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

Board Room, Hengrave House, Torbay Hospital and via Microsoft Teams
25 November 2020 11:30 - 25 November 2020 13:30

AGENDA

#	Description	Owner	Time
1	Board Corporate Objectives Information Board Corporate Objectives.pdf 7		
2	PART A: Matters for Discussion/Decision		
2.1	Apologies for Absence Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Minutes of the Board Meeting held on the 28th October 2020 and Outstanding Actions Approve 20.10.28 - 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 21	CE	
2.6	Integrated Performance Report - Month 7 Receive and Note Integrated Performance Report - Month 7.pdf 33	DTP	
2.7	Winter Plan 2020/21 Approve Winter Plan 2020-21.pdf 105	COO	

#	Description	Owner	Time
2.8	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 137	MD	
2.9	Guardian of Safe Working Hours Information Report of the Guardian of Safe Working Hours.pdf 153	MD	
2.10	Research and Development Annual Report Information Research and Development Annual Report.pdf 159	MD	
3	PART B: Matters for Approval/Noting Without Discussion		
3.1	Reports from Board Committees		
3.1.1	Finance, Performance and Digital Committee - 26th October and 23rd November 2020 Receive and Note FPDC Chair's Report - 26th October 2020.pdf 201	C Balch	
3.1.2	Quality Assurance Committee - 23rd November 2020 Receive and Note	J Lyttle	
3.1.3	People Committee - 5th November 2020 Receive and Note	V Matthews	
3.2	Reports from Executive Directors Receive and Note		
3.2.1	Report of the Chief Operating Officer Receive and Note Report of the Chief Operating Officer.pdf 203	COO	
3.2.2	Estates and Facilities Management Update Receive and Note Estates and Facilities Update.pdf 213	CFO	

#	Description	Owner	Time
4	Compliance Issues		
5	Any Other Business Notified in Advance	Ch	
6	Date of Next Meeting - 9.00 am, 27th January 2021	Ch	
7	Exclusion of the Public	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARD ROOM, TORBAY HOSPITAL AND VIA MICROSOFT TEAMS
ON WEDNESDAY 28TH OCTOBER 2020

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	* Mrs V Matthews	Non-Executive Director
	* Mr R Sutton	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mr J Welch	Non-Executive Director
	* Mr I Currie	Medical Director
	* Dr R Dyer	Deputy Chief Executive
	* Mrs J Falcao	Director of Workforce and Organisational Development
	* Mr J Harrison	Chief Operating Officer
	* Ms A Jones	Director of Transformation and Partnerships
	* Mr D Stacey	Chief Finance Officer
	* Mrs J Stockman	Torbay Council Representative
In attendance:	Mrs J Downes	Company Secretary
	*Ms S Burns	Freedom to Speak Up Guardian (part)
	*Mr J Murray	Deloitte LLP
	*Ms L Taylor	Deloitte LLP

* via video-conference

		ACTION
186/10/20	**Board Corporate Objectives** The Board noted the Trust's corporate objectives.	
	PART A: Matters for Discussion/Decision	
187/10/20	**Apologies for Absence** An apology for absence was received from Ms L Davenport, Chief Executive.	
188/10/20	**Declarations of Interest** There were no interests declared.	

189/10/20 **Minutes of the Board meeting held on the 30th September 2020 and outstanding actions**

The minutes of the Board meeting held on 30 September 2020 were approved as a correct record.

The outstanding actions log was reviewed and actions deemed completed were agreed for deletion.

190/10/20 **Report of the Chairman**

The Chairman briefed the Board on activities undertaken since the previous meeting.

The Chairman referred to the Staff Heroes Awards that were continuing to be presented during Covid-19 and commended the recent awards made in both the acute and community settings. He was sighted on the positive impact the Staff Heroes Awards had on staff and spoke about his visits to several teams during the past month, including the Staff Heroes Awards presentation to the Dart Ward staff at Totnes Hospital, in which he was accompanied by Chris Balch, Non-Executive Director. It was noted that the Staff Heroes Annual Event would be held this year, albeit it would be a virtual event due to Covid.

The Shadow ICS Partnership Board had been formally established and had held its first Board meeting.

The October Governor Network meeting had been well supported and the contribution of Adel Jones, Director or Transformation and Partnerships and Judy Falcao, Director of Workforce and OD to the discussion was acknowledged. The Governors would be meeting again on 4 November at the quarterly Council of Governors meeting.

The Chairman, along with the Liz Davenport, had met with the Chair and Chief Executive of the Royal Devon and Exeter NHS Foundation Trust to discuss networking and collaboration opportunities.

The Trust had recently appointed Deloitte LLP to undertake the Trust's Well-led Governance and Leadership Review. The Review had commenced and would complete by the end of the calendar year.

The Trust had recently appointed a Programme Director to support the HIP2 Redevelopment Programme.

Chris Balch commented on the Staff Heroes Awards and endorsed the visit to Totnes Hospital with the Chairman. He also referred to the recent work undertaken by the staff at Brixham Hospital in the context of ensuring they were recognised appropriately by the Board.

191/10/20 **Report of the Chief Executive**

Rob Dyer Deputy Chief Executive, presented the Report of the Chief Executive in the absence of Liz Davenport, and highlighted the following key points.

Response and Recovery – Covid-19
Despite the increasing number of cases, the Trust had managed to continue to provide safe urgent and emergency care, as well as stepping-back planned care. The challenges being experienced from increasing number of patients who were Covid-19 positive, along with increased numbers of other unwell patients as winter approaches, had put the Trust, and its staff in particular, under a high degree of pressure. Maintaining non-Covid services was therefore the main changed approach as the second wave of Covid-19 approached.

A number of Covid-19 outbreaks had been experienced within the hospital. Rob Dyer briefed the Board on the causes of the outbreak and avoidance measures put in place to mitigate the risk of further spread, however this was evolving situation. Guidance for staff was being provided at every opportunity, advising on precautions to take both within and outside of the hospital setting.

Rob Dyer reported that the Trust had reached the trigger point for the enactment of the 'blue/green pathway', following the rapid increase in the number and frailty of patients. The state of readiness for the Nightingale Hospital Exeter ('NHE') was outlined. Preparatory work was being undertaken to ensure it could open if and when deemed necessary. The Board noted there was a nationally mandated protocol for the opening of the Nightingale Hospitals.

Vikki Matthews commented on the impact of Covid-19 on the health and wellbeing of staff and said the learnings from the first wave of Covid-19 were being brought in to the People Committee. Rob Dyer responded to a Vikki Matthews' question about the impact on staff arising from opening the NHE, and said the Board was aware of the shared responsibility for staffing the NHE and gave assurance that staff were being supported and well looked after.

Chris Balch said the ability to communicate the challenges to the public would be important as the Trusts move in to the Covid-19 second wave, and asked for assurance that this would be picked up by the Trust's Communications Team. Adel Jones acknowledged this was an iterative process, and confirmed that communications around Covid-19 would be a priority for the Communications Team.

Care Homes and Covid-19
The Trust was continuing to work closely with Devon County Council and Torbay Council to support care homes during the pandemic.

Whilst the rate of Covid-19 cases in the local population in comparison to other areas in England remained low, the numbers of staff in care homes testing positive was increasing. Where there were positive results, the Trust

was providing support to those care homes to help prevent transmission and give additional advice and support where needed.

Robin Sutton endorsed the earlier comments about care homes and the approach the Trust is taking.

Winter Planning and Flu Campaign
The Trust has developed a system-wide plan that described how it will safely and effectively manage the care needs of the population whilst navigating the challenges of the forthcoming winter period.

The Torbay and South Devon system would face specific and additional challenges this winter, notably due to the effect of the ongoing Covid-19 pandemic as well as the disruption caused from the essential building works in the emergency department. Planning for winter this year would therefore particularly complex.

It was anticipated that the plans would be fully operational from November, with some additional schemes taking a little longer to come on-line. The final winter plan would be presented at the November Board meeting. COO

Rob Dyer reported that the staff flu vaccination programme had commenced with c.3,500 staff (over half the workforce) vaccinated to date.

Director for Diversity
It was noted that Judy Falcao, Director of Workforce and OD had been nominated as the Trust's Director for Diversity, and would present an action plan to the Board outlining how the Trust will achieve the requirement to have a senior leadership reflecting the diversity of the Trust within five years. DWOD

Queen's Birthday Honours List
The Board formally congratulated Jane Viner, former Chief Nurse and Professional Practice Lead, on her MBE in recognition of outstanding service.

192/10/20 **Integrated Performance Report – Month 6**

The Board discussed the Integrated Performance Report for month 6.

Quality and Safety

Deborah Kelly, Chief Nurse drew the Board's attention to the CQC update action plan in which two areas had been highlighted as overdue. With regard to the resuscitation training programme, work was ongoing and plans were in place to review the programme. Assurance was given with regard to the second area relating to the medical device rolling replacement programme, in that the Trust had an asset register, and a prioritisation group led by clinicians, was in place. The escalation process was however the element that was overdue.

During September the Trust reported five STEIS reportable incidents, of which two were reported as Never Events. Deborah Kelly said the impact of Covid-19 on the safety culture was key factor, and was aware of the

disruption Covid-19 had caused. As a result, a Quality and Safety Summit had been scheduled to take place in November to focus on a number of Covid-19 related themes, including staff rostering and safer staffing.

Workforce

Judy Falcao, Director of Workforce and OD reported on the following key points.

An increase in staff sickness was becoming evident as the winter period approaches.

A training recovery plan was being developed for sessions that required face-to-face training.

The People Committee had commissioned a deep-dive in to the continuing under-performance of staff appraisals against the target figure of 90% and would receive a progress report at the December meeting. It was noted that when benchmarked against Trust's across the region, the Trust compared well.

The rate of bank and agency expenditure had slowed during the year due to Covid-19. The reasons cited included the reduced need for bank staff and the dwindling availability of bank staff as people found employment elsewhere.

Performance

John Harrison, Chief Operating Officer reported on the following key areas.

The Emergency Department had maintained its Covid-19 escalation whilst responding to a steady increase in attendances and emergency admissions. Estate changes to provide a Covid-19 secure Emergency Department and Medical Receiving Unit had commenced. The resulting ward changes and overall loss of beds throughout these works would be a challenge, particularly heading in to the winter period and the potential impact of a second wave of Covid-19 hospitalisations. Emergency plans to maintain emergency flow included flexing in to elective bed capacity and working with system partners across Devon to utilise system capacity and ultimately escalation in to the Nightingale Hospital Exeter should the Covid-19 triggers be hit.

Elective activity levels remained below pre-Covid-19 levels, however there had been a significant increase during September particularly for outpatient and day cases, up from 78% of the previous year in August to 85% in September.

In September, whilst cancer and urgent treatment had continued to be prioritised, there had been a deterioration in performance to the extent that the two-week urgent referral to be seen standard, 28-day faster diagnosis standard and the 62-day referral to treatment standard, had not been met.

Good progress had been made across Radiology specialties to maintain capacity and manage waiting times. Overall performance against the Trust's position for the percentage of patients waiting over six weeks was however being impacted by waits for echocardiography, neurophysiology and endoscopy. Escalation of the operational challenges in these areas and

presentation of business cases to increase capacity plans were in place, and would improve waits across these areas.

Rob Dyer said agreement had been reached to adopt a national protocol across the system to monitor patients waiting a long time for review and/or treatment.

Jacqui Lyttle said that through the Quality Assurance Committee, the high risk areas and quality and safety quadrants had been reviewed, together with the clinical risk stratification.

Vikki Matthews commented on the competing dynamics described in the report, in that the Trust was having to deal with a difficult situation whilst planning for the future. She added that despite the challenges, it was good to see progress had been made in a number of areas.

Robin Sutton referred to the issue of patient flow and commented on the testing regime that currently existed within in care homes.

Finance

In presenting the finance headlines for month six, Dave Stacey, Chief Finance Officer reported that month six represented the final month of the retrospective Covid-19 top-up regime.

Setting aside the impact of Covid-19, a year to date surplus of £9m had been incurred, offset by incremental Covid-19 costs of £14.4m, resulting in a year to date top-up of £5m to meet the required break-even position. Dave Stacey commented that the income allocation was more than planned for and therefore the Trust's underlying position is worse than forecast.

It was reported that in-month performance showed Covid-19 costs reduced to £425k, broadly tracking NHSE/I's expectation; an accrual for a back-dated medical pay aware of £0.4m; and, accruals of £0.7m to reflect ongoing strategic projects, legal fees and employment matters.

Also noted were the material balance sheet movements including the refinancing of historic debt reclassified to public dividend capital as part of a national exercise. The underlying cash position remained challenging and would be a key focal point over the coming months in a context where there was a significant capital programme to deliver and the receipt of income in advance is likely to unwind.

Chris Balch said whilst the Trust had been successful in unlocking the availability of capital funding this year which would provide opportunities for development, the Board should not be under a misapprehension that the task in hand would be difficult to deliver.

The Integrated Performance Report for month 6 was received and noted.

193/10/20 **National Adult Inpatient Survey 2019 Results**

In presenting the Adult Inpatient Survey 2019 Report, Deborah Kelly stated the survey pointed to a number of distinct improvement areas for 2020/21.

The Report presented an improvement plan and process for receiving feedback, however due to Covid-19 there had been significant disruption to the feedback process during the year given the lack of opportunity for face-to-face patient contact. Senior nurse leaders had therefore been working to reinstate an appropriate methodology for collating patient feedback, as evidenced by the resumption of the Friends and Family Test in September.

A number of views were expressed by Non-Executive Directors in relation to the value of receiving patient feedback. Jacqui Lyttle also commented on the benefit of co-creating new pathways with patients as the Trust moved forward with its hospital investment plans. The Chairman added that in the past there may have been a discord between the future strategic developments of the Trust, and highlighted the need to be cognisant of the importance of involving patients in their future care. Rob Dyer concurred and said there was good engagement with the Patient Feedback Engagement Group.

The National Inpatient Survey 2019 was noted for information.

194/10/20 **Staff Experience Report**

Judy Falcao presented the Staff Experience Report and reported on the following key points.

- The learning from the first wave of the Covid-19 pandemic and how it would be used to inform the wave two Covid-19 response; in particular the adoption of digital in to new ways of working, staff health and wellbeing and planning for winter.
- The Trust's response to equality, diversity and inclusion.
- The role of the staff survey in obtaining feedback about staff experience

It was noted that the National Staff Survey was now live and staff were being encouraged to participate.

Sally Taylor reported that the Trust was positively supporting BAME staff and staff health and wellbeing initiatives via charitable donations provided by the NHS Charities Together.

The Staff Experience Report was noted for information.

195/10/20 **Freedom to Speak up Guardian Report**

Sarah Burns, Lead Freedom to Speak Up Guardian('FTSU') presented the six-monthly report.

The Board noted there had been a slight increase in the number of cases from the previous six-month period, although this was seen as positive and a reflection of the awareness campaign which had raised the profile of the FTSU Guardians.

Of the main concerns raised, bullying and harassment had been cited as the key theme. Sarah Burns said the Trust was broadly in line with national trends in this respect and within Devon STP, the Trust compared well with three of its neighbouring Trusts, apart from Northern Devon Healthcare NHST. It was noted that Northern Devon Healthcare NHST had also scored highly in the Freedom to Speak Up Index, which quantifies a culture of speaking up by specific questions in the Staff Survey. Rob Dyer said it would be beneficial if the Trust could seek learning from Northern Devon Healthcare NHST.

Sarah Burns commented that FTSU is about culture and the quality and safety culture goes hand in hand. FTSU should therefore provide the ability for the Trust to take a temperature check on its culture, values and behaviours, however at present it did not feel that the Trust had got it right. She therefore asked whether the Board was aware of the areas she was current working with, and what the Board could provide in support.

Vikki Matthews said it was good to see the report and it was interesting that increasing numbers of concerns raised was seen as a positive. It was a good challenge and as Chair of the People Committee she recognised some of the themes raised within the report, and added that it was concerning not all of the themes were known. Vikki Matthews said she appreciated the interventions and would receive suggestions for improvements. Judy Falcao said how the Trust can make the work of the FTSU visible is a good challenge, and the People Committee was starting to raise awareness.

Judy Falcao asked if there was any intelligence that supports the impact of Covid-19 on the number of concerns being raised with the FTSU. Sarah Burns agreed that some low-level concerns have come to the fore since the emergence of Covid-19.

Judy Falcao referred to the behavioural framework and asked whether it was having a positive effect. Sarah Burns said the role of the FTSU was to provide a break or breathing space between the concern being raised and it entering formal process. At the Chairman's suggestion, it was agreed to refer a more detailed review of the impact of the behavioural framework to the People Committee. DWOD/ FTSU

Dave Stacey's comment on the '*Civility Saves Lives'* campaign and whether this could provide support in relation to standards of behaviour, was noted. Rob Dyer said he would include reference to '*Civility Saves Lives'* in the Trust Talks for October.

A number of comments and views were expressed around the need for Executive Directors to provide support for managers and also the Trust culture, which Judy Falcao confirmed were both reflected in the Trust People Plan.

Jon Welch, as FTSU Non-Executive champion, commended the work of the FTSU Guardians and the development of the reporting format.

In concluding the report, Sarah Burns commented on the need to ensure consistency of messaging and ensuring we live by our pledges.

The Freedom to Speak Up Guardian Report was received and noted.

196/10/20 **Quality Account 2019/20**

The Chief Nurse presented the draft Quality Account 2019/20.

In approving the Quality Account 2019/20, the Board:

(i) Noted the Statement of Directors' responsibilities in respect of the Account;

(ii) Confirmed to the best of their knowledge and belief that they have complied with the requirements in preparing the Quality Account; and

(iii) Delegated authority to the Chairman and Chief Executive to sign the Quality account 2019/20 on behalf of the Board. — Chair/ CEO

PART B: Matters for Approval/Noting Without Discussion

Reports from Board Committees

197/10/20 **Finance, Performance and Digital Committee – 28th September and 26th October 2020**

The Chair's Report of the meeting held on 28 September 2020, was received and noted.

Chris Balch reported that the meeting held on 26 October 2020 had focussed its agenda on the following key items:

- Month 7-12 financial plan
- Capital programme update and increasing pressure to achieve and deliver
- Cash position monitoring
- Strengthening of the business cases process
- Governance arrangements around the Trust's Commercial Strategy and S.106 contributions
- Revisions to the Trust's Standing Financial Instructions and the Scheme of Delegation

198/10/20 **Quality Assurance Committee – 28th September 2020**

The Chair's Report of the meeting held on 28 September 2020, was received and noted.

199/10/20 **Audit Committee – 21st October 2020**

	A written report would be presented to next Board meeting.	Audit Chair
	Reports from Executive Directors	
200/10/20	**Report of the Chief Operating Officer** In presenting the report, John Harrison, Chief Operating Officer, drew the Board's attention to the ongoing work within Children and Family Health Devon to strengthen the governance processes and improve waiting times. Community services across the Torbay and South Devon Systems were also highlighted, including a position statement within the report, on the development of Health and Wellbeing Centres.	
201/10/20	**Compliance Issues** No compliance issues were raised.	
202/10/20	**Any Other Business Notified in Advance** No other business had been notified in advance of the meeting.	
203/10/20	**Date of Next Meeting – 9.00 am, Wednesday 25th November 2020**	

Exclusion of the Public

It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1.	Provide detail of any members of staff who contracted Covid whilst supporting care homes.	M Fox (via MD)	Update 28 October: No reported cases. Action completed	29/07/20
2.	Provide detail in respect reasons for increased headcount since March 2020.	DWOD	Update 28 October: Increase of 66 WTE. All identified as vacancies and within plan. Action completed	29/07/20
3.	Assurance to be provided to Mrs Taylor in respect of the social care assessments backlog.	SDNPP	Update 28 October: Information presented and reviewed at the Quality Assurance Committee Action completed	29/07/20
4.	Provide information showing total people costs including bank and agency by activity.	CFO	Update 28 October Board referred action to the Finance, Performance and Digital Committee Action completed	29/07/20
5.	Review resource dedicated to the new network implementation programme.	DTP		30/09/20
191/10/20	Present Winter Plan to the November Board meeting	COO		28/10/20
195/10/20	People Committee to undertake a detailed review of the impact of the behavioural framework.	DWOD	Update 25 November Item added to People Committee Workplan Action completed	28/10/20
196/10/20	Chairman and Chief Executive to sign Quality Account 2019/20 on behalf of the Board	Chairman/ CEO	Update 25 November Quality Account 2019/20 signed Action completed	28/10/20

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 25 November 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 17 November 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: 25 November 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 28 October 2020 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Ongoing response and recovery to the COVID-19 outbreak

The number of people becoming seriously ill with COVID-19 has been increasing in recent weeks, as have hospital admissions and, sadly, COVID-19-related deaths. This is why the government introduced a four-week national lockdown. It is also behind the announcement by the NHS Chief Executive, Sir Simon Stevens, that the health service has returned to its highest level of emergency preparedness. The confirmation of this 'Level 4' readiness means that there is once again national co-ordination of the pandemic, and if a hospital reaches capacity, then people may be taken to other hospitals or areas for treatment.

We, along with all other NHS Trusts, have robust plans in place to maintain essential NHS services and the increase in the numbers of admissions of patients with COVID-19 to our hospitals. The majority of patients who have become acutely unwell with COVID-19 recover well and are able to return home.

The demographics of our area mean that we care for a higher proportion of frail and elderly residents, many with pre-existing conditions.

We continue to work with our local authority colleagues to support care homes to manage any cases amongst their residents and staff, by offering infection prevention and control advice, carrying out deep cleans and helping to provide nursing and medical cover. This approach has helped them to keep hospital admissions for their residents with COVID-19 to a minimum. As well as supporting care homes when they receive positive test results, there are also a number of multi-agency task and finish groups running, led by local public health officers. These are looking at any areas where further support would be helpful, such as protecting domestic and kitchen staff and how visiting could safely start.

We are doing all that we can to reduce the impact of the high level of escalation on our services, and are continuing to run urgent and emergency services, alongside working hard to ensure that people waiting for less urgent treatment and operations can be treated safely during this second wave.

We are using digital technology to assess and review more people remotely, but we do offer face to face appointments for people who need them. We have separate areas for treating our COVID-19and non-COVID-19 patients, and have put in place extra infection prevention and control measures across all our sites, so that we can continue to provide services safely.

Throughout Devon, we are working in partnership right across health and social care services to make sure that we make the most of our capacity, and to support our staff with wellbeing initiatives, including for those who are in the clinically extremely vulnerable group. Thanks to a new national programme which started this month, we are also now able to offer regular saliva testing to our frontline staff, so that we will be able to identify any asymptomatic staff who need to self-isolate.

Our fundraising lead is working hard to ensure that we support our staff and local community during Covid-19 through the very generous donations that we have received from the national NHS Charities fund and our local donations. Care packages have been distributed to all areas that care for Covid-19 patients, which offers vital support for our staff who work on these wards. For our community we have made collection points available for staff and local people to donate food items for the local food bank. A large part of our community has been hard hit by the Covid-19 pandemic and there is a growing gap of inequality across the local population. As a trust we are committed to supporting the wellbeing of our local people and invite our staff and local community to donate food to those who need it during these difficult times.

Comment

I would like to pay tribute to the dedication and professionalism of our staff for their incredible commitment during this challenging time.

For people in our communities, I would like to reassure you that we have put in place additional infection prevention and control measures to keep all our facilities and services safe. If you have been offered an appointment, it means that you **do** need support from our health and care teams, and I would urge you to attend, so that we can provide the care you need.

We are also asking for your help: help us to help you, by using our services wisely and by always adhering to the national ‘hands, face, space’ guidance. This is the best way that, together, we can work to reduce the spread of COVID-19 and ensure we protect our NHS for everyone who needs it this winter.

You can also help us by choosing the most appropriate service for your needs: for example, a minor injury can be treated at Newton Abbot and doesn’t require a visit to Torbay Hospital’s Emergency Department (ED). On the other hand, anyone experiencing chest pain or showing signs of a stroke needs the immediate care of our ED team.

NHS111 can signpost people to the most appropriate services, and a new pilot is underway for a ‘heralded’ arrival to ED (see section 3.1.3 below).

I Care Campaign for staff - Hands, Face, Space
For our staff in particular, we have launched an 'I Care' campaign, which encourages us to be role models, showing that we are doing bit and actively supporting and challenging each other to:

- correctly wear the appropriate PPE
- be rigorous in our handwashing
- maintain social distancing at all times and places.

To help improve social distancing between patients in many of our inpatient areas at Torbay Hospital, we have installed new plastic curtaining between beds. Perspex screens have also been fitted in many reception areas across our Trust.

Nationally published data
Each Thursday, NHS England publishes information about COVID-19 cases for every Trust in the country. The figures are published a week in arrears and provide monthly data for the ongoing the COVID-19 situation. The figures below were published on 12 November and provide a snapshot for our Trust for the 24 hours to 5 November 2020, unless otherwise stated.

COVID-19 admissions	5
Inpatients diagnosed with COVID-19	0
New hospital cases	1
New admissions to hospital from the community	1
New hospital admissions from a care home	0
Total beds occupied	356
Beds occupied by COVID-19 patients	37
Mechanical ventilation beds (ICU) occupied	6
Mechanical ventilation beds (ICU) occupied by COVID-19 patients	1
COVID-19 discharges from hospital	4
COVID-19 related staff absences (4 November)	155
Total deaths within 28 days of COVID-19 positive test during pandemic period	60

Regular staff testing for COVID-19
NHS England and NHS Improvement have published a letter stating that asymptomatic testing for COVID-19 can be made available to all NHS staff who are in direct contact with patients. Currently, this is being rolled out to a limited number of trusts as a pilot. One of the Trusts taking part in the pilot is University Hospitals NHS Trust, Plymouth, and they have informally reported that they have not received adequate number of test kits to fulfil the programme.

Staff will be asked to test themselves at home twice a week, using the saliva tests and they will have the results before leaving for work. All positive results will need to be cross-checked using PCR swabbing tests.

We are planning how we will deliver this programme across our frontline staff and will update you when we receive further details of the national rollout.

Drive-through swabbing
On Thursday 19 November 2020, the drive through COVID-19 swabbing service moved from its previous location at the Crowthorne Unit to its new location at Newton Abbot Racecourse, Newton Road, Newton Abbot, TQ12 3AF. The service continues to provide swabbing in the same way as before to symptomatic NHS and care provider staff, as well as to patients who need to be swabbed prior to treatment and procedures. All staff and patients are informed at the time of booking the swab when and where they need to attend.

COVID-19 vaccination
Sir Simon Stevens announced in a press briefing this month that there is a possibility a vaccine may be ready before Christmas. The government has asked the NHS to prepare and be ready to deliver a COVID-19 vaccination programme. It isn't yet certain when the vaccine will be available, but Devon CCG is working closely with NHS England to ensure we have system-wide plans in place ready for when it is. The model is likely to follow that for flu vaccination, where we would vaccinate our health and care workers and GPs would be responsible for vaccinating their eligible populations.

Visiting our hospitals
We are caring for a relatively high number of people who have tested positive and know that the incidence of COVID-19 in our communities has been increasing.

In view of this we took the difficult decision to review our visiting policy. We know that seeing loved ones is extremely important for patient recovery and wellbeing, and also very important for families. We have therefore continued with some limited visiting arrangements, as set out below, and are supporting people to keep in touch using technology.

General areas
- Patients in the final days of life will be able to receive visitors on compassionate grounds as agreed with the ward
- One carer who is supporting someone with a mental health issue such as dementia, a learning disability or autism, where them not being present would cause the patient to be distressed

Children's areas
- In the neonatal (newborn) unit fathers / guardians can visit for one hour per day and be with the mother. There is a rota in place to support social distancing, which will be monitored by the ward staff.
- On our children's ward, Louisa Cary, one parent / guardian can visit and they are swabbed so this person becomes the key parent on the ward during the stay. If there is a need to change then other parent / guardian is swabbed prior to visiting.
- Unfortunately, only one parent will be allowed into children's theatres, due to lack of space, and sadly siblings are not able to visit at this time.

Maternity
Visits to maternity were also reviewed following the government's announcement of a national 'lockdown' that commenced on 5 November 2020. During thist time, the following arrangements were put in place and were due for review at the end of lockdown:

- A birthing partner will be able to stay during established labour, birth and the early postnatal period on delivery suite.
- A birth partner can join expectant Mums when they attend for induction of labour (09.00-17.00) or for assessment because they are possibly in labour.
- One nominated individual living in the same household will be allocated a 1-hour time slot each day to see mother who have given birth in our postnatal ward.
- Birth partners can also join expectant Mums attending for their dating and anomaly ultrasound scan appointments.

Mortuary
Along with the vast majority of funeral directors, we are unable to facilitate viewings of COVID-19 positive patients in the mortuary. Our general capacity for viewings is also very limited. This is predominantly to protect members of the public, as they would be entering a COVID-19 area for viewings and potentially coming into contact with staff who work in a COVID-19 positive environment.

Comment

We recognise that these restrictions can be difficult and distressing for many people and we are extremely sorry that we have had to take this action. However, we need to do everything we can to reduce the circulating virus, to protect lives and maintain the services provided by the NHS. This is a very challenging time for us all and I would like to thank all our staff and local people for your continued co-operation in helping us to keep people safe.

1.1.2 Care homes visitor testing pilot

The impact of COVID-19 has hit our most vulnerable people hardest, and it's very difficult to stop it spreading in people's homes, whether that's a family home or a care home. From Monday 16 November, the government started a four-week rapid testing pilot in around 20 care homes across Hampshire, Cornwall and Devon. Devon homes were asked to volunteer via the WhatsApp group.

Each resident will be able to have one relative or friend who can be their 'key visitor' who will take a COVID test, and then be able to visit indoors without a screen. Visitors will be offered either regular swabbing (PCR) tests which they can do at home, or the new 30-minute rapid lateral flow saliva tests (LFTs), which can be administered in person at care homes before a visit. All the homes in our area taking part in this pilot are using the new saliva testing kit:

Homes taking part in our communities
Summercourt, Teignmouth
The Grange Residential Hotel, Ipplepen, Newton Abbot
Sefton Hall, Dawlish
Somerforde Limited, Newton Abbot

If successful, the pilot is expected to be rolled out more widely in time for Christmas. In the meantime, we continue to work closely with Devon County Council and Torbay Council to support care homes during the pandemic.

Comment

We know just how difficult it has been for people not being able to visit their loved ones during the pandemic. We believe that it is vital that we continue to provide care homes with support so that residents can be safe. We look forward to successful results from this pilot so that more people can visit their loved ones soon.

1.1.3 Winter resilience

As part of our planning to keep people moving smoothly through our services over the winter, we introduced our discharge lounges earlier this month. These lounges provide dedicated waiting areas with comfortable seating for patients who are going home. This means ward staff have earlier access to clean and prepare the beds they are vacating for the next acutely unwell patients being admitted. The facility will also contribute to the prevention of crowding in the emergency department, ensuring the department can continue to operate safely during busy times. Our discharge lounge service runs from 9.30am until 8pm, seven days a week.

We also continue with a programme of temporary ward moves and relocations, whilst we carry out improvement works across our emergency pathways. This week, the planned relocations of Ricky Grant (Oncology/Haemotology day unit services) and Short Stay Paediatric Assessment Unit (SSPAU) took place to allow us to ensure our children's services are COVID-19 safe ahead of the anticipated annual winter upsurge of bronchiolitis. Ricky Grant has a temporary home on McCullum ward and SSPAU is currently on Ricky Grant. The number of cots on our Special Care Baby Unit has been reduced from 10 to eight. Maternity staff have increased the hours of the maternity assessment unit to help manage evening surges and reduce overnight stays, having vacated McCallum. We are grateful to all our staff teams including logistics, cleaning and IT for ensuring that the moves were able to happen quickly, safely and with as little disruption to patients as possible.

Flu vaccination campaign

We are continuing to vaccinate our staff, with a higher uptake than last year. We started by prioritising patient-facing, frontline staff and have now opened up the campaign to all other staff groups, who can attend a pre-booked clinic slot or request a peer vaccinator. Our aim is to complete as many staff vaccinations as possible by the end of November, to enable the requisite 'window' between vaccinations , if a COVID-19 vaccination is rolled out as anticipated from next month.

We are also supporting the CCG-led campaign to encourage people to have their free flu jab if they are eligible.

1.2 Valuing our Workforce, Paid and Unpaid

1.2.1 Staff Heroes Annual Awards

Last year we presented our annual Staff Heroes awards during a gala celebration evening at the Grand Hotel in Torquay. This year, that option is not open to us – and it is not clear when we might be able to plan for a face-to-face event. However, the Chairman and I felt it was extremely important that these awards go ahead to mark the

extraordinary commitment and outstanding achievements of so many of our staff during the past year.

The judging panel, which included representatives of governors, staffside, clinical and support staff as well as Healthwatch, met remotely and agreed the winners and runners-up across all our categories. This year, I was particularly pleased to see finalists from some of our valued partner organisations.

The Chairman and I have filmed a presentation to announce the winners, and this will be shared with staff at a launch in December. We will then visit each of the winners to make their presentations, or arrange to deliver awards if they are home-working or self-isolating.

We also hope to hold an open event next summer, in which we can thank all of our staff for their significant contribution to keeping services running during what has been our most challenging year ever.

1.2.2 Trust Governor elections

We very much value the role that our Governors play in the accountability of this organisation as a Foundation Trust. An important element of being a Foundation Trust is that the Trust has a Council of Governors, who take on very important statutory duties including:

- working with the Board of Directors to ensure that the Trust follows its constitution
- helping to set the Trust's strategic direction
- representing the views of local people to ensure Trust plans are shaped appropriately.

Elections for the Council of Governors are held annually and we are starting the election cycle in December for appointments commencing on 1 March 2021. Currently we have vacancies in both our Torbay constituency and Teignbridge constituency and will be looking for a diverse range of candidates who are enthusiastic, interested in health and social care and willing to represent the views of their communities.

2. Chief Executive Engagement: October

I have continued to engage with external stakeholders and partners; however, due to the continuing pandemic and necessary social distancing, most meetings have been held remotely with the aid of digital technology. Along with the executive team, I remain very conscious of the need to maintain direct contact with our staff, providing visible leadership and ongoing support, as our teams continue to strive for outstanding care during exceptionally challenging circumstances across all services.

Internal	External
• Staff Side • Video blog sessions • Consultant Medical Staffing Committee	• Chief Officer for Adult Care and Health, DCC • Director of Children Services, Torbay Council

• Child and Family Heath Devon Board – Senior Leaders Meeting
• Staff Heroes Virtual Annual Awards filming
• Visits:
  o Pre-Assessment
  o Ophthalmology/Outpatients
• Freedom to Speak up Guardians
	• Accountable Officer, Devon CCG
	• System Chairs, Leaders, Directors of Adult Social Services Meeting
	• Devon Health and Local Authority Chief Officers' Meeting
	• South West Regional Chief Executives
	• Teignmouth Learning Review
	• Principal South Devon College
	• Director of Adult Social Services, Torbay Council
	• Devon Children and Family Partnerships Executive Meeting
	• Chief Executive, AHSN
	• Regional Medical School Liaison Meeting

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

3.1.1 CCG Coastal consultation update

Moe than 1,000 local people took part in the Devon CCG-led formal public consultation about the future delivery of services in the Teignmouth and Dawlish areas. The consultation ran from 1 September to 26 October. Face-to-face meetings couldn't take place due to the pandemic and fewer people were visiting places where they would normally find information, so an even greater than normal effort was made to ensure as many people as possible heard about the proposal and could give their feedback.

Over the period, consultation documents were distributed to 16,000 local households and a further 133,000 leaflets were distributed right across Torbay and South Devon to ensure as many people as possible could take part. People were able to phone, email or write in with their feedback, as well as attend one of six online meetings. A further online session was set up in response to a request.

Healthwatch Devon, Plymouth and Torbay are independently collating the feedback and some initial high-level feedback shows:

- 96.64% of respondents understood the proposal
- 83.10% said that the reasons for why change is needed was clearly explained
- 77.44% said they had 'completely' or 'mostly' been able to get the information they needed to and had been able to contribute their feedback and only 5.13% answered 'no' to this question

Some common themes emerged from the online meetings:

- **Integration of Services** There is significant support for the idea of services being joined up so that care can be well coordinated round individual needs

- **Health and Wellbeing Centre** This is viewed as a positive addition to health care local services
- **Parking/Transport** There is significant concern that parking would be difficult which would make travel by car an issue. Concerns raised about the public transport to Dawlish
- **COVID-19** People wanted to know that this has this been fully taken into account
- **Teignmouth Community Hospital** The hospital is greatly valued and for some irreplaceable
- **Workforce** Concern that there would not be enough nurses and care workers to care for people at home
- **Space** Ensuring there is enough space in the new Health and Wellbeing Centre

Next steps

During the consultation people were asked to give any alternative proposals and these will be fully considered by a representative panel. Proposals will be evaluated against the same criteria that was used to assess the options considered for the public consultation.

Devon County Council's Health and Care Scrutiny Committee, will also review the information collated by Healthwatch, before it is considered by the Devon CCG Governing Body on 17 December, along with the conclusions of the representative panel.

3.1.2 Planning application for Dartmouth Health and Wellbeing Centre

The Health and Wellbeing Centre Planning Application was submitted on 29 May 2020. The usual timeframe for a decision is 13 weeks, however our application is still to be determined, and we are now expecting it to be considered at the planning meeting on 2 December. Questions from the Planning Department led to a review about the number of trees to be retained around the council car park. We also had to monitor rainwater drainage on the site for a period of time, to be sure we fully take account of drainage requirements.

In the meantime, detailed design work has continued to refine the infrastructure requirements of the building. Room data sheets have been reviewed, both from a CVODI-19 perspective and to ensure that the design of spaces remain fit-for-purpose. All Trust and GP service leads occupying the Centre have now confirmed their readiness to proceed with the design, which meant we were able to issue a tender for the build contractor in November and ultimately appoint the main building contractor.

We are still aiming to start work on site in February 2021.

3.1.3 NHS 111 referral of patients to ED being trialled across Devon

This month, our Emergency Department (ED) along with all other EDs across Devon, has been trialling a new way of receiving patients into emergency care.

People who contact NHS 111 and who are assessed as being appropriate for emergency treatment that only ED can provide, can be referred directly by NHS 111 by email to our ED, which will let them know the patient is coming. The process is called 'heralding'. This initiative is taking place ahead of a national campaign, which will be

launching in December, that seeks to encourage people to contact NHS 111 before attending their local ED if they need urgent treatment.

After contacting NHS 111 the caller will be assessed and prioritised. If their need is for emergency medical treatment they will then be directed to their nearest ED, but if their need is less urgent then they may also be directed to somewhere else more suitable in our local health system. As always, our aim is to provide the best care in the right place at the right time while ensuring our most capable emergency services are used and available to serve the most critical needs of our community.

This is happening ahead of a national campaign launching in December to encourage people to contact NHS 111 before attending their local ED. After contacting NHS 111, the caller will be triaged; if they need emergency medical treatment they will be directed to their nearest ED, but if their need is urgent and can be met elsewhere within the NHS they will be directed accordingly. All this is designed to reduce the number of people attending walk-in services unnecessarily, especially ED, and instead to signpost them to the most appropriate care setting, so helping to maintain public and staff safety and reserve urgent and emergency services for those who most need them.

3.1.4 plans for a new long-COVID service

The government is making funding available to set up long-COVID assessment services across the country, for patients who have experienced COVID-19 symptoms for 12 weeks or more. We are expecting around £1million for the South West as a region to get the service up and running to March 2021. Devon Clinical Commissioning Group (CCG) is currently finalising details for this service across Devon. It will include medical, physical, cognitive, psychological and diagnostic assessment and seamless onward referral for support as needed.

3.1.5 Beech Ward

Devon Partnership Trust (DPT) is currently carrying out a £2.2m refurbishment of Beech ward, which is based on the Torbay hospital site and provides services for older people with mental health needs. Beech ward will be closed from 8 December and DPT has to find alternative hospital accommodation for its patients and staff team. Having explored a number of alternatives, the decision has been taken to use a ward in Taunton which is owned by Cygnet Health Care. This is the nearest alternative location that can provide a safe, high quality facility. The ward team has already spoken to current patients and their families and will be doing everything possible to ease any difficulties created by this temporary situation. When the refurbished Beech Ward re-opens next year, it will bring a very welcome improvement in the ward environment for both patients and staff.

4 Local Media Update

4.1 News release and campaign highlights include:

We continue to maximise 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.

A Devon-wide media campaign, led by the CCG, is underway to ensure local people are aware of how to access the right services, and are confident that we have put in place good infection prevention and control measures to reduce the risk of transmission of COVID-19.

Since the last board report, coverage to promote the work of our staff and partners has included:

- New app connects multiple sclerosis (MS) patients with trusted advice
  The app, one of the first NHS MS apps in the country with local content, connects health and care professionals from Torbay Hospital's MS service with patients, allowing remote sharing of trusted advice based on a mutual understanding and experience of the condition.
- Newly Qualified Assistant Practitioners
  - 22 apprentices qualified as Assistant Practitioners after a two-year apprenticeship and foundation degree. During the pandemic they had been re-assigned to support different areas, but with resilience and determination all of them completed their course and look forward to taking the next step in their career.
- Little Ones Memorial Weekend 2020
  - Promoting next month's little one's memorial weekend; an annual event where families who have lost a baby or infant take part in activities to remember, reflect and be supported. This has been adapted this year so that craft activities can be sent home and the service will be virtual. Early promotion of the event is aimed at ensuring that as many affected families as possible can take part.
- BBC Spotlight interview with Medical Director, Mr Ian Currie on the COVID-19 status of the Trust

Recent engagement on our social media channel includes:

- We are here for you
- World Radiology Day
- Occupational Therapy Week
- Dart Ward Accreditation
- New assistant Practitioners
- Remembrance Sunday
- Diwali
- Children in need
- Healthwatch 111 consultation
- Halloween babies
- Southwest Peninsula NHS Bank launch
- Changes to visiting arrangements

5 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report of Board of Directors			
Report title: Integrated Performance Report (IPR): Month 7 2020/21 (October 2020 data)			Meeting date: 25 November 2020
Report appendix	M7 2020/21 IPR focus report M7 2020/21 - Dashboard of key metrics Appendix 1 – System Finance Report Appendix 2 - Covid finance report		
Report sponsor	Director of Transformation and Partnerships Chief Finance Officer		
Report author	Head of Performance		
Report provenance	ISU and System governance meetings – review of key performance risks and dashboard Executive Directors: 17 November 2020 Integrated Governance Group: 18 and 19 November 2020		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • Review evidence of overall delivery, against national and local standard and targets • Interrogate areas of risk and plans for mitigation • provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator. Areas of exception 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 Board is asked to **review** the documents and evidence presented.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks	

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

This report reflects the following corporate risks:

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

Report title: Integrated Performance Report (IPR): Month 7 2020/2021 (October data)		**Meeting date:** 25 November 2020
Report sponsor	Director of Transformation and Partnerships Chief Finance Officer	
Report author	Head of Performance	

The main areas within the Integrated Performance report that are being brought to the Committees attention are:

1. Quality headlines

Incidents

- There have been 4 STEIS incidents reported in October
- Never Event – This occurred in ophthalmology and involved the incorrect strength lens implant. The patient suffered no lasting harm, Duty of Candour was completed and is subject to the never event investigation process.

Infection control

- October has seen an increase in the admission of COVID 19 positive patients and a number of outbreaks across the inpatient setting. The pattern of outbreaks reflects a national picture and we are working with regional and local partners to continually review systems and processes in line with national guidance, ensuring we are applying optimal IPC precautions at all times.

VTE performance remains below the required 95% standard

- The Trust's Task and Finish Group has met and instigated a number of immediate actions with the aim of improving performance to the 95% compliance by April 2020
- There is a need to ensure that the coding and data sets for patients eligible for risk assessments is correct
- Awareness raising of the importance of VTE and its inclusion on the drug chart was agreed
- To progress work with Info flex manager to ensure the data system is and consider inclusion as a mandatory filed within the system

Safer Staffing

The organisation is focused on maintaining optimum staffing to ensure patient safety and the highest quality of care. In line with the National Quality Board requirements, the Trust has implemented a regular reporting framework around nurse staffing levels. As a result of recent ward reconfigurations, bed closures and reassignment of staff, the data flows captured in the CHPPD and Planned versus Actual report have been disrupted, as such it does not present an accurate position of the staffing position across the organisation.

In the spirit of ensuring that the Trust publishes and makes available information underpinned by validated data, we have reluctantly withdrawn the monthly CHPPD with a view to strengthening this over the next 2 Months.

The Board should note that as part of the routine safer staffing assurance framework we will continue to monitor staffing levels through the range of existing measures and controls that are deployed as part of business as usual procedures. These include;

- Program of work around the annual establishment reviews setting and agreeing skill mix and nurse to patient ratio
- Ensuring robust rostering practices,
- Review of staffing levels through the control meetings whereby four times a day.
- Senior nurse leadership report against expected nurse to a patient ratio for each ward, identifying and mitigating against gaps in capacity.

More recently we have developed an enhanced framework that ensure we are taking a risk-based approach to staffing during extremis. The Board, along with STP Executives, has approved a risk management framework and approach to ensure the safest deployment of staff within the context of nurse to patient ratios. Within this, there are agreed thresholds of risk that triggers to enable interventions and /mutual aid internally and externally. Crucially a shared set of principles have been agreed that include

- No one organisation staffing levels are compromised
- Equivalent Ratios across the system through the agreed risk assessment framework
- Collective commitment to Nightingale requirements
- Common set of assurance frameworks for Board Assurance

2. Workforce Headlines

- The WTE (hours worked) workforce number across the 3 main staff groups is consistently in excess of the budgeted establishment, this includes bank and agency staffing. The Nursing Establishment review will enable the Trust to reset the appropriate staffing levels based on service need.
- The fragility in the Medical Workforce as a result of gaps and retirements is impacting on the following speciality services Neurology, Obstetrics and Gynaecology, Oncology, Cardiology and Microbiology. Mutual Aid support has been requested from the system for Microbiology.
- In October we experienced a 17% total absence rate taking account of Vacancies, Sickness, Covid Impact and Maternity and Special Leave, putting significant pressures into the system. The Covid impact of absences continues to rise.
- Agency expenditure has increased in month 7, being £0.68m (M6 £0.58m) – this is higher than the plan submitted to NHSE/I (£0.54m).

3. Performance Headlines

- **Elective inpatient capacity:** The Trust has converted additional elective capacity to support provision of the safest possible care as the number of COVD-19 patients admitted increased. The team leading elective care have fully

assessed the impact on the phase 3 plans at specialty level and the risks, alongside mitigation plans, are being monitored through the Integrated Governance Group. Specialities highlighting an impact on patient care, will be subject to review by the Quality Assurance Committee.

- **Covid-19 escalation:** The co-ordination of the response to COVID-19 is being delivered across the Trusts in North, East and South Devon via a twice daily meeting. This ensures that, where possible, capacity is being shared to support the safest possible care for all patients across the 3 providers.

- **Diagnostics:** The operational plan for diagnostics capacity has been impacted as a result of a mobile CT scanner being moved to another area and room to deliver endoscopy not being available until March 2021. Alternative capacity is being utilised, however this puts the delivery against the Phase 3 plans for 100% recovery to pre covid levels of activity and maintain the 6 week maximum waiting time at risk. As revised trajectory of phase 3 plan as a result will be presented to the December committee.

4. Finance Headlines

Month seven represents the first month of a 'more normal' financial regime, following the demise of the retrospective top up process, save for Nightingale, laboratory and hospital discharge costs. In line with NHSI/E requirements, YTD variances to M6 have been zeroed out. The following points with respect the Trust's financial performance are noteworthy:

- In month, a surplus of £0.4m was delivered, which is a £0.1m favourable position, against the phased H2 plan. This included £3.2m of prospective Covid income, of which £3.0m is from the STP allocation and £0.2m from the lab testing fund (which remains on a top up regime).
- Overall income was £0.9m adverse to plan in month, comprising TP (£0.6m) and CCG / Torbay Council income which will be received later in the year (£0.5m) offset by variable income and ASC client contribution (£0.2m).
- Substantive pay is £0.4m favourable to plan, representing expected investments not yet coming on stream, albeit partly offset by an increase in the agency run rate of almost £0.1m.
- Non-pay expenditure (exc ASC) is £0.2m adverse to budget, driven by TP costs of sales (£0.5m) offset by lower than planned spend on lab testing and non-clinical supplies.
- Adult social care and placed people spend is £1.0m favourable to plan in month owing primarily to a fall in residential nursing placement costs in CHC.

With respect to Covid costs in the year to date:

- £5.4m of pay costs relate to covid, mainly additional shifts for existing workforce (£2.6m) and backfill for staff absence (£2.3m).
- £5.2m of non-pay costs (exc hospital discharge) relate to covid, mainly testing (£1.5m), segregation of patient pathways (£1.2m) and locally-sourced PPE (£1.2m).

- £9.4m has been spent on hospital discharge and infection control support to the independent sector, of which £4.1m funded by the council and the balance through Covid top up (£4.4m) and the CCG (£0.9m).

Balance sheet, capital & cash:

- The cash position remains strong at £56.3m, albeit masking an underlying cash position of c. £7m. This continues to be monitored in the context of an expected unwinding of the payment in advance regime.
- YTD capital expenditure of £11.2m has been incurred, an increase of £3.6m in month. Nevertheless, this is £1.7m less than the phased capital plan, and continued focus is required to drive a step change in the pace of delivery.

Looking ahead, the following areas of risk and focus remain:

- Covid escalation and the impact on Phase 3 recovery, staff availability and support costs e.g. cleaning, service moves.
- Escalating costs within the independent sector, delayed delivery of ASC savings programmes and safely managing Scheme 1 and Scheme 2 of the hospital discharge programme.
- Quantifying the movement in underlying deficit position, and taking action to accelerate 2021-22 CIP delivery.
- Delivery of the required profitability targets within TP.

5. Recommendations

The Board is asked to review the performance information and action plans presented to address key issues highlighted.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

November 2020 (Month 7): reporting period October 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 exceptions

1. HSMR - The latest Hospital Standardised Mortality Rate (HSMR), released for time period to June 2020 compared against the National benchmark (100) is 99.4 being representative of and within control limits for alerting.

2. Incidents - There have been 4 STEIS are reported in October

- A Grade 4 Pressure Ulcer (PU) within the community - an in-depth review of reported PUs, has commenced and will be reported to the Quality Assurance Committee in November
- Fall - The Trust has reported a fall in Totnes resulted in a fractured neck of femur, evidence shows that there is more to do ensure timely and accurate risk assessments and interventions.
- Wrong patient called for scan – PAS Data had been wrongly changed. An alert was cascaded to remind staff regarding patient identity checks to include NHS number, full name and DoB are used to identify patients. In this case
- Never Event – This occurred in ophthalmology and was a wrong lens implant . The patient suffered no lasting harm, Duty of Candour was completed and is subject to the never event investigation process.

3. Infection control – October has seen an increase in the admission of COVID 19 positive patients. The Trust has seen a number of outbreak across the inpatient setting which reflects a national picture and is working with regional and local partners to continually review systems and processes in line with national guidance

4. VTE performance remains below the required 95% standard - The Trust's Task and Finish Group has met and instigated a number of immediate actions with the aim of improving performance to the 95% compliance by April 2020

1) Evidence shows there is a need to ensure that the coding and data sets for patients eligible for risk assessments is correct
2) Awareness raising of the importance of VTE and its inclusion on the drug chart was agreed
3) To progress work with Info flex manager to ensure the data system is and consider inclusion as a mandatory filed within the system

CQC update

Within the CQC improvement plan there are 3 must do areas that are currently overdue , these are;

- Ensure clear oversight of compliance with resus training
- Ensure equipment and premises are fit for use
- Ensure there is a rolling equipment replacement programme

There is actions being undertaken to deliver against the 3 must do's that are overdue that are interdependent of wider programmes of work that is progressing.

During October the operational leads and ISUs have had a range of individual meetings to review the progress of the evidence associated with the actions related to the CQC improvement plans. There has been positive engagement and involvement of the teams to capture and assess completion of the actions, which includes demonstration and validation of evidence to provide achievement and embedding of the actions in practice.

The discussions regarding the evidence has been positive, however there is still further work for the evidence to be in a position to be validated. Therefore these evidence meetings will be monthly in order to work alongside the teams to provide continued monitoring of the implementation plan and focussing on the good best practice evidence as part of the improvements to the fundamental standards with each CQC domain (Safe, effective, caring, responsive and well-led).

CQC Compliance Actions Status

CQC Core Service	No. of Actions		Completed		On track		Risks overdue		Overdue / Concern	
	Must	Should	Must	Should	Must	Should	Must	Should	Must	Should
Trustwide	1	0	0	0	0	0	1	0	0	0
Urgent and Emergency	8	6	0	0	8	6	0	0	0	0
Medical Care	9	12	0	0	9	12	0	0	0	0
Surgery	4	5	0	0	2	5	2	0	0	0
Maternity	4	11	1	1	3	8	0	2	0	0
Children and Young People (Acute)	1	5	1	0	0	5	0	0	0	0
Community Inpatients	1	4	0	0	1	4	0	0	0	0
TOTAL	**28**	**43**	**2**	**1**	**23**	**40**	**3**	**2**	**0**	**0**

Achieved
Reported Incidents – Severe
Reported Incidents - Death
VTE - Risk Assessment on Admission (Community)
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams
Formal complaints - Number received
Hand Hygiene
Infection Control - Bed Closures - (Acute)
Hospital standardised mortality rate (HSMR)

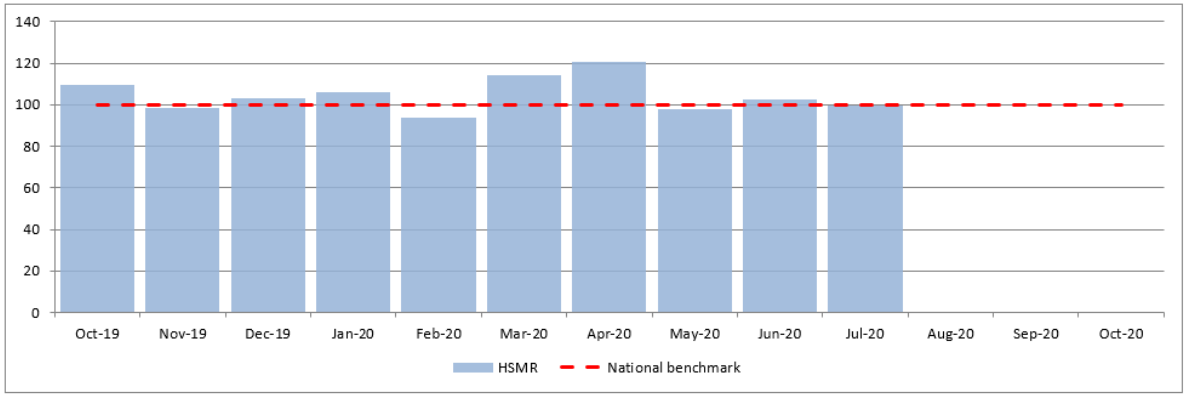
Not Achieved
Never Events
Avoidable New Pressure Ulcers - Category 3 +
VTE - Risk Assessment on Admission (Acute)
Fracture Neck Of Femur - Time to Theatre <36
Follow ups 6 weeks past to be seen date
Stroke patients spending 90% of time on a stroke ward- not yet available
Strategic Executive Information System (STEIS)(Reported to CCG and CQC)

Under Achieved
Safer Staffing - ICO – Daytime
Safer Staffing - ICO – Night time
Medication errors resulting in moderate harm

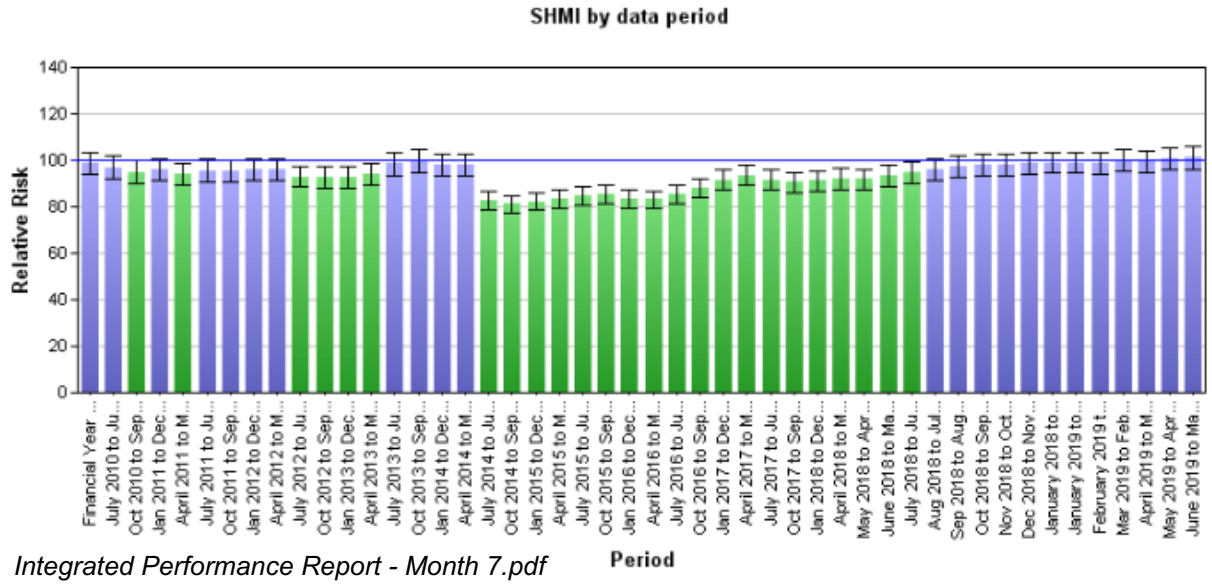
No target set
Medication errors - Total reported incidents

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
HSMR	109.7	98.6	103.3	106	93.9	114.4	120.7	98.1	102.6	99.4	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, July 2020, for Dr Foster HSMR is showing a relative risk of **99.4** which is below the national benchmark and well within the tolerance to trigger an alert.

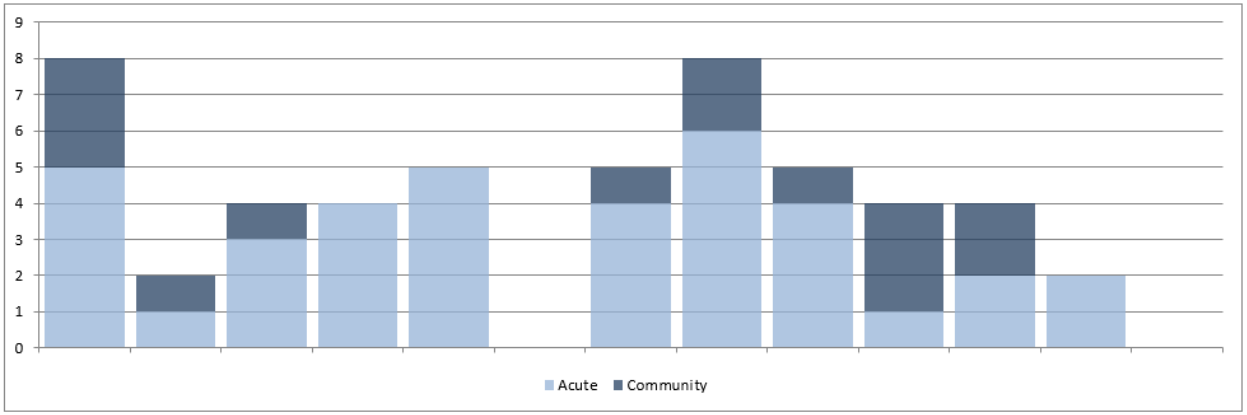


The Summary Hospital Mortality Index (SHMI) data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trust at 101.08 against a national average benchmark of 100. Latest data for period June 2019 to May 2020. SHMI, HSMR, and Dr Foster alerts are 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

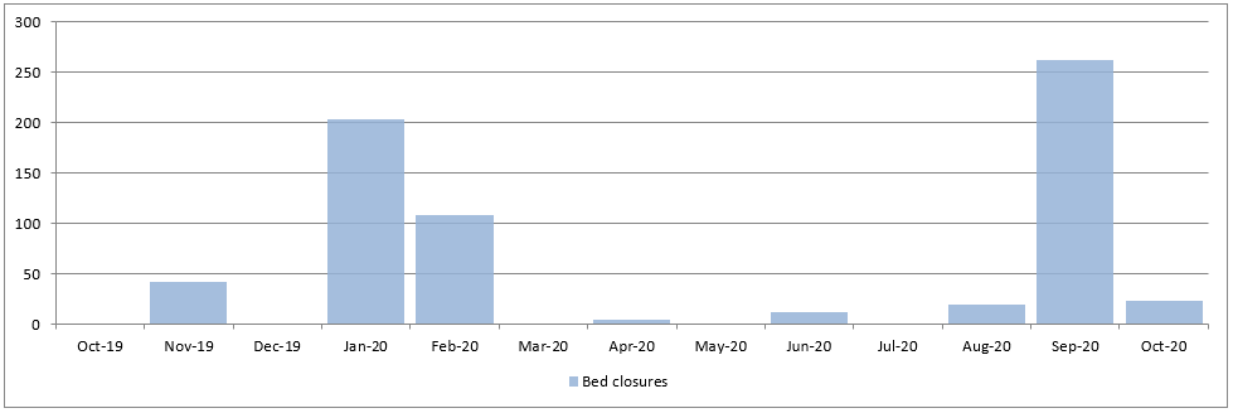
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Acute	5	1	3	4	5	0	4	6	4	1	2	2	0
Community	3	1	1	0	0	0	1	2	1	3	2	0	0



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. There have been no cases identified in October.

Infection control - Bed closures (Acute)

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Bed closures	0	42	0	204	108	0	4	0	12	0	20	262	23

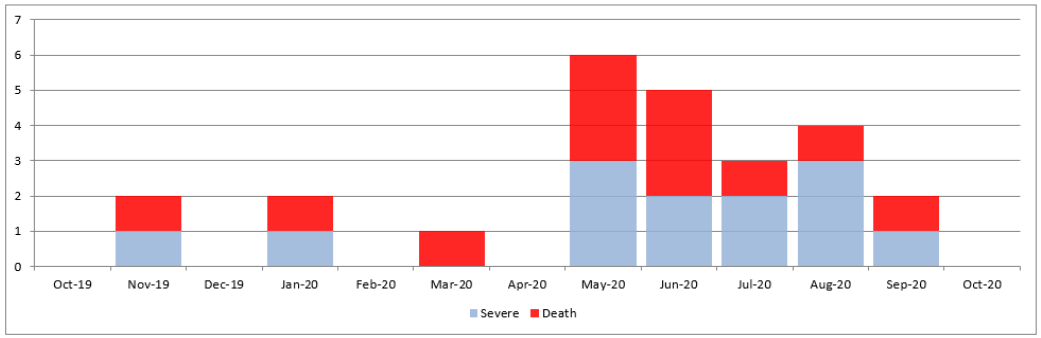


The Infection Prevention and Control (IPC) Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.
October has seen 2 ward areas close due to covid- 19 outbreaks these were Midgely and Cheetham Hill the input of IPC measures and the monitoring put in place, resulted in the wards opened as soon as the patients were isolated appropriately and a deep clean was carried out.

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

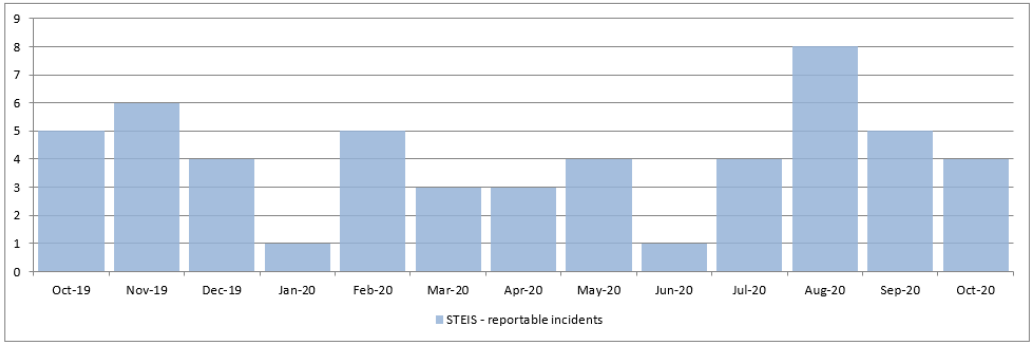
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Severe	0	1	0	1	0	0	0	3	2	2	3	1	0
Death	0	1	0	1	0	1	0	3	3	1	1	1	0



No severe or death incidents are reported in October.

STEIS Reportable Incidents

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
STEIS - reportable incidents	5	6	4	1	5	3	3	4	1	4	8	5	4

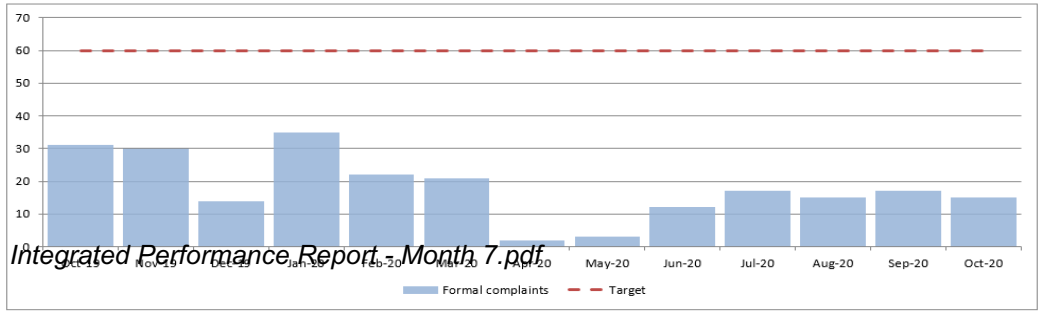


The Trust reported four incidents in October on the Strategic Executive Information System (StEIS).

1. Wrong patient called for scan
2. Fall and fracture - Totnes Hospital
3. Category 4 Pressure Ulcer – Coastal Community
4. Never event Ophthalmology – Incorrect strength implant

Formal complaints

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Formal complaints	31	30	14	35	22	21	2	3	12	17	15	17	15
Target	60	60	60	60	60	60	60	60	60	60	60	60	60

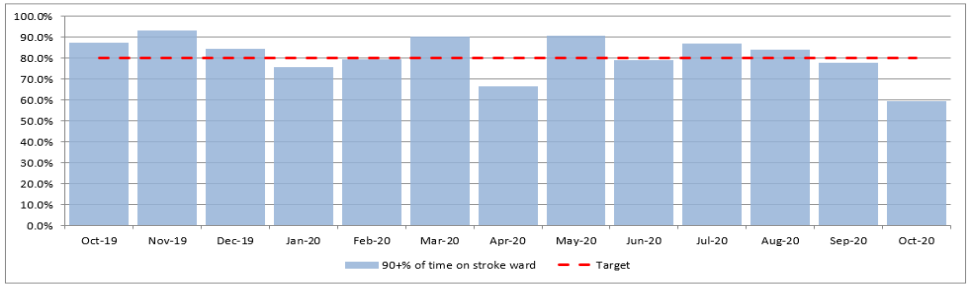


- The Trust received 15 formal complaints
- The themes of these have been recorded in the weekly CLICC report, these are related to Treatment and Assessment
- The formal complaint level is still slightly lower that pre Covid period. Work will progress in December to ensure that patients are being supported and sign posted to raise concerns and provide feedback to the Trust
- All complaints and contacts are investigated locally and shared with area/locality for learning.

Quality and Safety- Exception Reporting

Stroke

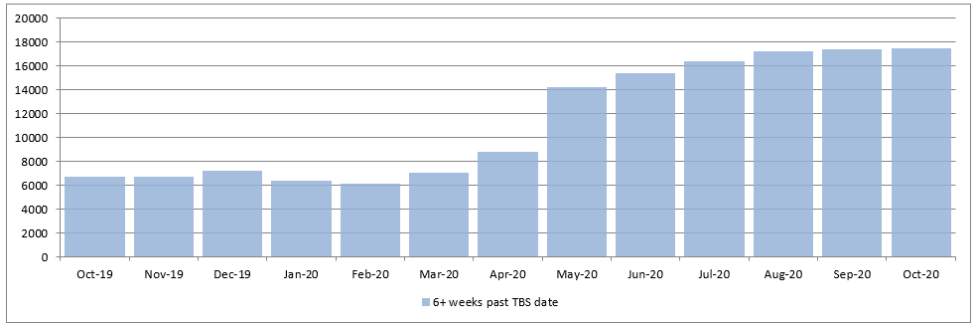
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
90+% of time on stroke ward	87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%	90.6%	79.1%	86.8%	83.9%	77.6%	59.5%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Stroke: The percentage of patients spending greater than 90% of time on the stroke ward from admission is reported as 59.5 % against a target of 80%.

Follow ups 6 weeks past to be seen by date

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
6+ weeks past TBS date	6694	6725	7243	6391	6147	7056	8824	14211	15398	16408	17220	17408	17519

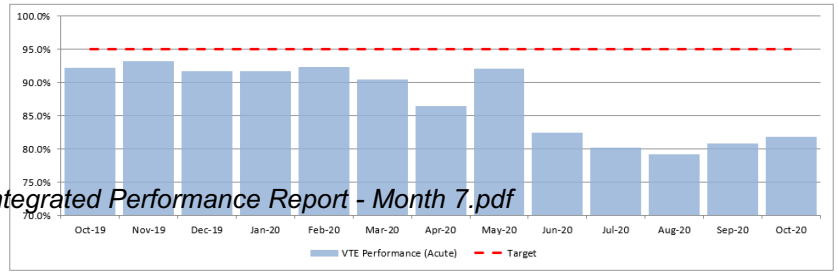


Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased to 17519. This is a direct result of the COVID-19 response and the standing down of routine outpatients services in April. Telephone and video clinics have allowed 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 constrained by IPC and social distancing.
Phase 3 national planning shows local recovery plan of 92% of pre-covid activity levels for follow-ups with 50% being delivered non-face to face by March 2021.
The Quality Assurance Group maintain oversight and assurance regarding any harm to patients.

VTE: VTE performance in the acute setting remains below the standard of 95% 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. The VTE task and finish group have had a meeting, identifying a number of actions

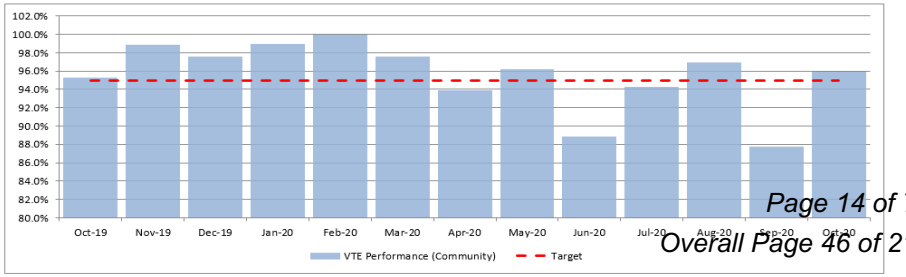
VTE risk assessment on admission - (Acute)

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
VTE Numerator	6196	6129	5743	6303	5768	4482	2325	3158	3484	3939	4013	4253	4412
VTE Denominator	6721	6577	6262	6875	6246	4952	2690	3430	4225	4914	5068	5260	5392
VTE Performance (Acute)	92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%	80.2%	79.2%	80.9%	81.8%
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)

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
VTE Numerator	81	90	82	92	93	81	31	25	40	49	63	43	70
VTE Denominator	85	91	84	93	93	83	33	26	45	52	65	49	73
VTE Performance (Community)	95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%	94.2%	96.9%	87.8%	95.9%
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

November update

The workforce team are continuing to support the increased prevalence of covid through; reintroduced daily associated absence reporting, updated guidance for extremely clinically vulnerable and other FAQ's, re-established support to silver incident command, continued signposting, and guidance to support workforce health and well-being.

Work to progress the development of the Trust's People Plan with underpinning actions and links to the to the emerging STP and regional People Plan requirements, as well as our HIP2 work was presented to and endorsed by the People Committee.

The workforce team are working with the ISU leadership teams to assist with the business and workforce planning processes.

Further work to consolidate the feedback and next steps in respect of Three Horizons feedback is being undertaken.

Performance exceptions and actions

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

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

The Trust's turnover rate now stands at 10.51% for the year to October 2020.

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

The annual rolling sickness absence rate was 4.39% to end of September 2020. This is against the target rate for sickness of 4%. The monthly sickness figure for September was 3.79% .

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 89.75% for October 2020 against a target of 85% and this is a minor increase from the 89.68% in September.

Appraisal rate: **RED**

The Achievement Review rate for the end of October 2020 was 78.35% which has decreased from 79.35% as at the end of September.

Agency Expenditure – As at Month 07 the Trust Agency spend was is £0.675m and year to date £3.935m

Workforce Quadrant

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

Not Achieved
Staff Sickness Absence Rolling 12 months and current month (1 month in arrears)
Appraisal Completeness

Under Achieved
Monthly Sickness Absence

No target set

Workforce Absence and Vacancy analysis

Sub-Group	WTE Bud In Month	WTE Cont In Month	Vacancy	Bank Wkd	Bank Cost	Agency Wkd	Agency Cost	Oct Total Sick %	Oct Covid Absence	Oct Sickness and Covid Absence %	Total Absence (Sick, Hols etc) %
Medical and dental	526.76	520.59	6.17	18.10	£221,561	10.55	£220,451	1.78%	0.45%	2.23%	14.00%
Registered N&M and HV staff	1276.48	1220.69	55.79	37.31	£126,996	46.16	£330,833	4.19%	1.46%	5.65%	17.10%
Support to clinical staff	1867.38	1841.78	25.60	162.41	£371,874	0.00	£0	5.73%	0.95%	6.68%	17.89%
Grand Total	3670.62	3583.06	87.56	217.82	£720,431	56.71	£551,284	4.61%	1.05%	5.65%	17.03%

ISU Description	WTE Bud In Month	WTE Cont In Month	Vacancy	Bank Wkd	Bank Cost	Agency Wkd	Agency Cost	Oct Total Sick %	Oct Covid Absence	Oct Sickness and Covid Absence %	Total Absence (Sick, Hols etc) %
Children & Family Health Devon	266.51	267.85	-1.34	6.51	£24,208	1.69	£18,533	3.06%	0.02%	3.08%	12.86%
Coastal	1146.20	1108.99	37.20	34.82	£171,774	3.84	£48,256	3.95%	0.63%	4.58%	15.70%
Estates & Facilities	410.78	405.04	5.74	21.83	£52,019	10.70	£27,774	5.35%	0.94%	6.29%	18.85%
Moor to Sea	471.33	429.35	41.98	37.69	£126,982	0.20	£1,472	4.33%	1.77%	6.10%	18.17%
Newton Abbot	620.45	600.15	20.30	68.95	£249,369	32.53	£254,258	3.87%	1.44%	5.31%	16.57%
Paignton & Brixham	997.80	956.77	41.03	38.79	£113,342	14.23	£184,498	4.48%	1.19%	5.67%	16.30%
Torquay	782.27	774.69	7.58	16.96	£55,285	9.43	£115,870	5.07%	0.39%	5.46%	16.88%
Grand Total	4695.34	4542.84	152.50	225.54	£792,980	72.61	£650,660	4.35%	0.92%	5.27%	16.45%

	2015	2016	2017	2018	2019	2020
Historical Trust Oct Sickness	4.04%	4.43%	4.19%	4.54%	4.88%	4.08%

The first table seeks to review the 3 biggest staff groups across the Organisation, aligning the finance and workforce data to provide a position in respect of vacancies, (Budgeted and Contracted) Sickness, Covid impact and other absences and how this is impacting on our Bank and Agency expenditure.

The second table is a review by ISU, please note the WTE numbers will vary as these ISUs have also taken account of other staff groups AHPS, Scientists etc. which are not included in table 1 , however will be moving forward.

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	2020/03	2020/04	2020/05	2020/06	2020/07	2020/08	2020/09	2020/10	Change since ICO	% Change	Change since March	% Change
Allied Health Professionals	420.56	474.03	472.15	470.79	468.45	478.27	480.16	479.91	477.74	57.18	13.60%	3.72	0.78%
Health Care Scientists	89.69	93.66	92.05	92.82	92.82	92.82	93.31	94.41	94.11	4.42	4.93%	0.45	0.48%
Medical and Dental	425.99	512.83	510.80	529.05	526.68	538.19	519.02	523.29	523.61	97.62	22.92%	10.78	2.10%
NHS Infrastructure Support	1114.22	1085.14	1090.28	1088.08	1093.55	1094.75	1094.50	1099.09	1100.77	-13.45	-1.21%	15.63	1.44%
Other Scientific, Therapeutic and Technical Staff	301.99	373.03	373.79	375.39	377.05	373.84	385.27	383.76	386.53	84.53	27.99%	13.50	3.62%
Qualified Ambulance Service Staff	1.00	6.72	7.72	7.72	8.32	8.53	8.53	8.53	8.53	7.53	753.33%	1.81	26.98%
Registered Nursing, Midwifery and HV staff	1187.78	1199.91	1195.07	1190.67	1186.31	1188.77	1200.13	1212.96	1218.43	30.65	2.58%	18.52	1.54%
Support to clinical staff	1593.74	1825.21	1875.96	1893.59	1912.55	1886.78	1857.68	1846.33	1844.76	251.02	15.75%	19.55	1.07%
Grand Total	5134.99	5570.54	5617.82	5648.11	5665.74	5661.95	5638.60	5648.28	5654.49	519.50	10.12%	83.95	1.51%

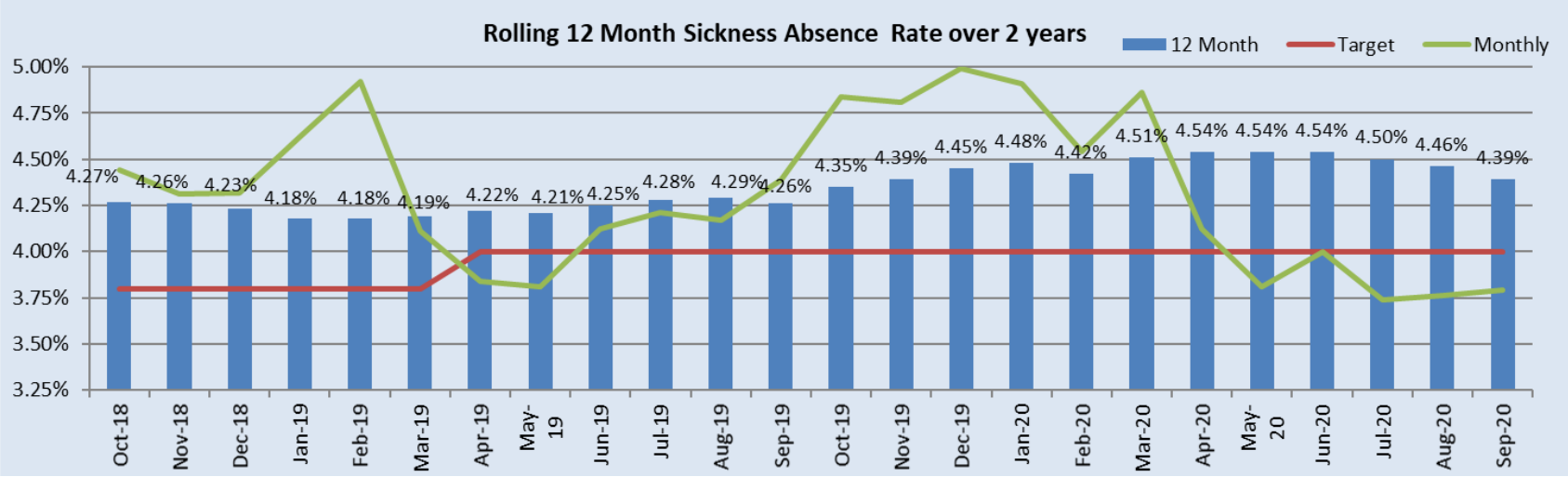
Pay Report Summary for previous 3 months

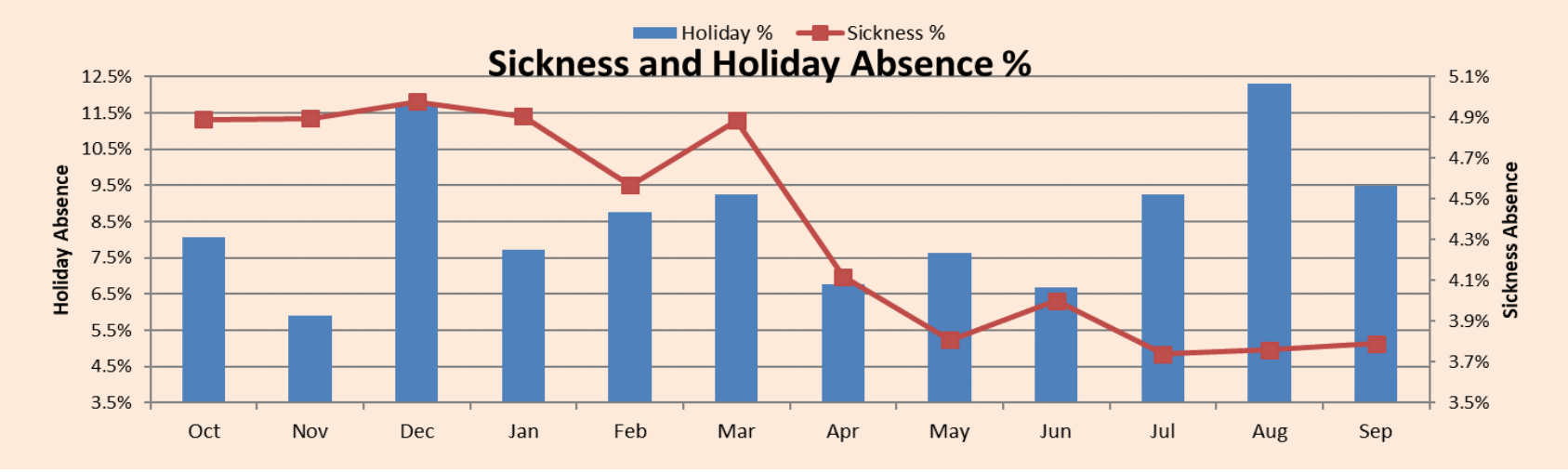
	JUN	JUL	AUG	SEP	OCT
Cost	£	£	£	£	£
Substantive	£21,208,528	£20,411,994	£20,485,568	£20,864,502	£20,529,163
Bank	£894,443	£900,491	£918,075	£877,866	£864,101
Agency	£580,586	£571,266	£547,290	£584,424	£674,784
Total Cost £	£22,683,557	£21,883,751	£21,950,933	£22,326,792	£22,068,048
WTE Worked	WTE	WTE	WTE	WTE	WTE
Substantive	5,650.32	5,637.07	5,616.97	5,615.22	5,658.21
Bank	227.25	234.33	342.66	264.86	272.48
Agency	102.35	83.29	73.44	72.52	76.33
Total Worked WTE	5,979.92	5,954.69	6,033.08	5,952.60	6,007.03

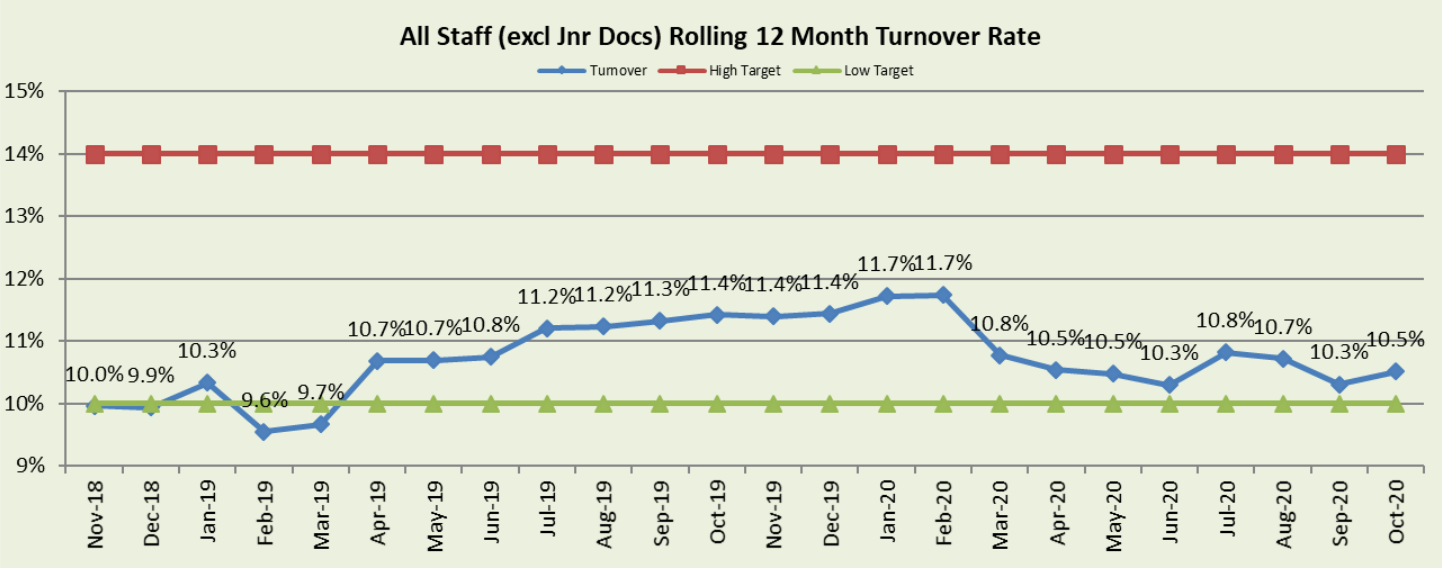
Rolling 12 month sickness rate (reported one month in arrears)

The annual rolling sickness absence rate was 4.39% at the end of September 2020 against the target of 4.00%.

The monthly sickness figure for September was 3.79 % which is a minor change from 3.76% as at the end August.

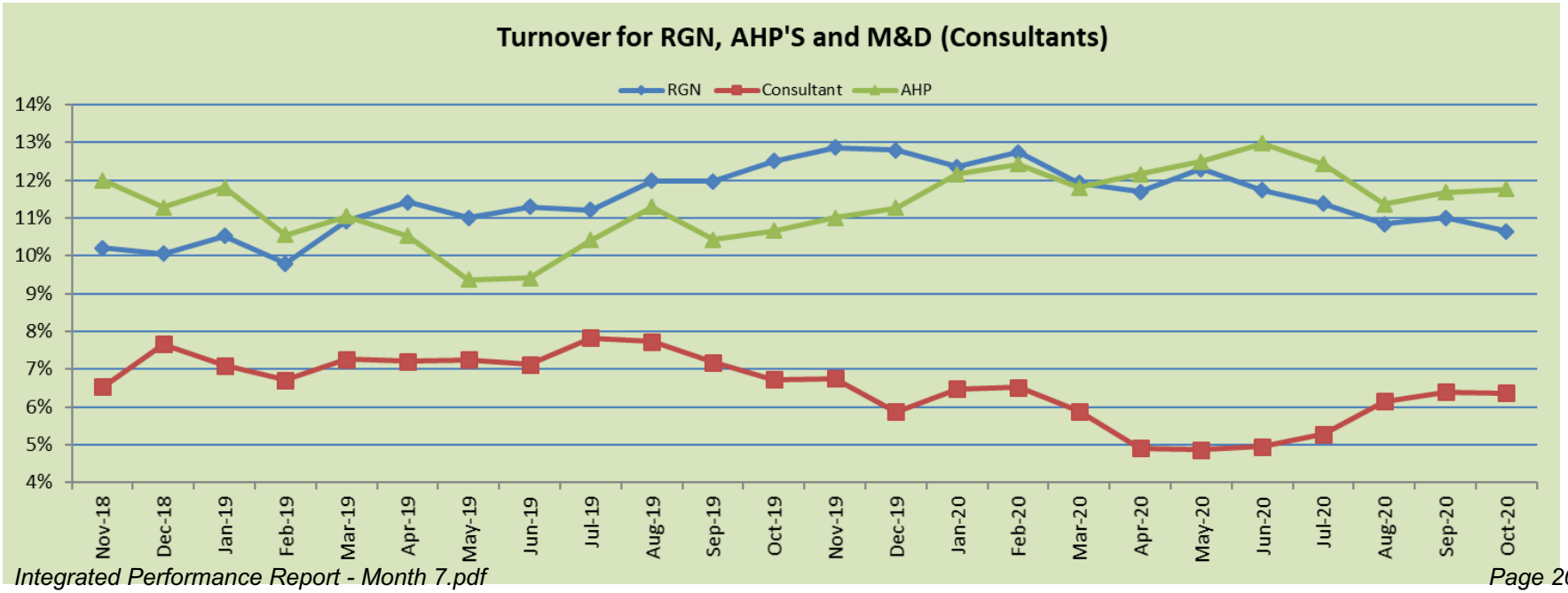


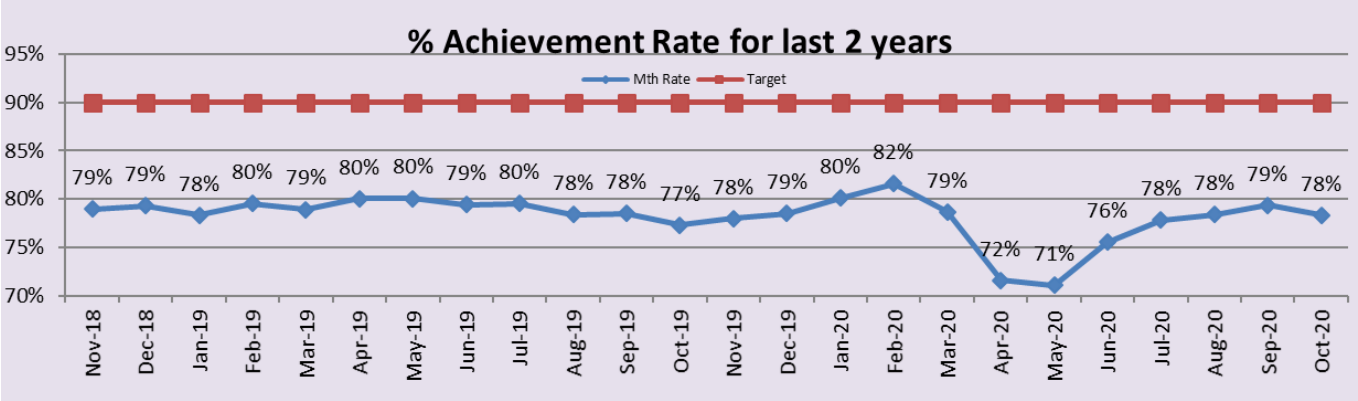




All Staff Rolling 12 Month Turnover Rate

The graph shows that the Trusts turnover rate now stands at 10.51% for the year to October 2020 which is an increase from 10. 31% in September.

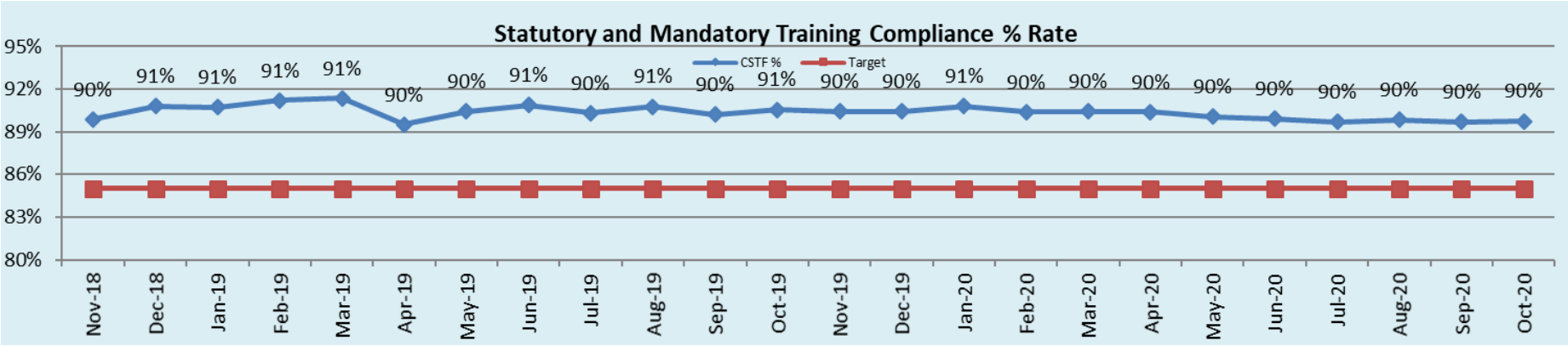




Achievement Review (Appraisal)
The Achievement Review rate for the end of October was 78.35% which is a decrease from the 79.35% in September.
Managers and ISU leads are provided with a detailed list of all staff and their appraisal status.

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 89.75% for September which is a marginal increase from the 89.68% in September.

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					Safeguarding Children Compliance		
Oct-20					Oct-20		
Level 1	Level 2	Level 3 & 4	Level 5	Level 6	Level 1	Level 2	Level 3
6647	4063	1143	75	6	2510	3398	739
6367	3415	456	32	4	2392	2828	488
95.79%	**84.05%**	**39.90%**	**42.67%**	**66.67%**	**95.30%**	**83.23%**	**66.04%**

Module	Target	Performance
Information Governance	95% and above	84.13%
Manual Handling	85% and above	71.70%

The table below shows the agency expenditure by staff Group for October and Year to Date.

Torbay and South Devon NHS Foundation Trust	Monthly Values							YTD
Total Agency Spend Financial Year 2020/21	Apr	May	Jun	Jul	Aug	Sep	Oct	
Registered Nurses	169	143	201	177	256	287	331	1564
Scientific, Therapeutic and Technical	52	59	37	46	41	46	61	342
of which Allied Health Professionals	39	50	22	26	21	29	40	227
of which Other Scientific, Therapeutic and Technical Staff	13	9	15	20	20	17	21	115
Support to clinical staff (HCA)	-1	0	0	0	0	0	0	-1
Total Non-Medical - Clinical Staff Agency	220	202	238	223	297	333	392	1905
Medical and Dental Agency	213	189	273	258	191	199	220	1543
Consultants	106	69	130	132	146	159	170	912
Trainee Grades	107	120	143	126	45	40	50	631
Non Medical - Non-Clinical Staff Agency	79	74	70	90	59	52	63	487
Total Pay Bill Agency and Contract	512	465	581	571	547	584	675	3935

Community and Adult Social Care Summary – September 2020*

Community Highlights and Covid-19 response

- The Adult Social Care Quality Assurance and Improvement Team and zone teams continue to work closely with care home and domiciliary providers to support the safe flow of clients. Daily dashboards of capacity, PPE availability, information about shielded clients and staff enable the providers to continue to function. Weekly conversations via MS Team conference calls are available and well attended.
- A Covid-19 resourcing panel created to support timely payment to the homes and providers is in place and continues to function well.
- Care Home providers are engaging in the centralised Tracker system which helps monitor capacity and ability to take new admissions.
- The ASC CV-19 Action Plan is being revisited against a RAG rated system to sense check any additional actions that may be required pending a second surge.
- The Trust supports swabbing of symptomatic care home staff through our TSDFT swabbing hub. Local policy for whole care home testing is triggered following two positives tests (staff and/or residents) is undertaken via community nurses.

Adult Social Care Improvement Plan (ASCiP)

- The Performance Committee has scheduled monthly meetings. Governance will be assured by Performance Committee reports feeding into both the ICO's Integrated Governance Group and Torbay Council's ASC Improvement Board.
- The Performance Committee will evaluate appropriate data which has been analysed and reported on by Community Service Managers (CSM). Over time we will see this data turning into meaningful knowledge that informs insights for future effective decision-making and practice initiatives.
- The central data workstream will also continue to support the drive towards a better use of data and a Torbay wide data culture which is currently absent.
- The Principal Social Worker is a party to the CSMs Performance Committee analysis; using this information alongside audit and shadowing supervision sessions to help identify and link core Social Care values, behaviours, and attitudes to the wider training needs that are being identified.
- The Review and Insight Team continue to be a central focus for the development and testing of the strength-based / asset-based and Community Led initiatives that are the central requirement of the Adult Social Care Improvement Plan. This is a thread seen throughout all the project workstreams that underpin this work.
- The annual s75 agreement between Torbay Council and the ICO has been extended to cover the same time frame as the already signed 3-year risk agreement (2020-2023). The strategic agreement is being progressed through appropriate ICO and Council boards for final approval.
- A risk register exists for the ASCiP and covers both overarching risk for ASC and also project level risk.
- The Front Door redesign which is a fundamental project within the wider ASCiP has just commenced. This will be critical to delivery of the required improvements and future savings.
- The development of the Community and Voluntary sector workstream has also gained some traction. This is a multi agency approach which will provide partnership working interdependent deliverables.

*Timings of meetings have precluded an update in time for this report

Achieved
Number of Delayed Discharges (Community)
Number of Delayed Transfer of Care (Acute)
Carers Assessments Completed year to date
Safeguarding Adults - % of high risk concerns where immediate action was taken
Intermediate Care - No. urgent referrals
Proportion of carers receiving self-directed support (ASCOF)
Percentage of Adults with learning disabilities in employment (ASCOF)
Percentage of Adults with learning disabilities in settled accommodation (ASCOF)
% reablement episodes not followed by long term SC support (ASCOF)

Under Achieved

Not Achieved
Clients receiving Self Directed Care
Community Hospital - Admissions (non-stroke)
Proportion of clients receiving self-directed support (ASCOF)
Permanent admissions (18-64) to care homes per 100k population (ASCOF)
Permanent admissions (65+) to care homes per 100k population (ASCOF)
Proportion of clients receiving direct payments (ASCOF)

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)
Deprivation of Liberty Standard

Social Care and Public Health performance metrics - Torbay

The Social Care and Public Health metrics below relate to the Torbay LA commissioned services. The Deputy Director of Social Care reviews all Adult Social Care (ASC) monthly metrics and escalates areas of concern at the monthly Integrated Governance Group (IGG). Governance will be assured by the ASC Performance Committee reports feeding into both the ICO's IGG and Torbay Council's ASC Improvement Board.

Social Care Performance Report

2020/21 Performance Scorecard to 31 October 2020

Torbay Social Care KPIs	2020/21 full year target	2020/21 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	80%	Below target (1305 / 1636) Impacted by reduced use of RAS for CLS. Paris assessment summary changes in progress.
% clients receiving direct payments	28%	28%	23.6%	Below target (386 / 1636). DPs will be addressed as part of the targeted response of the IPMO workstreams.
Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	20.2	A low outturn signifies better performance. Below target (15 admissions compared to challenging target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	565.4	A low outturn signifies better performance. Below target (207 admissions compared to target of 161)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	84.6%	On target.
% carers receiving self directed support	85%	85%	95%	On target.
% Adults with learning disabilities in paid employment	7.0%	7.0%	8.5%	On target.
% Adults with learning disabilities in settled accommodation	80%	80%	80.2%	On target.
Delayed transfers of care from hospital (delays per day) - Torbay residents (BCF)	TBC	TBC	..	A low outturn signifies better performance. KPI reported 1 month in arrears. No data as national collection suspended due to COVID19.

Measure	Target 2020/21	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date 2020/21
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		96.0%	95.5%	97.6%	85.5%	89.9%	76.4%	81.9%	84.5%	92.4%	94.5%	94.1%	90.7%	93.6%	90.5%
Children with a child protection plan *			184	176	192	202	191	194		223	217	219	221	200		200
4 week smoking quitters (Quarterly) **	200							231			56					56
Opiate users - % successful completions of treatment (Quarterly) **								6.1%			5.9%					5.9%

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

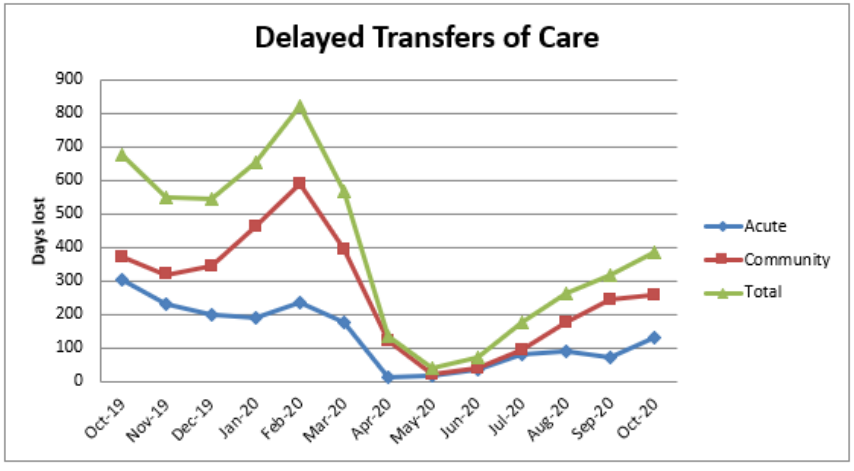
Measure	Target 2020/2021	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date 2020/21
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			13,845	12,392	10,852	10,582	9,261	8,467	6,690	7,409	7,948	8,221	7,178	7,290	7,471	52,207
Therapy activity	65,415		6,574	5,800	5,247	6,019	5,140	4,161	2,236	2,829	3,593	3,790	3,527	3,839	3,571	23,385
No. intermediate care urgent referrals	0		216	205	201	239	202	219	230	248	283	241	208	220	192	1,622
No. intermediate care placements			59	60	52	78	49	39	15	6	14	11	17	6	9	78
Intermediate Care - placement average LoS			20.7	16.1	17.5	18.7	22.0	20.8	25.5	38.7	38.9	18.3	15.8	28.7	20.3	26.5

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 - October-20

	Act. 19/20 Outturn	Aug-20	Sep-20	Oct-20	Total
Admissions / Discharges					
Total Admissions (General)	2,596	261	262	275	1,535
Direct Admissions (General)	242	22	18	21	124
Transfer Admissions (General)	2,354	239	244	254	1,411
Stroke Admissions	256	29	29	22	109
Transfers from CH to DGH	238	136	108	170	741
Beds					
Bed Occupancy [1]	95.1%	86.7%	91.6%	82.4%	77.9%
Bed Days Lost to Delays[2]	5,086	175	246	256	952
Bed Days Lost to Bed Closure	57	10	0	1	89
Length of Stay					
Delayed Discharges		30	60	59	230
Average Length of Stay - Overall (General)	13.1	9.0	9.7	9.9	9.5
Average Length of Stay - Direct Admissions	10.7	6.4	8.3	8.6	7.5
Average Length of Stay - Transfer Admissions	13.4	9.2	9.9	10.0	9.7
Average Length of Stay - Stroke	18.7	10.0	11.7	12.6	11.9
Long LoS (>30 days)	246	3	4	7	23
MIUs					
Total MIU Activity	41,656	2,690	2,637	2,065	13,888
New MIU Attendances	37,118	2,478	2,328	1,885	12,640
All Follow Up Attendances	4,518	212	309	180	1,248
Planned Follow Up Attendances	3,305	169	218	141	951
Unplanned Follow Up Attendances	1,213	43	91	39	297
MIU Four Hour Breaches	3	0	0	0	0
Average Waiting Time (Mins) - 95th Pctile	53	41	46	40	42

Community hospital admissions remain in-line with pre-covid levels and have seen a decreased bed occupancy to 82.4% in October. Average length of stay of 9.9 days compares well with the 13.1 days over 2019/20.
Bed days lost to delayed discharge has risen for the third month from 175 in August to 256 bed days lost in October.



Notes:

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

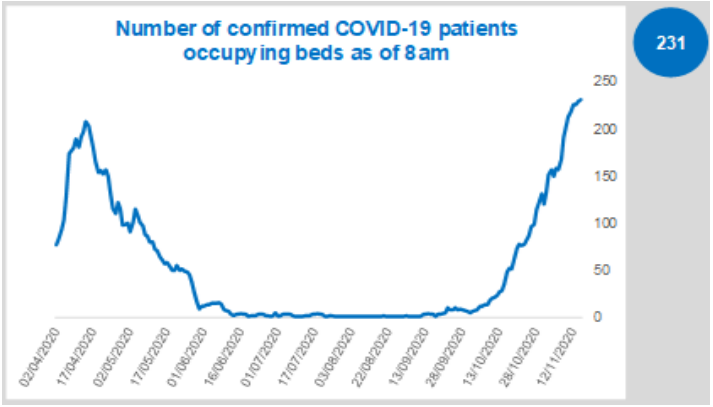
Figures for admissions, LOS etc for Newton Abbot hospital are for general rehabilitation and stroke in line with previous years.

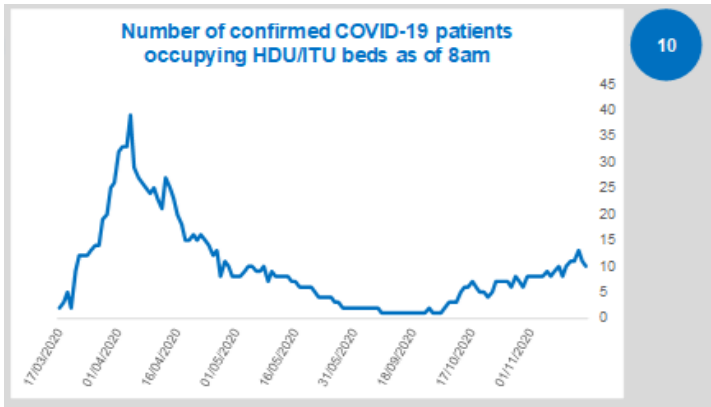
Performance oversight from Chief Operating Officer

- Covid-19 second wave: October has seen the number of patients requiring hospitalisation for managing covid-19 increase culminating with a significant internal incident being called on 19 October 2020. The number of patients quickly increased from 3 patients on 8 October 2020 to 34 patients on 29 October 2020 requiring the opening of a second covid ward at Torbay Hospital and the designation of Brixham Community Hospital as a covid inpatient step down ward.
- Emergency admissions : Levels of OPEL escalation have increased in October with 21 days at OPEL 3 compared to 1 day in September. Covid contacts led to the closure of a non covid ward from 26 October further reducing the available beds for patients requiring emergency admission. Bed occupancy has increased from 83% to 88% as a result and a number of routine operations have been cancelled to maintain available beds for emergency admissions.
- Performance against the 4 hour standard has reduced to 86.2% overall from 91.9% in September and ambulance handover delays increasing with 14 delays over 60 minutes recorded. There has been a continued increase in delayed discharges to 385 days in October compared to 318 days in September.
- The building works to provide covid secure ED and medical receiving unit are continuing to plan. Scheduled handover of the refurbished theatres; Main theatres (1 and 2) scheduled for mid November and Day surgery (DSU 3) by end of December.
- New referrals received for specialist assessment have increased to 90% of pre covid-19 levels whilst waiting list and in particular our longest waits continue to increase with 1143 patients (in line with our forecast for Phase 3 recovery) at end of October over 52 weeks and forecast to increase to 2700 by end of March.
- The focus on urgent and cancer pathways of care has seen the timeliness of cancer diagnosis and treatment maintained although there has been continued under performance against the 14 day from urgent referral, 28 day faster diagnosis standard, and 62 day from referral to treatment in October.
- Against Diagnostic tests plans have been approved to support capacity to target manage our longest waits in echocardiography and endoscopy with increases in activity. MRI replacement programme remains on track with activity remain reliant on mobile CT and MRI capacity.
- Activity is falling behind our submitted Phase 3 recovery plans that describe monthly activity forecasts as a percentage of pre covid through to March 2021. The submitted plans, however, are dependent on having no significant impact from a second wave of covid-19 and continued support from the independent sector including outsourcing to Mount Stuart Hospital.

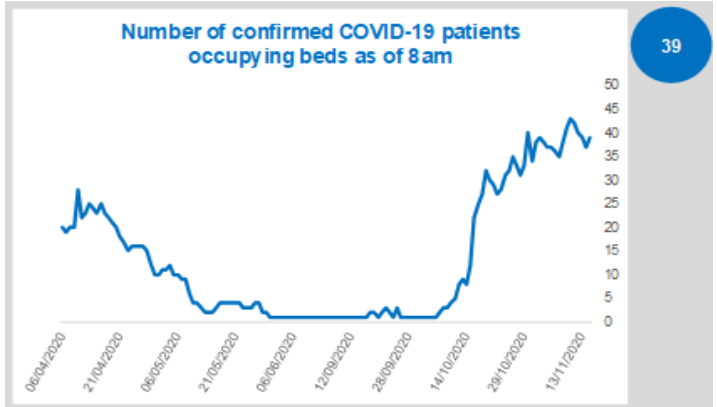
Covid - Hospitalisations

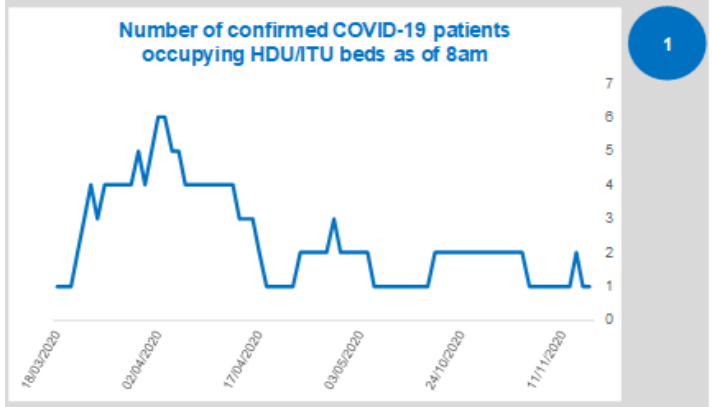
Devon ICS





Torbay and South Devon NHS FT





October has seen the number of patients requiring hospitalisation for managing covid-19 increase culminating with a significant internal incident being called on 19 October 2020.

The number of patients quickly increased from 3 patients on 8 October 2020 to 34 patients on 29 October 2020 requiring the opening of a second covid ward at Torbay Hospital and the designation of Brixham Community Hospital as a covid inpatient step down ward.

As at 15 November 2020 there were 39 confirmed Covid-19 patients occupying a bed at the Trust and one patient occupying a HDU/ITU bed.

The system plan to transfer covid patients to the Royal Devon and Exeter Hospital was not enacted due to the rapid increase in numbers and local escalation actions. To facilitate the opening of a second covid ward elective orthopaedics beds were closed. The strategy remains to maintain as much non covid elective activity as possible and not reduce significantly capacity for day case and outpatients departments during the second wave of covid hospitalisations. At this time, following extensive modelling of predicted covid second wave across the Devon providers, a decision on the opening of the Nightingale Hospital Exeter is to be confirmed. On 11 November the number of covid positive patients in hospital beds across Devon providers exceeded the maximum seen in the first wave (200 occupied beds). The main challenge in opening Nightingale is the staffing model required with all providers seeing staff absence due to covid greatly increased and impacting on ability to staff core beds.

Operational Performance Quadrant

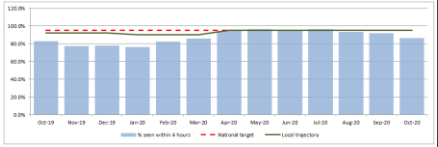
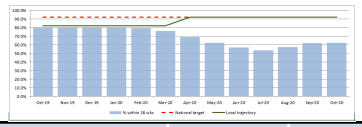
Achieved
Dementia Find (NHSI)
Number of Clostridium Difficile cases reported
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - 31-day wait for second or subsequent treatment - Surgery
On the day cancellations for elective operations
Cancer - Patient waiting longer than 104 days from 2ww
Ambulance handover delays > 30 minutes
Number of patients >7 days LoS (daily average)
Number of extended stay patients >21 days (daily average)
A&E - patients recorded as >60 min corridor care
Clinic letters timeliness - % specialties within 4 working days

No target set

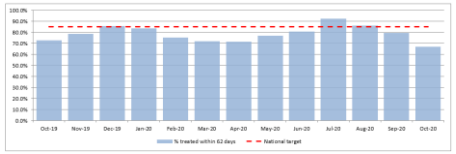
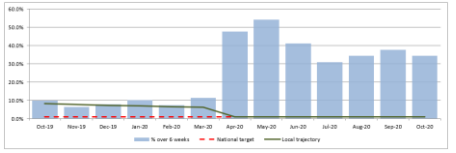
Not Achieved
A&E - patients seen within 4 hours (NHSI)
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)
Referral to treatment - % Incomplete pathways <18 wks (NHSI)
Diagnostic tests longer than the 6 week standard (NHSI)
Cancer - Two week wait from referral to date 1st seen
Cancer – 62-day wait for first treatment - screening
Care Planning Summaries % completed within 24 hours of discharge – Weekday
Care Planning Summaries % completed within 24 hours of discharge – Weekend
RTT 52 week wait incomplete pathway
Ambulance handover delays > 60 minutes
Trolley waits in A+E > 12 hours from decision to admit

Under Achieved
Cancer - 28 day faster diagnosis standard
Cancelled patients not treated within 28 days of cancellation
Bed Occupancy (overall system)
A&E - patients with >12 hour visit time pathway

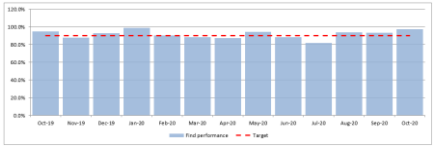
NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M7 86.2% Performance M6 91.9% Target 95% Risk level HIGH	October has seen ED attendances reduce from September and represent 77% of October last year. What we have seen is a steady increase in the number of patients now being directed to the Medical and Surgical Receiving Units; this planned reduction in ED attendances is helping to reduce crowding and delays in ED. The reported performance against the 4-hour standard for October is 86.2% down from 91.9% in September. There has been an increase in bed occupancy towards 90% driven from loss of 18 beds from ward reconfigurations to accommodate building works, increased delayed discharges, and an increase in covid admissions.	Building works to reconfigure the emergency floor space to maintain covid assessment pathways and Medical Receiving Unit are progressing. Wards have been flexed to accommodate the Medical Receiving Unit with an overall loss of surgical beds. Whilst this has supported the flow of emergency patients and minimised delays in ED there has been an impact on capacity to deliver the inpatient elective surgical programme. Throughout October emergency inpatient capacity has been impacted by the number of covid admissions. TSD are participating in all aspects of the system decision on whether to activate the Nightingale hospital as part of covid response.	 **Trajectories** M6: 95% M7: 95% M8: 95%
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M7 62.55% Performance M6 62.1% Target 92% Risk level HIGH	RTT performance has improved with 62.55% of people waiting less than 18 weeks for treatment. The total number waiting for treatment is 27289 an increase of 919 from September. With the increasing waiting lists and concerns of these long waits causing harm we are now required to report patients waiting over 78 weeks and confirm clinical validation of all patients waiting over 18 weeks. The clinical validation top be completed by the end of December. Activity levels are not increasing in line with the Phase 3 recovery submission The 2nd wave of covid hospitalisation is impacting of elective impatient activity with the loss of beds and further escalation impacting on Day Case and	Operational focus continues on maintaining urgent and cancer related work. Use of virtual non face-to-face outpatient consultations is vital to restore our overall levels of outpatient activity as social distancing is a significant constraint in all of our outpatient spaces. The use of Mount Stuart Hospital facilities will continue to be part of our strategy to provide capacity for of our recovery plan. A new National contract framework has been released to support use of the independent sector. The COO is reviewing operational plans with teams to optimise activity within available resources. Insourcing has commenced at weekends in	 **Activity variance vs previous year** Op new: M6 -10.5%, M7 -3.6% OP Follow up: M6 -13.4%, M7 -22.6% Day Case: M6 -13.9%, M7 -22.9% Inpatient: M6 -8.5%, M7 -35.9% **RTT Trajectories %** M6: 92% M7: 92% M8: 92%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M7**	Performance against the 62-day referral to treatment standard in October is 66.8%. Referrals into Urgent cancer pathways remain at 90% of last years level. Teams continue to prioritise capacity to see, diagnose, and treat patients on cancer pathways. Delays are being see with the time from referral to appointment in Lower GI / Urology Dermatology and Head and Neck specialties. Capacity for timely access to theatres and certain diagnostic procedures remains a risk.	Plans remain in place to ring-fence and prioritise capacity to support cancer pathways from referral, diagnosis, and treatment. Radiotherapy and medical oncology has continued with near normal capacity throughout the covid escalation period. The Day Surgery Unit Theatres 1 and 2 have now returned to elective surgical capacity, however, there remains a continued reliance the capacity offered in Mount Stuart Hospital during our covid escalation to maintain capacity. Plans are being prepared to target diagnostics delays including Template biopsies in Urology.	
	66.8%			
	Performance M6			
	79.3%			
	Target			
	85%			
	Risk level			
	HIGH			
				Trajectories
				M6 / **M7** / **M8**: 85% / 85% / 85%
Diagnostic tests longer than 6 weeks	**Performance M7**	Activity levels in October have been maintained with the continued reliance on mobile MRI and CT. Areas with longest waits include echocardiograph, endoscopy and neurophysiology. Urgent diagnostic tests continue to be prioritised often leaving limited capacity to see routine patients. Waiting times remain a challenge for certain procedures including those requiring aerosol generating procedures.	Procedures that are aerosol generating continued to be severely restricted however teams have been adapting their scheduling and procedures to best optimise the throughput of these patients. Business cases have been approved to support echocardiography and gastroenterology. Patients are now accessing the Nightingale Hospital Exeter (NHE) for echocardiography and CT as part of the recovery plans. As outpatient capacity increases we expect to see a further increase in demand for diagnostic tests and managing these waits will remain a challenge.	
	34.4%			
	Performance M6			
	37.6%			
	Target			
	1%			
	Risk level			
	HIGH			
				Trajectories
				M6 / **M7** / **M8**: 1% / 1% / 1%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M7	Performance against the Dementia Find assessment standard has improved to above the target of 90%.	The reliance on an HCA to support the dementia find process is being reviewed as part of the ward improvement work. Until a seamless electronic clinical record is available this may continue to require close operational support.	
	96.6%			
	Performance M6			
	89.2%			
	Target			
	90%			
	Risk level			
	LOW			

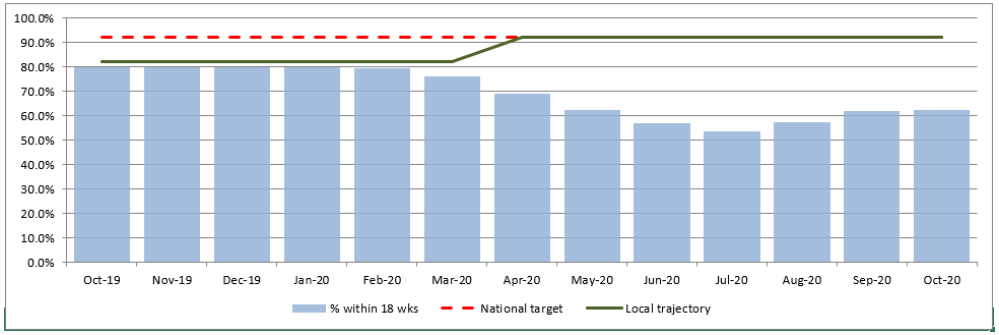
Trajectories		
M6	M7	M8
90%	90%	90%

Services with greater than 100 patients waiting over 18 weeks

OCTOBER 2020 Incomplete 92% table - National Specialty

Submitted Spec	Incomplete IPDC >126	Incomplete Outpatients >126	Grand Total	% < 18wk
Orthodontics		109	134	18.66
Respiratory Medicine		114	668	82.93
Pain Management	104	153	678	62.09
Gynaecology	105	167	1477	81.58
Dermatology		274	1284	78.66
Neurology	3	319	695	53.67
Colorectal Surgery	99	230	852	61.38
Cardiology	56	362	1567	73.32
Oral Surgery	150	287	1327	67.07
Gastroenterology	399	125	1935	72.92
Paediatrics	3	536	1293	58.31
ENT	108	536	1835	64.9
Upper Gastrointestinal Surgery	387	298	1263	45.76
Urology	387	608	2114	52.93
Trauma & Orthopaedics	687	935	3182	49.03
Ophthalmology	764	1441	4456	50.52
Grand Total	3361	6859	27289	62.55

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in October has improved with the proportion of people waiting less than 18 weeks at 62.5%; 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 27289 an increase of 919 from September.

52 week waits: For October 1143 people will be reported as waiting over 52 weeks, this being an increase on last month's 892. The impact of COVID-19 continues to adversely affect levels of activity and performance. Despite good progress across many areas, in Month 7 the activity levels reported has levelled off when compared to the same month last year (see activity charts that follow). Teams are being asked to review their plans as current performance does not see the planned return to pre covid levels of activity by March 2021, with inpatient elective capacity being greatly reduced now with the 2nd wave of covid hospitalisations impacting on capacity to admit patients.

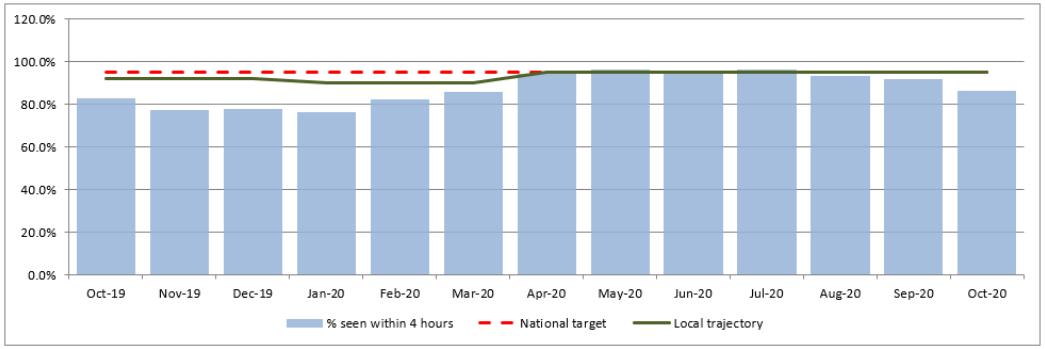
Recovery planning: The Day Surgery Unit has resumed activity although remains below pre covid levels. The theatre works on Main Theatres 1 and 2 now completed and in the process of hand over. There will continue to be a loss of operational productivity from enhanced infection prevention and control protocols so additional sessions will be required to deliver comparable levels of historical activity. Timely access to diagnostics and capacity for outpatients consultations that require a face to face interface also remain a challenge whilst complying with 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 additional capacity to address historical infrastructure and capacity constraints in theatres and diagnostics.

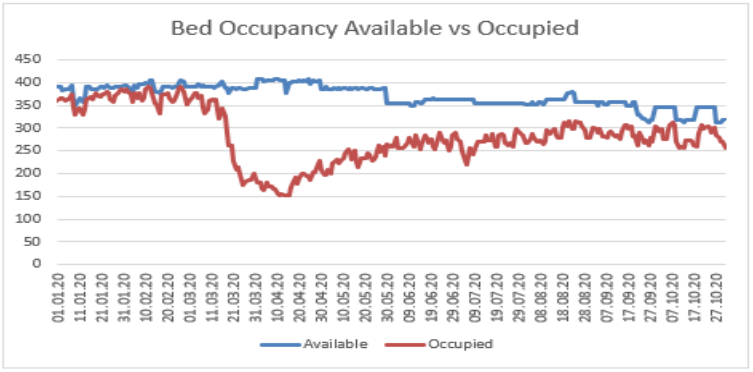
The work cross the Devon system to align capacity for elective and non elective care will become an increasing factor in the success of our recovery plans.

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 Integrated Governance Group (IGG).

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 whilst responding to a steady increase in ED attendances and emergency admissions. Direct admissions to the Surgical and Medical Receiving Units have helped to reduce the potential for overcrowding and delays to assessment in the ED department. Performance against the 4-hour performance standard for October is reported at 86.2%. Bed occupancy has risen to 88%, with system pressures and delays to access a specialist bed for new admissions are being seen. Notably the recorded days at escalation status (Opel status table below) of 3 or above has increased to 21 days in October from 1 day in September.

The first phase of these plans to increase ED footprint with the expansion into EAU3 has now commenced. Associated ward moves have seen a net loss of 18 bed during this period of capital works.

The onset of the second wave of Covid hospitalisations is a challenge with further loss of beds for non covid general admissions through the opening of second covid acute ward and a community ward that was not originally planned. The system response to utilise covid pathways to Royal Devon and Exeter FT and utilisation of the Nightingale Hospital have not so far been enacted.

Ward and community 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 medical and surgical review, inpatient treatment and discharge pathways into community and home settings. The Emergency Floor Improvement Workstream has re-commenced bi-weekly meetings.

12 hour Trolley wait: One 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 October there were 14 ambulance delay over 60 minutes, delays of over 30 mins increased to 73 from 59 last month.

Escalation status

Opel status	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Opel 1	2	0	0	0	0	5	17	25	21	22	28	24	13	2
Opel 2	13	12	3	8	7	12	13	5	9	22	3	7	16	8
Opel 3	11	19	18	15	19	8	1	0	1	0	0	0	1	21
Opel 4	4	0	9	8	5	4	0	0	0	0	0	0	0	0
A&E Performance	80.7%	82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%	96.4%	93.5%	91.9%	86.2%
Bed Occupancy (Acute)	95.4%	95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	75%	75.2%	80.0%	83%	88%

Cancer treatment and cancer access standards

		October 2020			
CWT Measure	Target	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	1048	370	1418	73.9%
14 Day - Breast Symptomatic referral	93%	85	2	87	97.7%
31 Day 1st treatment	96%	173	5	178	97.2%
31 Day Subsequent treatment - Drug	98%	76	0	76	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	57	0	57	100.0%
31 Day Subsequent treatment - Surgical	94%	27	1	28	96.4%
31 Day Subsequent treatment - Other		20	0	20	100.0%
62 day 2ww / Breast	85%	72.5	37	109.5	66.2%
62 day Screening	90%	4	2	6	66.7%
62 day Consultant Upgrade		1	1	2	50.0%
104 day breaches (2ww) - TREATED	0	4			

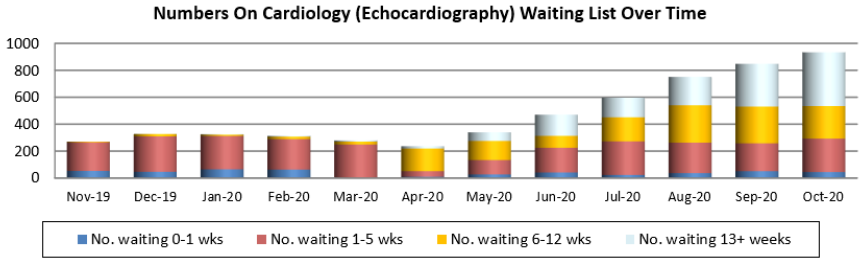
Cancer standards The table above shows the position for October 2020 (as at 13 November 2020). *Final validation and data entry is completed for national submission, 25 working days following the month close and at the end of the quarter.*

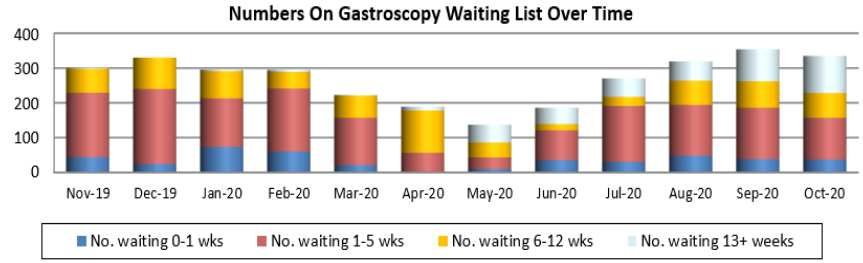
Urgent cancer referrals 14 day 2ww: At 73.9% is below the standard of 93%. We have seen a continued increase in referrals with the number of urgent referrals being 90% of last year. The most challenged pathways are Skin, Lower GI, Urology and head & Neck.
28 days From Referral to Diagnosis: Performance in October has remained below the new standard set at 75% with 72.1% being an improvement on September with 67.3% reported.

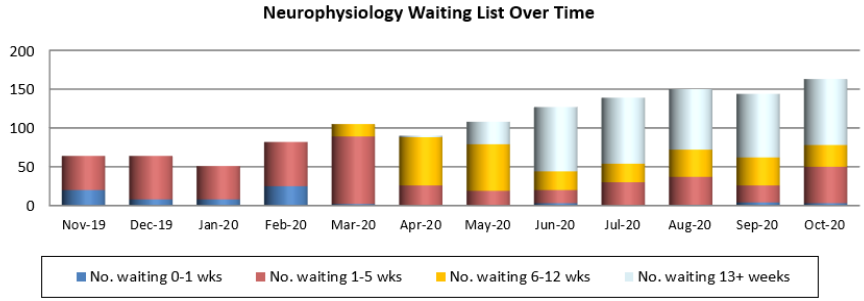
NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard is reported at 66.2% and 37 patients treated outside of standard. (target 85%)
With the Trust's ongoing response to COVID-19 risk remains in the pathways for Urology, lower GI, Breast and Skin. It is noted that good progress 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 and the reinstatement of Day Surgery Unit are significant factors to maintain this capacity.

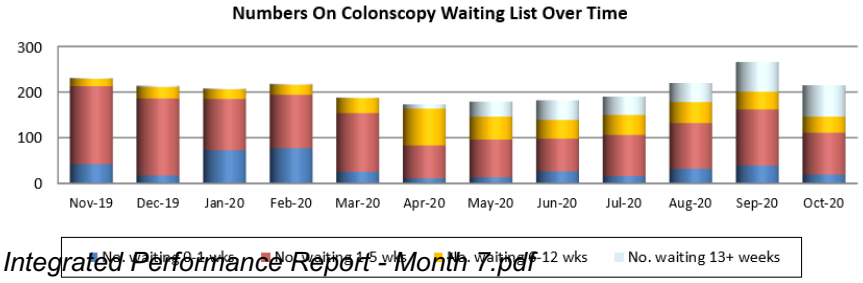
Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In October, 4 patients with confirmed cancer were treated beyond 104 days. The number of patients being tracked over 62 days has not increased with no significant change to historical levels.
All of the long wait patients are reviewed by the cancer team with pathway queries escalated to operational teams and the RTT Risk and Performance Assurance Group.

NHSI indictor - patients waiting over 6 weeks for diagnostics



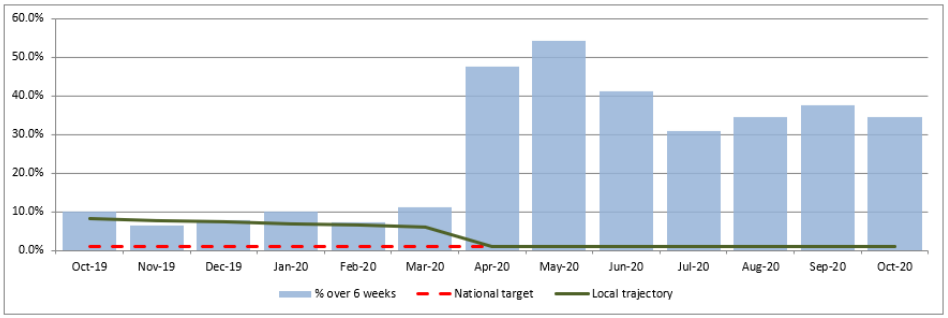






Diagnostic tests longer than the 6 week standard

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Patients	2823	2865	3051	2600	2816	2652	2266	2361	2883	2948	3207	3446	3810
Waiting longer than 6 weeks	282	182	240	264	207	299	1080	1282	1186	911	1106	1295	1312
% over 6 weeks	10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%	30.9%	34.5%	37.6%	34.4%
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	8.3%	7.8%	7.3%	6.9%	6.6%	6.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%



This month has seen a decrease in the percentage of patients with a diagnostic waiting time over six weeks to 34.3 % from 37.6% in September.

All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

The modalities with the greatest number of long waits are echocardiography, neuro physiology, and those requiring endoscopy investigations. These teams are working on recovery plans that will require support to increase capacity to offset the impact of covid precautions on historical utilisation rates.

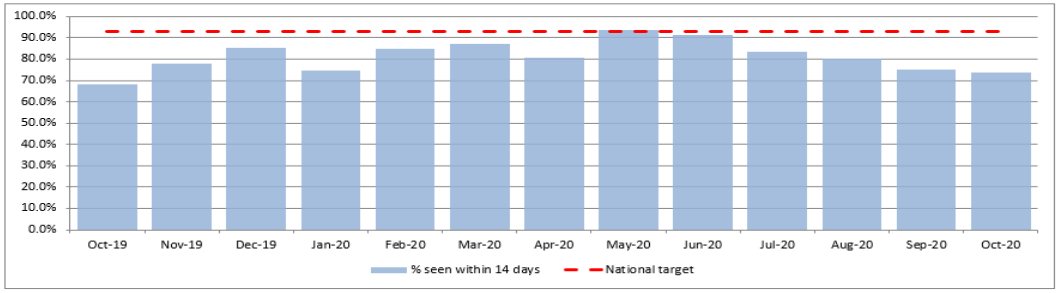
CT and MRI have seen a steady increase in capacity although dependent on the use of the additional capacity from insourcing through mobile vans.

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

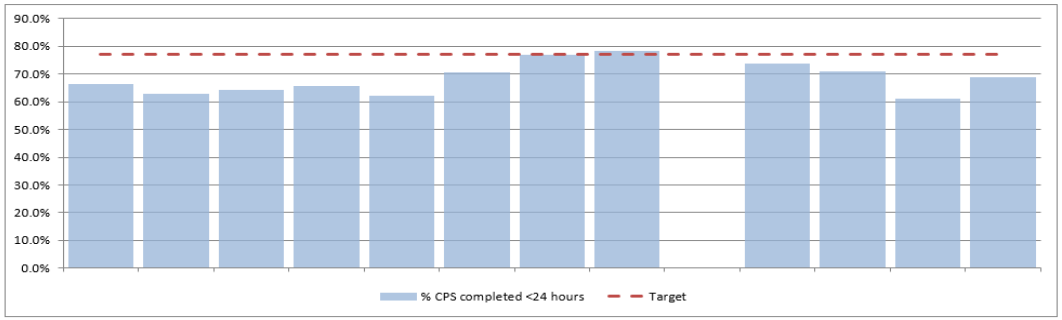
Cancer - Two week wait referrals

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
2ww referrals seen	1327	1459	1208	1241	1251	1397	549	847	1071	1281	1217	1336	1423
2ww breaches	422	324	177	313	190	180	107	54	92	213	242	333	371
% seen within 14 days	68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	80.5%	93.6%	91.4%	83.4%	80.1%	75.1%	73.9%
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%



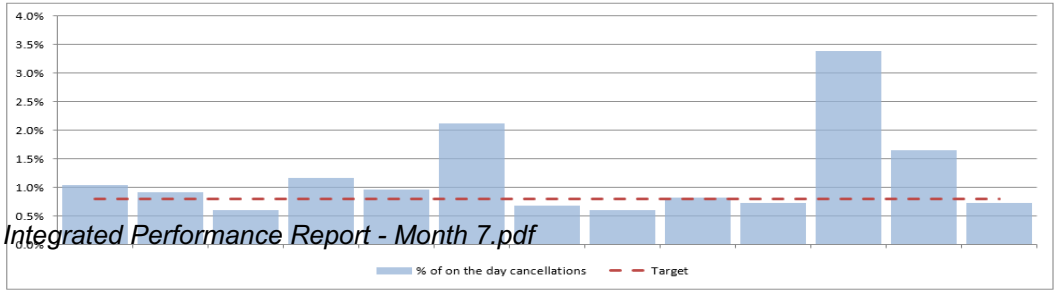
Care Plan Summaries completed within 24 hours of discharge - Weekday

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Discharges	1815	1627	1668	1683	1560	1376	885	1039	n/a	1405	1425	1361	1324
CPS completed within 24 hours	1206	1025	1069	1106	967	972	681	815	n/a	1034	1011	832	913
% CPS completed <24 hours	66.4%	63.0%	64.1%	65.7%	62.0%	70.6%	76.9%	78.4%	n/a	73.6%	70.9%	61.1%	69.0%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%



On the day cancellations for elective operations

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Cancellations	38	33	19	43	32	56	8	9	15	18	74	46	20
Elective spells	3616	3567	3133	3667	3332	2631	1174	1503	1826	2446	2189	2772	2742
% of on the day cancellations	1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%	0.7%	3.4%	1.7%	0.7%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



Cancer two-week wait referral

The number of cancer two-week wait referrals received has continued to increase and is close to pre- covid levels. Performance is below the 93% standard at 73.9%.

Care Planning Summaries (CPS)

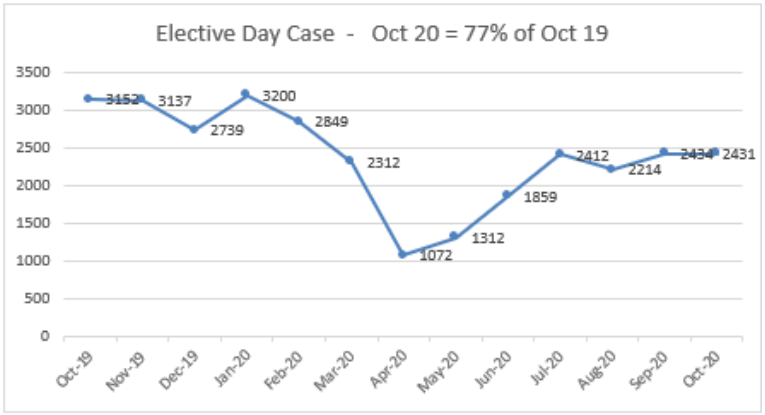
The improvement programme is working with wards and emphasising that timely completion of the CPS is a mandatory requirement.

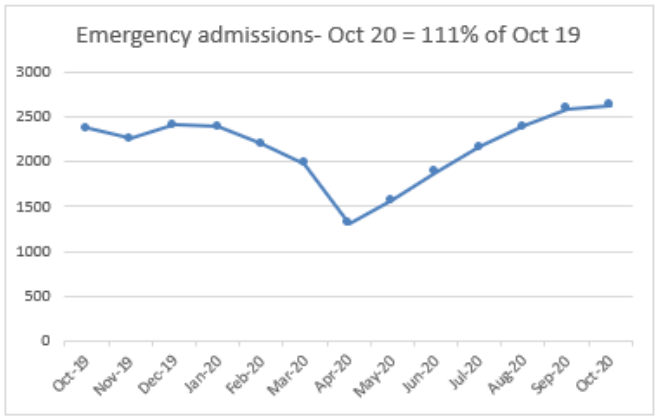
No improvement is currently being seen in the weekday CPS completion. This has been escalated through the Integrated Governance Group to clarify the plan in place and trajectory to improve performance.

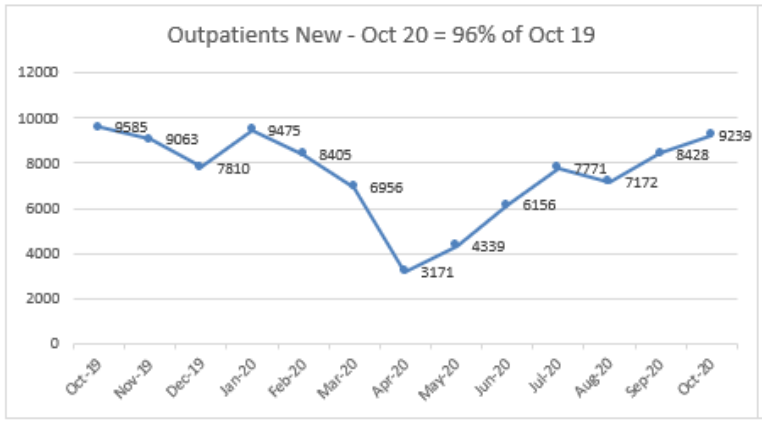
Cancelled operations

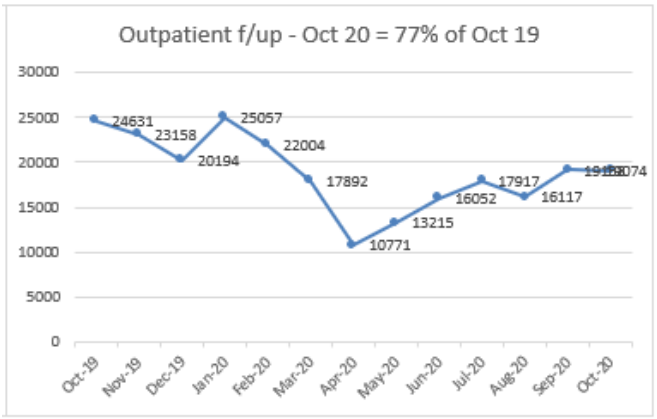
The number of operations cancelled on the day has decreased in October. Bed capacity and operational pressures has however become a significant factor in October for planned elective surgery with reduced number of admissions being scheduled.

Headline acute activity comparisons to last year









The charts above show the monthly run rate of reported contract activity (PBR). The percentage of activity compared to the same month last year is shown in the chart titles. We have seen a progressive increase through to September, however, in October this has slowed across elective inpatient day case procedures and follow up outpatients. Activity is falling behind our submitted Phase 3 recovery plans that describe monthly activity forecasts as a percentage of pre covid through to March 2021. The submitted plans, however, are dependent on having no significant impact from a second wave of covid-19 and continued support from the independent sector including outsourcing to Mount Stuart Hospital.

Phase 3 recovery planning - The Phase 3 Covid recovery planning return is showing a return to 92% for Outpatients and 95% for day case and inpatients elective admissions by March 2021.

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

Access and Waits

Following review of capacity plans with teams, agreement has been reached to bring back into operation all clinical areas, with IPC approval. This will have a positive impact on the capacity to see patients face to face. Work continues to fully utilise virtual clinics through telephone and Attend Anywhere although it is recognised that this is not suitable for all client interactions.

Access and waiting times across all pathways except CAMHS and Children's Nursing remain problematic. CAMHS has a robust reviewing process for children waiting and clear trajectories for waiting list recovery. There has been intensive focus on waits , on keeping children safe whilst waiting and improvement plans developed for ASD, CAMHS, OT, SALT and Physio with improvement trajectories . These have been shared with the CCG. The ASC waits are insurmountable within current resource and are subject to a business case for waiting time reduction.

Workforce

This month COVID-19 has impacted on some activities, with both Task and Finish Groups attendance reduced and some meetings cancelled. Staff wellbeing remains a high priority and managers are working with teams to ensure clear messaging on keeping safe and supported. Review dates on some actions reflect COVID-19 escalation. Recent departures and some imminent departures in the senior management team is creating increased strain on leadership capacity, in particular in the Integrated Therapies and Nursing team. The current People & OD Project Lead is also leaving to take a new role within the Torbay & South Devon Trust. This has highlighted further the need for clear service leadership structures to be designed and implemented as soon as practical; as well as clarity on the service business management support teams (e.g. HR, IT, Business Analytics, Finance, Communications) to be clearly agreed and put in place.

Governance

Following the step down of CFHD governance during the early stage of the C19 period, the Director, working closely with execs and senior leaders is in the process of reviewing the function and form of internal governance and external assurance meetings. Attention will be focused on all services in CFHD being able to evidence that they are inspection ready and that they have robust actions in place to address safety and quality risks as a priority where these exist.

18 week RTT Performance

September 2020		RTT % <18 weeks		Caseload		
Service	RTT longest waits (weeks)	Oct-19	Oct-20	Oct-19	Oct-20	Change last 12 months
CAMHS	53.6	81.4%	79%	4112	4034	- 78
Occupational Therapy	50.6	70%	57.3%	1241	1205	- 36
Speech and Language Therapy	100.3	68.3%	49.4%	3905	4885	+ 980
Autistic spectrum assessment team	124.4	25.9%	16.2%	1862	2515	+ 653
Physiotherapy	35.6	88.2%	93.4%	651	792	+ 141
Learning disability	15.4%	87.5%	100%	281	306	+ 25

Finance Report

Month 7 - Financial Year 2020/21

Finance, Performance & Digital Committee Meeting

23 November 2020

Contents

1. Overall Position - Executive Summary

Context

· The Trust from M7 2020/21 is being monitored as two distinct halves of the year, whereby the cumulative plan at M6 year to date has been matched to actual expenditure including the top-ups paid, with zero variances and the H2 second half of the year will be monitored against the mid-year plan.

· NHSE/I have now issued updated guidance around the allowed COVID expenditure, whereby only Laboratory costs and the Hospital Discharge costs will be treated as claimable on a pass through cost basis.

· The Council has been awarded an Infection Control fund for the second half of the year and this will again be passported through to Care Homes.

· Further COVID Guidance is presented on a separate report.

· Variance reporting has restarted, however the focus remains on run rate (i.e. change and trends in income and expenditure) monitoring and reporting to assess each ISU's financial performance ensuring that expenditure is controlled within the limits set by NHSE/I and represents value for money. Any variance from the H2 plan will require a recovery programme in order the Trust maintains a balanced position.

· Workforce WTE establishment budgets have been set for H2 using the financial forecast in lieu of an ISU workforce plan.

· H2 Budgets are now being distributed to Budget Holders at ISU level.

· In the H2 plan submitted no CIP schemes were identified and no achievement reported as at M7 due to the impact of COVID.

· The Trust plan submitted to NHSE/I last month show a deficit of £0.6m (after adjustment for Donated items); the Forecast as at end of M7 show that we are on target to achieve this plan.

· Following the STP prioritisation process, a 2020/21 Capital plan was submitted to NHSE/I in July at £29.7m. The October 2020 plan submission incorporated a capital plan of £38.7m. This followed the award of further PDC (including £9.0m for 2020/21 expenditure on the ED scheme).

Key Questions

1. What is our current financial performance for the period ending 31st October 2020?

	NHSI Plan YTD Month 7 £'000s	Actual YTD Month 7 £'000s	Variance Favourable (Adverse) £'000s
Total Income	309,522	308,394	-1,128
Total Expense	-297,066	-295,960	1,106
EBITDA	12,456	12,434	-22
Financing Cost	-12,640	-12,492	148
Surplus (Deficit)	-184	-58	126
NHSE/I Adjustments - Donated Items	512	499	-13
Adjusted Financial performance - Surplus (Deficit)	328	441	113

The year to date budget shown in the table above is the M1-M6 actual values notified to NHSE/I plus the plan for M7 per the October H2 submission. The in month variance and year to date variance are the same based on this financial architecture. The Trust has an underlying favourable variance of £0.1m as at M7. This include year to date COVID income of £16.79m (M1 to M6 block top up of £8.58m, M7 CCG top up income of £2.95m and cost reimbursement of £5.26m).

2 COVID Expenditure

There are 5 streams of COVID costs in the Trust Position:

1) Acute COVID spend ---> £10.1m YTD
2) Hospital Discharge ----> £6.2m YTD
3) Infection Control Care Homes --> £3.1m YTD
4) Swabbing Costs ------> £0.0m YTD
5) Laboratory Testing -------> £0.3m YTD

Hospital Discharge costs are now pass through costs to Devon CCG, Infection Control costs are pass through to Care Homes, and the Laboratory testing is pass through the NHSE.

Therefore the costs the Trust need to deliver on as part of the H2 plan are the acute COVID costs and associated swabbing costs.

The Trust is required to prepare detailed analysis in their monthly returns for items 1, 4 and 5.

A paper has been drafted for further information shown as Appendix 2 - COVID Finance Report October 2020.

3 Plan and Forecast

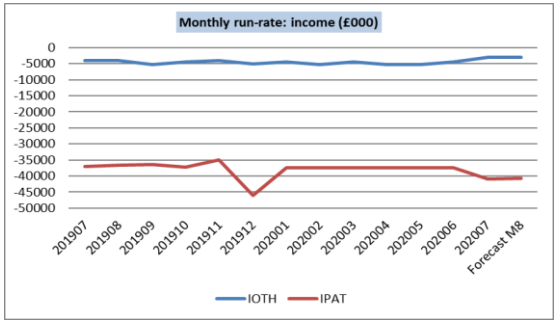
The H2 Trust plan submitted to NHSE/I last month show a deficit of £0.61m (after adjustment for Donated items); the full year plan consist of M1 to M6 actuals and M7 to M12 plan value. The Forecast as at end of M7 show that we are on target to achieve this plan; the summary table is below. The NHSE/I Return no longer requires a bridge analysis of COVID and Non COVID.

	NHSE/I Plan FY 2020/21 £'000s	Forecast FY 2020/21 £'000s	Variance Favourable (Adverse) £'000s
Total Income	546,117	546,131	14
Total Expense	-525,063	-525,063	0
EBITDA	21,054	21,068	14
Financing Cost	-22,537	-22,537	0
Surplus (Deficit)	-1,483	-1,469	14
NHSE/I Adjustments - Donated Items	878	864	-14
Adjusted Financial performance - Surplus (Deficit)	-605	-605	0

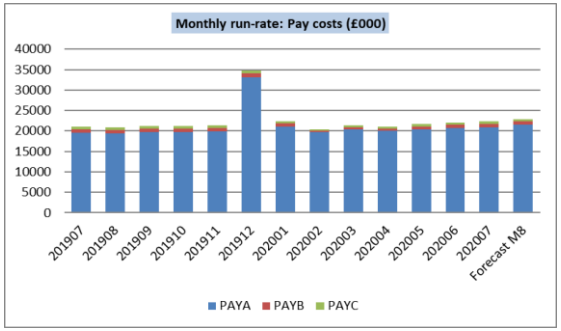
Key Risks and Mitigations to Forecast Outturn Delivery

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

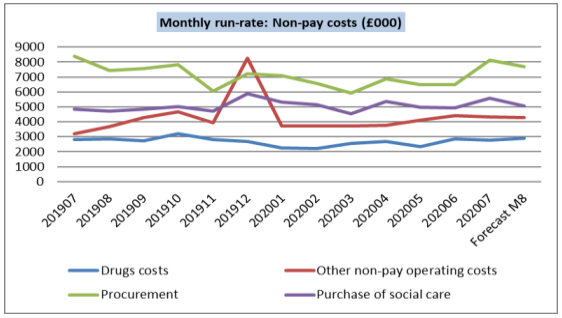
Non-COVID RELATED FORECAST, £'000's



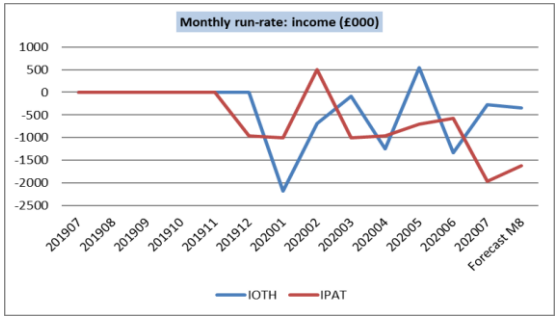
Key:
IOTH= Other Income
IPAT = Patient Income

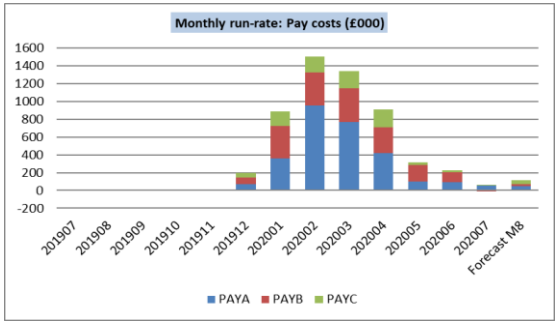


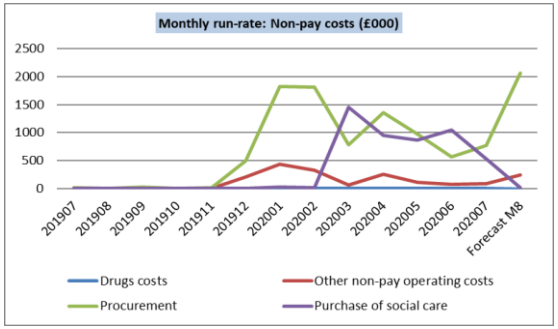
Key:
PAYA = Substantive
PAYB = Bank
PAYC = Agency



COVID RUN RATE & FORECAST £'000's







The variances in the Non COVID Trust reporting around contract and other income total £1.1m adverse. Of which £250k is Laboratory COVID pass through related and matched by a favourable COVID expenditure variance, £608k is TP Pharmacy sales related due to lower sales from all sources and the balance is £393k income above the H2 plan for the Torbay Council COVID support measures agreed for the independent sector offset by some small favourable other income changes.

Expenditure variances are £1.2m favourable to plan at M7, driven by the COVID lab pass through referred to above, along with acute COVID favourable variances of a further £386k, expected to swing back in November's reporting. There is also a reduced expenditure across staffing of circa £100k as the phase 3 activity plans on recruitment are behind plan. The risk here is the Business cases to confirm the capacity need to spend the phase 3 monies have not been through the Trust governance for approval at this stage. TP costs are also adverse due to increasedcost of production by £400k.
Depreciation is behind plan by £138k favourable.

The remaining variances are across the purchase of healthcare categories and other costs. Partly due to expectations of insourcing around hire of CT vans now not available, and other insourcing assumptions in the phase 3 activity plans, along with a reduced spend in Continuing Healthcare. Both CHC spend and ASC spend has multiple complexities regarding Care Home contracts and COVID support during this time and is expected to be highly volatile when comparing to planned expenditure against the baseline business as usual.

The net income and expenditure COVID position has a variance against plan of £813k year to date, which represent the same variance as at M7 due to months 1-6 now being matched to actual run rates per the latest NHSE/I financial architecture.
£393k of this favourable variance is the second £1m tranche of support for COVID from Torbay Council (agreed outside of the national programmes) and not yet allocated to the general independent sector budgets. The remaining favourable variance is related to acute COVID expenditure across pay and clinical supplies and is expected to increase alongside the COVID surge seen during November and be back on plan by the end of December.

Key Financial Information – Trustwide

		M7			YTD M7		
	£m	Budget	Actual	Variance	Budget	Actual	Variance
Income (excluding COVID19 Top-Up)	Patient Income - Block	29.25	29.08	(0.17)	198.21	198.04	(0.17)
	Patient Income - Variable	3.47	3.52	0.05	23.99	24.04	0.05
	ASC Income - Council	4.35	4.10	(0.25)	32.14	31.89	(0.25)
	Other ASC Income - Contribution	0.90	0.97	0.07	6.60	6.67	0.07
	Other Income	5.88	5.33	(0.55)	31.52	30.97	(0.55)
	Total (A)	**43.85**	**43.00**	**(0.85)**	**292.46**	**291.61**	**(0.85)**
Expenditure (incld Financing Costs)	Pay - Substantive	(22.14)	(21.75)	0.39	(152.80)	(152.41)	0.39
	Pay - Agency	(0.54)	(0.67)	(0.13)	(3.81)	(3.94)	(0.13)
	Non-Pay - Other	(12.34)	(12.56)	(0.22)	(74.92)	(75.14)	(0.22)
	Non- Pay - ASC/CHC	(10.14)	(9.08)	1.06	(65.54)	(64.48)	1.06
	Financing Costs	(1.86)	(1.73)	0.13	(12.12)	(11.99)	0.13
	Total (B)	**(47.02)**	**(45.79)**	**1.23**	**(309.19)**	**(307.96)**	**1.23**
	Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**(3.17)**	**(2.79)**	**0.38**	**(16.73)**	**(16.35)**	**0.38**
	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
	Covid19 - Top up income	3.50	3.23	(0.27)	17.06	16.79	(0.27)
	Donated Transactions	(0.07)	(0.06)	0.01	(0.51)	(0.50)	0.01
	Impairment	0.00	0.00	0.00	0.00	0.00	0.00
	Total (D)	**3.43**	**3.17**	**(0.26)**	**16.55**	**16.29**	**(0.26)**
	Net Surplus/(Deficit)	**0.26**	**0.38**	**0.12**	**(0.18)**	**(0.06)**	**0.12**

Key points

- The year to date budget shown in the table above is the M1-M6 actual values notified to NHSE/I plus the plan for M7 as per the October submission. In month variance and year to date will be the same based on the revised financial set up. As at M7 the Trust has a favourable variance of £0.1m.
- In M7 lower patient care income of £0.17m relate to a planning variance against CCG income (matched by cost reduction). The £0.25m adverse variance is for ASC income expected from Torbay Council in M7 but will be received in M8. Other income of £0.55m (net) relate to lower TP sales from all sources £0.61m offset by higher income from car parking, grants and miscellaneous income £0.06m. There is an increase of £0.12m from variable patient care activity and ASC contribution.
- Substantive Pay expenditure of £21.75m in M7 is £0.39m lower than budget due to expected investments not yet in place. This is offset by higher Agency cost of £0.13m mainly in Nursing due to step up of services, specialling, sickness and vacancies cover.
- Non-pay expenditure Other is £0.22m higher than budget due to: Clinical supplies £0.13m (higher TP cost of sales £0.45m offset by lower COVID lab testing than planned £0.33m), non clinical supplies £0.12m (cost increase in uniforms, cleaning materials and contract for laundry due to step up of activity), £0.13m in other cost mainly due to increase in ASC bad debt provision; offset by lower Drugs cost of £0.17m mainly homecare drugs issue.
- Independent sector Non-pay cost (ASC and Placed people (Health including CHC) is £1.06m lower than budget in M7. This is due to lower residential stay placements.
- Within the M7 year to date position COVID related costs incurred total £10.55m (pay £5.38m and non pay £5.17m). Further details have been included within the pay and non pay sections.

Statement of Financial Position

	Month 07		
	Plan £m	Actual £m	Variance £m
Non-Current Assets			
Intangible Assets	11.42	12.19	0.76
Property, Plant & Equipment	185.13	182.81	(2.32)
On-Balance Sheet PFI	17.22	17.22	0.00
Other	1.28	1.29	0.01
Total	**215.05**	**213.50**	**(1.55)**
Current Assets			
Cash & Cash Equivalents	47.48	56.31	8.82
Other Current Assets	37.33	38.96	1.63
Total	**84.81**	**95.27**	**10.46**
Total Assets	**299.86**	**308.77**	**8.90**
Current Liabilities			
Loan - DHSC ITFF	(4.81)	(4.81)	0.00
PFI / LIFT Leases	(1.04)	(1.04)	0.00
Trade and Other Payables	(80.93)	(93.23)	(12.30)
Other Current Liabilities	(2.76)	(2.71)	0.04
Total	**(89.52)**	**(101.78)**	**(12.26)**
Net Current assets/(liabilities)	**(4.71)**	**(6.52)**	**(1.80)**
Non-Current Liabilities			
Loan - DHSC ITFF	(31.48)	(31.48)	0.00
PFI / LIFT Leases	(17.09)	(17.09)	0.00
Other Non-Current Liabilities	(10.27)	(9.46)	0.81
Total	**(58.84)**	**(58.03)**	**0.81**
Total Assets Employed	**151.50**	**148.95**	**(2.55)**
Reserves			
Public Dividend Capital	115.08	112.40	(2.68)
Revaluation	46.08	46.08	0.00
Income and Expenditure	(9.65)	(9.53)	0.13
Total	**151.50**	**148.95**	**(2.55)**

Key points

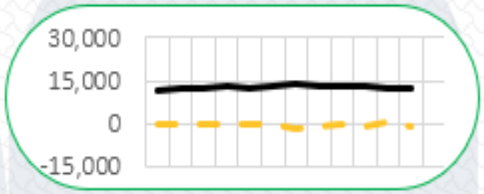
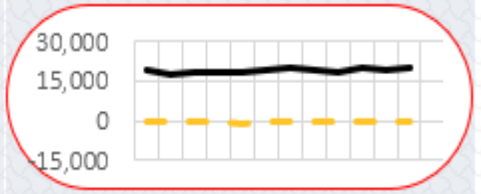
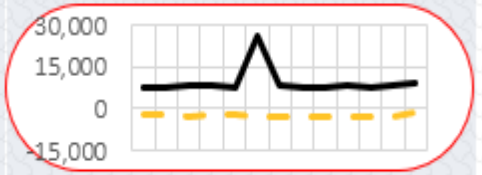
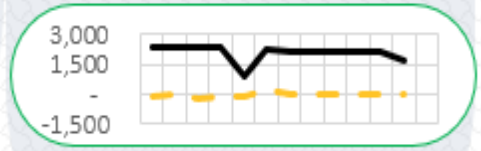
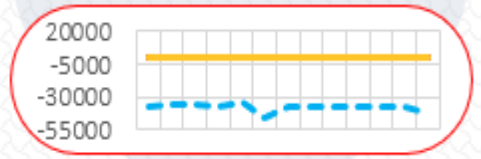
A balance sheet plan was submitted to NHSEI in October. Comparisions are therefore now being made against plan.

- Intangible Assets, Property, Plant & Equipment and PFI are £1.6m lower than Plan. This was principally due to capital expenditure £1.7m lower than Plan.
- Cash is £8.8m favourable to Plan, as explained in the commentary to the cash flow statement.
- Other Current Assets are £1.6m higher than Plan. This is principally due to debtors relating to the transition to the new Covid financial architecture £2.2m, Early Discharge funding £0.8m and Infection Control £0.8m, partly offset by NHSE 2019/20 washup paid one month earlier than expected £1.8m.
- Trade and Other Payables are £12.3m above Plan. This is principally due to increased Covid blocks in advance £6.5m, increased capital creditor £2.8m and increased CYP accruals £1.0m.
- Other Non-Current Liabilities are £0.8m lower than Plan due to reduced usage of finance leases, largely due to delayed capital expenditure.
- PDC reserves are £2.7m lower than Plan, due to delays in PDC-funded capital expenditure and in claiming the respective PDC funding.

2. Key Metrics

Board Table of Key Metrics

Total Expenditure
Other Income
Contract Income

	Drivers	Actions Taken:	Tick charts £'000 Oct 19 to Oct 20
South System & Shared operations	Expenditure now being seen for the MRU and elective step up, within phase 3 plan levels.	Likely to underspend Phase 3 winter/Elective plan in Nov/Dec with higher expenditure expected from January due to recruitment timeline.	
Torbay System	Average monthly expenditure is up by circa £1m, driven by COVID related costs of circa £1.3m (Hospital Discharge & Infection Control). Pay is static.	Future run rate will be impacted by some key assumptions on recovery plans developed, winter costs and national initiatives around COVID and funding agreements.	
Corporate (inc. Exec Directors, Financing, R&D, IA)	General repairs stepping back up, overseas nursing recruitment coming back on line, pay costs static, Pharmacy home delivery no longer charged to COVID.	Expect the HIS spend profile to be a potential risk, R&D resources remain re-deployed as income trials stopped. Continuation of estates moves.	
CFHD	Run rate fairly static, consultation remains on hold, risk share now applied from M7.	Activity back log requires funding, deferred income in 2019/20 not yet committed.	
Contract Income	H2 contract income now fixed except COVID pass through for labs and HD/IC.	Exit run rate and CCG contract income negotiations for FY 21/22 a risk.	

(Note: This data set excludes TP.)

2. Key Drivers of Financial Position

Key System Issues	ISU	Financial Commentary/Key Drivers
CFHD	CYP	Children's consultation remains paused. Vacancies within the service starting to fill. ADHD Backlog remains a risk. Deferred income for service configuration costs requires a plan in 2020/21 if unable to defer a further year. IT systems not yet implemented as reliant on the consultation for set up processes.
Torbay Pharmaceuticals	PMU	TP has had lost sales and due to the stock not being WIP increased costs.
Corporate	EFM	Car parking agreed in NHS Peoples Plan to remain FOC to staff for 2021. Increased cleaning, linen and repair costs seen as services move back and set back up.
	Exec. Directors	R&D staff remain redeployed due to trials income reduced. Pharmacy Healthcare at home now back in BAU run rate.
	Financing Costs	Financing costs marginally behind plan at M7.
	Other	Reserves has a provision for debt included at M7 due to IS payment of invoices, as well as backdated IS inflation claims provision.
South System	Coastal	Phase 3 slower to start than anticipated, but £2.4m recovery still forecast currently. Safer staffing review is being undertaken post the Phase 3 plan.
	Newton Abbot	MIU setting back up plus Winter costs, plus MRU costs now being seen. Safer staffing review per above, ED department review underway first.
	Moor to Sea	Run rates fairly static.
Torbay System	Independent Sector	Increased costs (circa 20%) due to COVID commitments. Multitude of changing funding arrangements throughout the financial year Increased costs (circa 20%) due to COVID and knock on impacts to other areas. Multitude of changing funding arrangements throughout the financial year means estimations are having to be used.
	Torquay	The second wave of COVID makes Recovery / Standing back up services challenging especially when combined with winter pressures.
	Paignton and Brixham	Ongoing management balancing recovery plans and dealing with second wave of COVID / winter pressures within revised budget envelope. Winter pressures within revised budget envelope.
Contract Income	Patient Income	Contract Income variation needs realigning due to COVID income planned in commissioner income and recorded in Other income at M7 – action for Contracting team.

Change in Financial & Activity Performance - M6 to M7

		Plan	Sep-20	Oct-20	Change	% Change		Oct-19	% change
Activity Drivers	A&E Attendances	9,270	8,138	6,934	-1,204	-15%		9,575	-28%
	Elective Spells	3,620	2,681	2,647	-34	-1%		3,489	-24%
	Non Elective Spells	3,196	3,182	3,196	14	0%		3,448	-7%
	Outpatient Attendances	28,088	26,762	27,473	711	3%		34,216	-20%
	Adult CC Bed Days	248	140	146	6	4%		288	-49%
	SCBU Bed Days	194	182	121	-61	-34%		316	-62%
Bed Utilisation	Occupied beds DGH		8,595	8,764	169	2%		10,728	-18%
	Available beds DGH		10,342	9,988	-354	-3%		11,440	-13%
	Occupancy		83%	88%	5%	6%		94%	-6%
Resource Consumption	Medical Staff Costs - £000's	4,887	4,881	4,833	-48	-1%		4,678	3%
	Nursing Staff Costs - £000's	5,326	5,196	5,143	-53	-1%		4,929	4%
	Temp Agency Costs - £000's	536	584	675	91	16%		585	15%
Key points	Total Pay Costs - £000's	22,679	22,327	22,425	98	0%		20,983	7%

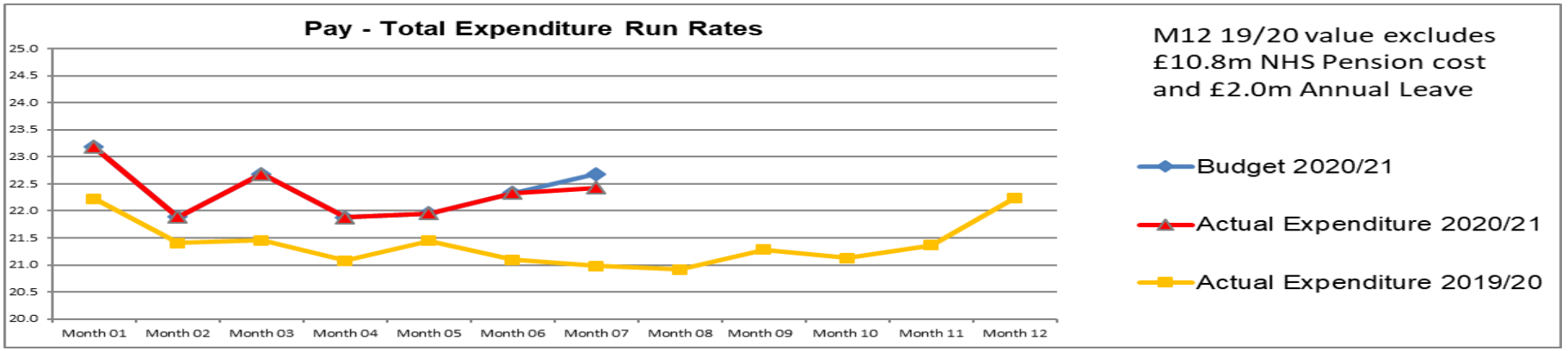
- **Activity Drivers:** Overall activity (Elective, Non Elective and Outpatient) numbers have increased by about 2% from M6 which was the previous highest month for activity. The main increase is in Outpatients, which shows services are increasing their activity to work towards FY 19/20 volumes. Both Elective and Non elective activity were very similar to M6 and Non Elective activity was again at plan levels. The Trust submitted a draft Phase 3 activity submission to the STP last month and a subsequent STP finance return that triangulated with these numbers was also submitted. NHSE/I are reviewing Phase 3 submissions and the STP reviewed and updated certain elements but, nothing material. Because of the impact of the 2nd wave of COVID, the Trust was not asked to calculate a value for EIS. We are waiting for further guidance to see whether this will continue, at least in the short term, unless the impact of COVID reduces and Providers are able to return to planned activity levels. The Trust is now also starting to focus on FY 2021/22 planning and setting the baselines for this piece of work.

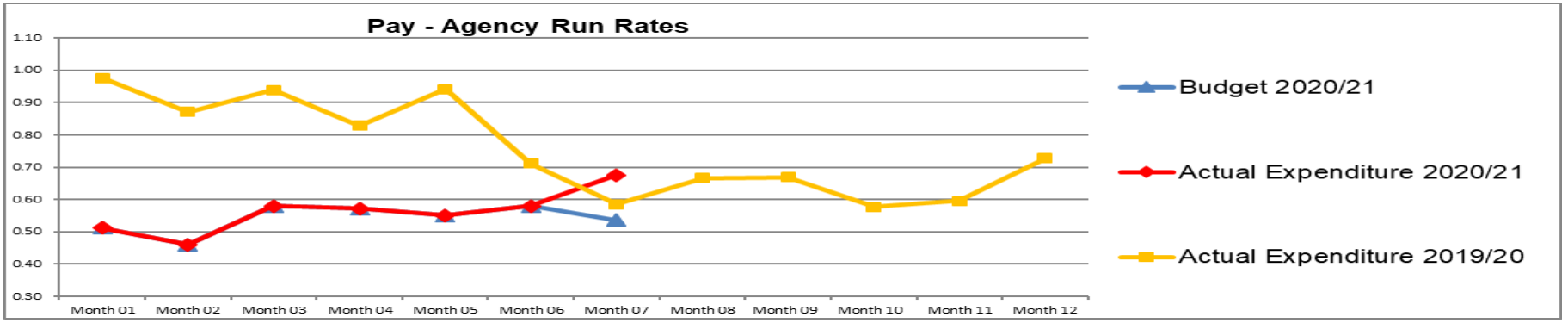
- **Bed utilisation:** In October, we have seen a continued increase of bed occupancy rate to 88% for general and Acute beds at the DGH. This increase has been accompanied with increasing operational challenges to maintain patient flow for emergency admissions. The onset of the 2nd wave of Covid-19 hospitalisations has seen capacity of the covid ward exceeded and a second ward converted for covid patients care. The number of available beds in October is reduced due to the reconfiguration of some wards for capital works in ED and for MRU and for the last week of the month one medical ward being closed due to infection control precautions relating to Covid-19 contacts. The system plan to limit the number of covid patients in Torbay Hospital beds using pathways to RDE and Nightingale have not been triggered. This has seen the cancellation of planned elective surgery with the expansion into surgical bed capacity by the second covid-19 ward. The Devon system assessment of ongoing risk assessment against predicted second wave hospitalisations continues with the decision re opening the Nightingale to be confirmed. 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 a slight increase of £0.1m within overall pay mainly in Agency cost. The increase is within Nursing £0.04m (speciall ing), Medical staff £0.02m, AHP and Other staff £0.03m due to step up of services.

Pay Expenditure

Current Performance

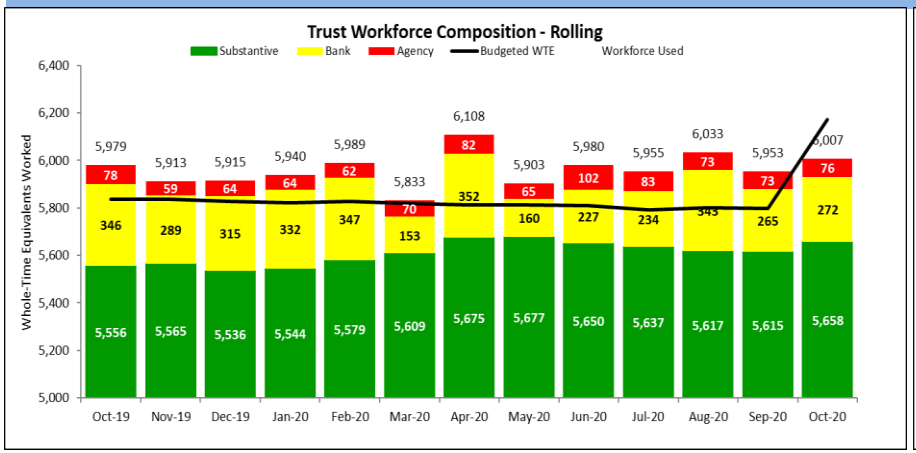


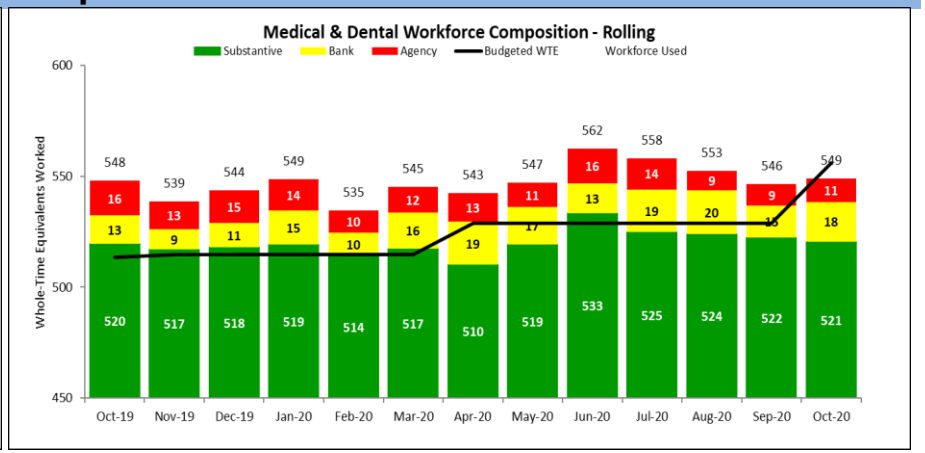


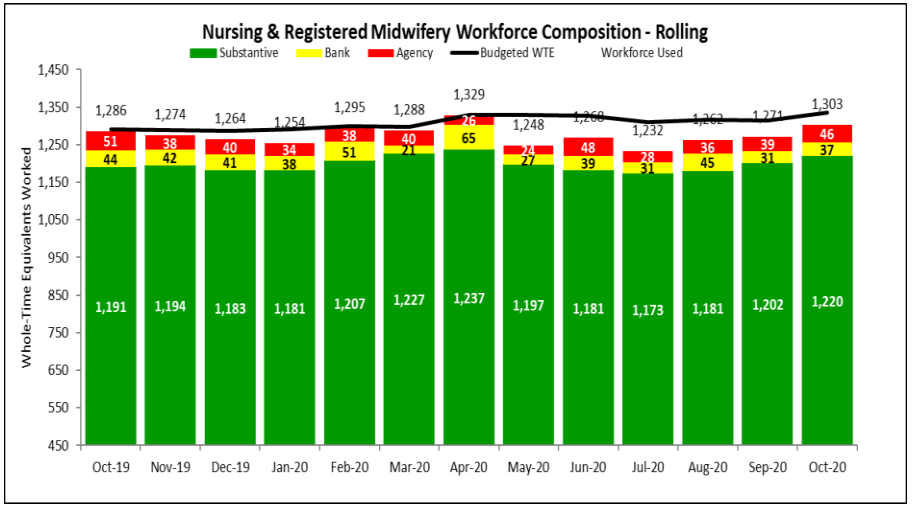
Key points

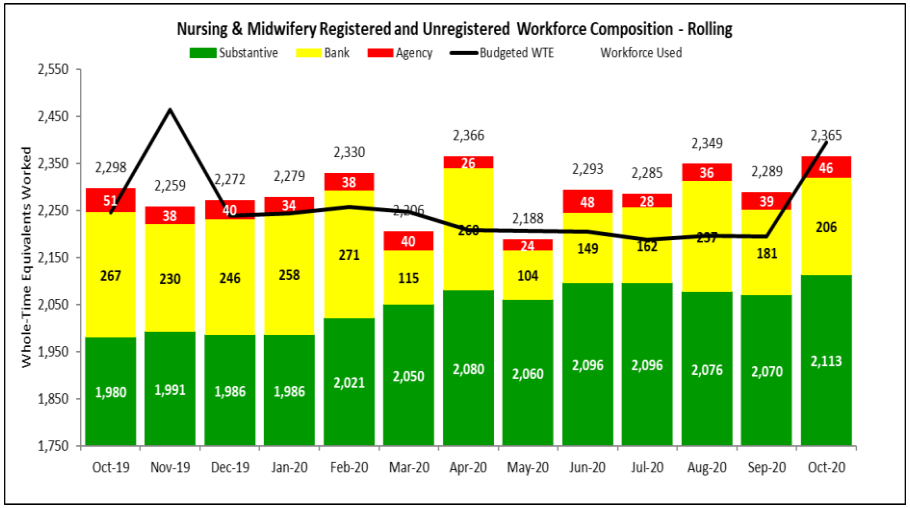
- Per NHSE/I's guidance for M7 onwards, the M1 to M6 actuals are now equal to budget, this is shown on the graph above.
- Total pay run rate in M7 (£22.33m) is £0.10m higher in comparison to previous month (M6 £22.33m) mainly within Agency cost.
- M7 Agency £0.09m increase pay is within Nursing £0.04m (specialling), Medical staff £0.02m, AHP and Other staff £0.03m due to step up of services.
- There is £5.38m of pay costs year to date related to COVID. The breakdown is as follows: additional shifts of existing workforce £2.60m, backfill for higher sickness absence £2.33m, workforce expansion £0.14m, sick pay £0.27m and testing £0.04m.
- The Apprentice levy balance at Month 7 is £1,914,487 (£1,872,657 at month 6). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

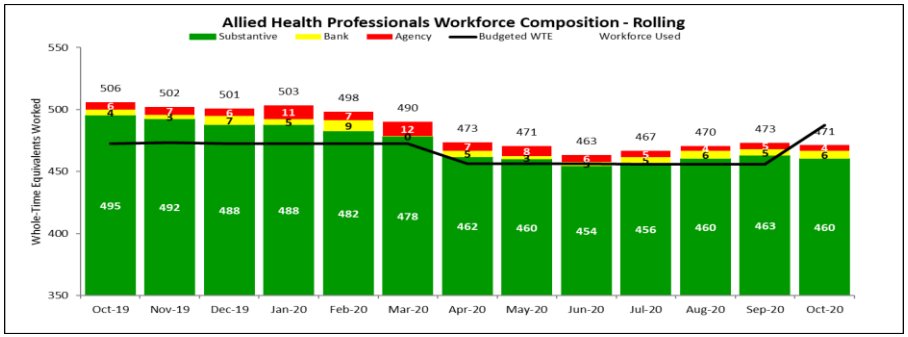
Workforce Composition

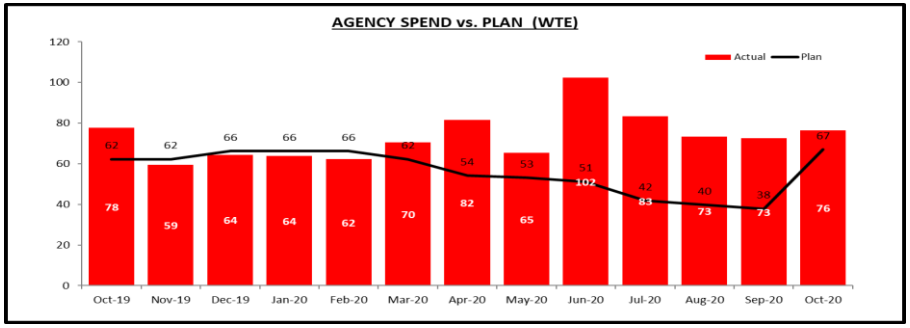




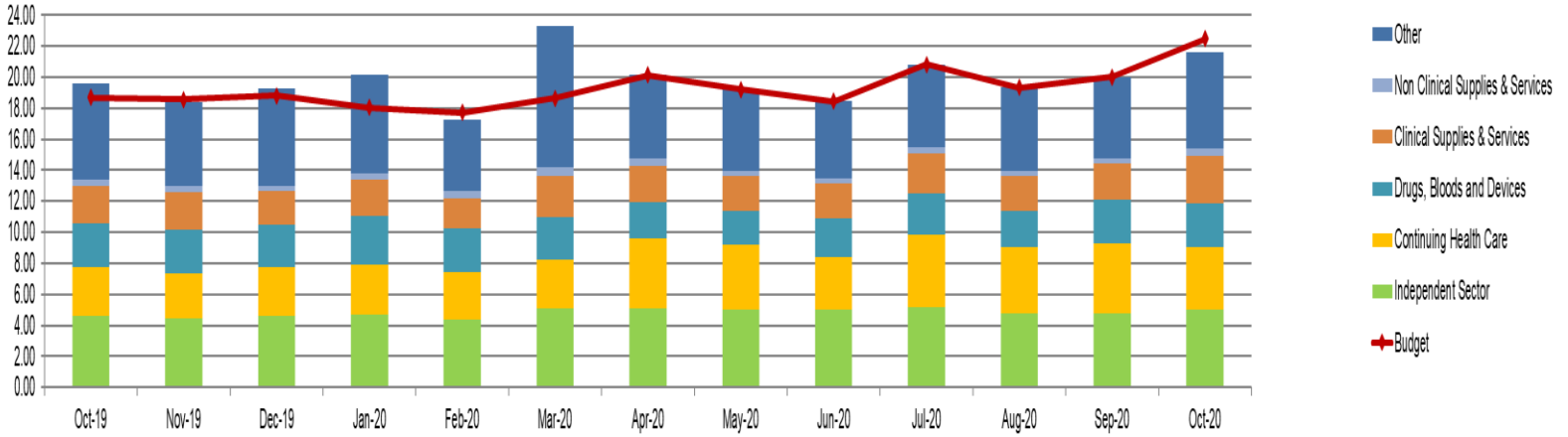








Non Pay Expenditure



Key Points

- Per NHSE/I's guidance for M7 onwards, the M1 to M6 actuals are now equal to budget, this is shown on the graph above.
- Total non pay run rate in M7 (£21.63m) is £1.61m higher in comparison to previous month (M6 £20.02m), details are below:
- There has been an increase in the run rate spend on Clinical supplies cost of £0.72m due to COVID equipment cost of £0.34m (M6 revenue to capital transfer of £0.24m), dressings and devices £0.10m due to step up of activity within the clinical areas. There is also a net TP cost of sales of £0.28m linked to lower production in month.
- In M7 spend in Non Clinical Supplies increased by £0.15m due to: additional contract cost for contaminated linens £0.05m, patient provision £0.02m, uniforms £0.03m, domestic materials, cleaning equipment, textiles and other £0.05m. As above these are due to step up of activity within the Trust.
- Independent Sector cost increased by £0.26m in month mainly due to domiciliary care and supported living.
- There is an increase of £1.01m within operating expenditure. Of this £0.52m relate to CFHD alliance cost, £0.22m relate to estates building contracts, materials and furniture purchases, £0.10m increase in commercial healthcare, day and intermediate care £0.10m, and £0.17m for other costs (postage, telephone, increase in bad debt provision and various other cost). These are offset by:
- Placed People (Health including Continuing Healthcare) decreased by £0.46m due to reduction in residential nursing placement cost.
- Drugs cost reduced by £0.06m mainly healthcare at home drugs issues.
- There is £5.17m of non pay costs year to date relating to COVID. This comprises of the following costs: testing £1.49m, remote management of patients £0.43m, increase in ITU capacity £0.59m, segregation of patient pathways £1.14m, locally procured PPE £1.15m, decontamination £0.18m, and various other £0.19m.

Capital

Current Performance

	Year to Date			Full Year 2020/21		
	October plan submission	Actual Expenditure £m	Variance	October plan submission £m	Forecast £m	Variance £m
Capital Programme	**12.86**	**11.18**	**(1.69)**	**38.71**	**38.84**	**0.13**
Scheme type						
HIS schemes	1.64	1.74	0.10	6.22	6.26	0.04
Estates schemes	8.37	6.70	(1.66)	23.67	22.42	(1.25)
Medical Equipment	1.27	1.06	(0.21)	6.45	6.46	0.01
TP	1.27	1.16	(0.12)	3.00	3.00	0.00
COVID 19 Claims	0.43	0.52	0.09	0.52	0.51	(0.01)
Contingency General	0.00	0.00	0.00	0.25	0.25	0.00
Prior Year	0.00	(0.00)	(0.00)	0.00	0.00	0.00
Planned slippage	(0.12)	0.00	0.12	(1.40)	(0.06)	1.34
Total	**12.86**	**11.18**	**(1.69)**	**38.71**	**38.84**	**0.13**
Funding sources						
Finance Leases	1.56	2.26	0.70	8.19	8.92	0.73
PDC - Agreed	5.23	1.99	(3.24)	18.89	18.92	0.03
PDC - Unagreed	1.40	1.40	0.00	1.40	1.40	0.00
Charitable Funds	0.00	0.01	0.01	0.00	0.01	0.01
Disposal of assets	0.08	0.00	(0.08)	0.30	0.22	(0.08)
Other Internal cash resources	4.60	5.52	0.91	9.94	9.37	(0.57)
Total	**12.86**	**11.18**	**(1.69)**	**38.71**	**38.84**	**0.13**

Key Points

- Current capital expenditure plans utilise all of the Trust's in year internal cash resources leaving a forecast cash position of circa £7m at 31/3/2021.
- An assumption has been made that Interim Revenue support in the form of PDC will continue to be provided by NHSE/I for any revenue deficit position that materialises during 2020/21.
- The capital programme that was presented to the FPDC (July 2020) was heavily reduced in value compared to the initial Trust March 2020 Plan submission, due to constraints introduced by the cash and capital regime.
- In late July 2020, the STP agreed an increased capital allowance of £9.16m for the Trust, enabling the programme to increase to £29.7m.
- Since August the forecast has increased by a further £9.0m - mainly in respect of the £9m ED Scheme.
- Of the £20.3m of PDC funding forecasted, Interim Support Capital PDC of £1.4m, relating to the Theatres project, has been highlighted as Unagreed.
- The adjacent revised capital programme includes an allowance of £0.55m for spend on enabling works to help with patient flow through ED.
- The year to date underspend of £1.7m is principally due to slippage on Estates projects, the most material component of which relates to the ED scheme. The full year slippage impact on that slippage is now estimated at £1.34m. Consequently the required slippage to remain within the Trusts overall capital funding envelope has moved from £1.4m in month 6

Cash and Working Capital

	YTD at month 07		
	Plan £m	Actual £m	Variance £m
Opening cash balance (net of working capital loans)	**(15.59)**	**(15.59)**	**0.00**
Capital Expenditure (accruals basis)	(12.86)	(11.18)	1.69
Capital loan drawndown	0.00	0.00	0.00
Capital loan repayment	(5.40)	(5.40)	0.00
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	0.01	2.82	2.81
Other capital-related elements	0.67	(0.26)	(0.94)
Sub-total - capital-related elements	**(17.58)**	**(14.02)**	**3.56**
Cash Generated From Operations	12.46	12.43	(0.02)
Working Capital movements - debtors	3.40	1.76	(1.64)
Working Capital movements - creditors	31.23	40.67	9.44
Net Interest	(1.76)	(1.67)	0.09
PDC Dividend paid	0.00	0.00	0.00
Other Cashflow Movements	35.33	32.74	(2.59)
Sub-total - other elements	**80.66**	**85.92**	**5.26**
Closing cash balance	**47.48**	**56.31**	**8.82**

Closing cash balance	47.48	56.31	8.82
Closing working capital facility	0.00	0.00	0.00
Closing interim revenue support facility	0.00	0.00	0.00
Closing cash balance (net of working capital facility)	**47.48**	**56.31**	**8.82**

Better payment practice code	**Paid in year**	**Paid within target**	**% Paid within target**
Non-NHS - number of bills	72,959	64,161	87.9%
Non-NHS - value of bills (£k)	139,087	115,504	83.0%
NHS - number of bills	997	608	61.0%
NHS - value of bills (£k)	10,539	4,115	39.0%
Total - number of bills	73,956	64,769	87.6%
Total - value of bills (£k)	149,626	119,619	79.9%

Key points

In recent years, the cash position has been presented net of amounts drawn down from the working capital and interim revenue support facilities, in order to show the underlying cash position. At 01/04/2020, the underlying cash position was minus £15.6m. The working capital and interim revenue support facilities were converted to PDC in M06, improving the underlying cash position by £25.7m. The underlying cash position has been temporarily boosted further in 2020/21 by the payment of block income a month in advance, although it has been assumed that this will cease in M12.

A cash flow plan was submitted to NHSEI in October. Comparisons are therefore now being made against plan.

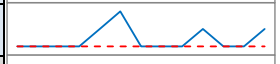
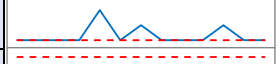
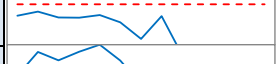
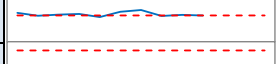
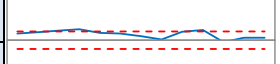
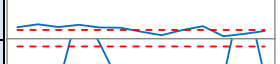
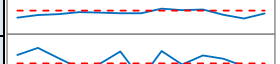
- Total capital-related cashflow is £3.6m lower than Plan. Accruals capex is £1.7m lower than Plan and the capital creditor has built up £2.8m higher than planned. These are partly offset by use of finance leases £1.0m lower than planned.

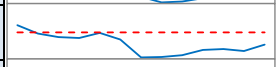
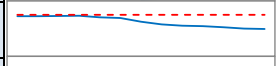
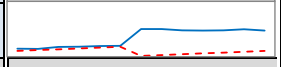
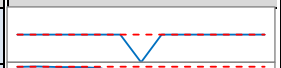
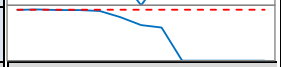
Other elements:

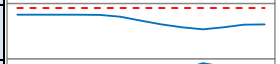
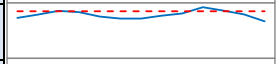
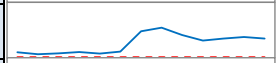
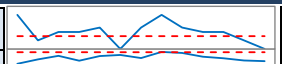
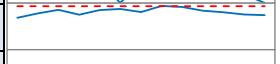
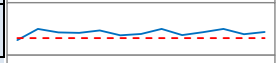
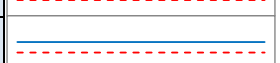
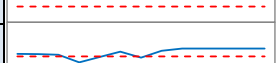
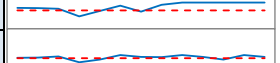
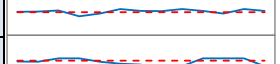
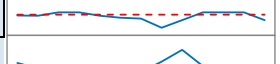
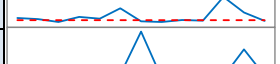
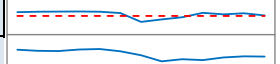
- Working capital debtor movements is £1.6m adverse to plan, due to debtors relating to the transition to the new Covid financial architecture £2.2m, Early Discharge funding £0.8m and Infection Control £0.8m, partly offset by NHSE 2019/20 washup paid one month earlier than expected £1.8m.

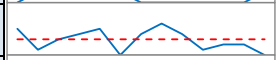
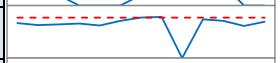
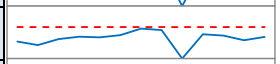
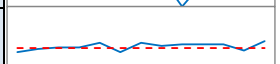
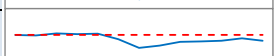
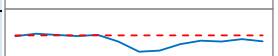
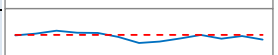
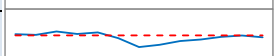
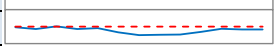
- Working Capital creditor movements is £9.4m favourable to plan, principally due to increased Covid blocks in advance £6.5m and increased CYP accruals £1.0m.

- Other cashflow movements is £2.6m adverse to plan. This is principally due to delayed drawdown of PDC funding (eg where formal PDC agreements have been issued late).

	ISU	Target	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	1	0	1	0	0	0	3	2	2	3	1	0	11
Reported Incidents - Death	Trustwide	<1		0	1	0	1	0	1	0	3	3	1	1	1	0	9
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	1	2	0	0	0	1	0	0	1	2
Medication errors - Total reported incidents	Trustwide	N/A		46	59	46	53	60	46	19	24	39	42	40	49	49	262
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	0	0	1	2	0	1	0	1	3	4	5		14
Never Events	Trustwide	<1		0	1	0	0	0	0	0	0	0	0	0	2	1	3
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		5	6	4	1	5	3	3	4	1	4	8	5	4	29
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	2	0	1	0	0	0	1	0	0	2
Formal complaints - Number received	Trustwide	<60		31	30	14	35	22	21	2	3	12	17	15	17	15	81
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		92.2%	93.2%	91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%	80.2%	79.2%	80.9%	81.8%	82.6%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		95.3%	98.9%	97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%	94.2%	96.9%	87.8%	95.9%	93.6%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		109.7	98.6	103.3	106	93.9	114.4	120.7	98.1	102.6	99.4				105
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		88.8%	89.6%	90.4%	91.3%	89.2%	88.9%	87.3%	85.4%	89.8%	90.8%	84.0%	86.4%	86.5%	87.1%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		91.6%	93.2%	91.7%	92.9%	91.4%	91.3%	89.0%	87.0%	89.9%	92.2%	86.4%	87.7%	89.4%	88.8%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		0	42	0	204	108	0	4	0	12	0	20	262	23	321
Hand Hygiene	Trustwide	>95%		96.1%	97.2%	94.1%	96.1%	93.5%	94.9%	99.4%	98.9%	97.9%	97.2%	98.3%	98.9%	96.8%	98.1%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		63.4%	73.1%	76.9%	83.9%	82.4%	80.0%	80.0%	97.5%	91.7%	94.6%	74.4%	60.0%	79.1%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		87.2%	93.3%	84.5%	75.8%	79.6%	90.2%	66.7%	90.6%	79.1%	86.8%	83.9%	77.6%	59.5%	77.9%
Follow ups 6 weeks past to be seen date	Trustwide	6400		6694	6725	7243	6391	6147	7056	8824	14211	15398	16408	17220	17408	17519	17519
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.0%		4.3%	4.4%	4.5%	4.5%		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.4%		4.3%
Appraisal Completeness	Trustwide	>90%		77.3%	78.0%	78.5%	80.1%	81.6%		71.6%	71.0%	75.6%	77.8%	78.4%	79.4%	78.4%	78.0%
Mandatory Training Compliance	Trustwide	>85%		90.6%	90.5%	90.4%	90.8%	90.4%		90.1%	88.0%	89.9%	89.9%	89.9%	89.7%	89.7%	90.3%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.4%	11.4%	11.4%	11.7%	11.7%		10.5%	10.5%	10.3%	10.8%	10.7%	10.3%	10.5%	

	ISU	Target	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		373	319	344	462	588	393	121	21	38	95	175	246	256	450
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		305	230	198	190	235	175	14	17	33	82	89	72	129	235
Clients receiving Self Directed Care	Trustwide	>90%		89.0%	89.0%	89.1%	89.3%	88.1%	87.7%	85.0%	83.1%	82.1%	81.8%	81.1%	80.0%	79.8%	81.1%
Carers Assessments Completed year to date	Trustwide	40% (Year end)		29.2%	28.4%	35.4%	36.6%	38.5%	39.6%	100.0%	100.0%	95.2%	94.3%	95.3%	99.2%	94.8%	16.2%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		184	176	192	202	191	194	197	223	217	219	221	200		219
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET							231			56					56
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET							6.1%			5.9%					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%		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		594	530	556	558	530	520	532	515	553	559	561	560	576	561
Intermediate Care - No. urgent referrals	Trustwide	113		216	205	201	239	202	219	230	248	283	241	208	220	192	1201
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		226	230	212	211	186	202	138	172	221	206	261	262	275	996
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide									85%	83%	82%	82%	81%	80%	80%	80%
Proportion of carers receiving self directed support	Trustwide									100%	100%	95%	94%	95%	99%	95%	95%
% Adults with learning disabilities in employment	Trustwide									9%	9%	9%	9%	9%	9%	9%	9%
% Adults with learning disabilities in settled accommodation	Trustwide									79%	79%	80%	79%	79%	79%	80%	80%
Permanent admissions (18-64) to care homes per 100k population	Trustwide									21.5	21.5	27	18.9	24.3	20.2	20.2	20.2
Permanent admissions (65+) to care homes per 100k population	Trustwide									506.9	504.1	502.6	538.1	524.4	557.2	565.4	565.4
Proportion of clients receiving direct payments	Trustwide									24%	23%	23%	23%	23%	23%	24%	24%
% reablement episodes not followed by long term SC support	Trustwide									87%	86%	85%	87%	86%	86%	85%	85%

	ISU	Target	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		82.7%	77.3%	77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%	96.4%	93.5%	91.9%	86.2%	93.3%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		79.9%	80.0%	79.9%	79.8%	79.5%	76.2%	69.3%	62.2%	57.0%	53.5%	57.3%	62.1%	62.5%	60.4%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		72.9%	78.8%	85.9%	83.6%	75.3%	71.8%	71.7%	77.1%	80.9%	92.3%	86.3%	79.3%	66.8%	78.7%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		10.0%	6.4%	7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%	30.9%	34.5%	37.6%	34.4%	39.1%
Dementia - Find - monthly report	Trustwide	>90%		87.5%	94.4%	88.4%	81.9%	93.7%	93.5%	97.6%	98.1%	94.5%	60.8%	84.4%	89.2%	96.6%	88.4%
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		8	2	4	4	5	0	5	8	5	4	4	2		28
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		68.2%	77.8%	85.3%	74.8%	84.8%	87.1%	80.5%	93.6%	91.4%	83.4%	80.1%	75.1%	73.9%	81.7%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		91.5%	100.0%	97.3%	97.1%	98.9%	95.1%	96.2%	100.0%	95.3%	97.4%	100.0%	95.9%	97.7%	97.4%
Cancer - 28 day faster diagnosis standard	Trustwide			71.8%	73.2%	71.9%	66.9%	74.5%	74.8%	60.2%	80.9%	80.8%	79.8%	72.0%	67.3%	72.1%	73.5%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		96.8%	98.0%	97.6%	96.8%	98.8%	99.0%	97.7%	99.2%	100.0%	99.4%	97.3%	97.4%	97.2%	98.2%
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%		95.9%	95.8%	95.2%	89.5%	93.5%	97.7%	93.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		94.7%	95.0%	97.1%	86.2%	91.4%	100.0%	96.6%	96.2%	100.0%	96.4%	91.3%	100.0%	96.4%	96.9%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		86.7%	85.7%	100.0%	100.0%	85.7%	76.5%	73.3%	33.3%	66.7%	100.0%	100.0%	100.0%	66.7%	76.0%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			39	27	24	24	21	21	19	42	68	32	9	9	8	8
RTT 52 week wait incomplete pathway	Trustwide	0		79	69	71	80	43	53	93	192	344	524	745	892	1143	1143
On the day cancellations for elective operations	Trustwide	<0.8%		1.1%	0.9%	0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%	0.7%	3.4%	1.7%	0.7%	1.3%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		8	7	3	3	10	5	46	2	1	5	3	29	4	90
Bed Occupancy	Overall System	80.0%		95.8%	97.6%	98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	74.7%	93.3%	86.7%	91.6%	82.4%	73.9%
Number of patients >7 days LoS (daily average)	Trustwide			127.4	121.5	120.1	128.1	130.3	119.8	100.5	70.8	80.9	76.5	89.3	94.9	94.0	70.8
Number of extended stay patients >21 days (daily average)	Trustwide			34.3	28.0	23.1	25.5	27.7	26.0	22.6	18.1	18.7	12.0	13.3	15.2	17.1	16.1

	ISU	Target	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		47	104	113	117	88	43	16	9	19	10	46	59	73	232
Ambulance handover delays > 60 minutes	Trustwide	0		5	13	14	14	7	5	1	0	4	1	3	0	14	23
A&E - patients recorded as >60min corridor care	Trustwide			382	494	463	495	335	115	0	0	0	0	0	0	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			103	247	158	182	136	32	1	0	5	0	1	10	16	33
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		0	1	3	1	3	1	0	0	0	0	0	0	1	1
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		5	1	3	4	5	0	4	6	4	1	2	2	n/a	19
Number of Clostridium Difficile cases - (Community)	Trustwide	0		3	1	1	0	0	0	1	2	1	3	2	0	n/a	9
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		66.4%	63.0%	64.1%	65.7%	62.0%	70.6%	76.9%	78.4%		73.6%	70.9%	61.1%	69.0%	71.1%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		32.6%	25.8%	36.8%	41.5%	40.5%	44.5%	57.1%	54.1%		46.3%	43.7%	35.0%	41.4%	45.6%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		68.2%	77.3%	81.8%	81.8%	95.5%	68.2%	95.5%	86.4%	90.9%	90.9%	90.9%	72.7%	100.0%	88.1%
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-3022	-4464	-6555	-9693	-13294	-23577	218	524	800	1323	1297	1220	-23	
Agency - Variance to NHSI cap	Trustwide			-1.03%	-1.06%	-1.07%	-1.01%	-0.98%	-0.87%	0.79%	0.87%	0.44%	0.39%	0.49%	0.38%	-0.10%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-1584	-2357	-2872	-4983	-7078	-9325								
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			4420	6559	7632	8191	9595	4249	567	1112	1813	2770	532	-236	-1686	
Distance from NHSI Control total (£'000's)	Trustwide			-1651	-2833	-4616	-7648	-10926	-20367	0	0	0	0	0	0	112	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	-2000	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			-5.8%	-9.3%	-1.4%	1.1%	0.6%	-15.8%	-64.3%	-53.6%	-28.6%	-20.7%	-12.7%	0.0%	-3.6%	-26.5%
Outpatients - Follow ups	Trustwide			-0.6%	-2.3%	5.6%	3.0%	4.7%	-16.2%	-49.5%	-41.2%	-26.6%	-24.5%	-22.4%	-13.4%	-22.6%	-28.4%
Daycase	Trustwide			-3.0%	6.3%	1.4%	-2.6%	1.5%	-23.7%	-62.2%	-57.7%	-33.5%	-20.0%	-23.3%	-13.9%	-22.9%	-33.4%
Inpatients	Trustwide			-4.3%	10.1%	31.9%	16.8%	15.3%	-15.0%	-61.6%	-50.3%	-27.4%	0.3%	-29.6%	-8.5%	-35.9%	-30.3%
Non elective	Trustwide			4.8%	2.1%	14.9%	5.9%	11.6%	-10.9%	-44.4%	-35.5%	-21.4%	-15.8%	-5.9%	-0.1%	-7.3%	-18.7%
Non elective	Torquay			-4.2%	-14.5%	1.4%	-14.6%	-9.2%	-33.6%	-50.1%	-47.8%	-47.3%	-31.5%	-13.1%	-17.1%	-16.8%	-31.8%

ISU	Target	13 month trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Year to date

Appendix 1 – System Finance Reports for Information

October 2020

FINANCE SCORECARD – TORBAY SYSTEM

Paignton & Brixham ISU - Torquay ISU - Independent Sector - COVID 'Hospital Discharge & Infection Control'

FINANCE RUN-RATE – rolling 13 months

Average monthly expenditure is £19.2m for the last seven month period compared to a previous average of £18.1m per month. This is being driven by COVID related costs of circa £1.3m (Hospital Discharge & Infection Control in the Independent Sector).

Within the IS position ASC costs are also higher from April 20 but these have been offset by reduced Placed People costs. Zones non pay costs are on average £0.4m lower since April 20 due to reduced activity levels (particularly high cost drugs).

Pay has remained relatively consistent over rolling 13 month period with a £0.1m (1.4%) monthly increase reflecting inflationary uplifts.

NHS Contract Income has been blocked for months 1-6 at Trust level linked to NHSI issuing a 6 month plan for providers to break even.

The financial architecture set by the DOH for H2 (months 7-12), which includes a fixed income value for COVID, set inflation values on expenditure (utilising last year's reference period of months 8-10), planning amendments such as CNST valuations and a set STP income allocation to cover the Trust's expected deficit, requiring the Trust to deliver a break even position.

INNOVATION PROJECTS / £ CIP

The plan for the system to deliver CIP in 2021 was set in the NHSI plan March 20. During 2020/21 these are now primarily void due to the impact of COVID.

Operational focus currently on developing savings plans for 2021/22 and where possible it is hoped some schemes will start to deliver pre April 2021 realising some savings in 2020/21.

Costs forecast to be £21.3m (10%) higher in 2020/21 compared to 2019/20 (driven by IS costs).

Cost base lower in months 1-7 due to COVID heavily impacting activity levels, particularly in P&B.

In months 8-12 cost base is modelled to 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 (Hospital Discharge & Local Authority – Infection Control).

Labs costs (Acute COVID) previously accounted for in Shared Ops in the first half of the financial year are now included in Torbay system and are a key driver in increasing spend for remainder of the year.

INCOME MONITORING

FORECAST REPORTING

Torbay - Board Table of Key Metrics

	Drivers	Risk	Actions Taken
P&B & Torquay ISU's	Phase 1 witnessed reduced activity due to COVID resulting and increased waiting lists. Ongoing social distancing requirements and second wave of COVID makes Recovery / Standing back up services challenging especially when combined with winter pressures.	Waiting lists could increase and KPI's / standards won't be achieved putting pressure on the financial position (new revised plan). Even if finance is available some resources might simply not be available.	Recovery plans have been developed and for specific areas (phase 3) these have formed part of an overall Devon STP review. Ongoing management balancing recovery plans and dealing with second wave of COVID / winter pressures within revised budget envelope.
Labs Testing	COVID and winter pressures will increase testing / activity levels and Trust has equipment capability to meet increased demand levels.	Increased testing will come at a cost and Trust needs to ensure this is both cost effective and within any additional allocations available at National level and resourced appropriately.	Financial options analysis undertaken on stepped level increases and regular meeting in place to review with lab manager. COVID-19 funding through national channels (monthly in arrears).
Independent Sector	Increased costs (circa 20%) due to COVID and knock on impacts to other areas. Multitude of changing funding arrangements throughout the financial year and set to continue for remainder of it. Incorporates Local Authority elements (Infection Control) and the Hospital / Early discharge.	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. New guidance in relation to Hospital Discharge puts additional responsibilities / deadlines into the area from 1st September 2020. New Infection Control (round 2) funding from 1st October 2020 but reduced level of funding provided and for longer time period.	Operational plan has been developed to meet new Hospital Discharge guidance with early assessment of financial impact and risk undertaken. Infection Control Fund being jointly managed by Trust / Torbay Council and plans being drawn up to meet grant conditions / support the market within the financial envelope available.

Underpinning the above is a reliance on staffing resources, be it within our own Trust or the Independent Sector providers. The ability to manage second wave of COVID, fatigue and annual leave requirements will be pivotal as we now move into the Winter period.

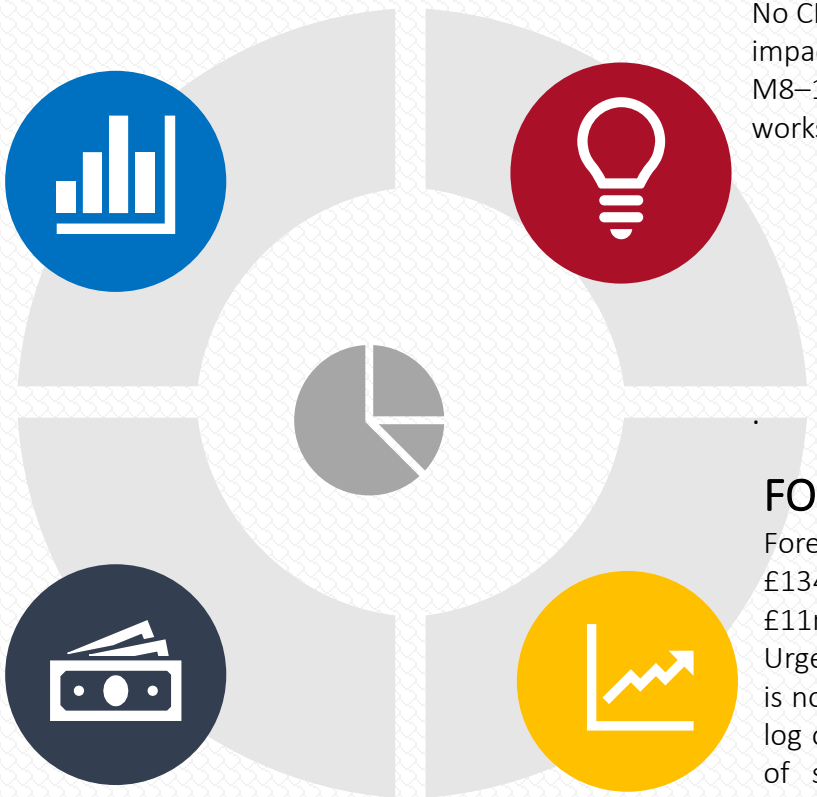
FINANCE SCORECARD

South Devon System view

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

FINANCE RUN RATE – rolling 13 months

Net run rate spend in M1-7 was a mean of £10.4m per month compared to a 13 month mean of £10.8m, continuing the higher level of spend seen in M6. This reflects the impact of the stepping back up of services, medical pay award and drug costs. Run rates are expected to increase further in M8 - M12 due to Phase 3 capacity and activity requirements, Urgent Care Pathway redesign, winter costs and seasonal demands.



INNOVATION PROJECTS AND £ CIP

No CIP is expected to be recorded in M1–7 due to impact of COVID. Targets are to be reset and issued for M8–12, with delivery of CIP within recovery workstreams, and revised business planning.

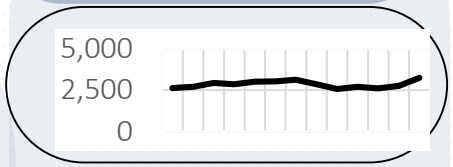
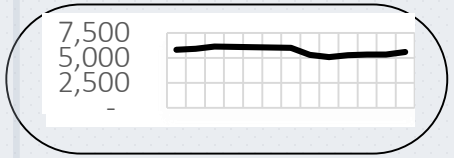
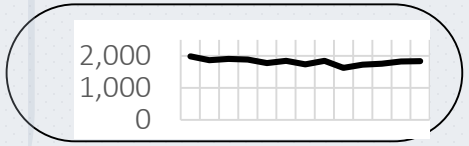
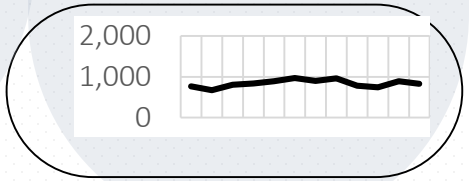
INCOME MONITORING

NHS Contract Income has been blocked for M1-6 at Trust level, and providers expected to break even.

FORECAST REPORTING

Forecast outturn baseline expenditure remains at £134m for South Devon System ISUs, and reduced to £11m for Shared Operations ISU. The PYE impact of the Urgent Care Pathway business case (broadly MRU/SRU) is now included in ISU forecasts. Risks are: growing back log of Patients, 52 week breaches, FYE and productivity of services as they resume, and business cases. Focus going forward is managing capacity to deliver Phase 3 plans.

South Devon Board Table of Key Metrics

	Drivers	Forecast/ risk	Actions Taken	Tick charts- 13 month actual rolling run rate
Newton Abbot ISU	M7 run reflects return to pre-Covid-19 activity levels. Agency and Bank spend is volatile. MRU staff being recruited and increased ICU RNs assumed in Forecast.	MRU implementation. ENP requested staff increase – pending business case. UTC/MIU recruitment to reopen MIU fully – agreed. ICU forecast included increased cost of training of ICU RNs.	MRU recruitment drive in process. Potential reliance on agency costs if recruitment a challenge, and also in ED re winter pressures and demand. Safer staffing business case in progress	
Coastal ISU	M7 run rate increase £0.1m; non pay in Endoscopy and Theatres. Stepping up of some services including, Theatres, Endoscopy, Eye Theatres, with further phase 3 increases as the year progresses.	Phase 3 activity assumptions to pre Covid-19 levels increase run rates £2.6m M7-M12 – may slip. Excludes clearance of back log – 52 WW increasing. Delay in Endoscopy rm 3 to Dec. and DSU to Jan. Loss of Ella.	Phase 3 activity to increase capacity to pre Covid-19 levels – plans under review due to covid spike. Significant risk to back log . Theatres 1&2 available from late Nov. National contract re continued use of MSH.	
Moor to Sea ISU	Fairly consistent spend run rate.	Increased Rapid Response support with fixed term contracts which may go over year end.	Winter planning in progress, enhance hospital discharge and Rapid Response teams additional support. Potential reliance on agency staff.	
Shared Operations ISU	M7 increase in Non Pay run rate to be reviewed.	Increased cost and run rates mainly Q3 and Q4 following increased M7 Non Pay.	Winter planning for seasonal demand, responding to Trust requirements and pressures.	

South System and Shared Operations ISU run rates are forecast to increase in M8– 12 reflecting Phase 3 plans, higher patient activity post Covid-19, recruitment into vacant posts, winter pressures. Recruitment drive in process for Urgent Care Pathway following business case approval. Risk of staff resource availability as the year progresses and reliance on temporary staffing. Covid-19 related incremental costs are £10.1m year to date and recorded separately within the Shared Operations ISU.

FINANCE SCORECARD

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

FINANCE RUN-RATE

Corporate net expenditure & Other Income is £1,287k lower (22%) than the expenditure incurred in month 6, but this is mainly due to an improvement in other income of £1,170k.

Innovation Projects/ £ CIP

The Corporate system budget for month 1-7 includes the CIP targets set out in the March version of the 2020 plan. The NHSI budget excludes CIP, but a cost reduction allocation of £1,764k has to be identified for removal from 2021/22 Corporate budgets.

NHS Contract Income has been blocked for months 1-6 at Trust level and providers were expected to break even during that period. In M7 a provision has been made in Reserves & Other Income for £884k of expected top up income above expected levels due to COVID & relaunch of services.

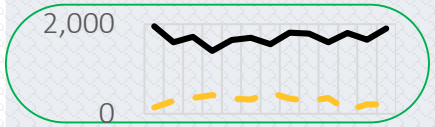
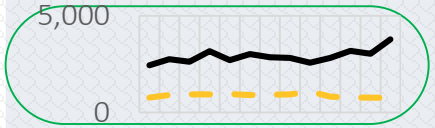
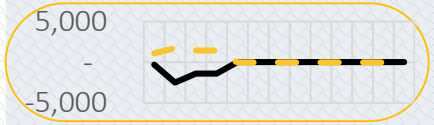
INCOME MONITORING

The forecast indicates that pay & non pay expenditure will be £12,331k less than the 19/20 outturn.

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	Reduced income from car parking & lease rentals continues. Expenditure on repairs & maintenance has increased post initial Covid-19 period.	ISU charge to Covid-19 of £281k 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 now re-started.	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	CEA awards have been moved to Medical Director. £884k additional expected top up income for Covid-19 & relaunch of services.	Risk that COVID top up income may not be received.		
Other ISUs	R&D trials activity reduced due to Covid-19. £40k accrual for Oxygen for Covid-19 stopped as no longer required.	R&D trials income unlikely to recover in the short-term. Pharmacy therefore showing adverse variance for pay costs of these posts.	R&D staff resources re-deployed. Need recognition for further income for Pharmacy held in Trust.	

Pay costs within the Corporate System had been fairly static until M08 where they increased by £360k 9% from the previous month, this is mainly within EFM due to increased Hotel Services rotas to meet required demand.
Non pay has also seen a rise in M07 by £661k 15% mainly attributable to the favourable recalculation of PDC dividend in M06 of £433k; increase of £75k of Estates repairs and maintenance; £41k equipment costs within HIS; £34K Pharmacy home delivery costs recharged to Covid-19 in M06.

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

CFHD System view

FINANCE RUN-RATE – ROLLING 13 MONTHS

Run Rates for the Alliance are static, with minimal changes on a month by month basis.
Months 01-06 2020/21 were during the Covid period in which any surplus / deficit within the Alliance were 100% dropped to the TSD bottom line. From month 07 onwards, this will revert to the original contract agreement with recharges being made to the Alliance partners.
Month 06-07 run rate change for pay reduced by (£3k) representing (0.40%); non pay increased by £491k, 66.1% which represents the re-introduction of alliance partner recharges, no change on other income.

INCOME MONITORING

NHS Contract Income is blocked for the current year, based on the original contract value.
Other sources of income are of a minimal value with no movement between Month 06 to 07.

INNOVATION PROJECTS / £ CIP

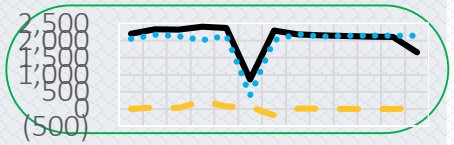
No CIP has been recorded to NHSI for months 01-07 due to the impact of COVID and £0 is forecast / expected for the current financial year.

FORECAST £ REPORTING

The forecast for M8-12 includes the filling of known approved vacancies and any spend known to vary from the previous 7 months run rate.
Pay cost forecast to increase by £29k from M01 to M12; *this allows for the filling of vacancies and change in the method for recharge of back office support costs*.
Non-pay costs fall of (16.7%) (£236k). *Mainly switch from non pay to pay of recharge costs and removal of surplus recharges to the Alliance.*
Other income fall of 53.5% £7k, *miscellaneous receipts*.

Total Expenditure
Other Income
Contract Income

CFHD Table of Key Metrics

	Drivers	FOT/Variance Risk	Actions Taken:	Tick charts 13 Month Actual Rolling Run Rate (£m)
CFHD	Expenditure Run Rate remains Constant: Staff consultation remains on hold; high level of vacancies. IT investment project now moving forward but no costs included in this years revenue account. Forecast does not include any additional VO income.	Forecast for approved fulfilment of vacancies and non commencement of consultation. New IT system pending consultation of clinical model. VO work could incur costs above income levels if CCG do not agree any additional VO income.	Vacancies under constant review. IT requirements will be assessed as service is evaluated. Constant evaluation being made on VO works.	

Due to the Covid block financial situation for M01-06, the Alliance did not distribute any surplus position to its partners. Any surplus or deficit generated from M07 onwards will revert to the original contract method. M01-06 generated a year to date surplus of (£590k); Month 07 (£2k) surplus.

Pay costs are fairly static, averaging at £908k per month (Month 07 was £917k); some posts have been filled during the second quarter of the year which means an increase in the run rate from M01-03, along with switch in the recharge categorisation for back office support from non pay.

Excluding the Alliance recharge, non-pay costs are also static; Month 07 includes a tiny recharge to the partners for the surplus position.

Other income run rates reduced in Months 01-02 but have remained constant since then, averaging at £9k per month.

Contract Income remains on plan.

BOARD OF DIRECTORS COVID REPORT OCTOBER 2020:

COVID Cost Area	£'000 M7 Actual	£'000 M1-7 YTD Actual	£'000 Plan 1-7 (note 1-6 has a zero variance)	£'000 Variance to Plan (Favourable)
Capital Submission	(Additional Capital claims are not part of the H2 COVID process)			
Acute COVID	£252	£10,060	£10,446	(£386)
Swabbing	£36	£36	£28	£8
Lab Testing	£278	£278	£519	(£240)
Hospital Discharge Tranche 1 & 2	£481	£6,235	£7,184	(£949)
Infection Control 1& 2	£393	£3,134	£3,134	£0
Nightingale	£0	£0	£0	£0
TOTAL	**£1,440**	**£19,743**	**£21,311**	**(£1,567)**

COVID Pass through Income	£'000 M7 Actual	£'000 M1-7 YTD Actual	£'000 Plan 1-7 (note 1-6 has a zero variance)	£'000 Variance to Plan
Lab Testing	£278	£278	£544	(£266)
*Hospital Discharge Tranche 1 & 2	£797	£797	£1,039	(£242)
*Infection Control 1 & 2	£393	£3,134	£3,134	£0
TOTAL	**£1,468**	**£4,209**	**£4,717**	**(£508)**

COVID NHSI Return M7 (note this return is a year to date cumulative report and excludes * HD and IC):

Covid-19 Expenditure	10AACTYTD	10ACOV53	10ACOV50	10ACOV1	10ACOV%
	Total Expenditure	COVID-19 In Envelope (10a1)	Outside Envelope COVID-19 (10a2)	Total COVID-19	COVID-19 % of Total Expenditure
	Actual	Actual	Actual	Actual	Actual
	31/10/2020	31/10/2020	31/10/2020	31/10/2020	31/10/2020
	YTD	YTD	YTD	YTD	YTD
	£'000	£'000	£'000	£'000	£'000
Purchase of healthcare from NHS and DHSC group bodies	8,313	0	0	0	**0.0%**
Purchase of healthcare from non-NHS and non-DHSC group bodies	26,288	0	0	0	**0.0%**
Purchase of social care	40,650	0	0	0	**0.0%**
Staff and executive directors costs	150,180	5,368	12	5,380	**3.6%**
Non-executive directors	107	0	0	0	**0.0%**
Supplies and services – clinical (excluding drugs costs)	16,876	3,099	266	3,365	**19.9%**
Supplies and services - general	2,653	551	0	551	**20.8%**
Drugs costs (drug inventory consumed and purchase of non-inventory drugs)	17,665	137	0	137	**0.8%**
Consultancy	1	0	0	0	**0.0%**
Establishment	1,585	92	0	92	**5.8%**
Premises - business rates payable to local authorities	1,175	0	0	0	**0.0%**
Premises - other	10,723	730	0	730	**6.8%**
Transport	1,451	71	0	71	**4.9%**
Depreciation	7,055	0	0	0	**0.0%**
Amortisation	1,715	0	0	0	**0.0%**
Movement in credit loss allowances	285	0	0	0	**0.0%**
Audit fees and other auditor remuneration	65	0	0	0	**0.0%**
Clinical negligence	4,474	0	0	0	**0.0%**
Research and development - staff costs	893	0	0	0	**0.0%**
Research and development - non-staff	16	1	0	1	**3.4%**
Education and training - staff costs	5,271	0	0	0	**0.0%**
Education and training - non-staff	917	19	0	19	**2.1%**
Lease expenditure	760	27	0	27	**3.6%**
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	559	0	0	0	**0.0%**
Other	5,053	174	0	174	**3.4%**
Total operating expenditure	**304,730**	**10,271**	**278**	**10,549**	**3.5%**

COVID Revenue Forecast at month 7

At month 7 the Trust is forecasting the H2 plan.
However due to the variances shown in the above M7 COVID tables what the latest forecast is showing is that a bell curve will be seen whereby we are likely to underspend the expected COVID plan over the next few months, but overspend during the winter Flu months.

COVID Capital Costs:

NHSE have confirmed that no further capital funds for the purposes of COVID19 response will be released to NHS organisations in the second half of this financial year. NHSE anticipate that the infrastructure required to respond will have been addressed within the first wave of the Pandemic. Given that the Trust has with the exception of some limited contingency funds a fully committed plan, approval from GOLD Command will be required to commit the Trust to further capital spend. Any such commitments would be taken first from general contingency funds. As at 31st October 2020 the sum of uncommitted contingency monies totals £250k.

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 (including the Infection Control Fund).

Spend to date this financial year is circa £9.37m and towards this Torbay Council has contributed £4.13m. This is summarised in the table 1 with more detail provided below.

COVID Costs and Income	October YTD Expenditure £'000	October YTD Council Contribution £'000	Net Cost to the Trust supported through COVID top up (1-6) £'000s	Supported through the CCG (7-12)(Hospital Discharge) £'000s
Hospital Discharge	6,235	1,000	4,438	941
Infection Control Fund (Round 1)	2,740	2,740	-	-
Infection Control Fund (Round 2)	394	394	-	-
Total	**9,369**	**4,134**	**4,438**	**941**

Torbay Council have agreed an initial £1m contribution towards Hospital discharge that has been applied over months 1-4. In addition to this the Council has provided an additional £1m support that is currently factored into the forecast post October.

In line with grant conditions Infection control monies (round 1) have been fully passported to providers within Torbay who provide Care services for Adults. Round 2 monies are due to be received in two tranches and the first one arrived in early October. In line with grant conditions the 80% funding element for Care Homes and CQC – regulated community care providers has been passported accordingly.

Area	YTD Total
	£000's
EXPENDITURE	
Residential & Nursing Home VOIDS	435
Dom Care & Supported Living VOIDS	211
Early Discharge Packages Torbay - Scheme 1	3,969
Early Discharge Packages Torbay - Scheme 2	383
Dom Care LW@H Rate Uplift	326
Agincare (additional block contract)	153
Financial Assistance (all providers)	744

Infection Control (Round 1)	2,740
Infection Control (Round 2)	394
Staffing - Assessment	14
Expenditure Total	**9,369**
INCOME	
Torbay Council COVID Core	1,000
Torbay Council – Infection Control Fund (Round 1)	2,740
Torbay Council – Infection Control Fund (Round 2)	394
CCG – Hospital Discharge process	941
Income Total	**5,075**
Net Cost to the Trust (supported through COVID top up)	**4,294**

Looking ahead for the remainder of the financial year this area will continue to see cost incurred. Initial forecast spend & income for months 8-12 that will be transacted through the Trust, is reproduced in the table below:

COVID Costs and Income	**Forecast (M 8-12) Expenditure £'000**	**Forecast (M8-12) Council Contribution £'000**	**Forecast (M8-12) Supported through the CCG (Hospital Discharge) £'000s**
Hospital Discharge – Scheme 1	1,086	-	1,086
Hospital Discharge – Scheme 2	2,084	-	1,940
Infection Control Fund (Round 2)	1,918	1,918	-
Provider Support	1,000	1,000	-
Total	**6,088**	**2,918**	**3,026**

It is worth noting that some of the above forecast figures will be subject to change as we progress through the remainder of the financial year. In particular the Hospital discharge elements have a number of assumptions underpinning them that are volatile in nature and some of the variables are listed below for context:

- **Scheme 1**- Can we get the appropriate resource to undertake the assessments, what will be the timing of the assessments?

- **Scheme 2-** What will be the number of clients that will pass through this process, will this fluctuate over the six-month period and what will be the cost of their package of care for the 6-week period?

Due to the volatile nature of this area, combined with the funding / reporting arrangements it has been designated as a high-risk area and as a result of this appropriate finance / operational resource will need to be ring fenced to provide monthly updates on actual and forecast spend.

RETROSPECTIVE COVID CLAIMS:

Updated COVID financial guidance has been issued.

We are asking ISU teams to review their expenditure at month 7 before we move any Allocate pay costs into the COVID acute cost centre, and we will also be reviewing all of the procurement direct orders on 75999 for appropriateness alongside under spends of Clinical supplies and services within the ISU's.

Therefore, the expenditure reported as COVID at month 7 is an estimate awaiting internal validation.

Currently we don't have a stock control system for the PPE, and although a large proportion of this stock is free of charge push stock the Trust PPE purchased is using the 75999 cost centre as an order and distribution point. An automated solution will be required for this if this becomes a long term distribution point to facilitate bot procurement and financial reporting.

At this stage the ISU pay variances are favourable despite including COVID Allocate costs of £170k within their positions for M7. This would suggest these are no longer incremental costs due to COVID and are within the tolerance of budgets set for the H2 winter period.
The COVID planned costs within shared operations for M7 pay, was £134k, which is currently showing as a favourable variance within that ISU.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Winter Plan 2020/21			**Meeting date:** 25th November 2020
Report sponsor	Chief Operating Officer		
Report author	David Allison Urgent and Emergency Care Capital Projects Manager		
Report provenance	Executive Team meeting 10/11/2020 considered and contributed to drafting		
Purpose of the report and key issues for consideration/decision	To inform Board of the Trust Winter Plan for 2020/21 and seek approval of the plan. <u>Clarity and Flexibility</u> The plan sets out the context and the response for this winter including the experienced impact and predicted future impact from Covid. The measures being taken to maintain safe and effective flow of patients requiring urgent care whilst optimising the level of elective care is a fine balance. The teams have tested this plan and developed it in recent weeks as required to accommodate unexpected variables. <u>Integration</u> The integrated nature of the Trusts services is illustrated throughout the plan with an ability to optimise discharge pathways home or home with support where needed and where necessary with support from community hospital and care home capacity. The ability to escalate rapidly across this entire pathway reducing the reliance on bed-based escalation will be critical this winter as the impact from Covid is felt. <u>Modelling and System Working</u> The demand forecasts used were developed at system level and identify the most significant variable is the expected level of reduction for non-Covid urgent care activity. This has been estimated at a 15% and equates to two wards. The Trusts response to variation from this estimate will be to flex capacity across the whole system from home-based care to securing further acute bed configuration. These plans are set out in the tables in the report. As stated the demand forecasts used are taken from the STP system modelling work developed to support all local Trusts and recommendations in respect of he Nightingale Hospital Exeter.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒

Recommendation	Consider and approve the winter plan.
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**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	

WINTER PLAN 2020-21

1 Background

The Trust is an Integrated Care organisation (ICO) providing acute health care services from Torbay Hospital, community health services and adult social care in Torbay. This requires the organisation to have the ability to collectively and effectively respond to external health and care related market factors with the overall aim of ensuring wellbeing of the local population.

The ICO is driven by strong clinical leadership throughout the structure, as the focus is very much on clinical pathways rather than the traditional division of elective and emergency acute bed-based services versus community health and social care provision.

The Trust model of care is delivered through five Integrated Service Units (ISUs), supported and enabled by a wide range of Trust-wide services (eg pharmacy, patient transport, infection control etc).

2 Introduction

It is an expectation of NHS England/ Improvement that a robust system wide plan is in place each winter. The Winter Plan is developed in collaboration with stakeholders across South Devon and Torbay A&E Delivery Board (AEDB). The AEDB must have assurance all commissioners and providers' plans evidence both individual organisation and system wide congruence and resilience.

The aim is to ensure quality, safety and operational resilience and to complement plans of partner providers, to ensure the delivery of safe and high-quality services to the population of South Devon and Torbay during the winter period. The plan is informed by:

- historical experience and facilitated 'lessons learnt' debrief events
- the learning and experiences of the Covid-19 pandemic first wave (March-June 2020)

Traditionally, the system experiences challenging winter periods with high levels of flu, higher acuity impacting ED, ICU, Cardiology, Stroke, Paediatrics, Mental Health and increased demand to maintain patients within the community and at home. In addition, adverse weather conditions, regular periods of surge demand and high levels of staff sickness also adversely impact on our resilience position. This Winter will carry additional and significant challenges posed by the COVID-19 pandemic, especially given we are now in the midst of a second surge.

The Winter Plan is operationalised through our Surge and Escalation Plan which describes in more detail the tiers and triggers of incidence and response. This escalation plans sits in support of additional plans, such as Winter Resilience and Capacity & Demand modelling and Major Incident Response.

The focus of the plan is to achieve OPEL 1 consistently as a system and to de-escalate quickly should pressures arise. OPEL 4 should be seen as a "never event" and all actions focused on restoring / maintaining OPEL level 1.

The standard is to have a robust escalation system to support sufficient and safe service capacity across the health and social care system, including:

- Providing transfers of care for the patient in the most appropriate setting.
- Supporting best practice in Infection Prevention and single sex accommodation, especially in light of COVID-19
- Supporting staff by clearly setting out roles and expectations
- Delivering the A&E 4 hour wait and other emergency metrics
- Keeping Delayed Transfers of Care (DToC) at a minimum
- The number of patients assessed and waiting for services is kept to a minimum
- Delivering speciality compliant 18 week pathways, as part of phase 3 (elective) COVID-19 recovery programme
- Support effective use of ambulance services
- Shared risk management across the whole system
- Shared responsibility across the system for effective patient flow

The Plan framework provides a consistent and co-ordinated approach to the management of pressures in South Devon and Torbay system and is designed to ensure the system is process driven and not person dependent.

We are clear locally about the expectations of NHS England / Improvement on our winter response, particularly in relation to

- Preventative measures including flu campaigns and pneumococcal immunisation programmes for patients and staff
- Joint working arrangements between health and care – particularly to prevent admissions and speed discharge
- Ensuring operational readiness (bed management, capacity, staffing, bank holiday arrangements and elective restarts)
- Delivery of critical and emergency care services in the face of an ongoing COVID-19 pandemic
- Delivery of out of hours' services
- Working with ambulance services – particularly around handover of patient care from ambulance to acute trust and strengthening links with primary care and A&E
- Strong and robust communication across the system.

At a high level, our response to winter will:

- Minimise the risk to patients/service users during a period when the service is under increased pressure, especially as a result of the COVID-19 pandemic
- Maximise the capacity of staff by working systematically and effectively in partnership
- Maximise the safety of the public by promoting personal resilience e.g. seasonal flu vaccination, and choosing the right service through the communications campaign and community engagement processes
- Maintain critical services, if necessary, by the reduction or suspension of other activities

3. Strategic Priorities

In light of the COVID-19 pandemic, our objectives this Winter must be robust, aligned with the Devon-wide Winter plan, but also informed by the predicted scale and impact of COVID-19 surges.

National

- COVID 19
    - Flexibility – retain the ability to respond to COVID-19 surges in an agile manner in relation to rapidly restoring / maintaining planned activity
    - Occupancy – we need to ensure that COVID-19 surges do not preclude us from providing safe and effective care for all hospital inpatients
- Phase 3 stepping up of services (elective care / cancer and diagnostics) – in accordance with national guidance

Devon System

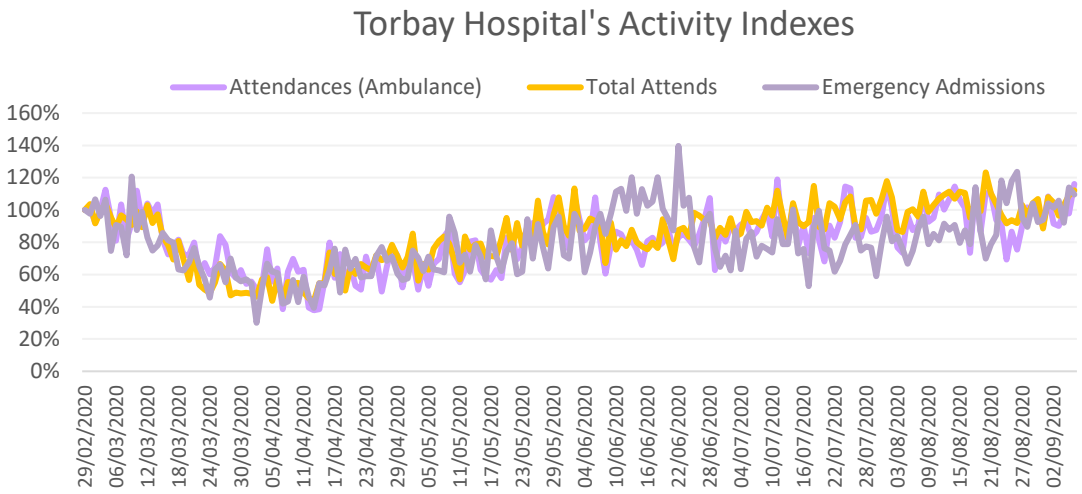
- Think 111 First rollout across Devon (national initiative) – providing a framework for the population to access care options as an alternative to attending ED/hospital admission
- COVID-19 Blue / Green status and pathways at Royal Devon & Exeter (RDE) and use of the Nightingale Hospital (NHE) – to ensure TSDFT remains primarily a green COVID-19 site (ref: section 5. Below)
- Delivering an expanded flu vaccination programme for priority groups and NHS staff
- Supporting primary care - a key aim is to secure the resilience of our primary care providers through a range of initiatives including through digital acceleration, enhanced support to care homes, and extended access, thus enabling them to maintain a level of access to their patients that can meet urgent primary care need and minimises risk of escalation to other parts of the system.
- Enhanced mental health provision - Initiatives have been started for surge capacity to include winter in the form of crisis prevention; additional beds (both inpatient and step down in the community); initiatives to prevent mental health pressure on other parts of the system
- The focus of our Ambulance services - going into winter 2020/21 ambulance trust focus will be on protecting call 999 answering and ambulance dispatch; increasing clinician presence in 999 calls through increased “hear and treat” Increasing front line capability; protecting business critical services; and increasing wider system support across planning, delivery and recovery.
- Working with the voluntary sector – optimising the NHS Volunteer Responders Scheme uptake and impact across the County and also further enhancing partnerships with large organisations, such as British Red Cross and Age UK.
- Activity plan and variation – to ensure we make the best use of care resources across the County, working in partnership with other system partners.

Trust

- Children and Family Health Devon (CFHD) – to ensure sustainable and safe continuation of a maximum level of service provision during the pandemic
- Integrated Service Units – Optimise community responses to keep people well in their usual place of residence, supporting nursing and residential homes as part of this response
- Bed and Pathway Reconfiguration
    - Optimising effectiveness of the Specialist assessment areas – Surgical Receiving Unit (SRU) Medical Receiving Unit (MRU) and the Short Stay Paediatric Assessment Unit SSPAU
    - Ensure we are COVID-19 ready – clear escalation framework in the event of subsequent local COVID-19 surges
    - Optimise capability and use of the Urgent Treatment Centre (UTC) at Newton Abbot – contribute to ED attendance avoidance/reduction
- Elective care / cancer and diagnostics – deliver phase 3 recovery plans for planned care to maintain optimum population health
- Safe ED and MRU/SRU surge management to secure social distancing at all times and maintain public health

4 Urgent and Emergency Capacity and demand

The graph below demonstrates the clear change and reduction in emergency presentations during the peak of COVID-19 activity during the Spring. Ambulance and other emergency activity started to steadily grow from May 2020 onwards. Levels of activity continued to increase during the summer months, particularly impacted by the air travel restrictions and the easing of hospitality lockdown which increased tourism to South Devon.



October has seen a national peak of COVID-19 cases and this has also been reflected locally with a second COVID-19 ward needing to be mobilised as well as finalising RD&E and NHE COVID-19 pathways.

The plan is designed to maintain both acute and community occupancy levels at <90% to ensure we have sufficient capacity to manage urgent and emergency pathways and the increasing demand generated by a return of elective workstreams.

As the level of elective throughput is increased and demand for urgent and emergency care continues to return to previous levels we will see an increase in the acute occupancy levels and to guide our management actions we have set occupancy targets of: -

- 80% on acute wards, rising to 90% as elective work steps back up.
- 90% Community wards.

There are key enablers already in place:

- Well controlled long length of stay (LLoS) within the Southwest region (6.8% >21day LOS – 2nd best in region)
- Sustainably low numbers of patients who are medically fit to be discharged and who remain in hospital waiting for support
- Integrated services (ICO impact)

5. COVID-19 Modelling

Based upon the current surge in cases during October, The Trust has already faced challenges due to increased numbers of patients being hospitalised with COVID-19.

The STP analytical team has projected the number of beds expected to be occupied by COVID-19 patients across the system including individual assessments for each Devon acute Trust. These forecasts include the anticipated impact from the lockdown between the 5th Nov to the 2nd Dec. The impact on the transmission rate (R rate) is estimated to drop to 0.95 as a result. Currently the R rate = 1.25 and is forecast to return to this level after lockdown ends on the 2nd December. The inpatient peak for the catchment population of TSD FT is expected at the end of November at a requirement for 90 beds. A small drop in beds occupied in is projected in December then increasing again by Christmas. There is a risk that cases will be higher in urban areas which could lead to a higher peak.

Further COVID-19 modelling analysis has been undertaken in relation to the bed scenario at TSD FT specifically and is attached in **Appendix A**.

The predicted demand model indicates a period of pressure between Mid-November and end of December, with;

- 40% reduction in elective activity (reduction of 15 beds) – noting that as of mid-November this reduction has already occurred due to the use of the elective orthopaedic ward.
- Based on experience from wave 1 and adjusted to account for the experience from areas in the country where wave 2 came earlier, there is a projected 15% reduction of non-COVID demand for urgent care beds (10% based on reduced admission, and 5% LOS reduction).
- The number of acute beds out of use due to COVID-19 takes us up to or near 100% bed occupancy for a potential 10 day period second half of November.
- At this point onwards until end of December, RD&E and NHE COVID-19 capacity will need to be at optimal, planned levels of occupancy.

This modelling does not include additional winter surge, it is considered this will be offset by a reduced impact from seasonal flu due to the increased social distancing and higher vaccination rates. However, the risk of any co-infection remains a potential issue.

Devon System COVID-19 response

The system has an agreed approach to escalation in the event of a COVID surge and of the triggers for opening the Nightingale Hospital Exeter (NHE). This is built on the system agreement that:

- The initial System Winter Plan was for TSD FT to be as "green" as possible with focus on day surgery and elective work in support of its own catchment and all Devon. Due to system wide pressures however, the Trust needed to expand its Covid capacity early on in the second wave to two acute wards and one community hospital. The Trust will remain flexible as illustrated here constantly responding to the changing and difficult to predict demands and working in collaboration with system partners to balance risk across the system.
- NDHT will seek to be as "green" as possible but will need to provide a small amount of COVID care as its location serves a very rural population.
- RDE is designated as the hub site to transfer suitable COVID ward-level care patients from TSD and NDHT, in order to reduce the total number of wards required for inpatient COVID care across North, East, South (NES) Devon. This will minimise the overall number of beds lost to COVID and allow the hospitals to operate as normally as possible (though all sites may need to accommodate an element of COVID activity). RDE have designated 2 wards for cohorting of Covid positive patients and at 75% capacity will escalate for a system decision to open ward level beds at Nightingale Exeter.
- UHP will provide for both COVID and non COVID pathways together with tertiary services and will work with RCHT to manage COVID demand and flow of patients into Nightingale Exeter from UHP. UHP have designated ward level beds for COVID escalation and at 75% occupancy (including any flow from RCHT) will escalate for a system decision to open ward level beds at Nightingale Exeter.

6. COVID-19 management and escalation

As stated above, it has been agreed that Torbay & South Devon will function as far as possible as a COVID-19 Green site and that Royal Devon & Exeter (RDE) has been designated as the 'blue' hospital' and the Nightingale Hospital will support COVID-19 patient flow during surge conditions. RD&E will receive COVID-19 positive patients within clear clinical parameters; clinical triage and pathways have been agreed and tested between the Trust, RD&E and North Devon.

The resilience and impact of these pathways is being tested currently, and TSD FT is prepared to accommodate the cohort of COVID-19 patients who do not fulfil the transfer clinical criteria and yet fulfil the Criteria to Reside (in accordance with the NHSEI & HM Government Hospital Discharge Service: Policy and Operating Model August 21st 2020 – Annexe A), and/or where flow pressures at RD&E (due to COVID-19/non-COVID-19 activity) prevent accommodating the planned number of TSDFT COVID-19 transfers.

It is critical that other measures working with the wider System and community partners where essential to a multi-dimensional response to the second wave. These include:

- Blue / Green plan working with System Partners
- Use of Nightingale Hospital Exeter (NHE) with regional partners
- Use of Community Hospitals (currently Brixham Community Hospital)
- COVID-19 care in the community, virtual wards - links with South Locality, CCG
- Focused discharge processes for COVID-19 patients
- Support for care homes

Given this, the Trust will continue to provide treatment for COVID-19 patients who fall outside the clinical criteria and this presents a key risk to the organisation. The creation of 'worst-case' COVID-19 on-site capacity will mitigate any potential COVID-19 surges in ED as there will be blue pathway outflow to meet surge demand. Based upon COVID-19 modelling, our escalation process is as follows:

COVID-19 Trigger	**COVID-19 escalation actions**	**Effect on other services**
<24 adult inpatients (8 +ve; 16 pending	Use of Cromie Ward (24 beds)	Phase 3 plans unaffected
>24 adult acute inpatients (8 +ve; **>16 pending**	Use of Cromie Ward and additional side rooms on other wards for pending	Close Ella Rowcroft to COVID-19, by discharging the patients and consolidating COVID-19 on Cromie with community hospital support. Deep clean Ella and return it to T&O use to support Phase 3 elective recovery plans.
Up to 48 patients	Open additional **second** COVID ward (EAU4 – 24 beds). 8 side rooms give additional pending capacity.	EAU4 moves to Ella Rowcroft – need to maintain short stay focus/efficiencies. Reduction of 'green' medical take numbers by 10% -20% would gives greater confidence in the function of medical assessment on Ella. Some loss of planned care activity. Continue to optimise surgical activity through Mount Stewart Hospital. Preserves MRU and DSU functions.
Up to 48 patients	Open additional COVID step down ward (Totnes Community Hospital – 18 beds) – total threshold 66 patients	With Brixham, further alleviates acute COVID-19 inpatient demand (ability to step down patients earlier against agreed clinical criteria)
Up to 68 patients	Open additional **third** COVID ward (Forrest – 25 beds) – declare internal critical incident.	Before reaching this level of escalation it is anticipated near 100% bed occupancy in the acute hospital and community beds, and attained maximum available capacity in the Nightingale. This scenario could also be triggered in the event of sustained pressure from the green medical take if the expected reduction does not materialise. Move MRU to DSU (100% DSU occupancy). Prior to enacting this

		scenario, DSU continues to function normally. Allerton would not be used for COVID-19 expansion due to its central function in management of the acute surgical take. Optimise use of Totnes and Brixham for COVID step down. Any more COVID wards etc would depend on the red take-green take balance.

7. Emergency Department management and escalation

The Winter plan will directly address any key known risks around ED and patient flow. Currently there are 3 relevant risks described in the ED Risk register.

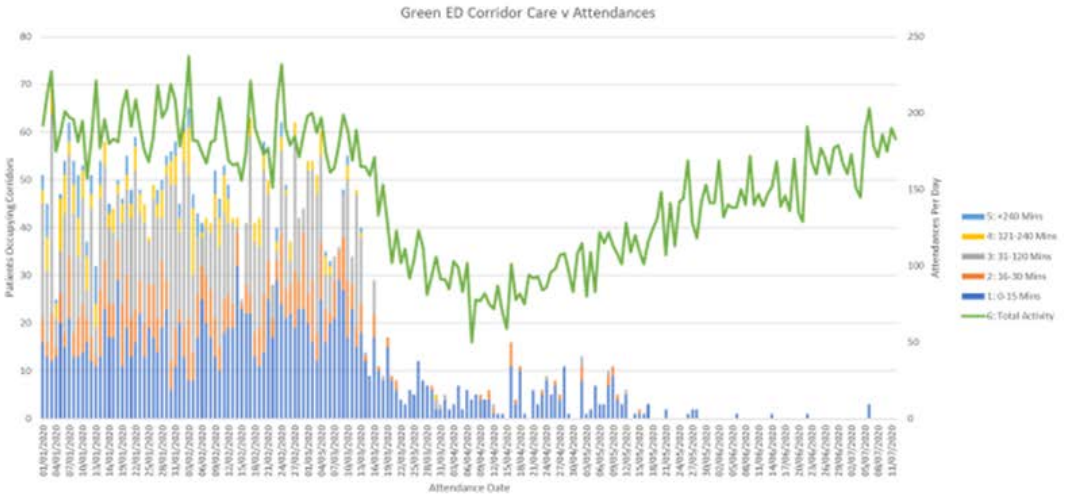
The 3 risks are:

Risk number	Risk description	Current score
1070	Emergency Departments inability to maintain 4-Hour Emergency Standard (95%)	25
1085	The Emergency Department environment is not fit for purpose	16
2774	ED patients held in the corridor for excessive periods of time	20

The escalation triggers and actions have been refreshed for Winter 20/21 to include measures for COVID-19 and COVID-19 test swabbing. This links to the Trusts overall escalation process to ensure capacity is maximised at times of peak demand or surges. We cannot hold patients in the corridor this Winter.

The mobilisation of both MRU and SRU has seen positive impacts on ED and these models will be sustained and developed through Winter. The chart and table below also demonstrate the eradication of corridor care despite the increasing numbers of attendances to ED. This is a key patient safety metric:

Significant reduction in corridor care



Metrics	April 19 - March 20	April 20 - October 20
Trust 4Hr performance	81.12%	93.59%
Average number of ambulance Handover waiting >15 mins	19	11
Average number of ambulance Handover waiting >30 mins	5	1
Average number of ambulance Handover waiting >60 mins	1	0
Average daily number of patients waiting in a corridor *	43	1
% of 1st Obs <15 mins	63.84%	80.90%

* No further patients cared in corridors from July 2020

The charts in **Appendix B** illustrate the early benefits of these two new Assessment Units in relation to emergency performance and the reduction in admissions. Weekend numbers are excluded due to the small numbers – although work is underway to optimise access to both units on Saturday and Sunday to further reduce ED attendance and admission. It is pivotal to the success of this Winter plan that both MRU and SRU perform at optimum efficiency and capacity, to continue to decongest ED and ensure patients get to the right place for the right care first time.

8. Additional Winter Bed Capacity

The establishment of the MRU and the SRU will provide additional assessment capacity and opportunities to reduce demand for beds. This year due to COVID-19 requirements and historic demand and bed modelling we have taken the decision to rebalance medical and surgical beds and to substantiate all ward areas rather than identifying a specific winter surge ward.
The bed reconfiguration in September 2020 delivered a net 18 bed reduction going into Winter (detailed fully in **Appendix C**).

9. Staff Wellbeing and Resilience

The Winter period will be extremely challenging for Trust staff, especially those on the clinical/operational 'front line', compounded by the COVID-19 pandemic. Staff resilience was significantly tested in the first COVID-19 surge early Summer, and as we are now entering a second wave, the Trust will need to support staff to both stay well and also stay at work where able/safe to do so. A range of measures are detailed fully in **Appendix E**, designed to support staff wellbeing and enable optimum staff retention through what will be an extremely challenging period. Whilst there is a need for a flexible workforce across the ICO to cope with any surge demand, this must be counter-balanced by judicious redeployment to ensure we minimise COVID-19 transmission between services/departments.

The organisation is focused on maintaining optimum staffing to ensure patient safety and the highest quality of care. There are a range of measures that are deployed as part of business as usual procedures to ensure that the Trust is meeting national and professional standards around safe staffing, these specifically include; robust rostering practices and monitoring framework, annual establishment reviews setting establishment and nurse to patient ratio, monitoring of CHPPD in line with Model hospital data as well as routine reviews of staffing levels through the control meetings.

In risk terms it is increasingly necessary to set out what is the safest approach as we absorb risk over the next few months. The current position calls for a non-standard approach justified by the circumstances the NHS finds itself in. The word safe in our current understanding within the NHS may not match the situation we are in. As such there is a need to consider replacing the language to safest and move to a resource allocation approach. This approach must be based on a risk framework, which allows risks to be taken where needed in an auditable and consistent manner.

The Board, along with STP Executives, has approved a risk management framework and approach to ensure the safest deployment of staff within the context of nurse to patient ratios. Within this, there are agreed thresholds of risk that triggers to enable interventions and /mutual aid internally and externally. Crucially a shared set of principles have been agreed that include

- No one organisation staffing levels are compromised
- Equivalent Ratios across the system through the agreed risk assessment framework
- Collective commitment to Nightingale requirements
- Common set of assurance frameworks for Board Assurance

10. Integrated Urgent Care Programme of Improvement

Prior to the COVID-19 outbreak March 2020, the 4-hour standard was consistently not met due to challenges with effective patient flow resulting in high levels of occupancy and escalation, particularly overnight and at weekends. The impact of the Surgical and Medical Receiving Units has been demonstrated as effective in improving this situation and relieving pressures during the initial wave of Covid and as normal levels of non-Covid activity picked up in late summer.

As previously outlined, during this forthcoming winter period social distancing must be maintained across the Emergency Floor: ED, EAU, SRU and MRU. In addition, plans to address and manage surge to maintain acute and community occupancy levels at <90% have been outlined.

In response to these challenges we have maintained a commitment to six key work streams. The improvement programme is system-wide and is designed to secure the protection and assessment of patients and timely rehabilitation and treatment plans:

- Surge enlargement and Green escalation plans.
- COVID-19 secure ED
- Adequate emergency assessment space to manage both acute and COVID-19 pending patients and other infections.
- Separate Medical Receiving Unit (MRU) to provide direct access to GP referrals.
- Separate Surgical Receiving Unit (SRU).
- Short Stay Paediatric Assessment Unit (SSPAU)
- Re-balancing of medical and surgical beds.
- Information dashboard with local and Trust-wide occupancy triggers.

11 Elective Plans

11.1 Day surgery

Day surgery procedures should be prioritised, where possible, especially during winter months, this includes not only the day surgery unit but also Level 5 main theatres.

The provision of a dedicated secondary recovery for patients operated on in main theatres is being developed.

Immediate challenges to resolve include the inability to use beds to recover patients but the problems posed by restricted use of the ED thoroughfare means that for many patients who could recover in DSU from General Theatres this is now a difficult option. Escalation to transport patients via level 2 to DSU recovery in the event of no capacity will be in place.

11.2 Emergency theatre sessions

Sufficient hot lists and second trauma lists will be scheduled to the match orthopaedic demand to ensure quick access to theatres and turnover of beds.

In the past elective lists have been taken down to react to non-elective demand which is poor patient experience for elective and non-elective patients, this extends length of stay and creates more operational rework.

11.3 Restriction of inpatients

In line with previous years during January 2021 inpatients should be restricted to cancer, urgent and over 52wk patients with a maximum of 10 per day, and these should be spread over surgical wards not dependant on any one or two wards.

Two weeks before the end of January consideration on extending this restriction into February will be undertaken.

Orthopaedic surgeons who only undertake inpatient work will be directed to support trauma in ED.

11.4 SRU

The purpose-built acute assessment unit has been built in the Trust's original intensive care unit. As illustrated previously this has already demonstrated significant improvement to the experience and early assessment of surgical patients. It has also reduced demand in ED and reduced delays. We anticipate this will continue to develop during the winter months and provide further improvements in bed management and admission avoidance.

12. Ward flows and SAFER processes

ECIST have been supporting the Trust on work to improve the efficiency of ward flows this year. There is ongoing support from the Quality Improvement (QI) and Programme Management Office (PMO) teams in this area. Current work involves continuing to work with ward teams during the week to strengthen SAFER meetings, particularly with a view to planning criteria led discharges over weekends.

Key areas concentrated upon are:

- Clearly recorded clinical criteria for discharge to enable nurse-led and weekend discharge
- Better communication between wards, bed managers and Emergency floor patients start to be pulled into admitting wards before 10 am.
- Early identification and case management of likely complex discharges
- Red to Green days – challenging all delays and ensuring escalation is in place.
- Medically fit patients are reviewed at daily MDT meetings and escalated to community services and teams as necessary.
- Implementing a discharge lounge function out of dayrooms in the Heatherington wards.

This work will continue and be a key focus over winter. We have established a task and finish sub-group to refocus and relaunch the acute adult ward initiatives (October/November).

13. Local Community Provision

13.1 Community Hospitals

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

We have agreed Blue COVID-19 step-down pathways at Brixham and Totnes that are key components of our COVID-19 escalation plan. This may further compromise non-COVID-19 pathway 2 capacity and we are currently risk assessing this to ensure we have some robust mitigating plans should COVID-19 levels continue to rise.

Hospital	Bed No	Escalation/Surge	Hospital	Bed No	Escalation/Surge
Brixham	Gen Med - 15 I/care – 4	No additional. Reduction of 1 bed for donning & doffing. Blue	Newton Abbot	Gen Med - 40 Stroke rehab – 15 Neuro rehab – 5	Release 2 GP beds

		COVID-19 pathway.			
Dawlish	Gen Med - 16	Gen Med – 1 (due to social distancing requirements).	Totnes	Gen Med – 16	Gen Med – 1. Blue COVID-19 pathway (due to Donning & doffing requirements)

To ensure occupancy levels throughout the community hospitals are maintained at <90% a comprehensive action plan has been agreed with clear steps to escalation if triggers are met.

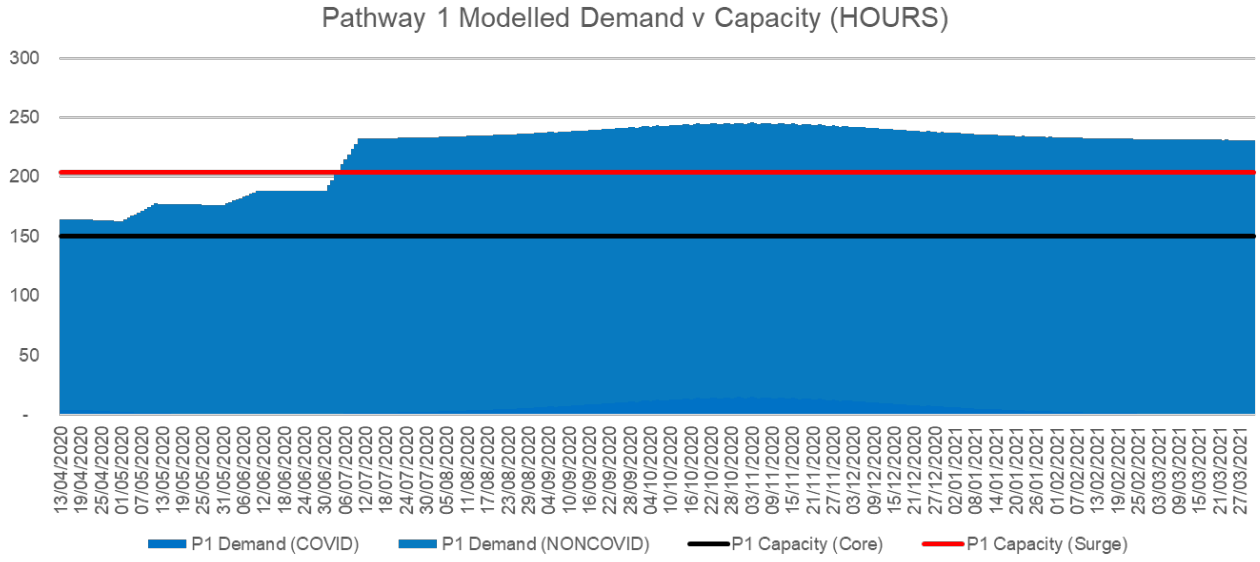
13.2 Urgent Treatment Centres (UTC)

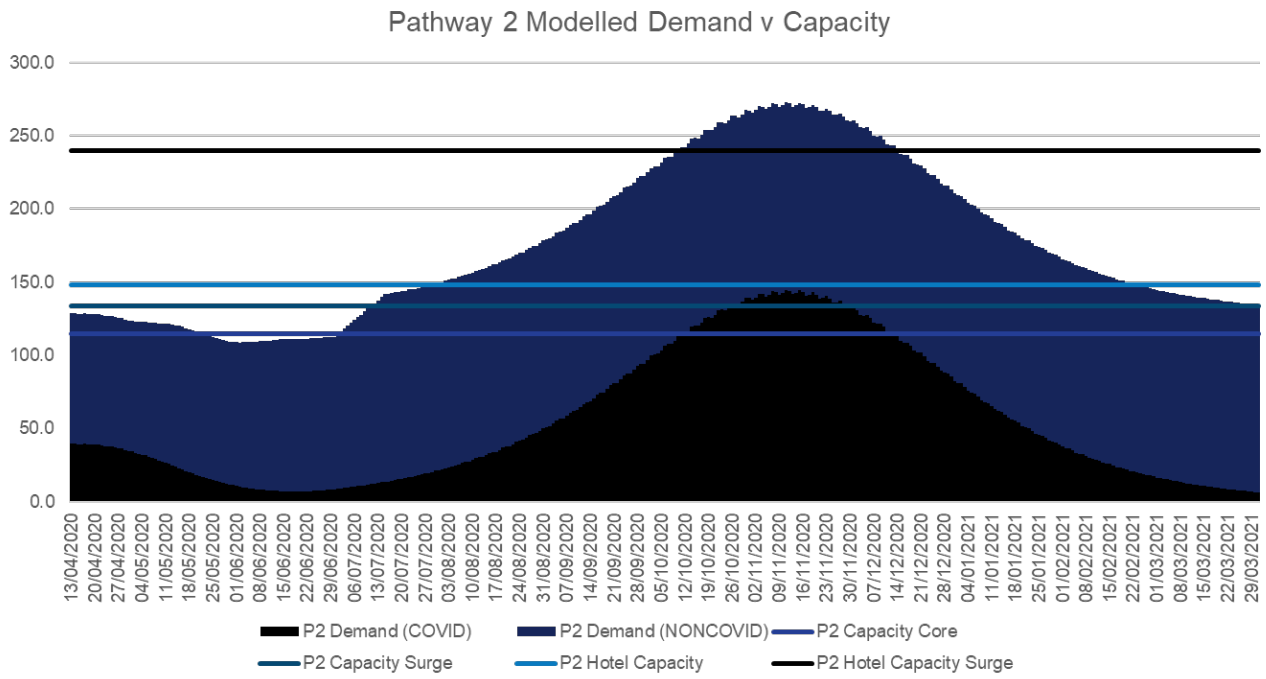
UTC staffing levels have been planned to meet anticipated capacity and demand over the winter period including bank holidays. The UTC will continue to support the Emergency Department over the winter period including supporting diverts of minors patients from ED during periods of escalation.

Attendances at our UTC are not yet back to pre-COVID-19 levels (70%) although at the current trajectory demand is forecast to be back to 100% this winter. 12-hour Radiology support is in place Monday-Friday.

13.3 Community Services

Based on the initial data that was received the Business Intelligence Team in the CCG have modelled the demand against the capacity if 'R' increased to 1.15. The graph below and those on the following slides illustrate this and suggests that there is not sufficient capacity for those patients requiring at home support (Pathway 1) and residential or nursing home support (Pathway 2) until March 2021





A deficit in the availability of short-term packages of care compared to demand has resulted in further investment in this sector, aiming to reduce this capacity and demand gap and this is in addition to that which was commissioned last year. However, capacity constraints remain within the independent sector, notably with recruitment cited as the largest challenge across both Devon and nationally.

Recent additional investment into the Torbay and South Devon Rapid Response teams is aiming to increase capacity over the winter period and to improve short-term provision, focusing on reablement for patients leaving hospital and reducing dependence on bed-based care. Risks remain in relation to ongoing capacity requirements in the light of COVID demand. Progress has been made in terms of recruitment to an extra 10 Rapid Response workers expected to be in place by November 2020. In addition, further negotiations are underway with domiciliary care providers to bolster capacity and support the ICO with Rapid Response capacity to mitigate potential capacity gaps.

13.4 Domiciliary care

The Trust and local authority colleagues continue to work closely with local domiciliary care providers to increase capacity where possible to provide support during the winter period. Both areas are working with therapists supporting care providers to review packages to liberate capacity where possible.

An additional 400 hours of domiciliary care resource for social care has been commissioned from Agincare for Torbay. Devon County Council has purchased an extra 250 hours from Prospero for South Devon and also continuing with 200 hours to support end of life care from Agincare. The aim is to keep people as well as possible at home for as long as possible.

13.5 Early Supported Discharge

The Early Supported Discharge proposal is being overseen by the A&E Delivery Board and managed through the relevant team in the Trust. The aim project will assess for short term services (Rapid Response and Reablement across the ICO) when a patient has been discharged from the hospital and not before discharge. The objective of this initiative is to reduce over prescription of short-term services with the aim of increasing capacity / using the resource of this team more efficiently. To enable initial capacity, it has been calculated that an additional 10 WTE's will be required and this being funded 50/50 from Torbay and South Devon funding. This will provide approximately 10 pathway 1 discharge 'slots' per day (70 discharges per week) – based upon c55% single handed visits and c45% double, and 4 times a day frequency of visits. We are also exploring the culture towards risk enablement under the Home First strategy across all teams involved with discharges from hospital. It is expected to reduce the number of patients being discharged into bedded care. The initiative is at the point of recruitment. Rapid learning is being taken from other systems where D2A is more established/embedded, especially in relation to Pathway 1 (home with support).

14. Ensuring safe and timely discharge

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

Key enablers to this are:

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

15. MENTAL HEALTH SERVICES

A Devon wide mental health winter plan has been developed. Devon Partnership Trust (DPT) has a number of ongoing projects such as First Response Service expansion, crisis house provision in Exeter, COVID-19 plans at Elysium, refurbishment of Russell clinic, expansion of Crisis Resolution and Home Treatment teams that will also add some capacity and resilience in readiness for the winter.

Confirmation has also been received that the following schemes will be funded from the Devon Improved Better Care Fund (iBCF) until 31 March 2020:

- Social navigators to support people on Community Mental Health waiting lists
- Planning for transitions
- Social workers on wards
- Additional resources for social care teams.

16. Winter schemes

The South locality system has agreed to following Winter Schemes to provide additional Winter Resilience:

Scheme number	Scheme title	Description	Main impact(s)	Any risk to delivery
TSDW01	Expansion of assessment capacity*	Provision of three assessment areas: Interim MRU (Forrest ward), SRU, SSPAU within existing estate	Reduce admissions, increase same day urgent care, reduce risk of corridor care in ED and reduce ED attendances. Support more high acuity patients ED is NOT single point of access/failure for unscheduled attendances and admissions	Workforce capacity Revenue funding - SSPAU Covid-19 and /or influenza outbreak or surges. Failure to optimise MRU/SRU & SSPAU pathways – ED crowding/bedding assessment areas.
TSDW02	Expansion of community capacity*	Identification of COVID-19 step down blue pathway (Brixham & Totnes) to enable safe transfer for pathway 3 patients (DHSC). Technology assisted assessment as default for all domiciliary care requests to maximise capacity. Increased spot purchase provision flexible use of block IC beds. National capacity tracker monitoring and use of Restore 2 via QAIT.	Flow out from the acute and community hospitals. Reduce long delays in acute beds thus improving flow through from ED/MRU. Mitigate impact of increased D2A pathway 2 capacity gaps.	Lack of workforce capacity. Multiple independent sector outbreaks. Dom care resilience. Impact of isolating /sickness.
TSDW03	Emergency department phase 1 capital works	COVID-19 secure ED	Reduce the risk of ED crowding and COVID-19 spread in the department. Reduce risk of corridor care	Covid-19 and /or influenza outbreak or surges. Overstretched demand and overcrowding
TSDW04	Workforce for winter escalation*	Workforce to enable/support Winter escalation plan with sufficient capacity across Winter period	Improve delivery of safe and timely care. Respond to service reconfiguration or expansion in an agile manner. Ensure resilience in Nightingale/Care Homes. Driving resilience based approach to staff wellbeing as nationally mandated	Staff wellbeing. Staff sickness absence/quarantine. Capacity does not match demand. Access to staff (perm or temp).
TSDW05	System co-ordinator/ central sitrep	Delivery of proactive management and prevention of outbreaks as key stakeholder within Torbay and South Devon	Across all care setting - reduce Covid-19 positive patients, reduce Covid-19 outbreaks and improve access to Care Homes and placements.	Covid-19 and /or influenza outbreak or surges. Funding for testing, cleaning and transportation for services that link to the ICO e.g. cleaning of care homes.
TSDW06	Paediatric expansion	Move of Ricky Grant to facilitate the delivery of a dedicated SSPAU for 3 months to support increased respiratory admissions/attendances in children.	Provide capacity ensure swift flow and direct admission to reduce ED pressures.	Further outbreaks preventing use of McCullum or move of Cancer services to protect green flow.
TSDW07	Complex high intensity users*	Supports admission avoidance by targeting high users of A&E to support them to flourish and avoid attendances and admissions.	Reduce readmissions and improve patient experience (5% reduction in readmissions). Freeing up front-line resources to focus on more patients.	Voluntary sector unable to identify coaches.
TSDW08	Transition of care – transport services	Transport capacity building and access to support, reduce discharges from a range of setting and enabling movement within the community to enable people to stay at home well	Reduce length of stay and improve access to services (wellbeing, health & care). Increase in outpatient appointments attended.	Access to SWAST or alternative provider on a timely basis and available capacity. Volunteers willing to support transport capacity. Capacity within transport services to support increased demand.

TSDW09	Discharge lounge*	Nursing workforce throughout Winter. Provide a discharge lounge facility [Hetherington dayrooms] 7 days a week (09.30 – 20.00). Provide suitable environment for both ambulatory and bedbound patients and pull all patients unless they fulfil the clear exclusion criteria.	Increase the number of medical and surgical discharges. Will reduce the need for pre-emptive transfer and/or boarding at ward level in OPEL 3 or 4. Reduce bed turnaround times. Reduce the risk of ED crowding/corridor care.	Available/suitable location
TSDW10	Home care capacity – end of life – South Devon & Torbay*	Extend funding for program of care, capacity delivery within Agincare – 200 hours (Torbay and South Devon)	Address market sufficiency's and challenges that would otherwise prevent provision of end of life care for people in own homes.	Workforce capacity. Effects of COVID-19 surge/outbreak.
TSDW11	Arranging support team expansion – South Devon	Expansion of capacity to extend to Sunday working	Enable same day discharge.	Workforce mobilisation.
TSDW12	Early supported discharge – enhanced rapid response services – Torbay and South Devon*	Additional investment: 5 rapid response workforce, Band 8a management – DCC 5 rapid response – Torbay	Increase capacity for same day discharge and increase number of people who go home from hospital.	Recruitment of rapid response roles.
TSDW13	Discharge hub expansion – Torbay and South Devon	Additional investment to ensuring staffing and activity through 7 days a week, 0800 – 1800 and additional management investment. Option appraisal for single point of contact supporting admission avoidance	Increase discharge co-ordination and supporting same day discharge.	Workforce capacity/resilience.
TSDW14	Waiting list initiative – South Devon*	Weekly review between community, AST and provider to unblock and prioritise	Minimise wait for domiciliary care; ensuring timely exit from short term services freeing capacity in those services.	None identified
TSDW15	Senior leadership 7 day support – South Devon & Torbay	Enhanced payment to support leadership co-ordination 7 days a week	Improve ability to support system during Covid-19 and winter.	None identified
TSDW16	Additional personal home care capacity – South Devon*	Buy in domiciliary care hours	Improve ability to discharge patients	None identified
TSDW17	GP Care Home Visiting Service (01 October / 01 November 2020 for 6 months)	Additional Early and Acute Visiting to Frail patients in community and continuation of the successful Early and Acute Care Home Visiting Service that already operates across the south locality. This is aligned to the elective proactive EHCH work (but it is clearly distinct and additional beyond this Framework. Service to run from 0800 – 1800 if able to work collaboratively, or 0800 – 1300 dependant on location and ability to work at scale. Provide additional clinical capacity to help fulfil the NHS England Covid recovery plan specifications, including progress on multi-disciplinary support, advanced care planning and medication reviews.	Early / timely discharge back to Care Home. Prevention of admissions/ admission avoidance / reduced ED attendance. Earlier assessment or admission for diagnostics to hospital. Reduced bed days. Reduced DDOC and primary care contacts. Inter-disciplinary care (community teams, social care and care home staff). Enhanced recognition and support for end of life care.	Covid-19 and /or Influenza outbreak or surges. Workforce issues related to the above. Funding is not currently secured.
TSDW18	Nurse-led proactive monitoring service for severely frail and extremely vulnerable (shielding) patients	Principally telephone and digital consulting with the potential to use Technology-Enabled Care or face-to-face visiting when required. Nurse would support severely frail and shielding patients by; promoting and signposting self-care for their chronic conditions / general health. Providing a first point of contact. Earlier identification and treatment of deteriorating physical health. Supporting personalised care planning and anticipatory care when	Reduce contacts to the ambulance service, Devon Doctors on call and ED. Reduce unplanned admissions and facilitate. Potential cost saving to T&SD NHS FT £127,680 per PCN £1,021,440 all 8 PCNs.	Covid-19 and /or Influenza outbreak or surges. Workforce issues related to the above and issues related to provision of social and community services in context of Covid-19. Funding is not currently secured.

		appropriate. Signposting to community care options in the event of acute illness (including intermediate care, frailty services and voluntary.		
TSDW19	Community Helpline - Torbay	Funds would contribute to overall cost of maintaining Helpline over winter; including call handling, daily triage to range of supports and tier 2 support (for example mental health and welfare advice).	Single point of contact with route into wide range of community supports and volunteers and good neighbours schemes to help reduce unplanned admissions and hospital discharge.	Other match funding to be secured to maintain Helpline – Covid-19 bid to National Lottery for 6 months funding to maintain core of Helpline has been secured this week.
TSDW20	Hospital discharge to home – South Devon	Volunteer co-ordination for discharge to match proposed in hospital co-ordinator already funded in South Devon.	Will enable discharge needs to be coordinated, sourcing volunteers and matching needs to volunteers.	Main risk is accessing volunteers to carry out activities, mitigated by creation and maintenance of Helpline system, which has access to circa 700 volunteers. Aspirations to passport hospital volunteers will also mitigate loss of volunteers as people return to work.
TSDW21	Supporting hospital discharge across rural moorland – South Devon*	Build the capacity of voluntary sector to liaise with discharge teams to better identify patients being discharged and to support with VCSE packages of care on discharge for 6 weeks.	Improved Hospital Discharge and reduced readmission	Remote rural access during poor weather.
TSDW22	Supporting those living with dementia/memory loss and their carers – South Devon	Support for memory/dementia cafes to reopen to support clients/carers who have found lockdown hard – funds needed to reopen safely (larger venues, sanitisation equipment etc). Increased capacity for VCSE Dementia Wellbeing Workers to support additional costs in delivery to meet Covid-19 guidelines – eg hire of space rather than home visits, new ways of delivering support including digital.	Reduced risk of carer breakdown leading to increased pressure on social care and poor health. Reduced risk of carer breakdown leading to social care and poor health.	Reduced engagement by clients and carers following Covid-19 crisis due to lack of confidence. None identified.
TSDW23	Home help support across South Devon	Increased capacity into VCSE (unregulated activity) support to keep people out of hospital; a short-term intervention by the voluntary sector.	Reduced re-admission to hospital; reduced impact on social care package.	Capacity being available.
TSDW24	Rapid responder (Torbay)*	To pick up unmet demand, where it is not possible to access a volunteer	Ensure timely discharge in all areas at all times (7 days a week).	None identified
TSDW25	Digital support – South Devon	Purchase digital equipment and having that set up for people who are leaving hospital; particularly those leaving with new health limitations, which will support them in accessing things online such as shopping online, providing peer support, information on their health condition (we have the health information library), engaging in health programmes such as Digital Hope. Given on loan on discharge with face to face and support to purchase their own if found useful.	Reduced readmission, improved self-care.	Hesitation to learn and engage.

Total of 24 schemes:

- **9 support hospital attendance avoidance/keeping people well**
- **11 support discharge from hospital/reduce risk of readmission**
- **4 support improved inpatient flow/safety**

Those schemes marked with an * will contribute towards bed efficiencies, and work is ongoing to quantify impact by scheme.

These schemes are being progressed at pace and delivery risks being actively mitigated. There are weekly system meetings to review progress. It has been agreed to have 3 formal system 'touchpoints' (December/January/February), with the last review focussing on pre-agreed triggers to escalate schemes and to pull any associated resources back as soon as demand allows and either way before the end of the Winter period. All these schemes have been costed and budgeted for through the local AE Delivery Board with support from the Trust finance team to ensure all commitments are managed within forecast levels of expenditure. The operational teams will ensure there are clear exit strategies to support standing down these commitments as the winter funding stops in April 2021.

17. System Escalation

The South Devon locality system triggers have been reviewed and finalised (**Appendix D**). These system triggers cover all services including primary care, community care, social care, ambulance, out of hours, 111 and mental health services. These will be monitored daily and will form part of the wider escalation process and linked to specific actions for system, commissioners and providers.

In addition, work is also underway focusing on the Devon system, aligning the four acute Trusts, ensuring each Trust has the same triggers to determine the OPEL escalation level. This work will incorporate these agreed system wide triggers and will be co-ordinated through the Devon Delivery Board to ensure consistency, resilience and mutual aid across the STP.

The Trust's OPEL Action Plan has been reviewed and updated in accordance with Covid-19 changes and rebalancing of activity and triggers in preparation for winter.

18. Winter plan measures/evaluation

The agreed system triggers (**Appendix D**) will be used to monitor the impact of the Winter plan as well as other key patient/staff safety and quality measures, including:

- % staff sickness by discipline (COVID-19 and non-COVID-19 related, and also due to work-related stress)
- % staff turnover by ISU and discipline
- Friends and family test results – key indicators

The measures will be triangulated with those reported via the Board Integrated Performance Report and then thematic review of incidents via the Quality Improvement Group.

Some schemes also have agreed specific success/impact measures and these will be reported by monthly reports via the South Locality Winter Planning Group.

19. Formal instigation of incident response

In the event that the pandemic needs to be escalated into formal incident response this will be at the recommendation of the PRT and the Emergency Preparedness Advisors from SSEP who will liaise with the COVID-19 Executive Lead.

The command structure for both community and acute elements of the Trust can be found in the Appendices. This includes examples decision making processes with regard to incident related tasks. The incident response teams will use the tactical plan to manage the incident.

20. Weekends/Bank Holiday Planning and Resilience

A 'review of the weekend' process has been successfully embedded led by the south locality. This process consists of two meetings on a weekly basis (Monday and Thursday). The primary objective of these meetings are:

- Monday, review of the weekend, highlight any issues and advise of escalation triggers that were met
- Thursday, weekend preparation, highlight any issues and mitigation in place for the weekend.

Membership consists of the Torbay and South Devon NHS FT, South Western Ambulance Service NHS FT, NHS Devon Clinical Commissioning Group and Devon Doctors.

The Festive fortnight will include a 4-day Christmas period and a weekend New Year break. The following principles will be adopted to ensure systemwide resilience:

- A benchmarked shift fill rate to deliver good cover in all areas including SWASFT, Devon Doctors and 111, with good rota cover.
- Each provider will be required to have a resilience plan.
- Devon 111: Pay enhancements for the bank holiday to ensure cover (health and clinical advisors) and predict in advance the anticipated Opel level.
- Devon Doctors: Maximise rota fill for out of hours, ensure minimal gaps and ensure the busiest hours (1900 – 2300) are well covered.
- SWASFT: Set up dedicated Incident Coordination Centre for this period, maximise clinical capacity in Hub to hear and treat also enhance internal clinical support and prior identification / intelligence of high risk events in the locality.
- The Trust will provide full rota cover in both acute and community hospitals. Support services and Emergency Department to be well staffed and prepared for anticipated demand. Focus on discharge throughout the Bank Holiday weekends supported by the Discharge Hub throughout. Short Term Services to cover all existing care runs, community teams to reinforce as needed. Infection prevention and control cover will be in place supported by the on call microbiologist. Diagnostics to be adequately covered in the acute and Newton Abbot.
- SWASFT, 111, DDOc and the Trust to consider conveyance and signposting in advance of this period to reduce the conveyance rate.
- Patients in Hospital with complex care discharge arrangements to be closely managed to ensure plans and transfers are in place throughout this period.

21. Key risks and mitigations

There are still some key risks to the delivery of the Winter plan, but we continue to progress mitigating actions at pace to reduce the risk levels:

Risks	**Mitigations**
Reduced adult acute inpatient bed base due to bed reconfiguration and housing MRU within main building (Forrest ward)	Acute ward patient flow and discharge sub group – embed a range of national initiatives to ensure optimum patient flow - we need a rapid and robust set of actions that sustainability and positively impact on internal flow – increasing the number of daily discharges, reducing LOS for pathways 0-3, increasing the % of discharges by 12 midday, keeping Trust bed occupancy <90%. The rapid improvement project seeks to ensure board and ward rounds are consistent and effective, and adequately focus on discharge/flow – relaunch SAFER/R2G. We will adopt a more prescriptive approach with Exec-led standards/expectations for each key role, and meaningful KPIs/audit process – a "**new norm**". We also plan to r**elaunch** clinical criteria for discharge (Drs) and criteria led discharge (nurses) and embed the NHS criteria to reside.
COVID-19 Blue and Green – lack of blue capacity increasing the COVID capacity required in Torbay (we should only be holding 4 +ve patients, and staying in one COVID-19 ward)	COVID-19 Blue and Green – we continue to support/facilitate development of sufficient capacity at RDE/NHE with robust enabling clinical pathways, as well as ensuring adequate contingency capacity/solutions at Torbay, including COVID-19 stepdown Blue pathways in our community hospitals
Phase 3 elective recovery plan – delayed care/treatment may have had a negative impact on patients. We need to preserve unscheduled patient safety and treat in order of clinical priority (a change from 'normal' pre-COVID-19 processes).	Clear and robust OPEL 2-4 actions for escalation/de-escalation (helps to preserve phase 3 recovery plan, and ensure no ED crowding/corridor care). Enhance private sector capabilities to enable sustained delivery of our phase 3 recovery plan. Continue to focus on clinical harm reviews of long elective waits, and the understanding of additional resulting surgical complexity once these patients present for treatment.
The schemes may not fully close the projected pathway 1 and 2 capacity gaps, especially pathway 2 due to the need for COVID-19 stepdown pathways for escalation	The relevant schemes are being quantified in terms of additional number of discharges per day/week. Contingency plans for capacity shortfalls are being worked through.
There are heightened workforce risks for some schemes - some of the schemes may be late to mobilise due to challenges in recruiting workforce	Winter nurse recruitment plan with weekly/monthly trajectories being finalised. Minimise staff redeployment to reduce extent of work-related COVID-19 transmission.
ED crowding/corridor care – adverse COVID-19 public health effects for patients/staff in the department	Effective ED triage/streaming – divert patients from ED to the right pathways to reduce the risk of ED crowding/corridor care. Embedding the MRU model (augmenting direct ambulance conveyance where possible)

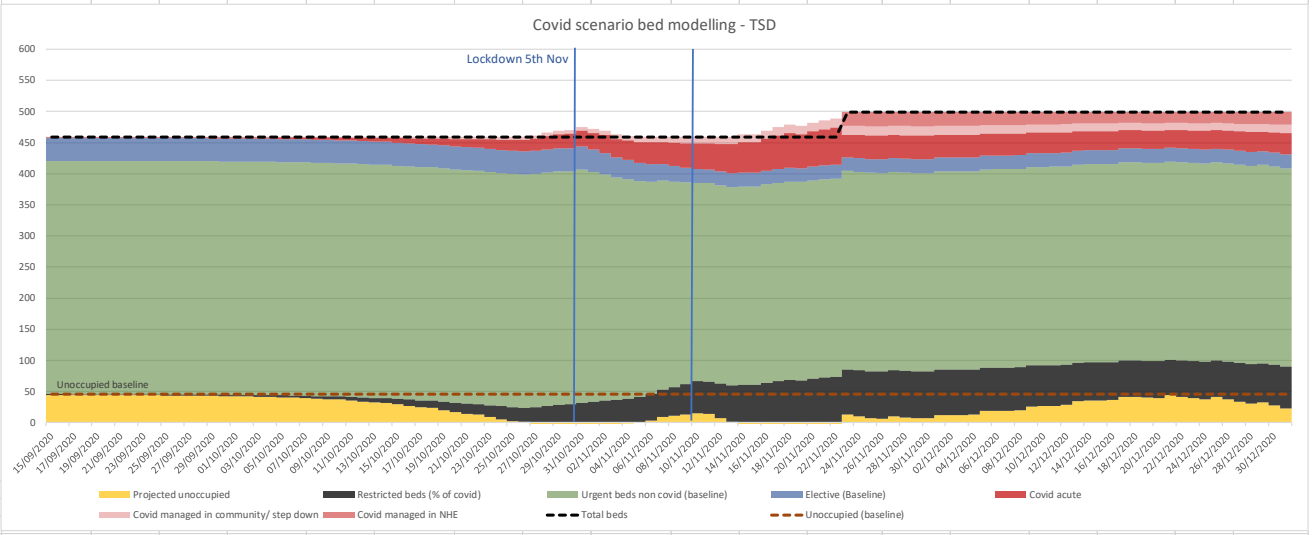
22. Process of Assurance and Sign Off

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

The plan is considered and approved by the TSD FT Trust Board.

Appendix A – TSDFT COVID-19 bed scenario modelling

Cov % chan	% suitable	Full trigger		Capacity	Capacity				0.02%	Baseline	% reduction	Baseline	% reduction		
Basic covid model									Activity changes						
Total covid beds	Suitable for NHE	NHE trigger	Covid managed in acute	Covid managed in community/ step down	Covid managed in NHE	Suitable for community	Surge beds	Restricted beds (% of covid)	Total beds	Unoccupied (baseline)	Urgent beds non covid (baseline)	Urgent beds (Reduction)	Elective (Baseline)	Elective (Reduction)	Residual	Projected unoccupied
0%	50%	8	17	19	40	20%	No	100%	459	10%	91%	-15.0%	9%	-40.0%		
		23/11/2020					0			Occupancy %	375	-56	37	-15		
		Yes					16/11/2020									



Area	Metric	At peak covid
Peak demand	Covid managed in acute	38
	Covid managed in community	15
	Covid managed in NHE	23
	Total covid beds occupied	76
Reduction in demand	Emergency beds	-15%
	Elective beds	-40%
Occupancy	Unoccupied beds	1.2%

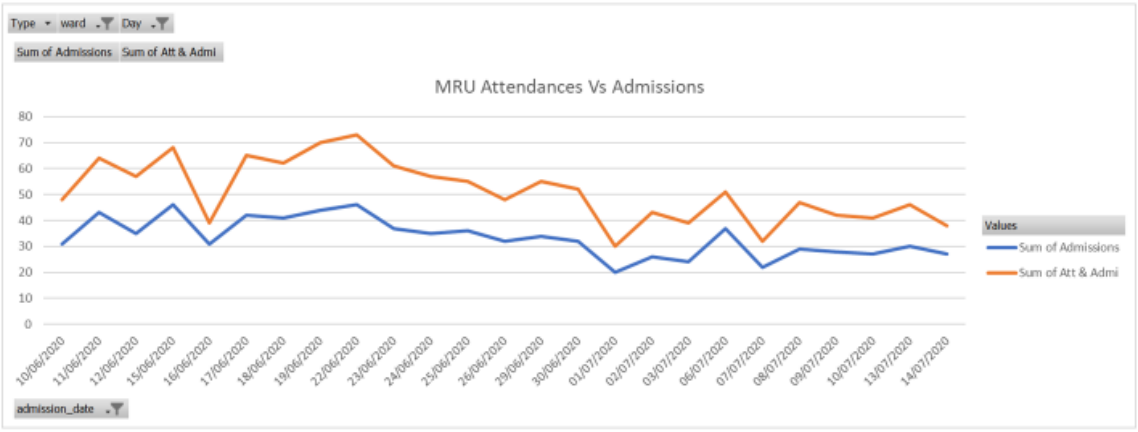
Metric	Assumption
NHE trigger	140
Covid managed in acute	240
Covid managed in community	56
Covid managed in NHE	116
Total covid beds	412
Total beds	2290
Unoccupied (baseline)	10.0%
Urgent beds non covid (baseline)	88.7%
Urgent beds (Reduction)	-10.0%
Elective (Baseline)	11.3%
Elective (Reduction)	-20.0%

Public

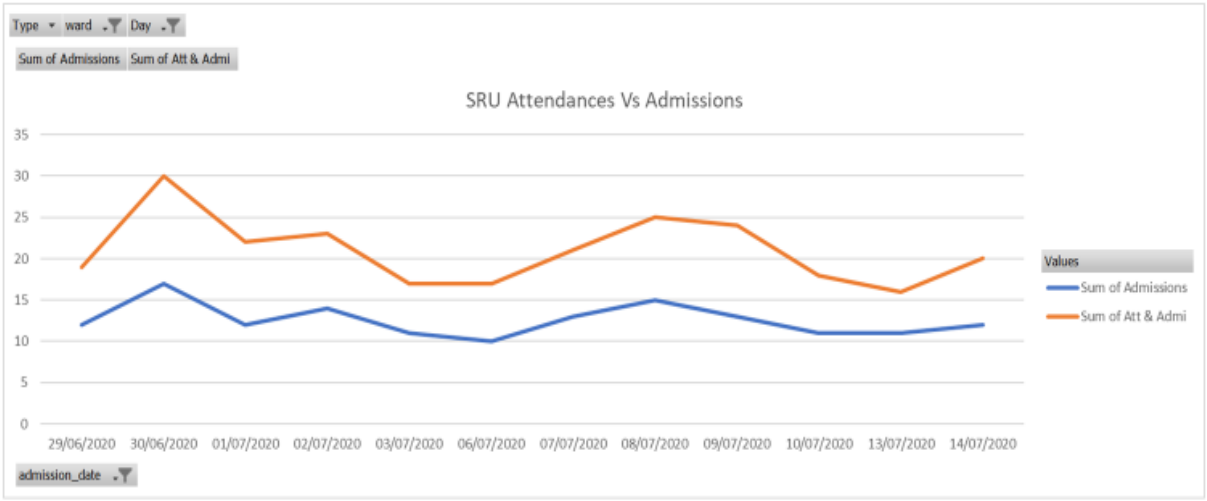
Appendix B – Impact of MRU and SRU

The early benefits of MRU and SRU in relation to emergency performance and the intended reduction in admissions:

MRU Attendances Vs Admissions (excluding weekends)



SRU Attendances Vs Admissions (excluding weekends)



Appendix C – Net bed reduction position following bed reconfiguration

Phase 3 baseline

Ward Code	Specialty / Description	Avail	Beds at 13/10 per CG
AINS	Trauma & Orthopaedics	26	26
ALL	Surgical / gastroenterology	29	29
CH	General Medical - Cote	28	28
CRO	Surgical – Urology (returned to full capacity August)	26	16 (COVID ward)
DUN	General Medical / Cardiac	24	24
EAU3	Emergency Assessment Unit	14	0 (EAU 3 removed as part of ED capital build)
EAU4	Emergency Assessment Unit	24	24
ELLA	Trauma & Orthopaedics	21	21
FORR	Surgical / Head & Neck	25	0 (Forrest beds removed as becomes MRU)
GE	Medical - assess/rehab	28	28
ICU	Intensive Care	10	10
JM	Maternity (not G+A)		
LC	Paediatric	14	14
LCHDU	Paediatric - High Dependency	2	2
LCYP	Paediatric - older children	6	6
MCC	Gynaecology (not G+A)		
MIDG	General Medical - Thoracic	29	29
RICU	Intensive Care - Recovery	0	
SIMP	General Medical - Cote	28	28
SLP	Thoracic	1	1
SPICU	Intensive Care - Overspill		
TCCU	Coronary Care	8	8
TCPU	Thoracic Care	6	6
TUR	Cancer Services	16	16
WARR	General Medical (18 beds for escalation from 25th August)		17
		365	**347**

ELIZ	14 beds from 1st Dec

Appendix D – Revised system OPEL triggers

Indicator	Target	National/Local	Local Trigger
Acute OPEL Rating		National	
Acute Trust 4 hour performance (ED)	95%	National	<85%
Combined ED and MIU 4 hour performance	95%	National	<90%
ED Type 1 Majors		Local	75% occupancy
ED Type 1 Minors		Local	80% occupancy
ED Type 1 Paediatrics		Local	75% occupancy
Type 1 ED attendances		Local	>185
4 Hour Wait Breaches – Type 1			<20 daily ave
Number of 12 + hours waits for admission	0	National	>0
Number of Ambulance attendances		Local	>80
Ambulance Handover delays 30 to 60 minutes	0	National	0
Ambulance Handover delays over 60 minutes	0	National	0
Recorded Ambulance Time Lost Over 15 minutes	03:00:00	National	>04:00:00 SWASFT SOP
Median time to clinician (target below 60 minutes)	<60 minutes	National	<60 minutes
Indicator	Target	National/Local	Local Trigger
Total Arrival to 1st Obs % within 15 mins (target 80%)	>80%	National	<80%

Ambulance Arrival to 1st Obs % within 15 mins (target 80%)	>80%	National	<80%
Other Arrival to 1st Obs % within 15 mins (target 80%)	>80%	National	<80%
Total number of admissions		Local	>90
Number of emergency admissions		Local	>85
Number of emergency admissions via A&E			>75
Emergency admissions conversation rate	10%	National	>25%
Core beds open	100%	Local	<95%
Discharges from the Acute Trust		Local	<85
Admission / discharge variance		Local	>5%
Acute medical % bed occupancy		Local	>90%
Acute surgical % bed occupancy		Local	>85%
Total acute % bed occupancy		Local	>90%
Indicator	Target	National/Local	Local Trigger
Length of stay is 7 days or more		Local	>70 patients

Length of stay is 14 days or more		Local	>35 patients
Length of stay is 21 days or more		Local	>21 patients
% community beds occupied		Local	>90%
Number of medical outliers		Local	>10 patients
Number of surgical outliers		Local	0
Number of patients MFFD >24hrs		Local	G2G >20 patients
% Re-attendance at ED within 7 days		National	>7%
Re-admission rate		National	>15%

Appendix E – Staff Wellbeing and Resilience measures

Wellbeing of Staff has added emphasis during winter pressures.

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

- Coaching – confidential 1-2-1 sessions crating a safe space for conversations which could help staff to explore building resilience and wellbeing.
- Employee Assistance Programme – There is a NEW Employee assistance programme still accessed through telephone 24/I 365 days a year or through their web page. Offering support, advice, information and web based online wellbeing assessment.
- Schwartz Rounds – Are returning after a COVID break with its new platform on Microsoft Teams. The first pilot for this new format being in October 2020. It will still provide an environment for sharing of emotions and feelings of working within the health care system
- HOPE – Self-care 6 week course looking at mindfulness, goal setting, fatigue, strengths, healthy eating and dealing with set backs. Specific staff courses will be provided with details advertised through the Bulletin and Staff Room
- Health promotion through wellbeing boards are promoting – taking your breaks, ensuring you get enough sleep and a check list of things to do before you leave. New staff wellbeing boards have been developed outside of Bayview restaurant
- Staff Benefits
- Mental Health Forum
- Closed wellbeing facebook dedicated solely for issues linked to staff wellbeing and only accessed by staff. **Whole-Beings Torbay & South Devon NHSFT**
- Mental Wellbeing Workshops and Training including:
    - F1 and F2 mental Health Wellbeing
    - Workshop – How do I support colleagues struggling with mental health
    - 'Having that conversation'- workshop for managers looking after staff who are struggling
    - Wellbeing Buddies
    - Sustaining Personal Strength
- New wellbeing pages - easy to use and easy to find pages and calendar
- Menopause group – Now has an established virtual network support group with dedicated pages on the Wellbeing Site
- Working from Home virtual chat room
- Hearts – Wednesday evening dial in event weekly, looking at how arts can support wellbeing. Content from staff talking about their art and how it helps then and open mike sessions for anyone to contribute.
- Schwarts rounds being changed onto a Team Microsoft platform creating a virtual experience for staff to access (starting October 2020)

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

- Mental Health First Aiders and Wellbeing Buddies merging to create a network of support across the Trust. Wellbeing buddies will effectively become a first line of support for colleagues and teams who will be sensitive to changes in colleagues and prompting a conversation of 'Just asking' how they are and signposting.

- Sanctuary site development – funded via COVID Charitable funds. Currently under development to enable staff to proactively look at their current relaxation spaces and to request funding to make changes.
- Indoor and outdoor spaces – funded via COVID Charitable funds to look at larger scale projects of creating wellbeing spaces across the Trust to utilise and develop of spaces available for relaxation for both staff and patients.
- New Wellbeing Newsletter. This resources will be building on the newsletter already being distributed to those staff working from home during COVID. It will contain up to date information and future plans as well and light hearted articles
- JIGSAW and TRIM – A new debriefing and staff support team ready to facilitate sessions across the Trust where staff have been affected by out of the ordinary events causing distress.
- New Retirement and Long service awards.
- New Carers Strategy completed and ratified to be uploaded.
- New Reasonable Adjustment policy and guidance ratified awaiting formatting and uploading. Cascading of information and vlog planned.
- Anti-Bullying advisors to be revisited after break in development due to COVID
- Annual Health and Wellbeing checks will be underdevelopment and planning following guidance within the People Plan
- Virtual Christmas Fair for November showcasing staff crafts ability and opportunity to sell.
- Decoration competition – awaiting confirmation to proceed

<u>Added measures throughout the winter season</u>:

- Flu Campaign – aiming to offer 100% of staff the vaccine, targeting frontline staff but offer will expand to all staff.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: November Mortality Score Card			**Meeting date:** 25th November 2020
Report appendix	List any supplementary information as shown below: Appendix 1:		
Report sponsor	Medical Director		
Report author	Patient Safety & Experience Lead		
Report provenance	The report will go to the next Quality Improvement Group Meeting 17th Nov 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. The Hospital Standardised Mortality Rate (HMSR) is within the expected range. The Summary Hospital Mortality Index (SHMI) for Q1 20/21 in higher than expected due to reduced inpatient activity during the first Covid surge. The total number of in hospital deaths rose during March and April 2020 due to Covid. The number of deaths during the summer months were lower than average.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors is asked to receive and note this report		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks	

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

This report is a record of the Trust's mortality as viewed through a number of different metrics. HSMR is within normal limits. SHMI is raised due to reduced activity in April and May as a result of Corvid. This pattern was seen in the HSMR data, at that time and will correct as SHMI catches up with more data points.

Report title: Mortality Surveillance Score Card		Meeting date: 25th November 2020
Report sponsor	Medical Director	
Report author	Patient Safety & Experience Lead	

1.0 Introduction & Data Source

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

The report also includes mortality cases reviewed via the Trust's 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)	Mortality	Dr Foster latest benchmark Month	Below the 100 line with an aim for a yearly HSMR ≤90	99.4
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		
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	14 positives
Appendix 5 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) remains within the accepted range for our population for July 2020. The effects of Covid are evident in the previous HSMR data for March and April 2020, namely in the reduced hospital activity/spells that followed lock down. This effect is now being seen in the Summary Hospital Mortality Index (SHMI) data, as this data is about 6 months behind HSMR.

The data after these periods show a reduction in hospital deaths during the summer months with a gradual return to normal levels. The HSMR for July 2020 is below the 100 average.

This report sees the increase in Medical Examiner activity as the service starts to roll out across the Trust and death scrutiny takes place. In total, 53 deaths have been reviewed by the Medical Examiners. In Q2 no major issues have been found and this is reinforced by the Structured Judgement Framework reviews carried out, as they have highlighted no avoidable deaths.

3.0 Appendix 1 – Hospital Mortality

This metric looks at the two main national 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 Aug 17 to Jul 20 (current month)
Chart one (as below) shows a longitudinal monthly view of HSMR.

The latest month's data, Jul 2020, has a relative risk of **99.4** and is below the 100 average**.** This is encouraging as hospital actively begins to recover post the first covid wave.

C1

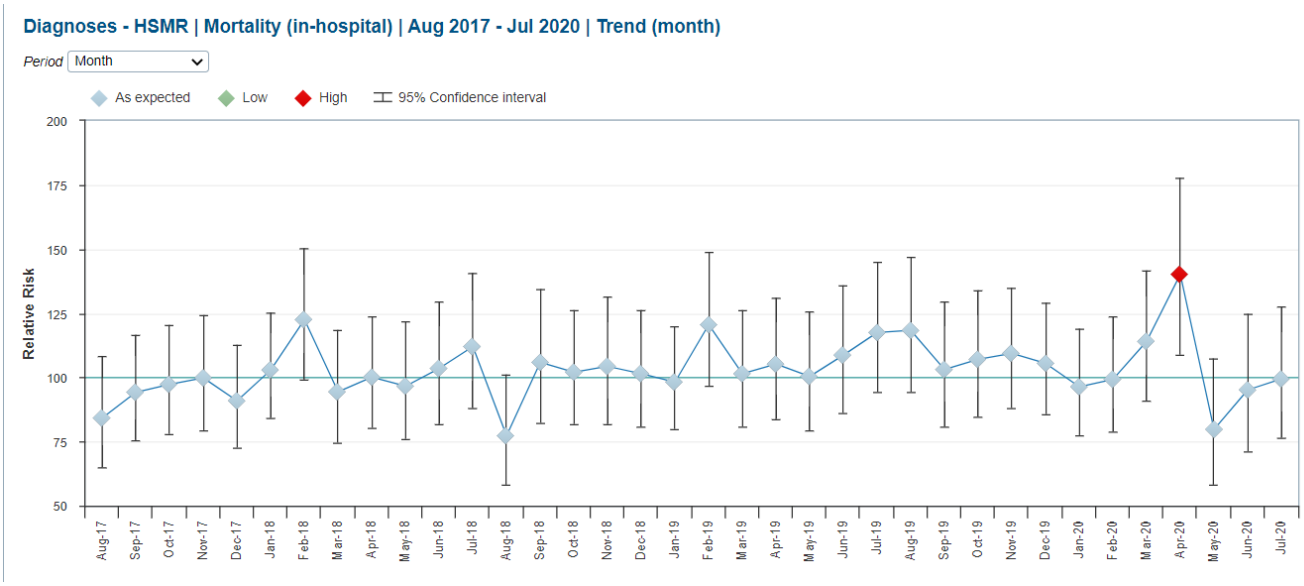


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is above the 100 line but below the standard deviation points. If the data point was above or below these lines, this could signify an issue. This measure is being observed via the Mortality Surveillance Group (MSG)

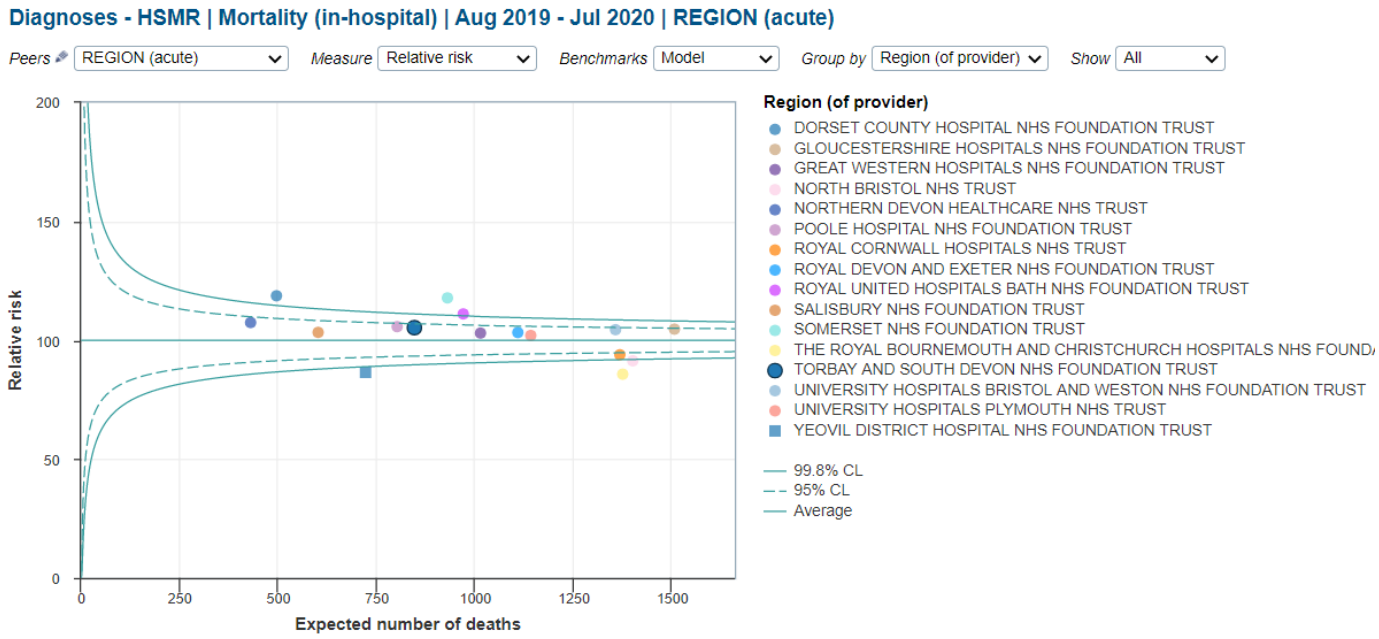
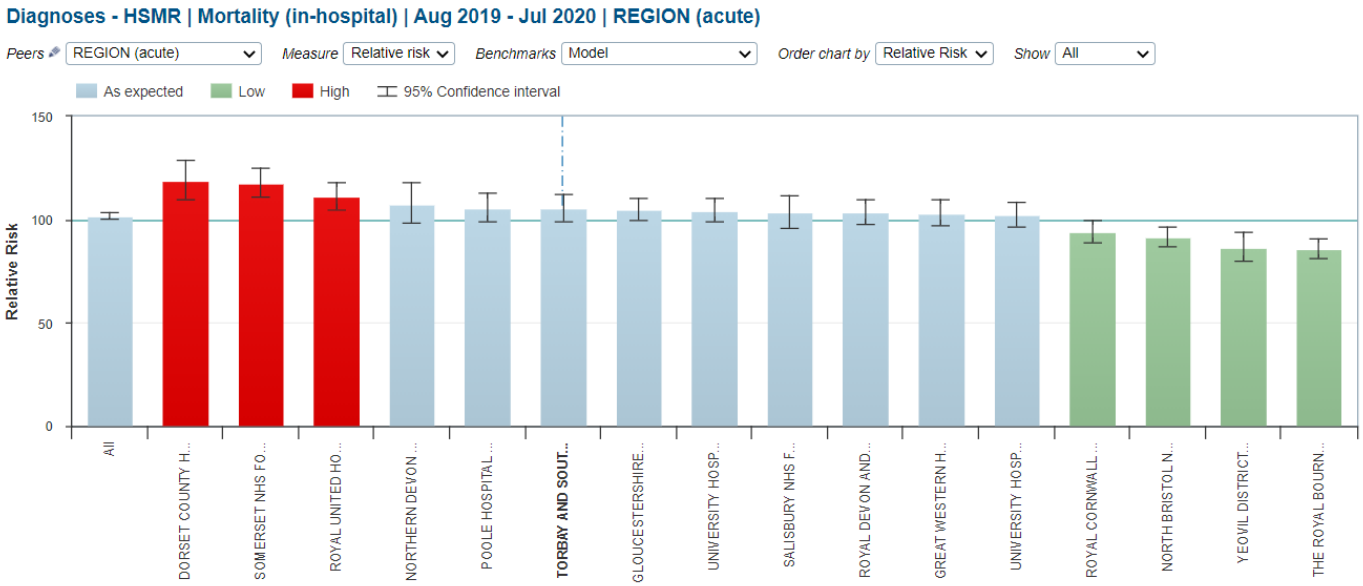


Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart. This remains the same as in the previous report

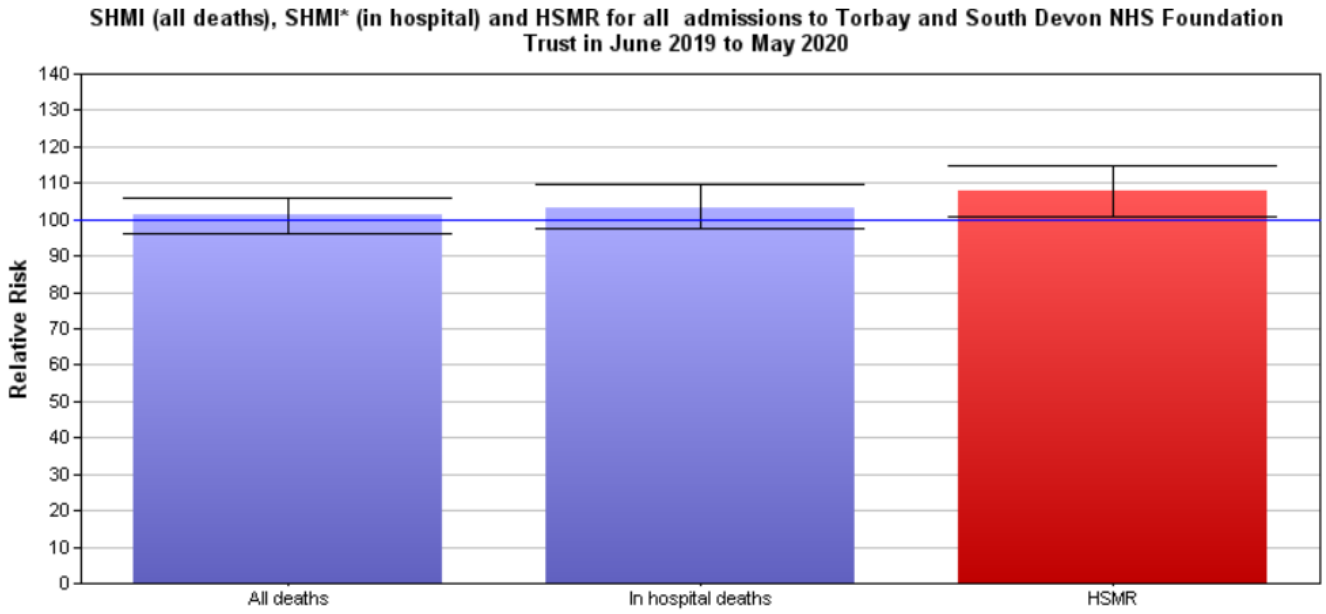


1B Summary Hospital Mortality Index (SHMI) Reporting Period June 2019 – May 2020

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* **June 2019 – May 2020** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarterly periods with all data points within the expected range except the last one, which exceeds the 100 mark. As SHMI is ***so*** retrospective this is now catching up with the Dr Foster data, reported a number of months ago, from the first wave of Covid. In April / May 2020, hospital activity was greatly reduced. This reduction in activity, i.e. the reduced hospital spells pushes up the SHMI as it did with HSMR as the denominator falls. The actual number of deaths rose slightly in April and then reduced thereafter – please see chart 9

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



The SHMI data within chart 6 show the yearly period June 19 – May 20 and highlight HSMR to be running higher than the SHMI, however all deaths remains as expected.

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

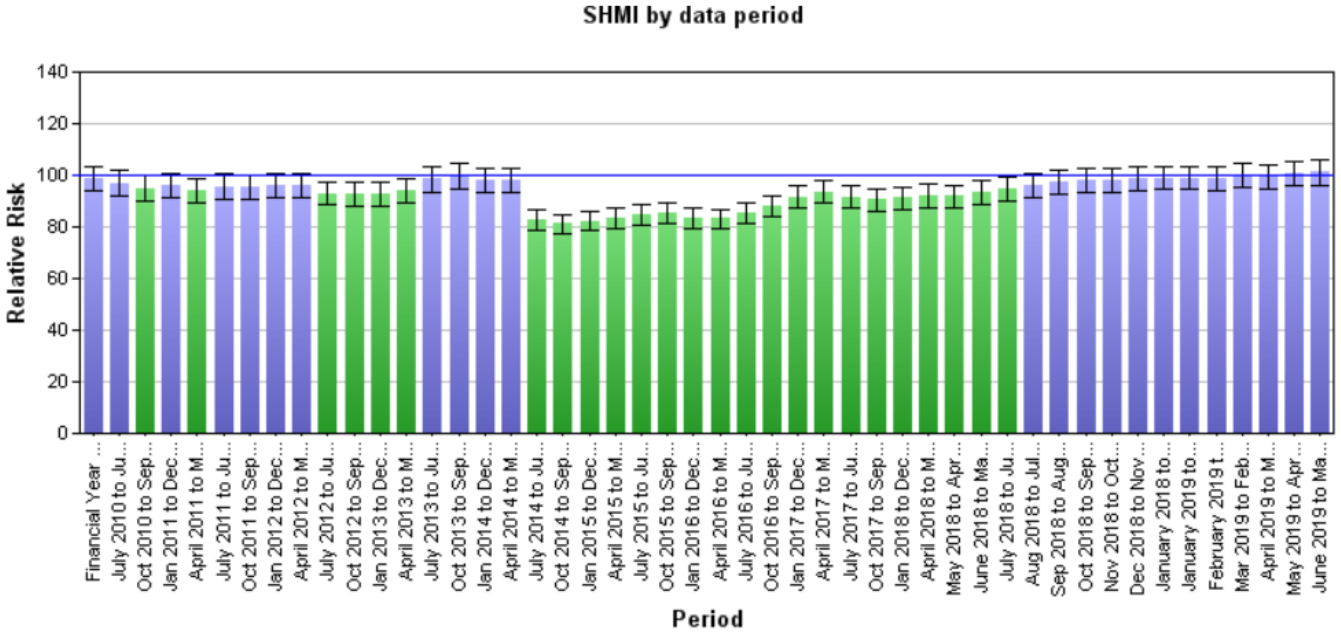
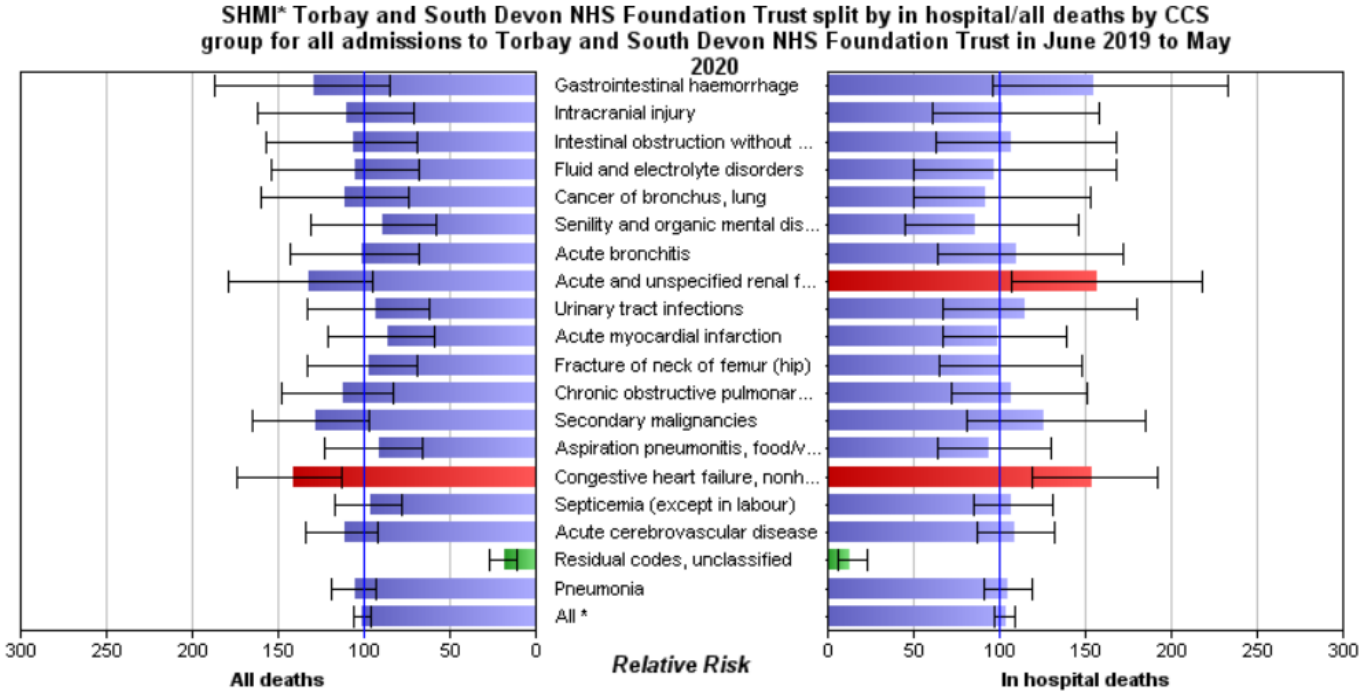


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm* except Congestive cardiac failure, which been look looked at in the past and nil was evident from the data. Acute and unspecified renal failure is a new alert and this will be looked at by coding and reported to the Mortality Surveillance group.



4.0 Appendix 2 – Unadjusted Mortality Rate

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

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

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

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

Chart 8, below, highlights the Trust's 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 lockdown period and highlights a rise in deaths in March and April 2020. The mortality rise in March is partly explained by a reduction in activity due to Covid changes. The mortality rise in April is solely down to reduced activity. In April 2019 we had 3036 discharges (the denominator) and in April 2020 this, due to Covid, 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 from March onward.

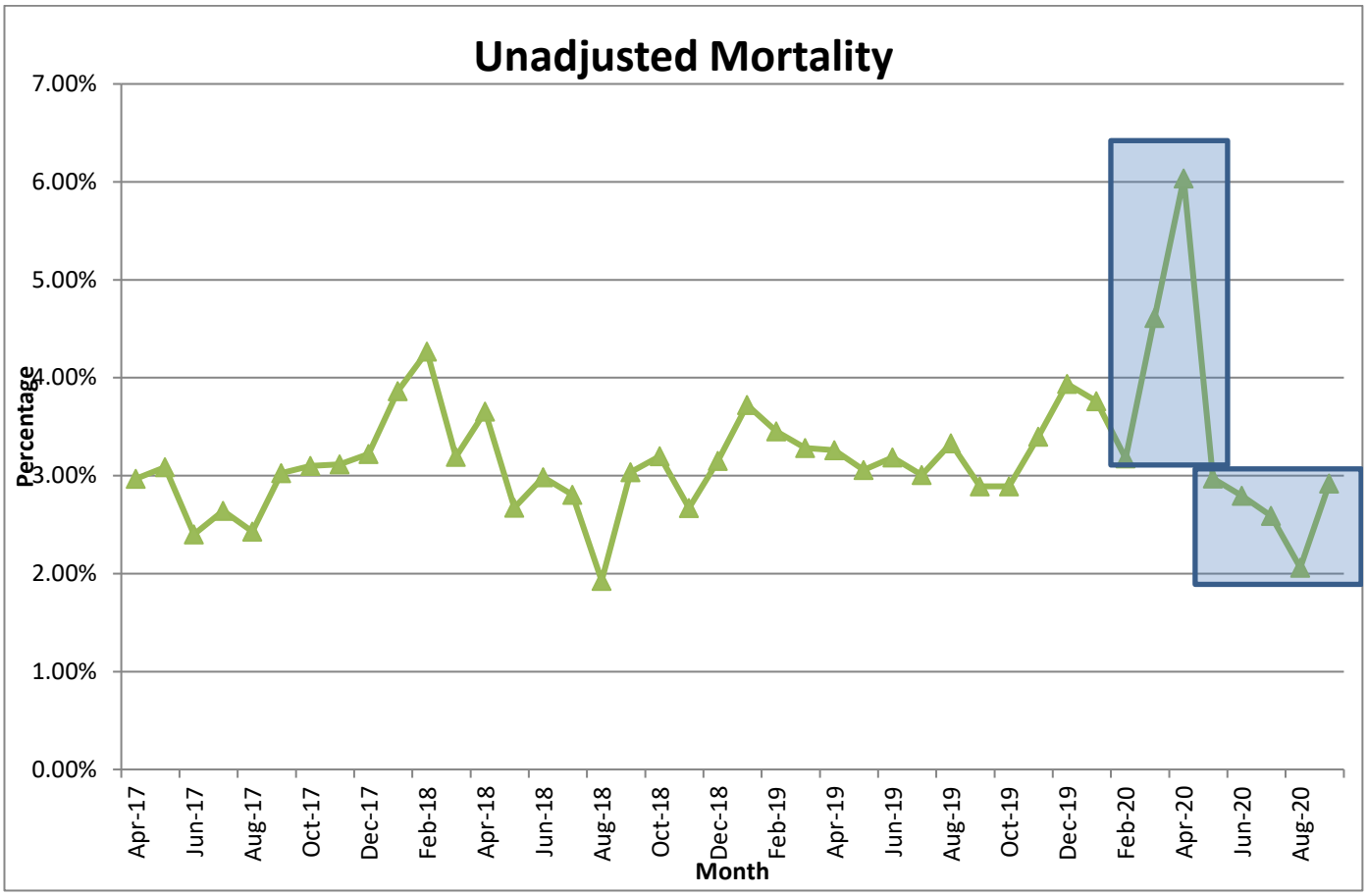


Chart 9 As below, monthly hospital deaths by number. This shows a rise in March and April 2020 due to Covid, before decreasing to very low numbers during Summer 2020.

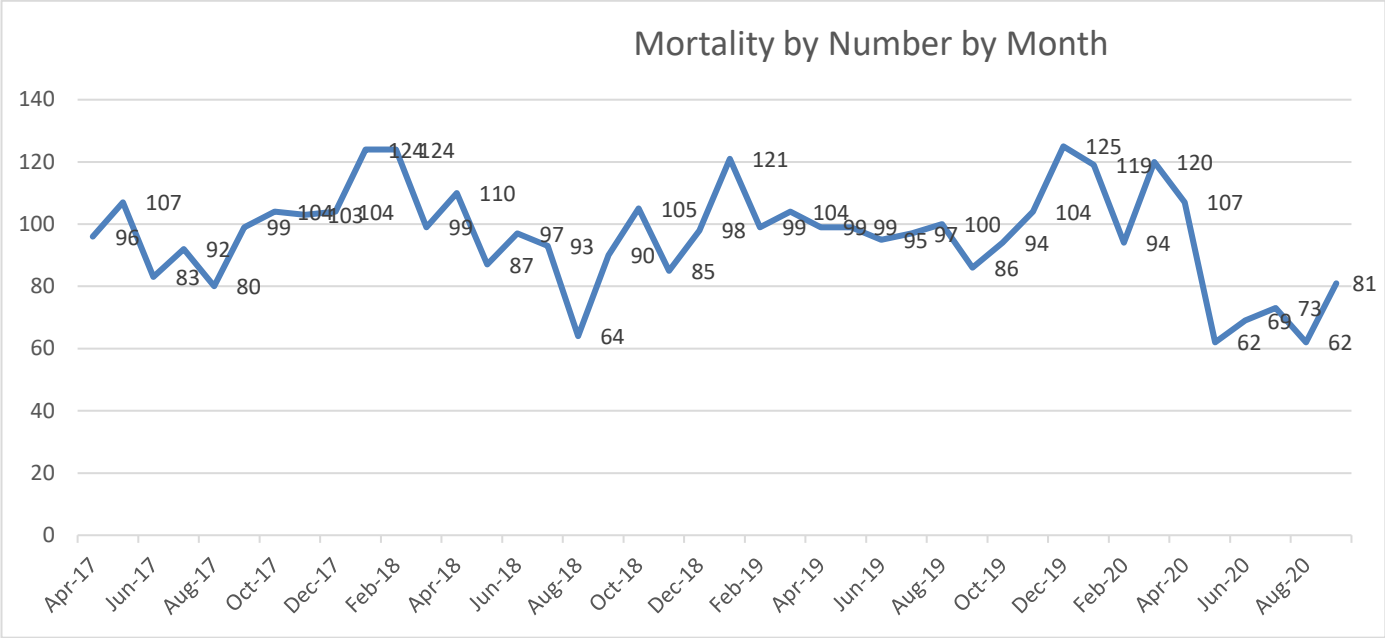


Table 2 – overleaf, looks at location of hospital deaths by area/ward. The data in this chart is as expected for each area will nil showing any deviations or unexpected findings.

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

Row Labels	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	Jul-20	Aug-20	Sep-20	Ave	Sparkline
AINSLIE	2	2	1	2	1	0	1	2	4	1	1	5	2	3	1	5	2	3	0	1	0	2	2	
ALLERTON	6	0	4	7	4	8	4	5	4	3	9	3	7	10	6	6	3	5	4	7	5	3	5	
BRIXHAM	0	0	1	4	1	0	1	0	0	2	1	1	0	1	2	0	1	1	1	0	0	0	1	
CHEETHAM HILL	7	13	18	11	8	11	11	11	11	5	9	8	6	19	3	10	13	9	8	14	7	12	10.5	
CROMIE	6	1	2	5	4	4	5	2	2	4	4	5	6	3	2	3	13	0	1	1	0	1	3	
DART	2	2	2	5	0	3	1	1	1	2	2	2	1	1	0	3	1	0	0	0	0	1	1	
DAWLISH	5	6	3	3	3	2	0	0	5	2	4	0	2	6	4	0	3	0	1	3	1	1	2.5	
DUNLOP	3	6	5	4	7	5	5	4	3	5	7	5	9	8	2	10	4	6	6	3	5	6	5	
EAU3	3	12	5	5	8	1	6	10	13	8	6	7	6	5	6	7	3	3	6	2	4	1	6	
EAU4	8	6	5	5	7	6	8	8	8	3	5	15	11	6	8	13	3	3	5	7	6	11	6.5	
ELLA ROWCROFT	0	1	1	1	0	1	2	1	0	1	0	0	0	1	0	1	3	2	1	0	2	0	1	
FORREST	2	3	5	1	2	0	1	3	1	0	1	2	2	2	1	8	7	4	1	0	0	0	1.5	
GEORGE EARLE	16	17	12	11	11	8	12	9	5	10	7	14	16	14	12	11	6	5	5	7	5	9	10.5	
INTENSIVE CARE UNIT	4	9	6	6	10	10	9	11	11	10	7	10	11	9	8	6	8	7	5	5	8	7	8	
LOUISA CARY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0	
MIDGLEY	10	11	9	14	10	9	9	11	11	9	8	10	17	12	9	7	4	8	11	10	3	13	10	
SIMPSON	8	10	9	7	10	6	6	7	10	8	6	2	12	5	6	13	5	2	4	7	4	7	7	
TEIGN WARD	2	3	1	2	1	3	3	2	2	1	2	0	1	1	1	3	5	1	5	5	2	3	2	
TEMPLAR WARD	2	2	1	1	0	1	2	1	2	3	5	4	6	3	6	2	8	2	1	0	4	0	2	
TORBAY CORONARY CARE BEDS	1	3	0	2	1	1	2	0	0	1	1	4	1	0	2	4	2	0	2	1	3	0	1	
TURNER	10	8	6	2	8	9	5	7	6	7	7	6	8	6	8	5	1	0	0	0	2	4	6	
WARRINGTON	1	5	3	6	3	10	2	2	0	0	0	0	0	4	6	2	7	0	0	0	1	0	1.5	
Grand Total	**98**	**121**	**99**	**104**	**99**	**99**	**95**	**97**	**100**	**86**	**94**	**104**	**125**	**119**	**94**	**120**	**107**	**62**	**69**	**73**	**62**	**81**	2.75	

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, acute and unspecified renal failure and intestinal infection are being looked at by coding in the first instance.

Table 3

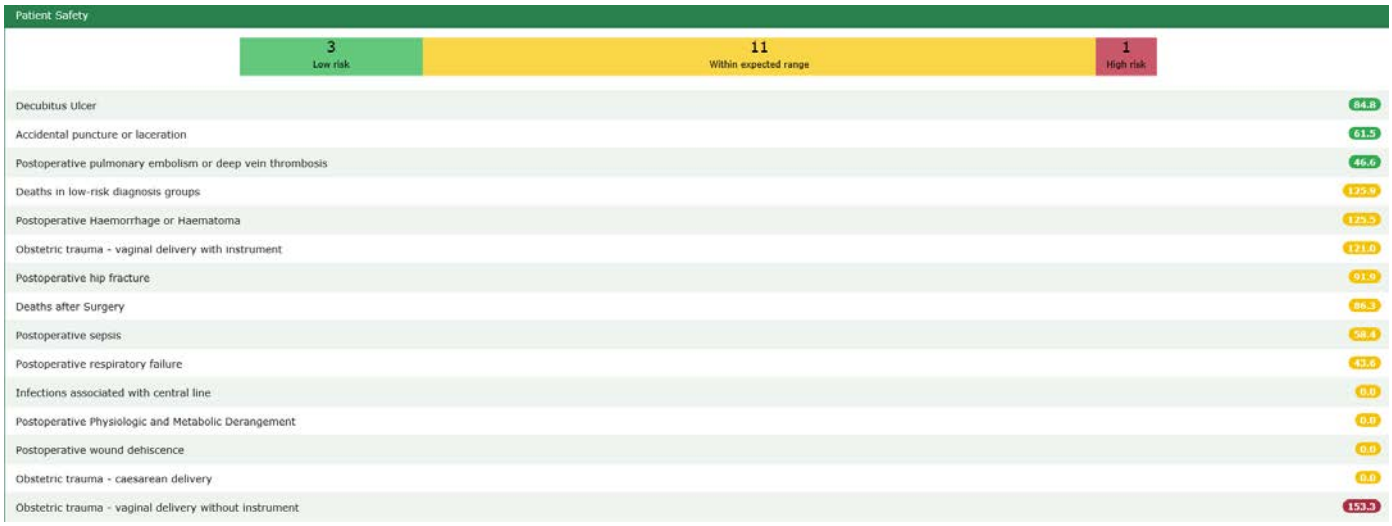
Title	CUSUM	Vol	Obs	Exp
All Diagnoses	7	69178	1121	1134.1
HSMR (56 diagnosis groups)		26455	894	848.9
Acute and unspecified renal failure	1	216	35	22.9
Alcohol-related mental disorders	1	157	2	0.5
Essential hypertension	1	70	1	0.1
Intestinal infection	1	609	17	8.5
Intrauterine hypoxia and birth asphyxia	1	4	1	0.0
Other congenital anomalies	1	33	1	0.1
Other psychoses		125	6	1.7
Pulmonary heart disease	1	176	5	8.2

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 13 Nov 2020, 11 indicators are within the expected norm with 3 are in the low risk category. 1 is in the high-risk category and Coding are looking to identify the records to assess the rationale for inclusion.

Table 4



7.0 Appendix 5 - Mortality Reviews

Number of deaths of a patient with a 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 Q2 we sadly had one death which has been referred for review.

The Trust received feedback on two prior reviews which found the care provided to be of a high standard and nil learning identified

Number of Neonatal, Perinatal, and Maternal Deaths
During this reporting period (July – Sept 2020), we have had no stillbirths nor neonatal deaths. Sadly, we had one late foetal loss, at 22 weeks and 2 days where spontaneous labour occurred.

Number of deaths in which complaints were formally raised by the family
The Trust has received 2 complaints. These involve end of life (EOL) issues and this case has been shared with the EOL group concerning breaking bad news and NG tube insertion and a case involving limited contact regarding a patient deterioration during Covid.

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 service formally began to scrutinise mortality in July 2020 and during Q2, the Medical Examiners have now reviewed 53 deaths and have found many examples of good practice. None have been referred to the Mortality Surveillance group.

Mortality reviews
During Q2 of 2020/21, 47 Structured Judgement Framework (SJF) reviews have taken place. Of those reviewed **nil** scored 1, which would have indication an avoidable death.

Learning from Inquests
During Q2 of 2020/21 there have been 2 Coroners inquests recording a narrative verdict and nil actions for the Trust. The Trust has no outstanding Regulation 28 reports.

Trust learning

Key Issues	Learning and actions taken
Treatment / Diagnostic learning Delay to follow up incidental findings on a Chest x-ray	 Shared with teams and Radiology. The Director for Patient Safety is leading a piece of work, along with Radiology, on incidental findings which is reporting into the Quality Improvement Group.
Communication Ensuring phone information is backed up with email or written letter Ensuring regular contact is given if visiting is restricted	 Use of communications video at Dr induction Point of contact for the ward – regular phone calls,
Documentation Dating, signing issues with documentation	*In all cases an investigation is undertaken and the teams are involved in the RCA, learning and sharing*

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: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			**Date:** 25th November 2020
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Dr Edward Berry, Consultant in Emergency Medicine and GOSWH		
Report provenance	Executive Directors' Meeting – 17th November 2020		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The Board is asked to note the report for information.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Guardian of Safe Working Hours – Doctors and Dentists in training	**Meeting date:** 25 November 2020
Report sponsor	Medical Director
Report author	Dr Ed Berry, Consultant in Emergency Medicine and GOSWH

1. Executive Summary

The following report concerns the time period of 21st of May 2020 up to the 13th of November 2020 based on the Exception Reports submitted by the Junior Doctor workforce.

- There are no surge rotas in current use. There are ongoing discussions regarding the potential relocation of Junior Doctors to prepare for increased COVID 19 workload.
- There are a large proportion of ERs from the F1/2 general surgical rota. This is under investigation but is potentially a result of poor reporting elsewhere rather than a failing rota.
- Every exception report completed more than 28 days previous to the 13/11/20 has been completed as per local agreement.

There remain significant cohorts of Junior Doctors who are not represented in Exception Reports; this missing data makes spotting patterns difficult. This has previously been reported to the Board and the GOSWH has implemented a number of innovations to encourage reporting and to make pre-authorisation of additional hours an option.

2. Introduction

- In July 2019 an agreement was reached between NHS Employers, the BMA and Department of Health on the amendments to the 2016 terms and conditions for doctors in training. The agreement covers the period from 1 April 2019 to 31 March 2023.
- The new terms were introduced in August 2019 with a phased implementation to include changes to new limits of working hours and safeguards on rest
- The following report aims to ensure Junior Doctors are working contracts compatible with the Junior Doctor Terms and Condition of Service 2016, that are sustainable and fair and that they are able to claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities or complete career enhancing objectives.

3. Exception Reports

There have been 32 Exception Reports in the period 21 September 2020 to 13 November 2020. This remains lower than similar periods in 2018 and 2019. This is partly likely to represent junior doctor professionalism and good will during the coronavirus pandemic. This is the third consecutive quarter that I have reported less ERs than expected so hopefully this represents a junior workforce that is happy and content with their rotas and job plans.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Acute medicine	2	2	0	
General Medicine	4	4	0	
General Surgery	24	17	7	The outstanding are less than one month old
Paediatrics	2	1	1	The outstanding ER is less than one month old
Total	32	24 (75%)	8 (25%)	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	25
F2	4
CT1-3	3
ST 4-9	0
Total	32

Table 3 – Nature of Exception

Additional Hours	28
Educational	2
Rota Concern	2

The specific theme from this quarter is that a large number of the exception reports have been submitted by junior doctors on the general surgical rotation. This is currently under investigation. It is also important to recognise that in previous quarters 24 ERs would represent an average number for a large rota. Therefore this may represent a paucity of reports from other rotas rather than a failing rota.

The overall number of exception reports remains extremely low. This makes patterns of exception reporting difficult to interpret. This quarter only 11 junior doctors filled out an exception report. If a rota contains a doctor correctly exception reporting, as per their contract, then this rota will automatically represent an outlier. This may explain the surgical rota this quarter.

Table 4 – Outcome of Exceptions

TOIL	4	The high number of payment outcomes is secondary to last quarter's implementation of a 28day limit to exception reports. At this point I completed the Exception Report and awarded payment. This represents 11 individual outcomes.
Payment	20	
No compensation required	0	
Agreed no further action required	1	
Outstanding	7	All within 28/7.

4. Comment on Exception Reports

There are low numbers of Exception Reports but 75% have been actioned. This represents 100% of Exception reports older than 28 days. It is a significant improvement in ER completion but is reliant on myself as GoSWH completing a number of the ERs (11/32). The fraction of ERs I have completed has decreased this quarter but probably represents natural variation around the mean given that the number of ERs over the last two quarters has been extremely low.

5. Rota Reviews

Rota reviews have been carried out by Practice Managers Reports working alongside Medical HR on every Junior Doctor rota as mandated by the development of the coronavirus pandemic. With hospital numbers of COVID 19 patients increasing there have been discussions between hospital management and the JDRC about the relocation of junior doctors onto at risk rotas, such as the nighttime medical on-call rota.

Any relocations are being performed within the framework of the Junior Doctor Contract and guidance produced by the British Medical Association.

The F1/F2 general surgical rota is currently under review but is compliant with the BMA Junior Doctor Contract.

6. Fines

There have been no Guardian fines for this period.

7. Qualitative Information

It is important to appreciate the complexity of the mandated reporting system. In order to receive TOIL or payment the current process requires the Junior Doctor to submit an exception report, have it signed by a clinical supervisor/lead, meet with a rota manager to agree TOIL/payment, submit a timesheet and log back into Allocate (the Exception IT System) to sign off the Exception report as complete.

8. Issues Arising

- TOIL/payment difficulties: The current process requires an on-line exception report and a paper submission for hours/TOIL. The duplication of work makes it more difficult to arrange payment. The time taken to complete the various discussions to get TOIL makes it unlikely an appropriate time can be found before the end of the rotation. TOIL cannot be taken forward onto new rotations.

8. Actions Taken to Resolve Issues

- Electronic exception reporting i.e. supervisors completing exception reports on Allocate without a meeting. Reducing the need for face to face meetings and including a maximum time for response (four weeks) and a default sign-off by the GoSWH (after four weeks, or at the end of a rotation). This has brought Torbay in-line with other local Trusts and the Junior Doctor contract. In this quarter 11 such inputs were required.
- TOIL/payment difficulties: The process for achieving TOIL/Payment against an Exception Report needs to be reviewed and if possible simplified. We are currently waiting for Medical HR to inform us about simplifying the process. Current IT systems are unable to calculate out of hours enhancements and are therefore unlikely to offer a solution. This remains in discussion.
- Lack of clarity for supervisors: the new contract has raised issues, such as TOIL for Quality Improvement Projects or ARCP preparation, which have no current local precedent. There is a local agreement that TOIL for non-clinical activity needs to be pre-agreed with supervisors.

9. Summary

Overall, all departments appear compliant and supportive of their Junior Doctors.

Junior Doctors, workforce practitioners and rota coordinators continue to show admirable flexibility, professionalism and diligence in the face of the COVID pandemic and Junior Dr Contract changes.

The priority for the coming quarter is to ensure that Junior Doctors being relocated from their expected rotas are consulted and supported through their new rotations.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Research and Development Annual Report			Meeting date: 25th November 2020
Report appendix	N/A		
Report sponsor	Medical Director		
Report author	Director of Research and Development		
Report provenance	Executive Directors' Meetting – 17th November		
Purpose of the report and key issues for consideration/decision	This report provides a summary of the Trust's activity, performance and delivery against Government metrics (KPIs) set for R&D in the NHS; as part of the National Institute for Health Research (NIHR) contracts / DHSC Research Strategy and agendas, including the impacts of covid. This report covers the 2019/20 financial year and also up to Q2 20/21 status.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Research and Development Annual Report		Meeting date: 25th November 2020
Report sponsor	Medical Director	
Report author	Director of Research and Development	

1.0 Introduction and background:

The R&D Department is responsible for overseeing all research activity in the organisation, with staff and expertise to support and facilitate research studies, clinical trials delivery, research advice, research governance & regulatory affairs.

1.1: Why is research important?

Research is shown to significantly contribute to improving quality, safety, patient care and outcomes. Research also brings many direct and indirect financial benefits, alongside positive staff and patient experiences too.

R&D is a core NHS business (NHS Constitution); a statutory requirement under the Health & Social Care Act 2012 and more recently is now part of CQC well led inspections.

CQC Well led: The basis and foundation of effective care is good research. In every core service the CQC inspect there are likely to be patient care provisions that were introduced on the basis of clinical research - because essentially, today's approach to treatments is a consequence of yesterday's research.

Good evidence shows that trusts which incorporate a higher level of research activity have better patient outcomes regardless of whether they are research participants.

Research should no longer be seen as separate to operational delivery as it is now a key part of improving patient care.

The CQC look at three Levels:

- **Research equity** – *how does the organisation support the research programme across the breadth of its services?*
- **Research facilitation** – *how does the organisation proactively support the delivery of research from board level to the clinical setting(s)?*
- **Research awareness** – *how does the organisation make research opportunity known to patients, the public and healthcare professionals?*

Examples of research related questions include:

- Are divisional staff aware of research undertaken in and through the trust, how it contributes to improvement and the service level needed across departments to support it?
- How do senior leaders support internal investigators initiating and managing clinical studies?
- Does the vision and strategy incorporate plans for supporting clinical research activity as a key contributor to best patient care?

- Does the trust have clear internal reporting systems for its research range, volume, activity, safety and performance?
- How are patients and carers given the opportunity to participate in or become actively involved in clinical research studies across the trust?

Additionally, there is also now a research access question included in the CQC Annual In-Patient Experience Survey: ***"During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?"***

1.2: Activity and contracts:

Research in England is driven by the National Institute for Health Research (NIHR) the research arm of the Department of Health and Social Care (DHSC); working through Clinical Research Networks (CRNs) to provide a unique opportunity to widen participation within research and help improve and reshape practice with evidence.

The Trust is a partner in the NIHR South West Peninsula CRN (SWP: CRN) and is commissioned and funded separately to patient care by the NIHR; to provide a clinical trials delivery service locally for NIHR studies; in line with relevant national R&D strategies and policies and the NIHR Performance and Operating Framework contracts. The local CRN is a devolved model and makes a contribution to purchase Trust research management & governance expertise, advice and services.

The Trust's primary research business centres around hosting (participating) in multicentre national and international commercial and non-commercial clinical trials (>90% of our overall business), sponsored by other organisations; mostly adopted by and part of the National Institute of Health Research Clinical Research Network (NIHR CRN) portfolio.

In addition, R&D supports a small level of own account research activity, Trust led (sponsored) studies, mostly fund via the local charity: The Torbay Medical Research Fund (TMRF). R&D also support staff and external researchers involved with projects as part of educational studies (undergraduate and postgraduate (Masters and PhDs).

R&D currently has a portfolio of 454 studies across over 33 specialities:

Open recruiting studies	118
Recruitment complete and in follow up	53
Suspended / under review to RESTART	31
In set up	34
Closed & FU complete but not archived yet.	218

1.3: Covid-19 Research:

Since March 2020 research; like all other parts of the Trust and the NHS has been impacted by the covid pandemic. Appendix 1 provides a more detailed summary on our work and contribution as part of our response to the covid-19 pandemic. In summary:

- Whilst most non covid research was paused during the first wave, covid-19 research has had an opportunity to make a real impact at scale and pace locally, nationally and globally.
- During the first wave, most research activity other than Urgent Public Health (UPH) covid-19 research and cancer research was paused to release staff to support this activity as well as non-research activity and as the Trust stood down activity.
- During this time prioritising research and gaining the support, involvement and engagement throughout the organisation was a refreshingly positive experience with everyone coming together to serve a common goal and showed a true collaborative spirit.

- The R&D team has worked hard and tirelessly to maximise Torbay's opportunities to access studies, supporting the clinical teams so we can play our part in this crucial national UPH covid-19 programme with currently 10 studies open to recruitment and more in set up.
- Torbay consistently had the highest conversion rate of those admitted with COVID being offered and enrolled in one of our studies across the region.
- The next big focus is on trialling the vaccines in development. Torbay was asked to stand up and make operational plans to deliver a vaccine study from early November but we had to withdraw / were stood down as the sponsor was unable to activate our site in the remaining recruitment timeframes. Instead we are currently listed provisionally for a new vaccine study commencing January 2021.
- The financial impact and risk to research is significant due to loss of activity and as a consequence loss of research income and grants. This has been raised with DHSC.
- Over the summer like the rest of the NHS we have been working hard to RESTART our paused research activity and look to take on new activity too, as well continuing to support the expanding covid research studies which is a challenge.
- We are now in the grips of a developing 2nd wave but this time is different. We all now have competing priorities as the NHS tries to maintain and continue all services as best as possible. In R&D the same applies: The ask is that while we must prioritise UPH covid research; especially the interventional studies, we must also continue to support non covid research too and prepare also to support large scale vaccine trials.
- Capacity and capability is an issue for R&D as with many other sectors of NHS business; with competing priorities for staff, time, labs, radiology and clinic space etc.
- The research programme has provided new effective treatments which are benefiting patients now reducing the death rates compared to the first wave. Research is fundamentally our only effective route out of this pandemic so it is imperative the UPH studies are prioritised and all Trusts support to their best ability.

What's next for Health Research?

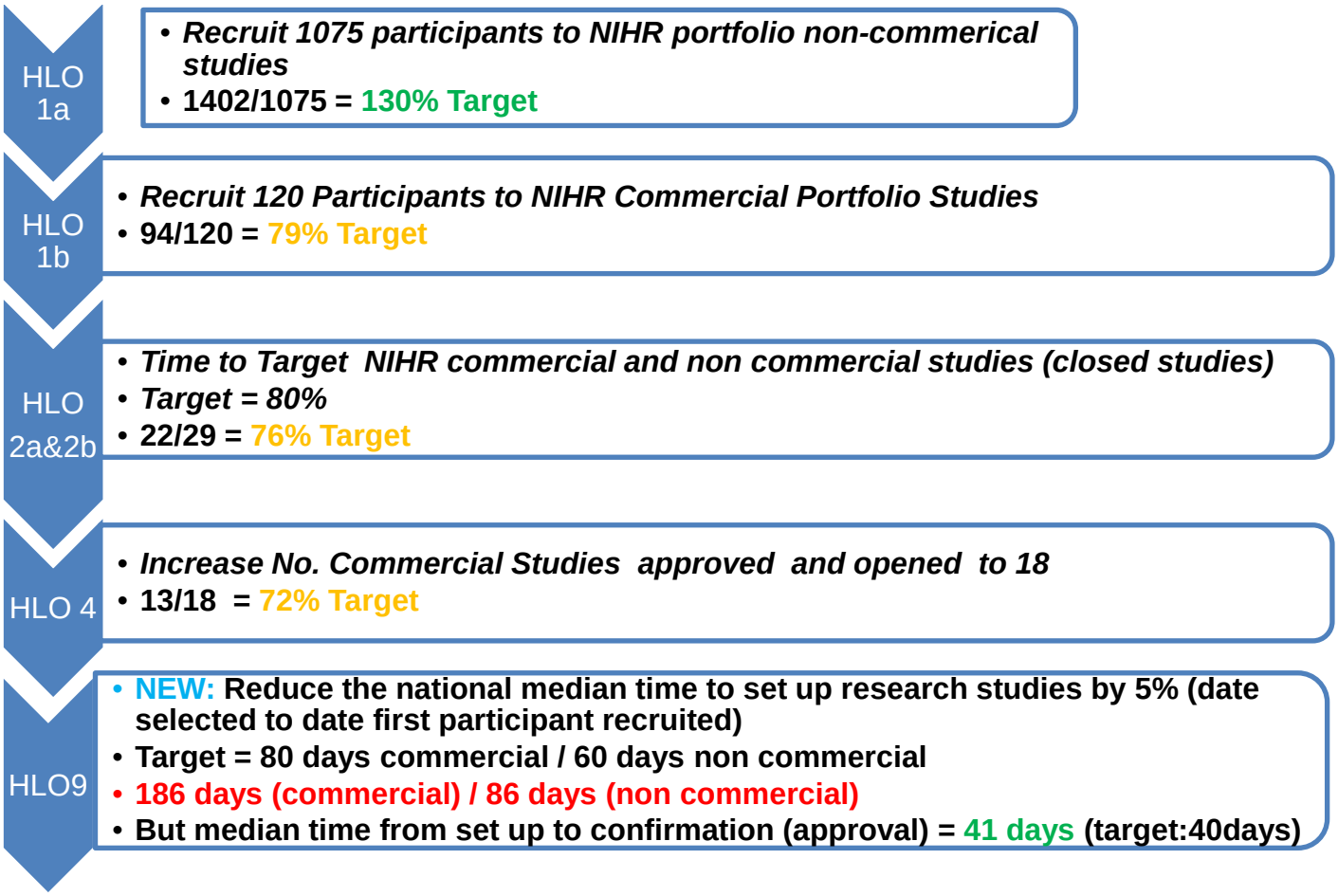
Reflections on how we can maximise the benefits and lessons learned from research during COVID-19, which despite all the progress made; relies still on the value research plays to our organisations. The collective view by key opinion leaders are *'that the most important and transformative intervention would be to make use of individual and organisational drivers to enable the behaviour change needed for clinical research to become business as usual across the health and care system."*

2.0 Summary of activity and performance:

2.1: NIHR Clinical Research Network contract: Key Performance Indicators (KPIs) / High Level Objectives (HLOs):

- In 2019/20 we met our recruitment target (130%); recruiting 1402 participants and improved on delivery to time and to target metrics. We fell slightly short of hitting the number of new commercial studies approved, although we had secured selection for at least a further 9 commercial studies which were still at various stages of set up.

- There is scope for improvement in the new study set up metric. This was changed in 2019/20 in response to improving the time taken to recruit the first patient. However, meeting this metric is very dependent on eligibility, screen failure rates and patient wishes as well as operational issues such as staffing, equipment, processes, supporting services etc. All of these factors will need careful monitoring and assessment to monitor and progress improvements.



- **2020/21:** Due to covid, the NIHR HLOs have been suspended and do not form part of our formal performance monitoring. New HLOs have been implemented instead as part of a revised NIHR performance and operating framework:

  - **New Commercial studies - Time to target (T2T)** = 70% (New' indicates opened on or after 1 April 2020 and closed to recruitment on or before 31 March 2021).
  - **UPH Study site set-up time:** Target = 9 working days as all are expedited (selection to confirmation / approval). The Ambition value was determined by experience setting up Urgent Public Health Studies earlier in this reporting year, under two working weeks being both ambitious and feasible. Current median set up times = **8 days**.
  - **RESTART metrics:**
    - A) Percentage of paused commercial contract studies that are no longer paused at 31 March 2021 (Ambition value 80%. The denominator, the number of 'Paused' studies, is the number of studies recorded by the CRNCC as 'Paused' on 18 May 2020. 'No longer paused' implies an update to the study status from 'Paused' to another status)
    - (B) Percentage of paused non-commercial studies that are no longer paused at 31 March 2021 (Ambition value 80%. The denominator, the number of 'Paused' studies, is the number of studies recorded by the CRNCC as 'Paused' on 18 May 2020. 'No longer paused' implies an update to the study status from 'Paused' to another status)

  Current data shows we are on track to meet this target.

2.2 Sponsored / Trust led activity and Research Grants:

Torbay Medical Research fund (TMRF) – a local independent charity.

Project Title	Applicant	Amount Awarded
Treating Crohn's disease with a whole-food dietary intervention	Dr Alan Desmond	£39,989
Point of care measurement of faecal nitric oxide production for the diagnosis of bacterial gastroenteritis –phase 2: development of sample pot and quantitative analysis for prognosis.	Dr Kyle Stewart	£41,032
Doctoral and pre-doctoral fellowship for nurses, midwives and allied health professionals. Funding to support two fellowship programmes with 1 fellowship for each programme over a period of three years: A Partnership between TMRF / University of Plymouth/ TSDFT: Awarded • Kathryn Bamforth, part time PhD fellowship (starting on October 1st 2019) • Harriet Hughes – part time pre-doctoral training fellowship. (starting tbc) • 2nd tranche appointed in summer 2020 - TBC	Prof Jane Viner	Pre- doctorate 1-3 year programme:£42,987 Post doctorate 6-8 year programme:£207,265
Investigating the prevalence of primary hyperaldosteronism in patients with hypertension and newly diagnosed obstructive sleep apnoea in a UK population.	Dr Mark Gilchrist	£31,220
Evaluating the impact of the implementation of patient information videos into cardiology clinical pathways of care with respect to health economics and patient experience.	Dr Phil Keeling	£9,273

N.B TMRF has not meet between January – October 2020

National NIHR grant application - collaborative bid with University of Plymouth

Building on Torbay's Researcher in Residence' (RiR) model and their work evaluating our changing models of health and social care as an Integrated Care Organisation (ICO) where 'prevention' is a high priority. This model is gaining more interest and traction using mixed methods evaluation as a better fit with the new DHSC research priorities looking at public health, social care, service delivery and organisational change research. Strong partnerships have been developed resulting in:

- Establishment of the Peninsula Adult Social Care Research Collaborative (PARC) - submitted a £2.5M grant proposal in response to a NIHR Social Care commissioned call: Successful stage 1 application and invited to submit a stage 2 application. Awaiting the outcome.

NIHR / HEE Fellowships / Internships:

2019/20

- Sarah Pavior, Physiotherapist - HEE/NIHR ICA Pre-doctoral Clinical Academic Fellowship 2019 - with University of Exeter (£51, 096) – Awarded and starting October 2019
- Jennifer Williams, Podiatrist – HEE/NIHR PCAF Pre-doctoral Clinical Academic Fellowship 2019 - with University of Plymouth (£51, 096) – Awarded and starting January 2010.
- Justine Tansley, Podiatrist – HEE/NIHR PCAF Pre-doctoral Clinical Academic Fellowship 2019 - with University of Plymouth – not awarded / unsuccessful.

2020/21

- Justine Tansley, Podiatrist – HEE/NIHR PCAF Pre-doctoral Clinical Academic Internship 2020 - with University of Plymouth. Awarded - 6 months starting September 2020 (£9,906).

Previously awarded NIHR Clinical PhD Studentships / Fellowships – progress report

- Richard Collings, podiatrist: Awarded (£270,033) as part of a NIHR Clinical Fellowship in 2017/18 – completing his part time PhD with the University of Plymouth looking at 'Reducing Foot Plantar Pressure (ReFPres) in people with diabetes using an instant insole solution: a mixed methods pilot study'. Completed recruitment and currently writing up papers and his thesis.
- Rachel Rapson, Physiotherapist: Awarded £319,952.00 during2018/19 as part of a NIHR Clinical Fellowship to study for a PhD part time with the University of Plymouth looking at 'A novel interactive dynamic training device to improve walking ability and quality of life for children with cerebral palsy: A mixed methods study'. The study has received regulatory approvals but has been paused due to covid.

NIHR regional CRN Fellowships: awarded by the Clinical Research Network South West Peninsula (CRN SWP) to part-fund Nursing, Midwifery, AHP (NMAHP) fellow roles to support current portfolio delivery as well as supporting where appropriate the development of future portfolio studies or gaining the skills to do so.

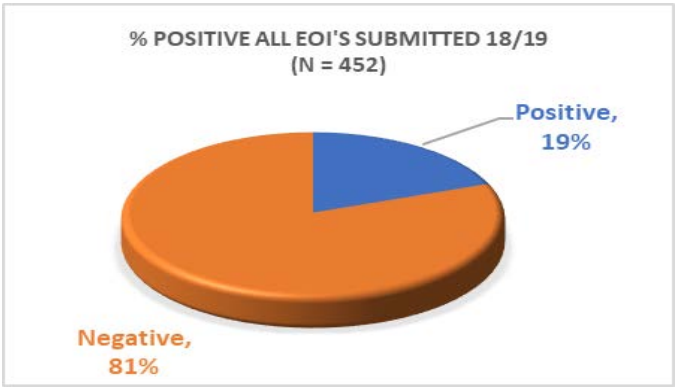
- **2019/20: none**
- **2020/21:**
    - Angela Foulds, research nurse 1-day week for 2 years - Sept 1st 20202-August 31st 2022
    - Abi McWhinney (Community midwife): 1 day a week for 6 months – October 2020-March 2021.
    - Rebecca Stride (CT Radiographer): 1 day a week for 12 months - October 2020-October 2021

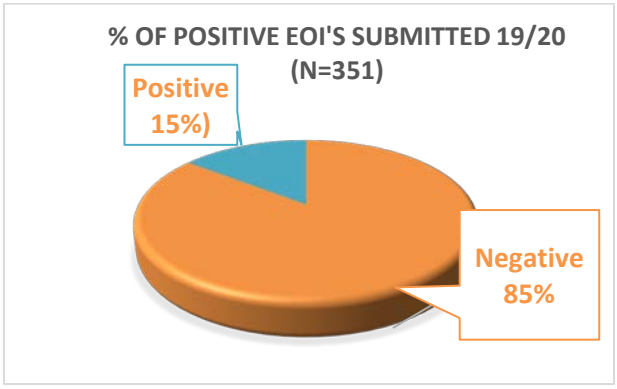
The in-house fellowship programme mentioned above is a partnership between the Trust / UoP Clinical Schools and the Torbay Medical Research Fund. It aims to compliment the CRN, NIHR, HEE programmes to support more pre-doctoral and PhD applications to increase locally opportunities to developed talented staff to be the clinical academics or senior clinical leaders of the future with research training and expertise integral to their roles to lead on and support research in action, quality and improvement.

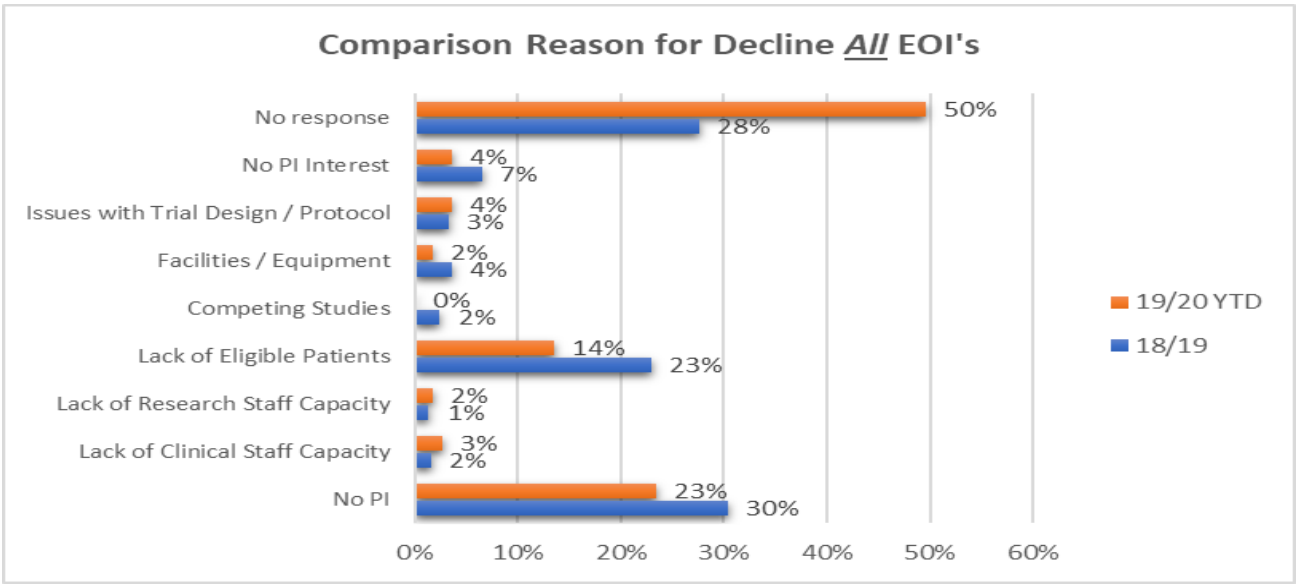
2.3 Hosted research activity (led by other organisations where the Trust participates)

2.3.1 Potential new studies (business): Expressions of Interest (EOIs):

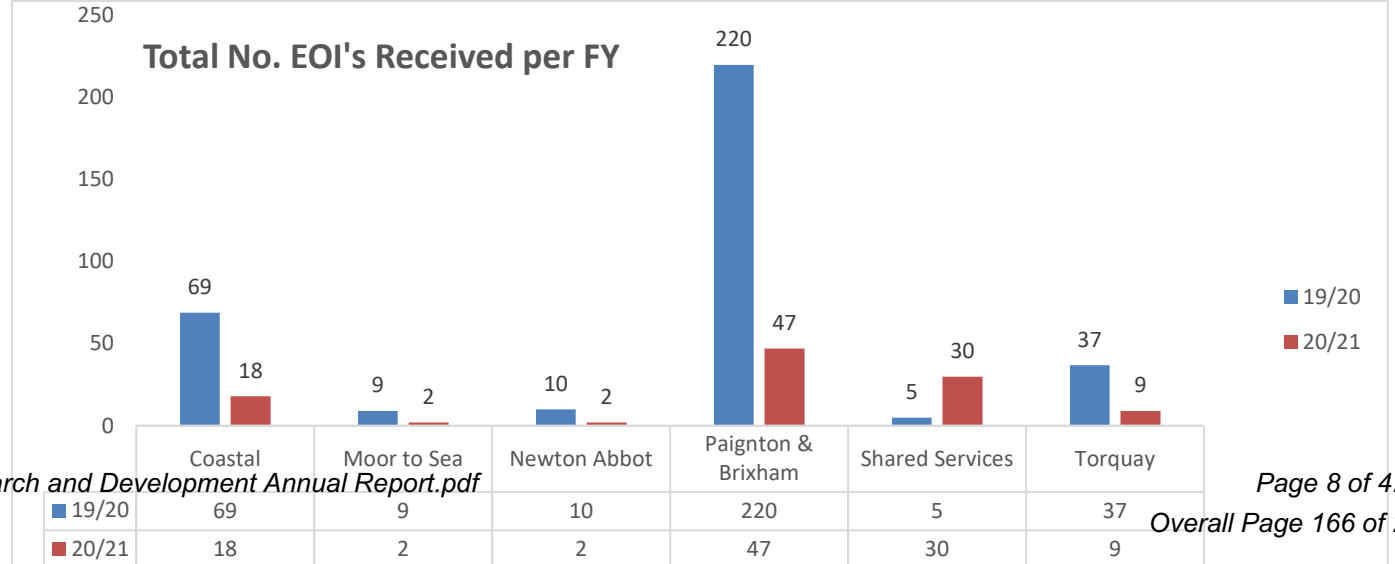
In 2019/20 we had a fewer number of EOIs in total and our positive response rate as part of bidding for potential new studies (business) declined from 19% to 15%. Excluding the lack of eligible patients, the main reason we are turning down studies is fundamentally due to a lack of response from and a lack of investigators (PIs); due to lack of time, operational pressures, capacity, interest, culture (i.e. seen as not part of core business but something extra), lack of recognition and appreciation at ISU level; amongst peers and managers; not included in job plans and difficulty in succession planning. Unless this problem can be address this will remain one of the key limitations to increasing activity and is a risk for continuing activity.

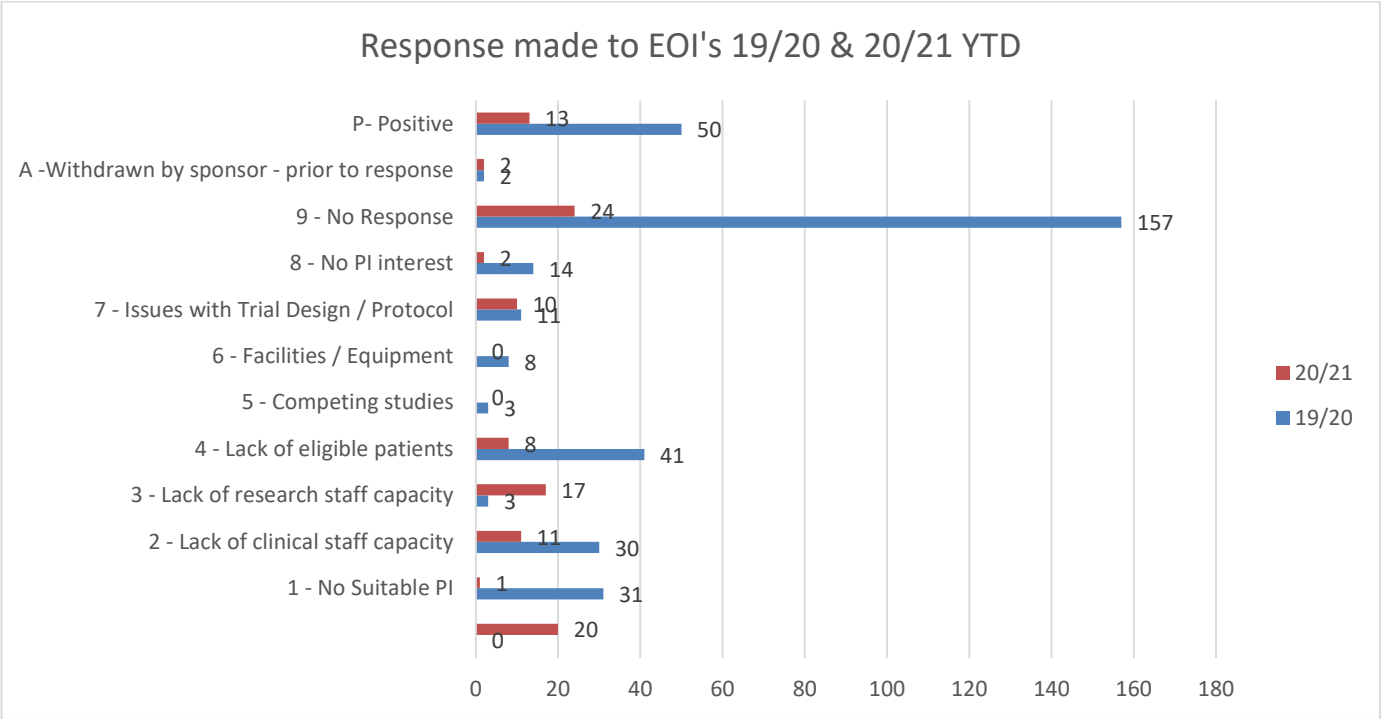






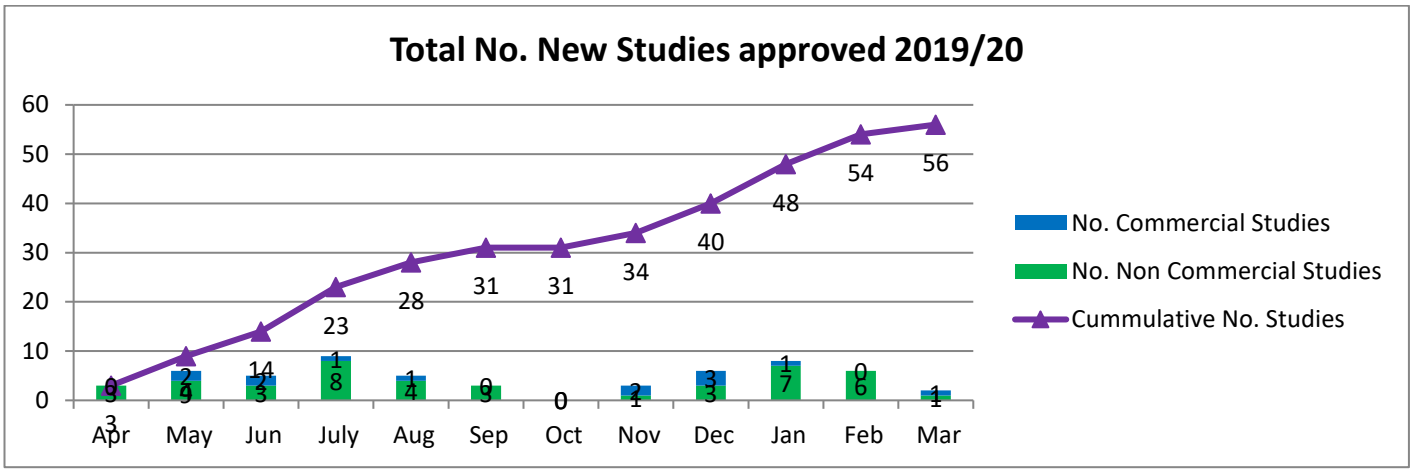
Data for 2020/21 compared to 2019/20 shown below by ISU for information.

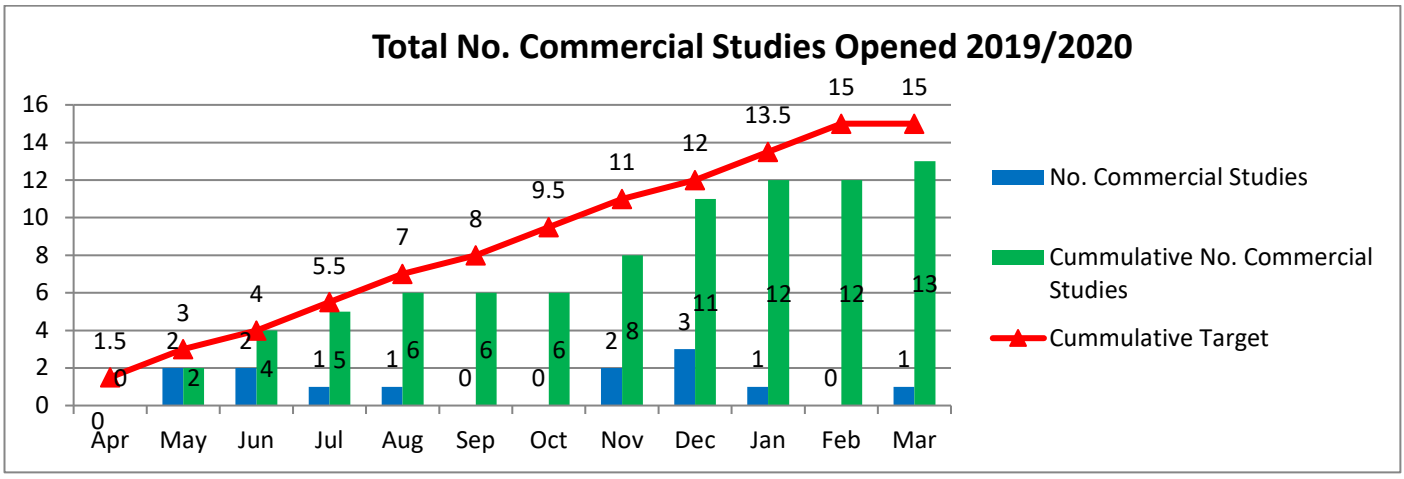




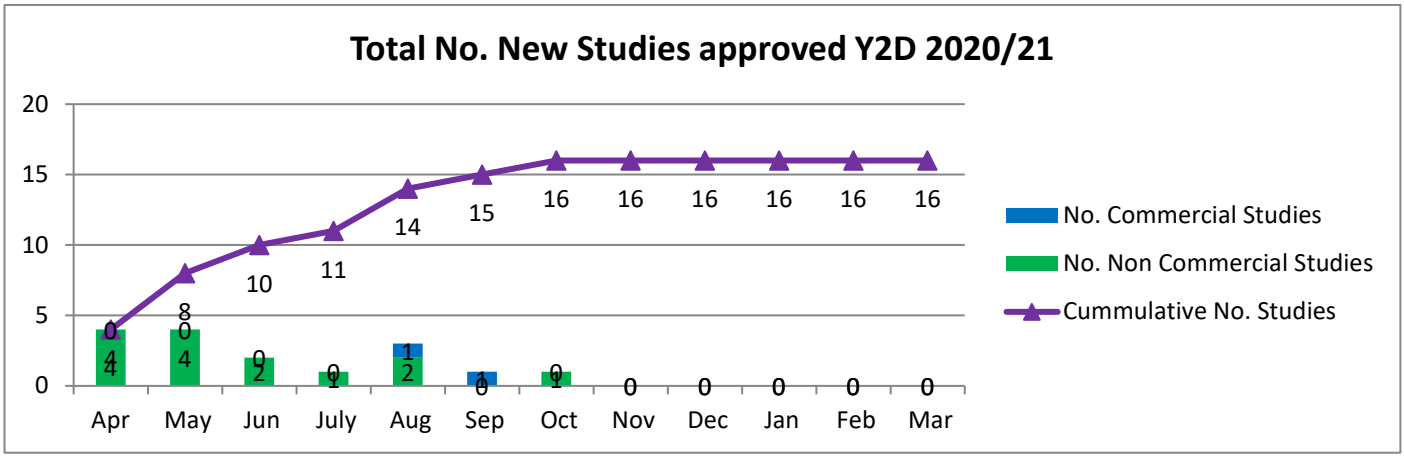
2.3.2 Total number of NEW studies approved (NIHR + non NIHR studies):

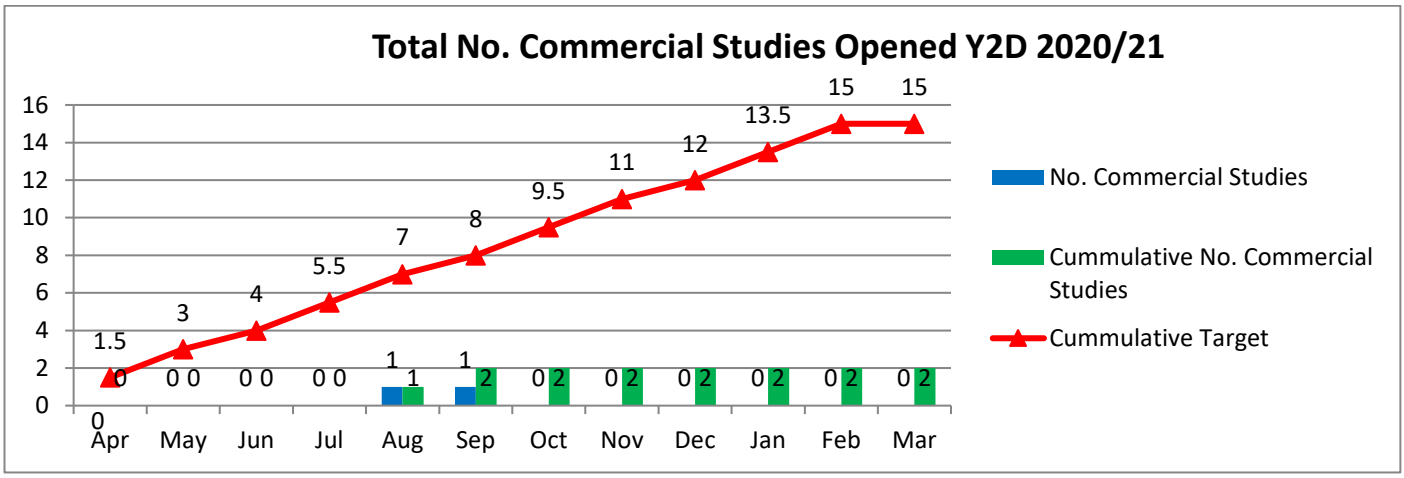
The Trust approved a total of 56 new studies in 2019/20 compared to 55 in the previous year of which 23% (n=13) were commercial.





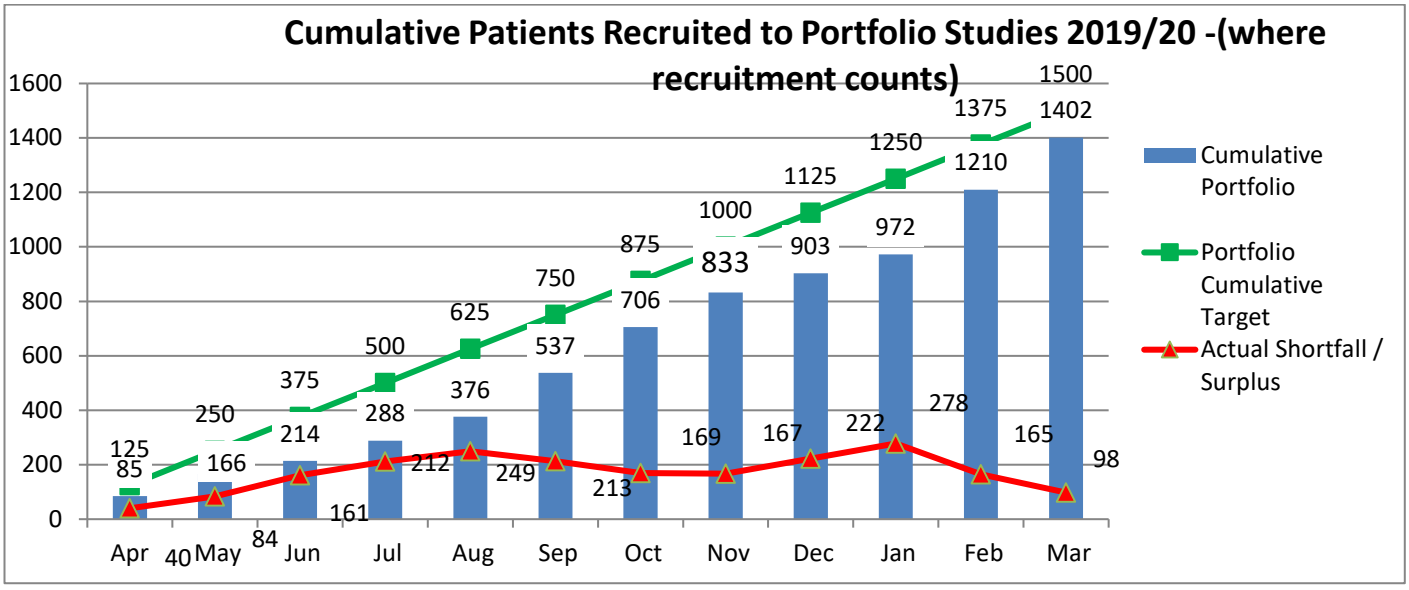
The mid-year 2020/21 activity shows the number of new studies approved = 16; of which 2 are commercial studies. This is significantly lower compared to last year (circa 50%); but expected due to pausing activity and a direct result and impact of covid.



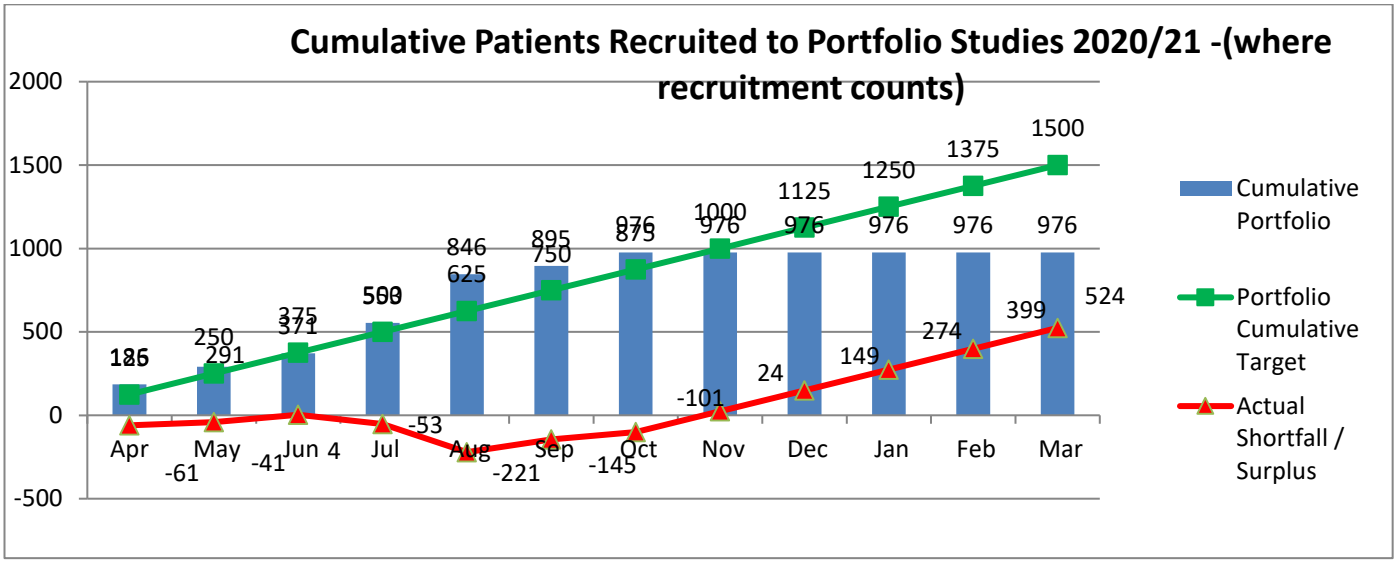


2.3.3 Recruitment to studies:

R&D set a lower target for 2019/20 (n= 1075) compared to 2018/19; due to downsizing the portfolio and with a smaller workforce as part of the financial recovery plans. However, we surpassed our target recruiting 1,402 participants in total to NIHR studies (130% against target).

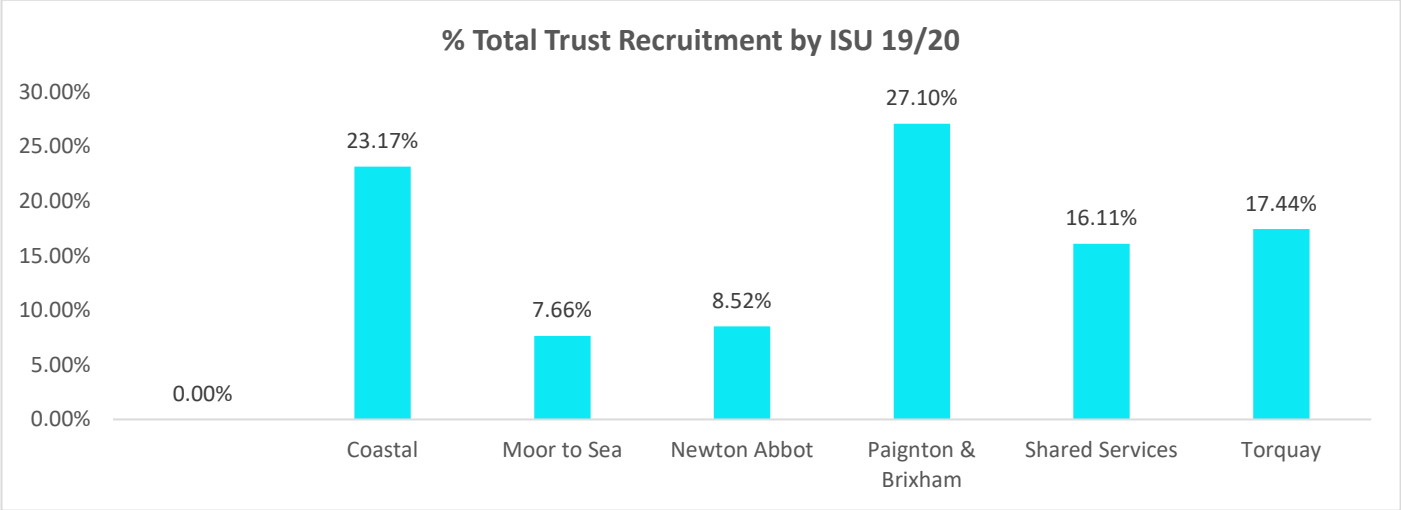


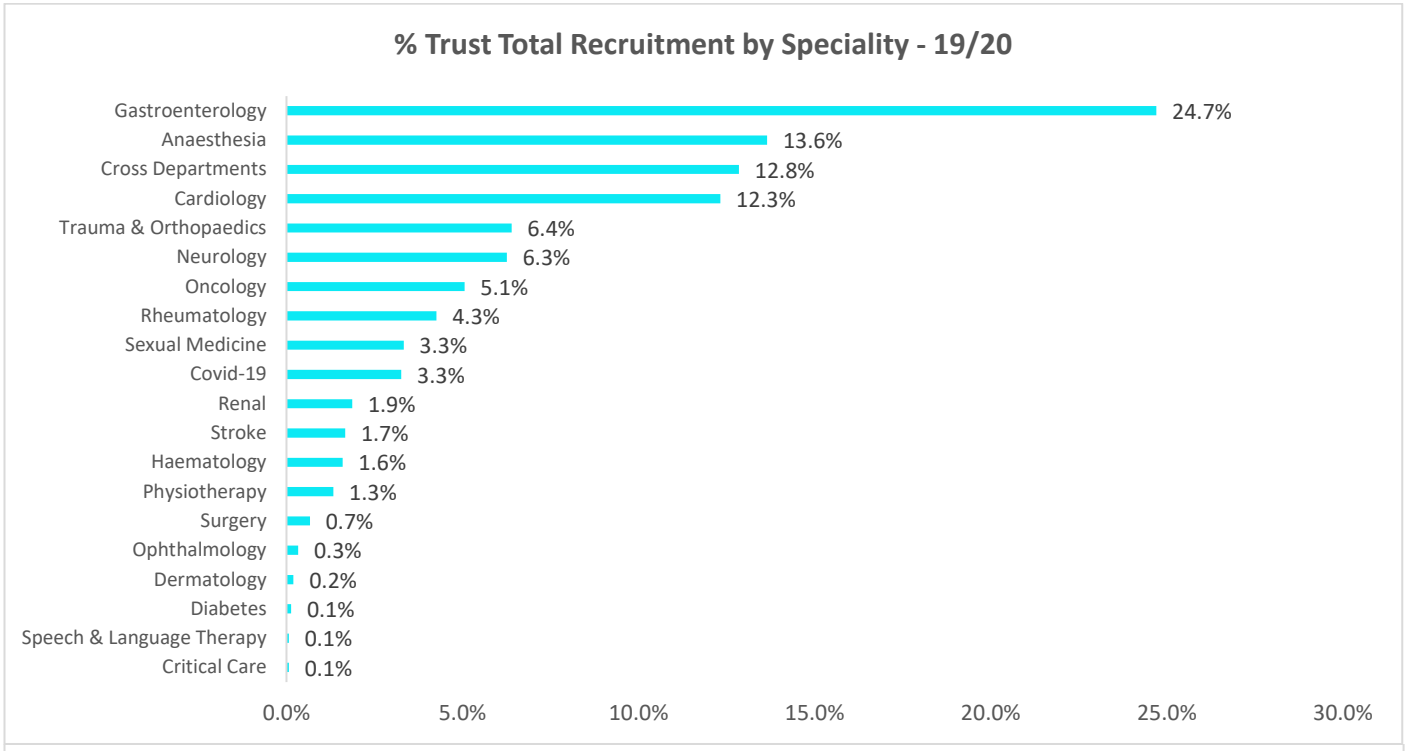
The 20/21 recruitment targets of 1,250 with a stretch target of 1,500 were set pre covid. These targets are suspended for this year. The graph below is for information only:

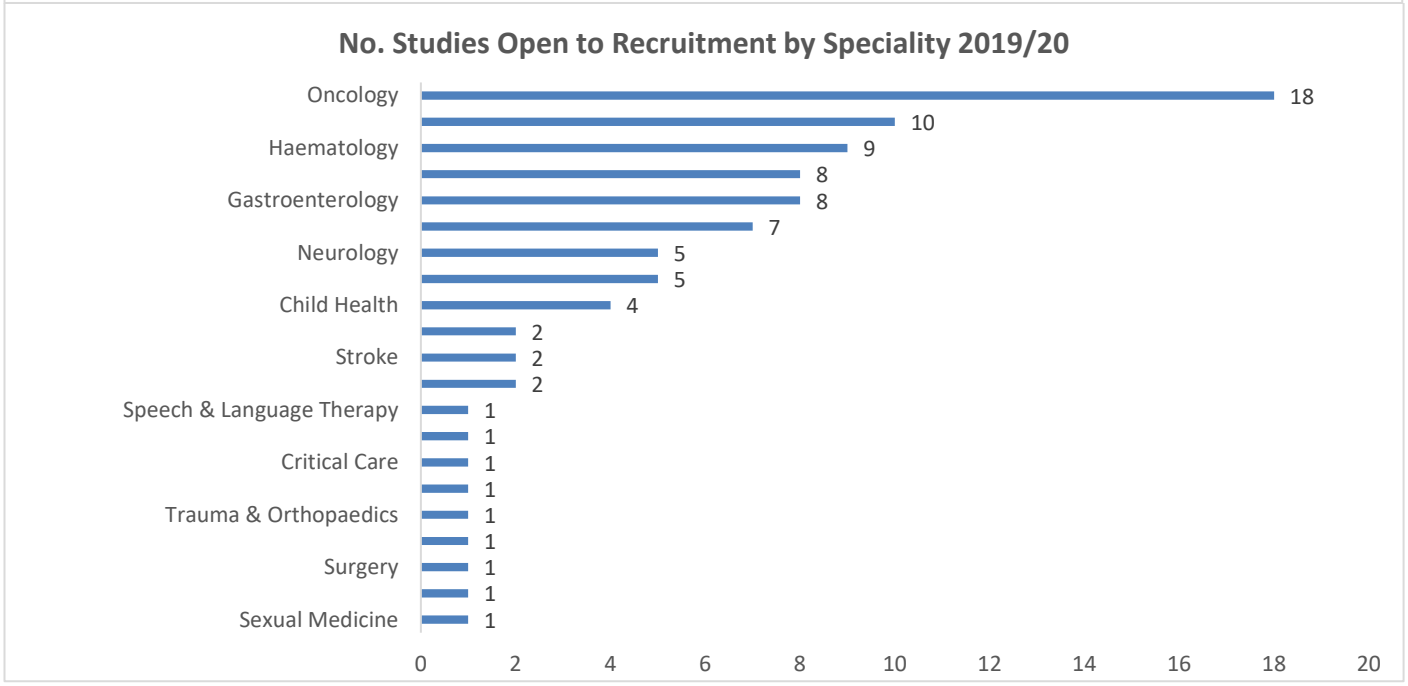


The Trust has recruited a total of 976 participants (data cut 05/11/2020) of which 496 recruits are to UPH covid studies.

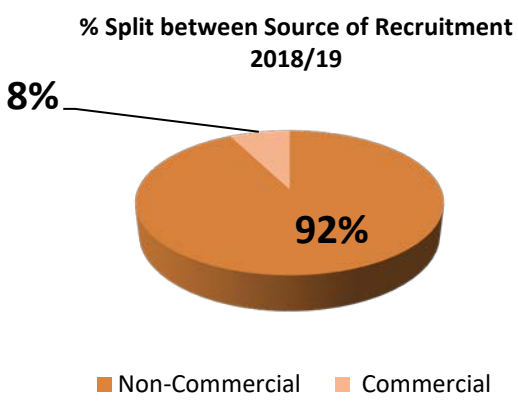
The distribution of research activity (studies and recruitment) across the ISUs is summarised below. Please note these statistics are strongly influenced by some ISUs having more of the specialities that have historically and currently an available study pipeline; hence more active compared to other ISUs (i.e. not an even distribution or access).

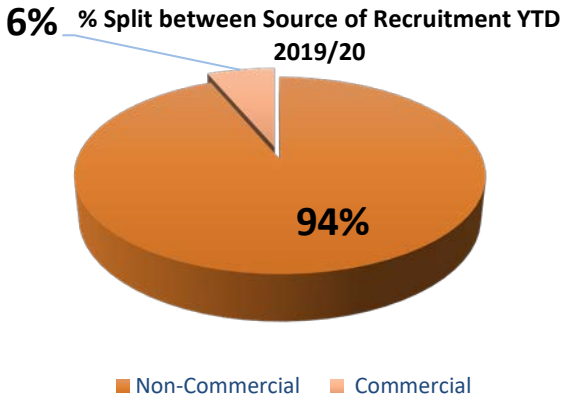


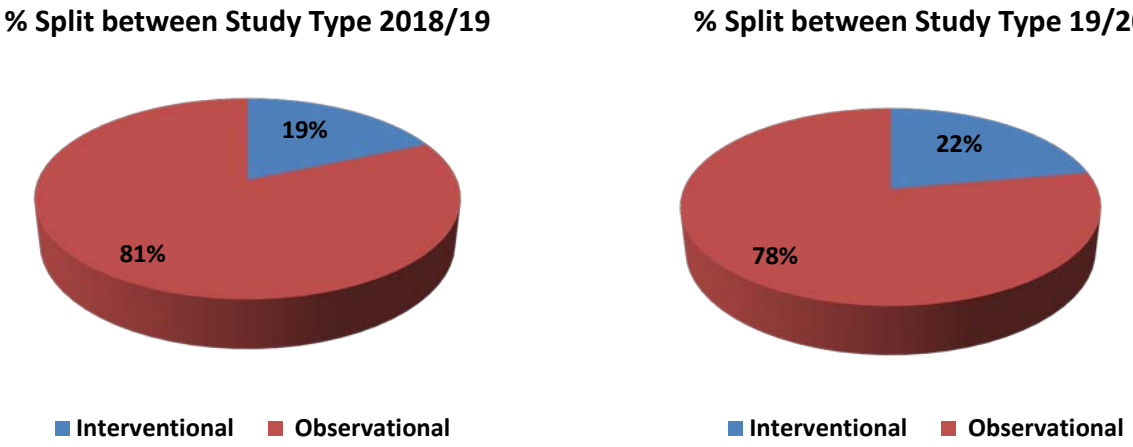




Our 19/20 performance shows a slight decrease in overall recruitment to commercial and an increase in overall recruitment % into interventional studies.





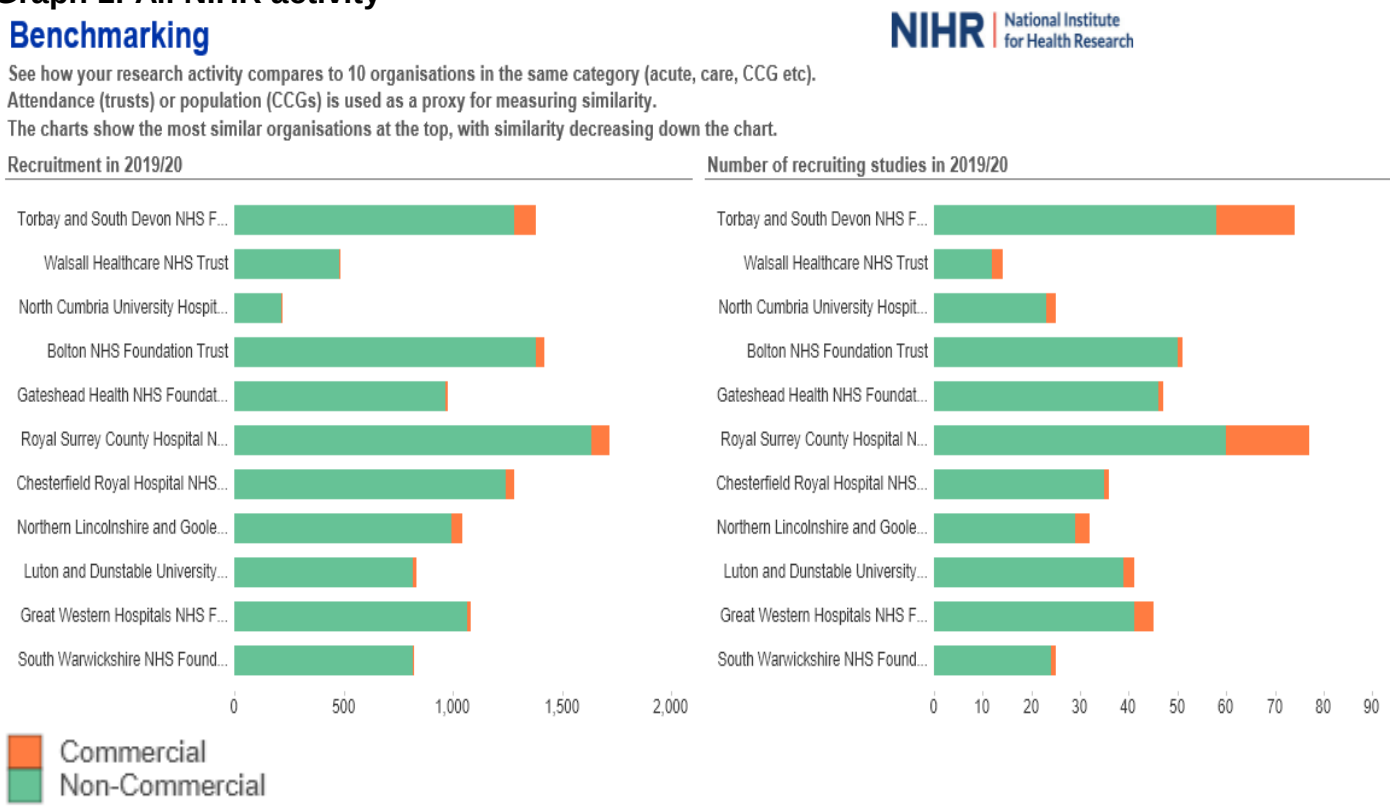


Unsurprisingly the recruitment distribution and study type for 20/21 is skewed due to the covid pandemic and that most other activity outside of cancer was paused for the majority of Q's1&2.

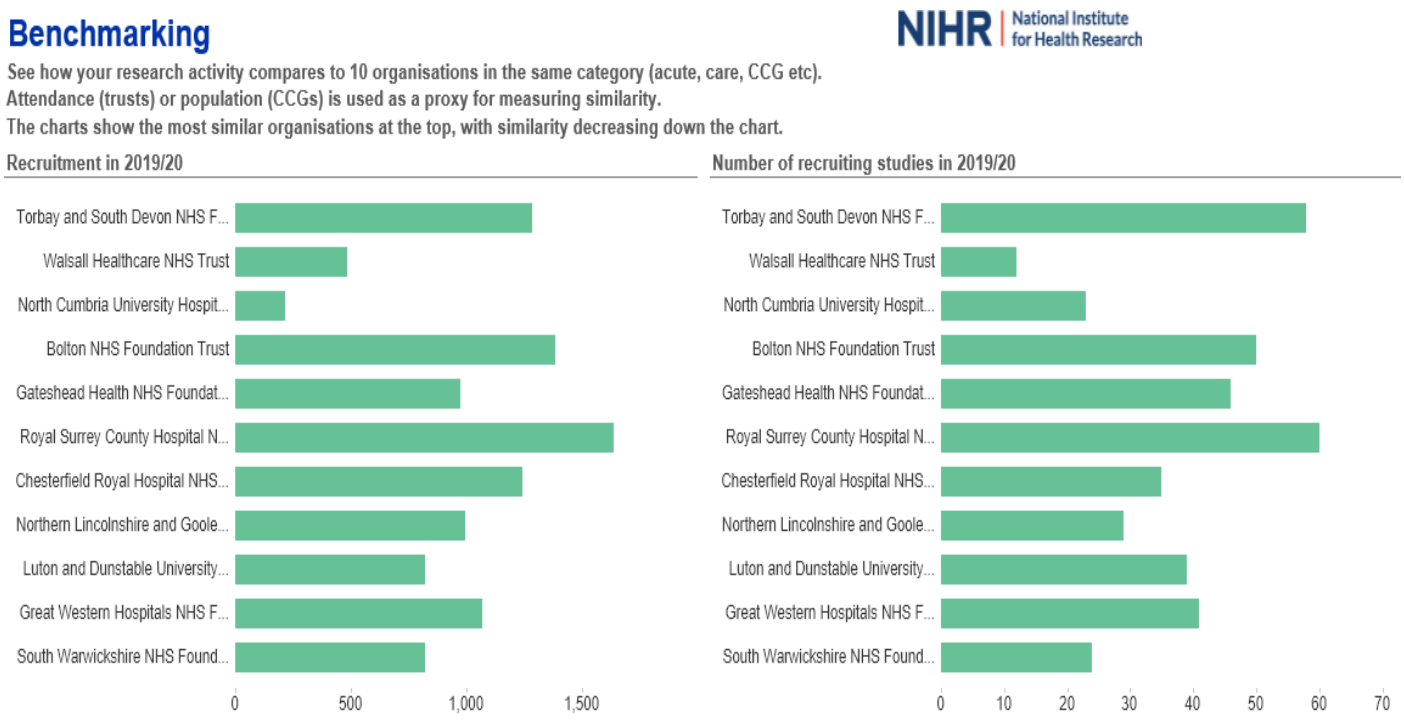
2.3.4 NIHR portfolio recruitment figures: National benchmarking against other Trusts of a similar size

A type of national NIHR benchmarking is against Trusts of a similar size in England (population outpatient attendances). The graphs below show where Torbay sits against the next nearest 10 similar sized organisations: Torbay rank 2nd best in class overall, but top in class for commercial studies in 2019/20:

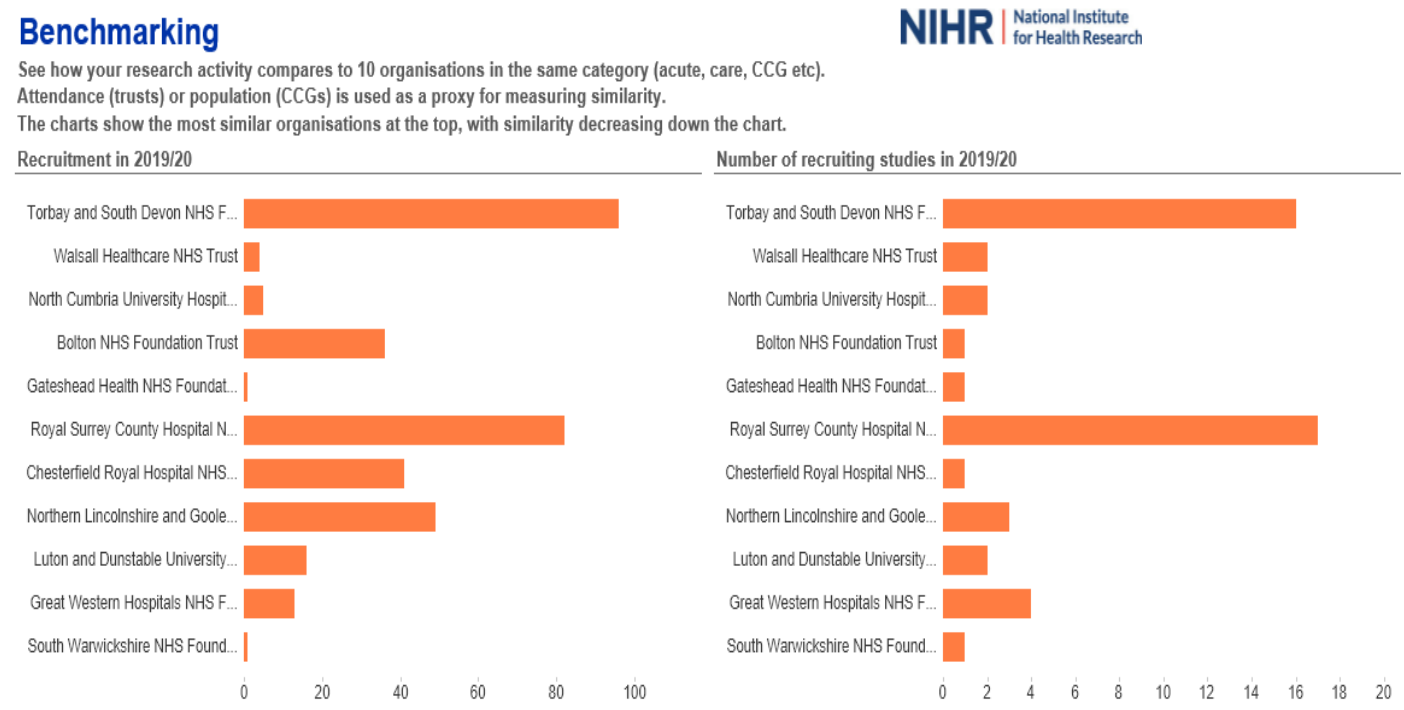
Graph 1: All NIHR activity



Graph 2: Non-commercial NIHR activity



Graph 3: Commercial NIHR activity



2.4: NIHR RESTART Framework.

Similar to NHSEs plans, R&D has to work towards the NIHR RESTART Framework looking at how to restart and restore a fully active portfolio, open new NIHR research and prioritise our resources.

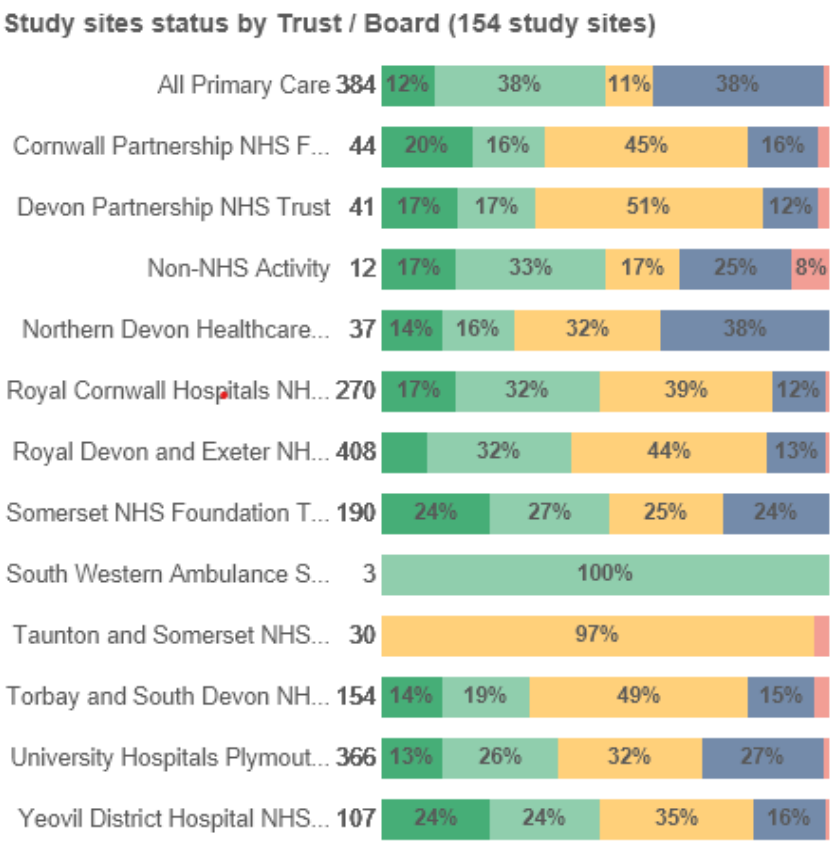
During the first covid-19 wave:

- Most research activity was 'paused' except for some cancer studies. This involved suspending recruitment to studies and where possible follow up activity providing safety was not compromised. This involved reviewing over 400 studies.
- Some R&D staff were redeployed to ICU and ED and we also needed to support the covid-19 research programmes.
- R&D has maximised a digital first approach – Attend anywhere, phone, self-reporting, e-consent, video, etc.
- Suspended all on site monitoring visits by sponsors (as part of regulatory and quality control and assurance programmes) and switched where possible to some form of remote monitoring although there are limitations.
- Since July R&D has been working with Sponsors, staff, support and clinical services to restart activity (both paused & new):
    - to assess viability of studies (design, logistics, financial etc)
    - Research should only restart/start when safe to do so for staff and patients.
    - List of pre-conditions must be met: site viability, re confirm capacity & capability, additional assessments (safety, IPC, PPE, needs, covid secure measures etc)
    - Restart plans need to link into / align with when and how Trust services are reinstated.
- Research must be prioritised based on urgency and importance to maximise use of research capacity and resources:
    - Level 1a: UPH studies – interventional studies including vaccines
    - Level 1b: UPH studies – observational / data collection
    - Level 2: potentially life-preserving or life-extending treatment not otherwise available to the patient
    - Level 3: all other research.

  In addition, R&D has reinstated some form of on-site monitoring (not during national or local lockdowns). R&D has written a new SOP to manage these requests to keep visits minimal and safe; whilst recognising this is part of 'essential; work as forms part of legal requirements for most drug-based studies. During 2nd lockdown these visits have been suspended and rescheduled.

- This 'restart' is not just returning to our previous ways of working. It is a complex situation and how best we can continue to deliver in the context of an emerging health and social care system not previously known / changing frequently and in a new challenging operating environment.
    - The 'Restart' of open studies needs to be managed alongside the growing Urgent Public Health (UPH) portfolio and the inclusion of new COVID-19 and other studies.
    - Be prepared for surges & winter pressures
    - Capacity & capability will be changeable
    - Plans have to be adaptable, agile and flexible
    - May need to stand down some activity again
- R&D is no different to other NHS services. It is a complicated balancing act between all our research activity and demands, need for safety, within a very challenged workforce, operational and financial environment.
- We need plan how we work together over the next phases as imperative R&D is not seen as an optional extra.

- The graph below shows the RESTART status of Torbay compared to all regional partners within the NIHR SWP: CRN



Please ignore data for Taunton & Somerset NHS Trust as now Somerset NHS FT. This is a glitch in the national system

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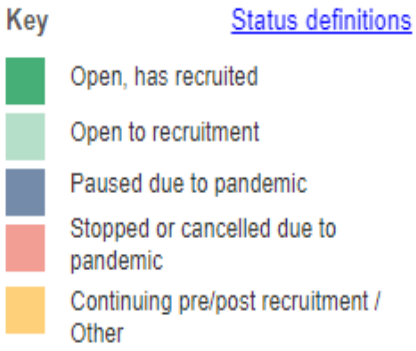


3.0 Patient & Public Involvement (PPI)

3.1 NIHR CRN Patient Experience of Research Participation (PRES) 2019/20

The Patient Research Experience Survey (PRES) has been used for the last five years by the CRN SWP to capture the experience of patients that have participated in research. PRES is mandated by the NIHR national co-ordinating centre.

The local PRES is organised by the NIHR's South West Peninsula Clinical Research Network and conducted across all partner organisations in the region. The 2019/20 format applied to:

- All participants seen for any research appointment across all disease specialties between the 2nd September 2019 and 29th November 2019 were asked to complete the survey. One survey is to be completed by each participant.

- The survey has enabled the CRN to identify positive patient experiences as well as identifying areas for development and continuous improvement.

This year the regional survey found that:

- **47%** of participants expected to be asked to participate in research.
- **93%** were given all the information that they needed in relation to the study.
- **93%** had a good experience of taking part in research.
- **86%** would be happy to take part in another research study.
- **92%** of participants would recommend taking part in a research study to other people.
- **35%** learnt more about their condition by taking part in research.
- **86%** wanted to know the result of the study.

The 2020/21 PRES is currently running between 30th September - 14th February and is an entirely digital survey this year to reduce transmission and resource impacts.

3.2 Patient Research Ambassadors (PRAs)

As part of the NIHR contract each CRN partner organisation has to appoint a Patient Research Ambassador (previously called Research Champions). This is an engagement role and PRAs work to a standardised job description so the remit is the same nationally. The aim of the PRA role is to address the problems of low public awareness and lack of diversity in research participants by providing a nationally-coordinated and assured way to help more of the public and patients to know about health and care research.

Elizabeth Welch; who is also a Trust Governor was appointed as Torbay's PRA and her role was formerly launched through the CEOs Vlog in November 2019. Since then Elizabeth has helped support and promote research through her contacts as a governor and working with the R&D team celebrating international clinical trials day (May 20th). See below her interview and with our PRES currently ongoing, Elizabeth has been involved with supporting the hand out of the survey details at research clinics on the Jubilee Research Unit (JRU).

'A Spotlight on being a PRA / Research Champion.

On Wednesday 20th May, it was International Clinical Trials Day and today, Elizabeth Welch, tells us why she became a Research Champion for Torbay and South Devon NHS Foundation Trust

What is your background and where did your interest in research and development come from?

I was a Financial Director for an international company based in London when life took a change of direction when my husband accepted an advisory post with the European Union (EU) to be based in Poland for two years. After leaving Poland we spent the next eight years living in Russia. Whilst there, on behalf of the EU, I worked with the Kazakhstan Government on the privatization of State Farms. Prior to our departure for Poland, my husband had led a multidisciplinary team looking into the effects on the health of both agricultural workers and animals within intensive farming systems, and that's where my interest in research grew.

How long have you been a Research Champion for TSDFT?

I became a Research Champion formally known as a Patient Research Ambassador, in September 2019.

How much of your time does being an Ambassador take up?

As it's a voluntary post, it is up to me how much time I spend promoting research and it varies. I take any and every opportunity that comes my way to raise awareness and engage people in the benefits of research. As I already volunteer at the hospital in my role as a Torbay Hospital Governor and as a Trustee for The Torbay Hospital League of Friends, I find it allows me the contact with the public and patients to promote the fact that 'today's treatments was yesterday's research'.

Which research programmes are you currently involved with?

I am involved in promoting CLIMB which is an online study about how patients think their health data should be used, "who it is shared with and by who and what consent should be given".

In addition, the PROTECT study which aims to understand how healthy brains age and why people develop dementia. There are currently IBS 'contact me' posters all over the hospital.

Of personal interest, I am participating in a national study for medication for hypertension.

Why would you encourage others to become a Research Champion?

I would always, if possible, choose to be treated in a hospital that is actively involved in research. If we don't have research, we don't have progress. Patients benefit from better outcomes and hospitals benefit from having volunteers help with their research. By being part of a research active Trust, we are contributing to cutting edge treatments and attracting staff interested in research too'.

4.0 Workforce:

The R&D Department has approximately 41WTEs comprised of clinical (medical, NMAHPs, registered and non-registered staff, A&C staff, laboratory MLAs, Pharmacists and pharmacy technicians. It is a small team of specialist trained staff covering R&D management, research advice, regulatory affairs, information, finance, governance and clinical trials delivery. As a small team; our main risks remain resilience and depth. As staffing levels are minimal and due to the specialist knowledge and hence time needed for training; it makes cover for absences and shortages difficult as parachuting someone in for example from the bank is not often an option, which makes our service both fragile and vulnerable at times.

The lack of senior medical staff willing or able to act as Investigators for research studies is another well recognised and significant risk area for R&D both at Torbay but across the UK. The Royal College of Physicians has published strategies to try to address the lack of recognition, value and incentivisation etc; but with limited affect to date.

Fundamentally there is a lack of funding, time and capacity in Job plans and we are overly reliant on a few interest individuals, with no ability to succession plan; which remains a real risk to the future of R&D at Torbay. R&D has been trying to address this through the revised consultant Job plan policy; working with the Medical Director, Clinical Directors and research active clinicians for the past few years but regrettably this remains a major issue still and has reached a stalemate situation.

In addition, there is a need for parity, equity and transparency between medical and other clinical staff too. There is a need for recognition of research activity in all job descriptions / plans for all staff. The messaging needs to change that research is core business and not an optional extra if time, interest or capacity allows.

4.1. Developing the investigators of the future:

NIHR 70@70 Champions:

- Chris Dixon, Lead Research Nurse was selected to become part of a brand-new nurse and midwife research initiative - the National Institute for Health Research's (NIHR) 70@70 Research Leader programme; starting from April 1st 2019.
- Chris is one of 70 senior nurses and midwives from across the UK to be accepted onto the scheme. The NIHR-funded three-year programme will champion research, innovate and drive improvements in future care.

This is a great achievement and accolade and sits very well with the appointment a few years ago of Richard Collings; a Trust Podiatrist, who is undertaking his PhD part time at the University of Plymouth, funded by the NIHR. Richard was appointed as one of only 13 Allied Health Profession (AHP) research champions by the National Institute for Health Research (NIHR) and Council for Allied Health Professions Research (CAHPR). AHP Research Champions serve as ambassadors and to champion the research work of AHPs, encouraging more AHPs to be aware of and get involved in health and social care research and the work of the NIHR for the benefit of patients.

Chris and Richard are working together with the NIHR CRN and through their respective programmes alongside developments with the University of Plymouth (UoP) clinical schools programme locally and regionally regarding the development of non-medics and research careers.

Chris Dixon believes that to modernise our research delivery service and raise the profile of clinical academic research amongst nurses, midwives and AHPs we need to blend academic roles into our R&D clinical delivery team and within the clinical services across our organisational footprint.

As an organisation we are very lucky to be able to collaborate with the Torbay Medical Research Fund (TMRF) and the Torbay Clinical School (Professor Mary Hickson & Professor Susie Pearce), Plymouth University as they have recently launched a non-medical fellowship programme which aims to increase opportunities for local staff to create new senior clinical leaders within research.

In addition to many other TSDFT clinically based academics such as Richard Collings, our R&D clinical delivery service now have a team leader undertaking a PhD (Kathryn Bamforth), a senior research nurse (Angie Foulds) awarded an NIHR Clinical Research Associateship and two new 70@70 Research Associates secondments: Rebecca Stride (Radiology) & Abi McWhinney (Midwifery). The 70@70 Research Associate schemes in collaboration with the NIHR and Torbay Clinical School are designed with 3 key objectives: Clinical research delivery, service-based improvement projects and time to pursue the next steps of their clinical academic career path.

We've recently established the Clinical Academic Research Exchange (CAFÉ) for these individuals to meet with other like-minded colleagues. This new group meets monthly and are always keen to hear from new people with academic interest.

5.0 Clinical Trials Unit (Jubilee Research Unit - JRU)

R&D's lack of fit for purpose dedicated clinic space has been a risk recognised for many years. The loss of most of the JRU (old Elizabeth Ward); due to operational pressures (relocation of pre-assessment; need to share with the vascular access team, frequent escalation back to a ward to increase bed capacity); created several challenges and issues that increasingly were having a negative impact on our capacity and services such as:

- Insufficient clinic capacity to see patients
- Loss of identity and dedicated space for research
- Loss of marketing to potential sponsors and loss of confidence by sponsors – Does the Trust have the necessary facilities and infrastructure to expand the portfolio and deliver contracts?
- Need to turn down contracts and loss of income because we are unable to deliver
- Not a good experience for staff or patients

During 2020/21, as part of standing back up services and through the recovery cell and big room discussions with the need for research clinic space for the UPH studies especially the SIREN study and vaccine studies, dedicated space was identified and the JRU has been relocated to the old GP streaming service clinics on Level 2 outpatients.

This has provided more appropriate and fit for purpose clinic outpatient space, the location also provides improved access for our patients alongside a greater visible presence on the Hospital site showing that the Trust is a research active organisation. This has enabled R&D to not only maintain research activity but enables us to offer UPH studies such SIREN and vaccines and support more non covid research too and importantly better experiences for both our staff and participants.

The OPD team has made R&D feel very welcome and working very well so far. This has generated interest in the work we are doing from our OPD colleagues which has been fantastic and very refreshing from our previous experiences.

We are very aware space is at a premium and R&D do feel more at risk; as often our work has been seen as an easy target as less important. This commitment from the Trust providing this space is very welcome and we hope now the benefits and value of our work is more recognised that any future move will mean re-provision of fit for purpose space is recognised. Equally it will be important to ensure R&D space is incorporated into the HIP2 plans.

5.1 NIHR Clinical Research Network (CRN): New National Patient Recruitment Centres (NPRCs)

As set out in the Life Sciences Sector Deal 2, a crucial objective of the Government's industrial strategy is to improve the speed and consistency with which late-phase commercial research is delivered in the NHS. As part of a suite of measures designed to support this objective, during 2019/20 DHSC invited Trusts to become one of five purpose-designed NIHR Patient Recruitment Centres (PRCs) dedicated to late-phase commercial research.

The Trust's excellent performance and track record in commercial trials led to Torbay being one of 15 Trusts shortlisted to the final stage and to tender for this new contract with pump prime funding worth £1.3M over 3 years to expand our commercial research activity. Whilst unsuccessful this time; this exercise has given insight as to what we need to do to prepare for the next invites to extend the NPRCs if this pilot is successful.

6.0 Trust R&D Committee

Building on meetings with our investigators; R&D has attempted to establish a new R&D Committee; to provide strategic leadership and oversight, helping to scope and shape the future direction; raise the profile and embed research further and to help improve linkages into the ISU and corporate agendas. However, we have failed to get this committee established and formalised for a variety of reasons. Covid has scuppered further work. R&D will try to resurrect this project and will need to be picked up next year following discussions with ISUs, researchers and the new Medical Director as Executive lead for research.

7.0 Information:

We are leading the way maximising a digital first approach through advanced development of EDGE as our primary R&D electronic system, using workflows and attributes to harmonise, streamline and improve our co-ordination, conduct and delivery of studies; helping to improve communications; reporting capability, performance; set up times, financial tracking and cost recovery. In particular:

- By capturing all of our financial income within EDGE this has allowed us to provide regular forecasting on our clinical trials income; shared across departments. This has allowed further growth and integration of research across the Trust. In the first year of managing our invoicing through EDGE we have identified and taken steps to recover an additional potential £50,000 trials income.
- The Follow up project: Through the use of a follow up attribute we now have the ability to capture and analyse our follow up burden, allowing us to monitor and adapt our capacity to aid feasibility reviews and workforce planning. This work was showcased at the EDGE national conference.
- Working with our CRN and partner organisations this project is being rolled out across the region and helping to inform a national approach. Our LCRN has commissioned us to roll out this blue print; sharing good practice at scale and pace across the Peninsula to our local colleagues. This has proved highly successful and we have also been able to demonstrate how this can be up scaled to work across multiple organisations and exemplifies the benefits of our collaborative working.

7.1 ISU Dashboards:

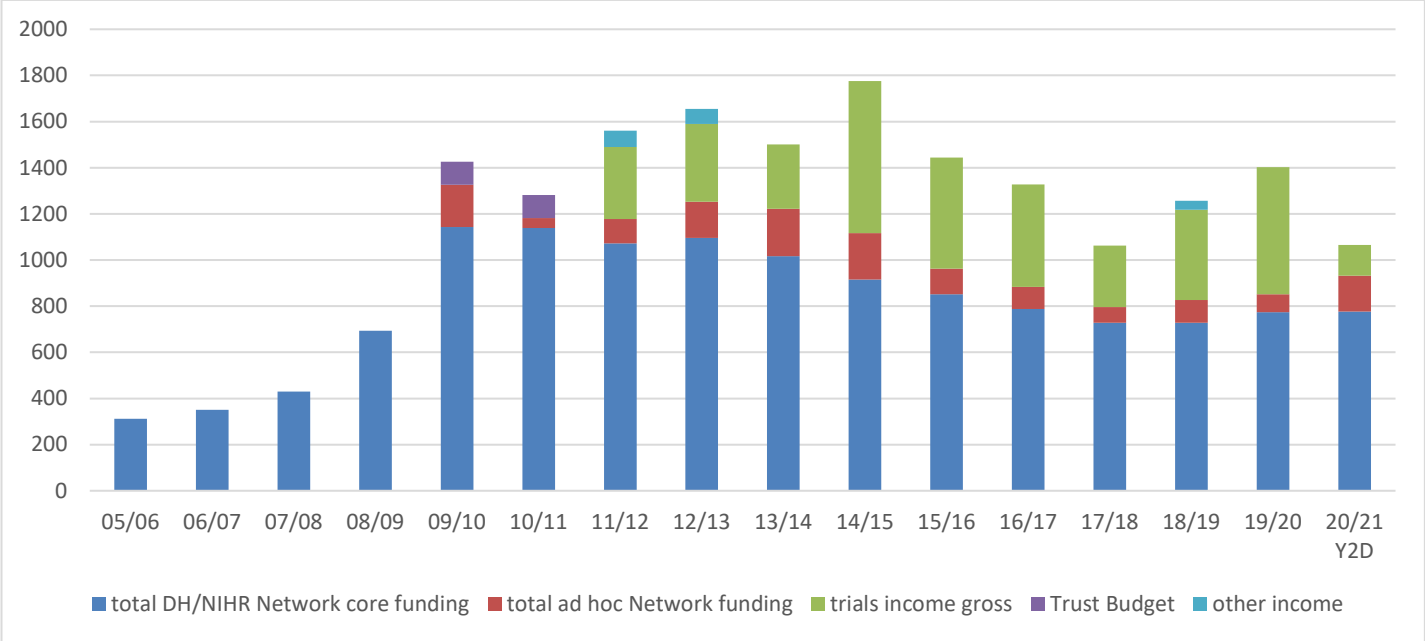
Historically research has been undertaken and driven by interested individuals and the level of engagement from peers and colleagues is very variable across specialties. With the dwindling number of potential investigators making R&D fragile, as part of the R&D strategy, there is a need to influence organisational ethos and culture; to help research become more ‘normal’ and seen as part of core NHS business and everyone’s responsibility. It is important research is driven at ISU level. R&D has worked with Rhoda Allison, in the Moor to See (M2S) ISU; to pilot a dashboard that is of use, interest and meaningful to the ISUs. The aim will be to routinely include research as an agenda item at the quarterly governance meetings and to review the data and dashboards and create wider conversations which aim to:

- Showcase and measure clinical research activity within the ISU
- Show ‘Impact & Value’ of published research, any wider savings or if the research results could change practice
- To identify capacity & capability issues to undertake research
- To identify and talent spot potential future academic researchers / encourage more investigators
- To share funding opportunities & encourage research equity, facilitation and awareness across the ISU

The pilot with M2S has proved successful with good engagement. More recently Dr Kate Lissett invited R&D to present at the Torquay ISU; with similar positive responses and engagement. The reports /dashboards will evolve based on feedback and we aim to roll out across all ISUs from 2021/22.

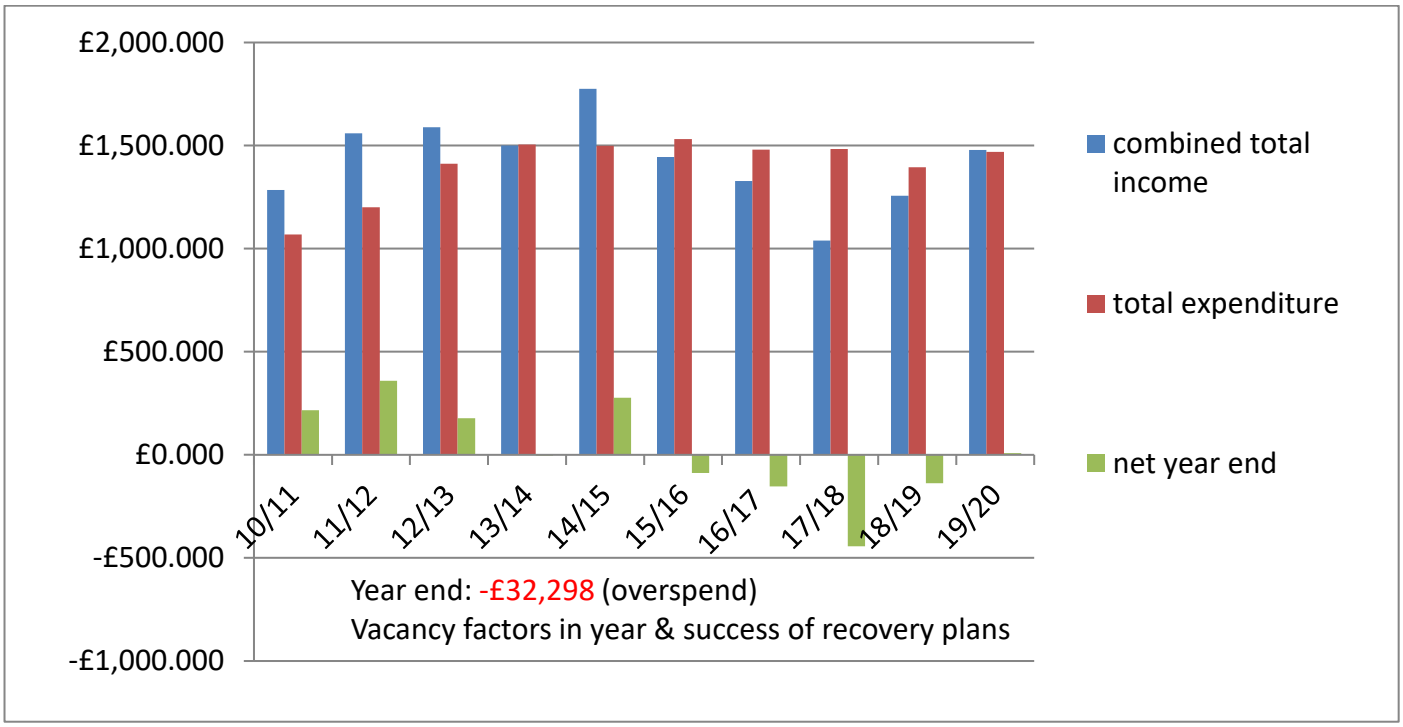
8.0. Finance:

- R&D has been commissioned separately to patient care services since mid-1990. DHSC deliberately created ring fenced and separate R&D budgets to protect and ensure research continued in the NHS. R&D's primary source of income comes from our commissioners (NIHR CRN). The other key source of funding comes from our commercial clinical trials contracts. The graph below summarises the R&D income streams over the years.

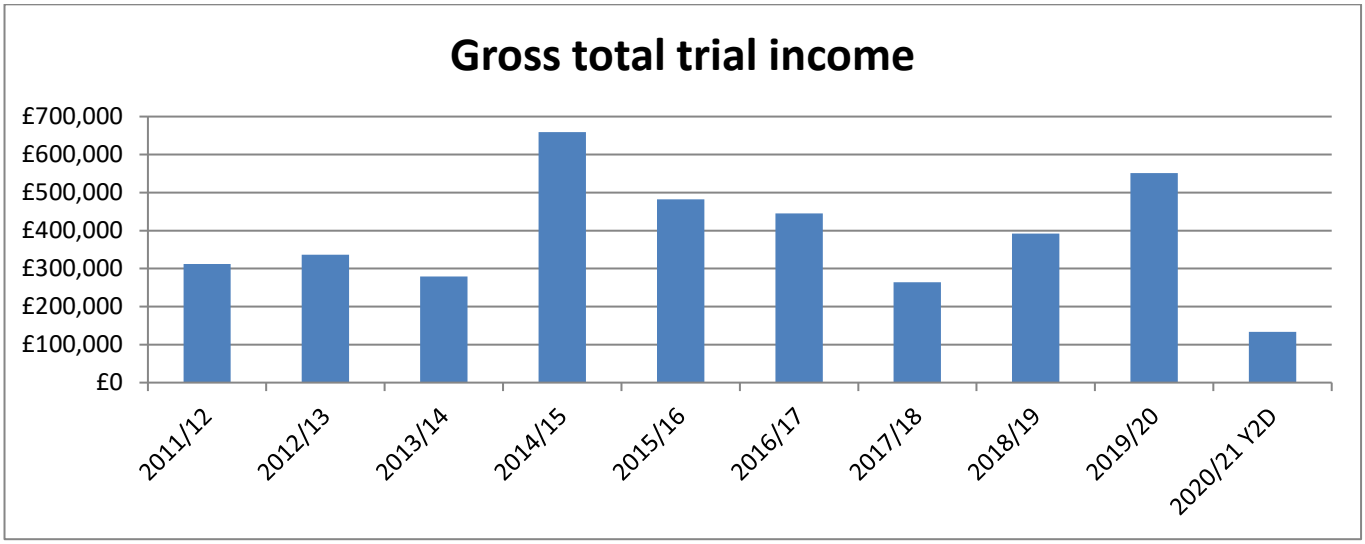


- Despite increasing research activity and performance over the years our NIHR CRN funding had year on year decreases although in 2019/20 the region and hence the Trust NIHR CRN contract increased by 6.2% (instead of an expected 5% cut) after successfully lobbying DHSC. In 20/21 the Trust received the same core budget as 2019/20 but additional funding to support vaccine planning has also be made recently.

- The graph below shows combined total income and expenditure and year end position.
  - ➢ Overall expenditure has remained steady with 95% of spend accounting for staff costs with increases associated with pay rises and pension increases.
  - ➢ Overall R&D improved the year end position = £38K deficit compared to £453K deficit in 17/18.

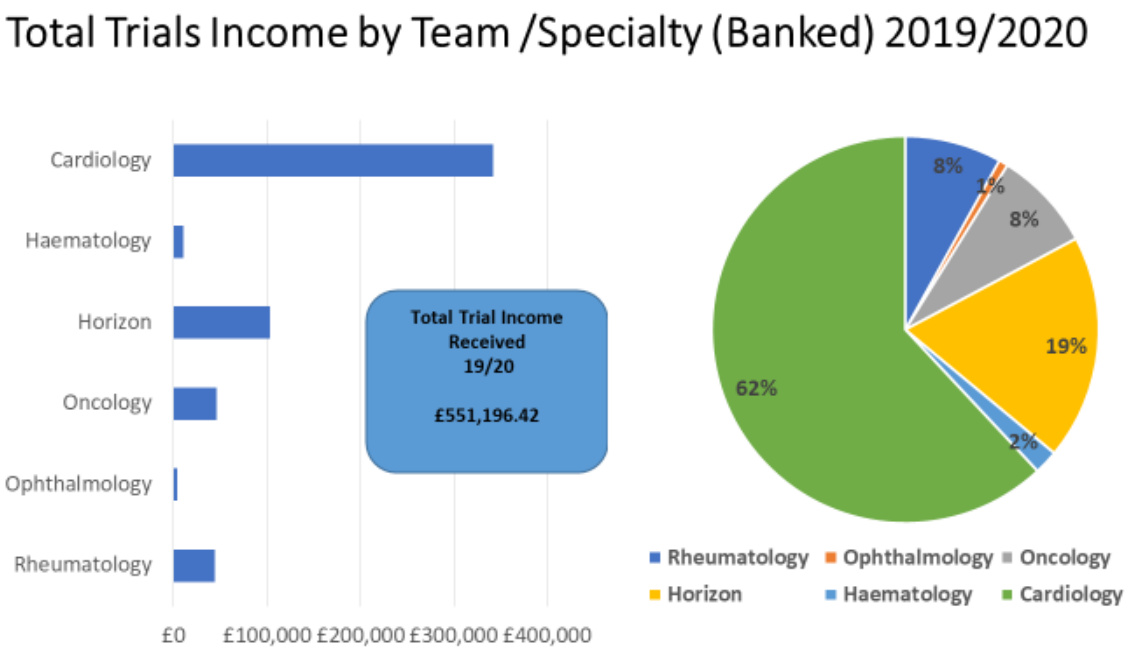


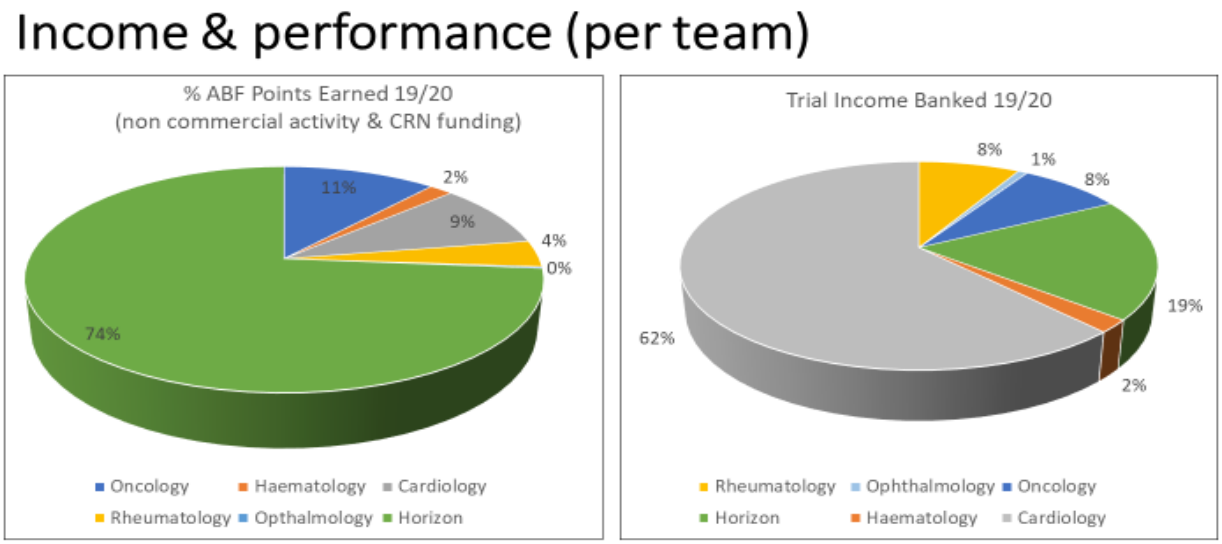
- The graph below shows gross trials income. The successful implementation of the 3-year recovery plan, increasing commercial activity, consolidating the portfolio to increase productive activity, workforce restructuring, improved financial recovery and tracking has seen an increase in the trial's income. Whilst good progress has been made the position is still very fragile. It will not take much to start a reverse/decline. Covid has significantly affected our activity and consequently significantly reduced our actual and potential earning power; which is a concern for 20/21 and the next few years too.



N.B 2020/21 – we have an income pipeline of activity / work completed but as yet still to be invoiced circa £279,636.

The graphs below show a breakdown of trials income per research team and the activity-based funding (ABF) points which is based on weighted non-commercial NIHR recruitment; dependant on study complexity, which is used to allocate NIHR CRN funding to Trusts. Whilst cardiology contributed 62% to the overall gross trial's income; the Horizon Team (covers all other areas not covered by the specialist teams) contributed the most activity to our ABF points to secure and maintain our CRN funding contract. It is therefore important to have a balanced portfolio of commercial and non-commercial activity to maximise both sources of funding.





- The recovery plans have started to address the imbalance between what we can earn and what we need to earn and therefore improving the financial sustainability of the service and staff on site. However, recovery post covid and the need to have a more inclusive and engaged community is important to return to sustained improvements.

8.1 R&D Finances – impact of Covid-19

- Nationally all NHS R&D Departments have raised concerns regarding the impact of covid. With the stopping of 90% of research activity, whilst the NIHR contract, as Government funding has continued; the trials income has significantly reduced by 50-70% in the first 6 months and forecasting up to 50% loss by year end (forecasted target was £800K) and with continued reduced activity recovery will take longer as the reduction in annual trials income will continue into 21/22 and potentially the following year.
- DHSC are aware and have provided assurances they do not want this to impact on and place at risk R&D staff or infrastructure.
- Further guidance will be provided detailing arrangements for NHS funding and treatment of lost income (including research income).

8.2 Clinical Cabinet / CCG / STP - Drug / other savings

- The benefits of research such as drug savings, reduced attendances, safer practice and care, better outcomes, improved staff recruitment and retention, better patient experience etc; these all contribute to 'softer' financial benefit; that are hard to quantify and do not pass through the R&D budgets; but instead through other Trust or the wider system budgets. It is imperative these benefits are taken into consideration when reviewing the R&D economic position.
- An NIHR report shows the estimated benefits to the NHS of contract (commercial) research as summarised in the graphic below:

Building on this work; R&D leads and the CRN successful submitted a business case to Devon' STP; to pilot a scheme based on a share of the savings to be reinvestment in research infrastructure in order to increase research activity; with the aim to generate greater savings in the whole system.

In 2019/20 the STP / SCG agreed to provide over £250K to support an increase in radiotherapy trials and awarded each radiotherapy centre £51K. This was the first-time commissioners have invested in research recognising system savings. This has helped us to employ a research radiographer, support training and quality assurance to enable commissioning of new SABRE technology; enabling the new technology advancements we now have with our new linear accelerators. To date the overall response by all organisations has shown this investment has provided significant savings to the system over an above the investment. See below an example of the benefits:

E.G Oncology: Fractions saved with Ca Prostate hyerfractionation: Estimated savings based on a couple of radiotherapy trials (involving reduced radiotherapy fractions):

- Over 7 months no. of fractions (#) saved by participation in 2 trials = 386 = equates to potentially £105,258 pa (based on circa £159per #)
- With 50% trial recruitment to 2 new studies will save 569 fractions = £93,651pa and if the trials become SOC and a reduction in # = 1114 = £177,126pa
- In addition, this also aids the Trusts ability to accommodate social distancing / covid-19 measures without compromising quality of care or service by reducing the number of tomes a patient has to come on site for treatment.

With the success of this pilot, there was agreement to continue funding into 20/21 to enable this good work to continue and a request for new additional business cases e.g. looking at biologic therapies; to invest further in providers to enable them to undertake more research trials to provide further system savings. Regrettably due to covid these conversations and agreements have not progressed.

9.0 Research Impacts, Outcomes, Awards and other good news stories:

Visit from national leader: Professor Chris Witty, CMO and Dr Louise Wood, Director for R&D, DHSC

In May 2019 Torbay showcased research and health work in a visit to the Trust and local council. Staff met Dr Louise Wood from the National Institute for Health Research and DHSC (unfortunately Prof.Chris Whitty was unable to attend on the day); to showcase how people with complex needs including children are supported locally and to learn more about our 'Researchers in Residence' model in evaluating our ICO and changing models of health care.

Three Trust consultants have been appointed to SWP: CRN posts:

- Dr Kirsten Mackay – Regional Clinical Speciality Lead for the Musculoskeletal portfolio
- Dr Tom Clarke - Clinical Sub- Speciality Lead for the Anaesthetics portfolio
- Dr Agne Straukeine Clinical Sub Speciality Lead for the Multiple Sclerosis portfolio

NIHR SWP:CRN Research Awards 2019-20

- **Early Career Researcher Award - Nominees**
- Shelley Chamberlain
- Kirsty Pearce

- **Principal Investigator (PI) Award**
- Dr Philip Keeling – Highly Commended
-
- **Public Engagement Award - Nominees**
- Guy Boswell

- **Patient Research Experience Team Award**
- Cardiology Research Nursing Team - Winners
- Horizon Research Team - Highly Commended

- **Research Nurse or Midwife Award**
- Debbie Hughes – Highly Commended
- **Nominees**
- Angela Foulds
- Chris Dixon
- Haem Research Team (Catherine Jordan, Charlotte McNeill and Angela Lord)
- Horizon Team Research Nurses

- **Research Allied Health Professional (AHP) Award - Nominees**
- Richard Collings

- **Innovation Award**
- Sarah Levio (podiatrist)– Highly Commended
- **Nominees**
- Dr Julian Elston and Dr Felix Gradinger
- Mia Jones
- Kathryn Bamforth
- Dr Fiona Roberts,
- Pharmacy clinical trials team (Louise Paatz, Sarah Wright, Sally Madison and Andy Harford-Brown)
- Professor Mary Hickson & Associate Professor Susie Pearce, University of Plymouth in partnership with TSDFT and the Torbay Medical Research Fund

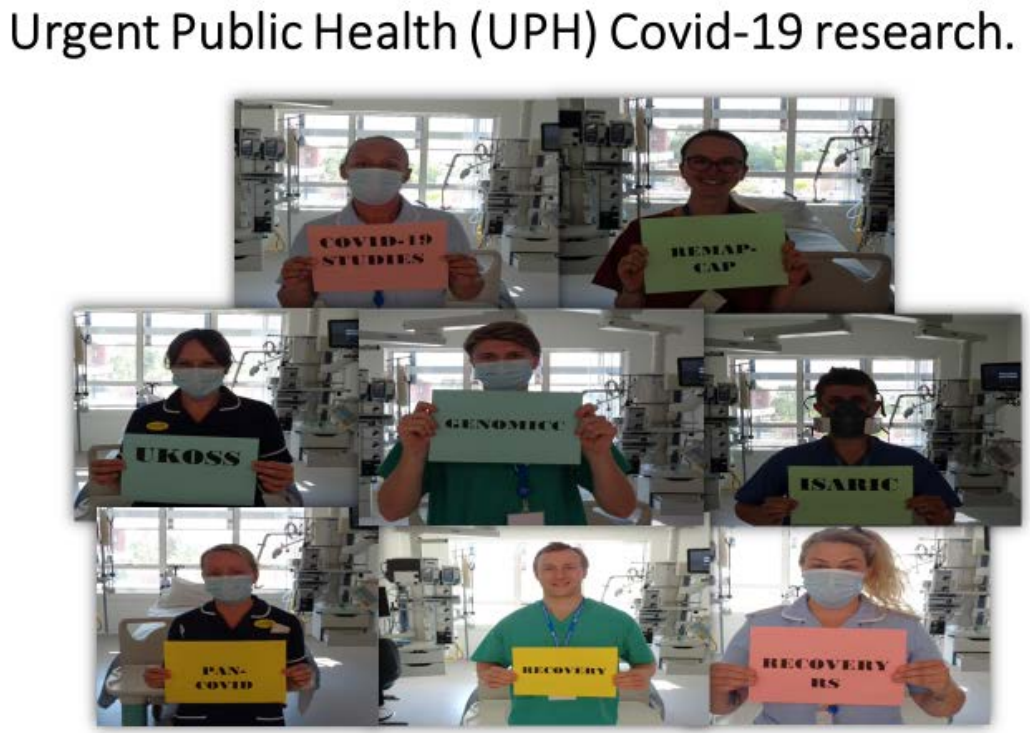
- **Research Administrator or Co-ordinator Award**
- Mia Jones - Winner
- **Nominees**
- Jon Buckley
- Research Administration Team
- Horizon Centre Research & Development Admin Team,
- **Outstanding Research Contribution Team Award - Nominees**
- Cardiology Research Nurse T
- Rheumatology Research Tear
- R&D Team
- Oncology Team
- Chris Dixon

Appendix 2 summarises some further god news stories and provides examples of and a flavour of the Trusts activity and performance

Appendix 3 summarises examples of impacts and outcomes from research activity and studies the Trust are or have been involved in and recently reported on. These provide a flavour of how research has informed the evidence base and influenced quality improvements, clinical care and services.

Appendix 1: 20/21: Covid -19 Research at Torbay: Below is a summary of R&Ds response to the pandemic:

- As with all parts of our lives and the NHS, R&D has been affected by covid-19. Whilst most non covid research was paused during the first wave, research has had an opportunity to make a real impact on covid-19 at scale and pace locally, nationally and globally.
- Urgent Public Health (UPH) covid-19 studies are prioritised by the Chief Medical Officer (CMO) as nationally the most important in the fight against the pandemic.
- These studies must take first priority on use of research infrastructure and resources.
- They all play a crucial role as part of the overall national response to the pandemic; alongside all other measures.
- The R&D team has worked hard and tirelessly to maximise Torbay's opportunities to access studies, supporting the clinical teams so we can play our part in this crucial national UPH covid-19 programme.
- Below is a picture montage showing both R&D and clinical staff on ICU highlighting the covid-19 studies:



- Torbay currently has 10 studies open to recruitment with 523 participants enrolled to date (data cut 09/11/2020) with further studies in set up.

RECOVERY	UKOSS
RECOVERY-RS	PAN COVID
REMAP-CAP	NEONATAL
ISARIC	SIREN
GENOMICC	CLARITY

- The studies summarised above are a mixture of data collection, genetic, interventional and devices studies covering both inpatient and outpatient covid-19 patients.
- Some studies involve staff: The SIREN Study: (Sarscov2 Immunity & REinfection EvaluatioN): This is the key PHE' antibody research testing programme recruiting over 10,000 health workers nationally.
    - The study aims to find out whether healthcare workers who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), compared to

those who do not have evidence of infection (negative antibody tests) are protected from future episodes of infection i.e. (level of immunity and for how long).
  - It requires testing staff every 2 weeks (both swabbing and blood testing) over the next 12-18 months plus completion of symptomatic diaries.
  - This study also serves as the only clinical surveillance programme on site.
  - Currently the SWP = highest recruiting region in England
  - Torbay recruited 297 staff members in less than 3 months over the summer. We are very grateful to all staff who have volunteered their time and to their managers for allowing their staff to take time out briefly to attend the research clinics on JRU.

- During the first wave:

  - Torbay consistently had the highest conversion rate of those admitted with COVID being offered and enrolled in one of our studies across the region.
  - Across the 12 recruiting sites in the Peninsula; Torbay ranked 2nd highest for open studies.
  - Everyone came together; most activity other than urgent care and cancer care for example was stood down. So, prioritising research and gaining the support, involvement and engagement throughout the organisation was a refreshingly positive experience and everyone coming together to help in a true collaborative spirit was shown by all.

- We are now in the grips of a developing 2nd wave but this time is different. We all now have competing priorities as the NHS tries to maintain and continue all services as best as possible. In R&D the same applies: The ask is that while we must prioritise UPH covid research; especially the interventional studies, we must also continue to support non covid research too. Capacity and capability is an issue for R&D as well as many other sectors of NHS business; with competing priorities for staff time and also labs, radiology and clinic space etc.

Covid Vaccine trials:

- The next big focus is on trailing the vaccines in development. Nationally all Trusts have been asked to prepare for the roll out of a programme of late phase clinical trials at scale and pace.
- Regionally RD&E opened the first vaccine study mid-October with both Plymouth and Truro due to open vaccine trials in mid-November.
- Torbay was asked to stand up and make operational plans to deliver a vaccine study from early November too but then we had to withdraw / were stood down as the sponsor was unable to activate our site in the remaining recruitment timeframes. Instead we are currently listed provisionally for a new vaccine study commencing January 2021.
- A regional vaccine group has been established by the local CRN which feeds into the Governments National Vaccine Task force and also provides a local platform for networking, share learning and provide operational support, allowing a system wide joined up approach to best use resources and serve our local populations.
- R&D has established a vaccine trials working party with clinical leadership from Drs Hawkes, Clark and Anning. The planning of vaccine studies involves complex logistics and the need for large numbers over short periods and to set up and deliver studies at scale and pace.
- The lack of study specific details until last minute means we have had to undertake modelling predicated on needing to support high throughput (50-75 per day) over approx. 8-week periods (screening & vaccinations) + Follow up for up to 12 months which will be refined once study specific details are made available.
- For operational reasons we will only be able to accommodate vaccine clinics over the weekends and will need to use both the Jubilee Research Unit (JRU) and adjacent OPD clinics / H&L waiting areas to accommodate the numbers and flow with covid secure measures.

- A larger workforce will be required other than the R&D staff / teams (medical, nursing, volunteers) and associated training put in place accordingly led by R&D. We have made some targeted calls and have a database of additional staff and volunteers to call upon once we have more definitive details but further workforce demands and calls may be needed especially as the impact of the 2nd surge and other winter pressures increase.
- This is a big risk area for R&D as this will tie up most R&D staff so will impact on ability to support other UPH covid and non covid RESTART work.
- We have also had to secure a new portacabin on site; to facilitate the symptomatic pathway - compulsory for all vaccine trial sites to enable review of symptomatic participants; separate to the Trusts local pathways.
- We need to be both agile and responsive; as this is a very fast moving and fluid agenda; constantly changing and a needs fully collaborative multi-disciplinary approach involving medical and non-medical staff, medical students, GPs, peer vaccinators, pharmacy, community pharmacy, labs, OPD and H&L managers, estates, IPC, workforce, recruitment; in addition to senior and executive support and leadership.
- The CRN has provided additional funding to support the procurements of additional equipment e.g. portacabin, -20, -80 freezers and a fridge to provide vaccine storage capacity in pharmacy and support cold chain transfers.

COVID-19 impacts and learning

- Research is fundamentally our only effective route out of this pandemic so it is imperative the UPH studies are prioritised and all Trusts support to their best ability. *'R+D are going to be critical in getting the answers we need to keep people safe and well……and are as much the frontline as other clinical staff and services in many ways'*
- The NHS as a health and social care system; complimented by the unique network of experienced, well trained research staff and use of research infrastructure in all NHS Trusts funded by the NIHR and trials income etc; has given the UK a leading edge compared to other countries regarding setting up, scaling up and delivering research to respond to this pandemic.
- The research programme has already provided new effective treatments which are benefiting patients now; reducing the death rates compared to the first wave.
    - Most notably we have contributed to the RECOVERY trial, with over 11,000 patients enrolled to date across 176 NHS hospitals in the UK.
    - Within 100 days, the RECOVERY trial provided results enabling change in global practice three times: This extraordinary national effort has shown that two drugs used to treat hospitalised COVID patients throughout the world, hydroxychloroquine and lopinavir-ritonavir, do not improve survival, whilst low-dose dexamethasone reduces the risk of death by about one-third among patients receiving ventilation and by one-fifth in those requiring oxygen alone (but with no benefit among those not requiring respiratory support).
    - This discovery will be instrumental in reducing the overall inpatient COVID mortality rates during this 2nd surge.
    - Very recently the news of the 1st vaccine to hopefully be licensed and rolled out as part of a UK wide mass vaccination programme.
- It has been critical gaining agreement & support via the recovery cell and big room function to re-provide our research clinics (JRU) on Level 2; otherwise our ability to support the Covid-19 UPH studies, vaccines & our RESTART programme would have been impossible.
- R&D staff and clinical staff all came together united to support and deliver a common goal.
- As a Trust our level of activity & performance has been recognised. An exceptional achievement and to be commended. – see below.
- A real testament to the dedication of the whole team and the Trusts collaborative efforts supporting this crucial work.
- Covid has provided greater visibility, gained wider recognition and has promoted why research is important: We made a difference and are still making a difference locally, nationally and globally.

- This applies generally not just to covid but also to non covid research.
- It is important to ensure we prioritise work that has the greatest value to society, our community and business.
- There is a need to build on this accelerated engagement and culture shift and continue this momentum and learning.

Staff Bulletin June 8th 2020: Research and Development

'Shout out for the Research and Development team who have managed to do really well in their recruitment this year in spite of significant challenges. Then, on top of that, they are right at the forefront of enrolling in trials relating to Covid-19. The Torbay R&D team has enrolled in the second highest number of research studies for Covid-19 in the South west and has new studies in its sights. Although we are a relatively small centre, the chances of a Covid-19 patient being recruited to a research study is higher in Torbay than anywhere in the peninsula. So, we are really doing our bit to increase the learning about Covid-19 and to give our patients opportunities to test new drugs.

This is down to the energy and enthusiasm of the team led by Fiona Roberts and Chris Dixon, now with some help from Dr Matt Halkes. It is also entirely dependent on the willingness of already very busy clinicians to act as investigators and to recruit patients. We should thank all of our staff involved in these studies. A special thanks to the COVID research team of nurses, AHPs and administrators, Dr Tom Clark, Dr Louise Anning and the respiratory team. This has been a fantastic effort and means we will continue to deliver on this Urgent Public Health Agenda.

Keep it up team!'

Rob Dyer, Medical Director

What's next for Health Research?

Reflections on how we can maximise the benefits and lessons learned from research during COVID-19, which despite all the progress made; relies still on the value research plays to our organisations. *The collective view by key opinion leaders are 'that the most important and transformative intervention would be to make use of individual and organisational drivers to enable the behaviour change needed for clinical research to become business as usual across the health and care system."*

Appendix 2 Examples of further good news stories / commendations for research at Torbay:

- **OPTIMA** Study (Oncology) - Torbay was in the top 10 recruiters in 2019
- **PICO ONBOARD** study - top recruiters
- **ContactMe-IBS Study:** How effective is Consent for Contact in increasing opportunities to participate, and patient recruitment to IBS clinical trials? October 2019 Newsletter – *Torbay is the top recruiters for Secondary Care nationally.*
- **IMREAL Study** (Oncology) an observational study, investigating the outcomes and safety of the immunotherapy medication Atezolizumab under real-world conditions in patients treated in routine clinical practice with extensive stage small cell lung cancer. The Trust are the first to recruit a patient to this study nationally.
- One of the highest recruiters into the **KEYNOTE 859 study** in the UK (a clinical trial looking at the treatment of Upper GI Cancer with the immunotherapy drug Pembrolizumab in combination with standard chemotherapy.
- Dr Keeling and the cardiology research team were the first UK site to reach 50 randomised patients in the SELECT study: 'On behalf of everyone here in Novo Nordisk, we would like to congratulate you all on reaching this fantastic milestone and thank you for the exceptional work and dedication you have all put into this study so far, your contribution has made a significant difference to the success of this trial, and you and your team are a real inspiration to all of us as well as the other clinical sites taking part in the study'.

- **TANDEM study:** A randomized, double-blind, multicentre study to assess the safety, tolerability, and efficacy of a combination treatment of tropifexor (LJN452) and cenicriviroc (CVC) in adult patients with non-alcoholic steatohepatitis (NASH) and liver fibrosis: Novartis and the Study Manager's message to the research nurse involved with the study at Torbay *"we are so grateful for all your hard work which has proved to the global team that it was worth keeping your site open. Assuming these two patients are randomised you will officially be the joint highest recruiting site in the UK for TANDEM…… on a global level you have helped to pull the UK from under delivering to over delivering! Well done, it's been a nice day to be here with you."*

- **COSMOS study** (Rheumatology): Sponsor Janssen's study manager sent a message to the Torbay rheumatology research team *'This is all really positive and it is lovely to hear about work that is continuing outside of COVID_19 which has to be the priority and the exceptional work that TSDFT are achieving. On behalf of Janssen, I would like to express our thanks to the Torbay rheumatology research team for ensuring that the COSMOS study is run to such a high standard. Achieving 100% on data entry and query resolution metrics for the entire study. Well done and thank you for achieving this'. ……' I would also like to thank you for your preparation for monitoring visits and calls and for ensuring the availability of, or input from the study team. It makes study management so much smoother and demonstrates a high quality of oversight and study execution'.*

- The work of the Trust's COVID-19 Upskilling Group has been recognised in a nomination in the Advancing Healthcare Awards 2020 Esteem scheme which highlights the contribution of AHPs. Healthcare scientists and those who work alongside them during the COVID-19 crisis. "The COVID-19 Upskilling Group at South Devon NHS Foundation Trust, established in just one month, brought together a small group of staff including AHPs and nurses with links to the education and R & D departments as well as representatives of the community teams and trust operations. Together they have trained over 700 staff including AHPs reassigned during the initial COVID-19 response, in areas such as vital signs, identifying the deteriorating patient, basic hygiene care, basic life support and patient manual handling through a mixture of virtual and socially distanced face-to-face sessions – with a focus on the impact of reassignment on staff wellbeing".

NIHR News publication:

Torbay Hospital Deliver Research at Home for Self-Isolating Patients: The Rheumatology Team at Torbay Hospital changed how they are delivering research to keep trials going and ensure patients continue to have access to research opportunities during the Covid-19 pandemic. Working in conjunction with the commercial sponsor Janssen, the R&D Department has found new ways of working and has continued to deliver the COSMOS Study.

The primary purpose of the COSMOS Study is to evaluate the efficacy of Guselkumab versus placebo in patients with active psoriatic arthritis (PsA) who have had an inadequate response to Anti-Tumor Necrosis Factor Alpha (TNF-alpha) therapy, by assessing the reduction in signs and symptoms of joint disease.

The R&D team took a new approach to delivering the study for their patients in the face of challenges presented by Covid-19. "Our R&D Department had to carefully plan on how best to manage the situation in line with research governance. Since our rheumatology research patients are self-isolating due to Covid-19, it was agreed that we can send the trial medications to patients' homes and complete remote telephone visits and follow-up calls. For patients who were not capable of self-administering their medication; home visits with proper precautionary measures where completed. The drug companies approved this management plan and have provided protocol amendments for us to carry-out the remote follow-up procedures."

Despite urgent public health Covid-19 research studies being given priority status, the team at Torbay Hospital where determined to continue to maintain medication and follow up appointment for patients who were already on the trial. This was balanced against setting up new Covid-19 research studies and helping the acute hospital service.

The patients' needs and quality of life were put at the centre of decision making and research clinic follow-ups of patients on the active treatment phase of the rheumatology clinical trials were scheduled to coincide with their follow-ups with the Rheumatology Service.

Trust Improvement Group and closer working with QI / Education / digital horizons etc:

Examples of synergies: between R&D and QI team

Health Coaching / Navigators

This is now operational and running at Torbay but originally the project and concept came through R&D, after expressing interest in a national Randomised Controlled Trial (RCT) looking at reducing hospital admissions among high users of urgent care. A meeting was hosted by Torbay with representatives from other regional stakeholders (Providers, CCGs, STP etc). A decision was eventually taken to not proceed with the RCT and create a separate new QI project to implement as a service change / development. As such Susan Martin took the lead and worked up the project with the Trust and company etc.

UoP Clinical Schools Programme

Joint meeting held at Torbay Hospital to celebrate the launch of the school in 2018 which brought together staff across South Devon to learn more about the programme and showcase some projects bringing together work from research, service evaluations / QI and academic projects as exemplars and to foster networking. The 2nd conference was held in October 2019.

Doctoral Fellowship / development programme with Torbay Medical Research Fund (TMRF).

This programme is a joint venture between the Trust (Jane Viner, Chief Nurse as Exec Sponsor, Susan Martin and R&D); UoP Clinical Schools and the TMRF to support Staff to access and undertake either pre-doctoral training or part time PhDs. The aim is to establish a programme locally to support clinical staff wishing to develop their careers in research but remain as senior leaders, researchers and clinicians within the NHS; as well as opportunities to become clinical academic researchers. This programme complements current national awards from HEE / NIHR to support as well as enable development of the workforce at the scale and pace needed to support, facilitate and enable transformational changes in the NHS.

A number of projects whilst research focused and orientated have complimented and fed into QI projects and to the Trusts agenda for change and improvement (see below examples).

Researcher in Residence' (RiR) model.

Several projects / ventures as examples of the diversity of work to date where R&D / QI have come together and met with relevant services to address issues of both local & national importance. See below

This model is gaining more interest and traction as this type of mixed methods evaluation fits belter with the new DHSC research priorities to look at social care, service delivery and organisational changes etc Increasing interest from several stakeholders and potentially looking to hold a regional workshop next year.

ICO care model evaluation: A combination of both QI and research projects; helping the organisation evaluate robustly the new ICO model. Both methods have been needed as one could not sufficiently measure all aspects. This combination has provided the necessary quantitative and qualitative data, bringing richness and context; alongside the rigour and robustness needed for a strong evidence base. Impacts / outcomes and added value: This has subsequently led to:

- Published papers: 2 papers in press, 1 published and 2 in process plus dissemination and international conferences
- Interest in the work Torbay doing - recent visit from senior Government Officials: Prof. Chris Whitty (Chief Scientific Officer) & Dr Louise Woods (R&D Director DHSC)
- Working together to build on the relationships we have developed to expand and diversify this model of work:

Current:

Bids currently in preparation to the Torbay Medical Research Fund and Exeter University (grants and PhDs) – potential to expand model and answer key areas locally as well as addressing new national research priorities in Public Health, Prevention, Social Care and Mental Health.

- Looked after children (highest in England)
- Social prescribing
- Self-organising teams

Appendix 3: Summary: Examples of the Impacts and outcomes from studies Torbay hospital has led or participated in.

Clinical Specialty	Study details
Cancer (bladder)	**Patient-reported Quality of Life Outcomes in Patients Treated for Muscle-invasive Bladder Cancer with Radiotherapy ± Chemotherapy in the BC2001 Phase III Randomised Controlled Trial** BC2001, the largest randomised trial of bladder-sparing treatment for muscle-invasive bladder cancer, demonstrated improvement of local control and bladder cancer-specific survival from the addition of concomitant 5-fluorouracil and mitomycin C to radiotherapy. The study also assessed the impact of treatment on the health-related quality of life (HRQoL) of BC2001 participants and showed that Quality of life of bladder cancer patients treated with radiotherapy±chemotherapy deteriorates during treatment, but improves to at least pre-treatment levels within 6 months. Addition of chemotherapy to radiotherapy does not affect patient-reported quality of life.
Cancer (breast)	**Synchronous Versus Sequential Chemo-Radiotherapy in Patients with Early Stage Breast Cancer (SECRAB): A Randomised, Phase III, Trial** The optimal sequence of adjuvant chemotherapy and radiotherapy for breast cancer is unknown. SECRAB. was a prospective, open-label, multi-centre, phase III trial looking to assess whether local control can be improved without increased toxicity by comparing synchronous to sequential chemo-radiotherapy, conducted in 48 UK centres. The study results show that synchronous chemo-radiotherapy significantly improved local recurrence rates. This was delivered with an acceptable increase in acute toxicity. The greatest benefit of synchronous chemo-radiation was in patients treated with anthracycline-CMF.
Cancer (breast)	**Hypofractionated breast radiotherapy for 1 week versus 3 weeks (Fast-Forward): 5-year efficacy and late normal tissue effects results from a multicentre, non-inferiority, randomised, phase 3 trial** A large number of Torbay patients took part in the pioneering Fast Forward Radiotherapy clinical research trial which found that a one-week course of radiotherapy – rather than the standard three-week treatment – will benefit women with early stage breast cancer. These results, have significant implications for both our patients and the Trust as a whole. Patients will now have to spend a lot less time travelling to receive treatments which will be crucial in ensuring reduced patient contact during the COVID pandemic. The ability to reduce the number of patient visits also has huge implications for NHS resources with an estimated saving of 50 million per year if all Trusts adopt this finding as standard of care.

	As soon as the results were published our local radiotherapy team worked tirelessly to develop and put in place protocols so that this new practice could be adopted. This is crucial to our COVID recovery plan and will help free up capacity and resources in the service during this difficult time.
Cancer (Colorectal)	**3-month versus 6-month adjuvant chemotherapy for patients with high-risk stage II and III colorectal cancer: 3-year follow-up of the SCOT non-inferiority RCT** Patients diagnosed with bowel cancer are likely to have surgery to remove the tumour. Patients diagnosed with a more advanced stage of the disease are then likely to be offered what is known as adjuvant chemotherapy. The study assessed the efficacy of 3-month versus 6-month adjuvant chemotherapy for colorectal cancer and to compare the toxicity, health-related quality of life and cost-effectiveness of the durations. Overall, the study showed that 3-month adjuvant chemotherapy for patients with bowel cancer is as effective as 6-month adjuvant chemotherapy and causes fewer side effects.
Cancer (Malignant Haematology)	**Characteristics Associated with Significantly Worse Quality of Life in Mycosis fungoides/Sézary Syndrome from the Prospective Cutaneous Lymphoma International Prognostic Index (PROCLIPI) Study** Mycosis fungoides (MF) and Sézary Syndrome (SS) are the most common cutaneous T-cell lymphomas. MF/SS is accompanied by considerable morbidity from pain, itching and disfigurement. The study aimed to identify factors associated with poorer health-related quality of life (HRQoL) in patients newly diagnosed with MF/SS. **Conclusions:** This is the first prospective study to investigate HRQoL in newly diagnosed patients with MF/SS. The results show that HRQoL is worse in women and in those with alopecia and confluent erythema. MF/SS diagnosis has a multidimensional impact on patient HRQoL, including a large burden of cutaneous symptoms, as well as a negative impact on emotional well-being. The results show that a comprehensive validated cutaneous T-cell lymphoma-specific questionnaire is urgently needed to more accurately assess disease-specific HRQoL in these patients.
Cancer (Malignant Haematology)	**The UK NCRI Study of Chlorambucil, Mitoxantrone and Dexamethasone (CMD) Versus Fludarabine, Mitoxantrone and Dexamethasone (FMD) for Untreated Advanced Stage Follicular Lymphoma: Molecular Response Strongly Predicts Prolonged Overall Survival** This trial was the first to prospectively assess molecular response and the impact on outcomes for 400 patients. Long-term follow-up data shows that no cases of progression occurred in minimal residual disease (MRD) negative patients after six years of follow-up. Although there was no difference in outcomes between arms, this is the first prospective study to report MRD negativity resulting in significantly improved Overall survival (OS).

Cancer (prostate)	**Addition of Docetaxel to Hormonal Therapy in Low- And High-Burden Metastatic Hormone Sensitive Prostate Cancer: Long-Term Survival Results From the STAMPEDE Trial** The STAMPEDE trial has previously reported that the use of upfront docetaxel improved overall survival (OS) for metastatic hormone naïve prostate cancer patients starting long-term androgen deprivation therapy. The clinically significant benefit in survival for upfront docetaxel persists at longer follow-up, with no evidence that benefit differed by metastatic burden. The research advocates that upfront docetaxel is considered for metastatic hormone naïve prostate cancer patients regardless of metastatic burden.
Cancer (renal)	**SORCE:** A phase III Randomised Controlled Study Comparing Sorafenib With Placebo In Patients With Resected Primary Renal Cell Carcinoma at High or Intermediate Risk of Relapse This study showed **no disease-free survival (DFS) or overall survival (OS) benefit** with either 1 or 3 years of adjuvant treatment with sorafenib and therefore Sorafenib will not be used to treat patients who have had their kidney cancer removed by surgery. This study has helped to make a real difference: people will not be given this ineffective treatment in the future. Careful observation with regular clinical reviews, imaging and blood tests, remains the best care for patients following surgery to remove a kidney cancer.
Covid-19 (Infection)	**Evaluation of COVid-19 thERapY (RECOVERY) Trial** **RECOVERY TRIAL**(Randomised Evaluation of COVid-19 thERapY) The RECOVERY trial has provided results enabling change in global practice three times. This extraordinary national effort has shown that two drugs used to treat hospitalised COVID patients throughout the world, hydroxychloroquine and lopinavir-ritonavir, do not improve survival, whilst one drug that was not recommended, dexamethasone, saves lives.' Low-cost dexamethasone reduces death by one-third in ventilated patients and by one fifth in other patients receiving oxygen only. There was no benefit among those patients who did not require respiratory support. Based on these results, 1 death would be prevented by treatment of around 8 ventilated patients or around 25 patients requiring oxygen alone. The survival benefit is clear and is now standard of care in these patients. Dexamethasone is inexpensive, on the shelf, and can be used immediately to save lives worldwide.

Critical Care	**Effect of Reduced Exposure to Vasopressors on 90-Day Mortality in Older Critically Ill Patients With Vasodilatory HypotensionA Randomized Clinical Trial (the 65 trial)** **Question** What is the effect on mortality at 90 days of reducing the exposure to vasopressors through permissive hypotension (mean arterial pressure target of 60-65 mm Hg) in intensive care unit (ICU) patients aged 65 years or older receiving vasopressors for vasodilatory hypotension? **Conclusions and Relevance:** Among patients 65 years or older receiving vasopressors for vasodilatory hypotension, permissive hypotension compared with usual care did not result in a statistically significant reduction in mortality at 90 days. However, the confidence interval around the point estimate for the primary outcome should be considered when interpreting the clinical importance of the study.
Gynaecology	**Surgical interventions for uterine prolapse and for vault prolapse: the two VUE Randomised Controlled Trials (RCTs)** About 1 in 10 women has pelvic organ prolapse (POP) surgery, and around three of these women require a further operation. The aim of this study was to identify the most appropriate surgery for two different types of POP found in women: (1) when the uterus itself has come down – the Uterine trial comparing surgical uterine preservation with vaginal hysterectomy – and (2) when a previous hysterectomy has resulted in the top of the vagina coming down – the Vault trial comparing abdominal procedures with vaginal procedures. The study considered clinical effectiveness, adverse events, quality of life and cost-effectiveness. There results show there was no difference in symptoms or quality of life between uterine preservation versus vaginal hysterectomy for uterine prolapse or between abdominal versus vaginal approaches for vault prolapse Women in both trials will be followed up for at least 6 years to determine longer-term costs and consequences.
Gastroenterology	**HALT-IT trial: Tranexamic Acid for the Treatment of Gastrointestinal Haemorrhage: An International Randomised, Double Blind Placebo Controlled Trial** A drug licensed to treat stomach bleeding, that some doctors felt was too effective to withhold. Tranexamic acid reduces bleeding in surgery and reduces deaths from bleeding after serious injury and childbirth – in both cases without increasing side effects, but it was unknown whether or not it was effective in reducing bleeding from the stomach. The results showed that tranexamic acid does not reduce deaths from stomach bleeding but increases the risk of thromboembolic events (clots in the veins of the legs that can move to the lungs). There were also more seizures with tranexamic acid. Re-bleeding was similar in both groups.

	The trial is hugely important to patient care as it shows that tranexamic acid is not effective for gastrointestinal bleeding, which is still a big cause of hospital admission and death in the UK and provides an excellent example of the need for clinical research and how a clinical trial studying a specific cause of bleeding can uncover that one treatment doesn't necessarily work the same for all causes of bleeding.
Health Services Research	**Capturing the Role of Context in Complex System Change: An Application of the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to an Integrated Care Organisation in the UK** **Purpose:** This study applied the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to investigate factors influencing the implementation and outcomes of a complex integrated care change programme in Torbay and South Devon (TSD) and, more specifically, in one of five sub-localities, Coastal. If integrated care approaches are to be properly adapted to local contexts, a better understanding is required of key determinants of implementation and how these might be appropriately supported. **Conclusions:** The CCIC Framework provided a useful tool capturing key elements of complex system change with key domains being transferable across settings, while also finding local variation in the UK. This would encourage its wider application so that further comparisons can be made of the ways in which different contextual and implementation properties impact upon delivery and outcomes.
Orthopaedics	**Midterm Outcomes of a Synthetic Cartilage Implant for the First Metatarsophalangeal Joint in Advanced Hallux Rigidus** A prospective, randomized, noninferiority clinical trial of synthetic cartilage implant hemiarthroplasty for hallux rigidus (big toe arthritis) demonstrated functional outcomes and safety equivalent to first metatarsophalangeal (MTP) joint arthrodesis at 24 months. The clinical and safety outcomes for synthetic cartilage implant hemiarthroplasty observed at 2 years were maintained at 5.8 years. The implant remains a viable treatment option to decrease pain, improve function, and maintain motion for advanced hallux rigidus.
Ophthalmology (Trust led and sponsored study - Mr Eddie Doyle)	**Measuring image distortions arising from age-related macular degeneration: An Iterative Amsler Grid (IAG)** **Objective -** Metamorphopsia, a condition experienced in age-related macular degeneration (AMD), is characterized by perceived distortion of a shape. In metamorphopsia, straight lines appear to be curved and wavy to patients with AMD and some other retinal pathologies such as epiretinal membrane. The conventional clinical tool to detect metamorphosia involves asking patients to identify irregularities in the Amsler Grid, which is composed of equally spaced vertical and horizontal lines. Any distortions or missing regions in the grid are taken as

	a sign of macular pathology. The researchers developed an iterative procedure (IAG), to obtain a reproducible and quantifiable map of visual deformations. **Design & Methods -** In this procedure, regular horizontal and vertical line segments are displayed on a computer screen and presented to subjects with conditions causing stable metamorphopsia, to probe selected regions of the visual field. If any of these line segments appear distorted, they are then adjusted by the subject to make them appear straight using the computer mouse. **Participants –** Ten control participants with normal or corrected-to-normal vision. **Results -** Control participants are able to reliably correct deformations that simulate metamorphopsia while maintaining fixation in the centre of the grid. In a further study, we attempt to obtain deformation maps from patients at various stages of AMD. For those patients, who were not confident using the computer mouse due to motor control problem or lack of practice with computers, we collected data by following their verbal instructions to the experimenter who then adjusted the tilt of line segments. Patients who had extensive scotomas or serious fixation problems found this procedure challenging, but others were comfortable using the IAG method and generated deformation maps that corresponded with their subjective reports. **Conclusion –** A computerized procedure as we developed (IAG) has a potential to not only indicate visual distortions in metamorphosia, but can also quantify and map them reliably.
Physiotherapy	**Exercise or manual physiotherapy compared with a single session of physiotherapy for osteoporotic vertebral fracture: three-arm PROVE RCT** Osteoporosis is a condition in which bones lose their strength and are more likely to break. It affects around 3 million people in the UK. Fractures of the spine are very common in people with osteoporosis. The objective was to investigate the clinical effectiveness and cost-effectiveness of two different physiotherapy programmes for people with OVF compared with a single physiotherapy session. This is the largest RCT to date assessing physiotherapy in participants with OVFs. At 1 year, neither treatment intervention conferred more benefit than a single 1-hour physiotherapy advice session on quality of life or muscle endurance.
Sexual Health	**PReP IMPACT trial: A pragmatic health technology assessment of PREP and implementation** The PrEP Impact study closed to new participants in July 2020 and a fully commissioned PrEP programme has now been agreed for England and Local Authorities have been sent a “toolkit” to help them commission PrEP services in their locality to provide medication through this route.

Stroke	**Dopamine Augmented Rehabilitation in Stroke (DARS): a multicentre double-blind, randomised controlled trial of co-careldopa compared with placebo, in addition to routine NHS occupational and physical therapy, delivered early after stroke on functional recovery** The results show that Co-careldopa in addition to routine NHS occupational and physical therapy is not clinically effective or cost-effective in improving walking, physical functioning, mood or cognition following stroke.
Surgery	**Robotic-assisted surgery compared with laparoscopic resection surgery for rectal cancer: the ROLARR RCT** This was a multicentre, randomised trial comparing robotic with laparoscopic rectal resection in patients with rectal adenocarcinoma. The study concluded that robotic surgery does not reduce the need to perform open surgery in a small number of patients with rectal cancer. Robotic surgery is more expensive than laparoscopic surgery, with no obvious benefits for patients in the short or long term.
Urology	**Clinical and Patient-reported Outcome Measures in Men Referred for Consideration of Surgery to Treat Lower Urinary Tract Symptoms: Baseline Results and Diagnostic Findings of the Urodynamics for Prostate Surgery Trial; Randomised Evaluation of Assessment Methods (UPSTREAM)** Clinical evaluation of male lower urinary tract symptoms (MLUTS) in secondary care uses a range of assessments. It is unknown how MLUTS evaluation influences outcome of therapy recommendations and choice, notably urodynamics (UDS; filling cystometry and pressure flow studies). This study is a randomised controlled trial evaluating whether symptoms are noninferior and surgery rates are lower if UDS is included. The initial findings show that men being considered for surgery have additional clinical features that may affect treatment decision making and outcomes, notably storage LUTS and impaired sexual function.

Torbay and South Devon NHS
NHS Foundation Trust

Report of Finance, Performance and Digital Committee Chair to TSDFT Board of Directors

Meeting date:	28th October 2020
Report by + date:	Chris Balch, 19th November 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 6, September 2020):

1. The Committee received an update on the Urgent and Emergency Care business case which has received approval from NHSE/I for £15m capital expenditure spread over 2 financial years.

2. The Committee discussed and approved the Trust responding to an ITT which is expected to be issued shortly by Torbay Council for the delivery of services to adults with multiple complex needs. This a re-tendering of the substance misuse community service currently delivered by TSDFT as part of a wider package of services. Approval for pursuing this tender was subject to the condition that the final bid should be scrutinised by the Committee.

3. The Committee reviewed the Integrated Performance Report for September. The continuing focus on quality was noted identifying emerging issues of concern requiring further investigation and appropriate action. The September IPR reveals the step up of elective and diagnostic activity as part of the Phase 3 plan albeit below pre-Covid levels. This is reflected in a significant increase in 18 week and 52 week waiting times. However, performance in urgent care and cancer treatment has been maintained at or close to target. The potential impact of winter pressures and a second wave of Covid-19 infection on performance was noted.

4. For assurance the Committee reviewed the Month 6 Financial Performance which, excluding Covid-19 expenses and top up income, is a surplus of £9.177m. 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 at the half year (Month 6).

5. The Committee received a presentation on the Trust's Financial Forecast and Planning Submission for Months 7 to 12. This forms an input to the system level planning submission agreed with the STP and approved by NHSE/I. While the underlying position of the Trust for Months 7 to 12 is a deficit of £9.4m, inclusive of the impact of the financial incentive scheme, agreement has been reached around the sharing of system resources to reduce the deficit to £605k which represents the loss of commercial income due to Covid-19. Achieving this position is subject to a range of risks and assumptions that will need to be kept under review and managed.

6. The Trust maintains a healthy cash position because of advance payments received as part of the Government's support package for the NHS. This can be anticipated to unwind at the end of the financial year.

7. The Committee received an update on the Trust's capital programme for 2020/21 which has approvals for expenditure of £38m. This has been subject to a detailed review to provide assurance over delivery. The Committee approved an increase of £2.94m in the use of the Trust's cash resources to fund some of the work. This will require more active debt management by the Trust.

8. The Committee were asked to approve an increase in expenditure of £790k for enabling works for the installation of the CT scanner approved by the Committee in September and an increase of £780 in the cost of the network replacement programme. While accepting these cost increases the Committee expressed concern about the reliability of cost estimates provided as part of business cases.

9. The Committee received a report on work being undertaken to update the Trust's commercial strategy. The nature of the Trust's work on securing financial contributions for health infrastructure through the planning system (s106) across Devon on behalf of the CCG and UHP was discussed. A governance process for overseeing this work by the Committee was agreed.

10. The Committee received and agreed minor changes to the Trust's scheme of delegation for approval by the Board.

11. The Committee reviewed the Board Assurance Framework and Corporate Risk Register focusing on those items which fall within its remit and were assured that the Committee agenda had addressed these risks.

12. Reports were received and noted on:

    - Torbay Pharmaceuticals financial performance in Month 6
    - SDH Developments Ltd
    - Capital Infrastructure and Environment Group
    - IM&T Group

Key Decision(s)/Recommendations Made:

1. To note the decisions as outlined in 2. and 9. as outlined above.

Name: Chris Balch (Committee Chair)

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report November 2020			**Meeting date:** 25th November 2020
Report sponsor	John Harrison		
Report author	System Directors		
Report provenance	Contents reflect latest updates from management leads across all Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)		
Purpose of the report and key issues for consideration/decision	To provide an operational update to complement the IPR monthly reports including performance metrics. The report explains the key risks and operational responses to support delivery of the winter plan and for delivery of elective services during COVID and the phase 3 plan. The report also provides information and greater visibility for a number of important areas of Trust business not fully covered in the IPR. Key issues for consideration are the continuation of the Covid-19 pressure on capacity, the consequential impact on elective pathways of care and the Trusts response in support of nursing and residential capacity in the context of Covid-19. Identification of operational capacity to deliver detailed efficiency plans is essential for delivery of the Trust business plan and strategy and is being prioritised.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

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

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<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>
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Report title: Chief Operating Officer's Report November 2020		**Meeting date:** 25 November 2020
Report sponsor	Chief Operating Officer	
Report author	System Director	

1. Purpose

This report provides the Board with an update on progress and the controls in place in relation to operational delivery across the Trusts 5 ISU's and CFHD

2. Content

This report provides an update in relation to impact of Covid-19 admissions, Phase 3 delivery, cancer diagnostics and stepping up of elective services. Also included is the Clinical prioritisation and validation of elective waiting lists, changes to the Emergency Department and Medical and Surgical Receiving units' activity. These developments are key in the safe and effective running of the urgent care pathways and the Emergency Department along with flow through our health and care system.

Other activities to be highlighted this month is the work to identify savings plans and within CFHD in respect of the work to strengthen governance and improve waiting times. Community services across the Torbay and South Devon Systems are highlighted including a position statement on the development of Health and Wellbeing centres. Progress update with transformation and CIP planning across the ISUs.

3. Covid-19 operational impact

In the October report it was reported that the Trust had triggered implementation of the Covid enlarge plan in response to growing numbers of people requiring treatment for Covid- 19. The Covid ward as per the enlarge plan was identified (Cromie) and Brixham hospital was set up as a 'blue hospital' to be the discharge route for post Covid patients. A further increase in acute admissions and a growing incidence of outbreaks in care homes triggered escalation to the next step of our enlarge plan and the transition of another elective surgical ward for the treatment of patients with covid-19. This change resulted in the cancellation of inpatient orthopaedic surgery.

The Trust has continued to work with system partners to ensure appropriate use of capacity across the acute sector which has allowed for the transfer of some patients to the RD&E Hospital in line with our winter plan. The numbers transferred were less than initial expected due to operational pressures that have existed in the East that have limited capacity. This is being kept under review.

The Health and wellbeing teams working in partnership with primary care and our Infection Prevention and Control (IPC) Team have continued to provide dedicated support to care homes across the footprint which have helped reduce the impact of the outbreak and with it the number of hospital admissions.

The incident management process was recommenced with silver and gold command structure to coordinate the operational response. Further planning to manage current flows and to ensure onward care is underway with a second community hospital for post Covid patients is being set up in late November.

4. Children and Family Health Devon (CFHD)

Extensive and focussed work has been on-going since late August to address the extended waiting times in a number of services. The drivers for the waiting time are numerous and all services have operationalised practices in place for reviewing risks and keeping children safe whilst they are waiting. The Alliance Director is working with partners to influence system wide change where this can support.

There are two significant strands of work underway to strengthen the CFHD infrastructure. A review of the CFHD governance architecture, which is focussed on creating an efficient reporting and assurance system for CFHD. This is being designed to satisfy requirements of TSD as lead contractor, and the requirements of partner providers. Connected to this is a piece of work to strengthen the approach in CFHD to managing and mitigating risks, which involves potential changes to reporting systems alongside cultural change in the identification and management of risks. The second strand in the infrastructure work involves identifying arrangements for corporate support functions, addressing gaps and establishing robust long-term arrangements.

Progress is being made to strengthen safeguarding governance and systems with the new Safeguarding Children Governance Group established a detailed action plan to steer improvements.

The transformation plan to implement the new service model is being refreshed with workforce, clinical pathway design, IT strategy and communication and engagement workstreams being put in place. The CFHD external review is complete and plans are in place to share it with the workforce and partnership board. Central to the learning from the review will be engaging our staff with the model and workforce refresh.

Active management of Covid in relation to the resurgence and national restrictions is in place. This will ensure service provision is optimal, that staff are adequately protected and the cumulative, adverse impacts of Covid-19 and national/local responses to the pandemic on children and young people are minimised.

5. Phase 3 recovery

The focused work to minimise the number of people waiting over 52 weeks for elective care is seeing some success. Over a 21-day period, teams reduced the number of patients who would have been waiting 52 weeks in March 2021 by 830. This is as a result of 516 patients being given an appointment date and others having been identified as in fact, no longer waiting.

The Trust continues outsourcing of echocardiography scanning for cardiology patients. This activity is reducing a significant backlog that has been compounded by the Covid. In parallel to this, mitigating work is being undertaken within the cardiology service to better understand echo machine and operator utilisation to ensure optimal use across seven days of the week. As a result of the outsourcing a waiting list backlog of echo requests from Primary Care has been cleared. Much of the improvement has been achieved by reducing the number of face to face appointments in an outpatient setting where this is safe and appropriate. Remote monitoring is key to being able to take this improvement further and the cardiology team, through the business planning process is seeking to support expansion of this aspect of the service. Other aspects of the diagnostic studies within cardiology, e.g. tape monitoring, pacemaker checks, and heart monitors have all seen an improvement in waiting times.

5.1 Cancer

Whilst it is still early days the second lockdown is already resulting in some patients choosing to ask for deferments for their treatment. The Cancer Team will be keeping this under review and is encouraging patients to attend for their appointments confirming the hospital a safe place to visit for these treatments.

The Peninsula Cancer Alliance (PCA) Surgical Hub meets weekly. All trusts are reporting COVID surge impacting on surgical capacity. Each surgical team is reviewing and categorising patients for clinical prioritisation and the PCA is requesting establishment of a daily clinical prioritisation process across all surgical specialties.

The Trust continues to maintain its compliance against the 31day standard and the current performance against the 28day standard is in excess of the 75% target.

The Trust is an outlier for the urology diagnostic pathway, a limiting factor being appropriate space in an outpatient setting. Priority is therefore being given to urology transformation. This work will benefit, day case theatre capacity as well as urology pathways.

In order to accommodate an urgent need to re-locate the paediatric short stay assessment service for the winter months the chemotherapy day service, currently based in Ricky Grant Day Unit, is to be relocated.

5.2 Diagnostics

As highlighted last month the Trust has had to transfer the mobile CT scanning service from Newton Abbot. This contract has been managed by NHSE/I since the start of the Covid crisis and greater need for the scanner was identified elsewhere in the country. Waiting times are starting to increase as a result, mitigating actions such as the use of NHE are being progressed but at risk if the use of NHE ramps up for the management of Covid-related patients. Alternative replacement CT capacity has not yet been identified until the installation of the 3rd CT scanner in quarter 4 this year. Following significant supply issues with the laboratory managed service partner (Roche) normal service has now resumed. Through collaborative working across local health partners the Trust was able to minimise impact to end users and

ultimately patients. Some disruption to non-urgent Primary Care was experienced but kept to an absolute minimum. The incident and its subsequent management highlighted the strength of collaborative working, a collaboration that is well established throughout the labs concerned.

The endoscopy staff consultation has concluded, increasing capacity within the service as business as usual. The timescale for reopening of one of the endoscopy rooms has been confirmed as the end of March, this is 3 months later than expected and is impacting significantly on the phase 3 recovery plans. The operational and clinical lead are working hard to mitigate the impact but at this stage the team is not able to confirm full recovery of the position.

5.3 Elective Care

Phase 3 recovery: estates and operational teams are working through detailed improvement plans for theatres to optimise activity and throughput. A bi-weekly meeting is in place to discuss progress and problem solve together.

Out patients are currently operating at approximately 70-80% of pre COVID levels, however congestion on Level 2 outpatients is currently an issue with the imperative to maintain social distancing. There is a workplan for level 2 with the relocation of ophthalmology laser suite and movement of the MAT team as part of the enabling plan for the new modular build. Appointments have been made in colorectal surgery starting in 21/22. A locum has been appointed to cover the intervening period along with a locum urology consultant.

As a result of the increased Covid admissions (blue pathway) a surgical ward has been temporarily converted from elective care. In addition, there has been a delay in returning theatres 1 and 2 and this has resulted in a loss of elective surgical activity this is being closely monitored to minimise risks to long waits. We continue to use the independent sector (MSH) to support activity in breast / urology / endoscopy. The team are implementing an STP harm review process which is 80% complete. Physiotherapy have made excellent progress and are leading the way with 75% of their patient contacts now non-face to face.

5.4 Risks to delivery and mitigations

- Support – Absence in some of the support to operational services is impacting on the workload and ability to provide the level of information required to help the operational team manage their workload.
- Emergent issue continues to present, diverting resource, e.g. coordination of Level 2 moves, this has been raised to ensure there is an SRO and a workplan with additional project management time.
- Room 3, theatres 1&2, Urology redesign, delays as described are reducing the capacity and ability to reach the planned trajectories.
- Loss of elective orthopaedic ward, optimising day surgery pathways, the independent sector are being used and further mitigation is still being sought.

Workload, reacting to changing circumstances, on top of business as usual is creating additional pressures for teams.

6. Emergency Department

6.1 Phase 1 COVID/Winter secure

The prevalence of COVID-19 has impacted on the ability to maintain the programme of works while ensuring patient, staff and contractors' safety at all times. This has led to an extension by 2 weeks pushing the delivery of the completed works to mid December 2020. The Emergency Department continues to monitor the situation daily so that safe emergency care can be provided and is working closely with the contractors.

6.2 Medical Receiving Unit

The Medical Receiving Unit (MRU) continues to provide essential care for acutely unwell medical patients without the need to attend the Emergency Department (ED). This continues to build on the Trusts vision treating patients in the right place at the right time. The MRU is situated on Forrest ward and continues to reduce the impact on the ED by accepting all medical GP referred patients without the need to attend the ED.

Work continues to deliver a new Medical Receiving Unit mid 2021/22.

6.3 Emergency Department Phase 2

Following Winter 2020/21, the Emergency Department (ED) will undertake further works to improve the environment to see and treat patients. This will build on the phase 1 works to extend the ED considerably for Paediatrics, waiting areas and treatment areas. It will also see the new MRU linked to the ED providing an improved environment for the treatment of all patients across emergency areas.

7. Torbay System Community Services

7.1 Adult Social Care Improvement Plan (ASCiP) and Continuing Health Care

The focus on the interim health funding reviews continues and a creative approach to the reviews of packages of care incorporating collaboration with other key partners for maximum impact across the sector.

The strength based and preventative approach is linking up key partners such as Technology Enabled Care and Public Health to drive early intervention and some of the key issues faced in mental health and diabetes.

Work initiated within the QAIT (Quality assessment and intervention) team to streamline and improve delivery has been scoped with detailed practical applications for future functioning described. The ASCiP has a focused work plan for contracting and market management

8. South Devon Community Services

Across the South Devon community system, the teams are prepared for setting up blue and green team working. In the event of COVID-19 patient number increases beyond the ability of individual teams being able to segregate caseloads safely, a separate team based at Teignmouth (1st step) with the potential to increase to a second team based at Ashburton (2nd step) will be triggered. This will include Rapid Response, Community Nursing and Therapy services. This team will cover the South Devon footprint 7 days per week.

From a social care perspective all teams are maintaining their ability to keep up with reviewing hospital discharges within the 6-week period with robust oversight by the Community Service Managers.

The Hospital discharge team continues to support the discharge HUB and in-reaching to support complex discharges. The urgent community care group continues to focus on delivery of D2A pathways across the 5 ISUs. Work is reaching conclusion to ensure clear education on the national discharge guidelines are met and leaflets and posters that have been co-designed are available in all areas and underpin clear performance against the standards.

8.1 Moor to Sea Health and Wellbeing Centre

A Dartmouth stakeholder meeting is planned for early December, we are waiting for an update from South Hams District Council regarding planning permission for the new development.

8.2 Newton Abbot Health and Wellbeing Centre

Work continues to further develop the Health and Wellbeing Centre in Newton Abbot as a hub for the community. This will provide a Multi-Disciplinary Team (MDT) working seamlessly to improve the health and wellbeing of Newton Abbot and the surrounding areas. Links to GP's through the Primary Care Networks are establishing the Enhanced Health in Care Homes and Population Health Management.

8.3 Moor to Sea

Frailty work continues to be developed with key leadership being provided across the system. Primary care and Heath Care for the Older Person (HOP) consultants engaged and work is progressing to develop this pathway.

All data around the long length of say (LLOS) and people fit to reside is being returned to NHS England. The team remains focused on maintaining a positive position with low numbers of people with stays over 21 days and low numbers of delays. Hard reset process now reported through the control room to ensure system oversight. Focus on support for patients recovering from Covid is also being delivered through this work.

9. Organisational progress on transformation and CIP delivery

Each ISU have had had round table discussions on their progress and plans to deliver the CIP targets, these sessions have been supported with transformation colleagues to detail what is possible and establish plans from granular speciality level through to cross ISU cross organisational ambitions.

10. Conclusion

Increased focus this month has been on stepping up the efficiency plans for the 2021/22 business planning round building on the work carried out prior to the pandemic. This has been a challenging month for all teams with continued efforts to ensure the stepping up on delivery of phase 3 activity combined with Covid-19 wave affecting not only our acute and community teams but also our workforce with the impact of staff Covid sickness and staff self-isolating. The teams have all worked exceptionally hard to maintain patient safety first and foremost.

11. Recommendation

The Board is asked to note the level of progress against operational priorities.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Estates and Facilities – Top line briefs, EFM performance, compliance and exception report		Meeting date: 25th November 2020
Report appendix	Summary Report	
Report sponsor	Chief Finance Officer	
Report author	Interim Director of Environment Associate Director, Estates and Facilities Operations	
Report provenance	Capital Infrastructure and Environment Group EFM Performance and Compliance Group EFM Senior Management Team Meeting 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 September and October 2020. **Estates and Facilities Operations Compliance Issues and Exceptions** **Estates and Facilities Operations Top Concerns.** **Tower Fire Strategy** -The Director of Environment is leading a scoping exercise to improve fire safety and the ability to evacuate the Tower Block in the event of a fire. This includes options around fire compartmentation, installation of fire evacuation lifts, evacuation equipment and lift access for the Devon and Somerset Fire and rescue service. **Fire Main –** A further temporary repair has been completed to ensure the Fire main is operational and water provided to all hydrants. A report has been received from a Specialist Consultant following the initial Fire Main review. Recommendations are currently being reviewed although the survey indicates a new Fire Main is required. Costs to replace the fire main are now being obtained from a specialist contractor. **Acute Site Lifts-** The Trusts Lift Authorising Engineers are undertaking a condition survey of all Lifts on the Acute Hospital Site. This report is expected before Christmas 2020 and will assist with a lift prioritisation replacement programme to enable business cases to be prepared for capital funds allocation in 2021/22. The Warrington/Ainslie Lift will be replaced this year, which will complete the programme to provide the Old Hospital with two new lifts. The existing Lift Maintenance Contract is due to end on the 31st December 2020 as part of the South West Peninsular contract. Options are currently being considered which may result in the Trust	

appointing a new lift maintenance contractor. In addition, the current contractor has been asked to provide critical spares to be kept on Trust site to speed up repairs and reduce downtime of out of service lifts.

Estates and Facilities Operations Action Plans

HSE – progress of the EFM actions within the overall Trust HSE action plan continue to be monitored by the Site Services Lead. The installation of a height restrictor at the Fracture clinic area will be completed by 31st March 2021. The Head of Procurement has indicated that additional logistics staffing will be required to support a system of opening and closing the barrier as goods vehicles arrive and is due to present this case for approval to the Chief Finance Officer.

Other EFM actions included improvements around street lighting and work has progressed to ensure the site is safe. This includes the implementation of a contract to carry out regular night scouts of the site ensuring failed lighting is reported and repaired.

Waste – Following receipt of the waste audit report, conducted by an external consultant, a revised action plan has been drawn up by the Head of Facilities and a full report will be presented to the Capital Infrastructure Group in December 2020 which will detail the key issues and recommendations the Trust should consider to develop a sustainable approach to waste management. This will include the benefits of implementing the recommendations, such as cost savings, improved health and safety of staff, patients and visitors and reducing environmental impact. The education of Trust staff around waste segregation will be key in delivering these improvements and training packages are currently being explored.

CQC Inspection March 2020 – EFM related CQC Inspection Must Do and Should Do remedial actions

Forrest Ward Windows -– An initial survey has been completed and concluded, due to the age of the current windows, are beyond repair and require replacement. This will require each ward to be decanted whilst the work is completed and capital funding of c£1.4m.

Simpson Ward flooring – The Clinical Teams, Infection Control and Health and Safety Manager have agreed to the replacement flooring to be carried out as a patch repair undertaken in the live environment as full decant of the ward is not possible. The Building Services Lead is currently scoping a programme of work following Silver Control agreement for this work to proceed. It is anticipated that the work will commence before Christmas 2020.

Hetherington Corridor / Ward Clutter- EFM will support the Clinical teams with this action once clarity is received from the ADNPP as to additional storage facilities required.

	Estates and Facilities Operations Update **Mechanical Services –** Two Band 7 Mechanical Services Leads have been appointed following successful recruitment, with one due to start 16th November and the second starting 11th January 2021. Both will be supported by the current Mechanical Services Lead, who will be retiring on the 31st March 2021. This will enable the relevant training to be undertaken by the two new members of staff in relation to Authorised Persons duties. ***The summary report is attached.***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to receive and note the: • Compliance issues and exceptions • EFM Compliance and Performance 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**	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 to:	Trust Board of Directors
Date:	25th November 2020
Lead Director:	Chief Finance Officer
Report Title:	Estates and Facilities Operations Compliance & Performance Report

1. Estates and Facilities Operations – Key Issues and Exceptions report for September and October 2020.

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the months of September and October 2020.

Table 1 below identifies the Key Performance Indicators variances for Estates and Facilities performance for the months of September and October 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: September and October 2020 Scorecard Indicator.

Green ✓ | Amber ! | Red ✘	**September 2020**	**October 2020**
Deteriorating Indicators		
% of Total tonnage of Clinical Non-Burn waste per month	!	✘
Statutory Waste Audits - % completed	✓	✘
Improving Indicators		
Urgent - % P2 completed in < 1 – 4 Days	✘	!
Routine - % P3 completed in < 7 Days	✘	✓
Red rated Indicators with no change		
Estates Internal Critical Failures per month	✘	✘
Estates - Fire Dampers Compliance - % in date	✘	✘
Estates – Portable Appliance Testing - % in date	✘	✘
% of Total tonnage of Clinical Non-Burn waste per month	✘	✘

Table 2: Areas with Specific Cause for Concern	
Estates	**Estates Critical failures September / October 2020**
Explanation	1. Blocked Drainage in Tower Block. A recurring issue due to incorrect disposal of wipes 2. Heart & Lung Lift failed – out of service for 3 weeks due to long lead time for parts – now back in service 3. DSU Chiller – fault, back in service 4. Cath Lab - %RH too high 5/6. Lift s B & C Tower Block – failed but put back in service next day
Estates	**Fire Dampers Compliance - % in date**
Explanation	2020 Testing round due to complete in November 2020 – results expected to be a vast improvement on the 2019 inspection as closer management of Contractors meant more dampers were tested. The current absolute compliance was 62%, of those tested in 2019, 99% functioned correctly.
Estates	**Estates – Portable Appliance testing - % in date**
Explanation	Community locations testing completed. The acute site prioritised testing programme is underway.
Waste	**% Total Tonnage of Clinical Non-Burn Waste / Recycling waste per month.**
Explanation	Increase in tonnage due to disposal of 20 pallets of drugs from Torbay Pharmaceuticals equating to 31 Tonnes.
Estates	**Fixed Wire Testing Compliance - % in date**
Explanation	Works underway in community sites. 8 Teams have been assembled for a rapid survey of the Acute site with the aim of completing all testing by March/April 2021.
Estates	**Critical Ventilation Verification Compliance - % in date**
Explanation	Theatre 1 and 2 Verifications to be repeated at AE(Ventilation) request. Re-testing planned for Sat 14th November 2020, which complete the commissioning phase for this project.
Estates	**Asbestos Inspections Compliance - % in date**
Explanation	Re-inspections required at Brixham Hospital Wards (delayed due to Covid-19), Kings Ash House and Walnut Lodge. All known asbestos remains in a safe condition and normal asbestos permit practice remains in place throughout.