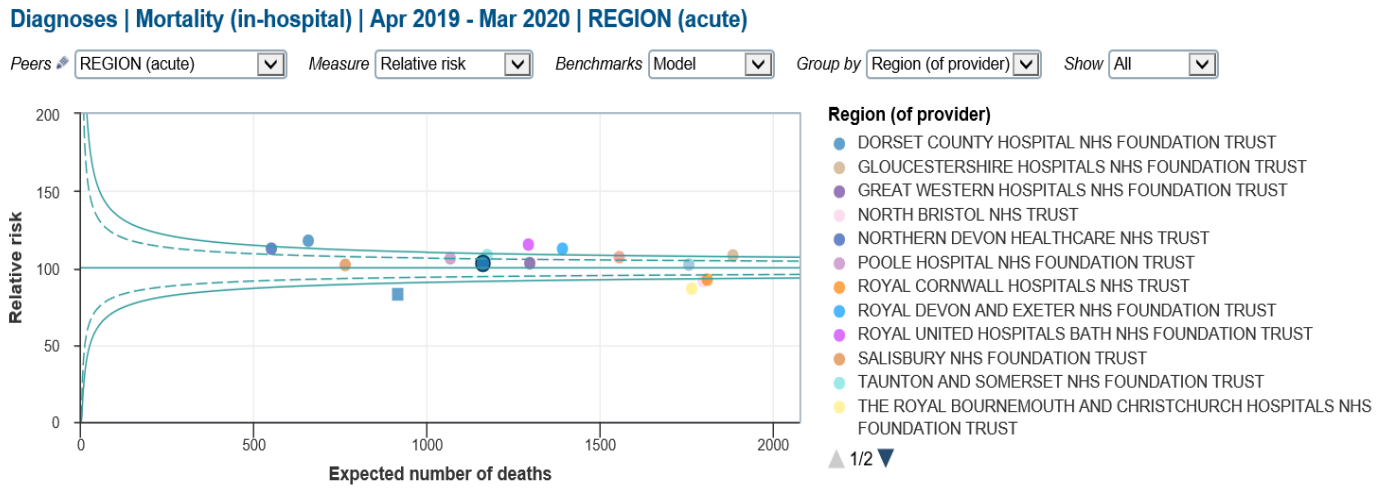
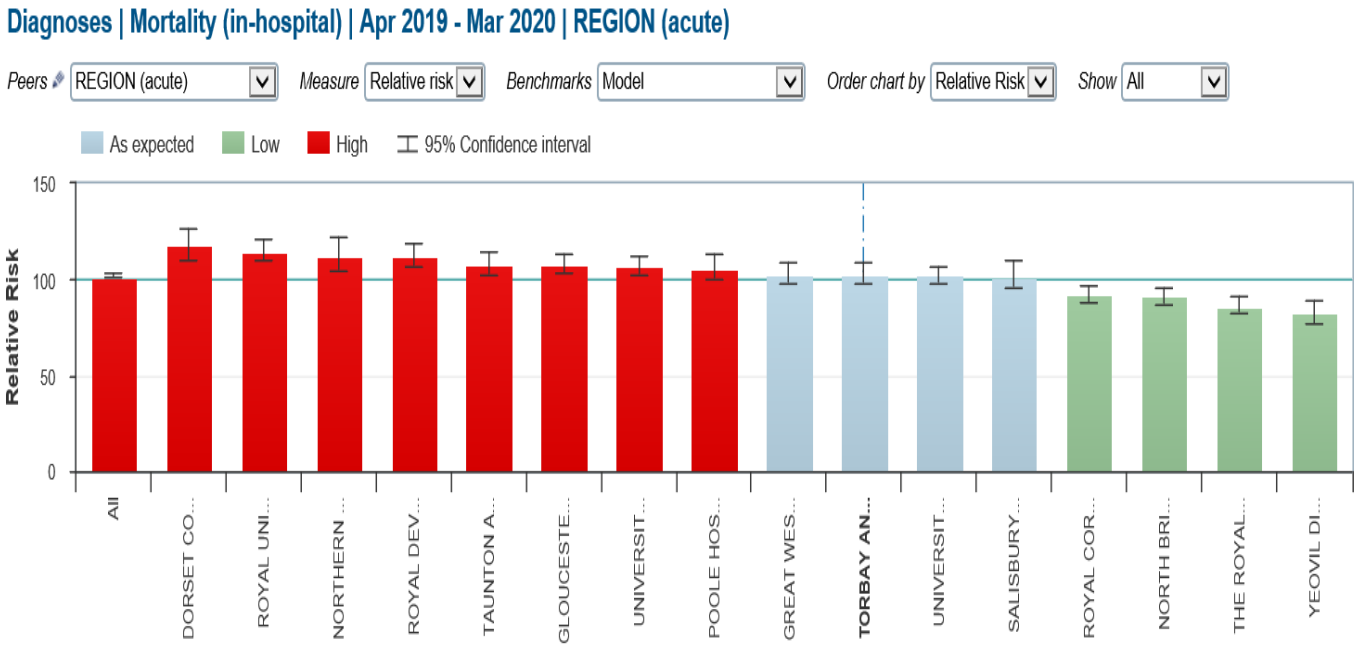


Chart 4 displays the above data as a Peer Comparison, ranked and as a bar chart.



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* **Feb 2019 – Jan 2020** *data period and is different to HSMR.*

Chart 5, as below, highlights SHMI by quarterly periods with all data points within the expected range and trending over the last 4 data points at the 100 mark.

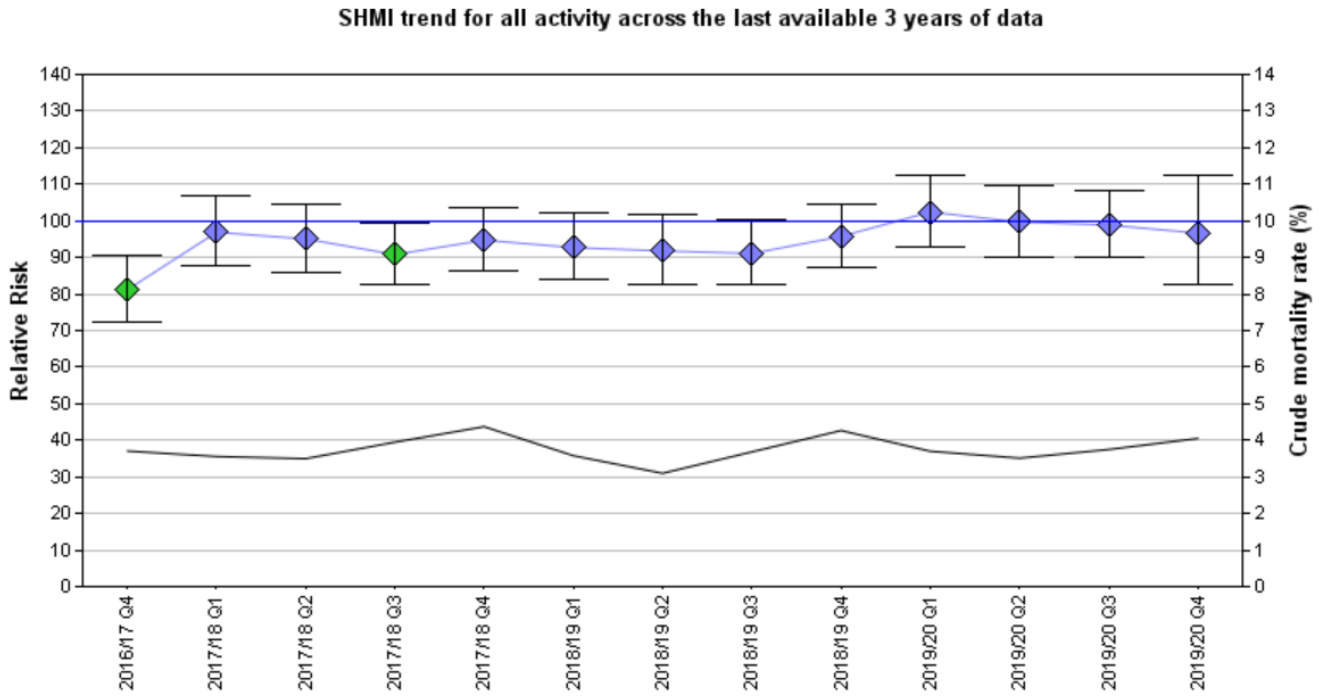
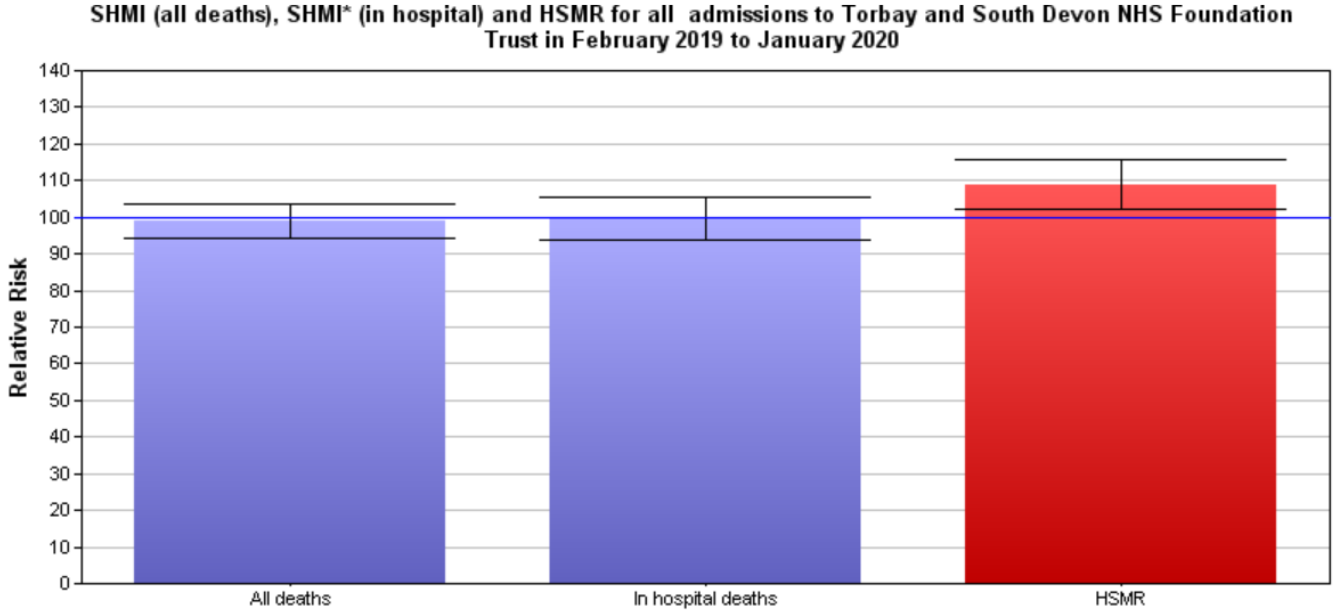


Chart 6 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison



The SHMI data within chart 6 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 Feb 19 – Jan 20 data. This is not evident in the HSMR analysis over this time period.

Chart 7, as below, expresses the 12-month rolling SHMI data by time period and is showing a SHMI below the 100 average.

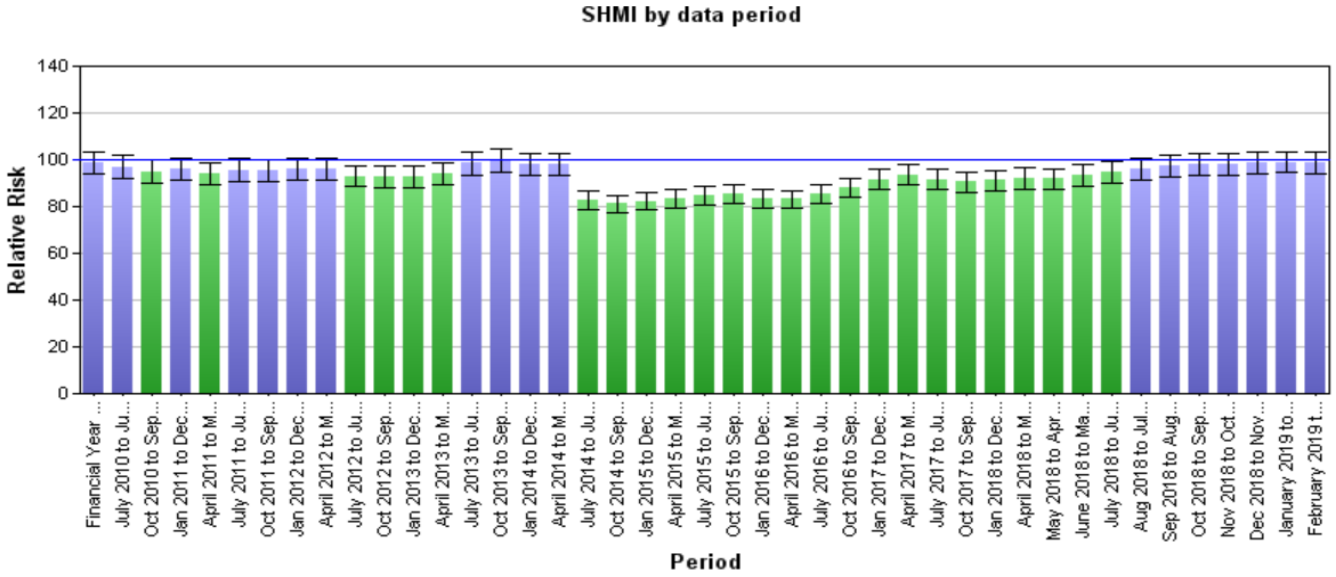
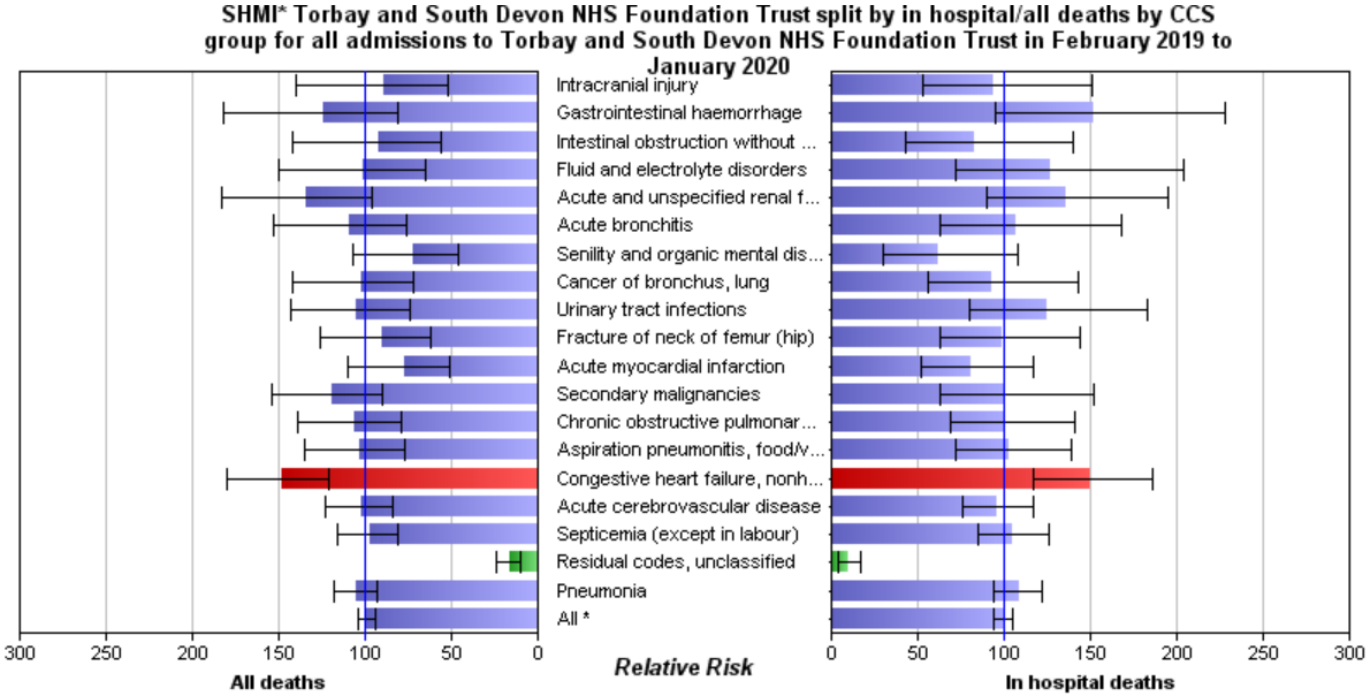


Chart 8 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Congestive cardiac failure. These areas have been discussed 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 9, as below, highlights the Trusts in hospital unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart includes the Covid period and highlights a rise in unadjusted mortality in March and April. As mentioned earlier, this rise in unadjusted mortality is partly explained by a reduction in the Trusts overall inpatient activity so reducing the denominator. As more seriously unwell patients remained in hospital, the in-patient deaths made up a higher percentage of the whole. In April 2019 we had 3036 discharges (the denominator) and in April 2020 this had reduced to 1773. The following chart 10, which simply looks at 'number of deaths', is also helpful as it shows the effect Covid had on deaths in March and April.

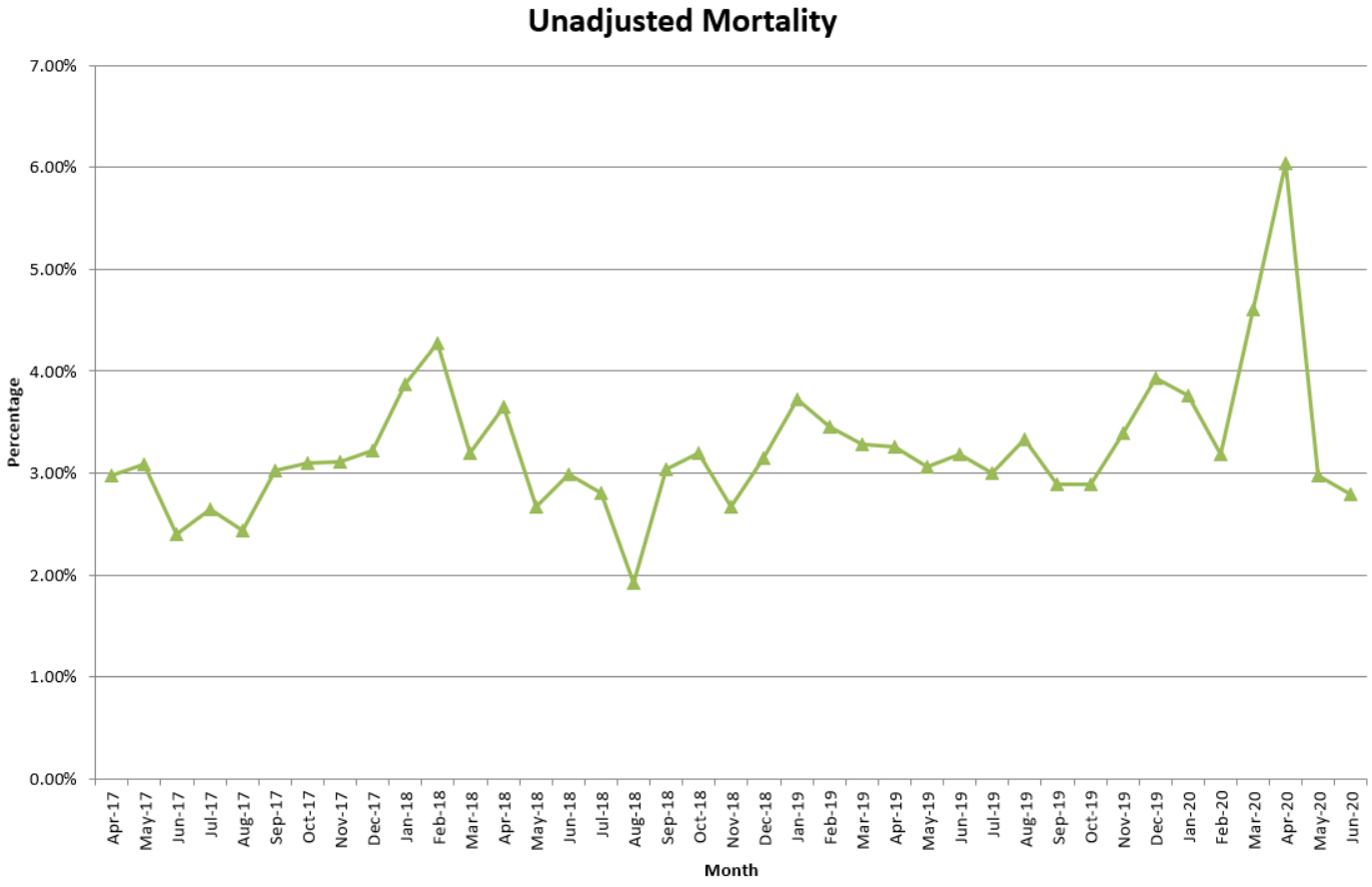


Chart 10 As below monthly hospital deaths by number. This shows a rise in March and April due to Covid, before decreasing to very low numbers in May and June. The Trust has recorded 39 Covid deaths to date.

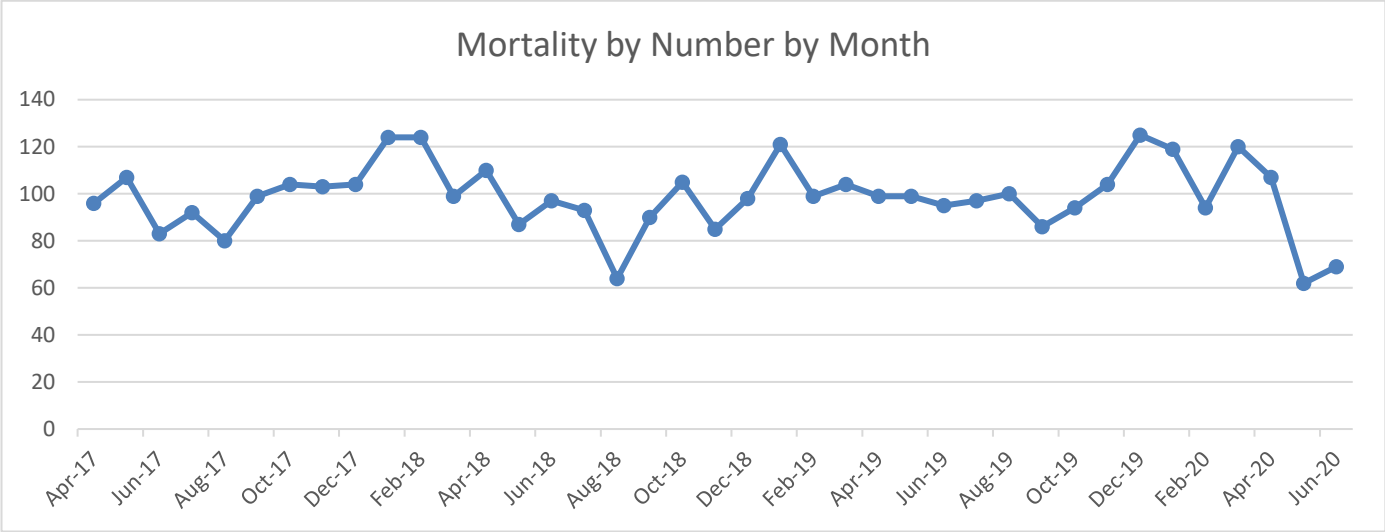
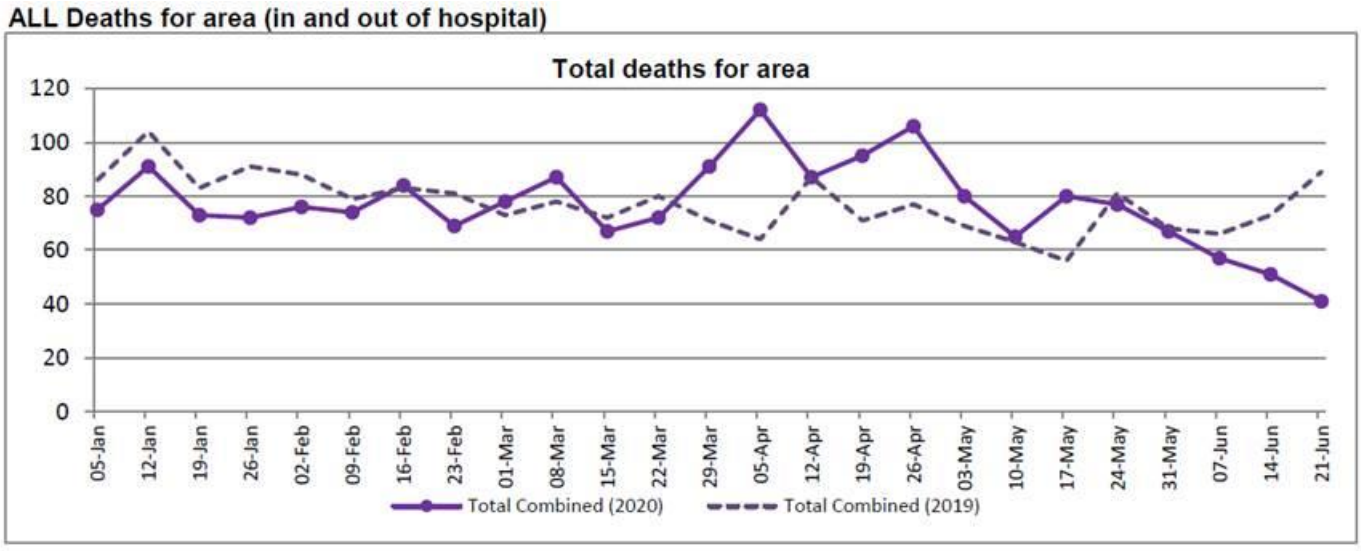


Chart 11, as below, records hospital and community deaths and also includes a comparator year, 2019



This chart shows a rise in March and April as against the prior year, due to Covid, and then a steady reduction downward to a position of much lower death's vs the prior year

Table 2 – as overleaf looks at location of hospital deaths by area/ward.

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

Row Labels	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	Apr-20	May-20	Jun-20	
AINSLIE	1	1	2	1	4	3	3	2	2	1	2	1	0	1	2	4	1	1	5	2	3	1	5	2	3	0	
ALLERTON	6	4	5	3	4	4	3	6	0	4	7	4	8	4	5	4	3	9	3	7	10	6	6	3	5	4	
BRIXHAM	1	1	3	0	3	0	1	0	0	1	4	1	0	1	0	0	2	1	1	0	1	2	0	1	1	1	
CHEETHAM HILL	12	9	8	10	13	9	9	7	13	18	11	8	11	11	11	11	5	9	8	6	19	3	10	13	9	8	
CROMIE	2	2	3	1	1	2	3	6	1	2	5	4	4	5	2	2	4	4	5	6	3	2	3	13	0	1	
DART	1	1	3	1	2	1	2	2	2	2	5	0	3	1	1	1	2	2	2	1	1	0	3	1	0	0	
DAWLISH	4	4	1	0	0	1	1	5	6	3	3	3	2	0	0	5	2	4	0	2	6	4	0	3	0	1	
DUNLOP	3	8	3	6	7	2	6	3	6	5	4	7	5	5	4	3	5	7	5	9	8	2	10	4	6	6	
EAU3	6	7	10	5	7	5	0	3	12	5	5	8	1	6	10	13	8	6	7	6	5	6	7	3	3	6	
EAU4	2	7	6	3	7	8	8	8	6	5	5	7	6	8	8	8	3	5	15	11	6	8	13	3	3	5	
ELLA ROWCROFT	1	2	2	0	0	0	2	0	1	1	1	0	1	2	1	0	1	0	0	0	1	0	1	3	2	1	
FORREST	2	0	1	1	2	3	0	2	3	5	1	2	0	1	3	1	0	1	2	2	2	1	8	7	4	1	
GEORGE EARLE	16	9	10	7	9	13	11	16	17	12	11	11	8	12	9	5	10	7	14	16	14	12	11	6	5	5	
INTENSIVE CARE UNIT	8	6	8	5	8	13	6	4	9	6	6	10	10	9	11	11	10	7	10	11	9	8	6	8	7	5	
LOUISA CARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	
MIDGLEY	8	10	8	5	6	17	9	10	11	9	14	10	9	9	11	11	9	8	10	17	12	9	7	4	8	11	
SIMPSON	4	9	10	6	9	9	8	8	10	9	7	10	6	6	7	10	8	6	2	12	5	6	13	5	2	4	
TEIGN WARD	1	1	0	3	0	2	3	2	3	1	2	1	3	3	2	2	1	2	0	1	1	1	3	5	1	5	
TEMPLAR WARD	3	1	3	2	2	5	3	2	2	1	1	0	1	2	1	2	3	5	4	6	3	6	2	8	2	1	
TORBAY CORONARY CARE BEDS	1	2	2	0	2	2	0	1	3	0	2	1	1	2	0	0	1	1	4	1	0	2	4	2	0	2	
TURNER	5	13	5	5	3	6	5	10	8	6	2	8	9	5	7	6	7	7	6	8	6	8	5	1	0	0	
WARRINGTON	0	0	0	0	0	0	0	1	5	3	6	3	10	2	2	0	0	0	0	0	4	6	2	7	0	0	
Grand Total	**87**	**97**	**93**	**64**	**90**	**105**	**85**	**98**	**121**	**99**	**104**	**99**	**99**	**95**	**97**	**100**	**86**	**94**	**104**	**125**	**119**	**94**	**120**	**107**	**62**	**69**	

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 note 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.

Coding reviews will also be carried out on Intestinal Infection 19 cases, congenital anomalies, 1 case, viral infection 10 cases and hypertension 1 case. If issues are found they will progress to full case note review.

Table 3

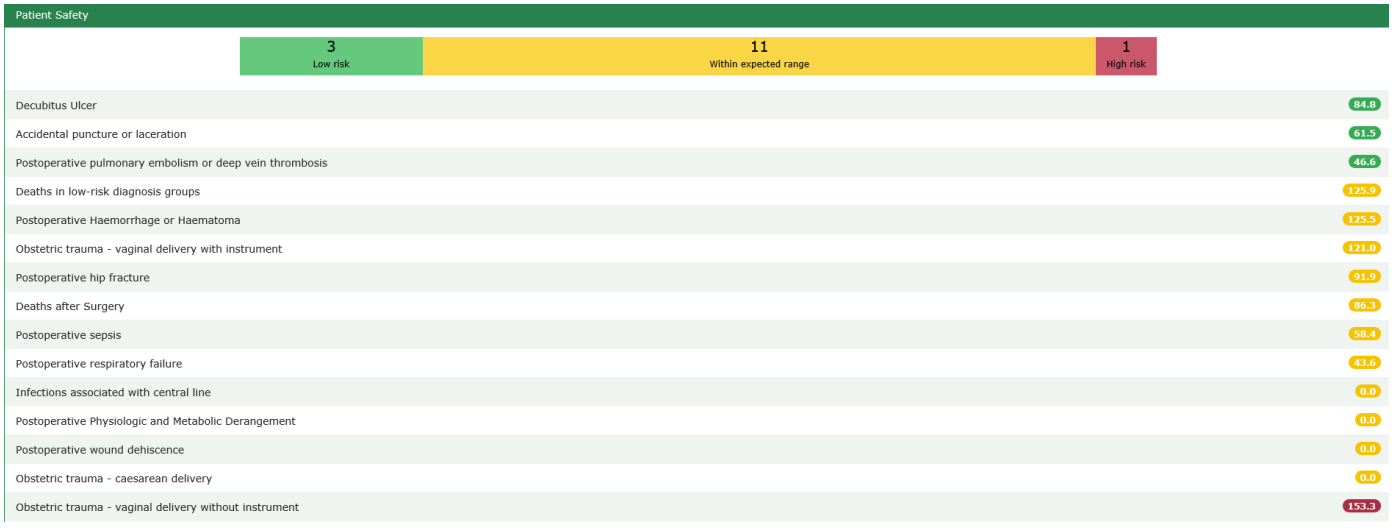
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	6	78924	1198	1164.5	1.5	102.9	
HSMR (56 diagnosis groups)		29879	991	918.2	3.3	107.9	
Essential hypertension	1	78	1	0.1	1.3	1051.0	
Genitourinary congenital anomalies	1	31	1	0.0	3.2	3027.2	
Intestinal infection	1	756	19	9.4	2.5	201.8	
Menopausal disorders	1	57	1	0.1	1.8	1995.8	
Pulmonary heart disease	1	199	12	9.1	6.0	131.2	
Syncope		406	5	1.5	1.2	327.8	
Viral infection	2	620	10	0.5	1.6	1868.8	

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.

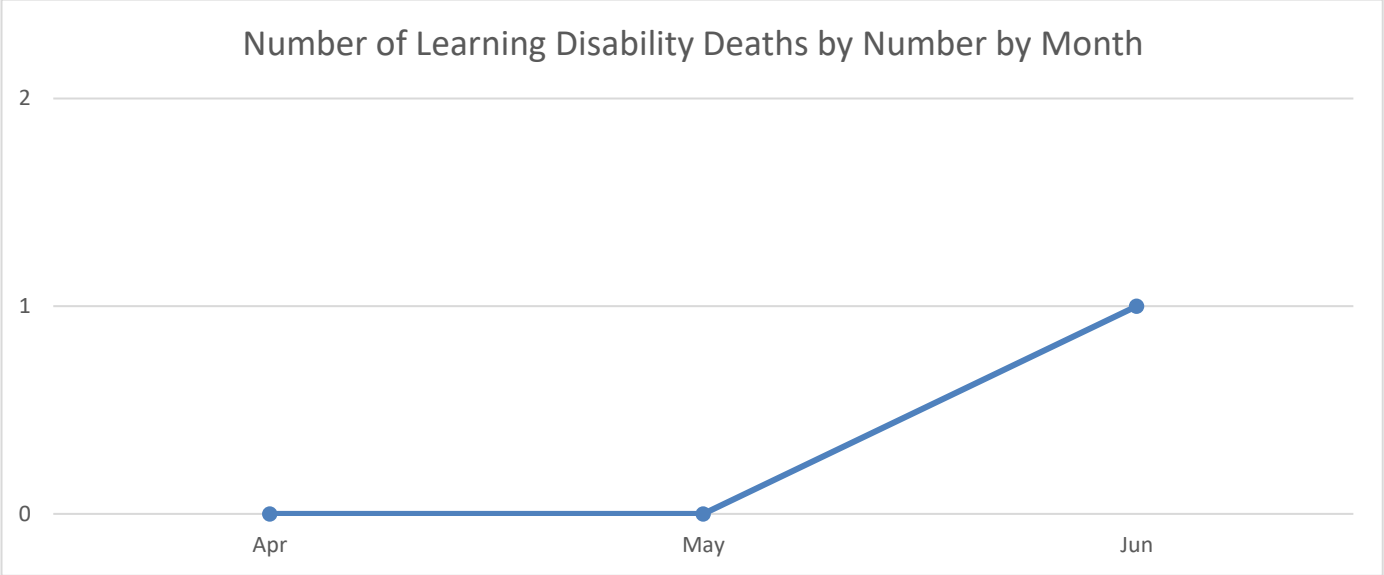
The data was pulled on the 16th July 2020, 11 indicators are within the expected norm with 3 are in the low risk category. 1 is in the high risk category and the data for this alert wil be reviewed.

Table 4



7.0 Appendix 5 - Mortality Reviews including learning

Number of deaths of a patient with a Learning disability
The data for this chart is taken from the SJF reviews and the Trusts PAS system which highlights a death of a patient with learning disability.



All deaths involving a learning disability are reviewed through the Learning Disabilities Mortality Review (LeDeR) process. This process feeds back into the Trust any learning. In Q1 we sadly had one death.

Number of Neonatal, Perinatal, and Maternal Deaths

During this reporting period (April – June 2020), we had two stillbirths. These were babies who were born with no signs of life at 24+ weeks and 30 weeks gestation. The 24-week stillbirth was a baby with known growth restriction and was being monitored closely.

We reported two neonatal deaths. One baby died at 25 weeks gestion of severe prematurity after presenting to the emergency department fully dilated. The baby was subsequently transferred to a Level 3 Neonatal Unit, but sadly died due to complications of severe prematurity.

The second neonatal death was a term baby but required extensive resuscitation and treatment including active cooling. The baby unfortunately died in the early neonatal period.

The Trust had 1 maternal death which is being investigated.

Number of deaths in which complaints were formally raised by the family
The Trust has received one such complaint related to the diagnosis and management of a brain tumour.

Total number of deaths which were investigated as a Serious Incident during Q1
A number of deaths were investigated as a Serious Incident during Q1. Issues discussed included diagnosis of bowel perforation, early management of stroke, follow up of incidental XRay findings, surgical positioning and necrotizing fasciitis.

The Trust Reviewed

Medical Examiner
The Trust has 5 medical Examiners in post, including a lead Medical Examiner and a Medical Examiner Officer. The service is based in the Medical Examiner's office, adjacent to the Bereavement office.

The Covid pandemic has impeded the full implementation of the service but from July 2020 the Medical Examiners are continuing the role within the Trust

Learning from Inquests
During Q1 of 2020/21 there have been no Coroners inquests and the Trust has no outstanding Regulation 26 reports

The Trust has no dates for any inquests in Q2 to date.

Trust learning

Key Issues	Learning and actions taken
Treatment / Diagnostic learning Possible delay to CT scan with contrast use balanced against risk of renal impairment	Discussions at M&M regarding renal impairment and CT contrast and alternatives available
An issue was raised regarding stroke alerts and that despite being on anti-coagulation this doesn't necessarily exclude thrombolytic treatment	Shared across the trust – always use the stroke alert process and the Stroke consultants will review and advise
Delay to follow up of incidental findings on a Chest x-ray	Issue shared at M&Ms and other groups, work is ongoing with order comms in radiology
Patient presented to ED with a fall and diagnosised with plantar fasciitis, then fell at home was subsequently represented and was diagnosised with necrotising fasciitis	Issue shared with ED and orthopaedics *In all cases an investigation is undertaken and the teams involved in the RCA, learning and sharing*
Communication Upward referral to consultant may have benefited the decision-making process	Use of communications video at Doctors' induction
Documentation Dating, signing issues with documentation	*In all cases an investigation is undertaken and the teams are involved in the RCA, learning and sharing*
Learning from Complaints	

8.0 Glossary of Terms

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

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

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

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

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

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Midwifery Staffing Oversight Report			**Meeting date:** 29 July 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology		
Report provenance	The content of this report is a summary of Midwifery Staffing within the maternity service to ensure safe staffing levels as recommended by NICE. This is monitored by the Maternity Clinical Governance Group.		
Purpose of the report and key issues for consideration/decision	There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through quarterly meetings between the Chief Nurse, System Director of Nursing and the Head of Midwifery and through inclusion in the Chief Nurse's 6 monthly Midwifery staffing report that are taken to the Board. The maternity service produces a monthly report summarising the staffing establishment, sickness rates, red flag issues, escalation and actions. A copy of this is sent to the Chief Nurse. The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 3, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows: a) A systematic, evidence based process to calculate midwifery staffing establishment is complete b) The midwifery co-ordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one care d) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board. This report covers the time period January 2020 to June 2020 and details compliance with the above standards.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐

Recommendation	For the maternity service to continue to monitor midwifery staffing on a monthly basis and ensure meeting the recommendation set out by NHS Resolution That the Board receives and notes the report.
Summary of key elements	
Strategic objectives supported by this report	<table><tr><td>**Safe, quality care and best experience**</td><td>**X**</td><td>**Valuing our workforce**</td><td></td></tr><tr><td>**Improved wellbeing through partnership**</td><td></td><td>**Well-led**</td><td>**X**</td></tr></table>
Is this on the Trust's Board Assurance Framework and/or Risk Register	<table><tr><td>**Board Assurance Framework**</td><td></td><td>**Risk score**</td><td></td></tr><tr><td>**Risk Register**</td><td></td><td>**Risk score**</td><td></td></tr></table>
External standards affected by this report and associated risks	<table><tr><td>**Care Quality Commission**</td><td>**X**</td><td>**Terms of Authorisation**</td><td></td></tr><tr><td>**NHS Improvement**</td><td>**X**</td><td>**Legislation**</td><td></td></tr><tr><td>**NHS England**</td><td>**X**</td><td>**National policy/guidance**</td><td>**X**</td></tr></table>

Midwifery Staffing Oversight Report		Date: 29 July 2020
Report sponsor	Chief Nurse	
Report author	Head of Midwifery and Gynaecology	

1.0 Introduction

There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months. This has been achieved through quarterly meetings between the Chief Nurse, System Director of Nursing and the Head of Midwifery and through inclusion in the Chief Nurse's 6 monthly Midwifery staffing report that are taken to the Board.

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

The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 3, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

a) A systematic, evidence based process to calculate midwifery staffing establishment is complete
b) The midwifery co-ordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service
c) All women in active labour receive one-to-one care
d) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board.

This report covers the time period January 2020 to June 2020 and details compliance with the above standards.

2.0 Midwifery Staffing Establishment (a)

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

The Birthrate Plus ® assessment was completed during the latter part of 2017 and the outcome of this has featured in previous reports. From April 2019, the maternity service began to use the Birthrate Plus ® Intrapartum Tool. This has enabled electronic monitoring of the acuity of women in our care, monitors supernumerary status of the delivery suite co-ordinator and captures red flag incidents, including one-to-one care.

In last report the maternity service recommended that the Birthrate Plus ® assessment be formally repeated in Autumn 2020. The timing was so that the service redesign changes had time to embed. Given the COVID-19 pandemic and the impact this has had on all services and external bodies, we would propose that this is now deferred to Spring 2021.

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

During the 6-month period covered within this report, we have seen a midwifery vacancy range of 2.0wte – 3.4wte (see Table 1). The service is usually recruited to establishment. Following the integrated team redesign, a number of retirements and two secondments have occurred during this time period, meaning that the service has not been fully established during. Due to gaps within the integrated teams we have extended the fixed term contracts that were covering maternity leave, which is why the maternity leave cover is slightly above the wte maternity leave.

We have continued to recruit and from July 2020, all vacancies will have been recruited to, with the exception of two secondments which are being back filled using bank. The first secondment (0.8wte) will end on 15 September 2020. The second secondment (0.6wte) runs until February 2020, however, it is likely to be extended.

Following implementation of the service redesign, we had a number of staff members request to work in different locations of the service. Therefore, we offered all staff the opportunity to move to different areas of the maternity service and were able to facilitate all requests. This was received very positively by staff.

As a service we have locally agreed minimum staffing requirements in order to ensure we can safely staff all areas of the maternity service and meet the Key Performance Indicators of having a supernumerary co-ordinator and providing one-to-one care to all women in labour. We have agreed that this is a minimum of 9 midwives per shift, however, we are in the process of reviewing this and is likely to increase to 10 due to the increasing requirements on the Maternity Service due to recommendations from the Better Births agenda. We continue to backfill vacancies utilising bank and substantive staff doing additional hours to ensure we meet the minimum staffing levels.

Table 1: Planned versus actual midwifery staffing levels

	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020
Establishment	87.3	87.3	87.3	87.3	87.3	87.3
In post during month	85.3	85.3	85.4	83.9	84	84
Maternity leave	4	3.2	3.2	3.2	3.2	3.2
Maternity leave cover	3.6	3.6	3.6	3.6	3.6	3.6

Another indicator of appropriate staffing levels is the use of the midwife to birth ratio. This is calculated by dividing the total number of births by the whole-time equivalent number of midwives. This is a crude calculation as only considers births and not all of the other activity that is required. The current national recommendation is a ratio of 1:28 midwives; however this ratio is likely to be reduced due to the recognition of the additional requirements for midwifery staff. It can be measured in two ways, firstly the total number of midwives excluding the Head of Midwifery (HOM) over the year's births. When calculated in this manner, the Midwife to Birth ratio at Torbay and South Devon (TSD) is **1:28.**

However, on a monthly basis, TSDFT are required to submit the Midwife to Birth ratio to NHS England South West to form part of the South West Maternity Network Dashboard. A standardised calculation is undertaken, which uses the current month's births and the whole-time midwifery establishment, this excludes the Head of Midwifery, midwifery matrons and specialist midwives. Table 2 details the Midwife to Birth Ratio that has been reported between January 2020 – June 2020.

Table 2: Midwife to Birth ratio (exc. HOM, matrons and specialist roles)

Time period	Midwife: Birth Ratio
Jan 2020	1:24
Feb 2020	1:25
Mar 2020	1:21
Apr 2020	1:25
May 2020	1:24
Jun 2020	1:24

The overall birthrate has dropped slightly, which is why the figures in table 2 reflect a lower midwife to birth ratio as it is calculated using the number of births for that month. However the complexity and acuity of women, both medically and socially, is increasing. This is evidenced by the increase rates of medical interventions, such as induction of labour and caesarean section, and a subsequent rise in the length of stay for women.

The number of midwives who are not included within the clinical numbers, such as specialist midwives and midwifery managers equates to 10% of the midwifery workforce. This is in line with the recommendations of Birthrate Plus ®

In addition to the above, there have been a number of national trajectories that have been set by NHSE in relation to the provision of maternity care. This has resulted in the requirement to redesign our midwifery service to meet the requirement that the majority of women receive continuity of carer from a small team of midwives. The new model was implemented on 2 March 2020, just prior to beginning the lockdown period with the COVD-19 pandemic. The national trajectories are currently on hold and we anticipate a relaunch in Autumn 2020.

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

The national recommendation is that each labour ward has a supernumerary Midwifery Co-ordinator. This is a specialist role that and ensure that a clinical specialist is available to oversee the safety within the department, providing support, advice and clinical interventions as required.

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

Table 3: Summary of Delivery Suite Co-ordinator Supernumerary Status

2020	Instances where delivery suite co-ordinator is not supernumerary
Jan	10
Feb	13
Mar	2
Apr	1
May	0
Jun	0

During the six-month period there were 26 instances out of 987 recording points. This equates to 2.4%, which is a decrease from the preceding 6 months (was 4%). For all instances where the co-ordinator was not in a supernumerary capacity, this had not been the intention for that shift. Our midwifery establishment is set to enable the co-ordinator to be supernumerary and this is supported by our maternity staffing document.

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

The maternity service has an escalation process to help mitigate against this risk, which includes an additional midwife available on-call to support at times of high acuity.

Within the last Board Report, we set the ambition to achieve 100%. Whist this has not been achieved (97.6%) there has been an improvement. We need to be mindful that we increased staffing levels during Apr-Jun, including an additional co-ordinator due to the pressures of COVID-19. However, moving forward, with the integrated teams full integrated, we should have an increase in the number of staff available and therefore able to reduce the need for the co-ordinator to take a small clinical caseload during their shift. We will continue to monitor this through the monthly staffing report to ensure that there is a sustained improvement.

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

The maternity service captured the number of women receiving one-to-one care in labour. It is completed for each woman and recorded on the STORK maternity system. The aim is to achieve 100%. We had identified that we had not meeting the target and was recording between 95 and 98% each month, please see below table. In May 2020, the Head of Midwifery asked the Quality Improvement Midwife to complete a detailed investigation. The notes of all women who were recorded as not receiving one-to-one care in labour were reviewed. There were a number of errors identified within the recording on the system. The actions from the investigation were to remind staff of the standards and plan to continue to review any notes that do not

meet the standards on a monthly basis. This data forms one of the maternity specific questions on the QUESTT tool.

Table 4: Percentage of women receiving one-to-one care in labour.

Time period	%
Jan 2020	96.9%
Feb 2020	98.2%
Mar 2020	95.7%
Apr 2020	100%
May 2020	100%
Jun 2020	99.4%

The maternity service works extremely hard to ensure this standard is met as can be seen in Table 4. Over the six-month time period, this equates to approximately 3 women per month not receiving one-to-one care in labour. A reduction from 8 in the preceding 6 months.

The raw data does not tell us for how long that woman did not receive one-to-one care. However, anecdotally, midwives report that this is usually for short periods of time, where they may be required to provide care for another woman whilst additional midwifery staffing is sought, such as use of the escalation on-call midwife. As a senior team we are assured that one-to-one care is prioritised and action is taken to remedy the situation as soon as practically possible.

5.0 Bi-annual report (d)

The senior midwifery leadership team completes a monthly staffing report, which is shared with all maternity staff team members. The purpose is to ensure that staffing levels are closely monitored by the leadership team. It provides transparency for the team and assurance that staffing is being monitored and actions taken.

The monthly staffing report contains information on sickness, minimum staffing levels, use of escalation staff, supernumerary status for delivery suite co-ordinator, one-to-one care in labour, red flags and the midwife to birth ratio. Feedback from staff is that they find the report useful and easy to read.

The monthly report is also shared with the Chief Nurse, System Director of Nursing and Professional Practice, along with the Torquay Integrated Service Unit Leadership Team. These are used to inform the content of the biannual report.

This is the Fourth specific maternity report. The biannual report is completed six-monthly, with the next report being due in January 2021.

6.0 Red flags

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

- Activities that need to be done on time are delayed or cancelled.
- After giving birth, a woman has to wait for 60 minutes or more before she is washed or given stitches, if she needs them.

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

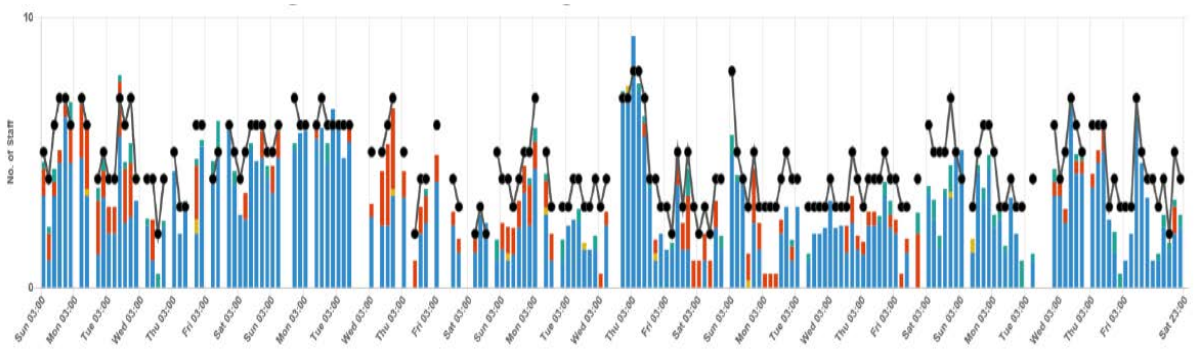
From April 2019, red flag events and actions taken in response to these were captured using the Birthrate Plus ® Acuity Tool.

Table 5: Midwifery Red Flag Events

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

The use of the acuity tool now enables us to track when red flags occur. Chart 1 provides an example of acuity data. Each bar indicates the number of women on delivery suite and the colour indicates acuity, with red and green being the highest acuity. The black dots indicate the number of midwives available at that time.

Chart 1: Staffing v Workload Example



From our analysis of the system, red flags generally occur at times of high acuity. The matrons review any red flag events with the co-ordinator, using the same process as the supernumerary status.

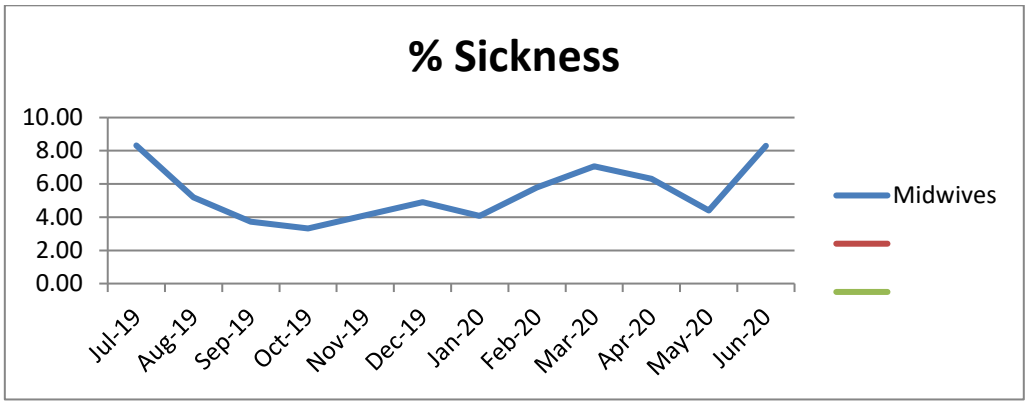
All red flag instances were due to a conscious decision to trigger the red flag to ensure safety across the whole service was maintained. None of the instances were due to omissions or lapses in care. The most common reason for a red flag within this reporting period has been the inability to provide an out-of-hospital birth. This was because of the requirement to have two staff members attend. All women were offered care within the hospital setting.

In March 2020 we changed our staffing model, which meant that more integrated team midwives were available. We also aimed to ensure that we had 10 midwives on duty for each shift due to the additional workload from the COVID-19 pandemic. Consequently, we have seen a reduction in the total number of red flags during this time period, in particular delays to care moving from 24 instances during July – December 2019 to 3 during this reporting period.

7.0 Sickness

During the six-month reporting period there was a peak in midwifery absence due to sickness in March 2020, at the beginning of the COVID-19 pandemic. This then reduced through April and May. The reason for the increase in March was absence due to suspected COVID symptoms, plus anxiety related to COVID However, we are now noticing that sickness levels are rising significantly again. The reasons are for a variety of reasons, which include musculo-skeletal and stress/anxiety. It appears that following a period of intense action in response to COVID-19, staff are now becoming fatigued. We are working with staff to ensure well-being. We have introduced a specific area that can staff can go to, in order to take time out, practice mindfulness and other relaxation activities. Our Professional Midwifery Advocates (PMAs) are also ensuring staff know that they are available for support, plus we have shared the Trust-wide and national resources available to staff.

Table 6: Midwifery Sickness Percentage



The leadership team work proactively with the Human Resources department and staff members to support them to return to work as soon as they are fit to do so. This is monitored with our monthly staffing report, which can identify specific areas within the maternity service that may require additional support. This includes where midwifery staffing levels do not meet the locally agreed minimum staffing levels. This is also shared with staff.

8.0 Escalation

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

Table 7: Summary of escalation midwife usage

Time period	No. of Times Escalation Midwife Used
Jan 2020	1
Feb 2020	10
Mar 2020	4
Apr 2020	0
May 2020	2
Jun 2020	2

9.0 Conclusion

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

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

This reporting period has been more challenging due to the change in midwifery model and also the COVID-19 pandemic. However, staff have worked tirelessly to ensure that we continue to provide a safe and quality service for the women and families that we care for.

10.0 Recommendations

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

That the Board receives and notes the report.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance Safety Report (1 April – 30 June 2020).			Meeting date: 29 July 2020
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity System (LMS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the membership of the Trust Board of the work being undertaken by the Maternity Governance Group. An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board. The Trust Board is asked to receive and note the report and the programme of work described.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note the contents of the report and to support the process of review of the reports on a quarterly basis.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** X; **Valuing our workforce** X **Improved wellbeing through partnership** X; **Well-led** X		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** N; **Risk score** **Risk Register** N; **Risk score**		

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

Report title: Maternity Governance Safety Report		**Meeting date:** 29 July 2020
Report sponsor	Chief Nurse	
Report author	Associate Director of Midwifery & Professional Practice/HoM Clinical Governance Co-ordinator Midwifery Matron Quality Improvement Midwife	

1.0 Introduction

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

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

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

In order for the Board to be sighted on progress and achievements, the maternity service provide a quarterly report to the Board. In addition, the maternity safety champions meet bi-monthly with the Executive Board Safety Champion, the Chief Nurse. This quarterly report will look back at the period 1 April 2020 – 30 June 2020.

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

2.0 Review and monitoring of safety within maternity services?

2.1 Safety Improvement

The maternity and neonatal services work on the Maternity and Neonatal Health Safety Improvement Programme has been suspended due to Covid-19. The programme will now move into Phase 2 with new measures to look at reducing smoking rates, optimisation & stabilisation of the newborn infant and deterioration improvement work. All local and national events had been suspended. The first local learning set is planned virtually to launch this new Phase 2 on the 31 July 2020. We continue to follow the principles of the “Keeping Babies Warm” project.

We have continued working towards the full adoption of the Obs Cymru QI Programme (Obstetric Bleeding Strategy for Wales) which was established to reduce harm and variability in the management of postpartum haemorrhage. The principles of the Obs Cymru are being followed by a local team including obstetricians, anaesthetists,

midwives, hospital transfusion team, theatres and laboratory teams are working on the project with the aim to reduce harm associated with Postpartum Haemorrhage (PPH).

We are very proud to be the first unit in the South West to join the Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) Project. We attended the launch meeting on the 9 July 2020 and have appointed a lead midwife (externally funded) to drive the initiative forward. The Quality Improvement methodology that we have gained during the MatNeo improvement programme in 2019/20 will help us in undertaking this project, and continue the cross working with Maternity Services and Neonates. This new neonatal care bundle aims to improve the outcomes for premature babies following a number of interventions that will demonstrate a significant impact on brain injury and mortality rates amongst babies born prematurely.

2.2 Mortality and Morbidity

2.2.1 Perinatal Mortality Review Tool (PMRT)

The PMRT tool is now embedded in practice following its introduction in 2018. It has been used at the local multi-disciplinary case reviews to inform the reviews. There are clear reporting timescales.

We have achieved the standard of completion of the reports, and the standard that there should be at least two obstetricians and two midwives present for each review. We continue to use these case reviews as teaching sessions for all clinical staff to attend and participate.

During this reporting period (April – June 2020), we had two stillbirths. These were babies who were born with no signs of life at 24^{+} weeks and 30 weeks gestation. The 24-week stillbirth was a baby with known growth restriction and was being monitored closely. The 30-week stillborn baby was born to a woman who had not booked for maternity care.

We reported two neonatal deaths. One baby died at 25 weeks gestion of severe prematurity, this woman was not booked for maternity care and presented to the emergency department fully dilated. The baby was subsequently transferred to a Level 3 Neonatal Unit, but sadly died due to complications of severe prematurity.

The second neonatal death was a term baby that was born alive, but required extensive resuscitation and treatment including active cooling. The baby unfortunately died in the early neonatal period. The investigation into the care and management of this mother and baby met the criteria for Healthcare Safety Investigation Branch (HSIB) to undertake the review.

Duty of candour was undertaken with all families and they were given the opportunity to ask any questions or to provide feedback that they would like to be included within the review of the care.

2.2.2 Healthcare Safety Investigation Branch (HSIB)

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

In the reporting timescale of April - June 2020 we had two cases that met the criteria. One case is detailed above. The second case was a mother admitted with significant bleeding, who required an immediate caesarean birth. Following birth, the baby met the criteria for active cooling and the family have agreed for HSIB to investigate.

As detailed in previous Board reports, we had referred two case for HSIB review in August 2019 and November 2019. We received and accepted the August 2019 case final report from HSIB in June 2020 We have written to the family with an outline of the actions recommended to the Trust by HSIB. We are awaiting the draft report, which is imminent for the November 2019 referral.

2.2.3 NHS Resolution

From the 1st April 2020 it was no longer necessary for trusts to report eligible cases to NHS Resolution due to the COVID-19 pandemic. This is due to be reviewed in September 2020. HSIB will triage all cases and prioritise those where there is evidence of harm to the baby and will share these cases directly with NHS Resolution.

2.2.4 Saving Babies' Lives Care Bundle

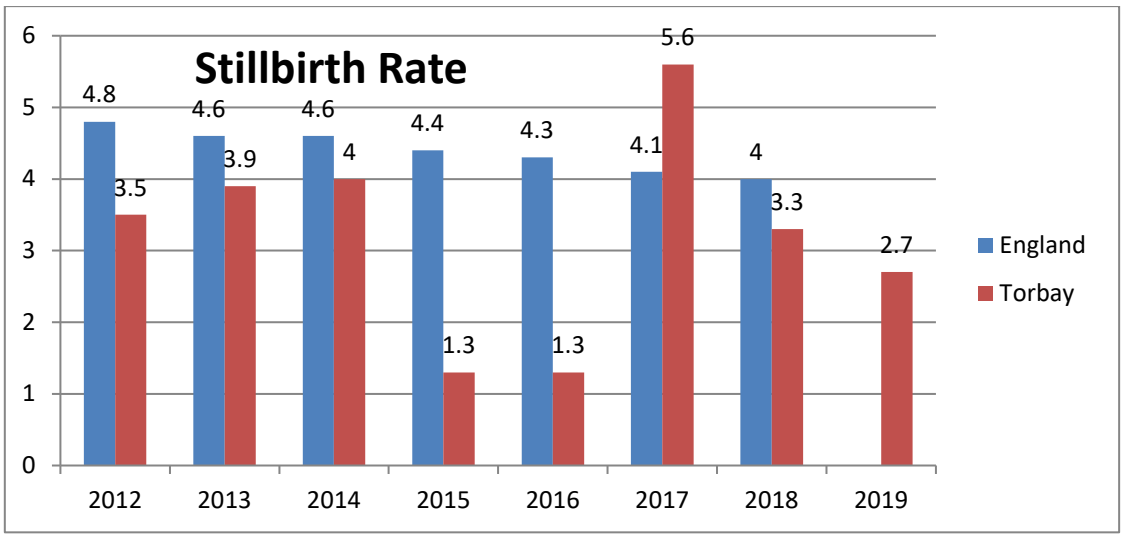
Saving Babies Lives Care Bundle Version 2 (SBLCB v2) was launched in March 2019. This builds on the existing bundle, but adds a fifth element (preventing preterm labour) for implementation. NHSE/I initially set an expectation that all elements would be implemented by 31 March 2020 and the maternity team completed a benchmarking exercise and developed an action plan to meet this. NHSEI then revised the implementation timeline with implementation by August 2020. However, due to COVID, this has been placed on hold by NHSE and we are awaiting a further revised timetable.

Following the benchmarking exercise, it was identified that it would not be possible to implement all aspects of the bundle without investment. The resources required will be additional Consultant Obstetric PAs, 0.4wte Band 7 Midwife and additional sonography capacity. The Business case for additional Consultant Obstetric PA has been successful and the plan is for interviews in September with a planned start date of January 2021. We are also working with the 3 other units in our LMS to make a submission for funding for 1.0 WTE sonographer and 0.4 Band 7 Midwife Fetal Monitoring Lead.

Regular flash reports, completion of quarterly surveys and meetings are in place to support implementation of the action plan. In light of current circumstances, the SBLCB Version 2 tracker survey is being paused until further notice.

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

Table 1: Annual Stillbirth Rate



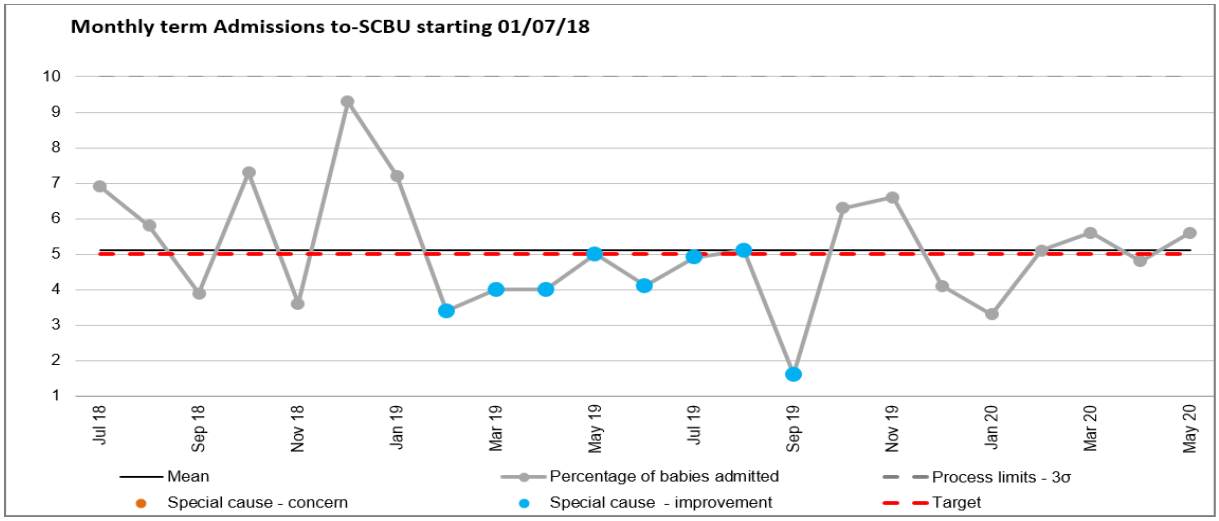
2.2.5 Avoiding Term Admissions into Neonatal Units – ATAIN

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

For this reporting period, 5.% of term births were admitted to the Special Care Baby Unit. This is a slight increase from the last reporting period and is just over the target of 5% or less. For the year 2019/2020, 4.8% of term births were admitted to Special Care, which remains within the target figure. See table 2 for monthly term admission to SCBU rate.

As a service we are at the limits of what we can achieve in relation to this important safety and quality action. This is due to space and capacity issues within the clinical area. The estates strategy for the Women's Health Unit, which has been approved but is awaiting allocation of capital funding, includes provision of dedicated Transitional Care Facilities. This would enable us to continue our improvement journey to support the on-going care of babies with additional needs, but not requiring SCBU and ensuring mothers and babies are not separated.

Table 2 for Monthly Term Admission to SCBU Rate



2.2.6 Maternity Safety Champions

The Trust have two designated Safety Champions (a midwife and an obstetrician), the obstetrician previously undertaking this role is now the Clinical Director for Obstetrics & Gynaecology, but has agreed to continue the Safety Champion role until a successor is identified. In addition, the Chief Nurse previously held the role of Board Level Safety Champion, but has now retired. It is the view of the maternity department that the role of the Chief Nurse aligned well with that of the Board Level Safety Champion and this has been agreed moving forward. The maternity and neonatal safety champions will continue to meet with the Board Level Safety Champion bi-monthly.

The majority of safety actions in relation to year 3 of CNST remain on hold due to the COVID-19 response. However, work is currently being undertaken with the LMS (Local Maternity System) to scope funding requirements from the LMS to support the requirements of Saving Babies Lives Version 2. The confirmed agreement to employee another O&G Consultant will also support with this.

Following the publication of the CQC report for 2020, safety was rated as 'requires improvement' in the recent CQC report because:

- Staff did not always use the tools available to identify risk of deterioration, and escalate these risks, consistently.
- Staff did not always complete checks of emergency equipment.
- Medical staff were not always up to date with mandatory training.
- Medical staff were not always aware of the safeguarding leads and were not all up to date with their safeguarding training.
- The quality and recording of handover information when women moved between sites needed to improve.
- At the time of the inspection there were not always enough medical staff, and consultant presence on the delivery suite needed to improve.
- Systems to ensure medicines available were within expiry dates were not always followed.

However,

- The service provided mandatory training in key skills to staff and had processes to make sure midwifery staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Midwifery staff had training on how to recognise and report abuse and they knew how to apply it.
- The service usually controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They generally kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks most of the time.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.
- The service had enough medical staff most of the time with the right qualifications, skills, training and experience to keep patients safe from avoidable

harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.
- Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Work is already underway within the service to address the ‘should do’ and ‘must do’ recommendations and an action plan has been developed to support this

3.0 CNST: 10 Key Safety Actions

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

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

The team continue to work towards achievement of the safety standards as they recognise the important role these standards play in improving safety within maternity services. However, it has been previously noted that to fully achieve the standards, there will be a requirement for additional resource. We are pleased to report that the Consultant Obstetrician and Gynaecology post has been approved and is out to advert. We are still awaiting the outcome of the business case for the additional training midwife, however have also put in a bid for external monies to meet this requirement, along with additional sonography capacity. The final requirement relates to IT and this is currently being reviewed as part of the capital prioritisation bids.

4.0 COVID-19

Maternity services have been identified as a priority service during the COVID-19 pandemic. As such, in March 2020, the maternity service in conjunction with the Trust developed a plan to support the continued provision of a safe maternity service. Any alterations to service provision meets guidance from Public Health England, and from the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives.

The maternity plan has been developed in conjunction with anaesthetic, paediatric and infection prevention and control colleagues. This was initially reviewed on a weekly basis, but has now moved to two-weekly. We are currently on Version 15. Daily team ‘huddles’ were implemented to develop the plan, identify issues, agree team communication and provide support to each other. These were then reduced to 2-3

times a week as the plan was completed and embedded. We now hold the meeting fortnightly as we have moved to ‘business as usual’

Staffing levels are being closely monitored and are currently at sustainable levels for midwifery. However, we are now starting to see a rise in sickness levels, with staff reporting feeling fatigued after such an intense period of time. In addition, the obstetric middle grade staffing levels are at risk and there is a contingency plan has been put in place. Planning at a Devon LMS level is being undertaken to ensure that resilience is maintained for obstetric staffing.

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

5.0 Conclusion

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

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

6.0 Recommendations

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

Torbay and South Devon
NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust Board Meeting			
Report title: **Torbay and South Devon Clinical School Annual Report**			Meeting date: 29 July 2020
Report appendix	Appendix 1: Torbay and South Devon Clinical School Annual Report 2019-2020		
Report sponsor	Chief Nurse		
Report authors	Co-directors of the Torbay and South Devon Clinical School Team Lead Podiatrist and South West AHP NIHR/CAHPR Research Champion Trust Lead Research Nurse & 70@70 National Research Leader		
Report provenance	Quality Improvement Committee		
Purpose of the report and key issues for consideration/decision	This paper follows up from the report submitted to the Board in June 2019. We describe the progress towards our previously reported goals and potential goals for the coming year. These include: • Torbay Research Fellowships • Other research fellowships • Mentoring and support • Annual conference 2019 • Other events in 2019/20 • Communications and profile • Research Funding • National and Regional Profile Goals for 2020/21 include: • Formalised membership for the Clinical School • Review sustainability of Clinical school • Increasing Clinical Academic fellowship awards • Communications and profile internally, regionally and nationally • Team and individual mentoring and support • Building research funding • Dissemination and education There is a requirement to review the funding arrangements of the members of the Clinical School at the Trust commitment to provide ongoing support and development of the Clinical School to ensure sustainability.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The clinical school team to review the sustainability module of the clinical school For the Board to provide its support for the ongoing development of the Clinical School.		

Summary of key elements	
Strategic objectives supported by this report	

Safe, quality care and best experience		**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	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks	

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

Torbay and South Devon Clinical School Annual Report 2019-2020

Background and Introduction

Torbay and South Devon Clinical School is part of the South West Clinical Schools network in conjunction with the University of Plymouth. This is a partnership between the School of Nursing and Midwifery, the School of Health Professions and local NHS Trusts. The aim is to develop a clinical academic workforce and support the development of research in practice.

Clinical academics are active health researchers who combine their clinical and research career. They work in health and social care as clinicians to improve, maintain, or recover health, delivering better outcomes for the patients. Clinical academic staff sit at the vital juncture between research, innovation dissemination, and education. They enable research to be translated into clinical practice and quality education and training. In particular, they bring patient-focused insights and conduct translational research which offers direct benefits to the quality of patient care.

There is increasing research evidence that research active healthcare organisations achieve better patient outcomes (Hanney *et al.*, 2013, Ozdemir *et al.*, 2015) and the Care Quality Commission have now included research as one of its metrics. There is a national strategy to increase nurse, midwife and allied health professional (NMAHP) led research and it is within this context that the South West Clinical Schools were created and continue to develop. Evidence based NMAHP care directly supports the service quality and improvement agendas, improved health outcomes, increased cost effectiveness and innovations which are underpinned by the best research (Baltruks & Callaghan, 2018).

The first clinical school started at the Royal Devon and Exeter NHS Trust in 2014. Current membership of the South West Clinical Schools includes the Royal Cornwall NHS Trust; Torbay and South Devon NHS Foundation Trust; Taunton and Somerset NHS Foundation Trust and University Hospitals Plymouth NHS Trust. https://www.plymouth.ac.uk/research/clinical-schools.

The Clinical School at this Trust began its development in May 2017. This involved Susie Pearce (Associate Professor for Nursing) and Mary Hickson (Professor of Dietetics) working one day a week supported by the University of Plymouth. Mary and Susie are working particularly with nurses, midwives and AHPs, but also with any other healthcare professional interested in improving practice with applied health research. Both have strong clinical and research backgrounds, and both have extensive experience in developing research in the clinical environment, strategically, and with individuals, teams and services to improve patient care.

The goal of the Clinical School is to develop practice relevant research aligned to the Trust's priorities of: safe quality care & best experience, improved wellbeing, valuing the workforce and being well-led. The aim is to develop powerful and sustainable translation of findings in practice; attract, recruit and retain high-quality, high-potential health professionals; increase research capacity within the organisation; and increase the capability of staff to develop practice-based research to improve service delivery and patient outcomes. Activities are targeted at two levels; one to change the ethos, strategy, culture and infrastructure to support research activity; and secondly to work with individual staff to support them to increase their research skills and knowledge, develop clinical academic careers, which will lead to innovative ideas that enhance clinical services within the Trust.

Susie and Mary work closely with the Chief Nurse (Jane Viner), the Director of Research and Development (Fiona Roberts), the Lead for Quality Improvement (Susan Martin) and other nursing, midwifery and allied health professional leads. The Chief Executive Officer of Torbay South Devon NHS Foundation Trust (Liz Davenport) and the Dean of the Faculty of Health and Human Sciences at the University of Plymouth (Sube Bannerjee) both fully support the initiative.

The University restructured over the last year and has combined the Schools of Health Professions, Nursing and Midwifery, Psychology, Medicine, and Dentistry within a new Faculty of Health. This Faculty is led by Professor Sube Bannerjee and offers new opportunities for integration of disciplines and professions in practice, education and research. Prof Bannerjee is extremely supportive of the Clinical School concept and will work with us to develop opportunities for clinical research within the new Faculty.

The Clinical School has also developed its structure within the Trust. Chris Dixon has been appointed a70@70 nurse (this is a national award providing leadership for nurse and midwifery professions to increase research capacity and capability) and she is now formally part of the Clinical School leadership team. The 70@70 role has very similar objectives to that of the Clinical School; to promote and support clinically relevant research and service development, thus this is an ideal collaboration. In addition, Rich Collings has been appointed to the Council of AHP Research (CAHPR) South West Champion. Thus, he too is contributing the leadership of the Clinical School.

This report outlines the progress the Clinical School made between 2019 and 2020 and the goals and objectives for 2020/2021. March to July 2020 has been affected by the altered landscape in education, research and practice, this will affect the coming year but also hopefully provide opportunity for both moving forward and for consolidation of the opportunities for developing research in practice at the Trust.

Achievements June 2019 to June 2020

1. Torbay Medical Research Fund Research Fellowship programme:

The clinical school was successful in obtaining funding to develop its own clinical career pathway. The first year of the scheme has been completed. There are three fellowship awardees to date: Kathryn Bamforth (Doctoral Fellow), Corinne Lindsey (Doctoral Fellow), and Harriet Hughes (Pre-Doctoral Fellow). Kathryn has successfully completed the first 10 months of her doctorate, "*How can healthcare organisations support the wellbeing of their staff to provide person-centred care*?" Harriet, who is examining *the use of Functional Electrical Stimulation in children with Cerebral Palsy*, has completed all but two of her goals; to submit a review paper and to complete the doctoral fellowship application. These will be completed after her maternity leave in January 2021. Corinne, a staff nurse at Totnes Community Hospital, was successful in this year's award and is starting her doctoral studies 1st Oct 2020: *An ethnographic and narrative investigation into nursing practice and nursing identity in an integrated Trust*.

These fellowships make a significant contribution to retain and recruit high calibre staff. The doctoral fellowship is for five years, and the pre-doctoral is for one year with the aim to transfer the fellow onto a doctoral pathway. During this time staff continue to combine working part-time in the clinical service with pursuing their academic development. They become role models for other staff, and share and disseminate their learning within their teams and wider staff groups.

The scheme has had a notable effect on the general interest of nurses, midwives and allied health professionals wanting to explore innovative pathways for their career, in particular research. The scheme offers a tangible option for staff seeking new challenges but wishing to remain within the Trust.

The Clinical School team mentor staff who have expressed an interest in the fellowship scheme to help them develop applications for next year and/or apply to other local or national schemes (see the next section).

2. Maximising applications to other fellowship schemes:

To enhance opportunities for more Trust staff to develop their research skills we have continued to talent spot and support individuals to apply for other local or national clinical academic schemes. For example, the HEE/NIHR Internship scheme, the Clinical Research

Network Internship programme and the NIHR Pre-doctoral and doctoral fellowships. The Trust already hosts the staff listed below and we will continue to support them to progress on their clinical academic career pathway and obtain further funding in the future:

- Rachel Rapson, Physiotherapist – NIHR Clinical Doctoral Fellowship 2018
- Richard Collings – NIHR Clinical Doctoral Fellowship 2016
- Sarah Pavior, Physiotherapist - HEE/NIHR ICA Pre-doctoral Clinical Academic Fellowship 2019
- Jennifer Williams, Podiatrist – HEE/NIHR ICA Pre-doctoral Clinical Academic Fellowship 2019
- Angie Foulds, Nurse - Clinical Research Network Internship 2020
- Innovation award to appoint 0.2wte research associate per week. This will be recruited to in the coming year.
- 0.2wte research associate per week to be appointed related to 70@70 programme in collaboration with the Clinical School.

(NIHR-National Institute of Health Research, HEE-Health Education England, ICA-integrated clinical academic)

3. Mentoring and support

As a team we mentor and support a large number of people to apply for awards. This is a huge commitment prior to taking on the role of supervisor and/or mentor for successful candidates. A large amount of time is spent before submission of applications discussing ideas, formalising what should be included in applications and reviewing written drafts. This is hidden time which is not easily captured and reported, but makes up a large proportion of the time contributed by the four authors.

4. Annual conference:

We delivered the annual Torbay and South Devon Clinical Schools Conference on 15th October 2019. The themes was innovation and integration in health and social care and energising the workforce. These were specifically chosen to showcase the innovative work staff were undertaking to develop and drive their services forward.

We welcomed over 80 people with over 20 staff presenting their innovative work. They demonstrated brilliant examples of service development initiatives and practice-based research. After a video from Mark Radford (Deputy Chief Nursing Officer, NHS England) we heard from Jane Viner, our Chief Nurse, about the national landscape for nurses, midwives, AHPs and social workers, linking to how we can move forward in the care we deliver.

A panel discussion explored how the Trust supported staff to move forward with their careers, think differently, and innovate in practice. Natasha Goswell (Systems Director for Nursing and Professional Practice) spoke about the Trust's exciting new journey on the

Pathway to Excellence and the development of a professional practice strategy for nurses, midwives and AHPs and social workers.

There was an amazingly high standard of posters and oral presentations highlighting many innovations in practice. Our congratulations go to our prize winners:

- Best Oral Presentations: Megan Clemence, Debrief after critical, clinical events: a scoping review
- Best Poster: Lisa Pullen, The experiences of consultant paediatricians involved in end-of-life care for children with a palliative diagnosis.
- The Excellence in Practice award: Orthopaedic Surgical Care Practitioners- Sarah Tomlinson and Claire Symonds
- Excellence in Research Award: Cardiology Research Team
- Excellence in Leadership Award: Richard Collings

People said:

"What was most of value was the opportunity to meet like-minded clinicians and explore the opportunities for developing a career in clinical academic research"

"I most valued hearing how others had driven through improvements and innovations"

"It was great to see nursing being promoted as leading and engaging in research - always previously seen so much as a medical preserve."

"An enjoyable day with lots of information which has given me some motivation to still pursue research and applying for a doctorate place next year"

5. Other events:

Several other events were organised and delivered during the year. These included:

End of Life Care Symposium and a Masterclass in complex communication

This was held in the Horizon centre on the 2nd October 2019. This was organised by Assoc Prof Susie Pearce and Prof Mo Coombs and 36 nurses, midwives and allied health professional from across Devon attended across the day. We were fortunate to have Professor Philip Larkin from the University of Lausanne and an acclaimed clinician and academic in palliative care facilitate the event.

Drop in clinics

Throughout the year Mary and Susie have held drop-in clinics to enable staff to seek advice and support on issues relating to development and evaluation of their service or forging a clinical academic career. Numerous staff attended to discuss fellowship applications, other grant opportunities, ideas for service improvement, presenting work and moving forward in their careers. Susie has also spent time with clinical teams developing ideas and potential research projects.

Understanding evidence

We facilitated the Peninsula Applied Research Collaboration (PenARC) to deliver a workshop on understanding the evidence and using evidence-based practice. This provided delegates with practical information about how to interpret scientific research and its application in practice. It also served as a forum for discussion and reflection about implementation of findings in practice.

Preceptorship programme

We contributed to the preceptorship programme highlighting to new staff potential career options including further educational options and clinical academic career opportunities. This is an important link into early career staff.

6. Continued to develop communication and profile within the Trust.

The Clinical Schools profile has been significantly raised in the last year and the purpose, function and presence of the Clinical School is better understood. We continue to work with the communications team to promote the work of the Clinical School. Importantly, Susie Pearce continues to attend the senior nurse strategy group and the Clinical School is now a core item on the agenda. Mary and Susie are involved with the on-going review of the Trust research and development strategy.

One aspect of this is marketing research across the organisation, and identifying funding streams and making stakeholders aware that there are suitable funding streams available. We are also looking at innovative new ways of working such as the new research associate roles mentioned in point 2. These research associated posts will provide band 5-6 staff gain research experience.

7. Contribution to research funding within the Trust

The Critical Care Unit at Torbay has been part of an NIHR Programme Development Grant SEIMIC: Study to Evaluate the Introduction of nurse staffing Models in Intensive Care. This multi-centred study is led by Professor Ruth Endacott and Susie Pearce and will be developed into further national studies with further bids involving Torbay being submitted in July 2020. Susie was also involved in a Macmillan Funded 'Brief Intervention for Advanced Care Planning pilot' led by Rowcroft Hospice in partnership with the Trust and this is being developed into further research studies being led by the Clinical School and the Trust.

8. National and Regional Profile

Susie and Mary represent the Trust on the Council of Deans of Health Clinical Academic Roles Implementation Network (CARIN). This provides a national profile and benchmarks the Trust against others in the UK for progress in developing infrastructure and activities to support clinical academic roles. Susie has co-authored a paper with other leading clinical academic nurses in the UK and this is currently out for peer-review: The strategic development of Clinical Academic Careers in Nursing and Midwifery.

We continue to contribute to the annual regional Clinical School conference, as well as delivering our own here at Torbay (section 3). This was due to take place in Exeter in May 2020 but was delayed due to Covid-19 pandemic. We are planning to deliver this remotely in September.

We were nominated for a Clinical Research Network Innovation award.

Plan for 2020/2021

This next year provides a great opportunity to develop existing areas to consolidate existing progress and to move forward. We have set the following programme of work which we aim to achieve collaboratively with the Chief Nurse, the System Directors for Nursing and Professional Practice and the wider Clinical School team.

1. To consolidate the clinical school and the critical mass of Clinical Academics at TSDFT

a) It is important to establish a formal membership structure for the Clinical School, now we have a significant number of people on a clinical academic pathway at TSDFT. We will provide formal honorary contracts for active members of the Clinical School with the University of Plymouth. We will work with the wider SW Clinical Schools to establish various honorary roles including Research Associate, Research Fellow, Senior Research Fellow.

b) Developing further partnership working of more senior roles within the Trust to the Faculty of Health at the University of Plymouth and the SW Clinical School.

c) Chris Dixon and Richard Collings to be incorporated within the management and organisation of the Clinical School within their Trust-wide research remits.

d) Develop an integrated strategy of embedding research into clinical practice.

2. To develop opportunities for NMAHPs and increase the number of NMAHPs applying for and obtaining clinical academic awards

a) Increase support, mentorship and applications to external schemes for interns, pre-doctoral, doctoral and post-doctoral fellowships, clinical lectureships, from NIHR, CRN, HEE funders. The being to increase the applications to these schemes to raise profile, talent spot, provide staff opportunities in the coming year.

b) Apply to renew the fellowship programme and funding with TMRF for a further three years.

c) Support the development of an in-house intern programme in collaboration with the R&D team, releasing staff from clinical areas and embedding experience of managing and developing research, including clinical trials and applied health. A clinical school- Research and development initiative. Aim for staff to be given essential experience that will help them to prepare to apply for a pre-doctoral opportunity.

d) To support the development of other clinical academic posts, such as nurse practitioner consultant posts, as part of the establishment of a clinical academic career pathway. This will support and utilise a cadre of clinical academics in practice, fully benefiting patient care, outcomes and services and maximising the clinical academic route. It is also crucial to provide appropriate opportunities for staff post PhD in order to retain them within the Trust and not to lose the investment thus far.

3. Develop leadership, communication and the profile of the Torbay Clinical School in the Trust, University and nationally

a) Embed the Clinical School more strategically at TSDFT by working with the new Chief Nurse and the executive NMAHP team, as well as senior nursing and AHP strategy groups and developments.

b) Continue with board level information at least annually and contribution to Trust strategy, during and post COVID.

c) Continue to contribute to the development of the Research and Development strategy, committee and Governance.

d) Define a clear communication strategy which supports a programme of communication with a top down and bottom up approach working with the workforce team. This will raise awareness of the opportunities for research in practice and the success awards brings for individuals and managers, for workforce outcomes, for patient centred care and effective high-quality services.

4. To support teams and individuals in research and project development

a) Support individuals and teams to attain small grants or awards, and support with implementation, and dissemination. We will aim to support two successful small grants to undertake independent research studies and five forms of oral or poster dissemination regionally and nationally from individuals and teams.

b) Active engagement of all those who have shown an interest in developing their careers. Talent spotting individual and teams, working with preceptors and student and newly qualified staff who show aspirations for research, nurture enthusiasms.

c) We will also widen our scope to include medical staff and research teams who are interested in developing applied health research.

d) We will build on the enthusiasm and priority given to Covid-19 research during the last 3 months. This has created a positive platform for future clinical research,

demonstrating how much can be achieved when there is a clear understanding of the benefits.

5. Building research

a) Develop and build the emerging research themes linking people and research and grants and masters dissertations to these:

- Interventions for clinical practice
- Workforce and developing the professions
- Integrated care

b) Further develop research funding grants with TSDFT and partners, linking into NIHR portfolio studies where possible. Our goal will be to submit at least two grant applications £100,000 involving TSDFT and the Clinical School and five publications submitted by NMAHPs from TSDFT by July 2021

6. Dissemination and Education

a) Continue to plan the annual conference for Nov 2020 - Celebrating innovation and integration in health and social care: moving forward with nurses, midwives, allied health professionals and social workers. Professor Joanne Bosanquet MBE (Queen's Nursing Institute) will speak on person centred care, and Professor Sube Banerjee (University of Plymouth) will discuss integrated care. This will support staff to present their work with prizes for best poster and presentation.

b) Develop an award for staff which will provide a structured mentorship programme seeking to support the development of the prize winner along the clinical academic career pathway. This raises awareness and value of the contribution of the Clinical School staff to supporting staff.

c) Be creative in developing platforms for knowledge and skills, develop online programme of webinars for education, research skill developments, and journal clubs.

Report Sponsor & Authors

Jane Viner, Chief Nurse and Deputy Chief Executive – Report Sponsor

Mary Hickson, Co-director of the Torbay and South Devon Clinical School, Professor in Dietetics, University of Plymouth

Susie Pearce, Co-director of the Torbay and South Devon Clinical School, Associate Professor in Clinical Nursing, University of Plymouth

Richard Collings, Team Lead Podiatrist and South West AHP NIHR/CAHPR Research Champion

Chris Dixon, Trust Lead Research Nurse & 70@70 National Research Leader

Torbay and South Devon
NHS Foundation Trust

BOARD OF DIRECTORS		
Report title: Risk Management Strategy and Risk Management Policy		**Meeting date:** 29.07.2020
Report appendix	Appendix 1: Risk Management Strategy Appendix 2: Risk Management Policy	
Report sponsor	Company Secretary	
Report author	Company Secretary and Risk Officer	
Report provenance	Reviewed by Risk Group (21.07.20) and Audit Committee (22.07.20)	
Purpose of the report and key issues for consideration/decision	The Risk Management Strategy and Risk Management Policy is subject to review and approval by the Board of Directors on an annual basis. Its aim is to create a coordinated and focussed framework for the management of risk within the Trust and is subject to regular review to ensure it remains fit for purpose reflecting current practice throughout the Trust. This report presents the outcome from the annual review of the risk management strategy and policy. No major changes are proposed to the Risk Management Strategy, other than minor amendments to reflect changes in role titles eg. Chief Finance Officer and the inclusion of additional narrative in the Introduction section. The following changes to the Risk Management Policy are proposed: • Inclusion of cross-reference to the Trust's whistleblowing policy • Inclusion of the People Committee in risk management structure and accountability appendix • Financial risk appetite amended and percentage of budget test deleted • Key references hyper-links updated • Inclusion of Equality Impact Assessment as an appendix • Change in role titles reflected eg Chief Finance Officer The Risk Group and Audit Committee have reviewed the documents and recommend approval to the Board of Directors.	

Action required (choose 1 only)	For information ☐	To receive and note ☐	To approve ☒
Recommendations	The Board of Directors is asked to approve the Risk Management Strategy and Risk Management Policy.		

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

Risk Management Strategy

Date: July 2020

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On receipt of a new version, please destroy all previous versions

Document Information

Date of Issue:	21 January 2017	Next Review Date:	July 2021
Version:	1.4	Last Review Date:	July 2020
Author:	Company Secretary		
Directorate:	Corporate		
Approval Route			
Approved By:		Date Approved:	
Risk Group		21 July 2020	
Audit Committee		22 July 2020	
Trust Board		29 July 2020	
Links or overlaps with other strategies/policies:			
Risk Management Policy			
Information Governance Policy			
Health and Safety Policy			
Incident Reporting and Management Policy			
(Others listed within this document)			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
V1.1	Draft	31/01/2018	Minor updates	Risk Group
V1.2	Draft	30/06/2019	Minor updates	Risk Group
V1.3	Draft	16/06/2020	Minor updates	Risk Group Audit Committee Trust Board
V1.4	Draft	21/07/2020	Changes to financial risk matrix Additional text 1.1. and 1.2 Introduction section	Risk Group Audit Committee Trust Board

The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.

Contents

1. Introduction

1.1. Strategic risk management is the process of identifying, assessing and managing the risks and uncertainties, affected by internal and external events or scenarios that could inhibit an organisation's ability to achieve its strategy and strategic objectives.

1.2. For the purposes of this Risk Management Strategy, risks are considered as occurences or opportunities that would impact on the delivery of activities, the quality of outputs, the achievement of strategic goals or reputation.

1.3. Torbay and South Devon NHS Foundation Trust ('the Trust') recognises that good risk management awareness and recording at all levels ensures that risks are managed systematically and consistently across all areas and where identified risk factors can be reduced to a tolerated level. This will result in improved safety and quality of health and social care and minimise the risks to staff, patients, clients, carers, families, service users and visitors.

1.4. The Trust recognises that risk management is an essential component in fulfilling its responsibilities effectively and responsibly. This risk strategy specifies the Trust's philosophy and prime objectives and approach for the management of risk.

1.5. Good risk management is the responsibility of all staff and the Trust recognises the importance all staff have to ensure risks are assessed and where applicable recorded and managed.

2. Scope

2.1 In recognising that clinical, health and social care is inherently complex and risky, all aspects of the provider and corporate business are within the scope of this strategy.

2.2 This strategy applies to all staff working in the organisation, including permanent, temporary, bank workers, agency staff and contractors.

2.3 This strategy applies to all risks that jeopardise the strategic objectives of the Trust. These include, but are not limited to:

- **Clinical/ Safety risk** – any issue that may have an impact on the achievement of high quality, safe and effective care for patients, clients, service users and the safety of staff.

- **Performance risk** – any non-compliance or repeated failure to meet internal standards or targets through to a gross failure to meet professional standards or national standards or targets.

- **Environmental Impact risk**– any risk that could affect the environment for example spillage or escape of clinical or toxic waste.

- **Financial risk** – any risk that could impact the Trust financially. For example where scheduled savings cannot be made, or litigation claims or fines from external regulators such as the Information Commissioner's Office.

- **Health and Safety risk** – any risk that could put a person at risk of harm in accordance with health and safety legislation in its various forms throughout the organisation.

- **Information and Communications Technology risk** - any issue that may have an impact on the digital information held or IT systems used by the Trust.

- **Information Governance risk** - any risk where the data protection act is not being adhered to, this is linked to the requirements of Data Security and Protection Toolkit. This includes quality of data, breaches of confidentiality and data losses.

- **Operational risk** – Any issue that may have an impact on the achievement of operational performance e.g. referral to treatment standards.

- **Patient/user experience risk** - any unintended or unexpected incident which could have or did lead to harm for one or more patients, clients, service users receiving health/social care. It is a specific type of adverse event.

- **Reputational risk** – Any risk that could have an impact on the reputation of the Trust for example negative media coverage including social media.

3. Statement of Intent

3.1. Our purpose is to provide safe, high quality health and social care at the right time, in the right place to support the people of Torbay and South Devon to live their lives to the full.

3.2. The vision, values, purpose and strapline that describes what the Trust is aiming to achieve can be read via the hyperlink above.

4. Aims

The main aim of this strategy is to ensure a holistic and integrated approach to risk management across the organisation. This will be summarised where appropriate using ORCA (Objectives, Risks, Controls and Assurance) and under the following key areas:

4.1 Developing risk management

- Develop and define an integrated approach to managing risk across all of the Trust's activities.
- Facilitate a single database for all risks to be centrally managed by the individual risk owners and associated action point holders.
- Ensure that all risks are identified, assessed, minimised or mitigated and wherever practicable eliminated.
- Promote stakeholder and staff involvement in risk management.
- Protect patients, clients, service users, carers, staff, contractors, partners and others who come into contact with the Trust, together with safeguarding the Trust as a whole along with its reputation.

4.2 Embedding risk management systems and processes

- Link the whole of risk management throughout the Trust to the strategic objectives, the Board Assurance Framework (BAF) and corporate level risks.
- Provide direction and ensure the Trust's Board of Directors (the Board) are aware of all significant risks and provide a commitment to effective risk management and mitigation within the organisation.

- Embed risk registers across all directorates, integrated service units, service areas and departments across the organisation.
- Introduce and maintain cost effective risk control measures to eliminate or reduce risk to an acceptable level by risk assessment / action plans, cost benefit analysis and evaluation and ongoing regular monitoring.
- Initiate a systematic and consistent approach to learning and promoting continuous improvement.

4.3 Ensuring compliance with international standards and best practice guidance

- Satisfy all mandatory and statutory duties and undertakings.
- Ensure the health and safety of all those who work for the Trust.
- Achieve and improve performance against all external and internal regulated risk management activities (appendix 8 of the Risk Management Policy refers).

4.4 Ensuring the Trust is risk aware and that staff are appropriately trained / skilled in risk management

- Provide stakeholders with an understanding of the Trust's purpose and intentions and how risk management is utilised to help achieve these.
- Raise awareness of risks and their management through a programme of communication and training.
- Foster an environment whereby all staff understand their role in suitable and sufficient risk assessments and risk management.

4.5 Ensuring the Trust is a learning organisation

- Ensure learning from experiences e.g. incidents, near misses, complaints, concerns, compliments, comments, PALS enquiries and any legal issues.
- Develop a reflective, supportive, challenging and open culture that encourages all staff to report incidents, accidents and near misses without reprisal and to share learning and best practice.
- Monitor and review learning to ensure it is acted upon and that best practice is adopted across the Trust where applicable.

5. Risk Management Structure and Accountability

5.1. The Trust recognises that responsibility for risk cannot simply be attributed to one person and is therefore an integral part of the normal management process. Responsbilities are laid out in appendices 1 and 2 of the Risk Management Policy.

5.2. The authority and responsibility for the establishment, maintenance, support and evaluation of the risk management processes and this strategy within the organisation is invested in the Board . The Board is responsible for all internal controls in the organisation, and for agreeing the annual governance statement which forms part of the annual report and accounts.

The Board must have a sound understanding of the principal risks facing the organisation and receive assurances via the BAF, corporate level risk registers, annual internal audit report and performance reports that the appropriate risk management policies and risk standard operating procedure (SOP) are operating efficiently and effectively.

6. Ensuring the Trust is Risk Aware and Staff are Appropriately Trained and Skilled in Risk Assessments and Risk Management

6.1. The Trust's holistic approach to risk management will be applied to training. The Trusts Risk Officer will continue to train all Risk Handlers in risk awareness and how to use the Datix Risk Module (DRM) before a login is provided.

6.2. Training Material for the DRM is available electronically to all staff via the Trust's intranet site (ICON). The Trusts Risk Officer will make themselves available to aid and assist with additional training to ensure a good level of continuity across the Trust.

6.3. A governance framework will drive senior management reviews of department, Integrated Service Unit/s (ISU) and directorate risk registers. Risk management interactive sessions have been designed to reinforce why risk assessment and risk management is an important part of Trust business. Risk Management pages are available via ICON to assist staff in understanding the Trust's approach to risk management.

6.4. The Trust will make available adequate training for staff in risk assessment and management.

7. Risk Assessment Process and Escalation

7.1 The risk assessment process is a systematic process and to be effective it will be holistically applied strategically and operationally to all systems, processes and services. This process and escalation procedure is outlined within the Risk Management Policy and Risk Management Standard Operating Procedure.

8. Implementation of the Risk Management Strategy

8.1 To be effective this strategy must be communicated widely. The implementation objectives are to:

- Raise awareness and develop a culture where all risks are identified understood and managed.
- Ensure an appropriate system and organisational structure is in place for the identification and control of risks.
- Provide assurance that key processes are in place to provide reliable information and enable management to make appropriate decisions.
- Embed risk assessment and risk management into all our activities, including day to day and future ongoing management of the Trust.

9. Monitoring, Auditing, Review and Evaluation of this Strategy

10.1 The Chief Finance Officer (Senior Information Risk Owner (SIRO)) through the Company Secretary is responsible for auditing, reviewing and evaluating the effectiveness of this strategy on an annual basis.

(e)quality impact assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	*Risk Management Policy*	***Version and Date***	*V3.2 29/07/2020*
Policy Author	*Risk Officer*		
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐	*Staff* ☒	*Other, please state…*	☐

Could the policy treat people from protected groups less favorably than the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EqIA and must be referred to the equality leads below***					
Age	*Yes ☐ No☒*	*Gender Reassignment*	*Yes ☐ No☒*	*Sexual Orientation*	*Yes ☐ No☒*
Race	*Yes ☐ No☒*	*Disability*	*Yes ☐ No☒*	*Religion/Belief (non)*	*Yes ☐ No☒*
Gender	*Yes ☐ No☒*	*Pregnancy/Maternity*	*Yes ☐ No☒*	*Marriage/ Civil Partnership*	*Yes ☐ No☒*
Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)					*Yes ☐ No☒*
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language[5] used throughout?					*Yes ☒ No☐ NA ☐*
Are the services outlined in the policy fully accessible[6]?					*Yes ☒ No☐ NA ☐*
Does the policy encourage individualised and person-centered care?					*Yes ☐ No☐ NA ☒*
Could there be an adverse impact on an individual's independence or autonomy[7]?					*Yes ☐ No☒ NA ☐*
EXTERNAL FACTORS					
Is the policy a result of national legislation which cannot be modified in any way?					*Yes ☐ No☒*
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
To set out Torbay and South Devon NHS Foundation Trust's expectations and procedures on Risk Management.					
Who was consulted when drafting this policy? *Members of Risk Group and Audit Committee*					
Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EqIA, please refer to the equality leads below					*Yes ☐ No☒*
ACTION PLAN: Please list all actions identified to address any impacts					
Action			***Person responsible***		***Completion date***
AUTHORISATION: ***By signing below, I confirm that the named person responsible above is aware of the actions assigned to them***					
Name of person completing the form	*Amanda Anders*		***Signature***	*AA*	
Validated by (line manager)	*Monica Trist*		***Signature***	*MT*	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated

[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives

[6] Consider both physical access to services and how information/ communication in available in an accessible format

[7] Example: a telephone-based service may discriminate against people who are deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Torbay and South Devon NHS Foundation Trust

Risk Management Policy

Date: July 2020

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative.
On receipt of a new version, please destroy all previous versions.

Document Information

Date of Issue:	01/03/2016	Next Review Date:	July 2021
Version:	3.2	Last Review Date:	July 2020
Author:	Risk Officer		
Owner:	Company Secretary		
Directorate:	Corporate		
Approval Route			
Approved By:		Date Approved:	
Risk Group		21 July 2020	
Audit Committee		22 July 2020	
Trust Board		29 July 2020	
Links or overlaps with other policies:			
Information Governance Policy			
Health and Safety Policy			
Incident Reporting and Management Policy			
The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership. The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
V1	Active	01/03/2016	New Trust Policy	Trust Board
V1.1	Active	25/08/2016	Correction to Graphics and a Typo on page 12.	N/A
V1.2	Draft	04/05/2017	Annual Review & Update.	Risk Group & Exec Team
V2	Active	02/08/2017	Policy approved after first year.	Trust Board
V2.1	Active	19-01-2018	Appendix 9 updated	Co Sec
V3	Draft	18/06/2019	Annual Review & Update.	Risk Group Trust Board
V3.1	Active	27/11/2019	Appendix 3 & 4 Updated	Risk Group
V3.2	Active	21/07/2020 22/07/2020 29/07/2020	Annual Review & Update	Risk Group Audit Committee Trust Board

Contents

1. Introduction

1.1. Torbay and South Devon NHS Foundation Trust (hereby referred to as the Trust) recognises that good risk management awareness, practice and recording at all levels ensures risks are managed systematically and consistently across all areas of the Trust and where identified, risk factors can be reduced to a tolerable level. This will result in improved safety and quality of care for patients/clients and the minimisation of risks for staff and visitors.

1.2. The Trust recognises that risk management is an essential component in fulfilling its responsibilities effectively and responsibly. The risk strategy specifies the Trust's philosophy, prime objectives and approach for the management of risk.

1.3. Good risk management is the responsibility of all staff and the Trust recognises the importance of all staff ensuring risks are identified, recorded and managed.

1.4 A comprehensive risk management policy and procedure will not themselves ensure good risk management. Equally important is that risk management is seen as an important tool by managers and clinicians alike. Ensuring the existence of an effective risk management culture is therefore an important task for the Executive Team and the Board of Directors. An effective culture maximises the likelihood that risks and concerns are identified within the organisation. The policy and procedures ensure that risks are escalated to and managed at the right level, with the whole process underpinned by effective accountability and performance arrangements.

2. Statement/Objective

2.1. An effectively planned, organised and controlled approach to risk management is an essential component of successful corporate governance for any NHS organisation.

2.2. The intention of this policy is, therefore, to detail and support a risk based approach to decision making and to embed a culture of creativity and innovation that is founded on risk management as an integral part of the Trust's objectives, practices and management systems.

2.3. This document is intended to help and support staff, enabling and empowering them to confidently and competently make decisions on a risk-based approach.

3. Roles & Responsibilities

3.1. **All Staff**

All staff have a responsibility to familiarise themselves with the Risk Management Policy and Risk Management Strategy. Staff should report to their line manager/supervisor any risk they

become aware of and take all necessary actions to reduce the risk.

All staff should be able to raise concerns about issues that may compromise any of the Trust's strategic objectives via their normal line management structure. Where it is felt that this could be difficult these concerns can be raised via the Trust's Risk Officer or through the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy (H30).

3.2 Responsibilities for the Chief Executive and other specific roles can be found in Appendix 1.

3.3 The risk management structure can be found in Appendix 2. The Chair of each Committee/Group will be responsible for ensuring the Terms of Reference (ToR) are kept up to date.

4. Risk Management

Risk management is the process by which risks are identified, assessed, recorded, mitigated and reviewed. A risk is the threat that an event or action will adversely affect the ability to achieve the Trust's strategic objectives.

Each risk will be recorded by the Risk Owner with the support of their Risk Handler where applicable. Where appropriate, risks should be managed at a local level depending upon its current risk score as shown in Appendix 5.

The Risk Handler for the Area, Local Team, Department or Integrated Service Unit (ISU), will be responsible for adding and arranging the review of risks, ensuring they are assessed and managed in accordance with this policy. The risk owner will be responsible for the risk and for ensuring that the Risk Handler, if applicable, is carrying out their role effectively.

There will be some risks that cannot be dealt with at the local level; these risks should be escalated through the risk management system as soon as it is clear that the risk cannot be controlled locally.
These will include:

- Any risk that cannot be managed within the Area, Local Team, Department or ISU or Directorate,
- Any risk where the necessary adjustments cannot be funded from within the Area, Local Team, Division or ISU or Directorates budgets,
- Any risk that has a current risk score of 15 or more in accordance with the risk scoring matrix Appendix 5.

4.1. Identifying Risks

Risks can be identified through various means, including but not limited to:

- Audit recommendations.
- External recommendations.
- Fault reports.
- Incident reports.
- Process reviews.
- Risk assessments.

4.2. Assessing Risks

It is essential that all staff be alert to risks on an on-going basis to ensure that we respond to any emerging issues. Risk assessments can be done through a specific planned process at all levels. The type of assessment will vary dependant of the type of risk but all will follow the process as laid out in Appendix 8.

4.3. Risk Scoring

Risks are scored using a potential 'Consequence' score multiplied by a potential 'Likelihood' score.

- Consequence table (Appendix 3),
- Likelihood table (Appendix 4),
- Risks must be scored using the Trusts Risk Matrix (Appendix 5) for the following:
  - Inherent Risk Score (when first identified).
  - Current Risk Score (once controls are put into place to reduce the Inherent Risk Score).
  - Residual Risk Score (the level aimed for to either mitigate this risk or reduce it to a tolerable level) post completion of actions.
  - Tolerated Risk Score (used with all Board and corporate/high level risks where the tolerated risk score is set by the Executive Director for that risk).

4.4. Recording Risks

All risks that cannot be addressed immediately should be recorded on the risk management system. This process is explained in the how to guides on ICON

4.5. Risk Tolerances, Accountability and Escalation

Risk tolerances and accountability are laid out in Appendix 5, the risk owner will ensure that reports are generated allowing information to be assimilated at the relevant levels.

Should the risk meet the criteria to be assessed for inclusion on the Corporate Risk Register, the Risk Officer will record this within the risks status and escalate it through the correct line of reporting as laid out in the Governance Organisational Structure.

It is important to note that the escalation of a risk will not negate the responsibilities of the risk owner or Area, Local Team, Department or ISU or Directorate.

4.6. Action Plan/Point

An action plan/point is required to mitigate all risks that cannot be resolved immediately. These are to be recorded on the risk management system within the risk record for any risks with a current score of 12 or more. This is not limited to a single action plan/point as multiples may be required to reach the desired residual score.

4.7. Corporate Level Risk Register > Reviewing > Consultation and Approval

Any risk which has a current risk score of 15 or more in accordance with the Risk Scoring Matrix will be reported to the Risk Group via the correct line of reporting as laid out in Appendix 2.

Any strategic risk that may result in a failure to achieve one or more of the Trusts strategic objects will be reported to the Risk Group via the correct lines of reporting as laid out in Appendix 2.

This full process is laid out in the Risk Management Standard Operating Procedure (SOP).

4.8. Board Assurance Framework > Reviewing > Consultation and Approval

The Board Assurance Framework (BAF) summarises the Trust's corporate objectives, the key risks in achieving these objectives and the controls and actions in place to prevent the occurrence of, or to mitigate the individual risks assurance(s) are recorded and linked to controls, as laid out in the process in Appendix 9

The Risk Group, Audit Committee and/or Board may ask for risk owners or action plan/point owners to provide reports on the progress and assurances that controls are sufficient. The framework is illustrated on the Risk Management pages on ICON.

The BAF will be reviewed by the Audit Committee at all of their meetings and then reported on to the Board.

4.9. Projects

It is understood that projects carried out by the Trust will be managed in accordance with standard protocols and a risk assessment will have been carried out and recorded as part of the project. It is not necessary for these to be recorded on the risk management system, unless the project has been delivered and a threat remains to one or more of the Trusts strategic objectives.

4.10. Risk Communication

All risks should be communicated locally with staff so that they can act accordingly in ensuring that all controls are carried out and any gaps in control are reported. Some risks will be reported on through the Trust's communications team so as to keep all staff informed. Corporate Risk Registers and Board Assurance Framework Reports are published in the Risk Management pages of ICON.

4.11. Monitoring of the Risk Register on Datix

The risk register is monitored by the Risk Officer who in turn produces reports for the Risk Group, Audit Committee and Board of Directors.

The risk management system allows for risks to be updated and the current risk levels adjusted to show an up to date record of all risks and their associated action plans/points. Details on how to use the system are on the ICON Risk Management pages and in the Risk Management SOP and show how risks are to be reviewed, along with how reports can be generated from the system.(Template located on ICON)

4.12. Risk Reporting Structure

It is important that, depending on the level of risk, it is reported to the correct level within the organisation in a timely manner. The risk management accountability is laid out in Appendix 2.

5. Training

Risk management system training and guidance is available for all Risk Owners and Risk Handlers, this will be provided by the Risk Officer and must be completed before a login is provided.

6. Monitoring, Auditing, Reviewing & Evaluation

6.1 This policy and associated Risk Management Strategy and Risk Management SOP will be reviewed every year (or sooner in the event of a major organisational or policy change) by the Company Secretary to ensure that it is relevant and effective.

6.2 Feedback from all staff regarding this policy is encouraged and should be sent to the Risk Officer.

6.3 Regular audits of the risk registers are carried out by the Risk Officer to ensure that each Area, Local Team, Department or ISU or Directorate is adhering to this policy and to identify any gaps, threats and opportunities presented in the current process.

6.4 An audit of risk system management and the BAF will be conducted by Internal Audit on an annual basis.

7. References

7.1. The key references for this policy can be found in Appendix 7.

8 Equality and Diversity Exceptions

8.1 None identified.

9 Distribution

9.1 This Policy is available to all staff and externally on the public website

10 Appendices

1. Roles and Responsibilities
2. Risk Management Structure & Accountability
3. Consequence Table
4. Likelihood Table
5. Risk Matrix
6. Summary of Risk Management Process
6a Risk Theme Identification Process
7. Key References
8. Risk Assessment Tools
9. Board Assurance Framework (BAF) Process
10. Equality Impact Assessment

Appendix 1 - Roles & Responsibilities

Title	Responsibilities
Chief Executive	Is ultimately accountable for ensuring that there is a comprehensive risk management system in place and is responsible for: • ensuring that management processes fulfil the responsibilities for risk management; • ensuring that full support and commitment is provided and maintained in every activity relating to risk management; • planning for adequate staffing, finances and other resources, to ensure the management of those risks which may have an adverse impact on the staff, finances or stakeholders of the Trust; • ensuring an appropriate corporate level risk register CLR Template is prepared and regularly updated and receives appropriate consideration; and, • ensuring that the governance statement, included in the annual reports and accounts, appropriately reflects the risk management processes in operation across the Trust.
Executive Directors	Have specific delegated responsibilities in relation to risk management, all directors must ensure that appropriate risk management processes are in place within their area of responsibility, and are responsible for: • ensuring the existence of an effective risk management culture is continually promoted; • ensuring that all relevant risks are identified and managed appropriately; • the maintenance of their area risk register, and to ensure that all relevant risks are added to the risk management system; • ensuring that the culture of their area of responsibility is such that staff are encouraged to participate in the risk management processes; • ensuring the performance management of risk management processes within their area of responsibility is linked to the performance and accountability framework for testing and assessing risk management priorities; • identifying relevant staff for risk management training; and • ensuring that they review and update the Board Assurance Framework (BAF) and the controls and assurances in place,

Systems Directors / Assistant Directors/ Senior Managers/ ISU Leads/ Department Heads/ Managers/ Matrons	Are responsible for the identification, recording, assessing and mitigating of risks within their areas of responsibility using the General Risk Assessment. They are responsible for: • ensuring that the culture of their directorate is such that staff are encouraged to participate in the risk management processes; • ensuring their General Risk Assessment is reviewed and up to date; • escalating risks, onto the risk management system; • escalating, where appropriate to the relevant line manager; • the maintenance of a directorate risk register, and to ensure that all relevant risks are added to the risk management system; • ensuring, as a minimum, that on a quarterly basis the overall risk position for their area is considered. This must include a review of multiple low level risks that could contribute to a bigger issue / risk e.g. failed inspection; • monitoring corporate level risks to understand higher level risks with the organisation; and • identifying relevant staff for risk management training.
All Staff (Including Bank and Agency staff)	All staff have a personal responsibility to: • familiarise themselves with this policy; • report all unidentified or potential risks to their line manager/supervisor; and • record incidents and near misses on the incident reporting system.
The Senior Information Risk Owner (SIRO)	The Chief Finance Officer undertakes the role of SIRO for the Trust and is responsible for: • ensuring that the Trust's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff; • providing a focal point for the resolution and/or discussion of information risk issues; and • ensuring the Board is adequately briefed on information risks.
Company Secretary	The Company Secretary is the lead for corporate governance, risk management and the Board Assurance Framework (BAF) and is responsible for: • ensuring that an effective risk management system is in place within the organisation which meets all statutory requirements and best practice guidance issued by the Department of Health and Social Care, as delegated by the Chief Executive; and • managing the strategic development and implementation of organisational risk management.

Risk Officer	The Risk Officer reports directly to the Corporate Governance Manager and in turn the Company Secretary. The Risk Officer will offer assistance, training and support to all involved in risk management and ensure the risk management system is kept up to date and is used in accordance with this policy and procedures across the organisation. The Risk Officer is responsible for: • the maintenance of a fully effective risk management system which supports the strategic direction of the Trust; • the day to day administration of the risk management system; • producing reports documenting progress of risks under various remits; • keeping an overview of all risks being entered on the system so as to report on any trends forming within the management of reported risks (Appendix 6A); • providing training and support to the Risk Handlers e.g. via drop in sessions and workshops on risk management and the risk management system; • providing training and support to all responsible for inputting on the risk management system; • attending key meetings to ensure the recording and actioning of risks discussed and reporting on these to the Risk Group; • ensuring maintenance and development of the Corporate/High Level Risk Register and the BAF; • providing input to the creation of and review of risk related documents for the Trust; • receiving and collating information on risks within the Trust, monitoring new developments in risk management, developing knowledge and expertise and acting as a liaison point for risk management issues, both within the Trust and with external bodies; and • monitoring proposed developments and initiatives and checking they are compliant within good risk management practice.
Risk Handler	The Risk Handler will enter risks onto the risk management system and ensure these risks and their associated actions are reviewed by the Risk and Action Owners ensuring they remain current and up to date and is responsible for: • co-ordination and maintenance of their areas risk register entries, using the risk management system. • being the central contact point for the collation and escalation of key risks within their area; • being the distribution point within their area for the cascade of any information about risk management; • liaising throughout, and to lead within, their area on all aspects of risk management; and • receiving additional appropriate training on risk management and the risk management system via drop in sessions and workshops.
Chairs of meetings	Chairs of meetings should ensure that records of meetings are completed to include explicit identifiable detail of the risks discussed (Datix ID No.) and of the actions agreed to be taken. Chairs should regularly seek assurance that the corresponding entries on Datix are updated to reflect the discussion of individual risks at their meetings.

Appendix 2 - Risk Management Structure & Accountability

Title	Responsibilities
Trust Board	Responsible for: • articulating the key risk management priorities for the Trust; • protecting the reputation of the Trust; • providing leadership in risk management; • determining the risk appetite for the Trust; • ensuring the approach to risk management is consistently applied; • ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately; and • endorsing risk related disclosure documents.
Audit Committee	On behalf of the Board, responsible for: • providing oversight of the establishment and maintenance of an effective system of assurance on risk management and internal control, across the whole of the Trust's activities that supports the achievement of the Trust's objectives; • ensuring the Board Assurance Framework (BAF) is received at each meeting, and appropriate consideration is taken during its review, • utilisation of Internal Audit, External Audit and other assurance functions as appropriate.
Quality Assurance Committee	Responsible for: • reviewing the establishment and maintenance of effective systems in relation to clinical and social care services to ensure the delivery of high quality, person-centred care against the Trust's quality strategy, local account of adult social care, carer's strategy and annual quality account; • receiving and reviewing at each meeting at least two deep dives of corporate level risks linked to the Trust's clinical and social care services; • receiving annual assurance reports in relation to clinical and social care services including infection control and safeguarding; • receiving and reviewing key person-centred submissions to national bodies and to make recommendations for sign-off by the Trusts Board; • receiving the annual clinical audit programme and assurance of the effectiveness of the Trust's clinical and social care audit function; • reviewing the quality related risks on the BAF and CRR.

Finance, Performance and Digital Committee	Responsible for: • scrutinising the development of the Trust's annual financial plan and long-term financial strategy and plan (both revenue and capital plans), including the underlying assumptions and methodology used, ahead of review and approval by the Board; • reviewing the Trust's monthly financial performance and identifying the key issues and risks requiring discussion or decision by the Board, recognising that the primary ownership and accountability for the Trust's financial performance rests with the Board; • conducting an annual review of service line reporting and discuss the implications for potential investment or disinvestment in services; • approving and keeping under review, on behalf of the Board, the Trust's investment and borrowing strategy and policies; • evaluating, scrutinising and approving the financial validity of individual investment decisions, including through the review of outline and final business cases; • reviewing post-implementation investment audits undertaken by or on behalf of the Trust. These should be carried out 12 months after business case approval; • receiving and reviewing the Trust's Financial, Performance and Digital risks scoring 12 and above; and • reviewing the financial, performance and digital related risks on the BAF.
People Committee	Responsible for: • reviewing national workforce guidance and strategies, for example the NHS People Plan, and their applicability to the Trust. • considering and recommending to the Board, the Trust's overarching People Plan and associated activity/implementation plan(s) to support Trust forward strategy. • obtaining assurance and monitoring delivery of the People Plan through the associated activity/implementation plan. • considering and recommending to the Board the key people and workforce performance metrics and targets for the Trust. • receiving regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. • reviewing and providing assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance. • reviewing workforce related risks identified on the Corporate Risk Register and seeking assurance in relation to risk mitigation and future activity/plans. • reviewing workforce related elements of the Integrated Performance Report and seek assurance on the adequacy of the Trust's performance against operational workforce metrics. • conducting reviews and analysis of strategic people and workforce issues at national and local level

	and, if required, agree the Trust's response. • reviewing workforce performance and metrics at intervals to be decided by the Committee. • providing assurance to the Audit Committee that that arrangements are in place to allow staff to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently. • seeking assurance on the adequacy and effectiveness of staff communication and levels of staff engagement
Executive Team	Responsible for: • collectively reviewing the BAF and updating so that it can be escalated through the Risk Group to the Audit Committee and on to Board; • ensuring that strategic and operational risks are actively monitored and managed within their areas of the business; • being owner and action owner of individual Board level risks on the BAF (including those delegated by the CEO), and • devising short, medium and long-term strategies to tackle identified risk, including the production of any mitigating action plans.
Risk Group	Responsible for: • reviewing and approving validated potential Corporate/High Level Risks for addition to the Corporate Risk Register • reviewing and approving Corporate Level Risks that no longer meet the scoring requirements to remain at that status with the view to down grading them to Non-Corporate Level Risk status • reviewing the Corporate Level Risk Register and Board Assurance Framework (BAF); • creating a new theme or overarching risk identified through the 'risk theme identification process'; • ensuring the co-ordination of the Trust's BAF and supporting risks, acting as a forum for examining and rating Potential Corporate/High Level Risks identified within the Trust and executing those recommendations; • implementing the Risk Management Strategy and providing a Trust-wide focus on the identification, control and management of risk in the development and delivery of the strategy in line with the International Standards Organisation (ISO) 31000 risk management standard; • ensuring that internal standards and procedures regarding strategic objectives / risks are developed, implemented and regularly reviewed by the relevant groups or managers; • ensuring the development and implementation of adequate, relevant and effective reporting, communication and information dissemination systems with managers and staff to comply with the ISO 31000 Risk Management Standard;

	• ensuring at each meeting that emerging risks are discussed; • monitoring the monthly Key Performance Indictors (KPI) Scorecard; • ensuring any actions and/or action plans are being linked to risks and ensuring risks are being updated accordingly; • providing regular progress reports to the Audit Committee; and • responding to the recommendations of the Audit Committee, ensuring that, where appropriate they are acted upon.
Integrated Service Units (ISU)	Responsible for: • ensuring that strategic and operational risks are actively managed at the right level within their areas of the business; • ensuring risks and their associated actions within the ISU are reviewed in a timely manner, escalating any potential Corporate/High Level Risks to the Risk Group; • ensuring actions plans/points are in place, leads are identified and timescales for delivery are recorded and then monitored to completion; and • ensuring risks are discussed at ISU meetings and recorded within the minutes using the relevant risk number.
Executive Assurance Level Groups/Committees	Responsible for: • ensuring that strategic and operational risks are actively managed at the right level within their areas of the business; • ensuring risks and their associated actions within the Group/Committee are reviewed in a timely manner, escalating any potential Corporate/High Level Risks to the Risk Group • ensuring actions plans/points are in place, leads are identified and timescales for delivery are recorded and then monitored to completion; and • ensuring risks are discussed at meetings and recorded within the minutes using the relevant risk number.

Appendix 3- Potential Consequences

Choose the Risk Type from the rows below, then select the Consequence from the column.

Consequence (Impact) Score and Examples of Descriptor

Score >	1	2	3	4	5
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Clinical Safety Risk *(Physical/ Psychological)*	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – any adverse event that ran to completion but no harm occurred.	Minor cuts or bruising, resulting in: - Any safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons. Affects 1-2 people.	Moderate injury resulting in: - Professional intervention. - Increase in length of hospital stay by 4-15 days. - An event which impacts on a small number of patients. - A referral to A&E. Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Moderate injury or illness requiring professional intervention. Affects 3-15 people**.**	Major injury resulting in: - Life changing injury/s. - Major injury/long term incapacity / disability (e.g. loss of limb). - Any incident /accident that could result in a RIDDOR reportable incident. Major untoward clinical / non-clinical issue leading to significant harm / death which requires investigation with executive director involvement. Increase in length of hospital stay by 15 days plus. Mismanagement of patient care with long-term effect. Affects 16 – 50 people.	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Multiple Deaths / Fatalities. Major untoward clinical issue either in a single specialty which requires executive or an independent review. Or a single clinician referred to the GMC due to clinical management. An event effecting 50 people plus.
Performance Risk	Failure to meet departmental standards or KPIs.	Failure to meet Trust / local standards or KPIs.	Failure to meet National standards or KPIs.	Failure to meet professional standards or statutory requirements.	Sustained failure to meet professional standards or statutory requirements.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Environmental Impact Risk	Minimal or no impact on the environment. Minor onsite release of substance. Not directly coming into contact with patients, staff or members of the public.	Minor impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Moderate impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Major impact on environment. On-site release with potential for detrimental effect leading to off-site release with potential for detrimental effect. Involvement by the Environmental Agency	Catastrophic impact on environment. Onsite/Offsite release with realised detrimental/ catastrophic effects. Suspension of Activity by Environmental Agency.
Financial Risk	Small loss £0 – 49k	£50k – £99k	£100k – £249k	£250k – £499k	£500k +
Health & Safety Risk	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – any adverse event that ran to completion but no harm occurred.	Minor cuts or bruising, resulting in: - No lost time or time off work. Affects 1-2 people.	Moderate injury resulting in: - Time off work for up to 7 days. - A referral to A&E. - Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Affects 3-15 people**.**	Major injury resulting in: - Life changing injury/s. - Major injury/long term incapacity / disability (e.g. loss of limb). - More than14 days off work. - Any incident /accident that could result in a RIDDOR reportable incident. Affects 16 – 50 people.	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Multiple Deaths / Fatalities. - Major untoward non-clinical issue either in a single specialty which requires executive or an independent review. An event effecting 50 people plus.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Infection Control & Prevention Risk	Business as usual	- Any Incident recorded for poor Infection control practices i.e cleanliness, hand hygiene practices, failure to perform HPV when requested by IP&C. - Failure to isolate a patient with an Alert organism (IP&CT will advise on level of risk) in a Moderate Risk area. - Sewage leaks. - Failure of Water supply. - Failure of Critical ventilation. - Failure of Decontamination. - Estates failure leading to closure of clinical areas. - HCAI e.g. Surgical Site Infections, CVC infections, Hospital acquired pneumonia, etc.	- Continued lack of compliance with infection control practices. - CDT infection TSDFT Hospital onset Healthcare associated. - MRSA infection (not colonisation) TSDFT Hospital onset Healthcare associated. - Failure to isolate a patient with an Alert organism in a High-Risk area.	- CDT infection >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - MRSA infection (not colonisation) >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - Seasonal flu cases leading to 2 ward closures in TSDFT. 4 or more cases of seasonal flu on ITU leading to cancellation of surgery and transfers out. - Norovirus cases leading to 2 ward closures in TSDFT. 4 or more cases of Norovirus on ITU leading to cancellation of surgery and transfers out. - Failure to isolate a patient with an Alert organism in a Very High Risk area.	- Pandemic, Swine Flu, Etc. CDT infection leading to death >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - MRSA infection (not colonisation) leading to death >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - Pandemic /seasonal Flu cases in hospital leading to cross infection and >2ward closure/and increased deaths. Staff sickness from pandemic/seasonal flu leading to low staffing levels. - Norovirus cases in hospital leading to cross infection and >2 ward closure/and increased deaths. Staff sickness from Norovirus leading to low staffing levels. - Failure to isolate >2 patient with an Alert organism in a Very High Risk area.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Information & Communications Technology Risk	Unplanned loss/interruption of service for up to 1 hour affecting one business critical system. Loss of data from a single business critical system that takes up to 1 hour to recover. Exposure of non-personal or confidential information to those not covered by a data sharing agreement or otherwise unintended.	Unplanned loss/interruption of service for up to 4 hours affecting one business critical system. Loss of data from a single business critical system that takes up to 8 hours to recover. Exposure of embarrassing information to unintended recipients.	Unplanned loss/interruption of service for up to 8 hours affecting one business critical system. Loss of data from a single business critical system that takes up to 24 hours to recover. Exposure of commercially confidential information to unintended recipients.	Unplanned loss/interruption affecting service of one business critical IT systems for up to 24 hours. Temporary loss of data from multiple business critical systems. Exposure of a single individuals' personal information to those not covered by a data sharing agreement or otherwise unintended.	Unplanned loss/interruption affecting service of many business critical IT systems for up to 1 hour. Permanent loss of data from a single business critical system. Exposure of multiple individuals' personal information to those not covered by a data sharing agreement or otherwise unintended.
Information Governance Risk	Failure to meet departmental standard.	Failure to meet Trust / local standard. - GDPR Incident raised on Datix.	Failure to meet national standards or KPI.	Failure to meet professional standards or statutory requirements.	Sustained failure to meet professional standards or statutory requirements.
Operational Risks	Loss/interruption of up to1 hour.	Loss/interruption of up to 8 hours.	Loss/interruption of up to 1 day.	Loss/interruption of up to 1 week.	Permanent loss of service or facility.
Patient Experience Risk	Reduced level of patient experience not directly related to delivery of care.	Unsatisfactory patient experience, readily resolvable.	Mismanagement of patient care. Unsatisfactory management of patient care – local resolution (with potential to go to independent review).	Serious concerns re patient experience for a particular patient or about a particular clinical service / clinician which required executive director involvement in investigation and onward action. Unsatisfactory management of patient care with long term effects. Significant result of misdiagnosis.	Totally unacceptable patient experience that would lead to an investigation by the CQC e.g. Mid Staffordshire. Totally unsatisfactory patient outcome or experience. Incident leading to death.

Consequence (Impact) Score and Examples of Descriptor*(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Reputation /Risk	Complaint / Rumours. Derogative posts on Social Media, (Facebook/Twitter/Instagram). Potential for public concern. Informal/locally resolved complaint. Potential for settlement/litigation up to £5K.	Local media coverage, short-term reduction in public confidence. Shared derogative posts on Social Media, (Facebook/Twitter/Instagram). Elements of public expectation not being met. Overall treatment/service substandard. Formal justified complaint Minor implication for patient safety if unresolved. Claim up to £10K.	Local media coverage. Long-term reduction in public confidence. Sustained postings of derogative posts on Social Media, (Facebook/Twitter/Instagram). Justified complaint involving lack of appropriate care. Major implications for patient safety if unresolved. Claim(s) between £10K-£100K.	National media coverage with <3 days service well below reasonable public expectation. Petition raised on Change.org or other social media platform. Multiple justified complaints leading to Independent review. Noncompliance with National standards with significant risk to patients if unresolved. Claim(s) between £100K-£1M.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House.) Total loss of public confidence. Multiple justified complaints - Single major claim - Inquest/ ombudsman inquiry -Claim >£1M

Appendix 4 - Assessment of Likelihood of a Risk

Qualitative and Quantitative Measures of Likelihood:

What is the likelihood of the consequence described in the Consequence Table, actually happening?

A frequency based score will be appropriate in most circumstances, except in the case of time-limited projects or objectives, where the probability or chance of reoccurrence based score could be used.

Level / Score	Matrix Description	Detailed Description	Frequency	Odds / Probability	% Chance of Occurrence / Reoccurrence
1	**Rare**	Highly unlikely, but it may occur in exceptional circumstance. It could happen but probably never will.	Not expected to occur for years	May occur = 1 in 1000 chance	1 - 5 %
2	**Unlikely**	Not expected but there is a slight possibility it may occur at some time.	Expected to occur at least annually	Could occur at some time = 1 in 100 to 1 in 1000	6 – 25%
3	**Possible**	The event might occur at some time if other factors precipitate or as there is a history of casual occurrence.	Expected to occur at least monthly	Might occur at some time = 1 in 10 to 1 in 100	26 – 50%
4	**Likely**	If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.	Expected to occur at least weekly	Will probably occur in most circumstances = 1 in 10 to evens odds	51 – 75%
5	**Almost Certain**	Very likely, The event is expected to occur in most circumstances if the activity continues without controls in place. Or may already be happening.	Expected to occur at least daily	Is expected to occur in most circumstances = evens to certain odds	76 – 100%

Appendix 5 – Risk Scoring Matrix

Consequence / Likelihood	1 - Minimal / Insignificant	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
5 - Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

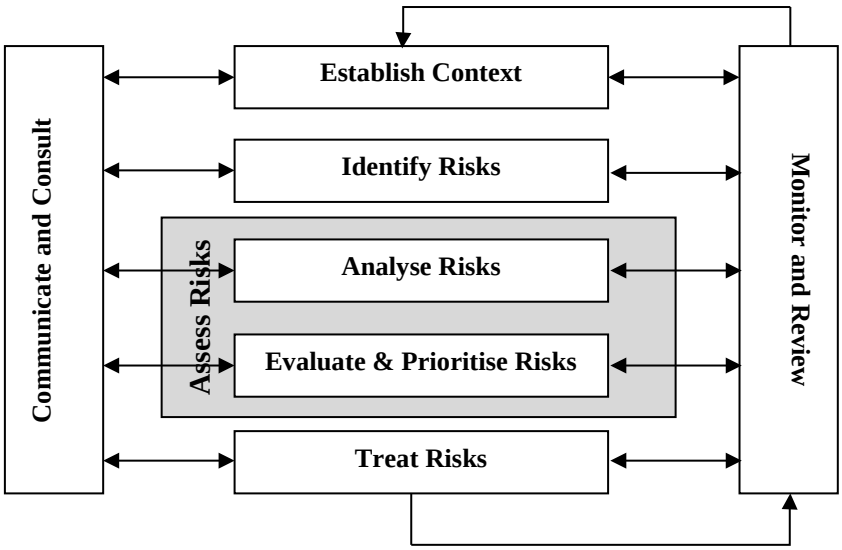
Risk scoring = consequence x likelihood (C x L)

KEY:

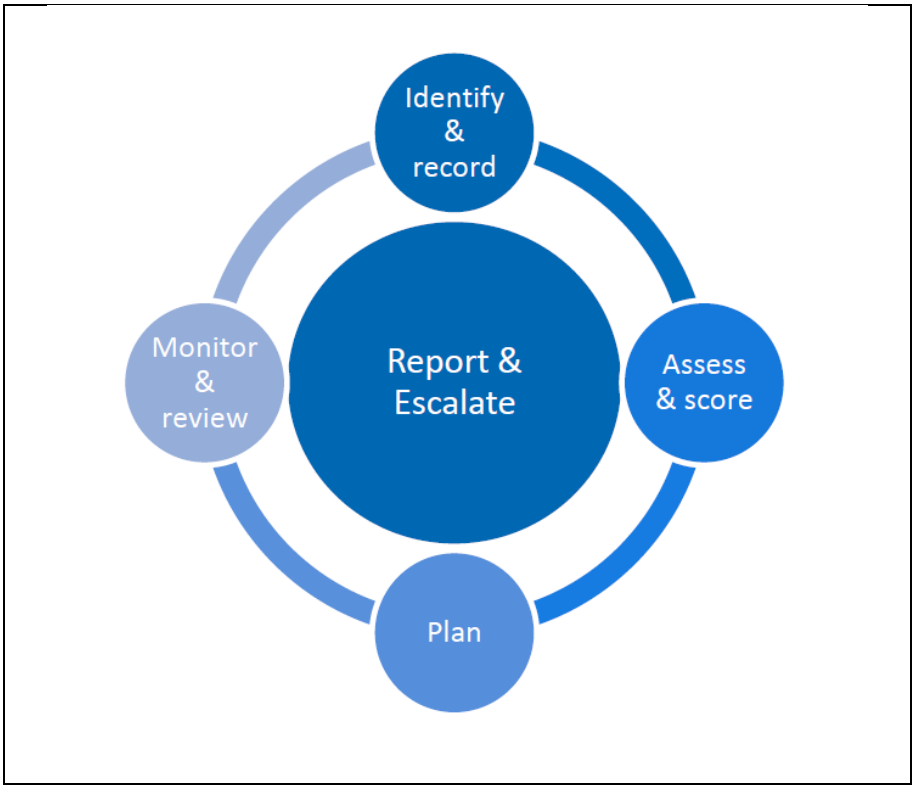
RAG Rating	Expected Level of Management
RED	Executive Team / Board
AMBER	Directorate / ISU
GREEN	General Manager

Appendix 6 - Summary of Risk Management Process

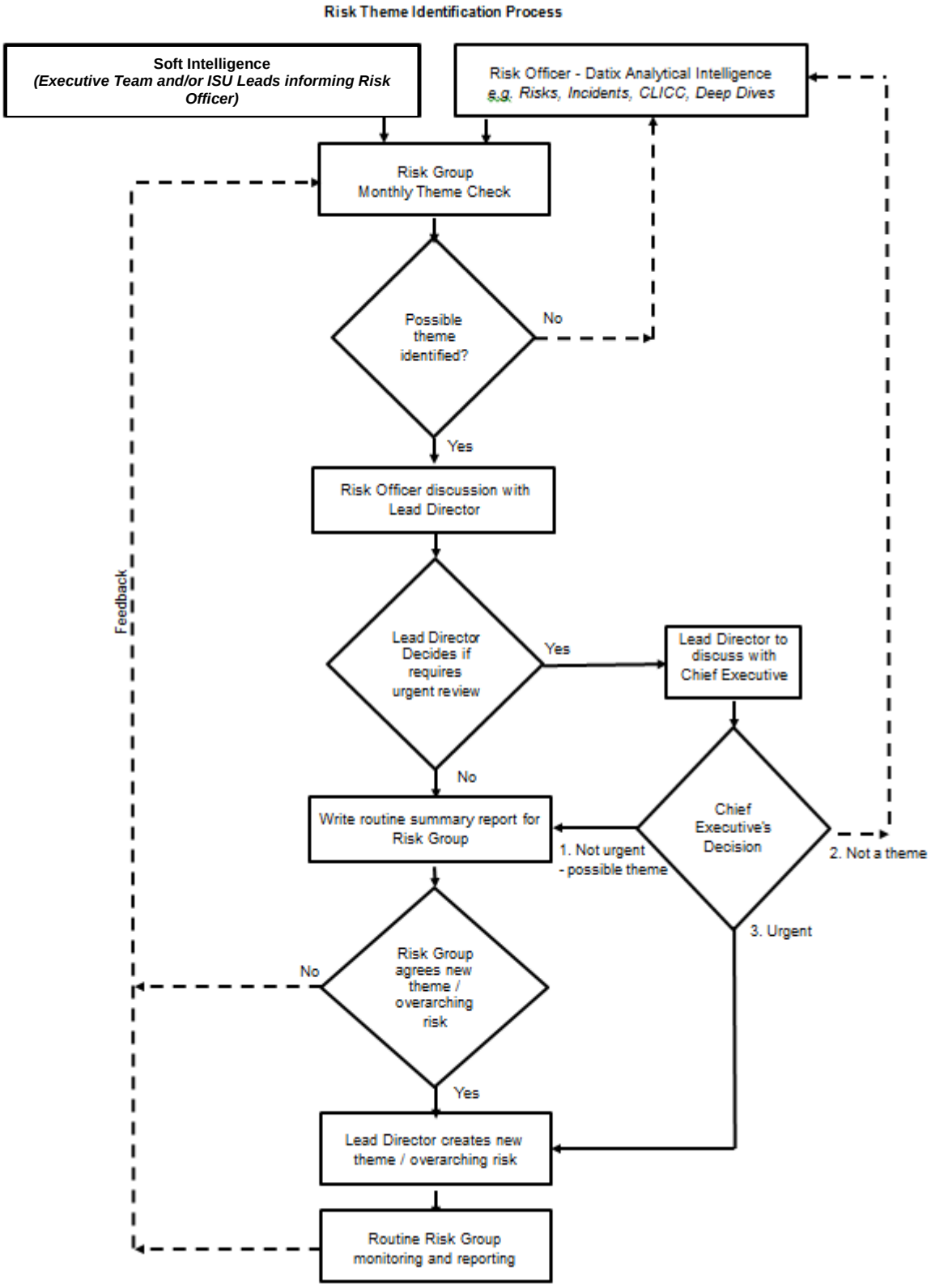
(Adapted from ISO 31000 Risk Management – Principles and Guidelines)



A risk can be any event that **might** occur or is occurring which **could or is** affecting the ability of the Trust/ISU to achieve its **objectives** – it is what could happen, how it could happen and who could be affected by it.



Appendix 6a - Risk Theme Identification Process

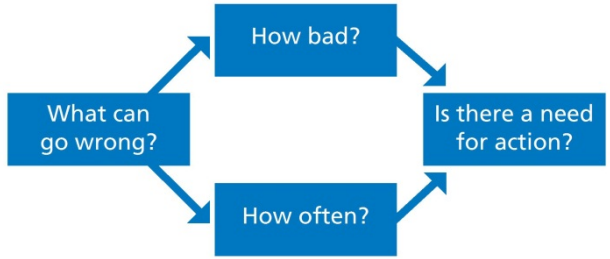


Appendix 7 - Key References

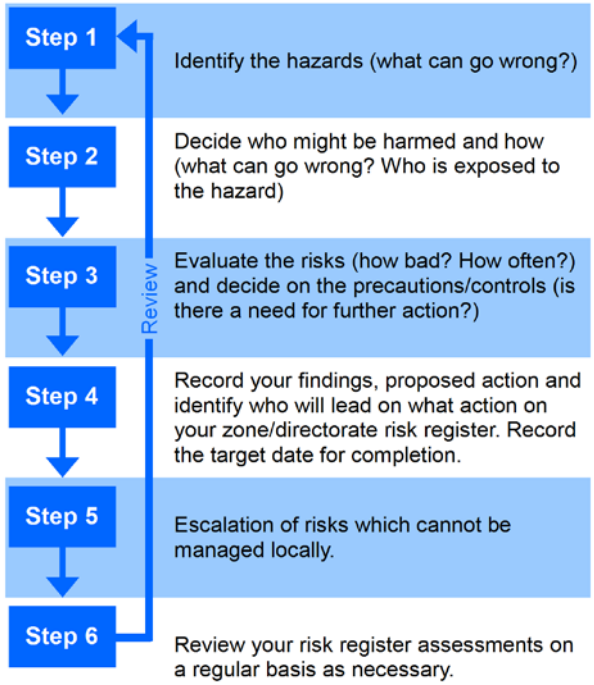
• The Healthy NHS Board 2013 – Principles for Good Governance • Francis Enquiry report into Mid-Staffs March 2010 • Health & Safety at Work Act 1974 • Seven Steps to Patient Safety (NPSA)	• Internal audit standards for the NHS • Management of Health & Safety at Work Regulations, (2006 Amendment & 1999) • NHS Information Risk Management - Information Governance Toolkit • Information Risk Management for SIROs and IAOs • DH: Information Security NHS Code of Practice (2007) • Audit Committee Handbook 2019.

Appendix 8 - Risk Assessment Tools

What is risk assessment? A risk assessment seeks to answer four simple, related questions:



It is not usually possible to eliminate all risks but health and social care staff have a duty to protect patients/service users, themselves and the organisation as far as 'reasonably practical'. This means you must avoid any unnecessary risk. It is best to focus on the risks that really matter – those with the potential to cause harm either clinically, financially or to the organisation as a whole. Keep risk assessment simple – do not use techniques that are overly complex for the type of risk being assessed.



In a risk assessment we need to look at:

Hazards – A hazard is something with the potential to cause harm. The harm could be injury or illness, damage to equipment or premises or some other loss.

Risks – A risk is the likelihood that a hazard will cause actual harm, or effect the successful operation of the organisation, department or project. (i.e. the consequence)
For each hazard identified it is important to decide whether it is significant and whether appropriate and sufficient controls or contingencies are in place to ensure that the risk is properly controlled.

Controls – Controls are the arrangements made, or the precautions taken, to a reduce risk. (It is what is in place now)

Risk Score/Rating – A risk score or rating is the calculation of hazard consequence x likelihood, taking into account current controls.

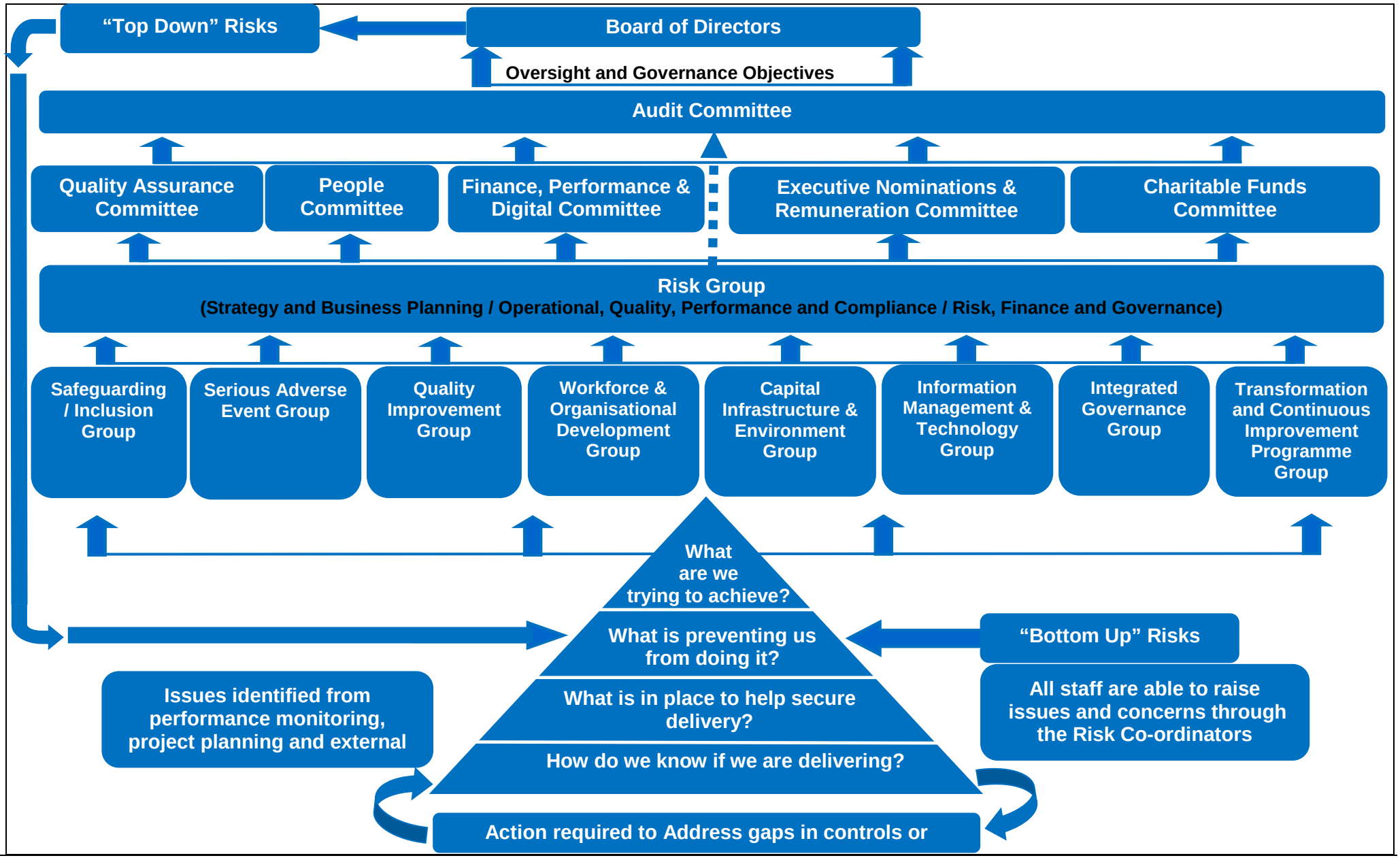
Risk Register – The Risk Register is where risks, once identified, are managed on a day to day basis.

Appendix 8 - Risk Assessment Tools *Continued*

Understanding the difference between a hazard and a risk – examples

A trailing PC cable lying across the floor is a **hazard**.
The **risk** is that someone trips over it.
If the cable is noticed and cleared by a member of staff, it was a **near miss**
If someone trips up and injures themselves before it is cleared away, this is an **incident**

Appendix 9 - Board Assurance Framework (BAF) Process



(E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	Risk Management Policy	**Version and Date**	V3.2 16/06/2020
Policy Author	Risk Officer		

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☒	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☒	Gender Reassignment	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Disability	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender	Yes ☐ No☒	Pregnancy/Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.	

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion	
Is inclusive language[5] used throughout?	Yes ☒ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☒ No☐ NA ☐
Does the policy encourage individualised and person-centered care?	Yes ☐ No☐ NA ☒
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒ NA ☐
EXTERNAL FACTORS	
Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☒
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)	
To set out Torbay and South Devon NHS Foundation Trust's expectations and procedures on Risk Management.	
Who was consulted when drafting this policy? Members of Risk Group and Audit Committee	
Does this document require a service redesign or substantial amendments to an existing process? *PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below*	Yes ☐ No☒

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Amanda Anders	**Signature**	AA
Validated by (line manager)	Monica Trist	**Signature**	MT

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Torbay and South Devon NHS
NHS Foundation Trust

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

Meeting date:	22nd June 2020
Report by + date:	Chris Balch, 23th June 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 2, June 2020):

1. For assurance the Committee reviewed the Month 2 Financial Performance which excluding Covid-19 expenses and top up income is a surplus of £3.2m. Under the arrangements put in place by DHSC to deal with the Covid-19 pandemic reimbursement for Covid-19 related expenditure and balancing adjustments will result in the Trust showing a break-even position for Months 1 to 4.

2. The control total and business planning/budgets for Months 5 to 12 remain unresolved in the absence of detailed guidance from DHSC/STP. The focus of financial management is therefore on the monthly run rate. In the case of staff related costs this is slightly higher due to increases in pay, although expenditure on bank and agency staff has reduced. Non pay related expenditure is significantly lower due to the reduced level of activity required as part of our response to Covid-19. This may be expected to increase as services are reinstated.

3. The Trust maintains a healthy cash position because of advance payments received as part of the Government's support package for the NHS.

4. The Committee reviewed the Integrated Performance Report for April 2020. This reveals a continuing focus on quality, a reduction in staff turnover, above target but reducing levels of staff sickness, maintenance of mandatory training targets but falling rates of appraisal. These changes are fully consistent with the impact of Covid-19.

5. Improved ED waiting times have been maintained because of reduced attendance. However, the deterioration in other headline indicators has continued because of the significant reduction in elective treatment and reduced diagnostic activity as a result of social distancing and infection control requirements.

6. The Committee discussed the draft CQC use of resources report and the emerging response to the recommendations. Plans were outlined for the development of a Medium-Term Finance Plan to address the challenge of achieving financial sustainability. It was agreed that this will be an important piece of work to guide future decisions of the Trust.

7. The challenges involved in standing back up its services in a Covid-19 world were discussed in the context of both short term and longer-term capital requirements. Allocations of capital for 2020/21 remain under discussion with the STP and NHSE/I. It

was emphasised that the inability to fund the capital programme agreed by the Trust for 2020/21 will result in a significant increase in risk which is being addressed through projects such as the IT network replacement. It will also limit the ability of the Trust to improve performance standards.

8. The status of the Wave 3 project for improved ED facilities was discussed. Significant changes have occurred in the original assumptions underpinning the plans which have been approved by NHSE/I including the need for additional space to operate in a Covid-19 world. An options appraisal is being developed as a matter of urgency explore possible alternative approaches including the possibility of bringing forward investment proposals for elective surgery and diagnostics. There is currently no funding for such schemes although they might be considered as part of enabling expenditure for the HIP2 programme if a strong enough case can be built and the support of key stakeholders mobilised.

9. The Committee agreed an approach to the consideration of Post Implementation Reviews of projects approved by the Trust to ensure that key learning points and captured and shared.

10. The Committee reviewed the risks identified in the updated Board Assurance Framework and was assured by the fact that these are the focus of much of its agenda.

11. The Committee received the report on the IT outage experienced in September 2019. This highlighted the very real nature of the risks faced by the Trust and the need to ensure that Business Continuity Plans take full account of the potential impact of infrastructure failures.

12. Reports were received and noted on:

    - Torbay Pharmaceuticals financial performance in Month 1
    - The work of the Capital Infrastructure and Environment Group including progress with key projects and the disposal of surplus assets.
    - IM&T Group

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Chris Balch (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

Report of People Committee Chair to the Board of Directors

Meeting date:	22nd June 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:

- **Learning from COVID** – work is being led by DWFOD to ensure that the Trust captures the learnings that have come from the COVID crisis and integrates these learnings in to future strategies, policies and practices.
- **System working** – the Committee was pleased to learn that the DWFOD has been appointed as the Lead for the regional workforce planning work as we continue to keep a watchful eye on agency spend, vacancy factors and recruitment issues. The Committee are seeking greater assurance that future roles, and the skills required to do those roles, are being considered and strategies to future proof the Trust will be integrated in to the forthcoming People Plan.
- **Appraisals** – as we move in to the recovery phase, the Committee was pleased to hear that the Trust is standing back up the expectation that achievement reviews and appraisals will be undertaken. Completion rates have been falling over recent years - from 83.33% in 2016 to 78.88% in 2019 against a target expectation of 90% - and this despite a repositioning of appraisals in 2018. The Committee was supportive of the proposed work to conduct an appraisal deep dive and asked that we address the question of quality as well as quality and get an accurate assessment of what stops managers from completing reviews. We encouraged expediency in this work as a strong performance review process will be critical to the difficult recovery phase that we are currently in.
- **Agency spend** – the Committee was advised that expenditure had reduced in the previous month due, in the main, to staff reassignment during the COVID period. The DWFOD advised us that the winter incentive payments that had been used earlier in year to encourage staff to work overtime and minimise agency usage had been successful and the approach would be used again this year.
- **Equality & Diversity** – the Committee received the report from the Equality Business Forum and noted the diversity data which formed part of the workforce information report. Currently only 6.24% of the Trust's staff classify themselves as BAME. The Committee asked whether this percentage, which seems low, is in line with the BAME percentage of our population and whether the Trust's aspirations should be higher in this area. DWFOD agreed to pick this up and bring a view to the next meeting.

Key decision(s)/recommendations made by the Committee:

1. Approach to the deep dive review for appraisals and achievement reviews signed off with a strong steer that the review should encompass quality and quality of reviews and an insight in to current blockers.
2. Information on the Trust's target for BAME staff was requested.

Torbay and South Devon
NHS Foundation Trust

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

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	x	**Risk score**	16
Risk Register	x	**Risk score**	16

External standards affected by this report and associated risks

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

Report title: Safer staffing and nursing work programme update		Meeting date: 29th July 2020
Report sponsor	Chief Nurse and Deputy Chief Executive	
Report author	System Director of Nursing and Professional Practice – South Devon	

1. Introduction

The purpose of this report is to provide information and assurance monthly to the Board regarding the Nursing and Midwifery Safer Staffing levels. The information supplied and triangulated is for June 2020. This report will also reflect the safe staffing element of maintaining standby for COVID19 and subsequent recovery/transition phase.

2. Discussion

2.1 COVID 19 Staffing – Stand up, Stand down, Standby

The coronavirus 19 infection has been circulating since 24th February in Torbay, we have seen a significant reduction of the number of patients admitted to hospital, this is also reflected in infections in the UK which have substantially reduced towards as at the end of June. Increased reduction of the lockdown restrictions has been phased and we are yet to see the impact of this. There are ongoing preparations for a second wave to impact utilising the learning from COVID 19.

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, were asked to volunteer themselves to be accepted temporarily on a register for up to 2 years. We had 14 Registered nurses who we processed and of these 9 were welcomed into the Trust. However, the national programme for recruitment of bring back staff is being stood down from 31st July to be managed locally

Year 3 Student nurses are being paid placement as Band 4's who will then be registered onto the NMC register after 6 months, we have welcomed 78 into the organisation. The paid placement aspect completes on the 31st July.

The COVID 19 workforce surge plans still remain the framework for delivery of any potential COVID outbreaks.

2.2 Exeter Nightingale

Exeter Nightingale will open early July 2020 for 112 beds and is progressing with the care model that includes oxygen dependent patients. As a Trust we are working in partnership with the STP and are supporting the provision of this in a variety of different mechanisms. Within workforce we are supporting a proportion in the opening of phase 1 (Daisy ward) and phase 2 (Clover ward) of the beds, this equates to opening of a total of 48 beds. We have currently seconded 8wte Registered nurses, 7.6 wte healthcare workers and 1.8 wte physiotherapy, 0.4 wte Matron, 0.2 wte infection prevention and control for the first 24 beds. An expression of interest for phase 2 staffing requirements for bed opening will be published in July with the .

2.3 Model Hospital Data

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. This now includes allied health care professionals and qualified nursing associates if they provide direct patient care as part of ward establishments, at present Torbay and South Devon NHS Foundation Trust does not include allied health care professionals and qualified nursing associates.

Currently during COVID-19 the national reporting and collation of data was stood down towards the end of March, as a Trust we were able to complete this and we are currently still capturing this information locally. During June the national reporting was reopened and information from March onwards was requested and has been provided, however model hospital has not been updated and are awaiting confirmation when this will occur.

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

The Table below shows the Trust CHPPD position for June 2020 alongside national median data and peer regional data. The Trust remains above the national and peer RN range at 4.98 and significantly above the national and peer for HCAs at 5.34.

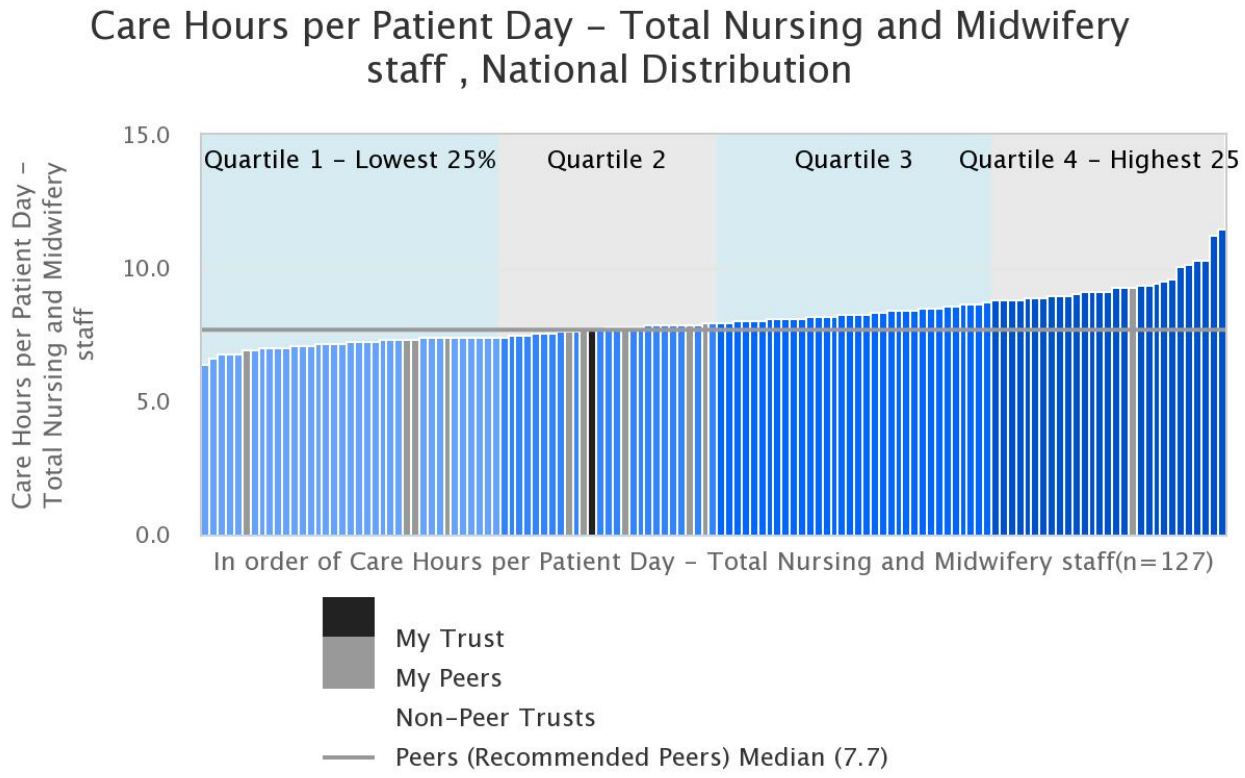
For June 2020 our position in the Trust has demonstrated that our overall comparison of total CHPPD is 10.31 against a national median of 7.9 (National data is December 19) and peer value of 7.7. The RN CHPPD position demonstrates that we are an outlier in relation to actual versus planned care hours, showing a large increase, however June has seen a decrease in this but still outside the December 2019 peer and national values. This is due to the response to working within Covid 19 and the reduction of activity, and increased bed capacity this has provided a position where true comparative data cannot be reviewed in the main.

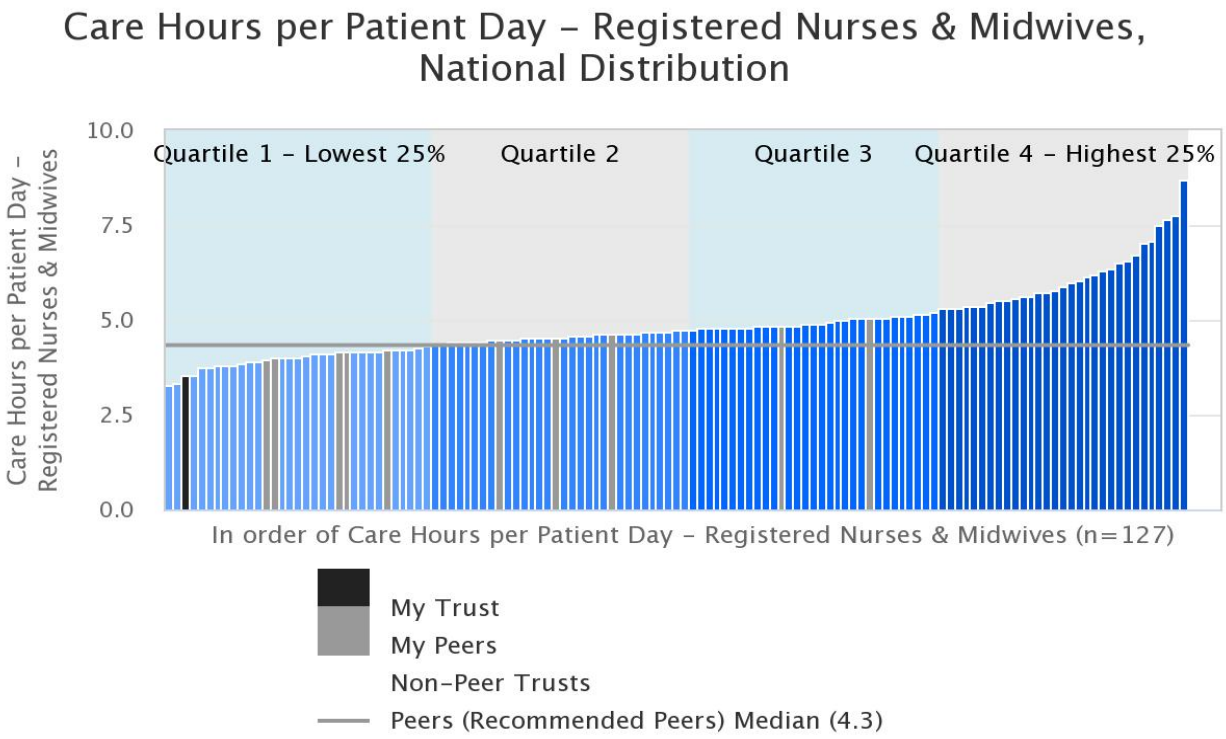
HCA CHPPD position has decreased from 6.10 in May to 5.34 in June which is a decrease from previous months, we still remain an outlier in relation to our peers and national position (see below graphs from model hospital), we know that this is due to current situation of COVID -19 response, recovery/transition of services to a stand up, standby and stand down mode, as well as enhanced supervision and backfill for unfilled RN shifts where it is deemed safe. Alongside the reconfiguration of the Trust COVID-surge response plans.

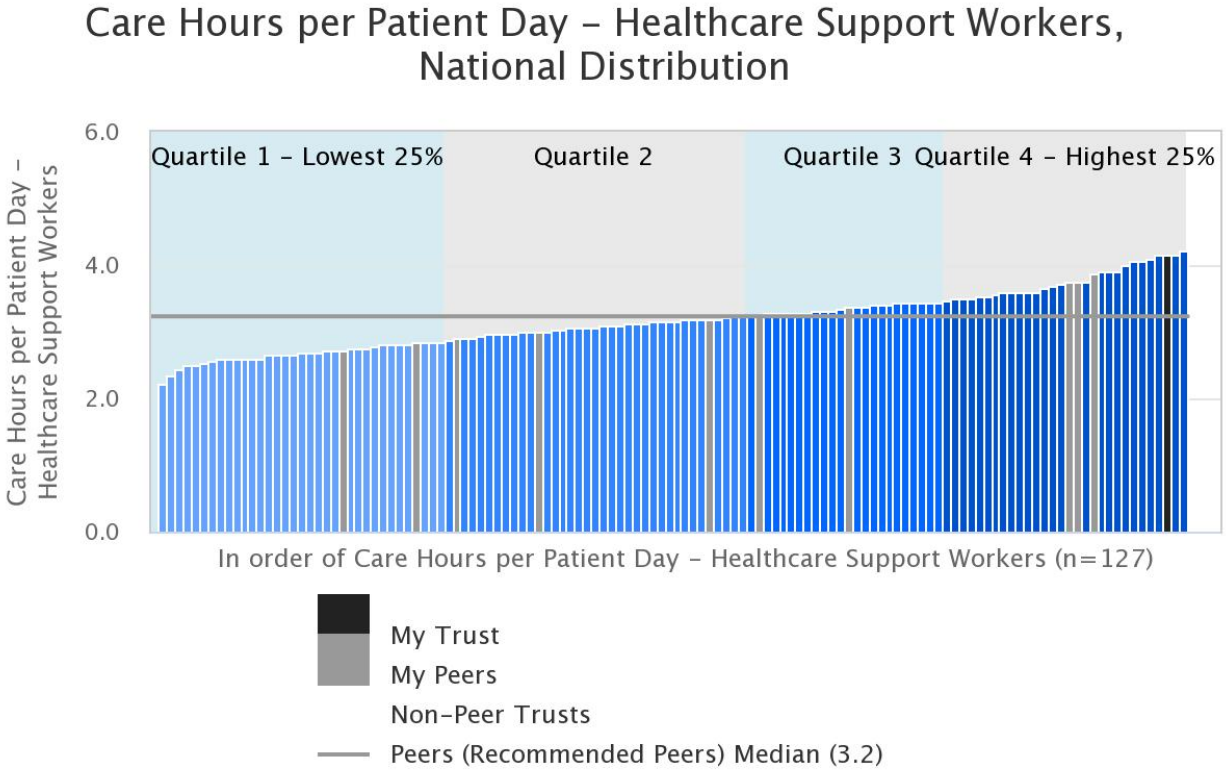
We are working on recruitment and retention solutions to address the registered nursing vacancies, which includes recruiting students from paid placements and the opening of international travel arrangements, as well as the effects that Covid 19 have had we may see a geographical change which will provide increased recruitment to RN posts.

									Model Hospital		
	TSDFT June 2020	TSDFT May 2020	TSDFT April 2020	TSDFT March 2020	TSDFT February 2019	TSDFT January 2020	TSDFT December 2019	TSDFT November 2019	TSDFT Dec 2019	Peer – Region Dec 2019	National Median Dec 2019
Total CHPPD	10.31	11.64	14.31	9.40	7.88	7.96	7.56	7.83	7.6	7.7	7.9
RN/ RM CHPPD	4.98	5.54	7.22	4.44	3.95	3.69	3.54	3.64	3.6	4.3	4.7
HCA / MCA CHPPD	5.34	6.10	7.08	4.96	3.93	4.27	4.02	4.19	4.1	3.2	3.2

Model Hospital data – December 2019 data



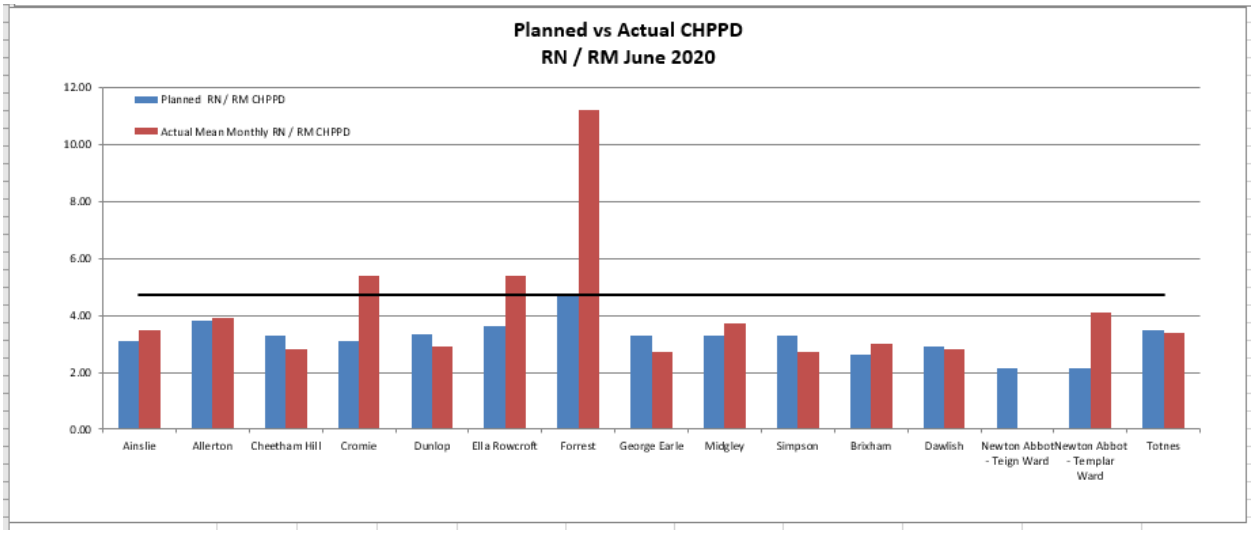


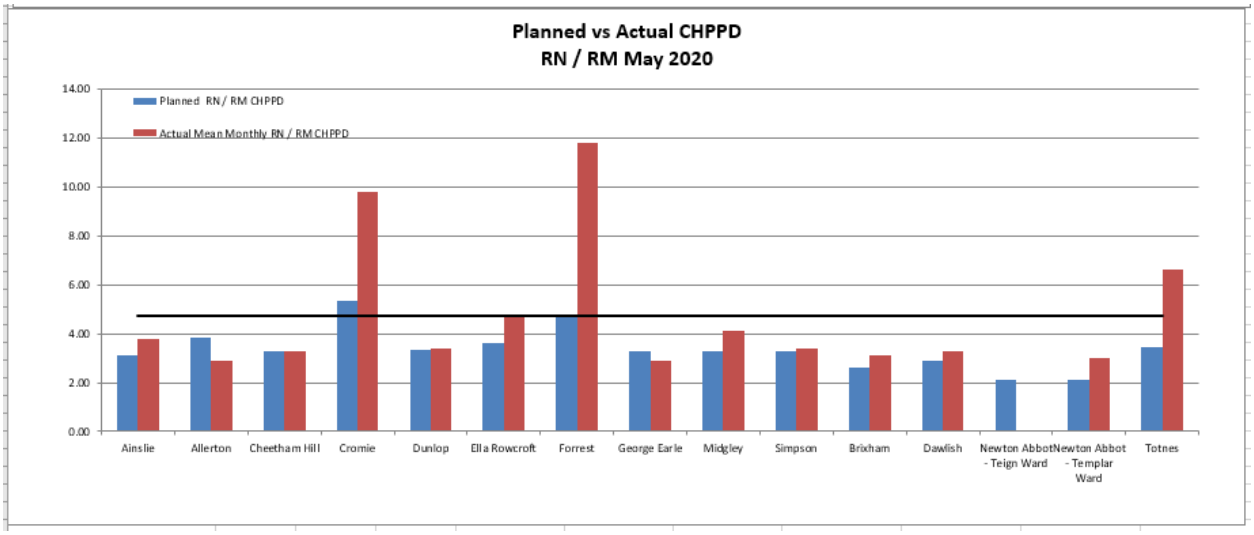


The graphs below illustrate the CHPPD data in June 2020 distributed separately for RNs and HCAs and shown as a total of all nursing staff. The model hospital data should be viewed with caution as it relies on accurate input from providers and validation of the accuracy is still in progress.

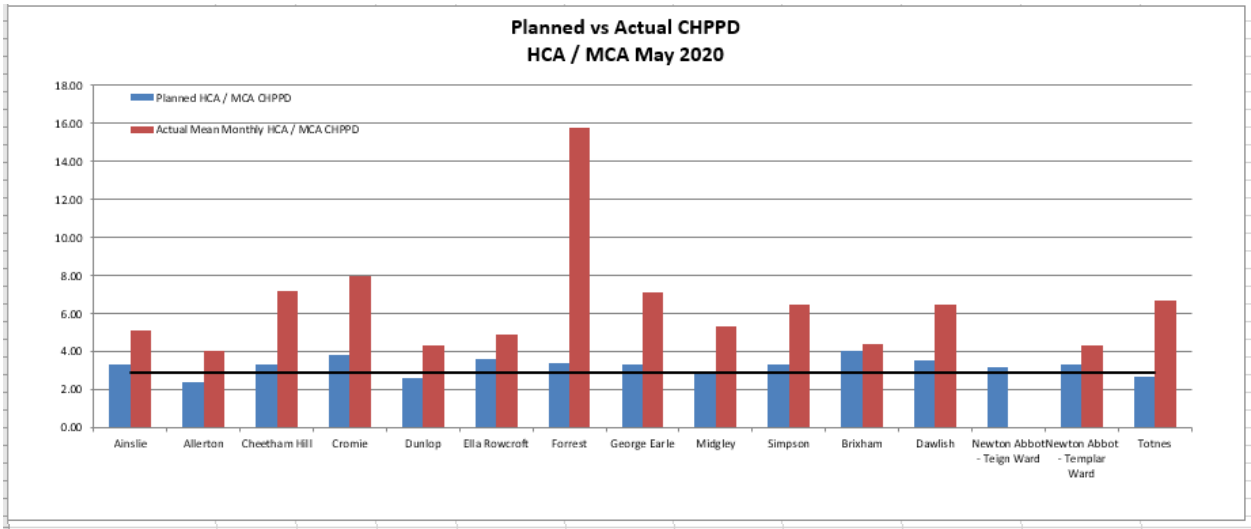
The graphs below reflect the position of the Trust during June where we still see RN and HCA above planned, this is due to the continued Covid19 response and reduced activity. The Trust responded to Covid19 through local reassignment of staff where base

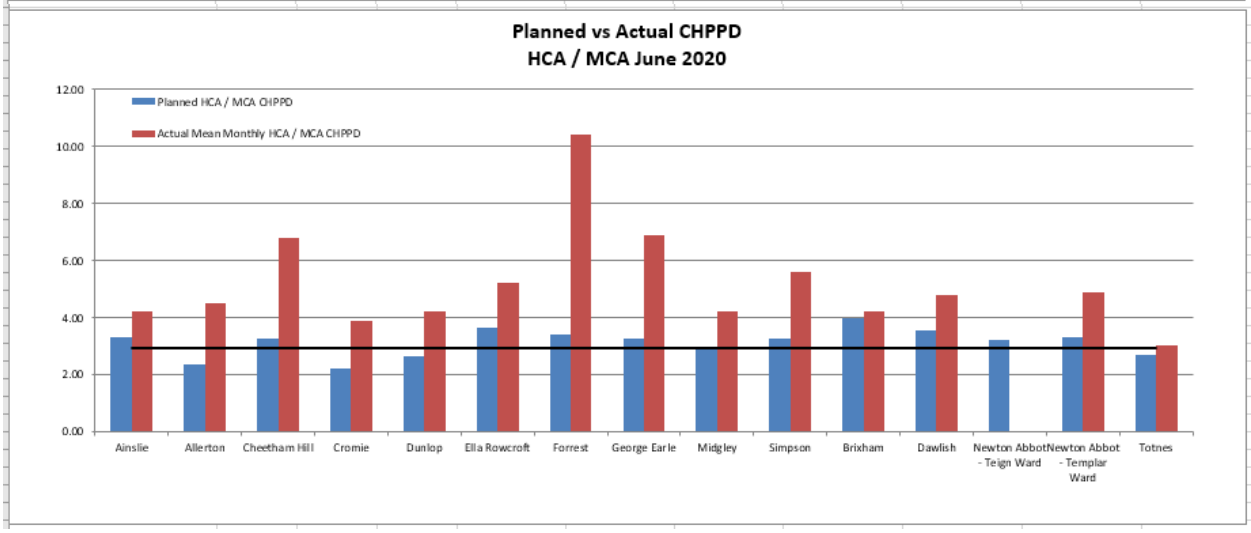
areas of work had activity stepped down and where bed occupancy remained low. We are now seeing an increase in activity and increased bed occupancy, whilst working through the post Covid 19 recovery phase.





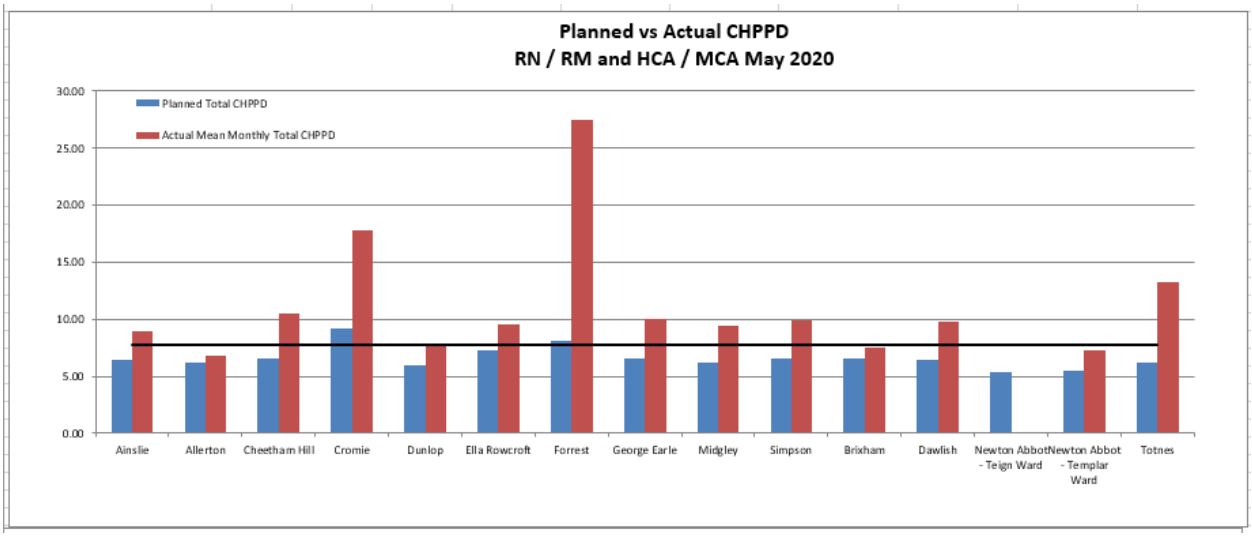
The graph above show that there are a number of areas where the actual RNs are above the current planned RN numbers; this in relation to the changes occurred within the organisation as a response to COVID-19 and the organisation moving to transition of standing services back up, whilst maintaining a standby modality and flexibility to stand down activity and respond in a timely fashion. Services are starting to move back to original or new locations, alongside the increasing remote working in a number of settings.

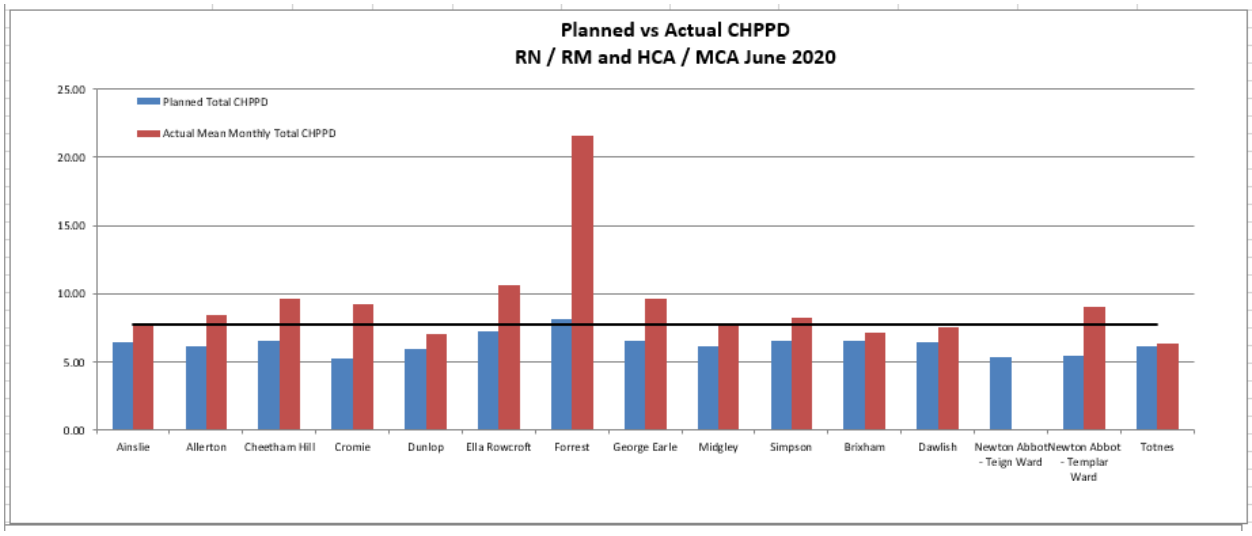




The graph above show that there are a number of areas above the current planned HCA numbers. This is in response to reduced activity and reduced bed capacity, there is also a required for ensuring enhanced care supervision to our patients requiring 1:1 supervision.

There are a number of areas where the RN/ HCA or both fell above planned levels, and there are also a few areas where the RN/HCA was above planned levels.





Safecare has provided Trustwide visibility of safe staffing across the organisation alongside real time acuity and dependency of patients within inpatient ward areas. This has allowed for areas to be much more fluid with staffing flexibility to ensure all areas across the Trust have safe staffing levels.

There has been a significant increase since February data on the number of areas where the actual RN/HCA or both are above the planned levels, this is primarily due to Covid 19 response, however June has seen a significant decrease as staff return to their areas and being transitioning to pre covid acitvity.

Other reasons include:

- Year 3 student nurses are on paid placement until 31st July 2020
- Daily safe staffing meetings reviewing safecare to increase flexibility of staffing across the organisation to maintain safe staffing levels, this has received positive feedback of its scrutiny and reduced reliance on temporary staffing,
- Bed occupancy has been and remains lower than 75%
- Bring Back staff – retire and return have provided further but limited resource

Actions over next month:

- Due to the COVID-19 situation monitoring and reporting will continue as the situation for each inpatient area will remain fluid as an organisation as we respond to the surges in different parts of the organisation.
- International recruitment will slowly reopen to travel arrangements and completion of competencies.
- Visibility and scrutiny of temporary staffing usage will continue on a daily basis through daily staffing meetings using safecare and weekly scrutiny meetings.
- To arrange an enhanced observations task and finish group to review and identify proposals for managing this area within the organisation

2.4 Organisational Alert status

This report includes an overview of the organisational Opel status which provides an indicator of the operational pressures present within the system, and therefore is a proxy indicator of the effects on clinical staffing.

The alert status for the organisation in June 2020 is summarised in the table below. The table demonstrates that during June 2020 the Trust experienced more days at Opel 1 and 2 with 0 days at Opel 3 and 4.

Overall the Trust experienced 73.3% of the time in Opel 1 demonstrating 22 days out of 30. For June 2020 the Trust spent 100% of the month in either Opel 1 or Opel 2. This demonstrates an overall improvement especially when activity has increased to near pre-covid 19 numbers an maintaining less than 75% occupancy.

TSDFT Alert Status	*No Days in Month June 2020*	*% days in Month*	*No Days in Month May 2020*	*% days in Month*
Opel 1	*22*	*73.33%*	*21*	*67.7%*
Opel 2	*8*	*26.66%*	*9*	*29.0%*
Opel 3	*0*	*0%*	*1*	*3.2%*
Opel 4	*0*	*0%*	*0*	*0%*

2.3 Newton Abbot ISU - Emergency Department

The department is continuing to use resources from temporary staffing and have a number of staff reassigned due to our upskilling for COVID-19 surge and they continue to run two departments Covid19 and non Covid19 areas.

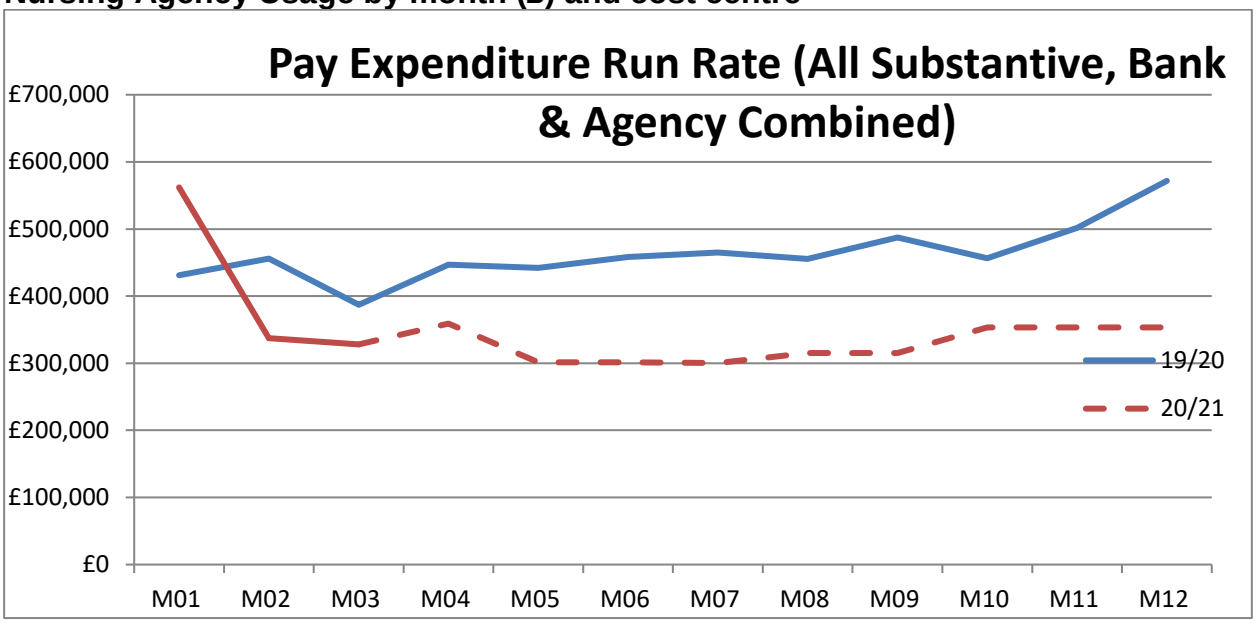
There were no shifts in May 2020 that were not filled at 100% RN.

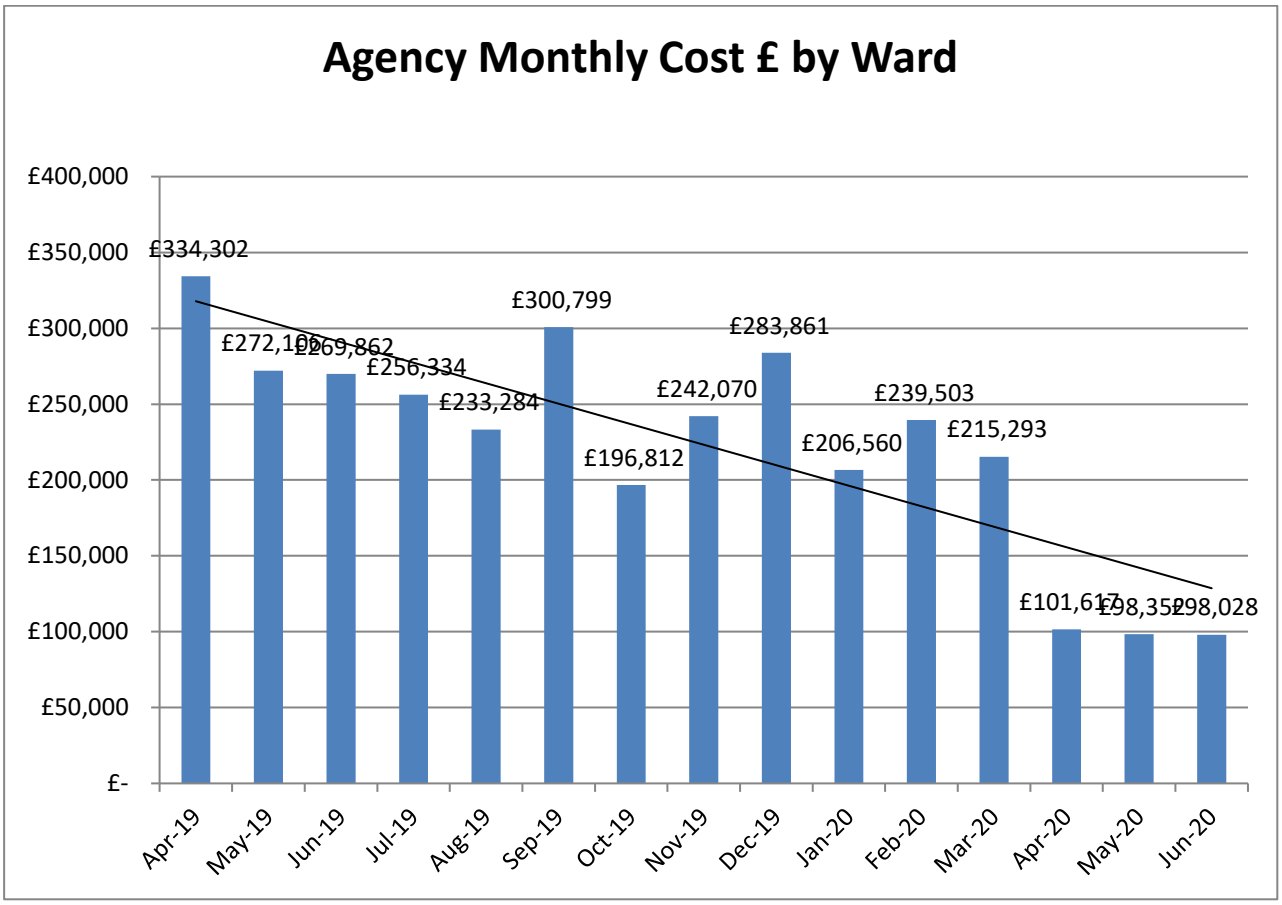
The actions below are still appropriate, however in relation to the workforce review and supportive framework, they have been temporarily stood down due to the Covid19 situation, these have been reinstated in May 2020 and are progressing to deliver a comprehensive workforce plan based on the evidence supplied.

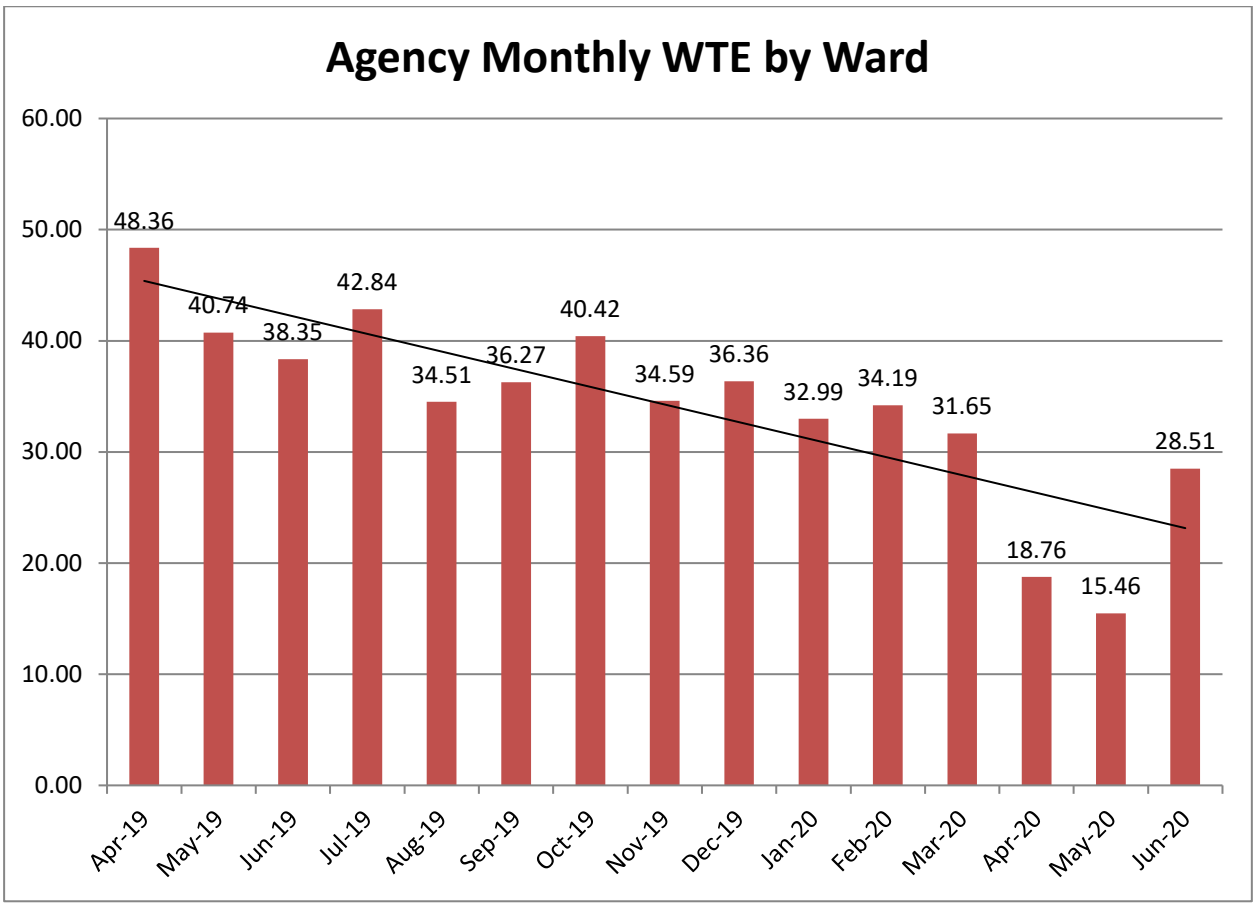
- The Baseline Emergency Staffing Tool (BEST) was used in 2016/17 to ensure staffing establishment was appropriate. At that time establishment was within expected benchmark but there were recommendations about shift pattern changes. This has been repeated in Q4 and the department are working through the data.
- The Trust engaged an interim Nurse Consultant in January 2020 to provide leadership support and to progress the supportive measures process at pace. This support will continues until end of June 2020.

2.4 Nursing Agency spend

Nursing Agency Usage by month (£) and cost centre






Agency Monthly WTE by Ward
60.00
50.00
40.00
30.00
20.00
10.00
0.00
48.36
40.74
38.35
42.84
34.51
36.27
40.42
34.59
36.36
32.99
34.19
31.65
18.76
15.46
28.51
Apr-19
May-19
Jun-19
Jul-19
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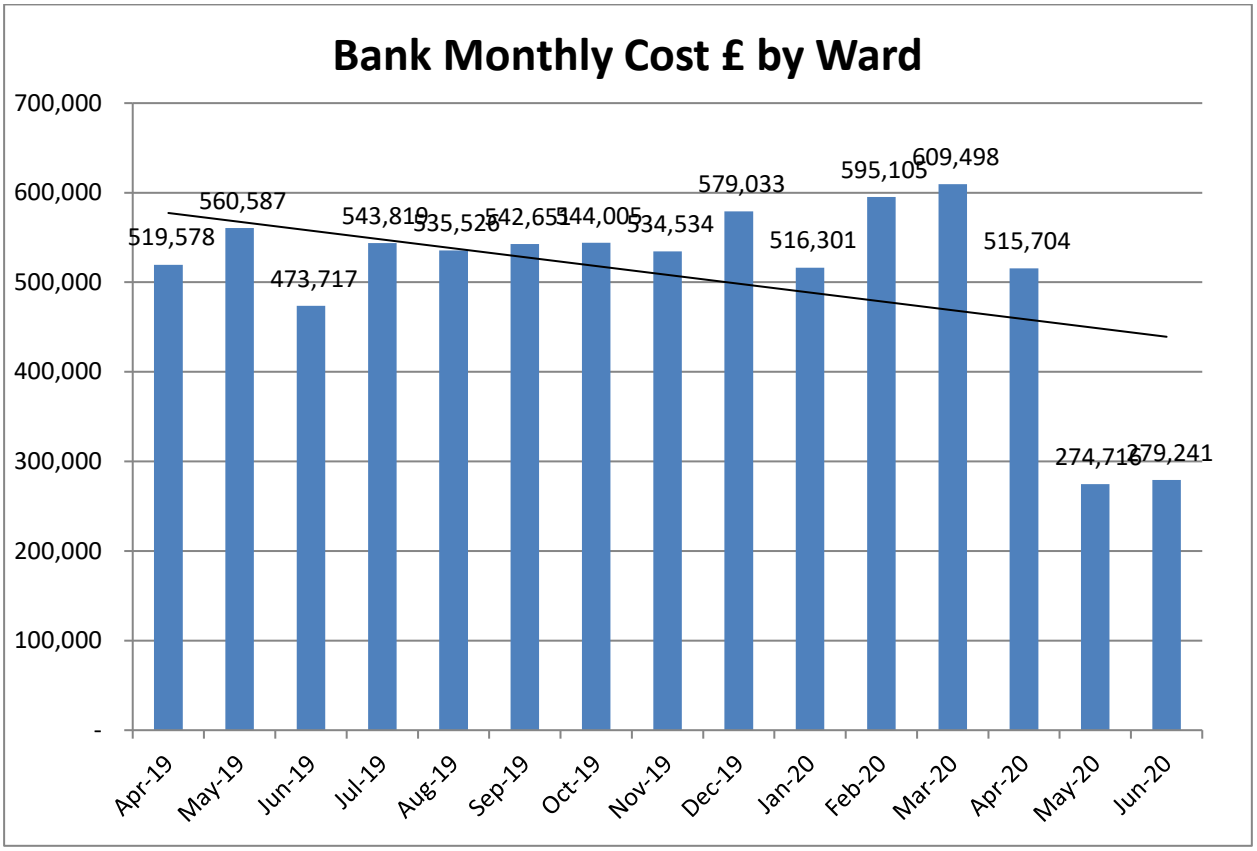
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20


Bank Monthly Cost £ by Ward
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
519,578
560,587
473,717
543,819
535,528
542,655
544,005
534,534
579,033
516,301
595,105
609,498
515,704
274,716
279,241
Apr-19
May-19
Jun-19
Jul-19
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Oct-19
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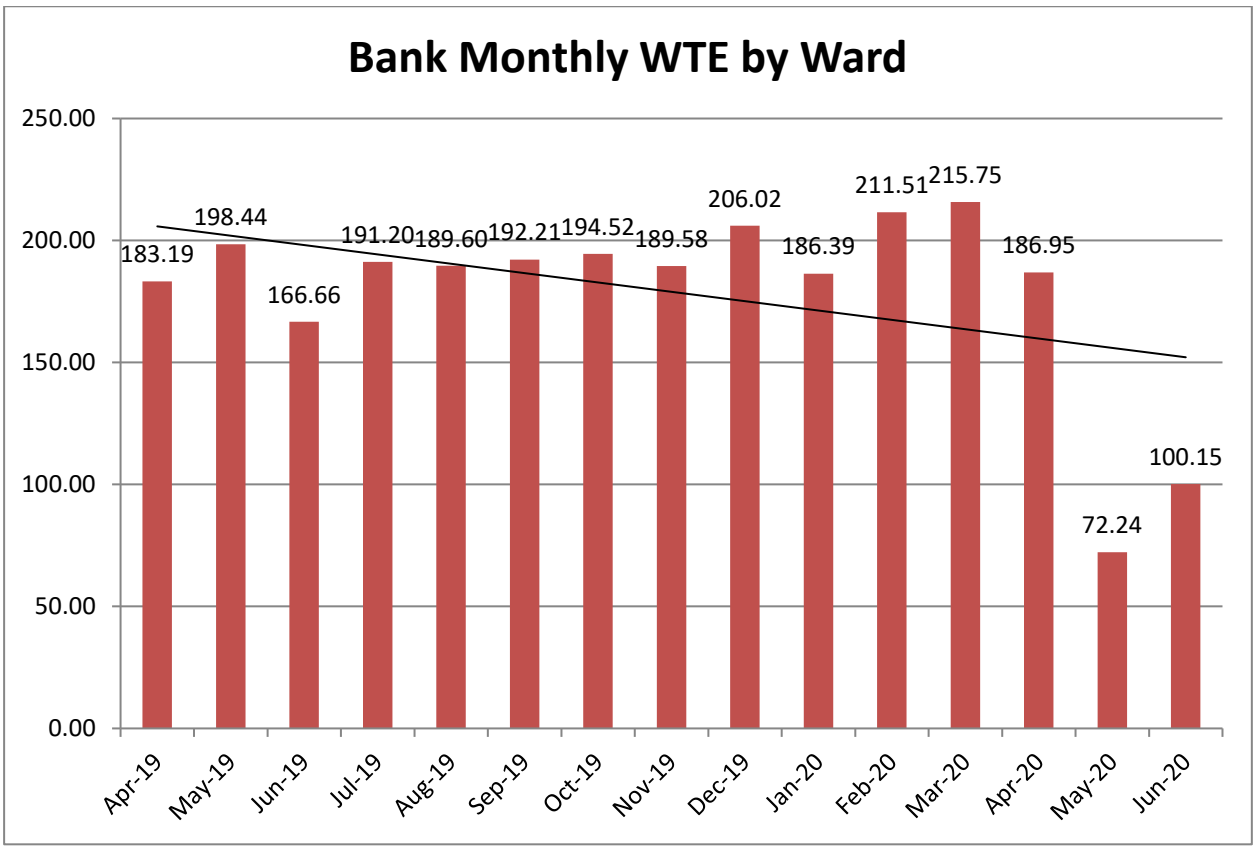
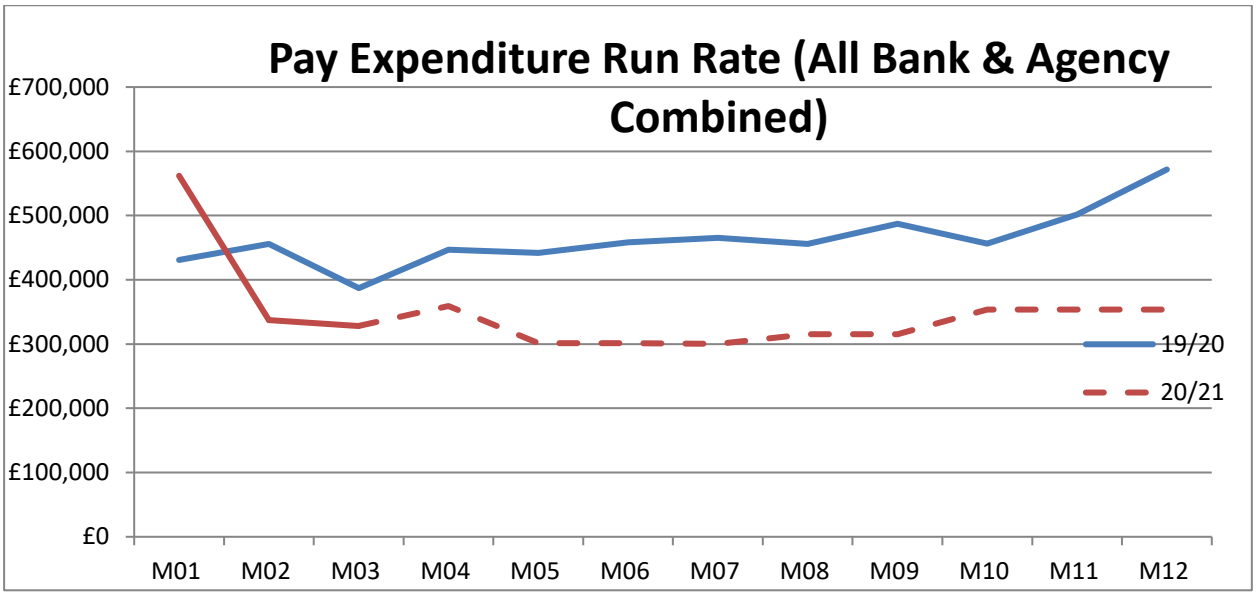
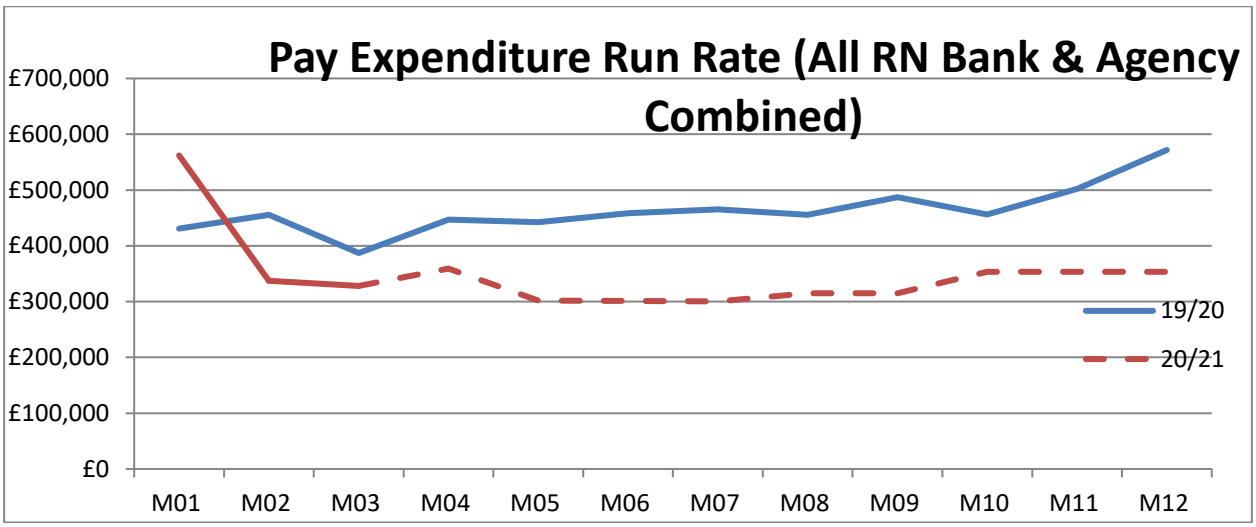
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

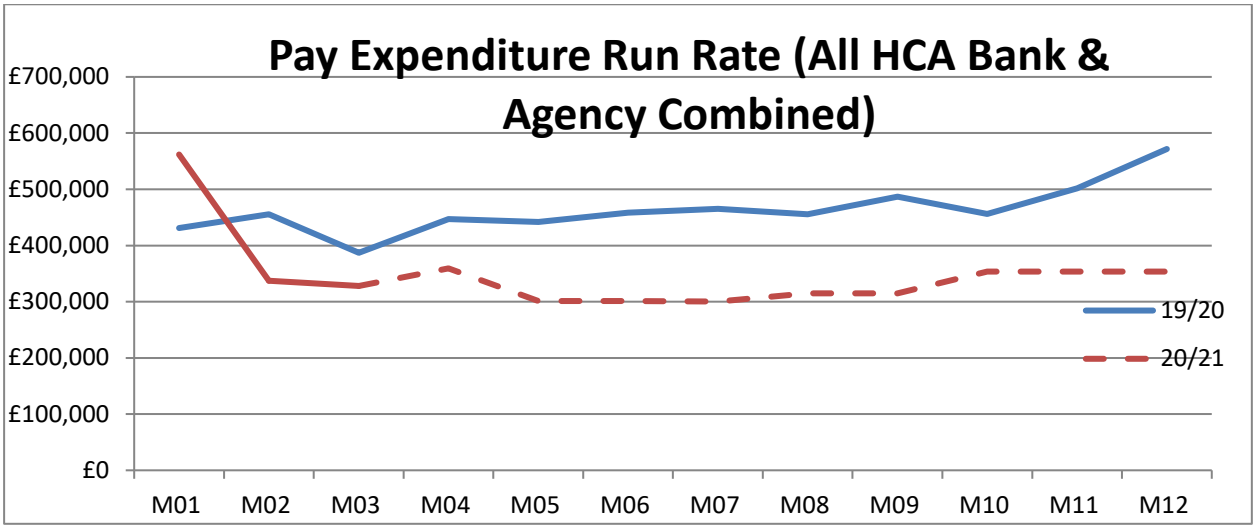


There is significant underspend in ward and non-bed based nursing establishment budgets which offsets the overspend on agency.

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.







Actions:

- The monitoring of bank and agency usage is to be maintained on a weekly basis
- The workforce redesign is to continue as services are stood up
- The opening of a surgical assessment unit and medical receiving unit as tests of change, commenced in June to enable the reduction of Emergency Department attendances – the evaluation of the departments are being presented in July

2.5 Nursing and midwifery vacancies

The recruitment strategies previously reported have resulted in an RN vacancy rate as at the end of June 2020 has maintained at between 10 and 11% Registered midwives continue with a <1% vacancy rate. The workforce cell is reviewing resourcing as part of the learning from covid 19, advertisement of vacant posts were encouraged by areas.

2.6 Electronic - E-rostering

There are 6 Key Performance indicators that monitor the efficiency and effectiveness of E-rostering across the Trust, these are below.

1. Rosters published 6 weeks prior to commencement
2. All contractual hrs are utilised when fully approval

3. All contractual hrs are utilised before over time assigned
4. Management hrs in line with Rostering guidelines
5. No of staff using employee online to request
6. Identifying areas that are not finalising payroll on time

The two areas of focus include KPI 1 and 2 for inpatient ward areas in order to assist with reducing the usage of temporary staffing;
KPI 1: Rosters published 6 weeks prior to commencement or
KPI 2: All contractual hrs are utilised when fully approval.

For June 36% of areas achieved KPI 1 and 56% of areas did not achieve full utilisation of hours

2.7 Quality and Safety

QuESTT

Each clinical area completes the monthly QuESTT tool which triggers actions as highlighted in the escalation procedure. The Associate Directors of Nursing and Professional Practice ensures contact is made for any area triggering an amber score or above and that appropriate actions to mitigate the issues causing the increase in scores is taken, these are reported as part of the governance accountability framework to all relevant forums.

For June 2020, the table below show that at the time the data was compiled all but 2 areas had not made a return this month.

There were 0 Red rated teams and 12 Amber rated teams for June 2020, 2 teams did not complete the return (where notified suspended services have been removed from the report) are as detailed below:

Amber rated teams:

- Torquay, and Paignton and Brixham Occupational Therapy – vacancy, sickness related to the constraints within COVID-19
- Newton Abbot, Torquay and Paignton and Brixham nursing – short term sickness, vacancy and shielding due to Covid19.
- Social Care – South Devon – due to number of referrals, vacancies, short term sickness and Covid19 related activity.
- Podiatry – recently retired, reduced activity due to response to Covid19 and sickness
- Public Health Nursing Paignton and Brixham – increased activity due to covid 19 response, sickness and increased referrals
- Brixham hospital – vacancies and sickness
- Urology - vacancies and sickness
- Ricky Grant - vacancies and sickness
- Cheetham hill - vacancies and sickness

The main theme is the continued shielding of staff due to covid 19, other reasons as described above are vacancies across nursing and allied healthcare professionals and short term sickness.

Workforce and organisational development are working alongside the departments, sisters, matrons and associate directors of nursing and professional practice to develop workforce redesign, wellbeing action plans and learning from covid for reassignment of staff which are being submitted to design a framework for use in short term contingency and longer term aspirations to work alongside the people plan strategy.

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

Quality Safety and Effectiveness Trigger Tool (QuESTT)

Torbay and South Devon NHS
NHS Foundation Trust

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

Service Type	Team	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020
% Complete		100%	96%	97%	99%	99%	96%	96%	94%	71%	92%	96%	97%
Total Purple (L3)		0	0	0	0	0	0	0	0	0	0	0	0
Total Red (L2)		2	2	2	0	0	0	0	2	0	1	0	0
Total Amber (L1)		7	8	5	10	8	10	7	7	12	12	10	12
Total Green (L0)		68	64	68	66	68	64	67	63	43	58	64	63
Average Score		10.1	10.1	9.8	10.0	9.4	10.3	9.7	10.1	10.6	10.7	9.8	9.9
Acute	Ainslie	11	10	11	10	7	10	10	13	9	9	11	15
	Allerton	13	12	14	9	6	5	8	7	6	9	11	4
	Anaesthetics	11	11	10	7	9	8	6	9	11	12	11	9
	Breast Care Unit	0	6	10	6	3	5	3	6	0	2	2	0
	Cath Lab	10	10	13	15	7	6	8	8	6	1	1	1
	Cheetham Hill	11	13	12	13	13	17	13	9	14	13	13	18
	Cromie	12	7	5	8	5	9	6	15	9	8	1	6
	Dunlop	4	5	6	7	6	7	5	6	11	10	10	11
	Early Pregnancy / Fertility Service	6	6	6	6	8	6	6	4	8	8	10	10
	EAU3	12		12	10	18	14	11			16	13	10
	EAU4	18	11	8	7	6	5	9	5	6	5	8	6
	Ella Rowcroft	12	8	10	9	8	11	11	8	6	8	7	9
	Emergency Department	18	20	19	19	18	15	10	12	16	13	11	11
	Endoscopy	3	8	6	8	3	3	3	6	5	10	8	8
	Forrest	12	8	8	15	7	10	10	12	12	6	3	6
	General Theatres	9		15	7	15	13	7	7		10	5	9
	George Earle	11	13	15		16	14	12	11	11	14	14	11
	Gynaecology Out-Patients Dept	9	7	7	8	3	7	7	5	11	7	11	11
	Hutchings	13	8	9	9	9	7	6	10		7	1	7
	ICU	11	9	3	9	14	6	8	10	19	16	12	8
	Louisa Cary	6	7	3	9	3		5	7	4		7	10
	MAT / TAIRU	10	9	4	7	7	8	5	4		2	3	
	Maternity	12	12	14	13	9	10	15	13	15	12	12	14
	Midgley	9	3	7	9	8	11	7	11		8	9	8
	OPD	6	6	3	2	4	6	11	6		6	4	4
	Ophthalmology	15	15	13	14	13	15	12		10	3	11	14
	Ortho Theatres	14	13	14	15	14	12	15	11	11	13	11	8
	Pre-assessment	8	10	12	16	14	12	6	8	8	10	6	10
	Radiology	9	11	9	14	10	9	13	9				13
	Recovery	8	10	11	15	15	14	11	10		20	13	14
	RGDU	13	15	12	9	7	10	11	15	10	8	9	16
	SCBU	4	2	1	3	5		1	5	3		2	5
	Sexual Health	11	10	5	6	6	12	11	10		11	6	7
	Simpson	8	11	11	9	11	12	10	10	15	10	11	9
	TCCU	4	8	9	14	10	6	7	11	12	12	10	9
	Turner	8		7	12	9	13		7		8	5	13
	Urology	7	10	4	6	5	10	5	7	6	10		16

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

3. Conclusion

The report for June 2020 demonstrates that the organisation is continuing to transition into recovery in order to stand up services but enable the workforce to be agile and flexible to be in standby and stand down modalities. This report provides a number of safety measures that are in place to ensure that nursing establishments and fill rates are monitored and appropriate action is taken to maintain staffing levels. This is triangulated with the quality and safety metrics for each bed-based area. These are robustly actioned by the senior nursing leadership in Associate Directors of Nursing and Professional Practice, matrons and senior sisters, alongside through the clinical site team function.

This paper assures the Trust board that there is nursing safe staffing in all inpatient areas within the Trust. The information is triangulated with the quality and safety metrics which demonstrate that these remain within the national requirements despite our current situation in responding to Covid19 and the transition to standing services back up as well as being agile enough to respond to a surge in COVID 19 cases.

4. Recommendation

The Board is asked to note the contents of this report.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report – July 2020			**Meeting date:** 29th July 2020
Report sponsor	Jayne Carroll Interim Director of Operations to 20th July 2020 John Harrison Chief Operating Officer		
Report author	System Director		
Report provenance	Contents reflect latest updates from management leads across all ISUs		
Purpose of the report and key issues for consideration/decision	To provide a broad narrative update on operational issues arising from the COVID 19 response and recovery planning.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	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**	20
Risk Register	x	**Risk score**	20

External standards affected by this report and associated risks

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

Report title: Report of the Chief Operating Officer		Meeting date: 29th July 2020
Report sponsor	Chief Operating Officer/Interim Director of Operations	
Report author	System Director	

1. Purpose

The report provides the Board with an update on key operational issues. The ongoing response to the COVID-19 pandemic and the restoration and recovery of services has been the predominant focus of operations over the last month.

2. Responding to the pandemic

The formal incident management structure was stood down in July. The organisation continues to maintain a COVID response in preparation for any surge that may be seen post the lifting of lockdown restrictions and the Incident Control Centre (ICC) is still staffed 5 days a week.

Covid-19 antibody testing is a service being provided to all TSDFT staff and contacts. In addition, South West Ambulance Services FT, Devon Partnership Trust & Clinical Commissioning Group staff are also being offered tests with the analysis done through our labs. As of 13th July over 6200 staff have been tested.

3. Urgent & emergency Care – patient flow

Demand for inpatient care reduced during the Covid-19 period but this is now starting to increase. Bed occupancy has long been a marker of good system health and performance and with the changes in demand and capacity due to COVID -19 this occupancy range has changed and is a trigger to the way we operate each day. Since early June we have maintained a range of 70-80% bed occupancy; the 7-day impact of low discharges on Sunday and high levels of activity on a Monday being the peak and create this variation.

To continue to achieve this range clinical/operational teams focus on ward SAFER processes and a daily review of patients who are fit for discharge or transfer. The control room team retain oversight and escalation of these processes, ensuring that any issues are rapidly resolved. The aim is to reduce bed occupancy over all available wards to 70% by Saturday; although this is becoming increasingly challenging as admission levels rise to near normal levels and thresholds may change. Community rehab beds are now being used at capacity levels due to the current ward configurations. Local action by teams are maintained to ensure that complex, long stay, social-care reviews are being closely managed and escalated. Stroke Rehab has returned to Newton Abbot on Templar Ward – which has also positively impacted on the acute stroke pathway. The complex care team are working daily across all acute and community bed-bases to ensure fast-track referrals to reduce any delays for patients awaiting social or health placements and placements are managed. Rapid response and reablement capacity continually

reviewed to ensure it remains agile. The labs have been able to provide additional resilience for rapid turnaround in their Covid-19 testing capability which positively impacts patient flow.

Further work is ongoing and expected to reach a conclusion shortly in relation to the redesign of the Emergency Care services to meet COVID requirements and prepare for winter. The Medical Receiving Unit is operational as a test of change, located in the day surgery unit footprint. An evaluation of its impact will be completed by the end of July, although its positive impact is already being seen on ED performance. The Acute Surgical Unit opened on the 29th of June in the 'old' ICU area, having been re-furbished as a result of investment from Winter monies. The aim of this service is to provide a fast pathway from ED for surgical patients – this will improve the pathway and experience for patients by ensuring they are in the most appropriate environment for their care. For urgent children referrals a short stay paediatric assessment unit has been created on Ricky Grant day unit whilst improvement works are underway to the Louisa Cary paediatric ward.

4. Restoration of services

Service restoration is increasing each day in line with the national priorities. Of the 157 requests made through the Recovery Cell restoration process, 121 have been approved. Once approved the operational teams are responsible for managing the actual commencement of the services, considering new ways of working, e.g. telephone & video consultations, space, locations, etc. 62 services have now re-started.

However, there are significant challenges in relation to achieving pre COVID levels of activity. This is due to; social distancing and impact on space requirements, PPE and cleaning requirements between patients, services which require aerosol generating procedures require extra time resulting in a productivity reduction. This is leading to lengthening waiting times, reflecting the national position and is of significant concern. The Trust recognises that its aging estate, is a compounding constraint to recovery and restoration of services in a COVID environment. Over the last month capital bids have been submitted to NHSE/I to increase diagnostic, planned care and urgent and emergency care physical capacity.

Meanwhile the operational focus is on maximising existing capacity, check and challenge meetings have been held with ISUs leadership teams and all options are being considered and worked through. Key actions from these sessions include; the development of speciality plans for extended working day and 7 day working, although recognising the workforce availability is a key constraint to be overcome to achieve this. Additional IT has been ordered and its allocation will be prioritised by System Directors to support the further expansion of virtual clinics. A review of all outpatient clinic capacity and utilisation across the ICO is underway to be completed at the end of July to identify capacity to enable the stand up of more services and maximise the use of our community facilities.

The complexity of standing up of services with interdependencies in terms of space, access and environment are managed through a 'Big Room Process'. This approach enables a collaborative approach between a range of clinical and operational stakeholders to problem solving which is required in the complex COVID

environment. Supported by System Leadership Teams this approach has enabled the standing up of paediatric day surgery and an increase in ophthalmology activity through the redesign of space within the day surgical unit footprint to support these services, as well as continuing to accommodate the expanded Emergency department.

The national contract with Mount Stuart Hospital as with other independent sectors providers has been extended, and this additional capacity is crucial to enable the Trusts' consultants to undertake urgent and cancer surgery across a range of specialties.

Diagnostics recovery is also progressing at pace. Demand for radiological investigations is rapidly approaching pre-Covid levels across all modalities. Radiology continues to access independent CT and MR scanning to assist with its capacity management. This includes Mount Stuart Hospital and the NHSE/I mobile scanners that are being based at Newton Abbot Hospital. A Nightingale CT scanner is now available.

The awaited 28 Day Cancer Referral to diagnosis standard has now been set. The Trust was part of the pilot to help determine an appropriate standard. This has been set at 75% of all patients should receive a diagnosis with 28 days of their referral. As a Trust we have been continually above this and currently in excess of 81%.

Community Services - Support has continued to our most vulnerable patients and those that are shielded. Individual patient testing is continuing to be delivered in peoples' homes. Activity is gradually increasing as part of recovery for therapy services and Intermediate care services. Further work is underway with our CCG partners to ensure there is a Devon wide approach to the swabbing requirements of staff visiting care homes to support care homes to remain COVID – 19 free.
We would like to draw attention to the work and innovation of the following services.

- Community Dentistry team have been operating as an Urgent Dental Care Hub since Mid-March (due to Covid-19) from Castle Circus Health Centre. To date (as of 8th July) they have provided 1574 remote consultations (phone or video via Attend Anywhere) and have provided 777 face to face treatments. The vast majority of patients are contacted, triaged and treated either the same day or within 24 hours, through the skills/expertise and the efforts of the team who aim to resolve the patients' dental issue in one appointment. This has meant not only the patient leaves the hub with their dental pain resolved, but also minimises the number of face to face contacts.

- Child & Family Health Devon (CHFD) have embraced using 'Attend Anywhere'(AA) widely across all service areas. The child/young person (CYP) enter with their carer a virtual waiting room and come into the clinic space when invited by their clinician. Devon & Torbay CAMHS is one of the highest users in the South West of this virtual platform. Speech and Language therapies, along with AA are using methods such as 'whats-app' for families to record speech videos that are then sent to the therapists for analysis and intervention, Physio teams are analysing video's of CYP in their home and

school settings and describing interventions to support and enable. In preparation for reopening of schools in September, CHFD are working with mainstream and special schools to align approaches to Infection prevention and control requirements to ensure staff can work effectively with vulnerable children in schools

- The Drug & Alcohol service are promoting the programme Breaking free online to support individuals who might benefit from reducing or moderating their alcohol consumption. It is a very user-friendly online programme that supports individuals by providing a ‘toolkit’ of psychoeducation, practical resources, and evidence-based coping skills to support their long-term recovery. It is completely free and can be used as an app on a smart phone or via a computer.

5. **Recommendation**

The Board is asked to note the content of this report

Trust Board of Directors		
Report title: Estates and Facilities – Top line briefs, EFM performance, compliance and exception report		Meeting date: 29/7/2020
Report appendix	Appendix 1 – Estates Performance and Compliance Report	
Report sponsor	Chief Finance Officer 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 May and June 2020 **Good News Story:** **Facilities Services New Ways of Working** The "New Ways of Working Project" originated in feedback from staff about working conditions, stress levels, staffing levels and general dissatisfaction mainly on the acute wards and in the Hospital setting. The management team led face to face session with the staff and established a working group to address the issues. The group proposed a new way of working that has now been rolled out to all wards within the Heatherington Unit and Women's Health Unit. Recent surveys carried out have continued to detail the benefits realised from the new operating model. The introduction of the bespoke Ward Caterer role to include undertaking the collation of the patient menus has freed up valuable nursing time. Ward nursing teams have time to support the Protected Meal Time service and the nursing teams are really pleased and supportive of the new way of working. Patient Satisfaction Survey results taken throughout May and June show that patients have rated the Catering Services on the ward as either very good or good overall. This included feedback that patients were offered the opportunity to wash their hands before the meal service for the first time and, if required, supported during the meal. Patients also advised that they were offered snacks during the day and had access to a drink whenever they needed one. Comments were also received that patients recognise the new caterer as the 'go to person' on the ward for all their catering needs. Time is allocated for the catering assistant to help the patients order their meals and this has resulted in greater satisfaction with meal choices. An audit of the Food Safety and HACCP records on the wards, achieved 100% audit ratings with all documentation and food safety in full compliance and evidenced on the ward. Cleaning standards have	

improved further and audits undertaken demonstrated 100% or 99% compliance during April, May and June 2020.

Facilities Staff working in these areas have reported they feel less stressed and their work life balance is improved with, at their request, the implementation of a variation of shift times.

The roll out has been slightly delayed due to the COVID-19 pandemic but work is now underway to implement the new ways of working in other areas across the Trust. A big thanks thank go to the Facilities team and staff side colleagues for all the hard work they have put into this extremely successful project.

Estates and Facilities Operations Compliance Issues and Exceptions.

Main exceptions:

Mechanical Services – The Mechanical Services Manager Band 6 post remains vacant and is currently advertised for the third time. Whilst this post is remains vacant there are gaps in the Authorised Persons roles for PSSR, Gas Safe Lead and deputy Authorised Person for Ventilation. This is temporarily being covered by the Authorised Engineer. The Associate Director of EFM Ops and the Head of Estates Ops are formulating a revised strategy around filling this post which may result in the need for agency back fill.

Medical Gases Pipe Systems – The final draft Medical Gases Policy was reviewed by the Health and Safety Committee who before they approved it asked for more clarity on the accountability, resource and delivery of the training for the use of gasses. The Medical Gas Committee is due to meet on the 21st July 2020. The final revised policy will come back to the H&S Committee when completed.

Action Plans

HSE – progress of the EFM actions within the overall Trust HSE action plan continues to be monitored by the Site Services Lead. Prime concern continues to be NHS Procurement vehicles reversing without trained Banksmen, in the Fracture clinic area. A meeting was held with the Head of Procurement and Director of EFM to review the processes which were put in place following the HSE improvement notice.

Compliance – The Canty Compliance Audit score remains at 72.3% and review and update of current Risk Assessments will improve compliance. EFM Managers have received Risk Assessment training and once the Estates Ops Team have returned to the original pre COVID-19 shift patterns, the updating of existing risk assessments will be prioritised.

	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 is asked to receive and note the: • Good news story • Compliance issues and exceptions • EFM Compliance and Performance Reports
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

Report title: Estates and Facilities – Performance and exception report		**Meeting date: 29/7/2020**
Report sponsor	Chief Finance Officer 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 July 2020.

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the months of May and June 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 months of May and June 2020. Any areas of specific cause for concern for the attention of the Capital Infrastructure and Environment Group are shown with appropriate explanation and action to achieve a resolution is shown at Table 2 below.

Table 1: May and June 2020 Scorecard Indicator.

Green ✓ | Amber ! | Red ✘	May	June
Deteriorating Indicators		
Waste - % of Total tonnage of Recycled waste per month	!	✘
EFM incidents resulting in no harm	✓	✘
Improving Indicators		
Estates - Routine % P3 completed in <30 Days	!	✓
Red rated Indicators with no change		
Estates - Fire Dampers Compliance - % in date	✘	✘
Estates – Portable Appliance Testing - % in date	✘	✘
Estates – Ladder Inspection Compliance - % in date	✘	✘
Waste - % of Total tonnage of Clinical Burn waste per month	✘	✘
Amber rated Indicators with no change		
Statutory PPM % success against plan	!	!

Table 2: Areas with Specific Cause for Concern	
Estates	**Estates Critical failures May and June 2020**
Explanation	1. June – Lift H (Old Hospital Ainslie / Warrington End) - a number of lift failures – contractor to carry out detailed investigation and rectification. 2. May - Power Failure Sub 4 - Northcott Hall – rectified.
Estates	**Fire Dampers Compliance - % in date**
Explanation	Contractor to recommence remedial works to improve access to Fire Dampers for testing once the step down / step up of services following the Covid 19 pandemic allows it to be safe to do so. The absolute compliance score for Fire damper testing remains at 62%, of those tested, 99% functioned correctly. Also dependent on £60,000 capital funding
Estates	**Estates – Portable Appliance testing - % in date**
Explanation	Community locations are complete, and the Electrical Services Manager is currently reviewing areas which are safe to access and will reinstate the testing programme as soon as contractor available.
Estates	**Estates – Ladder Inspection Compliance - % in date**
Explanation	All Portable ladders are being inspected in July 2020, with Fixed internal ladders to follow and fixed roof access ladders in September, after the seagull nesting season has finished in order to protect inspection staff from gull attack.
Waste	**% Total Tonnage of Clinical Burn Waste / Recycling waste per month**
Explanation	The total tonnage of waste has increased for the first month since COVID-19 by 23 tonnes mainly due to increased activity. Recycling waste has fallen by 9% but unfortunately this is due to contaminated masks being incorrectly disposed of into the recycling waste stream. The Site Services Team are working with the Clinical Waste Contractor to move off incineration only and a plan agreed to return to normal waste collection. It is envisaged that there will be a reduction in clinical burn waste over the next few months. The Trust will continue to be monitored by the Clinical Waste Contractor around waste segregation which could result in reverting back to incineration only if waste streams are found to be contaminated.
Safety	**EFM incidents resulting in no harm**
Explanation	Increase in incidents reported, 16 in month, relating to lift entrapments and fire alarm activation
Estates	**Statutory PPM % success against plan**
Explanation	Access restricted due to risk of COVID-19 transmission and 24 not completed in required time frame. (Annual inspection of Tower Block fire doors)
Estates	**Fire Extinguisher Testing Compliance - % in date**
Explanation	Programme of Inspections interrupted by contractor availability during COVID 19 restrictions. Expect programme to be resumed and compliance back on track when restrictions lifted.
Estates	**Fixed Wire Testing Compliance - % in date**
Explanation	Works to start in community sites and Acute site testing to restart as soon as possible.
Estates	**LEVs Testing Compliance - % in date**
Explanation	16 LEVs were due this month and the one in Hearing Aid Centre was not available - access being rearranged.
Estates	**Asbestos Inspections Compliance - % in date**
Explanation	Castle Circus Health Centre and Podium Block surveys are underway and all known asbestos remains in a safe condition and normal asbestos permit practice remains in place throughout.

EFM Performance Report

Domain	Estates & Facilities Operations Performance Data June 20 for July 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	944	964	1,088		9957	1249	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	367	356	368		6326	422	Variable				
	Statutory PPM % success against plan	98%	98%	96%	100%	95%	100%	98%	98%	90%	99%	96%	96%	97%	93%	92%			96%	97%	85%	85%	97%	24 Non completed - of which 8 due to covid - 9 FDs servicing in Tower Block
	Mandatory PPMs planned per month	485	422	441	505	449	552	431	438	519	443	481	521	431	453	530		7101	473	Variable				
	Mandatory PPM % success against plan	97%	100%	97%	99%	99%	98%	98%	97%	94%	99%	97%	99%	97%	97%	95%			98%	97%	85%	85%	95%	14 non completed - 10 due to access due to Covid, 3 O/S
	Routine PPMs planned per month	147	156	167	229	220	224	156	233	164	185	242	196	146	155	190		1696	187	Variable				
	Routine PPM % success against plan	67%	58%	80%	89%	85%	87%	67%	93%	68%	83%	77%	95%	73%	82%	76%			79%	90%	60%	60%	70%	
	Total Reactive Requests per month (not KPI)	851	910	974	1154	793	814	1028	1042	944	1038	915	722	548	652	688		8510	1006	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	2	4		1092	73	Variable				DEL on site 24-7 - not as many P1 raised.
	Emergency - % P1 completed in < 2hours	100%	99%	99%	99%	99%	98%	100%	100%	100%	100%	91%	100%	100%	100%	100%			99%	97%	90%	90%	95%	
	Urgent - P2 - requests per month	94	139	128	215	117	116	120	146	94	121	126	89	134	136	149		1169	128	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	98%	91%	85%	79%	87%	95%	87%	92%	93%	87%	93%	81%	89%	93%	90%			89%	97%	85%	85%	90%	
	Routine - P3 - requests per month	543	564	604	686	487	510	668	664	520	655	531	428	360	441	420		5246	539	Variable				
	Routine - % P3 completed in < 7 Days	90%	81%	82%	78%	73%	79%	72%	83%	74%	70%	63%	68%	88%	84%	89%			78%	97%	75%	75%	85%	New Works for Covid taking priority.
	Routine - P4 - requests per month	117	147	162	170	94	100	142	146	232	177	127	126	48	73	115		1310	132	Variable				
	Routine - % P4 completed in < 30 Days	86%	80%	79%	81%	79%	81%	67%	77%	49%	52%	61%	47%	90%	90%	86%			74%	97%	65%	65%	75%	
	Estates Internal Critical Failures per month	3	0	3	5	2	5	4	5	2	3	5	3	2	1	1		44	2.9	0	2	1	0	Multiple Lift Failures, Power Failure Sub 4 - Northcott Hall
Estates - Statutory / Mandatory Compliance Performance	Fire Alarm Testing Compliance - % In date		100%	100%	99%	98%	99%	99%	98%	99%	98%	99%	100%	100%	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%	97%	99%		Stat	99%	97%	85%	85%	97%	
	Fire Extinguisher Compliance - % In date		97%	96%	98%	97%	97%	97%	97%	98%	98%	97%	97%	97%	95%	96%		Stat	97%	97%	85%	85%	97%	Ext Contractor reports, COVID areas are outstanding but are programmed in as BAU is staged in
	Fire Dry Risers Compliance - % In date		100%	100%	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%	100%	100%		Stat	64%	97%	85%	85%	97%	
	Fire Dampers Compliance - % In date		93%	93%	93%	93%	93%	95%	62%	62%	62%	62%	62%	62%	62%	62%		Stat	75%	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%	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%	90%	89%		Stat	93%	97%	85%	85%	97%	Contract in place, start delayed due to COVID -19. to be restarted as soon as contractor safe to work. Outlying buildings to be done first
	Portable Appliance Testing - % in date		100%	100%	100%	100%	100%	100%	95%	83%	83%	83%	83%	70%	65%	60%		Mand	87%	97%	85%	85%	95%	PAT test regime delayed due to COVID -19. to be restarted as soon as contractoor 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%	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%	100%	100%		Mand	81%	97%	85%	85%	95%	
	Generator Load Test Compliance - % In date		92%	92%	92%	92%	92%	38%	23%	38%	77%	92%	92%	92%	100%	100%		Mand	79%	97%	85%	85%	95%	
	Lightning Protection Compliance - % In date		100%	100%	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%	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%	92%	94%		Stat	92%	97%	85%	85%	97%	One in Hearing Aid Centre - access to be rearranged
	Critical Vent Varification Compliance - % In date		97%	98%	94%	100%	97%	97%	100%	100%	100%	98%	100%	100%	100%	100%		Stat	99%	97%	85%	85%	97%	
	Kitchen + Extract Duct Cleaning - % In date		94%	94%	94%	94%	100%	100%	100%	100%	77%	77%	100%	100%	100%	100%		Stat	95%	97%	85%	85%	97%	
	Gas Pipework Compliance - % In date		95%	96%	71%	82%	93%	93%	86%	100%	100%	100%	100%	100%	100%	100%		Stat	94%	97%	85%	85%	97%	
	Gas Appliance Compliance - % In date		100%	100%	100%	100%	100%	100%	96%	97%	96%	96%	100%	100%	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%	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%	99%	100%		Stat	96%	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%	96%	95%		Mand	96%	97%	85%	85%	95%	
	Asbestos Inspections Compliance - % in date		75%	75%	80%	81%	93%	95%	95%	91%	91%	91%	91%	90%	94%	95%		Stat	88%	97%	85%	85%	97%	CCHC, Podium Block due inspection at end May - access
	Water Safety Checks - works % in date		98%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	98%	100%	100%		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%	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%	71%	71%		Stat	96%	97%	85%	85%	97%	Robust inspection regime in place to recover compliance.

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Domain	Estates & Facilities Operations Performance Data June 20 for July 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	8553	8986		130929	8729	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	2634	2786		35608	2374	Variable				
	Porters - Patient Transfer Tasks per month	2096	2445	2144	2316	2289	2219	2217	2117	2169	2078	1964	1875	1249	1716	1811		30705	2047	Variable				
	Porters - Notes Tasks per month	1542	1735	1521	1795	1623	1560	1928	1863	1698	1982	1725	1857	1330	1513	1992		25664	1711	Variable				
	Porters - Urgent Tasks per month	186	180	160	178	182	183	194	174	174	209	162	192	101	109	176			171	Variable				
	Porters - Routine Tasks per month	7939	8827	7156	8786	8146	7841	8600	8266	8272	8685	7829	8373	7640	8222	8546			8209	Variable				
	Porters - Booked Tasks per month	326	268	274	327	302	322	306	264	265	303	299	233	265	222	264			283	Variable				
Cleaning	Scores - Brixham Hosp - High Risk	99%	99%	99%	99%	99%	98%	98%	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%	100%			98%	85%	80%	80%	85%	
	Scores - Brixham Hosp - Low Risk	100%	100%	100%	100%	100%	99%	97%	94%	98%	98%	97%	97%	97%	97%	100%			98%	80%	75%	75%	80%	
	Scores - Dawlish Hosp - High Risk	100%	100%	100%	100%	99%	98%	99%	98%	99%	100%	98%	98%	98%	99%	99%			99%	95%	90%	90%	95%	
	Scores - Dawlish Hosp - Significant Risk	100%	100%	100%	100%	100%	100%	99%	98%	99%	99%	98%	98%	98%	98%	100%			99%	85%	80%	80%	85%	
	Scores - Newton Abbot Hosp - High Risk	99%	100%	99%	99%	99%	100%	98%	97%	99%	98%	98%	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%	100%			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%	95%			98%	80%	75%	75%	80%	
	Scores - Paignton H+WBC - High Risk	96%	100%	100%	100%	99%	99%	99%	98%	98%	98%	98%	98%	98%	98%	98%			98%	95%	90%	90%	95%	
	Scores - Paignton H+WBC- Significant Risk	98%	100%	99%	99%	99%	99%	99%	98%	98%	98%	99%	99%	98%	98%	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%	95%	96%			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%	99%			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%	97%			99%	95%	90%	90%	95%	
	Scores - Teignmouth Hosp - Significant Risk	99%	100%	100%	99%	99%	99%	99%	99%	97%	97%	95%	95%	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%	99%			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%	99%	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%	99%			98%	85%	80%	80%	85%	
	Scores - Torbay Hosp - Low Risk	85%	97%	100%	97%	97%	98%	98%	95%	95%	95%	95%	95%	95%	95%	95%			95%	80%	75%	75%	80%	
	Scores - Totnes Hosp - High Risk	99%	99%	100%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	99%	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%	100%			98%	85%	80%	80%	85%	
	Scores - Totnes Hosp - Low Risk	98%	98%	100%	90%	90%	94%	95%	94%	96%	98%	97%	97%	97%	97%	100%			96%	80%	75%	75%	80%	
	HPV Cleans per month	11	21	31	35	21	22	41	20	20	28	21	25	39	54	34		222	28	Variable				From Porter data HPV data
	Deep Cleans per month	854	887	801	880	779	746	805	789	774	1010	835	1090	1275	1127	1006		7315	911	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	4	8		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	0	0		2	0.1	0	2	1	0	

Domain	Estates & Facilities Operations Performance Data June 20 for July 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	0	0		3181	212.1	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	37,640	29,989	40,317	29,528	21,317		415870	27725	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	20352	24567		284690	28693	Variable				
	Meals purchased at Bayview Restaurant per month	3874	3917	4027	5848	5413	5769	6389	6292	5384	5732	5539	5071	2894	2595	2782		46913	4768	Trend				
	Meals purchased at Horizon Café per month	2791	2843	2807	2886	1991	2835	3035	3066	2022	2425	2547	1575	0	0	0		24276	2055	Trend				
	Red Catering Trays per month	748	763	724	784	798	783	738	759	793	787	792	752	708	684	693		6890	754	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%	2.4%	2.2%			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	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	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	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	5	5			4.3	5	2	2	4	
	EHO Audit Scores - Totnes Hospital	5	5	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	22	26	28			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	143.0	166.3		1533.7	163.9	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%	46.5%	35.1%			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%	0.0%	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%	1.5%	1.7%			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%	30.3%	39.8%			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%	1.3%	2.0%			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%	20.4%	21.5%			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	29.1	25.0		287.7	30.4	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%	100%			100%	Trend	90%	90%	95%	15 Audits per month

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Domain	Estates & Facilities Operations Performance Data June 20 for July 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	399	399			456		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	36	36			35					
	Facilities Management	23	23	22	22	21	21	20	20	20	20	20	22	21	22	24			21					
	Hotel Services - Catering	33	33	33	33	33	33	33	33	33	32	31	33	32	32	32			32					
	Hotel Services - Domestic	223	227	230	231	230	231	234	234	233	232	232	226	235	233	231			231					
	Hotel Services - Other	74	74	74	74	75	76	78	78	76	76	74	73	76	76	77			75					
	Achievement Review Compliance %	92%	95%	95%	93%	85%	85%	85%	85%	90%	89%	89%	87%	84%	81%	84%			88%	95%	80%	80%	90%	Estates 80%
	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%	4.2%				4.6%	3%	3.8%	3.8%	3.5%	1 month in arrears. Fac Mgt 8.7% Domestics 6.6% (was 8%)
	Mandatory Training - Conflict Resolution	93%	96%	97%	93%	96%	95%	95%	94%	94%	95%	96%	95%	94%	91%	93%			94%	90%	75%	75%	85%	
	Mandatory Training - Equality & Diversity	96%	98%	98%	98%	98%	95%	97%	97%	97%	96%	97%	94%	94%	94%	96%			96%	90%	75%	75%	85%	
	Mandatory Training - Fire Training	96%	98%	97%	97%	98%	94%	97%	98%	95%	94%	95%	92%	89%	90%	91%			95%	90%	75%	75%	85%	Catering 79%
	Mandatory Training - Health & Safety	95%	96%	98%	98%	98%	96%	98%	97%	97%	97%	98%	97%	95%	95%	95%			97%	90%	75%	75%	85%	
	Mandatory Training - Infection Control	94%	96%	96%	97%	96%	94%	94%	94%	95%	94%	93%	92%	91%	91%	89%			94%	90%	75%	75%	85%	
	Mandatory Training - Information Governance	94%	94%	94%	95%	97%	93%	94%	93%	92%	90%	91%	88%	86%	85%	86%			92%	95%	85%	85%	95%	Estates - 72% up 2%, Catering 81%
	Mandatory Training - Moving & Handling	97%	98%	99%	97%	96%	92%	95%	94%	96%	95%	96%	91%	91%	91%	90%			95%	90%	75%	75%	85%	
	Mandatory Training - Safeguarding Adult Level 1	96%	99%	98%	99%	98%	98%	98%	97%	99%	97%	98%	97%	95%	95%	95%			97%	95%	80%	80%	90%	Estates 83%
	Mandatory Training - Safeguarding Children	95%	96%	97%	98%	98%	96%	97%	97%	98%	97%	98%	94%	93%	94%	95%			96%	95%	80%	80%	90%	
	Mandatory Training - Resuscitation	91%	92%	94%	94%	96%	93%	94%	94%	94%	97%	94%	92%	91%	91%	92%			93%	90%	75%	75%	85%	
	Mandatory Training - Basic Prevent Awareness	97%	99%	99%	99%	98%	97%	97%	97%	98%	93%	98%	97%	95%	95%	96%			97%	90%	75%	75%	85%	
Safety	EFM Serious/RIDDOR incidents	1	0	0	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	1	0		14	0.9	0	3	3	1	
	EFM incidents resulting in minor harm	1	5	4	5	10	5	8	5	2	4	7	3	3	2	3		67	4.5	0	8	8	4	
	EFM incidents resulting in no harm	2	11	10	12	8	6	10	13	12	11	12	11	13	7	16		154	10.3	0	15	15	8	Lift Entrapments and false fire alarm activations
	CAS Alerts active and in Progress	9	8	7	7	5	3	3	2	2	4	4	5	3	3	3			5	Variable				Allergens in food and Door Buffers / stops
	CAS Alerts Overdue for Completion	5	7	6	5	4	1	2	1	1	1	1	1	1	1	1			2.5	0	2	2	0	IT Zebra Printers CAS Alert