Torbay and South Devon NHS Foundation Trust
Public Board of Directors

30 June 2021 09:00 - 30 June 2021 14:00

AGENDA

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2.2	Apologies for Absence Note	Ch	
2.3	Declaration of Interests Note	Ch	
3	Consent Agenda (Pre Notified Questions)		
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3.1.2	Finance, Performance and Digital Committee Chairs Report - 24th May 2021 Receive and Note 3.1.2 Finance Performance and Digital Chairs Repo... 13	P Richards	
3.1.3	Quality and Assurance Committee Chairs Report - 24th May 2021 Receive and Note 3.1.3 Quality and Assurance Committee Chairs Rep... 15	J Lyttle	

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7	Valuing our Workforce		
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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Report of Audit Committee Chair to the Board of Directors

Meeting date:	25/5/21
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. The Committee received and discussed a number of papers:

   The Statement of Internal Effectiveness (based on the risk arrangements for 20/21 and the internal control review work completed)

   The Annual Self-Certification re Provider License Conditions (evidence was presented to confirm compliance)

   The Draft Annual Report and the Unaudited Annual Accounts for 20/21

   The External Audit Progress report (no significant issues had been identified to bring to the committee at that point)

2. The Committee received the Internal Audit Interim Report and noted that all audits finalized since the last meeting provided satisfactory assurance.

3. The Committee was pleased to note that as at 18/5/21 there was only one recommendation (low risk) overdue for implementation.

Torbay and South Devon
NHS Foundation Trust

Report of Finance, Performance and Digital Committee Chair to the Board of Directors

Committee meeting date:	24 May 2021
Report author + date:	Paul Richards, Non-Executive Director 20 June 2021
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

Risk management

The committee received interim updates on the BAF, which would be re-defined once the Trust's new strategic objectives are launched. The merits of a Board development session on this, and including discussion of the Trust's risk appetite, were noted.

Strategy & planning

The committee received an updated budget setting analysis for the first half of the financial year, which resulted in a break-even position in line with national guidance. A discussion was held as to the need for external support in further driving reductions in the underlying deficit, and it was acknowledged that work was underway to reintroduce the usual 'good housekeeping' across operations and finance. In discussing the financial recovery imperative, the committee received two detailed presentations, and was mindful that SEND collaboration could offer avenues to improve quality and reduce unit costs in some specialties.

A brief update on capital planning for 2021-22 was presented. Despite the significant level of funding available, there remained pressure on local capital resources, and a prioritised programme would be presented to the next committee meeting, with QIAs undertaken for schemes which were on hold pending funding.

The committee received a report into the Trust's activity Recovery Plan and the risks and opportunities within in. It was noted that the Trust was experiencing significant non-elective demand, generating bed pressured which were compounded by the recent closure of Elizabeth Ward.

Performance

The committee received the M1 Integrated Performance Report, noting in particular:

- The Trust continued to experience significant pressures in unplanned care attendances and admittances. This was also being experienced across the Devon system. However, the Trust had not received any new Covid admissions in the reporting period
- The need to close Elizabeth Ward to inpatients had resulted in the loss of 14 beds, and work was underway to mitigate the impact of this and identify alternative uses for the space.
- In terms of activity, the Trust was beyond trajectory, however there had been a need to close a theatre due to humidity, the impact of which was not yet included in the data. Cancer performance was steady albeit challenged, and a small reduction in 52 week waits had been achieved. The committee discussed in detail the drop in performance in respect of two week waits for Breast and Urology, which had different causes. In respect of Breast services, the committee received assurance that the issues were time-limited and had now been resolved, however there were more underlying systemic issues that affected the urology performance. The COO drew the committee's attention to the overall shape of the waiting list – noting that current modest improvements in 52 week waits could be a reflection of the drop in referrals at the outset of the pandemic.
- A surplus of just over £400,000 had been achieved, cash was strong at £38.5m and capital spend totalled £0.5m in the year to date.

Key decision(s)/recommendations made by the Committee

Approved:

- The committee supported the H1 budget at break even for recommendation to the Board

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	24th May 2021
Report by + date:	Jacqui Lyttle Committee Chair 7th June 2021
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 discussed and decisions made

1. CFHD Service Review – Autism Spectrum Disorder Diagnostic Pathway

The committee received an excellent presentation which provided an overview of the

- Background
- Vision
- Current Position and risks
- Recovery Plan
- Performance trends and risks

The committee reflected on the enormous amount of improvement work that the service had already undertaken and the detailed plans in place to mitigate current risks. The review identified that several staff members had left to work for a private company who are paying higher levels of remuneration which was placing further strain on the remaining team members and was compromising quality and responsiveness to service users.

2. Building A Brighter Future (BBF) Progress Report

The committee received a presentation on the Building a Brighter Future Project, which gave specific information and assurance on how the BBF project would provide improved quality and safety for patients. There was discussion on how the public would be communicated with to allay fears that a change in service configuration would not be detrimental and the committee were assured that the trust will seek feedback from the local population and stakeholders on the shape of future services. The committee were assured that quality and safety was at the forefront of the planning process and would become a particularly important part of the SOC as it was further developed.

3. Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

The committee received the updated BAF and CRR relating to objective 5 *to provide safe, quality patient care and achieve best patient experience.*

Given the known risk of harm to patients on extended waiting lists due to the impact of Covid, the committee were informed that the risk group proposed that the risk score be increased from 16 to 25, this was supported by the committee members. The committee also considered whether it would be prudent to separate the risks associated with COVID and those associated with business-as-usual operations.

The committee agreed that these proposed changes should be escalated to the board for consideration in view of the impact of Covid on the Trust's performance and impact on quality and safety.

4. Clinical Governance Framework Update (CGF)

The committee received an update on the CGF and were assured that the framework was being socialised and embedded within the trust. The committee noted that the three priories for 2021/22

- patient safety
- clinical effectiveness
- patient experience

had been agreed and that a quality summit was being held on the 1st July.

The committee were assured that the development of the CGF was on track, that the appropriate quality metrics are being developed and mapped in-order to be able to measure the delivery of outcomes.

5. Quality Account 2020/21 (draft) and 2021-22 Priorities

The committee received and approved the quality account for 2020/21 and approved the quality priorities for 2021/22 for submission to the board

6. CQC quality assurance report

The committee received and approved the annual report for submission to the board.

7. Education annual plan

The committee received an excellent report and felt that it clearly articulated the trusts direction of travel and linked well to its clinical governance framework. For the progress of the plan to be appropriately considered it was agreed that a half year update be presented to the committee in November.

8. Maternity Services Governance and Safety Q4 Report

The committee received a very comprehensive report and received full assurance on several key performance and quality indicators. The following areas were highlighted in detail to the committee.

- The Trust had submitted its response to the immediate and essential actions detailed in the Ockenden report, with work continuing to ensure the Trust met the remaining actions
- The report detailed serious adverse events that had occurred, and the action taken following the events including reviews and any learning.
- Work had taken place to improve the department's quality and bereavement response following a baby death. A bid for funding to support a specialist bereavement midwife had been made and, in the interim, a temporary appointment had been made. The support provided by the postholder was already having a positive effect on families and also staff.
- The number of still births had reduced for the third year in succession.
- Work to meet CNST actions was on track.
- Following the Birth Rate Plus review a staffing shortfall of 13.2 whole time equivalent posts had been identified. A bid had been made for funding to support the Trust in employing substantive staff and if successful it was hoped staff would be in place by March 2022.

9. Quality Report incl performance metrics

The committee received the quality report and were assured that actions are in place to mitigate the risks. There were no new risks brought to the committee's attention not covered by the update. The report provided substantial assurance on several areas including STEIS reportable incidents, VTE, stroke pathways, and operational challenge facing the trust. The committee reflected on how the quality report had matured over the

past few months providing both greater assurance but also a better understanding of how risks are identified and managed,

10. Clinical Audit Forward Plan

The Committee received the Clinical Audit Programme report and reflected on the amount of work that had taken place over the past year. The plan aimed to improve the Trust's learning framework in terms of learning from clinical audits and build a culture of safety including safety huddles being used for their proper purpose and improved reporting. In addition, a Quality Hub would be introduced to support learning.
The committee welcomed the report noting that in the past it had been presented to the Audit Committee, which had struggled to drive improvement. The committee felt that it was more appropriate for the QaC to oversee the progress of the plan, and this would be articulated to the Audit Committee by its chair.

11. Torbay Carers' Strategy and Action Plan

The Committee received and noted the Torbay Carers' Strategy and Action Plan, particular attention was given to the following.

- All bar 2 of the 120 actions contained in the last strategy had been achieved. The 2 outstanding actions related to peer support and GP volunteer support. The peer support action was included in the new strategy; however, it was not possible to take forward the GP volunteer action due to issues with access to data.
- Despite Covid, there had been an over-achievement on the carer's assessment targets. Covid had had a huge impact on carers and several assessments had been carried out virtually.
- The Trust had signed up to a Commitment to Carers and the Trust was the only organisation in the Integrated Care System to have published its commitment.
- There was a need to ensure staff had the tools to identify carers at the earliest opportunity, so they had the option to access support if they wished. This included staff members who might be carers so they could be supported by the Trust if necessary.

12. <u>Accountability reporting</u>

The Committee received noted the following assurance reports.

- QIG
- SAE

Key Decision(s)/Recommendations Made:

- The staffing issues within the CFHD Autism team was identified as a risk to the stability of the service and it was agreed to escalate this issue to the board for their note and consideration.
- The committee recommend that the risk score for objective 5 be increased from 16 to 25 and that the COVID and non-COVID risks be separately identified. The committee ask the board to consider these recommendations.
- The committee recommended that the clinical audit work plan be overseen by the QaC.

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Report of BBF Redevelopment Committee Chair to TSDFT Board of Directors

Meeting date:	23rd June 2021
Report by + date:	Chris Balch, 24th June 2021
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 (June 2021):

1. The Committee received a presentation on the draft Strategic Outline Case (SOC) which had been circulated for comment prior to the meeting. While further work is underway to strengthen key elements of the case for change and attention is being given to consistency of presentation and messaging, the Committee were assured that the document will be ready for approval by the Board and submission in July. It was noted that presenting the case at a Programme level covering investment in both digital and estates is a challenge in terms of methodology and complexity. However, the transformation and long-term financial sustainability of the Trust's services is dependent on both components. The Committee noted the substantial progress made in developing the SOC and appreciated the hard work involved.

2. The Committee received an update on the communication and engagement plan for the SOC. Meetings have been arranged and are underway with the key internal and external partners to explain the emerging, high-level plans and seek expressions of support. The Committee heard that to date the response has been very positive.

3. The Committee approved the early submission of an application for seed funding for work on the Outline Business Case (OBC) totalling £13.948m. The Committee were assured that this is a prudent, yet reasonable sum given the scale and complexity of the Programme and falls within benchmark figures as a proportion of capital spend. It was noted from the financial report received by the Committee that the initial seed allocation for the production of the SOC will be exhausted by July. Early approval of the funding for work on the OBC will be required to allow work to progress without interruption.

4. The Committee noted that the BAF has been updated to incorporate the risk to the BBF programme of not securing early approval of funding to prepare the OBC.

5. The Committee noted the content of the letter received from the national New Hospital Programme (NHP) team. It welcomed confirmation that the Trust is programmed to start construction from January 2025 which is in line with our current planning. It was noted that the letter indicated strong central direction over procurement and standardised design to maximise the benefits of a programmatic approach.

Key Decision(s)/Recommendations Made:

1. To note the above.

Name: Chris Balch (Committee Chair)

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report June 2021			**Meeting date:** 30th June 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 Integrated Performance Report (IPR) monthly reports including performance metrics. The report explains the key risks and operational responses to support delivery of urgent and emergency flow and to increase the delivery of elective services as COVID -19 demand reduces. The report also provides information and greater visibility for a number of important areas of Trust business not fully covered in the IPR. Key areas for consideration; over the most recent 6-week period the Trust has experienced continuously high levels of demand through the urgent care system - ED/Medical Receiving Unit (MRU) and the Surgical Receiving Unit (SRU). During this time the Trust is also increasing elective activity in line with the elective recovery plan. This has put additional pressure on in-flow through ED alongside the challenges with patient flow through the Trusts Beds. Bed flow has also been compromised due to infection prevention and control issues (non-Covid) against a backdrop of reduced bed availability. Increased paediatric activity is predicted in line with NHS E/I guidance and intelligence. There is good news regarding the 3rd CT scanner which is now fully commissioned and the commencement of the "First Dental Steps research trial".		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board of Directors receive and note the report.		

<table>
<tr><th colspan="2">Summary of key elements</th></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></td><td>Well-led</td><td>X</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td>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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BAF: Corporate objective 2 – To deliver levels of performance in line with plans and national standards to ensure provision of safe, quality care and best experience.
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<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>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		**Meeting date:** 30th June 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. Introduction

Activity in non-elective care has exceeded pre-Covid19 levels. Outlined in this report are the operational pressures and impacts across the system. Actions have been taken to support system recovery with improvements to support 7-day enhanced working across the Trust. Other measures are being put in place to support increased urgent and emergency demand as the Trust moves forward towards summer including paediatric surge capacity and planning for winter pressures.

3. Flow and capacity

To put context to the Trusts operational flow pressures the impact of bed changes is set out below:

- The relocation MRU (medical receiving unit) on Forrest ward as an interim measure until new MRU is operational in spring 2022
- The repurposing of EAU3 as a result of ED covid security works
- The requirement to close Elizabeth ward
- The segregation of Cromie ward to enable 8 beds for safe management of any patients with covid Trust needs to admit

The impact on bed numbers is significant (circa 47) although mitigated to some extent by the functionality of the medical and surgical assessment units. The changes also include changes on specialist wards such as Turner and Midgley wards. The changes in use of ward areas have been tested and considered carefully at every stage with the operational and clinical assessment confirming the changes are required in order to deliver the safest possible care in the context the Trust is operating.

However, the Trust is experiencing increased demand with a rise in non-covid urgent care presentation above the level seen pre-covid alongside increased surgical activity to deliver the recovery requirements. This is essential activity needed to support reduction of waiting lists and ensure prioritisation of high priority elective patients.

The increasing level of urgent care demand for non-covid patients is a being experienced nationally and is also causing significant pressures locally on the system across Devon. The Trust is also planning for summer when non-covid demand is expected to increase due to staycations and into winter, where more acutely unwell patients will present. Consideration is being made in relation to the space which could

be used to mitigate the restricted bed capacity to ensure services are safe and effective for both covid and non-covid patient demand. A number of rapid improvement process reviews and tests of change are underway with the expert support of the transformation team including enhanced 7day response.

4. Children and Family Health Devon

4.1 Performance

This information from CFHD is provided to ensure the Trust Board has visibility of the contract performance as the Trust holds lead provider accountability for this service. Improvement in waiting times has continued to be a focus of the CFHD leadership and clinical teams. The key waiting times indicators and changes to the position are set out in the table below.

Overall RTT (Incomplete Pathway)

Service	Mean Wait	% waiting ≤ 18 weeks	% RTT ≤ 18 weeks compared to last month	% RTT ≤ 18 weeks over the last 12 months
Community Children's Nursing (CFH Devon)	4.9	88.2%	↓	
Learning Disability (CFH Devon)	6.0	100.0%	→	
Mental Health and Wellbeing (CFHD)	14.0	71.3%	↑	
Occupational Therapy (CFH Devon)	16.6	64.3%	↑	
Palliative Care (CFH Devon)	9.9	100.0%	→	
Physiotherapy (CFH Devon)	9.6	86.8%	↑	
Special School Nursing (CFH Devon)	Null	Null	→	
Specialist Autism Spectrum Assessment Team (CFHD)	62.1	9.2%	↓	
Specialist Children's Assessment Centre (CFHD)	28.7	33.5%	↓	
Speech & Language Therapy (CFH Devon)	28.0	37.1%	↓	

Learning Disability, Palliative Care and Specialist School Nursing remain high performing services with stable RTT at 100%. Improvement is shown in three services - Physiotherapy (87%), Occupational therapy (64%) and CAMHS (71%). There has been a decrease in performance for Community Nursing ((88%), ASD (9%) and Speech and Language Therapy (37%). However significant improvements in efficiency and productivity are being seen particularly in the ASD service. The predicted increase, post lockdown, in children's mental health presentations has begun to create pressure on waiting times.

As previously reported the Autism waits plan is being rolled out. The remote team is operational and the CFHD team has increased its efficiency by 95%. Overall, there are currently 2,408 CYP waiting for ASD assessment, having been reduced by 546 since the start of the project. The project is below its waiting list reduction trajectory due to the remote team not being fully established and staff retention issues. A plan is under development to recover the planned trajectory.

4.2 Transformation

The transformation programme continues at pace. Ten needs-led clinical pathway designs are now agreed. Work on the workforce re-structure and costing continues to the agreed timeline. A fully integrated workforce structure has been designed to support integrated delivery of care and treatment in accordance with the service specification. A review of corporate support is being undertaken as a part of this

process to ensure CFHD has the required support provided from the contributing trusts.

Whole service weekly Q&A sessions with the Director and Deputy Director have continued, to facilitate continued transparency and staff engagement. The complete operational and clinical model has been presented to two groups - clinical leaders and managers, and the whole service; the latter being attended by 150 staff members. Staff engagement has remained good with broad support for the service model. Staff do however, remain anxious about their roles in the new workforce structure which is eagerly awaited.

4.3 Risks

There remain three corporate level risks relating to CFHD; waiting times, vacancies in CAMHS and increased eating disorder referrals leading to longer than normal waits. In addition to these identified corporate risks a risk relating to access to the speech and language therapy service has been raised and is being considered for further action to mitigate.

4.4 Finance

The IPR contains the summary of the CFHD finance position this section of the report is consistent and explains some of the current opportunities which are being explored. Analysis has been undertaken which shows the run rates of spend are stable month on month. Work is ongoing to ensure that the CYP crisis care and eating disorders bids are updated and resubmitted to the CCG as requested by 18th June, this will include the ongoing recurrent costs. Further service development fund funding for 18-25-year olds has now been identified £0.4m and plans are been drawn up accordingly. CFHD have also been notified that Mental Health in Schools Teams Wave 5 funding has been awarded to CFHD to set up 3 further teams across Devon.

5. Phase 3 Recovery

5.1 Elective Care / Referral to Treatment (RTT)

Transformation of the elective and planned care pathways continue, attention has been focused towards data capture and driving through the virtual platforms and maximise opportunities for increased patient throughput. This support from the transformation team will be changing as two senior members of the team move on to new roles. It is hoped replacements can be found quickly to maintain the progress being made in outpatients, theatres, urology and orthopaedic GIRFT.

Further ward moves have been identified to secure a safe pathway for Elective inpatients should the Trust need to admit covid positive patients.

As noted the continued pressure on the front door puts elective recovery at high risk. The Trust took the very difficult decision to cease elective orthopaedic activity for a period of 2 weeks from the 21st June. During this time, with the support from the Transformation Team, described above and through an Incident Control Centre (ICC) approach the teams are seeking to de-escalate the system and restart regular elective orthopaedics as soon as possible.

The first tranche of elective recovery fund plans (ERF) have been approved and the team is now actively scheduling additional activity. The ERF plans will be updated weekly as opportunities arise.

The Coastal Associate Medical Director has been allocated additional time to work through job planning, a keystone in future capacity and demand planning. Progress from August should accelerate as a result.

5.2 Medicine Long Term Conditions (LTC) Referral to Treatment (RTT)

In April 2021 RTT incomplete performance across the Long-Term Condition specialities was 72% and positively supported the Trusts aggregate position. There has been a gradual improvement since the start of the recovery phase with performance over the last 4 months stabilising at this level, this mirrored the overall Trust performance trend.

The backlog position for patients waiting >6 months can be seen below:

	May-20		May-21			
	TOTAL on New PL	6 months +	TOTAL on New PL	6 months +	TOTAL on New PL	6 months +
Cardiology	605	142	642	63	6%	-56%
Dermatology	881	142	1076	221	22%	56%
Diabetes	92	13	61	0	-34%	-100%
Endocrinology	286	45	423	17	48%	-62%
Nephrology	29	0	58	0	100%	0%
Neurology	733	182	581	107	-21%	-41%
Respiratory	459	28	478	32	4%	14%
Rheumatology	425	9	564	92	33%	922%

The team monitor and prioritise treatment for all patients who's waiting time is approaching or in excess of 52 weeks (145), 78 weeks (14) and the 1 patient who has waited over 104 weeks. This patient has chosen to wait whilst undergoing treatment unrelated to the respiratory condition referenced here.

Through detailed capacity & demand modelling and weekly performance review LTC specialties continue to balance new & follow up capacity with outpatient demand.

Further improvement work is being undertaken to reduce the did not attend (DNA) rate which stood at 7.1% in April – this includes a focus within Diabetes and Endocrinology (specifically the obesity services) and Neurology.

5.3 Cancer Two Week Wait (2 WW) Performance

Dermatology continues to be a significantly pressured service with an average of 25 referrals being received daily, this is in excess of the available recurrent capacity. Significant activity is provided by locum consultants some of whom are leaving the Trust in the near future. The pressure will therefore increase in the coming weeks. However, at this point in time the team is improving the 2ww performance by reducing routine and follow-up appointments to accommodate 2ww demand thereby achieving the 92% performance standard.

5.4 Echocardiography

The echo backlog has reduced from 1,480 patients to 243. This is a significant improvement and has been achieved through outsourcing and additional sessions worked by physiologists at the Trust, replacement of old machines and the purchase of a 3rd Echo machine increasing capacity by circa 30 patients per week.

5.5 Neurophysiology

This service has been challenged for a prolonged period due to lack of a consultant service at the Trust. Partner organisations are also experiencing difficulties continuing to provide the support they have been. Temporary resource will continue through to February 2022. As a result, waiting times for a specific test (EMP) is at 24 weeks with 125 patients waiting. A recommendation to carry out a region wide review of service provision has been made.

5.7 Dexa scanner (for bone density)

The new Dexa scanner will be fully operational at the end of June, the team will then manage the backlog built up during this replacement period. Currently there are 160 new Dexa referrals and 50 follow up patients awaiting a Dexa scan.

5.8 Laboratory medicine

The Samba lab (rapid testing for Covid and other helpful near patient diagnostics) is progressing well, the recruitment is underway and the redesigned space almost completed. This development will be a significant asset in supporting timely flow through the ED and assessment areas. Current infrastructure issues associated with Histology Portacabin are being closely monitored to ensure there is no impact from the MRU build, early scoping of alternative sites across the hospital to re-site the histopathology laboratory is underway.

5.9 Diagnostics

Waiting times for all modalities remain challenged with a significant number of patients waiting beyond 6 weeks, particularly in CT and MR. At the current time, the position is holding. Patients referred for ‘urgent referrals’ or on 2ww pathways continue to be prioritised and waits here remain compliant.

There are common risks and issues impacting ability to recover at pace which include:

staffing levels, most significantly in CT and Plain Film. There are a significant number of new staff joining the service and although supporting and training this new cohort will put pressure on the existing team the impact of the additional staff will be very welcome. Unfortunately there is limited scope to source additional capacity for CT and MR scans due to an inability to site additional mobile capacity at the Trust. Capacity has been made available at the Nightingale hospital in Exeter (NHE) for CT, however contrast studies are not currently being delivered at NHE and this limits the impact from this capacity. There is also evidence that some patients do not wish to travel to the NHE. The 3rd CT scanner has now been fully commissioned and the new Gamma Camera installed and back in service. The backlog related to the nuclear medicine studies (Gamma Camera) continues to be supported by colleagues at the Royal Devon and Exeter (RDE).

6. Urgent & Emergency Care

6.1 Emergency Department (ED)

The low prevalence of COVID in Torbay and South Devon has allowed the ED to adapt to the increased demands following the easing of lockdown and the increased numbers of visitors to the region. The department is extremely busy with both emergencies and people needing urgent care. The ED is providing bookable appointments through NHS 111 seven days a week.

6.2 Emergency Department Phase 2

Work continues to progress on the development of the paediatric area with a view to commence in 2022. Discussions are continuing on the timing of the remaining phase 2 works to the “Building a brighter future” estate developments.

6.3 Medical Receiving Unit (MRU)

The MRU remains on Forrest ward and will celebrate its first anniversary of opening in June. Works to the new build have been difficult in May due to the challenging weather conditions but are still on timetable. The next phase of works includes demolishing activities and preparation for piling works which may introduce some noise disruption.

6.4 Urgent treatment centre (UTC) and Minor Injury Units (MIU’s)

In common with the ED the UTC has seen a significant increase in attendances for urgent care during May. The use of booked appointments through NHS 111 allows for the centre to manage busy times of the day and reduce waiting times for patients.

7. Child Health /Paediatrics

7.1 Child Health

Louisa Carey ward is currently experiencing an increase in admissions including the anticipated increase in respiratory infections. Initial scoping within the current ward estate has provided options for increasing capacity by up to 4 children (2 cots, 2 beds). Planning trajectories are suggesting a potential increase of 20-50% for respiratory

syncytial virus (RSV's) over the forthcoming months and into winter. Flexibility in the functioning of the short stay paediatric unit (SSPAU) will be required with the unit closing at times of high demand to provide additional space. The Trust is also experiencing high demand for beds for children / young people with eating disorders requiring intensive support and this puts additional pressure on the ward. Collaboration with the CFHD team is exploring options to support these young people.

7.2 0- 19 Torbay

The First Dental Steps research project commenced on 7th June 2021. This is a 6-month project looking at improving oral health in children. It has been developed by Public Health England and funded by NHS England and will run from June to September.

Funding has been secured by the 0-19 service from covid recovery funds and will enable the service:

- to provide 12 months family and resilience support for identified families under additional pressure as a result of the pandemic. This includes domestic abuse & sexual violence, family conflict, economic impact and mental health. A sub contract will be in place reaching young parents and delivered by Torbay Culture.
- to develop a blended job role for the Action for Children staff and the Trusts community nursery nurse roles working with families from pregnancy to the age of 2
- to appoint a community engagement worker to help families improve & maintain their health to promote & actively encourage empowerment & active participation.
- to design & create digital theme-based health resources for schools & early years settings to enable health to be a core part of the work. To include videos, lesson plans and other helpful resources for children, young people, families and professionals working in these settings.
- to work with the community sector to identify children who would benefit from additional resources to support children with anxieties relating to covid.
- Further funding was gained for 'fidget bags' and 'sensory bags' for children with additional needs.

7.3 Plus Size Project

From May 2019 until December 2020 an innovative pilot project was undertaken. This included a specialist community outreach coordinator programme for plus sized and housebound individuals in Torbay. This project highlighted the need for the client group to have more equal opportunities of services and support. The criteria for the service included clients who are housebound, plus sized, unable to access Tier 3 weight management services and lived in Torbay. The detailed evaluation report identified outcome barriers, opportunities and an options appraisal with the most cost-effective recommendations for the Trust outlined in the final summary.

The findings of the pilot showed significant clinically improved outcomes for the plus sized housebound clients in Torbay who engaged with this service allowing for better self-management of their health condition by increasing knowledge skills and confidence (activation level). In addition, the service demonstrated its positive affect to clients feeling of loneliness and thus positively impacted on their wellbeing.
The primary recommendations from the evaluation are being considered by the Torbay System Team.

8. Torbay System Community Services

8.1 Adult social care improvement plan (ASC)

An "Innovation Engine" has been designed to improve the process of transforming ideas into improvements, supporting staff to develop their ideas into solutions that result in an improvement in their area of work as part of continuous improvement. Recently the project working group in this area has agreed the following approach:
People, to improve the way we innovate together; Process, to strengthen the process, a mechanism to support good ideas is required, minimising the risk of ideas being lost or created in siloes or impact other areas with unintended consequences.
The team are exploring a 'challenge platform' as the best way to support continuous improvement in ASC and to consult with the experts: operational staff, in their area of work and understand potential benefits.

8.2 The New Front Door

The model was tested in mid-May and as it enters its next stage, implementation of telephony requirements, one set of processes has been developed across the Bay. The Bay wide testing has seen a consistent and faster approach to social care enquires being resolved through information, advice and guidance and access to voluntary sector services. A key benefit from the new model has been the early identification of preventative work which has been evidenced through this process, enabling enhanced conversations with commissioners.

8.4 Bay house/Tor hill house

The plan to hand back Bay House to the landlords and the reallocation of the teams to Sherbourne and Tor Hill (joint working space with Torbay Council and Torbay Public Health Team is progressing to the timetable.

9. South Devon Community Services

9.1 Health and Care System Development

Initiatives are in place across South Devon, in collaboration with partners across Torbay, to support development of the independent care market in key areas.
As restoration and recovery continue for community services there are early indications of an increasing number of safeguarding issues and work is underway with partners to better understand the situation.

9.2 Residential/Nursing Care Provision

A South Devon locality forum is promoting provider engagement with all elements of the enhanced health in care homes programme. Engagement from providers has been very positive, building upon relationships developed through the joint response to manage COVID - 19 outbreaks.
Community Teams are also working with Devon Partnership Trust and the Care Home Education and Support Teams in South Devon and Torbay to support market development for people who have challenging or expressive behaviour linked to dementia.

9.3 Domiciliary Care

Community teams are supporting an initiative led by Devon County Council (with support from the CCG) to work with domiciliary care providers developing two new initiatives: microzoning (providers working collaboratively to share packages of care and reduce travel and other 'downtime' and unsourced care) and block contracts in hard-to-source areas. The impact of these initiatives is expected to be fully realised through the third quarter of this year with potentially positive impacts supporting the winter pressure response.

9.4 Voluntary and Community Sectors

There is ongoing engagement with CCG, local authorities, and voluntary / community sector partners to understand the impact of covid and to support development of this sector in a joined-up and co-ordinated manner.

9. Newton Abbot Health and Wellbeing Centre

The building works related to health and safety and, in particular fire, have been delayed further at Sherbourne House. The expected completion of these works is now the end of July 2021. The teams have completed all of the preparatory work in readiness to move as soon as the site becomes available

10. Dartmouth Health and Wellbeing Centre

Building work starts in July on the new health and Wellbeing Centre which will serve the population of Dartmouth, bringing together primary care, community health and social care services and the voluntary sector. There will be a 'turf-cutting' ceremony on 6th July to launch this final phase of the project.

11. Coastal

11.1 Teignmouth Health and Wellbeing Centre

Teignmouth Health and Wellbeing Centre will be sited in the central area of Teignmouth and will bring together GP practices with Volunteering in Health alongside Trust outpatient services and community services and pharmacy space. This project is currently with Teignbridge Planning Dept and is waiting for the outcome of the application.

First workshops for stakeholders have begun and will continue during June / July 21

12. Conclusion

The challenges continue to be significant across both non-elective and elective care. The increased non-elective flow is incredibly challenging and has required and will continue to require, additional attention. This includes clinical and operational leadership, resource and oversight including mutual aid and system support when needed. Workforce gaps, annual leave and staff exhaustion are contributing to the difficulties, the support provided by the activities in the Trusts People Plan are essential. Significant progress has been made with planning the for the Elective Recovery Fund (ERF) to deliver increased elective care with a clear process for approvals following a number of test points to confirm deliverability, financial envelope and impact. Specialities have also completed in depth financial reviews looking at their capacity and demand, capability and workforce to deliver the efficiency requirements and mapping through H1 (half year1) and H2 (half year 2).

13. Recommendation

To note the contents and risks as described.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Directorate of Transformation and Partnerships Quarterly Report			Meeting date: 30th June 2021
Report appendix			
Report sponsor	Director of Transformation and Partnerships		
Report author	Director of Transformation and Partnerships		
Report provenance			
Purpose of the report and key issues for consideration/decision	The Board is asked to receive and note the update from the Directorate of Transformation and Partnerships. Particular areas of note are: • Significant work has been undertaken to deliver key transformation programmes • CIP planning and the ability to transact financial savings is highly challenging and escalation measures have been agreed • There remains significant challenges for all teams to commit their focus to the delivery of Transformation activity due to Covid recovery and cultural issues that will take time to resolve. • The Digital team for BBF have moved into the development of the OBC, following agreement of the Digital SOC. • The SEND Alliance have an agreed work programme supported by the Directorate • The Performance and Business Planning functions have now transferred to the CFO with the DTP now formally undertaking the SIRO role with effect from 1st April 2021. • The first draft of the Trust Strategy will be available for review in the development session by Trust Board on 30th June 2021.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked 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** X **Well-led** X		

<table>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td>X</td><td>Risk score</td><td>16</td></tr>
<tr><td>Risk Register</td><td>X</td><td>Risk score</td><td>16</td></tr>
</table>
BAF Objective 4 – To implement the Trust plans to transform services, using digital as an enabler to meet the demands of our local population.
</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td></td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td></td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td></td><td>National policy/guidance</td><td></td></tr>
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Report title: Directorate of Transformation and Partnerships Quarterly Report	**Meeting date:** 30th June 2021
Report sponsor & author	Director of Transformation and Partnerships

1. Introduction

The Directorate of Transformation and Partnerships has "transformed" following the re-structure of Executive portfolios. The Directorate now has a greater focus on transforming for our future through innovation, digital and the development of our hospital infrastructure, built on engaged partnerships with our communities and partner organisations. The addition of the Building a Brighter Future programme is a welcome focus for the Directorate and with that has come an opportunity to ensure that we align our strategy and the delivery of transformation today, with our future ambitions.

The over-sight of business planning and performance activity moving to the Chief Finance Officer's portfolio. In addition to the range of highlights you will see in this report from the senior leaders across the Directorate, key highlights in this quarter are:

- Commencement of engagement activities to support the Strategic Outline Case for Building a Brighter Future.
- Approval for the Digital SOC at Trust Board with an acceleration towards the Outline Business Case, which is scheduled for presentation to Trust Board in December 2021.
- Developing priorities for the collaboration of digital innovation with South Devon College.
- The transfer of interests in Health and Care Innovations resulting in the dissolution of the partnership.
- Building effective relationships with local partners to improve community wellbeing, through community wealth-building activities, including engaging Local Motion who are working with a small group of partners in Torbay to invest in our priority programmes over a ten-year period.
- Supporting the development and delivery of the Trust programme of work across SEND to maximise our provider collaboration potential. Four priority pathways have been agreed across SEND partners including: Stroke, Urology, Pathology and Obstetrics and Gynaecology.
- There has been a significant focus on the development and delivery of CIP plans in conjunction with the CFO and COO, who share accountability for aspects of this important work. Escalation activities have been agreed to improve the position.

The Directorate of Transformation and Partnerships continues to provide support to deliver key corporate objectives. This paper provides a summary of the work and ambitions for the next quarter, from the perspectives of each of the valuable teams within the Directorate.

2. Strategy – Lead Chris Winfield

A strategy group has been established which includes executive directors, system directors and a small number of other key leads. It has met twice since the last quarterly update to review progress developing the draft strategy and to debate and recommend key elements for subsequent approval by the Trust Board.

Early work focussed on agreement of a purpose statement and strategic goals by which the trust's long-term success can be measured. While wording nuances around the goals are still in discussion following feedback from discussion with non-executive directors, the broad essence of the following elements has received wide support:

At the time of this report strategic priorities and objectives are in development with individual executives and will be brought back to the strategy group in the form of a "strategic roadmap" for discussion at the end of June. A helpful session with the Non-Executive Directors was held on 18th May 2021 and a further development session is being held on 30th June 2021 with the board will inform the formal draft strategy.

The draft strategy will be formally shared for Board approval at the end of July before publication in the Summer. Key elements of the draft strategy are already in practical use to inform OD and communications developments looking at how we engage with staff and other partners.

It is anticipated that following completion of the strategy the team will put in place a light-touch framework for:

- Ensuring accountability for delivery of each element of the strategic plan is clear
- Monitoring delivery of the strategy and adjusting it dynamically as appropriate
- Reviewing the strategy on an annual basis

3. Improvement and Innovation Team – Lead Dawn Butler

The Improvement and Innovation team has committed efforts over the last 3 months to reset the focus on the Trust Transformation Plan, following the pause of some activity to concentrate on the COVID19 response in accordance with national directives. Delivering programmes of work to secure benefits that achieve improved financial sustainability and transform the way we deliver care, requires the collective efforts of

our Improvement Team, our operational, finance, workforce and clinical teams at a time of continued significant escalation. Despite the challenging operating environment, we have made important progress set out below.

3.1 Delivery of key Transformation Projects

a. The Urgent Community Care project has successfully delivered £120k of benefits to CIP and driven a new model of Urgent Community Care that is increasing access to assessment within 2 hours for urgent referrals and 2 days for routine referrals.
b. The Adult Social Care Improvement Plan for Torbay has achieved benefits of £490k as part of a larger transformation programme of work which has an overall target of £4.8m.
c. The Enhanced Health in Care Homes has delivered interventions that support older people to access the assessment and care they need in the care home that is their place of residence. This has supported a reduction in care home admissions that account for a reduction of 5146 bed days delivering a benefit opportunity of £720k.
d. The Diagnostic programme has successfully delivered on time three important tactical projects, including the installation of a 3rd CT scanner, a move of the blood bank and refurbishment of cellular pathology.

It is important to note that there are issues relating to the transaction of savings which have been raised at both Finance Delivery Group and Transformation and CIP Group.

3.2 Transformation of our Pathways of Care

1. The Planned Care programme has set out important changes to our surgical pathway including:
    a. Optimising virtual pre-operative assessment
    b. Efficiency of theatre utilisation
    c. Increasing the number of joints per list for orthopaedics
    d. Reduced length of stay
    e. Redesign of the urology care model with a greater emphasis on outpatient modes of delivery

2. We are putting in place plans to accelerate progress in transforming outpatients to increase access to non-face to face appointments. Full implementation of the Connect Plus App to drive the transformation of prevention, self-care and effectiveness in our long-term condition specialties. This is already successfully used in in rheumatology, MS and diabetic foot pathways.

3. Programmes of work with a focus on outflow/discharge and urgent/emergency care are integral to a new programme of work that has been established to urgently de-escalate the care system in response to sustained surges in demand through our Emergency Department and Medical Receiving Unit. The Improvement and Innovation Team have set up a rapid improvement programme of work with an immediate focus for action over the next 1-3 weeks. The evaluation of these improvement projects will shape plans for managing

summertime surges and next winter, in expectation of the continued challenges to flow.

3.2 Focus for the next three months are:

The Improvement and Innovation Team are developing a proposal that will better equip the team to respond comprehensively to all of the strategic objectives for our organisation. This includes balancing focus between tactical improvement work, transforming the way we work to deliver financial sustainability, embedding quality improvement in our clinical practice and equipping our people with the skills to lead change and to support the design of new models of care as part of our health and care strategy including the delivery of the transformation plan for Building a Brighter Future.

This is an exciting time as we build a talented team to work alongside our health and care design leaders to create improvement energy and focus that runs through our organisation and aligns with our system partners.

3.3 Issues for escalation to Board

The key issues of escalation to note from the Transformation and CIP group are:

- Due to the financial complexities of the national funding regime, and the pressures of business recovery, the ability to have clear processes to transact the benefits of transformation schemes needs to be resolved. There are actions underway to address this.
- For a number of projects, the work on the transformation has been completed and operational adoption is required, this includes the outpatient schemes, which has been escalated to Executive Directors.
- The need for robust business intelligence to support performance measurement and therefore improving performance management has been escalated a number of times and will need to form part of the Business Information Strategy, led by the CFO.

4. Project Management Office and CIP Development – Lead Carl Beardsmore

The Directorate oversees the development of CIP schemes, through the Project Management Office. The responsibility of the Directorate is to ensure that the CIP and Transformation plans developed by operational and finance teams are robust and that there is adequate oversight of delivery.

An external review of the PMO process to ensure greater rigor in the development and delivery of Trust CIP plans concluded in November 2020. A review on the implementation of the recommendations was concluded in April 2021.

Whilst the improvement in the due diligence required for performance assurance is in place, there is a need to ensure that the system that supports project planning (Smartsheet) is user friendly and meets the needs of the operational and finance teams.

A series of workshops are underway with the intention to rationalise and simplify the Trust recording system that supports the PMO.

The Transformation and CIP group continues to oversee the development of CIP plans, the delivery of which is significantly challenged. An escalation meeting with CEO, CFO and COO has taken place, with additional actions including:

- Confirmed opening budget positions for H2 required to support greater confidence in CIP values
- PMO Workshops to streamline the process on smartsheet
- Workshop with teams to ensure that clarity on roles and accountabilities for CIP are understood by all teams from operations, finance, PMO and improvement.
- Transaction of benefits needs to be resolved with a clear reinvestment process to support operational and finance teams to manage recovery whilst capturing the benefits of successful improvement work
- Bed modelling to be completed to ensure that all bed related benefits have a clearly understood transaction method.

5. Health Informatics Service – Lead Gary Hotine

The Trust Board receives regular reports on the digital strategy and plans to improve the digital offer. Highlights from the team for this quarter include:

- Progress on the 6 digital priorities, with an update provided to Board
- Significant progress on the EPR priority with the SOC completed and approved by Board and the OBC phase initiated, including securing the required resources to undertake the additional OBC-level work (such as for benefits)
- Progressing the wider Building a Brighter Future alignment of the digital elements
- Submission of the Data Security and Protection Toolkit (DSPT)
- Prioritisation of the capital plan for 2021/22 I&T elements, enabling a Trust capital plan to be submitted to FPDC for approval
- Development of an IT project prioritisation process and model that uses agreed criteria and gained the support from the Executive team, ICS and NHSIE
- Ongoing delivery of the IT projects already underway, including the data network replacement, cardiology system replacement, laboratory infrastructure upgrades, Ophthalmology ZEISS forum upgrades, server migrations to ensure cyber security, PACS technology refresh, finance system upgrade, migration of Intranet to SharePoint 2016 and N365, colposcopy and obstetrics reporting IT system upgrades, community IT and Maternity system implementations, CFHD implementations of Care-plus and infrastructure, and social care system upgrades.
- Formal closure after successful implementation of the Windows 10, eRS infrastructure upgrade, and community hospital VitalPAC, Infoflex and NerveCentre implementation including NEWS2 (National Early Warning Score 2)
- Responding to environment-driven data centre failures which cause major unplanned IT outages, including the recovery of services
- Ongoing support for COVID-19 recovery actions (both physical relocation support and IT system reconfigurations)
- Development of agile-working technology/booking solutions, including final pilots in Regent House
- Support for the new Trust SIRO, including facilitation of the required training
- Ongoing development of the Clinical Portal in response to clinical need

Focus for the next three months are:

- Delivery of the Outline Business Cases for an electronic patient record as part of the BBF digital programme
- Driving the delivery of the new capital investment projects that are IM&T-enabled
- Ongoing delivery of the established IT projects
- Analyse and identify the additional team resources required as part of the criteria-based prioritisation and development of a business case to support investment to increase capacity
- Support the Executive portfolio revisions as they apply to IM&T/HIS
- Developing the interface to enable PROMS and other forms to be completed by patients through the patient portal, supporting the clinical transformation.

6. Communications and Partnerships Team – Lead Jane Harris

Under the leadership of the Associate Director of Communications and Partnerships, there has been an acceleration of strategic input into the nature of our communication and engagement activity. Capacity to deliver on our strategic intention remains constrained and a review of the structure and resources to support an effective communications function is being undertaken. Key priority workstreams delivered over the last three months include:

- Scoping of our new organisational engagement and communications strategy including a workshop with our Governors on our aim, objectives and action plan
- Development of our building a brighter future engagement and communications strategy and preparation for engagement with key stakeholders on our strategic outline case
- Reformat of the weekly Friday vlog to increase Executive visibility
- Development of our strategic narrative, the Torbay way
- Refresh of the senior managers briefing with the Chief Operating Officer and Associate Director of People to focus on conversations which give our senior leaders the opportunity to influence and shape our thinking and reflect, debate and discuss our key issues, challenges and opportunities
- Working in partnership with our South Devon local care partnership engagement and communications leads to develop our local approach
- Creation and delivery of our summer urgent care campaign which complements the system summer campaign
- Delivery of a number of media releases, case studies and social media stories
- Establishment of monthly team development sessions.

Focus for the next three months are:

- Development and approval of our new organisational engagement and communications strategy alongside a supporting action plan and workplan
- Restructure of the team to facilitate the successful delivery of the strategy
- Full development of the engagement and communications plan for building a brighter future outline business case phase
- Working with our communities in Teignmouth and Dartmouth on the development of the health and wellbeing centres and the redevelopment of the former community hospital sites
- Supporting the launch of our people plan and supporting our people to recover

- Establishment of an effective engagement and communications plan for the south local care partnership

7. Recommendations

The committee is asked note the quarterly report from the Director of Transformation and Partnerships.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Engagement and communications strategy update			**Meeting date**: 30th June 2021
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Chief Executive and Director of Transformation and Partnerships on 23 June 2021		
Purpose of the report and key issues for consideration/decision	To provide an update on engagement and communications following the first three months in post of the Associate Director of Communications and Partnerships.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the engagement and communications update		

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**	9
Risk Register	X	**Risk score**	9

Objective 10: To actively manage the potential for negative publicly, public perception or uncontrollable events that may impact on the Trust's reputation.

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: Engagement and communications update		Meeting date: 30th June 2021
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

Introduction

This report is to provide an update and assurance to the Board on the development of our engagement and communications strategy, function and workplan.

Our emerging engagement and communications strategy

The Associate Director of Communications and Partnerships has been in post since 15 March 2021. A listening exercise was undertaken by the Associate Director of Communications and Partnerships during her first few weeks in post which informed and directed the draft aim and objectives of our new strategy.

A workshop was held with our Governors on 03 June to test assumptions and check and challenge the emerging aim and objectives for our strategy. Small group sessions took place as part of the workshop to help build the actions that will support the achievement of the objectives and drive the associated workplan for the team. A similar workshop was run with the communications team as part of their team development.

The learning and feedback from these sessions are directly informing the draft of the strategy which will be tested and checked with colleagues across clinical and corporate services in the next few weeks before being brought to the Board for discussion in July.

Our aim: To support meaningful conversations with our people and communities which will enable us to deliver our vision, goals and purpose

Our objectives:

- to build trusted relationships with our communities and people
- to make sure people's voices shape our services now and in the future
- create a diverse range of ways for people be informed about our work and engage with us

To deliver our aim and achieve our objectives we need:

- a strong, confident, competent, multi-disciplinary team who works as a team of teams and who are empowered, autonomous and effective
- a clear, coherent and congruent communications and engagement strategy that helps build confidence in us as a listening and responsive community partner
- a concise and compelling story about who we are, why we matter and how people can work with us and for us to help us achieve our vision
- our people at the heart of our story, showing what we do, telling our story in their own words, visible, present and connected

- congruence between what we say, how we say it, what we do, how it feels to work for us and how it feels to receive treatment
- open and honest communications in everyday language with consistent messages in a warm, human tone of voice

To support this work, we have:

Objective	Actions
Building trusted relationships with our communities and people	Begun a comprehensive stakeholder mapping exercise
	Worked with our partners in the South Local Care Partnership to begin developing an agreed approach to engagement and communications
	Developed our strategic narrative and our story with input from our people – identified our golden threads and begun the creation of case studies to tell our story through the voices of our people (staff, patients and carers)
	Created our tone of voice and begun work on our house style and refreshing our branding
Making sure people's voices shape our services now and in the future	Begun the development of a robust engagement and communications plan for our building a brighter future programme
	Begun work with our nursing and people colleagues on the development of an organisational involvement strategy and ensuring congruence between our people plan, patient feedback strategy and engagement and communications strategy
	Started a data cleanse and refresh of our membership database
Creating a diverse range of ways for people to be informed about our work and engage with us	Created a jointed funded digital communications assistant post with the People Directorate to focus on showcasing us as a great place to work and successfully recruited to this post
	Adopted our LinkedIn page to reach new audiences and promote recruitment
	Refreshed our monthly stakeholder newsletter to be more interactive and engaging while introducing analytics to track engagement and activity
	Created a monthly planner to co-ordinate internal communications activity – including proactive content planning for Trust Talks, Chief Executive and Executive vlogs, ICO News
	Created an award writing toolkit for our teams

Conclusion

Good progress is being made in the development of the engagement and communications strategy, workplan and action plan. These will be brought to Board for discussion in July and we aim for Board approval in September.

Positive feedback on developments has been received from engagement and communications leads in the Devon system and NHS England and Improvement South West.

Work is ongoing to prioritise work and activity within the team to ensure that outputs and outcomes are as effective as possible.

Capacity and resource continue to be an issue however this is being actively addressed through business planning.

Recommendation

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

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
AT 11.30 AM ON WEDNESDAY 26TH MAY 2021

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mrs V Matthews	Non-Executive Director (part)
	* Mr R Sutton	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mr J Welch	Non-Executive Director
	Ms L Davenport	Chief Executive
	* Dr R Dyer	Deputy Chief Executive
	* Ms A Jones	Director of Transformation and Partnerships
	* Mrs D Kelly	Chief Nurse
	* Mr D Stacey	Chief Finance Officer
	* Mr J Harrison	Chief Operating Officer
In attendance:	* Mr Darran Armitage	Associate Director of People
	* Mrs J Downes	Director of Corporate Governance
	* Dr K Lissett	System Medical Director, South Devon
	Ms S Toull	Board Secretary
	* Mrs K Heard	Carers Lead (part)
	* Mrs J Bose-Carter	Service User (part)
	* Rachel Glasson	Head of Maternity Services (part)

* via Microsoft Teams

		ACTION
	Preliminary Matters	
77/05/21	**User Experience Story** Deborah Kelly, Chief Nurse, introduced Julie Bose-Carter, who had been a carer for her husband after his diagnosis of end stage kidney failure. Also, in attendance was Katy Heard, Carer's Lead. Deborah Kelly explained Julie's husband sadly passed away in 2020 and Julie had wished for the Board to hear her insight into being a carer.	

Julie wished the Board to note that what she would say would not take away her appreciation and gratitude for the NHS and explained she had never identified herself as a carer for her husband only as a supportive partner.

Julie described how her husband had been under the care of Torbay and South Devon Foundation Trust, however while on holiday he had been taken ill. Being aware of the difficulties if he were to be admitted into a hospital out of the area she had driven home to Torbay where he was admitted to the Emergency Ward for ten days. Julie commented that the admission experience as being amazing.

Julie said that visiting her husband at the hospital every day for long periods of time had been costly due to the car parking charges, which was of great concern to her. Therefore, she had contacted the telephone number on the carer posters displayed across the Trust and being identified as an unpaid carer was entitled to free car parking.

Julie also spoke about an occasion whereby her husband's condition has worsened necessitating admission to hospital. Unfortunately, on this occasion they experienced a very busy Emergency Department, and a team who she described as obstructive and not as compassionate at a time where she was anxious and fearful. She reflected that all people in a public serving, patient facing role needed to be mindful of how one moment becomes the one memory of someone.

Since her husband's death, Julie had become a member of the 'Mind the Gap Project Torbay' whose purpose was to raise awareness for those that do not consider themselves carers.

Liz Davenport, Chief Executive, recognised the impact and importance of the Trust values being communicated and upheld throughout the Trust and how important it was to recognise carers and individual needs.

Vikki Matthews, Non-Executive Director said how this highlighted if one part of the chain was not been effective the whole chain was ineffective; especially, as Julie had highlighted the Trusts good care but, had also recounted that it was difficult receptionists and car parking worries that caused her a bad experience. Julie said there were a couple of examples of poor care but these were resolved.

Vikki Matthews, asked if there would be the opportunity to share this learning with all Trust staff to ensure Julie's time with the Board added value. Adel Jones, Director of Transformation and Partnerships said there was a need to consider how we communicate with our staff patient experiences, to enhance compassion and understanding. In doing so she referred to the strategy behind identifying carers and ensuring personalised care each family.

Deborah Kelly, highlighted carers week which was taking place between 7th and 13th June 2021, and the launch of the Carers Strategy both of which would reignite and showcase the value of carer's and their insight.

Chris Balch, Non-Executive Director, asked if volunteers could come alongside and support carers, Katy Heard said that when there is capacity or funding in the system support for carer's was prioritised.

The Chairman, thanked Julie for her account and said her engagement with Katy Heard would be of benefit and provide learning to the Trust

78/05/21 **Welcome and Introductions**

The Chairman welcomed those in attendance to the Torbay and South Devon Foundation Trust Board meeting.

79/05/21 **Board Corporate Objectives**

The Trust Board's Corporate Objectives were noted.

The Board received and noted the Board Corporate Objectives

80/05/21 **Apologies for Absence**

The Board noted apologies of absence from Mr Ian Currie, Medical Director, Judy Falcao, Chief People Officer, Dr Joanne Watson, Health and Care Strategy Director.

The Board noted Dr Kate Lissett's attendance on behalf of the Medical Director and Mr Darran Armitage' attendance on behalf of the Chief People Officer.

81/05/21 **Declaration of Interests**

There were no declarations of interest.

Consent Agenda (Pre-notified questions)

Reports from Board Committees and South East North Devon (SEND) Alliance for noting

82/04/21 **Audit Committee – 21st April 2021; and Committee Annual Report**

The Board received the Chair's report of the Audit Committee meeting held on 21st April 2021 and noted the Committee Annual Report.

The Board received and noted the Audit Committee Chairs Report and approved the Committee Annual Report

83/05/21 **Finance, Performance and Digital Committee – 26th April 2021; and Committee Annual Report**

The Board received the Chair's report of the Finance, Performance and Digital Committee meeting held on 26th April 2021 and Committee Annual Report.

The Board received and noted the Finance, Performance and Digital Committee Chairs Report and Committee Annual Report

84/05/21 **People Committee Chair's Report - 26th April 2021; and Committee Annual Report**

The Board received the Chair's report of the People Committee meeting held on the 26th April 2021 and the Committee Annual Report.

The Board received and noted the People Committee Chairs Report and Committee Annual Report

85/05/21 **Non-Executive Director Nomination and Renumeration Committee 25 March and 19 May; and Terms of Reference**

The Board received the Chair's report of the Non-Executive Director Nomination and Renumeration Committee meetings held on the 25th March and 19th May 2021. The revised Terms of Reference were presented with one amendment noted.

The Board received and noted the Non-Executive Director Nomination and Renumeration Committee Chairs Report and approved the Non-Executive Director Nomination and Renumeration Committee Terms of Reference

86/05/21 **Building a Brighter Future Chairs Report 18 May 2021; and Committee Annual Report**

Adel Jones referred to the comment in the Chair's Report around 'arrangements which are being put in place to ensure adequate consultation on the Strategic Outline Case ('SOC')' and asked for further clarification.

Chris Balch, explained the difference between a formal public consultation and consulting with the public and clarified that the SOC would not require formal public consultation. He stressed however the need to communicate and engage with the public to explore the broader options around the SOC and to ensure all key stakeholders could have confidence in the SOC the Trust submit.

Rob Dyer, Deputy Chief Executive, assured the Board the Trust was now entering into a period of engagement with all stakeholders.

The Board received and noted the Building a Brighter Future Chairs Report and Committee Annual Report

87/05/21 **QAC Committee Annual Report**

The Board received the QAC Committee Annual Report.

The Board received and noted the QAC Committee Annual Report

89/05/21 **SEND Alliance – Chair's Report May 2021**

The Board received the Chairs report of the inaugural SEND Alliance, meeting held on 11th May 2021.

The Board received and noted the SEND Alliance Chairs Report

Reports from Executive Directors

90/05/21 **Chief Operating Officer's Report May 2021**

Adel Jones, asked the Chief Operating Officer, whether the 'green shoots' highlighted in the Report was due to improvement in activity levels or the waiting list position.

John Harrison, Chief Operating Officer, explained 'green shoots' related to the data confirming the Trust had achieved pre-pandemic levels of activity. Therefore, for the first time since COVID, the Trust had seen a reduction in patients who had waited over 52 weeks for treatment. The Board was asked to be mindful this was due to a lower referral rate during the first wave of COVID and therefore an artificial reduction.

The Board received and noted the Chief Operating Officers Report

For Approval

91/05/21 **Minutes of the Meeting held on the 28th April 2021**

The Board approved the minutes of the meeting held on 28th April 2021.

For Noting

92/05/21 **Action Log and 'Parking Lot' of Deferred Items**

The Chairman confirmed the Nursing Establishment Review would be deferred to July and was on the Board workplan. The parking lot of deferred items was agreed as closed.

93/05/21 **Report of the Chairman**

The Chairman briefed the Board on the following key events:

- The Trust Board had held a Board to Board meeting with North Devon and Royal Devon & Exeter Trusts.

- The inaugural meeting of South East North Devon (SEND) Alliance had taken place and the potential to develop integrated working for the benefit of the local population had commenced although, it was in its infancy.

- The Torbay Clinical School Conference had been a successful event., He commended the Clinical Schools work and the value it provided to the Trust clinical staff.

- He announced the retirement of Dr Rob Dyer, Deputy Chief Executive and assured the Board a robust appointment process was in place to recruit his successor.

- He assured the Board that a process was underway to recruit to the position of Director of Corporate Governance and Trust Secretary.

- Two Non-Executive Director's would be stepping down this year and the recruitment process with Governor involvement had commenced.

- The Trust had hosted a visit from Jane Milligan ICS and NHS Devon CCG Chief Executive.

- The new Lead Governor had attended the recent Governors Nomination and Renumeration Committee together with two new staff governor members.

94/05/21 **Report of the Chief Executive**

Liz Davenport, Chief Executive briefed the Board on the following key issues:

- Although the country was moving in a positive direction post the second wave of the COVID, the Trust would be facing challenges to clinical services.

- The Trust had hosted a 'prayer and meditation for India' and were mindful of all those who have been significantly impacted by the pandemic in India including families or members of the Trust's staff.

- Equality Diversity and Inequality and Human Rights month was taking place in May, and the Board were focused on this highly important agenda.

- The Trust was conscious of the mental health and wellbeing of the workforce and wider community, especially during mental health awareness week.

- The Health and Safety Executive had recently undertaken a visit to the Trust in respect of the COVID response and the Trust was awaiting their feedback.

- The publication of the Devon Long Term Plan although delayed, was consistent with the Trust's ambitions and provides a framework for Building a Brighter Future and Transformation Programmes.

- £11.3m had been awarded to the Devon System from the Accelerator Programme to address some of the significantly challenged pathways.

- Dr Ian McGill, a significant leader of clinicians at the Trust had sadly passed away earlier this month. The Board's condolences were offered to the family of Dr McGill.

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

Safe Quality Care and Best Experience

95/05/21 **Integrated Performance Report – Month 1 2021/22 (April 2021 data)**

Dave Stacey, Chief Finance Officer, presented the Integrated Performance Report for Month 1 and drew the following to the Board's attention:

Quality and Safety

- Two serious incidents reported were under investigation.
- Progress had been made against the stroke pathway despite recognised fragility of service provision.
- Hospital Standardised Mortality Rates were reported within control limits and levels of expectation.
- Deborah Kelly, was leading on the patient experience strategy, which would concentrate on themes of assessment diagnosis, complaints and communication.
- Safer staffing data did not suggest unsafe skill mix challenges although nursing cover was slightly below target.

Workforce

- Sickness was at 3.8% which brought the rolling 12 month figure below 4%.

Performance

- There had been a significant pressure in unelective care demand but the Trust was below national standard which reflected how well the Trust was coping.
- Across the acute site there was high occupancy levels but, progress had been made on the delivery of planned care with a reduction in 2 week wait referrals.
- Delays had been reported in the cancer, urology and breast pathway. Urology had a recovery plan in place; and capacity issues had been addressed in the breast care radiology so the pathway would recover.
- Computerised Tomography and Echocardiography wait lists have seen an improved position due to investment.

Financial framework

- The Trust reported a £0.4m surplus in month 1 (April) and held a positive cash position of £38.5m. The financial plan had been updated and the Trust was forecasting a break-even plan for the first half of the financial year.

The Chairman, confirmed one of the Serious Incidents relating to Sepsis was under investigation, and the report would be brought to Board.

Vikki Matthews, reflected on the sickness level and highlighted the pastoral support that has been wrapped around staff during a challenging year.

Adel Jones, asked about the continued increase in Domiciliary Care hours and whether the Trust should expect the hours to reduce. John Harrison, said there was early evidence to show 25% of unplanned care could be supported by the voluntary sector.

Chris Balch, said it was encouraging to see the investment in diagnostics had resulted in an improved position. He reflected on the Chief Executive's Report and whether a collaborative approach would be the correct solution to the challenge faced. John Harrison said that the Trust was actively utilising scanning capacity with the former Nightingale Hospital, Exeter and the Trust had commissioned a third CT scanner. However, surge capacity would require the Trust to rely on mobile units or system based solutions. Diagnostics was a national and regional concern and the South West Medical Director, NHSEI was leading on developing an effective diagnostic hub, which was a strategically important piece of work.

The Board received and noted the Integrated Performance Report – Month 1

96/05/21 **Mortality Scorecard – May 2021**

Dr Kate Lissett, System Medical Director presented the Mortality Scorecard and in doing so assured the Board that the HSMR data was rag rated at 111.

Dr Lissett reported that the figures would have been affected by the spikes in COVID rates and she talked the Board through the impact of COVID but confirmed more recently values had returned to the normal range.

The governance process was described and the Board assured in the event of concern the Harm Lead would review cases, prior to cases being escalated to the Mortality Service Group and then on to Board.

The Trust was awaiting the report of a Learning Disabilities Mortality Review (LeDeR) to ensure all patients received equitable care. There were also two still birth cases within the Trust and, the Health Safety Investigation Branch (HSIB) would investigate as a matter of course.

It was reported Trust Medical Examiners were involved in 93% of all deaths which showed a marked improvement.

The Board received and noted the Mortality Scorecard

97/05/21 **Trust Quality Account Quarter 4 Update Report**

Deborah Kelly reported against the four quality improvements for 2021:

1. **Implementation of RESTORE2 in nursing and care homes**
   The Trust had worked in partnership with the Care Homes to roll-out RESTORE2 and it was now successfully embedded ensuring the appropriate care interventions were made.
2. **Replacement of the Trust's IT data network**
   The Board was asked to note that delivery was expected in Autumn of 2021/22.
3. **Introduction of the FAMCARE feedback tool relating to End of Life experience.**
   Due to COVID19 there had been a delay to the roll-out although questionnaires had been sent to families and the roll-out would be prioritised for 2021/22. However, notable improvements had been made in this area.
4. **Bereavement bags**
   The implementation of bereavement bags had been successfully achieved.

Chris Balch, reflected on the need to ensure proactive working in partnership to ensure the Trust were intervening at the most appropriate stages of care.

The Board received and noted the Trust Quality Account Quarter 4 Update Report

98/05/21 **Carers Update including Torbay Carers Strategy and Action Plan**

Deborah Kelly was pleased to report that the Trust was only one of two NHS Trusts to be NHS Carer Level 2 accomplished. She explained the Torbay Carers Strategy was a clear multi-agency vision for the next three years.

Katy Heard, Carer's Lead highlighted the need to embed the key messages such as compassion and humanity throughout the Trust and in doing so She referred to Julie's story told earlier in the meeting. She said it was the responsibility of all health and social care staff to use every opportunity to identify carers. She highlighted the importance of carer awareness and the need for essential training of all staff.

Katy Heard reflected on the huge amount achieved by her team during the pandemic. She said supporting carers reduced the need for acute admissions, residential care and had massive cost savings and benefits.

She explained they had been using carers to support projects such as the 'Mind the Gap Project' which had been reaching out to ethnic minorities carers, within their communities.

She explained to the Board that one in six NHS workers were unpaid carers and by supporting staff to fulfil their care commitments whilst working, would ensure vital employees were not lost. She said the messaging around unpaid carers needs to be spread wider with a personal approach.

The Chairman, recognised that mandatory training would not be the right platform to support the behavioural change message and asked what the best vehicle would be to drive the messaging.

Liz Davenport, recognised the comprehensive, ambitious nature of the report, that is of benefit to the wider system. She raised the unique needs of young carers who might have a life of caring. Katy Heard explained the Carers Under 25 Strategy was to be relaunched in the next six to nine months.

Adel Jones, recognised the great work being undertaken in the carers sector and asked if her team was linked in with the Voluntary Services and the Trust's Head of Personalised Care. It was confirmed they were very well linked.

Katy Heard assured the Board that to ensure the Carers Strategy ran efficiently, a project officer had been appointed.

Vikki Matthews, asked if carers were recognised as part of the volunteer group. Katy Heard reflected on the question and stated carers do not tend to recognise themselves as carers and would not necessarily choose the role. Some people who become carers suffer abuse, anxiety and emotional issues and it can be a very negative experience. In general, at the time of becoming a carer they would not have the motivation to take on additional training or the offers the volunteer sector may enjoy. However, in some cases former carers would willingly come alongside and offer support to current carers. Those that volunteer chooses to do so and it was likely to be a positive life style choice.

Katy Heard thanked the Board for their support with regard to the Strategy.

The Board received and noted the 2018-21 Carers Strategy and the 2021-24 Carers Strategy

99/05/21 **Maternity Governance and Safety Report Q4 2020/21**

Deborah Kelly presented the Report and in doing so highlighted a number of areas relating to the Ockenden Report. She explained that some of the recommendations from the Ockenden Report were dependent on the national position.

There had been two still births within Q4, however this was a downward trend.

The Board was informed progress made around the risk management framework and the positive work that had been undertaken within the department to support, enable and empower staff.

Liz Davenport asked Rachel Glasson, Head of Maternity how she felt encouraging staff to engage had been received. Rachel Glasson explained the department had followed the Pathway to Excellence and Shared Governance Frameworks and three councils had been established, namely Safety, People and Leadership. Rachel Glasson explained although the Maternity Senior Leadership Team would receive the outcomes, the councils had been developed by staff to empower staff. Staff have been positive and

had engaged with the process and changes were taking place.

Chris Balch enquired about national funding to ensure safe staffing levels and the financial challenges the Trust would face. Rachel Glasson explained nationally it had been recognised maternity services had been underfunded. A bid to cover the costs of safe staffing levels had been worked through and submitted to Region for scrutiny, prior to national submission. The Trust would receive confirmation of the funding during week commencing 7 June 2021. If the Trust was successful in the bid, the Trust would engage with the CCG to establish recurrent funds.

Paul Richards asked if there were midwives available to recruit in to new posts created from the additional funding. Rachel Glasson, provided assurance that the Trust had good staff retention rates but would be looking to recruit 13 whole time equivalent at Band 6 level. She explained that in preparation, maternity student placements had been increased and there were staff currently on fixed term contracts who could be offered permanent positions if the funding was secured. She also highlighted due to the COVID and a change in lifestyles midwives were looking to relocate to the South West. She acknowledged the challenge of the Trust ensuring it presents itself to prospective midwifes as a great place to work.

The Board received and noted the Maternity Governance and Safety Report Q4 2020/21

Valuing our workforce

100/05/21 **Freedom to Speak Up Guardian Six Monthly Board Report**

Darran Armitage, Associate Director of People presented the Freedom to Speak Up Board Report on behalf of Sarah Burns, Freedom to Speak Up Guardian. He explained the Report was seeking Board approval to align the Trust with the national Freedom to Speak Up approach.

He explained how Freedom to Speak Up was effective if it is supported by Managers and there was a clear understanding that every member of staff had the right to speak up.

He explained that the thirty complaints described in the Report had been primarily raised by Nursing and Allied Health Professional colleagues and those concerns raised were primarily around recruitment and culture. The Board was provided with assurance that a review of recruitment practice, software and mandatory training was being progressed; and conditions to enable a cultural framework were being undertaken.

Liz Davenport, explained to the Board the importance of staff feeling able to raise issues and referenced the strong link between ‘outstanding’ CQC Trusts and the delivery against the Freedom to Speak Up process.

Darran Armitage highlighted the need for the Trust to develop processes and support for staff who feel they suffer a detriment as a result of speaking up. He reflected it was important to be aware of the culture we are trying to change.

The Chairman, reflected that this is an objective position and Freedom to Speak Up could not be easily measured. He said it was for the Trust to feel comfortable that the culture was moving in the correct direction. He said his feeling there was a lot of evidence the Trust was shifting culture in the right direction but, we were not there yet.

Chris Balch highlighted the need to raise the Non-Executive profile amongst Trust staff, and reflected on the difficulties of achieving this during the pandemic due to social distancing rules. It was agreed, Deborah Kelly and Joanne Watson, Director of Infection Prevention and Control would keep the Board updated on national guidance. The Chairman said he now had the opportunity to visit other sites but stressed that he undertakes twice weekly lateral flow tests in order to ensure he is safe to undertake such visits.

John Welch, highlighted how the Freedom to Speak Up Guardians tend to deal with situations that middle management should be supporting, as staff feel the quickest route to resolution is speaking with the Freedom to Speak Up Guardian. It was acknowledged that support was needed for middle management to succeed in this area. He also acknowledged Liz Davenport's excellent engagement and escalation in the Freedom to Speak Up space.

The Board received and noted the Freedom to Speak Up Report and approved the recommendation to re-align the Freedom to Speak Up model in line with National Guardian Office recommendations

Improved Well-Being Through Partnerships

101/05/21 **Building a Brighter Future Programme Update**

Dr Rob Dyer, Deputy Chief Executive updated the Board on progress of the Strategic Outline Case ('SOC') and explained the second draft would be ready for review in two weeks' time. He highlighted areas of uncertainty around the elective care strategy as the Trust needed to reflect system requirements and this was being developed through the Devon ICS.

As per the Digital Strategy Update reported to the Board, the Outline Business Case ('OBC') was being developed. Options for a collaborative Devon or Peninsula approach were under discussion and a Board paper would be prepared for all Trust Boards to consider outlining the possible next steps.

The Chairman reflected on how staff had engaged enthusiastically with the Building a Brighter Future process.

Rob Dyer explained that he would be retiring in July and Adel Jones, Director of Transformation and Partnerships would become the Senior Responsible Officer ('SRO'), with the overarching senior leadership team consisting of Liz Davenport, Dave Stacey, Chris Knights and Joanne Watson.

The Board received and noted the Building a Brighter Future Report

Well Led

102/05/21 **CQC Registration Annual Assurance Report**

Deborah Kelly presented the report and in doing so explained that the Statement of Purpose had been adapted during COVID. Assurance was provided that the CQC had been notified of each change.

She explained that in March 2020, the Trust's inspection had been paused due to COVID, but inspections were now being reinstated. Throughout the pandemic, the Trust had been engaged with the CQC regarding Infection Prevention and Control, Emergency Department and Maternity Services. She said the engagement opportunities had been welcomed as it had benefited our improvement journey.

Deborah Kelly said that the Trust should approach CQC as a continuous improvement journey and always reflect and monitor the progress against the core fundamental standards. She said the Trust should focus, reflect and celebrate what needed to take forward.

The Board approved the change to the statement of purpose and noted the CQC Registration Annual Assurance Report

103/05/21 **Board Development Programme 2021/22**

The Board approved the Board Development Programme for 2021/22. It was agreed that a Freedom to Speak Up Development session would be included in the programme.

The Board Development Programme 2021/22 was received and noted

104/05/21 **Compliance Issues**

There were no compliance issues reported.

105/05/21 **Any Other Business Notified in Advance**

There was no other business raised for discussion.

106/05/21 **Date and Time of Next Meeting:**

11.30 am, Wednesday 30th June 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).

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 30 June 2021
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 22 June 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 are asked to receive and note the Chief Executive's Report		

Summary of key elements

Strategic objectives supported by this report

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

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

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

- BAF objective 1 - risk score 20
- BAF objective 10 - risk score 9

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

- To develop and implement the Long-Term Plan with partners and local stakeholders to support the delivery of our ICO Strategy
- To actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on our reputation

Report title: Chief Executive's Report		Meeting date: 30 June 2021
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our purpose

Our purpose is to support the people of Torbay and South Devon to live well.

2 Our strategic goals

We are currently reviewing our strategic goals through our Strategy Group. Our strategic goals will help us achieve our purpose. These will be brought to the Board of Directors for approval in the next few months.

Our draft strategic goals are:

- Excellent population health and wellbeing
- Excellent experience receiving and providing care
- Excellent value and sustainability

This report is structured around our draft strategic goals to help us measure our progress, address our challenges and celebrate our successes.

3 Our key issues and developments

Key issues and developments to bring to the attention of the Board since the last Board of Directors meeting held on 26 May 2021 are as follows:

3.1 <u>Excellent population health and wellbeing</u>

Carer confident employer

We have become one of only two NHS trusts to be recognised with an award for support staff members who care for someone outside of work.

We have gained the Carer Confident Employer, Level 2 'Accomplished' Award which demonstrates the high level of support available to the many staff members who, alongside their job, care for a family member or friend with long term physical or mental ill health, disability or have problems related to old age.

Our staff survey in 2021 showed that more than 1 in 3 of our people are caring for a family member or friend, not including childcare. In recent years, our people have been able to access a carers' health and wellbeing check in their workplace and during work time.

During the pandemic, an online staff carers' forum was started to make sure that our people could easily talk to someone about their caring role and access any support required.

We reaffirmed our commitment to carers during carers week earlier this month, encouraging all our people to help us identify and support carers. As we heard so

movingly at last month's Board meeting in Julie Bose-Carter's story, many people don't identify themselves as carers and so miss out on the available support.

Building a brighter future – engagement with key stakeholders
Further to our provisional allocation of a share of £3.7 billion under the Government's New Hospitals Programme, we are developing our strategic outline case which is due to be submitted to NHS England and Improvement at the end of July. We are currently undertaking engagement with key stakeholders to share our early thinking and to seek support for their health and care strategy, as well as their direction of travel.

We call our programme building a brighter future as it offers us a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people. For us, it is not just about building a better hospital in Torquay, it is about further building on our integrated approach to service delivery to provide better outcomes for our population and better working environments for staff across all the communities that we serve. We aim to take advantage of new technologies and the latest improvements in health and social care, planning not only for the needs of our people today but also for the future.

Dartmouth health and wellbeing centre
Following confirmation from South Hams District Council that all planning conditions have been met, building work has begun on the purpose-designed centre, on land previously used as an overflow for the park and ride.

This day has been a long time coming and we are delighted that work is now starting on site to deliver a fantastic new facility for the people of Dartmouth and surrounding villages. We are investing in services based in local communities, so that different healthcare professionals can work together to better meet people's individual wellbeing needs. This has been a long process, and we are grateful to everyone in Dartmouth and the surrounding areas for their support and patience.

The centre is due to open its doors in late summer 2022 and will give local people access to a broad range of health and wellbeing services in one place, by bringing together GPs, community nurses, therapists, Dartmouth Caring and a pharmacy.

A small, socially distanced turf cutting event is planned for 06 July with local key stakeholders. Sir Richard and I will represent our colleagues of behalf of the organisation.

G7 summit
The G7 summit took place in St Ives, Cornwall, between 11 and 13 June. As part of the wider NHS planning process for major events, we were ready to do our bit, if needed, to support our fellow NHS providers in Cornwall and Devon while keeping our services running safely and supporting each other.

Our priority was making sure we could continue to run our services safely while also being ready to provide mutual aid in the event of a major incident, should this have occurred.

We used our existing COVID structure with our on-call teams out of hours to operate our **gold and silver command structure for 10 to 13 June**. We also created a team of emergency trained clinicians to be available, if needed, to be deployed to an emergency treatment centre to provide treatment and care between 10 and 13 June.

While we were, thankfully, not called on to support our fellow NHS providers or to deploy our team of emergency trained clinicians, key members of our team joined the system, regional and local resilience forum calls throughout week commencing 07 June and over the weekend itself. We thank them for their flexibility and dedication.

3.2 Excellent experience receiving and providing care

Creating a fairer and more inclusive NHS

The national People Plan sets out a number of requirements and expectations for organisations with regards to equality, diversity and inclusion. In response, a facilitated board development session was held last month to explore through the lens of equality, diversity and inclusion what it means to us as individuals, how we lead as a board and what are the conditions we need to create in order for us to fulfil our future vision.

The session was facilitated by Dr Eden Charles, Senior Consultant, Chief Executive of People Opportunities Limited and Faculty member, Programme Director and consultant to the NHS Leadership Academy.

Dr Cathryn Edwards OBE

Dr Cathryn Edwards, consultant physician and gastroenterologist, has been awarded an OBE (Officer of the Most Excellent Order of the British Empire) in the Queen's Birthday Honours. Cathryn joined Torbay Hospital in 2002 and we are extremely proud that she has been a part of our Torbay and South Devon family for so many years.

Cited in the honours for her role as the immediate Past President of the British Society of Gastroenterology (2018-20) and her services to medicine, Cathryn's OBE comes less than three months after she was announced as the first female registrar for the Royal College of Physicians (RCP).

We are thrilled and delighted for Cathryn that her dedication to medicine, passion for excellence and inspiring leadership has been recognised with this prestigious honour.

Graduation event

We are planning a celebration event to recognise our people who have qualified during the pandemic and acknowledge their achievements in becoming qualified healthcare professionals in very difficult times. Many of our people have not been able to receive a face to face graduation following completing of their training.

We initially planned this event for 29 June 2021, however, due to the recent Government announcements we have taken the decision to postpone the graduation event to early September 2021. We are really keen for this event to be ahead to recognise these individuals and will work with our Director of

Infection Prevention and Control to ensure that it does not pose additional risks to those attending the event.

Thank you from the people of Brixham
Eighteen of our health and care staff were treated to a cruise thanks to the generosity of the people of Brixham on 17 June 2021.

The classic Brixham trawler, *Vigilance*, embarked on two separate cruises exclusively for our people who also enjoyed lunch on board.

The boat is run entirely by volunteers, many of whom live in Brixham, and this event was their way saying thank you to a representative group of our people for their incredible response over the past eighteen months.

Jon Welch, Non-Executive Director, is also a skipper of *Vigilance*, and he was at the helm for both cruises. I would like to thank Jon and his fellow volunteers for their generosity.

I would also like to thank all businesses and members of the public who have provided donations and gifts for our people and patients throughout the pandemic.

3.3 Excellent value and sustainability

Appointment of Deputy Chief Executive and Senior Responsible Officer for building a brighter future
Rob Dyer, our Deputy Chief Executive and Senior Responsible Officer for our building a brighter future programme, is retiring at the end of June after 23 years with us. Rob joined us in April 1998 as a Consultant in Diabetes and Endocrinology and became Executive Medical Director in October 2015.

Our Chair, Sir Richard Ibbotson, chaired an appointment panel for our new Deputy Chief Executive earlier this month. The membership of the appointment panel included external Executive expertise from Suzanne Tracey, Chief Executive of Northern Devon Healthcare NHS Trust and Royal Devon and Exeter NHS Foundation Trust.

We have appointed Dave Stacey as our new Deputy Chief Executive. Dave will undertake this role alongside his role as our Chief Finance Officer.

Adel Jones will be our new Senior Responsible Officer for our Building a brighter future programme/New Hospital Programme. Adel will undertake this role alongside her role as our Director of Transformation and Partnerships.

Both Adel and Dave are exceptional leaders who combine strength and kindness with a determination to help us achieve our purpose and vision and I very much congratulate them on their new roles.

Health and Safety Executive visit
The Health and Safety Executive (HSE) carried out a planned visit to our services on 11 May 2021. The visit was arranged to assess our performance with

regard managing staff COVID-19 safety within both clinical and nonclinical settings.

We received positive acknowledgement that we had responded well to the learnings gained through the early phases of the pandemic, within clinical settings. The HSE were also clear of the need to remain alert and vigilant as the pandemic evolves, and we must be ready to respond by maintaining safe clinical environments for our staff.

The visit also highlighted that we were not maintaining appropriate levels of COVID-19 staff safety within nonclinical settings in the building that they visited (Regents House), therefore remedial action was required. While we were assessed as not compliant on this site on this occasion, the HSE are satisfied with the actions we have taken in response and will further review the situation in a month's time.

Our security, safety and emergency planning team and the local management teams within Regents House are ensuring a robust action plan of remedial actions is completed as soon as possible. To ensure consistency and compliance, further areas will be inspected by the security, safety and emergency planning team. Progress on both matters will be tracked through the Health and Safety Committee.

4. Chief Executive engagement May/June

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 to deliver excellent care during exceptionally challenging circumstances across all our services.

Internal	External
• Staff side • Video blog sessions • Freedom to speak up guardian • Lead governor meeting • Hosting visit from Chief Executive Officer, Devon Integrated Care System • Partnership forum • F1 quality improvement presentations • Children and young people partnership board • Chief Executive briefing • Staff heroes presentations • Medical Staffing Committee meeting	• Chief Executive, Devon integrated care system • Deputy Chief Executive, Devon Integrated Care System • Director of Strategy, Devon Clinical Commissioning Group • Devon NHS Chief Executives • Devon Health and Local Authority Chief Officers' Meeting • South West Regional Chief Executives • Director of Adult Social Services, Torbay Council • South Local Care Partnership Executive • Long Term Plan Roadmap Steering Group • Long Term Plan Implementation Group

	• South West Integrated Personalised Care Enabling Board • Locality Director, Devon Clinical Commissioning Group • Devon Integrated Care System Executives meeting • Chief Executive Officer, Healthwatch Torbay • Getting It Right First Time (GIRFT) programme meeting • Interim Human Resources Director, Devon Integrated Care System • Integrated Care System Partnership Board • Chief Executive Officer, South West Academic Health Science Network • Chief Pharmaceutical Officer, NHS England and Improvement • System Transformation and Efficiency Board • Head of Planned Care Commissioning, Devon Clinical Commissioning Group • Health Systems Partnership Meeting • Interim Director of People, South Western Ambulance Service NHS Foundation Trust • Torbay Overview and Scrutiny Committee • Devon Children and Families Partnership Executive Group • Chief Executive, Devon Doctors • Neuro Rehab and Spinal Cord Injury Delivery with the South West meeting • Meeting with the Chairman and Deputy Chief Executive of Royal Devon & Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust • Meeting with Anthony Magnall MP • Chief Executive, Devon Partnership Trust NHS Trust • Chief Officer for Children's Services • Programme Director, NHS England and Improvement • Meeting with Anne Marie Morris MP • Principal, South Devon College • Children and Families Health Devon Board Senior Leaders Meeting • Provost and Senior Deputy Vice Chancellor, University of Exeter • Devon Long Term Plan Workshop

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1. Devon recovery

Before the pandemic, too many people were waiting too long for care, and in some cases were having to travel out of the county to be treated.

Long treatment waits have risen substantially because some services were halted during the pandemic to allow the NHS to focus on treating Covid-19 patients and maintaining emergency and urgent cancer care.

In March 12,719 people had been waiting a year or more for treatment. We expect this figure to rise because capacity is still affected by extra infection control measures and we don't know how many people delayed asking for treatment during the pandemic.

We know long waits cause anxiety and impact on people's lives. We will prioritise the most urgent patients and those waiting longest. We are working on how best to support people on waiting lists and will keep them informed.

The accelerator programme will mean people from Devon and nearby counties are diagnosed and treated earlier through: additional theatres at University Hospitals Plymouth, diagnostic services and two new theatres at the former Nightingale Exeter hospital and community ophthalmology facilities. Staff will use best practice to make maximum use of facilities.

5.1.2 Devon integrated care system and local care partnerships

The Devon System was approved for designation as an integrated care system (ICS) from 1 April 2021. The place function in Devon is carried out by five local care partnerships (LCPs).

It is recognised that in order for the LCPs to succeed they will need to take account of different histories, population health and care needs and are therefore likely to require different structures and ways of working.

The shadow Devon ICS Board has set down the following aims for each of the LCPs:

- deliver Devon system strategies at local level
- improve health and wellbeing outcomes for the local population
- reduce inequalities
- improve people's experience of care
- improve the sustainability of the health and care system

In addition, the Devon ICS has set down the following activities that each LCP should focus on:

- coproduce plan with integrated care system Partnership Board which will deliver improved health and care services at population level
- develop integrated services
- create conditions for healthy living
- manage resources within available budget
- plan services through engagement with citizens

- develop community assets
- support local engagement including with Primary Care Networks

5.1.3 South local care partnership

We are proud partners in the south local care partnership (LCP).

An agreed joint session pulling together members of the emerging Executive and Delivery architecture took place on 20 May and considered among other things, a refresh of the arrangements in respect of the infrastructure for the locality; the emerging themes and priorities which we will work together to deliver; visibility of how programmes of work are overseen and issues escalated and the way we want to collaborate and communicate as we progress. The core groups that will be in place to support in this area include the Executive, Delivery, Performance Improvement and Locality Forum.

The work done in relation to the emerging themes suggests a set of initial priorities that would include a focus on Discharge to Assess, Population Health Management and the Community Mental Health Framework. Specific areas for focus and inclusion include self-harm, suicide and alcohol to deliver against once the final priorities have been agreed.

An approach to engagement and communications is being further developed in conjunction with leadership from Jane Harris (Associate Director of Communications and Partnerships, Torbay and South Devon NHS Foundation Trust) and respective partners which will help take us forward.

The key priorities for the next few months include:

- further development of the LCP, finalising the engagement plan, establishing communications, and delivering against the priority ambitions
- local performance oversight and improvement sub-group arrangements
- supporting the arrangements in respect of the rollout of the vaccination programme in conjunction with primary care networks and system partners
- maintaining focused attention on discharges and the robustness of associated data reporting in line with national expectations
- embedding the learning from the Population Health Management pilot to other network areas
- contributing to and ensuring arrangements which seek to deliver against more short-term deliverables within the operating plan and long-term plan roadmap.

The main areas of risk to consider are:

- the capacity to manage respective priorities and pace, particularly while we look to shift our focus toward planning and restoration of services
- maintaining focus on the development of the LCP priorities alongside those in relation to our response to COVID-19, vaccination programme & operational pressures will be key
- workforce pressures and capacity across local providers with particular challenges in relation to clinical staff and the necessity for recovery as a result of the impact felt from the period of the pandemic.

7 Local media update

7.1 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 the people of Torbay and South Devon have access to timely, accurate information, to support them to live well and access services appropriately when needed.

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

Recent key media releases and responses:

- Video appointments win patient approval – promoting the increase in virtual consultations by highlighting the extremely positive feedback from patients and encouraging uptake and requests
- Support for staff carers recognised with award – celebrating our Carers Confident Award which recognised our support and care for staff who have caring responsibilities outside of work
- Cruise ship rumours – responded to rumours raised by BBC Spotlight about 15 cruise ship crew being treated for COVID-19 at Torbay Hospital with the positive news that there were no cases of COVID-19 across our sites
- OPEL status – worked with our system colleagues before confirming our OPEL status as part of a Spotlight piece on pressures in Plymouth

Recent engagement on our social media channels includes:

- Choose Well messaging – encouraging the public to utilise 111 to be directed to the most appropriate service and visit our Urgent Treatment Centre where appropriate. This was a major focus over the bank holiday weekends
- Attend Anywhere – video consultations continue to grow and the positive news on fantastic patient feedback was shared
- Clinical Trials Day – celebrating our wonderful Research and Development teams with some impressive statistics of their work over the past year
- International Nurses Day – stories from an international acute nurse, two community nurses and an AP as we celebrated International Nurses Day
- International Day of the Midwife – a video of some of our fantastic midwives and maternity staff telling us why they love their jobs
- Increase in visitors – updated guidance on the number of named visitors for patients increasing from one to three
- Video library – sharing the fantastic resource that is available to help our community, produced in partnership with HCI
- Deaf Awareness Week – video from our Sensory team, promoting the accessibility arrangements available for patients and the support on offer
- Vaccination Hub – celebrating the end of our incredible hospital hub with a video marking the achievements of the centre
- Updated guidance on parking – publishing the new concessionary guidance for parking on our sites to make those in greatest need aware that free parking is available

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 31 May 2021
LinkedIn	5,000 followers	2,878	3,048 ↑ 170 followers
Facebook	15,000 likes	12,141	12,266 ↑ 125 followers

	12,499 followers	12,499	12,626 ↑ 127 followers
Twitter	8,000 followers	6,801	6,880 ↑ 79 followers

8 Recommendation

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

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 2 2021/22 (May 2021 data)			Meeting date: 30 June 2021
Report appendix	M2 2021/22 IPR focus report M2 2021/22 Dashboard of key metrics		
Report sponsor	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 June 2021 Integrated Governance Group: 23 and 24 June 2021 Finance, Performance, and Digital Committee: 28 June 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 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 Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to received and note the documents and evidence presented.		
Summary of key elements			

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks	

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

This report reflects the following corporate risks:

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

Report title: Integrated Performance Report (IPR): Month 2 2021/22 (May 2021 data)		**Meeting date:** 30 June 2021
Report sponsor	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

Hospital Standardised Mortality Rate (HSMR)
The latest Hospital Standardised Mortality Rate (HSMR) released for time period to February 2021 is showing a relative risk of 90.5 (from January's risk of 114.3) which is below the national benchmark and within the tolerance. There is further analysis within the Mortality Surveillance group meeting, which assists in determining key areas to focus a review and identify any learning.

Incidents
The Trust reported Five new severe incidents and zero deaths in May:

1. Hospital IT failure
2. Category 4 pressure ulcer
3. Fall - fractured arm
4. Treatment delay – diagnosis
5. Clinical assessment delay due to fall

The following three have met the criteria for a serious incident and has been reported onto the Strategic Executive Information System (StEIS):

- Fall – fractured arm
- Treatment delay – diagnosis
- Hospital IT failure

VTE performance remains below the required 95% standard
The VTE performance continues to be at 92% remaining slightly lower than the standard of 95%. The VTE task and finish group continue to ensure the validation of data sets; the VTE task and finish group continue to drive improvements;

- The CPS will now have a mandatory field for VTE from 1st August 2021;
- Educational and training session on VTE is in development and will delivered by the VTE consultant haematology lead;
- Further improvements regarding the reporting framework is being designed.

Stroke
The percentage of stroke patients spending 90% of time on a stroke ward in May has decreased significantly from 84.1% in April to 65.9% in May. This relates to the following reasons;

- Attendances to the Trust in May have exceed pre-covid levels and access to stroke beds has been impacted due to bed capacity, delaying stroke patients being transferred to a stroke bed.
- Improve the timeliness covid swab results within the Emergency Department.

- A stroke improvement collaborative is being developed to progress improvement plans, which will also focus on the pathway to stroke patients between ED and the ward.

CQC

During May we were able to close 2 must do's:

- Records storage in-line with data protection and information governance – This requires movement of the patient record to a more secure space and has been completed.
- Ensure patients have access to their disability aid – on admission we ask what the patient requires, whether they have them and actions taken and is documented.

The remaining 4 Must Do's which are overdue from the date of completion are being progressed. Of the 4 Must do's these are themed into 3 areas, these in summary are:

1. Ensure staff are up to date with all mandatory training to include safeguarding training and resus – The Trust has improved its oversight of compliance training and has implemented a mandatory training framework. Each ISU have detailed plans including dates for attending the face to face elements of the training.
2. Ensure staff are up to date with appraisals – there has been a continued slow improvement seeing an improvement to 86% against the target of 90%, All ISU's have detailed trajectory for improvement including arranged dates for appraisal completion.
3. MCA and MHA training and compliance - The Trust has improved its oversight of compliance training. Work is ongoing to achieve the 90% compliance targets May has seen a 10% improvement from April in all levels of MCA training compliance.

The CQC Compliance Group is reviewing all plans in relation to the 'Should Dos' - with the majority of these in maternity, surgery and Medicine relating to statutory and mandatory training.

An evidence peer review programme has been implemented and involves a list of senior leads being assigned specific areas of the must do improvements reviewing the evidence against the following criteria:

- Accurate
- Timely
- Reliable
- Legible
- Relevant
- Indelible
- Complete

Once the evidence is reviewed a period of testing the evidence within areas across the Trust is being completed and feedback is to be received at the CQC assurance meeting on 29th June as part of our improvement journey story.

Safer Staffing – Planned versus actual hours and CHPPD

In regards to the planned versus actual hours

- The Registered Nurse (RN) average fill rate for day has marginally increased in May to 90% from 89% in April and night has decreased from 90.3% in April to 88% is below the 100% optimum.
- The RN position in the following clinical areas George Earle, ICU and Louisa Carey is above the 100% planned this is in response to enhanced care and higher acuity of patients.

- In the Majority of clinical areas, the HCA position is above the 100% planned reflecting demand for additional duties for enhanced care.
- In those areas where the fill rate is below 100%, the actual number of staff rostered reflects the impact of short-term sickness, vacancies and maternity leave on the planned nursing rosters in particular areas such as EAU 3 (Cromie) the deficit in planned hours are driven by the ward refurbishment for covid secure and Elizabeth (Cromie) moved wards.
- Regular control meetings remain a key element in reviewing staffing levels throughout the day and staffing requirements.

For the Care Hours Per Patient Day (CHPPD)

In May the overall number of care hours per patient per day for both RN & HCA combined, is marginally below the national average of 9.3 with TSDFT recording 8.16.

- The higher acuity of patients we have seen in attendance in May in some of our specialist areas such as ICU and Louisa Carey has demonstrated a CHPPD position that exceeds the national average in relation to for RN numbers.
- HCA higher CHPPD are related to supporting the backfill of RN's and to support our patients requiring enhanced observations and escalation areas due to increased attendances within the Trust, the enactment of the staffing risk framework for safest COVID staffing is in place to safely deploy staff across the Trust.

2. Workforce Headlines

The May 2021 WTE (hours worked) of 6143 is a reduction from the April figure of 6282 and is mainly due to less nursing and medical and support staff worked hours. Vacancies based on the 2021-22 budget for the end of May against contracted staff stand at 196 FTE which represents a vacancy factor of 3.28% with nursing and medical vacancies at 5.72%.

April monthly sickness absence rate is currently 3.57% which continues the low sickness rates this calendar year to date, the significant reduction in seasonal illness is the key reason why overall sickness has reduced year on year. The April cumulative 12-month rolling figure is 3.98% which is the first time since December 2015 that the rolling sickness figure has been below 4%. Initial sickness figures for May do show an increase and the monthly figure for May could be in the region of 4.1%.

The continued improvement in Achievement Review compliance was seen at the end of May with the rate being 86.61% which is the third month in a row we have seen an increase from the 78.45% in February and a level considerably higher than pre-Covid levels and the highest in the last four years.

Agency expenditure for May was £876k with the Financial year to date £1.583m.

3. Performance Headlines

Details of specific national performance indicators are contained in the IPR focus report. The key performance indicator headlines demonstrate significant pressure on acute services across both elective and emergency care, but service levels for emergency and urgent care including cancer pathways are being maintained.

There has been a continued increase in referrals with the number of urgent referrals being now back to or exceeding pre-covid levels. The most challenged pathways are Breast, Urology, Lower GI, and Head and Neck services.

Operational headlines

Covid - the Trust has continued to have no Covid admissions and is maintaining ward capacity to a maximum of 8 bed spaces before having to escalate should there be a need to accommodate covid positive inpatients.

Acute bed occupancy has increased in May to 92%; this reflects the increased demand from the high acuity of patients presenting for assessment and recent loss of 14 beds from core beds stock. The risk of high bed occupancy impacting on patient flow and elective cancellations is recognised. Any significant increase in bed capacity will not be available until the MRU development is completed in 2022.

It is noted that in June demand for acute beds has caused significant operational challenge with OPEL 4 status being declared, resulting in some cancellation of elective inpatients scheduled for surgery and from 21st to 23rd June, a temporary partial closure of the Day Surgery Unit to support the escalation response.

Activity in May is slightly down on that delivered in April, however, remains above the trajectory submitted in recovery plans. The future delivery of these plans for elective admissions is contingent on managing the emergency admissions through the available beds and not requiring elective cancellations. This is recognised as a risk and work is ongoing to seek mitigation across local and system capacity to reduce these risks.

In Month 2 PBR contract activity levels, when compared to pre-covid Month 2 19/20 activity levels, are: Outpatient New 77%, Outpatient follow up 86%, Day case 78%, inpatient 80%. For outpatient activity the focus remains on adopting virtual non-face-to-face appointments where ever possible. Local performance against the percent of recorded non-face-to-face appointment is lower than neighbouring trusts and this is being picked up by ISU leaders and supported by the Transformation team.

Children's services (CFHD) remain challenged with long waits, however, plans now agreed to increase capacity will see steady improvement over the coming months. Work continues with the design and approval of the clinical model that is a pre-requisite for continuing the work on the CFHD System One IT implementation.

The Adult Social Care improvement work is gathering pace and is being closely monitored.
The Front Door model was tested in mid-May as it enters its next stage, implementation of telephony requirements and development of one set of processes across the Bay

Waiting time headlines

The number of patients waiting over 52-weeks decreased in May to 1596 (from 1895 in April).

Performance against the cancer access standards has been maintained, however, remains below the national performance targets.

Diagnostics performance has seen improvements in CT and echocardiography however waits remain high for Ultrasound, MRI, and Gastro diagnostic procedures.

Performance monitoring and assurance headlines
The Integrated Governance Group (IGG) meetings were all completed in May with each of the Integrated Service Units and CFHD able to highlight areas of performance risk and give assurance to the executive and escalate where further support is required.

4. Finance headlines

Reporting of financial performance to NHSE/I recommenced for Month 2, with actuals monitored against the H1 plan submitted, in line with the national timetable, on 26 May.

For the month of May, the Trust is reporting a £2.1m surplus, which gives rise to a c. £2.3m favourable variance to plan. The key driver for actual performance being receipt of £1.4m Elective Recovery Funding (ERF) from the CCG in Month 2.

The cash position remains strong with a month end balance of £36.6m. To date the Trust has spent c. £1.2m on capital schemes, which will accelerate as the year progresses. Meetings are currently being arranged with scheme leads to support this.

Looking ahead, a detailed re-submission of the H1 plan was made on 22 June, which reflects a break-even position. The Trust's current forecast, as at the end of Month 6, indicates that this will be achieved.

Integrated Performance Focus Report (IPR) Trust Board

Torbay and South Devon NHS Foundation Trust

June 2021: Reporting period May 2021 (Month 2)

	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

HSMR
The latest Hospital Standardised Mortality Rate (HSMR), released for time period to February 2021 is showing a relative risk of 90.5 (from January's risk of 114.3) which is below the national benchmark and within the tolerance. There is further analysis within the Mortality Surveillance group meeting, which assists in determining key areas to focus a review and identify any learning.

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- Legible
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- Complete

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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	0	n/a	0	n/a	1	n/a
Urgent and Emergency	8	6	8	5	0	0	0	0	0	1
Medical Care	9	12	7	7	0	0	0	0	2	5
Surgery	4	5	3	0	0	0	0	0	1	5
Maternity	4	11	4	11	0	0	0	0	0	0
Children and Young People (Acute)	1	5	1	4	0	0	0	0	0	1
Community Inpatients	1	4	1	4	0	0	0	0	0	0
TOTAL	**28**	**43**	**24**	**31**	**0**	**0**	**0**	**0**	**4**	**12**

Achieved
Hospital Standardised Mortality Rate (HSMR)
Avoidable New Pressure Ulcers - Category 3 +
Reported Incidents – Death
Never Events
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams
Formal complaints - Number received
Infection Control - Bed Closures - (Acute)
Safer Staffing - ICO – Night time
Fracture Neck Of Femur - Time to Theatre <36

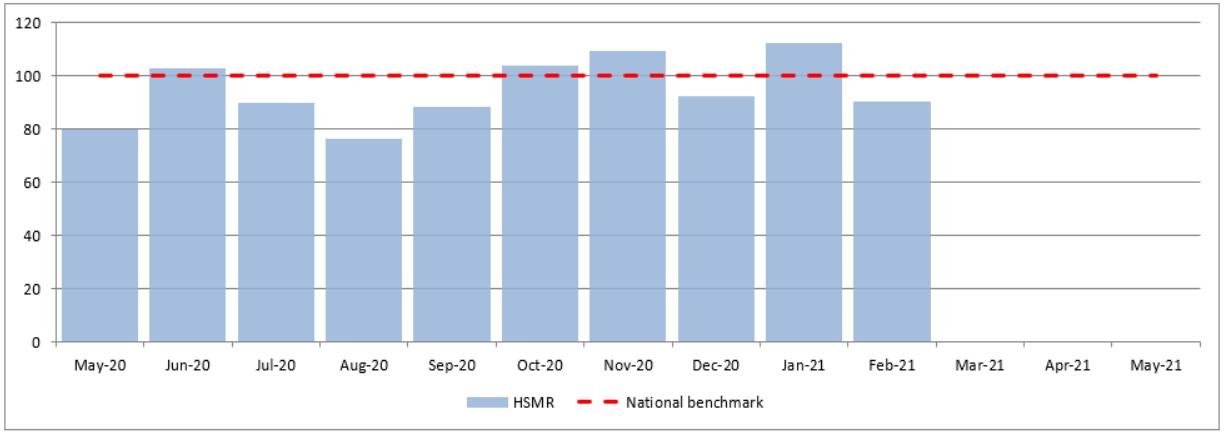
Not Achieved
Reported Incidents – Severe
VTE - Risk Assessment on Admission (ICO)
Stroke patients spending 90% of time on a stroke ward
Follow ups 6 weeks past to be seen date
Strategic Executive Information System (STEIS)

No target set
Medication errors - Total reported incidents

Under Achieved
Medication errors resulting in moderate harm
Safer Staffing - ICO – Daytime
Hand hygiene

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

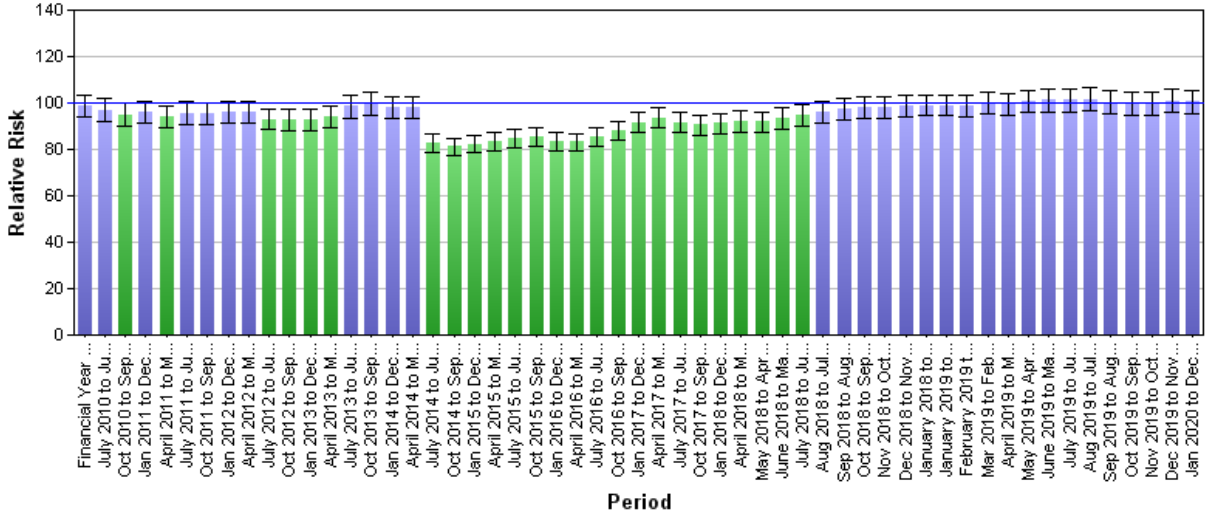
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
HSMR	79.8	103.1	90.1	76.5	88.4	104	109.4	92.5	112.3	90.5	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



Trust wide mortality is reviewed via a number of different metrics, however, Dr Foster allows for a standardised rate to be created for each hospital and, therefore, this is a hospital only metric. This rate 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, February 2021, for Dr Foster HSMR is showing a relative risk of 90.5 (from January's risk of 114.3) which is below the national benchmark and within the tolerance. There is further analysis within the Mortality Surveillance group meeting, which assists in determining key areas to focus a review and identify any learning.

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 99.65 against a national average benchmark of 100.

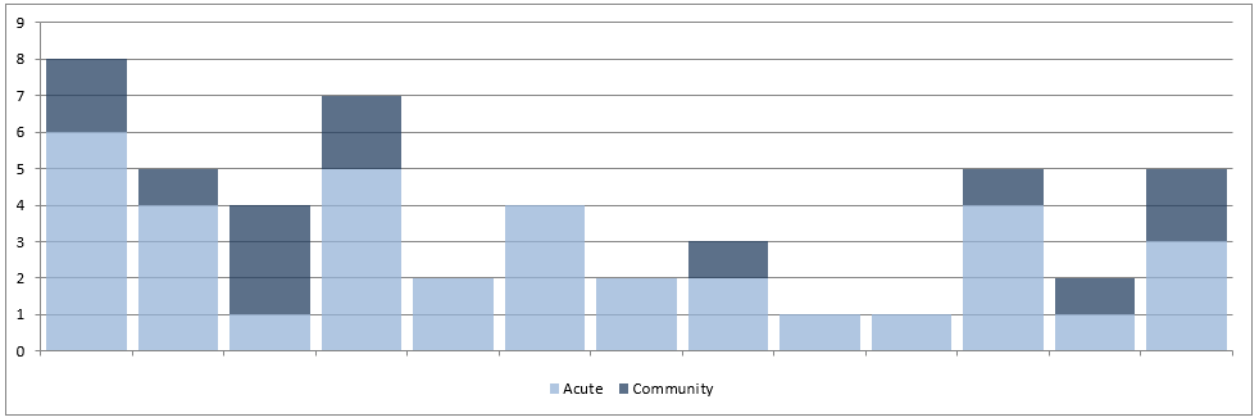
The latest data for period January 2020 to December 2020, which is a different reporting period than HSMR, it is within the expected norm.

A score of 100 represents the weighted population average benchmark.

A more detailed analysis of mortality is discussed within the board report

Number of Clostridium Difficile cases

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Acute	6	4	1	5	2	4	2	2	1	1	4	1	3
Community	2	1	3	2	0	0	0	1	0	0	1	1	2



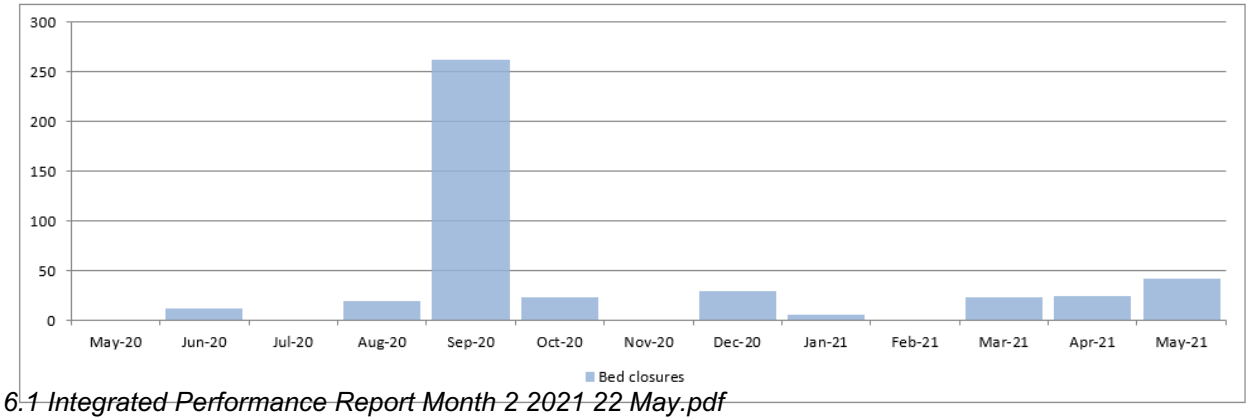
For May the number of C.Diff cases was 5 which is an increase from April and were reported from the following area:

- Teign ward
- Cromie
- MRU
- Dart
- Simpson

All appropriate actions are being taken with a RCA being conducted- A review of practice across the Trust is being conducted by the IPC team and are working with the areas to enhance practice improvements.

Infection control - Bed closures (Acute)

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Bed closures	0	12	0	20	262	23	0	30	6	0	23	24	42



The Trust continues to see a number of bed closures due to infection.

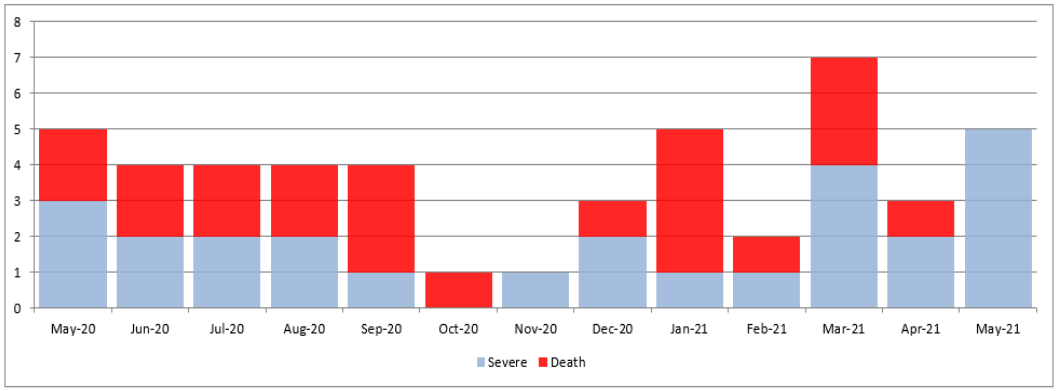
For May 2021 we have had a total of 42 beds closed over the month for:

- C. Diff
- Non C.Diff diarrhoea

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Severe	3	2	2	2	1	0	1	2	1	1	4	2	5
Death	2	2	2	2	3	1	0	1	4	1	3	1	0



The Trust reported Five new severe incidents and zero deaths in May:

The Five severe incidents

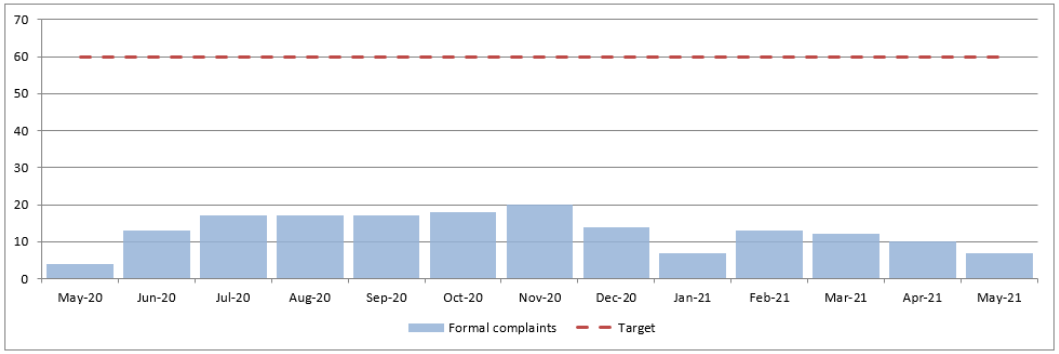
1. Hospital IT failure
2. Category 4 pressure ulcer
3. Fall - fractured arm
4. Treatment delay – diagnosis
5. Clinical assessment delay due to fall

The following three have met the criteria for a serious incident and has been reported onto the Strategic Executive Information System (StEIS):

- Fall – fractured arm
- Treatment delay – diagnosis
- Hospital IT failure

Formal complaints

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Formal complaints	4	13	17	17	17	18	20	14	7	13	12	10	7
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



The Trust received seven formal complaints for the month of May this was a decrease from the previous month.

The themes of the complaints include:

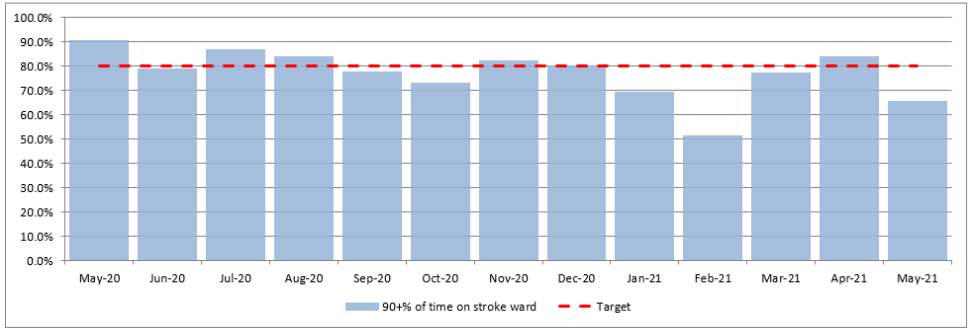
- Treatment – concerns related to type of treatment
- Assessment and diagnosis care – questions regarding assessment and diagnosis.
- Communication – this is related to not having enough information and explanation

The patient experience framework and strategy is being designed and an improvement plan is being developed.

Quality and Safety- Exception Reporting

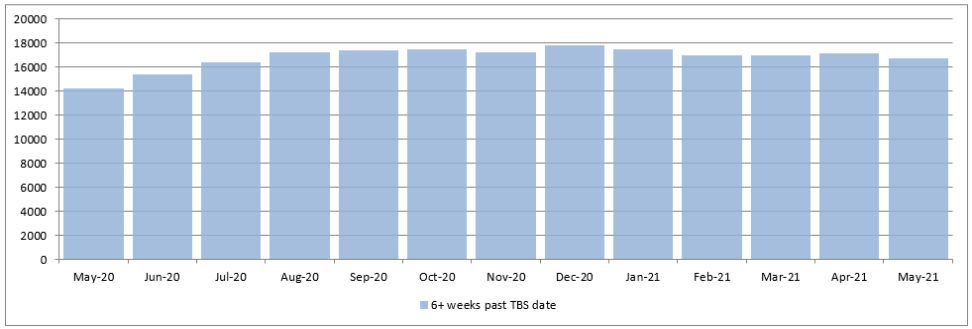
Stroke

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
90+% of time on stroke ward	90.6%	79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%
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%



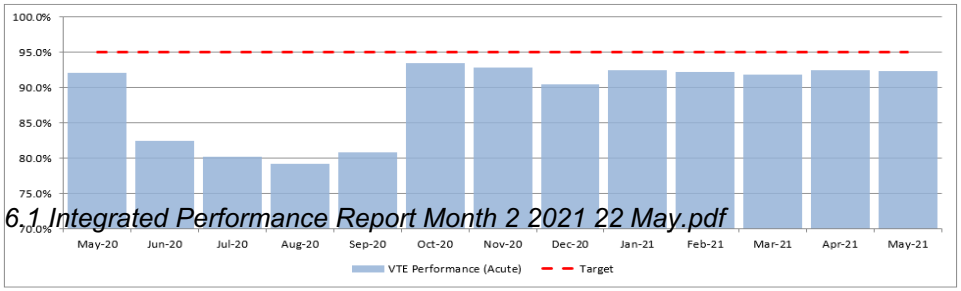
Follow ups 6 weeks past to be seen by date

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
6+ weeks past TBS date	14211	15398	16408	17220	17408	17519	17229	17837	17489	16986	16950	17118	16713



ICO VTE risk assessment on admission

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
VTE Numerator	3158	3484	3939	4013	4253	5066	4837	4903	4705	4457	5307	5491	5400
VTE Denominator	3430	4225	4914	5068	5260	5423	5209	5423	5091	4831	5775	5938	5851
VTE Performance (Acute)	92.1%	82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%
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%



Stroke: The percentage of stroke patients spending 90% of time on a stroke ward in May has decreased significantly from 84.1 % in April to 65.9% in May. This relates to the following reasons and continued areas that we are focusing on to improve our positions;

- Attendances to the Trust in May have exceed pre-covid levels and access to stroke beds has been impacted due to bed capacity delaying stroke patients being transferred to a stroke bed
- Improve the timeliness covid swab results within the Emergency Department

- A stroke improvement collaborative is being developed to progress improvement plans, which will also focus on the pathway to stroke patients between ED and the ward

Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has seen a decrease from April from 17118 to 16713.

- Focused harm review meetings are being progressed and thematic reviews being conducted against our longest waiting patients.
- The main areas are ophthalmology, urology.
- Detailed recovery plans have been devised with an improvement trajectory.
- Further programmes of work are being developed

VTE

The VTE performance continues to be at 92% remaining slightly lower than the standard of 95%.

The VTE task and finish group continue to drive improvements;

- the CPS will now have a mandatory field for VTE
- Educational and training session on VTE is in development and will delivered by the VTE consultant haematology lead.
- Further improvements regarding the reporting framework is being designed

Following the publication of the Ockenden Report (Dec 2020), national guidance sets out the requirement to strengthen and optimise board oversight for maternity and neonatal safety. Review of maternity and neonatal safety and quality is required monthly by the Trust board

Metric	Target	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	YTD
% of Caesarean sections	25-30%	26.9%	33.1%	24.7%	29.9%	26.8%	34.9%	26.7%	28.7%	24.3%	29.5%	34.0%	31.4%	**29.2%**
Breast feeding rates	>75%	77.1%	72.5%	78.8%	77.7%	70.1%	69.8%	82.2%	78.1%	75.7%	81.8%	73.5%	76.2%	**76.2%**
% of women booked for 'Continuity of carer' model	>35%	63.7%	64.0%	78.3%	64.9%	66.0%	63.3%	60.1%	61.7%	62.3%	67.9%	57.0%	64.2%	**64.5%**
No. of stillbirths	0	0	0	0	0	0	0	1	1	1	0	0	0	**3**

- The maternity services continue to see a rise in acuity, this will naturally lead to higher rates of intervention, such as increased induction of labour, caesarean section and admission to the Special Care Baby Unit.
- The caesarean section rate has reduced in May from the previous reporting period in April, however remained slightly higher than the national average. This can be accounted for by the rise in acuity, plus natural deviation in the monthly rate. The team will continue to closely monitor the rates of caesarean section to identify if a trend is emerging over a three month period
- The breast feeding rates were noted to return back to expected levels during May and will continue to monitor.
- There was no mortality to report during May and no cases meeting the STEIS reportable criteria.

June 2021 Update of Progress Against Our People Plan

Our People Plan

Our People plan was approved by the Board 31st March 2021, we now provide updates against the underpinning pillars which reflect how the plans are being implemented, embedded and monitored through the ISU structures:

Growing for Our Future

The Resourcing Hub has been providing increased levels of support particularly around assessment/selection days. We have started to introduce new applicant booklets to support our employer brand and attraction activity. These new interactive booklets showcase our Integrated Care Organisation to an expanded audience so we can share vacancies via social media. This includes working closely with EDI Leads with further work planned to strengthen recruitment practice through an inclusivity lens.

The Devon International Recruitment (IR) Hub has been developing new recruitment networks/forums across Devon to connect partners to share best practice for onboarding. Later this month we are hosting a training event to support the local international recruitment teams. Then Devon IR Hub has successfully created a pipeline of nurses ready to support the local Devon workforce and conversations to supply the Devon Trusts is underway.

A team from across a number of departments have been contributing to refreshing our external webpages (Work with Us) to strengthen our current employer brand, and be ready for our new recruitment system TRAC, see below. Future applicants will apply through our website. This work we review our current organisation employer brand, and how it is used to attract people to join us.

Our new recruitment system (TRAC) remains on track to go live 1st July 2021 and we have been running recruiting manager demonstrations session to help equip our managers ready to help with the smooth implementation.

Looking After Our People

Workforce and Organisational Development Directorate Survey - In May the Workforce and OD Directorate carried out a customer survey across the Trust to review quality and effectiveness of the services that we deliver. The survey closed on 21 May with over 150 responses. We are currently working through the feedback and will use it to build our service improvement plans over the summer. This will be published and our progress tracked in order to ensure that the ways we work and the services we provide improves working lives.

The workforce team continue to supporting responses to Covid-19 through; absence reporting, updated guidance/FAQ's and workforce health and well-being.

New Ways of Working and Delivering Care, including Medical Workforce

The baseline Trust Workforce plan has now been created and submitted.

Medical Job Planning - The Trust has now gone live with the new Job Planning Software hosted by L2P. L2P is a leading provider of Job Planning and Appraisal software, working with over 60 healthcare organisations across the country. A Job Planning Strategy Group has been created to oversee and make decisions relating to the new job planning system to ensure a fair and transparent job planning process is reflected in policy. The group includes members from both clinicians and operational managers.

Speciality & Associate Specialist Contract Reform 2021 - SAS doctors on National Terms & Conditions of Service (TCS) will be given the opportunity to remain on their current TCS or move to the new contracts.

From 1st April 2021 the ONLY available contracts for new appointments are the Specialty Doctor and Specialist Doctor.

Transitional arrangements are NOT APPLICABLE to doctors on local terms and conditions, this includes those doctors who were regraded to Associate Specialist after 2008.

Medical workforce will write to individual SAS doctors to confirm eligibility and invite expression of interest, deadline Sept 2021.

Belonging

Organisational Values - Given the hugely challenging year with Covid-19 and on both a professional and personal level, many have reflected and re-visited what matters to them. A small working group, who have already contributed to discussions about reviewing our organisational values, are engaging with our people to understand what matters to them to inform whether our organisational values are fit for purpose. The essence of this plan will be to harness this sense of purpose to best effect for our organisation, rather than impose values on our people that are not meaningful, not referred to or used. As a starting point we will conduct a quick poll on ICON to establish whether our people feel that our current organisational values are fit for purpose - or if we need something else. We will follow up on this through open conversations with our own people through multiple forums, small focus groups at a team/departmental level and through existing networks and groups.

Creating the Conditions to Enable Transformation

Just and Learning culture - outputs from the recent training event with MerseyCare attended by both Staff Side Chair and People Hub Service Manager, are being presented to various groups to inform our future approaches and policy review. An initial awareness session was completed with Staffside.

Increasing Skills and Confidence in Improvement; England Partnership supported the development of Improvement and Innovation Team purpose and have further developed a system change programme. An Improvement and Innovation prospectus has been constructed and a training programme has been developed.

Cultural Framework and Manager's Essentials; 'Imanage' has been agreed as the name for the Manager's Essential training and is being develop on HIVE. The outline structure of imanage has been agreed and amended by the management reference group. The Cultural Framework and Imanage have been shared/socialised with People Business Partners, Design leaders, System Directors, QAIT team.

Digital Skills; HEE 'Access to IT' pilot in the South West is progressing and approach made to ICS – Torbay will be a pilot site (IT infrastructure assessment for education). Linking with HEE Digital Literacy national Lead to organise a framework and digital competencies toolkit to be worked into our own LMS. Funding has been identified, with a contribution from Plymouth University to support a research fellow post for fixed term to support digital literacy workflow – including evaluation, feedback and engagement models.

Workforce Status

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

Under Achieved
Appraisal Completeness Monthly Sickness Absence & Rolling 12 months and current month (1 month in arrears)

Not Achieved

Performance exceptions and actions

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

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

The Trust's turnover rate now stands at 11.03% for the year to May 2021.

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

The annual rolling sickness absence rate was 3.98% to end of April 2021 the first time since Dec 2015 this figure has been below 4%. - This is against the target rate for sickness of 4%. The monthly sickness figure for April was 3.57%

Mandatory Training rate: **GREEN**

The current rate is 90.10% for May 2021 against a target of 85% and this is a small increase from the 90.06% in April.

Appraisal rate: **Amber**

The Achievement Review rate for the end of May 2021 was 86.61% which is for the third month running a significant improvement from the 78.45 % as at the end of February continuing to identify the renewed focus and Achievement Reviews and now well above the pre-Covid compliance.

Agency Expenditure – As at Month 02 the Trust Agency spend was is £827k giving an annual figure of £1.583m

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 Group	2021/03	2021/04	2021/05	Change since March 2021	% Change
Allied Health Professionals	484.62	482.43	485.82	1.20	0.25%
Health Care Scientists	94.17	95.17	93.71	-0.45	-0.48%
Medical and Dental	531.34	527.82	524.87	-6.47	-1.22%
NHS Infrastructure Support	1122.74	1120.22	1121.66	-1.08	-0.10%
Other Scientific, Therapeutic and Technical Staff	381.75	387.41	387.12	5.38	1.41%
Qualified Ambulance Service Staff	10.72	9.52	9.52	-1.20	-11.19%
Registered Nursing, Midwifery and HV staff	1241.94	1237.33	1239.03	-2.91	-0.23%
Support to clinical staff	1906.40	1880.31	1889.59	-16.80	-0.88%
Grand Total	5773.68	5740.22	5751.33	-22.35	-0.29%

Pay Report Summary for the final 3 months of 2020-21 and April/May 2021-2022

	JAN	FEB	MAR	APR	MAY
Cost	£	£	£	£	£
Substantive	£24,645,064	£21,483,866	£31,299,992	£21,340,031	£21,422,432
Bank	£1,052,959	£1,074,886	£1,253,501	£1,058,626	£1,040,420
Agency	£666,436	£572,475	£1,053,038	£755,150	£827,832
Total Cost £	£26,364,459	£23,131,226	£33,606,531	£23,153,807	£23,290,684
WTE Worked	WTE	WTE	WTE	WTE	WTE
Substantive	5,711.13	5,816.28	5,844.37	5,838.43	5,757.26
Bank	248.71	331.21	301.34	328.09	269.23
Agency	116.38	102.39	160.15	115.40	116.45
Total Worked WTE	6,076.21	6,249.88	6,305.86	6,281.92	6,142.94

Workforce – Vacancies (12 months rolling)

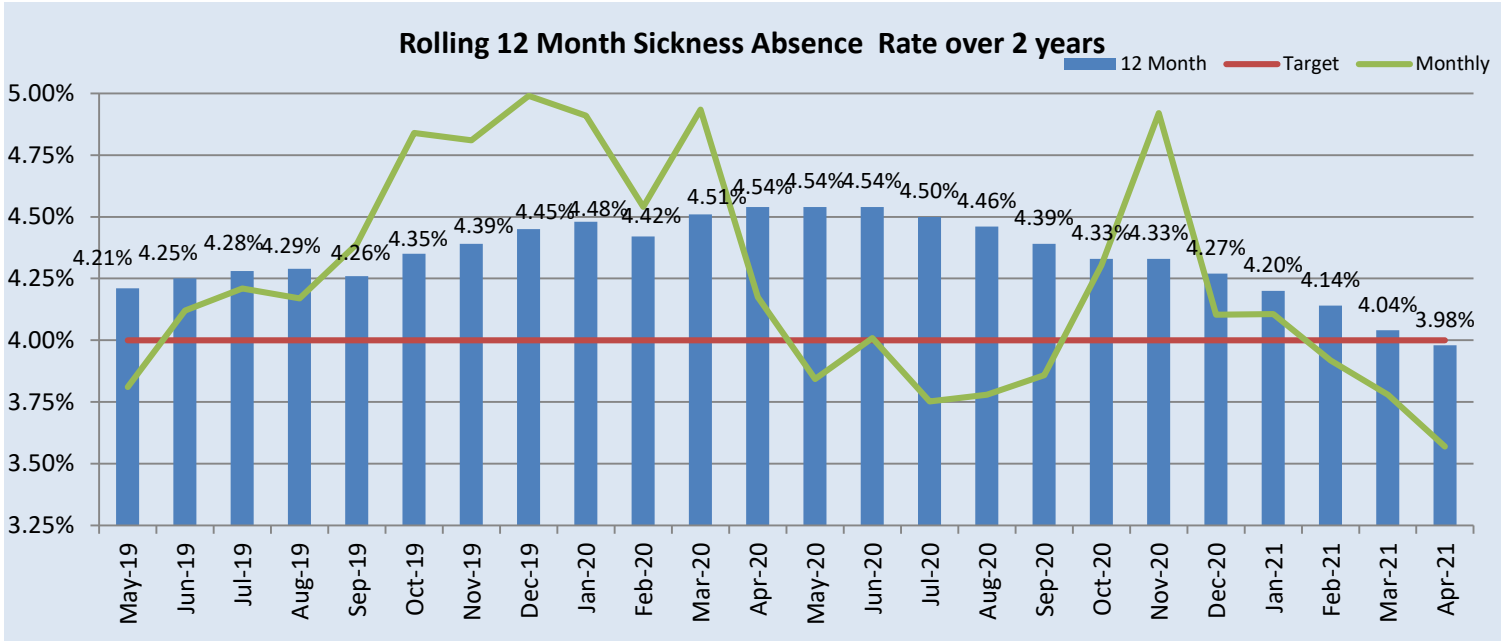
Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Medical And Dental	518.35	518.35	518.35	518.35	527.76	531.47	531.98	532.11	532.75	530.01	541.66	542.30
Nursing And Midwifery Registered	1,242.27	1,239.27	1,243.27	1,243.27	1,276.48	1,301.80	1,306.14	1,318.38	1,322.60	1,323.27	1,325.10	1,321.76
Support To Clinical Staff	1,782.16	1,782.16	1,782.16	1,782.16	1,856.95	1,871.02	1,873.98	1,873.08	1,874.40	1,878.97	1,917.95	1,917.53
Add Prof Scientific and Technic	378.94	378.94	378.94	378.94	427.92	429.39	435.21	436.21	436.14	437.55	431.92	431.19
Allied Health Professionals	447.57	447.57	447.57	447.57	479.19	483.13	484.06	490.23	490.83	491.07	493.43	495.28
Healthcare Scientists	93.16	93.16	93.16	93.16	105.02	104.43	104.43	104.43	104.43	104.43	99.60	99.60
Administrative And Estates	1,148.40	1,148.40	1,149.40	1,149.40	1,173.83	1,179.06	1,183.11	1,182.75	1,183.84	1,184.64	1,157.25	1,157.46
Total Staff Budgeted WTE	5,610.85	5,607.85	5,612.85	5,612.85	5,855.77	5,908.94	5,927.54	5,945.82	5,953.62	5958.57	5,972.71	5,970.92

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-20	May-20
Medical And Dental	522.02	518.04	592.68	525.00	521.19	518.49	519.24	517.75	533.98	527.31	524.76	522.61
Nursing And Midwifery Registered	1,188.26	1,186.14	1,199.95	1,215.61	1,221.69	1,232.54	1,223.95	1,237.38	1,240.80	1,244.21	1,246.22	1,246.20
Support To Clinical Staff	1,868.96	1,885.26	1,851.30	1,820.93	1,834.67	1,828.35	1,856.95	1,849.09	1,883.86	1,905.39	1,898.96	1,878.21
Add Prof Scientific and Technic	383.55	397.82	409.47	410.34	402.49	406.08	404.14	406.15	405.08	405.12	406.84	406.93
Allied Health Professionals	470.40	474.20	476.38	482.55	478.15	474.20	471.91	485.89	481.30	482.42	479.38	480.14
Healthcare Scientists	101.37	97.82	98.82	99.41	101.37	99.72	99.17	99.17	99.17	99.17	99.17	100.17
Administrative And Estates	1,124.24	1,098.02	1,094.86	1,107.69	1,108.59	1,110.50	1,113.61	1,114.21	1,122.69	1,135.62	1,128.59	1,134.90
Total Staff Worked WTE	5663.52	5665.84	5731.98	5670.05	5676.69	5678.20	5697.30	5718.16	5777.59	5809.97	5794.64	5774.76

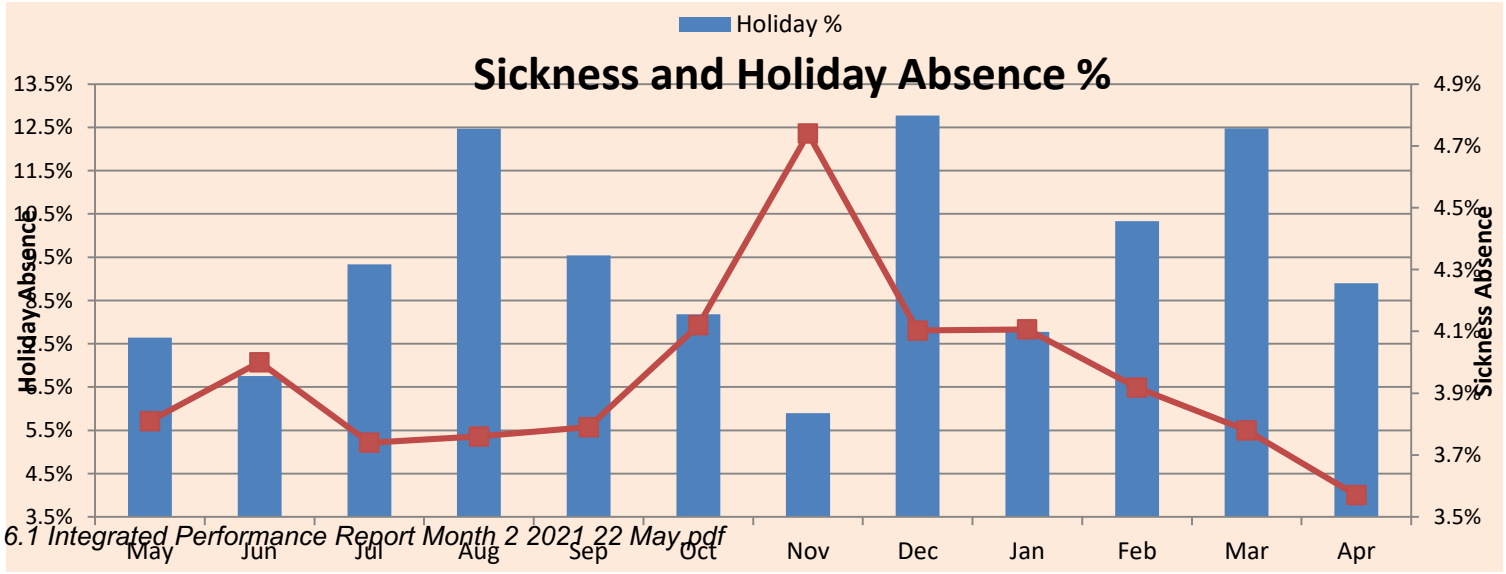
Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-20	May-20
Medical And Dental	-3.67	0.31	-74.33	-6.65	6.57	12.98	12.74	14.36	-1.22	2.70	16.90	19.69
Nursing And Midwifery Registered	54.01	53.13	43.32	27.66	54.79	69.26	82.19	81.00	81.80	79.05	78.88	75.56
Support To Clinical Staff	-86.80	-103.10	-69.14	-38.77	22.28	42.67	17.03	23.99	-9.46	-26.42	18.99	39.32
Add Prof Scientific and Technic	-4.61	-18.88	-30.53	-31.40	25.43	23.31	31.08	30.06	31.07	32.44	25.08	24.26
Allied Health Professionals	-22.83	-26.63	-28.81	-34.98	1.04	8.93	12.15	4.34	9.53	8.65	14.05	15.14
Healthcare Scientists	-8.21	-4.66	-5.66	-6.25	3.65	4.72	5.26	5.26	5.26	5.26	0.43	-0.57
Administrative And Estates	24.16	50.38	54.54	41.71	65.24	68.57	69.51	68.54	61.14	49.02	28.66	22.56
Total Staff Worked WTE	-47.95	-49.46	-110.60	-48.66	178.99	230.44	229.95	227.55	178.12	150.70	182.99	195.96

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



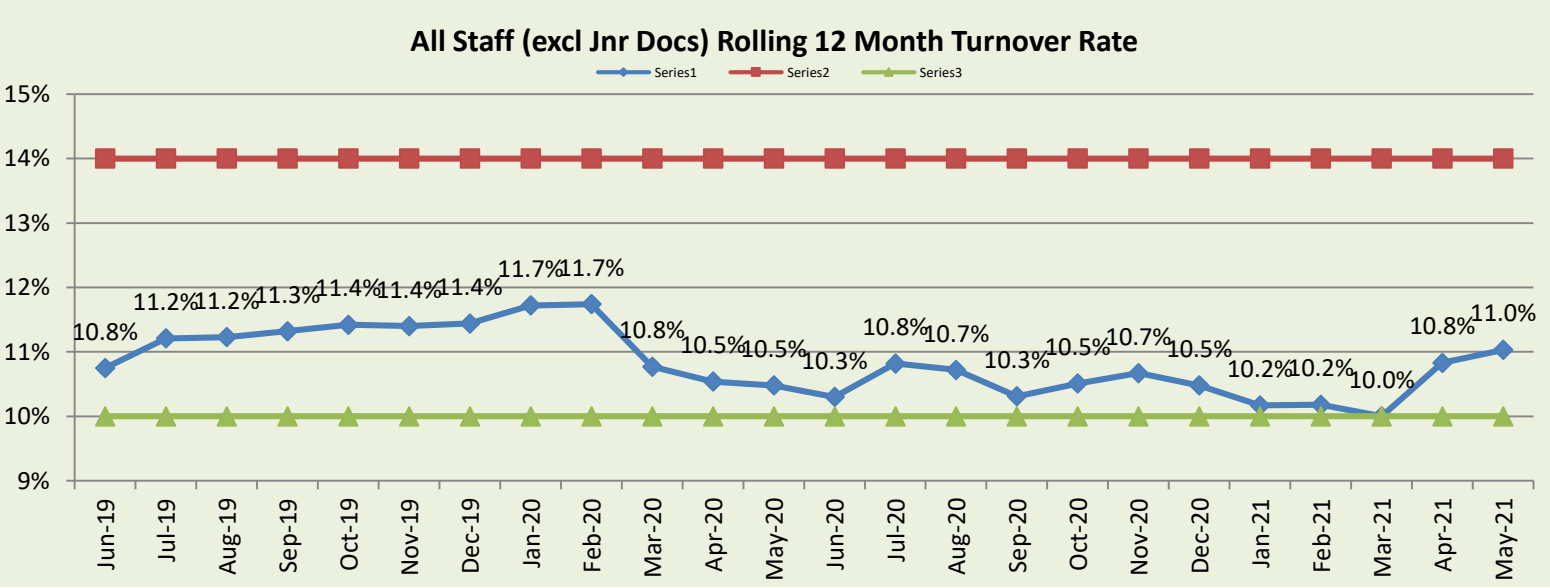
The annual rolling sickness absence rate was 3.98% at the end of April 2021 against the target of 4.00%; this is the first time since Dec 2015 it has been below 4%. The continued reduction in overall sickness is driven predominantly by the over 70% reduction in episodes and calendar days for the predominantly seasonal illnesses of colds and flu / chest and respiratory in the January to March period year on year.

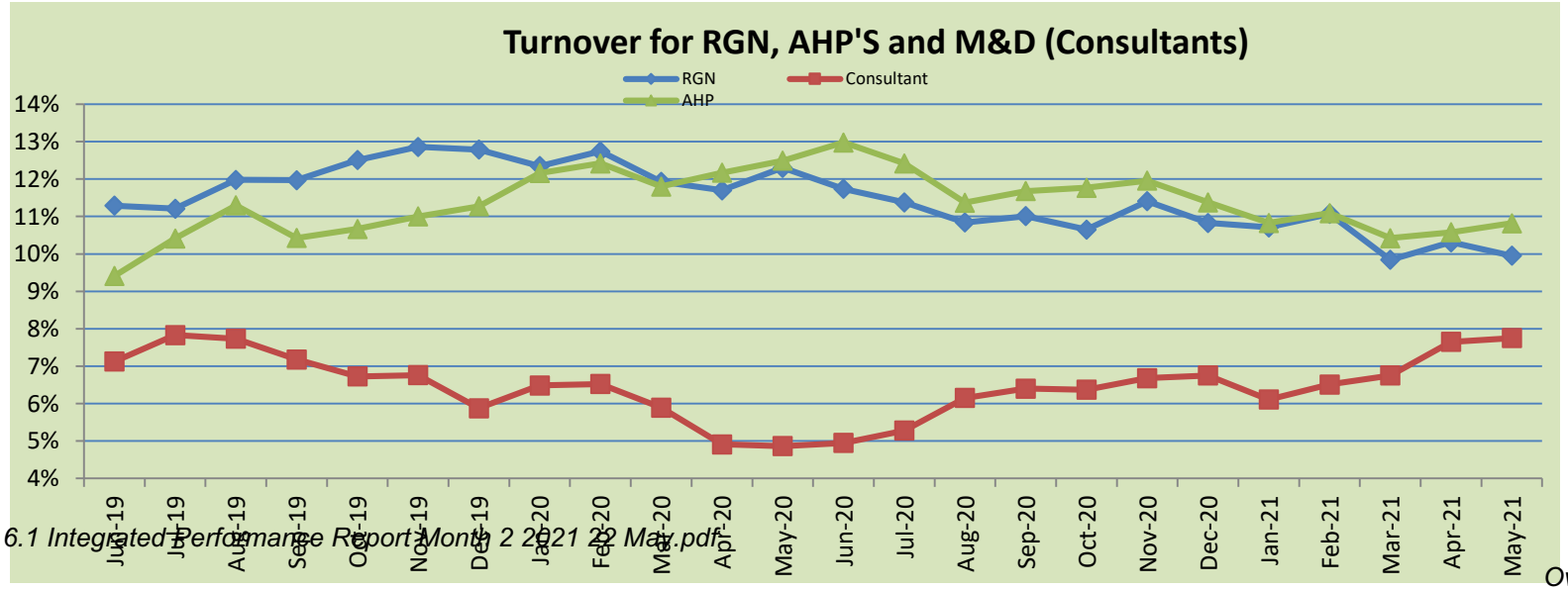
The monthly sickness figure for April was 3.57% which is another decrease from the 3.78% as at the end of March.

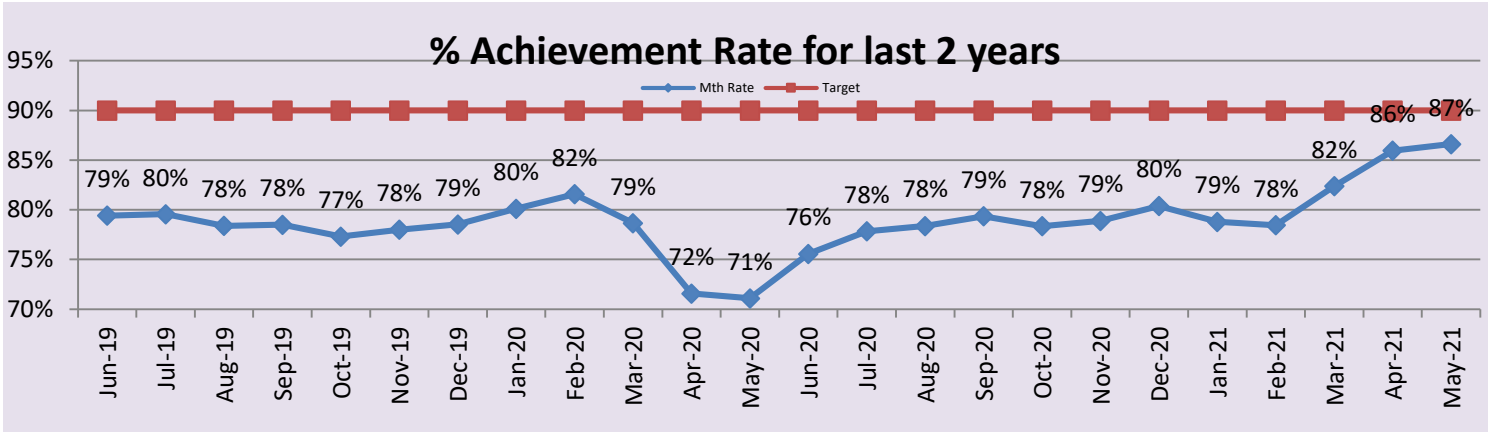


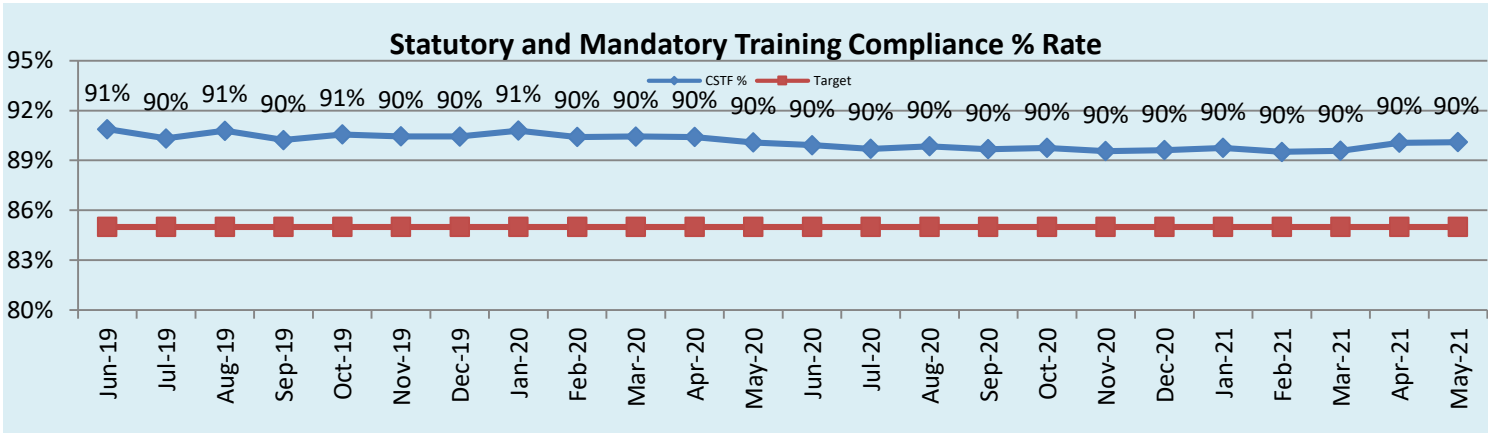
All Staff Rolling 12 Month Turnover Rate

The graph shows that the Trusts turnover rate now stands at 11.03% for the year to May 2021 which is an increase from the 10.83% in April.









Achievement Review (Appraisal)
The Achievement Review rate for the end of May was 86.61% and this is the third month running there has been a significant increase from the 78.45% in February. This highlights the increased focus on Achievement Reviews and to a level much higher than prior to them being stood down last year in the 1st Covid wave.

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 90.10% for May which is a marginal increase from the 90.06% in April.
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		
May-21						May-21		
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 1	Level 2	Level 3
6738	4129	354	43	4	9	2533	3471	734
6477	3710	188	22	1	6	2357	2864	552
96.13%	**89.85%**	**53.11%**	**48.84%**	**25.00%**	**66.67%**	**93.05%**	**82.51%**	**75.20%**

Module	Target	Performance
Information Governance	95% and above	83.75%
Manual Handling	85% and above	76.11%

The table below shows the agency expenditure by staff Group monthly for the last 3 months of 2020 -21 Financial Year and 2021 – 2022 Financial Year to date.

Torbay and South Devon NHS Foundation Trust	Monthly Values			2020 - 2021	2021 -2022		2021 - 2022
Total Agency Spend Financial Year 2020/21	**Jan**	**Feb**	**Mar**	**Total**	**Apr**	**May**	**Total**
Registered Nurses	310	289	316	3012	356	348	704
Scientific, Therapeutic and Technical	12	14	32	504	43	99	142
of which Allied Health Professionals	6	1	25	336	31	45	76
of which Other Scientific, Therapeutic and Technical Staff	6	13	7	168	12	54	66
Support to clinical staff (HCA)	31	56	45	214	-1	-10	-11
Total Non-Medical - Clinical Staff Agency	353	359	393	3730	398	437	835
Medical and Dental Agency	193	47	442	2704	244	262	506
Consultants	178	141	310	1961	214	203	417
Trainee Grades	15	-94	132	743	30	59	89
Non Medical - Non-Clinical Staff Agency	121	166	218	1196	114	128	242
Total Pay Bill Agency and Contract	667	572	1053	7630	756	827	1583

Safer Staffing –planned versus actual

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff								
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours		Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
Ainslie	1426	1402	0	0	1604	1632	1070	1031	0	0	1070	1104	714	98.3%	0.0%	101.7%	96.4%	0.0%	103.2%
Allerton	2297	2025	0	0	1070	1627	1070	1070	0	0	1070	1334	894	88.2%	0.0%	152.1%	100.0%	0.0%	124.7%
Cheetham Hill	1783	1581	0	0	2139	2990	1070	897	0	0	1426	2288	863	88.7%	0.0%	139.8%	83.9%	0.0%	160.4%
Coronary Care	1426	1423	0	0	0	0	1070	1070	0	0	0	0	382	99.8%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1426	1316	0	0	891	839	1070	912	0	0	713	754	660	92.3%	0.0%	94.1%	85.2%	0.0%	105.7%
Dunlop	1426	1336	0	0	1248	1464	1070	817	0	0	713	998	744	93.7%	0.0%	117.4%	76.3%	0.0%	140.0%
EAU3	1725	527	0	0	1380	439	1380	529	0	0	1035	357	221	30.5%	0.0%	31.8%	38.3%	0.0%	34.4%
EAU4	1783	1551	0	0	1426	1397	1426	1553	0	0	1070	1127	726	87.0%	0.0%	98.0%	108.9%	0.0%	105.4%
Ella Rowcroft	1012	927	0	0	1311	986	955	874	0	0	713	598	10	91.6%	0.0%	75.2%	91.6%	0.0%	83.9%
Forrest	1070	1082	0	0	713	748	713	713	0	0	713	725	512	101.1%	0.0%	104.9%	100.0%	0.0%	101.6%
George Earle	1783	1841	0	0	2139	2465	1070	1035	0	0	1426	1875	832	103.3%	0.0%	115.3%	96.7%	0.0%	131.5%
ICU	3565	2396	0	0	0	150	3209	2427	0	0	0	0	169	67.2%	0.0%	0.0%	75.6%	0.0%	0.0%
Louisa Cary	1426	1849	0	0	713	903	1426	1572	0	0	713	646	379	129.6%	0.0%	126.7%	110.2%	0.0%	90.6%
John Macpherson	713	905	0	0	621	653	713	723	0	0	357	949	302	126.9%	0.0%	105.1%	101.3%	0.0%	266.1%
Midgley	1783	1585	0	0	1426	1715	1070	1081	0	0	1070	1242	856	88.9%	0.0%	120.2%	101.1%	0.0%	116.1%
SCBU	1426	951	0	0	357	231	1070	736	0	0	357	322	50	66.7%	0.0%	64.8%	68.8%	0.0%	90.3%
Simpson	1783	1769	0	0	2139	2867	1070	840	0	0	1426	1742	868	99.2%	0.0%	134.0%	78.5%	0.0%	122.1%
Turner	1426	1369	0	0	1426	2090	713	713	0	0	1070	1150	375	96.0%	0.0%	146.5%	100.0%	0.0%	107.5%
Total (Acute)	*29275.5*	*25829.41*	*0*	*0*	*20602.25*	*23194.7*	*21229*	*18588*	*0*	*0*	*14938.5*	*17207.75*	*9557*	88.2%	0.0%	112.6%	87.6%	0.0%	115.2%
Brixham	868	760	0	0	1736	1568	682	703.5	0	0	682	924	598	87.6%	0.0%	90.3%	103.2%	0.0%	135.5%
Dawlish	868	780	0	0	1302	1093	744	547	0	0	682	793	466	89.9%	0.0%	83.9%	73.5%	0.0%	116.3%
Newton Abbot - Teign Ward	1302	1185	0	0	1953	1941	682	693	0	0	1023	1243	912	91.0%	0.0%	99.4%	101.6%	0.0%	121.5%
Newton Abbot - Templar Ward	1302	1225	0	0	1953	2024.5	682	682	0	0	1116	1188	895	94.1%	0.0%	103.7%	100.0%	0.0%	106.5%
Totnes	938	1371	0	0	1449	785.33	744	713	0	0	341	682	530	146.2%	0.0%	54.2%	95.8%	0.0%	200.0%
Organisational Summary	34554	31150	0	0	28995	30607	24763	21927	0	0	18783	22038	12958	90.2%	0.0%	105.6%	88.5%	0.0%	117.3%

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	6.91	3.83	0.00	3.08	8.16	4.10	0.00	2.91
Total Planned Beds / Day	500							
Days in month	31							

- The Registered Nurse (RN) average fill rate for day has marginally increased in May to 90% from 89% in April and night has decreased from 90.3% in April to 88% is below the 100% optimum .
- The RN position in the following clinical areas George Earle, ICU and Louisa Carey a few clinical areas is above the 100% planned this is in response to enhanced care and higher acuity of patients
- In the Majority of clinical areas the HCA position is above the 100% planned reflecting demand for additional duties for enhanced care.
- In those areas where the fill rate is below 100% the actual number of staff rostered reflects the impact of short term sickness, vacancies and maternity leave on the planned nursing rosters, and in particular EAU 3 (Cromie) the deficit in planned hours are driven by the ward refurbishment for covid secure and Elizabeth (Cromie) moved wards
- Regular control meetings remain a key element in reviewing staffing levels throughout the day and staffing requirements.

Safer Staffing – Care hours per patient day (CHPPD)

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	6.41	3.10	0.00	3.32	7.20	3.40	0.00	3.80	4	7	0	3	12.9%	22.6%	0.0%	9.7%	7.74	4.74	0	2.91
Allerton	6.21	3.83	0.00	2.38	6.80	3.50	0.00	3.30	2	21	0	0	6.5%	67.7%	0.0%	0.0%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	9.00	2.90	0.00	6.10	0	24	0	0	9.7%	61.3%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.50	6.50	0.00	0.00	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	7.39	4.11	0.00	3.29	5.80	3.40	0.00	2.40	5	8	0	6	74.2%	71.0%	0.0%	80.6%	7.74	4.74	0	2.91
Dunlop	5.99	3.35	0.00	2.64	6.20	2.90	0.00	3.30	6	25	0	0	19.4%	80.6%	0.0%	0.0%	7.74	4.74	0	2.91
EAU3	7.67	4.31	0.00	3.35	8.40	4.80	0.00	3.60	1	1	0	2	10.0%	10.0%	0.0%	20.0%	7.74	4.74	0	2.91
EAU4	7.67	4.31	0.00	3.35	7.80	4.30	0.00	3.50	17	15	0	8	54.8%	48.4%	0.0%	25.8%	7.74	4.74	0	2.91
Ella Rowcroft	10.62	5.31	0.00	5.31	9.50	4.90	0.00	4.60	0	4	0	3	0.0%	0.0%	0.0%	300.0%	7.74	4.74	0	2.91
Forrest	5.75	3.19	0.00	2.56	6.40	3.50	0.00	2.90	7	5	0	9	22.6%	16.1%	0.0%	29.0%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	8.70	3.50	0.00	5.20	2	12	0	2	6.5%	38.7%	0.0%	6.5%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	29.40	27.70	0.00	0.90	4	4	0	0	19.4%	19.4%	0.0%	0.0%	7.74	4.74	0	2.91
Louisa Cary	7.26	4.84	0.00	2.42	13.10	9.00	0.00	4.10	0	0	0	2	0.0%	0.0%	0.0%	6.5%	7.74	4.74	0	2.91
John Macpherson	4.03	2.30	0.00	1.73	10.70	5.40	0.00	5.30	0	0	0	1	0.0%	0.0%	0.0%	3.2%	7.74	4.74	0	2.91
Midgley	5.95	3.17	0.00	2.78	6.60	3.10	0.00	3.50	3	17	0	1	9.7%	54.8%	0.0%	3.2%	7.74	4.74	0	2.91
SCBU	6.90	4.60	0.00	2.30	12.50	9.40	0.00	3.10	0	0	0	7	0.0%	0.0%	0.0%	22.6%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.30	3.00	0.00	5.30	3	19	0	0	9.7%	61.3%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.97	4.60	0.00	5.37	14.20	5.60	0.00	8.60	0	6	0	1	0.0%	19.4%	0.0%	3.2%	7.74	4.74	0	2.91
Brixham	6.40	2.50	0.00	3.90	6.60	2.40	0.00	4.20	5	23	0	6	16.1%	74.2%	0.0%	19.4%	7.74	4.74	0	2.91
Dawlish	7.25	3.25	0.00	4.00	6.90	2.80	0.00	4.40	21	22	0	15	67.7%	71.0%	0.0%	48.4%	7.74	4.74	0	2.91
Newton Abbot - Teign Ward	5.33	2.13	0.00	3.20	5.60	2.10	0.00	3.50	8	17	0	8	25.8%	54.8%	0.0%	25.8%	7.74	4.74	0	2.91
Newton Abbot - Templar Ward	5.43	2.13	0.00	3.30	5.70	2.10	0.00	3.60	6	8	0	5	19.4%	25.8%	0.0%	16.1%	7.74	4.74	0	2.91
Totnes	6.22	2.89	0.00	3.33	6.70	3.90	0.00	2.80	4	1	0	21	12.9%	3.2%	0.0%	67.7%	7.74	4.74	0	2.91

- In May the overall number of care hours per patient per day for both RN & HCA combined, is marginally below the national average of 9.3 with TSDFT recording 8.16
- The higher acuity of patients we have seen in attendance in May in some of our specialist areas such as ICU and Louisa Cary has demonstrated a CHPPD position that exceeds the national average in relation to for RN numbers.
- HCA higher CHPPD are related to supporting the backfill of RN's and to support our patients requiring enhanced observations and escalation areas due to increased attendances within the Trust, the enactment of the staffing risk framework for safest COVID staffing is in place to safely deploy staff across the Trust.

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 – not available
Intermediate Care - No. urgent referrals
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) – not available
Proportion of carers receiving self-directed support (ASCOF)

Under Achieved

Not Achieved
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)
Permanent admissions (65+) 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
Community Hospital - Admissions (non-stroke)

Adult Social Care (ASC) Improvement Plan Highlights – 2021 May

- **The Innovation Engine** is designed to improve the process of transforming ideas into improvements, supporting staff to develop their ideas into solutions that result in an improvement in their area of work as part of continuous improvement. The Innovation Engine is working to support and improve the TSDFT's and Torbay Council's ability to be innovative as integrated partners. More recently, project working group has been meeting and agreed an approach:
  - **People** – To improve the way we innovate together, we have to work together to improve our working culture, increasing psychologically safety to express areas of concern and support our colleagues to do the same. The Innovation Engine will support staff to identify a good idea and develop training for staff in how to develop, test and spread this across teams.
  - **Process** – To strength the process, a mechanism to support good ideas is required, minimising the risk of ideas being lost or created in siloes, or impact other areas with unintended consequences. The interim structure for adult social care will support the efficient delivery through a clear pathway.
  - **Platform** – To optimise improvement processes and support staff to communicate their ideas and work collaboratively across teams about emerging challenges we are exploring a 'challenge platform' as best way to support continuous improvement in ASC and to consult with the experts: operational staff, in their area of work and understand potential benefits. A challenge platform assures our work that ideas and solutions created in alignment with existing work and to evidence measurable benefits. An expression of interest document has been developed for the challenge platform and will be passed through procurement to explore what solutions are available to us to develop this further.
- The **Front Door model** was tested in mid-May as it enters its next stage, implementation of telephony requirements and development of one set of processes across the Bay. The Baywide testing has seen a consistent and faster approach to social care enquires being resolved through information, advice and guidance and access to voluntary sector services. A key benefit to the Front Door was the early identification of preventative work which has been evidenced through this process, enabling enhanced conversations with commissioners.
- Due to recent staff changes, senior management need to introduce a new **interim structure** across our Health & Adult Social Care teams. These changes will support the implementation of our ASC Improvement Plan, giving us the best opportunity for fulfilling our 'Vision' in Torbay and help us to improve our capacity. Our interim structure will be a Baywide structure, moving us away from separate Torquay / Paignton & Brixham zones, working to three CSMs (Adult Social Care, Health, OPMH). In this interim position the two zone localities will move towards a model where we have a 'front end' service and 'complex care' provision. They will both share unified and reliable systems and process and be replicated across our Baywide area. OPMH and U65MH Social Care will remain as per their current structures during our interim period and we will continue to work closely with these teams to ensure alignment in practice with the ethos of 'Thriving Communities where everyone can prosper' being key to all decision making.
- We are working transparently and openly in this interim structure, and engaging in communication with staff to come and talk about any hopes, fears and aspirations . It is important going forward, in our interim model and beyond, that we understand what the vision of adult social care and our integrated system means to staff and as new teams, in their work. Measuring success as we move forwards includes the way we touch the lives of others, including staff here in our integrated system.

Social Care and Public Health performance metrics - Torbay

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

Social Care Performance Report

2021/22 Performance Scorecard to 31 May 2021

Torbay Social Care KPIs	2021/22 full year target	2021/22 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	72%	Not meeting target (1238 / 1722) Impacted by paris changes for CLS. Workaround changes to assessment summary in progress.
% clients receiving direct payments	28%	28%	19.8%	Not meeting target (341 / 1722). 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	20.2	A low outturn signifies better performance. Not meeting target (15 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	510.8	A low outturn signifies better performance. Not meeting target (187 admissions compared to target of 164)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	..	Data currently unavailable following changes to paris IC referral.
% carers receiving self directed support	85%	85%	98%	On target.
% Adults with learning disabilities in paid employment	7.0%	7.0%	7.4%	On target.
% Adults with learning disabilities in settled accommodation	80%	80%	82.3%	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.

Measure	Target 2021/2022	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date 2021/22
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		84.5%	92.4%	94.5%	94.1%	90.7%	95.7%	88.7%	88.0%	90.0%	80.2%	91.9%	92.5%	86.6%	89.7%
Children with a child protection plan *			223	217	219	221	200	214	221	223	223	207	223	234		234
4 week smoking quitters (Quarterly) **	200			56			124			199						..
Opiate users - % successful completions of treatment (Quarterly) **	Var			5.9%			5.4%			4.4%						..

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 2021/2022	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date 2021/22
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			7,407	7,954	8,228	7,178	7,429	7,819	7,858	7,697	7,165	7,031	8,064	7,625	7,230	14,855
Therapy activity	65,415		2,829	3,620	3,849	3,499	3,837	3,609	2,708	2,638	2,783	3,016	3,593	3,166	3,192	6,358
No. intermediate care urgent referrals	0		248	283	242	211	221	200	207	235	175	146	155	169	151	320
No. intermediate care placements			6	14	12	18	6	11	20	19	13	14	42	36	37	73
Intermediate Care - placement average LoS			38.7	39.1	18.3	16.8	26.4	16.8	28.8	28.7	37.4	34.1	21.0	27.1	16.4	22.0

The Community Hospital Dashboard should be reviewed in the context of the significant changes in services and service demand from the COVID-19 response. Face to Face contacts have greatly reduced during Covid -19; teams are using virtual telephone and video conferencing.

Community Hospital Dashboard - Summary of Key Measures - May-21

	Act. 20/21 Outturn	Apr-21	May-21	Total
Admissions / Discharges				
Total Admissions (General)	2,677	239	247	486
Direct Admissions (General)	186	17	15	32
Transfer Admissions (General)	2,491	222	232	454
Stroke Admissions	220	24	21	45
Transfers from CH to DGH	179	26	37	63
Beds				
Bed Occupancy [1]	84.5%	94.2%	96.1%	95.2%
Bed Days Lost to Bed Closure	244	1	0	1
Length of Stay				
Delayed Discharges		25	8	230
Average Length of Stay - Overall (General)	10.4	11.5	11.4	11.4
Average Length of Stay - Direct Admissions	8	8.8	9.1	9.1
Average Length of Stay - Transfer Admissions	10.5	11.7	11.5	11.5
Average Length of Stay - Stroke	14.4	17.0	16.7	16.4
Long LoS (>30 days)	246	10	5	15
MIUs				
Total MIU Activity	22,487	2,516	2,897	5,413
New MIU Attendances	20,310	2,322	2,645	4,967
All Follow Up Attendances	2,177	194	252	446
Planned Follow Up Attendances	1,650	163	192	355
Unplanned Follow Up Attendances	527	31	60	91
MIU Four Hour Breaches	1	0	1	1
Average Waiting Time (Mins) - 95th Pctile	43	49	50	50

Community Hospitals

Community hospital admissions remain in-line with pre-covid levels. Bed occupancy remain relatively high with 96.1% reported in May.

Average length of stay remains consistent at 11.4 days and compares well with the 13.1 days pre covid in 2019/20.

Minor Injury Unit activity has increased from 2516 in April to 2897 in May 2021 with one four-hour breach and no change in average waiting time.

Care home outbreaks have reduced and the ICO continues to offer full support for infection, prevention and control. For any outbreak a debrief takes place with learning shared across organisations and Public Health.

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.

Community Services – Domiciliary Care Hours by Week

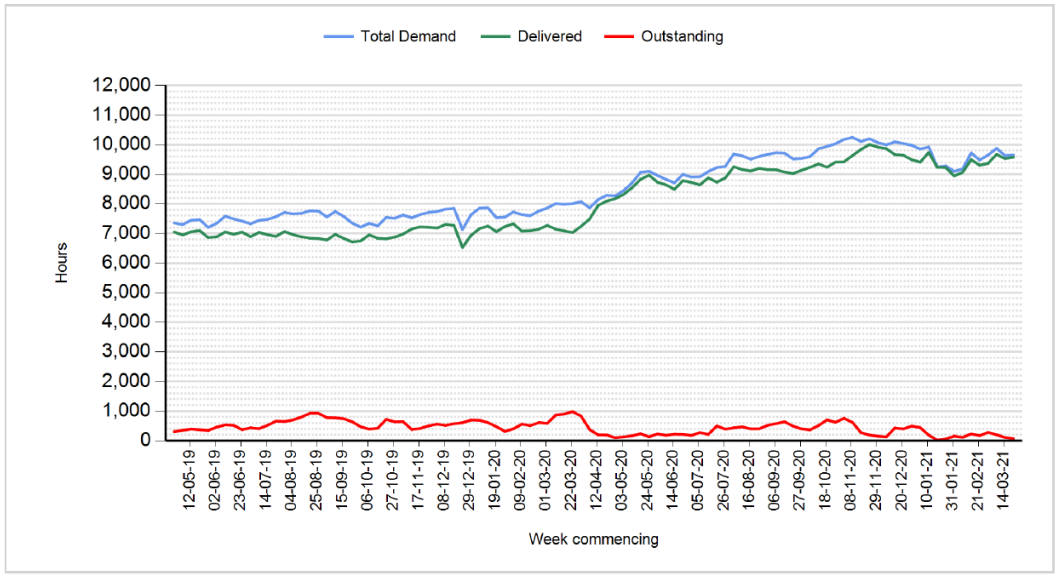
As a provider of Health and Social Care, Trust teams either commission directly from the independent sector or work in partnership with Devon County Council to secure the necessary capacity in the community. This includes domiciliary care which is essential to provide people as much independence as possible avoiding people spending time in bed-based care where this is not adding clinical value. This capacity also enables people to remain safe in their own home. For these reasons, domiciliary care is often referred to as the bedrock of the integrated care model. The Trusts teams are supported with information on the demand and capacity each day as well as the assessment the level of unfilled packages of care. As part of the Trusts response to covid-19 additional capacity has been secured from the independent sector as well as directly within the Trusts rapid response teams. This has included capacity for covid positive home-based care being managed by a specific team each day.

The ability to measure unfilled packages and correlate these with patients awaiting support to step down from short term placement or from community or acute hospital bed provision enables action to be taken to close capacity gaps.

Domiciliary Hours by Week (Health & Social Care)
Updated to w/c 22/03/21

Torbay and South Devon NHS
NHS Foundation Trust

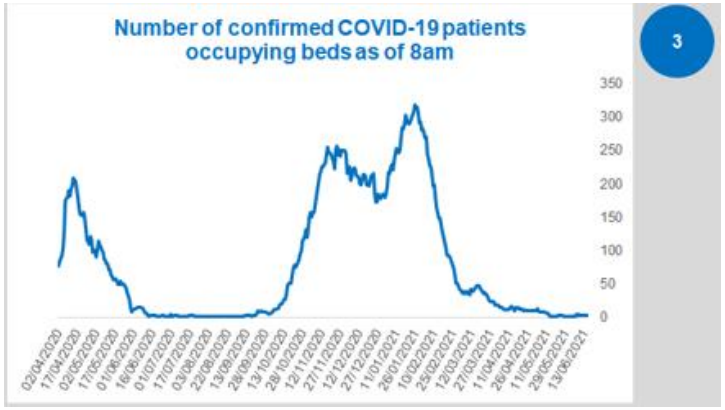
1) Standard domiciliary care delivered and outstanding:

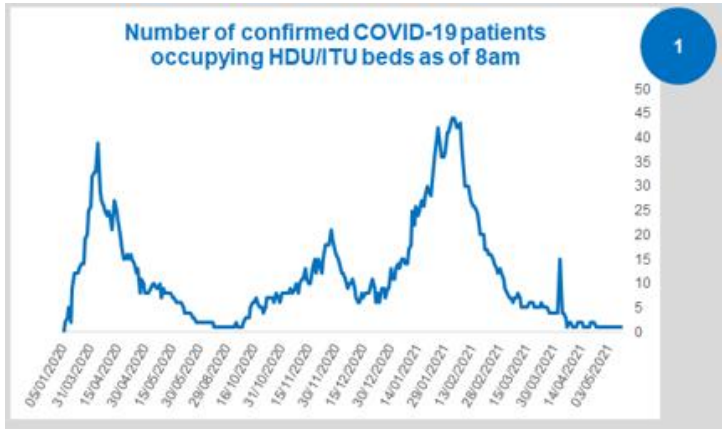


Due to a technical reporting issue the above graph cannot be updated but latest data (as at 21 June 2021) shows that there were 284 domiciliary care hours outstanding.

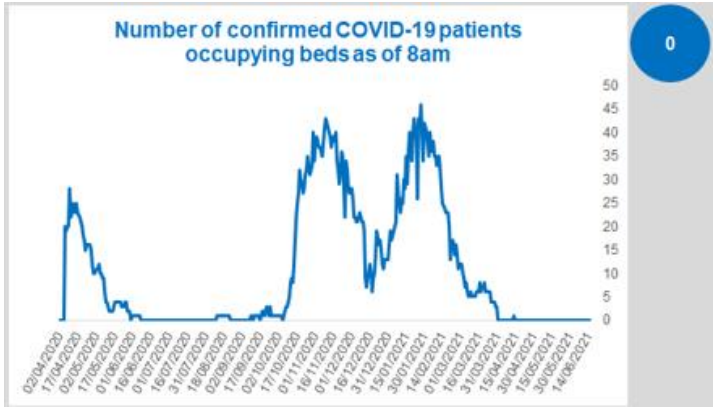
Covid - Hospitalisations

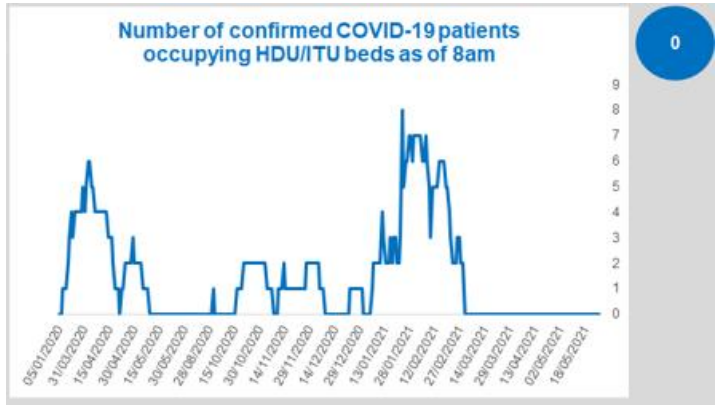
Devon ICS
(as at 16 June 2021)





Torbay and South Devon NHS FT
(as at 16 June 2021)





The Nightingale Hospital has now discharged all patients but remains on standby to provide more care if needed. Whilst on standby, the facility will continue to support the Devon system through hosting diagnostic testing.

May has continued to see zero patients occupying beds in TSDFT for covid-19 in line with modelling.
Should there be a return of Covid Hospitalisation system colleagues at the Royal Devon and Exeter Hospital continue to support the treatment and transfer of patients with covid (blue pathway) from the Torbay and South Devon areas to enable TSDFT to increase access to urgent and emergency care services and access to elective care for patients who have been waiting for treatment.

Ring-fenced beds remain on stand-by at Torbay Hospital if needed for covid patients.

Operational Performance Summary – May 2021

Operational headlines

Covid - the Trust has continued to have no Covid admissions. The Trust is maintaining a ward capacity to a maximum of 8 bed spaces before having to escalate should there be a need to accommodate covid positive inpatients.

Acute bed occupancy has increased in May to 92%; this is a reflection of the increased demand high acuity of patients presenting for assessment and recent loss of 14 beds from core beds stock. The risk of high bed occupancy impacting on patient flow and elective cancellations is recognised. Any significant increase in bed capacity will not be available until the MRU development is completed in 2022. It is noted that in June demand for acute beds has caused significant operational challenge with OPEL 4 status being declared, significant cancellation of elective inpatient scheduled for surgery and on 21st – 23rd June a temporary closure of the day surgery initiated to support the escalation response to create additional assessment space and inpatient bed capacity.

Activity in May is slightly down on that delivered in April, however, remains above the trajectory submitted in recovery plans.

The future delivery of these plans for elective admissions is contingent on managing the emergency admissions through the available beds and not requiring elective cancellations; this is recognised as a risk and work is ongoing to seek mitigation across local and system capacity to reduce these risks.

In Month 2 PBR contract activity levels, when compared to pre covid M2 19/20 activity levels, are: OP new 77%, Op f/up 86%, Day case 78%, inpatient 80%. For Outpatient activity the focus remains on adopting virtual non face-to-face appointments where ever possible. Local performance against the percent of recorded non face-to-face appointment is, however, lower than neighbouring trusts and this is being picked up by the Transformation Programme.

Children's services (CFHD) remain challenged with long waits, however, plans now agreed to increase capacity will see steady improvement over the coming months whilst the planned changes to the clinical model across Devon and IT system implementations are completed.

The ASC improvement work is gathering pace and is being closely monitored.

Recovery and waiting time headlines

The number of patients waiting over 52 weeks has decreased with 1596 recorded at the end of May.

Performance against the Cancer access standards has been maintained however remains below the national performance targets

Diagnostics performance has seen improvements in CT and echocardiography however waits remain high for Ultrasound, MRI, and Gastro diagnostic procedures.

Performance monitoring and assurance headlines

The Integrated Governance Group (IGG) meetings were all completed in May with each of the Integrated Service Units and CFHD able to highlight areas of performance risk and give assurance to the executive that plans are in place or where further support is required.

Operational Performance Quadrant

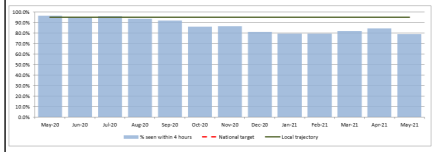
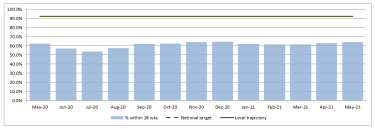
Achieved
Dementia Find (NHSI)
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - Patient waiting longer than 104 days from 2ww
Cancer - 31-day wait for second or subsequent treatment - Surgery
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
Ambulance handover delays > 30 minutes
Cancer - 28 day faster diagnosis standard
Number of patients >7 days LoS (daily average)
On the day cancellations for elective operations

Not Achieved
Cancer - Two week wait from referral to date 1st seen
A&E - patients seen within 4 hours (NHSI)
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients
Cancer – 62-day wait for first treatment - screening
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)
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
Cancelled patients not treated within 28 days of cancellation
Bed Occupancy (overall system)

Under Achieved
A&E - patients with >12 hour visit time pathway
Number of Clostridium Difficile cases reported

No target set

NHSI Performance Indicator Summary

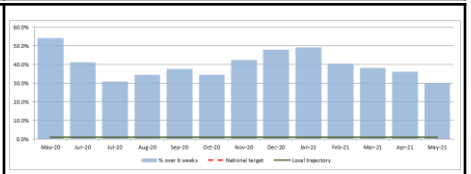
Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M2 78.9% Performance M1 84.4% Target 95% Risk level HIGH	The reported performance against the 4-hour standard for May is 78.9%. Increasing demand and access to inpatient beds has been the main cause of increasing delays in ED and increased ambulance handover waiting times. Overall bed numbers at Torbay Hospital remain reduced with a net reduction of 44 beds from winter 2019/20. The pathways to Medical and Surgical Receiving Units has helped to spread the demand for assessment however access to bed remains high risk. The performance is reflected across the Region with other Trusts similarly experiencing increased demand and impact on ED performance.	A bed / ward reconfiguration plan has been agreed for implementation end of June to increase the number of medical beds. This plan requires a scaling back of elective surgical work and review of surgical inpatient bed usage. As well as optimising discharge pathways and admissions avoidance the Trust are working closely across the SEND network to agree local balancing of demand and capacity pressures. This will include triggers for demand divert as well as exploring sustainable plans to mitigate risk into next winter. In the event of requiring covid admissions the blue pathways to RD&E remain in place.	
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M2 63.9% Performance M1 62.7% Target 92% Risk level HIGH	The total number waiting for treatment is 28,830 an increase of 201 from last month. 327 patients are waiting longer that 78 weeks and 12 patients waiting longer than 104 weeks. All over 52 week waits have been validated by the Performance Team to provide assurance that they are legitimate breaches. Based on activity plans the overall waiting time forecast is not showing any reductions in RTT waiting times in the short term. Medium to longer terms plans will need to address the full backlog accumulated over the covid period. Critical to this will be the 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.	Operational focus continues on maintaining urgent and cancer related work. The use of Mount Stuart Hospital facilities has been extended to offset some of the lost capacity. Patients will be booked in line with the current clinical prioritisation requirements ensuring that capacity is directed more to urgent clinical priorities. Teams are being asked to review their plans to identify opportunities to increase capacity as part of the requirement for 2021/22 Business planning. Insourcing continues at weekends in ophthalmology and endoscopy. Additional insourcing weekends are being scheduled using ERF funding.	

Trajectories		
M1	M2	M3
95%	95%	95%

Activity variance vs 2019/20 baseline	M1	M2
Op new	-11.6%	-23.1%
OP Follow up	-8.4%	-14.1%
Day Case	-9%	-21.9%
Inpatient	1.8%	- 20.5%

RTT Trajectory %		
M1	M2	M3
92%	92%	92%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M1**	Performance against the 62-day referral to treatment standard in May is 74.3%. The highest risk specialties are – Urology and lower GI against the 62 day target. Referrals into urgent cancer pathways are now back to pre covid levels however overall 14% down over the last 12 months. There is a risk that we will see a surge in later diagnosis and place additional demand on capacity over the coming months. Delays are being seen with the time from referral to appointment in Lower GI, Urology and waits for template biopsy remain a significant challenge and cause of treatment delays.	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 to maintain timely access for treatment from diagnosis and treatment plan confirmation. Critical to reducing waits to diagnosis on Urology pathways is the provision of new OP procedure room capacity. These estate changes are in planning stage.	
	71.2%			
	Performance M12			
	64.8%			
	Target			
	85%			
	Risk level			
	HIGH			
				Trajectories
				M12 / **M1** / **M2**: 85% / 85% / 85%
Diagnostic tests longer than 6 weeks	**Performance M2**	Diagnostic waiting times for Endoscopy Echocardiography MRI remain a risk to the timely treatment of cancer and urgent patients. Having no site for a mobile scanner on the DGH site remains a constraint for bringing in additional mobile capacity The additional echocardiography capacity has been successful in reducing wait numbers.	Endoscopy ventilation air change compliance work now complete with lists to commence mid June. Increase endoscopy insourcing lists from two to three weekends per month has been agreed. CT waits have improved but remain a risk whilst new staff recruited complete their training so that the 3rd scanner capacity can be fully optimised. Opportunities for additional mobile capacity, outsourcing and mutual aid from neighbouring trusts and NHE have been explored with little scope to change current capacity levels identified.	
	30.1%			
	Performance M1			
	36.3%			
	Target			
	1%			
	Risk level			
	HIGH			
				Trajectories
				M11 / **M2** / **M3**: 1% / 1% / 1%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M2	Performance against the Dementia Find assessment standard continues to remain above the target of 90%.	The reliance on an HCA to support the dementia find process is being reviewed as part of the ward improvement work. Until a seamless electronic clinical record is available this may continue to require close operational support.	
	96.9%			
	Performance M1			
	98.5%			
	Target			
	90%			
	Risk level			
	LOW			

Trajectories		
M11	M2	M3
90%	90%	90%

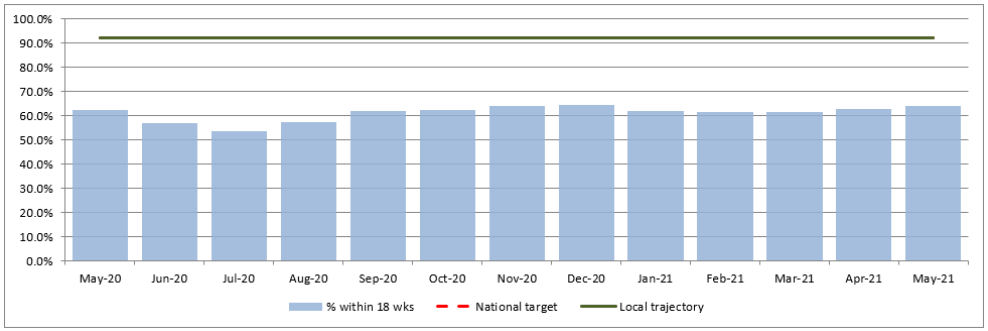
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

MAY 2021 Incomplete 92% Table - National Specialty (based on weekly PTL 30.05.21)

	>126			
Submitted Spec	Incomplete IPDC >126	Incomplete OP >126	Grand Total	%<18wks
Clinical Neuro-Physiology		134	178	24.72%
Pain Management	50	111	556	71.04%
Respiratory Medicine		200	699	71.39%
Neurology	8	289	744	60.08%
Dermatology		369	1410	73.83%
Cardiology	23	394	1669	75.01%
Oral Surgery	182	293	1682	71.76%
Colorectal Surgery	136	361	1101	54.86%
Gynaecology	239	267	1765	71.33%
Paediatrics	4	503	1259	59.73%
Gastroenterology	393	136	1856	71.50%
ENT	174	488	1994	66.80%
Upper Gastrointestinal Surgery	390	417	1334	39.51%
Urology	342	875	2408	49.46%
Ophthalmology	279	1341	4684	65.41%
Trauma & Orthopaedics	985	707	3198	47.09%
Grand Total	3292	7186	28830	63.66%

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in May has continued to stabilise with the proportion of people waiting less than 18 weeks at 63.6%; this is behind the Operational Plan trajectory of 82% and national standard of 92%. We have continued to see an increase in the total number of incomplete pathways (waiting for treatment) to 28,830 from 28,629, an increase of 201 from the April position.

52 week waits: For May 1,596 people will be reported as waiting over 52 weeks, this being a decrease on last month's 1,876, and is the second month on month reduction we have achieved. Overall long waits are increasing, patients waiting longer that 78 weeks have increased to 327 from 289 in April and patients waiting longer than 104 weeks have increased in May to 13 from in 6 April (consisting of 1-P2, 2-P3, 6-P4, 1-P5 and 3-P6 patients). The impact of COVID-19 continues to reduce, with levels of activity slowly improving but remain below pre-COVID levels. Teams are being asked to review their plans to maximise every opportunity to return activity levels to pre-COVID levels as quickly as possible in line with the Phase 4 ask and access to Elective Recovery Fund (ERF) funding.

Recovery planning: Utilisation of Mount Stuart Hospital capacity for T&O, UPGI, Urology, and Gynae for both long waiting outpatients and day cases has had a slow start due to lack of admin resource to support the process. Patients will be booked in line with the current clinical prioritisation requirements ensuring that capacity is directed more to urgent clinical priorities. Cromie and EAU 4 have swapped locations, this allows a COVID capability to be maintained via EAU4 on Level 6, due to space constraints the 4 bedded bays within Cromie new location have had to be reduced to 3 resulting in a further loss of 4 surgical beds. Insourcing and outsourcing will continue in June and July, with additional session being scheduled utilising ERF monies. 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. The Echocardiology recovery plan is on track; Endoscopy plans are holding the position, and additional MR capacity has been booked to improve their position – the lack of a second pad constrains the use of Mobile capacity . Urology's plan to redevelop Level 2 has now been stopped, with plans being developed to utilise Elizabeth as an alternative. Work continues to transform outpatients with a shift to non-face to face appointments but there remains more work to do with our percentage of non face to face delivered outpatients being below national and local peers. Waiting time forecasting is not showing any reductions in RTT waiting times in the short term. Medium to longer terms plans will need to address 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. Teams are being asked to review their plans in line with the requirement for 2021/22 Business planning.

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).

Specialities with the highest Follow-up Backlog April 2021			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	828	1237	5052
Rheumatology	240	361	868
Ear Nose Throat	191	251	869
Paediatrics	209	288	477
Neurology	121	194	469
Urology	95	137	410
Orthoptist	110	123	316
Respiratory Medicine (Chest)	103	86	317
Orthodontics	67	77	309
Colorectal Surgery	55	62	297
Geriatric Medicine	35	102	262
Cardiac Testing	161	162	68
Orthopaedics	71	88	192
Gynaecology	61	85	182
Cardiology	75	110	122
Breast Surgery	46	45	202
Dermatology	79	106	8
Pain Management	47	48	34
Restorative Dentistry	5	32	73
Diabetic	28	32	45
Grand Total	2799	3781	10721

Specialities with the highest Follow-up Backlog May 2021			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	671	1190	5108
Rheumatology	193	382	897
Ear Nose Throat	155	271	907
Paediatrics	171	304	507
Neurology	104	195	437
Urology	93	117	361
Orthoptist	117	131	314
Respiratory Medicine (Chest)	69	129	231
Orthodontics	35	101	288
Colorectal Surgery	40	67	317
Geriatric Medicine	37	64	231
Cardiac Testing	39	150	84
Orthopaedics	40	82	190
Gynaecology	88	95	211
Cardiology	42	75	105
Breast Surgery	25	37	192
Dermatology	72	121	39
Pain Management	37	61	42
Restorative Dentistry	7	16	74
Diabetic	23	25	52
Grand Total	2211	3768	10730

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
-157	-47	56
-47	21	29
-36	20	38
-38	16	30
-17	1	-32
-2	-20	-49
7	8	-2
-34	43	-86
-32	24	-21
-15	5	20
2	-38	-31
-122	-12	16
-31	-6	-2
27	10	29
-33	-35	-17
-21	-8	-10
-7	15	31
-10	13	8
2	-16	1
-5	-7	7
-588	-13	9

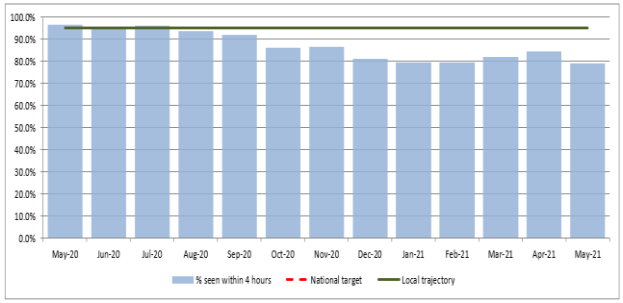
The table above shows the specialties with the highest backlog for follow appointments. The number of overdue follow ups in the 18 plus weeks category has increased by 9 patients but has reduced in the 6-12wk and 12-18wk.

A process is in place to report to the Harm Review Group and Quality Assurance Group giving assurance with risk assessment against the cohorts of longest waiting patients by specialty.

The incident reporting process in Datix will be relied upon to document any actual harm that is encountered and this will again be reported through the Harm Review Group with appropriate Root Cause Analysis.

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

A&E and MIU patients seen within 4 hours



Performance 4 hour standard : Performance has deteriorated in May to 79% from 84.5% in April. Access to suitable inpatients beds has contributed to delays at peak times. The levels of escalation as recorded by the Daily OPEL score reflect the increased levels of escalation with 13 days at OPEL 3 in May.

12 hour Trolley wait: Three patients are reported as having a trolley wait from decision to admit to admission to an inpatient bed of over 12 hours.

Ambulance Handovers: In May there were 26 ambulance delay over 60 minutes; delays of over 30 mins increased from 90 to 128.

Patients with a greater than 12-hour visit time pathway: 46 patients has a greater than 12-hour visit time

Corridor Care: No patients recorded as receiving corridor care

Operational delivery:

The Emergency Department activity in May is 90% of that seen in May 2019 as a pre covid benchmark. This reflects the increased number of direct admissions to the Surgical and Medical Receiving Units now receiving 30% of emergency attendances (400 per week). This diversion of demand and developments to reconfigure and expand clinical floor area and assessment capacity within ED have helped to reduce the potential for overcrowding.

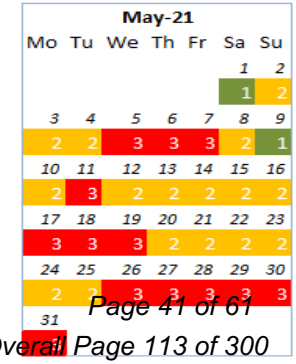
Performance against the 4 hour standard however has remained challenged in the last few months with high acuity of patients requiring assessment and increasing delays for those patients requiring admission due to bed availability.

Improvement work continues to focus on front door assessment processes, clinical assessment and escalation to reduce hospital length of stay, and avoidance of admission to reduce overall bed occupancy. Operational control meetings take place four times a day to direct operational responses to system capacity and demand pressures.

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

Escalation status

Opel status	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Opel 1	21	22	28	24	13	2	0	1	0	0	1	3	2
Opel 2	9	22	3	7	16	8	14	16	4	0	23	26	16
Opel 3	1	0	0	0	1	21	17	14	26	28	7	1	13
Opel 4	0	0	0	0	0	0	0	0	1	0	0	0	0
A&E Performance	96.5%	94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%	74%	79%	82%	84%	79%
Bed Occupancy (Acute)	64.8%	75%	75.2%	80.0%	83%	88%	85%	83%	89%	89%	85%	87%	92%



Cancer treatment and cancer access standards

As at 09.06.2021	2021											
	Q2											
	April				May				June			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	1,049.0	499.0	1,548.0	67.8%	1,221.0	232.0	1,453.0	84.0%	625.0	234.0	859.0	72.8%
14 day - Breast Symptomatic Referral	60.0	37.0	97.0	61.9%	46.0	39.0	85.0	54.1%	21.0	38.0	59.0	35.6%
28 day - Faster Diagnosis Standard	1,123.0	370.0	1,493.0	75.2%	1,014.0	328.0	1,342.0	75.6%	237.0	74.0	311.0	76.2%
31 day - 1st Treatment	198.0	6.0	204.0	97.1%	178.0	6.0	184.0	96.7%	142.0	5.0	147.0	96.6%
31 day - Subsequent Treatment - Drug	79.0	1.0	80.0	98.8%	73.0	0.0	73.0	100.0%	31.0	1.0	32.0	96.9%
31 day - Subsequent Treatment - Radiotherapy	62.0	1.0	63.0	98.4%	47.0	0.0	47.0	100.0%	41.0	2.0	43.0	95.3%
31 day - Subsequent Treatment - Surgery	25.0	0.0	25.0	100.0%	26.0	0.0	26.0	100.0%	22.0	2.0	24.0	91.7%
31 day - Subsequent Treatment - Other	25.0	0.0	25.0	100.0%	18.0	0.0	18.0	100.0%	2.0	0.0	2.0	100.0%
62 day - 2ww referral	91.5	40.5	132.0	69.3%	73.0	25.5	98.5	74.1%	96.0	14.0	110.0	87.3%
62 day - Screening Referral	4.0	1.0	5.0	80.0%	10.0	7.0	17.0	58.8%	4.0	1.0	5.0	80.0%
62 day - Consultant Upgrade					1.0	0.0	1.0	100.0%				

Cancer standards The table above shows the position for May 2021 (as at 9th June 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: 84.0% is below the standard of 93%. We have seen a continued increase in referrals with the number of urgent referrals being now back to or exceeding pre-covid levels. The most challenged pathways are Breast (77.22%), Urology (65.28%), Lower GI (87.29%), and Head and Neck (46%).

28 days From Referral to Diagnosis: Performance in May is 75.2% (unvalidated) against the target of 75%.

NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has improved slightly in May (un-validated) with 74.1% within target meaning 25.5 patients treated falling outside the target time of referral to treatment within 62 days.

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

Currently there are 23 (unvalidated) patients with a greater than 104 day wait, 10 with confirmed cancer. 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. Urology are the most challenged with 13 waits longer than 104 days and 7 patients with confirmed cancers.

Breast Symptomatic: Has deteriorated again to 54.1% and remains below the standard of 93%; Radiographer cover due to annual leave and capacity being flexed to see two-week-wait has seen an unusual drop in performance.

As of 15 April 2021 - 2ww referrals are down in 2020/21 by 14% compared to 2019/20. The number of confirmed cancers is reduced by 27% (approx. 630 cancers). This trend is seen across all the specialties and raises concern that patients will be presenting with later stage cancer, requiring more diagnostics and complex treatments. We have also seen in many specialties, an increase in patients being diagnosed through an emergency/urgent pathway rather than a 2ww referral. These patients are presenting at a later stage with more complex diagnosis and treatment needs.

Cancer standards – speciality level

As at 09.06.2021

	2ww (93%)						62 day (85%)						28 day (75%)					
Site	Dec-20	Jan-21	Feb-21	Mar-21	Apl-21	May-21	Dec-20	Jan-21	Feb-21	Mar-21	Apl-21	May-21	Dec-20	Jan-21	Feb-21	Mar-21	Apl-21	May-21
Breast	86% (157/25)	72.2% (130/50)	90.5% (152/16)	87.68% (178/25)	47.4% (101/112)	77.22% (139/41)	89% (16.5/2)	86.2% (12.5/2)	76.9% (10/3)	100% (18/0)	100% (10/0)	83.33% (15/3)	96% (181/8)	89.8% (150/17)	100% (44/0)	94.9% (205/11)	93.0% (214/16)	91.74% (200/18)
Breast Symptomatic													92% (79/7)	77.1% (74/22)	100% (9/0(	91.7% (100/9)	90.72% (90/1))	88.09% (74/10)
Gynae	95% (90/5)	94.6% (88/5)	92% (81/7)	84.4% (103/19)	94.16% (113/7)	93.33% (84/6)	71% (2.5/1)	100% (2.5/0)	100% (5.5/0)	100% (1.5/0)	77.7% (7/2)	40.0% (2/3)	68% (62/29)	71.8% (56/22)	47.8% (11/12)	68.7% (77/35)	63.93% (78/44)	64.63% (53/29)
H&N	78% (90/26)	67.8% (80/38)	87% (107/16)	90.37% (122/13)	39.0% (55/86)	87.34% (69/79)	100% (5/0)	100% (1/0)	66.7% (4/2)	61.5% (8/5)	80.0% (4/1)	75.0% (3/1)	70% (86/37)	77.1% (91/27)	92.5 (49/4)	92.2% (107/9)	82.7% (110/23)	80.15% (105/26)
Haem	100% (10/0)	100% (12/0)	100% (7/0)	100% (13/0)	100% (13/0)	90.90% (10/1)	100% (1/0)	75% (3/1)	100% (4/0)	66.6% (2/1)	75.0% (3/1)	80.0% (4/1)	79% (11/3)	90% (9/1)	100% (2/0)	88.8% (8/1)	100% (15/0)	75.0% (3/1)
LGI	82% (158/35)	72.6% (159/60)	91.3% (157/15)	79.7% 126/32)	76.4% (182/56)	87.29% (213/31)	62% (5/3)	66.7 (6/3)	88.9% (8/1)	44.4% (4/5)	36.4% (4/7)	42.85% (3/4)	38% (64/105)	35.8% (68/122)	55.3% (21/17)	36.6% (67/116)	45.61% (78/93)	44.84% (74/91)
Lung	73% (11/4)	66.7% (14/7)	84% (21/4)	96.3% (26/1)	90.9% (30/3)	86.66% (26/4)	100% (2/0)	50% (1/1)	100% (1/0)	85.7% (6/1)	85.7% (3/0.5)	83.33% (5/1)	72% (13/5)	94.4% (17/1)	100% (3/0)	93.1% (27/2)	100% (24/0)	89.65% (26/3)
Skin	78% (301/87)	94.4% (306/18)	97.2% (344/10)	93.3% (421/30)	76.3% (425/132)	97.75% (523/12)	88% (36.5/5)	88.9% 32/4)	89.2% (33/4)	100% (28/0)	86.6% (46.5/6.5)	91.42% (32/3)	83% (294/58)	75.2 (239/79)	84.6% 55/10)	88.3% (356/47)	76.16% (361/113)	82.82% (352/73)
UGI	77% (61/18)	80.3% (106/26)	91.2% (62/6)	73.4% (69/25)	63.5% (47/27)	82.41% (75/16)	80% (4/1)	100% (3/0)	100% (6/0)	72.7% (4/1.5)	60.8% (7/4.5)	60.0% (3/2)	79% (65/17)	85.3% (99/17)	83.3% (10/3)	78.3% (65/18)	69.04% (58/26)	84.26% (75/14)
Urol	45% (46/55)	31.8% (41/88)	60.6% (57/37)	55.3% (62/50)	48.9% (71/74)	65.28 (79/41)	31% (6/13.5)	30.8% (6/13.5)	29.4 5/12)	22.95% (7/23.5)	26.1% (6/17)	44.44% (6/7.5)	54% (41/35)	51.6% (48/45)	25% (3/9)	24.0% (31/98)	35.59% (42/76)	43.24% (48/63)
Aggregate	79.4% (933/255)	77.2% (943/293)	89.6% 993/112)	84.9% (1120/195)	67.8% (1049/499)	84.0% (1221/232)	77.1% (82.5/25.5)	73.4% (69/24.5)	77.6% (78.5/22.5)	66.8% 79.5/38)	69.3% (91.5/40.5)	74.1% (73/25.5)	75.6% (904/305)	75.4% (859/354)	77.0% (209/54)	76.0% (1043/346)	75.2% (1123/370)	75.6% (1014/328)
	(Total <14 DAYS / Total >14 days						(Total <62 days / Total >62 days)						(Total <28 days / Total >28 days)					

Mitigating Actions

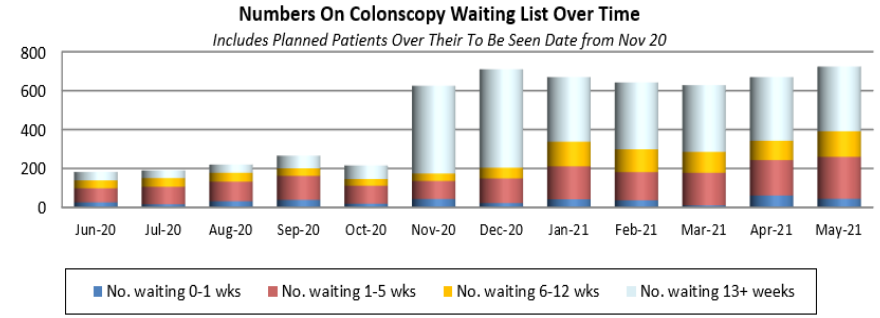
Urology:

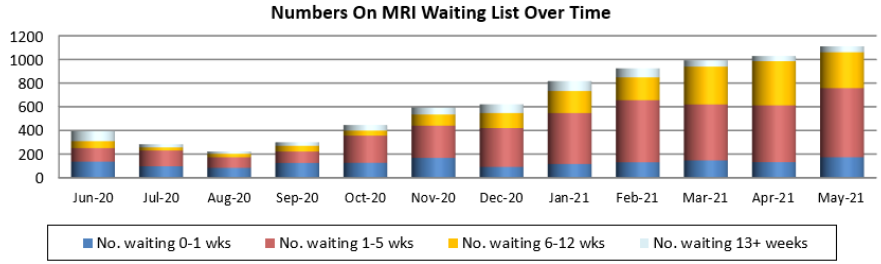
- Continued use of Mount Stuart Hospital (sending 11 new referrals per week with possible surgery); admin resource is still required.
- Increasing capacity for urgent outpatients and diagnostic assessments, this will require additional outpatient based facilities configured for one stop processes. Elizabeth Ward is now being considered as an alternative to Level 2 for Urology Outpatients.
- Increase in the number of Cystoscopes (now 20). (Lancer Cabinet required to maximise use)
- Sheath System on site for use on surveillance patients 2 days/week – this increases the capacity for the number of scopes that can be done.
- Disposables scopes can be used at clinical space identified at Paignton Hospital
- Replacement Locum appointed starts 12/07/21
- Running x3 Saturday Clinics on Hutchings ward will see 60 Patients and reduce backlog

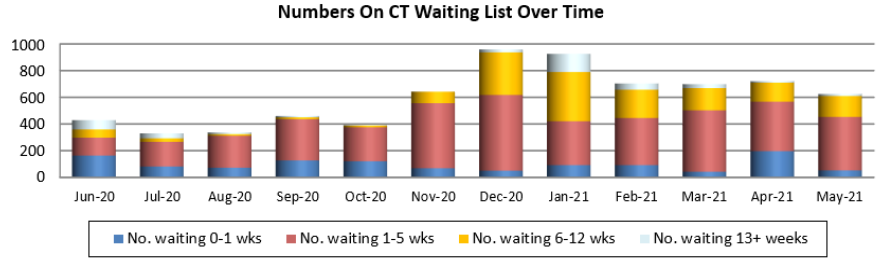
Lower GI:

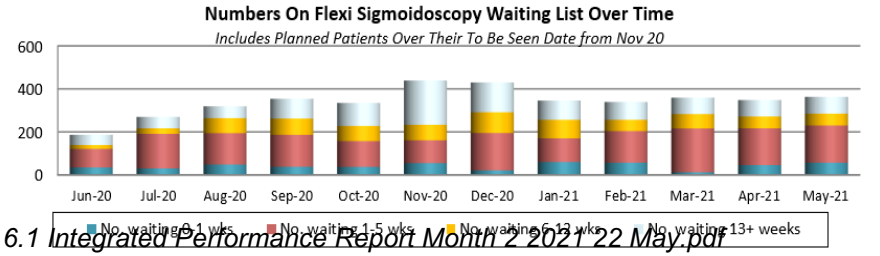
- Second new consultant starting June 2021.
- Rm 3 Endoscopy out of action for 8 weeks – 8 sessions at MSH being used however net loss of capacity during this period
- Continuation of weekend insourcing (weekends per month) local team doing 2 in 7 weekends.
- Advert out for new Gastro Consultant – will start to reduce delays in the diagnostic phase of the LGI cancer pathway.
- Theatre capacity remains limited due to conflicting clinical priorities and available staffed lists

NHSI indictor - patients waiting over 6 weeks for diagnostics



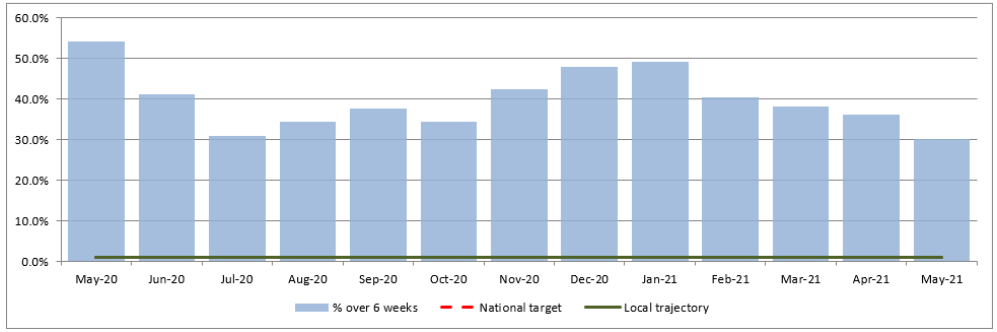






Diagnostic tests longer than the 6 week standard

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Patients	2361	2883	2948	3207	3446	3810	4624	4989	5013	4934	4957	4876	4909
Waiting longer than 6 weeks	1282	1186	911	1106	1295	1312	1957	2389	2462	1992	1892	1768	1478
% over 6 weeks	54.3%	41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local trajectory	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%



May has seen a improvement in the overall percentage of patients with a diagnostic waiting time over six weeks to 30.1% from 49.1% in January.
All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

MRI waits continue to be a concern and seeing a steady increase in demand. Additional capacity has been made available through mobile unit insourcing to November 2021. Further work around MRI capacity and demand is being undertaken through the Risk and Assurance Group chaired by the Chief Operating Officer. Limited access for mobile capacity is constrained by the availability of only one pad for the mobile van as shared with mobile CT.

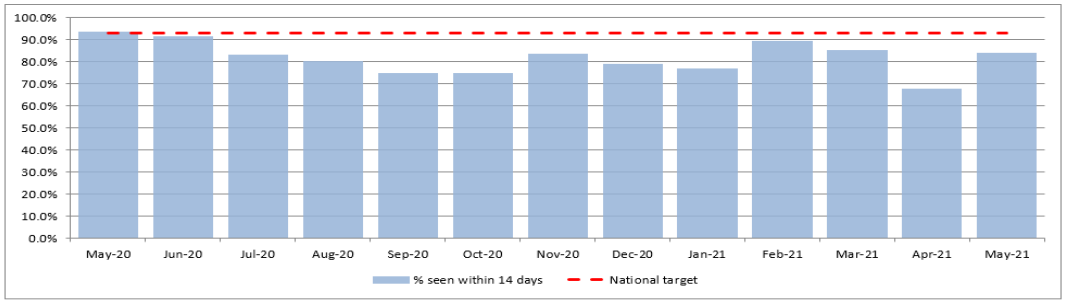
Colonoscopy – numbers remain high, however, there are robust plans in place that will see improvement using insourcing at weekends / additional in-house sessions, and sessions contracted at the local independent sector provider. Remedial works to Room 3 air-handling is on schedule and the room should be available 21 June 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

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
2ww referrals seen	847	1071	1281	1217	1336	1410	1345	1183	1235	1102	1319	1547	1455
2ww breaches	54	92	213	242	333	356	221	250	283	115	196	499	233
% seen within 14 days	93.6%	91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.9%	77.1%	89.6%	85.1%	67.7%	84.0%
National target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

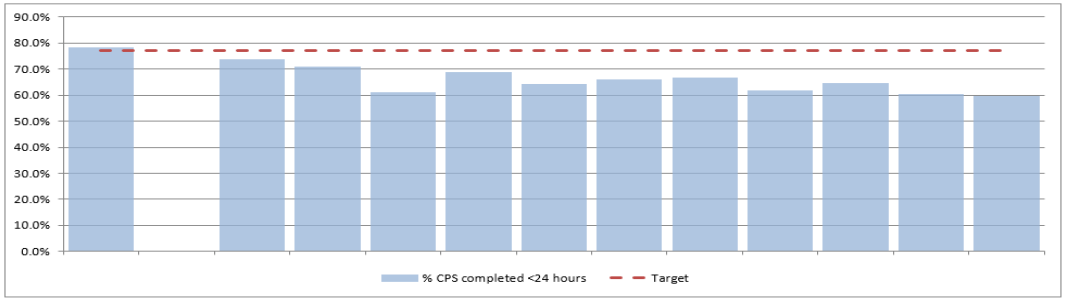


Cancer two-week wait referral

The number of cancer two-week wait referrals are now back at pre-covid levels and for some sites, greater than pre-covid levels. In May performance is below the 93% standard at 84% of patients seen within two weeks from referral with a forecast for June of 81.3%. Head and neck, Colorectal, Urology, and Breast have the greatest number of breaches.

Care Plan Summaries completed within 24 hours of discharge - Weekday

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Discharges	1039	n/a	1405	1425	1361	1324	1176	1436	1157	1049	1282	1434	1484
CPS completed within 24 hours	815	n/a	1034	1011	832	913	754	950	774	650	828	868	884
% CPS completed <24 hours	78.4%	n/a	73.6%	70.9%	61.1%	69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.5%	59.6%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%

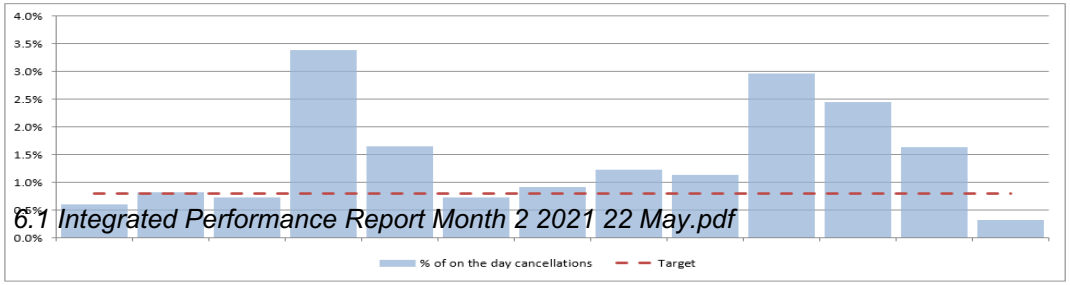


Care Planning Summaries (CPS)

No improvement is currently being seen in the weekday CPS completion. A pilot on Dunlop is taking place with the aim to improve timely production of the CPS. The impact of making this a mandatory field is being assessed against the risk of delaying discharge.

On the day cancellations for elective operations

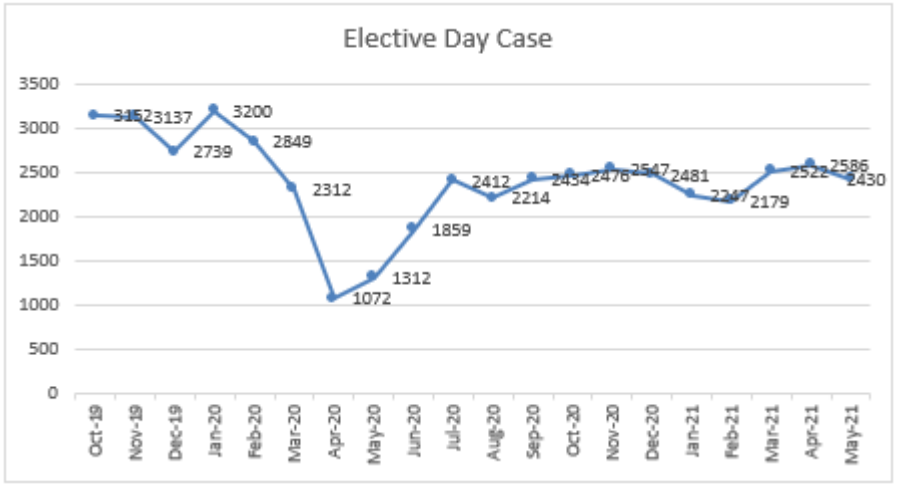
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Cancellations	9	15	18	74	46	20	26	35	29	71	71	48	9
Elective spells	1503	1826	2446	2189	2772	2742	2835	2835	2550	2400	2904	2922	2760
% of on the day cancellations	0.6%	0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%

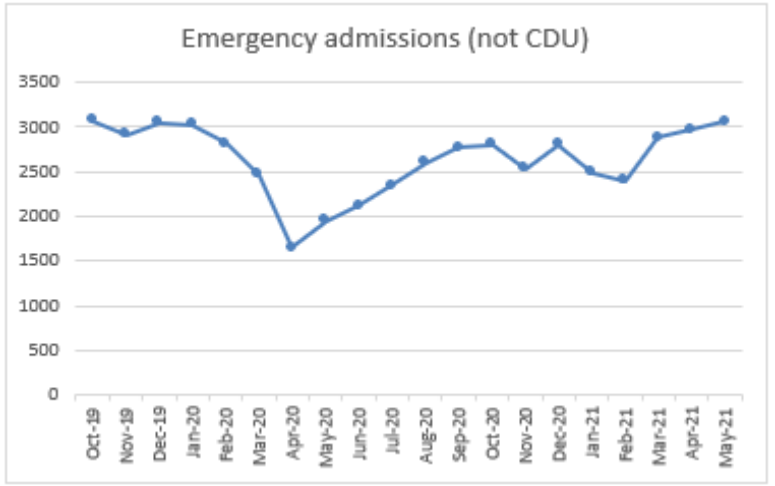


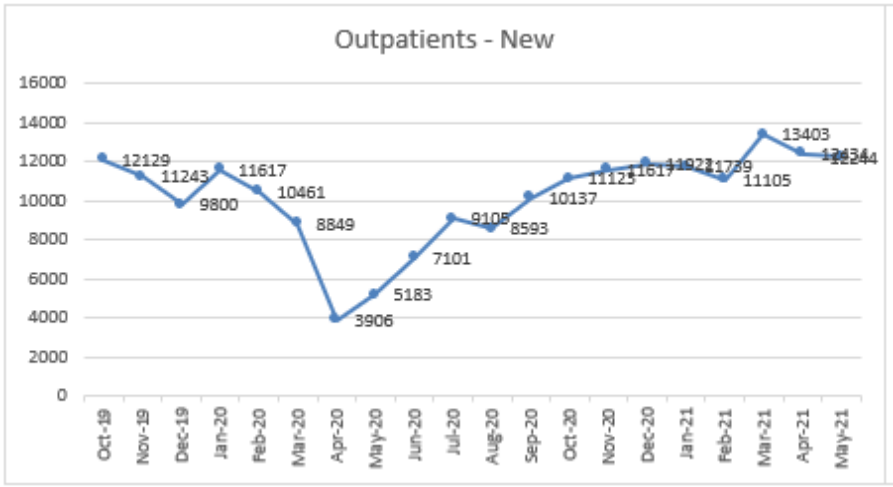
Cancelled operations

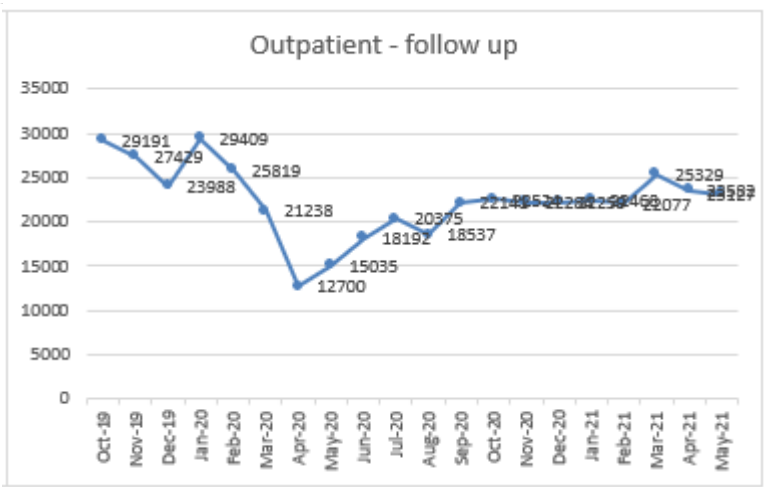
The total number of elective procedures cancelled on the day decreased in May to 9 (0.3%).

Headline acute activity comparisons 2019/20 v 2020/21









The charts above show the monthly activity run rate of reported contract activity to end of May 2021. We have seen a steady increase in activity levels and a step change in some areas following the de-escalation of covid. The draft data for Month 2 has shown a stabilising of these activity increases.

The focus is now on building back capacity and having robust processes to ensure all available capacity is being fully utilised. There are areas where further recovery of annual leave will continue to supress some activities.

Teams are also preparing plans to utilise the Elective Recovery Fund (ERF) where this is operationally possible and working with system partners to optimise these opportunities.

The Children and Family Health Devon report performance exceptions and operational variances through the monthly Integrated Governance Group (TSDFT) and the Alliance Partnership Board.

CAMHS

- The CAMHS Service remains under pressure due to staff vacancy and recent increased levels of demand; they continue to use 'the keeping children safe' SOP to ensure consistent contact is kept up with families who are waiting. There are key interim positions in key leadership roles, JD's are in the matching process. Operational capacity remains impacted by 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 under pressure to meet the required service required. Additional monies for Crisis, Easting Disorder & Mental health in schools has been awarded.
- Safeguarding Children Level 3 training and appraisal compliance remains a focus for the team with plans in place to achieve 90% compliance by end of May 2021, CAMHS have improved significantly on their position this year.
- There remains a high level of demand for Eating Disorder referrals; routine waits are increasing and team are needing support from partner organisations to maintain service capacity.
- Overall the service is seeing a return to a higher level of face-to-face activity, retaining virtual appointments where this is clinically appropriate and effective.

Integrated therapies and nursing

- Recovery plans for ASD waiting times have been approved and now being implemented – these are reported to NHS-E and the CCG fortnightly.
- RTT performance has improved in Learning Disability and Physio services. Autistic Spectrum Disorder (ASD), Speech and Language Therapy (SLT) have the greatest challenge on reducing waiting times for treatment. Plans are being monitored with the CCG and Integrated Governance Group.
- All teams have completed initial capacity and demand analysis and now working to overlay actions to provide trajectory forecasts for ongoing monitoring – Support from NHSI is being provided to support the validation of recovery trajectories and improved capacity monitoring against plan.
- Care notes clinical system now rolled out to all IT&N Torbay services so a single system now in use. The Business case is now approved for System One as a single clinical records system across CFHD.

18 week RTT Performance

April 2021		RTT % <18 weeks		Caseload		
Service	Number waiting over 52 weeks	May - 20	May-21	May - 20	May-21	Change last 12 months
CAMHS	29	63.9%	70.8%	3905	4458	+ 553
Occupational Therapy	1	46.6%	64.3%	1199	1167	- 32
Speech and Language Therapy	310	45.7%	37%	4087	5275	+ 1188
Autistic spectrum assessment team	1712	20.7%	11.9%	2302	3569	+ 1267
Physiotherapy	0	74.8%	86.7%	433	479	+ 46
Learning disability	0	81.8%	100%	325	269	- 56

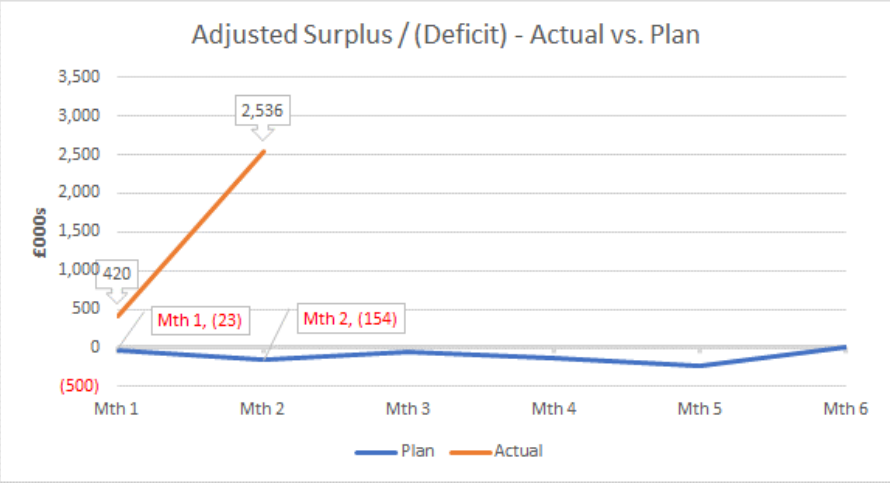
Financial Performance – Month 2
FY 2021 / 22

Financial Overview – Month 2, May 2021

High Level Summary

For Period ended - 31 May 2021, Month 2	Plan £m	Actual £m	Variance £m
Total Operating Income	92.63	96.95	4.32
Total Operating Expenditure	(91.49)	(93.18)	(1.69)
Adjusted Surplus/(Deficit)	(0.15)	2.54	2.69
Capital	3.16	1.15	(2.01)
Cash & Cash Equivalents		36.59	

Adjusted Surplus / (Deficit)



Operating Income

Operating income for the year to date totals £97.0m, within which income for patient care activities totals £89.4m. The favourable variance is driven by additional income compared to plan including ERF income of £1.4m.

Operating Expenditure

Total operating expenditure of £93.2m, which includes £46.4m of staff costs.

Adjusted Surplus / (Deficit)

At month 2 the Trust is recording a £2.7m favourable variance against plan.

Cash

The Trust is showing a healthy cash position at the end of Month 2, with £36.6m held in cash and cash equivalents. A planned cash position was not required as part of the H1 submission

Capital

To date the Trust has spent c. £1.2m on capital schemes. A separate capital report has been prepared for the Trust's FPDC.

H1 plan

The Trust submitted a detailed plan to NHSE/I last month for the first six months of the financial year (H1), with a re-submission made in June showing a break-even position and including ERF income and other relevant changes.

I&E Position – Month 2, May 2021

Income & Expenditure – Performance versus Plan

£m	M2 - In Month			M2 - YTD		
	Budget	Actual	Variance	Budget	Actual	Variance
Patient Income - Block	30.52	30.46	(0.06)	61.03	60.92	(0.11)
Patient Income - Variable	4.20	4.85	0.65	8.39	9.11	0.72
ERF Funding	0.00	1.42	1.42	0.00	1.42	1.42
ASC Income - Council	4.58	4.58	0.00	9.17	9.17	0.00
Other ASC Income - Contribution	1.01	0.98	(0.03)	1.98	1.96	(0.02)
Torbay Pharmaceutical Sales	1.66	1.69	0.03	3.08	3.42	0.34
Other Income	1.79	2.11	0.32	3.58	3.82	0.24
Covid19 - Top up & Variable income	2.70	2.93	0.23	5.40	7.13	1.73
Total (A)	**46.46**	**49.02**	**2.56**	**92.63**	**96.95**	**4.32**
Pay - Substantive	(22.56)	(22.46)	0.10	(45.13)	(44.86)	0.27
Pay - Agency	(0.48)	(0.83)	(0.35)	(0.93)	(1.58)	(0.65)
Non-Pay - Other	(12.67)	(12.46)	0.21	(25.21)	(24.72)	0.49
Non- Pay - ASC/CHC	(8.81)	(8.98)	(0.17)	(17.36)	(19.16)	(1.80)
Financing & Other Costs	(2.14)	(2.25)	(0.11)	(4.29)	(4.24)	0.05
Total (B)	**(46.66)**	**(46.98)**	**(0.32)**	**(92.92)**	**(94.56)**	**(1.64)**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**(0.20)**	**2.04**	**2.24**	**(0.29)**	**2.39**	**2.68**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.07	0.08	**0.01**	**0.14**	**0.15**	**0.01**
Adjusted Financial performance - Surplus / (Deficit)	**(0.13)**	**2.12**	**2.25**	**(0.15)**	**2.54**	**2.69**

In Month 2 the Trust recorded a surplus of £2.1m against a planned deficit of £0.1m.

The year to date position shows a surplus of £2.5m against a planned deficit of £0.2m, giving a favourable variance of £2.7m.

The forecast as at end of M6 is a break even position as per H1 plan.

Income

- Higher variable patient care income (£0.65m) is due to pass through drugs and devices (matched by cost).
- The Trust received £1.42m of Elective Recovery Funding (ERF) in Month 2 from the CCG.
- Other income is £0.32m higher mainly due to non-patient care and other services.
- COVID income is £0.23m higher due to hospital discharge and vaccination (matched by costs).

Pay

- In Substantive pay there is a net favourable variance in month (£0.10m) mainly due to vacancies.
- Agency cost is £0.35m higher than budget due to Nursing (£0.23m) linked to A&E activity, specialling and RMN requirements. Various other staff groups account for £0.12m.

Non-pay

- Main drivers of the favourable non-pay other position (£0.21m) include: lower than planned clinical and general supplies costs (£0.36m) and lower Drugs issues (£0.21m), offset by increases in various other operating costs.
- The £0.17m adverse position for ASC/CHC costs is mainly due to COVID spend of £0.52m (matched by income), offset by lower than anticipated activity in month £0.35m (lower domiciliary care hours, lower activity levels in residential short stay and nursing long stay and reduction in client numbers in residential long stay).

Change in Activity Performance – Month 1 to Month 2

		Plan	Apr-21	May-21	Change	% Change		May-20	% change
Activity Drivers	A&E Attendances		8,129	9,009	880	11%		*6,053*	49%
	Elective Spells	2,931	2,862	2,675	-187	-7%		*1,456*	84%
	Non Elective Spells		3,392	3,558	166	5%		*2,164*	64%
	Outpatient Attendances	26,962	27,448	26,654	-794	-3%		*17,203*	55%
	Adult CC Bed Days		227	304	77	34%		*133*	129%
	SCBU Bed Days		140	99	-41	-29%		*139*	-29%
Bed Utilisation	Occupied beds DGH		8,862	9,392	530	6%		*7,245*	30%
	Available beds DGH		10,169	10,248	79	1%		*11,914*	-14%
	Occupancy		87%	92%	4%	4%		61%	31%
Resource Consumption	Medical Staff Costs - £000's	5,022	4,908	5,123	215	4%		*5,015*	2%
	Nursing Staff Costs - £000's	5,395	5,491	5,368	-123	-2%		*5,056*	6%
	Temp Agency Costs - £000's	480	755	828	73	10%		*465*	78%
	Total Pay Costs* - £000's	23,036	23,154	23,291	137	1%		*21,892*	6%

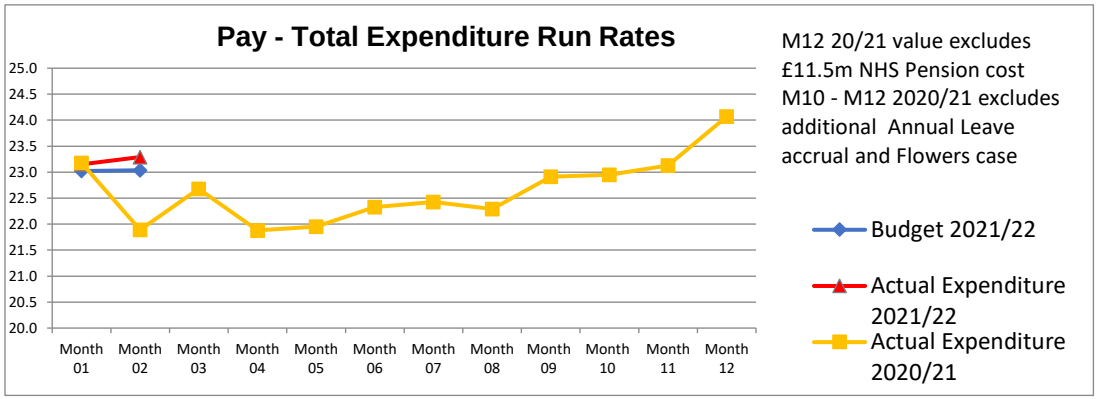
Activity Drivers

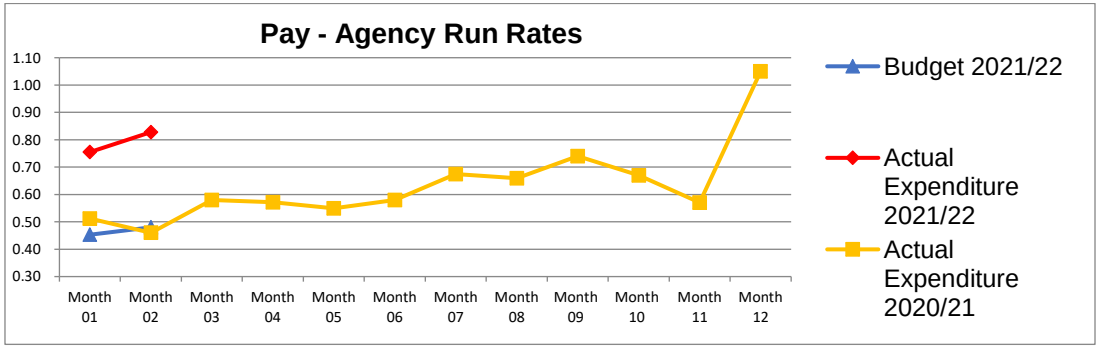
- No formal plan (for contracting purposes) has been created for A&E, Non Elective, or ACC/NCC. This is as a result of the focus being on the recovery of elective activity.
- Overall, elective activity levels are on par with, or just above plan, but are below that of 2019/20, which is the comparator year for NHSE/I purposes.
- ISU's are looking at ways to increase their activity, including making use of the ERF available to increase capacity to see more patients to reduce waiting lists and ensure patients are treated as quickly as possible.
- The Trust has recently submitted a revised activity plan. This was to allow all providers to include any additional activity via additional ERF schemes and also to include the activity relating to COVID swabbing of patients.

Bed utilisation

- In May, overall bed occupancy is 92%, being the highest recorded since the start of COVID pandemic (April, 87%). NB - overall occupancy includes specialist wards for cancer, COVID, paediatric and maternity wards.
- Similar to previous periods, access to beds for medical and surgical emergencies has been a major operational constraint with delays in ED being reported against the 4-hour standard.
- A 14-bed ward was permanently closed in May and this reduced the available beds for the short and medium term. A review of options to reconfigure the allocation of wards has been completed, with the associated ward moves scheduled to take place by the end of June.

Pay Expenditure – Month 2, May 2021



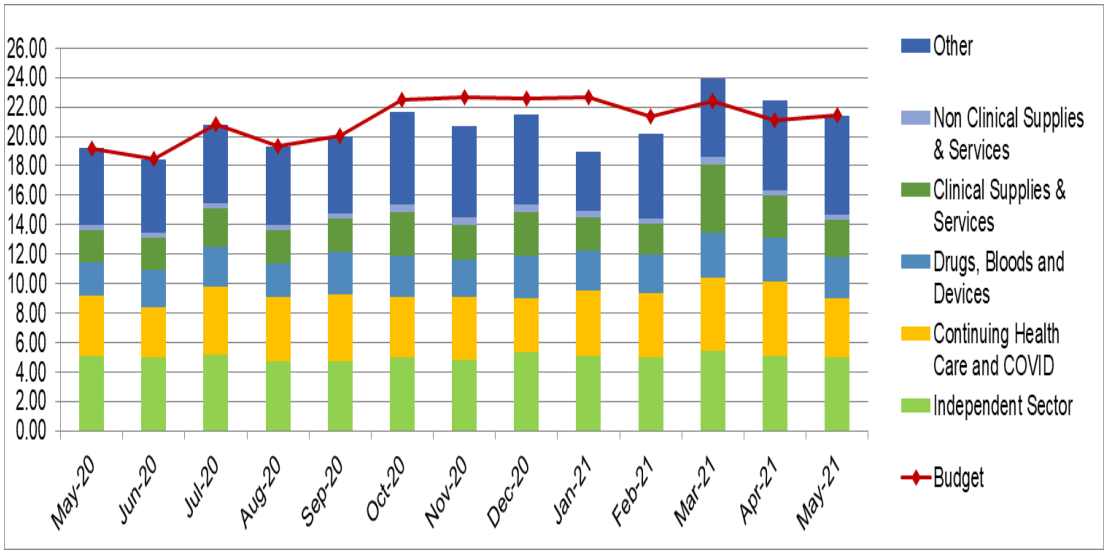


In Month 2 the total pay expenditure is £23.29m, which is £0.14m higher compared to Month 1 (£23.15m). Further details are provided below:

- Substantive pay increased by £0.08m which includes accrual for Flowers legal case of £0.20m.
- Bank pay net decrease of £0.02m.
- Agency cost were £0.07m higher than Month 1 (various staff groups).
- Of the year to date pay costs, those associated with COVID account for £0.22m, comprised of:
  - vaccination - £0.18m, and
  - testing – £0.04
- The Apprentice levy balance at Month 2 is £2.1m (no change from Month 1). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

Temporary staffing spend will be a key feature in Executive-led financial recovery efforts over the first half of the year.

Non-Pay Expenditure – Month 2, May 2021



The total non-pay run rate in Month 2 (£21.45m) is £0.99m lower in comparison to previous month (£22.44m), key details are provided below:

- Decreases in
  - Placed People (Health including Continuing Healthcare) and COVID – £1.06m due to: COVID costs £1.23m, (Month 1 included allocations paid out for rapid testing and infection control on behalf of Torbay Council - nothing in Month 2) offset by increase in Placed people cost of £0.17m due to additional day in May,
  - Clinical supplies – £0.32m due to: TP cost of sales £0.23m (linked to production) and lower medical and surgical equipment purchases £0.09m,
  - Independent sector – £0.13m as a result of lower activity across all areas,
  - Drugs costs – £0.13m due to lower usage mainly within outpatient high cost drugs,
  - Non-clinical supplies – reduced by £0.01m; offset by:
- Increases in
  - Net Operating expenditure – £0.66m. Material movements are: inflation increase in independent sector £0.20m, travel and general transport £0.16m, CFHD alliance charge £0.10m, establishment costs £0.09m (stationery, mobile phone and broadband rental) and other operating expenditure £0.11m.

COVID Cost Analysis – Month 2, May 2021

COVID Expenditure	Testing Actual 31/05/2021 YTD £'000	Vaccination Programme Actual 31/05/2021 YTD £'000	Total Actual 31/05/2021 YTD £'000
Staff and executive directors costs	40	181	221
Non pay expenditure	402	1	403
Total operating expenditure	**442**	**182**	**624**

Hospital Discharge, Rapid Testing and Infection Control COVID	Total Cost Actual 31/05/2021 YTD £'000	Supported through CCG Actual 31/05/2021 YTD £'000	Council Contribution Actual 31/05/2021 YTD £'000	Provider Refunds Actual 31/05/2021 YTD £'000
Hospital Discharge Programme	753	753		
Rapid Testing & Infection Control	1,420		1,420	
General	85			85
Total	**2,258**	**753**	**1,420**	**85**

As highlighted above, within the Trust's pay position at Month 2 COVID costs account for £0.22m.

Within non-pay COVID costs account for £0.40m, which is comprised primarily of Testing.

Hospital Discharge COVID Return
Given the integrated nature of the Trust this element of the COVID analysis is a combination of Health and Adult Social Care funding streams.

- Spend to date is £2.26m, with a contribution of £1.42m received from Torbay Council towards this.
- Rapid Testing and Infection Control grants (Q1 2021/22) have been fully passported to providers within Torbay in line with grant conditions.
- Hospital discharge costs are being reclaimed through Devon CCG for the first half of 2021/22. Discharge criteria will see client's entitlement drop from six to four weeks from the 1st July.
- Looking ahead costs will continue to be incurred but it is anticipated this will be matched with an appropriate income stream for the first half of the financial year.

Key Drivers of System Positions – Month 2, May 2021

System	ISU	Financial Commentary / Key Drivers
CFHD	CYP	Expenditure run rate remains constant. Staff consultation - the Senior Team are commencing internal discussions on options; ongoing high level of vacancies. IT investment project business case has now been approved; no costs included in this year's revenue account.
Torbay Pharmaceuticals	PMU	TP sales in M2 in line with budget and ahead of the year to date by £0.35m.
Corporate	EFM	Backdated SWAST ambulance station income & small increase in visitor parking income are main reasons for increase in income. Car parking to remain FOC to staff into 2021/22. This is offset by slight increase in pay & non-pay spend due to increased cleaning & use of temporary staff as well as increasing utility costs.
	Exec. Directors	Operating within funding envelope due to underspends in pay from on-going vacancies across several directorates and increased income mainly in Finance & Medical Examiner income.
	Financing Costs	Costs are in line with plan.
	Other	Reserves has a provision for Independent Sector inflation.
South System	Coastal	Underspent at M2 against budget £0.4m mainly due to delays in recruitment, savings in theatre supplies and drugs at the earlier stages of recovery. Run rate is expected to increase as recovery plans advance in the coming months in line with the expected capacity increases.
	Newton Abbot	Cost pressure mainly ED with reliance on agency and bank nursing staff, and medical locum to cover staff sickness, vacancies and absence £0.3m. Additional cost for Covid ward £0.1m due to closure later than planned. Underspend in ICU year to date due to vacancies (to be filled imminently), and delays in MIU recruitment £0.1m.
	Moor to Sea	Marginally over budget at M2 due to ward specialling requirements and increase in purchase of intermediate care beds which is currently under review. This is offset by savings due to delays in recruitment.
	Shared Operations	Broadly in line with budget at M2 showing a marginal underspend in non-pay mainly medical electronics and postage (excluding Coronavirus costs that are currently coded to this area).
Torbay System	Independent Sector	Cost YTD is £1.7m higher than budget but this is entirely due to COVID related spend (Hospital Discharge, Rapid Testing and Infection Control). COVID costs total circa £2.2m and this is matched by an equivalent value in Patient Income. Outside of COVID spend is lower than planned YTD materially in ASC and is driven by lower activity (than planned) on all main long stay care areas.
	Torquay	ISU is operating within the budget envelope with minimal variances across pay and non-pay.
	Paignton and Brixham	ISU has a minor YTD £55K underspend. This is driven by a material £472K non-pay underspend (Labs Medicine) but this is primarily offset by £400K under recovery of other income (Labs Medicine). The labs Medicine area is heavily impacted by COVID / Testing and extremely difficult to plan / judge (months in advance).
Contract Income	Patient Income	The Trust has received the following income: 1) £1.4m of Elective Recovery Funding (ERF) at M2 from the CCG. 2) Additional £0.6m of variable income from Specialised Commissioning relating to pass through drugs. There is a corresponding increase in drugs costs. 3) Circa £0.8m additional income via the CCG relating to the Hospital Discharge Programme (HDP). There is a corresponding cost to offset this. 4) An additional c£1.4m relating to grants received by Torbay Council, which is then passported to us to pay out as per the grant conditions to providers such as care homes to cover costs for extra IPC and rapid testing.

Cash Position – Month 2, May 2021

	YTD at Month 2 Position 31st May 2021 £m
Opening cash balance	**45.45**
Capital Expenditure (accruals basis)	(1.15)
Capital loan drawndown	0.00
Capital loan repayment	(0.72)
Proceeds on disposal of assets	0.00
Movement in capital creditor	(8.97)
Other capital-related elements	2.37
Sub-total - capital-related elements	**(8.47)**
Cash Generated From Operations	3.77
Working Capital movements - debtors	(3.10)
Working Capital movements - creditors	(0.33)
Net Interest	(0.48)
PDC Dividend paid	0.00
Other Cashflow Movements	(0.25)
Sub-total - other elements	**(0.39)**
Closing cash balance	**36.59**
Closing cash balance (net of working capital facility)	**36.59**

Better payment practice code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	23,938	20,962	87.6%
Non-NHS - value of bills (£k)	49,285	42,521	86.3%
NHS - number of bills	349	249	71.3%
NHS - value of bills (£k)	3,920	1,864	47.6%
Total - number of bills	24,287	21,211	87.3%
Total - value of bills (£k)	53,205	44,385	83.4%

Key points of note:

- A planned cash position was not required by NHSE/I for the first six months of the year. However, a full year cash plan has been prepared and is incorporated into a separate FPDC capital and cash report. As will be seen from that report, the Trust is forecasting that it will have access to adequate cash resources during the course of the year to enable the Trust to deliver its capital program and meet its existing debt commitments, albeit access to Public Dividend Capital support through proven routes will be required.

- Cash balances across the first two months of the year have decreased by £8.86m predominantly due to the exceptional high level of capital creditors at 31st March 2021 being settled.

- Cash balances still remain high at £36.59m as at 31st May 2021, but are expected to decrease further during the course of the year as deferred income balances unwind, debtors increase to a more business as usual position, and some of the Trust's cash reserves are used to support capital expenditure.

- To mitigate against substantial increases in debtors, the Trust's Treasury Team and Income & Planning sections will continue to closely monitor the value of outstanding income and where necessary, debt management will be escalated to Director level.

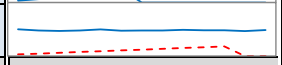
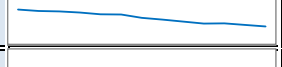
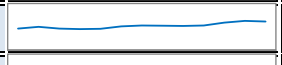
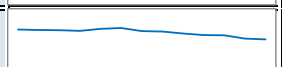
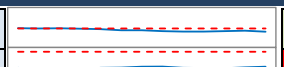
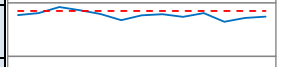
Statement of Financial Position (SoFP) – Month 2, May 2021

	Month 2		
	Position 31st March 2021 £m	Position 31st May 2021 £m	Movement £m
Non-Current Assets			
Intangible Assets	10.09	9.87	(0.22)
Property, Plant & Equipment	202.37	200.98	(1.39)
On-Balance Sheet PFI	17.11	17.02	(0.09)
Other	2.04	1.12	(0.92)
Total	**231.61**	**228.99**	**(2.62)**
Current Assets			
Cash & Cash Equivalents	45.45	36.59	(8.86)
Other Current Assets	33.19	37.51	4.32
Total	**78.64**	**74.10**	**(4.54)**
Total Assets	**310.25**	**303.09**	**(7.16)**
Current Liabilities			
Loan - DHSC ITFF	(4.80)	(4.80)	0.00
PFI / LIFT Leases	(1.17)	(1.17)	(0.00)
Trade and Other Payables	(64.46)	(55.44)	9.02
Other Current Liabilities	(7.80)	(9.43)	(1.63)
Total	**(78.23)**	**(70.84)**	**7.39**
Net Current assets/(liabilities)	**0.41**	**3.26**	**2.85**
Non-Current Liabilities			
Loan - DHSC ITFF	(29.08)	(28.36)	0.72
PFI / LIFT Leases	(16.60)	(16.41)	0.19
Other Non-Current Liabilities	(15.87)	(14.62)	1.25
Total	**(61.55)**	**(59.39)**	**2.16**
Total Assets Employed	**170.47**	**172.86**	**2.39**
Reserves			
Public Dividend Capital	130.75	130.75	0.00
Revaluation	49.15	49.15	0.00
Income and Expenditure	(9.43)	(7.04)	2.39
Total	**170.47**	**172.86**	**2.39**

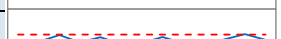
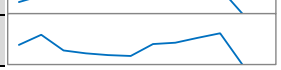
Key points of note:

- Cash balances at 31st May 21 remain high but are expected to decrease during the course of the year. Please refer to the Cash Position report above for further details.
- In line with expectations, Creditors (mostly relating to Capital Creditors) have decreased by circa £9m since 31st March 21.

	ISU	Target	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		3	2	2	2	1	0	1	2	1	1	4	2	5	7
Reported Incidents - Death	Trustwide	<1		2	2	2	2	3	1	0	1	4	1	3	1	0	1
Medication errors resulting in moderate harm	Trustwide	<1		0	0	1	0	0	0	0	0	0	2	0	0	1	1
Medication errors - Total reported incidents	Trustwide	N/A		24	40	41	39	51	52	53	34	41	50	53	49	64	113
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	1	1	1	1	3	0	0	0	1	0	0		0
Never Events	Trustwide	<1		0	0	0	0	2	1	0	0	0	0	1	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		4	1	4	8	5	5	2	4	7	6	6	6	7	7
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	1	0	0	0	0	0	0	0	0	0	0
Formal complaints - Number received	Trustwide	<60		4	13	17	17	17	18	20	14	7	13	12	10	7	17
VTE - Risk Assessment on Admission	Trustwide	>95%		92.1%	82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	92.2%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		79.8	103.1	90.1	76.5	88.4	104	109.4	92.5	112.3	90.5				98.7
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		85.4%	89.8%	90.8%	84.0%	86.4%	86.5%	90.1%	89.7%	90.3%	85.8%	82.5%	89.0%	90.2%	89.6%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		87.0%	89.9%	92.2%	86.4%	87.7%	89.4%	84.8%	88.5%	88.6%	88.3%	85.4%	90.3%	88.5%	89.4%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		0	12	0	20	262	23	0	30	6	0	23	24	42	66
Hand Hygiene	Trustwide	>95%		98.9%	97.9%	97.2%	98.3%	98.9%	96.9%	97.8%	97.0%	98.3%	95.3%	92.8%	95.9%	94.8%	99.1%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		97.5%	91.7%	94.6%	74.4%	60.0%	74.5%	75.7%	75.6%	85.3%	94.4%	78.1%	73.2%	90.3%	72.5%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		90.6%	79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	74.9%
Follow ups 6 weeks past to be seen date	Trustwide	6400		14211	15398	16408	17220	17408	17519	17229	17837	17489	16986	16950	17118	16713	16713
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.5%	4.5%	4.5%	4.5%	4.4%	4.3%	4.3%	4.3%	4.2%	4.1%	4.0%	4.0%		4.1%
Appraisal Completeness	Trustwide	>90%		71.0%	75.6%	77.8%	78.4%	79.4%	78.4%	78.9%	80.4%	78.8%	78.4%	82.4%	85.9%	86.6%	82.4%
Mandatory Training Compliance	Trustwide	>85%		88.0%	89.9%	89.9%	89.9%	89.7%	89.7%	89.6%	89.6%	89.7%	89.5%	89.6%	90.1%	90.1%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.5%	10.3%	10.8%	10.7%	10.3%	10.5%	10.7%	10.5%	10.2%	10.2%	10.0%	10.8%	11.0%	

	ISU	Target	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		21	38	95	175	246	256								
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		17	33	82	89	72	129								
Carers Assessments Completed year to date	Trustwide	40% (Year end)		100.0%	95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	97.5%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		223	217	219	221	200	214	221	223	223	207		234	0	234
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET			56			124			199				0	0	..
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET			5.9%			5.4%			4.4%				0.0%	0.0%	..
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		515	553	559	561	560	576	599	658	617	615	616	0	608	608
Intermediate Care - No. urgent referrals	Trustwide	113		248	283	242	211	221	200	207	235	175	146	155	169	151	320
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		172	221	206	260	262	274	193	242	249	205	255	282	291	573
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			83.1%	82.1%	81.8%	81.1%	80.0%	79.8%	77.6%	76.4%	75.1%	73.8%	74.0%	72.9%	71.9%	71.9%
Proportion of carers receiving self directed support	Trustwide			100.0%	95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	97.5%
% Adults with learning disabilities in employment	Trustwide			8.9%	8.9%	8.7%	8.6%	8.8%	8.5%	8.5%	8.2%	8.1%	8.3%	8.3%	7.5%	7.4%	7.4%
% Adults with learning disabilities in settled accommodation	Trustwide			79.2%	80.0%	79.3%	79.0%	79.1%	80.2%	80.6%	80.5%	80.4%	80.6%	81.8%	82.6%	82.3%	82.3%
Permanent admissions (18-64) to care homes per 100k population	Trustwide			21.5	27.0	18.9	24.3	20.2	20.2	14.8	18.9	14.8	17.5	16.2	17.5	20.2	20.2
Permanent admissions (65+) to care homes per 100k population	Trustwide			504.1	502.6	538.1	524.4	557.2	565.4	573.6	579.0	587.2	540.8	464.3	499.8	510.8	510.8
Proportion of clients receiving direct payments	Trustwide			23.1%	22.9%	22.9%	22.7%	23.3%	23.6%	22.6%	22.4%	21.7%	21.2%	21.1%	20.1%	19.8%	19.8%
% reablement episodes not followed by long term SC support	Trustwide			85.6%	85.2%	87.1%	86.2%	85.9%	84.6%	85.2%	85.5%	85.4%	85.7%	85.8%	-	-	..
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		96.5%	94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	81.5%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		62.2%	57.0%	53.5%	57.3%	62.1%	62.3%	64.2%	64.3%	61.8%	61.4%	61.4%	62.7%	63.9%	63.3%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		77.1%	80.9%	92.3%	86.3%	79.3%	67.9%	77.0%	78.9%	73.8%	80.9%	64.8%	71.8%	74.3%	72.9%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		54.3%	41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	33.2%
Dementia - Find - monthly report	Trustwide	>90%		98.1%	94.5%	60.8%	84.4%	89.2%	96.6%	94.4%	97.7%	94.8%	98.0%	95.0%	96.7%	96.9%	96.8%

	ISU	Target	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		8	5	4	4	2	4	2	3	1	1	5	2	5	7
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		93.6%	91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.9%	77.1%	89.6%	85.1%	67.7%	84.0%	75.6%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		100.0%	95.3%	97.4%	100.0%	95.9%	97.8%	86.6%	94.0%	75.0%	96.3%	95.2%	61.9%	54.1%	58.2%
Cancer - 28 day faster diagnosis standard	Trustwide			80.8%	81.5%	79.8%	72.4%	66.6%	72.7%	75.3%	75.9%	72.2%	77.3%	75.0%	75.6%	75.0%	75.3%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		99.2%	100.0%	99.4%	97.3%	97.4%	97.7%	99.0%	97.5%	97.5%	98.8%	99.0%	97.4%	96.7%	97.1%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	98.6%	100.0%	99.3%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	96.0%	100.0%	100.0%	100.0%	98.5%	100.0%	99.1%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		96.2%	100.0%	96.4%	91.3%	100.0%	93.3%	96.3%	93.3%	96.4%	97.0%	84.8%	100.0%	100.0%	100.0%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		33.3%	66.7%	0.0%	100.0%	100.0%	60.0%	75.0%	66.7%	77.8%	83.3%	100.0%	75.0%	62.5%	65.0%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			42	68	32	9	9	8	13	14	11	6	15	15	17	17
RTT 52 week wait incomplete pathway	Trustwide	0		192	344	524	745	892	1141	1277	1435	1570	1823	2041	1895	1596	1596
On the day cancellations for elective operations	Trustwide	<0.8%		0.6%	0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	0.6%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		2	1	5	3	29	4	1	1	5	6	8	6	11	48
Bed Occupancy	Overall System	80.0%		64.8%	74.7%	93.3%	86.7%	91.6%	82.4%	90.5%	89.8%	94.4%	93.4%	99.5%	94.2%	96.1%	95.2%
Number of patients >7 days LoS (daily average)	Trustwide			70.8	80.9	76.5	89.3	94.9	94.0	95.4	95.1	109.5	114.2	98.2	97.0	104.5	100.7
Number of extended stay patients >21 days (daily average)	Trustwide			18.1	18.7	12.0	13.3	15.2	17.1	16.7	14.0	20.8	27.8	19.9	15.2	21.3	18.2
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		9	19	10	46	59	73	38	138	75	82	94	90	128	218
Ambulance handover delays > 60 minutes	Trustwide	0		0	4	1	3	0	14	1	19	15	20	32	19	26	45
A&E - patients recorded as >60min corridor care	Trustwide			0	0	0	0	0	0	0	0	0	0	0	0	0	0
A&E - patients with >12 hour visit time pathway	Trustwide			0	6	0	1	10	16	4	18	18	27	28	14	46	60
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		0	0	0	0	0	1	0	1	2	3	5	2	3	5
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		6	4	1	5	2	4	2	2	1	1	4	1	3	4
Number of Clostridium Difficile cases - (Community)	Trustwide	0		2	1	3	2	0	0	0	1	0	0	1	1	2	3
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		78.4%		73.6%	70.9%	61.1%	69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.5%	59.6%	60.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		54.1%		46.3%	43.7%	35.0%	41.4%	41.6%	32.4%	47.4%	30.9%	41.0%	25.5%	33.1%	29.8%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		86.4%	90.9%	90.9%	90.9%	72.7%	100.0%	90.9%	86.4%	81.8%	95.5%	81.8%	86.4%	90.9%	88.6%

	ISU	Target	13 month trend	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			524	800	1323	1297	1220	-23	1420	2378	3635	937	3180		2623	
Agency - Variance to NHSI cap	Trustwide			0.87%	0.44%	0.39%	0.49%	0.38%	-0.10%	-0.20%	-0.20%	-0.20%	-0.20%	-0.25%		-1.40%	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			1112	1813	2770	532	-236	1686	5147	6653	9748	11822	2305		2004	
Distance from NHSI Control total (£'000's)	Trustwide			0	0	0	0	0	112	1493	1858	3993	1179	655		2690	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	0	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs 2019/20 BASELINE																	
Outpatients - New	Trustwide			-55.5%	-32.4%	-23.9%	-15.8%	-3.2%	-5.6%	4.5%	-0.9%	-21.7%	-14.0%	26.8%	-11.6%	-23.1%	-17.5%
Outpatients - Follow ups	Trustwide			-42.2%	-28.2%	-26.5%	-24.3%	-15.0%	-23.8%	-18.5%	-8.5%	-25.3%	-17.0%	16.8%	-8.4%	-14.1%	-11.3%
Daycase	Trustwide			-58.0%	-34.1%	-20.7%	-23.9%	-14.4%	-21.9%	-18.9%	-9.4%	-29.8%	-23.5%	9.1%	-9.0%	-21.9%	-15.7%
Inpatients	Trustwide			-51.6%	-28.8%	-1.9%	-30.6%	-10.4%	-37.7%	-33.8%	-9.9%	-33.4%	-44.8%	-18.8%	1.8%	-20.5%	-10.0%
Non elective	Trustwide			-36.5%	-22.6%	-17.5%	-7.0%	-1.3%	-9.7%	-15.4%	-13.3%	-20.2%	-16.5%	18.0%	4.5%	4.5%	4.5%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			513	568	479	410	471	425	423	494	473	464	502	#N/A	#N/A	
Intermediate Care GP Referrals	Trustwide			115	127	107	82	96	90	83	106	106	98	95	#N/A	#N/A	
Average length of Intermediate Care episode	Trustwide			8.5661	9.1331	11.478	13.158	21.333	14.744	10.846	11.798	12.237	12.336	12.498	#N/A	#N/A	
Total Bed Days Used (Over 70s)	Trustwide			5262	6759	6821	7229	8613	8693	8211	8812	9280	3075	0	#N/A	#N/A	
- Emergency Acute Hospital	Trustwide			3733	4408	4486	4786	5220	5582	5202	5538	5584	0	0	#N/A	#N/A	
- Community Hospital	Trustwide			1142	1764	2060	2224	3208	2943	2606	2844	3172	2461	0	#N/A	#N/A	
- Intermediate Care	Trustwide			387	587	275	219	185	168	403	430	524	614	0	#N/A	#N/A	

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report Title: Report of the Guardian of Safe Working Hours ('GOSWH') – Doctors and Dentists in Training			**Meeting Date:** 30th June 2021
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Consultant in Emergency Medicine and GOSWH		
Report provenance	Nil		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board are asked to receive and note the report.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	N/A	**Risk score**	N/A
Risk Register	N/A	**Risk score**	N/A

External standards affected by this report and associated risks

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

Report title: Report of the Guardian of Safe Working Hours ('GOSWH') – Doctors and Dentists in Training		**Meeting date:** 30th June 2021
Report sponsor	Medical Director	
Report author	Consultant in Emergency Medicine and GOSWH	

1. Executive Summary

The following report concerns the time period of 2nd March 2021 up to the 22nd May 2021 based on the Exception Reports submitted by the Junior Doctor workforce.

There remain significant cohorts of Junior Doctors who are not represented in Exception Reports; this missing data makes spotting patterns difficult.

2. Introduction

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

3. Exception Reports

There have been 85 Exception Reports in the period 2 March 2021 to 22nd of May. This remains lower than similar periods in 2018 and 2019. It is slightly more than the last four quarters. This is partly likely to represent junior doctor professionalism and good willing during the coronavirus pandemic. This is the fifth consecutive quarter that I have reported less ERs than expected so hopefully this represents a junior workforce that is happy and content with their rotas and job plans.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Emergency Medicine	2	0	2	
Acute medicine	12	7	5	
Anaesthetics	3	1	2	
ENT	2	0	2	
Gastroenterology	5	5	0	
General Medicine	18	4	14	
General Surgery	26	2	24	
Haematology	2	0	2	
Obstetrics and Gynaecology	2	0	2	
Paediatrics	9	0	9	
Urology	4	1	3	
Total	85	20 (24%)	65 (76%)	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	39
F2	16
CT1-3	24
ST 4-9	6
Total	85

Table 3 – Nature of Exception

Additional Hours	76
Service support	1
Educational	1
Pattern	7

Table 4 – Outcome of Exceptions

TOIL	1	The high number of payment outcomes is caused by a general failure to complete ERs by supervisors. This is compounded by myself being unable to complete them at 28days. They will be completed before next quarter.
Payment	19	
No compensation required	0	
Agreed no further action required	0	
Outstanding	65	

4. Comment on Exception Reports

There are low numbers of Exception Reports and only 24% have been actioned. This represents 64% of Exception reports older than 28 days. The Trust recently changed it's rota software from Allocate and unfortunately the Guardian access to ERs was interrupted. It has taken a prolonged period to regain access and this is reflected in the failure to complete 36% of the ERs older than 28 days. Once this is fixed then I will complete the outstanding ERs. This issue shows how reliant ER completion is on myself as GoSWH completing a large fraction of the ERs.

5. Rota Reviews

Rota reviews have been carried out by Practice Managers Reports working alongside Medical HR on every Junior Doctor rota as mandated by the Junior Doctor Contract. In the wake of low COVID-19 cases, the 'Junior Doctor Reassignment' meeting is being closed. There are no rotas in a 'surge' pattern and redistributed junior doctors have returned to their parent specialty rotas.

6. Fines

There have been no Guardian fines for this period.

7. Qualitative Information

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

8. Issues Arising

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

- The Surgical Registrar rota is short of doctors. Rota co-ordinators have written a rota compliant with the Junior Dr contract and are looking to create jobs which offer training opportunities (research, locum etc) but which also support the rota.

- The Junior Doctor Contract allows exception reporting for:

- Any activities required for the successful completion of Annual Review of Competency Progression (ARCP) and any additional educational or development activities explicitly set out in the agreed personalised work schedule.
- Activities that are agreed between the doctor and their employer, such as quality improvement or patient safety tasks directly serving a department or wider employing organisation, or their doctors (e.g. attending a JDF, activities related to Rota management, BMA roles, delivering teaching, or setting up training programmes).
- All professional activities that doctors are required to fulfil by their employer (e-portfolio, induction, e-learning, quality improvement and quality assurance projects, audits, mandatory training/courses).

  This is one of the more opaque and difficult areas of the contract to apply. Most Junior Drs accept that they must work towards career goals in and out of work. All junior Drs have significant academic and career administration workloads preparing for ARCP (a yearly review of competence which serves as a potential barrier to progression). Rota planners, myself and the JDRC are currently trying to ensure that there is room within job plans to give in-work opportunities to complete these tasks.

  For F1s and F2s, administration time is written into their rota patterns. For more senior, specialised junior Drs this creates difficulties as their rotas are more closely matched to the requirements of the service. There comes a natural tension between a) rotoring administration time, b) promoting widespread exception reporting of (pre-authorised) administration time or c) expecting junior doctors to complete the work outside of working hours (and the clauses of their contract).

  Our current batch of junior doctors can be commended for completing their administerial work in their own time/quiet work periods. There have been no exception reports for administerial time lost. There is nowhere in the country that has solved this issue and our policy is in line with local other hospitals within the Peninsular training region.

8. Actions Taken to Resolve Issues

- Electronic exception reporting i.e. supervisors completing exception reports on Allocate without a meeting. Reducing the need for face to face meetings and including a maximum time for response (four weeks) and a default sign-off by the GoSWH (after four weeks, or at the end of a rotation). This has brought Torbay in-line with other local Trusts and the Junior Doctor contract.
- Local agreement is that TOIL or payment for non-clinical (administerial) activity needs to be pre-agreed with supervisors. This prevents junior doctors being disappointed by a lack of opportunity to claim TOIL and protects rotas from losing hours at short notice.

- The MD1 and MD2 policies (pertaining to junior doctor contracts) have been amalgamated into a single (MD1) policy with a FAQ section which clarifies our local interpretation and enforcement of the junior doctor policy. This has been agreed between myself, medical HR and the JDRC.

9. Summary

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

Junior Doctors, workforce practitioners and rota coordinators continue to show admirable flexibility, professionalism and diligence.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: NHS Resolution Maternity Incentive Scheme – Year 3			Meeting date: 30 June 2021
Report appendix	Appendix 1: Neonatal Nursing Workforce Action Plan Appendix 2: Screen Shot of Board Declaration Form Appendix 3: Maternity Mandatory Training Position as of 31 May 2021.		
Report sponsor	Chief Nurse		
Report author	Associate Director of Midwifery & Professional Practice / Head of Midwifery and Gynaecology		
Report provenance	The content of this report is a summary of the Trust's status and evidence in relation to compliance with NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 3 standards. Achievement of the 10 Safety Actions will result in a minimum rebate of the Trust's contribution to the incentive fund (calculated at 10% of our maternity premia).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide the Trust Board with a self-declaration of the Trust position in relation to achieving the standards set out within the CNST maternity incentive scheme. A summary of the evidence that supports the self-assessment is provided to enable the Trust Board to complete the declaration form to be submitted to NHS Resolution. The paper sets out specific action for the Trust Board to enable full compliance with the 10 standards		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to: i. Review the report and evidence that supports declaration of compliance with CNST Standard ii. Note and approve the action plan to show how the Trust is working towards meeting the neonatal nursing workforce standards iii. Provide written commitment to local, in person fetal monitoring training and multi-disciplinary training subject to COVID restrictions in place iv. Document compliance with the anaesthetic standards within the Board Minutes		

	v. Confirm the Trust position of compliance against all 10 Safety Actions that enables the Chair to sign the declaration form on behalf the Trust
Summary of key elements	
Strategic objectives supported by this report	

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

Report title: NHS Resolution Maternity Incentive Scheme – Year 3		**Meeting date:** 30 June 2021
Report sponsor	Chief Nurse	
Report author	Associate Director of Midwifery & Professional Practice / Head of Midwifery and Gynaecology	

1.0 Introduction

In January 2018, NHS Resolution launched the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme which was introduced to support the delivery of the Department of Health and Social Care's Maternity Safety Strategy. This strategy set out an ambition to reward those who have taken action to improve maternity safety and 10 maternity actions were developed to support this aim.

Torbay and South Devon NHS Foundation Trust has provided evidence of full compliance for years 1 & 2 in 2018 and 2019.

The third year of the scheme was launched in December 2019. The 10 maternity safety actions remained; however, additional requirements were added to each safety action. Due the COVID-19 pandemic, the submission date was delayed a number of times in recognition of the challenges experienced by maternity services to maintain safe, quality services. The Trust are required to make a self-declaration of achievement against the actions.

This will be signed off by the Trust Board and submitted to NHS Resolution by 12.00 noon Thursday 15 July 2021. See appendix 1 for screenshots of self-declaration form The Trust Board must sign a declaration confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate

- The content of this form has been discussed with the commissioner(s) of the trust's maternity services

- If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s)

- We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

The Board declaration form has four tabs:

- Tab 1 - Guidance
- Tab A - Safety Actions Entry Sheet (1-10)
- Tab B - Action Plan Summary Sheet
- Tab C - Action Plan Entry Sheet
- Tab D - Board Declaration Form

Evidence of achieving all 10 actions will qualify the Trust for a minimum rebate of their contribution to the incentive fund (calculated at 10% of our maternity premia).
This report provides the Board with an overview of the status of each of the 10 safety actions and the evidence to demonstrate achievement of each action.

2.0 CNST Self-Assessment Summary of 10 Maternity Safety Actions

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Y
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?	Y
4	Can you demonstrate an effective system of clinical workforce planning to the required standard? *(specifically relating to Anaesthetic standards and neonatal workforce plan)*	Compliance will be achieved subject to Board Approval of Neonatal Nursing Workforce Action Plan in Appendix 1 and noting of compliance with anaesthetic standards within Board papers
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Compliance will be achieved subject to Board noting commitment to face to face training (P19)
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Y
8	Can you evidence that the maternity unit staff group have attended as minimum a half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of the MIS year three in December 2019?	Compliance will be achieved subject to Board noting commitment to face to face training (P26)
9	Can you demonstrate that the trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Y
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?	Y

Table 1: Summary of Trust Position Against 10 Maternity Safety Actions

2.1 Amber rated standards

Table 1 sets out the Trust position with regard to compliance against the 10 core standards. The Board will note that there are 3 amber rated standards, all of which will meet compliance subject to review and approval of this Board submission. These include the following compliance requirements:

A. Confirmation that an action plan has been produced to show how the Trust is working towards meeting the neonatal nursing workforce standards that is signed off by the Board (section 3 – standard 4 of this paper)
B. Written commitment by the Board to facilitate local, in-person, fetal monitoring training when this is permitted (section 3 – standard 6 of this paper)
C. Written commitment by the Board to facilitate local, in person multi-disciplinary training when this is permitted (section 3 – standard 8 of this paper)
D. Documentation within Board minutes that Trust compliance with anaesthetic standards (section 3 – standard 4 of this paper)

3.0 CNST: 10 Safety Actions. Summary of Evidence

No	Safety Action	Requirement	Status and evidence
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	All perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	2/2 eligible cases notified within 7 working days (4 days and 2 days respectively). 100% 2/2 surveillance information completed within 4 months of each death 100% Database maintained of all cases that qualify for a PMRT.
		Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	8 cases reviewed using PRMT. 7 completed and one in progress. 100%
		Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	1 report is not yet completed, as this is a HSIB investigation and the trust is waiting for the finalised report. NHS Resolution recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB and this may delay the start of the local review using the PMRT. Achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. Of the remaining 7 cases 6 had multi-disciplinary review as set out by the standards (85%). The one case only had one obstetrician present, rather than two.

		For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Duty of candour letters were sent to all families and where possible contact is made detailing that a case review would take place. No babies who were born at home met the criteria. We do offer all parent the opportunity to meet with the clinical team and provide a single point of contact / liaison to ensure the family is supported as part of the review and Duty of Candour process
		For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Duty of candour letters were sent to all families, which included asking families to share any questions or feedback about their care. We do offer all parents the opportunity to meet with the clinical team and also provide a single point of contact / liaison to ensure the family is supported as part of the review and Duty of Candour process.
		If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	All reviews were completed in the correct timescale, excluding the HSIB cases. For these cases the HSIB team liaised with the family to ensure they were updated about the timescales for completion of the HSIB report.
		Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Quarterly reporting to the Board process in place. For reporting period from 1 October 2021 have included action plans For year 3 of MIS, quarterly report submitted for 1.10.2020 – 31.12.2020 – Board 25.1.2021 1.1.2021 – 31.3.2021 – Board 26.5.2021
		Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes: Chief Nurse, Executive Maternity Safety Champion. Deputy Head of Midwifery, Midwifery Safety Champion

2	Are you submitting data to the Maternity Services Data Set to the required standard?	Were your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?	13/13 criteria met in December 2021 Email confirmation from NHS Digital.
		Has the Trust Board confirmed to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 and 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT?	Not able to fully conform with standards because our local IT system STORK does not have this functionality. There is a locally agreed Locally agreed action plan in place, which includes clinical coding in SNOMED-CT. This has been agreed with the maternity safety champion and Devon LMNS. System 1 which is being implemented currently and due to go live in November 2021 will meet standards.
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	In place
		Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC	Review and report completed in November 2020. Included impact of • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding There were no adverse effects noted during the COVID period. Therefore, no actions required.

		• changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	The team continued to monitor all term admissions
		Do you have evidence of the following • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	Due to there being no adverse effects noted in the audit of term admissions due to COVID 19, an action plan relating to these specifically was not indicated. As part of the services wider learning commitment, the team continued to monitor and audit all term admissions. From January 2021, the team met on a monthly basis to monitor the ATAIN data. During March 2021, the team reviewed and collated all of the ATAIN data. No modifiable factors were identified, however the team identified two areas of learning that were shared with the wider team. This would not have impacted on the admission to SCBU. This report and the action were shared and agreed with neonatal, maternity safety champion and Board level champion. ATAIN data is reported through the Trust-wide Quality Improvement Group (QIG) via the Maternity Monthly Clinical Governance Quality Report, which is chaired by the Board level safety champion. It is also reported to the Trust Board on a quarterly basis via the maternity safety and governance report.

		Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	See above – no action plan was required as no learning was identified. For the purpose of the CNST submission, the maternity and neonatal service will mark this as yes, as there is no not applicable option available on the form.
		Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion?	See above – no action plan was required as no learning was identified. The ATAIN group meet monthly, the group includes both the neonatal and maternity safety champions.
		Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	See above – no action plan was required as no learning was identified. The ATAIN group meet monthly, the group includes both the neonatal and maternity safety champions. The ATAIN information is reported to QIG, which is chaired by Board safety champion.
4	Can you demonstrate an effective system of medical workforce planning to the required standard	Anaesthetic medical workforce Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	We are fully compliant with this standard subject to Board approval and recording of this paper in Board minutes With regard to the specifics around this standard. The following are in place: ➢ 1.7.2.5 Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff ➢ 1.7.2.1 A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, our systems and processes and medical workforce models ensure that they are able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients. ➢ 1.7.2.6 The duty anaesthetist for obstetrics should participate in labour ward rounds

		If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	No action plan required
		Neonatal medical workforce Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes – the following is in place. Tier 1 A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit
		If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	No action plan required.
		Neonatal nursing workforce Does the neonatal unit meet the service specification for neonatal nursing standards	No – working with the South West Neonatal Network (ODN), it has been identified that there is currently a gap of 3.85wte registered nurses required, plus an additional 1.54 of registered nurses that require QIS (Qualified in specialty) training.

		If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	National funding is being made available to increase neonatal nursing establishments across the country. Action Plan is detailed in appendix 1 and has been shared with the RCN. We are fully compliant with this standard subject to Board approval of action plan
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	Formal Birthrate Plus© assessment of midwifery establishment completed in October 2017 and report received. Establishment set at right level therefore no action plan required. The Birthrate Plus© assessment was repeated over the Winter of 2020/21, with the final report being available in March 2021 Establishment monitored monthly by midwifery matrons, plus midwifery ratio reported to SW Maternity Clinical network. Monthly staffing reports completed by Head of Midwifery reviewing midwifery staffing levels.
		Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	Birthrate Plus© assessment includes specialist midwives. This identified the requirement for additional hours within specialist roles.
		Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	A Board report was completed detailing the findings of the Birthrate Plus© assessment and recommendations in relation to a deficit of 13.2wte. The report set out the actions that were being taken to address this, namely a request has been made to NHS England and Improvement for a share of national maternity funding to enable the Trust to recruit to the posts required. Should the funding bid be unsuccessful or only partially the Trust will work with the ICS and LMNS to consider strategies to address the implication of this on TSDFT and wider service delivery

		Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	Bid for funding submitted and awaiting outcome. Currently have increased each hospital-based shift with 1 Registered Midwife, utilising bank to meet this shortfall. The Trust also undertook a confirm and challenge with the regional Chief Midwife around strength workforce models and approaches
		Do you have 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 in the scheme reporting period? This must include mitigations to cover shortfalls.	The labour ward co-ordinator has supernumerary status. This is supported by our midwifery staffing document. Acuity tool is in place to monitor any occasion where the co-ordinator is not supernumerary for any part of shift and actions taken to remedy this. During July to December 2020, there were 29/989 instances where the co-ordinator was not able to remain supernumerary (97%). This is detailed in the bi-annual report submitted to the Board. None of these instances were planned and the co-coordinator was rostered to be supernumerary. The majority of the instances were for very short periods. In all instances the co-ordinator returned to supernumerary status as soon as was practicable. All instances are reviewed by the matrons and remedial action taken as indicated. Monitored on a weekly basis and reported in monthly maternity
		If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	Action plan for meeting 100% compliance included in July-December 2020 Maternity Staffing Oversight Board paper. Next report due for submission to Board on 28 July 2021
		Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with	Trust compliance with women receiving 1:1 care in labour is 100%. This is monitored through our STORK IT system. For the period 1 January 2021 to 31 May 2021, all women received 1:1 care in labour

		1:1 care in labour in the scheme reporting period? This must include mitigations to cover shortfalls.	
		If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with 1:1 care in labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	Not applicable
		Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves	A weekly COVID-19 maternity meeting was established, along with a maternity specific Standard Operating Procedure, which was initially reviewed weekly and then moved to fortnightly. This was based on guidance being provided by the Royal Colleges and NHSE&I. The monthly staffing reports continued during this time and included a specific section on COVID-19 and the impact on staffing with the maternity services. The six-monthly Maternity Staffing Oversight Board paper also included details regarding the impact of COVID-19. The maternity service had a well-established escalation policy. An additional template was developed to support this process specifically in relation to the COVID-19 pandemic. The team developed innovative approaches to utilise staff who were unable to be in clinically facing roles to support the remainder of the team using virtual methods.
		Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	Midwifery Staffing Oversight Report submitted six-monthly during reporting period. January 2020, July 2020, February 2021

6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Quarterly Maternity Safety and Governance Board reports details compliance with SBLCBv2 during time period
		Has each element of the SBLCBv2 been implemented?	Yes – see below
		The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. Have you completed and submitted this?	5 quarterly surveys submitted by submission deadlines.
	ELEMENT 1 - Reducing smoking in pregnancy	Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. Has standard a) been successfully implemented (80% compliance or more)?	Yes – audit compliance 85%
		If the process metric scores are less than 95% for Element 1 standard A, has an action plan for achieving	Action plan in place.

		>95% been completed?	
		Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. Has standard b) been successfully implemented (80% compliance or more)?	CO monitoring in process of being reintroduced following COVID-19 service changes, Standard met as standard a) achieved.
		If the process metric scores are less than 95% for element 1 standard b), has an action plan for achieving >95% been completed?	Achieved as action plan in place for standard a)
		Standard c) Percentage of women where CO measurement at 36 weeks is recorded. Has standard c) been successfully implemented (80% compliance or more)?	CO monitoring in process of being reintroduced following COVID-19 service changes, Standard met as standard a) achieved.
		If the process metric scores are less than 95% for element 1 standard c), has an action plan for achieving >95% been completed?	Achieved as action plan in place for standard a)
	ELEMENT 2 - Risk assessment, prevention and surveillance of	Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. Has standard a) been successfully implemented (80% compliance or	Yes – audit compliance 99.2%

	pregnancies at risk of fetal growth restriction	more)?	
		If the process metric scores are less than 95% for element 2 standard a), has an action plan for achieving >95% been completed?	Not applicable
		Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Policy in place which sets out requirement for ultrasound and BMI>35kg/m^2 uterine artery doppler flow velocimetry Data captured monthly re percentage of babies born <3rd centile, >37+6 weeks. All cases reviewed as part of GAP SCORE missed cases audit.
		If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	Not applicable

		If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	Not applicable
		If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	Not applicable
		If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	Not applicable

	ELEMENT 3 Raising awareness of reduced fetal movement	Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. Has standard a) been successfully implemented (80% compliance or more)?	Yes – audit compliance 86%
		If the process metric scores are less than 95% for element 3 standard a), has an action plan for achieving >95% been completed?	Action plan in place.
		Standard b) Percentage of women who attend with RFM who have a computerised CTG Has standard b) been successfully implemented (80% compliance or more)?	Yes – audit compliance 99.3%
		If the process metric scores are less than 95% for element 3 standard b), has an action plan for achieving >95% been completed?	Not applicable
	ELEMENT 4 Effective fetal monitoring during labour	Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when	We are fully compliant with this standard subject to Board approval and recording of this approval in Board minutes. In terms of meeting the standard – the Trust is fully complaint Data from 31.5.21 ➢ CTG (taught session): ➢ 93% Midwives ➢ 100% Consultants ➢ 90% Registrars ➢ 97% all staff ➢ Compliance met

		this is permitted?	Fetal monitoring lead midwife and lead obstetrician in post and providing additional face-to-face training within clinical areas.
		If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shortfall in reaching the 90% and commit to addressing those?	Not applicable
		Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment. Have training resources been made available to the multi-professional team members?	Mandatory assessment (K2): 90% Midwives 100% Consultants 90% Registrars 95% all staff Compliance met K2 fetal monitoring training system available to all staff
		If the process metric scores are less than 90% for Element 4 standard b), has the trust board identify shortfall in reaching the 90% and commit to addressing those when this is permitted?	Not applicable
	ELEMENT 5 Reducing preterm births	Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth Has standard a) been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes – audit compliance 80%

		If the process metric scores are less than 85% for Element 5 standard a), has an action plan for achieving >85% been completed?	Action plan in place.
		Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. Has standard b) been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes – audit compliance 100%
		If the process metric scores are less than 85% for Element 5 standard b), has an action plan for achieving >85% been completed?	Not applicable
		Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Has standard c) been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes – audit compliance 91.8%
		If the process metric scores are less than 85% for Element 5 standard c), has an action plan for achieving >85% been completed?	Not applicable
		Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm	Additional Obstetric Consultant appointed and preterm birth clinic commenced on 26.3.21. Policy in place, which includes cervical length assessment. Audit completed, 93.3% compliance (1 woman gave birth more than 7

		birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	days after steroids).
7	Can you demonstrate that you have a patient feedback mechanism for maternity service and that you regularly act on feedback?	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes - Terms of Reference in place and copy saved
		Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Minutes of quarterly meeting, plus additional meeting to identify how feedback could be obtained from women from ethnic minority backgrounds. Minutes of the personalisation and choice workstream, attended by MVP representative. MVP work plan detailing activities for June to September 2021 period.
		Do you have evidence of service developments resulting from coproduction with service users?	We have developed a range of services and initiatives with services user including: ➢ Personalisation and Choice in Pregnancy and Birth ➢ We have co-produced COVID-19 Frequently Asked Questions with the MVP and wider system. These are reviewed on a fortnightly basis. ➢ Developed a SOP for perinatal support for BAME ➢ Locally we engage with families regarding how to improve services. Examples include, development of leaflets,

			development of electronic resources ➢ A Devon-wide Maternity Voices Partnership (MVP) was commissioned in the latter part of 2018. The MVP is independent of any providers. Formal meetings were re-established in May 2019, with TSD having a user rep participating. ➢ The Local Maternity System in conjunction with the MVP commissioned a Devon-wide user engagement programme. This has been used to establish the priorities for developing maternity services across Devon. The MVP also participates in the Devon LMS Board meetings. ➢ Engagement is through a number of mediums, with electronic appearing to be the favoured approach for women. We have active Facebook pages – maternity and breast feeding, which are valued by women and their families. They are able to provide feedback, positive and areas for improvement. It also provides the service with the opportunity to feedback any changes. An example being COVID-19 visiting ➢ As part of duty of candour, with any serious incidents we ask the families to provide feedback, encourage them to ask any questions and meet with them to discuss the findings. ➢ Feedback and engagement are specific topics that are addressed at a number of meetings, including: LMS Board meeting, Maternity Clinical Governance meeting ➢ We also encourage women to feedback through the friends and family form, which is provided in paper and electronic format
		Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	Yes, in place - service user chair has recently stepped down. The vice chair has provided written confirmation of remuneration for them. They have confirmed that the service user members are able to claim out of pocket expenses.
		Do you have evidence that the MVP is prioritising the voice of woman from	Co-production of standard operating procedure (SOP) 'Perinatal Support for Black, Asian and Minority Ethnic Women During COVID-19

		Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Pandemic' https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G2674.pdf In addition, the MVP workplan includes how to improve diversity of outreach, this includes women from ethnic minorities and families who live in areas of high deprivation.
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies session within the last training year.?	Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:	COVID-19 specific E-learning available to staff listed below.
		Obstetric consultants	Yes
		All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Yes
		Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
		Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
		Obstetric anaesthetic consultants	Yes
		All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric	Yes

		rota	
		Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Not applicable as none of these staff providing care on the maternity unit. For the purpose of the CNST submission, the maternity will mark this as yes, as there is no not applicable option available on the form.
		Can you evidence that 90% of all staff groups in line 1-7 above have attended the multi-professional training outlined in the technical guidance?	Yes – see appendix 2 for details of each staff groups compliance
		If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	Not applicable
		NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019	In-house training provided by NLS qualified instructors

		Neonatal Consultants or Paediatric consultants covering neonatal units	Yes - 28% - dates have been booked.
		Neonatal junior doctors (who attend any deliveries)	Yes - 100%
		Neonatal nurses (Band 5 and above)	Yes – 90%
		Advanced Neonatal Nurse Practitioner (ANNP)	Yes – 100%
		Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes – 93%
		Can you evidence that 90% of all staff groups in line 10-14 above have attended the neonatal resuscitation training as outlined in the technical guidance?	No - see above and appendix 2 for details
		If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	Due to COVID-19 face-to-face training was restricted. The NLS instructors have now reintroduced face-to-face training and have focussed on achieving compliance with the neonatal nursing team and paediatric junior doctors. The team are currently working with the Paediatric Consultant team to gain full compliance. We are fully compliant with this standard subject to Board approval and recording of this approval in Board minutes.

9	Can you demonstrate that the trust safely champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Version 1 developed 25.2.20 Version 2 developed 25.11.20
		Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	Displayed in all clinical areas
		Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Included in safety champion pathway, version 1 & 2.

		Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?	Yes
		Was a monthly feedback session for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	14.1.20 19.2.20
		Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	Meetings held 19.11.21, 8.1.21, 11.3.21, 17.5.21
		Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Minutes of monthly meeting clearly details actions and progress against concerns raised. These are stored in a shared IT area for maternity and neonatal services. You said, we did poster developed and displayed in clinical areas.
		Is the progress with actioning named concerns from staff workarounds visible from no later than 26 February 2021?	Minutes of monthly meeting clearly details actions and progress against concerns raised. These are stored in a shared IT area for maternity and neonatal services. You said, we did poster developed and displayed in clinical areas. Pathway posters displayed in clinical areas detail how staff can access action relating to concerns raised.

		Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	Action plan in place. Reviewed in October 2020 and able to demonstrate meeting achievement of national trajectories. Plan updated and agreed by Board Level safety Champion. In light of action plan being closed and meeting national trajectories, no requirement to be overseen by Board. Maternity dashboard shared with Chief Nurse (Executive Board Member) on a monthly basis, which details continuity of carer rates.
		Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Maternity service continuity of carer model established in March 2020 was designed to meet needs of women from ethnic backgrounds and the most deprived areas. Data demonstrates compliance with minimum trajectory. Dashboard detailing compliance shared on a monthly basis with Board level safety champion.
		Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed I) Maternal and neonatal morbidity and mortality rates including a focus on women	Action plan developed drawing on two named reports. 27.11.20 action plan approved by Board Safety Champion. Outline of actions taken in response to letter for targeted perinatal support shared with Devon Local Maternity and Neonatal System.

		who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020? II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III) The MBRRACE-UK SARS-COVID19 report IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	
		Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	Action plan developed drawing on two named reports. 27.11.20 action plan approved by Board Safety Champion.
		Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas: • work with Patient Safety Networks, local maternity systems, clinical networks,	Evidence folder of attendance at MatNeoSIP events, clinical network safety forum meetings, LMNS. These include extra-ordinary meeting relating to COVID-19 Maternity service has completed SCORE survey twice, once in 2017 and repeated in 2019.

		commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems • utilise SCORE safety culture survey results to inform the Trust quality improvement plan • Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	All qualifying incidents meeting criteria for Each Baby Counts reported to NHS Resolution EN scheme via HSIB 3/3 (100%)
		Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	All qualifying incidents meeting criteria for Each Baby Counts reported to HSIB 3/3 (100%)
		For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	1. Between October 2020 and March 2021, there was one case that met the criteria for referral to HSIB, the family received a phone call from the Trust contact to inform them of the role of HSIB and also a letter to follow up on this phone call. This case did not meet the criteria for referral to the Early notification scheme. 2. They received a duty of candour of letter from the Trust.

		Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	Database maintained by both Maternity and the Litigation services. Any qualifying cases are highlighted to the Board through the quarterly Maternity Governance and Safety Board report.

Table 2: CNST: 10 Safety Actions. Summary of Evidence

The evidence to support the 10 safety actions is stored electronically within the Maternity Services Shared Drive Dir_Man (\\sdhfs03): CNST 2021; CNST May 2021. This can be accessed by the senior staff within the maternity services to demonstrate compliance as required. The Chief Nurse, South Devon and System Director of Nursing also have access to this evidence.

NHSR have provided technical guidance and conditions to support collation of evidence and completion of declaration. These can be accessed via the following link:

Maternity-Incentive-Scheme-year-3-guidance-FINAL-revised-April-2021.pdf (resolution.nhs.uk)

At the recent Devon Local Maternity System Safety and Governance Workstream, the 4 providers reviewed the position of each Trust to ensure that each had taken the same approach to benchmarking and providing evidence. The members of the workstream were assured that this was the case. As part of the CNST submission and approval process, there must be evidence of this declaration being discussed with commissioners. A draft Report has been submitted to the ICS Chief Nurse

4.0 Summary of Actions Required by Trust Board

There are three remaining elements to complete to gain full compliance.

I) Confirmation that an action plan has been produced to show how the Trust is working towards meeting the neonatal nursing workforce standards that is signed off by the Board
II) Written commitment by the Board to facilitate local, in-person, fetal monitoring training when this is permitted.
III) Written commitment by the Board to facilitate local, in person multi-disciplinary training when this is permitted.

In addition,

- Documentation within Board minutes that Trust compliance with anaesthetic standards (section 3 – standard 4 of this paper)

The Trust Board will need to confirm that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
- The content of this form has been discussed with the commissioner(s) of the trust's maternity services
- There are no reports covering either this year (2020/21) or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
- We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

5.0 Conclusion

The Maternity Service has worked extremely hard to ensure that processes and systems are in place to meet the requirements set by NHS Resolution. These 10 key actions are designed to drive safety improvements within maternity and neonatal care.
This report provides a summary of the evidence of achievement of the 10 safety actions.
The Board are now required to review the evidence provided to assure themselves of achievement of the standards. The Chairman will need to sign the Board declaration on behalf of the Board.

6.0 Recommendations

1. Review the report and evidence that supports declaration of compliance with CNST Standard
2. Note and approve the action plan to show how the Trust is working towards meeting the neonatal nursing workforce standards
3. Provide written commitment to local, in person fetal monitoring training and multi-disciplinary training subject to COVID restrictions in place
4. Document compliance with the anaesthetic standards within the Board Minutes
5. Confirm the Trust position of compliance against all 10 Safety Actions that enables the Chair to sign the declaration form on behalf the Trust

Appendix 1: Neonatal Nursing Workforce Action Plan

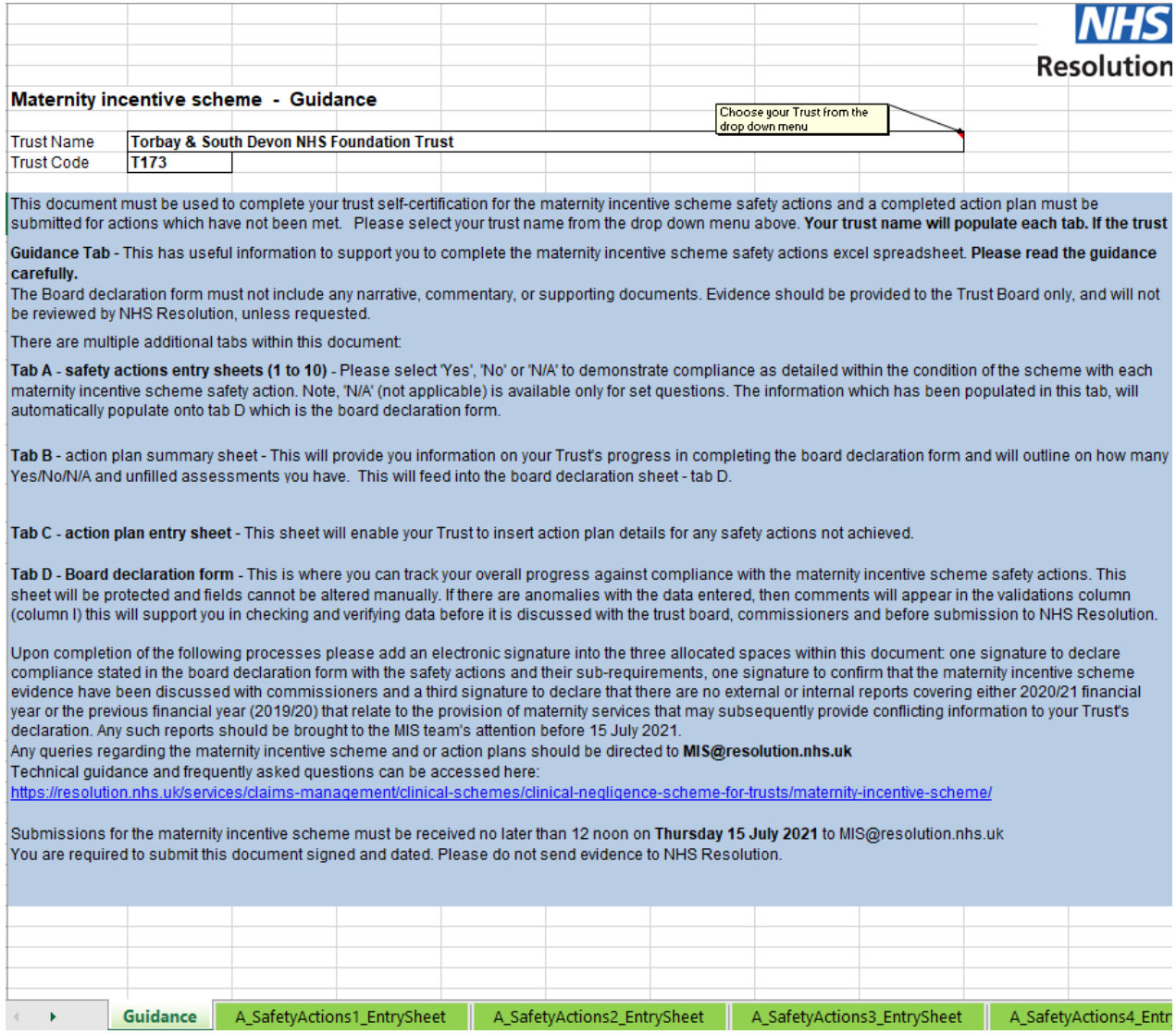
Introduction:
There are required service specifications for neonatal nursing standards. A review of the nursing establishment for the Special Care Baby Unit (SCBU) at Torbay and South Devon NHS Foundation Trust has been completed. It identified that additional staffing resource was required to ensure nurse staffing met the national recommendations. This assumes 80% bed occupancy.
Workforce analysis:
Number of additional Registered Nurses required: +3.85wte, of which 1.54wte should be Qualified in Specialty (QIS)
Number of Non-Registered Workforce required: -0.58wte
Action plan:

Monitoring:
The action plan will be presented to the Trust Board as part of the Maternity Incentive Scheme (CNST) requirements and shared with the ODN and RCN.
This action plan will be monitored through the monthly SCBU clinical governance meeting, and progress will be reported through the usual Trust governance processes.

ACTION PLAN FOR TO MEET NEONATAL NURSING ESTABLISHMEMT STANDARDS					
ACTION NUMBER	**ACTION**	**CURRENT STATUS**	**RESPONSIBLE**	**COMPLETION BY DATE**	**COMPLETED**
1	To work with neonatal network to submit a bid for additional staffing in response to the Neonatal Critical Care Review (NCCR)	▪ Bid submitted	Child Health Matron	31 January 2021	January 2021
2	To commence recruitment into posts once funding has been received for year 1, 2021/22	▪ Recruitment in progress	Ward manager	31 October 2021	
3	To commence recruitment into posts once funding has been received for year 2, 2022/23	▪ Not yet started	Ward manager	31 October 2022	
4	Skill mix to increase Registered Nurses, when Non-Registered vacancies arise	▪ Not yet started	Ward manager	To be confirmed	
5	Risk register to be updated reflecting workforce analysis finding and mitigations taken in response, including this action plan	▪ In progress	ADNPP	30 June 2021	

Appendix 2 Screen Shots of Board Declaration Form

Tab 1: Guidance



NHS Resolution

Maternity incentive scheme - Guidance

Choose your Trust from the drop down menu

Trust Name	**Torbay & South Devon NHS Foundation Trust**
Trust Code	**T173**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**
The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the three allocated spaces within this document: one signature to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the maternity incentive scheme evidence have been discussed with commissioners and a third signature to declare that there are no external or internal reports covering either 2020/21 financial year or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 15 July 2021.
Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 15 July 2021** to MIS@resolution.nhs.uk
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Guidance | A_SafetyActions1_EntrySheet | A_SafetyActions2_EntrySheet | A_SafetyActions3_EntrySheet | A_SafetyActions4_Entr

Tab A: Example of Safety Action Entry Sheet

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	N/A
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Guidance | A_SafetyActions1_EntrySheet | A_SafetyActions2_EntrySheet | A_SafetyActions3_EntrySheet | A_SafetyActions4_EntrySheet | A_SafetyAction ...

Tab B: Safety Summary action sheet

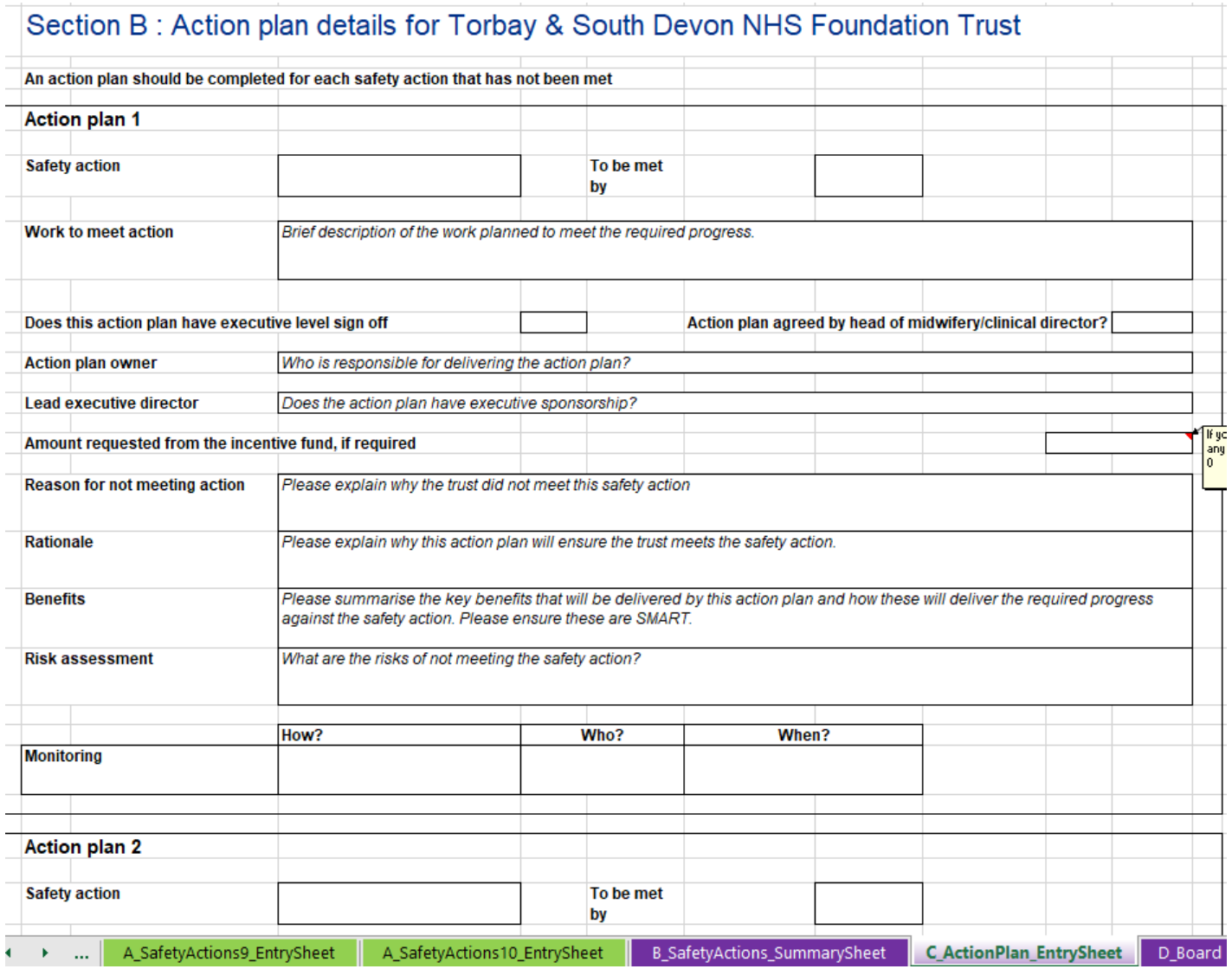
Current status at time of completion of Baord report. 100/103 met. Anticipate full complinace in time for submission.

Section A : Maternity safety actions - Torbay & South Devon NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	2	0	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No	3	1	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	No	32	1	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	No	13	1	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi monthly with Board level champions to escalate locally identified issues?	Yes	19	0	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes	4	0	0

... | A_SafetyActions8_EntrySheet | A_SafetyActions9_EntrySheet | A_SafetyActions10_EntrySheet | B_SafetyActions_SummarySheet | C_Action

Tab C: Action Plan Entry Sheet



Section B : Action plan details for Torbay & South Devon NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

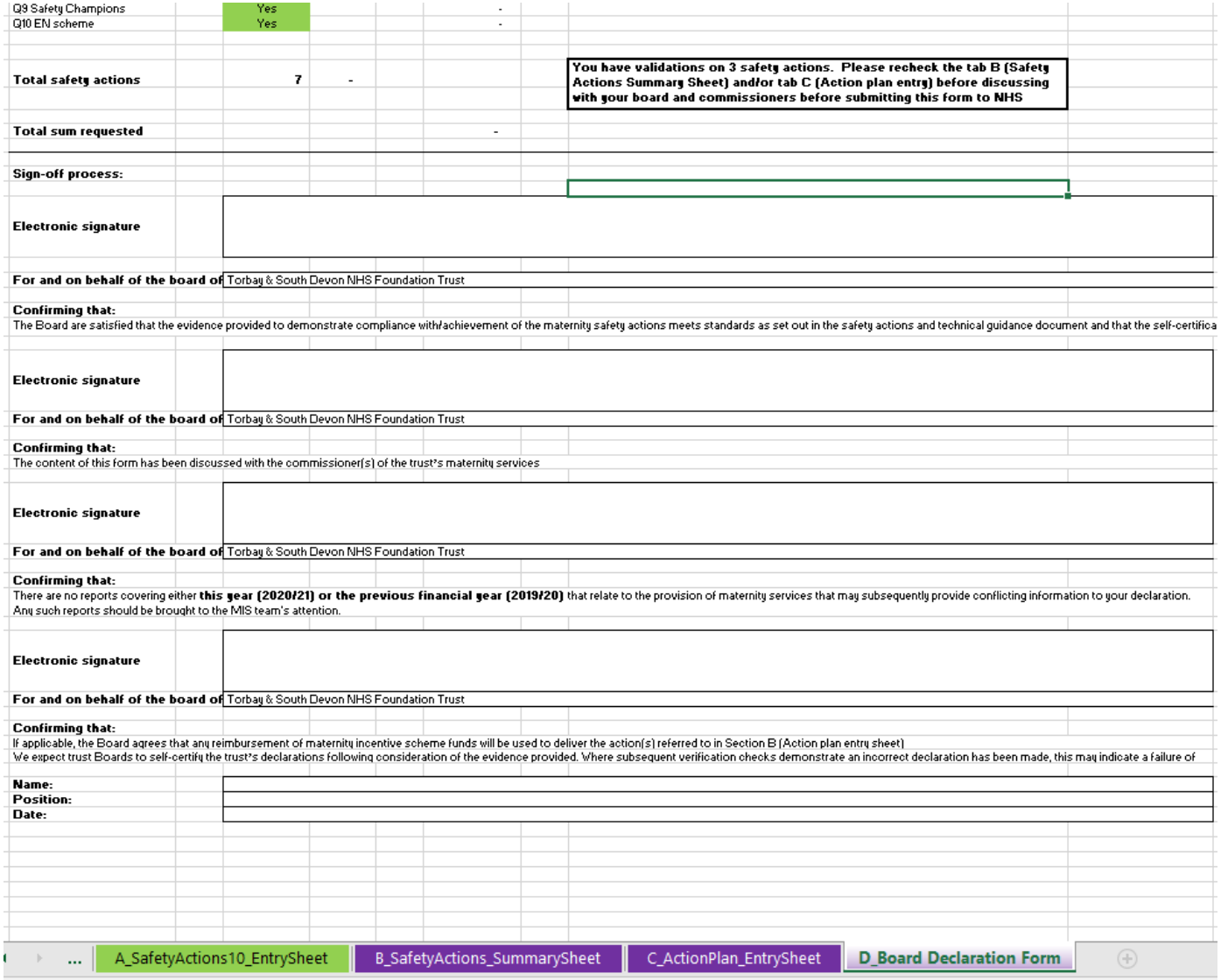
	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	

... A_SafetyActions9_EntrySheet | A_SafetyActions10_EntrySheet | B_SafetyActions_SummarySheet | C_ActionPlan_EntrySheet | D_Board

Tab D: Board Declaration Form



Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**7**	-		**You have validations on 3 safety actions. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS**
Total sum requested			-	
Sign-off process:				
Electronic signature				
For and on behalf of the board of	Torbay & South Devon NHS Foundation Trust			
Confirming that:				
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certifica				
Electronic signature				
For and on behalf of the board of	Torbay & South Devon NHS Foundation Trust			
Confirming that:				
The content of this form has been discussed with the commissioner(s) of the trust's maternity services				
Electronic signature				
For and on behalf of the board of	Torbay & South Devon NHS Foundation Trust			
Confirming that:				
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.				
Electronic signature				
For and on behalf of the board of	Torbay & South Devon NHS Foundation Trust			
Confirming that:				
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet) We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of				
Name:				
Position:				
Date:				

... | A_SafetyActions10_EntrySheet | B_SafetyActions_SummarySheet | C_ActionPlan_EntrySheet | D_Board Declaration Form

Appendix 3 – Maternity Mandatory Training Position as of 31 May 2021.

Table 3: In-house multi-professional emergencies.

Attendance: May 2021												
Training day/session	No. staff eligible to attend	Midwives eligible	MSW's eligible	Medical Staff eligible	Total staff attended	Midwives attended	MCA's attended	Medical Staff attended	% staff attended	% of Midwives attended	% of MCA's attended	% of Medical Staff attended
BLS, NLS, FM, Blood	158	110	30	18	153	102	28	18	97	93	93	100
Obstetric PROMPT (K2)	144	109	17	18	144	102	16	16	100	94	94	90
Electronic CTG e-learning	128	110		18	121	98		17	95	90		94
Anaesthetic staff (PROMPT)	42				38				90			

Table 4: Neonatal resus training

Staff group	Attendees	% attendance
Midwives	102	93%
Neonatal nurses	17	90%
Advance Practitioners	1	100%
Consultant Paediatricians	4	28%
Paediatric Registrar	11	100%
Paediatric SO	10	100%

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Draft Building a Brighter Future (BBF) Strategic Outline Case			**Meeting date:** 30th June 2021
Report appendix	Appendix 1: NHP Strategic Outline Case		
Report sponsor	SRO, New Hospital Programme		
Report author	Programme Director, New Hospital Programme		
Report provenance	Re-development Committee People Committee Finance, Digital and Performance Committee		
Purpose of the report and key issues for consideration/decision	To give members of the Trust Board an overview of draft Strategic Outline Case		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendations	The Trust Board are asked to receive and note the content of this paper.		

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**	12
Risk Register		**Risk score**	

BAF Objective 11: To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring it meets the needs of the local population and the Peninsula System

External standards affected by this report and associated risks

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

Report title: Draft Building a Brighter Future Strategic Outline Case		Meeting date: 30th June 2021
Report sponsor	SRO, New Hospital Programme	
Report author	Programme Director, New Hospital Programme	

1. Purpose of Report

This paper has been written to give members of the Trust Board an overview of the draft Strategic Outline Case. The final version of the Strategic Outline Case (SOC) will be presented to the BBF Redevelopment Committee and thereafter to the Trust Board in July. Subject to the approval of the SOC, it will then be forwarded to the NHSE/I Regional team for their assessment and subsequent presentation to the NHSE/I national team.

Members of the Trust Board are asked to note the progress that has been made.

2. Current position

A significant amount of work has been undertaken to progress the SOC to this stage. This version of the SOC does still requires further amendment, particularly in relation to ensuring that the language used in the document is consistent throughout. In addition, all appendices to the document also need to be included in the final version. However, this document is now completed in sufficient detail to commence all the necessary internal and external engagement, and on that basis, the Board sub-committees of People; Finance, Performance and Digital and Redevelopment will receive a draft of the SOC in June to provide an opportunity for the respective committees to make comment/request amendment before the preparation of the final version in July. Quality Committee did receive an update in May, but do not meet in June.

The supporting information contained in this paper therefore presents the draft SOC to members of the Trust Board

3. Strategic Outline Case

The 3rd draft of Strategic Outline Case has now been completed and was sent to all Executive Directors and members of the BBF committee on Friday 11th June, and has therefore not been included in this paper. However, to provide more background a slide deck to assist with the SOC presentation has been included (see appendix A)

Key points for the committee to note:

- It is important to note that the SOC is not required to highlight a preferred shortlisted option, it is however required to confirm an initial preferred way forward. This is clearly highlighted within the digital and infrastructure components of the SOC.
- The initial preferred way forward for infrastructure and digital are both delivered within the affordability threshold of £370m. This includes a

£20m uplift to the £350m NHP allocation to be supplied from Trust resources.

- From the planning assumptions that have been made, the revenue position of the Trust is made sustainable in the longer term with recurrent surplus made from 2034 onwards.
- The SOC is aligned to the position of the other NHP sites within the SW peninsula. TSD, UHP and ND are all aligned in terms of content (particularly in relation to planned care) and also in terms of timetable for presentation.

4. Next Steps

Following this round of discussions with board sub committees and Trust Board, the following actions will be taking place:

(i) All comments will be addressed in a final version which will be prepared by 15th July
(ii) All appendices will be included in the final version
(iii) External engagement will continue and letters of support will be included in the final version
(iv) The final version will be circulated to all sub committees and the Trust Board for their July meetings and subject to approval the SOC will be submitted to NHSE/I on 28th July

5. Project risks

Summary

The programme office has already developed a detailed risk register and this will be proactively managed and reported on throughout the life cycle of the project. This risk register covers the work of all workstreams within the programme and the Programme Director and NHP Programme Manager will ensure that the level of risk within the programme continues to be reviewed and mitigated and when appropriate closed down.

The figure below illustrates the current top 5 risks of the programme (as at 31st May 2021).

Ref No	Programme Stage	Workstream	Risk Description	Prior to mitigation - Probability	Prior to mitigation - Impact	Prior to mitigation Risk Rating	Action Plan Completed?	Time / Cost Impact	Mitigation	Post mitigation Probability	Post mitigation Impact	Post mitigation Risk Rating
19	OBC	Support Service	Lack of alignment across Devon for certain support services e.g. switchboard	4	4	16		Time & Cost	Torbay and South Devon's position , once defined, will be shared with partners for further discussion and agreement. This area has to be addressed by the health economy to ensure OBC and FBC approval.	4	4	16
50	FBCOBC	Business Case Authorship	Trust planned operational efficiency requirements not delivered (CIP) to underpin investment	4	4	16		Cost	- This areas remains a top priority for the operational teams to address. A risk mitigation plan will need to be developed to address this specific issue	4	4	16
125	Commissioning	Workforce	Trust workforce plan not delivered - staff numbers required and skill mix	4	4	16		Time	- This will remain a significant risk untill the completion of the programme. The workforce plan will be delivered during the business case phases for OBC and FBC as they are fundamental to the delivery	4	4	16
142	FBCOBC	Business Case	Site enabling budget is insufficient to cover the cost of the scheme	4	4	16		Time & Cost	- Business case will not be submitted until the cost of the project has been agreed - Most enabling work will be delat with through BAU Trust Capital, however for matters that need to be addressed with the PSCP an early cost plan will be required from the PCSP to agree the position as early as possible.	4	4	16
23	OBC	Support Service	Inability to capitalize on the expected efficiencies from shared services	5	3	15		Cost	The planning advisors and the programme office have already agreed the requirement to reduce to 16,000m2 therefore this requirement has to be delivered at OBC and FBC.	5	3	15

Top 5 risks

The top 5 risks as noted within the programme office risk register are noted below. All the risk scores noted are post mitigation scores

1. **Lack of alignment across Devon for certain support services e.g. switchboard (risk score 16)**
   This risk addresses the requirement for alignment of all providers within the South West peninsula on the issue of clinical and non-clinical support services. The objective being to ensure that the provision of these services is delivered as efficiently as possible, which may require services to be provided across the region rather than by each provider. Torbay and South Devon's position, once defined, will be shared with partners for further discussion and agreement. This area has to be addressed by the health economy to ensure OBC and FBC approval

2. **Trust planned operational efficiency requirements not delivered (CIP) to underpin investment (risk score 16)**
   Torbay and South Devon recognise that the delivery of a sustainable break-even position is a significant challenge and as such this area remains a top priority for the operational teams to address.

   A strategic transformation plan for the Trust will need to be in place on completion of the OBC / FBC. This will be agreed across the organisation and then passed to the transformation team to deliver.

3. **Trust workforce plan not delivered - staff numbers required and skill mix (risk score 16)**
   This will remain a significant risk until the completion of the programme. The workforce plan will be delivered during the business case phases for OBC and FBC as they are fundamental to the delivery of the Trust affordability models. Once agreed, the implementation will take place from FBC approval and will be required to be in place by the end of the construction period.

   This risk will remain at a high level until the new workforce model has been safely implemented.

4. **Site enabling budget is insufficient to cover the cost of the scheme (risk score 16)**
   These costs will be fully detailed at the Outline Business Case stage, and this case will not be submitted until the cost of the project has been agreed.

   Most enabling work will be dealt with through Business as Usual Trust Capital, however for matters that need to be addressed with the PSCP an early cost plan will be required from the PCSP to agree the position as early as possible. The Trust recognises the requirement to deliver this programme of works within the overall affordability threshold for the project.

5. **Inability to capitalize on the expected efficiencies from shared services (risk score 15)**
   The planning advisors and the programme office have already agreed the requirement to reduce to 16,000m2 therefore this requirement has to be delivered at OBC and FBC.

   The aspect of the project will be fundamental to the overall delivery as some of the assumptions being made in relation to site enabling are that they will be addressed by the support services workstream, and will therefore not be reprovided within the NHP investment. Again, as with some of the other risks noted it is likely that this risk will remain high throughout the life cycle of the programme.

6. Summary

As mentioned a significant amount of work has been undertaken to get the SOC into the format presented. The SOC presents a strong case of need and is delivered within the overall affordability set by the New Hospital Programme, on that basis the programme office would recommend that it can be presented to the Trust Board and all sub committees in July.

In terms of next steps, the programme office is sighted on the transitional requirements for the OBC stage and also the engagement requirements that are very likely in respect of the elective care strategy for Devon.

7. Conclusion

Members of the Trust Board are asked to note the progress that has been made.

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NHP Strategic Outline Case

Update

14 June 2021

Our Estate
Our People
Our Digital

Outline

- Status update and timeline recap
- Update on latest draft SOC
- Update on Estates and Digital initial preferred way forward
- Revisit key financial questions
- Next steps
- Summary

Current status and plan

SOC development on schedule
Second draft of SOC complete
Updated financials included (refinement required)

May	• Review of draft financial models with PWC • Revise cost estimates • Further benefits workshop • Include option F
June	• Restate financial models • Internal and external engagement commenced • Review with regional NHSEI team • Further refinement of financials ahead of submission
July	• Approval by Redevelopment Committee and Board • Submission to NHSEI

Our work in recent weeks

- Strengthened the overall flow to align the five cases and create a consistent ‘golden thread’ throughout the case
- Ensured the narrative is consistent across the cornerstone workstreams which underpin the overarching programme of work
- Improved clarity - reduced jargon and improved wording
- Financial analysis added in Economic Case and Finance Case
- Other gaps in first draft now completed
- Improved formatting and branding
- Tested against NHSEI fundamental criteria
- Some further refinement on language still required

The strategic case has been strengthened by

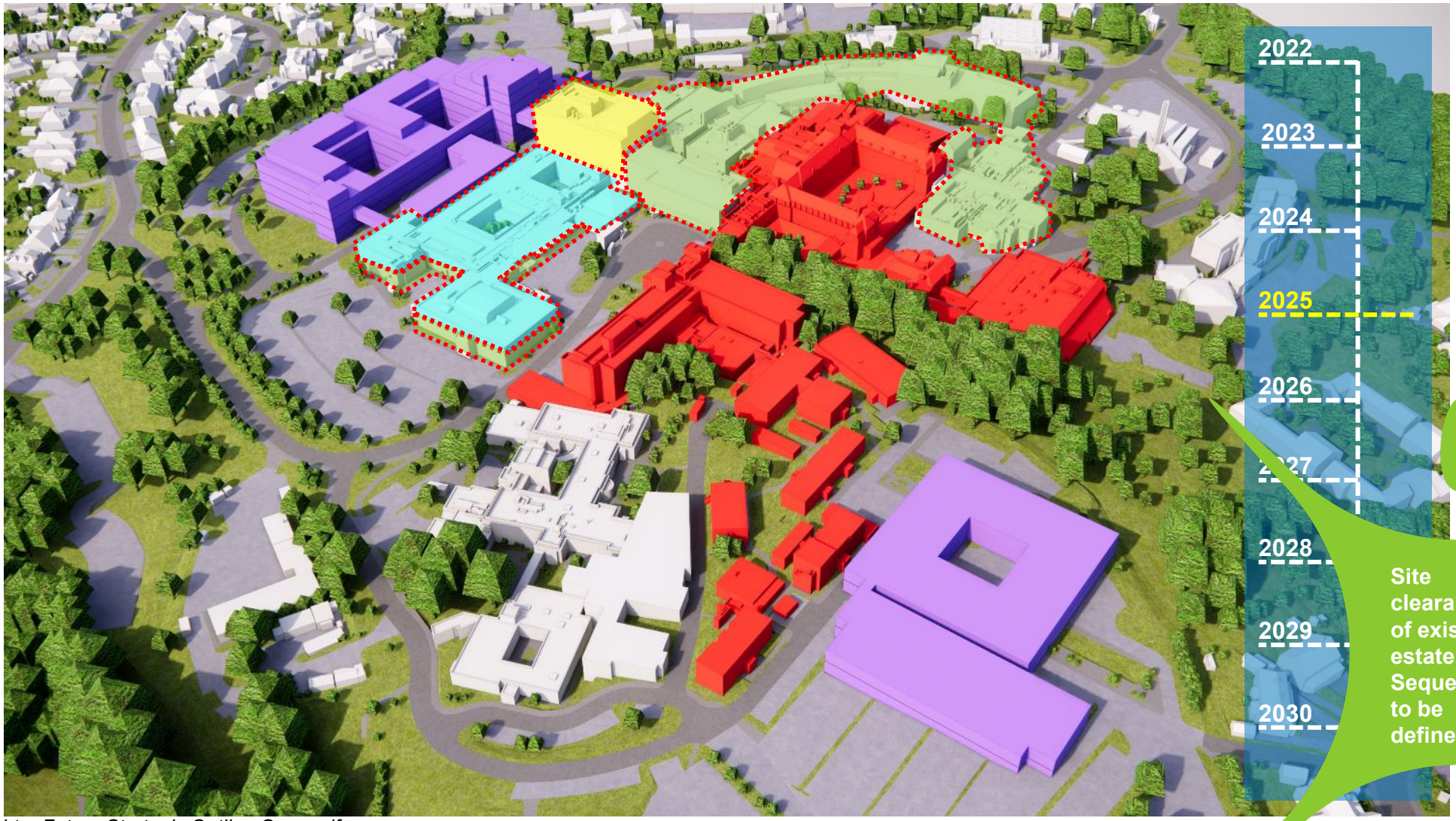
- Developing narrative to provide an improved regional perspective
- Aligning the narrative relating to the Trusts strategic risks with the narrative relating to the Programme's risk management processes
- Preparing the overview relating to the condition of the estates infrastructure in preparation for further detail which will be delivered via the six facet survey

Estate initial preferred way forward update

- Estates Infrastructure Option 1 – Counterfactual
- Estates Infrastructure Option 2 – Do Minimum
- Estates Infrastructure Option 3 – DCP Option F
- Estates Infrastructure Option 4 – Intermediate
- Estates Infrastructure Option 5 – Do Maximum

Our Estate REIMAGINED

DCP Option F


2022
2023
2024
2025
2026
2028
2029
2030
Site clearance of existing estate. Sequence to be defined

DCP Option F

Torbay and South Devon NHS Foundation Trust

Item	Notes
Phase 1 & 2	15,650m2
Elective Care Phase 2	5,000m2
Total New Build Development	**20,650m2**
Refurbished Areas	Podium Level 3 – 3,797m2 / Tower 3,817m2
Total New / Refurbished Areas	**28,264m2**
Programme	2025 - 2028
Site Disruption / Risk	Low – limited interfaces with existing estate.
Planning risk	Medium - scale to North
Costs	£313m

Responds to HIP initiatives around MMC / Net Zero & feedback around 70:30 single / multi-bed bays solutions. HIP1 influences being tracked

Reprovision of inpatient medical beds and emergency surgery beds in the hospital

Separation of planned and unplanned services

Non clinical services to be moved off the hospital site

Emergency Department and SDEC services to be completely upgraded

Digital initial preferred way forward

- Digital side of the case requires further consideration
- Option 3 – open procurement of an EPR showing strongest economic case currently
- Financials require further work
- Need to reconsider further the value of a collaborative approach (options 4 and 5)

Our Digital CONNECTING

Is there likely to be an investment option that is?

1. Affordable in terms of the capital funding available?
2. Economic case - attractive in terms of value for money?
3. Finance case - affordable for the Trust in the long term?

Our Digital CONNECTING

Capital affordability

Capital funding Envelope:

NHP funding	£350m
Local capital	£ 20m
	£370m

	Option 2 – do minimum	Option 3 – DCP Option E	Option 4 – DCP Option D	Option 5 – Do maximum
Infrastructure	£25m	£314m	£322m	£987m
Digital (Option 3)	£58m	£58m	£58m	£58m
Combined	**£83m**	**£372m**	**£380m**	**£1,045m**

Economic case - digital

Table 2.16 - CIA outputs for Digital short listed options

Economic Summary	Option 1	Option 2	Option 3	Option 4	Option 5
Incremental costs					
Capital	-	(3,865)	24,226	25,281	24,405
Revenue	-	181,001	22,511	63,271	66,250
Risks	-	-	-	-	-
Total incremental costs	-	177,136	46,737	88,552	90,655
Incremental benefits					
Cash releasing	-	66,730	200,991	200,991	200,991
Non-cash releasing	-	45,313	155,360	155,360	155,360
Societal	-	-	-	-	-
Total incremental benefits	-	112,043	356,351	356,351	356,351
Risk-adjusted NPSV	-	(65,092)	309,615	267,800	265,696
Benefit:Cost Ratio	-	0.64	7.62	4.02	3.93
Overall ranking	N/A	4	1	2	3

Economic case - estates

Table 2.17 - CIA outputs for Estates Infrastructure shortlisted options

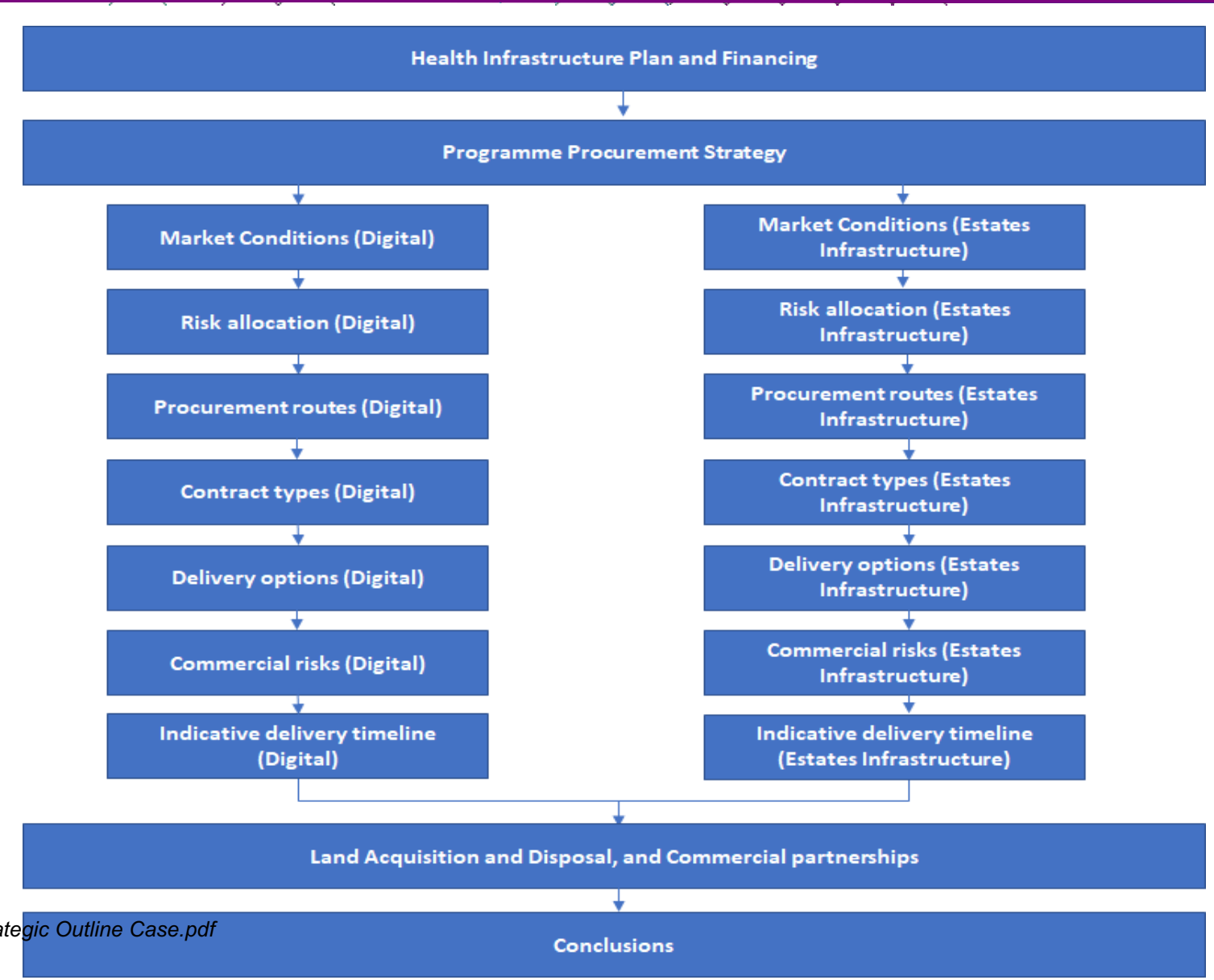
Economic Summary	Option 1	Option 2	Option 3	Option 4	Option 6
Incremental costs					
Capital	-	25,269	132,875	137,975	372,072
Revenue	-	-	5,811	5,811	6,710
Total incremental costs	-	25,269	138,686	143,786	378,782
Incremental benefits					
Cash releasing	-	-	67,213	64,815	91,345
Non-cash releasing	-	-	59,336	59,336	59,019
Societal	-	-	76,762	77,791	209,929
Risks	-	6,449	241,843	241,792	263,677
Total incremental benefits	N/A	6,449	445,153	443,733	623,970
Risk-adjusted NPSV	-	(18,820)	306,468	299,947	245,187
Benefit:Cost Ratio	N/A	0.26	3.21	3.09	1.65
Overall ranking	N/A	4	1	2	3

Economic case - combined

Table 2.18 - CIA outputs for Programme Initial Preferred Way Forward

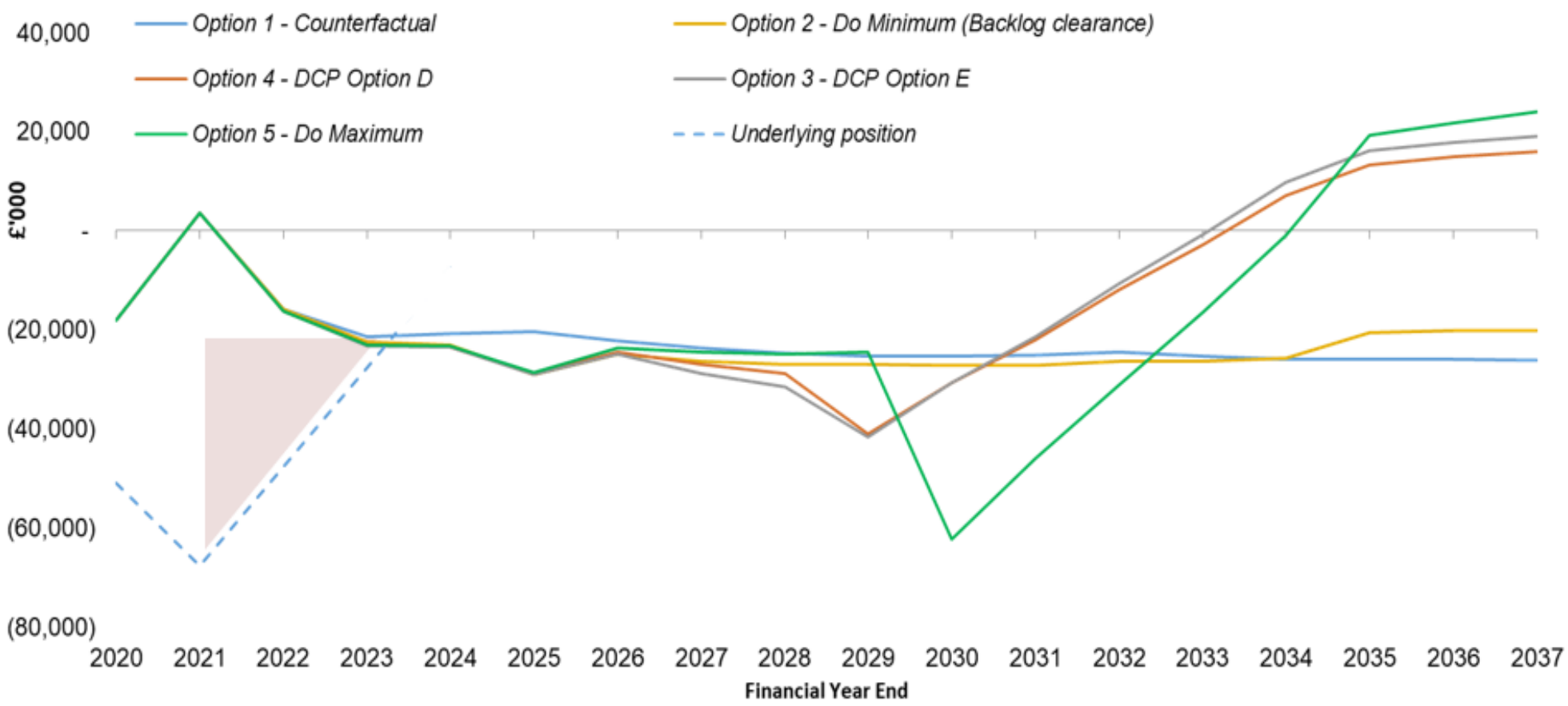
Economic Summary	Combined Initial Programme Preferred Way Forward
Incremental costs	
Capital	157,100
Revenue	28,321
Total incremental costs	185,421
Incremental benefits	
Cash releasing	268,204
Non-cash releasing	214,696
Societal	76,762
Risks	241,843
Total incremental benefits	801,505
Risk-adjusted NPSV	616,083
Benefit:Cost Ratio	4.32

Commercial case



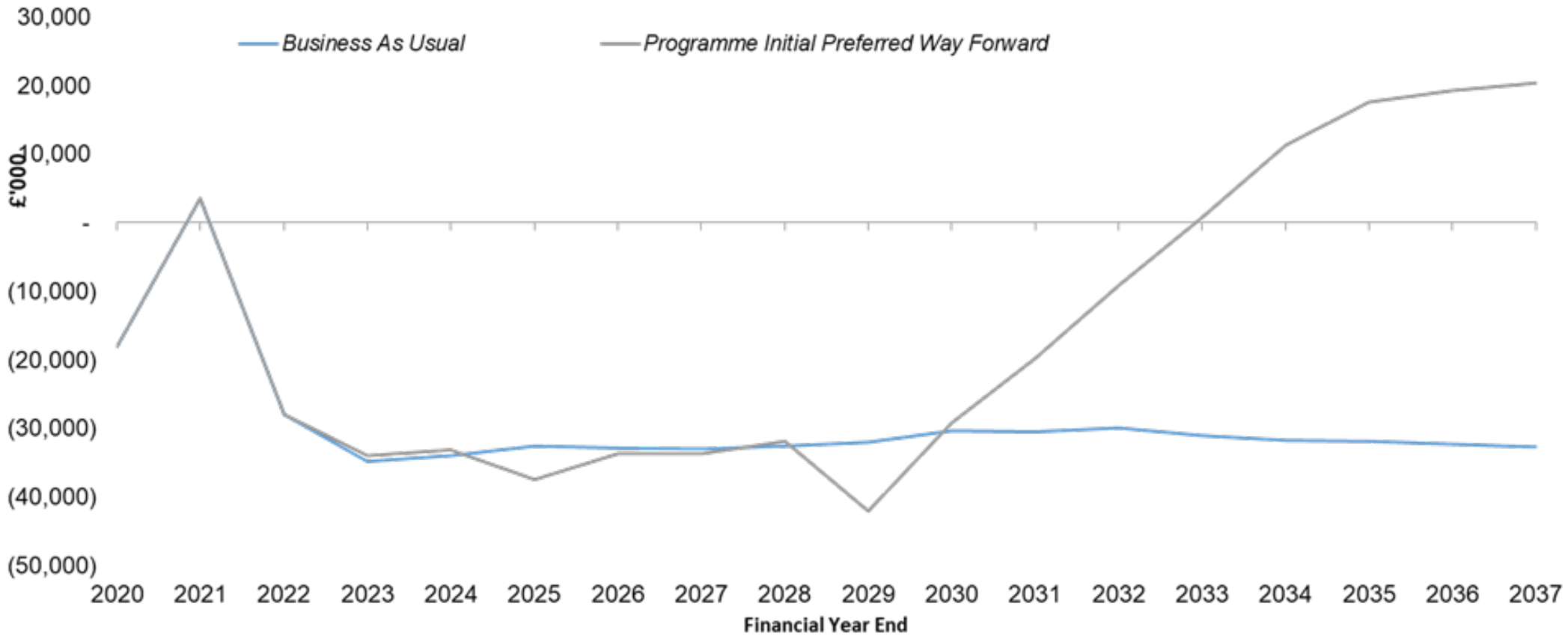
Finance Case – Affordability (Combined case)

Graph shared previously…



Finance Case – Affordability (Combined case)

Updated graph…



The management case has been strengthened by:

- Ensuring that the programme management structure reflects the skills and experience within the team
- Development of the narrative relating to the Programmes Change Management Strategy
- Reflecting the programmes approach to Communication and engagement
- Establishing the risk management process, including populating and costing the risk register
- Robust reporting and governance arrangements

Fundamental criteria – current self assessment

NHSEI fundamental criteria checks

Five case model category	Question	Self assessment	Comments
Strategic case	1		
	2		
	3		We have a full list of stakeholders that we intend to approach to secure a letter of support and are close to finalising the the briefing pack ahead of briefing sessions that are currently being scheduled.
	4		
	5		
Economic case	6		
	7		
	8		
Commercial case	9		
	10		
	11		
	12		
Finance case	13		
	14		Revenue affordability is subject to ongoing review and discussion with system partners. Incremental statements (including SoCI) to be added following discussion with Region.
Management case	15		
	16		Resource plan has been developed and will be incorporated into the SOC narrative and appended.
	17		We have set out a plan for change and contract management in the Management Case however we are in the process of reviewing the plan to ensure that it meet the reuqirements for SOC and the stage of the project that we are currently at.
	18		

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Next steps

Second draft of SOC produced	**31st May**
Devon system wide alignment	**7th July**
Review with Regional NHSEI team	**16th June**
Review by Board sub committees	**June**
Review at Redevelopment Committee	**23rd June**
Approval at CCG Board	**1st July**
Final approval by Trust Board	**28th July**
Submission to NHSEI	**28th July**

Summary

- Second draft SOC produced – good improvement
- Self assessment against fundamental criteria favourable
- Key financial questions answered but further work required (particularly digital)
- Clear plan of next steps
- On track to deliver the final SOC on time

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Thank you

Our Estate
Our People
Our Digital

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Report to the Trust Board of Directors			
Report title: Building a Brighter Future Communication and Engagement Plan			**Meeting date:** 30th June 2021
Report appendix	Appendix 1: Internal and External Engagement Appendix 2: Presentation – Our Opportunity		
Report sponsor	SRO Building a Brighter Future programme		
Report author	Building a Brighter Future Programme Director Associate Director of Communications and Partnership		
Report provenance	Building a Brighter Future Committee		
Purpose of the report and key issues for consideration/decision	To give members of the Trust Board an overview of the work being undertaken on the communications and engagement that is taking place in relation to the strategic outline case.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendations	Member of the Trust Board are asked to note the content of this paper		

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**	12
Risk Register		**Risk score**	

External standards affected by this report and associated risks

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

Report title: Building a Brighter Future Communication and Engagement Plan	Meeting date: 30th June 2021
Report sponsor & author	SRO Building a Brighter Future programme Building a Brighter Future Programme Director Associate Director of Communications and Partnership

1. Introduction

This paper has been prepared to give members of the Trust Board an update on the progress that has been made on with the external engagement of the Strategic Outline Case.

Members of the Trust Board are asked to note the contents of this paper.

2. Overview of the Communication and Engagement Strategy

The aim and objectives of the Communication and Engagement Strategy are noted below:

Our aim:

- to inform, involve and engage our people and communities in our vision to enable the successful delivery of our programme

Our objectives:

- For staff to understand the purpose of the programme and to have a range of opportunities to share their views and inform the development of the work
- For our key stakeholders to be kept informed and given regular opportunities to question, check and challenge our thinking and progress
- For patients and the public to be able to access accessible information easily in a range of formats about what we are doing and why we are doing it and have the opportunity to share their views, thoughts and feedback
- For all public engagement and consultation to be delivered in line with best practice, legal requirements, relevant timelines and in partnership with the Devon system

In relation to the current phase of planning (SOC) it is vitally important for our key stakeholders to be kept informed and given regular opportunities to question, check and challenge our thinking and progress. Through the engagement, with key stakeholders at this high-level, early stage, we will start to build a shared consciousness about why we are progressing with the BBF programme in terms of the challenges we face and the opportunity we have. Furthermore, support from our key stakeholders will strengthen our SOC submission and provide a strong platform to build on as we progress to OBC stage.

3. Progress to date

With regard to the progress that has been made to date, some of the key points to highlight are noted below: -

Strategy

- Initial actions to support each objective have been identified. These will be further developed via the Governors working group which is being established. Four Governors have volunteered to be part of the working group.
- For each action we are identifying timeframes, measurements, leads and interdependencies. Early draft of workplan attached for information.

- We are also developing the timeline for engagement and communications as part of the overall programme timeline.

- We are also working with the other NHP programmes in Devon to ensure consistency and minimise confusion for our audiences.

Immediate priorities

- SOC engagement - support the scheduling, delivery and capturing of feedback for the SOC – in progress.

- Delivery of full suite of templates and assets from ICE Creates and roll them out across all channels and empower colleagues to utilise appropriately. Organisational branding refresh project scheduled to action adoption trustwide alongside tone of voice and house style.

- Photography - agree brief, identify appropriate professional, agree fees, agree schedule, execute – photographer booked for w/c 21 June, scheduling in progress with a wide cross section of community, social care and hospital teams.

Key priorities for June

- Set up and establish working group with Governors to develop the communications and engagement strategy and plan for the OBC and FBC. Co-produce with input and guidance from NHSEI and CCG as appropriate. Monthly meetings will be established, first invitations to go out before the end of the month

- Work with Foundation Trust office to refresh the membership database. Commission company to write out to all members and move as many as possible onto online membership and then update demographic details at the same time.

- Work with Transformation Team and others to gather case studies of stories which support our direction of travel on digital, service changes, workforce roles and estate (staff and patient stories as well as stories which show our challenges). Initial conversations have begun, digital horizons on board for filming stories, story identification underway.

- Further develop our stakeholder mapping with our VCSE and system partners. This work is also in progress and running this alongside the development of the South Local Care Partnership engagement and communications approach

4. Planned engagement

Appendix A provides an overview of all the planned internal and external engagement that will take place throughout June and July. It is important to note that for meetings that cannot be held prior to the submission of the SOC, stakeholders will be offered private briefings. At this stage, it would appear as though most stakeholders will be engaged through a formal meeting/ presentation.

The timetable noted will be reviewed on a weekly basis by the Programme Director and Programme Manager, and this progress will be monitored through the fortnightly programme group meetings. The BBF Redevelopment Committee will receive updates on progress at the July meeting to receive the assurance that the engagement noted has taken place. In addition, as requested the Council of Governors have also received an update on all engagement activities.

Appendix B provides an overview of the external engagement presentation that will be given to all stakeholders within the engagement process.

5. Recommendation

Members of the Trust Board are asked to note the contents of this paper.

Appendix 1 – Internal and External engagement

Int & ext engagement timetable with socialization

	Task Name	Duration	Start	Finish	Assigned To	% Complete	Status
1	Present, scrutiny, approval of SOC (draft 1) Received 10/05/2021	25d	07/05/21	10/06/21		94%	
2	Redevelopment Committee	8d	07/05/21	18/05/21		100%	Complete
3	Develop finance slide deck for Redevelopment Committ	8d	07/05/21	18/05/21	Alan Welsh	100%	Complete
4	Internal Trust socialization of the SOC and the finance presentation	6d	11/05/21	18/05/21	Chris Knights	100%	Complete
5	Finance papers to be circulated for Redevelopment Committee	1d	11/05/21	11/05/21	Alan Welsh	100%	Complete
6	Overview of CIA and affordability slide deck presented to Redevelopment Committee	1d	18/05/21	18/05/21	Alan Welsh	100%	Complete
7	Present draft SOC to NHP Programme Team	1d	12/05/21	12/05/21	Chris Knights	100%	Complete
8	Exec Directors	5d	12/05/21	18/05/21	Chris Knights	100%	Complete
9	Share draft SOC to Exec Directors	1d	12/05/21	12/05/21	Chris Knights	100%	Complete
10	Present draft SOC to Exec Directors	1d	18/05/21	18/05/21	Chris Knights	100%	Complete
11	Present draft SOC to NHP Programme Team	1d	17/05/21	17/05/21	Chris Knights	100%	Complete
12	Torbay Overview and Scrutiny committee	1d	09/06/21	09/06/21	Chris Knights, Liz Davenport		Complete
13	Present draft SOC to Programme Group	1d	10/06/21	10/06/21	Chris Knights	100%	Complete
14	Second page turn with PwC	1d	01/06/21	01/06/21	Alan Welsh, Chris Knights, Sandi Clemo	100%	Complete
15	Present, scrutiny, approval of SOC (draft 2) Received 11/06/2021	17d	15/06/21	07/07/21		0%	
16	Exec review - 2nd draft	1d	15/06/21	15/06/21	Alan Welsh, Chris Knights, Rob Dyer	0%	Not yet due
17	Page turn with NHSEI regional team	1d	16/06/21	16/06/21	Alan Welsh, Chris Knights	0%	Not yet due
18	Redevelopment Committee - 2nd draft	1d	23/06/21	23/06/21	Alan Welsh, Chris Knights	0%	Not yet due
19	CCG Governing Body meeting- present - 2nd draft	1d	24/06/21	24/06/21	Chris Knights	0%	Not yet due
20	Finance, Performance and Digital Committee - 2nd draft	1d	28/06/21	28/06/21	Alan Welsh, Chris Knights	0%	Not yet due
21	People Committee - present - 2nd draft	1d	28/06/21	28/06/21	Chris Knights	0%	Not yet due
22	Peninsula Partnership Board - 2nd draft	1d	29/06/21	29/06/21	Chris Knights	0%	Not yet due
23	Board of Governors - present 2nd draft	1d	07/07/21	07/07/21	Chris Knights	0%	Not yet due
24	ICS Partnership Board review - 2nd draft	1d	07/07/21	07/07/21	Chris Knights	0%	Not yet due
25	Present, scrutiny, approval of SOC (final version) Expected 01/07/2021	7d	21/07/21	29/07/21		0%	
26	Redevelopment Committee - final version	1d	21/07/21	21/07/21	Chris Knights	0%	Not yet due
27	Finance, Performance and Digital Committee - final version	1d	26/07/21	26/07/21	Alan Welsh, Chris Knights	0%	Not yet due
28	Quality Assurance Committee - final version	1d	28/07/21	28/07/21	Chris Knights	0%	Not yet due
29	Present to Trust Board - final version	1d	28/07/21	28/07/21	Chris Knights	0%	Not yet due
30	Peninsula Partnership Board - final version				Chris Knights	0%	To be confirmed
31	CCG Governing Body meeting - final version	1d	29/07/21	29/07/21	Chris Knights	0%	Not yet due
32	SOC socialization	17d	15/06/21	07/07/21		0	
33	Trust Talks	1d	01/07/21	01/07/21	Adel Jones, Liz Davenport	0%	Not yet due
34	Staff side monthly forum meeting	1d	07/07/21	07/07/21	Chris Knights	0%	Not yet due
35	Joint Liaison Negotiation Committee				Chris Knights	0%	To be confirmed
36	Workforce & OD Team Meeting				Chris Knights	0%	To be confirmed
37	Local MPs	14d	15/06/21	02/07/21	Liz Davenport	0	Not yet due
38	Anthony Magnall	1d	15/06/21	15/06/21	Liz Davenport	0%	Not yet due
39	Kevin Foster	1d	02/07/21	02/07/21	Liz Davenport	0%	Not yet due
40	Anne Marie Morris				Liz Davenport	0%	To be confirmed
41	Steve Darling				Liz Davenport	0%	To be confirmed
42	Torbay Council Overview and Scrutiny Committee	1d	09/06/21	09/06/21	Chris Knights	100%	Complete
43	Devon County Council Overview and Scrutiny Committee				Chris Knights	0%	To be confirmed
44	League of Friends	1d	06/07/21	06/07/21	Chris Knights	0%	Not yet due
45	Brixham Town Council				Chris Knights	0%	To be confirmed
46	Exeter and Plymouth Universities				Chris Knights	0%	To be confirmed
47	South Primary Care Collaborative Board				Chris Knights	0%	To be confirmed
48	Devon County Council Public Health Lead				Chris Knights	0%	To be confirmed
49	Torbay Together	1d	18/06/21	18/06/21	Jane Harris	0%	Not yet due
50	Torbay Health and Wellbeing Board	1d	24/06/21	24/06/21	Chris Knights	0%	To be confirmed
51	Devon Local Medical Committee	1d	24/06/21	24/06/21	Chris Knights	0%	Not yet due

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Page 1 of 2

	Task Name	Duration	Start	Finish	Assigned To	% Complete	Status
52	Torbay Community Development Trust	1d	25/06/21	25/06/21	Chris Knights, Jane Harris	0%	Not yet due
53	Teignbridge District Council				Chris Knights	0%	To be confirmed
54	South Devon College	1d	16/06/21	16/06/21	Deborah Kelly	0%	Not yet due
55	South Hams District Council	1d	30/06/21	30/06/21	Chris Knights	0%	To be confirmed
56	Our people networks	1d	30/06/21	30/06/21	Chris Knights	0%	Not yet due
57	Governors and members	1d	07/07/21	07/07/21	Joanne Watson	0%	Not yet due
58	Healthwatch Devon	1d	17/06/21	17/06/21	Chris Knights	0%	Not yet due
59	Torbay Development Authority				Chris Knights	0%	To be confirmed
60	Torbay Culture	1d	24/06/21	24/06/21	Jane Harris	0%	Not yet due
61	Rowcroft Hospice	1d	22/06/21	22/06/21	Chris Knights, Jane Harris	0%	Not yet due
62	Teignbridge CVS	1d	01/07/21	01/07/21	Chris Knights	0%	Not yet due
63							
64							
65							
66							
67							
68							
69							

BUILDING A Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Our opportunity

June 2021

Our Estate
Our People
Our Digital

BUILDING A Brighter Future

Our opportunity

NHS Torbay and South Devon NHS Foundation Trust

- we have been given a share of £3.7 billion government funding for a new hospital development. This is a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people
- we are developing our strategic outline business case to make the case for investment in our services and that is why we are talking to you today – we want to share what we are doing and why we are doing it
- we want to build our brighter future together

Our Estate
Our People
Our Digital

Why it matters

- this is not only about building a better hospital in Torquay, but exploring opportunities to deliver our services in ways that provide better outcomes for our population and better working environments for staff across all the communities that we serve
- building a brighter future focuses on our estate, our people and our digital set-up – these are where our biggest challenges are and where we can have the most impact

Our Devon long-term plan

our Devon long-term plan (owned by local councils and the NHS) focuses on:

- new hospital developments in Torbay, Plymouth and North Devon, changing how we can deliver services and also modernising our GP estate
- investing in diagnostics and technology to do things differently
- more partnership working, sharing resources and helping each other to meet increasing needs

Our vision is developing…..

Our vision is a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes.

When we need care we have choice about how our needs are met, only having to tell our story once.

Our vision is developing…..

We will enable our whole community to live well and independently, managing their own health and wellbeing digitally or as close to home as possible

As an Integrated Care Organisation, we will get the best value for the community, working with people, carers and our partners to improve people and carers' experiences by providing accessible health and care and optimise health and wellbeing outcomes

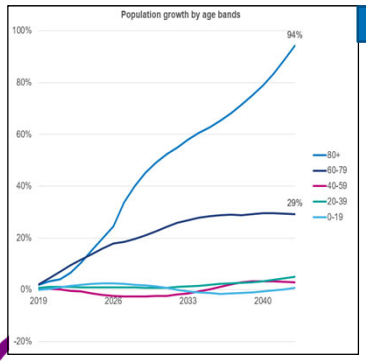
What this would mean for Dawn . . .

- Dawn has arthritis and has been experiencing difficulties with her mobility.
- She would be prescribed a range of physiotherapy measures to reduce the risk of surgical intervention.
- She regularly sees her GP who orders blood tests and a range of scans to keep her updated on her condition.
- She has her scans at her local diagnostic centre and these are reviewed virtually by the orthopaedic service
- If Dawn does have a hip replacement at her nearest planned care centre – she is discharged home the next day.
- All her pre-operative and post-operative care is provided either in her own home through virtual appointments, at her GP surgery or locally at her health and wellbeing centre.

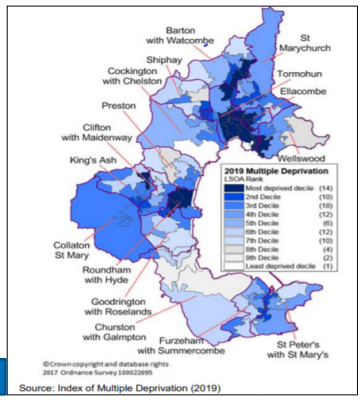
Our challenges

- an **ageing estate** that doesn't offer us the **flexibility** we need, doesn't provide a good **working environment** for our people or a good **experience** for people who use our services
- IT solutions that **do not support our business**, with **lots of standalone** systems that do not talk with one another
- A workforce who are **held back** from transforming services by our poor estate infrastructure and IT solutions, **so unable to deliver the care they aspire to provide**
- **Do nothing is not an option**

Our drivers for change



- Demographic Challenge



Social Deprivation indices

Source: Index of Multiple Deprivation (2019)

Case for Change

Estates

- Failing infrastructure
- Lack of single room provision
- Poor clinical adjacencies
- Lack of natural light and ventilation
- No separation of planned and unplanned care
- No space for people in mental heath crisis

Digital

- Inadequate IT solutions for delivering our new Health & Care Strategy
- We have no integrated EPR
- We have no integrated community and social care solution
- Critical systems are at end of life
- We do not have a platform to transform our services

Case for change

Bill's story

- Bill has Chronic Obstructive Pulmonary Disease (COPD), receives visits from a community nurse and has twice daily packages of care from social care.
- After a visit to his GP because he is feeling unwell, Bill is taken to hospital by ambulance, he is seen in the Emergency Department, admitted to a hospital ward and receives treatment and care.
- On his discharge from hospital, he continues to receive care from his community nurse and from social care as well as his GP.
- This one episode of care for Bill resulted in our people having to use **25 separate digital and paper information systems**. Our people had to remember, print, write and speak to connect these systems together.

Building our brighter future together

- digital solutions that enable seamless care pathways leading to better outcomes and care
- robust digital systems that talk to each other and reduce bureaucracy and duplication for our people
- flexible, modern spaces that are easy to maintain and operate, enabling care to be provided and received in different ways

Building our brighter future together

- systems and set-ups that support our people to transform services, deliver the high quality care they aspire to while attracting and retaining the best people to work with us
- sustainable spaces that are value for money, support local economic regeneration and are kind on the environment
- all of which support collaborative working across all our services and beyond

How do we achieve this?

- submission of our programme strategic outline business case to NHS England and NHS Improvement at the end of July 2021
- digital Outline business case will be submitted – December 2021
- high level options to be taken forward in the outline business case – due to be submitted October 2022
- interdependencies include Devon Integrated Care System elective care strategy
- Full Business Cases will be submitted in 2023

Scope

- digital transformation of our services
- a robust and agile single electronic record system with inbuilt e-prescribing solution for use by all our services
- redevelopment of the Torbay hospital site
- address our backlog maintenance
- all of which will support an empowered and energised workforce

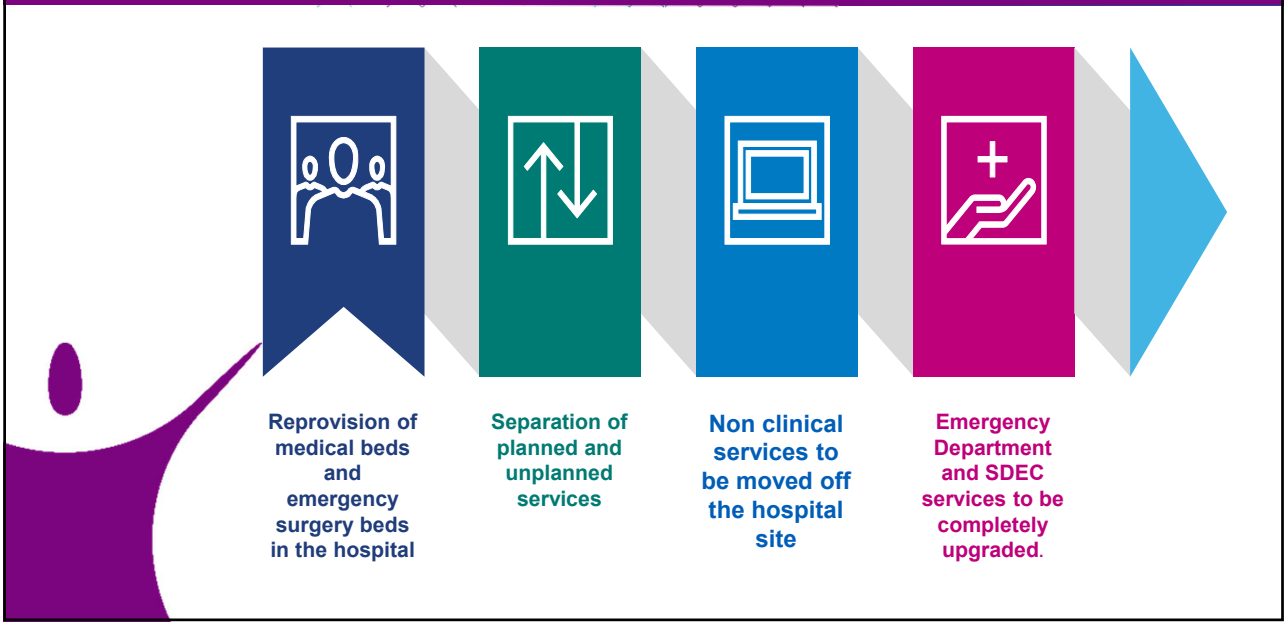
Scope

- digital transformation of our services
- Implement a connected health and care digital solution across the ICS, with an integrated EPR at its cornerstone
- redevelopment of the Torbay hospital site
- address our backlog maintenance
- all of which will support an empowered and energised workforce

Our digital short listed options

- digital option 1 – counterfactual: continuation of the current multiple systems strategy
- digital option 2 – do minimum: maximise the current multiple systems strategy
- digital option 3 – integrated electronic record system
- digital option 4 – join RD&E's integrated electronic record system independently
- digital option 5 - join RD&E's integrated electronic record system as a collective group of trusts with regional partners.

Key principles in our estate planning



Our estates short listed options

- estates option 1 – counterfactual: do nothing
- estates option 2 – do minimum
- estates option 3 – option D
- estates option 4 – option F
- estates option 5 – do maximum

Option F

Existing hospital.

Option F

Phase 0. Medical Receiving Unit.

Option F

Phase 1: Modular Theatre project (Wave 3 Capital).

Option F

Phase 2: Demolish Medical Records, Histopathology etc to North & Kitson, Bryant & Stevens to South.

Option F

Phase 2: New hospital wards to enable Tower decanting and new elective care centre (Ph2).

Option F

Phase 3: Re-modelling of Emergency Department and ward refurbishment to Tower.

Option F

Retained estate. Sequential refurbishment of retained estate funded by Trust Capital.

Option F

Site clearance of existing estate. Sequence to be defined.

Option F

Item	Notes
Phase 1 & 2	15,650m2
Elective care phase 2	5,000m2
Total new build development	**20,650m2**
Refurbished areas	Podium Level 3 – 3,797m2 / Tower 3,817m2
Total new / refurbished areas	**28,264m2**
Programme	2025 - 2028
Site disruption / risk	Low – limited interfaces with existing estate.
Planning risk	Medium - scale to north.
Costs	**£313m**

Responds to NHP initiatives around MMC / Net Zero & feedback around 70:30 single / multi-bed bays solutions.

HIP1 influences being tracked.

- Reprovision of medical beds and emergency surgery beds in the hospital
- Separation of planned and unplanned services
- Non clinical services to be moved off the hospital site
- Emergency Department and SDEC service to be completely upgraded

Our opportunity

- we have been given a share of £3.7 billion government funding for a new hospital development. This is a once in a lifetime opportunity to make a real difference in how we deliver services with, to and for our people
- we want to build our brighter future together
- help us shape our thinking . . .

Our Estate
Our People
Our Digital

Your questions

Your opportunity to help us shape our future

- have we explained what we are doing and why we are doing it?
- what have we got right?
- what have we missed?
- do we have your support?

Your statement of support

- we would like to include a statement of support from you in our strategic outline business case
- statements can be in the form of a letter or email and should be sent to Liz Davenport, Chief Executive by 14 July 2021 (liz.davenport@nhs.net)
- we thank you for your support

What happens next

- your feedback will be included in our strategic outline business case
- we will submit this to NHS England and NHS Improvement at the end of July
- we will then start working on our outline business case which will include:
  - benefits appraisal and economic appraisal of shortlisted options
  - risk assessment
  - identifying the preferred option, demonstrating affordability
  - procurement plan and delivery plan

What happens next

- we will share information about building a brighter future on our website, in our newsletters and on social media, including case studies featuring our people
- we will begin community conversations about building a brighter future which will include listening events and a range of ways that people can share with us what matters to them
- we will work with you to make sure we hear from as many people as possible, particularly those who may be affected by changes we may make


BUILDING A
Brighter Future
NHS
Torbay and South Devon
NHS Foundation Trust
Thank you
Our Estate
Our People
Our Digital

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: **Peninsula Pathology Network Development**			Meeting date: 30th June 2021
Report appendix	Appendix 1: Peninsula Pathology Network Report to Trust Board Appendix 2: Peninsula Pathology Collaboration Agreement		
Report sponsor	Deputy Chief Executive, Torbay and South Devon Foundation Trust		
Report author	Claire Higdon, Strategic Planning Consultant		
Report provenance	This paper from the Peninsula Pathology Network Board is for Trust Boards to be submitted alongside the Collaboration Agreement. This paper sets out the maturity levels for network development and plots the network ambition over a timeline and the actions required to achieve this. This will provide the requisite confirmation for NHSEI as and when funding is allocated for network development.		
Purpose of the report and key issues for consideration/decision	**To note the ambition for Pathology Network development including the requirement to approve a Collaboration Agreement**		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Peninsula Pathology Network Collaborative Agreement		
Summary of key elements			

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Corporate Risk Register

	• 1697 Difficulty in Recruiting Service Critical Staff and the Scheduling of Staff • 2966 Overarching Recruitment Risk in Lab Medicine An external review took place in February 2020 which involved a series of individual meetings with various members of the pathology network, local acute trusts as well as other stakeholders. Trust Boards have since been briefed via Board papers as well as Ann James verbal briefing at STP CEO meetings and briefings at the Peninsula Partnership Board. All members of the Peninsula Pathology Network Board have had opportunity to influence the development of the Collaboration Agreement and the initial network work programme.

Report title: Peninsula Pathology Network Collaboration Agreement: Implications		Meeting date: 30th June 2021
Report sponsor	Deputy Chief Executive, Torbay and South Devon Foundation Trust	
Report author	Claire Higdon, Strategic Planning Consultant	

Introduction

The initial recommendation from NHSE, set out in 2016/17, was for the set-up of 29 pathology networks across England, in order to reduce unwarranted variation, improve the efficiency of resource utilisation and additionally, generate financial savings of around £4m. The NHSE proposed South 1 network includes all five acute hospitals covering the population of Devon, Cornwall and the Isles of Scilly.

Discussion

Executive Summary

An external review of Pathology was commissioned in February 2020 to test out the ambition of the network and make recommendations for improvement. The outcome from the external review with its recommendations has been shared in previous Board papers.

There is consensus across partners that the network should continue at a Peninsula level and at this stage operate at Level one. The development of the Collaborative Agreement is seen to be a critical component to confirm the shared ambition to work together to provide a consistently high quality clinical service.

The Collaboration Agreement describes the following strategic objectives to be delivered by the Network:-

Objective one – Establish Governance framework based on Clinical Effectiveness and resource the Clinical Effectiveness Group so it can be successful in driving a quality service judged on whole system impact and outcomes for patients;
Objective two – support the establishment of three service providers; South, East and North Devon (SEND), Plymouth and Cornwall ensuring that these pathology services meet the present and future health/service needs of both their local and peninsula wide population in accordance with the commissioning intentions and ambitions;
Objective three – to provide mutual aid support to ensure business continuity and resilience ensuring continuing service delivery during normal operations and in times of crisis;
Objective four – support service providers in developing workforce plans, which may include working between organisations, to optimise the use of existing personnel, harmonise work practices, create attractive work roles to retain and attract new staff to deliver sustainability of services;
Objective five - influence wider south west region to agree a high level strategy for progressing pathology IT in the peninsula, as part of requirement to deliver seamless access to patient results; agree plan to maximise interoperability and interconnectivity between systems to allow for the easy and safe transfer of work where required.

It also describes the overarching governance processes for the Network. Overall, the Collaboration Agreement seeks to provide clearer structure, agreed principles and functions of the network.

External review
An external review was commissioned in February 2020 to test out the ambition of the network, especially in terms of the proposed models, look at the governance and advise on appropriate leadership structures. When presented to this Network Board, the external review outcomes were generally welcomed and the six main 'principles' were accepted summarised below:

1. Trusts should commit to Pathology Transformation and support the integration of pathology across the Peninsula.
2. A staged transformation with a revamped Pathology Network Board mandated to deliver progressive centralisation of laboratory services initially with 3 hubs
3. Establish a clear vision for financial and service sustainability.
4. Trusts and commissioners empower the Pathology Network Board. The needs of patients for access to high quality, sustainable services should have precedence over all other issues.
5. A focus on the vision and key drivers for change.
6. The Pathology Network Board is mandated to deliver seamless access to patient results.

There was, however, a wide-ranging discussion in terms of the evidence base for some of the findings and this provided more evidence that the proposed service model to support the clinical vision as outlined in the SOC needs to be revisited, hence the agreement to draft a Collaboration Agreement.

Collaboration Agreement
A Collaboration Agreement (**Appendix 1**) has been developed to describe the relationship of the five Trusts and how their Pathology Services will work together collaboratively to provide a high quality service to primary and secondary care clinician users and their patients.
In the absence of formal NHSEI guidance, the Pathology Network, under the governance umbrella of the Peninsula Partnership Board, will observe the Clinical Service Delivery Network Levels and will operate at Level 1 – Service Quality and Effectiveness Network. At this stage, this will enable a focus on the quality of service to the user/patient and investment in clinical effectiveness for each Party as a Service Provider working to five strategic objectives, summarised as follows:-

1. Establish Governance framework based on Clinical Effectiveness
2. Support the establishment of three service providers; South, East and North Devon (SEND), Plymouth and Cornwall
3. Ensure business continuity and resilience
4. Develop workforce plans to deliver sustainability of services
5. Influence wider south west region to agree a high level strategy for progressing pathology IT

Work programme
The agreement describes a work programme and three 'First order priorities':-

1. New laboratory build at Treliske
2. SEND provider development
3. New laboratory provision for Plymouth

These are incorporated into the Work programme as each of the above three developments are significant programmes which the Network would wish to have visibility of and the opportunity to influence and gain peninsula wide benefits wherever appropriate.

The other main work programme priority will be the work progressed by the Clinical Effectiveness Group and the Operational Delivery Group including consolidation of test provision, alignment of test profiles and delivering quality improvements outlined by GIRFT.

Network development

Appendix 2 describes the levels of Network Development as drafted for the Peninsula Clinical Service Delivery networks. Pathology is already recognised as one of these for the Peninsula and by virtue of the Collaboration Agreement is confirming its position at Level One at this point in time.

Level one is described as a 'Service Quality and Effectiveness Network' which accurate reflects the initial ambition of all Parties to the Collaboration Agreement. Over time, it is anticipated that through the successful working of the Clinical Effectiveness Group, that parties will look to strengthen the network with cross-site delivery of all or some provision of service. This reflects a Level two network and would be appropriate where there are services where one or more Trusts do not have the capacity or capability (workforce, infrastructure, etc) needed to deliver that service to the standards required and may have to contract with another Trust to secure that capacity for part or all of the service that they are commissioned to deliver. This may require workforce to travel to provide the service on another site, or patients to travel to another hospital to receive the service.

Resourcing the Network

Where the work is on a Network footprint, such as Clinical Effectiveness, funding will be required to support network resources to progress the work. NHSEI Network Development funding is expected but should that not be forthcoming, the expectation is that each of the Trusts contribute to a centrally held fund to support the following needs:-

- Resourcing clinical effectiveness
- Digital Histopathology – project management
- Network wide roles to support the Board's work and sub groups
- Digital development

If NHSEI funding is made available, in addition to the needs outlined above, any remaining funding could be used to support the programmes of work within SEND, UHP, RCHT. Eg corporate service time limited posts to support service changes. Notwithstanding the expectation of NHSEI funding, wherever possible, the Trusts are encouraged to service the work programme by providing people and agreeing to fund additional people for the purpose of achieving the Network ambition. Contributions to date for this specific purpose have been £35k per party and it is anticipated that a higher level of investment will be required to further the work of the Network as well as the deliverables in Schedule one, hence the reliance on NHSEI funding. As is currently the case, the budget will be held by one Trust on behalf of the Network (UHP).

Conclusion

The Collaboration Agreement was approved by the Pathology Network on 28th April with aim of going to Trust Boards in May and June. The new governance is aimed to be in place for 1st July 2021.

It was agreed by the Devon and Cornwall STP CEOs that the Collaboration Agreement would need to go to Trust Boards for information. Within this document, they would be expecting to see the underpinning infrastructure in terms of governance and initial work programme.

Recommendations

The Board is asked to note and approve the Peninsula Pathology Network Collaborative Agreement

Peninsula Pathology
NHS Network

SUMMARY REPORT	
REPORT FOR TORBAY AND SOUTH DEVON FOUNDATION TRUST BOARD	**30TH JUNE 2021**
Title of Report	**Peninsula Pathology Network Development**
Accountable Officer	Ann James, Chair of Network
Author(s)	Claire Higdon, Strategic Planning Consultant
Purpose of Report and verbal briefing	This paper from the Peninsula Pathology Network Board is for Trust Boards to be submitted alongside the Collaboration Agreement. This paper sets out the maturity levels for network development and plots the network ambition over a timeline and the actions required to achieve this. This will provide the requisite confirmation for NHSEI as and when funding is allocated for network development.
What is the action for the Board	**To note the ambition for Pathology Network development including the requirement to approve a Collaboration Agreement.**
Consultation Undertaken to Date	An external review took place in February 2020 which involved a series of individual meetings with various members of the pathology network, local acute trusts as well as other stakeholders. Trust Boards have since been briefed via Board papers as well as Ann James verbal briefing at STP CEO meetings and briefings at the Peninsula Partnership Board. All members of the Peninsula Pathology Network Board have had opportunity to influence the development of the Collaboration Agreement and the initial network work programme.
Executive Summary	An external review of Pathology was commissioned in February 2020 to test out the ambition of the network and make recommendations for improvement. The outcome from the external review with its recommendations has been shared in previous Board papers. There is consensus across partners that the network should continue at a Peninsula level and at this stage operate at Level one. The development of the Collaborative Agreement is seen to be a critical component to confirm the shared ambition to work together to provide a consistently high quality clinical service. The Collaboration Agreement describes the following strategic objectives to be delivered by the Network:- **Objective one** – Establish Governance framework based on Clinical Effectiveness and resource the Clinical

	Effectiveness Group so it can be successful in driving a quality service judged on whole system impact and outcomes for patients; **Objective two** – support the establishment of three service providers; South, East and North Devon (SEND), Plymouth and Cornwall ensuring that these pathology services meet the present and future health/service needs of both their local and peninsula wide population in accordance with the commissioning intentions and ambitions; **Objective three** – to provide mutual aid support to ensure business continuity and resilience ensuring continuing service delivery during normal operations and in times of crisis; **Objective four** – support service providers in developing workforce plans, which may include working between organisations, to optimise the use of existing personnel, harmonise work practices, create attractive work roles to retain and attract new staff to deliver sustainability of services; **Objective five** - influence wider south west region to agree a high level strategy for progressing pathology IT in the peninsula, as part of requirement to deliver seamless access to patient results; agree plan to maximise interoperability and interconnectivity between systems to allow for the easy and safe transfer of work where required. It also describes the overarching governance processes for the Network. Overall, the Collaboration Agreement seeks to provide clearer structure, agreed principles and functions of the network.
Next Steps	The Collaboration Agreement was approved by the Pathology Network on 28th April with aim of going to Trust Boards in May and June. The new governance is aimed to be in place for 1st July 2021. It was agreed by the Devon and Cornwall STP CEOs that the Collaboration Agreement would need to go to Trust Boards for information. Within this document, they would be expecting to see the underpinning infrastructure in terms of governance and initial work programme.

Background

The initial recommendation from NHSE, set out in 2016/17, was for the set-up of 29 pathology networks across England, in order to reduce unwarranted variation, improve the efficiency of resource utilisation and additionally, generate financial savings of around £4m. The NHSE proposed South 1 network includes all five acute hospitals covering the population of Devon, Cornwall and the Isles of Scilly.

Strategic Context

At this stage each of the five Trusts have their own Trust Boards. However, Northern Devon Healthcare is planned to merge with Royal Devon & Exeter Healthcare NHS FT with effect from 1st April 2022 and already shares a joint Executive Team. A further alliance including these two Trusts with Torbay and South Devon NHS FT has also been agreed known as South, East and North Devon Alliance (SEND). It is on this footprint that Pathology services will be developed for those three Trusts. Plymouth and Cornwall will be the other two service footprints.

External review

An external review was commissioned in February 2020 to test out the ambition of the network, especially in terms of the proposed models, look at the governance and advise on appropriate leadership structures. When presented to this Network Board, the external review outcomes were generally welcomed and the six main 'principles' were accepted summarised below:

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There was, however, a wide-ranging discussion in terms of the evidence base for some of the findings and this provided more evidence that the proposed service model to support the clinical vision as outlined in the SOC needs to be revisited, hence the agreement to draft a Collaboration Agreement.

Collaboration Agreement

A Collaboration Agreement (**Appendix 1**) has been developed to describe the relationship of the five Trusts and how their Pathology Services will work together collaboratively to provide a high quality service to primary and secondary care clinician users and their patients.

In the absence of formal NHSEI guidance, the Pathology Network, under the governance umbrella of the Peninsula Partnership Board, will observe the Clinical Service Delivery Network Levels and will operate at Level 1 – Service Quality and Effectiveness Network. At this stage, this will enable a focus on the quality of service

to the user/patient and investment in clinical effectiveness for each Party as a Service Provider working to five strategic objectives, summarised as follows:-

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The other main work programme priority will be the work progressed by the Clinical Effectiveness Group and the Operational Delivery Group including consolidation of test provision, alignment of test profiles and delivering quality improvements outlined by GIRFT.

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Level one is described as a 'Service Quality and Effectiveness Network' which accurate reflects the initial ambition of all Parties to the Collaboration Agreement. Over time, it is anticipated that through the successful working of the Clinical Effectiveness Group, that parties will look to strengthen the network with cross-site delivery of all or some provision of service. This reflects a Level two network and would be appropriate where there are services where one or more Trusts do not have the capacity or capability (workforce, infrastructure, etc) needed to deliver that service to the standards required and may have to contract with another Trust to secure that capacity for part or all of the service that they are commissioned to deliver. This may require workforce to travel to provide the service on another site, or patients to travel to another hospital to receive the service.

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is that each of the Trusts contribute to a centrally held fund to support the following needs:-

- Resourcing clinical effectiveness
- Digital Histopathology – project management
- Network wide roles to support the Board's work and sub groups
- Digital development

If NHSEI funding is made available, in addition to the needs outlined above, any remaining funding could be used to support the programmes of work within SEND, UHP, RCHT. Eg corporate service time limited posts to support service changes.

Notwithstanding the expectation of NHSEI funding, wherever possible, the Trusts are encouraged to service the work programme by providing people and agreeing to fund additional people for the purpose of achieving the Network ambition. Contributions to date for this specific purpose have been £35k per party and it is anticipated that a higher level of investment will be required to further the work of the Network as well as the deliverables in Schedule one, hence the reliance on NHSEI funding. As is currently the case, the budget will be held by one Trust on behalf of the Network (UHP).

COLLABORATION AGREEMENT

between

NORTHERN DEVON HEALTHCARE NHS TRUST

and

ROYAL CORNWALL HOSPITALS NHS TRUST

and

ROYAL DEVON AND EXETER HEALTHCARE NHS FOUNDATION TRUST

and

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

and

UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST

COLLABORATION AGREEMENT

between

NORTHERN DEVON HEALTHCARE NHS TRUST, an NHS provider under CQC registration number xxxxxx, and having its main administrative offices at North Devon District Hospital, Raleigh Park, Barnstaple, Devon EX31 4JB

and
ROYAL CORNWALL HOSPITALS NHS TRUST, an NHS provider under CQC registration number xxxxxx] and having its main administrative offices at Bedruthan House, Treliske Hospital, Truro, Cornwall TR1 3LQ

and

ROYAL DEVON AND EXETER HEALTHCARE NHS FOUNDATION TRUST, an NHS provider under CQC registration number xxxxxxxxx, and having its main administrative offices at Wonford Hospital, Barrack Road, Exeter EX2 5DW

and

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST, an NHS provider under CQC registration number xxxxxxx,], and having its main administrative offices at Hengrave House, Torbay Hospital, Newton Road, Torquay, Devon TQ2 7AA

and

UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST, an NHS provider under CQC registration number xxxx, and having its main administrative offices at Derriford Hospital, Derriford Road, Plymouth, Devon PL6 8DH

For the purposes of this agreement, Northern Devon Healthcare NHS Trust, Royal Devon and Exeter Healthcare NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust have established an alliance known as South East and North Devon (SEND). This will be considered to be one of the "Parties"

Therefore, each of the following will be a 'Party':-

1. South East and North Devon (SEND)
2. Royal Cornwall Hospitals NHS Trust (RCHT)
3. University Hospitals Plymouth NHS Trust (UHP)

hereinafter referred to collectively as the "Parties"

For the purposes of this agreement, **Pathology** includes the departments of Clinical Microbiology, Cellular Pathology[1], Blood Sciences[2] including Clinical Chemistry, Immunology, Haematology, Blood Transfusion services, Point of care testing, IT, where it is pathology specific and not part of corporate IT systems, Mortuary and all of the pathology support services. *Where services such as genetics services are nationally commissioned and organised, these are not in scope.*

[1] To include Neuropathology
[2] To include Histocompatibility and Immunogenetics

Purpose

The “Parties” to this Agreement wish to collaborate and enter into a mutually beneficial provider relationship to accomplish the most clinically effective, efficient and sustainable service delivery model for a pathology network across Devon, Cornwall and the Isles of Scilly.

NHS England/Improvement has announced its intention to make funding available to support pathology network development, subject to parties entering into an agreement governing their collaboration. This Agreement governs the parties’ collaboration in relation to that network.

In the absence of formal NHSEI guidance, the Pathology Network, under the governance umbrella of the Peninsula Partnership Board, will observe the Clinical Service Delivery Network Levels and will operate at Level 1 – Service Quality and Effectiveness Network. This will enable a focus on the quality of service to the user/patient and investment in clinical effectiveness for each Party as a Service Provider.

The “Parties” wish to collaborate to support the transformation of pathology across the Peninsula. This to be a staged transformation with the latter mentioned Pathology Network Board playing a key role in supporting the three service providers in their development of laboratory services with initial focus on clinical effectiveness and user focused delivery, particularly as part of whole system pathways.

As part of this transformation via clinical effectiveness, some pathology service delivery may be consolidated into one, or fewer, service provider/location(s) and this will be agreed on a case by case basis using the principles agreed via the later mentioned Clinical Effectiveness Group and be signed off by the Board.

This Agreement sets out the terms under which Parties intend to collaborate in the provision of those Services, and to work together in procuring systems, equipment and technology, delivering clinically effective services across system wide patient pathways, and building a sustainable workforce.
It also sets out a work programme for the first two years with deliverables that will test out how the emerging structure of the network model supports the joint working and to check the suitability of the proposed governance model.

Background

The initial recommendation from NHSE, set out in 2016/17, was for the set-up of 29 pathology networks across England, in order to reduce unwarranted variation, improve the efficiency of resource utilisation and additionally, generate financial savings of around £4m.

The Peninsula Pathology NHS Network (Project) Board was established in December 2017 to provide the strategic direction and decision-making for the South 01 pathology network Parties as outlined above.

Before the COVID pandemic, the Network was not embedded as part of business as usual and many Pathology Board members felt it needed some type of reinvigoration. An external review was commissioned to test out the ambition of the Network, especially in terms of the proposed models, look at the governance and advise on appropriate leadership structures. This was undertaken during February 2020 by Mark Hackett and Professor William Roche.

Overall, the development of this Collaboration Agreement was seen as a vital component to formalise the Network and confirm the overarching governance, leadership and deliverables. The Agreement sets out the governance of the network, establishes how this will be achieved and in doing so it confirms support for this approach by all signatories. It sets out the principles of collaborative working which will underpin the successful delivery of the shared ambition of the Network.

THE COLLABORATION AGREEMENT

It is agreed:

1 Commencement, duration and status of this Agreement

1.1 This Agreement comes into effect on the date that it is executed by all of the Parties, and, unless terminated earlier, will expire on:

1.1.1 the exit of any Party from any Acute Services Commissioner/Provider Contract.

1.2 If there is any conflict between the terms of this Agreement and the terms of any Commissioner/Provider Contract, the terms of the relevant Commissioner/Provider Contract will prevail.

1.3 If any Commissioner/Provider Contract is varied, this Agreement will, to the extent necessary, be interpreted as including whatever variation may be necessary to make this Agreement consistent with the Commissioner/Provider Contracts.

2 Principles of the Collaborative

2.1 In performing their respective obligations under this Agreement and any related Commissioner/Provider Contracts, the Parties must:

2.1.1 be committed to developing an approach focussed on clinical effectiveness, improving patient outcomes and releasing value to the whole health system;

2.1.2 at all times act in good faith towards each other; a willingness to be open and transparent where business developments, staffing changes and procurements are being considered. As a minimum, the pathology service provider's annual business plan should be shared with each Party; Anticipating that the Board would escalate issues that might hinder the Network's ambition.

2.1.3 act in a timely manner, in accordance with agreed action deadlines.

2.1.4 share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

2.1.5 at all times, observe relevant statutory powers, Health Service Executive (HSE), Medicines and Healthcare products Regulatory Agency (MHRA) requirements and best practice to ensure compliance with accreditation standards e.g. ISO 15189, applicable laws and standards including those governing procurement, data protection and freedom of information.

3 Function of the Network

3.1 The function of the Network is to support the Parties to act collaboratively in their planning, design and delivery of Pathology Services to include oversight of an agreed work programme, workforce planning and in particular, to:

3.1.1 support their establishment as three service providers across South, East and North Devon (SEND), Plymouth and Cornwall such that these pathology services meet the present and future health/service needs of both their local and peninsula wide population in accordance with the commissioning intentions and ambitions;

3.1.2 ensure participation in the Pathology Clinical Effectiveness Group which has clinical leadership to optimise the delivery of pathology services. Over time, this Group will review opportunities for improvement and set clinical specifications for the quality standard that pathology services are required to provide;

3.1.3 participate in the above mentioned Group, taking account of emerging technologies and environmental impacts of current and future service delivery.

3.1.4 review the workforce challenges that are well-described across Devon and Cornwall as part of the review of the most appropriate model of pathology services. This workforce review needs to include how highly specialised skills are shared across each service provider and across the whole network and must include an agreement to harmonise clinically effective and efficient working practices where they impact on total capacity;

3.1.5 share best practice and use benchmarking to ensure that services are clinically effective and represent best value for money to the whole system, recognising that service changes can be a cost to pathology but greater savings to the system;

3.1.6 represent Parties in discussions as part of the wider south west region to agree a high level strategy for progressing pathology IT in the peninsula, as part of requirement to deliver seamless access to patient results;

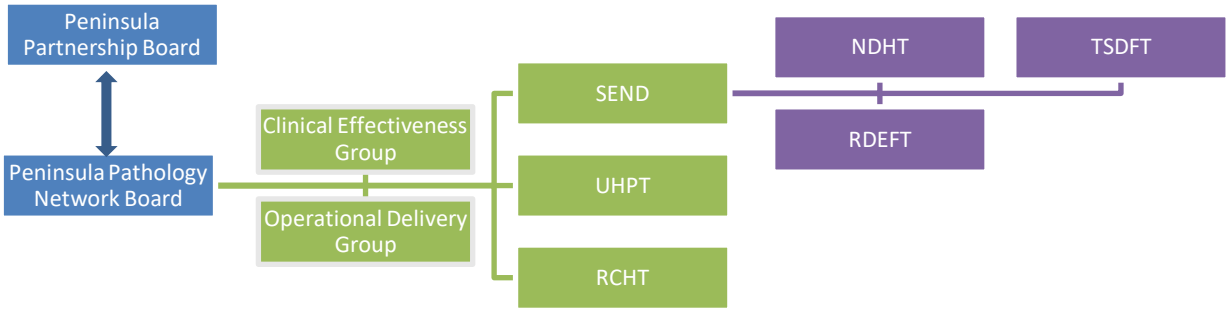
3.1.7 be a key stakeholder influencing the wider digital strategies of peninsula organisations across the whole health and care system to ensure we maximise interoperability and interconnectivity between systems to allow for the easy and safe transfer of work where required; this could include common LIMS platform and Order comms;

3.1.8 agree the range of Network and service level deliverables which will be captured in the annual work programme.

4 Governance, Board composition, meetings and decision making

4.1 Governance

4.1.1 Pathology is one of the Clinical Service Delivery Networks initially identified by the Peninsula Clinical Services Strategy, now to be overseen by the Peninsula Partnership Board. Therefore, the Governance for the Pathology Network Board and hence this collaboration agreement will be through the Peninsula Partnership Board which is responsible for setting the strategic direction of hospital based services across Devon, Cornwall and the Isles of Scilly. The following chart shows the relationship between the Boards and the feed in by each of the Parties.



4.1.2 The Pathology Network Board should have as its key focus, the discussion of matters relating to the pursuit of the objectives and performance of the Network. The Board will be accountable for the Network deliverables and ensuring these are delivered in line with the agreed objectives and within the approved budgets, delegated to the Network.

4.1.3 The Board will hold overall accountability for the performance of the Network against its initial schedule of work (see Schedule one) with the exception of items P1/P2/P3 which are present on the schedule as they are significant programmes which the Network would wish to have visibility of and have the opportunity to influence and gain peninsula wide benefits wherever appropriate.

4.1.4 The Network Board will report to the Peninsula Partnership Board which has representation from each of the Parties in the collaboration.

4.2 Board composition – Network Board

4.2.1 As a Level 1 Network, the Network Board requires senior representation by lead clinicians and managerial/divisional directors who have responsibility for pathology from each Party aware of strategic plans and operational challenges. This could be at Executive or Care Group level. This individual will be responsible for briefing their organisations on Network Board discussions/decisions/actions as appropriate.

4.2.2 The Board is currently chaired by one of the Party Chief Executive Officers.

4.2.3 In order to ensure effective stakeholder involvement via Primary Care and Secondary Care users, the Board will also need membership identified for these.

4.2.4 Senior clinical lead and financial lead also needs to be nominated from one of the Parties.

4.2.5 Programme management should also be in place to support the Board and be the conduit for reporting progress on the delivery of the work programme.

4.3 Meetings

4.3.1 General meetings of the Network Board will be held at least once every 2 months, or as otherwise agreed by the Parties from time to time, and will be convened on behalf of the Chair by at least [5] days' prior notice by e-mail to each member.

4.3.2 Special meetings of the Network Board may be called by any of the Parties by giving at least [48 hours] notice by e-mail to each member for the consideration of any matter which that Party considers of sufficient urgency and importance that its consideration cannot wait until the date of the next general meeting.

4.3.3 The quorum for conducting a meeting is the attendance of representatives, or their delegated representative on behalf of all of the Parties.

4.4 Decision making

4.4.1 Each Party is responsible for ensuring that its representatives have sufficient delegated authority, in accordance with that Party's constitution, to act on behalf of that Party within the remit of the Pathology Network; The level of decision making will vary for each area of work and be described within the Work programme.

4.4.2 It is the intention that the Network Board will arrive at a consensus regarding recommendations being made to the Parties concerning the work programme items.

4.4.3 Where a consensus is not able to be reached, the voting of members of the Board can be recorded and communicated to each Party by its representative, and each Party will take its own decision in respect of the recommendation.

Pathology Clinical Effectiveness

5.1 **Pathology Clinical Effectiveness Group**

5.1.2 The Pathology Clinical Effectiveness Group has been formed to co-ordinate a consistent response from pathology to wider system requirements and deliver improvements to the users of pathology services across Cornwall & Isles of Scilly and Devon. It is responsible for reviewing current guidance and within the context of a whole system pathway, advise on optimal choice of test groups for both clinicians in primary and secondary care and for patients. Their work plan may also be directed by the Peninsula Pathology Network Board or influenced by Planned Care Boards.

5.1.3 Reporting directly to the Pathology Network, Board, the Group is currently chaired by a Clinical member at Executive level from the Network Board.

5.1.4 The Group has chosen to have a Core membership for regular meeting and some Reference Group members who may join meetings from time to time. Further representation is then drawn from workstream specific clinicians and user stakeholders. These are then supported by people with financial and analytical skills.

5.1.5 The Pathology Effectiveness Group will make recommendations either on its own or in conjunction with the Operational Delivery Group for consideration by the Board.

5.1.6 A comprehensive project structure document should be approved by the Network Board which outlines the role, function and outputs for the Network Board and the Delivery Group and its sub-groups and append to the agreement. The Clinical Effectiveness Group has developed a schedule of resources required to support its work which will be part of the budget requirement from the Parties.

6 **Operational Delivery**

6.1 **Operational Delivery Group**

6.1.2 The Pathology Operational Delivery Group has been formed to assist in implementing recommendations from the Clinical Effectiveness Group and it is expected to have oversight of some of the deliverables set out in Schedule one of this Agreement and any other directed by the Peninsula Pathology Network Board. The potential to collaborate on procurement shall be debated on an individual case by case basis.

6.1.3 Reporting directly to the Pathology Network Board, the Group will be chaired by one of the members from the Network Board. Representation should include as a minimum, operational managerial leads from each of the three service provider areas.

6.1.4 The Operational Delivery Group will make recommendations either on its own or in conjunction with the Pathology Effectiveness Group for consideration by the Board.

6.1.5 Project management should be run from this Group with key decisions presented to the Board for approval. A comprehensive project structure document should be approved by the Network Board which outlines the role, function and outputs for the Network Board and the Delivery Group and its sub-groups and append to the agreement. Any additional expenditure to support this should form part of the budgetary requirement request as described above at 5.1.6.

7.1 Financial planning, oversight and funding

7.1.1 All parties should share their financial plans for pathology investment so that the Board may have strategic oversight of all capital investments where they have direct or indirect impact on pathology services.

7.1.2 Programme expenditure plans to support the resourcing for Network groups such as Clinical Effectiveness and Operational Delivery will be agreed by the Board, with business cases being required for procurements or changes to service and staffing, dependant on their value and in accordance with the scheme of delegation of the host organisation.

7.1.3 The project resources required should be explicitly set out and the schedule of work delivered for this resource, so the Network Board can be held to account for the investment by partners. The Network Board is accountable for ensuring processes are in place for allocation and control of programme spending.

7.1.4 Where there is jointly held monies either provided via NHSEI funding or allocations from the Parties, the nominated Finance Lead is accountable for accounting for expenditure against the budget, including compliance with the host organisation's Standing Financial Instructions. The budget should be held by one of the Parties on behalf of the Network.

7.1.5 The Board will receive quarterly financial updates from the nominated Finance lead.

8 Network Vision, objectives, work programme and stakeholders

8.1 Vision

8.1.1 The vision of the Network as set out in the Network's October 2018 Strategic Outline Case (SOC) is

"to provide high quality, innovative pathology services, which will be at the heart of new models of patient centred care"

8.2 Objectives

8.2.1 As already outlined in the 'Functions of the Network' section, there are a number of priority deliverables identified to be within the remit of the Network. These reflect the following **strategic objectives** to be delivered by the Network.

Objective one – Establish Governance framework based on Clinical Effectiveness and resource the Clinical Effectiveness Group so it can be successful in driving a quality service judged on whole system impact and outcomes for patients

Objective two – support the establishment of three service providers; South, East and North Devon (SEND), Plymouth and Cornwall ensuring that these pathology services meet the present and future health/service needs of both their local and peninsula wide population in accordance with the commissioning intentions and ambitions

Objective three – to provide mutual aid support to ensure business continuity and resilience

ensuring continuing service delivery during normal operations and in times of crisis.

Objective four – support service providers in developing workforce plans, which may include working between organisations, to optimise the use of existing personnel, harmonise work practices, create attractive work roles to retain and attract new staff to deliver sustainability of services

Objective five - influence wider south west region to agree a high level strategy for progressing pathology IT in the peninsula, as part of requirement to deliver seamless access to patient results; agree plan to maximise interoperability and interconnectivity between systems to allow for the easy and safe transfer of work where required

8.3 **Work Programme**

8.3.1 The work programme at Schedule one will focus on areas towards the achievement of the strategic objectives.

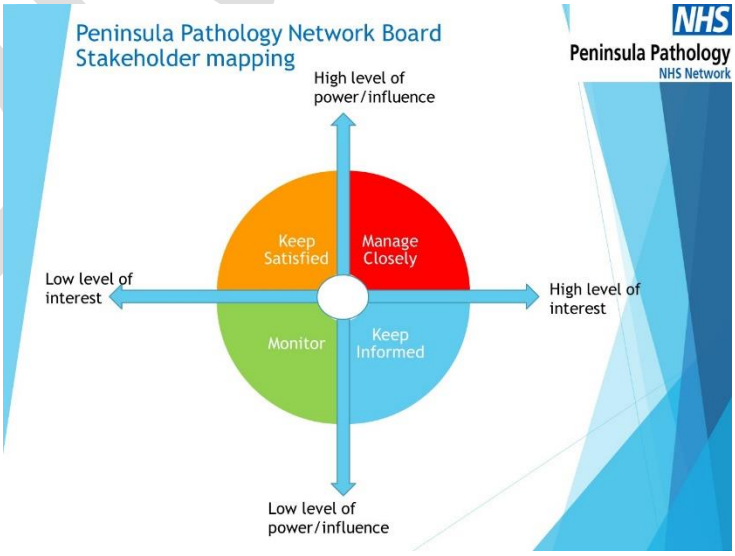
8.3.2 It starts with three 'First order priorities':-

1. New laboratory build at Treliske
2. SEND provider development
3. New laboratory provision for Plymouth

These are incorporated into the Work programme (P1/P2/P3) as each of the above three developments are significant programmes which the Network would wish to have visibility of and the opportunity to influence and gain peninsula wide benefits wherever appropriate. However, they remain under the governance and control of their host organisations.

8.3.3 Throughout the work programme, in order to describe the involvement of stakeholders, each activity has been annotated with its lead Party and also the expected stakeholder involvement for each of the other Parties

eg.
- Manage Closely
- Keep Satisfied
- Keep Informed
- Monitor



8.4 **Stakeholder groups and their interests**

8.4.1 As Pathology is a diagnostic service within clinical pathways, it has a huge range of stakeholders having an interest in its success. The main stakeholder groups to be involved in work attributed to the Network and its sub-groups are:-

- user stakeholders – primary care and secondary care referring clinicians
- staff stakeholders – laboratory department workforce
- clinical pathway stakeholders – Peninsula Cancer Alliance, other diagnostic services
- end user stakeholders – patients in receipt of pathology testing
- strategic stakeholders – Planned Care Board members

8.4.2 As well as the Parties, the above stakeholder groups feature heavily in pathology services improvements. It is essential that they are aware of this Collaboration Agreement and the intention of the Parties to form three service providers and to work more expansively as a single Network.

8.4.3 Through the Network Board's reporting line to the Peninsula Partnership Board, it is expected that senior system leaders will have full visibility of the pathology ambition and the ability to influence.

8.4.4 The key operational interface is anticipated to occur at the two Planned Care Boards for both ICSs of Devon and Cornwall & Isles of Scilly. Link membership across these with the Network Boards will be essential to ensure engagement with relevant stakeholders is maintained.

8.4.5 The Peninsula Cancer Alliance is an equal partner reporting into the Peninsula Partnership Board and link membership with this key diagnostics user will be critical to maximising access to resources to improve pathology services to support better cancer outcomes.

8.4.6 As substantial end users, primary and secondary care clinicians will be represented at both the Network Board, Operational Delivery Group and Pathology Effectiveness Group.

9 Resourcing the work programme

9.1 Investment must support the delivery of the priority programmes of work. In some instances, this will be funded directly via the Parties and will be in pursuit of their local development of pathology services.

9.3 Where the work is on a Network footprint, such as Clinical Effectiveness, funding will be required to support network resources to progress the work. The hope at the time of the Collaboration Agreement is that NHSEI Network Development funding will become available. This is not yet confirmed and therefore, the expectation is that Parties contribute to a centrally held fund to support the following needs:-

- Resourcing clinical effectiveness – Clinical time (pathology, primary and secondary care clinicians), programme support
- Digital Histopathology – project support.
- Network wide roles that support the Board and other related work eg. PID,
- Digital transformation

9.4 If NHSEI funding is made available, in addition to the needs outlined above at 9.3, any remaining funding could be used to support the programmes of work within SEND, UHP, RCHT. Eg. time limited corporate services support for service changes. This to be agreed by the Network Board on a case by case basis.

9.5 Notwithstanding the expectation of NHSEI funding, wherever possible, the Parties are encouraged to service the work programme by providing people and agreeing to fund additional people for the purpose of achieving the Network ambition. Contributions to date for this specific purpose have been £35k per party and it is anticipated that a higher level of investment will be required to further the work of the Network as well as the deliverables in Schedule one, hence the reliance on NHSEI funding. As per section 7 above, the budget will be held by one Party on behalf of the Network.

9.6 No additional partners or subcontractors shall be hired or procured without approval by the Board.

9.7 In addition to the Network Development and work programme, it is noted that additional resource may be hired/retained to support the work on the Outline Business Case and subsequent Full Business Case, if this is still required by NHSEI.

10 Savings, income generation, procurement

10.1 As per the agreed Financial Smoothing arrangement (Network Board, July 2019), the general principle is that where an investment or procurement saving is of overall benefit to the Network, financial adjustments will be made so that the costs or savings are shared equitably. Moreover, no organisation should be worse off. The savings are shared equitably between the 5 Trusts, based on the percentage of network expenditure. This should be established at the outset for each project where a financial impact is anticipated, whether cost or saving.

10.2 Any shared financial obligations shall be repaid using the proceeds from the collaboration's efforts. This includes the above referenced excess capital contributions from either of the involved parties, as well as any overhead costs associated with the project, such as remuneration for managers, consultants, subcontractors, or equipment.

10.3 The arrangements for requiring additional funds or addressing a deficit will be a matter for the Board to consider and agree on an individual basis.

10.4 Where a joint procurement is to be considered as part of the Network, the Parties should ensure that, where appropriate, individual tender specifications are written to include options for number of Trusts contracted to final solution and an agreement on cost reimbursement is agreed before the tendering exercise is commenced.

11 Intellectual Property (IP)

11.1 Intellectual Property (IP) creation is likely to be minimal. Any IP created by the Network will be owned by Network Partners and the cost of creating the IP will be shared between the parties. The parties cannot enter into a contract to exploit or dispose any shared IP without the approval of the Board. If the Board approves, then the Network parties will share proceeds of exploitation disposal equally.

12 Insurance

12.1 The Parties agree to maintain insurance adequate to protect their respective personnel and assets from loss, theft, or damage. This would need to be held by the host organisation on behalf of the other parties.

12.2 The Parties agree to name each other in their respective insurance policies, and to indemnify and hold each other harmless in all cases save for those of gross or wilful misconduct or neglect.

13 Monitoring Performance

13.1 The Network Board work programme and the resourcing of the work will be under regular review, as a standing item at the Board and as part of the Operational Delivery Group, with the intention that there is a two year rolling programme. Project update papers will be submitted to the Board to report the performance recognising the jurisdiction of the Network..

13.2 The Board shall be responsible for monitoring the performance of all Parties in respect of their commitment to collaboration and participation in activities relating to this agreement. If it is felt that there are instances where Parties are not maintaining their commitment, this will be brought forward to the Network Board for discussion and conflict resolution if required.

14 Termination

14.1 Where one of the Parties wishes to withdraw from the Network, before being released from this Agreement, they will need to notify the other Parties in order for any financial liability to be calculated.

14.2 If the Party pursues its withdrawal from this agreement, they will need to provide a minimum of twelve (12) month's written notice to the Network Board regarding their intention to withdraw from the collaboration, and meet the financial liability as calculated in 14.1 and complete any outstanding reporting and service delivery commitments.

15 Agreement Extension

15.1 This Collaboration Agreement may be extended or amended only by written approval from the aforementioned Parties co-signaturing this document. The decision to amend or extend the agreement shall include the date of the amendment/extension, and the signatures of appointed representative of each participating organisation as well as any new terms and conditions amended or added to this agreement.

16 Acceptance

16.1 Each Party has had the ability to read and accept all conditions and terms listed above and including Schedule one, Work programme and indicates full acceptance and approval of this collaboration agreement by signing electronically below.

The parties

Suzanne Tracey, Chief Executive	Northern Devon Healthcare NHS Trust Royal Devon & Exeter Healthcare NHS FT
Kate Shields, Chief Executive	Royal Cornwall Hospitals NHS Trust
Liz Davenport, Chief Executive	Torbay and South Devon Healthcare NHS FT
Ann James, Chief Executive	University Hospitals Plymouth NHS Trust

Signed By:
Suzanne Tracey

_____

Date:

Signed By:
Kate Shields

_____

Date:

Signed By:
Liz Davenport

_____

Date:

Signed By:
Ann James

_____

Date:

SCHEDULE ONE

PENINSULA PATHOLOGY (PP) NETWORK – WORK PROGRAMME

Definition of terms

Lead Organisation or Group – Where responsibility sits for delivery of a programme of work. Where this is a PP group, it is the PP group, through discussion between stakeholder pathology services that agrees strategy/programme/specification and required output. A pathology service will be responsible for delivering the output for their service, as they see fit to meet the requirement and can be held to account for doing so. Where the pathology service is responsible for strategy/programme/specification and required outputs as well as delivering the output, they must observe the principle of 'keep informed' through an appropriate PP forum.

Manage closely – A pathology service provider is responsible for the close management and delivery of a programme of work. They are Responsible to the Lead Organisation or Group for that programme of work (PP group or self).

Keep informed – A service provider/lead group is responsible for providing regular updates on these programmes to PP. The information will be detailed and allow shared learning with PP partners and allow others to inform/influence the work where the programme may have consequences or benefits to the PP network as a whole. Service providers are not obliged to adjust plans to meet the need of other services, but in the interest of collaboration should consider views objectively so they mitigate consequences, if any, to other services. Ambition or changes in one service should not negatively impact on another.

Workstream /Task – project briefing/terms of reference should be developed, in an agreed format for each programme of work so stakeholders are clear on their role and responsibilities as well as the benefits and opportunities for PP.

Strategic Objectives – in summary

1. Establish Governance framework based on Clinical Effectiveness
2. Support the establishment of three service providers; South, East and North Devon (SEND), Plymouth and Cornwall
3. Ensure business continuity and resilience
4. Develop workforce plans to deliver sustainability of services
5. Influence wider south west region to agree a high level strategy for progressing pathology IT

			Meeting Strategic Objectives						SERVICE PROVIDERS Level of stakeholder involvement			
Task ID	**Workstream area**	**Description of task**	**1**	**2**	**3**	**4**	**5**	**Lead organisation /Group**	**Cornwall**	**SEND**	**Plymouth**	**Target date**
P1	Estates	New laboratory build at Treliske	✔	✔	✔	✔		RCHT	Manage closely	Keep informed	Keep informed	tba
P2	Integration	SEND provider development	✔	✔	✔	✔		SEND	Keep informed	Manage Closely	Keep Informed	March 2023
P3	Estates	New laboratory provision for Plymouth	✔	✔	✔	✔		UHP	Keep informed	Keep informed	Manage closely	tba
1	Pathology Optimisation	Optimising Pathology requesting, testing and reporting	✔	✔	✔			Effectiveness Group	Manage closely	Manage closely	Manage closely	On-going
2	GIRFT – pathology optimisation	An evidence-based test repertoire, or directory, linked to best practice	✔	✔	✔			Effectiveness Group	Manage closely	Manage closely	Manage closely	On-going
3	GIRFT – service delivery	Test directory based on clinical pathways with test service quality (eg turnaround time, minimum retest intervals, accuracy, sensitivity, specificity and cost).	✔	✔	✔			Effectiveness Group	Manage closely	Manage closely	Manage closely	
4	Planned care	To provide the required Pathology services to support improving patient pathways	✔	✔		✔		Planned Care/ Peninsula Partnership and Planned Care Boards	Manage closely	Manage closely	Manage closely	On-going
5	Blood sciences	Consolidation of referral testing (various)	✔	✔	✔			Effectiveness Group	Manage closely	Manage closely	Manage closely	March 2022
6	Microbiology	Consolidation of referral testing (various)	✔	✔	✔			Effectiveness Group	Manage closely	Manage closely	Manage closely	

			Meeting Strategic Objectives						SERVICE PROVIDERS Level of stakeholder involvement			
Task ID	**Workstream area**	**Description of task**	**1**	**2**	**3**	**4**	**5**	**Lead organisation /Group**	**Cornwall**	**SEND**	**Plymouth**	**Target date**
7	Histopathology	Produce a plan for reporting capacity issues relating to vulnerable specialties eg renal, liver, sarcoma and lymphoma	✔	✔	✔	✔		Operational Delivery Group	Manage closely	Manage closely	Manage closely	On-going
8	Service delivery	Individual service reviews to assess workforce/equipment building on work to date	✔	✔	✔	✔		Operational Delivery Group	Manage closely	Manage closely	Manage closely	On-going
9	Workforce	Review of out of hours		✔	✔	✔		Operational Delivery Group	Manage closely	Manage closely	Manage closely	June 2022
10	Workforce	Workforce strategy to produce a sustainable trained and competent workforce		✔	✔	✔		Operational Delivery Group	Manage closely	Manage closely	Manage closely	June 2022
11	IT - Digital	Influence the plan for LIMS replacement in the strategic context of broader EPR development		✔	✔		✔	Peninsula Pathology Board	Manage closely	Manage closely	Manage closely	On-going
12	IT - Digital	Develop business case for digital transformation across primary and secondary care		✔			✔	Operational Delivery Group	Manage closely	Manage closely	Manage closely	Dec 2021
13	Histopathology	Digital histopathology introduction of new technologies, tests and techniques, specifically	✔	✔	✔		✔	Operational Delivery Group	Manage closely	Manage closely	Manage closely	Dec 2021

			Meeting Strategic Objectives						SERVICE PROVIDERS Level of stakeholder involvement			
Task ID	**Workstream area**	**Description of task**	**1**	**2**	**3**	**4**	**5**	**Lead organisation /Group**	**Cornwall**	**SEND**	**Plymouth**	**Target date**
		to include molecular and digital technology.										
14	Service contracts	Develop a longer term plan to replace existing MLS contracts	✔	✔	✔			Operational Delivery Group	Manage closely	Manage closely	Manage closely	On-going
15	Quality	Develop a longer term plan for harmonisation of quality management systems	✔	✔	✔	✔		Operational Delivery Group	Manage closely	Manage closely	Manage closely	March 2023

Torbay and South Devon
NHS Foundation Trust

Report to the Board Trust of Directors			
Report title: Risk Management Strategy and Risk Management Policy			**Meeting date:** 30th June 2021
Report appendix	Appendix 1: Risk Management Strategy Appendix 2: Risk Management Policy		
Report sponsor	Director of Corporate Governance		
Report author	Director of Corporate Governance and Risk Officer		
Report provenance	Reviewed by Risk Group (15.06.21) and Audit Committee (25.06.21)		
Purpose of the report and key issues for consideration/decision	The Risk Management Strategy and Risk Management Policy is subject to review and approval by the Board of Directors on an annual basis. Its aim is to create a coordinated and focussed framework for the management of risk within the Trust and is subject to regular review to ensure it remains fit for purpose reflecting current practice throughout the Trust. This report presents the outcome from the annual review of the risk management strategy and policy. No major changes are proposed to the Risk Management Strategy, other than minor amendments to reflect changes in role titles etc. The recommendations from the recent internal audit report on risk management have also been reflected in the updated documents. The Risk Group and Audit Committee have reviewed the documents and recommend approval to the Board of Directors.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations	The Board of Directors is asked to approve the Risk Management Strategy and Risk Management Policy.		

Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks

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

Torbay and South Devon NHS Foundation Trust

Risk Management Strategy

Date: June 2021

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On receipt of a new version, please destroy all previous versions

Document Information

Date of Issue:	21 January 2017	Next Review Date:	June 2022
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Author:	Director of Corporate Governance		
Directorate:	Corporate		
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Approved By:		Date Approved:	
Risk Group		15 June 2021	
Audit Committee		25 June 2021	
Trust Board		[30 June 2021]	
Links or overlaps with other strategies/policies:			
Risk Management Policy			
Information Governance Policy			
Health and Safety Policy			
Incident Reporting and Management Policy			
(Others listed within this document)			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
V1.1	Draft	31/01/2018	Minor updates	Risk Group
V1.2	Draft	30/06/2019	Minor updates	Risk Group
V1.3	Draft	16/06/2020	Minor updates	Risk Group Audit Committee Trust Board
V1.4	Draft	21/07/2020	Changes to financial risk matrix Additional text 1.1. and 1.2 Introduction section	Risk Group Audit Committee Trust Board
V1.5	Draft	15/06/2021	Minor updates	Risk Group/Audit Cttee

The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.

Contents

1. Introduction

1.1. Strategic risk management is the process of identifying, assessing and managing the risks and uncertainties, affected by internal and external events or scenarios that could inhibit an organisation's ability to achieve its strategy and strategic objectives.

1.2. For the purposes of this Risk Management Strategy, risks are considered as occurences or opportunities that would impact on the delivery of activities, the quality of outputs, the achievement of strategic goals or reputation.

1.3. Torbay and South Devon NHS Foundation Trust ('the Trust') recognises that good risk management awareness and recording at all levels ensures that risks are managed systematically and consistently across all areas and where identified risk factors can be reduced to a tolerated level. This will result in improved safety and quality of health and social care and minimise the risks to staff, patients, clients, carers, families, service users and visitors.

1.4. The Trust recognises that risk management is an essential component in fulfilling its responsibilities effectively and responsibly. This risk strategy specifies the Trust's philosophy and prime objectives and approach for the management of risk.

1.5. Good risk management is the responsibility of all staff and the Trust recognises the importance all staff have to ensure risks are assessed and where applicable recorded and managed.

2. Scope

2.1 In recognising that clinical, health and social care is inherently complex and risky, all aspects of the provider and corporate business are within the scope of this strategy.

2.2 This strategy applies to all staff working in the organisation, including permanent, temporary, bank workers, agency staff and contractors.

2.3 This strategy applies to all risks that jeopardise the strategic objectives of the Trust. These include, but are not limited to:

- **Clinical/ Safety risk** – any issue that may have an impact on the achievement of high quality, safe and effective care for patients, clients, service users and the safety of staff.

- **Performance risk** – any non-compliance or repeated failure to meet internal standards or targets through to a gross failure to meet professional standards or national standards or targets.

- **Environmental Impact risk**– any risk that could affect the environment for example spillage or escape of clinical or toxic waste.

- **Financial risk** – any risk that could impact the Trust financially. For example where scheduled savings cannot be made, or litigation claims or fines from external regulators such as the Information Commissioner's Office.

- **Health and Safety risk** – any risk that could put a person at risk of harm in accordance with health and safety legislation in its various forms throughout the organisation.

- **Information and Communications Technology risk** - any issue that may have an impact on the digital information held or IT systems used by the Trust.

- **Information Governance risk** - any risk where the data protection act is not being adhered to, this is linked to the requirements of Data Security and Protection Toolkit. This includes quality of data, breaches of confidentiality and data losses.

- **Operational risk** – Any issue that may have an impact on the achievement of operational performance e.g. referral to treatment standards.

- **Patient/user experience risk** - any unintended or unexpected incident which could have or did lead to harm for one or more patients, clients, service users receiving health/social care. It is a specific type of adverse event.

- **Reputational risk** – Any risk that could have an impact on the reputation of the Trust for example negative media coverage including social media.

3. Statement of Intent

3.1. Our purpose is to provide safe, high quality health and social care at the right time, in the right place to support the people of Torbay and South Devon to live their lives to the full.

3.2. The vision, values, purpose and strapline that describes what the Trust is aiming to achieve can be read via the hyperlink above.

4. Aims

The main aim of this strategy is to ensure a holistic and integrated approach to risk management across the organisation. This will be summarised where appropriate using ORCA (Objectives, Risks, Controls and Assurance) and under the following key areas:

4.1 Developing risk management

- Develop and define an integrated approach to managing risk across all of the Trust's activities.
- Facilitate a single database for all risks to be centrally managed by the individual risk owners and associated action point holders.
- Ensure that all risks are identified, assessed, minimised or mitigated and wherever practicable eliminated.
- Promote stakeholder and staff involvement in risk management.
- Protect patients, clients, service users, carers, staff, contractors, partners and others who come into contact with the Trust, together with safeguarding the Trust as a whole along with its reputation.

4.2 Embedding risk management systems and processes

- Link the whole of risk management throughout the Trust to the strategic objectives, the Board Assurance Framework (BAF) and corporate level risks.
- Provide direction and ensure the Trust's Board of Directors ('the Board') are aware of all significant risks and provide a commitment to effective risk management and mitigation within the organisation.

- Embed risk registers across all directorates, integrated service units, service areas and departments across the organisation.
- Introduce and maintain cost effective risk control measures to eliminate or reduce risk to an acceptable level by risk assessment / action plans, cost benefit analysis and evaluation and ongoing regular monitoring.
- Initiate a systematic and consistent approach to learning and promoting continuous improvement.

4.3 Ensuring compliance with international standards and best practice guidance

- Satisfy all mandatory and statutory duties and undertakings.
- Ensure the health and safety of all those who work for the Trust.
- Achieve and improve performance against all external and internal regulated risk management activities (appendix 8 of the Risk Management Policy refers).

4.4 Ensuring the Trust is risk aware and that staff are appropriately trained / skilled in risk management

- Provide stakeholders with an understanding of the Trust's purpose and intentions and how risk management is utilised to help achieve these.
- Raise awareness of risks and their management through a programme of communication and training.
- Foster an environment whereby all staff understand their role in suitable and sufficient risk assessments and risk management.

4.5 Ensuring the Trust is a learning organisation

- Ensure learning from experiences e.g. incidents, near misses, complaints, concerns, compliments, comments, PALS enquiries and any legal issues.
- Develop a reflective, supportive, challenging and open culture that encourages all staff to report incidents, accidents and near misses without reprisal and to share learning and best practice.
- Monitor and review learning to ensure it is acted upon and that best practice is adopted across the Trust where applicable.

5. Risk Management Structure and Accountability

5.1. The Trust recognises that responsibility for risk cannot simply be attributed to one person and is therefore an integral part of the normal management process. Responsbilities are laid out in appendices 1 and 2 of the Risk Management Policy.

5.2. The authority and responsibility for the establishment, maintenance, support and evaluation of the risk management processes and this strategy within the organisation is invested in the Board . The Board is responsible for all internal controls in the organisation, and for agreeing the annual governance statement which forms part of the annual report and accounts.

The Board must have a sound understanding of the principal risks facing the organisation and receive assurances via the BAF, corporate level risk registers, annual internal audit report and performance reports that the appropriate risk management policies and risk standard operating procedure (SOP) are operating efficiently and effectively.

6. Ensuring the Trust is Risk Aware and Staff are Appropriately Trained and Skilled in Risk Assessments and Risk Management

6.1. The Trust's holistic approach to risk management will be applied to training. The Trusts Risk Officer will continue to train all Risk Handlers in risk awareness and how to use the Datix Risk Module (DRM) before a login is provided.

6.2. Training Material for the DRM is available electronically to all staff via the Trust's intranet site (ICON). The Trusts Risk Officer will make themselves available to aid and assist with additional training to ensure a good level of continuity across the Trust.

6.3. A governance framework will drive senior management reviews of department, Integrated Service Unit/s (ISU) and directorate risk registers. Risk management interactive sessions have been designed to reinforce why risk assessment and risk management is an important part of Trust business. Risk Management pages are available via ICON to assist staff in understanding the Trust's approach to risk management.

6.4. The Trust will make available adequate training for staff in risk assessment and management.

7. Risk Assessment Process and Escalation

7.1 The risk assessment process is a systematic process and to be effective it will be holistically applied strategically and operationally to all systems, processes and services. This process and escalation procedure is outlined within the Risk Management Policy and Risk Management Standard Operating Procedure.

8. Implementation of the Risk Management Strategy

8.1 To be effective this strategy must be communicated widely. The implementation objectives are to:

- Raise awareness and develop a culture where all risks are identified understood and managed.
- Ensure an appropriate system and organisational structure is in place for the identification and control of risks.
- Provide assurance that key processes are in place to provide reliable information and enable management to make appropriate decisions.
- Embed risk assessment and risk management into all our activities, including day to day and future ongoing management of the Trust.

9. Monitoring, Auditing, Review and Evaluation of this Strategy

10.1 The Chief Finance Officer through the Director of Corporate Governance is responsible for auditing, reviewing and evaluating the effectiveness of this strategy on an annual basis.

(e)quality impact assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	*Risk Management Strategy*	***Version and Date***	*V3.3 June 2021*
Policy Author	*Risk Officer*		
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐	*Staff* ☒	*Other, please state…*	☐

Could the policy treat people from protected groups less favorably than the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EqIA and must be referred to the equality leads below***					
Age	*Yes ☐ No☒*	*Gender Reassignment*	*Yes ☐ No☒*	*Sexual Orientation*	*Yes ☐ No☒*
Race	*Yes ☐ No☒*	*Disability*	*Yes ☐ No☒*	*Religion/Belief (non)*	*Yes ☐ No☒*
Gender	*Yes ☐ No☒*	*Pregnancy/Maternity*	*Yes ☐ No☒*	*Marriage/ Civil Partnership*	*Yes ☐ No☒*
Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)					*Yes ☐ No☒*
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language[5] used throughout?					*Yes ☒ No☐ NA ☐*
Are the services outlined in the policy fully accessible[6]?					*Yes ☒ No☐ NA ☐*
Does the policy encourage individualised and person-centered care?					*Yes ☐ No☐ NA ☒*
Could there be an adverse impact on an individual's independence or autonomy[7]?					*Yes ☐ No☒ NA ☐*
EXTERNAL FACTORS					
Is the policy a result of national legislation which cannot be modified in any way?					*Yes ☐ No☒*
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
To set out Torbay and South Devon NHS Foundation Trust's expectations and procedures on Risk Management.					
Who was consulted when drafting this policy? *Members of Risk Group and Audit Committee*					
Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EqIA, please refer to the equality leads below					*Yes ☐ No☒*
ACTION PLAN: Please list all actions identified to address any impacts					
Action			***Person responsible***		***Completion date***
AUTHORISATION: ***By signing below, I confirm that the named person responsible above is aware of the actions assigned to them***					
Name of person completing the form	*Amanda Anders*		***Signature***	*AA*	
Validated by (line manager)	*Sarah Fox*		***Signature***	*SF*	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated

[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives

[6] Consider both physical access to services and how information/ communication in available in an accessible format

[7] Example: a telephone-based service may discriminate against people who are deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Torbay and South Devon
NHS Foundation Trust

Risk Management Policy

Date: June 2021

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative.
On receipt of a new version, please destroy all previous versions.

Document Information

Date of Issue:	01/03/2016	Next Review Date:	June 2022
Version:	3.3	Last Review Date:	June 2021
Author:	Risk Officer		
Owner:	Director of Corporate Governance		
Directorate:	Corporate		
Approval Route			
Approved By:		Date Approved:	
Risk Group		15 June 2021	
Audit Committee		25 June 2021	
Trust Board		[30 June 2021]	
Links or overlaps with other policies:			
Information Governance Policy			
Health and Safety Policy			
Incident Reporting and Management Policy			
The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership. The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
V1	Active	01/03/2016	New Trust Policy	Trust Board
V1.1	Active	25/08/2016	Correction to Graphics and a Typo on page 12.	N/A
V1.2	Draft	04/05/2017	Annual Review & Update.	Risk Group & Exec Team
V2	Active	02/08/2017	Policy approved after first year.	Trust Board
V2.1	Active	19-01-2018	Appendix 9 updated	Co Sec
V3	Draft	18/06/2019	Annual Review & Update.	Risk Group Trust Board
V3.1	Active	27/11/2019	Appendix 3 & 4 Updated	Risk Group
V3.2	Active	21/07/2020 22/07/2020 29/07/2020	Annual Review & Update	Risk Group Audit Committee Trust Board
V3.3	Active	15/06/2021	Annual Review	Risk Group/Audit Cttee

Contents

1. Introduction

1.1. Torbay and South Devon NHS Foundation Trust ('the Trust') recognises that good risk management awareness, practice and recording at all levels ensures risks are managed systematically and consistently across all areas of the Trust and where identified, risk factors can be reduced to a tolerable level. This will result in improved safety and quality of care for patients/clients and the minimisation of risks for staff and visitors.

1.2. The Trust recognises that risk management is an essential component in fulfilling its responsibilities effectively and responsibly. The risk strategy specifies the Trust's philosophy, prime objectives and approach for the management of risk.

1.3. Good risk management is the responsibility of all staff and the Trust recognises the importance of all staff ensuring risks are identified, recorded and managed.

1.4 A comprehensive risk management policy and procedure will not themselves ensure good risk management. Equally important is that risk management is seen as an important tool by managers and clinicians alike. Ensuring the existence of an effective risk management culture is therefore an important task for the Executive Team and the Board of Directors. An effective culture maximises the likelihood that risks and concerns are identified within the organisation. The policy and procedures ensure that risks are escalated to and managed at the right level, with the whole process underpinned by effective accountability and performance arrangements.

2. Statement/Objective

2.1. An effectively planned, organised and controlled approach to risk management is an essential component of successful corporate governance for any NHS organisation.

2.2. The intention of this policy is, therefore, to detail and support a risk based approach to decision making and to embed a culture of creativity and innovation that is founded on risk management as an integral part of the Trust's objectives, practices and management systems.

2.3. This document is intended to help and support staff, enabling and empowering them to confidently and competently make decisions on a risk-based approach.

3. Roles & Responsibilities

3.1. **All Staff**

All staff have a responsibility to familiarise themselves with the Risk Management Policy and Risk Management Strategy. Staff should report to their line manager/supervisor any risk they

become aware of and take all necessary actions to reduce the risk.

All staff should be able to raise concerns about issues that may compromise any of the Trust's strategic objectives via their normal line management structure. Where it is felt that this could be difficult these concerns can be raised via the Trust's Risk Officer or through the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy (H30).

3.2 Responsibilities for the Chief Executive and other specific roles can be found in Appendix 1.

3.3 The risk management structure can be found in Appendix 2. The Chair of each Committee/Group will be responsible for ensuring the Terms of Reference ('ToR') are kept up to date.

4. Risk Management

Risk management is the process by which risks are identified, assessed, recorded, mitigated and reviewed. A risk is the threat that an event or action will adversely affect the ability to achieve the Trust's strategic objectives.

Each risk will be recorded by the Risk Owner with the support of their Risk Handler where applicable. Where appropriate, risks should be managed at a local level depending upon its current risk score as shown in Appendix 5.

The Risk Handler for the Area, Local Team, Department or Integrated Service Unit (ISU), will be responsible for adding and arranging the review of risks, ensuring they are assessed and managed in accordance with this policy. The risk owner will be responsible for the risk and for ensuring that the Risk Handler, if applicable, is carrying out their role effectively.

There will be some risks that cannot be dealt with at the local level; these risks should be escalated through the risk management system as soon as it is clear that the risk cannot be controlled locally.
These will include:

- Any risk that cannot be managed within the Area, Local Team, Department or ISU or Directorate,
- Any risk where the necessary adjustments cannot be funded from within the Area, Local Team, Division or ISU or Directorates budgets,
- Any risk that has a current risk score of 15 or more in accordance with the risk scoring matrix Appendix 5.

4.1. Identifying Risks

Risks can be identified through various means, including but not limited to:

- Audit recommendations.
- External recommendations.
- Fault reports.
- Incident reports.
- Process reviews.
- Risk assessments.

4.2. Assessing Risks

It is essential that all staff be alert to risks on an on-going basis to ensure that we respond to any emerging issues. Risk assessments can be done through a specific planned process at all levels. The type of assessment will vary dependant of the type of risk but all will follow the process as laid out in Appendix 8.

4.3. Risk Scoring

Risks are scored using a potential 'Consequence' score multiplied by a potential 'Likelihood' score.

- Consequence table (Appendix 3),
- Likelihood table (Appendix 4),
- Risks must be scored using the Trusts Risk Matrix (Appendix 5) for the following:
  - Inherent Risk Score (when first identified).
  - Current Risk Score (once controls are put into place to reduce the Inherent Risk Score).
  - Residual Risk Score (the level aimed for to either mitigate this risk or reduce it to a tolerable level) post completion of actions.
  - Tolerated Risk Score (used with all Board and corporate/high level risks where the tolerated risk score is set by the Executive Director for that risk).

4.4. Recording Risks

All risks that cannot be addressed immediately should be recorded on the risk management system. This process is explained in the how to guides on ICON

4.5. Risk Tolerances, Accountability and Escalation

Risk tolerances and accountability are laid out in Appendix 5, the risk owner will ensure that reports are generated allowing information to be assimilated at the relevant levels.

Should the risk meet the criteria to be assessed for inclusion on the Corporate Risk Register, the Risk Officer will record this within the risks status and escalate it through the correct line of reporting as laid out in the Governance Organisational Structure.

It is important to note that the escalation of a risk will not negate the responsibilities of the risk owner or Area, Local Team, Department or ISU or Directorate.

4.6. Action Plan/Point

An action plan/point is required to mitigate all risks that cannot be resolved immediately. These are to be recorded on the risk management system within the risk record for any risks with a current score of 12 or more. This is not limited to a single action plan/point as multiples may be required to reach the desired residual score.

4.7. Corporate Level Risk Register > Reviewing > Consultation and Approval

Any risk which has a current risk score of 15 or more in accordance with the Risk Scoring Matrix will be reported to the Risk Group via the correct line of reporting as laid out in Appendix 2.

Any strategic risk that may result in a failure to achieve one or more of the Trusts strategic objects will be reported to the Risk Group via the correct lines of reporting as laid out in Appendix 2.

This full process is laid out in the Risk Management Standard Operating Procedure (SOP).

4.8. Board Assurance Framework > Reviewing > Consultation and Approval

The Board Assurance Framework (BAF) summarises the Trust's corporate objectives, the key risks in achieving these objectives and the controls and actions in place to prevent the occurrence of, or to mitigate the individual risks assurance(s) are recorded and linked to controls, as laid out in the process in Appendix 9

The Risk Group, Audit Committee and/or Board may ask for risk owners or action plan/point owners to provide reports on the progress and assurances that controls are sufficient. The framework is illustrated on the Risk Management pages on ICON.

The BAF will be reviewed by the Audit Committee at all of their meetings and then reported on to the Board.

4.9. Projects

It is understood that projects carried out by the Trust will be managed in accordance with standard protocols and a risk assessment will have been carried out and recorded as part of the project. It is not necessary for these to be recorded on the risk management system, unless the project has been delivered and a threat remains to one or more of the Trusts strategic objectives.

4.10. Risk Communication

All risks should be communicated locally with staff so that they can act accordingly in ensuring that all controls are carried out and any gaps in control are reported. Some risks will be reported on through the Trust's communications team so as to keep all staff informed. Corporate Risk Registers and Board Assurance Framework Reports are published in the Risk Management pages of ICON.

4.11. Monitoring of the Risk Register on Datix

The risk register is monitored by the Risk Officer who in turn produces reports for the Risk Group, Audit Committee and Board of Directors.

The risk management system allows for risks to be updated and the current risk levels adjusted to show an up to date record of all risks and their associated action plans/points. Details on how to use the system are on the ICON Risk Management pages and in the Risk Management SOP and show how risks are to be reviewed, along with how reports can be generated from the system.(Template located on ICON)

4.12. Risk Reporting Structure

It is important that, depending on the level of risk, it is reported to the correct level within the organisation in a timely manner. The risk management accountability is laid out in Appendix 2.

5. Training

Risk management system training and guidance is available for all Risk Owners and Risk Handlers, this will be provided by the Risk Officer and must be completed before a login is provided.

6. Monitoring, Auditing, Reviewing & Evaluation

6.1 This policy and associated Risk Management Strategy and Risk Management SOP will be reviewed every year (or sooner in the event of a major organisational or policy change) by the Company Secretary to ensure that it is relevant and effective.

6.2 Feedback from all staff regarding this policy is encouraged and should be sent to the Risk Officer.

6.3 Regular audits of the risk registers are carried out by the Risk Officer to ensure that each Area, Local Team, Department or ISU or Directorate is adhering to this policy and to identify any gaps, threats and opportunities presented in the current process.

6.4 An audit of risk system management and the BAF will be conducted by Internal Audit on an annual basis.

7. References

7.1. The key references for this policy can be found in Appendix 7.

8 Equality and Diversity Exceptions

8.1 None identified.

9 Distribution

9.1 This Policy is available to all staff and externally on the public website

10 Appendices

1. Roles and Responsibilities
2. Risk Management Structure & Accountability
3. Consequence Table
4. Likelihood Table
5. Risk Matrix
6. Summary of Risk Management Process
6a Risk Theme Identification Process
7. Key References
8. Risk Assessment Tools
9. Board Assurance Framework (BAF) Process
10. Equality Impact Assessment

Appendix 1 - Roles & Responsibilities

Title	Responsibilities
Chief Executive	Is ultimately accountable for ensuring that there is a comprehensive risk management system in place and is responsible for: • ensuring that management processes fulfil the responsibilities for risk management; • ensuring that full support and commitment is provided and maintained in every activity relating to risk management; • planning for adequate staffing, finances and other resources, to ensure the management of those risks which may have an adverse impact on the staff, finances or stakeholders of the Trust; • ensuring an appropriate corporate level risk register CLR Template is prepared and regularly updated and receives appropriate consideration; and, • ensuring that the governance statement, included in the annual reports and accounts, appropriately reflects the risk management processes in operation across the Trust.
Executive Directors	Have specific delegated responsibilities in relation to risk management, all directors must ensure that appropriate risk management processes are in place within their area of responsibility, and are responsible for: • ensuring the existence of an effective risk management culture is continually promoted; • ensuring that all relevant risks are identified and managed appropriately; • the maintenance of their area risk register, and to ensure that all relevant risks are added to the risk management system; • ensuring that the culture of their area of responsibility is such that staff are encouraged to participate in the risk management processes; • ensuring the performance management of risk management processes within their area of responsibility is linked to the performance and accountability framework for testing and assessing risk management priorities; • identifying relevant staff for risk management training; and • ensuring that they review and update the Board Assurance Framework (BAF) and the controls and assurances in place,

Systems Directors / Assistant Directors/ Senior Managers/ ISU Leads/ Department Heads/ Managers/ Matrons	Are responsible for the identification, recording, assessing and mitigating of risks within their areas of responsibility using the General Risk Assessment. They are responsible for: • ensuring that the culture of their directorate is such that staff are encouraged to participate in the risk management processes; • ensuring their General Risk Assessment is reviewed and up to date; • escalating risks, onto the risk management system; • escalating, where appropriate to the relevant line manager; • the maintenance of a directorate risk register, and to ensure that all relevant risks are added to the risk management system; • ensuring, as a minimum, that on a quarterly basis the overall risk position for their area is considered. This must include a review of multiple low level risks that could contribute to a bigger issue / risk e.g. failed inspection; • monitoring corporate level risks to understand higher level risks with the organisation; and • identifying relevant staff for risk management training.
All Staff (Including Bank and Agency staff)	All staff have a personal responsibility to: • familiarise themselves with this policy; • report all unidentified or potential risks to their line manager/supervisor; and • record incidents and near misses on the incident reporting system.
The Senior Information Risk Owner (SIRO)	The SIRO for the Trust and is responsible for: • ensuring that the Trust's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff; • providing a focal point for the resolution and/or discussion of information risk issues; and • ensuring the Board is adequately briefed on information risks.
Director of Corporate Governance	The Director of Corporate Governance is the lead for corporate governance, risk management and the Board Assurance Framework (BAF) and is responsible for: • ensuring that an effective risk management system is in place within the organisation which meets all statutory requirements and best practice guidance issued by the Department of Health and Social Care, as delegated by the Chief Executive; and • managing the strategic development and implementation of organisational risk management.

Risk Officer	The Risk Officer reports directly to the Corporate Governance Manager and in turn the Director of Corporate Governance. The Risk Officer will offer assistance, training and support to all involved in risk management and ensure the risk management system is kept up to date and is used in accordance with this policy and procedures across the organisation. The Risk Officer is responsible for: • the maintenance of a fully effective risk management system which supports the strategic direction of the Trust; • the day to day administration of the risk management system; • producing reports documenting progress of risks under various remits; • keeping an overview of all risks being entered on the system so as to report on any trends forming within the management of reported risks (Appendix 6A); • providing training and support to the Risk Handlers e.g. via drop in sessions and workshops on risk management and the risk management system; • providing training and support to all responsible for inputting on the risk management system; • attending key meetings to ensure the recording and actioning of risks discussed and reporting on these to the Risk Group; • ensuring maintenance and development of the Corporate/High Level Risk Register and the BAF; • providing input to the creation of and review of risk related documents for the Trust; • receiving and collating information on risks within the Trust, monitoring new developments in risk management, developing knowledge and expertise and acting as a liaison point for risk management issues, both within the Trust and with external bodies; and • monitoring proposed developments and initiatives and checking they are compliant within good risk management practice.
Risk Handler	The Risk Handler will enter risks onto the risk management system and ensure these risks and their associated actions are reviewed by the Risk and Action Owners ensuring they remain current and up to date and is responsible for: • co-ordination and maintenance of their areas risk register entries, using the risk management system. • being the central contact point for the collation and escalation of key risks within their area; • being the distribution point within their area for the cascade of any information about risk management; • liaising throughout, and to lead within, their area on all aspects of risk management; and • receiving additional appropriate training on risk management and the risk management system via drop in sessions and workshops.
Chairs of meetings	Chairs of meetings should ensure that records of meetings are completed to include explicit identifiable detail of the risks discussed (Datix ID No.) and of the actions agreed to be taken. Chairs should regularly seek assurance that the corresponding entries on Datix are updated to reflect the discussion of individual risks at their meetings.

Appendix 2 - Risk Management Structure & Accountability

Title	Responsibilities
Trust Board	Responsible for: • articulating the key risk management priorities for the Trust; • protecting the reputation of the Trust; • providing leadership in risk management; • determining the risk appetite for the Trust; • ensuring the approach to risk management is consistently applied; • ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately; and • endorsing risk related disclosure documents.
Audit Committee	On behalf of the Board, responsible for: • providing oversight of the establishment and maintenance of an effective system of assurance on risk management and internal control, across the whole of the Trust's activities that supports the achievement of the Trust's objectives; • ensuring the Board Assurance Framework (BAF) is received at each meeting, and appropriate consideration is taken during its review, • utilisation of Internal Audit, External Audit and other assurance functions as appropriate.
Quality Assurance Committee	Responsible for: • reviewing the establishment and maintenance of effective systems in relation to clinical and social care services to ensure the delivery of high quality, person-centred care against the Trust's quality strategy, local account of adult social care, carer's strategy and annual quality account; • receiving annual assurance reports in relation to clinical and social care services including infection control and safeguarding; • receiving and reviewing key person-centred submissions to national bodies and to make recommendations for sign-off by the Trusts Board; • receiving the annual clinical audit programme and assurance of the effectiveness of the Trust's clinical and social care audit function; • receiving and reviewing at each meeting at least two service review deep-dives linked to the Trust's clinical and social care services; • receiving and reviewing the Trust's quality-related risks scoring 15 and above; and • reviewing the quality related risks on the BAF and CRR.

Finance, Performance and Digital Committee	Responsible for: • scrutinising the development of the Trust's annual financial plan and long-term financial strategy and plan (both revenue and capital plans), including the underlying assumptions and methodology used, ahead of review and approval by the Board; • reviewing the Trust's monthly financial performance and identifying the key issues and risks requiring discussion or decision by the Board, recognising that the primary ownership and accountability for the Trust's financial performance rests with the Board; • conducting an annual review of service line reporting and discuss the implications for potential investment or disinvestment in services; • approving and keeping under review, on behalf of the Board, the Trust's investment and borrowing strategy and policies; • evaluating, scrutinising and approving the financial validity of individual investment decisions, including through the review of outline and final business cases; • reviewing post-implementation investment audits undertaken by or on behalf of the Trust. These should be carried out 12 months after business case approval; • receiving and reviewing the Trust's Financial, Performance and Digital risks scoring 15 and above; and • reviewing the financial, performance and digital related risks on the BAF.
People Committee	Responsible for: • reviewing national workforce guidance and strategies, for example the NHS People Plan, and their applicability to the Trust; • considering and recommending to the Board, the Trust's overarching People Plan and associated activity/implementation plan(s) to support Trust forward strategy; • obtaining assurance and monitoring delivery of the People Plan through the associated activity/implementation plan; • considering and recommending to the Board the key people and workforce performance metrics and targets for the Trust.; • receiving regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case; • reviewing and providing assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance; • reviewing workforce related risks identified on the Corporate Risk Register and seeking assurance in relation to risk mitigation and future activity/plans; • reviewing workforce related elements of the Integrated Performance Report and seek assurance on the adequacy of the Trust's performance against operational workforce metrics; • conducting reviews and analysis of strategic people and workforce issues at national and local level

	and, if required, agree the Trust's response; • reviewing workforce performance and metrics at intervals to be decided by the Committee; • providing assurance to the Audit Committee that that arrangements are in place to allow staff to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently; • seeking assurance on the adequacy and effectiveness of staff communication and levels of staff engagement; and • receiving and reviewing the Trust's people risks scoring 15 and above.
Executive Team	Responsible for: • collectively reviewing the BAF and updating so that it can be escalated through the Risk Group to the Audit Committee and on to Board; • ensuring that strategic and operational risks are actively monitored and managed within their areas of the business; • being owner and action owner of individual Board level risks on the BAF (including those delegated by the CEO), and • devising short, medium and long-term strategies to tackle identified risk, including the production of any mitigating action plans.
Risk Group	Responsible for: • reviewing and approving validated potential Corporate/High Level Risks for addition to the Corporate Risk Register • reviewing and approving Corporate Level Risks that no longer meet the scoring requirements to remain at that status with the view to down grading them to Non-Corporate Level Risk status • reviewing the Corporate Level Risk Register and Board Assurance Framework (BAF); • creating a new theme or overarching risk identified through the 'risk theme identification process'; • ensuring the co-ordination of the Trust's BAF and supporting risks, acting as a forum for examining and rating Potential Corporate/High Level Risks identified within the Trust and executing those recommendations; • implementing the Risk Management Strategy and providing a Trust-wide focus on the identification, control and management of risk in the development and delivery of the strategy in line with the International Standards Organisation (ISO) 31000 risk management standard; • ensuring that internal standards and procedures regarding strategic objectives / risks are developed, implemented and regularly reviewed by the relevant groups or managers;

	• ensuring the development and implementation of adequate, relevant and effective reporting, communication and information dissemination systems with managers and staff to comply with the ISO 31000 Risk Management Standard; • ensuring at each meeting that emerging risks are discussed; • ensuring any actions and/or action plans are being linked to risks and ensuring risks are being updated accordingly; • providing regular progress reports to the Audit Committee; and • responding to the recommendations of the Audit Committee, ensuring that, where appropriate they are acted upon.
Integrated Service Units (ISU)	Responsible for: • ensuring that strategic and operational risks are actively managed at the right level within their areas of the business; • ensuring risks and their associated actions within the ISU are reviewed in a timely manner, escalating any potential Corporate/High Level Risks to the Risk Group; • ensuring actions plans/points are in place, leads are identified and timescales for delivery are recorded and then monitored to completion; and • ensuring risks are discussed at ISU meetings and recorded within the minutes using the relevant risk number.
Executive Assurance Level Groups/Committees	Responsible for: • ensuring that strategic and operational risks are actively managed at the right level within their areas of the business; • ensuring risks and their associated actions within the Group/Committee are reviewed in a timely manner, escalating any potential Corporate/High Level Risks to the Risk Group • ensuring actions plans/points are in place, leads are identified and timescales for delivery are recorded and then monitored to completion; and • ensuring risks are discussed at meetings and recorded within the minutes using the relevant risk number.

Appendix 3- Potential Consequences

Choose the Risk Type from the rows below, then select the Consequence from the column.

Consequence (Impact) Score and Examples of Descriptor

Score >	1	2	3	4	5
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Clinical Safety Risk *(Physical/ Psychological)*	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – any adverse event that ran to completion but no harm occurred.	Minor cuts or bruising, resulting in: - Any safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons. Affects 1-2 people.	Moderate injury resulting in: - Professional intervention. - Increase in length of hospital stay by 4-15 days. - An event which impacts on a small number of patients. - A referral to A&E. Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Moderate injury or illness requiring professional intervention. Affects 3-15 people.	Major injury resulting in: - Life changing injury/s. - Major injury/long term incapacity / disability (e.g. loss of limb). - Any incident /accident that could result in a RIDDOR reportable incident. Major untoward clinical / non-clinical issue leading to significant harm / death which requires investigation with executive director involvement. Increase in length of hospital stay by 15 days plus. Mismanagement of patient care with long-term effect. Affects 16 – 50 people.	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Multiple Deaths / Fatalities. Major untoward clinical issue either in a single specialty which requires executive or an independent review. Or a single clinician referred to the GMC due to clinical management. An event effecting 50 people plus.
Performance Risk	Failure to meet departmental standards or KPIs.	Failure to meet Trust / local standards or KPIs.	Failure to meet National standards or KPIs.	Failure to meet professional standards or statutory requirements.	Sustained failure to meet professional standards or statutory requirements.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Environmental Impact Risk	Minimal or no impact on the environment. Minor onsite release of substance. Not directly coming into contact with patients, staff or members of the public.	Minor impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Moderate impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Major impact on environment. On-site release with potential for detrimental effect leading to off-site release with potential for detrimental effect. Involvement by the Environmental Agency	Catastrophic impact on environment. Onsite/Offsite release with realised detrimental/ catastrophic effects. Suspension of Activity by Environmental Agency.
Financial Risk	Small loss £0 – 49k	£50k – £99k	£100k – £249k	£250k – £499k	£500k +
Health & Safety Risk	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – any adverse event that ran to completion but no harm occurred.	Minor cuts or bruising, resulting in: - No lost time or time off work. Affects 1-2 people.	Moderate injury resulting in: - Time off work for up to 7 days. - A referral to A&E. - Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Affects 3-15 people.	Major injury resulting in: - Life changing injury/s. - Major injury/long term incapacity / disability (e.g. loss of limb). - More than14 days off work. - Any incident /accident that could result in a RIDDOR reportable incident. Affects 16 – 50 people.	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Multiple Deaths / Fatalities. - Major untoward non-clinical issue either in a single specialty which requires executive or an independent review. An event effecting 50 people plus.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Infection Control & Prevention Risk	Business as usual	- Any Incident recorded for poor Infection control practices i.e cleanliness, hand hygiene practices, failure to perform HPV when requested by IP&C. - Failure to isolate a patient with an Alert organism (IP&CT will advise on level of risk) in a Moderate Risk area. - Sewage leaks. - Failure of Water supply. - Failure of Critical ventilation. - Failure of Decontamination. - Estates failure leading to closure of clinical areas. - HCAI e.g. Surgical Site Infections, CVC infections, Hospital acquired pneumonia, etc.	- Continued lack of compliance with infection control practices. - CDT infection TSDFT Hospital onset Healthcare associated. - MRSA infection (not colonisation) TSDFT Hospital onset Healthcare associated. - Failure to isolate a patient with an Alert organism in a High-Risk area.	- CDT infection >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - MRSA infection (not colonisation) >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - Seasonal flu cases leading to 2 ward closures in TSDFT. 4 or more cases of seasonal flu on ITU leading to cancellation of surgery and transfers out. - Norovirus cases leading to 2 ward closures in TSDFT. 4 or more cases of Norovirus on ITU leading to cancellation of surgery and transfers out. - Failure to isolate a patient with an Alert organism in a Very High Risk area.	- Pandemic, Swine Flu, Etc. CDT infection leading to death >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - MRSA infection (not colonisation) leading to death >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - Pandemic /seasonal Flu cases in hospital leading to cross infection and >2ward closure/and increased deaths. Staff sickness from pandemic/seasonal flu leading to low staffing levels. - Norovirus cases in hospital leading to cross infection and >2 ward closure/and increased deaths. Staff sickness from Norovirus leading to low staffing levels. - Failure to isolate >2 patient with an Alert organism in a Very High Risk area.

Consequence (Impact) Score and Examples of Descriptor *(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Information & Communications Technology Risk	Unplanned loss/interruption of service for up to 1 hour affecting one business critical system. Loss of data from a single business critical system that takes up to 1 hour to recover. Exposure of non-personal or confidential information to those not covered by a data sharing agreement or otherwise unintended.	Unplanned loss/interruption of service for up to 4 hours affecting one business critical system. Loss of data from a single business critical system that takes up to 8 hours to recover. Exposure of embarrassing information to unintended recipients.	Unplanned loss/interruption of service for up to 8 hours affecting one business critical system. Loss of data from a single business critical system that takes up to 24 hours to recover. Exposure of commercially confidential information to unintended recipients.	Unplanned loss/interruption affecting service of one business critical IT systems for up to 24 hours. Temporary loss of data from multiple business critical systems. Exposure of a single individuals' personal information to those not covered by a data sharing agreement or otherwise unintended.	Unplanned loss/interruption affecting service of many business critical IT systems for up to 1 hour. Permanent loss of data from a single business critical system. Exposure of multiple individuals' personal information to those not covered by a data sharing agreement or otherwise unintended.
Information Governance Risk	Failure to meet departmental standard.	Failure to meet Trust / local standard. - GDPR Incident raised on Datix.	Failure to meet national standards or KPI.	Failure to meet professional standards or statutory requirements.	Sustained failure to meet professional standards or statutory requirements.
Operational Risks	Loss/interruption of up to1 hour.	Loss/interruption of up to 8 hours.	Loss/interruption of up to 1 day.	Loss/interruption of up to 1 week.	Permanent loss of service or facility.
Patient Experience Risk	Reduced level of patient experience not directly related to delivery of care.	Unsatisfactory patient experience, readily resolvable.	Mismanagement of patient care. Unsatisfactory management of patient care – local resolution (with potential to go to independent review).	Serious concerns re patient experience for a particular patient or about a particular clinical service / clinician which required executive director involvement in investigation and onward action. Unsatisfactory management of patient care with long term effects. Significant result of misdiagnosis.	Totally unacceptable patient experience that would lead to an investigation by the CQC e.g. Mid Staffordshire. Totally unsatisfactory patient outcome or experience. Incident leading to death.

Consequence (Impact) Score and Examples of Descriptor*(continued)*					
Score >	**1**	**2**	**3**	**4**	**5**
Risk Type	**Minimal**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Reputation /Risk	Complaint / Rumours. Derogative posts on Social Media, (Facebook/Twitter/Instagram). Potential for public concern. Informal/locally resolved complaint. Potential for settlement/litigation up to £5K.	Local media coverage, short-term reduction in public confidence. Shared derogative posts on Social Media, (Facebook/Twitter/Instagram). Elements of public expectation not being met. Overall treatment/service substandard. Formal justified complaint Minor implication for patient safety if unresolved. Claim up to £10K.	Local media coverage. Long-term reduction in public confidence. Sustained postings of derogative posts on Social Media, (Facebook/Twitter/Instagram). Justified complaint involving lack of appropriate care. Major implications for patient safety if unresolved. Claim(s) between £10K-£100K.	National media coverage with <3 days service well below reasonable public expectation. Petition raised on Change.org or other social media platform. Multiple justified complaints leading to Independent review. Noncompliance with National standards with significant risk to patients if unresolved. Claim(s) between £100K-£1M.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House.) Total loss of public confidence. Multiple justified complaints - Single major claim - Inquest/ ombudsman inquiry -Claim >£1M

Appendix 4 - Assessment of Likelihood of a Risk

Qualitative and Quantitative Measures of Likelihood:

What is the likelihood of the consequence described in the Consequence Table, actually happening?

A frequency based score will be appropriate in most circumstances, except in the case of time-limited projects or objectives, where the probability or chance of reoccurrence based score could be used.

Level / Score	Matrix Description	Detailed Description	Frequency	Odds / Probability	% Chance of Occurrence / Reoccurrence
1	**Rare**	Highly unlikely, but it may occur in exceptional circumstance. It could happen but probably never will.	Not expected to occur for years	May occur = 1 in 1000 chance	1 - 5 %
2	**Unlikely**	Not expected but there is a slight possibility it may occur at some time.	Expected to occur at least annually	Could occur at some time = 1 in 100 to 1 in 1000	6 – 25%
3	**Possible**	The event might occur at some time if other factors precipitate or as there is a history of casual occurrence.	Expected to occur at least monthly	Might occur at some time = 1 in 10 to 1 in 100	26 – 50%
4	**Likely**	If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.	Expected to occur at least weekly	Will probably occur in most circumstances = 1 in 10 to evens odds	51 – 75%
5	**Almost Certain**	Very likely, The event is expected to occur in most circumstances if the activity continues without controls in place. Or may already be happening.	Expected to occur at least daily	Is expected to occur in most circumstances = evens to certain odds	76 – 100%

Appendix 5 – Risk Scoring Matrix

Consequence / Likelihood	1 - Minimal / Insignificant	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
5 - Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

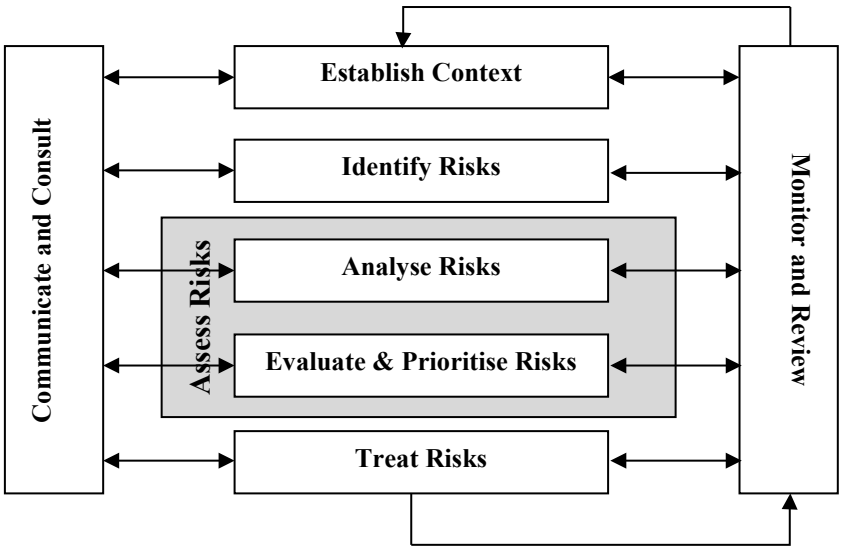
Risk scoring = consequence x likelihood (C x L)

KEY:

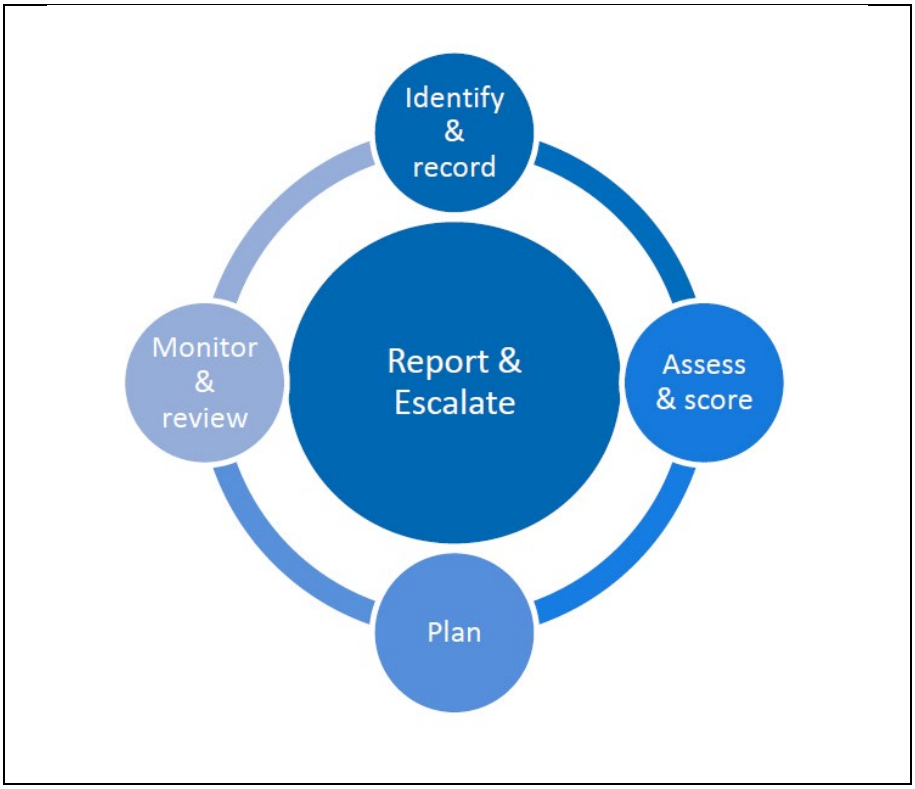
RAG Rating	Expected Level of Management
RED	Executive Team / Board
AMBER	Directorate / ISU
GREEN	General Manager

Appendix 6 - Summary of Risk Management Process

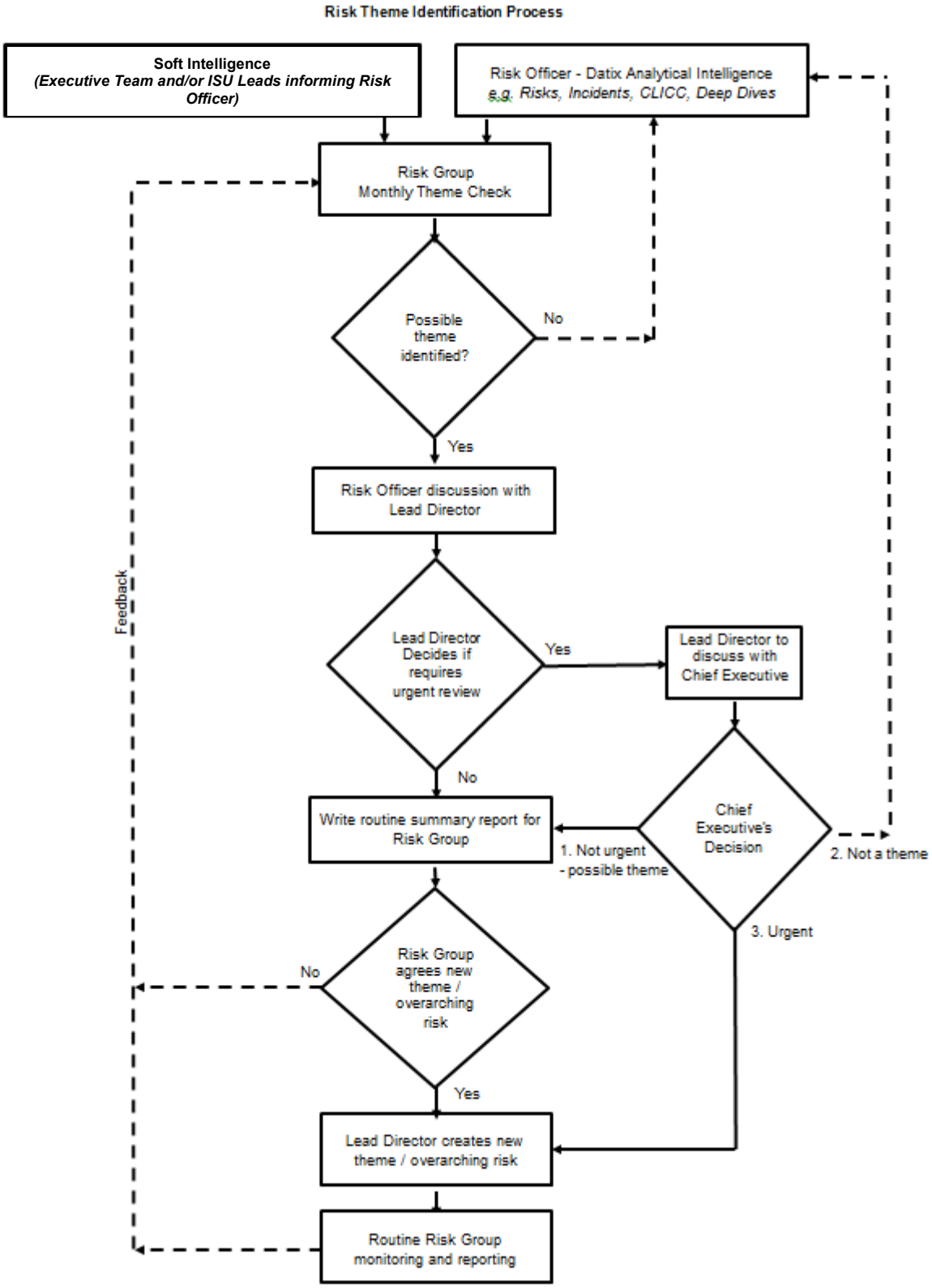
(Adapted from ISO 31000 Risk Management – Principles and Guidelines)



A risk can be any event that **might** occur or is occurring which **could or is** affecting the ability of the Trust/ISU to achieve its **objectives** – it is what could happen, how it could happen and who could be affected by it.



Appendix 6a - Risk Theme Identification Process

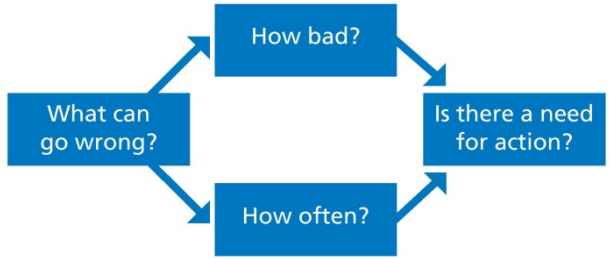


Appendix 7 - Key References

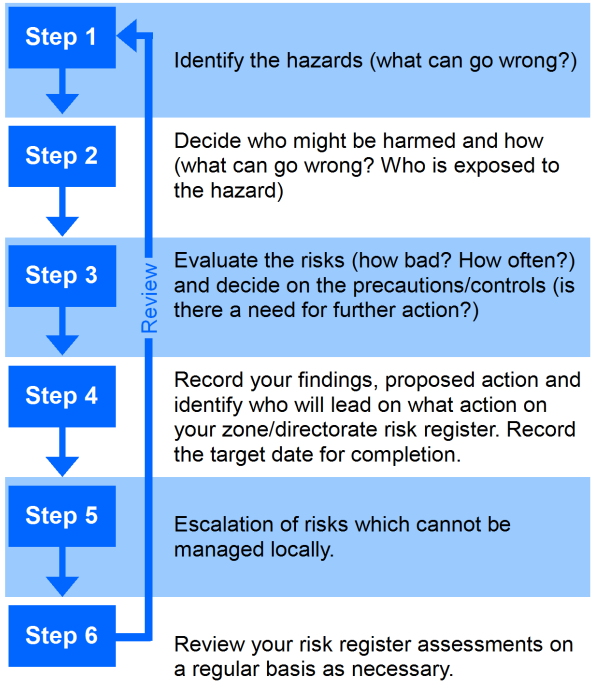
• The Healthy NHS Board 2013 – Principles for Good Governance • Francis Enquiry report into Mid-Staffs March 2010 • Health & Safety at Work Act 1974 • Seven Steps to Patient Safety (NPSA)	• Internal audit standards for the NHS • Management of Health & Safety at Work Regulations, (2006 Amendment & 1999) • NHS Information Risk Management - Information Governance Toolkit • Information Risk Management for SIROs and IAOs • DH: Information Security NHS Code of Practice (2007) • Audit Committee Handbook 2019.

Appendix 8 - Risk Assessment Tools

What is risk assessment? A risk assessment seeks to answer four simple, related questions:



It is not usually possible to eliminate all risks but health and social care staff have a duty to protect patients/service users, themselves and the organisation as far as 'reasonably practical'. This means you must avoid any unnecessary risk. It is best to focus on the risks that really matter – those with the potential to cause harm either clinically, financially or to the organisation as a whole. Keep risk assessment simple – do not use techniques that are overly complex for the type of risk being assessed.



In a risk assessment we need to look at:

Hazards – A hazard is something with the potential to cause harm. The harm could be injury or illness, damage to equipment or premises or some other loss.

Risks – A risk is the likelihood that a hazard will cause actual harm, or effect the successful operation of the organisation, department or project. (i.e. the consequence)
For each hazard identified it is important to decide whether it is significant and whether appropriate and sufficient controls or contingencies are in place to ensure that the risk is properly controlled.

Controls – Controls are the arrangements made, or the precautions taken, to a reduce risk. (It is what is in place now)

Risk Score/Rating – A risk score or rating is the calculation of hazard consequence x likelihood, taking into account current controls.

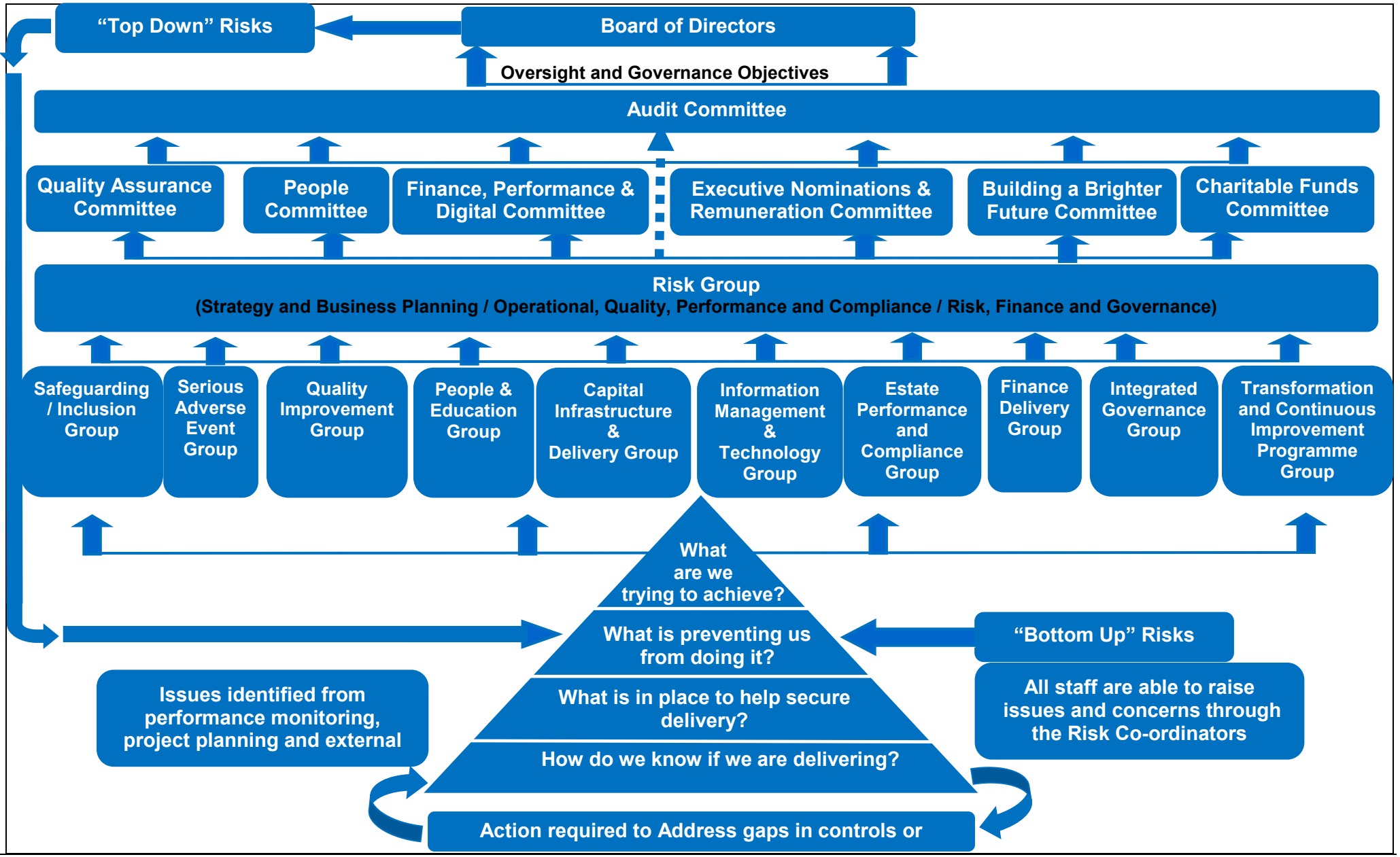
Risk Register – The Risk Register is where risks, once identified, are managed on a day to day basis.

Appendix 8 - Risk Assessment Tools *Continued*

Understanding the difference between a hazard and a risk – examples

A trailing PC cable lying across the floor is a **hazard**.
The **risk** is that someone trips over it.
If the cable is noticed and cleared by a member of staff, it was a **near miss**
If someone trips up and injures themselves before it is cleared away, this is an **incident**

Appendix 9 - Board Assurance Framework (BAF) Process



(E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	Risk Management Policy	**Version and Date**	V3.3 June 2021
Policy Author	Risk Officer		

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☒	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☒	Gender Reassignment	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Disability	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender	Yes ☐ No☒	Pregnancy/Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☒ No☐ NA ☐
Does the policy encourage individualised and person-centered care?	Yes ☐ No☐ NA ☒
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

To set out Torbay and South Devon NHS Foundation Trust's expectations and procedures on Risk Management.

Who was consulted when drafting this policy?
Members of Risk Group and Audit Committee

Does this document require a service redesign or substantial amendments to an existing process? *PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below*	Yes ☐ No☒

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Amanda Anders	**Signature**	AA
Validated by (line manager)	Sarah Fox	**Signature**	SF

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy