Torbay and South Devon NHS Foundation Trust
Public Board of Directors

28 July 2021 10:30 - 28 July 2021 14:00

AGENDA

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3.2	Apologies for Absence Note	Ch	
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4.1.2	Finance, Performance and Digital Committee Chairs Report - 28th June 2021 Receive and Note 4.1.2 Finance Performance and Digital Committee... 13	P Richards	
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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 title: SEND Alliance – Chair's Report (July 2021)	**Meeting date:** 1st July 2021
Report sponsor	SEND Alliance Chair (Sir Richard Ibbotson)
Report author	Interim AD for Strategy and Provider Partnerships (Chris Winfield)

Introduction

This report summarises the outcomes from the July meeting of the SEND Strategic Alliance. It will be shared with the Board of each member organisation to ensure consistent communications across the Alliance.

Summary

The SEND Strategic Alliance Board met on 1st July 2021 with representatives of each member organisation in attendance, and the CEO for University Hospitals Plymouth NHS Trust observing.
All key actions from the previous meeting had been undertaken, including the identification of an executive-level senior responsible officer (SRO) for each of the priority specialty work-streams.

Electronic Patient Records (EPR)

The group discussed the plans to coordinate implementation of an EPR across the South West Peninsula. It was agreed that it would not be necessary to develop a new IT strategy for the SEND Alliance, rather we should ensure that our plans are developed in such a way as to be consistent with the existing Peninsula-wide IT strategy and with the needs of specific pathways across SEND.

New Hospital Programme (NHP) funding alignment

The work-in-progress development of business cases to access NHP funds in Northern Devon Healthcare NHS Trust and Torbay and South Devon NHS FT were provided in summary. The alignment of these business cases with each other and the Devon LTP was emphasised. The Board agreed that it would be useful to give more strategic direction to teams developing their services so they understand what the SEND Alliance means for clinical pathways. This will be agreed by the next meeting and will feature in future communications to all staff relating to the Alliance.

Collaborative response to urgent care pressures

The Board considered a diagnostic diagram describing the pressures in different elements of the North and East urgent care services. Organisations are working together closely across Devon in response to the challenges, although current staffing models and resources are not meeting demand. There is more that can be done to understand the pressures across the whole of Devon and to work with partners to shift into a more proactive approach across the system.

Priority specialty work-stream updates

SROs have been recently agreed and they are considering the appropriate level of ambition with regard to collaboration across SEND in discussion with clinical teams across all organisations. There is most clarity and support within the pathology services, and others will need further engagement and support to bring focus to their ambitions. There will be a more detailed review of the priority specialties in the next SEND Alliance Board meeting.

In order to provide a clear message for SROs to share with teams across the three organisations the following form of words was agreed to describe the ambition for the priority services:

The principle strategic intent of these work programmes is to mitigate the risk for services across South, East and Northern Devon. Particularly those that are vulnerable due to their small scale, with associated clinical, operational or economic risks. We will do this by:

1. *Thinking as an Alliance and thinking radically – putting on the table whatever changes are appropriate to do the right thing for our population as a whole.*
2. *Developing "whole Alliance" solutions, including potential fundamental redesign of:*
   - *Care model, pathways and processes*
   - *Workforce*
   - *Finances*
   - *Systems and digital technology*
   - *Organisational roles and responsibilities*
3. *Focussing initially on a small number of services where benefits are feasible to deliver within 12 months.*
4. *Aiming for consistent quality and equitable access across our catchment area.*

This process is not:

- *Mutual aid – organising short term support to see through a difficult period.*
- *One organisation doing favours for others.*
- *A simple commercial or operational exchange between organisation.*

Conclusion

The SEND Strategic Alliance is engaging with teams across all three organisations to commence work in four priority specialty areas. It also demonstrating use of the Alliance Board as a forum to share and respond to key strategic matters across the organisations.

Recommendations

The Board is asked to note this report and continue to provide necessary support to executive leads and priority specialty SROs in the course of their work.

Torbay and South Devon
NHS Foundation Trust

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

Meeting date:	28th June 2021
Report author:	Paul Richards, Non Executive Director
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private:	Public ☒ or Private ☐

Key issues to highlight to the Board:

Risk management

The committee received and reviewed the Board Assurance Framework and corporate risk register. It was noted that the development of the BAF had been paused pending the review of the Trust's strategy, which was underway, but no significant issues or changes to risk scores were noted. A more detailed discussion was held regarding interim solutions and mitigations for digital risks, and assurance was offered around the clear and robust prioritisation process which had taken place to inform the capital plan. Any residual risks would be presented to the Board for debate. Once funding was secured, the risk scores would be amended.

The importance of timely and complete updates to the corporate risk register was emphasised.

Strategy & service development

The Committee reviewed the draft Strategic Outline Case for the Building a Brighter Future programme. The Programme Director gave a short presentation detailing progress to date with a focus on the financial and economic case. A thorough debate was held, covering the importance of community investment alongside the acute campus redevelopment, carbon neutrality and the overall economic case and return on investment. The committee welcomed progress on developing the business case.

The Committee also received a report on Safer Staffing, covering inpatient wards, paediatrics; community hospitals, the Emergency Department and assessment areas; and Coronary Care. In developing the establishment review, allowance had been made for ward managers to be 100% supervisory, which was not currently the case. Furthermore, the approach also corrected the Trust's skill mix, which was lean in places. The report recommended an investment of 87 whole time equivalent posts in the Trust's nursing establishment. Assurance was offered on recruitment trajectories and commitment made

to reducing bank and agency spend through better workforce planning and rostering. The committee supported the approach and request, but noting the need for the CNO to report back to the Committee in three months on the improvement programme and six months on delivery of the recruitment programme.

The Committee also received an update on the H1 budget, which reflected the latest ICS position with respect to the elective recovery fund. Noting the resultant balanced I&E position, the H1 plan was approved. The Committee also received an update on H2. Despite the lack of guidance, it was expected that the Trust's funding allocation would be reduced, which could give rise to a deficit position. Progress on CIP development was discussed and the vital nature of increasing confidence in our delivery was underlined.

The Committee received and approved the Capital Plan for 2021-22. It was highlighted that, although ambitious, the plan was not risk free given uncertainties around Wave 3 Capital Funding. The Chief Nurse endorsed the approach to setting the plan and emphasised the need for good communication around our investment decisions. The Committee welcomed the robust planning approach, but noted some risk in that a number of the schemes within the plan would span multiple years. The plan was endorsed, noting the need to accelerate delivery.

Finally, the Committee received an update on commercial development and the bid management process. The bid management process was clear in setting gateways and was supported. One current opportunity was discussed in more detail and it was agreed further work would be undertaken within the bid process on the clinical model.

Performance

Financial performance was better than planned, with a £2.1m surplus reported for Month 2 (£2.3m better than plan). This included receipt of £1.4m elective recovery funding for Months 1 and 2, which had not been reported in Month 1 as receipt had not been confirmed. Increasing agency spend was noted as an area of concern.

In terms of operational performance, unprecedented high demand for unplanned care continued to challenge the Trust. Bed occupancy was running at 92% and measures had been taken to ensure the Trust's pathways were safe, including stepping down elective orthopaedic work for two weeks and moving the Emergency Department partly into the Day Surgery Unit for two days.

A more detailed discussed was held regarding Cancer performance. Areas of concern continued to be Urology, Head and Neck and Breast services. The committee has commissioned a deep dive in order to gain greater assurance.

The committee also received a standalone update on CQC Use of Resources. Since the last report, ten actions had been progressed. The remaining gaps were noted as:

- GIRFT
- Inventory Management
- Effectiveness of Allied Healthcare Professional workforce
- Pathology Network Development and LIMS replacement.

The CFO provided assurance these areas were being addressed and it was noted the Board was receiving a report on the Pathology Network Development and LIMS replacement at its meeting later in the month. It was agreed a further update report would be brought to the Committee in six months' time.
Key decision(s)/recommendations made by the Committee: The Committee endorsed the Capital Plan and Safer Staffing Review subject to final Board approval. The Committee approved the bid management process.

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People Committee
Chair's Report to the Board of Directors

Meeting date:	28th June 2021
Report by:	Vikki Matthews, Non-Executive Director
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 ☐

Long term workforce strategy - the Committee received a presentation on the Trust's work on the long term workforce strategy. The Committee welcomed the presentation and stressed the criticality of planning now for our future workforce needs, using the Building a Brighter Future programme as the catalyst together with the increasing emphasis on system working. The Committee asked that long term workforce strategy be a standing item on the Committee's agenda for the coming months and years.

Medical Appraisal and Revalidation Report – the Committee received and noted a paper on medical appraisal and revalidation. The medical appraisal process in 2020 had been paused due to the pandemic and since then the process has been amended to combine the need for a lighter touch process whilst retaining rigour. The Committee asked that the Trust's medical and non-medical appraisals share a common underpinning approach.

Absence – the Committee were pleased to learn that the annual rolling sickness absence rate was 3.98% against the target of 4.00% which is the first time since Dec 2015 it has been below 4%. Despite this good news story, the Committee were of the view that this figure risks rising dramatically over the coming months and a request was made that we start to make the necessary preparations with leaders for this rise.

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

- Long term workforce planning to be a standing item on the Committee's agenda
- New approach to medical appraisal and revalidation agreed

Torbay and South Devon
NHS Foundation Trust

Building a Brighter Future Committee
Chair's Report to the Board of Directors

Meeting date:	21st July 2021
Report by:	Chris Balch, Non-Executive Director
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private:	Public ☒ or Private ☐

Key issues to highlight to the Board (July 2021):

1. The Committee received a first report on the risks associated with the BBF Programme. This outlined the governance arrangements which have been put in place to manage the risks involved in a programme of the scale and complexity planned. An initial overview was provided, including the identification of the current top 5 risks. It was agreed that the Committee will receive regular updates on the key risks and the way in which they are being managed. This will enable the Committee to ensure that the BAF fully reflects the risks associated with the BBF Programme.

2. The Committee received an update on work undertaken to finalise the Strategic Outline Case (SOC). This has taken into account comments received on the previous draft including the views from NHSE/I's regional team. Further work has been undertaken to strengthen the economic and affordability cases which are based on prudent and robust assumptions. The Committee discussed the need for detailed work to be undertaken with clinical teams at the OBC stage to ensure that the benefits from investment in both digital and estate infrastructure will be delivered. The Committee were assured that the engagement meetings which have been held with key stakeholders have demonstrated a high level of support for our SOC.

3. The Committee commended the efforts of all involved in assembling a strong case for change on programme and under challenging conditions. While the focus of the SOC is on transforming our digital infrastructure and the acute hospital site it was noted that it will enable the delivery of the Trust's and wider Devon system's health and care strategies. The Committee agreed to recommend the SOC for approval by the Trust Board and to put in place arrangements for non-material amendments to be made in response to queries arising during the approval process.

4. The Committee received reports on plans which are being put in place to ensure the necessary engagement with stakeholders and clinical teams through the next stages of work. These include a proposal to establish a regular meeting with a stakeholder group and specific arrangements to engage with clinical teams around demand and capacity planning and key specialties. The Committee will receive a project plan for progressing the OBCs in September.

5. The Committee noted the finance report which indicated that the initial allocation of seed funding to prepare the SOC will be fully spent in the coming months. The application for funding for work on the OBC has been submitted and is being actively pursued. The ability to maintain momentum and make early progress with the digital OBC will depend on early approvals. This risk is noted in the BAF.

Key Decision(s)/Recommendations Made:
1) To note the above

Torbay and South Devon
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Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report July 2021			**Meeting date:** 28th July 2021
Report sponsor	Chief Operating Officer		
Report author	System Directors		
Report provenance	Contents reflect latest updates from System Directors and 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 a high-level operational update to complement the Integrated Performance Report (IPR). As a result of the significant level of urgent care escalation the Trust is operating at the report this month focusses on the current risks and operational pressures in responding. The increase in COVID -19 activity and the significant rise in non-COVID - 19 urgent care activity has proven extremely challenging. Of note is the recognition of the work that all teams have undertaken in a rapid period of time under significant pressure and thanks go to all of the Trusts teams.		
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		**Well-led**	X

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

Board Assurance Framework	X	**Risk score**	20
Risk Register		**Risk score**	

BAF Objective 2 To deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care and best experience

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

Report title: Chief Operating Officer's Report		**Meeting date:** 28th July 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

The report this month sets out the key activities in relation to operational challenges across the Trust as a result of increased demand for urgent and emergency care services along with rising demand in relation to COVID – 19 and the impact of these.

The Trust has been in a position of significant escalation over recent weeks as a result of urgent and emergency care demand and rising incidence of COVID -19. This has required the instigation of gold and silver command structures to co-ordinate our response. The associated daily Incident Control Centre (ICC) process provides speed of decision making and enhanced governance and it was considered essential to move to this position.

3. Urgent and Emergency Care

Activity through the Emergency Department (ED), Surgical Receiving Unit (SRU) and Medical Receiving Unit (MRU) remains high and exceeded pre COVID - 19 levels of activity during May and June. Further increases in patient numbers attending are expected as part of the predicted summer surge. Due to a number of factors, bed capacity has been reduced and this has placed significant pressure on the Trusts Emergency Floor services.

Additional pressure on reduced bed numbers is anticipated to lead to challenges with patient flow and capacity in emergency care. The Trust has been reporting, as a consequence, increasing numbers of ambulance delays and 12-hour breaches. During this time all teams are focused on safety of patients and this is at the forefront of actions taken through the Control Room and the Trusts Opel escalation processes.

In order to mitigate these challenges a rapid piece of work to de-escalate urgent and emergency care was instigated on the 18th June. This de-escalation group was led by the Chief Operating Officer supported by System Directors and the Transformation Team. A range of rapid actions were put into place to support de-escalation. These include the move of two wards to create COVID – 19 capacity, opening assessment beds overnight to support demand, opening escalation capacity in the ED when required and actions to reduce weekend variation. The planned actions also included stepping down some planned inpatient surgery in order to provide additional bed capacity for medical patients. The initial plan was for this to be for a period of 2 weeks this period has had to be extended.

4. COVID – 19

The Trusts COVID -19 escalation plan has been refreshed and enacted as a result of increasing COVID -19 demand. These plans include moving the MRU and reducing the Day Surgery Unit (DSU) footprint to facilitate these moves. This has also enabled the required ward to be made available for COVID -19 patients and the short stay medical ward to be re-provided. Work is completing to identify staffing resource for this area, includes Nursing, Medical and Therapist workforce. These moves are expected to conclude during the week ending 23rd July 2021.

The SEND Alliance Network continues to support de-escalation of the Trusts urgent and emergency care pathways and the COVID -19 pathway. However, demand for urgent and emergency care has been significant across the South West with partners being unable to support at times. The summer surge as a result of "staycations" is likely to result in further demand.

The estates and space constraints on the acute Trust site mean no other space is available to re-provide extra ward capacity. The impact is that planned surgical activity will be further reduced as a result of enacting the COVID – 19 plan. Clinical review and prioritisation of patients is in place ensuring the planned patients presenting with the highest clinical risk are seen first however unfortunately patients will experience further prolonged waits for surgery. The Trust and the Independent Sector providers are working with the Clinical Commissioning Group to maximise opportunities for planned surgery. In addition, work is progressing across the system to consider how the South East and North Devon (SEND) Alliance Network can support restoration of as many services as possible.

Workforce capacity across the Trust has also been impacted as a result of sickness and staff being required to self-isolate following track and trace. The Trust workforce is also tired and less able to take on additional shifts.

The Heatwave level 3 plan has been implemented on 20/7/21 though gold and silver processes ensuring appropriate risk assessments are in place to support the safety of patients and staff.

5. Planned care

5.1 Elective Care / Referral to Treatment (RTT)

Transformation of the planned care pathways continues with focus on data capture and the increased use of virtual platforms to maximise opportunities for increased patient throughput. Progress is being made in outpatients, theatres, urology and orthopaedic GIRFT, together with projects and innovations for Ophthalmology treatments.

With the support of the Transformation Team, day surgery activity is being completed in main theatres as a result of the Covid enlarge plan however theatre activity on the Torbay site will be reduced. Further actions are being taken to maximise activity at weekends and ringfence beds for elective care.

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

In June 2021 RTT incomplete performance across the Long-Term Condition (LTC) specialities was 74% and positively supported the Trusts aggregate position. There has been improvement since the start of the recovery phase with performance over the last 6 months stabilising at this level, this mirrored the overall Trust performance trend.

Operational teams monitor and prioritise treatment for all patients waiting times and those approaching or in excess of 52 weeks (128), 78 weeks (28). Currently there are no LTC patients waiting in excess of 104wks.

A workstream has been established to understand the reasons for, and reduce the did not attend (DNA) rate which stood at 6% in June – this includes a focus within Diabetes and Endocrinology 10% (specifically the obesity services) and Neurology.10%

6. Children and Family Health Devon (CFHD)

6.1 Performance

The Autistic Spectrum Disorder (ASD) waiting list project aims clear the backlog of children on the waiting list. After 13 weeks of running the project the number of children waiting has reduced from 2,954 to 2,078, a reduction of 876. This is being achieved by a combination of assessment clinic re-design using Lean principles and productivity improvements, a remote team of agency clinicians and an SLA with Alliance partners Livewell South West.
A robust approach to waiting list management continues across all CFHD services.

6.2 Demand and the impact of the pandemic

Children and young people experienced multiple deprivations during 2020/21 as they could not attend school or see their friends for long periods of time, and were more exposed to the resilience and / or vulnerabilities within their familial / caring environments. Consequently, the pandemic and subsequent lockdowns had a disproportionate impact on the day to day experience, health and development of children with existing vulnerabilities. These outcomes can be discerned from the continuing overall increased demand (around 20%) and acuity of the children referred to CFHD since they returned to school in the Autumn of 2020. Of note, when compared to 2019/20, there has been a 43% increase in SALT referrals and a 38% increase in eating disorder presentations, along with overall increases in common mental health disorders, which is mirrored nationally.

Services are incrementally increasing face to face interventions with children and young people having undertaken 80% of contacts with patients remotely during the pandemic. It will clearly be important to develop practice-based evidence of the efficacy of these remote interventions, to inform our future offer of remote and direct delivery of care and patient choice.

6.3 Transformation

The workforce re-design and costing is nearing completion and work is underway to agree the principles for funding the corporate support functions for CFHD in support of the alliance operating model..

7. Community Services and the Independent Sector

Wave 3 COVID -19 is impacting significantly in community services with an increase in employees either testing positive or being required to self-isolate following notification of contact with a person who has tested positive. This is mirrored in the Trusts independent sector partners with an increase positive tests among domiciliary care agencies and in care homes. The workforce issue is further pressurised as the Trusts domiciliary and care home providers are struggling to recruit.

Teams have instigated business continuity plans and are flexing their workforce to focus on D2A (discharge to assess) and urgent 2-hour community response. Prevention work and community therapy activity has been reduced as a result. In Torbay a weekly care home meeting has been stepped up to identify opportunities to provide support and update on activity across community services. Twice weekly meetings with domiciliary care providers in place are also in place. This was found to be highly effective in previous COVID -19 waves.

All providers have a RAG system to identify which are the most critical and at-risk clients who would need prioritising should business continuity plans require initiating. The Arrange and Support Team (AST) are calling providers daily to check their status and offer support.

7.1 Extra Care Housing

The Adult Social Care Improvement Board (ASCIB) approved the market commissioning strategy in May 2021, this included the approach to extra care housing (ECH). Torbay Council are now in a position to resource and commence the ECH scheme capital build. The Trust is committed to utilising this alternative capacity as the provision becomes available. This will support people to live with care and support in the community. As this is a housing-based model in a supported community environment the Trust is expected to see a reduction in the weekly cost for individuals living / moving there. The process of identifying individuals appropriate for ECH will be managed carefully in order to optimise the opportunity for individuals using services alongside delivery of the ASCIB strategy.

12. Conclusion

This report provides an overview of the key activities that the Trust has undertaken this month in relation to urgent and emergency care pressures and rising levels of COVID - 19 demand. All teams have worked incredibly hard as have those from support services and should be commended for their compassion and commitment in relation to making all of the moves on the acute site happen in a very short timeframe.

13. Recommendation

To note the contents of the report.

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 30TH JUNE 2021

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mr R Sutton	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	Ms L Davenport	Chief Executive
	* Dr R Dyer	Deputy Chief Executive
	* Mr I Currie	Medical Director
	* 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
	* Mrs J Falcao	Chief People Officer
	* Dr J Watson	Health and Care Strategic Director
In attendance:	* Mrs J Downes	Director of Corporate Governance
	Ms S Toull	Board Secretary
	* Dr J Harris	Associate Director of Communications Partnerships
	* Mrs R Glasson	Head of Maternity Services (part)
	* Mr C Knights	Building a Brighter Future Programme Lead (Part)
	* Mrs J Stockman	Councillor, Torbay Council
	* Ms T Hipkin-Wale	CQC Inspector

* via Microsoft Teams

		ACTION
	Preliminary Matters	
107/06/21	**Welcome and Introductions** The Chairman welcomed those in attendance to the Torbay and South Devon Foundation Trust Board meeting.	

The Board welcomed Tracey Hipkin-Wale, CQC Inspector and Jackie Stockman, Torbay Council representative.

108/06/21 **Board Corporate Objectives**

The Trust Board's Corporate Objectives were noted.

The Board received and noted the Board Corporate Objectives

109/06/21 **Apologies for Absence**

The Board noted apologies of absence from Mrs Vikki Matthews, Non-Executive Director and Jon Welch, Non-Executive Director.

110/06/21 **Declaration of Interests**

There were no declarations of interest.

Consent Agenda (Pre-notified questions)

Reports from Board Committees

111/06/21 **Audit Committee – 25th May 2021**

The Board received the Chair's report of the Audit Committee meeting held on 25th May 2021.

The Board received and noted the Audit Committee Chairs Report

112/06/21 **Finance, Performance and Digital Committee – 24th May 2021**

The Board received the Chair's report of the Finance, Performance and Digital Committee meeting held on 24th May 2021.

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

113/06/21 **Quality Assurance Committee Chairs Report – 24th May 2021**

Adel Jones, Director of Transformation and Partnerships referred to the staff retention issues reported in the Autism service attributed to higher salaries being offered in the private sector and asked what were the Trusts plans to address the retention and recruitment issues; and when could the Trust expect to see an improved position.

Jacqui Lyttle, Non-Executive Director said an in-depth conversation had taken place, giving her assurance, around the staffing risk in the Child Family Health Devon Autism service was carrying. She understood a third of their staff had been approached and employed by a local private provider. The team had therefore looked at different ways to work with families and this had led to

service improvements but, further service improvement work was being undertaken.

Deborah Kelly, Chief Nurse, explained the service affected was a small service, that had seen a significant increase in demand. She informed the Board that vacancies had been back-filled by agency staff and internal staff that could offer support with the autism assessment pathway. She said a new manager was in post and a recruitment campaign was also in place. She was confident appointments would be made to vacant posts in early August.

The Board received the Chair's report of the Quality Assurance Committee meeting held on the 24th May 2021.

The Board received and noted the Chairs Report of the Quality Assurance Report

114/06/21 **Building a Brighter Future Committee Chairs Report - 23rd June 2021**

The Board received the Chair's report of the Building a Brighter Future Committee Chairs meeting held on 23rd June 2021.

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

Reports from Executive Directors

115/06/21 **Chief Operating Officer's Report June 2021**

Chris Balch, Non-Executive Director referred to the Chief Operating Officers Report and the Integrated Performance Report and noted an increase in emergency activity. He asked what the impact of cancelling elective orthopaedics; what measures were in place to address the position; and, what was the Trust's confidence on the delivery of Minor Injury Unit Services prior to summer.

John Harrison, Chief Operating Officer responded that this was a national, regional and local response, and work ongoing across the system was progressing at pace.

With regard to the Totnes and Dawlish Minor Injury's Units, John Harrison acknowledged the Trust was commissioned to provide these services and a recruitment drive was underway. He declared the Trusts intent to re-open the Minor Injury's Units and highlighted the need for them.

Liz Davenport, Chief Executive, highlighted the importance of the Trust's Integrated Care Organisation status, which would drive opportunities to work with the communities and partners, as the community facing model would be key to the Trusts response.

The Board received and noted the Chief Operating Officers Report

116/06/21 **Directorate of Transformation and Partnerships Quarterly Report**

The NHSEI refusal of the Wave 3 Capital Funding was highlighted in the report and Joanne Watson, Health and Care Strategic Director asked Chris Balch, to outline the step's the Trust would take to ensure this would not impact on the New Hospital Programme.

Chris Balch, explained one of the key aspects of Building a Brighter Future (BBF) was to separate Urgent and Emergency Care from Elective Care. The Wave 3 capital funding would have enabled the Trust to provide an uninterrupted service during the Building a Brighter Future ('BBF') Programme build. He confirmed the Trust was challenging the NHSEI decision as the Wave 3 capital funding was a key component in the BBF plan.

Liz Davenport, Chief Executive, said the management of elective care was part of the ICS long term plan and the ICS had, in principle, agreed to support the Trust's appeal, which would be submitted on Thursday 1st July 2021.

The Board received and noted the Director of Transformation and Partnerships Quarterly Report

117/06/21 **Engagement and Communications Strategy Report**

The Board received and noted the Engagement and Communications Strategy Report.

The Board received and noted the Engagement and Communications Strategy Report

For Approval

118/06/21 **Minutes of the Meeting held on 26th May 2021**

The Board approved the minutes of the meeting held on 26th May 2021.

The Board approved the minutes of the meeting held on 26th May 2021

For Noting

119/06/21 **Report of the Chairman**

The Chairman briefed the Board on the following key events:

- On Monday 28th June 2021 the Board had approved the Trust's Annual Reports and Accounts and Quality Report.

- The ICS Partnership Board was in the process of recruiting a Chairperson.

- A quarterly meeting with the League of Friends Chairs on 6th July 2021 was scheduled to take place.

- On the 6th July 2021 the ceremonial turf cutting of the Dartmouth Health and Well Being Centre would take place and the Chairman looked forward to attending with Liz Davenport, Chief Executive.

- Following interviews for the position of Deputy Chief Executive, Dave Stacey, Chief Finance Officer had been appointed. He thanked Suzanne Tracey, Chief Executive Officer of Royal Devon & Exeter and North Devon Foundation Trust for her participation as the external panel member.

- The Chairman thanked Dr Rob Dyer, Deputy Chief Executive for his contribution and input at Board Director level, as this was to be his last Board meeting before retirement.

120/05/21 **Report of the Chief Executive**

Liz Davenport, Chief Executive, paid tribute to Dr Rob Dyer, who would be retiring on Monday 5th July 2021 after 23 years of service with the Trust. She reflected on his career and how he had transformed Diabetic Services within the Trust; and championed integrated care. She said his approach to clinical leadership had shaped medical leadership within the Trust and acknowledged the confidence he had built amongst the clinical cohort. Building a culture of collaboration was Rob Dyer's legacy and this has been evident throughout the COVID pandemic. She explained Rob Dyer had driven opportunities for the Trust including, digital innovation and the New Hospital Programme. Liz Davenport, thanked him for his support, passion and commitment to the values of the Integrate Care Organisation and she reflected how he would be missed

Liz Davenport briefed the Board on the following key issues:

- The recruitment for Non-Executive Directors had commenced, which presented local people with a great opportunity to represent the community of Torbay and South Devon.

- The Trust has been awarded Carer Confident Employer Status.

Engagement with the Building a Brighter Future Programme had commenced with the community.

- Dr Eden Charles had facilitated a development session with the Board, the focus of which had been inclusivity and diversity.

- Dave Stacey, Chief Finance Officer had been appointed as Deputy Chief Executive of the Trust from 6th July 2021; and Adel Jones, Director of Transformation and Partnerships had been appointed as the SRO for the Building a Brighter Future Programme.

- A Devon System meeting had taken place with Pauline Phillip, National Director for Emergency and Elective Care; the purpose of which was to review and progress the Recovery Plan.

- The ICS governance architecture to deliver the Devon Long Term Plan through to 2021/22 and beyond was taking shape.

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

Safe Quality Care and Best Experience

121/06/21 **Integrated Performance Report – Month 2, 2021/22**

Judy Falcao, Chief People Officer, presented the Integrated Performance Report for Month 2, 2021/22 and drew the following to the Board's attention:

Quality and Safety

- The Trust had reported five reported incidents, with three serious incidents being submitted to the Strategic Information System.
- Work had been undertaken to improve the Venous thromboembolism (VTE) position, which was currently performing at 92%.
- An improvement collaborative had been developed to consider the Emergency Department to Stroke ward pathways.

CQC

- A senior leader peer review programme had been introduced and was now embedded.

Workforce

- Sickness was reported at 3.57%. The Chairman asked as social distancing rules were relaxed whether there needed to be mechanisms in place to prevent higher sickness rates. Judy Falcao, confirmed the flu vaccination programme would be well promoted which would help support staff health and wellbeing.
- An increase in staff isolating due to COVID infections in the community was noted, and the Board was assured the Trust was working with the System and National teams to support staff.
- Workforce achievement review's now included wellbeing conversations.

Performance

- The Trust had declared Opel 4 status on a number of occasions as demand pressures had exceeded pre-Covid levels. The current bed occupancy rate of 92% was noted.
- Orthopaedic and Day Surgery had been stood down for two weeks.
- Ambulance time had been lost due to patient flow issues. A reset programme and rapid improvement process review was underway, aided by support at System level.

- Recovery plans had been enacted and additional activity was being supported by the Elective Recovery Fund. The Trust was currently reporting a stable elective position.
- Improvements had been seen in the 2 week wait cancer pathway.
- Referrals into care pathways were at pre-Covid levels. and teams had formulated waiting lists based on risk.

Financial framework

- The Trust reported a £2.1m surplus, giving rise to a circa £2.3m favourable variance to plan; the key factor being receipt of £1.4m Elective Recovery Funding from Devon CCG.
- There was a net favourable variant in respect of staff pay however, the Board was asked to note the significant increase in agency spend due to service pressures.

Liz Davenport, asked how the Trust was supporting the mental wellbeing of its workforce. Judy Falcao, explained that the Trust together with Devon Partnership Trust had been successful in a joint bid for a Well Being Hub. This had resulted in a comprehensive offer for Trust staff, which could be accessed either individually or as part of a team.

Jacqui Lyttle, Non-Executive Director noted the Trust was not meeting the hours of care for a patient per day. She asked whether there was an associated increase in incidents due to staffing pressures and if there was a plan in place to improve the position.

Deborah Kelly, Chief Nurse, explained, the Trust had been able to fulfil the care hours per patient per day requirement over the last month. She assured the Board the Trust had deployed staff within the correct ratios with the support of Bank and Agency staff. She explained within the Trust there was a trend of skill mixing which caused the care hours per patient per day to appear lower but, the correct protocols were in place.

Deborah Kelly said the Trust was not seeing disproportionate levels of incidents however, increased levels of harm had been seen as a result of increased activity, rapid redeployment and complex cases, all of which are subject to review.

Jacqui Lyttle raised on behalf of the Governors, the recent IT failure and asked what the implications for patients and clinical care were.

Adel Jones, Director of Transformation and Partnerships explained that an investigation had taken place. As a result, investments based on the findings were being made, with all actions dealt with and an approved approach to infrastructure and resourcing had also taken place.

Robin Sutton, asked why the Trust was underperforming on non-face to face outpatients' appointments.

Adel Jones, Director of Transformation and Partnerships explained the actual figures were higher than that reported and had now been corrected. She also highlighted the wider cultural issues that non face-to-face consultations posed but assured the Board of the ongoing work that had been co-produced to

support and promote virtual consultations. Joanne Watson, Health and Care Strategic Director provided assurance that an improved position would be seen in the second half of 2021/22.

Ian Currie, Medical Director, explained that a Quality Improvement Project on the Care Planning Summary, in particular, on Venous Thromboembolism (VTE) was being led by Dr Cate Lissett. Assurance was provided that the Quality Discharge Improvement to patient safety would coincide with the Junior Doctor's joining the Trust in August 2021.

Robin Sutton, Non-Executive Director, asked with some elective surgery having been cancelled how was the Trust managing an increase in demand and what forward plans were in place.

John Harrison, Chief Operating Officer. explained that due to urgent care demands, fifty elective care appointments had been cancelled. The Trust was however determined to minimise the impact. The Board was assured that the System Level Gold and Silver Incident Control Hubs had been established.

He highlighted how challenged the Trust was with a 92% bed occupancy level, and recognised, that patients had to move around the hospital to ensure safe care. Therefore, he explained the Trusts key focus was its occupancy rates. He acknowledged weekend discharges were lower and assured the Board a range of specific actions had been put in place to resolve this and ensure patients flowed through the system safely.

Paul Richards, Non-Executive Director, queried the diagnostic test problems and the lack of space on the acute site for a mobile scanner. Assurance was given that there was space for a mobile scanner at Newton Abbot Hospital and the Trust had access to the scanners at Mount Stuart Hospital and the Nightingale Hospital. Acknowledgement was given to the loss of mobile scanner space on the Trust site due to Covid adaptions, but the Board needed to be mindful that mobile scanners had limitations in terms of its usage.

The Board received and noted the Integrated Performance Report – Month 2, 2021/22

122/06/21 **Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training**

In presenting the Report, Ian Currie explained that thematically there were no changes to highlight to the Board.

The Board received and noted the Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training

123/06/21 **NHS Resolution Maternity Incentive Scheme - Year 3**

Deborah Kelly, presented the NHS Resolution Maternity Incentive Scheme Report, which set out the evidence of compliance against areas of action. The

Board noted the need to submit the declaration of compliance by 12 Noon on Thursday 15th July 2021.

The Board received and noted the NHS Resolution Maternity Incentive Scheme Report and approved the action plan. The Board gave delegated authority to the Chairman to sign the certificate on behalf of the Board.

Improved Well Being through Partnerships

124/06/21 **Building a Brighter Future (BBF) Strategic Outline Case (draft)**

Rob Dyer, Deputy Chief Executive, the draft Building a Brighter Future Strategic Outline Case.

The Board considered the presentation and understood the next presentations would be to the CCG Devon Board on 1st July 2021 and the ICS Partnership Board on Wednesday 7th July 2021.

The Board sub-committees would receive the final Strategic Outline Case, risk register and cost advisor costings for review in July. Jane Downes, Director of Corporate Governance, added that the draft Strategic Outline Case would also be presented to, and discussed at the Board to Council meeting on 7th July.

Chris Balch, Non-Executive Director, highlighted the complexity of bringing the Strategic Outline Case together at programme level.

The draft BBF Strategic Outline Case was received and noted.

125/06/21 **Building a Brighter Future Communications and Engagement Plan**

Adel Jones, presented the Building a Brighter ('BBF') Future Engagement Plan. She explained the presentation slides had also been used to engage, involve and evolve the development of the Strategic Outline Business Case.

Adel Jones, highlighted the engagement activities that had taken place and Liz Davenport in her Chief Executive Report had highlighted the positive feedback that had been received from stakeholders.

Jane Harris, Associate Director of Communications and Partnerships had also established an engagement working group with Governors with a view to communicating with Foundation Trust Members.

The BBF Communications and Engagement Plan was received and noted.

126/06/21 **Peninsula Pathology Network Collaboration Agreement**

Rob Dyer, Deputy Chair of Peninsula Pathology Network presented the Peninsula Pathology Network Collaboration Agreement.

He articulated the benefits of the collaborative approach for service development and to support individual provider services but, acknowledged the lack of resilience in pathology services.

In respect of funding, the Peninsula Pathology Network would receive £400k per year for two years to support the work although progress had been difficult to make at pace. For clarity, he explained that histopathology would receive a separate funding stream of £3.7m.

It was noted that there was an external review to refine the collaborative agreement but the SEND clinicians had endorsed the agreement.

The Board Peninsula Pathology Network approved the Collaboration Agreement

Well Led

127/06/21 **Risk Management Strategy and Risk Management Policy**

It was noted that the Risk Group and Audit Committee had reviewed and agreed the Risk Management Strategy and Risk Management Policy.

The Board of Directors approved the Risk Management Strategy and Risk Management Policy

Improved Well-Being Through Partnerships

128/06/21 **Compliance Issues**

There were no compliance issues reported.

The Board received and noted the Building a Brighter Future Report

Well Led

129/06/21 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

130/06/21 **Date and Time of Next Meeting:**

11.30 am, Wednesday 28th July 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**: 28 July 2021
Report appendix	n/a		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 20 July 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: to develop and implement the Long-Term Plan with partners and local stakeholders to support the delivery of our ICO Strategy - risk score 20
BAF objective 10: to actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on our reputation - 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

Report title: Chief Executive's Report		Meeting date: 28 July 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 30 June 2021 are as follows:

3.1 Excellent population health and wellbeing

Dartmouth health and wellbeing centre

On 06 July we celebrated the start of building a brand-new health and wellbeing centre in Dartmouth with a turf cutting. The £4m centre will bring together community health services with the GP practice and a pharmacy.

At the ceremony Dartmouth's deputy mayor, Graham Evans along with Dr Tony Anderson from Dartmouth Medical Practice and Iris Pritchard, President of Dartmouth Caring broke the ground to mark the start of the building of Dartmouth's brand-new Health and Wellbeing centre.

The centre, based at the top of town in Dartmouth, is planned to open in the summer of 2022.

Due to the pandemic, the ceremony was a small, private event, however we made sure it was attended by representatives from key partners and the local community including our chair, Sir Richard, and myself.

Redevelopment of former site of Dartmouth and Kingswear community hospital

We know that the people of Dartmouth and surrounding villages are keenly interested in the future of the former hospital site and we want to work with them to provide best value for Dartmouth and for the NHS.

We have worked with community representatives to create a stakeholder engagement group who will help develop a shortlist of options that will create social value for local people and communities. They will also help us to listen to and hear from as many people in Dartmouth and surrounding villages as possible, involving the whole community in a conversation in the coming months.

The first meeting of the stakeholder engagement group took place on 14 July 2021 and we were delighted to have the input of three Dartmouth Town Councillors. The group produced some excellent ideas, which are now being taken forward. A further meeting of the stakeholder engagement group will take place shortly.

G7 summit
We have received a thank you from Devon and Cornwall Police and the communities of Cornwall for the part we played in the recent G7 summit which recognised our dedication and commitment in helping to deliver a world-class policing service, ensuring a safe and secure G7 summit.

The message highlighted that ‘some of you may have been working in the heart of the G7 community, others may have been offering specialised skills and many of you would have been supporting the summit from wider afield in different locations. Whatever your role, you played a vital part in helping to keep both the delegates of the summit and the communities of Devon and Cornwall safe.”

Challenges faced by coastal communities
England’s Chief Medical Officer, Professor Chris Whitty, has released his 2021 annual report.

This important report shines a spotlight on the challenges we face locally here in Torbay and South Devon which are reflected in other coastal communities across the country.

The report highlights that… ‘despite the significant efforts of local leaders, coastal communities continue to have a high burden of health challenges across a range of physical and mental health conditions, often with lower life expectancy and higher rates of many major diseases.’

Other key points from the report include:

- older, retired citizens – who have more and increasing health problems – often settle in coastal regions but without the same access to healthcare as urban inland areas
- an oversupply of guest housing has led to houses in multiple occupation (HMOs) which lead to concentrations of deprivation and ill health
- the sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. The least wealthy often have the worst health outcomes.

You can read the full report on GOV.UK

3.2 Excellent experience receiving and providing care

Creating a fairer and more inclusive NHS
On 24 June the Devonwide BAME staff network held an online event for staff from across the Devon Integrated Care System to hear the findings and recommendations from Devon's report into the experiences of BAME staff and communities.

The full report is available via this link

Jane Milligan, chief executive of the Integrated Care System for Devon, and Lincoln Sargeant, chair of Devon's Health Inequalities Leadership Group, outlined how the report's recommendations will be implemented and answered questions.

I have reaffirmed with our staff our zero tolerance approach to racism and to aggressive and abusive behaviour of any kind and reminded them that we will support them to challenge this wherever they encounter it. We will continue to work with our colleagues and partners to create a fairer and more inclusive culture both here in Torbay and South Devon and in the wider NHS. We will continue to work with our staff and our BAME network to learn and improve.

Ward accreditations
As part of the national scheme in line with the ambition of Ruth May, Chief Nurse of NHS England and Improvement, we have begun a process of ward accreditation.

The accreditations are in alignment with the Care Quality Commission core standards, and ensuring that the care that we deliver is standard across every area. This has only been rolled out in inpatient areas to date and there will be a plan to roll this out more widely across the community nursing services in the coming months.

Nationally, there has been a direct correlation between achieving good results from ward accreditation with fewer vacancies, staff satisfaction, better patient outcomes, and experience.

During June and July seven of our wards were assessed under the scheme. The Coronary Care Unit and Ainslie ward received gold accreditation while silver accreditation has been awarded to Dunlop ward, Louisa Cary, George Earle, Teign and Templer. The Coronary Care Unit, Ainslie ward, Dunlop ward, Louisa Cary and George Earle have all had their certificates formally presented by Deborah Kelly, our Chief Nurse, alongside the system directors of nursing. Teign and Templer will be presented with their certificates shortly.

DAISY award

The DAISY awards recognise outstanding contributions to healthcare from nurses. The award scheme was set up by the family of a deceased patient to recognise the work that nurses do and began in America.

Nominations can be made by anyone (patients, families, colleagues or staff) through the DAISY website, by using a QR code or by a paper submission.

The DAISY committee meet virtually once a month to review the nominees and to select a winner based on a criteria set by the DAISY team. Our DAISY committee including lay members, voluntary services, current nurses and nurses from Torbay nursing league.

Each month a socially distanced local award ceremony takes place with our Chief Nurse presenting the winner with a DAISY award along with a certificate, a pin badge and a 'healers touch' sculpture. Cinnamon buns are ordered for the team in which the winner works at the request of the DAISY foundation (as cinnamon buns were the only food that the patient could eat during his final days).

In June our DAISY award winner was Christine Donnelly, a staff nurse on our Coronary Care Unit, who was nominated by one of her patients. The nomination highlighted:

"*Although she had to wear a mask and keep as socially distanced as possible her smile shone through. Whenever you were down her care and compassion helped to raise your spirits. If you were worried in the night she would offer you tea and chat about interests outside of the hospital and always find things to laugh at. She wasn't like this to just me but everyone in the ward. Although very professional and efficient she always seemed to find time for each and every one of us put us at our ease and make all our concerns easier to bear*."

Celebrating exceptional long service
Earlier this month our Chair, Sir Richard, and I were privileged to give a special award to Jim Clarke, one of our registered nurses in the Outpatients Department. Jim has worked as a nurse for 50 years, and has spent his entire career, from nurse training as an Enrolled Nurse to completing his full registration, working at Torbay Hospital.

Jim has worked in a number of departments over the years, but has spent a significant proportion of his career in Outpatients. We were proud to give him the award to recognise his significant contribution to the Torbay and South Devon community.

Associate Medical Director confirmed as President-Elect of the HCSA – the Hospital Doctor's Union
Subramanian Narayanan (known as Naru) is our Associate Medical Director of the Torquay Integrated Service Unit and a Consultant Obstetrician and Gynaecologist. He has been a member of our Torbay and South Devon family for the last 14 years.

Naru was recently confirmed as President-Elect of the HCSA-the Hospital Doctor's Union. We congratulate him on his appointment.

Consultant Radiologist nominated for award
Dr Antony George, Consultant Radiologist, was nominated for the Junior Radiologists' Forum Trainer Award 2021.

Many consultant radiologists dedicate their time and effort to deliver high-quality teaching and training of radiology to trainees. The purpose of this award is to identify and acknowledge those individuals whose hard work is often unrecognised.

Tony's nomination is a testament to his excellent work with radiology trainees and the high esteem that he is held in by trainees. We congratulate him on his nomination.

Welcoming back our volunteers
Due to the pandemic, we have seen very few volunteers around our hospital sites over the last year but the Volunteer Services Team are keen to get our volunteers back as soon as we can. The team are working with Infection Control to bring back volunteers to the hospital sites, including wards.

3.3 Excellent value and sustainability

Queen awards the George Cross to the NHS
The Queen has awarded the George Cross to the National Health Services of the United Kingdom.

A personal message from The Queen in support of the Award, handwritten by Her Majesty, reads:

It is with great pleasure, on behalf of a grateful nation, that I award the George Cross to the National Health Services of the United Kingdom.

This award recognises all NHS staff, past and present, across all disciplines and all four nations. Collectively, over more than seven decades, they have supported the people of our country with courage, compassion and dedication, demonstrating the highest standards of public service.

You have the enduring thanks and heartfelt appreciation of us all.

ELIZABETH R.

Details of the presentation of the Award will be confirmed at a later date.

We are a quality data provider
Torbay Hospital has been named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits and meeting a number of targets related to patient safety.

The NJR Quality Data Provider certificate scheme is designed to offer hospitals a blueprint for reaching standards relating to patient safety and rewards those who have met registry targets.

In order to achieve the award, hospitals were required to meet a series of six ambitious targets during the audit period 2019/20. One of the targets was compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.

The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients, clinicians and the industry. It collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care and overall effectiveness in joint replacement surgery.

Health and Safety Executive visit

As I shared with you in my June report, 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.

The action plan is ongoing, and tracked and managed through our health and safety committee for governance and assurance. The plan remains on track and a detailed update will be brought to the September Board meeting for further assurance.

Rising levels of demand and pressure across all services

We are currently seeing rising levels of demand across all our services from adult social care, to community services, and our hospital sites, as well as in our corporate functions.

In addition, we have rising numbers of COVID-19 cases in our communities and now in our inpatient services as well.

Our priority continues to be the safety and wellbeing of our patients and staff. Our approach is focused on the full range of services we provide and centres on how we balance the risks to continue to provide high quality, safe care in the environment we have available to us with the available workforce.

We are working with our staff, patients, partners and the public to explain the challenges we face, the difficult decisions we are having to take and why, in some cases, people are having to wait longer for care or facing having their appointments cancelled.

We continue to prioritise those patients in most urgent need, however, we understand the frustrations of those who are having to wait for treatment, surgery or diagnostics. These frustrations are shared by our staff who want to provide the care and treatment that is needed by so many. None of this is easy for anyone and it will only continue to get harder for everyone involved.

People often ask us how they can help and our answer is simple. If you are eligible for a COVID-19 vaccination, please take up the offer. The more of us are vaccinated, the better we can protect our staff, patients and services. And while we understand everyone's frustrations, there is absolutely no excuse for abusive or aggressive behaviour. Please treat our staff and volunteers as you would wish to be treated and they will do the same by you.

No changes to infection prevention and control guidance in healthcare settings

While lockdown restrictions have been further lifted as of 19 July 2021, the infection prevention and control guidance in healthcare settings remains unchanged. The detailed guidance has been reissued to our people to help them ensure that we keep everyone as safe as possible.

For the public this means that all patients and visitors to all our sites are still required to wear a face covering (unless exempt). Signage and posters to this effect are in place in all services and sites.

People attending appointments are being asked to continue to attend alone unless there are exceptional circumstances.

Current visiting restrictions still remain, hand hygiene stations are present at all our entrances and everyone is encouraged to use them. Social distancing of 2 metres remains in place as standard practice in all health and care settings including our catering areas.

Exemption from contact isolation for fully vaccinated health and social care staff in exceptional circumstances

We have received the latest guidance issued on 19 July 2021 and we are implementing this in a robust and considered way to make sure we keep staff and patients as safe as possible.

4. Chief Executive engagement June/July

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
• Weekly vlogs • Our staff mental health representatives • Representing our staff at the turf cutting event for the new Dartmouth Health and Wellbeing Centre • Board to Council of Governors • Deputy Chair and Member of LGBTQIA+ Network	• Chief Executive of Integrated Care System for Devon • Deputy Chief Executive, Devon Integrated Care System • Director of Long-Term Plan, Devon Clinical Commissioning Group • Devon NHS Chief Executives • Devon Integrated Care System meeting • Chief Executive Officer, Healthwatch Torbay • South West Regional Chief Executives • South Local Care Partnership Executives

	• Devon Integrated Care System Partnership Board • Chief Executive of Devon Partnership Trust • Elective Roundtable Recovery Meeting • Peninsular Partnership Board • Chief Executive Officer, Royal Devon and Exeter NHS Foundation Trust • Kevin Foster MP • Chief Finance Officer, Devon Integrated Care System • Chief Executive, University Hospitals Plymouth NHS Trust • League of Friends Chairs meeting • South West Chief Executives - Leadership for Inclusion Programme Launch • Talent Project Manager – South West Talent Team • Neuro Rehab and Spinal Cord Injury Delivery within the South West • Interview Panel for Devon County Council, Deputy Chief Officer, Children's Services and Head of Social Care • Meeting with Care Quality Commission Inspector • Chief Superintendent Nikki Leaper • Chief Officer for Adult Care and Health, Devon County Council • Locality Director, South & West, Devon Clinical Commissioning Group • Interim Medical Director, Devon Integrated Care System • Police and Crime Commissioner Visit

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1. Devon Long-Term Plan

NHS organisations and local councils are working together to finalise Devon's Long-Term Plan – a vision for how health and care services will be delivered in the next five years.

Our Long-Term Plan road map will set out a number of proposals that would help us to transform the way health and care services are delivered in Devon.

The proposals are in draft form and any further development will be supported by involvement and, where required, formal consultation with staff, patients, communities and stakeholders.

Engagement with staff will begin in July with public engagement likely beginning in September.

We have big, bold ambitions set out in our Long-Term Plan to truly deliver on our vision to ensure *"equal chances for everyone in Devon, to lead long, happy and healthy lives"*.

5.1.2 Devon integrated care system and local care partnerships

The national Integrated Care System (ICS) Design Framework was published in June by NHS England and NHS Improvement and sets out expectations for the next stage of system developments including:

- ICS NHS body and ICS Partnership functions
- governance and management arrangements
- opportunities for partner organisations to work together
- key elements of good practice, including strong clinical and professional leadership, engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- key features of the financial framework.

Workstreams are being set up to manage all aspects of the ICS development and include partners from across the Devon system.

5.1.3 Recovery and Restoration

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 July 2021, approximately 10,000 people have 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.

Health inequalities have been made worse by the pandemic. Addressing this is a key priority.

6 Local media update

6.1 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.

In June we relaunched our monthly stakeholder newsletter in a new, interactive format which supports us to use analytics to measure reach and engagement. The new format newsletter reached over 550 people from the initial mailing and received overwhelming positive feedback from stakeholders. We will continue to build on and refine this development over the coming months.

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

Recent key media releases and responses:

- Hospital pressures – release issued on the pressures that our services are currently facing, and urging the public to choose the most appropriate service for their need and save our Emergency Department for emergencies
- Torbay and South Devon Consultant awarded OBE in Queen's Birthday Honours list – celebrating the news that Dr Cathryn Edwards, consultant physician and gastroenterologist was awarded an OBE in the Queen's Birthday Honours.
- Staff thanked with unique cruise experience – release issued on the fantastic news that some of our staff who were involved in our COVID-19 response were thanked by the people of Brixham with a unique cruise experience onboard Vigilance
- Long COVID clinics – two enquiries were received around Long COVID clinics waiting lists. A system response was issued explaining that clinic information will be published on the NHS England website in the Summer.
- 'Prioritising' Electronic Patient Record – two enquiries were received following details in our board papers on our decision to use some of the New Hospital Programme funding on a new EPR. Response outlined the benefits that investing in our digital provision will bring to our patients, and that solely investing in infrastructure will not help resolve all of the challenges that we face

Recent engagement on our social media channels includes:

- Hospital pressures – video with Dr Amy Jones, an emergency department consultant who talks about the pressures we are facing and some of the alternatives when someone's medical need is urgent but not an emergency
- Handi Paediatric app – promoting the app which allows parents to check their child's symptoms, as part of a regional campaign and reinforcing our 'choose well' messaging
- Euro 2020 – content tied in with England games to encourage the public to keep safe and remember to follow the guidance in place

- Nuclear Medicine new scanner – celebrating the fantastic news of a new scanner and camera installed in our Nuclear Medicine department
- Learning Disabilities Week – we gave a shout out to our wonderful team at Hollacombe Community Resource Centre, a day centre for people aged 18+ with learning disabilities and complex needs
- CPR awareness raising – shared helpful resources to encourage all to learn CPR, following Christian Eriksen's cardiac arrest at Euro 2020
- Warm weather alerts – messaging to remind the public of the importance of staying safe in the sun, the actions you can take and the need to look out for others during warm weather

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 30 June 2021
LinkedIn	5,000 followers	2,878	3,140 ↑ 262 followers
Facebook	15,000 likes	12,141	12,379 ↑ 238 followers
	12,499 followers	12,499	12,754 ↑ 255 followers
Twitter	8,000 followers	6,801	6,918 ↑ 117 followers

7 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 3 2021/22 (June 2021 data)			**Meeting date:** 28 July 2021
Report appendix	Appendix 1 - M3 2021/22 IPR focus report Appendix 2 - M3 2021/22 Dashboard of key metrics		
Report sponsor	Deputy CEO and Chief Finance Officer		
Report author	Head of Performance		
Report provenance	ISU and System governance meetings – review of key performance risks and dashboard Executive Directors: 20 July 2021 Finance, Performance, and Digital Committee: 26 July 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 **review** the documents and evidence presented.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	Yes	**Risk score**	**20**
Risk Register	Yes	**Risk score**	**20**

<table>
<tr><td></td><td>BAF Objective 2 – Deliver levels of performance that are in line with our plans and national standards – Current Risk 20
BAF Objective 3 – Achieve financial sustainability – Current Risk 16
BAF Objective 4 – To provide safe quality patient care – Current Risk 20</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
</table>
This report reflects the following corporate risks:

• failure to achieve key performance standards;
• inability to recruit/retain staff in sufficient number/quality to maintain service provision;
• failure to achieve financial plan.
</td></tr>
</table>

Report title: Integrated Performance Report (IPR): Month 3 2021/22 (June 2021 data)		**Meeting date: 28 July 2021**
Report sponsor	Deputy Chief Executive & Chief Finance Officer	
Report author	Head of Performance	

The main areas within the Integrated Performance report that are being brought to the Board's attention are:

1. Quality headlines

Incidents

The Trust reported four new severe incidents and two deaths in June:
All four have met the criteria for a serious incident and has been reported onto the Strategic Executive Information System (StEIS):

- Fall – one fractured pubic rami, one fractured pelvis;
- Medical collapse – compound fracture;
- Pressure Ulcer

The two death incidents were:

- Drug and alcohol related

VTE performance remains below the required 95% standard

- Current compliance at 92% and has been sustained for a number of months (see Graph below).
- From 8 July 2021 VTE assessment completed within 24 hours for all inpatients became a mandatory field on the Care Plan Summary. This is the data source for reporting and therefore essential for accurate reporting.
- Screen saver in relation to the change and session with senior clinical and medical staff
- The distribution list for the weekly VTE compliance report has been changed and updated. Clinical service leads receive the report alongside matrons and ward managers to address deficits.
- Education session to be provided to Doctors joining the Trust as part of their training face to face and HIVE training is also being explored with the medical education junior doctor lead.

Stroke

The percentage of stroke patients spending 90% of time on a stroke ward remains below the 90% target at 66%.
A number of measures are in place to improve compliance:

- Access to stroke beds is ringfenced to enable direct transfer to a stroke bed, however this is impacted due to increased attendances and admissions to the Trust in May and June, these have exceeded pre-covid levels.
- The control room continue to monitor the stroke beds.
- There is a stroke specialist nurse allocated to ED every day, to review and progress the treatment and transfer to a stroke bed
- The ED and Stroke Teams are meeting bi-monthly, to discuss any issues with the stroke pathway.
- Covid swabbing delays due numbers of attendances

Infection, Prevention, and Control
For June the number of C.Diff cases was two, which is a decrease from May, and were reported from the following area:

- Ainslie
- George Earle

All appropriate actions are being taken with a Root Cause Analysis being conducted.

CQC
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.

For June the four remaining Must Do's which are overdue from the date of completion are being progressed. Of the four Must Do's these are themed into three areas, these in summary are:

- 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. Overall June mandatory training is at 90.5%. Within the different levels of training resus, moving and handling and safeguarding has seen a slight improvement from 72% to 77% which remains below target for these specific levels.
- Ensure staff are up to date with appraisals – there has been a continued slow improvement, however June saw a dip from 86.6% to 84.7% against the target of 90%. All ISU's have detailed trajectory for improvement including arranged dates for appraisal completion. MCA and MHA training and compliance - The Trust has improved its oversight of compliance training. Work is ongoing to achieve the 90% compliance targets June has seen a 10% improvement from May in all levels of MCA training compliance.

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 and testing this within clinical areas.

Executive validation of evidence with the core service leads and testing within practice with staff is following the same criteria as the peer to peer programme is planned for July, sessions are in place.

Maternity Metrics
During June 2021, the maternity service has started to see the projected rise in the number of births. For June, there have been 200 births as opposed to 160 in the preceding two months. The rise is expected to continue with 241 births anticipated during July and in excess for 200 births per month until October 2021.

The service has also continued to see a rise in acuity, which naturally leads to higher rates of intervention, such as increased induction of labour, caesarean section and admission to the Special Care Baby Unit. This is supported by the data with a rise in caesarean section rates and also the induction of labour rate (41.8% in month, 2020 average = 36.4%). The recent Health Select Committee maternity review of safety published in July 2021 has suggested that reviewing caesarean section rates purely as a percentage should be avoided, and that Robson Groups should be used to assess,

monitor and compare rates. The team are beginning to collect the data in this way and will be able to report on this in the future.

There was no mortality to report during June and no cases meeting the STEIS reportable criteria.

There have been a number of challenges in relation to staffing during June. Details are set out in the Maternity Staffing Oversight report that has been submitted to the Board in July 2021. This has been compounded by the rise in birth rate and our midwife to birth ratio rose in month from 1:23 to 1:29.

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 shifts has remained comparable to previous months at 87.1% in June compared to 90% in May and the night shift has again remained stable at 89.4% in June compared to 88% in May.
- The RN position for Louisa Cary is well above the 100% planned fill rates due to an increased requirement for Mental Health Nurses to provide specialist clinical care. John MacPherson has also seen an increase in fill rate for Midwives and Maternity Care Assistants due to a temporary increase in establishment.
- The majority of acute wards are reporting over 100% fill rate for Health care Assistants during the day and night shifts. This is predominantly due to a high demand for additional staff to provide 1:1 care to patients requiring an enhanced level of supervision. Community Hospitals are generally reporting 100% fill rates during the day but are reporting above 100% fill rate at night. Totnes Hospital has increased its bed capacity to support operational pressures.
- Those areas that are reporting less than 100% fill rate are risk assessed throughout the day and overnight to ensure patient safety is maintained.
- Regular control meetings continue throughout the day to ensure safe staffing levels are maintained and staff redeployed to high risk areas as necessary.

For the Care Hours Per Patient Day (CHPPD):

- In June the overall number of Care Hours per Patient Day (CHPPD) for both RN's & HCA's combined, is recorded as an actual of 7.71 against a planned of 6.88 and national average of 9.2.
- High attendances continue through the Emergency Department and the increase in staffing requirements and has been reflective of the operational position. Staff continue to be redeployed to those high-risk areas on a daily basis to ensure patient safety.
- EAU 3 is no longer an inpatient ward and this footprint is being used by ED hence no data provided.
- Following the recent establishment review, George Earl and Turner have been rostering staff to the recommended levels – work is in progress to update templates to reflect these changes.
- Ella Rowcroft have changed staffing requirements due to respond to demand and at are at the escalated bed levels and template being updated to reflect this.

2. Workforce Headlines

The June 2021 WTE (hours worked) of 6241 is a large increase from 6143 in May and is over the planned budget for month by 17 WTE.
Agency expenditure for June was £1.096m (M2 £0.827m) – The increase is across all disciplines and converted to WTE shows an increase to 162 WTE from 116 WTE the previous month.

May monthly sickness absence rate is currently 4.14% which is a large increase from the 3.57% in April and pushed the 12-month rolling figure back to 4.00%. The preliminary June figures show another jump to approximately 4.55% for the month which will be the highest June figure in 10 years.
The Achievement Review compliance for June has seen a drop for the May high of 86.61% down to 84.73%.

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 both community and acute services across both elective and emergency care.

Operational headlines
Throughout June the Trust continued to have no Covid admissions. The first covid patient of the forecast third wave was admitted on 3 July 2021. The trust has now stood back up the Gold and Silver incident control structure. Third wave modelling gives a predicted Trust peak in late August/early September. Escalation to manage this demand, and continued high demand from green pathways, will put the elective recovery programme for Inpatient and Day Case elective surgery at risk.

Acute bed occupancy has increased in June to 95% up from 92% reported in May The demand for acute beds has caused significant operational challenge with OPEL 4 status being declared on 8 occasions with cancellation of non-urgent elective inpatients. On 21st to 23rd June a temporary closure of the Day Surgery Unit was required to support the escalation response to create additional assessment space and inpatient bed capacity. On 16th July, due to continued pressure on beds, the decision was made to relocate the MRU to Day Surgery, in a planned way, allowing the release of ward beds to support the increasing surge in Covid admissions.

The A&E 4-hour standard performance is 72.6%. There has been an increase in the number of ambulance delays with 380 patients waiting over 30 minutes on handover, 32 patients reported as waiting over 12 hours from decision to admit to admission to a ward bed and 246 patients having a stay of over 12 hours in the emergency department, being the worst performance to date. Minor Injury Unit activity has increased from 2898 in May to 3488 in June 2021(a 24% increase allowing for calendar days), with one four-hour breach and a slight increase in average waiting time.

Contracted elective activity in June is above plan and shows a good improvement to levels achieved in May. Overall activity is up by 2,700 patients in June being 95% of June 2019 baseline (May achieved 85% of May 2019 baseline).

In Month 3 PBR contract activity levels, when compared to pre-covid M3 2019/20 activity levels, are: Outpatient new 95%, Outpatient follow up 94%, Day case 105%, Inpatient 75%. 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 and Data Engineering teams. 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.

Domiciliary care, which is essential to provide people as much independence as possible avoiding people spending time in bed-based care and delayed discharges, has seen a monthly increase in the number of reported unfilled packages from an April position of 50 hours to a position end of June of 607 hours requested and unfilled. Staffing shortages in this sector continue to pose a risk to good flow.

Community hospitals admissions have risen above pre-covid levels with bed occupancy increasing to 98%. Average length of stay remains consistent at 11.6 days and compares well with the 13.1 days pre covid in 2019/20.

The Adult Social Care improvement work is gathering pace and is being closely monitored. Performance against the ASC key performance indicators can be found in the Focus Report.

Recovery and waiting time headlines

In June 1,562 people will be reported as waiting over 52 weeks, this being a decrease on last month's 1,596 and is the third month on month reduction achieved. Performance against the cancer access standards has deteriorated. Staff pressures in Dermatology are impacting on the time to be seen from urgent referral and capacity pressures remain across Urology and Lower GI pathways. Diagnostics performance has seen improvements in CT and echocardiography, however, waits remain high for Ultrasound, MRI, and Gastro diagnostic procedures.

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.

Performance monitoring and assurance headlines

To release time for clinical and operations leads to manage operational pressures the Integrated Governance Group (IGG) meetings were stood down in June, and subsequently July with a process in place to escalate risks or issues to the Chief Operating Officer for Executive Review.

4. Finance headlines

For the month of June, the Trust is reporting a £0.04m surplus, which gives rise to a £0.06m adverse variance to plan. Year to date, the position is a surplus of £2.6m, giving a favourable variance to plan of £2.6m.

The main driver of the favourable year to date position is within income, largely relates to the timing differences in income and cost for budgeted pass through drugs and

devices (£1.1m), additional CCG top-up for COVID activities (£0.8m), Torbay pharmaceutical surplus (£0.5m) and various other income streams (£0.2m).

In overall terms, pay costs are showing a £0.6m adverse variance driven by agency costs, with non-pay also showing an adverse variance of £0.2m. Within non-pay the main driver of the adverse variance is the position in relation to ASC/CHC costs, although it should be noted that this is offset with increased top-up income.

The cash position remains strong with a month end balance of £27.8m. To date the Trust has spent c. £2.7m on capital schemes, an increase of c. £1.5m from Month 2.

Looking ahead, the Trust is currently reporting that it will achieve its planned break-even position as at the end of Month 6. It should be noted that the thresholds for accessing ERF funding have been revised for Quarter 2. Originally set at 85% (of baseline) this has now been increased to 95%. This will have an impact on the wider System performance as it will not earn as much ERF as expected. An initial estimate of this risk to the Trust is £2.0m.

Integrated Performance Focus Report (IPR) Trust Board

Torbay and South Devon NHS Foundation Trust

July 2021: Reporting period June 2021 (Month 3)

	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

Incidents: The Trust reported four new severe incidents and two deaths in June:
All four have met the criteria for a serious incident and has been reported onto the Strategic Executive Information System (StEIS):

- Fall – one fractured pubic rami, one fractured pelvis;
- Medical collapse – compound fracture;
- Pressure Ulcer.

The two death incidents were:

- Drug and alcohol

Stroke: The percentage of stroke patients spending 90% of time on a stroke ward remains below the 90% target at 66%.
A number of measures are in place to improve compliance:

- Access to stroke beds is ringfenced to enable direct transfer to a stroke bed, however this is impacted due to increased attendances and admissions to the Trust in May and June, these have exceeded pre-covid levels.
- The control room continue to monitor the stroke beds
- There is a stroke specialist nurse allocated to ED every day, to review and progress the treatment and transfer to a stroke bed
- The ED and Stroke Teams are meeting bi-monthly, to discuss any issues with the stroke pathway.
- Covid swabbing delays due to numbers of attendances.

VTE performance remains below the required 95% standard

- Current compliance at 92% and has been sustained for a number of months
- From 8 July 2021 VTE assessment completed within 24 hours for all inpatients became a mandatory field on the Care Plan Summary. This is the data source for reporting and therefore essential for accurate reporting.
- The distribution list for the weekly VTE compliance report has been changed and updated.
- Education session to be provided to Doctors joining the Trust as part of their training face to face and HIVE training is also being explored with the medical education junior doctor lead.

IPC: For June the number of C.Diff cases was two which is a decrease from May and were reported from Ainslie and George Earle.
All appropriate actions are being taken with a Root Cause Analysis being conducted

Maternity:

- During June 2021, the maternity service has started to see the projected rise in the number of births. For June, there have been 200 births as opposed to 160 in the preceding two month. The rise is expected to continue with 241 births anticipated during July and in excess for 200 births per month until October 2021.
- The service has also continued to see a rise in acuity, which naturally leads to higher rates of intervention, such as increased induction of labour, caesarean section and admission to the Special Care Baby Unit. This is supported by the data with a rise in caesarean section rates and also the induction of labour rate (41.8% in month, 2020 average = 36.4%).
- There was no mortality to report during June and no cases meeting the STEIS reportable criteria.

CQC update

The focus of the June meeting was for Improvement Plan leads to present the plan for completion of each overdue Must Dos (RAG-rated Red). The table below shows the status of Must Dos (MD) and Should Dos (SD) per CQC core service:

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.

For June the four remaining Must Do's which are overdue from the date of completion are being progressed. Of the four Must do's these are themed into three areas, these in summary are:

- 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. Overall June mandatory training is at 90.5%. The different levels of training within resus, moving and handling and safeguarding has seen a slight improvement from 72% to 77% which remains below target for these specific levels.
- Ensure staff are up to date with appraisals – there has been a continued slow improvement, however June saw a dip from 86.6% to 84.7% against the target of 90%, All ISU's have detailed trajectory for improvement including arranged dates for appraisal completion.
- MCA and MHA training and compliance - The Trust has improved its oversight of compliance training. Work is ongoing to achieve the 90% compliance targets June has seen a 10% improvement from May into June in all levels of MCA training compliance.

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	5	0	0	0	0	0	0
Community Inpatients	1	4	1	4	0	0	0	0	0	0
TOTAL	**28**	**43**	**24**	**32**	**0**	**0**	**0**	**0**	**4**	**11**

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 and testing this within clinical areas.
Feedback was received at the CQC assurance meeting on 29th June as part of our improvement journey story.
Executive validation of evidence with the core service leads and testing within practice with staff is following the same criteria as the peer to peer programme is planned for July, sessions are in place.

Achieved
Hospital Standardised Mortality Rate (HSMR) – update not available
Avoidable New Pressure Ulcers - Category 3 +
Never Events
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams
Formal complaints - Number received
Infection Control - Bed Closures - (Acute)
Safer Staffing - ICO – Daytime
Hand hygiene

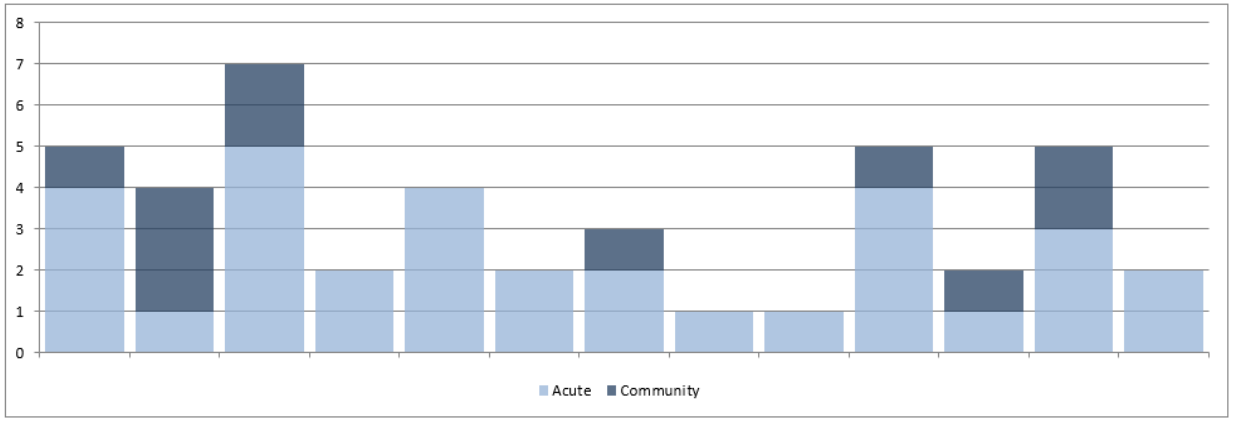
Under Achieved
Safer Staffing - ICO – Night time
Fracture Neck Of Femur - Time to Theatre <36
Reported Incidents – Severe

Not Achieved
Reported Incidents – Death
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)
Medication errors resulting in moderate harm

No target set
Medication errors - Total reported incidents

Number of Clostridium Difficile cases

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



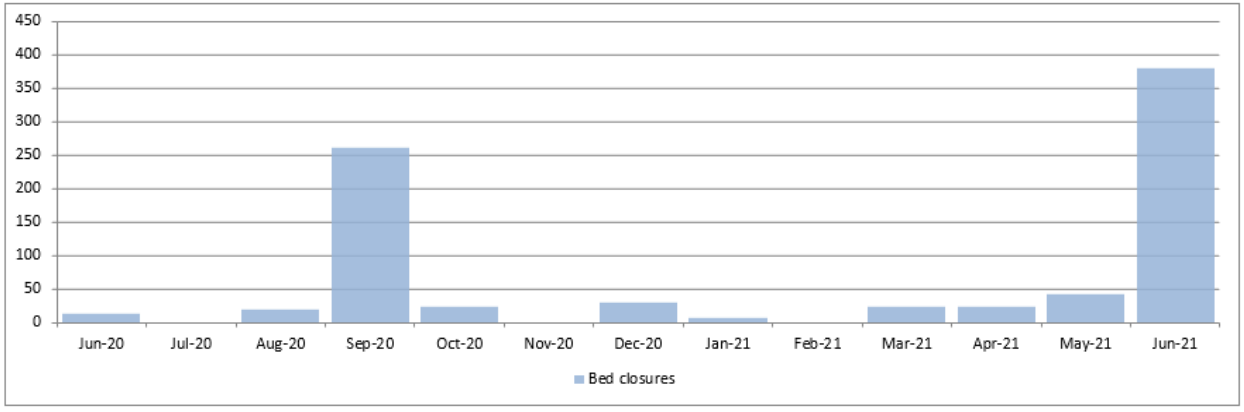
For June the number of C.Diff cases was 2 which is decrease from May and were reported from the following area:

- Ainslie
- George Earle

All appropriate actions are being taken with a RCA being conducted.

Infection control - Bed closures (Acute)

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Bed closures	12	0	20	262	23	0	30	6	0	23	24	42	381



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

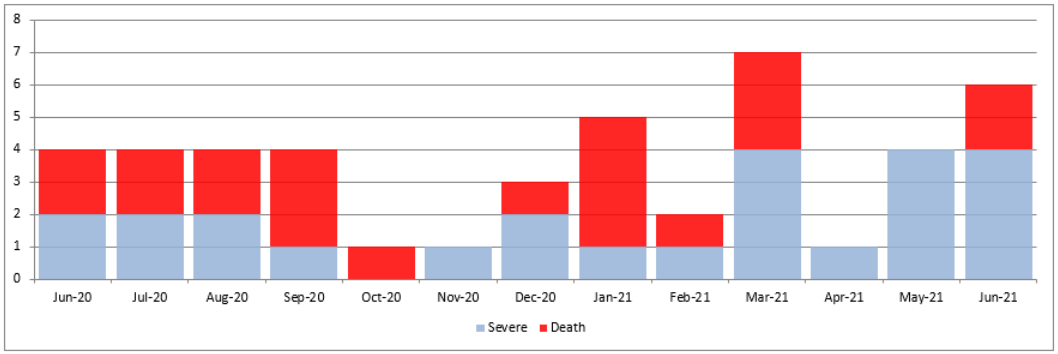
For June 2021 we have had a total of 381 beds across the Trust closed over the month for:

- C. Diff
- Non C.Diff diarrhoea

Management of these have followed IPC guidelines including increased levels of cleaning.

Reported Incidents - Severe and Death

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



The Trust reported four new severe incidents and two deaths in June:

The following 4 severe incidents have met the criteria for a serious incident and has been reported onto the Strategic Executive Information System (StEIS):

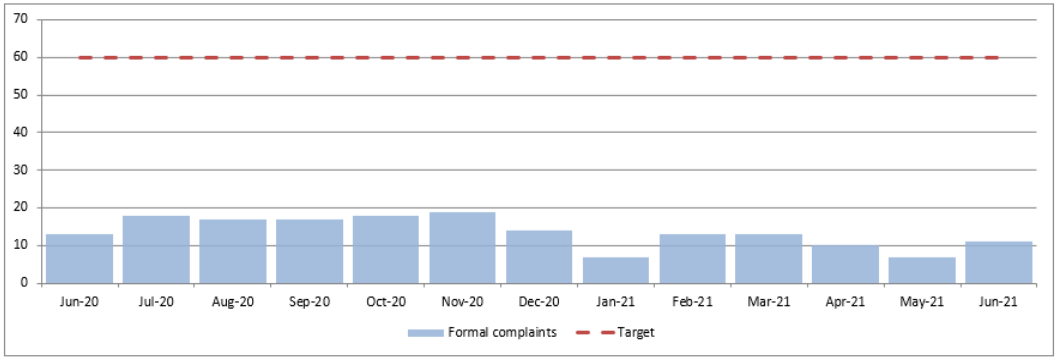
- Fall – one pubic rami, one pelvis;
- Medical collapse – compound fracture;
- Pressure Ulcer

The two death incidents were:

- Drug and alcohol

Formal complaints

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Formal complaints	13	18	17	17	18	19	14	7	13	13	10	7	11
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



In June we have seen an increase in the number of complaints received at 11 from 7 in May.

The themes of the complaints include:

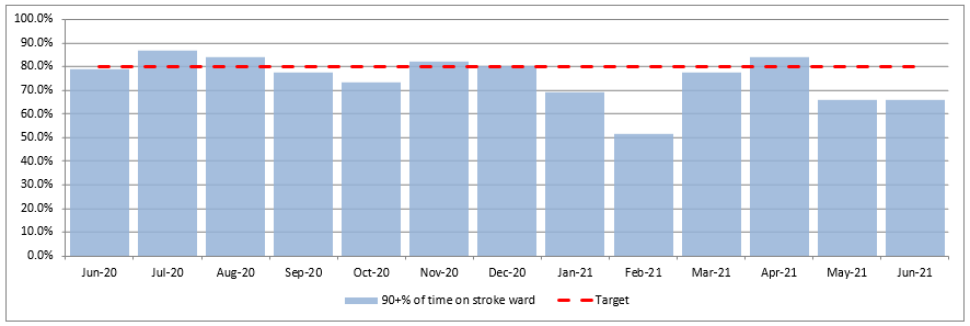
- Treatment –concerns related to treatment delivery
- Care – delivery of care provided
- Discharge – these have been in relation to not enough information supplied

The patient experience framework and long term plan is being designed with an co-design engagement session in July and an improvement plan is in place.

Quality and Safety- Exception Reporting

Stroke

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
90+% of time on stroke ward	79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%
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%

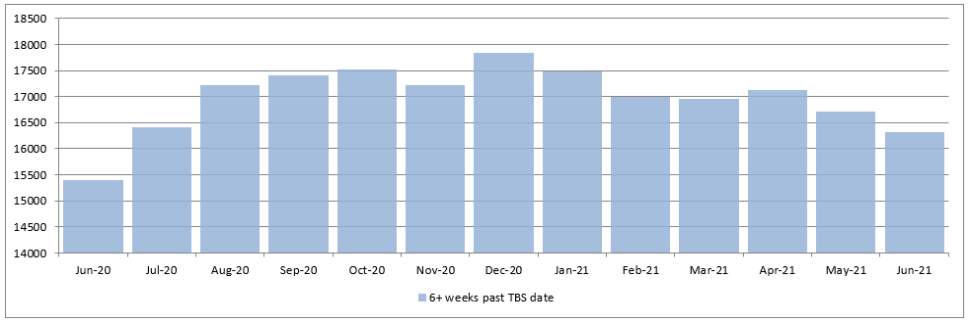


The percentage of stroke patients spending 90% of time on a stroke ward remains below the 90% target at 66%. A number of measures are in place to improve compliance:

- Access to stroke beds is ringfenced to enable direct transfer to a stroke bed, however this is impacted due to increased attendances and admissions to the Trust in May and June, these have exceeded pre-covid levels.
- The control room continue to monitor the stroke beds.
- There is a stroke specialist nurse allocated to ED every day, to review and progress the treatment and transfer to a stroke bed.
- The ED and Stroke Teams are meeting bi-monthly, to discuss any issues with the stroke pathway.
- Covid swabbing delays due numbers of attendances.

Follow ups 6 weeks past to be seen by date

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6+ weeks past TBS date	15398	16408	17220	17408	17519	17229	17837	17489	16986	16950	17118	16713	16323

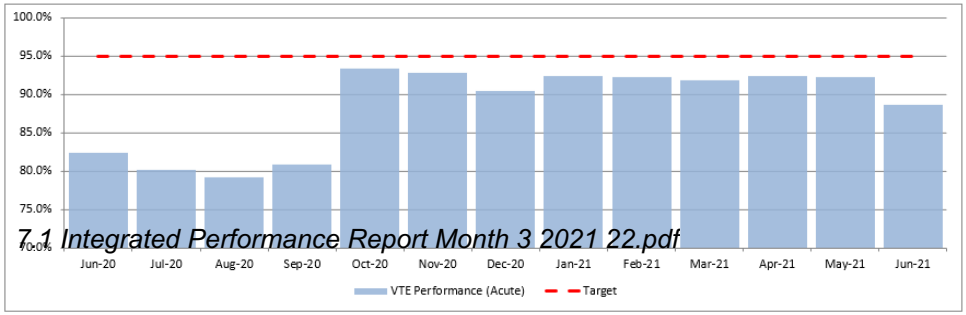


Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has seen a decrease from May from 16713 to 16323.

- Focused restoration and recovery programme with improvement plan is in place
- Harm review meetings are being progressed and thematic reviews being conducted against our longest waiting patients.
- The main areas are ophthalmology, urology.
- Further programmes of work are being developed

ICO VTE risk assessment on admission

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
VTE Numerator	3484	3939	4013	4253	5066	4837	4903	4705	4457	5307	5491	5400	5518
VTE Denominator	4225	4914	5068	5260	5423	5209	5423	5091	4831	5775	5938	5851	6228
VTE Performance (Acute)	82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE

- Current compliance at 92% and has been sustained for a number of months
- From 8 July 2021 VTE assessment completed within 24 hours for all inpatients became a mandatory field on the Care Plan Summary. This is the data source for reporting and therefore essential for accurate reporting.
- The distribution list for the weekly VTE compliance report has been changed and updated.
- Education session to be provided to Doctors joining the Trust as part of their training face to face and HIVE training is also being explored with the medical education junior doctor lead.

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	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD
% of Caesarean sections	25-30%	33.1%	24.7%	29.9%	26.8%	34.9%	26.7%	28.7%	24.3%	29.5%	34.0%	31.4%	36.2%	**30.0%**
Breast feeding rates	>75%	72.5%	78.8%	77.7%	70.1%	69.8%	82.2%	78.1%	75.7%	81.8%	73.5%	76.2%	75.3%	**76.1%**
% of women booked for 'Continuity of carer' model	>35%	64.0%	78.3%	64.9%	66.0%	63.3%	60.1%	61.7%	62.3%	67.9%	57.0%	64.2%	64.3%	**64.5%**
No. of stillbirths	0	0	0	0	0	0	1	1	1	0	0	0	0	**3**

- During June 2021, the maternity service has started to see the projected rise in the number of births. For June, there have been 200 births as opposed to 160 in the preceding two month. The rise is expected to continue with 241 births anticipated during July and in excess for 200 births per month until October 2021.

- The service has also continued to see a rise in acuity, which naturally leads to higher rates of intervention, such as increased induction of labour, caesarean section and admission to the Special Care Baby Unit. This is supported by the data with a rise in caesarean section rates and also the induction of labour rate (41.8% in month, 2020 average = 36.4%). The recent Health Select Committee maternity review of safety published in July 2021 has suggested that reviewing caesarean section rates purely as a percentage should be avoided, and that Robson Groups should be used to assess, monitor and compare rates. The team are beginning to collect the data in this way and will be able to report on this in the future.

- There was no mortality to report during June and no cases meeting the STEIS reportable criteria.

- There have been a number of challenges in relation to staffing during June. Details are set out in the Maternity Staffing Oversight report that has been submitted to the Board in July 2021. This has been compounded by the rise in birth rate and our midwife to birth ratio rose in month from 1:23 to 1:29.

Workforce Summary

July 2021 Update of Progress Against Our People Plan

Our People Plan

Our People plan was approved by the Board 31st March 2021 and the plan to formally launch on 12th July but was stood down due to operational pressures. We are now considering how to launch differently/creatively, given the fact the pressures will be with us for some time, 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 (including helping and supporting transition to different ways of working in a compassionate environment as part of the People Plan).

The Resourcing Hub continues to provide increased levels of support particularly around assessment / selection days; applicant booklets to support our employer brand and attraction activity showcasing our Integrated Care Organisation to an expanded audience via social media, working closely with EDI Leads with further to strengthen recruitment practice through an inclusivity lens.

The Devon International Recruitment (IR) Hub has been developed new recruitment networks/forums across Devon to connect partners to share best practice for onboarding. It has successfully created a pipeline of nurses ready to support the local Devon workforce and allocation conversations underway.

Our new recruitment system (TRAC) went live 1st July 2021 and we are supporting its smooth implementation.

Looking After Our People

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

We currently have over 60 Wellbeing Champions across the Trust providing peer support to their teams.

The anti-bullying network has been launched and promoted to our people.

Work is currently in progress to incorporate Health and Wellbeing as a key element of local induction so that Health and Wellbeing conversations become business as usual.

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.

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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, wo 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 Mersey Care 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.

Increasing Skills and Confidence in Improvement; The system change programme developed by England Partnership is being piloted and refined with a key group of stakeholders in July. The training programme designed to supplement the Improvement and Innovation prospectus has been further 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; a portal is being developed on the LMS around digital skills and literacy, which will include workshops and useful external and internal training materials. The lead has engaged with the HEE digital literacy lead and are working out deployment of some of the national toolkit.

Refreshing/redesigning a digital champions programme. The Plymouth University research fellow is helping to build a 'cookbook' of digital terminology and technologies and helping guide a 'Torbay' definition of digital (likely to be a digital resource and start to shape our own toolkit/approach).

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Workforce Status

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

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

Under Achieved
Appraisal Completeness

Performance exceptions and actions

Of the four workforce KPIs on the IPR dashboard two are RAG rated Green, one Amber and one Red as follows:
Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 11.28% for the year to June 2021.

Staff sickness/absence: RED for 12 months and RED for current month
The annual rolling sickness absence rate was 4.00% to end of May 2021 - This is against the target rate for sickness of 4%. The monthly sickness figure for May was 4.14%

Mandatory Training rate: **GREEN**
The current rate is 90.51% for June 2021 against a target of 85% and this is a small increase from the 90.10% in May.

Appraisal rate: **Amber**
The Achievement Review rate for the end of June 2021 was 84.73% a reduction from the 86.61 % as at the end of May.

Agency Expenditure – As at Month 03 the Trust agency spend was is £1,095k giving an annual figure of £2.679m (£1.3m above plan)

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	2021/06	Change since March 2021	% Change
Allied Health Professionals	524.97	527.08	528.95	525.24	0.27	0.05%
Health Care Scientists	94.17	95.17	93.71	93.71	-0.45	-0.48%
Medical and Dental	531.34	527.82	524.87	528.10	-3.25	-0.61%
NHS Infrastructure Support	1122.74	1120.22	1121.66	1124.29	1.55	0.14%
Other Scientific, Therapeutic and Technical Staff	341.40	342.77	343.99	341.57	0.18	0.05%
Qualified Ambulance Service Staff	10.72	9.52	9.52	9.52	-1.20	-11.19%
Registered Nursing, Midwifery and HV staff	1241.94	1237.33	1239.03	1237.38	-4.56	-0.37%
Support to clinical staff	1906.40	1880.31	1889.59	1907.90	1.50	0.08%
Grand Total	5773.68	5740.22	5751.33	5767.72	-5.96	0.03%

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

	JAN	FEB	MAR	APR	MAY	JUNE
Cost	£	£	£	£	£	£
Substantive	£24,645,064	£21,483,866	£31,299,992	£21,340,031	£21,422,432	£21,269,748
Bank	£1,052,959	£1,074,886	£1,253,501	£1,058,626	£1,040,420	£991,252
Agency	£666,436	£572,475	£1,053,038	£755,150	£827,832	£1,095,792
Total Cost £	£26,364,459	£23,131,226	£33,606,531	£23,153,807	£23,290,684	£23,356,792
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	5,711.13	5,816.28	5,844.37	5,838.43	5,757.26	5,762.25
Bank	248.71	331.21	301.34	328.09	269.23	317.11
Agency	116.88	102.39	160.15	115.40	116.45	161.63
Total Worked WTE	6,076.21	6,249.88	6,305.86	6,281.92	6,142.94	6,240.99

Workforce – Vacancies (12 months rolling)

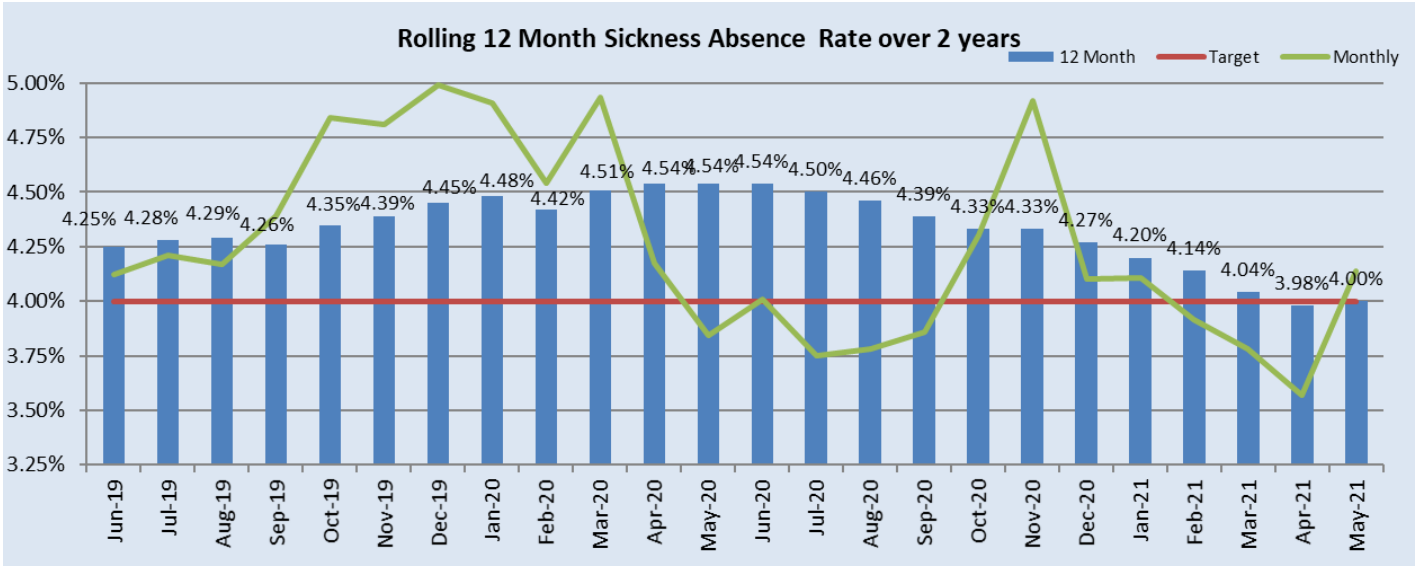
Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso

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
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Medical And Dental	518.35	518.35	518.35	527.76	531.47	531.98	532.11	532.75	530.01	541.66	542.30	543.04
Nursing And Midwifery Registered	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	1,323.84
Support To Clinical Staff	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	1,921.00
Add Prof Scientific and Technic	378.94	378.94	378.94	427.92	429.39	435.21	436.21	436.14	437.55	431.92	431.19	434.19
Allied Health Professionals	447.57	447.57	447.57	479.19	483.13	484.06	490.23	490.83	491.07	493.43	495.28	498.80
Healthcare Scientists	93.16	93.16	93.16	105.02	104.43	104.43	104.43	104.43	104.43	99.60	99.60	100.02
Administrative And Estates	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	1,162.98
Total Staff Budgeted WTE	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	5,989.69

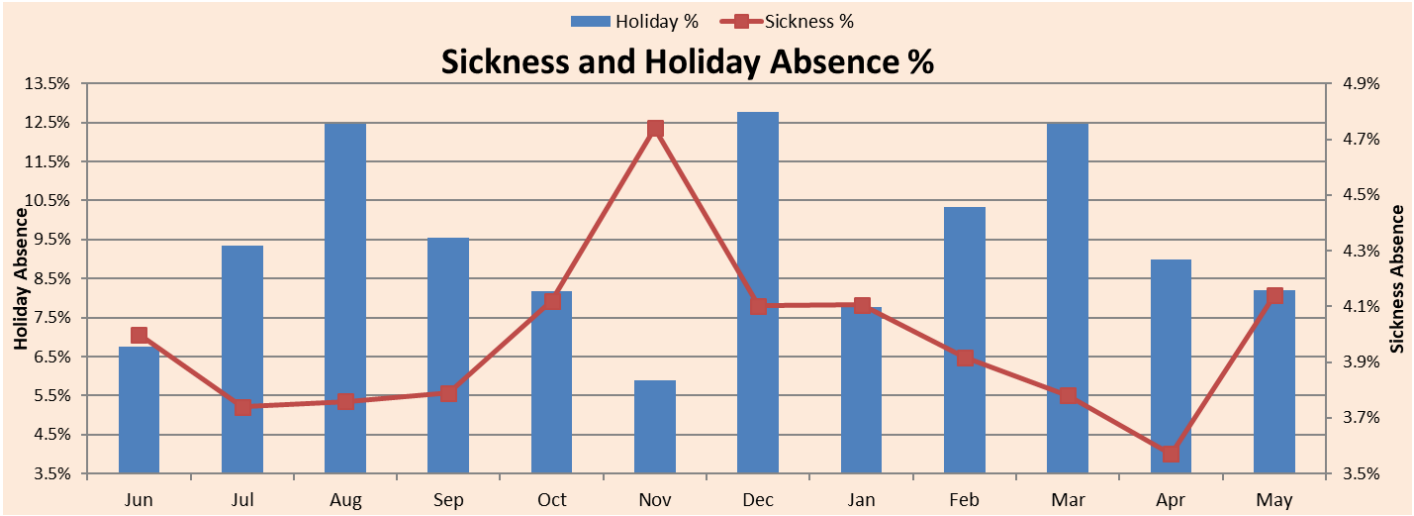
Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Medical And Dental	518.04	592.68	525.00	521.19	518.49	519.24	517.75	533.98	527.31	524.76	522.61	524.21
Nursing And Midwifery Registered	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	1,246.99
Support To Clinical Staff	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	1,909.51
Add Prof Scientific and Technic	397.82	409.47	410.34	402.49	406.08	404.14	406.15	405.08	405.12	406.84	406.93	410.04
Allied Health Professionals	474.20	476.38	482.55	478.15	474.20	471.91	485.89	481.30	482.42	479.38	480.14	479.20
Healthcare Scientists	97.82	98.82	99.41	101.37	99.72	99.17	99.17	99.17	99.17	99.17	100.17	98.72
Administrative And Estates	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	1,132.52
Total Staff Worked WTE	5665.84	5731.98	5670.05	5676.69	5678.20	5697.30	5718.16	5777.59	5809.97	5794.64	5774.76	5807.70

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
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Medical And Dental	0.31	-74.33	-6.65	6.57	12.98	12.74	14.36	-1.22	2.70	16.90	19.69	18.83
Nursing And Midwifery Registered	53.13	43.32	27.66	54.79	69.26	82.19	81.00	81.80	79.05	78.88	75.56	76.85
Support To Clinical Staff	-103.10	-69.14	-38.77	22.28	42.67	17.03	23.99	-9.46	-26.42	18.99	39.32	11.49
Add Prof Scientific and Technic	-18.88	-30.53	-31.40	25.43	23.31	31.08	30.06	31.07	32.44	25.08	24.26	24.15
Allied Health Professionals	-26.63	-28.81	-34.98	1.04	8.93	12.15	4.34	9.53	8.65	14.05	15.14	19.61
Healthcare Scientists	-4.66	-5.66	-6.25	3.65	4.72	5.26	5.26	5.26	5.26	0.43	-0.57	1.30
Administrative And Estates	50.38	54.54	41.71	65.24	68.57	69.51	68.54	61.14	49.02	28.66	22.56	30.46
Total Staff Worked WTE	-49.46	-110.60	-48.66	178.99	230.44	229.95	227.55	178.12	150.70	182.99	195.96	182.70

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

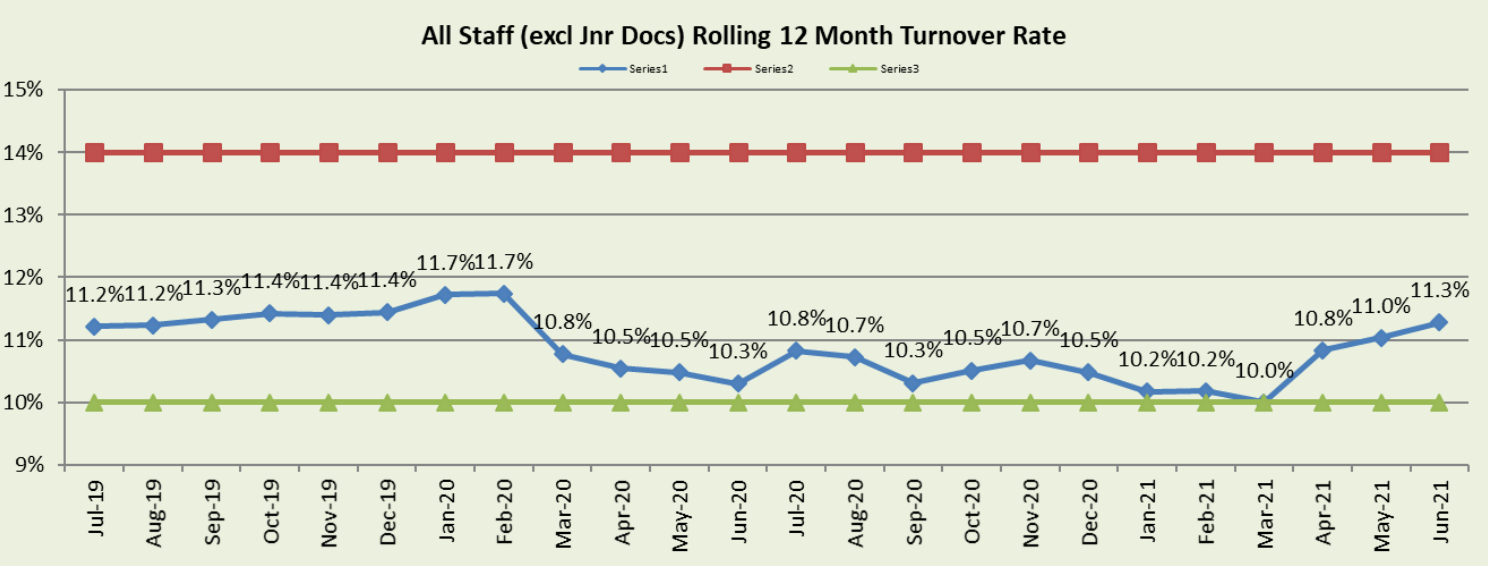


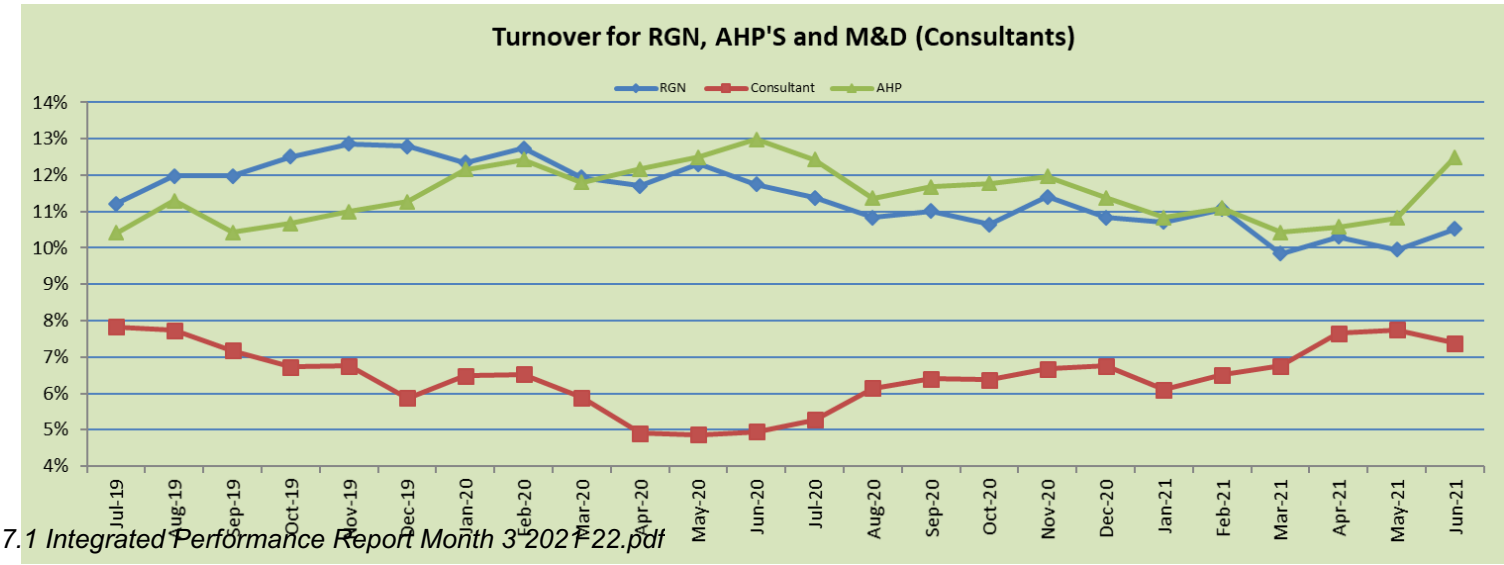
The annual rolling sickness absence rate was 4.00% at the end of May 2021 against the target of 4.00% - The monthly sickness figure for May was 4.14% which is a significant increase from 3.57% in April. Initial June figures are showing another big jump in the monthly sickness figure to approximately 4.55%.

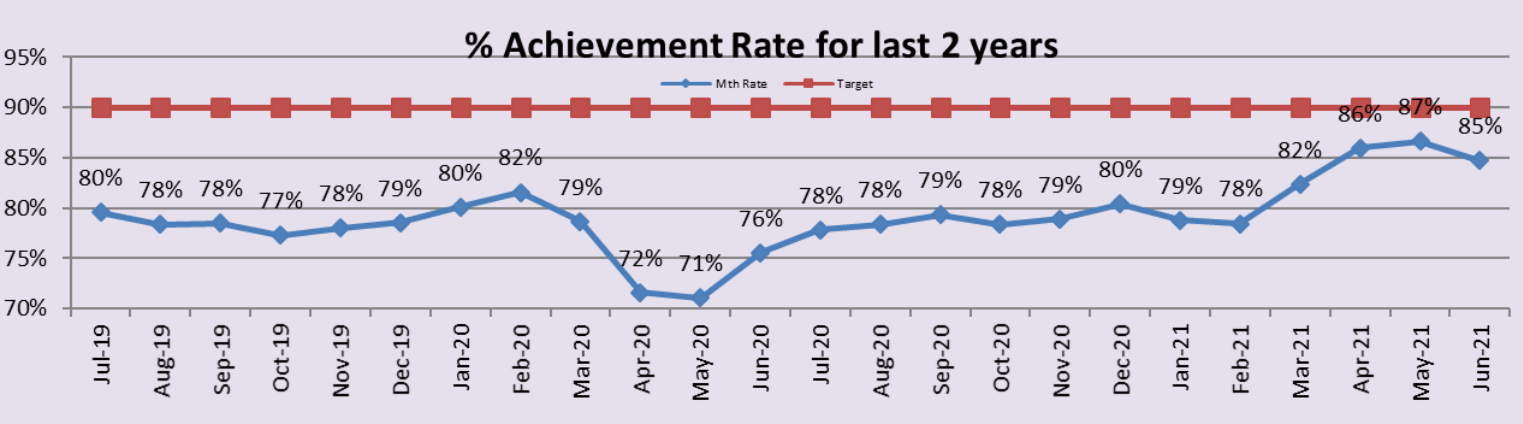


All Staff Rolling 12 Month Turnover Rate

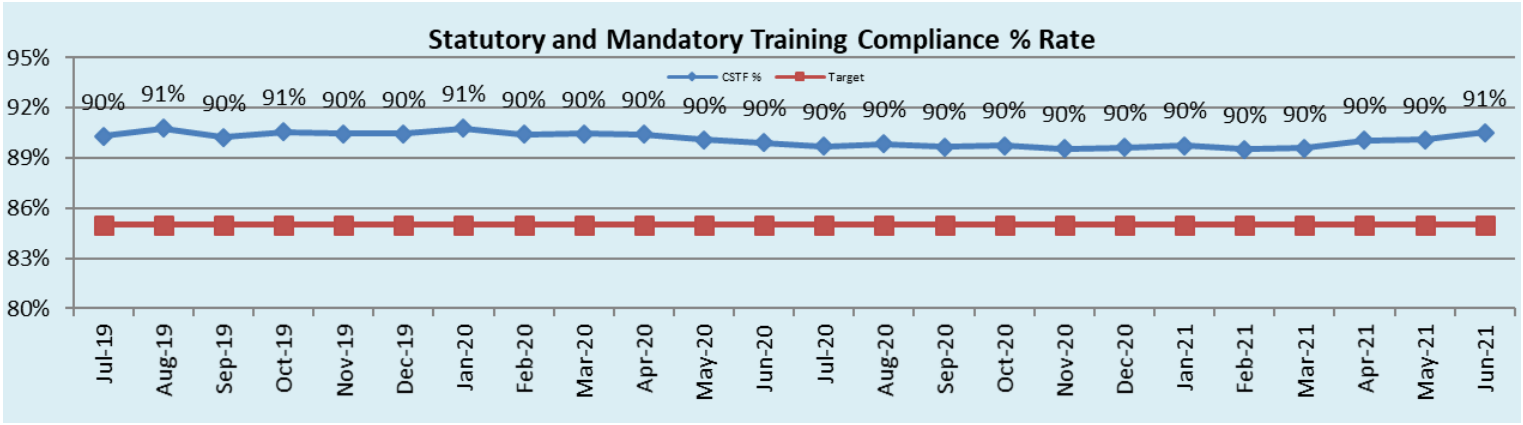
The graph shows that the Trusts turnover rate now stands at 11.28% for the year to June 2021 which is an increase from the 11.03% in May.







Achievement Review (Appraisal)
The Achievement Review rate for the end of June was 84.73% which is a dip from the historical high of May being 86.61%. This will be partly due to the increased pressures and increased sickness through May and June.



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 90.51% for June which is an increase from the 90.10% in May.
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		
Jun-21						Jun-21		
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 1	Level 2	Level 3
6774	4140	357	44	4	9	2550	3495	729
6509	3724	205	26	1	6	2385	2890	529
96.09%	**89.95%**	**57.42%**	**59.09%**	**25.00%**	**66.67%**	**93.53%**	**82.69%**	**72.57%**

Module	Target	Performance
Information Governance	95% and above	84.75%
Manual Handling	85% and above	77.46%

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. June showed a significant rise in agency spend across all groups and the end of June agency stands at £1.267m above plan after the first 3 months of the Financial Year.

Torbay and South Devon NHS Foundation Trust	2020-2021			2020 - 2021	2021 -2022			
Total Agency Spend Financial Year 2020/21	**Jan**	**Feb**	**Mar**	**Total**	**Apr**	**May**	**Jun**	**Total**
Registered Nurses	310	289	316	3012	356	348	468	1172
Scientific, Therapeutic and Technical	12	14	32	504	43	99	142	284
of which Allied Health Professionals	6	1	25	336	31	45	63	139
of which Other Scientific, Therapeutic and Technical Staff	6	13	7	168	12	54	79	145
Support to clinical staff (HCA)	31	56	45	214	-1	-10	-3	-14
Total Non-Medical - Clinical Staff Agency	353	359	393	3730	398	437	607	1442
Medical and Dental Agency	193	47	442	2704	243	262	353	858
Consultants	178	141	310	1961	213	203	281	698
Trainee Grades	15	-94	132	743	30	59	72	161
Non Medical - Non-Clinical Staff Agency	121	166	218	1196	114	128	136	378
Total Pay Bill Agency and Contract	667	572	1053	7630	755	827	1096	2679

Safer Staffing –planned versus actual

- The Registered Nurse (RN) average fill rate for day shifts has remained comparably to previous months at 87.1% in June compared to 90% in May and the night shift has again remained stable at 89.4% in June compared to 88% in May.
- The RN position for Louisa Cary is well above the 100% planned fill rates due to an increased requirement for Mental Health Nurses to provide specialist clinical care. John MacPherson has also seen an increase in fill rate for Midwives and Maternity Care Assistants due to a temporary increase in establishment.
- The majority of acute wards are reporting over 100% fill rate for Health care Assistants during the day and night shifts. This is predominantly due to a high demand for additional staff to provide 1:1 care to patients requiring an enhanced level of supervision. Community Hospitals are generally reporting 100% fill rates during the day but are reporting above 100% fill rate at night. Totnes Hospital has increased its bed capacity to support operational pressures.
- Those areas that are reporting less than 100% fill rate are risk assessed throughout the day and overnight to ensure patient safety is maintained.
- Regular control meetings continue throughout the day to ensure safe staffing levels are maintained and staff redeployed to high risk areas as necessary.

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							
Ainslie	1380	1296	0	0	1553	1641	1035	897	0	0	1035	1116	678	93.9%	0.0%	105.7%	86.7%	0.0%	107.8%
Allerton	2235	1763	0	0	1035	1821	1035	1068	0	0	1035	1219	859	78.9%	0.0%	175.9%	103.2%	0.0%	117.8%
Cheetham Hill	1725	1399	0	0	2070	2584	1035	805	0	0	1380	2185	833	81.1%	0.0%	124.8%	77.7%	0.0%	158.3%
Coronary Care	1380	1365	0	0	0	4	1035	1012	0	0	0	0	382	98.9%	0.0%	0.0%	97.8%	0.0%	0.0%
Cromie	1380	1332	0	0	863	1060	1035	1005	0	0	690	747	753	96.5%	0.0%	122.9%	97.1%	0.0%	108.3%
Dunlop	1380	1230	0	0	1208	1497	1035	794	0	0	690	989	719	89.1%	0.0%	123.9%	76.7%	0.0%	143.3%
EAU3	1668	0	0	0	1334	0	1334	0	0	0	1001	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
EAU4	1725	1555	0	0	1380	1394	1380	1493	0	0	1035	1027	696	90.1%	0.0%	101.0%	108.2%	0.0%	99.2%
Ella Rowcroft	989	855	0	0	1288	1380	943	886	0	0	690	679	435	86.4%	0.0%	107.1%	93.9%	0.0%	98.3%
Forrest	1035	1045	0	0	690	849	690	725	0	0	690	805	495	100.9%	0.0%	123.0%	105.0%	0.0%	116.7%
George Earle	1725	1760	0	0	2070	2595	1035	1018	0	0	1380	2249	828	102.0%	0.0%	125.4%	98.4%	0.0%	162.9%
ICU	3450	2356	0	0	0	145	3105	2392	0	0	0	0	164	68.3%	0.0%	0.0%	77.0%	0.0%	0.0%
Louisa Cary	1380	1946	0	0	690	968	1380	1714	0	0	690	671	449	141.0%	0.0%	140.3%	124.2%	0.0%	97.2%
John Macpherson	690	822	0	0	587	575	690	734	0	0	345	688	322	119.2%	0.0%	98.0%	106.3%	0.0%	199.4%
Midgley	1725	1525	0	0	1380	1739	1035	1070	0	0	1035	1253	829	88.4%	0.0%	126.0%	103.3%	0.0%	121.0%
SCBU	690	920	0	0	345	261	690	748	0	0	345	276	228	133.3%	0.0%	75.7%	108.3%	0.0%	80.0%
Simpson	1725	1643	0	0	2070	2758	1035	955	0	0	1380	1568	830	95.3%	0.0%	133.2%	92.2%	0.0%	113.6%
Turner	1380	1123	0	0	1725	2082	690	689	0	0	1035	1012	433	81.3%	0.0%	120.7%	99.8%	0.0%	97.8%
Total (Acute)	*27661.5*	*23931.8*	*0*	*0*	*20286*	*23350*	*20217*	*17999.8*	*0*	*0*	*14455.5*	*16482.6*	*9933*	86.5%	0.0%	115.1%	89.0%	0.0%	114.0%
Brixham	840	755.25	0	0	1680	1412	660	638	0	0	660	704	582	89.9%	0.0%	84.0%	96.7%	0.0%	106.7%
Dawlish	840	777	0	0	1260	1110	720	516	0	0	660	792	484	92.5%	0.0%	88.1%	71.7%	0.0%	120.0%
NA - Teign Ward	1260	1139.5	0	0	1890	1853.25	660	671	0	0	990	1197	887	90.4%	0.0%	98.1%	101.7%	0.0%	120.9%
NA - Templar Ward	1260	1138.5	0	0	1890	1844	660	660	0	0	1080	1242.75	885	90.4%	0.0%	97.6%	100.0%	0.0%	115.1%
Totnes	896	802.5	0	0	1414	1243.5	720	653.5	0	0	330	746	527	89.6%	0.0%	87.9%	90.8%	0.0%	226.1%
[illegible]	32758	28545	0	0	28426	31813	23637	21136	0	0	18776	21164	13791	87.1%	0.0%	111.9%	89.4%	0.0%	116.9%

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	6.91	3.78	0.00	3.13	7.64	4.74	0.00	2.78
Total Planned Beds / Day	497							
Days in month	30							

Safer Staffing – Care hours per patient day (CHPPD)

- In June the overall number of Care Hours per Patient Day (CHPPD) for both RN's & HCA's combined, is recorded as an actual of 7.71 against a planned of 6.88 against the national average of 9.2
- High attendances continue through the Emergency Department and the increase in staffing requirements and has been reflective of the operational position. Staff continue to be redeployed to those high-risk areas on a daily basis to ensure patient safety.
- EAU 3 is no longer an in patient ward and this footprint is being used by ED hence no data provided.
- Following the recent establishment review, George Earl & Turner have been rostering staff to the recommended levels – work is in progress to update templates to reflect these changes
- Ella Rowcroft have changed staffing requirements due to respond to demand and at are at the escalated bed levels and template being updated to reflect this.

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 2018)	Carter Median CHPPD RN (September 2018)	Carter Median CHPPD NA (September 2018)	Carter Median CHPPD HCA (September 2018)
Ainslie	6.41	3.10	0.00	3.32	7.30	3.20	0.00	4.10	1	9	0	1	3.3%	30.0%	0.0%	3.3%	7.74	4.74	0	2.91
Allerton	6.21	3.83	0.00	2.38	6.80	3.30	0.00	3.50	5	25	0	0	16.7%	83.3%	0.0%	0.0%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.40	2.60	0.00	5.70	2	26	0	0	3.3%	50.0%	0.0%	6.7%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.20	6.20	0.00	0.00	4	4	0	0	13.3%	13.3%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.09	3.10	0.00	1.99	5.50	3.10	0.00	2.40	3	15	0	1	10.0%	50.0%	0.0%	3.3%	7.74	4.74	0	2.91
Dunlop	5.99	3.35	0.00	2.64	6.30	2.80	0.00	3.50	5	27	0	1	16.7%	90.0%	0.0%	3.3%	7.74	4.74	0	2.91
EAU3	7.67	4.31	0.00	3.35					0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
EAU4	7.67	4.31	0.00	3.35	7.90	4.40	0.00	3.50	9	10	0	8	30.0%	33.3%	0.0%	26.7%	7.74	4.74	0	2.91
Ella Rowcroft	10.62	5.31	0.00	5.31	8.70	4.00	0.00	4.70	17	20	0	12	56.7%	66.7%	0.0%	40.0%	7.74	4.74	0	2.91
Forrest	6.09	3.38	0.00	2.71	6.90	3.60	0.00	3.30	3	4	0	2	10.0%	13.3%	0.0%	6.7%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	9.20	3.40	0.00	5.80	0	12	0	0	0.0%	40.0%	0.0%	0.0%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	29.80	28.90	0.00	0.90	3	5	0	0	10.0%	16.7%	0.0%	0.0%	7.74	4.74	0	2.91
Louisa Cary	7.26	4.84	0.00	2.42	11.80	8.20	0.00	3.70	0	0	0	1	0.0%	0.0%	0.0%	3.3%	7.74	4.74	0	2.91
John Macpherson	4.03	2.30	0.00	1.73	8.80	4.80	0.00	3.90	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Midgley	5.95	3.17	0.00	2.78	6.70	3.10	0.00	3.60	3	15	0	1	10.0%	50.0%	0.0%	3.3%	7.74	4.74	0	2.91
SCBU	6.90	4.60	0.00	2.30	9.70	7.30	0.00	2.40	1	0	0	11	3.3%	0.0%	0.0%	36.7%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.30	3.10	0.00	5.20	1	15	0	2	3.3%	50.0%	0.0%	6.7%	7.74	4.74	0	2.91
Turner	10.73	4.60	0.00	6.13	11.30	4.20	0.00	7.10	5	22	0	0	16.7%	73.3%	0.0%	0.0%	7.74	4.74	0	2.91
Brixham	6.40	2.50	0.00	3.90	6.00	2.40	0.00	3.60	19	19	0	23	63.3%	63.3%	0.0%	76.7%	7.74	4.74	0	2.91
Dawlish	7.25	3.25	0.00	4.00	6.60	2.70	0.00	3.90	25	25	0	13	83.3%	83.3%	0.0%	43.3%	7.74	4.74	0	2.91
NA - Teign Ward	5.33	2.13	0.00	3.20	5.50	2.00	0.00	3.40	9	21	0	5	30.0%	70.0%	0.0%	16.7%	7.74	4.74	0	2.91
NA - Tiverton Ward	5.33	2.13	0.00	3.20	5.50	2.00	0.00	3.50	9	17	0	5	30.0%	56.7%	0.0%	16.7%	7.74	4.74	0	2.91
Totnes	6.22	2.89	0.00	3.33	6.50	2.80	0.00	3.80	6	20	0	4	20.0%	66.7%	0.0%	13.3%	7.74	4.74	0	2.91

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
Permanent admissions (65+) to care homes per 100k population (ASCOF)

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)

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

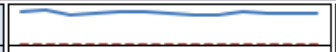
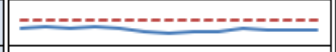
2021/22 Performance Scorecard to 30 June 2021

Torbay Social Care KPIs	2021/22 full year target	2021/22 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	71.0%	Not meeting target (1207 / 1699) Impacted by paris changes for CLS. Workaround changes to assessment summary in progress.
% clients receiving direct payments	28%	28%	19.5%	Not meeting target (332 / 1699). 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	23.1	A low outturn signifies better performance. Not meeting target (17 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	487.3	A low outturn signifies better performance. Not meeting target (181 admissions compared to target of 167)
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%	98.3%	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%	81.7%	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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date 2021/22
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		92.4%	94.5%	94.1%	90.7%	95.7%	88.7%	88.0%	90.0%	80.2%	91.9%	92.5%	86.6%	80.4%	86.2%
Children with a child protection plan *			217	219	221	200	214	221	223	223	207	223	234			234
4 week smoking quitters (Quarterly) **	200		56			124			199			334				
Opiate users - % successful completions of treatment (Quarterly) **	Var		5.9%			5.4%			4.4%			3.7%				

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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date 2021/22
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			7,954	8,228	7,178	7,429	7,819	7,858	7,697	7,165	7,031	8,064	7,623	7,448	7,685	22,756
Therapy activity	65,415		3,620	3,849	3,499	3,837	3,609	2,708	2,638	2,783	3,016	3,593	3,168	3,340	3,343	9,851
No. intermediate care urgent referrals	0		283	242	211	221	200	207	235	175	146	155	165	155	128	448
No. intermediate care placements			14	12	18	6	11	20	19	13	14	42	38	37	41	116
Intermediate Care - placement average LoS			39.1	18.3	16.8	26.4	16.8	28.8	28.7	37.4	34.1	21.0	27.4	16.5	25.6	23.3

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 - June-21

	Act. 20/21 Outturn	Apr-21	May-21	Jun-21	Total
Admissions / Discharges					
Total Admissions (General)	2,677	239	247	245	731
Direct Admissions (General)	186	17	8	18	43
Transfer Admissions (General)	2,491	222	239	227	688
Stroke Admissions	220	24	22	27	73
Transfers from CH to DGH	179	26	34	24	84
Beds					
Bed Occupancy [1]	84.5%	94.2%	96.1%	98.0%	96.1%
Bed Days Lost to Bed Closure	244	1	1	5	7
Length of Stay					
Delayed Discharges		25	8	13	230
Average Length of Stay - Overall (General)	10.4	11.5	11.4	11.6	11.6
Average Length of Stay - Direct Admissions	8	8.8	8.8	9.1	9.1
Average Length of Stay - Transfer Admissions	10.5	11.7	11.6	11.7	11.7
Average Length of Stay - Stroke	14.4	17.0	16.7	17.9	17.9
Long LoS (>30 days)	246	10	5	15	30
MIUs					
Total MIU Activity	22,487	2,516	2,898	3,488	8,902
New MIU Attendances	20,310	2,322	2,646	3,180	8,148
All Follow Up Attendances	2,177	194	252	308	754
Planned Follow Up Attendances	1,650	163	192	227	582
Unplanned Follow Up Attendances	527	31	60	81	172
MIU Four Hour Breaches	1	0	1	1	2
Average Waiting Time (Mins) - 95th Pctile	43	49	50	65	56

Community Hospitals

Community hospital admissions have risen above pre-covid levels. Bed occupancy has increased to 98% in June.

Average length of stay remains consistent at 11.6 days and compares well with the 13.1 days pre covid in 2019/20.

Minor Injury Unit activity has increased from 2898 in May to 3488 in June 2021 with one four-hour breach and a slight increase in average waiting time.

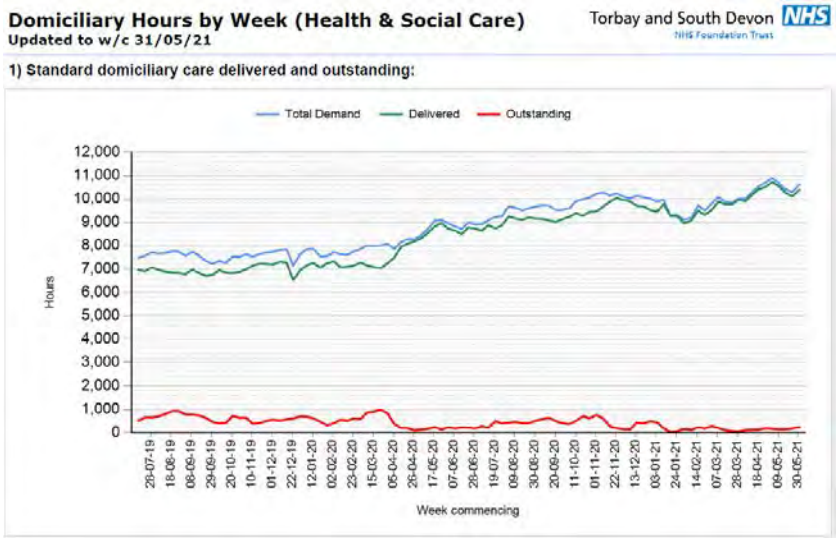
Notes:

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

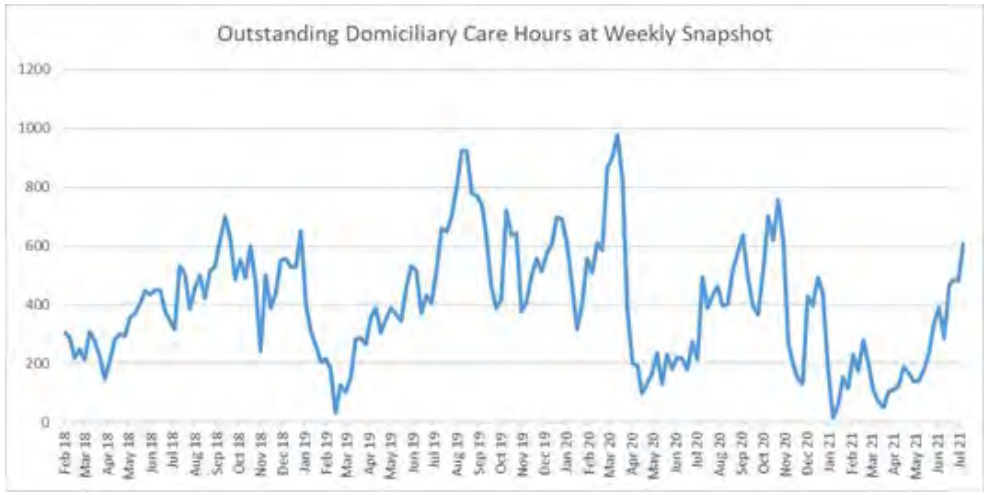
Figures for admissions, LOS etc for Newton Abbot hospital are for general rehabilitation and stroke in line with previous years.

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.

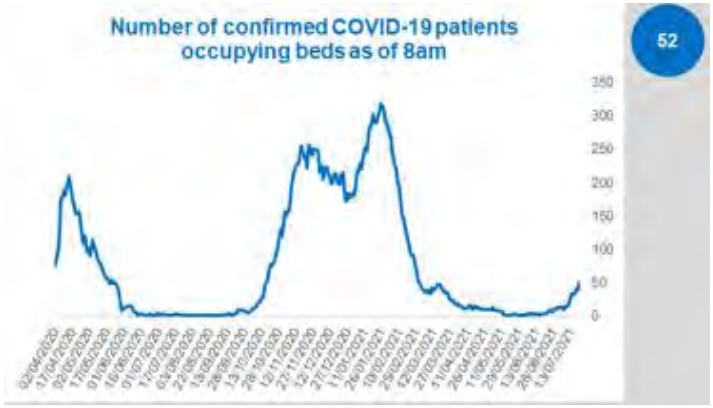


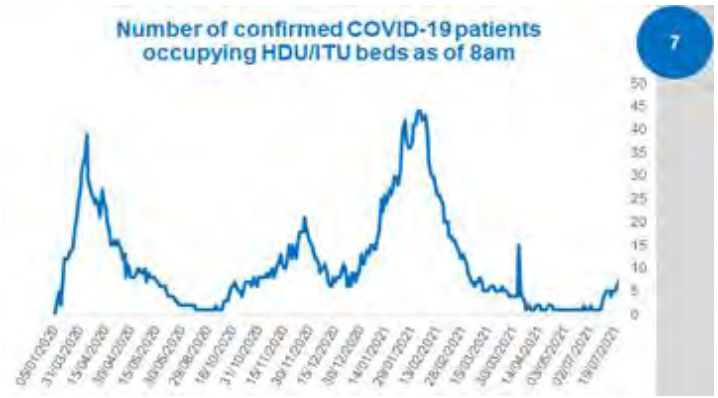
The chart above shows the latest data available for total commissioned domiciliary hours by week for Torbay. As of week commencing 31 May 2021 (latest data available), 10,382 hours of domiciliary care were delivered, 235 hours (2.2% of total demand) were outstanding, reflecting a total demand of 10,617 hours compared to a total demand of 8,074 hours in March 2020.



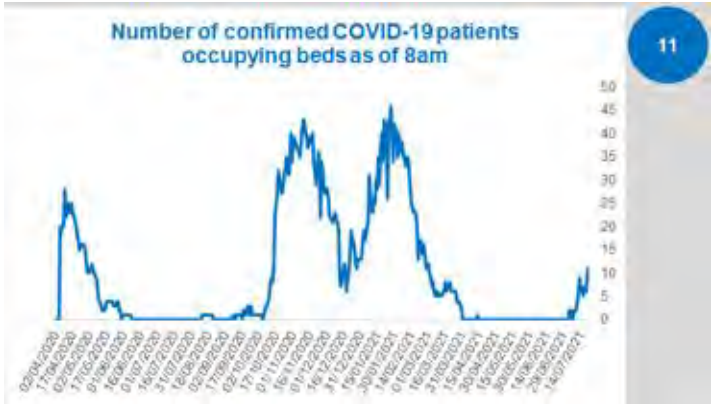
The graph above shows a weekly snapshot from February 2018.
As at 19 July 2021 607 domiciliary care hours have been requested. The graph shows the recent increase in unfilled packages of care. This does follow a seasonal trend with increases generally seen over summer periods.

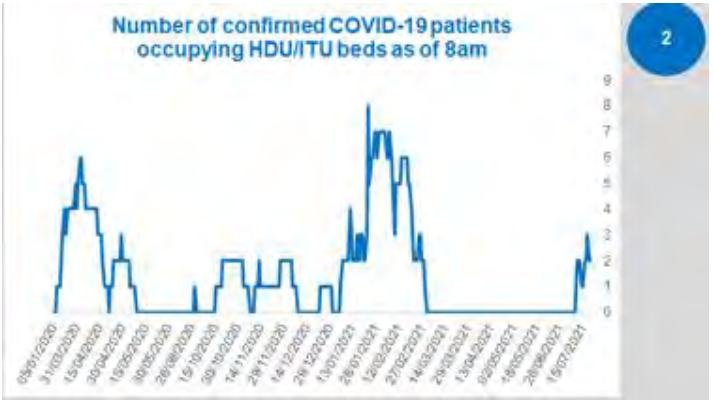
Devon ICS
(as at 20 July 2021)





Torbay and South Devon NHS FT
(as at 20 July 2021)





The Nightingale Hospital continues to support the Devon system through hosting diagnostic testing and future capacity for elective recovery.

In June, no patients occupied beds in TSDFT for covid-19. During July we have started to see admissions with covid-19. Cromie Ward is being utilised as a covid ward to bed covid patients. On 15 July, due to increased number of hospitalisations and the risk of exceeding covid capacity impacting on green pathways, the decision was made to re-locate the Medical Receiving Unit into the Day Surgery Unit releasing Forrest Ward back to inpatient capacity. The implication of this escalation is the stepping down on non-urgent day case procedures. Plans are in place to secure sufficient theatre capacity for urgent and cancer pathways throughout this escalation.

System working: The transfer of suitable blue patients to RD&E remains in place subject to meeting clinical criteria and daily capacity.

Latest modelling forecasts a peak of hospitalisations across Devon in late August/September.

Operational Performance Summary – May 2021

Operational headlines

Covid – Throughout June the Trust continued to have no Covid admissions. The first covid patient of the forecast third wave was admitted on 7 July 2021. Third wave modelling gives a predicted peak in late August/early September. Escalation to manage this demand, and continued high demand from green pathways, will put the elective recovery programme for Inpatient and Day Case elective surgery at risk.

Acute bed occupancy has increased in June to 95% up from 92% reported in May. In June demand for acute beds has caused significant operational challenge with OPEL 4 status being declared on 8 occasions with cancellation of non urgent elective inpatients. On 21st to 23rd June a temporary closure of the Day Surgery Unit was required to support the escalation response to create additional assessment space and inpatient bed capacity. On 16th July, due to continued pressure on beds, the decision was made to relocate the MRU to Day Surgery in a planned way allowing the release of ward beds to support the increasing surge in Covid admissions.

The 4 hour standard performance is 72.6%. There has been an increase in the number of ambulance delays with 380 patients waiting over 30 minutes on handover. Also in June 32 patients reported as waiting over 12 hours from decision to admit to admission to a ward bed and 246 patients having a stay of over 12 hours in the emergency department, being the worst performance to date.

Contracted elective activity in June is above plan and pre covid 2019/20 baseline and shows an good improvement to levels achieved in May. Overall activity is up by 2,700 patients in June being 95% of June 2019 baseline (May achieved 85% of May 2019 baseline).

In Month 3 PBR contract activity levels, when compared to pre-covid M3 2019/20 activity levels, are: OP new 95%, Op f/up 94%, Day case 105%, inpatient 75%. 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.

Recovery and waiting time headlines

For June 1,558 people will be reported as waiting over 52 weeks, this being a decrease on last month's 1,609, and is the third month on month reduction achieved. Performance against the cancer access standards has deteriorated. With staff pressures in Dermatology impacting on the time to be seen from urgent referral and capacity pressures remain across Urology and Lower GI pathways. 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 stood down in June due to operational pressures with a process in place to escalate any risks or issues to the Chief Operating Officer for Executive Review. All IGG meetings are schedules to go ahead in July.

Operational Performance Quadrant

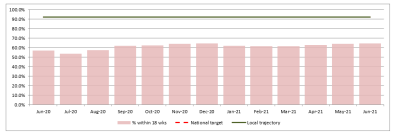
Achieved
Dementia Find (NHSI)
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - Patient waiting longer than 104 days from 2 week wait
Number of extended stay patients >21 days (daily average)
Clinic letters timeliness - % specialties within 4 working days
Cancer - 28 day faster diagnosis standard
Number of Clostridium Difficile cases reported

Under Achieved
Cancelled patients not treated within 28 days of cancellation
Number of patients >7 days LoS (daily average)

No target set

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
Cancer - 31-day wait for second or subsequent treatment - Surgery
Ambulance handover delays > 30 minutes
Ambulance handover delays > 60 minutes
A&E - patients recorded as >60 min corridor care
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
A&E - patients with >12 hour visit time pathway
Bed Occupancy (overall system)
On the day cancellations for elective operations

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	**Performance M3** **72.6%** **Performance M2** **78.9%** **Target** 95% **Risk level** **HIGH**	The reported performance against the 4-hour standard for June is 72.6%. 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.	The bed/ward reconfiguration plan has been implemented to increase the number of medical beds. This plan has resulted in the scaling back of elective surgical work and 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	 **Trajectories** **M2**: 95% **M4**: 95% **M4**: 95%
Patients waiting longer that 18 weeks from Referral to Treatment	**Performance M3** **64.4%** **Performance M2** **63.9%** **Target** 92% **Risk level** **HIGH**	The total number waiting for treatment is 29,677 an increase of 709 from last month. 368 patients are waiting longer that 78 weeks and 22 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.	 **Activity variance vs 2019/20 baseline** Op new: M2 -23.1%, M3 -0.3% OP Follow up: M2 -14.1%, M3 -1.0% Day Case: M2 -21.9%, M3 3.7% Inpatient: M2 - 20.5%, M3 -16.1% **RTT Trajectory %** **M2**: 92% **M3**: 92% **M4**: 92%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M3** **66.4%** **Performance M2** **71.2%** **Target** 85% **Risk level** HIGH	Performance against the 62-day referral to treatment standard in June is 66.4%. The highest risk specialties are – Urology with 19 of 28 patients treated > 62 day target and upper GI (6 of 12 > 62 days) Increasing referrals is of increasing concern. Referrals in June into urgent cancer pathways have increased to above pre covid levels with 1,624 in June 21 compared to 1,216 June 2019. 650 skin referrals received in June. Significant delays continue in Urology pathways with waits over 6 weeks for template biopsy.	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. The estates solution remains in the planning stage. In lieu of this mutual aid is being sought to provide increased capacity.	 **Trajectories** **M2** / **M3** / **M4** 85% / 85% / 85%
Diagnostic tests longer than 6 weeks	**Performance M3** **32.2%** **Performance M2** **30.1%** **Target** 1% **Risk level** HIGH	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 commenced mid June. Increase endoscopy insourcing lists from two to three weekends per month 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.	 **Trajectories** **M2** / **M3** / **M4** 1% / 1% / 1%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M3	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.	
	97.4%			
	Performance M2			
	96.9%			
	Target			
	90%			
	Risk level			
	LOW			

Trajectories		
M2	M3	M4
90%	90%	90%

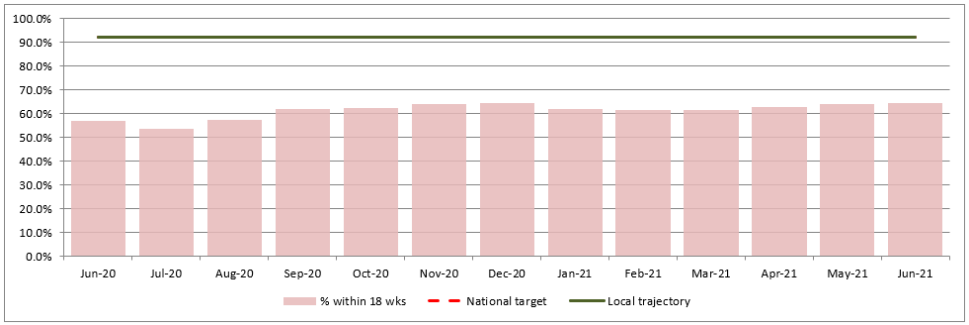
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

JUNE 2021 Incomplete 92% Table - National Specialty

	>126			
Submitted Spec	Incomplete IPDC >126	Incomplete Outpatients >126	Grand Total	% < 18wk
Endocrinology		100	415	75.90
Rheumatology	21	89	447	75.39
Clinical Neuro-Physiology		134	192	30.21
Pain Management	54	103	539	70.87
Respiratory Medicine		222	834	73.38
Neurology	7	295	790	61.77
Dermatology		383	1453	73.64
Gastroenterology	346	66	1760	76.59
Cardiology	18	400	1973	78.81
Oral Surgery	142	294	1685	74.12
Colorectal Surgery	124	399	1123	53.43
Paediatrics	3	536	1328	59.41
Gynaecology	243	358	1877	67.98
ENT	155	498	2081	68.62
Upper Gastrointestinal Surgery	457	354	1368	40.72
Urology	348	931	2446	47.71
Ophthalmology	311	1212	4394	65.34
Trauma & Orthopaedics	1004	702	3196	46.62
Grand Total	3287	7279	29677	64.40

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in June has continued to stabilise with the proportion of people waiting less than 18 weeks at 64.4%; 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 29,677 from 28,968 an increase of 709 from the May position.

52 week waits: For June 1,562 people will be reported as waiting over 52 weeks, being a decrease on last month's 1,609, and the third month on month reduction achieved. Overall long waits are increasing, patients waiting longer that 78 weeks have increased to 368 from 327 in June and 104 weeks have increased to 22 from 13 in May. The loss of elective activity from emergency pressures on beds is starting to be seen, with inpatient elective activity for T&O being stood down. Teams are being asked to review plans to maximise every opportunity to return activity levels to pre-COVID levels as quickly as possible in line with the Phase 4 Elective Recovery plan.

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. 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 and IPC constraints.
Endoscopy now have Rm3 back and are continuing to do 5 sessions/week at MSH to try and reduce backlogs. Urology's plan to increase outpatient treatment and diagnostic capacity remains on hold awaiting suitable estates solution.
Work continues to transform the outpatient model of delivery with a shift to increased non-face to face appointments however 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 across the Devon system to align capacity for elective and non elective care will become increasingly relevant in the success of our recovery plans.

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

The table below shows the specialties with the highest backlog for follow appointments. The number of overdue follow ups in the 6 to 12 week and 18 plus weeks category has increased by 188 and 38 patients respectively but has reduced in the 6 to 12 week category by 524.

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.

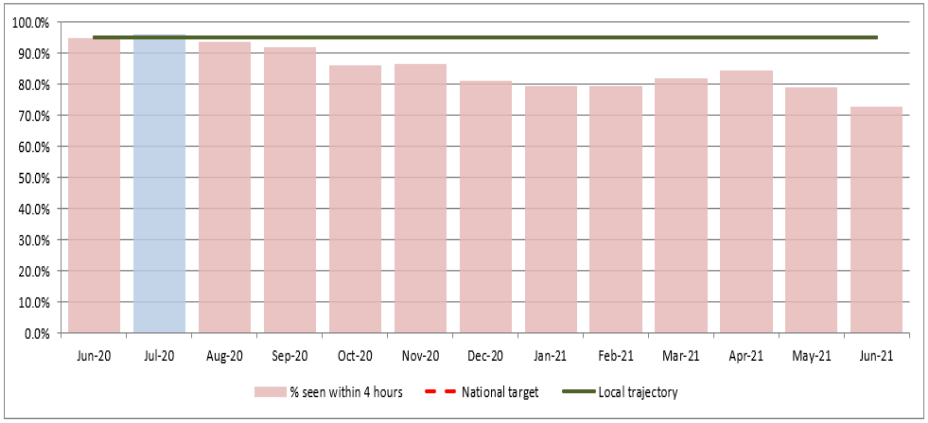
Specialtities with highest Follow-Up Backlog Passed TBS as at 30.05.2021			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	671	1190	5108
Rheumatology	193	382	897
Ear Nose Throat	155	271	907
Paediatrics	171	304	507
Neurology	104	195	437
Orthoptist	117	131	314
Urology	93	117	361
Gynaecology	88	95	211
Respiratory Medicine (Chest)	69	129	231
Orthodontics	35	101	288
Colorectal Surgery	40	67	317
Orthopaedics	40	82	190
Dermatology	72	121	39
Geriatric Medicine	37	64	231
Cardiac Testing	39	150	84
Gastro-Enterology	54	9	8
Breast Surgery	25	37	192
Cardiology	42	75	105
Pain Management	37	61	42
Oral Surgery	25	17	5
Plastic Surgery	26	35	31
Diabetic	23	25	52
Upper Gastrointestinal Surg	16	28	47
Restorative Dentistry	7	16	74
Grand Total	2211	3768	10730

Specialtities with highest Follow-Up Backlog Passed TBS as at 04.07.2021			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	700	1130	5049
Rheumatology	173	301	901
Ear Nose Throat	163	198	903
Paediatrics	210	250	494
Neurology	92	182	434
Orthoptist	152	138	314
Urology	97	140	379
Gynaecology	66	99	255
Respiratory Medicine (Chest)	48	88	238
Orthodontics	32	70	297
Colorectal Surgery	41	84	311
Orthopaedics	78	59	204
Dermatology	86	69	51
Geriatric Medicine	36	58	232
Cardiac Testing	23	22	62
Gastro-Enterology	96	26	6
Breast Surgery	23	35	209
Cardiology	29	57	99
Pain Management	49	69	53
Oral Surgery	37	22	12
Plastic Surgery	63	34	49
Diabetic	19	26	29
Upper Gastrointestinal Surg	23	22	63
Restorative Dentistry	10	12	76
Grand Total	2399	3244	10768

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
29	-60	-59
-20	-81	4
8	-73	-4
39	-54	-13
-12	-13	-3
35	7	0
4	23	18
-22	4	44
-21	-41	7
-3	-31	9
1	17	-6
38	-23	14
14	-52	12
-1	-6	1
-16	-128	-22
42	17	-2
-2	-2	17
-13	-18	-6
12	8	11
12	5	7
37	-1	18
-4	1	-23
7	-6	16
3	-4	2
188	-524	38

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 June to 72.6% from 78.9% in May. 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 8 days at OPEL 4 in June.
12 hour Trolley wait: 32 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 June there were 173 ambulance delay over 60 minutes; delays of over 30 mins increased from 128 to 380.
Patients with a greater than 12-hour visit time pathway: 246 patients had a greater than 12-hour visit time.
Corridor Care: No patients recorded as receiving corridor care.

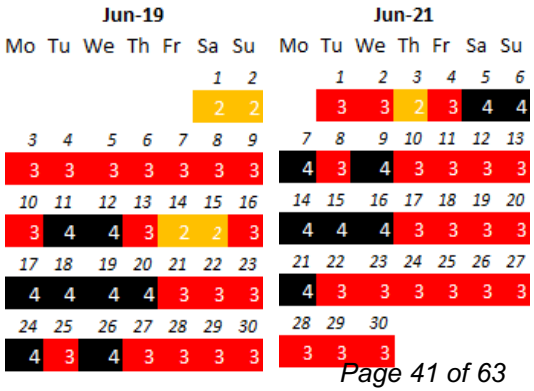
Operational delivery:
The Emergency Department is seeing unprecedented numbers of patients attending combined with an increasing prevalence of COVID-19. The patients have higher levels of acuity both arriving by ambulance and walk in.

Performance against the 4 hour standard remains challenged with increased delays for patients that require admission due to bed availability.

The Emergency Department continues to monitor its internal professional standards to expedite patient treatment and ensure that patient safety is maintained at all times. Staffing pressures remain along with the use of bank and agency staff to maintain the rota.

Escalation status

Opel status	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Opel 1	22	28	24	13	2	0	1	0	0	1	3	2	0
Opel 2	22	3	7	16	8	14	16	4	0	23	26	16	1
Opel 3	0	0	0	1	21	17	14	26	28	7	1	13	21
Opel 4	0	0	0	0	0	0	0	1	0	0	0	0	8
A&E Performance	94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%	74%	79%	82%	84%	79%	73%
Bed Occupancy (Acute)	75%	75.2%	80.0%	83%	88%	85%	83%	89%	89%	85%	87%	92%	95%



As At 12.07.2021	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	500.0	1,549.0	67.7%	1,233.0	236.0	1,469.0	83.9%	1,342.0	277.0	1,619.0	82.9%
14 day - Breast Symptomatic Referral	60.0	37.0	97.0	61.9%	46.0	39.0	85.0	54.1%	51.0	39.0	90.0	56.7%
28 day - Faster Diagnosis Standard	1,158.0	371.0	1,529.0	75.7%	1,101.0	356.0	1,457.0	75.6%	1,188.0	374.0	1,562.0	76.1%
31 day - 1st Treatment	201.0	6.0	207.0	97.1%	178.0	6.0	184.0	96.7%	202.0	3.0	205.0	98.5%
31 day - Subsequent Treatment - Drug	79.0	1.0	80.0	98.8%	82.0	0.0	82.0	100.0%	83.0	0.0	83.0	100.0%
31 day - Subsequent Treatment - Radiotherapy	62.0	1.0	63.0	98.4%	48.0	0.0	48.0	100.0%	59.0	3.0	62.0	95.2%
31 day - Subsequent Treatment - Surgery	25.0	0.0	25.0	100.0%	29.0	1.0	30.0	96.7%	36.0	4.0	40.0	90.0%
31 day - Subsequent Treatment - Other	25.0	0.0	25.0	100.0%	22.0	0.0	22.0	100.0%	33.0	0.0	33.0	100.0%
62 day - 2ww referral	93.5	40.5	134.0	69.8%	77.0	21.5	98.5	78.2%	83.0	41.5	124.5	66.7%
62 day - Screening Referral	5.0	1.0	6.0	83.3%	11.0	4.0	15.0	73.3%	6.0	2.0	8.0	75.0%
62 day - Consultant Upgrade					1.0	0.0	1.0	100.0%				

Cancer standards The table above shows the position for June 2021 (as at 12th July 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: 82.9% 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 Head and Neck (52.55%), Lower GI (66.8%), Urology (68.99%), and Breast (80.20%). Urology have run additional sessions seeing an additional 288 patients, this will unfortunately have an impact on 31 and 62-day targets due to increased volumes.

28 days From Referral to Diagnosis: Performance in June is 76.1% (unvalidated) against the target of 75%.

NHSI monitored Cancer 62 day standard: The 62 day referral to treatment standard has deteriorated in June (un-validated) with 66.7% within target meaning 41.5 patients treated falling outside the target time of referral to treatment within 62 days. – Urology account for 46% of the breaches

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

Currently there are 11 (unvalidated) patients with a greater than 104 day wait in June, 5 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 9 patients waiting longer than 104 days, all with confirmed cancers.

Breast Symptomatic: Has improved slightly in June to 56.7% 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.

Cancer standards – speciality level

As at 12.07.2021

Site	2ww (93%)						62 day (85%)						28 day (75%)					
	Jan-21	Feb-21	Mar-21	Apl-21	May-21	Jun-21	Jan-21	Feb-21	Mar-21	Apl-21	May-21	Jun-21	Jan-21	Feb-21	Mar-21	Apl-21	May-21	Jun-21
Breast	72.2% (130/50)	90.5% (152/16)	87.68% (178/25)	47.4% (101/112)	77.22% (139/41)	80.22% (146/36)	86.2% (12.5/2)	76.9% (10/3)	100% (18/0)	100% (10/0)	83.33% (15/3)	90.47% (19/2)	89.8% (150/17)	100% (44/0)	94.9% (205/11)	93.0% (214/16)	91.74% (200/18)	92.19% (189/16)
Breast Symptomatic													77.1% (74/22)	100% (9/0(	91.7% (100/9)	90.72% (90/1))	88.09% (74/10)	92.3% (84/7)
Gynae	94.6% (88/5)	92% (81/7)	84.4% (103/19)	94.16% (113/7)	93.33% (84/6)	83.76% (98/19)	100% (2.5/0)	100% (5.5/0)	100% (1.5/0)	77.7% (7/2)	40.0% (2/3)	37.5% (3/5)	71.8% (56/22)	47.8% (11/12)	68.7% (77/35)	63.93% (78/44)	64.63% (53/29)	64.03% (73/41)
H&N	67.8% (80/38)	87% (107/16)	90.37% (122/13)	39.0% (55/86)	46.62% (69/79)	52.55% (103/93)	100% (1/0)	66.7% (4/2)	61.5% (8/5)	80.0% (4/1)	75.0% (3/1)	50.0% (2/2)	77.1% (91/27)	92.5 (49/4)	92.2% (107/9)	82.7% (110/23)	80.15% (105/26)	71.97% (131/51)
Haem	100% (12/0)	100% (7/0)	100% (13/0)	100% (13/0)	90.90% (10/1)	100% (12/0)	75% (3/1)	100% (4/0)	66.6% (2/1)	75.0% (3/1)	80.0% (4/1)	33.33% (1/2)	90% (9/1)	100% (2/0)	88.8% (8/1)	100% (15/0)	75.0% (3/1)	91.66% (11/1)
LGI	72.6% (159/60)	91.3% (157/15)	79.7% 126/32)	76.4% (182/56)	87.29% (213/31)	66.84% (127/63)	66.7 (6/3)	88.9% (8/1)	44.4% (4/5)	36.4% (4/7)	42.85% (3/4)	66.66% (4/2)	35.8% (68/122)	55.3% (21/17)	36.6% (67/116)	45.61% (78/93)	44.84% (74/91)	33.17% (71/143)
Lung	66.7% (14/7)	84% (21/4)	96.3% (26/1)	90.9% (30/3)	86.66% (26/4)	96.15% (25/1)	50% (1/1)	100% (1/0)	85.7% (6/1)	85.7% (3/0.5)	83.33% (5/1)	40.00% (2/3)	94.4% (17/1)	100% (3/0)	93.1% (27/2)	100% (24/0)	89.65% (26/3)	95.45% (21/1)
Skin	94.4% (306/18)	97.2% (344/10)	93.3% (421/30)	76.3% (425/132)	97.75% (523/12)	98.30% (639/11)	88.9% 32/4)	89.2% (33/4)	100% (28/0)	86.6% (46.5/6.5)	91.42% (32/3)	97.37% (37/1)	75.2 (239/79)	84.6% 55/10)	88.3% (356/47)	76.16% (361/113)	82.82% (352/73)	91.22% (447/43)
UGI	80.3% (106/26)	91.2% (62/6)	73.4% (69/25)	63.5% (47/27)	82.41% (75/16)	88.59% (101/13)	100% (3/0)	100% (6/0)	72.7% (4/1.5)	60.8% (7/4.5)	60.0% (3/2)	52.17% (6/5.5)	85.3% (99/17)	83.3% (10/3)	78.3% (65/18)	69.04% (58/26)	84.26% (75/14)	82.52% (85/18)
Urol	31.8% (41/88)	60.6% (57/37)	55.3% (62/50)	48.9% (71/74)	65.28 (79/41)	68.99% (89/40)	30.8% (6/13.5)	29.4 5/12)	22.95% (7/23.5)	26.1% (6/17)	46.15% (6/7.5)	32.14% (9/19)	51.6% (48/45)	25% (3/9)	24.0% (31/98)	35.59% (42/76)	43.24% (48/63)	58.26% (74/53)
Aggregate	77.3% (959/281)	89.6% 988/115)	85.0% (1125/195)	67.7% (1049/500)	83.9% (1233/236)	82.89% (1342/277)	73.4% (69/24.5)	77.6% (78.5/22.5)	66.8% 79.5/38)	69.8% (93.5/40.5)	78.2% (77/21.5)	66.7% (83/41.5)	75.4% (859/354)	76.9% (948/284)	75.9% (1102/349)	75.7% (1158/371)	75.6% (1101/356)	76.1% (1188/374)
	(Total <14 days / Total >14 daya						(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 day surgery as well); 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 – plans are being drawn up.
- Increase in the number of Cystoscopes (can do 50 per week). (Lancer Cabinet required to maximise use – going through procurement)
- Advertisement out for two HCA – will support Sheath systems.
- Disposables scopes can be used at clinical space identified at Paignton Hospital – needs nurses to support.
- Replacement Locum started 12/07/21 – (3 months initially).
- Clinicians asked if they can do any more template biopsy Saturday sessions.

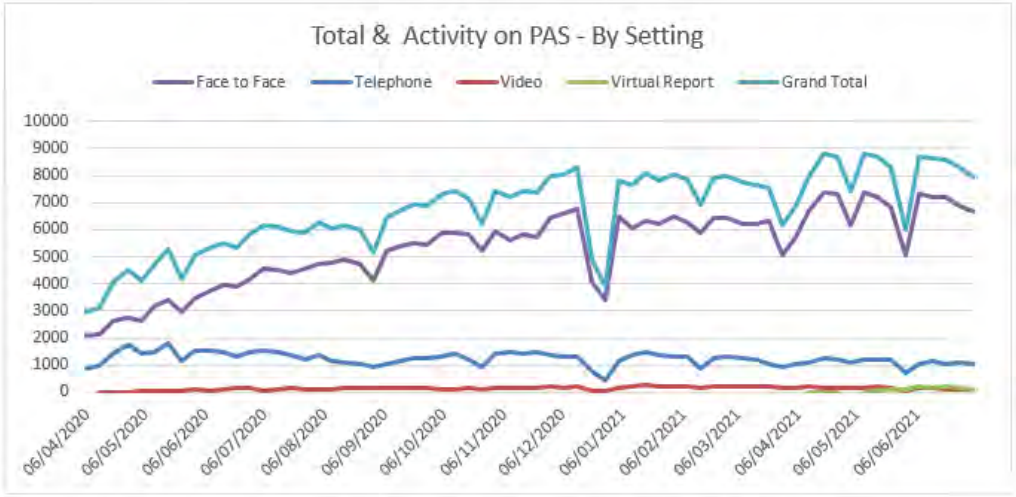
Lower GI:

- Second new consultant has started.
- Rm 3 Endoscopy now back up and running – will continue with 5 sessions at MSH (with annual leave only using 3 session through out July and August).
- Continuation of weekend insourcing (weekends per month) – bid for ERF to do an additional 9 weekends - local team doing 2 in 7 weekends.
- New Gastro Consultant recruited (starting October) – 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.

Virtual appointments

The implementation of new models of care in the delivery of non face to face consultations will be key to reduce the waiting time for patients. The Trust is demonstrating some good practices and new approaches for virtual/ telephone appointments are being adopted, however the Trust is not meeting the national targets. In June we have reported a further increase in activity levels against the overall number of outpatients completed, this being in line with recovery plans, however, a significant portion of this activity has been face-to-face

The target required to meet Elective Recovery Fund (ERF) system gateway is to deliver a minimum of 25% non face-to- face outpatient appointments in reported activity.



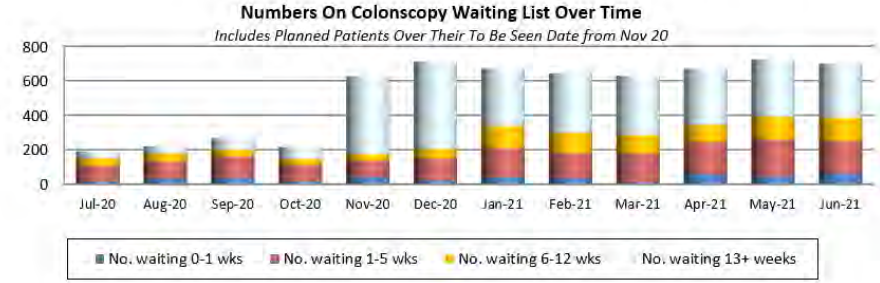
The latest overall performance for non face-to-face for May is 17% (5505 non face-to face appointments out of 36,870) for new and follow appointments (April 16%). To achieve 25%, 9218 of the 36,870 need to be non face to face.

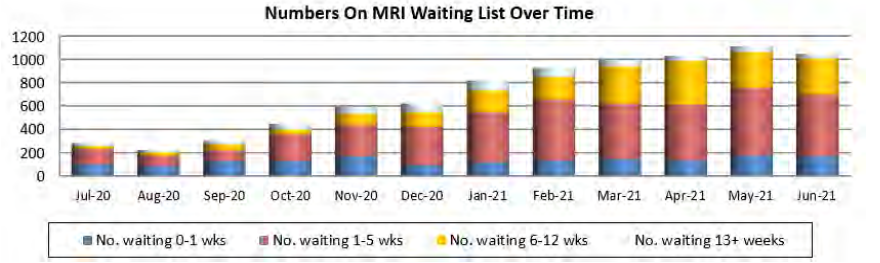
Actions

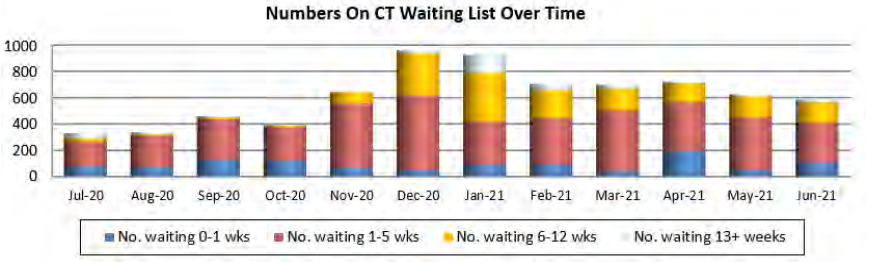
The following actions are being taken to improve Trust performance:

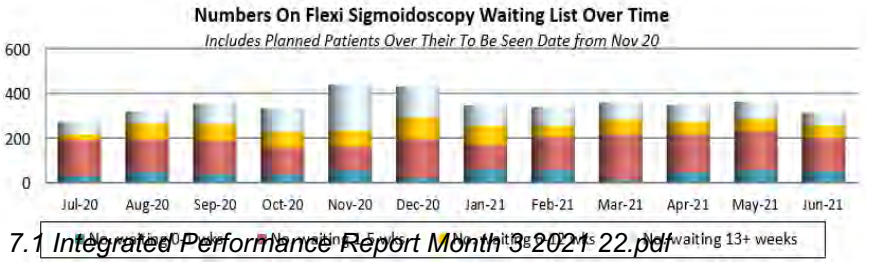
- Offering to support the teams linking with North Devon services that are achieving highest non-face-to-face rates, to see how they operate differently;
- Sharing good practice from one service to another wherever possible/appropriate;
- Providing services with essential information on performance and highlighting where there are areas for improvement;
- Supporting teams with their clinic space booking whilst looking at alternative, external e-scheduler booking systems, to improve access and access to clinic space;
- Making fields on PAS mandatory to record if appointments are telephone/video/ or face-to-face to move away from a face-to-face appointment being the default.
- Working with teams to ensure accurate recording of all activity to enable to improve data capture and data quality.
- Dedicated project manager to over see the Outpatient Transformation Programme with oversight though the Outpatient Transformation Delivery Board.

NHSI indictor - patients waiting over 6 weeks for diagnostics



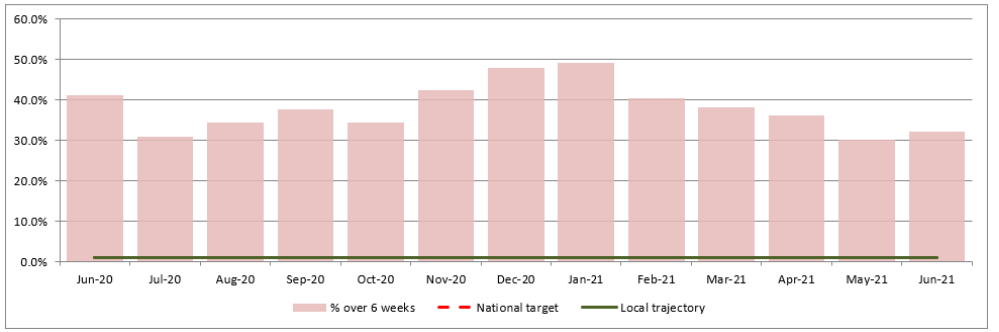






Diagnostic tests longer than the 6 week standard

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Patients	2883	2948	3207	3446	3810	4624	4989	5013	4934	4957	4876	4909	4702
Waiting longer than 6 weeks	1186	911	1106	1295	1312	1957	2389	2462	1992	1892	1768	1478	1516
% over 6 weeks	41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%
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%



June has seen a deterioration in the overall percentage of patients with a diagnostic waiting time over six weeks to 32.2% from 30.1% in May (49.1% in January); the national target is 1%. TSDFT performance does, however, compare favourably with other local Trusts.
All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

MRI waits and total number on the list 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 remains constrained by the availability of only one pad for the mobile van as shared with mobile CT.

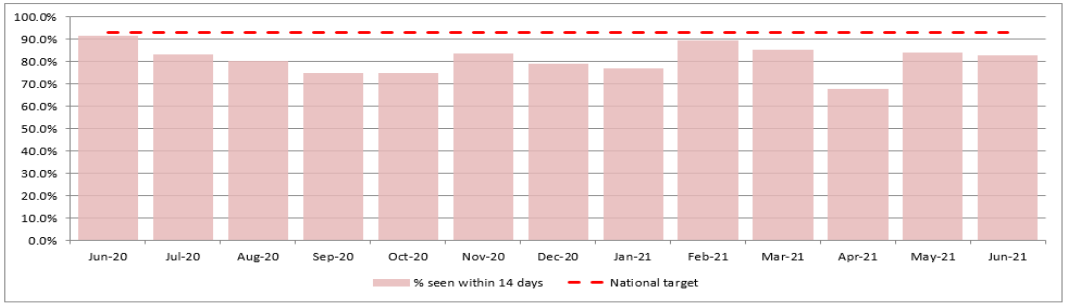
Colonoscopy numbers remain high, however, there are robust plans in place that will see improvement using insourcing at weekends / additional in-house sessions, and sessions contracted at the local independent sector provider. Remedial works to Room 3 air-handling is completed.

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

Other performance exceptions

Cancer - Two week wait referrals

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
2ww referrals seen	1071	1281	1217	1336	1410	1345	1183	1235	1102	1319	1547	1470	1622
2ww breaches	92	213	242	333	356	221	250	283	115	196	499	237	277
% seen within 14 days	91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.9%	77.1%	89.6%	85.1%	67.7%	83.9%	82.9%
National target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

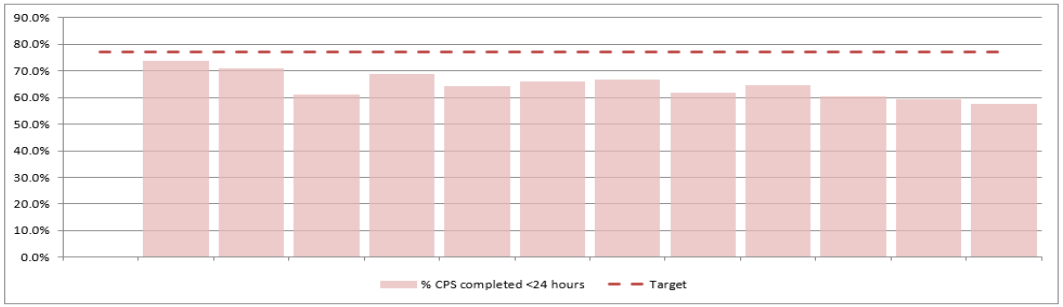


Cancer two-week wait referral

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 June performance is below the 93% standard at 83% of patients seen within two weeks from referral. Head and neck, Colorectal, Urology, and Breast have the greatest number of breaches.

Care Plan Summaries completed within 24 hours of discharge - Weekday

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Discharges	n/a	1405	1425	1361	1324	1176	1436	1157	1049	1282	1434	1484	1475
CPS completed within 24 hours	n/a	1034	1011	832	913	754	950	774	650	828	866	883	851
% CPS completed <24 hours	n/a	73.6%	70.9%	61.1%	69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.7%
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%



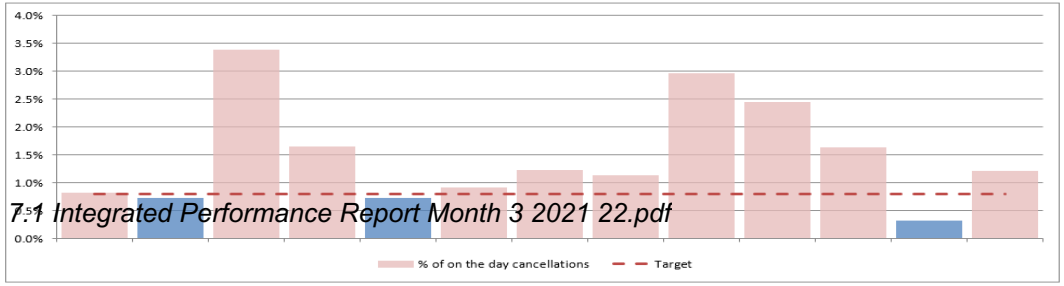
Care Planning Summaries (CPS)

No improvement is currently being seen in the weekday CPS completion. During the trial Dunlop had 31 discharges which were eligible for a CPS, 93.5% were completed within 24 hours.

CPS completion will become mandatory before discharge from 1st August for Phase 1 wards; wards in Phase 1 are paediatrics wards medical wards (community wards in Phase 1 to be confirmed).

On the day cancellations for elective operations

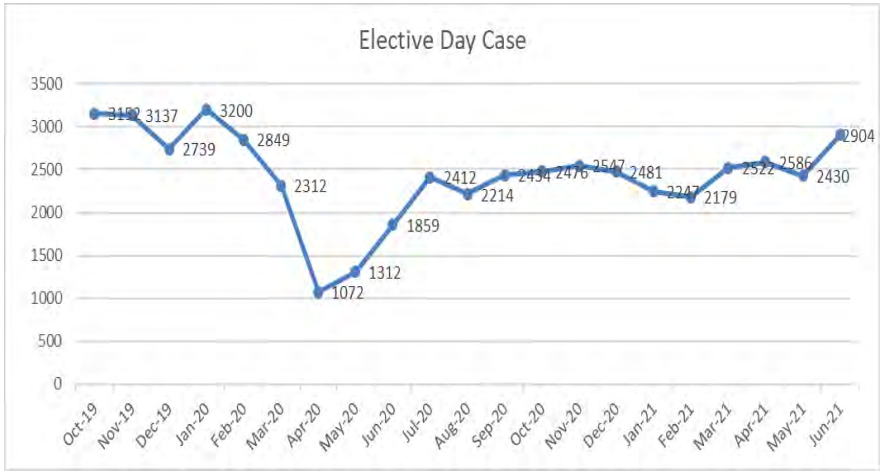
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Cancellations	15	18	74	46	20	26	35	29	71	71	48	9	40
Elective spells	1826	2446	2189	2772	2742	2835	2835	2550	2400	2904	2922	2760	3276
% of on the day cancellations	0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%

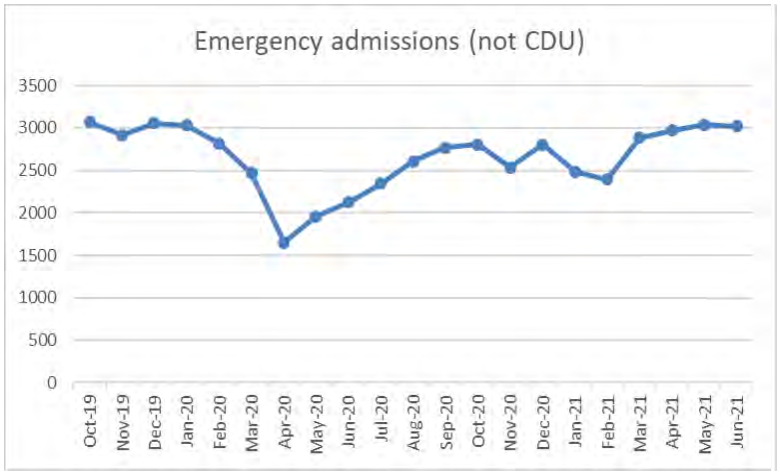


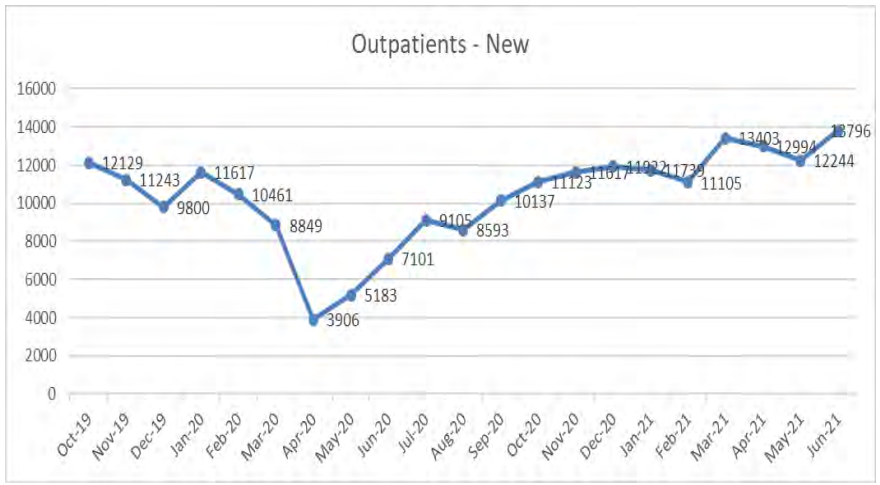
Cancelled operations

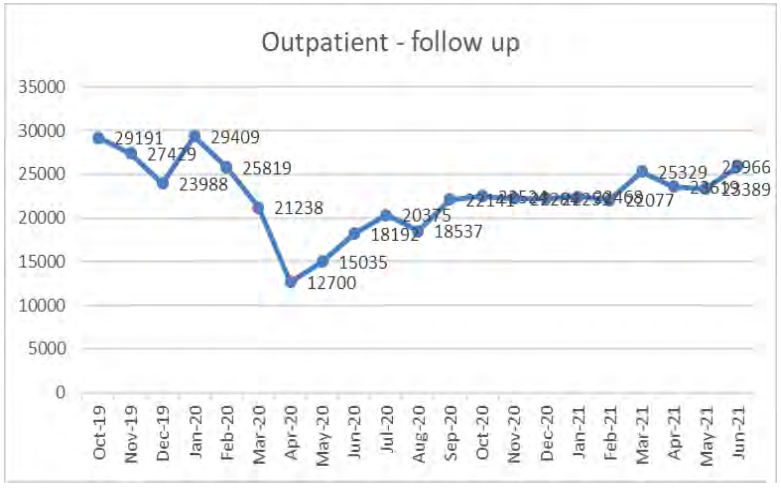
The total number of elective procedures cancelled on the day increased in June to 40 (1.2%).

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 June 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 3 shows a continued recovery when compared to pre-covid levels of activity.

The recent escalation and stepping down of non urgent elective inpatient and some day cases will impact on the level of activity seen over the next few months. We do however expect to see a continued progress in stepping back up and increasing overall outpatient activity levels. The focus remains on building back capacity and having robust processes to ensure all available capacity is being fully utilised.

Teams continue to seek opportunities to increase activity to utilise the Elective Recovery Fund (ERF) where this is operationally possible and working with system partners to optimise these opportunities.

Children and Family Health Devon

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' Standard Operating Procedure to ensure consistent contact is kept up with families who are waiting. There are key interim positions in key leadership roles, job descriptions 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. Additional monies for crisis, easting disorder and mental health in schools has been awarded and the service model developed. Recruitment is under way.
- Safeguarding Children Level 3 training and appraisal compliance improved significantly on their position this year and is currently rag rated green.
- 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; significant new investment from NHS England has been announced, model developed, and recruitment progressing.
- 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 however there will be a delay in implementing the new system due to delays in the transformation programme.

18 week RTT Performance June - 2021		RTT % <18 weeks		Caseload		
Service	Number waiting over 52 weeks	June - 20	June-21	June - 20	June-21	Change last 12 months
CAMHS	35	66.6%	70.6%	3865	4502	+ 637
Occupational Therapy	1	41.9%	60.1%	1257	1115	- 142
Speech and Language Therapy	425	39.6%	30.2%	4112	5255	+ 1143
Autistic spectrum assessment team	1662	17.3%	8.1%	2266	3395	+ 1129
Physiotherapy	0	73.9%	83.4%	444	496	+ 52
Learning disability	0	75%	94.4%	324	273	- 51

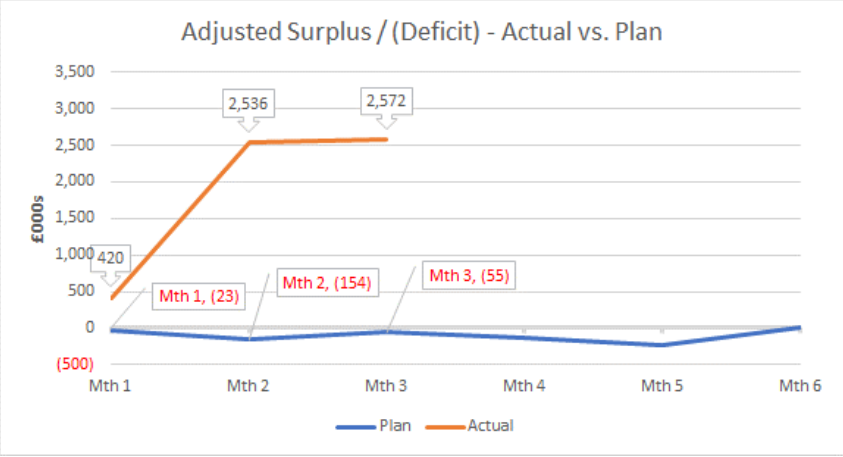
Financial Performance – Month 3
FY 2021 / 22

Financial Overview – Month 3, June 2021

High Level Summary

For Period ended - 30 June 2021, Month 3	Plan £m	Actual £m	Variance £m
Total Operating Income	141.05	144.41	3.36
Total Operating Expenditure	(139.15)	(139.89)	(0.74)
Adjusted Surplus/(Deficit)	(0.06)	2.57	2.63
Capital	5.89	2.69	(3.21)
Cash & Cash Equivalents		27.80	

Adjusted Surplus / (Deficit)



Operating Income
Operating income for the year to date totals £144.4m, within which income for patient care activities totals £132.7m. The favourable variance is driven by additional pass through and variable income, e.g. additional COVID related income (£2.1m favourable) and ASC client contribution (£0.2m favourable which is matched by additional costs) and Torbay pharmaceutical sales (£0.8m favourable).

Operating Expenditure
Total operating expenditure of £139.9m, which includes £69.8m of staff costs, and the reported overspend of £0.74m is largely related to pay cost and increased usage of Nursing agency staff primarily in A&E.

Adjusted Surplus / (Deficit)
At month 3 the Trust is recording a £2.6m favourable variance against plan, largely relates to the timing differences in income and cost for budgeted pass through drugs and devices (£1.1m), additional CCG top-up for COVID activities (£0.8m), Torbay pharmaceutical surplus (£0.5m) and various other income streams (£0.2m).

Cash
The Trust is showing a healthy cash position at the end of Month 3, with £27.8m 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. £2.7m on capital schemes. A separate capital report has been prepared for the Trust's FPDC.

H1 plan
The Trust provided a detailed resubmission of the H1 plan to NHSE/I last month, showing a break-even position and including ERF income and other relevant changes.

I&E Position – Month 3, June 2021

Income & Expenditure – Performance versus Plan

£m	M3 - In Month			M3 - YTD		
	Budget	Actual	Variance	Budget	Actual	Variance
Patient Income - Block	37.46	32.75	(4.71)	98.49	98.30	(0.19)
Patient Income - Variable	3.80	3.95	0.15	11.40	12.23	0.82
ERF Funding	1.96	0.54	(1.42)	1.96	1.96	0.00
ASC Income - Council	4.58	4.58	0.00	13.75	13.75	0.00
Other ASC Income - Contribution	0.97	1.22	0.24	2.95	3.17	0.22
Torbay Pharmaceutical Sales	1.72	2.20	0.48	4.80	5.62	0.82
Other Income	(2.46)	1.85	4.31	6.54	6.20	(0.34)
Covid19 - Top up & Variable income	0.39	0.41	0.02	1.16	3.22	2.05
Total (A)	**48.41**	**47.48**	**(0.93)**	**141.05**	**144.44**	**3.39**
Pay - Substantive	(22.71)	(22.26)	0.45	(67.84)	(67.12)	0.72
Pay - Agency	(0.48)	(1.10)	(0.62)	(1.41)	(2.68)	(1.27)
Non-Pay - Other	(14.55)	(13.00)	1.56	(39.76)	(37.72)	2.04
Non- Pay - ASC/CHC	(8.50)	(8.99)	(0.48)	(25.86)	(28.14)	(2.28)
Financing & Other Costs	(2.14)	(2.10)	0.04	(6.44)	(6.34)	0.10
Total (B)	**(48.39)**	**(47.44)**	**0.95**	**(141.31)**	**(142.00)**	**(0.69)**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**0.03**	**0.05**	**0.02**	**(0.26)**	**2.44**	**2.70**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.07	(0.01)	**(0.08)**	**0.21**	**0.14**	**(0.07)**
Adjusted Financial performance - Surplus / (Deficit)	**0.10**	**0.04**	**(0.06)**	**(0.05)**	**2.58**	**2.63**

In Month 3 the Trust recorded a minimal surplus against a planned surplus of £0.1m. The year to date position shows a surplus of £2.6m against a planned breakeven position, giving a favourable variance of £2.6m.

The forecast as at the end of M6 is a break even position as per H1 plan. Key risks to the position are:

- ERF – the threshold has been amended to 95% (from 85%) thereby System will not earn as much ERF as expected. The estimate of this risk is £2m for the Trust.
- Funded nursing care assessments backlog – there is currently a backlog of approximately 200 cases, a proportion of which would lead to backdated claims for continuing health care.
- Wave 3 Covid – the Trust has budget for the next three months of £0.8m for costs relating to Covid, that are not funded on a passthrough basis (such as increased cost of infection control). It is unclear whether this level of budget is sufficient should there be a significant impact from a surge in Covid cases.

In Month Position:

Income

- Within the H1 resubmission there is a reclassification of over £4m in M3 between patient income block and other income re: top up income from the CCG. Higher variable patient care income (£0.15m) is due to pass through drugs and devices (matched by cost).
- The Trust recognised £0.54m of Elective Recovery Funding (ERF) in Month 3 from the CCG.
- ASC Client contribution income is £0.24m higher in month (matched by cost).
- Torbay Pharmaceutical sales were £0.48m higher than planned in month from all sources.

Pay

- In Substantive pay there is a net favourable variance in month (£0.45m) mainly due to vacancies.
- Agency cost is £0.62m higher than budget within all staff group but primarily due to Nursing (£0.35m) linked to A&E activity, specialling and RMN requirements. Various other staff groups account for £0.27m.

Non-pay

- Main drivers of the favourable non-pay other position (£1.56m) include: contingency (£1.87m) offset by higher than planned Drugs issues (£0.17m) and clinical supplies costs (£0.14m) linked to increase in A&E and Elective activity.
- The £0.48m adverse position for ASC/CHC costs is due to: COVID spend of £0.21m (matched by income), ASC £0.15m driven by higher costs in Nursing Long Stay, Day Care and Supported Living areas of care (matched by increase in client contribution) and Placed People £0.13m due to higher costs in Torbay CHC. This is a result of costs being estimated for the backdated impact of delayed Funded Nursing Care.

Change in Activity Performance – Month 2 to Month 3

		Plan	May-21	Jun-21	Change	% Change		Jun-20	% change
Activity Drivers	A&E Attendances		9,014	9,859	845	9%		*6,691*	47%
	Elective Spells	2,679	2,719	3,143	424	16%		*2,047*	54%
	Non Elective Spells		3,534	3,450	-84	-2%		*2,457*	40%
	Outpatient Attendances	26,166	27,573	28,865	1,292	5%		*21,546*	34%
	Adult CC Bed Days		308	223	-85	-28%		*129*	73%
	SCBU Bed Days		183	162	-21	-11%		*127*	28%
Bed Utilisation	Occupied beds DGH		9,392	9,219	-173	-2%		*8,076*	14%
	Available beds DGH		10,248	9,692	-556	-5%		*10,740*	-10%
	Occupancy		92%	95%	3%	3%		75%	20%
Resource Consumption	Medical Staff Costs - £000's	5,105	5,123	5,060	-63	-1%		*5,187*	-2%
	Nursing Staff Costs - £000's	5,379	5,368	5,442	74	1%		*5,230*	4%
	Temp Agency Costs - £000's	481	828	1096	268	32%		*581*	89%
	Total Pay Costs* - £000's	23,195	23,291	23,357	66	0%		*22,684*	3%

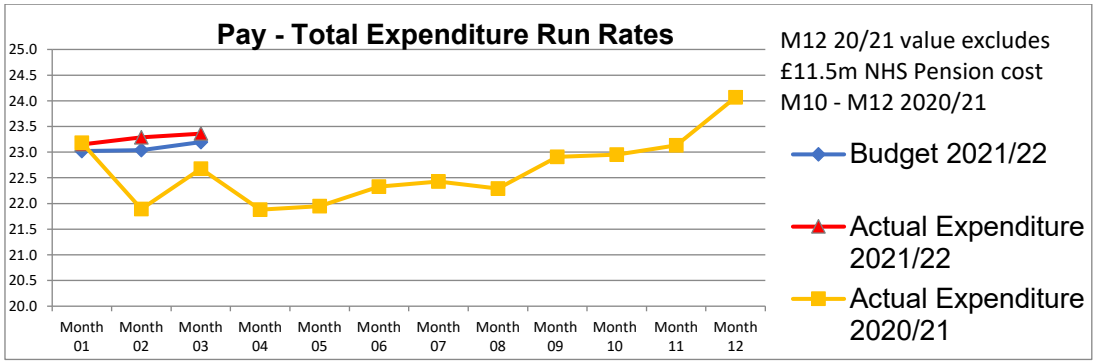
Activity Drivers

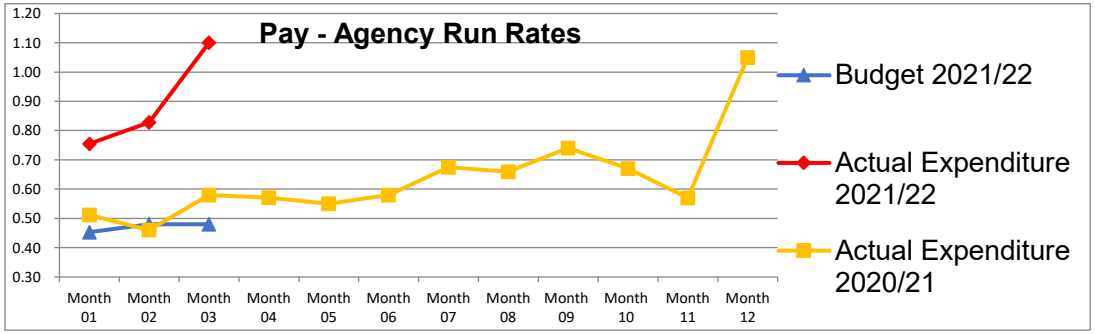
- No formal plan (for contracting purposes) has been created for A&E, Non Elective, or ACC/NCC. This is as a result of the focus being on the recovery of elective activity.
- Overall, elective activity levels are above plan at Month 3, but are below that of 2019/20, which is the comparator year for NHSE/I 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 June, overall bed occupancy is 95% up from 92% reported in May. This being the highest recorded occupancy level since the start of the COVID pandemic. 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. In June OPEL 4 has been declared on 8 days.
- The need to escalate bed capacity to maintain patient flow in June has meant a suspension of routine elective orthopaedic surgery with one of the two orthopaedic wards being set aside for medical patients. Prioritisation of Trauma and priority P1 and P2 surgical patients has continued. This loss of capacity remains a high risk when taken with the known risk of 3rd wave of covid hospitalisations predicted over the next 13 weeks.

Pay Expenditure – Month 3, June 2021



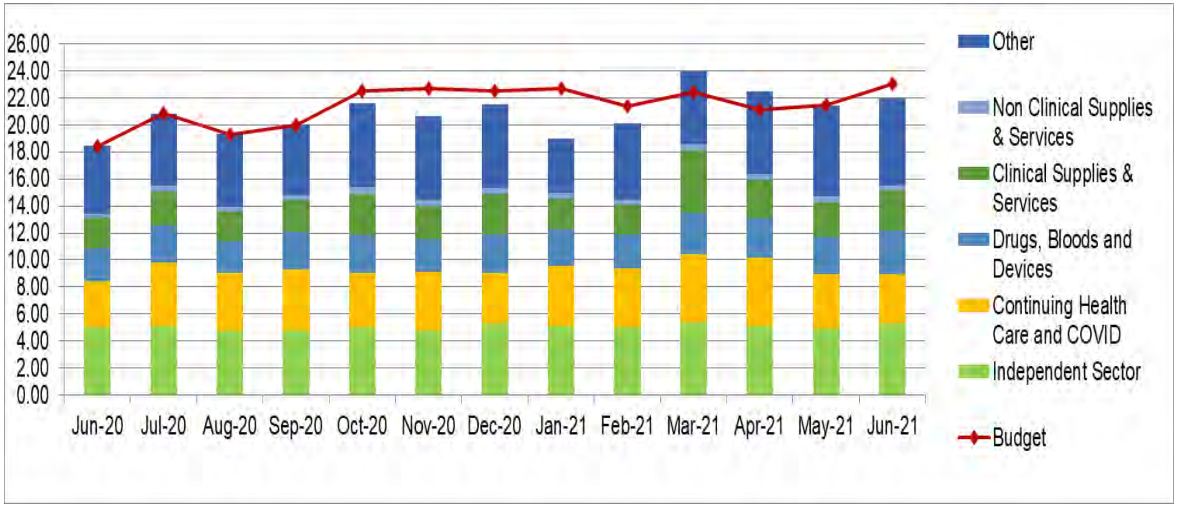


In Month 3 the total pay expenditure is £23.36m, which is £0.07m higher compared to Month 2 (£23.29m). Further details are provided below:

- Substantive pay decreased by £0.15m mainly in Medical staffing.
- Bank pay net decrease of £0.05m primarily within Nursing and HCA staff.
- Agency costs were £0.27m higher than Month 2 across all staff groups.
- Of the year to date pay costs, those associated with COVID account for £0.81m, comprised of:
  - Sick pay - £0.45m,
  - vaccination - £0.19m
  - additional shifts of existing workforce – £0.10m, and
  - testing – £0.07m
- The Apprentice levy balance at Month 3 is £2.1m (no change from Month 2). 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 3, June 2021



The total non-pay run rate in Month 3 (£21.98m) is £0.53m higher in comparison to previous month (£21.45m), key details are provided below:

- Increases in:
  - Clinical supplies – £0.44m primarily TP linked to production: chemical consumables £0.29m and cost of sales £0.04m, medical and surgical equipment and general appliance purchases £0.11m (due to clinical activity),
  - Drugs costs – £0.38m higher usage mainly within high cost drugs £0.24m, cancer £0.08m and inpatient & outpatient drugs £0.06m,
  - Independent sector – £0.31m linked to increased costs on Nursing Long Stay, Day Care, Supported Living and Residential Short Stay areas of care. This increase is partially mitigated by £0.22m of higher income levels (client contributions),
  - Non-clinical supplies – increased by £0.02m due to patient provisions and uniforms; offset by:

- Decreases in:
  - Placed People (Health including Continuing Healthcare) and COVID – £0.31m lower as a result of estimated costs for HDP in April & May not coming through as anticipated, combined with lower June costs / activity.
  - Net Operating expenditure – £0.31m. Material movements are: reserves £0.39m, CFHD alliance charge £0.05m, establishment £0.05m, professional services and consultancy £0.05m, lower bad debt provision £0.04m and various other operating expenditure £0.13m offset by an increase of £0.40m re: IT development (N365).

COVID Cost Analysis – Month 3, June 2021

COVID Expenditure	Inside Envelope Actual 30/06/2021 YTD £'000	Outside Envelope Actual 30/06/2021 YTD £'000	Total Actual 30/06/2021 YTD £'000
Staff and executive directors costs	544	267	810
Supplies and services – clinical (excluding drugs costs)	23	534	557
Supplies and services - general	26	1	27
Establishment	19	0	19
Premises - other	45	0	45
Transport	10	0	10
Other	45	0	45
Total operating expenditure	**711**	**802**	**1,513**

Hospital Discharge, Rapid Testing and Infection Control COVID	Total Cost Actual 30/06/2021 YTD £'000	CCG Income Actual 30/06/2021 YTD £'000	Council Income Actual 30/06/2021 YTD £'000	Provider Refunds Actual 30/06/2021 YTD £'000
Hospital Discharge Programme (HDP) Scheme 2	984	(984)		
Rapid Testing & Infection Control	1,420		(1,420)	
General	65			(96)
Total	**2,468**	**(984)**	**(1,420)**	**(96)**

As highlighted above, within the Trust's pay position at Month 3 COVID costs account for £0.81m.

Within non-pay COVID costs account for £0.70m, comprised of:

- Testing - £0.53m, and
- Segregation of patient pathways - £0.17m

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 £2.47m, 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. Torbay Council have just been allocated further national funding for Rapid Testing and Infection Control grants (Q2 2021/22) and it is anticipated these will be fully passported to providers within Torbay, in line with grant conditions, during July.

Key Drivers of System Positions – Month 3, June 2021

System	ISU	Financial Commentary / Key Drivers
CFHD	CYP	Expenditure run rate remains constant. Staff consultation - the Senior Team are progressing internal discussions on pathway options and cost; ongoing high level of vacancies. IT EPR business case approved but commencement delayed to ensure it supports new clinical pathways; no costs included in this year's revenue account.
Torbay Pharmaceuticals	PMU	TP sales in M3 £0.5m higher than plan and ahead of the year to date by £0.8m, due to increased sales from all sources.
Corporate	EFM	Backdated income for paper towel rebates & continuing small increase in visitor parking income are main reasons for increase in income. Car parking to remain FOC to staff into 2021/22. Hotel Services pay underspend as agency costs recharged to COVID.
	Exec. Directors	Underspent mainly in Finance due to vacancies, VAT reclaims & Court of Protection income and in Medical Director due to Medical Examiner income & reduced CEA payment this year.
	Financing Costs	Costs are in line with plan.
	Other	Reserves includes plan adjustments plus provision for Independent Sector inflation, SharePoint CALS & miscellaneous small other provisions.
South System	Coastal	Underspent at M3 against budget £0.7m mainly due to slower than expected recruitment, savings in theatre supplies and drugs at earlier stages of recovery. Run rates are expected to increase as recovery plans advance, but spend against plan is predicted to be underspent at the half year by c£0.4m.
	Newton Abbot	Overspent against plan at M3 by £0.5m due to cost pressures in ED for agency and bank nursing staff, and medical locum to cover staff absence £0.7m, offset with underspends in ICU, wards and community teams £0.2m. The cost pressures are expected to continue with a forecast overspend of £0.9m predicted at the half year, being ED and medical staffing £1.3m offset with savings £0.4m.
	Moor to Sea	Marginally over budget at M3 by £0.1m due to ward specialling requirements and increase in purchase of intermediate care beds offset by savings due to delays in recruitment. Run rates are expected to increase in ward expenditure bank and agency costs due to staff absence and specialling requirements, with a predicted £0.2m overspend against plans at the half year.
	Shared Operations	Broadly in line with budget at M3 showing a marginal underspend of £62k which is mainly due to vacant posts. The forecast at the half year is also predicting a marginal underspend against plan.
Torbay System	Independent Sector	ISU is £416K underspent against a YTD budget envelope of £23.3m. Cost YTD is £2.3m higher than budget but this is entirely due to COVID related spend (Hospital Discharge, Rapid Testing and Infection Control). COVID costs total circa £2.47m and this is matched by an equivalent value in Income. Outside of COVID, spend is lower than planned YTD materially in ASC and is driven by lower activity (than planned) on Dom Care, Residential Care (both long and short stay) combined with higher than budgeted client contributions.
	Torquay	ISU is operating in line with the YTD budget envelope of £9.9m, with minimal overspends across pay and non-pay being offset by additional income.
	Paignton and Brixham	ISU has a minor YTD £30K underspend against at YTD budget envelope of circa £21m. This is driven by a material £645K non-pay underspend (Labs Medicine) but this is primarily offset by £602K 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) £2.0m of Elective Recovery Funding (ERF) at M3 from the CCG. 2) Additional £0.9m of variable income from Specialised Commissioning relating to pass through drugs (corresponding increase in drugs costs). 3) C. £1.0m 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 3, June 2021

	YTD at M03 £m
Opening cash balance	**45.45**
Capital Expenditure (accruals basis)	(2.68)
Capital loan drawndown	0.00
Capital loan repayment	(0.99)
Proceeds on disposal of assets	0.00
Movement in capital creditor	(9.71)
Other capital-related elements	(0.38)
Sub-total - capital-related elements	**(13.76)**
Cash Generated From Operations	8.72
Working Capital movements - debtors	(5.40)
Working Capital movements - creditors	(6.15)
Net Interest	(0.75)
PDC Dividend paid	0.00
Other Cashflow Movements	(0.30)
Sub-total - other elements	**(3.88)**
Closing cash balance	**27.80**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	38,527	33,759	87.6%
Non-NHS - value of bills (£k)	75,890	64,159	84.5%
NHS - number of bills	527	390	74.0%
NHS - value of bills (£k)	6,787	4,299	63.3%
Total - number of bills	39,054	34,149	87.4%
Total - value of bills (£k)	82,677	68,458	82.8%

Key points of note:

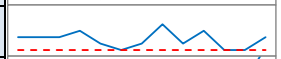
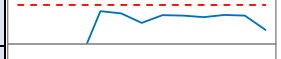
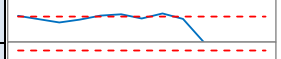
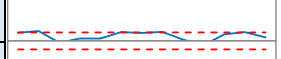
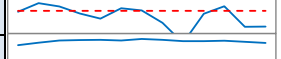
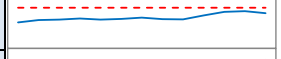
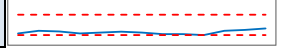
- A 2021/22 cashflow plan has not been required by NHSE/I for the first six months. A full-year cashflow plan was incorporated into a FPDC capital and cash report at M02. The Trust is planning that its cash balance will decrease over the year from the exceptionally high March 2021 level of £45m, to £4m. This plan assumes that the capital plan is delivered and that planned Public Dividend Capital support will be obtained.
- Over the year to date, cash balances have decreased by £17.6m. This was principally due to the paying down of capital creditors (£9.7m), the agreed repayment of 2020/21 funding to the CCG (£4.0m), and the build-up of accrued income (including ERF £2.0m, Covid reimbursement £0.9m and HDP £0.9m). These movements are consistent with the full-year cashflow plan.
- As per the cashflow plan, cash balances are expected to decrease further during the course of the year as deferred income balances unwind, debtors reach a more normal level, and some of the Trust's cash reserves are used to support capital expenditure.
- NHSE/I has indicated that there will be increased focus on the Better Payment Practice Code and options to improve performance are being reviewed.

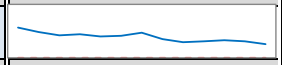
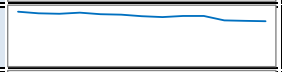
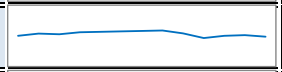
Statement of Financial Position (SoFP) – Month 3, June 2021

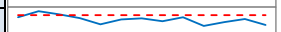
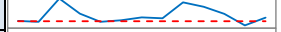
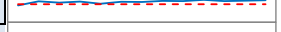
	Month 3		
	Position 31 March 2021 £m	Position 30 June 2021 £m	Movement £m
Non-Current Assets			
Intangible Assets	10.09	10.23	0.14
Property, Plant & Equipment	202.37	200.78	(1.59)
On-Balance Sheet PFI	17.11	17.03	(0.08)
Other	2.04	2.00	(0.04)
Total	**231.61**	**230.04**	**(1.57)**
Current Assets			
Cash & Cash Equivalents	45.45	27.80	(17.65)
Other Current Assets	33.20	38.69	5.49
Total	**78.64**	**66.49**	**(12.15)**
Total Assets	**310.25**	**296.53**	**(13.72)**
Current Liabilities			
Loan - DHSC ITFF	(4.80)	(4.80)	0.00
PFI / LIFT Leases	(1.17)	(1.20)	(0.04)
Trade and Other Payables	(61.81)	(47.06)	14.75
Other Current Liabilities	(10.44)	(10.75)	(0.31)
Total	**(78.23)**	**(63.82)**	**14.41**
Net Current assets/(liabilities)	**0.41**	**2.67**	**2.25**
Non-Current Liabilities			
Loan - DHSC ITFF	(29.08)	(28.09)	0.99
PFI / LIFT Leases	(16.60)	(16.27)	0.33
Other Non-Current Liabilities	(15.88)	(15.44)	0.43
Total	**(61.55)**	**(59.80)**	**1.75**
Total Assets Employed	**170.47**	**172.91**	**2.44**
Reserves			
Public Dividend Capital	130.76	130.76	0.00
Revaluation	49.15	49.15	0.00
Income and Expenditure	(9.44)	(7.00)	2.44
Total	**170.47**	**172.91**	**2.44**

Key points of note:

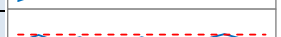
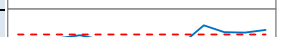
- Non-current assets have reduced by £1.6m, principally as depreciation (£4.2m) has exceeded capital expenditure (£2.7m).
- Cash has reduced by £17.6m, as explained in the commentary to the cashflow section.
- Other current assets have increased by £5.5m, principally due to increased accrued income (e.g. ERF £2.0m, Covid reimbursement £0.9m, HDP £0.9m).
- Trade and other payables have reduced by £14.8m, principally due to the paying down of the capital creditor (£9.7m) and the agreed repayment of 2020/21 funding to the CCG (£4.0m).
- Non-current DHSC loan liabilities have reduced by £1.0m due to scheduled loan repayments.

	ISU	Target	13 month trend	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		2	2	2	1	0	1	2	1	1	4	1	4	4	9
Reported Incidents - Death	Trustwide	<1		2	2	2	3	1	0	1	4	1	3	0	0	2	2
Medication errors resulting in moderate harm	Trustwide	<1		0	1	0	0	0	0	0	0	2	0	0	1	3	4
Medication errors - Total reported incidents	Trustwide	N/A		40	41	39	51	52	53	34	41	50	53	50	64	57	171
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	1	1	1	3	0	0	0	1	0	0	0		0
Never Events	Trustwide	<1		0	0	0	2	1	0	0	0	0	1	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		1	4	8	5	5	2	4	7	6	6	6	7	11	8
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	1	0	0	0	0	0	0	0	0	0	0	0
Formal complaints - Number received	Trustwide	<60		13	18	17	17	18	19	14	7	13	13	10	7	11	28
VTE - Risk Assessment on Admission	Trustwide	>95%		82.5%	80.2%	79.2%	80.9%	93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%	92.2%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		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%		89.8%	90.8%	84.0%	86.4%	86.5%	90.1%	89.7%	90.3%	85.8%	82.5%	89.0%	90.2%	87.1%	88.8%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		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%	89.4%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		12	0	20	262	23	0	30	6	0	23	24	42	381	447
Hand Hygiene	Trustwide	>95%		97.9%	97.2%	98.3%	98.9%	96.9%	97.8%	97.0%	98.3%	95.3%	92.8%	96.0%	94.8%	97.6%	98.6%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		91.7%	94.6%	74.4%	60.0%	74.5%	75.7%	75.6%	85.3%	94.4%	78.1%	73.2%	90.6%	85.3%	83.0%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		79.1%	86.8%	83.9%	77.6%	73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%	71.3%
Follow ups 6 weeks past to be seen date	Trustwide	6400		15398	16408	17220	17408	17519	17229	17837	17489	16986	16950	17118	16713	16323	16323
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.5%	4.5%	4.5%	4.4%	4.3%	4.3%	4.3%	4.2%	4.1%	4.0%	4.0%	4.0%		4.1%
Appraisal Completeness	Trustwide	>90%		75.6%	77.8%	78.4%	79.4%	78.4%	78.9%	80.4%	78.8%	78.4%	82.4%	85.9%	86.6%	84.7%	82.4%
Mandatory Training Compliance	Trustwide	>85%		89.9%	89.9%	89.9%	89.7%	89.7%	89.6%	89.6%	89.7%	89.5%	89.6%	90.1%	90.1%	90.5%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.3%	10.8%	10.7%	10.3%	10.5%	10.7%	10.5%	10.2%	10.2%	10.0%	10.8%	11.0%	11.3%	

	ISU	Target	13 month trend	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Number of Delayed Discharges (Community) *	Trustwide	<315		38	95	175	246	256							424		
Number of Delayed Transfer of Care (Acute)	Trustwide	<240		33	82	89	72	129									
Carers Assessments Completed year to date	Trustwide	40% (Year end)		95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	98.3%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		217	219	221	200	214	221	223	223	207		234			234
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		56			124			199				334			334
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET		5.9%			5.4%			4.4%				3.7%			3.7%
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		553	559	561	560	576	599	658	617	615	616		608	629	629
Intermediate Care - No. urgent referrals	Trustwide	113		283	242	211	221	200	207	235	175	146	155	165	155	128	448
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		221	206	260	262	274	193	242	249	205	255	282	294	291	867
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			82.1%	81.8%	81.1%	80.0%	79.8%	77.6%	76.4%	75.1%	73.8%	74.0%	72.9%	71.9%	71.0%	71.0%
Proportion of carers receiving self directed support	Trustwide			95.2%	94.3%	95.3%	99.2%	94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	98.3%
% Adults with learning disabilities in employment	Trustwide			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%	7.4%
% Adults with learning disabilities in settled accommodation	Trustwide			80.0%	79.3%	79.0%	79.1%	80.2%	80.6%	80.5%	80.4%	80.6%	81.8%	82.6%	82.3%	81.7%	81.7%
Permanent admissions (18-64) to care homes per 100k population	Trustwide			27.0	18.9	24.3	20.2	20.2	14.8	18.9	14.8	17.5	16.2	17.5	20.2	23.1	23.1
Permanent admissions (65+) to care homes per 100k population	Trustwide			502.6	538.1	524.4	557.2	565.4	573.6	579.0	587.2	540.8	464.3	499.8	510.8	487.3	487.3
Proportion of clients receiving direct payments	Trustwide			22.9%	22.9%	22.7%	23.3%	23.6%	22.6%	22.4%	21.7%	21.2%	21.1%	20.1%	19.8%	19.5%	19.5%
% reablement episodes not followed by long term SC support	Trustwide			85.2%	87.1%	86.2%	85.9%	84.6%	85.2%	85.5%	85.4%	85.7%	85.8%	-	-	-	..

	ISU	Target	13 month trend	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		94.8%	96.4%	93.5%	91.9%	86.2%	86.5%	81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	72.6%	78.3%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		57.0%	53.5%	57.3%	62.1%	62.3%	64.2%	64.3%	61.8%	61.4%	61.4%	62.7%	63.9%	64.4%	63.7%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		80.9%	92.3%	86.3%	79.3%	67.9%	77.0%	78.9%	73.8%	80.9%	64.8%	71.8%	77.9%	66.4%	71.6%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		41.1%	30.9%	34.5%	37.6%	34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%	32.9%
Dementia - Find - monthly report	Trustwide	>90%		94.5%	60.8%	84.4%	89.2%	96.6%	94.4%	97.7%	94.8%	98.0%	95.0%	96.7%	96.9%	97.4%	97.0%
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		5	4	4	2	4	2	3	1	1	5	2	5	2	9
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		91.4%	83.4%	80.1%	75.1%	74.8%	83.6%	78.9%	77.1%	89.6%	85.1%	67.7%	83.9%	82.9%	78.2%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		95.3%	97.4%	100.0%	95.9%	97.8%	86.6%	94.0%	75.0%	96.3%	95.2%	61.9%	54.1%	56.7%	57.7%
Cancer - 28 day faster diagnosis standard	Trustwide			81.5%	79.8%	72.4%	66.6%	72.7%	75.3%	75.9%	72.2%	77.3%	75.0%	75.6%	75.6%	75.6%	75.6%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		100.0%	99.4%	97.3%	97.4%	97.7%	99.0%	97.5%	97.5%	98.8%	99.0%	97.4%	96.7%	98.5%	97.6%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	98.6%	100.0%	100.0%	99.6%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	96.0%	100.0%	100.0%	100.0%	98.5%	100.0%	95.2%	97.7%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		100.0%	96.4%	91.3%	100.0%	93.3%	96.3%	93.3%	96.4%	97.0%	84.8%	100.0%	96.7%	89.7%	94.7%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		66.7%	0.0%	100.0%	100.0%	60.0%	75.0%	66.7%	77.8%	83.3%	100.0%	75.0%	73.3%	75.0%	74.1%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			68	32	9	9	8	13	14	11	6	15	15	17	10	10
RTT 52 week wait incomplete pathway	Trustwide	0		344	524	745	892	1141	1277	1435	1570	1823	2041	1895	1596	1562	1562
On the day cancellations for elective operations	Trustwide	<0.8%		0.8%	0.7%	3.4%	1.7%	0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%	0.7%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		1	5	3	29	4	1	1	5	6	8	6	11	3	49
Bed Occupancy	Overall System	80.0%		74.7%	93.3%	86.7%	91.6%	82.4%	90.5%	89.8%	94.4%	93.4%	99.5%	94.2%	96.1%	98.0%	96.1%
Number of patients >7 days LoS (daily average)	Trustwide			80.9	76.5	89.3	94.9	94.0	95.4	95.1	109.5	114.2	98.2	97.0	104.5	120.5	106.8
Number of extended stay patients >21 days (daily average)	Trustwide			18.7	12.0	13.3	15.2	17.1	16.7	14.0	20.8	27.8	19.9	15.2	21.3	25.0	20.3

	ISU	Target	13 month trend	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		19	10	46	59	73	38	138	75	82	94	90	128	380	598
Ambulance handover delays > 60 minutes	Trustwide	0		4	1	3	0	14	1	19	15	20	32	19	26	173	218
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			1	0	1	10	16	4	18	18	27	28	14	46	246	306
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		0	0	0	0	1	0	1	2	3	5	2	3	32	37
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		4	1	5	2	4	2	2	1	1	4	1	3	2	6
Number of Clostridium Difficile cases - (Community)	Trustwide	0		1	3	2	0	0	0	1	0	0	1	1	2	0	3
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%			73.6%	70.9%	61.1%	69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.7%	59.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%			46.3%	43.7%	35.0%	41.4%	41.6%	32.4%	47.4%	30.9%	41.0%	25.5%	33.1%	32.4%	30.6%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		90.9%	90.9%	90.9%	72.7%	100.0%	90.9%	86.4%	81.8%	95.5%	81.8%	86.4%	90.9%	100.0%	92.4%

	ISU	Target	13 month trend	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			800	1323	1297	1220	-23	1420	2378	3635	937	3180		2623	2551	
Agency - Variance to NHSI cap	Trustwide			0.44%	0.39%	0.49%	0.38%	-0.10%	-0.20%	-0.20%	-0.20%	-0.20%	-0.25%		-1.40%	-1.80%	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			1813	2770	532	-236	1686	5147	6653	9748	11822	2305		2004	3206	
Distance from NHSI Control total (£'000's)	Trustwide			0	0	0	0	112	1493	1858	3993	1179	655		2690	2621	
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			-32.4%	-23.9%	-15.8%	-3.2%	-5.6%	4.5%	-0.9%	-21.7%	-14.0%	26.8%	-5.3%	-15.9%	-0.3%	-7.4%
Outpatients - Follow ups	Trustwide			-28.2%	-26.5%	-24.3%	-15.0%	-23.8%	-18.5%	-8.5%	-25.3%	-17.0%	16.8%	-8.2%	-13.1%	-1.0%	-7.5%
Daycase	Trustwide			-34.1%	-20.7%	-23.9%	-14.4%	-21.9%	-18.9%	-9.4%	-29.8%	-23.5%	9.1%	-8.9%	-20.5%	3.7%	-9.0%
Inpatients	Trustwide			-28.8%	-1.9%	-30.6%	-10.4%	-37.7%	-33.8%	-9.9%	-33.4%	-44.8%	-18.8%	1.8%	-19.8%	-16.1%	-11.8%
Non elective	Trustwide			-22.6%	-17.5%	-7.0%	-1.3%	-9.7%	-15.4%	-13.3%	-20.2%	-16.5%	18.0%	4.5%	3.8%	8.7%	5.6%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			568	479	410	471	425	423	494	473	464	502	#N/A	#N/A	#N/A	
Intermediate Care GP Referrals	Trustwide			127	107	82	96	90	83	106	106	98	95	#N/A	#N/A	#N/A	
Average length of Intermediate Care episode	Trustwide			9.1331	11.478	13.158	21.333	14.744	10.846	11.798	12.237	12.336	12.498	#N/A	#N/A	#N/A	
Total Bed Days Used (Over 70s)	Trustwide			6759	6821	7229	8613	8693	8211	8812	9280	3075	0	#N/A	#N/A	#N/A	
- Emergency Acute Hospital	Trustwide			4408	4486	4786	5220	5582	5202	5538	5584	0	0	#N/A	#N/A	#N/A	
- Community Hospital	Trustwide			1764	2060	2224	3208	2943	2606	2844	3172	2461	0	#N/A	#N/A	#N/A	
- Intermediate Care	Trustwide			587	275	219	185	168	403	430	524	614	0	#N/A	#N/A	#N/A	

Report to the Trust Board of Directors			
Report title: Safe Staffing Annual Establishment Review			Meeting date: 28th July 2021
Report appendix	Appendix 1: Specialist Areas Establishment Professional Guidance		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice		
Report provenance	Executive Directors Finance, Performance and Digital Committee		
Purpose of the report and key issues for consideration/decision	The purpose of this paper is to outline the process and outcome of the 2020/21 nursing safer staffing annual review. The Trust is required to comply with national guidance in relation to safer staffing as set out by the National Quality Board in 2016 and 2018. The establishment review is concentrated on inpatient areas only within the Trust, this includes; • Paediatrics • Community hospitals • Emergency Department and assessment areas • Coronary Care Unit In doing so the paper will set out the following: • The scope and approach to the establishment review including the governance and oversight in 202021, including internal and external scrutiny of the process • The key outcomes including the professional drivers underpinning a case for change to the baseline establishment of 2019/20 • National benchmarking data for Care Hours Per Patient Day (CHPPD) • Financial impact of proposed uplifts to establishment • Expected quality impact resulting from proposed uplift • Proposed efficiency and productivity plan		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	**Recommendations:** The Board is asked to; ➢ Receive and discuss the safer staffing establishment review. ➢ Note the governance and oversight set out in the revised approach in 2020/21 ➢ Note the benchmarking and professional drivers underpinning case for change to the baseline establishment ➢ Discuss the financial impact of proposed uplifts in establishment ➢ Note the anticipated impact and benefits resulting from proposed uplift		

<table>
<tr><td></td><td>➢ Note the efficiency and productivity proposals set out in section 8
➢ Approve proposed uplift to establishment and funding requirements</td></tr>
<tr><td colspan="2">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td>
<table>
<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td>x</td></tr>
<tr><td>Improved wellbeing through partnership</td><td></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>16</td></tr>
<tr><td>Risk Register</td><td>x</td><td>Risk score</td><td>16</td></tr>
</table>

BAF Objective 4: To provide safe, quality patient care and achieve best patient experience
</td></tr>
<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></td><td>National policy/guidance</td><td>x</td></tr>
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Report title: Safe Staffing Annual Establishment Review		**Meeting date:** 28th July 2021
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice	

Introduction

The purpose of this paper is to outline the process and outcome of the 2020/21 nursing safer staffing annual review. The Trust is required to comply with national guidance in relation to safer staffing as set out by the National Quality Board in 2016 and 2018. In doing so the paper will set out the following:

- The scope and approach to the establishment review including the governance and oversight in 202021, including internal and external scrutiny of the process
- The key outcomes including the professional drivers underpinning a case for change to the baseline establishment of 2019/20
- National benchmarking data for CHPPD
- Financial impact of proposed uplifts to establishment
- Expected quality Impact resulting from proposed uplift
- Proposed efficiency and productivity plan

Scope of Establishment Review

Table 1 sets out the scope of the Establishment Review. It is anticipated that a programme of work that will be progressed to review safer staffing establishment review in the other key areas in the coming months to ensure an updated position of all areas within the Trust and this will be presented.

In scope	Out of Scope
Paediatrics	Maternity (separate staffing review following birthrate plus and Ockenden report)
Community hospitals	ITU
Emergency Department and Assessment areas	Endoscopy
Coronary Care	Other specialist areas such as theatres
	Community services
	Allied Health Professionals
	SRU and MRU as this was included in the MRU and SRU business case where the movement of Forest to Warrington move enabled the staffing to be utilised to substantiate SRU and AMU and EAU3 staffing were utilised to substantiate MRU
	Paignton health and wellbeing centre – as this requires a business case to proceed

Maternity

An external review of the Maternity workforce has been completed using the NICE endorsed Birthrate Plus® methodology; following a process of validation the final report has been published. The review has recommended changes to the current skill mix and total establishment to increase by 13.27wte within the Maternity Service which requires further investment. The Birthrate ® analysis provides a clear baseline on which to further scope and create models of care aligned to the requirements within the Maternity Transformation Programme (NHS England (NHSE), Better Births, and provide additional detail with regard to any additional resources required through this change.

A report to April Board provided an outlining action plan to address the findings from the full analysis where changes in staffing levels have been identified and any progress in addressing those actions. The funding requirements for the additional investment has been submitted to the Devon LMNS and NHS England, we continue to wait an outcome of the funding decision.

Background and Context

Safer staffing requirements have been well documented following Mid-Staffordshire NHS Foundation Trust Public Inquiry (Feb, 2013). In more recent years the Carter Review (February 2016) and the National Quality Board (2016 and 2018) set out the national guidance for ensuring safe staffing.

In January 2018 the NQB published a series of resources to inform safe staffing, these included; acute adult inpatients, district nursing, mental health, learning disability and maternity. These were followed in June 2018 by the publication of resources for children's and young people's services, neonatal care and emergency care. A further and the need to undertake an in-depth nursing and midwifery staffing review annually, with a review and update on actions highlighted to the Board at six months.

National and Local Context

The NHS and the political landscape within the UK continue to go through an unprecedented period of change. There continues to be a number of factors which may affect our ability to recruit and retain our Nursing and Midwifery workforce in the future. The main factors are outlined below:

COVID Impact

The COVID-19 pandemic has had major implications for the NHS workforce and the impact will extend far beyond the immediate crisis. Many front-line staff have gone above and beyond to provide care in very difficult circumstances and with health and wellbeing is a major concern for staff, so too is the ability to retain staff in the coming 2-3 years ahead.

In response to COVID 19 nurses and nursing teams have experienced widespread disruption across TSDFT with rapidly changing scope of practice in response to redeployment and service reconfiguration. Wards have altered their primary function and moved locations multiple times across the Trust over the last year. Staff were reassigned during both waves with a collaborative agreement and this was factored in

within the COVID safest staffing risk framework. A COVID safest staffing risk framework was introduced and agreed at Board to provide assurances around Safer staffing.

Health and Wellbeing of Nursing Staff

The health and wellbeing of all staff during the pandemic is a major concern moving forward. While a range of measures were implemented to support staff and ensures that their health and welfare remained at the forefront of our decision making and response, it is clear, many have been adversely affected with staff reporting anxiety and post-traumatic stress disorder, as well as contracting COVID and long COVID. The People Plan sets out our continued commitment to support the ongoing recovery of staff.

Brexit

The UK has now officially left the European Union. There are no immediate changes in place in terms of immigration, however, the issue of supply of nurses from within EU countries remains uncertain and will depend on the immigration rules. There is cautious optimism that there will be a change to the current immigration rules which may positively influence recruitment.

Recruitment

Continued challenge in recruitment nationally across the healthcare sector there are reports of approximately 50,000 Nursing and Midwifery vacancies. Torbay and South Devon have an attrition position of approximately 10.8 % and multiple plans are in place to ensure continued focus on attracting, retaining and 'growing our own' staff such as; nursing associate and degree nursing apprenticeships, international nurse recruitment, student nurses qualifying

NHS England announced funding to establish International Recruitment Hubs within systems, Torbay and South Devon NHS Foundation Trust are the host organisation for the Devon International Recruitment Hub following a successful £1.1million bid for a 12-month period to provide 800 nurses for across Devon and plans to submit a long-term programme after February 2022 when the initial program completes.

Training and Introduction of new roles

The Government has committed to training a further 50,000 nurses (18,000 of which are already trained with the aspiration is to retain them within the NHS). In addition, the government announced that all student nurses on new and continuing courses from September 2020 will receive a payment of at least £5,000 a year which they will not have to pay back. Torbay and South Devon have set out a clear plan to achieve our contribution to the regional and national growth in capacity.

The first wave of Nursing Associates from the national pilot sites obtained their NMC registration in January of 2019. The Nursing Associate role has now been recognised as a registered profession in law.

Establishment Review Process and Governance

In October 2020 a revised framework to progress the establishment review was co-designed with the nursing senior leadership. The process has been professionally led,

ensuring that Ward Managers and ISU senior nurse leads have been engaged throughout the process. Close partnership working with finance and workforce has been a key feature throughout the process.

Underpinned by evidence-based tools, the staffing review have been triangulated with a variety of guidance documents which have been published by the Royal College of Nursing (RCN) to aid assessments of nurse staffing

A set of principles and assumptions were agreed as part of the process which included:

- Consideration of dynamic workforce models and skill mix through the introduction of new roles and scopes of practice (AHP Assistant Roles/ Associate Nurse)
- Commitment to ensure that the workforce models enabled and underpinned the model of care espoused by the ICO.
- Commitment to optimizing productivity and efficiency through workforce modelling and nurse deployment practice.
- Adherence to national best practice guidance around the role of ward manager and support for the supervisory scope of Band 7 on every ward as detailed in the Francis recommendations.
- Optimizing skill mix skill mix to ensure the ratio of registered nurses to health care assistants between 60:40 and 70:30.
- On wards with more than 20 beds there should be a senior nurse of Band 6 or above in charge on each shift.
- Triangulation of staffing with key quality and patient and experience data
- Review of staffing experience
- Benchmarking with Model Hospital Data around Care Hours Per Patient Day (CHPPD)
- Review of workforce metrics were also reviewed including; sickness, turnover, appraisal rates
- Financial model assumed an agreed Uplift position of 23% across all inpatient areas. This is in line with national guidance which suggests a range of 21-25% headroom.

Oversight and scrutiny

Throughout the process a number of confirm and challenges sessions have been held between the Chief Nurse, Chief Finance Officer and Chief People Officer. In addition to the internal scrutiny around process and outcomes, the Chief nurse sought external scrutiny around governance and process from the regional Chief Nurses Office. A confirm and challenge session was undertaken in June to test out and ensure appropriate professional due diligence was applied.

Establishment Review Outcome

The Establishment review identified a number of key themes which are outlined below:

Supervisory Ward Managers

National guidance advises that all Ward Managers should be 100% supervisory to practice.

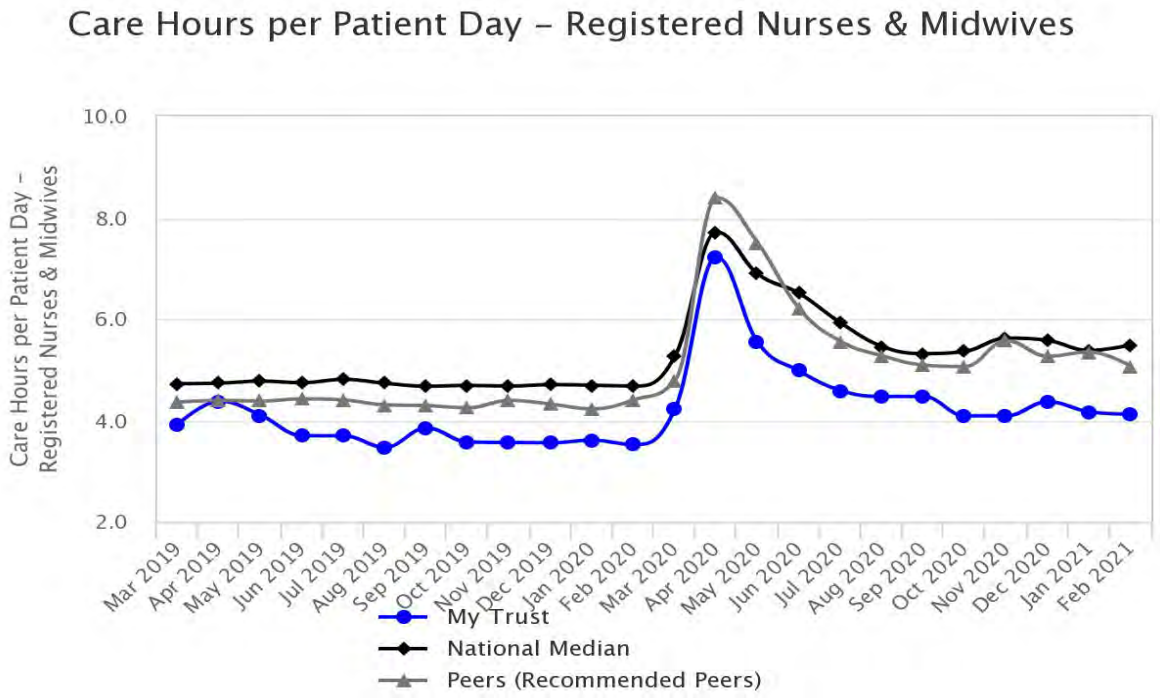
At the time of the establishment review it is noted that the average time ward managers are supervisory is between 20 - 40% supervisory which is not in line with national

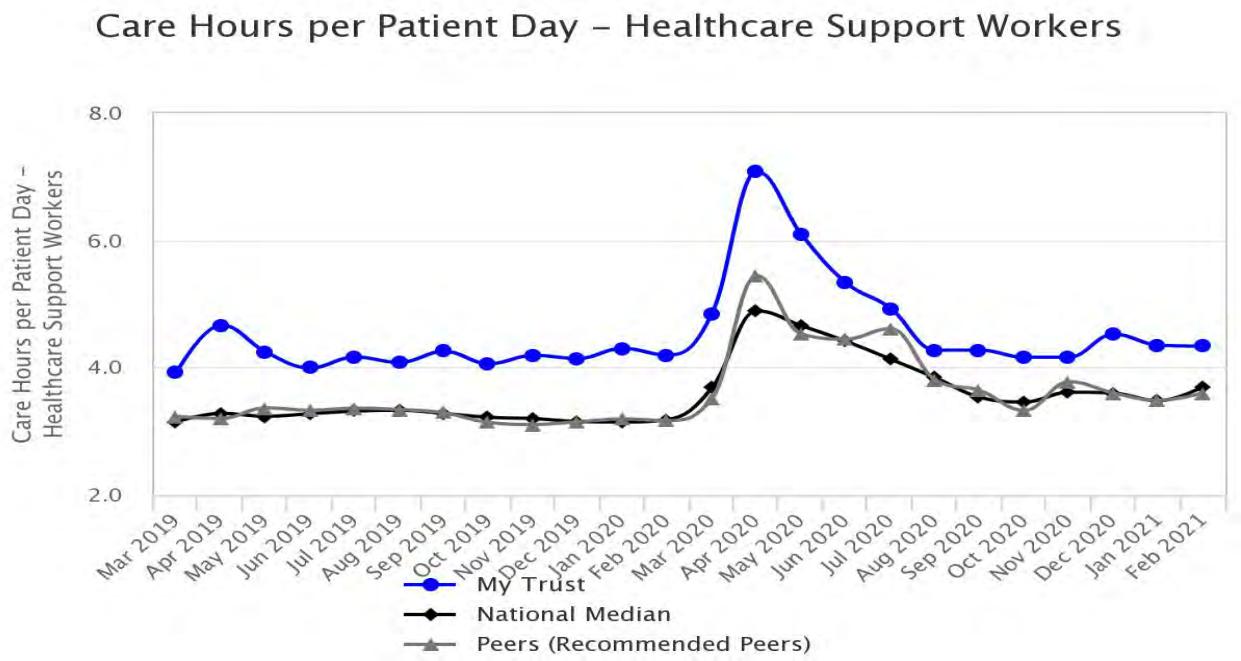
guidance. This deficit significantly undermines and hampers the ability of ward managers to fulfil their clinical leadership role.

The Ward Manager posit is crucial in terms of being the overall accountable lead role the quality and safety of patient care. Within that, they are accountable for the safe and effective deployment of staff oversee and efficient use of resources. In the current environment, ward managers are unable to fulfil all the requirements of their role which includes due to the disproportionate reliance on their time being factored into the roster to also take care of patients. National evidence demonstrates that this adversely impacts on staff retention and wellbeing, patient outcomes and patient experience if not able to be supervisory.

Care Hours Per Patient Day (CHPPD)

The CHPPD calculation measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. From September 2018 this measure has been used to provide assurance externally of staffing levels and is published monthly on NHS Choices website. Model Hospital data tables below demonstrates that CHPPD for registered nurses for the Trust is currently below the peer average and National average of 4.7, and unregistered CHPPD is higher than both peer and national averages at 3.5.





The analysis above demonstrates an over reliance on unregistered staff to deliver direct care resulting in a diluted skill mix. This is apparent within the majority of areas, particularly medical wards and community inpatient ward.

Skill Mix

The RCN recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. For Emergency Departments, CCU and Level 2 High Dependency respiratory is recommended at 80:20 registered nurse/unregistered.

The current position for the Trust for inpatient ward areas has been predominately a 45:55 registered nurse/unregistered. For the Emergency Department the skill mix has averaged as a 55:45 registered/unregistered position. Following the establishment review the proposed skill mix review is towards a 60:40 registered nurse/unregistered, there is also the introduction of nursing associate band 4.

Current Acuity and Dependency

Utilising the Safer Nursing Care Tool (SNCT) acuity and Dependency scoring tool, the comparison of acuity and dependency data has identified a continuing shift in the care requirements of the patients across the Trust.

Level 1a and 1b patients remain the highest category of patients occupying inpatient beds across the Trust, they account for 60-70% of all inpatient beds. These patients generally require all nursing care and in addition often have complex health and social care needs requiring oversight and scrutiny by registered staff.

There has been an increase seen in the number of Safer Nursing Care Tool (SNCT) Level 2 patients occupying general inpatient beds. This is reflective of the age group of those admitted and the complexity of managing their multiple co-morbidities, and the increasing number of patients who are ill but do not meet the criteria for admission to ICU.

Registered staff are essential in the planning, co-ordination, supervision and delivery of care, and the reduced performance in the quality metrics detailed within the report indicate that the care being provided is being compromised as a result of this dilution. SNCT data provides evidence that there are insufficient care hours to meet the needs of our patients, therefore conversion of unregistered posts to registered posts will not address the issue of dilution, and this is will also negatively impact on nurse sensitive indicators. It is also important to note that a significant proportion of SNCT Level 2 patients are those accessing NIV treatment on the respiratory ward. British Thoracic Society guidelines recommend that these patients are nursed on a 1:2 basis which is currently not fully funded within the ward establishment; this is addressed within this establishment review.

Current outcomes in terms of Nurse Sensitive Indicator position

When reviewing quality outcomes for nursing the core nationally and internationally recognised Nurse Sensitive Indicators (NSIs) are monitored and reviewed routinely by all inpatient areas. These measures help to reflect the impact of care that nurses working in inpatient services provide. In addition, they assist in determining the link between the care provided and funded staffing establishment within the ward. Table 2 illustrates current performance with regard to a subset of key NSIs.The below table provides a review of the last 3 years

Nurse Sensitive Indicator	2018/2019	2019/2020	2020/2021
CDIF Cases	16	52	37*
Total Falls	936	1080	826**
Medication Administration Incidents	554	566	527
Pressure Ulcers	903	948	1023

Table 2

*NB: Due to the response of the covid pandemic bed occupancy has been significantly reduced

Key Messages

- On review of the harms data above it can be seen that there has been a high level of reported harms with an overall increase in all areas in 2019/2020 in comparison to 2018/2019. The 2020/2021 data demonstrates that the harm data still increasing with the true effect not fully realised due to the impact of closures of beds and admissions as we responded to the COVID -19 pandemic.
- The number of inpatient falls reported by the Trust has continued to increase. Whilst the majority of the falls reported in no physical harm to the patient, the psychological impact of a fall in an elderly patient cannot be underestimated and this will inevitably impact on length of stay.
- There has been an increase in the number of medication administration incidents reported in comparison from 2018/2019 to 2019/2020, from further analysis the key areas where this is predominantly higher errors within care of the elderly and emergency department. NHS Improvement estimates that medical errors cost the NHS £98.5 million annually and contribute to 1700 deaths per year.
- With respect to pressure ulcer the Trust has seen an increase in the reporting of Acquired Pressure Ulcers since April 2018 within care of the elderly; this service has also seen the greatest dilution in skill mix. Beyond the human cost, the financial cost of treating a pressure ulcer varies from £1,214 (category 1) to £14,108 (category IV).

Costs increase with ulcer severity because the time to heal is longer and the incidence of complications is higher in more severe cases.

Proposed Changes to establishment in 2021/22

The establishment review outcome identified a number of key themes that reveal the need to revise the current establishment to ensure the Trust is best placed to:

- Establish the ward managers role to a 100% supervisory level, enabling this group of clinical leaders to effectively coordinate and manage their clinical areas.
- All nursing staff are well placed to achieve the highest level of quality in care and outcomes for patients.
- Re-balance the diluted skill mix to enable nursing teams to respond to increasing levels of complexity.
- Improve the experience of nursing staff in undertaking the full scope of their practice
- Address quality improvement requirements and efficiency opportunities

Proposed uplift in establishment to achieve the outcomes above equates to an uplift in nursing establishment of 87.05 WTE. Table 3 page 10 sets out the proposed uplift by speciality and ISU. Table 4 illustrates the key thematic drivers.

ISU	Drivers for increase in Establishment	wte
Coastal 6 inpatient wards surgery and community	➢ Ward managers supervisory ➢ Skill mix diluted on nights ➢ Increased acuity and dependency - patients increased co-morbidities and complex ➢ Mental health increased – eating disorders ➢ Uplift of RN's on nights to meet national RN/patient ratio's	6.43
P&B 5 inpatient wards (cardiac, respiratory, cancer and community	➢ Ward Managers ➢ Level 2 increased acuity across Midgely and CCU ➢ Increased cancer demand requiring SACT & non-SACT requirements ➢ Uplift of RN's at community hospital inpatient wards	18.00
Newton Abbot ED, 3 wards (assessment, community stroke and rehab)	➢ Ward Managers ➢ CQC – Paediatrics recommendation in ED ➢ Mental health provision increased ➢ RN:patient ratio community hospitals meet benchmarked requirements ➢ skill mix moved towards national recommendations in ED and community hospital	44.28
Moor To Sea 4 inpatient wards, care of the elderly, stroke and community	➢ 40% RN workforce less than 2 years qualified (65% on some wards) ➢ Skill mix diluted ➢ Impact on quality, safety & experience ➢ Increased acuity and dependency: Enhanced care- up to 50% pts need DoLs ➢ Mental health	2.81

	➢ Stroke pathway- not fulfilling HASU staffing	
Torquay 2 wards (paediatrics)	➢ NCCR recommendations ➢ Skill mix not at national recommendation which is 1:4	15.53
Total		87.05

Table 3: Establishment review investment and Key Drivers

Drivers	Impact	WTE Required
Ward manager Supervisory	100% supervisory	33.24
Skill Mix	Skill mix move to a position of 60/40 from 45/55	27.06
General uplift against national guidance	RN:patient ratio as per guidance	10.64
CQC Recommendation	Paediatrics uplift in ED to ensure 2 RN per shift and Louisa Carey	16.11
Total		**87.05**

Table 4

Financial Impact

The financial impact of the proposed uplift is as follows:

Financial Model and Assumptions

- 2019/20 was used as a baseline year as it was pre-COVID. The response to the pandemic required a number of changes so we have chosen to use a pre-COVID position as the comparator for previous spend levels.
- A comparison of the financial outcome against the Current Half year (21/22) budget and the actual full-year spend for 2019/20 is shown below
- The full year spend on nursing staff within the in-scope areas in 2019/20 was **£36.6m**
- The impact of inflation is estimated to be £1m based on the 20/21 pay scales (with the estimated cost increase for pay between 19/20 and 20/21 at 2.9%, per 20/21 tariff guidance)
- Increasing the 19/20 spend by the estimated pay increase (2.9%) uplifts it to c. **£37.6m**
- The outcome of the safer staffing review suggests a full-year cost of **£38m.**
- The temporary staffing element retained out of the 23% headroom is 6.5%
- It should be noted that the uplift of 23% inclusive of a 6.5% element for temporary staff is to cover short term sick, holiday and annual leave entitlements and should be noted does not include:
  - Escalation Beds
  - Expansion of services
  - Enhanced care for increased acuity and complexity of patients

When comparing to the current part year (H1) budget, the outcome of the safer staffing review requires an investment **£455k,** and therefore for a full year an additional **£910K** will be required in addition to existing budgets.

Improvement Program around Efficiencies and Productivity

There are two key areas of improvement that the Trust will be progressing in 2021/22 to ensure that we are driving productivity and efficiencies across the Nursing workforce, these include the following:

- Improvements in application and use of E Rostering
- Reductions in Bank and Agency Spend

The impact and benefits of the two key areas include:

- Improved compliance of rota's being approved 6 weeks in advance and therefore more agility for the organisation to deploy nursing workforce in a safe and timely manner
- Better utilisation of the nursing resource through monitoring and oversight of unused/additional hours
- Achieving a greater level of compliance of the erostering KPI framework provides greater confidence in the efficient and productive deployment of resource, and ultimately reductions in bank and agency demand
- Improved patient outcomes as less reliance on temporary staff providing increased continuity of care

E- rostering

The electronic rostering platform has been implemented and utilised since 2017, the benefits realisation of its introduction has not been fully realised.

To measure the productivity and efficiency of the electronic rostering system, there are a range of key performance indicators (KPIs) that are required to be monitored and validated.

These are required by NHS Improvement guidelines (updated Sept 2020) set out in table 5.

1.	E-rostering level of attainment:	this should be broken down by professional group and monitored at organisation level. It should be reported at least quarterly.
2.	Percentage of staff on the e-rostering system:	the organisation records the percentage of clinical staff who have an account on the e-rostering system. Organisations are aiming for more than 90%. This should be broken down by team and professional group and monitored at organisation level. It should be reported at least monthly.
3.	Percentage of e-rosters approved six weeks before the e-roster start date:	this should be reported at least monthly. It should be broken down by team and

		professional group and monitored at organisation level.
4.	Percentage of system-generated e-roster (auto-rostering):	this is the percentage of shifts filled by the system-generated functionality. It should be reported at least monthly. It should be broken down by team and professional group and monitored at organisation level.
5.	Planned versus delivered hours (net hours) per WTE:	cumulative variance between the number of planned contracted hours and actual delivered hours per WTE per roster period, excluding doctors in training. The organisation should aim for less than a variance of 13 hours per WTE. This should be reported at least monthly, broken down by team and professional group and monitored at organisation level.
6.	For nursing staff:	percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom): this should be reported at least monthly. It should be broken down by team and monitored at organisation level.

Table 5

The Trust does monitor the KPIs and it is recognised that we are consistently underperforming against these. Key areas of underperformance include:

- KPI 3 – achieving the 6 weeks in advance publication; this is only met 50% of the time across the Trust, there is no particular area where there is a reduced proportion of compliance, which provides clarity that further productivity and efficiency gains is available.
- KPI 5: planned versus delivered hours, where there is minimal grip on monitoring and validation.

It is evident that the efficiency and productivity opportunities and in 20221/22 it is anticipated that a comprehensive program of improvement will be deployed.

Bank and Agency Reduction

Benchmarking in Table 7 (Model Hospital) demonstrates that as a Trust for nursing and midwifery, substantive staff costs are below the median peer costs, this triangulates against the CHPPD registered value for which we as a trust are under the peer and national levels. However, we recognise that subject to appropriate baseline establishments, there is an opportunity to drive efficiencies in the use of bank and agency staffing.

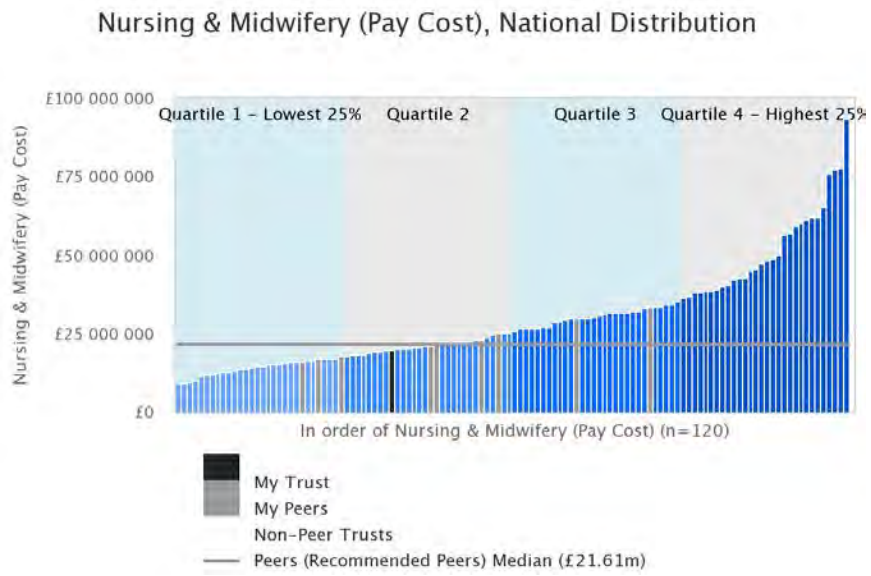


Table 6

Analysis of spend set out in table 7 shows a total spend by ISU of £8.7m on Bank and Agency in 2019/20

ISU	Bank	Agency	Total
Coastal	1,546,673	235,014	1,781,687
Moor to Sea	1,755,692	573,127	2,328,819
Newton Abbot	1,237,915	1,578,911	2,816,826
Paignton & Brixham	1,211,832	326,675	1,538,507
Torquay	130,824	65,367	196,191
Total	**5,882,936**	**2,779,094**	**8,662,030**

Table 7

The analysis of the key drivers for requesting bank and agency include: Enhanced supervision, Sickness and COVID related sickness, Vacancies, Increased acuity and dependency and Covid-19

The analysis shows that as a Trust we were utilising an average of an extra 30wte agency staff and 120 wte bank across the trust per month. Our highest usage areas for bank and agency is the Emergency Department and care of the elderly wards.

There are a number of controls that are currently in place that include a temporary staffing utilisation framework with systems and process for escalation and sign off. There is a weekly meeting to monitor, check and challenge and validate the usage of bank and agency on a weekly basis.

In 2021/22 the Trust will be progressing a comprehensive program of improvement with the support of the NHS Improvement regional team to better understand where the opportunities are for bank and against reductions and to ensure that thresholds of spend beyond the 6.5% uplift contingency are reasonably set and ISUs supported to strengthen controls to minimise usage.

Outcomes and impact of investment

There are a range of outcome measures that the Trust will be seeking to achieve as a result of the investment.

- Greater Confidence in the efficient and effective deployment of nursing resource with enhanced controls on Bank and agency usage
- Improvements in the Nurse Sensitive indicators with a specific target reduction on falls and pressure ulcers and 100% compliance with Nursing risk assessments
- Implementation of ward accreditation framework
- Improved patient and staff experience
- Targeted reduction in complaints

Recruitment Strategy

The overall recruitment to these posts will be in a planned phased approach to ensure maximum support for new recruits. This will incorporate an emphasis on the people plan and associated workstreams; new ways of working, growing our own, looking after our own, belonging in the NHS and three main elements;

- It is anticipated that the majority of nurses will be recruited through the IR hub and plans are in place to ensure that TSDFT will onboard between 15-20 IR nurses a month from August subject to approval at Board for uplift.
- There is a healthy pipeline of IR nurses, however the Trust must be mindful of onboarding timescales and double running costs while IR nurses are being inducted (13 weeks)
- In addition, the Trust will develop an attraction strategy which will build on professional reputation, targeted recruitment campaigns, socially inclusive employer, local community/market, national and international recruitment markets, innovative recruitment solutions – digital platforms, enhancing recruitment processes, engaging with local academic institutes
- A corporate nursing retention strategy which will capitalise on the people plan through associated career pathways including flexible careers, flexible working, temporary, staff involvement and engagement.

Table 8 below provides a model of recruitment, the trajectory for recruitment includes international nurses, qualifying students, qualifying apprentices and factors in a 10% attrition rate.

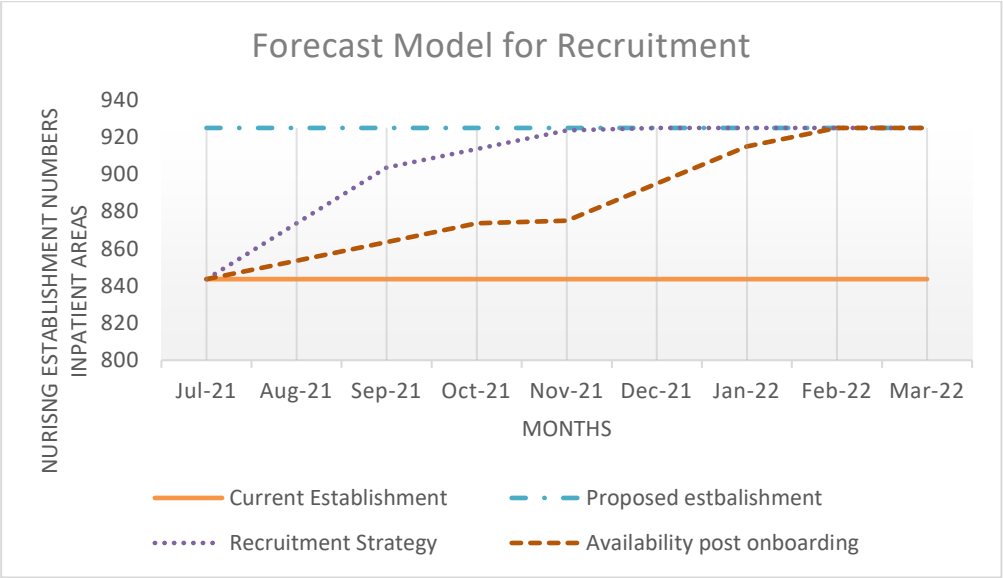


Table 8

The forecast for recruitment suggests a full establishment by November 2021, however due to training of our international nurses the actual availability as active registrants will be realised from February 2022. There is a realisation that there will be ongoing recruitment throughout 2021/2022 and beyond to actively recruit to our attrition rate at 10% a further modelling for workforce will continue.

Recommendations

The Board is asked to:

- Receive and discuss the safer staffing establishment review.
- Note the governance and oversight set out in the revised approach in 2020/21
- Note the benchmarking and professional drivers underpinning case for change to the baseline establishment
- Discuss the financial impact of proposed uplifts in establishment
- Note the anticipated impact and benefits resulting from proposed uplift
- Note the efficiency and productivity proposals set out in section 8
- Approve proposed uplift to establishment and funding requirements

Appendix 1: Specialist Areas Establishment Professional Guidance

Specialist area	Professional guidance
Paediatrics	Defining staffing levels for children's and young people's services - standards for clinical professionals and service managers – RCN (2013)
Paediatric Intensive Care	Paediatric Intensive Care Society (PICS) (2001 and 2010) (SCAMPS, a validated paediatric acuity/dependency tool is tool is being developed in Scotland)
Neonates	British Association of Perinatal Nursing (2010) and DH (2009) Defining staffing levels for children's and young people's services - standards for clinical professionals and service managers – RCN (2013)
Elderly Care	AUKUH-SNCT Elderly Care Classification System.
Adult Intensive Care Unit	British Association of Critical Care Nurses (BACCN) (2010)
Theatres	Association for Peri-Operative Practice
Day Surgery	British Association of Day Surgery (BADS) (2003)
Accident & Emergency	There are no current agreed nationally recommended guidelines for minimum staffing levels. Benchmarked against peer organisations Defining staffing levels for children's and young people's services - standards for clinical professionals and service managers – RCN (2013)
Catheter Laboratory	British Cardiovascular Society (2007) Non-medical catheter laboratory staffing working group report
Endoscopy	Royal College of Physicians Joint Advisory Group on gastrointestinal endoscopy (2007)
Radiology	The Royal College of Radiologists and the RCN (2006)
Chemotherapy	Benchmarked against peer organisations
Haemato- oncology	British Committee for Standards in Haematology (BCSH); Haemato-Oncology Task Force (2009); FACT-JACIE (The Joint Accreditation Committee-ISCT (Europe) & EBMT) (2011); National Cancer Peer Review Programme (2012)
Renal Dialysis	National Renal Workforce Planning Group (2002)
Adult Bone Marrow Transplant	There are no current agreed nationally recommended guidelines for minimum staffing levels for stem cell transplant/haematology wards. However, there are general agreed principles outlined in the quality measures of regulatory bodies and peer review processes that apply to nurse staffing levels in specialist haemato-oncology centres
Maternity	Royal College of Midwives (2014) and Nice Guidance on safe midwife staffing in maternity setting (2015)

References

Aiken. L.H et al (2017)Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. British Medical Journal. *BMJ Quality & Safety* 2016; **26** 525-528

National Quality Board (2013) How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability

National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing

RCN (2010) Guidance on Safe Nurse Staffing Levels in the UK. London. RCN

RCN (2012) Safe Staffing for Older People's Wards. London. RCN

RCN (2011) Making the Business Case for Ward Sisters / Team Leaders to be Supervisory to Practice. London. RCN

Hurst. K. (2003) Selecting and Applying Methods for estimating the Size and Mix of Nursing Teams. Leeds. Nuffield Institute for Health

Association of UK University Hospitals / Shelford Group (2013) Safer Nursing Care Tool.

NICE (2014) Safe Staffing for Nursing in Adult Impatient Wards in Acute Hospitals – Safe Staffing Guideline

NHS England (2016) Leading Change, Adding Value – A Framework for Nursing, Midwifery and Care Staff

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1 April 2021 – 31 June 2021).			**Meeting date:** 28th July 2021
Report appendix	Appendix 1: PMRT Report 73847 – Action Plan		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity System (LMS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the Trust Board of the work being undertaken by the Maternity Governance Group. It also informs the Board of recent recommendation made within the Ockenden Interim Report (Dec 2020) The Board is asked to approve the report and the programme of work described. An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to: • Note progress against the Ockenden essential safety action areas • Note the learning and findings from the Perinatal Mortality Reviews completed and HSBIB investigations. • Note compliance against Saving Babies Lives Care Bundle v2 • Note the staffing challenges and impact on service delivery, in conjunction the Safety and Governance report, to ensure oversight and scrutiny as recommended by the CNST standards and Ockenden Interim Review.		
Summary of key elements			

<table>
<tr><td>Strategic objectives supported by this report</td><td>
<table>
<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td>x</td></tr>
<tr><td>Improved wellbeing through partnership</td><td>x</td><td>Well-led</td><td>x</td></tr>
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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>N/A</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>N/A</td><td>Risk score</td><td></td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td>x</td></tr>
</table>

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

Report title: Quarterly Maternity Governance Safety Report (1 April 2021 – 31 June 2021)		Report date: 28th July 2021
Report author	Associate Director of Midwifery & Professional Practice/HoM Clinical Governance Co-ordinator Maternity Safety Champion/Deputy Head of Midwifery Quality Improvement Midwife	

1.0 Introduction

Safety, quality and experience has always been a priority for the maternity and neonatal services at Torbay and South Devon NHS Foundation Trust. The publication of the Ockenden Interim Review of Maternity Care at Shrewsbury and Telford, December 2020) sadly provides all maternity and neonatal providers and commissioners with evidence of the devastating effects and consequences that poor culture and governance can have on families. NHS England & Improvement have set out clear expectations in response to the Ockenden Report for all providers of maternity care.

The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme also set out 10 key safety actions, which includes providing a quarterly maternity safety and governance report to the Trust Board to enable them to be sighted on maternity safety, progress and achievements.

This is the third quarterly report since the publication of Ockendon. As with the previous reports, it will be constructed to meet the recommendations within the Ockenden report. We plan for this to be an iterative process, firstly as the Board and maternity services work to review, amend and strengthen existing reporting mechanisms, and secondly as NHS England & Improvement (NHSEI) provide additional resources to support Trusts in enhancing their safety culture.

This quarterly report will look back at the period 1 April 2021 – 31 June 2021

2.0 Review and monitoring of safety within maternity services

2.1 Governance process

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

The maternity services have a clinical service lead who is a Consultant Obstetrician, who also undertakes the role of obstetric safety champion, and a Head of Midwifery (Associate Director of Midwifery and Professional Practice). Additionally, there is a midwifery safety champion and neonatal nursing and medical safety champions. The maternity safety champions meet bi-monthly. The governance processes are supported by a dedicated Clinical Governance Co-Ordinator (Senior Midwife). The governance pathway was shared with the Board in a previous report.
The Trust has also implemented a monthly Maternity Safety Collaborative, which is attended by the Chief Executive, Chief Nurse, Medical Director, and Non-Executive Director Maternity Safety Champion, along with members of the senior maternity leadership team.

In addition to this, the service has been working towards implementing Pathway to Excellence. As part of this we have been following the principles of shared governance

and as such have developed three staff council: people, safety and leadership. Updates of the progress of the councils has been shared with the Maternity Safety Collaborative.

This quarterly report will initially be submitted to the Quality Assurance Committee, whereby representative of the Board will be provided with opportunity to interrogate safety and quality metrics, information and governance process within the maternity service. The report will also be submitted to the Trust Board for further assurance.

2.2 Ockenden Interim Maternity Review

As noted in the last quarterly report, the Ockenden Interim Report into Maternity Services at Shrewsbury and Telford NHS Trust was published in December 2020. 12 immediate and essential actions were identified by NHS England and Trusts were asked to report their compliance with these by 21 December 2020. TSDFT were able to demonstrate compliance with 7 of the 12 actions.

Following this the Trust were required to complete a detailed assurance template, providing the Trust position in relation to the 12 immediate and essential actions, the remaining Ockenden actions, CNST standards and staffing by 15 February 2021. TSDFT were able to demonstrate full compliance with the 12 immediate and essential actions.

The maternity service have developed a Task and Finish group that is responsible for reviewing and implementing the action plan. The Trust's position as of 30 June 20212021 is summarised in Tables 1 & 2.

Table 1: Compliance with Ockenden, CNST and Immediate and Essential Actions.

Seven themes	i)	ii)	iii)	iv)	v)	vi)	vii)	Viii)
1)Enhanced safety							*	*
2) Listening to women and their families							*	*
3) Staff training and working together						*	*	
4) Managing complex pregnancy						*	*	
5) Risk assessment throughout pregnancy					*			
6) Monitoring fetal wellbeing					*			
7) Informed consent						*		

Within table 2, the Asterix denotes an immediate and essential action. It should be noted that the three non-green areas are actions that require action to be taken by stakeholders outside of the Organisation. For example, in theme 2, the senior

independent advocate role is being developed by NHSE and further information will be made available later in the year. For theme 4 maternal medicine specialist centres are currently in development in Plymouth and Bristol.

Table 2: Summary of workforce, NICE and leadership recommendation compliance

Domain	Compliance June 2021	
Workforce	Medical	Midwife
NICE		
Leadership	Director of Midwifery	
	Midwife at Senior Level	
	Consultant Midwife	
	Specialist midwives	
	Education and Research	
	Fund leadership development	
	External Recruitment & Section Process	

An evidence 'portal' was opened for submission of how each maternity provider was meeting the actions by 20 June 2021. This was an extensive piece of work to complete and the team can confirm that the deadline was met. The evidence will be reviewed by an independent team, who will report back to the Regional Team at the end of July 2021. Due to the amount of evidence required and limited time to provide the data, there is a potential that further evidence may be required by Trusts.

2.3 Perinatal Clinical Quality Surveillance Model

As part of the Ockenden Review and the NHSEI 12 urgent actions, a model has been proposed to improve oversight of safety metrics within Maternity and Neonatal Services. The Perinatal Clinical Quality Surveillance (PCQS) Model is based on three principles, with principle one relating to trust level, principle two at system level and principle three at regional level.
Principle one focuses on strengthening trust level oversight for quality, with 6 requirements. Progress against these are detailed in Table 3.

Table 3: Perinatal Clinical Quality Surveillance Model

PCQS Requirements	TSDFT position

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	In place Sally Taylor, NED
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	In place Maternity metrics included within Integrated Performance Report (IPR)
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.	In place
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.	In place Dashboard included in IPR. SI's – as above Minimum dataset being reported within quarterly report to Board. See Table 3.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	In development
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model	In progress

Work is on-going with the Devon LMNS regarding requirement 5, with trust-level data being shared with the LMNS. As a system we will be working with the Regional Chief Midwife to develop processes to meet requirement, however as a Service and in conjunction with the Executive, we would escalate any safety concerns to the Chief Midwife.

2.4 Trust Board Reporting – Quality and Safety within Maternity Services

As described above maternity metrics are now reported as part of the Board IPR. These are still birth rate, caesarean section rate and smoking status at time of birth. The full PCQS dataset forms part of the maternity service monthly Governance report that is shared at the Torquay ISU Governance meeting, the Quality Improvement Group and the Integrated Governance Group on a monthly basis and will be summarised within the quarterly Safety and Governance Board reports that are submitted to the Quality Assurance Committee and the Trust Board. See Table 4 for PCQS minimum dataset information summary

Table 4: PCQS Minimum Dataset Information Summary

	April	**May**	**June**

Findings of review of all perinatal deaths using the real time data monitoring tool	PMRT in use	PMRT in use	PMRT in use
Findings of review all cases eligible for referral to HSIB.	0 cases	0 cases	0 cases
Report on: • The number of incidents logged graded as moderate or above and what actions are being taken • Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training • Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	**Incidents -** 2 moderate - unexpected admission to ICU for low sodium levels – MDT case review completed. Bladder damage at LSCS – reviewed no further action **Training -** 78-100% compliance **Staffing** – report to Board noting midwifery shortfall identified in Birthrate Plus assessment and actions to meet gap	**Incidents -** 3 moderate – baby having seizures following birth, baby transferred to Level 3 Neonatal intensive care, baby unexpected admission to SCBU – cases reviewed and being presented as part of MDT Perinatal meeting **Training –** 90-100% compliance **Staffing** – bid made for national funding to meet shortfall identified within Birthrate Plus assessment	**Incidents** – 0 moderate **Training** – 90-100% **Staffing** – awaiting outcome of national funding bid. See also 6 monthly maternity staffing oversight Board paper (Jan -Jun 21)
Service User Voice feedback	Feedback mechanisms in place	Feedback mechanisms in place	Feedback mechanisms in place
Staff feedback from frontline champions and walk-abouts	Completed	Completed	Completed
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil
Coroner Reg 28 made directly to Trust	Nil	Nil	Nil
Progress in achievement of CNST 10	On track for 9/10.	On track for 9/10.	10/10 met

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	72%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	100%

2.5 Serious Adverse Events

2.5.1 Perinatal Mortality Review Tool (PMRT)

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

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

The team are now using the templates that are provided on the PMRT website, and record all family feedback and questions into the parent engagement section of the PMRT.

2.5.1.1 PMRT - Notifications

During this April - June 2021, we had no cases that met the reporting criteria.

2.5.1.2 *PMRT – Completed Reviews*
Case 1 PMRT Reference number 73847-20210611
During this reporting period we completed one multidisciplinary review into the care of a mother whose Baby was stillborn at 27 weeks gestation. The baby had been diagnosed with a fetal abnormality after referral to the Regional Specialist Centre.

Summary of learning from completion of the PMRT:

- The Mother and her partner received bereavement care from a staff member(s) who had not received bereavement care training.
- The placental histology was performed but not by a paediatric pathologist.
- Family members who smoke were not referred to smoking cessation services
- Following the birth the Mother did not have a Kleihauer (blood) test despite it being requested.
- The completed action plan is in the Appendix 1

Case 2
A Mother’s baby was stillborn at term following an emergency admission for bleeding. The Mother had been screened by ultrasound scans during the pregnancy to monitor the placental location. This case met the criteria for referral to the Healthcare Safety Investigation Branch (HSIB), and the investigation is ongoing.

This case has not undergone a PMRT review within the required timescale. It is recognised for a small number of deaths (term intrapartum stillbirths and early neonatal

deaths at term) where investigations are carried out by HSIB, that this may delay the start of the the local review using the PMRT. The review of this case has been delayed by timeframes beyond the Trust's control.

Since the last report we have been able to meet two actions from previous PMRT reviews and HSIB investigations. A bereavement midwife has been appointed on a fixed term contract to support mother and families following baby loss at any gestation. We have also had agreement from the CCG that placentae can be sent to Bristol for a detailed paediatric histopathology review.

These are both important service requirements to support women and their families and improve the care that we provide following baby loss.

2.5.2 Healthcare Safety Investigation Branch (HSIB)

2.5.2.1 Referrals to HSIB

HSIB continue to investigate births and maternal deaths that meet their referral criteria. In the reporting timescale of April - June 2021 we had no cases that met the criteria.

2.5.2.2 Finalised investigation reports from HSIB

During this time period, we have not received any final reports from HSIB.

2.5.2.3 Quarterly Engagement Visit with South West Maternity Investigation Team

In April 2021 we met with the South West HSIB Maternity Investigation Team to learn about the progress of HSIB investigations nationally.

The HSIB team have started sharing a Maternity Newsletter which include sharing learning from trusts across the whole of England. This has been shared with our local clinical teams.

2.5.3 NHS Resolution

From the 1st April 2020 it became no longer necessary for trusts to report Early Notification (EN) cases to NHS Resolution. This decision was reviewed in September 2020 and national agreement made to extend the current reporting arrangement until March 2021.

As a service we will report all cases that meet the EN criteria to HSIB, and HSIB will triage all cases and prioritise those where there is evidence of harm to the baby and will share these cases directly with NHS Resolution.

2.6 Safety Improvement

2.6.1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP)

The maternity service is continuing its work on the Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) Project (focussed project aimed at improving outcomes for pre-term babies). The bundle consists of 10 elements, which have all been introduced at Torbay and South Devon. Work is now ongoing to embed the elements into normal practice.

The Obs Cymru QI Programme (Obstetric Bleeding Strategy for Wales) is now continuing following a pause whilst elements of the pathway were embedded in practice. The Multi-Disciplinary Team is now in the process of reviewing management of blood loss and the introduction of the pathway documentation.

2.6.2 Saving Babies Lives Care Bundle

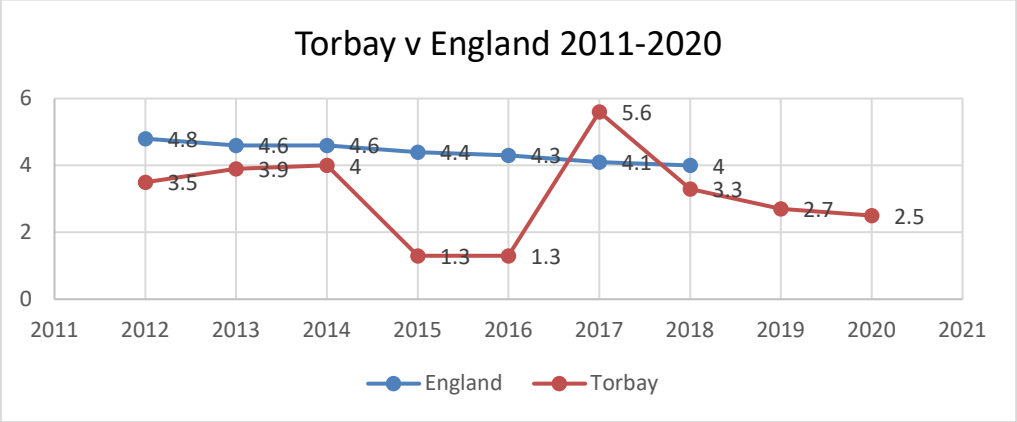
Saving Babies Lives Care Bundle Version 2 (SBLCB v2) was launched in March 2019. This builds on the existing bundle, but adds a fifth element (preventing risk of preterm birth) for implementation. Full implementation of the care bundle was achieved by the expected date of 31 March 2021.

The final SBLCBv2 quarterly report submitted in April 2021 we were able to demonstrate full compliance. We therefore fully meet the standard 3 of the CNST safety actions.

2.6.3 Stillbirth Rate

One of the aims of SBLCB v1 and v2 is to reduce the number of still birth. Our 2020 annual data is now available and has shown that the still birth rate has reduced at TSD for the 3rd year in a row. This is shown in Table 5 (Note: national comparative data is not yet available for 2019 or 2020)

Table 5: Annual Stillbirth Rate per 1000 births

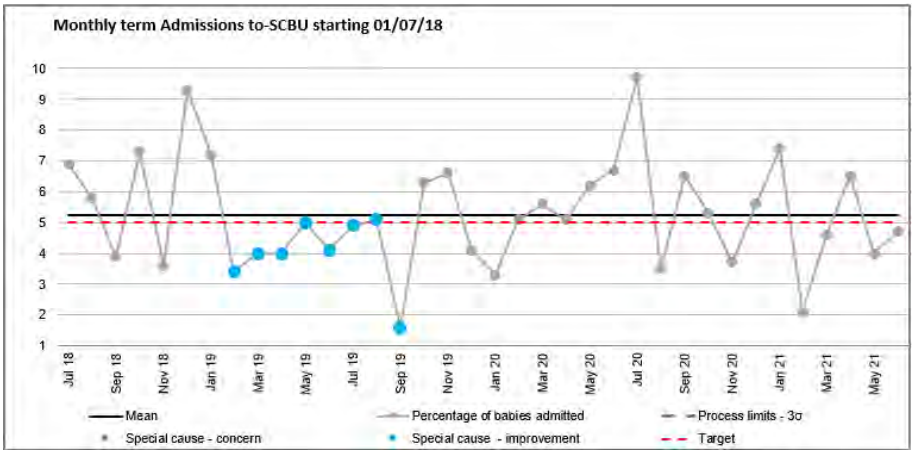


2.6.4 Avoiding Term Admissions into Neonatal Units – ATAIN

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

For this reporting period, 5% of term babies were admitted to the Special Care Baby Unit. This is a slight increase from the last reporting period and is at the target of 5% or less. For the year 2020/2021, 5.5% of term births were admitted to Special Care, which is just above the target figure. See table 6 for monthly term admission to SCBU rate.

Table 6: Monthly Term Admission to SCBU Rate



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

2.7 Maternity Safety Champions

The Maternity and Neonatal Safety Champions are working together to improve safety within the two services and ensure that staff have a communication route through which they can raise safety concerns. These can then be addressed within the service or escalated to the Board Level Safety Champions as appropriate. From April 2021 the Neonatal Safety Champion will be joined the bi-monthly meetings between the Maternity and Board Level Safety Champions to further enhance this collaborative work.

In addition to a generic email account, the safety champions have introduced a safety concerns box, whereby staff are able to complete a card describing any safety concerns they have. These are then taken to the monthly safety champion meeting, which is open to all maternity and neonatal staff. An example of issues raised to the Maternity Safety Champions include concerns relating to staffing levels and this resulted in the development of a rota for the specialist midwives and managers to support with clinical shifts. Issues raised are discussed with the Board Level Safety Champion and action plans developed as a consequence.

With regards to the CQC improvements for maternity, the 4 'Must Do' actions and the 11 'should do' recommendations have been completed.

3 CNST: 10 Key Safety Actions

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

The team re-established the 'CNST' task and finish group to ensure that we are able to meet and evidence compliance with the standards. In June 2021, the maternity service provided the Board with a paper setting out how the Trust was meeting the safety

standards. The Board approved the paper and the declaration of compliance will be submitted to NHS Resolution during the submission window of 19 July 2021 to midday on 22 July 2021. Table 7 provides a summary of our final position.

Table 7: CNST Maternity Incentive Scheme Year 3: Summary position

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

4 COVID-19 Pandemic

As previously reported, during the COVID-19 pandemic, the team have been able to maintain a full maternity service following the NICE schedule of care. Our COVID-19 maternity plan that was developed in conjunction with anaesthetic, paediatric and infection prevention and control colleagues, continues to be reviewed regularly.

During the reporting period we re-introduce partner/supporter attendance along the whole pregnancy pathway, with full introduction on 12 April 2021. To support this, pregnant women and their partners were asked to undertake lateral flow testing twice weekly. Families have embraced this and have welcomed the improvements in access for partners/supporters.

The team have also supported colleagues who have been shielding or in alternative roles to return to their clinical roles. It has been lovely to welcome colleagues back. However, we do continue to identify alternative ways of working for some colleagues who are only able to return to a partial role at this time.

We continued to work closely as a system facilitated by the Devon Local Maternity System (LMS) and the Maternity Voices Partnership. A system wide set of FAQs was been developed in conjunction with the Maternity Voices Partnership, which are reviewed on a fortnightly basis.
During June 2021, the team have recognised that we are moving into a third ‘wave’ and have continued to monitor the situation.

5 Staffing

During the end of May and throughout June 2021, maintaining optimum staffing levels has proved challenging (See Full staffing report with risks/ mitigations) .This is due to a number of factors, including a rise in the level of sickness absence, in particular mental health symptoms, maternity leave and altered duties. We are also seeing an increase in the number of staff having to self-isolate due to the NHS Track and Trace system. In addition, both substantive and temporary staff are reporting high levels of fatigue, resulting in colleagues not being able to work additional shifts. Staffing levels have been closely monitored during the COVID-19 pandemic and colleagues have been extremely flexibility and committed.

As previously reported, the Birthrate Plus® Establishment Review finalised report was received in March 2021. This is the recognised tool to determine maternity establishments and is externally facilitated. This identified a shortfall of 13.27wte midwives for the maternity service. A bid for national funding for 14.1wte to meet the Birthrate Plus® gap and the Ockenden recommendations was submitted. A report was submitted to the Board in April 2021 providing an overview of the Trust position and an overview of the planned bid submission. The outcome of the funding bid was received on 8 July 2021. Unfortunately, the maternity services were only allocated funding for 5.0wte in Maternity Services.

The 6 monthly Maternity Staffing Overview report is also being presented to the July 2021 Quality Assurance Committee and the Board meeting. This will provide more information in relation to maternity staffing, along with details of the requirement of the Trust to identify how the midwifery staffing shortfall can be addressed to achieve safe staffing levels.

6 Conclusion

There has been a shortfall identified within the funded midwifery establishment and a paper has been developed that will be shared with the Quality Assurance Committee and the Board to identify how this shortfall can be addressed.

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. The team are committed to reviewing and fully implementing the recommendations from the Ockenden Interim Report and strengthening the oversight provided by the Trust Board.

7 Recommendations

The Board is asked to:

- Note progress against the Ockenden essential safety action areas
- Note the learning and findings from the Perinatal Mortality Reviews completed and HSBIB investigations.
- Note compliance against Saving Babies Lives Care Bundle v2
- Note the staffing challenges and impact on service delivery, in conjunction the Safety and Governance report, to ensure oversight and scrutiny as recommended by the CNST standards and Ockenden Interim Review.

Appendix 1: PMRT Report 73847 – Action Plan

Torbay and South Devon NHS Foundation Trust

MATERNITY SERVICE ACTION PLAN – PMRT 73847						
ACTION NUMBER	**RECOMMENDATION**	**ACTION**	**CURRENT STATUS**	**RESPONSIBLE**	**COMPLETION BY DATE**	**COMPLETED**
1	This mother lives with family members who smoke but they were not offered referral to smoking cessation services	We will remind midwives of the ability to refer partners as well as mothers to the Stop Smoking Service. We will discuss with the Stop smoking training provider to include this information in the Mandatory training sessions.	Now included in Mandatory training	Public Health midwives	Complete	Complete
2	This mother and her partner received bereavement care from a staff member(s) who had not received bereavement care training	Since this mother had her Baby we have now appointed to a 30-hour lead midwife for bereavement	Complete	NA	Complete	Complete
3.	The Trust to ensure placentae are sent for pathological examination including histology in line with national guidance	Escalate to CCG and LMNS	Has been escalated to CCG and LMNS and this provision has now been agreed	CCG	The CCG confirmed on at the LMNS Board meeting that we have an arrangement in place to send placentae to Bristol for histopathology.	14.6.2021
4	This mother did not have Kleihauer test despite it being requested Mothers who tested Rh positive in pregnancy.	To check with the haematology department that they are not rejecting samples.	The laboratory and bereavement lead midwife have discussed this action and will in future ensure that these samples are tested.	Bereavement lead midwife		Complete

Torbay and South Devon NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Mortality Safety Scorecard			Meeting date: 28th July 2021
Report appendix	Appendix 1 – Hospital Mortality Appendix 2 – Unadjusted Mortality Rate Appendix 3 – Mortality Analysis Appendix 4 – Dr Foster Patient Safety Dashboard Appendix 5 – Focused Mortality Reviews		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	The report will be presented to the Quality Improvement Group Meeting 20th July 2021 and Mortality Surveillance Group on 12th August 2021.		
Purpose of the report and key issues for consideration/decision	The report is for monthly assurance to ensure learning from deaths. The Hospital Standardised Mortality Rate (HSMR) showed a significant peak in April 2020 predominately due to a reduction in-hospital activity due to the first wave of Covid. The HSMR the returns to within the expected range. The Summary Hospital Mortality Index (SHMI) for Q1 2020/2021 was higher than expected due to reduced inpatient activity during the first Covid surge. The weekly deaths show a rise in out of hospital deaths in some localities during the second Covid wave. The total number of in-hospital deaths rose during March and April 2020 due to Covid. The number of deaths reduced during the summer months and in winter 20/21 were lower than average.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To receive and note the mortality safety scorecard.		

Summary of key elements				
Strategic objectives supported by this report	**Safe, quality care and best experience**	X	**Valuing our workforce**	
	Improved wellbeing through partnership	X	**Well-led**	X

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

Report title: Mortality Surveillance Score Card		Meeting date: 28th July 2021
Report sponsor	Medical Director	
Report author	Medical Director	

1.0 Introduction & Data Source

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

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

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

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

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

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

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

Safety Indicator		Data Source	Target	RAG
Appendix 1 • A. Hospital Standardised Mortality Rate (HSMR)	Mortality	Dr Foster latest benchmark Month	Below the 100 line with an aim for a yearly HSMR ≤90	101.5
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	2.97%

Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH SHMI data	Zero alerts - CuSuM flags only	CuSuM Flags Acute Renal Failure & Intestinal infections
Appendix 4 • Dr Foster Patient Safety Dashboard		Dr Foster	All safety indicators positive	All positive
Appendix 5 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is above the expected level of 100 for our population for February 2021 although this is not statistically significant. The HSMR for the latest 12-month period is within the expected range. As previously discussed, the significant reduction in hospital activity/spells in March and April 2020 during the first wave of Covid is a major influence on the raised HSMR during this time due to a reduction in the denominator superspells. This effect of the first Covid wave is now being seen in the Summary Hospital Mortality Index (SHMI) data, as this data is several months behind HSMR.
The data after these periods show a reduction in hospital deaths during the summer months with a gradual return to expected levels. The HSMR for Aug 2020 is significantly below the 100 average.
The Trust has a slightly lower than average palliative care coding rate although this coding rate is stable over time (3.83% vs a national average of 4.63%). The Trust also has a lower than average Charlson co-morbidity upper quartile rate (95 vs national average of 100). This may be affected by the level of clinical recording of co-morbidity and subsequent coding.
The weekly deaths show a rise in out of hospital deaths for some localities during January 2021 (Covid Wave 2) particularly Newton Abbot compared to previous years.
This report shows a continued increase in Medical Examiner activity as the service starts to roll out across the Trust and death scrutiny takes place. Medical examiners have referred deaths to the Coroner and for further local assessment by the Trusts' Clinical Governance process.

Appendix 1 – Hospital Mortality

This metric looks at the two main national mortality tools and is therefore split into:

- 1A – Dr Foster's Hospital Standardised Mortality Rate (HSMR) and,
- 1B – Department of Health's Summary Hospital Mortality Index (SHMI)

1A The HSMR is based on the *Diagnosis all* Groups using the Oct 19 monthly benchmark and analysed by Relative Risk - Trend / Month

Our HSMR aim is to reduce and sustain the HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated

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Chart 1 - HSMR by Month March 2020 to February 2021 (latest month available)
Chart one (as below) shows a longitudinal monthly view of HSMR.

The latest month's data, February 2021, has a relative risk of **101.5** and is above the 100 average although the confidence interval encompasses 100.

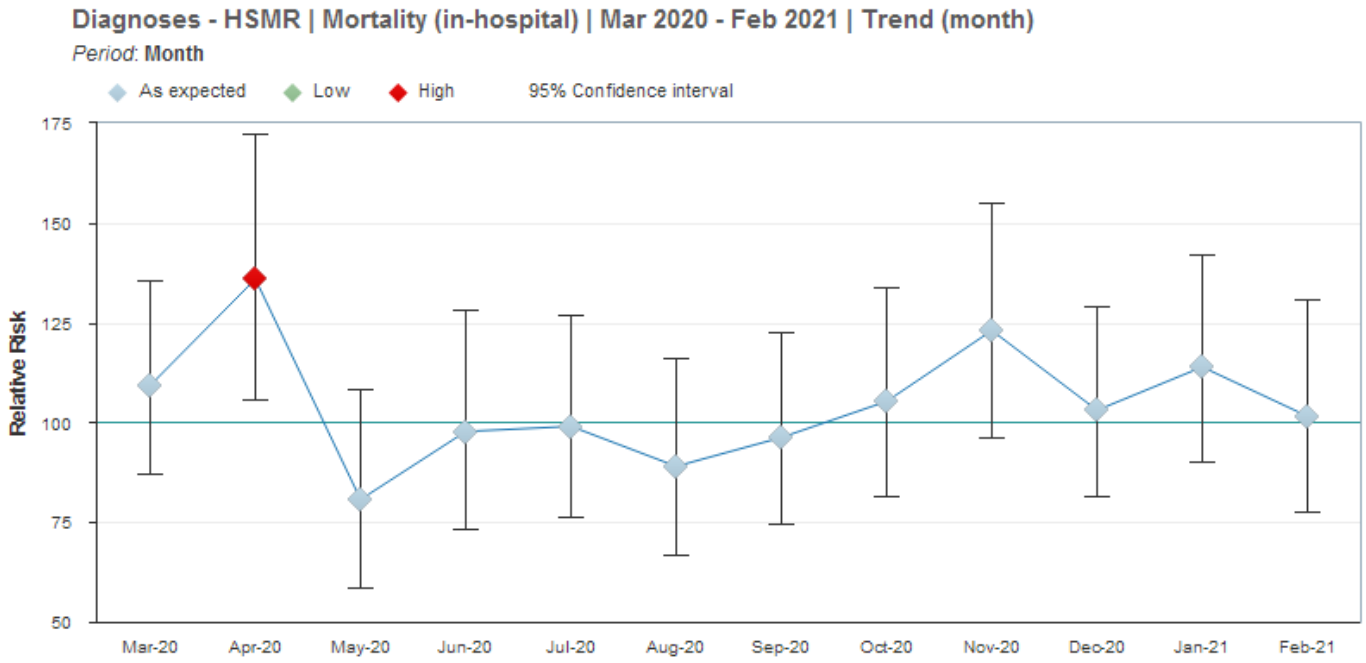


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is just above the 100 line and within the standard deviation lines. This measure is being observed via the Mortality Surveillance Group (MSG)

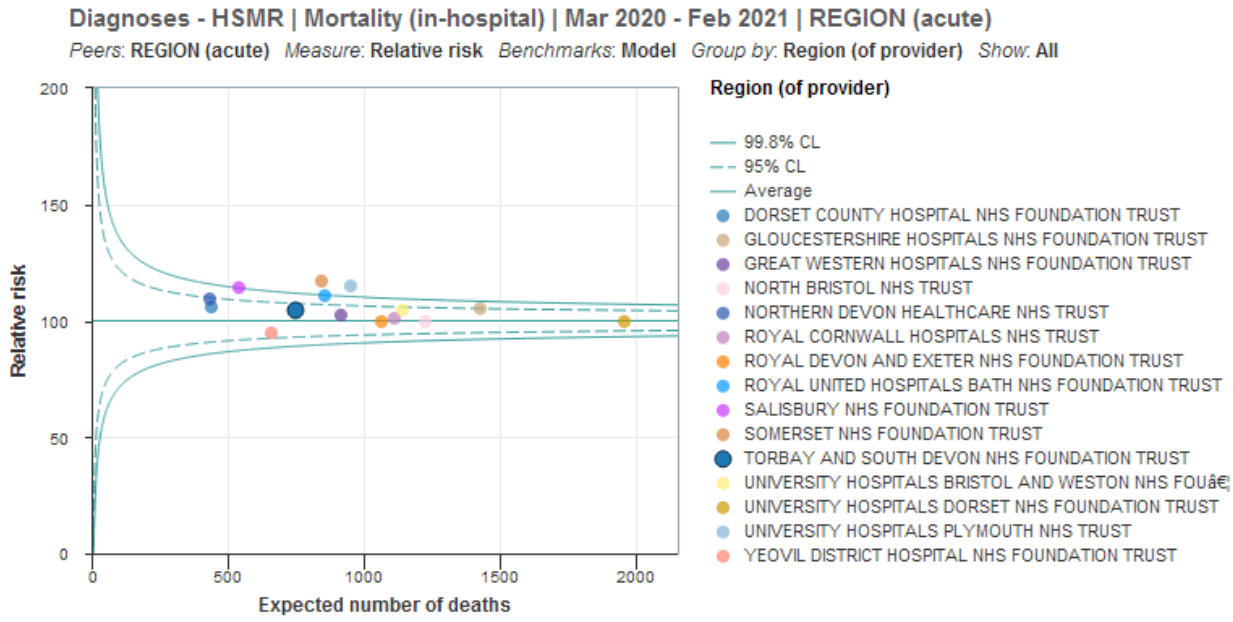
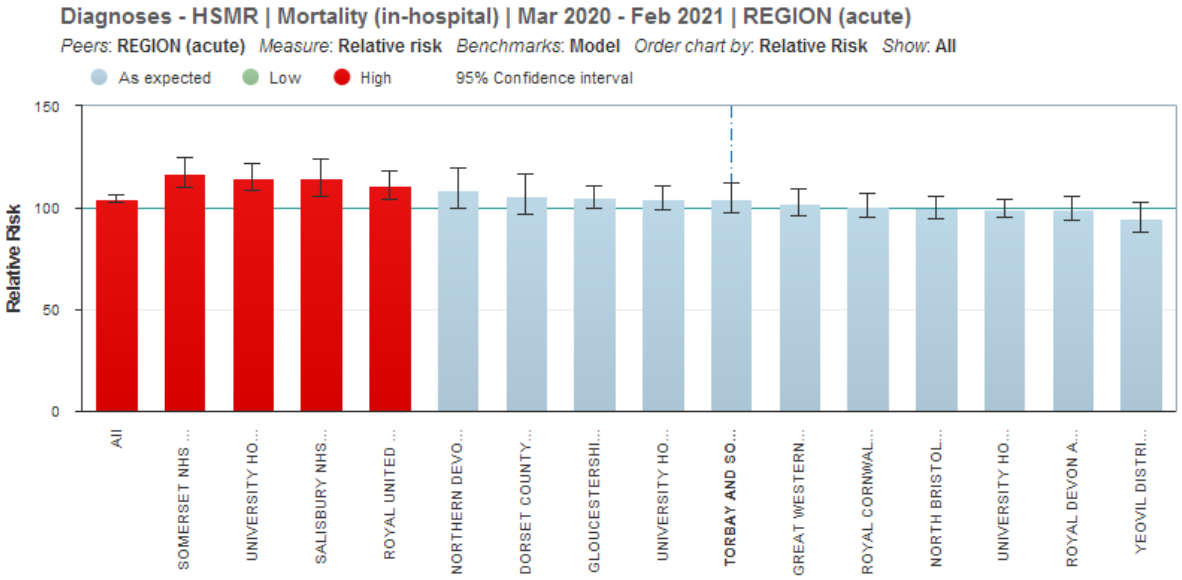


Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart.
The 12-month average HSMR is near the expected rate. Torbay and South Devon is not an outlier during this time period.



1B Summary Hospital Mortality Index (SHMI) Reporting Period October 2019 – December 2020

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon inpatient deaths **and** deaths up to **30 days post discharge** from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective, therefore, please note the data periods are different to HSMR.

Chart 4, as below, highlights SHMI by quarterly periods with all data points within the expected range except one, which exceeds the average 100 relative risk mark. This data point is from the first wave of Covid in Q1 of 2020/21 when hospital activity was greatly reduced. The data thereafter, shows SHMI returning to its normal variance, as activity increased.

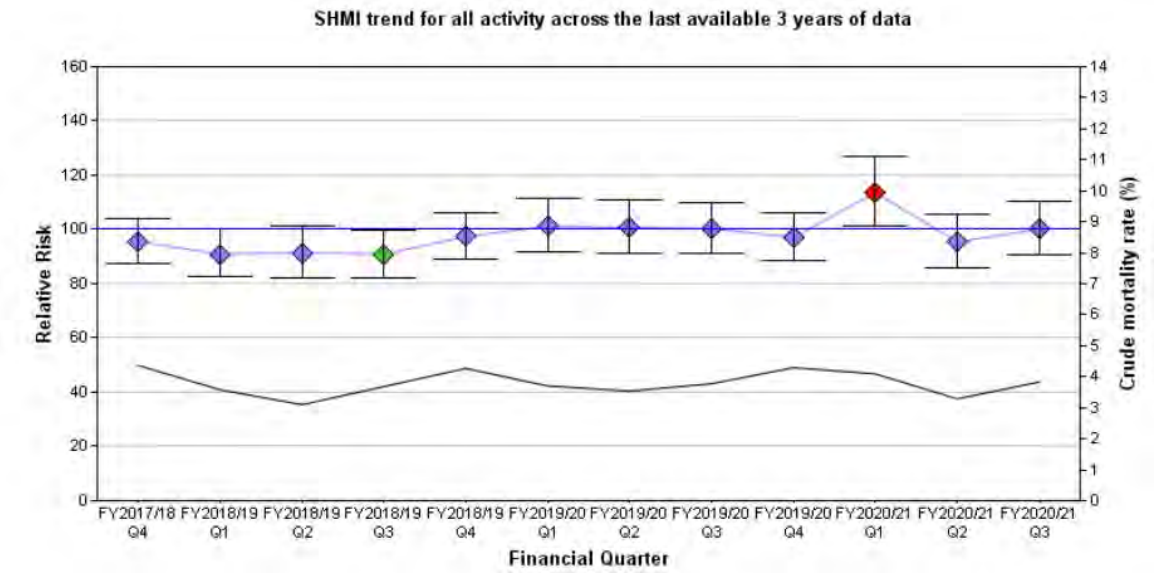


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths and HSMR comparison, all within normal limits

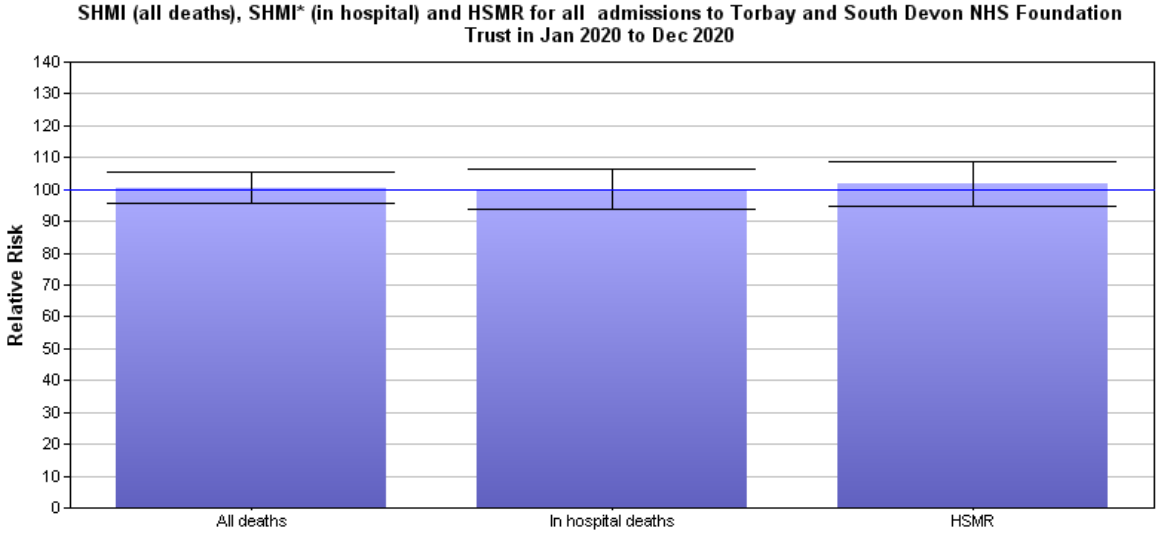
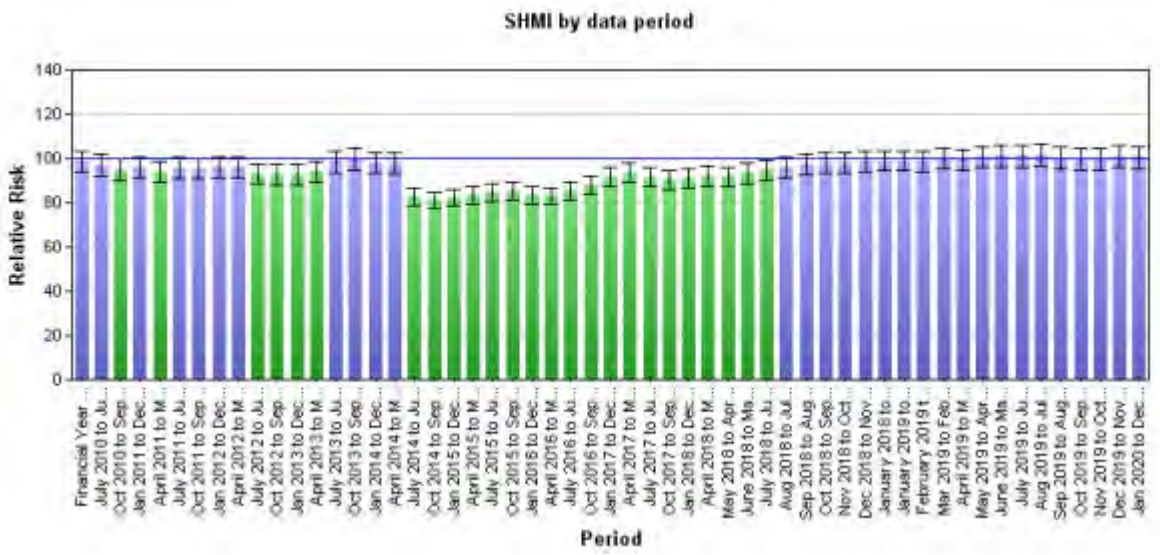


Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period.



Appendix 2 – Unadjusted Mortality Rate

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

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

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

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

Chart 7, below, highlights the Trust's in hospital unadjusted mortality. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart includes the Covid lockdown period and highlights a rise in deaths in March and April 2020. The mortality rise in March is partly explained by a reduction in activity due to Covid changes. The mortality rise in April is solely down to reduced activity. In April 2019 we had 3036 discharges (the denominator) and in April 2020 this, due to Covid, had reduced to 1773. Unadjusted mortality has remained stable over the last two months.

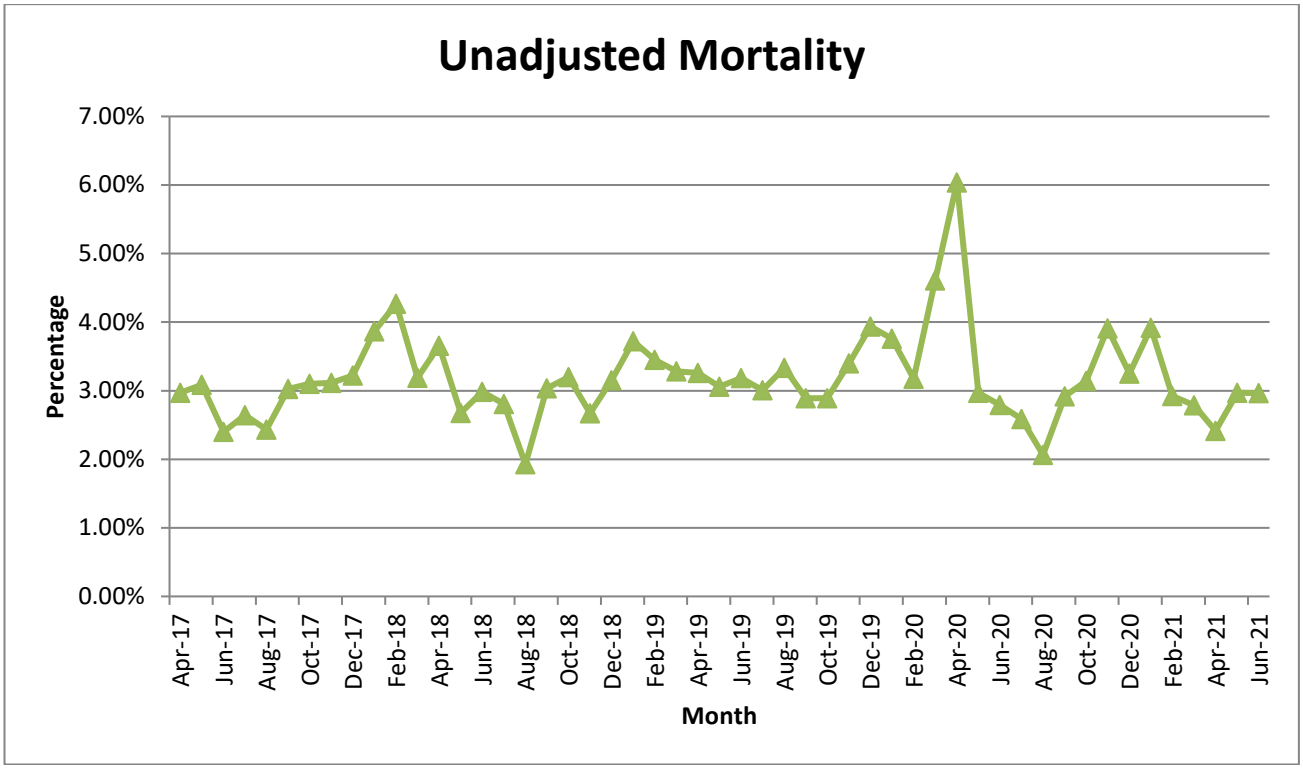


Chart 8 As below, indicates the monthly number of hospital deaths. This shows a rise in March and April 2020 partly due to Covid, before decreasing to very low numbers during Summer 2020 with a gradual return to expected numbers of deaths for the last 3 months.

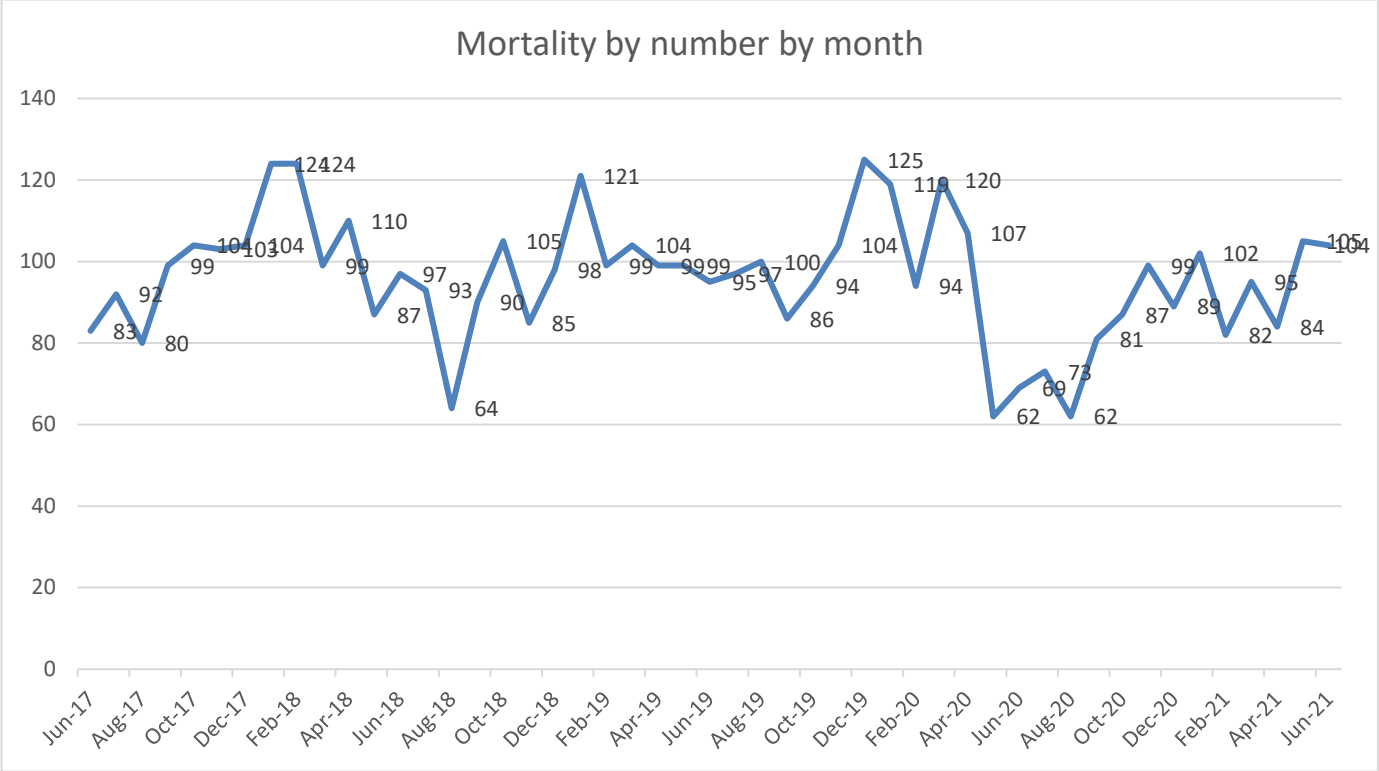


Chart 9, records hospital and community deaths (people's homes) and includes a comparator year, 2019.

There is a rise in total deaths in March and April 2020 (Covid Wave 1), as against the previous year, and then a return to the 2019 level for the rest of 2020.
In 2021 there is a rise in deaths in January (Wave 2) reducing again in early February with a further peak in mid-April.
The last two data points may be prone to data lag and will change in next month's review.

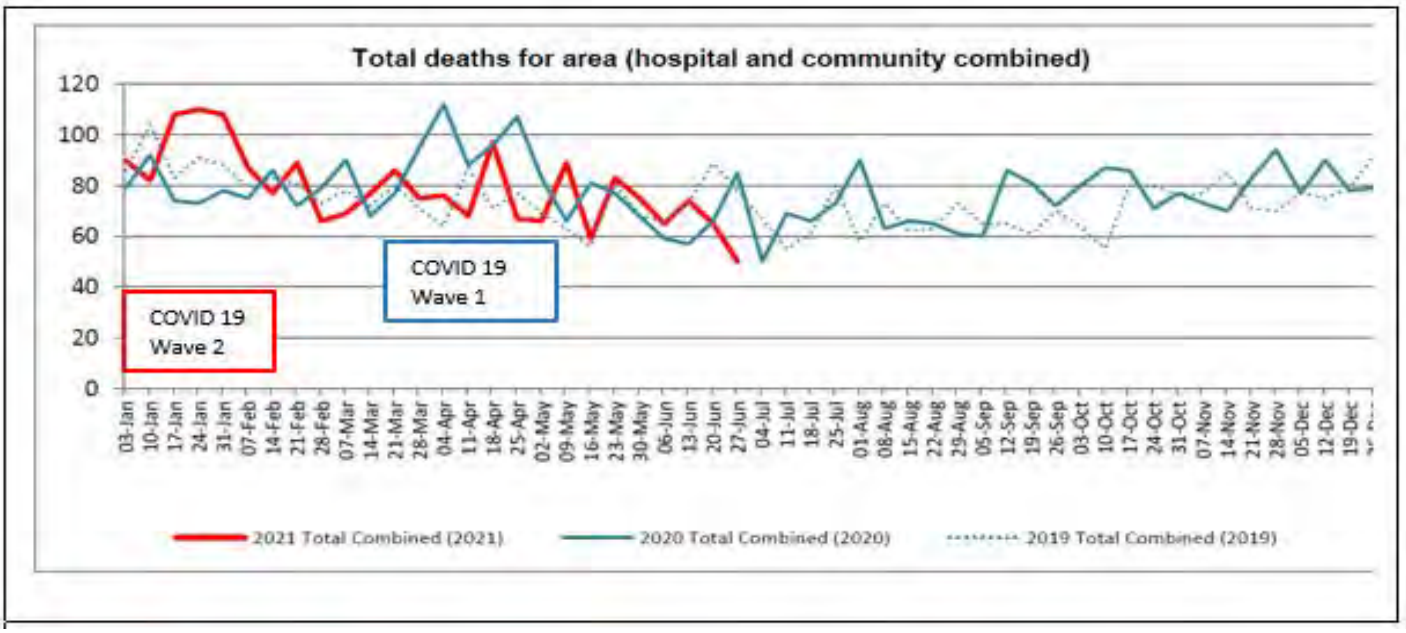
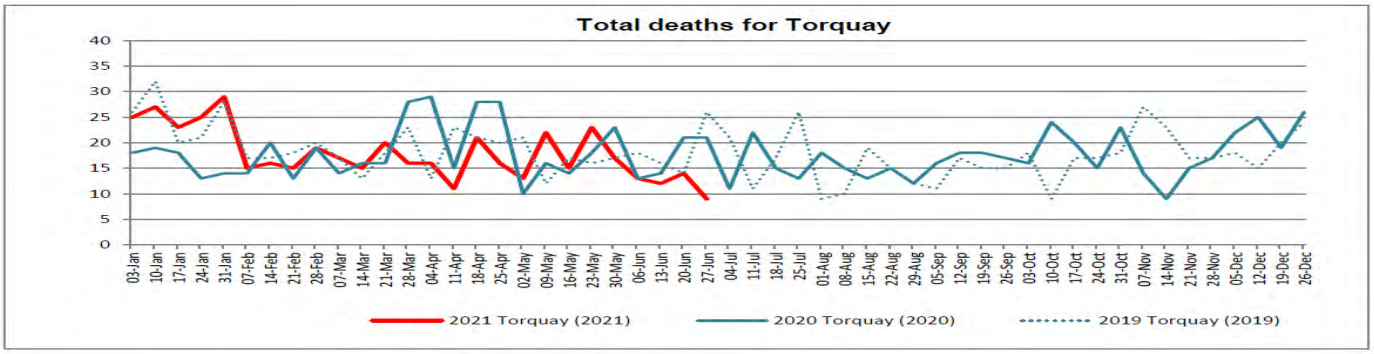
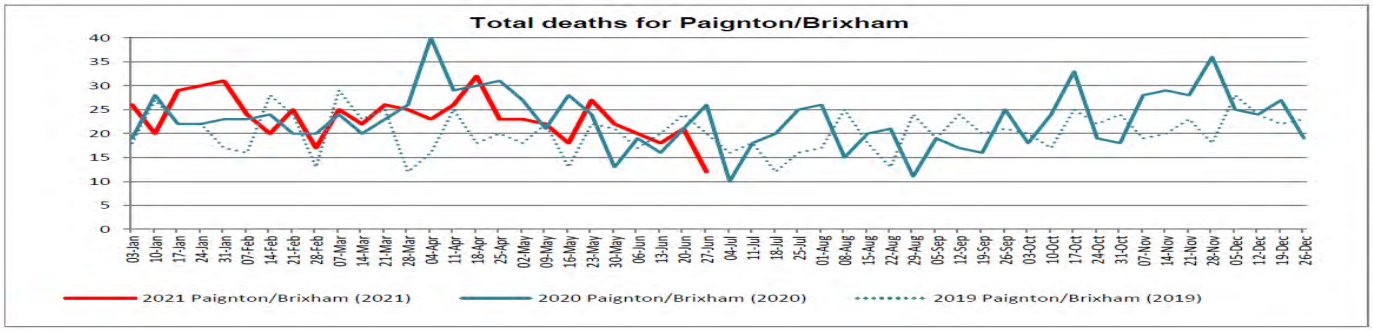
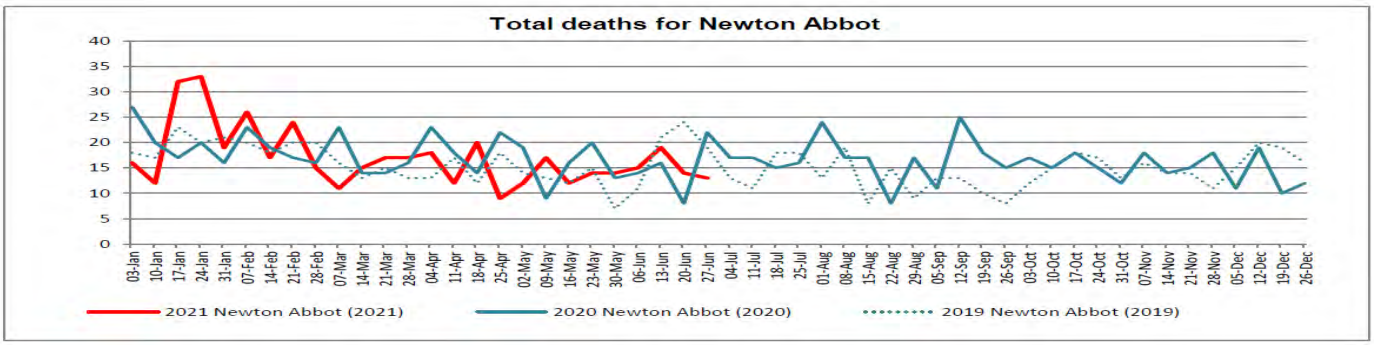
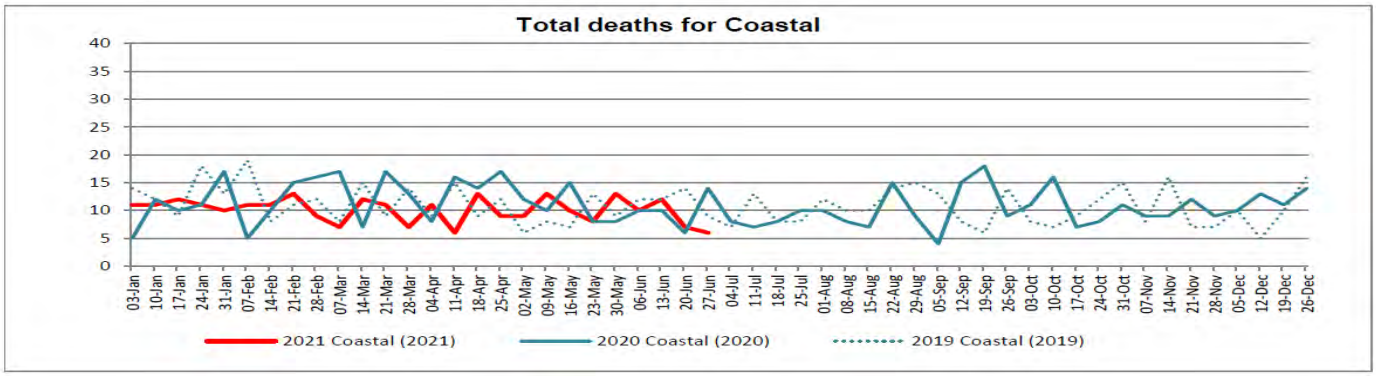


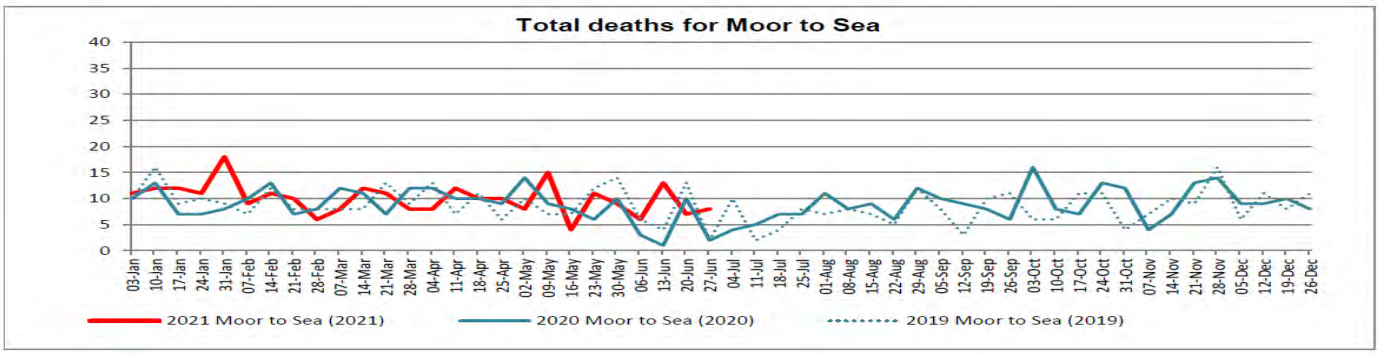
Chart 10 - Total Deaths by ISU locality











Appendix 3 – Mortality Analysis

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

	Jan-20	Feb-20	Mar-20	Apr-20	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	Jun-21	
ACUTE MEDICAL RECEIVING UNIT						1													
AINSLIE	3	1	5	2	3		1		2		2	1	2	1	1	1			
ALLERTON	10	6	6	3	5	4	7	5	3	7	8	8	2	3	8	4	6	4	
BRIXHAM	1	2		1	1	1				3	4	2	6	4		5	1	1	
CARDIAC CATHETER SUITE																		1	
CHEETHAM HILL	19	3	10	13	9	8	14	7	12	6	11	11	12	10	11	10	11	7	
CROMIE	3	2	3	13		1	1		1	8	8	7	13	6	2	2	7	2	
DART	1		3	1					1	1	1				2	3	3		
DAWLISH	6	4		3		1	3	1	1				4	1	1			1	
DELIVERY SUITE															1				
DUNLOP	8	2	10	4	6	6	3	5	6	2	4	3	4		5	4	3	3	
ELIZABETH												3	1	3	1	1	1		
EAU3	5	6	7	3	3	6	2	4	1										
EAU4	6	8	13	3	3	5	7	6	11	7	7	9	17	10	11	8	9	16	
ELLA ROWCROFT	1		1	3	2	1		2		4	3			3		1			
FORREST	2	1	8	7	4	1							4	5	4				
GEORGE EARLE	14	12	11	6	5	5	7	5	9	14	16	9	8	4	8	10	8	13	
INTENSIVE CARE UNIT	9	8	6	8	7	5	5	8	7	5	6	12	2	5	4	5	10	16	
LCHDU			1																
LOUISA CARY		1			1	1													
MEDICAL RECEIVING UNIT																1		3	
MIDGLEY	12	9	7	4	8	11	10	3	13	13	10	7	13	16	14	13	18	12	
MOTHER AND BABY																			
RECOVERY INTENSIVE CARE UNIT				5															
SIMPSON	5	6	13	5	2	4	7	4	7	6	10	8	5	2	8	9	16	12	
TEIGN WARD	1	1	3	5	1	5	5	2	3	1	3	2	2	1	2	1	3	2	
TEMPLAR WARD	3	6	2	8	2	1		4		3		1		1	2	4		1	
TEMPORARY INTENSIVE CARE UNIT													1	1					
THEATRES													1						
TORBAY CHEST PAIN UNIT																			
TORBAY CORONARY CARE BEDS		2	4	2		2	1	3			2	3	1	2	1		2	2	
TURNER	6	8	5	1				2	4	5	2	3	2	3	8		5	6	
WARRINGTON	4	6	2	7				1		2	2		2	1	1	2	2	2	
Grand Total	119	94	120	107	62	69	73	62	81	87	99	89	102	82	95	84	105	104	

Dr Foster utilises an alerting system, as below. Triggers are raised when the expected number is exceeded by the actual number and Dr Foster also provides a guide should an alert occur. Deaths due to 'Acute and unspecified renal failure' are higher than expected (46 observed v 25 expected). This does not appear to be a coding issue. A case notes review has been organised with by the Director of Patient Safety and a Renal Consultant. Deaths due to intestinal infection are higher than expected (18 observed v expected 8.4). Again, this does not appear to be due to coding issues and has been discussed at Mortality surveillance review.

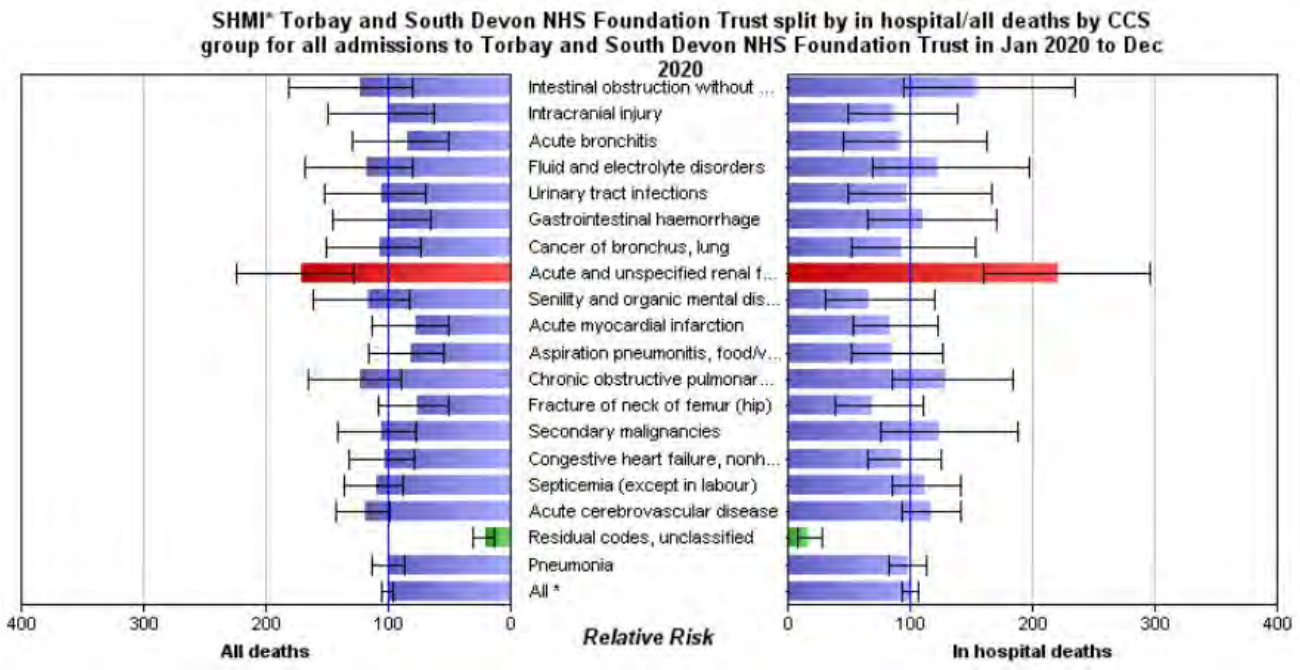
Table 3 – **Dr Foster Alerts by clinical classification**

The latest month data is showing no new alerts.

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	10	60716	1037	1050.5	1.7	98.7	
HSMR (56 diagnosis groups)		23816	782	749.3	3.3	104.4	
Abdominal pain	1	1769	5	1.5	0.3	332.0	
Acute and unspecified renal failure	3	237	46	25.0	19.4	183.8	
Alcohol-related mental disorders	1	162	4	0.5	2.5	754.3	
Blindness and vision defects	1	40	1	0.1	2.5	1148.9	
Immunizations and screening for infectious disease	1	11	1	0.1	9.1	1550.2	
Intestinal infection	2	561	18	8.4	3.2	214.4	
Intrauterine hypoxia and birth asphyxia	1	6	1	0.0	16.7	4582.5	
Other psychoses		140	7	2.5	5.0	280.9	
Peritonitis and intestinal abscess	1	17	4	1.3	23.5	312.7	
Syncope	1	306	4	1.1	1.3	355.7	
Viral infection	1	739	91	76.2	12.3	119.4	

Chart 7 The SHMI clinical classification software (CCS), clusters patient diagnoses and procedures into a number of manageable and meaningful groups. This chart shows deaths occurring in hospital and all deaths (i.e. in hospital deaths and deaths occurring within 30 days after discharge) by clinical cluster. In hospital deaths due to 'Acute and unspecified renal failure' are greater than expected. Initial investigation suggests this is **not** related to coding issues. This month's position reflects no change for the period reported.



Appendix 4 – Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which in turn are based on procedure codes used in the NHS.

The data was pulled on 5 July 2021. For the 12-month period March 2020 to February 2021 there were no alerts in these patient safety indicators. The Trust has a statistically lower than expected relative risk for 5 of the indicators (green in 'Relative risk' below).

Table 4 – Patient Safety Indicators

Quality Safety

Patient Safety Indicators

Period: 12 months (Mar 20 to Feb 21)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	46491	51	70.4	1.1	1.5	72.5
Deaths after surgery	405	23	30.8	56.8	76.1	74.6
Deaths in low-risk diagnosis groups	17246	53	71.3	3.1	4.1	74.3
Decubitus ulcer	6785	346	420.7	51.0	62.0	82.2
Infections associated with central line	8967	1	0.5	0.1	0.1	185.9
Obstetric trauma - caesarean delivery	518	1	2.4	1.9	4.5	42.5
Obstetric trauma - vaginal delivery with instrument	216	14	14.7	64.8	68.3	94.9
Obstetric trauma - vaginal delivery without instrument	992	36	29.2	36.3	29.4	123.4
Postoperative haemorrhage or haematoma	10841	3	4.7	0.3	0.4	64.5
Postoperative physiologic and metabolic derangement	8326	0	1.6	0	0.2	0.0
Postoperative pulmonary embolism or deep vein thrombosis	11087	19	42.4	1.7	3.8	44.8
Postoperative respiratory failure	7380	1	8.0	0.1	1.1	12.6
Postoperative sepsis	120	0	2.0	0	16.6	0.0
Postoperative wound dehiscence	460	0	0.4	0	0.8	0.0

Appendix 5 – Focused Mortality Reviews

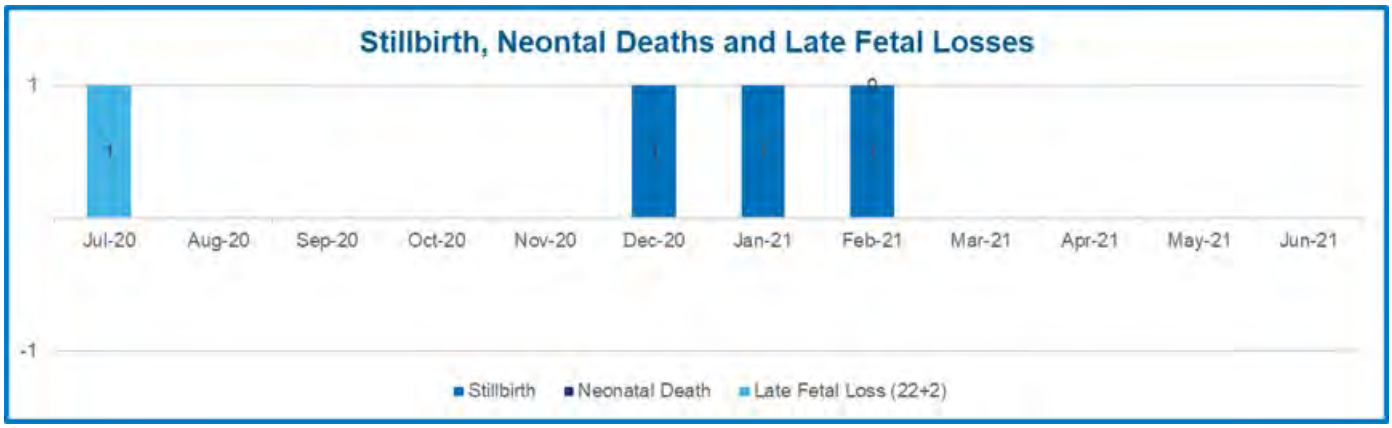
Number of deaths of a patient with a Learning disability

All deaths involving patients with a learning disability are reviewed through the Learning Disabilities Mortality Review (LeDeR) process. This process feeds back into the Trust any learning. In Q4 2020 / 2021 there were 4 deaths in hospital for review via this process

Number of Neonatal, Perinatal, and Maternal Deaths

During the Q1 reporting period (April - June 2021), we had no stillbirth, maternal or neonatal Deaths.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Number of deaths in which complaints were formally raised by the family

In Q1 2021/2022 the Trust received one complaint from a family with concerns regarding a patient's death. This complaint is still active.

Medical Examiners

During Q1 the Medical Examiners Service has been impacted by sickness resulting in reduced Medical Examiner capacity. The regional Medical Examiner was informed but no external support for the service was available. Despite this a total of 198 (86.5%) of eligible adult inpatient deaths have been independently scrutinised. Of these a total of 12 (6.06%) have been referred to clinical governance for review.

There is now a national requirement for the Medical Examiners service, hosted by the Acute Trust on behalf of the National Medical Examiner, to be rolled out into the community and independent settings by March 2022. At the time medical examiner scrutiny of deaths will become a statutory requirement with the legislative process for this statuary footing currently progressing through parliament. Project planning is underway to manage this rollout.

Table 5 – Medical Examiners Performance Summary

	Performance					Outcomes						
Month	Total number of adult deaths	Number not currently included in ME process (COVID ward / direct to coroners)	Number scrutinised by ME	% Total deaths scrutinised	% deaths included in ME process scrutinised	Number scrutinised referred to coroner	% referred to coroner	Number MCCD issued within 5 days (non coroners)	% MCCD issued within 5 days (non coroners)	Number MCCD issued within 3 days (non coroners)	% MCCD issued within 3 days (non coroners)	Number raised to clinical governance
Jan-21	104	46	45	43.3%	77.6%	10	22.2%	23	65.7%	11	31.4%	5
Feb-21	81	7	67	82.7%	90.5%	16	23.9%	41	80.4%	31	60.8%	8
Mar-21	97	13	68	70.1%	81.0%	9	13.2%	49	83.1%	30	50.8%	10
Apr-21	72	13	55	76.4%	93.2%	8	14.5%	42	89.4%	31	66.0%	3
May-21	92	11	66	71.7%	81.5%	6	9.1%	52	86.7%	31	51.7%	0
Jun-21	113	24	77	68.1%	86.5%	6	7.8%	65	91.5%	40	56.3%	9

National Cardiac Arrest Audit

Full year audit data for 2020 / 2021 and indicates nothing out with the normal expected range for the Trust. There were a total number of 55 cardiac arrests during this year. This rate is on the national average and maintains the downwards trend since 2018. The mean age was 71 (down from 79yrs in 2018) and was 60% male.
The survival to discharge rate was 20% which is an increase from 17% in 2017 and is on the national average. The Trust is slightly above average for shockable arrests and slightly below for Pulseless Electrical Activity (PEA) arrests.

Learning from Inquests

During Q1 of 2021/22 there were 11 Coroner's requests for information. The Trust attended two coroners' inquests during this quarter with three witnesses from the Trust attending in total.

The learning from the maternity inquest centred around enabling 1:1 contact with new mothers at home which at the time when the mother who died in this case, had been stepped down because of Covid 19 in March 2020. 1:1 contact with mothers post birth was resumed after the Covid first wave ended in summer 2020.
The Trust has no outstanding Regulation 28 reports.

Trust learning: Serious Adverse Event Group May and June 2021

Key Issues	Learning and actions taken
Treatment / Diagnostic learning	
Neonatal death after therapeutic cooling for ischaemic encephalopathy	Issues relating to antenatal care, fetal monitoring and timeliness of transfer for urgent section were discussed.
Death of Patient under care of Drug and Alcohol team in community	Need for good communication between, pharmacy, GP and Drug and Alcohol teams
A never event involving misplacement of a nasogastric tube was discussed in a patient with a stroke	Discussion regarding decision to commence NG feeding in patient with severe co-morbidities and safeguards to ensure correct placement

Documentation Dating, signing issues with documentation	In all cases an investigation is undertaken and the teams are involved in the RCA, learning and sharing

Glossary of Terms

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

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

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

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

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Medical Appraisal and Revalidation Report			Meeting date: 28th July 2021
Report appendix	Appendix 1: Senior Support Booklet		
Report sponsor	Medical Director		
Report author	Trust Appraisal Lead		
Report provenance	People Committee 28th June 2021		
Purpose of the report and key issues for consideration/decision	This is the annual report relating to medical appraisal and revalidation presented by the Medical Director. The report addresses key issues as follows: • The impact of the COVID 19 pandemic • Light touch Appraisal 2020 • Wellbeing and support of senior clinicians within the Trust The monitoring of appraisal and revalidation continues as described and reporting will be undertaken on an annual basis.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve the contents of the Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation and delegate authority to the Chief Executive to sign the Statement of Compliance on behalf of the Board.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks	

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

Report title: Annual Medical Appraisal and Revalidation Report		**Meeting date: 28th July 2021**
Report sponsor	Medical Director	
Report author	Trust Appraisal Lead	

Introduction

Background

Medical revalidation was introduced in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Doctors wishing to maintain their licence to practise medicine in the UK must demonstrate on an ongoing basis that they are up to date and fit to practise.

Revalidation continues to provide assurance to employers and the public by ensuring that appraisal of a doctor's whole scope of work takes place on an annual basis. Throughout the appraisal process particular emphasis is placed on supported reflection on the information provided to the appraiser, including feedback from colleagues and patients.

Employers have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisation;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought regularly so that their views can inform the appraisal and revalidation process for their doctors and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Discussion

On 19th March 2020, NHSE wrote to Trusts suspending annual appraisal for consultants and SAS doctors to enable medical teams to focus on the challenges of the Covid pandemic. In October 2020, the Trust re-introduced annual appraisals for senior medical staff using a 'light touch' approach as recommended by the GMC. This stresses appraisal as a process of facilitated self review, emphasizing support and guidance. Medical staff continue to re-engage with the appraisal process. Numbers of completed appraisals, incomplete appraisals and 'approved missed appraisals' for the last year are set out in the Annual Board Report.

Conclusion

Medical Appraisal and revalidation processes have been significantly affected by the Covid-19 pandemic. The Trust has followed GMC guidance and medical staff are now re-engaging in this process. The GMC are presently reconsidering how appraisal and revalidation develop after the experience of the last 18 months. The Trust seeks to support the wellbeing and welfare of senior medical staff and the Senior Doctor Support Booklet has been well received. Currently, there is active recruitment into the appraiser role with targeted training and ongoing support.

Recommendations

The Board is asked to note the contents of designated body annual board report produced in a standard template as advised by NHSE/I.

The Board is asked to approve the Statement of Compliance on page 21 of the report.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Executive Board of Torbay and South Devon NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Not applicable Action from last year: Not applicable. Comments: Medical appraisal was suspended between March 2020 – September 2020 due to the COVID 19 pandemic and appraisals due during this time period were recorded as 'approved missed appraisals'. Data for Consultant and SAS doctor appraisals only are detailed as follows: <u>01 April 2020 – 30 September 2020</u> Approved Missed appraisals = 116 Completed appraisals = 19 <u>01 October 2020 – 31 March 2021</u> Completed appraisals = 73 <u>01 April 2020 – 31 March 2021</u> Incomplete appraisals = 29 Action for next year: Continue to re-engage medical staff with the appraisal process.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Not applicable Comments: Mr Ian Currie has taken over the post of Responsible Officer from Dr Rob Dyer. Action for next year: Continue

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Not applicable Comments: Action for next year: Continue

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Not applicable. Comments: Whilst we endeavour to be as accurate and up-to-date as possible, there is margin for doctors to connect themselves inappropriately or fail to connect to the list. Action for next year: Continue to maintain list as accurately as possible.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Not applicable. Comments: Appraisal and Revalidation Policy under review. Action for next year: To be agreed at the Joint Local Negotiating Committee meeting on 03 August 2021.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Not applicable. Comments: Unclear what NHS England's plans for peer review would be since the COVID pandemic. Action for next year: Await regional and national guidance.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Not applicable. Comments: Trust Doctor Lead post out to advert to support this group. No formal process for locum doctors. Action for next year: Revisit formal process for locum doctors with Responsible Officer and Medical Workforce.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Not applicable. Comments: Medical appraisal suspended between March 2020 – September 2020 due to the COVID 19 pandemic. Now that appraisal has recommenced within the Trust we have adopted the Appraisal 2020 'light touch' approach and are encouraging all doctors who did not have an 'approved missed appraisal' to have a light touch appraisal. We feel strongly that appraisal should be a supportive and developmental process for doctors. Action for next year: Continue

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Not applicable. Comments: Continue to monitor timelines and encourage doctors to have a supportive appraisal meeting. Missed appraisals to be identified, reasons understood and appropriate action taken. Action for next year: Continue to monitor and provide support.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Not applicable. Comments: Appraisal and Revalidation Policy is under review. To be approved by the Joint Local Negotiating Committee in August 2021. Action for next year: Nil. Next renewal date 2023.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Not applicable. Comments: New Consultant and SAS appraisers recruited in 2020. Further training scheduled for June 2021. Team Job Planning in specialties where there is a shortage of appraisers eg Paediatrics to encourage recruitment of appropriate new appraisers and incorporation into Job Plans. Action for next year: Active recruitment to the appraiser role.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Not applicable. Comments: Appraiser Update session held on 13 November 2020 with further refresher training planned for Autumn 2021. MS Teams Appraiser update session held monthly. To include a session on psychological support and mediation awareness training. Action for next year: Continue.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Not applicable. Comments: Superseded due to the COVID 19 pandemic. Action for next year: Await regional and national guidance.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Not applicable. Comments: The Responsible Officer has regular meetings with the GMC Employment Liaison Officer to discuss any potential fitness to practice issues. Action for next year: Continue.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Not applicable. Comments: All revalidation recommendations have been submitted to the GMC prior to the doctor's revalidation date. No late recommendations have been submitted. Revalidation recommendations are communicated to the doctor after submission via GMC Connect. Deferral recommendations are communicated to the doctor before submission to the GMC and an action plan is discussed with the doctor by the Appraisal Lead. Action for next year: Continue.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Not applicable. Comments: Medical Examiner system now in place. Incidents, complaints and litigation cases recorded in the Datix system. Responsible Officer chairs the Serious Adverse Events Group. Action for next year: Continue.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Not applicable. Comments: Performance monitored by: annual appraisal; complaints and incidents data via the Datix system; divisional performance data; departmental clinical governance meetings; Dr Foster data, Maintaining High Professional Standards policy; Transfer of Information requests. Action for next year: Continue.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Not applicable. Comments: Maintaining High Professional Standards and Remediation policies. Close liaison between the Responsible Officer, Appraisal Lead and Medical Workforce team. Action for next year: Continue.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Not applicable. Comments: Following a Maintaining Professional Standards Investigation the Case Manager will meet with the Case Investigator and Medical Workforce team to debrief and consider any lesson that can be learned. These are communicated to the Responsible Officer. The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No individual will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010. Action for next year: Continue.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Not applicable. Comments: Transfer of Information requested from previous organisation and provided, on request, to the doctor's next employer. Regular liaison meetings between the Responsible Officer and the GMC Employment Liaison Officer provide a forum to discuss any concerns about a doctor who may not be relocating to another employing organisation. Action for next year: Continue.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Not applicable. Comments: The Responsible Officer and Medical Workforce Service Managers meet on a regular basis with the GMC Employment Liaison Officer to discuss, in confidence, any concerns and agree the best way of handling these concerns balancing the safety of patients with supporting the clinician. Action for next year: Continue.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Not applicable. Comments: All medical staff, both substantive and locum, are subject to pre-employment checks as per the NHS Employers Employment Check Standards and NHS Employers Guidance on appointment of Locum Doctors. Action for next year: Continue.

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions:

- Appointment of new Appraisal Lead.
- Appraisal and Revalidation system, PReP, contract renewed until 2022.
- New Appraiser training held on 28 September 2020 with seven consultant/SAS doctors joining the Trust Appraiser group.
- Monthly Appraiser Group updates held via MS Teams
- Senior Support booklet now in place to provide support, guidance and signposting to senior clinicians within the Trust (Appendix 1)
- Dedicated e-mail address to provide support for senior clinical staff.
- Mediation session on 11 December 2020 facilitated by Ms Veronica Conboy, Associate Medical Director
- Light touch appraisal introduced by NHS England and implemented within the Trust and will continue until March 2022. Academy of Medical Royal Colleges currently developing appraisal process for April 2022 onwards but likely to continue to be less bureaucratic with an emphasis on support and development.
- Survey to assess impact of the light touch appraisal currently in progress.
- Trust Doctor Lead post advertised.
- Annual Organisational Audit stood down due to impact of COVID 19 pandemic.

Current Issues:

- Challenges due to the impact of COVID 19 pandemic – reduced resilience among the clinical staff with work in progress to re-build motivation while providing support and guidance to this group of doctors. Light touch appraisal encouraged with emphasis on doctors having a supportive meeting if a formal appraisal not appropriate.

Actions:

- Focus on locum and short-term doctor pathway.
- National review of appraisal process with implementation within the Trust as appropriate from April 2022.

Appendix One:

Torbay and South Devon NHS Foundation Trust

Senior Doctor Support Booklet

2020/21

Wellbeing and Welfare at Torbay

Torbay hospital is a friendly and supportive place to work and most of us will seek help from our colleagues over our years in the trust, this is a normal part of being a senior clinician.

We all need extra support sometimes, whether it is when we are taking on new responsibilities, feeling stuck in a rut, having difficulties with colleague relationships, struggling to maintain a work-life balance or when we experience other work-related incidents such as complaints or a request to attend a coroners court. Often, we can go to our colleagues for advice, but sometimes this is not appropriate for a variety of reasons.

Most of the time, we can seek help and support, whilst continuing to work. However, on occasions things become overwhelming, whether that is because of a particularly difficult incident or when things all stack up on us. When this happens, it is important to know that it may be the right thing to take time off work. This happens to many people at some point in their careers and colleagues will help to support you if this happens.

In a survey undertaken at Torbay pre-Covid, 50% of doctors at all levels of seniority felt their mental and physical wellbeing were being negatively impacted on by work. Nationally, since Covid, it is estimated that around 55% of doctors are experiencing mental health issues such as burnout, depression, stress or anxiety. Therefore, it is more important now than ever that there are clearly signposted support mechanisms for us all if we need them. After all, as leaders, how can we support others if we are not supported ourselves?

With this in mind, we have developed a number of options available to senior clinicians in our trust which are outlined in this booklet.

What is right for me?

Mentoring: You would engage a mentor if you were looking for specific advice from someone in your field who has more experience or is further ahead in their career.

Coaching: Coaching can support you to take positive steps to move aspects of your life forward and in the direction you choose. Typically, a very small proportion of the coaching session is spent exploring your past. Coaching can address obstacles that are blocking your way i.e. self-limiting beliefs, unhelpful patterns of behaviour, conflicting values, etc.

Talking therapies (e.g. Counselling, Psychological Therapy) are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change and / or enhance their wellbeing.

Peer Mentoring Support

As senior clinicians, we have a wealth of experience and knowledge which we can use to support others when they need it. As such, a group of senior colleagues have offered to be peer mentors.

Peer mentors can offer confidential support in a number of different areas, for example, if you are a new consultant and would like support or an established consultant who would like advice around developing leadership skills, improving work-life balance, job planning, complaints or coroners' cases, litigation, GMC referrals, job planning, issues with teams or colleagues or more general support needs. We have a variety of senior clinicians who have offered to do this from across the organisation and in a variety of specialities.

How do I access peer support?

- Email address: tsdft.peermentoring@nhs.net. This is a confidential email address which will only be visible to Maria Saunders (Clinical Lead for Staff Experience and Gastroenterology Consultant), Jo Sykes (Appraisal Lead and Palliative Care Consultant) and Laura Travers (PA to Ian Currie) so that they can co-ordinate the mentors as needed.
- In order to access peer mentoring, please email the above address including your contact details, speciality where you work and a theme of support you need (see suggested themes in the paragraph above) – please do not include details, just a theme.
- You will then be matched with a peer mentor who is outside of your speciality, but who has identified themselves as being able to help with the area of support you are asking for, if possible.
- An email will be sent to you, via the generic email address, with the name and contact details of your mentor to ensure that you are happy with the person who has been selected for you. If the person selected for you is unsuitable, for whatever reason, let us know and we will re-allocate you.
- You can then email your peer mentor and decide on how and when to meet between yourselves.
- It will be up to you and your mentor to decide if this is will be a one-off conversation or part of a more regular set of meetings. This will be dependent on each individual, their need for support and personal preference.

Following on from your initial meeting, you will be contacted via the generic email address to give feedback on the process of peer mentor support. We will not ask for details of the support you have received but will ask about ease of use and usefulness. This is so that we can develop this service in the future, using your feedback.

Coaching

Coaching is a totally confidential service which is available to all staff and focuses on how you want things to be, what you need to achieve and how you are going to get there. It not only covers tasks and goal setting but raises awareness of patterns of your thinking that may be keeping you 'stuck'. It also allows insights into beneficial behaviour that can be adopted.

We all have dreams, visions and goals that spur us on to keep learning, working and taking action. When you work with a coach towards the dream, vision or goal the first step is to identify what your individual drivers are – your core values that give your goals meaning and a sense of purpose in whatever it is you're doing in your career or your life. Once you have elicited your values it makes it easier to clarify what the big goals in life are, as well as the sub-goals that you need to achieve, in order to reach your destination.

What types of situations can you bring to a coaching session?

Coaching can:

- help you look at behavioural issues like communication skills, confidence and assertiveness
- give you the space and time to reflect on problems or challenges in your career
- help you when dealing with difficult relationships, both professional and personal
- support you to prepare for interviews or presentations
- give you clarity when feeling over-whelmed or stuck
- support you to look at a work/life balance

How can I access coaching?

- You can access coaching by completing the electronic request form on the Coaching web page on ICON. The Coaching Intranet page has more information about the service and also the coaches (both internal and external) that are currently available.
- A coach experienced in supporting senior staff members will be selected for you once you fill in the online form.
- If you have any queries you can contact us on tsdft.coaching@nhs.net

External Coaches

Sometimes, for a variety of reasons, people feel more comfortable seeking coaching from outside the Trust. If you feel this would fit better for you, there are many to choose from if you Google 'Coaching for Doctors'. However, the best way to find a good coach is to ask colleagues who have experienced coaching who they would recommend. The truth is you often do not know if a coach is right for you until you work with them.

Clinical Psychology and Talking Therapies

The Clinical Psychology Team, accessible via ellen.young1@nhs.net or allyson.turnbull-jukes@nhs.net, can support senior clinicians in a number of ways outlined below:

- **Compassion fatigue workshops** for teams of senior doctors: An opportunity to look at the common challenges and emotional impacts of working in healthcare and how we manage these as teams and individuals. These workshops were well received in the past and allowed colleagues to discuss their experiences in a supported group of peers.
- **Acceptance and Commitment Therapy (ACT) in the workplace** group course applies the principles of ACT to work life wellbeing. This could be either as a group of senior doctors or as an MDT, whatever works best in your team.
  At times work can be overwhelming and exhausting, at these times we can feel disconnected from what matters to us individually. The focus of the course is on helping us to turn up to work and life in ways that fit with our values and help to learn more adaptive ways of relating to difficult or unhelpful thoughts/feelings. Such programs have been rolled out within NHS teams and they have received positive feedback and outcomes. Research within the UK and outside of the UK have reported the benefits of using components of ACT in the workplace in improving wellbeing and psychological health.
  A progression from this course is the offer of **Prosocial for teams**: a way of exploring team functioning and well-being.
- **Reflective practice sessions** for senior doctors: an opportunity to talk through themes of work-related difficulty and reflect on how we manage these (on a 1-1 basis). This works best if the individual has attended one of the above sessions but is not compulsory.

If you need one to one psychotherapy, this is not a service that is offered in house by our clinical psychology team, for a number of reasons. However, there is support available via:

- The **Employee Assistance Programme**, which is available for emotional support, stress, anxiety, problems with careers, money, legal rights and counselling - 0800 031 4674 or for further information https://tsdft.optimise.health/
- **Talkworks** offer a priority wellbeing support service to all NHS, Social Care and Police staff. They offer support to help you look after your own emotional wellbeing via self-referral at https://www.talkworks.dpt.nhs.uk/nhs-mental-health-support/nhs-social-care-worker-support
- The **Association of Clinical Psychologists** are currently running a confidential self-referral service for senior medial staff, clinical team leaders and senior management to provide one-to-one psychological support for those who feel they would benefit from it. This is available via https://acpuk.org.uk/covid_19_response_1to1_support/
- **DocHealth** is a confidential, not for profit, psychotherapeutic consultation service for all doctors. It is delivered by Consultant Medical Psychotherapists based at BMA House in London. Although located in London the service is open to all doctors in the UK. This is available via https://www.dochealth.org.uk/
- The **BMA** also run a 24 hour counselling helpline which is free and confidential, open to all doctors, even those who are not a member of the BMA. This is available via 0330 123 1245.
- To find an independent therapist, please look at the BABCP, BACP and BPS websites as these can provide some assurance of qualifications for your chosen therapist.

Supervising Junior Doctors

Supervising trainees can be one of the most rewarding, but also most stressful, things about being a senior doctor. We are often well trained and supported with the educational or clinical aspects of supervision, what is required at ARCP or within a portfolio, but the non-clinical aspects can be more difficult.

As supervisors, senior doctors are asked to provide both clinical and pastoral support. Trainees also can, at times, struggle themselves and turn to senior clinicians for support. Sometimes this is well within our skill set, but other times we are either overwhelmed ourselves, or it is something we feel less skilled or comfortable in managing.

For support with supervising juniors, there are several people who you can go to for assistance:

- Colleagues within your team who may have more experience with supervision
- College Tutors or Foundation Programme Directors (dependant on which training level the trainee is)
- Pastoral Tutors – tsdft.pastoraltutors@nhs.net
- SuppoRRT Champion – tsdft.supporttchampion@nhs.net
- Associate Director of Medical Education for Support – maria.saunders@nhs.net
- Director of Medical Education - jacqueline.rees-lee@nhs.net
- Peninsula Support Unit - https://peninsuladeanery.nhs.uk/about-us/professional-support-and-well-being-south-west/

What to do if you are concerned about a trainee's mental health?

If you are worried about a trainee's mental health, particularly if they have discussed self-harm or suicide, it can be difficult to know what to do. In the first instance, openly discuss this with them and encourage them to seek help.

Help them to decide what they need to do next, this could be encouraging them to see their GP or a friend, or if you have significant concerns about suicide risk, you can speak to the Liaison Psychiatry Consultant for advice, during working hours. Otherwise the normal routes for accessing support out of hours exist, these are the out of hours GP, 111 and the DPT Single Point of Access (SPA) 0300 5555000, all of these options offer triage and arrange suitable assessment. In extremis, they could attend the Emergency Department and be seen there by the Liaison Psychiatry team. If you have significant concerns, and they refuse to seek help, you have a duty of care to escalate your concerns. Although this will feel difficult, you must breach their confidentiality if you have significant concerns that they may be a risk to themselves, or others, as you would for a patient.

This is a rare situation, but it is important to know what to do if you find yourself in this position.

Assertiveness, Professional Behaviour, Bullying and Undermining

At Torbay Hospital we want to continue to develop a culture where all staff can work and contribute without feeling undermined. We want to encourage professional behaviour and identify and support those witnessing or experiencing undermining behaviour. We are also aware that, when people are under pressure or stressed, they can act in ways that are unacceptable and may need support too.

Are you being bullied? Sometimes we can feel uncomfortable with the way we are being treated, or with some behaviours we witness. Any member of a team can be affected by poor behaviour within the team. The perpetrator may be senior or junior to the individual being affected.

Is someone's behaviour towards you bullying or just challenging? Everyone can have a bad day, when they say something they regret. Persistent behaviour which makes you feel intimidated, reluctant to contribute or inadequate, is bullying.

What are the signs that you are experiencing bullying or harassment? These situations may be your experience, or you may witness a colleague in this situation

- You are avoiding a colleague as you know they will make remarks about you
- You feel targeted by one person, and the rest of the team don't support you when that person is present
- You feel too scared or intimidated to contribute to a discussion or raise a question
- You notice that a team member uses a different tone of voice when speaking to you
- Someone in the team often raises their voice or uses bad language so that the team try to avoid triggering this behaviour and try to conceal it
- You find yourself treating others badly, so that you are not proud of how you have behaved

What can you do?

- **Speak up** and politely challenge the behaviour if you feel empowered to.
- **Report it**. Speak to a clinical lead or line manager. Document every interaction. If unsure, or needing support, speak to the Freedom to Speak Up Guardians
- **Reflect** on your own behaviour – see below
- **Educate and develop**. Consider an online or face to face course for assertiveness or diffusing undermining interactions.

How does your behaviour impact on others? Are you a bully?

- Do you listen to all the other members of the team?
- Do members of the team come to you with suggestions?
- Does your sense of humour involve jokes that are racist, homophobic or sexist?
- Do you always apologise if you lose your temper?
- Do your colleagues look you in the eye?
- Do you blame others for problems that occur?
- Does banter form a big part of your interaction with others? How does that make others feel?

Points of Contact for Support

Health and Wellbeing:

- **Employee Assistance Programme (EAP)** – for emotional support, stress, anxiety, problems with careers, money, legal rights and counselling - 0800 031 4674 or for further information https://tsdft.optimise.health/
- **Occupational Health:** - 01803 653489 A referral can be made by your practice manager
- **Needlestick Hotline**: - 07768 560068
- **Your GP.** Find a GP here: https://www.nhs.uk/service-search/find-a-GP
- **Trust-wide Health and Wellbeing options** via health and wellbeing page on ICON network

Mental Health:

- **Talkworks** (previously Depression and Anxiety Services) https://www.talkworks.dpt.nhs.uk/nhs-mental-health-support/nhs-social-care-worker-support or 03005553344.
- **BMA wellbeing support service:** Offering telephone counselling or peer support to all doctors (you do not have to be a member of the BMA) 0330 123 1245
- **Practitioner Health Programme:** https://www.practitionerhealth.nhs.uk/ is now open for doctors across the UK. There are a number of resources on their website and they also offer a text support service, text SHOUT to 85258.
- **DocHealth:** https://www.dochealth.org.uk/ is a confidential, not for profit, psychotherapeutic consultation service for all doctors.
- **Samaritans**: call 116123 or visit www.samaritans.org

Websites with useful resources:

- https://www.aomrc.org.uk/supportfordoctors/
- https://www.gmc-uk.org/news/coronavirus/coronavirus-wellbeing-resources-for-doctors
- https://www.bma.org.uk/advice-and-support/your-wellbeing
- https://doctors-in-distress.org.uk/useful-resources/
- Most of the Royal Colleges also have resources on them, so look up your relevant College and see what options they have

Section 7 – Statement of Compliance:

The Executive Board of Torbay and South Devon NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of designated body: Torbay and South Devon NHS Foundation Trust

Name: ---------- Signed: ----------

Role: ----------

Date: ----------

Report to the Trust Board of Directors			
Report title: Annual Infection Prevention and Control Report 2020/21			Meeting date: 28th July 2021
Report appendix	Four appendices detailing IPC work in 2020/21 included for assurance: a) Compliance with PHE and NHSEI key COVID 19 guidance b) Tables summarising COVID 19 outbreaks in inpatients across TSDFT in i) October 2020 and ii) January 2021 c) *Clostridium difficile* infections recorded within TSDFT 2020/21 d) Antimicrobial plan 2020/21		
Report sponsor	Chief Nurse		
Report author	Director of Infection Prevention and Control		
Report provenance	Infection Prevention and Control Group		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide the Board with information on ICO performance across a broad range of infection prevention and control issues. The report provides assurance that suitable processes are being employed to prevent and control infections.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve the Annual Infection Prevention Control 2020/21		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	X	**Risk score**	16
Risk Register		**Risk score**	

BAF Ref 4: To provide safe, quality patient care and achieve best patient experience

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

The Board is asked to note and support IPC work as everyone's business. This work is of central & core importance to our business in health and care, forced into the forefront of work in 2020/21 with the COVID 19 Pandemic.

Report title: Infection Prevention & Control Annual Report 2020/21		**Meeting date: 28th July 2021**
Report sponsor	Chief Nurse	
Report author	DIPC Microbiologist and Consultant in Infection Control Lead Infection Prevention & Control Nurse	

Infection Prevention & Control Annual Report 2020/21
and Annual Forward Plan 2021/22

Dr Joanne Watson DIPC
Dr Selina Hoque Microbiologist and Consultant in Infection Control
Mrs L Kelly Lead Infection Prevention & Control Nurse

Ratified Infection Prevention and Control Group July 2021
Board date 28 July 2021

Contents

1. Key Points and Executive Summary

The data in this report are for the period 1st April 2020 to 31st March 2021, thus spanning the height of the first wave of COVID 19 to the end of the second wave. COVID 19 has been the dominant infection for IPC in the last twelve months as we have responded and learnt about this new virus during this time.

A summary of the contribution of Infection Prevention & Control (IPC) to our ICO's response is included in this report. At present IPC have a crucial role in the return of pre-pandemic activity across the ICO whilst maintaining preparedness for any increase COVID 19 cases and ensuring more traditional infection control standards are delivered to the highest possible level.

The year has seen successes and challenges some of which were novel to our experienced IPC Team. Points for both are highlighted below and described in more detail throughout the report. Section 12 outlines how we have taken the opportunity to reflect and refocus our efforts to prevent as many infections as possible with our forward-looking improvement plan 'Journey to Excellence'.

Highlights:

<u>COVID 19 related</u>

- Covid 19 – our response as a whole ICO is to be commended and recorded. We learnt much about ourselves and our functions through our responses.
- The significant changes to our estate to contain the infection, limiting spread etc were inventive and appropriate in the main as demonstrated by a low nosocomial infection rate.
- Our microbiology laboratory has performed outstandingly well during the Pandemic and continues with exemplary performance. The laboratory staff provided (provide) one of the fastest turnaround times for a COVID 19 tests and throughout have served staff testing and care home testing. A major resource in our response to limiting infections
- Exemplary working with care homes to prevent COVID 19 spread; multiple examples of support to our local care homes working with Devon CCG and public health to provide IPC essential advice immediately and/ or proactively
- Vaccination responses have been at the highest level for us in 2020-21:
    - Flu vaccination achieved >70% for the first time in a shortened window
    - COVID 19 vaccination rates across staff groups very high >90% double vaccination achieved in 2021

<u>Standard IPC issues to highlight</u>

- Two MRSA bacteraemias reported in 2021. These have been investigated with actions taken to improve the causal factors identified
- Gram negative bacteraemia incidence fell during 2020-21; in line with national target to reduce by 50% between 2019 and 2024
- *Clostridium difficile* infections increased. This is in line with the national situation
- Antimicrobial resistance surveillance is on-going with lower incidence in our ICO than national picture.
- Two WTE vacancies for consultant microbiologists puts our current two consultants under considerable pressure especially in our current times

Assurance

Policy/ Statutory Responsibility	Annual Performance	Gaps identified with mitigations made
COVID 19 – compliance with national/ regional processes	Review included in section 3; essentially compliant with regulations with COVID 19 BAF reviewed, understood and monitored	Ongoing monitoring and adjustments made with further updates and learning on COVID 19
Clostridium difficile – external trajectory	55 attributable cases against a 36 trajectory (carry over of 2019/20 target due to official standing down of this standard in response to COVID 19) 4 lapses in care identified through post-infection review processes	Quality Improvement programme to improve management of these cases with aim to have no lapses in care identified with these reportable cases
MRSA bacteraemia- NHSE/I 'zero tolerance' approach	2 cases in 2020/21 with factors contributing to these identified following post infection review processes	Support for the PICC Team regarding appropriate space for their work
Reduction in Gram negative Bacteraemia	~20% reduction in GNB in 2020/21 compared to previous year; national target to improve position annually	Lower number of people admitted in 2020/21 acknowledged.

2. Requests to the Quality Assurance Committee and Board

2.1 The Committee and Board is asked to note and consider the contents of this report and raise any issues of concern or outline any specific action they request to the Chief Nurse as the Executive Lead.

2.2. The Committee and Board is asked to confirm the following:

- The continued role of Dr Joanne Watson as the Director of Infection Prevention and Control
- Support to ensure infection prevention and control remains a foremost organisational priority as infection prevention and control is everyone's business

3. COVID 19 Summary of our IPC Responses

The year 2020 will be remembered for the start of the global pandemic of COVID 19, as a year that changed our lives dramatically. It has brought infection prevention and control measures to the forefront in daily life both within our health and care settings as well as our homes and lives outside of work. The responses required to control the virus have drawn considerable resource and focus from all departments and professions across our ICO.

Included in this report is an overview of key IPC areas of focus in the COVID 19 response. The work was wide ranging as services are provided to both our ICO as well as partners in local care homes and primary care. The overview starts with a table below that focuses on key tactics which influenced IPC approaches as well as developing these so as to support the operational functionality of the ICO. After the

table there are summaries of key areas which have worked together to manage and control this infection. Included in Appendix A1 is a table summarising key national policies/ guidance around IPC and a description of our response and overall compliance. The COVID 19 BAF is available for oversight and assurance.

3.1 Table summarising key points of responses to COVID during 2020/21

	Q1 Apr-Jun 2020	**Q2 Jul-Sep 2020**	**Q3 Oct-Dec 2020**	**Q4 Jan-Mar 2021**
National Phase	Wave 1 Lockdown 1	Semi-release	Wave 2 begins Lockdown 2 Nov	Wave 2 Lockdown 3
Approx max incidence in Torbay	Not available	5-10/100000	100/ 100000	300/100000 (compared to ~1000/100000 in London)
No of COVID 19 tests performed by TSD microbiology (positive numbers in brackets)	12089 (269)	27961 (57) (testing on discharge for care home now standard)	39865 (814) (inpatient testing routine alternate days for first 7 days of admission- now standard)	42328 (894)
Inpatients in TSDFT	63 inpatients March 2020	0 June- July	579 patients through Cromie ward with additional people on ICU 4 admissions to Paediatrics including 1 baby on the Special Care Baby Unit	
Total inpatients COVID 19 deaths in ICO = 111 people				
Escalation Plan across TBH (levels 1-4)	Level 3 COVID Expand	Level 1 COVID Decant	Level 3 COVID Expand	Level 3 COVID Expand
Estate used for direct COVID Care including Estate expansion changes – wards involved	ED expanded into DSU Expanded ICU into Theatre Recovery Wards receiving COVID +ve people: EAU3 Forrest Cromie Allerton Totnes with Paediatric expansion into Turner ward	Restoration with return of oncology/ haematology Inpatient care to TBH MRU function established on Forrest Ward	MRU in DSU Expanded ICU into SRU COVID +ve people: Cromie Ella Rowcroft Brixham Totnes with Paediatric expansion into Ricky Grant Day-care Unit • Nightingale Exeter	MRU in DSU Expanded ICU Wards receiving COVID +ve people: Cromie Nightingale Brixham with Paediatric expansion into Ricky Grant and RGDU moved to McCullum Ward

	Oncology moved to Newton Abbot (Green Site)		opened Dec 2020	
Personal Protective Equipment including Mask Fit Testing	National issue during Wave 1 Landmark directive- *PHE guidance April 2020 to use a surgical mask rather than FFP3 mask for non-aerosol generating* procedures (standard care) Mask fit testing established, expanded and maintained throughout trainer programme	15th June 2020 Landmark directive – *wearing a fluid resistant surgical mask in hospital standard practice*	• PPE supply chain issues mainly resolved • Ongoing requirement for mask-fitting for new or returning staff, supply changes • Regular calls by Unions and Royal Colleges to review PHE guidance. • TSDFT follows PHE guidance with exception of level 3 PPE used during cardiac resuscitation as recommended by the Cardiac Resuscitation Council; policy determined by Medical Director & Chief Nurse	
Covid secure pathways	Red, Amber and Green pathways for in and outpatients set up in all sites across multiple specialties including theatres & ICU	Blue (previously Red) Covid pathways and Green/ Amber pathways established and maintained. Regular review required with changing estates and relative risk balancing e.g. paediatric admission pathways as department expanded into Ricky Grant for Winter due to concerns re safety with possibility of aerosol generating procedures increasing due to winter season of RSV (did not materialise). Note 3 short admissions with COVID 19 for children over winter only; one baby on SCBU. After first lockdown completed, COVID secure workplaces identified as a concept with PHE and Health & Safety Guidance on how to establish COVID secure sites at work. Audited by matrons in clinical areas and managers in non-clinical		
Equity during COVID 19	Identified BAME staff at higher risk of death from COVID. Letter to colleagues for risk assessment and further support	Risk assessments for all staff regarding suitability of work and exposure to COVID 19 BAME staff (Spring 2020). Higher risk people invited first for vaccination programme (Jan 2021 onwards) IPC team advising staff members with high level risk assessments in terms of actions to mitigate risk or change work. In many organisations this was carried out through occupational health services. Advice given to union representatives		

		around IPC issues and how these were perceived in terms of risk for different groups.

3.2 In addition to the above, IPC staff and connected services worked with remarkable dedication on key issues for TSDFT in terms on our effective responses to the Pandemic. There were some outstanding areas described below. The order of these connects to the journey travelled by people within our Organisation:

Tactical planning of pathways for staff and service user flow For every estates move, site and service the flow of people had to be considered. The separation of blue pathways (Covid positive) at every stage had to be planned for. IPC team members planned with colleagues and put mitigations in place when separation was not complete. Adherence to these pathways stood the ICO in good stead, as evidenced by low levels of nosocomial transmission. The careful planning of how our community sites would be used for inpatient care and then deployed with a willingness to look again contributed to growing confidence in our IPC measures.

These tactics extended to our care home partnerships as well. Advice for putting in effective IPC during outbreaks in care homes both supported the care homes and grew confidence. Lynn Kelly's (Lead IPC Nurse) models (virtual visits) are used across other Devon areas in care homes and her work with the local prison service was shared as good practice.

Testing for COVID 19 The testing for COVID 19 developed rapidly with new services and service expansion happening at pace throughout the year. Initially there was a shortage of testing availability. Even during these lean times though our laboratory staff, led by Gilly Hewlett, was able to secure and set up high quality, fast turnaround testing. Excellence in laboratory services include:

- Staff testing established early in the first wave; first in Devon
- Consistently one of the fastest swab to result turnaround times for COVID 19 testing in the South West; vital part of flow as this excellence contributes significantly to people being placed on the correct pathways
- Pillar 1 testing (acute provider sites) supported care home outbreaks with significantly faster turnaround times reduction in spread of infection

Staff in the microbiology lab supported a 24/7 model despite vacancies in this staff group and unfamiliarity with these initially new tests. Recently (May 2021) the 150,000 COVID 19 test mark was reached. The high-quality services continue.

Torbay PHE and IPC team set up a local track and trace system manging to identify contacts and isolate quicker than national Track and Trace. Local partnership work strengthened due to the Pandemic here.

Gilly Hewlett was also seconded over winter to set up the new Lighthouse Lab for COVID testing in Plymouth.

Cleaning and Hotel Services have responded remarkably well throughout the Pandemic ensuring protocols for high standards of cleaning are followed. COVID 19 requires enhanced cleaning in the ward areas where COVID 19 people are being treated. Twice daily cleaning of public areas and blue pathways are normal practice for COVID 19. During the height of wave 2 with the outbreak areas as well, much of

the ICO required twice daily cleaning with appropriate viricidal agents. PHE Guidance on cleaning is followed and there is a strong relationship between IPC and cleaning & hotel services. We would like to extend our thanks to these vital members of staff who have worked so hard to keep us all safer.

Outbreaks of COVID 19 in staff groups TSDFT was one of the first in the South West to have a staff outbreak (September 2020) after the first lockdown finished. This was in the ED department with action taken to contain as quickly as possible. With subsequent inpatient ward outbreaks in October (Cheetham Hill, Midgley and Brixham) we were to learn at pace how to manage these; staff working when symptomatic was the common start to outbreaks which connects with the importance of staff testing.

As a result of the October outbreaks we developed a management outbreak plan which when applied in the second wave (January 2021), the containment was quicker with a 50% reduction in the number of staff affected and those receiving inpatient care. Analysis of our IPC actions and on-going continual learning we have been able to demonstrate that we are learning from initial experience and application of national guidance to further protect everyone (staff, service-users and visitors). Appendix B contains summary analysis of the two major outbreaks occurrences occurring at the beginning and height of wave 2. A link in Appendix B to our outbreak management plan is included for reference.

Our nosocomial rate was at the bottom end of the range for NSHE acute provider organisations. Key learning for us included:

- Early ward closure- one positive patient precipitated this
- Frequent testing (nearly daily) for all – staff and patients
- Keep contacts together, moving them led to more infection as happened with Brixham (October 2020)

Staff Testing Early identification of COVID 19 including asymptomatic people is another way for infection transmission to be decreased. The NHS staff testing programme began in November 2021. Initially this was for those staff in direct contact with service users. The programme has been widened to all staff in 2021.

The Lateral Flow Test (LFT) approach has been widely adopted and remains TSDFT's chosen method. This is a voluntary programme with testing carried out by the individual staff member twice a week. The result is recorded centrally by the staff member. There has been high uptake of the testing. Recording is an issue as we this dropping off now: similar to the national picture.

Vaccination Programme at TSDFT Our vaccination centre opened in the Horizon Centre on 4 January and closed 13 May (short break March 1-21). In this time around 34,350 vaccines (first and second doses) were administered with over 90% of our staff engaging with our programme. The majority of our staff received their first dose (Pfizer vaccine) within 4 weeks of the centre opening.

We worked with our partners in the CCG, Devon County Council and Torbay Council to vaccinate health and social care staff, patients and carers, and other key workers such as opticians, pharmacists, funeral directors etc.
We provided a bedside vaccination service, however the numbers for this were very low. We continue to provide the last batch of second vaccinations, and run an at-

risk clinic with an anaesthetist for those who have been identified as having severe allergies. This was a great collaborative programme providing a sense of joy and accomplishment at work with support from many different teams to make possible from car parking attendants to IT. This programme has contributed to the high uptake of vaccination in the local population (80% first dose in Torbay over 17 population, end of May 2021, 65% double dose administered)

3.3 In response to the COVID 19 Pandemic IPC guidance has been disseminated by various bodies. Our prime sources of guidance and direction have been Public Health England (guidance has been for the four countries to the UK) and NHS England/ Improvement. Appendix A shows our compliance to major IPC guidance from central bodies (Public Health England, NHSEI etc)

4. Performance against alert organisms and infections including antimicrobial resistance

4.1 Clostridium difficile

Healthcare related *C. difficile* infections continue to be a significant safety concern with a renewed focus given the national rise in incidence seen in the last year (2020-21 and ongoing). This rise is related to the COVID Pandemic in several ways, which include:

- Changes in threshold for treating infections with antibiotics
- Use of alcohol gel for hand hygiene versus hand washing with soap (spores not killed by alcohol hand gel)
- Multiple ward moves in the Torbay site- associated with higher *C. difficile* infections
- High rate of admissions leading to faster turnaround of bed occupancy

The external objective for reportable cases of *C. difficile* for 2020/21 was stood down due to the COVID Pandemic. We have reported below against the target set for 2019/20 and show a similar performance to 2019/20. We did not meet the target (55 cases against a target of 36 cases). It is important to note that the target set is for an acute-care provider and not an ICO with ~25% of the total bed capacity as community hospital beds with an inherent higher risk of *C. difficile* infections for people in these care-settings.

Attributable cases for our ICO are those that have *C. difficile* toxin detected in the stool (enzyme-linked immunoassay or EIA positive) within specific time conditions. Below is shown data on these cases in 2020/21. The ICO must determine and report to Devon CCG any reportable cases deemed to involve a lapse in care.

Hospital onset healthcare associated (HOHA): cases that are detected in the hospital > 48 hours after admission = 24 cases

After Action Reviews (AARs) are carried out on all *C. difficile* HOHA. Four of these cases were identified as lapses in care and increasing the risk of infection; all related to lapses in good antibiotic prescribing.

Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks = 31 cases

2019/20 C. difficile target was 36 – this year our total (HOHA + COHA) = 55 (52 2019/20)

Our results on *C. difficile* infections and the increased risk noted in current times means that we will be focusing on improving these results in the coming year. We know that antibiotic prescribing can be improved and with this a decreased risk in *C. difficile* infections.

Of particular note in the time period of this Annual Report there has been one increased incidence of *C. difficile* - defined as more than one patient with of *C. difficile* on a ward within 28 days. In March 2021, six in-patients (2 EIA toxin positive) were diagnosed with *C. difficile* infection in George Earle with transfers from this ward to Newton Abbot Hospital also affected. This cluster was managed efficiently with all actions satisfactorily completed and no further spread across TSDFT.

There were no cases during 2020/21 where *C. difficile* was cited as a cause of death on the final death certificate.

4.2 MRSA & MSSA Blood Stream Infections (BSI)

MRSA- Meticillin Resistant *Staphylococcus aureus*: NHS England has a 'zero-tolerance' approach to MRSA bacteraemia meaning that the ICO objective is for zero attributable cases assigned to us. In 2020/21 there have been two MRSA bacteraemia or BSI which were both connected with peripheral central line insertions; a specialised, long-term form on intravenous access.
AAR were carried out for both cases. Lymphoedema was a contributory factor along with these infections being associated with a specialised type of cannula. Important actions have included:

- the introduction of a passport for the care and maintenance of these specialised peripheral lines
- specialist care for these lines when a person has a complicating issue such as lymphoedema
- the service for the insertion of these semi-permanent intravenous access lines has moved on several occasions in the last year due to changes required for COVID IPC measures to be in place. Work in continuing to improve the accommodation for this service
- prefilled syringes of flushing agent used to keep the cannula open are going to be procured

MSSA- Meticillin Sensitive *Staphylococcus aureus*: Cases of MSSA are reportable to PHE but there is no formal objective for the ICO. The ICO has seen a stable incidence of attributable MSSA bacteraemia in 2020/21 compared to the previous year. Up till the end of March 2020, the ICO had a total of 62 MSSA cases, 14 of which were attributable. For the same period in the previous reporting year the figures were 58 and 13.

4.3 Gram Negative Bacteraemia

There is a national ambition for England to reduce the healthcare - attributable Gram-negative bacteraemia (GNB) by 25% by 2020/21 and by 50% by 2023/24. For the purpose of this ambitious goal GNB are defined as three organisms: *Escherichia coli* (*E. Coli*), *Klebsiella* (all species) and *Pseudomonas aeroginosa* as these constiture a majority of reported GNB. Of these three, *E.coli* are by far the most numerous, many of which are community onset with health care associations through the GP.

Since 2018, PHE assigned these infections to community or assigned to a provider organisation based on whether the positive culture was indentifed within 48 hours of admission. For 2020/21 the numbers of ICO assigned cases were *E. coli* 18 (2019/20 = 21); *Klebsiella* 2 (7) and *P. aeroginosa* 5 (3). The rates of infection are falling in line with the national ambition and quality improvement work for IPC will focus on this to improve performance further.

4.4 Antibiotic Resistance

E. Coli BSI

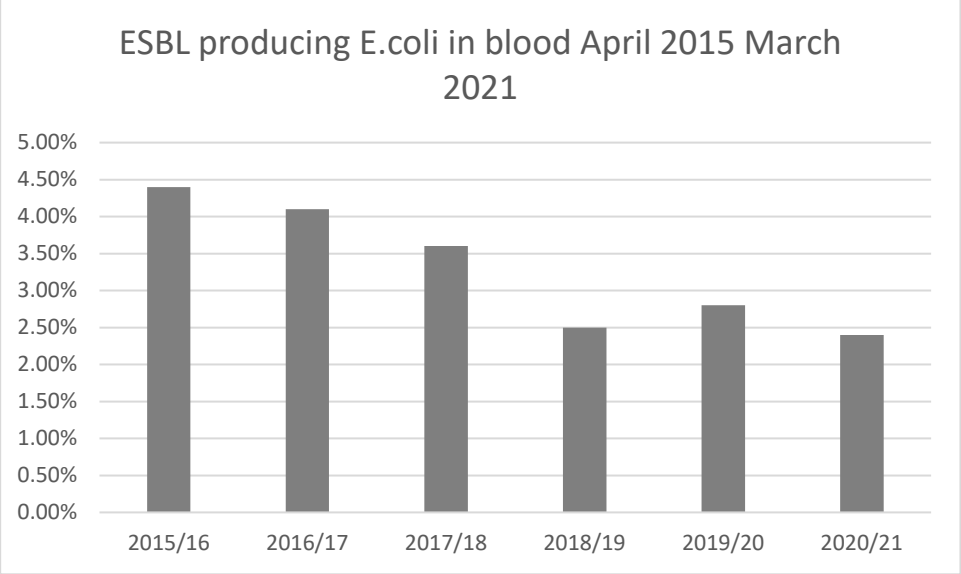
Extended Spectrum Beta-Lactamase (ESBL) producing bacteria *E. Coli* in blood cultures are one of the markers of antibiotic resistance in bacteria and by definition are resistant to 3rd generation cephalosporins.

Below the graph shows the total rate of ESBLs in blood cultures most of the E. coli BSI are from admissions from the community (5) at a rate of 2.2% and fewer are HCAI occurring 48 hours after admission (2) at a rate of 2.9%: the overall rate is 2.4%. This is lower than the 2.8% the previous year.

In the UK, the English Surveillance Programme for Antimicrobial Utilisation Report (ESPAUR) Report 2019-20 reported the South of England to have a resistance rate, to 3rd generation cephalosporins, in blood stream infections (BSI) of around 15% in E. coli so it can be seen that TSDFT has antibiotic resistance rates well below the national average.

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936199/ESPAUR_Report_2019-20.pdf)

ESBL producing E. coli blood stream infections. April 2015 March 2021



Antibiotic Resistance to First Line Sepsis Treatment

TSDFT's recommendations for first-line sepsis treatment is Tazocin and Gentamicin and the rate of E. coli resistance to this combination is 0.8% so this remains an effective treatment combination for Sepsis. This is an increase in resistance compared to the previous two years when the resistance rate were 0.7% (both years).

Carbapenemase Producing Enterobacteriaciae (CPE)

These are bacteria that have resistance mechanisms against the third-line antibiotics. This means that if a patient develops a serious infection with a CPE then treatment is likely to be sub-optimal. In 2020/21 there was zero CPE acquired at TSDFT.

5. Antimicrobial Stewardship

5.1 The prescribing policy is documented in CG1098. Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) and paediatrics (CG1118) on the Trust intranet site and the Apple and Android App. called *BugBuster3000*. The TSDFT three year Antimicrobial Strategy is due to be updated this coming year (2021/22) with a working version summer 2021. Appendix D shows the completion details of the Antimicrobial Plan in the second half of 2020/21 with the outline of the plan for the coming year at the end of this section.

5.2 The Antimicrobial Team (AMT) consists of a consultant microbiologist and a pharmacist. However, the consultant microbiologist left TSDFT in December 2020; there are two WTE vacant consultant microbiologist posts at TSDFT. These vacancies are of significance to our organisation and on the risk register. Mitigation is in place with this also being an important test of the SEND clinical network as combined on call to give out of hours coverage is required by CQC. The 50% vacancy with the need for 24/7 on call being provided by two consultants limits the scope of work which is possible; hence the longer time frame for updating our Antimicrobial Strategy.

5.3 The use of antimicrobial agents safely and effectively is an important safety aspect of care provided. The use is audited monthly with overall TSDFT compliance at 82%

(target >85%). This is a focus for the up coming year in terms of improvement. Ward doctors are the main prescribers of antibiotics within the ICO and a programme of work with them having responsibility for improving the audit data is a key change we will be focusing on.

5.6 National bench-marking shows that our overall use of antibiotics appears appropriate. We are in line with similar trusts, though direct comparisons are blunt tools as for example, no account of age is included in the PHE Fingertips data and our community hospital use is not included.

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

Indicator (rate per 1000 admissions)	TSDFT	England same Trust type	Comment on Benchmark
Total antibiotic prescribing DDDs **2019/20**	4,746	4,798	Green
Total antibiotic prescribing DDDs Q2 **2020/21**	4,642	4,498	Amber
Carbapenem prescribing DDDs **2019/20**	76	67	Amber
Carbapenem prescribing DDDs Q2 **2020/21**	66	70	Green

5.7 The AMT's Antimicrobial Stewardship Annual Forward Plan: April 2021 to March 2022

Objective	**Completion**
Establish a system for surveillance of antimicrobial resistance: • Continue to calculate local resistance rates for antimicrobials in current guidelines and monitor annually. • Present results in the Annual Antimicrobial Stewardship Report.	April 2022
Establish a Job Plan for the Antimicrobial Pharmacist: • Ensuring that sufficient time is allocated to Antimicrobial Stewardship • Include sending out Saving Lives results with Action plans and check that these are completed.	June 2021
Review Trust antibiotic guidelines: • Literature search and review of evidence re efficacy and safety of antimicrobial • Discuss guidelines with stakeholders • Ensure compliance with NICE prescribing guidelines and document the reason for any exceptions	March 2022

• Aim to align with those guidelines of East & North Devon as part of the work towards a SEND Microbiology service.	
Compliance with CQC's Antimicrobial Stewardship Quality Standards: • Discuss with Medical, Surgical, Gynae, Paediatric, T&O, Acute Medicine & Respiratory consultants, interested in Antimicrobial prescribing, the setting up of an Antimicrobial Stewardship Group. • Set Action plans for prescribers to follow so that all areas score 85% in their Saving Lives monthly Antimicrobial Audits.	March 2022
Update Antimicrobial 3 year Strategy and to include Horizon scanning	June 2021

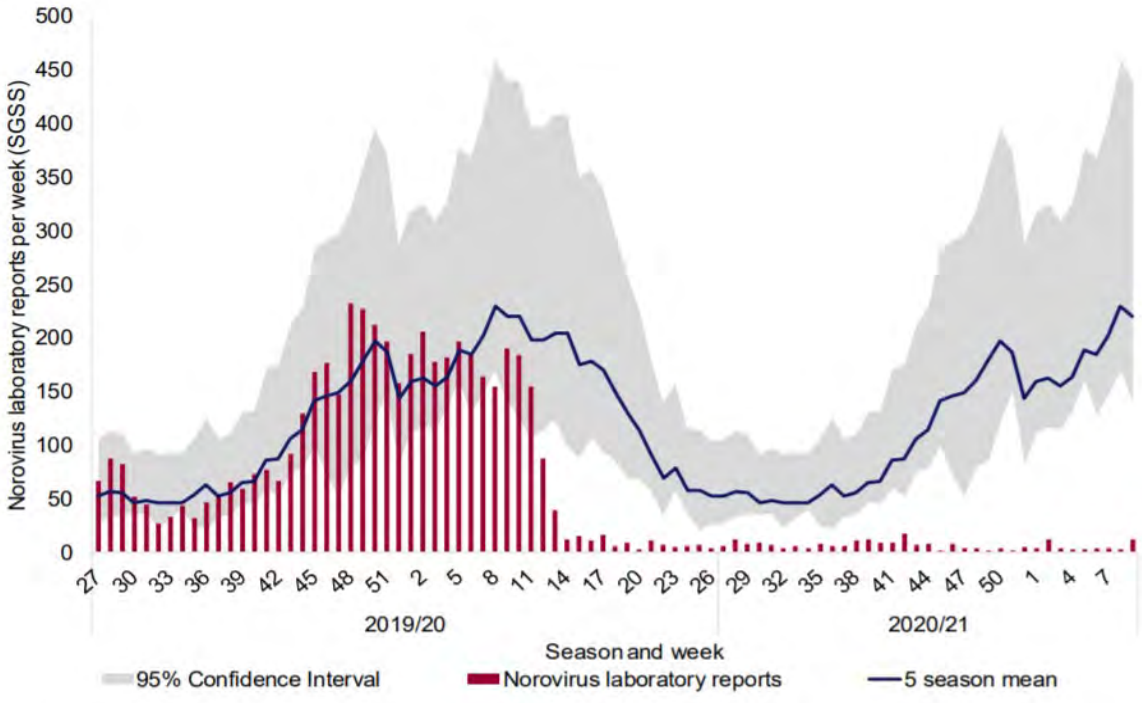
6. Seasonal Viral Infections (not COVID 19)

6.1 Norovirus and other Viral Gastroenteritis

From April 2020 to March 2021 there was one ward closure due to viral gastroenteritis. This compares with 2019/20 which had 4 ward closures and 2018/19 which had no ward closures.

In 2020/21 there was a near incredulous fall in Norovirus circulating in the communities compared to the standard incidence. Public health precautions and national lockdowns including the closure of schools contributed to less transmission of our usual viruses. The risk of significantly increased infection rates in 2021/22 is a focus of attention now as this has been seen in parts of Australia.

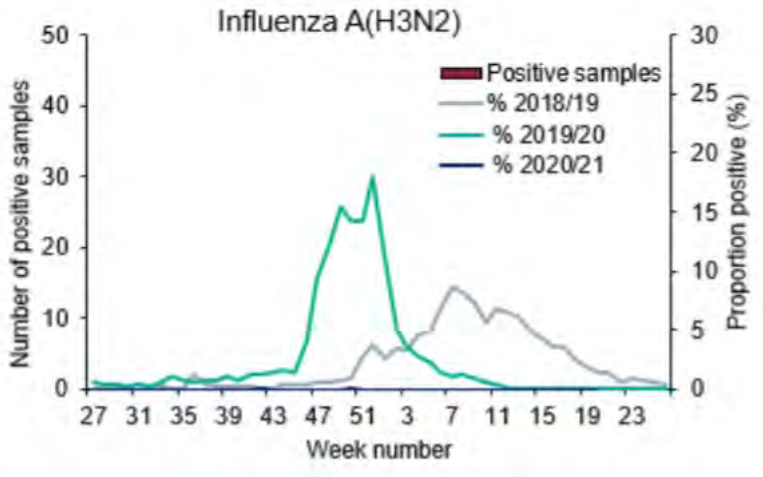
PHE's Summary of confirmed cases of Norovirus from 2019/20 to 2020/21 with five year rolling average displayed for comparison



6.2 Influenza

A similar picture with influenza (flu) played out during the winter of 2020/21. This was predicted given that the Southern Hemisphere experienced near zero levels of flu (all types) throughout their Winter; we mirror their season in standard years.

The graph below for PHE data describes confirmed cases of the dominant flu strain in 2019/20, there are so few cases of the reporting year that the line is not apparent as it runs along the X axis.



6.3 Staff Flu Vaccination Programme

The staff vaccination programme succeeded in vaccinating 70.42% of frontline staff. An extensive programme was run along similar lines to previous years with multiple access points for staff to attend. The percentage of frontline staff vaccinated is the highest in recent years, in the shortest programme run as the COVID vaccination programme was to take precedence.

The flu vaccination programme for 2021/22 will need particular attention and support as we are predicted to have increased risk to the coming season after so low incidence last winter.

7. Surveillance, Audit and Mandatory Training in Infection Prevention and Control

7.1 Monthly Saving Lives Audits & Hand Hygiene Audits

The IPC Team perform these audits for:

- Hand hygiene
- Care of peripherally inserted cannulas,
- Care of centrally inserted lines
- Care of urinary catheters.

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

Data collection in the twelve months of this report was affected by the initial focus on COVID (April 2020 no data collected). The multiple ward moves within our ICO were not reflected in the IT reporting system. Thus continuity of results was not recorded and a decision made not to report formally on results. Interpretation overall of what data was collected is that standards were able to be followed through with and care of urinary catheters is the area for focus and improvement.

7.2 Surgical Site Infection Surveillance (SSIS)

The national surveillance is run by PHE and every year it is compulsory to do total hip replacement (THR) and total knee replacement (TKR) SSIS. IPC work with Trauma & Orthopaedics to run a lab-based ward SSIS using internationally recognised definitions and post-discharge surveillance for a year.

National SSIS data from PHE

Date SSIS done	TSDFT infection rate	National infection rate
THR 2020	0%	~1%
TKR 2020	0%	~1%

7.3 Mandatory Training

The IPC Team work with the Education & Training Team in the important area of mandatory training for IPC. Across our ICO we have an acceptable level of training compliance averaging throughout 2020/21 85.7%. This is for levels 1 & 2 IPC mandatory training. Level 2 requires a focus on it as this level averages 82.2%.

8. Report on Community based IPC Activity

8.1 As an ICO our IPC team work across the hospital and out of hospital sites. Since April 2020 our IPC team has been contracted through Devon CCG to provide IPC advice to our local Care Homes as well. With the COVID Pandemic and the way this affected us here in the UK with significant spread of infection through our Care Homes, this relationship has been particularly important in the last year. It is a source of pride in our ICO on how we responded to the COVID infections in care homes of which the IPC Team were a key part of these responses. Critical interventions by our staff (operational, clinical and IPC) included:

- Sharing of PPE during wave 1 when the supply chain was weak and national shortages were common
- Immediate and practical responses to Care Homes hit hard (staff and residents) with the CCG to put our IPC team into set up containment practices
- Our staff working (delivering care) in affected care homes
- PCR testing provided through TSDFT microbiology lab for same day results; standard practice is to use the PHE Laboratory services where results available at 48 hours or more

These and other immediate responses limited the spread and prevented care collapsing in these homes. Similar responses happened in waves 1 and 2 of COVID with daily information through the Torbay Quality Assurance & Improvement Team (QAIT) Team on COVID infections thus early information that a home was at risk which precipitated immediate IPC intervention. The relationships and trust developing between the care homes and our teams has reaped benefits. A recent Care Home work shop on general IPC measures by our IPC Lead Nurse was attended by over 50 Care Homes and was well received; this is an example of how ongoing engagement has improved through working together.

8.2 Other Community IPC Work

Community Hospitals all perform and submit the same Saving Lives and Hand Hygiene Audits as detailed in section 7 above. The same monitoring and actions are required in these settings as with Torbay Hospital, our acute site.
Domiciliary Care and Care Homes – our IPC work extends to these areas and involves all aspects of IPC, including COVID. Work is on going in areas such as decreasing urine infections and improving catheter care in these environments with demonstrations of best practice and care. This links in with our ICO vision to be helping people to as well and independent in their own homes as possible. Prevention of UTIs at home will decrease admissions to Torbay Hospital. Surveillance of Care Homes continues and when issues are raised with these, IPC supports here as asked to by CCG/ QAIT and Torbay Council.

9. Decontamination

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

9.2 The Hospital Sterilisation & Decontamination Unit's (HSDU) Washer Disinfectors and Sterilisers for surgical instruments have all servicing and testing up to date. The Reverse Osmosis Water Systems that supply the Washer Disinfectors and Sterilisers are also serviced and satisfactory. The HSDU have an annual compliance audit carried out by a Notified Body (Société Générale de Surveillance), appointed on behalf of the MHRA. The successful 2020/21 audit shows that the HSDU continues to be accredited to the Medical Devices Directive 93/42/EEC and allows the department to continue to supply sterile medical devices outside of the Trust.

9.3 The Endoscopy Washer Disinfectors' (EWD) servicing and water tests are satisfactory. There has been an issue with cystoscopes (urology) with deposits from the cleaning process on the lens. Investigation into the causes of this problem have led to the satisfactory restoration of services here.

9.4 The annual audit and training for areas using the high-level disinfection with the Tristel (chlorine dioxide) Tri-wipe and Tristel Duo Systems was trust wide and was satisfactory.

10. Water Safety

10.1 Water Systems Management Group
This group meets quarterly to review water safety and ensure compliance with HBN 01-04. Positive results for Legionella species or *Pseudomonas aeruginosa* are subject to remedial actions, re-tested until clear and reported to the group and Capital Infrastructure and Environment Group (CIEG).

10.2 Sewage leaks in the Tower which were reported in 2019/20, have not recurred. At this time the risk of recurrent leaks is mitigated as far as it can be, assisted by the decrease in in-patient activity during the year. The case for refurbishment and

replacement of the sewage stack will be included in the Building a Brighter Future Programme as the risk remains until replacement of this core facility; see section 12 for further reference to the Building a Brighter Future Programme.)

10.3 Legionella species have been isolated in Paignton Hospital and separately in the Tower Block of Torbay Hospital. Actions taken to successfully eradicate these isolates. Surveillance remains ongoing after containment of these issues. No isolation of pathogenic Legionella species has occurred this year.

11. Ventilation

11.1 All specialist ventilation systems in theatres and other interventional departments have comprehensive maintenance monitoring with reviews by specialist engineering contractors as required. A programme of maintenance, improvement and refurbishment is followed. Theatres 1 & 2 have had the air handling units replaced in 2020/21. Within the DSU the issues with humidity have been dealt with as new chiller units have been installed, adding further improvement to the new air handling system in the previous year.

11.2 Ventilation is a known to be critical factor in infection prevention and control. Florence Nightingale herself advocated that the windows should be kept open in hospitals. Whilst the interventional departments in the main have good ventilation our older estate and inpatient wards do not have assisted ventilation. Windows not opening in both the Tower and Hetherington ward blocks have long been documented and recorded on risk registers. The complexity (height considerations, infrastructure, ward clearance requirements) and costs for replacement have resulted in these risks being held. COVID 19 has clearly brought issues around ventilation to the fore and opening windows on the wards is included in IPC good ward management and outbreak prevention principles.

Ventilation improvements are planned with the refurbishment of the Tower Block and new ward building in the Building a Brighter Future Programme; see section 12 for further reference to this important programme

12. Infection, Prevention & Control Annual Plan for 2021/2020

2020 taught us that IPC is key to keeping ourselves, our people (staff, service users, families) and our community safe. The whole IPC team is committed to building on our core work and achieving even better infection prevention/ control. We recognise that we work within the context of what we need to achieve as an anchor organisation within our community and the wider Devon Integrated Care System.

Our Vision:

In our ICO the responsibility of infection prevention and control is everyone's business. Our work is to continuously build the skills and knowledge that keep us safe from infections who ever and where ever we are in our ICO and community.

Our Goals:

- Excellence in low rates of Hospital Acquired Infections: we will achieve a 25% reduction in *alert organisms* HAI in 2021/22 (*C. difficile, GNB)*

- Excellence in staff knowledge and practice in infection prevention and control measures: we will achieve this through a variety of interventions and improvements throughout 2021/22
- Excellence in IPC measures within the Building a Brighter Future Programme as we establish plans for the rebuild/ refurbishment of Torbay Hospital

Our Measures:

- Incidence of HAI
- Attributable HAI to our ICO
- Bed closures due to HAI outbreaks
- Compliance with Saving Lives Audit & Hand Hygiene
- Antibiotic Prescribing standards
- Completion of Mandatory IPC training level 2
- Flu vaccination uptake (may include further COVID vaccinations)

Our Plan

- Journey to Excellence work – complete gap analysis on current state and actions required to improve – July 2021
- Join regional Breakthrough Series Collaboration on decreasing *C. difficile* infections with stated aim to decrease this HAI – starts July 2021
- Complete action plan to accomplish goals by 31 March 2022- building on our previous compliance work into continuous improvement
- IPC to be a central development of the Outline Business Case for the Torbay Hospital new build and refurbishment plans in our Building a Brighter Future Programme

13. Concluding Remarks

The Annual IPC Reports by DIPCs across NHS England will all read very differently to those which have gone before. It has been a year like no other for many aspects of our lives. IPC is no exception and our work has come to the forefront of health and care organisations. In this report, we have outlined responses and results of the IPC team to the COVID 19 Pandemic and our routine work.

We are taking this opportunity to develop ourselves and approaches in the coming year to improvement and building on our foundations of compliance to achieve even better results. For infection prevention and control, good looks like the continuation of business as usual (or in these times, the new norm). We will be working on this.

14. Appendices

Appendix A: Covid 19 IPC compliance status with central guidance

In response to the COVID 19 pandemic IPC guidance has been disseminated by various bodies. Most important and relevant have been Public Health England (PHE) and national/ regional NHS EI. The guidance has been updated throughout the year with constant attention applied in order to remain current in practice and compliance.

The table below summarises the current iteration of the content of guidance from the above bodies and TSDFT's compliance status.

Content Area	PHE Guidance[1]	NHS Operating Framework[2]	TSDFT Status
Organisational preparedness	Overview of organisational systems to identify and control Covid 19	Planning testing capacity, medicines supply, consumables and PPE.	Compliant
Reducing the risk of transmission of Covid 19 in the hospital setting	A description of the suite of IPC processes including practices, protocols, patient placement and movement, and use of facilities eg theatres, including aspects of engineering. Environmental management including waste cleaning, equipment and linen. Handling the deceased.	Follow PHE guidance	Compliant
Personal Protective Equipment (PPE)	Descriptions of the two levels of PPE ensemble and where and when to wear them. Includes Fit Testing and reuse and sessional use of PPE and description of the correct use of the range of PPE items.	Follow PHE guidance	Compliant: for cardiac resuscitation level 3 PPE used in line with Cardiac Resuscitation Council Guidance; PHE recommended level 2 PPE

Occupational Health and staff deployment	Principles of exclusion from work, deployment, redeployment, risk assessment, training and monitoring.	Consistency in staff allocation and avoidance of staff cross over between pathways.	Compliant
Planning, scheduling and organisation of clinical activity	Not covered in detail	Principles of patient pathways for planned and elective care, and urgent emergency care. Maximising opportunities for physical and/or visible separation between patients on different pathways. Managing asymptomatic and 'protected' (14 day isolation and test) as well as shielded patients separately from the emergency and urgent pathway. Triage, separation and testing within the emergency pathway.	Compliant
Testing of patients and staff	Not covered	Describes existing and proposed tests for patients and staff. Patient according to pathway.	Compliant
Monitoring and surveillance	Not covered	New central surveillance programs	Compliant

1. Public Health England: COVID-19 infection prevention and control guidance (updated throughout 2020/21)
2. NHS Operating framework for urgent and planned services in hospital settings during COVID-19 (updated throughout 2020/21)

Appendix B

Tables summarising COVID 19 outbreaks in inpatients across TSDFT in i) October 2020 and ii) January 2021

i) October 2020; 4 areas infecting 43 patients, 53 staff

	Emergency Dept, TBH	Cheetham Hill, TBH	Midgley, TBH	Brixham Community Hospital
Start of outbreak (index case + 1 other)	19/09/2020	8/10/2020	18/10/2020	17/10/2020
End of outbreak (28 days after start)	17/10/2020	5/11/2020	15/11/2020	14/11/2020
Total number of patients infected with COVID as a result of the outbreak	1 + contact	18 (inc those transferred to Brixham)	19 (inc those transferred to Brixham)	4 (includes Allerton patient) N.B. 13 in total (x1 Allerton, x1 Midgely, x3 Brixham & 8 Cheetham Hill)
Total no. staff contracting COVID, related to outbreak	7	7	22	25
Number of deaths within 28 days of COVID positivity (patients, as none in staff members)	0	4	3	0 deaths reported from initial ward
Index case identified	Yes- staff working with symptoms	Yes- staff working with symptoms	Not determined	Yes- staff working with symptoms
Site closed?	No (risk assessed)	Immediately: after outbreak declared	Later- bay shut initially	Immediately: after outbreak declared

ii) January 2021- 5 areas, infecting 38 patients, 19 staff

	Allerton, TBH	Simpson, TBH	Midgley, TBH	Dunlop, TBH	Dawlish, DCH
Start of outbreak (index case + 1 other)	11/01/2021	22/01/2021	21/01/2021	17/01/2021	27/01/2021
End of outbreak (28 days after last positive patient)	22/03/2021	18/02/2021	18/02/2021	13/02/2021	03/03/2021
Total number of patients infected with COVID as a result of the outbreak	8	10	2	9	9
Total no. staff contracting COVID, related to outbreak	5	2	0	9	3
Number of deaths within 28 days of COVID positivity (patients, as none in staff members)	2	2	0	4	1
Index case identified	Not determined	Patient incubating on admission	Not determined	Not determined	Unclear if TSDFT or RD&E source of HAI
Site closed?	Immediately	Staged review	Immediately	Immediately	Immediately

Appendix C
Table summarising the different types of *C. difficile* infections 2020-21

Month	HOHA	COCA	COIA	COCA
April	2	4	1	2
May	6	2	1	1
June	1	4	1	2
July	0	5 (3 community hospital)	2	2
August	2	6 (1 community hospital)	0	1
September	2	0	0	4
October	4	1	4	2
November	3	0	2	6
December	2	2	0	0
January	1	0	1	2
February	1	3 (1 community hospital)	0	5
March	1	4 1 (community hospital)	1	4
TOTAL	**24**	**31**	**13**	**31**

Appendix D
The AMT's Antimicrobial Stewardship 6-Month Plan: October 2019 – March 2020 – Actions updated in 2021

Objective	Completion
Establish a system for surveillance of antimicrobial resistance: • Create PathManager queries to monitor local resistance rates - *completed* • Calculate local resistance rates for antimicrobials in current guidelines and monitor quarterly – *This is done on an Annual basis and not quarterly because the TSDFT's resistance rates indicated by ESBLs is 2.4% and the rate for the South of England is 15%.*	31 Dec 2019 *Completed April 2021*
Review Trust antibiotic guidelines: • Review local antimicrobial resistance rates • Literature search and review of evidence re efficacy and safety of antimicrobial • Ensure optimisation of dose and duration • Ensure compliance with NICE prescribing guidelines and document the reason for any exceptions – *Completed for Respiratory Tract infections.* • Aim to reduce selection pressure for multi-drug resistant organisms	30 Mar 2020 *Ongoing plan to complete in March 2022*
Reinstate monthly antimicrobial audits: • Feed results back to ward teams • Identify any areas that require improvement and work with clinical teams to improve results	30 Nov 2020 *Completed January 2020 but further work with Teams to improve results is ongoing*
Horizon scanning: • Maintain awareness of new antimicrobials in Stage II and III trials • Evaluate need for bringing new agents on to the formulary and guidelines – *Temocillin was evaluated but breakpoints pending, not licensed and expensive*	Ongoing
Investigate alternative platforms to Bug Buster for hosting Trust guidelines – *This is with IT a suitable platform has been identified by the Microbiology consultants.*	30 Mar 2019 implement Q2 2020. *Completed but awaiting IT*
Complete annual report at end of financial year – *This was completed by Dr Amy Bond in 2020 and submitted to the DIPC.*	30 Mar 2019 *Completed*

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Complaints, Feedback and Engagement Service Annual Report 2020/2021			Meeting date: 28th July 2021
Report appendix	List any supplementary information as shown below: Appendix 1: FFT results 2020/21		
Report sponsor	Chief Nurse		
Report author	System Director for Nursing and Professional Practice (Torbay System) Interim Service Lead for Feedback and Engagement Quality and Experience Lead		
Report provenance	Feedback and Engagement Group.		
Purpose of the report and key issues for consideration/decision	The report provides the Trust Board with assurance that during 2020/21 the Trust has met its statutory accountabilities and provides assurance that as a Trust we put people experience of our services at the centre. Patient and service user feedback from people about their experience of accessing and using services provided by the trust, are managed and responded to effectively. Where learning is identified and change is required this is implemented at a local or trust wide level to support continual improvement. The report includes: • An overview of the current Feedback and Engagement services provided across the Trust during 2020/21 • The challenges experienced during the COVID 19 pandemic in 2020/21. • The future plans to enhance the Feedback and Engagement service through developing a five-year strategy co-designed with people who use our services.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To note the content of the report and the achievements aligned to feedback and engagement during a global pandemic. To support the development of a Feedback and Engagement Strategy and Delivery Framework that will enhance and underpin the provision of high-quality health and care services that consistently provide an excellent experience to the people we serve.		

Summary of key elements	
Strategic objectives supported by this report	

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

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

Board Assurance Framework	x	**Risk score**	16
Risk Register	N/a	**Risk score**	N/a

BAF Objective 4: To provide safe, quality patient care and achieve best patient experience

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**	

Report title: Complaints, Feedback and Engagement Service Annual Report 2020/2021	**Meeting date: 28th July 2021**
Report sponsor	Chief Nurse
Report author	Director for Nursing and Professional Practice (Torbay System)

1.0 Introduction

1.1 This is the Trust Annual Complaints, Feedback and Engagement report for 2020/21 that forms part of our regulatory requirement.

1.2 The aim of the report is to provide oversight of the service provision continued during the Covid-19 pandemic and the areas that were paused in line with government guidance at that time and the steps taken to relaunch and enhance the Feedback and Engagement service across the Trust during 2021/22.

1.3 Torbay and South Devon NHS foundation Trust have a dedicated small corporate team that oversees and coordinates the feedback and engagement functions of the Trust. The Feedback and Engagement (PALS) Team work directly with patients/clients and their carers to provide information, facilitate speedy resolution of concerns and refer patients and their carers to external or specialist support and advocacy services as required. The team works with colleagues across the organisation and external stakeholders to promote and develop the service and create robust, effective links and working relationships between the Feedback and Engagement Team and other services. The team also liaise with other PALs, advice and advocacy services in both the local health and social care communities in such a way as to ensure a seamless service for patients/clients.

1.4 The Feedback and Engagement (PALS) Team are based on the Torbay Hospital site, although during the COVID-19 pandemic the team have been effectively working remotely for the majority of the time in line with government guidelines, covering the office on a rota basis.

1.5 Throughout the COVID pandemic, the Feedback and Engagement (PALS) Team were able to continue working effectively and were able to manage all PALS queries, concerns and complaints as per Trust policy and in line with NHS complaints regulations. Although there was national guidance that Trusts could pause their acceptance of complaints during the initial phase of the COVID pandemic, the Trust continued to function and respond to all complaints and concerns within the normal national guidance time frames.

1.6 There are a number of routes through which people accessing our services and can submit their feedback including telephone, email, through the public website or in writing. The Feedback and Engagement (PALS) Team do not currently have a walk-in service available as the team are based off the main site in a building inaccessible to patients/service users. There is also a lack of appropriate rooms in which to meet members of the public on the main site at present. This is an area that will form part of the planned work for 2021/22 to identify a location that is patient facing and visible to people who use our services.

1.7 We have started the journey to develop a Patient /Service User Feedback and Engagement Five Year Strategy. This will include the people in our local community who access, use and interface with our services. On 13 July 2021 we held an initial event with our health and care partners to reflect and understand what works well, where we can improve and consider what great would look like. This will shape our vision and are underpinned by agreed principles. Our next step with support for Healthwatch and our partners is to fully involve our local communities to understand what matters to them, as individuals, families and communities to develop a collaborative co designed programme that underpins what is important to the people we serve.

2.0 Accountability and Responsibility Framework:

2.1 The Chief Executive is accountable for ensuring the Trust complies with NHS complaints regulations. The Chief Executive delegates the responsibility for the effective delivery of the Trust's policy to the Chief Nurse.

2.2 The Trust Board and senior managers have key responsibilities to ensure that the culture of the organisation reflects that the Trust takes feedback and complaints seriously and expects them to be acted on appropriately

2.3 Under the management of the System Director for Nursing and Professional Practice (Torbay), the Patient Safety Lead is responsible for the operational management of the Feedback and Engagement Team comprising of the Complaints Team and Patient Advice and Liaison Service (PALS).

2.4 The Feedback and Engagement Team support the Trust in the delivery of the Feedback and Complaints process through the policy that underpins practice. Their roles and responsibilities include:

- ✓ To ensure that feedback is dealt with efficiently
- ✓ To discuss with the person and work with them to resolve their concerns in the best possible way.
- ✓ To promote PALs as an informal, client focused service that deals with problems and concerns as quickly and effectively as possible
- ✓ To ensure people are treated with respect and courtesy
- ✓ To ensure complaints are properly investigated
- ✓ To ensure people receive help to understand the complaints procedure
- ✓ To ensure people receive advice on where they may obtain assistance with the procedure
- ✓ To ensure people receive a response that provides an explanation and response to their complaint and are clear about the outcome of the investigation
- ✓ To ensure that action is taken, if necessary, to ensure the Trust learns from the feedback
- ✓ To ensure that good practice is recognised and acknowledged

2.5 At an Integrated Service Unit (ISU) level, the Associate Directors for Nursing and Professional Practice (ADNPP) or Associate Directors for Operations (ADO) are responsible for ensuring complaints are investigated and responded to in line with the policy. They lead on ensuring, where appropriate, that lessons are learnt and remedial action is implemented, evaluated and embedded in sustainable change.

2.6 The ADNPP or ADO within each ISU are responsible for allocating a lead person for the investigation who will be responsible to update the ADNPP or ADO on the progress of the investigation. The ADNPP or ADO are also responsible for reviewing the relevant investigation documentation and drafting a letter of response. This is reviewed by the System Directors for Nursing and Professional Practice before progressing to the Chief Executive or Chief Nurse to sign prior to sending to the complainant or their representative.

3.0 The Governance Framework for the Feedback and Engagement Service

3.1 The feedback and engagement work across the Trust is overseen by the Feedback and Engagement Group. The Trust Feedback and Engagement Group has a membership that includes trust members, but also the wider health and care community such as the Clinical Commissioning Group, Advocacy Service, Health Watch, Carers lead and local independent hospital, Mount Stuart. The purpose is to provide a forum for staff and wider system members who are responsible or are involved with the patient experience and engagement of the Trust to share learning and best practice.

3.2 The main focus of the group is to review the effectiveness of the Trust's response and provide assurance to the Board that the actions taken in response to feedback are completed and disseminated across the Trust. The sharing of good practice and continuing to develop a patient-centred culture across the Trust is pivotal. The Group meets monthly and invites /co-opts specific people when required to enhance the group with additional skills, knowledge and competence.

3.3 The ISU governance groups have oversight of the feedback and engagement work within their ISU and via the monthly Quality Report provide the Quality Improvement Group with key work being undertaken in line with feedback and engagement. Sharing wider learning across the organisation through this governance group and the Feedback and Engagement Group.

3.4 The Quality Improvement Group report to the Quality Assurance Committee which in turn reports to the Trust Board.

4.0 Discussion

4.1 Statutory Regulations

Complaints are managed in line with the Trust's policy and in line with NHS complaints regulations. The Trust are required by NHS complaints regulations to acknowledge all complaints within three working days. During 2020/21, there was only one complaint that was not acknowledged within the timeframe, this was due to the highly complex nature of the complaint, the number of organisations and services involved and the large amount of information received which needed careful consideration before acknowledgment. NHS complaints regulations also require the Trust to investigate and respond to a complaint within 12 months of receipt. However, the Trust aim to investigate and respond in a much shorter timeframe as delays can both hinder the effectiveness of the investigation and cause increased distress to the complainant. *72%* of the complaints received in 2020/21 were extended beyond the original timeframe agreed with the complainant which is an area noted for improvement during 2021/22, considering that extra time is factored in at the start if a complaint is identified as being complex (for example a complaint spanning various organisations, services or

Integrated Service Units). 38% of complaints were extend once,16% of complaints were extended twice, 14% were extended three times and 4% were extended four times. All complainants were informed of the extensions and the rationale for the extension is shared in an open and transparent manner.

4.2 Learning from Feedback

All staff have a responsibility to acknowledge where care has not been of the required standard and to do everything in their power to learn and to amend practice. Learning from complaints should happen throughout the organisation depending on the issues of concern. In some instances, the issue may relate to a single department, but the theme may be applicable to other areas. It is the role of the senior staff in the ISUs to ensure that issues and the resulting action plans are appropriately shared. The Feedback and Engagement Team will work with the ISUs to ensure actions are monitored and accurately recorded on the Risk management system. Where appropriate staff should incorporate the learning into their annual achievement review with their manager. The capture and sharing of significant learning from complaints is led by the Trust's Feedback and Engagement Group. One of the main objectives the Trust has in relation to patient experience is to implement in 2021/22 a Patient/Carer Story Framework to enable the sharing of learning. These stories can then be shared in the appropriate forums, for example, at Board meetings, End of Life Group meetings, Feedback and Engagement Group or within speciality groups.

Examples of complaints which have identified either learning or good practice to be shared.

COM-xxx This was a complaint about a patient's discharge from an inpatient ward. The investigation found that the patient self-discharged (signing a self-discharge form), so the full assessments could not be completed. Appropriate medical follow-up was requested and the GP was also informed. However, no consideration was given to onward referral to the community, for example, a referral to the community nursing service. The complaint was shared with the specialty team with regard to the missed opportunity to refer for further community follow-up.

COM-xxx Complaint about discharge from hospital. The ward has now introduced a system where soiled belongings are placed in a water-soluble bag which can be put directly into a washing machine and a sign for the bag which states that there are soiled belongings which can be placed directly into a washing machine in the bag. The Occupational Therapist (OT) did not make it clear that patient's therapy care would be taken over by a different member of staff, in response to this, the therapists have discussed at their team meetings how they can improve communication with regard to onward care. The Matron has also reminded staff that a new TEP form should be completed and there is now a specific group set up to consider how to improve outcomes in relation to patient discharge.

COM-xxx Concerns about the care and treatment provided to a resident in a care home during the COVID-19 crisis where the placement was commissioned by the Trust. The investigation found that the care home complied with government guidelines on infection control and personal protective equipment at the time of the COVID-19 pandemic. Following a case review, no single factor has been identified that caused the client to contract COVID-19. The care home complied with their contract with the Trust

and the Trust is confident in the care provided. This has been shared with the Quality Assurance and Improvement Team (QAIT) within the Trust.

4.3 Ombudsman Cases

The Trust were contacted in relation to 10 complaints between 01/04/2020 and 31/3/2021 by either the Parliamentary and Health Service Ombudsman or the Local Government and Social Care Ombudsman. Of these 10 complaints, 2 were not investigated by the Ombudsman following an initial review and 1 was partly upheld. The remaining 7 complaints are still being investigated.

For the complaint that was partly upheld (COM-xxx), the Paediatric Doctor responded to a question about whether the Trust would accept a private diagnosis of autism before discussing it with colleagues who advised that printing the assessment report and accepting the assessment would not be possible. It was also identified that the Trust had accepted private assessments previously on rare occasions. The Trust explained that due to the length of time that families were being required to wait for an Autistic Spectrum Disorder (ASD) assessment, which is a national issue, at the time of the child's initial assessment, an increasing number of families were arranging private ASD assessments. Following the complaint (and complaints from other families), the Trust identified that on previous occasions, private assessments had been accepted and identified a need to ensure there was a formal process in place for this. The Trust also explained that it should not have accepted the previous assessments without there being a robust process in place to ensure that the assessment met NICE guidelines. It explained that it was an error to accept the previous private assessments without a governance process being in place. After the Trust became aware that there was no policy in place for accepting private ASD assessments, it began a significant piece of work in December 2019 to address this deficit. Although paused due to the first wave of COVID-19 this is now fully operational.

There is currently a more than 26 week waiting timeframe for cases to be allocated to an investigator within the Parliamentary and Health Service Ombudsman. This will have a detrimental impact on the Trust's ability to comment on cases where staff members have left or memories have inevitably faded.

4.4 The feedback and engagement categories and numbers received Q1-Q4 2020/21.

Table 1 shows the contacts received in Q1, 20/21

*** Please note that some contacts have more than one issue identified and may therefore span more than one ISU ***

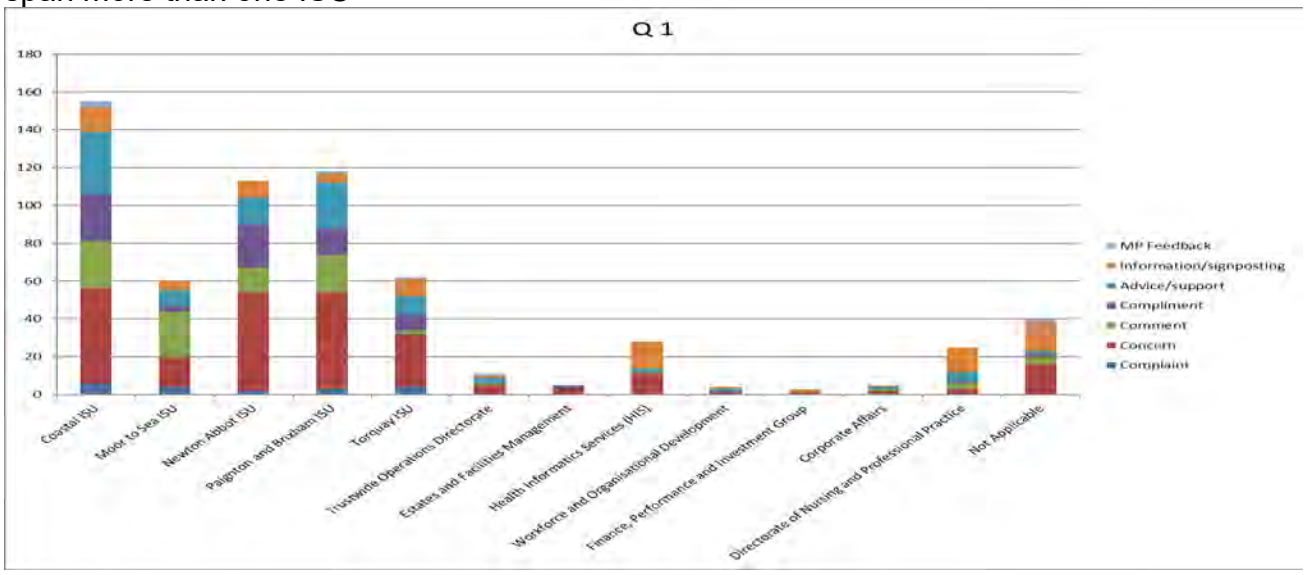


Table 2 shows the contacts received in Q2, 20/21

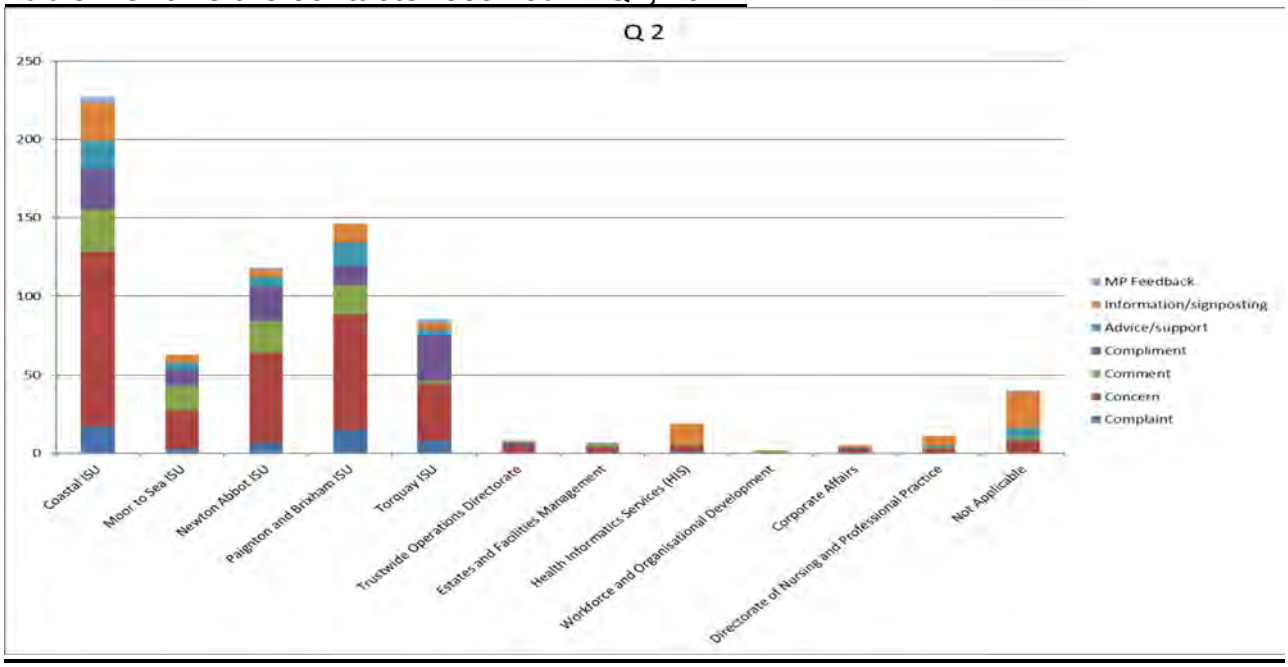


Table 3 shows the contacts received in Q3, 20/21

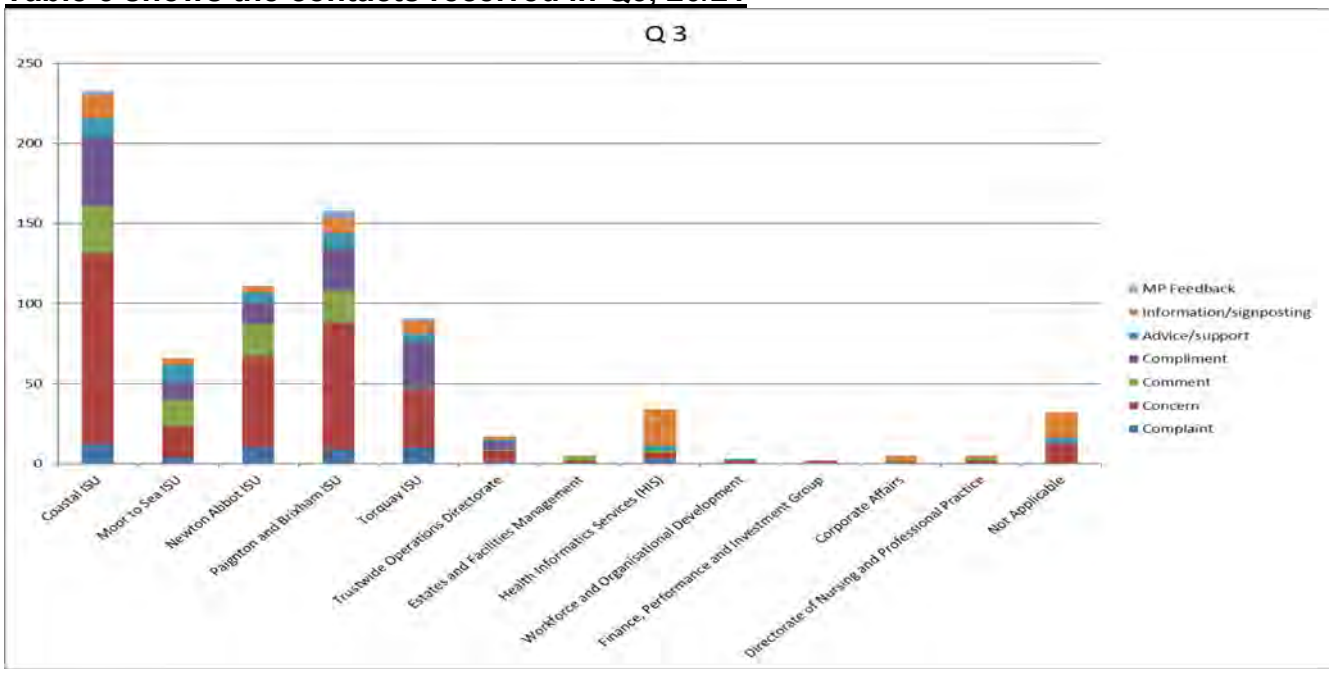
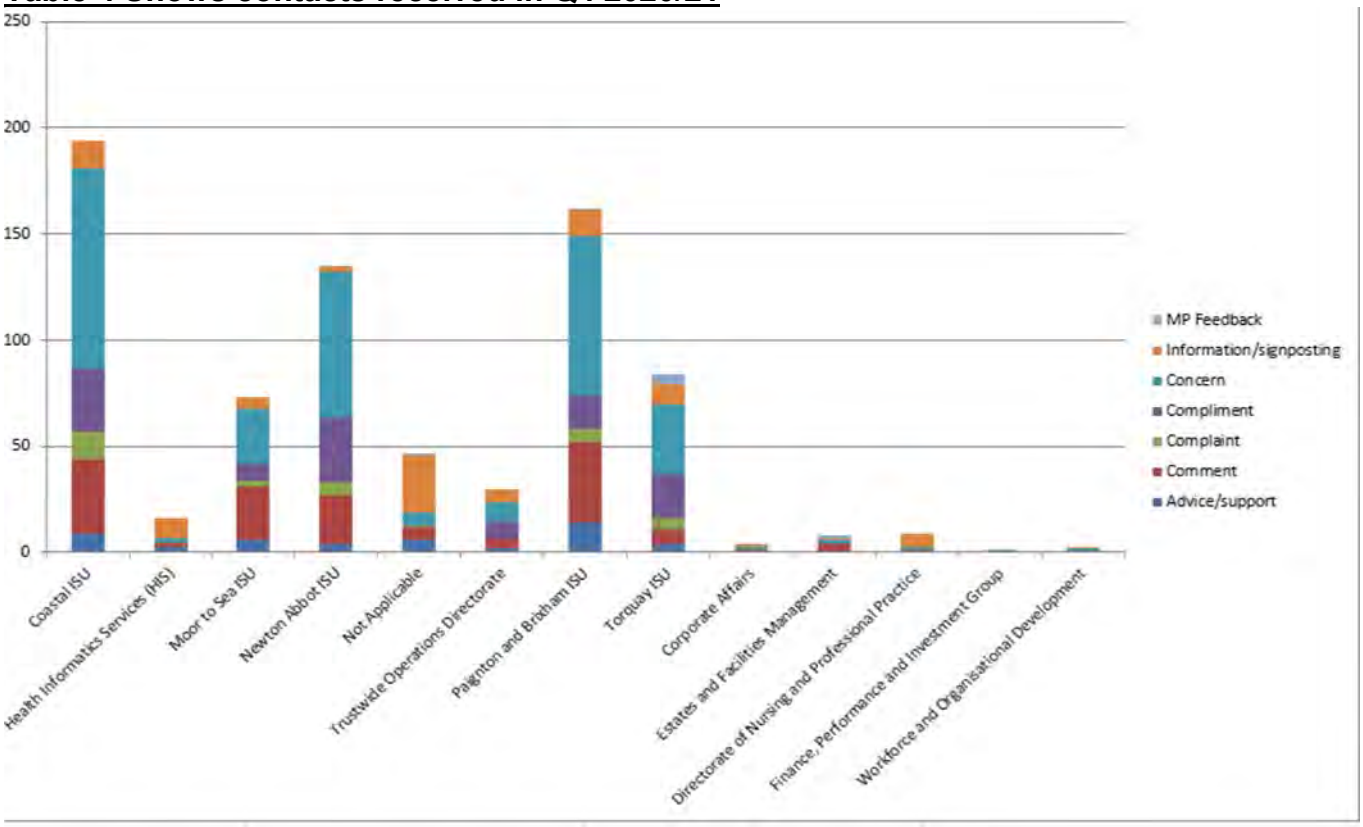


Table 4 Shows contacts received in Q4 2020/21



The tables above demonstrate that there was a significant reduction in contacts received in Q1, in line with the initial phase of the COVID-19 pandemic. Since Q1, contacts have increased and have now surpassed usual levels (761 contacts received in Q3, 19/20) compared to 1273 Q3 20/21. In Q4, 772 contacts were received, which is a decline compared to Q3, again reflecting the national lockdown at that time.
The full extent of the COVID-19 pandemic is not yet clear, however we know there is an impact on increased waiting times for care and treatment. The Trust will require sufficient capacity going forward to effectively and efficiently meet the anticipated

increase in demand of complaints and concerns and a plan to manage this increase in demand will be a focus for 2021/22

Table 5: The categories and themes of complaints for 2020/21

	Accessibility	Admission, discharge, transfers	Appointment delays, cancellations	Appropriateness, consent to treat	Attitude of Staff	Availability, Non-Delivery, access to treatment/drugs	Commissioning services	Communication	Alledged Competence, Negligence	Effectiveness	Eligibility	Information Handling	Procedures, patient care	Timeliness, delays, waiting times	Total
Appointment	1	0	0	0	0	0	0	1	1	0	0	0	0	0	3
Assessment	4	0	2	0	3	1	1	5	0	8	2	0	0	0	26
Care	2	1	0	0	2	1	0	5	4	12	1	0	0	0	28
Equipment	1	0	0	0	0	0	0	0	1	0	0	0	0	0	2
Record Management	4	0	0	0	0	0	0	1	1	0	0	1	0	0	7
Treatment	18	2	0	1	8	3	0	11	34	27	0	0	2	1	107
Discharge	0	7	0	0	0	0	0	0	1	1	0	0	0	0	9
Diagnosis	0	0	0	0	0	1	0	3	10	10	0	0	0	0	24
Referral	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	30	10	2	1	13	6	1	27	52	58	3	1	2	1	207

The majority of the complaints received by the Trust relate to either treatment, assessment or care. However, there is a number of complaints received which relate to record management which could be due to urgent changes in process related to the COVID-19 pandemic. In relation to our delivery of the service, effectiveness, alleged competence/negligence and accessibility are the top three complained about themes.

The complexity and diversity of services and the range of concerns and complaints result in high level themes that frequently require bespoke service level change. Please note some complaints have more than one theme and the number of complaints for 2020/21 was 156.

Table 6: The last four years numbers of complaints and concerns by theme

COMPLAINTS - TOTAL	2017/2018	2018/2019	2019/2020	2020/2021	Total
Treatment	132	155	157	77	521
Assessment	51	42	39	22	154
Care	58	29	32	21	140
Diagnosis	27	19	22	17	85
Discharge	14	22	16	7	59
Appointment	18	11	9	3	41
Record Management	4	6	8	6	24
Non-Clinical Support	8	4	6	0	18
Referral	2	4	5	1	12
Total	319	301	302	156	1078

CONCERNS TOTAL	2017/2018	2018/2019	2019/2020	2020/2021	Total
Treatment	290	516	595	449	1850
Appointment	175	220	207	120	722
Assessment	106	189	155	218	668
Care	118	128	106	143	495
Discharge	34	55	80	72	241
Diagnosis	42	51	66	39	198
Record Management	27	50	50	57	184
Non-Clinical Support	37	46	31	32	146
Premises	12	31	21	21	85
Total	906	1375	1393	1228	4902

During the COVID-19 pandemic one theme has been communication and the impact on effective communication due to changes in visiting. As visiting was suspended, with the exception of end of life care and bespoke patient need a new model of effective communication was required. We introduced the use of i-pads on in-patient wards to support communication with family and loved ones for both clinicians and patients and address this challenge. We recognise that although we worked to adopt new models of communication, relatives and loved ones of inpatients experienced difficulty in contacting wards for updates on their loved one's progress during the height of the pandemic.

Another important development during the COVID pandemic was the introduction of the Sending Love Service, which is a way that relative, friends and carers can send a direct message and/or photograph to their loved one (on the same working day if submitted by 10am). This service has been incredibly important, as one of the major themes throughout the COVID pandemic is the impact of visiting restrictions on patients, relatives and carers and difficulty gaining information from the inpatient wards in a timely fashion. This service has continued and is now embedded as part of the service we provide to families and loved one and is led by our Carer's Service.

It is important to ensure we review and focus the compliments that services and wards receive (Table 8). We recognise compliments are often spontaneous and some services may not be reporting them into the main system. You will note that the number of compliments remains relatively unchanged for the last 4 years and treatment and care are the main reasons for compliments being received which aligns to our core business as a health and care organisation.

Table 8 The numbers of Compliments by Theme

COMPLIMENTS TOTAL	2017/2018	2018/2019	2019/2020	2020/2021	Total
Assessment	2	18	10	24	54
Care	88	206	251	207	752
Corporate	2	0	5	1	8
Equipment	1	2	1	3	7
Non-Clinical Support	18	3	6	8	35
Personal Welfare	6	3	1	5	15
Referral	1	0	2	4	7
Treatment	280	203	200	146	829
Appointment	0	14	8	12	34
Diagnosis	0	1	6	3	10
Total	398	456	494	418	1766

4.5 The Trust effectively manages all contacts received by the Feedback and Engagement Team who are proficient in identifying the key issues and managing the contact in line with the enquirer's expectations and this has been achieved through 2020/21 despite the COVID pandemic. However, due to the increased amount of contacts and the increased complexity of the complaints received, the Feedback and Engagement Team are currently unable to answer "live" phone contact, the effect of which is that some contacts will be lost as people may not want to leave an answerphone message or use another form of communication. Reinstating this service is currently a focus to be achieved early in 2021/22.

4.6 The Torbay Carers service

Torbay Carers Strategy 2021-24 has already been presented to the board but it is important to highlight that working with Healthwatch Torbay a survey from November 2020 – January 2021 focused to identify the needs of carers in Torbay and underpinned developing the strategy. 447 responses were received and the full report can be viewed here: www.torbayandsouthdevon.nhs.uk/uploads/carers-consultation-2021-2024-strategy.pdf

The findings of the report helped Torbay Carers Service to develop their strategy for 2021-24, which focuses on improving the experience of Carers in five key areas:

1. Identification of Carers at the first opportunity
2. Information, advice and support services available to all Carers
3. Carers Assessments proportionate to need, including whole family approach
4. Involvement of Carers in service delivery, evaluation and commissioning
5. Enhancement of support to the person being cared for

Key areas of focus highlighted through Healthwatch's survey Carers' Consultation to Support the 2021-24 Torbay Carers' Strategy" and dated March 2021 were as follows:

- Carers said their situation would be improved if they were better supported; they would like accessible replacement care (respite), a better relationship with health and social care services, and somebody who could check on their welfare (ideally a consistent worker).
- Missed opportunities for identifying Carers happened most in GP surgeries (63%).
- Carers were often unaware of information, advice and guidance opportunities on offer. A booklet to summarise this would be helpful.
- The majority of respondents to the hospital-based support questions (Hospital Carer Support Worker, Advice Point, Family / Carer Supporters, orange lanyards and free parking found them either 'useful' or 'extremely useful'.
- Although relatively few respondents had used the Community Helpline, the majority of those who had found it helpful.
- Nearly half of the respondents were struggling to some extent with the impact of COVID-19, and over a third had concerns about finances or benefits. Respondents said that consistent communication from health and social care services, social support, and practical support would make a difference to them during the pandemic.
- More than half of respondents who used acute mental health services felt 'not at all' or 'not very' supported. Respondents with negative experiences described a poor attitude and lack of staff. Long waiting times for treatment was also a theme.

Carers Action Plan Questionnaire

Torbay Carers Service undertook an evaluation in summer 2020 to explore the local impact of COVID-19 on Carers. 115 responses were received and the key learning was as follows:

- Carers are providing more care (an increase of 10 hours per week) and many are struggling (12% struggling a lot, 32% struggling a little) during the COVID-19 pandemic. More support, particularly emotional support, was needed.
- Carers are keen for services to re-start, but only if safe to do so.
- Support from family and friends has been of greatest help during the pandemic.
- Phone calls / contact with services have been appreciated and useful.
- Technology can play a part in supporting many Carers, but many are not keen to use video calls / online training etc. Most prefer face-to-face contact.

Carer access to hospital services during COVID-19
Carers told us that they were finding it difficult to have a meaningful supportive role for the people they care for while they were in hospital due to COVID-19 restrictions. At a time when no visitors were allowed Carers found this extremely difficult. Communication with people on the wards was particularly difficult if patients did not have access to a mobile phone.

Torbay Carers worked with the hospital trust to improve this experience for Carers. As restrictions were eased it has been easier for Carers to visit the wards to support the people they care for.

COVID-19 response

Torbay Carers Service telephoned over 1,000 Carers on its register which were flagged up as being under additional pressure due to COVID-19 restrictions. These contacts received positive feedback from those who received calls and the Carers Service was able to support many Carers either emotionally or practically with signposting to support services in the community.
Carers told us that they needed access to PPE during the early stages of COVID-19 restrictions when usual supply lines were compromised. The Carers Service worked with Public Health at Torbay Council to make PPE available to all of Torbay's Carers who supported someone who lived in another property, or if they employed care workers privately. Over 140 Carers used this service, either by collecting PPE or through deliveries provided by a voluntary sector provider (Torbay Community Development Trust).

Several calls identified safeguarding needs due to domestic abuse, and were escalated to the Safeguarding Team, and practical support needs were referred to mobility support providers. Many Carers were suffering from isolation, and they either received a regular call from the team or were referred to the Carers Phone Line for ongoing peer support.

4.7 Friends and Family Test.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for people to give their view after receiving NHS care or treatment.

The Friends and Family Test has been a mandatory requirement across all NHS Trusts since 2013 and although every person must be given the opportunity to provide feedback on the service they have accessed, it is optional to respond. In September 2019 NHSE announced changes to the mandatory questions where the key question was changed to ask:

"*overall, how was your experience of our service "?*

Previously there had been two further prescribed questions and with the changes of the FFT nationally the Trust had an opportunity to develop our own questions. The Feedback and Engagement Group considered this opportunity and made the decision to ask the following questions:

- *Please can you tell us why you gave your answer? (*to the FFT question*)*
- *What one thing could we have done better?*
- *Please tell us what you, your family members and carers think should always happen when you use our services?* (This is to support the Always Events Initiative).

The Revised FFT test was due to commence in April 2020 but due to the COVID 19 pandemic the launch was paused across the country until September 2020. The challenges experienced by the Trust in developing the FFT provision during the COVID pandemic included the paper- based model that had been in place pre-COVID which provided challenges with infection, prevention and control. Pre- populated locations /wards that ensures feedback was accurately attributed was also a challenge as a large number of wards during COVID and beyond, changed configuration in the care they provided, although the name of the ward remained the same. Although FFT has been reintroduced, in line with the national drive to avoid handling of paper where possible the Trust is working to develop and introduce digital solutions in the long term.

The paper- based FFT collection has been reinstated via either completion of feedback whilst an inpatient or within the service or via Royal Mail. This has resulted in and delay in recommencing the collection of feedback within services and wards and is evident from the data analysis set out in Appendix 1**.**

From the data (appendix 1) from 1 April 2020 – 31 March 2021 at Integrated Service Unit level demonstrates that the majority of people rated their experience as "very good" or "good" this is from a total of 987 response received in this time frame. It should be noted at present the number of responses is low. This requires a significant focus and by Matrons, ward managers and service managers to promote and encourage patients and service users to complete the FFT. As we move forward into 2021/22 we will work to consider a range of digital and other solutions, as the current paper-based system is both labour intensive and results in time lapses from receiving feedback to analysis and sharing with staff.

Table 7: Total Experience Rate from 1/04/2020* – 31.3.2021

Note*- *the FFT was stood down at this time but people using our services can submit their response at any point from when they are in receipt of the FFT questions.*

Through the Feedback and Engagement Group an improvement plan has been developed and is monitored monthly that will aim to encourage people using our services to lets us know how we have done and what we could do better. Nationally through NHSE national team there are resources that we can adapt and adopt going forward.

Further reports are currently being developed to analysis the additional FFT questions which will be reported going forward to the Quality Improvement Group and enable the trust to address areas for improvement proactively and also celebrate success and build on what works well.

Adopting a QR code for services and wards is currently being piloted in the emergency department. The individual can scan the QR code onto their mobile phone and access the FFT questionnaire for completion and submission for the service/ward and will support a digital model to complement the paper- based model.

A reduction in face to face consultations/contact with patients/service users with virtual consultation requiring a solution to enable timely feedback. One system adopted is “AttendAnywhere” which is video/virtual out patient service. The team leading this work have now implemented a facility to provide feedback on the users experience and other information requested nationally at the end of the virtual consultation. An initial report has recently been prepared demonstrating approximately 200 people per month are providing feedback against 2,000 virtual consultations a month. At present a number of patient experience questions are asked including if the person felt their needs were met, were they treated with dignity and respect and were they listened to in the consultation.

The results demonstrated high scoring in these domains which is very positive. Work will now progress to include the FFT questions into “AttendAnywhere.” Services that use

this virtual model of consulting in high numbers are speech and Language Therapy for children, physiotherapy and clinical psychology.

4.8 Real time Patient feedback through the “Working With Us Panel”, where volunteers visit wards and gain feedback from inpatients has not been achievable due to COVID restrictions. As we progress forward into 2021/22 a small number of wards have trained staff to provide this valued service supporting in time feedback and allowing prompt action to improve experience of the service we offer across our inpatient wards. One key area identified in a number of inpatient wards was noise at night. In response to this the trust now provide comfort packs with eye shields and ear plugs for patients. During 2021/22 we hope to re-engage the volunteers in this valued work.

4.9 There is an improvement journey to be undertaken over 2021/22 to develop the range of ways that people can provide FFT and wider feedback to the Trust that will enable services to focus on what works well and what can be improved aligned to a post COVID world. This will be underpinned through the development of our patient and service user Feedback and Engagement Strategy and delivery framework that will be overseen through the Trusts governance framework.

5.0 National Inpatient Survey 2020

The CQC National Annual Inpatient Survey completed in 2020 is yet to be published. On publication the Feedback and Engagement Group will review the results and develop a plan to address areas where improvements are required and celebrate successes.

6.0 Conclusion

6.1 Through the pandemic the complaints, concerns and compliments from people who use our services have been sustained, which is a credit to the feedback and engagement team and wider staff in the organisation who review, investigate and respond to this feedback.

6.2 As wave three of the COVID pandemic recedes and the full range of services resume across the organisation, a refocus on a Trust wide Feedback and Engagement Strategy and Framework needs to be developed to align to a post COVID world linking with the Trust Digital Strategy.

6.3 The development of the Strategy will adopt an inclusive approach with a wide range of stakeholders including service users. This will be underpinned by the Trust vison and strategy to deliver care closer to home. This, in turn will raise the profile of the importance of patient and service user experience in developing and delivering high - quality effective services that provide a positive experience.

6.4 The impact of the COVID 19 pandemic has been evidenced in our ability over 2020/21 to receive proactive feedback from people who use our services. The changes in care delivery going forward provides a platform for us to review and modernise our model into 2021/22 and beyond.

6.5 A post-COVID plan is also required to manage the expected increase in contacts, complaints and concerns in line with delays to care and treatment following the global pandemic and ensure capacity meets demand.

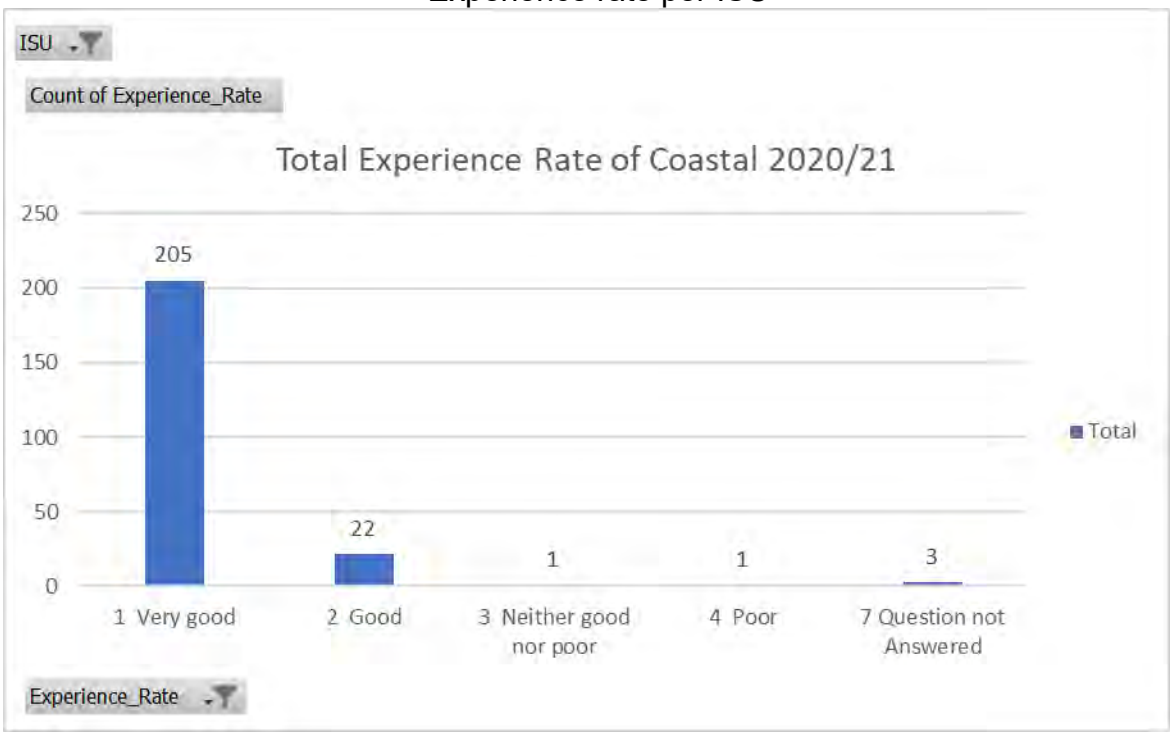
7.0 Recommendations

7.1 To note the content of the report and the achievements aligned to feedback and engagement during a global pandemic.

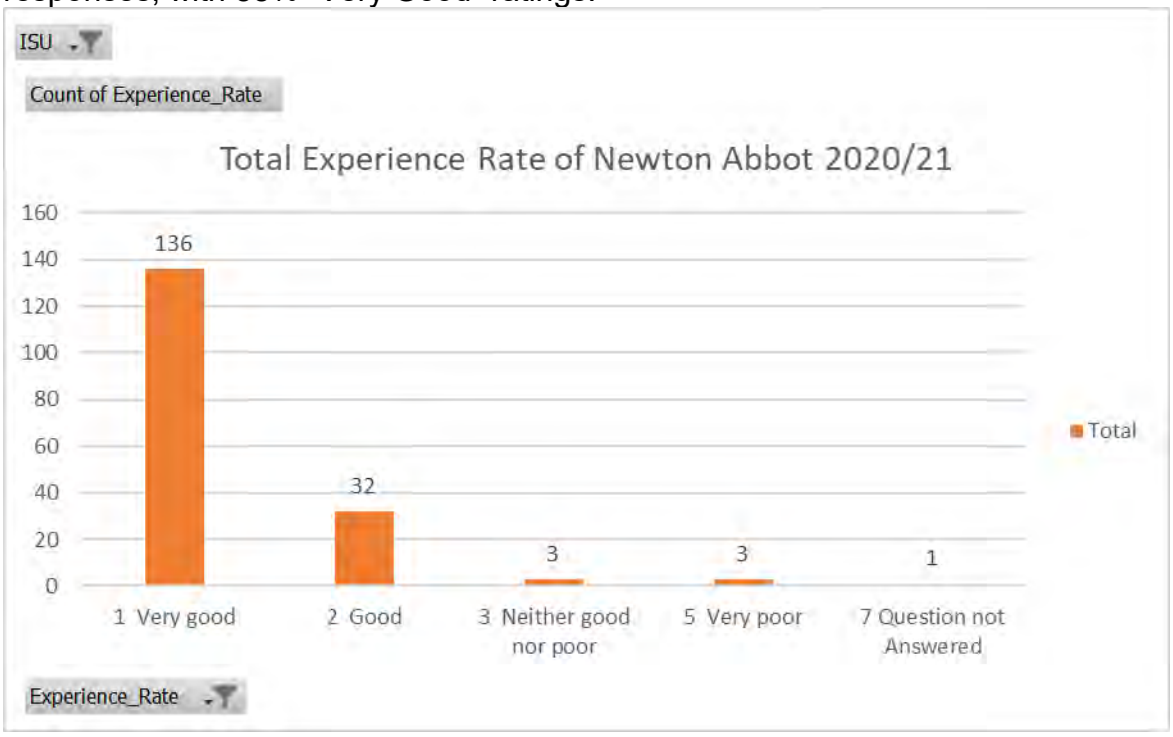
7.2 To support the development of a Feedback and Engagement Strategy and Delivery Framework during 2021/22 that will enhance and underpin the provision of high -quality health and care services as we strive to consistently provide an excellent patient experience.

Appendix 1: Friends and Family Test 1 April 2020 - 31 March 2021 by Integrated Service Unit (ISU)

Experience rate per ISU

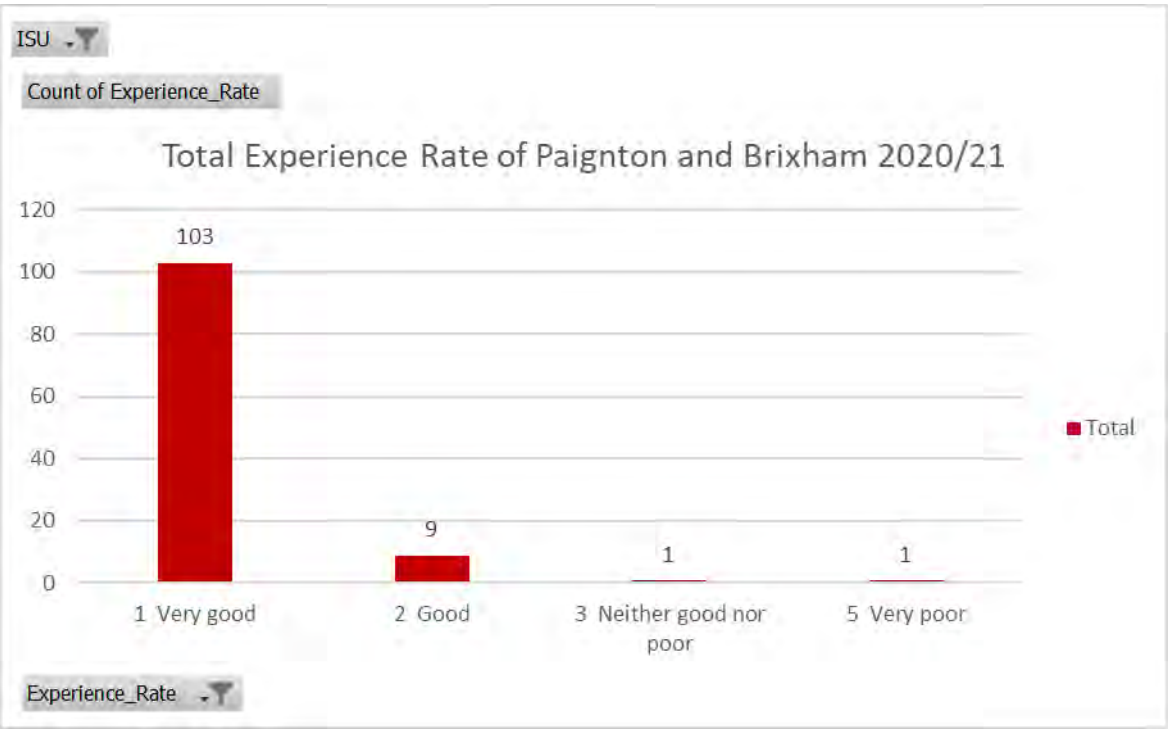


Over the period outlined in the table above Coastal received the highest number of FFT responses, with 88% “Very Good” ratings.

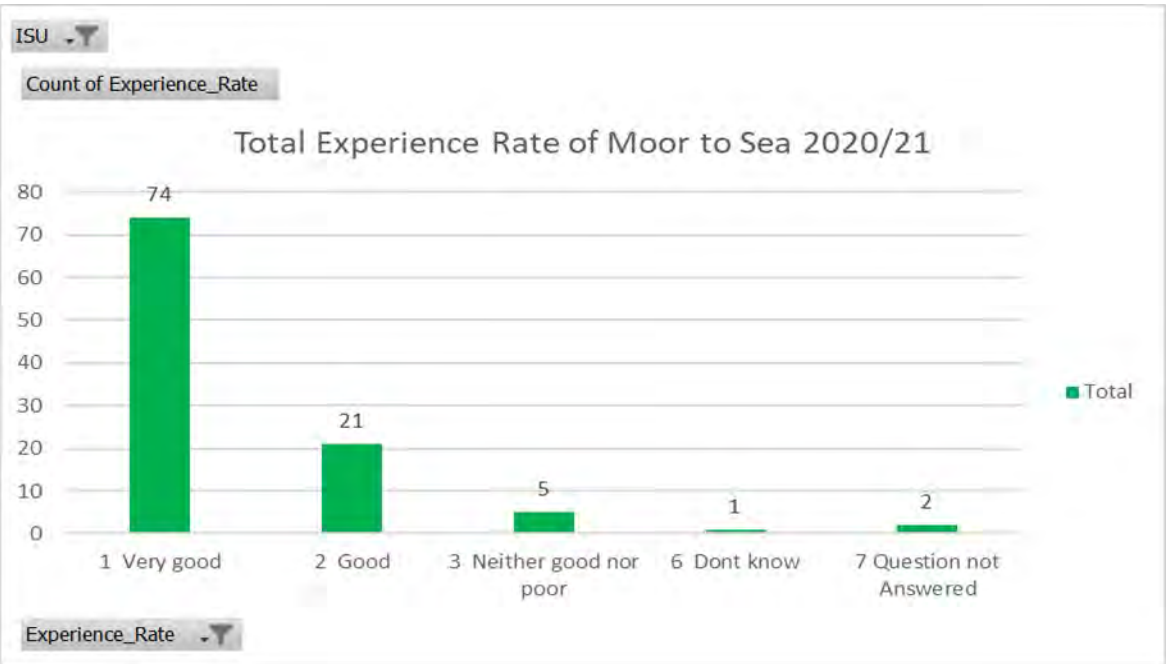


Newton Abbot received the second highest number of responses, with 78% “Very Good”, showing a slight decrease in ratings in comparison to Coastal. There are also 3 recorded answers of “very poor”, representing 75% of the 4 “very poor” results recorded

across the year 1.4.2020-31.3.2021. The main reasons given for these results were a lack of communication and long waiting times



Paignton and Brixham received 1 ‘Very poor’ response due to “Cramped conditions” and “Lack of COVID security measures”. However, it received a 90% ‘Very Good’ response rate.



Moor to Sea received a 72% ‘Very Good’ rating, the lowest of the ISUs; however, it did not receive a ‘Poor’ or ‘Very Poor’ rating.

Torquay received the lowest number of total responses, but an 86% ‘Very Good’ rating.

Report to the Trust Board of Directors			
Report title: Children and Family Health Devon – Annual Report			**Meeting Date:** 28th July 2021
Report appendix	Appendix 1 - Performance: CFHD Waiting times 2020 / 2021 Appendix 2 – Transformation Appendix 3 - Key workforce metrics 2020/21		
Report sponsor	Chief Operating Officer		
Report author	Children's Alliance Director		
Report provenance	The report has been prepared by the leadership Team of Children and Family Health Devon		
Purpose of the report and key issues for consideration/decision	The report details progress against delivery objectives for 2020/21. Issues for the Board to note: • Challenges faced by CFHD in the first 2 years of operation • Progress with the transformation programme • Impact of Covid- 19 on service demand and delivery • The approach to engagement and involvement of staff		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board are asked to receive and note the Child Family Health Devon Annual 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	1,3,8	**Risk score**	20
Risk Register		**Risk score**	

BAF Objective 1: To develop and implement the Long Term Plan with partners and local stakeholders to support the deliver of the Trust's ICO Strategy
BAF Objective 3: To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.

	BAF Objective 8: To implement and continuously review the impact of the Trust People Plan ensuring the Trust is 'a great place to work'
External standards affected by this report and associated risks	

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

Report title: Children and Family Health Devon – Annual Report		**Meeting date: 28th July 2021**
Report sponsor	Chief Operating Officer	
Report author	Children's Alliance Director	

Introduction

In 2018 the NHS Clinical Commissioning Groups and Local Authorities across Devon chose an Alliance of NHS organisations to deliver a county-wide children and young people's service (Children & Family Health Devon - CFHD). The 7-year (+/-3 year) contract commenced on 1st April 2019. The Alliance of organisations is led by Torbay and South Devon NHS Foundation Trust (TSDFT), comprising Devon Partnership NHS Trust (DPT), Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare NHS Trust, University Hospitals Plymouth NHS Trust and Livewell Southwest. The Alliance is partnered with key voluntary sector organisations including Young Devon, Vranch House, and XenZone, alongside academic partners the University of Plymouth, the University of Exeter and Plymouth Marjon University.

The service model describes an integrated service across health, education, social care, and the voluntary sector, integrating physical and mental healthcare, across community and acute services. The community health services include CAMHS, Children in Care services, Learning Disability Services, Therapy Services and Community Nursing Services with the two provider / employing organisations being TSDFT for Integrated Therapies and Nursing and DPT for CAMHS. The model comprises a system of place-based care, across three localities with a standardised offer and operating model across the county. We aim to enhance the opportunities for prevention, resilience building and early intervention, whilst delivering high quality evidence-based, outcomes informed care and treatment, for those requiring specialist help, organised according to the Thrive Framework for System Change (Wolpert, M. et al (2019).

The contract had been transferred at speed and the new service model required a large-scale transformational change programme to be undertaken. A formal service consultation was commenced in July 2019 but was paused in November 2019 as the degree of change proposed in the new service model was not well received by staff. In response, the decision was taken to augment leadership capacity by creating the new role of Children's Alliance Director, to take stock and to identify and apply the learning from the first year of the contract.

Year 2 of the contract

<u>Governance infrastructure</u>

Whilst the CFHD Alliance creates opportunity for ambitious improvements in integrated care and treatment, it also creates a range of challenges and complex requirements in relation to accountability, governance, contractual and performance reporting and cross-organisational arrangements, including service provision operating across numerous different patient record systems. Operationally the CFHD Alliance arrangements between organisations also lead to corporate support being

provided by both DPT and TSDFT with, for example, TSDFT being the provider of IT, informatics and safeguarding services and DPT leading on finance and estates.

The governance arrangements which had been developed during the bidding process, operated during the first year of the contract and into 2020/21. However, given the innovative nature and purpose of the Alliance, the governance architecture remains under review whilst we apply our learning from experience to the re-design of the service. The complex assurance arrangements involve reporting to the Alliance, TSDFT and DPT require simplification.

When the contract was first awarded, it was intended that staff would be transferred into the Trusts which would host the CFHD workforce for each of the three localities. During 2020/21, it became clear that this would undermine the ambition to deliver a service which had integrity across the county and would be unpalatable for staff. Alliance partners therefore agreed not to proceed with this plan but review it again in five years. As it was originally intended that the provision of corporate support functions for CFHD would also transfer to the Trusts, it became necessary to review this provision across DPT and TSDFT.

Performance

During the first year of the contract, performance - specifically waiting times for some clinical services had deteriorated in the context TUPE transfer of staff, increasing demand, staff vacancies and from March 2021, the onset of Covid-19. Further, there were long-standing legacy waits in the Speech and Language Therapy and Autism Spectrum Assessment services.

Therefore, a key focus during 2020/21 has been the improvement of waiting times. This has involved analysis of productivity, capacity and demand with an emphasis on proactive management of waits and efficiency improvements, which in turn, provided the foundation for some significant waiting list reduction work in Qs1 and 2 of 2021/22 e.g. ASD waits. During the year, RTT was maintained at 100% in 3 services, improved in 3 services and deteriorated in 4 services, the latter being those services most affected by the above factors. See Appendix 1.

Transformation

It was a priority during 2020/21 to reflect on the experience of staff of a challenging first year and to re-start the transformation programme. An independent review of the first year of CFHD, using ‘Appreciative Inquiry’ was undertaken with staff. This, and the learning for the Alliance Board was shared across the service leading to a commitment from senior leaders to embark on co-production of the new service model, with authentic staff engagement throughout. The aim was to harness the considerable expertise and lived experience of the staff delivering CFHD services, to build on the existing good practice and create clinically-led innovative approaches to delivering integrated care.

The principles of the service model design were outlined and leadership responsibility for designing the clinical pathways was delegated to clinical leaders and their teams. Robust engagement activities were established with organisational development

support for change management, reviews, service wide Q&A sessions, opportunities for staff feedback, newsletters, and check and challenge in place. See Appendix 2. Staff engagement throughout was very good with broad support for the clinical model. Re-designing the operating model and workforce followed this process at the beginning of 2021/22.

Response to Covid-19

During the first phase of the pandemic a number of children's community services were stood down, in accordance with NHSEI guidance and requirements; and a proportion of CFHD staff were redeployed to support the local health response to Covid-19. Adaptations to the delivery of care and treatment were swiftly implemented as face to face interventions were restricted to children presenting with vulnerabilities, risks and complexities which could not be managed remotely. Approximately 80% of care was delivered remotely using the online platform 'Attend Anywhere'. Staff demonstrated considerable commitment and flexibility during this period in which development and implementation of digital approaches to care was accelerated.

Children and young people experienced multiple deprivations during 2020/21 as they could not attend school or see their friends for long periods of time, and were more exposed to the resilience and / or vulnerabilities within their familial / caring environments. Consequently, the pandemic and subsequent lockdowns had a disproportionate impact on the day to day experience, health and development of children with existing vulnerabilities. These outcomes could be discerned from the overall increased demand (around 20%) and acuity of the children referred to CFHD once they returned to school in the Autumn of 2020. Of note, when compared to 2019/20, there has been a 43% increase in SALT referrals and a 38% increase in eating disorder presentations, along with overall increases in common childhood mental health disorders, which is mirrored nationally.

Children's Safeguarding

During 2020/21 there was a need identified to strengthen the governance, systems and practice of children's safeguarding. An Alliance Safeguarding Group was established in September 2020 led by the Children's Alliance Director, which has been driving improvements via a comprehensive action plan. Good progress has been made including the appointment of a Named Doctor for children's safeguarding in CFHD.

System Leadership

CFHD has a specific role in leading systemic change in relation to the integration of children's health services within the wider system of education, children's social care and the voluntary sector. Both Devon County Council and Torbay Council's children's services have been rated 'Inadequate' through Ofsted inspections since 2020 and 2015 respectively. It has therefore been critical that CFHD leaders fully engage with, influence, contribute to or lead as partners, in the system improvement programmes which are underway. For example, design of the SEND offer as part of DCC's SEND transformation programme, membership of Devon's Improvement Partnership,

Torbay's Early Help Board and TSDFT's CEO is a member of the Devon Children and Families Partnership Board.

Workforce

The pre and post procurement period during 2018-19 had been a challenging time for staff who had faced a good deal of uncertainty and change, over 50% of whom having transferred employer in April 2019. The onset of the pandemic within the year, created further uncertainty and anxiety for staff with illness, loss and adjustments to remote working to be managed. This meant that staff were dealing with the cumulative impact of a number of stressors over a prolonged period of some three years.

In this context, it was important to establish a leadership presence internally with culture of collaborative and compassionate leadership which clearly recognised the expertise and professionalism of staff. A clear vision for the future state was communicated and through developing a shared sense of purpose it has been possible to establish a culture of performance management alongside the more creative endeavour of service re-design. There is both qualitative and quantitative evidence that staff are broadly supportive of the changes, focussed on building on good practice and improvement where this is required. It is noteworthy, that the senior leadership team has worked extremely well in driving change and improvement in performance, whilst supporting staff. However, it is also important to note that the leadership team is currently small, consisting of interim roles ahead of recruitment to key leadership posts, and has limited capacity.

During 2020/21 there has been a keen focus on improving compliance in relation to key workforce metrics, such as safeguarding training (CAMHS) vacancy rates (CAMHS) and supervision and appraisals (all). See Appendix 3.

Policy framework

It is recognised that the needs of children are diverse, complex and require a higher profile at a national level with investment to begin to address the structural inequity in the provision of children's healthcare. For example, children comprise 20% of the population nationally but CYP mental health spend is 8% of the overall mental health spend and 7% in the South West[1]. This is reflected in the NHS Long Term Plan and in relation to mental health, there is a commitment '*that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending*' (NHS LTP, 2019). The LTP outlines a number of deliverables in specific areas relevant to CFHD's portfolio of services, as follows:

- CYP Community and improving access – including extending access for 18-25 year olds
- CYP Eating Disorders – maintaining the waiting time standards at 95%
- CYP Crisis – providing 24/7 crisis provision combining crisis assessment, brief intervention and home treatment

[1] NHS Benchmarking Network

- Mental Health in Schools Teams established – working with schools to provide input for mild to moderate level mental health needs and develop whole school approaches to foster emotional wellbeing
- ASD Diagnosis and support – Improvements in waiting times for specialist services; designated Key Worker for CYP with LD and / or ASD by 2023/24

There have been significant developments within CFHD in response to the LTP. Building on two Mental Health in Schools Teams[2] in Exeter and Torbay, a further team was established in North Devon during 2020/21. A time limited *Wellbeing Education Return to Schools Project* was set up to provide support, advice and consultation to schools once children returned following the first lockdown. CAMHS also began delivering a Learning Disability and Autism Keyworker Pilot during 2020/21, working across community and paediatric services to support multi-agency working to meet the complex and high risk needs of children with mental health needs alongside autism and learning disability diagnoses. This is part of a National pilot to reduce admissions to CAMHS inpatient beds for this population of vulnerable children whose outcomes in an inpatient setting are not favourable. The CAMHS service has also become part of the SW Provider Collaborative as it prepares to 'go live' during 2021.

Finance

We have successfully operated within the resources available through the financial regime implemented to support the NHS's resilience during the pandemic. Our income for 2020/21 was £26.9m and if it were not for the impact of the interim financial framework under which the NHS was working there would have been a reported underspend.

During the year the Trust also secured funding for Mental Health in Schools, Children's Keyworker Pilot and WERS. In addition, non-recurrent investment was committed to reduce the ASD waiting list.

Our contract discussions for 2021/22 have been constructive and Devon CCG is committed to the investment in and development of improvements in mental health and community services for children. In addition to the mental health investment standard minimum uplift the national financial framework provides significant additional funds for CAMHS through transformation funds to support long term plan implementation and additional funding identified in the October 2020 spending review which provide the organisation with opportunity to further develop the services that we can offer children and young people.

Our financial performance is a credit to the hard work and professionalism of our staff both on the frontline and in our support functions. In particular I would like to acknowledge the dedication and professionalism of the finance, procurement, estates and digital departments for their significant efforts to meet the additional requirements

[2] This work follows a National pilot programme in line with the Green Paper 'Transforming children and young people's mental health provision' (2018) https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

set out by the national financial framework, delivering significant programmes of work at short notice and maintaining a high standard of business as usual work.

Risks and challenges

There are two key contractual risks relating to the CFHD contract. Firstly, the implementation of the new service model is delayed and secondly the service specification represents an extension of pre-existing provision. It is anticipated that implementation of the new service will now take place in Q3 or 4 of 2021/22. The extended service specification will have significant implications for demand for services, with additional health conditions and cohorts of children within scope. Whilst atypical, demand for services during 2020/21 and trends 'post-Covid' indicate a higher level of demand than assumed when the contract was let. Once the design stage of the transformation programme is complete, we will take an informed view on any areas of risk in being able to deliver the full service specification.

Throughout the year, corporate level risks related to vacancy rates in CAMHS, waiting times increasing across a number of services, a lack of clinical capacity in the eating disorders service in the context of increasing in demand, and a gap in corporate support for Subject Access Requests. Plans were in place to mitigate all risks.

Objectives for 2021/22

Transformation

1. Complete the transformation planning process and mobilise the new service model including development of SystemOne, the new electronic patient record system

2. Review and establish the governance and reporting arrangements across the two provider organisations

3. Develop the website and suite of digital resources for the community of children, young people and their families and professionals

4. Embed use of routine clinical outcomes monitoring across CFHD, reporting at individual, team and service level

5. Standardisation and integration across clinical pathways in the children's system – continue to work with Paediatrics and SEND transformation to develop multi-agency pathways of support, care and treatment

Business as Usual

6. Re-instate more face to face care and treatment but retain choice for service users with a mixed economy of face to face and remote access

7. Finalise service design and finance plans for the development of the crisis pathway, eating disorders pathway and 18-25 service

8. Bid for forthcoming NHSEI investment in services for children and young people with learning disabilities and/ or Autism
9. Develop a CFHD People plan – to include recruitment and retention, commitment to on-going staff engagement and development of staff including leadership development

10. Improve performance – embed productivity standards, creating optimal activity, clarity regarding capacity and demand management; establish and maintain sustainable waiting times

Conclusion and summary

2020/21 was the second year of the CFHD contract and followed a challenging first year in which the mobilisation of the new service model had been paused. Attention was paid to engaging staff in reviewing the first year of the service and in a clinically-led co-design process of the new clinical model. This process produced high quality, evidence based, innovative clinical pathways and an ambitious fully integrated operating model. There has been a very good level of engagement from staff and evidence of our workforce becoming more settled and invested in CFHD.

During the year there was considerable focus on improving performance and strengthening the governance arrangements. Our response to Covid manifested in swiftly-made adjustments to the delivery of care with 80% of care delivered via digital platforms. Services have experienced increased demand since the first lockdown which had a disproportionately adverse impact on vulnerable young people.

We have responded to the NHS Long Term Plan with developments in a number of areas to be implemented during 2021/22. The objectives for the year ahead relate to performance and quality improvements alongside elements of transformation.

Appendix 1

Performance: CFHD Waiting times 2020 / 2021

Service	Mean Waits in weeks			18 weeks RTT		
	April 2020	March 2021	Performance	April 2020	March 2021	Performance
Community Children's Nursing	5.6	1.7	↑	100%	100%	↔
Specialist School Nursing	0	0	↔	100%	100%	↔
Palliative Care	0	0	↔	100%	100%	↔
Learning Disability	8.2	3.3	↑	96.7%	100%	↑
CAMHS	14.8	13.4	↑	66.5%	72.7%	↑
Occupational Therapy	18	14	↑	48.2%	65.6%	↑
Speech & Language Therapy	19	22.8	↓	52.9%	48.5%	↓
Physiotherapy	12.3	12.3	↔	81.5%	72.2%	↓
Autism Assessment Service	41.5	55.7	↓	23.9%	17.7%	↓
Specialist Developmental Assessment Centre	17.9	21.5	↓	56%	45.2%	↓

Appendix 2

Transformation

CFHD Service Model

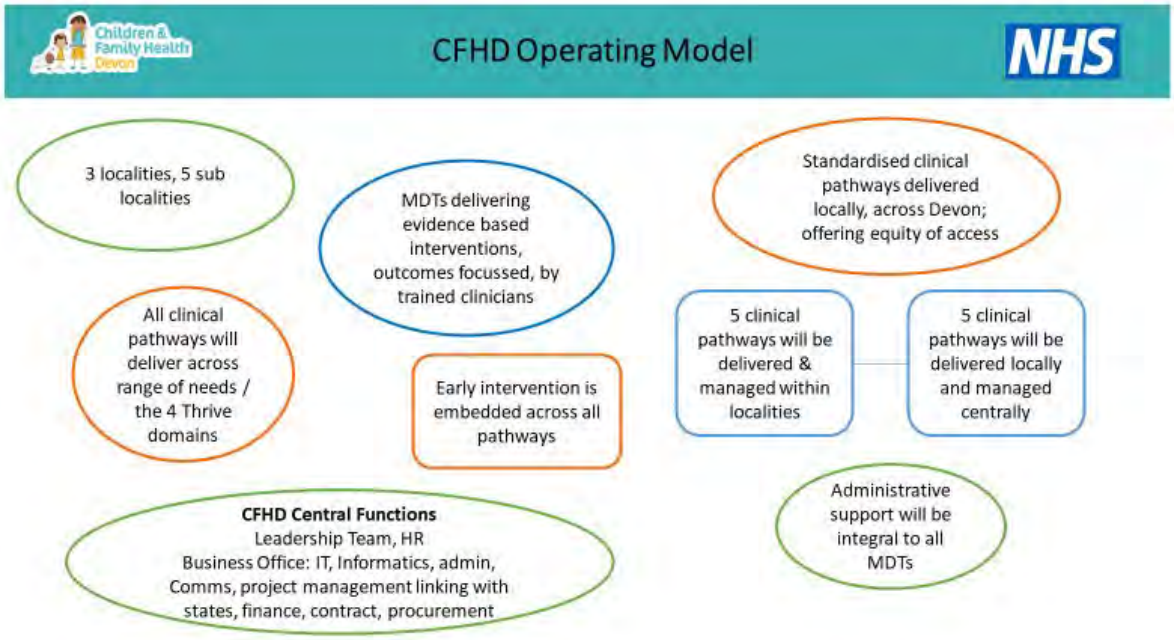
3 key developmental elements in the strategy:

- Increasing access to prevention and early intervention
- Integrating care and treatment across physical and mental healthcare and community and acute
- Integrating multi-agency provision across health, education, social care and the voluntary sector

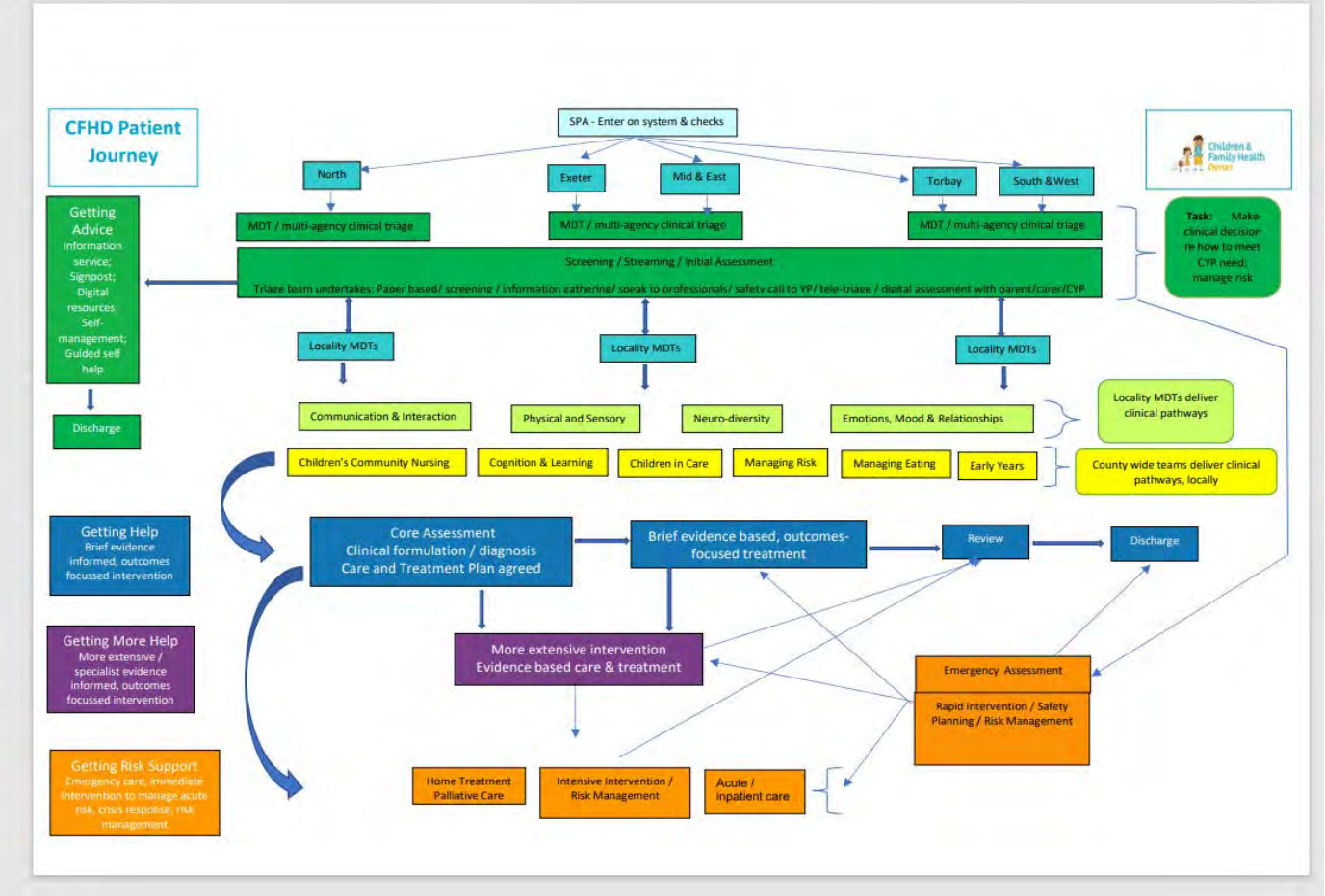
CFHD Service Model: Key elements

- Deliver high quality, outcomes-informed, compassionate care – working in partnership with our children and young people to achieve great clinical outcomes which improve their quality of life and their life chances
- Accessible to all who need it across all of our communities. Children are able to access the same range of services and quality of care and access wherever they live - a service offer which has integrity across Devon
- Provide evidence-based care and treatment and makes use of routine outcome measures
- Care is integrated and co-ordinated across specialties and agencies; integrating physical and mental healthcare, community and acute care pathways
- Children and young people are protected from harm – staff are skilled, knowledgeable and effective in safeguarding practice
- Children, young people and their families, are treated with compassion, understanding, respect and dignity and would recommend CFHD to their friends and family

CFHD Service Model: iThrive


CFHD Operating Model
NHS
3 localities, 5 sub localities
MDTs delivering evidence based interventions, outcomes focussed, by trained clinicians
Standardised clinical pathways delivered locally, across Devon; offering equity of access
All clinical pathways will deliver across range of needs / the 4 Thrive domains
Early intervention is embedded across all pathways
5 clinical pathways will be delivered & managed within localities
5 clinical pathways will be delivered locally and managed centrally
Administrative support will be integral to all MDTs
CFHD Central Functions
Leadership Team, HR
Business Office: IT, Informatics, admin, Comms, project management linking with states, finance, contract, procurement


Clinical Model
NHS
Clinical pathways
Physical & Sensory
Children's Nursing
Communication & Interaction
Children in Care
Managing Neurodiversity
Managing Risk
Managing emotions, mood & relationships
Managing Eating
Early years (infants & under 5s)
Cognition and Learning
Clinical pathway design was led by clinical leaders, undertaken with clinicians from the different specialties
Pathway design templates looked at.....
Children in scope, evidence based practice, professions required, routine clinical outcomes, alignment with service specification, pathway mapped onto the 4 Thrive Quadrants
The design leads then met with the CFHD leadership Team to review pathways
Pathway reviews also looked at....
Can the pathways be standardised across Devon? Are the interfaces with partner agencies described? Are opportunities for prevention/self-help/early intervention developed? Is care integrated across professions and agencies? Is the digital offer developed?


CFHD Patient Journey
SPA - Enter on system & checks
North
Exeter
Mid & East
Torbay
South &West
Getting Advice
Information service; Signpost; Digital resources; Self-management; Guided self help
MDT / multi-agency clinical triage
MDT / multi-agency clinical triage
MDT / multi-agency clinical triage
Screening / Streaming / Initial Assessment
Triage team undertakes: Paper based/ screening / information gathering/ speak to professionals/ safety call to YP/ tele-triage / digital assessment with parent/carer/CYP
Task: Make clinical decision re how to meet CYP need, manage risk
Discharge
Locality MDTs
Locality MDTs
Locality MDTs
Communication & Interaction
Physical and Sensory
Neuro-diversity
Emotions, Mood & Relationships
Locality MDTs deliver clinical pathways
Children's Community Nursing
Cognition & Learning
Children in Care
Managing Risk
Managing Eating
Early Years
County wide teams deliver clinical pathways, locally
Getting Help
Brief evidence informed, outcomes focussed intervention
Core Assessment
Clinical formulation / diagnosis
Care and Treatment Plan agreed
Brief evidence based, outcomes-focused treatment
Review
Discharge
Getting More Help
More extensive / specialist evidence informed, outcomes focussed intervention
More extensive intervention
Evidence based care & treatment
Emergency Assessment
Rapid intervention / Safety Planning / Risk Management
Getting Risk Support
Emergency care, immediate intervention to manage acute risk, crisis response, risk management
Home Treatment
Palliative Care
Intensive Intervention / Risk Management
Acute / inpatient care

Appendix 3

Key workforce metrics 2020/21

	CAMHS			Integrated Therapies & Nursing		
	April 2020	March 2021	Performance	April 2020	March 2021	Performance
Core training	79%	88%	↑	90%	92%	↑
Safeguarding L3 training	69%	82%	↑	78%	86%	↑
Vacancy rate	20%	14%	↑			
Staff turnover	20%	17%	↑	12%	17%	↓
Supervision	9% (May)	55%	↑			
Appraisal	14% (May)	64%	↑	44%	68%	↑

NHS
Torbay and South Devon
NHS Foundation Trust

Trust Board of Directors			
Report title: Building a Brighter Future Strategic Outline Case			**Meeting date:** 28th July 2021
Report appendix	Appendix A – Final version and appendices – Strategic Outline Case Appendix B – Estate Strategy		
Report sponsor	Director of Transformation and Partnerships		
Report author	Building a Brighter Future Programme Director		
Report provenance			
Purpose of the report and key issues for consideration/decision	To ensure that the Trust Board are able to scrutinise the Strategic Outline Case of the Building a Brighter Future programme, for submission to the national team for approval.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations	Members of the Trust Board are asked to approve the Strategic Outline Case and the Estates Strategy contained within the appendices section		

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: Building a Brighter Future Strategic Outline Case	**Meeting date: 28th July 2021**
Report sponsor	Director of Transformation and Partnerships
Report author	Building a Brighter Future Programme Director

1. Purpose of Report

This paper has been written to give members of the Trust Board an opportunity to review the Strategic Outline Case (SOC). Subject to the approval of the SOC by the Trust Board, 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 approve the SOC and recommend that the SOC can now be presented to the NHSE/I.

2. Review of initial draft

The SOC was presented to the Building a Brighter Future (BBF) committee in draft format at their June meeting and feedback received from this meeting has been incorporated in this final draft. The draft document was also used for the SOC engagement programme with external partner organisations and their feedback has also been included in the final version in the form of supporting letters.

It is important to highlight that the SOC has been subject to a further review by the regional NHSE/I team to ensure that all fundamental criteria required have been included. This second meeting took place on 16th July 2021.

3. Current position

This version of the SOC is the final version and includes all appendices including:

- **Trust Estates Strategy** – one of the fundamental criteria from SOC approval is the completion of a Trust Estates Strategy. This document has now been prepared and is included in the appendices section of the SOC. It is important to note that the Estate Strategy will require approval by the Trust Board prior to the submission of SOC.

  The Estates Strategy is currently developed to a SOC level of detail, which highlights broad principles for the development of the sites over the medium term. As the Outline Business Case for the BBF programme develops, the intention of the Programme Director and Interim Director of Environment will be to further develop the Estate Strategy into the level of detail required for an Outline Business Case.

- **Additional letters of support** – the Programme Office continue to receive letters of support from partner organisations. Any additional letters received by 28th July will be appended to the SOC.

4. Strategic Outline Case

The final draft of the SOC has now been completed and is enclosed as appendix A (with all associated appendices). However, to provide more

background a slide deck to assist with the SOC presentation has been included (see appendix B)

Key points for the Board to note are:

- 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 at £375m. This is slightly above the affordability threshold of £370m, but the SOC is clear that the Programme Office will ensure the affordability of £370m (which includes a £20m uplift to the £350m NHP allocation to be supplied from Trust resources) will be delivered at the Outline Business Case stage.
- 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.
- The benefit to cost ratio for the programme delivers the required 4:1 ratio. It is important to note that the Programme Office have taken a conservative view on the assessment of benefits (both cash releasing and non-cash releasing) with a view to ensuring this position can be improved at the OBC/FBC stage.

5. Next Steps

Subject to the approval of the Trust Board, the following actions will be progressed by the Programme Office

(i) The final version will be presented to the Regional NHSE/I team for their review.
(ii) The seed allocation for the OBC will constantly requested to ensure that the Programme Office is able to commence the work associated with the OBC as swiftly as possible.
(iii) Work will commence with the Integrated Care System (ICS) on the requirements associated with the delivery of any formal public consultation.

6. Recommendation

Members of the Trust Board are asked to:

(i) Approve the £370m Strategic Outline Case.
(ii) Approve that any non-material changes to the SOC requested by the NHSE/I can be undertaken by the Programme Director as required with the final version signed off by the Senior Responsible Owner (SRO).
(iii) Approve the Estates Strategy contained as an appendix to the Strategic Outline Case.
(iv) Approve the submission of the Strategic Outline Case to the Regional NHSE/I team for their review and approval.

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

BUILDING A
Brighter Future

Strategic Outline Case

for the Building a Brighter Future Programme

Our Estate REIMAGINED
Our People AT THEIR BEST
Our Digital CONNECTING

1 Foreword

The Trust views this capital investment as a 'once in a lifetime' opportunity, and this Strategic Outline Case (SOC) is the foundation from which this ambition can become a reality. It really is about us 'building a brighter future', not only from the perspective of our estate and digital systems, but also about being able to put the Trust in a sustainable financial position.

Throughout the development of this SOC we have taken a collaborative approach with all system partners across the South West Peninsula. We are committed to continuing to work closely with other regional (Devon) providers in receipt of New Hospitals Programme (NHP) capital allocations to ensure that the capital investment is delivered in a cohesive and efficient manner, and this commitment extends to our commissioning, local authority and voluntary sector partners, as well as local NHS provider organisations who are not in receipt of NHP capital allocations, who have also been fully engaged with in the development of the SOC.

From the outset of the NHP the Trust has taken the view that all the plans presented should be affordable from both a capital and revenue perspective, and we believe that this requirement has been delivered within this SOC. Furthermore, we firmly believe that this SOC provides a compelling case for change for the investment to be made into our digital and estate infrastructure at Torbay Hospital. We face significant daily operational challenges due to the very poor condition of our estate and the lack of an integrated Electronic Patient Record. These all adversely impact on the experience we are able to offer, and the plans presented in this SOC really will make a significant positive impact on the care we are able to provide.

This SOC represents the first milestone for Torbay and South Devon NHS Foundation Trust in our journey to secure £350m of capital investment from the NHP (and to which we will add £20m from our own resources). It has been a significant undertaking from everyone involved in both getting the SOC completed in accordance with the agreed timetable, but more importantly, ensuring that it is fully understood and supported by the multitude of key internal and external system partners across Torbay and South Devon.

Finally, we believe that this SOC is aligned to the priorities noted within the Devon Long Term Plan and that it will be a significant and essential enabler for change within Torbay and South Devon.

Sir Richard Ibbotson
Chairman
Torbay and South Devon NHS FT

Liz Davenport
Chief Executive Officer
Torbay and South Devon NHS FT

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Glossary of terms

AVfM	Absolute Value for Money
AUC	Assets Under Construction
BBF	Building a Brighter Future
BCR	Benefit:Cost Ratio
BAU	Business As Usual
CAPEX	Capital Expenditure
CRB	Cash Releasing Benefits
CDIS	Clinical and Digital Information Systems
CCG	Clinical Commissioning Group
CSS	Clinical Services Strategy
CIA	Comprehensive Investment Appraisal
CIP	Cost Improvement Programme
CSF	Critical Success Factor
CCS	Crown Commercial Service's
DHSC	Department of Health and Social Care
ED	Emergency Department
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
EU	European Union
EMC	Executive Management Committee
FM	Facility Management
F&I	Finance and Investment
FY	Financial Year
FBC	Full Business Case
GP	General Practice / Practitioner
JCT	Joint Contracts Tribunal
MMC	Modern Methods of Construction
NHP	New Hospitals Programme
NHS	National Health Service
NPC	Net Present Cost
NCRB	Non-Cash Releasing Benefits
NEC	New Engineering Contract
NHSE/I	NHS England and Improvement
NPSV	Net Present Social Value
OB	Optimism Bias
OBC	Outline Business Case
OJEU	Official Journal of the European Union
p.a.	per annum
PCN	Primary Care Network
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PHE	Public Health England
PP&E	Property, Plant & Equipment
PPU	Private Patient Unit
PRINCE 2	Projects In a Controlled Environment
PSCP	Preferred Supply Chain Partner
QALY	Quality-Adjusted Life Year
R&D	Research and Development
SB	Societal benefits
SDEC	Same Day Emergency Care

GIRFT	Getting It Right First Time
HIP	Health Infrastructure Plan
HMT	Her Majesty's Treasury
IPA	Infrastructure and Projects Authority
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICU	Intensive Care Unit
IAS	International Accounting Standards
IFRS	International Financial Reporting Standards
IO	Investment Objective
SOC	Strategic Outline Case
SoCF	Statement of Cash Flow
SoCI	Statement of Comprehensive Income
SoFP	Statement of Financial Position
TSDFT	Torbay & South Devon Foundation Trust
UB	Unmonetisable Benefits
UK	United Kingdom
VAT	Value Added Tax
VfM	Value for Money

2 Executive Summary

2.1 Introduction

We are Torbay and South Devon NHS Foundation Trust (the Trust). We are here to support the people of Torbay and South Devon to live well.

This Strategic Outline Case (SOC) makes the case for a £370m investment in our services (comprising £350m capital investment under the New Hospitals Programme (NHP), to which we will add £20m from our own resources).

We will use this investment to transform our Digital and Estates Infrastructure so that we can 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.

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.

2.2 Strategic Case

Key messages

- We are completely aligned to the Devon Long Term Plan and to the need to work as a system to resolve the financial challenges that exists.
- The key drivers for change with the Torbay and South Devon area all demonstrate an increasing demand for health care services over the next decade.
- We have a compelling case for change with both digital and infrastructure with significant backlog maintenance and very poor digital connectivity.
- We see that this Programme has to be seen as a strategic transformation Programme that develops the opportunity of £350m capital investment into a completely new and sustainable clinical model.
- Our investment plans have received strong local support from a range of partner organisations across Devon.

We have an ageing population and high levels of deprivation. Our children and young people are struggling on many fronts – health, wellbeing, emotional fragility, education, housing, employment.

We need to support our people to live well and give them hope, and we have expressed this in our vision:

"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 carer's experience and optimise health and wellbeing outcomes."

To realise our vision we have invested in our Building a Brighter Future (BBF) Programme, which this SOC presents. BBF focuses on the investments needed in our estate, our people and our digital set-up – these are where our biggest challenges lie and where we can have the most impact.

Our Programme is integrated with the Devon Long Term Plan, owned by all local authorities and the NHS and which focuses on:

- New hospital developments in Torbay, Plymouth and North Devon and modernising our GP estate;
- Investing in diagnostics and technology to do things differently; and
- More partnership working, sharing resources and helping each other to meet increasing needs.

The challenges we face are:

- An ageing estate that does not offer us the flexibility we need and does not 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 estates infrastructure and IT solutions, so unable to deliver the care they aspire to provide.

Doing nothing is not an option

Dawn's story – what BBF will mean for her

- Dawn has arthritis and has been experiencing difficulties with her mobility.
- She is prescribed a range of physiotherapy measures to reduce the risk of surgical intervention.
- She regularly sees her General Practitioner (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.

Bill's story

- Bill has Chronic Obstructive Pulmonary Disease, 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 (ED), 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.

Our 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; and
- No space for people in mental health crisis.

Digital:

- Inadequate IT solutions for delivering our new Health & Care Strategy;
- No integrated Electronic Patient Record (EPR);
- No integrated community and social care solution;
- Critical systems are at end of life; and
- We do not have a platform to transform our services.

We need:

- 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;
- 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 (VfM), support local economic regeneration and are kind on the environment; and
- All of which support collaborative working across all our services and beyond.

Our Programme responds to this need with a scope which encompasses:

- Digital transformation of our services;
- A robust and agile single electronic record system with inbuilt e-prescribing solution for use by all our services;
- A connected health and care digital solution across the Integrated Care System (ICS), with an integrated EPR at its cornerstone;
- Redevelopment of the Torbay Hospital site; and
- Addressing our backlog maintenance.

All of which will support an empowered and energised workforce.

2.3 Economic Case

Key messages

- The right options - Robust and reasonable long list of options has been created from which we have been able to select a strong shortlist for both digital and estates aspects. These are the right options to consider because they have been tested against clear CSF's linked to our Investment Objectives.
- The right appraisal method - Shortlisted options have been subjected to robust economic appraisal in line with green book and required CIA model.
- Robust appraisal inputs - Financial appraisal is felt to be robust because we have made reasonable and prudent estimates of costs and benefits, using external expert advice where appropriate and taking account of risk.
- Compelling economic case – A preferred way forward has been identified that represents a compelling case, good value for money with a cost:benefit ratio of 1:4.47 and it is believed that it is likely to be possible to make an even stronger economic case at OBC stage due to the very prudent approach taken to estimating costs and benefits.

We generated shortlists of options for delivery of the Digital and Estates Infrastructure elements shown below. All Estates Infrastructure options also meet the following Key Principles:

Table 2.1 – Key Principles

1.	2.	3.	4.
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**	**ED and Same Day Emergency Care (SDEC) services to be completely upgraded**

Table 2.2 – Shortlisted Digital and Estates Infrastructure Options

	Digital Short List Options	Estates Infrastructure Short List Options
Combined	**Option 1 – BAU (Business as Usual) / Counterfactual:** Continue with current multiple-systems strategy. Patient records are spread across multiple separate systems (electronic and paper based). Key systems replaced as part of natural succession.	**Option 1 – BAU / Counterfactual:** All existing services are maintained on the acute Torbay site, with capital investment to clear critical estates backlog maintenance.
	Option 2 – Do Minimum: Optimise the current multiple systems strategy. Replace key health and care systems that are outdated or inoperable, plus increased integration, system support and vendor management capacity.	**Option 2 – Do Minimum:** All existing services are maintained on the acute Torbay site, with capital investment to clear all backlog maintenance on the site.
	Option 3 – Initial Preferred Way Forward: Embark on an open procurement exercise to source a single integrated EPR system.	**Option 3 – Initial Preferred Way Forward:** Planned and unplanned care will be separated on the acute Torbay site, retaining a 24/7 ED. Capital investment will focus on rebuilding elements of the existing acute Torbay site, with targeted refurbishment of those areas retained. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
	Option 4 – Intermediate Option: Embark on an open procurement exercise to source a single integrated EPR system as a collective group of Trusts in the region.	**Option 4 – Intermediate Option:** as Option 3, except capital investment will focus on refurbishing the existing acute Torbay site, rebuilding discrete elements.
		Option 6 – Do Maximum: Reprovision of all services delivered at present, splitting unplanned and emergency care from planned pathways with extra capacity, with a full new build reprovision of the entirety of the existing site.

We have costed the options as follows:

Table 2.3 – High level capital requirement for Digital Options

	Digital Options	Option 2	Option 3	Option 4
Digital	Capital required	£7m	£58m	£61m

Table 2.4 – High level capital requirement for Estates Infrastructure Options

	Estates Infrastructure Options	Option 2	Option 3	Option 4	Option 6
Estates	Capital required	£131m	£317m	£326m	£987m

When combined, Digital Infrastructure Option 3 and Estates Infrastructure Option 3 come to a total capital requirement of £375m. The Trust has an overall affordability threshold of

£370m which is made up from a combination of NHP funding (£350m) and Trust local capital (£20m), we will ensure that the Programme is delivered within this affordability threshold.

The combination of Digital Option 3 and Estates Infrastructure Option 3 is the closest to this capital funding envelope.

In terms of our estate, this combined Option will enable us to accomplish the following:

Total new build development	20,650m^2
Total new / refurbished areas	28,261m^2
Programme	FY 2024/25 – FY 2028/29
Site disruption risk	Low – limited interfaces with existing estate
Planning risk	Medium

The table below summarises the results of the Economic Appraisal undertaken on the combined Programme options (combining Digital and Estates Infrastructure individual options). It is important to note that the funding requirements described above are not comparable to the figures shown in the following table. As per the requirements of the Comprehensive Investment Appraisal (CIA), the values used in the Economic Appraisal do not include the effect of inflation or Value Added Tax (VAT). In addition, the timing of cash flows and the net present cost nature of the figures creates further discrepancy. Further detail can be found at section 5.5 of the Economic Case, in addition to a bridging figure which articulates these differences.

Table 2.5 – Economic Summary of Combined Options

Combined	Economic Summary (£'000 NPV)	BAU	Option 2 Combination	Programme Initial Preferred Way Forward
	Incremental costs			
	Capital	-	105,376	141,755
	Revenue	-	181,001	33,432
	Total incremental costs	-	286,377	175,187
	Incremental benefits			
	Cash releasing	-	66,730	251,981
	Non-cash releasing	-	45,313	214,696
	Societal	-	-	74,592
	Risks	-	6,449	241,843
	Total incremental benefits	-	118,492	783,112
	Risk-adjusted Net Present Social Value (NPSV)	-	(167,885)	607,925
	Benefit:Cost Ratio	N/A	0.41	4.47
	Overall ranking	N/A	2	1

The Programme Initial Preferred Way Forward produces a ratio of 4.47, meeting the HM Treasury's (HMT's) required economic threshold of 4.0. The Programme Initial Preferred Way Forward allows significant levels of transformation to be undertaken within our organisation which in turn generates material benefits, both from a cash releasing and non cash releasing perspective.

The combined Do Minimum option (combination of Digital Option 2 and Estates Infrastructure Option 2) clears backlog maintenance on our acute Torbay site, however it does not address the fundamental changes required in order that the Devon Health and Care Strategy can be successfully implemented. As such, the level of benefits generated by this option are limited, seen through the low level Benefit Cost Ratio (BCR).

When incrementally compared to the Business as Usual position, the Programme Initial Preferred Way Forward has lower overall costs compared to the combined Do Minimum option. This is driven by high revenue costs for the Do Minimum Digital solution and the significant £162.8m required to clear the existing backlog maintenance on the site.

2.4 Commercial and Estates Case

Key messages

- We have given early consideration and have identified a direction of travel in relation to the Digital procurement options.
- We recognise that the procurement strategy for our Estates Infrastructure will be dependent on evolving National guidance and we will update and refine it on that basis.
- Modern methods of construction and net zero carbon have been considered in the development of our Estates Infrastructure options. We will undertake more detailed work in these areas at OBC to reflect further development of the options as well as National guidance and best practice from the NHP pathfinder schemes.
- We have started and will continue to explore the opportunity for disposals and potential commercial partnerships to seek ways to reduce the level of NHP funding required to deliver our Programme of investment.

The Commercial and Estates Case considers the procurement strategy for the Programme. At this early stage our view is that framework procurements are the likely procurement routes which best deliver on our commercial objectives of delivering:

- **price certainty**
- **VfM**
- **appropriate risk transfer**
- **compliance** with NHP and wider government guidance on procurement and construction processes
- **deliverability** for the Trust from the perspective of the resource and capacity available to manage the chosen procurement route
- a Programme which will generate **market appetite** among appropriate contractors.

2.5 Financial Case

Key messages

- There is an initial preferred way forward that is affordable in capital terms.
- The initial preferred way forward is affordable in revenue terms in that it will significantly improve the revenue position of the Trust within a reasonable timeframe.
- The proposed investment is expected to dramatically improve the financial sustainability of the Trust, taking it from repeated deficit positions towards financial balance and into surplus in future years. There is no prospect of this being achieved without the proposed investment.
- Support from key stakeholders has been secured and letters of support have been received following extensive engagement work.

The Financial Case examines the affordability of the shortlisted Digital and Estates Infrastructure options, taking into account funding and financing costs, inflation, optimism bias, planning contingency and VAT.

The NHP capital allocation for the Programme is estimated to be c.£350m (including fees, inflation and VAT), of which approximately £30.86m will be spent up to Full Business Case (FBC) submission. The Trust will add a further £20m of its own resource to bring overall

spend to c.£370m. At the current time costs are noted at £375m, the Trust is clear that this will be reduced to £370m as the Programme progresses. Within the Financial Case it is also clear that the initial capital costs are affordable within the available capital envelope, as demonstrated in the table below:

Table 2.6 – Funding requirement for Programme Initial Preferred Way Forward

	Funding requirement (£'000)	Total
Combined	Funding Source	
	NHSX (Public Dividend Capital (PDC))	6,000
	STP Digital Match funding (PDC)	6,000
	National – NHP (PDC)	350,000
	Other funding	13,228
	TOTAL	**375,228**
	Application of Funding	
	Build costs per OB Forms	226,113
	Equipment	12,984
	Professional fees	21,704
	Build Planning Contingency	18,990
	Optimism bias	37,142
	EPR Licenses	12,757
	EPR Implementation	30,203
	Paperless Investment	3,098
	Warranted Environment costs	4,254
	Migration from existing systems	379
	Digital Contingency	7,604
	TOTAL	**375,228**
	Source less Application	0

The Programme offers a significant opportunity to deliver a sustainable improvement to the Trust's underlying financial position, as transforming our clinical model, working with our system partners to align with Devon Long Term Plan priorities and making significantly required Estates Infrastructure improvements will achieve significant cash-releasing benefits in the longer term.

2.6 Management Case

Key Messages

- Our governance of the project is robust at a system and local level.
- We have a Programme team with the capacity and capability to deliver the programme.
- Our Design Leaders will play a key role in being able deliver the required transformation.
- Our risk management systems are now fully operational.
- Our timetable is consistent with the national planning assumptions on when construction would be able to commence.

The Management Case sets out the leadership, governance and management arrangements the Trust has put in place to deliver the Programme. Key points are:

- The Trust Board will be ultimately accountable for delivery of the Programme and for ensuring that we continue to work with our system partners, people who use our services and our staff, that we remain aligned to Devon Long Term Plan priorities and maintain our focus on delivering operationally and financially sustainable services;
- Adel Jones, Director of Transformation and Partnerships, is Senior Responsible Officer for the Programme;
- Programme and business case delivery is being managed through a structure which comprises:
  - Seven Workstreams reporting to the BBF Programme Group and BBF Programme Board; and
  - A Programme Office which supports the Workstreams and Programme Group and BBF Committee.

The Trust is working to the following Programme Plan:

Table 2.7 – Programme Plan

	Milestone	Date
Combined	Start of SOC development	Q4 2020
	Submission of SOC	July 2021*
	Submission of OBC (digital)	December 2021*
	Submission of OBC (infrastructure)	October 2022*
	Submission of FBC (digital)	July 2022*
	Submission of FBC (infrastructure)	October 2023*
	Start of site enabling works	January 2024**
	Start of construction works	From January 2025**
	Completion of construction works	2029***

* 'Critical path' items.

** Dependant on advice from national team

*** Dependent on the design option selected.

3 Introduction

3.1 Background and Context

Significant limitations in our digital and estates infrastructure have been present for over a decade, which have meant that our acute services infrastructure is neither fit for purpose at present or into the future and prevents us from achieving the service transformation envisaged in our Health and Care Strategy and/or putting our finances on a sustainable footing.

In September 2019 the Government announced the Health Infrastructure Plan (HIP) and subsequently the delivery vehicle for this new policy, the NHP. The NHP is to deliver 40 new hospitals by 2030, with our Trust being selected as one of the schemes to form the second tranche of programmes (delivery between 2025 and 2030). As part of the NHP our Programme – Building a Brighter Future – has received seed funding to explore the options open to us in order to deliver our overarching Programme objectives, with the view that we progress to the next stage of investment appraisal in order that these options can be examined in further detail.

The Trust initiated the Building a Brighter Future Programme over the course of 2020 and, working closely with our system partners, people who use our services and staff, developed a credible and well-founded case for change and Programme which aligns with Devon Long Term Plan priorities, as well as the Five Year Forward View and NHS Long Term Plan. By working closely with our regional (Devon) colleagues in the development of the underpinning strategies for our Programme, we have ensured alignment and cohesive strategic direction.

3.2 Purpose of this SOC

As articulated through the above narrative, it is a recognised position that urgent investment is required into both our aged acute estate physical infrastructure and our not-fit-for-purpose digital infrastructure. The main purpose of this document is to articulate this urgent need for investment in order to support the implementation of our transformative Health and Care Strategy.

Specifically this SOC seeks approval to move to the next stage of the business case development process, the Outline Business Case (OBC), and conduct a more detailed analysis of the redevelopment options to recommend a preferred way forward in order that procurement activities can commence.

3.3 Structure and Content

This SOC has been prepared using the agreed standards and format for business cases set out in both HMT's Green Book and Better Business Case (BBC) Guidance: Guide to Developing the Programme Business Case. In addition to these central guidance tools we have worked with our regional partners including Devon Clinical Commissioning Group (CCG), the Integrated Care System for Devon (ICSD) and NHS England and Improvement (NHSE/I) to reflect their requirements and ensure that our Programme align with Devon Long Term Plan priorities.

In developing our Programme we have identified two specific investment requirements:

- **Digital:** investment into an Electronic Patient Record
- **Estates Infrastructure:** investment into the estate at the Torbay acute site.

This SOC uses the 'five case' model, with the two Programme elements – Digital and Estates Infrastructure – clearly identified throughout:

- The **Strategic Case** sets out the strategic context and rationale for the Programme, articulating the overarching case for change and the supporting Programme wide Investment Objectives which encompass both Digital and Estates Infrastructure elements;
- The **Economic Case** sets out and appraises two sets of options capable of delivering on the Programme Investment Objectives, one examining the Digital element of NHP investment and the second the Estates Infrastructure aspect of the Programme. An Initial Preferred Way Forward for each element is detailed, which when combined creates the Programme Initial Preferred Way Forward
- The **Commercial and Estates Case** outlines the respective commercial strategy for the Programme and its constituent elements – Digital and Estates Infrastructure;
- The **Financial Case** confirms the funding arrangements and affordability of both the Digital and Estates Infrastructure shortlisted options, in addition to drawing conclusions as to the financial position of the Programme Initial Preferred Way Forward
- The **Management Case** demonstrates that the Programme is achievable and can be delivered successfully to cost, time and quality; and sets out how we will manage the OBC and FBC stages of appraisal and delivery of the Programme, building on the structures we have put in place to enable delivery of this SOC.

4 Strategic Case

Key messages

- We are completely aligned to the Devon Long Term Plan and to the need to work as a system to resolve the financial challenges that exists.
- The key drivers for change with the Torbay and South Devon area all demonstrate an increasing demand for health care services over the next decade.
- We have a compelling case for change with both digital and infrastructure with significant backlog maintenance and very poor digital connectivity.
- We see that this Programme has to be seen as a strategic transformation Programme that develops the opportunity of £350m capital investment into a completely new and sustainable clinical model.
- Our investment plans have received strong local support from a range of partner organisations across Devon.

4.1 Introduction

We are Torbay and South Devon NHS Foundation Trust. We are here to support the people of Torbay and South Devon to live well. We aim to achieve this by implementing a Programme which, by modernising our Digital and Estates Infrastructure, will enable us to "build a brighter future" by implementing our Health and Care Strategy, putting in place services which will deliver excellent care while putting us on a financially sustainable footing and align with Devon Long Term Plan.

'Building a Brighter Future' is the name of our Programme that is borne out of the funding that was promised through the Health Infrastructure Plan (HIP) in 2019 and has since been subsumed within the NHP. We prefer the title "Building a Brighter Future" because it describes what our aims are but also because it includes all aspects of the services that we provide as an integrated care organisation and is not just about building a new hospital. However, for the reader these terms are broadly synonymous.

We are proud to have been the first NHS Trust in England to integrate hospital and community care with adult social care in 2015. As a well-established Integrated Care Organisation (ICO) of more than five years' standing we have direct experience of the positive impact that working together in partnership with others has for our local population. Therefore we really are 'building a brighter future' together.

Through our Building a Brighter Future Programme we have a once in a generation opportunity to make a real difference in how we deliver services for our people and to meet the future health and care needs of our population by making a real difference to how services are experienced by service users through innovations in delivery. By building on our integrated approach to service delivery with significant investment into our Digital and Estates Infrastructure, we can provide better outcomes for patients and better working environments for staff across all the communities that we serve whilst aligning with Devon Long Term Plan priorities.

This Strategic Case sets out a clear rationale for our Programme, our ambition, and how we aim to improve care and outcomes for those who use our services while supporting better ways of working for our staff (who have been fully engaged in the development of our Health and Care Strategy and this SOC). It provides an organisational overview including our

vision, our present services and workforce before describing the local and strategic context within which our Programme is being developed.

The Existing Arrangements and Business Needs sections provide further information on the Digital and Estates Infrastructure arrangements and the improvements required. Our aim in these two sections is to provide an understanding of how a historic lack of investment in our Digital and Estates Infrastructure has restricted implementation of our Health and Care Strategy (attached at Appendix 9.1.1 and referred to throughout). A high-level description of the Programme and the investments required to deliver it is provided.

We describe our system partner engagement undertaken to date. The outcomes of this engagement lead into the Investment Objectives, which are used (together with the Critical Success Factors) to assess options described in the Economic Case. We are part of a network of providers and other organisations, and the Strategic Case also provides narrative on how we are working with our Partners, including the South Local Care Partnership and the Devon Integrated Care System to ensure that our Programme aligns with Devon Long Term Plan priorities.

The Strategic Case concludes by setting out the high-level benefits the Programme will deliver and the Programme's risks, and the constraints and dependencies within which we must operate.

4.2 Organisational Overview

This section provides a high-level factual overview of our organisation. More detailed information on the impact and significance of the facts presented here is developed in the Case for Change.

We are Torbay and South Devon NHS Foundation Trust (TSDFT)

Torbay and South Devon NHS Foundation Trust is an integrated care organisation, with multiple sites across our footprint.

We became an ICO in October 2015 when South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust merged.

As an ICO we deliver acute health care services, community health services and adult social care. We are proud to be the first NHS Trust in England to join up hospital and community care with social care. We have a number of community sites across our geographical footprint, including five community hospitals. Torbay Hospital is our main hospital site.

Our area of operations is divided into five localities. Our localities are indicated in the map below along with the main population centres. The Acute and Community Hospitals are also specifically shown in the map.

Torbay Hospital is our main site and provides a full range of district hospital services. It is the location for our planned and unplanned health and care services as well as the Trust's Emergency Department and Maternity Services. Other key direct clinical care sites are our four Community Hospitals and three Health & Wellbeing Centres. Our Community Hospitals are located in Brixham, Dawlish, Newton Abbot, Teignmouth and Totnes. There are 112 beds within our community hospitals and these sites provide a range of services, extending provision of acute services to support access within the community, including general surgery, gynaecology, midwifery and specialist physiotherapy. In addition to this, Teignmouth Hospital has day surgery facilities. The Dawlish and Totnes sites have Minor

Injuries Units, and Newton Abbot Hospital has an Urgent Treatment Centre. All three have X-ray capabilities and Newton Abbot has ultrasound, CT and MRI provision

The three Health and Wellbeing Centres are situated in Brixham, Dartmouth and Paignton. The three sites provide a range of local community clinics and act as a base for our community health and care teams providing nursing, therapy and social care support to our patient's in the community. A holistic approach is the key focus for health and well-being centres connecting services provided by the ICO with those provided by the third sector (i.e. non-governmental voluntary and community groups).

Figure 4.1 – Our main area of operations

Our workforce

As at 31 March 2020 we had 5,518 employees (whole time equivalent). The table below provides further details of the breakdown of employees.

Table 4.1 – Employee numbers breakdown

Combined		2019/20			2018/19
	NHSI Staff Group	Total Number	Permanently Employed	Other Number	Total Number
	Allied Health Professionals	478	468	10	402
	Health Care Scientists	92	92	0	91
	Medical and Dental	505	248	257	507
	NHS Infrastructure Support	1,068	1,027	41	1,009
	Other Scientific, Therapeutic and Technical Staff	365	353	12	359
	Qualified Ambulance Service Staff	7	6	1	7
	Registered Nursing, Midwifery and Health visiting staff	1,194	1,171	23	1,163
	Support to clinical staff	1,809	1,746	63	1,700
	Total	**5,518**	**5,111**	**407**	**5,238**

Analysis of worked full time equivalents (FTEs) (audited information)

We are required to provide an analysis of average staff numbers, in categories defined in the NHS Information Centre's Occupational Code Manual. This analysis distinguishes between 'permanently employed' and 'other' staff.

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating full time equivalent numbers is used, i.e. dividing the contracted hours of each employee by the standard working hours. Staff on outward secondment are not included in the average number of employees.

During 2019/20, we reviewed the way in which we categorise staff numbers, in order to improve alignment with NHS Digital's guidance on the categorisation of staff using Occupation Codes.

Future development of our workforce

We have an ageing workforce; approximately 26% of our staff are over 55 with the percentage significantly higher in some functions. This presents a demographic challenge, as we can expect to see a large number of staff retiring over the next 5 to 10 years. We therefore need to attract, recruit and retain younger staff to ensure our sustainability and to support our local communities. A facility that is a great place to work is key to attracting and retaining the highest calibre of staff.

We know we have work to do to **support our staff in developing enhanced digital skills to support new ways of working** and we are committed to doing so in a supportive manner and at pace.

Our vision

The vision approved by our Board has been developed through discussion with staff and stakeholders from across the organisation reflecting the breadth of service provision and clinical and professional opinion:

> *"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 carer's experience and optimise health and wellbeing outcomes."*

We know that our current model of care must change in order to achieve this vision, to fulfil our purpose to support people to 'live well' and to enable us to "build a brighter future". During 2020 we invested in developing our new Health and Care Strategy (attached at Appendix 9.1.1). At the heart of the Strategy is the principle that we will be fundamentally digitally enabled, providing services in physical settings only where this is absolutely necessary – a *digital first* approach. Our Strategy sets out the following visions for digitally- and physically-enabled care.

Our Health and Care Strategy

Digitally enabled care: services will be **'digital wherever possible'**, embracing the full spectrum of digital solutions for people accessing services as well as staff and partner organisations working behind the scenes:

- People and their carers will be empowered to access services through digital channels while in the community or at home, improving access.
- Interoperability of systems across the ICO and with partners will make transfer of information seamless and reliable.

We will embrace automation and artificial intelligence for routine tasks in combination with specialist clinical expertise. This will enable our skilled staff to spend as much time as possible on activities of greatest value.

Physically enabled care: through maximising the potential of digital and moving more activity to the community and people's homes, we will reduce the impact of rising demand on the physical space requirement of services on the Torbay Hospital site:

- We will make use of a broad range of physical spaces to deliver care, including those owned by our partner organisations such as primary care and local authorities.
- Our Torbay Hospital site will be prioritised for clinical activity and will have appropriate adjacencies between services to optimise care pathways, maximising safety, quality of care, efficiency and flow.
- We will increase the number of single rooms at least in line with national expectations to improve patient experience and increase resilience against infectious diseases.
- We intend to share physical resources with neighbouring providers to maximise resilience, value for money and quality of particular services.

The graphic below shows how we will make use of a wide range of assets to achieve the right balance of digital and physical service delivery (a fuller description can be found in our Health and Care Strategy at Appendix 9.1.1).

Figure 4.2 – Key features of digitally and physically enabled care

We recognise that our ability to implement the **'digital first'** approach is limited by the digital systems and infrastructure of the Trust and the age and condition and inflexibility of our Estates Infrastructure:

- Our Estates Infrastructure is no longer fit for purpose: it suffers from a significant maintenance backlog and many deficiencies have a detrimental impact on patient and staff experience.
- We do not have an integrated EPR solution and consequently do not have a single consistent view of patient records across the ICO. There is a high reliance on paper records and multiple different IT systems are used, many of which are not able to communicate with one another.

The key limitations associated with our current Digital and Estates Infrastructure are described in more detail in the **Existing Arrangements** section below.

Financial position

Our annual operating budget is around £500m. The most recent audited financial statements show a net deficit of £18m in the year to 31 March 2020. A deficit for the following two financial years was also forecast, with the impact of the Covid-19 pandemic cited as a significant uncertainty in the context of our short-term financial plan.[1]

For several years we have been operating in a difficult financial environment in which a rebalancing of NHS finances across the NHS in England has been sought. In this context we have been required to achieve year on year efficiency savings.

In recent years expenditure on infrastructure has been undertaken primarily to maintain it to the current standard: we have not had sufficient free cashflow to facilitate the upgrade of infrastructure in a manner which would enhance the quality of care provided. The table below provides a summary of the key financial metrics for the most recent year for which we have published our financial results. The Financial Case provides commentary on our financial results from 2019/20 along with comparable prior year figures.

[1] Torbay and South Devon NHS Foundation Trust, Annual Report and Accounts 2019/20

Table 4.2 – Summary of Key Financial Metrics (2019/20)

	£'m	2019/20
Combined	Total income	500
	Pay costs	(259)
	Non pay costs	(252)
	Operating deficit	(11)
	Net deficit for the year	(18)

Underlying financial position

It should be noted that there is a material difference between the Trust's reported financial position (as set out above) and its underlying performance. This is primarily driven by the receipt of £23m of non-recurrent support from NHS Devon CCG in 2019-20. It is acknowledged that this quantum of support is not affordable in the long term, recognising a structural deficit for the Devon Integrated Care System of some £330m. We are committed to reducing our underlying deficit through a five-year financial recovery programme, which will put us into a better position to absorb the revenue consequences of the NHP investment.

The drivers of the Trust's deficit are set out below:

Table 4.3 – Drivers of Trust's Deficit

	Domain	Value £'m	Description & source
Combined	Operational factors	(7) (14)	Inefficiencies vs peers (KPMG) Historic undelivered CIP (KPMG+)
	Strategic factors	(17) (6)	ASC & Placed People (KPMG) CCG contract value (PWC)
	Structural factors	(1)	PFI cost of capital, geographic isolation (DS)
	Total	**(45)**	

COVID-19

Our experience of the Covid-19 pandemic has informed our Strategic Case by:

- Providing evidence and experience of the effectiveness and acceptability of digitally enhanced care to service users and staff.
- Reinforcing the need for multiple access points for emergency care.
- Demonstrating the need for single rooms and for facilities to be designed so that beds can be isolated.
- Reinforcing the need to provide 'protected planned care' facilities, both in day case and inpatient care.

While the pandemic is not a key driver within the Case for Change, it has highlighted some areas that do need to be addressed to ensure that any future pandemic could be managed in a more effective and efficient manner. The pandemic has reinforced our direction of travel and demonstrated that our plans will be beneficial in multiple ways.

Our activity

The table below provides an indication of the levels of activity across the services we provide and shows decreases in activity across all but the last metric. The significant decreases can be attributed to the reduction in clinical services that could not be delivered during the pandemic.

Table 4.4 – Our Activity (2019/20 and 2020/21)

	Measure	2019/20	2020/21	Change
Combined	New outpatient attendances	113,110	92,693	-20,417
	Follow-up outpatient attendances	314,644	244,341	-70,303
	Total outpatient attendances	**427,754**	**337,034**	**-90,720**
	Day case	37,232	25,227	-12,005
	Planned IP	3,883	2,832	-1,051
	Emergency department attendances	115,601	79,636	-35,965
	Unplanned admissions – SDEC	4,455	7,562	3,107

4.3 Local population

Overview

We serve a geographical area of 350 square miles with a resident population of over 290,000. At any one time during a typical summer holiday season the population increases by about 100,000 visitors. This leads to increased seasonal demand on our services and places extra pressure on our existing Digital and Estates Infrastructure.[2]

Demographic challenge

With an average age of 45 (compared to the English average age of 40), our geographical area has a relatively high proportion of older residents[3]: in 2018, 27% of the local population was aged 60-79 and 7% of the local population was aged 80 or over. The graph below shows that these figures are significantly higher than for England as a whole, where 19% of the population was aged 60-79 in 2018 and 5% of the population was aged 80 or over.[4] It is established that utilisation of health and care services increases in a predictable manner with the increasing age of the population, as theatres, outpatients and inpatient beds are disproportionately used by older age groups. The Trust has observed that over 60s account for almost three quarters of inpatient activity and over half of theatre activity.[5]

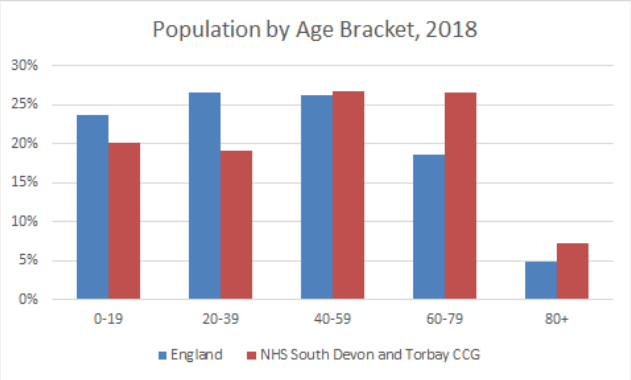
[2] Torbay and South Devon NHS Foundation Trust, Annual Report and Accounts 2019/20

[3] Joint Strategic Needs Assessment for Torbay 2018-2020

[4] Office for National Statistics (ONS), Population projects for clinical commissioning groups and NHS regions: Table 3, March 2020

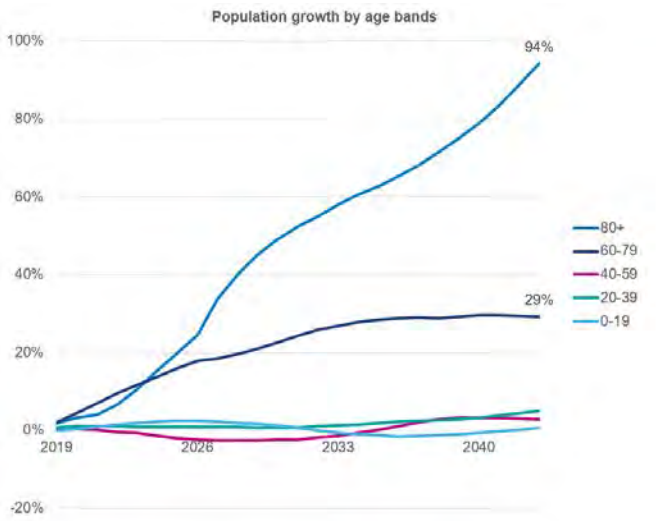
[5] Torbay and South Devon NHS Foundation Trust, historic activity datasets

Figure 4.3 – Population by age bracket, 2018



Furthermore, over the next twenty years the number of people aged 80 or over in Torbay and South Devon is projected to grow by 94%, and the number of people aged 60 to 79 by 29%.[6] These trends are demonstrated by the graph below.

Figure 4.4 – Population growth by age bands – Torbay and South Devon



Deprivation and social inequalities

Torbay and South Devon has a predominantly low-wage, low-skill economy that is over-reliant on the seasonal tourist industry focused around the coastal towns of Torquay, Paignton and Brixham.

Torbay records the highest levels of deprivation in South West England, with around 25% of children living in poverty (i.e. in households where income is less than 60% of the median income).[7]

Furthermore, in 2017 there were 285 Looked After Children in Torbay in the care of the local authority. This figure was equivalent to 112 per 10,000, one of the highest rates in England. The South Devon district of Teignbridge has the highest teenage conception rate in the whole of Devon, with the rate of 28 per 1,000 females being well above the English average of 19 per 1,000 females.[8]

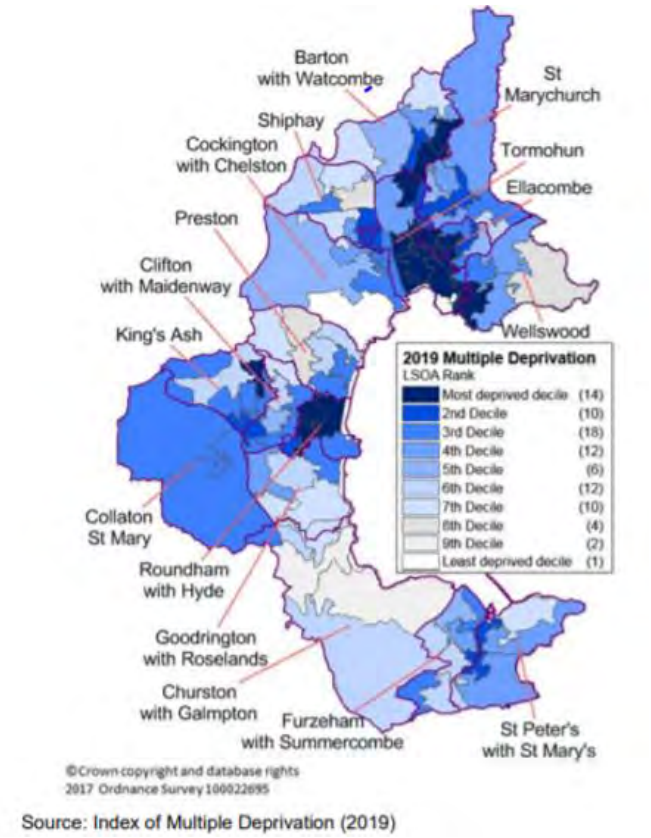
[6] Office for National Statistics (ONS), Population projects for clinical commissioning groups and NHS regions: Table 3, March 2020

[7] Joint Strategic Needs Assessment for Torbay 2018-2020

[8] Devon County Council, Joint Strategic Needs Assessment, June 2018

The map below shows the results of the 2019 Index of Multiple Deprivation, which measured relative deprivation in small geographical areas called Lower-layer Super Output Areas (LSOA). The map highlights the significant variations in deprivation levels across Torbay in particular.

Figure 4.5 – English indices of deprivation 2019 – rank of Index of Multiple Deprivation



Source: Index of Multiple Deprivation (2019)

Social inequalities have an impact on health, as evidenced by the fact that residents in the most affluent areas of Torbay can expect to live six years longer than those in more deprived parts of the borough.[9]

We have relatively high rates of emergency admissions to hospital: from 2014/15 to 2016/17 there were 39,260 unplanned care (Emergency Department and Minor Injuries Unit) attendances per 100,000 of the population; this compares to the English average of 35,450 per 100,000 for the same period.[10] The high levels of deprivation within the local area should be considered a contributory factor: according to NHS Digital, in 2019/20 in England as a whole there were nearly twice as many attendances to emergency departments for the 10% of the population living in the most deprived areas, compared with the 10% living in the least deprived areas.[11]

Health challenges

Smoking and obesity contribute to poor health amongst the South Devon and Torbay population. In Torbay 1 in 6 adults smokes and around 6 in 10 adults are overweight or

[9] Joint Strategic Needs Assessment for Torbay 2018-2020

[10] Joint Strategic Needs Assessment for Torbay 2018-2020

[11] NHS Digital, Hospital Accident & Emergency Activity 2019-20

obese. The percentage of women recorded as smoking at the time of child delivery (17.7%) is significantly higher than the average rate for England (11.4%).

Rates of alcohol and obesity-related hospital admissions are significantly higher than the English average: for example from 2014/15 to 2016/17 the rate of obesity related admissions in Torbay was 2,164 per 100,000, more than double the English average of 1,007 per 100,000 for the same period. The interdependence of physical and mental health pressures is demonstrated by the fact that Torbay has high levels of mental ill health and self-harm in the population: from 2014/15 to 2016/17 the rate of long-term support for mental health was 207 per 100,000, notably higher than the English average of 168 per 100,000 for the same period.[12]

4.4 Strategic Context

This section outlines the ICS and local strategic context within which we are seeking investment to "build a brighter future" by implementing our Programme, making ourselves financially sustainable and aligning with Devon Long Term Plan priorities.

National context

New Hospitals Programme

We have responded to the NHP by putting in place a strategy for transforming our health and care services – our Health and Care Strategy. The NHP gives us a "once in a lifetime" opportunity to transform our services and finances through investment in Digital and Estates Infrastructure.

We understand that, in reviewing individual investment programmes, the NHP team will look for opportunities where it may be feasible for Trusts to work together to develop and procure their digital and/or estates solutions and therefore deliver better value for money.

We further understand that the NHP will work together with Trusts to maximise opportunities to identify and, where feasible, implement emerging digital technologies which have the potential to greatly improve patient care and experience. We are already working with our system partners across the Devon and Cornwall peninsula to leverage implementation resource and knowledge sharing, to ensure that future systems will be inter-operable, and to implement an EPR solution at scale. Inter-operability of systems is considered in the Digital options appraised in the Economic Case.

Design guidance on intelligent hospitals has been prepared. This guidance will be provided to all NHP project teams and should form the basis of the approach to design across all individual programmes. The aim of the guidance is to maximise the benefits of the use of standardised design, modern methods of construction, digital and net zero carbon.

NHS Long Term Plan

The NHS Long Term Plan was published in 2019 and was the strategic plan for the NHS to improve the quality of patient care and health outcomes. The plan focuses on building an NHS fit for the future by:

- Enabling everyone to get the best start in life;
- Helping communities to live well; and
- Helping people to age well.

[12] Joint Strategic Needs Assessment for Torbay 2018-2020

The Plan has been developed in partnership with frontline health and care staff, patients and their families. It will improve outcomes for major diseases, including cancer, heart disease, stroke, respiratory disease and dementia.

The plan also includes measures to:

- Improve out-of-hospital care, supporting primary medical and community health services;
- Ensure all children get the best start in life by continuing to improve maternity safety including halving the number of stillbirths, maternal and neonatal deaths and serious brain injury by 2025;
- Support older people through more personalised care and stronger community and primary care services; and
- Make digital health services a mainstream part of the NHS, so that in 5 years, patients in England will be able to access a digital GP offering.

Carter Report

The Carter Report was drafted in 2015, however the recommendations made are still very relevant six years after its publication.

The report looked at productivity and efficiency in English non-specialist acute hospitals, which account for half of the total health budget, using a series of metrics and benchmarks to enable comparison. It concluded that there was significant unwarranted variation across all of the main resource areas.

The report made fifteen recommendations to tackle this variation and help trusts improve their performance to match the best. Some of the more relevant recommendations to this SOC are noted below:

- All Trusts should have key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of ‘meaningful use’ standards and incentives;
- Trusts should operate at or above the benchmarks agreed by NHS Improvement for the operational management of their estates and facilities functions, with all Trusts (where appropriate) having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space, so that estates and facilities resources are used in a cost-effective manner;
- Trusts should, through a Hospital Pharmacy Transformation Programme, develop plans to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration;
- Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement;
- The Department of Health and NHSE/I should work with local government to provide a strategy for Trusts to ensure that patient care is focused equal on patients’ recovery and how they can leave acute hospitals beds or transfer to a suitable step-down facility as soon as their clinical needs allow; and
- NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.

Health Infrastructure Plan

Health is the nation's biggest asset and the NHS is the Government's top domestic priority. The Government has already committed to increasing the NHS's day-to-day spending by £33.9 billion by 2023-24, to back the NHS's own Long-Term Plan (LTP). The NHS and the healthcare services it provides to the nation are underpinned by capital funding for infrastructure comprising buildings, including hospitals, equipment, ambulances, frontline technology as well as technological advances in areas such as Artificial Intelligence (AI) and genomics.

Capital spend on NHS infrastructure is essential to the long-term sustainability of the NHS's ability to meet healthcare needs, unlocking efficiencies and helping manage demand. It is also fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery to staff being better able to care for patients using the equipment and technology that they need. The NHS is also supported by research and public health facilities and networks, and adapted or specialised housing that reduces or delays the need for healthcare.

What is the Health Infrastructure Plan?

The Health Infrastructure Plan will deliver a long-term, five-year rolling programme of investment in health infrastructure, including capital to build new hospitals, modernise primary care estate, invest in new diagnostics and technology and address critical safety issues. At the centre of this will be a new hospital building programme to ensure the NHS' hospital estate supports the provision of world-class healthcare services.

The Government has announced six new large hospital builds that are receiving funding to go ahead now (aiming to deliver by 2025), and 21 more schemes that have the green light to go to the next stage of developing their plans (with the aim of being ready to deliver between 2025-2030). In total this first tranche involves more than 40 hospital building projects.

The HIP is not just about capital to build new hospitals – it is also about capital to modernise mental health facilities, improve primary care and build up our infrastructure in interconnected areas such as public health and social care – all of which, together, ensure this country has the world class facilities that it needs.

The Department of Health and Social Care will receive a new multi-year capital settlement at the next capital review, which will be additional to the £3.9bn extra capital funding announced at the 2017 Spring and Autumn Budgets

Regional (Devon) context

Devon Long Term Plan

We have worked together with Devon's other NHS organisations[13], Livewell Southwest and the local councils to produce the Devon Long Term Plan (the "Plan") which will ensure that Devon's health and care system supports people to live healthier lives; improves physical and mental health outcomes for children, adults, older people and families; promotes wellbeing; and reduces health inequalities across the whole of Devon.

The Plan's vision is "Equal chances for everyone in Devon to lead long, happy and healthy lives."

[13] Devon Partnership NHS Trust, NHS Devon Clinical commissioning Group, Northern Devon Healthcare NHS Trust, Royal Devon & Exeter NHS Foundation Trust and University Hospitals Plymouth NHS Trust.

Background

The approach to health and care services will by necessity vary in different places and different parts of Devon but the overall strategy will remain constant. Members of local authorities (county, district, borough, town and parish councils), community and voluntary organisations and health and wellbeing boards all have a key role to play in bringing the strategy to bear on the local tactical approaches.

People's physical and mental health and wellbeing is influenced by a wide range of social, economic and environmental factors. The Plan puts more resources into prevention and early intervention to reduce the spend on later, high cost interventions. The wider determinants of health can only be addressed through local action on employment, skills, housing, social, culture and community networks.

The physical health of some people with mental illness is significantly worse than the health of Devon's population as a whole. Health and care providers, commissioners, professional bodies, service user and carer organisations, and charities in Devon are committed to working together to bring about equal physical health for people with a mental illness.

Personalised care and support helps people make decisions about managing their health so they can live the life they want to live based on what matters to them, working alongside clinical information from the professionals who support them. It aims to identify what is most important to each person for them to live a healthy life and ensure that the support they receive is designed and coordinated around their desired outcomes. This approach is fundamental to the delivery of the Plan.

The context for the Devon Long Term Plan

Devon's health and care system faces many challenges:

- Whilst more people are living longer it is often in ill-health.
- Preventable illnesses are increasing.
- There are persistent inequalities in life expectancy and health outcomes.
- The population is growing and the proportion of older people is set to increase, and this will increase the demand for services.
- Vital health and care jobs are unfilled and numbers of working age adults will reduce in future.
- There is continuing pressure on hospital beds.
- There is unwarranted variation in clinical outcomes across Devon.

Funding for health services is increasing nationally but is not keeping peace with the demand for services. This is a particular challenge for the NHS in Devon, which has spent more than its allocation for a number of years. Significant savings will need to be achieved through cost containment and cost reduction. Over the next five years resources will need to be allocated to maximise efficiency and avoid organisations overspending. The approach to ensuring the financial sustainability of the NHS is detailed in the Plan and aligned with the NHS's direction of travel.

Devon's health and care system also performs poorly against some key national targets. The performance of services will be improved by meeting the standards set out in the NHS Constitution for the waiting times for non-urgent operations, the speed of treatment in emergency departments and the time taken for people to receive the diagnostic tests recommended by their GP.

Devon Long Term Plan ambitions

The NHS Long Term Plan describes how challenges for health and care will be tackled over the next five years by transforming services and redesigning systems. The Devon plan sets out six shared ambitions:

1. Effective and efficient care

Reducing waste, tackling unwarranted clinical variation and improving productivity everywhere so that Devon taxpayers' money is used to achieve best value for the population.

2. Integrated Care Model

Enhancing primary care, community, social care and voluntary and community services to provide more care and support out of hospital care.

3. A Devon deal

Nurturing a citizen-led approach to health and care which reduces variations in outcomes, gaps in life expectancy and health inequalities across Devon.

4. Children and young people

Investing more in children and young people to have the best start in life, be ready for school, be physically and emotionally well and develop resilience throughout childhood and on into adulthood.

5. Digital Devon

Investing to modernise services using digital technology.

6. Tackling inequalities

Working together to tackle the inequalities in the physical health of people with mental illness, learning disabilities and/or autism.

The organisations that shape Devon's health and care system will be organised so as to reflect the interdependencies between services. This will pave the way for continuous improvements, transformed models of health and care and delivery of a financially sustainable system.

In coming together the health and care organisations will:

- Seek solutions that work for the system: no organisation will knowingly create an adverse impact on another or the system.
- Standardise practice and services where it makes sense to do so.
- Focus on cost reduction and cost containment. The drivers of cost include growth, inflation and unwarranted variation in practice. Partners will commit to adopt best practice and support one another in doing so.
- Recognise that participation will be required at system, locality, neighbourhood and organisational level on the priority areas.
- Invest in out of hospital models which provide the right care in the right place, acknowledging that sourcing investment may cross organisational boundaries and take time to secure sustainable delivery.
- Invest in the estate portfolio to reflect the new models of care so that different services can be delivered from different sites across the county and take opportunities to establish centres of excellence.
- Ensure equitable distribution of funding and outcomes by locality.

- Jointly develop an annual implementation plan and only invest what can be afforded.
- Not make new investments that total more than the funding allocation growth received into the system.
- Consider financial decisions alongside quality (i.e. safety, effectiveness and any impact on patient experience of care.
- Share risks and benefits across the system and ensure they are fully understood by all parties.

A Devon Integrated Care System has been established. The Devon ICS will set objectives and outcomes for improvements to health and care services in line with the Plan.

Devon Long Term Plan programmes and key priorities for action

The programmes for delivery of the Plan are shown below and will transform how services are provided. The programmes' main impacts will be measured against national metrics and success judged against targets. Programme management arrangements will provide the framework for implementation and ensure that controls are in place on quality, risk, investment and financial viability.

Peninsula Clinical Services
As medical and clinical knowledge advances and health needs change, services need to continually transform. There will be a greater focus on day surgery, better access to diagnostic testing and more specialist centres to improve outcomes for patients.

Planned care
The capacity for planned surgery will be increased, which will cut long waits and reduce waiting lists. Services will be developed to enable the most effective and efficient provision of planned care.

Integrated Care Models
Groups of GP practices including doctors, nurses, pharmacists and physiotherapists will come together and work closely with community health and social care teams, mental health professionals and voluntary and community services to better support local people and communities. The choice and control that people have over their own care and support will be expanded and enhanced through shared care planning and increasing use of personal health budgets.

Mental health
Mental health care and support services will be transformed and the inequities for people with mental ill-health who suffer poorer physical health care will be tackled.

Caring for children and young people
More help will be provided so that fewer children require statutory intervention. Better services will be provided for emotional wellbeing and mental health, together with support for children and young people with special educational needs and disabilities.

Better Births Devon
It is now much safer to have a baby than ten years ago, but more will be done to improve care and support.

Medicines optimisation
Unwarranted clinical variation will be addressed and resource utilisation improved, to minimise preventable medication-related admissions.

Unplanned and emergency care
People will get the care they need quickly through access to a range of same day services including NHS111, GP surgeries or via digital technology. This will relieve pressure on Emergengy Departments.

Prevention
Focused on action to reduce premature deaths due to smoking, poor diet, high blood pressure, obesity, and alcohol and drug use, so that people live longer in good health.

Workforce
The health and care system will be the best place to work and staff will be trained and deployed more effectively, with more use of digital technology, to meet the projected increase in demand for health and care services.

Digital
People will have access to information about their care via the NHS App, while local care records will enable better sharing of data. Everyone will be able to consult with their GP online, where they want to, giving them quicker and easier access to GP services.

Technology will help people to monitor their health at home and in their communities, especially in rural and isolated areas.

An electronic patient record through which information will be shared between health and care organisations will be implemented.

Devon Integrated Care System Strategic Outcomes Framework

Building on the principles of the Devon Long Term Plan, the Devon ICS Strategic Outcomes Framework has been designed to monitor the health of the population and the integrated care system in Devon. The framework is based on a number of indicators, including life expectancy, low birth rate, infant mortality and child poverty. The content is to be populated by both intelligence teams and topic leads, building on the population health management currently in place.

Even though all of the outcomes of the framework are yet to be finalised, the way in which the framework will measure outcomes is clear. It is imperative that we align our strategic direction in a manner which allows it to deliver against the outcome measures.

Planned care strategy for Devon and Cornwall

The Devon ICS has agreed to review the provision of planned care based on historical suboptimal performance (exacerbated by Covid-19 pandemic), the observation that modelled demand in unplanned care will swamp planned capacity within 10 years and on the financial deficit position of the ICS. All providers have contributed to the first stage of the review which concluded that there was a need for innovative transformation which should include all partners and the provision of Protected Planned Capacity through a variety of options. Therefore the Devon Trusts which have received NHP funding allocations – ourselves, Northern Devon Healthcare NHS Trust (NDHT) and University Hospitals Plymouth NHS Trust (UHP) – are working together with NHS Devon CCG to demonstrate how the investment from the NHP can support reconfiguration of planned capacity overall and specifically what level/type of planned care should be provided on individual district general hospital sites. We understand that the planned care components of our individual programmes are dependent upon agreement of a Devon-wide planned care programme.

Detailed evaluation of the agreed options for planned care will take some months to deliver and may be subject to wider and formal public consultation, and this will need to be considered within the timescales of our subsequent business cases to deliver our BBF Programme.

A document which sets out our understanding of the current position in more detail is attached at Appendix 9.1.2.

Local context

Local partnership

We have proactive partnerships with Torbay and Devon County Council and will collaborate with the Council across a number of elements of the Programme. These include delivery of a net zero carbon agenda; flexible estate solutions to support the delivery of new agile working arrangements for non-clinical and clinical support services; and a designated planning officer to support us in the planning and delivery of our Programme.

We are also in discussion with partner organisations from within Torbay (Torbay Development Association and NHS Devon CCG) regarding the development of a Cavell Centre in the centre of Torquay. These discussions are currently focused on how to deliver health and wellbeing services for local residents so that the need for people to attend the main acute site at Torbay Hospital is reduced. These services could include:

- Primary Care Urgent Response Unit
- Community Podiatry
- Sexual Medicine
- Health and Wellbeing Services
- Cancer Counselling Services
- Community Dental.

We currently manage in the region of 14,000 Emergency Department (ED) attendances at Torbay Hospital each year that would fall into the primary care response category and these people could be very safely managed with the support of a Cavell Centre. Furthermore, the community services noted would also benefit from being able to operate from new fit for purpose accommodation within a community environment.

The Trust is focused on the delivery of care as close to patients homes as possible and these partnership arrangements will assist the Trust in being able to delivery this objective.

Climate change

In 2019 a range of public, private and voluntary organisations from across Devon formed the Devon Climate Emergency Response Group. This group declared a climate emergency and endorsed the principles of the Devon Climate Declaration which acknowledged the significant implications of climate change for Devon's communities.

NHS Devon CCG is a member of the Devon Climate Emergency Response Group and we recognise that the upgrade of our Estates Infrastructure will need to clearly demonstrate contributions towards reducing carbon emissions. This will be incorporated in our plans.

Local infrastructure

As an ICO one of our key aims is to provide care as close as possible to where people live. We have good local infrastructure to support this. We have appointed GPs as Locality Clinical Directors in each of the five ISUs, who work with the Trust part-time. Their role is to help us integrate services between primary care and community and hospital services.

The aim is to offer people comprehensive support including access to rehabilitation services in their own homes and communities. Successful local-system working has resulted in us reaching out and providing more support to care homes, as well as building up health and wellbeing services with voluntary sector partners and referring more people to our community healthcare teams rather than to hospital.

This joined-up approach is making a real difference: more people are benefiting from social prescribing and receiving more out of hospital support.

Sustainability and Transformation Partnership (STP) estate strategy

The STP Estate Strategy (attached at Appendix 9.1.6) was published in 2018 and made a number of recommendations that are consistent with the development of this SOC. The recommendations made in the report are noted below:

- **Service led estates changes –** In order to deliver the transformational service changes in Devon the estate must change.
- **Business continuity risk management (backlog) –** Tackling backlog maintenance is a key priority in Devon to ensure a safe environment for service delivery.
- **Performance of the estate –** In Devon it is clear that there are significant opportunities for estate optimisation; achieving efficiency savings associated with these is highly dependent upon the articulation of the service delivery model.
- **Transformation of primary care –** This is a core requirement to improving and integrating out-of-hospital care.
- **Surplus estate – I**t is clear that there are significant opportunities for estates rationalisation across the partner organisations in Devon and work is ongoing to optimise the estate in support of the STP's clinical and service strategy.
- **Improving utilisation and the reduction of voids –** The estates and facilities efficiency workstream will continue to drive efficiency across the acute estate in line with Carter Report requirements and the model hospital.
- **Governance –** Well-developed governance arrangements are in place to ensure that the estate is a key enabling workstream at the core of the STP.
- **Capacity to deliver transformational estates change –** The Devon STP has created capacity to enable the recruitment of an Estates Delivery Unit to drive estates change within the new structure of the commissioner.
- **Linkage between STP service themes and estates changes required –** Investment in acute estate is key to the delivery of modern, safe services, improving ED performance and reducing backlog maintenance.

Further to the STP estate strategy, our own estate strategy has been refreshed throughout 2021, found at Appendix 9.1.8. This sets out the state of our existing estate, our future ambition and how we will look to deliver this change.

4.5 The Case for Change

Our Case for Change builds on our integrated approach to service delivery and presents the case for significant investment into our Digital and Estates Infrastructure. With this investment we will be able to provide better outcomes for patients and better working environments for staff across all the communities we serve, taking advantage of new technologies and the latest improvements in healthcare, planning not only for the needs of our people today but also for the future. We will be able to "build a brighter future" by overcoming our long term operational and financial challenges; realise the ambitions we

have heard from our system partners, people who use our services and staff; and align with Devon Long Term Plan priorities.

The Organisational Overview highlighted the population challenges we face. Addressing these challenges will require investment in the Trust's Digital and Estates Infrastructure in order to ensure that it is more responsive, efficient, joined-up and agile.

The two pillars of our Case for Change are investment in our Digital solutions and investment in our Estates Infrastructure. They are crucial to the successful delivery of the **digital first** approach outlined in our Health and Care Strategy, and therefore drive our investment requirements.

Our Health and Care Strategy is:

- Clinically led and committed to sustainable clinical services and value for money
- An opportunity to deliver better care and patient outcomes in different ways
- Realistic about what we can achieve depending on the monies we receive
- Inclusive, open and honest
- Not just about hospital services or buildings, but about everything we do
- About transforming how we work and provide care over the next ten years
- About supporting our people to live well

Digital

A co-ordinated Digital solution will enable us to drive significant positive change in the safety, quality of care and experience of patients, carers and staff. Without significant investment in Digital we will not be able to deliver our Health and Care Strategy, support our people to live well or "build a brighter future" by delivering sustainable services which align with Devon Long Term Plan priorities.

Our Digital solution is being developed to reflect the methodology, framework and best practice set out in the NHSX NHP Blueprint for Digitally Advanced Hospitals (Version 5).

Table 4.5 – Digital Case for Change

	Area of change	Description
Digital	Increasing capacity with limited resources	Standardised care pathways will reduce waste. Joined up pathways will improve flow through the health and care system with seamless pathways reducing duplication, resulting in a better experience for patients and carers and more job satisfaction as well as less bureaucracy and waste for staff.
	Improving safety and quality	A modern, joined up digital solution will aid clinical decision support. It will reduce the risk of transcription errors and of making decisions in an information void, resulting in better, safer care for patients and improved patient outcomes.
	Empowering patients and carers	Technology will give patients and carers the information they need to self-manage and work with their care providers in various settings, resulting in improved patient outcomes, care being provided at home or in the community while enabling staff to support more people.
	Facilitating better information sharing	Currently patient records are held across multiple electronic and paper based systems that do not talk to one another. Access to a single electronic record will enable a patient's information to follow them everywhere and facilitate wider collaboration between care providers, resulting in better, safer care for patients, improved patient outcomes and reduction in waste and duplication for staff.

	Being data driven	This will lead to integrated reporting across organisational and geographical boundaries. It will also facilitate evidence-based decision-making with near real time information. Data will be used to prompt patients and carers into making their own health and care choices, resulting in better, safer care for patients and improved patient outcomes.
	Reforming the user experience of technology	This change will enhance interactions between patients, carers and providers. It will meet the demands of the environment whether mobile or clinic based, resulting in reduced paperwork and waste for staff and a better patient experience.
	Cost saving efficiencies	Technology will reduce the cost of using and managing paper, make services more efficient and achieve secondary financial benefits through improved safety and quality, resulting in reduced waste and improved sustainability.

Estates Infrastructure

We believe that a major transformation of our Estates Infrastructure is required, together with the Digital element of our Programme, to address key deficiencies including the unsuitable clinical layout, lack of spare capacity and condition of the buildings. Unless resolved these deficiencies will obstruct our ability to “build a brighter future” by securing sustainable services which align with Devon Long Term plan priorities.

Our Estates Infrastructure Case for Change is based on the following four pillars:

Clinical flow

The existing Estates Infrastructure on the main Torbay Hospital site creates a complex pathway for patients to navigate, with poor adjacencies and overall clinical flow. A fundamental reconfiguration of the Estates Infrastructure will allow for the implementation of the new clinical model of care, in turn leading to significant clinical efficiency and improvements in patient experience and outcomes.

The diagrams of the departmental sections set out in Appendix 9.1.3 help to demonstrate the topography challenges that exist at our Torbay Hospital site. Within this site the main tower block faces notable complexities in respect of clinical adjacencies, for example ambulatory care and operating theatres are both spread over two different floors. All ambulatory care and all operating theatres should be located on single floors. Furthermore the configuration of the Emergency Department is suboptimal, as a consequence of our buildings having been extended in an *ad hoc* manner over time.

Financial sustainability

Investment into our aged Estates Infrastructure will enable a solid base for our future long-term financial sustainability through the realisation of both clinical and operational efficiencies.

Digital

Our Estates Infrastructure is not compatible with the modern digital solution required to implement our new Health and Care Strategy. A critical objective of the generational NHP is the delivery of digital assets to enable efficiency, safety and quality benefits.

Fit for purpose Estates Infrastructure

Carbon neutral ambition

- Our existing Estates Infrastructure does not allow for the delivery of a carbon neutral health asset, which is a national and international priority.

Delivery of our Health and Care Strategy

- The existing site configuration does not allow for separation of planned and unplanned care.

Backlog maintenance

- Our estate degradation is significant as evidenced through our backlog maintenance which stands at £162.8m overall (including on-cost, contingency and VAT) from FY 2021/22 to FY 2031/32, with £32.2m classed as condition D – critical.

Pandemic-readiness

- Our existing Estates Infrastructure requires significant investment to make it ready for a future pandemic. In particular it requires increased single room capacity, resilient medical gas infrastructure and improved clinical pathways.

Flexible spaces

- Our existing Estates Infrastructure is inflexible, which drives poor utilisation of spaces and an inability to adapt to short-term and longer-term changes in service demand.

Operational challenges

The Digital and Estates Infrastructure at Torbay Hospital is stretched and is not fit for purpose. Our operational teams face daily challenges in endeavouring to deliver a high quality service, and the table below provides an overview of some of the issues faced – many on a daily basis.

Table 4.6 – Key operational challenges

Combined	**Digital**
	Prevention and well-being: There is little ability to provide citizens with access to the technologies they need to self-manage or access to their health and care records. The digital citizen is not adequately connected to care providers. At best, citizens can access generic resources such as signposting apps and Trust intranet. Poor quality, disjointed information means services cannot use digital to support their clients at a population level. **Care closer to home:** Our current digital systems are constrained to a limited number of devices and are therefore not suitable for particular use cases or environments. This restricts workflow and where/how care can be delivered. Care remains centralised because the record cannot be shared. **Integration:** The integration needs of our Health and Care Strategy are not being addressed. The main hospital record predominantly remains paper-based, and Trust digital systems are limited in content and accessibility. Movement between providers and systems requires transcription to reconcile the medical record, with associated clinical risk and inefficiency, and this will worsen as the digital divide across organisations widens. Diagnostics are constrained to single providers. Pathways only exist within each organisation; they are not seamless and there is no integration or standardisation. **Value:** Innovation and transformation in planned and unplanned care can only be delivered where they do not require digital support. Staff have no incentive to modernise using digital, limited opportunity to develop shared pathways with provider partners, and no opportunity to develop their digital skills. We fail to provide our citizens with the opportunity to improve their health literacy and independence through digital. **Digital buildings:** Our digital operating solutions for our built environment currently reside in the 20th century.
	Estate

Our wards provide inadequate environments that are not compliant with HBN/HTM guidance. They are poorly designed, which significantly compromises our ability to effectively manage either surges in activity or infection control issues. Overall the wards adversely affect privacy and dignity through lack of showering and toilet facilities, as none of the side rooms have en-suite provision. We have no space for bariatric patients without losing bed capacity in other areas of the ward, a problem that is exacerbated by the lack of any ceiling-mounted hoists in any ward areas.

From a wellbeing perspective there is a lack of social space in ward areas to engage patients in wellbeing activities, and the day rooms are not fit for purpose. The ward areas also have limited natural light and lack of ventilation, as none of the windows in our Tower Block can be opened. Furthermore, there are no designated mental health crisis spaces for patients in any area within the Trust.

In terms of access throughout the site, our passenger lifts regularly break down, we also regularly lose swipe door access into clinical areas.

From an environmental perspective we generate a significant carbon footprint as we do not use any renewable energy. In addition, we suffer from a lack of usable green space for staff and patients and we are not able to promote green travel due to the lack of staff changing facilities.

4.6 Existing Arrangements

This section sets out the Existing Arrangements in respect to our Digital and Estates Infrastructure and highlights the key deficiencies.

4.6.1 Digital

Overview

Our existing digital technology cannot support our ambitions.

There are currently over 150 different IT systems in use across our services. Most of these systems do not communicate with each other – for example the Emergency Department system does not interact with the in-patient system. Inadequate integration of systems causes inefficiencies through the duplication of work and also increases the risk of errors as a result of inputs being required from numerous different staff members. It also creates additional burdens on staff by requiring them to access multiple systems simultaneously to perform different aspects of their roles and to manually transpose data between systems.

These challenges will be exacerbated with the significantly increasing collaboration between providers, with more patient care pathways spanning organisational boundaries. This will require more standardisation within and between providers.

We have begun to implement some foundational activities in support of the change required. For example, the Board of Directors has approved a programme to become a digitised organisation in collaboration with NHS Health Education England. Furthermore, there has been a concerted effort to invest in a secure and reliable infrastructure.

Our challenge remains that there are fundamental digital issues that require urgent resolution. These are described below.

Lack of integrated Electronic Patient Record solution

We do not have an integrated EPR solution. Patient records are currently held across multiple digital systems which do not interact effectively with each other. An integrated EPR solution would reduce paperwork and is considered to be an essential requirement for achieving the operational efficiencies and standardisation of processes which we are seeking to achieve. It is important to note that all of the planning of our future digital care

model has taken into account the NHS Digital Blueprint which addresses how digital services can influence fabric, footprint and flow within new hospital infrastructure.

The lack of an integrated EPR solution can adversely affect patients' experience – for example operations can be cancelled at short notice because surgical teams only see the patient's medical records on the day of surgery.

Lack of integrated community and social care digital solution

We are currently operating three separate digital solutions for community and social care services and this hinders realisation of the full benefits of operating as an ICO. For example, transfer from hospital to a lower acuity setting can be delayed because hospital staff do not have access to accurate information on the availability of community care resources. Conversely community care staff cannot "pull" patients from hospital because they cannot see which patients are available to be moved into the community.

Difficulties in mobile working

Key systems cannot be accessed on mobile devices and do not allow for offline working. This means that community staff are not able to remotely update patient records and obtain details of their next visit or call. They therefore need to regularly return to central locations for online access to our information systems. This reduces the number of patients they can see in a day.

Critical legacy systems are at end of life

Our critical legacy systems – for example the Patient Administration System (PAS) – have reached the end of their working life. We are one of the few remaining users of a PAS system that is over 40 years old. It is however important to note that there are a number of critical legacy systems that require urgent replacement to enable us to achieve our vision, purpose and strategic objectives.

Lack of a digital platform to transform our services

Transforming services to effectively meet the changing needs of our patients, carers and staff is the key to delivering our ambitions. However, seamless care cannot be achieved alongside poor interoperability across multiple systems. For example, two-week wait outpatient appointments are scheduled by post. The letter can take up to five days to arrive, leaving little time to re-book and fill an appointment if the time offered is not convenient to the patient.

4.6.2 Estates Infrastructure

Overview

Our Estate infrastructure is old and life-expired. This was demonstrated by the uncontrolled loss of critical mechanical and engineering infrastructure in 2018, which was the result of a "fail, mend and repair" culture in anticipation of a new Private Finance Initiative (PFI) Hospital.

In 2018 it was clear that this approach was no longer sustainable or viable to maintain patient safety and therefore we developed an Estates Infrastructure improvement programme in response. This process has identified a significant maintenance and capital infrastructure backlog and operational improvements which need to be resolved and implemented to maintain patient safety and deliver efficiencies.

Layout and capacity

Our current layout is substandard in many parts of the estate. The lack of agility and flexibility with our old estate, in particular a lack of single rooms, was demonstrated and exacerbated during the Covid-19 pandemic when whole wards had to be cordoned off to put proper infection control measures in place, resulting in significant capacity issues.

To compound these issues further, our estate has no decant space or spare capacity and this is restricting our ability to innovate and expand. For example, breast and gynaecology services have an ambition to take on additional imaging capacity but are not able to do so due to a shortage of space.

This lack of flexibility and the general poor condition of our estate is a significant hindrance to the morale of our staff and impacts our ability to bring forward innovation.

Condition of the Estates Infrastructure

We have backlog maintenance which stands at £162.8m overall, with £32.2m classed as condition D – Critical. Without investment the estate's condition will worsen, which will further increase the risk of critical failures and create an environment of firefighting and missed opportunities where the backlog will only increase. As set out above in Table 4.6, there are numerous aspects of our Estate Infrastructure's current condition which can have an adverse impact on the experience of patients and staff.

The images set out below help to illustrate the poor condition of parts of the estate.

Figure 4.6 – Image below: Roof repairs on maternity building

Figure 4.7 – Image below: Dilapidated building housing office and clinical support services accommodation and storage

Figure 4.8 – Images below: Temporary accommodation which is no longer fit for purpose, being used to accommodate a range of services long term.

Figure 4.9 – Image below: Disused portacabin. The building behind accommodates medical teams for office based work.

Sustainability

Our heating and hot water system is reliant on fossil fuels, with a life expectancy until 2024-2029. It is therefore difficult for us to significantly reduce our carbon footprint and support the local decarbonisation strategy. Starting a new-build utilising modern methods of construction in 2025 or sooner will align with our sustainability ambition to significantly reduce our carbon emissions.

4.7 Business Needs

4.7.1 Digital

As previously mentioned we recently developed our Health and Care Strategy. At the heart of the Strategy is the key principle that we will adopt a *digital first* approach. We have five key ambitions which specifically require the adoption of a *digital first* approach:

- Prevention and wellbeing;
- Care closer to home;
- Integration;
- Value; and
- Digital buildings.

The realisation of the first four of these ambitions through the *digital first* approach is considered immediately below, while the fifth ambition is considered within section 4.7.2 – Digital buildings. Supplementing our Health and Care Strategy is our Digital Strategy, found at Appendix

Prevention and wellbeing

There will be increased attention on prevention and empowering people to manage their own health, care and wellbeing. We will improve and enhance self-care and communicate the advantages of independence. People will increasingly have access to a range of digital tools that will allow them to monitor their health and wellbeing. Where appropriate these digital tools will be able to interact with care professionals and systems.

People will be able to use digital tools to access their records. Our current solution for individual's access to their health and care records is Patient Knows Best (PKB), but sign-up and usage are low. In light of its increased importance under a *digital first* approach we are re-examining its role in our portfolio of health and care applications.

To address the challenge of digital exclusion, we will adopt a holistic approach to prevention and wellbeing to help prevent the digital exclusion of demographic groups which are less digitally enabled.

Care closer to home

We will harness digital capability to deliver timely care closer to home. There will be a reduction in reliance on our facilities and more emphasis on mobility and being flexible in respect of the locations at which staff see patients.

Community staff will be able to update information systems while with their patients and pick up the details for their next call while on the move, without the need to return to a base location. This will be achieved through ensuring that our systems can be accessed by mobile devices and can allow for offline working.Integration

Collaboration between providers will increase significantly, with more patient and carer journeys crossing organisational boundaries. This will require more standardisation within and between providers.

- The Covid-19 pandemic has led to a reinforcement of system working, with shared support and network leadership becoming more robust across the system.
- As part of the South East North Devon (SEND) network, we have entered into a new strategic alliance to co-operate and collaborate to develop an agreed and over-arching SEND clinical model. This includes the development of corporate services, estate and digital strategies and pan-SEND clinical strategies.

- Head and neck cancer patients will receive their care in the Royal Devon & Exeter, Derriford and Torbay Hospitals, with major surgery being undertaken in Royal Devon & Exeter and Derriford only, as has been the case for some time.
- Getting It Right First Time (GIRFT) is an NHS Improvement programme designed to improve quality of care by reducing unwanted variations. We are using the GIRFT model with our orthopaedic team, but this relies on accurate data and efficient systems to inform and positively influence care delivery.
- The Peninsula Clinical Services Strategy (PCSS) and Peninsula Cancer Alliance has led the way in creating networks across hospitals to share expertise and facilities to provide better care in specialised centres for complex cases. The PCSS has supported the development of networks to raise standards of care and ensure consistency in provision, as well as providing a vehicle for planning the future shape of those services.
- Development of Community Diagnostic Hubs and Diagnostic Network – the plan to develop shared rapid response diagnostic centres to improve waiting times, meet national access targets and increase productivity was a target in the Devon Long Term Plan. This is now a more significant issue as diagnostic waits increase following the Covid-19 pandemic.
- The Peninsula Pathology Network – to provide more efficient and effective services, pathology services will be provided across Devon and Cornwall out of three hubs in Cornwall, Plymouth, and the SEND network.

The new models of care require greater cohesion between all providers across the whole Devon ICS with consistent levels of digital maturity. Examples of seamless pathways which feature digital as a key enabler include:

- Cardiology patients have care pathways which span self-management/home monitoring to complex tertiary care. Their clinical record will comprise contributions from the patient, remote monitoring devices, primary care, community care, secondary care and tertiary care.
- Inpatient vascular surgery has been centralised to major hospitals but other aspects of care are provided by district hospitals, supported in the community by primary care. The patient's medical record, including imaging, needs to be shared between providers and there would be a significant benefit to a shared solution for workflow and scheduling.
- Many cancer pathways include aspects provided in tertiary care facilities, but other treatments, diagnostic clinics, follow-up and rehabilitation are delivered in secondary care or the community. At present the handover is mostly based on paper and transcription between digital systems and lacks a single record to which the patient and their family might have access.

Value

Our *digital first* approach will enable us to realise better value from our services: for example, a reduction in the use of paper systems will reduce the costs associated with transposition errors.

Covid-19 highlighted the value in using technology to reduce face-to-face contact and in questioning as to when face-to-face is absolutely necessary. This paradigm shift is a key component of demonstrating value.

4.7.2 Digital Buildings

Overview

Capital investment will prioritise the redevelopment of buildings and the relocation of services. The creation of digitally-enabled Estates Infrastructure will be a key element of

renovation works on existing buildings and digital technology will be at the forefront of design plans for new buildings.

Rebuilding our Estates Infrastructure for the 21st century

We will use the NHSX Blueprint for Digital Hospitals, which sets out three fundamental components for the NHP:

- Fabric – planning for digital during the construction phase in alignment with ecologically sound principles. This includes the infrastructure layer, architecture and design for digital, and applications to support building management.
- Footprint – interaction of people with the building, and the building with the wider care ecosystem. This includes patient experience, virtual care, integrated care, and staff engagement.
- Flow – the operating models that underpin our health and care services. These are largely building agnostic and include core health and care systems (e.g. EPR, Local Health Care Record, prescriptions, document management), learning and cognitive systems, and security and information governance.[14]

Our proposal is to implement the key Digital Flow components (i.e. the EPR solution) in advance of the implementation of the Estates Infrastructure NHP element of the Programme (which include the Fabric and Footprint components).

This means that there will be two OBCs that follow our BBF Programme SOC (this document):

1. An overall BBF Programme OBC that predominantly covers Fabric and Footprint; and
2. A Digital Flow OBC that predominantly covers Flow.

The reasons to deliver these Flow digital solutions ahead of estates are as follows:

- The case for change for the Flow component is the most pressing and is therefore a priority for us to address immediately.
- The Flow component is predominantly building agnostic, so may be achieved at a quicker pace than the overall NHP Programme.
- Implementing the Flow component early provides an opportunity to realise benefits sooner.
- Unnecessary risk is avoided from the conflicts of two major change programmes running at the same time.

Improved clinical layout

Adjustments will be made to the layouts of our buildings to avoid the unnecessary passing of staff through the Emergency Department and to co-locate services to optimise efficiencies.

The redesign of layouts will provide better separation of planned and unplanned care sites. Services on the planned site will include routine orthopaedics, urology, endoscopy, cataract operations and hernia surgery. The unplanned site will include maternity services and an emergency department. While separate, the planned and unplanned care sites will remain close together to avoid difficulties where escalations to emergency or inpatient care are required.

We will increase the number of single-bed rooms relative to the number of 4-bed bays.

[14] A more detailed description of the three fundamental components can be found in section 6.3 of the Commercial and Estates Case

4.8 Engagement

We have proactively engaged with a wide range of internal and external system partners as we have developed our Health and Care Strategy and this SOC, detailed below. This engagement has enabled us to remain true to our goals of addressing our long term challenges with our infrastructure to deliver our Health and Care Strategy and achieve operationally and financially sustainable services, and aligning with Devon Long Term Plan priorities.

Internal engagement on the Health and Care Strategy

The development of the Health and Care Strategy was clinically led through internal engagement. We engaged virtually with 158 staff members across 55 touch points, including nursing, medical, allied health professional and operational teams, as well as our leadership teams, Healthwatch and carers groups representatives, through the events below:

- Three executive sessions
- Two Clinical Management Group sessions – this group includes senior clinicians and operational leads from across the ICO
- Four workshops with the Health and Care Reference Group – a task and finish group which included ICO clinical and system leads, Primary Care representatives for ICO systems, Staff Side representatives and BBF Programme leads for the ICO responsible for developing the overarching strategy
- 10 workshops with health and care staff and our carers lead
- 21 1:1 and small group discussions with clinicians
- Three discussions with organisational operations staff
- 10 small group discussions with Integrated Service Unit (ISU) triumvirate leads
- Two testing sessions across health and care staff groups

External engagement

During June and July 2021, we undertook a comprehensive programme of external engagement. The table below provides an overview of the stakeholders engaged with. It is important to note that this engagement will continue throughout the OBC and FBC phases of the Programme, to ensure that all remain fully engaged and supportive of the proposed investment into our Digital and Estates Infrastructure.

Table 4.7 – Stakeholders engaged

	Stakeholder	Date of engagement
Combined	**Present, scrutiny and approval of SOC (final version)**	
	ICS Partnership Board	7 July 2021
	CCG Governing Body meeting	1 July 2021
	SOC socialisation	
	Local MPs:	
	- Anthony Magnall	15 June 2021
	- Kevin Foster	2 July 2021

- Anne Marie Morris	17 June 2021
- Steve Darling	1 July 2021
Torbay Council Overview and Scrutiny Committee	9 June 2021
Devon County Council Overview and Scrutiny Committee	16 July 2021
League of Friends	6 July 2021
Brixham Town Council	14 July 2021
Exeter Universities	22 June 2021
Plymouth Universities	28 June 2021
South Primary Care Collaborative Board	22 June 2021
Devon County Council Public Health Lead	*TBC*
Torbay Together	18 June 2021
Torbay Health and Wellbeing Board	13 August 2021
Devon Local Medical Committee	24 June 2021
Torbay Community Development Trust	25 June 2021
Teignbridge District Council	29 June 2021
South Devon College	16 June 2021
South Hams District Council	24 June 2021
Our people networks	5 July 2021
Governors and members	7 July 2021
Healthwatch Devon	17 June 2021
Torbay Development Authority	1 July 2021
Torbay Culture	24 June 2021
Rowcroft Hospice	22 June 2021
Teignbridge CVS	1 July 2021

Letters of support / Supporting letters

A letter of support from NHS Devon CCG has been provided in accordance with the requirements of annexe 12 in the planning guidance (see Appendix 9.1.4). It is important to note that the Trust has a strong relationship with the two other NHP sites in Devon (North Devon and University Hospitals Plymouth) and on that basis, the discussion that took place with NHS Devon CCG on 1 July 2021 was jointly presented by all three Trusts. This relationship will continue through the remaining phases of the Programme, with a view to ensuring the alignment of preferred options with the requirements for the Devon system.

In addition to the above, the Trust has looked to ensure that all partner organisations have been given the opportunity to comment on the SOC as it has been developed. All letters of support received are noted in Appendix 9.1.4.

Subject to the approval of the SOC, this partner engagement will continue as the project progresses through subsequent phases of Outline and Full Business Cases.

Public consultation

The Trust is working with the other NHP providers across the South West Peninsula to ensure that the NHP investment delivers in a manner that is consistent with the Devon Long Term plan and in particular the Devon Planned Care Strategy. Our joint plans were presented to the NHS Devon CCG Board on 1 July 2021 and to the Devon Overview and Scrutiny Committee on 16 July 2021. Our investment and strategic transformation plans will require review from these stakeholders to establish whether formal public consultation will be required.

All NHP sites are aware of the potential requirement for a pre-consultation business case, and very clearly would not look to indicate any preferred option to the local population until the formal consultation had taken place.

Design process

System partner engagement in the design process will be significant. The detailed development phase of the Programme will commence at OBC stage and system partner engagement will be established through the governance framework of ‘user groups’ with the support of our technical advisers. The following phases of design development will take place:

- Development Control Plans
- Clinical adjacencies
- 1:200 department layouts
- 1:50 room layouts

At each stage a fully representative group of clinicians, nursing, allied health professionals and operational colleagues will be involved in ensuring that the design output delivers the required footprint from which our clinical model can be delivered. These groups will also include patient and carer representatives to ensure that their perspectives are addressed in the design of the new hospital.

We will also ensure that we engage with and involve our local communities and the public as we build our OBC. The Communications and Engagement workstream team will ensure appropriate and effective engagement and involvement and formal consultation where necessary, with system partners’ governing bodies/boards, members, clinical leaders,

frontline staff, partners in the health and social care system, patients, service users, carers and the public.

Planning is already underway to ensure effective continuing communications and engagement with all system partners. Further information on this planning is set out in the Management Case.

4.9 Programme Investment Objectives

This section sets out the Investment Objectives associated with our Programme. Together with the Critical Success Factors (CSFs) these will be used to appraise the potential delivery options in the Economic Case and provide a reference point for post implementation evaluation.

Our Programme Investment Objectives have been determined following consideration of BBC guidance and industry best practice. They are designed to address the drivers for intervention and they clearly articulate what we are seeking to achieve in terms of targeted outcomes.

The Investment Objectives help us to stay focused on our objectives of "building a better future" by using investment to address our infrastructure challenges and secure sustainable services, working with our system partners to align with Devon Long Term Plan priorities and engaging people who use our services and staff as we develop our plans.

A single set of SMART Investment Objectives is proposed for the Programme as a whole, with separate CSFs identified for each of the Digital and Estates Infrastructure elements.

Table 4.8 – Programme Investment Objectives

	Number	Programme Investment Objective
Combined	1	To improve the quality of health and wellbeing services for Torbay and South Devon people, working with our partners and neighbours to deliver more coordinated and collaborative services across the Devon ICS and wider system.
	2	To provide a safe environment through the provision of a high-quality facility that is easy to maintain and operate, by removing all backlog maintenance on the existing Torbay Hospital site.
	3	To ensure our long-term financial sustainability by delivering operational efficiencies, improving patient pathways and transforming our Digital and Estates Infrastructure.
	4	To support economic regeneration and innovation through collaborative strategic partnerships that deliver significant local and regional (Devon) growth.
	5	To deliver a facility that is a great place to work which attracts and retains the highest calibre of staff.
	6	To deliver an asset which is kind on the environment, delivering an asset in line with the net zero carbon agenda identified through the climate emergency status set by the Torbay local authority.

The below tables set out the SMART nature of each of our Programme IOs:

Table 4.9 – SMART nature of Investment Objective 1

Combined	Investment Objective 1	
	To improve the quality of health and wellbeing services for Torbay and South Devon people, working with our Partners and neighbours to deliver more coordinated and collaborative services across the Devon ICS and wider system.	
	Specific	To improve the quality of health and wellbeing services for Torbay and South Devon people such that it is more coordinated, timely, accessible and better enables delivery of clinical quality targets and the best possible experience for Torbay and South Devon people.
	Measureable	Evidenced by: • Joint Strategic Needs Assessment (JSNA) data • Reduction in hospital re-admission rates • Reduction in mortality rates • Comparative indices (e.g. Dr Foster)
	Achievable	By the development of new facilities and systems that allow the implementation of clinical best practice as captured in the clinical mode as well more effective collaboration to deliver services across Devon ICS and wider system.
	Relevant	In line with national and local guidance and plans: • Torbay and South Devon NHS FT Health and Care Strategy • Devon Planned Care Strategy (in development) • Devon Long Term Plan • Clinically led Review of NHS Access Standards (March 2019) • NHS Long Term Plan (January 2019)
	Time-bound	We would expect to see this objective being fully met over time but starting to see the benefits in the measures from the year after the new facilities and systems are fully operational.

Table 4.10 – SMART nature of Investment Objective 2

Combined	Investment Objective 2	
	To provide a safe environment through the provision of a high-quality facility that is easy to maintain and operate, by removing all critical backlog maintenance on the existing Torbay Hospital site.	
	Specific	To resolve current estates and digital infrastructure issues with the aim of delivering healthcare facilities and systems that are safe, compliant, flexible and right sized for the future delivery of clinical and other services, and enable service transformation.
	Measureable	Evidenced by: • Compliance with Health Technical Memoranda (HTM) and Health Building Notes (HBN), other statutory standards and best practice; • 6 facet survey results and ERIC returns; • Reduction in number of estates related critical incidents • Equality impact assessments • Disability Discrimination Act (DDA) compliance
	Achievable	Delivering tried and tested national standards and expected levels of compliance.
	Relevant	In line with national and local guidance and plans: • Torbay and South Devon NHS FT Estates Strategy • Devon STP Estates Strategy • NHP Guidance – Modern Methods of Construction • NHS Property and Estates: Why the estate matters for patients (March 2017) • The Carter Report (June 2015, revised Feb 2016)
	Time-bound	Compliance with national standards in relation to the physical infrastructure will be signed off in line with the timelines for schedule of accommodation and 1:200s. Ongoing assessments for compliance and to assess quality of the physical and digital infrastructure will be undertaken once the assets are operational and will demonstrate further achievements against this objective.

Table 4.11 – SMART nature of Investment Objective 3

Combined	Investment Objective 3	
	To ensure our long-term financial sustainability by delivering operational efficiencies, improving patient pathways and transforming our Digital and Estates Infrastructure.	
	Specific	To develop health services, enabled by transformation of our Digital and Estates Infrastructure in a way which makes a positive contribution to achieving long-term sustainability for the Trust.
	Measureable	Evidenced by: • Financial statements of Torbay and South Devon NHS FT • Trust annual report • CIP delivery • Benefits realisation plan
	Achievable	Robust and detailed demand and capacity modelling alongside implications on financial performance will be undertaken utilising realistic assumptions and targets (for both the Trust and the Devon ICS.
	Relevant	In line with national and local guidance and plans: • Devon Long Term Plan • Clinically led Review of NHS Access Standards (March 2019) • NHS Long Term Plan (January 2019) • Next Steps on the NHS Five Year Forward View (March 2017)
	Time-bound	Benefit realisation will be felt in full by one year after new facilities and systems are fully operational. Improvements in financial performance of the Trust will be felt over the medium term.

Table 4.12 – SMART nature of Investment Objective 4

Combined	Investment Objective 4	
	To support economic regeneration and innovation through collaborative strategic partnerships that deliver significant local and regional (Devon) growth.	
	Specific	To ensure that the investment in our Digital and Estates Infrastructure is not only beneficial to the Trust but supports our wider stakeholders and partners to deliver wider and more intensive economic regeneration and innovation, both locally and across the Devon region.
	Measureable	Evidenced by: • Increased numbers of clinical and non-clinical apprenticeships offered by the Trust • Opportunity for local supply chain to tender subcontractor packages that deliver the investment • Increased training and development offered by local Education institutions • % of locally sourced construction staff will be a requirement of the Trust.
	Achievable	The scale of investment being made by the Trust is such that these benefits will be achievable and capable of being measured / captured by the business case process, the construction period and when the assets and systems are in operation.
	Relevant	In line with national and local guidance and plans: • Devon Long Term Plan • Torbay and South Devon NHS FT – People Plan (found at Appendix 9.5.3) • NHP Guidance / Green Book – Social Economic Gain
	Time-bound	Throughout construction and from operational start date.

Table 4.13 – SMART nature of Investment Objective 5

Combined	Investment Objective 5	
	To deliver a facility that is a great place to work which attracts and retains the highest calibre of staff.	
	Specific	To provide a high-quality facility that offers increased opportunities to motivate and retain our existing staff and to attract new staff.
	Measureable	Evidenced by: • Friends and family survey • NHS staff survey • Pulse check survey (Trust led / quarterly measure) • Staff turnover rates • Staff absence rates • Reduction in level of agency rates / cost • Use of key worker accommodation
	Achievable	The scale of transformation from a physical and digital perspective will provide staff, existing and new, with opportunities to work in a safer, higher-quality, more innovative environment.
	Relevant	In line with national and local guidance and plans: • Torbay and South Devon NHS FT – People Plan • NHS People Plan
	Time-bound	We would expect to see this objective being fully met over time but starting to see the benefits in the measures from the year after the new facilities and systems are fully operational.

Table 4.14 – SMART nature of Investment Objective 6

Combined	Investment Objective 6	
	To deliver an asset which is kind on the environment, delivering an asset in line with the net zero carbon agenda identified through the climate emergency status set by the Torbay local authority.	
	Specific	To build an asset that is compliant with national standards in relation to the environment and net carbon zero. And where possible, to go further to ensure that the Trust makes a significant contribution as possible to supporting the climate emergency plans of the Torbay local authority.
	Measureable	Evidenced by: • Carbon emissions / footprint • % of energy usage that is renewable • % of energy that is supported by fossil fuel • % of staff that access agile working practices • Locally sourced materials • BREEAM Excellent
	Achievable	Ensuring that the assets is sustainable from an environment perspective is a necessity and a key objective of the National Hospital Programme.
	Relevant	In line with national and local guidance and plans: • Carbon Neutral Torbay – Initial Action Plan • Delivering a 'Net Zero' National Health Service (October 2020)

	Time-bound	Throughout construction and from operational start date.

As can be seen from the tables above, the IOs can be measured in a number of ways using a multitude of existing performance indicators and the Trust is considering the right blend of measures to represent Programme success for each objective. At OBC stage these will be articulated in detail with baseline and target values included but further work is required to develop this. Measures are likely to include improvement targets across a range of performance indicators.

4.10 Potential Scope of the Programme

Development of the Torbay Hospital site

The Programme will deliver new, digitally enabled and net-zero carbon care facilities which will replace parts of our current Estates Infrastructure at the Torbay Hospital site.

The Economic Case sets out the options for developing our Estates Infrastructure at Torbay Hospital and the approach to appraising these options in detail. This analysis has identified 'Estates Infrastructure Option 3' as the Initial Preferred Way Forward. This option restricts new build development to 17,000 square metres, maximises the impact of available funding and delivers on our key principles.

The Estates Infrastructure options were considered in the context of an affordability requirement and the four clinical requirements set out below:

- Re-provision of inpatient medical beds and emergency surgery beds in the hospital
- Separation of planned and unplanned services
- Clinical and non-clinical support services to be moved off the hospital site wherever possible
- Emergency Department and Same Day Emergency Care services to be completely upgraded with integrated pathways.

Estates Infrastructure Option 3 falls within our affordability envelope (with estimated costs of £313m) and meets the four clinical requirements.

Estates Infrastructure Option 3 is also favoured because site disruption risk is considered 'medium', with only minimal demolition to the old hospital required. Furthermore, planning risk is considered 'low' because the historic core of our estate is retained and the scale of development at the north side of the estate is reduced in comparison with other options.

Estates Infrastructure Option 3 would be delivered over a five-year period from 2025 to 2030. The table below shows the split of new build development and refurbished areas:

Table 4.15 – Breakdown of new build development and refurbished areas

	Development type	Area
Estate	New build	17,060 sq m
	Refurbished areas	12,114 sq m
	Total	29,174 sq m

The site plan below has been taken from our Development Control Plan and provides an indication of the layout of the Torbay Hospital site following completion of development under Estates Infrastructure Option 3. More detail is provided in the Economic Case and Appendix 9.1.5.

Figure 4.10 – Site plan from Estates Infrastructure Option 3

Key to site plan above:

- Green building:
  - Re-modelling of ED.
- Yellow building:
  - Ward refurbishment to Tower.
- Purple buildings:
  - New major inpatient development over four storeys linked to Tower (top left of site plan).
  - New planned care centre (bottom right of site plan).

Key elements of the scope of the Programme include the following:

Separated facilities

The Programme will deliver two separate facilities to replace the existing building. There will be a modern, fit for purpose and appropriately sized acute hospital with a separate planned care centre to enable segregation of acute service provision from planned services. This approach will align with the community focus and 'care closer to home' model to be adopted as part of our Health and Care Strategy. The new facility for planned care in particular will contribute to the provision of enhanced quality of care across Devon.

Digital building transformation

The new Estates Infrastructure will be digitally enabled. This is imperative as we aim to create a much more efficient facility on a smaller footprint than the existing hospital, which will only be possible if it is part of an efficient system which emphasises community first preventative care and self-care.

Integrated EPR system

The Digital element of the Programme will involve the implementation of an integrated EPR system to replace multiple existing systems, many of which are approaching the end of their useful life. The choice of EPR would determine the extent of our further system replacements and upgrades, and it is important to note that implementing an EPR would not in and of itself be sufficient to support our ambitions, but is the single most important element of the Digital element of our Programme.

Summary of investment requirements

The table below summarises the capital requirement of the Programme Initial Preferred Way Forward for the Programme which totals £375m. £317m of this is attributable to Estates Infrastructure and £58m of this total is attributable to Digital.

Table 4.16 – Summary of investment requirements

	Investment requirement description	Indicative capital cost (£'m)
Combined	Estates	317
	Digital	58
	Total	**375**

4.11 System Partners

We will work with a wide range of Devon system partners to deliver services effectively and to achieve the best outcomes for the local population. Our key system partners, the purpose of our engagement with them and their roles are set out in the table below:

Table 4.17 – List of partners and their role

	System Partner	Purpose of engagement	Role of system partner in delivering health and care functions
Combined	Devon Integrated Care System (ICS)	Implementation of Devon ICS Strategic Outcomes Framework	We will align our health and care model with the principles of the Devon ICS Strategic Outcomes Framework.
	Royal Devon & Exeter NHS Trust / Northern Devon Healthcare NHS Trust	SEND strategic alliance network	We intend to share acute and diagnostic services with neighbouring NHS providers to deliver the best quality of service for people and their carers and to improve the resilience of challenged services.
	Torbay Council	Torbay planning and consistency with local plan	The councils in Torbay and South Devon are key partners: we provide social care services on behalf of the councils, and the councils' collaboration on strengths-based reablement and a 'home first' approach to care will be essential in the future care model.
	Teignbridge Council	Teignbridge planning and consistency with local plan	
	Devon County Council	Devon CC – key lead in ICS planning	

University Hospitals Plymouth NHS Trust (UHP)	Wider ICS plan – Plymouth and West Devon	We will work closely with UHP through the wider Integrated Care System plan in the region.
Devon Partnerships Trust (DPT)	Local Care Partnerships / ICS vision and place-based care	DPT is a mental health and learning disabilities service provider in Devon. DPT's support will be incorporated into a number of our activities.
South Western Ambulance Service NHS Foundation Trust (SWASFT)	ICS	SWASFT plays a critical role in managing demand for acute unplanned care services. We will partner with SWASFT in delivering on our ambitions for unplanned care through a shared approach to community based unplanned care and making sure acute services are reserved for those who most need them.
NHS England / Improvement (NHSE/I)	Regional NHSE/I approval	NHSE/I has combined oversight of planning, budgets and delivery of services by NHS Trusts. NHSE/I will be kept informed of our future health and care model and its integration with our plans for NHP.
Anthony Magnall; Kevin Foster; Anne-Marie Morris	Supportive local, regional and national politicians	We will engage with politicians and will seek their support in furthering our ambitions.
Torbay Development Agency (TDA)	Link to economic prosperity	We will liaise with TDA to ensure that the building of new infrastructure is closely linked to the economic regeneration of Torbay.
Primary care networks (PCNs)	LCP – clinical model of strength based and primary care led	PCNs will play a critical role in prevention and keeping well activities across Torbay and South Devon. We intend to work closely with PCNs to understand the needs of the population and plan services appropriately.
Rowcroft Hospice services	End of life care	Transforming end of life care will be a key element of the future health and care model and will involve including patients and their carers in decision making. Hospice services will play a key role in achieving this vision.
Social care providers	Community care delivery	We commission social care providers to deliver care in Torbay. It is essential that these providers understand and are supportive of our vision for tech-enabled care at home. We will curate a high-functioning market which is capable of getting patients out of hospital and back home as quickly and safely as possible, maximising technology solutions in the process.
Voluntary and charity sector	Community care support	The voluntary and charity sector can play an important role in delivering more services in the community, particularly in relation to prevention. The sector could engage more volunteers in outreach work for hard to reach groups vulnerable to the risks of deprivation often seen in Torbay.

	Healthwatch and carers groups	Community engagement	Healthwatch England is a national organisation which collects the views of people who use health and care services. This is done to inform and influence decisions and indicate areas for improvements. It is a clear route into engaging with local communities. There are also multiple carer groups which we consult in order to inform decisions relating to health and care.
	User groups	User engagement	Our programme plan includes engagement with a range of user groups.

4.12 Benefits

We have identified and quantified Programme benefits under the following categories:

- Clinical efficiencies
- Emergency and ambulatory care
- Outpatients
- Medication
- Pathway management
- Radiology and laboratory
- Theatres
- Workforce
- Care closer to home
- Paperless
- Repatriated clinical activity
- Additional commercial income

These benefits are reflected in the economic appraisal conducted in the Economic Case. The methodology in respect of the identification and quantification of benefits is also set out in full in the Economic Case.

4.13 Risks

Summary

The Programme Office has developed a detailed risk register and this will be proactively managed and reported on throughout the life cycle of the Programme. This risk register covers all workstreams, and the NHP Programme Director and Programme Manager will ensure that the level of risk within the Programme is continuously reviewed and mitigated and that risks are closed down when appropriate.

Part 8.8 of the Management Case provides further information in respect of how we identify and manage risks.

4.13.1 Top Five Risks

The top five risks 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 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. TSDFT'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 are not delivered (CIP) to underpin investment (risk score 16)

TSDFT recognises 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. The Trust's workforce plan is not delivered – staff numbers required and skill mix (risk score 16)

This will remain a significant risk until completion of the Programme. The workforce plan will be delivered during the OBC and FBC phases as they are fundamental to the delivery of the Trust affordability models. Once agreed, 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 Programme (risk score 16)

These costs will be fully detailed at OBC stage, and the OBC will not be submitted until the cost of the Programme 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 Preferred Supply Chain Partner(s) (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 Programme.

5. Inability to capitalise on the expected efficiencies from shared services (risk score 15)

The Programme Office and planning advisers have already agreed a requirement to reduce support services/office accommodation at the Torbay acute site from 23,000m2 to 16,000m2.

This aspect of the Programme will be fundamental to its overall delivery as some of the site-enabling assumptions will be addressed through the work of the 'support services' workstream, and therefore will not need to be re-provided within the BBF Programme 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.

4.14 Constraints

The Programme Office has identified the following key constraints which will cotninue to be proactoively managed as the Programme develops.

- **Torbay Climate Emergency** – In 2019 Torbay Council declared a climate emergency and joined the Devon Climate Emergency Response Group (previously referenced in part 4.3 – Local population of this Strategic Case). In order to ensure that we obtain local planning approvals on a timely basis, our plans for improving our Digital and Estates Infrastructure will need to clearly demonstrate contributions towards reducing carbon emissions.
- **Substandard Digital Infrastructure** – Our existing Digital Infrastructure is substandard and acts as a constraint to us being able to properly implement our Health and Care Strategy to meet the current and future needs of our patients and staff. Investment in and commitment to digital transformation is necessary to allow us to realise our ambitions of providing better care outcomes for our patients and better working environments for our staff.
- **Availability of local construction market** – The local construction market in Devon and the wider South West England region is limited in size. There are few local construction companies with experience of delivering large scale and complex construction projects and there is a lack of skilled construction workers based in the region. These factors could constrain our ability to realise improvements to our Estates Infrastructure within the desired timescales.
- **Corporate Social Responsibility (CSR)** – We recognise the important role we play within the local community as both a health care provider and a major employer. We take proactive steps to further build our links with the local community, for example by holding open day events for local pupils and students on NHS careers. We will need to ensure that the Programme is properly aligned to and supports our CSR ambitions.
- **Funding availability** – The capital allocation for the Programme through the NHP will be restricted to £350m. We will be adding a further £20m of our own resources to bring the overall spend to £370m. Any expenditure in excess of this amount would be limited as it would need to be funded through our cash reserves and available BAU capital.
- **Short term capital investment** – It is anticipated that £31m will be invested in the Programme in the short term up to FBC submission. This amount will form part of the overall spend of £370m and will be restricted to ensure as much funding as possible remains available for delivery of the Programme following FBC submission. We intend to manage the capital cost of £375m to within £370m when we move to OBC.

- **Revenue challenges** – We will be required to ensure that the Programme delivers long term financial sustainability not only for our Trust, but also for the wider Devon system. This will require alignment with all system partners across a range of areas, including the delivery of new and innovative clinical models of care, digital systems and workforce models that will all need to be developed in a manner that supports the Programme Investment Objectives noted in part 4.9. We are currently in a deficit position and this will continue for some years until the Cash Releasing Benefits derived from our investment are realised. It is understood that short-term adverse revenue impacts of the NHP Programme are recognised at a NHSE/I national level and this is subject to discussion with the NHSE/I South West Regional Team in order to identify transitional funding solutions.
- **Workforce challenges –** As set out in part 4.2 – Organisational overview of this Strategic Case, we are facing a demographic challenge in respect of our workforce with a large number of staff expected to retire over the next 5 to 10 years. Furthermore we have experienced challenges in respect of recruiting and retaining staff. These workforce challenges could constrain our ability to deliver the Programme and successfully implement our Health and Care Strategy.

4.15 Dependencies

There are a number of dependancies that the Prgramme Office will need to manage as the Programme develops, these include the following:

- **Planned care strategy for Devon and Cornwall** – As set out previously in the Strategic Case, NHP funding is to be allocated to ourselves, NDHT and UHP in order to transform planned care across Devon and Cornwall. The three Trusts are working with Devon CCG on the configuration of planned care overall. It is understood that the progression of individual programmes is dependent on the identification of a Devon-wide planned care programme.
- **Peninsula Digital Strategy** – In order to ensure the delivery of more efficient and effective health and care services across the South West Peninsula, our digital strategy will need to be aligned with the digital strategies of NDHT and UHP, including in respect of the Shared Care Record and SWP Accelerated EPR programme.
- **Macroeconomic context** – As noted within the Financial Case, the Covid-19 pandemic has created significant financial pressures on the NHS. The deliverability of the Programme is dependent on the continued availability of required funding. It is particularly dependent on the continued allocation of NHP funding to us in accordance with the previously agreed national timetable.
- **Enabling works** – The timely commencement of construction is dependent on the completion of essential enabling works. These works will need to be undertaken by a suitably qualified contractor appointed at an appropriate time.
- **Planning permission / risk** – The development of our site is dependent on us obtaining the necessary planning permission from the relevant local planning authority. We will engage closely with this authority to help ensure that our prospective plans satisfy any local requirements.
- **Green transport plan** – In order to reduce the carbon footprint of our sites, our patients and staff need to be provided with viable low carbon options for travelling to and from our sites. The implementation of a ‘green transport plan’ across the region will contribute to improvements to low carbon transport.

5 Economic Case

Key messages

- The right options - Robust and reasonable long list of options has been created from which we have been able to select a strong shortlist for both digital and estates aspects. These are the right options to consider because they have been tested against clear CSF's linked to our Investment Objectives.
- The right appraisal method - Shortlisted options have been subjected to robust economic appraisal in line with green book and required CIA model.
- Robust appraisal inputs - Financial appraisal is felt to be robust because we have made reasonable and prudent estimates of costs and benefits, using external expert advice where appropriate and taking account of risk.
- Compelling economic case – A preferred way forward has been identified that represents a compelling case, good value for money with a cost:benefit ratio of 1:4.47 and it is believed that it is likely to be possible to make an even stronger economic case at OBC stage due to the very prudent approach taken to estimating costs and benefits.

5.1 Introduction

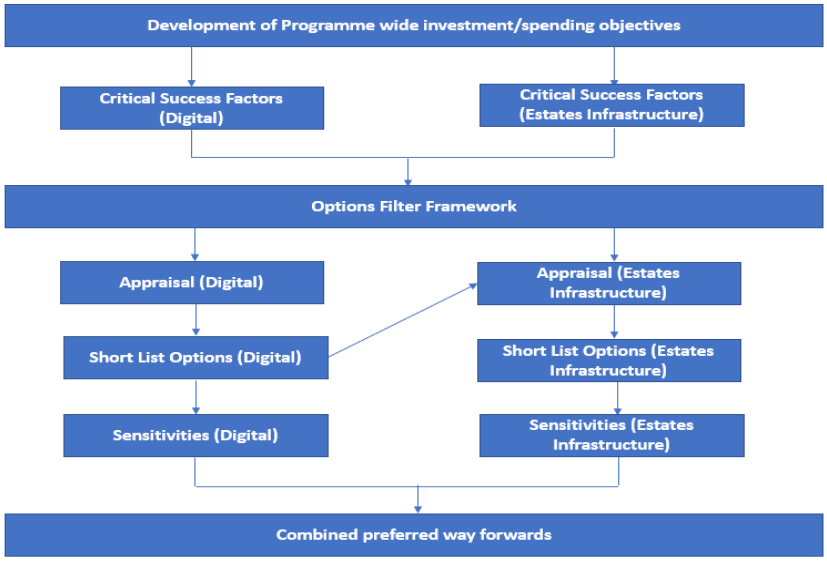
The Strategic Case described the clear rationale for our Programme and its Digital and Estates Infrastructure elements. It demonstrated that our existing Digital and Estates Infrastructure present daily challenges to operational efficiency, quality and safety of patient care and set out at a high level the investments we want to make.

This Economic Case sets out and appraises the available options for implementing the Digital and Estates Infrastructure elements of the Programme in ways which will use our investment to "build a brighter future" by transforming services, addressing the long term challenges we face, putting ourselves on a sustainable financial footing, aligning with Devon Long Term Plan priorities and meeting the Programme Investment Objectives. The Economic Case is concerned with VfM, using the BCR.

5.2 Appraisal Approach

The figure below outlines the approach followed in the development of this Economic Case:

Figure 5.1 – Structure of the Economic Case



As set out in the Strategic Case, we have developed a single set of Programme Investment Objectives, with key stakeholder input, which cover both the Digital and Estates Infrastructure elements of the Programme.

Recognising the difference in the assets being delivered under each element of the Programme, separate CSFs have been developed for both Digital and Estates Infrastructure. While the CSFs for the respective elements of the Programme are separate, both sets link back to the overarching Programme Investment Objectives.

In line with HMT Green Book, and its supplementary 2019 BBC guidance, the Options Filter Framework has been utilised to develop and assess the long list of options available under both Digital and Estates Infrastructure. First, the Digital long list options appraisal was undertaken and the Initial Preferred Way Forwards identified, which then formed the context for the Estates Infrastructure long list options appraisal.

Following completion of the Options Filter Framework, both sets of shortlisted options have been agreed by the Programme team and ratified by our Board. Each of the short list options has been subjected to a quantitative economic appraisal utilising the CIA Model – the economic appraisal tool recommended for use by the Department of Health and Social Care (DHSC) and HMT.

The Digital and Estates Infrastructure Initial Preferred Ways Forward have then been combined to provide a single Programme Initial Preferred Way Forward. In order to test the robustness of the conclusions drawn from the quantitative economic appraisal a sensitivity analysis has been undertaken on both of the short list option sets, in addition to the Programme Initial Preferred Way Forward. In undertaking the sensitivity analysis key assumptions are further tested and altered to assess the robustness of the respective Initial Preferred Way Forward.

5.3 Critical Success Factors

In order that the options open to us to deliver on the Programme Investment Objectives (for both Digital and Estates Infrastructure) can be appropriately appraised, individual sets of CSFs are required to be developed. As per HMT Green Book and BBC guidance, CSFs are *"the attributes essential for successful delivery of the programme, against which the initial assessment of the options for delivery of the project will be appraised, alongside the Investment Objectives".*

The CSFs were developed by the Programme Team with input sought from key stakeholders/system partners. Our Executive Directors then discussed and agreed the CSFs in March 2021. Both the Investment Objectives and CSFs were subsequently presented to and approved by our Programme Board on 24 March 2021.

Both the Digital and Estates Infrastructure CSFs are set out in the tables below, each table identifying the overarching CSF theme as per central guidance, the agreed CSF itself and then linking each to the relevant Programme Investment Objective.

5.3.1 Digital

Table 5.1 – CSFs for Digital options

	DCSF	Theme	Critical Success Factor
Digital	DCSF1	Strategic fit and business needs	To what extent is the Option considered to be supportive of the ambition we set out in our Health and Care Strategy? ● Prevention and wellbeing. Empowering of digital citizens with their health, care and wellbeing ● Care closer to home. Harnessing digital to deliver care closer to home and in community settings ● Integration. Increasing standardisation between Trusts and more seamless pathways across the ICS ● Value. Provide excellent citizen, patient, carer experience. Using digital assets to get the best value, recognising scarce resource. ● Digital buildings. Our ambitions for rebuilding our estate for the 21st century. Physical environments fit for the digital age
	DCSF2	Potential value for money	To what extent is the Option considered to have Social Cost Benefit for the Trust and the region? ● Costs ● Benefits ● Risks
	DCSF3	Potential affordability	Is the option deliverable within the identified NHP / HIP capital envelope and does it contribute to the delivery of efficiencies which drive a sustainable improvement in the Trust's revenue position?
	DCSF4	Potential achievability	To what extent do we consider the Option is likely to be delivered and the outcomes realised? ● Capability. The level of confidence we have in our abilities to implement. ● Capacity. The level of confidence we have that we will be able to commit to meet the scale of the challenge. ● Outcome. The level of confidence we have that the change will enable our digital vision of transforming health and care

5.3.2 Estates Infrastructure

Table 5.2 – CSFs for Estates Infrastructure Options

	EICSF	Theme	Critical Success Factor
Estates	EICSF1	Strategic fit and business needs	Does the option provide a sustainable long term solution for care and clinical services, which meets the present and future needs of the Trust?
	EICSF2		Does the option drive opportunities for further collaboration with partners and improve the quality of care for Torbay & South Devon people?
	EICSF3	Potential value for money	Does the option allow for the delivery of significant benefits in the form of: ● Benefits to patients through quality and safety of care; ● Jobs and economic regeneration for the people of Torbay and South Devon; and ● A sustained reduction in the backlog maintenance position of the organisation.
	EICSF4	Supplier capacity and capability	In the context of the wider HIP / NHP programme, is the option attractive in a competitive market?
	EICSF5	Potential affordability	Is the option deliverable within the identified capital envelope and drive clinical and operational efficiencies which allow the delivery of a sustainable improvement in the Trust's revenue position?
	EICSF6	Potential achievability	Is the option likely to be acceptable and supported by staff, public and partner organisations – Local Authority, 3rd sector. Ability of the organisation to be able to deliver the option in terms of: ● People with the right skills ● Digital solutions to support service transformation

The below tables show the standalone CSFs and how they relate to our overarching Programme Investment Objectives:

Table 5.3 – Digital CSFs link to Investment Objectives

	Digital Critical Success Factors	Investment Objective 1	Investment Objective 2	Investment Objective 3	Investment Objective 4	Investment Objective 5	Investment Objective 6
Digital	DCSF1 – Strategic fit and business needs	✓	✓	✓	✓	✓	
	DCSF2 – Potential value for money	✓	✓	✓	✓	✓	✓
	DCSF3 – Potential affordability	✓	✓	✓	✓	✓	
	DCSF5 – Potential achievability	✓	✓	✓	✓	✓	

Table 5.4 – Estates Infrastructure CSFs link to Investment Objectives

	Estates Infrastructure Critical Success Factors	Investment Objective 1	Investment Objective 2	Investment Objective 3	Investment Objective 4	Investment Objective 5	Investment Objective 6
Estates	EICSF1 – Strategic fit and business needs	✓	✓	✓	✓	✓	✓
	EICSF2 – Strategic fit and business needs	✓	✓	✓	✓	✓	✓
	EICSF3 – Potential value for money	✓	✓	✓	✓	✓	✓
	EICSF4 – Supplier capacity and capability		✓		✓		✓
	EICSF5 – Potential affordability	✓	✓	✓	✓	✓	✓
	EICSF6 – Potential achievability	✓	✓	✓	✓	✓	✓

5.4 Options Appraisals

Following the agreement of the Programme Investment Objectives and CSFs, the Options Filter Framework has been used to develop and assess the long list of options for each of the Digital and Estates Infrastructure elements of the Programme. The key which follows shows how we have used and assigned our Red-Amber-Green ('RAG') rating when appraising the key dimensions of the options for both the Digital and Estates Infrastructure elements of the Programme.

RAG Rating Key

Meets CSFs
Meets CSFs but is less attractive
Fails to meet CSFs

5.4.1 Digital

Long List Options Appraisal – Options Filter Framework

As per central guidance we have used the Options Filter Framework to support us in the identification and articulation of the long list of potential options.

Discussion and challenge in relation to the population of the Options Filter Framework was held on 19 March 2021 at a meeting of the Programme Team and Executive Directors. The CEO, CFO, Director of Transformation, COO, Medical Director as well as other Executives and Programme team members attended and participated in the discussion.

The following long listed options were considered:

Table 5.5 – Long Listed Options for Digital

	Options	Option Narrative
Digital	Option 1 – BAU / Counterfactual	Continue with the current multiple-systems strategy. Patient records are spread across multiple separate systems (electronic and paper based). Key systems will be replaced as part of natural succession, under business as usual.
	Option 2 – Do Minimum	Optimise the current multiple systems strategy: replace key health and care systems that are outdated or inoperable, plus increased integration, system support and vendor management capacity.
	Option 3 – Initial Preferred Way Forward	Open procurement exercise for an Integrated EPR: embark on an open procurement exercise to source a single integrated EPR system. For example, specify our requirements and enter into a competitive tender process.
	Option 4 – Intermediate Option	Open procurement exercise for an Integrated EPR: embark on an open procurement exercise to source a single integrated EPR system as a collective group of Trusts in the geographic region.
	Option 5 – Intermediate Option	We design and build a bespoke single EPR system from scratch to service the requirements of our Trust.

Table 5.6 – Digital Options Filter Framework

	Dimension	BAU	Do Minimum	Intermediate Option	Intermediate Option	Intermediate Option	Intermediate Option	Do Maximum
Digital	1. Service Scope – as outlined in Strategic Case	1.1 – Existing digital systems utilised at TSDFT	N/A	1.2 – Patient and care records systems	N/A	N/A	N/A	1.3 – Reprovision and modernisation of all digital infrastructure
		Carried Forward		Preferred Way Forwards				Discounted
	2. Service Solution – in relation to the preferred scope	2.1 – Continued investment into the existing TSDFT systems in line with license requirements. Resulting in the continued utilisation of the multiple-systems strategy with the patient record spread across multiple separate systems (paper and electronic)	2.2 – Continued investment into the existing TSDFT systems in line with license requirements, but replace key systems and increase interfacing and vendor management capacities	2.3 – Source an integrated EPR solution	N/A	N/A	N/A	N/A
		Carried Forward	Carried Forward	Preferred Way Forwards				

3. Service Delivery – in relation to preferred scope and solution	3.1 – Current arrangements.	3.2 – In-house development of a bespoke EPR solution – solution design, build, implement, and support	3.3 – Outsource for an integrated EPR *and* in-house interfacing for systems outside the EPR scope (An independent TSDFT approach)	3.4 – Outsource for an integrated EPR *and* in-house interfacing for systems outside the EPR scope as part of a collective group of Trusts in the region (A SEND approach).	N/A	N/A	N/A
	Carried Forward	Discounted	Preferred Way Forwards	Carried Forward			
4. Implementation – in relation to preferred scope, solution and method of service delivery	4.1 – Current arrangements	4.2 – Single-phase implementation	4.3 – Two-phase implementation.	4.4 – Multi-phased sequential implementations	4.5 – Multi-phased overlapping implementations	N/A	4.6 – Sequential Trust by Trust implementations
	Discounted	Preferred Way Forwards	Carried Forward	Carried Forward	Discounted		Carried Forward
5. Funding – in relation to preferred scope, solution, method of service delivery and implementation	5.1 – Trust BAU Capital	5.2 – Central PDC funding	5.3 – Central PDC funding and other third party sources of finance	5.4 – Private finance	N/A	N/A	5.5 – Mixed public and private finance
	Carried Forward	Carried Forward	Preferred Way Forwards	Discounted			Discounted

We have undertaken a full analysis of each of the constituent Option Filter Framework key dimension identified in the table above through engagement with key stakeholders of the Programme. The full analysis and associated rationale can be found at Appendix 9.2.1 – this includes a Strength, Weaknesses, Opportunities and Threats (SWOT) analysis as per BBC guidance. A summary of the results of the analysis is presented below, with focus given to the Initial Preferred Way Forward identified for each key dimension.

Service Scope

Initial Preferred Way Forward: 1.2 – Patient and care records systems

Scope item 1.2 – Patient and care records systems has been brought forward as the Initial Preferred Way Forward based on its potential transformative nature – meeting each of the Investment Objectives and CSFs. By limiting the scope of digital services to patient and care records, the achievability of the scope is increased while still having the ability to deliver transformation benefits in line with our Health and Care Strategy. Implementation of patient and care record systems has been seen across a significant number of other NHS organisations, validating the achievability of the service scope.

Service Solution

Initial Preferred Way Forward: 2.3 – "Source an Integrated EPR solution"

Service solution item 2.3 has been identified as the Initial Preferred Way Forward for the delivery of the identified scope, scoring well against each of the assessment criteria. The collation of patient and care records into an integrated EPR would directly support the delivery of our Health and Care Strategy. Citizens will be empowered to use their health and care records online and engage with their care providers, giving wider societal benefits around prevention and wellbeing of the local community. The service solution item 2.3 scores highly against all CSFs and the overarching Programme Investment Objectives.

Service Delivery

Initial Preferred Way Forward: 3.3 – "Outsource for an integrated EPR and in-house interfacing for systems outside the EPR scope – the Trust independently"

Service delivery item 3.3 has been brought forward as the Initial Preferred Way Forward, in the context of the identified scope and service solution. The assessment of the service delivery item concludes that it allows for the ability to procure a recognised solution, with a track record of integration with other systems. We can control our requirements in full and go to an established supplier market to meet these needs.

While the Initial Preferred Way Forward has been identified at this time as service delivery item 3.3, the Programme team has identified a further iteration (3.4) which would see a number of organisations collectively procure an integrated EPR, also with in-housing of interfacing for systems outside the EPR scope. The Programme team intends to scrutinise this option more closely at OBC stage to ensure it is given full consideration.

Implementation

Initial Preferred Way Forward: 4.2 – "Single-phase implementation"

Implementation item 4.2 has been brought forward as the Initial Preferred Way Forward, in the context of the preferred scope, service solution and service delivery items. Single-phase implementation has been deemed the most appropriate methodology for implementing an EPR solution as it minimises disruption to services in the long term. Furthermore, it allows for a faster return on the investment into the system as the benefits are realised from go-live.

Although single-phase implementation presents a higher risk on the basis that the whole Trust would be impacted (i.e. if something goes wrong the process of reverting to old systems can be more complicated and the implementation would be disruptive), we would only face the risk for a minimal period of time.

Funding

Initial Preferred Way Forward: 5.3 – "Central Public Dividend Capital (PDC) funding and other third party sources of finance"

The identified Initial Preferred Way Forward for funding is through option 5.3. This option has been brought forward as it recognises the ability for us to increase the capital envelope for the Programme and the initial messaging from the NHP national team indicates that additional third party sources of finance would be supported by approvers – it should be noted that third party sources of finance in this context are not deemed to be what has historically been known as "private finance" in which we are required to take a long term obligation in return for financing which would ultimately impact both national and our own CDEL requirements.

Digital Short List Options

In line with HMT Green Book and BBC guidance, the Digital Options Filter Framework outlined above has been used to generate the short list of Digital options which will be brought forwards for further analysis through this SOC and onwards to the next stages of the business case process. The table below outlines the Digital short list options with reference to the Options Filter Framework above:

Table 5.7 – Description of Shortlisted Digital Options

	Options	Shortlist Option Narrative
Digital	Option 1 – BAU / Counterfactual	Continue with the current multiple-systems strategy. Patient records are spread across multiple separate systems (electronic and paper based). Key systems will be replaced as part of natural succession, under business as usual.
	Option 2 – Do Minimum	Optimise the current multiple systems strategy: replace key health and care systems that are outdated or inoperable, plus increased integration, system support and vendor management capacity.
	Option 3 – Initial Preferred Way Forward	Open procurement exercise for an integrated EPR: embark on an open procurement exercise to source a single integrated EPR system. For example, specify our requirements and enter into a competitive tender process.
	Option 4 – Intermediate Option	Open procurement exercise for an integrated EPR: embark on an open procurement exercise to source a single integrated EPR system as a collective group of Trusts in the geographic region.

Table 5.8 – Summary of Shortlisted Digital Options brought forward from Options Filter Framework

Digital	Options	Option 1 – BAU / Counterfactual	Option 2 – Do Minimum	Option 3 – Initial Preferred Way Forward (PWF)	Option 4 – Intermediate Option
	Scope	1.1	1.1	1.2	1.2
	Solution	2.1	2.2	2.3	2.3
	Service Delivery	3.1	3.1	3.3	3.4
	Implementation	4.4	4.4	4.2	4.2
	Funding	5.1	5.2	5.3	5.3

Qualitative Digital Short List Options Appraisal

Prior to undertaking a detailed quantitative analysis on the agreed Digital short list options, an assessment of each option has been undertaken against the Programme Investment Objectives and CSFs. Where a Programme Investment Objective is geared towards the Estates Infrastructure element of the Programme a mark of “N/A” is given as part of this assessment.

This analysis provides a qualitative assessment base before looking to identify the VfM of the options – set out at section 5.5.7 of this Economic Case.

Table 5.9 – Qualitative assessment of Shortlisted Digital Options

Digital	Digital – Summary assessment of options	Option 1	Option 2	Option 3	Option 4
	Option Description	**BAU / Counterfactual**	**Do Min**	**Initial PWF**	**Intermediate**
	Programme Investment Objectives				
	1. To improve the quality of health and wellbeing services for Torbay & South Devon people, working with our partners and neighbours to deliver more coordinated and collaborative services across the ICS and wider System.				
	2. To provide a safe environment through the provision of a high quality facility that is easy to maintain and operate, by removing all backlog maintenance on the existing TSDFT site.	N/A	N/A	N/A	N/A
	3. To ensure the long term financial sustainability of the Trust by delivering operational efficiencies, improving patient pathways and transforming our Digital and Estates Infrastructure.				
	4. To support economic regeneration and innovation through collaborative strategic partnerships that deliver significant local and regional growth.				
	5. To deliver a facility that is a great place to work which attracts and retains the highest calibre of staff.				
	6. To deliver an asset which is kind on the environment, delivering an asset in line with the net zero carbon agenda identified through the climate emergency status set by the Torbay local authority.				
	Critical Success Factors				

	Strategic fit and business needs	🔴	🟡	🟡	🟡
	Potential value for money	🔴	🔴	🟢	🟢
	Supplier capacity and capability	🔴	🟡	🟢	🟢
	Potential affordability	🔴	🟡	🟡	🟢
	Potential achievability	🔴	🔴	🟢	🟢
	Summary				

The above analysis will be revalidated as the Programme moves to OBC stage. The short-listed options are subject to a quantitative economic assessment later in this Economic Case.

5.4.2 Estates Infrastructure

Following the completion of the Digital long list options appraisal, we set out to assess the available options with regards to the Estates Infrastructure element of the Programme. As with the Digital section detailed above, the following sections set out the process we followed to identify and assess options. The Options Filter Framework is set out, with conclusions drawn and a short list of options presented. A qualitative assessment of the shortlisted Estates Infrastructure options is undertaken in line with that undertaken on the Digital shortlisted options, prior to a quantitative assessment of each option. The analysis set out below is made in the context of the Digital Initial Preferred Way Forward being an outsourced EPR solution.

Long List Options Appraisal – Options Filter Framework

The summary of Long List Options below and Estates Infrastructure Options Filter Framework below sets out the analysis undertaken by the Programme team and Executive Directors:

Table 5.10 – Long List Options for Estates Infrastructure

	Options	Option Narrative
Estates	Option 1 – BAU / Counterfactual	All existing services are maintained on the acute Torbay site, with capital investment made in order to clear critical estates backlog maintenance (Category D) on the site.
	Option 2 – Do Minimum	All existing services are maintained on the acute Torbay site, with capital investment made in order to clear all backlog maintenance on the site.
	Option 3 – Initial Preferred Way Forward	Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on rebuilding elements of the existing acute Torbay site, with targeted refurbishment of those areas retained. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
	Option 4 – Intermediate Option	Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on refurbishing the existing acute Torbay site, rebuilding discrete elements. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
	Option 5 – Intermediate Option	Unplanned care will be separated from planned care. There will be a new day case care building on the Torbay site serving the planned care needs of the population of Torbay and South Devon. Therefore, a focus on rebuilding elements of the existing TSDFT site and targeted refurbishment of those areas retained.
	Option 6 – Do Maximum	Reprovision of all services delivered at present, splitting unplanned care from planned pathways with extra capacity, with a full new build reprovision of the entirety of the existing Torbay acute site.

Table 5.11 – Estates Infrastructure Options Filter Framework

	Dimension	BAU / Counterfactual	Do Minimum	Intermediate Option	Intermediate Option	Intermediate Option	Do Maximum
Estates	1A. Main Service Scope – as outlined in strategic case	1A.1 - All existing services provided on the TSDFT site	N/A	We will retain a 24/7 ED on the acute hospital site in Torbay, along with all the support functions to deliver unplanned care services (in line with PCSS and the Devon LTP)			1A.5 – Reprovision of all services delivered at present, splitting unplanned and emergency care from planned pathways, with extra capacity.
				1A.2 – Unplanned care will be separated from planned care. There will be a new day case care building on the Torbay site serving the planned care needs of the population of Torbay and South Devon.	1A.3 – Unplanned care will be separated from planned care. There will be a new day case care building on the Torbay site serving the planned care needs of the population of South, East and North Devon	1A.4 – Unplanned care will be separated from planned care. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon	
		Carried Forward		Carried Forward	Carried Forward	Preferred Way Forwards	Carried Forward
	1B. Diagnostic Service Scope – as outlined in Strategic Case	1B.1 – All diagnostic services remain on the TSDFT site.	N/A	1B.2 – All diagnostic services related to unplanned care services to remain on the TSDFT site. Some routine diagnostic services to be provided from a diagnostic Hub elsewhere in Devon.	N/A	N/A	N/A
		Carried Forward		Preferred Way Forwards			
	2. Service Solution	2.1. –	2.2 –	2.3 –	2.4 –	N/A	2.5 –

– in relation to the preferred scope	Clear Category D urgent backlog maintenance on the TSDFT site.	Clear all backlog maintenance (Categories A – D) on the TSDFT site identified through the Six facet Survey.	Focus on refurbishment of the existing TSDFT site and rebuild discrete elements.	Focus on rebuilding elements of the existing TSDFT site and targeted refurbishment of those areas retained.		Full reprovision of the existing TSDFT site as a new build solution.
	Carried Forward	Carried Forward	Carried Forward	Preferred Way Forwards		Carried Forward
3. Service Delivery – in relation to preferred scope and solution	3.1 – Current arrangements	3.2 – In-house	3.3 – Outsource	3.4 – Mix in house and outsource	N/A	3.5 – Strategic Partner
	Carried Forward	Discounted	Discounted	Preferred Way Forwards		Carried Forward
4. Implementation – in relation to preferred scope, solution and method of service delivery	4.1 – Current arrangements	N/A	4.2 – Multi-phase implementation.	4.3 – Two-phase implementation.	N/A	4.4 – Single-phase of implementation.
	Carried Forward		Preferred Way Forwards	Carried Forward		Discounted

5. Funding – in relation to preferred scope, solution, method of service delivery and implementation	5.1 – Trust BAU Capital	5.2 – Central PDC funding	5.3 – Central PDC funding and other third party sources of finance	5.4 – Private finance	N/A	5.5 – Mixed public and private finance
	Carried Forward	Carried Forward	Preferred Way Forwards	Discounted		Discounted

In line with the Digital appraisal undertaken at section 5.4.1, a full analysis of each of the constituent Option Filter Framework key dimensions identified in the table above has been undertaken through engagement with key stakeholders. The full analysis for the Estates Infrastructure element of the Programme, and the associated rationale for conclusions can be found at Appendix 9.2.2 – this includes a SWOT analysis as per BBC guidance. A summary of the results of the analysis is presented below, with focus given to the Initial Preferred Way Forward identified for each key dimension.

Main Service Scope

Initial Preferred Way Forward: 1A.4 – "Unplanned care will be separated from planned care. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon"

Main scope items 1A.2, 1A.3 and 1A.4 all outline that we will retain a 24/7 ED on the acute hospital site in Torbay, along with all the support functions to deliver unplanned care services (in line with PCSS and the Devon LTP). Each of these scope options sees the separation of planned and unplanned care, with the variance between options seen through the servicing of those planned care needs. Main scope item 1A.4 sets out that a new planned care facility will be developed somewhere in Devon, serving the planned care needs of the population of South, East and North Devon. This option is brought forwards as the Initial Preferred Way Forward, recognising the ability for true partnership and wider system working to be implemented. The option scores well against each of the CSFs and indeed against the overarching Programme Investment Objectives, particularly *Programme Investment Objective 1 – to improve the quality of health and wellbeing services for Torbay & South Devon people, working with our partners and neighbours to deliver more co-ordinated and collaborative services across the ICS and wider System.* The option addresses the fact that our existing services model is unsustainable, with patient care and safety likely to be significantly improved when compared to the counterfactual position.

Diagnostic Service Scope

Initial Preferred Way Forward: 1B.2 – "All diagnostic services related to unplanned care services to remain on the Trust's site. Some routine diagnostic services to be provided from a diagnostic Hub elsewhere in Devon".

Diagnostic scope item 1B.2 has been brought forward as the Initial Preferred Way Forward. This option is in line with the expectations set through national guidance and allows for consistency with the Preferred Way Forward set out at 1A.4 in the context of unplanned care remaining on our site.

Service Solution

Initial Preferred Way Forward: 2.4 – "Focus on rebuilding elements of the existing TSDFT site and targeted refurbishment of those areas retained"

The Initial Preferred Way Forward solution is determined to be service solution item 2.4. The rationale for this is that it is likely to be deliverable within the identified NHP capital envelope while having the ability to deliver against the preferred scopes set out, in addition to maximising our ability to meet the identified Programme Investment Objectives and the CSFs.

Service Delivery

Initial Preferred Way Forward: 3.4 – "Mix in house and outsource"

Service delivery item 3.4 – a combination of in-house and outsourced service methodology has been deemed as the Initial Preferred Way Forward. This service delivery methodology will likely see us managing the overarching delivery of the Programme, with a construction partner procured to undertake the major works. This methodology allows for all services to be delivered by the best placed party – we will maintain ownership and control, with external capacity and capability properly utilised where they can add the most value.

Implementation

Initial Preferred Way Forward: 4.2 – "Multi-phase implementation"

Implementation item 4.2 has been brought forward as the Initial Preferred Way Forward. Recognising the delivery constraints and risks associated with adopting a single or two phased approach, multi-phase implementation has been deemed the most appropriate methodology based on the practicality of the site, planning permissions and decant requirements. It is recognised that the use of this option could add a greater level of programming complexity and length to the Programme, however we will mitigate this risk as the Programme moves forward and greater design clarity is available.

Funding

Initial Preferred Way Forward: 5.2 – "Central PDC funding and other third party sources of finance"

In line with the assessment made as part of the Digital Options Filter Framework, the Initial Preferred Way Forward option for funding is 5.3. In line with the comments made earlier in this Economic Case, this option has been brought forward as it recognises the ability to increase the capital envelope for the Programme and that the initial messaging from the NHP national team indicates that additional third party sources of finance would be supported by approvers. It should be noted that third party sources of finance in this context are not deemed to be what has historically been known as "private finance" in which we are required to take a long term obligation in return for financing which would ultimately impact both national and our own CDEL requirements.

Estates Infrastructure Options Short List

As per the process undertaken at section 5.4.1 with regards to the Digital short list option, in line with the HMT Green Book and BBC guidance the Estates Infrastructure Options Filter Framework has been used to generate the short list of Estates Infrastructure options:

Table 5.12 – Description of Shortlisted Estates Infrastructure Options

	Options	Shortlist Option Narrative
Estates	Option 1 – BAU / Counterfactual	All existing services are maintained on the acute Torbay site, with capital investment made in order to clear critical estates backlog maintenance (Category D) on the site.
	Option 2 – Do Minimum	All existing services are maintained on the acute Torbay site, with capital investment made in order to clear all backlog maintenance on the site.
	Option 3 – Initial Preferred Way Forward	Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on rebuilding elements of the existing acute Torbay site, with targeted refurbishment of those areas retained. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
	Option 4 – Intermediate Option	Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on refurbishing the existing acute Torbay site, rebuilding discrete elements. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
	Option 6 – Do Maximum	Reprovision of all services delivered at present, splitting unplanned and emergency care from planned pathways with extra capacity, with a full new build reprovision of the entirety of the existing Torbay acute site.

Table 5.13 – Summary of Shortlisted Estates Infrastructure Options brought forward from Options Filter Framework

	Options	Option 1 – BAU / Counterfactual	Option 2 – Do Minimum	Option 3 – Initial PWF	Option 4 – Intermediate Option	Option 6 – Do Maximum
Estates	Main Scope	1A.1	1A.1	1A.4	1A.4	1A.5
	Diagnostic Scope	1B.1	1B.1	1B.2	1B.2	1B.2
	Solution	2.1	2.2	2.4	2.3	2.5
	Service Delivery	3.1	3.1	3.4	3.4	3.4
	Implementation	4.1	4.1	4.2	4.2	4.2
	Funding	5.1	5.2	5.3	5.3	5.3

Short List Options Appraisal

Prior to undertaking a detailed quantitative analysis on the agreed Estates Infrastructure short list options, an assessment of each option has been undertaken against the Programme Investment Objectives and CSFs.

Table 5.14 – Qualitative assessment of Shortlisted Estates Infrastructure Options

Estates	Estates Infrastructure – Summary assessment of options	Option 1	Option 2	Option 3	Option 4	Option 6
	Option Description	**BAU / Counterfactual**	**Do Min**	**Initial PWF**	**Intermediate**	**Do Max**
	Programme Investment Objectives					
	1. To improve the quality of health and wellbeing services for Torbay & South Devon people, working with our partners and neighbours to deliver more coordinated and collaborative services across the ICS and wider System.	🔴	🔴	🟢	🟢	🟡
	2. To provide a safe environment through the provision of a high quality facility that is easy to maintain and operate, by removing all backlog maintenance on the existing TSDFT site.	🔴	🔴	🟢	🟢	🟢
	3. To ensure the long term financial sustainability of the Trust by delivering operational efficiencies, improving patient pathways and transforming our Digital and Estates Infrastructure.	🔴	🔴	🟢	🟡	🟡
	4. To support economic regeneration and innovation through collaborative strategic partnerships that deliver significant local and regional growth.	🔴	🔴	🟢	🟢	🟢
	5. To deliver a facility that is a great place to work which attracts and retains the highest calibre of staff.	🔴	🔴	🟢	🟢	🟢
	6. To deliver an asset which is kind on the environment, delivering an asset in line with the net zero carbon agenda identified through the climate emergency status set by the Torbay local authority.	🔴	🔴	🟡	🟡	🟢
	Critical Success Factors					
	Strategic fit and business needs	🔴	🔴	🟢	🟢	🟡

	Potential value for money	🔴	🔴	🟢	🟢	🟢
	Supplier capacity and capability	🟡	🟡	🟢	🟢	🟢
	Potential affordability	🟡	🟡	🟢	🟡	🔴
	Potential achievability	🟢	🟢	🟢	🟢	🟡
	Summary					

5.4.3 Capital Requirements

The capital requirements for each of the shortlisted options, both Digital and Estates Infrastructure are identified below:

Table 5.15 – High level capital requirement for Digital Options

Digital	**Digital Options**	**Option 2**	**Option 3**	**Option 4**
	Option Description	**Do Min**	**Initial PWF**	**Intermediate**
	Capital required	£7m	£58m	£61m

Table 5.16 – High level capital requirement for Estates Infrastructure Options

Estates	**Estates Infrastructure Options**	**Option 2**	**Option 3**	**Option 4**	**Option 6**
	Option Description	**Do Min**	**Initial PWF**	**Intermediate**	**Do Max**
	Capital required	£131m	£317m	£326m	£987m

The above capital requirements are inclusive of inflation and VAT. A further breakdown of these costs is available at sections 7.6 and 7.7 of the Finance Case. These capital costs will be utilised in the Economic Appraisal set out below.

5.5 Quantitative Short List Options Appraisal

5.5.1 Approach

In line with HMT Green Book and BBC guidance the short list of options derived from each of the above appraisals is to be subjected to quantitative analysis. The quantified benefits, costs and risks will be identified and appraised for each of the shortlisted options across the Digital and Estates Infrastructure options, with the two Initial Preferred Way Forward combined to show a holistic Programme position, set out in section 5.5.8.

5.5.2 CIA Model

The quantitative analysis has been carried out on a Discounted Cash Flows (DCF) basis using the CIA Model; the DHSC and NHSE/I recommended economic appraisal tool for investment business cases. The CIA Model looks at the economic value of an investment over a defined appraisal period.

The CIA Model requires a variety of cost inputs, including:

- Anticipated capital costs;
- Optimism bias;
- Maintenance and lifecycle costs;
- Revenue expenditure;
- Net (income) contribution costs – this refers to income generated from non-public sector organisations as a consequence of the investment;
- Opportunity costs; and

- Transitional costs where relevant.

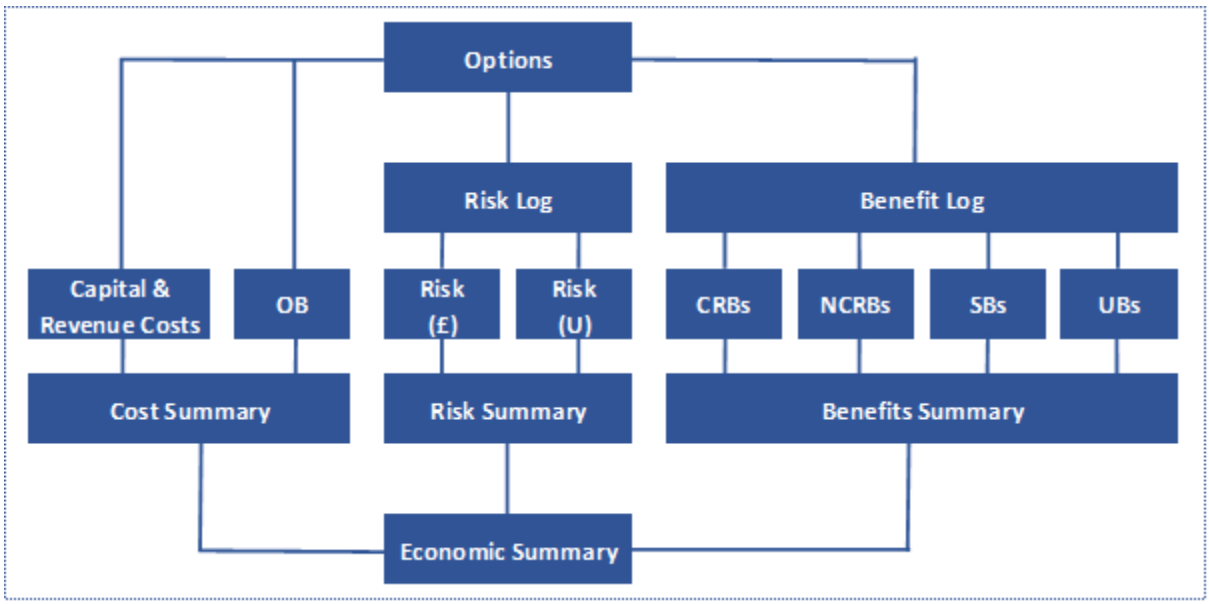
All of the above costs should exclude inflationary impact, and any transfer payments[15]. These cost inputs are discounted over the appraisal period to inform the Net Present Cost ("NPC") of options.

The risks of each option which have been identified and quantified in the CIA Model are considered to determine the risk-adjusted NPSV for each option. The quantifiable benefits which include cash-releasing, non-cash releasing and societal benefits are then assessed against the incremental NPSV. This determines a BCR for each of the options analysed. The BCR is used to evaluate the VfM delivered by the options, with DHSC stipulating that the BCR of options should be no less than 4:1 achieved on public capital in order to demonstrate VfM.

Although they cannot be monetised and therefore do not have an effect on the BCR, unmonetisable benefits are also recorded in the CIA Model and should be taken into account when examining the overall VfM of each shortlisted option through the Economic Case.

The flow chart in the figure below describes how the CIA model inputs are translated into the VfM outputs for each option in the Economic Summary. The full CIA Model can be found in Appendix 9.2.3.

Figure 5.2 – Summary of CIA Model structure



A quantitative economic assessment has been undertaken for each of the shortlisted options for the Digital and Estates Infrastructure elements respectively. Each of the initial identified Preferred Way Forward for the Digital and Estates Infrastructure elements of the Programme are then combined to create a holistic Programme view.

[15] Defined as the transfer of resources between people which do not lead to the consumption of these resources (e.g. gifts, taxes, grants, subsidies or social security payments). Income from other public sector bodies counts as a circular flow and must be excluded from the Economic Case. *Source: Comprehensive Investment Appraisal (CIA) Model: User Guide, December 2019, DHSC.*

The key appraisal assumptions are set out below, followed by the results of the respective analysis and sensitivity analysis for each. Appendix 9.2.4 provides further commentary on the approach and assumptions made with regards to the CIA Model.

5.5.3 Key Appraisal Assumptions

Key assumptions and principles of the economic appraisals are identified below, for both Digital and Estates Infrastructure:

Table 5.17 – CIA Model assumptions for Digital and Estates Infrastructure Shortlisted Options

	Assumption	Digital	Estates Infrastructure
Combined	Capital Cost estimates	Provided by our Finance and IT teams, based on soft market testing and existing system costs	Provided by our technical advisors, Turner & Townsend
	Optimism Bias (OB)	Provided by our Finance and IT teams. OB has been set at different levels for each option depending on the reliability of information used to inform the capital spending plan e.g. market tested quotes have been utilised where available. OB is set as follows for each option: Option 1 and 2 – 20% Option 3 – 15% Option 4 – 5%	Provided by our technical advisory team. The level of OB differs between options, recognising the inherently different risk profile of each option – this is further set out at Section 7.7 of the Financial Case. In line with Central guidance, it is important to note that throughout the development of the options risk will be managed and mitigated, which will lead to OB reducing as the Programme progresses and further detail is available
	Lifecycle / Hard FM Cost estimates	N/A – license renewals included in overarching capital cost estimates	Re-provided estate: £2m per annum assumed for re-provided estate under Options 3, 4 and 5 Retained estate: £7m per annum assumed under Options 1 and 2 in order to maintain retained estates elements. £3.5m per annum assumed for Options 3 and 4, proportionate to the area covered through the NHP investment.
	Revenue Costs	Provided by our Finance and IT teams based either on existing revenue costs, inflated to recognise growth, or benchmarked with other implemented schemes	Provided by our Finance team, consistent with revenue assumptions made under the affordability modelling to support the Financial Case
	Price base for Cost inputs	All costs are based on a FY 2020/21 price base, with costs shown in £'000's unless otherwise stated.	
	Appraisal Period	70 year appraisal period, to cover implementation period of Digital infrastructure and systems and to account for useful asset life of the assets. Costs have been extrapolated over this period to account for technology changes and developments over this time,	70 year appraisal period, to allow for 10 years of construction and 60 year useful asset life for the Infrastructure asset in line with Central guidance

		and to match the period required for infrastructure
	Discount rate	In line with central guidance, 3.5% real for years 1 to 30 and 3.0% real for years 31 to 70

As required by the CIA appraisal guidance, all internal public sector and accounting transactions (such as depreciation, capital charges, PDC and VAT have been excluded from the appraisal. In addition, all values have been input in real (uninflated) terms. Any amounts shown in tables below are real (exclude inflation) and are stated in present value terms.

5.5.4 Benefits

Benefits identification and quantification took place through a series of workshops with attendance from a multi-disciplinary team including key Programme internal stakeholders – attendance requirements as per guidance – facilitated by our advisory team. The benefit assumptions, and methodologies for quantifying these benefits, were discussed and agreed upon during these sessions. The workshop attendees included, but were not limited to, Executive Directors, clinicians, nursing representatives, corporate functions (finance, transformation and strategy) and technical advisers.

Benefits are categorised into four main categories: Cash Releasing Benefits (CRBs), Non-Cash Releasing Benefits (NCRBs), Societal Benefits (SBs) and Unmonetisable Benefits (UBs). Further details of each of these benefit types, and assumptions made in benefits development, are provided at Appendix 9.2.5.

Tables (5.18 and 5.19) below outline the benefits assessed to be achievable under each of the respective short list options for the Digital and Estates Infrastructure elements of the Programme. The benefits summarised are assumed to be incurred from the first full financial year following asset implementation / completion and are recurrent on an annual basis until the end of the appraisal period. Further detail on the assumptions behind the quantums and the methodology used to arrive at these figures can be found at Appendix 9.2.3 (CIA Model) and Appendix 9.2.4 (CIA Model Assumptions). It should be noted that the tables below do not show the unmonetisable benefits.

Digital

Table 5.18 – Summary of benefits for Digital Shortlisted Options

Digital	Incremental Digital Benefits (NPV £'000 over 70 year period) (2019/20 Base year)	Benefit Description	Option 1 BAU / Counterfactual	Option 2 Do Minimum	Option 3 Initial PWF	Option 4 Intermediate
	Cash releasing					
	Emergency and Ambulatory	An electronic patient record visible across health and social care promotes better informed decision making by hospital colleagues and providers of care nearer to home that reduces A&E attendances, Inpatient admissions, and associated conversion rates.	-	-	10,811	10,811
	Outpatient	The transformation of outpatients enabled by an EHCR with an effective patient view allowing communication and monitoring by clinicians closer to home is anticipated by NHSX to potentially half face to face consultations.	-	66,730	116,494	116,494
	Radiology and Laboratory	EHR streamlines the ordering process reducing unnecessary tests and supports efficient tracking and validation of results	-	-	3,111	3,111
	Workforce (in addition to workforce savings included above)	EHR will reduce administration/re -transcribing time spent by nurses, which can be realised as a reduction in agency spend Greater colleague productivity associated with nearer real time information can help our trust manage occupancy levels and better plan for discharge Time spent by colleagues retrieving paper records is reduced	-	-	16,234	16,234
	Paperless	EHCR promotes paperless working with a resultant reduction in the cost of producing, storing, and retrieving	-	-	31,163	31,163

		paper case notes. Paper, postage, and printer vendor costs are reduced.				
	Litigation	Alert functionality in an EPR improves clinical management of patients with a potential reduction in litigation due to safer clinical practice with the EPR directly enabling this benefit	-	-	6,956	6,956
	Community and Social Care	Efficiency improvement of 2% in operational costs as Community and Social Care Modules combined with offline working, reduces the need for colleagues to search in disparate records and the dependency on memory, re – transcribing and printing to use and share information effectively	-	-	-	16,223
	TOTAL		**-**	**66,730**	**184,768**	**200,991**
	Non-cash releasing					
	Emergency and Ambulatory	See CRB description	-	-	90,406	90,406
	Outpatient	See CRB description	-	45,313	26,134	26,134
	Medication	An EHCR with an automated Electronic Prescription and Medication Administration (EPMA) will reduce clinically significant errors, which represent the greatest risk to patient safety	-	-	13,014	13,014
	Pathway Management	Alerts functionality with treatment plans in EHCR and automated EPMA means: ● Patients with Sepsis are screened effectively, and treatment started earlier reducing morbidity. ● The VTE assessment process is improved. ● Avoidable AKI is reduced. ● Standardised pathway management reduces readmissions.	-	-	205	205
	Workforce	See CRB description	-	-	19,236	19,236

	Bed days	20% reduction in delayed discharge bed days, through sharing online care planning with Social and Community Care.	-	-	6,365	6,365
	Mobile and Offline working	Functional mobile and offline working as a result of the EPR, will allow frontline staff to see more patients per day than they currently are because they would not need to return to their offices regularly	-	-	-	10,848
	Single Record Across ICS	Access to cross peninsular information enabled by a shared care record is anticipated to reduce the burden on business intelligence costs associated with: ● benchmarking ● retrieving and collating intelligence from disparate information systems	-	-	-	1,650
	TOTAL		**-**	**45,313**	**155,360**	**167,858**

Estates Infrastructure

Table 5.19 – Summary of benefits for Estates Infrastructure Shortlisted Options

Estates	Incremental Estates Infrastructure Benefits (NPV £'000 over 70 year period) (2019/20 Base year)	Benefit Description	Option 1 BAU / Counterfactual	Option 2 Do Minimum	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Maximum
	Cash releasing						
	Major Incidents	Reduction in major incidents occurring in the physical assets. Specifically, theatre outages where a significant number of operations have had to be cancelled	-	-	8,031	8,031	7,730
	Additional CIP	Efficiencies in the form of clinical adjacencies and increase in energy efficiency through new build capability, allow for further efficiencies to	-	-	28,427	26,336	41,106

	be realised above the baseline position. Also, a modern estate which is adaptable and has a number of different uses to meet changes in demand using modern methods of construction					
Workforce agency savings	Ability to attract and retain a greater amount of substantive colleague base rather than having to rely on Agency, due to the renewal of the Estate	-	-	7,229	6,923	13,605
Repatriated income	Renewal of the Estate means there is ability to repatriate services to our trust from the Independent Sector	-	-	22,693	22,693	27,302
Additional retail income	Improved commercial terms can be agreed upon on current contracts held due to improvement of Estate	-	-	832	832	1,602
TOTAL		**-**	**-**	**67,213**	**64,815**	**91,345**
Non-cash releasing						
Health & Safety	Productivity improvement from reduction in colleagues' absence due to health and safety infrastructure related incidents	-	-	1,872	1,872	3,003
Reduced Estates management	Modernisation of facilitates means there is a reduction in the time required to manage the Estate	-	-	1,101	1,101	1,766
Split of planned and unplanned care on the hospital site	There are obvious and material productivity issues with our theatre utilisation and the amount of planned work that gets cancelled. Therefore, cost savings can be made from Estates investment	-	-	56,363	56,363	54,250
TOTAL		**-**	**-**	**59,336**	**59,336**	**59,019**

Societal						
Construction Net GVA	Contribution to the wider economy through: ● Employment ● Training opportunities i.e. apprenticeships ● Income to the area through construction team members shopping	-	-	70,696	72,821	201,210
Carbon benefit	Care closer to home reduces carbon effect on the environment and also the renewal of the Estate allows for more carbon neutral buildings	-	-	3,896	3,877	8,719
TOTAL		**-**	**-**	**74,592**	**76,698**	**209,929**

5.5.5 Costs

The costs included in the CIA Model align with those included in the affordability modelling undertaken to support the Financial Case of this SOC. Full details of the capital cost bases can be found at Sections 7.6 and 7.7 of the Finance Case.

In line with DHSC guidance the items below have been excluded from the cost base included in the CIA Model (as such the figures included as part of the CIA Model do not correspond directly with those included for the purposes of the affordability modelling seen as part of the Finance Case):

- VAT
- Inflation
- Sunk costs
- Transfer payments – depreciation, capital charges and income derived from other public sector bodies

The quantum for each cost category (separated by each option) have been summarised below for both the Digital and Estates Infrastructure shortlisted options. The total present values of costs are shown for the full 70-year appraisal period.

Digital

Table 5.20 – Summary of Digital costs for Shortlisted Options – NPC of capital over 70-year period [FY 2019/20 – FY 2088/89]

Digital	Incremental Digital Costs (NPV £'000 over 70 year period) (2019/20 Base year)	Option 1 BAU / Counterfactual	Option 2 Do Minimum	Option 3 Initial PWF	Option 4 Intermediate
	Capital Costs	-	12,586	24,226	24,405
	Revenue Costs	-	181,001	27,621	55,037
	TOTAL	**-**	**193,586**	**51,847**	**79,442**

Costs for Option 4 are estimated to be higher to reflect the likely need to compromise with other Trusts in this scenario and to acknowldge that they may be likely to favour more expensive solutions.

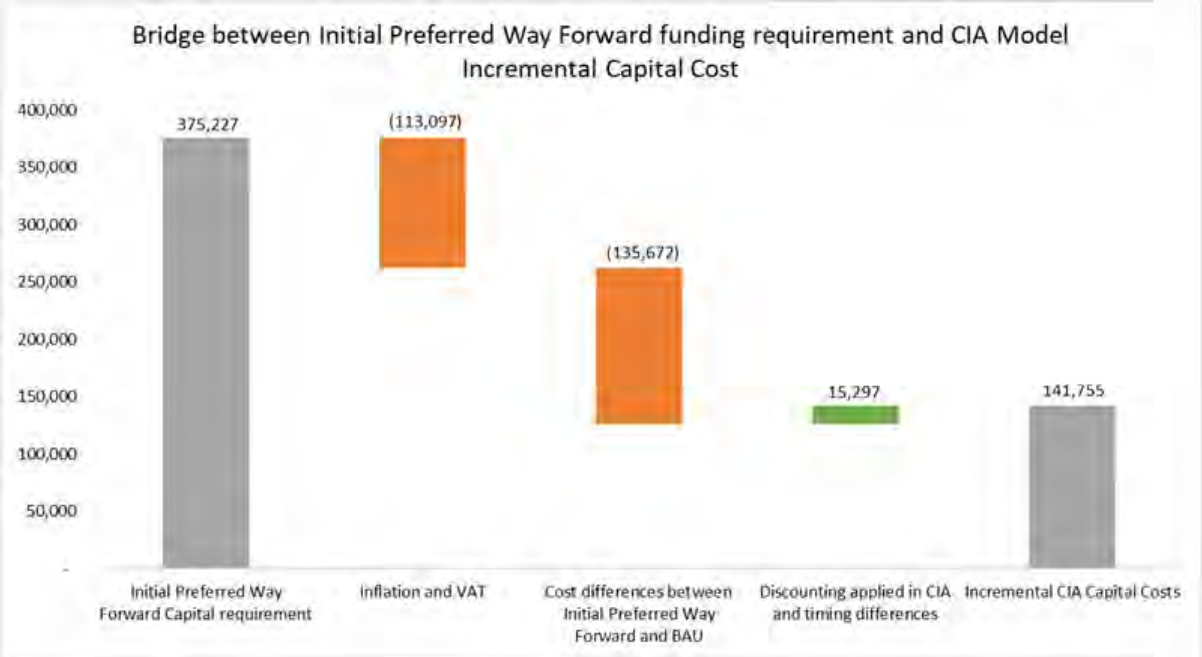
Estates Infrastructure

Table 5.21 – Summary of costs for Estates Infrastructure Shortlisted Options

Estates	Incremental Estates Infrastructure Costs (NPV £'000 over 70 year period) (2019/20 Base year)	Option 1 BAU / Counterfactual	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
	Capital Costs	-	92,791	117,529	122,697	359,818
	Revenue Costs	-	-	5,811	5,811	6,710
	TOTAL	**-**	**92,791**	**123,340**	**128,508**	**366,528**

As stated throughout this case, the CIA requires inflation, VAT and other elements such as sunk costs to be removed from the cost base. The result of these exclusions, in addition to the net present value nature of outputs of the CIA and the 70-year appraisal period, is that the outputs above are not immediately reconcilable to the capital costs and associated funding requirements seen elsewhere in this case. As such, a costs bridge has been provided below to show the difference between the funding requirement and the capital costs set out in the above table:

Figure 5.3 – Bridge between Finance Case figures and Economic Case figures



NB: Incremental CIA Capital Costs of £141,755k represents the captial costs for Digital (£24,226k) plus the capital costs for Estates (£117,529k) under Option 3, as per Tables 5.20 and 5.21 above.

5.5.6 Risks

The CIA Model requires a quantified risk analysis to be undertaken, with the probability assessed of risks identified on a pre-populated risk register materialising, and the associated value impact (£) analysed. These quantified risks are applied to the cost base of each option, resulting in a risk adjusted NPSV.

In addition to the pre-populated risks set out as part of the CIA Risk Log, we have sought to quantify the impact of additional Programme risks, inputting these as additional risks into the CIA Risk Log. Rationale for quantified additional risks is outlined at Appendix 9.2.4.

Similarly to the benefits for each shortlisted Digital and Estates Infrastructure option, workshops were used to discuss and quantify the pre-populated CIA risks in addition to the additional risks highlighted above.

The following tables summarising the risks only include those risk which have been quantified. Other risks from the pre-populated register in the CIA and additional risks which have not be quantified at this stage can be found in the CIA Model at Appendix 9.2.3.

Digital

It is assumed that all risks are dealt with through the contingency sums included in each option. This will be reviewed at OBC stage and a more detailed examination of digital risks will be conducted.

Estates Infrastructure

Table 5.22 – Summary of risks for Estates Infrastructure Shortlisted Options

	Incremental Estates Infrastructure Risks (NPV £'000 over 70 year period) (2019/20 Base year)[16]	Option 1 BAU / Counterfactual	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
Estates	Construction	-	(1,743)	(30,510)	(31,072)	(97,098)
	Operating	-	560	(8,331)	(7,756)	(10,430)
	Additional[17]	-	7,632	280,685	280,621	371,204
	TOTAL	-	6,449	241,843	241,792	263,677

5.5.7 CIA Outputs / Value for Money Analysis

In line with HMT and DHSC guidance the BCR for each shortlisted Digital and Estates Infrastructure option has been examined in order to determine the Absolute Value for Money ("AVFM").

The optimal threshold as per HMT and DHSC for public health spending is currently a ratio of 4:1. In essence this means that for every £1 of cost associated with an option, at least £4 of quantified benefits should be delivered as a result of the investment to demonstrate VfM. This ratio has been determined for each option by considering the benefits and risk adjusted costs discussed previously.

For the purposes of the economic assessment, and in line with the approach undertaken in the Financial Case of this SOC, the BAU / counterfactual option is utilised as the baseline position against which all other options are considered. Benefits and risk adjusted costs have therefore been incrementally compared against this position, with a BCR calculated on this basis. The tables below outline the results of the economic analysis for the individual Digital and Estates Infrastructure shortlisted options, as well as for the combined Programme Initial Preferred Way Forward:

[16] Negative values denote a cost associated with the risk for the option in question. Positive values denote there is an incremental cost reduction from the risk(s).
[17] Please see Appendix 9.2.4 detailing CIA assumptions for more detail on these Additional risks

Digital

Table 5.23 – CIA outputs for Digital Shortlisted Options

Digital	Economic Summary (NPV £'000)	Option 1 BAU / Counterfactual	Option 2 Do Minimum	Option 3 Initial PWF	Option 4 Intermediate
	Incremental costs				
	Capital	-	12,586	24,226	24,405
	Revenue	-	181,001	27,621	55,037
	Risks	-	-	-	-
	Total incremental costs	-	193,586	51,847	79,442
	Incremental benefits				
	Cash releasing	-	66,730	184,768	200,991
	Non-cash releasing	-	45,313	155,360	167,858
	Societal	-	-	-	-
	Total incremental benefits	-	112,043	340,128	368,849
	Risk-adjusted NPSV	-	(81,543)	288,281	289,407
	Benefit:Cost Ratio	N/A	0.58	6.56	4.64
	Overall ranking	N/A	3	1	2

The BCR for Option 1 is N/A due to the nature of the CIA discounted cash flow model, where all other options are incremental to Option 1. Option 2 provides a limited number of benefits but still requires a substantial investment over and above Option 1 in order to maintain the significant number of patient record systems used across our organisation. It should be noted that no cost avoidance can be achieved under this option either – it is deemed to not represent a VfM proposition.

In contrast to Options 1 and 2, Options 3 and 4 both meet the required 4.0 BCR within the CIA and as such are deemed to represent good VfM propositions. While Option 4 is assumed to deliver a slightly higher level of benefits, cost avoidance differences between these Options allows Option 3 to outperform Option 4 in VfM terms.

In addition to the higher level of cost avoidance seen under Option 3, the profile of capital spend under the option, with spend spread over a longer period at lower levels when compared to Option 4, sees Option 3 perform better than Option 4. Option 4 has higher upfront capital costs when compared to Option 3 providing a higher cost base under the discounting nature of the CIA.

Option 3 is deemed to be the Preferred Way Forward from an economic perspective due to its significantly higher BCR. This analysis will be further developed as we move to the OBC stage, with particular focus given to differentiation of options from a benefit perspective.

Estates Infrastructure

Table 5.24 – CIA outputs for Estates Infrastructure Shortlisted Options

Estates	Economic Summary (NPV £'000)	Option 1 BAU / Counterfactual	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
	Incremental costs					
	Capital	-	92,791	117,529	122,697	359,818
	Revenue	-	-	5,811	5,811	6,710
	Total incremental costs	-	92,791	123,340	128,508	366,528
	Incremental benefits					
	Cash releasing	-	-	67,213	64,815	91,345
	Non-cash releasing	-	-	59,336	59,336	59,019
	Societal	-	-	74,592	76,698	209,929
	Risks	-	6,449	241,843	241,792	263,677
	Total incremental benefits	-	6,449	442,983	442,640	623,970
	Risk-adjusted NPSV	-	(86,342)	319,643	314,132	257,441
	Benefit:Cost Ratio	N/A	0.07	3.59	3.44	1.70
	Overall ranking	N/A	4	1	2	3

As seen under the Digital Options set, the BCR for Option 1 is N/A due to each Option being compared back to the counterfactual position within the CIA Model.

Option 2 provides a benefit to our organisation through clearing backlog maintenance and the material levels of risk associated with this remaining outstanding under the counterfactual position. While this risk is reduced, Option 2 requires a material level of capital investment over and above the investment made in Option 1 in order to rectify all of the existing backlog maintenance requirements on the Torbay acute site. No benefits have been assumed to be derived from Option 2 due to the clearance of backlog maintenance not driving operational change or transformation, giving Option 2 a BCR of 0.07.

The transformation investment made under Options 3, 4 and 6 allows for significant levels of value to be derived, both through benefits, lower long term costs and lower risk for our organisation. While these options deliver significant levels, when viewed in isolation without the benefits derived from the Digital investment, each Option does not meet the 4.0 threshold.

At this early stage of appraisal Option 3 and 4 are deemed to deliver comparable levels of benefits due to the similar nature of the Estates Infrastructure investment being made. While this is the case, Option 3 is deemed to deliver a higher level of clinical efficiency benefit due to the works undertaken on the Emergency Department of our hospital, undeliverable under Option 4.

As is to be expected from the Do Maximum Option, Option 6 has the highest level of capital cost requirement due to the Option representing a full new build reprovision of the existing

Torbay acute site. While the costs of Option 6 are higher, so too are the level of recognisable benefits when compared to Options 3 and 4 due to there being no retained estate and the limitations which are brought by this e.g. no full clinical adjacency redesign being able to be implemented. While the level of benefits are greater, the very significant capital costs mean that the option delivers a comparatively low BCR of 1.70, not being deemed VfM.

At this stage of appraisal, Option 3 currently provides the greatest VfM proposition for our organisation. The Option delivers within the available capital envelope for the Programme and derives significant levels of benefits, while de-risking our organisation's estate as we move forwards. We recognise that when viewed in isolation as an Estates Infrastructure investment the Option does not meet the 4.0 BCR threshold, however we will be undertaking further analysis and mobilising benefits realisation workstreams as our Programme moves to OBC stage with the view that further benefits will be identified and risk will be mitigated as our Programme matures.

5.5.8 Programme Initial Preferred Way Forward

In order to show a holistic positions for the wider Programme combining both the Digital and Estates Infrastructure elements, a number of combined Digital and Estates Infrastructure options have been identified.

The first of these is the combined BAU option, the counterfactual position of the organisation including both the Digital and Estates Infrastructure Option 1 capital amounts. Secondly a combined Do Minimum position is examined, with both Option 2s from the Digital and Estates Infrastructure aspects of the Programme. Finally the Programme Initial Preferred Way Forward is examined; created by taking the respective Initial Preferred Way Forward from both the Digital and Estates Infrastructure short lists of options to create a single position. The Initial Preferred Way Forward consists of Digital Option 3 and Estates Infrastructure Option 3. The expected value for money of this combined position is shown below:

Table 5.25 – CIA outputs for Programme Initial Preferred Way Forward

Combined	Economic Summary (NPV £'000)	BAU	Combined Do Minimum	Programme Initial Preferred Way Forward
	Incremental costs			
	Capital	-	105,376	141,755
	Revenue	-	181,001	33,432
	Total incremental costs	-	286,377	175,187
	Incremental benefits			
	Cash releasing	-	66,730	251,981
	Non-cash releasing	-	45,313	214,696
	Societal	-	-	74,592
	Risks	-	6,449	241,843
	Total incremental benefits	-	118,492	783,112
	Risk-adjusted NPSV	-	(167,885)	607,925
	Benefit:Cost Ratio	N/A	0.41	4.47
	Overall ranking	N/A	2	1

Only estates and digital options that conform to the same logic are combined in this anlaysis e.g. two do minimum scenarios can be combined because they represent a common approach in principle. It is not necessary or appropraite to combine further options as they don't logically align and multiple permutations would be required that make little sense.

In line with CIA guidance, and as with the prior ratios seen in the above sections, the Initial Preferred Way Forward has been compared to the single Programme Counterfactual (Digital and Estates Infrastructure Options 1). In addition to this the combined Do Minimum position for the Programme is shown.

The Programme Initial Preferred Way Forward shows a BCR of 4.47, meeting the required threshold and therefore being deemed to represent VfM. The combined Do Minimum position shows a very limited BCR of 0.41.

5.5.9 Unmonetisable Benefits

It should be noted that the above ratios do not consider the impact of additional Unmonetisable Benefits ("UBs") – those benefits which will be delivered as a direct result of the investments made, but are unable to be quantified in monetary terms at this point of development. The UBs identified for both the Digital and Estates Infrastructure elements of the Programme are outlined and analysed in Appendix 9.2.5.

It is important to note that while these UBs do not impact the BCR outputs of the CIA Model, they are still tangible benefits which must be taken in context when assessing the overarching VfM and AVFM of options as part of appraisals. These benefits will be revisited

at OBC and FBC stage development in order to ascertain whether they can be moved to monetisable categories as further information presents itself as the Programme matures.

5.5.10 Sensitivity Analysis

In order to test the robustness of the conclusions of the quantitative economic appraisal, a sensitivity analysis has been undertaken in which some of the key assumptions are altered to assess the impact, if any, on the options and their AVFM / BCR outputs.

The section below sets out the results of these sensitivities in the context of the Programme Initial Preferred Way Forward – i.e. the combination of the Digital and Estates Infrastructure Preferred Ways Forward.

Costs

- + / – 20% Capital Costs
- + / – 20% Revenue Costs

Benefits

- + / – 15% of all Benefits achieved
- + / – 25% of all Benefits achieved

Table 5.26 – Capital Cost sensitivities for Programme Initial Preferred Way Forward

	Capital Cost Sensitivities	Benefit:Cost Ratio
Combined	**Programme Initial Preferred Way Forward**	
	Current level of Capital Costs	4.47
	20% Increase in Capital Costs	3.42
	20% Decrease in Capital Costs	6.46

As is to be expected, the BCR outputs are sensitive to material movements in the capital cost base, with a 20% increase meaning the Programme Initial Preferred Way Forward drops below the 4.0 VfM threshold. Costs will be managed through the contingency sums included in order to mitigate any upward movement as the Programme progresses.

Table 5.27 – Revenue Cost sensitivities for Programme Initial Preferred Way Forward

	Revenue Cost Sensitivities	Benefit:Cost Ratio
Combined	**Programme Initial Preferred Way Forward**	
	Current level of Revenue Costs	4.47
	20% Increase in Revenue Costs	3.52
	20% Decrease in Revenue Costs	5.59

Similarly to the movement seen with regards to the capital costs, increasing the level of revenue costs by 20% moves the Programme Initial Preferred Way Forward below the 4.0 threshold. When compared to the capital costs, the ratio is less sensitive to changes in the revenue costs, due in large to the immediate timing of the capital costs and their significant quantum when compared to the revenue costs. When costs of a higher value occur earlier in the appraisal period, a lower discount factor is applied to the cost base.

Table 5.28 – Benefit sensitivities for Programme Initial Preferred Way Forward

	Benefit Sensitivities	Benefit:Cost Ratio
Combined	**Programme Initial Preferred Way Forward**	
	Current level of Benefits	4.47
	15% Increase in all Benefits	4.91
	15% Decrease in all Benefits	3.99
	25% Increase in all Benefits	5.21
	25% Decrease in all Benefits	3.68

When compared with the sensitivities run on costs, the BCR output is less sensitive to the alteration of benefits realised under the Programme Initial Preferred Way Forward. The Programme is still deemed to represent VfM even when benefits are decreased by c. 15%.

In the context of the prudent approach which we have taken to benefit identification and quantification, we are confident that our Programme will continue to represent VfM, with further opportunities identified in order to quantify additional benefits as our Programme matures and moves to the OBC stage.

5.6 Conclusions

In assessing the options open to our Programme we have sought to assess a wide array of potential solutions, ensuring key stakeholder engagement throughout. We have gone through a robust options appraisal process, utilising the Options Filter Framework to define and appraise our long list of options for both the Digital and Estates Infrastructure aspects of our Programme, and the CIA Model in order to test the economic value derived through our shortlisted options.

The Programme Initial Preferred Way Forward, which comprises Digital Option 3 and Estates Infrastructure Option 3, results in the lowest risk adjusted NPC, highest NPSV and the highest benefit: cost ratio of the short-listed options, 4.47. We have sought to be prudent in our benefit assumptions, meaning there are further opportunities to quantify additional benefits as our Programme moves to OBC stage, including transitioning benefits categorised currently as unmonetisable to cash or non cash releasing benefits.

6 Commercial and Estates Case

Key messages

- We have given early consideration and have identified a direction of travel in relation to the Digital procurement options.
- We recognise that the procurement strategy for our Estates Infrastructure will be dependent on evolving National guidance and we will update and refine it on that basis.
- Modern methods of construction and net zero carbon have been considered in the development of our Estates Infrastructure options. We will undertake more detailed work in these areas at OBC to reflect further development of the options as well as National guidance and best practice from the NHP pathfinder schemes.
- We have started and will continue to explore the opportunity for disposals and potential commercial partnerships to seek ways to reduce the level of NHP funding required to deliver our Programme of investment.

6.1 Introduction

The Economic Case has identified the shortlisted options and Preferred Ways Forward for each of the Digital and Estates Infrastructure elements of the Programme.

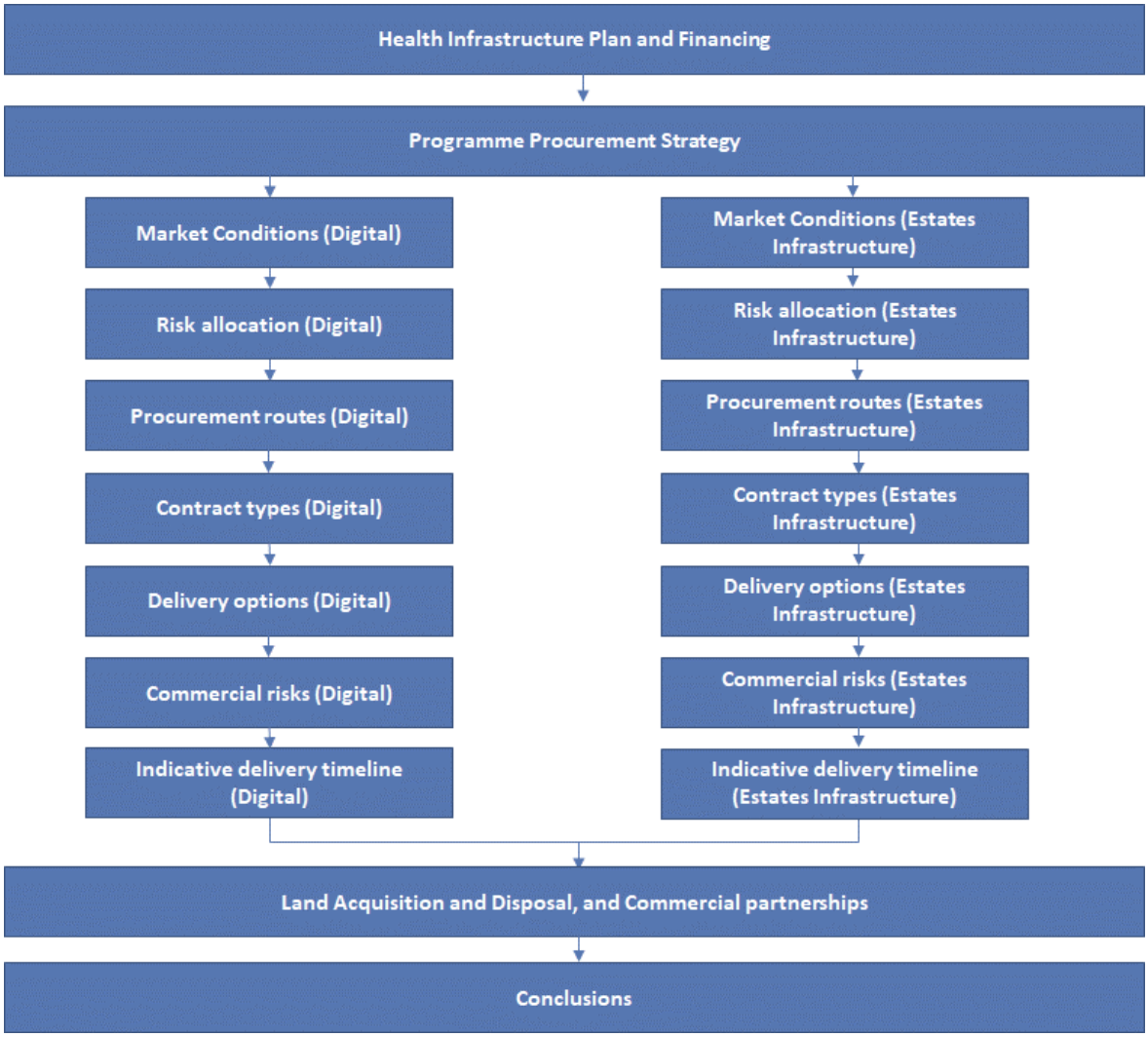
This Commercial Case describes how we could procure each of the Digital and Estates Infrastructure shortlisted options, and sets out the commercial arrangements which will need to be in place to allow for a successful, timely delivery.

The separation of the Digital and Estates Infrastructure elements of the Programme in this Commercial and Estates Case recognises the interconnectability of these elements, whilst allowing for the Digital element to be progressed in advance of the wider Estates Infrastructure element.

In developing our commercial approach we have sought to apply learnings seen across the early tranche of NHP / HIP schemes.

The graphic below sets out the approach used to develop this Commercial and Estates Case:

Figure 6.1 – Structure of the Commercial and Estates Case



The Case examines the consistent commercial elements across the Programme, including:

- **NHP and financing:** the context in which this Commercial and Estates Case is drafted and the overarching assumptions including financing and central commercial management; and
- **Programme procurement strategy:** outlining the overarching approach and key objectives and priorities from a Programme perspective.

Following the discussion as to the consistent elements across the Programme, the nuances for each of the below will be examined for both the Digital and Estates Infrastructure components of the Programme. The chapter will first focus on the Digital element of the Programme, then focus on Estates Infrastructure:

- **Market conditions:** analysis of the current state of the respective markets for both the Digital and Estates Infrastructure elements is set out, specifically looking at the EPR and UK construction markets respectively. The UK construction market conditions analysis being undertaken in the context of the NHP central delivery and the impact of our Trust's geographic location on the procurement of a contractor;
- **Risk allocation:** identification of our preferred position in terms of the appropriate allocation of risk and responsibilities for the Digital and Estates Infrastructure elements of the Programme;
- **Procurement routes:** discussion as to the procurement routes open to us across both elements of the Programme, the options being an open procurement through the use of

Find a Tender Service (FTS) – the replacement to the former Official Journal of the European Union (OJEU) compliant route – or the use of an existing or new Framework;
- **Contract types:** a high level analysis of the contract types open to us for the commercial implementation of both elements of the Programme;
- **Delivery options:** discussion as to the methodology of delivery for the Estates Infrastructure element of the Programme – the two delivery options contemplated being the traditional approach and design and build; and
- **Commercial risks:** confirmation as to the main commercial risks for both the Digital and Estates Infrastructure elements of the Programme are set out.

At the conclusion of the above sections the Commercial and Estates Case explores the initial requirements with regards to land acquisitions requirements and the opportunities for land disposals and associated capital receipts against the shortlisted Estates Infrastructure options. The initial work that we have undertaken to identify potential commercial partnerships associated with a number of the shortlisted options is also outlined.

6.2 Programme Procurement Strategy

6.2.1 Introduction

As outlined in the introduction to this Commercial and Estates Case we will examine the Digital and Estates Infrastructure elements of the Programme separately, recognising the significant differences in their requirements and, as such, appropriate procurement strategies and methodologies. While each will be examined in turn, a number of overarching elements are relevant to the commercial approaches to both the Digital and Estates Infrastructure elements of the Programme. This brief section sets out these common assumptions.

6.2.2 New Hospitals Programme and Financing

The NHP, – the major health infrastructure investment programme across England – provides us with a generational opportunity to deliver a digitally enabled new core health asset, fit to serve the changing population and their respective needs in the future. We are one of a number of Trusts which will be part of the second wave of schemes to be delivered under the NHP.

Our Trust Programme Office received a letter from the National team on 9th June, (see Appendix 9.3.1) which confirmed that a Prior Information Notice (PIN) would shortly be issued to the market to gain an understanding on the level of interest from the market in respect of the development of a 'progressive alliance' model . It highlights that this model will have three distinct features:

- It will be centrally controlled and locally delivered
- It will evolve with each phase of the programme, starting with the earlier schemes, iterating to improve the model with each cohort
- It will create and sustain a collaborative environment which enables application of Modern Methods of Construction (MMC) across the delivery of the programme.

Our Trust will ensure that it delivers its commercial strategy for the Programme in line with these national requirements, and will continue to work with the national team as this procurement strategy develops. At the time of writing further guidance as to the alliance model has not yet been published. As such this Commercial and Estates Case has been written in the context of how we would approach the commercial implementation of the shortlisted options, however we are keen to stress that we will comply with any and all NHP guidance on commercial implementation when it becomes available.

With regards to the financing of NHP schemes, it is our understanding that central PDC will be made available. This assumption has been made in conjunction with the central policy change in October 2018, which removed the use of privately financed infrastructure. We understand that funding for the second wave of NHP schemes will be confirmed under the 2025 Comprehensive Spending Review. In line with this expectation, we have focused on public procurement processes for both elements of the Programme.

6.2.3 Objectives and Priorities

We have identified a number of overarching key procurement objectives and priorities which the Programme must meet. These objectives and priorities sit across both the Digital and Estates Infrastructure elements of the Programme:

- **Price certainty:** we are cognisant of the capital affordability requirements in order that the Programme can be managed within the existing financial capital envelope, meaning price certainty under both Digital and Estates Infrastructure elements is of paramount importance. Under both elements of the Programme we require fixed prices to be bid
- **Value for Money:** the chosen procurement routes must implement a commercial solution which generates a VfM end result for us
- **Appropriate transfer of risk:** risk should be transferred to the party best placed to manage and mitigate that risk
- **Fully compliant implementation:** the commercial solution must comply with all relevant central NHP and wider government guidance with regards to procurement and construction processes
- **Resource and capacity in our Trust:** the resource and capacity available within our Trust is adequate to allow the chosen procurement route to be managed appropriately
- **Market appetite:** it is of key importance that appropriate contractors are attracted to the Programme given the number of other NHP schemes and other significant government led infrastructure projects that are likely to have similar timelines and are effectively competing for the same base of contractors
- **Supply chain:** when looking at the implementation of successful major projects elsewhere, a key feature has been a successful and appropriate supply chain. The length of the supply chain must be appropriate, fitting within our commitments made under the Devon Climate Emergency announcements. In addition a key objective for us will be the use of suppliers who utilise local resources in order to generate employment and stimulate the wider local economy.

In reviewing the available procurement routes open to us the above objectives and priorities have been considered and will be further examined as the Programme moves to OBC stage, recognising the emerging central guidance which will likely be available at that time.

6.3 Digital

6.3.1 Short Listed Options

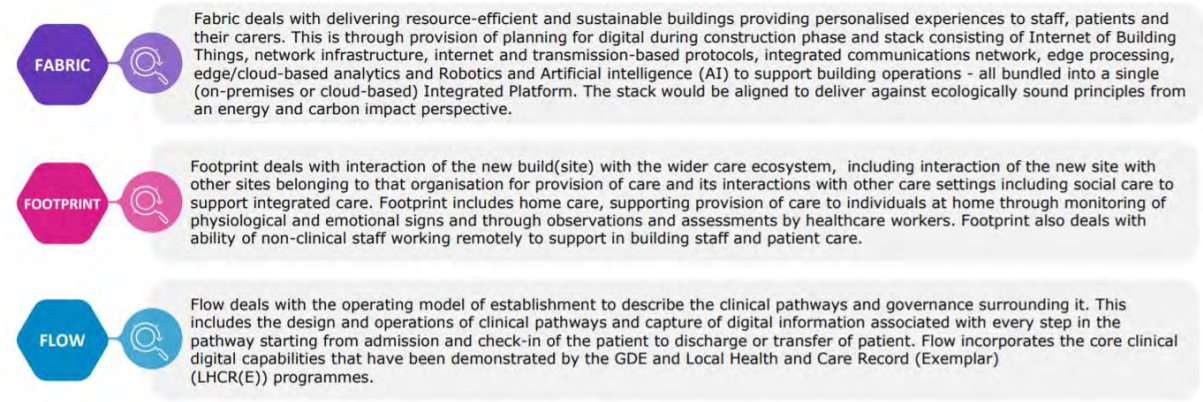
The shortlisted Digital options are set out in detail at Section 5.4.1 of the Economic Case. In summary these options are:

1. Digital Option 1 – Counterfactual: continuation of the current multiple systems strategy
2. Digital Option 2 – Do Minimum: optimise the current multiple systems strategy
3. Digital Option 3 – Procure an integrated EPR solution independently
4. Digital Option 4 – Procure an integrated EPR solution as a collective group of Trusts in the region

6.3.2 Procurement Scope

As described in section 4.7 of the Strategic Case, the NHP Blueprint for Digitally Advanced Hospitals (The Digital Blueprint) – the central guidance issued with regards to the digital element of NHP schemes – sets the expectation with regards to the digital transformation required under NHP financed programmes. The Digital Blueprint identifies three fundamental categories: the fabric of the building; the footprint of the establishment; and the flow of the operating model. The figure below defines these categories:

Figure 6.2 – HIP Blueprint for Digitally Advanced Hospitals



Source: New Hospitals Programme: Blueprint for Digitally Advanced Hospitals, Version 5, Pg. 23

As outlined in the Economic Case, the discrete Digital element of investment under our Programme relates to the implementation of an EPR solution – the "Flow" element identified above. The Fabric and Footprint elements are encompassed within the wider Estates Infrastructure element of the Programme.

The Digital solution has been structured in order that it can be progressed ahead of the wider Estates Infrastructure works, with the Estates Infrastructure solution to be developed in a way that will allow for the incorporation of the Digital solution. In practice this means that the EPR solution can be advanced while the Estates Infrastructure solution is being further developed. As set out in the Economic Case, the development of the Estates Infrastructure options has been made in the context of the initial Digital Preferred Way Forward. The nature of EPR systems examined and to be procured means that the solution will be compatible with any of the shortlisted Estates Infrastructure options.

6.3.3 Market Conditions

The UK-based EPR market is competitive, with a number of major international providers operating in it. It is stable, with established procurement frameworks and NHS Trusts consistently undertaking major procurement activities across the country.

6.3.4 Procurement Routes

The shortlisted Digital options range from a continuation of the status quo, replacing existing systems as and when required, to a replacement of existing systems with an integrated EPR solution.

The main public procurement routes open to us for the delivery of each of these options are:

- **Open procurement – Find a Tender Service (FTS):** undertaking a fully compliant, openly advertised procurement which allows responses from all relevant parties; or
- **Use of an established framework:** running a competition using an existing framework arrangement – in all likelihood the London Procurement Partnership – Clinical Digital Solutions (CDS) Framework.

Each of the identified short list options has their own nuances, and as such the preferred procurement route and associated commercial challenges differ for each. These nuances and challenges are outlined below:

Option 1 – Do Nothing, Business as Usual

In this option we will continue to use the existing multiple-systems strategy in place at present, which has patient records spread across multiple separate systems. Key solutions will be replaced as part of natural succession, using BAU Trust capital to fund requirements as per our capital plan.

We currently undertake the majority of IT procurements through existing framework arrangements, with some bespoke elements being openly tendered. These existing procurement approaches will continue to be used under Option 1, however a number of inherent issues will be addressed – specifically issues with vendor engagement, selection, and contract management.

To address these issues under Option 1, we will invest in a basic vendor management model in order to have a single view of IT contracts held within our Trust. This will ensure that we can adopt a proactive and strategic rather than a responsive approach to system replacement as is currently the case. We will examine the outsourcing of this system as the Programme progresses.

Option 2 – Optimise the current multiple systems strategy

Option 2 is the Do Minimum option identified for appraisal, continuing to use our existing multiple systems but replacing key health and care systems that are outdated or inoperable and increasing integration and vendor management capacity and capabilities.

Similarly to Option 1, Option 2 will use the existing procurement arrangements for IT systems, with the majority of solutions procured through existing framework arrangements. While a series of framework procurements will be utilised, we will aim to strengthen the IT procurement process and vendor management to ensure full control over commercials for our entire IT estate.

Options 3 and 4 – implementation of an integrated EPR solution

Options 3 and 4 both require the outsourced procurement of an integrated EPR solution, however these options differ with regards to the commercial implementation of the outsourced provision.

Under Option 3, we will go to the market independently for provision of an integrated EPR solution, with established EPR providers requested to respond to these requirements. At this time it is proposed that we will use the London Procurement Partnership – Clinical Digital Solutions (CDS) Framework to undertake a pre-qualification exercise.

The pre-qualification exercise would stimulate competition and establish the options, risks, cost envelope and how best to structure the procurement. Once these are understood we would design the contracting route and proceed to run the defined process. At this time it is suggested that the likely process would be through the utilisation of a mini competition utilising the CDS Framework, however a competitive procedure with negotiation could be utilised if the market test fails to narrow down the options.

Under Option 4, will utilise the same methodology as seen in the commercial delivery of Option 3, however the procuring authority role will be played by the collective of organisations which will allow a single solution to be procured.

As the Digital element of the Programme progresses to OBC stage, we will continue to work with NHSE/I and regional partners to further develop the commercial delivery methodologies for each of the shortlisted Digital options.

6.3.5 Contract Types

As the Digital element of the Programme progresses to OBC stage we will further analyse the contract types open to us.

6.3.6 Commercial Risks

The figure below outlines the key commercial risks and mitigating actions in relation to the Digital element of the Programme:

Table 6.1 – Digital Commercial Risks and Mitigations

	Risk	Mitigation
Digital	Current vendor management capacity and capabilities are minimal, so there is low control over the 150+ systems suppliers or digital landscape.	Ensure requirements for vendor management are considered.
	Commitment to an integrated EPR is long-term, so we need to get it right first time. There is no simple exit plan.	Ensure Trust requirements are clear. Ensure Trust commitment to outcomes, implementation, and impact. Ensure exit plans are detailed.
	The commercial constructs for Option 4 is likely to be non-standard, and new ground for our Trust.	Work through the commercial options with partner organisations as we move to OBC.

6.4 Estates Infrastructure

6.4.1 Short Listed Options

The shortlisted Infrastructure options are set out in detail at Section 5.4.2 of the Economic Case. In summary these options are:

1. **Estates Infrastructure Option 1 – Counterfactual:** All existing services are maintained on the acute Torbay site, with capital investment made in order to clear critical estates backlog maintenance (Category D) on the site.
2. **Estates Infrastructure Option 2 – Do Minimum:** All existing services are maintained on the acute Torbay site, with capital investment made in order to clear all backlog maintenance on the site.
3. **Estates Infrastructure Option 3 – Initial Preferred Way Forward:** Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on rebuilding elements of the existing acute Torbay site, with targeted refurbishment of those areas retained. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.
4. **Estates Infrastructure Option 4 – Intermediate Option:** Planned and unplanned care (in line with PCSS and the Devon LTP) will be separated on the acute Torbay site, retaining a 24/7 Emergency Department. Capital investment will be delivered in order to achieve this, focusing on refurbishing the existing acute Torbay site, rebuilding discrete elements. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon.

5. **Estates Infrastructure Option 6 – Do Maximum:** Reprovision of all services delivered at present, splitting unplanned and emergency care from planned pathways with extra capacity, with a full new build reprovision of the entirety of the existing Torbay acute site.

6.4.2 Procurement Scope

A number of Estates Infrastructure works are to be delivered in the coming years, including BAU works associated with historic STP Wave 3 Capital bids, enabling elements to the NHP scheme and the NHP itself. Recognising the timelines associated with the Wave 3 Capital scheme, and the fact that it is subject to a separate business case process, it is deemed outside the scope of this Commercial and Estates Case and NHP procurement exercise.

In order to deliver the requirements identified through the Strategic Case in relation to the NHP elements of the Programme, the shortlisted Estates Infrastructure options range from backlog maintenance in the counterfactual position (the true business as usual position which the options will be compared against), through to the Do Maximum Option which incorporates a full greenfield new build of the acute hospital . Each of these shortlisted Estates Infrastructure options differs significantly in size, scale and complexity. In delivering these options there will be a need for enabling works, refurbishment of the existing estate, new build construction, and equipping of the facilities. The procurement considered in this Commercial and Estates Case will only focus on the main capital construction works associated with the option in question.

For the purpose of this SOC, the planned care centre is assumed to be delivered on our existing acute site at Torbay. Further work is being undertaken on a regional basis to understand the attractiveness of this planned care centre being extended to act as a central hub for multiple providers within the regional geography. The assumption for the purpose of this SOC is that the planned care centre will be procured alongside the main contractor works required under the Estate Infrastructure options identified in relation to our acute site. This assumption will be tested as the Programme moves to OBC stage and as further work is undertaken on a regional basis.

Recognising the likely central management of the procurement process, at present our strategy is to appoint a single prime contractor to take on all works associated with each option. The single contractor will be appointed by us and will be responsible for the delivery of all main construction services on site. No other services will be included in the scope and brief of this contractor. For example, Hard FM, delivery of equipment and other elements outside the main construction elements. If guidance is released which contradicts this strategy we will default to the position as per that guidance.

6.4.3 Market Conditions

The NHP will see multiple NHS Trusts coming to the market, adhering to very similar timescales and looking to procure very similar skill sets – both for Design Team appointments and main contractor procurements. This will likely lead to a constrained supply market where demand is significant – compounded further by major central government-driven building initiatives in other sectors.

We recognise that the delivery of major health infrastructure is complex and can bring with it significant risks for contractors, in large part due to the significant Mechanical and Electrical (M&E) requirements of major health building programmes. When compared to what could be seen as more straightforward, less risky builds in other sectors (e.g. schools and prisons), it is important that we make our scheme as attractive as possible in order that a suitably qualified contractor, with sufficient capacity, be appointed.

In this context we recognise the importance of understanding the marketplace from which the Programme will be delivered. Focusing on the main contractor position, there are currently several contractors in the UK market active in the healthcare sector. However, it should be noted that the experience of these contractors differs significantly, with only a limited number of Tier 1 contractors having a strong track record of delivering major health infrastructure projects in excess of £200m.

In addition to the varied experience, the UK construction market has suffered significant financial challenges over recent years which have been heavily publicised. For example, both Carillion and Interserve have entered default positions, resulting in compulsory liquidation and administration proceedings respectively. COVID-19 implications are still to fully play out, with the furlough scheme being further extended meaning the impact on wider building projects is yet to be felt. As the Programme moves to OBC stage and guidance is released as to the national management of the NHP, we, through our advisers, will continue to monitor the state of the construction market. We do not plan to undertake any construction supplier market engagement activities, as per central guidance.

We are acutely aware of the implications of our geographic location, further emphasising the requirement that the scheme be attractive to the construction market. The limited access points to Devon and the wider region, in addition to the limited local labour base could serve to make our Programme less attractive to Tier 1 contractors than those NHP schemes coming to market at a similar time in more accessible areas of the country with access to greater levels of labour and the wider supply chain.

We understand the conditions of the market both locally and nationally, and recognise that a robust procurement strategy and process is required to mitigate the identified risks of overtrading and potential issues of contractor default. In order to mitigate these issues, particularly concerns of contractor financial stability, we would look to implement methodology from the Cabinet Office's Outsourcing Playbook where appropriate. We are committed to working with the central NHP team in delivering a robust procurement process and will adhere to guidance in full as and when it is available.

6.4.4 Global Pandemic – COVID-19 Impact

On 11 March 2020 COVID-19 was declared an international pandemic by the World Health Organisation (WHO). Due to this declaration a number of interventions were made by the UK Government to slow transmission, including a national stay at home order and social distancing requirements. While construction sites could remain open during the initial lockdown period, productivity on sites was significantly impacted due to the distancing requirements.

At the time of writing this SOC social distancing remains in place as the UK gradually eases out of lockdown following the second wave of the virus. While social distancing remains the main hindrance to on-site productivity, the UK Government has outlined a roadmap out of lockdown for England. While this roadmap has been developed, it is reliant on the progress of the vaccination programme and other metrics, with social distancing likely to remain in place for the coming years in some guise.

As the Programme progresses to OBC and beyond, and recognising construction timelines, the Programme team will continue to monitor the construction market impact of the pandemic and work with NHSE/I colleagues to manage the procurement process in the most appropriate manner, as per guidance as and when it is available.

6.4.5 Delivery Options

In the absence of detailed national guidance at this time, we have undertaken a high level review of the two main delivery options for the main construction works – the traditional approach and design and build (D&B) method. Each of these methodologies has a single and two stage variation:

- **Traditional – Single-stage:** A complete design is worked up and tendered by us. A construction company is procured to develop the specific design usually under a lump sum price;
- **Traditional – Two-stage:** The selected contractor works alongside our Design Team to input into the design process and ensure buildability at an early stage. The completed design is tendered to the market at the second stage;
- **Design and Build (D&B) – Single stage:** A contractor is appointed to both design and construct the works fully; and
- **Design and Build – Two-stage:** The Client employs a Design Team at the first stage who works up the design which is then tendered for the second stage. When the contractor has been chosen, the original Design Team is novated from us to the contractor for the remainder of the works period.

Under the Traditional approach the Contractor does not take on risk for design coordination, designer performance and buildability. Design coordination and performance (both in terms of quality of information and production timeliness) of the design team rests entirely with us, whereas under D&B the contractor owns the risk for design coordination, designer performance and buildability.

In relation to the D&B approach, rather than producing a detailed design for which they have responsibility, we produce an output based specification, defining the physical, environmental and performance parameters that the building has to achieve (often referred to as Employer's Requirements). The contractor is then responsible for delivering a build which meets the parameters set out, but they can choose the optimum approach which they would like to follow to achieve these.

Having considered both overarching delivery options, our preference would be for the use of the D&B approach as it offers us responsibility for both the design and the construction, better delivering against the overarching objectives and priorities highlighted in the above sections. D&B provides greater cost certainty, more appropriate level of risk transfer, and it supports the integration of team work as required under the Government Construction Strategy. The decision to adopt a Single-stage or Two-stage approach will be further explored by us as the scheme progresses, and will be informed by central guidance as it is available.

It is recognised that this decision may be taken centrally, however we are happy to work with NHSE/I and other national colleagues to establish the most appropriate delivery solution for the Programme.

6.4.6 Procurement Routes

Under a public procurement process we have two main options:

- **Open procurement – Find a Tender Service (FTS):** undertaking a fully compliant, openly advertised procurement which allows responses from all relevant parties; or
- **Use of an established framework:** running a competition utilising an existing framework arrangement – the two main options open to us are:

- Crown Commercial Service's (CCS) Construction Works and Associated Services Framework
- Procure 2020 (P2020): the soon to be established DHSC construction works procurement framework, replacing the Procure 22 (P22) framework

While we understand that it is highly likely that a framework procurement exercise will be utilised centrally, in the absence of further clarity we have undertaken a high level assessment as to the benefits and potential limitations of both methodologies:

Table 6.2 – Summary of Procurement Routes

		Open procurement	Framework procurement
Combined	Cost certainty	No pre-agreed rates. Cost certainty mechanism able to be applied dependent on contract form.	Ceiling prices that can be further reduced by competition at call off. Further cost certainty mechanism able to be applied dependent on contract form.
	Contract form	Ability to dictate standard form.	Use an already negotiated contract form which can be tailored.
	Potential for legal challenge	Medium – requirement for careful monitoring of process with potential for material risk of legal challenge if not managed properly.	Low – understood procurement process with agreed standard forms.
	Timescales	Significantly longer than framework agreements – no pre-agreed bidders included meaning short listing exercise is significantly protracted depending on interest in tender.	Relatively short – a significant benefit of the framework procurement route is the ability to compress timescales by utilising an already established mechanism – allowing an earlier appointment by us, recognised as being attractive in the current environment.
	Cost of process	Potential for the process to take significantly longer	Well understood procurement route with likely costs able to be estimated
	Market appetite	Allows us to reach a wider market rather than the set number of suppliers who are already on the existing procurement frameworks – particularly important given the market conditions outlined above.	Limited to the participants existing on the framework lot in question.
	Bidder due diligence	Significant – ability for our trust to undertake all appropriate real-time due diligence on bidders from financial and capability perspectives.	Significant – on framework formation due diligence undertaken in order to allow framework members access for call-offs. Further due diligence able to be undertaken at call-off stage to mitigate risk of real-time issues e.g. Covid-19 global pandemic impact.
	Administration requirements	Significant – our Trust running full procurement with limited external support (other than anticipated Project Speed guidance).	Limited – support able to be provided by framework owner, coupling with overall limited

		requirement given the pre-set nature of the framework.
Ability for customisation	Significant – ability to entirely tailor process within procurement regulation parameters.	Limited ability to alter standard form.

It is understood that in all likelihood the NHP national team will dictate the use of the soon to be established P2020 DHSC construction framework. We are supportive of the use of a procurement framework methodology recognising the above analysis against the overarching Programme procurement objectives. A framework approach would also allow for more efficient delivery due to the shortened timescales involved when compared to the open procurement methodology.

6.4.7 Contract Types

At present it is unclear which standard contract form will be employed under the DHSC P2020 framework, with recognition that there will likely be framework specific derogations from existing standard form contracts. As stated throughout this Commercial and Estates Case, we will implement the contract type as required under guidance.

Within this context, and in line with ongoing discussions with NHSE/I colleagues, we have sought to explore the most commonly used contract forms. The two most appropriate contract forms have been deemed to be:

- New Engineering Contract (NEC)
- Joint Contracts Tribunal (JCT)

Both of these contract forms are recognised and understood well across the construction industry, with most public works in the UK undertaken using these forms. The recognition of these contracts is a significant benefit, meaning construction partners understand the risk profiles and they are often pre-approved for use by contractors by their Boards. This in turn drives cost effectiveness of implementation when compared to specific alternatives, as they are familiar to the parties involved (reducing tendering, negotiation and administration costs), and tend to contain less unforeseen aspects. They can also allow some flexibility, with a wide range of variations, options and schedules that can be tailored to meet the needs of a specific scheme without altering the contract clauses. Where this does not give sufficient flexibility, it is possible to amend standard forms of contract.

Recognising that there is no confirmation at present of the contract form under the DHSC P2020 framework, we will undertake further due diligence on the contract type when this is available.

6.4.8 Modern Methods of Construction

Modern Methods of Construction (MMC) is a wide ranging term, embracing a number of offsite manufacturing and onsite techniques that provide alternatives to traditional building and forms part of the Government's recent policy (2017) for future construction in the public sector. In practice the MMC approach allows for the building of structures more quickly, reliably and sustainably.

The Government's Infrastructure and Projects Authority (IPA) guidance 'Transforming Infrastructure Performance' (2017) also refers to MMC as 'smart construction' defined under the following three categories which covers a range of techniques with greater levels of

activity taking place off site and increased levels of standardisation, underpinned by digital design and engineering.

I Manufactured: whilst not widely used this offers the greatest opportunities to improve delivery efficiency and boost productivity. This approach enables high levels of customisation by developing and using standard components and assemblies.
II Volumetric: e.g. fully fitted modules.
III Components: e.g. standardised design elements (WC / shower pods, pre-assembled bed head services etc).

MMC is a collective term to describe these alternative construction practices, MMC being largely characterised by off-site, factory production of the component parts of buildings. MMC offers a number of advantages over more traditional construction methods:

- Modular, factory-based production of component parts can result in more consistent quality of construction, arguably linked to a reduction in the risk of defects;
- Off-site construction can lead to more reliable timescales for construction projects, as factors such as adverse weather have less impact;
- The need for on-site labour is also considerably reduced, in turn leading to benefits linked to health and safety of the site and wider site disruption; and
- MMC helps in overcoming a skills shortage in the construction industry and should also result in a reduction in project time and cost whilst improving safety and quality throughout the whole of an asset's life.

The site related benefits of MMC explored above are a significant set of benefits to us given the options identified are largely to take place on the existing acute Torbay site, with care continuing to be delivered throughout any redevelopment works.

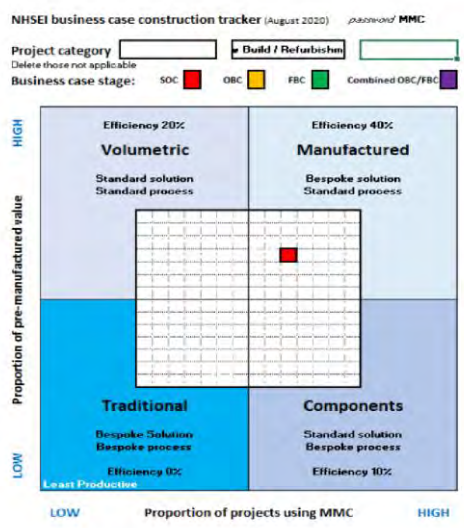
We recognise the importance of MMC under the NHP and Project Speed contexts, being a key enabler for acceleration of Programme and the ability to drive cost efficiencies. In order to maintain prudence, our capital costs do not at present assume efficiencies from the use of MMC principles in options delivery.

At present the proportion of refurbishment and rebuild works under the options is defined at a high level and will be further refined as the Programme moves to OBC. We, with the support of our technical advisory team, have analysed the space and outturn costs of the Initial Preferred Way Forward as identified in the Economic Case into the MMC categories set out below:

Table 6.3 – MMC Categories and option requirements

	#	Heading	Requirement
Estates	1	New build GIA/m2	20,650 m2
	1a	Major refurbishment GIA/m2 (<90% > 65% of new build project average cost £m2/GIA)	7,611 m2
	1b	Other refurbishment GIA/m2 (<65% of new build project average cost £m2/GIA)	-
	Total project GIA/m2		28,261 m2
	2	New build total estimated outturn cost excluding VAT and inflation	£178,046,920

2a	Major refurbishment total estimated outturn cost excluding VAT and inflation	£43,331,974
2b	Other refurbishment estimated outturn cost excluding VAT and inflation	-
Total project estimated outturn cost excluding VAT (and excluding inflation)		£221,378,894
3	Which of the following is the Trust currently considering and for how much of the total project GIA/m2 and estimated outturn cost excluding VAT and inflation?	All forms considered
3a	Volumetric	70% New Build ~ 14,455 m2 / £124,632,844 10% Refurb ~ 761 m2 / £4,333,197
3b	Manufactured	Ditto – all forms considered
3c	Component	Ditto – all forms considered
3d	Traditional	30% New Build ~ 6,195 m2 / £53,414,076 90% Refurb ~ 6,850 m2 / £38,998,776
4	What is the likely option or what is the agreed option for procuring these works?	As 4a
4a	Pre-tendered framework:	Framework likely procurement route
4b	Other procurement process:	
5	Are the current designs considered to be standardised / repeatable?	The approach to the reprovision of inpatient beds will be to use a standardised / repeatable approach where possible at a departmental level. Where extension / adaption is proposed standardised room types (singular / multi- bed bay to suit healthcare planning requirements) will be adopted. Generally: at a room layout level, standardised room types will be utilised wherever possible. Our designs will be further developed at OBC stage following learning / feedback from the HNP Technical reviews of HIP1 projects which are currently ongoing.
5b	If 'Yes' to # 5 provide details of which other NHS organisations have used these designs and when	IBI consistently utilise standardised room layouts as part of the P22 Healthcare frameworks. Projects such as Chase Farm Hospital, Royal Free NHS Foundation Trust are reflective of the use of standardised room types.
5c	If 'No' to # 5 provide details why 'MMC' options are not being considered and where in the business case there is evidence to support this	

6	Trust is required to complete an updated version of the MMC tracker (attached) at each business case stage	Extract from MMC Strategy Report (March 2021)  Figure 12 – MMC business case tracker

During the OBC process the concept design (from SOC) will be fully evaluated and scrutinised to ensure that MMC is front and centre in all design considerations, ideally exceeding expectations in terms of MMC construction content.

6.4.9 Sustainability and Building Research Establishment Environmental Assessment Method (BREEAM)

In response to the growing threat of climate change, a range of public, private and voluntary organisations from across Devon came together in 2019 to form the Devon Climate Emergency Response Group (DCERG). The group recognises the significant impacts of climate change for Devon's communities and is developing a Devon Carbon Plan. An interim plan has been developed and is currently under consultation with the Final Devon Carbon Plan expected to be published this year. The plan outlines a roadmap for Devon to achieve net-zero carbon by 2050 at the latest, with an interim target of 50% reduction by 2030 from 2010 levels. We recognise the importance of collaboration with the local authority and the Net-Zero Task Force to support the implementation of the Devon Carbon Plan. In particular, we will look to align our net-zero plans with wider aims to decarbonise local energy systems and the need to relocalise services and technology to reduce the carbon associated with transport systems.

We are currently progressing the development of a Green Plan which will act as a live strategy document for our sustainability agenda for a 3 – 5 year period. The plan will cover a broad spectrum of sustainability areas including corporate approach, travel, utilities, capital projects, green space/biodiversity and sustainable models of care. We recognise that it is of critical importance to align the design principles of the hospital redevelopment to the aims and objectives of our Green Plan. As such, the development of the Green Plan will include significant input on the area of capital projects from the teams overseeing the proposed site redevelopment.

It is noted that NHSE/I require new hospital builds to have a BREEAM rating of >70% requiring the Programme to target an "Excellent" rating. All costings and design work to this stage have targeted the achievement of an Excellent rating, and as the Programme progresses to OBC stage and as further work is undertaken on all shortlisted options, we are

committed to delivering on this basis. The capital costings underpinning this SOC include the delivery of this target.

It should be noted that under all options, save for Estates Infrastructure Option 6 (Do Maximum), material elements of existing estate infrastructure remain in use due to the limited ability to replace all Estates Infrastructure within the capital envelope available to us. Achieving a BREEAM Excellent rating in this context for that retained Estates Infrastructure is not immediately within the scope of this SOC, however in the longer term we are committed to working with central teams and their technical advisers to explore the options open to our Trust with regards to these areas of retained Estates Infrastructure.

6.4.10 Net Zero Carbon

We confirm that, in line with central guidance, each of the shortlisted Estates Infrastructure options (which do not only clear backlog maintenance e.g. Estates Infrastructure Option 2) will be constructed in line with net zero carbon principles over the entirety of the asset life. A provision of 12.5% of works costs has been included in the capital costs of each Estates Infrastructure option to address low carbon requirements – this is split 5% for enhanced fabric costs, and 7.5% for enhanced MEP costs.

We recognise that to meet the NHS's targets for a Net Zero health service (for the "NHS Carbon Footprint") by 2040, it is critical to reconsider how we supply heat and a Domestic Hot Water System (DHWS) to our buildings. The current means of supply involves burning natural gas to raise steam. This is incompatible with our long-term Net Zero goal. In light of this, the energy strategy for the redeveloped hospital will rely on use of Low Temperature Hot Water (LTHW) as the primary medium for distributing thermal energy around new and refurbished buildings. The transition to lower temperature heating infrastructure enables, either in the near-term, or medium-term future to switch generation assets from gas boilers to low carbon heat pump technology.

Heat pumps typically operate with a high efficiency, and therefore low carbon impact, when the heat-source being used is at a high temperature. Opportunities to use heat available above the ambient temperature of air as a source for a future heat pump will be considered at future design stages. These opportunities include local wastewater, refrigeration system waste heat, potential future district heat networks and borehole groundwater. Combining the electrification of thermal demand with provision of electricity via renewable sources, such as a proposed local solar PV array or via a Power Purchase Agreement, will largely eliminate the carbon impact associated with the operation of our buildings.

Given the level of influence our Trust has over the emissions scope "NHS Carbon Footprint" as outlined within the *Delivering a Net Zero National Health Service* report produced by Greener NHS, it is important that this comprises our primary focus for achieving net zero in as short a time as possible. However, we remain cognisant of the longer-term target to reach net zero for the "NHS Carbon Footprint Plus" by 2045, which encompasses a much wider scope of emissions, within which building operational emissions are typically only 15-20%. In light of this, the carbon impact of wider aspects of the development will be assessed and design mitigation options considered at the OBC stage. Considerations will be made for embodied carbon of construction materials and services, patient and staff travel and virtualisation.

6.4.11 Development Control Plans and the Programme Initial Preferred Way Forward

Alongside our technical advisers we have developed and iterated a series of Development Control Plans (DCPs) leading to an Initial Preferred Way Forward that illustrates new buildings that will comprise the new hospital configuration. These DCPs can be found at Appendix 9.1.5.

At the forefront of this process is the imperative of embracing standardisation of design and room repeatability that will facilitate the maximisation of MMC, leading to shorter build programmes and a reduction in construction cost/risk.

Estates Infrastructure Option 3 has been identified through the Economic Case as the Initial Preferred Way Forward. The DCP for this option is outlined below:

Figure 6.3 – Estates Infrastructure Option 3 Development Control Plan

6.4.12 Equipment

Included in the capital costs for this SOC stage is an allowance for an amount equal to 15% of construction costs for each option in order to deliver new required equipment. As the Programme moves to OBC and is further refined, work will be undertaken to reduce this capital allocation through equipment audits and assessment of the transferability of existing equipment.

At present the likely equipment procurement strategy is to maximise agreed framework contracts where appropriate to ensure efficient delivery and to achieve savings on procurement costs. It is recognised that we will take some risk on delivery and design issues relating to the building and timing of supply of the equipment; this will be mitigated through tight programme management through each of the shortlisted options, and has been recognised through the economic modelling. This approach will allow our team flexibility and greater choice in equipment replacement. We will make use of existing national and local frameworks, tendering where necessary and through FTS depending on the value. Resources will be made available to undertake this procurement and commissioning.

6.4.13 Hard FM and Lifecycle

Both Hard and Soft Facilities Management (FM) is deemed to be excluded from the scope of this procurement exercise. At present our Hard FM services are predominantly insourced, with some services outsourced as and when required for more major works.

At this stage of development it is proposed that we will continue to use our Existing Arrangements as to the provision of Hard FM and lifecycle arrangements across each of the shortlisted Estates Infrastructure options.

During the OBC development we, alongside our technical advisers, will carefully consider all aspects of life cycle assessment with regards to the appropriate selection of both building and engineering sub components/assets.

It is vital that the selection considers a number of key factors that will include:

- Energy and carbon impact
- Reliability and serviceability of selected components
- Supply chain for spares over life cycle
- Environmental impact and life cycle expiry
- Overall life cycle revenue model

6.4.14 Commercial Risks

The most relevant commercial risks to the Estates Infrastructure element of the Programme are outlined below, alongside mitigations which we have sought to implement.

Table 6.4 – Estates Infrastructure Commercial Risks and Mitigation

	Risk	Mitigation
Estates	The procurement fails to attract a contractor with the right capability and capacity to undertake works as per the Programme.	Engagement with the central NHSE/I and DHSC national teams in order to understand preferred market route and requirements.
	Stipulation of use of local supply chain (workforce, local organisations etc)	We will continue to engage with the NHP central team in order to understand the commercial strategy moving forwards and how we can input into this.
	Contractor default occurs during construction of the Estates Infrastructure	Contractual provisions will be implemented aimed at mitigating disruption and financial exposure for the public sector in the context for main contractor default. Provision of performance and retention bonds in the commercials.
	Procurement delays resulting in inflationary cost pressures	Continued engagement with the central NHSE/I and DHSC national teams.

6.5 Delivery Timeline

A delivery timeline for the Programme is found at Section 8.5 of the Management Case.

6.6 Land Acquisition / Disposal

6.6.1 Land Acquisition

A site acquisition is only required in Estates Infrastructure Option 6 (Do Maximum), due to all other Estate Infrastructure options being designed to be developed on the existing acute site in Torbay, with no requirement for any additional land acquisitions. Recognising the likely capital and revenue affordability challenges associated with Estates Infrastructure Option 6, in addition to the location-agnostic nature of the SOC, we have not sought to commit to a detailed exploration of site acquisitions at this time.

For the purpose of the analysis undertaken as part of this SOC no acquisition or disposal is assumed under Estates Infrastructure Option 6. This recognises that the option is already deemed to be unaffordable from a capital perspective, and it is deemed likely that a disposal of the existing Torbay acute site would result in a net cost required to acquire a new site. This additional capital requirement serves to make the option further unaffordable from a capital perspective.

Any land acquisition requirement in line with the planned care centre will be explored as the scheme progresses and further work is undertaken at a regional level.

6.6.2 Capital Disposals

We have sought to explore disposal opportunities with regards to the wider acute and community estate, both under the counterfactual position and under each of the shortlisted Estates Infrastructure options. A number of disposals of our owned community assets are planned under our existing capital plan in FY 2021/22; as such these disposals make up part of our counterfactual position.

In addition to the baseline position disposals, we are committed to exploring further disposal opportunities under each of the shortlisted options through rationalisation of estate on the Torbay acute site, from disposing of fringe elements of the site to the entirety of the estate under Estates Infrastructure Option 6 (Do Maximum). No acquisition under Option 6 has been assumed and as such no disposal of the existing Torbay acute site is assumed at this stage. Each of the opportunities presented under the short list options will be explored as the Programme moves to OBC stage.

6.7 Commercial Partnerships

We have had a number of discussions with the independent sector provider in the Torbay locality (Mount Stuart Hospital, part of Ramsay Health Care Limited) as to commercial opportunities arising from the redevelopment of the acute Torbay site. Initial discussions have been encouraging, with the provider confirming their interest in discussing a partnership approach including the provision of capital financing for the development of a private patients unit on the Torbay acute site.

The provider has confirmed that their desire is to fund the capital costs of a private patients unit facility, in which all activity delivered would be non-NHS. Discussions are at an early stage, however we are cognisant of the significant opportunity which this may bring to the Devon System. The Devon planned care strategy includes agreement around the need for a strategic approach to working collaboratively with the independent sector.

It is expected that this opportunity would be structured as a land transaction, with our Trust taking no space within the privately funded asset. It is likely that we would grant a long lease to the private provider for the space on our site, the rental income being structured in such a

way that value would be captured based on activity undertaken. In this way there would be no finance lease obligation created on our balance sheet, meaning there would be no CDEL implications for our organisation. We are committed to exploring this opportunity as we move forward to the OBC stage, and will engage with NHSE/I as appropriate.

6.8 Conclusions

We recognise that the commercial strategy and implementation will likely be directed at a NHP wider programme level, however we have sought to explore the available commercial options in the context of the developing national policy.

We have developed a set of objectives and overarching principles which are key for the successful commercial delivery of our Programme. At this early stage we have explored a number of commercial routes for both the Digital and Estates Infrastructure elements of the Programme, with framework procurements the likely procurement routes which best deliver on our commercial objectives. In addition to identifying the likely preferred procurement route, we have also undertaken a high level review of the available contracting options – this exercise undertaken in the context of national guidance being awaited.

We are ensuring that MMC is at the centre of the delivery of our Programme in addition to also having developed our thinking with regards to the net zero carbon and sustainability agenda, again ensuring that these principles are at the heart of our Programme – we will further develop these as guidance is available.

We will refine our Programme commercial strategy as and when national guidance is available and will ensure that our Programme is in line with these requirements from both a Digital and Estates Infrastructure perspective as required. In addition to these policy related refinements we have identified a number of further commercial opportunities which we will develop to a greater degree as the Programme moves forward to the OBC stage.

7 Financial Case

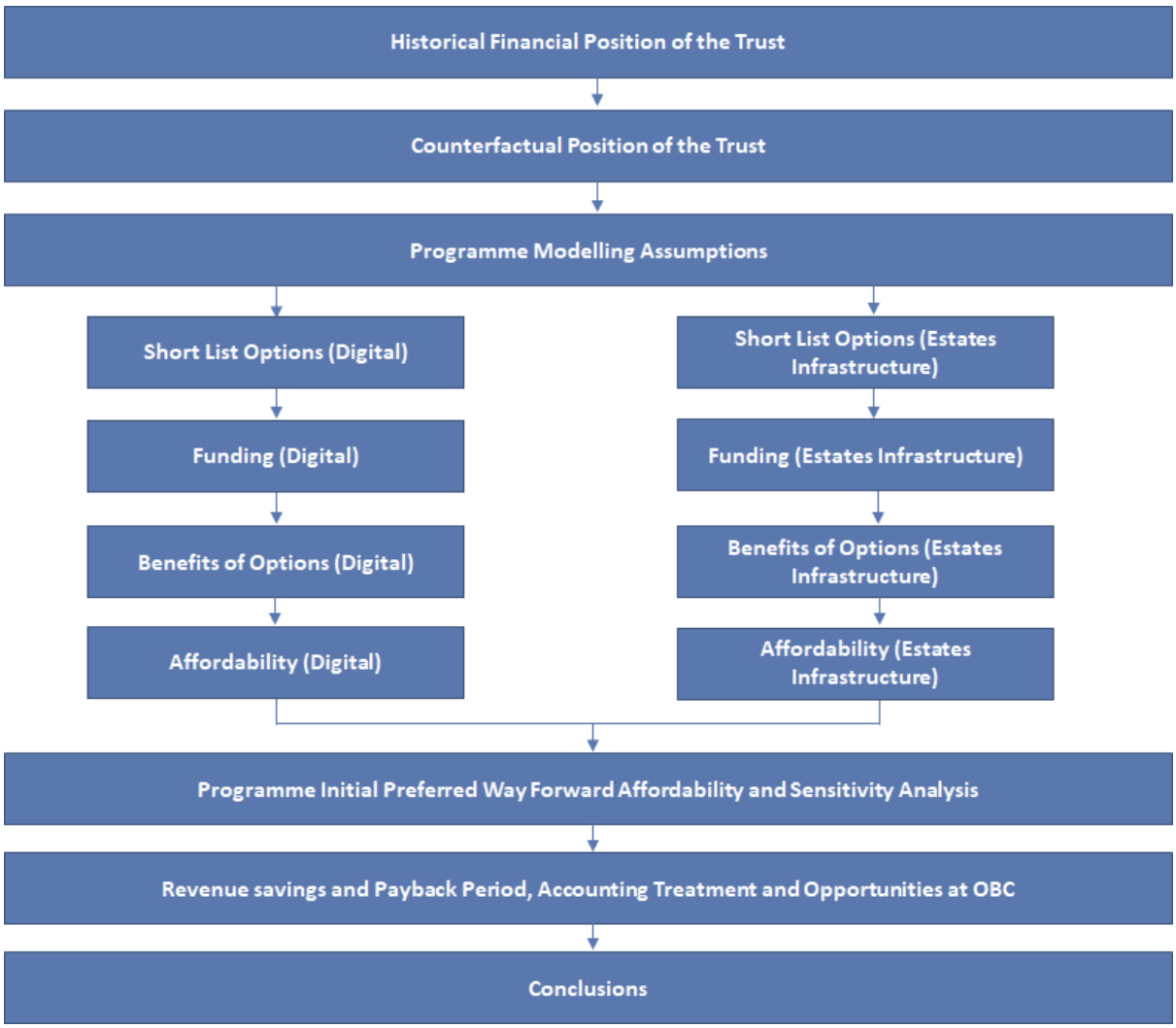
Key messages

- There is an initial preferred way forward that is affordable in capital terms.
- The initial preferred way forward is affordable in revenue terms in that it will significantly improve the revenue position of the Trust within a reasonable timeframe.
- The proposed investment is expected to dramatically improve the financial sustainability of the Trust, taking it from repeated deficit positions towards financial balance and into surplus in future years. There is no prospect of this being achieved without the proposed investment.
- Support from key stakeholders has been secured and letters of support have been received following extensive engagement work.

7.1 Introduction

This Financial Case examines the financial affordability of each of the shortlisted Digital and Estates Infrastructure options identified in the Economic Case. The figure below sets out the structure of this Financial Case:

Figure 7.1 – Structure of the Financial Case



An overview of our historic financial position provides context to the required investment. The counterfactual position of our organisation is then examined, which incorporates the minimum level of capital investment required from both a Digital and Estates Infrastructure perspective, in order to maintain the status quo position – as per HMT Green Book and BBC guidance.

We have provided an overview of the financial assumptions applied across the Programme. Then for each of the shortlisted options, for both Digital and Estates Infrastructure, we have set out the funding requirements and projected impact on our financial position.

In line with the Economic Case, the Initial Preferred Ways Forward for Digital and Estates Infrastructure have been combined to form the Programme Initial Preferred Way Forwards. The three key financial statements of our organisation are set out for the Programme Initial Preferred Way Forward.

Finally, sensitivity analysis has been undertaken in order to test robustness, alongside a narrative of the appropriate accounting treatment.

7.2 COVID-19 Pandemic Impact

The global Coronavirus COVID-19 pandemic (COVID-19) has created significant pressures across the NHS, both operationally and financially. From a financial perspective NHS England (NHSE) has established a block payment methodology, which was in place for the entirety of the 2020/21 financial year (FY), continuing into FY 2021/22. It should be noted that we have operated on block payment contracts prior to COVID-19.

In addition to the block payment methodology, other financial support packages have been provided by NHSE and central government in the form of emergency COVID-19 related PDC with no requirement for payment of the 3.5% PDC charge associated with these investments, in addition to revenue funding support for COVID-19 related costs.

For the purpose of the financial analysis undertaken for this Programme SOC, COVID-19 related costs and income have been included in the financial position of our organisation across both FY 2020/21 and FY 2021/22. The rationale for this approach being that the inclusion of these income and expenditure items ensures the alignment of our financial position in the SOC with information submitted to NHSE/I and other key stakeholders. In line with guidance received from regional NHSE/I colleagues we have continued to forecast income on the basis of the national tariff architecture model, with the movements for FY 2020/21 and FY 2021/22 COVID-19 related income and expenditure brought into our financial position on a non-recurrent basis. The result of this approach is that our forecast financial position will not be skewed by the associated COVID-19 spend past FY 2021/22, while the initial years will align with expectations at a regional and national level.

In addition, and in order to take a prudent view of longer term COVID-19 related costs, and to reflect operational reality, 20% of FY 2020/21 COVID-19 related costs are assumed to be incurred on a recurrent basis from FY2022/23 throughout the remaining appraisal period. It is assumed that there is no national funding available to meet this recurrent cost.

7.3 Financial Background

7.3.1 Context

Our underlying financial position has been challenged in recent years. The Programme, as described in this SOC, offers a significant opportunity to deliver a sustainable improvement to our underlying financial position. The Programme will enable us to transform our clinical

model in order to deliver long term safe and sustainable services and make much needed Digital and Estates Infrastructure improvements which will achieve significant cash-releasing benefits in the longer term.

7.3.2 Historical Financial statements

The following tables set out our key historical financial statements, based on our audited financial statements.

Statement of Comprehensive Income (SoCI)

Table 7.1 – Historical SoCI [18]

£'000	2018/19	2019/20	2020/21
Operating income from patient care activities	391,510	447,606	496,344
Other operating income	49,536	52,603	63,621
Total Income	**441,046**	**500,209**	**559,966**
Pay costs	(224,238)	(258,862)	(274,552)
Non pay costs	(199,139)	(239,365)	(263,056)
Total Operating Expenses	**(423,377)**	**(498,227)**	**(537,608)**
Operating Surplus/(Deficit)	**17,669**	**1,982**	**22,358**
Depreciation, amortisation & impairments	(9,200)	(13,258)	(15,899)
Finance income	102	158	7
Finance expense	(3,419)	(3,647)	(2,825)
PDC Dividends payable	(2,972)	(3,171)	(3,479)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**2,180**	**(17,936)**	**161**
(Losses)/gains on disposal of assets	(12)	(74)	(265)
Other tax movements	(22)	(32)	(20)
Net Surplus/(Deficit) for the year	**2,146**	**(18,042)**	**(124)**
Revaluations	2,902	4,230	3,233
Total comprehensive income / (expense)	**5,048**	**(13,812)**	**3,109**

Our operating income from patient care activities has increased to c.£447.6m in FY 2019/20 from c.£391.5m in 2018/19. A key driver has been the increases seen under the other NHS clinical income category, including income we receive as lead provider for Children's Family Health Devon services £22.5m (FY 2018/19 £0m) and other variable activity services such as critical care and pathology services.

We delivered a net deficit position (excluding revaluations) in FY 2019/20 of c. £18m, driven largely by a c. £75m increase in total operating expenses. This has been driven by significant increases in our Pay and Non-pay costs from FY 2018/19 to FY 2019/20. We have seen increased income over the last financial year, over and above the increases we have seen to our cost base – income increased by c. £59m whereas operating expenses increased by c. £39m.

[18] Please note that within the Trust's Statutory Accounts, Depreciation (and Amortisation) is embedded within "Non pay costs". Depreciation and Amortisation have been split out in the above SoCI for the SOC.

Statement of Cash Flow (SoCF)

Table 7.2 – Historical SoCF

£'000	2018/19	2019/20	2020/21
Operating surplus / (deficit) from continuing operations	8,469	(11,276)	6,458
Depreciation and amortisation	9,200	13,258	15,898
Impairments	(4,136)	(8)	3,702
Other Non-cash items	(4,201)	13,374	18,147
Net cash generated / (used in) operations	**9,332**	**15,348**	**44,205**
Interest received	102	158	7
Purchase of intangible assets	(3,612)	(3,323)	(2,542)
Purchase of PP&E and investment property	(8,907)	(10,559)	(16,515)
Sales of PP&E and investment property	3	290	92
Receipt of cash donations to purchase capital assets	1,314	85	86
Net cash generated / (used in) investing activities	**(11,100)**	**(13,349)**	**(18,872)**
Public dividend capital received	1,683	3,106	63,140
Loans received/(repaid) from/to Department of Health	3,595	11,326	(45,086)
Capital element of service concession payments	(892)	(1,303)	(2,088)
Interest paid	(1,604)	(1,753)	(1,033)
Interest element of service concession obligations	(1,831)	(1,879)	(1,917)
PDC dividend paid	(3,145)	(3,565)	(3,041)
Net cash generated from financing activities	**(2,194)**	**5,932**	**9,975**
Increase / (decrease) in cash and cash equivalents	**(3,962)**	**7,931**	**35,308**
Cash and cash equivalents at 1 April	**6,168**	**2,206**	**10,137**
Cash and cash equivalents at 31 March	**2,206**	**10,137**	**45,445**

Our net cash balance has remained positive over recent years, increasing from a net credit balance of c. £2.2m to a net credit balance of c.£10.1m in FY 2019/20. This increased position was achieved after further accessing the Foundation Trust's working capital facility within FY 2019/20 (£0.5m), and also by the drawdown of Interim Revenue Loan Finance support from the DHSC totalling £14.7m. Our net cash balance increased substantially in FY 2020/21 to £45.4m. This was driven by a large increase in cash generated from operations. Namely it has been driven by a much improved SoCI position and also favourable working capital movements.

Statement of Financial Position (SoFP)

Table 7.3 – Historical SoFP

£'000	2018/19	2019/20	2020/21
Non-current assets	202,523	211,869	231,612
Current assets (excl Cash)	40,016	40,847	33,199
Cash	2,206	10,137	45,444
Current liabilities	(44,300)	(87,121)	(78,228)
Total assets less current liabilities	**200,445**	**175,732**	**232,027**
Non-current liabilities	(85,515)	(71,508)	(61,554)
Total net assets employed	**114,930**	**104,224**	**170,473**
Financed by			
Public dividend capital	64,509	67,615	130,755
Revaluation reserve	41,869	46,089	49,152
Income and expenditure reserve	8,552	(9,480)	(9,434)
Total taxpayers' and others' equity	**114,930**	**104,224**	**170,473**

Our SoFP position has remained relatively stable over recent years, the most significant movement being the c. £42.8m increase in our current liabilities position from 2018/19 to 2019/20. This movement is largely driven by changes to the cash and capital regimes which included issue of new PDC capital to extinguish interim revenenue and capital loans. From FY 2019/20 to FY 2020/21 total net assets employed has increased substantially due to loans being converted to PDC as per central policy, meaning current liabilities have decreased while PDC has increased.

Section 4.2 of the Strategic Case sets out the fact that there is a material difference between our Trust's reported financial position and its underlying performance; the primary driver of this being non-recurrent support from NHS Devon CCG. As stated at Section 4.2, we are committed to reducing our underlying deficit through a five-year financial recovery programme, which will put us into a better position to absorb the revenue consequences of the NHP investment.

7.4 Counterfactual Position

In line with HMT Green Book and BBC guidance, the performance of each of the shortlisted options is to be assessed against the counterfactual position. HMT Green Book and BBC guidance defines the counterfactual position as maintaining the status quo. The guidance also recognises that the counterfactual position is not always the "Do Nothing" option and that there may be a requirement to invest in order to maintain our existing position.

In the context of this definition, the counterfactual position will include significant investment in backlog maintenance. The level of backlog maintenance has been determined by a Six Facet Survey, carried out by The Oakleaf Group, analysis of which examines the condition of our building stock and other physical assets. The Six Facet Survey assesses the remaining useful asset life of these assets, categorising these as per NHS Estates guidance. Assets which fall into category "D" are deemed to have either exceeded their useful asset life, or are at risk of immediate failure. For the purpose of our counterfactual position, investment will be made into those assets which fall under Category D. In addition to this required Estates Infrastructure investment, the counterfactual position also includes the minimum required spend on the Digital element of the Programme to maintain systems and IT Infrastructure at its current state.

This single counterfactual position will form the baseline position when examining both the Digital and Estates Infrastructure shortlisted options, in addition to being used to assess the Programme Initial Preferred Way Forward.

Table 7.4 – Backlog figures from the Six Facet Survey output

Estates	Backlog Condition	Capital requirement (£'000)[19]											
	FY	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	Total
	Condition B&C	97,699	1,529	1,464	2,863	923	8,009	719	5,092	3,645	1,845	6,866	**130,654**
	Condition D	24,063	377	361	705	227	1,973	177	1,254	898	454	1,691	**32,180**
	TOTAL	**121,762**	**1,906**	**1,825**	**3,568**	**1,151**	**9,981**	**896**	**6,346**	**4,543**	**2,299**	**8,558**	**162,834**

As outlined in the above table, the Six Facet Survey has identified a requirement of £32.2m of backlog spend on the acute estate over the period to 2031/32 in order to clear the condition D backlog maintenance.This capital investment is assumed under our counterfactual position, Estates Infrastructure Option 1.

It is assumed that this critical infrastructure backlog maintenance will not be fully required under each of the shortlisted Options due to the replacement of a significant portion of assets under these options which would otherwise require backlog maintenance clearance. To recognise this, it has been assumed that half of all critical infrastructure backlog maintenance will be required under these options. It has also been assumed that all critical infrastructure backlog maintenance will be cleared and therefore the cost ceased in the year prior to completion of the shortlisted Estates Infrastructure Options.

Over and above the critical infrastructure backlog maintenance of £32.2m, the Six Facet Survey identified a further £130.7m to cover non urgent backlog maintenance works (Conditions B and C). To satisfy the "Do Minimum" requirements as per the HMT Green Book, Estates Infrastructure Option 2 assumes that the cost of all (Conditions B, C and D) backlog maintenance on the Torbay acute site will be met.

[19] Please note figures are inclusive of Prelims, Contingency, Fees and VAT

7.4.1 Counterfactual Capital Expenditure Plan

Our financial baseline will also include the capital requirements in relation to:

- The STP Wave 3 Capital funding (Wave 3) – a £13m investment into Ophthalmology At the time of writing, the Full Business Case (FBC) for this investment will be submitted to NHSE/I for approval by September or October 2021. On the assumption that we are able to secure successful approval of this FBC, the Wave 3 funded asset is assumed to be operational from FY 2022/23 under the counterfactual position of this SOC. This is a key enabler to the wider NHP investment and therefore must be in place within the timescales noted.
- A number of IFRS 16[20] Finance Leases are to be entered into for the delivery of Health and Wellbeing Centres over the next few financial years. These Health and Wellbeing Centres are to be located at:
  - Dartmouth
  - Teignmouth
  - The Cavell Centre – Torquay

For the purpose of the affordability modelling, IFRS 16-compliant finance leases for Dartmouth and Teignmouth (and the associated benefits, e.g. onwards rental income) have been modelled due to the commercial terms for these leases being well developed. The finance lease obligation for The Cavell Centre will be included at OBC stage following further development of the commercial model.

The capital expenditure requirements excluding any backlog maintenance (set out in Section 7.4 above) are outlined in the table below:

Table 7.5 – Summary of Counterfactual Capital Expenditure from FY 2021/22 to FY 2025/26

	Capital Expenditure Plan (£'000)	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25	FY 2025/26	Total
Combined	Estate (Trust funded)	9,789	198	267	1,092	329	11,675
	Estate (PDC)	16,584	13,730	4,767			35,081
	Estates (Wave 3 PDC)	6,655	6,655				13,310
	IT (Internally funded)	2,774	1,893	4,195	4,195	4,195	17,252
	IT (PDC)		3,107	1,805	1,805	1,805	8,522
	Plant / Machinery (Internally funded)		558	3,000	3,000	3,000	9,558
	Plant / Machinery (PDC)	9,000					9,000
	Medical Equipment (Internally funded)	25	3,000	4,000	4,000	4,000	15,025
	Total Expenditure	**44,827**	**29,141**	**18,034**	**14,092**	**13,329**	**119,423**

[20] Recognised in the financial modelling as IFRS 16 compliant right of use assets on our balance sheet

7.4.2 Financial Statements

The forecast financial impact of the counterfactual position is shown across our three key financial statements.

Please note, the Financial Statements shown below (and throughout the case for the shortlisted Options) have been forecasted for a 15-year period. This is to allow for the longest construction period required by the shortlisted options (Estates Infrastructure Option 6) of 10 years and an additional 5 years to show the operational impact of the investment.

Statement of Comprehensive Income (SoCI)

Table 7.6 – Counterfactual SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,976)	(315,028)	(321,217)	(328,404)	(335,760)	(343,279)	(350,969)	(358,835)	(366,880)	(375,109)
Non pay costs	(256,534)	(258,586)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(284,977)	(290,065)	(295,249)	(300,525)	(305,896)	(311,365)	(316,935)	(322,607)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(606,194)**	**(618,469)**	**(631,009)**	**(643,804)**	**(656,865)**	**(670,200)**	**(683,815)**	**(697,716)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**7,883**	**7,608**	**7,324**	**7,026**	**6,709**	**6,374**	**6,021**
Depreciation, amortisation & impairments	(19,886)	(22,829)	(25,017)	(26,814)	(28,646)	(30,316)	(31,326)	(32,201)	(32,009)	(31,945)	(31,320)	(32,169)	(32,572)	(32,522)	(32,635)	(32,637)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(578)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,903)	(7,312)	(7,875)	(7,562)	(7,253)	(7,050)	(6,931)	(6,882)	(6,910)	(6,822)	(6,727)	(6,723)	(6,728)	(6,628)	(6,588)	(6,607)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,986)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**
(Losses)/gains on disposal of assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,986)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**
Impairments	(2,295)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(31,280)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**

The SoCI shows a net deficit of c. £30m faced by our Trust if we continue to implement short-term solutions to our ever increasing Estates and Digital needs. The planned expenditure under the 5-year capital plan, in addition to the critical backlog requirements, lead to increased depreciation and PDC dividend payable charges. The increase in these capital charges mitigates any EBITDA improvement derived through the income growth associated with additional activity.

The Trust faces a number of financial challenges that are reflected in this underlying position, including operational, strategic and structural elements. The ability of the organisation to deliver financial improvement is severly limited by the inadequate range of legacy digital systems and the current nature and condition of the physical estate.

Statement of Financial Position (SoFP)

Table 7.7 – Counterfactual SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	296,845	329,921	326,637	315,831	302,464	297,871	289,393	288,610	284,134	276,822	272,388	270,851	267,467	260,087	260,957	257,828
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(29,102)	(71,232)	(101,267)	(125,102)	(147,246)	(168,390)	(185,227)	(208,847)	(227,211)	(242,175)	(259,396)	(280,155)	(299,071)	(313,654)	(336,408)	(354,227)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**223,737**	**215,608**	**184,190**	**149,106**	**114,242**	**88,456**	**63,000**	**38,347**	**15,910**	**(6,891)**	**(27,990)**	**(49,965)**	**(72,159)**	**(94,023)**	**(115,002)**	**(136,029)**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**174,707**	**162,577**	**134,481**	**103,162**	**71,417**	**48,797**	**26,648**	**5,554**	**(13,727)**	**(32,839)**	**(50,800)**	**(69,972)**	**(89,470)**	**(108,747)**	**(128,032)**	**(147,287)**
Financed by																
Public dividend capital	163,974	187,502	194,125	196,117	197,993	209,201	220,474	232,293	244,403	256,773	269,839	282,812	296,152	309,867	323,963	338,450
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Income and expenditure reserve	(38,420)	(74,076)	(108,796)	(142,107)	(175,728)	(209,556)	(242,977)	(275,890)	(307,282)	(338,764)	(369,791)	(401,936)	(434,774)	(467,766)	(501,148)	(534,889)
Total taxpayers' and others' equity	**174,707**	**162,577**	**134,481**	**103,162**	**71,417**	**48,797**	**26,648**	**5,554**	**(13,727)**	**(32,839)**	**(50,800)**	**(69,972)**	**(89,470)**	**(108,747)**	**(128,032)**	**(147,287)**

In line with the SoCI shown above, the SoFP also demonstrates the worsening financial position of our Trust under the counterfactual option, demonstrating the unsustainability of the option. As seen in the SoCI, the deficit position continues at a steady state of c. £30m, which ultimately accumulates over time through the Income and Expenditure reserve. Ultimately the counterfactual option would move our Trust into a negative asset and equity position by FY 2028/29 owing to the significant deficits accumulated within the SoCI. This effect is also felt through the cash position which also worsens over time, articulated below. This worsening cash position is due to the continuation of required capital expenditure, while the deficit continues to worsen, and therefore accumulate. In addition, the assumption that backlog maintenance requirements would be cash funded in the majority means that the PDC received to offset some of the capital expenditure requirement is not material enough to counter weigh the equity position. The counterfactual SoFP demonstrates that a significant investment is required not only to improve and update the estate, but to allow our Trust to move to a financially sustainable position.

Statement of Cash Flow (SoCF)

Table 7.8 – Counterfactual SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,836)	(27,700)	(26,402)	(25,111)	(25,734)	(26,149)	(25,868)	(25,415)	(23,874)	(24,062)	(23,713)	(24,845)	(25,546)	(25,813)	(26,260)	(26,616)
Depreciation and amortisation	19,886	22,829	25,017	26,814	26,646	30,316	31,326	32,201	32,009	31,945	31,320	32,169	32,572	32,522	32,635	32,637
Impairments	2,295	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) operations	**(655)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**7,883**	**7,608**	**7,324**	**7,026**	**6,709**	**6,374**	**6,021**
Purchase of PP&E and investment property	(82,672)	(46,637)	(21,733)	(16,008)	(15,279)	(25,724)	(22,847)	(31,418)	(27,534)	(24,632)	(26,887)	(30,632)	(29,188)	(25,143)	(33,505)	(29,507)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(81,652)**	**(46,637)**	**(21,733)**	**(16,008)**	**(15,279)**	**(25,724)**	**(22,847)**	**(31,418)**	**(27,534)**	**(24,632)**	**(26,887)**	**(30,632)**	**(29,188)**	**(25,143)**	**(33,505)**	**(29,507)**
Public dividend capital received	33,219	23,527	6,624	1,992	1,875	11,209	11,272	11,819	12,110	12,370	13,068	12,973	13,340	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(18,118)	(4,811)	(3,881)	(2,917)	(2,917)	(2,372)	(2,372)	(2,372)	(2,372)	(2,382)	(2,388)	(1,832)	(1,305)	(1,089)	(894)	0
Capital element of service concession payments	(1,168)	(1,312)	(1,276)	(301)	(725)	(601)	(629)	(747)	(973)	(545)	(1,042)	(998)	(1,173)	(1,241)	(1,315)	(1,269)
Finance lease repayment	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,903)	(7,312)	(7,675)	(7,562)	(7,253)	(7,050)	(6,931)	(6,882)	(6,910)	(6,822)	(6,727)	(6,723)	(6,728)	(6,628)	(6,588)	(6,807)
Net cash generated from financing activities	**7,760**	**9,377**	**(6,917)**	**(9,529)**	**(9,778)**	**413**	**552**	**1,013**	**1,034**	**1,785**	**2,058**	**2,549**	**3,246**	**3,851**	**4,376**	**5,667**
Increase / (decrease) in cash and cash equivalents	**(74,547)**	**(42,130)**	**(30,035)**	**(23,834)**	**(22,144)**	**(21,144)**	**(16,837)**	**(23,619)**	**(18,364)**	**(14,965)**	**(17,221)**	**(20,759)**	**(18,916)**	**(14,583)**	**(22,754)**	**(17,819)**
Cash and cash equivalents at 1 April	**45,445**	**(29,102)**	**(71,232)**	**(101,267)**	**(125,102)**	**(147,246)**	**(168,390)**	**(185,227)**	**(208,847)**	**(227,211)**	**(242,175)**	**(259,396)**	**(280,155)**	**(299,071)**	**(313,654)**	**(336,408)**
Cash and cash equivalents at 31 March	**(29,102)**	**(71,232)**	**(101,267)**	**(125,102)**	**(147,246)**	**(168,390)**	**(185,227)**	**(208,847)**	**(227,211)**	**(242,175)**	**(259,396)**	**(280,155)**	**(299,071)**	**(313,654)**	**(336,408)**	**(354,227)**

Cash generated from operating activities is relatively flat throughout the forecast period rising to c. £6m – £7m p.a. by the end of the modelled period. This cash from operating activities is insufficient to meet the assumed annual spend on capital expenditure (both for Digital and Estates Infrastructure) and backlog requirements, which peak at £82.7m in FY 2021/22 and settles to a range of between £20.0m – £34.0m from FY 2026/27 through to FY 2036/37. Whilst it is assumed that there is a modest level of PDC received, the majority of this is offset by the PDC dividend paid on an annual basis – resulting in net cash generated from financing activities running at a low level. Taken together, these factors cause the closing cash position to increase significantly over the modelled period, rising from a forecast deficit of £29.1m in FY 2021/22 to £354.2m in FY 2036/37.

7.5 Short Listed Options – Programme Modelling Assumptions

In line with HMT Green Book and BBC guidance the financial modelling undertaken to support this SOC operates on an incremental basis, assessing each shortlisted option for both Digital and Estates Infrastructure, over and above the counterfactual position. As such a set of consistent assumptions has been applied across all shortlisted options, set out below:

Table 7.9 – Programme Modelling Assumptions

	Assumption	Description
Combined	**General**	
	Financial modelling start date	Inputs represent FY 2019/20 in order that COVID-19 income and expenditure does not skew forecasts for following years – in line with regional guidance.
	Cash Releasing Benefits	CRBs are assumed to come online from the start of the financial year directly following asset completion – this approach allows a full financial year for benefits to be realised
	Inflation on external non NHS revenue	Based on current CPI forecasts – flat rate of 2% used from FY 2020/21 for full appraisal period
	Income	
	Growth	In line with activity growth modelled for the Devon STP / ICS and is consistent with NHS Devon CCG planning assumptions
	Weighted Inflation	2.4% p.a. from FY 2020/21 to FY 2021/22, then dropping to 2.0 p.a. from FY 2022/23 for the full appraisal period – in line with the NHS Long Term Implementation Framework 2019
	Tariff Efficiency	-1.1% p.a. from FY 2020/21 for the full appraisal period – in line with the NHS Long Term Implementation Framework 2019
	BAU CIP	2% in FY 2021/22 then drops to 1.7% from FY 2022/23 to FY 2024/25. CIP then ranges between 1.25% and 1% for the rest of the appraisal period – in line with national requirements.
	Costs	
	Pay Cost Inflation	2.4% has been assumed for all categories of Pay Costs in FY 2020/21 and FY 2021/22. 2.0% is then assumed from FY 2022/23 for the rest of the appraisal period in line with the NHS Long Term Implementation Framework 2019.
	Pay Costs – Marginal Cost	Marginal cost assumptions for each non pay cost category have been included to recognise the marginal cost of delivering additional income. These assumptions are based on additional income representing a third contribution, with the cost base split proportionality across pay and non pay costs based on expenses incurred during FY 2019/20.
	Non Pay Cost Inflation	2.4% has been assumed for all categories of Non Pay Costs in FY 2020/21 and FY 2021/22. 2.0% is then assumed from FY 2022/23 for the rest of the appraisal period in line with the NHS Long Term Implementation Framework 2019.
	Non Pay Costs – Marginal Cost	Marginal cost assumptions for each non pay cost category have been included to recognise the marginal cost of delivering additional

	income. These assumptions are based on additional income representing a third contribution, with the cost base split proportionality across pay and non pay costs based on expenses incurred during FY 2019/20.

7.6 Digital Short List Options

7.6.1 Short Listed Options

The below table reconfirms the shortlisted options identified in the Economic Case:

Table 7.10 – Shortlisted Digital Options

	Option	Description
Digital	2	Do minimum – optimise the current multiple systems strategy
	3	Initial Preferred Way Forward – Open procurement exercise for an integrated EPR solution independently
	4	Intermediate Option – Open procurement exercise for an integrated EPR solution as a group of Trusts in the region

7.6.2 Funding Assumptions

Under the NHP it is understood that all schemes will be funded directly through PDC monies, with the associated annual PDC dividend of 3.5% to be paid on our average net relevant asset value. For the purpose of this SOC it has been assumed that any capital requirements above the allocated £350m NHP monies and £20m Trust funded capital will be funded through our cash reserves and any available BAU capital. The difference between both funding streams has been shown below for the Digital shortlisted options.

We understand that discussions are ongoing at a national level as to additional capital monies being made available through NHSX. We are keen to explore these opportunities as the Programme moves to OBC stage. Separately to these national level discussions we are continuing to explore the availability of other central digital programme monies.

The capital costs and funding requirement for each of the Digital shortlisted options are outlined below from FY 2021/22 to FY 2026/27.

Table 7.11 – Total Capital Cost and Funding requirements for all Shortlisted Digital Options from FY 2021/22 to FY 2026/27

	Capital Summary (£'000)	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate
Digital	**Funding Source**			
	NHSX (PDC)	6,000	6,000	6,000
	National – NHP	919	52,294	54,677
	Total	**6,919**	**58,294**	**60,677**
	Application of Funding			
	EPR Licenses			24,438
	EPR Implementation			29,450

EPR Infrastructure			2,165
Intersystem 3rd Party software			1,194
Migration from existing systems		379	541
EPR Licenses		12,757	
EPR Implementation		30,203	
Paperless Investment		3,098	
Warranted Environment costs		4,254	
Electronic Prescribing and Medicines Administration	2,397		
Paperless Investment	3,098		
Task Management System	271		
Contingency	1,153	7,604	2,889
Total	**6,919**	**58,294**	**60,677**
Source *less* Application	0	0	0

The above capital costs for each option have been provided by our Digital workstream and are based on the following assumptions:

Table 7.12 – Capital Cost Assumptions for Shortlisted Digital Options

Digital	Capital Cost Assumption	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate
	Inflation	Inflation assumed to track CPI rate – flat rate of 2% p.a. assumed		
	Optimism Bias[21] (OB)	20%	15%	5%
	VAT recovery	VAT recovery has not been assumed on any capital costs		
	Impairment	N/A	£2.6m of digital assets impaired in 4-year period from FY 2021/22 to FY 2024/25	£3.4m of digital assets impaired in 4-year period from FY 2021/22 to FY 2024/25

7.6.3 Digital Short Listed Option Benefits

In addition to the consistent assumptions set out in the previous section, a set of option-specific Cash Releasing Benefits ("CRBs") associated with each of the Digital options is set

[21] Different OB assumptions have been made for each of the Digital shortlisted options recognising the different levels of maturity and certainty in analysis undertaken to date, including market tested costs for Options 4 and 5. Higher OBs are applied to Option 2 and 3 due to a lack of market testing and less of an understanding at this stage on the costs associated.

out below. The figures below have been provided in nominal terms. It should be noted that the table below demonstrates the recurrent benefit achieved once the full benefit has been accumulated over a 3 year period. To see how these benefits accumulate over a 3-year period, please refer to Appendix 9.4.1.

Table 7.13 – Summary of Cash Releasing Benefits for Shortlisted Digital Options

Digital	CRBs (£000)[22]	Option 1 BAU / Counterfactual	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate
	Emergency and Ambulatory	N/A	-	500	500
	Outpatient	N/A	3,089	5,393	5,393
	Radiology and Laboratory	N/A	-	144	144
	Workforce	N/A	-	752	752
	Paperless	N/A	-	1,443	1,443
	Litigation	N/A	-	322	322
	Community and Social Care	N/A	-	-	751
	TOTAL	**N/A**	**3,089**	**8,554**	**9,305**

7.7 Estates Infrastructure Short List Options

7.7.1 Short Listed Options

The below table reconfirms the shortlisted options identified in the Economic Case.

Table 7.14 – Shortlisted Estates Infrastructure Options

Estates	Option	Description
	2	Do Minimum – clearance of all backlog maintenance
	3	Initial Preferred Way Forward – rebuilding elements of the existing acute Torbay site, with targeted refurbishment of those areas retained. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon
	4	Intermediate Option – refurbishing the existing acute Torbay site, rebuilding discrete elements. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon
	6	Do Maximum – full new build reprovision of the entirety of the existing Torbay acute site

7.7.2 Funding assumptions

As described in the Digital section, under the NHP it is understood that all major works associated with schemes will be funded through PDC monies, with the associated annual

[22] These benefit amounts exclude inflation as presented. Inflation is included in financial modelling at 2% p.a.

PDC dividend of 3.5% to be paid on our average net relevant asset value. We have assumed that our backlog maintenance requirements in each of our options will be self-financed, with all other capital requirements being serviced through PDC. Hard FM and ongoing lifecycle capital requirements are assumed to be self-financed.

The capital costs and funding requirements for each of the Estates Infrastructure shortlisted options over their construction period are outlined below, with OB forms found at Appendix 9.4.1.

Table 7.15 – Capital Cost and Funding requirements for all Estates Infrastructure Options

	Capital Summary (£'000)	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
Estates	**Funding Source**				
	Trust self-finance within Operational STP/ICS Capital Envelopes	130,654			
	NHSX (PDC)				
	National – NHP (PDC)		316,933	325,967	987,060
	Total	**130,654**	**316,933**	**325,967**	**987,060**
	Application of Funding				
	Build costs per OB Forms		226,113	232,731	690,929
	Equipment		12,984	13,429	36,769
	Professional fees		21,704	22,253	65,845
	Planning Contingency		18,990	19,473	53,244
	Optimism bias		37,142	38,081	140,274
	Backlog maintenance	130,654			
	Total	**130,654**	**316,933**	**325,967**	**987,060**
	Source *less* Application	**0**	**0**	**0**	**0**

The above capital costs for each option have been provided by our Cost Consultants and are based on the following assumptions:

Table 7.16 – Capital Cost Assumptions for Shortlisted Estates Infrastructure Options

	Capital cost Assumption	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
Estates	Inflation	Average CPI rate of 2% used	The inflation to the mid-point of construction has been included within the cost estimate based upon the latest BCIS PUBSEC indices available at the date of the cost forms preparation (Dec-2020). Where PUBSEC Indices are not available (due to the extended nature of		

		programme), BCIS TPI forecast inflation indices have been used. Thereafter a long-term average annual inflation rate of 3.5% has been used to forecast inflation to the end of the programmed works		
Optimism Bias	N/A – backlog maintenance	Average of 22% on works and non-works costs	Average of 22% on works and non-works costs	27% on works and non-works costs
Planning contingency	N/A	15% on works costs	15% on works costs	15% on works costs
VAT recovery	N/A	N/A	N/A	N/A
Finance leases	As per counterfactual			
Impairment	As per counterfactual			

7.7.3 Short Listed Option Benefits

In addition to the assumptions set out in the previous section, a set of option-specific assumptions used to size the benefits associated with each of the shortlisted options is set out below. The monetary value and build up of these benefits have been detailed in Appendix 9.4.1.

Table 7.17 – Benefits for Shortlisted Estates Infrastructure Options

Estates	Benefit Assumption[23]	Option 2 Do Min	Option 3 Initial PWF	Option 4 Intermediate	Option 6 Do Max
	Agency saving	N/A	Agency spend assumed to fall to 3.25% at asset completion and continue to decrease to 3.05% over a 5-year period. Average p.a. saving of £240k.		Agency spend assumed to fall to 3.00% at asset completion and continue to decrease to 2.80% over a 5-year period. Average p.a. saving of £470k.
	Repatriated income	N/A	Net benefit of £1.2m assumed at asset completion. £2.0m benefit with contribution at 60%.		Net benefit of £1.5m assumed at asset completion. £2.5m benefit with contribution at 60%.
	Additional CIP	N/A	Additional 1.35% CIP delivered above BAU for a 5-year period.	Additional 1.25% CIP delivered above BAU for a 5-year period. Average	Additional 2.0% CIP delivered above BAU for a 5-year period. Average benefit of £12.9m

[23] A 5-year breakdown of the yearly quantum of these benefits is provided in Appendix 9.4.1, for each option

		Average benefit of £8.7m	benefit of £8.0m
Additional Retail Income	N/A	At asset completion, 20% additional retail income assumed above current contract values. Results in a £44k additional benefit	At asset completion, 40% additional retail income assumed above current contract values. Results in a £88k additional benefit
Lack of major incidents	N/A	At asset completion, annual benefit of £425k realised due to reduction in theatre outages. Around 168 cancellations on average occurred in the past 3 years, with an average tariff per operation of £2.5k.	

These benefits are also aligned to those presented within Section 5.7.1 of the Economic Case. More detail on assumptions made for these benefits can be found in the CIA Model (Appendix 9.2.3).

7.8 Affordability Summary

7.8.1 Short Listed Options for Digital and Estates Infrastructure

This section analyses the affordability of each of the shortlisted Digital and Estates Infrastructure options, setting out the impact on our three key financial statements.

This SOC assesses affordability through two distinct lenses; affordability to the wider health system through the SoCI; and our own affordability through the SoCF. A summary of the affordability position is presented in this Financial Case, with the full SoCI, SoCF and SoFP for each individual shortlisted option across both the Digital and Estates Infrastructure elements of our Programme included at Appendix 9.4.2.

Programme Counterfactual Position – Digital Option 1 & Estates Infrastructure Option 1

For consistency a single counterfactual position is shown across the Programme. This single counterfactual position combines Digital Option 1 and Estates Infrastructure Option 1 and therefore includes the respective investment required under each element of the Programme. The narrative on the SoCI and SoCF below provides context to the affordability numbers presented in this Financial Case.

SoCI

The SoCI movements shown between FY 2019/20 and FY 2021/22 represent the reported financial position of our organisation over the period. The surplus delivered in FY 2020/21 is primarily due to the COVID-19 financial regime that was implemented for the year. In line with guidance received from our regional colleagues, we have forecast forward our position based on our FY 2019/20 position in order that the COVID-19 non-recurrent income / expenditure does not skew projections for following financial years – explaining the sharp downwards movement in the deficit position seen in the period FY 2021/22.

SoCF

As articulated through this Case, it is assumed that we will finance backlog maintenance requirements under all options. In this context, it should be noted that at this stage we have

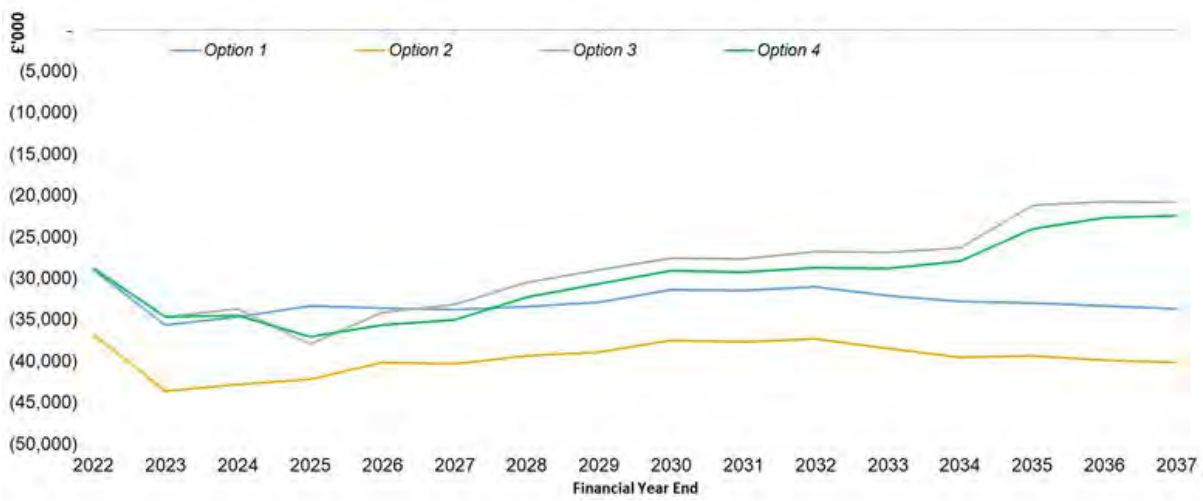
not sought to model additional borrowings in order that the cash position of the organisation be maintained, rather for illustrative purposes we have shown cash deficit positions accruing.

As our Programme progresses, we will seek opportunities to work with regional and national colleagues to understand the ability to support the cash position of our organisation and / or assess the financial impact of borrowing cash sums in order that we may satisfy our liabilities in a timely manner.

SoCI Summary – Digital Options

The graph below shows our I&E position for all Digital Options:

Figure 7.2 – SoCI (Net Surplus / (Deficit) for the year for Shortlisted Digital Options from FY 2019/20 to 2036/37



Option 1

The inclusion of both ongoing Digital and critical Estates Infrastructure investment moves the deficit position down further from FY 2021/22, reaching £36m at March 2023 due to the associated revenue charges of depreciation and PDC dividend payable on the new assets. The rectification of backlog maintenance requirements does not derive cash releasing benefits meaning there is no ability to mitigate the capital charges to the SoCI. The deficit position remains relatively constant through the period.

Option 2

Option 2 deviates from the trend seen under Option 1 immediately due to the additional levels of capital investment required in order to supplement the existing Digital EPR related systems of the organisation, falling to a deficit position of £44m at March 2023.

Unlike Option 1, Option 2 does have the ability to deliver cash releasing benefits, albeit a limited amount, due to the additional investment being made in order to optimise the current multiple systems strategy. The upward trend seen at FY 2025/26 shows these benefits coming online, being delivered on a recurrent basis. These benefits are not enough to offset the additional investment requirement, meaning the Option 2 deficit position does not recover to that seen under Option 1.

Neither Option 1 or 2 delivers an improved sustainable financial position to our organisation, nor allows for the digital transformation required to support our long-term needs.

Options 3 and 4

Both Options move closely in line with the position seen under Option 1. Small differences are driven by the capital investment made on systems being kept by our Trust, depending on the option. Additional downward movements are seen in FY 2024/25 as the Digital assets become operational and revenue charges of depreciation and PDC dividend payable impact the deficit position of the organisation.

As the EPR system becomes operational across both options in FY 2025/26 cash releasing benefits are realised, with a steady build up seen over a three year period recognising that implementation will take time with regards to training etc, improving the deficit position of the organisation and can be seen in the improvement in the financial position. Although the identified cash releasing benefits across both options are consistent, Option 3 delivers an improved position in comparison to Options 4 due to the lower revenue costs assumed under the option.

In FY 2034/35 an improved deficit position is delivered as the capital expended on EPR associated implementation costs has been fully depreciated down over a 10-year period (in line with Trust accounting policies), meaning the associated depreciation and PDC dividend charges seen in the previous years are no longer applicable. Systems are still operational past this time, with ongoing support costs categorised as annual revenue costs to the organisation meaning the cash releasing benefits are
still deliverable.

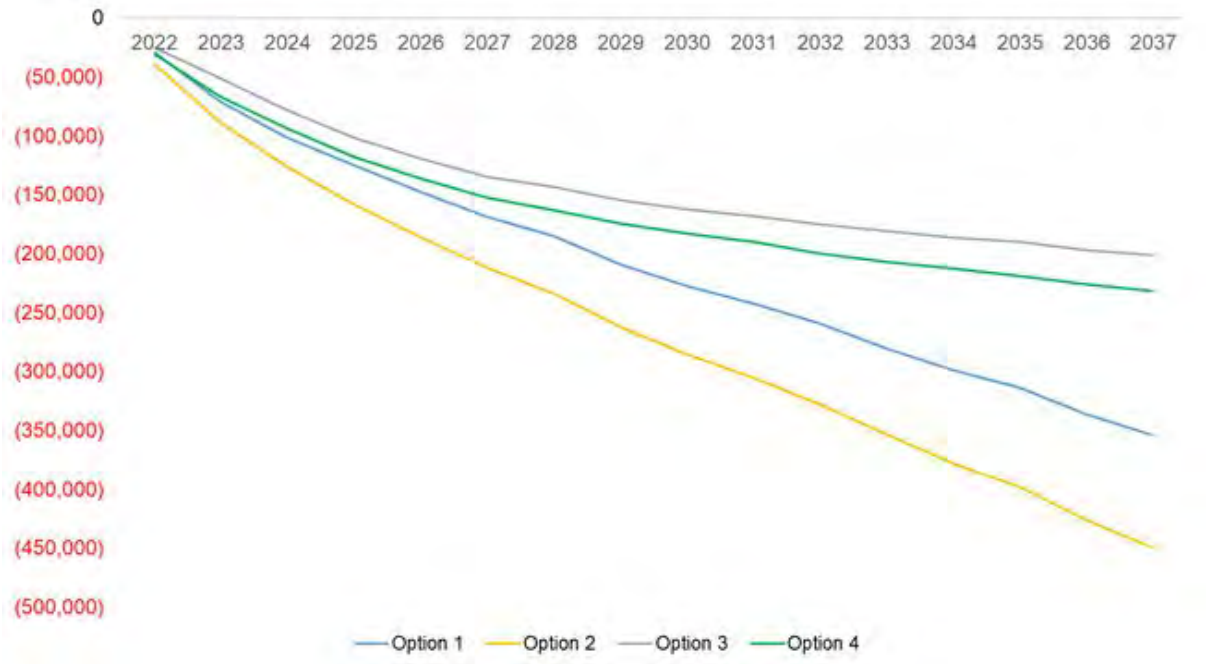
Conclusions

At this early stage of investment appraisal, Option 3 is deemed to be the most affordable Digital option to the wider System, through its delivery of a sustained improvement to the financial position of our organisation over and above that shown in the other options. This improved position is driven mainly due to the lower annual revenue support costs when compared to Options 4, while the same level of benefit is delivered across both options.

SoCF Summary – Digital Options

The graph below shows our cashflow position for all Digital options:

Figure 7.3 – SoCF for Shortlisted Digital Options from FY 2019/20 to 2036/37



Option 1 – Counterfactual

For the counterfactual position, it is assumed that investment into the re-licensing requirements for existing systems will be self-financed. The closing cash deficit continues to increase year on year as backlog maintenance requires to be financed, with the cash generated from operating activities insufficient to mitigate the pressure on cash.

Option 2

Option 2 shows a higher cash deficit across the period compared to the counterfactual position. This is due to the additional levels of capital investment required to supplement the existing Digital EPR related systems of the organisation.

Options 3 and 4

Options 3 and 4 follow a similar cashflow profile until around FY 2025/26. Although the identified cash releasing benefits across the three options are consistent, Option 3 delivers an improved cash deficit position in comparison to Options 4 due to the lower revenue costs associated with the option which can be seen on the graph.

Further work will be undertaken as the scheme moves to OBC stage in order to assess the potential for System support for these cash positions in the short term, in addition to the ability to utilise borrowings to meet our obligations prior to cash releasing benefits becoming operational.

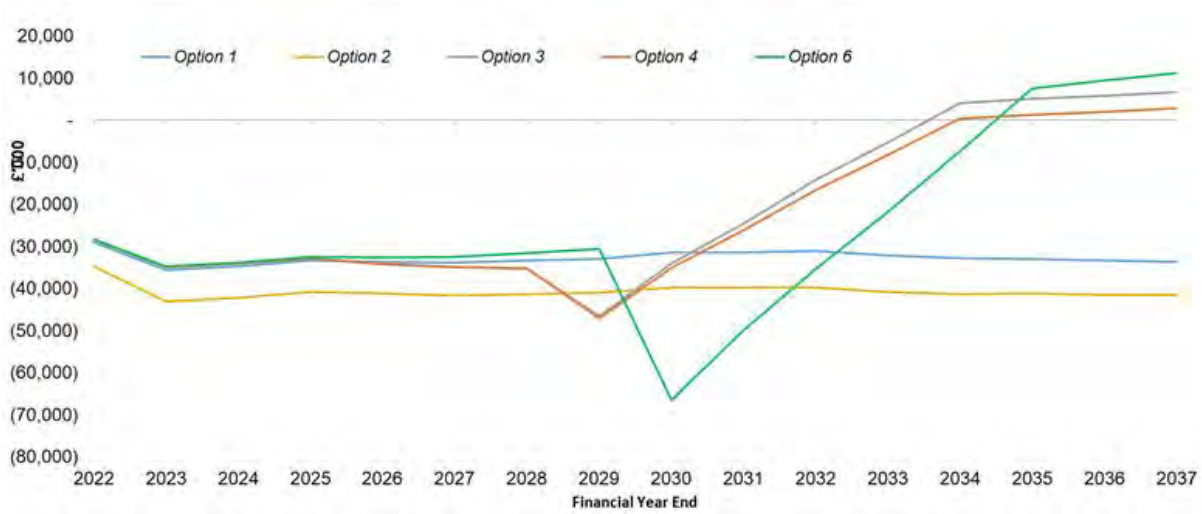
Conclusions

Options 3 and 4 provide our organisation with a lower cash deficit position when compared to Option 1 and 2, driven by the significant cash releasing benefits realisable under the options which allow for the delivery of a full EPR solution. Option 3 derives the most significant improvement due to the lower assumed revenue costs when compared to Option 4 which requires a higher level of annual support.

SoCI Summary – Estates Infrastructure Options

The graph below shows our I&E position for all Estates Infrastructure options

Figure 7.4 – SoCI (Net Surplus / (Deficit) for the year) for Shortlisted Estates Infrastructure Options from FY 2019/20 to 2036/37



Option 1

The counterfactual position has been described in the section above.

Option 2

Option 2 requires further capital investment over and above that seen in Option 1 in order to rectify all of the existing backlog maintenance requirements on the Torbay acute site. As with Option 1, no cash releasing benefits are assumed to be delivered through this investment, as rectifying maintenance requirements does not fundamentally alter the asset. The result of the increased capital expenditure and its associated revenue charges sees Option 2 fall below Option 1, with the position not being recovered.

Options 1 and 2 do not deliver a sustained improvement to the financial position of the organisation. The main rationale for this is that the investments required do not solve the fundamental issues with the existing acute estate, with Option 2 only mitigating the backlog requirement in the short term, meaning the acute estate would continue to carry a very significant level of failure risk moving forwards. Moreover, neither Options 1 or 2 allow for the delivery of our new transformative clinical model and as such do not allow for the future proofing of the Torbay acute site for the long term needs of the local population.

Option 3, 4 & 6

Options 3, 4 and 6 are in line with the deficit incurred in Option 1 across the first few years of the appraisal period. In FY 2023/24, Options 3 and 4 deviate from Option 1 as the capital expenditure on refurbishment works begins, due to the PDC dividend and depreciation charges seen on these investments, unlike the lack of requirement to realise PDC dividends payable and depreciation charges on assets while they remain under construction,

The most significant deficit positions under Options 3 and 4 are seen at March 2029 as the new build asset elements of these redevelopment options come online and their respective charges are realised.

Both Option 3 and 4 benefit from significantly improved financial positions from the operational date of the asset as the efficiency savings and additional revenue opportunities begin to be realised. Option 3 and 4 both move into a surplus in FY 2033/34.

When Option 6 comes online it is noted that the materially higher capital value of the assets attracts larger PDC and depreciation charges resulting in a substantially greater deficit position for our Trust in FY 2029/30. However, Option 6 delivers a surplus after 4.5 years (FY 2034/35) given the greater level of clinical efficiencies that are assumed under a new build option.

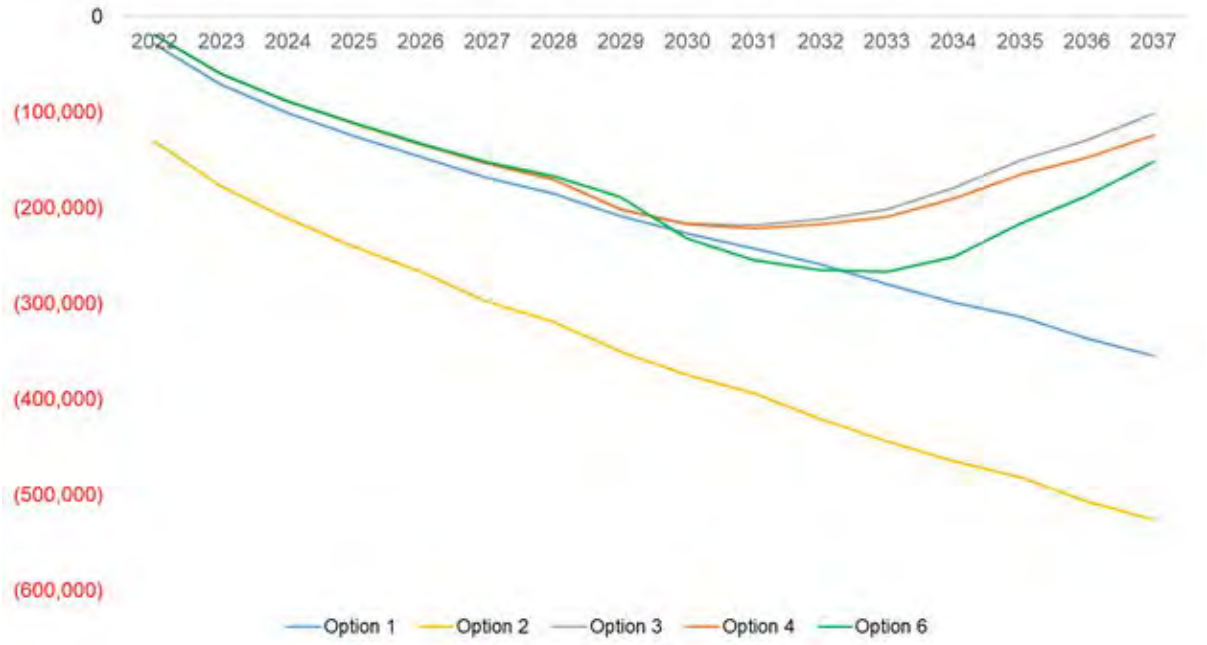
Conclusions

At this early stage of investment appraisal, Option 3 is deemed to be the most affordable Estates option to the wider system through its delivery of a sustained improvement to the financial position of our organisation. This improved position allows us to deliver a surplus quicker than the rest of Estates Infrastructure Options proposed.

SoCF Summary – Estates Infrastructure Options

The graph below shows our cashflow position for all Estates Infrastructure options:

Figure 7.5 – SoCF for Shortlisted Estates Infrastructure Options from FY 2019/20 to 2036/37



Option 1 – Counterfactual

The cash deficit position for Option 1 is primarily driven by the need to clear critical estates backlog maintenance (Category D) on the site, assumed to be self-financed. As no cash releasing benefits are derived from this option and all existing services are maintained on the acute Torbay site, the cash deficit position continues to increase year on year driving a very significant cash deficit position for our organisation.

Option 2

Option 2 follows a broadly similar trend across the 15 year appraisal period to Option 1, albeit the additional capital requirement to clear all backlog maintenance sees a greater deficit position delivered. Similar to Option 1, as limited cash releasing benefits are derived from this option the cash deficit position continues to increase year on year

Options 3, 4 and 6

Options 3, 4 and 6 follow a broadly similar cash flow position as each other until FY 2028/29, at which point assets become operational and the associated PDC dividend charges become payable. As shown on the above graph, the cashflow profile for both Option 3 and 4 benefits from significantly improved cash deficit positions from the operational date of the asset as the efficiency savings and additional revenue opportunities begin to be realised.

Option 6 falls to a greater cash deficit position in FY 2028/29 as compared to Options 3 and 4 due to the materially higher levels of PDC dividends payable on the significantly greater sized asset base. The opportunity for cash releasing benefits is deemed to be greatest under Option 6 due to the entirety of the estate being a new build reprovision, as compared to Options 3 and 4 where significant elements (c. 50%) of the estate is retained, inherently limiting the ability to deliver efficiencies such as higher levels of clinical adjacencies or energy savings.

The cash releasing benefits for all 3 options significantly outweigh their respective associated PDC dividend payable charges, improving the cash position of the organisation year on year.

Further work will be undertaken as the scheme moves to OBC stage in order to assess the potential for system support for these cash positions in the short term, in addition to the ability to utilise borrowings to meet our obligations prior to cash releasing benefits becoming operational.

Conclusions

Each of Options 3, 4 and 6 deliver an improved cash position when compared to Option 1 for our organisation. Option 3 delivers a higher level of cash releasing benefits than Option 4, meaning from a cash affordability perspective it is deemed as the Initial Preferred Way Forward. Option 6 delivers significant efficiencies when operational, however the associated PDC payable charges on the significant capital value of the assets under the option mean Option 6 delivers a greater cash deficit than Option 1 over a period of c. 5 years.

7.8.2 Programme Initial Preferred Way Forward

The following section, as outlined in the approach of this Financial Case, shows the effect of combining the Initial Preferred Way Forward from both the Digital and Estates Infrastructure elements of our Programme in order to show the Programme Initial Preferred Way Forward. In this context, the Programme Initial Preferred Way Forward combines Digital Option 3 and Estates Infrastructure Option 3.

The funding assumptions associated with the Programme Initial Preferred Way Forward are set out in the below sections, following which its effect on our financial standing is analysed.

Funding assumptions

As per the Fundamental Business Case Criteria (March 2021), funding and CDEL tables have been completed in respect of the Programme Initial Preferred Way Forward:

Table 7.18 – Funding table from Fundamental Business Case Criteria

Combined	CAPITAL (£'000)	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	Total
	Funding Source										
	NHSX (PDC)			3,220	2,780						6,000
	STP / ICS Digital match funding (PDC)			3,220	2,780						6,000
	National – NHP (PDC)	5,884	5,101	1,882	78,825	116,008	101,716	31,526	9,058		350,000
	Trust capital								11,422	1,806	13,228
	Total	**5,884**	**5,101**	**8,322**	**84,385**	**116,008**	**101,716**	**31,526**	**20,480**	**1,806**	**375,228**
	Application of Funding										
	Build costs per OB Forms	4,197	3,636	3,631	24,541	78,898	72,482	22,644	14,787	1,298	226,113
	Equipment	239	212	212	1,431	4,623	4,284	1,199	714	68	12,984
	Professional fees	402	351	353	2,381	7,660	7,029	2,094	1,315	120	21,704
	Build Planning Contingency	352	307	309	2,086	6,712	6,168	1,820	1,132	104	18,990
	Optimism bias	693	594	597	4,035	12,952	11,753	3,770	2,531	216	37,142
	EPR Licenses				12,757						12,757
	EPR Implementation			2,800	22,913	4,490					30,203
	Paperless Investment				3,098						3,098
	Warranted Environment costs				4,254						4,254
	Migration from existing systems				379						379
	Digital Contingency			420	6,510	673					7,604
	Total	**5,884**	**5,101**	**8,322**	**84,385**	**116,008**	**101,716**	**31,526**	**20,480**	**1,806**	**375,228**
	Source less Application	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 7.19 – CDEL table from Fundamental Business Case Criteria

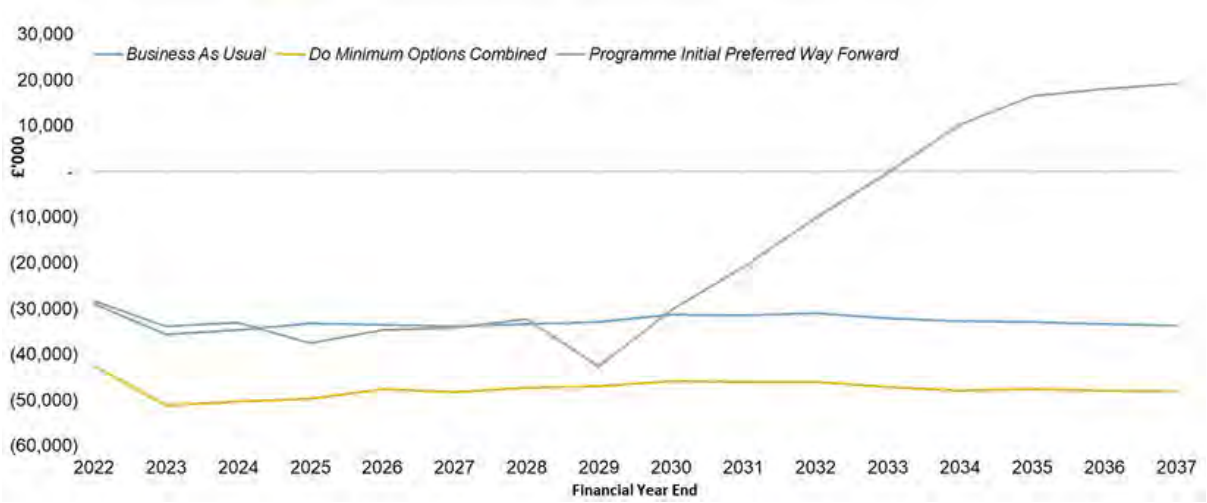
	CDEL (£'000)	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	Total
Combined	Gross Capex (approval value)	5,884	5,101	8,322	84,385	116,008	101,716	31,526	20,480	1,806	375,228
	Less NBV of Disposals										
	Less Grants and Donations (must be in the same financial year as the capex)										
	CDEL	5,884	5,101	8,322	84,385	116,008	101,716	31,526	20,480	1,806	375,228

7.8.3 Affordability and Financial Statements

SoCI Summary

The graph below shows our I&E position for the Programme Initial Preferred Way Forward

Figure 7.6 – SoCI (Net Surplus / (Deficit) for the year) for Programme Initial Preferred Way Forward from FY 2019/20 to 2036/37



The graph above shows our SoCI position for the Programme Initial Preferred Way Forward, the combination of Digital Option 3 and Estates Infrastructure Option 3. As outlined in the constituent sections above, our option stays in line with the counterfactual position in the first few years of the appraisal period due to backlog maintenance requirements and other planned Capital Expenditure. Capital expenditure requirements under the Programme Initial Preferred Way Forward begin in FY 2022/23 with the associated capital charges moving the option into a lower deficit position when compared to the counterfactual.

As the EPR system becomes operational in FY 2024/25 cash releasing benefits are realised, with a steady build up seen over a three-year period, improving the deficit position of the organisation and can be seen in the improvement in the financial position.

The most significant deficit position under the Initial Preferred Way Forward is found in FY2028/29 as the new build asset elements of the Estates Infrastructure Option 3 become operational, the respective charges being realised at this point.

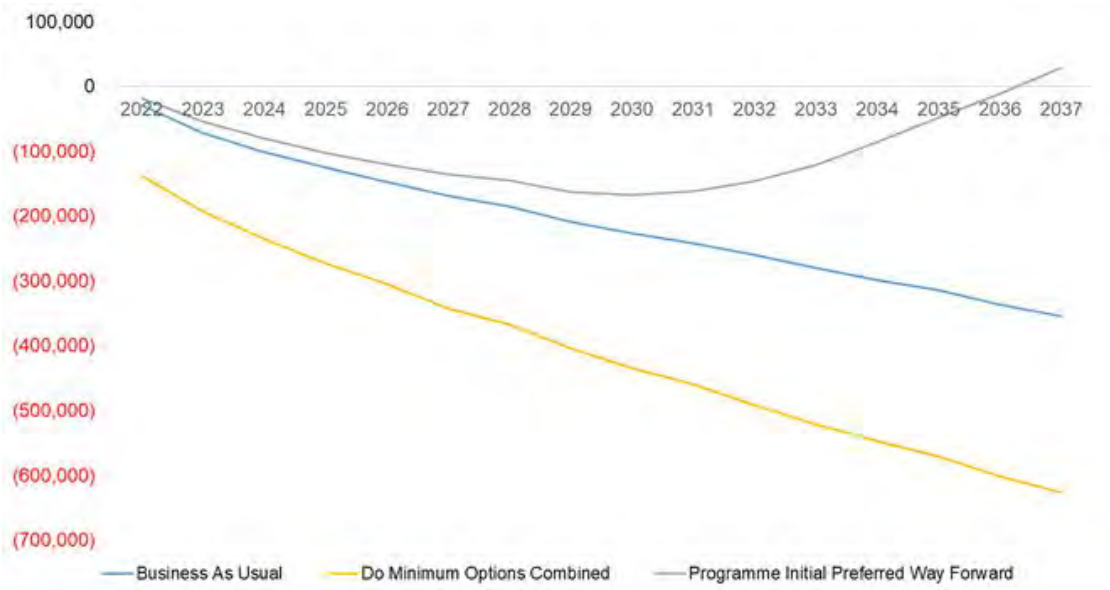
The related cash releasing benefits significantly improve the financial position of the organisation from the operational date of the asset as the efficiency savings and additional revenue opportunities begin to be realised which leads to a surplus starting to be made at the beginning of FY 2033/34.

Both ourselves and the Devon ICS recognise the challenge of funding the deficit position and will be the subject of greater scrutiny at the OBC stage. It is understood that the NHSE/I Regional Team are in discussions with the NHSE/I National Team on transitional funding solutions to the shorter term challenges presented by the large scale NHP capital investment programme.

SoCF Summary

The graph below shows our cashflow position for the Programme Initial Preferred Way Forward:

Figure 7.7 – SoCF for Programme Initial Preferred Way Forward from FY 2019/20 to 2036/37



The above graph shows the SoCF position for the Programme Initial Preferred Way Forward – the combination of Digital Option 3 and Estates Infrastructure Option 3. As per our previous assumptions, at this stage we have not sought to model additional borrowings in order that the cash position of the organisation be maintained.

The Programme Initial Preferred Way Forward drives a significantly improved cash position for the organisation when compared to the major cash deficits seen under the counterfactual position. In line with the movements seen in the constituent element graphs (Digital and Estates Infrastructure) in the above sections, the cash releasing benefits which come online in FY 2025/26 for the Digital element and in FY 2028/29 drive improvements to the SoCI position which is seen positive impacting the SoCF. These cash releasing benefits outweigh the PDC dividend payable charges, improving the cash position of the organisation year on year.

In the context of the opening comments with regards to the material cash deficits seen under each redevelopment option, the SoCF shows the Programme Initial Preferred Way Forward as being the most affordable solution to our Trust. The Programme Initial Preferred Way Forward does not ultimately recover the significant cash deficit position driven by the major deficit positions seen in Option 1, it does however significantly improve the position with a view to recovering to a cash surplus position over the period post FY 2036/37.As our Programme progresses we will explore options for these cash deficits to be mitigated through a combination of borrowings and System / central support. In the absence of these mitigants, strategic decisions will be required to be made with regards to the level of critical backlog maintenance investments in order that the cash amounts can be directed at the areas in which they will have the most impact whilst limiting the extent to which the organisation falls into a cash deficit position.

Financial Statements

The detail behind the graphs above, including the SoFP, can be seen in the financial statements for the Programme Initial Preferred Way Forward below. Counterfactual statements are repeated here for ease of reference:

SoCI

Table 7.20 – BAU / Counterfactual Full SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,978)	(315,028)	(321,217)	(328,404)	(335,760)	(343,279)	(350,969)	(358,835)	(366,880)	(375,109)
Non pay costs	(256,534)	(258,585)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(284,977)	(290,065)	(295,249)	(300,525)	(305,896)	(311,365)	(316,935)	(322,607)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(606,194)**	**(618,469)**	**(631,009)**	**(643,804)**	**(656,865)**	**(670,200)**	**(683,815)**	**(697,716)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**7,883**	**7,608**	**7,324**	**7,026**	**6,709**	**6,374**	**6,021**
Depreciation, amortisation & impairments	(19,886)	(22,829)	(25,017)	(26,814)	(28,646)	(30,316)	(31,326)	(32,201)	(32,009)	(31,945)	(31,320)	(32,169)	(32,572)	(32,522)	(32,635)	(32,637)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(578)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,903)	(7,312)	(7,675)	(7,562)	(7,253)	(7,050)	(6,931)	(6,882)	(6,910)	(6,822)	(6,727)	(6,723)	(6,728)	(6,628)	(6,588)	(6,607)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,986)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**
(Losses)/gains on disposal of assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,986)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**
Impairments	(2,295)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(31,280)**	**(35,657)**	**(34,720)**	**(33,311)**	**(33,621)**	**(33,828)**	**(33,421)**	**(32,913)**	**(31,392)**	**(31,482)**	**(31,027)**	**(32,145)**	**(32,838)**	**(32,991)**	**(33,382)**	**(33,741)**

Table 7.21 – Programme Initial Preferred Way Forward Full SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	556,623	567,986	579,583	591,419	603,499	615,827	628,409	641,250
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**616,373**	**628,438**	**640,746**	**653,300**	**666,107**	**679,171**	**692,497**	**706,092**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(294,571)	(299,829)	(304,687)	(310,654)	(312,509)	(314,777)	(317,094)	(319,447)	(321,842)	(329,142)	(336,610)	(344,251)
Non pay costs	(256,534)	(258,585)	(261,499)	(264,423)	(265,716)	(269,220)	(272,286)	(276,355)	(276,822)	(277,882)	(278,497)	(279,317)	(280,146)	(285,088)	(290,143)	(295,311)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,525)**	**(555,986)**	**(560,287)**	**(569,048)**	**(576,974)**	**(587,008)**	**(589,331)**	**(592,659)**	**(595,591)**	**(598,763)**	**(601,988)**	**(614,230)**	**(626,753)**	**(639,562)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,530)**	**1,681**	**8,268**	**10,611**	**14,014**	**15,534**	**27,042**	**35,979**	**45,155**	**54,537**	**64,119**	**64,941**	**65,745**	**66,530**
Depreciation, amortisation & impairments	(19,335)	(21,517)	(23,654)	(30,578)	(33,503)	(35,350)	(36,822)	(40,990)	(41,162)	(41,325)	(40,495)	(40,571)	(40,192)	(35,141)	(34,632)	(34,561)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(578)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,704)	(6,852)	(7,194)	(8,002)	(8,848)	(8,896)	(8,834)	(16,862)	(15,563)	(14,947)	(14,314)	(13,712)	(13,175)	(12,766)	(12,483)	(12,232)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,237)**	**(33,884)**	**(33,020)**	**(37,535)**	**(34,717)**	**(34,263)**	**(32,264)**	**(42,734)**	**(30,290)**	**(20,892)**	**(10,242)**	**(323)**	**10,188**	**16,485**	**18,095**	**19,200**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,237)**	**(33,884)**	**(33,020)**	**(37,535)**	**(34,717)**	**(34,263)**	**(32,264)**	**(42,734)**	**(30,290)**	**(20,892)**	**(10,242)**	**(323)**	**10,188**	**16,485**	**18,095**	**19,200**
Impairments	(2,295)	0	0	(301)	0	0	0	(50,387)	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(30,532)**	**(33,884)**	**(33,020)**	**(37,836)**	**(34,717)**	**(34,263)**	**(32,264)**	**(93,121)**	**(30,290)**	**(20,892)**	**(10,242)**	**(323)**	**10,188**	**16,485**	**18,095**	**19,200**

Table 7.22 – Programme Initial Preferred Way Forward Incremental SoCI from BAU / Counterfactual.

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	0	0	0	0	0	0	0	0	2,044	2,086	2,129	2,172	2,217	2,262	2,309	2,356
Other operating income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,044**	**2,086**	**2,129**	**2,172**	**2,217**	**2,262**	**2,309**	**2,356**
Pay costs	0	0	0	0	2,678	3,222	4,289	4,374	8,707	13,628	18,666	23,833	29,127	29,893	30,269	30,857
Non pay costs	0	0	(145)	(22)	2,678	3,222	4,267	4,374	8,156	12,383	16,752	21,208	25,750	26,277	26,792	27,298
Total Operating Expenses	**0**	**0**	**(145)**	**(22)**	**5,355**	**6,444**	**8,556**	**8,749**	**16,863**	**26,010**	**35,419**	**45,041**	**54,877**	**55,170**	**57,062**	**58,154**
Operating Surplus/(Deficit)	**0**	**0**	**(145)**	**(22)**	**5,355**	**6,444**	**8,556**	**8,749**	**18,907**	**28,096**	**37,547**	**47,214**	**57,094**	**58,232**	**59,370**	**60,509**
Depreciation, amortisation & impairments	551	1,313	1,383	(3,762)	(4,857)	(5,034)	(5,496)	(8,790)	(9,153)	(9,381)	(9,175)	(8,402)	(7,620)	(2,819)	(1,997)	(1,944)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividends payable	198	460	481	(441)	(1,594)	(1,846)	(1,903)	(9,780)	(8,653)	(8,126)	(7,587)	(6,989)	(6,448)	(6,137)	(5,896)	(5,624)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**749**	**1,773**	**1,699**	**(4,224)**	**(1,096)**	**(435)**	**1,157**	**(5,821)**	**1,102**	**10,590**	**20,786**	**31,822**	**43,026**	**49,476**	**51,477**	**52,941**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**749**	**1,773**	**1,699**	**(4,224)**	**(1,096)**	**(435)**	**1,157**	**(5,821)**	**1,102**	**10,590**	**20,786**	**31,822**	**43,026**	**49,476**	**51,477**	**52,941**
Impairments	0	0	0	(301)	0	0	0	(50,387)	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**749**	**1,773**	**1,699**	**(4,525)**	**(1,096)**	**(435)**	**1,157**	**(60,208)**	**1,102**	**10,590**	**20,786**	**31,822**	**43,026**	**49,476**	**51,477**	**52,941**

SoFP

Table 7.23 – BAU / Counterfactual SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	296,845	329,921	326,637	315,831	302,464	297,871	289,393	288,610	284,134	276,822	272,388	270,851	267,467	260,087	260,957	257,828
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(29,102)	(71,232)	(101,267)	(125,102)	(147,246)	(168,390)	(185,227)	(208,847)	(227,211)	(242,175)	(259,396)	(280,155)	(299,071)	(313,654)	(336,408)	(354,227)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**223,737**	**215,608**	**184,190**	**149,106**	**114,242**	**88,456**	**63,000**	**38,347**	**15,910**	**(6,891)**	**(27,990)**	**(49,965)**	**(72,159)**	**(94,023)**	**(115,002)**	**(136,029)**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**174,707**	**162,577**	**134,481**	**103,162**	**71,417**	**48,797**	**26,648**	**5,554**	**(13,727)**	**(32,839)**	**(50,800)**	**(69,972)**	**(89,470)**	**(108,747)**	**(128,032)**	**(147,287)**
Financed by																
Public dividend capital	163,974	187,502	194,125	196,117	197,993	209,201	220,474	232,293	244,403	256,773	269,839	282,812	296,152	309,867	323,963	338,450
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Income and expenditure reserve	(38,420)	(74,076)	(108,796)	(142,107)	(175,728)	(209,556)	(242,977)	(275,890)	(307,282)	(338,764)	(369,791)	(401,936)	(434,774)	(467,766)	(501,148)	(534,889)
Total taxpayers' and others' equity	**174,707**	**162,577**	**134,481**	**103,162**	**71,417**	**48,797**	**26,648**	**5,554**	**(13,727)**	**(32,839)**	**(50,800)**	**(69,972)**	**(89,470)**	**(108,747)**	**(128,032)**	**(147,287)**

Table 7.24 – Programme Initial Preferred Way Forward SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	289,835	323,129	326,069	394,268	491,092	577,190	590,036	539,922	519,370	497,008	475,824	455,910	438,933	426,415	417,614	407,632
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(18,241)	(53,728)	(79,960)	(102,996)	(120,434)	(135,155)	(144,750)	(163,194)	(167,897)	(161,884)	(146,261)	(121,349)	(85,626)	(47,613)	(11,278)	28,596
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**227,589**	**226,320**	**204,910**	**249,648**	**329,683**	**401,010**	**404,120**	**335,313**	**310,460**	**293,786**	**288,580**	**293,900**	**312,752**	**338,346**	**366,784**	**396,599**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**178,559**	**173,290**	**155,201**	**203,705**	**286,857**	**361,351**	**367,769**	**302,519**	**280,822**	**267,838**	**265,770**	**273,892**	**295,442**	**323,622**	**353,754**	**385,340**
Financed by																
Public dividend capital	169,372	197,988	212,919	299,259	417,128	525,886	564,568	592,440	601,033	608,941	617,114	625,559	636,920	648,616	660,654	673,040
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Income and expenditure reserve	(39,965)	(73,850)	(106,870)	(144,706)	(179,423)	(213,686)	(245,951)	(339,072)	(369,363)	(390,254)	(400,496)	(400,819)	(390,631)	(374,146)	(356,051)	(336,852)
Total taxpayers' and others' equity	**178,559**	**173,290**	**155,201**	**203,705**	**286,857**	**361,351**	**367,769**	**302,519**	**280,822**	**267,838**	**265,770**	**273,892**	**295,442**	**323,622**	**353,754**	**385,340**

Table 7.25 – Programme Initial Preferred Way Forward Incremental SoFP from BAU / Counterfactual

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	(7,010)	(6,791)	(568)	78,437	188,628	279,318	300,643	251,312	235,235	220,186	203,436	185,058	171,466	166,327	156,656	149,805
Current assets (excl Cash)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash	10,862	17,504	21,287	22,106	26,812	33,236	40,478	45,653	59,314	80,491	113,135	158,806	213,446	266,041	325,130	382,823
Current liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total assets less current liabilities	**3,852**	**10,713**	**20,720**	**100,542**	**215,440**	**312,554**	**341,121**	**296,965**	**294,549**	**300,677**	**316,570**	**343,864**	**384,911**	**432,369**	**481,787**	**532,627**
Non-current liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total net assets employed	**3,852**	**10,713**	**20,720**	**100,542**	**215,440**	**312,554**	**341,121**	**296,965**	**294,549**	**300,677**	**316,570**	**343,864**	**384,911**	**432,369**	**481,787**	**532,627**
Financed by	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public dividend capital	5,398	10,486	18,793	103,141	219,136	316,684	344,094	360,147	356,630	352,167	347,275	342,747	340,768	338,749	336,690	334,590
Revaluation reserve	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(1,546)	227	1,926	(2,599)	(3,695)	(4,130)	(2,974)	(63,182)	(62,080)	(51,491)	(30,705)	1,117	44,143	93,619	145,097	198,038
Total taxpayers' and others' equity	**3,852**	**10,713**	**20,720**	**100,542**	**215,440**	**312,554**	**341,121**	**296,965**	**294,549**	**300,677**	**316,570**	**343,864**	**384,911**	**432,369**	**481,787**	**532,627**

Statement of Cash Flow (SoCF)

Table 7.26 – BAU / Counterfactual SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,836)	(27,700)	(26,402)	(25,111)	(25,734)	(26,149)	(25,868)	(25,415)	(23,874)	(24,062)	(23,713)	(24,845)	(25,546)	(25,613)	(26,260)	(26,616)
Depreciation and amortisation	19,886	22,829	25,017	26,814	28,646	30,316	31,326	32,201	32,009	31,945	31,320	32,169	32,572	32,522	32,635	32,637
Impairments	2,295	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) operations	**(655)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**7,883**	**7,608**	**7,324**	**7,026**	**6,909**	**6,374**	**6,021**
Purchase of PP&E and investment property	(82,672)	(46,637)	(21,733)	(16,008)	(15,279)	(25,724)	(22,847)	(31,418)	(27,534)	(24,632)	(26,887)	(30,632)	(29,188)	(25,143)	(33,505)	(29,507)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(81,652)**	**(46,637)**	**(21,733)**	**(16,008)**	**(15,279)**	**(25,724)**	**(22,847)**	**(31,418)**	**(27,534)**	**(24,632)**	**(26,887)**	**(30,632)**	**(29,188)**	**(25,143)**	**(33,505)**	**(29,507)**
Public dividend capital received	33,219	23,527	6,624	1,992	1,875	11,209	11,272	11,819	12,110	12,370	13,066	12,973	13,340	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(18,118)	(4,811)	(3,881)	(2,917)	(2,917)	(2,372)	(2,372)	(2,372)	(2,372)	(2,382)	(2,388)	(1,832)	(1,305)	(1,089)	(894)	0
Capital element of service concession payments	(1,166)	(1,312)	(1,276)	(301)	(725)	(601)	(629)	(747)	(973)	(545)	(1,042)	(998)	(1,173)	(1,241)	(1,315)	(1,269)
Finance lease repayment	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,903)	(7,312)	(7,675)	(7,562)	(7,253)	(7,050)	(6,931)	(6,882)	(6,910)	(6,822)	(6,727)	(6,723)	(6,728)	(6,628)	(6,588)	(6,807)
Net cash generated from financing activities	**7,760**	**9,377**	**(6,917)**	**(9,529)**	**(9,778)**	**413**	**552**	**1,013**	**1,034**	**1,785**	**2,058**	**2,549**	**3,246**	**3,851**	**4,376**	**5,467**
Increase / (decrease) in cash and cash equivalents	**(74,547)**	**(42,130)**	**(30,035)**	**(23,834)**	**(22,144)**	**(21,144)**	**(16,837)**	**(23,619)**	**(18,364)**	**(14,965)**	**(17,221)**	**(20,759)**	**(18,916)**	**(14,583)**	**(22,754)**	**(17,819)**
Cash and cash equivalents at 1 April	**45,445**	**(29,102)**	**(71,232)**	**(101,267)**	**(125,102)**	**(147,246)**	**(168,390)**	**(185,227)**	**(208,847)**	**(227,211)**	**(242,175)**	**(259,396)**	**(280,155)**	**(299,071)**	**(313,654)**	**(336,408)**
Cash and cash equivalents at 31 March	**(29,102)**	**(71,232)**	**(101,267)**	**(125,102)**	**(147,246)**	**(168,390)**	**(185,227)**	**(208,847)**	**(227,211)**	**(242,175)**	**(259,396)**	**(280,155)**	**(299,071)**	**(313,654)**	**(336,408)**	**(354,227)**

Table 7.27 – Programme Initial Preferred Way Forward SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,285)	(26,387)	(25,184)	(28,894)	(25,236)	(24,739)	(22,808)	(25,456)	(14,120)	(5,346)	4,660	13,966	23,928	29,800	31,113	31,949
Depreciation and amortisation	19,527	22,018	24,155	31,077	34,004	35,851	37,323	41,491	41,663	41,826	40,996	41,072	40,693	35,642	35,133	35,082
Other Non-cash items	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(1,029)**	**2,182**	**8,769**	**11,112**	**14,515**	**16,035**	**27,543**	**36,480**	**45,656**	**55,038**	**64,620**	**65,442**	**66,246**	**67,031**
Interest received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of PP&E and investment property	(75,303)	(46,043)	(27,095)	(99,576)	(130,829)	(121,949)	(50,169)	(41,765)	(21,111)	(19,465)	(19,812)	(21,158)	(23,716)	(23,124)	(26,332)	(25,100)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(74,283)**	**(46,043)**	**(27,095)**	**(99,576)**	**(130,829)**	**(121,949)**	**(50,169)**	**(41,765)**	**(21,111)**	**(19,465)**	**(19,812)**	**(21,158)**	**(23,716)**	**(23,124)**	**(26,332)**	**(25,100)**
Public dividend capital received	38,617	28,616	14,931	86,340	117,870	108,758	38,682	27,872	8,593	7,908	8,174	8,445	11,361	11,696	12,038	12,386
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Finance lease repayment	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,704)	(6,852)	(7,194)	(8,002)	(8,848)	(8,896)	(8,834)	(16,662)	(15,563)	(14,947)	(14,314)	(13,712)	(13,175)	(12,766)	(12,483)	(12,232)
Net cash generated from financing activities	**13,355**	**14,925**	**1,872**	**74,378**	**104,622**	**96,116**	**26,059**	**7,286**	**(11,136)**	**(10,803)**	**(10,421)**	**(8,968)**	**(5,181)**	**(4,305)**	**(3,578)**	**(2,057)**
Increase / (decrease) in cash and cash equivalents	**(63,686)**	**(35,488)**	**(26,252)**	**(23,016)**	**(17,438)**	**(14,721)**	**(9,595)**	**(18,444)**	**(4,703)**	**6,213**	**15,423**	**24,912**	**35,724**	**38,013**	**36,335**	**39,874**
Cash and cash equivalents at 1 April	**45,445**	**(18,241)**	**(53,728)**	**(79,980)**	**(102,996)**	**(120,434)**	**(135,155)**	**(144,750)**	**(163,194)**	**(167,897)**	**(161,684)**	**(146,261)**	**(121,349)**	**(85,626)**	**(47,613)**	**(11,278)**
Cash and cash equivalents at 31 March	**(18,241)**	**(53,728)**	**(79,980)**	**(102,996)**	**(120,434)**	**(135,155)**	**(144,750)**	**(163,194)**	**(167,897)**	**(161,684)**	**(146,261)**	**(121,349)**	**(85,626)**	**(47,613)**	**(11,278)**	**28,596**

Table 7.28 – Programme Initial Preferred Way Forward Incremental SoCF from BAU / Counterfactual

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	551	1,313	1,218	(3,784)	498	1,411	3,060	(41)	9,754	18,716	28,372	38,811	49,474	55,613	57,373	58,565
Depreciation and amortisation	(359)	(812)	(862)	4,263	5,358	5,535	5,997	9,291	9,654	9,882	9,676	8,903	8,121	3,120	2,498	2,445
Impairments	(2,295)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) operations	**(2,102)**	**501**	**356**	**479**	**5,856**	**6,945**	**9,057**	**9,250**	**19,408**	**28,597**	**38,048**	**47,715**	**57,595**	**58,733**	**59,871**	**61,010**
Interest received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of PP&E and investment property	7,368	593	(5,361)	(83,568)	(115,550)	(96,225)	(27,322)	(10,347)	6,423	5,168	7,074	9,474	5,472	2,019	7,172	4,407
Sales of PP&E and investment property	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**7,368**	**593**	**(5,361)**	**(83,568)**	**(115,550)**	**(96,225)**	**(27,322)**	**(10,347)**	**6,423**	**5,168**	**7,074**	**9,474**	**5,472**	**2,019**	**7,172**	**4,407**
Public dividend capital received	5,398	5,088	8,307	84,348	115,994	97,549	27,410	16,053	(3,517)	(4,462)	(4,892)	(4,528)	(1,979)	(2,019)	(2,059)	(2,100)
Loans received/(repaid) from/to Department of Health & Capital element of service concession payments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance lease repayment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC dividend paid	198	460	481	(441)	(1,594)	(1,846)	(1,903)	(9,780)	(8,653)	(8,126)	(7,587)	(6,989)	(6,448)	(6,137)	(5,896)	(5,624)
Net cash generated from financing activities	**5,596**	**5,548**	**8,788**	**83,907**	**114,400**	**95,703**	**25,507**	**6,273**	**(12,170)**	**(12,588)**	**(12,479)**	**(11,517)**	**(8,427)**	**(8,156)**	**(7,955)**	**(7,724)**
Increase / (decrease) in cash and cash equivalents	**10,862**	**6,642**	**3,783**	**818**	**4,707**	**6,424**	**7,242**	**5,175**	**13,661**	**21,177**	**32,643**	**45,671**	**54,640**	**52,596**	**59,089**	**57,693**
Cash and cash equivalents at 1 April	**0**	**10,862**	**17,504**	**21,287**	**22,106**	**26,812**	**33,236**	**40,478**	**45,653**	**59,314**	**80,491**	**113,135**	**158,806**	**213,446**	**266,041**	**325,130**
Cash and cash equivalents at 31 March	**10,862**	**17,504**	**21,287**	**22,106**	**26,812**	**33,236**	**40,478**	**45,653**	**59,314**	**80,491**	**113,135**	**158,806**	**213,446**	**266,041**	**325,130**	**382,823**

7.9 Sensitivity Analysis

For robustness and in line with guidance, sensitivity analysis has been undertaken on our financial position. The section below demonstrates how the Programme Initial Preferred Way Forward would be affected under each sensitivity.

This sensitivity analysis assesses the position against movements in the capital cost base,the realisation of CRBs and alternative PDC charges. The sections below show each of the constituent scenario impacts on both our SoCI and SoCF.

Capital cost sensitivity

Our capital cost estimates have been founded on strong assumptions, with detailed health planning work having been undertaken and conservative Planning Contingency and Optimism Bias assumptions applied. We are confident that each of the shortlisted options can be delivered within the estimated financial envelope.

To ensure all scenarios are accounted for, a number of sensitivity scenarios have been run to understand the effect of an increased capital requirement on the affordability of the combined position. This sensitivity analysis has been undertaken on the entire Estates Infrastructure-related capital requirement, meaning both backlog maintenance and option-specific capital is impacted. The capital costs of the Digital options have also been adjusted for these sensitivities under the Programme option. For clarity, these capital cost increases are deemed to occur prior to construction or Digital implementation contract signature and would therefore be required to be borne by ourselves.

The following scenarios have been considered:

7. Capital costs + 5%
8. Capital costs + 10%.

The table below shows the impact of these capital sensitivities on our SoCI and SoCF positions:

Table 7.29 – Programme Initial Preferred Way Forward Capital Cost Sensitivities

	Capital Cost Sensitivities	SoCI (Surplus/deficit before impairments)			SoCF		
		Highest Deficit	Year of breakeven	FY 2036/37 Position	Highest Deficit	Year of breakeven[24]	FY 2036/37 Position
		£'000	FY	£'000	£'000	FY	£'000
Combined	**Initial Preferred Way Forward**						
	Current state	(42,734)	2033/34	19,200	(167,897)	2036/37	28,596
	5% Increase in CAPEX	(43,852)	2033/34	18,578	(169,334)	2036/37	24,512
	10% Increase in CAPEX	(44,970)	2033/34	17,956	(170,771)	2036/37	20,429

[24] FY in which cash and cash equivalents at 31st March move from deficit into surplus

The following conclusions can be drawn from the above capital cost sensitivities:

- As expected, the increase in the level of capital requirement under both scenarios ultimately has an adverse effect on both the SoCI and SoCF. In both scenarios, the worsened position is driven by the increased PDC and depreciation charges driven by the increased value of the assets under the options..
- While the positions are worsened, our Trust is still able to deliver a surplus position in the same time period, due to the level of cash releasing benefits deliverable under the option.

While these sensitivities have been shown, we will ensure mitigating steps are taken on our Programme to ensure delivery within our agreed capital envelope. We would look to mitigate increased costs through our Programme contingency sums, de-scoping elements of the Initial Preferred Way Forward if required, in addition to engaging in further central discussions to understand ways of supporting our financial position.

Revenue sensitivity

As with the capital cost estimates we have been prudent in our revenue estimates and the assumptions which drive those estimates. The revenue sensitivities centre on the realisation of the financial benefits (CRBs) projected under the Programme Initial Preferred Way Forward. In order to assess our financial position two scenarios have been tested:

3. 85% of the projected financial benefits (CRBs) are achieved; and
4. 75% of the projected financial benefits (CRBs) are achieved.

The table below shows the impact of these revenue sensitivities on our SoCI and SoCF positions:

Table 7.30 – Programme Initial Preferred Way Forward Revenue Sensitivities

	Revenue Sensitivities	SoCI (Surplus/deficit before impairments)			SoCF		
		Highest Deficit	Year of breakeven	FY 2036/37 Position	Highest Deficit	Year of breakeven	FY 2036/37 Position
		£'000	FY	£'000	£'000	FY	£'000
Combined	**Initial Preferred Way Forward**						
	Current state	(42,734)	2033/34	19,200	(167,897)	2036/37	28,596
	85% of Benefits	(44,267)	2033/34	10,120	(176,166)	N/A[25]	(32,288)
	75% of Benefits	(45,289)	2034/35	4,016	(182,809)	N/A	(73,135)

The following conclusions can be drawn from the above revenue sensitivities:

- The realisation of a reduced amount of cash releasing benefits has an adverse effect on both the SoCI and the SoCF. Due to a lower amount of CRBs being realised, it takes longer for our Trust to move into a surplus position in the SoCI. The cash position would also stay in a deficit for a longer period of time passed FY 2036/37.
- While as expected a lower amount of CRBs will deliver a lower surplus in terms of SoCI compared to the current state, the underlying position of our Trust would still be improved significantly from the current position.

[25] Cash at 31 March remains in deficit throughout the time period analysed

- The SoCF is more sensitive to this change due to the accumulation of worsened SoCI positions over the time period analysed. With fewer CRBs, we would struggle to improve the significant deficit accumulated prior to this option coming into effect, as a result of Business as Usual spend on elements such as critical backlog.
- In order to mitigate the tested sensitivities, we have developed robust assumptions on benefits throughout the SOC stage. We will continue to revisit and refine our benefits and assumptions behind them as we move forward to OBC.

Public Dividend Capital charge sensitivity

On the advice of the NHSE/I National Cash and Capital team, we understand that it would be beneficial to model the financial impact of a change in the 3.5% PDC charge payable on our average net relevant assets. For all intents and purposes the PDC charge acts as an interest charge on public capital: this sensitivity recognises the current market conditions with regards to the commercial debt markets and assesses the impact of the PDC rate being lowered to recognise this.

The table below shows the impact of this PDC sensitivity on our SoCI and SoCF positions:

Table 7.31 – Programme Initial Preferred Way Forward PDC Charge Sensitivities

	PDC Sensitivity	SoCI (Surplus/deficit before impairments)			SoCF		
		Highest Deficit	Year of breakeven	FY 2036/37 Position	Highest Deficit	Year of breakeven	FY 2036/37 Position
		£'000	FY	£'000	£'000	FY	£'000
Combined	**Initial Preferred Way Forward**						
	Current state	(42,734)	2033/34	19,200	(167,897)	2036/37	28,596
	1.5% PDC Charge	(33,213)	2032/33	26,189	(122,626)	2034/35	131,558

The following conclusions can be drawn from the above PDC sensitivity:

- Lowering the PDC charge from 3.5% to 1.5% significantly improves the SoCI and SoCF positions. Having this lower charge on our net relevant asset base reduces our PDC charge substantially, therefore improving these positions.
- A lower PDC charge would also allow our Trust to move into a surplus position quicker as compared to our base case. In both cases the SoCI and SoCF would move into a surplus a year or two earlier than the current state of 3.5% PDC charge.
- The cash position reaches a considerable value due to the accumulation of improving SoCI positions over the time period analysed, while maintaining the same level of cash releasing benefits.

7.10 Opportunities as the Programme Moves to OBC

We have identified a number of areas which represent further opportunities to improve the affordability position of the shortlisted options from both a SoCI and SoCF perspective. Additional work will be undertaken to further develop these opportunities as the Programme moves forwards to OBC:

Table 7.32 – Opportunities at OBC

	Opportunity	Description
Combined	Ability to realise benefits at an earlier point	Benefits are currently assumed to be realised the first full financial year following full asset completion. As further analysis of the programme matures there is the opportunity to realise benefits at earlier points, for example to realise cash releasing benefits in line with enabling works, and also to mitigate in-year SoCI charges.
	Potential for additional benefits to be identified	In line with central guidance, this SOC identifies high level benefits. As our Programme moves forwards further analysis will be undertaken within our organisation to identify and quantify additional cash releasing benefits. This also extends to validation of existing benefits which have been quantified using conservative assumptions at this stage.
	More accurate cost estimation	Great accuracy of cost estimation will be available as the Programme moves into the design stage, including refinement of OB and other contingencies.
	Cost reduction through greater VAT recovery	VAT recovery is only assumed on professional fees at this stage of development – we understand that there are further opportunities for cost reduction through VAT recovery on other elements of the Programme
	Opportunities to identify additional funding sources to drive greater benefits	We are actively assessing opportunities to access additional sources of capital financing, both in relation to our Digital investment and our Estates Infrastructure requirement. These additional sources of finance have the potential to drive additional benefits through both the infrastructure they enable
	Greater understanding of Digital and impact on Estates Infrastructure	As we move forward, we will be undertaking further analysis to understand the impact of the Digital investment on our Estates Infrastructure (footprint and fabric as per the Digital Hospital Blueprint). This analysis has the potential to derive further cash releasing benefits which we will look to capture.
	Further refinement of workforce requirements	As our Programme moves forward significant work will be undertaken as to refining our workforce strategy. This presents opportunities for further cash releasing savings through the implementation of transformative ways of working.
	Opportunities at scale to work together across Devon	There are significant opportunities presented by potential partnership working across the three NHP schemes within the Devon region. Work is ongoing at a regional level as to these opportunities and their potential to realise economies of scale from both a clinical services and commercial perspective.
	Further commercial opportunities	Our Programme is at an early stage, but significant discussions have already occurred as to a number of further potential commercial opportunities which we could look to recognise as our Programme moves forwards to OBC stage. These commercial

	opportunities include partnership working with our Local Authority (Devon County Council) in terms of the provision of Photovoltaic power farms which bring with them more efficient energy usage. In addition, and as set out at Section 6.7 of the Commercial Case of this document, early discussions have been held with the Independent Sector provider in the locality who have expressed interest in contributing capital for the development of a Private Patients Unit. This presents the opportunity of us being able to take a guaranteed income stream; the commercial structuring of this opportunity will be explored further at OBC stage.
Opportunity to share services	The Programme may allow for the Back-Office function at our Trust to be transformed into shared services and therefore provide cost savings. The extent of this benefit will be analysed further as the Programme progresses
Land disposal opportunities	There is an opportunity for our Trust to look at areas of the Estate which they can dispose of due to the Estates Infrastructure redevelopment options in question. Specific areas which this applies to and possible valuations of this land will be explored further at OBC stage.
QALY ("Quality Adjusted Life Years") benefits	Early discussions between the Programme team have identified possible QALY's which could be derived as a result of the investment. Due to the challenge in calculating these benefits, QALY's will be revisited as the Programme moves to OBC.

7.11 Revenue Savings and Payback Period

The Programme Initial Preferred Way Forward's Payback Period is outlined in the table below. Cash releasing benefits derived from the Digital investment are realised from FY 2025/26 with the Estates Infrastructure cash releasing benefits being realised from FY 2029/30.

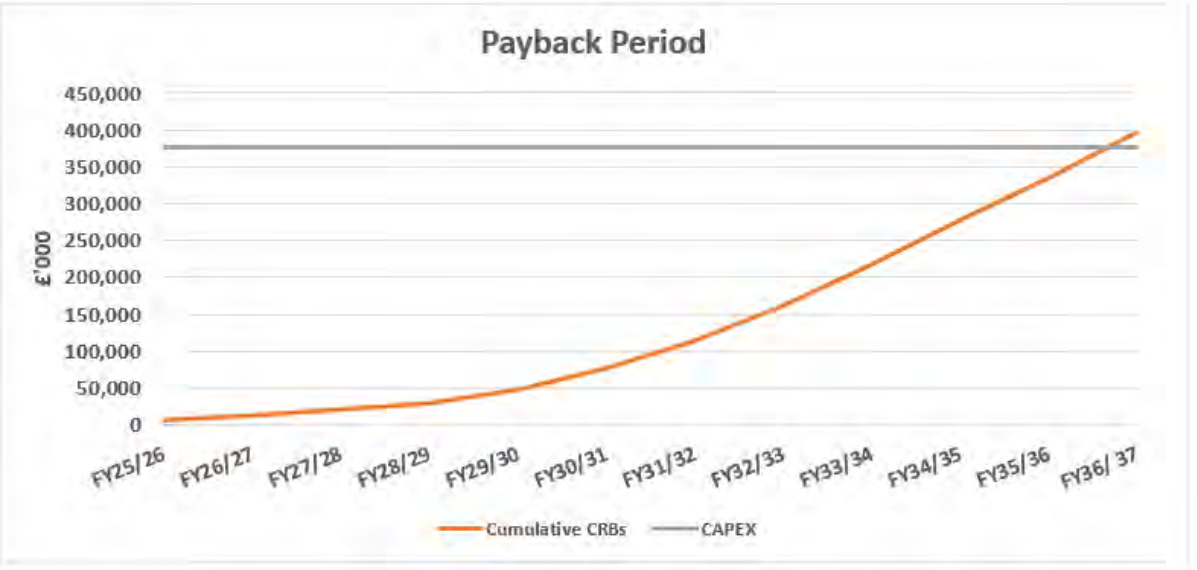
Accumulation of cash releasing benefits from both Programme elements allow our Trust to achieve a 12-year Payback Period. By FY 2036/37, cash releasing benefits accumulate to a total of c.£400m, as can be seen in Figure 7.8 below.

Table 7.33 – Payback Period from Cash Releasing Benefits for the Programme Preferred Way Forward

Payback Period (£'000)	FY24/25	FY25/26	FY26/27	FY27/28	FY28/29	FY29/30	FY30/31	FY31/32	FY32/33	FY33/34	FY34/35	FY35/36	FY36/37
Asset Completion	**Digital asset complete**				**Estates asset complete**								
CRBs		5,355	6,444	8,556	8,749	18,907	28,096	37,547	47,214	57,094	58,232	59,370	60,509
Option CAPEX	375,228[26]												
Payback Period	**12 Years**												

[26] CAPEX total from Programme Preferred Way Forward Funding table

Figure 7.8 - Payback period from Cash Releasing Benefits for the Programme Preferred Way Forward



7.12 Accounting Treatment

7.12.1 Finance Leases

While none of the shortlisted options requires us to hold finance leases under development agreements, as outlined at the outset of this Financial Case a number of finance leases are assumed under the counterfactual position. These finance leases are to be taken in respect of a number of Health and Wellbeing Centre assets, to be entered into over the next number of years – agnostic to the NHP investment.

These leases are classified as such in line with IFRS 16 guidance where all leases will be recognised on our Balance Sheet, and hence will contribute towards the PDC charge payable on our average net relevant asset position. Within this structure, we will take leasehold obligations for the Health and Wellbeing Centre assets.

It should be noted that all existing leases held by ourselves have been modelled as per their existing state under IAS 17 as at FY 2020/21 unless stated otherwise.

7.12.2 VAT / Tax Treatment

We will detail appropriate VAT and tax treatment of the shortlisted options as these are further refined through the OBC stage of investment appraisal. As detailed through this Financial Case, VAT recovery is only assumed on professional fees at this stage.

7.12.3 Conclusions

This case assessed the affordability of each of the shortlisted Digital and Estates Infrastructure Options. Further analysis has also been carried out on the Programme Initial Preferred Way Forward, consisting of Digital Option 3 and Estates Infrastructure Option 3. The Programme Initial Preferred Way Forward is deemed to be affordable to the system and it significantly improves the underlying deficit of our Trust through delivery of several cash releasing benefits.

The Programme Initial Preferred Way Forward also mitigates considerable Estates Infrastructure risk identified in the counterfactual position of this case and throughout, by redeveloping areas of the Estate. The Estates development considered, alongside the investment into an EPR system will also improve the efficiency of our Trust significantly.

We will commit to undertake further work in order to refine our assumptions as we move into OBC stage, including analysing the opportunities identified in section 7.10. As we move to OBC stage, we are aware of the challenges of funding the deficit position incurred by the NHP capital investment programme. We would like to engage more with the system to help understand transitional funding solutions for the short term to help improve these positions.

8 Management Case

Key Messages

- Our governance of the project is robust at a system and local level.
- We have a Programme team with the capacity and capability to deliver the programme.
- Our Design Leaders will play a key role in being able deliver the required transformation.
- Our risk management systems are now fully operational.
- Our timetable is consistent with the national planning assumptions on when construction would be able to commence.

8.1 Introduction

In the preceding Cases we have set out the strategic rationale for our Programme; identified a Programme Initial Preferred Way Forward and examined cost and affordability; and considered our approach to procurement.

We have demonstrated that the Programme is complex, and requires two elements – Digital and Estates Infrastructure – to be brought together.

This Management Case sets out the leadership, governance and management arrangements we have put in place to successfully deliver the Programme. It also provides details of the Programme plan and budget and our approaches to stakeholder engagement and communication, risk management and mitigation and benefits realisation.

Over and above delivery of the Programme, it demonstrates how we will use our investment to deliver our vision and our long-term objective to "build a brighter future", by continuing to work with our system partners, consistently aligning our Programme with Devon Long Term Plan priorities and continuing to engage with people who use our services and our staff as we move through the business case process.

8.2 Trust Governance and Board

As a Foundation Trust we are responsible for our own management. We are led by the Board of Directors (the "Trust Board"), which is accountable to local people represented by the Council of Governors. The role of the Trust Board is to provide effective and proactive leadership, set strategic aims, ensure the quality, safety and effectiveness of the services we provide and ensure that we are well-governed in every aspect of our activities.

The Trust Board meets monthly and is chaired by Sir Richard Ibbotson. The Trust Board members as at 30 June 2021 are noted in the table below and biographies are provided in Appendix 9.5.1.

Table 8.1 – List of Trust Board members and their roles

	Trust Board member	Role
Combined	Sir Richard Ibbotson	Chairman
	Liz Davenport	Chief Executive
	Chris Balch	Non-Executive Director

Jacqui Lyttle	Non-Executive Director and Senior Independent Director
Vikki Matthews	Non-Executive Director
Paul Richards	Non-Executive Director
Robin Sutton	Non-Executive Director
Sally Taylor	Non-Executive Director and Vice Chair
Jon Welch	Non-Executive Director
Dr Ian Currie	Executive Medical Director
Judy Falcão	Chief People Officer
John Harrison	Chief Operating Officer
Adel Jones	Director of Transformation and Partnerships
Deborah Kelly	Chief Nurse
David Stacey	Chief Finance Officer
Dr Joanne Watson	Health and Care Strategy Director

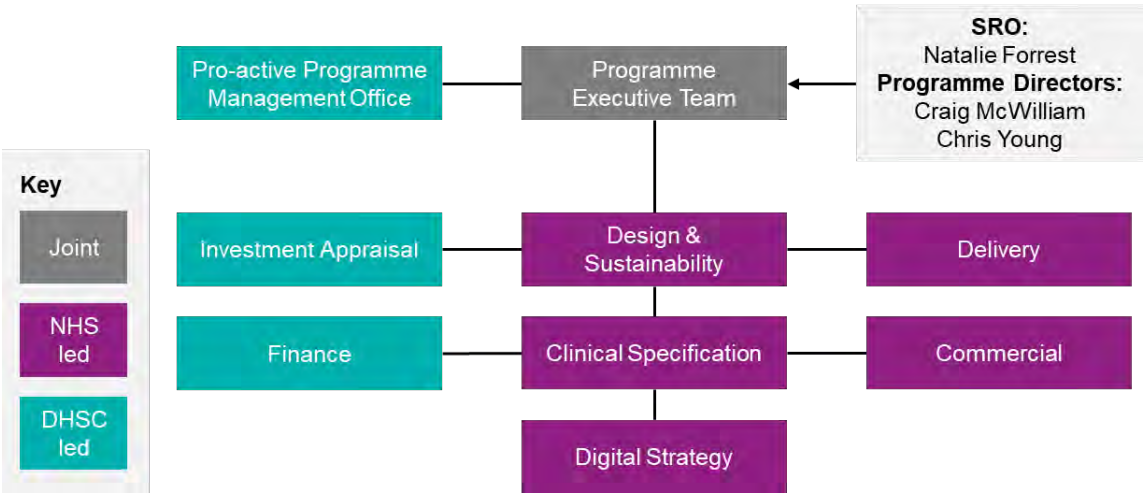
National Governance

At a national level a joint DHSC/NHSE&I Programme Team has been established to discharge the NHP element of the UK Government's Health Infrastructure Plan. Programme strategy, running/enabling and appraisals will be DHSC responsibilities. NHSE&I will lead on the delivery of standards, transformation and value.

The NHP executive consists of a Senior Responsible Officer (SRO) and two joint Programme directors. Responsibilities within the executive team are arranged so that the NHS leads on project delivery and DHSC leads on Programme finances and cross-government stakeholder management.

Support will also be provided by other government bodies, including senior commercial resource seconded from the Government Commercial Organisation, digital resource supported by NHSX, Programme support from the Infrastructure and Projects Authority and support from NHS teams (transformation, service change, estates, PTOM, etc). The governance structure at national level is shown in the organigram below:

Figure 8.1 – Governance structure at national level



Regional Governance

The Peninsula NHP Leads Group was established in response to the clear requirement for alignment, coherent system planning and collaborative working to maximise the potential value to be captured from sharing planning and resource across sites.

An informal forum was established in February 2020 with representation from the four Trusts in Devon and Cornwall and Isles of Scilly as well as NHSE/I.

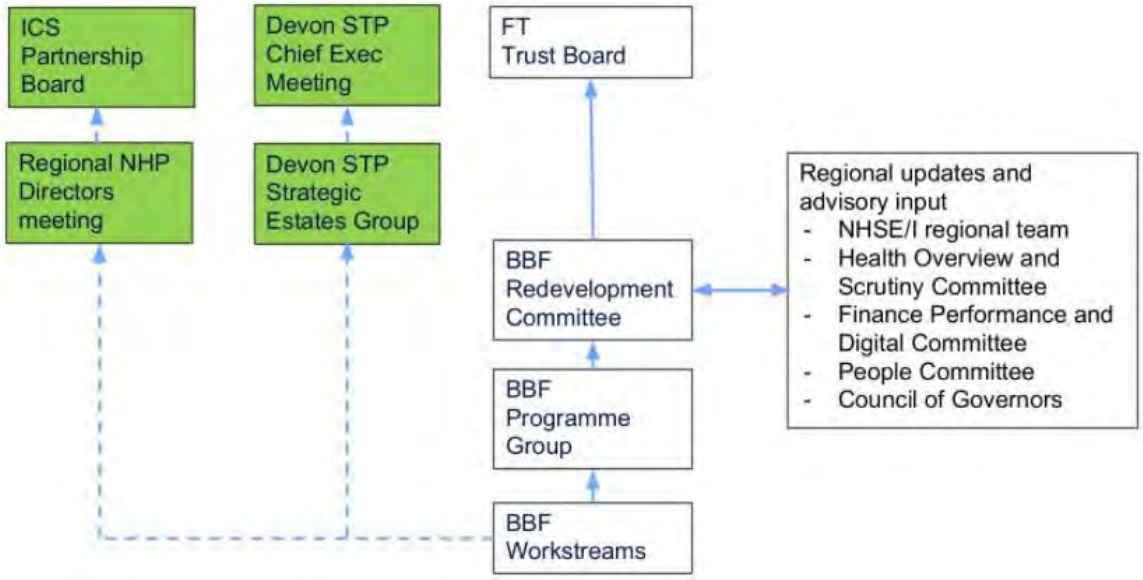
The Group's key areas of focus are:

- Understanding the scope and scale of the NHP programmes within each Trust to share good practice, approach and understanding of the broader capital investment landscape
- Having a whole-system awareness and approach to job descriptions for key appointments as well as procurement templates and specifications for external support
- Establishing shared intelligence and analysis regarding:
  - Carbon Neutral requirements
  - Digital developments, including EPR and 'Digital citizen'
  - Health and Care Model development
  - Learning from Covid
  - Staff wellbeing
  - Engagement
  - Research opportunities jointly with Universities
- Alignment of care models and programme plans to achieve the overarching CCG health and care strategy through a coordinated approach to demand/capacity modelling
- Development of ICS estate strategies to support early identification of opportunities to share services and optimise best value for the Peninsula NHP programmes
- Alignment of organisational and system digital strategies, including:
  - Digital citizen, a strategy which aims to identify opportunities for services and patients to interact digitally
  - NHSX / ATOS Blueprint
  - Input into the Peninsula digital programmes (Shared Care Record and SWP Accelerated EPR programme)

The Group is supported by ICS and regional estates and transformation leads and has been a means of collaboration and a route through which the 4 NHP programmes of Devon and Cornwall have linked to the national NHP team.

The organigram below shows how local (Torbay and South Devon) governance structures align with and input into the wider Trust, as well as Devon and Peninsula governance and meeting arrangements.

Figure 8.2 – Regional governance



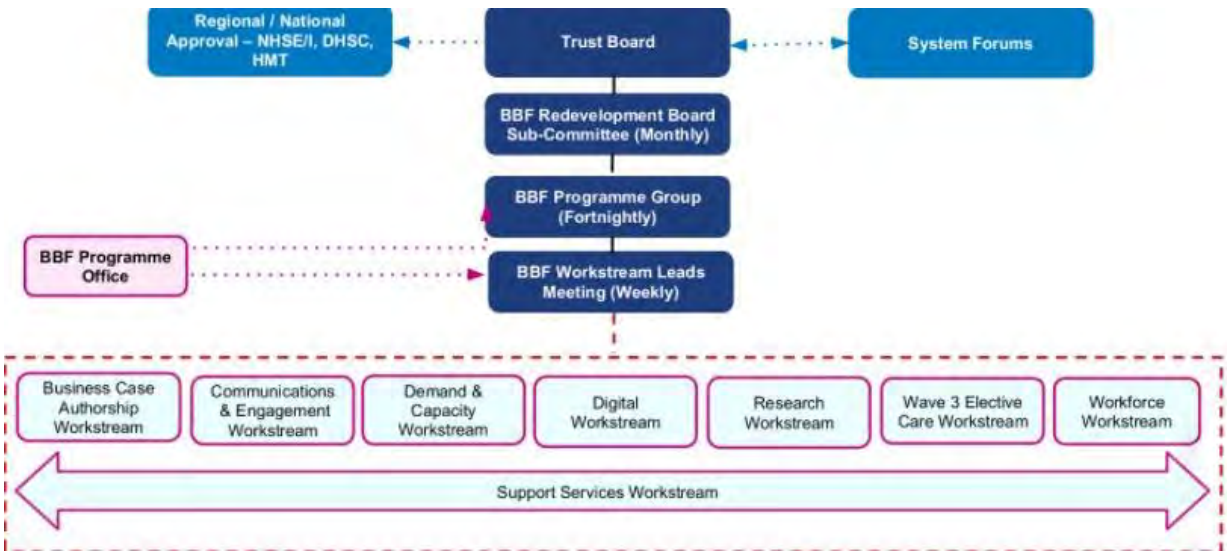
Programme Governance

The Programme is of critical importance to our Health and Care Strategy, therefore the Trust Board has full visibility and will lead the approach to each stage of the Programme, including SOC, OBC and FBC.

The Trust Board will ensure that we continue to work with our system partners, people who use our services and staff; remain aligned to Devon Long Term Plan priorities; and maintain our focus on achieving a transformation which will enable us to deliver services which will be sustainable operationally and financially.

The detailed governance structure for the Programme is shown in the organigram below. The workstreams identified in this diagram will be developed over time as the Trust progresses through the different stages of the Programme.

Figure 8.3 – Programme governance structure



The key elements of the governance structure are described below.

Trust Board

As previously described, the Trust Board is made up of non-executive and executive directors and is chaired by Sir Richard Ibbotson, the Trust's Chairman. The Trust Board will make strategic decisions on the Programme and maintain oversight of its delivery. The Trust Board is therefore ultimately accountable for the Programme.

BBF Redevelopment Board Sub-Committee

The BBF Redevelopment Board Sub-Committee will provide independent assurance to the Trust Board on the delivery of the Programme. The Sub-Committee is chaired by Professor Chris Balch, Non- Executive Director. It takes reports on all aspects of the Programme, and will ultimately be responsible for ensuring that the Programme is delivered in accordance with the agreed timetable.

BBF Programme Group – "Building a Brighter Future"

The BBF Programme Group is responsible for overseeing the day-to-day development and implementation of the Programme. It is accountable to the Trust Board through the BBF Redevelopment Board Sub-Committee. It meets fortnightly and is chaired by the Programme Director. It takes reports from all the workstream leads and ensures that risks are being proactively managed, and escalated as required.

BBF Programme Office

The BBF Programme Office will ensure that all aspects of the Programme are delivered in accordance with requirements and timetable. In addition, it will facilitate the reporting of progress and delivery of the different workstreams to the BBF Programme Group.

Dr Rob Dyer – SRO to July 2021

Dr Rob Dyer, Deputy Chief Executive and previously consultant physician (since 1998) and Medical Director of the Trust, was the SRO for the Programme until his retirement in July 2021. He was also Lead Medical Director and SRO of the Digital programme for ICS for Devon. Rob was instrumental in setting the strategic direction for our Programme and also jointly led the development of the Southwest Peninsula Digital Strategy and the Devon Health and Care Strategy. He established the NHP Peninsula Leads Group, described earlier.

Adel Jones – SRO from July 2021

Adel Jones, Director of Transformation and Partnerships, will lead our Programme through the required approval stages and ensure that transformation remains the key deliverable for the investment being made into our Digital and Estates Infrastructure.

Adel also manages our portfolio of relationships with our partners and will ensure that the Programme maintains strategic alignment with them so that the services we deliver remain fit for purpose for the people of Devon.

Adel was shadow SRO for 4 months before Dr Roby Dyer's retirement.

A senior leadership group has been established to support the handover from Dr Rob Dyer to Adel Jones, and to support the SRO as the Programme moves into OBC Stage. The group includes the Trust Chief Executive, Trust Chief Finance Officer and Director of Estates, BBF Programme Director and Health and Care Strategy Director.

Chris Knights – Programme Director

Chris reports to the SRO and is overseeing the successful delivery of the Programme against its objectives. Chris is also responsible for managing the Programme's resources and ensuring that it runs on time and to budget.

Chris has worked in the NHS for over 25 years within a variety of strategic planning and operational roles. He led the development of the £380m FBC for St Helens and Knowsley NHS Trust, which was presented to HM Treasury in 2007. He has also acted as Project Director on a number of medium-sized capital developments including the new planned care centre at Wrightington Hospital in 2014/15. Chris joined the Trust in October 2020, leaving his previous role of 8 years at Wrightington, Wigan and Leigh NHS Foundation Trust.

Dr Joanne Watson – Health and Care Strategy Director

Joanne leads our Programme from a clinical perspective and will ensure that the agreed clinical model of care is delivered.

Joanne is an experienced clinician, having held consultant positions in Taunton and TSDFT and bringing extensive strategic and operational experience which she gained over many years in a range of organisational and system leadership roles. Joanne has a national reputation in Quality Improvement, developed since working at the Institute for Healthcare Improvement 2008-09, and whilst her focus is on provider organisations she has been influential in areas of national policy such as the central role of patient experience and improvement in maternity services. At TSDFT she has been Deputy Medical Director/System Medical Director and Director of Quality Improvement since 2016. Joanne leads our Programme from a clinical and professional perspective and will ensure that the agreed clinical model of care is delivered.

Alan Welch – Associate Director of Project Finance

Alan leads our finance function for the Programme providing financial advice, information and analysis across all of the Programme workstreams. Alan ensures that the financial aspects of the Programme are connected to the Trust's wider financial planning and liaises with external stakeholders on financial matters. He has responsibility for overseeing completion of the affordability and Capital Investment Models and ensures these are agreed both internally and externally.

Paul McLean – Digital Lead

Paul leads our digital team and ensures that all aspects of the Digital programme are delivered. This role will become vitally important as the Digital OBC and FBC planning commences (subject to SOC approval). Paul has linked with the NHSX National team to ensure that all their requirements are contained within our Programme plans.

Fiona Beaumont and Lauren Parisi – People Project Managers

Fiona and Lauren will lead on the development of the workforce plans for the OBC and FBC. These plans will be a fundamentally important element of the business cases and it is therefore essential that the People Project Managers deliver robust workforce plans that are both understood and agreed across the Trust. Their role will then transition into implementation (subject to FBC approval).

Steven Williscroft – Capital Planning Manager

Steven will lead the design development phase of our Programme and ensure that the technical advisory team works closely with all key stakeholders during this phase. Subject to final approval Steven will then be the main link with the Preferred Supply Chain Partner when they are appointed and ensure that the Programme is delivered to timetable and budget.

Laura Jenkins and Helen Haynes – Communication Officers

Our two communication officers will be responsible for the delivery of the communication and engagement plans of the BBF Programme Office. A Programme of this size and complexity requires constant management of all key stakeholders, and these two posts will be vitally important in ensuring that we are able to deliver the Programme in a way that meets the expectations of all stakeholder groups.

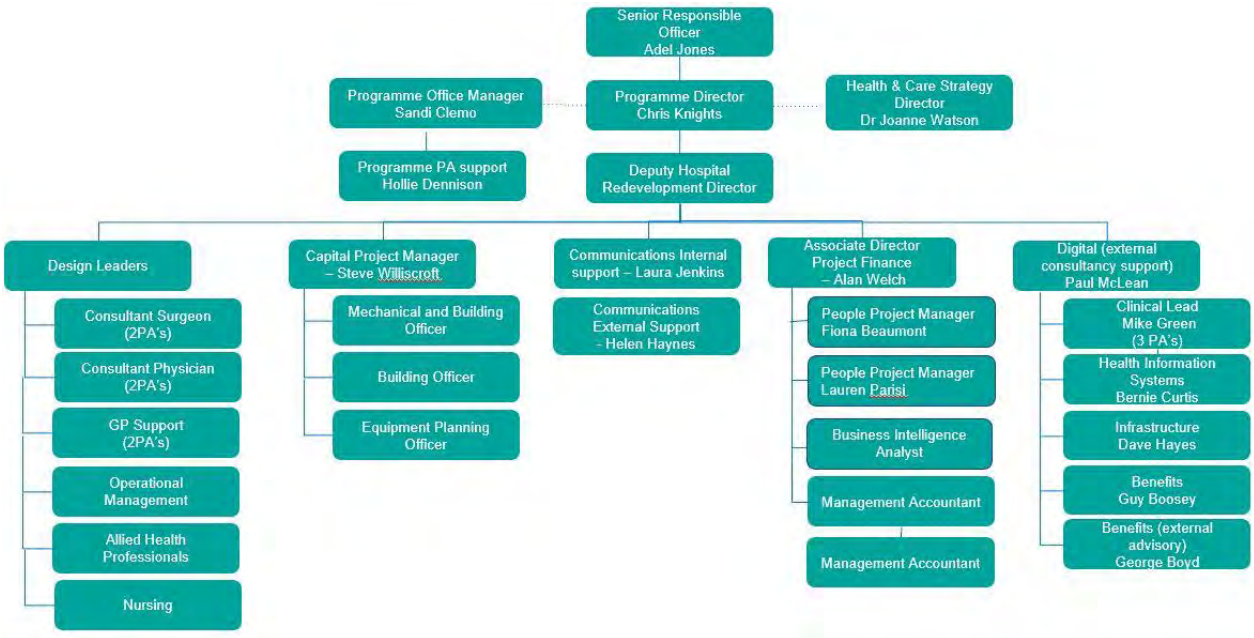
Sandi Clemo – BBF Programme Office Manager

Sandi leads the governance requirements for the BBF Programme Office, leading fortnightly workstream lead meetings which report on progress and identify workstream interdependencies to support collaborative working with status reports then provided to the BBF Programme Group and Executive Team. Sandi also manages the Project Risk register, including reporting and escalation of issues when required.

The Programme will be broadly managed in accordance with PRINCE 2 (PRojects IN a Controlled Environment) principles as well as Agile methodologies, and will be aligned to the gateway process. We will maintain a focus on the delivery of benefits, financial balance and patient-driven outcomes and follow a structured approach to risk management.

The diagram below shows the structure of our BBF Programme Office. We have developed the structure to provide sufficient time and resource to support the Programme as we progress from SOC into OBC stage. This team will be solely focused on delivery of the Programme.

Figure 8.4 – BBF Programme Office structure



As the Programme progresses the resource requirement within the BBF Programme Office will be consistently reviewed to ensure that each aspect of the Programme is successfully managed.

Appendix 9.5.2 provides more information on the roles and responsibilities of the key individuals who will be involved in the delivery of the Programme.

8.3 Programme Workstreams

Several different Workstreams have been set up to ensure successful delivery of the Programme. They report to the BBF Programme Office and are chaired by senior representatives of the Trust.

Wave 3 Planned Care Centre Workstream

This Workstream is focused on delivery of the Wave 3 Planned Care Centre, which is a key enabler of the Programme. At the time of writing we understand that the submission date of the FBC for the project is July 2021 and, subject to approval, the FBC will be completed in Autumn 2022. This workstream is chaired by Veronica Conboy, Associate Medical Director, Coastal ISU.

This project will deliver a twin theatre ophthalmic unit, which will assist us in recovering the waiting list position within the specialty, which has deteriorated during the pandemic. It is essential that this FBC is approved to ensure that this key enabler to the delivery of the Programme is in place and operational well in advance of the wider Digital and Estates Infrastructure investments under the BBF Programme.

Business Case Authorship Workstream

This Workstream has owned the timetable and plan for authorship of the SOC. Moving into OBC stage it will ensure that the OBC authorship timetable (and progress against it) are fully communicated to all stakeholders. It will also ensure that required workshop events are arranged and that appropriate attendance at these workshops is maintained. It will also oversee the drafting of the OBC and ensure that the document receives the required consideration by all key stakeholders before final submission to the Trust Board and NHSE/I. This Workstream is chaired by Chris Knights.

Digital Workstream

We have adopted a *'digital first'* approach to the Programme, reflected in the case for investment in Digital to drive forward our Health and Care Strategy presented in this SOC. The Digital Workstream will ensure that digital investment is optimised, and that digital options are business-led, not IT-led. Subject to approval of this Programme SOC, building agnostic digital investment (e.g. the EPR) will be accelerated and a Digital OBC and Digital FBC aligned with the overall Programme prepared by this Workstream.

Support Services Workstream

The role of this Workstream is to develop, agree and clearly articulate our support services strategy in alignment with delivery of the SOC and progression to OBC. Its main focus is to ensure that all clinical and non-clinical support services are reviewed and that, through Digital investment and agile working approaches, the space utilisation requirements of these services are reduced where possible. The clinical and non-clinical support services are defined as those services that do not directly have contact with our patients. Non-clinical support services include Finance, People, IM&T and Estates, whereas clinical support services include Pathology, Medical Electronics and Medical Records. This Workstream will

also ensure that only those services that are required on an acute hospital site remain on the site. This Workstream is chaired by Chris Knights.

Communications workstream

This Workstream will remain in place throughout the duration of the Programme and focus on delivery of its internal and external communication and engagement planning requirements. The Workstream is led by Dr Jane Harris, Associate Director of Communications and Partnerships.

Workforce Workstream

This Workstream is responsible for ensuring that the Workforce Plan ('Our People Plan and Promise') supports the Health and Care strategy. It is important to note that the workstream will be closely linked to the workplan of the People Sub Committee. The development of the workforce plan is a crucial element of the next phase of the Programme and the People Committee will ensure that this is being developed in a manner that is consistent with the strategic objectives of the Trust's People Plan.

Research Workstream

This workstream will ensure that the NHP research programme is developed in collaboration and through proactive engagement with research networks, academia and the local health and care system to optimise additional research capacity into the NHP. Research projects are delivered in accordance with the requirements of grants, and outcomes are shared within the ICO, the wider community across Devon as well as regional and national forums. This workstream is chaired by Dr Joanne Watson, Health and Care Strategy Director.

Health and Care Strategy

The Health and Care Strategy workstream will ensure that the Trust's Strategy is aligned with the Devon system Health and Care Strategy and, where possible, there is also alignment across the peninsula. Opportunities for delivering services in a different way will be explored. The workstream is chaired by Dr Joanne Watson, Health and Care Strategy Director.

8.4 External Advisers

The Trust engages external advisers to provide specialist skills, knowledge and input which we do not possess and is not required on a full-time basis, in a timely and cost-effective manner. Our advisers include:

- DAC Beachcroft – legal
- IBI Group – architecture, engineering and planning
- PwC – financial, commercial and business case drafting
- Turner & Townsend – technical cost advisers

The contracts which we hold with all of our external advisers contain appropriate break clauses. We also confirm that we will not enter into any further obligations in relation to OBC work with our external advisers until confirmation of OBC seed funding has been received from national and regional colleagues.

8.5 Programme Plan

Subject to approval of the SOC, the Programme Office will work towards the completion of a separation of the Digital and Estates Infrastructure elements of the Programme.

To ensure that we deliver our Digital programme as swiftly as possible, the Programme will be based on separate Digital and Estates Infrastructure OBCs and FBCs.

At their round table event on 3 March 2021, the Trust tested this assumption with the NHP National Team and was given assurance that this approach of an accelerated Digital programme would be acceptable. Clearly more detailed discussions with the National Team will be required, however in respect of the Estates Infrastructure elements to the Programme, the current planning assumption is that the Trust is looking towards an FBC submission in October 2023. This requirement is necessary given the significant site enabling works that will be required in advance of the main build for the project. Nonetheless, we are now planning for construction to commence in January 2025.

The table below provides an indicative timetable for delivery of the respective Programme OBCs and FBCs.

Table 8.2 – Programme Plan

	Milestone	Date
Combined	Start of SOC development	Q4 2020
	Submission of SOC	July 2021*
	Submission of OBC (digital)	December 2021*
	Submission of OBC (infrastructure)	October 2022*
	Submission of FBC (digital)	July 2022*
	Submission of FBC (infrastructure)	October 2023*
	Start of site enabling works	January 2024**
	Start of construction works	From January 2025**
	Completion of construction works	2029***

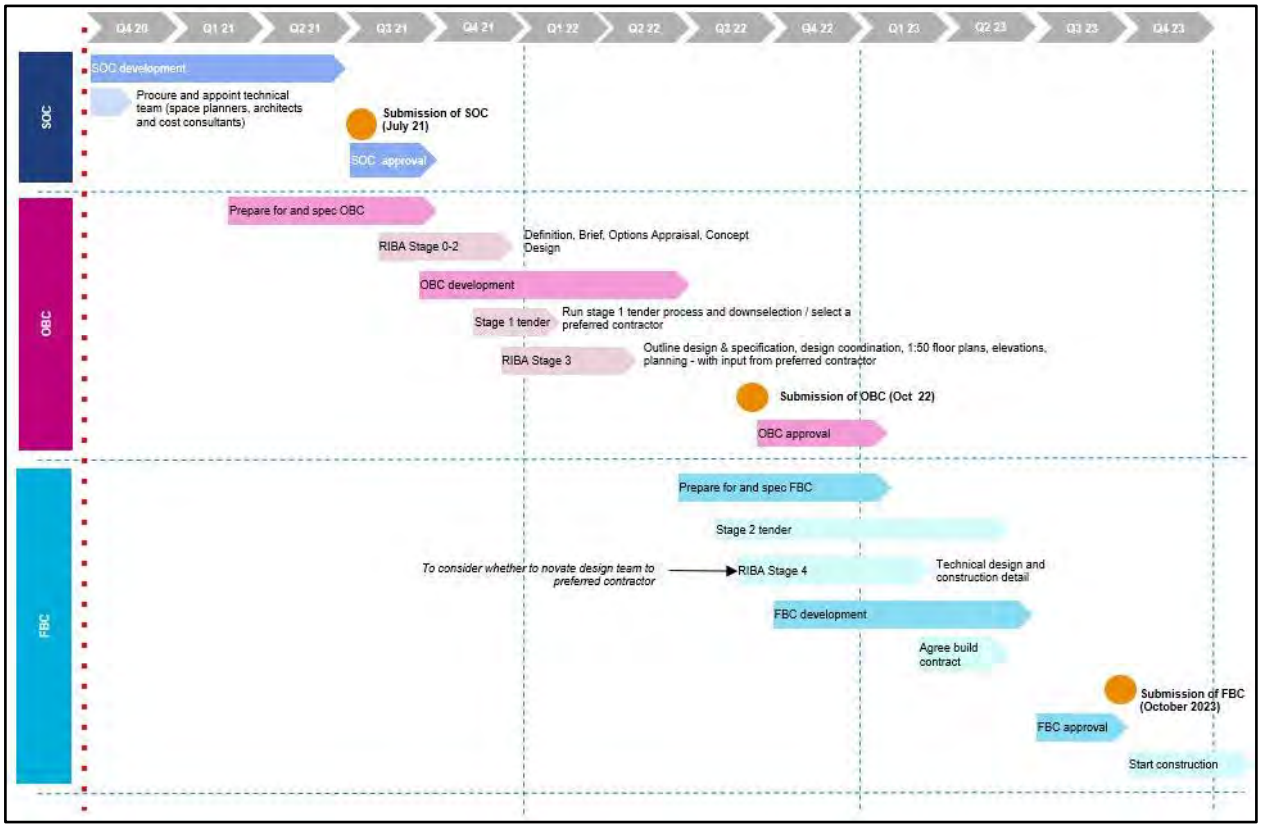
* 'Critical path' items.

** Dependant on advice from national team

*** Dependent on the design option selected.

The timeline below gives a high-level overview of the activities which have taken place since commencement of SOC development in Q4 2020 and activities which will take place up to the start of construction:

Figure 8.5 – Timeline of activities



8.6 Gateway Reviews / Approvals Process

In their letter of 8 April 2021 the NHP team made it clear that the release of funding will be tied to gateway reviews that will be used to provide regular formal review and challenge points to ensure that projects are being planned, designed, procured and built in accordance with the NHP's objectives.

The NHP team's ambition is to be able to sponsor and champion business cases without qualification by working with programme teams to ensure that individual programmes fully reflect targets for the use of repeatable and standardised design, modern methods of construction, digital and net zero carbon that the Government has set.

We will therefore ensure that our BBF Programme Office is able to deliver these requirements and that gateway reviews are accommodated within our project timetable in accordance with guidance to be issued.

8.7 Budget

The capital allocation for the Programme is £350m (including fees, inflation and VAT) and we will ensure that the allocation is not exceeded. We will be adding a further £20m of our own resources to bring overall spend to £370m.

We received a 'seed' allocation of £3.7m to fund development of the SOC. This spend is reported and reviewed on a monthly basis at the BBF Redevelopment Committee. As the Programme progresses to OBC and FBC stages we will require further investment. The table detail below summarises our requirements

Table 8.3 – Programme budget requirements

Combined	Description	SOC £'000	OBC £'000	FBC £'000	TOTAL £'000
	Project Management/Business Case Development	990	3,369	2,155	6,514
	Architect & Cost Consultants	1,980	9,812	3,385	15,177
	Communication and Engagement	178	250	250	678
	Miscellaneous costs	552	517	1,119	2,188
	Total	**3,700**	**13,948**	**6,909**	**24,557**

Seed allocation

The £3.7m seed allocation provided to support the development of the SOC will have been fully utilised by 31 July 2021. On this basis, in order to ensure continuity of the project, an OBC seed allocation was provided to NHSE/I on 24 June 2021. This allocation request was for a total of £13.94m, and would cover the costs associated with the project until 31 January 2023.

The seed allocation will allow all of the planning associated with the development of the OBCs for Digital and Estates Infrastructure to continue in accordance with the Programme timetable and will cover the costs of the Programme Office, technical and professional advisers, digital technical team and communication and engagement.

A further requirement for the seed allocation requirements at FBC will be made at an appropriate time.

PUBSEC costing

As highlighted in part *8.5 Programme Plan* the programme team are now planning on the basis that the main construction element of the Programme will commence in January 2025. The table below highlights the PUBSEC indices that have been applied to the Programme over its life cycle.

Figure 8.6 – PUBSEC indices

The resultant inflation indices used have been set out below.

Source	Period	Index	Source	Period	Index	Source	Period	Index
PUBSEC	1Q 2020	264	BCIS	4Q 2022	276	T&T Est	4Q 2025	307
PUBSEC	2Q 2020	264	BCIS	1Q 2023	279	T&T Est	1Q 2026	312
PUBSEC	3Q 2020	261	BCIS	2Q 2023	281	T&T Est	2Q 2026	314
PUBSEC	4Q 2020	260	BCIS	3Q 2023	283	T&T Est	3Q 2026	316
PUBSEC	1Q 2021	259	BCIS	4Q 2023	287	T&T Est	4Q 2026	318
PUBSEC	2Q 2021	260	BCIS	1Q 2024	290	T&T Est	1Q 2027	323
PUBSEC	3Q 2021	263	BCIS	2Q 2024	292	T&T Est	2Q 2027	325
PUBSEC	4Q 2021	265	BCIS	3Q 2024	293	T&T Est	3Q 2027	327
PUBSEC	1Q 2022	268	BCIS	4Q 2024	297	T&T Est	4Q 2027	329
PUBSEC	2Q 2022	269	BCIS	1Q 2025	301	T&T Est	1Q 2028	334
PUBSEC	3Q 2022	272	BCIS	2Q 2025	303	T&T Est	2Q 2028	336
			BCIS	3Q 2025	305	T&T Est	3Q 2028	338
						T&T Est	4Q 2028	341
						T&T Est	1Q 2029	346

8.8 Change Management Strategy

The management of resources within the NHP to meet the degree and pace of the change required for the Programme will be jointly managed by the Programme Director, Chris Knights, and the SRO, Adel Jones.

The Programme team will be reviewed and appointed to, in line with the degree and pace of change required for the Programme, with the appointment of specialist advisers where expert knowledge and skills are required.

A review of the governance, systems and processes within the Programme Management Office function, developed during the SOC phase of the Programme, will be undertaken to support a methodology of continuous improvement.

A team of Design Leaders has been recruited, who will undertake a pivotal role in not only bringing knowledge and experience from their own disciplines to the Programme but will also provide invaluable insight into the future design of health and care pathways as we collectively develop this new and transformative care model.

The collaborative, multi-professional approach adopted in the development of the Health and Care Strategy, with both clinician and operational representatives from across the Trust as well as representatives providing patient and carer perspectives, will also be continued. A culture change campaign will be developed, aligned to the Trust's existing People Plan, as part of the OBC phase of the Programme. The Programme Team is cognisant that the delivery of sustainable clinical and financial benefits will not be optimised without a planned, considered approach to cultural change management. This will be a key objective of the Workforce Workstream.

The workforce aspects of the organisational transformation required will be managed and delivered through the organisational People Plan. The Plan is already working to deliver the current needs of our workforce, and also has a long-term focus to equip our people to maximise the use of resources in the most effective ways possible. The People Plan encompasses all the work across the Trust relating to workforce transformation. The work planned falls under the NHS four Pillars: "Looking After our People", "Belonging in the NHS", "New Ways of Working" and "Growing for the Future", as well as a fifth pillar we have created: "Creating the conditions to enable transformation".

The work already started directly relating to our future needs includes:

- Creating the processes and policies to support a Just and Learning Culture
- A refresh of our organisational values
- Leadership and management skills
- Developing an employer brand to attract applicants to work in South Devon
- Launching an International Recruitment Hub
- Creating a Trust Resourcing Hub
- Creating and embedding a consistent, robust approach to workforce planning, owned by the services, facilitated by the People Team
- Developing new approaches to career pathways
- Assessing digital literacy
- Creating an improvement methodology, based on QI and OD
- Continuous two-way engagement with our people
- Improving our awareness of EDI issues and addressing inequalities.

Future initiatives will include:

- Rationalising our role profiles in light of service redesign
- Skills analysis
- Engaging with our local communities on career opportunities
- Learning and development strategies
- Consultation and engagement
- Redundancy policies and skills
- Selection processes
- Re-training opportunities.

The delivery of the People Plan is led by Associate People Director Sarah Lehmann, with support from the People Project Managers.

Learning and reflections relating to the organisation's experience from the Covid-19 pandemic will further support our approach to change management, and this will be embedded within our engagement and communication strategies to meet the objective of empowering and engaging staff both within our organisation and the wider system, and our patient population.

Design Leaders

The Trust has taken an innovative approach to the planning of this Programme SOC. In addition to the Programme Office function noted earlier, we have seconded 25 design leaders from a number of disciplines across the organisation – including Clinicians, Nursing, Allied Health Professional, Community Nursing, Operational Management, Health Promotion and IM&T – to work with the Programme Office for one day per week. The intent of these appointments is to bring support from a multi-disciplinary team into a number of key elements of the Programme, including:

- The development of new clinical pathways;
- The introduction of new digital systems;
- The development of a new workforce plan for the Trust; and
- The development of innovative design solutions for the Estates Infrastructure element of the Programme.

The design leaders were appointed in March / April 2021, and have undertaken a detailed induction programme. Their input will help to create a new, innovative and sustainable solution for the Torbay area.

In addition, we have also taken the step of recruiting a range of junior doctors to help drive the future clinical innovation that the Programme Office is focused on delivering.

Our approach to communications and engagement

Aim: to inform, involve and engage our people and communities in our vision to enable the successful delivery of our Programme.

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 system partners 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.

We are working in conjunction with our system communications and engagement teams to develop our plans together, given the interdependencies around engagement and consultation. We are planning to co-host as much of the engagement, meetings and discussions together as we move forward as many of the changes to the way services will be delivered will affect people and staff across the county. We also plan to use the Devon Virtual Voices Panel to seek views and feedback as well as testing our messaging for accessibility and understanding.

By working closely together, we can avoid duplication, reduce confusion and give clear and consistent messages while engaging people in meaningful conversations about change. We can also ensure that any elements of our plans which require public consultation are supported in a robust and timely manner.

Our partner mapping is currently in development and engaging with those who are often ‘seldom heard’ will be a priority for us, particularly given the significant levels of deprivation we have in Torbay and South Devon.

Our partner mapping will directly inform the development of our engagement plan, which will define and target activity by audience. Audiences will include staff, patients and their representatives, carers, TSDFT Governors and members, GPs, local government scrutiny, the general public, local councillors, MPs, Healthwatch, voluntary community and social enterprise partners, local charities and local health system partners.

Engagement is key to the successful delivery of our Programme – it is not enough to inform, share and communicate. We need to actively listen to and involve our people in the development of our plans and show how we have done this. We need to work with and for our people.

We are looking at embracing a community asset-based approach where we will work with our voluntary, community and social enterprise partners who are already working with and trusted by many of the people we need to reach.

Such an approach will focus on empowering (and commissioning) our VCSE partners not only to share information about the Programme and how people can have their say but also to undertake focus groups and semi-structured interviews on our behalf. It will provide us

with much richer insight that would be gained from a more traditional NHS approach to engagement and consultation.

Benefits Realisation

The Strategic Case outlines the benefits to our staff and patients of implementing the Programme. In order to help ensure the successful delivery of these benefits, a robust benefits realisation approach needs to be put in place.

A benefits register will be developed for the OBC, and is likely to include:

- Benefits by category (e.g. design, estate, organisational, patient,
- Stakeholders
- Enablers required
- Desired outcomes
- Current baseline
- Target date for achieving the benefit
- Person responsible
- How we will measure whether the benefit is being achieved
- Progress

Risk Management

This section describes how we identify and manage risks associated with the Programme. A risk register has been developed using the following approach to risk management:

- Identification and prioritisation of risks
- Assessment of the probability of those risks occurring
- Impact on the Programme of those risks.

The Strategic Case set out the high-level risks to the Programme.

Workstream level risks are currently managed through the Workstream leads and are escalated to our BBF Programme Group and the Trust Board as required.

Programme-level risks are reviewed at the Programme Group meetings and at the BBF Redevelopment Committee and Trust Board as required. The Programme Group meetings are fortnightly and have a monthly risk agenda item. The Board Assurance Framework is reviewed each month at the BBF committee and any matters requiring escalation through to the Trust Board are addressed and agreed at this meeting.

Evaluation

Post Project Implementation Review process

In 2020 our Finance, Performance and Digital Committee (FPDC) agreed a process of post-project implementation reviews, referred to as the Project Implementation Review (PIR) process.

The PIR process aims to ensure that we achieve maximum learning from our programmes and projects and that this learning helps us to make effective investment decisions. The key elements of the PIR process are set out below:

1. All business cases will be expected to articulate clearly the benefits of the investment and the likely timeframe for delivery of the benefits post-implementation.
2. At the point the FPDC makes an approval to proceed an active conversation is held to agree whether a business case requires a full PIR; the key questions that the committee will want the PIR to address; and the timeframe for the PIR.

3. The project details will be captured in full on the prioritised PIR list with a target date for delivery of the PIR.
4. The Finance Delivery Group (FDG) will be the executive-led group that will review the PIR list on a monthly basis to ensure deadlines are met.
5. The FDG will provide a six-monthly report to the FPDC on learning from the PIRs.
6. A standardised template is used to capture learning and included in all PIRs.

NHS

Torbay and South Devon
NHS Foundation Trust

BUILDING A Brighter Future

Appendices

Our Estate REIMAGINED
Our People AT THEIR BEST
Our Digital CONNECTING

Contents

9.1 Strategic Case

Appendix 9.1.1 Health and Care Strategy

Attachment called **"Appendix 9.1.1_Final Torbay and South Devon Health and Care Strategy with Appendices"**

Appendix 9.1.2 Planned Care Appendix

Planned Care across Devon

1. Current position

There is significant clinical and service transformation occurring across Devon, with a number of system-level decisions and recommendations already identifying key opportunities to enhance the health and care outcomes of the Devon population. The *Peninsula Clinical Services Strategy* in particular identifies a number of clinical specialties and pathways that have the potential to collaborate for improved delivery.

There is a pressing need for a strategic and transformational approach to specifically tackle our challenges in delivering planned care, given long waiting times both pre and post pandemic. We need to be ready, with agreed plans, to take advantage of emerging funding and workforce opportunities and deliver safe, resilient and affordable planned care services. This is a key priority within Devon ICS's long-term plan and a significant indicator of performance to build confidence in the Devon system. Both short term recovery requirements as a result of COVID-19 and more strategic service transformation are required.

An initial review of the Devon planned care system has already taken place with the purpose of obtaining consensus and alignment across Devon partners on the need for transformational change to address the key challenges in planned capacity, and identify the high impact changes needed. A shared aim for this work was agreed which is '**To create the planned capacity needed to deliver safe, effective and timely care for the people of Devon**'.

Through engagement with senior clinical, operational and commissioning leaders, the development of system-wide Protected Planned Capacity has been identified as a key transformational change for planned care. Through this high-level engagement process, a range of options have been developed for further and more detailed work and wider engagement with clinical and operational leaders.

A driver for the timelines of this project was for the strategic direction for planned care and options for delivery to shape and inform Devon Trusts' development of their Strategic Outline Cases for the New Hospital Programme (New Hospitals Programme) all of which will be submitted by August 2021.

2. Setting the strategic direction for NHP programmes

It is clear that although the list of options provides some clarity for the three Devon Trusts (NDHT, TSDFT and UHP) that have received NHP funding allocations, there is further work required to understand the full implications of the options on configuration of planned capacity overall and specifically what level/type of planned care should be provided on individual DGH sites.

Detailed design for the agreed options for planned care options will take some months to deliver and may be subject to wider public engagement, and this will need to be considered within the timescales of our business cases to deliver our Programme.

3. Setting the strategic direction for NHP programmes.

In addressing the requirement for planned care reconfiguration, the three sites have all agreed that the following should all be planned for within the context of the respective SOC's

- Change is likely to be seen across all DGH sites
- Success requires an agreed system strategy
- NHP is not the only driver for change, but requires a level of urgency
- We will collaborate to be transformational as a system

4. Devon Statement of intent

Our shared aim was agreed as 'To create the planned capacity needed to deliver safe, effective and timely care for the people of Devon'.

This will require the development of Protected Planned Capacity for our most challenged specialties that will:

- Support increased productivity by 18%.
- Reduce cancelled activity due to emergency pressures.
- Reduce waiting times for these specialties to at least national standards without additional investment in Independent Sector support to do so.
- Enable a reconfiguration of inpatient capacity for planned care across and between the DGHs in Devon.

5. Links to ongoing system work

The initial assessment of the system has considered and linked in the system recovery priorities of the Devon Planned Care Board where these supports and shape the strategic direction for planned care. Therefore, the development of options for planned care in Devon will be firmly rooted in commissioning decisions already made in relation to the continued provision of Emergency Departments in all Devon District General Hospitals (DGHs), continuing work to optimise day case procedures for planned care and modernising outpatient services.

Three of the four Trusts in Devon have been selected for New Hospitals Programme Funding to address the need to replace aging facilities and redesign their hospital-based services. Therefore, there is an urgent need to agree on a collective system direction and strategy for planned care in advance of Trusts' NHP strategic outline submissions.

6. Why is change in the Devon planned care System required?

The following points highlight why the initial assessment into the Devon planned care system took place:-

- **Projected demand for emergency inpatient care could outstrip current DGH bed capacity as early as 2026/27 if demand is not mitigated, and by 2036/7 at the latest even with full mitigation**
  By 2036/37 at the latest, all inpatient beds may be occupied by emergency admissions alone. In 2019/20 the Trusts were operating at 94% capacity and waiting lists for planned care were steadily increasing pre-Covid.

- **We need to create protected planned capacity for Devon so that we can safely, sustainably and reliably deliver waiting list standards**
  We need sustainable solutions to our workforce, infrastructure and financial challenges

that allow us to be confident we can safely and consistently deliver planned care within nationally mandated targets, and to protect that capacity from the pressures of unplanned care demand

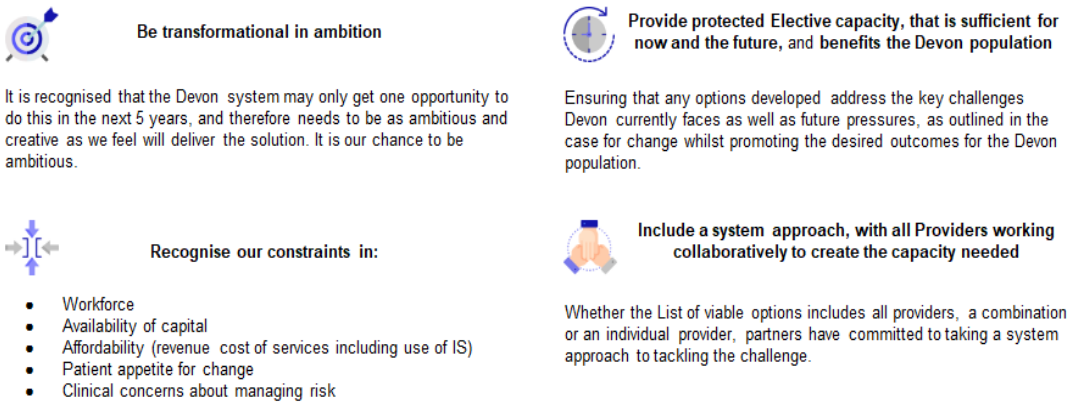
- **We need a commitment to a System-led, networked approach for planned care**
  Devon ICS cannot create the workforce, nor afford the cost of, each DGH independently managing planned care demand. By sharing a network of protected planned capacity across Devon and re-configuring care for the highest acuity cases, we can improve the quality and affordability of planned care for the population

- **We need a strategic partnership with the Independent sector, but not unnecessarily increase the cost/activity we send there**
  Devon spends c£25m pa in the Independent Sector to manage lower acuity patient waiting lists. By transforming planned care we can invest this money more strategically with IS partners and develop NHS services to address ongoing capacity gaps.

7. Option appraisal criteria

In developing the options noted later in this section, the initial assessment reviewed each option against the criteria noted below (see *Figure 1 - Planned care review criteria).* The options should be transformational in ambition, ensure that planned capacity is essentially future proofed, that all providers should work collaboratively in delivering the options and that the constraints in delivering the system reform should be recognised.

Figure 1 - Planned care review criteria

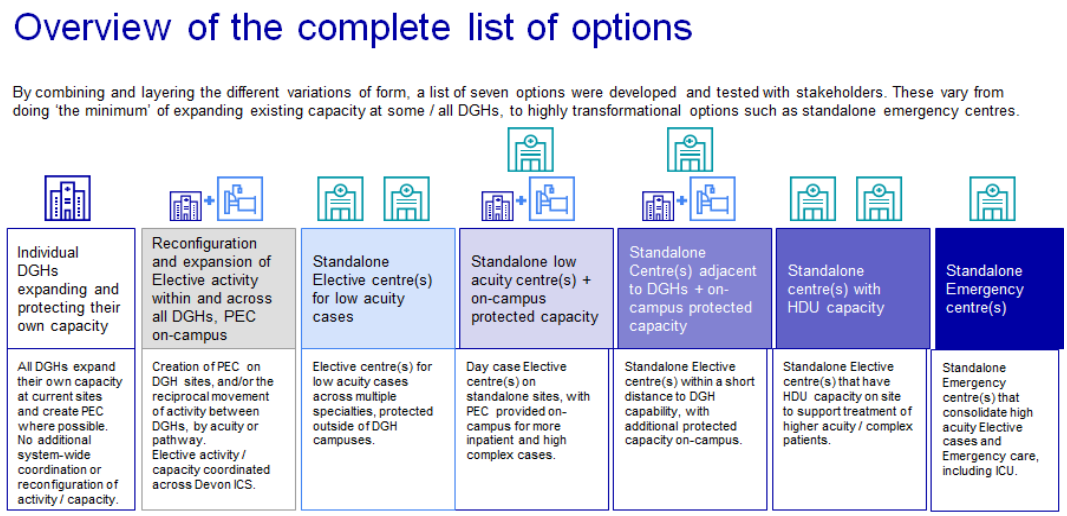


8. Planned care review options

The following two graphics highlight the scope of the initial option appraisal and the short-listed options that will now be taken through to a more detailed assessment.

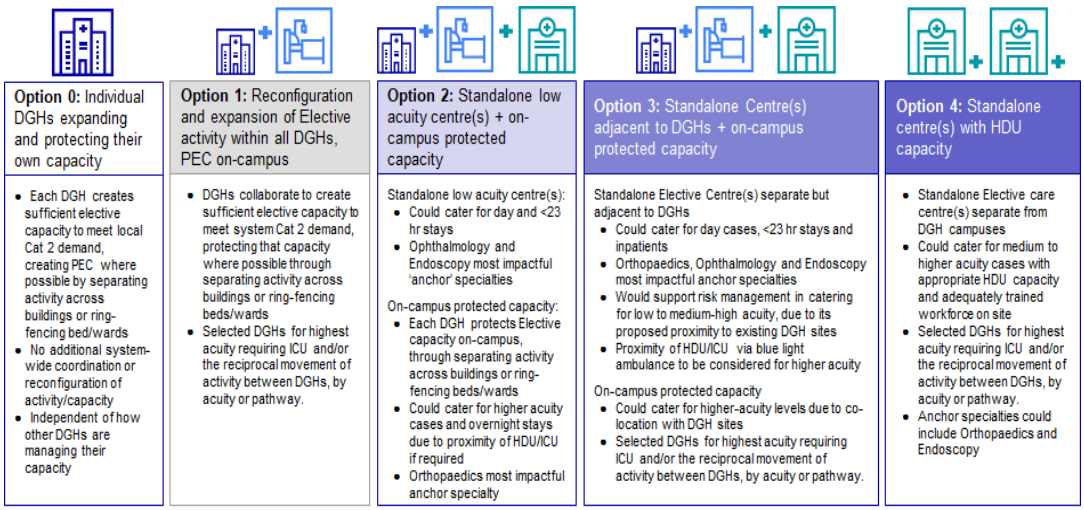
The initial long list developed 7 options ranging from all Trusts looking to protect their own planned care capacity with little or no system working through to stand alone emergency centres with protected capacity for high acuity planned care cases including the provision of HDU capacity. (see *Figure 2 - initial long list of options*)

Figure 2 - initial long list of options



Having then undertaken a review of all the long-listed options, the options noted below (see *Figure 3 - short listed options for planned care*). Whilst option 0 has to be taken forwarded for further assessment, this is essentially only to highlight the benefits associated with remaining short-listed options. Therefore, the initial review will look at four options.

Figure 3 - short listed options for planned care

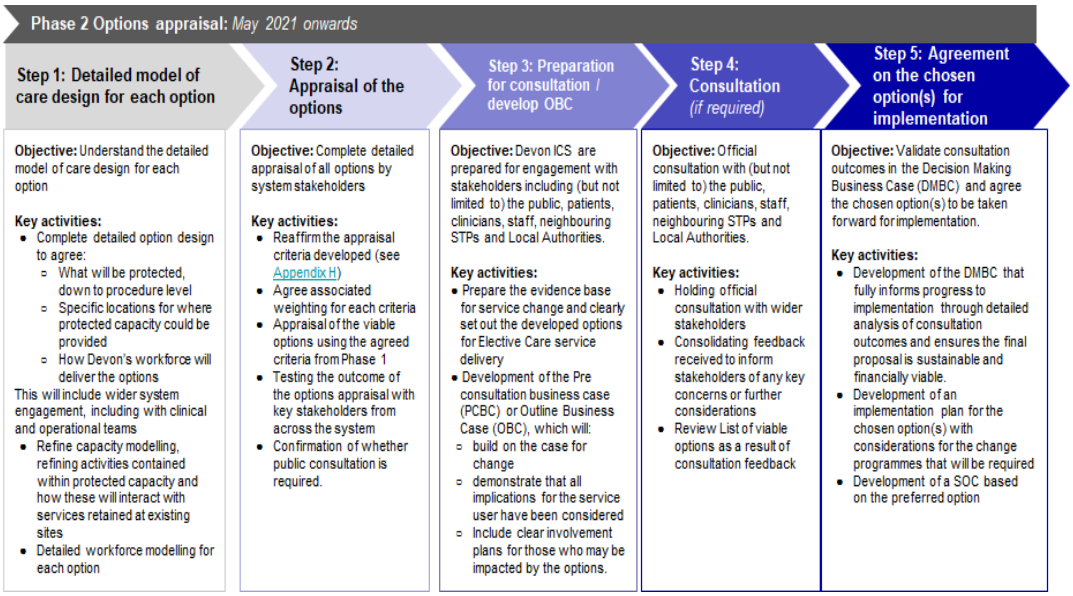


- **Option 1 – Reconfiguration and expansion of Planned activity with all DGH's:-** all sites would look protect their planned activity to meet the demand for services. Some sites within Devon would be selected for HDU care and activity requiring this support would transfer to these sites.
- **Option 2 – Standalone low acuity centres and protected on site activity:** low acuity centres would be created to manage activity on a regional/sub regional basis. Each site would then look to protect its planned activity through development of separate facilities.
- **Option 3 – Standalone planned centres adjacent to DGH's:** Stand-alone planned centres would exist adjacent to the DGH sites. These centres would include all planned and day case activity for the regional/ sub regional areas except for the highest acuity patients that would travel to the high-risk sites.
- **Option 4 - Standalone centres with their own HDU capacity.** – all planned activity would be undertaken in standalone centres away from the DGH sites. This would include all HDU cases.

9. Next steps

The extract from the Devon Health and Care review (see *Figure 4 - Next steps in the development of the options appraisal.*) illustrates the next steps that Devon CCG will be undertaking in the development of the option appraisal.

Figure 4 - Next steps in the development of the options appraisal.



Depending on the scope and scale of the change that is being proposed, the graphic highlights that consultation on the options could be required. This process will be led by Devon Clinical Commissioning Group, though clearly the three NHP sites will be fully involved with and engaged in the option appraisal.

10. Risks

The risks of the planned care system reconfiguration are noted below:

- **Population willingness to travel for certain procedures**
  Further work may be required to identify what members of the population are willing and not willing to travel for as this could have implications for the viability of certain options and how patients could be chosen to use planned sites.
- **Inpatient anxiety and resistance to hospitals and bed admission**
  Factors such as antibiotic resistance and COVID have caused patient resistance to being admitted to hospital or staying overnight where it is known that covid patients are being treated there. However improved outcomes for patients seen in cold sites and wider socio-economic advantages for the population highlight the benefits protected capacity can offer
- **Resistance to change - motivating the population to see the benefits**
  The appetite for change in the population could be low. Change management may be required in consultation and implementation for the population to accept some of the options, requiring the development of a cultural change programme.
- **Managing disruptions to pathways within workforce constraints**
  Certain specialities, such as Orthopaedics may require further exploration of patient pathways and whether there is adequate workforce resource within these specialities to facilitate changes to these.

- **Resistance to change - motivating partners to see the benefits**
  There may be the resistance if providers believe they could be financially worse off if they 'give up' or 'share' certain services they currently relieve a good return on.

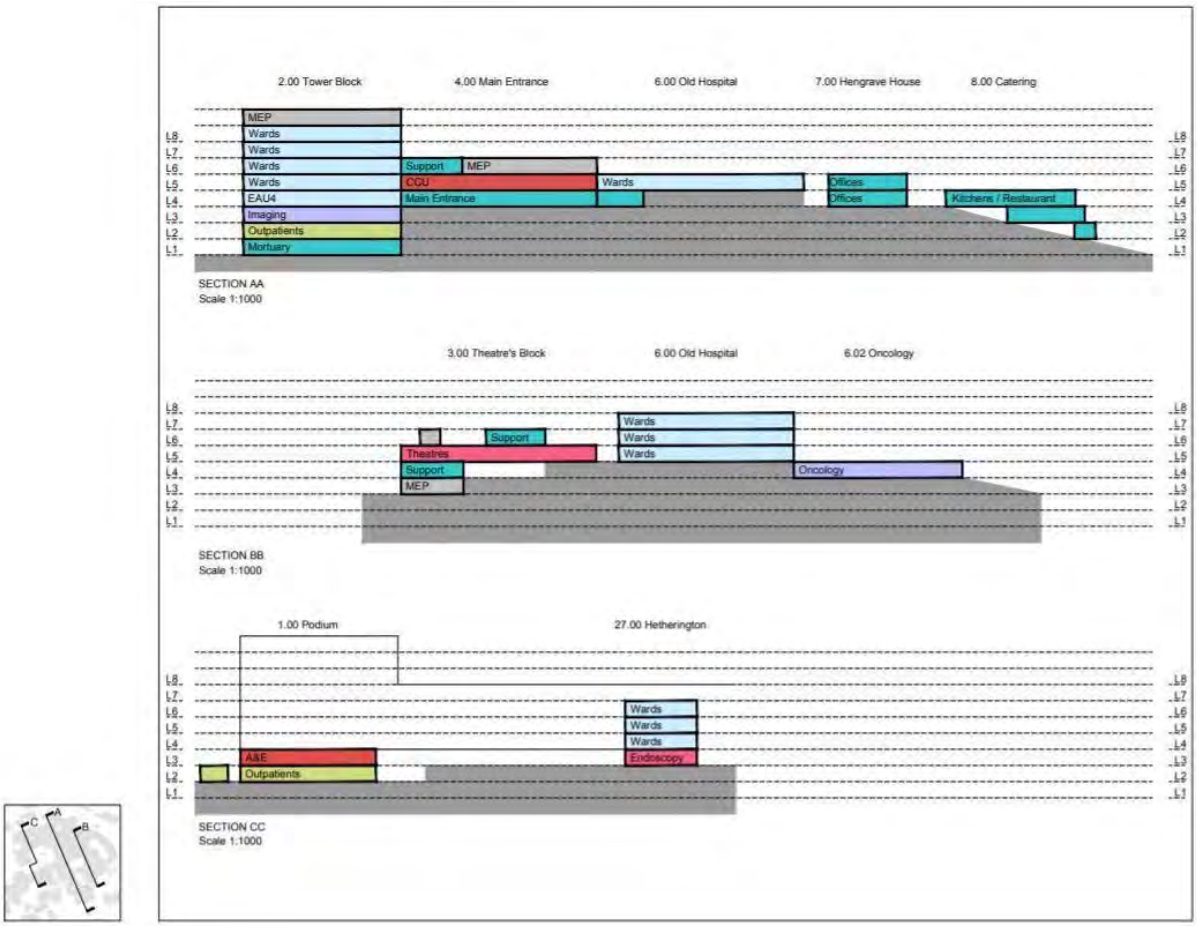
11. Summary

As a sign of the engagement that has taken place across the Devon system, each of the three NHP sites have agreed that this section on planned care will be replicated in each of the respective Strategic Outline Cases. Each Trust recognises that more detailed business case submissions in the form of the respect Outline Business Cases (infrastructure) cannot be completed until this review process has both been completed and agreed. This agreement on the future provision of planned care services will then form the basis of the respective Trust infrastructure plans.

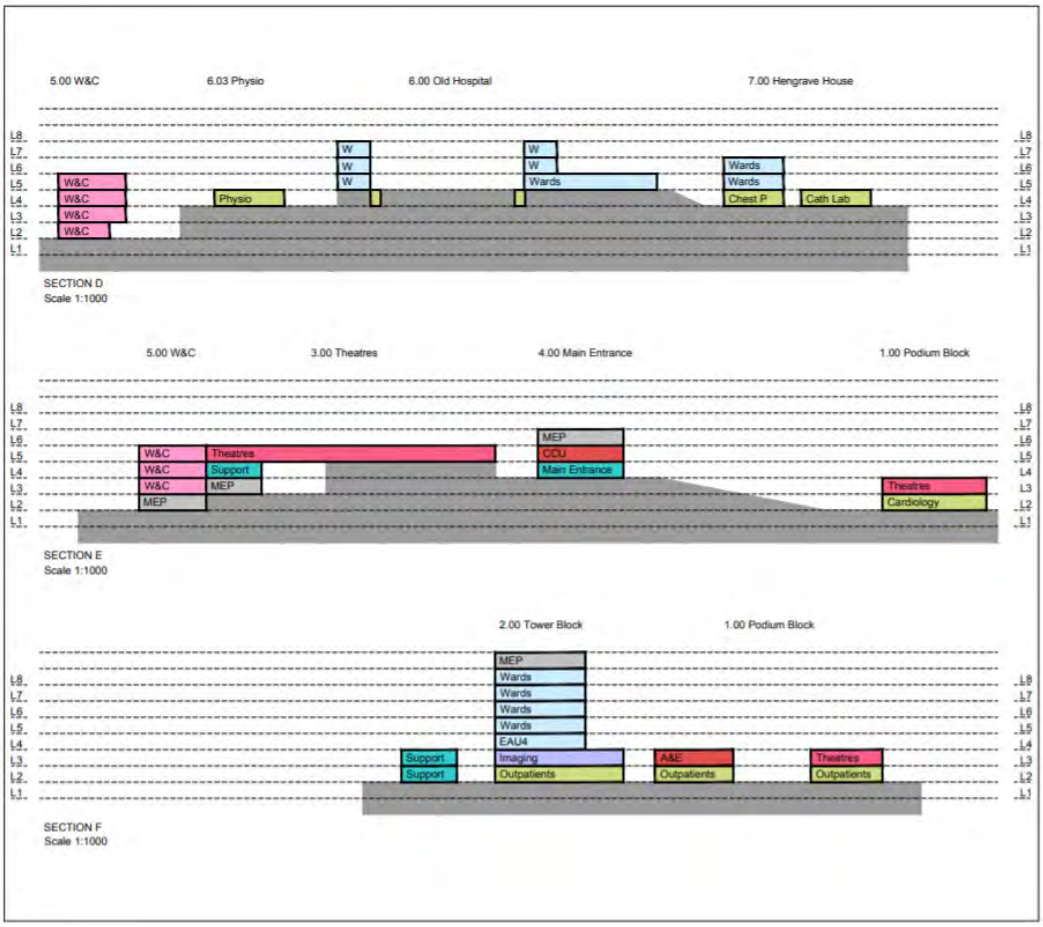
It is also important to note that each NHP Trust recognises the requirement for planned care system reform and is fully supportive of the requirement for the review and its timing.

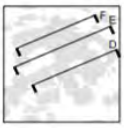
Appendix 9.1.3 Departmental sections

Sections AA, BB and CC



Sections D, E and F





Appendix 9.1.4 Letters of Support

We are grateful to have received letters of support from the following partners and key local stakeholders.

NHS Devon Clinical Commissioning Group

Liz Davenport
Chief Executive
Torbay and Southern Devon Healthcare NHS
Foundation Trust
Lowes Bridge
Torquay
TQ27AA

NHS Devon CCG
County Hall
Topsham Road
Exeter
Devon
EX2 4QD

01392 205 205
D-CCG.CorporateServices@nhs.net

12 July 2021

Dear Liz,

The purpose of this letter is to indicate that Devon Clinical Commissioning Group (CCG) Governing Body support the proposals set out in the Strategic Outline Case (SOC) for the development of the T&SD New Hospital Programme (NHP) scheme.

As a system we are aware of the need to invest in our hospital and digital infrastructure to address the quality and sustainability of the services we provide the people of Devon. Your case sets out the need for that investment but also indicates how you will ensure clinical services are developed and improvements made, not only as part of your NHP scheme, but in delivering the Devon Long-Term Plan (LTP)

In reaching our conclusion to support your SOC we have considered the following:

- Level of transformation, collaboration and alignment with the Devon Long-Term Plan (LTP) and how the SOC supports the system as a whole.
- Alignment with system demand and capacity modelling. Which sets the context for developing models of care which improve quality and outcomes, minimises unwarranted clinical variation, supports shared learning and innovation to modernise the delivery of care and makes the necessary changes to develop a more affordable service offer.
- Opportunities identified to improve and integrate all aspects of the patient journey, to help reduce health inequalities and unnecessary bed-based care, and how this will be further developed through conversations with local communities.
- Cost implications in the delivery and transformation of services. How the case demonstrates and evidences containment and cost reduction and cost-effective innovation in the models of service delivery.

The CCG has invested significant time and energy in looking carefully at both our population's health and care needs and the inequalities that need to be addressed in the Devon system This SOC indicates that this has been considered alongside the need to transform the way we provide care to our population in line with the LTP.

It is clear that a good level of collaboration across the NHP schemes and wider networks has begun, and this will be essential when finalising the LTP and service requirements across the system. Each NHP scheme will need outline in their final solution how their schemes will work together to deliver the system requirements.

As an ICS, all partners have agreed to work together to ensure high quality, sustainable services acknowledging that the detail of the individual hospital plans need to work for the system as whole, standardising and modernising services where it makes sense to do so and focusing on cost containment and cost reduction in the delivery of transformation of services.

Investing in the hospital infrastructure is a key enabler to deliver this change and will be significant in supporting the transformation in the way services are delivered as set out in the LTP. Which gives us a once in a generation opportunity to transform the way we deliver health and care for our population.

To transform the way our population receives their care we need to develop the concept of a hospital without walls and look at how care is delivered in the community, to reduce the need for hospital care wherever possible. When care in a hospital is required, people will be treated in modern facilities with faster diagnosis and delivery of care – improving experiences for those who receive our care but also those who deliver it.

Your SOC evidences steps towards transforming the delivery of clinical services across Devon, through the collaboration between the three NHP schemes and the alignment of the core assumptions. Further context on how this transformation will be developed will be an important of the OBC.

We recognise that the SOC supports the national objectives for the NHP – reducing backlog maintenance and estates risk, and modernising care by delivering the hospitals of tomorrow. However, we welcome the evidence within the case that you plan to utilise this programme of work to support transformation in the Devon LTP.

The NHP investment opportunity at T&SD will also allow for the modernisation of hospital estate to support the changing service delivery model.

Within the Devon LTP there is recognition of the need for significant clinical and service transformation. The Peninsula Clinical Services Strategy that ran in 2019, delivered a set of recommendation that were agreed by system leaders in February 2020.

These significant proposals for substantial improvements in quality, access and sustainability of services include:

- Implementation of the National Model for Surgery in Children in the Peninsula through a safe, high quality and sustainable surgical model that delivers care within national waiting time standards, and to work with the Regional Specialist Centre (BRHSC) to maximise the sub-specialist services provided

within the Peninsula to reduce the need for children and their families to travel to Bristol for treatment.

- Minimising the need for inpatient admission for paediatric surgery by maximising surgery in children day case rates across the Peninsula in line with 'upper quartile' BADS and GIRFT best practice.
- Developing and implementing at pace an integrated model of paediatric medical care that reduces the need for children and their families to attend hospital and be admitted for care based on best practice, standardised model for acute and community paediatric services that brings together acute, community, mental health, primary care, social care, with strong links to education and the voluntary services sector.
- Addressing the challenges in delivering elective care, given long waiting times both pre and post pandemic through the development of system-wide protected elective capacity proposals. These will build on continuing work across our system to ensure the delivery of best practice in elective care taking account of BADs and GIRFT recommendations.
- Developing the proposals for improved access to timely diagnostic services both within the hospital and through the development of community diagnostic hubs providing additional capacity and enhanced access within more local community settings.
- Reducing the need to access emergency care through implementation of integrated care across community for adults and children working with statutory providers, PCNs and non statutory sector together to provide community support alongside the delivery of a consistent community urgent care offer which is in line with the national specification and policy and offers an alternative to ED attendance.
- Addressing manpower and other capacity challenges by increased networking and implementation of new models of delivery which better balance the challenges of providing equitable access to specialist services and local access to care.

All NHP programmes have acknowledged options for reconfiguration of some services and this may need to be incorporated into capital planning within Outline Business Cases. As NHPs progress, any future decisions around reconfiguration options will need to follow national guidance on engagement and, where required, formal public consultation. This work will be progressed across the Peninsula through LTP implementation governance.

The digital SOC describes two favoured options for the development of a shared EPR system either with RDE and NDDH in SEND or as a whole peninsula collaborative approach. Either will support the clinical strategy across SEND, creating seamless care and mitigate barriers to accessing care and all the benefits that can be realised from the same will be significant catalyst for much more change alongside the investment of NHP resources

The SOC also identifies the opportunity to improve and integrate all aspects of the patient journey. In future iterations, the benefits of reducing bed-based care and inequalities needs to be clearly articulated. Local Care Partnerships should involve communities in the development of these plans

The financial context for Devon is challenging, with significantly more being spent on service provision than is affordable within the nationally set allocation for the population we serve. The Devon ICS has agreed a financial recovery strategy built around four key pillars.

- Maximise productivity, therefore reducing the need to increase capacity to meet growth in demand
- Minimise new investment from growth in the system allocation to narrow the gap between current spending and available funding
- Deliver real terms cost reduction through transformation and lower cost service delivery configuration
- Maximise productivity and efficiency from our corporate and support services.

The timescale for financial recovery will require significant progress to be made ahead of the infrastructure changes delivered through the NHP. Support for this SOC is given with the expectation that the case demonstrates how the new infrastructure will continue to contribute to containment and cost reduction and cost-effective innovation in the current models of service delivery.

From an affordability perspective, there are two key conditions to the support for the SOCs.

1. Capital build costs are contained within the capital spending limit set by the NHP funding. In order to achieve this, it will be essential that the investment plans support and are supported by the transformational change to service delivery models that will make this achievable.
2. From a Revenue perspective, whilst capital investment generates a revenue impact, it is expected that the business case will demonstrate how this is more than offset by the efficiency and cost saving benefits that the new infrastructure will generate.

To fully demonstrate these opportunities have been maximised, the business cases will need to show that: productivity is in top quartile nationally and service delivery and associated infrastructure are built on the most cost-effective configurations on a whole Devon basis. For the purposes of the SOC capital planning, the impacts of these workstreams have only been identified on basis of broad assumptions as noted above.

The financial sustainability for both the Trust and ICSD over the period of time that this plan is taken forward will need to be agreed in conjunction with NHSE&I. One of the guiding principles for the ICS is to reduce health inequalities and the agreement as to how this will be resolved in relation to the allocation of resources will be key element of the financial framework. The agreement of this framework is basis of the letter of support for this plan.

The opportunities that will improve financial sustainability for (provider) are set out clearly within the SOC, and details such as the sensitivity of the projections with regard to assumptions relating to availability (or not) of sustainability funding over the medium term will need to be tested further as detailed planning progresses but at this point are not of sufficient concern to prevent agreement to the case.

As we continue to align the NHP schemes and Devon LTP, the opportunities to share, collaborate, modernise and deliver consistent health and care for our population will grow and are the cornerstones of this strategic case.
We look forward to working closely with you on the delivery of this proposal and seeing the benefits reflected in an enhanced healthcare offer for the future.

With kind regards

Jane Milligan
Chief Executive

Cc Richard Schofield, NHS England SW Regional Team

healthwatch
in Devon, Plymouth and Torbay

For the attention of:

Liz Davenport
Torbay and South Devon NHS Foundation Trust
Torbay Hospital
Lowes Bridge
Torquay
TQ2 7AA

Wednesday, 30 June 2021

Dear Liz,

Our Ref: Building a Brighter Future: Our Statement of Support

On behalf of Healthwatch Devon, Plymouth and Torbay I would like to take this opportunity to offer our support for the case for change in relation to the Building a Brighter Future project, which aims to improve the way that local hospital services are delivered in the future.

We understand the complexity of the task ahead and we very much welcome the opportunity to be involved in the discussions from the outset.

We look forward to working together to enable those who will be affected by the proposals to have their say about what matters to them, so that their views and experiences help to shape the way in which future services can meet the needs of local people safely and effectively.

Yours sincerely,

Kevin Dixon
Chair, Engaging Communities South West
Interim Chair, Healthwatch Devon, Plymouth and Torbay

Engaging Communities South West, Paignton Library & Information Centre, Great Western Road, Paignton TQ4 5AG
T: 08000 520 029
E: info@engagingcommunitiessouthwest.org.uk
Company Name: Healthwatch Torbay and Engaging Communities South West Ltd
Company Number 8396325 Charity number 1153450

NHS
Devon Partnership
NHS Trust

Devon Partnership NHS Trust
Wonford House
Dryden Road
Exeter
Devon
EX2 5AF

Telephone: 01392 208662
Email: melanie.walker6 @nhs.net

Our ref: PM/MW/jm
9 July 2021

John Harrison
Building a Brighter Future Programme
By email: jharrison7@nhs.net

Dear John

Thank you for sharing the aspirations of your 'Building a Brighter Future' programme with us during our Executive Team meeting on 8 July 2021.

We can clearly see the compelling need for the regeneration of the Torbay Hospital site and digital infrastructure. We welcome the opportunity to continue to be involved in the shaping of this programme where appropriate and in particular reference to both the mental health facilities we currently lease from you on the site and also supporting you with the design of your new facilities so they consider the needs of people with mental health issues.

On that basis Devon Partnership NHS Trust is happy to provide this letter of support to the programme

Yours sincerely

Melanie Walker MBE
Chief Executive

cc: Hollie Dennison, Building a Brighter Future Programme Office

From: Buckley, Teresa
To: DENNISON, Hollie (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST)
Subject: Building a Brighter Future Programme Response from Torbay Council Overview and Scrutiny Board - 9th June 2021
Date: 11 June 2021 14:27:38
Attachments: image002.jpg

Hi Hollie please find below the formal response from Torbay Council's Overview and Scrutiny Board. I am happy if you want to delete this sentence for these comments to be forwarded as necessary to help your bid. The attendees present at the meeting were:

Present Board Members: Councillors Douglas-Dunbar, Mandy Darling, Atiya Alla, Loxton, Bye, Johns, Hill, David Thomas
Also present: Anne-Marie Bond, Karen O'Shea, Lincoln Sargeant, Councillors Chris Lewis, Law, Jackie Thomas, Stockman, Carter and Cowell

Dear Liz, I am writing on behalf of Torbay Council's Overview and Scrutiny Board to thank you and Chris for such an informative presentation at their meeting held on 9 June 2021 in respect of the Building a Brighter Future Programme.

The Board acknowledged the great work of the Torbay and South Devon NHS Foundation Trust, particularly during the Covid-19 pandemic and welcomed the significant investment being made through the Building a Brighter Future Programme to help improve health and social care services, along with the wider economic benefits for the residents of Torbay.

They resolved unanimously:

"That the Overview and Scrutiny Board supports the proposed approach to developing the strategic outline business case as outlined at the meeting for the Building a Brighter Future Programme."

Their full draft Minutes can be found on our website at Minutes Template (torbay.gov.uk)

Kind regards, Teresa

Teresa Buckley | Democratic Services Team Leader | Governance Support
Town Hall, Castle Circus, Torquay, TQ1 3DR | 01803 207013 |
teresa.buckley@torbay.gov.uk

www.torbay.gov.uk
Facebook | Twitter | LinkedIn | Instagram

Following Government social distancing guidelines, I am currently working from home and can be contacted by email.

We want to support our communities during this current climate. Thank you for

support and understanding.

Pride month

NHS
Torbay and South Devon
NHS Foundation Trust

Equality Business Forum
People Directorate
Regents House
Regents Close
TQ2 7AN

12th July 2021

christopher.knights1@nhs.net
via email to avoid delay

Dear Chris,

Letter of Support from the Equality Business Forum (EBF) and Staff Network Groups for the Building a Brighter Future Programme at TSDFT

Thank you for meeting with us on 5th July 2021 to share the development of your plans for the New Hospital Programme, known internally as the 'Building a Brighter Future' Programme, at Torbay and South Devon NHS Foundation Trust.

We wholeheartedly appreciate you taking the time to engage with us and affording us the opportunity to ask questions and offer feedback. We are excited by the ambitious plans you have shared and are fully supportive of the investment from the New Hospital Programme taking place in Torbay and South Devon as there is a clear need for this.

The purpose of the EBF is to monitor, develop, and improve the Trust's work on the workforce equalities and inclusion agenda on behalf of the Trust Board of Directors, holding the organisation to account where necessary. We are therefore pleased to hear that you would like to continue engaging with the EBF and staff network groups to ensure all staff voices are heard with preferences and abilities taken into consideration, understanding that the workforce has diverse needs. Staff need to feel comfortable to be themselves and feel that their views are listened to.

The advance to a provision of single rooms with en-suite facilities per ward is a great step forward in maintaining the privacy and dignity of patients under the care of TSDFT. The LGBTQIA+ Network recognises that limited access to single room provisions and the current estate of limited single sex wards can be detrimental to the wellbeing and recovery of LGBTQIA+ peoples; particularly those undergoing gender reassignment processes.

Under the Equality Act 2010, individuals who have proposed, begun or completed reassignment of gender enjoy legal protection against discrimination; and as such should be provided spaces of equal privacy and dignity to their cisgender counterparts, and housed according to their gender identity. This is regardless of physical reassignment or gender affirming surgeries a person may undergo as part of their assignment process. However, there have previously been incidents of discrimination by other patients who have concerned about the housing of gender diverse people conflicting with the provisions of single sex accommodation.[1]

[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf

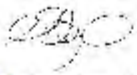
The move to single room accommodation will allow for privacy and dignity of all patients to be maintained and allows for compassionate care of gender diverse people, to not have to disclose their transgender status to be housed accordingly.

We welcome your understanding of the importance of staff mental health and wellbeing as we are aware that the best patient outcomes occur when staff feel supported and valued. The surroundings in which employees spend their working lives is an important source of job satisfaction and the ambition of the new hospital must be guided by a commitment to improve staff wellbeing. This includes assessing plans for physical work environments and engaging with staff regarding the design requirements.

We are reassured to hear that the long-term future of the Chapel is secure and that the Chapel will be protected during building works. We are also pleased to hear that consideration will be given to a large dedicated space for meditation, use as a multi-faith prayer room, for quiet prayer and reflection to be used by patients, relatives and staff.

We are also reassured by your plans for wider public involvement and engagement as the plans develop. We look forward to hearing from you again soon and please do let us know how we can support this further.

Yours sincerely,



Chris Edworthy
Equality Business Forum Chair

Supported by:
Debbie Maynard, Joint Diversity and Inclusion Lead
Sanita Simadree, Joint Diversity and Inclusion Lead, Chair of Devon Wide BAME Network
Paul Norrish, Chair of the Mental Health Forum
Hollie Dennison, Under 30's Network Group Lead
Barry Jackson, Chair LGBTQIA+ Network
Jacob Gibbons, Deputy Chair LGBTQIA+ Network
Julian Wright, Diversity and Inclusion Guardian
Julie Turley-Lister, Menopause Support Group
Hannah Matson, Overseas Nursing Representative
Angela Sumner, Faith and Belief Representative

Staff Network Group Members:
Subramanian Narayanan
Gabriella Gay
Emma Pearson
Anna Pryor
Mark Berryman
Ashraf Awad
Fahida Manby
Josh Langdon
Pandurangan Govindaraj

TORBAY CULTURE
BECAUSE IT MATTERS | EST. 2015

Chris Knights
Hospital Redevelopment Programme Director
Torbay and South Devon NHS Foundation Trust
TORQUAY TQ2 7AA

5 July 2021

Dear Chris,

Thank you for meeting with us on 24 June to share the plans for the new hospital developments in Torbay and South Devon.

We appreciate your taking the time to engage with us as you develop the *Building A Brighter Future* proposals. The proposals that you shared are significant and will transform patient provision in the bay. We are very supportive of the investment from the New Hospital Programme taking place in Torbay and South Devon. There is a strong need for this investment in the local area.

Our own work in commissioning programmes of work to support better health and wellbeing – through engagement in culture and creativity – illustrates the value of innovation, people-led design and creative thinking. Recent developments, including our partnership with Torbay Hospital and HeArTs to commission Zoe Singleton's *Waymarker* trail at the hospital as part of Torbay Culture's *Create To Recover* programme in 2020; and the evaluation of the pioneering social prescribing work we delivered in partnership with the NHS during 2016-20 provides evidence. We very much appreciate the reassurance that there will be creative thinking and design incorporated into the future hospital plans and feel positive about the future.

In 2022 we will be working with the Hospital Rooms charity, Devon Partnership NHS Trust and Healthwatch to deliver artist commissions in the new mental health facilities. That approach provides a model for the future. The Torbay and South Devon region has a proud history of partnership working and it is so good to see this exemplified in your approach. Your plans for wider public involvement and engagement are also really positive.

With good wishes,

Jacob Brandon
Chair, Torbay Culture
jacobbrandon@artizangallery.co.uk

tda TORBAY COUNCIL English Riviera GEOPARK HERE FOR CULTURE

TDA is the accountable body for Torbay Culture, established by Torbay Council, TDA and the Arts Council in 2015 to progress the cultural strategy for Torbay and its communities. TDA is a trading name of Torbay Economic Development Company Limited, a company registered in England and Wales No. 7604855. Registered Office: Tor Hill House, Union Street, Torquay, Devon TQ2 5QW

LF/LK

23rd June 2021

Chris Knights
Programme Director
Torbay and South Devon NHS Foundation Trust

By email only to: christopher.knights1@nhs.net

Cc: liz.davenport@nhs.net
hollie.dennison@nhs.net

South Devon College

Principal
Laurence Frewin

South Devon College
Long Road
Paignton
TQ4 7EJ

01803 540540
southdevon.ac.uk
enquiries@southdevon.ac.uk

To whom it may concern

Support for Building a Brighter Future Programme – Strategic Outline Case

I am writing to confirm that South Devon College fully supports the Strategic Outline Case for the 'Building a Brighter Future Programme' and very much looks forward to continuing to work with the Torbay & South Devon NHS Trust to support the development of their exciting and ambitious proposals.

We are certainly in support of the Trust's exciting ambitions, strategies, plans, and thinking for the future. We are committed to working collaboratively across their organisation, and with other Trusts, to plan for and meet the wider needs of the existing and future workforce. As part of "Building a Brighter Future" we are very keen to explore what more we need to do to help the Trust to develop its workforce pipeline and consider early and immediate development of future NHS talent as well as more pressing needs. We are discussing immediate requirements such as the skills and people which Tier 1 construction contractors, and their supply chain, will require for the construction element of the plans. Further, we have committed to exploring together how we can deliver the skills within the existing workforce of the Trust, and our wider community, which will be needed to support early and ongoing, digital infrastructure changes. The success of the "Building a Brighter Future Programme" is a critical catalyst to achieving all of this.

This collaboration is already happening with ongoing conversations, planning and activities taking place with the Trust's Senior Leadership Team, and we believe the Strategic Outline Case for the "Building a Brighter Future Programme" will provide better opportunities and outcomes for the people who live in our community and will positively support local economic growth and future prosperity, a vital part of improving social mobility and delivering successful outcomes for people in our area.

I ask the Government to support the "Building a Brighter Future Programme", to approve the Strategic Outline Case and to work with the NHS and South Devon College to start to level up the economy in Torbay and South Devon and invest in its future.

Yours faithfully

Laurence Frewin
Principal & CEO

From: Laurence Frewin
To: KNIGHTS, Christopher (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST)
Cc: DENNISON, Hollie (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST); Maria Woodger; Louise Knight
Subject: RE: Building a Brighter Future Programme - Slide Deck following Engagement Session
Date: 18 June 2021 13:18:37

Dear Chris

It was great to meet you, albeit virtually, and thank you for taking the time to present the Building a Brighter Future Programme overview.

The proposals are very exciting and will clearly need all of us to continue to work closely together to re-imagine the shape of the future workforce as we move through the current decade and, in turn, what South Devon College needs to do which will support this.

We are certainly in support of the Trusts ambitions and current thinking, are keen to work across the organisation, and with other Trusts where relevant, to consider the wider needs of the existing and future workforce. We are very keen to explore how we can help you build the pipeline and consider early development of your future talent as well as more pressing needs such as the skills and people which Tier 1 construction contractors and their supply chain will require and the skills to support your earlier digital infrastructure changes. All of this ties in really well with conversations we are already having with Deborah Kelly and her teams and Adel Jones and her teams!

I am delighted that you and your colleagues will be able to come along to our first SLT Planning Meeting of the new academic year on 21st October as we discussed. I have pencilled in 2.00pm on our draft agenda. We can allow a full hour, including questions & discussion, so maybe 30 minutes presentation including brief introductions etc then 30 minutes discussion including questions and next steps – would that be suitable?

Perhaps we can leave Hollie and Louise to liaise over timings and arrangements etc?

In the meantime I am looking forward to seeing you again at this afternoon's Torbay Together meeting!

Warmest regards

Laurence

Laurence Frewin | Principal & CEO
laurencefrewin@southdevon.ac.uk | **01803 540581 | 07889 318 977**

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From: DENNISON, Hollie (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST) <hollie.dennison@nhs.net>
Sent: 18 June 2021 12:21

Chris Knights
Programme Director: Building a Brighter Future Programme
Torbay and South Devon NHS Foundation Trust
Hengrave House
Torbay Hospital
Lowes Bridge
Torquay TQ2 7AA

36 – 38 Market Walk
Newton Abbot
Devon
TQ12 2RX

Tele: 07791 899 158

chiefexec@teigncvs.org.uk
www.teigncvs.org.uk

5th July 2021

Dear Chris,

Letter of Support for Building a Brighter Future Programme - Torbay and South Devon NHS Foundation Trust

Thank you for meeting with over 50 voluntary and community sector groups from Torbay and South Devon on 1st July 2021 to share the development of your plans for the New Hospital Programme in Torbay and South Devon. Groups appreciated you taking the time to meet and present to them and to provide time and space to take questions and opinion from our sector to inform your plans.

The Voluntary and Community Sector recognise the value of the Programme's ambitions for residents within our communities and for the many service users we support and are excited and pleased to see that the health and care of our residents remain at the heart of your plans.

We are fully supportive of the investment from the New Hospital Programme taking place in Torbay and South Devon. There is clear need for this investment and the outcomes from the programme for patient health are clear.

We are excited for the continued engagement with our sector as you move forward and confident that the plans you have for ensuring the voice of our residents and their communities is clearly a priority.

We look forward to the journey and offer you our support along the many steps.

Yours sincerely

Susan Wroe
Chief Officer
On behalf of wider VCSE providers from South Devon

LMC Devon

Deer Park Business Centre
Haldon Hill
Kennford
Exeter, EX6 7XX

Mr C Knights
Building a Brighter Future Programme Director
South Devon and Torbay Foundation Trust
(by email)

30 June 2021

Dear Chris,

SOUTH DEVON AND TORBAY FOUNDATION TRUST – BUILDING A BRIGHTER FUTURE

Thank you so much for meeting with Bob Fancy and I to discuss the future plans for South Devon and Torbay Foundation Trust. The brief you provided was very informative and I admire your appetite for a challenge.

We are all aware of the desperate need for this investment in Torbay and I can certainly vouch for the requirement having worked at the hospital. The LMC will always have a specific interest in the impact the programme will have on General Practice and I would ask for our early involvement in planning where there is likely to be a bleed across to Primary Care so that we can collaborate and find solutions to what are going to be some very difficult issues to resolve, especially during the transition period.

The requirement for this Programme is axiomatic and the LMC supports the investment.

Yours sincerely,

Dr Rachel Ali
Chair

Information:

CEO, Devon LMC
Dr Trevor Avis – Chair, Southern Primary Care Collaborative Board

rowcroft hospice

Avenue Road
Torquay
Devon
TQ2 5LS

tel: 01803 210800
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info@rowcrofthospice.org.uk
www.rowcrofthospice.org.uk

Liz Davenport
Chief Executive
Torbay & South Devon NHS Foundation Trust
Torbay Hospital
Lowes Bridge
Torquay
TQ2 7AA

BY POST & EMAIL

25th June 2021

Dear Liz

I just wanted to write and offer my letter of support for the New Hospital Programme in Torbay and South Devon.

I have met with Christopher Knights, and some of his team, on a few occasions now (the latest being 22nd June 2021) and he has kindly shared the development of your plans. I really appreciate your team taking the time to engage with us as you develop your plans, and offering us the opportunity to hear direct and take our views on board.

We are excited by the plans shared and pleased to see that they reflect our own direction of travel as an organisation. We recognise your story and we are in agreement with the content of the case you presented.

We are fully supportive of the investment from the New Hospital Programme taking place in Torbay and South Devon. There is clear need for this investment which is evident from our own experience as a hospice providing specialist palliative and end of life care across Torbay & South Devon, and also from what our population health data tells us.

We are very keen to work with you on the wider development of clinical models that support people with long-term conditions and make sure that only those patients who require an acute admission are admitted to hospital. We thank you for the reassurance provided that you are equally keen to work with us and involve us in the development of these models. The Torbay and South Devon region has a proud history of partnership working and it is fantastic to see this exemplified in your approach.

We are also reassured by your plans for wider public involvement and engagement as the plans develop. It is really important that we take our population and communities with us on this journey.

Yours sincerely

Mark Hawkins
Chief Executive

cc: Christopher Knights

torbay COMMUNITY development trust

30th June 2021

Dear Chris,

Re Building a Brighter Future Project submission by Torbay and South Devon NHS Foundation Trust

It is with great pleasure that I am writing to you on behalf of our Board of Trustees in support of your project. I would like to thank you on behalf of the Trustees for taking the time to present to us at our recent Trustee meeting on 25th June.

Torbay Community Development Trust has been a strategic stakeholder and partner with your Trust since its inception in 2013 and we have been collaborating on our shared agenda to enable the wellbeing of residents across Torbay on a range of partnership programmes. As you know we are also the conduit to a relationship with over 700 voluntary and community groups across Torbay, many of whom are engaged with us on supporting people in need to improve their wellbeing.

The latest of these is the creation of the community helpline which involves over 60 voluntary, faith and community groups and over 1000 residents supporting people through the pandemic, including Wellbeing Coordinators funded by you and hosted in Age UK and Brixham Does Care. As you know we are now working with you to develop this vcse ecosystem into the new front door for adult social care, which will contribute to the aspirations of Building a Brighter Future, which, as you outlined, is not just about upgrading the hospital site, but about ensuring that we all work together to enable people to lead healthy lives, where possible with support at home, ensuring that people access the hospital only when they need to.

Our Board of Trustees voted unanimously in favour of your project and you have our full support in securing the necessary resources to progress.

Many thanks

Simon Sherbersky
Strategic Director, Torbay Community Development Trust
On behalf of the Board of Trustees

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Building a Brighter Future Programme Office
Torbay and South Devon NHS Foundation Trust
First Floor, Belmont Court
124 Newton Road
TQ2 7AD

Please reply to: Councillor Jackie Stockman
C/O Governance Support Officer
Town Hall
Castle Circus
Torquay
TQ1 3DR

Sent by Email Only

Telephone: 01803 851255
E-mail: jackie.stockma@torbay.gov.uk
Date: 16 July 2021

To request a copy in another format or language phone 01803 207064

Dear Liz

New Hospital Programme at Torbay and South Devon NHS Foundation Trust

Your letter and corresponding power point was electronically circulated to the Members of the Health and Wellbeing Board. I, on behalf of the Health and Wellbeing Board, am delighted to convey the Boards support for the New Hospital Programme at Torbay and South Devon NHS Foundation Trust.

I look forward to hearing more about the programme at the briefing on 13 August.

Yours sincerely

Councillor Jackie Stockman
Chair of the Health and Wellbeing Board

UNIVERSITY OF PLYMOUTH

THE QUEEN'S ANNIVERSARY PRIZES 2019

Liz Davenport
Chief Executive
Torbay and South Devon NHS Foundation Trust
Hengrave House
Torbay Hospital
Lowes Bridge
Torquay TQ2 7AA

17 July 2021

Dear Liz

RE: NEW HOSPITALS PROGRAMME AT TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

It was great to meet with you on 28th June 2021 and hear your exciting plans for the New Hospital Programme in Torbay and South Devon.

We appreciate your taking the time to engage with us as you develop your plans and offering us the opportunity to hear from you direct and take our views on board.

We in the Faculty of Health at the University of Plymouth agree that this is a once in a lifetime opportunity to make a real difference in how services are delivered. The mission of our Faculty is to improve the heath of the populations we serve and we are delighted to partner with you in your vision to develop, deliver, and evaluate new and integrative solutions to the challenges posed by 21st century healthcare. We are excited by the plans you have shared and they reflect our own priorities, we are in agreement with the content of the case you presented.

There is real need for investment in health infrastructure and new ways of delivering care in south Devon and this includes new ways of educating and delivering the workforce of the future. We are fully supportive of the investment from the New Hospital Programme taking place in Torbay and South Devon and will be pleased to work with you on delivering the education and training needed for the current and future workforce.

We are very keen to work with you on innovation in care delivery for those with long-term conditions and multimorbidity. We look forward to partnering with you on this exciting journey.

With all best wishes

Sube Banerjee
Executive Dean & Professor of Dementia

Sube Banerjee MBE, MBBS MSc MBA MD FRCPsych, Executive Dean, Faculty of Health, University of Plymouth, Drake Circus, PL4 8AA
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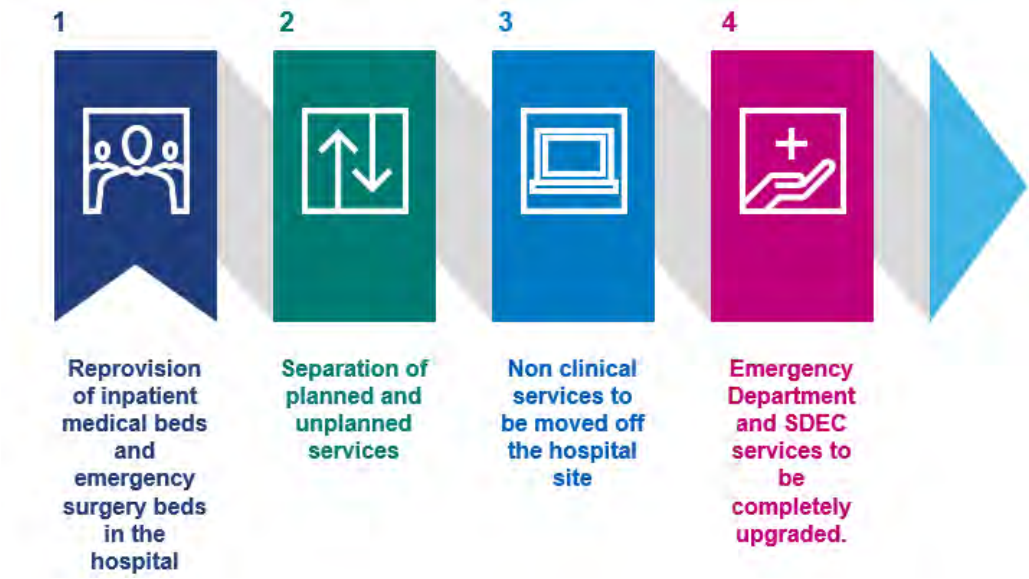
Appendix 9.1.5 Development Control Plans

The Trust has gone through a number of iterations of its development control plan (DCP). This section highlights how the Trust has concluded that option F is its initial preferred way forward.

In developing its DCP for the project the Trust had 4 key principles that needed to be secured before any evaluation of cost was undertaken. These were as follows:



In achieving these four key principles we have been cognisant of the requirement to deliver an option which meets the available capital envelope for our scheme under the NHP.

We have gone through a process of development which has looked at the design options open to us.

DCP Option A

Option A was looked at and provided a multi-face solution in the centre of the site. It provided a total of c. 40,000m^2 of new and refurbished accommodation. However, when assessed, the costs exceeded £500million. On this basis, the Trust looked to discount this option as a way forward.

DCP Option B

Option B focussed on a different location for the main ward block and a complete removal of the Edwardian building stock on the site. When a detailed assessment took place, all fixed points were achieved, however, for c. 35,000m^2 of development, the costs still exceeded £450million and therefore, Option B was discounted.

DCP Option C

Option C involved three significant phases of development which encompassed all of the four fixed points within an overall development of c. 40,000m^2. When the costs were assessed, a budget estimate of £498million meant that Option C was again unaffordable and therefore Option C was discounted.

DCP Option D (Identified as Estates Infrastructure Option 4 in our SOC)

Having assessed Options A – C, it was clear that the new build component of the project needed to be significantly reduced. By way of feasibility, Option D was reduced to 21,500m^2. However, it did not address the inpatient bed requirements, nor did it allow for any funding to be put towards the upgrade to ED. Furthermore, whilst the costs did significantly reduce to £345million, it was still not within the affordability threshold of the project, so this option was discounted.

DCP Option E

Option E involved a significantly reduced new build footprint and an upgrade to existing Edwardian accommodation. All fixed points could be delivered within an overall development size of 20,000m^2 of new and refurbished accommodation. The initial assessment was £338million which, within the context of affordability, allowed Option E to go through to a more detailed assessment. Option E was also discussed in detail with the Executive Team and senior clinicians from across the Trust. Following consultation and a more detailed assessment, it was felt that the Trust needed to revert to a more substantial new build component as opposed to upgrade of outdated existing accommodation. Option E was therefore discounted.

DCP Option F (Identified as Estates Infrastructure Option 3 in our SOC)

Option F has been confirmed as the initial preferred way forward for our Building a Brighter Future programme. Current assessment is that all fixed points can be delivered within a build cost of £317million commencing January 2025. This provides an overall affordability threshold of the programme of £370million including digital and it will be this option that is explored in more detail as we progress to OBC.

Appendix 9.1.6 STP Estate Strategy

Attachment called **"Appendix 9.1.6_Devon STP Wave 4 Estate Strategy"**

Appendix 9.1.7 TSDFT Digital Strategy

Attachment called **"Appendix 9.1.7_TSDFT Digital Strategy"**

Appendix 9.1.8 TSDFT Estate Strategy

Attachment called **"Appendix 9.1.8_TSDFT Estate Strategy"**

9.2 Economic Case

Appendix 9.2.1 Option Filter Framework for Digital

Attachment called **"Appendix 9.2.1_08072021 TSD Digital Options Filter Framework"**

Appendix 9.2.2 Option Filter Framework for Estates Infrastructure

Attachment called **"Appendix 9.2.2_08072021 TSD Estates Options Filter Framework"**

Appendix 9.2.3 CIA Model

Please refer to the following attachments:

- **"Appendix 9.2.3_T&SD Digital Only CIA Model_080721"** - CIA Model containing all shortlisted Digitals options
- **"Appendix 9.2.3_T&SD Estates Only CIA Model_080721"** - CIA Model containing all shortlisted Estates Infrastructure options
- **"Appendix 9.2.3_T&SD Combined CIA Model_080721"** - CIA Model containing combined positions from both Digital and Estates Infrastructure

Appendix 9.2.4 Approach to CIA Model and Assumptions

Cost Quantification Approach

The cost base included within the CIA is consistent with what has also been included in the affordability modelling which underpins the Finance Case of this SOC. However, as mentioned in the main body of the Economic Case it is important to understand that the figures used in the CIA Modelling do not match with the figures used in the affordability modelling. In line with guidance for the CIA Model, the items below are excluded from the cost base included in the modelling:

- Inflation;
- Value Added Tax (VAT);
- Sunk costs; and
- Transfer payments - this includes capital charges, depreciation and any income contribution received from other public sector bodies

Capital Costs

Estates Infrastructure Capital cost forms have been prepared by the technical advisors of the Trust, Turner & Townsend, for each of the shortlisted Estates Infrastructure options. Capital costs have been supplied by the Digital team of our Trust, with the costs being based on market testing. For the purposes of the economic appraisal, as already highlighted, the capital costs exclude both inflation and VAT.

Costs provided for the Digital aspect of the Programme cover a 25-year period. Therefore, in order to compare this on a similar basis to the Estates Infrastructure elements the Digitals costs provided have been extrapolated across the 70-year appraisal period. The rationale for this is that after 25 years new technologies may be available, including new modules within the IT systems. Therefore, Digital infrastructure and systems within our Trust may need to be upgraded. This would require similar infrastructure costs and implementation costs if the new technologies were substantial.

Under Option 1 and 2, £20m of Capital costs have been extrapolated out for the whole period past construction to account for IT costs (over and above the Digital specific elements), equipment and plant and machinery. This also includes a £7m per annum provision to account for areas of the retained estate. Similar costs have been included for Options 3, 4 & 6 in terms of IT, equipment and plant & machinery. However, the retained estates cost for Option 3 and 4 is £3.5m to take into account the amount of estates elements refurbished or rebuilt due to the scheme. Lifecycle costs of £2m per annum have been included to account for the new areas of the estate.

Option 6 does not include any provision for retained estate due to this option involving a full rebuild of the estate. However this option does include a £2m per annum Lifecycle cost to account for the newly built estate.

The Capital costs section of the CIA Model also includes Planned Capital expenditure over the next 5 years which is felt across all options. This section also includes expenditure on areas of the site which are retained after the various options and also Lifecycle costs to upkeep the renewed elements of the Estate.

It is also important to note that our Cost consultants have calculated Optimism Bias outside of the CIA Model. Optimism Bias has been included in the Capital costs section of the CIA Model

Revenue Costs

Revenue costs relate to the on-going operating costs of carrying out services. All options are modelled using the same assumed activity demand to keep them consistent and comparable. All revenue costs have been developed based on the expected impact from both Digital and Estates change. These costs are split by clinical costs, non-clinical costs, building running costs and other revenue costs.

These costs have been inferred from the financial affordability model underpinning the Financial Case within our SOC. The impact of VAT and inflation was removed from this version of the model before being used in the CIA.

Opportunity Costs

Opportunity costs represent the value that could have been achieved if the resources committed under an option were used for their next best alternative purpose, or the benefits that have been lost from undertaking alternative options. For the purposes of this economic appraisal, no opportunity costs have been explored.

Net contribution

Income which is generated from public sector bodies represents a circular flow from an economic appraisal perspective and has therefore been excluded from the CIA Model. Net contributions have not been incurred from non-public sector companies either due to the investment characteristics. Therefore, no net contributions have been included within the CIA Model.

Quantitative Risk Assessment

As part of the appraisal process, we have considered any risks that may be incurred from carrying out each option over the full appraisal period.

A series of workshops were held with the wider stakeholders, including the clinical, estates, and finance teams. The purpose of these workshops was to consider the anticipated risks of each option across a number of key areas: Design, Construction, Performance, Operational, Technology (and Digital) and Demand. These risks were agreed by stakeholders and then an agreement was made on which risks could be quantified in monetary terms.

The methodology applied to quantify the agreed risks was using a multi-point probability analysis in line with CIA modelling requirements. For each risk, a range of possible outcomes was estimated. The ‘expected outcome’ is the average of all possible outcomes, taking into account their varying probabilities. Under each option, the following risk parameters were discussed and agreed:

- The cost driver which is most appropriate for the risk (e.g. average salary across the Trust)
- The likely impact if that risk materialises - high, medium and low (e.g. percentage of the cost driver)
- The likelihood of the risk occurring - high, medium and low, where the total likelihood of occurrence is 100%
- The length of time (years) the risk could happen for and therefore the length of time the risk should be quantified for.

The parameters above were determined and calculated alongside technical advisors. The key assumptions and parameters discussed here have been laid out in further detail in the CIA Model.

The risks detailed above are pre-populated as part of the CIA Model template and a number of these risks were deemed to be not applicable or too difficult to quantify at this stage. Therefore, these risks were not quantified as part of the risk process.

Additional risks were also identified which were more specific to the Trust. Some of these risks were deemed to be quantifiable in monetary terms. Details of Additional risks which were quantified have been included below:

Partial Redevelopment Risk: Due to Option 1 (the BAU Option) consisting of clearing critical backlog requirements, there is a risk that in c.15 years the estate will require a significant intervention in order to allow for continued compliance and the delivery of future care models. While under Option 2 all conditions of backlog requirements will be rectified, this approach only deals with the immediate estates issue, rather than providing a material change in our base position to deliver new models of care and address the fundamental estates constraints faced on the site. As such it has been deemed under each of these options that a major intervention will be required for both Option 1 and 2 at the 15-year mark.

Under these options the requirement would be a full reprovision of the estate. The full cost of the Do Maximum option has been used in order to quantify this risk. Option 1 has been assigned a 100% high impact probability due to the lack of impact clearing critical backlog will have on the estate. Therefore, it would be inevitable in the future for us to require a full reprovision.

Option 3 and 4 also carry this risk due to this option only affecting c.50% of our estate. Therefore, 50% of the retained estate would be untouched and would require a similar intervention. Due to these options giving a higher level of transformation, and therefore benefits, compared to Option 1 and 2 this partial reprovision would not be required until c.25 years from now. The cost of the Do Maximum option has also been applied to quantify this risk.

Approach to Benefits

Cash Releasing, Non-Cash Releasing and Societal Benefits

Similar to the approach undertaken in the identification of risks, a number of workshops were held with specific sessions on benefits in order to talk through and agree the assumptions for each of the shortlisted options. The attendees invited along to the various workshops included executive directors, clinicians, operational leaders, nursing representatives, corporate function staff (strategy, transformation and finance) and technical advisors. These workshops were also attended by our advisory team.

Benefits are categorised into four main categories which are as follows: Cash releasing benefits, non-cash releasing benefits, societal benefits, and unmonetisable benefits.The assumptions used for these benefits have been discussed below.

An important point to note is that benefits can be deemed as QALYs (Quality-Adjusted Life Years) or non QALYs. However, for this stage of the scheme, only non QALY benefits have been outlined in the economic appraisal. QALYs will be explored further at the Outline Business Case stage.

The assumptions and methodology used for each benefit category are set out below. Further detail can be found on each benefit in the Benefits Log of the CIA Model. The underlying value driver / cost reduction is identified from the benefit on an annual basis to determine the 'Equivalent Annual Benefit', which is likely to be different under each option.

The appropriate phasing of the benefit is determined over the period the annual benefit is expected to be realised (for example operational benefits are realised from commencement of full services on asset completion date).

Cash releasing benefits (CRBs)

Benefits that release cash in the budget of the organisation, reducing the cost of organisations in such a way that allows for resources to be allocated elsewhere.

The financial affordability model informs the CRBs input into the CIA model. The model used has been adapted to exclude inflation for the purposes of the CIA model. Under the Options that require an intervention on site, CRBs are assumed to come online the year after construction has finished.

Non-cash releasing benefits (NCRBs)

Benefits which are quantifiable in monetary terms but do not create a budgetary release. Instead, they result in productivity savings or efficiencies such as staff time is saved which can be used elsewhere.

A number of NCRBs were identified in workshops with the wider Trust. These productivity gains have been quantified using data provided by the Trust. Most of these benefits have been quantified using an average salary quantum. The Benefit Log in the CIA model provides a brief rationale for these NCRBs.

Societal Benefits (SBs):

Benefits which are quantifiable in monetary terms, however the benefit is realised by wider society outside of the immediate organisation and NHS.

We have provided some brief explanation on the quantified Societal Benefits for this appraisal, Construction Gross Value Added (GVA) and Carbon which can be derived from the shortlisted options in the CIA Model. We have provided further details on the applied rationale and calculation of these benefits below:

Construction (Net GVA)

Redevelopment options 3 through 6 have an impact on the Construction Industry in the form of the direct employment and consequential GVA generated from the redevelopment options. This GVA is generated as a result of the revenue in which construction firms can make from these schemes. The benefit is calculated by using the construction costs of each of the redevelopment options and applying the GVA to output ratio (0.41) from the 2017 UK Input-Output tables published by the Office of National Statistics.

The table below provides a summary of the estimated gross, undiscounted benefits that are forecast to be generated within the UK economy across the shortlisted options. The GVA benefit will apply during the whole construction period of each redevelopment option. Option 3 drives a benefit of £89m while Option 6 is able to deliver a gross economic impact of £263m on the construction industry. It is important to note that as with all inputs used for the CIA Model, the construction costs exclude inflation and VAT.

£'000	Construction Cost (excl. VAT and inflation)	GVA Impact
Option 3 - Option F	214,410	89,065
Option 4 - Option D	220,498	90,691
Option 6 - Option Do Max	639,292	262,941

Un-monetisable Benefits (UBs)

These are benefits which bring value to the organisation and society, but are unable to be expressed in monetary terms. It is important to note that these UBs are not factored into the quantified outputs of the CIA model, and are therefore required to be viewed as an overlay to these outputs.

Within these benefit categories; a further categorisation is made as to whether the identified benefits are deemed to be either quality-adjusted life years (QALY) or non-QALY based. This further categorisation informs the appropriate discount rate.

In this section, the UBs were populated and worked through with the Trust to decide which benefit applied to each of the redevelopment options.

Although these benefits are not captured within the CIA Benefit-Cost Ratio, we are committed to recognise the quantitative impact of these where possible, as they all have a significant economic impact. A number of these unmonetisable benefits will be analysed in more detail at the Outline Business Case stage to realise their value.

Appendix 9.2.5 Unmonetisable benefits for Digital and Estates Infrastructure Options

The tables below outline the unmonetisable benefits which have been agreed upon by our Programme team for both Digital and Estates Infrastructure. We have applied a RAG rating to the tables to show the following:

- Benefit would not be achieved under the Option
- Benefit may or may not be achieved under the Option
- Benefit would be achieved under the Option

Digital

Digital UBs		BAU/ Option 1	Option 2	Option 3	Option 4
Category	**UB**				
Emergency and Ambulatory	Senior staff spend 50% less time investigating 4 hour breaches				
Medication	27% reduction in medication prescribing and administration errors				
Medication	100% reduction in sedation-related prescribing errors in paediatrics				
Medication	100% recording of the indication for antibiotic prescribing				
Medication	Nurses can read the Doctor's handwriting				
Medication	Nursing administration errors – potential to half or eliminate				
Medication	Reduced errors on drug orders with complex calculations				
Medication	Clinical messaging within the system for pharmacy				
Radiology and Laboratory	Consolidated patient data: radiologists and other users have simultaneous access to inpatient and outpatient				
Radiology and Laboratory	Radiology supported by allergen checking				
Pathway Management	42% reduction in sepsis mortality				
Pathway Management	100% Sepsis screening in A&E				

Pathway Management	80% increase in Sepsis patients receiving antibiotics within 90mins of being in A&E	●	●	●	●
Pathway Management	50% increase in the proportion of patients with Sepsis that receive antibiotics within an hour of diagnosis	●	●	●	●
Pathway Management	VTE assume 10% improvement in assessment process	●	●	●	●
Theatre	Improved WHO compliance: Sign-out on 99.8% and a WHO Sign-in on 93.1%	●	●	●	●
Theatre	Preference cards: 85% of cases begin intra-op documentation with a pre-populated list of supplies and implants using core pick lists mapped to preference cards, saving critical time for theatre support workers.	●	●	●	●
Theatre	Relevant information on patients history, condition and treatment is available electronically for Theatres staff	●	●	●	●
Workforce	Less Bed Manager, operations team, time spent chasing the status of beds, patient movement, theatre sessions & ED patient allocations	●	●	●	●
Workforce	System Escalation calls – improved access to near real time operational information improves decision making in response to changes in health and social care system pressures	●	●	●	●
Care closer to Home	Capability of recording and sharing images such as wounds which could be communicated back to Tissue Viability specialists in the acute site, or progress monitored in conjunction with primary care when compared to initial presentation	●	●	●	●
Paperless	Inpatients reduced use of paper record by 80%	●	●	●	●
Paperless	Outpatients reduced use of paper record of 40%	●	●	●	●

Estates Infrastructure

Estates UBs		BAU/ Option 1	Option 2	Option 3	Option 4	Option 6
Category	**UB**					
Release land	Ability to release land for development opportunities	🔴	🔴	🟡	🟡	🟢
Local authority partnership working	PV farm being discussed in terms of energy provision. helping address the wider socio-economic position. Shared spaces with them in terms of corporate support structures etc.	🔴	🔴	🟢	🟢	🟢
Patient experience	Improved overarching patient outcomes would reduce the amount of patients in the hospital and contribute to the long term care strategy	🔴	🔴	🟢	🟢	🟢
Health of the local population	Improved health of the local population through better quality of care	🔴	🔴	🟢	🟢	🟢
Quality improvement	Improvement in quality of care translating to improvements in CQC rating	🔴	🔴	🟢	🟢	🟢
Staff wellbeing and morale	Staff satisfaction and morale is increased due to working in a comfortable, modern environment with purpose built welfare facilities e.g. changing and shower facilities.	🔴	🔴	🟢	🟢	🟢
Education and training improvements	Prevention	🔴	🔴	🟢	🟢	🟢
Staff experience	Increased staff work experience through upgraded estate	🔴	🔴	🟢	🟢	🟢
Improved disabled access	Provide access for patients, staff and visitors with disabilities - provide compliant accommodation	🔴	🔴	🟢	🟢	🟢

Fire compliance / Health and Safety	To provide safe and fire compliant accommodation in line with HBN and HTM guidance	🔴	🔴	🟡	🟡	🟢
Economic regeneration of the local area	A significant redevelopment will act as a catalyst to promote and deliver economic regeneration of the local area	🔴	🔴	🟢	🟢	🟢
Improving health of the local population	Health gain in terms of social deprivation	🔴	🔴	🟢	🟢	🟢
Inequality transformation	Improving the wider imbalance within the population.	🔴	🔴	🟢	🟢	🟢
Pandemic proofing	Improvements in the flow and single room usage.	🔴	🔴	🟡	🟡	🟢
Care closer to home	Location is crucial in the context of the Trust's integrated care strategy - the acute hospital development needs to be portrayed in that context - 'closer to home' it's should be more about right place/right service rather than just geography."	🔴	🔴	🟢	🟢	🟢

9.3 Commercial & Estates Case

Appendix 9.3.1 PIN Launch - Letters to Trust

Department of Health & Social Care

NHS

Craig McWilliam
Craig.mcwilliam@nhs.net

09/06/21

Dear NHP Trust Project Director,

Initiation of market engagement for the New Hospital Programme – Launch of the Prior Information Notice (PIN)

I am writing to advise you regarding the initial steps we are taking to engage with the market as, part of our overarching common commercial and procurement strategy.

We are intending a 'progressive' alliance model approach over evolving phases of the NHP with three key features:

- It will be centrally controlled and locally delivered
- It will evolve with each phase of the programme, starting with the earlier schemes, iterating to improve the model with each cohort
- It will create and sustain a collaborative environment which enables application of Modern Methods of Construction (MMC) across the delivery of the programme, supporting investment in the market

As a first step in this process, understanding the market's appetite for contracts to deliver the programme will be vital in ensuring we are able to meet out timelines for building 40 new Hospitals by 2030. At this early stage in pre-procurement, the central programme team is seeking to invite a range of potential suppliers of all sizes and

across a range of construction disciplines to express their interest in engaging with the Programme.

We will be using Prior Information Notices (PIN) to promote early market engagement, which will publicly announce the commencement of our initial engagement activity. We will be inviting suppliers from across the construction market to express interest in the programme. This approach ensures impartial and transparent engagement, compliant with public procurement legislation.

The PIN will provide details of an online smart survey where suppliers can register their interest with the Supply Markets Team within the programme. We are asking them to do this by filling in an online survey which captures their contact details and

some very high-level information about the type of goods or services they provide. The PIN will be live for 6 weeks, but the ability to register interest as a supplier via the smart survey link will be ongoing.

Once firms have registered their interest, the Supply Markets Team will use their details to plan a range of future market engagement activities. This engagement is designed to build market appetite so that when we begin procurement, we have an accurate idea in the level of interest in building our new hospitals. This will leave us in a better position to ensure sufficient capacity in the market to meet our level of demand, as well as an appropriate level of competition.

We have set up a dedicated email address; nhp.suppliers@nhs.net where you can direct any interested suppliers. The Supply Markets Team will respond to all enquires and invite suppliers to sign up to receive future updates and communications regarding the New Hospital Programme as it develops.

This is just the first step in the market engagement plan, and we will share further details with you about the timeline for this work and the other stages within it in due course. We appreciate that there is a desire for further detail on the upcoming stages of our common commercial and procurement strategy, and what this will mean for the procurement for schemes at different stages of development. As we roll out our market engagement programme, we will share the details with you, including how we can best work collaboratively in some areas.

By taking a whole programme approach to building our new hospitals, it will mean the experience gained from working with the currently more developed schemes can be consolidated into the programme for the benefit of less developed schemes, including in the implementation of standardisation, digital technology, sustainability and MMC. We are planning a briefing to share more specific details on our commercial approach with the earlier schemes, within the next 3-4 weeks.

Trusts should note that the NHP PIN being issued is for the purposes of market engagement only and is separate from any PIN that will be issued by CCS regarding the procurement of the new successor to P22 (Procure22) / Lot 5 Construction Works and Associated Services.

Thank you for your continued collaboration with the programme, which will ensure both NHS staff and patients have access to world-class, state of the art facilities and care that are fit for the future. We look forward to continuing this work with you and delivering this ambitious programme together.

Yours sincerely

Craig McWilliam
Joint Programme Director - New Hospital Programme
NHS England & Improvement

9.4 Finance Case

Appendix 9.4.1 OB Forms

The OB forms for our options have been split into consituent elements of each of the respective options, with some elements being common across a number of options. Please refer to the following attachments:

- **"Appendix 9.4.1_OB form summary document"** – summary document detailing options analysed by the technical advisory team
- **"Appendix 9.4.1_Option 3_Phase 1 New Wards_OB Form"** – OB form covering Option 3 Phase 1 New Wards works
- **"Appendix 9.4.1_Option 4_Phase 1 New Wards_OB Form"** – OB form covering Option 4 Phase 1 New Wards works
- **"Appendix 9.4.1_Option 3 and 4_New Elective Care_OB Form"** – OB form covering both Options 3 and 4 elective care elements
- **"Appendix 9.4.1_Option 3 and 4_Refurb Tower Ward_OB Form"** – OB form covering both Options 3 and 4 refurbishment of Tower Ward
- **"Appendix 9.4.1_Option 3 and 4_A&E_OB Form"** – OB form covering both Options 3 and 4 A&E works
- **"Appendix 9.4.1_Option 6 _OB Form"** – OB form covering entirety of works associated with Option 6

Appendix 9.4.2 Cash releasing benefits summary for each shortlisted Option

Digital

CRBs (£000)[1]	Year 6 2025/26	Year 7 2026/27	Year 8 2027/28	Year 9 2028/29	Year 10 2029/30
Option 2					
Outpatient	2,162	2,471	3,089	3,089	3,089
TOTAL	**2,162**	**2,471**	**3,089**	**3,089**	**3,089**
Option 3					
Emergency and Ambulatory	350	400	500	500	500
Outpatient	3,775	4,314	5,393	5,393	5,393
Radiology and Laboratory	101	115	144	144	144
Workforce	526	601	752	752	752
Paperless	1,010	1,154		1,443	1,443
Litigation	225	258	322	322	322
TOTAL	**5,987**	**6,842**	**8,554**	**8,554**	**8,554**
Option 4					
Emergency and Ambulatory	350	400	500	500	500
Outpatient	3,775	4,314	5,393	5,393	5,393
Radiology and Laboratory	101	115	144	144	144

[1] Timeline only goes to Year 10 because from this point the benefit quantum remains the same on a recurrent basis

Workforce	526	601	752	752	752
Paperless	1,010	1,154	1,443	1,443	1,443
Litigation	225	258	322	322	322
Community and Social Care	526	601	751	751	751
TOTAL	**6,513**	**7,443**	**9,305**	**9,305**	**9,305**

Estates Infrastructure

CRBs (£000)[2]	Year 10 2029/30	Year 11 2030/31	Year 12 2031/32	Year 13 2032/33	Year 14 2033/34	Year 15 2034/35
Option 3						
Agency Saving	65	150	237	325	414	414
Repatriated income	1,200	1,200	1,200	1,200	1,200	1,200
Additional CIP	8,540	17,111	25,714	34,371	43,078	43,078
Additional Retail income	44	44	44	44	44	44
Lack of major incidents	425	425	425	425	425	425
TOTAL	**10,274**	**18,930**	**27,620**	**36,365**	**45,161**	**45,161**
Option 4						
Agency Saving	61	143	226	311	397	397
Repatriated income	1,200	1,200	1,200	1,200	1,200	1,200
Additional CIP	7,909	15,854	23,838	31,880	39,976	39,976
Additional Retail income	44	44	44	44	44	44
Lack of major incidents	425	425	425	425	425	425
TOTAL	**9,639**	**17,666**	**25,733**	**33,860**	**42,042**	**42,042**
Option 6						
Agency Saving	N/A	348	458	567	677	788
Repatriated income	N/A	1,500	1,500	1,500	1,500	1,500

[2] Timeline only goes to Year 14 because from this point the benefit quantum remains the same on a recurrent basis. Net contribution of benefit shown.

Additional CIP	N/A	12,952	25,863	38,767	51,653	64,512
Additional Retail income	N/A	88	88	88	88	88
Lack of major incidents	N/A	425	425	425	425	425
TOTAL	**N/A**	**15,313**	**28,334**	**41,347**	**54,343**	**67,313**

Appendix 9.4.3 SoCF, SoCI and SoFP for all shortlisted Digital and Estates Infrastructure options

Estates Infrastructure Option 2

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,976)	(315,028)	(321,217)	(328,404)	(335,760)	(343,279)	(350,969)	(358,835)	(366,880)	(375,109)
Non pay costs	(256,534)	(258,586)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(284,977)	(290,065)	(295,249)	(300,525)	(305,896)	(311,365)	(316,935)	(322,607)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(606,194)**	**(618,469)**	**(631,009)**	**(643,804)**	**(656,865)**	**(670,200)**	**(683,815)**	**(697,716)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**7,883**	**7,608**	**7,324**	**7,026**	**6,709**	**6,374**	**6,021**
Depreciation, amortisation & impairments	(23,951)	(26,960)	(29,211)	(31,134)	(33,008)	(35,047)	(36,090)	(37,208)	(37,194)	(37,221)	(36,946)	(37,794)	(38,197)	(38,147)	(38,260)	(38,262)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(7,810)	(10,683)	(10,957)	(10,778)	(10,391)	(10,207)	(10,098)	(10,000)	(10,034)	(9,880)	(9,787)	(9,738)	(9,546)	(9,250)	(9,012)	(8,835)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(34,759)**	**(43,159)**	**(42,196)**	**(40,848)**	**(41,120)**	**(41,716)**	**(41,352)**	**(41,038)**	**(39,700)**	**(39,816)**	**(39,712)**	**(40,785)**	**(41,282)**	**(41,238)**	**(41,432)**	**(41,594)**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(34,759)**	**(43,159)**	**(42,196)**	**(40,848)**	**(41,120)**	**(41,716)**	**(41,352)**	**(41,038)**	**(39,700)**	**(39,816)**	**(39,712)**	**(40,785)**	**(41,282)**	**(41,238)**	**(41,432)**	**(41,594)**
Impairments	(2,295)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(37,054)**	**(43,159)**	**(42,196)**	**(40,848)**	**(41,120)**	**(41,716)**	**(41,352)**	**(41,038)**	**(39,700)**	**(39,816)**	**(39,712)**	**(40,785)**	**(41,282)**	**(41,238)**	**(41,432)**	**(41,594)**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	394,233	424,299	417,906	405,439	388,248	387,624	374,723	374,518	368,800	358,003	356,152	348,488	338,978	325,473	320,217	310,961
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(130,811)	(177,141)	(211,421)	(240,833)	(266,537)	(298,347)	(318,568)	(349,896)	(374,528)	(398,894)	(420,540)	(443,814)	(465,047)	(481,751)	(506,429)	(525,974)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**219,616**	**204,078**	**165,306**	**122,982**	**80,736**	**48,253**	**14,989**	**(16,795)**	**(46,742)**	**(77,429)**	**(105,371)**	**(135,986)**	**(166,624)**	**(196,735)**	**(225,764)**	**(254,643)**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**170,586**	**151,048**	**115,596**	**77,039**	**37,910**	**8,594**	**(21,363)**	**(49,588)**	**(76,379)**	**(103,377)**	**(128,181)**	**(155,993)**	**(183,935)**	**(211,458)**	**(238,794)**	**(265,902)**
Financed by																
Public dividend capital	167,921	191,542	198,287	200,577	202,568	214,968	226,383	239,176	252,084	264,904	279,812	292,785	306,125	319,839	333,936	348,422
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Income and expenditure reserve	(46,488)	(89,647)	(131,842)	(172,690)	(213,810)	(255,526)	(296,878)	(337,916)	(377,616)	(417,432)	(457,145)	(497,930)	(539,211)	(580,449)	(621,882)	(663,476)
Total taxpayers' and others' equity	**170,586**	**151,048**	**115,596**	**77,039**	**37,910**	**8,594**	**(21,363)**	**(49,588)**	**(76,379)**	**(103,377)**	**(128,181)**	**(155,993)**	**(183,935)**	**(211,458)**	**(238,794)**	**(265,902)**

SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(26,901)	(31,831)	(30,596)	(29,431)	(30,096)	(30,880)	(30,631)	(30,423)	(29,059)	(29,338)	(29,338)	(30,470)	(31,172)	(31,438)	(31,885)	(32,241)
Depreciation and amortisation	24,143	27,481	29,712	31,635	33,509	35,548	38,591	37,709	37,695	37,722	37,447	38,295	38,698	38,648	38,761	38,763
Other Non-cash items	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(884)**	**2,204**	**3,414**	**4,668**	**5,959**	**7,286**	**8,636**	**8,384**	**8,109**	**7,825**	**7,527**	**7,210**	**6,875**	**6,522**
Interest received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of PP&E and investment property	(184,317)	(48,259)	(23,318)	(19,169)	(16,319)	(34,924)	(23,689)	(37,504)	(31,977)	(26,926)	(35,595)	(30,632)	(29,188)	(25,143)	(33,505)	(29,507)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(183,297)**	**(48,259)**	**(23,318)**	**(19,169)**	**(16,319)**	**(34,924)**	**(23,689)**	**(37,504)**	**(31,977)**	**(26,926)**	**(35,595)**	**(30,632)**	**(29,188)**	**(25,143)**	**(33,505)**	**(29,507)**
Public dividend capital received	37,166	23,621	6,744	2,290	1,992	12,400	11,395	12,812	12,909	12,819	14,908	12,973	13,340	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest paid	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
Interest element of service concession obligations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC dividend paid	(7,610)	(10,683)	(10,957)	(10,778)	(10,391)	(10,207)	(10,098)	(10,000)	(10,034)	(9,880)	(9,787)	(9,736)	(9,546)	(9,250)	(9,012)	(8,835)
Net cash generated from financing activities	**9,999**	**6,100**	**(10,078)**	**(12,447)**	**(12,799)**	**(1,554)**	**(2,492)**	**(1,110)**	**(1,290)**	**(824)**	**840**	**(466)**	**428**	**1,229**	**1,952**	**3,440**
Increase / (decrease) in cash and cash equivalents	**(176,056)**	**(46,530)**	**(34,280)**	**(29,412)**	**(25,704)**	**(31,810)**	**(20,222)**	**(31,328)**	**(24,632)**	**(19,366)**	**(26,646)**	**(23,274)**	**(21,234)**	**(16,704)**	**(24,678)**	**(19,546)**
Cash and cash equivalents at 1 April	**45,445**	**(130,611)**	**(177,141)**	**(211,421)**	**(240,833)**	**(266,537)**	**(298,347)**	**(318,568)**	**(349,896)**	**(374,528)**	**(393,894)**	**(420,540)**	**(443,814)**	**(465,047)**	**(481,751)**	**(506,429)**
Cash and cash equivalents at 31 March	**(130,611)**	**(177,141)**	**(211,421)**	**(240,833)**	**(266,537)**	**(298,347)**	**(318,568)**	**(349,896)**	**(374,528)**	**(393,894)**	**(420,540)**	**(443,814)**	**(465,047)**	**(481,751)**	**(506,429)**	**(525,974)**

Estates Infrastructure Option 3

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	556,623	567,986	579,583	591,419	603,499	615,827	628,409	641,250
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**616,373**	**628,438**	**640,746**	**653,300**	**666,107**	**679,171**	**692,497**	**706,092**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,976)	(315,028)	(316,940)	(319,267)	(321,644)	(324,053)	(326,496)	(333,891)	(341,455)	(349,193)
Non pay costs	(256,534)	(258,586)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(281,255)	(282,156)	(283,054)	(283,932)	(284,793)	(289,851)	(295,000)	(300,244)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(598,195)**	**(601,423)**	**(604,698)**	**(607,985)**	**(611,291)**	**(623,742)**	**(636,455)**	**(649,437)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**18,178**	**27,015**	**36,047**	**45,316**	**54,815**	**55,429**	**56,042**	**56,655**
Depreciation, amortisation & impairments	(19,440)	(22,406)	(24,616)	(26,608)	(29,067)	(30,962)	(32,434)	(37,133)	(36,807)	(36,811)	(35,790)	(36,525)	(36,919)	(36,859)	(36,961)	(36,952)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,715)	(6,954)	(7,352)	(7,345)	(7,392)	(7,516)	(7,613)	(15,664)	(14,822)	(14,404)	(13,948)	(13,595)	(13,334)	(13,012)	(12,749)	(12,545)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,353)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(46,627)**	**(34,058)**	**(24,598)**	**(14,278)**	**(5,381)**	**3,999**	**5,008**	**5,798**	**6,641**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,353)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(46,627)**	**(34,058)**	**(24,598)**	**(14,278)**	**(5,381)**	**3,999**	**5,008**	**5,798**	**6,641**
Impairments	(2,295)	0	0	0	0	0	0	(50,387)	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(30,648)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(97,015)**	**(34,058)**	**(24,598)**	**(14,278)**	**(5,381)**	**3,999**	**5,008**	**5,798**	**6,641**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	290,464	328,362	329,885	352,868	449,297	540,120	557,355	515,549	501,360	483,963	467,975	457,053	446,841	432,606	426,589	416,543
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(18,986)	(60,070)	(89,100)	(111,864)	(133,532)	(153,655)	(170,585)	(201,231)	(216,064)	(218,523)	(212,333)	(201,471)	(178,702)	(150,448)	(129,194)	(101,815)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,664)	(72,750)	(72,828)
Total assets less current liabilities	**227,473**	**225,212**	**199,605**	**199,381**	**274,789**	**345,441**	**345,604**	**272,903**	**244,282**	**223,902**	**214,659**	**214,921**	**227,585**	**241,701**	**257,844**	**275,099**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**178,443**	**172,182**	**149,896**	**153,437**	**231,963**	**305,782**	**309,253**	**240,110**	**214,645**	**197,954**	**191,850**	**194,914**	**210,274**	**226,978**	**244,814**	**263,840**
Financed by																
Public dividend capital	169,372	197,988	209,898	246,128	358,834	467,592	506,274	534,146	542,739	550,646	558,820	567,265	578,626	590,322	602,360	614,746
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(40,081)	(74,958)	(108,954)	(141,843)	(176,023)	(210,962)	(246,173)	(343,188)	(377,246)	(401,844)	(416,123)	(421,504)	(417,504)	(412,496)	(406,698)	(400,057)
Total taxpayers' and others' equity	**178,443**	**172,182**	**149,896**	**153,437**	**231,963**	**305,782**	**309,253**	**240,110**	**214,645**	**197,954**	**191,850**	**194,914**	**210,274**	**226,978**	**244,814**	**263,840**

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£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,390)	(27,277)	(26,002)	(24,905)	(26,154)	(26,795)	(26,975)	(30,348)	(18,629)	(9,596)	257	8,790	17,897	18,570	19,082	19,703
Depreciation and amortisation	19,632	22,907	25,117	27,109	29,568	31,463	32,935	37,634	37,308	37,112	36,291	37,026	37,420	37,360	37,462	37,453
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(884)**	**2,204**	**3,414**	**4,668**	**5,959**	**7,286**	**18,679**	**27,516**	**36,548**	**45,817**	**55,316**	**55,930**	**56,543**	**57,156**
Purchase of PP&E and investment property	(76,038)	(51,537)	(26,640)	(50,093)	(125,996)	(122,287)	(50,169)	(46,217)	(23,118)	(19,716)	(20,303)	(26,104)	(27,209)	(23,124)	(31,445)	(27,407)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(75,018)**	**(51,537)**	**(26,640)**	**(50,093)**	**(125,996)**	**(122,287)**	**(50,169)**	**(46,217)**	**(23,118)**	**(19,716)**	**(20,303)**	**(26,104)**	**(27,209)**	**(23,124)**	**(31,445)**	**(27,407)**
Public dividend capital received	38,617	28,616	11,711	38,430	112,706	108,758	38,882	27,872	8,593	7,908	8,174	8,445	11,361	11,896	12,038	12,386
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest element of service concession obligations	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,715)	(6,954)	(7,352)	(7,345)	(7,392)	(7,516)	(7,613)	(15,664)	(14,822)	(14,404)	(13,948)	(13,595)	(13,334)	(13,012)	(12,749)	(12,545)
Net cash generated from financing activities	**13,344**	**14,823**	**(1,507)**	**25,125**	**100,915**	**97,496**	**27,280**	**8,285**	**(10,394)**	**(10,260)**	**(10,055)**	**(8,851)**	**(5,339)**	**(4,552)**	**(3,844)**	**(2,370)**
Increase / (decrease) in cash and cash equivalents	**(64,431)**	**(41,083)**	**(29,031)**	**(22,764)**	**(21,668)**	**(20,123)**	**(16,930)**	**(30,646)**	**(14,833)**	**(2,459)**	**6,190**	**10,862**	**22,769**	**28,254**	**21,254**	**27,380**
Cash and cash equivalents at 1 April	**45,445**	**(18,986)**	**(60,070)**	**(89,100)**	**(111,864)**	**(133,532)**	**(153,655)**	**(170,585)**	**(201,231)**	**(216,064)**	**(218,523)**	**(212,333)**	**(201,471)**	**(178,702)**	**(150,448)**	**(129,194)**
Cash and cash equivalents at 31 March	**(18,986)**	**(60,070)**	**(89,100)**	**(111,864)**	**(133,532)**	**(153,655)**	**(170,585)**	**(201,231)**	**(216,064)**	**(218,523)**	**(212,333)**	**(201,471)**	**(178,702)**	**(150,448)**	**(129,194)**	**(101,815)**

Estates Infrastructure Option 4

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	556,623	567,986	579,583	591,419	603,499	615,827	628,409	641,250
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**616,373**	**628,438**	**640,746**	**653,300**	**666,107**	**679,171**	**692,497**	**706,092**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,976)	(315,028)	(317,283)	(319,956)	(322,682)	(325,444)	(328,247)	(335,675)	(343,274)	(351,049)
Non pay costs	(256,534)	(258,586)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(281,558)	(282,766)	(283,974)	(285,167)	(286,346)	(291,435)	(296,616)	(301,892)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(598,841)**	**(602,722)**	**(606,656)**	**(610,610)**	**(614,594)**	**(627,110)**	**(639,890)**	**(652,941)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**17,532**	**25,717**	**34,090**	**42,690**	**51,513**	**52,061**	**52,607**	**53,151**
Depreciation, amortisation & impairments	(19,440)	(22,406)	(24,616)	(26,608)	(29,067)	(30,962)	(32,434)	(37,266)	(36,925)	(36,729)	(35,907)	(36,643)	(37,036)	(36,976)	(37,078)	(37,070)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(578)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,715)	(6,954)	(7,352)	(7,345)	(7,392)	(7,516)	(7,613)	(16,059)	(15,078)	(14,639)	(14,179)	(13,822)	(13,557)	(13,231)	(12,964)	(12,755)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,353)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(47,155)**	**(35,077)**	**(26,249)**	**(16,585)**	**(8,352)**	**357**	**1,303**	**2,031**	**2,808**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,353)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(47,155)**	**(35,077)**	**(26,249)**	**(16,585)**	**(8,352)**	**357**	**1,303**	**2,031**	**2,808**
Impairments	(2,295)	0	0	0	0	0	0	(52,383)	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(30,648)**	**(34,877)**	**(33,996)**	**(32,889)**	**(34,180)**	**(34,939)**	**(35,211)**	**(99,538)**	**(35,077)**	**(26,249)**	**(16,585)**	**(8,352)**	**357**	**1,303**	**2,031**	**2,808**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	291,234	327,787	329,436	354,215	468,789	553,029	572,063	523,400	508,147	490,633	474,528	463,488	453,160	438,807	432,673	422,509
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(18,986)	(60,070)	(89,100)	(111,864)	(133,532)	(153,655)	(170,585)	(201,625)	(217,361)	(221,354)	(217,353)	(209,345)	(190,101)	(165,434)	(147,831)	(124,166)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**228,243**	**224,636**	**199,157**	**200,727**	**284,281**	**358,349**	**360,312**	**280,358**	**249,773**	**227,742**	**216,192**	**213,483**	**222,504**	**232,916**	**245,291**	**258,713**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**179,212**	**171,606**	**149,447**	**154,783**	**241,455**	**318,690**	**323,961**	**247,565**	**220,135**	**201,793**	**193,382**	**193,476**	**205,193**	**218,192**	**232,261**	**247,455**
Financed by																
Public dividend capital	170,141	197,412	209,250	247,474	368,328	480,500	520,982	544,125	551,772	559,680	567,854	576,299	587,660	599,356	611,393	623,779
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(40,081)	(74,958)	(108,954)	(141,843)	(176,023)	(210,962)	(246,173)	(345,712)	(380,789)	(407,039)	(423,624)	(431,975)	(431,619)	(430,315)	(428,284)	(425,476)
Total taxpayers' and others' equity	**179,212**	**171,606**	**149,447**	**154,783**	**241,455**	**318,690**	**323,961**	**247,565**	**220,135**	**201,793**	**193,382**	**193,476**	**205,193**	**218,192**	**232,261**	**247,455**

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£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,390)	(27,277)	(26,002)	(24,905)	(26,154)	(26,795)	(26,975)	(30,481)	(19,392)	(11,012)	(1,818)	6,047	14,477	15,085	15,529	16,081
Depreciation and amortisation	19,632	22,907	25,117	27,109	29,568	31,463	32,935	37,767	37,425	37,230	36,408	37,144	37,537	37,477	37,579	37,571
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(884)**	**2,204**	**3,414**	**4,668**	**5,959**	**7,286**	**18,033**	**26,218**	**34,591**	**43,191**	**52,014**	**52,562**	**53,108**	**53,652**
Purchase of PP&E and investment property	(76,807)	(50,192)	(26,767)	(51,888)	(134,142)	(125,703)	(51,969)	(41,487)	(22,173)	(19,716)	(20,303)	(26,104)	(27,209)	(23,124)	(31,445)	(27,407)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(75,787)**	**(50,192)**	**(26,767)**	**(51,888)**	**(134,142)**	**(125,703)**	**(51,969)**	**(41,487)**	**(22,173)**	**(19,716)**	**(20,303)**	**(26,104)**	**(27,209)**	**(23,124)**	**(31,445)**	**(27,407)**
Public dividend capital received	39,386	27,270	11,838	38,225	120,852	112,174	40,482	23,143	7,647	7,908	8,174	8,445	11,361	11,696	12,038	12,386
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest element of service concession obligations	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,715)	(6,954)	(7,352)	(7,345)	(7,392)	(7,516)	(7,613)	(16,059)	(15,078)	(14,639)	(14,179)	(13,822)	(13,557)	(13,231)	(12,964)	(12,755)
Net cash generated from financing activities	**14,114**	**13,478**	**(1,379)**	**26,920**	**109,060**	**100,912**	**29,079**	**3,161**	**(11,596)**	**(10,495)**	**(10,287)**	**(9,078)**	**(5,562)**	**(4,771)**	**(4,059)**	**(2,581)**
Increase / (decrease) in cash and cash equivalents	**(64,431)**	**(41,083)**	**(29,031)**	**(22,764)**	**(21,668)**	**(20,123)**	**(16,930)**	**(31,040)**	**(15,735)**	**(3,993)**	**4,001**	**8,009**	**19,244**	**24,667**	**17,604**	**23,665**
Cash and cash equivalents at 1 April	**45,445**	**(18,986)**	**(60,070)**	**(89,100)**	**(111,864)**	**(133,532)**	**(153,655)**	**(170,585)**	**(201,625)**	**(217,361)**	**(221,354)**	**(217,353)**	**(209,345)**	**(190,101)**	**(165,434)**	**(147,831)**
Cash and cash equivalents at 31 March	**(18,986)**	**(60,070)**	**(89,100)**	**(111,864)**	**(133,532)**	**(153,655)**	**(170,585)**	**(201,625)**	**(217,361)**	**(221,354)**	**(217,353)**	**(209,345)**	**(190,101)**	**(165,434)**	**(147,831)**	**(124,166)**

Estates Infrastructure Option 6

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	568,489	580,096	591,941	604,031	616,370	628,963	641,815
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**628,941**	**641,258**	**653,823**	**666,640**	**679,714**	**693,051**	**706,657**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(297,249)	(303,051)	(308,976)	(315,028)	(321,217)	(320,809)	(320,893)	(321,000)	(321,137)	(321,311)	(328,627)	(336,112)
Non pay costs	(256,534)	(258,586)	(261,355)	(264,402)	(268,393)	(272,442)	(276,553)	(280,729)	(284,977)	(284,318)	(283,190)	(282,031)	(280,847)	(279,644)	(284,592)	(289,629)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,380)**	**(555,965)**	**(565,642)**	**(575,493)**	**(585,529)**	**(595,757)**	**(606,194)**	**(605,126)**	**(604,083)**	**(603,031)**	**(601,983)**	**(600,955)**	**(613,218)**	**(625,742)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,385)**	**1,703**	**2,913**	**4,167**	**5,458**	**6,785**	**8,135**	**23,815**	**37,175**	**50,792**	**64,656**	**78,759**	**79,833**	**80,915**
Depreciation, amortisation & impairments	(19,385)	(22,321)	(24,500)	(26,282)	(28,109)	(29,533)	(30,333)	(30,969)	(41,155)	(41,311)	(40,379)	(41,001)	(41,173)	(40,888)	(40,760)	(40,517)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,892)	(6,896)	(7,271)	(7,166)	(6,867)	(6,524)	(6,130)	(5,816)	(33,001)	(31,981)	(31,693)	(31,024)	(30,404)	(29,728)	(29,161)	(28,658)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,275)**	**(34,733)**	**(33,799)**	**(32,383)**	**(32,697)**	**(32,518)**	**(31,628)**	**(30,614)**	**(66,628)**	**(50,076)**	**(35,484)**	**(21,810)**	**(7,485)**	**7,593**	**9,377**	**11,222**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,275)**	**(34,733)**	**(33,799)**	**(32,383)**	**(32,697)**	**(32,518)**	**(31,628)**	**(30,614)**	**(66,628)**	**(50,076)**	**(35,484)**	**(21,810)**	**(7,485)**	**7,593**	**9,377**	**11,222**
Impairments	(2,295)	0	0	0	0	0	0	0	(191,884)	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(30,569)**	**(34,733)**	**(33,799)**	**(32,383)**	**(32,697)**	**(32,518)**	**(31,628)**	**(30,614)**	**(258,513)**	**(50,076)**	**(35,484)**	**(21,810)**	**(7,485)**	**7,593**	**9,377**	**11,222**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	301,218	349,303	363,113	362,313	478,751	669,391	875,780	1,081,459	994,278	995,467	970,452	950,526	928,803	905,828	891,207	872,695
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(18,963)	(59,988)	(88,938)	(111,523)	(132,666)	(151,797)	(167,244)	(188,668)	(231,724)	(254,961)	(265,388)	(266,479)	(250,940)	(216,071)	(187,439)	(151,913)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**238,250**	**246,234**	**232,996**	**209,167**	**305,110**	**476,570**	**667,370**	**831,374**	**721,540**	**698,969**	**664,081**	**643,387**	**637,309**	**649,300**	**664,217**	**681,153**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**189,220**	**193,203**	**183,287**	**163,223**	**262,284**	**436,911**	**631,019**	**798,581**	**691,903**	**673,021**	**641,271**	**623,379**	**619,998**	**634,577**	**651,187**	**669,895**
Financed by																
Public dividend capital	180,071	218,787	242,670	254,989	386,747	593,892	819,628	1,017,805	1,169,639	1,200,833	1,204,568	1,208,486	1,212,589	1,219,574	1,226,807	1,234,292
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(40,003)	(74,736)	(108,535)	(140,918)	(173,615)	(206,134)	(237,761)	(268,376)	(526,888)	(576,964)	(612,449)	(634,258)	(641,743)	(634,150)	(624,772)	(613,550)
Total taxpayers' and others' equity	**189,220**	**193,203**	**183,287**	**163,223**	**262,284**	**436,911**	**631,019**	**798,581**	**691,903**	**673,021**	**641,271**	**623,379**	**619,998**	**634,577**	**651,187**	**669,895**

SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Actual/Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Operating surplus / (deficit) from continuing operations	(22,335)	(27,191)	(25,886)	(24,579)	(25,196)	(25,368)	(24,875)	(24,184)	(33,020)	(17,496)	(3,204)	9,791	23,483	37,871	39,073	40,398
Depreciation and amortisation	19,577	22,822	25,001	26,783	28,610	30,034	30,834	31,470	41,656	41,812	40,880	41,502	41,674	41,389	41,261	41,018
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(884)**	**2,204**	**3,414**	**4,668**	**5,959**	**7,286**	**8,636**	**24,316**	**37,676**	**51,293**	**65,157**	**79,260**	**80,334**	**81,416**
Purchase of PP&E and investment property	(86,737)	(61,638)	(38,811)	(25,983)	(145,048)	(220,674)	(237,222)	(217,149)	(166,360)	(43,002)	(15,864)	(21,576)	(19,951)	(18,413)	(26,641)	(22,506)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(85,717)**	**(61,638)**	**(38,811)**	**(25,983)**	**(145,048)**	**(220,674)**	**(237,222)**	**(217,149)**	**(166,360)**	**(43,002)**	**(15,864)**	**(21,576)**	**(19,951)**	**(18,413)**	**(26,641)**	**(22,506)**
Public dividend capital received	49,316	38,716	23,682	12,319	131,758	207,145	225,736	198,177	151,834	31,194	3,735	3,917	4,104	6,985	7,233	7,485
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest element of service concession obligations	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,692)	(6,896)	(7,271)	(7,166)	(6,867)	(6,524)	(6,130)	(5,816)	(33,001)	(31,981)	(31,693)	(31,024)	(30,404)	(29,728)	(29,161)	(26,658)
Net cash generated from financing activities	**24,066**	**24,982**	**10,746**	**1,194**	**120,491**	**196,875**	**215,816**	**188,438**	**114,668**	**(4,551)**	**(32,239)**	**(30,808)**	**(29,666)**	**(25,978)**	**(25,061)**	**(23,384)**
Increase / (decrease) in cash and cash equivalents	**(64,408)**	**(41,025)**	**(28,950)**	**(22,585)**	**(21,143)**	**(19,131)**	**(15,447)**	**(21,424)**	**(43,056)**	**(23,237)**	**(10,427)**	**(1,091)**	**15,539**	**34,868**	**28,632**	**35,526**
Cash and cash equivalents at 1 April	**45,445**	**(18,963)**	**(59,988)**	**(88,938)**	**(111,523)**	**(132,666)**	**(151,797)**	**(167,244)**	**(188,668)**	**(231,724)**	**(254,961)**	**(265,388)**	**(266,479)**	**(250,940)**	**(216,071)**	**(187,439)**
Cash and cash equivalents at 31 March	**(18,963)**	**(59,988)**	**(88,938)**	**(111,523)**	**(132,666)**	**(151,797)**	**(167,244)**	**(188,668)**	**(231,724)**	**(254,961)**	**(265,388)**	**(266,479)**	**(250,940)**	**(216,071)**	**(187,439)**	**(151,913)**

Digital Option 2

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,608	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(261,216)	(266,763)	(291,050)	(295,668)	(300,219)	(305,903)	(311,523)	(317,626)	(323,866)	(331,107)	(338,517)	(346,091)	(353,837)	(361,760)	(369,863)	(378,152)
Non pay costs	(280,402)	(282,531)	(265,379)	(268,604)	(271,363)	(275,293)	(279,122)	(283,327)	(287,627)	(292,789)	(298,006)	(303,337)	(308,785)	(314,291)	(319,919)	(325,672)
Total Operating Expenses	**(541,618)**	**(549,294)**	**(556,429)**	**(564,272)**	**(571,581)**	**(581,196)**	**(590,644)**	**(600,952)**	**(611,493)**	**(623,896)**	**(636,523)**	**(649,428)**	**(662,622)**	**(676,051)**	**(689,782)**	**(703,824)**
Operating Surplus/(Deficit)	**(10,687)**	**(12,762)**	**(9,435)**	**(6,605)**	**(3,027)**	**(1,536)**	**343**	**1,590**	**2,836**	**2,456**	**2,094**	**1,700**	**1,268**	**858**	**407**	**(88)**
Depreciation, amortisation & impairments	(19,923)	(22,914)	(25,102)	(27,303)	(29,135)	(31,008)	(32,018)	(32,893)	(32,701)	(32,637)	(32,012)	(32,813)	(33,449)	(32,995)	(33,107)	(32,907)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(596)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,909)	(7,330)	(7,899)	(7,646)	(7,391)	(7,203)	(7,095)	(7,022)	(7,026)	(6,913)	(6,801)	(6,780)	(6,799)	(6,717)	(6,659)	(6,666)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(36,766)**	**(43,652)**	**(42,878)**	**(42,193)**	**(40,188)**	**(40,376)**	**(39,392)**	**(38,940)**	**(37,493)**	**(37,692)**	**(37,306)**	**(38,470)**	**(39,544)**	**(39,403)**	**(39,895)**	**(40,179)**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(36,766)**	**(43,652)**	**(42,878)**	**(42,193)**	**(40,188)**	**(40,376)**	**(39,392)**	**(38,940)**	**(37,493)**	**(37,692)**	**(37,306)**	**(38,470)**	**(39,544)**	**(39,403)**	**(39,895)**	**(40,179)**
Impairments	(2,295)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(39,061)**	**(43,652)**	**(42,878)**	**(42,193)**	**(40,188)**	**(40,376)**	**(39,392)**	**(38,940)**	**(37,493)**	**(37,692)**	**(37,306)**	**(38,470)**	**(39,544)**	**(39,403)**	**(39,895)**	**(40,179)**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	296,992	329,954	326,084	318,331	303,974	300,216	290,544	288,569	282,900	274,395	269,141	266,459	264,025	255,672	255,568	251,667
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(38,948)	(88,487)	(126,094)	(157,820)	(185,540)	(212,040)	(233,856)	(262,109)	(285,387)	(305,389)	(327,676)	(353,615)	(377,859)	(397,880)	(426,173)	(449,659)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**214,040**	**198,387**	**158,811**	**118,888**	**77,458**	**47,151**	**15,723**	**(14,957)**	**(43,501)**	**(72,512)**	**(99,517)**	**(127,817)**	**(154,389)**	**(182,665)**	**(210,157)**	**(237,621)**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**165,009**	**145,356**	**109,102**	**72,944**	**34,632**	**7,492**	**(20,629)**	**(47,750)**	**(73,139)**	**(98,460)**	**(122,327)**	**(147,824)**	**(171,700)**	**(197,389)**	**(223,187)**	**(248,879)**
Financed by																
Public dividend capital	164,351	188,350	194,974	201,009	202,884	216,120	227,392	239,211	251,322	263,692	277,131	290,104	305,772	319,487	333,584	348,070
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(48,494)	(92,146)	(135,024)	(177,217)	(217,404)	(257,781)	(297,173)	(336,113)	(373,612)	(411,304)	(448,610)	(487,080)	(526,624)	(566,028)	(605,922)	(646,102)
Total taxpayers' and others' equity	**165,009**	**145,356**	**109,102**	**72,944**	**34,632**	**7,492**	**(20,629)**	**(47,750)**	**(73,139)**	**(98,460)**	**(122,327)**	**(147,824)**	**(171,700)**	**(197,389)**	**(223,187)**	**(248,879)**

SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(30,610)	(35,676)	(34,536)	(33,908)	(32,162)	(32,545)	(31,674)	(31,303)	(29,865)	(30,180)	(29,916)	(31,113)	(32,181)	(32,137)	(32,701)	(32,995)
Depreciation and amortisation	20,115	23,415	25,603	27,804	29,636	31,509	32,519	33,394	33,202	33,138	32,513	33,314	33,950	33,496	33,608	33,408
Net cash generated / (used in) operations	**(10,495)**	**(12,261)**	**(8,934)**	**(6,104)**	**(2,526)**	**(1,035)**	**844**	**2,091**	**3,337**	**2,957**	**2,595**	**2,201**	**1,769**	**1,359**	**908**	**413**
Purchase of PP&E and investment property	(83,049)	(47,109)	(21,733)	(20,051)	(15,279)	(27,751)	(22,847)	(31,418)	(27,534)	(24,632)	(27,260)	(30,632)	(31,516)	(25,143)	(33,505)	(29,507)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(82,029)**	**(47,109)**	**(21,733)**	**(20,051)**	**(15,279)**	**(27,751)**	**(22,847)**	**(31,418)**	**(27,534)**	**(24,632)**	**(27,260)**	**(30,632)**	**(31,516)**	**(25,143)**	**(33,505)**	**(29,507)**
Public dividend capital received	33,596	23,999	8,624	6,035	1,875	13,236	11,272	11,819	12,110	12,370	13,439	12,973	15,668	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,216)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest paid	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,909)	(7,330)	(7,699)	(7,846)	(7,391)	(7,203)	(7,095)	(7,022)	(7,026)	(6,913)	(6,801)	(6,780)	(6,799)	(6,717)	(6,659)	(6,866)
Net cash generated from financing activities	**8,131**	**9,831**	**(6,940)**	**(5,571)**	**(9,916)**	**2,287**	**387**	**873**	**919**	**1,693**	**2,357**	**2,492**	**5,503**	**3,763**	**4,304**	**5,609**
Increase / (decrease) in cash and cash equivalents	**(84,392)**	**(49,539)**	**(37,607)**	**(31,726)**	**(27,721)**	**(26,500)**	**(21,615)**	**(28,454)**	**(23,278)**	**(19,982)**	**(22,307)**	**(25,939)**	**(24,244)**	**(20,021)**	**(28,293)**	**(23,486)**
Cash and cash equivalents at 1 April	**45,445**	**(38,948)**	**(88,487)**	**(126,094)**	**(157,820)**	**(185,540)**	**(212,040)**	**(233,656)**	**(262,109)**	**(285,387)**	**(305,369)**	**(327,676)**	**(353,615)**	**(377,859)**	**(397,880)**	**(426,173)**
Cash and cash equivalents at 31 March	**(38,948)**	**(88,487)**	**(126,094)**	**(157,820)**	**(185,540)**	**(212,040)**	**(233,656)**	**(262,109)**	**(285,387)**	**(305,369)**	**(327,676)**	**(353,615)**	**(377,859)**	**(397,880)**	**(426,173)**	**(449,659)**

Digital Option 3

SoCI

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,606	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(294,571)	(299,829)	(304,687)	(310,654)	(316,755)	(323,853)	(331,118)	(338,544)	(346,139)	(353,908)	(361,855)	(369,983)
Non pay costs	(256,534)	(258,586)	(261,499)	(264,423)	(265,716)	(269,220)	(272,286)	(276,355)	(280,515)	(285,536)	(290,607)	(295,790)	(301,088)	(306,439)	(311,910)	(317,503)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,525)**	**(555,986)**	**(560,287)**	**(569,048)**	**(576,974)**	**(587,008)**	**(597,270)**	**(609,389)**	**(621,725)**	**(634,335)**	**(647,227)**	**(660,347)**	**(673,765)**	**(687,487)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,530)**	**1,681**	**8,268**	**10,611**	**14,014**	**15,534**	**17,059**	**16,964**	**16,892**	**16,793**	**16,663**	**16,561**	**16,424**	**16,249**
Depreciation, amortisation & impairments	(19,781)	(21,940)	(24,054)	(30,781)	(33,083)	(34,705)	(35,714)	(36,058)	(36,364)	(36,659)	(36,026)	(36,215)	(35,845)	(30,804)	(30,306)	(30,265)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(598)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,892)	(7,209)	(7,517)	(8,219)	(8,709)	(8,430)	(8,152)	(7,881)	(7,652)	(7,365)	(7,092)	(6,840)	(6,589)	(6,381)	(6,322)	(6,294)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,870)**	**(34,665)**	**(33,743)**	**(37,958)**	**(34,158)**	**(33,152)**	**(30,474)**	**(29,020)**	**(27,565)**	**(27,659)**	**(26,814)**	**(26,838)**	**(26,315)**	**(21,174)**	**(20,739)**	**(20,828)**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,870)**	**(34,665)**	**(33,743)**	**(37,958)**	**(34,158)**	**(33,152)**	**(30,474)**	**(29,020)**	**(27,565)**	**(27,659)**	**(26,814)**	**(26,838)**	**(26,315)**	**(21,174)**	**(20,739)**	**(20,828)**
Impairments	(2,295)	0	0	(301)	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(31,164)**	**(34,665)**	**(33,743)**	**(38,259)**	**(34,158)**	**(33,152)**	**(30,474)**	**(29,020)**	**(27,565)**	**(27,659)**	**(26,814)**	**(26,838)**	**(26,315)**	**(21,174)**	**(20,739)**	**(20,828)**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	296,023	323,994	321,827	355,535	342,063	332,243	318,876	309,284	297,944	286,165	275,035	264,005	253,354	247,191	244,776	241,210
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(24,698)	(51,463)	(78,218)	(101,803)	(119,216)	(134,457)	(143,459)	(154,375)	(162,049)	(167,724)	(175,035)	(180,994)	(188,120)	(190,103)	(196,928)	(201,398)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**227,320**	**229,451**	**202,231**	**212,108**	**181,871**	**156,761**	**134,251**	**113,492**	**94,882**	**75,904**	**59,018**	**42,350**	**26,679**	**16,632**	**8,296**	**183**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,859)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**178,290**	**176,421**	**152,521**	**166,165**	**139,045**	**117,102**	**97,900**	**80,699**	**65,244**	**49,956**	**36,208**	**22,343**	**9,368**	**1,908**	**(4,734)**	**(11,076)**
Financed by																
Public dividend capital	169,736	202,531	212,376	284,278	271,316	282,525	293,797	305,616	317,727	330,097	343,163	356,136	369,476	383,191	397,287	411,774
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(40,598)	(75,263)	(109,006)	(147,265)	(181,423)	(214,575)	(245,049)	(274,069)	(301,634)	(329,293)	(356,107)	(382,945)	(409,260)	(430,435)	(451,173)	(472,001)
Total taxpayers' and others' equity	**178,290**	**176,421**	**152,521**	**166,165**	**139,045**	**117,102**	**97,900**	**80,699**	**65,244**	**49,956**	**36,208**	**22,343**	**9,368**	**1,908**	**(4,734)**	**(11,076)**

SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,731)	(26,810)	(25,584)	(29,100)	(24,815)	(24,093)	(21,700)	(20,524)	(19,306)	(19,695)	(19,134)	(19,421)	(19,182)	(14,243)	(13,882)	(14,016)
Depreciation and amortisation	19,973	22,441	24,555	31,282	33,584	35,206	36,215	36,559	36,865	37,160	36,527	36,716	36,346	31,305	30,807	30,766
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(1,029)**	**2,182**	**8,769**	**11,112**	**14,515**	**16,035**	**17,560**	**17,465**	**17,393**	**17,294**	**17,164**	**17,062**	**16,925**	**16,750**
Purchase of PP&E and investment property	(81,937)	(41,143)	(22,188)	(65,491)	(20,111)	(25,386)	(22,847)	(26,967)	(25,526)	(24,381)	(26,396)	(25,685)	(25,695)	(25,143)	(28,391)	(27,201)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(80,917)**	**(41,143)**	**(22,188)**	**(65,491)**	**(20,111)**	**(25,386)**	**(22,847)**	**(26,967)**	**(25,526)**	**(24,381)**	**(26,396)**	**(25,685)**	**(25,695)**	**(25,143)**	**(28,391)**	**(27,201)**
Public dividend capital received	38,981	32,798	9,844	51,902	7,039	11,209	11,272	11,819	12,110	12,370	13,066	12,973	13,340	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest paid	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,892)	(7,209)	(7,517)	(8,219)	(8,709)	(8,430)	(8,152)	(7,881)	(7,852)	(7,365)	(7,092)	(6,840)	(6,569)	(6,381)	(6,322)	(6,294)
Net cash generated from financing activities	**13,532**	**18,748**	**(3,538)**	**39,723**	**(6,070)**	**(967)**	**(669)**	**15**	**293**	**1,241**	**1,692**	**2,432**	**3,404**	**4,098**	**4,642**	**5,980**
Increase / (decrease) in cash and cash equivalents	**(70,143)**	**(26,764)**	**(26,755)**	**(23,586)**	**(17,413)**	**(15,241)**	**(9,001)**	**(10,917)**	**(7,673)**	**(5,675)**	**(7,311)**	**(5,960)**	**(5,126)**	**(3,983)**	**(6,825)**	**(4,470)**
Cash and cash equivalents at 1 April	**45,450**	**(24,693)**	**(51,458)**	**(78,213)**	**(101,798)**	**(119,211)**	**(134,452)**	**(143,454)**	**(154,370)**	**(162,043)**	**(167,719)**	**(175,030)**	**(180,989)**	**(186,115)**	**(190,098)**	**(196,923)**
Cash and cash equivalents at 31 March	**(24,693)**	**(51,458)**	**(78,213)**	**(101,798)**	**(119,211)**	**(134,452)**	**(143,454)**	**(154,370)**	**(162,043)**	**(167,719)**	**(175,030)**	**(180,989)**	**(186,115)**	**(190,098)**	**(196,923)**	**(201,393)**

Digital Option 4

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£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating income from patient care activities	476,716	481,471	491,288	501,306	511,531	521,967	532,617	543,486	554,579	565,900	577,455	589,247	601,282	613,564	626,100	638,894
Other operating income	54,215	55,061	55,707	56,361	57,023	57,693	58,371	59,056	59,750	60,452	61,162	61,881	62,606	63,344	64,089	64,842
Total Income	**530,931**	**536,532**	**546,995**	**557,668**	**568,555**	**579,660**	**590,988**	**602,542**	**614,329**	**626,352**	**638,617**	**651,128**	**663,890**	**676,909**	**690,189**	**703,736**
Pay costs	(277,347)	(282,817)	(287,026)	(291,563)	(295,727)	(300,964)	(305,757)	(311,745)	(317,868)	(324,989)	(332,276)	(339,726)	(347,344)	(355,137)	(363,109)	(371,262)
Non pay costs	(256,534)	(258,585)	(261,871)	(264,476)	(266,871)	(270,355)	(273,356)	(277,446)	(281,629)	(286,671)	(291,765)	(296,971)	(302,293)	(307,668)	(313,164)	(318,782)
Total Operating Expenses	**(533,881)**	**(541,403)**	**(548,897)**	**(556,039)**	**(562,598)**	**(571,319)**	**(579,114)**	**(589,191)**	**(599,497)**	**(611,660)**	**(624,042)**	**(636,697)**	**(649,637)**	**(662,806)**	**(676,273)**	**(690,044)**
Operating Surplus/(Deficit)	**(2,950)**	**(4,871)**	**(1,902)**	**1,629**	**5,957**	**8,341**	**11,874**	**13,351**	**14,832**	**14,693**	**14,575**	**14,431**	**14,253**	**14,103**	**13,916**	**13,692**
Depreciation, amortisation & impairments	(19,781)	(21,940)	(24,376)	(29,848)	(32,949)	(34,826)	(35,836)	(36,063)	(36,357)	(36,650)	(36,284)	(36,486)	(35,758)	(32,018)	(30,655)	(30,242)
Finance income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance expense	(248)	(645)	(642)	(639)	(634)	(629)	(623)	(615)	(607)	(596)	(588)	(576)	(564)	(550)	(535)	(518)
PDC Dividends payable	(5,892)	(7,209)	(7,568)	(8,101)	(8,516)	(8,430)	(8,196)	(7,911)	(7,666)	(7,378)	(7,153)	(6,937)	(6,841)	(6,417)	(6,314)	(6,262)
Net Surplus/(Deficit) after Depreciation, Amortisation, Impairments and finance costs	**(28,870)**	**(34,665)**	**(34,487)**	**(36,959)**	**(36,142)**	**(35,544)**	**(32,783)**	**(31,238)**	**(29,798)**	**(29,933)**	**(29,450)**	**(29,549)**	**(28,709)**	**(24,881)**	**(23,587)**	**(23,330)**
Other tax movements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Surplus/(Deficit) for the year	**(28,870)**	**(34,665)**	**(34,487)**	**(36,959)**	**(36,142)**	**(35,544)**	**(32,783)**	**(31,238)**	**(29,798)**	**(29,933)**	**(29,450)**	**(29,549)**	**(28,709)**	**(24,881)**	**(23,587)**	**(23,330)**
Impairments	(2,295)	0	0	(1,102)	0	0	0	0	0	0	0	0	0	0	0	0
Total comprehensive income / (expense)	**(31,164)**	**(34,665)**	**(34,487)**	**(38,061)**	**(36,142)**	**(35,544)**	**(32,783)**	**(31,238)**	**(29,798)**	**(29,933)**	**(29,450)**	**(29,549)**	**(28,709)**	**(24,881)**	**(23,587)**	**(23,330)**

SoFP

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Non-current assets	296,023	323,994	324,521	345,877	340,675	333,634	320,144	309,731	298,309	285,528	278,123	266,461	254,965	247,589	243,887	240,242
Current assets (excl Cash)	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198	33,198
Cash	(30,459)	(66,492)	(93,670)	(117,514)	(136,713)	(153,414)	(164,602)	(176,916)	(186,740)	(194,687)	(204,748)	(212,787)	(219,463)	(225,939)	(234,325)	(241,217)
Current liabilities	(77,203)	(76,279)	(74,377)	(74,822)	(74,174)	(74,223)	(74,364)	(74,614)	(74,211)	(74,736)	(74,180)	(73,858)	(73,752)	(73,654)	(72,750)	(72,828)
Total assets less current liabilities	**221,559**	**214,421**	**189,672**	**186,739**	**162,986**	**139,194**	**114,376**	**91,399**	**70,556**	**49,303**	**32,393**	**13,014**	**(5,052)**	**(18,806)**	**(29,990)**	**(40,605)**
Non-current liabilities	(49,031)	(53,030)	(49,709)	(45,943)	(42,826)	(39,659)	(36,351)	(32,793)	(29,638)	(25,948)	(22,810)	(20,007)	(17,311)	(14,724)	(13,030)	(11,259)
Total net assets employed	**172,528**	**161,391**	**139,963**	**140,795**	**120,161**	**99,535**	**78,025**	**58,606**	**40,918**	**23,355**	**9,583**	**(6,994)**	**(22,363)**	**(33,530)**	**(43,020)**	**(51,863)**
Financed by																
Public dividend capital	163,974	187,502	200,561	239,454	254,961	269,880	281,152	292,971	305,082	317,452	333,129	346,102	359,442	373,157	387,253	401,740
Revaluation reserve	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152	49,152
Charitable funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income and expenditure reserve	(40,598)	(75,263)	(109,750)	(147,811)	(183,953)	(219,497)	(252,280)	(283,517)	(313,316)	(343,249)	(372,698)	(402,248)	(430,957)	(455,838)	(479,425)	(502,755)
Total taxpayers' and others' equity	**172,528**	**161,391**	**139,963**	**140,795**	**120,161**	**99,535**	**78,025**	**58,606**	**40,918**	**23,355**	**9,583**	**(6,994)**	**(22,363)**	**(33,530)**	**(43,020)**	**(51,863)**

SoCF

£'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Operating surplus / (deficit) from continuing operations	(22,731)	(26,810)	(26,277)	(26,219)	(26,992)	(26,486)	(23,962)	(22,712)	(21,524)	(21,957)	(21,709)	(22,036)	(21,505)	(17,915)	(16,739)	(16,550)
Depreciation and amortisation	19,973	22,441	24,877	30,349	33,450	35,327	36,337	36,564	36,858	37,151	36,785	36,987	36,259	32,519	31,156	30,743
Net cash generated / (used in) operations	**(2,758)**	**(4,370)**	**(1,401)**	**2,130**	**6,458**	**8,842**	**12,375**	**13,852**	**15,333**	**15,194**	**15,076**	**14,932**	**14,754**	**14,604**	**14,417**	**14,193**
Purchase of PP&E and investment property	(81,937)	(41,143)	(25,403)	(52,806)	(28,249)	(28,286)	(22,847)	(26,151)	(25,436)	(24,369)	(29,380)	(25,305)	(24,764)	(25,143)	(27,454)	(27,098)
Sales of PP&E and investment property	1,020	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Receipt of cash donations to purchase capital assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash generated / (used in) investing activities	**(80,917)**	**(41,143)**	**(25,403)**	**(52,806)**	**(28,249)**	**(28,286)**	**(22,847)**	**(26,151)**	**(25,436)**	**(24,369)**	**(29,380)**	**(25,305)**	**(24,764)**	**(25,143)**	**(27,454)**	**(27,098)**
Public dividend capital received	33,219	23,527	13,080	38,893	15,507	14,919	11,272	11,819	12,110	12,370	15,677	12,973	13,340	13,715	14,097	14,486
Loans received/(repaid) from/to Department of Health	(19,284)	(6,123)	(5,137)	(3,218)	(3,642)	(2,973)	(3,001)	(3,119)	(3,345)	(2,927)	(3,428)	(2,830)	(2,478)	(2,330)	(2,209)	(1,269)
Interest element of service concession obligations	(273)	(715)	(728)	(742)	(758)	(773)	(788)	(804)	(820)	(837)	(853)	(871)	(888)	(906)	(924)	(942)
PDC dividend paid	(5,892)	(7,209)	(7,568)	(6,101)	(8,516)	(8,430)	(8,198)	(7,911)	(7,666)	(7,378)	(7,153)	(6,937)	(6,841)	(6,417)	(6,314)	(6,262)
Net cash generated from financing activities	**7,771**	**9,480**	**(373)**	**26,832**	**2,592**	**2,743**	**(715)**	**(15)**	**279**	**1,229**	**4,243**	**2,335**	**3,333**	**4,063**	**4,650**	**6,013**
Increase / (decrease) in cash and cash equivalents	**(75,904)**	**(36,033)**	**(27,177)**	**(23,844)**	**(19,199)**	**(16,701)**	**(11,188)**	**(12,314)**	**(9,824)**	**(7,947)**	**(10,061)**	**(8,039)**	**(6,676)**	**(6,476)**	**(8,386)**	**(6,892)**
Cash and cash equivalents at 1 April	**45,445**	**(30,459)**	**(66,492)**	**(93,670)**	**(117,514)**	**(136,713)**	**(153,414)**	**(164,602)**	**(176,916)**	**(186,740)**	**(194,687)**	**(204,748)**	**(212,787)**	**(219,463)**	**(225,939)**	**(234,325)**
Cash and cash equivalents at 31 March	**(30,459)**	**(66,492)**	**(93,670)**	**(117,514)**	**(136,713)**	**(153,414)**	**(164,602)**	**(176,916)**	**(186,740)**	**(194,687)**	**(204,748)**	**(212,787)**	**(219,463)**	**(225,939)**	**(234,325)**	**(241,217)**

9.5 Management Case

Appendix 9.5.1 Biographies of the Trust Board as at 30 June 2021

Richard Ibbotson Chairman **Appointed:** June 2014 **Reappointed:** April 2017 and June 2020	Sir Richard Ibbotson was appointed Chair of the Trust in June 2014, shortly after retiring from a career in the Royal Navy. This included periods in command of Britannia Royal Naval College Dartmouth, Commander British Forces Falkland Islands and Deputy Commander-in-Chief Fleet (effectively Chief Operating Officer of the Royal Navy and Royal Marines). He has considerable experience in operating at Board level and dealing with operational pressures and challenging budgets. As well as being knighted for his services, Richard is a Companion of the Most Honourable Order of the Bath and holds the Distinguished Service Cross and the NATO meritorious service medal. His academic background includes a degree in chemistry, a master's degree in defence technology, and an honorary doctorate in technology. He also holds other public roles, notably as a Deputy Lord Lieutenant for Devon. Richard has been a Governor of Plymouth University and Chairman of the Royal Navy Royal Marines Charity and was a Member of the Armed Forces Pay Review Body. Richard is Chair of the Non-Executive Nominations and Remuneration Committee and the Governor Nominations and Remuneration Committee, and is a lay-member of the Ethics Committee
Liz Davenport Chief Executive **Appointed:** October 2018	Liz as Chief Executive is responsible for the overall management of Trust activities delivering high quality services to the standards set within the resources available. As Accountable Officer she is responsible for ensuring that the Trust meets all of its statutory duties. Liz started work in the Trust in Torbay in September 2014 and was appointed as the Chief Operating Officer for the Integrated Care Organisation in January 2015. She took a key role in leading the implementation of the integrated care model, including the development of community services. Liz was appointed in October 2018 as the Trust's substantive Chief Executive following a period in the Interim role. Liz has a clinical background, and has been employed in the NHS since qualifying in 1986 as an Occupational Therapist. She has a passion for service improvement and transformation designed to improve outcomes and experiences for people in our communities making the best use of resources and evidence of what works well. Her career started in mental health services where she was involved in the setting up of community services for people with mental health needs. She has subsequently continued to work in a number of NHS organisations across the country leading on a number of service improvement projects in mental health, learning disabilities and social care services. She has also held a broad portfolio of Executive Director positions including Director of Operations, Director of Workforce and Organisation and Deputy Chief Executive in Devon Partnership Trust before making the transition to Acute and Community services in Torbay.

Chris Balch Non-Executive Director **Appointed:** April 2019	Chris Balch joined the Board as Non-Executive Director in April 2019. Chris is Emeritus Professor of Planning at Plymouth University and is a Chartered Town Planner and Surveyor. Prior to his academic career he held senior executive positions with an international property advisory company, latterly as Managing Director of DTZ UK & Ireland, now part of Cushman & Wakefield. He has extensive experience of providing consultancy advice to public and private sector clients across the UK and overseas specialising in the planning and delivery of major regeneration projects and Programmes. He was Chair of Basildon Renaissance Partnership, a member of the Council of Essex University, a Director of Torbay Development Agency and was until 2017, Non-Executive Chairman of Hilson Moran, a consultancy specialising in the energy performance of complex buildings. He is currently a member of the Supervisory Board of Ecorys BV, a European policy and research consultancy and is a Trustee of South West Lakes Trust. His interest lies in tackling the underperformance of places and managing positive change within professional organisations and communities. Chris is Chair of the Building a Brighter Future Committee (previously known as the HIP2 Redevelopment Committee). He is also a Board member of the Trust's subsidiary SDH Innovations Partnership LLP.
Jacqui Lyttle Non-Executive Director and Senior Independent Director **Appointed:** October 2014 **Reappointed:** October 2017 and October 2020	Jacqui Lyttle joined the Board as a Non-Executive Director in October 2014 having spent over 20 years working in the NHS at very senior manager and executive board level before establishing her own healthcare consultancy in 2008. She has a genuine passion for improving care for patients and speaks both nationally and internationally on quality and service improvement, commissioning for outcomes and the management of change within healthcare. Jacqui has an interest in the management of pain and is an executive member of the Chronic Pain Policy Coalition, a standing committee of an all Parliamentary Party Advisory Group. Other areas of interest include rheumatology, dermatology, endocrinology, cardiology and oncology with Jacqui working extensively in these areas across the UK Jacqui continues to work actively within the NHS, undertaking service reviews and leading on large scale quality improvement Programmes and acts as an executive commissioning advisor to several Royal Colleges and health related charities including Action on Pulmonary Fibrosis, Neuroendocrine Cancer UK and Diabetes UK. Jacqui is a lecturer on the NHS for Health Education England and has a keen interest in developing future clinical leaders. She is also an NHS advisor to several professional bodies including the British Society for Rheumatology and the British Association of Dermatology. Jacqui is Chair of AGE UK Torbay. Jacqui is Chair of the Quality Assurance Committee and the Torbay and South Devon NHS Charitable Funds Committee and is the Trust's Senior Independent Director.
Vikki Matthews Non-Executive Director **LLB (Hons)** **MBA** **FCIPD** **Appointed:** December 2017 **Reappointed:** December 2020	Vikki Matthews joined the Board as Non-Executive Director in December 2017. She is currently the Interim Executive Director for People at South Western Ambulance Foundation Trust. She is also the owner of a strategic consulting and executive coaching business and lectures in the areas of HR and leadership. Prior to this, Vikki was the Chief Talent Officer for Plymouth University and before that held several Global and EMEA-wide Director level roles for Nike based in Holland and the USA. Vikki Chaired a Multi Academy Trust based in Plymouth from 2012-2017 and is currently the Company Secretary for a small education charity in Brighton. Vikki is Chair of the People Committee.

Paul Richards Non-Executive Director **Appointed:** November 2017 **Reappointed:** November 2020	Paul Richards joined the Board as a Non-Executive Director in November 2017. In the early part of his career, he spent many years working in the NHS at senior manager and board level leading the digital and information agenda, taking the lead on clinical computing and Electronic Patient Records ('EPR') Programmes. Paul went on to move to the commercial sector where he has led a variety of successful software and services business at Director, Managing Director and Partner level with a range of well-known technology brands working internationally in the healthcare industry. As a result, Paul has extensive experience of running complex digital led health and social care Programmes. Today, he works with organisations and individuals to help them achieve their business objectives and grow their business. He has often been brought into organisations to turnaround acquisitions, develop governance arrangements and lead new business critical initiatives. Paul has a passion for improving and connecting health and social care to improve services to patients and ensure high quality outcomes. He continues to have a variety of business interests amongst them a local visitor attraction and conservation Programme which aims to protect wildlife and provide wildlife education to visitors. Paul is Chair of the Finance, Performance and Digital Committee.
Robin Sutton Non-Executive Director **Appointed:** May 2016 **Reappointed:** May 2019	Robin Sutton joined the Board as Non-Executive Director in May 2016. Robin is a chartered accountant with over thirty years of financial experience gained at a senior level for both private and public enterprises in both executive and Non-Executive Director roles. Robin has previously held Non-Executive Director and senior positions at several multi-national organisations including Sifam, Fianium Holdings, CompAir Holman, Rolls-Royce PLC and Deloittes. Robin's interest in healthcare stems from a variety of different factors, ranging from consulting for Lowell General Hospital in Massachusetts through to working with Novartis in developing ultrafast fibre laser technology for eye surgery. He has also been heavily involved with care services and social care covering a spectrum of services from meals on wheels, day care, supported living and residential care. Robin currently has local business interests in the care home industry. Robin has also enjoyed completing an Innovating in Healthcare program with Harvard University with a team of like-minded people looking at smart phone applications in the field of dementia. Robin is Chair of Torbay Pharmaceuticals, a Director of the Trust's subsidiary SDH Developments Limited, and a Board member of Health and Care Innovations LLP.
Sally Taylor Non-Executive Director and Vice Chair **Appointed:** January 2013 (South Devon Healthcare NHSFT) **Reappointed:** January 2016 and January 2019	Sally Taylor joined the Board when the ICO was formed having previously been a Non-Executive Director of South Devon Healthcare NHS Foundation Trust from January 2013. Sally was appointed Chair of Cornwall Care Limited in January 2021. She was the Chief Executive of St Luke's Hospice in Plymouth from 1994 to 2016. St Luke's delivers specialist palliative care, including advice and support to other professionals, for patients in Derriford, at home and in the hospice in-patient unit. Prior to that she spent nine years as a Chartered Accountant with PricewaterhouseCoopers LLP in London, specialising in corporate finance for small and growing businesses. Sally has been Trustee/ treasurer/chairman of several charities including Hospice UK (the national membership body for hospices), the Harbour Centre drug and alcohol advisory service and the Barbican Theatre in Plymouth. Sally is Chair of the Audit Committee.
Jon Welch	Jon Welch joined the Board in 2015 having previously been a Non-Executive Director of Torbay and Southern Devon Health and Care NHS Trust that had corporate responsibility for both community health and for adult social care provision.

Non-Executive Director **Appointed:** October 2015 **Reappointed:** October 2018	Jon comes from a Royal Navy background, with his last appointment before he retired being Head of Research and Technology for NATO Transformation Command in the USA. He received a letter of appreciation and commendation from the NATO Secretary General following his successful formation of a new department with high level NATO interest. He was also honoured with the Legion of Merit by the US President; the highest award the USA can give to a foreign national.
Ian Currie Executive Medical Director **Appointed:** September 2020	Ian is responsible for provision of high quality, safe and effective care and providing medical input into shaping strategy as well as the Caldicott Guardian for the Trust. Ian joined the Trust in 1998 as Consultant Vascular Surgeon, having previously been Senior Registrar in General and Vascular Surgery at Plymouth Hospitals NHS Trust. Prior to this, Ian worked at several hospitals in the South West, including Cheltenham General Hospital, Bristol Hospitals, Gloucestershire Royal Hospital, as well as John Radcliffe Hospital in Oxford. This period also included a year spent working in Sydney, Australia. Ian has a long-standing interest in integrated care models, urgent and emergency care and planned care, and has held a range of appointments in educational and leadership roles throughout his career. He has a strong interest in prevention and previously developed and led the South Devon and Exeter Abdominal Aortic Aneurysm screening Programme.
Judy Falcão Chief People Officer (previously Director of Workforce and Organisational Development) **Dip MS, FCIPD, MSc HRM** **Appointed:** August 2016	Judy Falcão is responsible for the delivery of the Trust People Plan. Her key areas of responsibility cover services and functions including the Resourcing Hub, People Hub (HR Practice Advisory Services), Business Partnering, Payroll and Pensions, Workforce Information and Planning, Health and Wellbeing including Occupational Health, Organisational Development including Staff Experience, Leadership Development, Coaching, Cultural Change, Talent Management, Equality and Diversity and Freedom to Speak Up. Judy joined the Trust in August 2016. Prior to joining the Trust, she was the Director of Workforce and Organisational Development at Poole Hospital NHS Foundation Trust. Judy has held several Executive Director roles across the NHS including Acute, Mental Health, Health Authority, and the Ambulance Service.
John Harrison Chief Operating Officer **Appointed** April 2019	John Harrison is responsible for developing, implementing and ongoing oversight of health and social care delivery for the Trust's population. He is also responsible for overseeing health and safety and security management functions for the Trust. John joined the Trust in February 2012 and in January 2018 took on the operations portfolio as Interim Chief Operating Officer, having previously been Deputy Chief Operating Officer. He was appointed to the substantive Chief Operating Officer position in April 2019. Prior to joining the Trust, John was Director of the Peninsula Cancer Network and led the process across Devon and Cornwall to secure necessary service changes to deliver the NHS Cancer Plan improvements. He has 21 years of healthcare experience and was previously Director of Commissioning for Plymouth Primary Care Trust, having run GP Fundholding for the previous Health Authority. John's external interests include acting as a Trustee of SPACE Youth Service for Devon.
Adel Jones	Adel Jones is responsible for the development of the Trust vision for the future and the strategy to deliver our strategic ambitions, including transformation Programmes. Her portfolio includes the delivery of the Trust Digital Strategy, its

Director of Transformation and Partnerships **Appointed:** July 2019	aims of which are to ensure that we harness the potential of technology, to enable the delivery of care in our facilities, to enable more care to be delivered closer to home and to support our local population to engage more effectively in their care to improve wellbeing. Working with staff, local people and partnership organisations is integral to the development and delivery of our strategy and this is a core part of Adel's portfolio, including responsibility for communications, partnerships and charitable fundraising. Adel joined the Trust in July 2019 and has significant experience of operational management across acute and community services, service improvement, strategic planning and workforce development. She is passionate about service transformation and in particular ensuring that we have effective partnerships with our local people, councils, voluntary sector and other health and social care organisations to meet the needs of our local people. Adel is a Board member of the Trust's subsidiary, Health and Care Innovations LLP.
Deborah Kelly Chief Nurse **Appointed:** August 2020	Deborah Kelly is responsible for the quality and safety of the care provided by the Trust, including infection prevention. Deborah joined the Trust in August 2020 and as Chief Nurse leads on several objectives including quality, professional practice, patient experience, safeguarding, infection prevention and control, and clinical governance. Deborah qualified as a nurse in 1985 and has spent the majority of her career working in London in a range of leadership roles in community, acute and tertiary services. Deborah was previously Deputy Chief Nurse for Barts Health NHS Trust and more recently returned from working in the Middle East as the Deputy Chief Nurse and Chief Nurse for Informatics at Sidra Medicine, Doha Qatar. In her previous roles she has devised quality, clinical governance and patient experience strategies, ensuring that staff and patients voice are heard. Deborah feel passionately around creating opportunities to empower staff and has successfully introduced models of shared governance, enabling staff led change and improvement. Her work around patient and public engagement was cited as best practice internationally by the Canadian Agency for Drugs and Technologies in Health 2017 and she has successfully partnered with the Kings Fund in 2015/16 through the Collaborative Pairs Programme.
David Stacey Chief Finance Officer **Appointed:** January 2020	Dave Stacey is responsible for the Foundation Trust's financial planning and performance. Dave joined the Foundation Trust in January 2020 from North Middlesex University Hospital, where he spent three years as Director of Finance leading a successful financial turnaround, securing significant external funding for large capital Programmes and overseeing a major digital transformation Programme. His previous roles include Deputy Director of Transformation at Chelsea and Westminster NHS FT, where he played a pivotal role in the successful integration of West Middlesex Hospital, and Director of Strategy at England's biggest mental health trust, West London Mental Health. Prior to joining the NHS in 2013, he spent 7 years in KPMG's healthcare team, delivering audit and advisory services to a range of UK and international healthcare organisations.
Dr Joanne Watson Health and Care Strategy Director **Appointed:** February 2021	Joanne Watson is responsible for delivering our Health and Care Strategy which focuses on making sure our services meet the current and future needs of our people while supporting them to live well. Her unique Board-level position showcases our innovative approach to providing integrated care and ensuring the best use of the monies we will receive from the Government's New Hospital Programme. We are proud to be one of only 40 recipients of this once in a generation programme which will support us to make a real difference in how we deliver services with, to and for our people.

Joanne joined us in 2016 as Deputy Medical Director and Consultant Physician in Acute Medicine. She is an accomplished medical leader with extensive strategic and operational experience which she has gained over many years as a senior clinician in a range of organisational and system leadership roles.

Joanne held a twelve months fellowship working at the world leading Institute for Healthcare Improvement using quality improvement skills gained there in her daily work. She has been instrumental in areas of national policy such as the central role of patient experience and improvement in maternity services.

Joanne qualified as a doctor in 1991, graduating from London University. Prior to joining us she was a consultant at Taunton and Somerset NHS Foundation Trust in endocrinology and diabetes. She has held positions with the King's Fund, Royal College of Physicians and the South West Academic Health Science Network.

Appendix 9.5.2 Roles and Responsibilities (Management Case)

Area of expertise	Source	Roles and Responsibilities
Programme Management	Programme Director	• Credible Executive level Director with ability to work across organisational boundaries • Programme Leadership • Ensuring that all key stakeholders are fully engaged • Reporting of progress to SRO and Board Sub Committee
	Programme Manager	• Responsible for the management of the PMO function • Management of Risk register • Management of Administration support
Clinical	Health and Care Strategic Director	• Senior Board level clinical leader • Responsible for the delivery of the new clinical model • Leadership of the research function
	Chief Clinical Information Officer	• Clinical lead for the Digital aspect of the Programme • Responsible for the clinical engagement in the digital Programme
	Design Leaders	• A Multi-Disciplinary team from across the Trust will deliver system design thinking across a range of areas including clinical pathways, digital systems and design of hospital infrastructure
Development and planning	Capital Planning Manager	• Lead manager for the delivery of the capital infrastructure element of the project • Link with the technical advisory team • Delivery of the project within capital allocation • Delivery of the project timetable
	IBI Group – Architect	• Specialist architectural and engineering advice • Planning advice
	Turner Townsend – Cost Advisors	• Specialist cost advice
Digital	Digital Planning Lead	• Lead for the delivery of the digital investment (OBC/FBC and implementation) • Specialist technical advice on procurement of systems
Commercial, Finance and Legal	Associate Director of Project Finance	• Lead manager for the financial elements of the project. (i.e. Capital Investment Appraisal and Affordability model)
	Business Case Advisors	• Management consultancy advice on the completion of the business cases required (to HMT Green Book Standard)
	Legal Advisors	• Specific Legal advice as required

Workforce	People Project Manager(s)	● Delivery of the workforce plan for the OBC and FBC ● Involvement in the wider Organisational development required by the new clinical model
Communications	Communication and Engagement Manager	● Internal advice on the internal and external communication requirements of the Programme ● Management of the engagement required to secure the support from the local community
Procurement	Procurement Lead	● Support the procurement of equipment required for the new development within both digital and infrastructure ● In line with national advice ensure the procurement of construction contract is managed

Appendix 9.5.3 People Promise and Plan

Please refer to attachment **"Appendix 9.5.3_People Promise and Plan".**

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Estate Strategy

July 2021

Our Estate
Our People
Our Digital

About this document

- This document provides a high-level outline of the role of the Trust's estate in the transformation of care in the region, as outlined in the TSDFT Health & Care Strategy.
- This document and the content within it is presented at a 'strategic outline' level (SOC). As the Trust continues to develop and refine its thinking through the Building Brighter Futures (BBF) Programme and the Outline Business Case (OBC) process, the content of this document will also be developed and refined as future space needs and opportunities to realise operational efficiencies and deliver sustainability benefits through better occupancy and utilisation, facilitated by Modern Methods of Construction (MMC), are explored both within the acute and community settings and in collaboration with partners across the Devon system. In parallel, the Trust's understanding of its future capital requirements and the relationship between Trust capital and NHP funding will also be refined and updated as the BBF OBC and FBC are finalised in 2022 and 2023 respectively.

- The purpose of this 'strategic outline' Estate Strategy document is to:
  - Describe the Estate Strategy for the next 10 years that will provide the framework for future property-related decisions and recommendations;
  - Set out the aims and objectives of the Estate Strategy reflecting the Trust context and its vision for the future;
  - Provide an assessment of the current estate and consideration of the major issues and challenges that need to be addressed in the future;
  - Provide a sense of the future-state estates footprint and its constituent elements i.e. a right-sized and reconfigured acute site with fit for purpose support services throughout the region which enable better outcomes for patients;
  - Outline the project options and opportunities and emerging capital plans that aim to address the issues and challenges identified and their contribution towards the delivery of the Trust's strategic ambition;
  - Set out a high-level implementation plan alongside the key risks, constraints and benefits associated with its delivery;
  - Summarise the key next steps to take this document through to its next iteration at OBC stage.

Note:

- The future-state estates options set out in this 'strategic outline' Estates Strategy are at different stages of development. The BBF Programme is well defined at SOC stage and is underpinned by pre-feasibility, feasibility and concept designs articulated in Development Control Plans with the support of technical advisors. Some thinking is, however, less mature and subject to evolution through the OBC process.
- A number of estates opportunities that have the potential to realise efficiencies and enable the Trust's strategic ambitions have been flagged within this document but will be subject to rigorous appraisal as part of the BBF OBC process e.g. the Support Services Workstream which will consider the most efficient and effective use of the Trust's leased estate going forward and implementation of Net Zero Carbon initiatives.

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NHS
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Executive Summary

Our Estate
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Executive Summary (1 / 3)

Introduction

- The Trust's estate infrastructure is a critical enabler for the delivery of its Health and Care Strategy.
- Significant limitations in the Trust's digital and estates infrastructure have been present for over a decade, which has meant that acute services infrastructure is neither fit for purpose now or in the future, preventing the Trust from achieving its transformation goals.
- Implementation of a 'digital first' approach to care is critical to reducing the impact of the rising demand on physical capacity in the acute environment. Without intervention, a future acute site footprint would need to be c.50% larger than it is today.
- The BBF programme, facilitated by NHP funding, will enable the Trust to deliver a new care model that will underpin its financial, clinical and environmental sustainability.
- As the first NHS Trust in England to integrate hospital and community care with adult social care in 2015, the Trust is well placed to leverage the experience it has developed to provide high quality care to its population, but must be supported by appropriate investment in its estate and digital infrastructure.

Scope of this Estate Strategy

- This 'strategic outline' Estates Strategy document sets out:
  - the current picture of the estate;
  - a vision for the future estate and capital needed to deliver transformation;
  - the enablers for delivering this strategy; and
  - the next steps required to take this strategy forward to OBC level.
- This Estate Strategy has been written in parallel with the development of the SOC for the BBF Programme. It is high-level in nature and will be matured and refined in line with the development of the BBF OBC and FBC in 2022 and 2023. Certain elements of this strategy will need to iterate as thinking develops e.g. Elective Care and the Support Services workstream which will rigorously appraise the Trust's needs for space off the acute campus.

Current picture of the estate

- The current estate covers almost 140,000 sqm across 24 sites. This includes an acute hospital in Torbay, 5 community sites, 3 Health and Wellbeing Centres and 15 other ancillary sites / support services locations.
- The region is organised into 5 Integrated Service Units (ISUs), which vary in the number of services and pathways they provide in the acute and community setting.
- The largest site is Torbay Hospital which provides acute services to the region and is set to undergo significant investment as part of the NHP.
- The estate has suffered from years of underinvestment resulting in an £85m backlog maintenance bill over the next 10 years, with over £64m required immediately across the estate. NHP funding is not expected until 2025.
- The community estate is in better condition, but is not set up to enable delivery of modern day healthcare services. Additional investment to bring forward new projects will further support the Trust's transformation objectives.

Executive Summary (2 / 3)

Vision for the future estate	• An optimised future estate:
	  ○ An acute site in Torbay which provides medical and emergency surgery beds, separates planned and unplanned care, upgrades ED and SDEC service and moves non-clinical services to a new location on site;
	  ○ A right-sized solution with a smaller overall footprint which reflects a digitally enabled strategy and supports a better community footprint through new community sites and support services;
	  ○ Optimal community services in the region by providing integrated services which leverage the Trust's capability as the country's first ICS;
	  ○ A estate which is effectively utilised and has aligned with regional goals such as the Devon Long Term Plan, following robust engagement and collaboration with partners in the region.
	• The Trust has made good progress in the previous five years to position itself to deliver its strategic ambitions:
	  ○ A number of leases have been exited and a number of disposals (e.g. Midvale Clinic) are either completed or underway
	  ○ New HWBCs are being built in Dartmouth and Brixham with planning submitted for more e.g. Teignmouth
	• The future estate will align with the net zero carbon principles of the Trust and National priorities.

Enablers for delivering this strategy	• There are a number of key enablers driving this strategy:
	  ○ **BBF** - The 'Building a Brighter Future' Programme seeks to modernise the Digital and Estates Infrastructure through significant investment across the estate, including NHP funding at the acute site
	  ○ **Digitisation** - Implementation of a 'digital first' approach is critical to reducing the impact of the rising demand on physical capacity across the estate and supports the Trust's ambition to deliver care closer to home to deliver better patient outcomes
	  ○ **Funding** - Whilst the the Trust will seek to maximise the impact of funding received through NHP, additional funding is likely to be required to deliver a range of community and support services projects over the next 5 years
	  ○ **Collaboration** - working closely with partners in the region will not only create opportunities to drive operational efficiencies, but could enable optimal provision of services in the region to maximise patient outcomes.
	• Successful implementation of this strategy will result in a smaller acute site, with services optimised to support the care needs of the population the Trust serves.
	• It is envisaged that this strategy will provide the framework for the development of several waves of accelerated business cases, beginning with the Trust's submission of its Strategic Outline Case for Torbay Hospital.

Executive Summary (3 / 3)

Next steps

- This document sets out the Estate Strategy as it relates to the SOC being developed for the purposes of the BBF Programme and NHP funding and will therefore iterate as the SOC moves through to OBC at the end of 2022.
- The following are considered to be the key next steps to evolving this Estate Strategy alongside the OBC development:
    - Adding sufficient detail to the existing community estate projects proposed to determine cost, risk and deliverability and understanding which projects will deliver the greatest benefits given the funding available
    - Develop a detailed implementation plan at project and programme level to understand the key risks and challenges associated with delivering the proposed strategy
    - Identifying pools of funding which could be accessed to support and bolster the current capital funding available
    - Evolve Trust thinking with regard to key priorities: elective care plans, support services, net zero carbon, key worker housing and car parking,
    - Putting in place a robust governance structure to oversee the delivery of community projects, aligned to BBF Programme governance
    - Engagement with partners in the region to socialise proposed plans and explore opportunities for further collaboration
- This Estate Strategy will undergo further revision and refinement with a view to submitting a refreshed Estate Strategy which aligns to the depth and detail required at OBC stage.

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Introduction and context

Our Estate
Our People
Our Digital

The TSDFT vision sets out the core ambition of the Trust to enable the people of the region to live well

"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 carer's experience and optimise health and wellbeing outcomes."

TSDFT Health & Community Care Estate Overview

290,000
Population Supported by Torbay and South Devon Foundation Trust

500,000
Face to face contacts with patients and 78,000 A&E admissions

140,000 sqm
Of space occupied

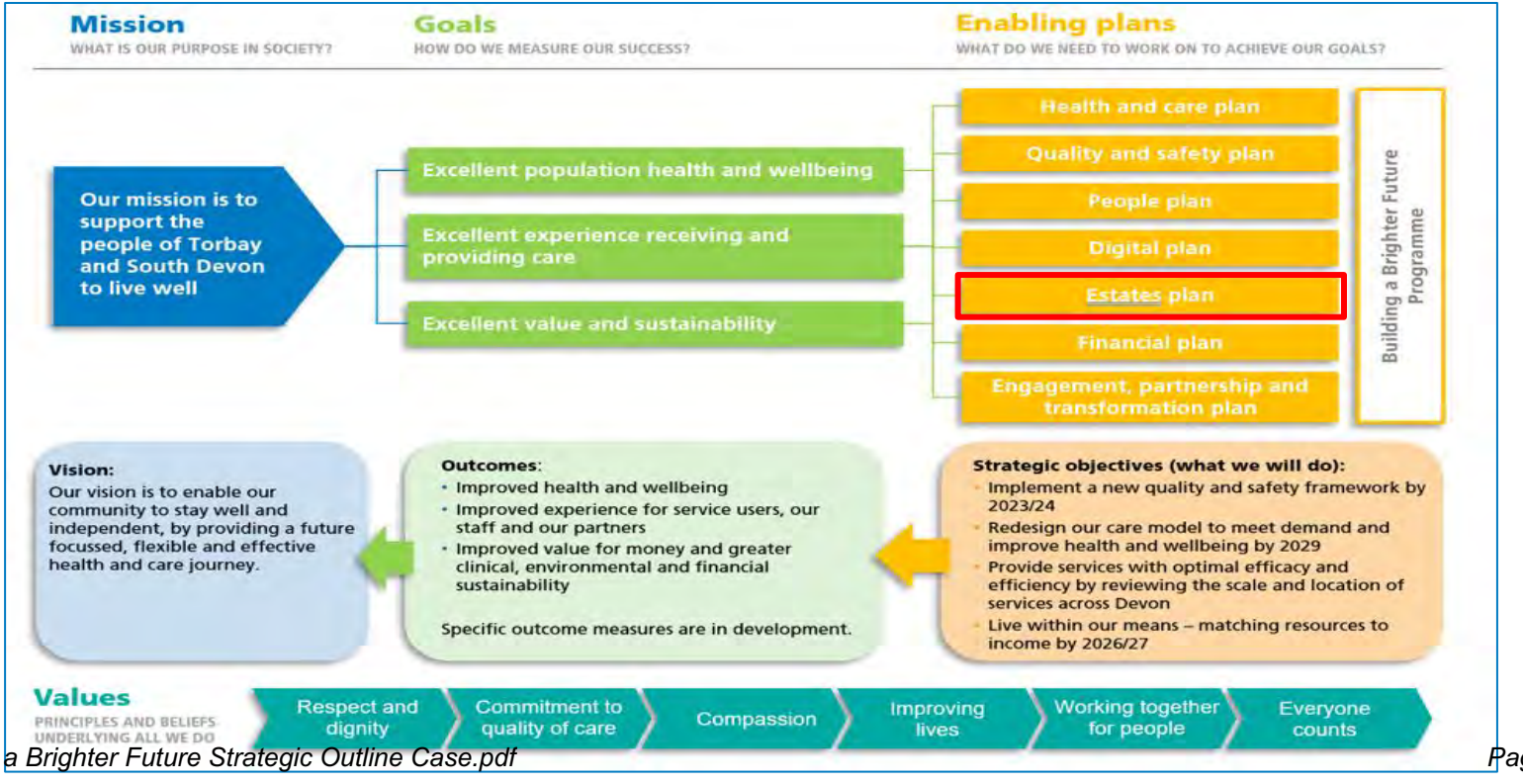
529 Beds
And 166 single bedrooms across 5 different localities

24
Total number of sites including 5 community hospitals (2 PFI) and 7 support services offices

£76 million
TSDFT estates running costs including hard and soft FM, utilities and waste management

Sources: July 2021 ERIC Data, 2016 - 2021 Estates Strategy & Development Plan, EDI Governance Data

The TSDFT Health & Care Strategy describes a transformation underpinned by a series of enabling plans including Estates



The 2021 Estate Plan is a critical enabler of the Trust's strategic objectives to deliver a new care model that will underpin its financial, clinical and environmental sustainability

Purpose of the estate

- **Facilitate day-to-day services**
- **Support delivery of future care model in next 10 years**
- **Improve environmental sustainability**

Estate principles

- **Fit for purpose**
- **Located appropriately**
- **Sufficiently flexible**
- **Well maintained**
- **Value for money**

Key estate objectives

Implement Building a Brighter Future (BBF) developments in **support of new care model and a sustainable estate**

Continue to balance **ongoing investment in the c. £64.1m requirement for backlog maintenance** with the reliability of facilities, recognising the interdependence with Building a Brighter Future (BBF) to reduce backlog to £0 by 2029

Complete work in progress Health and Wellbeing Centres developments as part of community service reconfiguration

Support the national direction towards **net zero carbon NHS services by 2040**

The principle of 'digitally enabled care' is at the heart of the Trust's plans and will reduce the impact of rising demand on physical capacity

The Trust developed a Health Care Strategy in 2020 with the core principle being to take a digital first approach to care - this is expected to significantly reduce the number of physical appointments over time and thus the demand for physical capacity across the region, creating an opportunity to right-size the estate over time.

Subject to funding required to facilitate transformation, a range of digital assets will be used by people and their carers as well as staff in the ICO, including:

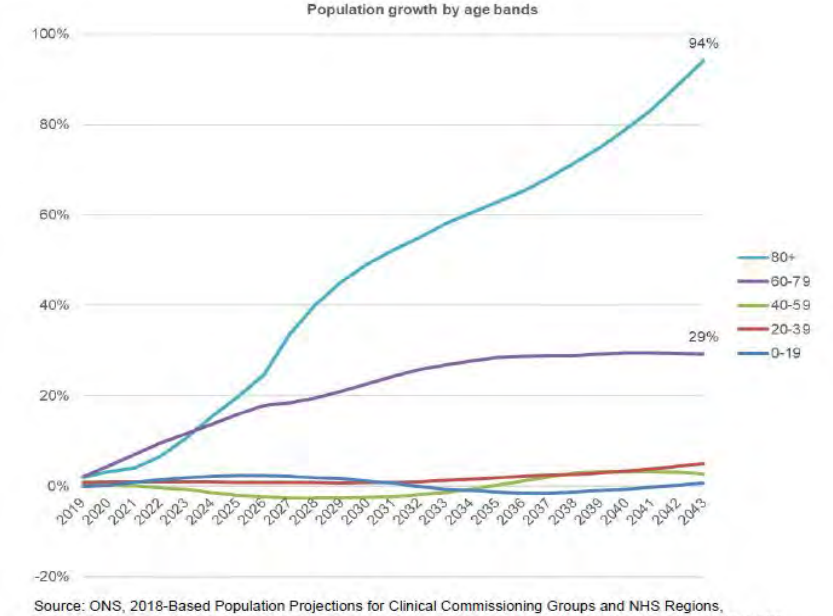
- **Virtual consultations and assessments -** enabling people to receive care in their homes
- **Self management -** in terms of managing their conditions to booking diagnostics and accessing results

The result will be a smaller hospital setting with more activity delivered at home and in community settings:

- **Hospitals -** will be optimised for services to minimise transitions in care and transfer times
- **Primary care -** the Trust w**ill** maximise the use of partners' assets to integrate services, particularly around prevention
- **Self care -** empowerment of patients through access to medical advice and support

Without intervention, a future acute site footprint would need to be c.50% larger than it is today

In support of the development of the BBF Programme, the Trust commissioned demand and capacity modelling work which collated demand, capacity and workforce intelligence including demographic and service demand data



Summary findings

- Older populations are set to grow significantly in the region between now and 2043, with those above the age of 80 set to grow 94% compared to the regional average of 23%
- These age groups tend to be the higher users of health care meaning that if left constrained the footprint for a future footprint would likely need to be much larger:
  - Analysis undertaken suggests those over the age of 60 utilise more than 50% of the services relating to:
    - Outpatient appointments (56%);
    - Inpatient bed days (72%); and
    - Theatre slots (52%)
- Demand and capacity modelling work from December 2020 indicates that a future hospital would need to be 50% larger without any interventionary measures:
  - Population growth will increase demand for services
  - The focus of demographic growth (i.e. an ageing population) on hospital capacity such as days in an inpatient bed increases the demand for space in the future

Under a 'Do Nothing' scenario bed, ward and theatre numbers would need to increase significantly

Metric	2020	2035	% change
Medical wards	267	366	37%
Surgical wards	95	125	32%
Bed/chair/cot (total)	106	111	5%
Outpatient rooms	111	132	19%
Theatre hours	9,195	10,920	19%
Theatres	10	12	20%
ED trolleys	28	30	7%

Comments

- The number of core medical/surgical beds is forecast to grow by 36% from 362 in 2020 to 491 by 2035
- This is predominantly driven by a large increase in the medical bed requirement associated with an aging population and growth in the number of people living in the region above the age of 60
- There will be a 16% increase in the capacity required for face-to-face outpatient appointments

When considering the scale of the changes at hand, ***'doing nothing'*** is not a feasible option. The Trust will need to develop a response which allows it to ***live within its means whilst transforming its care model within a capital constrained environment.***

Significant progress has been made since the 2016 Estates Strategy was published to address many of the challenges presented by the portfolio within a constrained financial envelope

2016 - 2021 Estate Strategy summary

- Set out the estate requirements to facilitate and support the implementation of the new care model
- Focused on innovative and forward looking solutions to achieve a productive estate
- Highlighted the poor condition elements of acute and community estate and opportunities to rationalise leases or invest to ensure the right quality of buildings in the right place
- Identified sufficient surplus in the community estate to offset required investment for the period (c.£5m)
- Identified a total estates investment of c. £54m required to deliver the strategy
- Core risk of delivery - availability of funding

Achievements 2016 Estate Strategy

- Reduced number of sites, both owned and leased through disposals and lease termination
- Whilst the significant levels of investment required to drive whole estate transformation has not been forthcoming, progress has been made to improve the estate to facilitate and support new care model through the development of 6 new HWBC's
- Total backlog in 2016 was £45m, of which £31m was deemed significant risk. Progress has been made - in 2021 the significant backlog figure is less than £25m

The section that follows sets out the Trust's current estate footprint and summarises the key issues and challenges that will need to be addressed in order for the Trust to achieve its future vision of providing better outcomes to patients

Sources: *July 2021 ERIC Data, 2016 - 2021 Estates Strategy & Development Plan*

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Where are we now?

Our Estate
Our People
Our Digital

Estate Overview

The TSDFT health and community care estate comprises 9 key assets which provide capacity for 529 beds and a total footprint of c.140,000 sq.m across five Integrated Care Units (ICU's)

1 Acute Centre Site

420 Beds in Torbay Hospital

£62.4M Total Acute FM Spend

529 Total Beds

9.7k sqm Total PFI Area

6 Office Locations

109 Total Beds in Community Hospitals

5 Integrated Service Units

5 Community Hospitals

73.4k sqm Total GIA

£9.6M Total FM Spend

13 Freehold Assets

166 Total Single Beds

£64.0m Total Cost to Eradicate Backlog

3 Health & Wellbeing Centres

4.5k sqm Total GIA

16.2k sqm Total GIA

110.0k sqm Total Freehold Area

1 Health & Wellbeing Centre Under Construction

Sources: July 2021 ERIC Data & IEDI Coverage Data

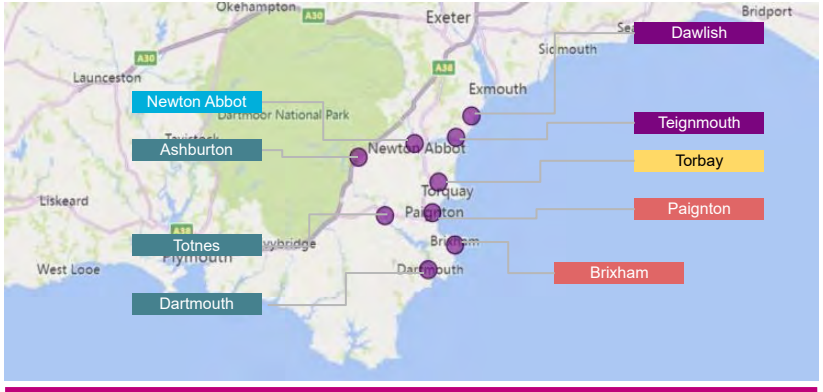
Integrated Service Units (ISU) - Overview

The Trust serves an area covering 350 square miles including 75 miles of coastline, with a population of around 290,000 (rising by around 100,000 during summer months). Health and community services have been structured in five ISU localities with dedicated teams of staff working within each

1	**Moor to Sea**	• Moor to Sea covers the south and west area and includes the towns of Ashburton, Buckfastleigh, Totnes and Dartmouth and extends to Chillington and its surrounds. • The Moor to Sea ISU provides older people reablement and rehabilitation services and comprises three assets of which: 1 Community Hospital, 2 Health and Wellbeing Centres • The total GIA associated to the 3 assets equates to c. 3,600 sqm (c. 3.4% of total Trust portfolio)
2	**Torquay**	• The Torquay ISU provides children, families and young people health care services from ten key assets. The Acute site is located in the locality together with 4 office sites, and 5 Ancillary assets. • The total GIA associated with 10 assets equates to c. 82,300 sqm (c. 78.2% of total)
3	**Newton Abbot**	• The Newton Abbot ISU provides urgent care and emergency care services and comprises three assets: 1 PFI Community Hospital, 1 freehold office and 1 ancillary asset currently in use as a dental surgery • The total GIA associated to the 3 assets equates to c. 8,500 sqm (c. 8.1% of total)
4	**Costal**	• The Coastal locality covers the towns of Teignmouth and Dawlish and surrounding villages • The Coastal ISU provides planned care services and comprises 3 assets: 1 PFI Community Hospital and 2 Outpatient Clinics (OP Clinics) owned on a freehold basis • The total GIA associated to the 3 assets equates to c. 2,100 sqm (c. 2.0% of total)
5	**Paignton and Brixham**	• The Paignton & Brixham ISU provides long-term conditions and cancer services and comprises 5 assets: 1 Community Hospital, 1 Health and Wellbeing Centres and 3 Support Services or Ancillary assets • The total GIA associated to the 5 assets equates to c. 8,700 sqm (c. 8.3% of total)

Estate Overview

The Trust's estate portfolio across the ICU's can be further categorised by type: i) acute care ii) community sites, iii) Health and Wellbeing Centres, iv) ancillary facilities and v) surplus land and assets



Estate Overview - Summary Table

Metric	Value
Total Freehold area (sqm)	110,460
Total PFI Floor area (sqm)	9,374
Total Leasehold area (sqm)	7,092
Total Sublet Area (sqm)	10,800
Total owned property value (£,m)	80.0
Total lease cost per annum (£,m)	0.6
Total lease income per annum (£,m)	0.3
Total FM Spend (£,m)	75.9
Total Backlog Maintenance (£,m)	85.7

Integrated Service Unit Key:

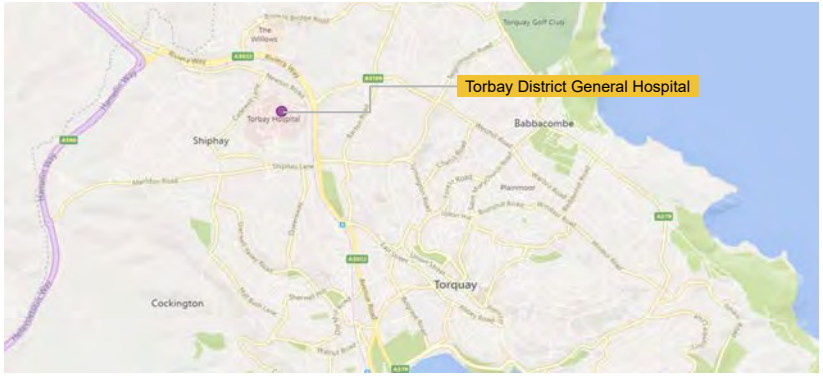
Torquay

Estate Information

- Torbay and South Devon NHS Foundation Trust operates across a wide geographical footprint and the portfolio comprises 24 assets which include 9 key healthcare facilities in addition to 15 support services and ancillary assets. The total area associated to the portfolio equates to c.140,0000 sqm which provides accommodation to c.5.5k NHS staff
- The key healthcare portfolio comprises 9 key facilities, the age of which varies across the portfolio from 100 to ten years. The estate can be grouped into 3 main categories:
  - **Acute Care**
  - **Community Hospitals;** and
  - **Health & Wellbeing Centres**
  - The Trust also occupies a significant amount of ancillary facilities and offices utilised by Support Services. Office accommodation is predominantly leased and and located across different integrated service units
  - Within the portfolio there are an additional 2 assets which have been disposed and considered surplus by the Trust. The Midvale Clinic and Bovey Tracey Hospital) closed in March 2020 and March 2017 respectively
- Within the hospitals and health and wellbeing centres portfolio there are 9 assets of which 7 are owned on a freehold basis (77%) and 2 PFI sites subject to unitary charges (23%)
- The annual FM cost (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy, energy costs, waste and cleaning) related to the portfolio equates to £75.9m, whereas rental liabilities amount to c. £659k p.a
- Within the portfolio there is a significant amount of backlog maintenance that needs to be addressed over the next 10 years. The total backlog maintenance equates to c. £85.7m
- Across the estate there is capacity for 529 patient beds of which 166 are single bedrooms (31%). Of the 166 single bedrooms, 110 bedrooms provide ensuite facilities (66%) whereas 56 beds are rooms without ensuite facilities (34%)

Acute Site

The Torbay District General Hospital is located within the Torquay ISU and provides acute care services to the community



Acute Site - Summary Table

Metric	Value
Total Freehold area (sqm)	70,692
Total Sublet Area (sqm)	6,305
Total Leasehold area (sqm)	2,699
Total Property Value (£,m)	61.3
Total Lease cost per annum (£,m)	0.5
Total Lease income per annum (£,m)	0.1
Total FM Spend (£,m)	62.4

Integrated Service Unit Key:

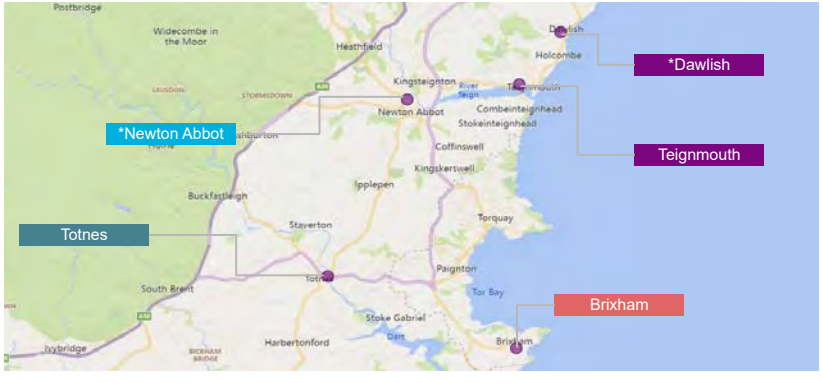
Coastal | Moor to Sea | Newton Abbot | Paignton & Brix. | Torquay

Property Information

- The Torbay Hospital is the main site within the portfolio and provides a full range of district hospital services. It is the location for acute services and for planned and unplanned health and care services as well as the Trust's Emergency Department and Maternity Services
- The Torbay Hospital building dates back to 1928 and is located c. 2.4 miles away from Torquay city centre
- The acute site extends for c. 48.2 acres (equivalent to over 32 football fields) with the buildings on the site comprising a total Gross Internal Area (GIA) of approximately c. 73,400 sqm
- From a tenure perspective, the Torbay hospital main site and the hospital annexe are held on a freehold basis.
- The existing portfolio has a total capacity of 529 beds of which the Torbay site has capacity for 420 beds for patients (79%)
    - Of the total 420 beds provided in the Torbay hospital, 67 are single beds with en-suites (15%) and 54 are single beds without ensuite facilities (12%)
    - Within the building there are also an additional 8 isolation rooms
- The total FM costs (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy, energy costs, waste and cleaning) associated to the Acute site equate to c. £62.4m
- The existing estates infrastructure on the main Torbay Hospital site creates a complex pathway for patients to navigate, with poor adjacencies and overall clinical flow
- In addition, the existing site configuration is inflexible, driving poor utilisation of space, does not allow for separation of planned and unplanned care and has come under significant pressure during the pandemic
- Significant investment is required at the site to address some of these operational challenges

Community Hospitals

The Trust manages five Community Hospitals which extend provision of acute services to support access within the community



Community Hospitals - Summary Table

Metric	Value
Total Freehold area (sqm)	17,705
Total Sublet Area (sqm)	324
Total Leasehold area (sqm)	5,700
Total PFI Floor Area (sqm)	9,734
Property Value (£,m)	18.0
Lease cost per annum (£,k)	0.2
Lease income per annum (£,k)	0.7
FM Spend (£,m)	10.9

Integrated Service Unit Key:

Coastal | Moor to Sea | Newton Abbot | Paignton & Brix. | Torquay

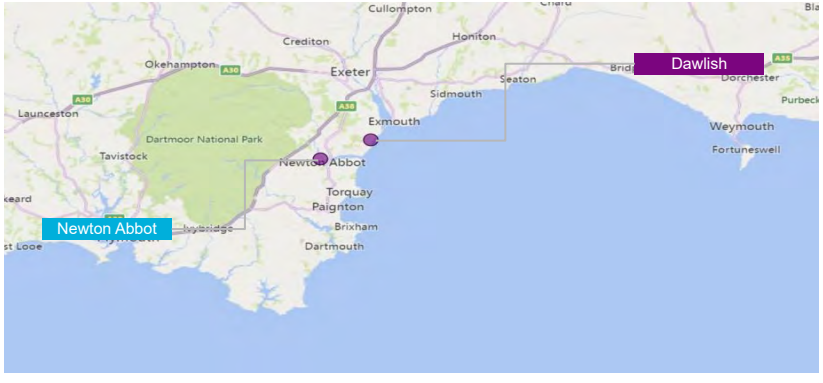
Property Information

- The Torbay and South Devon Foundation Trust community hospitals are located in:
  - Brixham
  - Dawlish
  - Newton Abbot
  - Teignmouth; and
  - Totnes
- Community hospitals are of a varying age and provide a range of services, extending provision of acute services to support access within the community, including general surgery, gynaecology, midwifery and specialist physiotherapy
  - Of the total 529 beds within the portfolio, 109 beds (21%) are located within community hospitals
  - Of the 109 total beds, 43 (39%) are single bedrooms with ensuite facilities
- Facilities are of varying age and quality. Some community hospitals date back to the 1920's and present some operational challenges in addition to not offering ward layout flexibility
- Due to the ageing condition of the estate and its operational challenges, the TSDFT long term strategy is to gradually dispose of community hospitals and replace them with health and wellbeing centres
  - **Teignmouth** - the hospital is in the process of being disposed and will be replaced by a new Health and Wellbeing Centre
  - **Dawlish** - PFI Site expires in 3 years and option appraisals to extend the agreement or buy out the asset are currently being conducted
- The total FM costs (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy, energy costs, waste and cleaning) related to community hospitals equate to c. £10.9m

Note - *Site funded through Private Finance Initiative (PFI) and subject to unitary charges

PFI Community Hospitals

Two community hospitals within the Trust's portfolio are funded through the Private Finance Initiative (PFI) and are subject to unitary charges (Dawlish and Newton Abbot)



Property Information

- The total area associated to the PFI hospitals equates to c. 9,900 sqm (56% of total community hospitals area)
  - The **Dawlish Hospital** was built in built in 1999 and its total area equates to c.2,100 sqm whereas the total PFI unitary payments is £1.2m. The contract term in relation to the hospital is 23+10 years presenting an expiry date in June 2024. Due to the approaching critical date extension, buy out options are currently being investigated
  - The **Newton Abbot Hospital** was built in 2006 and its total area equates to 7,000 sqm. Total PFI unitary payments are £2.6m. The contract term in relation to the hospital is 25 years presenting an expiry date in October 2034
- The two PFI sites are owned and managed by Rydon Maintenance and Sir Robert McAlpine who provide Facilities Management services to maintain the hospitals over the contract period
- The total FM costs (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy, energy costs, waste and cleaning) related to Community Hospitals equate to c. £5.8m of which the Newton Abbot accounts for the 79% whereas the Dawlish Hospital accounts for the remaining 21%

Community Hospitals - Summary Table

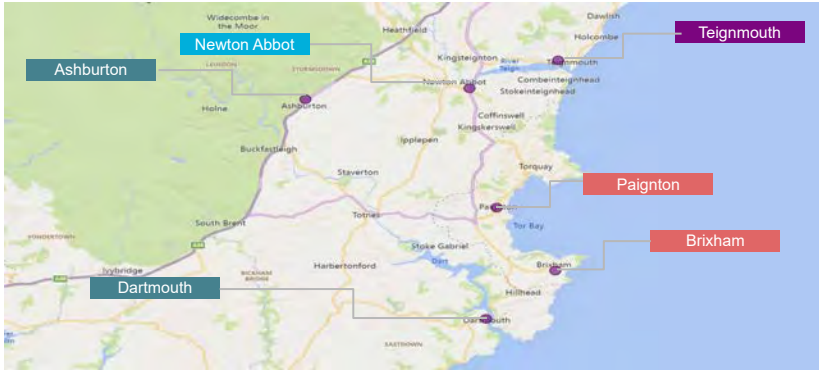
Metric	Newton Abbot	Dawlish	Total
Total PFI Floor Area (sqm)	7,843	2,111	9,954
Total Clinical Space (sqm)	7,046	1,705	8,751
Total Non Clinical Space area (sqm)	797	406	1,203
Total PFI Unitary Payment (£,m)	2.6	1.2	3.8
Total PFI (contractor/SPV) management costs (£,m)	0.69	0.38	1.08
FM Spend (£,m)	4.6	1.2	5.80

Integrated Service Unit Key:

Coastal | Moor to Sea | Newton Abbot | Paignton & Brix. | Torquay

Health & Wellbeing Centres

The Trust is creating modern Health and Wellbeing centres via the refurbishment of existing premises or construction of new facilities which will bring integrated health services into local communities



Health & Wellbeing Centres - Summary Table

Metric	Value
Total Freehold area (sqm)	4,593
Total Sublet area (sqm)	-
Total Leased area (sqm)	-
Total PFI Floor Area (sqm)	-
Total Property Value (£,m)	TBC
Total Lease cost per annum (£,k)	-
Total Lease income per annum (£,k)	-
Total FM Spend (£,m)	6.7

Integrated Service Unit Key:

Coastal | Moor to Sea | Newton Abbot | Paignton & Brix. | Torquay

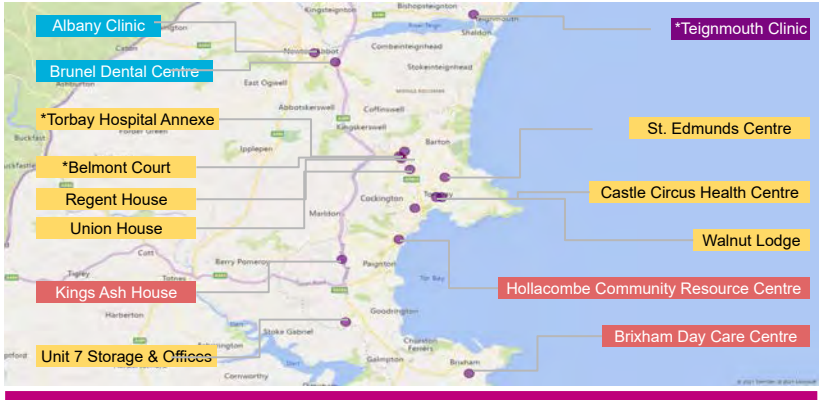
***Note** - total FM costs includes some support services and ancillary assets as ERIC report is aggregated and not split between sites*

Property Information

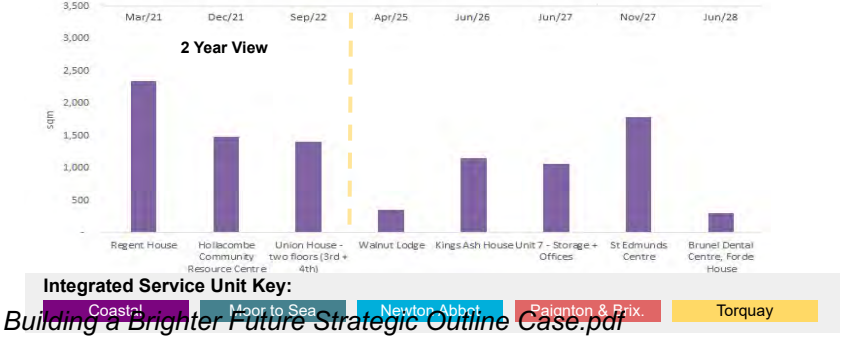
- The Trust has been progressing with the disposal of poor quality buildings to create local health and well-being services wrapped around co-located GP services in newly created and some instances newly built health and well-being centres. The sites provide a range of local community clinics and act as a base for community health and care teams providing nursing, therapy and social care support to patient's. Within the portfolio there are 4 existing Health and Wellbeing Centres; a further additional 2 centres are currently in the pipeline
  - **The Brixham Centre** opened in May 2019 and has been funded by Brixham Community Hospital's League of Friends who provided c.£800k for the build in addition to a £1m investment contribution from the Trust
  - **In Dartmouth**, the Trust is currently building a modern £4.7 million health and wellbeing centre which will also house Dartmouth Medical Practice, Dartmouth Caring, and other services such as a retail pharmacy
  - I**n Newton Abbot**, services are planned to be relocated from the unsuitable Albany Clinic into a newly refurbished accommodation at Sherborne House. The development is underway and occupation will start from the Autumn 2022
  - **In Paignton**, following the closure of inpatient beds at Paignton Hospital in 2016/17, the Trust has been able to refresh the use the building to continue to provide a full range of health and wellbeing services
  - **In Ashburton,** the Trust refreshed the existing premises which provide health and wellbeing services to the communities of Ashburton and surrounding villages
  - **In Teignmouth,** the existing facilities cannot be repurposed to provide modern health & wellbeing services. The Trust applied for planning permission for the creation of a new Health and Wellbeing centre on the Brunswick Street site
  - The total FM costs (inclusive of Estates and Facilities finance costs, Hard & Soft FM and Cost of Occupancy) related to Health and Wellbeing Centres equate to c. £6.7m

Support Services & Ancillary Assets

The Support Services portfolio includes 15 assets. Within the portfolio there are six office sites predominantly occupied on a leasehold basis



Leasehold Portfolio Expiry Profile by Total Area



Property Information

- Within the portfolio there are 15 ancillary assets which include a variety of uses and asset classes. The total area associated with these assets equate to c. 14,600 sqm
  - The Trust occupies 6 assets which are offices and support services designated buildings. The total area equates to c. 7,000 sqm. From a tenure perspective, the office portfolio is predominantly occupied on a leasehold basis and the average time to expiry equates to 3.4 years. Within the next two years there are 3 assets which present lease end dates.
  - Approaching lease events at Unit 2 Bay House, Regent House and Union House provide the opportunity to accelerate exits and/or extend lease term in exchange of incentives. The total area which can be exited equatss to c. 5,200 sqm accounting for 52% of total.
- In addition to the office portfolio, the Trust manages 6 additional locations which are being utilised as a Dental Surgery, OP Clinic, Drug Services or Adult Social Care
  - The total area related the these assets equate to c. 7,500 sqm and the total FM costs (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy) related to the ancillary and support services portfolio equate to c. £6.7m

Property Name	Main Use	Tenure
Albany Clinic, Albany Street, Newton Abbot	Offices	Freehold
Brunel Dental Centre, Forde House	Dental Surgery	Leasehold
Castle Circus Health Centre	OP Clinic	Freehold
Hollacombe Community Resource Centre	Adult Social Care	Leasehold
Kings Ash House	Offices	Leasehold
Regent House	Offices	Leasehold
St Edmunds Centre	Adult Social Care	Leasehold
Totnes Community Hospital	Clinical Hub	Freehold
Union House - two floors (3rd + 4th)	Offices	Leasehold
Unit 7 - Storage + Offices	Support Services	Leasehold
Walnut Lodge	Drug Service	Leasehold
Torbay Hospital Annexe	Acute Hospital	Freehold
Belmont Court	Offices	Freehold
Teignmouth Clinic	OP Clinic	Freehold

Note - *The lease at Regent House has recently been extended*

Surplus Land & Property

The Trust has identified a number of surplus sites across the portfolio and work is ongoing to assess more opportunities as the Trust seeks to realise further efficiencies through Elective Care and Support Services workstreams

Surplus Land

- **Midvale Clinic –** Disposal commenced in April 2018 and concluded on the 23rd March 2020 with returns to the Trust of £325k less Lease and sale fees
- **Bovey Tracey Hospital –** Closed in March 2017, by which time the site became subject to 'Asset of Community Value' restrictions, activating a Community Right to Buy option. Two rounds of Right to Buy Moratoria have elapsed without a viable community buyer coming forward. A developer has approached the Trust to purchase the site, and submitted planning to Teignbridge District Council for 6 new homes. This application was unsuccessful however the developer has submitted revised plans for Planning approval and a decision is currently awaited

No Longer Surplus

- **Paignton Hospital –** Initial plans for disposal, based on the provision of a new Health and Wellbeing Centre on a site adjacent to the current Paignton Library building, were not viable. The old hospital site is successfully operating as a Health & Wellbeing Centre and the future use of the whole site is being considered
- **Torbay Hospital Lowes Bridge Lodge -** Following the successful HIP2 bid, this site will be retained as it is a strategically important element if separate housing / hospital routes are required on the future Torbay Hospital site

Opportunities

- **Dartmouth Hospital** – The hospital closed on the 3rd April 2017. Work to determine the optimum route of disposal has commenced and includes working with local stakeholders to ensure that the Trust's commitment to achieving an element of social value to the local community through the disposal is realised
- **Three Parcels of Land at Brixham Hospital** – These are all vacant land parcels, identified in 2017 and the Trust is currently working up development options with a developer with a view to commencing disposal in 2020-21
- **Dartmouth Clinic –** Requires completion of the Dartmouth Health and Wellbeing Centre (expected Q2 2022), which commenced on site in July 2021
- **Teignmouth Hospital –** This option requires completion of a new Teignmouth Health and Wellbeing Centre on a site in Brunswick Street. Once achieved, the Teignmouth Hospital site could be disposed of in its entirety as soon as 2022-23
- **Albany Street Clinic** – It is anticipated that the teams currently resident in Albany Street could transfer to Sherborne House in Newton Abbot during Autumn 2021. If so Albany Street could then be re-assessed as surplus in 2021-22 with a view to disposing in the last quarter or beginning of 2022/3

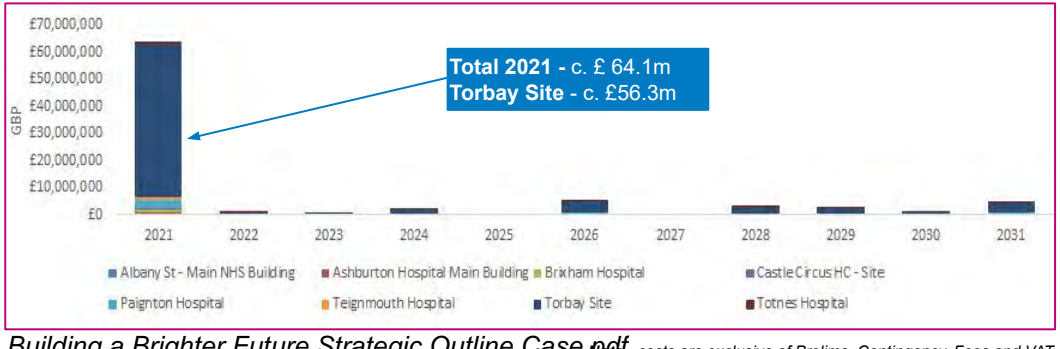
Backlog Maintenance (1/4)

The Trust has commissioned a Six Facet Survey which examines the condition of its building stock and other physical assets. Existing backlog maintenance is currently c. £64.1m and is forecast to rise to c.£85.7m in 10 years in the absence of significant intervention. Torquay ICU accounts for 87% of the total backlog (c. £74.7m)

Overview

- The existing portfolio and estate infrastructure is dated and in need of urgent repair as it suffers from a substantial maintenance backlog, with many deficiencies having a detrimental impact on the patient and staff experience. This was demonstrated by the uncontrolled loss of critical mechanical and engineering infrastructure in 2018, which was the result of a "fail, mend and repair" culture
- Of the total backlog over the next 10 years, c. £74.7m sit within the Torquay ICU (87%), whereas the Paignton and Brixham and Moor to Sea ICUs account for 6% and 4% respectively
- In Torbay the total 2021 backlog equates to c. £56.3m equating to 88% of total whereas the Paignton Hospital total backlog for the year is c. £3.2m resulting in 5% of total

10 Year View Backlog Maintenance Summary



Note - costs are exclusive of Prelims, Contingency, Fees and VAT

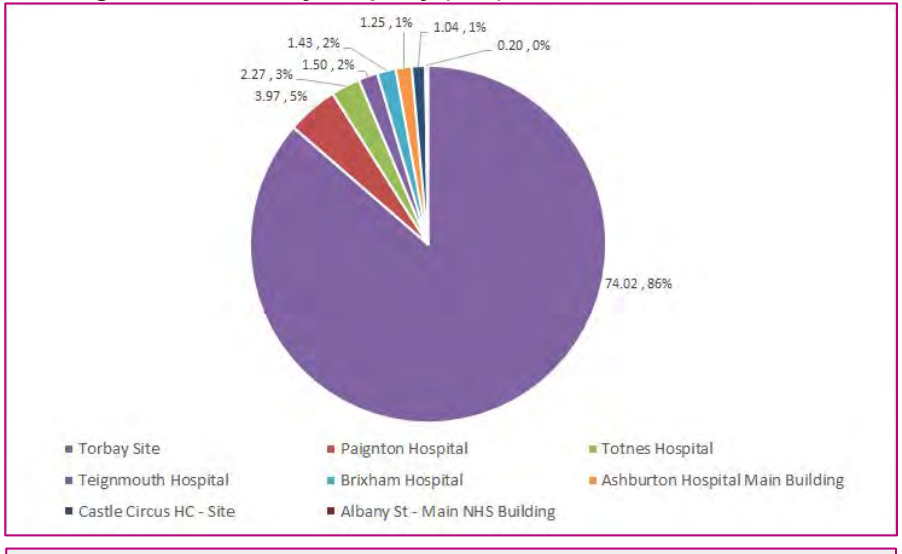
Operational challenges created

- The scale of the investment needed, and the technical/operational complexity of undertaking the backlog of maintenance work whilst maintaining operational services presents a multitude of operational challenges, including:
  - **The need to undertake the work at a pace** that reduces the level of backlog as quickly as possible
  - **Maintaining operational and business continuity** and reducing the impact on the public and staff whilst carrying out major infrastructure work within operational departments
  - **The lack of decanting space available** within the Hospital which seriously restricts the vacation of areas/departments within the Hospital to allow work to be undertaken

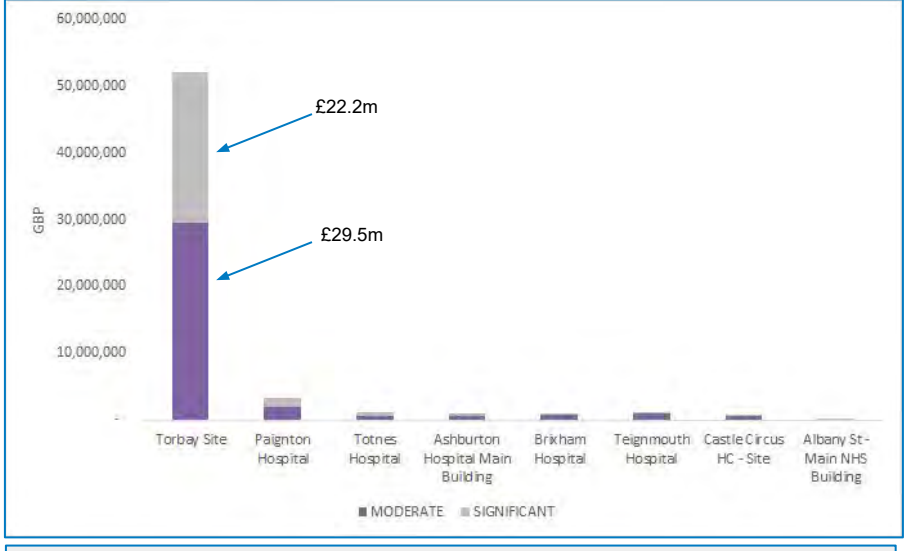
Backlog Maintenance (2/4)

Within the total existing backlog maintenance there are c. £24.5m works which are classified as 'significant'. Of the total 'significant' works, c. 90% sit within the Torbay hospital site

Backlog Maintenance by Property (£,m)



'Significant' & 'Moderate' backlog by Property (£,m)



Comments

- The Torbay site backlog over the next 10 years equates to c. £74.7m accounting for 86% of total. Of the total Torbay backlog, c. 56.3m (76%) is required in 2021 / 2022
- The backlog associated to the remaining sites equates to c. £11.6m (14%) and is distributed across 8 sites

Comments

- The existing backlog has been categorised into 4 risk rank categories (Low, Moderate, High and Significant) The total backlog that falls into the "Moderate" and "Significant categories equates to c. £60.3m (70%)
- The Torbay site "Moderate" and "Significant" backlog equates to c. £52.0m resulting in 86% of total

Backlog maintenance (3/4)

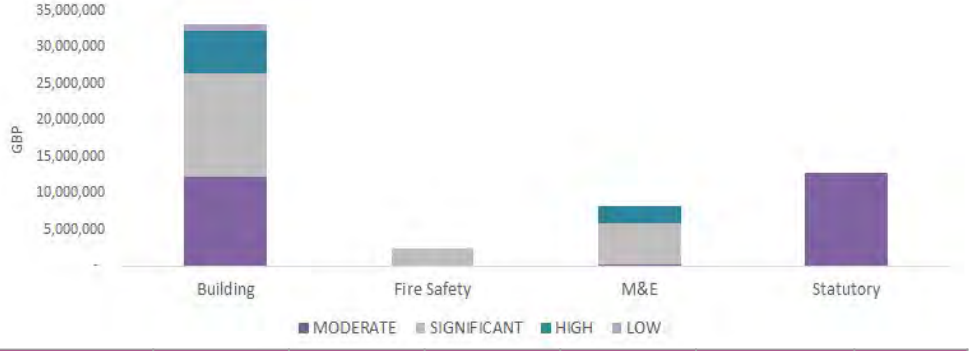
There is £56.3m of immediate backlog maintenance required at the acute site, £22.2m of which is classified as 'significant' according to the Six Facet Survey definition

Acute Site Overview

- The performance of the estate and its growing backlog maintenance requirement demonstrates the challenges in relation to the existing portfolio and the care environment. Key issues relate to:
  - Comparatively lower than average floor area per bed;
  - Low numbers of single rooms;
  - A significant, backlog maintenance liability; and
  - Age of infrastructure but increasingly due to functional unsuitability.
- The **Acute hospital** site presents areas that are in poor condition and that require investment. Although some aspects of the acute site are in good condition, the Hetherington wards, podium support services, the old residences, some outpatient areas, ED and Hengrave House are in need of improvement.
- The poor condition of aspects of the acute site has resulted in an immediate backlog requirement of £56.3m.
- Almost 40% of the immediate backlog maintenance required is classified as 'significant' and is a priority for the Trust to rectify to ensure a fit for purpose estate and compliance with statutory requirements.
- **Confidence in the veracity of the c. £56.3m figure is high, given that it results from the findings of the Six Facet Survey.** The survey sets out the costs of remediating emergent fire safety works and additional costs of modernising aged buildings that are expected to be retained beyond the delivery of the NHP/HIP2 project

Acute Site Summary

2021 Breakdown of existing backlog by risk rank & work type



	Building	Fire Safety	M&E	Statutory	Grand Total	%
MODERATE	12,132,700	-	99,650	12,706,174	**24,938,524**	**44.3%**
SIGNIFICANT	14,212,050	2,278,953	5,666,650	-	**22,157,653**	**39.4%**
HIGH	5,958,000	-	2,351,860	-	**8,309,860**	**14.8%**
LOW	882,400	-	-	-	**882,400**	**1.6%**
Grand Total	**33,185,150**	**2,278,953**	**8,118,160**	**12,706,174**	**56,288,437***	**100%**

**The existing backlog of c. £56.2m in relation to the Acute site refers to the immediate interventions required in 2021*

Backlog maintenance (4/4)

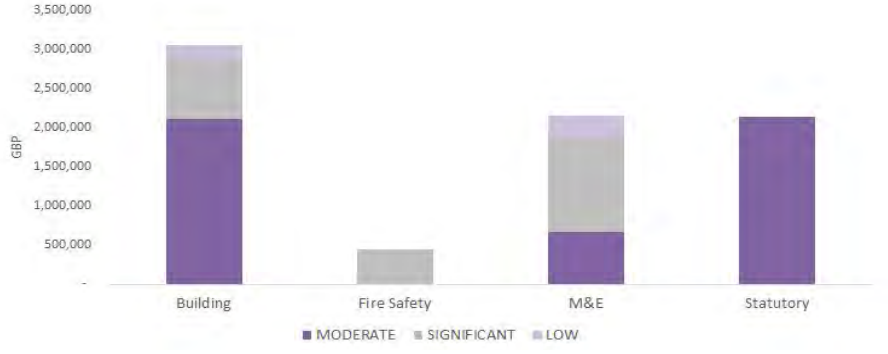
The estates community hospitals are in need of investment to enable provision of more modern health services. Planned investment is expected to bring key emergency services up to statutory compliance standard; this will include interventions on wards, emergency departments and theatres

Community Estate Overview

- Community **facilities** are of varying quality and whilst the building fabric is in generally good condition there are some significant challenges in the patient environment in some of the older community Hospitals:
  - **Totnes Hospital -** the total cost to clear the existing backlog equates to c. £1.2m. There is c. £0.5m backlog which is considered 'Significant' (43%)
  - **Teignmouth Hospital -** the total cost to clear the existing backlog equates to c. £0.9m. There is c. £0.1m backlog which is considered 'Significant' (11%)
  - **Brixham Hospital -** the total cost to clear the existing backlog equates to c. £0.8m. There is c. £0.1m backlog which is considered 'Significant' (11%)
  - **No backlog maintenance has currently been identified in the more modern Dawlish and Newton Abbot sites**
- The challenge with the existing community estate is that some sites are not currently fit for the delivery of modern day hospital services and are not configured in a way that allows for collaboration or improving utilisation of space
- The condition of the existing buildings and their relative assessment of whether they are considered fit for purpose in the future will drive the Trust's development and investment plan going forward

Community Estate Summary

2021 Breakdown of existing backlog by risk rank & work type



	Building	Fire Safety	M&E	Statutory	Grand Total	%
MODERATE	2,108,750	-	673,200	2,134,859	**4,916,809**	**61.3%**
SIGNIFICANT	778,000	450,314	1,198,000	-	**2,426,314**	**31.1%**
LOW	170,050	-	283,500	-	**453,550**	**5.8%**
Grand Total	**3,056,800**	**450,314**	**2,154,700**	**2,134,859**	**7,796,673**	**100%**

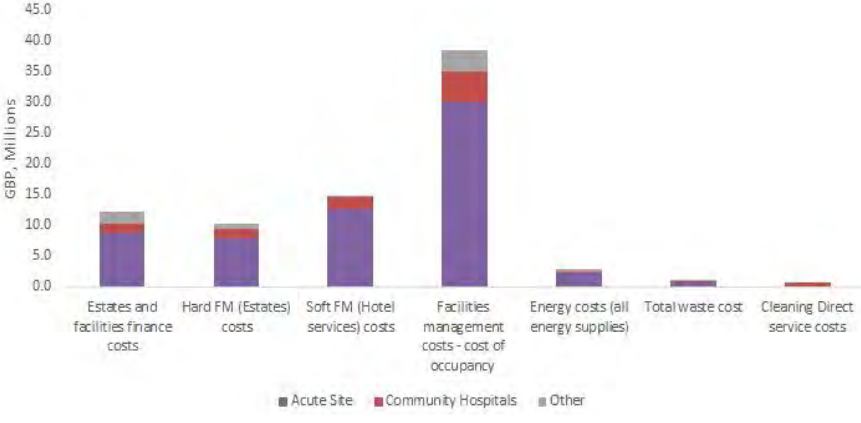
***Note -** total cost includes backlog figures from the following : Paignton, Totnes, Ashburton, Teignmouth, Brixham, Castle Circus, Albany St.*

Facilities Management Costs Summary

The total FM spend associated to the portfolio equates to £80.4m of which £62.4m (77.6%) is associated to the Torbay Acute Site. Community Hospitals and Health and Wellbeing centres account for 13.5% and 8.8% of the total spend respectively

Commentary

- The Trust annually submits data returns to the central NHS database 'ERIC', (Estates Reporting Information Centre) as do all other Trusts. Using ERIC data it is possible to benchmark and RAG rate key estates and facilities performance against other organisations of a similar size and nature. An overview the Trust estate performance according to 'ERIC' for the acute and community settings for last year is provided below.
- The FM operation total cost (inclusive of Estates and Facilities finance costs, Hard and Soft FM and Cost of Occupancy) equates to c. £80.4m. Hard and Soft FM spend accounts for 31% of total whereas cost of occupancy liabilities equate to 47% of total.
- Spend analysis carried out highlighted that 77% of the total FM spend is attributable to the Acute site (Torbay General Hospital) whereas Community Hospitals account for 13.5% of the total FM spend.



FM Financial Baseline Summary Table (£m)

Cost category	Acute Site	*Community Hospitals	Health & Wellbeing and Other Sites	Total	%
Hard FM costs	7.9	1.4	0.9	10.2	12.7%
Soft FM costs	12.7	1.8	0.4	14.9	18.5%
Facilities management costs - cost of occupancy	30.1	4.9	3.4	38.5	47.9%
Energy costs (all energy supplies)	2.2	0.4	0.3	2.9	3.6%
Total waste cost	0.8	0.1	0.0	1.0	1.2%
Cleaning Direct service costs	0.0	0.6	0.0	0.6	0.7%
Estates and facilities finance costs	8.7	1.6	2.0	12.3	15.3%
Total	**62.4**	**10.9**	**7.1**	**80.4**	**100%**

***Note** - *Excludes costs related to the Teignmouth Community Hospital which is reported separately due to planned disposal*

Where are we now - summary

Estate Performance Summary

- The **physical condition of estate is of varying quality** - the Acute site is not considered fit for purpose and will require significant maintenance intervention in order to clear out the existing backlog
- Across the portfolio there is, however **c. £64.1m of backlog required** in the current period (2021) of which **£24.5m (38%) is classified as 'Significant'**
- The **estate generates a significant carbon footprint** which will need to improve in order to align with net zero carbon targets
- **The leasehold portfolio (all support services assets) average time to expiry is 3.4 years**. The Trust has an opportunity to release leasehold space which is not considered fit for purpose and potentially relocate some of its functions into more modern facilities and realise cost savings and efficiencies

Acute site

- **Acute services infrastructure is no longer fit for purpose** and is preventing the Trust achieve the level of service transformation envisaged in the Health and Care Strategy
- The site faces an **immediate backlog challenge which is estimated to cost £56m to remediate**

Community Hospitals Estate

- The community estate is in fairly good condition, with the majority of buildings either being condition A or B
- The challenge with the existing community estate is that some sites are not currently fit for the delivery of modern day hospital services and are not configured in a way that allows for collaboration or improving utilisation of space

Issues & Challenges

Digital infrastructure	• Current IT solutions do not support the business, with many standalone systems that do not communicate effectively. A new Electronic Patient Record (EPR) solution is therefore essential to facilitating a material decrease in demand for physical capacity and enabling the ambition to provide care closer to home
Estate footprint	• Years of underinvestment has resulted in a significant maintenance backlog - latest estimates indicate £85m is required to clear the current backlog which will double in the next 10 years without intervention. Annual capital investment is required, as is true with any BAU solution, but to really make a transformational impact and halt the growing backlog requirement, the Trust needs to think differently about the size and configuration of the current portfolio and how digital solutions may shape the future look of the estate • There are a number of challenges within the estate which need to be addressed so that infrastructure meets statutory compliance standards (e.g. Health and Safety and DDA) • The use of the current estate is not optimised - many of the community hospitals are old and not configured in a way which supports delivery of modern health care services. Investment is required to reconfigure the estate in order to create a smaller, more efficient acute site with improved clinical pathways and layouts and to eliminate surplus assets and reduce non-clinical accommodation
Financial	• The Trust runs a deficit and the current capital plan does not generate enough cash to fund capital improvements which are required. 'Doing something' is predicated on there being the required level of capital available for the Trust to execute its proposed Estate Strategy. There is a role for the Estates Department to explore opportunities to maximise the impact of NHP funding and identify options to realise efficiencies and create value through elective care and support services workstreams as the Trust progresses towards financial sustainability • Funding which is expected to come from the NHP will not be granted until 2025 - the Trust may need additional funding support in order to address some of the more immediate estate challenges
Net zero	• The estate generates a significant carbon footprint and suffers from a lack of useable green space for staff and patients to use. The Trust needs to align with regional and national priorities by taking forward initiatives which support the national ambition to be net zero carbon by 2040

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Where do we want to be?

Our Estate
Our People
Our Digital

The Trust aims to provide an estate which is both fit for purpose and financially sustainable, providing high quality patient outcomes

1

Acute site in Torbay:

- Reprovision of medical beds and emergency surgery beds with more single rooms
- Separation of planned and unplanned care
- Non clinical services to be moved
- ED and SDEC services to be completely upgraded
- A welcoming place to work
- Net zero carbon health asset

2

Right sized estate to reflect digitally enabled strategy

- 17,000 sqm of new build space and 12,000 sqm of refurbished space at the Acute site
- New HWBC's at Dartmouth and Teignmouth
- Smaller overall footprint

3

Optimised community services to the region providing:

- More Health and Wellbeing Centres
- Closer to home care
- Integrated services which leverage the Trust's capability as the country's first ICS

4

Improved utilisation across the region

- Improved clinical pathways
- Safe and efficient care settings
- Collaboration with other Trusts to deliver strategic ambitions
- Alignment of estate footprint to the vision of the Long Term Devon Plan
- Support services which enable Trust ambitions

Implementation of a 'digital first' approach is critical to reducing the impact of the rising demand on physical capacity in the acute environment

The Trust has consulted with technical teams and partners to develop a series of scenarios modelling how the demand and capacity requirements for the acute site change over time in a 'Do Nothing' and 'Do something' environment, using demographic forecasts and demand data to develop outcomes.

Metric	Do Nothing 2035	Do Something 2035	Do something 2035 (split)
Medical wards	366	314	332 (-9%)
Surgical wards	125	101	106 (-19%)
Face to face rooms	72	34	34 (-53%)
Telephone rooms	34	17	17 (-50%)
Community rooms	22	22	0 (0%)

Commentary

- Demand capacity modelling undertaken sought to understand the impact of a successful implementation of a digitally enabled Clinical Strategy.
- The core medical/surgical beds will reduce by 15% from 492 beds forecast in 2035 to 415 beds once the Clinical Strategy has been implemented, increasing to 438 beds once planned and unplanned care have been separated
- Implementation of the Clinical Strategy will lead to a significant reduction in outpatient clinic rooms from 72 to 34 (53%). It will however require an increase of 3 rooms that support telephone appointments and 10 spaces for community outpatient appointments.
- Implementation of the Clinical Strategy will offset the growth in theatre requirements with the current number of theatres being sufficient in most cases

Investing in a quality, right-sized and reconfigured estate will enable the Trust to deliver financial and operational efficiencies and develop a solid base for long-term financial sustainability

TSDFT Financial Position in numbers

£500m Operating budget	**£85m** Total backlog requirement (2021 - 2031)	**£370m** Planned investment in Services
£18m 19/20 Net deficit	**£74m** Backlog at Acute site (2021 - 2031)	**£350m** NHP funding amount
£119m Capex required FY21-25	**£64m** Backlog requirement 2021	**£20m** Additional Trust funding
£33m Do Nothing Trust deficit in FY 25/26	**£25m** 'Significant' backlog currently	**2033/34** First Trust surplus following NHP funding

Commentary

- The Trust has historically run a deficit from its £500m operating budget.
- The current operating forecast to FY36/37 does not generate any surplus funding to fund the capital investment required to clear backlog and bring forward new projects.
- In addition to the current challenges surrounding backlog maintenance, of which £25m falls into the 'significant' category, there is £120m of capex required between FY21 - FY25 across the estate.
- As a result, in a 'Do Nothing' scenario, the Trust is forecast to report a net deficit in excess of £30m each year from FY22/23.
- Further, the pandemic has increased financial pressures on the health system and it remains unclear what the impact of the pandemic will have on the Trust's financial position in the next 5 -10 years.
- The proposed NHP investment is expected to dramatically improve the financial sustainability of the Trust within a reasonable timeframe, taking it from a net deficit position to surplus by FY 2033/34.
- Whilst the proposed funding shows a pathway to long term financial sustainability, there remains an immediate challenge ahead of the proposed funding in 2025 to address the significant amount of backlog maintenance.

Sources: *Strategic Outline Case, July 2021 ERIC data*

Planned Estate Infrastructure investment will improve the current estate does which does not support the net zero carbon ambitions of the Trust, or align with regional or national priorities

Where we are

- The Trust generates a significant carbon footprint and no reliance is placed on renewable energy. The current heating and hot water system at the acute site is reliant on fossil fuels and due to expire between 2024 - 2029
- Legacy energy infrastructure makes emissions reduction, in particular the decarbonisation of heat, exceedingly challenging on the current estate
- Current site designs often prevent promotion of green travel due to lack of changing facilities or wide scale availability of EV charging
- Planned Estate Infrastructure Investment through the NHP will be constructed in line with net zero carbon principles, with a particular focus on the electrification of heat and transportation which will drive significant emissions reductions alongside wider environmental benefits such as noise reduction and improvements in local air quality.

Where we need to be

- In accordance with the plan for Delivering a Net Zero National Health Service, the Trust must achieve;
  - Net zero carbon for controllable emissions across the estate by 2040, with an ambition to reach an 80% reduction by 2032.
  - Net zero carbon for other indirect emissions that we can influence by 2045, with an ambition to reach 80% reduction by 2039.
- Ensure carbon reduction plans align with regional plans and requirements e.g. the Devon Carbon Plan (DCP) wherever possible.
- Improvements to facilities to enable green initiatives e.g improving changing facilities for staff to enable cycle to work.

How will we get there?

- Demonstrate commitment to environmental sustainability in all future projects being brought forward (e.g. new HWBC's)
- Adoption of Net Zero principles in all new builds and major refurbishments e.g. utilising Modern Methods of Construction (MMC), quantifying and mitigating embodied emissions and specifying low temperature heating systems to enable immediate or near-future transitions to low carbon heat generation.
- Maximise the impact of Sustainable Models of Care thereby reducing staff and patient travel distances by delivering care closer to home
- Focussed investment in 'low-regrets' energy efficiency improvements e.g. upgrading lighting to LED
- Closer involvement with regional action groups e.g. the Devon Climate Emergency response Group
- Investigating potential for on or near-site renewable energy generation e.g. direct wire Power Purchase Agreement for electricity produced by local solar PV farm

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

How do we get there?

Our Estate
Our People
Our Digital

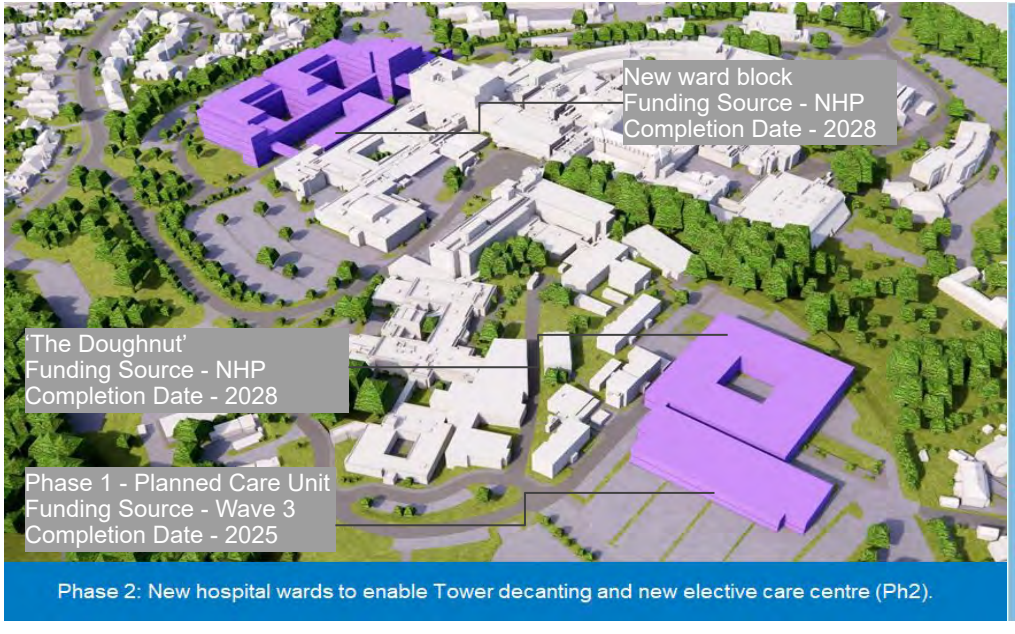
The ‘Building a Brighter Future’ Programme seeks to modernise the Digital and Estates Infrastructure through significant investment across the estate, including NHP funding at the acute site

What is BBF?	The Building a Brighter Future Programme will deliver the investment needed across the TSDFTs estate over the next 10 years and includes NHP investment into the acute site to address the biggest challenges currently being faced
How will it benefit the Trust?	The Programme is looking to enable the wider strategic ambitions of the Trust and to provide a fit for purpose, modern estate. NHP funding will secure £370m of investment in Trust services, £350m of which will come from the New Hospital Programme subject to approval of an FBC by NHSE/I.
What will the NHP investment fund?	The primary focus is on development at the acute site of over 17,000 sqm of new buildings and 12,000 sqm of refurbishment .This will entail minimal demolition to the old hospital. Planning risk is considered ‘low’ due to the historic core of the estate being retained and the scale of development at the north side of the estate being reduced in comparison with other options investigated
When will the project complete?	The Programme is already underway, with works at the acute site to be delivered between 2025 and 2030, assuming completion of the Full Business Case by the end of 2023. Proposed developments are expected to cause limited disruption to the existing estate
Does it align with other Trusts plans?	The Programme is integrated with the Devon Long Term Plan, owned by local councils and the NHS. Funding will enable collaboration and sharing of services between Trusts within the region
What is the current status?	The Programme is being presented as part of a Strategic Outline Case, due for submission to NHSE/I in July 2021. Feasibility designs have been developed and are set out on the following pages

The existing site requires a number of its buildings to be demolished in order to enable the rebuild envisaged under the NHP

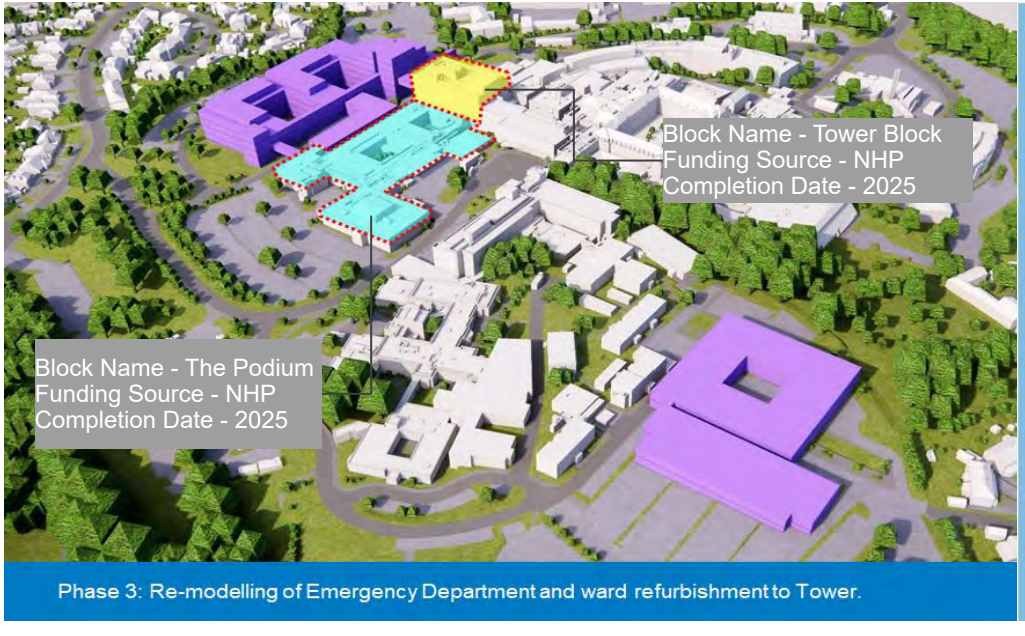
- 27 buildings represent existing infrastructure which is due to be removed to make way for new buildings on the acute site
- Demolition works will be funded through Trust Capital and are expected to take place in 2024
- Sites in purple represent a new Acute Medical Unit (AMU) and a Modular Theatre building (‘the stick’) which will be funded through the UEC fund

Following the demolition and removal of 27 existing buildings at the acute site, construction will commence on a new ward block and planned care facility



- Demolition works will take place to enable the construction of two new buildings - the new ward block and and planned care facility ('the doughnut')
- Construction of these sites is expected to commence in 2025 and run to 2028

In 2027, redevelopment and remodelling of key sections of the acute site in Torbay will take place with a focus on Urgent & Emergency Care facilities



- The site development plan focuses on investment and development of acute services around a central core, moving non clinical services to the Hetherington Block.
- Additional key areas of focus will be bringing clinical areas and patient areas that are below standard up to modern space and facilities requirements and invest in staff services and suitable and compliant non-clinical services
- Key areas identified for additional intervention include the refurbishment of the Urgent and & Emergency care centre

The current preferred option will use capital investment to separate planned and unplanned care, retain a 24/7 ED, rebuild elements of the acute site and refurbish retained areas

Main service scope	Unplanned care will be separated from planned care. There will be a new planned care facility somewhere in Devon, serving the planned care needs of the population of South, East and North Devon. Further work is required through development to OBC to understand the extent to which this investment is brought forward by the Trust alone or is realised through collaboration with other partners in the region.
Diagnostic service scope	All diagnostic services related to unplanned care services to remain on the Trust's site. Some routine diagnostic services to be provided from a diagnostic Hub elsewhere in Devon
Service solution	Focus on rebuilding elements of the existing TSDFT site and targeted refurbishment of those areas retained
Service delivery	A combination of in-house and outsourced service methodology has been deemed as the Initial Preferred Way Forward. This service delivery methodology will likely see TSDFT managing the overarching delivery of the Programme, with a construction partner procured to undertake the major works
Implementation	Recognising the delivery constraints and risks associated with adopting a single or two phased approach, multi-phase implementation has been deemed the most appropriate methodology based on the practicality of the site, planning permissions and decant requirements
Funding	Central PDC funding and other third party sources of finance

Note - *Additional information on the BBF Programme is set out in a specific SOC*

NHP funding of the BBF will provide the investment required to develop a fit for purpose acute site, enabling improved provision of services to the region through an right-sized estate & modern digital solution

Facilitate day-to-day services	• By improving clinical pathways at the acute site and separating planned and unplanned care • Digitally enabled through a new EPR implementation
Support delivery of future care model in next 10 years	• Digitally led Programme to provide more services to patients closer to home
Improve environmental sustainability	• Modern Methods of Construction (MMC) to reduce environmental impact of the build
Fit for purpose	• Developing an acute site which is optimised for future demand and capacity
Located appropriately	• Separation of key services with plans to develop new sites offering planned services to the region
Sufficiently flexible	• Improved clinical layout will allow for better handling of 'surge' events e.g. a pandemic
Value for money	• Initial plans are costed within the funding bracket provided
Well maintained	• Implementation of an asset and condition based maintenance schedule, ensuring active engagement of operational staff in planning of delivery

BBF investment is a significant step towards achieving the Estate Strategy for the acute site. Enabling the community estate for the future will also require additional investment, building on recent successes

	Ambitions of this Estate Strategy	How this will be enabled
Acute site	• Development of a smaller acute hub • Delivery of services as part of a combined whole system • Investment to bring essential emergency services up to standard • Reduction in the number of inpatient beds • Relocate services currently provided in temporary blocks • Reduce footprint through disposal of surplus assets	• The BBF Programme, if implemented, will address the strategic ambitions of the Trust in relation to the acute site • Existing proposals for NHP funding will see significant investment in at the acute site and a new planned care facility built somewhere in Devon. • Non-clinical services will be relocated away from the acute site - the strategy of how best to do this is currently in development.
Community estate	• Change the need and type of health and care services to be provided in communities in the future • Consider services provided in community hospitals and the investment requirement to make them fit for purpose • More partnerships with other agencies and councils • Dispose of some community facilities and rationalise leases - reinvest capital receipts into new facilities • Future community estate needs to be sustainable, fit for purpose and provide quality buildings in the right place	• A number of leases have been exited and a number of disposals (e.g. Midvale Clinic) are either completed or underway • New HWBCs are being built in Dartmouth and Brixham with planning submitted for more e.g. Teignmouth • A further pipeline of projects either i) in flight or ii) to be brought forward will further enable delivery of the Estate Strategy, however additional investment will be required to achieve this.

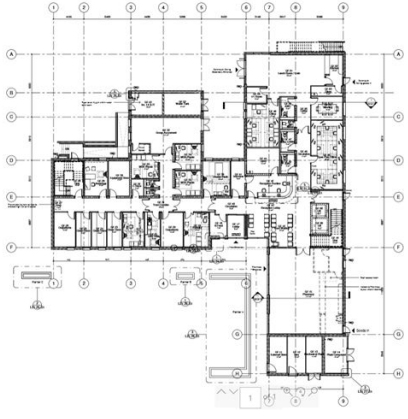
A number of key projects for the region are currently underway or in the pipeline to address future community estate requirements

Many plans for HWBC's, community hospitals and planned disposals are underway, and work streams are currently being established to explore opportunities across asset categories in support services and other assets to determine where operational efficiencies could be achieved to facilitate the delivery of the Estate Strategy.

	Health and Wellbeing Centres	Disposals / redevelopment	Support services / Other activity
Moor to Sea	• Dartmouth HWBC	• Dartmouth Hospital • Dartmouth Clinic	• Optimise Ashburton Hospital site
Torquay	• Cavell centre in Torquay		• Rationalise leaseholds
Newton Abbot	• Sherbourne House HWBC	• Bovey Tracey Hospital disposal • Dispose Albany Clinic	
Costal	• Teignmouth HWBC	• Teignmouth Hospital	
Paignton and Brixham	• Brixham HWBC • Paignton HWBC	• Brixham Hospital (land)	

Moor to Sea ISU - planned and future estate requirements

Dartmouth's new HWBC



Comments

- Construction commenced during the summer of 2021 to build a new HWBC which will relocate GP practices and pharmacy services into a new space by the end of 2022.

Ashburton Hospital

Comments

- There is a potential opportunity to optimise the Ashburton hospital site as it currently notably underutilised.

Moor to Sea ISU - Planned disposals

Dartmouth Hospital


Top View


Retain Existing Building for Conversion


Existing Internal Carpark

Comments

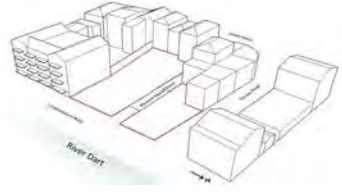
- The hospital closed on the 3rd April 2017.
- Work to determine the optimum route of disposal has commenced and includes working with local stakeholders to ensure that the Trust's commitment to achieving an element of social value to the local community through the disposal is realised.

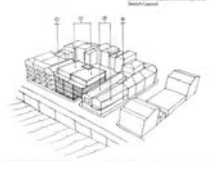
Dartmouth Clinic


Top View


Retain Existing Building for Conversion


Existing Internal Carpark





1. New Build Penthouse 3-bed apartments @ 120sqm each
2. Newbuild 2-bed apartments @90sqm each
3. x3 Refurbished 2/3 bed apartments @ 105sqm each
4. x2 Commercial Units @ 95sqm each

Comments

- There is an opportunity to dispose of this site which has a value of C. £700k.
- Progress requires completion of the Dartmouth Health and Wellbeing Centre (expected Q2 2022), which commenced on site in July 2021.
- The space may be retained to be used as office space, but further work will be required to finalise the support services strategy to decide the best route forward.

Torquay ISU - planned and future estate requirements

Cavell Centre in Torquay

Comments

- There is an opportunity to build a new Cavell centre co-located with a GP centre at the heart of Torquay which fits with Council regeneration plans and co-locate non clinical accommodation.
- Discussions are underway to provide for one of the regions 7 proposed Cavell centres in Torquay.
- A site has been identified and could develop 2000sqm of space to provide an integrated and broad service offer.
- To pursue this option, other sites such as Union House and Castle House may need to be rationalised.

Leasehold rationalisation opportunity

Comments

- The support services workstream of the BBF Programme is carrying out work which considers the optimal use of the community based leased estate.
- Through this process, the BBF team will determine the most efficient use of the leased estate going forward.

Newton Abbot ISU - planned and future estate requirements

Sherbourne house HWBC

Comments

- This HWBC in Newton Abbot town centre is currently under refurbishment and is due to complete in the Autumn of 2021.
- The HWBC will provide additional space to relocate services from other parts of the estate e.g. Albany Clinic.
- The building provides 2,722 sqm of space on the ground and first floor to provide a full range of service to the Newton Abbot population.

Newton Abbot ISU - Planned disposals

Bovey Tracey

Comments

- Closed in March 2017, by which time the site became subject to 'Asset of Community Value' restrictions, activating a Community Right to Buy option.
- A developer has approached the Trust to purchase the site, but was unsuccessful in planning to Teignbridge District Council for 6 new homes.
- With the sale subject to Planning approval, the developer has submitted revised plans for Planning approval and a decision is currently awaited.

Albany Clinic

Comments

- It is anticipated that the teams currently resident in Albany Street could transfer to Sherborne House in Newton Abbot during Autumn 2021.
- If so, Albany Street could then be re-assessed as surplus in 2021-22 with a view to disposing in the last quarter or beginning of 2022/3.

Coastal ISU - planned and future estate requirements

Teignmouth HWBC

Comments

- Located on Brunswick Street, the site will accommodate two Teignmouth GP practices and a range of other services for the local population.
- These will include the health and wellbeing team of community nurses and therapists and lifestyles and prevention services. It will help connect people to wider services and activities to support their physical health, mental health, social care and wellbeing.
- Planning consent has been submitted for a new HWBC with an outcome expected later this year.

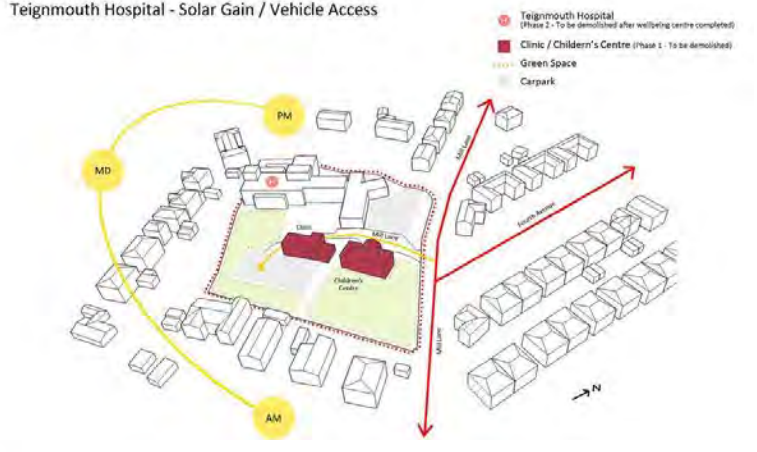
Coastal ISU - Planned disposals

Teignmouth Hospital


Top View


Teignmouth Hospital Carpark


Junction between Mill Lane and Lower Kingsdown Road



Comments

- Teignmouth hospital was opened in 1954, the first hospital built under the NHS.
- The hospital cannot be economically reconfigured to provide modern facilities required today and in the future.
- The most recent Hospital conditions survey shows that the building is nearing the end of its effective life with wear and tear taking its toll as a healthcare setting.
- The latest valuation, in 2018, valued the site at £1.2m. A disposal can take place once the HWBC in Teignmouth is completed and will undergo a similar disposal process to the one at Dartmouth.
- Once Teignmouth closes, it is anticipated that the services provided will move to the new HWBC or to the Dawlish PFI.

Paignton & Brixham ISU - planned and future estate requirements

Brixham HWBC

Comments

- 300 sqm of space is currently under construction to build the Brixham HWBC.
- The project, costing C. £1m has been funded by the Brixham league of friends.

Paignton HWBC

Comments

- The Trust is currently developing options to determine the services which should operate out of Paignton, which will determine the proposed estate strategy.
- Existing options include provision of HWBC services in the current community hospital with support from local GP practices , development of a new HWBC.

Paignton & Brixham ISU - Planned disposals and redevelopment

Brixham Hospital

Comments

- There are three vacant land parcels covering half a hectare, identified in 2017 which the Trust is currently working up development options with a developer with a view to commencing disposal in 2020-21.
- Sale proceeds are expected to be c. £450,000 for the plots.

The Trusts 5-year capital plan submitted to ICS is pending approval. It sets out the financial parameters the Trust will need to operate within to deliver its Estate vision

What the capital plan envisages

- The capital plan sets out the planned spending of the Trust over the next 5 years.
- The main sources of funding for the Trust are Trust Capital and the proposed NHP funding which is due on submission of an FBC in 2023.
- As this Estate Strategy progresses to OBC stage, the interdependencies between BBF funding and Trust Capital funding will be clearly defined.

What the capital plan will provide

- The capital plan seeks to maximise the efficiency of the funding available to the Trust over the next 5 years.
- The significant amount of backlog is a key priority which the capital plan aims to invest in to mitigate the amount of high and significant risks across the estate.
- The plan includes funding relating to projects currently being delivered and those that have received capital approval.
- There are a number of known unknowns with regard to the feasibility and suitability of additional capital projects, as set out above, which the Trust will need to find the required funding for in order to bring forward.

How the capital plan relates to the BBF Programme

- The current plan, without the long term investment which will be provided through NHP as part of BBF, will continue to implement short-term solutions to the current Estate needs.
- The interaction between NHP funding and the capital plan is therefore critical to transforming the estate and appropriately managing risk across the estate.
- The current plan is part of an iterative process across the Devon healthcare system to ensure that capital is appropriately allocated to the most impactful and value for money projects.

A funding gap is anticipated and needs to be bridged to bring acute and community sites into a condition and layout which enables effective delivery of the Health and Care Strategy

Additional funding routes are understood to be limited, with the Trust financial position not of a strength to support delivery of all currently proposed projects. The Estate Strategy needs to maximise the impact of NHP funding and look to drive efficiencies across the community estate, particularly through the Support Services workstream

ICS funding
A new approach to NHS capital funding was introduced in 2020/21, the main purpose of which is the allocation of a capital envelope for each ICS. The aim of this is to provide greater clarity and confidence on the level of capital resource available; support system working and discussion on capital priorities; and enable faster access to national capital funding for critical safety issues.

Trust Capital
Trust capital is limited although it could provide an initial investment to kick start transformation. Whilst capital is not readily available, and a portion of this capital is required to maintain statutory compliance whilst the transformation plan is being implemented, TSDFT will be expected to fund some of the proposed strategic development internally.

Decarbonisation Fund
TSDFT could consider applying to The Department for Business, Energy and Industrial Strategy (BEIS) Salix Public Sector Decarbonisation Scheme for a significant amount of funding to deliver a range of energy efficiency technologies and heat decarbonisation schemes within the Estate.

Addressing the funding gap and exploring opportunities to optimise existing NHP funding will require the Trust to continue working in collaboration with partners

- Collaboration with partners will be essential to ensure alignment with the following key frameworks:
  - **NHS Long Term Plan -** the current strategic plan for the NHS to improve the quality of patient care and health outcomes
  - **Devon Long Term Plan -** aims to ensure that Devon's health and care system supports people to live healthier lives; improves physical and mental health outcomes for children, adults, older people and families; promotes wellbeing; and reduces health inequalities across the whole of Devon
- The Trust is already working with Partners across the peninsula to leverage resource and knowledge sharing to ensure that future systems will be inter-operable and to implement IT infrastructure at scale.
- Sharing of guidance regarding design and other capabilities amongst partners will give the Trust the best chance at maximising benefits available to it.
- There are plans for 7 new Cavell centres in the region in the coming years, two of which are proposed in Torbay & South Devon. There is an opportunity for the Trust to collaborate through the development of these sites to maximise efficiencies and ensure optimal delivery of services to the region.

Partners

Primary Care Networks

Torbay Council

Care Homes

NHS Royal Devon and Exeter NHS Foundation Trust

Devon County Council

Hospice Services

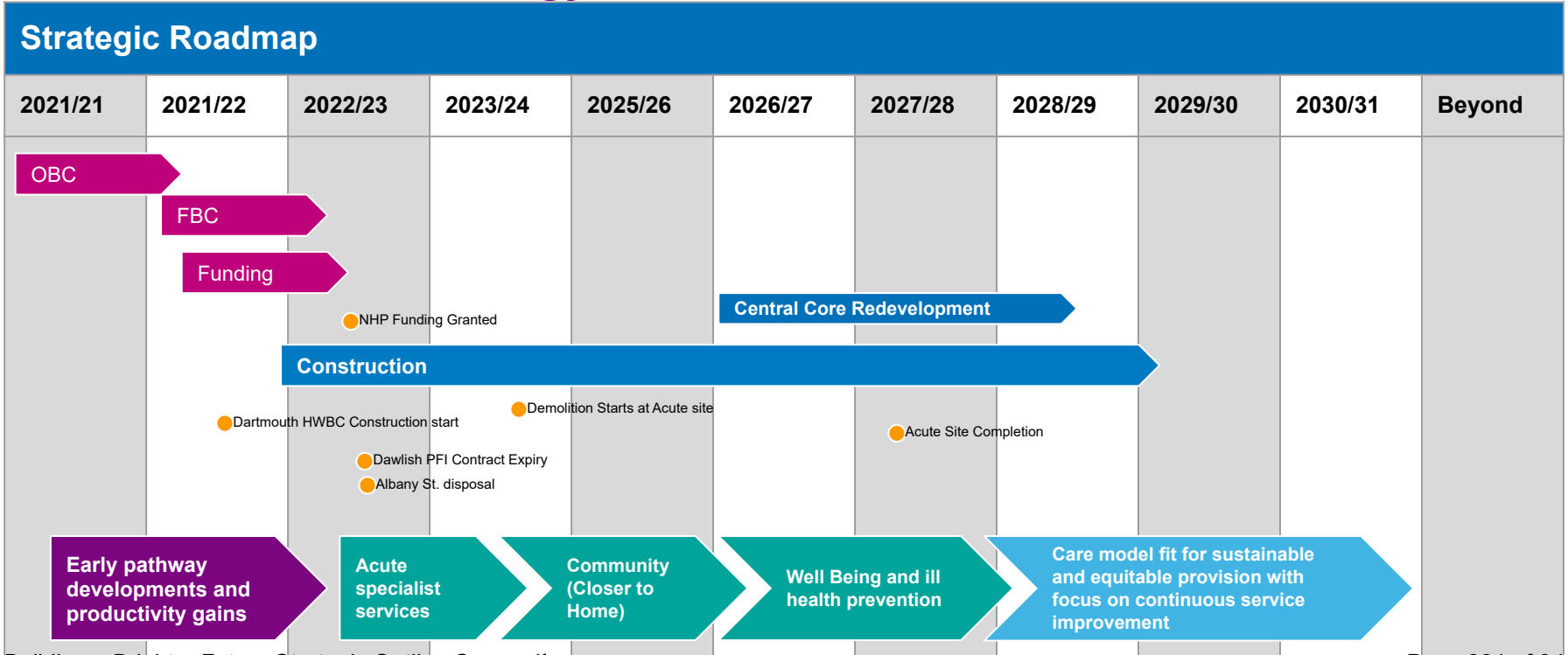
NHS Devon Partnership NHS Trust

Social care providers

NHS South Western Ambulance Service NHS Foundation Trust

Frameworks

The Implementation Roadmap set out below maps the key activities and milestones which the Trust will need to deliver to successfully execute its Estate Strategy



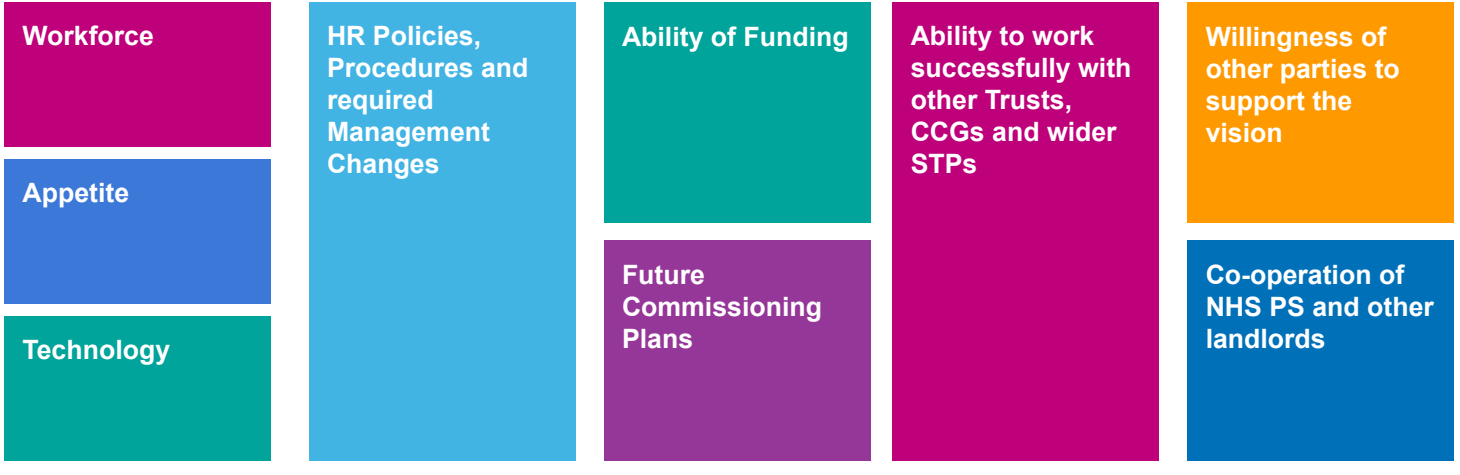
Robust governance is in place to drive the effective delivery of the BBF programme. Estate level projects outside of BBF will be managed by a central PMO to bring forward business cases on a project by project basis

Trust and Governance Board	The role of the Trust Board is to provide effective and proactive leadership, set strategic aims, ensure the quality, safety and effectiveness of the services we provide and ensure that we are well-governed in every aspect of our activities.
National Governance	At a national level a joint DHSC & NHSE/I Programme Team has been established to discharge the NHP element of the UK Government's Health Infrastructure Plan. Programme strategy, running/enabling and appraisals will be DHSC responsibilities. NHSE/I will lead on the delivery of standards, transformation and value.
Regional Governance	The Peninsula NHP Leads Group was established in response to the clear requirement for alignment, coherent system planning and collaborative working to maximise the potential value to be captured from sharing planning and resource across sites.
Programme governance	The Programme is led by the Trust Board who coordinate the efforts to deliver it. Within the governance structure sits a Redevelopment Board sub-committee who meet monthly, a BBF Programme Board and a working group of BBF Workstream leads who are coordinated through a Programme Office.
Community estate PMO	The Trust can leverage the governance framework in place for the BBF to support and enable the delivery of projects to the wider community estate. A central Programme Office will be required to coordinate the delivery of project by project business cases which will quantify funding requirements and set out detailed implementation plans.

Constraints and barriers

There are a number of constraints and barriers which may impact implementation. Constraints and barriers identified throughout this process will be considered in more depth within Business Cases brought forward on a project by project basis.

As with all large-scale strategic developments there will be a number of constraints and barriers which will impact the implementation of which include but not limited to the following:



Given the multi-project nature and extent of the required development programme, successful outcomes will be dependent on the Trust's financial position in any given year and each development will need to be phased and prioritised. This does not, however, change the need over time and some additional mitigating actions may need to be taken to continue to manage safety and quality in the interim.

Benefits

The strategic development of the estate will provide a number of tangible benefits for patients, staff, visitors and the wider health and social care economy. A Benefits Realisation Plan will be developed as part of the the next iteration of this Estates Strategy but at a high level it is anticipated that key benefits will include:

1	A cost effective quality estate which is safe, sustainable, efficient & fit for purpose, delivering services in the right place at the right time
2	Alignment with Trust, Regional and National objectives including the reduction of out of area placements, strengthening of community service and development of specialist services
3	Alignment with the expectation of regulators eg. NHSI/E, CQC, HSE
4	An estate that better meets the current and future needs of the population served
5	Increased level of enhancements of services in the community
6	Improved flexibility to respond to an evolving care model and to be ready for future health emergencies (e.g. a pandemic)
7	A working partnership with other providers and partner organisation across the region
8	An estate which meets national targets such as those indicated in the Carter Review and Carbon Reduction Commitment
9	Demonstrable improvements in quality and patient experience
10	Improved environmental performance (including carbon reduction)

Next Steps

Work is ongoing to understand the funding requirements and delivery timelines for many of the projects identified and will be progressed alongside the BBF as it moves towards OBC

Current project maturity	The NHP funding application is currently at SOC stage and expected to by approved in an FBC by the end of 2023. Progress of other community estate projects vary, ranging from sites in development (e.g. Dartmouth HWBC) to those which required detailed engagement, costing and development of a detailed implementation plan.
Evolution from SOC to OBC	Enabling work streams for each of the capital projects which are to be brought forward will need to be set up to determine the options for delivery, develop a plan to deliver and identifying funding and risks associated with each project. The outputs from these workstreams will enable the Trust to further refine its understanding of its capital requirements within the lifespan of this Estate Strategy, with particular focus on clinical efficiency and space utilisation.
What questions do we need to answer by OBC stage?	This SOC-level Estate Strategy sets out the strategic ambitions of the Trust and sets a vision for the future estate centred around the BBF and Health and Care Strategy for the region. The Trust will need to mature its thinking during the OBC process around the deliverability of each of the proposed projects in this strategy, and potentially others, and determine those which represent opportunities which are best value for money.
Implementation work plan - key messages	The high level steps in an implementation work plan in the next 5 years should focus on the following critical aspects: • Adding detail to the existing community estate projects to determine cost, risk and deliverability; • Identifying pools of funding which could be accessed to support and bolster the current capital funding available; • Evolve Trust thinking with regard to key priorities: elective care plans, support services, net zero carbon, key worker housing, car parking; • Collaboration between the BBF Programme office and NHS national teams to work effectively to develop MMC guidance to a point where it can be effectively implemented within projects across the estate; • Putting in place a robust governance structure to oversee the delivery of community projects, aligned to BBF Programme governance; and • Engagement with partners in the region to socialise proposed plans and explore opportunities for further collaboration. The implementation plan needs to align the Estate Strategy with the SOC's evolution to an OBC in late 2022.

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Annex A: Additional estate information

Our Estate
Our People
Our Digital

Portfolio Images (1 / 3)

The Torquay ISU houses 9 assets of which 3 are offices which house Support Services functions

Unit 2 Bay House

Use - Offices
Tenure - Leasehold
Area - 735 sqm

Torbay Hospital Annex

Use - Child Development / Office
Tenure - Freehold
Area - TBC

Torbay Hospital

Use - Acute Hospital
Tenure - Freehold
Area - 73,419 sqm

Regent House

Use - Offices
Tenure - Leasehold
Area - 2,345 sqm

St. Edmunds Centre

Use - Adult Social Care
Tenure - Leasehold
Area - 1,785 sqm

Union House

Use - Office
Tenure - Leasehold
Area - 1,405 sqm

Castle Circus Health Centre

Use - OP Clinic
Tenure - Freehold
Area - 1,249 sqm

Walnut Lodge

Use - Drug Service
Tenure - Leasehold
Area - 354 sqm

Portfolio Images (2 / 3)

An addition to the 5 community hospitals the Trust [2] clinics and [1]dental centre

Brixham Hospital

Use - Clinical Hub
Tenure - Freehold
Area - 2,713 sqm

Totnes Hospital

Use - Clinical Hub
Tenure - Freehold
Area - 3,590 sqm

Dawlish Hospital

Use - Clinical Hub
Tenure - PFI Unitary Charges
Area - 2,111 sqm

Newton Abbot Hospital

Use - Clinical Hub
Tenure - PFI Unitary Charges
Area - 7,863 sqm

Teignmouth Hospital

Use - OP Clinic
Tenure - Freehold
Area - TBC

Brixham Day Care Centre

N/A

Use - Day Care Centre
Tenure - Freehold
Area - TBC

Albany Clinic

Use - Offices
Tenure - Freehold
Area - 364 sqm

Brunel Dental Centre

Use - Dental Surgery
Tenure - Leasehold
Area - 301 sqm

Portfolio Images (3 / 3)

The Moor to Sea and Paignton & Brixham ISUs house 3 Health and Wellbeing Centres

Paignton HWBC

Use - Health & Wellbeing
Tenure - Freehold
Area - 3,382 sqm

Dartmouth HWBC

Use - OP Clinic
Tenure - Freehold
Area - 344 sqm

Ashburton HWBC

Use - OP Clinic
Tenure - Freehold
Area - 866 sqm

Hollacombe Community Resource Centre

Use - Adult Social Care
Tenure - Leasehold
Area - 1,481 sqm

Kings Ash House

Use - Offices
Tenure - Leasehold
Area - 1,147 sqm

Portfolio Summary Table (1 / 2)

Ref	Property Name	Locality	ISU	Primary Function(s)	Tenure	Length of Lease	Lease Expiry	Total Single Bedrooms
1	Torbay Hospital - Main Site	Torquay	Torquay	Acute Hospital	Freehold	-	-	420
2	Belmont Court	Torquay	Torquay	Offices	Freehold	-	-	-
3	Torbay Hospital - Annexe	Torquay	Torquay	Child Development / Offices	Freehold	-	-	-
4	Regent House	Torquay	Torquay	Offices	Leased	15 Years	28-Aug-21	-
5	Unit 7 - Storage + Offices	Paignton	Torquay	Support Services	Leased	25 Years	11-Jun-27	-
6	Castle Circus Health Centre	Torquay	Torquay	OP Clinic	Freehold	-	-	-
7	Unit 2, Bay House, Riviera Park	Torquay	Torquay	Offices	Leased	15 Years	12-Jul-20	-
8	St Edmunds Centre	Torquay	Torquay	Adult Social Care	Leased	10 years	30-Nov-27	-
9	Union House - two floors (3rd + 4th)	Torquay	Torquay	Offices	Leased	10 Years	01-Sep-22	-
10	Walnut Lodge	Torquay	Torquay	Drug Service	Leased	5 Years	01-Apr-25	-
11	Paignton Health & Wellbeing Centre	Paignton	Paignton & Brixham	Health & Wellbeing Centre	Freehold	-	-	-
12	Kings Ash House	Paignton	Paignton & Brixham	Offices	Leased	10 Years	15-Jun-26	-

Portfolio Summary Table (1 / 2)

Ref	Property Name	Locality	ISU	Primary Function(s)	Tenure	Length of Lease	Lease Expiry	Total Single Bedrooms
13	Hollacombe Community Resource Centre	Paignton	Paignton & Brixham	Adult Social Care	Leased	2 Years	18-Dec-21	-
14	Brixham Hospital	Brixham	Paignton & Brixham	Clinical Hub	Freehold	-	-	16
15	Brixham Daycare Centre	Brixham	Paignton & Brixham	Daycare Centre	Under construction	-	-	-
16	Ashburton & Buckfastleigh Hospital	Ashburton	Moor to Sea	OP Clinic	Freehold	-	-	-
17	Dartmouth Clinic	Dartmouth	Moor to Sea	OP Clinic	Freehold	-	-	-
18	Dawlish Community Hospital	Dawlish	Coastal	Clinical Hub	PFI	23 + 10 Years	22-Jun-24	16
19	Newton Abbot Hospital	Newton Abbot	Newton Abbot	Clinical Hub	PFI	25 yrs	01-Oct-34	60
20	Albany Clinic, Albany Street, Newton Abbot	Newton Abbot	Newton Abbot	Offices	Freehold	-	-	-
21	Brunel Dental Centre, Forde House	Newton Abbot	Newton Abbot	Dental Surgery	Leased	10 yrs	20-Jun-28	-
22	Teignmouth Hospital	Teignmouth	Coastal	OP Clinic	Freehold	-	-	-
23	Teignmouth Clinic	Teignmouth	Coastal	OP Clinic	Freehold	-	-	-
24	Totnes Community Hospital	Totnes	Moor to Sea	Clinical Hub	Freehold	-	-	17

Backlog Maintenance Summary Table

Total Backlog Maintenance costs Exclusive of Prelims, Contingency, Fees and VAT.

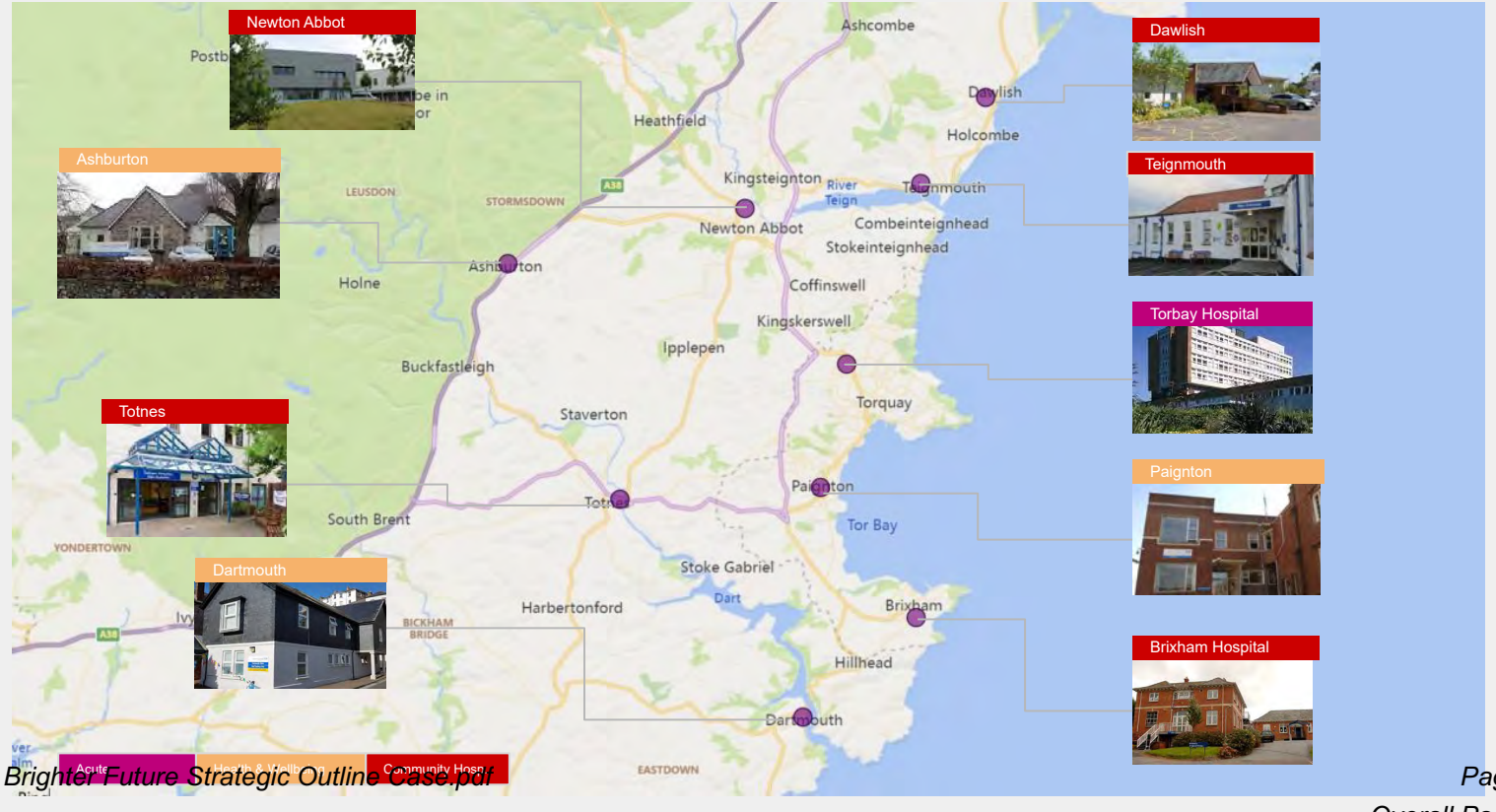
Site Name	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	Grand Total
Albany St - Main NHS Building	£111,587			£6,000		£47,000		£30,000			£10,000	£204,587
Ashburton Hospital Main Building	£1,011,082	£17,600		£31,000		£129,500			£15,000	£15,000	£33,000	£1,252,182
Brixham Hospital	£829,683	£57,000		£28,500		£68,500		£70,500	£124,000	£11,500	£243,950	£1,433,633
Castle Circus HC - Site	£502,311					£260,000		£115,000			£166,000	£1,043,311
Paignton Hospital	£3,224,395	£66,500		£119,000		£195,350		£6,900	£135,000		£224,000	£3,971,145
Teignmouth Hospital	£923,172	£46,000		£70,000		£285,000		£180,000				£1,504,172
Torbay Site	£56,288,437	£666,000	£960,550	£1,585,360	£605,550	£4,132,900	£471,370	£2,266,800	£2,097,200	£1,183,550	£3,763,050	£74,020,767
Totnes Hospital	£1,194,444	£150,000		£38,000		£135,000		£671,000	£20,000		£64,000	£2,272,444
Grand Total	**£64,085,111**	**£1,003,100**	**£960,550**	**£1,877,860**	**£605,550**	**£5,253,250**	**£471,370**	**£3,340,200**	**£2,391,200**	**£1,210,050**	**£4,504,000**	**£85,702,241**

Total Backlog Maintenance costs Inclusive of Prelims, Contingency, Fees and VAT.

Site Name	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	Grand Total
Albany St - Main NHS Building	£212,015			£11,400		£89,300		£57,000			£19,000	£388,715
Ashburton Hospital Main Building	£1,921,055	£33,440		£58,900		£246,050			£28,500	£28,500	£62,700	£2,379,145
Brixham Hospital	£1,576,398	£108,300		£54,150		£130,150		£133,950	£235,600	£21,850	£463,505	£2,723,903
Castle Circus HC - Site	£954,392					£494,000		£218,500			£315,400	£1,982,292
Paignton Hospital	£6,126,350	£126,350		£226,100		£371,165		£13,110	£256,500		£425,600	£7,545,175
Teignmouth Hospital	£1,754,026	£87,400		£133,000		£541,500		£342,000				£2,857,926
Torbay Site	£106,948,031	£1,265,400	£1,825,045	£3,012,184	£1,150,545	£7,852,510	£895,603	£4,306,920	£3,984,680	£2,248,745	£7,149,795	£140,639,458
Totnes Hospital	£2,269,444	£285,000		£72,200		£256,500		£1,274,900	£38,000		£121,600	£4,317,644
Grand Total	**£121,761,710**	**£1,905,890**	**£1,825,045**	**£3,567,934**	**£1,150,545**	**£9,981,175**	**£895,603**	**£6,346,380**	**£4,543,280**	**£2,299,095**	**£8,557,600**	**£162,834,257**

Hospitals and Health & Wellbeing Centres

The Trust portfolio serve a geographical area of 350 square miles with a resident population of over 290,000



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Our People
Our Digital

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: 2021/22 Business Planning Update			**Meeting date:** 28th July 2021
Report appendix	N/a		
Report sponsor	Deputy CEO and Chief Finance Officer		
Report author	Interim Associate Director of Strategy and Partnerships		
Report provenance	Executives		
Purpose of the report and key issues for consideration/decision	This report provides an update on the planning process which will produce plan submissions for the second half of 2021/22 and beyond.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to note progress developing plans internally and in coordination with the Devon ICS within the national planning framework for 2021/22.		

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**	3
Risk Register		**Risk score**	

Objective 3: To deliver levels of performance that are in line with our plans and national standards

External standards affected by this report and associated risks

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

Report title: 2021/22 Business Planning update		**Meeting date: 28th July 2021**
Report sponsor	Deputy CEO & Chief Finance Officer	
Report author	Interim Associate Director of Strategy and Partnerships	

1. 2021/22 Half 1 – Plan Submission

The national planning framework has divided 2021/22 into two halves for planning purposes. For this reason alongside an ambition to shift the thinking around planning to more of a rolling/ongoing process we will describe the process as "Business planning" rather than "Annual planning" going forwards.

Despite late publication of national planning guidance alongside challenges presented by the pandemic, corporate support teams successfully prepared and submitted plans for the first six months of 2021/22 in collaboration with operational teams and ICS colleagues. Plans were heavily influenced by capacity recovery targets and Devon-wide interventions, including proposals to secure national "Elective Recovery Fund" (ERF) resources to deliver additional capacity this year.

Performance, finance, workforce and improvement teams are commended for the significant effort expended, particularly in consideration of their sensitive engagement with clinical and operational leads through such challenging circumstances.

2. Half 2 – Planning process and timeline

Following submission of "Half 1" (H1) plans in June, our focus now turns to the second half of the year. The national guidance and planning timetable has indicatively been set out as follows:

Key events	Possible timings
H2 2021/22 settlement confirmed	Sept 2021
H2 2021/22 planning	Sept – Nov 2021
2022/23 preparatory work: • Review NHS block payments and system top-up baselines	By Nov 2021
Spending review outcome	Dec 2021
2022/23 planning	Jan – Mar 2022

For clarification the "Half 2" (H2) planning period runs from September 2021 to March 2022. The timetable indicates that income information will be provided after the start of the period in question and a significant degree of planning work will need to be carried out retrospectively within the period.

Key planning parameters for the second half of 2021/22:

- We are expecting ICS-led deep dives into our financial plans and CIP in late August / early September. Work is underway to prepare for this, including analysis of movements in the underlying position since the Intensive Support Team review was carried out some 20 months ago.

- While there will be significant external focus on the numbers and plans for this six month period alongside the operational management of our COVID response, we need to maintain a broader view and support teams to plan for the longer term too.

- There will be a significant focus on in-year improvement and transformation that can be implemented in advance of the BBF programme outcomes in order to:

    - Increase capacity to reduce pandemic-related waiting lists
    - Improve quality in areas where it is below expectations
    - Deliver better financial value, with a CIP requirement of around £8m recurrent benefits for this six-month period

- The Devon ICS has developed a list of 23 "impactful transformation programmes" which aim to improve the way health and care is delivered over the coming months. The ICS ambitions for these programmes are as follows:

    1. Efficient and Effective Care – ensuring evidence based care, tackling unwarranted clinical variation and improving productivity everywhere so that Devon taxpayer's money is used to achieve best value for the population
    2. Integrated Care– enhancing primary care, community, social care and voluntary and community service to provide more care and support out of hospital care Including urgent response
    3. Equally Well – working together to tackle the inequalities in the physical health of people with mental illness, learning disabilities and/or autism
    4. Children and Young People – investing more in children and young people to have the best start in life, be ready for school, be physical and emotionally well and develop resilience throughout childhood and on into adulthood
    5. Patient Led Care/the Devon-wide Deal – nurturing a citizen led approach to health and care which reduces variations in outcomes, gaps in life expectancy and health inequalities in Devon
    6. Digital Devon – investing to modernise services using digital technology

    Our organisation will have an important role to play in this alongside delivering the collaborative care model changes through the South, East and Northern Devon (SEND) Strategic Alliance.

- From a practical planning perspective, corporate support teams will need to balance the pressures that clinical and operational teams are facing while also maintaining a clear and firm focus on what is necessary to plan for sustainable and high-quality services. This will require effective leadership throughout the process from Board-level down to individual relationships between corporate support teams and clinical/operational teams.

3. Strategy Refresh

Merging the hospital and care trust in 2014 then delivering care model changes alongside integration benefits associated with the ICO has formed the major part of our strategy in recent years. Now, with a maturing ICS in Devon, the BBF programme in development, and other strategic factors influencing our community, we are refreshing our strategy. This will account for changes in the external environment and internal operations to refocus on the most important objectives to see us into a successful and sustainable future.
The refresh encompasses:

- Vision, mission and organisational goals
- Strategic objectives and enabling plans

This strategic planning will set direction for business plans in the second half of 2021/22 and beyond. The timing of this work synergises with similar exercises being undertaken by the Devon ICS and RD&E at the current time.
Early draft outputs have already been discussed with the Board and the strategy documentation will be firmed up over coming weeks before wider sharing and testing with stakeholders over the Summer.

4. Recommendations

The Board is asked to note the completion of plans for the first half of 2021/22 as previously reported, and the anticipated factors to consider in planning for the second half of this year.

Torbay and South Devon NHS Foundation Trust

Report to the Board of Directors			
Report title: Ethics Committee – Terms of Reference			**Meeting date:** 28th July 2021
Report appendix	n/a		
Report sponsor	Medical Director		
Report author	Director of Corporate Governance		
Report provenance	Reviewed Ethics Committee 8 July 2021		
Purpose of the report and key issues for consideration/decision	The Ethics Committee was re-established in April 2020 in response to the Covid-19 pandemic. Since then the Committee has met on a number of occasions to respond to ethical issues raised by individual staff, staff groups and/or the wider system. The governance process and Committee format are working well and therefore no changes of substance are suggested to the Terms of Reference; the only proposed change being to reflect the frequency of meetings under paragraph 10.2 of the attached Terms of Reference. At the most recent meeting held on 28 July 2021, the Committee agreed the Terms of Reference for approval by the Board of Directors. The Committee members were supportive of notifying the Board of its discussions at that meeting around the ongoing impact of Covid-19 in relation to end of life care and also the protection of in-patient beds for planned care.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations	The Board is asked to approve the Ethics Committee Terms of Reference.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** 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** **Risk Register** n/a; **Risk score**		

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

Torbay and South Devon
NHS Foundation Trust

ETHICS COMMITTEE

TERMS OF REFERENCE

Version:	**2.0**
Approved by:	**Ethics Committee**
Date approved:	**8 July 2021**
Approved by:	**Board of Directors**
Date approved:	**28 July 2021**
Date issued:	**28 July 2021**
Review date:	**July 2022**

ETHICS COMMITTEE
TERMS OF REFERENCE

1. Constitution

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

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

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

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

2. Authority

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

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

3. Purpose

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

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

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

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

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

4. Powers

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

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

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

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

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

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

5. Duties and responsibilities

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

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

5.3 The duties and responsibilities of the Committee shall be:

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

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

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

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

5.3.5 To consider requests by clinicians for the use of novel therapies using an evidence-based approach and to make recommendations to the Trust Medical Director or Deputy Medical Directors and Board of Directors, if appropriate.

5.3.6 To establish a clinically responsive committee to support clinicians when faced with an ethical or moral dilemma, or if making difficult clinical decisions where there are no existing clinical guidelines to refer to, or if there are specific reasons for going against existing or contradictory guidelines.

5.3.7 Where clinicians are used to making these decisions and they feel able to follow existing processes for escalating, imposing ceilings of treatment or withdrawing treatment there will be no expectation that the Panel will need to be consulted.

5.3.8 To work in partnership with the South West Regional Group and the Devon Ethical Reference Group in developing broader ethical policies for the region.

6. Membership and Attendance

6.1 Core membership shall be made up of the following:

- Executive Medical Director
- Deputy Medical Director
- Chief Nurse
- System Director of Nursing and Professional Practice
- Chaplaincy representative

6.2 The following shall attend in an advisory capacity:

- Medical Ethics Advisor
- Trust Chairman, Lay-Advisor
- Director of Corporate Governance, Governance Advisor

6.3 Members of the Committee shall be permitted to nominate a deputy to attend a meeting in their absence.

7. Chair

7.1 The Executive Medical Director shall act as Committee Chair. In their absence, Chief Nurse shall be appointed as acting Chair for the meeting.

8. Meeting Administration

8.1 The Committee shall be supported by the Director of Corporate Governance (or their nominee), whose duties in this respect will include:

(i) Issuing the meeting agenda and reports.
(ii) Keeping a record of decisions made.
(iii) Ensuring matters requiring notification to the Trust Board are actioned.

9. Quorum

9.1 The quorum necessary for the transaction of business shall be 3 members, of which the Executive Medical Director or Chief Nurse must be present.

9.2 Deputies shall count towards the quorum.

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

10. Frequency of Meetings

10.1 The Committee shall meet as and when required but at least on a bi-annual basis.

11. Meetings

11.1 The agenda will be sent out to the Committee members at least three days prior to the meeting date, together with any other associated papers.

11.2 Urgent items may be raised under ‘any other business’.

11.3 Meetings, other than those regularly scheduled as above, shall be summoned by the Committee Secretary at the request of the Chair.

12. Reporting

12.1 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes shall be presented to the next meeting for approval.

12.2 An annual report will be presented by the Committee Chair to the Trust Board.

12.3 The Chair of the Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

13. Conduct of Meetings

13.1 Except as outlined above, meetings shall be conducted in accordance with the provisions of the Trust's Standing Orders.

14. Review

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

14.2 The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

15. Monitoring Effectiveness

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

- the objectives set out in section 3 were fulfilled; and
- agenda and associated papers were distributed three days prior to the meeting taking place.

Appendix 1: Reporting Structure