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

Board Room, Hengrave House, Torbay Hospital and via Microsoft Teams

27 January 2021 11:30 - 27 January 2021 13:30

AGENDA

#	Description	Owner	Time
1	Preliminary Matters	Ch	
1.1	Welcome and Introductions Note	Ch	
1.2	User Experience Story Receive and Note	Ch	
1.3	Board Corporate Objectives Information Board Corporate Objectives.pdf 9	Ch	
1.4	Apologies for Absence Note	Ch	
1.5	Declaration of Interests Note	Ch	
2	Consent Agenda (Pre Notified Questions)		
2.1	Reports from Board Committees (for noting)		
2.1.1	Quality Assurance Committee - 25th November 2020 and 25th January 2021 Receive and Note	J Lyttle	
2.1.2	Charitable Funds Committee - 2nd December 2020 (including approval of Committee Terms of Reference) Approve Charitable Funds Chair's Report - 02.12.20.pdf 11	J Lyttle	
2.1.3	Non-Executive Director Nominations and Remuneration Committee - 10th December 2020 and 7th January 2021 Receive and Note NED Nomination and Remuneration Committee Ch... 21	Ch	

#	Description	Owner	Time
2.1.4	Finance, Performance and Digital Committee - 21st December 2020 and 25th January 2021 Receive and Note	P Richards	
2.1.5	People Committee - 21st December 2020 Receive and Note People Committee Chair's Report - 21.12.20.pdf 23	V Matthews	
2.1.6	Audit Chair Committee Report - 13th January 2021 Receive and Note Audit Chair Report - 13.01.21.pdf 25	S Taylor	
2.2	Reports from Executive Directors (for noting)		
2.2.1	Report of the Chief Operating Officer Receive and Note Report of the Chief Operating Officer.pdf 27	COO	
2.2.2	Estates and Facilities Management Update Receive and Note Estates and Facilities Update Report.pdf 39	CFO	
2.3	For Approval		
2.3.1	Unconfirmed Minutes of the Meeting held on the 25th November 2020 Approve 20.11.25 - Board of Directors Minutes Public.pdf 47	Ch	
2.4	For Noting		
2.4.1	Action Log Receive and Note	Ch	
2.4.2	Report of the Chairman Receive and Note	Ch	

#	Description	Owner	Time
2.4.3	Report of the Chief Executive Receive and Note Report of the Chief Executive.pdf 61	CE	
3	Safe Quality Care and Best Experience		
3.1	Integrated Performance Report - Month 9 Receive and Note Integrated Performance Report - Month 9.pdf 75	DTP	
3.2	Mortality Safety Scorecard Receive and Note Mortality Safety Scorecard.pdf 149	MD	
3.3	Assurance Framework for Seven Day Hospital Services Receive and Note Assurance Framework for Seven Day Hospital Serv... 161	MD	
3.4	Maternity Governance Safety and Governance Report Approve Maternity Safety and Governance Report.pdf 171	CN	
3.5	Midwifery Staffing Oversight Report Approve Midwifery Staffing Oversight Report.pdf 201	CN	
3.6	CQC Assurance Report Receive and Note CQC Assurance Report.pdf 217	CN	
4	Valuing our Workforce (no reports this cycle)		
5	Improved Well-Being Through Partnerships		
5.1	Joint Strategic Needs Analysis Presentation	DTP	

#	Description	Owner	Time
6	Developmental Review of Leadership and Governance using the Well-Led Framework Receive and Note Developmental Review of Leadership and Governa... 243	CE/Ch	
7	Compliance Issues	Ch	
8	Any Other Business Notified in Advance Note	Ch	
9	Date and Time of Next Meeting - 11.30 am, Wednesday 24th February 2021 Note	Ch	
10	Exclusion of the Public	Ch	

INDEX

BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting date:	2nd December 2020
Report by + date:	Jacqui Lyttle, Committee Chair 29th December 2020
This report is for:	Information☐ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Board:

1. **Investment Manager report** - the committee received a very comprehensive report from the investment manager, being fully assured that the fund portfolio continued to out-perform against its own benchmark and that of other NHS charities. The investment manager was also able to provide full assurance that due to tactical asset management and it was reassured to note that the portfolio balance was at the same level as 12 months ago. The committee was also assured that Brexit would not have significant detrimental impact on the investment portfolio.

2. **Central funds** – the committee received a detailed report and noted that whilst the central fund remained in a negative position, there had been a positive movement of 100K in the last quarter. The committee were assured that plans were in place to reduce the negative balance over the next 12 months in line with the investment strategy.

3. **COVID - COVID funding** – the committee received a comprehensive verbal update on COVID charitable income and expenditure and was assured that appropriate processes are in place to submit Trust specific or system level applications by 31st March 2021.

Key Decision(s)/Recommendations Made:

1. **Investment policy review –** the committee reviewed and agreed an amended investment policy, taking note of changes to the asset allocation range to minimise risk and minor narrative changes proposed by internal audit.

2. **Terms of reference** – the committee received and approved amended terms of reference relating to meeting quoracy. The terms of reference are presented to the Board for approval in its capacity as corporate trustee.

3. **Review of guidelines for fund managers -** the committee received a report detailing the key changes to the guidelines, the main change related to situations where it was either impossible or inappropriate to acknowledge donations. The committee approved the changes including the appropriate alignment of guidelines to SFIs**.**

4. **Risk register** – the committee received the Charitable funds risk register and agreed that a new risk should be included **'inability to develop the fundraising strategy due to lack of staff resourcing'** the committee also considered the increased risks related to **'safe nursery services'** and requested that an independent review of the governance structure should be

undertaken due to the current dual accountability of the rainbow nursery to both the trust and the charity.

5. **Fundraising –** The committee received a comprehensive report from the Director of Transformation and Partnerships relating to the recruitment of a fundraising manager. As already detailed in 4 above, lack of resource has been identified as a risk to explore fundraising opportunities in the short to medium term and approved the secondment of an interim fundraising manager for 12 months. (This is a formal secondment of the current incumbent who has provided support since the start of the pandemic)

Torbay and South Devon
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

Version:	**2.0**
Approved by:	**Charitable Funds Committee**
Date approved:	**2 December 2020**
Approved by:	**Board of Directors**
Date approved:	**27 January 2021**
Date issued:	**27 January 2021**
Review date:	**November 2021**

Torbay and South Devon NHS Foundation Trust

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Torbay and South Devon NHS Charitable Fund ('the charity') is registered with the Charity Commission (no. 1052232).

1.2 Torbay and South Devon NHS Foundation Trust is public benefit organisation. As a corporation, the Trust is appointed to act as the Corporate Trustee of the charity. The Trust has a Board of Directors which exercises the powers of the Trust on its behalf except where any of these powers have been delegated by the Board. The Board of Directors fulfils the purpose of the Corporate Trustee on behalf of the Trust and is the sole Trustee of the charity.

1.3 The Charitable Funds Committee ('the Committee') is accountable to the Corporate Trustee for its performance and effectiveness in accordance with these terms of reference.

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

1.5 The Committee has delegated responsibility for the day to day management of charitable funds on behalf of the Corporate Trustee. Overall liability for the governance of charitable funds is retained by the Trustee and no liability will be attributed to members of the Committee.

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

2. Authority

2.1 The Committee is authorised by the Corporate Trustee to:

- Govern, manage and regulate the finances, accounts, investments, assets, business and all affairs whatsoever of the charity
- Approve the charity's strategy including financial strategy
- Approve annual plan and expenditure priorities for funds

- Approve major expenditure proposals having a value of over £50,000 and where thought necessary, proposals with a lower value
- Approve the charity's Annual Report and Accounts
- Appoint Fund Managers
- Appoint investment advisers and review every three years
- Approve the charity's fundraising plans

3. Purpose

3.1 On behalf of the Corporate Trustee, the purpose of the Committee is to manage the routine affairs of the charity, in accordance with the Scheme of Delegation.

3.2 The Committee will assure the Corporate Trustee that the Trust's charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does note remove from the Trustee the overall responsibility for stewardship of the Committee but provides a forum for a more detailed consideration of all charitable activity within the Trust.

3.3 The Committee will ensure that funds are spent in accordance with any legally-binding constraints over the use of funds and take due account of any non-binding wishes expressed by donors.

3.4 The Committee will oversee and review the strategic and operational management of the charity.

3.5 The Committee will ensure co-operation with the external auditors in the regulation of charitable funds.

4. Powers

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

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

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

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

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

4.6 In cases where a decision on any investment proposal is viewed as urgent, the Committee have delegated the power to authorise such changes to any two of the following members of the Committee: Chief Finance Officer, Committee Chair or Non-Executive Director. In exceptional circumstances, and in the absence of the Chief Finance Officer, the Deputy Director of Finance may act as an authorised person. Any such decisions must be reported to the next meeting of the charity.

5 Duties and Responsibilities

5.4 The Committee is required to:-

5.4.1 Govern, manage and regulate the finances, accounts, investments, assets, business and all affairs whatsoever of the charity.
5.4.2 Ensure that systems are in place to provide appropriate and effective financial control and compliance with legal and regulatory requirements including due consideration of donor's wishes and reputational risks.
5.4.3 Review and approve annual expenditure priorities for funds, and the charity's annual plan and ensure compliance with agreed priorities and monitor performance against plan.
5.4.4 Consider and approve charitable expenditure proposals with a value over £50,000 and where thought necessary, proposals with a lower value.
5.4.5 Encourage the use of funds for the benefit of patient welfare.
5.4.6 Consider the report from the charity's auditor and consider and approve the charity Annual Report and Accounts
5.4.7 Review and approve the charity's investment policy. Appoint and monitor performance of the charity's investment managers, and review their performance every three years.
5.4.8 Determine and approve the strategy of the charity and monitor performance against it.
5.4.9 Appoint Fund Managers.
5.4.10 Review and approve fundraising plans and monitor performance ensuring compliance with fundraising regulatory requirements.
5.4.11 Further to 5.4.3 above, approval for individual purchases should be obtained from:

Up to £5,000	Fund Holder
£5,0001 to £20,000	Chief Finance Officer
£20,000 to £50,000	Chief Executive
Over £50,000	Charitable Funds Committee

The authorisers detailed above may also, in circumstances where thought necessary, authorise expenditure with a value below their specified range.

6 Membership

6.1 The Committee shall consist of the following members:

- Non-Executive Director (Committee Chair)
- Non-Executive Director
- Medical Director
- Chief Finance Officer

6.2 One of the Non-Executive Directors shall act as Committee Chair. In their absence, the other Non-Executive Director shall be nominated and appointed as acting Chair for the meeting.

6.3 The following shall be required to attend all meetings of the Committee:

- Senior Finance Manager – Corporate Services

6.4 The following shall be invited to attend all meetings of the Committee:

- Governor observer (see 6.5 for appointment process)

6.5 The process for selecting the Governor observer is a matter for the Chair of the Council of Governors and Governors. In the event that the nominated Governor observer is unable to attend a meeting, the Committee Chair will allow a substitute Governor to attend.

6.6 Other members/attendees may be co-opted or requested to attend as considered appropriate.

7 Attendance

7.1 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

8. Quorum

8.1 The quorum necessary for the transaction of business shall be 3 members, comprising two Non-Executive Directors (of which one must be the named NED) and one Executive Director.

8.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

8.3 Deputies will count towards the quorum.

9. Administration

9.1 The Committee shall be supported by the Corporate Governance Manager or their nominee, whose duties in this respect will include:

- In consultation with the Committee Chair and Chief Finance Officer develop and maintain the reporting schedule to the Committee.
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the group of scheduled agenda items.
- Agreeing the action schedule with the Chair and ensuring circulation.
- Maintaining a record of attendance.

10. Meetings

10.1 Meetings will be held on the following basis:

- Meetings will be held bi-annually or more often if called by the Chair.
- Meeting duration will be no longer than 2 hours.
- Items for the agenda should be sent to the Corporate Governance Manager a minimum of 7 days prior to the meeting. Urgent items may be raised under 'any other business'.
- The agenda with be issued by email to the Committee members and attendees, one week prior to the meeting date, together with the action schedule and other associated papers.
- An action schedule will be circulated to members following each meeting and must be duly completed and returned to the Corporate Governance Manager for circulation with the following meeting's agenda and associated papers.

11. Reporting

11.1 The Committee will provide a report to the Corporate Trustee in support of its work on promoting good management and assurance processes. The report shall include matters requiring escalation and key risks (as applicable).

11.2 The Committee will receive reports as per the meeting work plan.

12. Review

12.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

12.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Corporate Trustee.

13. Monitoring effectiveness

13.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled; and
- An annual self-assessment on the effectiveness of the Committee is undertaken.

Torbay and South Devon
NHS Foundation Trust

Chair's Report
Non-Executive Director Nomination and Remuneration Committee
to the Board of Directors

Meeting date:	10 December 2020 and 7 January 2021
Report by:	Sir Richard Ibbotson Chairman
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☒ or Private ☐

Key issues to highlight to the Board:

1. The Chief Executive briefed the Committee on the succession planning arrangements for the HIP2 Medical Lead – a role currently being undertaken by Dr Rob Dyer, the Trust's Deputy Chief Executive and former Medical Director. A formal proposition and job description would be presented to the Committee in the new year.

2. A progress update was provided on the Trust's Senior Management Talent Management and Succession Planning programme. Aligned to the wider Trust arrangements for talent management, the Committee would be focusing on executive succession planning in the early part of next year. A draft Board skills matrix was presented which would form the catalyst for this programme of work.

3. The Committee accepted that the annual review of Board composition should be paused for a short period of time to enable the newly published RACE Equality Code 2020 to be reflected on. The Chief Executive would be liaising with the Director of Workforce and OD to consider the Code further and agree next steps.

4. National guidance issued by NHSI/E in relation to 2020/21 annual pay increase recommendations for Very Senior Managers was received and actioned.

5. Governance matters considered by the Committee included noting the changes to Committee membership and the outcome of the annual self-assessment of committee effectiveness. The Committee also noted that the annual committee workplan had considered all matters within its work programme.

Torbay and South Devon NHS
NHS Foundation Trust

Report of the People Committee Chair to the Board of Directors

Meeting date:	21st December 2020
Report by:	Vikki Matthews
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issues to highlight to the Board:

- **People Plan** – the Committee received the Trust's draft People Plan which is now in its final stages. The Committee agreed that the content, direction and tone of the plan is in the right place but members continue to be concerned about the level of ambition and activity outlined and have offered a strong recommendation that this is scaled back before the plan comes to Board for sign off. The Committee were also pleased to see how well the People Plan aligns with other Trust strategic agendas such as HiP2 and the Digital strategy and reinforced the importance of this alignment and integration going forward. The Committee has asked for more detail to come to the next meeting outlining how the team will resource the implementation of the plan, particularly in light of the ongoing winter and Covid pressures and the general workforce fatigue.

- **Race Equality Code** – we were pleased to receive the Race Equality Code and commended its ambition and action orientation. It was noted that this is not a statutory requirement but that it represents good practice and should be seen as an indicator of future national guidance. The Committee recommended that the work to achieve the code's stated aims is fully integrated in to existing worksteams and business processes and tied to the Trust's equality, diversity and inclusion work programme. The Committee's recommendation is that the Trust adopts the code informally in the first instance until such time that we fully understand what needs to be done against each of the 4 principles enshrined in the document.

- **People dashboard** – of note against this agenda item is the sickness absence rate which continues to rise and is standing at 5.88% for November. The Committee also continues to keep a watchful eye on the issue of outstanding annual leave and the financial (and wellbeing) challenge this brings. It was reassuring to hear that staff are being encouraged by their managers, and through regular communications, to book their accrued leave and that national guidance indications were that up to 20 days may be carried over for up to two years.

Key decision(s)/recommendations made by the Committee:

1. The Committee approved the direction and focus of the Trust's developing People Plan.
2. The Committee received the Race Equality Code and recommended informal adoption of the principles contained therein
3. The Committee has recommended that the Trust's People Plan be shared at the next Board meeting for sign off.

Torbay and South Devon NHS
NHS Foundation Trust

Report of Audit Committee Chair to the Board of Directors

Meeting date:	13/1/21
Report by:	Sally Taylor
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☒ or Private ☐

Key issues to highlight to the Board:

1. Committee reviewed the BAF and noted that the Deloitte review observed many areas of good practice followed and made some further recommendations. Internal Audit Assurance review of the BAF concluded a "significant assurance" opinion. The committee discussed Cyber Security and concluded they would require further assurance on the effectiveness of our processes.

2. Risk Group summary report received. It was reported that increased attendance by Exec team members has contributed to enhanced robustness of discussion.

3. Committee reviewed ICO Tender waivers of standing orders, which have increased from the previous quarter and mainly relate to Covid expenditure and the acceleration of capital expenditure. Assurance was received that checks are still made re Value for Money.

4. Internal Audit confirmed that a Head of IA report would be provide for 20/21

5. Committee also reviewed progress on implementing recommendations made on 4 earlier internal audit reports that resulted in limited assurance opinions. The Exec leads attended to report. Most recommendations have now been implemented although it was noted that there were some delays due to Covid (for example, where lead staff have been reallocated to a Covid role). Internal Audit will continue to follow up.

6. External Auditors reported that there are delays in presenting their audit plan due to other client work being delayed. However, committee was assured that finance team are in discussion with the auditors and no issues are envisaged currently.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report January 2021			**Meeting date:** 27th January 2021
Report sponsor	Chief Operating Officer		
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 the current wave of COVID-19. 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 escalated Covid-19 requirements to safely manage system flow and the impact of stepping down a number of elective pathways. The South, East and North Devon provider network and critical care network have been instrumental in supporting the Trusts response to secure, as well as to provide mutual aid across the network.		
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

<table>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Board Assurance Framework</td><td>X</td><td>Risk score</td><td>20</td></tr>
<tr><td>Risk Register</td><td></td><td>Risk score</td><td></td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
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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>
<tr><td>NHS England</td><td>X</td><td>National policy/guidance</td><td></td></tr>
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Report title: Chief Operating Officer's Report January 2021		**Meeting date:** 27th January 2021
Report sponsor	Chief Operating Officer	
Report author	System Directors	

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 five Integrated Service Units and Children and Family Health Devon.

2. Content

This report provides an update in relation to impact of a further surge in Covid-19 admissions. There has been significant physical site reconfiguration in recent days to facilitate safe flow in line with the Trusts Covid-19 response plan and tailored to the predicted rise in Covid-19 admissions. This has been supported by the requirement to step down P3 and P4 activity enabling a refocus of staff and physical resources towards the current and predicted Covid-19 position. The table in appendix A explains the clinical priority levels represented by P1, P2, P3 and P4.

The focus has also been to maintain access for urgent and cancer pathways and this has ensured no cancellations of cancer patients at this time. The latest changes to the Emergency Department and Medical and Surgical Receiving units' alongside stepping up "green surge" capacity for ICU are fundamental to the safe and effective running of the urgent care pathways during this Covid-19 phase. This is supported by the actions taken to deliver timely and safe discharge through our health and care system.

Other activities highlighted this month are the Adult social care improvement plan alongside health and wellbeing centre updates, the emergent risk in delivery of timely CT scanning and a CFHD position update.

3. Covid-19 operational impact

3.1 Acute

The Covid surge tactical plan for the acute site has been refreshed in conjunction with all key clinical and operational stakeholders. The resultant reassignment of physical space is described in more detail within this report. The intelligence gained through the modelling and tracking of covid surge and activity has prompted stepping down, where appropriate, all P4 activity and a number of P3 activities. Continued attention to waiting times and harm reviews within all specialities is aimed at keeping patients as safe as possible. The surge plan releases ward space by reassigning day surgery unit (DSU) as the medical receiving unit (MRU) and re-siting recovery of day surgery procedures to Ella Rowcroft. Forrest ward has been vacated by MRU to establish expansion for green or Covid-19 pathways dependant on the level of Covid-19 escalation. The surgical receiving unit has also been moved to the DSU to enable the ICU to increase their capacity. The Trust is grateful to all the teams who have again worked with professionalism, dedication and skill including over the

weekends to make these moves happen and to settle the services as safely and effectively as possible in the new locations.

3.2 Community

Community care @home bronze cell has been re-established with 3 objectives 1) Reviewing all services that can be stepped down in Care at Home to release staff for critical functions and services. 2) Set up Covid-19 Virtual Ward to provide Early Supported Discharge for people recovering from Covid-19 who required hospital admission. 3) Increase capacity for Discharge to Assess in readiness for surge via Improvement to Discharge Hub process and via increased capacity in community pathways. The command structure has been fully reinstated to manage the tactical response to this surge, twice daily calls across the South, East and North Devon (SEND) network take place along with engagement in the dynamic decision-making group.

3.3 The SEND network

Representatives from the three acute Trusts that make up the South, East and North Devon (SEND) Network meet twice a day to review activity, Covid-19 demand and to ensure optimal use of the Nightingale Hospital (NHE). This network also considers aspects of mutual aid across Trusts and has recently been joined by University Hospital Plymouth (UHP) and Taunton and Somerset Foundation Trust.

3.4 Critical Care Network:

There is a well-developed Critical Care Network that provides mutual support, principally managing local need but during the Covid-19 third wave has been extended to cover the national position with ITU beds. This has meant that the Trust has now received a number of patients from outside the Region to support areas experiencing unprecedented demand. This is being managed through daily meetings which focus on the assessment of demand and Trusts are able to offer excess capacity across the country to facilitate transfer of patients.

4. Children and Family Health Devon (CFHD) Performance

4.1 Covid-19

CFHD continues to provide all services, with a mixture of face to face and remote delivery of care via ‘Attend Anywhere’. The national lockdown is placing significant pressure on staff who are balancing the needs of delivering care for their clients whilst also having their own families in their home environments.

A small number of nursing staff from non-referral to treatment (RTT) services have been identified who may be released in extremis for acute care support. The service managers are undertaking an impact assessment to determine any negative consequences of redeployment on children and young people. Prior to releasing staff this impact assessment will be considered by the CFHD Board and will require agreement with the CCG team prior to stepping down any service. Any changes would be for a limited period and would be chosen not to impact on areas of significant clinical or safety risk.

CFHD continues to have a challenge in our sites where staff from different employers have differing infection, prevention and control (IPC) protocols. This has been escalated appropriately for resolution.

The Service is now experiencing increasingly regular ‘events’ of possible transmission, between colleagues and from families who later test positive. This is likely to effect service delivery due to self-isolation requirements, however the significant use of attend anywhere as a remote clinical platform will mitigate these impacts.

All services remain focused on waiting times improvements. Should the impact of national lockdown be similar to the first, it is expected there will be a reduction in referrals and with that, a deteriorating RTT position as the number of accepted referrals under 18 weeks reduces. The Service will therefore ensure there is a clear focus on completed assessments and treatment activity levels alongside RTT as a proxy measure of efficiency.

All data was taken from end December 2020.

4.2 Child and Adolescent Mental Health (CAMHS)

RTT @ 81% of young people being seen within 18 weeks, referral numbers increased in the autumn with December referrals showing a 16% increase on December 2020. An enhanced assessment & waiting times programme has been developed by the CAMHS senior management team and is expected to be operationalised soon.

4.3 Speech and Language Therapy (SALT)

RTT remains at 54.7% with steady accepted numbers. Work continues with the service manager who is working to balance the delivery model across the county and ensure that Devon and Torbay teams are working to the same operational framework. There have been a number of recent leavers from the service and maternity leaves which may affect performance in Q4.

4.4 Occupational Therapy (OT)

Children’s OT remains at 57% with an overall reduction in numbers of children and young people waiting for assessment and treatment. Issues previously described with equipment provision for their statutory work are being actively addressed.

4.5 Autism Service (ASC)

Numbers of referrals have remained steady, the overall RTT position has remained unchanged at 14% RTT against a backdrop of being stood down for 4 months in 2020. The efficiency work described in the December report continues robustly. Wider work with the Alliance reference group has been positive with full engagement of Alliance medical paediatric and psychiatry staff.

4.6 Quality & safety

Alignment of risk and safety reporting systems at the local level has improved. The single risk register is more robust and has been reported to the Torbay and South Devon FT Integrated Governance Meeting (IGG).

4.7 IM&T

Business cases for the replacement of telephony and System One are progressing. The limited functionality of the telephony servers in the Single Point of Access (SPA)

limit flexibility meaning staff have to work at base rather than being able to work at home.

4.8 Workforce

The process of approval to recruit (ATR) management is well established and all clinical posts, if in the run rate are being approved. There are significant vacancies in CAMHS, especially Eastern Devon and Torbay. The service is using the remote clinical platform to ensure that assessments and interventions can be provided pan Devon and Torbay to reduce geographical variation.

4.9 Transformation

The change programme has commenced with the Alliance Board and all staff teams have access to a film which was produced as an outcome of the independent service review. The Alliance Board will also film their responses to the messages and this will be circulated to staff. There is a plan in place for staff engagement to fine tune the service model. This will rely heavily on staff engagement in co-design and will commence week commencing 8th February 2021. The Indicative timeline for consultation is the beginning of May. Managers will attend workshops on managing change, to support staff through the forthcoming process. The staff engagement approach has been broadly well received by staff. A detailed briefing has been sent to all teams outlining the plan and the rationale underpinning it. The full timeline and 'Road Map' for change will be shared with colleagues in the forthcoming weeks.

5. Phase 3 recovery

5.1 Echo

Outsourcing of Echo Scanning capacity continues. Since moving from the Nightingale Hospital the Trust has been able to offer a scanning room at Dawlish Hospital. In addition, TSD staff have now extended their working week and at present are able to offer a 7-day service. The peak number of patients waiting for an echo following the earlier wave of Covid was 1467. As of 11th January 2021 this position is 1,118 patients waiting and the service is still on track to have no patients waiting over 6 weeks by the end of March.

5.2 Long Term Conditions RTT

In June 2020 the RTT performance across the Long-Term Condition specialities had deteriorated to 62% as a result of stepping down activity. There has been a gradual improvement since the start of the Recovery phase and as of 11th January 2021 performance has reached 76% and on track to be recovered by the end of March, notwithstanding any reduction in non-urgent activity during this latest Covid period.

5.3 Cancer

The Trust achieved compliance against the 31 Day Cancer Target for Quarter 3. Performance against the 28-day 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.

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 are keeping

this under review and 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-19 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.

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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.

5.4 Diagnostics

The 3rd CT Scanner project is progressing; however, the scanner will not be operational until the 1st quarter of 2021/22. To provide the space required for the scanner radiology staff are being relocated to Bowyer Building. This has been enabled by the move of a significant number of teams from the first floor of Bowyer Building to other sites such as Regents House.

Due to capacity constraints resulting from the loss of the mobile CT scanner Radiology is unable to book routine CT scans within the required 6 weeks. A review of outstanding referrals has been proposed. The Trust Executive lead and radiology team continues to lobby NHSE/I for a greater share of the national mobile CT resource, mutual aid from Plymouth and Exeter has also been sought.

5.5 Pathology

The Trust is supporting University Hospitals Plymouth (UHP) with the development of a Lighthouse Laboratory based at Derriford Business Park. The Trust's Microbiology Laboratory Manager (Gillian Hewlett), has been seconded to project manage the development. Through Gillian's leadership and her team's innovative working the Covid-19 testing service at TSDFT has been a key part in supporting patient flow throughout the Covid-19 period. Turnaround times for Covid testing is second only to Bath in the S-W Region and by far the best in the Peninsula

5.6 Endoscopy

The endoscopy staff consultation has concluded, increasing capacity within the service as business as usual. The estates team have developed a temporary solution for room 3 this should be in place by the end of January and will deliver two addition months of work before the permanent replacement of the air handling unit is in place for April. The operational and clinical lead continue to focus on mitigating the impact on delivery with a number of additional sources of activity.

5.7 Elective Care

Day Surgery Unit has been converted to the Trusts MRU to release Forrest ward as an inpatient ward. This has reduced surgical capacity significantly, booked lists have been amalgamated prioritising the most urgent patients. As directed only patients with a priority of P1, P2 and clinically appropriate P3 are now being booked. Ella Rowcroft ward will be used for secondary recovery of day surgery patients treated in main theatres, half of Ella will be maintained as beds for these priority patients.

The current Covid-19 position will undoubtedly impact on the Trusts phase 3 plans for elective recovery. However, stepping down of routine services will be kept to a minimum, this includes retaining insourcing of cataract surgery and endoscopies.

As a result of a mutual aid request UHP have offered up endoscopy and urology sessions at a private provider, Practice plus, the teams are working to maximise these sessions.

6. Emergency Department Phase 1 Covid-19 / Winter secure

The phase 1 works to the Emergency Department (ED) are now largely complete, commissioning of the air supply to the additional resuscitation room, is to be completed during January 2021. All other areas have been officially handed over to the Trust and are now fully operational. The ED have made further changes to its footprint to create a better segregated Covid-19 treatment area which also allowed the return of a day surgery theatre.

6.1 Medical Receiving Unit

The Trust's response to the third COVID-19 surge requires the MRU to relocate and occupy the DSU as it did in the first wave.

This move was successfully completed on 14th January 2021, and is part of a wider response to the prevalence of COVID-19. The MRU is expected to move back to Forrest ward as soon the Trusts response to COVID can de-escalate.

The new MRU building is on track to be delivered in Mid 2021/22.

6.2 Emergency Department Phase 2

Work continues on phase 2 of the ED in conjunction with the MRU building works. The build is expected to commence in April 2021 however, the extent of the disruption during the works requires careful planning and consideration.

6.3 Emergency Floor

The creation of an ED, MRU and Surgical Receiving Unit (SRU) creates an Emergency Floor that allows acutely unwell patients to be seen in the right place, at the right time, first time. The benefits to patients are already visible in the provisional estate that these units reside, as 20/21 progresses we will see the Emergency Floor develop into the new estate created by the works described above.

These units have been designed to provide an environment that meet the needs of urgent and emergency care, wellbeing and the latest understanding of the pandemic for both patients and staff.

7. Torbay System Community Services

7.1 0-19 children's services

Expression of interest (EOI) was recently submitted (jointly with Torbay Council) for local funding through Nesta- to build long-term innovation partnerships with local areas.

The partnerships will form around the shared mission of supporting the most disadvantaged children during their early pre-school years to enable them to be ready to start school with a good level of social, emotional and cognitive development.

The outcome of EOI is expected at the end Jan.

7.2 Drug & Alcohol

Joint working between the acute wards and the community D&A service have led to agreement of alcohol detoxes being improved and reduces acute bed days required for hospital alcohol detox admissions. This workstream is gathering momentum and resource within community service is being utilised to ensure alcohol detoxes are completed in the community. The hospital has also supported arranged detox with 2 frequent attendees so the D&A service can ensure community support is in place at the right time to maximise potential recovery rather than ad-hoc regular admissions for very physically unwell alcohol patients.

7.3 Community Dentistry

An MEPG request for purchase of dental equipment was approved and is now in the process of procurement – this is to the value of around £130k. This will provide much needed modernisation of the equipment for the team and their patients.

7.4 Adult Social Care Improvement Plan (ASCiP) and Continuing Health Care

"Front Door, Gateway & Flow", one of the ASCiP's critical projects, continues to formulate the operating model and strategy for operational management of services from adult social care. The Voluntary Sector are critical partners and as key stakeholders work is being undertaken around the structure and processes which will result in high quality customer service and support the strategic commissioning of services for evidenced need in our community.

"Data Culture and Measurement for Improvement" is also being developed with the support of experts in the region including the SW AHSN
which will support evidence-based decision making and simulation modelling in Adult Social Care.

Community Mental Health Framework collaborative discussion involving Torbay ASC staff are continue to progress well.

The Professional Practice Performance Project completes its architecture to derive outcomes and will begin populating the content of its workstreams.

ASC Market Shaping blueprint and the subsequent planning are being prepared to begin in January. These plans will work in tandem with the Trusts ASC market management work currently being undertaken and being reported through the ASC Transformation Group

8. South Devon Community Services

Currently focus in the Moor to Sea ISU is on three key elements that will support whole system response to the anticipated surge ensuring resilience and efficiency in hospital discharge personnel and processes; ensuring resilience and effective deployment of resources in discharge pathways; ensuring support is optimised across community services; including domiciliary care, unregistered care, and residential and nursing care providers across the Southern Devon patch.

8.1.1 Hospital discharge

Work is underway embedding process re-design to ensure greater effectiveness in discharge to assess in the discharge hub. A community services manager has been reassigned to lead this work and to set direction in delivering the Discharge Co-ordinator function that is now prescribed in national requirements.

A gap analysis which identifies the shortfall in personnel within the discharge services, has brought in some capacity through stepping down some elements of community work and reassigning resources. This will continue to be shared with all ISUs through the Care @ Home bronze cell, and resources requested to support discharge in real time if / when pressure builds.

A similar gap analysis has been completed with regard to Short Term Services (STS). This largely addresses the time lag from recruitment to deployment of the additional resources committed through the winter plan / service redesign. Significant additional resources to deliver domiciliary care have been identified to plan for significant increase in pathway 1 discharges; to ensure timely flow out of short-term services; and to recover the STS backfill situation. This has drawn upon additional hours commissioned in the DCC footprint, and improvements to realise additional capacity in both Local Authority areas. Work is also underway to identify residential/nursing care resources that can better support timely Pathway 2 and Pathway 3 discharges.

8.2 Community Teams across South Devon are continuing to very actively support Care Homes in outbreak. There are currently a number of homes in South Devon with outbreaks that have escalated significantly in a short period of time.

The Healthcare of the Older Person Team are also involved in establishing the structure to best support virtual wards in community which will enhance the support through care homes despite outbreak.

8.3 Moor to Sea Health and Wellbeing Centre

At the December Dartmouth stakeholder meeting it was confirmed planning permission had been granted for the Health and Wellbeing Centre. Final sign off at partner organisation Boards is required in January, with the build predicted to start in March 2021. The local stakeholder group will continue and members will be asked to participate in the discussions relating to the ‘softer’ decisions.

8.4 Newton Abbot Health and Wellbeing Centre

Work continues on the development of the Health and Wellbeing Centre in Newton Abbot. It is planned that work will commence at the end of January 2021 and the development operational end of March 2021.

9. Organisational progress on transformation and CIP delivery

Progress continues to identify opportunities for CIP and transformation. Identification of the key transformation plans is advancing as quickly as capacity allows with competing pressures however some good progress is being made.

10. Conclusion

Another challenging period impacting across the board with incredible examples of strong clinical and operational leadership and agility to respond to the very dynamic and emergent picture. The ability shown by our clinical and operational teams to keep patients safety at the core of their delivery whilst maintaining as much business as usual is testament to their commitment and strength

11. Recommendation

To note the content and risks exposed in this report.

Appendix A

Priority	Threshold	Action	Threshold	
1a Emergency: operation/treatment needed within 24 hours to save life	Unable to treat within 24 hours	***Seek mutual support***		
1b Urgent: operation/treatment needed with 72 hours	Unable to treat within 72 hours	***Seek mutual support***		
2 Elective surgery with the expectation of cure or deterioration without treatment, prioritised according to within 4 weeks	Unable to treat within 4 weeks (31 days for cancer)	*Review priority. Escalate or review at next threshold*	Unable to treat within 8 weeks	***Seek mutual support***
3 Elective surgery can be delayed for 10-12 weeks	Unable to treat within 12 weeks	*Review priority. Escalate or review at next threshold*	Unable to treat in Agreed appropriate timescale	***Seek mutual support***

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors		
Report title: Estates and Facilities – Top line briefs, EFM performance, compliance and exception report		Meeting date: 27th January 2021
Report appendix	Nil	
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 November and December 2020. **ERIC Return** The annual ERIC return was submitted in September 2020 and the results will be available in Model Hospital in the next few weeks. Once the data is available a report will be compiled and presented to FPDC. The Trust ERIC return submission for 2019/20 equated to £27,562,877 compared to £26,311,851 for the 2018/19 return, a movement of £1,251,026 equating to 5%. Further detailed work around the cost of waste and utilities was identified following the submission and an external energy consultant has already been commissioned to: • review utility bill tracking data to verify energy consumption & cost for 2019/20 ERIC return • appraise current tracking processes, • benchmark performance with comparable Trusts, • carry out a high-level energy survey for Torbay hospital to identify opportunities for further investigation • carry out a basic appraisal of hospital Building Management System (BMS) to scope opportunity for optimisation In addition, a bid has been submitted o the Public Sector Low Carbon Skills Fund for £1.3 million capital funding to implement energy saving schemes funds which could deliver c£250,000 annual savings. Schemes include LED Lighting, Building Management System upgrade and replacing steam calorifiers	

	Review of the Efficiency of Facilities Services Ecovate Group have been commissioned to undertake a high-level review of the soft facilities services provided in the Trust. Ecovate have detailed knowledge and understanding of the NHS and the review will include benchmarking the facilities services against Model Hospital Data and to carry out an assessment of the current services provided. An initial scoping meeting has already taken place and report expected February 2021. Any recommendations or efficiencies identified will form part of the Estates and Facilities Business Plans for 2021/22 **Trust Fire Safety** The monthly Fire Safety Group (FSG) meeting is now established with clinical representation from Paignton and Brixham, Moor to Sea and Coastal ICU's. However, the FSG still requires representation from Torquay and Newton Abbot. The Trust Fire Safety Advisors are currently focussing on fire safety training for staff who work in the Tower block floors. A summary dashboard is being established and will be presented within future Trust Board reports. The Trust Authorising Engineer (Fire Safety) has been commissioned to complete a fire strategy review of all Trust buildings, this work should complete within the next three to four months. Physical improvements to fire safety within the Tower block are ongoing, orders have been placed to covert the three Tower Block lifts into fire evacuation lifts, work is expected to be completed by March 2021. Further works to improved fire compartmentation within the Tower block are currently being designed for the lift & stair core and ward areas. **Critical Internal Incident 26 November 2020** Following the incident in November which resulted in the loss of water to various areas of the acute hospital site, a debrief was undertaken with the Estates teams involved and a report produced by the Head of Estates Operations. This has been discussed and reviewed with the EFM Senior Management Team and actions agreed for implementation, including reviewing and updating EFM business continuity plans.

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:	27th January 2021
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 November and December 2020.

This report aims to summarise and highlight key concerns and exceptions regarding Estates and Facilities Operations performance for the months of November and December 2020.

Table 1 below identifies the Key Performance Indicators variances for Estates and Facilities performance for the months of November and December 2020. Any areas of specific concern for the attention of the Trust Board are shown with appropriate explanation and action to achieve a resolution is shown at Table 2 below.

Table 1: November and December 2020 Scorecard Indicator.

Green ✓ | Amber ! | Red ✘	November	December
Deteriorating Indicators		
EFM Incidents resulting in No Harm	!	✘
Improving Indicators		
Urgent - % P2 completed in < 1 – 4 Days	✘	!
Routine - % P3 completed in < 7 Days	!	✓
Routine - % P4 completed in < 30 Days	✘	✓
% of Total tonnage of Recycled waste per month	!	✓
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	✘	✘
% of Total tonnage of Clinical Offensive waste per month	✘	✘
Statutory Waste Audits - % completed	✘	✘

Table 2: Areas with Specific Cause for Concern	
Estates	**Estates Critical failures November and December 2020**
Explanation	1. Large Water Leak in Steam Duct at feed to Copper/Silver station. Water supply to labour ward and theatres interrupted. Critical internal incident declared **26 Nov 2020**. Sterile scrub water provided to maintain emergency lists and kitchens provided drinking water to affected wards. Fire Brigade assisted to pump duct water. Pipe replaced 2am 27 Nov 2020. 2. Blocked Drainage in Tower Block. Recurring fault due to inappropriate items placed into drainage system. 3. Catering UPS – fault occurred 9 Dec 2020 – new unit being procured December 2020 for commissioning in **January 2021**. 4. Ophthalmology Theatres Humidity – Ophthalmology Clinicians require low humidity for procedures – being manually managed at Trend BMS Controller. 5. Surgical Assessment Unit roof leaks – temporary repair in place **31 December 2020**, contactor to effect permanent repair in **January 2021**.
Estates	**Fire Dampers Compliance - % in date**
Explanation	2020 Testing schedule completed in October – November 2020. Compliance has improved to 74.2% (62% from 2019), 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 but access due to COVID is restricted.
Waste	**% Total Tonnage of Clinical Non-Burn Waste / Recycling waste per month / Statutory Waste Audits.**
Explanation	Continued incorrect waste segregation on the wards (Orange waste being incorrectly placed into Tiger bags), has led to increased risk of contaminated waste going to deep landfill. Therefore, increased incineration to minimise risk of waste non-compliance on Tiger waste from January 2021 to reduce risk of Trust prosecution. This has been discussed at the Environment Group as this causes a severe non-compliance issue at the disposal site. Offensive waste has increased due to COVID activity.
Estates	**Asbestos Inspections Compliance - % in date**
Explanation	Re-inspections required at Brixham Hospital Wards (delayed due to COVID-19), Union House, Hollacombe, Paignton Training Hall and Walnut Lodge. All known asbestos remains in a safe condition and normal asbestos permit practice remains in place throughout.

2. Estates and Facilities Operations Top Concerns.

Tower Fire Strategy – Design is completed and orders have been placed to covert the 3 Tower Block lifts into fire evacuation lifts, which will be completed **by March 2021**

Chilled Water Systems – Temporary Chiller installed for DSU 1 and 2 to mitigate pipework issues. Design Consultant scoping new Chilled Water circuit for DSU3 and Eye Theatre to use A+E Chiller plants by end of **January 2021**. Programme and planning for delivering the EFM Chilled Water strategy for the Acute core services is due to complete by the end of **March 2021**.

Fire Dampers – A total of 983 Fire Dampers were scheduled for testing across Torbay, Brixham, Totnes and Paignton Hospitals between October and November 2020. 254 Fire dampers (25.8%) could not be accessed due to not located (57) no access (108) or obstructions (89). 741 Dampers were accessed and tested and 728 passed (98.2% success rate. A schedule of remedial works has been provided to be programmed for completion.

Fire Main – Following the repair in December, the subsequent survey report from the Specialist Contractor indicates a new Fire Main is required. Costs to replace the fire main are being obtained as the fire main remains in a fragile state.

3. Estates and Facilities Operations Rising Concerns.

Acute Site Lifts - The Trusts Lift Authorising Engineers are completing a condition survey of all Lifts on the Acute Hospital Site which will identify a schedule of replacements for the capital programme in **2021-22**. The Warrington/Ainslie Lift will be replaced in **2020-21**, which will conclude the replacement of both lifts in the Old Hospital.

The existing Lift Maintenance Contract (part of the South West PPSA contract) ended on the **31st December 2020.** Extension to the contract is being explored and options include appointing an alternative lift maintenance contractor. In the meantime, 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.

4. Estates and Facilities Operations Action Plans.

HSE – progress of the EFM actions within the overall Trust HSE action plan continues to be monitored by the Site Services Lead. Capital expenditure has been approved and orders placed to to install a height restrictor at the Fracture clinic area which will complete in **February 2021**. A trial SOP has been agreed with the Head of Procurement and Site Services Lead to ensure the safe management of traffic in the area around opening and closing the barrier as goods vehicles arrive. This is to ensure additional safety risks are not incurred.

Waste –An action plan has been drawn up by the Head of Facilities following receipt of the external waste audit. A report and the action plan will be presented at the Capital Infrastructure and Environment Group which will detail a number of recommendations which will include the implementation of mandatory waste training for all staff which is critical to ensure waste is disposed of in the correct waste streams.

CQC Inspection March 2020 – EFM related CQC Inspection Must Do and Should Do remedial actions:

> **Must Do 17 update - Simpson Flooring -** Two separate patch repair processes have been undertaken, both of which have failed due to the poor condition of the underfloor substrate and limited access. Investigations are underway to assess the suitability of a third option, based on a two-pack bonding substance that is claimed to penetrate into the underfloor material and may provide a stronger and more durable repair.
>
> Whilst it is fully understood that clinical pressures are preventing the ward from being closed, this will be required to carry out a full repair of the flooring, discussions have commenced with the Head of Operations to plan a decant in the Spring 2021

Must Do 20 Update - Forrest Windows – no change, a further bid for window replacement will be made for the 2021-22 capital programme.

A prior evaluation of this work gave an indicative cost of £1.4m and project duration in the region of 2 to 3 months. The affected wards would need to be closed, one at a time, for this work to be undertaken.

Ward refurbishment of Forrest is dependent on availability of ward. Investigation of sewerage flooding on Forrest has found inappropriate materials being put into system is causing blockages and overflowing.

Hetherington Corridor / Ward Clutter. Must Do 17; EFM will support the Clinical teams with this action once clarity is received from senior nursing teams.

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 25TH NOVEMBER 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
	Mrs L Davenport	Chief Executive
	* Dr R Dyer	Deputy Chief Executive (part)
	* Mrs J Falcao	Director of Workforce and Organisational Development
	* Mr J Harrison	Chief Operating Officer
	* Ms A Jones	Director of Transformation and Partnerships (part)
	* Mrs D Kelly	Chief Nurse
	* Mr D Stacey	Chief Finance Officer
In attendance:	Mrs J Downes	Company Secretary
	Mrs S Fox	Board Secretary
	* Ms Kate Mitchell	Patient (for item 205/11/20)
	* Mr J Murray	Deloitte LLP
	* Ms Laura Shenton	Consultant Physiotherapist (for item 205/11/20)

* via video-conference

		ACTION
204/11/20	**Board Corporate Objectives** The Board noted the Trust's corporate objectives.	
205/11/20	**User Experience Story** The User Experience Story was presented by Kate Mitchell. Ms Mitchell was diagnosed with Multiple Sclerosis (MS) in 1997 and she described her journey since diagnosis. In 1997 there was no co-ordinated service or MS Nurses in the Trust's footprint and only one treatment option available (intravenous	

steroids). Since that time the advancements in treatment and management have been exponential, in particular around management of fatigue. Fatigue was a major symptom of MS and it was originally considered good practice to rest when a MS sufferer was feeling tired. In 2002 Ms Mitchell was involved in some research carried out in the South West looking at the benefits of targeted balance and strength exercises for people with MS. A pilot was set up and patients assessed at the beginning and end of a 10 week exercise programme. It was found at the end that all of them had gained improvements from the programme and it had not increased fatigue, with many patients actually feeling better following the exercise. Over the past 17 years the Trust's Physiotherapy Department had been delivering exercise classes to MS patients at Newton Abbot Hospital, which have been very popular and well-supported.

When the Covid lockdown commenced the classes were put on hold, however Ms Mitchell applied for Covid lottery funding on behalf of the MS Society to provide online exercise classes for MS patients. A six week trial had taken place, providing access to exercise classes for patients in their own homes via Microsoft Teams. Feedback received has been very positive, in particular from patients who have had very little contact with other people during the lockdown and were feeling isolated. It also enabled patients to highlight individual issues with physiotherapists. Patients were encouraged to self-manage their condition, but to contact the Physiotherapy Department if there had any concerns, and whilst this system had worked well in the past, it had ceased during lock-down, and was not yet back up and running. It was well understood that any delay in assessing and management changes in condition could affect the progression of the disease.

Ms Mitchell also referred to difficulties in sourcing the right specialist to read scans which affected the prescribing and administering of disease modifying treatments.

Both Ms Mitchell and Ms Shenton asked the Board to consider, as soon as was practicably possible, the reinstatement of the exercise classes at Newton Abbot Hospital. John Harrison, Chief Operating Officer, said work was taking place to seek alternative options to reprovide the Newton Abbot Hospital facility, however he could not, at present, confirm the alternative location.

Jacqui Lyttle, Non-Executive Director, thanked Ms Mitchell for her presentation and reflected how the online classes had provided support to MS patients not only in relation to the condition, but also for those who were feeling isolated.

Chris Balch, Non-Executive Director, reflected on how much treatment had changed since Ms Mitchell was first diagnosed and he asked if the online classes were reaching more patients than before and if there were plans to extend the service. Ms Mitchell said that it was a new facility and patients were being encouraged to try it and as yet there were no plans to extend the service. Ms Shenton added that the class content has had to be significantly adapted in order for it to be delivered virtually and the effectiveness had not yet been analysed. She said that currently the online classes had to be based around sitting exercises, however when the classes were provided on a face to face basis the exercises were tailored to the ability of the patients attending the sessions.

Liz Davenport, Chief Executive, thanked Ms Mitchell for her presentation and reflected on the positive impact of the online classes in not only supporting patients in their physical wellbeing, but by giving them some psychological support during lockdown. She added that the Board also needed to be cognisant of the impact of waiting times for patients which had been affected by Covid.

PART A: Matters for Discussion/Decision

206/11/20 **Apologies for Absence**

Apologies for absence were received from Mrs Jackie Stockman, Torbay Council Representative.

207/11/20 **Declaration of Interests**

There no interests declared.

208/11/20 **Minutes of the Board Meeting held on the 28th October 2020 and Outstanding Actions**

The minutes of the Board Meeting held on the 28th October 2020 were approved as an accurate record of the meeting.

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

209/11/20 **Report of the Chairman**

The Chairman briefed the Board on activities that had taken place since the previous meeting.

With the Chief Executive, he had met with the Torbay League of Friends ('League') who continued to support the Trust during the pandemic. He referred to the difficulties for the League whilst Level 2, Torbay Hospital, was not available for use and he wished to place on record his thanks to the League for their continued support.

The Staff Heroes awards process continued and was well received by staff. The annual event would be provided virtually this year.

The shadow Integrated Care System (ICS) Board had met earlier in the month and confirmed the appointment of the ICS Chief Executive/ Accountable Officer. It was expected the successful candidate would take up post sometime in the New Year. The Board noted that it was likely an additional meeting would be required in December to discuss the ICS governance proposal before it was presented to the Region in early January.

The Trust Governor Network Meetings continued to take place. These were well attended and continued to provide valuable engagement and challenge.

It was noted that an election process was currently underway for Trust Governors.

Finally, it was noted that the Trust was putting plans in place, in line with Government guidelines, to support the Covid vaccination programme.

210/11/20 **Report of the Chief Executive**

Liz Davenport highlighted the following to the Board from her report:

a) **Covid Pandemic**

The Board noted that the number of Covid cases had stabilised, meaning the Trust had been able to move to having one Covid ward on the acute site; access to intensive care treatment; and two community hospitals providing care to Covid patients. The Trust could therefore optimise urgent and emergency care for non-Covid patients and elective services as part of the Phase 3 plan.

The Trust continued to maintain its internal command and control structure to provide a timely operational response to changes in the Covid environment. This included working at a system level to flex capacity and provide a consistent system response to demand.

b) **Lateral Flow Tests**

Liz Davenport report that the lateral flow test would be implemented at the start of December for front facing staff who were asymptomatic, in line with national policy. In addition, the testing was being introduced in some care homes in the Trust's footprint on a pilot basis to understand how testing could support families visiting loved ones in a care home.

Robin Sutton, Non-Executive Director, informed the meeting that he had tried the lateral flow test and said the process took around 15 minutes, which was a great step towards allowing visitors back into care homes.

c) **Covid Vaccination**

The Trust was working with national and regional teams to put in place an comprehensive vaccination programme, This was being co-ordinated by the Devon Clinical Commissioning Group (CCG).

Robin Sutton said that there was good communication into care homes from GP practices in respect of the vaccinations, however there was limited information available at present.

Liz Davenport said it was important to acknowledge the need for the right level of resource to support the vaccination programme and for it to be co-ordinated across Devon. She said that the system Chief Executives had therefore agreed to recruit additional capacity to manage the roll-out of the vaccine.

The Chairman added that the Primary Care Networks (PCNs) in the Trust's footprint were very supportive of the work taking place and in addition the Trust had agreed for GP practices to use Trust estate to administer the vaccines.

d) **Coastal Consultation**

The response to the consultation which was in relation to the configuration of services and the establishment of a Health and Wellbeing Hub in Teignmouth, were in the process of being evaluated. This was being led by the CCG and it was expected would result in a decision by the end of the calendar year.

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

211/11/20 **Integrated Performance Report – Month 7**

Adel Jones, Director of Transformation and Partnerships, drew the following issues to the Board's attention:

a) **Safety and Quality**
The Board noted that the Safer Staffing Care Hours Per Patient Day (CHPPD) data had been removed from the report. It was not accurate due to ward moves that had taken place. Adel Jones provided assurance that the Trust had a robust process in place to review safer staffing and ensure staffing ratios were appropriate.

Assurance was also provided that, with the opening of the Nightingale Hospital and the need to provide staffing to support the facility, a robust risk management process was in place to ensure safe staffing levels across the system. This framework had been developed and agreed by providers across Devon.

Care Quality Commission (CQC) Assurance meetings continued to take place and in addition the CQC recent undertook a review of the Trust's Emergency Department in respect of patient flow. The CQC were complimentary and positive in terms of the Trust's and wider system processes in respect of patient flow.

b) **Workforce**
The Board noted that the Trust's number of nursing hours worked was currently above establishment. In addition, there was some fragility in the Trust's medical workforce in certain specialties and in some cases mutual aid was being sought alongside changes agreed as part of the Peninsula Clinical Services Strategy.

The Trust's overall absence rate was 17%.

Chris Balch queried the fragility in the medical workforce and the need for mutual aid. He suggested the need for more system-wide working and asked if this was taking place. John Harrison explained that the Trust had transferred some patients to the Royal Devon and Exeter Foundation Trust under an agreed framework put in place to support a system response to Covid, and to support creating resilience in elective services. The mutual aid scheme had also been used to provide support to fragile specialties, however all Trusts were challenged and it was clear that more collaborative working and solutions were required across the system to provide a robust service to patients and service uses.

Liz Davenport added that it had been acknowledged that a more formal strategic alliance was required to take this work forward and that the Trust

was in the process of discussing and agreeing a framework with the Royal Devon and Exeter Foundation Trust and North Devon NHS Trust.

Vikki Matthews, Non-Executive Director, said she was delighted to see that an STP wide approach was in place in respect of safer staffing. She also queried the cause of fragility in the medical workforce.

Judy Falcao, Director of Workforce and Organisational Development, explained that the challenge around medical vacancies was a long standing issue and the Trust had tried many different ways to create programmes and opportunities for staff to develop their skills. Ian Currie, Medical Director, added that the Trust had both short and long term vacancies in its medical workforce. The long term vacancies tended to be positions that were hard to fill across the country and required a system approach to finding a solution.

Deborah Kelly, Chief Nurse, added that the Trust's overall nursing vacancy rate was not large compared to other Trusts, but was significant as the Trust had a large number of staff self-isolating or shielding and it affected in particular very small teams. Deborah Kelly said that an establishment review was essential to establish a skills need to support work to address those hard to fill posts and look at alternative opportunities and workforce redesign. This was in addition to ensuring the Trust had a flexible agile rostering system, to manage staff rotas.

Liz Davenport added that the Trust's close links with its local education providers and work to adopt flexible approaches to education and training were helping to support the Trust in finding solutions to difficult to fill positions.

Vikki Matthews commented on the Trust's overall gap in establishment of 17%, which was a sobering figure. Judy Falcao agreed and said this data would help support work to better deploy staff throughout the hospital and better manage use of bank and agency staff. To support staff, the Trust had a number of health and well-being initiatives for staff. In addition, the Devon System had been informed it had been successful in gaining £600,000 to support an international nursing recruitment campaign.

c) **Performance**

The Trust was tracking the agreed Phase 3 Recovery Plan performance trajectories. There were some specialties where it was known there was an increased risk to patients of harm due to the length of waiting times. These included Orthopaedics, Urology, Ophthalmology and Endoscopy. The Quality Assurance Committee had received reports on these areas and action was being taken to minimise the impact of the waits.

Diagnostic Phase 3 performance had been affected by the need to move a CT scanner and also development of a third room in Endoscopy. Mitigation plans were in place and were being closely monitored through the Integrated Governance Group framework.

Jon Welch, Non-Executive Director, queried ambulance turnaround times and the increase in handover delays in October. John Harrison explained that turnaround times had improved significantly and was due not just to the impact of Covid, but to the establishment of the Medical and Surgical Assessment Units, which had improved patient flow through the Emergency

Department. A reduction in urgent activity had been experienced during Covid and it was expected turnaround times would improve as the current surge reduced.

Jacqui Lyttle informed the meeting that the Quality Assurance Committee had planned to receive a report on the elective areas where a risk of harm to patients due to waiting lists had been identified, however due to time constraints it had been agreed to undertake a review outside of the meeting to ensure timely action.

Paul Richards, Non-Executive Director, commented on the number of areas where the Trust was not meeting its targets and asked for information around when it was expected these targets would be met.

John Harrison explained that the targets and trajectories in the paper were those that were set at the start of the financial year, ie pre-Covid. He said that it would be helpful to include the agreed Phase 3 targets and trajectories in the performance data and said he would ensure these were added for future meetings. COO

Ian Currie, Medical Director, informed the meeting that a Harms Review process was currently taking place looking at learning from retrospective harm, and prospective potential harm to patients waiting longer than normal for treatment so that action could be taken where necessary.

d) **Finance**

Month 7 performance reflected the first month of a return to a normal financial regime and it was apparent that the financial regime earlier in the year had masked an underlying deficit position for the Trust. A robust CIP savings programme was in place, alongside the Phase 3 recovery plans.

Jon Welch asked if the Risk Share Agreement would support the shortfall in adult social care spend at the end of the financial year. Dave Stacy, Chief Finance Officer, explained that at the beginning of the year the Trust agreed a new three year funding contact with Torbay Council in respect of adult social care provision. This was a fixed income contract with a core allocation of £43m, and a £3m non-recurrent cost base. It was understood this did not reflect the full cost of adult social care provision and meant the Trust would need to find ways of reduce costs. This work was taking place with Torbay Council.

The Board of Directors received and noted the Month 7 Integrated Performance Report.

212/11/20 **Winter Plan 2020/21**

John Harrison presented the Winter Plan for approval. He explained that the document had been refined following discussions at last month's meeting and incorporated increased learning both from last year's winter period and more recently Covid. He said the plan had been written to focus on clarity and flexibility; integration; and modelling and system working.

At this point Rob Dyer, Deputy Chief Executive, left the meeting.

Vikki Matthews noted that the need for staff wellbeing and resilience was included in the report, but it was not easy to find. This was acknowledged.

The Chairman reflected on the statement that moving to Opel 4 incident level should be seen as a Never Event and how this might be read by staff.

Liz Davenport noted the amount of work that had taken place to produce the report, and the systems and processes that sat behind it to deliver the plan.

Both Chris Balch and Paul Richards welcomed the plan as a robust document and Jacqui Lyttle said that, as Chair of the Quality Assurance Committee, she felt assured the plan would ensure patient safety during the winter period.

Adel Jones suggested that next year, the plan could also include data on deliverable bed equivalents in the System and this was agreed. John Harrison said he would take this forward with the CCG, to enable consistency of planning across the System. | COO

The Board of Directors approved the Winter Plan 2020/21. Chief Operating Officer to make appropriate changes as discussed above.

213/11/20 **Mortality Safety Scorecard**

Ian Currie briefed on the Board on the data contained in the Mortality Safety Scorecard and the following was highlighted:

- **Overall mortality** – as reported last month, there had been a drop in April due to Covid, but this had returned to normal over the last few months. The Trust was not an outlier compared to peer hospitals.

- **Deaths 30 days after an inpatient stay** – due to the Covid-related reduction in activity this number had increased.

- **Unadjusted Mortality** – again the data was skewed due to Covid and a reduction in activity over the summer.

- There had been no perinatal deaths during the reporting period.

In summary, Ian Currie said that there were no areas of concern highlighted by the data in the Mortality Safety Scorecard.

Ian Currie then described the work that took place around deaths in certain groups of patients. For example, it was known that people with learning disabilities tended to live 15-20 years less than people without learning disabilities. The Trust needed to ensure that it did not treat them any differently when presenting with a concern or condition. Ian Currie said that in the current year one learning disability patient had died in the Trust, and that person's disability had not been a factor in their death. Liz Davenport added the Trust also ensured it applied best practice in terms of treatment patients with learning disabilities.

Ian Currie reminded the Board of the role of the Medical Examiner and said that it was hoped that all inpatient deaths would be reviewed by the Examiner

by the end of the financial year. To date around 50% of inpatient deaths had been reviewed.

The Chairman asked if the reviews of deaths focussed on Black, Asian and Monitory Ethnic (BAME) patients as it was understood they were of a higher risk of dying from Covid. Ian Currie explained that the Trust had experienced 39 deaths due to Covid and each one of them had been reviewed, including if anyone had come from a BAME background. He said that it had not been identified as a factor in terms of overall deaths.

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

214/11/20 **Guardian of Safe Working Hours Report**

Ian Currie presented the Report of the Guardian of Safe Working Hours. He highlighted the difference in number of exception returns between surgical and medical staff, with a higher number of surgical returns than anticipated. Ed Berry, the Guardian of Safe Working Hours, had noted that the number of surgical returns was around normal and in fact the number of returns from other areas had reduced. The Board was reminded that completion of the exception repots was not mandatory and many doctors felt that working over their allotted hours was to be expected and was part of their professional contract.

Ed Berry had reported that he felt junior doctors had a good relationship with their managers and would flag any concerns to him if necessary.

Vikki Matthews noted that the process of submitting an exception report was time consuming and so junior doctors found it difficult to engage with it, and asked if there was any way to improve the system. Ian Currie said that there was no way of improving the system, however if areas of concern were highlighted the Guardian would undertake an investigation.

Finally the Board noted that if additional hours were worked which were not approved within eight weeks of submission, junior doctors were automatically paid. Ian Currie said that the process of approving additional hours was being addressed to make it as streamlined as possible.

The Board of Directors received and noted the report of the Guardian of Safe Working Hours.

215/11/20 **Research and Development Annual Report**

In presenting the Research and Development Annual Report, Ian Currie informed the Board the Trust undertook three areas of research: National Institute for Health Research; commercial research; and smaller areas of research for example funded by the Torbay Medical Research Fund.

Ian Currie said the report showed the Trust benchmarked well against other organisations in terms of the amount of research undertaken, however the service was dependent on a small team and was not properly embedded across the Trust. The Board was reminded that research was an important pillar of overall quality in an organisation.

In addition, the research team have had to move location several times over the last few months and the need for a suitable location to undertake research and obtain commercial bids was important. An example was the need to move location at short notice recently, resulting in a need to contact a cohort of the SIREN study patients to inform them they would need to attend a different location for their testing.

Robin Sutton asked how research could be imbedded in the wider organisation and suggested that it should be taken forward with the Trust's junior colleagues to encourage them to continue research throughout their career. Ian Currie explained that this was something that could be addressed through the job planning process, with members of teams taking the lead on areas such as research, for example. In addition, when doctors joined the Trust their weekly rota included four hours a week for them to devote to educational activity which could include research. It was also something that was discussed with potential consultant candidates at interview.

Deborah Kelly added that there was a need to ensure research was aligned to the Trust's strategic priorities, notwithstanding the need to raise income from commercial studies. The need to have greater visibility of research was discussed and agreed.

Chris Balch said that, mostly, research was clinically focussed and he suggested the Trust needed to think about how research could support HIP2 and innovative ways of working and suggested there needed to be more direction on areas of research undertaken. Adel Jones suggested that this could be taken forward through the Transformation and CIP Group, and it was agreed Ian Currie and Adel Jones would discuss further outside of the meeting. The theme of research and development was also agreed for discussion at a future Board Strategy session. DTP/ MD

The Chairman, reflecting on the fact that the Research and Development Department have had to move locations several times over the past few months, asked that consideration be given to finding the team a permanent location. This was agreed. MD

The Board of Directors received the Research and Development Annual Report for information.

PART B: Matters for Approval/Noting without Discussion

Reports from Board Committees

216/11/20 **Finance, Performance and Digital Committee – 26th October and 23rd November 2020**

Paul Richards reported that the meeting discussed the need to ensure, given the current financial environment, that business case benefits realisation programmes were in place and regular reviewed, alongside post implementation reviews to ensure programmes of work were either cash releasing or had resulted in a productivity gain.

The Committee would also be seeking to gain deeper assurance in relation to ISU performance and Trust performance against national targets and the triangulation of workforce data.

The meeting received a paper detailing the Trust's National Reference Costs for 2019/20. The Trust's costs were high, highlighting the need to reduce costs.

Finally, the meeting received a report from the Children's Alliance Director around work to date on the Child and Family Health Devon Programme.

217/11/20 **Health Improvement Programme (HIP2) Redevelopment Committee – 18th November 2020**

Chris Balch reported that the meeting focused on reviewing the risks attached to the HIP2 project on the Board Assurance Framework and agreed the strength of assurances risk rating should be rated 'amber'.

The Committee would continue to progress the Strategic Outline Case (SOC) and the critical path to produce the Health and Care Strategy. The Board Strategy day on the 9th December would be discussing these areas in some depth.

The SOC timetable had been agreed alongside the resource needed to take forward the project.

218/11/20 **Quality Assurance Committee – 23rd November 2020**

Jacqui Lyttle reported the Committee received a presentation from the Trust's Tissue Viability lead, focussing on grade 3 and 4 ulcers and the work being undertaken to reduce the incidence of these ulcers in the community.

An update on the Care Quality Commission Inspection Action plan was received, along with a quarterly Maternity Governance Safety Report. Of note was a report around the Trust's inability to undertake placental histopathology. This was a service that the Trust was not commissioned to provide, resulting in some poor outcomes. The issue had therefore been escalated to the Clinical Commissioning Group.

The Chairman reminded the Board that teams such as the Tissue Viability Service and also the Infection Prevention and Control Team were geographically spread across a number of locations. He suggested that as their work was complementary these be brought together in some way.

219/11/20 **People Committee – 5th November 2020**

Vikki Matthews reported the Committee considered two risks related to workforce and leadership and also the fact that the Trust's workforce was currently fatigued.

The Committee also reviewed work to date on the People Plan with feedback offered around focus and organisational capacity to take forward transformational change.

It was noted that pre-Covid, 73% of staff had reported a positive wellbeing at work, however this figure had reduced significantly during Covid. A further survey was being undertaken to ascertain the current figure.

Sanita Simadree, Equality Business Forum lead, attended the meeting and provided the Committee with feedback from fellow BAME colleagues about their experiences of working at the Trust. This work was continuing to ensure BAME colleagues were able to have their voices heard.

The Committee noted that Freedom to Speak up referrals had increased. The Trust's Freedom to Speak Up Guardian had report that it was a positive sign that referrals were rising, especially as some of them were from traditionally 'hard to reach' groups.

Reports of Executive Directors

220/11/20 **Report of the Chief Operating Officer**

John Harrison highlighted to the Board the challenges facing teams around the need to prioritise time and capacity to focus on CIP plans in the current environment.

221/11/20 **Estates and Facilities Management Update**

Dave Stacey reported that progress was being made on the fire safety issues reported at earlier meetings and said that a comprehensive plan to resolve the issues would be presented to the Board in near future.

222/11/20 **Compliance Issues**

There were no compliance issues raised.

223/11/20 **Any Other Business Notified in Advance**

There was no business notified in advance.

224/11/20 **Date of Next Meeting – 11.30 am, Wednesday 27th January 2021**

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.	Review resource dedicated to the new network implementation programme.	DTP	**Completed.** Adel Jones confirm that she was content the right level of resource was available to the programme.	30/09/20
2.	Present Winter Plan to the November Board meeting	COO	**Completed**	28/10/20
3.	Include Phase 3 trajectories in future Integrated Performance Reports.	COO		25/11/20
4.	Future Winter Plans to include data on deliverable bed equivalents in the system. To also ensure consistency of planning across the system.	COO		25/11/20
5.	Consider how to use research to support HIP2 and direction of areas of research taken.	DTP/MD		25/11/20
6.	Secure permanent location for the Research and Development Team.	MD		25/11/20

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 27 January 2021
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 19 January 2021		
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 is 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: 27 January 2021
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 25 November 2020 are as follows:

1.1 Safe Care, Best Experience

1.1.1 Escalation to cope with winter and the second wave of COVID-19

Current position
With the continued incidence of COVID-19 across the country, and the rapid increase in hospital admissions and deaths from COVID-19, NHS Chief Executive, Sir Simon Stevens, has confirmed that the health service is to maintain its highest level of emergency preparedness, known as 'Level 4' readiness, until at least the end of this financial year. This has been important in enabling national arrangements for mutual aid, under which some patients from London and the South East have been transferred out of area for intensive care. The South West has received some of these patients.

However, we are also experiencing a surge of new COVID-19 cases, with an increased prevalence of the new variant. In the coming weeks we expect to see an increased COVID-19 impact.

Sustainability and Transformation Partnership (STP)
Working with our colleagues across the STP, we have in place thorough and robust plans so that we can continue to provide good and safe care for our patients. This includes opening beds within the Nightingale Exeter Hospital, increasing ICU capacity, reviewing our daily bed occupancy across the whole system and providing mutual aid when needed, to ensure we make best use of our capacity.

Our escalation plans
We know the coming weeks will be challenging, but we have planned well, learnt from previous experience and we will manage our response to the expected surge, with mutual aid arrangements in place across the whole South West region, to make the most of the capacity available to us. The following are some of our key actions:

- temporarily relocating and reducing our day case activity and using the vacated Day Surgery Unit for our Medical and Surgical Receiving Units.
- expanding our ICU capacity (into the space vacated by Surgical Receiving Unit)

- developing new services in the community to support more people out of hospital – including 'virtual wards' and supporting people to monitor their blood saturation levels at home (pulse oximetry)
- increasing our intermediate care services and support for people who require complex packages of care
- pausing much of our routine elective activity for at least one month, where this releases staff and capacity to support our COVID-19 and urgent care response
- reviewing nursing ratios and tasks to maintain patient safety and increasing HCA and admin support to clinical teams in areas under pressure.

Ensuring safe care during pause of routine elective surgery
Whilst we aim to maintain as many non-urgent services as we can, pausing some routine surgery and other services means we can increase capacity to treat those most in need of emergency and urgent care, both COVID-19 and non COVID-19.

We appreciate how difficult it is for people to have their surgery cancelled or postponed. However, our clinical teams will keep waiting lists under continuous review and we will continue to communicate with people whose planned care has been disrupted about how they will be looked after, and who to contact in the event that their clinical circumstances change

Supporting our staff
The past year has been unlike any other and the pressure on staff across all our health and social care services has been intense. Following the first wave of the pandemic, we carried out a 'Three Horizons' learning review across our organisation, to make sure we took learning from staff experience. Many teams have been involved in creating local 'surge plans', and the combined effort across all our services has been impressive. As a result, we are much better prepared than during the first phase of the pandemic to manage the challenges that face us. However, we know the coming weeks are still going to be really challenging.

A key priority is supporting and enabling our staff to be safe, and ensuring they have the equipment they need. Activity supporting this priority includes:

- ramping up our vaccination programme for health and social care staff, running clinics 7/7 from 8am to 8pm
- improving our rostering of staff
- creating 'virtual teams' and 'super teams' to provide better induction and support for all those who may be asked to take on new roles or work in different locations
- matching people to roles that suit their skills and experience, if they are asked to reassign
- continuously monitoring working arrangements and reviewing risk assessments to keep each other, our service users and our patients safe
- prioritising our engagement and communication with staff, including launching a cascade briefing system over the winter so that all staff, in all roles, have the opportunity to hear and discuss key messages.

Staff parking
Contrary to inaccurate reports in local media recently, staff are not being charged for parking at our sites. Staff who are eligible for a parking permit will be able to park free of charge at our sites for as long as the government continues to support this. Staff who are not eligible for a parking permit are advised about other local alternatives and asked not to park in spaces reserved for patients and visitors.

Supporting our communities
We continue to provide infection prevention and control support to care homes in our area, including helping them respond to local cases and providing rapid result swab testing. Our community nursing teams are visiting care homes impacted by severe staff shortages due to COVID-19, and our dietitians are providing nutrition advice for residents who are recovering. We are also responsible for delivering the COVID-19 vaccination to a broad range of health and care staff in our communities, including staff of Devon Partnership NHS Trust, paramedics, social care staff, opticians, dentists, undertakers and hospice staff.

We are also supporting local food bank initiatives, and providing facilities for our own staff to be able to donate to this community effort. Whilst many of our teams are working under intense pressure and are very tired after a long year, they are also acutely aware that they are fortunate to be in employment, and are grateful for the support they have received from our communities. This is one way we can show our gratitude.

Torbay Council and Public Health run a programme of public information for COVID-19 called 'COVID Champions'. These COVID-19 Champions help keep residents, businesses and the community up-to-date with the best advice about COVID-19 (Coronavirus), and enable them to make informed choices. Last week, our Director of Infection Prevention and Control, Dr Joanne Watson, held a Q&A workshop for these champions.

Comment
Implementation of our escalation plans has required many service moves. This is as disruptive and challenging for our teams as it is for our patients – if not more so – and some have had to move on multiple occasions. I am grateful to each and every one of them for their ongoing commitment to providing the best possible care for our patients.

I am grateful too for the patience, resilience and support of local people: thank you for helping us to do the best we can.

I would also like to remind everyone just how important it is to follow national lockdown rules and infection prevention and control measures to keep all of us safe, and help to contain the pandemic.

When they are at work, our staff wear appropriate PPE to protect each other and our service users and patients. When they are on breaks, in meetings or moving around our hospitals, clinics and other buildings, they too must observe social distancing. It is important to keep 2m apart, to wear a face covering and to wash hands frequently.

We are also asking for local people to help us to help you, 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. If in doubt, NHS111 can help you decide where best to attend.

1.1.2 COVID-19 vaccination programme

Dawlish Community Hospital is being used as a primary care network vaccination centre, where GPs are offering the vaccine to priority groups from the local population.

Torbay Hospital received its first batch of the Pfizer/BioNTech vaccine on Monday 4 January, and we are progressing well in vaccinating health and care staff with their first dose of the vaccine. We are following the guidance issued by the Joint Committee on Vaccination and Immunisation (JCVI) for targeting staff who belong in the priority groups first. Therefore, while all Trust staff will be offered the vaccination over the coming weeks, staff who are clinically vulnerable or work in patient-facing roles were asked to book to receive their vaccine before other staff.

From Monday 18 January, we also extended our vaccination programme to frontline social care staff employed by Torbay Council and Devon County Council, and staff employed by Devon Partnership Trust who are located near to Torbay Hospital. We will also be extending our hospital hub offer to other health providers in the community including dentists, podiatrists , optometrists and funeral directors

The government changed the immunisation schedule to ensure as many people as possible received their first COVID-19 immunisation in order to protect the population. We will therefore be providing all second vaccination doses12 weeks after the first, starting the end of March 2021.

Anyone who is in a priority group and hasn't yet been invited for a vaccination, need not worry: the Primary Care Networks across the system are working through patient lists in priority order, as set out in the national guidance, and will make contact with everyone who is eligible in due course. Local people are asked not to contact their general practice or hospital to ask about an appointment – the NHS will contact you when it's your turn.

1.1.3 Managing cases of COVID-19

Staff swabbing

We continue to follow guidance from NHS England and NHS Improvement in implementing lateral flow testing (nasal and saliva self-test kits) for our staff who are in direct contact with patients. As this test returns some false positives, all positive results are cross-checked using PCR swabbing tests. The testing has had a massive benefit in preventing staff with asymptomatic COVID 19 from attending work and reduced the risk of transmission to other staff and patients or clients accessing our services. This helps to identify staff who may be positive and not showing any symptoms of COVID-19, and to take swift action to prevent spread of infection.

Patient swabbing
In line with government guidance, we are offering lateral flow testing in maternity, so that partners can safely accompany women for key appointments and during their labour and birth.

Following recent learning from COVID-19 cases in our hospitals, we have reviewed the intervals for patient swabbing. All patients are now being swabbed on attendance, if they are over 70 or going to be admitted. Further swabbing for inpatients takes place on day 3, day 5 and day 7. Swabbing will then continue every 7 days if the patient remains in hospital. This approach led us to identify a positive patients on Midgely ward, one of our non-COVID-19 wards. Thanks to the very prompt response of our staff, we were able to ensure other patients and staff were kept safe, and the COVID-19 positive patient was transferred to safely to Cromie Ward. With a very careful and rigorous approach to infection prevention and control, no other patients or staff members have tested positive although we are continuing to carefully monitor the situation. The ward was closed to new admissions until all patients had safely quarantined, and the ward was then deep cleaned before re-opening. We have implemented very detailed infection control procedures for our teams to follow when staff or patients test positive in any of our community or hospital services.

1.1.4 HIP2 update
As part of the national HIP2 (Health Infrastructure Plan) programme, we have been allocated £3.7million of 'seed' funding to proceed with the planning of a new £350 million hospital development - subject to the approval by NHSE/I and HM Treasury of our Full Business Case.

Our plans are progressing well and we recently reached an exciting milestone with the internal recruitment launch for our Health and Care Design Champions. There will be 20 posts and the Champions will join us to work on our vision for the future.

There are a number of key areas where we will be looking for support and engagement from the Champions as we work towards the construction of our new facilities:

1) Clinical pathways – making sure they are fit-for-purpose for the next 30-50 years
2) Workforce design – help us to design our workforce model for our new facilities
3) Input in to the design of our new facilities

There has been a really high level of interest from across the organisation regarding the Champions and the recruitment process will proceed as quickly as possible.

New national leadership appointment
Natalie Forrest has been appointed as the Senior Responsible Officer of the New Hospital Programme – part of the Health Infrastructure Plan.

Ms Forrest will oversee the construction of the 40 new hospitals across the UK by 2030. She brings a wealth of health, construction and project management experience, most recently as Chief Executive of Chase Farm Hospital in London. She has worked for the NHS for over 30 years and is a registered nurse. She also led construction of the NHS Nightingale Hospital in London.

1.1.5 Flu vaccination

This year we were successful in meeting the national vaccination target of vaccinating 70% of staff against the flu – and in a much shorter timescale than usual due to setting up as a hospital hub and running COVID-19 vaccination clinics from 4 January.

Public Health England is continuing to report vaccination figures until the end of March and we will continue to offer the flu vaccine through peer vaccinators and clinical site managers.

1.1.6 New HOPE for new mums

The first Virtual HOPE Programme for Postnatal Emotional Wellbeing began this month. The programme is for new mums who are in need of some support, and would like to meet other mums who are going through something similar. The two facilitators delivering this course have been through postnatal depression themselves, so have a good understanding of participants' experiences.

A similar programme for carers also started this month. For information on these and other HOPE courses, email: hope.devon@nhs.net.

1.2 Valuing our Workforce, Paid and Unpaid

1.2.1 Staff Heroes Annual Awards

As I reported to the Board in November, the 2020 annual Staff Heroes award ceremony was run as a virtual event. However, in an effort to create the same sense of occasion, the Chairman and I dressed as though we were hosting the gala ceremony in person, when we recorded the video announcing our winners. Following the launch of the video via social media coverage in Torbay Weekly, we were joined by the executive team to deliver certificates, trophies and small gifts to our winners in the run-up to Christmas.

1.2.2. Focus on staff wellbeing

We are extending our wellbeing offer and making sure staff are aware of what is available to them, including:

- Wellbeing buddies – new training based on effective communication, basics of supportive conversations, wellbeing tools and practices.
- Anti-bullying Advisors will be available to support staff from February and include voluntary staff from Workforce and OD as part of the group
- New Wellbeing Newsletter (launched just before Christmas)
- Long service award - in recognition and support of those staff who have given long service to the NHS.
- Schwartz Rounds, Hearts and Minds and HOPE programme have all been successfully transferred onto Microsoft Teams
- 1-hour wellbeing sessions taken up to wards looking at resilience tools and techniques including mindfulness, relaxation, and the relationship between feelings, thoughts and behaviour.
- Since April 2020, we have been awarded grants totalling £193,000 by NHS Charities Together and many of these are supporting staff wellbeing, for example:
    - 45 care packages (shampoos, hand creams, deodorants and shower gels) have been delivered to wards where staff work directly with COVID-19 patients

- eleven new wellbeing and green space projects across the Trust. One of these projects involves upgrading eight staff areas and kitchens to provide more comfortable communal facilities for hundreds of staff, thanks to a £40,000 award.

1.2.3 Extraordinary nurses recognised in Torbay and South Devon

A nurse who works in Torbay Hospital's Emergency Department was honoured recently with The DAISY Award for Extraordinary Nurses. The award is part of the international DAISY Foundation's mission to recognise the extraordinary, compassionate nursing care that is provided for patients and families every day.

Christina Harrison was nominated by Matron, James Merrell, for consistently demonstrating a caring and compassionate attitude towards all patients within the Emergency Department, remaining non-judgmental and always putting the Trust values into action.

Nurses may be nominated by patients, families, and colleagues. The award recipient is chosen by a committee to receive The DAISY Award and awards are presented throughout the year at celebrations attended by colleagues, patients, and visitors. Each award winner receives a certificate commending them as an "Extraordinary Nurse".

1.2.4 Tribute to Barbara Inger

Barbara Inger, who served as a Teignbridge Public Governor since 2015, sadly passed away suddenly in Torbay Hospital intensive care unit on 29 December 2020. The Chairman and I contacted her immediate family to express condolences on behalf of the Trust Board and all governors.

Barbara was a thoroughly engaged and committed governor, and had taken up many roles in her long serving period as a governor, including Lead Governor for the Teignbridge Constituency, member of the Governor Nomination and Remuneration Committee, member of the FT Constitution Task and Finish Group and member of the Membership Committee, as well as being a regular contributor and attendee at events for Trust members. Barbara had also applied to stand for re-election for a third term to serve the Teignbridge Constituency.

Our thoughts and condolences go to her family and friends following their sad loss.

1.2.5 Staff governor election

The Council of Governors consists of 32 elected and appointed governors, who help ensure the views of the wider hospital community, including staff, are communicated to and considered by the Trust Board. Following the recent nomination process for staff governors – we have a contested election for the Moor to Sea Integrated Service Unit (ISU). Staff in the Moor to Sea constituency are being asked to vote for their preferred candidate between Wednesday 13 January and Friday 5 February 2021.

1.2.6 New safeguarding training framework

Last year, the Torbay and Devon Safeguarding Adult Partnership ratified a new safeguarding training strategy for use across the Torbay and Devon partnership. The strategy reflects national competency frameworks including NHS intercollegiate guidance and the National Core Skills Training Framework. As a result of the new guidance, we reviewed our own training provision and have been rolling out our new

training framework since December. Under the new arrangements, some staffing groups will see changes in the levels of mandatory training they need to undertake. Many staff will be able to access a blended mix of on-line training and face to face, which will allow greater flexibility and a reduced requirement for face to face training.

2. Chief Executive Engagement December/January

I have continued to engage with external stakeholders and partners – in the main 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 • Child and Family Heath Devon Board – Senior Leaders Meeting • Freedom to Speak up Guardians • Equality, Diversity and Inclusion - A Way Forward Event • Partnership Forum	• Chief Officer for Adult Care and Health, DCC • Accountable Officer, Devon CCG • System Chairs, Leaders, Directors of Adult Social Services Meeting • Devon NHS Chief Executives • Devon Health and Local Authority Chief Officers' Meeting • South West Regional Chief Executives • Director of Adult Social Services, Torbay Council • Devon Children and Family Partnerships Executive Meeting • Locality Director, South West NHSE/I • Annual Senior Leader Engagement Meeting, Health Education England • Prime Minister's Implementation Unit Round Table Meeting (Elective Care) • Torbay Council Overview and Scrutiny Board • Integrated Care System Partnership Board • CCG Governing Body • Peninsular Partnership Board • South LCP Executive • Executive to Executive Meeting with Devon Partnership Trust • Chief Executive, Torbay Healthwatch

3. Local Health and Care Economy Developments

3.1 Partner and partnership updates

3.1.1 Public engagement on the design of the Teignmouth Health and Wellbeing Centre

In December, Devon Clinical Commissioning Group (CCG) Governing Body approved plans to modernise services in the Coastal Locality, following a formal public consultation in the autumn.

The final recommendations, which were approved by the Governing Body, were influenced by the outcomes of the public consultation as below:

a. Approve the move of the most frequently used community clinics from Teignmouth Community Hospital to the new Health and Wellbeing Centre
b. Approve the move of specialist outpatient clinics, except ear nose and throat clinics and specialist orthopaedic clinics, from Teignmouth Community Hospital to Dawlish Community Hospital, four miles away
c. Approve the move of day case procedures from Teignmouth Community Hospital to Dawlish Community Hospital
d. Continue with a model of community-based intermediate care, reversing the decision to establish 12 rehabilitation beds at Teignmouth Community Hospital
e. Approve the move of specialist ear, nose and throat clinics and specialist orthopaedic clinics to the Health and Wellbeing Centre
f. Request Torbay and South Devon NHS Foundation Trust consider in detail the suggestions put forward for additional services at the Health and Wellbeing Centre
g. Request Torbay and South Devon NHS Foundation Trust consider providing secondary office space at Dawlish Community Hospital for physiotherapists, occupational therapists and district nurses
h. Request Torbay and South Devon NHS Foundation Trust work with Teignbridge District Council to mitigate parking issues in Teignmouth Town centre and with the voluntary sector and bus operators to further support and enhance the development of community transport to mitigate transport issues when accessing services at Dawlish Community Hospital for staff and patients as far as possible.

The full paper that was considered by the Governing Body can be found on the CCG website.

On behalf of all partners involved, the Trust is now taking forward plans to build a new £8million Health and Wellbeing Centre on the Brunswick Street site in the heart of Teignmouth. The centre, which is due to open in 2022, will house GPs from Teignmouth's largest practice, Channel View Medical Group, the health and wellbeing team and Volunteering in Health.

As part of the planning process, this month the Trust held a two-week public engagement on the design of the building. The pandemic and lockdown prevented face-to-face meetings, so a dedicated website was launched, showcasing the detailed design of the new centre. This, along with a live webinar Q&A session with the architects, enabled people to find out more about the building, its location and the detailed design. Feedback on the design is being into our planning submission.

3.1.2 CCG appoints deputy chief nurse

Susan Masters has been appointed as the CCG's deputy chief nursing officer and will join the nursing and quality directorate from March. Susan has many years' experience in a variety of senior NHS leadership roles in acute and community settings, including as associate director of nursing and quality at a south west clinical commissioning group.

She is currently the director of nursing, policy and public affairs for the Royal College of Nursing (RCN) and previously was the director for RCN South West.

3.1.3 Purple Angels campaign supporting Torbay Hospital

We have been working with Norman McNamara and his Purple Angels campaign in recent years, both to increase awareness of dementia and to provide better support for people using our service who have dementia. During the pandemic, the Purple Angels charity has provided 15 pre-loaded MP3s for five wards at Torbay Hospital, with three MP3s each for Simpson, Cheetham Hill, George Earl, Midgley Ward, and Dunlop wards. Each MP3 is loaded with music suitable either for people in their 50s to 70s or for the over 70s. This helps people to relax and feel calm – and is much appreciated by our ward staff as well as their patients.

3.1.4 Staff take part in SIREN study

Over 300 Trust staff took part in a Public Health England study, which found that past coronavirus (COVID-19) infection provides some immunity for at least 5 months, but people may still carry and transmit the virus. The research study involved testing healthcare workers (swab and antibody testing) every two weeks to assess immunity. We are grateful to all those who took part – their support has helped to gather important information about COVID-19, which has and will be critical to fighting the pandemic.

3.1.5 Consultation open on new standards for emergency care

Consultation has now opened on proposals arising from the clinical review of access standards, as piloted in the South West by University Hospitals Plymouth and Poole Hospital.

Patients, clinicians and the public are being invited to give their views on a comprehensive set of indicators for urgent care. The proposed new standards aim to capture what matters clinically and to patients, end hidden waits and reduce the risk of spreading COVID-19. Proposals take account of changes in the way that urgent care is delivered, such as the roll-out of Same Day Emergency Care and strengthening of NHS 111. Under the new measures, hospitals would be expected to see and assess patients within 15 minutes.

Local health systems could receive a rating that reflects the whole patient journey, as measured by ten new indicators, including 111 performance, ambulance response times and patient handovers, timely assessments and time spent in emergency departments (EDs).

Data on individual trusts' performance would still be published each month.

The consultation is backed by the Academy of Medical Royal Colleges, Royal College of Emergency Medicine, Healthwatch, Doctors' Association, College of Paramedics , Patients Association, Stroke Association, Royal College of Physicians, UK Sepsis Trust, Royal College of Psychiatrists, Association of Ambulance Chief Executives, NHS Clinical Commissioners (NHSCC) on behalf of NHSCC and NHS Confederation. People can have their say until Friday 12 February 2021.

3.1.6 NDHT and RD&E a stage closer to formally joining together

Northern Devon Healthcare NHS Trust (NDHT) and the Royal Devon and Exeter NHS Foundation Trust (RD&E) have received the go-ahead from NHS England and NHS Improvement (NHSEI) to continue working on plans to formally join together.

In November 2020, both Boards approved a 'Strategic Case' which sets out how the Trusts propose to become a single integrated organisation and submitted it to NHSEI for review. This formal document signalled the organisations' intent to join together and set out the benefits this would provide for patients, staff and local communities.

The approval to proceed from NHSE/I means the organisations can now proceed to develop an Integration Business Case which will describe in more detail how the two organisations become a single integrated organisation working across Northern and Eastern Devon for the benefit of both communities.

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.

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

- Dartmouth Health and Wellbeing Centre plans approved
    - Exciting plans for a modern £4.7 million health and wellbeing centre in Dartmouth were approved at a meeting of South Hams District Council's Development Management Committee. The purpose-designed centre will give local GPs the facilities they need to support the service into the future, and enable close working relationships and joined up care services with our community teams and voluntary sector partners
- Torbay's Health and Care organisations across Torbay have pledged their commitment to supporting people who care for family members or friends
- Extraordinary nurses recognised in Torbay and South Devon – DAISY award
- Torbay Hospital launches as a vaccination hub
- Public invited to share views on plans for a modern Health and Wellbeing Centre in Teignmouth
- A new waymarker sculpture trail was unveiled on the Torbay Hospital site as part of a celebration of green spaces and in recognition of their benefits for wellbeing.

Recent engagement on our social media channels includes:

- Building vaccine confidence
- National restrictions reminders
- Hands Face Space
- Think111
- HCI digital video library
- 12 Days of Christmas staff messages
- Christmas jumper activities
- Vaccine reassurance – roll-out continuing
- Christmas/New Year maternity births
- Teignmouth Health and Wellbeing Centre design consultation
- Dartmouth Health and Wellbeing Centre plans approval
- Trust vaccination programme begins

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 to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 9 2020/21 (December 2020 data)			Meeting date: 27 January 2021
Report appendix	M9 2020/21 IPR focus report M9 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: 21 January 2021 Finance, Performance, and Digital Committee: 25 January 2021		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Finance, Performance, and Digital Committee (FPDC) and Trust Board to: • 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		

<table>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Board Assurance Framework</td><td>Yes</td><td>Risk score</td><td>25</td></tr>
<tr><td>Risk Register</td><td>Yes</td><td>Risk score</td><td>25</td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
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<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
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This report reflects the following corporate risks:

• failure to achieve key performance standards;
• inability to recruit/retain staff in sufficient number/quality to maintain service provision;
• failure to achieve financial plan.
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Report title: Integrated Performance Report (IPR): Month 9 2020/2021 (November data)		**Meeting date:** 27 January 2021
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 Board's attention are:

1. Quality headlines

Incidents

- There have been 4 STEIS incidents reported in December;
  - 2 falls
  - Grade 4 pressure ulcer
  - Complex clinical and safeguarding

Infection control

- We continue to see numbers of patients admitted due to COVID 19. The pattern of outbreaks reflects a national picture and we are utilising Exeter Nightingale as part of our plans for caring for our covid patients.

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

Harm reviews

- 2 dimensions to the harm review prospective and retrospective.
- The prospective view has identified 4 the areas of concern due to the clinical priority level. These include:
  - Trauma and orthopaedic
  - Ophthalmology
  - Upper Gastrointestinal surgery
  - Urology and Oral surgery
- The retrospective review identified 19 incidents involving harm to patients due to cancelled services, delays to be seen or assessed or due to delayed treatment. These are categorised as moderate, 9. 4 as low harm, 2 classed as severe, 1 as death and 3 near miss. Investigations are being completed as per governance.

Safer Staffing

As an organisation we are utilising our covid safest staffing and risk mitigation and escalation framework that ensures we are taking a risk-based approach to staffing during extremis for our inpatient ward areas and Allied health professionals are utilising the risk framework that they have designed to support the reassignment and clinical flexible working strategy. We are moving to an amber position for our staffing for our inpatient wards.

2. Workforce Headlines

The December 2020 WTE (hours worked) 6143, is in excess of the budgeted establishment (5927), 6279 includes bank and agency staffing. There were 229 vacancies in December 2020. The Nursing Establishment review, currently underway, will enable the Trust to reset the appropriate staffing levels based on service need.

In December the rolling sickness absence rate was 4.07%, 4.24% cumulative taking account of vacancies, sickness, Covid-19 impact putting significant pressures into the system. The Covid-19 absences continued to rise, as of 19 January 2021, 46 staff off with covid confirmed, 155 staff overall absent covid related i.e. self-isolating, clinically extremely vulnerable etc.

Agency expenditure has increased in month 9, being £0.74m (M8 £0.66m) –Increased across Nursing and Medical/Dental due to vacancies, winter pressures and covid.

As of 20 January 2021, the Trust had provided 5892 of which 5421 Torbay staff covid vaccinations others include DPT, SWAST, and the local hospice.

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 supported to minimise this impact and ensure corporate oversight via the Quality Assurance Committee. To date despite this escalation the Trust has avoided any cancellation of any cancers and priority (P1) cases.

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. During the week commencing the 18th January this group has been expanded to include Trusts across Dorset and Somerset.

Diagnostics: The operational plan for diagnostics capacity has been impacted as a result of a mobile CT scanner being moved to another region. In addition one of the 3

endoscopy rooms was out of action, although recently a solution has been found to enable delivery of safe procedures of procedure wc 25th January.

Additional endoscopy capacity has been also identified through private sector and mutual aid to stabilise and start to reduce the waiting list position – This will take us toward 100% recovery of pre covid activity levels.

4. Finance Headlines

Key points of note for the Trust's financial performance as at 31 December 2020 (Month 9) are provided below.

4.1. I&E Position

For Month 9, the Trust is reporting an in-month surplus of £0.7m which is £1.0m favourable to plan, and a year to date surplus of £2.4m being £2.5m favourable to plan. These values are after the donated asset adjustments.

Within the YTD position:

- Overall income is £2.8m adverse to plan, mainly driven by TP (£1.5m), Torbay Council income which will be received later in the year (£0.7m), Hospital Discharge (£0.7m), and COVID testing (£0.5m). It should be noted that the lower income for Hospital Discharge and COVID testing is matched by a lower than planned spend.

- Overall pay costs are £1.3m favourable to plan due to slippage on proposed investments identified as part of Phase 3 planning. However, it should be noted that costs in-month of £22.9m were £0.6m higher than Month 8 (£22.3m) with the majority of the increase in substantive pay (£0.4m).

  Within the position agency costs were c. £0.1m higher in Month 9 compared to Month 8, with the main drivers including nursing and urgent care medicine. Compared to plan, agency costs are £0.2m adverse (above plan) in-month, and £0.5m adverse for the year to date.

- Non-pay expenditure, excluding ASC, is £1.1m favourable to plan. Details in relation to Adult Social Care and placed people are provided separately below.

  Total non-pay expenditure in-month was £21.5m, an increase of £0.8m compared to Month 8. Within the increase was a higher spend in month on clinical supplies, £0.5m, and on drugs £0.3m.

- Adult Social Care (ASC) and placed people spend is now £2.8m favourable to plan, with the £1.0m improvement in-month due primarily to lower than anticipated costs associated with COVID i.e. PPE costs now covered nationally, and lower client numbers for Hospital Discharge Scheme 1 and 2. In addition the growth in client numbers for CHC has been lower than originally anticipated.

4.2. COVID Costs

Within the Trust's Month 9 position:

- £6.1m of pay costs relate to COVID, mainly additional shifts for existing workforce (£2.7m) and backfill for staff absence (£2.6m).

- £6.2m of non-pay costs (exc. hospital discharge) relate to COVID, mainly testing (£2.4m), segregation of patient pathways (£1.3m), locally-sourced PPE (£1.2m), and supporting an increase in ITU capacity (£0.6m).

- c. £11.3m has been spent on hospital discharge and infection control support to the independent sector, of which £5.0m is funded by the council and the balance through COVID top up (£4.4m) and the CCG (£1.9m).

4.3. Balance Sheet, Cash & Capital

The cash position remains strong at £64.4m, supported by the 2020/21 financial regime (block payments in advance). However, it should be noted that the underlying cash position is c. £6m-£7m. This continues to be monitored, as the current arrangements are expected to be unwound in the coming months.

Capital expenditure at Month 9 totals £16.5m, an increase of £2.5m in month. However, this is currently £6.7m less than the phased capital plan and requires increased focus in order to drive a step change in the pace of delivery between now and year end. The following actions have been/are being taken in order to further utilise the capital funding available:

- Additional and more regular meetings with project managers have been organised.

- Requests have been made to all project managers to explore if any planned expenditure for 21/22 can be brought forward into the current financial year.

- Incorporating a confidence rating (out of 100%) for achievement of projects, which is verified and confirmed with project managers

- Improvement and streamlining of processes, such as CA1s for Medical equipment

- Additional resource has been brought into the Capital Accounting team, and currently exploring the opportunity to increase resource within Procurement and Estates

Further detail on capital is provided separately this month.

4.4. Forecast Outturn

The Trust's plan for the second half of the financial year (Months 7 to 12) leads to a deficit of £0.6m, after donated asset adjustments. Based on current performance, the Trust is forecasting that it will achieve its plan at year end.

Within this assessment a number of risks and opportunities have been identified, including:

- Risks
    - COVID escalation and the impact on Phase 3 recovery, staff availability and support costs e.g. cleaning, service moves.
    - Independent sector cost volatility, delayed delivery of ASC savings programmes and safely managing Scheme 1 and Scheme 2 of the hospital discharge programme.
    - Increase in the current Annual Leave provision as a result of untaken leave due to the COVID response
    - Delivery of the required profitability targets within TP.

- Opportunities
    - Lower costs associated with business as usual activities due to the impact of COVID (wave 2)
    - Slippage on investments identified as part of the Phase 3 planning (noting, however, that backlogs will have to be addressed in future, at great cost)
    - Lower ongoing COVID costs than originally assessed as part of Phase 3 planning
    - Release of prior year commissioner income following resolution of outstanding disputes
    - Additional funding sources for COVID associated costs, additional to the initial system envelopes

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

January 2021: Reporting period December 2020 (Month 9)

	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 Summary

Quality and safety exceptions

1. HSMR

The latest Hospital Standardised Mortality Rate (HSMR), released for time period to Sept 2020 compared against the National benchmark (100) is 87.8 and within the control limits and expectation.

2. Incidents

There have been 4 STEIS reported in December :

1) A patient was admitted following a fall at home and had laid on her left leg. This leg had become ischaemic and a vascular opinion was not sought for 24 hours resulting in an urgent admission to the RD&E for amputation – A&E Majors (NA). This incident has also been reported to Safeguarding and is subject to a section 42 meeting. The area has alerted all staff to the incident and the need for any limb to be referred for a vascular opinion if a long lie is evident

2) Grade 4 natal cleft pressure ulcer – Community Inpatient Nursing (M2S) – An immediate review of the care plan was initiated and the SKINN prevention model used. Focus has been on the nutritional and hydration needs as well as using the a pressure relieving bed.

3) Patient fell getting out of bed fracturing his neck of femur – Cardiology (P&B)

The incident has been shared with the Falls team and they are working with the ward re lying and standing blood pressure recording

4) Patient fell when walking unaided and fractured his right hip - Community Inpatient Nursing (Coastal) – The matron has met with the team and they have discussed the timely use of the activity pads as the staff were trying to get to the patient as she stood up and then fell. The day before the had moved the patient to the bay opposite the nursing station for closer observation

3. 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 2021 This includes

1) Refreshing the inclusion criteria for VTE requirement, as the new MDU and SDU are currently not excluded and these patients do not need VTE assessment.
2) Training for Medics Nurses and AHPs to ensure the assessments complete on the drug chart and this is included on the Infoflex CPS
3) To train Pharmacy to ensure they are actively checking the VTE completion when the receive the drug charts preparing the medications to take home.
4) To scrutinise Infoflex to see if point three can be made mandatory on the system

4. Harm Reviews for delays in follow ups, waiting lists and retrospective harms due to Covid

Phase 3 national planning and clinical classifications are being conducted and focused harm review meetings are taking place to look at any harm caused due to delay for treatment, diagnostic or assessment. The focus is both retrospective and prospective with the aim of reducing harm to zero for our patients

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

- Ensure equipment and premises are fit for purpose - focused meetings have occurred to provide a workplan and trajectories which are interdependent of wider programmes of work which is progressing.
- Ensure medical staff in maternity are up to date with all mandatory training to include safeguarding training – passporting of education is being completed, a wider programme of work is being progressed in around safeguarding in order to meet the demand
- Ensure there is a rolling equipment replacement programme – A review of the meetings including membership are in place, further programme of work is being devised currently

Updates from the CQC for December included;

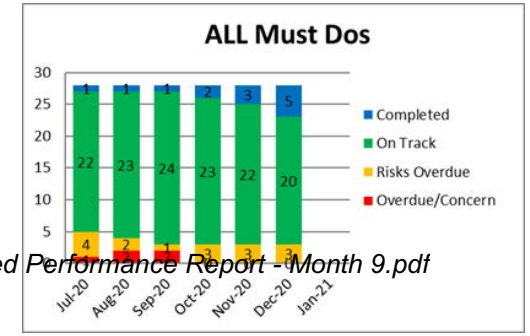
The quarterly engagement session held on the 3rd Dec included a focus on three core services: Community Adults, Medical care and Diagnostics Imaging with focus group sessions on Community Adults clinical leads meeting, Complaints team meeting, Walnut Lodge clinical leads meeting, Diagnostic Imaging Clinical Leads meeting

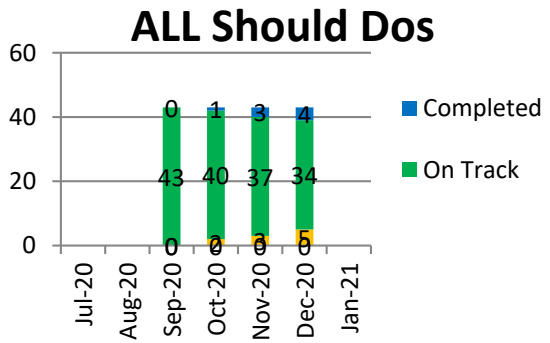
Peer review process has been discussed and a design group met in December to develop a framework, further development sessions have been arranged for January to progress this work aiming for launch in march 2021.

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. Feedback to the ISU's will be in December and a focused evidence discussion will be held in January 2021.

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	n/a	1	n/a	0	n/a	0	n/a
Urgent and Emergency	8	6	2	1	6	5	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	2	3	1	3	1	5	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**	**5**	**4**	**20**	**34**	**3**	**5**	**0**	**0**





Achieved
Reported Incidents – Severe
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)
Stroke patients spending 90% of time on a stroke ward
Never Events

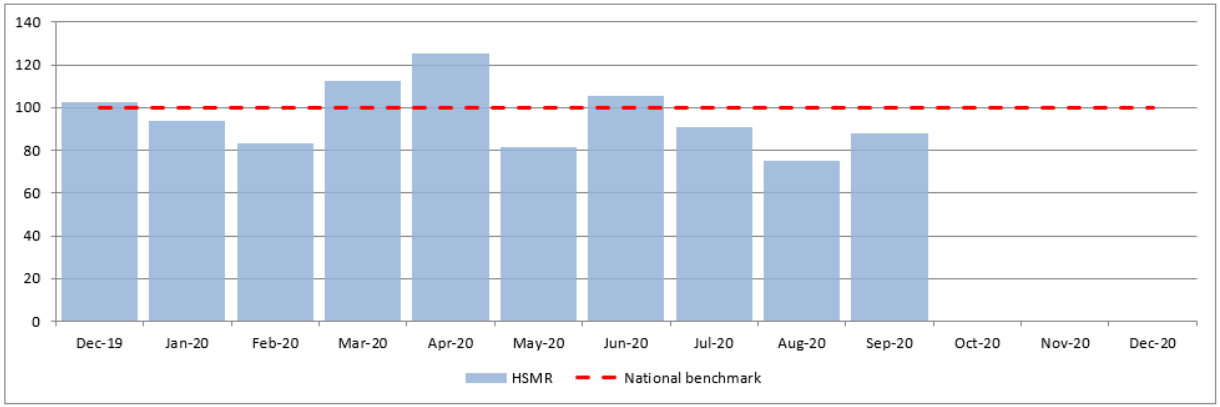
Under Achieved
Safer Staffing - ICO – Night time
Safer Staffing - ICO – Daytime
Medication errors resulting in moderate harm
Strategic Executive Information System (STEIS)(Reported to CCG and CQC)

Not Achieved
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
Reported Incidents – Death
VTE - Risk Assessment on Admission (Community)

No target set
Medication errors - Total reported incidents

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

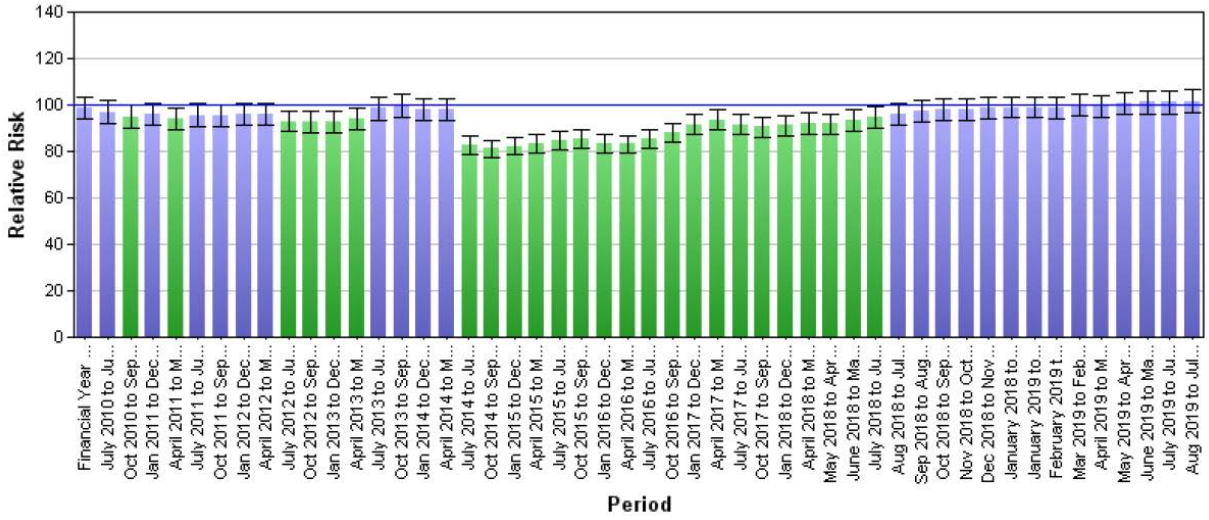
	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
HSMR	102.6	93.5	83.1	112.6	125.4	81.7	105.7	90.9	74.8	87.8	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



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, September 2020, for Dr Foster HSMR is showing a relative risk of 87.8 which is below the national benchmark and well within the tolerance to trigger an alert. There is further analysis discussed at mortality and morbidity which assists in determining key areas to focus a review.

SHMI by data period



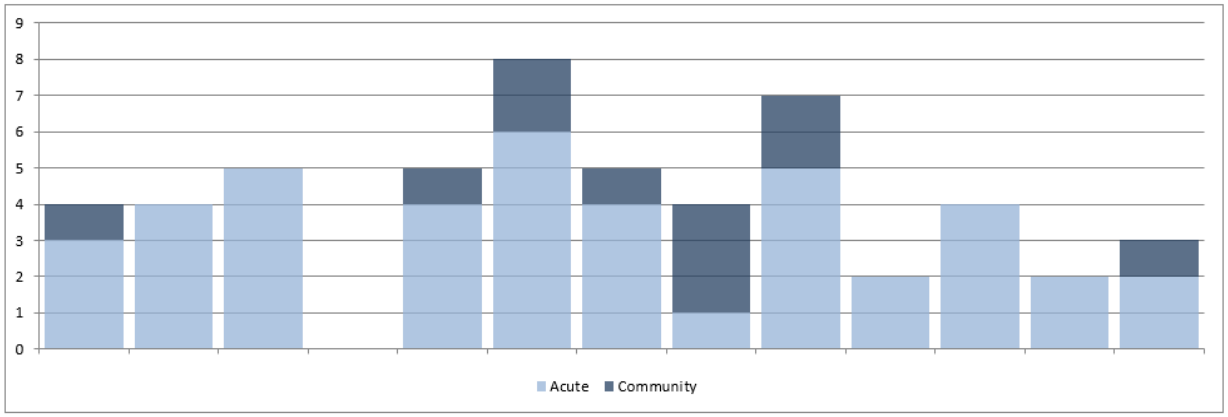
The Summary Hospital Mortality Index (SHMI) data reflects all deaths recorded either in hospital or within 30 days of discharge from hospital and records the Trust at 101.31 against a national average benchmark of 100.

The latest data for period August 2019 to July 2020, which is a different reporting period than HSMR is within the expected norm.

A score of 100 represents the weighted population average benchmark.

Number of Clostridium Difficile cases

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

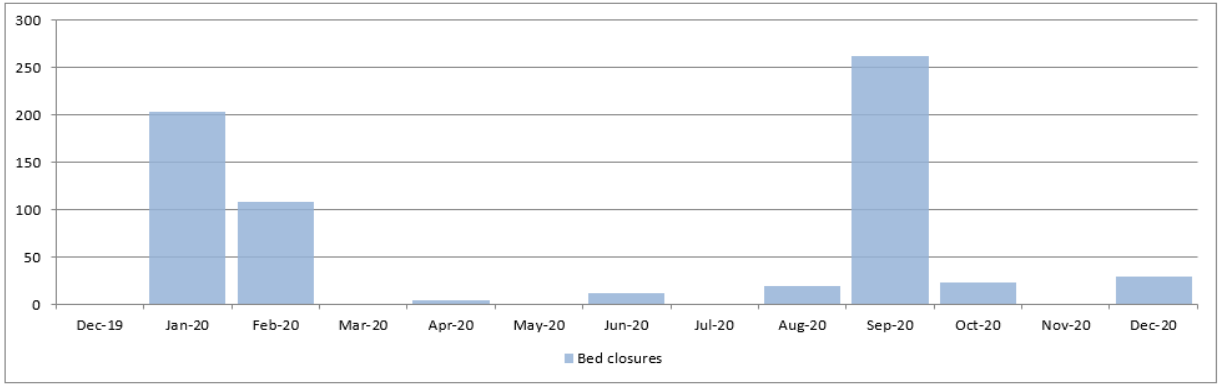


There have been three cases of C.Diff identified in December. These figures remain low and represent good patient care.

A Root Cause Analysis is being conducted to understand the learning and review of systems and processes. Feedback is used to inform teams to embed learning.

Infection control - Bed closures (Acute)

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Bed closures	0	204	108	0	4	0	12	0	20	262	23	0	30



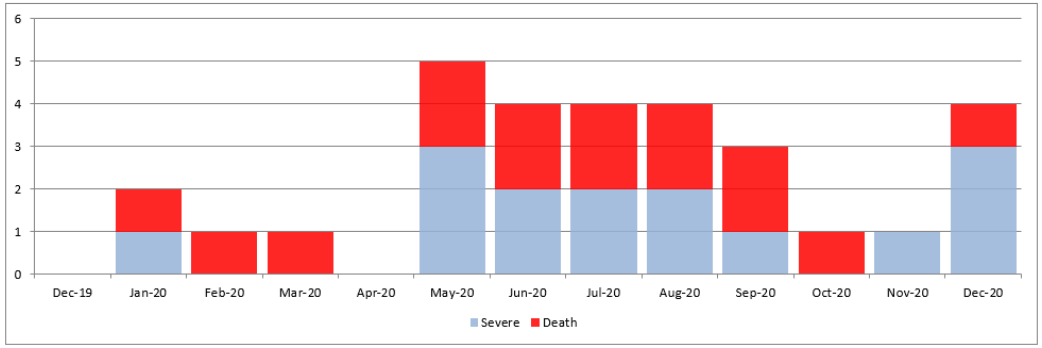
The Infection Prevention and Control (IPC) Team continue to manage all cases of outbreaks with individual case by case assessment and control plans.

December saw 30 bed closures due to infection control issues, this remains at a very low level .

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

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



The Trust recorded three severe incidents and one death in December:

1.The mortality incident is under review and follows a patient's discharge to a care home and their subsequent readmission the next day.

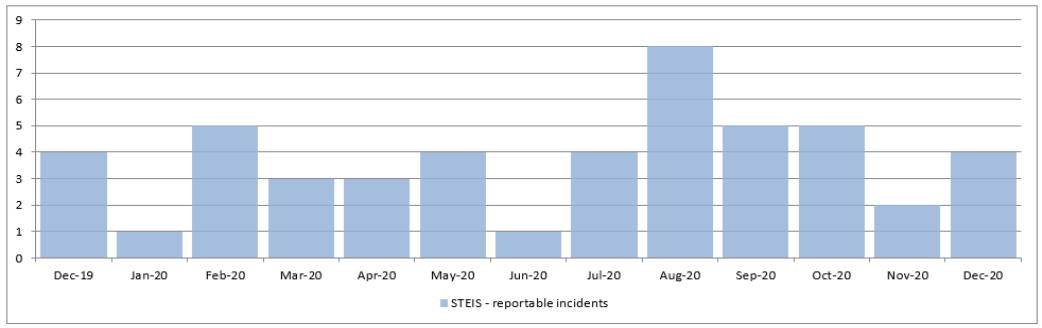
2.Patient admitted following a sustained period on the floor and a referral to Vascular was delayed resulting in a referral to RD&E and amputation.

3. Patient fell getting out of bed fracturing his neck of femur.

4. Patient fell when walking unaided and fractured his right hip.

STEIS Reportable Incidents

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
STEIS - reportable incidents	4	1	5	3	3	4	1	4	8	5	5	2	4



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

1. Patient admitted following a sustained period on the floor and a referral to Vascular was delayed resulting in a referral to RD&E and amputation.

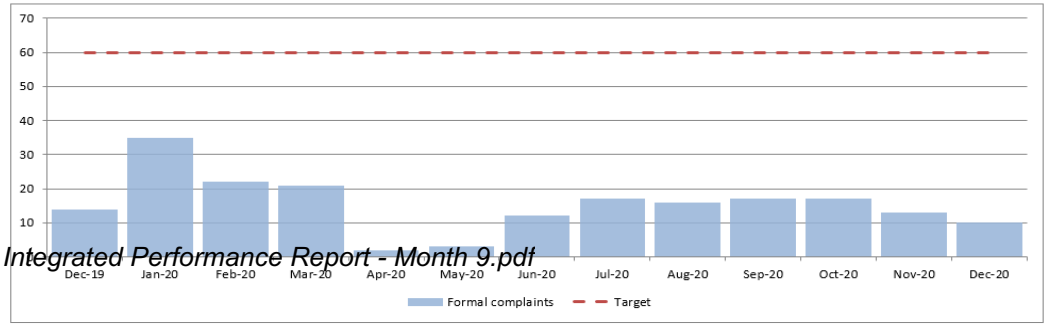
2.Grade 4 natal cleft pressure ulcer Community Inpatient Nursing.

3. Patient fell getting out of bed fracturing his neck of femur.

4 .Patient fell when walking unaided and fractured his right hip.

Formal complaints

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Formal complaints	14	35	22	21	2	3	12	17	16	17	17	13	10
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



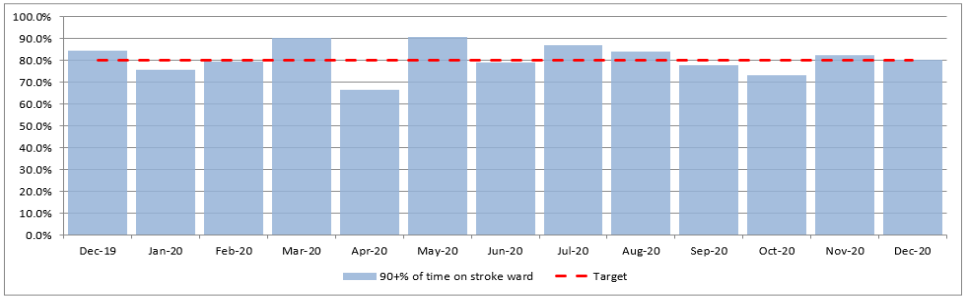
The Trust received 10 formal complaints for the month of December this was a decline from the previous month.

The themes of the complaints include: patients complaining about the treatment (4), assessment (4), Equipment (1) diagnosis (1) Once the investigations are completed the learning will be shared and any improvements made.

Quality and Safety- Exception Reporting

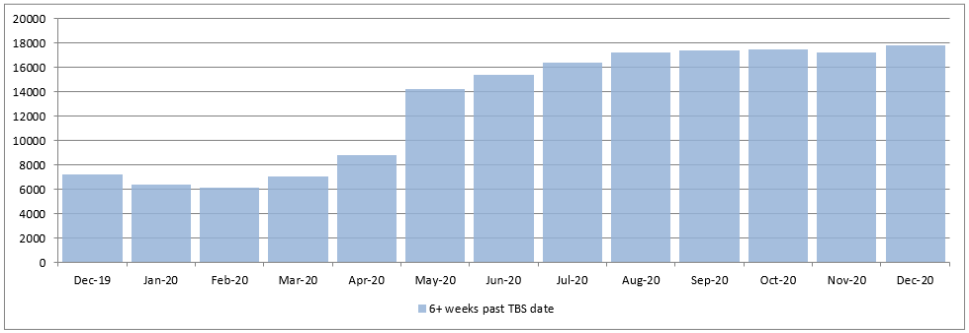
Stroke

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
90+% of time on stroke ward	84.5%	75.8%	79.6%	90.2%	66.7%	90.6%	79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%
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%



Follow ups 6 weeks past to be seen by date

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
6+ weeks past TBS date	7243	6391	6147	7056	8824	14211	15398	16408	17220	17408	17519	17229	17837



Stroke: The percentage of patients spending greater than 90% of time on the stroke ward from admission is reported as 80.4% against a target of 80%. This is the second month in succession that the target has been met. Work will continue to improve the performance to higher level

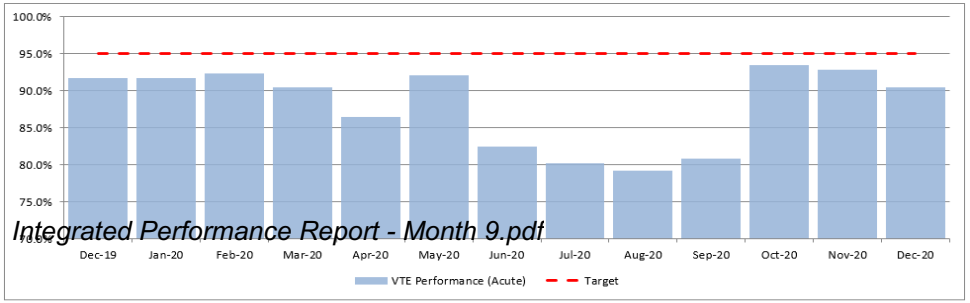
Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' increased to 17837. Alternative measures are in place to reduce face to face consultations.
Phase 3 national planning shows local recovery plan of 92% of pre-covid activity levels for follow-ups with 50% being delivered non-face to face by March 2021.
Focused harm review meetings are being progressed and thematic reviews being conducted.

VTE performance in the acute setting is currently at 90.4%, much improved but below the standard of 95%. The VTE task and finish group have put in place a number of measures including:

- Training for medics, nurses and AHPs to ensure the assessments complete on the drug chart and this is included on the Infoflex CPS.
- To utilise Pharmacists to ensure they are actively checking the VTE completion when the receive the drug charts preparing the medications to take home.
- To scrutinise Infoflex to see if the pharmacist input into Infoflex can be mandatory on the system.

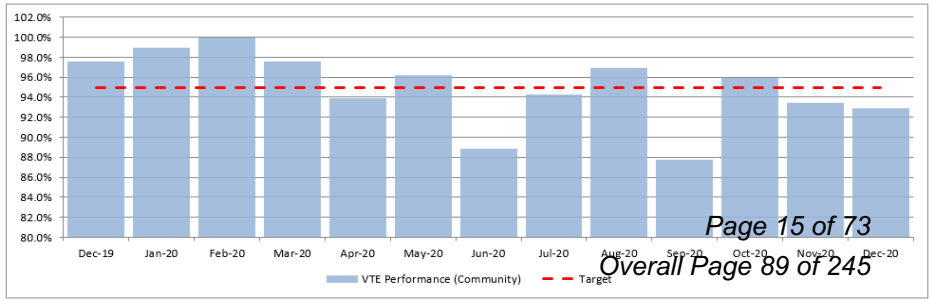
VTE risk assessment on admission - (Acute)

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
VTE Numerator	5743	6303	5768	4482	2325	3158	3484	3939	4013	4253	5066	4837	4903
VTE Denominator	6262	6875	6246	4952	2690	3430	4225	4914	5068	5260	5423	5209	5423
VTE Performance (Acute)	91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE risk assessment on admission - (Community)

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
VTE Numerator	82	92	93	81	31	25	40	49	63	43	70	57	65
VTE Denominator	84	93	93	83	33	26	45	52	65	49	73	61	70
VTE Performance (Community)	97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%	94.2%	96.9%	87.8%	95.9%	93.4%	92.9%
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

Covid-19 Response: The workforce team are supporting responses to Covid-19 through;

- daily absence reporting, updated guidance/FAQ's, support to silver incident command and workforce health and well-being.
- Resourcing support to scale up the Nightingale Hospital, we have met with our staff commitments, including an STP position on terms applicable and plans for system response requirements.
- Support to the mass vaccination programme with logistical support and reporting requirements.

Our People Plan: Work continues to progress the development of the Trust's People Plan which will be presented to Trust Board in February.

Resourcing: The Trust is hosting the Devon Hub for International Recruitment, system bid of £1.1m secured. Work to progress the implementation of the project is well underway; system service level agreement, infrastructure and delivery requirements scoped.

Wellbeing and Staff Experience:

JIGSAW (Critical incident support management) is being promoted throughout January to aid de-briefing processes as identified in the first wave
Our wellbeing offer has been developed/refreshed in response to the feedback questionnaire,

- Wellbeing buddies – new training package developed, to aid local access to support and information,
- New Long service award creation – to enhance long service recognition,
- Re-registered with Mindful Employer – to access support and information from the network,
- Schwartz Rounds, Hearts and Minds, and HOPE programme - all now via Microsoft Teams,
- 1 hour wellbeing sessions taken to wards – to enable increased direct access
- Tools created for resilience, mindfulness, relaxation and the relationship between feelings, thoughts, and behaviour – to aid self-help and easy access
- New Anti-bullying Advisors – a network of advisors will be available to support staff in February.

Medical Workforce:

Medical Workforce Business Partners are supporting the Medical Director and System Medical Director with the medical responses to Covid-19 - plans in place for clinician reassignment including supporting the NHE.
Medical Workforce are leading on the procurement of a new IT Job planning system - tender presentations have been scheduled for February.

ISU Support:

The Workforce Business Partners are supporting services to develop their workforce plans through iterative live documents reviewed at least quarterly. This work is ongoing and contributes to monthly sitreps, quarterly reviews and annual planning as part of an ongoing cycle.

Equality, Diversity and Inclusion

We are taking part in a project, run by McMillan Cancer - to gauge the experience of BAME communities of our health and care services across Devon.
We hosted a mini-conference in December led by our Chief Executive to increase awareness of experiences of BAME colleagues across Devon - speakers included National WRES experts and Roger Kline, author of "Snowy White Peaks". A further conference will be arranged in Spring.

Workforce Quadrant and status

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

Under Achieved

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

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 10.48% for the year to December 2020.

Staff sickness/absence: Red for 12 mths and Red for current mth

The annual rolling sickness absence rate was 4.33% to end of November 2020. This is against the target rate for sickness of 4%. The monthly sickness figure for November was 4.74% .

Mandatory Training rate: **GREEN**

The current rate is 89.62% for December 2020 against a target of 85% and this is a small increase from the 89.56% in November.

Appraisal rate: **Amber**

The Achievement Review rate for the end of December 2020 was 80.38% which has increased from 78.88% as at the end of November.

Agency Expenditure – As at Month 09 the Trust Agency spend was is £0.741m and year to date £5.338m

Lateral flow testing (LFT) (as of 21 January 2021)

Total number of LFT kits issued	6158
Total number of LFT recorded	28558
Approximate number of results reported (half week)	2935
Approximate number of results reported (full week)	5760
Total number of positive cases detected by LFT	65

The kits have been distributed to patient facing staff, services who were felt to be at risk (e.g. courier service) and some external providers (e.g. Rowcroft). The testing is voluntary. Staff test 2 x weekly. The reporting is via ICON and we are continuing to work on ways of improving. The kits last for 3 months and staff will have new testing kits sent to their work place automatically.

Covid Vaccination programme status:
As at Tuesday 12th January 2021 the below table shows daily and cumulative vaccinations numbers to date. Volume will continue to increase as more staff support the administering of the vaccines and with planned - day working assuming continued availability of vaccine supply.

	Mon 4th	Tues 5th	Wed 6th	Thrs 7th	Fri 8th	Sat 9th	Mon 11th	Tues 12th
Daily Total	**116**	**245**	**269**	**299**	**327**	**135**	**439**	**477**
Running Total	**116**	**361**	**630**	**929**	**1256**	**1391**	**1830**	**2307**

Workforce - WTE

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

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

NHSI Staff Grp	2015/09	2020/03	2020/04	2020/05	2020/06	2020/07	2020/08	2020/09	2020/10	2020/11	2020/12	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	479.78	477.74	472.20	480.55	59.99	14.26%	6.52	1.38%
Health Care Scientists	89.69	93.66	92.05	92.82	92.82	92.82	93.31	94.41	93.11	94.71	94.17	4.48	4.99%	0.51	0.54%
Medical and Dental	425.99	512.83	510.80	529.05	526.68	538.19	519.02	522.54	523.05	525.40	525.72	99.72	23.41%	12.88	2.51%
NHS Infrastructure Support	1114.22	1085.14	1090.28	1088.08	1093.55	1094.75	1094.50	1099.04	1101.57	1106.20	1106.04	-8.18	-0.73%	20.90	1.93%
Other Scientific, Therapeutic and Technical Staff	301.99	373.03	373.79	375.39	377.05	373.84	385.27	383.76	385.53	383.69	383.17	81.17	26.88%	10.14	2.72%
Qualified Ambulance Service Staff	1.00	6.72	7.72	7.72	8.32	8.53	8.53	8.53	8.53	8.33	8.33	7.33	733.33%	1.61	24.01%
Registered Nursing, Midwifery and HV staff	1187.78	1199.91	1195.07	1190.67	1186.31	1188.77	1200.13	1218.99	1224.18	1221.71	1217.33	29.55	2.49%	17.42	1.45%
Support to clinical staff	1593.74	1825.21	1875.96	1893.59	1912.55	1886.78	1857.68	1844.85	1838.53	1844.05	1855.89	262.15	16.45%	30.68	1.68%
Grand Total	5134.99	5570.54	5617.82	5648.11	5665.74	5661.95	5638.60	5651.89	5652.25	5656.29	5671.20	536.22	10.44%	100.67	1.81%

Pay Report Summary for previous 7 months

	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Cost	£	£	£	£	£	£	£
Substantive	£21,208,528	£20,411,994	£20,485,568	£20,864,502	£20,529,163	£21,827,283	£21,168,578
Bank	£894,443	£900,491	£918,075	£877,866	£864,101	£720,783	£1,002,331
Agency	£580,586	£571,266	£547,290	£584,424	£674,784	£501,963	£740,871
Total Cost £	£22,683,557	£21,883,751	£21,950,933	£22,326,792	£22,068,048	£23,050,028	£22,911,780
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	5,650.32	5,637.07	5,616.97	5,615.22	5,658.21	5,669.00	5,725.69
Bank	227.25	234.33	342.66	264.86	272.48	222.89	306.90
Agency	102.35	83.29	73.44	72.52	76.33	107.23	110.72
Total Worked WTE	5,979.92	5,954.69	6,033.08	5,952.60	6,007.03	5,999.12	6,143.30

Workforce - Vacancies

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Medical And Dental	518.35	518.35	518.35	518.35	518.35	518.35	527.76	531.47	531.98
Nursing And Midwifery Registered	1,242.27	1,242.27	1,242.27	1,239.27	1,243.27	1,243.27	1,276.48	1,301.80	1,306.14
Support To Clinical Staff	1,782.16	1,782.16	1,782.16	1,782.16	1,782.16	1,782.16	1,856.95	1,871.02	1,873.98
Add Prof Scientific and Technic	378.94	378.94	378.94	378.94	378.94	378.94	427.92	429.39	435.21
Allied Health Professionals	447.57	447.57	447.57	447.57	447.57	447.57	479.19	483.13	484.06
Healthcare Scientists	93.16	93.16	93.16	93.16	93.16	93.16	105.02	104.43	104.43
Administrative And Estates	1,148.40	1,148.40	1,148.40	1,148.40	1,149.40	1,149.40	1,173.83	1,179.06	1,183.11
Total Staff Budgeted WTE	**5,610.85**	**5,610.85**	**5,610.85**	**5,607.85**	**5,612.85**	**5,612.85**	**5,855.77**	**5,908.94**	**5,927.54**

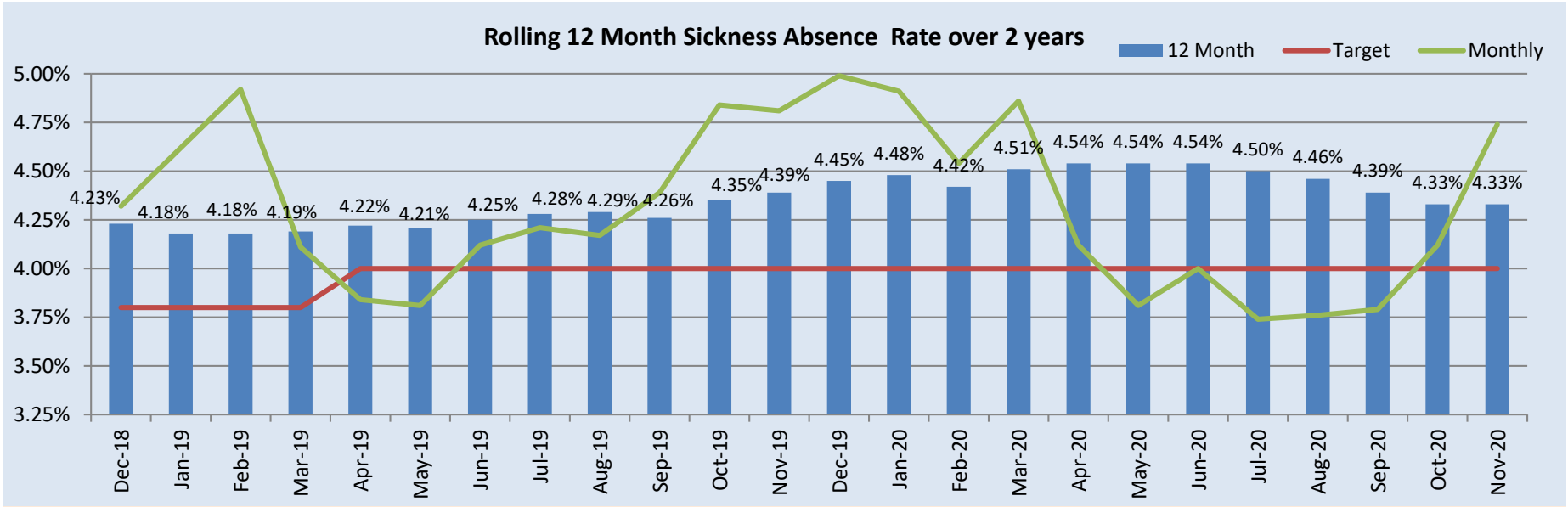
Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Medical And Dental	500.08	521.48	522.02	518.04	592.68	525.00	521.19	518.49	519.24
Nursing And Midwifery Registered	1,198.67	1,194.89	1,188.26	1,186.14	1,199.95	1,215.61	1,221.69	1,232.54	1,223.95
Support To Clinical Staff	1,719.80	1,756.75	1,868.96	1,885.26	1,851.30	1,820.93	1,834.67	1,828.35	1,856.95
Add Prof Scientific and Technic	383.27	383.39	383.55	397.82	409.47	410.34	402.49	406.08	404.14
Allied Health Professionals	478.57	476.69	470.40	474.20	476.38	482.55	478.15	474.20	471.91
Healthcare Scientists	102.99	103.37	101.37	97.82	98.82	99.41	101.37	99.72	99.17
Administrative And Estates	1,200.17	1,208.08	1,124.24	1,098.02	1,094.86	1,107.69	1,108.59	1,110.50	1,113.61
Total Staff Worked WTE	**5,583.55**	**5,644.65**	**5,663.52**	**5,665.84**	**5,731.98**	**5,670.05**	**5,676.69**	**5,678.20**	**5,697.30**

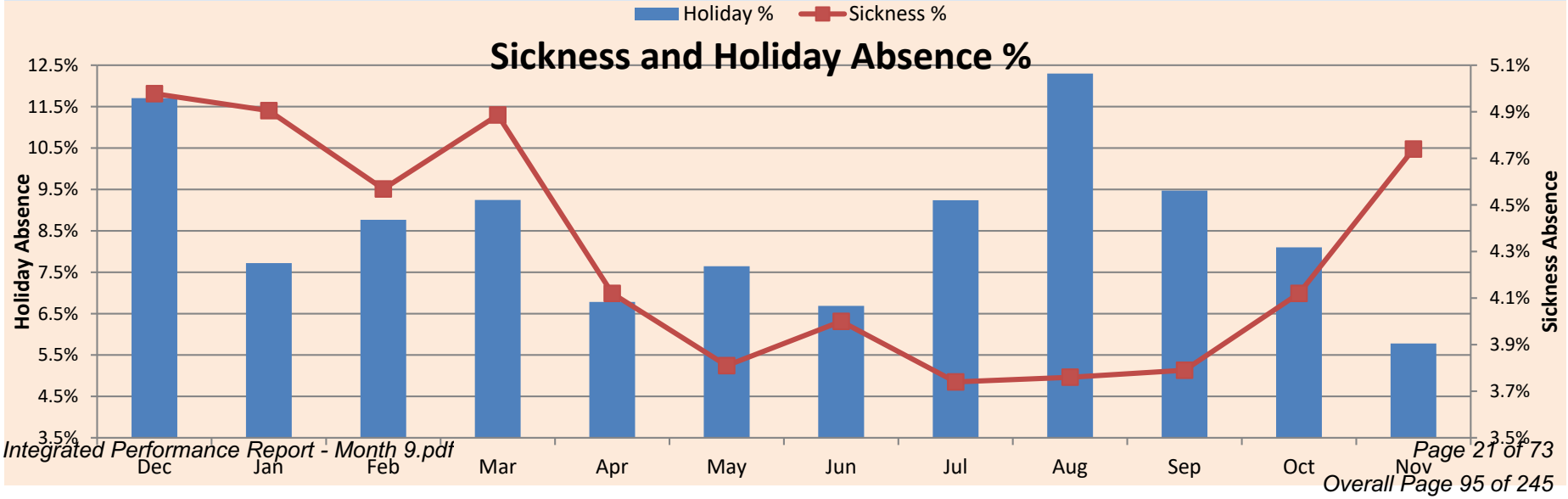
Staff Group	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE	Vacancy WTE
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Medical And Dental	18.27	-3.13	-3.67	0.31	-74.33	-6.65	6.57	12.98	12.74
Nursing And Midwifery Registered	43.60	47.38	54.01	53.13	43.32	27.66	54.79	69.26	82.19
Support To Clinical Staff	62.36	25.41	-86.80	-103.10	-69.14	-38.77	22.28	42.67	17.03
Add Prof Scientific and Technic	-4.33	-4.45	-4.61	-18.88	-30.53	-31.40	25.43	23.31	31.08
Allied Health Professionals	-31.00	-29.12	-22.83	-26.63	-28.81	-34.98	1.04	8.93	12.15
Healthcare Scientists	-9.83	-10.21	-8.21	-4.66	-5.66	-6.25	3.65	4.72	5.26
Administrative And Estates	-51.77	-59.68	24.16	50.38	54.54	41.71	65.24	68.57	69.51
Total Staff Worked WTE	**27.30**	**-33.80**	**-47.95**	**-49.46**	**-110.60**	**-48.66**	**178.99**	**230.44**	**229.95**

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso

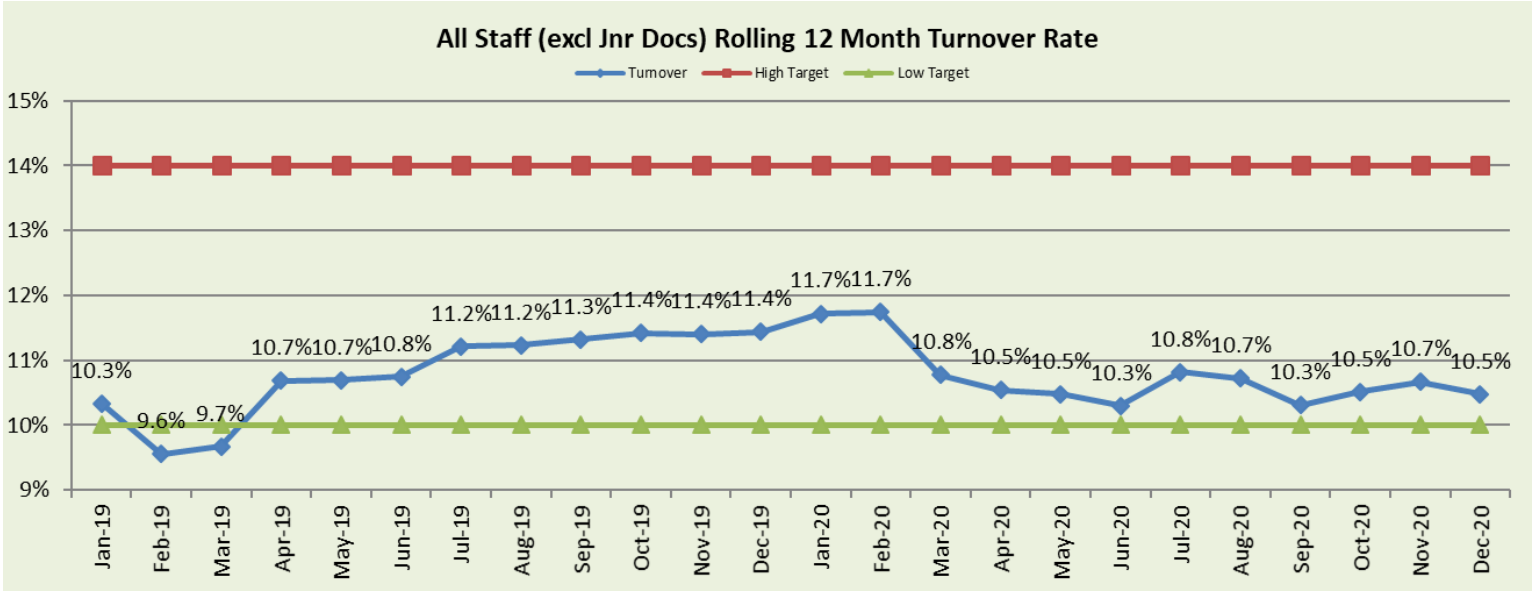
Rolling 12 month sickness rate (reported one month in arrears)

The annual rolling sickness absence rate was 4.33% at the end of November 2020 against the target of 4.00%
The monthly sickness figure for October was 4.74% which is an increase from 4.12% as at the end of October.



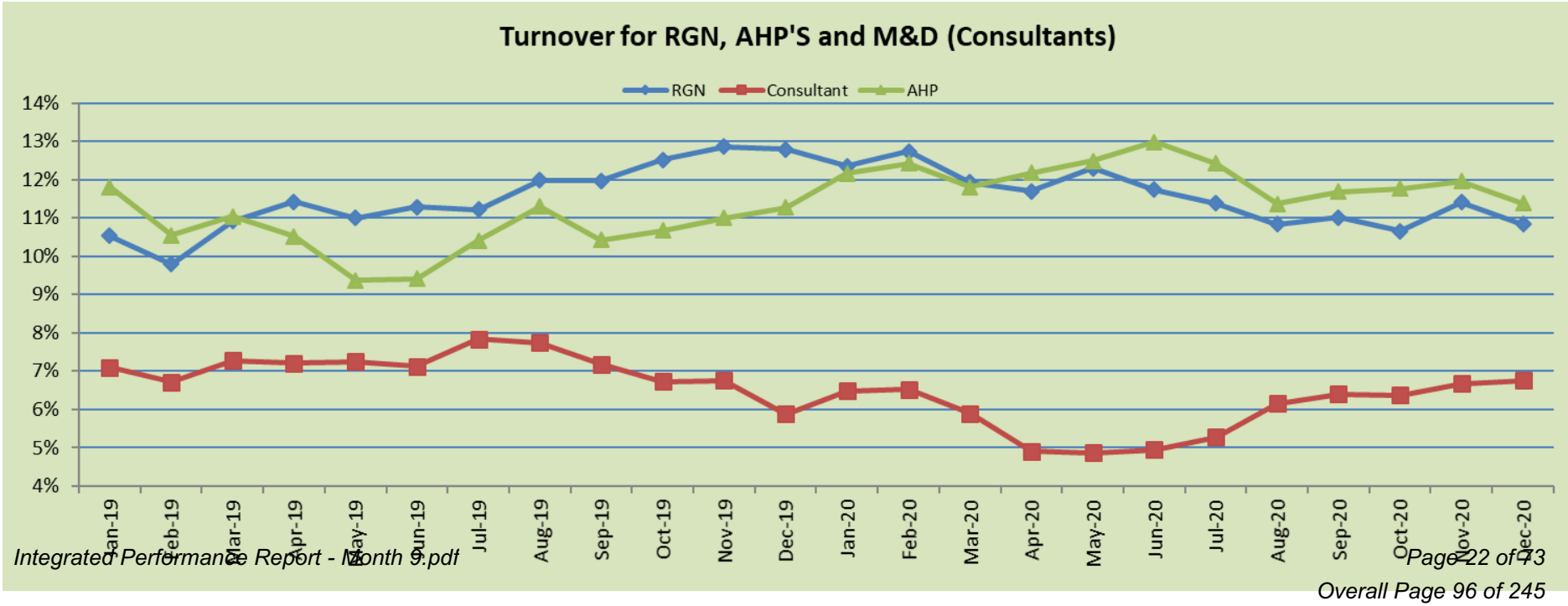


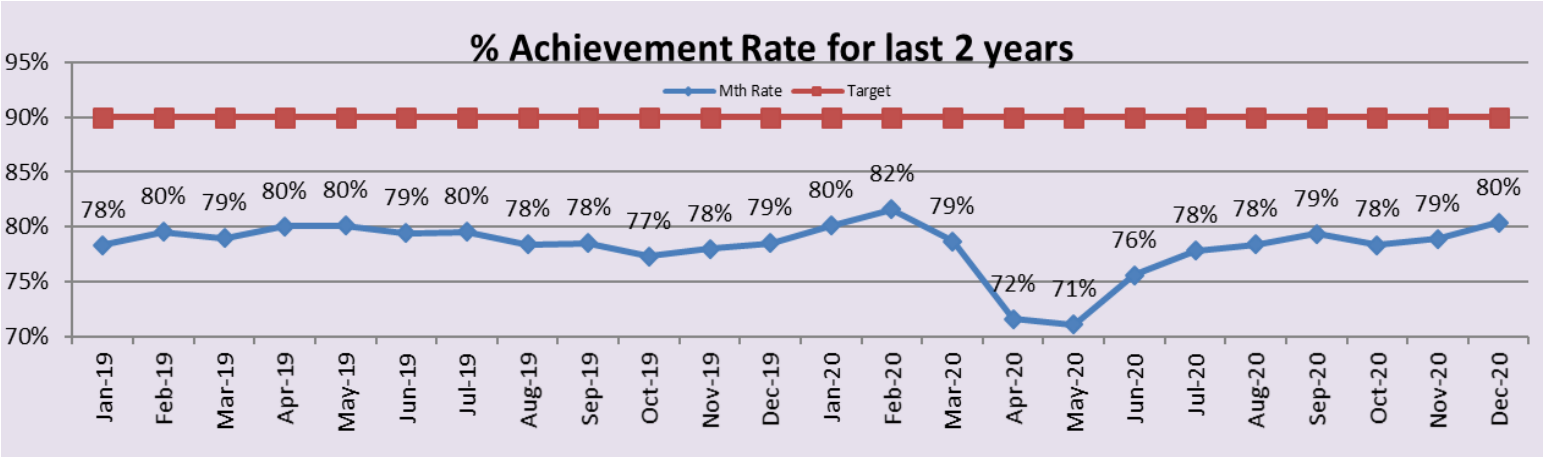
Workforce - Turnover



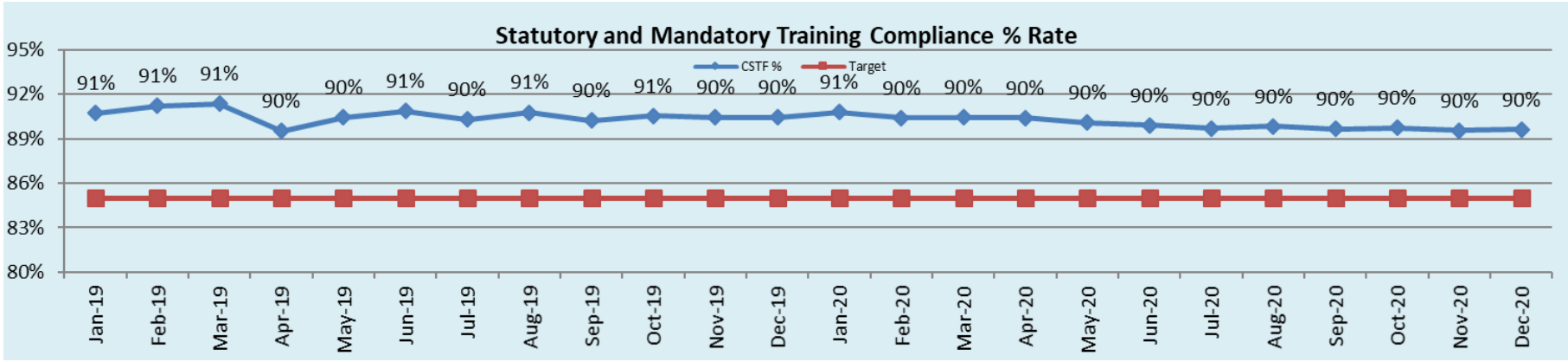
All Staff Rolling 12 Month Turnover Rate

The graph shows that the Trusts turnover rate now stands at 10.48% for the year to December 2020 which is down from 10. 67% in November.





Achievement Review (Appraisal)
The Achievement Review rate for the end of December was 80.38% and has increased to over 80% for the first time since February of last year- this is compared to Novembers figure of 78.88%.



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 89.62% for December which is a marginal increase from the 89.56% in November.
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		
Dec-20						Dec-20		
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 1	Level 2	Level 3
6661	4063	358	23	1	11	2516	3413	732
6397	3563	175	8	1	6	2356	2843	538
96.04%	**87.69%**	**48.88%**	**34.78%**	**100.00%**	**54.55%**	**93.64%**	**83.30%**	**73.50%**

Module	Target	Performance
Information Governance	95% and above	83.89%
Manual Handling	85% and above	71.40%

The table below shows the agency expenditure by staff Group for December 2020 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	Nov	Dec	
Registered Nurses	169	143	201	177	256	287	331	259	274	2097
Scientific, Therapeutic and Technical	52	59	37	46	41	46	61	53	51	446
of which Allied Health Professionals	39	50	22	26	21	29	40	42	35	304
of which Other Scientific, Therapeutic and Technical Staff	13	9	15	20	20	17	21	11	16	142
Support to clinical staff (HCA)	-1	0	0	0	0	0	0	39	44	82
Total Non-Medical - Clinical Staff Agency	220	202	238	223	297	333	392	351	369	2625
Medical and Dental Agency	213	189	273	258	191	199	220	210	269	2022
Consultants	106	69	130	132	146	159	170	179	241	1332
Trainee Grades	107	120	143	126	45	40	50	31	28	690
Non Medical - Non-Clinical Staff Agency	79	74	70	90	59	52	63	101	103	691
Total Pay Bill Agency and Contract	512	465	581	571	547	584	675	662	741	5338

Adult Social Care - Improvement Plan (ASCiP)

- Assurance arrangements for ASCiP projects was undertaken including deep dives into projects resulting in action plans to ensure projects are managing risk, issues and their project plans. This resulted in some project requiring additional support from the iPMO to ensure they are planning and monitoring the interdependencies which are crucial to the overall success of the ASCiP. The next deep will be at the end of 2020/21 Q4.
- Direct Payments are at risk in terms of support package review timeframes, process and best practice, and overall flow through the ASC operation. The Review & Insight Project started reviewing the DP support packages from which insight is being transferred to the Professional Practice Project. The result of the transfer of knowledge is to build the best practice and processes with the PP Project and roll out to Review & Insights to test and then to overall ASC operations. The outputs of both project will result in a reduction of risk to TSDFT.
- Front Door, Gateway & Flow, one of ASCiP's critical projects, continues to formulate the operating model and strategy for operational management of services from adult social care. The Voluntary Sector are critical partners in this endeavor and as key stakeholders work is being undertaken around the structure and processes which will result in an high quality customer service and support the strategic commissioning of services for evidenced need in our community.
- Data Culture and Measurement for Improvement is being developed with the support of experts in our region including the SW AHSN which will support evidence based decision making and simulation modelling in Adult Social Care.
- Community Mental Health Framework collaborative discussion involving Torbay ASC staff are continue to progress well and the data workstream is being supported by the ASCiP and associated iPMO in their Task & Finish group
- Professional Practice Performance Project completes its architecture to derive outcomes and will begin populating the content of its workstreams. These workstream are being informed through the channels created by the ASCiP to collaborate on risks and insights throughout the entire plan.
- ASC Market Shaping blueprint and the subsequent planning are being prepared to begin in January. These plans will work in tandem with the ICO ASC market management work currently undertaken and being reported through the ASC Transformation Group.
- ASC are developing an approach with the TSDFT audit function to complement and support the work being undertaken in the by ASCiP. Work has been ongoing to review how the Safeguarding Team receives referrals from the single point of contact (SPOC) system and from the Quality Assurance and Improvement Team (QAIT) to ensure the consistency of practice allowing referrals to be actioned appropriately and in a timely manner in order to protect adults at risk of abuse.

ASC Vision Statement

Achieved
Number of Delayed Discharges (Community) - national return suspended
Number of Delayed Transfer of Care (Acute) - national return suspended
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
Percentage of Adults with learning disabilities in employment (ASCOF)
Percentage of Adults with learning disabilities in settled accommodation (ASCOF)
Percentage of reablement episodes not followed by long term SC support (ASCOF)

Under Achieved

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

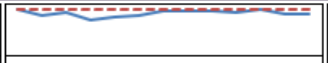
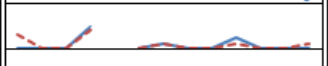
No target set
Children with a Child Protection Plan (one month in arrears)
4 Week Smoking Quitters (reported quarterly in arrears)
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)
Deprivation of Liberty Standard

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 December 2020

Torbay Social Care KPIs	2020/21 full year target	2020/21 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	76%	Below target (1270 / 1662) Impacted by reduced use of RAS for CLS. Paris assessment summary changes in progress.
% clients receiving direct payments	28%	28%	22.4%	Below target (373 / 1662). DPs will be addressed as part of the ASC improvement plan.
Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	18.9	A low outturn signifies better performance. Below target (14 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	579.0	A low outturn signifies better performance. Below target (212 admissions compared to target of 161)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	85.5%	On target.
% carers receiving self directed support	85%	85%	96%	On target.
% Adults with learning disabilities in paid employment	7.0%	7.0%	8.2%	On target.
% Adults with learning disabilities in settled accommodation	80%	80%	80.5%	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 2020/2021	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date 2020/21
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		97.6%	85.5%	89.9%	76.4%	81.9%	84.5%	92.4%	94.5%	94.1%	90.7%	95.7%	88.7%	88.0%	90.3%
Children with a child protection plan *			192	202	191	194		223	217	219	221	200	214	221		221
4 week smoking quitters (Quarterly) **	200					231			56			124				124
Opiate users - % successful completions of treatment (Quarterly) **	Var					6.1%			5.9%			5.4%				5.4%

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.

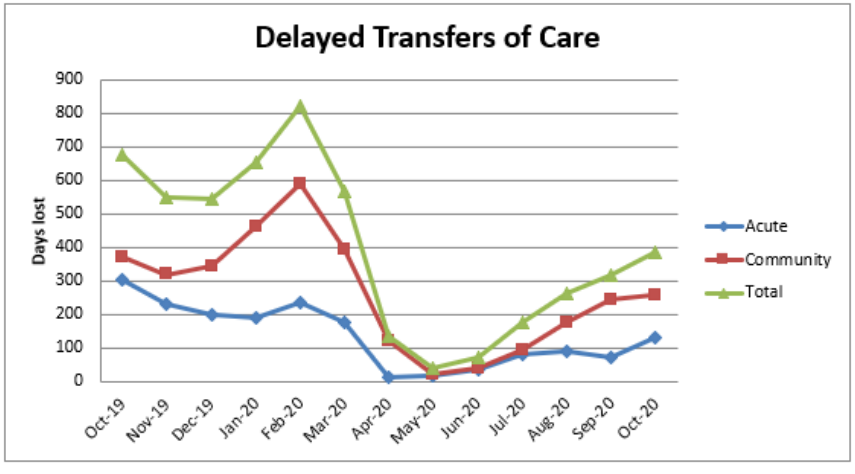
Measure	Target 2020/2021	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date 2020/21
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			10,852	10,582	9,261	8,467	6,686	7,407	7,953	8,226	7,177	7,430	7,819	7,760	7,450	67,908
Therapy activity	65,415		5,247	6,019	5,140	4,161	2,236	2,829	3,593	3,790	3,510	3,837	3,606	2,707	2,562	28,670
No. intermediate care urgent referrals	0		201	239	202	219	230	248	283	242	211	221	199	207	222	2,063
No. intermediate care placements			52	78	49	39	15	6	14	11	17	6	11	17	12	109
Intermediate Care - placement average LoS			17.5	18.7	22.0	20.8	25.5	38.7	39.1	18.3	15.8	26.4	16.8	27.7	17.6	25.1

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 - December-20

	Act. 19/20 Outturn	Oct-20	Nov-20	Dec-20	Total
Admissions / Discharges					
Total Admissions (General)	2,596	274	193	242	1,968
Direct Admissions (General)	242	15	7	17	141
Transfer Admissions (General)	2,354	259	186	225	1,827
Stroke Admissions	256	23	21	17	148
Transfers from CH to DGH	238	160	66	96	890
Beds					
Bed Occupancy [1]	95.1%	82.4%	90.5%	89.8%	80.6%
Bed Days Lost to Bed Closure	57	1	35	16	140
Length of Stay					
Delayed Discharges		59	0	0	230
Average Length of Stay - Overall (General)	13.1	10.0	10.7	10.8	9.9
Average Length of Stay - Direct Admissions	10.7	8.6	9.4	9.1	7.7
Average Length of Stay - Transfer Admissions	13.4	10.0	10.8	10.9	10.1
Average Length of Stay - Stroke	18.7	12.6	13.6	15.0	13.3
Long LoS (>30 days)	246	7	6	9	38
MIUs					
Total MIU Activity	41,656	2,065	1,782	1,778	17,446
New MIU Attendances	37,118	1,885	1,598	1,550	15,788
All Follow Up Attendances	4,518	180	184	228	1,658
Planned Follow Up Attendances	3,305	141	140	175	1,265
Unplanned Follow Up Attendances	1,213	39	44	53	393
MIU Four Hour Breaches	3	0	0	0	0
Average Waiting Time (Mins) - 95th Pctile	53	40	42	42	42

Community hospital admissions remain in-line with pre-covid levels and have seen a decrease in bed occupancy to 89.8% in December. Average length of stay of 10.8 days compares well with the 13.1 days over 2019/20.



Notes:

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

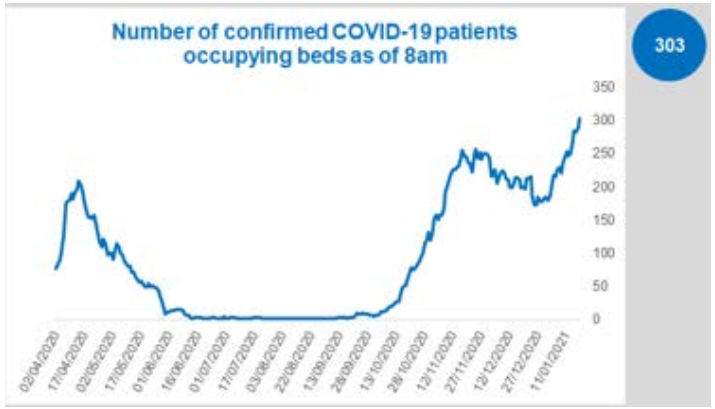
Figures for admissions, LOS etc for Newton Abbot hospital are for general rehabilitation and stroke in line with previous years.

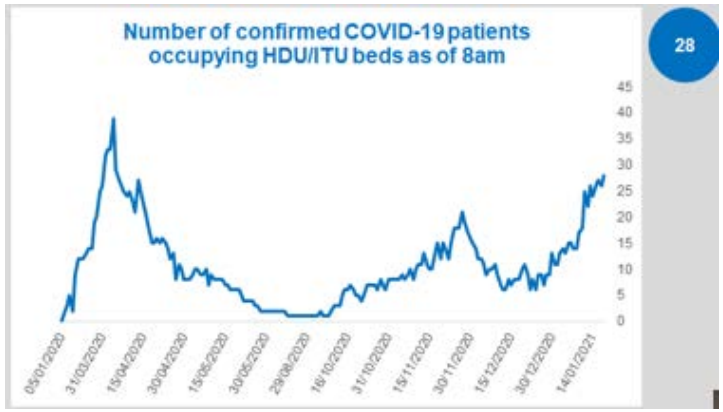
Performance oversight from Chief Operating Officer

- Covid-19 second / third wave: Covid hospitalisations reduced in December with 9 patients recorded on 14th December down from a peak of 43 in November. As predicted in January we are now responding to the third wave on increased infections and although local numbers to date have remained in line with a forecast peak similar to that seen in the second wave a wider system response has been triggered to ensure mutual aid for ICU capacity can be provided. The opening of the Nightingale Hospital Exeter and planned expansion to maximum bed capacity helped to relieve the overall system risk, however the staffing across the system is a material risk to maintain covid response capacity and cover potential sickness absences.
- To facilitate this escalation for covid inpatient pathway and ICU expansion the Day Surgery Unit has been repurposed to provide clinical space for the Medical and Surgical Receiving Units. The freed up areas support ICU expansion and second Covid ward. The released staff is supporting the ICU expansion and other staffing resilience.
- Further preparedness – Teams are working through options to step down further non-urgent services if required over the coming weeks in the event of a need to more widely re-deploy staff to maintain the emergency and covid response.
- The building works to provide covid secure and increased ED assessment space alongside Medical Receiving Unit are continuing to plan. The scheduled handover of the refurbished theatres now achieved; Main theatres (1 and 2) completed and Day surgery (DSU 3) at the end of December.
- Restoring levels of elective activity to pre-covid levels has remained a challenge during December with the number of patients on waiting lists and number of patients waiting over 52 week continuing to increase. The January escalation measures described with see a further period of reduced elective activity and add to the future challenge of meeting the clinical needs of elective patients.
- The focus on maintaining fast access for urgent and cancer pathways has continued and overall performance is being maintained. Waiting times for initial outpatient assessments completed against the 14 day standard has fallen in December to 78% from 83% in December.
- Diagnostics – Greatest emerging risk is with CT long waits with the redeployment of the mobile scanner by the National team. The service is likely to only meet demand for urgent emergency department and inpatient referrals. Many routine referrals will not be able to be seen until additional capacity can be established.
- Progress is being made to reduce in longest waits in echocardiography and plans now agreed to see return of the third endoscopy suit by end of January.
- Community services – Community service have implemented a robust escalation plan to support priority service areas over the coming weeks of escalated covid capacity risk – this has been done on a risk-based basis at patient level and additional contracted activity with care providers.
- The latest round of ISU governance meetings has provided a high level of assurance with a number of areas for escalation being reported to the Integrated Governance Group with action plans being agreed with executive support.

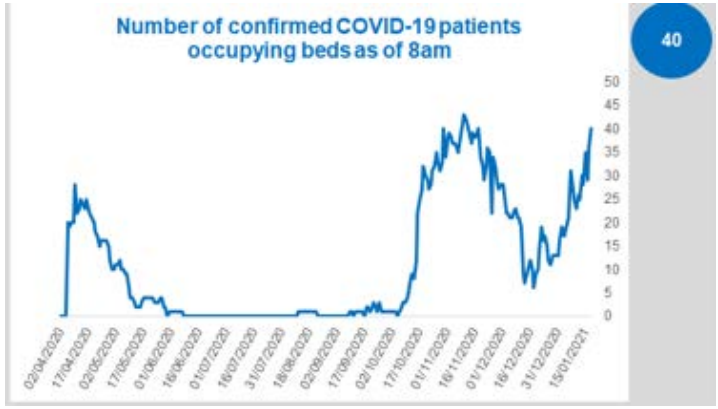
Covid - Hospitalisations

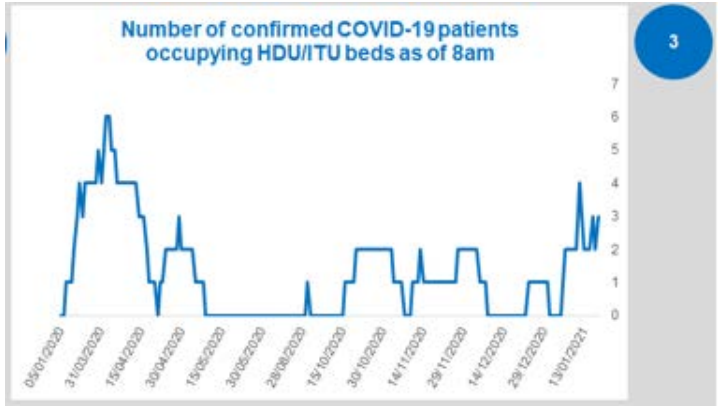
Devon ICS
(as at 15 January 2021)





Torbay and South Devon NHS FT
(as at 15 January 2021)





December has seen the number of patients occupying beds in TSDFT for managing covid-19 decrease. We are now experiencing the third peak in line with national escalation.

As at 18 January 2021 the Trust has initiated the next level of escalation to increase ICU capacity and inpatient beds. This requires stepping down of day surgery unit activity and relocation of the medical and surgical receiving units.

Covid demand modelling for Devon ICS is showing a peak of hospitalisation towards the end of January 2021 and then a gradual improvement; this being subject to the effectiveness of lockdown, containment of the new variant, the vaccination programme, and infection control measures in hospital and care home settings.

The Graphs above show that number of covid inpatients at TSDFT has reduced at a greater rate from the second wave peak than the wider Devon ICS (Integrated Care System) with over 300 patients still in hospital beds across the Devon System.

Operational Performance Quadrant

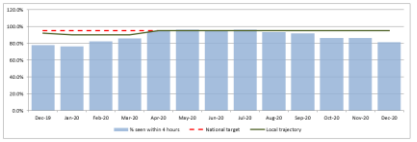
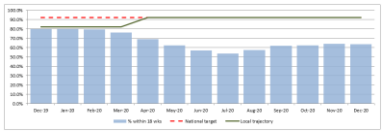
Achieved
Dementia Find (NHSI)
Number of Clostridium Difficile cases reported
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - 31-day wait for second or subsequent treatment - Surgery
Cancelled patients not treated within 28 days of cancellation
Cancer - Patient waiting longer than 104 days from 2ww
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
Cancer - 28 day faster diagnosis standard
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients

Not Achieved
A&E - patients seen within 4 hours (NHSI)
Ambulance handover delays > 30 minutes
Ambulance handover delays > 60 minutes
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
Trolley waits in A+E > 12 hours from decision to admit
On the day cancellations for elective operations

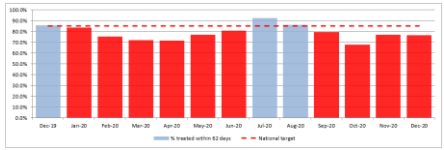
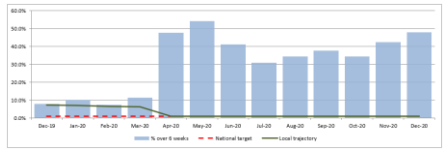
Under Achieved
A&E - patients with >12 hour visit time pathway
Bed Occupancy (overall system)

No target set

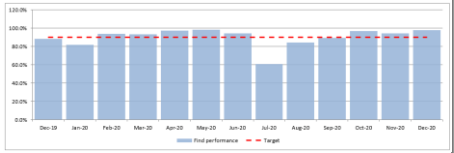
NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M9 81.2% Performance M8 86.5% Target 95% Risk level HIGH	The reported performance against the 4-hour standard for December is 81.5% from 86.5% in November. Teams have had to manage through the disruption of the building works to maintain the necessary segregation for covid and non-covid pathways. During December access to inpatient beds has been a challenge. The pathways to Medical and Surgical Receiving Units has helped to spread the demand and ease the impact on crowding within ED however increased numbers of ambulance delays have been observed. Staffing has continued to be a pressure with reliance on bank and agency.	Building works to reconfigure the emergency floor space to incorporate the additional floor area of the Emergency Assessment Unit has been completed. Wards have been flexed to accommodate the expanded ED and Medical Receiving Unit with an overall loss of inpatient beds. Whilst this has supported the flow of emergency patients with much of the daily medical and surgical take able to bypass ED there has been an impact due to overall loss of beds on capacity to deliver the inpatient elective surgical programme.	 **Trajectories** M8: 95% M9: 95% M10: 95%
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M9 63.6% Performance M8 64.2% Target 92% Risk level HIGH	The total number waiting for treatment is 28058 an increase of 1416 from November and ahead of our Phase 3 trajectory. Concerns that these long waits will cause harm - we are reporting patients waiting over 78 weeks with exception reports for any wait over 104 weeks (currently 2 patients). The Trust has gone beyond the national requirement and are prioritising all patients on the waiting list. Activity levels are not increasing in line with the Phase 3 recovery submission. The 3rd wave of COVID hospitalisation is impacting on elective inpatient activity with the loss of beds and DSU being stood down.	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. The use of Mount Stuart Hospital facilities will continue to be part of our strategy to provide capacity for of our recovery plans. There remains uncertainty as to what Independent Sector capacity remains available to us, with ongoing discussions at System level and will be dependent on the scale of the COVID surge response required. The COO is reviewing operational plans with teams to optimise activity within available resources. Insourcing continues at weekends in ophthalmology and endoscopy.	 **Activity variance vs previous year** Op new: M8 -0.6%, M9 -1.0% OP Follow up: M8 -16.9%, M9 -10.3% Day Case: M8 -20.8%, M9 -10.4% Inpatient: M8 -34.1%, M9 -9.6% **RTT Trajectories %** M8: 92% M9: 92% M10: 92%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M9**	Performance against the 62-day referral to treatment standard in December is 76.4%. The highest risk specialties are – Urology and lower GI against the 62 day target. 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 seen with the time from referral to appointment in Lower GI, Urology, Skin, and Head and Neck specialties. Gaps in oncology consultant cover.	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. There remains a continued reliance the capacity offered in Mount Stuart Hospital to support Urology and Gastro cancer pathway investigations Mutual aid has been requested to support clinical oncology consultant cover for new breast pathways.	
	76.4%			
	Performance M8			
	77%			
	Target			
	85%			
	Risk level			
	HIGH			
				Trajectories
				M8 / **M9** / **M10**: 85% / 85% / 85%
Diagnostic tests longer than 6 weeks	**Performance M9**	Loss of facilities to support endoscopy (air handling compliance) and CT (mobile van re-deployed by NHSI from 7 days to 2 days support 100 scans per week) This loss of capacity has led to activity levels not being achieved and increasing waits for these tests.	Progress has been made with the endoscopy estates compliance with the third endoscopy room now scheduled to be operational from 25th January 2021. CT capacity remains high risk with no solution to the reduced mobile scanner capacity. Clinical prioritisation is in place so cancer and urgent requests are prioritised however waiting times for routine test requests will continue to increase.	
	47.9%			
	Performance M8			
	42.3%			
	Target			
	1%			
	Risk level			
	HIGH			
				Trajectories
				M7 / **M8** / **M9**: 1% / 1% / 1%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M9	Performance against the Dementia Find assessment standard remains 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.	
	97.7%			
	Performance M8			
	94.4%			
	Target			
	90%			
	Risk level			
	LOW			

Trajectories		
M8	M9	M10
90%	90%	90%

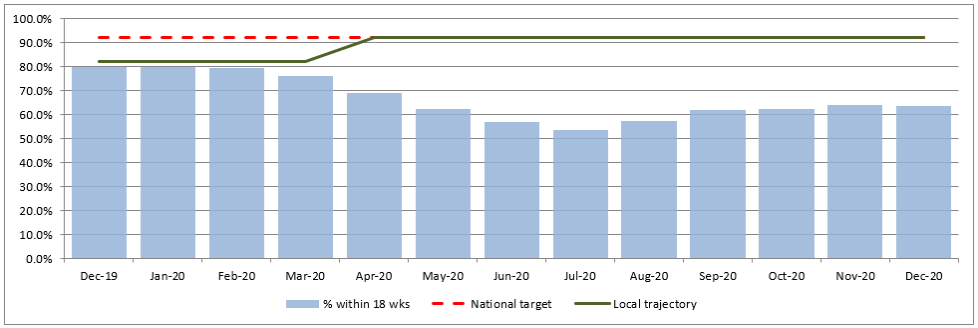
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

DECEMBER 2020 Incomplete 92% Table - National Specialty

	>126			
Submitted Spec	Incomplete IPDC >126	Incomplete Outpatients >126	Grand Total	% < 18wk
Orthodontics		113	158	28.48
Respiratory Medicine	2	149	706	78.61
Pain Management	50	121	484	64.67
Gynaecology	111	110	1302	83.03
Dermatology		308	1217	74.69
Neurology	9	306	694	54.61
Cardiology	28	388	1709	75.66
Colorectal Surgery	100	316	996	58.23
Paediatrics	5	465	1214	61.29
Oral Surgery	133	346	1418	66.22
ENT	96	435	1648	67.78
Gastroenterology	373	166	1835	70.63
Upper Gastrointestinal Surgery	341	368	1270	44.17
Urology	369	758	2232	49.51
Trauma & Orthopaedics	701	962	3234	48.58
Ophthalmology	627	1434	4569	54.89
Grand Total	3041	7174	28058	63.59

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in December has improved with the proportion of people waiting less than 18 weeks at 63.59%; 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 28,058 from 19995 in March 2020 and increase of 1,416 from November position. This is below our Phase 3 trajectory in M9 of 29,657 with end of year of planning trajectory of 32,744.

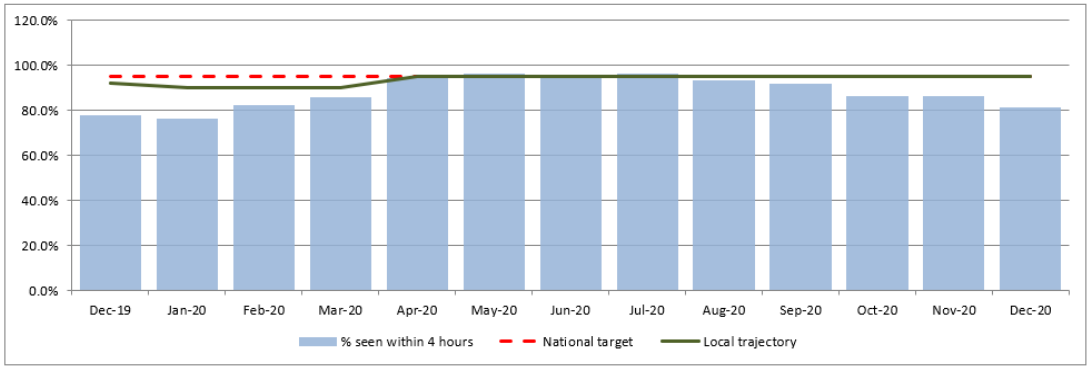
52 week waits: For December 1,435 people will be reported as waiting over 52 weeks, this being an 168 increase on last month's 1277, but remains ahead of our Phase 3 trajectory of 1821 and end of year phase 3 planning trajectory of 2731. The impact of COVID-19 continues to adversely affect levels of activity and performance. Despite good progress across many areas, in Month 9 the activity levels reported have decreased when compared to the same month last year. 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 third wave of covid hospitalisations impacting on capacity to admit patients.

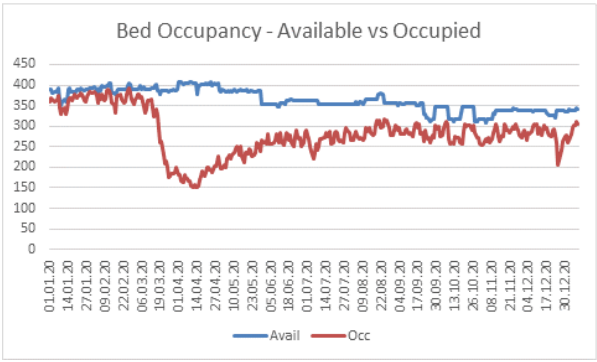
Recovery planning: Although the Day Surgery Unit had resumed activity in September, due to the increased number of COVID admissions it has now been stood down as part of the latest Trust COVID response and will therefore see a reduction in activity for long wait routine patients over the coming weeks. Main theatres are doing both Inpatient and daycase procedures in line with current clinical prioritisation requirements ensuring that capacity is directed more urgent clinical priorities. Uncertainty remains with the NHSI Independent Sector contract which could result in activity having to be repatriated back to the Trust. 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. Waiting time forecasting is therefore not showing confidence in reducing RTT waiting times in the short term. Medium to longer terms plans will need to ensure that services are stood back up as soon as COVID capacity allows and the full implementation of new models of care in the delivery of non face to face consultations and 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 increasingly relevant 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 to pre-covid levels. Direct admissions to the Surgical and Medical Receiving Units (30% of emergency admissions) have helped to reduce the potential for overcrowding and delays to assessment in the ED department. Performance against the 4-hour performance standard for December is reported at 81.2% with increased bed occupancy impacting on the timely flow of patients out or the department. Levels of escalation as recorded by the Daily OPEL score reflect system pressure with 14 days at OPEL 3 reported in December. Building works to reconfigure the department and expand into the footprint of EAU3 (previous emergency assessment ward) now complete.

Staffing pressures have continued with reliance on bank and agency to maintain full staffing rota.

Ward and community teams continue the initiatives developed through the improvement workstreams prior to covid to focus on timely discharge maintain patient flow. 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 December there was 19 ambulance delay over 60 minutes; delays of over 30 mins increased from 38 to 138.

Escalation status

Opel status	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Opel 1	0	0	5	17	25	21	22	28	24	13	2	0	1
Opel 2	8	7	12	13	5	9	22	3	7	16	8	14	16
Opel 3	15	19	8	1	0	1	0	0	0	1	21	17	14
Opel 4	8	5	4	0	0	0	0	0	0	0	0	0	0
A&E Performance	77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%
Bed Occupancy (Acute)	98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	75%	75.2%	80.0%	83%	88%	85%	83%

Cancer treatment and cancer access standards

CWT Measure	Target	October 2020				November 2020				December 2020				Quarter 3 Total			
		Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance	Within Target	Breached Target	Total	Performance
14 Day - 2ww referral	93%	1054	356	1410	74.8%	1132	223	1355	83.5%	932	255	1187	78.5%	3118	834	3952	78.9%
14 Day - Breast Symptomatic referral	93%	86	2	88	97.7%	98	17	115	85.2%	93	6	99	93.9%	277	25	302	91.7%
31 Day 1st treatment	96%	168	4	172	97.7%	200	2	202	99.0%	163	5	168	97.0%	531	11	542	98.0%
31 Day Subsequent treatment - Drug	98%	79	0	79	100.0%	61	0	61	100.0%	99	0	99	100.0%	239	0	239	100.0%
31 Day Subsequent treatment - Radiotherapy	94%	56	0	56	100.0%	50	1	51	98.0%	47	2	49	95.9%	153	3	156	98.1%
31 Day Subsequent treatment - Surgical	94%	28	2	30	93.3%	26	1	27	96.3%	28	1	29	96.6%	82	4	86	95.3%
31 Day Subsequent treatment - Other		0	0	0	100.0%	26	0	26	100.0%	23	0	23	100.0%	49	0	49	100.0%
62 day 2ww / Breast	85%	71	33.5	104.5	67.9%	76.5	23.5	100	76.5%	83.5	25.5	109	76.6%	231	82.5	313.5	73.7%
62 day Screening	90%	3	2	5	60.0%	8	2	10	80.0%	2	1	3	66.7%	13	5	18	72.2%
62 day Consultant Upgrade		1.5	1	2.5	60.0%	2	0	2	100.0%	1.5	0	1.5	100.0%	5	1	6	83.3%
104 day breaches (2ww) - TREATED	0	3				3.5				5.5				12			

Cancer standards The table above shows the position for December 2020 (as at 14th January 2021). *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 78.5% 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 continue to be Skin (78%), Lower GI (82%), Urology (45%), and Head and Neck (78%).
28 days From Referral to Diagnosis: Performance in December has plateaued at 75.0% and is currently achieving the new standard set at 75% being a minor decrease on November with 75.2% reported.

NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has improved from November (72.3%) and is currently reported at 76.6% and 25.5 patients treated outside of standard. (target 85%).
With the Trust's ongoing response to COVID-19 risk remains in the pathways for Urology (31%) , Lower GI (62%). 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. Plans are in train to repatriate Urology back to the Acute site from Mount Stuart at the end of January 2021. There remains uncertainty as to what Independent Sector capacity remains available with ongoing discussions at System level, and will be dependent on the scale of the COVID surge response required. Teams continue to seek Mutual Aid across the system for Clinical Oncology (Breast) and Urology with prostate biopsy waits being the main factor in urology breaches of standard.

Longest waits greater than 104 days on the 62 day referral to treatment pathway:
In December, 5.5 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.

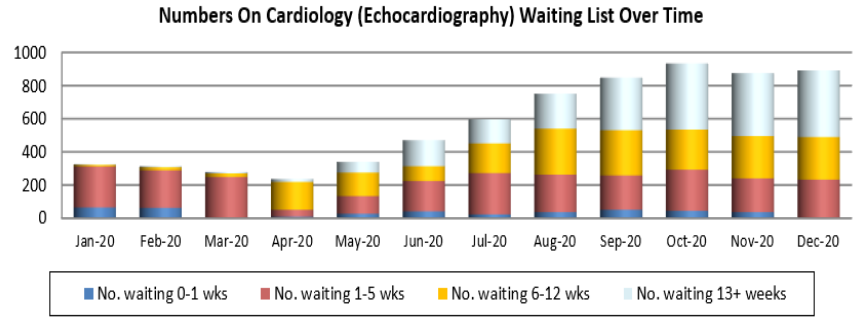
	2ww (93%)			62 day (85%)			28 day (75%)		
Site	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Breast	93% (203/16)	79& (185/49)	86% (157/25)	100% (12/0)	94% (16/1)	89% (16.5/2)	98% (155/3)	96% (221/10)	96% (181/8)
Breast Symtomatic							97% (78/2)	99% (74/1)	92% (79/7)
Gynae	97% (114/3)	94% (90/6)	95% (90/5)	50% (1/1)	43% (3.5/2)	71% (2.5/1)	70% (69/30)	65% (64/34)	68% (62/29)
H&N	49% (61/63)	59% (94/64)	78% (90/26)	100% (1/0)	100% (2/0)	100% (5/0)	74% (81/29)	87% (112/17)	70% (86/37)
Haem	50% (1/1)	100% (12/0)	100% (10/0)	33% (2/4)	67% (2/1)	100% (1/0)	100% (2/0)	86% (6/1)	79% (11/3)
LGI	80% (174/43)	88% (189/26)	82% (158/35)	30% (3/7)	71% (6/3.5)	62% (5/3)	38% (98/162)	63% (70/122)	38% (64/105)
Lung	80% (22/3)	68% (16/7)	73% (11/4)	78% (7/1)	100% (3/0)	100% (2/0)	100% (22/0)	94% (15/1)	72% (13/5)
Skin	71% (365/155)	98% (403/7)	78% (301/87)	92% (36/4)	82% (28/6)	88% (36.5/5)	82% (416/92)	75% 309/101)	83% (294/58)
Testi	89% (8/1)	100% (9/0)	100% (9/0)			100% (1/0)	86% (6/1)	70% (7/3)	89% (8/1)
UGI	81% (70/17)	88% (86/12)	77% (61/18)	0% (0/2)	86% (7/1)	80% (4/1)	82% (76/17)	86% (87/14)	79% (65/17)
Urol	40% (41/61)	46% (44/52)	45% (46/55)	34% (7.5/16)	48% (8/9)	31% (6/13.5)	44% (44/56)	44% (32/41)	54% (41/35)
Aggregate	75% (1059/368)	84% (1131/223)	78% (933/255)	68% (70.5/35)	77% (76.5/23.5)	76% (82.5/25.5)	73% (1048/393)	74% (1000/345)	75% (904/305)
	(Total<14 days / Total >14 days)			(Total <62 days / Total >62 days)			(Total <28 days / Total >28 days)		

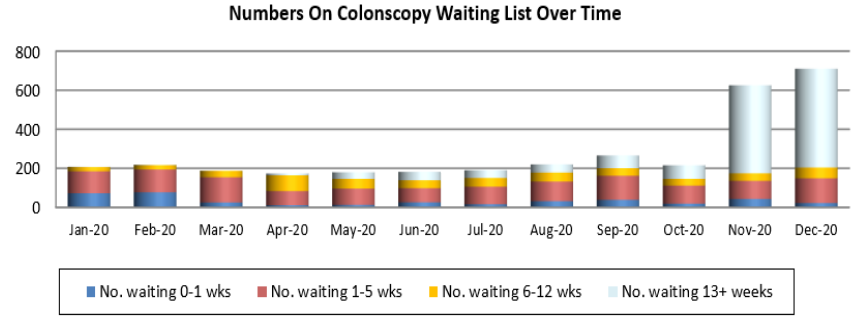
Mitigating Actions

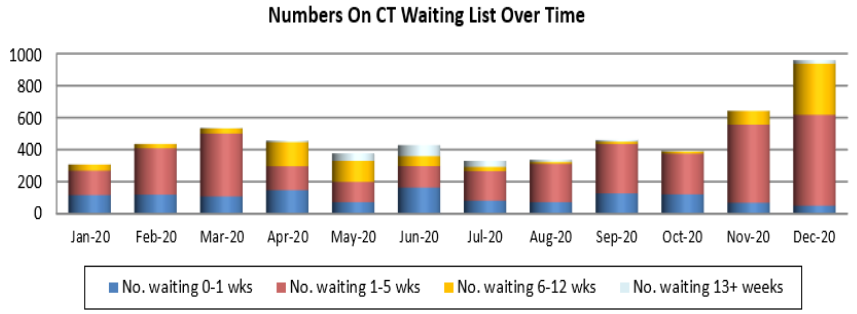
Urology : Plans include increasing capacity for urgent outpatients and diagnostic assessments – this will require additional OP based facilities configured for one stop processes and an increase in the number of cystoscopes. Team are currently working up plans with estates and capital approvals.

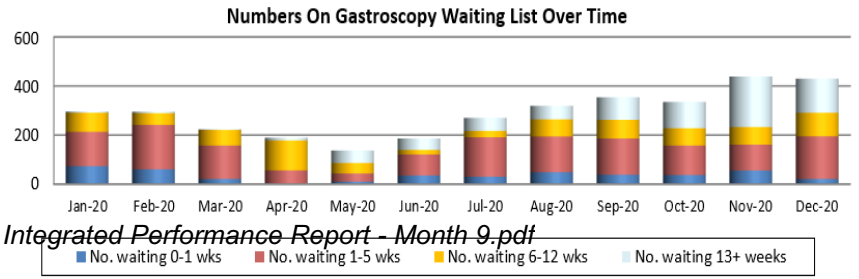
Lower GI – Diverting proportion of GP referrals into UHP representing 1 days worth of weekly activity as part of mutual aid is in place – The 3rd endoscopy room is back on line at end January this together with 5 lists per week at MSH and continuation of weekend insourcing (2 weekends per month) will start to reduce delays in the diagnostic phase of the LGI cancer pathway.

NHSI indictor - patients waiting over 6 weeks for diagnostics



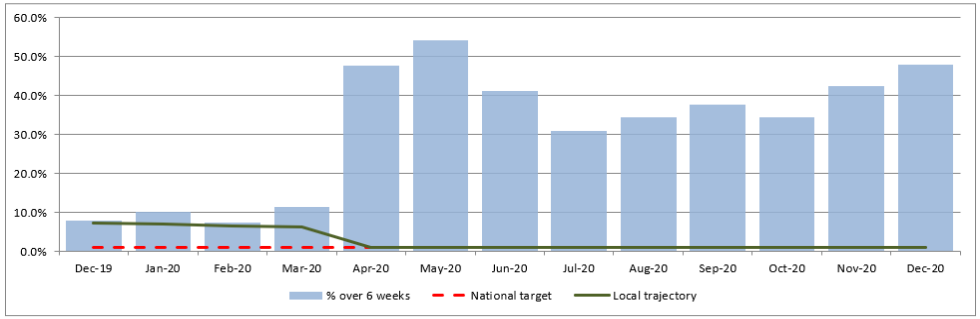






Diagnostic tests longer than the 6 week standard

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Patients	3051	2600	2816	2652	2266	2361	2883	2948	3207	3446	3810	4624	4989
Waiting longer than 6 weeks	240	264	207	299	1080	1282	1186	911	1106	1295	1312	1957	2389
% over 6 weeks	7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%
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	7.3%	6.9%	6.6%	6.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%



This month has seen an increase in the percentage of patients with a diagnostic waiting time over six weeks to 47.9% from 42.3% in November.
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, colonoscopy, endoscopy, and increasingly CT investigations. The rise in CT waits is due to the removal of the NHSE commissioned CT scanner, and reduced capacity at the Nightingale and Mount Stuart Hospitals.
Mutual aid requests for interim support has been requested from local providers to support capacity for Gastroenterology and CT.

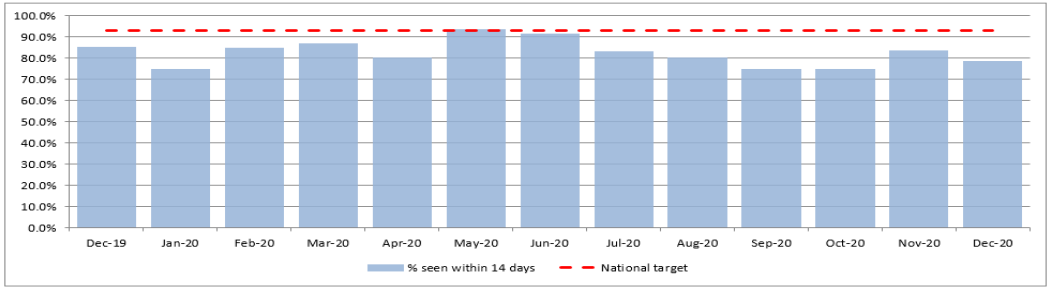
The reduction of the centrally commissioned mobile CT capacity from 7 to 2 days is a significant risk. To date there are no effective plans to re-provide this lost capacity in the short term. The 3rd CT installation will commence in December 2020 for completion in May 2021.

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

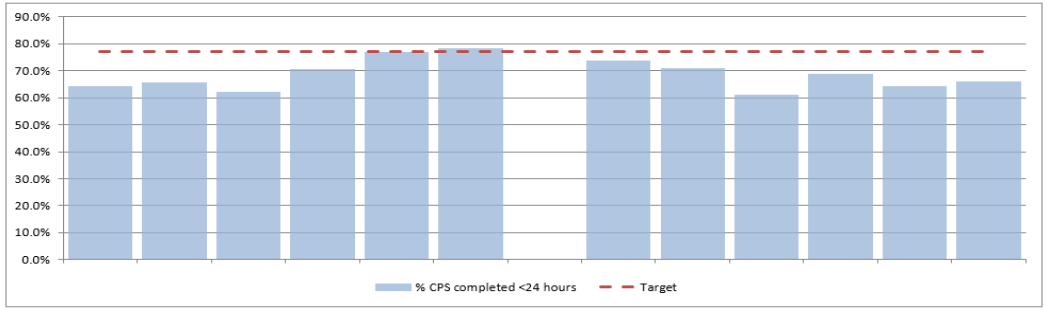
Cancer - Two week wait referrals

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
2ww referrals seen	1208	1241	1251	1397	549	847	1071	1281	1217	1336	1410	1345	1187
2ww breaches	177	313	190	180	107	54	92	213	242	333	356	221	255
% seen within 14 days	85.3%	74.8%	84.8%	87.1%	80.5%	93.6%	91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.5%
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%



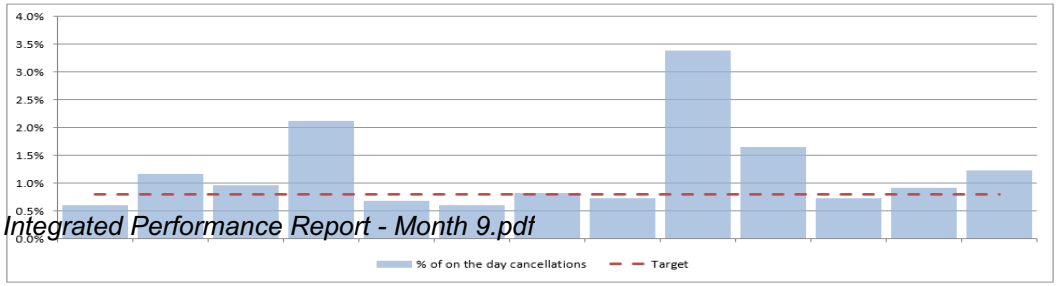
Care Plan Summaries completed within 24 hours of discharge - Weekday

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Discharges	1668	1683	1560	1376	885	1039	n/a	1405	1425	1361	1324	1176	1436
CPS completed within 24 hours	1069	1106	967	972	681	815	n/a	1034	1011	832	913	754	950
% CPS completed <24 hours	64.1%	65.7%	62.0%	70.6%	76.9%	78.4%	n/a	73.6%	70.9%	61.1%	69.0%	64.1%	66.2%
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

	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Cancellations	19	43	32	56	8	9	15	18	74	46	20	26	35
Elective spells	3133	3667	3332	2631	1174	1503	1826	2446	2189	2772	2742	2835	2835
% of on the day cancellations	0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



Cancer two-week wait referral

The number of cancer two-week wait referrals received has continued to be close to pre- covid levels. Performance is below the 93% standard at 78.5% pf patients seen within 2 weeks from referral.

Care Planning Summaries (CPS)

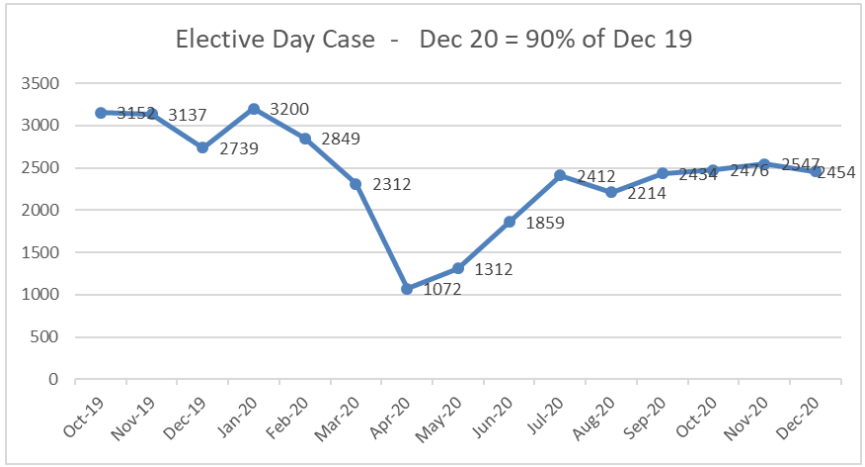
The improvement programme is working with wards and emphasising that timely completion of the CPS is a mandatory requirement.

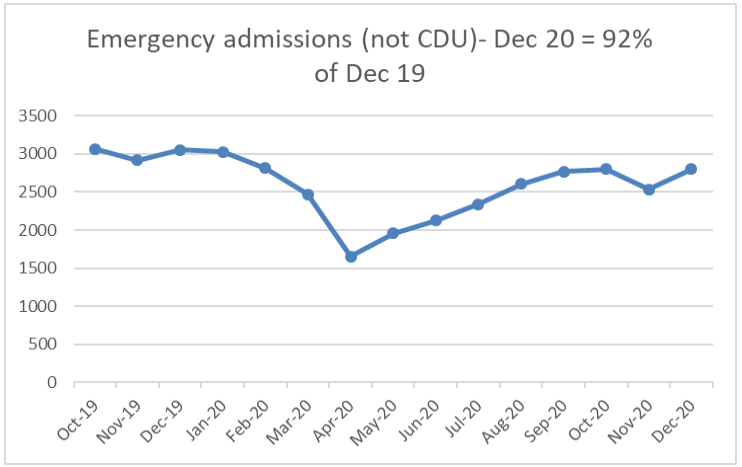
No improvement is currently being seen in the weekday CPS completion. This has been escalated through the Integrated Governance Group to clarify the plan in place and trajectory to improve performance. The impact of making this a mandatory field are being assessed against the risk of delaying discharge. At the present time improvement focus is on maintaining ward capacity covid escalation response so no significant change is forecast.

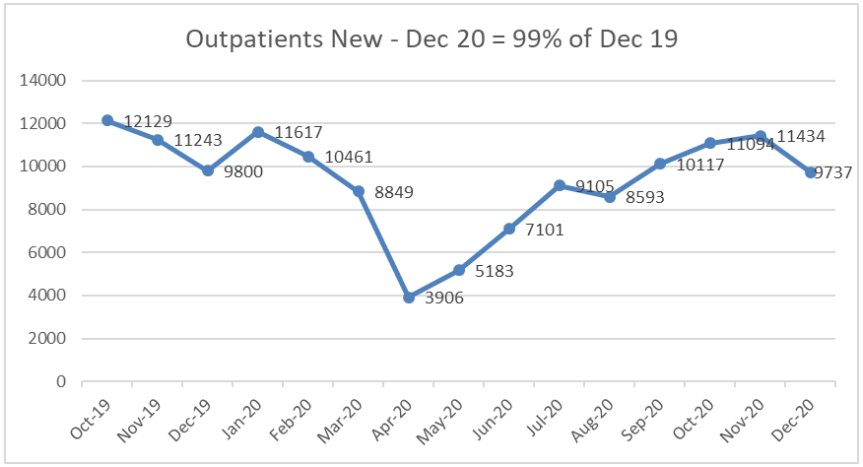
Cancelled operations

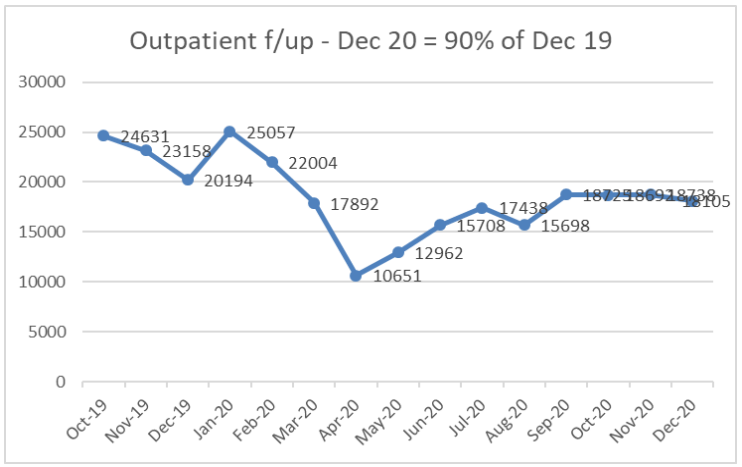
The number of operations cancelled on the day has increased in December. Bed capacity and operational pressures remains a significant factor for planned elective surgery with orthopaedic ward given over to covid capacity and reduced number of admissions scheduled. On 11th January covid escalation triggered the closure of the day surgery unit with all non urgent patients booked being cancelled – only cancer and most urgent elective patients will re scheduled for surgery during this time.

Headline acute activity comparisons to last year









The charts above show the monthly run rate of reported contract activity. The percentage of activity compared to the same month last year is shown in the chart titles. We have seen a progressive increase in activity levels. December is normally a lower month of elective activity, so the slight fall is expected – the activity comparisons to December last year however remain good. The Covid escalation in January with the stepping down of some elective capacity in response to the 3rd wave will see an impact on activity recovery levels. We are however in a far better position for stepping back up these services once the level of escalation falls than we were after the first wave.

Teams are preparing to step up efforts to again optimise capacity and manage the clinical prioritisation of patients who may have had their treatment delayed. The overall waiting list size has continued to increase and this will become a significant challenge across the Devon ICS on how capacity is increased to address the backlog of elective work and long waiting times over the coming year.

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

CAMHS

- The CAMHS Service is under pressure due to high vacancy numbers, interim positions in key workforce roles, demand outstripping capacity, COVID response, local, national and regional developments requiring CAMHS time, newly funded service growth (MHST, WERS), internal service improvements and CFHD service redesign and consultation.
- Acute, crisis and out of hours activity is an area of focus, with additional staff redeployed to work weekends through COVID. The crisis service model is also under resourced to meet need or to provide the required service that has been commissioned in line with the ambitions of the long-term plan.
- Safeguarding Children level 3 training remains a focus for the team with plans in place that should achieve 90% compliance by end of March 2021
- Eating disorder capacity is unable to meet demand. Routine waits are now starting to appear.
- COVID challenges are noted in relation to shared sites with DCC colleagues who are working to different PPE Guidance.

Integrated therapies and nursing

- RTT performance has improved in Learning Disability and Physiotherapy services. Autistic Spectrum Disorder (ASD), Speech and Language Therapy (SLT) have the greatest challenge on reducing waiting times for treatment. Plans to address waiting lists and are being monitored with the CCG and Integrated Governance Group.
- Heavy focus on waiting list initiative work for SLT, Occupational Therapy and ASD services, has resulted in improved understanding for teams around how data quality can equal good outcomes for CYP, families and carers.
- COVID cases amongst staff impacting on capacity and current recovery trajectories. Evidence in services highlights need to change “front door”, utilise acceptance criteria and robust triage/screening with virtual offers to decrease #s of cases coming to statutory first.
- CFHD responded to SEND 3 design options, and in January 2020 will be more involved in designing services especially what triage/screen and front door could look like.
- Work is progressing towards System one as a single clinical records system across CFHD with CAMHS planned to be early adopters.

18 week RTT Performance

December 2020		RTT % <18 weeks		Caseload		
Service	RTT longest waits (weeks)	Dec-19	Dec-20	Dec-19	Dec-20	Change last 12 months
CAMHS	85.1	80%	79.9%	4134	4183	+ 49
Occupational Therapy	50.4	67.2%	59.4%	1231	1221	- 10
Speech and Language Therapy	100.1	72.1%	54.7%	3709	4842	+ 1133
Autistic spectrum assessment team	133.1	25.2%	16.3%	1918	3366	+ 1448
Physiotherapy	26	96.6%	80.5%	463	521	+ 58
Learning disability	23.7	93.1%	97.7%	280	295	+ 15

Finance Report

December / Month 9 - Financial Year 2020/21

Finance, Performance & Digital Committee Meeting

25 January 2021

Contents

1. Overall Position - Executive Summary

Context

The basis of financial monitoring of the Trust for the 2020/21 year falls into two distinct phases. For the first half of the year (to 30 September) the Trust was re-imbursed for the impact of COVID-19 via a top-up payment, resulting in a full recovery of costs incurred.

In October the Trust submitted a revised plan to NHSE/I for the second half of the year and this forms the basis of the budget for the current period.

The revised plan shows an operating deficit for the year of of £0.6m (after adjustments for items relating to receipt and depreciation of donated assets).

The income to be received in this period has been matched to the plan on a block basis with the following exceptions:

- COVID-19 costs in relation to laboratory testing and the Hospital Discharge Programme will be re-imbursed by the Department of Health as incurred;
- COVID-19 costs in relation to infection control in care homes will be re-imbursed by the local authority as incurred.

Budgets for each service have now been set based on this plan, and it is now possible to measure the financial delivery through variance analysis. However, a focus on changes and trends in income and expenditure will continue, to identify risks in delivery of the plan. These budgets (which include workforce establishments) have been distributed to budget holders.

In the revised plan no cost improvement schemes were identified, and as at the end of December (Month 9) the Trust is reporting no achievement of cost reduction programmes, due to the impact of COVID-19.

The results for the year to 31 December 2020 show a surplus of £2.39m, against a revised plan deficit of £0.13m (after donated asset adjustments). The current forecast out-turn suggests that the Trust will deliver its plan. Further analysis continues to be undertaken, identifying opportunities and risks to delivery.

A separate Capital report has been drafted.

Key Questions

1. What is our current financial performance for the year to date at 31st December 2020?

	NHSE/I Plan YTD Month 9 £'000s	Actual YTD Month 9 £'000s	Variance Favourable (Adverse) £'000s
Total Income	404,244	401,453	-2,791
Total Expense	-388,488	-383,319	5,169
EBITDA	15,756	18,134	2,378
Financing Cost	-16,546	-16,393	153
Surplus (Deficit)	-790	1,741	2,531
NHSE/I Adjustments - Donated Items	659	645	-14
Adjusted Financial performance - Surplus (Deficit)	-131	2,386	2,517

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-M9 per the October H2 submission. The Trust has a favourable variance of £2.5m as at M9. This includes year to date COVID income of £23.8m (M1 to M6 block top up of £8.6m, M9 YTD CCG top up income of £9.1m and YTD cost reimbursement of £6.1m).

2 COVID Expenditure

There are 6 streams of COVID costs in the Trust Position:

1) Acute COVID spend ---> £11.7m YTD
2) Hospital Discharge ----> £7.3m YTD
3) Infection Control Care Homes --> £3.9m YTD
4) Swabbing Costs ------> £0.2m YTD
5) Laboratory Testing -------> £1.6m YTD
6) Nightingale hospital -------> £0.0m YTD

Hospital Discharge costs are borne by Devon CCG as incurred, Infection Control income from the council is passported through to the independent sector providers, lab testing costs sit outside the Trust envelope and are borne by NHS England, and costs relating to Nightingale hospital are rechargable to RD&E. Therefore the focus of costs versus plan for the Trust is in relation to acute COVID and associated swabbing costs.

The Trust is required to prepare detailed analysis in their monthly returns for items 1, 4, 5 and 6.

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

3 Plan and Forecast

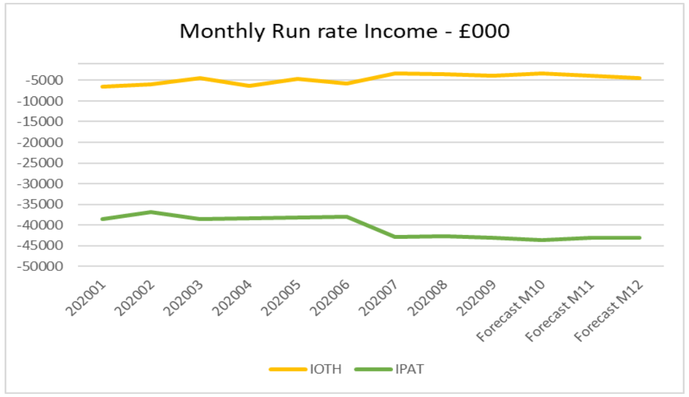
The H2 Trust plan submitted to NHSE/I in October shows a deficit of £0.6m (after adjustment for donated items); the full year plan consists of M1 to M6 actuals and M7 to M12 plan value. The Forecast as at end of M9 suggests the Trust will deliver its plan, with further work being undertaken to identify opportunities and risks to this position.

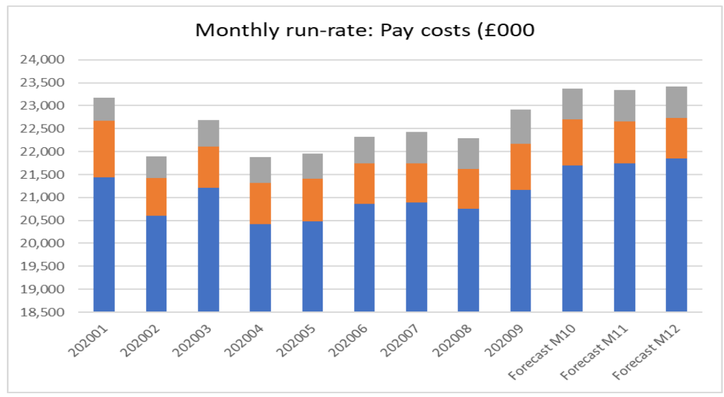
	NHSE/I Plan FY 2020/21 £'000s
Total Income	546,117
Total Expense	-525,063
EBITDA	21,054
Financing Cost	-22,537
Surplus (Deficit)	-1,483
NHSE/I Adjustments - Donated Items	878
Adjusted Financial performance - Surplus (Deficit)	-605

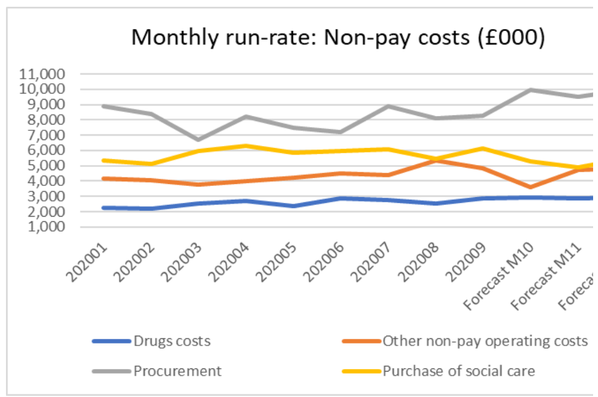
Key Risks and Mitigations to Forecast Outturn Delivery

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

Trust Run rate and Forecast, £'000's (M1 to M9 Actual, M10-M12 Forecast)







Key:
IOTH= Other Income
IPAT = Patient Income

Key:

Substantive
Bank
Agency

Key Issues

1. Forecast

The forecast out-turn for the Trust, as declared to NHS E/I, is a deficit (after adjustment for donated asset income and depreciation) of £0.6m in line with the revised operating plan submitted in October 2020.

As at the 31 December 2020, the Trust is showing a surplus of £2.4m against a planned deficit of £0.1m (after donated items adjustment). This is largely driven by slippage in investments in services to recover backlog positions in the light of the second and now third wave of Covid-19.

Whilst it is anticipated that a degree of the investment will be utilised before the end of the financial year, it's expected that it will be limited due to the current situation with the pandemic. As a result, the Trust is well placed to achieve the required financial performance, and indeed may be in a position to deliver a result that improves on the forecast, subject to the identification and validation of risks and opportunities between now and the end of the financial year.

2. Risks

The main risk associated with delivering the financial plan is any potential impact of the third wave of Covid-19 cases in the midst of winter pressures. This will further depress any recovery of performance and add potential additional costs to the services. This will also add pressure into the 2021-22 plan, as backlogs will have to be recovered at a later date.

3. Mitigations

The Covid-19 risk to the Trust is mitigated by elements of funding that are variable (for example, the Hospital Discharge Programme and Infection Control in Care Homes). In addition, there is capacity within the forecast budget to accommodate some increased costs of working, although that will impact on performance trajectories.

4. Recurring impact

Key Financial Information – Trustwide

	£m	M9 Budget	M9 Actual	M9 Variance	YTD M9 Budget	YTD M9 Actual	YTD M9 Variance
Income (excluding COVID19 Top-Up)	Patient Income - Block	29.37	29.37	0.00	256.81	256.81	0.00
	Patient Income - Variable	3.48	3.59	0.11	30.94	31.08	0.14
	ASC Income - Council	4.36	4.19	(0.17)	40.85	40.28	(0.57)
	Other ASC Income - Contribution	0.91	0.96	0.05	8.39	8.57	0.18
	Other Income	5.06	5.43	0.37	41.44	40.93	(0.51)
	Total (A)	**43.18**	**43.54**	**0.36**	**378.43**	**377.67**	**(0.76)**
Expenditure (incld Financing Costs)	Pay - Substantive	(22.63)	(22.17)	0.46	(197.98)	(196.21)	1.77
	Pay - Agency	(0.52)	(0.74)	(0.22)	(4.82)	(5.34)	(0.52)
	Non-Pay - Other	(12.46)	(12.43)	0.03	(100.24)	(99.15)	1.09
	Non- Pay - ASC/CHC	(10.09)	(9.05)	1.04	(85.44)	(82.61)	2.83
	Financing Costs	(1.89)	(1.82)	0.07	(15.89)	(15.75)	0.14
	Total (B)	**(47.59)**	**(46.21)**	**1.38**	**(404.37)**	**(399.06)**	**5.31**
	Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**(4.41)**	**(2.67)**	**1.74**	**(25.94)**	**(21.39)**	**4.55**
	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	4.12	3.40	(0.72)	25.81	23.78	(2.03)
	Donated Transactions	(0.07)	(0.07)	0.00	(0.66)	(0.65)	0.01
	Impairment	0.00	0.00	0.00	0.00	0.00	0.00
	Total (D)	**4.05**	**3.33**	**(0.72)**	**25.15**	**23.13**	**(2.02)**
	Net Surplus/(Deficit)	**(0.36)**	**0.66**	**1.02**	**(0.79)**	**1.74**	**2.53**
	NHSE/I Adjustments - Donated Items	**0.07**	**0.07**	**0.00**	**0.66**	**0.65**	**(0.01)**
	Adjusted Financial performance - Surplus (Deficit)	**(0.29)**	**0.73**	**1.02**	**(0.13)**	**2.39**	**2.52**

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-M9 as per the October submission. In M9 the Trust achieved a £0.73m surplus against a planned deficit of £0.29m. Year to date surplus is £2.39m against a planned deficit of £0.13m, a favourable variance of £2.52m. (These values are after the donated asset adjustments).
- In M9 higher patient care variable income of £0.11m relates to pass through income from CCG (matched by cost increase). There is a a further £0.17m adverse variance for Adult Social Care (ASC) income in M9 due to the phasing of the second tranche of £1m included in the plan for period M7-M10, against actual income which is accrued based on corresponding cost incurred. Other income of £0.37m (net) relates to higher education and R&D income £0.22m, variable COVID income £0.38m (labs testing matched by cost) and various income sources £0.06m offset by lower Torbay Pharmaceutical sales of £0.29m. There is an increase of £0.05m from ASC client contribution. COVID income is £2.03m lower as at M9, this is due to deferred income from Devon CCG £1.59m and lab testing £0.44m (matched by cost).
- Substantive Pay expenditure of £22.17m in M9 is £0.46m lower than budget due to expected investments not yet in place and vacancies. This is offset by higher Agency cost of £0.22m in Nursing (£0.09m) and HCA (£0.05m) posts due to specialling, sickness and vacancy cover; also increased Domestic Agency staff cost (£0.08m) due to increased cleaning requirement re: COVID/infection control.
- Non-pay expenditure Other is £0.03m (net) lower than budget due to: operating expenses £0.17m (lower spend and reserves movement £0.56m, estate contracts £0.17m and various operating cost £0.16m offset by increased provision due to change in discount rate £0.20m and reassessment of liabilities in respect of injury benefit provisions £0.52m) and Drugs cost £0.02 (lower usage within healthcare at home, inpatient and cancer drugs £0.14m offset by high cost and outpatient drugs £0.12m); offset by higher cost in Clinical supplies £0.07m (lab medicine backdated charge and temporary increase of stock levels to mitigate Brexit impact £0.18m; medical supplies, equipment and chemicals stock increase £0.18m offset by lower COVID lab testing than planned £0.29m) and non clinical supplies spend £0.09m (increased cost of scanning of notes and images £0.04m, mats and domestic cleaning equipment £0.04m and uniforms £0.01m).
- Independent sector Non-pay cost (ASC and Placed people (Health including CHC) is £1.04m lower than budget in M9. The underspend is driven by lower than anticipated COVID costs (PPE being picked up nationally for the Local Authority element) and lower than anticipated client numbers for Hospital Discharge scheme 1 and 2. In addition to this CHC growth in client numbers has been lower than anticipated when budget was set. (Base budget was set in September with a high level of uncertainty in relation to COVID impact and guidance / funding streams).
- Within the M9 year to date position COVID related costs incurred total £12.31m (pay £6.08m and non pay £6.23m) excluding hospital discharge and infection control. Further details have been included within the pay and non pay sections.
- Financing cost is £0.07m lower than budget due to lower depreciation (£0.05m) of owned and leased assets and lower interest on finance lease (£0.02m).

Statement of Financial Position

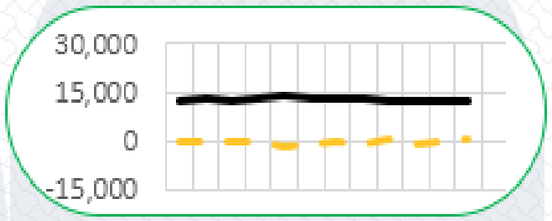
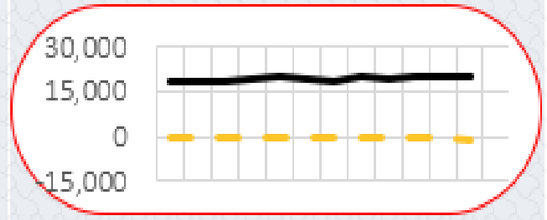
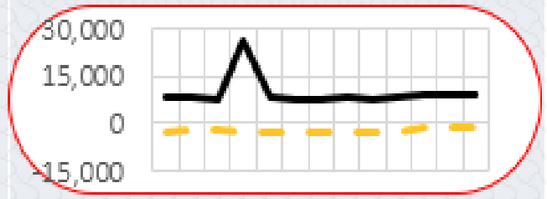
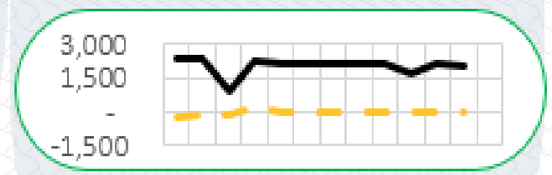
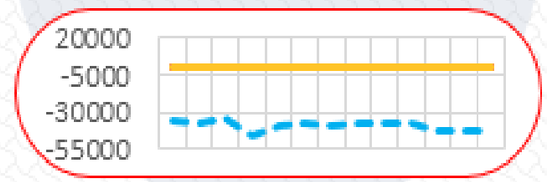
	Month 09		
	Plan £m	Actual £m	Variance £m
Non-Current Assets			
Intangible Assets	11.63	8.31	(3.32)
Property, Plant & Equipment	192.51	189.34	(3.17)
On-Balance Sheet PFI	17.15	17.08	(0.07)
Other	1.28	2.03	0.74
Total	**222.57**	**216.75**	**(5.82)**
Current Assets			
Cash & Cash Equivalents	46.20	64.37	18.17
Other Current Assets	36.56	35.82	(0.74)
Total	**82.76**	**100.19**	**17.43**
Total Assets	**305.33**	**316.94**	**11.61**
Current Liabilities			
Loan - DHSC ITFF	(4.80)	(4.80)	0.00
PFI / LIFT Leases	(1.09)	(1.09)	(0.00)
Trade and Other Payables	(78.78)	(60.47)	18.31
Other Current Liabilities	(3.13)	(38.95)	(35.81)
Total	**(87.81)**	**(105.32)**	**(17.51)**
Net Current assets/(liabilities)	**(5.04)**	**(5.12)**	**(0.08)**
Non-Current Liabilities			
Loan - DHSC ITFF	(30.49)	(30.49)	(0.00)
PFI / LIFT Leases	(16.89)	(16.89)	0.00
Other Non-Current Liabilities	(11.92)	(11.16)	0.75
Total	**(59.30)**	**(58.54)**	**0.75**
Total Assets Employed	**158.23**	**153.09**	**(5.14)**
Reserves			
Public Dividend Capital	122.41	114.74	(7.67)
Revaluation	46.08	46.08	(0.00)
Income and Expenditure	(10.26)	(7.73)	2.53
Total	**158.23**	**153.09**	**(5.14)**

Key points

- Non-Current Assets are £5.8m lower than Plan. This was principally due to capital expenditure £6.7m lower than Plan, partly offset by the recognition of a £0.7m NHSE debtor in respect of the NHS clinician's pension tax scheme (offsetting the liability also recognised).
- Cash is £18.2m favourable to Plan, as explained in the commentary to the cash flow statement.
- Other Current Assets are £0.7m lower than Plan. This is principally due to reduced TP debtors £1.2m, partly offset by CCG debtors above plan £0.5m.
- Trade and Other Payables are £18.3m lower than Plan. This is principally due to the NHSEI-requested recategorisation to Other Current Liabilities of block income received in advance £32.9m, partly offset by increased capital creditor £3.0m, DPT creditor dispute £3.4m, and increased deferred income (incl HEE £1.2m and infection control £2.5m).
- Other Current Liabilities is £35.8m higher than Plan, primarily due to the NHSEI-requested recategorisation of block income paid in advance £32.9m and increased block income paid in advance £3.4m, partly offset by reduced usage of finance leases (largely due to delayed capital expenditure).
- Other Non-Current Liabilities are £0.8m lower than Plan due to reduced usage of finance leases (largely due to delayed capital expenditure) £2.2m, partly offset by reassessment of liabilities in respect of injury benefit provisions £0.5m and recognition of a £0.7m provision for the NHS clinician's pension tax scheme.
- PDC reserves are £7.7m lower than Plan, due to delayed PDC-funded capital expenditure and PDC funding being claimed later than planned.

Board Table of Key Metrics

Total Expenditure
Other Income
Contract Income

	Drivers	Actions Taken:	Tick charts £'000 Nov 19 to Nov 20
South System & Shared operations	Expenditure now being seen for the MRU and elective step up, within phase 3 plan levels. Now starting to see the impact of the COVID surge and requirement of escalation.	Likely to continue to underspend Phase 3 winter/Elective plan in Dec with higher expenditure expected from January due to recruitment timeline.	
Torbay System	Average monthly expenditure is up by circa £2.0m compared to the 9 month period for the previous year, 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.	Current spend in HIS has a potential upside risk to the end of year position. R&D resources remain re-deployed as income trials stopped. Continuation of estates moves.	
CFHD	Run rate fairly static, consultation remains on hold, but senior team are in internal discussions on options given high level of vacancies.	Activity back log requires funding, deferred income in 2019/20 not yet committed.	
Contract Income	Contract income for second half now fixed except COVID pass through for lab testing and Hospital Discharge/Infection Control programmes.	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 had lower sales realised from all sources M7-M9.
Corporate	EFM	Car parking agreed in NHS Peoples Plan to remain FOC to staff for 2020/21. Increased cleaning, linen and repair costs seen as services move back and set back up, plus additional spend for cleaning due to pandemic.
	Exec. Directors	Operating within budget envelope due to underspends in pay and increased education income.
	Financing Costs	Underlying costs are behind plan, but M9 result has been impacted by one-off costs relating to recalculation of estimates within provisions for injury and early retirement benefits.
	Other	Reserves has a provision for debt included at M8 due to IS payment of invoices, as well as backdated IS inflation claims and investment slippage provision. Very limited spend in M9 going through reserves.
South System	Coastal	Phase 3 slower to start than anticipated and it is not anticipated that this will recover by the end of the year given the current position with regard to the pandemic. 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, so cost pressure exists in budgets. Safer staffing review per above.
	Moor to Sea	Pay costs have increased in M9 with recruitment taking effect, but still operating within budget envelope.
Torbay System	Independent Sector	Costs fairly static, month on month. ISU is operating within funding envelope.
	Torquay	The second wave of COVID makes recovery / standing back up services challenging especially when combined with winter pressures. ISU operating at budget levels.
	Paignton and Brixham	Ongoing management balancing recovery plans and dealing with second wave of COVID / winter pressures within revised budget envelope. Slippage in some investment areas and operating comfortably within revised budget envelope.
Contract Income	Patient Income	Contract Income below plan due to variable COVID elements within the budget, which are offset by reduction in cost in the Independent Sector ISU.

Change in Financial & Activity Performance - M8 to M9

		Plan	Nov-20	Dec-20	Change	% Change		Dec-19	% change
Activity Drivers	A&E Attendances	8,447	5,998	6,424	426	7%		*9,461*	-32%
	Elective Spells	3,272	2,780	2,738	-42	-2%		*3,053*	-10%
	Non Elective Spells	3,289	2,848	3,087	239	8%		*3,463*	-11%
	Outpatient Attendances	26,441	28,185	25,835	-2,350	-8%		*28,004*	-8%
	Adult CC and SCBU Bed Days - M9 data unavailable								
Bed Utilisation	Occupied beds DGH		8,453	8,648	195	2%		*10,928*	-21%
	Available beds DGH		9,945	10,368	423	4%		*11,553*	-10%
	Occupancy		85%	83%	-2%	-2%		95%	-12%
Resource Consumption	Medical Staff Costs - £000's	4,987	4,908	5,001	93	2%		*4,699*	6%
	Nursing Staff Costs - £000's	5,453	5,143	5,280	138	3%		*4,937*	7%
	Temp Agency Costs - £000's	526	662	741	79	12%		*669*	11%
	Total Pay Costs - £000's	23,161	22,290	22,912	622	3%		*21,285*	8%

Key points

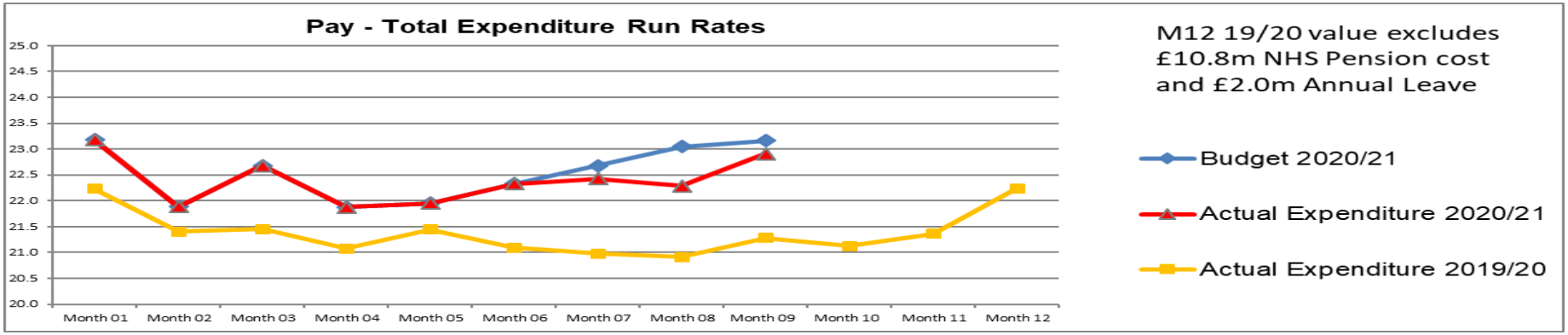
- **Activity Drivers:**
  Overall activity numbers are below plan and below that provided last month. The main reduction is in Outpatients, where volumes were the lowest since August. Non elective activity was 8% higher than last month and there was a similar increase in A&E attendances. The Trust submitted a Phase 3 activity submission to the STP in September and a subsequent STP finance return that triangulated with these numbers was also submitted. NHSE/I reviewed our Phase 3 submissions and the STP/Trust reviewed and updated certain elements but, nothing material. The Trust is now being monitored against these plans. At month 9, we are showing behind this plan. Because of the impact of the 2nd wave of COVID, Providers nationally were not asked to calculate a value for Elective Incentive Scheme (EIS - a financial incentive scheme based on recovering elective activity). Whilst we are still waiting for further guidance to see whether this scheme will continue, the STP, along with Trusts are collating data to review and assess the potential risk to income across the System. The Trust has recently submitted both a Financial and activity return to the STP as the starting point for 2021.22 planning. Both submissions was based on the actual values for 2019/20 and adjusted to reflect the latest position. The activity submission was completed at a high level due to all the uncertainties at present and the pressure on operational teams. We are also waiting for the national guidance, which we believe has been delayed until at least February. It is possible planning will be delayed further as a result of the COVID impact.

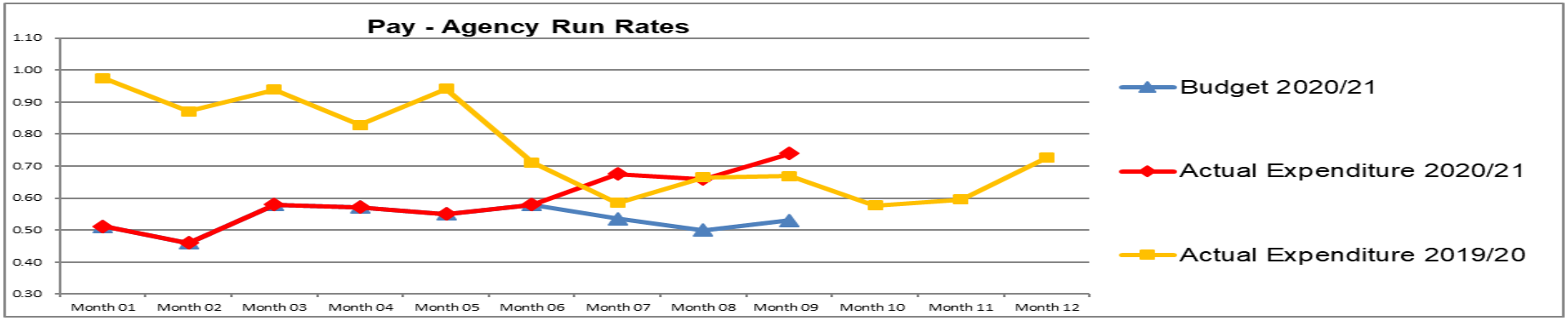
- **Bed utilisation:**
  In December, overall bed occupancy is 83% for general and Acute beds at the DGH. It is noted that this includes specialist wards not open for routine emergency admissions including cancer, Covid-19 , Paediatric and maternity wards with these wards often running at a lower occupancy level. It is noted that in December as part of the system Covid response the Nightingale Hospital Exeter is open and has taken a number of patients from Torbay Hospital. 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):**
- In M9 there is an increase in Medical staff cost of £93K - this is due to clinical activity and increased staffing per business case within A&E and Medical services. Nursing cost increased by £138K linked

Pay Expenditure

Current Performance

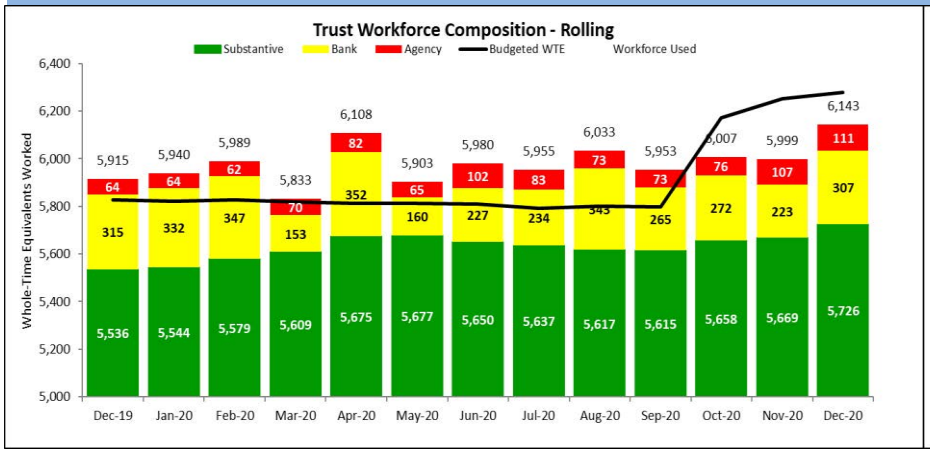


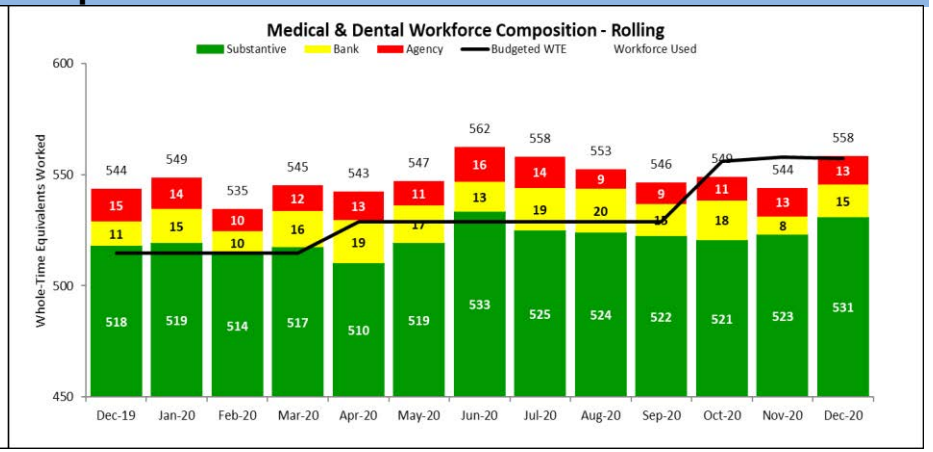


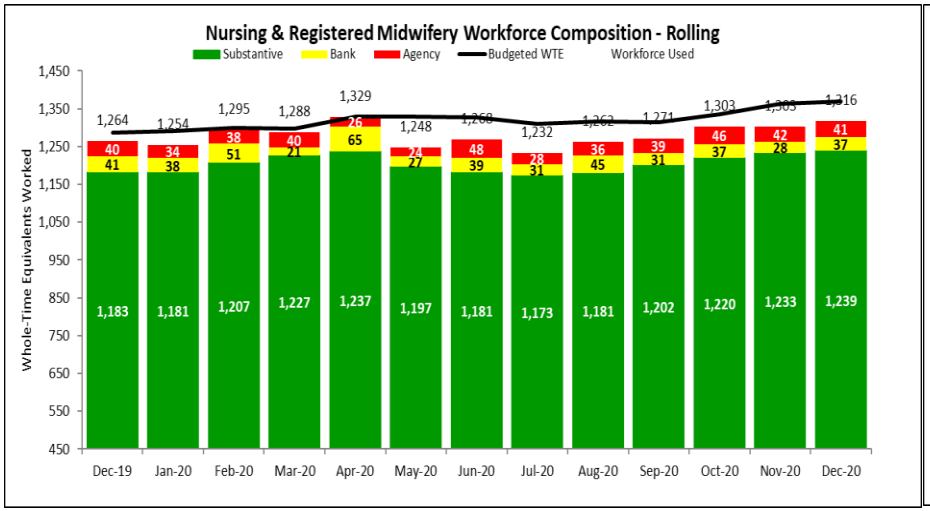
Key points

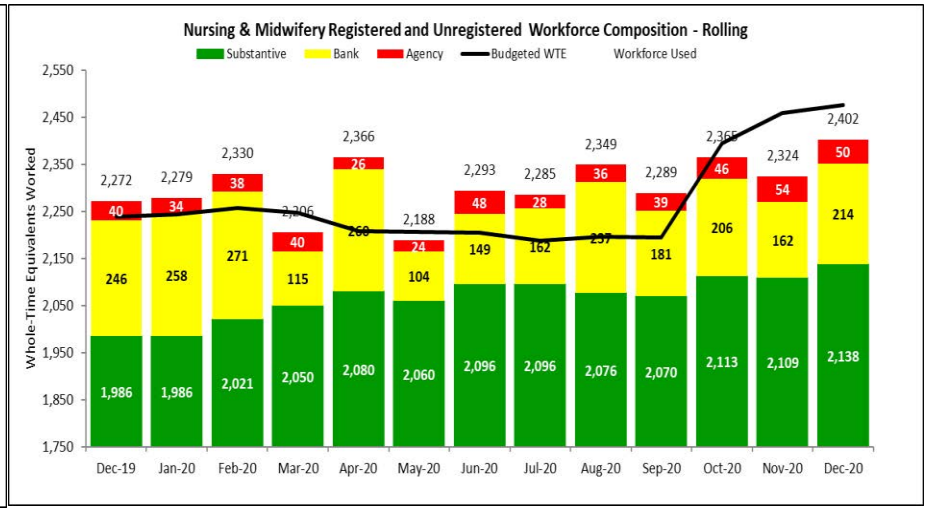
- Total pay run rate in M9 (£22.91m) is £0.62m higher in comparison to previous month (M8 £22.29m); the increase is within Substantive pay £0.41m, Bank £0.13m and Agency £0.08m, the details are provided below.
- The M9 increase in Substantive pay of £0.41m relates to the following: Nursing (£0.11m) and HCA (£0.09m) pay cost linked to clinical activity and winter incentive payment; MARS payment of £0.13m (previously accrued in reserves) and £0.08m net increase in various staff groups.
- The increase of £0.13m in Bank cost is due to the following: Domestic staff £0.09m (increased cleaning requirement due to COVID/infection control), Medical staff (£0.03m) and Nursing (£0.02m) due to clinical activity increase. M9 Agency increase of £0.08m is within Medical staff (£0.06m) and Nursing (£0.02m) in A&E and Medical specialties - the increase in staff numbers are per approved business case pending recruitment of permanent staff.
- There is £6.08m of pay costs year to date related to COVID. The breakdown is as follows: additional shifts of existing workforce £2.74m, backfill for higher sickness absence £2.64m, workforce expansion £0.14m, sick pay £0.31m, testing £0.21m and Exeter Nightingale running cost £0.04m.
- The Apprentice levy balance at Month 9 is £1,966,881 (£1,932,746 at month 8). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

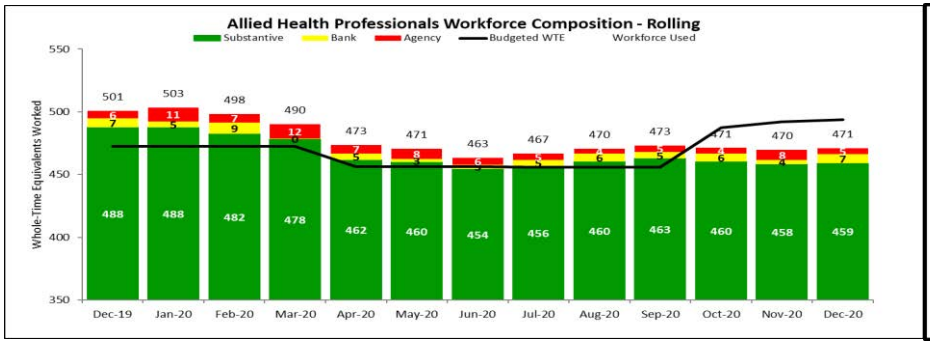
Workforce Composition

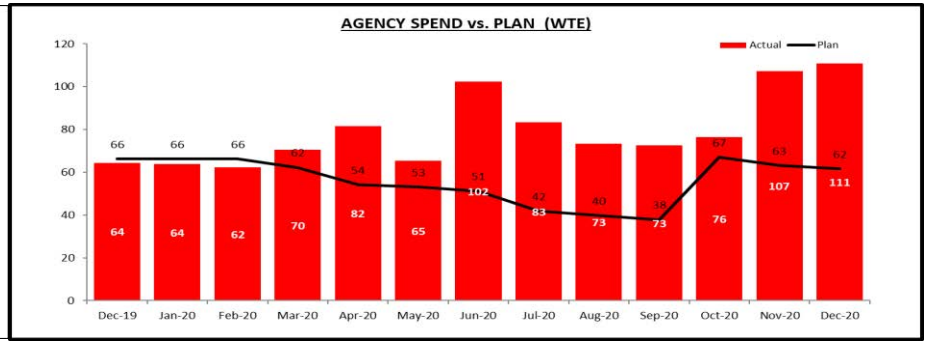




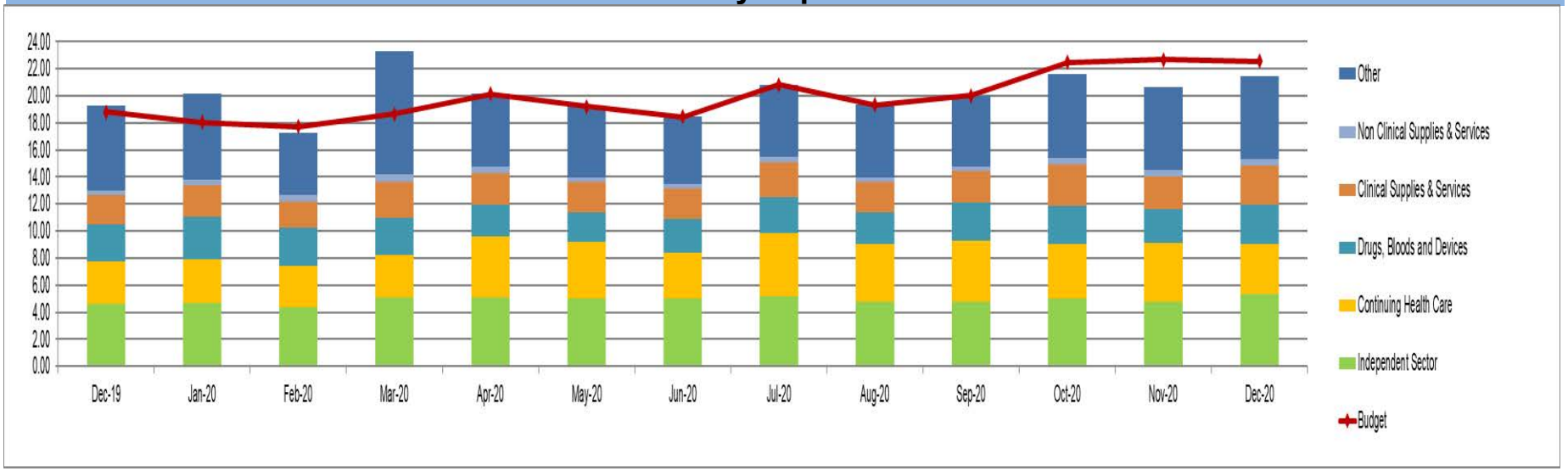








Non Pay Expenditure



Key Points

- Total non pay run rate in M9 (£21.48m) is £0.81m higher in comparison to previous month (M8 £20.68m), the details are below:
- There has been an increase in the run rate spend on Clinical supplies cost of £0.53m due to: higher spend of medical and sugical equipment and devices £0.27m in Theatres, Endoscopy, Cardiac Catheter suite, lab medicine managed service due to backdated charge and temporary increase of stock levels to mitigate Brexit impact £0.17m, TP cost of sales £0.12m (linked to production), dressings £0.04m, contract testing £0.04m and various clinical supplies £0.04m offset by lower chemical consumable cost £0.15m (mainly TP).
- Drugs cost increased by £0.34m due to higher usage within high cost drugs (£0.16m), cancer drugs (£0.10m), inpatient (£0.05m) and outpatient (£0.03m).
- Independent Sector cost increased by £0.53m in month due to higher residential stay cost of £0.30m (additional day in month), repatriation of clients and higher Domiciliary care costs £0.23m.
- Non Clinical Supplies cost increased by £0.03m due to: domestic materials, cleaning equipment and textiles £0.02m and patient provisions £0.01m; the cost increases are offset by cost reduction in the following:
- Placed People (Health including Continuing Healthcare) decreased by £0.56m due to reduction in demand caused by high number of placements ending contrasted to new packages during December.
- There is a net decrease of £0.06m within operating expenditure. Material movements are: £1.0m phase 3 investment slippage offset by increased provision due to change in discount rate £0.20m and reassessment of liabilities in respect of injury benefit provisions £0.57m and increase in CFHD alliance cost £0.17m.
- There is £6.23m of non pay costs year to date relating to COVID. This comprises of the following costs: testing £2.38m, remote management of patients £0.46m, increase in ITU capacity £0.59m, segregation of patient pathways £1.27m, locally procured PPE £1.15m, decontamination £0.20m, and various other £0.18m.

Cash and Working Capital

	YTD at month 09		
	Plan £m	Actual £m	Variance £m
Opening cash balance (net of working capital loans)	**(15.59)**	**(15.59)**	**0.00**
Capital Expenditure (accruals basis)	(23.21)	(16.56)	6.65
Capital loan drawndown	0.00	0.00	0.00
Capital loan repayment	(6.39)	(6.39)	0.00
Proceeds on disposal of assets	0.00	0.00	(0.00)
Movement in capital creditor	0.41	3.40	2.99
Other capital-related elements	2.61	0.01	(2.60)
Sub-total - capital-related elements	**(26.58)**	**(19.54)**	**7.04**
Cash Generated From Operations	15.76	18.13	2.38
Working Capital movements - debtors	4.25	4.25	0.00
Working Capital movements - creditors	28.02	46.15	18.12
Net Interest	(2.25)	(2.27)	(0.02)
PDC Dividend paid	(0.00)	(1.65)	(1.65)
Other Cashflow Movements	42.60	34.90	(7.70)
Sub-total - other elements	**88.37**	**99.51**	**11.13**
Closing cash balance	**46.20**	**64.37**	**18.17**

Closing cash balance	46.20	64.37	18.17
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)	**46.20**	**64.37**	**18.17**

Better payment practice code	**Paid in year**	**Paid within target**	**% Paid within target**
Non-NHS - number of bills	93,342	82,611	88.5%
Non-NHS - value of bills (£k)	179,858	151,574	84.3%
NHS - number of bills	1,289	792	61.4%
NHS - value of bills (£k)	11,676	4,804	41.1%
Total - number of bills	94,631	83,403	88.1%
Total - value of bills (£k)	191,534	156,378	81.6%

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. The working capital and interim revenue support facilities were converted to PDC in M06, improving the underlying cash position by £25.7m.

- Total capital-related cashflow is £7.0m lower than Plan. Accruals capex is £6.7m lower than Plan and the capital creditor has built up £3.0m higher than planned. These are partly offset by use of finance leases £2.5m lower than planned.

Other elements:

- Cash Generated From Operations is £2.4m favourable, due to EBITDA £2.4m favourable.

- Working capital debtor movements is in line with plan. This is principally due to reduced TP debtors £1.2m, partly offset by increased CCG debtors £0.5m and clinician's pension tax scheme debtor £0.7m.

- Working Capital creditor movements is £18.1m favourable to plan. This is principally due to increased deferred income (block income £3.4m, Infection Control £2.5m, HEE £1.2m) and increased payables (incl DPT dispute £3.4m, clinician's pension tax scheme provision £0.7m and payments delayed by the Christmas break).

- PDC Dividend paid is £1.7m adverse. This is due to a dividend having been taken unexpectedly in M08. The normal predictable schedule of Dividend payments has been disrupted by Covid.

- Other cashflow movements is £7.7m adverse to plan. This is principally due to PDC drawdown being £7.7m adverse, largely due to delayed PDC-funded capital expenditure and PDC funding being claimed later than planned.

Better Payment Practice Code. Performance has been adversely affected by the dispute with DPT.

	ISU	Target	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	1	0	0	0	3	2	2	2	1	0	1	3	14
Reported Incidents - Death	Trustwide	<1		0	1	1	1	0	2	2	2	2	2	1	0	1	12
Medication errors resulting in moderate harm	Trustwide	<1		0	0	1	2	0	0	0	1	0	0	0	0	1	2
Medication errors - Total reported incidents	Trustwide	N/A		47	54	60	46	19	24	40	41	39	51	51	53	32	350
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	1	2	0	1	1	1	3	4	5	6	7		28
Never Events	Trustwide	<1		0	0	0	0	0	0	0	0	0	2	1	0	0	3
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		4	1	5	3	3	4	1	4	8	5	5	2	4	36
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	2	0	1	0	0	0	1	0	0	0	0	2
Formal complaints - Number received	Trustwide	<60		14	35	22	21	2	3	12	17	16	17	17	13	10	107
VTE - Risk Assessment on Admission (Acute)	Trustwide	>95%		91.7%	91.7%	92.3%	90.5%	86.4%	92.1%	82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%	86.4%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		97.6%	98.9%	100.0%	97.6%	93.9%	96.2%	88.9%	94.2%	96.9%	87.8%	95.9%	93.4%	92.9%	93.5%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		102.6	93.5	83.1	112.6	125.4	81.7	105.7	90.9	74.8	87.8				96.1
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		90.4%	91.3%	89.2%	88.9%	87.3%	85.4%	89.8%	90.8%	84.0%	86.4%	86.5%	90.1%	89.7%	87.8%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		91.7%	92.9%	91.4%	91.3%	89.0%	87.0%	89.9%	92.2%	86.4%	87.7%	89.4%	84.8%	88.5%	88.3%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		0	204	108	0	4	0	12	0	20	262	23	0	30	351
Hand Hygiene	Trustwide	>95%		94.1%	96.1%	93.5%	94.9%	99.4%	98.9%	97.9%	97.2%	98.3%	98.9%	96.9%	97.8%	97.0%	97.9%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		76.9%	83.9%	82.4%	80.0%	80.0%	97.5%	91.7%	94.6%	74.4%	60.0%	74.5%	75.7%	73.5%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		84.5%	75.8%	79.6%	90.2%	66.7%	90.6%	79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%	80.4%
Follow ups 6 weeks past to be seen date	Trustwide	6400		7243	6391	6147	7056	8824	14211	15398	16408	17220	17408	17519	17229	17837	17837
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.0%		4.5%	4.5%		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.4%	4.3%	4.3%		4.3%
Appraisal Completeness	Trustwide	>90%		78.5%	80.1%	81.6%		71.6%	71.0%	75.6%	77.8%	78.4%	79.4%	78.4%	78.9%	80.4%	78.0%
Mandatory Training Compliance	Trustwide	>85%		90.4%	90.8%	90.4%		90.1%	88.0%	89.9%	89.9%	89.9%	89.7%	89.7%	89.6%	89.6%	90.3%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.4%	11.7%	11.7%		10.5%	10.5%	10.3%	10.8%	10.7%	10.3%	10.5%	10.7%	10.5%	

	ISU	Target	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		344	462	588	393	121	21	38	95	175	246	256			450
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		198	190	235	175	14	17	33	82	89	72	129			235
Carers Assessments Completed year to date	Trustwide	40% (Year end)		35.4%	36.6%	38.5%	39.6%	100.0%	100.0%	95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	16.2%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		192	202	191	194	197	223	217	219	221	200	214	221		219
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET					231			56			124				56
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET					6.1%			5.9%			5.4%				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%
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		556	558	530	520	532	515	553	559	561	560	576	599	599	561
Intermediate Care - No. urgent referrals	Trustwide	113		201	239	202	219	230	248	283	242	211	221	199	207	222	1201
Community Hospital - Admissions (non-stroke)	Trustwide	18/19 profile		212	211	186	202	138	172	221	206	260	262	274	193	242	996
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide							85.0%	83.1%	82.1%	81.8%	81.1%	80.0%	79.8%	77.6%	76.4%	76.4%
Proportion of carers receiving self directed support	Trustwide							100.0%	100.0%	95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	95.8%
% Adults with learning disabilities in employment	Trustwide							8.9%	8.9%	8.9%	8.7%	8.6%	8.8%	8.5%	8.5%	8.2%	8.2%
% Adults with learning disabilities in settled accommodation	Trustwide							79.3%	79.2%	80.0%	79.3%	79.0%	79.1%	80.2%	80.6%	80.5%	80.5%
Permanent admissions (18-64) to care homes per 100k population	Trustwide							21.5	21.5	27.0	18.9	24.3	20.2	20.2	14.8	18.9	18.9
Permanent admissions (65+) to care homes per 100k population	Trustwide							506.9	504.1	502.6	538.1	524.4	557.2	565.4	573.6	579.0	579.0
Proportion of clients receiving direct payments	Trustwide							23.7%	23.1%	22.9%	22.9%	22.7%	23.3%	23.6%	22.6%	22.4%	22.4%
% reablement episodes not followed by long term SC support	Trustwide							86.8%	85.6%	85.2%	87.1%	86.2%	85.9%	84.6%	85.2%	85.5%	85.5%
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		77.9%	76.2%	82.2%	86.1%	94.1%	96.5%	94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%	91.4%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		79.9%	79.8%	79.5%	76.2%	69.3%	62.2%	57.0%	53.5%	57.3%	62.1%	62.3%	64.2%	63.6%	61.2%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		85.9%	83.6%	75.3%	71.8%	71.7%	77.1%	80.9%	92.3%	86.3%	79.3%	67.9%	77.0%	76.4%	78.4%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		7.9%	10.2%	7.4%	11.3%	47.7%	54.3%	41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%	41.0%
Dementia - Find - monthly report	Trustwide	>90%		88.4%	81.9%	93.7%	93.5%	97.6%	98.1%	94.5%	60.8%	84.4%	89.2%	96.6%	94.4%	97.7%	90.2%

	ISU	Target	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		4	4	5	0	5	8	5	4	4	2	4	2	3	37
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		85.3%	74.8%	84.8%	87.1%	80.5%	93.6%	91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.5%	81.7%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		97.3%	97.1%	98.9%	95.1%	96.2%	100.0%	95.3%	97.4%	100.0%	95.9%	97.8%	86.6%	93.9%	95.1%
Cancer - 28 day faster diagnosis standard	Trustwide			71.9%	66.9%	74.5%	74.8%	47.1%	80.8%	81.5%	79.8%	72.4%	66.6%	72.7%	75.5%	75.2%	73.1%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		97.6%	96.8%	98.8%	99.0%	97.7%	99.2%	100.0%	99.4%	97.3%	97.4%	97.7%	99.0%	97.6%	98.3%
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%		95.2%	89.5%	93.5%	97.7%	93.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	95.9%	98.6%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		97.1%	86.2%	91.4%	100.0%	96.6%	96.2%	100.0%	96.4%	91.3%	100.0%	93.3%	96.3%	96.7%	96.4%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		100.0%	100.0%	85.7%	76.5%	73.3%	33.3%	66.7%	0.0%	100.0%	100.0%	60.0%	75.0%	66.7%	73.7%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			24	24	21	21	19	42	68	32	9	9	8	13	14	14
RTT 52 week wait incomplete pathway	Trustwide	0		71	80	43	53	93	192	344	524	745	892	1141	1277	1464	1464
On the day cancellations for elective operations	Trustwide	<0.8%		0.6%	1.2%	1.0%	2.1%	0.7%	0.6%	0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%	1.2%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		3	3	10	5	46	2	1	5	3	29	4	1	1	92
Bed Occupancy	Overall System	80.0%		98.6%	98.6%	97.8%	92.4%	54.6%	64.8%	74.7%	93.3%	86.7%	91.6%	82.4%	90.5%	89.8%	73.9%
Number of patients >7 days LoS (daily average)	Trustwide			120.1	128.1	130.3	119.8	100.5	70.8	80.9	76.5	89.3	94.9	94.0	95.4	95.1	70.8
Number of extended stay patients >21 days (daily average)	Trustwide			23.1	25.5	27.7	26.0	22.6	18.1	18.7	12.0	13.3	15.2	17.1	16.7	14.0	16.1
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		113	117	88	43	16	9	19	10	46	59	73	38	138	408
Ambulance handover delays > 60 minutes	Trustwide	0		14	14	7	5	1	0	4	1	3	0	14	1	19	43
A&E - patients recorded as >60min corridor care	Trustwide			463	495	335	115	0	0	0	0	0	0	0	0	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			158	182	136	32	1	0	6	0	1	10	16	4	18	56
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		3	1	3	1	0	0	0	0	0	0	1	0	1	2
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		3	4	5	0	4	6	4	1	5	2	4	2	2	30
Number of Clostridium Difficile cases - (Community)	Trustwide	0		1	0	0	0	1	2	1	3	2	0	0	0	1	10
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		64.1%	65.7%	62.0%	70.6%	76.9%	78.4%		73.6%	70.9%	61.1%	69.0%	64.1%	66.2%	69.5%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		36.8%	41.5%	40.5%	44.5%	57.1%	54.1%		46.3%	43.7%	35.0%	41.4%	41.6%	32.4%	43.7%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		81.8%	81.8%	95.5%	68.2%	95.5%	86.4%	90.9%	90.9%	90.9%	72.7%	100.0%	90.9%	86.4%	89.4%

	ISU	Target	13 month trend	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-6555	-9693	-13294	-23577	218	524	800	1323	1297	1220	-23	1420	2378	
Agency - Variance to NHSI cap	Trustwide			-1.07%	-1.01%	-0.98%	-0.87%	0.79%	0.87%	0.44%	0.39%	0.49%	0.38%	-0.10%	-0.20%	-0.20%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-2872	-4983	-7078	-9325										
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			7632	8191	9595	4249	567	1112	1813	2770	532	-236	1686	5147	6653	
Distance from NHSI Control total (£'000's)	Trustwide			-4616	-7648	-10926	-20367	0	0	0	0	0	0	112	1493	1858	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	-2000	0	0	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs PREVIOUS YEAR																	
Outpatients - New	Trustwide			-1.4%	1.1%	0.6%	-15.8%	-65.2%	-55.7%	-32.4%	-23.9%	-15.9%	-3.5%	-5.9%	4.2%	-1.0%	-22.6%
Outpatients - Follow ups	Trustwide			5.6%	3.0%	4.7%	-16.2%	-50.1%	-42.3%	-28.2%	-26.5%	-24.4%	-15.2%	-24.1%	-19.1%	-10.3%	-26.7%
Daycase	Trustwide			1.4%	-2.6%	1.5%	-23.7%	-62.2%	-57.7%	-33.6%	-20.0%	-23.3%	-13.8%	-21.5%	-18.8%	-10.4%	-29.1%
Inpatients	Trustwide			31.9%	16.8%	15.3%	-15.0%	-61.6%	-50.3%	-27.4%	0.3%	-29.6%	-8.9%	-35.0%	-33.2%	-9.6%	-28.2%
Non elective	Trustwide			14.9%	5.9%	11.6%	-10.9%	-44.4%	-35.5%	-21.4%	-16.0%	-6.0%	-0.1%	-8.2%	-14.2%	-10.9%	-17.4%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			400	450	368	358	430	512	567	479	409	472	424	421	461	
Intermediate Care GP Referrals	Trustwide			94	125	89	78	95	116	127	107	82	100	91	82	95	
Average length of Intermediate Care episode	Trustwide			14.987	14.172	14.281	14.035	10.308	8.9511	9.5382	11.718	13.541	21.422	14.736	10.905	11.603	
Total Bed Days Used (Over 70s)	Trustwide			10484	11576	10490	10430	11751	10385	9944	6821	7199	8613	8694	8169		
- Emergency Acute Hospital	Trustwide			6328	6879	6067	5938	6920	6336	5759	4486	4786	5220	5583	5203		
- Community Hospital	Trustwide			3174	3387	3147	3239	3168	2756	3031	2060	2224	3208	2943	2606		
- Intermediate Care	Trustwide			982	1310	1276	1253	1663	1293	1154	275	189	185	168	360		

Appendix 1 – System Finance Reports for Information

December 2020 / Month 9

FINANCE SCORECARD – TORBAY SYSTEM

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

FINANCE RUN-RATE – rolling 14 months

Average monthly expenditure is £19.5m for the last four month period compared to a previous averages of £19m (Apr to August 20) and £18m (Nov 19 to Mar 20). The material increase from April 20 is being driven by COVID related costs of circa £1.25m per month (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 CHC costs.

Pay has increased over the last four month period and is £0.2m (3%) per month higher than previous periods. This is due to inflationary uplifts and staffing levels being stepped back up to increase activity within Covid restrictions.

INCOME MONITORING

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.

Year to date the net expenditure is £153.2m, which against a revised budget of £157.6m is an underspend of £4.4m. This is being driven by, delayed implementation in additional investments to increase activity levels, NHSI centrally funding CT scanning costs, Infection Control funding being provided from Torbay Council and lower than anticipated CHC costs.

This underspend is forecast to increase to £6.8m by year end based on a continuation of CT costs being picked up nationally and Infection Control funds being received for the remainder of the financial year.

YTD / FORECAST REPORTING

Torbay System - Board Table of Key Metrics

	Drivers	Risk	Actions Taken
P&B ISU – Investment Slippage	Budget for months 7-12 contains non recurrent 'recovery' investment funding including outpatient and diagnostic initiatives. Delays and difficulties being experienced with investment implementation.	Under delivery of planned activity levels with potential knock on impact into 2021/22, with higher backlog numbers to be dealt with (operational & finance impact). Funding is only non-recurrent and specific for 2020/21 which will result in material underspend and missed opportunity.	Regular review with ADO & finance, teams have been submitting plans and following ECF processes to access funds. Slippage released at Month 9 to allow other ISU's to access/utilise.
P&B ISU – Labs Stock Levels	Impact on activity levels as a result of national strategies / approaches (lockdown etc.) make this an extremely difficult area to forecast. Also note that financial plan (months 7-12) was set on assumptions made during September. Stock levels have temporarily increased to mitigate impact of Brexit.	Expenditure and Income areas will have material variations to plan but for COVID-19 related elements, income should directly offset associated expenditure. Concern over supplies from Europe and associated price risk. Potential financial variation at year-end due to stock takes/adjustments.	Regular meeting in place to review with lab manager and finance. Appropriate COVID-19 funding being accessed through national channels (monthly in arrears). Service lowering stock levels as minimal impact experienced through Brexit transition.
Independent Sector	Increased costs YTD of circa 17% 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 discharge process.	COVID will continue to impact the IS and that providers will demand that temporary financial assistance measures are put on a more formal permanent basis. 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.	Tactical plan been developed and discussed with COO & DOF to meet new Hospital Discharge guidance with 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 current COVID / winter pressures, fatigue and annual leave requirements will be pivotal as we work through the winter period.

Focus Point – COVID Hospital Discharge & Council related (Torbay facing)

Months 1-9	£000's
Placement Costs (Scheme 1)	4,522
Placement Costs (Scheme 2)	748
Financial Assistance	806
TFM RES Void Payments	435
TFM DAD Void Payments	211
LW@H Premium	326
Infection Control	3,904
Additional Dom Care Support (includes Agincare)	262
Staffing - Assessments	32
Expenditure Total	**11,246**
Income - Torbay Council COVID Core	-1,068
Income - Torbay Council Infection Control	-3,904
Income – CCG (Hospital Discharge Process from M7)	-1,914
Income Total	**-6,886**
Net Cost to Trust (supported through COVID top up)	**4,360**

- **Year to date** spend of £11.25m, of which £4.97m has been funded by Torbay Council.
- From October, Hospital Discharge (Health COVID) costs (£1.92m) are to be reclaimed from the CCG.
- Net Cost to the Trust is £4.36m. This has been accounted for in the Trusts M9 financial position and supported through the COVID top up that was available between M1-6.
- Placement costs now split into 2 schemes. Scheme '2' commenced 1st September 2020 and any clients now discharged under the Hospital Discharge Process only get a maximum of six weeks funding.

- **Forecast** spend for months 10-12 of £4.0m and it is anticipated that Torbay Council will fund £2.1m of this. Within this £932K contingency held for market sustainability for winter resilience above infection control initiatives.
- Balance of cost (£1.9m) is Hospital Discharge related and will be financed by Devon CCG who have the facility to claim against Hospital Discharge National funding stream.
- Volatile area, especially placement costs due to client numbers being extremely variable (key driver of cost).

Months 10-12 Forecast	£000's
Placement Costs (Scheme 1)	628
Placement Costs (Scheme 2)	955
Infection Control	1,156
Financial Assistance	932
Additional Dom Care Support (includes Agincare)	174
Assessments (Staffing & Outsourcing)	176
Expenditure Total	**4,021**
Income - Torbay Council Infection Control (round 2)	-1,156
Income - Torbay Council COVID Core	-932
Income – CCG (Hospital Discharge Process)	-1,933
Income Total	**-4,021**
Net Cost	**0**

FINANCE SCORECARD

South Devon System view

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

FINANCE RUN RATE – rolling 13 months

Net run rate spend over the past quarter for the South system and Shared Ops is an average of £12.6m per month compared to Months 1-6 of £11.9m. Run rates reflect a higher level of spend due to the initial impact of the stepping back up of services, medical pay award and drug costs, but with M9 now starting to see the impact of the unplanned second covid surge mainly in pay costs. Run rates are expected to increase further in M9 - M12 due the impact and response to the covid surge and requirement of escalation. Some phase 3 activity now suspended, although revised plans in progress.
Month 08-09 pay run rate increase in £0.3m (3%) due to activity demand and escalation of covid, sickness (including those self isolating) and maternity. Non pay increase £0.2m (1.2%) mainly theatre supplies in expectation of phase 3 activity.

INCOME MONITORING

Contract Income has been blocked for months 1-6 at Trust level, and providers expected to breakeven. The finance architecture has been set by NHSI for months 7 - 12, with activity set as per phase 3, with income fixed levels for areas of specified COVID spend, with the expectation of a year end break even position.

INNOVATION PROJECTS AND £ CIP

The NHSI plan for 20/21 had an expectation of cIP delivery, but due to the impact of COVID this has been paused. There is however Operational focus to develop robust savings and transformation plans for 21/22 with schemes expected to deliver from April 21.

FORECAST MONITORING

Forecast outturn baseline expenditure is £134m for South Devon System ISUs, and Shared Operations £11m with a predicted underspend of c£0.3m. Cost base increases M10-M12 with PYE impact of the Urgent Care Pathway business case (MRU/SRU), response to second covid surge additional substantive and temporary staffing costs, and other winter pressures. Some phase 3 activity suspended due to covid surge. Current focus is response to covid surge, managing capacity to deliver Phase 3 plans where possible. Slippage on Phase 3 investments funds currently £1m in Q4.

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South Devon System - Board Table of Key Metrics

	Drivers	Forecast/ risk	Actions Taken
Newton Abbot ISU	Expenditure increase due to impact of covid surge, patient acuity and demand in ED. High sickness levels including self isolation with an increased reliance on bank, agency and locums. Phased recruitment of MRU staff challenges with recruitment delays.	Impact of second covid surge, pressures in ED, staff sickness. Forecast £1.2m adverse against H2 budget due to MRU business case funding not allocated, increase ED agency costs, medical locum costs, staff absence, impact of covid.	MRU recruitment drive in process although slower than expected and further reliance on agency costs. Response to covid surge and escalation plans in progress. On going review of medical pay and temporary costs Finance, ADO and Ops teams.
Coastal ISU	Implementation of Phase 3 investments to increase activity mainly elective and OP have slipped / paused due to impact of Covid surge. Challenges due to escalation and stepping down of some services and reconfigured wards to support covid.	Phase 3 investments are non recurrent, and under delivery of activity this year will impact on activity and demand into 2021/22, and in addition to an existing growing back log and 52WW. Forecast expenditure £1.2m favourable against H2 plan due to investment slippage.	Full review of phase 3 investment funding with Ops teams, and under continual review to meet changing demands and response to covid. Escalation costs yet to be defined pending imminent decision and approval. Use of MSH under review due to covid surge.
Moor to Sea ISU	Expenditure run rate increase in pay as nursing vacancies filled, and Rapid response staff for winter pressure, Senior medical pay arears.	Increased Rapid Response support with fixed term contracts which may go over year end. Winter pressure demands, and impact of COVID surge. Potential reliance on agency staff.	Winter planning in progress, enhance hospital discharge and Rapid Response teams additional support, response to covid surge. Review underway of winter pressures income and allocation.
Shared Operations	Expenditure run rate remains relatively constant but with an increase in pay M9 due to recruitment in OP offset with reduction in non pay due to Medical Electronic recharges.	Run rates reviewed and consistent going into Q4. Risk of winter pressures and impact of covid surge.	Winter planning for seasonal demand, responding to covid Trust requirements and pressures under review, and subject to change.

South System and Shared Operations ISU run rates are forecast to increase in M10 – 12 (c£800k pm) reflecting the current impact of second covid surge, with some Phase 3 plans delayed and paused. Risk of staff resilience, sickness, annual leave requirements and reliance on temporary staffing to manage Covid and other winter pressures.

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 £47k lower (1%) than the expenditure incurred in month 8.

Innovation Projects/ £ CIP

No CIP has been reported to NHSI for months 01-09 due to the impact of COVID and, none is forecast / expected for the current financial year.

INCOME MONITORING

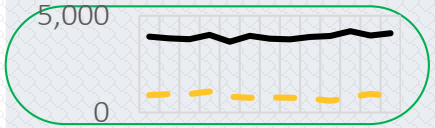
NHS Contract Income has been blocked for months 1-6 at Trust level and providers were expected to break even during that period. In M7 top-up income for COVID was incorporated into the main contract Patient income in M9 is £384k (0.9%) higher than M8.

FORECAST £ REPORTING

The forecast indicates that pay & non pay expenditure will be £9,084k less than the 19/20 outturn.

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.	Reduced level of income and increased Covid-19 costs have now been reflected in the forecast, reducing the risks in this area.	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 year. Education & overseas nursing recruitment activity now re-started.	HIS spend in the FOT has now been adjusted to reflect the likely costs. Future impact of reduced training provision.		
Reserves	Top up income for Covid-19 & relaunch of services now incorporated into main contract.	The bulk of income is now fixed with changes largely driven by offsetting changes in related cost.		
Other ISUs	R&D trials activity reduced due to Covid-19.	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 consistent, with a small increase in M9 of £137k (3%) from the previous month, but consistent with the average for the year.
Non pay has seen a reduction in M09 of £297k (6%) due to a reduction in costs attributable to changes in reserves in M8, offset by increased costs arising from changes in the assumptions applied to injury benefit and early retirement provisions.

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 financial agreement is to continue with the Alliance partners meaning TSD will pick up any overall surplus / deficit.

Month 08-09 run rate changes: Pay reduced by (£14k) representing (1.5%); non pay increased by (£202k), 18.4% which is an increase from DPT re net CAMHS expenditure recharge and a M8 VAT reclaim benefit; 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 £1k adverse movement between Month 08 to 09.

INNOVATION PROJECTS / £ CIP

No CIP has been reported to NHSI for months 01-09 due to the impact of COVID and, £0 is forecast / expected for the current financial year.

FORECAST £ REPORTING

The forecast for M9-12 includes the filling of known approved vacancies and any spend known to vary from the previous 9 months run rate.

Pay cost forecast to increase by £58k 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 decrease of (0.3%) (£4k). *Mainly switch from non pay to pay of recharge costs and removal of any recharges to the Alliance partners.*

Other income fall of 53.8% £7k, *miscellaneous receipts*.

Total Expenditure
Other Income
Contract Income

CFHD Table of Key Metrics

CFHD

Drivers

Expenditure Run Rate remains constant: Staff 'consultation' plans remain on hold, although the Senior Team are commencing internal discussion on options; ongoing high level of vacancies. IT investment project now moving forward but no costs included in this years revenue account.
Forecast includes additional VO income for CAMHS MHIS Wave 2 and 3 for Months 7-12 spend.

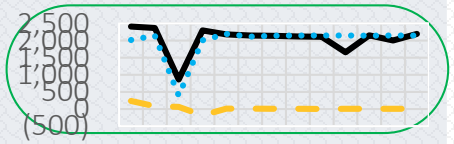
FOT/Variance Risk

Forecast for approved fulfilment of vacancies and non commencement of any workforce changes / consultation. New IT system pending approval of business case but no cost expected this financial year.
ASD WL VO work could incur costs above income levels if CCG do not agree any additional VO income.

Actions Taken:

Vacancies under constant review.
IT requirements will be assessed as service is evaluated.
Constant evaluation being made on VO works.

Tick charts 13 Month Actual Rolling Run Rate (£m)



Due to the Covid block financial situation for M01-06, the Alliance did not distribute any surplus position to its partners. The Alliance Partners have agreed that this principle will now continue to the end of this financial year; any surplus or deficit generated will fall to the TSD Trust I&E bottom line. M01-06 generated a year to date surplus of (£590k); Month 07-09 (£110k) surplus, total CFHD surplus for M01-09 (£700k).

- Pay costs are fairly static, averaging at £906k per month (Month 09 was £892k); 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.
- Non-pay costs are fluctuating at a very small level; average £1,155k per month, Month 09 £1,300k; Month 09 run rate has increased with an increase in net expenditure costs for the CAMHS service provided by DPT;
- Other income run rates reduced in Months 01-02 but have remained constant since then, averaging at £8k per month (Month 09 was £6k)
- Contract Income remains on plan with no change in monthly run rates.

FDG COVID REPORT DECEMBER 2020:

COVID Cost Area	£'000 M9 Actual	£'000 M1-9 YTD Actual	£'000 Plan 1-9 (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	£375	£10,951	£11,729	(£778)
Swabbing	£79	£191	£206	(£15)
Lab Testing	£375	£1,134	£1,631	(£497)
Hospital Discharge and Infection Control Tranche 1 & 2	£1,012	£11,246	£13,466	(£2,220)
Nightingale	£37	£37	£0	£37
TOTAL	**£1,878**	**£23,559**	**£27,032**	**(£3,473)**

COVID Pass through Income	£'000 M9 Actual	£'000 M1-9 YTD Actual	£'000 Plan 1-9 (note 1-6 has a zero variance)	£'000 Variance to Plan
Lab Testing	£375	£1,134	£1,631	(£497)
Hospital Discharge and Infection Control Tranche 1 & 2	£992	£5,816	£6,965	(£1,150)
TOTAL	**£1,367**	**£6,950**	**£8,596**	**(£1,646)**

COVID Recharge Income	£'000 M9 Actual	£'000 M1-9 YTD Actual	£'000 Plan 1-9 (note 1-6 has a zero variance)	£'000 Variance to Plan
Nightingale	£37	£37	£0	£37
TOTAL	**£37**	**£37**	**£0**	**£37**

COVID NHSI Return M9 (note this return is a year to date cumulative report and excludes * HD and IC):

Covid-19 Expenditure	Total Expenditure Actual 31/12/2020 YTD £'000	COVID-19 In Envelope (10a1) Actual 31/12/2020 YTD £'000	Outside Envelope COVID-19 (10a2) Actual 31/12/2020 YTD £'000	Reimbursement Nightingale COVID-19 (10a3) Actual 31/12/2020 YTD £'000	Total COVID-19 Actual 31/12/2020 YTD £'000	COVID-19 % of Total Expenditure Actual 31/12/2020 YTD £'000
Purchase of healthcare from NHS and DHSC group bodies	10,773	0	0	0	0	**0.0%**
Purchase of healthcare from non-NHS and non-DHSC group bodies	33,412	0	0	0	0	**0.0%**
Purchase of social care	52,236	1	0	0	1	**0.0%**
Staff and executive directors costs	193,515	5,992	48	37	6,077	**3.1%**
Non-executive directors	137	0	0	0	0	**0.0%**
Supplies and services – clinical (excluding drugs costs)	22,210	3,135	1,086	0	4,222	**19.0%**
Supplies and services - general	3,601	608	0	0	608	**16.9%**
Drugs costs (drug inventory consumed and purchase of non-inventory drugs)	23,068	142	0	0	142	**0.6%**
Consultancy	0	0	0	0	0	**0.0%**
Establishment	2,049	105	0	0	105	**5.1%**
Premises - business rates payable to local authorities	1,503	0	0	0	0	**0.0%**
Premises - other	13,727	855	0	0	855	**6.2%**
Transport	1,916	79	0	0	79	**4.1%**
Depreciation	9,378	0	0	0	0	**0.0%**
Amortisation	2,254	0	0	0	0	**0.0%**
Impairments net of (reversals)	0	0	0	0	0	**0.0%**
Movement in credit loss allowances	483	0	0	0	0	**0.0%**
Audit fees and other auditor remuneration	96	0	0	0	0	**0.0%**
Clinical negligence	5,753	0	0	0	0	**0.0%**
Research and development - staff costs	1,158	0	0	0	0	**0.0%**
Research and development - non-staff	24	1	0	0	1	**2.3%**
Education and training - staff costs	6,873	0	0	0	0	**0.0%**
Education and training - non-staff	1,266	15	0	0	15	**1.2%**
Lease expenditure	945	27	0	0	27	**2.9%**
Redundancy costs - staff costs	0	0	0	0	0	**0.0%**
Redundancy costs - non-staff	0	0	0	0	0	**0.0%**
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT	743	0	0	0	0	**0.0%**
Charges to operating expenditure for off-SoFP PFI/LIFT schemes	0	0	0	0	0	**0.0%**
Other	7,832	181	0	0	181	**2.3%**
Total operating expenditure	**394,952**	**11,142**	**1,134**	**37**	**12,314**	**3.1%**

COVID Revenue Forecast at month 9

The Trust is forecasting the H2 plan M10 -M12.
However due to the variances shown in the above M9 COVID tables what the latest forecast is showing is that spend is likely to increase in further responses to Covid in Q4, and although underspent YTD costs will increase during the Covid surge and winter Flu months.

Costs are also likely to increase for Nightingale due to response to Covid, but will be recharged to RD&E and therefore cost neutral to the Trust.

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 December 2020 the sum of uncommitted contingency monies totals £30k.

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 £11.25m and towards this Torbay Council has contributed £4.97m. This is summarised in table 1 with more detail provided below.

COVID Costs and Income	December YTD Expenditure £'000	December YTD Council Contribution £'000	Net Cost to the Trust supported through COVID top up (1-6) £'000s	Supported through the CCG (M7-12) (Hospital Discharge) £'000s
Hospital Discharge	7,342	1,068	4,360	1,914
Infection Control Fund (Round 1)	2,748	2,748	-	-
Infection Control Fund (Round 2)	1,156	1,156	-	-
Total	**11,246**	**4,972**	**4,360**	**1,914**

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 and has now been fully passported to providers in-line with the grant conditions (80% funding element must be for Care Homes and CQC – regulated community care providers).

Area	YTD Total
	£000's
EXPENDITURE	
Residential & Nursing Home VOIDS	435
Dom Care & Supported Living VOIDS	211
Early Discharge Packages Torbay - Scheme 1	4,522
Early Discharge Packages Torbay - Scheme 2	748
Dom Care LW@H Rate Uplift	326
Additional Dom Care Support (includes Agincare)	262
Financial Assistance (all providers)	806
Infection Control (Round 1)	2,748
Infection Control (Round 2)	1,156
Staffing - Assessment	32

Expenditure Total	**11,246**
INCOME	
Torbay Council COVID Core	1,068
Torbay Council – Infection Control Fund (Round 1)	2,748
Torbay Council – Infection Control Fund (Round 2)	1,156
CCG – Hospital Discharge process	1,914
Income Total	**6,886**
Net Cost to the Trust (supported through COVID top up)	**4,360**

Looking ahead for the remainder of the financial year this area will continue to see cost incurred but it is anticipated this will be matched with an appropriate income stream. Initial forecast spend & income for months 10-12 that will be transacted through the Trust, is reproduced in the table below:

COVID Costs and Income	Forecast (M 10-12) Expenditure £'000	Forecast (M10-12) Council Contribution £'000	Forecast (M10-12) Supported through the CCG (Hospital Discharge) £'000s
Hospital Discharge – Scheme 1	804	-	804
Hospital Discharge – Scheme 2	1,129	-	1,129
Infection Control Fund (Round 2)	1,156	1,156	-
Provider Support	932	932	-
Total	**4,021**	**2,088**	**1,933**

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 / keep the appropriate resource to undertake the assessments especially as nursing capacity to undertake the assessments might be redirected to support frontline areas. In addition to this, what will be the timing of the assessments?

- **Scheme 2-** What will be the number of clients that will pass through this process (post-Christmas surge), 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 9 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 9 is an estimate awaiting internal validation with estimated Allocate costs of £175k included.

Currently we don't have a stock control system fully implemented 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 procurement and financial reporting.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: December Mortality Score Card			Meeting date: 27th January 2021
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Patient Safety & Experience Lead		
Report provenance	The report will be reviewed at the next Mortality Surveillance Group Meeting.		
Purpose of the report and key issues for consideration/decision	The report provides a record of Trust mortality and monthy assurance		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors is asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	X	**Valuing our workforce**	
Improved wellbeing through partnership	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 and SHMI are within normal limits. Season mortality is lower than in previous years due to the lockdown

Report title: Mortality Surveillance Score Card		Meeting date: 27th January 2021
Report sponsor	Medical Director	
Report author	Patient Safety & Experience Lead	

1.0 Introduction & Data Source

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

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

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

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

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

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

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

Safety Indicator		Data Source	Target	RAG
Appendix 1 • A. Hospital Standardised Mortality Rate (HSMR)	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	15 positives
Appendix 5 • Mortality Reviews and Learning Quarterly data. Quarter 3 will be reported in Februarys Mortality Score Card		Quarterly Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) remains within the accepted range for our population for the current month. The effects of Covid are evident in the previous HSMR and SHMI data for March & April 2020, namely in the reduced hospital activity/spells that followed lock down.

The data after these periods show a reduction in hospital deaths with a gradual returning to normal levels. This normalisation sees both the HSMR and SHMI return to the 100 average. The unadjusted mortality data is showing lower than normal mortality due to the Covid lock down, especially in December.

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 July 20 monthly benchmark and analysed by HSMR 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 Oct 19 to Sept 20 (current month)
Chart one (as below) shows a monthly view of HSMR over time. Data extraction 19/1/2021

The latest month's data, Sept 2020, has a relative risk of **96.3** and is below the 100 average**.** The Trusts trend over time is average below the 100 mark

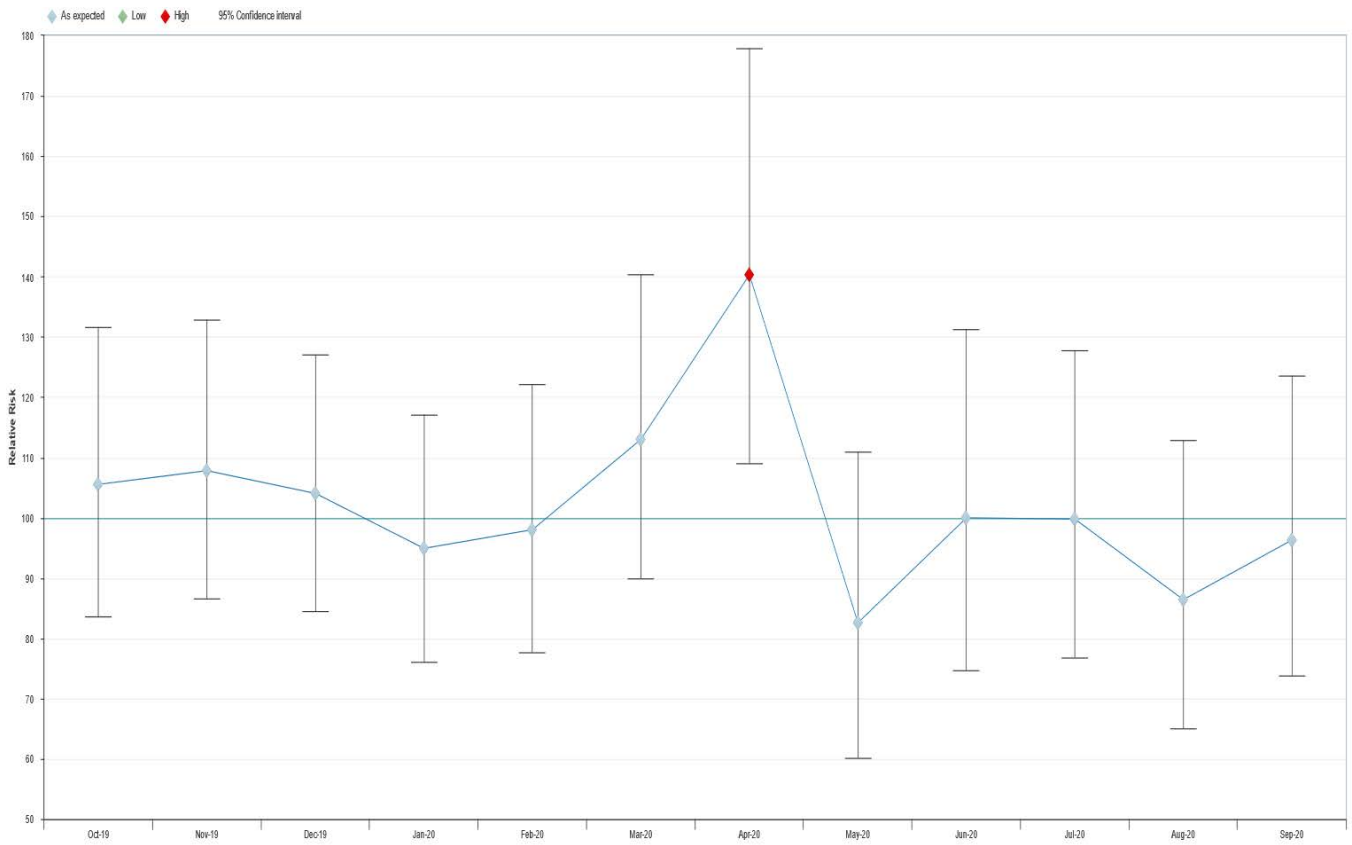


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is below the 100 line

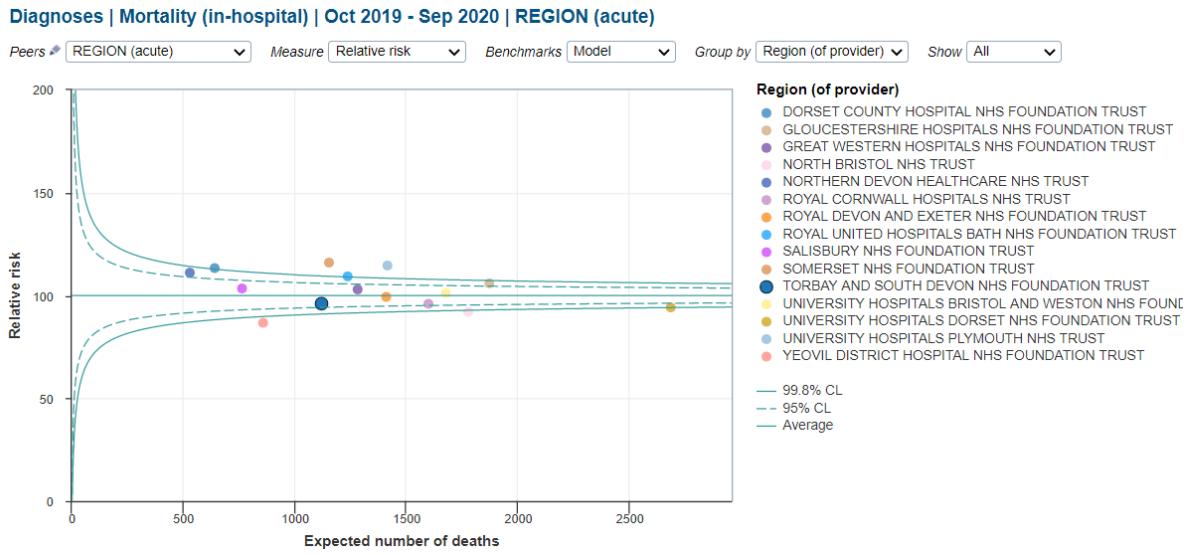
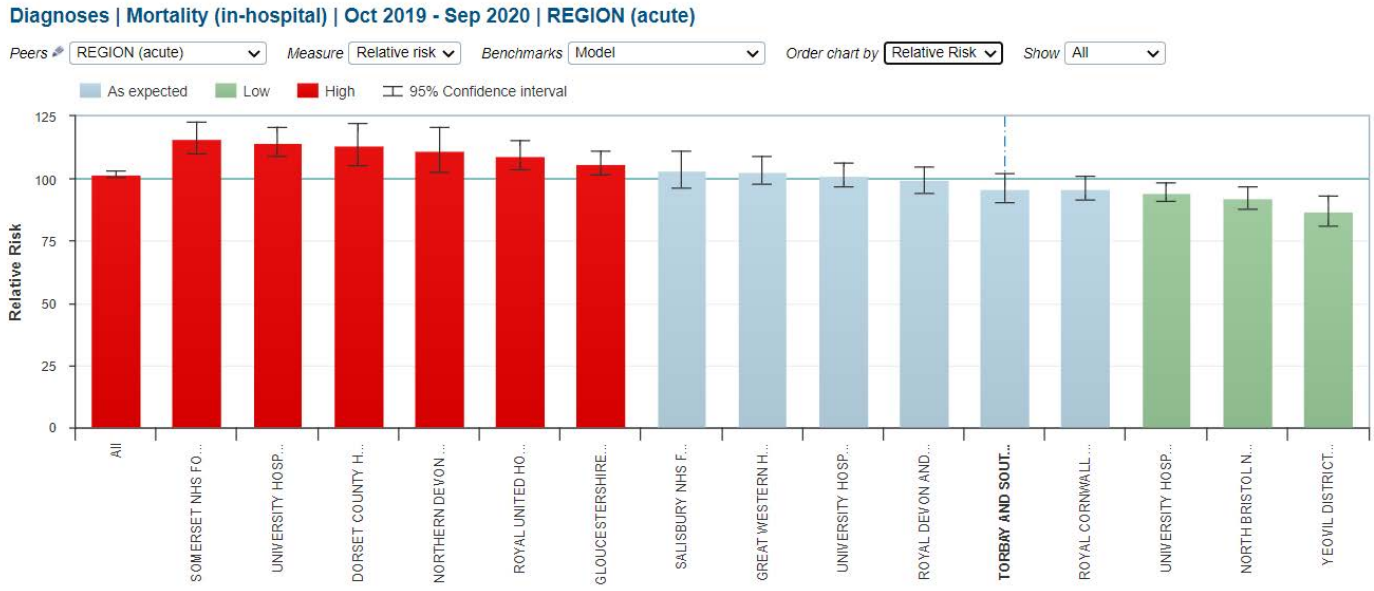


Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart.



1B Summary Hospital Mortality Index (SHMI) Reporting Period Aug 2019 – July 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* **Aug 2019 – July 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 l one, which exceeds the 100 mark. This data period is from the first wave of Covid in Q1 of 2020/21 when hospital activity was greatly reduced. The data period thereafter, shows SHMI returning to its normal variance, as activity increased

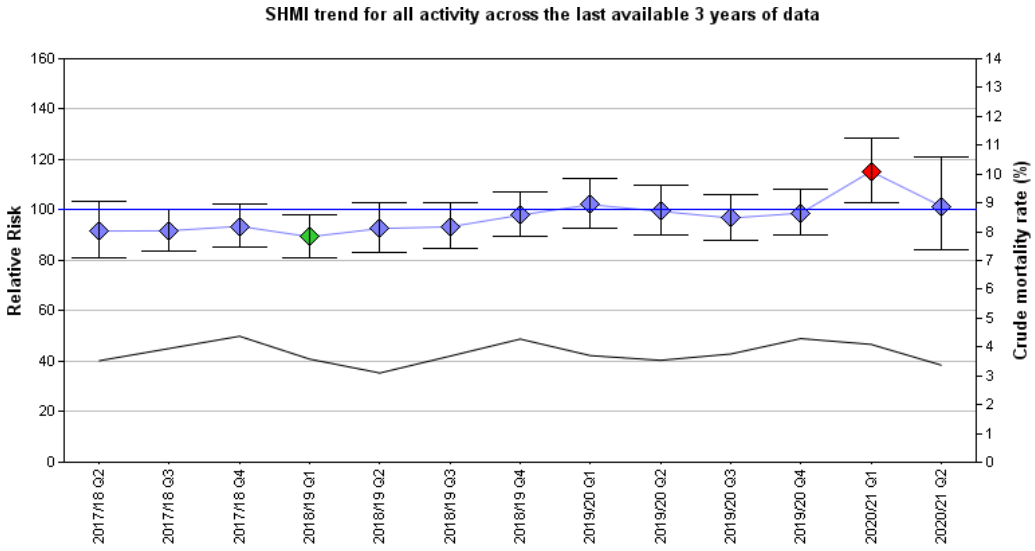


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison, all within normal limits

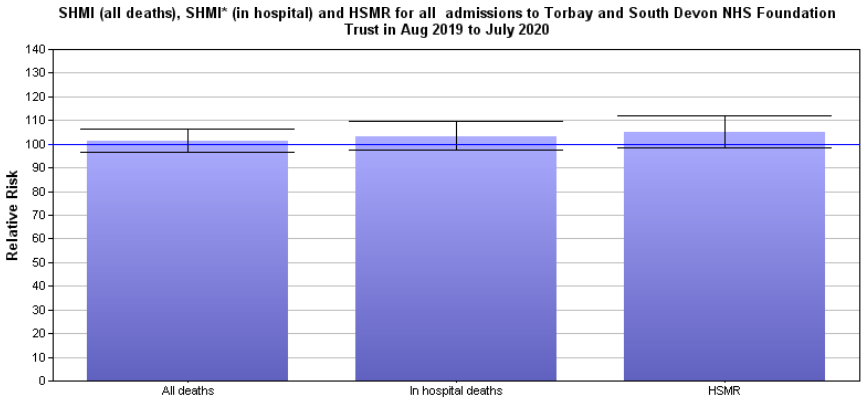


Chart 6, as below, expresses the 12-month rolling SHMI data by time period and is showing a SHMI to be running as expected.

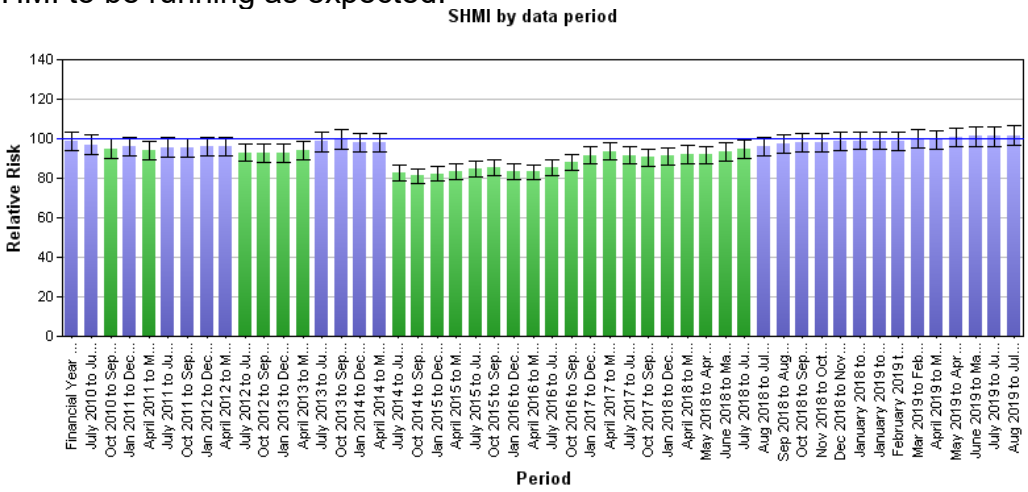
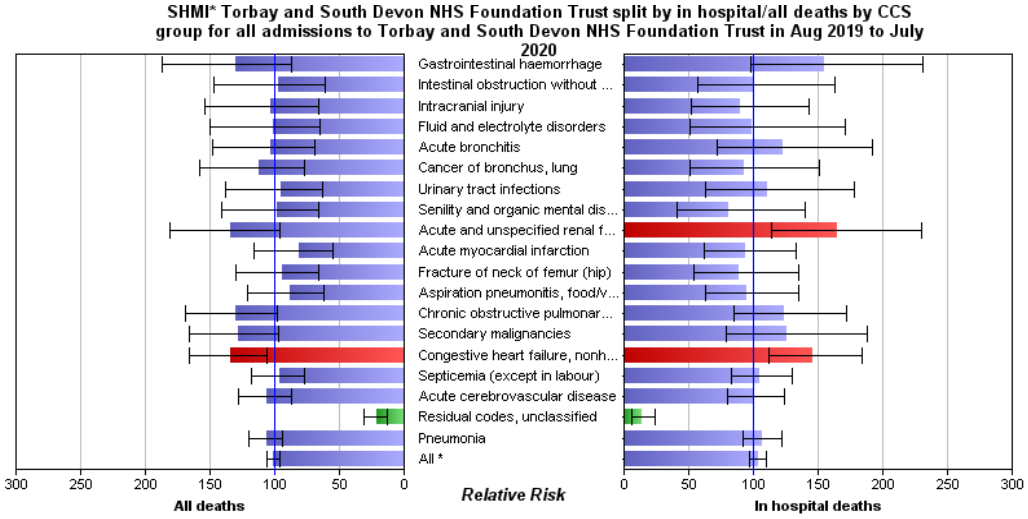


Chart 7 allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). All areas are within *normal range* or are performing *better than the norm*. The flag on 'Congestive Cardiac Failure' is historic and coding have been reviewed and cannot see anything that was entered incorrectly; 'renal failure' was flagged in the last report and coding are reviewing the ICD10 codes, this will then go to the Surveillance group for next actions.



4.0 Appendix 2 – Unadjusted Mortality Rate

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

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

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

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

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

This chart includes the Covid lock down period and highlights a rise in deaths in March and April 2020. The rise in March 2020 is partly explained by a reduction in activity due to Covid changes and in April 2020 this is mainly due to reduced activity. Thereafter, the normal variance returns as activity increases again.

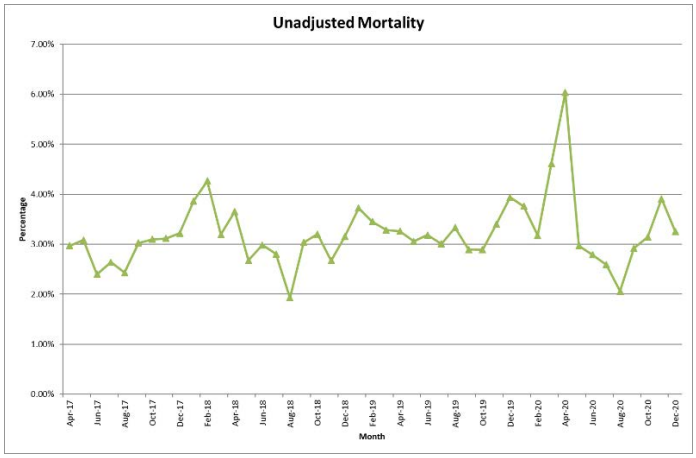


Chart 9 Below, the monthly number of hospital deaths is shown. This shows a rise in March and April 2020 due to Covid, before decreasing to lower than average numbers. In-hospital mortality remains relatively low, thus far, this winter.

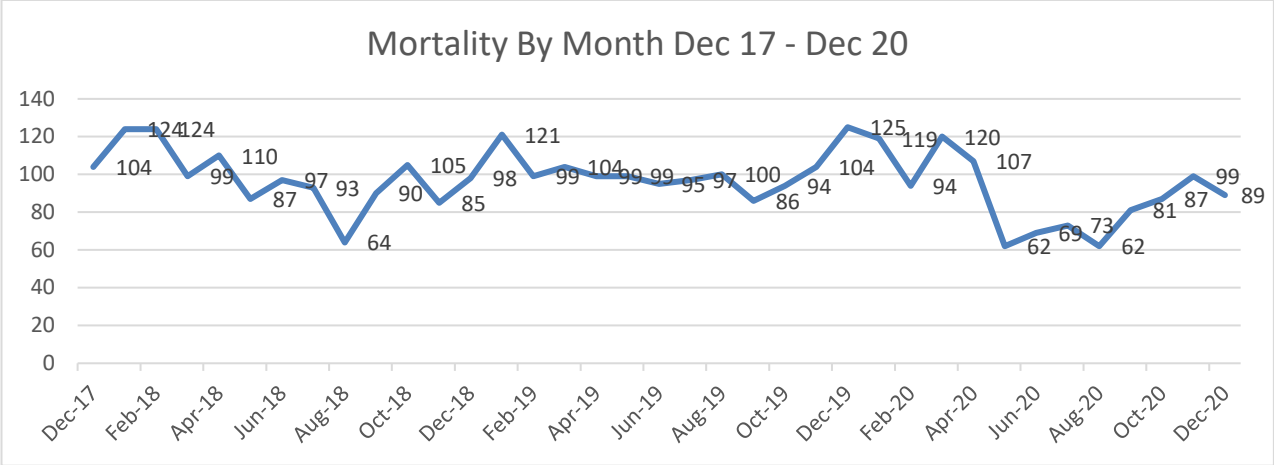


Table 2 – overleaf, looks at location of hospital deaths by area/ward. The data in this chart is as expected for each area with no obvious deviations or unexpected findings.

Table 2 –highlights mortality by location by month and are within the expected norms for each area
Please note Elizabeth ward is now open and taking patients

Wards / Month	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	Oct-20	Nov-20	Dec-20	Med Avg	sparkline
AINSLIE	2	2	1	2	1	0	1	2	4	1	1	5	2	3	1	5	2	3	0	1	0	2	0	2	1	2	
ALLERTON	6	0	4	7	4	8	4	5	4	3	9	3	7	10	6	6	3	5	4	7	5	3	7	8	8	5	
BRIXHAM	0	0	1	4	1	0	1	0	0	2	1	1	0	1	2	0	1	1	1	0	0	0	3	4	2	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	6	11	11	11	
CROMIE	6	1	2	5	4	4	5	2	2	4	4	5	6	3	2	3	13	0	1	1	0	1	8	8	7	4	
DART	2	2	2	5	0	3	1	1	1	2	2	2	1	1	0	3	1	0	0	0	0	1	1	1	0	1	
DAWLISH	5	6	3	3	3	2	0	0	5	2	4		2	6	4	0	3		1	3	1	1	0	0	0	2	
DUNLOP	3	6	5	4	7	5	5	4	3	5	7	5	9	8	2	10	4	6	6	3	5	6	2	4	3	5	
ELIZABETH	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	
EAU3	3	12	5	5	8	1	6	10	13	8	6	7	6	5	6	7	3	3	6	2	4	1	0	0	0	5	
EAU4	8	6	5	5	7	6	8	8	8	3	5	15	11	6	8	13	3	3	5	7	6	11	7	7	9	7	
ELLA ROWCROFT	0	1	1	1	0	1	2	1	0	1	0	0	0	1	0	1	3	2	1	0	2	0	4	3	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	0	0	0	1	
GEORGE EARLE	16	17	12	11	11	8	12	9	5	10	7	14	16	14	12	11	6	5	5	7	5	9	14	16	9	11	
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	5	6	12	8	
MIDGLEY	10	11	9	14	10	9	9	11	11	9	8	10	17	12	9	7	4	8	11	10	3	13	13	10	7	10	
SIMPSON	8	10	9	7	10	6	6	7	10	8	6	2	12	5	6	13	5	2	4	7	4	7	6	10	8	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	1	3	2	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	3	0	1	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	0	2	3	1	
TURNER	10	8	6	2	8	9	5	7	6	7	7	6	8	6	8	5	1	0	0	0	2	4	5	2	3	6	
WARRINGTON	1	5	3	6	3	10	2	2	0	0	0	0	0	4	6	2	7	0	0	0	1	0	2	2	0	2	
Grand Total	**98**	**121**	**99**	**104**	**99**	**99**	**95**	**97**	**100**	**86**	**94**	**104**	**125**	**119**	**94**	**120**	**107**	**62**	**69**	**73**	**62**	**81**	**87**	**99**	**89**	98	

5.0 Appendix 3 - Dr Foster Alerts

Dr Foster utilises an alerting system, as below. Triggers are raised when the expected number is exceeded by the actual number and Dr Foster also provides a guide should an alert occur. In the first instance the coding on each patient is looked at and amended as necessary, second to this is a notes review to confirm cause of death and coding.

For December there are no new alerts flagging

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 19 Jan 2020, all of the 15 indicators are within the expected norm and none are flagging an alert.

Table 4

Indicator	Volume	Observed
Accidental puncture or laceration	51708	55
Deaths after surgery	382	23
Deaths in low-risk diagnosis groups	19364	33
Decubitus ulcer	7342	386
Infections associated with central line	10168	0
Obstetric trauma - caesarean delivery	541	0
Obstetric trauma - vaginal delivery with instrument	221	16
Obstetric trauma - vaginal delivery without instrument	1000	39
Postoperative haemorrhage or haematoma	12602	4
Postoperative hip fracture	10347	1
Postoperative physiologic and metabolic derangement	10089	0
Postoperative pulmonary embolism or deep vein thrombosis	12879	21
Postoperative respiratory failure	9026	4
Postoperative sepsis	215	1
Postoperative wound dehiscence	441	0

7.0 Glossary of Terms

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

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

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

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

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

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Report to the Trust Board of Directors			
Report title: Assurance Framework for Seven Day Hospital Services			Meeting date: 27th January 2021
Report appendix	Appendix 1 – Reporting Template		
Report sponsor	Medical Director		
Report author	System Medical Director (South Devon)		
Report provenance			
Purpose of the report and key issues for consideration/decision	This is a report on the progress made by Torbay and South Devon Foundation Trust in relation to seven-day hospital services (7DS). This programme supports providers of acute hospital services to tackle variation in outcomes for patients admitted to hospitals in an emergency, at the weekend and during weekdays. This work is built on 10 clinical standards (CS) developed by the NHS Services, Seven Days a Week Forum in 2013. Four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high-quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week. Full details of all the clinical standards are available at: https://improvement.nhs.uk/resources/seven-day-services-clarification-four-priority-clinical-standards/ In addition to the 7DS clinical standards for all emergency patients, there are 5 urgent network clinical services which have been given priority: hyperacute stroke, paediatric intensive care, STEMI heart attacks, major trauma and emergency vascular surgery. The Trust reports on hyperacute stroke and STEMI heart attacks. Other urgent clinical services are provided by neighbouring Trusts. The seven-day services work is a major quality improvement initiative for all NHS acute Trust in England. Trusts must demonstrate progress in providing safe and effective emergency care to patients seven days a week. Full explanation of the new Board assurance framework can be found at: https://improvement.nhs.uk/documents/3494/7DS_Board_assurance_guidance_v2a.pdf		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements	
Strategic objectives supported by this report	

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

Is this on the Trust's Board Assurance Framework and/or Risk Register			
Board Assurance Framework	x	**Risk score**	16
Risk Register		**Risk score**	

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

Report title: Assurance Framework for Seven Day Hospital Services		Meeting date: 27th January 2021
Report sponsor	Medical Director	
Report author	System Medical Director (South Devon)	

1. Introduction

The report provides a summary of the progress in the development of 7 day working since July 2020:

- Assessment of all emergency patients by a consultant within 14 hours of admission is monitored in real time in acute medicine ("O" drive) and General Surgery (Clinical Portal). Between 60 and 70% of patients are recorded as being seen by a consultant physician within 14 hours of referral (depending on the week of admission). It is likely this is an underestimate of performance as the data requires manual entry into the "O Drive". Since March 2020 Consultant physicians are on site until 8:30 PM every evening Monday to Friday and 6 PM on weekdays.
- Consultant directed diagnostic tests (CS5) were available within an appropriate time scale for emergency patients in >90% of cases achieving the national target.
- Consultant directed interventions (CS6) such as critical care, interventional radiology and interventional endoscopy were available to emergency patients 7 days a week in 100% of cases.
- On-going consultant review of patients with high dependency needs were provided twice a day in 100% of patients.
- Consultant job plans in General Surgery, Trauma and Orthopaedics and Paediatrics should enable consultant review of all emergency patients every day. In medicine, consultant job plans enable daily consultant review of patients in the Emergency Department and Emergency Assessment areas. Weekend review of patients on the inpatient medical wards is potentially available between 12:00 and 14:00 although this depends on the demand on physician time by the acute assessment wards. This potential conflict can contribute to low discharge rates at weekends and consequent problems with emergency flow. This has been mitigated by the addition of a second "discharge" registrar at weekends. Review of patients in whom consultant review would not affect the patient pathway is delegated to other members of the multidisciplinary team.
- Management of STEMI heart attacks achieved over 90% compliance with all four of the priority clinical standards.
- Management of hyperacute stroke did not meet the 90% target for standards 2 and 8. Management of hyperacute stroke is subject to an STP development.

Progress against clinical standards has been measured by a biannual self-assessment survey by acute Trusts reporting to NHS England since 2016. In November 2018 NHSE recommended that Trust Boards should provide direct oversight of 7DS progress. This process consists of a standard template to assess progress in delivering 7DS which is then assured by the Trust Board before submitting results to regional and national 7DS teams. The new 7DS board assurance framework should be completed bi-annually, with sign off by the Trust Board before submission.

2. Discussion

The 10 seven-day CS and five network standards are designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. 4 standards (**in bold**) are priority standards to improve patient safety. Our performance is captured at Appendix 1.

1. Patient experience Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals within 14 hours of admission.

2. **Time to first consultant review. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.**

3. MDT review All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team. overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours

4. Shift handovers: Handovers must be led by a competent senior decision maker, with multi-professional participation. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

5. **Diagnostics Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.**

6. **Intervention / key services Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions.**

7. Mental Health Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

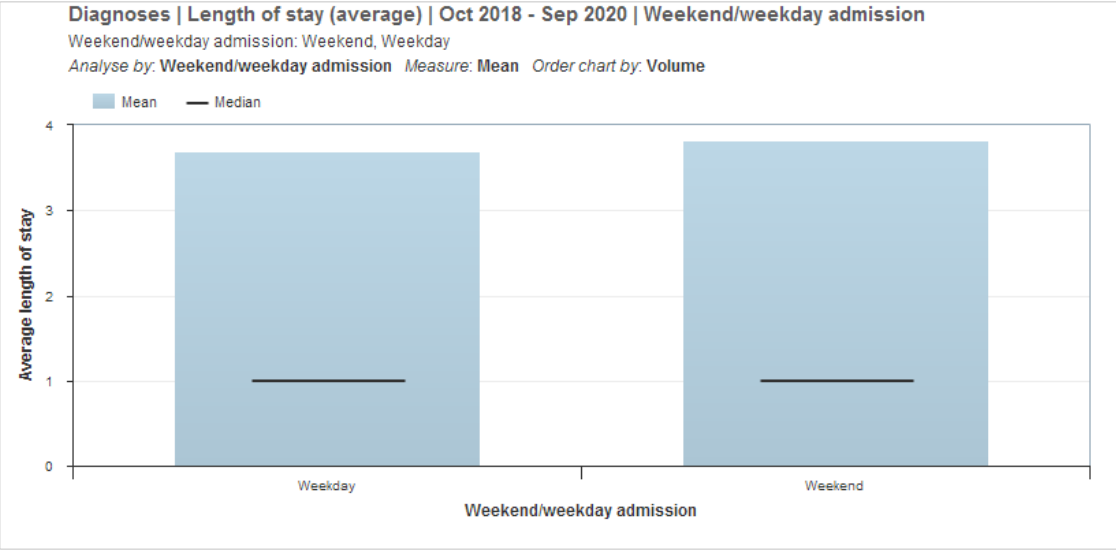
8. **Ongoing review All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.**

9. Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

10. Quality improvement All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

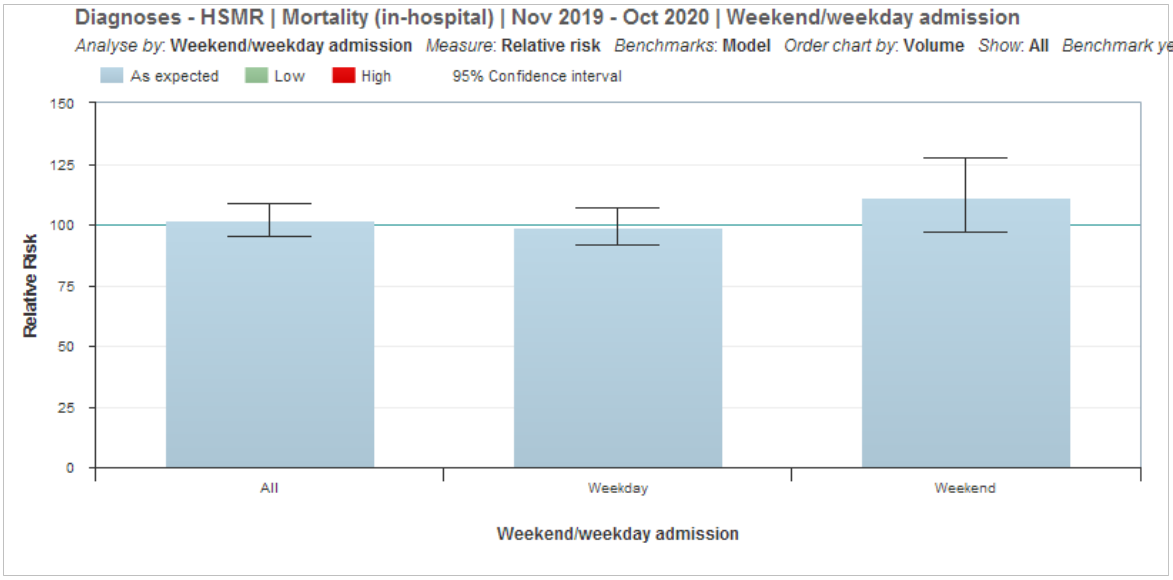
As an organisation we have reported on our performance in achieving the **priority standards** since 2016. Over this time, our performance has improved particularly around the 14-hour standard to consultant review (standard two). Job planned consultant time to front door patients has increased in medicine and surgery in particular, and the development of the medical receiving unit and is acute surgical unit are also designed to improve performance in this key standard. COVID 19 has provided additional impetus to change. Performance has also improved in diagnostics (particularly in access to echocardiography and MRI scans) and is ongoing. Work is ongoing to improve performance (for example by improving consultant cover on cardiology wards at the weekend).

One purpose of these standards is to support patient flow and improve patient safety. Average length of stay is similar for both weekday and weekend. These are lower than National averages (linked to model of care and perhaps driving our slightly higher readmission rates).



Mortality is slightly higher at the weekend both locally at TSDFT and across with wider CCG. Local data is not significantly different from the national picture (thus represented in blue) and the explanation is likely to be multifactorial (partly sicker patients presenting later at the weekend, partly models of care (well patients admitted for semi elective procedures during the week increasing the weekday denominator and thus reducing the mortality rate, and some environments where low risk admitted patients are cared for (for example Ricky Grant day care unit and historically AMU being closed at the weekend).

TSDFT



A deep dive into weekend mortality data, trying to examine these variables in planned.

There remains some way to go particularly in the “non-priority” standards. Patient experience, for example in the availability of social care professionals, access to the wider multidisciplinary team (i.e.: medication reconciliation, speech and language therapy, dietetics and routine imaging), and support services across the ICO is different at the weekend. Potentially delivering a true seven-day service across the ICO, would not only improve patient experience, but may reduce the number of inpatient beds we require. Hence development of seven-day working strategy is an integral part HIP2.

This report is the fourth of a new Board Assurance Process. A further report to assess progress against standards is planned for July 2021 Board.

3. Recommendations

The Board is asked to note the report and to receive a further report in July 2021.

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	We are compliant in this standard in paediatric admissions, however are not compliant in surgical, and general medical admissions with the reported performance around 70% rather than 90%. This reflects an improvement in performance over the last few years, and job planned consultant time for front door review has improved. Currently the demand among medicine to staff a Covid wards has removed some acute medical staff from the front door.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Echocardiography is available at the weekend for critical patients and urgent patients (through the consultant cardiologist on-call, and many of our ITU consultants) however routine echocardiography is not available over the weekend. MRI is available for critical and urgent patients over the weekend, however is not available for routine patients. During the week routine patients may expect to wait more than 24 hours for an MRI at present.	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	No the test is only available on or off site via informal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	We are compliant with this standard. Interventional radiology is delivered by a joint rota shared across between the SEND network. Renal replacement therapy is delivered either on the intensive care unit for patients with other intensive care needs, or by transfer to Exeter for appropriate patients.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Twice daily review is available on ITU, Medical receiving unit , and SRU for applicable patients. Once daily review for appropriate patients in other clinical environment is available (In the vast majority of patients), and time is provided in consultant job plans. Where this would not affect the patient pathway reviews at the weekend may be delegated to other members of the multidisciplinary team. Weekend review in stable patients is not available in cardiology patients, on Dunlop ward (but is available for patients on the chest pain unit and coronary care unit).	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards, highlighting areas where progress has Over the past five years there has a significant improvement in the services available at the weekend. These include the availability of the multi-professional MDT to support shared decision-making, and the availability of support services. Many of the service is however still do not reach the 14 hour standard record recommended, with a reduced availability of services at the weekend. Some services for example medicines reconciliation at the weekend and the availability of primary care services remain very limited. been made since 2015

7DS and Urgent Network Clinical Services

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

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Key challenges remain the delivery of stroke specialist consultant review, and twice daily consultant review of hyperacute stroke patients at the weekend

Template completion notes

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Safety and Governance Report (1 July – 31 December 2020)			Meeting date: 27 January 2021
Report appendix	Appendix 1: Ockenden Interim Report/NHSEI 12 Immediate Actions – TSDFT Position, Future Actions and Next Steps https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf Appendix 2: Perinatal Clinical Quality Surveillance Model – Minimum Dataset Appendix 3: HSIB/PMRT Action Plan Appendix 4: Saving Babies Lives Care Bundle v2 Oct 2020 Tracker Survey		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity System (LMS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the Trust Board of the work being undertaken by the Maternity Governance Group. It also informs the membership of recent recommendation made within the Ockenden Interim Report (Dec 2020) and the proposal for change in relation to reporting, scrutiny and oversight • The paper specifically sets out the Trust position and compliance with the Ockenden Report and key priority areas, noting 2 areas of noncompliance with a view to full compliance on 31st January • Setting out the Trust position in relation to perinatal mortality and morbidity, specifically reduction in still births. • Progress and next steps with regard to achievement of CNST key safety actions An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒

<table>
<tr><td>Recommendation</td><td>The Trust Board of Directors are asked to:

• Discuss key findings from the Ockenden Report and note the progress and compliance position with regard to the priority areas
• Note the key quality and safety issues identified in the report
• Note progress and next steps with regard to the CNST process
• Approve the proposals made for reporting of governance, safety and quality within the maternity and neonatal services for Torbay and South Devon NHS Foundation Trust</td></tr>
<tr><td colspan="2">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td>
<table>
<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td>x</td></tr>
<tr><td>Improved wellbeing through partnership</td><td>x</td><td>Well-led</td><td>x</td></tr>
</table>
</td></tr>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td>N</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>N</td><td>Risk score</td><td></td></tr>
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<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td>x</td></tr>
</table>

CNST set clear safety standards for Trusts in relation to maternity services. Demonstration that these standards have been met result in the Trust being eligible for a rebate on their maternity CNST contribution and a share of any unallocated funds.
</td></tr>
</table>

Maternity Safety and Governance Report (1 July – 31 December 2020)		Date: 27 January 2021
Report sponsor	Chief Nurse	
Report author	Associate Director of Midwifery and Professional Practice/Head of Midwifery and Gynaecology	

1.0 Introduction

Safety, quality and experience has always been a priority for the maternity and neonatal services at Torbay and South Devon NHS Foundation Trust. The recent publication of the Ockenden Interim Review of Maternity Care at Shrewsbury and Telford, December 2020) sadly provides all maternity and neonatal providers and commissioners with evidence of the devastating effects and consequences that poor culture and governance can have on outcomes of care. The Trust, along with the maternity and neonatal services welcome the publication of the Ockenden Interim Report as it provides the opportunity to review our governance approach to optimise the safety, effectiveness and experience of our maternity service.

Following the development of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme in 2017, the maternity service has a well-established process for providing a quarterly maternity governance report to ensure that the Trust Board is sighted on maternity safety, progress and achievements.

This is the first quarterly report since the publication of Ockendon and will be constructed to meet the recommendations within the report. We plan for this to be an iterative process, firstly as the Board and maternity services work to review, amend and strengthen existing reporting mechanisms.

This quarterly report will look back at the period 1 October 2020 - 31 December 2020

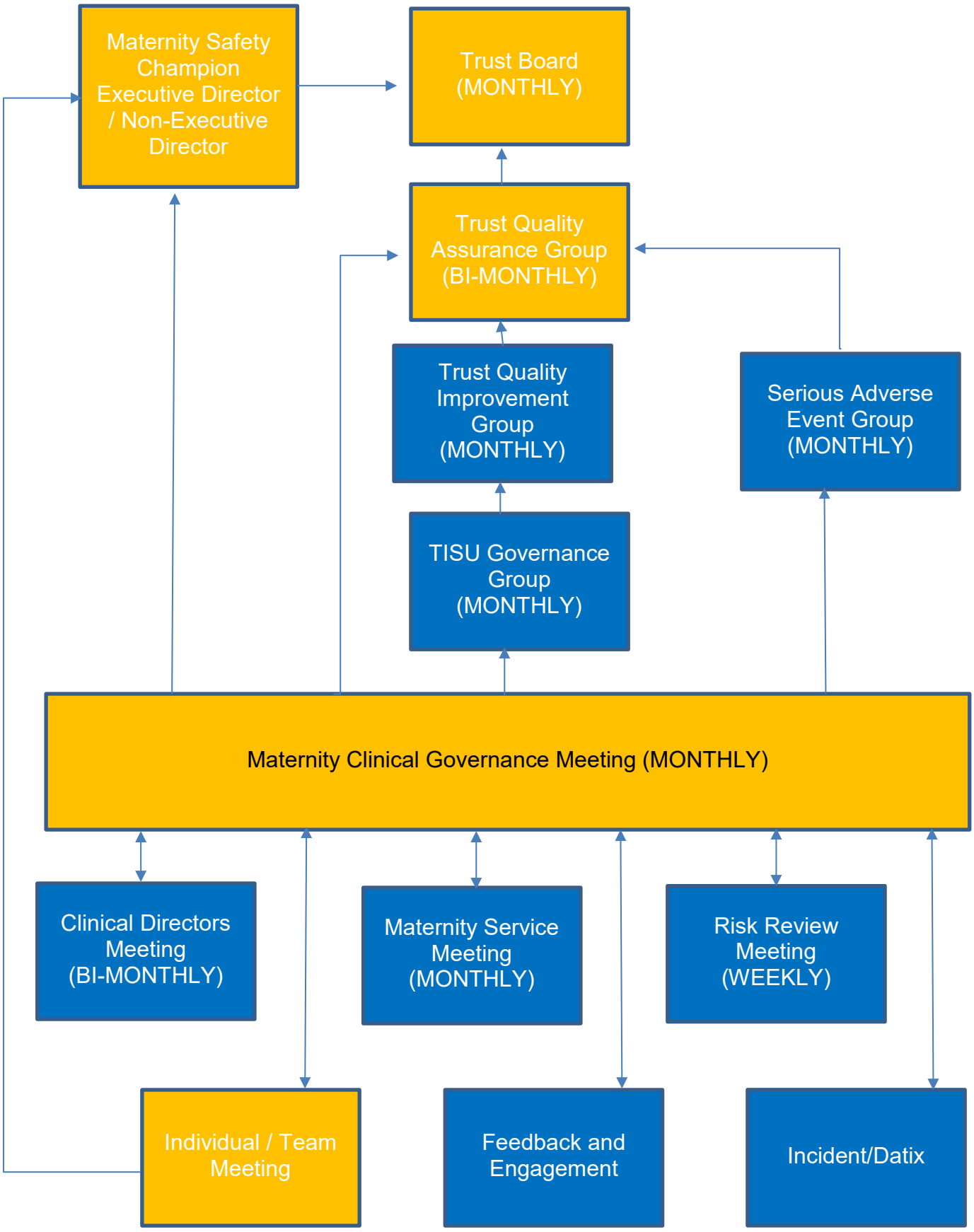
2.0 Review and monitoring of safety within maternity services

2.1 Governance process

The Chief Nurse has Trust responsibility for safety, quality and experience, and as such is the named Executive Maternity Safety Champion. A named Non-Executive Director has been appointed with a clear remit to champion safety within maternity services.

The maternity services have a clinical service lead who is a Consultant Obstetrician, who also undertakes the role of obstetric safety champion, and a Head of Midwifery (Associate Director of Midwifery and Professional Practice). Additionally, there is a midwifery safety champion and neonatal nursing and medical safety champions. The maternity safety champions meet bi-monthly. The governance processes are supported by a dedicated Clinical Governance Co-Ordinator (Senior Midwife). The governance pathway is shown within diagram 1.

Diagram 1: Maternity Governance - Floor to Board



This quarterly report will initially be submitted to the Quality Assurance Committee, whereby representative of the Board will be provided with opportunity to interrogate safety and quality metrics, information and governance process within the maternity service. The report will also be submitted to the Trust Board for further assurance. In addition, the maternity safety champions meet bi-monthly with the Executive Board Safety Champion, the Chief Nurse.

2.2 Ockenden Interim Maternity Review

In 2017, the Secretary of State for Health and Social Care commissioned a review assessing the quality of investigations relating to newborn, infant and maternal Harm at the Shrewsbury and Telford Hospital NHS Trust. Initially the review comprised of 23 families, however, this was expanded in 2019 and the final review will encompass care of over 1000 families.

The review is still on-going, however a number of emerging themes have been identified and that needed to be addressed by the Trust involved and by the wider maternity community across England. Therefore, an interim report was published on the 10 December 2020, which outlined seven themes and 25 Immediate and Essential Actions.

On the 14 December 2020, NHSEI Chief Operating Officer, Chief Nursing Officer and National Medical Director wrote to all Trusts. They had identified 12 urgent clinical priorities from the immediate and urgent actions be implemented by 5pm on 21 December 2021.

As an organisation we are always striving to optimise the safety, effectiveness and experience of our maternity service and therefore welcome the interim Ockenden report. We were able to provide assurance of implementation of 7 of the 12 actions by 21 December 2021 and included a clear time scale for implementation of those that the Organisation were not be able to achieve within the timeframe. The Trust compliance benchmarking is noted in Table 1.

Table 1: Trust Compliance with 12 Urgent Clinical Priorities

Theme	Immediate actions	Compliance	Planned compliance date
1) Enhanced Safety	a) Perinatal Clinical Quality Surveillance Model	Non-compliant	As soon as PCQS is launched
	b) All maternity SIs are shared	Partial compliance	31 January 2021
2) Listening to Women and their Families	a) Service user feedback, coproduce local maternity services	Compliant	
	b) Named non-executive director	Compliant	
3) Staff Training and working together	a) Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Partial compliance	31 January 2021
	b) MDT training schedule is in place.	Compliant	

	c) Funding allocated for maternity staff training / CNST MIS is ringfenced.	Partially compliant	31 January 2021
4) Managing complex pregnancy	a) Named consultant lead and process for audit	Compliant	
	b) Maternal medicine specialist centres	Compliant	
5) Risk assessment throughout pregnancy	a) Risk assessment, PSCP and audit	Compliant	
6) Monitoring Fetal Wellbeing	a) Lead midwife and a lead obstetrician in place	Non-compliant	31 January 2021
7) Informed Consent	a) Pathways of care posted on the trust website.	Compliant	

A detailed analysis of the Trust's position and actions planned were provided to NHSEI and are detailed in Appendix 1. The submission was signed off by the chair of the Devon Local Maternity and Neonatal System (LMNS).

Within the letter dated 14 December 2020, the Trust were also required to provide a further submission on 15 January 2021 detailing progress and also confirmation of maternity staffing in line with Birthrate Plus ® establishment recommendations. This includes the completion of a large assurance framework document. The response is in the process of being completed, however, the Regional Chief Midwife has advised the Head of Midwifery that in recognition of the increasing pressure on the system due to COVID-19 the submission date has been extended to the 15 February 2021.

The Ockenden Interim Report makes clear recommendations for Trusts in relation to oversight and scrutiny by the Trust Board. We have already begun to implement change to ensure that the Board receive appropriate information to have oversight and scrutiny. We recognise that this will be an iterative process as updated or new systems and processes embed.

The maternity service, in conjunction with the safety champions will also begin to benchmark and review the Trust position in response to the remaining 13 immediate and essential actions

2.3 Perinatal Clinical Quality Surveillance Model

As part of the Ockenden Review and the NHSEI 12 urgent actions (Appendix 1), a model has been proposed to improve oversight of safety metrics within Maternity and Neonatal Services. This includes publication of a minimum reporting data set for maternity, which is detailed within Appendix 2.

The Perinatal Clinical Quality Surveillance (PCQS) Model is based on three principles, with principle one relating to trust level, principle two at system level and principle three at regional level.

Principle one focuses on strengthening trust level oversight for quality, with 6 requirements:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

The team are committed to meeting this requirement and the local maternity dashboard will be amended to include the minimum dataset requirements (Appendix 2). This will be included within our monthly maternity governance report and reported within the quarterly maternity safety governance report.

2.4 Trust Board Reporting – Quality and Safety within Maternity Services

In light of the Ockenden Interim Maternity Report and wider guidance relating to quality and safety reporting to the Board, there will need to be a change in the reporting of maternity metrics and safety and quality issues.

The key changes with effect from February 2021 will involve oversight of all maternity SIs, a monthly review of maternity and neonatal safety and quality dashboard following the PCQS model and enhanced staffing and safety & governance reports.

It is proposed that the dashboard will incorporate the PCQS and 3 key safety indicators. These will be still birth rate, caesarean section rate and smoking status at time of birth.

The proposed reporting schedule is detailed in table 2.

Table 2: Proposed Reporting Schedule

	Maternity Governance Meeting	Torquay ISU Meeting	Serious Adverse Events Meeting (SAE)	Quality Improvement Group (QIG)	Quality Assurance Committee	Trust Board	Devon Local Maternity and Neonatal System
Serious Incidents Report & Summary	Monthly	Monthly	Monthly	Monthly	Bi-monthly	Monthly (Private)	Monthly
Quality and Patient Safety Metrics	Monthly	Monthly		Monthly	Bi-monthly	Monthly	Monthly
Maternity staffing	Monthly	Monthly		Monthly	6 monthly	6 monthly	
Overarching Maternity Safety & Governance Report	Quarterly	Quarterly		Quarterly	Quarterly	Quarterly	

2.5 Serious Adverse Events

2.5.1 Perinatal Mortality Review Tool (PMRT)

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

We write to all parents to advise them that a review will take place. They are given the opportunity to provide a perspective about their care and raise any questions that they have. We have learnt that not all parents wish to provide their perspective of care, or, indeed, may change their mind. Following completion of the review, we invite the parents to a follow up meeting to discuss their care and the findings of the local review.

2.5.1.1 PMRT - Notifications
During this reporting period (October - December 2020), we had one case that met the reporting criteria. This was a baby that was diagnosed with a rare fetal abnormality in early pregnancy. The parents declined a termination of pregnancy and the baby died in utero at 30 weeks and was stillborn late in December. Duty of candour has been undertaken with the parents, and this includes seeking the parent's perspectives and any concerns they have about their care. This will be used to inform the review that will be undertaken.

2.5.1.2 *PMRT – Completed Reviews*
We had one completed review, a Baby who died in May 2020 and the investigation was undertaken by HSIB. The PMRT was undertaken by a multidisciplinary review team on 12 December 2020 and an action plan developed (attached Appendix 3). The PMRT did not identify any additional findings to that of the HSIB review and report.

2.5.2 Healthcare Safety Investigation Branch (HSIB)

2.5.2.1 Referrals to HSIB

HSIB continue to investigate births and Maternal deaths that meet their referral criteria. In the reporting timescale of October-December 2020 we had no cases that met the criteria.

2.5.2.2 Finalised investigation reports from HSIB

During this time period, we have received one report 4 December 2021. This relates to a baby that received therapeutic cooling following birth in June 2020. We have written to the family with an outline of the actions taken in response to the HSIB report recommendations to the Trust. This report has also been submitted to the Trust's Serious Adverse Event Group as part of our normal governance process.

This new report along with four previous reports recommends that the Trust should ensure that placentae are sent for pathological examination including histology in line with national guidance. As explained in previous reports, the maternity team have explored how to achieve this but there is no service in place locally. This has been escalated to the Devon Local Maternity & Neonatal System, but there has currently been no resolution as yet. The maternity service has escalated this to the SAE Group have raised this with the local commissioners.

2.5.2.3 Quarterly Engagement Visit with South West Maternity Investigation Team

In December 2020 we met with the South West HSIB Maternity Investigation Team to learn about the progress of HSIB investigations nationally. We learnt that the number of cases that we have reported were within the expected number for our size Trust. The HSIB team were complimentary on how the Trust worked with the HSIB team during an investigation in providing information and supporting staff through the process.

2.5.3 NHS Resolution

From the 1st April 2020 it was no longer necessary for trusts to report Early Notification (EN) cases to NHS Resolution. This decision was reviewed in September 2020 and national agreement made to extend the current reporting arrangement until March 2021. As a service we will report all cases that meet the EN criteria to HSIB during this time. HSIB will triage all cases and prioritise those where there is evidence of harm to the baby and will share these cases directly with NHS Resolution.

2.6 Safety Improvement

2.6.1 Maternity and Neonatal Health Safety Improvement Programme

The maternity and neonatal services work on the Maternity and Neonatal Health Safety Improvement Programme has moved into Phase 2. An online event was held in December 2020, and a further on-line event focusing on optimisation and stabilisation is being held in March 2020.

Work continues on the Obs Cymru QI Programme (Obstetric Bleeding Strategy for Wales) aiming to reduce harm and variability in the management of postpartum haemorrhage. Weighing blood loss, on scales that have been purchased as part of this safety initiative, is now part of routine practice and this is evidenced in the Maternity records. As our next step, we have now purchased a Haemacue point of care machine to monitor Mother's haemoglobin levels prior to discharge home.

The Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) Project is a new neonatal care bundle which aims to have a significant impact on brain injury and mortality rates amongst babies born prematurely. The bundle consists of 10 elements. We have now introduced and improved the rates of early breast milk by ensuring babies receive the mothers expressed breast milk within first 6 hours of life. We are currently working towards optimising delayed cord clamping for vaginal deliveries.

2.6.2 Saving Babies Lives Care Bundle

Saving Babies Lives Care Bundle Version 2 (SBLCB v2) was launched in March 2019. This builds on the existing bundle, but adds a fifth element (preventing risk of preterm birth) for implementation. Full implementation of the care bundle is expected by 31 March 2021 and is included in the revised 2020/21 CNST incentive scheme, which was published on 30 September 2020. This can be viewed by accessing the NHS Resolution website https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

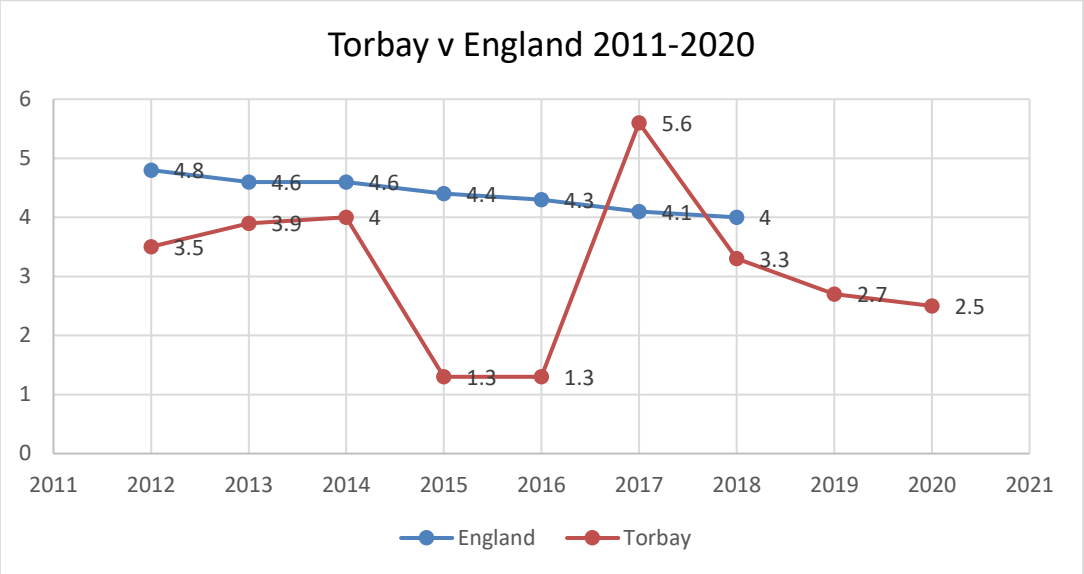
Following the initial benchmarking exercise, it was identified that it would not be possible to implement all aspects of the bundle without investment. An additional substantive Obstetric Consultant has been recruited to and commences in post in January 2021. A successful bid to the LMNS provided one year's funding of a 0.4wte Band 7 Midwife and 1.0wte sonographer. Recruitment is taking place during January 2021. On-going funding for these posts will need to be agreed as part of the Trust business planning process.

The SBLCB Version 2 tracker survey was initially paused but has now recommenced with data from September 2020. The SBLCBv2 quarterly report submitted in October 2020 demonstrated 73% compliance with the standards. Detail of compliance can be seen in Appendix 1. The recruitment of the above posts will enable us to move closer to compliance for each standard and we are on track to achieve full compliance by 31 March 2021.

2.6.3 Stillbirth Rate

One of the aims of SBLCB v1 and v2 is to reduce the number of still birth. Our 2020 annual data is now available and has shown that the still birth rate has reduced at TSD for the 3rd year in a row. This is shown in Table 3 (Note: national comparative data is not yet available for 2019 or 2020)

Table 3: Annual Stillbirth Rate per 1000 births

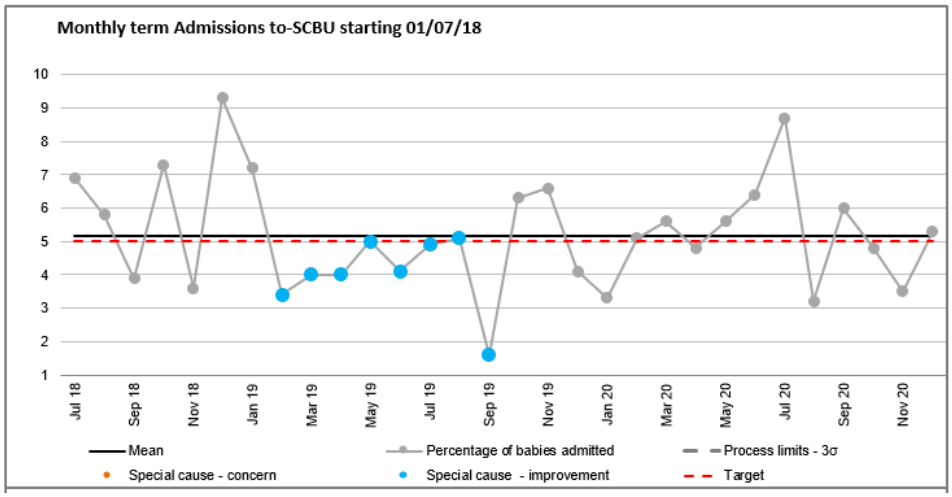


2.6.4 Avoiding Term Admissions into Neonatal Units – ATAIN

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

For this reporting period, 4.9% of term births were admitted to the Special Care Baby Unit. This is a decrease from the last reporting period and is just under the target of 5% or less. For the year 2019/2020, 4.8% of term births were admitted to Special Care, which remains within the target figure. See table 4 for monthly term admission to SCBU rate.

Table 4: Monthly Term Admission to SCBU Rate



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

2.7 Maternity Safety Champions

The Maternity Safety Champions (a midwife and an obstetrician) are continuing to work collaboratively with the Neonatal Safety Champions (a neonatal nurse and a paediatrician) and the Board Level Safety Champion (Chief Nurse). A Non-Executive Director has now been appointed to support with this work. Monthly Safety Champion meetings are being held to enable staff to raise safety concerns and the Board Level Safety Champion has been holding monthly walkarounds within the maternity unit.

The Maternity and Neonatal Safety Improvement Programme (MatNeoSip) safety network events are now being held virtually and are being attended by the Maternity Safety Champion, the Clinical Governance Coordinator for Obstetrics and Gynaecology and other relevant members of the team.

Work continues within the maternity service to meet the requirements of Year 3 of the NHS Resolution CNST Maternity Incentive Scheme (MIS). This was re-launched in October 2020, with a deadline for submissions of 20 May 2021. However, due to recognition of the pressures facing services caused by the Covid-19 pandemic, this has now been put back by 2 months to July 2021. The appointment of a Non-Executive Director as a Board Level Safety Champion is a strong recommendation of the Maternity Incentive Scheme, so this recent appointment by the trust will greatly support some of this work.

The maternity service is holding regular meetings to review its progress against the 'must do' and 'should do' recommendations from the Maternity CQC report for 2020.

Progress against the 'Must Do' actions is as follows:

- Ensure modified early obstetric warning score (MEOWS) is completed as per trust guidance across the maternity service. **A business case is currently being written to introduce Vitals (Vitalpac) electronic observation monitoring into maternity.**
- Ensure checks on emergency equipment are completed to ensure they are safe and ready for use. **We have recently completed 3 successive months of 100% completion of all emergency equipment checks.**
- Ensure medical staff are up to date with all mandatory training, to include safeguarding training. **All staff who are not up to date with training now have a date booked. However, challenges continue due to lack of availability of training dates until March 2021.**
- Ensure audit is used effectively and action plans and improvements are monitored and recorded. **Complete.**

Work is also ongoing to address the 11 'should do' recommendations, with three completed and all other in progress.

3.0 CNST: 10 Key Safety Actions

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

Due to the COVID-19 pandemic, NHS Resolution published revised standards on 30 September 2020. This required Trust to evidence compliance and complete a Board declaration by May 2021. This has now been deferred again to July 2021. Trusts that can demonstrate that they have achieved all of the ten safety actions will be eligible for a rebate on their maternity CNST contributions and will also receive a share of any unallocated funds.

The team have re-established the 'CNST' task and finish group to ensure that we are able to meet and evidence compliance with the standards. Good progress is being made towards achieving the standards. This appointment of a new Consultant and the recruitment for a fetal monitoring training midwife and additional sonography capacity will help to accelerate the progress over the coming months. In addition, approval of the business case for a new Maternity Information System and appointment of project

manager to support implementation will also support the team to meet the standards. Table 5 provides a summary of our current position.

Table 5: CNST Maternity Incentive Scheme Year 3: Summary position

Safety Action	Safety action summary	Status
1	Perinatal Mortality Review Tool (PMRT)	On- track
2	Maternity Services Data Set (MSDS)	On- track
3	Avoiding Term Admissions	On- track
4	Clinical Workforce (Obs, Anaes, Paed, NN Nursing)	On-track
5	Midwifery Workforce	On- track
6	Saving Babies Lives Version 2	On- track
7	Service User Feedback	On- track
8	Multi-Professional Training	Behind trajectory*
9	Maternity Safety Champions	On- track
10	HSIB and Early Notification Scheme	On- track

The one area that we are behind trajectory is multi-professional training. Mandatory training was placed on hold during wave one of the COVID-19 pandemic and was stepped back up using an innovative blended approach of on-line and face-to-face training, including multi-disciplinary in June 2020. The standard is that all staff groups should be 90% compliant with maternity multi-disciplinary training. Our current position ranges from 71% to 90%. The education lead midwife and obstetrician are working hard to return back to our planned trajectory and it is anticipated that this will be achieved by April 2021.

4.0 COVID-19 Pandemic

Maternity services continue to be identified as a priority service during the COVID-19 pandemic. During the reporting period, we have been able to maintain a full service following the NICE schedule of care. Adaptations have been made to where care is offered with the development of hubs for women to attend. Parent education has also moved on-line and virtual.
The maternity plan developed in conjunction with anaesthetic, paediatric and infection prevention and control colleagues is reviewed on a two-weekly basis. We are currently on Version 22 of this extensive document. In November 2020 as the second Wave was beginning to have an impact on health and social care provision, we returned to holding a weekly huddle, rather than three weekly, to review each area and any challenges that are being faced.

Staffing levels are being closely monitored. We have been able to maintain safe staffing levels due to the flexibility and commitment of our teams and midwifery bank staff. However, we are now starting to see a rise in absence levels, partly due to COVID-19 self-isolation or shielding, plus levels of personal stress are noted to be rising. The senior team are working with staff to provide support. Teams have also worked innovatively to support staff to work from home identifying activities that can be completed from home, which releases staff to complete patient-facing activities.

We are working closely as a system facilitated by the Devon Local Maternity System (LMS) and the Maternity Voices Partnership. A system wide set of FAQs has been

developed in conjunction with the Maternity Voices Partnership, which are reviewed on a fortnightly basis. We recognise that there is much to do to ensure that we are truly listening to the voices of women and their families and accept that we now need to accelerate this programme of work.

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

5.0 Conclusion

Despite the challenges presented by the COVID-19 pandemic, the maternity and neonatal teams continue to ensure the provision of a safe maternity service and to ensure that systems are in place to provide assurance. The team are committed to reviewing and fully implementing the recommendations from the Ockenden Interim Report and strengthening the oversight provided by the Trust Board. This will include developing a clear golden thread of governance to ensure safety and quality from floor to board.

6.0 Recommendations

The Trust Board of Directors are asked to:

- Discuss key findings from the Ockenden Report and note the progress and compliance position with regard to the priority areas
- Note the key quality and safety issues identified in the report
- Note progress and next steps with regard to the CNST process
- Approve the proposals made for reporting of governance, safety and quality within the maternity and neonatal services for Torbay and South Devon NHS Foundation Trust

Appendix 1: Ockenden Interim Report/NHSEI 12 Immediate Actions – TSDFT Position, Future Actions and Next Steps.

1) Enhanced Safety				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	• Locally produced dashboard detailing perinatal clinical quality indicators in place • Dashboard reviewed on a monthly basis at the Joint Maternity and Neonatal Perinatal Review meeting. • Contribute to South West Regional Maternity dashboard • Benchmark data against other providers within the South West of England. • Ability to provide data to national dashboard once rolled out • Meet national maternity data set reporting requirements (scored 11/11 September 2020). • Meet reporting requirements for national data requests, eg MBRRACE, PMRT, HSIB.	Non-compliant	• Trust will embed PCQS within Organisational reporting and governance structure	Immediate implementation once PCQS is launched
b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	• SIs are reported via StEIS • The Board is notified of all maternity SIs • Full report reviewed at Trust's Serious Adverse Events (SAE) group, chaired by the Medical Director and Trust Board Chair in attendance.	Partial compliance	• Quality Assurance Committee (sub-committee of Board, at which the Designated Non-Executive Director is a member) will receive an in-depth summary of SI reports,	31 January 2021

	• SIs meeting the HSIB criteria are reported to HSIB. • Final investigation reports are shared with NHS Devon CCG, who review the quality of the reports and sign off.		along with full report as an appendix. • Devon LMS operational group is changing its business process to ensure routine reporting and review of SIs for all provider Organisations.	
2) Listening to Women and their Families				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	• Friends and Family survey in place • Active member of the Devon LMS • Maternity Voices Partnership Chair is a member of the Devon LMS and meets regularly with all service providers • Devon LMS priorities developed following Devon-wide service user survey • Co-production of Frequently Asked Questions in relation to COVID19 and maternity services across Devon. • Devon MVP have Torbay and South Devon local representative • Annual CQC Woman's Experience of Maternity Services Survey. • Engagement with families to understand their desired outcomes when care outcomes or experience	Compliant	• We aspire as an organisation to work with women and their families to continually improve our service offer. This will include: o Strengthen relationships with local South Devon MVP representative o Service user representative will be invited to the monthly maternity multi-disciplinary governance meeting o Explore and co-design innovative ways in how to hear the voice of women and their families. In particular women / families whose voice if harder to hear.	

	does not meet expectations. This covers a wide spectrum of circumstances, from low level concerns to serious incidents. • Use of social media platforms to extend reach and improve accessibility of the maternity service to women and their families			
b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	• Chief Nurse is Executive Director with responsibility for maternity services. • Maternity safety champions in place - obstetrician, matron and neonatal. • Named Non-Executive Director identified with protected time	Compliant	• Ensure Non-Executive role is embedded and meeting guidance (once published).	
3) Staff Training and working together				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	• Monday to Friday - there are currently two ward rounds, one at 08.30 and one at 17.00. There is a clinical handover/update at 13.00 and a further virtual board round at 22.00	Partial compliance	• Review ward round times • Identify PA requirement to achieve recommendation	31 January 2021

	• Saturday and Sunday – there is one ward round each morning.		• Review of the Consultant Job planning (in progress) • As an interim measure we will ensure that a virtual board round is completed at 20.30hrs each evening	
b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	• Training is based on the PROMPT model, which is a nationally recognised exemplar platform. • Joint multi-disciplinary training with a clear and comprehensive training schedule in place. • Achieved year 1 & 2 standards for CNST • Training team have developed an innovative, blended approach to our training offer during COVID	Compliant		
c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	• Health Education England maternity specific monies ring-fenced These funds have been used to provide specific HEE. • Trust confirms CNST MIS refund for 2020/21 and future years will be used exclusively for improving maternity safety and will be placed within the maternity budget.	Partially compliant	• Establish greater clarity on other sources of training funding and arrange transfer into a specific maternity training/safety budget	31 January 2021
4) Managing complex pregnancy				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) All women with complex pregnancy must have a named	• All women with complex pregnancies have a named Consultant Lead.	Compliant		

consultant lead, and mechanisms to regularly audit compliance must be in place	• The requirement to audit compliance has been added to the obstetric audit programme			
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	• Trust understand position relating to maternal medicine specialist centres • Two hub and spoke centres for the South West of England agreed, based in Bristol and Plymouth. TSDFT are awaiting further information relating to the progress of this.	Compliant	• The Trust will work as a system to support the implementation of developed pathways once finalised.	
5) Risk Assessment throughout pregnancy				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	• Comprehensive risk assessment completed at first contact appointment and updated as risk changes during pregnancy • Place of birth is discussed with all pregnant women and a leaflet provided, which details the benefits and risks. • Team continually risk assess and should a woman choose a place of birth that would not be recommended by a health care professional, a clear plan of support is developed, detailing the risks and what actions are planned to mitigate risk or respond to emerging issues during birth. • From 21 December 2020, maternity staff will formally record that a risk	Compliant		

	assessment at each contact has taken place. • PSCP has been co-produced with the MVP, which includes place of birth. • Phased launch of the document in progress with full implementation by 28 February 2021 • Antenatal schedule of care policy updated to reflect change • Audit of risk assessment and PSCS added to obstetric audit schedule.			
6) Monitoring Fetal Wellbeing				
Immediate actions	**Trust position**	Compliance	Planned actions and next steps	Planned compliance date
a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	• 1-year fixed term fetal monitoring lead midwife being appointed to on 6 January 2021. • Once this post recruited to, compliant with Element 4 of Saving Babies Lives Care Bundle Version 2. • Delivery suite ward manager currently responsible for leading on fetal monitoring. • Lead obstetrician for delivery suite, who also has an interest in fetal monitoring, but no specific remit. The lead obstetrician supports reviews of cases.	Non-compliant	• Identify PA requirement to achieve recommendation • Review of the Consultant Job planning (in progress) • Secure substantive long-term funding through Trust's business processes for fetal monitoring lead midwife (already funded for 2021/22).	31 January 2021

Appendix 2: Perinatal Clinical Quality Surveillance Model – Minimum Dataset

Torbay and South Devon NHS Foundation Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring
	Requires Improvement	Requires Improvement	Good	Good

Maternity Safety Support Programme	Yes

2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: • The number of incidents logged graded as moderate or above and what actions are being taken • Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training • Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

Appendix 3: HSIB/PMRT Action Plan.

MATERNITY SERVICE ACTION PLAN – HSIB CASE 2004-1969 Recommendations						
ACTION NUMBER	**RECOMMENDATION**	**ACTION**	**CURRENT STATUS**	**RESPONSIBLE**	**COMPLETION BY DATE**	**COMPLETED**
1	The Trust to ensure that Dawes-Redman software is only used by clinicians that are fully trained in its use and interpretation and when escalation should occur.	▪ Review of the mandatory day training element on Dawes Redman ▪ Update fetal monitoring policy to include more detailed information on the interpretation of Dawes-Redman ▪ Produce a training video ▪ Share training video with all of the clinical team.	▪ COMPLETE ▪ COMPLETE ▪ COMPLETE ▪ IT issues being investigated to share training video.	Delivery Suite Ward Manager Delivery Suite Ward Manager Obs and Gynae Registrar	31.10.2020 31.10.2020 30.11.2020	19.10.2020 19.10.2020 26.11.2020

				Public Health Midwife	31.12.2020	
2	The Trust to implement the direct transfer of women to the obstetric operating theatre when a bradycardia of the Baby's heart rate is identified outside the delivery suite.	▪ Improve communication with theatre staff and the clinical teams on Delivery suite in providing emergency theatre.	▪ Daily handover of which theatre is available in case of an emergency.	Labour Ward Manager and Lead Consultant for Delivery suite	31.10.2020	31.10.2020
3.	The Trust to ensure placentae are sent for pathological examination including histology in line with national guidance	▪ Escalate to CCG and LMNS	▪ Not able to be provided locally or regionally ▪ On risk register ▪ Has been escalated to CCG and LMNS	Delivery Suite Obstetric Lead	31.1.2021	Being progressed through CCG/LMNS

Appendix 4: Saving Babies Lives Care Bundle v2 Oct 2020 Tracker Survey

Reducing Stillbirths Care Bundle Elements	
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	
1a. Are you meeting all requirements of Element 1 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, If "no", please go to question 1f.*	Yes
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	Yes
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	Yes
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	Yes
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	No
1f. If you answered "no" to question **1b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	
2a. Are you meeting all requirements of Element 2 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	No
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	No
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	Yes
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	No
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	No
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	No
2j. If you answered "no" to **2b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM	
3a. Are you meeting all requirements of Element 3 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	Yes
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	Yes
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	Yes
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	Yes
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance? Yes/no	Yes
3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	No
3h. If you answered "no" to **3b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 4: Effective fetal monitoring during labour	
4a. Are you meeting all requirements of Element 4 of the care bundle? *If "yes", the questions below (with exception to question 4d) will be automatically populated on dropdown selection. Please also complete question 4d. If "no", please complete all questions below.*	No
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? *If "yes", go to question 4c. If "no", please go to question 4h.*	Yes
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? *If "yes", go to question 4d. If "no", please go to question 4e.*	Yes
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	85%-95%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	Yes
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	Yes
ii. reassessment of fetal risk factors	Yes
iii. a fresh eyes/buddy system	Yes
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	Yes
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	No
4h. If you answered "no" to **4b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 5: Reducing preterm births	
5a. Are you meeting all requirements of Element 5 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	No
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	No
iii. All women being offered screening for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	No
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	No
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth? If so to what extent have you implemented this improvement activity?	Yes
v. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours? If so to what extent have you implemented this improvement activity?	Yes
vi. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vii. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation? If so to what extent have you implemented this improvement activity?	No
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to **5b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Midwifery Staffing Oversight Report (1 July – 31 December 2020).			Meeting date: 27 January 2021
Report appendix	Appendix 1: CNST Maternity Incentive Scheme Technical Guidance		
Report sponsor	Chief Nurse		
Report author	Associate Director of Midwifery and Professional Practice / Head of Midwifery and Gynaecology		
Report provenance	The content of this report is a summary of how the maternity service is meeting standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board Level at least every 6 months.		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the Board on a 6-monthly basis of the work being undertaken in relation to effective midwifery workforce planning as per NICE guidance, NG4 (2015) • Establishment position with regard to Birthrate plus with the 2017 position showing no requirement for variation in establishment • Capacity with regard to staff in post with no vacancies as of December 2020 • The Report draws specific attention to themes that are emerging around staffing in response to COVID pandemic in the last 12 months and during the COVID pandemic. • For the reporting period, the Midwife to Birth ratio at Torbay and South Devon (TSD) has fallen to 1:23. • The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 3, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a 6-monthly report will be presented to the Trust Board.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☒

Recommendation	The Trust Board is asked to: • Note the on-going monitoring arrangements and compliance in relation to midwifery staffing and standards • Support actions for achieving 100% compliance for supernumerary status of the Delivery Suite Co-Ordinators • note that the Birthrate Plus® establishment review has been brought forward and is currently in progress • note that the service has developed a model of care that meets the national recommendations and trajectories. • approve submission of an extra-ordinary report be presented to the Trust Board once the Birthrate Plus® is available.
Summary of key elements	
Strategic objectives supported by this report	**Safe, quality care and best experience** x **Valuing our workforce** x **Improved wellbeing through partnership** x **Well-led** x
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** N **Risk score** **Risk Register** N **Risk score**
External standards affected by this report and associated risks	**Care Quality Commission** **x** **Terms of Authorisation** **NHS Improvement** **x** **Legislation** **NHS England** **x** **National policy/guidance** **x** CNST set clear safety standards for Trusts in relation to maternity services. Demonstration that these standards have been met result in the Trust being eligible for a rebate on their maternity CNST contribution and a share of any unallocated funds.

Midwifery Staffing Oversight Report		Date: 27 January 2021
Report sponsor	Chief Nurse	
Report author	Associate Director of Midwifery and Professional Practice/Head of Midwifery and Gynaecology	

1.0 Introduction

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

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

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

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

This report covers the time period 1 July 2020 to 31 December 2020 and details compliance with the above standards.

2.0 Midwifery Staffing Establishment (a)

2.1 Birthrate Plus®

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

The Birthrate Plus® assessment was completed during the latter part of 2017. The findings were that there were no variations to the establishment. This outcome was reported to the Board.

In June 2018, the final report received demonstrated that the existing midwifery establishment was set at the right level for the activity at that time. It noted that the midwifery establishment was 1.18wte over, whilst the support worker role was 1.65wte under established. This resulted in a -0.47 variance. During August 2018, there had

been no significant changes to the midwifery activity and therefore the service took the opportunity to undertake further skill mixing and 1wte midwifery post was converted to a 1.4wte support worker role. This meant that the establishment now matched the recommendations set out within the Birthrate Plus® report.

From April 2019, the maternity service began to use the Birthrate Plus® Intrapartum Tool. This has enabled electronic monitoring of the acuity of women in our care, monitors supernumerary status of the delivery suite co-ordinator and captures red flag incidents, including one-to-one care.

In the last Maternity Staffing Oversight Report to the Board, the maternity service recommended that the Birthrate Plus® assessment be formally repeated in Autumn 2020. The timing was so that the service redesign changes had time to embed. In response to COVID-19 this was deferred and we are now in the process of collecting the data and will be well placed to receive the report/outcome in the Spring 2021.

Themes that are emerging around staffing in the last 12 months and during the COVID pandemic include:

- staff and managers had reported that the general complexity of women was significantly increasing
- changes to national guidance had resulted in an increase of interventions which also led to higher levels of acuity.
- as a result of shielding, there was a reduction in staff available for face-to-face care activities, which has presented some challenges in terms of rostering and a much greater reliance on bank staff to optimise staffing levels.

In light of this, the Birthrate Plus® establishment review commenced in mid-December 2020. It is anticipated that all data will be collected by the end of February and report available in the middle of March 2020. It is proposed that an extra-ordinary report be presented to the Trust Board once the Birthrate Plus® is available.

2.2 Monthly Establishment Review

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

During the 6-month period covered within this report, we have seen a midwifery vacancy range of 1.7wte – 3.7wte (see Table 1). The service is usually recruited to establishment. During this time period, we have continued to see a staff reaching retirement, along with staff choosing to follow different career pathways. This has resulted in being able to offer all our preceptee, substantive Band 6 posts after their first year, and also supported ex-student midwives to return to the maternity service from other units when we had been unable to offer them a post at Torbay and South Devon on qualification.

We have had one Band 6 integrated team vacancy that due to a number of issues we have been unable to recruit to, however it is currently out to advert and we are confident that this will be filled. There have also been a number of senior midwife posts available that have provided development opportunity for the staff.

Whilst we have not been able to recruit to the above post, it should be noted that the maternity service is over-established by 2.0wte. This is to take into consideration the average amount of maternity leave that occurs. During this 6 month period, we have seen three months with no maternity leave. However, projecting forward to January 2021, we will have 4.0wte (5 midwives).

As of December 2020, all vacancies have been recruited to, with the exception of a secondment and the above team post, The first secondment (0.8wte) will end on 15 September 2020.

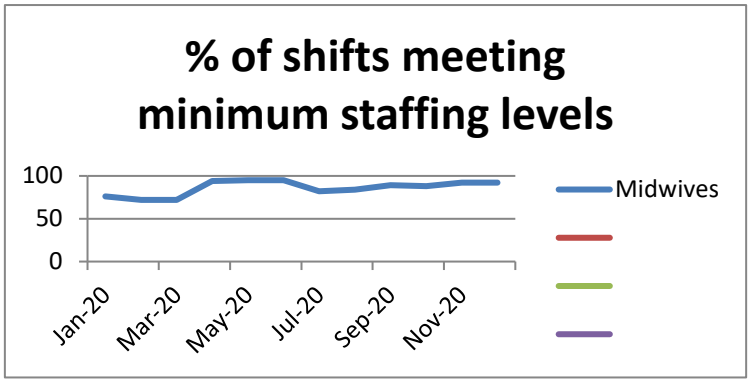
Table 1: Planned versus actual midwifery staffing levels

	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Establishment	87.9	87.9	88.3	87.7	87.7	87.7
In post during month	84.2	85	86.3	84	86	85
Variance	3.7	2.9	2.0	3.7	1.7	2.7
Maternity leave	0.8	0	0	0	0.92	1.82
Maternity leave cover	2.0	2.0	2.0	2.0	2.0	2.0

As a service we have locally agreed minimum staffing requirements in order to ensure we can safely staff all areas of the maternity service and meet the Key Performance Indicators of having a supernumerary co-ordinator and providing one-to-one care to all women in labour. We have agreed that this is a minimum of 9 midwives per shift. The new model that was implemented in Mar 2020 was designed to ensure 11 midwives were available per shift to cover the whole service. However, due to the COVID-19 pandemic we have been unable to achieve this due to shielding, working from home and reasonable adjustments.

We have a very flexible workforce, including a specific midwifery bank. This has meant that we have been able to backfill vacancies and gaps within the rota. Table 2 demonstrates the percentage of shifts that meet the minimum staffing levels. For the 6-month period this has ranged from 82% to 92%. This is the equivalent of 2-4 shifts per week and is usually due to short notice absence.

Table 2: Percentage of shifts meeting minimum staffing levels



Another indicator of appropriate staffing levels is the use of the midwife to birth ratio. This is calculated by dividing the total number of births by the whole-time equivalent number of midwives. This is a crude calculation as only considers births and not all of the other activity that is required. The current national recommendation is a ratio of 1 midwife to 28 women (1:28); however this ratio is likely to be reduced in the near future due to the recognition of the additional requirements for midwifery staff. It can be measured in two ways, firstly the total number of midwives excluding the Head of Midwifery (HOM) over the year's births. For the reporting period, the Midwife to Birth ratio at Torbay and South Devon (TSD) has fallen to **1:23.**

However, on a monthly basis, TSDFT are required to submit the Midwife to Birth ratio to NHS England South West to form part of the South West Maternity Network Dashboard. A standardised calculation is undertaken, which uses the current month's births and the whole-time midwifery establishment, this excludes the Head of Midwifery, midwifery matrons and specialist midwives. Table 3 details the Midwife to Birth Ratio that has been reported between January 2020 – June 2020.

Table 3: Midwife to Birth ratio (exc. HOM, matrons and specialist roles)

Time period	Midwife: Birth Ratio
Jul 2020	1:25
Aug 2020	1:28
Sep 2020	1:24
Oct 2020	1:25
Nov 2020	1:25
Dec 2020	1:23

The overall birthrate has dropped significantly over the past 2 years. However, as described above the complexity and acuity of women, both medically and socially, is increasing. This is evidenced by the increase rates of medical interventions, such as induction of labour and caesarean section, and a subsequent rise in the length of stay for women.

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

In addition to the above, there have been a number of national trajectories that have been set by NHSE in relation to the provision of maternity care. This has resulted in the requirement to redesign our midwifery service to meet the requirement that the majority of women receive continuity of carer from a small team of midwives. The new model was implemented on 2 March 2020, just prior to beginning the first wave of the COVD-19 pandemic. The recommended ratio for community midwifery care is 1:36, however our teams are currently configured for 1:45-50. We anticipate that this will be identified as part of the Birthrate Plus® review. The national trajectories are due for reporting in March 2021 and the team will be able to report exceeding the trajectories to the national team.

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

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

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

Table 4: Summary of Delivery Suite Co-ordinator Supernumerary Status

2020	Instances where delivery suite co-ordinator is not supernumerary
Jul	2
Aug	8
Sep	6
Oct	4
Nov	6
Dec	3

During the six-month period there were 29 instances out of 989 recording points. This equates to 3% and is a slight rise from the previous reporting period. For all instances where the co-ordinator was not in a supernumerary capacity, this had not been the intention for that shift. Our midwifery establishment is set to enable the co-ordinator to be supernumerary and this is supported by our maternity staffing document.

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

The maternity service has an escalation process to help mitigate against this risk, which includes an additional midwife available on-call to support at times of high acuity. It should be noted that in some circumstances the co-ordinator did not utilise the escalation midwife, as they deemed that they could maintain oversight for the short period they were caring for a woman with low acuity levels.

Within the last Board Report, we set the ambition to achieve 100%. Whilst this has not been achieved (97%) there has been an improvement. During the previous reporting period, it should be noted that we increased staffing levels during Apr-Jun, including an additional co-ordinator due to the pressures of COVID-19. We had anticipated that with the new integrated team models we should have an increase in the number of staff available and therefore able to reduce the need for the co-ordinator to take a small

clinical caseload during their shift. This has not been the case. As such we have developed the following actions set out in Table 5.

Table 5: Action plan for achieving 100% compliance with supernumerary status for the Delivery Suite Co-ordinator.

Action	Responsible	Date for completion
To complete a review of each instance where co-ordinator is not supernumerary	Senior Midwifery Manager, in conjunction with Delivery Suite Ward Manager	14 March 2021
To undertake thematic analysis of review data	Senior Midwifery Manager, in conjunction with Delivery Suite Ward Manager	28 March 2021
Triangulate thematic review with Birthrate Plus® data	Senior Midwifery Manager, in conjunction with Delivery Suite Ward Manager	28 March 2021
Develop actions to achieve 100% compliance with supernumerary status.	Senior Midwifery Manager, in conjunction with Delivery Suite Ward Manager and Co-ordinators	28 March 2021
Achieve 100% compliance	Senior Midwifery Manager, in conjunction with Delivery Suite Ward Manager and Co-ordinators	30 June 2021

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

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

Table 6 Percentage of women receiving one-to-one care in labour.

Time period	%
Jul 2020	100
Aug 2020	100
Sep 2020	100
Oct 2020	100
Nov 2020	100
Dec 2020	99.6

The maternity service works extremely hard to ensure this standard is met as can be seen in Table 6. Over the six-month time period, only one woman did not receive one-to-one care in established labour out of 990 women (0.1%). This occurrence was due to the shift being extremely busy. As a senior team we are assured that one-to-one care is prioritised and action is taken to remedy the situation as soon as practically possible.

5.0 Bi-annual report (d)

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

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

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

The biannual report is completed six- monthly, with the next report being due in July 2021.

6.0 Red flags

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

- Activities that need to be done on time are delayed or cancelled.
- After giving birth, a woman has to wait for 60 minutes or more before she is washed or given stitches, if she needs them.
- A woman does not get the medicines she needs when she's been admitted to a hospital or a midwifery-led maternity unit.
- A woman has to wait 30 minutes or more to get pain relief when she's been admitted to a hospital maternity unit or a midwifery-led maternity unit.
- A woman who is in labour or who has a problem needing midwife care has to wait 30 minutes or more for assessment after the midwife has been alerted.
- A woman is not given a full examination when she reports she is in labour.
- There is a delay of 2 hours or more between coming in for an induction and the induction being started.
- Delays in spotting and acting on signs that the woman may have a serious health problem
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman in established labour
- Unable to provide an out of hospital birth when requested*

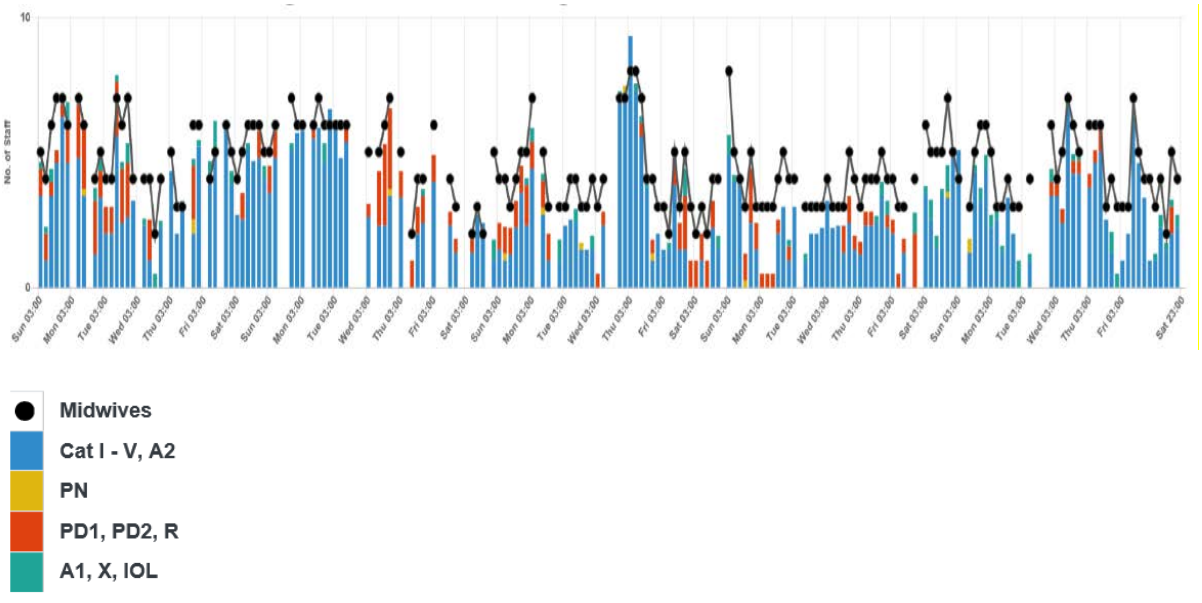
From April 2019, red flag events and actions taken in response to these were captured using the Birthrate Plus ® Acuity Tool. The midwifery red flags for the reporting period are detailed in Table 7.

Table 7: Midwifery Red Flag Events

Red flag	Descriptor	Incidence						
		Jul	Aug	Sep	Oct	Nov	Dec	Tot
RF1	Delayed or cancelled time critical activity	0	1	0	0	0	0	1
RF2	Missed or delayed care	0	3	2	3	0	1	9
RF3	Missed medication	0	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0	0
RF5	Delay between presentation and assessment	0	0	0	0	0	0	0
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	0	0	2	0	0	0	2
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
RF9	121 care in labour	0	0	0	0	0	0	0
RF10	Unable to facilitate out of hospital birth	0	1	1	3	3	0	8
	Totals	0	5	5	6	3	1	**20**

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

Chart 1: Staffing v Workload Example



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

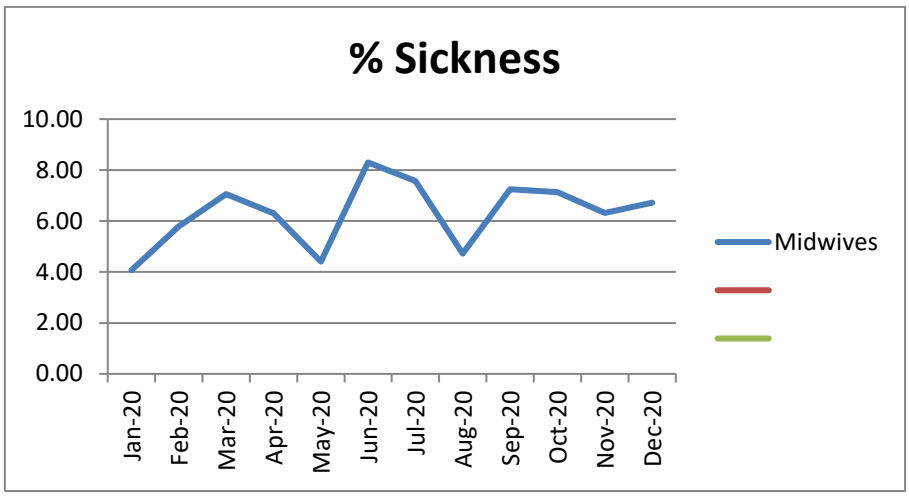
All red flag instances were due to a conscious decision to trigger the red flag to ensure safety across the whole service was maintained. None of the instances were due to omissions or lapses in care. The two most common reason for a red flag within this reporting period has been the inability to provide an out-of-hospital birth. This was because of the requirement to have two staff members attend. All women were offered care within the hospital setting. The second being delayed or missed care. In all instances this related to delayed care, with the majority due to being unable to transfer a woman to Delivery Suite from the antenatal ward to continue the induction of labour process. All women who experience this delay are advised of the reason and that they will be transferred as soon as the team are able to accept. The ward staff liaise with delivery suite regularly and if there is any concern, transfer would be expedited.

7.0 Sickness

During the six-month reporting period we have seen fluctuating sickness levels however they have been consistently above the Trust average. The team have had a number of staff with long-term medical conditions that have necessitated sickness absence, along with staff who have been affected by long-COVID.

We recognise that staff have been working extremely hard during the COVID pandemic and it is clear that staff (as with all health workers) are becoming fatigued. In view of this we have encouraged staff to take leave that is due and considered how we can support staff well-being. One colleague has offered free reflexology, whilst our Professional Midwifery Advocates (PMAs) are available to support staff.

Table 6: Midwifery Sickness Percentage



The leadership team work proactively with the Human Resources department and staff members to support them to return to work as soon as they are fit to do so. This is monitored with our monthly staffing report, which can identify specific areas within the

maternity service that may require additional support. This includes where midwifery staffing levels do not meet the locally agreed minimum staffing levels. This is also shared with staff.

We have also worked with the Organisational Development (OD) Team to undertake listening events with the staff, with the report being made available in mid-January 2021. The senior maternity team and OD team plan to meet with staff to identify and co-produce an improvement plan to support staff and their well-being. can be made

8.0 Escalation

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

Table 7: Summary of escalation midwife usage

Time period	No. of Times Escalation Midwife Used
Jul 2020	2
Aug 2020	5
Sep 2020	0
Oct 2020	2
Nov 2020	2
Dec 2020	2

9.0 COVID-19 and impact on staffing levels

COVID-19 has continued to have an impact on staffing. We currently have 4.4wte (6) midwives and 1.3 (2) MSWs in non-clinical roles, plus a number of staff who are not able to undertake their full roles due to risk assessments. We have developed temporary alternative ways of working for these individuals, so that they are able to fully contribute to the providing a safe, quality service. Examples include virtual clinics for first appointments, attending virtual safeguarding midwives, responding to telephone queries and audit.

The birth rate has reduced, which in conjunction with the extreme flexibility of our substantive and bank staff, has meant that we have been able to maintain staffing level. However, as described previously, there are many more highly complex cases, along with women choosing to follow a birth pathway that would not be recommended by the midwifery and obstetric teams. Along with the increase workload that this results in, it also has an emotional impact of the team. On-going support is available through line-manager, wider management team, Professional Midwifery Advocates and the Employee Assistance Programme.

It is anticipated following the introduction of wider national restrictions due to the third wave of the COVID-19 pandemic that the situation will become more challenging, particularly as we start to see an increase in COVID-19 positive cases. The team have developed a bespoke RAG status considering staffing, acuity and patient safety and quality indicators (table 8). This is reported to the Trust control room on a daily basis to

provide the overall position within maternity. The current maternity escalation policy is in the process of being updated to incorporate this tool.

Table 8: Bespoke Maternity staffing Risk Assessment

Level	Descriptor	Description
Low Risk	Business as usual	Normal staffing levels 1:1 care in labour No red flags Acuity and dependency expected within area.
Heightened Risk	Patient Safety and Quality Compromised / Impact on service delivery	7/8 midwives available for ward and birth services – ward ratio 1:12; birth 1:2; community 1:100 0/1 MSW available across 2 floors 0 Delivery Suite Co-ordinator 2 or more red flags 1 clinic not staffed Acuity and dependency above expected within clinical areas Staffing escalation plan reviewed and actioned
Significant Risk	Clinically unsafe / Unable to deliver a service	6 midwives available for ward and birth services – Ward ratio 1:20; birth 1:2+; community 1:120 0 Delivery Suite Co-ordinator 0/1 MSW available across 2 floors 3 clinics not staffed 1 midwife in ANC/MAU 2 or more red flags Acuity and dependency above expected within clinical areas Staffing escalation plan in effect
High Risk	Significant Clinical Risk and inability to deliver all services	5 midwives available for ward and birth services – Ward ratio 1:20; birth 1:2+; community 1:150 0 Delivery Suite Co-ordinator 0/1 MSW available across 2 floors 3 clinics not staffed 1 midwife in ANC/MAU 2 or more red flags Acuity and dependency above expected within clinical areas Staffing escalation plan in effect
Highest Risk	Significant Clinical Risk and inability to deliver all essential servcies	<5 midwives available for ward and birth services – Ward ratio >1:20; birth >1:2; community >1:150 0 Delivery Suite Co-ordinator 0/1 MSW available across 2 floors >3 clinics not staffed 1 midwife in ANC/MAU 2 or more red flags Acuity and dependency above expected within clinical areas Staffing escalation plan in effect

10.0 Conclusion

The midwifery staffing establishment is currently set according to the Birthrate Plus® establishment calculations from 2017. The birthrate has fallen by 300 births since that assessment, however, complexity has increased. The full Birthrate Plus® establishment review is currently being completed.

There is a flexible model of care that enables effective deployment of staff across the service. This is monitored closely by the leadership team, who have instigated a monthly reporting system to enable this monitoring and improve assurance.

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

This reporting period has been more challenging due to establishing the new midwifery model and the COVID-19 pandemic. However, staff have worked tirelessly to ensure

that we continue to provide a safe and quality service for the women and families that we care for.

11.0 Recommendations

The Board is asked to:

- note the on-going monitoring arrangements and compliance in relation to midwifery staffing and standards
- Support actions for achieving 100% compliance for supernumerary status of the Delivery Suite Co-Ordinators
- note that the Birthrate Plus® establishment review has been brought forward and is currently in progress
- note that the service has developed a model of care that meets the national recommendations and trajectories.
- approve submission of an extra-ordinary report be presented to the Trust Board once the Birthrate Plus® is available.

Appendix 1: CNST Maternity Incentive Scheme Midwifery Staffing Technical Guidance

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.
Minimum evidential requirement for Trust Board	The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing. • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified. • Maternity services should detail progress against the **action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls**. • The midwife: birth ratio. (Regular reviews and have plans to flexibly adjust midwife to woman ratio if needed due to Covid-19) • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. **Must include plan for mitigation/escalation to cover any shortfalls.** • Did Covid-19 cause impact on staffing levels?

	- Was the staffing level affected by the changes to the organisation to deal with Covid-19? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: CQC Assurance			Meeting date: 27 January 2021
Report appendix	Appendix 1: ASW Assurance "Draft Internal Audit Report: CQC Compliance – December 2020"		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice, South Devon; Quality and Compliance Manager		
Report provenance	Content summarised from the CQC and Compliance Assurance Group meeting discussion on 21 December 2020.		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide the Board with assurance of the position of the current CQC improvement plan, outcomes of ASW Assurance report on the Trust's CQC Compliance and the CQC regulation activities. The key areas for the board to be sighted in relation to CQC improvement plan include; • Impact of covid in relation to mandatory training due to demand and capacity, improvement trajectories in place and areas of high risk identified. • Evidence review for each core service has demonstrated that this requires further strengthening, session on evidence has been arranged		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to note the contents of the report.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	x	**Risk score**	
Risk Register	x	**Risk score**	12

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

Report title: CQC Assurance		Meeting date: 27 January 2021
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice, South Devon; Quality and Compliance Manager	

1. Introduction

This report provides an update to the Quality Assurance Committee on the discussions held at the CQC and Compliance Assurance Group (CQCCAG) meeting on 21 December 2020.

This report will provide updates on the:

- Status and exception reporting on progress on the Trust's CQC Improvement Plan
- ASW Assurance report on the Trust's CQC Compliance
- Use of Resources
- CQC-TSDFT December Engagement meetings
- Upcoming CQC regulation activities

2. CQC Improvement Plan

The Quality Assurance Committee has oversight of the position of assurance of the CQC improvement plan and CQC activities within the Trust. The CQC Compliance and Assurance Group has the main oversight role of monitoring, challenging and tracking progress towards the CQC Improvement Plan. This Improvement Plan is the Trust's plan to address the 28 Requirement Notices (Must Dos) and the 43 Should Do Improvements in TSDFT's CQC Inspection Report published on 2 July 2020.

The focus of the CQCCAG December meeting was for Improvement Plan leads to raise and highlight any areas where collective support was needed, and where actions are not on track. The table below shows the status of 'Must Dos' and 'Should Dos' per CQC core service:

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	n/a	1	n/a	0	n/a	0	n/a
Urgent and Emergency	8	6	2	1	6	5	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	2	3	1	3	1	5	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	5	4	20	34	3	5	0	0

Table 1

Table 2 sets out in more detail on the areas of improvement requirements that are overdue.

Table 2

Ref.	Core Service	Requirement Notice	Planned completion date	Updated position/risk to delivery	Impact/Action
M20	Surgery	Ensure equipment and premises are fit for use	20-Oct-20	• Programme of work is in place, works commenced on Simpson flooring for 20/21, however there is a need to decant the ward in order to complete the work. • Each ward requires estate package (which may include; floor redesign, redecoration, window replacement, fire safety compliance, increasing oxygen infrastructure) this programme will be 1 ward per 6 months (2 wards per year – 5 year programme of work) • Covid-19 has reduced ability to commence programme of work due to requiring decant space for wards	Programme of work to be developed aligned to operational plans ward and set out in overall Estates Strategy.
M21	Surgery	Ensure there is a rolling equipment replacement programme	31-Mar-21	• There is an equipment rolling programme within the trust which consists of capital and revenue programme • There is clear governance structure and decision-making process • Equipment is risk RAG rated with a clear process • The gap is the communication to teams from the decision-making meeting. • Clear funding stream for revenue rolling programme	75% of medical devices moved from capital to revenue as individual equipment below capital threshold 43% of revenue medical devices need replacing Covid 19 has impacted on ability to progress equipment decisions
M25	Maternity	Ensure medical staff are up to	31- Dec-20.	• Demand and capacity of training is reduced due to blended approach of e-learning and face to face and adhering to being COVID secure	72% compliance for all mandatory training for Medical staff - Risk

		date with all mandatory training, to include safeguarding training /			mitigated as medical staff booked on training

Should do's:

Table 3 sets out the 5 five 'Should Dos' RAG-rated as Amber, i.e. 'Risks overdue' are as follows:

Table 3

Ref.	Core Service	Requirement Notice	Planned completion date	Updated position/risk to delivery	Impact/ further actions Action
S24	Maternity	Review cleaning procedures so all equipment is free from dust	31-Oct-20	An audit programme has been instituted with the ward managers, compliance is not consistent.	More consistent monitoring of audits to be reported weekly Meetings with the ward/service managers to implement a systematic regime of cleaning and monitoring to ensure a greater level of compliance
S25	Maternity	Improve medical staff awareness of maternity safeguarding leads	31-Oct-20	Feedback from staff reveals an ongoing need to raise awareness	Process for recording outcomes of in terms of understanding & awareness to be implemented

					Posters of named midwife and Safeguarding midwife in place Included as part of Trust induction Improved visibility of safeguarding leads to be considered given the impact of COVID
S26	Maternity	Confirm all obstetricians are trained at the required level for safeguarding level 3 children	31- Dec-20.	Demand and capacity of training is reduced due to blended approach of e-learning and face to face and adhering to being covid secure	Staff overdue are booked with completion by April 2021
S27	Maternity	Improve the quality and recording of handovers to ensure women are kept safe when they move between sites or areas of the maternity unit	31-Oct-20	• Three-month audit completed in Oct-20 • QI methodology being utilised to improve handovers and embed change	80% compliance in weekly audit sampling currently
S33	Maternity	Review the provision of bereavement support across	30-Nov-20	Options appraisal completed Dec-20 around future provision	Funding stream identified for dedicated bereavement support

		the maternity pathway			More explicit and detailed strategy on how this will be implemented to be progressed through Improvement Collaborative established in response to Ockenden

2.2 Completed Actions

Must Do's:

Table 4 sets out the completed Must Dos reported as reported by the ISUs with the evidence is being validated with final sign off by the executive by 31st March 2021.

Table 4

Ref.	Core Service	Requirement Notice	Compliance Outcome	Actions required - completed	Impact /Further actions
M4	Urgent & Emergency	Ensure the safety of the emergency department. The trust must ensure risk based clinical decisions are completed when using parts of the emergency department to board patients for any length of time. This must include the safe staffing of the minor injuries area when used.	Length of stay in department Staffing ratios in Minors department	• Comprehensive estates improvement program in ED • Escalation cards in place and acted upon • Oversight of ED led by ED within trust control meetings. • SOP for the allocation of patients to board in minors is now available • Staffing levels evidence through risk framework	Performance position for patients waiting in ED beyond 4 hours between Oct -Dec has been 86-81% Zero episodes of Corridor care for 6 months Minors area has not been bedded since March 2020 Staffing ratios for minors are 3 x ENPs Mon-Thurs and 4 x ENPs Fri-Sun covering from 08:00-midnight. Staffing across

					ED is within the recommended staffing requirements
M9	Urgent & Emergency	Ensure governance is used effectively to drive and monitor change and to include regular meetings and accurate recordings of meetings and action plans.	80% of all scheduled meetings occur.	• ED leadership meeting/Governance meeting/learning from incidents • Action plans monitored, reviewed and evidence supplied for meetings	90% of meetings scheduled have occurred over last 3 months
M24	Maternity	Ensure checks on emergency equipment are completed to ensure they are safe and ready for use.	100% of checks completed	• Daily leadership walkabouts has demonstrated	100% Checks completed
M26	Maternity	Ensure audit is used effectively and action plans and improvements are monitored and recorded.	WHO audit 100% compliance	• WHO audits available within governance meetings and are maintained at 100% • Audit meeting minutes discussed at maternity governance meeting	100% Compliance
M27	Children & Young People (acute)	Ensure they can evidence compliance of paediatric resuscitation training in line with requirements set out in the training needs analysis.	Training levels meet Trust standards (90%)	• Meeting standard of 90% and proactive approach in identifying staff who are nearing expiry are booked onto next available course	90% compliance

3. Evidence

Review of evidence to support and seek assurance around sustained improvement has progressed and will be completed during in January – March 2021. There has been delays in undertaking a full review of the evidence due to the covid-19 pandemic, therefore we have taken this into consideration.

An education framework is being developed to provide a series of sessions on feedback, analysis and 'evidence best practice'. The first 'evidence best practice' session is being conducted in January's CQC Compliance Assurance Group meeting.

The process for Executive sign off of demonstrable evidence of sustained improvement will be implemented in February - March 2021.

4. CQC Peer Review / Internal Audit Assurance

As part of the 2020/21 Audit and Assurance Plan, ASW Assurance have undertaken a review of the Trust's arrangements to assure CQC Compliance. This year, this annual audit has been performed 2-3 months earlier than usual due to COVID. The overall objective of the review was to confirm that the Trust has appropriate arrangements in place to manage the response to CQC inspection reports. The review has concluded that the overall assurance opinion on the design and operation of controls is 'Significant'; this is the highest rating. ASW's draft internal audit report is in Appendix 1, and includes the Trust's management response.

A clinically-led TSDFT Peer-to-Peer Review process is being designed to review ongoing compliance against core standards and regulations. The review will analyse current practice and ensure appropriate evidence is in place to demonstrate compliance. Early review of evidence shows that ISUs need to strengthen the evidence to ensure it is organised in an easily accessible way and that the actual evidence is sufficiently granular that gives confidence that improvement is sustained.

In December a TSDFT working group formed to review initial ideas and share experiences of approaches within other Trusts of similar processes. Agreements included that the approach:

- should be a positive, supportive experience and provide a 'critical friend' to encourage reflection and improvement
- should look at evidence against CQC KLOEs
- should fit with the new Ward Accreditation Scheme, and the leadership and patient safety walkrounds.
- has potential for external support from CCG and non-executive directors.

Further meetings have been organised to further define, plan and build the process for a launch in March 2021.

5. Use of Resources

The Interim Deputy Director of Finance presented an update to the CQCCAG December meeting on the progress towards addressing the areas for improvement in the Use of Resources assessment conducted by NHSI, and published by the CQC on 2 July 2020.

The Finance and Digital Performance Committee hold oversight of the action plan developed in response to the findings. There were 13 actions reported: finance (6), digital (2), transformation (1), workforce (3) and clinical support services (1). Of the 13 actions, two are RAG-rated as green, the remainder are amber. An update was being taken to the FDPC on the same day as the CQCCAG meeting, and a further update will be received by CQCCAG in January/February 2021.

6. CQC-TSDFT Engagement December meetings

Engagement meetings are held quarterly between TSDFT and the CQC, as part of the CQC's ongoing monitoring of providers, in-line with the CQC's 2016-2021 strategy. A CQC-TSDFT Engagement meeting was held on the 3 December 2020. This full day of meetings involved the following:

- Business As Usual meeting including updates from three core services: Community Adults, Medical care and Diagnostics Imaging
- Chief Finance Officer interview
- Community Adults clinical leads meeting
- Complaints team meeting
- Walnut Lodge clinical leads meeting
- Diagnostic Imaging Clinical Leads meeting

A follow-up meeting was held with the CQC on 15 December 2020, which included the following items:

- Specific Quality Improvement Dashboard and Board Report performance metrics
- Further discussion on staffing
- CQC's future regulatory approach, further detail

A number of issues were raised at the meeting relating to a range of quality measures that were showing a deteriorating position. These specifically related to :

- ED Performance
- VTE
- Risk Assessments on Admission
- Nutrition and Hydration assessment

A follow up meeting was undertaken to provide greater assurance around steps being taken to address these issues and a number of actions have been instigated to ensure that there is an improved position, these include:

- Review of QI data to ensure data floes appropriately captured the position
- Improved Reporting at QIG and ISU level

- Targeted intervention at Ward / service level
- Weekly walkabouts with CNO and ADNPPs to review records
- Strengthen messages at ward/service level to staff

6.1 Future CQC changes to inspection regime

In the updates received from the CQC, the CQC inspectors relayed the following regarding changes the CQC are making to inspection reports under their new Transitional Regulatory Approach: “In line with CQC transitional regulatory approach, they are not returning to a routine programme of planned inspections, instead carrying out targeted and focused activity where they have concerns. To support this, the CQC have made some changes to our inspection reports.

For larger inspections, the CQC will replace the existing evidence appendix with an ‘evidence log’ detailing the evidence used to reach our judgements. It is anticipated that these changes will allow the CQC to publish reports more quickly and will have benefits for providers and members of the public.”

7. Upcoming CQC regulation activities

The next CQC-TSDFT Engagement meeting is on 3 March 2021; the agenda is yet to be received from the CQC.

The CQC’s new Transitional Monitoring Approach is a strengthened approach to monitoring, based on existing KLOEs, and is expected to include meetings via MS Teams with specific core services to review the service provision. These reviews will be similar to the Infection Prevention and Control review call held with the CQC via MS Teams in August 2020. If the CQC assesses there to be sufficient risk, they can conduct an on-site inspection.

As part of the CQC’s Transitional Regulatory Approach, the CQC will be carrying out targeted inspections of three key priorities this winter, as follows:

- Infection prevention and control
- Impact of winter on emergency departments
- Safety of maternity services

Whether a trust receives none, or up to three, of these inspections is based on the CQC’s risk assessment of that service for that provider. These inspections are expected to be focussed, one-day, unannounced, on-site inspections and will be similar to the Emergency Department inspection TSDFT received in February 2019. An inspection report is expected to result, but ratings will remain unchanged.

Nationally, the CQC have previously conducted two phases of local system Provider Collaboration Reviews, and will be conducting a further three phases in the ‘new year’ 2021.

- Phase 1 - interface between health and adult social care for the over-65 population group. Published in the CQC’s State of Care report in October 2020.
- Phase 2 - how providers are working together to deliver urgent and emergency care services in light of coronavirus. Report expected in January 2021.

- Phases 3-5 – virtual, expected in ‘new year’ 2021.
    - People who have used and are using cancer care services and pathways
    - People with a learning disability
    - People with a mental health condition

  Phases 2-5 will include a deep dive into health inequalities, with a focus on different ethnic groups.

8. Conclusion

This report has provided an update to the Quality Assurance Committee on the key areas of focus of the CQC and Compliance Assurance Group, including exception reporting on the Trust’s progress towards addressing the CQC findings from the 2020 CQC Inspection, and recent and upcoming CQC regulation activities.

9. Recommendations

The Quality Assurance Committee is asked to note the content of the report.

Torbay and South Devon NHS Foundation Trust
Draft Internal Audit Report: CQC Compliance

Report Reference: TSD04/21
December 2020

Distribution List (for action):

- Claire Burton, Quality and Compliance Lead
- Deborah Kelly, Chief Nurse

Additional Copies (final report, for information):

- Dave Stacey, Chief Finance Officer
- Jane Downes, Company Secretary
- Grant Thornton, External Auditors

Assurance Opinion	
Significant	✓
Satisfactory	
Limited	
No	

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2020/21 Audit and Assurance Plan, as approved by the Audit Committee, we were requested to undertake a review of the Trust's arrangements for Care Quality Commission (CQC) Compliance.

The CQC published its latest Inspection Report for the Trust on 2 July 2020. The overall Trust quality rating in this report was Good. This report included a total of 28 Requirement Notices, where action is necessary to bring services into line with legal requirements. A further 43 "should do" actions were identified in the *Areas for improvement* section of the CQC Inspection Report. The CQC also published a Use of Resources assessment report on 2 July 2020, and this was rated as Requires improvement.

Objectives and Scope of the Audit

The overall objective of this review was to confirm that the Trust has appropriate arrangements in place to manage the response to CQC inspection reports, and any Requirement Notices as identified in the Areas for improvement section of these reports. The scope of this review was limited to the CQC improvement Action Plans put in place to respond to the CQC Inspection Report, published on 2 July 2020, and the governance arrangements supporting the delivery and reporting of these planned actions. We confirmed:

- The Trust has prepared an appropriate CQC Improvement Action Plan that includes actions to address each of the Requirement Notices, and "should do" actions, as identified in the Areas for improvement section of the CQC Inspection Report of July 2020.
- Performance against the CQC Improvement Action Plan, including confirming the current status of agreed actions and their implementation, is routinely monitored by the CQC and Compliance Assurance Group.
- Progress against the CQC Improvement Action Plan is routinely reported to the Quality Improvement Group, Quality Assurance Committee and Trust Board.

We also considered the impact of COVID-19 and/or recovery/restoration and transformation on any changes to the systems/processes or procedures in place for this area.

OVERALL CONCLUSION

The Trust has a detailed and thorough set of governance arrangements in place to manage the delivery of the CQC Improvement Action Plan (CQC Action Plan), put in place in response to the CQC Inspection Report of July 2020. These include a comprehensive CQC Action Plan document, with mechanisms to identify and approve evidence and longer term compliance monitoring and the CQC and Compliance Assurance Group (CQCCAG), which meets monthly to review progress against the CQC Action Plan. The CQCCAG is attended by representatives from all relevant areas of the Trust. Additional review meetings, at an Integrated Service Unit (ISU) level, have been put in place to further support the delivery of the actions contained within the CQC Action Plan, and the collation of corresponding evidence.

The status of the CQC Action Plan is routinely reported to relevant governance groups or Committees and to each meeting of the Trust Board.

Our overall conclusion is supported by the conclusion for each area reviewed, as set out below:

Area reviewed	Rating	Conclusion
1. CQC Improvement Action Plan		The Trust has prepared the CQC Action Plan, which captures detailed actions to address all 28 Requirement Notices (Must Do actions) and all 43 Should Do actions, as identified in the Areas for improvement section of the CQC Inspection Report of July 2020. This was submitted to the CQC in two stages, with the Must Do actions submitted at the end of July 2020, and the Should Do actions submitted at the end of September 2020. The CQC Action Plan includes relevant CQC commentary from previous inspection reports, details of how compliance can be demonstrated and the evidence required to support individual actions, and details of which governance process will be used to monitor the actions to confirm they have been embedded. The CQC Action Plan also includes a mechanism to validate evidence provided and obtain Executive sign-off of each action. The CQC Action Plan is managed through the CQC and Compliance Assurance Group (CQCCAG), which convenes on a monthly basis. This group is chaired by the System Director for Nursing and Professional Practice, South Devon (SDNPP), and added the new Chief Nurse to its membership in August 2020. Each action on the CQC Action Plan has a target completion date, an identified lead, and an identified responsible Executive. Progress against the actions are discussed at the CQCCAG meetings, and updated on the CQC Action Plan document. The likelihood of timely completion of each action is assessed, and risk rated to give a Red/Amber/Green rating, which is used to inform these discussions.

Area reviewed	Rating	Conclusion
		In addition to the CQCCAG, the Trust has added a further governance process to support this completion of the CQC Action Plan. The SDNPP and the Quality and Compliance Manager meet with the three Associate Directors (Medical, Operations and Nursing and Professional Practice) for each Integrated Service Unit (ISU), and Safeguarding leads, on a monthly basis to review actions, and evidence, specific to each ISU. These meetings commenced in September 2020.
2. Performance Monitoring and the CQC and Compliance Assurance Group		Progress against individual actions is routinely updated on the CQC Action Plan, which is monitored on a monthly basis by the CQCCAG. At the time of our review the Trust had rated a total of 59 actions (22 Must Do and 37 Should Do) as "On track" (Green). Six actions (three Must Do and three Should Do) had been rated as "Overdue" (Amber). Each of these six actions had been discussed at meetings of the CQCCAGG, where additional actions to bring these back on track had been identified and agreed. At the time of our review a total of six actions had been recorded as completed. These had yet to be formally recorded on the CQC Action Plan document as signed off by the relevant Executive, and this sign off should be obtained.
3. Reporting		Progress against the CQC Action Plan is routinely reported to each meeting of the following governance groups or Committees: • Quality Improvement Group. • Quality Assurance Committee. • Finance Performance and Digital Committee. • Trust Board.

Overall Assurance Opinion

It is our view that the overall assurance opinion on the design and operation of controls is Significant as recorded in the table on the face of this report and in accordance with the opinion definitions under the *ASW Assurance - About Us* section of this report.

We would like to acknowledge the help and assistance given by the Quality and Compliance Lead during the course of this review.

Rating of Recommendations

Recommendations raised in this report have been rated in accordance with the organisation's risk matrix.

Jenny McCall, Director of Audit and Assurance Services

Report Data

Date of Work Undertaken	November – December 2020
Date of Issue of Draft Report	14 December 2020
Date of Return of Draft Report	XXX
Date of Approval of Final Report	XXX
Lead Auditor	Russell Scarbro, Senior Audit and Assurance Specialist
Client Lead Manager(s)	Claire Burton, Quality and Compliance Lead
Client Lead Director	Deborah Kelly, Chief Nurse
Governance/Regulatory Links	All CQC regulations

Action Plan

Rec no.	Recommendation	Risk rating	Management response	Manager responsible	Action date
1	The Trust should ensure that all completed CQC actions are formally signed of by the relevant Lead Executive, as per the CQC Improvement Action Plan.	Green (4)	Our overall aim is for each of the Executive leads to formally sign off he evidence and completed actions. At present we are working with each of the core service leads and ISUs, to ensure that the evidence that supports the completion for the CQC action plan are robust, rigorous and demonstrate improvements, are embedded within practice and are sustainable.	Natasha Goswell, System Director of nursing and Professional Practice	30/03/2021

Detailed Findings

1. CQC Improvement Action Plan

What We Checked

We reviewed the Trust's CQC Improvement Action Plan (CQC Action Plan) to confirm that it included all 28 Requirement Notices (Must Do actions) and all 43 Should Do actions that were reported in the CQC Inspection Report of July 2020. We then reviewed the plan to confirm that it made provision for the identification and validation of suitable evidence, and for the formal sign off of completed actions.

What We Found

The CQC Action Plan contains all 71 required actions (28 Must Do and 43 Should Do) as detailed within the CQC Inspection Report of July 2020 and also includes the following for each requirement:

- Details of CQC commentary from previous inspections.
- Details of required evidence, its validation, and Executive sign off.
- Details of governance / monitoring pathway.
- Details of Operational Lead and Executive Lead.
- Completion dates, review dates, actions taken, and a RAG rated assessment of progress to date.

The CQC Action Plan includes some actions assigned to generic roles, i.e. Matrons or Operational Managers, which may make accountability difficult to enforce.

Recommendations

Risk	Risk Rating	Recommendation
No recommendations have been made		

2. Performance Monitoring and the CQC and Compliance Assurance Group

What We Checked

We reviewed the business of the CQCCAG to confirm that progress of the CQC Action Plan is routinely monitored.

What We Found

The CQC Action Plan is routinely monitored by the CQCCAG, which is attended by senior representatives from all relevant areas of the Trust. The Plan document is regularly updated to reflect the latest status of actions.

As at 4 December 2020, the CQC Action Plan listed:

- 59 actions rated as on track (green).
- 6 actions rated as overdue (amber).
- 6 actions recorded as complete.

Each of the six completed actions is included in the CQCCAG minutes. The corresponding Evidence & Executive Validation cells within the CQC Action Plan document have not been completed for any of these, and this senior sign off should be obtained.

Recommendations

Risk	Risk Rating	Recommendation
If the Trust does not complete all stages of its own internal governance processes there is a risk that the overall assurance position may be overstated, and that further required actions may not be identified.	Likelihood (2) X Consequence (2) = 4 – Green	1. The Trust should ensure that all completed CQC actions are formally signed of by the relevant Lead Executive, as per the CQC Improvement Action Plan.

3. Reporting

What We Checked

We reviewed current arrangements for reporting of the status of the CQC Action Plan, to confirm that there is appropriate visibility of this key workplan, at suitably senior levels within the organisation.

What We Found

The CQC Action Plan is routinely reported to each meeting of the following governance groups or Committees:

- Quality Improvement Group.
- Quality Assurance Committee.
- Finance Performance and Digital Committee.
- Trust Board.

Recommendations

Risk	Risk Rating	Recommendation
No recommendations have been made		

ASW Assurance – About Us

ASW Assurance is the largest provider of internal audit, counter fraud and consultancy services in the South West. We maintain a local presence and close engagement within each health community, with audit teams based in Bristol, Exeter, North Devon, Plymouth, Torquay and Cornwall, linked by shared networks and systems. More information about us, including the services we offer, our client base, our office locations and key people can be found on our website at www.aswassurance.co.uk.

ASW Assurance is a member of TIAN; a group of NHS internal audit and counter fraud providers from across England and Wales. Its purpose is to facilitate collaboration, share best practice information, knowledge and resources in order to support the success and quality of our client's services.

All audit and assurance assignments are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

Confidentiality

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

Inherent Limitations of the Audit

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

Rating of Audit Recommendations

The recommendations in this report are rated according to the organisation's risk-scoring matrix and have been arrived at by assessing the risk in relation to the organisation as a whole.

Overall Assurance Opinion Definition

The overall assurance opinion on the front page of this report is based on the following definitions:

Significant	Controls are well designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Rating of Individual Findings

The following ratings have been used to summarise our evaluation of each area reviewed and helps form our overall assurance opinion:

	Processes are appropriately designed and appear to be operating well. Any areas for improvement that were identified are not significant and are unlikely to reoccur.
	Controls and arrangements are generally appropriately designed working well but we have identified areas where these arrangements should be further strengthened. We do not have significant concerns regarding this area and any issues that were identified are unlikely to reoccur if properly managed.
	Urgent action is needed to address weaknesses in the processes which are in place to manage the task or function. We have significant concerns regarding this area and consider that issues may arise or reoccur.

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NHS
Torbay and South Devon
NHS Foundation Trust

Trust Board of Directors			
Report title: Developmental review of leadership and governance using the well led framework – Deloitte's report			**Meeting date:** 27th January 2021
Report sponsor	Chairman and Chief Executive		
Report author	Chief Executive		
Report provenance	The Board agreed to commission a developmental review of leadership and governance using the well led framework at the March Board meeting and approved the proposal to let the contract to Deloitte at the September. The draft report has been presented to the Board at a development session in December 2020.		
Purpose of the report and key issues for consideration/decision	To provide an update on the completion of the developmental review of leadership and governance including report findings and approach to development of an improvement plan.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to: • Note the content of the report • Consider and support the approach to delivery of the Improvement plan		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	x	**Risk score**	9
Risk Register		**Risk score**	

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**

Report title: Developmental review of leadership and governance using the well led framework – Deloitte's report		**Meeting date: 27th January 2021**
Report sponsor	Chairman and Chief Executive	
Report author	Chief Executive	

1. Introduction

In June 2017, NHS Improvement issued updated guidance relating to well-led reviews, around the scoping of reviews, the commissioning of an external facilitator and descriptors of good practice against the eight Key Lines of Enquiry (KLOE's), and more detailed advice which provided template specifications and example evaluation criteria for use in any procurement process.

NHS Improvement encourages all Foundation Trusts to undertake a development review of leadership and governance against the well-led framework approximately every three years, which may be extended to five years. The Trust undertook an internal review against the KLOE's in preparation for the CQC well-led inspection that took place in 2018, and undertook a refresh ahead of the 2020 inspection. An externally facilitated review had not been undertaken however since the Trust became an ICO in 2015, and therefore the Board agreed in March 2020 to commission a review.

The objectives for the review

- Deepen the Boards own understanding of its leadership and governance through objective review and challenge;
- Identify development actions in relation to the well- led framework; and
- Enable some skills transfer and knowledge sharing from the external provider who will have experience from similar reviews elsewhere

The Trust used the NHS Supplier Framework to identify suitable suppliers and following a tender process Deloitte were awarded the contract and commenced the review on 1 October 2020.

2. Review process

Deloitte used all 8 developmental themes in the well led framework as a basis of the review; leadership, vision and strategy, culture, good governance, risks and performance, Information, stakeholder engagement, learning, development and innovation

The methodology used by the review Team included:

- Desk top review of relevant documents
- Anonymous online surveys with Board members, Council of Governors and staff
- Non-attributable interviews with each Board member
- Virtual meeting observations
- Observation of service line meetings
- Virtual staff focus groups
- Telephone interviews with external stakeholders

Following the completion of these activities emerging themes were shared with the Chairman, Chief Executive and Company Secretary and a virtual workshop was then held with the Board on 9 December 2020.

The draft report was made available to Board members and a factual accuracy check was conducted in December and January and comments submitted to Deloitte. The final report was submitted to the Trust on 22 January 2021.

3. Outcome of the review

Deloitte provided a final report in January 2021. The report detailed examples of good practice and 26 recommendations for improvement against each of the 8 key domains of the well led framework. The top-level themes highlighted in the report are:

- Optimising executive portfolio and coverage
- Executive interface with System Directors
- Executive oversight of the corporate strategy
- Whole system focus, increased attention on the community health and care
- Building clinical engagement
- Making best use of the Board agenda
- System and ISU governance

4. Developing an improvement plan

The Board agreed that when the report had been finalised a Board Development workshop would be held to collectively agree a response to the matters raised. A meeting has been arranged for 10 February 2021 for this purpose.

The Board will be asked to:

- Agree actions
- Align actions to Executive leads
- Align groups of recommendations to the appropriate committee to enable oversight of progress

5. Recommendation

- Note the content of the report
- Consider and support the approach to delivery of the Improvement plan